Scottish Borders Health and Social Care PARTNERSHIP

HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD MONDAY, 20TH JUNE, 2016

A MEETING of the HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD will be held in the BOARD ROOM, NHS BORDERS, NEWSTEAD on MONDAY, 20 JUNE 2016 at 2.00 pm

BUSINESS			
1.	**ANNOUNCEMENTS & APOLOGIES**		
2.	**DECLARATIONS OF INTEREST**		
3.	**MINUTES OF PREVIOUS MEETING** (Pages 1 - 10) Monday 18 April 2016		3 mins
4.	**MATTERS ARISING** (Pages 11 - 14) Action Tracker		5 mins
5.	**STRATEGIC**		40 mins
	5.1 **Integrated Care Fund Update**	(Pages 15 - 32)	
	5.2 **Revised Governance Arrangements for Integrated Care Fund**	(Pages 33 - 38)	
	5.3 **The Localities Framework for Integrated Health & Social Care**	(Pages 39 - 50)	
	5.4 **Draft: Health & Social Care Integration Partnership Mainstreaming Report and Equality Outcomes 2016/17**	(Pages 51 - 62)	
	5.5 **Delayed Discharges**	(Pages 63 - 110)	
6.	**GOVERNANCE**		30 mins
	6.1 **Draft Corporate Services Support Plan Update**	(Pages 111 - 118)	
	6.2 Clinical & Care Governance Framework	(Pages 119 - 128)	
	6.3 **Appointments to Sub-Committees/Groups**	(Pages 129 - 144)	
	6.4 **Health & Social Care Shadow Integration Board Annual Report 2015/16**	(Pages 145 - 158)	

7.	**FINANCE**		40 mins
	7.1 **Monitoring of the Joint Integrated Budget 2015/16**	(Pages 159 - 170)	
	7.2 **Delegated Functions 2016/17 Finance Plan Level of Investment and Savings**	(Pages 171 - 206)	
	7.3 **2016/17 Finance Plan - Social Care Funding**	(Pages 207 - 226)	
	7.4 **Alcohol & Drugs Partnership Funding 2016/17**	(Pages 227 - 250)	
8.	**FOR INFORMATION**		
	8.1 **Communications Quarterly Report**	(Pages 251 - 254)	
	8.2 **Chief Officer's Report**	(Pages 255 - 260)	
	8.3 **Committee Minutes**	(Pages 261 - 266)	
	8.4 **NHS Borders Pharmaceutical Care Services Plan 2016/17**	(Pages 267 - 318)	
9.	**ANY OTHER BUSINESS** Welcome to your Emergency Department Leaflet – available in all Health Centres and GP Practices		5 mins
10.	**DATE AND TIME OF NEXT MEETING** Monday 15 August at 2.00pm in Committee Room 2, Scottish Borders Council		

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

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

Minutes of a meeting of the **Health & Social Care Integration Joint Board** held on Monday 18 April 2016 at 2.00pm in Committee Room 2, Scottish Borders Council.

Present:	(v) Cllr C Bhatia (Chair)	(v) Mrs P Alexander
	(v) Cllr J Mitchell	(v) Mr J Raine
	(v) Cllr F Renton	(v) Mr D Davidson
	(v) Cllr I Gillespie	(v) Dr S Mather
	Mrs E Torrance	(v) Mrs K Hamilton
	Mrs S Manion	Mrs E Rodger
	Mr D Bell	Mr J McLaren
	Miss J Miller	Ms L Gallacher
	Mr A Leitch	Dr A McVean
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mr P McMenamin	Mrs T Logan
	Mrs J McDiarmid	Ms S Campbell
	Dr E Baijal	Mrs J Smyth
	Mrs K McNicoll	Mrs J Stacey
	Mrs C Gillie	Mr A Pattinson

1. Apologies and Announcements

Apologies had been received from Cllr Jim Torrance, Dr Andrew Murray, Dr Annabel Howell and Mrs Angela Trueman.

The Chair welcomed Andrew Leitch to the meeting who was deputising for Mrs Trueman.

The Chair welcomed Lynn Gallacher to the meeting who had replaced Fiona Morrison as the Carers Representative on the Health & Social Care Integration Joint Board.

The Chair confirmed the meeting was quorate.

The Chair welcomed members of the public to the meeting.

The Chair confirmed that there would be a short private meeting at the conclusion of the public meeting.

2. 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 there were none.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 7 March 2016 were amended at page 4 line 1 replace “muted” with “mooted” and with that amendment the minutes were approved.

The minutes of the Extra Ordinary Health & Social Care Integration Joint Board held on 30 March 2016 were approved.

4. Matters Arising

4.1 Code of Corporate Governance: Dr Stephen Mather suggested a member of the Health & Social Care Integration Joint Board attend the NHS Borders Clinical Governance Committee. Mrs Susan Manion advised that she would bring the Terms of Reference of the Health & Social Care Group to the next meeting. The purpose of that group would be to oversee the reports submitted to the Health & Social Care Integration Joint Board from both Scottish Borders Council and NHS Borders which she anticipated would resolve the matter raised.

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

5. Housing Contribution Statement

Mrs Susan Manion gave an overview of the content of the statement recognising the importance of housing in supporting the strategic plan and future planning needs of the population.

Cllr Frances Renton welcomed the statement and commented that there were a number of objectives within the plan and that housing was important to everybody.

Miss Jenny Miller noted that the objectives that flowed from the strategic plan did not correlate to those in the housing contribution statement and she suggested they be aligned to ensure consistency. She further enquired about the timescale for production of the 2016 statement. Mrs Manion advised that she would check the timescale for production.

Mrs Elaine Torrance welcomed the statement and highlighted the importance of adaptations to housing in terms of accessibility for the disabled, older people and those with learning difficulties.

The Chair suggested an opportunity for the future might be the utilisation of private sheltered housing which sat on the market for extended periods and could potentially prove more cost effective than building new houses.

Mrs Karen Hamilton enquired about the preventative element given that it was only the excessively critical needs that were currently covered. Mrs Torrance confirmed that there was limited funding for adaptations and the resources were therefore targeted to individuals in most need. She commented that it was a challenge for housing to build adaptable homes.

Mr David Davidson suggested it would be a matter for the registered social landlords to become involved in and the Chair confirmed that they were used as a delivery model alongside the council building programme. Mrs Manion noted that some of the capital referred to in the integrated care fund was used to support the joint borders ability equipment store in the provision of adaptations.

Cllr John Mitchell sought clarification of the measurement of outcomes. Mrs Manion advised

that the indicators within the strategic plan were applicable to make the cross reference to housing and she expected the housing contribution to produce specific plans for development, what would be different in the future and how that evidenced against the outcomes.

Mrs Pat Alexander asked to see how it correlated in locality terms in order to aid planning. The Chair suggested the fuller Strategic Housing Plan be circulated to the Health & Social Care Integration Joint Board as it contained the finer detail.

Mr John McLaren welcomed the report and commented that it helped to understand very easily the issues and commitment that housing were making. Mr McLaren sought clarity on, housing improvement allocations in terms of stock and quality of housing and also enquired if there was a consistent approach within housing associations in terms of the amount of support they gave their tenants. The Chair commented that the allocation of funding was prorata to the housing stock and did not encompass quality of stock. Mrs Manion suggested housing be a topic for a future development session to increase the knowledge of the Health & Social Care Integration Joint Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Scottish Borders Housing Contribution Statement and endorsed its submission with the Strategic Plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to schedule "Housing" as a topic for a future Development session.

6. Integrated Care Fund – Progress Update

Mrs Susan Manion gave an overview of the content of the update.

Mr John Raine expressed concern in regard to the projects and governance arrangements for the integrated care fund. He was unaware that the Health & Social Care Integration Joint Board had agreed to the total commitment of the £6.39m over 3 years. He sought greater clarity on what the £6.39m would purchase, what would be achieved and if it was viewed as a priority for the Health & Social Care Integration Joint Board. In terms of accountability he sought clear financial governance by the Health & Social Care Integration Joint Board for the approval of projects above a certain financial level, supported by documentation that clearly set out the projects contribution to meet the objectives in relation to the strategic plan, cost, sustainability and exit strategy.

Mrs Manion highlighted the governance arrangements detailed at Appendix 3 to the paper which was an attempt to simplify a cumbersome and bureaucratic system. She was clear in relation to the approved projects that they had been through a rigorous process in relation to the analysis of the criteria, analysis of where they sat in relation to outcomes and exit strategies. She confirmed that all additional posts/resources were short term contracts.

Mr David Davidson recalled that it had been previously agreed that the Health & Social Care Integration Joint Board would receive 6 monthly updates on which projects were progressing well and which were not and why. He did not recall the Health & Social Care Integration Joint Board delegating up to £500k without any reference to the Health & Social Care Integration

Joint Board itself or that the Chair or Vice Chair could sit in judgement on behalf of the Health & Social Care Integration Joint Board.

Dr Stephen Mather shared Mr Raine and Mr Davidson's concerns. He suggested that the integrated care fund had not been used for targeted planning and wished confirmation that proposals had been through a full robust business case to ensure monies were targeted better to give proper outcomes.

The Chair shared similar concerns and noted a key piece of missing information was how the projects would be mainstreamed. She commented that whilst the Change Fund had had its difficulties the learning from that process should be used to inform the process for the integrated care fund to ensure information was presented in an understandable, meaningful and straightforward way.

Mrs Jane Davidson commented that the Executive Management Team were also of the view that governance arrangements required revision. She advised that Mr David Robertson had been charged with simplifying the arrangements. In future she would expect the Executive Management Team to review all identified projects and for the Health & Social Care Integration Joint Board to be asked to approve, consider and endorse both those projects above and below the financial threshold provided they clearly stipulated the targeting of outcomes, mainstreaming and exit strategy.

Further discussion focused on: assurance from officers; the success of project My Home Life (training for managers in care homes); linking outcomes from projects to the strategic plan outcomes; engagement with GPs; interface with specialist contracted GPs; a 1% shift in resource; return on investment; shift in emergency admissions; provision of more care at home; and the role of internal audit.

Mrs Tracey Logan summarised that the integrated care fund had been operated as per an agreement reached some time ago, she assured the Health & Social Care Integration Joint Board that projects were scrutinised and outcomes were clear. She further commented that the integrated care fund was not as joined up strategically as the Health & Social Care Integration Joint Board would prefer and she appreciated that the Health & Social Care Integration Joint Board had not had the visibility of projects that it required. Mrs Logan suggested a full report be submitted to the next meeting of the Health & Social Care Integration Joint Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and agreed to accept a full report at its next meeting on 20 June 2016.

7. NHS Borders Local Delivery Plan 2016/17

Mrs June Smyth presented the NHS Borders Local Delivery Plan (LDP) for 2016/17 and advised that all Health Boards were required to provide an LDP ever year as per the contract between the Health Board and the Scottish Government. Health Boards were asked to engage with their Health & Social Care Integration Joint Boards over the development of the LDP. She assured the Health & Social Care Integration Joint Board that those officers/services that fell within the realm of the Health & Social Care Integration Joint Board had been involved in the development of LDP.

Mrs Jeanette McDiarmid assured the Health & Social Care Integration Joint Board that as the Chair of the Reducing Inequalities strand of the Community Planning Partnership the LDP had synergy with reducing inequalities.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the work in progress and agreed to provide feedback/comments on the NHS Borders Draft Local Delivery Plan 2016/17 to June Smyth by 25 April 2016.

8. Issue of Directions from Integration Joint Board 2016-17

Mrs Susan Manion commented that in future the discussion of direction from the Health & Social Care Integration Joint Board to NHS Borders and Scottish Borders Council would come before the end of one financial year and the beginning of the next.

Mr John Raine sought assurance that the directions were in line with guidance and legislation. Mr Paul McMenamin assured the Health & Social Care Integration Joint Board that whilst the directions were not detailed there were in line with guidance and legislation and a business and usual approach was expected. He provided assurance that the basis on which the resources and functions were delegated was detailed in the baseline direction.

Further discussion highlighted: the wording at item 3.1 of the cover paper was loose; confirmation that at the last Health & Social Care Integration Joint Board meeting there had been agreement to 50% of £5.267m social care funding to be allocated to Scottish Borders Council to address the living wage, etc and the remaining 50% to be held for the Health & Social Care Integration Joint Board to direct its use; more narrative on savings requirements; cost of living wage and any potential recurrent funding; and a combined efficiency plan.

Mr McMenamin clarified that within the financial statement NHS Borders delegated £92.4m (including £5.2m social care fund) and Scottish Borders Council delegated £46.5m. Within the partners respective financial plans NHS Borders clearly showed expenditure of £87m plus the £5.2m social care fund and Scottish Borders Council showed expenditure of £51.8m inclusive of the £5.2m social care fund. Mr McMenamin explained that the £5.2m would be used to address demographic pressures and the living wage, etc as per the John Swinney letter and approximate costs were estimated to be £2m-3m. He confirmed that the balance of that fund (50%) would remain uncommitted and for the Health & Social Care Integration Joint Board to determine its best use.

Mr David Davidson suggested the wording around the social care fund money of £5.2m was clumsy as it intimated that the monies were being double counted and he sought assurance

that it would be protected as funds for the Health & Social Care Integration Joint Board to direct as it felt appropriate.

The Chair commented that further advice and guidance over the direction of the use of the social care funding was anticipated.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Directions and instructed the Chief Officer to issue those on behalf of the Health & Social Care Integration Joint Board.

9. Health & Social Care Integration – Commissioning and Implementation Plan

Dr Eric Baijal gave a detailed overview of the content of the paper.

During discussion several observations were made including: the need for timescales for the 9 local objectives; supporting documentation in terms of specific measurables; analysis of current activity; wider engagement through the Joint Staff Forum and other existing groups; feedback from users and carers in terms of qualitative data and performance reporting; strengthen local objective 9 in terms of the Carers Bill; local objective 8 to be more ambitious in line with the health inequalities plan; and recognising the wellbeing of all staff across the partnership.

Mrs Jane Davidson left the meeting. Mrs Evelyn Rodger left the meeting.

Dr Angus McVean welcomed the document and the interlinking of primary care with other services. He cautioned against tying colleagues to services they no longer provided or would not wish to provide. He noted that local objective 9 in regard to carers had been an enhanced service however that was no longer the case and whilst many GPs continued with it, some did not as it was not a contractual obligation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the work that had been undertaken to develop the Commissioning and Implementation Plan and approved the approach to its continued development.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** confirmed that the priorities, and actions to address them, were in line with expectations and the overall strategic direction.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** recognised that further adjustment would be made to the document in light of comments received and as progress was made and engagement took place on specifics.

Cllr Frances Renton left the meeting.

10. Draft Performance Management Framework

Mrs Susan Manion gave an overview of the content of the paper.

Dr Stephen Mather questioned the indicator for National Health and Wellbeing Outcome 6 on page 9. Mrs Manion advised that the indicators had been provided in terms of the national

indicators that existed and had been identified as a local priority and she accepted it was an issue in terms of how it was described.

The Chair advised that she would raise the matter at the next Health & Social Care Integration Joint Board Chairs meeting.

Further discussion focused on: staff governance standard and identification of more measurables; indication of data sources as referred to in the strategic plan; and engagement with carers families and communities to gain feedback;

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the draft Performance Management Framework to enable further progress.

11. Monitoring of the Integrated Budget 2015/16

Mr Paul McMenamin presented the exception report for 2015/16 to the end of February 2016. He advised the projected net pressure of £678k had been mitigated and off-set. Areas of concern continued to be GP prescribing, on-going pressure in social care with older people and residential home care demand exceeding contractual arrangements. There continued to be vacancy management across a range of services and delivery of cash efficiency targets in year.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the reported projected position of £0.678m net pressures within the shadow delegated budget at 29 February 2016.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** 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 overspend.

12. Financial Statement 2016/17 – Overview of Due Diligence Process

Mr Paul McMenamin gave an overview of the follow on report to that provided to the Health & Social Care Integration Joint Board on 30 March to provide assurance over resources. He confirmed that the report outlined in full the process of due diligence followed in order to provide assurance over the sufficiency of resources delegated for 2016/17.

Mr John Raine sought assistance in understanding the comparison in outturn budgets. He referred to the Scottish Borders Council due diligence summary and noted the 2015/16 projected outturn was £48m which he assumed was due diligence savings historically, however the baseline budget was £46m and he wished to understand how those figures were reconciled. He further queried why the “social care fund not delegated by SBC” figure was included in the statement.

Mr McMenamin clarified that the social care fund including expenditure plans was for the Health & Social Care Integration Joint Board to determine the use of. The net bottom line contained considerable investment within the social care budget as well as planned efficiency savings. In previous reports to SBC there had been a trend of flat financial settlement and for 2016/17 there would be a reduction of funding overall. He explained that SBC had put forward savings in social care areas and a programme of efficiencies and had identified £2,663m of savings across SBC planned for next year. There was also £1.4m worth of investment and pressures so there was a net reduction in the social care budget when compared to previous years and that was demonstrable by the pressures on council funding. He confirmed that there were plans in place to deliver those efficiencies.

Mr Raine accepted that the net figure took account of the efficiency savings and he again questioned why the "social care fund not delegated by SBC" featured on the spreadsheet. Mr McMenamin agreed that the figure had been included in the total planned expenditure figure and was subsequently shown separately. He reiterated that a proportion (50%) of that social care fund would be used to address the cost of the living wage and increased charging thresholds and increased demand for services given demographic pressures. He further commented that the £46m baseline budget would increase considerably and he anticipated seeing a budget in excess of historical budgets in the next financial year.

Mr David Davidson sought clarification that on the basis of the explanation provided the £46m net figure included £2.3m of the social care funding, with the remaining £2.7m set aside for the Health & Social Care Integration Joint Board to determine its use, which meant the next figure would be as low as £46m but would be increased by £2.7m being the remaining social care fund balance. Mr McMenamin confirmed the assumption was correct.

Mrs Carol Gillie emphasised to the Health & Social Care Integration Joint Board that it was a complex matter and she suggested a simpler presentation of the level of investment and savings be produced for the Health & Social Care Integration Joint Board.

Cllr John Mitchell queried if the £4.7m savings to be allocated to the Health & Social Care Integration Joint Board was a proportional share of the efficiency target that NHS Borders expected to achieve. Mr McMenamin confirmed that the proportion delegated to the Health & Social Care Integration Joint Board was £4.239m.

Cllr Mitchell enquired if there was a breakdown of how that figure was determined during the period that budgets were aligned between the partners. Mr McMenamin confirmed that a breakdown was available and had been used as part of the due diligence process.

Cllr Mitchell requested to see the breakdown month on month. Mr McMenamin confirmed that it would be included in the monthly financial monitoring report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the due diligence process undertaken to provide assurance over the 2016/17 delegated budget.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the concluded position that based on all known factors at the time of setting budgets for the areas delegated, that there were no identified recurring pressures of a significant nature that had not been addressed as part of the 2016/17 or prior financial planning processes.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a report on the options for direction of £5.267m health and social care funding by the partnership would be made to the Health & Social Care Integration Joint Board in June 2016.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a full Schedule of Payments between the Health & Social Care Integration Joint Board and its partners would be reported on conclusion of all financial activity prior to the production of annual statutory accounts at the end of 2016/17.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the proposed budgetary control reporting basis for 2016/17.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive an abridged version of the level of investment and savings for the functions delegated to it by SBC and NHS Borders.

13. Update: Financial Governance and Management Arrangements

Mr Paul McMenamin gave an overview of the content of the paper.

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 was required to be in place prior to 1 April 2016.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the plan of actions for the remaining work requiring completion and approval before and beyond 1 April 2016.

14. Chief Officer's Report

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

15. Committee Minutes

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

16. Any Other Business

16.1 Health & Social Care Integration Joint Board Development Session: Mrs Susan Manion advised the Health & Social Care Integration Joint Board that the development session to be held on Monday 23 May would be an all day event in Kelso. The logistics for the day were being drawn up and the intention would be for Health & Social Care Integration Joint Board members to meet with staff, hear about the Cheviot project, integration and added value as well as visiting some of the local health and care facilities.

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

16.2 Inspection of Adult Services: Mrs Tracey Logan advised the Health & Social Care Integration Joint Board that there would be a forthcoming inspection of adult services and she enquired if the Health & Social Care Integration Joint Board wished to have a development session on adult services and service evaluation in the near future.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed Adult Services feature as a future Development session topic.

17. 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 20 June 2016 at 2.00pm in the Board Room, Newstead, NHS Borders.

The meeting concluded at 4.21pm.

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	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

Meeting held 18 April 2016

Agenda Item: Housing Contribution Statement

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to schedule "Housing" as a topic for a future Development session.	Susan Manion Cathie Fancy	2016	**In Progress:** Housing scheduled as discussion topic for networking lunch on 15 August 2016.	A

Agenda Item: Integrated Care Fund – Progress Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
3	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and agreed to accept a full report at its next meeting on 20 June 2016.	Susan Manion Paul McMenamin	20 June 2016	**Complete:** Item scheduled for 20 June 2016 Health & Social Care Integration Joint Board meeting.	G

Agenda Item: NHS Borders Local Delivery Plan 2016/17

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
4	7	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the work in progress and agreed to provide feedback/comments on the NHS Borders Draft Local Delivery Plan 2016/17 to June Smyth by 25 April 2016.	ALL	25 April 2016	**Complete:** Health & Social Care Integration Joint Board members were asked to pass comments directly to June Smyth.	G

Agenda Item: Financial Statement 2016/17 – Overview of Due Diligence Process

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
5	12	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive an abridged version of the level of investment and savings for the functions delegated to it by SBC and NHS Borders.	Paul McMenamin Carol Gillie	20 June 2016	**Complete:** Item scheduled for 20 June 2016 Health & Social Care Integration Joint Board meeting.	G

Agenda Item: Any Other Business: Inspection of Adult Services

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
6	16	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed Adult Services feature as a future Development session topic.	Susan Manion Elaine Torrance	2016	**In Progress:** Inspection of Adult Services scheduled as discussion topic for networking lunch on 17 October 2016.	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

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INTEGRATED CARE FUND UPDATE AT 31ST MAY 2016

Aim

1.1 The aim of this report is to provide IJB members with an update on the partnership's Integrated Care Fund (ICF) Programme and further detail on those projects approved to date in terms of their cost commitments and targeted outcomes.

Background

2.1 Integrated Care Funding was first allocated to the shadow partnership in 2015/16. The ICF commenced on the 1st April 2015 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of £6.39m over the 3 years of the programme. During this year, a number of projects were approved by the partnership through the governance structure in place at that time. Of the £2.13m allocated for 2015/16, £224k was spent by the partnership in 2015/16 and a further £94k to date in 2016/17, a combined total of £318k to date.

Current Position

3.1 Overall, 14 projects, projected to cost £1.621m have been commissioned as part of the ICF programme to date. In summary, these are:

Table 1 – Summary of 3-Year Resource Requirements of ICF Projects Approved to 31.05.16

		£'000
1	Programme delivery	220
2	Independent Sector representation	94
3	Transport Hub	139
4	Health Improvement (*phase 1*)	19
5	Transitions	65
6	Community Capacity Building	400
7	Mental Health Integration	38
8	My Home Life	71
9	Delivery of the Autism Strategy	99
10	Stress & Distress Training	166
11	Delivery of the ARBD pathway	102
12	BAES Relocation	100
13	Community Ward delivery(18mth pm, pso)	54
14	Health Care & Co-ordination (18mth pm, pso	54
	Total Approved to date	**1,621**

3.2 Each of these projects is outlined in in **Appendix 1** to this report where further detail of their planned timeframes, aims and objectives, progress in their delivery to date and funding requirement is provided.

3.3 **Appendix 2** of the report maps in detail how each particular project will deliver its contribution to both the National Health and Wellbeing Outcomes and more

specifically, the partnership's local strategic objectives as outlined within its Strategic Plan.

The Way Forward

4.1 Service redesign is a key priority of the Health and Social Care partnership's plans going forward and clear themes are emerging as to what models of care, delivery structures and targeted priorities are required in order to achieve the Partnership's strategic aims and local objectives. It is in funding the transformational shift to these models, structures and priorities that the enabling financial resources and in particular, the ICF, can deliver the greatest benefit.

4.2 A number of other projects within the programme therefore are currently being developed to support this this shift, at varying levels of development and approval within the fund's governance structure. In totality however, these proposals are being planned to deliver the partnership's new model and the development of new, improved pathways of care, a locality model for planning and delivering health and social care and meeting the expectations of the Scottish Government in terms of how the funding should be directed.

4.3 As the transformation programme develops, further reports will be brought forward to the IJB in order to ensure that a clear picture of each element of the partnership's plans is formed, in addition to an overall view, a picture that will consider not only how Integrated Care Funding is being used, but how all funding available to the partnership including its core delegated budget, large hospital budget set-aside, social care funding and change fund will support its delivery and enable future mainstreaming of the new delivery models.

Summary

5.1 As the Partnership's vision for health and social care integration develops and key themes for new models of care, delivery structures and key priorities emerge, the ICF programme continues to form in order to resource and deliver the transformation required.

5.2 To date £1.621m of the ICF has been committed, although of this, only £318k has been spent to date. Work is continuing to develop further proposals that will enable transformation to new models of health and social care. As progress is made, further reports over this delivery, the required temporary (transformational) and permanent (mainstreaming) resource requirements and expected priorities for investment and disinvestment will be made to the IJB.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and the progress made to date in the development of the partnership's transformation programme, in particular, those projects funded from within its Integrated Care Fund programme.

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
Susan Manion	Chief Officer, Health & Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	IJB Chief Financial Officer		

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INTEGRATED CARE FUND UPDATE AT 31ST MAY 2016

Aim

1.1 The aim of this report is to provide IJB members with an update on the partnership's Integrated Care Fund (ICF) Programme and further detail on those projects approved to date in terms of their cost commitments and targeted outcomes.

Background

2.1 Integrated Care Funding was first allocated to the shadow partnership in 2015/16. The ICF commenced on the 1st April 2015 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of £6.39m over the 3 years of the programme. During this year, a number of projects were approved by the partnership through the governance structure in place at that time. Of the £2.13m allocated for 2015/16, £224k was spent by the partnership in 2015/16 and a further £94k to date in 2016/17, a combined total of £318k to date.

Current Position

3.1 Overall, 14 projects, projected to cost £1.621m have been commissioned as part of the ICF programme to date. In summary, these are:

Table 1 – Summary of 3-Year Resource Requirements of ICF Projects Approved to 31.05.16

		£'000
1	Programme delivery	220
2	Independent Sector representation	94
3	Transport Hub	139
4	Health Improvement (*phase 1*)	19
5	Transitions	65
6	Community Capacity Building	400
7	Mental Health Integration	38
8	My Home Life	71
9	Delivery of the Autism Strategy	99
10	Stress & Distress Training	166
11	Delivery of the ARBD pathway	102
12	BAES Relocation	100
13	Community Ward delivery(18mth pm, pso)	54
14	Health Care & Co-ordination (18mth pm, pso	54
	Total Approved to date	**1,621**

3.2 Each of these projects is outlined in in **Appendix 1** to this report where further detail of their planned timeframes, aims and objectives, progress in their delivery to date and funding requirement is provided.

3.3 **Appendix 2** of the report maps in detail how each particular project will deliver its contribution to both the National Health and Wellbeing Outcomes and more

specifically, the partnership's local strategic objectives as outlined within its Strategic Plan.

The Way Forward

4.1 Service redesign is a key priority of the Health and Social Care partnership's plans going forward and clear themes are emerging as to what models of care, delivery structures and targeted priorities are required in order to achieve the Partnership's strategic aims and local objectives. It is in funding the transformational shift to these models, structures and priorities that the enabling financial resources and in particular, the ICF, can deliver the greatest benefit.

4.2 A number of other projects within the programme therefore are currently being developed to support this this shift, at varying levels of development and approval within the fund's governance structure. In totality however, these proposals are being planned to deliver the partnership's new model and the development of new, improved pathways of care, a locality model for planning and delivering health and social care and meeting the expectations of the Scottish Government in terms of how the funding should be directed.

4.3 As the transformation programme develops, further reports will be brought forward to the IJB in order to ensure that a clear picture of each element of the partnership's plans is formed, in addition to an overall view, a picture that will consider not only how Integrated Care Funding is being used and specific proposals will be brought to the next meeting. It is crucial to ensure the IJB sees the context for each project and is also able to see how all funding available to the partnership including its core delegated budget, large hospital budget set-aside, social care funding and change fund will support its delivery and enable future mainstreaming of the new delivery models.

Summary

5.1 As the Partnership's vision for health and social care integration develops and key themes for new models of care, delivery structures and key priorities emerge, the ICF programme continues to form in order to resource and deliver the transformation required.

5.2 To date £1.621m of the ICF has been committed, although of this, £318k has been spent to date. Work is continuing to develop further proposals that will enable transformation to new models of health and social care. As progress is made, further reports over this delivery, the required temporary (transformational) and permanent (mainstreaming) resource requirements and expected priorities for investment and disinvestment will be made to the IJB.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and the progress made to date in the development of the partnership's transformation programme, in particular, those projects funded from within its Integrated Care Fund programme.

The Health & Social Care Integration Joint Board is asked to **note** there will be a fulsome report to the next meeting on the wider investment towards the delivery of the strategic plan with specific plans for service redesign in keeping with the commissioning and implementation plan.

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
Susan Manion	Chief Officer, Health & Social Care Integration		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	IJB Chief Financial Officer		

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Appendix 1 – Integrated Care Fund Projects Approved to Date

Project	Objectives	Benefits Realised (ROI)		Progress	Sustainability	Funding
		Contribution to National Health and Wellbeing Outcomes	Contribution to Local Strategic Objectives			
ICF Project Delivery April 2015 - March 2016	To allocate the Integrated Care Fund in line with the ICF Plan 2015-18	• Providing support to all ICF projects in order to assist them in the delivery of their outcomes. • The team therefore contributes to all National Health and wellbeing outcomes and Local Strategic Objectives.		13 Projects are in progress and 3 are being supported to produce project briefs for appraisal. The governance structure is under review and the projects are under scrutiny for their performance and alignment the Strategic Plan. A resource has been secured to assist the projects with their monitoring and evaluation.	One off cost for the term of the ICF Funding. No ongoing costs.	£219,563
Independent Sector Representation April 2015 – March 2018	The provision of Independent Sector advice to the programme.	Outcome 4 • Training/educating care providers • Providing tools to assist delivery • Working with the service users	Objective 2 • Training/educating care providers • Providing tools to assist them in prevention and early interventions • Assisting providers in delivery of new models of care • Working with partners in gaining trust	Progress has been made in 3 key areas – the review of care assistants training needs, the setup of a second rapid reaction team from a care home and the development of the My Home Life Project.	One off cost for the term of the ICF Funding. No ongoing costs.	£93,960
Transport Hub	Putting in place a co-ordinated, sustainable	Outcome 1 • Simplification of	Objective 9 • Providing a more	Improvements have been	The project will be part of a bigger review of	£139,000

April 2015-March 2017	approach to community transport provision.	accessing transport to health services • Greater levels of support for users	efficient service with better utilisation of vehicles • Reduced duplication of journeys • Better coordination with planned facilities discharge.	reported around ease of use, appropriate transport provision, better vehicle utilisation, greater partnership working, improvement of the skill of the volunteer base and respite provision for carers.	transport provision in the Borders with a primary aim of being sustainable.	
Health Improvement, Self-Management Phase 1 September 2015 – June 2016	To improve shared management of LTCs amongst older people (Phase One). The new proposal (Phase Two) extends the basic concept to include all adults with Long Term Conditions (LTC's), including those with multiple conditions, so learning from experience and maximising the use of short-term funding.	Outcome 1 & 2 • Promoting shared management of existing conditions • Helping to bridge the gap between community and acute care • Development of knowledge, skills, pathways and processes • Supporting and enabling carers to look after their health	Objective 2 by • Equipping practitioners to build health improving measures into their assessments • Integrated anticipatory, treatment and recovery/re-ablement care plans • Supporting people to live well with their conditions	Phase 1 of this project is underway and showing improvement in service with 49% of people questioned rating the service as good and 50% rating the service as Excellent. This project has also evidenced a 10% improvement in wellbeing scores across the project.	The project will end with no ongoing costs as all the changes will have become business as usual.	£19,000 (for the extension to phase 1.)
Transitions August 2015 – May 2018	This project will focus upon young people who have a diagnosed learning disability between the ages of 14 and 21 who are moving	Outcome 3 • Ensuring people receive the correct information at the right time • Giving timely	Objective 7 • Creating a clear transitions pathway, accessible to all partners including	Planning is underway for the delivery of this project, which should commence fully in June 2016.	The project would specify that recommendations must be achieved within the existing resources across	£65,200

	towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education.	collaborative assessment and support plans	young people and their carers.		services. This may mean disinvestment in one area and re investment in another. More efficient and effective pathways for the customer would also have a positive impact upon staffing resources	
Borders Community Capacity Building September 2015 – May 2018	To develop a series of community support projects to bring together services and to support further development and growth of local services and activities.	• Outcome 1 Encouraging people to engage and participate in activities • Improving their mental and physical wellbeing • Reducing isolation	Objective 1 • Encouraging and supporting communities to create and run their own services.	BCCB have reported an increase in the number of people, from different communities, becoming engaged in physical activities and being more active in their communities. They are also reporting an improvement in their participants physical and mental wellbeing.	Projects initiated by this Team during the term of the ICF funding should be self-sustaining by 2018.	£400,000
Mental Health Integration – April 2015 – October 2015 **Project now complete**	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.	Outcome 9 • Integrating social work into the community • Reduce duplication • Ensuring referrals are managed effectively	Objective 5 • Providing support to admin staff and team managers • Ensuring effective and efficient delivery of social work services within an integrated model.	This project is now complete and has reported improvement in the service provided to patients, working relationships and communications. It has also reported a reduction in duplication of work. A final project evaluation evidencing this improvement is currently being developed.	One off cost to implement a new integrated model of service delivery.	£37,500
My Home Life	A fourteen month programme of	Outcome 4 • Educating and	Objective 3 • Providing different	This project is underway and delivering training to care	One off project – no ongoing costs.	£71,340

January 2016 – February 2017	leadership support and training to help improve quality of life in care homes.	providing tools to assist care homes in delivery of service improvements • Ensuring that staff are trained to the same level of competency. Developing care homes to provide different models of care	models of care supporting the discharge agenda and prevention of admission to hospitals	home Managers. A full evaluation against their identified outcomes will be undertaken in January 2017.		
Delivery of the Autism Strategy April 2016 – August 2018	Delivery of all of the work streams within the Borders Autism Strategy.	Outcome 3 • Improving awareness and understanding of the needs of those with autism	Objective 2 • Improving awareness and understanding of the needs of those with autism • Ensuring that those with autism receive the right support at the earliest opportunity	A project initiation document has been produced and the project delivery planned.	One off cost to deliver the Autism Strategy.	£99,386
Delivery of Stress and Distress Training July 2015 –	Stress & Distress Training provides training in an individualised, formulation driven approach to understanding and intervening in stress	Outcome 8 • Providing training to over 700 staff • Improve the experience, care, treatment and outcomes for people with	Objective 3 • Reducing the likelihood of situations becoming exacerbated and resulting in residential or	Work has been undertaken to train stress and distress trainers and plan the training sessions.	The potential for release of resources is a key task for the project group seeking sustainable support from internal/external funders. The evidence is that within	£166,000

April 2018	and distressed behaviours in people with dementia.	dementia, their families and carers	hospital care		prescribing alone it is expected that a £47k saving will be realised year on year.	
Implementation of the ARBD pathway April 2016 – August 2018	Delivery of the actions identified in the 2013 ADP needs assessment.	Outcome 2 • Assessing and improving pathways of care for those with ARBD • Reducing the need for out of area placements in residential care	Objective 4 • Assessing and improving pathways of care for those with ARBD • Reducing the need for out of area placements in residential care	A project initiation document has been produced and the project delivery planned.	The resource currently being used to fund residential places could be released and used differently in order to support improved coordination in the community.	£102,052
Borders Ability Equipment Store (BAES) Relocation February 2016 – December 2016	Relocation of the Borders Ability Equipment store to a purpose built location.	Outcome 2 • Efficiently providing individuals with the correct equipment to enable them to have care in the home setting.	Objective 4 - as outcome 2.	This project is currently in the process of tender.	One off cost.	£100,000
Community Ward Pilot Programme Management and Support	Programme Management and Support to develop, plan and deliver alternative proposal to replace Community Ward pilot	•			One off project – no ongoing costs.	£54,000
Health and Care	Programme	•			The project would	£54,000

Coordination Programme Management and Support	Management and Support to develop, plan and deliver Health and Care Coordination project			specify that recommendations must be achieved within the existing resources across services. This may mean disinvestment in one area and re investment in another or the direction of additional funding following the end of the pilot period.	

Appendix 2

How ICF Projects Approved to Date map to National Outcomes and Strategic Objectives

National Health and Wellbeing 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.

Our Local Strategic Objectives:

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.

Mapping of Projects against the Local Strategic Objectives,

Project	Objective 1 – Make services more accessible and develop our communities	Objective 2 – Improve prevention and early intervention	Objective 3 - Reduce avoidable admissions to hospital	Objective 4 – Provide Care close to home	Objective 5 – Deliver services with an integrated care model	Objective 6 - Enable people to have more choice and control	Objective 7 – Further optimise efficiency and effectiveness	Objective 8 – Reduce health inequalities	Objective 9 – Improve support for Carers to keep them healthy and able to continue their caring role
Programme Team	●	●	●	●	●	●	●	●	●
Independent Sector	★	★	★	★	●	★	■	■	■
Eildon Community Ward	★	★	★	★	★	★	★	★	★
Transport Hub	★	■	■	●	●	★	★	●	★
Transitions	★	★	★	★	★	★	●	★	★
Stress and Distress			★		★	●	●		●
My Home Life		★	★	★					★
Mental Health Integration	★	●	★	★	★	●	★	●	■
ARBD	●	★	★	★	★	★	●	★	★
Autism	●	★		●	★	★	●	★	★
Borders Community Capacity Building	★		■			●		■	x
BAES relocation	■	●	●	★	★	■	●	■	■
Locality Coordinators	★	★	★	★	★	★	★	★	★

★-High Impact ● - Medium Impact ■ - Low Impact

Mapping of Projects against the National Health and Wellbeing Outcomes

Project	Outcome 1 – People are able to look after and improve their own health and wellbeing and live longer	Outcome 2- People, including those with disabilities or LTC's 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 maintain or improve the quality of life of people who use these services	Outcome 5 – Health and social care services contribute to achieving health inequalities	Outcome 6 – People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	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
Programme Team	●	●	●	●	●	●	●	●	●
Independent Sector	★	★	★	★	■		★	★	★
Eildon Community Ward	★	★	★	★	★	★	★		★
Transport Hub		★	■	■		●			
Transitions	★	★	★	★	★	★	★	★	★
Stress and Distress		■	★	★			★	★	●
My Home Life	●		★	★			★	★	
Mental Health Integration	●	★	★	★	★	■	★	★	★
ARBD	●	★	★	★	★	★	★	★	●
Autism	●	★	★	★	★	★	★		●
Borders Community Capacity Building	●	■			■	■			●
BAES relocation	■	★	★	■	■	●	■	■	★
Locality Coordinators	★	★	★	★	★	★	★	★	★

★-High Impact ● - Medium Impact ■ - Low Impact

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REVISED GOVERNANCE ARRANGEMENTS FOR INTEGRATED CARE FUND

Aim

1.1 To provide Integration Joint Board (IJB) members with an overview of the proposed revised governance arrangements for the Integrated Care Fund (ICF) and other resources which will enable, through organisational transformation, the development and implementation of health and social care integration.

Background

2.1 The Scottish Government has made £100m available to Health and Social Care Partnerships in each of the next three years to support the delivery of improved outcomes for health and social care integration. For the Scottish Borders Partnership, this amounts to £2.13m per annum (2.13% of £100m p.a.), a total allocation of £6.39m over the 3 years. The ICF is available to test and drive innovative and preventative approaches to reduce future demand, support adults with multi-morbidity and address issues of inequity of access to health and social care services.

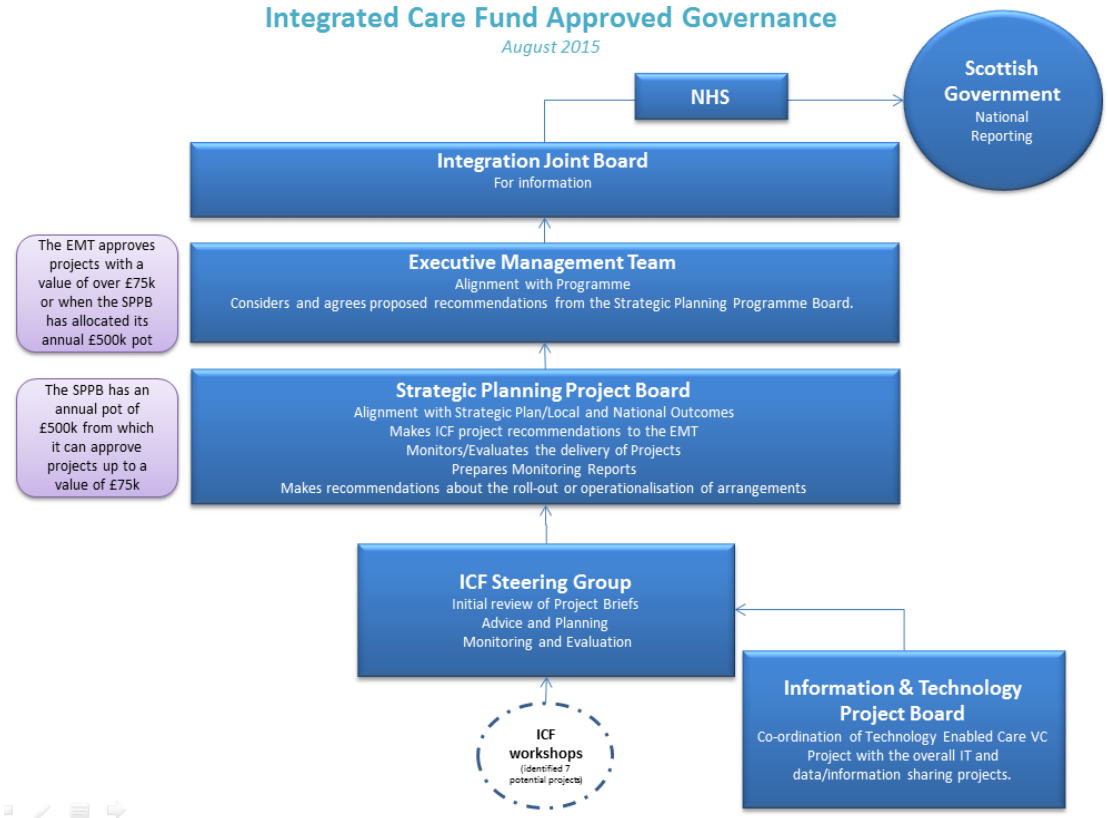
2.2 Effective use of the ICF will only be achieved by adopting the principles of strategic commissioning. The IJB is therefore ultimately responsible for the effective use of the ICF, as well as ensuring that the fund is utilised as a key enabler to demonstrate medium-term transformation, better outcomes for the people of the Scottish Borders and in essence, the delivery of the Partnership's new Strategic Plan.

2.3 The ICF is only one of a number of enabling component resources and tools. Other enabling financial resources include the Partnership's core delegated and notional set-aside budgets including how social care funding is used. Additionally, Directions are the instrument through which redesign, increased or decreased service levels and resource shifts will be exercised and commissioned. Across partner organisations, there are a range of other tools and processes such as people planning, which will also enable delivery.

The Case for Change

3.1 Since its inception on 1st April 2014, governance of the ICF, the planning and management of the projects it supports and the outcomes delivered has been governed within the structure detailed below:

Diagram 1 – Existing ICF Governance Arrangements



3.2 The ICF existed a full year before the IJB was established and before a strategic vision for the Partnership had been formed. Governance arrangements previously developed now require review, clarification and updating in line with the Strategic Plan, the Commissioning and Implementation Plan and the Scheme of Integration.

3.3 Any proposed governance over the use of the ICF should closely align with wider Partnership governance and enable and not encumber flexible and responsive direction of resources to ensure the timely delivery of the Partnership's strategic objectives.

3.4 The existing governance model (above – Diagram 1) requires review for the following reasons:

- The need for ICF to be consistent and wholly integrated with the wider Partnership governance arrangements;
- To clarify roles and responsibilities within these arrangements clearly differentiating between the functions of strategic planning & outcomes, decision-making and planning and delivery;
- To accelerate the process of planning and commissioning and the use of all supporting resources;
- To delegate decision making, responsibility and accountability for the delivery of new models of care;
- To reduce bureaucracy and duplication and increase clarity of roles and responsibilities.

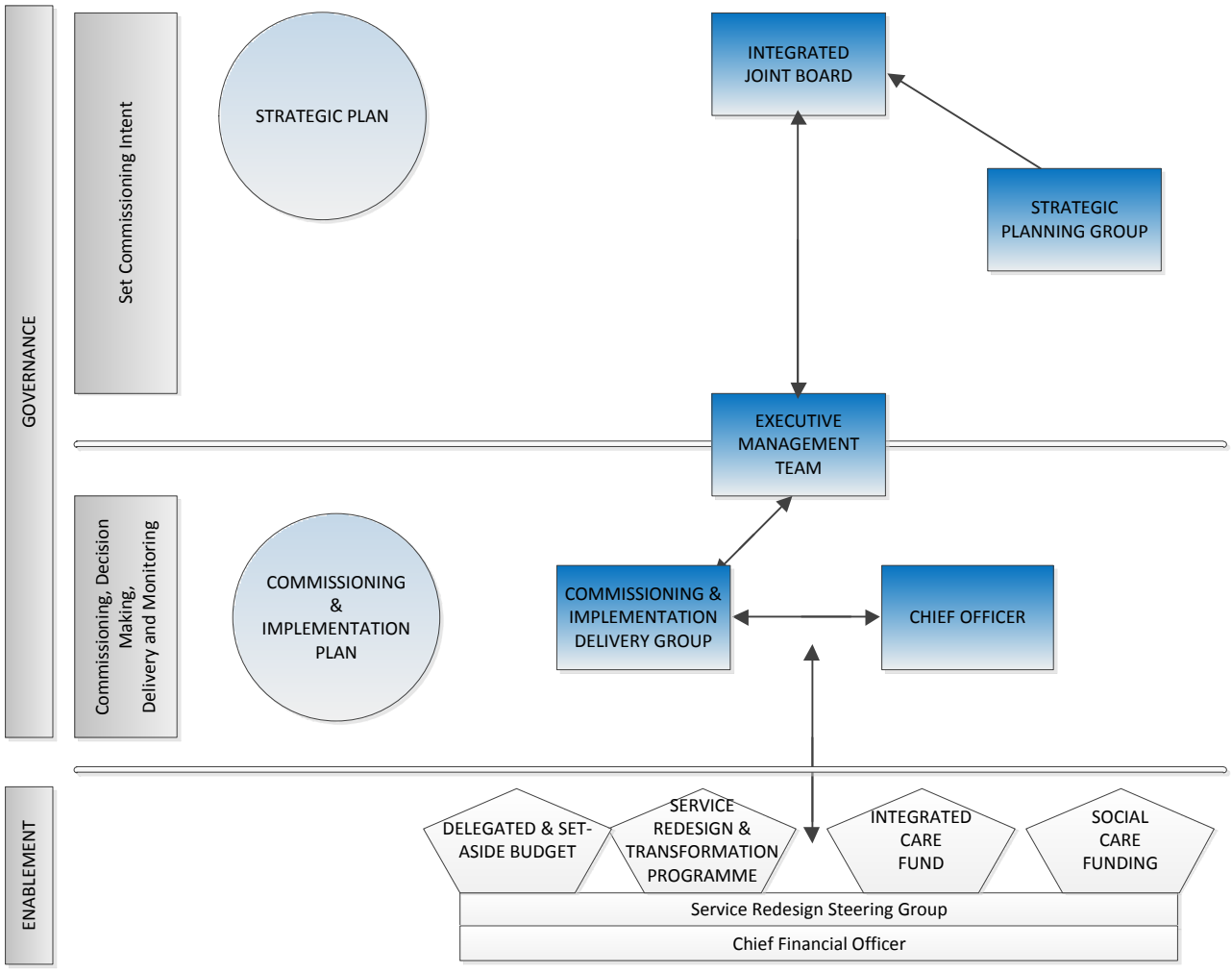
Proposed Arrangements

4.1 It is proposed that a more simplified model of governance is implemented for the ICF to include clearly defined governance arrangements for:

- Strategic Planning and Policy Formulation;
- Decision Making, Operational Planning and Commitment of Resources;
- Implementation and Delivery;
- Monitoring and Reporting.

The proposed arrangements are as follows:

Diagram 2 – Proposed ICF Governance Arrangements



4.2 The proposed model differentiates between Strategic and Operational responsibilities of key stakeholder groups.

The IJB

4.3 The role of the IJB, supported by the Strategic Planning Group is to set the strategic intent of the Partnership, define what it will look like and achieve in the medium-term and identify what resources will be available to deliver these achievements.

4.4 With an oversight and governance role, the IJB will be required to monitor progress and performance against its targeted aims and objectives. This includes delivery of services within budget and seeking maximum effectiveness in the timely use of resources. Frequent and regular reporting to the IJB will be a pre-requisite enabler of this and will be asked to ratify proposals approved by the Executive Management Team and may, when appropriate, refer proposals back to the EMT for further development before doing so.

Executive Management Team

4.5 It is proposed that the IJB will delegate responsibility for the delivery of the Commissioning and Implementation Plan, commissioning of projects and services, issuing of directions, investment/ disinvestment decisions and all management responsibilities to the Executive Management Team. The EMT will be responsible for contributing to, refining and approving proposals brought forward by the Chief Officer and the Commissioning & Implementation Group. Once approved, these proposals can be implemented by the Chief Officer as Chair of the C&I Group.

4.6 The EMT will also be responsible for their onward reporting to the IJB for ratification. With decision-making retained at EMT level, this is not full delegation of responsibility to the Chief Officer, which whilst less flexible, will still enable decisions to be made more flexibly and quicker than previously.

The Commissioning & Implementation Planning Group

4.7 The Chief Officer will be held to account by both EMT and IJB for the delivery of the partnership's planned objectives, service decision-making and delivery of redesign and be responsible operationally for all resource decisions. It is through commissioning of redesign by the IJB via directions issued by the Chief Officer that transformation will be delivered. Again, regular and frequent performance, financial and programme monitoring reports via the EMT to the IJB will provide assurance to the Board that its plans are being discharged and that sufficient and timely progress is being made in the transformation of services. Similarly, as Chair of the Commissioning & Implementation Planning Group, the Chief Officer will seek assurance that all deliverables are in line with the targets set out in the partnership's Commissioning and Implementation Plan. It is this group that will have responsibility for the delivery mechanisms through which the IJB will achieve its aims and objectives.

4.8 Further linkages require to be developed in relation to the redesign and transformation programmes across NHS Borders and Scottish Borders Council given the wider impact of such change and such projects will also form part of each individual organisation's wider transformation and redesign programme and within its own governance arrangements.

4.9 As schemes supporting the delivery of the ICF programme develop, reports will be brought forward to the IJB providing further detail on each project for ratification, following endorsement by the EMT.

Enablement of the Governance Model

4.10 It is proposed that a new Steering Group responsible for the planning, delivery, monitoring and reporting of all service redesign across the health and social care Partnership will replace the existing ICF Steering Group and support the Commissioning & Implementation Planning Group as the delivery unit of transformation.

4.11 These arrangements will also require adjustment to the membership of the key stakeholder groups detailed above. Similarly, revised terms of reference for each group will require to be developed which will further demonstrate how the arrangements will operate.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the revised governance arrangements for the Integrated Care Fund.

Policy/Strategy Implications	ICF supports the delivery of the Strategic Plan and the proposed governance aligns to the strategic planning and commissioning approach.
Consultation	Discussions held with key strategic leads.
Risk Assessment	To be reviewed in line with agreed risk management strategy.
Compliance with requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	No resourcing implications.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration	David Robertson	Chief Financial Officer, Scottish Borders Council

Author(s)

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Paul McMenamin	Chief Financial Officer, IJB		

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DRAFT: HEALTH AND SOCIAL CARE INTEGRATION PARTNERSHIP MAINSTREAMING REPORT AND EQUALITY OUTCOMES 2016/17

Aim

1.1 To provide the Integration Joint Board (IJB) with information regarding the legislative context for the Mainstreaming Report and to seek agreement on the draft Equality Outcomes for the Scottish Borders Health & Social Care Partnership.

Background

2.1 The Scottish Borders Integration Joint Board (IJB) is fully committed to the values and ethos placed upon them by the Equality Act 2010. The Partnership, made up of Scottish Borders Council and NHS Borders along with third and independent sector organisations, aim to work together to deliver joined up services that ultimately will be in the best interest of staff, service users, patients, families and carers. The Partnership's Equality Outcomes are directly tied into that overarching goal.

2.2 All public bodies across Scotland are required to comply with the three aims of the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012.

2.3 The Equality Act (2010) is the law which bans unfair treatment and helps achieve equal opportunities in the workplace and in wider society. This single Act replaces previous antidiscrimination laws to make the legislation simpler, to remove inconsistencies and to provide specific protection to people who are discriminated against on the basis of a defined set of nine "protected characteristics".

2.4 In Scotland, an additional set of specific duties were created by secondary legislation: the Equality Act (2010) (Specific Duties) (Scotland) Regulations 2012, which came into force in May 2012.

2.5 The legislation further requires that the set of equality outcomes and mainstreaming report is published no later than **30th April 2016** and subsequently at intervals of not more than 2 years a progress report on its approach to mainstreaming equality and at intervals of not more than 4 years for progress against its equality outcomes.

Summary

3.1 Both NHS Borders and Scottish Borders Council have published existing equality outcomes and they are outlined in Appendix 1. In mapping these outcomes against the Strategic Plan the proposed set of equality outcomes for the Health and Social Care Partnership are as follows:-

Users of health and social care services, their families and carers will:

- experience fair access to services that mitigate the impact of any protected characteristics under the Equality Act (2010) **Equality Outcome 1**
- be supported to access education, training and employment **Equality Outcome 2**
- have improved physical and mental wellbeing, experience fewer health inequalities and will be able to live independently **Equality Outcome 3**

- experience a workforce that feel valued, are skilled, competent, and reflect the diversity of the populace across the Scottish Borders **Equality Outcome 4**
- feel safe, be safe, healthy, achieving, respected and included **Equality Outcome 5**
- experience services that reflect the needs of the communities, address health inequalities, and which shift the balance of these services towards early intervention and prevention **Equality Outcome 6**
- be confident that the information they provide, particularly in relation to the protected characteristics, will be used to make improvements to services and the way they are planned and delivered. **Equality Outcome 7**

3.2 Each of the outcomes will contribute towards the national health and wellbeing outcomes and local objectives outlined in our Strategic Plan.

Recommendation

The Health & Social Care Integration Joint Board is asked **to agree** the equality outcomes outlined in paragraph 5.8 and Appendix 1 and **to note** the review by April 2017 to inform the development of the revised outcomes for 2017 onwards.

Policy/Strategy Implications	Meet legislative requirement and supports delivery of the Strategic Plan
Consultation	Linked to the consultation and engagement re Strategic Plan
Risk Assessment	To be reviewed in line with IJB risk approach
Compliance with requirements on Equality and Diversity	Meets legislative requirements for Equality and Mainstreaming report
Resource/Staffing Implications	Supporting delivery of the Strategic Plan

Approved by

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

Author(s)

Name	Designation	Name	Designation
Carin Pettersson	Communications Officer	Sandra Campbell	Programme Manager

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

DRAFT: HEALTH AND SOCIAL CARE INTEGRATION PARTNERSHIP MAINSTREAMING REPORT AND EQUALITY OUTCOMES 2016/17

CONTENTS

1. Introduction to Mainstreaming Report and Equality Outcomes

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1.2 The Partnership published its strategic plan for 2016-19, "changing health & social care for you", along with supporting documents in mid-April 2016. The plan was informed by three rounds of consultations and provides an overview of why integration of health and social care services is necessary and what can be expected to be the results of integration in the Scottish Borders. The plan is a high level working document which will change and grow throughout its life. Based on on-going assessment of need, the document will be reviewed at least every three years, and this process will always involve consultation with people living in the Borders. This process will also include cross referencing and benchmarking against the Partnership's equality outcomes.

1.3 This report contains our equality outcomes for the first year of the Integrated Partnership arrangements for the period 2016/17 and will outline the process to inform the development of new IJB outcomes for 2017 onwards.

1.4 Our equality outcomes are designed to help us achieve our vision of providing the best possible health and wellbeing for our communities and meet our general duty to eliminate discrimination and harassment, promote equality of opportunity and foster good relations.

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2.1 All public bodies across Scotland are required to comply with the three aims of the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012.

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3.1 The Equality Act (2010) is the law which bans unfair treatment and helps achieve equal opportunities in the workplace and in wider society. This single Act replaces previous antidiscrimination laws to make the legislation simpler, to remove inconsistencies and to provide specific protection to people who are discriminated against on the basis of a defined set of nine "protected characteristics". The nine protected characteristics are:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex

9. Sexual orientation

3.2 These characteristics cannot be used as a reason to treat people unfairly. Every person has one or more of the protected characteristics, so the Act protects everyone against unfair treatment.

3.3 The three aims of the Act's Public Sector General Equality Duty are as follows:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act
- Advance equality of opportunity between persons who share a relevant characteristic and persons who do not
- Foster good relations between people who share a protected characteristic and those who do not

3.4 The Public Sector General Equality Duty replaces the previous Race Equality Duty (2002), the Disability Equality Duty (2006) and the Gender Equality Duty (2007).

4 The Purpose of the Public Sector General Equality Duty

4.1 The purpose of the general Equality Duty is to ensure that all public bodies, including IJBs , mainstream equality into their day to day business by proactively advancing equality, encouraging good community relations and addressing discrimination. The current duty requires equality to be considered in relation to key functions including the development of internal and external policies, decision-making processes, procurement, service delivery and improving outcomes for patients/service users.

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5.1 In Scotland, an additional set of specific duties were created by secondary legislation: the Equality Act (2010) (Specific Duties) (Scotland) Regulations 2012, which came into force in May 2012.

5.2 The specific duties listed below are intended to support public bodies in their delivery of the General Equality Duty:

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- Publish equality outcomes and report progress
- Assess and review policies and practices (impact assessment)
- Consider award criteria and conditions in relation to public procurement
- Publish in a manner that is accessible.

5.3 In April 2015 the Scottish Government added IJBs to Schedule 19 of the Equality Act 2010 and to The Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015.

5.4 The amendment regulations require IJBs to publish the following information by the 30 April 2016:

- A report on mainstreaming the equality duty; and
- A set of equality outcomes

5.5 The legislation further requires that the set of equality outcomes and mainstreaming report is published no later than **30th April 2016** and subsequently at intervals of not more than 2 years a progress report on its approach to mainstreaming equality and at intervals of not more than 4 years for progress against its equality outcomes.

6 Overarching Operational Context

6.1 The IJB became a legal entity April 1 when integration went live. As a consequence, the IJB is responsible for planning and commissioning services, while the Scottish Borders Health and Social Care Partnership is responsible for delivering those services and improving outcomes for the people of the Borders.

6.2 Health and Social Care Partnerships must demonstrate that the services they are responsible for are delivering against the National Health and Wellbeing Outcomes identified by the Scottish Government:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

6.3 Acknowledging that there are regional differences, the Scottish Borders Health and Social Care Partnership has identified local objectives, all which are cross-referenced with the National Health and Wellbeing Outcomes:

1. Make services more accessible and develop our communities (Health &Wellbeing Outcomes 1, 2, 3, 4, 6 and 8)
2. Improve prevention and early intervention (H&W Outcomes 1, 2, 4, 5 and 8)
3. Reduce avoidable admissions to hospital (H&W Outcomes 1, 2, and 9)
4. Provide care close to home (H&W Outcomes 1, 2, 3, 4, 5, 6 and 9)
5. Deliver services within an integrated care model (H&W Outcomes 5, 8 and 9)
6. Seek to enable people to have more choice and control (H&W Outcomes 1, 2, 3, 4, 5, 6 and 7)
7. Further optimise efficiency and effectiveness (H&W Outcomes 8 and 9)

8. Seek to reduce health inequalities (H&W Outcomes 1, 2, 3, 5, 6 and 7)
9. Improve support for Carers to keep them healthy and able to continue in their caring role (H&W Outcomes 1, 2, 3, 4, 5, 6 and 7)

6.4 For year one, the Partnership's focus will be on ensuring that business as usual can continue, whilst key strategic change processes are delivered to enable us to move efficiently towards the delivery of towards our outcomes. In the future, individuals can expect to be supported to live not just longer, but healthier lives and will receive locally based service and support that best meets their needs and which are organised around them, their family and their informal support network. The necessary joined-up health and social care support will be provided to help individuals, their carers and families to better manage their conditions on a day-to-day basis, formalising networks within the community, and working with individuals as true partners, rather than just as patients or people who use services.

6.5 Each Health and Social Care Partnership is required to develop and publicly report on a Performance Monitoring Framework, inclusive of 23 indicators set by the Scottish Government, as well as the locally determined relevant measures. In line with the NHS Borders Local Delivery Plan and the Scottish Borders Council Corporate Plan, the IJB has identified two target areas to focus the activities in meeting the local objectives: supporting people at home and the wellbeing of our staff. The IJB has selected 7 of the 23 indicators set by the Scottish Government which will be used to measure the success of delivering against the two target areas:

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

6.6 Our priorities will be developed further as the Partnership progress in line with the IJB's commissioning arrangements and the development of directions in future years. Performance will be monitored against the above indicators. Development will also be influenced by the results of consultation and engagement activities undertaken to inform the Partnerships direction and provision.

7 Benefits of Equality Mainstreaming

7.1 Mainstreaming equality means integrating equality and diversity into our day-to-day working. We aim to do this by taking equality into account as part of the process of planning, commissioning and delivering health and social care services for the people in the Scottish Borders. Ongoing stakeholder management, engagement and collaboration are critical to the delivery of equality mainstreaming, activities that the IJB and the Partnership are committed to engage in to provide the best quality service and deliver on the goals of integration.

7.2 Mainstreaming equality has a number of benefits including:

- It helps to ensure that services are fit for purpose and meet the needs of our community
- It helps to attract and retain a productive workforce, rich in diverse skills and talents
- It helps to work toward social inclusion and allows us to support the staff, service areas and the communities to improve the lives of everyone who lives in the Borders
- It helps to continually improve and better perform through growing knowledge and understanding.

8 How to mainstream equality: our equality outcomes

8.1 An equality outcome is the desired aim to further one or more of the general equality duties; eliminate discrimination, advance equality of opportunity and foster good relations. Outcomes are changes that result for individuals, communities, organisations or society as a consequence of action taken. Outcomes include short-term benefits such as changes in awareness, knowledge, skills and attitudes, and long-term benefits such as changes in behaviours, decision-making, or social or environmental conditions.

8.2 Both NHS Borders and Scottish Borders Council have published existing equality outcomes and they are outlined in Appendix 1. In mapping these outcomes against the Strategic Plan the proposed set of equality outcomes for the Health and Social Care Partnership are as follows:-

Users of health and social care services, their families and carers will:

- experience fair access to services that mitigate the impact of any protected characteristics under the Equality Act (2010) **Equality Outcome 1**
- be supported to access education, training and employment **Equality Outcome 2**
- have improved physical and mental wellbeing, experience fewer health inequalities and will be able to live independently **Equality Outcome 3**

- experience a workforce that feel valued, are skilled, competent, and reflect the diversity of the populace across the Scottish Borders **Equality Outcome 4**
- feel safe, be safe, healthy, achieving, respected and included **Equality Outcome 5**

- experience services that reflect the needs of the communities, address health inequalities, and which shift the balance of these services towards early intervention and prevention **Equality Outcome 6**
- be confident that the information they provide, particularly in relation to the protected characteristics, will be used to make improvements to services and the they the way they are planned and delivered. **Equality Outcome 7**

8.3 Each of the outcomes will contribute towards the national health and wellbeing outcomes and local objectives outlined in our Strategic Plan.

9 Recommendations

9.1 Members are asked to:-

- agree the equality outcomes outlined in paragraph 5.8 and Appendix 1
- note the review by April 2017 to inform the development of the revised outcomes for 2017 onwards.

Appendix One

NHS Borders Equality Outcomes

In setting out Equality Outcomes we have considered the wider determinants of health and social inequalities including poverty, education, housing and local community. We have taken a Community Planning Partnership approach, working with Scottish Borders Council, local Police representatives, local Fire and Rescue Services representatives and Borders College. WE have agreed to align our equality outcomes with the Community Planning Partnership Equality Outcomes, with our own responsibilities and actions within the outcomes to take forward.

1. We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected and our workforce reflects our community.
2. Our services meet the needs of and are accessible to all members of our community.
3. Ours staff treat all service users, clients and colleagues with dignity and respect.
4. We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and democratic process.
5. We work in partnership with other stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced.
6. We work in partnership with other agencies and stakeholders to ensure our citizens have the freedom to make their own choices and are able to lead independent, healthy lives as responsible citizens.
7. We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from under represented groups is improved.
8. We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved.
9. We work in partnership with other agencies and stakeholder to ensure we have appropriate housing which meets the requirements of our diverse community.

Scottish Borders Council Equality Outcomes 2013 – 17

Our outcomes are designed to help us achieve our vision and meet our general duty to eliminate discrimination and harassment; promote equality of opportunity and promote good relations.

1. We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected and our workforce reflects our community.
2. Our services meet the needs of and are accessible to all members of our community and our staff treat all services users, clients and colleagues with dignity and respect.
3. Everyone has the opportunity to participate in public life and the democratic process.
4. We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living poverty.
5. Our citizens have the freedom to make their own choices and are able to lead independent, healthy lives as responsible citizens.

6. The difference in rates of employment between the general population and those from under represented groups is improved.
7. The difference in educational attainment between those who are from an equality group and those who are not is improved.
8. We have appropriate accommodation which meets the requirements of our diverse community.

DRAFT: HEALTH AND SOCIAL CARE INTEGRATION PARTNERSHIP MAINSTREAMING REPORT AND EQUALITY OUTCOMES 2016/17

Aim

1.1 To provide the Integration Joint Board (IJB) with information regarding the legislative context for the Mainstreaming Report and to seek agreement on the draft Equality Outcomes for the Scottish Borders Health & Social Care Partnership.

Background

2.1 The Scottish Borders Integration Joint Board (IJB) is fully committed to the values and ethos placed upon them by the Equality Act 2010. The Partnership, made up of Scottish Borders Council and NHS Borders along with third and independent sector organisations, aim to work together to deliver joined up services that ultimately will be in the best interest of staff, service users, patients, families and carers. The Partnership's Equality Outcomes are directly tied into that overarching goal.

2.2 All public bodies across Scotland are required to comply with the three aims of the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012.

2.3 The Equality Act (2010) is the law which bans unfair treatment and helps achieve equal opportunities in the workplace and in wider society. This single Act replaces previous antidiscrimination laws to make the legislation simpler, to remove inconsistencies and to provide specific protection to people who are discriminated against on the basis of a defined set of nine "protected characteristics".

2.4 In Scotland, an additional set of specific duties were created by secondary legislation: the Equality Act (2010) (Specific Duties) (Scotland) Regulations 2012, which came into force in May 2012.

2.5 The legislation further requires that the set of equality outcomes and mainstreaming report is published no later than **30th April 2016** and subsequently at intervals of not more than 2 years a progress report on its approach to mainstreaming equality and at intervals of not more than 4 years for progress against its equality outcomes.

Summary

3.1 Both NHS Borders and Scottish Borders Council have published existing equality outcomes and they are outlined in Appendix 1. In mapping these outcomes against the Strategic Plan the proposed set of equality outcomes for the Health and Social Care Partnership are as follows:-

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3.2 Each of the outcomes will contribute towards the national health and wellbeing outcomes and local objectives outlined in our Strategic Plan.

Recommendation

The Health & Social Care Integration Joint Board is asked **to agree** the equality outcomes outlined in paragraph 5.8 and Appendix 1 and **to note** the review by April 2017 to inform the development of the revised outcomes for 2017 onwards.

Policy/Strategy Implications	Meet legislative requirement and supports delivery of the Strategic Plan
Consultation	Linked to the consultation and engagement re Strategic Plan
Risk Assessment	To be reviewed in line with IJB risk approach
Compliance with requirements on Equality and Diversity	Meets legislative requirements for Equality and Mainstreaming report
Resource/Staffing Implications	Supporting delivery of the Strategic Plan

Approved by

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

Author(s)

Name	Designation	Name	Designation
Carin Pettersson	Communications Officer	Sandra Campbell	Programme Manager

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

DRAFT: HEALTH AND SOCIAL CARE INTEGRATION PARTNERSHIP MAINSTREAMING REPORT AND EQUALITY OUTCOMES 2016/17

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2. Our services meet the needs of and are accessible to all members of our community and our staff treat all services users, clients and colleagues with dignity and respect.
3. Everyone has the opportunity to participate in public life and the democratic process.
4. We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living poverty.
5. Our citizens have the freedom to make their own choices and are able to lead independent, healthy lives as responsible citizens.

6. The difference in rates of employment between the general population and those from under represented groups is improved.
7. The difference in educational attainment between those who are from an equality group and those who are not is improved.
8. We have appropriate accommodation which meets the requirements of our diverse community.

DELAYED DISCHARGES

Aim

1.1 This paper aims to provide the Health and Social Care Integrated Joint Board with an update on the performance for patients in relation to delayed discharges to the end of March 2016. The report provided is that provided to the NHS Borders Board Strategy and Performance Committee in April 2016 (Attachment A).

1.2 In the light of the Integrated Joint Board overall responsibility for the monitoring of Delayed Discharges as a key indicator, this paper will outline the key changes to how delays will be measured from July 2015 and outline the work being done to ensure oversight of both health and social care data and performance, recognising the whole system responsibility.

Background

2.1 A delayed discharge is a **hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date**.

2.2 Partnerships have previously worked towards discharging patients from hospital within a maximum time period of 6 weeks, reducing to 4 weeks then 2 weeks in April 2015.

2.3 However the national expert group considered a focus on maximum delay to only drive activity towards reducing the lengthiest delays, at the expense of facilitating the discharge of those closer to being able to go home.

2.4 Two weeks was therefore felt not to be ambitious enough for the majority of people who should be able to return to the community within 72 hours of being ready for discharge.

2.5 It is very clear that being delayed in hospital can be harmful and debilitating – and in the case of older people, can often prevent a return to living independently at home.

2.6 Reliably achieving timely discharge from hospital is an important indicator of quality and is a marker for person-centred, effective, integrated and harm free care. Older people may experience functional decline as early as 72 hours after being clinically ready for discharge and the risk increases with each day delayed in hospital. This increases the risk of harm and of a poor outcome for the individual and further increases the demand for institutional care or more intensive support at home.

2.7 Information is also provided of the forthcoming changes to the nationally required data definitions and reporting requirements which are effective from the 1st July 2016. The relevant documents are included in the paper (Attachments B and C).

Summary

3.1 Delayed Discharges continue to be a priority focus for NHS Borders Board. The Board has been regularly updated on progress. Across health and social care

progress continues to be made in relation to understanding and jointly managing delayed discharges by NHS Borders and Scottish Borders Council and there is a clear partnership commitment to continue to do this.

3.2 There is a commitment to realign and rebalance working practices in response to changes across the system, taking forward the service redesign required to make an impact on the whole pathway of care, supporting more people at home, reducing unnecessary admissions and ensuring people return home or to an appropriate home like environment as soon as their acute episode is complete.

3.2 The number of delayed discharge cases and the number of associated occupied bed days have both reduced over the last four years to March 2016. The operational response to the areas of concern outlined in the NHS Borders Board Strategy and Performance Committee report intended to deliver a sustained improvement during 2016/17.

3.3 The Partnership performance in relation to the 72 hour indicator will be provided in future reports.

Recommendation

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

Policy/Strategy Implications	Delivery of the HEAT Target requires that no patient will wait more than 14 days to be discharged into a more appropriate care setting once treatment is complete from April 2015: followed by a 72 hour maximum from April 2016.
Consultation	N/A
Risk Assessment	The Delayed Discharge Report is developed in conjunction with the Delayed Discharges Operational Group
Compliance with requirements on Equality and Diversity	Risks associated with the delivery of Delayed Discharge Standard are outlined within the Local Delivery Plan. Performance against the target is reported in the monthly Clinical Executive Performance Scorecard and given a rag status based on whether the trajectory has been achieved.
Resource/Staffing Implications	There are a number of resource implications associated with this report which are considered in individual service plans

Approved by

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

Author(s)

Name	Designation	Name	Designation
Alasdair Pattinson	General Manager, Primary and Community Services, NHS Borders.		

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Borders NHS Board

DELAYED DISCHARGES

Aim

This paper aims to provide the Strategy and Performance Committee with an update on the performance for patients in relation to delayed discharges.

Background

Patients should not have to wait unnecessarily for the most appropriate care to be provided after treatment in hospital. Waiting unnecessarily in hospital is a poor outcome for the individual, it means they are not able to access the care and support they need to be able to progress independently if they need to go home. It is not a good use of resources.

A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons, for example, awaiting assessment or awaiting residential or nursing care placement or care at home.

National Targets Associated with Delayed Discharges

From April 2013, the target came into being that no patient should wait more than 4 weeks from when they are clinically ready for discharge. Then from April 2015 it was determined that no patient should wait more than 2 weeks for their discharge to take place.

In December 2014 integration authorities were asked to describe improvement against the following indicator:

"The proportion of adults discharged within 72 hours of their ready for discharge date"

The Discharge Task Force envisaged that there would be a lead-in time of between 6 and 12 months, therefore it was recommended that we use the proposed 2 week standard from April 2015 until the new measure can be rolled out.

In addition it is recommended that integration authorities, measure their performance on *bed days lost to delayed discharge* to be introduced at the same time as the 72 hour indicator, after which the two week standard would become obsolete. For some time NHS Borders Health Board has recognised the occupied bed days (bed days lost to delayed discharge) indicator as a relevant measure. As we enter this new performance year we will use the two week standard alongside the 72 hour target in line with guidance, and set improvement trajectories for the reduction in the percentage of bed days spent in hospital after admission and not just the proportion of days recorded as a delay.

Performance Overview

Considerable effort by Scottish Borders Council and NHS Borders has elicited a positive impact on the total number of delayed discharges for patients in NHS Borders. The total number of delayed discharge cases has reduced from 747 in 2010/11, of which 189 were delayed over the national target of 4 weeks, to 600 in 2013/14, of which 15 were delayed over 4 weeks. The percentage of associated occupied bed days has also reduced from 11.9% in April 2010 to 6.0% to the end of March 2014.

In October 2015 we predicted that delayed occupied bed days would account for 5.0% of our total occupied bed days. The actual percentage of occupied bed days due to delayed discharges at the end of March 2016 was 5.5% (see **Appendix 1**). Although the improvement in performance is positive, we need to ensure improvement trajectories are maintained.

Complex Cases

Complex cases are often referred to as code 9 patients for reporting purposes. This was introduced for very limited circumstances where Partnerships could explain why the discharge of their patients could not be achieved within the national targets. This will continue in the context of the new target regime.

The table below highlights the total occupied bed days and number of cases for such patients within NHS Borders from April 2010 to March 2016.

For the individual inpatients areas related performance has varied over the last four years with improvement maintained in Borders General Hospital (BGH) and Mental Health (MH) however a significant deterioration in performance in the Community Hospitals where complex cases occupied bed days has increased from November to March.

Complex Delayed OBDs

Month	Total					
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Apr	1691	167	131	97	116	241
May	1565	383	118	42	217	172
Jun	1962	320	172	114	226	51
Jul	124	200	183	124	267	244
Aug	158	230	217	188	129	208
Sep	90	239	173	245	173	142
Oct	73	288	206	174	199	168
Nov	137	243	115	131	131	315
Dec	185	65	121	259	210	392
Jan	176	99	168	234	236	322
Feb	127	129	76	260	171	194
Mar	173	212	51	238	120	227
Grand Total	6461	2575	1731	2106	2195	2676
Percentage Complex Delayed Days of Total	**4.4%**	**1.9%**	**1.3%**	**1.6%**	**1.7%**	**2.1%**

Current Position

Throughout 2015/16 the ongoing partnership working between NHS Borders and Scottish Borders Council has endeavoured to maintain the overall improvement seen since 2011. However, achieving the 2 week target is proving to be challenging and on occasion there have been breaches of the previous 4 and 6 week target. See table below.

Type of Delay	Duration of Delay	2015 Apr	2015 May	2015 Jun	2015 Jul	2015 Aug	2015 Sep	2015 Oct	2015 Nov	2015 Dec	2016 Jan	2016 Feb	2016 Mar
All Delays (Standard and Code 9)	*Total Delays*	*11*	*6*	*14*	*19*	*18*	*12*	*22*	*19*	*20*	*15*	*14*	*18*
Standard Delays	*Total Standard Delays*	*4*	*1*	*9*	*14*	*11*	*9*	*18*	*13*	*7*	*7*	*9*	*12*
	Total Standard Delays (excluding delays between 1 and 3 days)	4	1	9	9	5	9	14	13	4	6	8	10
	Between one and three days	-	-	-	5	6	-	4	-	3	1	1	2
	>three days and up to 2 weeks	4	1	8	5	4	5	8	10	2	-	3	6
	2 to 4 weeks	-	-	1	3	1	4	3	2	1	4	2	1
	4 to 6 weeks	-	-	-	-	-	-	3	-	1	-	2	3
	More than 6 weeks	-	-	-	1	-	-	-	1	-	2	1	-
	More than 4 weeks	-	-	-	1	-	-	3	1	1	2	3	3
	More than 2 weeks	-	-	1	4	1	4	6	3	2	6	5	4

The following tables illustrate the performance between April 2010 and March 2016 for each of our inpatient areas.

The total performance overview is shown in full in **Appendix 1**.

Year	BGH					
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total Cases	109	158	111	105	135	92
Delayed OBDs	1384	2007	1204	1113	1464	833
Total OBDs	80377	76601	76085	78177	82195	79041
Percentage Delayed Days	**1.7%**	**2.6%**	**1.6%**	**1.4%**	**1.8%**	**1.1%**

Year	CH					
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total Cases	481	410	410	391	464	444
Delayed OBDs	8947	6508	5024	4840	5132	4795
Total OBDs	39309	35521	32233	29856	30186	29475
Percentage Delayed Days	**22.8%**	**18.3%**	**15.6%**	**16.2%**	**17.0%**	**16.3%**

Year	MH					
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total Cases	157	136	117	104	143	99
Delayed OBDs	7248	2540	1738	1800	2680	1438
Total OBDs	28091	26081	23116	20855	20521	20348
Percentage Delayed Days	**25.8%**	**9.7%**	**7.5%**	**8.6%**	**13.1%**	**7.1%**

Areas of concern

The key reasons for delay experienced by patients are currently being influenced by challenges relating to the following issues:

1. Care at home – we continue to be challenged in sourcing care at home across the Borders.
2. Choices of care home placements and availability thereof, and
3. A number of complex cases with a significant length of stay
4. Boarded patients in the BGH

Operational Response

Ongoing focus is being placed upon supporting the discharge of delayed patients awaiting their next stage of care across the system. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 hour ED Standard; quality of care and ensuring people are in the right care setting; and the avoidance of disruption to planned surgical admissions.

There are weekly delayed discharge meetings with senior managers and senior colleagues from Scottish Borders Council and SB Cares including Head of Delivery Support, Chief Officer of Health and Social Care, Director of Nursing, Midwifery and Acute Services and General Managers for P&CS and Unscheduled Care, amongst others have been meeting regularly since January to add impetus to the improvement required. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring, and implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

Appendix 2 lists actions taken and those planned and monitored by this oversight group to ensure daily oversight to solve individual issues but also recognising we need to take steps to achieve more sustainable improvement.

Summary

Progress continues to be made in relation to understanding and jointly managing delayed discharges by NHS Borders and Scottish Borders Council. There is clear partnership commitment to continue to do this, and to realign and rebalance working practices in response to changes across the system.

The number of delayed discharge cases and the number of associated occupied bed days have both reduced over the last four years to March 2016, but we recognise the most recent trends are not accurate. However, the operational response to the areas of concern outlined above are intended to deliver a sustained improvement.

We are also working on the new trajectories for performance and will be adjusting our reporting format accordingly.

Recommendation

The Strategy and Performance Committee is asked to **note** the report.

Rationale for submission to Strategy & Performance Committee	
Policy/Strategy Implications	Delivery of the LDP Standard requires that no patient will wait more than 14 days to be discharged into a more appropriate care setting once treatment is complete from April 2015: followed by a 72 hour maximum from April 2016.
Consultation	N/A
Consultation with Professional Committees	The Delayed Discharge Report is developed in conjunction with the Delayed Discharges Operational Group
Risk Assessment	Risks associated with the delivery of Delayed Discharge Standard are outlined within the Local Delivery Plan. Performance against the target is reported in the monthly Clinical Executive Performance Scorecard and given a RAG status based on whether the trajectory has been achieved.
Compliance with Board Policy requirements on Equality and Diversity	An impact assessment is made for the standard as part of the Local Delivery Plan.
Resource/Staffing Implications	There are a number of resource implications associated with this report which are considered in individual service plans.

Approved by

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

Author(s)

Name	Designation	Name	Designation
Alasdair Pattinson	General Manager, Primary and Community Services, NHS Borders.	Jane Douglas	Group Manager for Adult Social Care and Health SBC

Appendix 1

Delayed Cases

Month	Total					
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Apr	30	63	66	46	55	51
May	14	69	66	54	70	43
Jun	20	68	46	39	66	41
Jul	51	58	60	42	74	64
Aug	51	72	51	60	63	51
Sep	70	58	53	62	53	54
Oct	90	46	68	50	73	53
Nov	102	53	49	53	54	67
Dec	81	59	40	45	71	64
Jan	73	54	45	59	62	58
Feb	86	54	46	42	56	46
Mar	79	50	48	48	45	43
Grand Total	747	704	638	600	742	635

Delayed OBDs

Month	Total					
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Apr	2244	1103	741	523	840	513
May	1792	1175	874	586	1173	456
Jun	2154	1180	657	547	865	301
Jul	908	1266	751	518	1000	482
Aug	947	1327	690	704	715	520
Sep	1135	898	616	704	661	545
Oct	1685	911	774	479	898	646
Nov	1334	720	543	824	604	758
Dec	1545	575	533	742	717	891
Jan	1290	638	624	885	794	783
Feb	1228	739	522	584	593	561
Mar	1317	523	641	657	416	610
Grand Total	17579	11055	7966	7753	9276	7066

Total OBDs

Month	Total					
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Apr	12512	11279	11466	10558	11231	10776
May	12626	12553	11315	9876	11433	11136
Jun	12343	11730	10362	9460	11014	10620
Jul	12172	11824	11176	10534	10690	10241
Aug	12214	11900	11197	10972	10907	10546
Sep	11845	11193	11044	11038	10991	10594
Oct	12590	11427	10976	11470	11190	11170
Nov	11738	10718	10504	11042	10318	10902
Dec	12449	11264	10722	11114	11085	10671
Jan	13009	11613	11187	11532	11785	11227
Feb	11820	11102	10388	10473	10710	9805
Mar	12459	11600	40735	10819	11548	11176
Grand Total	147777	138203	131434	128888	132902	128864

Percentage Delayed Days of Total	**11.9%**	**8.0%**	**6.1%**	**6.0%**	**7.0%**	**5.5%**

Appendix 2

Initiatives implemented 2016	Responsible person/s	Status
Reviewed membership of weekly Joint Operational DD Group - Thursdays	Alasdair Pattinson	Complete
Weekly Joint Strategic and Escalation Group	Susan Manion	Ongoing
Daily case review at BGH START Discharge Hub meeting	Elizabeth Duffel	Ongoing
Improved visibility of residential accommodation availability	Barbara Elder	Complete
Community Hospital weekly Discharge Profiling	Warwick Shaw/Alasdair Pattinson	Complete
Joint Delayed Discharge Focus Group twice weekly Monday and Thursday	Warwick Shaw, Susan Manion, Alasdair Pattinson	Ongoing
Joint Improvement Team facilitated Discharge Planning session	Connected Care	Complete
Short Term	**During May 2016**	
Update on refurbishments of Salt Greens and Waverley and timeline to reopening of beds.	SBCares	Complete
Senior Management attendance and support to Community Hospital MDT meetings	Alasdair Pattinson, Warwick Shaw, Beverly Meins	Ongoing
Home Care coordination - implement Matching Unit	Susan Manion/Gwyneth Johnstone	In progress
Redesign BGH START Hub	Connected Care	In progress
Host advisory visit from John Bolton (Glasgow)	Elaine Torrance	Being arranged for August
Revise NHS Discharge Policy and Processes based on output from JIT visit	Connected Care/Warwick Shaw	Ongoing
Implement 72hr reporting approach in line with revised national requirements	Alasdair Pattinson/Susan Manion	Commence July 2016
Medium Term	**By September 2016**	
Initiatives to reduce emergency admissions and demand on acute care – review High Resource Individuals	Tim Patterson/Susan Manion/ Simon Watkin	In progress
Criteria around packages of home care and assessments	Susan Manion/Elaine Torrance	Ongoing
Developments of a 'Discharge to Assess' unit to support a shift in assessment approaches.	Susan Manion/SBCares	Ongoing
Communication Plan with Medical, Nursing and AHP staff around revised Discharge Policy and	Warwick Shaw/Philip Lunts	Ongoing

responsibilities		
Long Term	**2017**	
Introduce new Community based models of care	Susan Manion	Pending
Introduce models of care and self care to reduce emergency admissions	Alasdair Pattinson/Annabel Howell	Pending
Increased uptake of Anticipatory Care Plans	Alasdair Pattinson/Annabel Howell	Pending

Delayed Discharge Definitions Manual

Effective from 1st July 2016 (supersedes May 2012 version)

Main version changes	Date Issued	Changes made
Version effective from July 2016	**01/07/2016**	**New reason codes** · "Health" reasons and "Social" reasons for delay combined to "Health and Social reasons" to reflect introduction of health and social care partnerships · **27A** - awaiting place availability in an intermediate care facility **New sections** · Intermediate care & Interim beds **Revised sections** · Background and definition of a delayed discharge · Ready for Discharge · Changes in patient health circumstances · Code 9 - clarification around use of codes · Commissioning/Reprovisioning (code 100) **Removed sections** · Healthcare delays **Other changes** · National data requirements document amended
Version effective from May 2012	**01/05/2012**	**New reason codes** · **Code 9 25X** "Awaiting completion of complex care arrangements- in order to live in their own home" has been introduced. · **All code 9** cases must be accompanied by a secondary reason code. **Update of wording** · **24DX** Awaiting place availability in Specialist Facility for younger age groups (<65) where the Facility is not available · **24EX** Awaiting place availability in Specialist Facility for older age groups (65+) where the Facility is not available **Reason codes withdrawn** · **Code 83** been removed **Other changes** · **Three day rule** Patients included if their Ready for Discharge Date is up to 3 working days prior to the census. (These were previously excluded) · Requirement to gather bed days occupied by delayed discharge patients by quarter
Version effective from July 2010	**01/07/2010**	**New reason codes** · **24F** Awaiting place availability in care home (EMI/Dementia bed required). · **26X** Care Home/facility closed – patient well but cannot be discharged at point of census. · **41A** Non-availability of NHS funding to purchase care home place. · **41B** Non-availability of NHS funding to purchase any other care package. · **46X** Ward closed – patient well but cannot be discharged due to closure at point of census. · **67** Disagreement between patient/carer/family and health/social work · **81** Disagreement over funding between health and social care. · **82** Disagreement over assessment between health and social care. · **83** Other disagreement between health and social care. · **100** Reprovisioning/Recommissioning **Reason codes withdrawn** · **31** awaiting commencement/completion of post-hospital healthcare assessment. · **45** awaiting routine discharge: routine administrative arrangements are complete and prospective discharge date is known. · **66** Disagreement between health and social Work. **Other section changes** **1.1** Policy Context: Historical information removed. Highlights expected standard. **2.1** Ready-for-Discharge-Date: Definition expanded to clarify setting of date and involvement of Multi-disciplinary team. Note 5 describes Multi-disciplinary team. **2.6** New Reprovisioning/Recommissioning section. **2.7** New Mental Health - Detention section. **2.10.1** Reason codes, highlights no facilities in NHS Board area. **2.10.3** Reason code 51X, narrative to be supplied on code 9 form if delayed for longer than 6 months. **2.11** Change in patients health circumstances, highlights decision made by the Consultant/GP. **2.12** Infection control, new section outlining process when ward/care facility closed due to infection. This has generated 2 new codes **26X** and **46X**. **2.14** Out-of-area delays / **3.6** EDISON - new sections. **4.3.5** No fixed abode, mention of homeless patient and patient with a foreign address. **4.6** Specialty: only adult specialties are shown.
Version effective from May 2006		**Main changes** · Introduction of code 9 reason code: Patients delayed due to awaiting place/bed availability in a specialist residential facility where no facilities exist (codes 24DX, 24EX and 42X) or due to requirements of the Adults with Incapacity Act (code 51X) will now be categorised under a new principal reason code 'Complex Needs' (Code 9) with the code 24DX, 24EX, 42X and 51X operating as a secondary reason code to Code 9. **Zero delays:** From the July 2006 census patients who have a zero delay (i.e. their duration of delay is 3 working days or less) are not included in the census totals. **Planned discharges**: From the July 2006 census patients who have a planned discharge and an agreed discharge date within 3 working days of the census date are not included in the census.
For previous versions back to 2001 contact ISD		

1 Introduction

1.1 Purpose

The purpose of this manual is to provide guidance to health and social care partnerships on defining a delayed discharge. The manual sets out a number of definitions and instructions that must be followed in order to ensure consistency of data collection across Scotland.

The advice and guidance set out in this manual should be applied from 1st July 2016.

This document should be read in conjunction with the Delayed Discharge National Data Requirements effective from 1st July 2016 and can be found: http://isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/

1.2 Background

A delayed discharge is a **hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date**.

Following the integration of adult health and social care, any distinctions between health reasons and social work reasons for delay have ceased therefore delayed discharges are reported (from April 2016) in three main categories – health and social care reasons; patient and family related reasons; and code 9. Delays reported under 'Health and Social Care' reasons are those where the patient remains inappropriately in hospital after treatment is complete and are awaiting the appropriate arrangements to be made by the health and social care partnership for safe discharge.

Inter-hospital transfers and people being appropriately treated in intermediate care or non-hospital facilities should **not** be classified as delayed discharges.

While the responsible clinician has ultimate responsibility for the decision to discharge, the ready for discharge decision must focus on the needs of the individual and on achieving the best outcome for that individual. The decision must be made through a multi-disciplinary process in consultation with all agencies involved in planning that patient's discharge.

This manual covers all adult (aged 18 years and over) patients, in all hospital specialties and significant facilities.

1.3 Policy Context

Partnerships have previously worked towards discharging patients from hospital within a maximum time period of 6 weeks, reducing to 4 weeks then 2 weeks in April 2015. However a focus on

maximum delay drives activity towards reducing the lengthiest delays, at the expense of facilitating the discharge of those closer to being able to go home. Two weeks is not ambitious enough for the majority of people who should be able to return to the community within 72 hours of being ready for discharge.

It is very clear that being delayed in hospital can be harmful and debilitating – and in the case of older people, can often prevent a return to living independently at home. Reliably achieving timely discharge from hospital is an important indicator of quality and is a marker for person centred, effective, integrated and harm free care. Older people may experience functional decline as early as 72 hours after being clinically ready for discharge and the risk increases with each day delayed in hospital. This increases the risk of harm and of a poor outcome for the individual and further increases the demand for institutional care or more intensive support at home.

From April 2016 there is a new national indicator to measure the proportion of patients experiencing a discharge delay of up to 72 hours. This will require data to be captured accurately *to identify patients discharged within 72 hours of their ready for discharge date.*

The Delayed Discharge Expert Group recommended measuring bed days occupied by delayed discharges, and these data have been gathered since April 2012. (http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets/Delayed-Discharge/Expert-group-report)

2 Definitions and Guidance

2.1 Ready for discharge

It is important that discharge planning starts as early as possible in the patient's journey. Key agencies such as social work, housing and community support, along with the patient's main carer, should be involved as early as possible in this process. Professionals should agree a planned date of discharge with the patient and family supported by agreed criteria that will demonstrate readiness for discharge.

The **Ready for discharge date (RDD)** is the date on which a hospital **inpatient** is clinically ready to be discharged from **inpatient hospital care**.

This is determined by the consultant/GP responsible for the inpatient medical care **and** where a multi-disciplinary team, in consultation with all agencies involved, agree that the individual's care needs can be further assessed or properly met outside a hospital setting.

Where the patient remains inappropriately in a hospital bed, no longer receiving treatment but merely waiting for an appropriate place in the community, then they should be classified as a delayed discharge.

A small number of patients will have an agreed planned discharge date but require a phased discharge involving trial periods of assessment and rehabilitation at home. These patients are not yet fully ready for discharge from hospital so should **not** be classified as a delayed discharge.

2.2 Bed days occupied by delayed discharges

The total number of days patients spend delayed in hospital following their ready for discharge date.

For national or other reporting purposes it is necessary to attribute bed days to the month(s) when they occurred. For example the number of bed days occurring in a particular month may be divided by the number of days in the month to give the average daily number of beds that were occupied in that month by delayed discharge patients.

In order to ensure consistency, a 'midnight bed count' approach should be applied to each delay episode to determine which particular days should contribute to the bed day count. The 'ready for discharge' date (RDD) should not be counted, as the first midnight occurring in the delay episode is attributable to the day after the RDD. The discharge date (the date the delay ended) should be counted as the assumption is that the patient was delayed at 00:00 on that day.

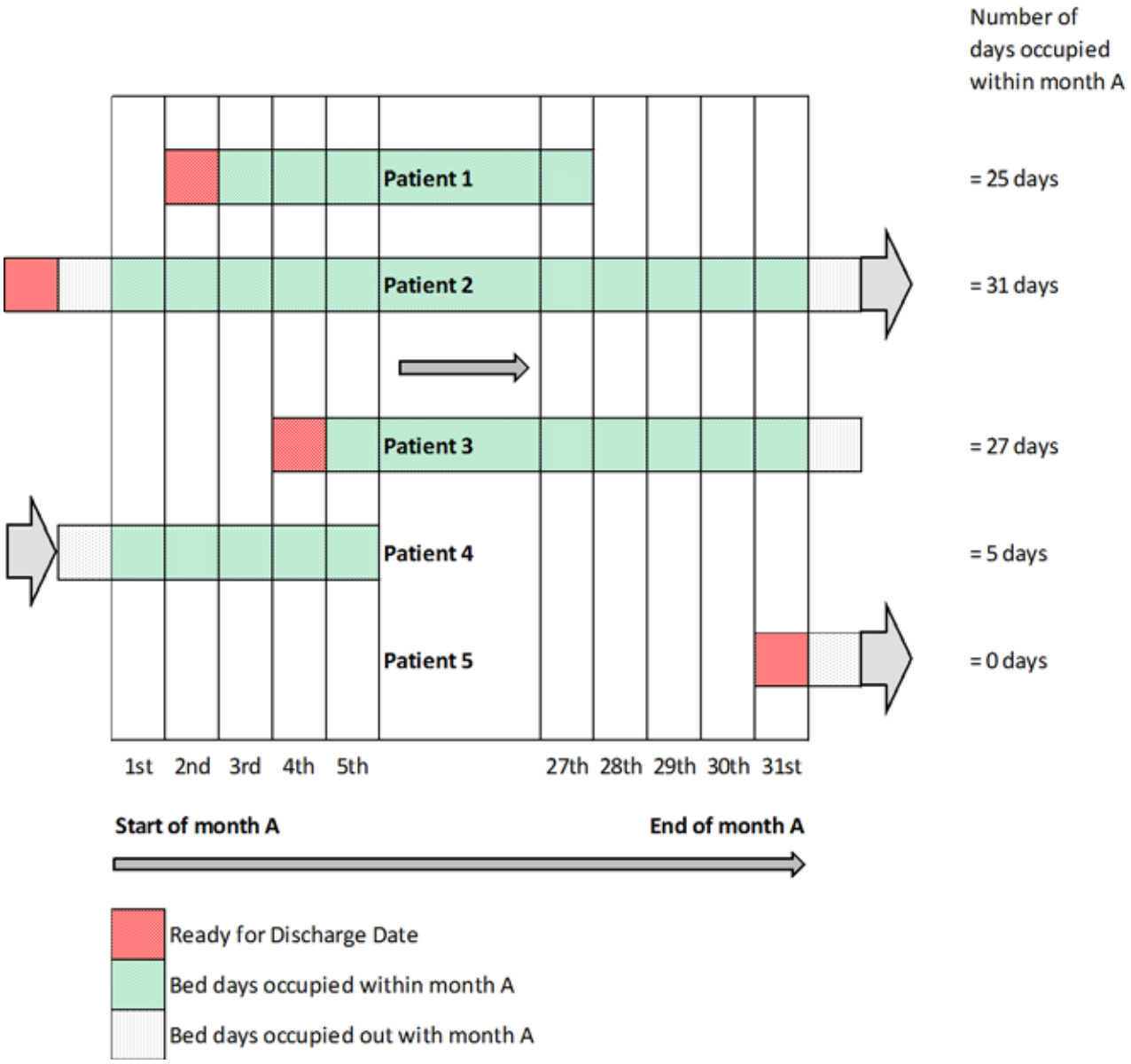
Therefore, the following applies to calculating bed days occupied for delayed patients:

1. Count all days that occur between the 'ready for discharge' date (RDD) and the discharge date (the date the delay ended)

2. Do **not** count the 'ready for discharge' date (RDD)
3. Do count the 'discharge date' (the date the delay ended)

For example, if the RDD of a patient was on the 1st of the month and the delay ended on the 5th, the number of days delayed is 4 and the days counted in this delay are the 2nd, 3rd, 4th and 5th.

Figure 1: Example of counting bed days occupied by delayed discharge patients in a calendar month



In this example: Total number of bed days occupied in calendar month A: 88 days

Number of days in calendar month A: 31 days

Average daily number of beds occupied: 88/31 = 2.84 beds

2.3 Commissioning / Reprovisioning (code 100)

Some patients destined to undergo a change in care setting should not be classified as delayed discharges and can be categorised as:

- Long-term hospital inpatients whose medical status has changed over a prolonged period of treatment and discharge planning such that their care needs can now be properly met in non-hospital settings. These might be Mental Health patients or Hospital Based Complex Clinical Care patients who have been reassessed as no longer requiring such care.

- Patients awaiting a 'reprovisioning' programme where there is a formal (funded) agreement between the relevant health and/or social work agencies.

Information on all such patients should be recorded as code 100. It is acknowledged that while such patients may be classed as 'ready for discharge' the standard discharge planning processes and timescales are not appropriate. Gathering information on code 100 patients should mean that all patients for whom hospital is no longer the optimum setting can be accounted for.

Information on patients recorded as code 100 will not be published but details will be made available to the Scottish Government in anonymised form.

2.4 Mental Health – Detention

Patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, who cannot be discharged from hospital, should **not** be classified as delayed discharges.

If however, where there is MDT agreement that it is safe and reasonable for a patient to be transferred to a more appropriate setting, and meets the criteria laid out in section 2.1 then such patients should be classified as a delayed discharge and coded accordingly.

2.5 Intermediate Care

Intermediate Care beds provide time-limited episodes of care / intervention / rehabilitation, commissioned and supported by the partnership, and provided in dedicated capacity within a care home, housing with care, or community hospital settings. Such beds are appropriate community placements that have been commissioned as quality alternatives to acute hospital care and patients occupying these beds should **not** be classified as delayed discharges.

"Maximising Recovery, Promoting Independence" - An Intermediate Care Framework for Scotland

2.6 Interim Care Beds

Interim care beds are for short-term stays in care homes until the care home of choice becomes available. These are appropriate community placements where the individuals are no longer hospital inpatients and should **not** be classified as delayed discharges. Some partnerships use interim care home beds for temporary accommodation for patients lacking capacity and awaiting guardianship. These are also appropriate community placements and should **not** be classified as delayed discharges.

2.7 Change in Patient Health Circumstances

Patients who are deemed medically fit for discharge, but subsequently become unwell, should not be classified as delayed discharges for period of time they are unwell.

- When the patient is fit for discharge again, a new delay record should be created with a new ready for discharge date.
- These decisions must be made by the Consultant / GP responsible for the inpatient's medical status.
- It is important that as far as is possible and reasonable the patient's priority for any local service provision remains unchanged.

However if local operational data systems are unable to record accurate, real-time changes in health circumstances to support the requirement for recording information as described above, then the following rules apply:

If a delayed discharge patient's period of illness is longer than three days, or means they will miss their planned discharge date, they should no longer be classified as a delayed discharge:

- If the period is **more than 3 days** the patient's delay record should be closed and a new record entered when the patient is fit for discharge again with a new ready for discharge date.
- If the period is **three days or less** the patient's delay record should retain the original ready for discharge date.
- The patient's priority for any local service provision should remain unchanged as far as is possible and reasonable.

2.8 Infection Control

Patients who are classified as a delayed discharge, and are in a ward closed for infection control purposes (such as a norovirus outbreak) should remain as a delayed discharge unless:

- They are ill themselves due to the outbreak in which case follow the process outlined in section 2.7.
- They were due to be discharged, and as a result of the ward closure could not be moved (code 46X).
- Their discharge was to a care home or facility closed for infection control purposes (code 26X).

An assumption should be taken that patients should be discharged wherever possible, following national and/or local guidelines on infection control.

2.9 Code 9

Code 9 and its various secondary codes, should only be used by partnerships that are unable, for reasons beyond their control, to secure a patient's safe, timely and appropriate discharge from hospital. This code was introduced for very limited circumstances when the NHS Chief Executive and Local Authority Directors of Social Work (or their nominated representatives) could explain why the discharge of patients was out with their control. This decision will now be the responsibility of the health and social care partnership Chief Officer, or their nominated representative.

These codes should only be used in the specific circumstances where:

- the patient lacks capacity, is going through a Guardianship process, and for whom the use of S13za of the Social Work (Scotland) Act 1968 is not possible. (http://www.gov.scot/Publications/2008/03/20114619/12)
- the patient is delayed awaiting availability of a place in a specialist facility, where no facilities exist and an interim move would not be appropriate (i.e. no other suitable facility available)
- patients for whom an interim move is not possible or reasonable

2.9.1 Secondary reason codes to code 9

All code 9 delays should have a secondary reason code.

24DX and 24EX - patients awaiting place/bed availability in specialist residential facilities where no appropriate facilities exist

25X - patients awaiting completion of complex care arrangements – in order to live in their own home

These codes should be used to record patients delayed awaiting placement in specialist homecare or specialist residential facilities **where no facilities exist** within the partnership area. They **should not** be used to record delays due to limited availability in an existing local specialist facility.

71X – patients exercising statutory right of choice where an interim move is not possible or reasonable

This code should only be used where **long travel distances** or limited **transport infrastructures** restrict the ability of families and friends to visit and where the placement may isolate the individual from a vital family and social network. This code should only be applied where remaining in a hospital setting is a more appropriate outcome and is the only viable alternative to an interim move. In all other choice cases (code 71) the underlying principle should be that remaining in hospital is not an option.

This code **should not** be used where a consultant deems an interim move detrimental to the health of the individual. In that situation, **the patient is not considered to be a delayed discharge**.

51X - patients delayed due to the requirements of the 'Adults with Incapacity Act' 2000

This code should be applied after:

- it has been agreed that the patient lacks capacity, and
- the use of S13za of the Social Work (Scotland) Act 1968 to discharge the patient has been ruled out, and
- an application for Guardianship or Intervention Order is to be progressed through the Courts

Once the process has been completed the patient will revert to another reason code and the delay will be calculated from a new ready for discharge date.

A good practice guide for discharging patients who may lack capacity is available on the Scottish Government website at http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets/Delayed-Discharge/Good-Practice.

2.9.2 Notification of code 9s

Narrative must be provided to explain the reasons for code 9 delays and supplied quarterly to ISD. The narrative should provide clear justifiable reasons for applying the code, why the process has taken so long, details of what actions are being pursued to facilitate discharge of the individuals concerned, list the barriers that have hindered progress and what is being done to overcome them.

This requirement does not extend to patients under code 51X who have been delayed less than **three** months or patients delayed under code 26X and 46X.

The reason for delay should detail the specific issues blocking the patient's discharge and **should not** simply be a description of the code used (e.g. "awaiting place in specialist facility").

This will help inform on-going work within the Scottish Government to map and investigate the reasons behind code 9 delays across Scotland.

2.10 Out of Area Delays

There will be occasions when patients who are resident out with the partnership area in which they are being treated cannot be discharged home directly and require to be transferred closer to home, where practical and appropriate, to a suitable facility within the NHS Board of residence for any further inpatient care needs.

Such cases are not considered delayed discharges if they require further inpatient hospital care but early notification must be made to contact the patients NHS board of residence to organise discharge/transfer arrangements.

A delayed discharge reason for delay code must be agreed by both partnerships where there is a

- Health and Social care delay: In such cases early notification must be made to contact the patients local authority area of residence (preferably on admission) to organise discharge arrangements. A delayed discharge code cannot be applied without this notification and the code must be agreed by the Board of treatment and the local authority of residence. The NHS Board of residence should also be informed of the delay as a courtesy.
- Patient/Carer/Family-related and other delays: Early notification should be made to both the local authority and NHS Board of residence to agree arrangements for discharge/transfer. The delayed discharge code should be agreed by all relevant agencies involved.

3 Contacts

For any issues about interpretation of this manual please contact:

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Delayed Discharge
National Data Requirements

Effective from 1st July 2016 (supersedes May 2012 version)

Version 1.0

1 National data requirements

This document must be read in conjunction with the Delayed Discharge Data Definitions Manual effective from 1st July 2016 and can be found: http://isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/

From July 2016 NHS Boards are required to submit one national data return to ISD containing:

- Details of ALL patients delayed for one or more days within the calendar month. The reporting period covers from 00:00 on the 1st calendar day of the month to 23:59 on the last calendar day of the month.

Submission of the full data download will allow the following to be calculated:

- **Bed days occupied** by ALL patients classified as a delayed discharge and delayed for one or more days within the calendar month.
- **Census snapshot** position as at the last Thursday of the calendar month at 00:00 hours. This will report the total number of patients who are delayed as at the start of the last Thursday of the month.
- **Support** the measurement of the 72 hour health and social care outcome indicator. http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators

2 Quality assurance and verification

For the purposes of comparison and trend analysis it is essential that there is a uniform and consistent interpretation and application of the definitions and data recording rules by all partnerships.

Should a partnership need to make changes to local recording arrangements (e.g. as a result of improved quality assurance measures or from improved interpretation of national definitions) ISD must be advised as soon as possible, and prior to the submission of any data returns.

Any further revisions or points of clarification will be agreed by the National Advisory Group for Delayed Discharges Information.

It is the responsibility of each NHS Board and local authority partner to ensure all processes to agree data locally are carried out and that validated data are submitted within the national timescales to ISD.

A local verification form should be completed along with the full data download on a monthly basis.

Detailed reasons for code 9 delays should be submitted to ISD on quarterly basis.

The relevant forms and guidelines for completion can be found on the ISD website at http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/

3 Data extract

The following data items fields should be returned in the full data download for all patients delayed for one day or more within the specified calendar month:

- Hospital location code
- Community Health Index (CHI) number
- Postcode of residence
- Local authority code
- Date of birth
- Specialty code
- Date of referral for social care assessment
- Ready for discharge date
- Principal reason for delay in discharge
- Secondary reason for delay in discharge
- Out of area case indicator
- Original admission date
- Gender
- Date of discharge
- Discharge reason

Data definitions for each data item can be found in Section 6.

Data contained in the full data download:

- Should be returned on a monthly basis in an Excel spreadsheet or comma separated file.
- Should be returned at delay episode level i.e. it is possible for the same patient to have more than one delay episode within the specified period.
- Reflect the reason for delay as at the discharge date for patients discharged within the calendar month
- Reflect the reason for delay as at the report run date for patients not discharged within the period
- If a particular data item is unavailable or not applicable it should be left blank; do not exclude records because of incomplete data.
- Code 100 records should be included in the full data download but these figures will not be published.

Partnerships using EDISON and the Business Objects reporting system may use the standard Business Objects report available to extract the required information for the full data extract.

Detailed instructions of how to run the report are available on the ISD website or by emailing NSS.DelayedDischarges@nhs.net.

4 Census snapshot

The full data download will allow ISD to identify the number of patients delayed at the census point.

From July 2016, the census snapshot will report the position as at the last Thursday of the month at 00:00 hours. This is the position at the start of Thursday.

For all patients meeting the definition of a delayed discharge the census snapshot will:

1. **Include** all adults aged 18 years and over as at their Ready for Discharge (RDD) date, in all specialties and significant facilities
2. **Include** patients who were discharged on the last Thursday of the month (as the assumption is that they were delayed as at 00:00 hours on that day)
3. **Exclude** patients where the RDD is the same as the last Thursday of the month (as the assumption is that they were not delayed as at 00:00 hours on that day)
4. **Exclude** patients delayed for the following reasons: 26X, 46X and 100
5. Assign patients with blank reason for delay codes to code 11A (awaiting assessment)

Previous guidance excluded patients from the census snapshot who were discharged within three working days of the census date. In order to provide continuing trend information the full data download will allow ISD to also identify those patients who were discharged within three days of the census point i.e. patients who were discharged up to, but not including, the Tuesday following the census point.

5 Bed days occupied

The total number of days a patient spends delayed in hospital following their ready for discharge date.

Bed days occupied are calculated as the number of bed days occupied for all patients meeting the definition of a delayed discharge in each calendar month and will:

- **Include** all adults, aged 18 years and over as at their Ready for Discharge (RDD) date, in all specialties and significant facilities
- **Include** patients delayed for all health and social care, patient and family related and code 9 reasons

- **Include** patients who have been delayed for one day or more within the calendar month
- **Include** patients who were discharged on the 1st of the month (as the assumption is they were delayed at 00.00 on that day)
- **Exclude** patients where their RDD is the last day of the month (as the assumption is that they were not delayed as at 00:00 hours on that day)
- **Exclude** code 100s
- Reflect the reason for delay as at the discharge date for patients discharged within the calendar month
- Reflect the reason for delay as at the report run date for patients not discharged within the period
- Assign bed days occupied for patients with blank reason for delay codes to code 11A (awaiting assessment)

Appendix A gives further clarification around the calculation of bed days occupied.

6 Data item definitions

6.1 Location

The location of the patient experiencing a delay in discharge.

This is a mandatory data item.

A location is any building or set of buildings where events pertinent to the NHSScotland take place. Locations include hospitals, health centres, GP surgeries, clinics, NHS board offices, nursing homes and schools. Each location has a location code (formerly Institution code). This is a five character code which is maintained by ISD and National Records Scotland (NRS). (http://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=L&ID=310&Title=Location).

This records the location where the patient is undergoing a delay in discharge.

The location code should be entered with no spaces between characters;

	Health Board	Assigned Number	Type
A101H =	A	101	H

6.2 CHI (Community Health Index)

The Community Health Index (CHI) is a population register, which is used in Scotland for health care purposes. The CHI number uniquely identifies a person on the index. http://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=C&ID=128&Title=CHI%20Number

This is a mandatory data item and should be recorded for every record - advice should be sought from your CHI Administrator/Medical Records Manager/Practitioner Services Division if no CHI is available. EDISON related CHI advice can be sought from Joe Donnelly at joseph.donnelly@nhs.net

Each CHI record has a unique 10 digit number (CHI number) which consists of the date of birth and four other numbers. The entry should be left justified with no spaces between characters.

It is essential that the CHI is completed as accurately and consistently as possible as this data item may be used as an identifier for data linkage.

6.3 Postcode of Residence

The code allocated by the Post Office to identify a group of postal delivery points.

Record the postcode of the patient's home address. The postcode should be left justified with no spaces between characters.

Examples

Kirkcaldy KY4 8DW = KY48DW

Edinburgh EH12 8JH = EH128JH

Glasgow G4 6HR = G46HR

If a postcode cannot be found using the Postcode Directory, the appropriate Postcode Enquiry office should be contacted.

- Where a patient's address is not known and all reasonable means of attempting to trace the address have been exhausted the following entry should be put in the postcode field:

  NK010AA

- If a patient has no fixed abode, then the following entry should be recorded for the postcode: NF11AB

Either of the above could be used in the event of a homeless patient or a patient with a foreign address of residence until a CHI number is generated.

Please note each NHS Board should have a process in place to generate a CHI number in these circumstances.

6.4 Local Authority Partner Code / Local Authority Responsible

The code which identifies the local authority partner involved in the patient's post hospital discharge planning.

This is a mandatory data item.

Identifying Responsible Local Authority Partner

The postcode and address of a person's normal residence will be the primary indicator of the responsible local authority partner. A code list can be found in Appendix B.

If a person is admitted whilst temporarily staying at an address in another local authority partnership area then the permanent address still dictates the responsible local authority partnership.

If the person has two addresses, then the address they regard as their current home would dictate the responsible local authority partner, e.g. the person has an address in local authority A but has moved to local authority B to live, then local authority B is responsible. However, if the person has an address in local authority A but is temporarily in local authority B (holiday, respite etc) then local authority A is responsible.

In the event of a dispute, 'Ordinary residence' guidelines should be applied in all cases. These state that "the individual's needs should be met by the local authority in which the individual is physically present (the local authority of the moment) at the earliest opportunity and disputes about payment should not result in delays in meeting need".

http://www.gov.scot/Topics/Health/Support-Social-Care/Financial-Help/OrdinaryResidence

For **Homelessness** or a **patient with a foreign address refer** to section 6.4 above.

6.5 Date of Birth

The date on which a person was born or is officially deemed to have been born, as recorded on the Birth Certificate.

http://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=D&ID=186&Title=Date%20of%20Birth

This is a mandatory data item.

All dates must consist of eight digits by entering preceding zeros for single digits in day and month. The full year of birth must be recorded

- Date of Birth must be entered in the format DD/MM/CCYY thus:

	Day	Month	Year
9th February 1942	09/	02/	1942

6.6 Specialty

A specialty is defined as a division of medicine or dentistry covering a specific area of clinical activity and identified within one of the Royal Colleges or Faculties.

This is a mandatory data item.

This field should be coded to the specialty of the consultant or GP who is in charge of the patient episode within which a delayed discharge is being experienced. If the consultant is formally recognised and contracted to work in more than one specialty then the patient's problem or condition should dictate the specialty.

Note that this is the ONLY rule for completing this field. The designation of the beds is not used.

The specialty/discipline codes can be found in the Appendix which relate ONLY to those codes which are valid in Scottish Morbidity Record (SMR) Record Types 01 and 04.

A full list of specialty/discipline codes can be found in Appendix C and in the Health and Social Care Data Dictionary:

http://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=S&ID=473&Title=Specialty/Discipline

6.7 Date of Referral for Social Care Assessment

The date the patient was referred to the Social Work Department for an assessment of the type of post-discharge care to be provided.

This data item should be entered as a date in its own right for cases where it is appropriate. This date should not be estimated using the ready for discharge date.

All dates must consist of eight digits by entering preceding zeros for single digits in day and month. The full year of referral must be recorded.

- Date of Referral must be entered in the format DD/MM/CCYY thus:

	Day	Month	Year
9th August 2015	09/	08/	2015

Points to note:

1 The date of referral for social care assessment is commonly before the patient is ready for discharge. However, it may also be on the same date as the patient is declared clinically ready for discharge by the clinician (in consultation with all agencies involved in planning the patient's discharge).

2 If the reason for delay in discharge is within the Patient/Carer/Family related reasons category a date of referral to social work would not be expected to be recorded.

6.8 Ready for Discharge Date (RDD)

*The date on which a hospital **inpatient** is clinically ready to be discharged from **inpatient hospital care**.* See section 2.1 of the data definitions document for further clarification.

This is a mandatory data item.

All dates must consist of eight digits by entering preceding zeros for single digits in day and month. The full year ready for discharge must be recorded.

Ready for discharge date must be entered in the format DD/MM/CCYY thus:

	Day	Month	Year
8th March 2015	08/	03/	2015

6.9 Principal Reason for Delay in Discharge

The main reason for the delay is discharge.

This is a mandatory data item.

The PRINCIPAL reason for delay in discharge must be recorded for each delay episode and should reflect either:

- the principal reason for delay as at the discharge date for delay episodes with a discharge date

OR

- the principal reason for delay as at the date the data extract is taken for delay episodes without a discharge date.

The principal reason for delay must be agreed by all agencies involved in each patient's discharge planning.

Reason for delay codes can be found in Appendix D.

All code 9 cases require a secondary reason code to be recorded.

Should there is any ambiguity about which code to use, please contact ISD for advice (nss.delayeddischarges@nhs.net).

6.10 Out of Area Case Indicator

Indicates whether the delay is an out of area case.

In cases where the local authority of residence of the patient is outwith the NHS Board area of treatment this data item should be set to "Yes" otherwise it should be left blank.

6.11 Date of discharge

The date the delay episode ended.

This may not be the date the patient was discharged from hospital. The delay episode may have ended due to a change in patient health circumstances (see the data definitions manual section 2.7) where the patient became unwell and was therefore not fit for discharge.

The date of discharge (i.e. when delay episode ended) is used in conjunction with the Ready for Discharge Date to calculate the number of bed days a patient has been delayed and also whether they were delayed as at the census point.

The date of discharge must be completed for all delay episodes that have ended.

All dates must consist of eight digits by entering preceding zeros for single digits in day and month. The full year of discharge must be recorded.

Ready for discharge date must be entered in the format DD/MM/CCYY thus:

	Day	Month	Year
8th March 2015	08/	03/	2015

If the delay episode is ongoing and the patient's delay episode has not ended the date of discharge should be left blank.

6.12 Original Admission Date

The date on which the inpatient admission leading to the delay episode occurs.

This is a mandatory data item.

The Original Admission Date will allow ISD to determine whether a patient has experienced multiple delay episodes within a single hospital episode.

All dates must consist of eight digits by entering preceding zeros for single digits in day and month. The full year of admission must be recorded.

Ready for discharge date must be entered in the format DD/MM/CCYY thus:

	Day	Month	Year
8th March 2015	08/	03/	2015

6.13 Discharge Reason

The type of location to which a patient is discharged or transferred to following their delay episode.

If a patient has a date of discharge and their delay episode has ended then a discharge reason must be entered.

Codes

01	Placement (to a residential / nursing home)
02	Discharge home with home care
03	Discharge home
04	Death – the patient is deceased
05	Not Fit for Discharge

6.14 Gender

The state of being male or female.

A list of gender codes can be found in the Health and Social Care Data Dictionary:

http://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=G&ID=452&Title=&Title2=Gender%20(Sex)

Codes

1	Male
2	Female
9	Not specified (includes not stated by patient, or not recorded)

7 Data submission

Timescales for data submissions can be found on the ISD website at http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/.

The full data download extract should be submitted monthly to ISD together with the local verification form. Data should be submitted to ISD in an Excel spreadsheet and must be submitted through SWIFT (Submission with Internet File Transfer), a web based application designed to allow submission of data files easily and securely, which facilitates encrypted data submissions to ISD and allows an electronic audit trail to be maintained.

The Code 9 spreadsheet should be submitted to ISD via SWIFT on a quarterly basis.

Data should be gathered by each NHS Board of treatment and are responsible for advising their localities of the ISD timetables. NHS Boards and partnerships should adhere strictly to the confidentiality guidelines agreed locally for the transmission of patient identifiable data.

The data must be submitted to ISD in line with the timescales given. Failure to adhere to the timetable may result in the national data being published without certain Partnerships' information.

To use SWIFT you must have a user name and password. Delayed Discharge contacts at NHS Boards are set up to use SWIFT and have been issued with user guidelines. If you require a new member of staff to be issued a SWIFT account, have any problems submitting your files or any other queries please contact nss.delayeddischarges@nhs.net.

File naming convention

The **file naming convention** for the monthly data submissions are as follows:

1. Naming convention for the monthly data extract file submission:

   MonthlyDD_HEALTHBOARDCIPHER_yyyymm_Data.xls

2. Naming convention for the local verification form submission:

   MonthlyDD_HEALTHBOARDCIPHER_yyyymm_Verification.doc

3. Naming convention for the code 9 form submission (required quarterly):

   MonthlyDD_HEALTHBOARDCIPHER_yyyymm_Code9.xls

The HEALTHBOARDCIPHER is the only part of the file names that can be changed and should relate to the Health Board that is submitting the file.

Example: Data submissions from Ayrshire & Arran for July 2016 would be named:

Data extract:	**MonthlyDD_A_201607_Data.xls**
Local verification form:	**MonthlyDD_A_201607_Verification.doc**
Quarterly code 9 form:	**MonthlyDD_A_201607_Code9.xls**

8 Publication of information

Information is published monthly by ISD on the ISD website.

National Delayed Discharge information is published in accordance with the publications policy on Health and Care statistics.

Publication of delayed discharge information is subject to ISD's disclosure control protocol.

9 Contacts

For any issues regarding national data requirements please contact:

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Appendix A – How bed days occupied are counted

For national reporting purposes it is necessary to attribute bed days to the month(s) when they occurred. For example the number of bed days occurring in a particular month may be divided by the number of days in the month to give the average number of beds that were occupied in that month by delayed discharge patients.

In order to ensure consistency, a 'midnight bed count' approach should be applied to each delay episode to determine which particular days should contribute to the bed day count. The 'ready for discharge' date (RDD) **should not** be counted, as the first midnight occurring in the delay episode is attributable to the day after the RDD. The discharge date (the date the delay ended) **should** be counted as the assumption is that the patient was delayed at 00:00 on that day.

Therefore, the following applies to calculating bed days occupied for delayed patients:

1. Count all days that occur between the RDD and the discharge date (the date the delay ended)
2. Do **not** count the RDD
3. Do count the 'discharge date' (the date the delay ended)

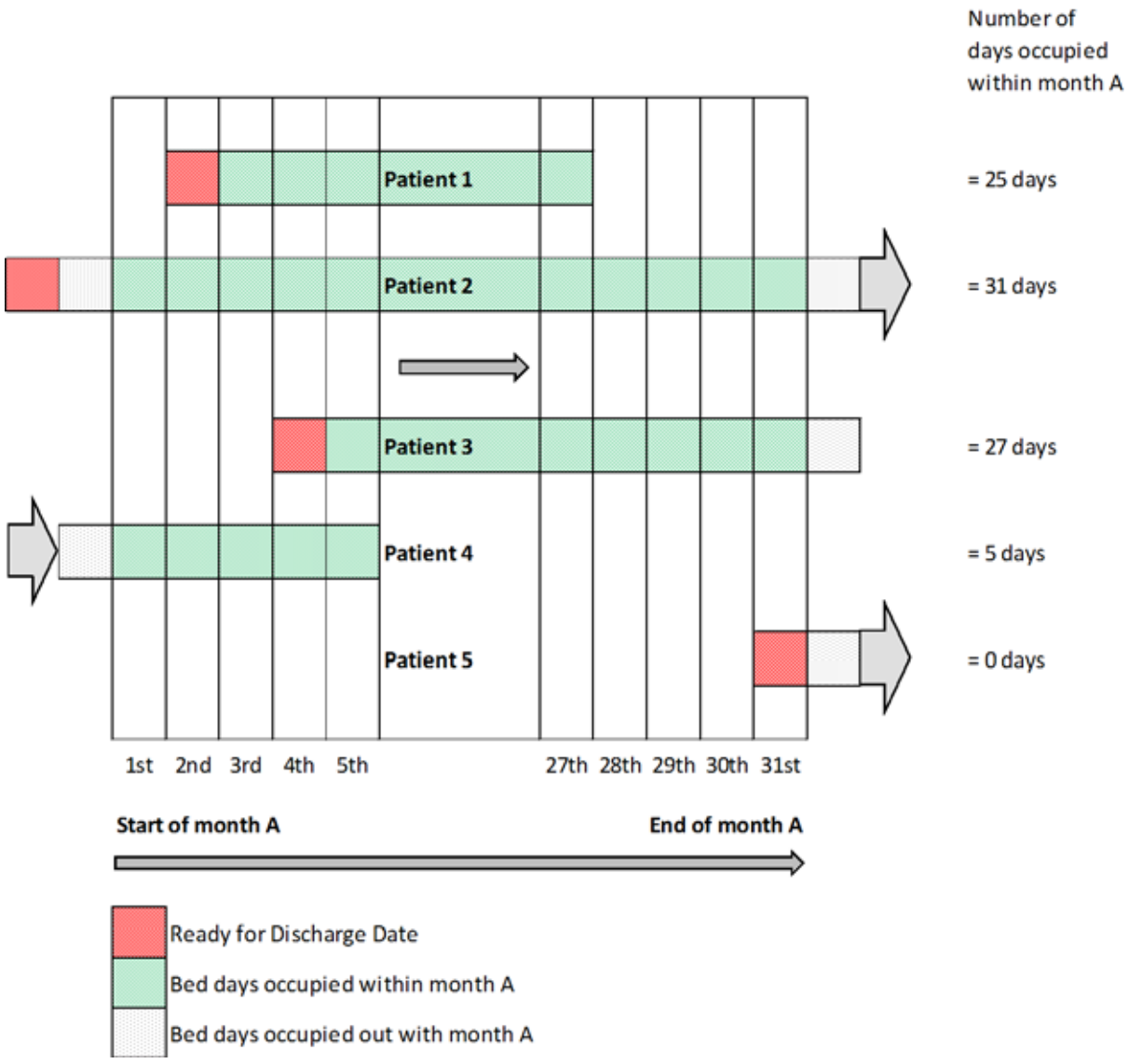
For example, if the RDD of a patient was on the 1st of the month and the delay ended on the 5th, the number of days delayed is 4 and the days counted in this delay are the 2nd, 3rd, 4th and 5th.

Other considerations:

- Where delay episodes span more than one month the bed days should be attributed to each of the months involved. Figure 1 on the next page illustrates the scenarios that may occur when considering a particular reporting month. The calculation of occupied bed days for Patients 1 and 2 are as follows:
  - Patient 1 is ready for discharge on the 2nd of the month; this date is not included in the bed days occupied count. The discharge date is the 28th of the month, this date is included. Therefore the count of bed days occupied for Patient 1 is from the 3rd to the 27th (inclusive), which gives a total of 25 days for that patient.
  - Patient 2 is recorded as ready for discharge in the preceding month. The first day that would be counted towards bed days occupied in the given month would be the 1st. Patient 2 is not discharged until after the end of the month, therefore the bed days occupied for the month in question would be from the 1st to the 31st which gives a total of 31 days for that patient.
- If the date the delay episode ended is missing it should be assumed that the patient is still delayed and has been since the RDD.
- When a patient's condition deteriorates and they are no longer medically fit for discharge the patient is no longer delayed. The date when this occurs should contribute to the bed

day count but subsequent days should not be counted as long as the patient is not medically fit for discharge. When the patient is again deemed ready for discharge the bed day count should resume on the following day (first midnight). See section 2.7 of the data definitions manual for further guidance.

Figure 1: Example of counting bed days occupied by delayed discharge patients in a calendar month



In this example:

Total number of bed days occupied in calendar month A:	88 days
Number of days in calendar month A:	31 days
Average daily number of beds occupied in calendar month A:	88/31 = 2.84 beds

Appendix B – Council area codes

Local Authority Code	Council Name
01	Aberdeen
02	Aberdeenshire
03	Angus
04	Argyll & Bute
05	Scottish Borders
06	Clackmannanshire
07	West Dunbartonshire
08	Dumfries & Galloway
09	Dundee City
10	East Ayrshire
11	East Dunbartonshire
12	East Lothian
13	East Renfrewshire
14	City of Edinburgh
15	Falkirk
16	Fife
17	Glasgow City

Local Authority Code	Council Name
18	Highland
19	Inverclyde
20	Midlothian
21	Moray
22	North Ayrshire
23	North Lanarkshire
24	Orkney
25	Perth & Kinross
26	Renfrewshire
27	Shetland
28	South Ayrshire
29	South Lanarkshire
30	Stirling
31	West Lothian
32	Comhairle nan Eilean Siar
90	Other
99	Undetermined

Appendix C - Specialty/discipline codes

Dental specialties	
D1	Community Dental Practice
D2	General Dental Practice
D3	Oral Surgery
D4	*Oral Medicine*
D5	*Orthodontics*
D6	Restorative Dentistry
D7	Dental Public Health
D9	Oral Pathology
DA	Oral Microbiology
DB	Dental & Maxillofacial Radiology
DC	Surgical Dentistry
DD	Fixed & Removable Prosthodontics
General practice specialties	
E1	General Practice
E11	GP Obstetrics Pathology specialties
E12	GP Other than Obstetrics
Mental health specialties	
G1	General Psychiatry
G22	Adolescent Psychiatry
G3	Forensic Psychiatry
G4	Psychiatry of Old Age
G5	Learning Disability (Mental Handicap)
G6	Psychotherapy

Medical specialties	
A1	General Medicine
A2	Cardiology
A3	*Clinical Genetics*
A5	Clinical Pharmacology & Therapeutics
A6	Infectious Diseases (Communicable Diseases)
A7	Dermatology
A8	Endocrinology & Diabetes
A9	Gastroenterology
AA	Genito-Urinary Medicine
AB	Geriatric Medicine (see note 1)
AC	Homeopathy
AD	Medical Oncology
AF	Paediatrics (Medical Paediatrics)
AG	Renal Medicine (Nephrology)
AH	Neurology
AK	Occupational Medicine (Occupational Health)
AM	Palliative Medicine
AN	Public Health Medicine
AP	Rehabilitation Medicine
AQ	Respiratory Medicine
AR	Rheumatology
AS	Audiological Medicine
AT	Medical Ophthalmology
AV	Clinical Neurophysiology
AW	*Allergy*

Obstetrics and gynaecology specialties	
F1	Obstetrics & Gynaecology
F2	Gynaecology
F3	Obstetrics
F31	Obstetrics Ante-natal
F32	Obstetrics Post-natal
Pathology specialties	
J1	Histopathology
J2	Blood Transfusion
J3	Clinical Pathology (Clinical Chemistry)
J4	Haematology
J5	Immunology
J6	Medical Microbiology & Virology
Radiology specialties	
H1	Clinical Radiology
H2	Clinical Oncology
H3	Nuclear Medicine

Notes:

1. Patients under the care of a GP in a GP or community hospital must be given the specialty code E12 (GP other than Obstetrics) regardless of whether the patients are in a short stay or long stay facility.
2. The specialties identified in italics are not expected to have delayed discharges recorded under them on a regular basis.

Appendix D - Reason for delay codes

Health and Social Care Reasons		
Assessment	11A	Awaiting commencement of post-hospital social care assessment (including transfer to another area team). Social care includes home care and social work OT
	11B	Awaiting completion of post-hospital social care assessment (including transfer to another area team). Social care includes home care and social work OT
Funding	23C	Non-availability of statutory funding to purchase Care Home Place
	23D	Non-availability of statutory funding to purchase any Other Care Package
Place Availability	24A	Awaiting place availability in Local Authority Residential Home
	24B	Awaiting place availability in Independent Residential Home
	24C	Awaiting place availability in Nursing Home
	24D	Awaiting place availability in Specialist Residential Facility for younger age groups (<65)
	24DX*	Awaiting place availability in Specialist Facility for high level younger age groups (<65) where the Facility is not currently available and no interim option is appropriate
	24E	Awaiting place availability in Specialist Residential Facility for older age groups (65+)
	24EX*	Awaiting place availability in Specialist Facility for high level older age groups (65+) where the Facility is not currently available and an interim option is not appropriate
	24F	Awaiting place availability in care home (EMI/Dementia bed required)
	26X*	Care Home/facility closed
	27A	Awaiting place availability in an Intermediate Care facility
	46X*	Ward closed – patient well but cannot be discharged due to closure
Care Arrangements	25A	Awaiting completion of arrangements for Care Home placement
	25D	Awaiting completion of arrangements - in order to live in their own home – awaiting social support (non-availability of services)
	25E	Awaiting completion of arrangements - in order to live in their own home – awaiting procurement/delivery of equipment/adaptations fitted
	25F	Awaiting completion of arrangements - Re-housing provision (including sheltered housing and homeless patients)
	25X	Awaiting completion of complex care arrangements - in order to live in their own home

Patient/Carer/Family-related reasons		
Legal/Financial	51 51X* 52	Legal issues (including intervention by patient's lawyer) - e.g. informed consent and/or adult protection issues Adults with Incapacity Act Financial and personal assets problem - e.g. confirming financial assessment
Disagreements	61 67	Internal family dispute issues (including dispute between patient and carer) Disagreement between patient/carer/family and health and social care
Other	71 71X* 72 73 74	Patient exercising statutory right of choice Patient exercising statutory right of choice – interim placement is not possible or reasonable Patient does not qualify for care Family/relatives arranging care Other patient/carer/family-related reason

Transport		
Transport	44	Awaiting availability of transport

Other reasons		
Complex Needs	9	Code 9 should be used with the following secondary codes: 24DX, 24EX, 25X, 26X, 46X, 51X, 71X. All code 9 delays should have a secondary reason code.
Unpublished	100	Reprovisioning/Recommissioning (see data definitions manual section 2.3)

* Indicates secondary code 9 reason for delay code.

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DRAFT CORPORATE SERVICES PLAN – UPDATE

Aim

1.1 To provide the Integration Joint Board (IJB) with an update on progress towards the development of the Corporate Services Plan for the Partnership.

1.2 The paper provides information re the key services that will be included in the plan and the draft timescales for completion.

Background

2.1 The legislation embedded in the Scheme of Integration requires that Scottish Borders Council and Borders Health Board agree the corporate support services required to fully discharge IJB duties under the Act.

2.2 Section 4.7 of the Scheme of Integration lays out the requirement for the development of the Corporate Services Plan. In this section it specifies the minimum services to be covered as follows:

"These support services will include, but not be limited to:-

- Finance (including capital planning)
- HR
- ICT
- Administrative Support
- Committee Services
- Internal Audit
- Performance Management
- Risk
- Insurance."

2.3 As well as the services required to be included by the legislation, our Corporate Services Plan will also include communications support to the Partnership. In addition, we will include the role of Planning and Performance services under the Performance Management category.

2.4 As we move through year one, and in line with our approach to the Commissioning and Implementation plan, the partner organisations are working together to ensure that we deliver a joined up and informed approach to providing the support services, to ensure continuity within existing business structures. However, we are also planning to review the requirements for these corporate services so that we can agree, where appropriate, the ways in which these will develop and evolve in subsequent years.

Summary

3.1 Through the various programme workstreams to date, each of the service leads for these areas have been involved in, and contributed to the development of the

programme and project outputs and they are aware of the need to establish our longer term approach to corporate services.

3.2 We plan to work through each service to identify any changes and/or efficiencies that can be achieved to improve joint working and to meet the needs of the Partnership, whilst retaining the level of service necessary to meet the demands of the individual organisations.

3.3 We will provide a further update to the IJB at the August meeting.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and confirm that we should proceed with our approach to developing the longer term Corporate Services plan.

Policy/Strategy Implications	Meet legislative requirements and support delivery of the Strategic Plan
Consultation	Engagement with management team and key corporate services leads will be fundamental to the delivery of the plan
Risk Assessment	To be carried out through the development of the plan
Compliance with requirements on Equality and Diversity	Advice on EIA requirement will be sought throughout the development of the plan
Resource/Staffing Implications	To be determined through development of the plan

Approved by

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

Author(s)

Name	**Designation**	**Name**	**Designation**
Sandra Campbell	Programme Manager		

Scottish Borders
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CORPORATE SERVICES PLAN- UPDATE

CONTENTS

1. Introduction to Corporate Services Plan

1.1 The legislation embedded in the Scheme of Integration requires that Scottish Borders Council and Borders Health Board agree the corporate support services required to fully discharge Integration Joint Board (IJB) duties under the Act.

1.2 Section 4.7 of the Scheme of Integration lays out the requirement for the development of the Corporate Services Plan. In this section it specifies the minimum services to be covered as follows:

"These support services will include, but not be limited to:-

- Finance (including capital planning)
- HR
- ICT
- Administrative Support
- Committee Services
- Internal Audit
- Performance Management
- Risk
- Insurance."

1.3 As we move through year one, and in line with our approach to the Commissioning and Implementation plan, the partner organisations are working together to ensure that we deliver a joined up and informed approach to providing the support services, to ensure continuity within existing business structures. However, we are also planning to review the requirements for these corporate services so that we can agree, where appropriate, the ways in which these will develop and evolve in subsequent years.

2. Scope of Corporate Services

2.1 As well as the services required to be included by the legislation, our Corporate Services Plan will also include communications support to the Partnership. In addition, we will include the role of Planning and Performance services under the Performance Management category.

2.2 Through the various programme workstreams to date, each of the service leads for these areas have been involved in, and contributed to the development of the programme and project outputs and they are aware of the need to establish our longer term approach to corporate services.

2.3 It should be noted that those staff working within the corporate services will continue to work for, and be employed by, NHS Borders or Scottish Borders Council (i.e. not a new organisation). The approach that we are taking demonstrates our intent on working together to achieve the IJB strategic plan outcomes and supporting the new entity to facilitate joined up delivery.

3. Approach to Development of Corporate Services Plan

3.1 We plan to work through each service to identify any changes and/or efficiencies that can be achieved to improve joint working and to meet the needs of the

Partnership, whilst retaining the level of service necessary to meet the demands of the individual organisations.

3.2 It will be essential to the success of the Partnership that we ensure that we have a clear view of how the various functions will support the integrated services.

3.3 We will be carrying out a number of focused workshops to determine the requirements that the Partnership has from each service. The first of these is scheduled to take place on 16th June and this will focus on Planning and Performance (P&P).

3.4 The workshop is aimed at providing information that will allow the P&P functions in both NHS Borders and Scottish Borders Council to get a sense of:

- What the joint information needs will look like as we move forward
- What this means in terms of the individual teams and how they will need to work together
- What changes we need to make to ensure that the teams continue to deliver the service demands coming from their own organisation as well as those coming from the Partnership.
- How we manage the delivery of routine information v project based information requirements.

3.5 Throughout the development of the plan, we will engage with appropriate stakeholders to ensure that we can effect a smooth transition to any changed arrangements and to protect the current level of services that are being delivered within each organisation. Staff are a key stakeholder group within this. As a result, we will be working with the management team to ensure that staff communications and engagement activities take place regularly, and are planned and managed effectively, through managers, as well as existing channels.

3.6 The aim is to minimise additional work for the existing services. Therefore, in reviewing and agreeing business requirements for the Partnership, we will be seeking to maximise the use of existing processes, data collection, management information production etc.

4. Specific Services

4.1 We will adopt this approach for the following services:

- Finance (including capital planning and insurance)
- HR
- ICT
- Administrative support
- Committee Services
- Planning & Performance
- Communications
- Internal Audit
- Risk

4.2 It should be noted that work is already underway in each of these areas, through the individual workstreams, to identify ways in which we will deliver the longer term Partnership requirements, whilst continuing to deliver to meet our year one objectives. This will feed into the workshops and subsequent planning, enabling us to move quickly to the development and delivery of the longer term plan. For example, within HR there has already been an analysis of current best practice processes within each organisation; this will help to inform the plan once we have a clear view of the overall longer term Partnership requirements. Similarly, under the ICT workstream, work is already underway to understand potential improvements in our approach to delivering IT support services for Partnership staff teams sharing premises and networks.

4.3 In the development of the Corporate Services provision, we will take account of the appropriate committee structure. For example, the role and cycle of reporting of the IJB's Audit Committee will need to be aligned to ensure that its focus and business plan is in line with the key objectives of the Partnership.

4.4 We will also give consideration to potential VAT impacts arising from the support services arrangements that are put in place, and what the financial flows, if any, associated with the arrangements are.

5. Conclusion

5.1 The Health & Social Care Integration Joint Board is asked to **note** the report and confirm that we should proceed with our approach to developing the longer term Corporate Services plan.

6. Next Steps

6.1 Following the first workshop in June, we will develop a detailed schedule of activities which will result in a final version of the Corporate Services Plan. We will adapt our approach where necessary, to ensure that the specific nature of each service is reflected, whilst maintaining consistency in our delivery standards and expectations.

6.2 We will provide regular updates to the IJB on this schedule and our progress to completion of the longer term Corporate Services Plan.

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CLINICAL AND CARE GOVERNANCE FRAMEWORK

Aim

1.1 This report provides an update to the Integration Joint Board (IJB) on Clinical and Care Governance Assurance Arrangements including: An overview of the clinical and care governance reporting arrangements within NHS Borders and Scottish Borders Council and how those arrangements will provide Clinical & Care Governance reports and assurances to the IJB.

1.2 The IJB were provided with a paper outlining the Clinical &Care Governance arrangements at the February meeting. This was agreed in principle, with a request for a further paper to be brought back that provided more detail on the process by which the arrangements would be delivered. This paper provides this further information, shown under section 6.

Background

2.1 There is a requirement for robust and effective governance, accountability and liability arrangements in order to ensure the delivery of safe, effective, person centred and quality services. The IJB Board requires assurance these arrangements are in place.

Summary

3.1 The partner organisations Scottish Borders Council and NHS Borders will report on clinical & care governance measures via the existing reporting structures.

3.2 NHS Borders Board will provide reports through their accountable Executive Directors (Medical and Nursing) and their Clinical Governance Committee.

3.3 Scottish Borders Council will provide reports through the Chief Social Work Officer and their Corporate Management & Executive Management Group at a frequency to be advised and incorporated into the business cycle of the IJB.

3.4 The IJB will receive Clinical & Care Governance assurance through the Chief Officer who will be supported by a Clinical & Care Governance Assurance Group comprising:

- Chief Social Work Officer
- Medical Director
- Director of Nursing, Midwifery & Acute Services

Recommendation

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

Policy/Strategy Implications	In compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	The report content has been provided on the basis previous updates to the IJB
Risk Assessment	A full risk assessment and risk monitoring process for the Integration Programme is in place as part of the Integration Programme arrangements.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	The report is based on the governance procedures and resources already established within the IJB partner organisations to provide assurance to the IJB of Clinical & Care Governance requirements.

Approved by

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

Author(s)

Name	Designation	Name	Designation
Karen McNicoll	Associate Director Allied Health Professionals		

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Scottish Borders Health & Social Care Integration Joint Board

CLINICAL AND CARE GOVERNANCE ASSURANCE FRAMEWORK

CONTENTS

1. Objectives

1.1 The primary objectives of this assurance framework are to:

- Identify how clinical & care governance assurance will be reported to the Integration Joint Board (IJB).
- Ensure that the Clinical & Care Governance Assurance Framework facilitates the identification of the key issues affecting the delivery of the Health and Social Care Strategic Plan and supporting Commissioning & Implementation Plan.
- Establish standards and principles for the efficient and effective management of clinical & care governance, including regular monitoring, reporting and review.

2. Reporting Structure

2.1 The IJB is responsible for the strategic planning of the functions delegated to it and the risks arising from that undertaking.

2.2 The partner organisations Scottish Borders Council and NHS Borders will report any relevant clinical & care governance issues via the existing reporting structures.

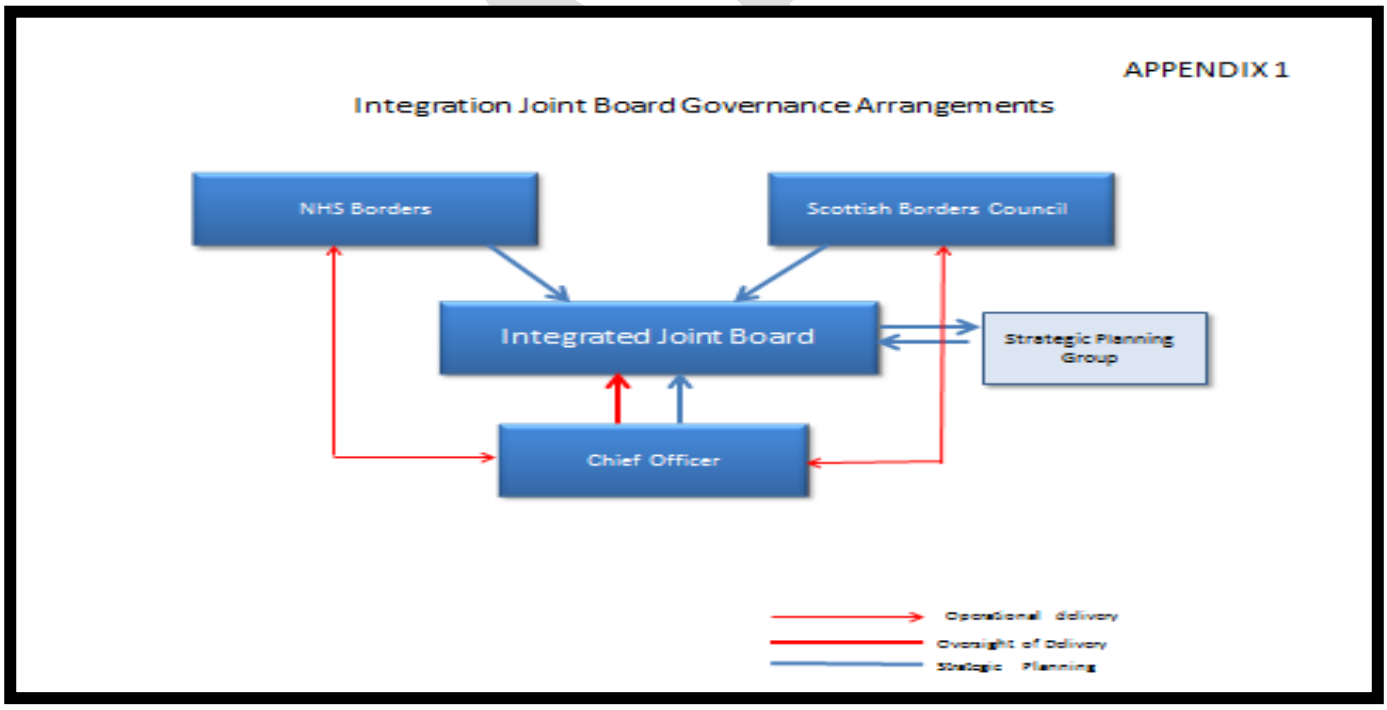

Diagram 1: Integration Joint Board Governance Arrangements Source: Scheme of Integration

3 Types of Topics to be Reported

3.1 This assurance framework takes a positive and holistic approach to clinical & care goverance assurance, including;

- Adverse events
- Patient feedback
- Clinical effectiveness
- Infection control
- Patient safety
- Medicines safety
- Adult Protection
- Child Protection
- Risk management (see Risk Management Strategy)
- Claims management
- Research governance
- National, internal and external audit or inspection reports (Care Inspectorate and Healthcare Improvement Scotland reports)

.

4 Clinical & Care Governance Assurance Framework and Process

4.1 This document represents the Clinical & Care Governance Assurance Framework to be implemented across the services delivered under the direction of the IJB and will contribute to the IJB's wider corporate governance arrangements.

4.2 There are five process steps to support clinical & care governance assurance;

- Information on safety and quality of services is recieved
- Information is scrutinised to identify areas of action
- Actions arising from scrutiny and review of information are documented
- Impact of actions is monitored, measured and reported
- Information on impact is reported against key priorities

.

5 Roles and responsibilities

5.1 All aspects of the work of the IJB should be driven by and designed to support efforts to deliver the best possible quality of health and social care. Clinical & care governance however, is principally concerned with those activities which directly affect the care, treatment and support that people receive.

5.2 Members of the IJB are responsible for:

- Collective ownership of clinical & care governance.
- Ensuring that delegated functions for clinical & care governance are being adequately and appropriately managed.
- Having oversight of clinical & care governance arrangements.
- Receiving and reviewing clinical & care governance issues that require to be brought to its attention.

5.3 The Chief Officer has overall accountability for the IJB's Clinical & Care Governance Assurance Framework, ensuring that suitable and effective arrangements are in place relating to the services delivered under the direction ofthe IJB. The Chief Officer will be responsible for drawing to the attention of the IJB any new or escalating clinical & care governance risks and associated mitigations to ensure appropriate oversight and action.

5.4 The Chief Officer will keep the IJB and the Chief Executives of the partner organisations informed of any significant existing or emerging clinical & care governance risks that could seriously impact the IJB's ability to deliver the outcomes and objectives of the Strategic Plan or the reputation of the IJB or the partner organisations.

5.5 Assurance to the IJB and subsequently, Scottish Borders Council and Borders Health Board in respect of the key areas of governance will be achieved through explicit and effective lines of accountability. This accountability begins in the care setting within an agreed Clinical & Care Governance Assurance Framework established on the basis of existing key principles embedded in the governance and scrutiny arrangements for Borders Health Board and Scottish Borders Council.

5.6 The Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing and Director of Public Health) share accountability for clinical governance of NHS services as a responsibility/function delegated from the Chief Executive of Borders Health Board.

5.7 These Directors continue to hold accountability for the actions of the Borders Health Board clinical staff who deliver care through health and social care integrated services. They attend the Borders Health Board Clinical Governance Committee which oversees the clinical governance arrangements of all services delivered by health care staff employed by Borders Health Board and which in turn will provide assurance to the IJB.

5.8 As part of the integration arrangements the Chief Social Work Officer will provide oversight and advice to the IJB on the quality of social work services delivered by social work staff through health and social care integrated services. The Chief Social Work Officer will continue to provide professional leadership for social work and be accountable for statutory decisions relating to social work. The Chief Social Work Officer is then held to account by Scottish Borders Council for such decisions and ensures that links are made across all social work services. The Chief Social Work Officer also advises Scottish Borders Council on the delivery of social work services through an annual report which will be made available to the IJB for assurance purposes. Scottish Borders Council will in turn provide assurance to the IJB via the Chief Social Work Officer.

5.9 The IJB and, where required, the Strategic Planning Group, will receive clinical & care governance reports from the parties on matters relating to the delegated functions.

5.10 As part of the regular monitoring process the IJB may, as required, also take advice from other appropriate professional forums and groups as outlined in Scottish Government guidance, including the Adult Protection Committee, Child Protection

Committee (for universal children's health services), Area Clinical Forum and Area Drug and Therapeutics Committee.

5.11 The appropriate appointed Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing and Director of Public Health) will support the Chief Officer and the IJB in the manner they support Borders Health Board for the range of their responsibilities.

5.12 The Chief Social Work Officer will support the Chief Officer and the IJB in the same manner they support Scottish Borders Council. Appropriate arrangements are in place for the Chief Social Work Officer to discharge their responsibility to health and social care staff who have a professional or corporate accountability to the Chief Social Work Officer.

6 Implementing Clinical & Care Governance Arrangements

6.1 Clinical & Care governance is key to the effective delivery of the objectives within the Strategic Plan.The following activities and outputs are in progress.

6.2 At the February 2016 meeting of the IJB the following action was identifed:

A clear statement describing the processes required to ensure clinical & care governance assurance arrangements in place for all services commissioned by the IJB.

6.3 A Professional Assurance Framework encompassing NHS Borders clinical services is in development by the NHS Borders Director of Nursing, Midwifery & Acute Services.

6.4 Chair of the Clinical Governance Committee of NHS Borders Board will be extending an invitation to the Chief Social Work Officer (or nominated officer) to join the Clinical Governance Committee as an attendee.

6.5 Chair of the Area Clinical Forum (ACF) will be extending an invitation to the Chief Social Work Officer (or nominated officer) to join the ACF as an attendee.

6.6 Mental Health and Learning Disabilities integrated services report within existing arrangements of both organisations. The Primary Care & Community Clinical Governance Group will be reviewed for opportunites to enhance social care colleagues and performance reports.

6.7 The Chief Officer will be supported by a group of responsible officers in each Partnership organisation and their staff to provide reports and assurance:The Clinical and Care Assurance Group which previously worked to map out existing assurance systems and processes and further requirements for the Partnership in line with the requirements for the Integration Scheme will be reconstituted to provide support to the Chief Officer and Integrated joint Board.

6.8 Membership of the Clinical and Care Governance Assurance Group, in addition to the Chief Officer, includes:

- Chief Social Work Officer
- Director of Nursing, Midwifery & Acute Services
- Medical Director

7 Communication of IJB Key Messages Relating to Clear and Transparent Understanding of Clinical & Care Governance Requirements.

7.1 An IJB Communications Plan will encompass key messages relating to clinical and care governance.

8 Implementation of Clinical & Care Governance Reporting and Monitoring Arrangements.

8.1 A report will be provided to the next meeting of the IJB.

9 Identification of Key Reports and Implementation of Reporting Timetable.

9.1 NHS Borders Board Clinical Governance Committee will provide assurance reports verbally in the first instance through the Chair of the Clinical Governance Committee who is also a member of the IJB.

9.2 The Chief Officer will provide assurance reports verbally in the first instance to IJB meetings on key performance indicators relating to Care Governance.

9.3 Reports will be built into the Business Cycle of the IJB by the Clinical & Care Governance Assurance Group and Board Secretary.

10 Next Steps

10.1 An evaluation of the efficiency and effectiveness of the IJB's clinical care governance assurance and reporting arrangements will be carried out as part of the annual assurance process on the IJB's corporate governance arrangements. The output will be considered by the IJB's Audit Committee within the annual governance reports.

10.2 Reports will be agreed by the Clinical & Care Governance Assurance Group and built into the Business Cycle of the IJB by the Clinical & Care Governance Assurance Group and Board Secretary.

APPOINTMENTS TO SUB COMMITTEES/GROUPS

Aim

1.1 To identify the nomination of members of the Health & Social Care Integration Joint Board to the Audit Committee, Strategic Planning Group and SB Cares Governance Group.

Background

2.1 Attached are the Terms of Reference for the Audit Committee. The Committee is to be made up of four voting members of the Health & Social Care Integration Joint Board.

2.2 Attached are the Terms of Reference of the Strategic Planning Group. The Committee seeks one voting member of the Health & Social Care Integration Joint Board.

2.3 Attached are the Terms of Reference for the SB Cares Governance Group. The Group seeks one non Council member of the Health & Social Care Integration Joint Board.

Summary

3.1 The Chair of the Health & Social Care Integration Joint Board will invite nominations of members to the 3 groups set out above.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** and **approve** the nominations agreed within the meeting.

Policy/Strategy Implications	As detailed within the Terms of Reference of the Committees/Groups.
Consultation	Health & Social Care Integration Joint Board.
Risk Assessment	As detailed within the Terms of the Reference of the Committees/Groups.
Compliance with requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	None.

Approved by

Name	Designation	Name	Designation
Cllr Catriona Bhatia	Chair, Health & Social Care Integration Joint Board		

Author(s)

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration	Iris Bishop	Board Secretary

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AUDIT COMMITTEE TERMS OF REFERENCE

CONSTITUTION

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

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

Chair

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

Quorum

Three members of the Committee will constitute a quorum.

Functions Referred

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

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

2. Assess the adequacy and effectiveness of the IJB's risk management arrangements and consider the assurances on compliance with an appropriate risk management strategy within annual governance reports.

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

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

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

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

7. The committee is responsible for assessing the adequacy and effectiveness of the IJB's corporate governance arrangements that underpin the delivery of best value

services and consider the assurances on value for money service delivery within annual governance reports.

8. Investigate any activity within its terms of reference, and in so doing, seek any information it requires.

Strategic Planning Group –Terms of Reference

1. Purpose

This paper sets out the proposed terms of reference and role for the Borders Health and Social Care Partnership's Strategic Planning Group.

2. Background

The Integration of health and social care is the Scottish Government's ambitious programme of reform to improve services for people who use health and social care services. Underpinned by the Public Bodies (Joint Working) (Scotland) Act 2014, it aims to ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.

This means from April 2016, the partnership between NHS Borders and Scottish Borders Council will bring together the following functions (or services to which these functions relate):

- District Nursing
- General Medical Services
- Public Dental Services
- General Dental Services
- Ophthalmic Services
- Community Pharmacy Services
- Community Geriatric Services
- Community Palliative Care
- Community Learning Disability Services
- Mental Health Services including child and adolescent mental health services (CAMHS)
- Continence Services
- Kidney Dialysis outwith the hospital
- Services provided by health professionals that aim to promote public health
- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Drug and Alcohol Services
- Community Care and Assessment Teams
- Care Home Services
- Adult Placement Services
- Health Improvement Services
- Aspects of housing support, including aids and adaptations
- Day Services
- Local Area Co-ordination
- Respite Provision
- Occupational Therapy Services
- Re-ablement Services

There are a number of functions delegated above that apply to children as well as adults. Those are:-

- District Nursing
- Public Dental Services
- General Dental Services
- Ophthalmic Services
- Community Pharmacy Services
- Community Learning Disability Services
- Mental Health Services including child and adolescent mental health services (CAMHS)
- Kidney Dialysis outwith the hospital
- Community Addiction services
- Allied Health Professionals services

There are number of housing functions which must be delegated and some that may be delegated. The Scottish Government Housing Advice Note of 2015 gives more detail in relation to these. From 1 April 2016, Scottish Borders Council and NHS Borders will delegate responsibilities – and associated budgets - to a joint legal body called the 'Integration Joint Board'. In the meantime, a Shadow Integration Board has been created to oversee the work.

Integration will see NHS, SBC and the voluntary and independent care partners, work as one to deliver services which are integrated around the needs of individuals, their Carers and family members.

3. Strategic Commissioning Plan

As part of the requirements laid down in the Public Bodies (Joint Working) (Scotland) Act 2014, the Integration Joint Board must produce a Strategic Commissioning Plan, and, in 2015, the Scottish Government published Statutory Guidance which requires that Strategic Commissioning Plans must also include a Housing Contribution Statement. The Strategic Plan must set out how they will plan and deliver services for the Borders over the medium term (three years) and, through this, how they will meet the National Health and Wellbeing Outcomes and achieve the core aims of integration:

- To improve the quality and consistency of services for patients, carers, service users and their families;
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

4. Strategic Planning Group (SPG)

Stakeholder Engagement

All stakeholders must be fully engaged in the preparation, publication and review of the Strategic Commissioning Plan as part of an on-going, cyclical process. To ensure this, the Act requires each Integration Authority to establish a Strategic Planning Group. The Integration Authority is required to consult the Strategic Planning Group on the Strategic Plan as it developed; the Strategic Planning Group acts as an advisory committee to the Integration Joint Board.

Role

The role of the Strategic Planning Group (SPG) is to support the Integration Joint Board in the cyclical development and finalising of the Plan and the continuing review of the progress in its delivery against the agreed national and local outcomes.

The Strategic Planning Group will be concerned with a series of questions throughout the commissioning process, such as the following, based on work by Audit Scotland:

- How many people will need services and what type will they need?
- What is the current provision, is it the right level, quality and cost?
- How can these services improve people's lives?
- Which services will best achieve this?
- How do we develop these services at an affordable cost?
- How do we procure and deliver these services to best effect?
- How do we monitor and review these services?

The process itself does not start or end with the publication of the Strategic Commissioning Plan. Engagement with stakeholders and the involvement of the Strategic Planning Group are all part of a continual, iterative cycle.

The role of the Strategic Planning Group is in developing and finalising the Strategic Commissioning Plan and in continuing to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators. The Strategic Commissioning Plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.

Localities

The views of localities must be taken into account with the Integration Authority required to identify the most appropriate person to represent each locality on the Strategic Planning Group. Local flexibility is allowed, so that an individual can represent more than one locality.

5. Members' Roles

Strategic commissioning is crucially about establishing a mature relationship between different partners from across the public, third and independent sectors in a way which will help to achieve the best services for the population. Providers

themselves will bring knowledge and experience of their services and the outcomes they are delivering. Every partner has a role to play in strategic commissioning, and that is why it is important that local arrangements promote mature relationships and constructive dialogue.

Members will be expected to:

- Act in an advisory capacity
- Represent their sector or professional area (community of interest) see table 1 below.
- Ensure the interests of the agreed localities are represented
- Develop and maintain the necessary links and networks with groups and individuals in their community of interest to enable views to be sought and represented over the development, review and renewal of the Strategic Commissioning Plan
- In the first year, to take an active role in the development of the initial draft of the Strategic Commissioning Plan (as well as the subsequent drafts)
- Help ensure the Plan reflects the needs and expectations (and that there has been an adequate assessment of those needs and expectations) both across the Borders and in the localities

6. Membership

The membership of the SPG is given in Appendix 1. Should the group identify that other stakeholders or partners would add value then appropriate representatives will be invited to attend. Attendees are there to support the Strategic Planning Group.

7. Quorum

No business shall be transacted at a Strategic Planning Group meeting unless there are present both Service Users and Carers of Service Users and at least half of the whole number of Members of the Strategic Planning Group.

Appendix 1

Members of the Strategic Planning Group

Prescribed Group/Title	Role	Name and Deputy
Health Professional	Chair of Area Clinical Forum	Karen McNicoll Deputy: ACF Committee Member
GP	GP Sub-Committee Representative	Tim Young Deputy: Sandy Morris
User of Health Care	Representative from NHS Public Participation Network	Dr Peter Symms
Carers of Users of Health Care	Manager, Borders Carers Centre	Lynn Gallacher Deputy: Linda Jackson
Social Care Professional	Acting Group Manager/Specialist Teams Manager Health & Social Care, SBC	Gwyneth Johnston Deputy: David Powell
Users of Social Care	Co-ordinator, Borders Voluntary Care Voice	Jenny Miller Deputy: Kathleen Travers
Carers of Users of Social Care	Manager, Borders Carers Centre	Lynn Gallacher Deputy: Linda Jackson
Commercial Providers of Social Care	Local integration Lead, Scottish Care	Margaret McGowan Deputy: Margaret McKeith
Statutory Housing Authority	Housing Strategy Manager, SBC	Gerry Begg Deputy: Donna Bogdanovic
Non-Commercial Social Housing Providers	Director of Housing and Care Services, Eildon Housing Association	Amanda Miller Deputy: tbc
Third Sector Bodies whose activities relate to Health and Social Care	Executive Officer, The Bridge	Morag Walker Deputy: tbc
Staff Representative SBC	Staff Officer, SBC	David Bell
Staff Representative NHS Borders	Mental Health and Learning Disability Services Partnership Chair	Shirley Burrell
Non-Commercial Providers of Health Care		tbc
Non-Commercial Providers of Social Care		Representative from SBCares tbc

In attendance

Susan Manion	Chair & Chief Officer
Eric Baijal	Director of Strategy
Elaine Torrance	Chief Social Work Officer
Tim Patterson	Joint Director of Public Health
Paul McMenamin	Interim Chief Financial Officer for Integrated Joint Board
Alasdair Pattinson	General Manager Primary & Community Services

	NHS Borders
Sandra Campbell	Programme Manager (Integration)
Julie Kidd	Principal Information Analyst NSS
Clare Malster	Strategic Community Engagement Officer
Steph Errington	Head of Performance and Planning NHS Borders
Clare Richards	Project Manager (Integrated Care Fund)
Carin Pettersson	Communications Officer (Integration)
Trish Wintrup	Locality Co-ordinator
Stewart Barrie	Locality Co-ordinator
Shona Donaldson	Locality Co-ordinator
Jane Robertson	Service Development Manager
Cathie Fancy	Group Manager for Housing Strategy & Services
Julie Watson	Organisational Design & Change Business Partner

Dr Eric Baijal

17 May 2016

LLP STRATEGIC GOVERNANCE GROUP

Constitution

(a) Five Elected Members of Scottish Borders Council being:-

(i) the Executive Member for Social Work
(ii) the Depute Leader (Finance)
(iii) three other Elected Members.

(b) One non-Council member of the Health and Social Care Integration Joint Board as a non-voting member.

Chairman

The Chairman shall be the Executive Member for Social Work.

Quorum

Three SBC Elected Members of the Sub-Committee shall constitute a quorum

Functions Referred

The following functions of the Council in relation to the LLP (SB Cares) shall stand referred to the Sub-Committee:-

Decision-Making

1. Approve the Scheme of Financial Governance for the LLP and any changes proposed, including but not limited to, the adoption of a Financial Risk Register, the delegation of financial approvals within set limits to particular officers or staff of the LLP and any approvals in respect of signatures on cheques.

* 2. Approve all staffing matters affecting the terms and conditions of employees of the LLP, Early Retirement/Voluntary Severance, potential compulsory redundancies, the variation of HR Policies and Procedures, any variation in conditions of employment.

3. Approve the expansion or contraction of the business of the LLP, including the pursuit of, bid for, or provision of any new workstreams or Services, or the relinquishment of any existing workstream or Service.

4. Approve the cessation of any part of the Services provided by the LLP.

*5. Approve the LLP Business Plan.

6. Approve or amend the LLP's scheme of internal delegation authorising named employees or Officers of the LLP to execute certain deeds on its behalf.

7. Approve amendments to the terms of Service Level Agreements.

8. Approve any significant amendments to the business structure of the LLP.

9. Approve any significant alteration to the nature of the LLP's business.

10. Approve the sale, disposal, assignment or otherwise alienation of any assets of the LLP of individual value of more than £50,000 or any interest in any properties.

11. Approve the acquisition of any assets of individual value of more than £50,000 or any interest in any properties.

12. Approve the issue of any loan capital or entry into any commitment with respect to the issue of any loan capital.

13. Approve the formation of any subsidiary, or acquisition of any shares in a company or participation in any partnership or joint venture.

14. Approve any closing down or the making of any material change to the nature scope or location of any business operation

15. Approve the amalgamation or merger with any other company or undertaking

16. Approve the entry into, variation or termination of any commitment by way of a transaction or series of related transactions (including any leasing transactions) which would involve the LLP in the payment or receipt of consideration and having an aggregate value in excess of £50,000

17. Approve any arrangement, contract or transaction which relates to capital expenditure with a value in excess of £50,000

18. Approve the creation of, or give permission to be created any mortgage, charge, encumbrance with other security interests whatsoever over the whole or part of the business undertakings or assets of the LLP or agree to do so, other than liens arising in the ordinary course of business or any charge arising by the operation or purported operation of title retention clauses and in the ordinary course of business

19. Approve any loan (otherwise and by way of a deposit with a bank or other institution the normal business of which includes acceptance of deposits), or, grant any credit (other than in the normal course of trading), or, give any guarantee (other than in the normal course of trading) or indemnity

20. Approve the appointment of a new bank or bank as the Banker to the LLP.

*21. Approve any change to the status of the pension fund, pension benefit for employees or employer contributions.

Scrutiny

*22. Monitor the financial records (including Profit and Loss Accounts, Balance Sheet and cash flow) and financial performance of the LLP. Such financial records shall be reported to the Local Authority annually, in arrears, and within one month of the end of the reporting period.

23. Monitor quarterly budgetary control statements to be submitted within one calendar month of each financial quarter close, and make any recommendations as appropriate to the LLP or to Council.

24. Monitor any Extra-Ordinary expenditure requirement which shall be reported by the LLP within one month of having been identified

25. Request any further information in the possession or control of the LLP regarding financial condition and operations of the LLP as the Local Authority may reasonably request.

26. Monitor any dispute arising between the LLP and any union representing its employees.

27. Monitor on a quarterly basis the performance of the LLP as measured against:

(a) the Key Performance Indicators contained within the Service Contract;

(b) the business plans of the LLP.

28. Monitor any claim made, or likely to be made, relating to the LLP, its Business or property (including any progress on such claims) and of which the LLP has knowledge which might impact financially or reputationally on the LLP, SB Supports or the Local Authority.

29. Monitor all reports prepared by the Care Inspectorate in respect of any part of the Services provided by the LLP.

NOTE: In terms of the LLP Partnership Agreement, any matters falling within Part 2 of the Schedule in the Agreement (Items 1 to 21 above) which are already detailed in the current approved LLP Business Plan, shall not require further specific approval.

Functions Delegated
All functions above NOT marked *. Those functions marked * are referred to the Sub-Committee for consideration and recommendation only and must receive approval of the Council.

HEALTH & SOCIAL CARE SHADOW INTEGRATION BOARD ANNUAL REPORT 2015/16

Aim

1.1 To provide the Health & Social Care Integration Joint Board with a report on the business it has undertaken during the period 1 April 2015 to 31 March 2016.

Background

2.1 An annual report of the business of the Health & Social Care Integration Joint Board should be produced as part of good practice processes.

Summary

3.1 This Annual Report forms part of the assurance required for the Governance Statement as produced for the NHS Borders Audit Committee as part of the Borders NHS Board Annual Accounts process.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the Health & Social Care Integration Joint Board Annual Report 2015/16 report.

Policy/Strategy Implications	Required as part of the governance statement process for NHS Borders.
Consultation	Not required.
Risk Assessment	Required as part of the governance statement process for the NHS Borders Annual Accounts process.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	Not applicable.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

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HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
ANNUAL REPORT 2015/16

1 Purpose

1.1 The Public Bodies (Joint Working)(Scotland) Act 2014 required Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. They could also choose to integrate planning and delivery of other services – additional adult health and social care services beyond the minimum prescribed, and children's health and social care services:

1.2 The Act required that the Local Authority and the Health Board jointly prepare, consult and then agree an Integration Scheme for the Local Authority area, prior to submission to Scottish Ministers for final approval. The Act stated that the purpose of an integration scheme was to set out:

- which integration model was to apply; and
- the functions that were to be delegated in accordance with that model.

1.3 The remit of the Scottish Borders Health & Social Care Integration Joint Board was to plan and commission services to ensure national and local outcomes were met, based on providing a more person centred approach with a focus on supporting individuals, families and communities.

1.4 In line with the legislation, the Scottish Borders Health & Social Care Integration Joint Board was remitted to plan and oversee the delivery of the integrated services for which it had responsibility. In line with its Strategic Commissioning Plan, the Health & Social Care Integration Joint Board required that the Local Authority and Health Board provide services to match what was required and it would oversee performance and targets to ensure that delivery was in line with the outcomes.

Vision, Aims and Outcomes

1.5 By maximising the opportunities presented through legislation the Health & Social Care Integration Joint Board aimed to achieve the highest outcomes for the people of the Scottish Borders. By creating new integrated arrangements across health and social care it would enhance, strengthen and develop the formerly separate services for the provision of adult health and social care. By integrating service delivery and fulfilling the expectations of the Strategic Commissioning Plan it sought to enhance and promote the health and wellbeing of the people of the Scottish Borders.

1.6 Working with the Third and Independent Sector, it would provide a unified approach across the public sector with a common sense of purpose. It would engage with service users, carers, staff and members of the public to empower individuals and communities to be a driving force for how the services would be shaped and developed. In turn, it would deliver the best possible services that would be safe, of the highest quality, person centred, efficient and fair.

1.7 The main purpose of integration was to improve the wellbeing of people who used health and social care services, particularly those whose needs were complex and involved support from health and social care at the same time. The Health & Social Care Integration Joint Board set out within its Strategic Commissioning Plan how it was to deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under Section 5(1) of the Act namely:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- 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.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- 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.
- Resources are used effectively and efficiently in the provision of health and social care services.

1.8 During the period 2015/16 the Health & Social Care Integration Joint Board had the following functions:-

- delegated local authority functions as agreed by Council;
- delegated NHS functions as agreed by the Health Board;
- exercise NHS and Council functions relating to the development and delivery of the partnership Integration Plan;
- exercise NHS and Council functions relating to the development and delivery of the Integration Board's Strategic Plan;
- development of locality planning;
- development of a communication strategy for both internal and external use;
- development of joint performance management arrangements; and
- equalities impact assessment
- finances

1.9 To fulfil its remit the Health & Social Care Integration Joint Board:-

- informed and considered the implications for the integration of services in Scottish Borders of national developments pertaining to the passage through

Parliament of the Public Bodies (Joint Working) (Scotland) Bill, the work produced by the National Working Groups, and the content of any consequential regulations or guidance issued by Scottish Ministers.

2 Management Support

2.1 The Health & Social Care Integration Joint Board was supported in its work through the Chief Officer for Health & Social Care Integration.

2.2 During 2015/16 the Health & Social Care Integration Joint Board appointed an Interim Chief Financial Officer and a Chief Internal Auditor.

3 Professional Advice

3.1 The Health & Social Care Integration Joint Board had the authority to access appropriate professional advice and guidance to fulfil its remit.

4 Health & Social Care Integration Joint Board

4.1 The Health & Social Care Integration Joint Board for 2015/16 was chaired by Cllr Catriona Bhatia, the membership was as follows:-

Voting Membership	
Elected Members of Scottish Borders Council	Cllr Catriona Bhatia (Chair) Cllr David Parker *member until 07.03.16* Cllr Frances Renton Cllr John Mitchell Cllr Jim Torrance Cllr Iain Gillespie *member from 07.03.16*
NHS Borders Non Executive Members	Mrs Pat Alexander (Vice Chair) Mr John Raine Dr Stephen Mather Mr David Davidson Mrs Karen Hamilton
Non Voting Membership	
Chief Officer	Mrs Susan Manion
NHS Borders Medical Director	Dr Sheena MacDonald/Dr Cliff Sharp/Mr Andrew Murray
NHS Borders Director of Nursing, Midwifery & Acute Services	Mrs Evelyn Rodger
SBC Chief Social Work Officer	Mrs Elaine Torrance
Joint Staff Forum Chair	Mr David Bell
NHS Borders Staff Side	Mr John McLaren
Borders Voluntary Care Voice Coordinator	Miss Jenny Miller
Borders Carers Centre	Mrs Fiona Morrison
Public Partnership Forum Chair	Mr Andrew Leitch/Mrs Angela Trueman
GP	Dr Angus McVean
Attendees	

Board Secretary	Miss Iris Bishop
Interim Chief Financial Officer	Mr Paul McMenamin
NHS Borders Chief Executive	Mrs Jane Davidson
SBC Chief Executive	Mrs Tracey Logan
SBC Depute Chief Executive	Mrs Jeanette McDiarmid
NHS Borders Director of Finance	Mrs Carol Gillie
SBC Chief Financial Officer	Mr David Robertson
Programme Manager	Mr James Lamb/Ms Sandra Campbell
Director of Strategy Integration	Dr Eric Baijal
NHS Borders Director of Workforce & Planning	Mrs June Smyth
IJB Chief Internal Auditor	Mrs Jill Stacey

5 Meetings

5.1 The Health & Social Care Integration Joint Board met on eight occasions during the year from 1 April 2015 to 31 March 2016, on the following dates:-

- 27 April 2015
- 22 June 2015
- 10 August 2015
- 12 October 2015
- 14 December 2015
- 1 February 2016
- 7 March 2016
- 30 March 2016 – Extra ordinary meeting

5.2 The Health & Social Care Integration Joint Board also undertook a series of development sessions throughout 2015/16 on the following dates:-

- 20 May 2015
- 23 September 2015
- 11 November 2015
- 20 January 2016

5.3 Appendix 1 details the schedule of business for 2015/16 and Appendix 2 the attendance record for 2015/16.

6 Conclusion

6.1 The Health & Social Care Integration Joint Board has worked to develop the joint agenda and strengthen the partnership between NHS Borders, Scottish Borders Council, the voluntary sector and the public.

7 Statement of Approval

7.1 The report has been produced as a record of work undertaken during the year ending 31 March 2016.

Approved by: Cllr Catriona Bhatia (Chair)

Signed: .....(Cllr Catriona Bhatia)

Date: .....

Health & Social Care Integration Joint Board
Schedule of Business considered: 1 April 2015 to 31 March 2016

Date of Meeting	Title of Business Discussed
27 April 2015 Not quorate	Minutes of Previous Meeting on 9 March 2015 Matters Arising & Action Tracker
	STRATEGY
	Programme Highlight Report Draft Strategic Plan Communications and Stakeholder Engagement Organisational Development Plan Interim Standing Orders
	GOVERNANCE
	Scheme of Integration Update Annual Report 2014/15
	FINANCE
	Monitoring of the Shadow Integrated Budget 2014/15 Integrated Budget 2015/16 Integrated Care Fund Update
Date of Meeting	Title of Business Discussed
22 June 2015	Minutes of Previous Meeting of 9 March 2015 & 27 April 2015 Matters Arising & Action Tracker
	STRATEGY
	Programme Highlight Report Draft Strategic Plan
	GOVERNANCE
	Nursing & Midwifery Council (NMC) proposed model for Revalidation Business Cycle 2015/16
	FINANCE
	Monitoring of the Shadow Integrated Budget 2014/15 Monitoring of the Shadow Integrated Budget 2015/16
Date of Meeting	Title of Business Discussed
10 August 2015	Minutes of Previous Meeting of 22 June 2015 Matters Arising & Action Tracker
	STRATEGY
	Development of Draft Strategic Plan
	GOVERNANCE
	Programme Highlight Report Interim Standing Orders Integration Scheme Update Communications Update
	DEVELOPMENT UPDATES
	Mental Health Service Update Integration: The difference it can make to individuals Transforming Nursing & Midwifery Roles

	Exploring the implications for integration of social work services
	FINANCE
	Monitoring of the Integration Joint Budget 2015/16 Chief Financial Officer Update
Date of Meeting	Title of Business Discussed
12 October 2015	Minutes of Previous Meeting of 10 August 2015 Matters Arising & Action Tracker
	STRATEGY
	Consultation on the Draft Strategic Plan Integrated Care Fund Progress Report
	GOVERNANCE
	Programme Highlight Report Integration Scheme update Communications Update
	FINANCE
	Monitoring of the Integration Joint Budget 2015/16
	FOR INFORMATION
	NHS Borders Winter Plan 2015/16 Annual Report of the Chief Social Work Officer 2014/15
Date of Meeting	Title of Business Discussed
14 December 2015	Minutes of Previous Meeting of 12 October 2015 Matters Arising & Action Tracker
	STRATEGY
	Update on consultation on draft Strategic Plan Organisational Development Plan Update on Scottish Borders Dementia Strategy
	GOVERNANCE
	H&SC Integration Programme: End of Phase 1 Report Chief Officer Report H&SC Integration Joint Board Business Cycle 2016 Integrated Joint Board Governance – Draft Financial Regulations
	FINANCE
	Monitoring of the Integration Joint Budget 2015/16 Integrated Care Plan Update
	FOR INFORMATION
	Committee Minutes
Date of Meeting	Title of Business Discussed
1 February 2016	Minutes of Previous Meeting of 14 December 2015 Matters Arising & Action Tracker
	STRATEGY
	Health & Social Care Strategic Commissioning Plan Integrated Care Fund Progress Update
	GOVERNANCE
	Chief Officer's Report Communications Update Appointment of Chief Internal Auditor Integration Joint Board Audit Committee arrangements

	FINANCE
	Monitoring of the Integration Joint Budget 2015/16 Integrated Joint Board Governance – draft financial regulations
	FOR INFORMATION
	Committee minutes Audit Scotland Report Chief Financial Officer
From Saturday 6 February 2016 the Scottish Borders Health & Social Care Integration Joint Board was legally established	
Date of Meeting	Title of Business Discussed
7 March 2016	Minutes of Previous Meeting of 1 February 2016 Matters Arising & Action Tracker
	GOVERNANCE
	Code of Corporate Governance Workforce Planning Framework
	STRATEGY
	Health & Social Care Strategic Plan
	FINANCE
	Monitoring of the Integration Joint Budget 2015/16 Integrated Resources Advisory Group Financial Statement and assurance over the sufficiency of resources
	FOR INFORMATION
	Chief Officer's Report Committee minutes
Date of Meeting	Title of Business Discussed
30 March 2016 Extraordinary meeting	H&SC Partnership Financial Statement 2016/17 and assurance over the sufficiency of resources

Appendix 2

Health & Social Care Integration Joint Board
Attendance Record: 1 April 2015 to 31 March 2016

VOTING MEMBERS	27.04.15	22.06.15	10.08.15	12.10.15	14.12.15	01.02.16	07.03.16	30.03.16 Extra Ordinary
Cllr Catriona Bhatia (Chair) SBC Elected Member	P	P	P	A	P	P	P	A
Cllr David Parker SBC Elected Member *Member until 07.03.16*	A	A	P	A	A	A	-	-
Cllr Iain Gillespie SBC Elected Member *Member from 07.03.16*	-	-	-	-	-	-	P	P
Cllr Frances Renton SBC Elected Member	A	P	P	P	P	A	P	P
Cllr John Mitchell SBC Elected Member	A	P	P	P	P	P	P	P
Cllr Jim Torrance SBC Elected Member	P	A	P	P	A	P	A	A
Mrs Pat Alexander (Vice Chair) NHS Borders Non Executive	P	A	P	P	P	P	P	P
Mrs Karen Hamilton NHS Borders Non Executive	P	P	A	P	P	P	P	P
Dr Stephen Mather NHS Borders Non Executive	A	P	P	P	P	A	P	P
Mr David Davidson NHS Borders Non Executive	P	P	P	P	P	P	P	P
Mr John Raine NHS Borders Non Executive	A	P	P	A	P	A	P	P

NON VOTING MEMBERS	27.04.15	22.06.15	10.08.15	12.10.15	14.12.15	01.02.16	07.03.16	30.03.16 Extra Ordinary
Mrs Susan Manion Chief Officer	P	P	P	P	P	P	P	P
Dr Sheena MacDonald NHS Borders Medical Director *Retired 31.12.15* *Deputy Cliff Sharp*	A	A	D	A	A	-	-	-
Dr Cliff Sharp NHS Borders Interim Medical Director *Member from 01.01.16 to 22.03.16*	-	-	-	-	-	P	P	-
Dr Andrew Murray NHS Borders Medical Director *Member from 22.03.16*	-	-	-	-	-	-	-	P
Mrs Evelyn Rodger NHS Borders Director of Nursing, Midwifery & Acute Services	P	P	A	P	P	P	P	A
Mrs Elaine Torrance SBC Chief Social Work Officer	P	P	P	P	A	A	P	A
Mr David Bell Joint Staff Forum Chair	P	P	A	P	P	P	P	P
Mr John McLaren NHS Borders Staff Side	P	P	P	A	P	P	P	A
Miss Jenny Miller Borders Voluntary Care Voice Coordinator	A	A	O	P	A	P	A	P
Mrs Fiona Morrison Borders Carers Centre *Deputy L Gallacher/L Jackson*	D	P	P	A	A	D	D	A
Mr Andrew Leitch Public Partnership Forum Chair	O	A	P	O	O	-	-	-

Member until 01.02.16								
NON VOTING MEMBERS	**27.04.15**	**22.06.15**	**10.08.15**	**12.10.15**	**14.12.15**	**01.02.16**	**07.03.16**	**30.03.16 Extra Ordinary**
Mrs Angela Trueman Public Partnership Forum *Member from 01.02.16*	-	-	-	-	-	P	P	P
Dr Angus McVean GP *Member from 12.10.15*	-	-	-	P	P	P	P	A
ATTENDEES	**27.04.15**	**22.06.15**	**10.08.15**	**12.10.15**	**14.12.15**	**01.02.16**	**07.03.16**	**30.03.16 Extra Ordinary**
Miss Iris Bishop Board Secretary	P	P	A	P	P	P	P	P
Mr Paul McMenamin Interim Chief Financial Officer *Attendee from 01.02.16*	-	-	-	-	-	P	P	P
Mrs Jane Davidson NHS Borders Chief Executive	P	P	P	A	P	P	P	P
Mrs Tracey Logan SBC Chief Executive	A	P	P	P	A	A	P	A
Mrs Jeanette McDiarmid SBC Depute Chief Executive	A	A	P	P	P	A	A	P
Mrs Carol Gillie NHS Borders Director of Finance	P	P	P	P	P	P	P	A
Mr David Robertson SBC Chief Financial Officer	P	P	P	P	P	A	P	P
Mr James Lamb Programme Manager *Attendee until 14.12.15*	P	P	A	P	P	-	-	-
Ms Sandra Campbell Programme Manager *Attendee from 14.12.15*	-	-	-	-	P	P	P	A

Dr Eric Baijal Director of Strategy Integration	-	P	A	P	P	P	P	P
Mrs June Smyth NHS Borders Director of Workforce & Planning *Attendee from 14.12.15*	-	-	-	-	P	A	A	A
Mrs Jill Stacey IJB Chief Internal Auditor *Attendee from 01.02.16*	-	-	-	-	-	P	P	P

P = Present / A = Apologies / 0 = Did Not Attend/No Apologies received / D = Deputy

MONITORING OF THE JOINT INTEGRATED BUDGET 2015/16

Aim

1.1 To provide the Integration Joint Board with a budgetary control statement on the Scottish Borders Health and Social Care Partnership's shadow revenue budget based on provisional outturn expenditure and income to 31st March 2016, with explanations of the major variances between projected outturn expenditure and income and the current approved budget.

Background

2.1 The total Shadow Revised Integrated Budget, at the 31st March 2016, is **£137.991m**.

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 delegated budgets being managed on an aligned basis only. Accordingly, any cost pressures, for which remedial action has not been possible, remain the responsibility of the originating partner organisation.

Key Issues

3.1 At 31st March 2016, the shadow partnership's delegated budget is reporting an overall position of an adverse variance of **£923k**. This position is net of any additional permanent or temporary investment into budgets during the year. Where possible, remedial actions have been taken in order to mitigate the impact of the pressures experienced during the year.

3.2 Total projected spend on the shadow budget at the 31st March 2016 is **£138.914m**, against a budget of **£137.991m**. The partnership is therefore reporting an adverse variance of **£923k**. The main element of this overspend relates to GP Prescribing which was previously project to be **£1.1m** overspent at year end, with the actual out turn being an adverse variance of **£1.3m**. This overspend is partly offset by underspends across a number of areas such as dental and mental health services.

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

Older People's Service

3.4 The level of both residential care beds and care at home hours commissioned externally during 2015/16 consistently exceeded the level of budget. This was further exacerbated by other exceptional factors including the transfer of homecare contracts to SB Cares, the Council's provider of last resort following the termination of two major care at home contracts by external providers, and new night support sleep-in wage costs as a result of employment legislation changes. These pressures were mitigated temporarily in-year 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, investment in the 2016/17 financial plan has been aimed at permanently addressing these and additional emerging pressures such as the increase in costs from the recent Older People care at home tender.

Generic Services

3.5 The highest area of risk and largest adverse variance across the delegated budget continues to be within GP Prescribing which reported an overspend of **£1.277m** due to the increased drugs prices due to the global short supply of certain drugs. This overspend has been partly offset by underspends across other generic services including Dental Services and Sexual Health. These underspends relate mainly to vacancies within dental and a small supplies underspend in sexual health. Similarly, the delivery of additional remedial savings targets across locality offices **£181k** and targeted management of staff turnover has contributed towards delivering savings to offset the social care pressures within Older People.

3.6 The joint Mental Health Service underspent by £187k mainly on staffing vacancies targeted in order to reduce the overall adverse position across the delegated budget in 2015/16.

3.7 2015/16 was a shadow year with budgets aligned only, any year-end overspends are the responsibility of the delegating organisation. NHS Borders will manage its element of any overspend having set aside a small contingency in its financial plan which will directly meet the outturn adverse variance of **£839k** on the delegated budget. Savings delivered across non-delegated services within Scottish Borders Council will be used to offset the provisional outturn adverse variance of **£84k**.

3.8 The Board will be informed should any further issues arise across either organisation relating to the 2015/16 audit process and consequential movement from the provisional position reported above.

Summary

4.1 At 31st March 2016, the Partnership's shadow delegated budget is reporting an overall position of an adverse variance of **£923k**. This position is net of considerable further pressures which have required permanent or temporary investment into key areas of budget during the year. Total projected spend against the shadow budget at the 31st March 2016 is **£138.914m**, which represents an increase in spend of **£429k** since the last reported position, attributable to a range of factors, including further adverse movement of **£177k** in the costs of GP Prescribing and a shortfall in the delivery of targeted financial plan savings/additional income of **£189k**, both within

Generic Services. NHS Borders has delivered a provisional outturn adverse variance of **£839k** on the shadow delegated budget whilst Scottish Borders Council is reporting a provisional outturn adverse variance of **£84k.** Both organisations will manage their respective variances through a combination of contingency and offset by savings made across non-delegated budgets.

4.2 The largest financial pressure experienced during the financial year related to GP Prescribing where a year-end adverse variance of **£1.277m** is forecast. A number of other pressures were experienced during the year particularly across Older People and Generic Services but planned and targeted temporary savings across other areas of the delegated budget has enabled the provisional position of £923k adverse variance to be reported.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the above reported projected provisional outturn position of **£923k** net adverse variance within the shadow delegated budget at 31st March 2016.

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 have a delegated budget of around £140m, within the existing scope. The budget may change as other functions are brought within the scope of the IJB Board.

Approved by

Name	Designation	Name	Designation
David Robertson	Chief Financial Officer		

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 Summary | **2015/16** | **AT END OF MTH: March**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Final Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,073**	**18,317**	**18,096**	**221**	**18,317**	**18,096**	**221**	**52**	**19**	**21**	Staff vacancies and review and management of care packages is projected to deliver a saving within the Learning Disability service.
Joint Mental Health Service	**15,795**	**15,717**	**15,530**	**187**	**15,717**	**15,530**	**187**	**344**	**311**	**311**	Management of staffing vacancies is projected to deliver a considerable saving across the Joint Mental Health service.
Joint Alcohol and Drug Service	**1,076**	**867**	**843**	**24**	**867**	**843**	**24**	**3**	**3**	**3**	
Older People Service	**24,148**	**24,458**	**24,652**	**(194)**	**24,458**	**24,652**	**(194)**	**23**	**0**	**0**	An increase in the number of care home beds and non-block contract homecare hours commissioned during February has increased the projected pressure across older people by £150k for 2016/17.
Physical Disability Service	**3,250**	**3,276**	**3,249**	**27**	**3,276**	**3,249**	**27**	**0**	**0**	**0**	
Generic Services	**74,412**	**75,836**	**77,024**	**(1,188)**	**75,836**	**77,024**	**(1,188)**	**599**	**497**	**504**	The majority of this adverse variances relates to GP prescribing, where there is considerable pressure resulting from increased drug prices. In addition, further pressures are being experienced within Primary & Community Management (increased requirement for flex-beds £202k) and as a result of the non-delivery of social care financial plan savings projected for 2016/17 (£170k) this year. These are largely offset by a range of savings from vacancy management within Public Dental Services and Service Management and Planning, in addition to the delivery of in-year targeted savings across Locality Teams.
SB Cares Contribution	**(480)**	**(480)**	**(480)**	**0**	**(480)**	**(480)**	**0**	**0**	**0**	**0**	Reduction of £69k in projected SB Cares Surplus from position previously reported at the end of December due to a retrospective reassessment of accrued holiday pay for care staff relating to public holidays worked during 2015/16 and other additional commitments, now £9k below budgeted contribution level.
Total	**136,274**	**137,991**	**138,914**	**(923)**	**137,991**	**138,914**	**(923)**	**1,021**	**829**	**839**	
Financed By:											
AEF, Council Tax and Fees & Charges	47,568	48,306	48,390	(84)	48,306	48,390	(84)				
NHS Funding from Sgovt etc	88,706	89,685	90,524	(839)	89,685	90,524	(839)				
Total	**136,274**	**137,991**	**138,914**	**(923)**	**137,991**	**138,914**	**(923)**				

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Final Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,073**	**18,317**	**18,096**	**221**	**18,317**	**18,096**	**221**	**52**	**19**	**21**	
Residential Care	4,181	4,255	4,276	(21)	4,255	4,276	(21)	0	0	0	
SBC Carers	2,065	2,055	2,059	(4)	2,055	2,059	(4)	0	0	0	
Homecare	667	2,727	2,613	114	2,727	2,613	114	0	0	0	
Day Care	791	632	648	(16)	632	648	(16)	3	0	0	
Community Based Services	8,181	6,365	6,320	45	6,365	6,320	45	0	0	0	
Respite	200	200	212	(12)	200	212	(12)	0	0	0	
Other	1,988	2,083	1,968	115	2,083	1,968	115	49	19	21	
Joint Mental Health Service	**15,795**	**15,717**	**15,530**	**187**	**15,717**	**15,530**	**187**	**344**	**311**	**311**	
Residential Care	21	0	0	0	0	0	0	0	0	0	
Homecare	227	202	201	1	202	201	1	0	0	0	
Day Care	182	181	172	9	181	172	9	5	0	0	
Community Based Services	835	720	699	21	720	699	21	0	0	0	
Respite	15	15	49	(34)	15	49	(34)	0	0	0	
SDS	44	107	110	(3)	107	110	(3)	0	0	0	
Choose Life	69	0	0	0	0	0	0	0	0	0	
Mental Health Team	14,402	14492	14299	193	14492	14299	193	339	311	311	
Joint Alcohol and Drug Service	**1,076**	**867**	**843**	**24**	**867**	**843**	**24**	**3**	**3**	**3**	
D & A Commissioned Services	945	709	683	26	709	683	26	0	0	0	
D & A Team	131	158	160	(2)	158	160	-2	3	3	3	
Older People Service	**24,148**	**24,458**	**24,652**	**(194)**	**24,458**	**24,652**	**(194)**	**23**	**0**	**0**	
Residential Care	5,557	6,353	6,646	(293)	6,353	6,646	(293)	0	0	0	
Homecare	8,107	7,843	7,726	117	7,843	7,726	117	0	0	0	
Day Care	198	210	234	(24)	210	234	(24)	0	0	0	
Community Based Services	1,018	1,456	1,406	50	1,456	1,406	50	16	0	0	
Extra Care Housing	7,272	8,006	8,091	(85)	8,006	8,091	(85)	0	0	0	
Housing with Care	283	439	450	(11)	439	450	(11)	0	0	0	
Delayed Discharge	267	267	262	5	267	262	5	0	0	0	
Other	1,446	-116	(163)	47	-116	(163)	47	7	0	0	
Physical Disability Service	**3,250**	**3,276**	**3,249**	**27**	**3,276**	**3,249**	**27**	**0**	**0**	**0**	
Residential Care	503	503	362	141	503	362	141	0	0	0	
Homecare	1,801	1,667	1,674	(7)	1,667	1,674	(7)	0	0	0	
Day Care	192	195	196	(1)	195	196	(1)	0	0	0	
Community Based Services	682	839	945	(106)	839	945	(106)	0	0	0	
Other	72	72	72	0	72	72	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**74,412**	**75,836**	**77,024**	**(1,188)**	**75,836**	**77,024**	**(1,188)**	**599**	**497**	**504**	
Community Hospitals	4,593	4,651	4,719	(68)	4,651	4,719	(68)	125	127	124	
GP Prescribing	21,349	20,935	22,212	(1277)	20,935	22,212	(1277)	0	0	0	Risk area for the partnership due to price volitility and currently little information
AHP Services	5,445	5,557	5,559	(2)	5,557	5,559	(2)	146	138	143	
General Medical Services	16,132	16,852	16,747	105	16,852	16,747	105	4	4	4	
Community Nursing	4,232	4,282	4,243	39	4,282	4,243	39	110	103	105	
Assesment and Care Management	238	300	294	6	300	294	6	0	0	0	
Group Managers	263	149	162	(13)	149	162	(13)	0	0	0	
Service Managers	160	4	1	3	4	1	3	0	0	0	
Planning Team	247	226	132	94	226	132	94	0	0	0	
Locality Offices	2,636	2,587	2,406	181	2,587	2,406	181	69	0	0	
SB Carers	471	473	517	(44)	473	517	(44)	0	0	0	
BAES	246	260	270	(10)	260	270	(10)	0	0	0	
Duty Hub	51	0	2	(2)	0	2	(2)	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	56	53	3	56	53	3	0	0	0	
Respite	42	12	8	4	12	8	4	0	0	0	
SDS	96	97	97	0	97	97	0	0	0	0	
OT	58	84	83	1	84	83	1	0	0	0	
Grants to Voluntary	43	43	34	9	43	34	9	0	0	0	
Out of Hours	110	117	4	113	117	4	113	0	0	0	
Community Based Services	7	35	132	(97)	35	132	(97)	0	0	0	
Sexual Health	599	624	558	66	624	558	66	7	6	6	
Public dental Services	3,992	3,667	3,415	252	3,667	3,415	252	81	80	82	
Community Pharmacy Services	3,856	4,023	4,023	0	4,023	4,023	0	0	0	0	
Continence Services	435	446	492	(46)	446	492	(46)	3	3	3	
Smoking Cessation	255	239	201	38	239	201	38	4	4	5	
Primary & Community Management	1,617	2,289	2,475	(186)	2,289	2,475	(186)	15	20	20	
Health Promotion	508	535	538	(3)	535	538	(3)	8	12	12	
Opthalmic Services	1,605	1,631	1,631	0	1,631	1,631	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	878	878	878	0	878	878	0	0	0	0	
Resource Transfer	2,563	2,609	2,603	6	2,609	2,603	6	0	0	0	
Other	1,629	2,175	2,535	(360)	2,175	2,535	(360)	28	0	0	
SB Cares Surplus Contribution	**(480)**	**(480)**	**(480)**	**0**	**(480)**	**(480)**	**0**				
Total	**136,274**	**137,991**	**138,914**	**(923)**	**137,991**	**138,914**	**(923)**	**1021**	**829**	**839**	
Financed By:											
AEF, Council Tax and Fees & Charges	47,568	48,306	48,390	(84)	48,306	48,390	(84)	0	0	0	
NHS Funding from Sgovt etc	88,706	89,685	90,524	(839)	89,685	90,524	(839)	0	0	0	
Total	**136,274**	**137,991**	**138,914**	**(923)**	**137,991**	**138,914**	**(923)**	**0**	**0**	**0**	

0

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Final Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**3,585**	**3,585**	**3,540**	**45**	**3,585**	**3,540**	**45**	**20**	**19**	**21**	
Residential Care	2,689	2,689	2,684	5	2,689	2,684	5	0	0	0	Fluctuating demand for assessment & treatment
SBC Cares	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
Other	896	896	856	40	896	856	40	20	19	21	Staffing vacancies
Joint Mental Health Service	**13,807**	**13,828**	**13,625**	**203**	**13828**	**13,625**	**203**	**319**	**311**	**311**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	0	0	0	0	0	0	0	0	0	
Choose Life	0	0	0	0	0	0	0	0	0	0	
Mental Health Team	13,807	13,828	13,625	203	13,828	13,625	203	319	311	311	Staffing vacancies
Joint Alcohol and Drug Service	**879**	**664**	**665**	**(1)**	**664**	**665**	**(1)**	**3**	**3**	**3**	BAS reported under mental health
D & A Commissioned Services	768	532	532	0	532	532	0	0	0	0	
D & A Team	111	132	133	(1)	132	133	(1)	3	3	3	
Older People Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Housing with Care											
Delayed Discharge	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	
Physical Disability Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

0

Joint Health and Social Care Budget **NHS** **2015/16** **AT END OF MTH:** **March**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**70,435**	**71,608**	**72,694**	**(1086)**	**71,608**	**72,694**	**(1086)**	**502**	**497**	**504**	
Community Hospitals	4,593	4,651	4,719	(68)	4,651	4,719	(68)	125	127	124	
GP Prescribing	21,349	20,935	22,212	(1277)	20,935	22,212	(1277)	0	0	0	Increased drug prices
AHP Services	5,445	5,557	5,559	(2)	5,557	5,559	(2)	146	138	143	
General Medical Services	16,132	16,852	16,747	105	16,852	16,747	105	4	4	4	
Community Nursing ex HV/SN	4,232	4,282	4,243	39	4,282	4,243	39	110	103	105	
Assesment and Care Management	0	0	0	0	0	0	0	0	0	0	
Group Managers	0	0	0	0	0	0	0	0	0	0	
Service Managers	0	0	0	0	0	0	0	0	0	0	
Planning Team	0	0	0	0	0	0	0	0	0	0	
Locality Offices	0	0	0	0	0	0	0	0	0	0	
SB Carers	0	0	0	0	0	0	0	0	0	0	
BAES	246	260	270	(10)	260	270	(10)	0	0	0	
Duty Hub	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Joint Health Improvement	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	0	0	0	0	0	0	0	0	0	
OT	0	0	0	0	0	0	0	0	0	0	
Grants to Voluntary	0	0	0	0	0	0	0	0	0	0	
Out of Hours	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Sexual Health	599	624	558	66	624	558	66	7	6	6	
Public dental Services	3,992	3,667	3,415	252	3,667	3,415	252	81	80	82	
Community Pharmacy Services	3,856	4,023	4,023	0	4,023	4,023	0	0	0	0	
Continence Services	435	446	492	(46)	446	492	(46)	3	3	3	Increased demand for service
Smoking Cessation	255	239	201	38	239	201	38	4	4	5	Reduction in patient numbers
Primary & Community Management	1,617	2,289	2,475	(186)	2,289	2,475	(186)	15	20	20	Use of flex beds higher than funded
Health Promotion	508	535	538	(3)	535	538	(3)	8	12	12	
Opthalmic Services	1,605	1,631	1,631	0	1,631	1,631	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	878	878	878	0	878	878	0	0	0	0	
Resource Transfer	2,563	2,609	2,603	6	2,609	2,603	6	0	0	0	
Other	2,130	2,130	2,130	0	2,130	2,130	0	0	0	0	
Total	**88,706**	**89,685**	**90,524**	**(839)**	**89,685**	**90,524**	**(839)**	**844**	**829**	**839**	
Financed By:											
AEF, Council Tax and Fees & Charges	0	0	0	0	0	0	0				
NHS Funding from Sgovt etc	88,706	89,685	90,524	(839)	89,685	90,524	(839)				
Total	**88,706**	**89,685**	**90,524**	**(839)**	**89,685**	**90,524**	**(839)**	**0**	**0**	**0**	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Final Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Joint Learning Disability Service	**14,488**	**14,732**	**14,556**	**176**	**14,732**	**14,556**	**176**	**32**	
Residential Care	1,492	1,566	1,592	(26)	1,566	1,592	(26)	0	A number of provider rate increases that were expected late in the financial year were not agreed resulting in the delivery of savings in Care at Home in particular in order to offset pressures in this area within the Older People's service.
SB Cares	2,065	2,055	2,059	(4)	2,055	2,059	(4)	0	
Homecare	667	2,727	2,613	114	2,727	2,613	114	0	
Day Care	791	632	648	(16)	632	648	(16)	3	
Community Based Services	8,181	6,365	6,320	45	6,365	6,320	45	0	
Respite	200	200	212	(12)	200	212	(12)	0	
Other	1,092	1,187	1,112	75	1,187	1,112	75	29	
Joint Mental Health Service	**1,988**	**1,889**	**1,905**	**(16)**	**1,889**	**1,905**	**(16)**	**25**	A breakeven position was previously reported during 2015/16 for the Joint Mental Health service. Reporting to the end of February however warned of the risk of new packages of care that were being planned at that time and these were then implemented before the end of the financial year.
Residential Care	21	0	0	0	0	0	0	0	
Homecare	227	202	201	1	202	201	1	0	
Day Care	182	181	172	9	181	172	9	5	
Community Based Services	835	720	699	21	720	699	21	0	
Respite	15	15	49	(34)	15	49	(34)	0	
SDS	44	107	110	(3)	107	110	(3)	0	
Choose Life	69	0	0	0	0	0	0	0	
Mental Health Team	595	664	674	(10)	664	674	(10)	20	
Joint Alcohol and Drug Service	**197**	**203**	**178**	**25**	**203**	**178**	**25**	**0**	
D & A Commissioned Services	177	177	151	26	177	151	26	0	
D & A Team	20	26	27	(1)	26	27	(1)	0	
Older People Service	**24,148**	**24,458**	**24,652**	**-194**	**24,458**	**24,652**	**(194)**	**23**	Demand for residential care beds and homecare hours has consistently outstripped budgeted levels during 2016/17. The level of homecare hours remained constant during March but a rise in the number of residential care beds that require to be commissioned has resulted in a further increase in the pressure against budget within this area.
Residential Care	5,557	6,353	6,646	(293)	6,353	6,646	(293)	0	
Homecare	8,107	7,843	7,726	117	7,843	7,726	117	0	
Day Care	198	210	234	(24)	210	234	(24)	0	
Community Based Services	1,018	1,456	1,406	50	1,456	1,406	50	16	
SB Cares	7,272	8,006	8,091	(85)	8,006	8,091	(85)	0	
Housing with Care	283	439	450	(11)	439	450	(11)	0	
Delayed Discharge	267	267	262	5	267	262	5	0	
Other	1,446	(116)	(163)	47	(116)	(163)	47	7	
Physical Disability Service	**3,250**	**3,276**	**3,249**	**27**	**3,276**	**3,249**	**27**	**0**	A small managed saving on the PWPD budget has been delivered to contribute towards wider pressures across the Adult Social Care budget.
Residential Care	503	503	362	141	503	362	141	0	
Homecare	1,801	1,667	1,674	(7)	1,667	1,674	(7)	0	
SB Cares	192	195	196	(1)	195	196	(1)	0	
Community Based Services	682	839	945	(106)	839	945	(106)	0	
Other	72	72	72	0	72	72	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Generic Services	**3,977**	**4,228**	**4,330**	**-102**	**4,228**	**4,330**	**-102**	**97**	Despite an in-year programme of targeted savings across Generic Services being put in place in order to offset pressures across the wider Adult Social Care budget, an adverse variance has been delivered at the end of the financial year. Savings across locality teams, service planning and management and the Out of Hours service have been more than offset by the delay in delivery of some Financial Plan efficiency savings / additional income pertaining to Day Services and Ability and Equipment Store income in particular.
Community Hospitals	0	0	0	0	0	0	0	0	
GP Prescribing	0	0	0	0	0	0	0	0	
AHP Services	0	0	0	0	0	0	0	0	
General Medical Services	0	0	0	0	0	0	0	0	
Community Nursing	0	0	0	0	0	0	0	0	
Assesment and Care Management	238	300	294	6	300	294	6	0	
Group Managers	263	149	162	(13)	149	162	(13)	0	
Service Managers	160	4	1	3	4	1	3	0	
Planning Team	247	226	132	94	226	132	94	0	
Locality Offices	2,636	2,587	2,406	181	2,587	2,406	181	69	
SB Cares	471	473	517	(44)	473	517	(44)	0	
BAES	0	0	0	0	0	0	0	0	
Duty Hub	51	0	2	(2)	0	2	(2)	0	
Extra Care Housing	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	56	53	3	56	53	3	0	
Respite	42	12	8	4	12	8	4	0	
SDS	96	97	97	0	97	97	0	0	
OT	58	84	83	1	84	83	1	0	
Grants to Voluntary	43	43	34	9	43	34	9	0	
Out of Hours	110	117	4	113	117	4	113	0	
Community Based Services	7	35	132	(97)	35	132	(97)	0	
Sexual Health	0	0	0	0	0	0	0	0	
Public dental Services	0	0	0	0	0	0	0	0	
Community Pharmacy Services	0	0	0	0	0	0	0	0	
Continence Services	0	0	0	0	0	0	0	0	
Smoking Cessation	0	0	0	0	0	0	0	0	
Primary & Community Management	0	0	0	0	0	0	0	0	
Health Promotion	0	0	0	0	0	0	0	0	
Ophthalmic Services	0	0	0	0	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	
Accommodation Costs	0	0	0	0	0	0	0	0	
Resource Transfer	0	0	0	0	0	0	0	0	
Other	(501)	45	405	(360)	45	405	(360)	28	
SB Cares Contribution to General Fund	(480)	(480)	(480)	0	(480)	(480)	0		
Total	**47568**	**48306**	**48390**	**(84)**	**48306**	**48390**	**(84)**	**177**	
Financed By:									
AEF, Council Tax and Fees & Charges	47568	48306	48390	(84)	48306	48390	(84)		
NHS Funding from Sgovt etc	0	0	0	0	0	0	0		
Total	**47568**	**48306**	**48390**	**(84)**	**48306**	**48,390**	**(84)**		

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DELEGATED FUNCTIONS 2016/17 FINANCIAL PLAN LEVEL OF INVESTMENT AND SAVINGS

Aim

1.1 To provide Integration Joint Board (IJB) members with further detail over the level of investment and planned efficiency and savings targets within NHS Borders and Scottish Borders Council's 2016/17 Revenue Financial Plans, on which the level of resources delegated to the IJB in 2016/17 have been based.

1.2 All efficiency savings and additional income targets require delivery in full in order to ensure the level of resources supporting the functions delegated to the IJB for 2016/17, remains affordable and sufficient. The report also therefore provides an overview of the progress made over the planning and delivery of the targeted efficiencies and savings, since the plans were agreed, highlighting any projected challenges or identified risks.

Background

2.1 On the 30th March 2016, the IJB noted 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. This report enabled the Partnership to approve the 2016/17 Financial Statement, following due diligence over the budget for its first year of operation, noting key areas of financial risk and the proposed actions for mitigation.

2.2 It was noted within the report that both NHS Borders and Scottish Borders Council have experienced considerable challenge in delivering balanced and affordable financial plans for 2016/17 due to a number of factors including:

- The impact of Scottish Government funding settlements on both organisations.
- Historic or emerging pressures arising from inflationary and other cost factors.
- Demographic-driven increases in demand for services.
- The requirement to direct resources to deliver priority outcomes.

2.3 In addition, the Financial Statement agreed was considered only indicative until such time as the Scottish Government agrees NHS Borders Local Delivery Plan and all areas of funding such as ring-fenced grants are formally notified.

2.4 Considerable investment has been made within the 2016/17 revenue budget across both organisations in order to address the above pressures, as concluded from the due diligence work and financial assurance undertaken. At the time of approving the Financial Statement however, it was highlighted to the Board that the level of resources delegated to the IJB in 2016/17 by each organisation, to support its direction of the functions for which it is now responsible, requires to be made within a budget that is both fully funded and deliverable and as such requires assurance over not only the sufficiency of resources in absolute terms, but that investment is targeted into the areas that require additional resources and that all savings plans are realistic and deliverable.

2016/17 Investment and Prevalent Pressures

3.1 Within the Health and Social Care Integration Scheme for the Scottish Borders, it is defined that in the first year of operation of the IJB, the baseline payment made to it for delegated functions will be established by reviewing past performance and existing plans for NHS Borders and Scottish Borders Council for the functions delegated, adjusted for material items. Specifically therefore, the 2016/17 delegated budget therefore 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 IJB's Strategic Plan.
- Other emerging areas of financial impact.

3.2 A key consideration therefore will be to ensure that the risk of pressures recurring from 2015/16 have been addressed, either through uplift and additional investment into these budget areas, permanent transfer of resource from other areas or through planned cost-reduction in 2016/17. This section of the report summarises the work both partner organisations undertook as part of setting their 2016/17 Financial Plans in addressing pressures experienced during 2015/16.

NHS Borders

3.3 Taking account of both (prevalent and emerging) pressures coupled to priority outcomes within the Partnership's Strategic Plan, a number of areas of investment have been made within the 2016/17 budget delegated to the IJB, including further indicative increases for 2017/18 and 2018/19.

3.4 Within NHS Borders draft financial plan, a range of uplifts, budget increases and targeted investment is planned over the next three years and specifically to the 2015/16 provisional outturn position, there is sustained ongoing investment into the *Drugs and GP Prescribing* budget, the largest area of historic and ongoing financial pressure within the delegated budget. In totality, **£1.495m** has been further invested by NHS Borders into this budget area for 2016/17 to meet both increased demand and price increases. Whilst, prima facie, this is sufficient to meet the recurring impact of pressures experienced in 2015/16, NHS Borders has little control over the cost drivers of this service, particularly market price increases and any future volatility may result in further financial pressure being experienced.

3.5 NHS Borders other area of significant adverse variance evident in the provisional shadow budget outturn statement, that was experienced during 2015/16, is within *Primary and Community Management*, mainly as a result of the continued use of flex-beds, which has put considerable pressure on the budget. As part of the wider transformational plan for Health and Social Care, the ongoing provision of these beds will cease during 2016/17 resulting once again in overall affordability within budget of this service as a whole.

3.6 An aggregate overspend of **£1.463m** in 2015/16 in these two service areas has been offset and the bottom-line pressure reduced to **£839k** overall through the delivery of savings across other delegated services at outturn, in particular the Joint

Mental Health Service **(£203k)**, Public Dental Services **(£252k)** and General Medical Services **(£105k)**.

3.7 The majority of these savings have arisen either as a result of staff turnover/vacancy management or are attributable to a number of smaller temporary causes. As a result therefore, it is clearly not assured that similar flexibility to offset pressures arising elsewhere across delegated budgets will be available during 2016/17 and any further emerging financial pressures which may arise, particularly in the GP Prescribing budget, will require a plan of remedial action to be agreed between the Partnership and NHS Borders.

3.8 Finally, in terms of other expected cost increases, provision has been made within NHS Borders financial plan to ensure that pressures associated with pay inflation are fully funded; this includes incremental and discretionary pay awards, and agreed low pay settlements.

3.9 A summary of all additional investment made within NHS Borders draft 2016/17 Financial Plan is detailed below:

	16/17
	£'000
Drugs & GP Prescribing	1,495
Total	**1,495**

Scottish Borders Council

3.10 During 2015/16, there were a number of service areas where cost and demand factors drove increased total spend pressures. Within *Older People's services*, the level of care at home hours commissioned during 2015/16 continued to exceed the level of budget available, compounded by factors including the transfer of homecare contracts to SB Cares, provider of last resort, and night support sleep-in wage costs. These pressures in totality were met temporarily in-year by a range of actions including a managed underspend in the Joint Learning Disability service **(£176k)** vacancy freeze across a number of service areas **(84k)**, targeted locality savings **(£181k)** and a residual adverse variance of **£84k** has been delivered at provisional outturn.

3.11 In order to recognise other pressures within the social care budget, particularly those recurring from 2015/16 as well as new and emerging pressures, Scottish Borders Council has further invested additional resources across functions delegated to the IJB on a recurring basis, in addition to meeting the costs of continuing existing service provision (e.g. manpower inflation, energy inflation, etc.). Elements of this, in line with Scottish Government direction (Social Care funding conditions), have been assumed to be funded from the additional resources transferring from health care to social care, whilst other elements are as a result of direction by the Council to meet historic or current pressures and can be summarised as follows:

	16/17 £'000
COSLA RCH Contract	36
Day Services	4
Living Wage and Service Developments *	1,754
Commissioned Care Arrangements	536
Demographic Increases (Older People, Other Adults)	783
Closing Historic Gap in Care at Home Budget	300
Reduction in Client Charging Income	130
Direct Payments	449
Health and Social Care Funding Uncommitted *	2,717
	6,709

*these figures were based on likely estimates at the time of approval of Scottish Borders Council's financial plan and relate entirely to assumed use of social care funding which has subsequently been updated as detailed work has been undertaken during the period since.

3.12 The above investment includes specific provision to permanently resource the transfer of homecare contracts to SB Cares and night support sleep-in wage costs that were met only temporarily from reserves during 2015/16. It also includes the assumed application of approximately half of the social care funding allocation from the Scottish Government to directly fund the additional costs associated with demand/capacity pressures (both current and projected demographic increases) and the living wage and specifically to 2015/16, to addressing the 2015/16 pressure in care at home outlined above.

3.13 Similar to NHS Borders, provision has been made within Scottish Borders Council's financial plan to ensure that pressures associated with pay inflation are fully funded.

2016/17 Financial Plan Proposed Efficiency and Other Savings

4.1 This budget is predicated therefore on the planning and delivery of a considerable programme of efficiency, other savings and additional income measures within both NHS Borders' and Scottish Borders Council's Financial Plans and where required, the identification of additional efficiency measures or other funding options, in order to address the remaining gap reported at the time the Financial Statement was approved in March. In relation to the efficiency and other savings measures specifically, it was reported that the majority of proposals had been identified and plans were, or were in the process of being, developed for their delivery, noting the high level of risk attached to the majority of these.

4.2 At the time of approving the 2016/17 Financial Statement, the IJB was asked to consider the basis on which the level of resources delegated was made, in terms of the absolute level of funding, the areas of targeted increased investment through uplift and other service pressures/growth and the proposed targets for efficiency and other recurring revenue savings. Within the Statement, the proposed programme of efficiency and other savings for both partners on which their financial

plans and ultimately, the level of resources delegated to IJB, was based was summarised as follows:

Table 1: NHS Borders Planned Efficiencies/Savings 2016/17

NHS Borders 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)**
Required 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)***

Table 2: Scottish Borders Council Planned Efficiencies/Savings 2016/17

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)**

4.3 Across both organisations therefore and wholly within the **£139.150m** of budget delegated to the IJB in 2016/17 is the requirement to plan and deliver **£6.902m** (£4.239m+£2.663m) of efficiency and further savings measures in 2016/17. Additionally, as identified in Table 1 above, **£793k** of proposals for the delivery of efficiency savings remained unidentified at 30th March 2016.

Overview of Planned Efficiencies and Other Savings

4.4 At the meeting of the IJB in April, it was agreed that further detail relating to the efficiency and other savings which underpin the overall affordability of the Financial Statement would be provided. Within **Appendix 1** of this report therefore, a summary of each proposal has been provided, together with a risk rating based on a number of factors such as the financial magnitude of each saving, progress made against their planning and delivery and identified challenges faced. Additionally however, further detail over what each planned efficiency or saving or additional income proposal involves has also been provided for each of NHS Borders and Scottish Borders Council's Financial Plans (**Appendices 2 and 4 respectively**) in order to inform members in more detail of the extent of scope of each proposal and visibility over the extend of the challenge of delivery.

4.5 What is clear from the proposals across both organisations is that they involve a significant level of service redesign and transformation. Traditionally, these areas tend to slip and in order to mitigate against any adverse financial impact of this, both organisations must work to identify additional opportunities and actions to temporarily deliver additional savings.

Planning and Delivery - Progress to Date

4.6 Work was undertaken during the period leading up to the agreement of the Financial Statement in March to define and scope each of the projects that will

deliver the targeted efficiency, savings and additional income on which the level of delegated resources requires. This work has now progressed to the planning and delivery stage and an update of the progress made can be provided, together with a current overview of any identified inherent risks or projected issues (**Appendices 3 (NHSB) and 5 (SBC)**).

NHS Borders

4.7 There are 14 key areas within NHS Borders Financial Plan requiring a planned approach to delivering **£3.917m** of efficiency savings in 2016/17. In addition, there remains a further **£793k gap** between the level of efficiency savings allocated to the delegated budget **(£4.239m)** and the total value of the proposals brought forward above **(£3.917)** of which **£471k** relates to a reduction in ring-fenced grant funding and **£322k** relates to other functions within the delegated budget, which to resolve, requires a total of 16 project plans for the delivery of savings within the delegated budget. A number of these efficiencies form part of a wider efficiency programme across NHS Borders services that are both delegated and non-delegated but delivery in full of the proposed targets is required nonetheless to ensure the overall affordability of Partnership's budget in 2016/17.

4.8 **Appendix 2** provides further detail of each efficiency proposal that is in progress currently, whilst **Appendix 3** provides an update of the progress made in planning and delivering each saving, together with a high-level risk rating.

4.9 Of the 14 efficiency proposals identified to date, 5 have been assessed as being LOW risk, 6 as MEDIUM or MEDIUM-HIGH risk (at initial, outline stage with low to reasonable confidence) (£2.108m) and 3 as HIGH RISK (£1.043m). In addition, no proposals have been brought forward since the start of the financial year to address the remaining **£793k** funding gap and which therefore results in the highest risk level applying to this level also.

4.10 There is a proposal to part-address **£220k** of the funding gap relating to the Alcohol and Drug Partnership (ADP) element of the ring-fenced grant reduction of **£471k** (Social Care funding), which if approved will reduce the overall funding gap and unallocated savings to **£251k** for 2016/17, but the delivery of this residual gap will remain highest risk until options for remediation are delivered.

4.11 Whilst early in the financial year it is clear that further work is intensively required to plan and deliver the full value of required efficiencies in 2016/17. Given that **£3.151m** remain as Medium or High Risk then rigorous and concentrated effort is required in the short-term to develop and deliver efficiency plans as soon as possible. Given this degree of high-value risk, the longer-term nature of some proposals and timing of reviews for some, in addition to the fact that months one and two of the financial year have now passed, it is likely that additional proposals will require to be brought forward to temporarily meet cash-savings targets this year.

Scottish Borders Council

4.12 Forming the nine identified themes within the 2016/17 savings programme planned by Scottish Borders Council are 14 project plans aimed at delivering **£2.663m** of savings in 2016/17. A summary assessment of progress relating to each of the 9

themes/14 workstreams is detailed in **Appendix 5**. Of the 14 workstreams, 7 are deemed to currently be LOW risk (established and progressing, with a high level of confidence), whilst 7 are deemed to be MEDIUM-HIGH risk **(£1.877m)** (At initial, outline stage with low to reasonable confidence).

4.13 Further planning and implementation work is clearly required urgently in relation to some projects therefore and additionally, it is again likely that temporary remedial actions will require bringing forward and delivery during 2016/17 in order to offset any delay or under-delivery in the overall planned savings programme target.

4.14 Partners will not only require to work thoroughly to deliver plans which are now in place and finalise the development of others, but close working and direction between the IJB and its partners to identify additional solutions to further close the remaining efficiencies gap and reduce the likelihood of non-delivery of higher-risk savings is also now required. Given the redesign nature of many of the higher value proposals (which is reflected within the risk rating currently attached to each) and the likelihood of slippage and non-delivery in financial terms during 2016/17, it is critical that both organisations and the IJB work together to identify additional options for savings delivery in order to mitigate any adverse impact.

Governance

4.15 In order to provide assurance over the ongoing affordability of the delegated budget and in particular, the sufficiency of resources to deliver functions delegated to the IJB, periodic financial performance reports will continue to be delivered. The basis of frequency of these reports will be:

- IJB: A full management report to each scheduled IJB (initially bi-monthly)
- Executive Management Team (EMT): An exception report and summary on a monthly basis to each meeting of the EMT.

4.16 This regular and frequent reporting will provide ongoing assurance over the delivery of the planned savings targets in the context of the wider financial position of the total integrated budget supporting the delivery of functions delegated to the IJB, taking account not only the delivery of planned efficiencies and savings, but also other factors such as emerging cost or demand pressures, remedial savings actions and other factors such as service transformation or legislative change.

4.17 The level of savings which require to be made within both partners' revenue financial plans is considerable and as high as it has historically been in recent financial years. Clarity and assurance over progress made therefore is paramount and additionally therefore, it is proposed that a quarterly monitoring report specific to the delivery of planned efficiencies and savings is made to the IJB in order to provide specific update on the delivery of each specific proposal. This will draw heavily on the governance arrangements which are now in place within both partner organisations specific to the planning and delivery of the planned level of savings.

4.18 For NHS Borders, each identified scheme will be submitted to the Clinical Executive Strategy Group for discussion and agreement, operational delivery and implementation will be undertaken by local delivery groups and monitored monthly by a Quality and Efficiency Board. An Executive lead will be identified for each

project to provide appropriate oversight in terms of delivery and ensure mitigation or action is undertaken where schemes are not progressing as anticipated. A detailed report on delivery against the efficiency programme will be made to the Strategy & Performance Committee for each of its meetings during the course of the year.

4.19 Within Scottish Borders Council, all savings projects will be subject to monthly reporting to the Adult Services Transformation Board & Delivery Group which will have responsibility for both the oversight and delivery of planned financial targets. Additionally, specific transformation savings reports, accompanying the monthly revenue monitoring report, will be made to the Council's Corporate Management team (CMT) and where scheduled, reported onward to the Council's Executive.

4.20 It is anticipated that these processes provide adequate governance over the required delivery of the efficiency and savings targets on which the 2016/17 budget is predicated and will enable transparency and clarity of progress made and any associated impact of non-delivery to be reported regularly and frequently to the IJB.

Summary

5.1 A summary of the budget movement from 2015/16 to 2016/17 is detailed below.

Table 3: Summary Budget movement 2015/16 to 2016/17 against 2015/16 Outturn

		NHSB £000	SBC £000		Total £000
A	2015/16 Shadow Base Budget	88,706	47,568		136,274
	2015/16 Outturn Spend	90,524	48,390		138,914
	2015/16 Variance against Base Budget	(1,818)	(822)		(2,640)
B	**Investment:**				
	Pay Uplift, etc	1,158	12		1,170
	Uplift and Targeted Investment	1,495	6,709	*	8,204
	Adjustments to Base Budget	232	172		404
	* includes £5.27m social care funding assumption				
C	**Savings:**	(4,239)	(2,663)		(6,902)
	2016/17 Delegated Base Budget (*A+B-C*)	**87,352**	**51,798**		**139,150**

5.2 In totality, the budget has increased from a shadow budget in 2015/16 of £136.2m to a delegated budget in 2016/17 of **£139.150m**. Whilst actual outturn spend in 2015/16 was **£138.914m**, which is **£236k** less than the total budget for 2016/17, it is noted that:

- 2016/17 includes **£1.342m** of Pay Uplift which in real-terms means that overall, the budget has reduced by £1.106m when pay is excluded.
- The investment required to ensure that the pressures identified during 2015/16 are addressed require substantial efficiency and other savings to be delivered.
- All savings plans must be delivered. These include:
  - Planned savings within the 2016/17 Financial Plan.

- Planned savings to reduce 2016/17 spend to below 2015/16 outturn levels.

6 Summary

6.1 Both partner organisations have undertaken work as part of setting their 2016/17 Financial Plans in order to address pressures experienced during 2015/16. Key areas of financial pressure during the year and adverse outturn at 31st March have primarily been addressed, including GP Prescribing and Care at Home. This however assumes that no further pressures emerge in these areas during 2016/17. It is also worthy of note that if further pressures do arise during 2016/17, then the same level of flexibility experienced during 2015/16 to deliver savings elsewhere across delegated budgets may not exist to the same extent.

6.2 Across both organisations and within the £139.150m of budget delegated to the IJB in 2016/17 is the requirement to plan and deliver £6.902m (£4.239m NHS Borders / £2.663m Scottish Borders Council) of efficiency and further savings measures in 2016/17. Proposals are in place to deliver £6.109 of these savings whilst £793k of proposals for the delivery of efficiency savings remained unidentified at 30th March 2016.

6.3 There is currently a high degree of risk attached to many of the proposals and over £5.0m in proposal value is currently assessed as Medium or High Risk. This factor alone is of critical concern and considerable work must now be quickly progressed to ensure delivery of all financial savings where possibility exists.

6.4 It is imperative also that the both partners now work closely with the IJB to identify and deliver further savings opportunities with immediate effect in order to mitigate the financial impact of any non-delivery of planned opportunities during 2016/17 and bridge the remaining funding gap resulting from unidentified savings proposals.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the the further detail provided as to the areas of targeted investment made by NHS Borders and Scottish Borders Council in relation to the 2016/17 budget for those services delegated to the IJB from 1st April 2016, specific to the summary of areas of key pressure experienced during and at the end of 2015/16. The Health & Social Care Integration Joint Board is also asked to **note** the further detail provided on each partner's 2016/17 efficiency/savings programme on which their Financial Plans are based and the full delivery of which is required in order to ensure that the 2016/17 delegated budget is fully affordable and funded, noting progress to date, associated risks of each proposal and resultant overall risk to the affordability of the delegated budget as a whole.

Policy/Strategy Implications	Supports the delivery of the Strategic Plan.
Consultation	Discussions held with key strategic leads.
Risk Assessment	To be reviewed in line with agreed risk managememt strategy.
Compliance with requirements on Equality and Diversity	Compliant.

Resource/Staffing Implications	No resourcing implications.

Approved by

Name	Designation	Name	Designation
David Robertson	Chief Financial Officer, Scottish Borders Council	Susan Manion	Chief Officer

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Chief Financial Officer, IJB		

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RISK SUMMARY OF EFFICIENCY / SAVINGS PROPOSALS

APPENDIX 1

Unidentified	U - Unidentified
High - *At initial / feasibility stage, confidence low currently*	R - Red
Medium to High	A - Amber
Medium - *At outline stage, project initiation, reasonable confidence*	Y - Yellow
Low - *Established and progressing, high level of confidence*	G - Green

NHSB Savings	**2016/17 £'000 recurring**	**2016/17 £'000 n/recurring**	**2016/17 £'000 total**	**RISK (URAYG)**
Nursing Skill Mix Review	(93)	0	(93)	R
Non Support Service Admin	(118)	0	(118)	A
Better Procurement Supplies Uplift 2016/17	(235)	0	(235)	G
Travel Costs	0	(95)	(95)	G
Suspend Clinical Excellence Fund 2016/17	0	(186)	(186)	G
Clinical Productivity	(750)	0	(750)	R
Borders Wide Day Hospitals Review	(200)	0	(200)	R
Drugs & Prescribing	(600)	0	(600)	Y
Review - Step Up / Down Facilities	(200)	(350)	(550)	A
Improving Pathway of Care	(640)	0	(640)	A
MH & LD Management Arrangements	(100)	0	(100)	Y
AHP Management Model	(100)	0	(100)	Y
Review Public Health	0	(150)	(150)	G
Other Schemes	(100)	0	(100)	G
Total Savings Proposed	**(3,136)**	**(781)**	**(3,917)**	
Target Savings	**(3,261)**	**(979)**	**(4,239)**	
Net deficit against allocated target	*(125)*	*(198)*	*(322)*	U
Ringfenced Allocation Reductions	(471)	0	(471)	U
Total savings deficit against allocated target	*(596)*	*(198)*	*(793)*	

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

NHS Borders **APPENDIX 2**

Revenue Financial Plan 2016/17

Efficiencies / Savings Detail - NHS Borders

Nursing Skill Mix Review		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Nursing Budgets		(93)	0	0	0	0	(93)
Description of Proposal	A comprehensive review of nursing establishments and skill mix within teams will be undertaken during 2016/17. There is an expectation that this should identify savings through opportunities identified for modifying skill mix within and between clinical teams. The work is starting in June and is likely to continue for 12-15 months.							

Non-Support Service Administration Costs		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Admin Budgets		(118)	0	0	0	0	(118)
Description of Proposal	This the second stage of a wide ranging review of administrative support provided to clinical teams right across NHS Borders (exluding corporate service). Savings are anticipated from a review of locality arrangements, better integration of support teams, a review of team structures, and from a review of opportunities presented by better use of technology.							

Better Procurement - Supplies Uplifts		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Supplies Budgets		(235)	0	0	0	0	(235)
Description of Proposal	Ongoing review of procurement arrangements and supplies savings opportunities. This will include an assessment of authorisation limitis and local controls to ensure these are consistant with responsibility and accountability frameworks at the level of cost commitment and day to day operational decision making.							

Travel Costs		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Travel Budgets		(95)	0	0	0	0	(95)
Description of Proposal	Non-Recurring Savings - Provision set aside for significant rise in fule prices and a corresponding rise in allowances paid for travel. Released against requirement for non-recurring savings in 2016/17.							

Suspend Clinical Excellence Funded		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Reserve		(186)	0	0	0	0	(186)
Description of Proposal	Non -recurring savings. Development fund set aside to support schemes promoting clinical excellence. Proposal to release against the requirement to meet non recurring savings during 2016/17 given the significant in year savings requirement.							

Clinical Productivity		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	P&CS, MH & LD		(750)	0	0	0	0	(750)
Description of Proposal	A comprehensive review of working practices across a number of clinical areas. This includes work scheduling, administrative support, and operational planning. This work has been piloted in Mental Health supported by an external facilitator and has indicated potential benefit for service performance, patient experience, and highlighted some opportunity for efficiency associated with better work planning across teams. NHS Borders is developing a programme of work to roll out the work undertaken in mental health to other service areas having taken into account the leassons learned.							

Borders Wide Day Hospital Review		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	P&CS, MH & LD		(200)	0	0	0	0	(200)
Description of Proposal	A Borders wide review of arrangements for provision of day care and day hospital services within the context of Health and Scoal Care integration. Current proposal concerns the arrangement in Peebles, and at opportunities within a single locality to consolidate and integrate services, improve access and to identify if this promotes better use of exisiting resources. Some early indication that longer terms savings may be possible but unlikely to release immediate savings and will required some mitigation, or identification of alternative savings in the interim.							

Drugs and Prescribing		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Drug Budgets		(600)	0	0	0	0	(600)
Description of Proposal	Significant opportunity for avings within the overall consolidated drugs budget have been identified. The majority of savings in the short term are related to high cost drugs in secondary care (biologics), however the Pharmacy Team are working closely with primary care teams to support a review of polypharmacy, general prescribing and drug costs asscociated with a number of chronic health care conditions.							

Step Up/Step Down Care Arrangements		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	P&CS		(550)	0	0	0	0	(550)
Description of Proposal	Supporting a comprehensive review of community hopsital length of stay with a view to standardising at 18 days for all community hospitals in the Borders. To be achieved through the range of activity associated with investment in transistional care arrangements, reablement services and adult care assessment. Significant investment from ICF is anticipated to support redesign during 2016/17 but detail and specific porposal h							

Improving Pathways of Care		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	NHS Borders		(640)	0	0	0	0	(640)
Description of Proposal	NHS Border is currently committed to a number of ad hoc capacity arrangements during the winter to support both an expected upturn in admission, but also a range of additional delays that extend hospital admission, particiularly for older adults and frail or elderly patients. A range of measure are being introduced during 2016 that will address some of the systems issues that introduce uncessary delays for patients and ensure that systems performance is improved as a consequence and ad hoc or short term capacity measure are not required at current levels.							

Review Mental Health & Learning Disability Management Arrangements		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	MH & LD		(100)	0	0	0	0	(100)
Description of Proposal	Saving to be identified from the integration of adult mental health and social care services as part of a wider review of management arrangements in both services.							

Review of AHP management model		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	AHP Services		(100)	0	0	0	0	(100)
Description of Proposal	Service Management savings to be identified from the integration of AHP services across health and social care.							

Review of Public Health Services		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Public Health		(150)	0	0	0	0	(150)
Description of Proposal	Non-recurring savings to be identified from integration of management arrangements between health and social care. Will form part of a wider review of public health service moving forward.							

Other Minor Schemes/Review of Costs		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	P&CS, AHP		(100)	0	0	0	0	(100)
Description of Proposal	A number of recurring underspends indeitifed as part of wider budget review exercise to be released to savings on a recurring basis.							

Unidentified Savings - Non-Ringfenced		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	P&CS, AHP		(322)	0	0	0	0	(322)
Description of Proposal	At the time of setting the budget, there was a gap of £322k between the level of savings allocated to functions to be delegated to the Integrated Joint Board and the total value of savings proposals made to date.							

Unidentified Savings - Ringfenced		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	P&CS, AHP		(471)	0	0	0	0	(471)
Description of Proposal	Funding has been reduced across across a range of services as a result of a reduction in the ring-fenced grant income from the Scottish Government in 2016/17, at a total value of £471k which will require additional savings measures / supplementary funding options to be brought forward.							

NHS Borders **APPENDIX 3**

Revenue Financial Plan 2016/17

Efficiencies / Savings Progress Update - NHS Borders

Nursing Skill Mix Review (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(93)	0	0	0	0	(93)
No of Projects: 1 Status: Ongoing Overall Current Risk: R	A detailled project plan has been developed to aimed at a systematic review of skill mix within wider team teams right across Acute, Primary and community, and mental health services. This is been undertaken in a targeted fashion, and will be supported by a number of recognised national tool to ensure skill mix within teams reflects best current advise on best practice. It is not evident at this point where savings will be identified and how easy it might be to release any identified given the work force implications. It is likely that alternative schemes will need to be identified for 2016/17 in order to mitigate this risk.							

Non Support Service Administration Costs (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(118)	0	0	0	0	(118)
No of Projects: 1 Status: Ongoing Overall Current Risk: R	This is a scheme carried forward from 2015/16. While a number of workstreams have been suggested only a proportion of the required overallsavings target has been identified, A detailed prject plan is currently being developed, and immediate opportunities for savings are being considered. This includes a detailed impact assessment and gapping post that are currently, or may become vacant, during the year as mitigation against savings.							

Better Procurement - Supplies Uplifts (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(235)	0	0	0	0	(235)
No of Projects: 1 Status: Ongoing Overall Current Risk: G	NHS Border has offset provision for general supplies inflation against savings to be identified from a review of product rationalisation and price comparison. This is thought to be low risk given low general price inflation for non drug items.							

Travekl Costs (non Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(95)	0	0	0	0	(95)
No of Projects: 1 Status: Ongoing Overall Current Risk: G	This the release of a provision held in anticpation of increasing fuel prices and an associated increase oin allowance paid to staff. There is little indication that fuel prices will increase to previous levels during 2016/17 so this will be released on a non recurring basisi to support achievement of in year non recurring pressures as part of our overall finacial plan.							

Suspend Clinical Excellence Fund (Non Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(186)	0	0	0	0	(186)
No of Projects: 1 Status: Ongoing Overall Current Risk: G	Low risk, this will result in applications aganist the clinical excellence fund not be considered during 2016/17 and fund being released to savings on a non recurring basis pending delivery of savings targets in full.							

Clinical Productivity (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(750)	0	0	0	0	(750)
No of Projects: 1 Status: Ongoing Overall Current Risk: R	A pilot programme undertaken in 2015/16 has demonstrated that there is considerable potential associated with the overall clinical productivity work stream. However the process is intensive and requires significant support in terms of facilitation.							

Day Hospital Service Review (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(200)	0	0	0	0	(200)
No of Projects: 1 Status: Ongoing Overall Current Risk: R	This forms part of a wdier review of day care and day hospital services right across health and socail care. Current proposal are for a test of change in a single locality that incvolves a consolidation of apporpriate service aaround a signle service hub. Any longer term measures will required significant impact and quality assessment and a period of consultation. While longer term options are being consdiered short term opportunities for savings to mitigate risks will be explored.							

Drugs & Prescribing (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(600)	0	0	0	0	(600)
No of Projects: 1 Status: Ongoing Overall Current Risk: A	In total £700k of drugs and precribing savings have been identified against a global target for NHS Border of £1.2m. A range of futher measure is being considered, along with a review of national work that might support NHS Borders in briding the current savings gap. There is a reasonable levl of confidence that this will be bridged in the current finacial year.							

Step Up/Step Down Care Arrangements (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(550)	0	0	0	0	(550)
No of Projects: 1 Status: Ongoing Overall Current Risk: R	An outline business case for the development of transiational care services has been developed with a number of potential options included. This will go to the ICF for a discussion on support and depending on preferred option ageed progressed in advance of winter 2016/17. Clarity on preferred options and associated impact assessment is being sought to establish potential phasing on savings that could be realised from this development.							

Improving Pathways of Care (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(640)	0	0	0	0	(640)
No of Projects: 1 Status: Ongoing Overall Current Risk: R	A review of winter plans for 2015/16 is underway. A range of measures are proposed for the coming winter period that would reduce the dependance on ad hoc capacity in the Borders Genernal Hospital, Community Hospitals and Nursing Homes. This includes the work with IHO on surgical pathways, a review of acute medicine, community hospital lenght of stays, transitional care, and alternative arrangement for long term care assessment. This should support a significant reduction in planned expenditure levels over the winter period for 2016/17 moving forward. A detailed project pan is being developed.							

Review Mental Health & Learning Disability Management Arrangements (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
			(100)	0	0	0	0	(100)
No of Projects: 1 **Status: Ongoing** A **Overall Current Risk:**	Discussion on arrangements for management of Mental Health and Learning Disability Services are ongoing. There is an expecation that a level of saving will be release as a result of integration and a change in management structures, howver this has yet to be finalised and the level of savings are unclear. There are vacant post within existing structure that may support the realisation of savings in the short term once agreed.							

AHP Management Arrangements (Recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
			(100)	0	0	0	0	(100)
No of Projects: 1 **Status: Ongoing** A **Overall Current Risk:**	Discussions are ongoing in relation to alternative service management arrangements post integration. Options have been developed and are under discussion. It is not clear at this stage that savings will be realised in the short term althought post are being held vacant in support of structural changes.							

Review of Public Health Services (non recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
			(150)	0	0	0	0	(150)
No of Projects: 1 **Status: Ongoing** **Overall Current Risk:** G	Public Health services are being reviewed as part of the overall integration agenda. In the interim there is an opportunity to release a non-recurring saving associated with currently vacant posts while this is completed.							

Other Minor Schemes/Review of Community Costs (recurring)		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
			(100)	0	0	0	0	(100)
No of Projects: 1 **Status: Ongoing** **Overall Current Risk:** A	This is a general review of budgets and financial performance over an extended period. There are a number of recurring underspend that can be released to support the overall efficiency agenda and these are beeing review and risk assessed. It is anticipated that this will be an achieveable target on a recurring basis.							

Scottish Borders Council **APPENDIX 4**

Revenue Financial Plan 2016/17 to 2020/21

Efficiencies / Savings Detail - Scottish Borders Council

Supporting Independence when providing Care at Home		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	48,285	(316)	0	0	0	0	(316)
Description of Proposal	Project underway to develop an independence-focussed approach to Care at Home including the use of assistive technology. It is expected that on implementation, a number of improved outcomes for clients will result such as quicker assessment, reablement and decreased dependency on homecare and other care services improving affordability and sustainability of services going forward. This is also linked to a review of how key day and night care services are currently delivered. Additionally, one of the key benefits of implementing this approach will be the projected reduction in the need for the most complex care and support. There are currently 64 clients across Adult Services in receipt of Direct Payment or homecare packages in excess of 25 hours per week (2,338 hours in total). (1,322/1,016 respectively). Through systematic review an average reduction of 10% (230 hours) is targeted.							

Further Contribution from SB Cares		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	(480)	(547)	(177)	(162)	(152)	0	(1,038)
Description of Proposal	Improved efficiency and increased income from enhanced trading opportunities are planned through the implementation of a new Council Care Company ("ALEO") for the delivery of Care services - further profiled increases in contribution by SB Cares to Scottish Borders Council following each year of trading.							

Commissioned Services		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Corporate	28,161	(378)	(160)	0	0	0	(538)
Description of Proposal	A demand and capacity review of all existing commissioning arrangements across all Adult Services commissioned from its main providers (including SB Cares) will be undertaken in order to maximise the cost-effectiveness and efficiency of contract and spot purchase arrangements (£320k). Additionally, a Review of Contracts with and Payments to Voluntary Organisations will be undertaken, with a targeted efficiency saving of (£58k).							

Residential and Home Care Efficiencies and Income		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(235)	0	0	0	0	(235)
Description of Proposal	The Assessment Review Team will be redeployed across localities, filling existing vacancies, re-establishing the reviewing cycle within the assessment & care management function. 2016/17 Manpower implications are likely to be in the region of 4FTE (£131k). Additionally, more flexible use of 10 short-stay residential beds will be targeted to increase income from client contributions (£104k).							

Redesign of Assessment & Care Management Model		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	N/A	(100)	0	0	0	0	(100)
Description of Proposal	A review & redesign of assessment and care management following best practice across the sector including, reviewing every package of care (all reviewed within 6 months), splitting complex cases from non-complex cases, establishing a cycle of review (all cases regularly reviewed within 12mths), encouraging staff out from the office (via hot-desking, mobile working etc), realigning the service from a geographical set up to a 'value-stream' service, based around (e.g.): assessment, reablement and service provision/deliver with the aim to increase the number of reviews undertaken per assessor.							

Review Adult Services Middle Management and Specialist Posts		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Corporate	N/A	(300)	(50)	0	0	0	(350)
Description of Proposal	Ongoing review of service management, planning and specialist services staffing structures in order to deliver efficiencies emanating from changing requirements, delivery models and better ways of working, within the additional context of joint service delivery with NHS Borders as part of the agenda for the Integration of Health and Social Care.							

Review of Adults with Learning Disabilities service to meet demand		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	14,510	(549)	0	0	0	0	(549)
Description of Proposal	More effective deployment of Social Worker and Care staff to support client needs to deliver a more efficient delivery model to support adults with learning disabilities and physical disabilities.							

Review of Older People service to reflect demand		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	24,191	(234)	(237)	0	0	0	(471)
Description of Proposal	More effective deployment of Social Worker and Care staff to support client needs to deliver a more efficient delivery model to support Older People.							

Bordercare Inflation		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	(225)	(4)	(4)	(4)	(4)	(4)	(20)
Description of Proposal	Inflation on all Bordercare Fees and Charges							
			(2,663)	**(628)**	**(166)**	**(156)**	**(4)**	**(3,617)**

Scottish Borders Council **APPENDIX 5**

Revenue Financial Plan 2016/17 to 2020/21

Efficiencies / Savings Progress Update - Scottish Borders Council

Supporting Independence when providing Care at Home		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	48,285	(316)	0	0	0	0	(316)
No of Projects: 3 Status: Ongoing Overall Current Risk: A	Night Support Review savings (£50k) have been delivered.							G
	EMT have approved the approach to Reablement as part of locality model, but ICF funding and wider project / programme planning required. May require temporary savings to be delivered in order to allow for locality development lead-in time.							A
	Review of Complex Care Packages (£166k) is underway but initial outcomes project that targeted level of savings will not be realised, requiring extension of review and further additional actions.							A

Further Contribution from SB Cares		Base	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	(480)	(547)	(177)	(162)	(152)	0	(1,038)
No of Projects: 1 Status: Ongoing Overall Current Risk: G	SB Cares Business Plan in place to develop further trading opportunities and deliver efficiency targets in order to generate additional £547k of trading contribution back to Scottish Borders Council on 31st March 2017, a total contribution of £1,027k per annum, at the end of year 2 of operation.							G

Commissioned Services		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Corporate	28,161	(378)	(160)	0	0	0	(538)
No of Projects: 3	Reduction in Voluntary Sector Grants / Contracts (£58k) - savings plan in place and delivered within AWLD, Older People and Housing Support.							G
Status: Ongoing	External contract reduction (£120k) remains only at outline planning stage.							A
Overall Current Risk: A	SB Cares Business Plan in place to deliver reduction in core block contract price (£200k).							G

Residential and Home Care Efficiencies and Income		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services		(235)	0	0	0	0	(235)
No of Projects: 2	A proposal to convert a minimum 10 short-stay beds to income generating long-stay beds was developed and signed off in January 2016 and actioned thereon. (£104k)							G
Status: Ongoing	Reprovision of the Review process has been discussed at People Planning (April 2016) and agreed with HR.							
Overall Current Risk: G	Discussed with Trade Unions and the service will continue to work with OD and HR to deliver the proposed changes. Meantime, these savings will be temporariliy made through vacancies. (£131k)							G

Redesign of Assessment & Care Management Model		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	N/A	(100)	0	0	0	0	(100)
No of Projects: 1	Remains at outline planning stage. May require ICF funding and linkage to matching unit proposal.							
Status: Ongoing	Significant further work required to develop this proposal and resulting development and implementation plan. (£100k)							A
Overall Current Risk: A								

Review Adult Services Middle Management and Specialist Posts		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Corporate	N/A	(300)	(50)	0	0	0	(350)
No of Projects: 1 Status: Ongoing Overall Current Risk: A	Further clarity is required within the People Plan as to how £200k of the above saving will be delivered. The targeted saving above (together with its like-area saving on NHS Borders' side also requires to be factored into the new locality model resource envelope, although in reality, this may require temporary measures during 2016/17 before any transformation is fully implemented.							A

Review of Adults with Learning Disabilities service to meet demand		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	14,510	(549)	0	0	0	0	(549)
No of Projects: 1 Status: Ongoing Overall Current Risk: A	Remains at outline planning stage.							A

Review of Older People service to reflect demand		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	24,191	(234)	(237)	0	0	0	(471)
No of Projects: 1 Status: Ongoing Overall Current Risk: A	Remains at outline planning stage.							A

Bordercare Inflation		Base Budget 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Adult Services	(225)	(4)	(4)	(4)	(4)	(4)	(20)
No of Projects: 1 Status: Ongoing Overall Current Risk: G	Inflation on all Bordercare Fees and Charges - complete							G
			(2,663)	(628)	(166)	(156)	(4)	(3,617)

2016/17 FINANCIAL PLAN – SOCIAL CARE FUNDING

Aim

1.1 To provide Integration Joint Board (IJB) members with an update on its commitments in relation to direction of social care funding in 2016/17 in order to meet Scottish Government requirements, and to provide a summary of the remaining resource available in this and future financial years to support the delivery of its strategic objectives.

Background

2.1 The Scottish Government has distributed £250 million to IJBs, on a recurring basis from 2016/17, via its annual allocation to NHS Boards. Individual allocations to IJBs based on a distribution methodology the same as was applied to the Integrated Care Fund (ICF) have been calculated and the Scottish Borders Partnership will receive £5.267m in 2016/17.

2.2 This allocation forms part of the budget delegated to the IJB and was a component element of the Financial Statement for 2016/17 approved on 30th March 2016:

	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**

**years 2 and 3 are indicative and will be subject to change in light of Scottish Government allocation and/or inflation*

2.3 On the 27th March 2016, the Deputy First Minister wrote to COSLA and the leaders of all Scottish local authorities confirming details of the allocation. Specifically, the letter states that:

"£250 million will be provided from the Health budget to integration authorities in 2016/17 for social care:

That of the £250 million, £125 million is provided to support additional spend on expanding social care to support the objectives of integration, including through making progress on charging thresholds for all non-residential services to address poverty. This additionality reflects the need to expand capacity to accommodate growth in demand for services as a consequence of demographic change.

That of the £250 million, £125 million is provided to help meet a range of existing costs faced by local authorities in the delivery of effective and high quality health and social care services in the context of reducing budgets. This includes our joint aspiration to deliver the Living Wage for all social care workers as a key step in improving the quality of social care. The allocation of this resource will enable councils to ensure that all social care workers including in the independent and third sectors are paid £8.25 an hour. This assumes that private and third sector providers will meet their share of the costs. The Government would prefer implementation on the 1 April but we accept COSLA's point that preparatory work will be required to ensure effective implementation. We therefore agree to an implementation date of 1 October.

In 2016-17, Councils can allocate up to £125 million of their 2015/16 costs of providing social care services to Integrated Joint Boards including the uprating of staff to the Living Wage. This will ensure an overall benefit to the provision of health and social care of £250 million."

2.4 Interpreting this direction therefore, the following conclusions can be drawn:

- The funding is being provided from the NHS Budget to the IJB.
- There are two distinct elements, of equal value, to the social care funding which in Scottish Borders terms amounts to £2.6335m each (£5.267m in total).
- Each element is intended to be specifically used for a given purpose:

Tranche 1 (£2.6335m)		Tranche 2 (2.6335m)	
REF		REF	
(1a)	Support additional spend on expanding social care to support the objectives of integration	(2a)	Help meet a range of existing costs faced by local authorities
(1b)	Make progress on charging thresholds for all non-residential services	(2b)	Deliver the Living Wage for all social care workers with an implementation date of 1 October
(1c)	Expand capacity to accommodate growth in demand for services as a consequence of demographic change		

Specific Required Commitments

3.1 Since the direction was given by the Scottish Government, work has been ongoing to identify the full financial implications of its intentions for how the funding should be used. Primarily, this work has related to:

- The cost of an increase in the living wage to £8.25 (ref. 2b).
- The cost/income foregone resulting from an increase in the threshold for charging (ref. 1b).
- The increased financial capacity required to accommodate 2015/16 demographic pressure across social care services (ref. 1c).

- Identifying other specific areas for consideration by the IJB over the wider use of the additional resource (ref. 1a).

3.2 Each of these specific commitments/matters for consideration are detailed in the remainder of this report. In summary, the total calculated cost of meeting the Scottish Government's required commitments is **£2.048m** in 2016/17 and **£2.861m** in future years. In relation to the two tranches, this can be summarised as:

REF	Tranche 1 (£2.6335m)	REF	Tranche 2 (2.6335m)
(1a)	Support additional spend on expanding social care to support the objectives of integration	(2a)	Help meet a range of existing costs faced by local authorities
(1b)	Make progress on charging thresholds for all non-residential services **2016/17 cost = £0.154m** **2017/18 cost = £0.154m**	(2b)	Deliver the Living Wage for all social care workers with an implementation date of 1 October **2016/17 cost = £0.813m** **2017/18 cost = £1.626m**
(1c)	Expand capacity to accommodate growth in demand for services as a consequence of demographic change **2016/17 cost = £1.081m** **2017/18 cost = £1.081m**		

3.3 Sections 3-5 of this report provide further detail on the costs relating to each of the three areas of required financial commitment in the table above (referenced as 1b, 1c and 2b). By the IJB directing resources in order to meet these commitments, of the **£5.267m** total allocation in 2016/17 recurring received, **£3.219m** will remain uncommitted in 2016/17 and **£2.406m** in future years (following the full year implementation of the living wage in 2017/18).

3.4 It will be for the IJB to direct how the social care funding allocation by the Scottish Government is used. Clearly however, in order to comply with the conditions expressed in 1.3 above, **£2.048m** requires to be approved on the above basis now. The Chief Officer will, going forward, bring specific proposals to the Partnership for approval on how the remaining resource in 2016/17 and future years should be used. Primarily this will be in order to both meet pressures across the Partnership and to support the development and implementation of new models of care, in line with the remaining Scottish Government criteria for utilising the allocation to its best effect. One such proposal is in relation to short-term transitional funding of the Alcohol and Drug Partnership (ADP) budget in 2016/17, on which members will be asked to consider within a separate report to the Partnership.

Increase in the Living Wage to £8.25 from 1st October 2016 (ref 2b)

4.1 As part of the 2016/17 Scottish Government financial settlement with local authorities, Councils are obliged to ensure that, from 1st October 2016, a Living Wage of £8.25 per hour is paid to all care workers in Adult social care providing direct care and support, regardless of age. This is intended to cover those involved in the provision of a range of Adult services:

- Residential Care
- Care at Home
- Housing Support
- Specialist Support Services
  - People with Physical Disabilities
  - Adults with Learning Disabilities
  - Adults with Mental Health Needs
  - Drug and Alcohol Services

4.2 Whilst not prescribed explicitly, nor will Local Authorities be held to account for, adults in receipt of Self-Directed Support (Direct Payments) who employ personal assistants are expected to pay a Living Wage of £8.25 from 1st October 2016. This may be a consideration for the Partnership/Scottish Borders Council in terms of minimising the risk of challenge on the grounds of equal treatment and potential discrimination.

4.3 All care hours require to be paid at Living Wage rate, including sleep-ins, which historically tended to be paid at a lower (hourly) rate than waking hours.

4.4 In order to calculate the impact of the introduction of a Living Wage of £8.25, a number of factors require consideration, including the on-cost impact of National Insurance (NI) and pension contributions, travel time and holiday pay. Pay differentials within each provider organisation may also be considered.

4.5 A copy of the tri-partite guidance issued on the delivery of a Living Wage of £8.25 has been included as **Appendix 1** to this report for information.

4.6 For the Scottish Borders, the following component elements have been considered (all including the impact on on-costs of NI and pension contributions) from 1st October 2016 and their full future-year effect:

1. Living Wage-direct implications of increased hourly rates submitted as part of the recent Care at Home tender process (Older People).
2. The requirement to increase existing provider rates to reflect increased hourly pay rates (at Living Wage) within Adults with Learning Disabilities and Adults with Mental Health Needs.
3. The direct impact of the Living Wage on the agreed COSLA residential care home settlement.
4. The impact of all care hours including sleep-ins at Living Wage.
5. The impact of all SDS personal assistants being paid at Living Wage.

4.7 Presently, the impact of pay differentials within each provider organisation have not been considered as this remains a wider implication only, is not directly legislatively or funding-condition required and is dependent on the existing baseline position and cost structure of each individual provider.

4.8 Any other cost implication of the recent Care at Home tender process not directly associated with the introduction of a Living Wage of £8.25 has been excluded from this analysis also, but is considered later in this report.

4.9 The Deputy First Minister's letter states that in order "*to ensure transparency for the flow of funding support for local authorities and delivery of the Living Wage commitment the arrangements will be signed off at a local level by the appropriate Integration Authority Section 95 Officer.*"

4.10 All social care services provided by SB Cares, Scottish Borders Council's arms-length care organisation have been excluded from the calculation of the additional costs of implementing the proposed Living Wage. From inspection, all SB Cares staff responsible for the delivery of residential, home and day care are already paid at an hourly rate at or above the minimum requirement. The additional projected costs of its implementation relate therefore to those hourly rates paid by external providers and can be summarised as follows:

		2016/17 £'000	2017/18 £'000
1.	**Living Wage-direct implications of increased hourly rates submitted as part of the recent Care at Home tender process (Older People)**	**266**	**532**
Provision of Care at Home to Older People cost Scottish Borders Council £7.0m. This service has recently been put to tender following the end of the extension of the previous contract which has been in place since 2013. Fundamental to the rates tendered was the requirement to clearly demonstrate the impact of an increase in hourly rate of £8.25 plus on-costs from the 1st October 2016. Each preferred provider's rates have been scrutinised and validated and the additional costs specific to the impact of the living wage element-only calculated.			
2.	**The requirement to increase existing provider rates to reflect increased hourly pay rates (at Living Wage) within Adults with Learning Disabilities and Adults with Mental Health Needs**	**355**	**710**
During the Spring of 2016, a survey of all care companies providing social care services was undertaken by Scottish Borders Council to determine provider staff's underlying pay rates. An initial response rate of 70% was received which following further work has enabled a forecast of the additional costs, including on-costs, relating to a Living Wage-driven increase in the contracted hourly rates paid to providers to be made.			
3.	**The direct impact of the Living Wage on the agreed COSLA residential care home settlement**	**183**	**366**
The COSLA residential care home settlement for 2016/17 has now been agreed and increases to weekly residential and nursing bed rates for those external residential care homes with whom Scottish Borders Council commissions from, who are part of the contract, require to be implemented. The Council spends £8.6m per annum on external residential and nursing care beds across the Older People, Learning Disability and Physical Disability services and the COSLA settlement reflects an uplift of 2.5% from 1st April in respect of inflationary measures and 3.9% from 1st October 2016 in respect of the implementation of a Living Wage of £8.25 per hour. The costs of this latter factor have been detailed above.			
4.	**The impact of all care hours including sleep-ins at Living Wage**	**9**	**18**

As part of the survey work undertaken in 2.above, the rates paid for sleepover care was also considered and the additional costs attributable to implementation of a sleepover rate of £8.25 plus on-costs per hour calculated.

5.	**The impact of all SDS personal assistants being paid at Living Wage**	**n/k**	**n/k**
At this point in time it has not been possible to identify what, if any, the impact will be on implementing a Living Wage for the employment by clients of a personal assistant. Personal assistants employed via Self-Directed Support (Direct Payments) are not explicitly included in the commitment to deliver the Living Wage and Local Authorities will not be held to account for ensuring that a Living Wage is paid to personal assistants directly employed by an individual. Nonetheless, the Living Wage guidance does highlight that Councils may be at risk of challenge on the grounds of equality and discrimination should there not be consistency across all care provider groups, but to date, no policy intent has been made within the Scottish Borders and substantial further work is required, in conjunction with individuals and Encompass - the agency through which a number of individuals employ their carers - before an estimate of any additional costs can be made in this respect.			

TOTAL	**813**	**1,626**

4.11 The total cost of the implementation of a Living Wage of £8.25 for all social care staff, from the 1st October 2016 is therefore **£813k** in 2016/17 and **£1.626m** per annum from 1st April 2017.

Increase in the Charging Threshold (ref 1b)

5.1 People who receive non-residential social care services can be charged for these services by their local authority. A 'non-residential service' is a service to meet social care needs in the community and does not include supported or residential accommodation but includes services such as personal care (non-older people), equipment, alarms, telecare, laundry, shopping, meals, day opportunities and direct payments. The local authority assesses a person's ability to pay for social care and when doing so, needs to make sure that everyone has the minimum amount they need to live on - this is called the charging threshold.

5.2 Currently, the charging threshold is calculated by adding a buffer (currently 16.5%) to the appropriate DWP rate(s) for the following groups of people:

- For people aged below state pension qualifying age the Income Support Personal Allowance and the Disability Premium are added together with the buffer added to the sum of these two rates.
- For people aged state pension qualifying age or above the Pension Credit Guarantee is used as the basis for the charging threshold calculation with the buffer added.

5.3 Fulfilment of the Scottish Government's funding settlement condition requires an increase in the buffer rate from 16.5% to 25%. Across Scotland, it is estimated that this increase in buffer will cost approximately £7m (representing the difference in income foregone - previously £47m increasing to £54m), based on the number of existing Social Care users.

5.4 For the Scottish Borders, it has been calculated that, given the current taper-rate (how much of a client's net income above the charging threshold level can be asked

for in charges) level (43.5%) is largely consistent with the national average (45.5%), this will result in an additional cost of **£154k** per annum recurring**.**

Increase Capacity to meet Demographic Pressure (ref 1c)

6.1 Within the Scottish Borders Council 2016/17 Financial Plan, based on assumed approval by the IJB in line with the Deputy First Minister's direction, provision has been made for Social Care Funding to be allocated towards meeting areas of current and future pressure arising from increased demand for services. Whilst the Council has invested across a range of areas in the Social Care 2016/17 budget, including an increase in the Direct Payment rate, expected market cost increases for homecare and other legislative impacts, it has specifically assumed that Social Care Funding will be directed towards three demographic and demand-driven areas of financial pressure:

6.1.1 2015/16 additional cost of demand for homecare hours above budgeted levels (£300k).

- During 2015/16, the average number of homecare hours exceeded the level budgeted by over 500 hours per week, at a total cost pressure of just over £300k per annum.

6.1.2 Increase in the demand for older people's services, based on the projected increase in the number of 65+ and 75+ cohort requiring care from 2015/16 to 2016/17 (£234k).

- From 2015/16 to 2016/17, the service expects an increase of 2.29% in the 65+ cohort (approximately 13 clients) and 1.8% approximately 51 clients in the 75+ cohort. Complexity of need across these client forecasts will vary as will the cost of their care support plans.

6.1.3 Increase in the demand for Adult's with Learning Disabilities services based on an increase in the number of clients requiring care from 2015/16 to 2016/17, primarily those specifically identified young people in transition to adulthood and Adult Services' provision (£547k).

- This relates to over 70 specifically named individuals who will move into the care of Adult Services at an average cost of care of around £8k per annum, although again, complexity of need across these client forecasts will vary.

6.1.4 This budget provision amounts to a total 2016/17 additional funding requirement of **£1.081m** recurring**.**

Matters for Further Consideration

7.1 In addition to the costs calculated above against which the allocation from the Scottish Government is intended to address as stated by the Deputy First Minister, there is also scope for the IJB to direct some of the allocation to meet other priorities, specifically "*supporting additional spend on expanding social care to support the objectives of integration*" and "*helping meet a range of existing costs faced by local authorities*".

7.2 These two key components are equally as important as those which require councils to implement a Living Wage, increase the charging buffer or meet increased demand for services. Direction of resources towards these areas by the

IJB will not only help further progress in enabling transformation of Health and Social Care services and delivery of the Partnership's Strategic Plan, but also will ensure that any decisions made are fully funded and affordable within the overall delegated budget resource envelope.

7.3 When considering how the integration authority's recurring allocation from the Scottish Government in respect of social care funding should be directed, there are two key factors which require to be considered:

Help meet a range of Existing Costs faced by Local Authorities

7.4 As the recent Older People's Care at Home tender process has highlighted, social care faces widespread market cost pressures going forward in addition to the impact of the Living Wage implementation. This is also a financial risk factor across other delegated services including the Joint Learning Disability Service, Mental Health Services and other specific services, not least, GP Prescribing. When considering the impact such pressures may have on the overall affordability of services through 2016/17 and beyond, how the IJB may wish to direct remaining Social Care funding in 2016/17 and in planning how it will use this resource in future years is essential in order to minimise future financial risk to the Partnership. When work analysing all such emerging pressures is complete, a report will be brought back to the IJB for further consideration.

Expanding Social Care to Support the Objectives of Integration

7.5 Work is continuing in a variety of ways across the Partnership to develop a new model for the delivery of health and social care. The development and implementation of new models of care is a fundamental pre-requisite of the delivery of the strategic aims and local objectives of the Partnership which as other reports to the IJB have highlighted will carry a considerable resourcing requirement. A prudent approach would be to ensure that significant flexibility is retained within the IJB's delegated budget and resources set-aside to meet these costs in the short to medium-term future and the Chief Officer, working in conjunction with the Strategic Planning Board (SPB) and Executive Management Team (EMT) will bring forward proposals for using a proportion of the remaining uncommitted resource to enable the delivery of the strategic objectives expressed in the Partnership's Commissioning and Implementation Plan.

Alcohol and Drug Partnership (ADP)

7.6 Within the 2016/17 Financial Statement, it was highlighted that of the £6.902m of efficiency and further savings measures in 2016/17, £793k of proposals for their delivery remained unidentified at 30th March 2016. Of this, £471k relates to expected funding reductions through NHS ring-fenced grants from the Scottish Government.

7.7 The ring-fenced grant reduction of highest value relates to the funding of the ADP and ADP chairs across Scotland have been advised of an estimated 20% reduction in the national allocation for ADPs in 2016/17, which if applied locally here in the Scottish Borders, would equate to a reduction of £271k in 2016/17, against an overall ADP budget of £1.3m. Similar to some other areas of the IJB's budget, at

the time of writing this report, this position remains indicative and no formal and final funding settlement has yet to be made.

7.8 The ADP is responsible for the planning and delivery of a range of functions, primarily through the commissioning of services/outcomes from three key partners. Following a process of redesign, new service level agreements/contract arrangements were put in place with each of these providers at the beginning of financial year 2014/15, initially for 3-5 years. In addition to these services, the ADP funds a range of other projects and service provision including service planning, pharmacy and support to the Partnership overall. Any substantial change to the funding envelope of the Partnership will have a considerable impact on any ability to sustain the current model and level of delivery and a programme of further redesign and change will now be required in order to ensure future service delivery is both affordable and resources are directed in a prioritised way. It is anticipated that with the estimated reduction in available funding therefore, this redesign work will now be required during 2016/17, in addition to identification of immediately realisable cost-savings where possible, in order to reduce overall spend nearer estimated funding settlement levels. This will therefore require one-off transitional funding to be allocated to the Partnership in order to bridge the funding gap and sustain the current contracted services until a fully agreed plan and new commissioning arrangements are in place.

7.9 Transitional funding of £220k will be required on a one-off basis during 2016/17 in order to sustain remaining services, contracted or otherwise, for the remainder of the financial year. Members will be asked to consider, in a separate report to the IJB, one-off expenditure to the ADP during 2016/17 from the social care funding that is uncommitted currently, thus reducing the overall amount remaining to **£2.999m** this financial year, with no impact on the **£2.406m** which remains available for 2017/18.

Summary

8.1 Of the £5.267m social care funding allocated to the Scottish Borders Health and Social Care partnership, it is proposed to direct £2.048m in 2016/17 in order to fulfil the Scottish Government's conditions and intended use for the resource in order to meet the additional costs of implementing a Living Wage of £8.25 from 1st October 2016 (£813k), an increase in the charging threshold (£154k) and an increase in budget capacity to meet existing social care demographic pressures (£1.081m). The full year impact of this direction will be £2.861m from 2017/18, assuming no further changes. Additionally, it is proposed to direct £220k of funding to the ADP on a non-recurrent basis in 2016/17 in order to fund services for 1 year until a new model of delivery can be developed and implemented, due to expected reduction in level of ringfenced grant.

8.2 Further proposals for direction of the remaining social care funding will be brought forward to the IJB when they are developed or cost pressures fully fully analysed and it is expected that primarily, funding will require to be directed towards meeting increasing market costs of social care provision, particularly within Care at Home and to further enable the development of new models of care and delivery structures within a new integrated health and social care model.

Recommendation

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

- **approve** the direction of £2.048m of 2016/17 social care funding in order to meet the commitments outlined above
- **approve** the direction of a further £220k in 2016/17, on a one-off basis, to the Alcohol and Drug Partnership in order to sustain services until transition to a new affordable model for delivery is made by 1st April 2017.
- **note** that the full year impact of these commitments from 2017/18 will be £2.861m and that further proposals for directing the remaining uncommitted social care funding will be brought to the Board when developed for consideration and approval.

Policy/Strategy Implications	Supports the delivery of the Strategic Plan.
Consultation	Discussions held with key strategic leads.
Risk Assessment	To be reviewed in line with agreed risk management strategy.
Compliance with requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	No resourcing implications.

Approved by

Name	Designation	Name	Designation
David Robertson	Chief Financial Officer, Scottish Borders Council	Susan Manion	Chief Officer

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Chief Financial Officer, IJB		

Guidance to support delivery of the Living Wage Commitment to Care at Home and Housing Support

1. Introduction

This guidance is a tripartite document informed and agreed by Scottish Government, COSLA, and CCPS and Scottish Care on behalf of providers. Its purpose is to support local authorities and providers in their local decision making to help implement the Living Wage commitment as part of a positive approach to fair work practices. The Living Wage commitment was agreed between Scottish Government and Local Government as part of the Local Government Settlement. Moving forward, a tripartite approach is being taken to delivery with the full involvement of providers.

The guidance deals with the particular issue of implementing the commitment to pay all care workers in adult social care regardless of age, £8.25 per hour from October 1st 2016. The guidance does not direct a particular route or mechanism for delivery but rather supports a consistent understanding of the risks that need to be balanced in taking local decisions when implementing the commitment and a description of some of the options which could be used to support the delivery of the commitment.

It is at the same time important to keep in mind when considering options for implementation that the purpose behind this commitment is to value and improve the quality of care. It is an opportunity to invest in social care as a career of choice by addressing one aspect of the recruitment and retention challenge in the sector. However it would be counter to the aim and intention of the investment if this were achieved for example at the expense of fair work practices more generally, including training, development, and broader terms and conditions etc. which influence and underpin social care as a quality career option.

These discussions are an opportunity to ensure that a focus on the quality of care and support and the drive towards continuously improving outcomes for people continues to be at the heart of this agenda. This process may also represent an opportunity in the longer term for Integrated Joint Boards and local authorities in collaboration with partners, to review models of care and revise commissioning, procurement and contract monitoring policies and processes which can support and drive improved and innovative services.

It should be noted that every local authority will need to take a range of local advice in deciding a way forward including legal, financial and professional advice in addition to this guidance. This reflects the fact that the risks present in each local authority will differ due to local circumstance and local employment and market dynamics.

2. Background

The Living Wage commitment made by Scottish Government and Local Government as part of the 16/17 settlement is to ensure that the Living Wage of £8.25 per hour from October 1st 2016 is paid to care workers providing direct care and support to adults in care homes, care at home, and housing support (as per the Scottish Social Service Sector report on Workforce Data). This covers all purchased services, including specialist support services such as those for people with physical disabilities, learning disabilities, mental health difficulties and substance misuse issues. The new rate applies for all hours worked and therefore encompasses sleepovers, travel time and holiday pay and should be achieved as part of a positive approach to fair work practices.

Personal assistants employed via Self-Directed Support (Option 1 – Direct Payment) were not explicitly included in the commitment to deliver the Living Wage of £8.25 per hour for adult social care workers. However, Local Authorities may be at risk of challenge with regards to principles of equal treatment and discrimination if allowances aren't sufficient to pay a personal assistant the Living Wage of £8.25. The Scottish Government will make arrangements to ensure that people supported under the Independent Living Fund are also enabled in this way. We will work with Self-directed Support Scotland, Centres for Inclusive Living and Personal Assistant Employers Network to encourage the payment of Living Wage to all personal assistants. Local authorities will not be accountable for ensuring Living Wage is paid to personal assistants directly employed by an individual.

The Scottish Government and Local Government have provided resources to contribute to this commitment for 2016/17 within the £250m Health and Social Care monies. However, it will be important to bear in mind that as well as the increase to basic pay, employers will incur additional costs including National Insurance contributions, employer pension contributions and adjustment of pay differentials with the organisation. This will affect the total cost of the commitment. Costs are also likely to vary locally depending on local markets including employment, provider business models and on the implementation method adopted.

The agreement to pay £8.25 per hour to adult social care workers from 1st October 2016 is part of an overall Local Government settlement. Within the terms of the 2016/17 settlement, councils are required by the Scottish Government to deliver on a package of commitments. If a council does not deliver on these commitments, including the Living Wage commitment, then the Scottish Government has stated that it reserves its position to take action to remove access to, or recover, the specific funding identified in the settlement letter. This settlement agreement between Scottish Government and Local Government was predicated on providers making a contribution to the overall cost of the Living Wage commitment. Providers were not party to this formal agreement.

The scale and timeframe for implementing the Living Wage means that a collaborative approach between commissioners and providers will be critical. Local authorities will need to engage care providers in negotiations to reach a voluntary agreement and this will be facilitated by a funding process that is fair, transparent and collaborative, and achieves 'buy-in' from providers. This approach in itself should reduce the risk of challenge and increase the likelihood of compliance and a successful voluntary agreement.

It is also important to keep in mind that this commitment is not, as of yet, a commitment to the Living Wage as an ongoing benchmark for wages, but to the delivery of £8.25 per hour from October 1st 2016. Any further commitments would be subject to spending review negotiations for 2017/18 and beyond. However, in implementing this year's commitment local authorities may wish to be cognisant of the potential for further commitments to the Living Wage as these may be driven by local decisions and prioritisation as well as national ones.

3. Implementation

We acknowledge that implementing this commitment will present a number of challenges - some to do with matters of legality around procurement and state aid and others relating to adhering to social care policy legislation and principles. However, these need not be prohibitive and there are a number of options which should be considered so as to minimise any risks which may be present. Some of these are described below although this cannot be taken as universal legal advice and the application of this guidance will need to be judged on a case by case basis by each local authority according to their specific local circumstance. **There is no single answer which will work for all care arrangements and local authorities are best placed to undertake a risk assessment to help them identify the best local solution.**

In this guide we seek to highlight some of the areas of particular vulnerability. The risks associated with procurement and state aid are of particular importance but so too are wider social care policy and principles.

Partners should therefore ensure that their selected mechanism:

- Supports the intention of improving the quality of care by investing in the workforce;
- Supports the recruitment and retention of the right people to support and promote stability and continuity of care and support for the user;
- Prioritises choice and control for people supported by care services;

In addition, the delivery mechanism should take into account the key considerations that a contracting authority should have before and when procuring care and support services, including the key principles of fairness; transparency; and collaboration with partners, those with an interest and those affected. Further details are provided in supporting guidance. It is worth noting that having considered and evaluated these risks transparently before making a decision about which mechanism to choose is in itself a protective measure which, done in collaboration between authorities and providers, is likely to limit the potential for challenge and the risk of a successful challenge to the decisions taken.

While cost is not the only, nor necessarily the dominant factor in commissioning services, affordability will be a key question to address when considering the delivery mechanisms for implementation. It is suggested that if they have not already done so, local authorities formally establish the breadth of the current wage rates paid to care workers by providers in their local area as well as any other costs associated with a minimum wage rate of £8.25. Understanding the full cost of this commitment as thoroughly as possible will help with the immediate implementation and the costing of any future commitments.

4. Procurement and fair work, including the Living Wage

The Scottish Government has obtained clarification from the European Commission on the application of the Living Wage in procurement processes. This confirms that contracting authorities are unable to make the payment of any specified wage rate above the legal minimums enshrined in law a mandatory requirement as part of a competitive procurement process. In the UK, this is the National Minimum Wage and National Living Wage, dependant on age. It is, therefore, not possible to reserve any element of the overall tender score specifically to the payment of the Living Wage.

However, where relevant to the delivery of the contract, it is possible for a contracting authority to take account of a bidders approach to fair work practices which includes, for example, the payment of £8.25 per hour, and to evaluate this as part of the procurement process. Fair work practices will be particularly relevant to consider where the quality of the service being delivered is directly affected by the quality of the workforce engaged in the contract. The Scottish Government has issued statutory guidance on this issue.[1]

Evaluation criteria in a tender process must be relevant and proportionate to the subject matter of the contract being let and it is for contracting authorities to determine the balance that meets their requirements for the service. In a sector such as care services, where quality and continuity of service and low staff turnover are likely to be closely related to fair work practices such as recruitment, remuneration and other terms of engagement, the weighting being given to fair work practices will be particularly significant in contributing to the desired outcome for quality of service. A contracting authority therefore does have a significant discretion to set evaluation criteria in a way that recognises the impact of fair work practices on the quality of the services, and therefore a higher percentage weighting for fair work practices, including the payment of £8.25 per hour, is likely to be justified. Where a contract is let in compliance with the relevant legislation, there is limited scope for a tenderer to challenge the weighting which is assigned to evaluation criteria.

When evaluating fair work practices as part of a procurement exercise contracting authorities must consider a bidder's overall approach to fair work and all bids must be treated equally. This should include consideration of all relevant evidence, including (but not limited to) recruitment, remuneration, terms of engagement, skills utilisation and job support and worker representation. A bidder's approach to fair work practices may vary depending on the bidder's size and the scope of the contract and the contracting authority must take a measured and balanced approach based on this.

The statutory guidance states that any decision to include a question on fair work practices should be made on a case by case basis taking into account commitments set out in the contracting authority's procurement strategy. The question should be framed in a way that is consistent with the principles deriving from the Treaty on the Functioning of the European Union: transparency, equality of treatment and non-discrimination.

[1] http://www.gov.scot/Resource/0048/00486741.pdf

A commitment to pay £8.25 per hour to adult social care workers would be a strong indication of a positive approach to fair work practices. Payment of the Living Wage is not the only indicator of fair work, however, and it should be emphasised that whilst failure to pay the Living Wage would be a strong negative indicator it does not mean that the employer's approach automatically fails to meet fair work standards. The question should ask bidders to describe the package of measures which demonstrates their positive approach to fair work practices in delivering the public contract. This context further demonstrates the need to progress this commitment as far as possible in collaboration and through the voluntary agreement of providers.

5. State Aid

Entering into a contract following an open and transparent procurement procedure which complies with the relevant legislation would be unlikely to raise any state aid risks. Similarly, varying a contract in a way that is compatible with procurement legislation should not constitute an award of unlawful state aid. Where there are doubts as to the state aid position, additional support to undertakings should be given in a manner that is compliant with state aid requirements.

The state aid position will always depend on the particular factual (local) matrix at hand and there will inevitably be cases where the state aid position is not clear. Where there is a risk that a measure constitutes state aid, appropriate mitigation measures should be taken. This may include awarding uplifts under the general de minimis regulation[2].

Local authorities will inevitably need to form their own view on the state aid compatibility of any particular locally applied measure.

6. Best Value and Procurement

Generally Scottish Government policy requires that contracts are awarded through a genuine and effective competition which also enables local authorities to evidence best value. However, in relation to contracts for health or social services, the Procurement Reform (Scotland) Act 2014 (Section 12) makes provision for authorities to award contracts without competition where their value is lower than the EU threshold of €750,000 (the relevant guidance provides further detail). Those contracts or framework agreements with a value greater than, or equal to €750,000 can all apply 'light-touch' provisions (described in regulations 74-76 of The Public Contracts (Scotland) Regulations 2015).

Below the EU-regulated procurement threshold the European Commission has confirmed that these services will 'typically not be of interest to providers from other Member States, unless there are concrete indications to the contrary, such as Union financing for cross-border projects' [3]. However, it is for a contracting authority to assess whether there is cross-border interest. As such a public body should decide on a case-by-case basis whether or not to seek offers in relation to proposed contracts or framework agreements with a value of £50,000 or more, but less than €750,000. It is important to highlight that the Treaty on the Functioning of the

[2] Commission Regulation 1407/2013, OJ L352/1, 24.12.2013

[3] EU Directive 2014/24/EU, Recital, 114

European Union fundamental principles should always be considered where relevant.

Public bodies should secure best value by balancing quality and cost and having regard to efficiency, effectiveness, economy, equal opportunities and sustainable development. Public bodies should determine the appropriate quality/cost ratio. When procuring care and support services, greater emphasis should be placed on quality rather than cost as far as practicable.

7. Monitoring

Scottish Government will be assured of the use of the allocated contribution via the Integration section 95 officer sign-off process. Local Government will be responsible for ensuring that this commitment is delivered through local contracts and agreements. The settlement agreement between Scottish Government and Local Government was predicated on providers making a contribution to the overall cost of the commitment.

Given that a council cannot direct or stipulate that the Living Wage of £8.25 per hour is paid as part of a procurement process, any agreement to do so would need to be voluntary and agreed in partnership with providers. Where, following a compliant procurement process, a provider emerges as the preferred bidder, they cannot be disqualified on the basis that they do not commit to the Living Wage. However, the main scope for mitigating this risk lies in the contracting authority's ability to take account of a bidder's approach to fair work practices as part of the evaluation criteria as detailed above and working collaboratively and in partnership with providers to seek a voluntary agreement.

Once agreed, the monitoring of that commitment can be a condition of contract and be a part of the contract management process. Effective contract management and monitoring should also ensure that wider fair work practices, as agreed within the contract, continue to be applied throughout the duration of the contract, e.g. by requesting information on the pay, terms and conditions of workers involved in the delivery of the contract. In the longer term, this should also help to monitor the outcomes and impact of increased wages on the quality of services which people receive.

8. Delivery mechanisms - Identifying and assessing risk

The mechanism used to deliver the Living Wage commitment is a matter for local authorities to decide and will depend upon a local assessment of the risks presented by each of the options.

No option is entirely risk free. How the procurement rules apply; what local financial regulation and local standing orders say; and the benefits and risks to service users of each approach will need to be individually assessed according to local circumstance. All these options are equally applicable to self-directed support, including Direct Payments.

The key risks that will need to be considered and weighted against the overall objective include:

1. Social care outcomes
2. Impact on the quality of care
3. Proportionality of the mechanism
4. The impact on local trade and the local market
5. Compliance with state aid and procurement rules
6. Best value
7. Impact on market continuity

(a) Modification / contract variation

There are a number of relevant factors to take into account when determining whether modification of a particular contract is permissible and authorities should take advice in relation to specific contract variations.

Local authorities will need to consider the particular context for each proposed variation and look to provisions of regulation 72 of the Public Contracts (Scotland) Regulations 2015, which provide further detail of the circumstances in which a contract can be varied. The provisions of regulation 72 only apply in a strict sense to contracts valued at €750,000 or above. Contracts below this value are less likely to be of interest to operators in the rest of the EU and contracting authorities are not bound by the restrictions in these cases where there is no evidence of cross border interest [4].

However, when calculating whether the 10% threshold referred to in regulation 72(5) of the Public Contracts (Scotland) Regulations 2015 has been exceeded, the element which is taken into consideration is that which relates to the monies paid by the contracting authority: any contribution by the provider does not form part of the contract sum. In this context we also draw authorities' attention to regulation 72(1)(5)(a) which requires that any modifications under regulation 72(1)(5) are also below the regulation 5 threshold.

Varying a contract in a way that is compatible with the relevant legislation should not constitute an award of unlawful state aid. Where there are doubts as to the state aid position, additional support to undertakings should be given in a manner that is compliant with state aid requirements.

There are a number of ways that a council can vary the contract in order to pay the Living Wage of £8.25 per hour. These are detailed below, and it may be necessary to adopt a range of approaches or take a staged approach and implement the commitment using one mechanism while considering another mechanism for a longer term approach if required.

[4] Scottish Government has recently published Guidance on the Procurement of Care and Support Services 2016 (Best-Practice). Public bodies should take account of this guidance which provides further advice on the amending of care contracts below the value of €750,000, in particular see Sections 8.12, S9.9, S9.18, S9.20, S9.26 and S9.63

The main risks of these example approaches are highlighted but should be considered within the wider context of a complete risk assessment and in particular in the context of social care outcomes.

- **Apply a percentage increase across the board: uplift all contract values/hourly rates by uniform amount on condition that providers volunteer to pay £8.25 to care workers.** This approach would be relatively easy to administer and would remove any competitive disadvantage between providers who may or may not already have invested in workforce wages. However Local Authorities will need to satisfy themselves as to the overall affordability of this option (depending on local circumstance and against their allocated resource) and be content that there would not be others interested in the terms of this contract, if this had been the basis of the original tendering process.

- **Apply a differing percentage increase per provider, through individual negotiation based on their particular costs.** This may be a more bureaucratic process dependent upon how many contracts and providers there are in each council. There may also be issues around the overall transparency of the process which, as noted, will be important for provider 'buy-in' to this initiative. It would however target the resources available to the purpose of addressing low pay and delivering the Living Wage commitment. If this approach were pursued then Local Authorities would need to be clear that in order to comply with state aid, providers could not be treated inequitably.

- **Set a standard rate for each local authority within which the £8.25 per hour wage for care workers is affordable.** To deliver this approach the rate would have to be set at a level adequate to cover all costs, not just the Living Wage commitment. The desirability and affordability of this approach would need to be assessed on a case by case basis. More generally this option can be insensitive to the fact that costs may legitimately vary depending on level of need, service model, skill mix of staff, quality of service and would also be insensitive to other justified variation of cost within local authorities where rurality and employment market dynamics impact on viable business models. This option may also include state aid and procurement issues around the equitable treatment of providers which would need to be assessed locally.

- **Set a suite of rates.** This option, whilst addressing the issue raised (above) regarding legitimate variation in service costs, goes beyond the requirement to implement the Living Wage commitment. The desirability and affordability of this approach would need to be assessed locally and in line with longer term commissioning agendas. Negotiating and implementing such an approach across Local Authorities, particularly if supported by service specifications, could be lengthy and so consideration on whether this is deliverable by October the 1st would also be required.

(b) Undertake a new procurement of services in line with new statutory and best practice guidance on social care and 'Fair Work Practices'

Generally, entering into a contract following an open and transparent procurement procedure which complies with the relevant legislation would be unlikely to raise any state aid risks. Retendering may therefore be an option for some Local Authorities – particularly for those who were otherwise expecting to need to tender for adult social care services regardless of this commitment and depending on the assessed risk of a challenge to the other models of contract variation. However this mechanism has to be balanced against the time, expense and potential disruption (to providers and clients) that a retendering process could bring. Additionally, bearing in mind that the overarching intention of this initiative is to invest in and value the workforce, the potential impact of retendering on that workforce will need to be carefully considered before proceeding.

9. Definitions

The National Minimum Wage: is a legal minimum wage for 21-24 year olds. This means that all employers must pay all of their staff that are between 21 and 24 a minimum of £6.70 per hour.

The National Living Wage: is an enhanced legal minimum wage for over 25's. This means that all employers must pay all of their staff that are over 25 a minimum of £7.20 per hour.

Age group	Nationally defined legal minimum wages
25 and over	£7.20
21 - 24	£6.70
18 - 20	£5.30
16 – 17	£3.87
Apprentices	£3.30

The Living Wage: set by the Living Wage Foundation is currently £8.25 per hour. This is up-rated annually and a new rate will be announced in November.

The Living Wage commitment: agreed as part of the 2016/17 Local Government settlement is to pay all adult social care workers the current Living Wage rate of £8.25 per hour from October 1st 2016. There is no requirement on local authorities as part of this agreement to increase wages to the new Living Wage rate when it is announced in November.

Adult social care workers: This commitment specifically applies to care workers providing direct care and support to adults in care homes, care at home and housing support settings (as per the Scottish Social Service Sector report on Workforce Data). This covers all purchased services, including specialist support services such as those for people with physical disabilities, learning disabilities, mental health difficulties and substance misuse issues.

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ALCOHOL AND DRUG PARTNERSHIP FUNDING 2016/17

Aim

1.1 To provide Integration Joint Board (IJB) members with an update on the likely funding position of the Alcohol and Drug Partnership (ADP) budget for 2016/17 and a recommended way forward to ensuring the ongoing affordability of services during the financial year.

Background

2.1 Within the 2016/17 Scottish Borders Health and Social Care Partnership Financial Statement, it was highlighted that of the £6.902m of efficiency and further savings measures in 2016/17, £793k of proposals for their delivery remained unidentified at 30th March 2016. Of this, £471k relates to expected funding reductions through NHS ring-fenced grants from the Scottish Government.

2.2 The ring-fenced grant reduction of highest value relates to the funding of the ADP, a function which has been delegated to the IJB from 1st April 2016. This ring-fenced funding is managed by the ADP and hosted for administrative purposes by NHS Borders.

2.3 ADP chairs across Scotland have been advised of an estimated 20% reduction in the national allocation for ADPs in 2016/17, which if applied locally here in the Scottish Borders, would equate to a reduction of £271k in 2016/17. This reduction is against an overall ADP budget of £1.3m. Similar to some other areas of the IJB's budget, at the time of writing this report, this position remains indicative and no formal and final funding settlement has yet to be made.

2.4 The ADP is responsible for the planning and delivery of a range of functions, primarily through the commissioning of services/outcomes from three key partners providing individual support and treatment for alcohol and drugs:

- *Action for Children*: provides support for children and young people impacted by their own or others alcohol and drug use and parents with alcohol and drugs problems.
- *Addaction*: treatment and support service for alcohol and drugs users aged over 16; re-integration service to support wider recovery and injecting equipment provision.
- *Borders Addiction Service (BAS)*: treatment (including prescribing and detoxification) service for alcohol and drugs users aged over 16 and the provision of a Substance Misuse Liaison Service in BGH.

2.5 Following a process of redesign, new service level agreements/contract arrangements were put in place with each of these providers at the beginning of financial year 2014/15, initially for 3-5 years. In addition to these services, the ADP funds a range of other projects and service provision including service planning, pharmacy and support to the Partnership overall.

2016/17 Funding Requirement and Proposed Way Forward

3.1 Any substantial change to the funding envelope of the Partnership will have a considerable impact on any ability to sustain the current model and level of delivery. In April 2016, a report was made by the ADP to the Chief Executives of NHS Borders and Scottish Borders Council which outlined:

- The likely funding reduction to Alcohol and Drug ring-fenced grant funding.
- Options for preserving the current level of spend by the Partnership or reducing it immediately or over time.
- An overview of how the existing budget is utilised.
- The impact and risks associated with any reduction to the current funding arrangements.

3.2 A copy of the April paper is attached to this report as **Appendix 1**. On consideration by both partner organisations' Chief Executives, the preferred option (#3) was to implement an immediate funding reduction to non-support and treatment areas in 2016/17 whilst preserving the level of funding across all other areas of the Partnership's budget on a non-recurring basis. This will provide ongoing sustainability for the year until further work is undertaken to develop a new model of delivery, within the likely future resource constraints.

3.3 During 2016/17 therefore, a programme of further redesign and change will be required in order to ensure future service delivery is both affordable and resources are directed in a prioritised way. Additionally, identification of immediately realisable cost-savings where possible will be required, in order to reduce overall spend nearer estimated funding settlement levels.

3.4 Since indication of the likelihood of a 20% reduction in overall ADP funding was received, work has been ongoing to identify potential areas where immediate savings could be delivered through a reduction in discretionary or easier-to-exit areas of spend. The ADP has identified potential recurrent savings of £72k within **Appendix 1**. Due to the delay in confirming budgets however and the requirement to give notice on contracts, £51k will be realisable within 2016/17. A reduction in, or cessation of, these services will still require robust planning and management and require liaison with a range of stakeholders, but are deliverable in the short-term.

3.5 Preserving the level of budget across other areas of the Partnership for 2016/17 will therefore require one-off transitional funding to be allocated to the Partnership in order to bridge the funding gap and sustain the current contracted services until a fully agreed plan and new commissioning arrangements are in place.

3.6 Transitional funding of the remaining deficit (£220k) will still be required on a non-recurrent basis during 2016/17 in order to sustain remaining services, contracted or otherwise, for the remainder of the financial year. During this time, service redesign and a new, affordable and prioritised commissioning strategy will be developed in partnership with key stakeholders, including those providers above. It is proposed that this non-recurrent funding be allocated from the remaining uncommitted social care funding available for 2016/17. This redesign will build on the previous work undertaken prior to April 2014, re-prioritising outcomes with reference to available resources and value for money.

3.7 From the 1st April 2017, the resultant outcome of a new ADP strategy and commissioning model leading to new provider contracts/service level agreements

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will be in place and clear targeted investment into other priority service areas will be implemented. A report will be brought to the IJB during 2016/17 when work on developing the options for the new model, affordable within the likely financial context going forward, is complete.

Summary

4.1 ADP chairs across Scotland have been advised of an estimated 20% reduction in the national allocation for ADPs in 2016/17. This would result in a reduction of £271k in ADP grant funding in 2016/17 although no formal grant settlement, at the time of writing, has yet been made. The ADP has identified potential recurrent savings of £72k which could be delivered but due to the delay in confirming budgets and the requirement to give notice on contracts, only £51k will be realisable during the remainder of 2016/17.

4.2 Transitional funding of the remaining deficit (£220k) will still be required on a non-recurrent basis during 2016/17 in order to sustain remaining services, contracted or otherwise, for the remainder of the financial year and the IJB is asked to approve the direction of £220k of 2016/17 social care funding on a non-recurring basis to the ADP.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the direction of £220k of 2016/17 social care funding on a non-recurring basis to the Alcohol and Drug Partnership and to **note** the proposals for reducing spend in 2016/17 by 51k across non-supported and treatment areas of budget.

Policy/Strategy Implications	Supports the delivery of the Strategic Plan
Consultation	Discussions held with key strategic leads
Risk Assessment	To be reviewed in line with the agreed risk management strategy
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	No resourcing implications

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer, Health & Social Care Integration	Carol Gillie	Director of Finance, Procurement, Estates & Facilities, NHS Borders
David Robertson	Chief Financial Officer, Scottish Borders Council		

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APPENDIX 1

Borders Alcohol & Drugs Partnership (ADP) report to the Executive Management Team of the Integrated Joint Board

8th April 2016

Options Paper relating to reduction in ADP Budget for 2016-17

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1 Introduction

This paper presents supporting information relating to the impact of the proposed 20% reduction to ADP funding. Overall details of the ADP Budget are outlined in Appendix 1. It describes the impact of potential funding reductions on the ADP budget and makes recommendations to the Executive Management Team (EMT) in relation to these potential reductions.

2 Background

ADP ring fenced funding is currently managed by the ADP and hosted for administrative purposes by NHS Borders. The Borders Integrated Joint Board (IJB) Scheme of Integration includes this funding as part of its commissioning remit.

On 18 December 2015 ADP Chairs were advised of a 20% reduction in the national allocation for ADP's. If applied locally this equates to a reduction of £270,438 to Borders' £1.3 million budget.

On 7 January 2016 the Cabinet Secretary for Health, Wellbeing and Sport wrote to NHS Chief Executives about the reduction in the national allocation and advised that 'from the board baseline budgets we would expect a total of £15 million to also go towards....maintaining the overall spend on addressing alcohol and substance misuse, maintaining alcohol and drugs treatment performance at existing levels across ADP locales'.

The ADP commissions three services providing individual support and treatment for alcohol and drugs:

- Action for Children: provides support for children and young people impacted by their own or others alcohol and drug use and parents with alcohol and drugs problems

- Addaction: treatment and support service for alcohol and drugs users aged over 16; re-integration service to support wider recovery and injecting equipment provision.
- Borders Addiction Service (BAS): treatment (including prescribing and detoxification) service for alcohol and drugs users aged over 16. Provision of a Substance Misuse Liaison Service in BGH.

These organisations have been asked how they will achieve this reduction and identify the impact on the services they provide.

The budgets associated with other funded areas have been scrutinised and a potential saving of £71,820 has been identified within Appendix 1.

3 Options

Four options are presented for consideration by the Executive Management Team.

Option 1: The EMT agrees to maintain the overall spend in the ADP budget and the ADP continues ongoing review of spending.

Option 2a: The EMT agrees the implementation of a reduction of 20% applied across all support and treatment services and minimum of 20% across other funded areas which are currently in place.

Option 2b: The EMT agrees the implementation of a reduction of 20% applied across all support and treatment services and minimum of 20% across other funded areas which are currently in place but provide a full year non recurrent funding to allow more detailed work to continue on possible ways to mitigate the effects of the funding reduction.

Option 3: The EMT agrees the implementation of a reduction in funding of £71,820 relating to non support and treatment areas but also provides a full year non recurrent funding to allow more detailed work to continue on possible ways to mitigate the effects of the proposed funding reduction.

4 Current funding levels and savings proposals

The table below outlines proposed savings across the individual treatment and support services and the total savings proposed from other funded areas.

Service	ADP funding	Proposed reduction	Percentage
Action for Children	171,063	34,212	20%
Addaction	269,871	53,974	20%
BAS (includes Support Workers)	603,695	120,739	20%
Associate Psychology post (BAS)	25,154	5,031	20%
Other funded areas	288,341	71,820	25%
Total	1,357,484	285,648	21%

5 Impact on Support and Treatment Services

Addaction, Action for Children and Borders Addiction Service provide treatment and support to some of the most marginalised and vulnerable individuals and families in Borders. The impact of the proposed reduction of 20% is likely to have a serious impact on vulnerable people and may result in an increase in waiting times and reduction in individual numbers accessing treatment for alcohol and drugs addictions and subsequent poor outcomes for service users, families and communities as well as an increase in inequalities.

These services were commissioned following the ADP Investment Review which identified the suite of interventions and services required in Borders to develop a Recovery Orientated System. Services work in an integrated manner to deliver on outcomes for service users. Any shift in provision in one service will impact across the system.

A Risk Matrix Tool (Appendix 2) was used to help assess risks by assigning a score to potential risks associated with the proposed reductions. These are immediate and short term risks. In the longer term the reduction in Outcomes for services/organisations are likely to result in increased demand for services through reduction in prevention work and lack of up to date knowledge and skills in the wider workforce. Immediate and short-term risks are outlined in Table 2 (below). An Equalities Impact Assessment is in draft form and a Health Inequalities Impact Assessment is required.

Table 2: Immediate and Short –Term Risks

	Risk Score		
Outcome area	**Action for Children**	**Addaction**	**Borders Addiction Service**
Outcomes for individuals and families			
Increase in waiting times for clients (LDP Standard)	High	High	High
Fewer service users reducing substance use	High	High	High
Increase in drug related deaths	High	High	High
Increased Blood Borne Virus (BBV)	Medium	High	High
Increased impact of parental substance misuse on children and young people	High	High	High
Increase in alcohol and drugs problems in children and young people	High	Medium	Medium
Reduction in recovery outcomes	Medium	High	Medium
Increase in discarded sharps within the community	-	Medium	Medium
Reduction in Alcohol Brief Interventions (LDP Standard)		Medium	Medium
Outcomes for services/organisations			
Increase in health inequalities	Medium	Medium	Medium
Increased demand and costs in to NHS and SBC	Medium	Medium	Medium
Increased criminality/costs to Community Justice services	Medium	Medium	Medium
Reduction in prevention work in young people's settings	Medium	-	-
Destabilisation of alcohol and drugs services workforce	Medium	Medium	Medium
Inability to provide training	Medium	Medium	Medium
Reduced ability to support work placements	Medium	Medium	Medium
Reputational damage to ADP and partners	Medium	Medium	Medium
Negative impact on partnership relations	Medium	Medium	Medium
Poor assessment in Care Inspectorate processes	Low	Low	Low

The impact of the proposed savings will also limit the potential to fill identified gaps in provision. For example, the 2014 Mental Health Needs Assessment carried out by Figure 8 includes dual-diagnosis as an area for action within its Recommendation 10:

Undertake regular needs assessment and specific, targeted research to address areas of unmet mental health need and inequality.

(Service specific information is included in Appendices 3, 4 and 5.)

5 Discussion

Reducing the harm caused by alcohol and drugs to individuals, families and communities in Borders should be a top priority for the IJB. The proposed reduction of 20% will, if implemented in our local system, likely impact on some of the most vulnerable people in our community and increase health inequalities.

The ADP is concerned not only about the immediate risks but also the sustainability, in particular of the third sector commissions, which will require to reduce staffing from their existing complement of 6.18 WTE (Action for Children) and 7.66 WTE (Addaction) should the proposed savings be implemented. Both these services provide a wide range of interventions across Borders.

The Chief Medical Officer's has recently reduced the low risk guidelines for alcohol consumption for men from 21 to 14 units a week. The most recent Scottish Health Survey reports that 46% of males and 40% of females drink above the recommended limits. It is however recognised that these are significant underestimates and it is likely that up to 80% of males are drinking over the new lower recommended limit of 14 units. The ADP is conscious of a potential need for additional alcohol brief interventions and raised concerns for individuals.

It is on this basis that the recommendation below is made to the EMT.

Recommendation

Because of the significant impact of the cuts on services as outlined in Table 2 and the challenge of the new national lower drinking limits, the ADP recommends that Option 1 is accepted by the EMT.

Prepared on behalf of the ADP by Fiona Doig, ADP Coordinator.

APPENDIX 1 ADP BUDGET 2015-16 INCLUDING PROPOSED SAVINGS

ADP ALLOCATION 15-16	
Alcohol Prevention, Treatment and Support	£1,039,066
Drug Services and Support	£315,141
TOTAL ALLOCATION	**£1,354,207**
Expenditure	
Support and Treatment Services	
Action For Children	£171,063
Addaction	£269,871
NHS Borders Addiction Service	£573,207
Total	**£1,014,141**
Other funded areas	
Responsible Drinking	£1,000
Service User Involvement	£10,000
Advocacy	£10,000
NHS Borders Corporate Support	£45,104
SDF – Voluntary Sector Representation	£6,800
Star Outcomes	£1,386
Service User Involvement	£1,000
Development Fund	£7,000
Primary Care – Locally Enhanced Service (ABIs)	£50,000
Primary Care – Blue Bay Licence (ABIs)	£3,960
Pharmacist	£13,100
CAAP (BAS)	£24,514
Social Work Planner	£10,300
Social Work Support Worker (BAS)	£30,488
Naloxone Kits	£3,000
Total	**£217,652**
ADP Support Team	**£125,691**
TOTAL EXPENDITURE	**£1,357,484**

PROPOSED SAVINGS FROM OTHER FUNDED AREAS

Area of Expenditure	Budget 15/16	Reduction 2016-17	Proposed allocation 2016-17
Responsible Drinking	£1,000	£200	£800
Service User Involvement	£10,000	£5,000	£5,000
Advocacy	£10,000	£5,000	£5,000
NHS Borders Corporate Support[1]	£45,104	£7,727	£37,377
Scottish Drugs Forum - Voluntary Representation	£6,800	£1,360	£5,440
Star Outcomes	£1,386	£0	£1,386
Service User Involvement	£1,000	£1,000	£0
Development Fund	£7,000	£4,000	£3,000
Primary Care - Locally Enhanced Service (LES)[2]	£50,000	£25,000	£25,000[2]
Primary Care - Blue Bay Licence (ABIs)[3]	£3,960	£0	£3,960
Substance misuse pharmacist	£13,100	£2,620	£10,480
Social Work Planner	£10,300	£10,300	£0
ADP Support Team	£125,691	£9,613	£116,078
Total	£288,341	£71,820	£213,521

[1] This is calculated as a percentage of Borders Addiction Service and ADP Support Team funding therefore a reduction in these budget areas will reduce the Support Charge

[2] Current anticipated spend is £30,000 therefore £25,000 represents a 17% reduction to current funding utilised via the Local Enhanced Service (LES) for Alcohol Brief Interventions. For discussion at the Local Negotiating Committee.

[3] Required to support ABI data collection

APPENDIX 2 RISK MATRIX

IMPACT DEFINITIONS

Impact Score	Description	Impact on People	Reputation
5	Catastrophic	Death or life changing injury/ psychological damage	Highly damaging UK wide adverse publicity
4	Major	Serious Injury/ psychological damage	Major adverse publicity across Scotland
3	Moderate	Medical treatment required – physical or psychological	Some adverse local publicity, legal implications
2	Minor	First aid treatment/counselling required	Some public embarrassment, no real reputational damage
1	Negligible	No obvious injury or harm. No counselling required	No external interest

LIKELIHOOD OF THE RISK OCCURRING (within the next 12 months)

Likelihood / Probability		
5	**Almost Certain** (near miss)	Over 90%
4	**Likely** (has happened before)	Up to 90%
3	**Possible** (has happened elsewhere)	Up to 65%
2	**Unlikely** (not expected but possible)	Up to 20%
1	**Remote** (force majeure)	Less than 5%

The Risk Matrix

LIKELIHOOD

Almost Certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Remote	1	2	3	4	5
	None	Minor	Moderate	Major	Catastrophic

IMPACT

Managing Risk

Risk score	**How the risk should be managed**
High Risk **(15 – 25) RED**	**Requires active management** Risk requires active management and mitigation to manage down and maintain exposure at an acceptable level.
Medium Risk **(6 -12) AMBER**	**Review regularly** Medium-high scoring requires active risk mitigation to manage down and maintain exposure at an acceptable level. Medium-low scoring would require some mitigating actions to keep risks at this level.
Low Risk **(1 – 5) GREEN**	**Review periodically** Low scoring risks may require mitigating actions to keep risks at this level.

APPENDIX 3 Action for Children

The majority of work in Action for Children (AfC) is providing support for children and young people up to the age of 18 affected by their own or others alcohol and drugs use and for parents whose substance use is impacting on their children. Action for Children's work often involves working with several members of one family.

As part of this work AfC are part of the 'team around the child' and are active participants in professionals meetings and Meetings Around the Child (MAC's) on a regular basis.

AfC provides support to colleagues in other agencies to work with children and young people. For example, they provide staffing to Crucial Crew and Safe T, multi-agency events targeted at P7 and S4/5 respectively which is led by the Safer Communities Team. They have also provided bespoke sessions for particular staffing groups including the Wilton Centre and Tweeddale Youth Action.

The caseload at the end of January 2016 is 48.

Staffing

The current staffing team at AfC is as follows:

Post	Hours	WTE
Children's Services Manager	7.4	0.2
Practice Team Leader	37	1
Families Practitioner x 6	157	4.2
Group Worker	10	0.28
Business Support	19	0.5
Total		6.18

Outcomes

AfC reports on a variety of outcomes. Individuals attending select outcomes from an in-house suite, therefore, not all service users have the same outcomes in their plan. The table below shows the percentage of service users who have demonstrated overall improvements from April – October 2015.

Outcomes	% of Service Users who demonstrated an overall improvement
Young person reduces alcohol use	42%
Young person reduces drug use	39%
Parent reduces alcohol use	45%
Parent reduces drug use	60%
Improved emotional well-being of service user (parent / child / young person)	66%
Improvement in self-protection / personal safety skills (child / young person)	50%
Child / young person lives safely in home with parents / carers	67%
Child / young person / parent sustains / achieves potential in education / employment / training.	61%
Improved parenting skills / ability to maintain safe environment for child / young person.	44%

Delivery proposal

- To remove 2 part-time posts from the team; 10 hour Group Worker post and 21 hour Children and Families Practitioner post. Group work hours and a secondment in another Action for Children Service are available to avoid any redundancies.
- To reduce manager hours; retaining the 37 hour Practice Team Leader (PTL) post but reducing the Children's Service Manager (CSM) hours from 7.4 to 2 hours per week. This change was planned once the PTL had completed her probationary period and staff annual Performance Reviews were completed but this will now be brought forward to the 1 April 2016.
- To reduce Business Support hours by 4 hours per week.
- To reduce operational costs by £6000 which includes travel, external training, activity and stationery costs. The CSM will undertake to make applications through AfC Fund-raising team for funds to activity costs associated with direct work to ensure focused work is not impacted upon.

Impact

Reduced number of practitioners and practice hours (7 staff to 5 and 177 hours to 146 hours). This will result in a reduction in overall case-load (by approximately 8 - 12 cases over a 6 month period; dependent on complexity and assessed need) and ability to respond to requests to be involved in group events or provide informal training inputs e.g. Safe T, Crucial Crew. A waiting list will be used to manage demand for 1:1 and family work; which will be overseen by the Practice Team Leader and based on need and risk. One off demands for training inputs / group work will be assessed according available resources at that time; with direct work to referred children, young people and families prioritised.

A reduction in the CSM hours was planned with the recruitment of the PTL and completed induction to the Service and organisation. This reduction will be completed earlier than planned; leaving the 2 remaining hours to provide supervision of the PTL, cover for the PTL (during annual leave) and to complete service audit and monitoring tasks (including service budget and contract).

A reduction in operational costs would be managed at local level; with opportunities to secure additional funding through AfC and small grant awards. Staff would be encouraged to access free local training but time out to undertake tasks would be managed by the PTL to ensure direct work is kept to a minimum. Planned training / conferences for Jan - March 2016 has already been costed and covered in the 2015/16 budget.

APPENDIX 4 Addaction

Addaction provides a treatment and support service for alcohol and drugs users aged over 16. The largest proportion of Addaction's work is done on a one-to-one basis and includes structured preparation for change and psycho-social interventions.

Addaction also provide a re-integration service which includes provision of groups to support recovery, for example, Mutual Aid Partnership (MAP) groups, Recovery Life (fortnightly informal evening for people in Galashiels) and provision of employability support. Addaction also supports Reconnect, the Borders women's group for women at risk of offending. Re-integration accounts for around 20% of work.

Addaction provide a dedicated Injecting Equipment Provision (IEP) service which includes provision of Take Home Naloxone and Dry Blood Spot Testing which are also part of the treatment and support service.

The project offers an Open Access duty service that responds to immediate need and crisis. Activities offered through Open Access are ad hoc advice and information, low level emotional support and sexual and emotional health support. Harm Reduction and Open Access accounts for around 15-20% of work.

Addaction are contracted to deliver family support. A fortnightly group for carers is facilitated by staff and a small number of family members seek out support from Addaction. This area has been identified as an area of improvement for the service and the ADP.

The caseload at end January 2016 is 128.

Staffing

The current staffing team at Addaction is as follows:

Post	Hours	WTE
Service Manager	37.5	1
Team Leader	37.5	1
Project Worker x 5	187.5	5
Administrator and employability	25	0.66
Sessional Worker	(as required)	n/a
Total		7.66

An Addiction Worker Trainee (funded by ADP) and a Social Work student are on placement with Addaction at the moment. Addaction also has three volunteers supporting the service.

Outcomes

Addaction reports on outcomes for treatment via an outcomes tool and consumption data at discharge. Employability work is reported via established outcomes as shown below.

Recovery outcomes January – December 2015:

Addaction uses the STAR outcome tool to report on recovery outcomes across a variety of areas. Service users complete the star with their worker and discuss a score for each area. The table below shows the average proportion of the service users whose score for each outcomes area has increased (improved), decreased (worsened) or stayed the same at the most recent review. This table gives scores for people who have both planned and unplanned discharges.

Outcome area	**Decrease**	**Same**	**Increase**
Physical health	17%	21%	62%
Meaningful use of time	17%	19%	64%
Community	19%	30%	51%
Emotional health	19%	12%	69%
Accommodation	26%	51%	23%
Money	17%	53%	30%
Offending	9%	65%	26%
Family and relationships	22%	36%	42%

Consumption outcomes April 2014 – December 2015:

	Number	**%**
Number of planned discharges (Apr-Oct)	128	58% (of those starting treatment)
Reduced consumption at removal	55	43% (of planned discharges)
Abstinent at removal	52	41% (of planned discharges)

Employability outcomes April – December 2015:

	Total
Number of clients set up Individual Learning Accounts	3
Number of clients created CV	8
Number of clients starting College Course	3
Number of clients starting volunteering	0
Number of clients starting employment	5

IEP data 2014-15:

	Average per month
Number of clients accessing (April – Nov)	43
IEP transactions (April – Nov)	82
Syringes dispensed (April – Nov)	1664
Dry Blood Spot tests performed (April – Dec)	3*
Take Home Naloxone kits dispensed (April – Dec)	5*

* these functions may be performed for clients in main service

Open Access data Jan to December 2015

Activity	**Number**	**Average Per quarter**
Benefits	51	13
Housing	15	4
Emotional support	170	42
Advice & information	130	32
Food parcel	83	21
Use of phone to other services	292	73
Total	**741**	**185**

Impact of potential funding reductions and options for delivery

Addaction have been unable to identify any savings in 'backroom' costs and have identified that all savings will come from staff costs.

Potential staffing structure

Remove the Team Leader post (1 WTE) and one Project Worker post (1 WTE)and increase administration capacity to 1 WTE.

This allows the Administrator to support clinical administration currently undertaken by Project Workers (e.g. input to Waiting Times, SDMD and the Addaction data system) in order to maximise Service User work.

Finance

£54,000 equates to approximately:

Post	WTE	Savings
Team Leader	1	£33,894
Project Worker	1	£28,229
Increase Administrator Post	0.5 → 1	-£7642
Total Savings		£54,500

These figures include all on costs including the management fee of 7.5%
Redundancy costs are estimated at between £15,000 to £20,000. These have not been included in calculations.

In this proposed new staffing structure, the increased emphasis on team facing work and direct delivery would mean that the Service Manager would have less capacity to support training placements e.g. AWTP and Social Work students, wider agency work and capacity building and ability to support ADP sub-groups and other partnership developments.

Addaction have estimated that the current case load of roughly 110 people would be split between 5 project workers at 20 each, 5 for the Team Leader and the other 5 for students, averaged out over the year. This equates to the caseload being reduced to 77% in the proposed new structure.

Service Delivery models

Addaction have considered three delivery models within the proposed staffing structure. Given that Harm Reduction/Open Access and Re Integration account for 15-20% of workload, the most straightforward option would be to cut out one or other of these parts of the service in its entirety. These situations are represented in the first 2 options. Option 3 describes delivery of all 3 components but to a reduced extent.

Addaction have estimated that around one quarter of the Team Leader's capacity is taken up by direct work and this post, similarly to the Project Workers, supports Harm Reduction/ Open Access, Planned Care and Re- Integration activities. They have not factored in the extra work that supports family work as this is a small part of the

workload though note that this is an identified area for future development. This equates to frontline capacity being reduced to 77% in the potential new structure.

Model	Description	Impact on Service Delivery
Option 1:	Remove re-integration function. Harm Reduction and Open Access Service continue.	Lose individual re-integration work, employability activity, Mutual Aid and the range of other recovery activities, including Recovery Life and the Friday group as well as support for the volunteer programme. Increasing demand for treatment as people relapse
Option 2	Remove Harm Reduction (IEP) and Open Access service Re-Integration activities would function as normal.	Restrict access to the service by not providing an Open Access function. Project Workers would see people by appointment only. The impact of not providing Harm Reduction activities would curtail Injecting Equipment Provision, Dried Blood Spot Testing and Naloxone. Increased risk of drug deaths and blood borne virus infections
Option 3	Provide Harm Reduction/Open Access, Planned Care and Re-integration, but to a reduced extent.	This would equate to three quarters of front line work across the 3 core functions. A quarter of the people in need would not get a service Increased risk of drug deaths and BBVs

Planned Care

With Planned Care, the potential staffing model means a reduction in caseload capacity to 77% of current situation. Waiting times would increase as fewer clients will be seen.

Addaction have also considered centralising the service to the office base and dismantling the locality model, but this would not be equitable.

APPENDIX 5 Borders Addiction Service

2.3 Borders Addiction Service

Borders Addiction Service (BAS) provide a range of specialist treatment and support services for adults over 16. This includes psychosocial interventions; substitute prescribing (e.g. methadone) and community detoxification. There is also a Substance Misuse Liaison Nurse (SMLN) based in the BGH and an Addictions Psychological Therapies Team (APTT)

BAS is the local lead for delivering Alcohol Brief Interventions training to support the LDP standard and also co-ordinates the Take Home Naloxone programme. BAS provides a Drug Treatment and Testing Order (DTTO) service which is funded by Criminal Justice Social Work.

The caseload at end January 2016 is 328.

2.31 Staffing

The current staffing team at BAS is as follows:

Post	Hours	WTE
Service Manager	*10*	*0.26*
Consultant Psychiatrist – Addictions	37.5	1
Team Leader	37.5	1
Band 6 Staff Nurse	195.5	5.22
Band 5 Staff Nurse	150	4
Primary Care Facilitator	37.5	1
SMLN	75	2
(APPT) Consultant Clinical Psychologist	15	0.4
(APTT) Clinical Applied Associate in Psychology	18.75	0.5
Band 2 Admin	16	0.47
Social Work Support Worker	140	4
Team Administrator	37.5	1
Secretary	53.5	1.38
Specialist GP		0.5
	Total	22.73

2.32 Outcomes

Recovery outcomes – Core Team

BAS uses the star outcome tool to report on recovery outcomes across a variety of areas for service users in the core team. Service users complete the star with their worker and discuss a score for each area. The table below shows the average proportion of the clients whose score for each outcomes area has increased (improved), decreased (worsened) or stayed the same at the most recent review. This table will scores for people who have both planned and unplanned discharges.

Scale	Decrease	Same	Increase
Drug use	27%	51%	22%
Alcohol use	8%	43%	49%
Physical health	20%	30%	50%
Meaningful use of time	21%	28%	51%
Community	22%	36%	42%
Emotional health	21%	19%	60%
Accommodation	9%	57%	34%
Money	20%	40%	40%
Offending	12%	72%	16%
Family and relationships	23%	35%	42%

Consumption outcomes

	Number	%
Number of planned discharges (Apr-Oct)	108	76% (of those starting treatment)
Reduced consumption at removal	18	17% (of planned discharges)
Abstinent at removal	30	28% (of planned discharges)
Unknown	60	56%

Options for service delivery and impact

BAS is committed to exploring the impact and potential delivery options should the proposed 20% reduction be required and is currently consulting with the staff team on potential options for delivery.

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COMMUNICATIONS QUARTERLY REPORT - JUNE 2016

Aim

1.1 This report aims to provide the IJB with an update of the communications and engagement activity that has been undertaken to support the Health and Social Care Partnership, and to provide an indication of the work which is currently planned for the next period.

Background

2.1 The Partnership is committed to communications and engagement activity that delivers a shared understanding and builds our collaborative approach, so that we continue the conversation with stakeholders on how to provide the best services for the different local communities.

2.2 The communications teams in NHS Borders and Scottish Borders Council (SBC) are working closely together to develop and deliver these activities, in line with an agreed project plan, and as directed by the IJB and its sub committees and groups, e.g. Strategic Planning Group (SPG).

2.3 Over the last three months, we have delivered several key communications as well as having developed specific communications which are currently subject to approval and/or further discussion. These are summarised below.

Summary

3.1 The Strategic Plan and supporting documents were published on the Health & Social Care Integration pages of the SBC and NHS Borders websites, following the documents being approved by the IJB. This launch was supported by social media, and we issued a joint press release.

3.2 We continue to engage with and develop our relationship with the local media. We received solid press coverage leading up to Integration going live. Berwickshire News wrote an article published 10.03.16 after attending a presentation held by the Chief Officer at an area forum meeting. As a follow-up, we received a press inquiry which resulted in two substantial articles in Berwickshire News and the Southern Reporter.

3.3 We have recently delivered the facility for staff in both NHS Borders and SBC to access each other's email and telephone information through a shared address book within Outlook. This is a welcome step in helping us to support staff that are working across both organisations and has been received positively. The communications team provided information on this for all staff through direct mailings and intranet posts.

3.4 We provided communications support to the IJB Development Session in May. This was a key event in our engagement with staff within localities. We worked with the localities teams and research and information analysts, to ensure that the IJB were able to have key facts re the specific locality, enabling members to understand the Cheviot context. Staff engaged openly with the IJB on the day, giving a true

picture of the challenges and opportunities within that locality. We will capture these views and this will enable us to continue to improve both our communications activity in a targeted way, as well as informing the approach that the Locality Co-ordinators are taking in their key role.

3.5 We have developed a brochure which is aimed at informing and engaging with GPs. We see this as a step in helping us all to identify the key elements of how their role in the integration will be delivered. In developing this, we have worked with GPs to ensure that we have achieved the most appropriate format and information for that audience. Once approved, we will issue this through our normal channels, including the GP Sub Committee.

3.6 We then plan to adapt this format in communications for clinicians and for the third and independent sector. Similarly to the GP brochure, we will seek input from each of these stakeholder groups in developing the communications.

3.7 Upcoming communications include:

- H&SC Update, newsletter to all stakeholders
- SB Scene (internal magazine for SBC staff)
- SB Connect (newspaper from the Council to all households in the Borders).

3.8 We have drafted the Health and Social Care Partnership Communication and Engagement Strategy 2016/17 which has been reviewed by the SPG and will come forward to the IJB for approval in due course.

Recommendation

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

Policy/Strategy Implications	Communications activity to support the delivery of the Strategic Plan
Consultation	As part of our ongoing communications activity, we engage regularly with all stakeholders
Risk Assessment	To be included in programme risk management activity
Compliance with requirements on Equality and Diversity	To be reviewed vis a vis each communication item
Resource/Staffing Implications	Support provided from existing programme team

Approved by

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

Author(s)

Name	Designation	Name	Designation
Carin Pettersson	Comms Officer Integration		

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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

3.1 During April, May and June, with Elaine Torrance, Chief Social Work Officer, spent some time with the Social Work Teams in Kelso, Hawick, Galashiels and the Start Team in BGH to discuss current issues in social care and developments and opportunities through increasing joint working.

3.2 25 April: Attended the Area Pharmaceutical Committee to discuss the latest developments in relation to health and social care.

3.3 11 May: We were sorry to see Jane Douglas, acting Principal Assistant leave the local social work service to take up opportunities elsewhere. Revised management arrangements have been put in place by Scottish Borders Council.

3.4 12 May: Attended the Eildon Area Forum as a representative on 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.

3.5 23rd May: The communications team successfully ensured engagement from local press in advance of the IJB development session based at Kelso Hospital. There were positive media messages displayed in a number of local newspapers. Staff participating in the visits welcomed the interest and attention on key services issues from Board members.

3.6 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	Compliant

Equality and Diversity	
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		

HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD WORKPLAN/BUSINESS CYCLE 2016

Meeting	Date, Time and Venue	Session Items
H&SC Integration Joint Board **Development Session**	Wednesday 20 January 2016 9.30am – 12.30 Board Room, NHS Borders, Newstead	Financial Governance Update on strategic plan and locality approach (capacity building) – Eric and Elaine Commissioning Plan Delayed Discharges IJB Development – George Hunter
H&SC Integration Joint Board	Monday 1 February 2016 2pm - 4pm Committee Room 2 Scottish Borders Council	Chief Officer Report Budget Monitoring Communications Update Integrated care fund Update Financial Regulations Strategic Plan
H&SC Integration Joint Board	Monday 7 March 2016 9.30am – 12.30 Council Chamber, Scottish Borders Council	Formal establishment of IJB Appoint Chief Officer Appoint Interim Chief Financial Officer Code of Corporate Governance Formal Adoption of Standing Orders Approval of Strategic Plan Risk Management Strategy Clinical & Care Governance
Extra Ordinary H&SC Integration Joint Board	Wednesday 30 March 2016 10.00am – 12.00 Council Chamber, Scottish Borders Council	Health & Social Care Partnership Financial Statement 2016/17 and assurance over the sufficiency of resources
H&SC Integration Joint Board	Monday 18 April 2016 2pm – 4pm Committee Room 2, Scottish Borders Council	Chief Officer Report Integrated Care Fund Update Monitoring Integration Joint Budget 16/17 Due Diligence Statement – (incl Financial Reporting timetable, schedule of payments) Directions Performance Management Framework Commissioning & Implementation Plan Housing Contribution NHS Borders LDP
H&SC Integration Joint Board **Development Session**	Monday 23 May 2016 **9.30am – 4.00pm** **Kelso Hospital, Kelso**	**Cheviot Locality – Listen to staff, discuss Cheviot Project, Local Issues, What matters to staff (current view/aspirational view)** **Action: Locality Coordinators**
H&SC Integration Joint	Monday 20 June 2016	Chief Officer Report (Susan M)

Meeting	Date, Time and Venue	Session Items
Board	2pm – 4pm Board Room Newstead **(1pm to 2pm Networking Lunch – Discussion on Localities)**	Interim Chief Financial Officer Report (Paul M) Monitoring Integration Joint Budget 16/17 (Paul M) Integrated Care Fund 6 monthly report (Paul M) Communications Quarterly Report (Carin P) Corporate Resources (Sandra C) Clinical Governance Framework (Karen McN) Alcohol and Drugs Partnership (Tim Patterson) Localities Framework (Eric) Appointments to Sub Committees (Iris) Pharmaceutical Care Services Plan 2016 (Alison W) Annual Report 2015/16 (Iris) **Private session**: SB Cares Business Plan (Elaine T)
H&SC Integration Joint Board	Monday 15 August 2016 2pm – 4pm Committee Room 2, Scottish Borders Council **(1pm to 2pm Networking Lunch – Discussion on Inspection of Adult Services???)**	Chief Officer Report (Susan M) Interim Chief Financial Officer Report (Paul M) Monitoring Integration Joint Budget 16/17 (Paul M) GP Contract Update (Costas Kontothanassis) Scottish Borders Autism Strategy Update (Simon Burt) Dementia Strategy Update (Simon Burt)
H&SC Integration Joint Board **Development Session**	Monday 26 September 2016 9.30am – 4.00pm Peebles	**Tweeddale Locality – Listen to staff, discuss Housing, Local Issues - Transport, What matters to staff (current view/aspirational view)** **Action: Locality Coordinators**
H&SC Integration Joint Board	Monday 17 October 2016 2pm – 4pm Committee Room 2, Scottish Borders Council **(1pm to 2pm Networking Lunch – Discussion on Housing???)**	Chief Officer Report (Susan M) Interim Chief Financial Officer Report (Paul M) Monitoring Integration Joint Budget 16/17 (Paul M) Joint Organisational Development Plan (Sandra C/June S) Refresh of Communication and Engagement Plan? (Carin/Sandra) Community Pharmacy and Prescribing (Alison W/Alasdair Pattinson) Community Ward – Annabel Howell and Sandra Pratt (Discussion) Palliative Care in the Community – Annabel Howell (Discussion)
H&SC Integration Joint Board **Development Session**	Monday 21 November 2016 9.30am – 4.00pm Eyemouth	**Berwickshire Locality – Listen to staff, discuss Review of Day Services, Local Issues, What matters to staff (current view/aspirational view)** **Action: Locality Coordinators**
H&SC Integration Joint Board	Monday 19 December 2016 2.00pm – 4pm Committee Room 2 Scottish Borders Council **(1pm to 2pm Networking Lunch – Discussion on ???)**	Chief Officer Report (Susan M) Interim Chief Financial Officer Report (Paul M) Monitoring Integration Joint Budget 16/17 (Paul M) Integrated Care Fund 6 monthly report (Paul M) Communications Quarterly Report (Carin P) Improving clinical care support to care homes through the context of integration

Meeting	Date, Time and Venue	Session Items
		(discussion) (Susan M/Alasdair P) Train to Care (discussion) (June S)
H&SC Integration Joint Board **Development Session**	TBA January 2017 9.30am – 4.00pm	**Eildon Locality – Listen to staff, discuss Review of Day Services, Local Issues, What matters to staff (current view/aspirational view)** **Consequences and pace of change in terms of commissioning** **Action: Locality Coordinators**
H&SC Integration Joint Board	TBA February 2017	Chief Officer Report (Susan M) Interim Chief Financial Officer Report (Paul M) Monitoring Integration Joint Budget 16/17 (Paul M) Communications Quarterly Report (Carin P) National IT Security – Jackie Stephen and Sandra Campbell (Discussion)
H&SC Integration Joint Board **Development Session**	TBA March 2017 9.30am – 4.00pm Hawick	**Teviot & Liddesdale (Hawick) Locality – Listen to staff, discuss Review of Day Services, Local Issues, What matters to staff (current view/aspirational view)Review of Board Development - Jane Mudd – reflections – next steps** **Action: Locality Coordinators**

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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: 19.04.16

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
10.00am to 11.30am on 19 April 2016
Committee Room 2, Scottish Borders Council Headquarters

Minute

Present: Margaret McGowan, David Bell, Dr Peter Symms, Tim Young, Morag Walker, Eric Baijal (Chair)

In Attendance:, Gerry Begg, Clare Richards, Claire Penny, Clare Malster, Shona Donaldson, Trish Wintrup, Stewart Barrie, Sandra Campbell, Paul McMenamin, Suzanne Hislop (Minutes)

1.	**Welcome** The Chair explained that the meeting was not quorate due to the absence of representatives of 'Carers of Service Users' and less than half of members being present. It was agreed that directions or actions would therefore be homologated at the next meeting. The Chair officially appointed Lynn Gallacher (Acting Carers Centre Manager) as the replacement for Fiona Morrison who has left her post. The Chair expressed thanks on behalf of members for the contribution made by Fiona Morrison to the group and the programme as a whole. Lynn Gallacher will now be the lead representative for both 'Carers of Users of Health Care' and 'Carers of Users of Social Care' with Linda Jackson remaining as deputy.	
2.	**Apologies**: Karen McNicoll, Shirley Burrell, Amanda Miller, Jane Douglas, Linda Jackson, Jenny Miller, Susan Manion	
3.	**Minutes of the previous meeting** • The minutes of the previous meeting of 8 March were accepted as a true record. SPG Minutes.doc • The group went through the actions arising from the last minute and updated the action tracker. SPG Action Tracker.doc	
4.	**Matters Arising**	

	• None noted.	
5.	**Draft Commissioning & Implementation Plan** • SC gave a brief overview of the latest draft of the Commissioning & Implementation Plan that was presented to the Integration Joint Board (IJB) yesterday. • This document has been developed by the Health and Social Care Management Team. • Year one is based on a "business as usual" model as well as a focus on deliveringprojects(particularly via ICF) that will enable and facilitate progress towards transformationalchange. • Two key target areas for year one have been identified. These are supporting people at home and improving the well-being of staff. There are discussions ongoing around whether enough has been included around improving the wellbeing of staff and so this is being looked at. • Throughout year two the planning work that is going on with the Health & Social Care Management Team will be continued. • The intention is to carry out specific and targeted consultation and the SPG will help shape this consultation. A specific planning session to tease out this group's contribution to this process was proposed and thought is to be given to this. • The need to recognise that what has been set out may have to change over the next 6 months as GP clusters meet for the first time was acknowledged. It was agreed that GPs are crucial stakeholders and their feedback is vital in the success of the programme. TY to take the paper back to GP Sub-committee to discuss with colleagues and provide any feedback to group. • It was highlighted that we are in a continual process of development and this will involve a planning and reviewing mind-set. • Linking the budgets with the actions to give a sense of where we are going to focus funding was also discussed at the IJB meeting. Year one is challenging as this is a transitional period; however in years two and three the C&I plan will inform the financial planning process. The Directions lay out clearly the financial resources that are allocated and the Directions paper that went to the IJB yesterday is to be circulated. • It was agreed that as the individual components of the programme are brought to this group it can make it difficult to see the overall interconnection. Consideration to be given to a presentation that shows how the various documents such as the Commissioning & Implementation Plan and Performance Management Framework link to, and support each other. • Group to review the papers discussed today and provide any feedback at the next meeting on 18 May. The will be recorded in the minutes that will then go to the IJB meeting scheduled for 20 June.	**ACTION EB/SC** **ACTION TY** **ACTION SH** **ACTION EB/SC** **ACTION ALL**
6.	**Draft Performance Management Framework** • The Draft Performance Management framework was discussed. The Chair expressed thanks to colleagues for the tremendous amount of work that has gone into getting all of the documents discussed at yesterday's meeting to where they currently are. • It was suggested that there are similar reporting processes in the NHS and SBC that already exist and could be used. It was acknowledged that there are and that the Draft Framwork had been developed with reference to these, and aimed at minimising the level	

	of additiona data that would need to be gathered in year one. TY provided feedback from the GP Sub-Committee. The feeling is that the figures are largely based on admissions and discharges in relation to Borders General Hospital when we should perhaps be looking at other areas to stop these problems building up. It was suggested that more has to be spent in the community and a shift of resources realised to stop people being admitted to hospital. • It was acknowledged that there was some criticism around the hospital centric nature of some of the measures but these are ultimately linked to what is going on in the community. This underlines the need to ensure that we measure the extent to which the shift in resources (from hospital to community care) is achieved, to avoid any unintended consequences of the set of priority measures. • This group has a critical role to play in these decisions and this can be addressed through consultation with this group and others. • There was a desire from the IJB to see something around resource shift reflected in the document and the use of the Integrated Resource Framework for measuring this and thought needs to be given to this moving forward.	
7.	**Integrated Care Fund** • CR gave a brief overview of the ICF papers that went to the IJB yesterday. The IJB requested that information be presented in a different way and the report now gives a better idea of the timelines and more information about the outcomes that the projects are working to. • Return on Iinvestment (ROI) information was also requested by the IJB. However, this is not something that was asked of the projects initially, so there may now be difficulty in obtaining this information. • CR asked if any members had any changes they would like to see. More information on sustainability was suggested by DB who highlighted the posts that are being funded through the ICF. • It was explained that in terms of posts some will only run for the duration of the project, some will be mainstreamed and for others this is not known. It was agreed that projects are a catalyst for change and if we don't have posts then these projects cannot be progressed. The project descriptors should not be in terms of posts, they should be focused on the outcomes that will be achieved through their delivery, not on the specifics of the inputs. • The Eildon Project is only at initial scoping stage at the moment, there has been some confusion regarding this which will be addressed as the project progresses beyond initiation stage. • Was agreed that it is to be made clearer that this project is not at an advanced stage and the ICF papers needs to reflect this. • GPs are essential to this and there has been no engagement with GPs over this project raising concerns that there will be no buy in as a result of this. The project manager, when in post, will be engaging with GPs in developing the project plans. • The revised ICF Governance paper was discussed. The IJB agreed that it requires simplification with decision making too slow. It was decided not to change the procedures at the moment and further work on this will be brought to a later IJB meeting. Members were again asked to comment on this work at the next meeting so this may be used to inform this decision making process.	**ACTION CR**

	• In future, work will be be commissioned in line with the Strategic Plan and the C&I plan. The current approach to project bids will no longer be the mechanism for allocating funding. The Strategic Planning Board needs to be engaging with people around this table to identify what work is to be commissioned in order to have a totally strategic view. The locality work will also be required to be developed so that ideas are fed upwards.	
8.	**AOB** • PS highlighted the difference between the strategic document and the Local Delivery Plan produced by NHS Borders on the issue of sensory impairment. This is not addressed in the document produced by NHS Borders and represents a mismatch between what NHS Borders and the IJB are saying on sensory impairment which has long been a neglected issue. The Board should be advised that both sides of the Partnership need to know what the other is doing and present a consistent message. • PS agreed to provide a short paper on this issue and this is to be added to the agenda for the next meeting.	**ACTION PS** **ACTION SH**
9.	**Date and time of next meeting:** **The date of the next meeting was given as 18 May from 1.30pm to 3.00pm in Committee Room 2.**	

PHARMACEUTICAL CARE SERVICES PLAN 2016/2017

Aim

1.1 The NHS Borders Pharmaceutical Care services Plan 2016 is designed to evaluate the current service provision, identify any gaps and support the decision making process on any future application for a new community pharmacy in the Scottish Borders.

1.2 A secondary function of the plan is to inform and engage members of the public, health professions and planners in the planning of pharmaceutical services.

Background

2.1 The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 determines the process to be followed when applications are made to NHS Boards to provide NHS pharmaceutical services.

2.2 The 2011 Amendment Regulations (SSI 2011/32) make a number of changes to the Control of Entry arrangements and processes for inclusion on the pharmaceutical list. Regulation 6 amends Regulation 15 of the Principal Regulations so that Boards are obliged to publish ***Pharmaceutical Care Services Plans***.

2.3 Boards also have to monitor their Pharmaceutical Care Services Plan annually to reflect changes in service provision or patient needs.

Summary

3.1 From the evidence gathered and outlined within this plan it is apparent that the current service provision is adequate for the populations immediate needs. No major gaps have been identified and the Scottish Governments vision and action plan for pharmaceutical care, Prescription for Excellence, has provided the platform for community pharmacy services to develop significantly enabling them to make a fundamental contribution to the health of the population. Prescription for Excellence will facilitate change from the traditional role of each pharmacy dispensing in favour of clinical pharmacy services and access to pharmaceutical care. Future contract applications should be required to demonstrate partnership with patients and health and social care professionals and a plan to provide person-centred pharmaceutical care services to meet the specific needs of the population they serve.

3.2 Since the publication of the 2015 Pharmaceutical Care Services Plan, a new pharmacy has opened in Burnfoot, Hawick, which includes a Sunday service. The railway link to Edinburgh opened in 2015 with stations at Stow, Galashiels and terminating at Tweedbank. It may change pharmaceutical care needs in these areas depending on population changes.

3.3 Over the coming year priority areas where pharmaceutical care services are being developed or established are:

- Services to support safe medicines administration such as the medicines review service coinciding with the launch of the Sick Day Rules cards

- Medicines reconciliation at discharge and discharge follow up through a new Prescription for Excellence technician
- Reducing medicines waste and supporting Cost Effective Prescribing Initiatives
- Concordance support
- Clinical Medication Reviews in Care Homes
- Carers Support
- Supply of Specialist Treatments (e.g. HIV, Hepatitis C, Rheumatology & Oral Chemotherapy).
- Palliative Care Support
- Supporting common clinical conditions such a urinary tract infections; exacerbation of respiratory conditions; impetigo.

3.4 In order to ensure service continuity all pharmacies have been asked to submit their business contingency plans. Availability of a current plan will be a requirement for any pharmacy participating in a local enhanced service. A key challenge for the coming year will be to support and enable pharmacists, providing NHS pharmaceutical care, to become NHS accredited clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners.

3.5 It is evident that the quality, range and promotion of services being provided can vary between pharmacies and it should be the aim of NHS Borders to develop governance arrangements that will ensure that a patient can expect the same high standard of service in all the pharmacies regardless of location.

3.6 The Pharmaceutical Care Services Plan has been discussed at the groups listed below in Consultation.

Recommendation

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

Policy/Strategy Implications	Complies with the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 to amend the provisions for the control of entry application process regulations.
Consultation	Area Pharmaceutical Committee GP Sub-Committee Primary, Acute & Community Services Clinical Board Clinical Executive Strategy Group NHS Borders Board Area Clinical Forum Public Reference Group/Public Involvement
Risk Assessment	N/A
Compliance with requirements on Equality and Diversity	Supports NHS Borders Equality & Diversity through ensuring equitable access to Pharmaceutical care.
Resource/Staffing Implications	N/A

Approved by

Name	Designation	Name	Designation

Cliff Sharp	Interim Medical Director		

Author(s)

Name	Designation	Name	Designation
Alison Wilson	Director of Pharmacy	Keith Maclure	Lead Pharmacist

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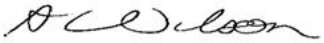
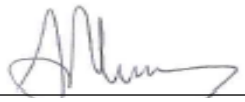
Pharmaceutical Care Services Plan

Version: 1
Issue Date: February 2016
Status: FINAL

Name	Job Title or Role	Signature	Date
Authored by:	**Alison Wilson** Director of Pharmacy		February 2016
Completion of the following signature blocks signifies the approver has read, understands, and agrees with the content of this document.			
Approved by:	**Andrew Murray** Medical Director		May 2016
Approved by:	NHS Borders Board	At meeting 5th May 2016	May 2016

Document Details

Document Pathway		Signed Off
Groups:	Area Pharmaceutical Committee	25th April 2016
	GP Sub-Committee of the Borders Area Medical Committee	18th April 2016
	Primary, Acute & Community Services Clinical Board	27th April 2016
	Clinical Executive Strategy Group	14th April 2016
	NHS Borders Board	5th May 2016
	Public Reference Group/Public Involvement	16th May 2016
File Location:	\Old Newstead Folder\Community Pharmacy\Pharmaceutical Care Services\NHS Borders PHARMACEUTICAL CARE PLANNING\2016	

Document Change Log

Version	Author	Issue Date	Comment
1.0	Alison Wilson	09.05.16	Added Berwick Pharmacy opening times (Page 19) on request from NHS Board

Contents

List of Figures & Tables

Figures

Tables

Executive Summary

NHS Borders provides health services to a population of approximately 116,600 (2015). This population is predicted to grow to 118,747 by 2020 and to 124,824 by 2035. The population is ageing with the number of people aged 65-74 set to increase by almost one third (32%) by 2035. This has been identified as the greatest potential risk to future health services.

From the evidence gathered and outlined within this plan it is apparent that the current service provision is adequate for the populations immediate needs. No major gaps have been identified and the Scottish Governments vision and action plan for pharmaceutical care, Prescription for Excellence, has provided the platform for community pharmacy services to develop significantly enabling them to make a fundamental contribution to the health of the population.

Prescription for Excellence (PfE) is the Scottish Government's vision and action plan for the right pharmaceutical care through integrated partnerships and innovation. This vision and action plan recognises the continuing and important role of pharmacists located in our communities and considers their future relationship with other local healthcare provision; crucial for future service planning in remote and rural areas and in our most deprived communities. The new Chief Pharmaceutical Officer is currently refreshing Prescription for Excellence and an update is expected in the new few months.

Prescription for Excellence will facilitate change from the traditional role of each pharmacy dispensing in favour of clinical pharmacy services and access to pharmaceutical care. Future contract applications should be required to demonstrate partnership with patients and health and social care professionals and a plan to provide person-centred pharmaceutical care services to meet the specific needs of the population they serve.

Since the publication of the 2015 Pharmaceutical Care Services Plan, a new pharmacy has opened in Burnfoot, Hawick, which includes a Sunday service.

The railway link to Edinburgh opened in 2015 with stations at Stow, Galashiels and terminating at Tweedbank. It may change pharmaceutical care needs in these areas depending on population changes.

Over the coming year priority areas where pharmaceutical care services are being developed or established are:

- Services to support safe medicines administration such as the medicines review service coinciding with the launch of the Sick Day Rules cards
- Medicines reconciliation at discharge and discharge follow up through a new Prescription for Excellence technician
- Reducing medicines waste and supporting Cost Effective Prescribing Initiatives
- Concordance support
- Clinical Medication Reviews in Care Homes
- Carers Support

- Supply of Specialist Treatments (e.g. HIV, Hepatitis C, Rheumatology & Oral Chemotherapy).
- Palliative Care Support
- Supporting common clinical conditions such a urinary tract infections, exacerbation of respiratory conditions, impetigo.

In order to ensure service continuity all pharmacies have been asked to submit their business contingency plans. Availability of a current plan will be a requirement for any pharmacy participating in a local enhanced service.

Key Challenges

Population aging and deprivation will provide future opportunities for community pharmacy growth and the evidence highlights some potential risks and challenges in the short to medium term. These challenges need to be addressed as part of ongoing service development, with the focus on equal opportunities and meeting the changing needs of the population.

No community pharmacist has come forward to train as an independent prescriber in the last year. This is likely to be a reflection of uncertainty around long-term funding for Community Pharmacy clinics and how these might be reflected in future National pharmacy contract discussions. A challenge will be to support and enable pharmacists providing NHS pharmaceutical care to become NHS accredited clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners.

It is evident that the quality, range and promotion of services being provided can vary between pharmacies and it should be the aim of NHS Borders to develop governance arrangements that will ensure that a patient can expect the same high standard of service in all the pharmacies regardless of location.

Quality Strategy & 20:20 Vision

Outlined below is how the pharmaceutical care service plan is consistent with and aligned to the 3 Quality Ambitions and 6 Dimensions of Healthcare Quality contained within The Healthcare Quality Strategy and 2020 Vision for NHS Scotland.

Quality Ambitions	How the Plan Aligns
1. Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.	The plan seeks to assess and improve access to pharmacy services for all sectors of the population, with an emphasis on meeting the needs of specific groups. The plan gives the Board the opportunity to identify gaps and enhance services available to a wide range of target groups including those covered by the Equality Act.
2. There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.	The plan seeks to ensure that all community pharmacy services are provided within the national care standards and that governance arrangements are in place to ensure both safety and quality of service.
3. The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.	The plan has been designed to be a dynamic document which will be continually reviewed and developed to meet the changing needs of the population.
Dimensions of Healthcare Quality	**How the Plan Aligns**
1. Person-centred	This plan and its actions will reduce the variation in service provision across the region and ensure services are available where needed.
2. Safe	Governance, monitoring and adherence to the national care standards will ensure patient safety.
3. Effective	The plan will drive continuous improvement of services to ensure the highest quality of care and services are available in areas of need.
4. Efficient	Services will be continually reviewed and added or removed as defined by patient need.
5. Equitable	Variations in service will be identified and addressed in conjunction with the governance, national care standards and changing needs of the population.
6. Timely	The plan is a live document and as such will look to address changing areas of need in a dynamic and timely manner. The plan will also be officially reviewed annually by the Lead Pharmacist, Medicines Utilisation and Planning

Background

The Scottish Borders

The Scottish Borders is a rural local authority with 5 towns with a population of between 5,000 and 15,000 (Hawick, Galashiels, Peebles, Kelso and Selkirk) and a further 5 towns with a population of 2,000 to 5,000 (Jedburgh, Eyemouth, Innerleithen, Duns and Melrose). According to the Scottish Government's 6-fold urban-rural classification, 47% of the population of the Scottish Borders live in rural areas compared to 18% for all of Scotland. The rural nature of the Scottish Borders can lead to additional challenges for those experiencing inequalities.

The region has one local government authority, Scottish Borders Council, and will form a single Health and Social Care Partnership on 1st April 2016.

Figure 1: The Scottish Borders

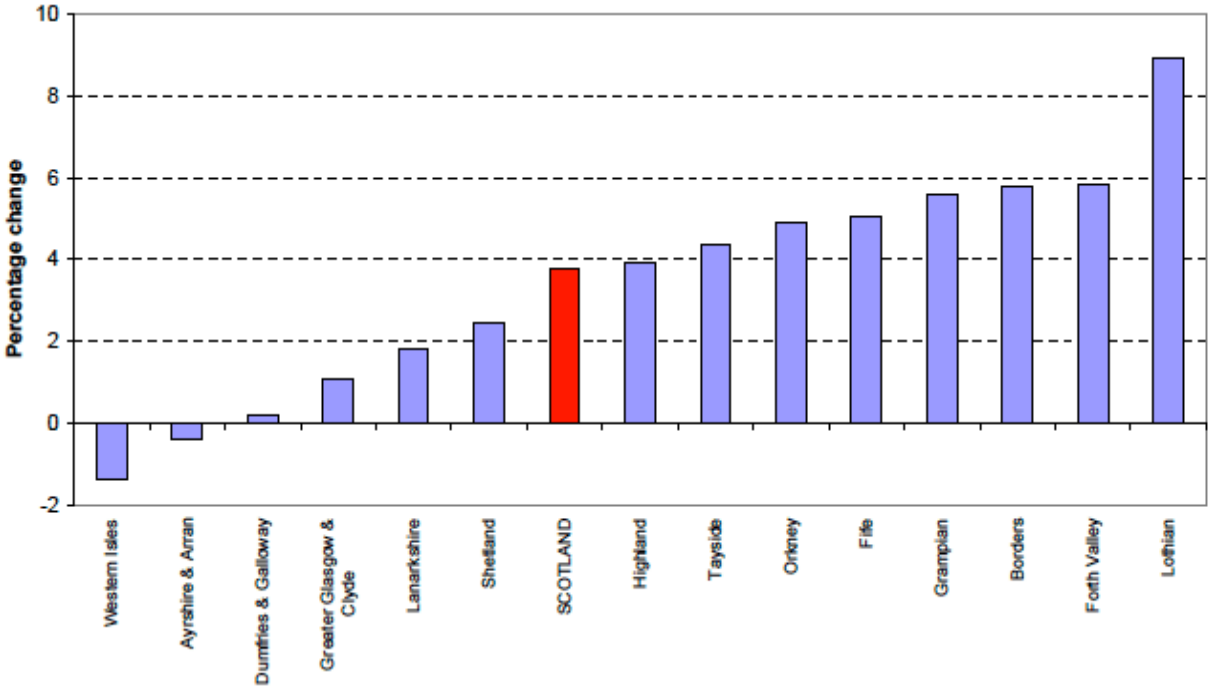
Population

The 2016 General Practice population for Scottish Borders is 116,815 (January 2016); an increase of 228 from 116,587 in 2015. The population of Scottish Borders accounts for 2.1 per cent of the total population of Scotland. There may be very little change in the overall number of people resident in Scottish Borders between 2012 (113,710) and 2032 (114,881), however, the numbers of people aged 65-74 may increase by almost one third (32%), whilst the numbers aged 75 and over may increase by 75%.

Ethnic minorities make up 0.6% of the Scottish Borders population, significantly lower than the Scottish average of 2.7%.Census data may not capture the seasonal economic migration that occurs in the Borders. A population whose health needs are undetermined.

Population shifts within the Borders tends to reflect the growth of new housing areas. The railway link to Edinburgh opened in 2015 with stations at Stow, Galashiels and terminating at Tweedbank. This may contribute to further growth along its commuter catchment area.

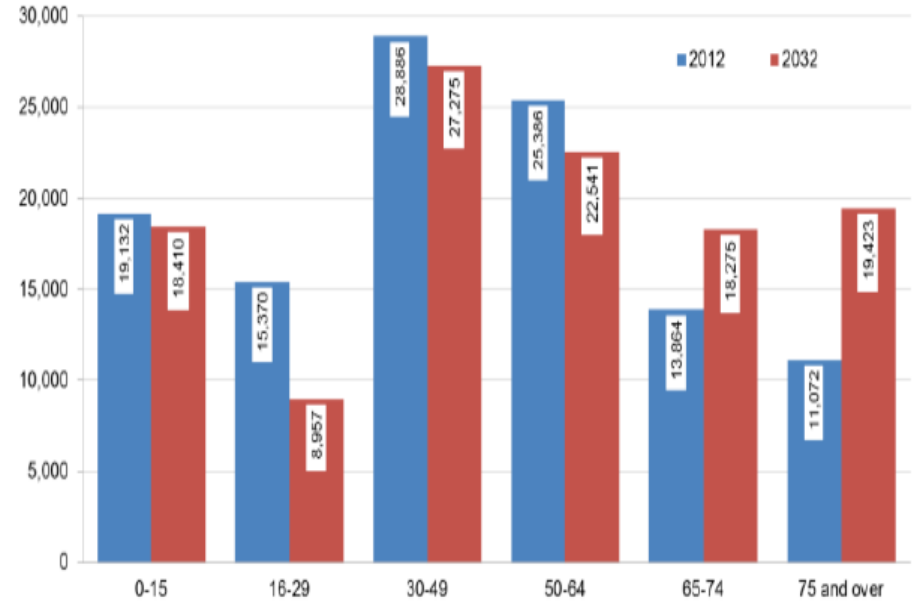
Figure 2: Percentage Change in Population, NHS Board Area Mid-2001 Mid-2011



Source: General Register Office for Scotland GRO (S).

Population estimates for The Scottish Borders by age band are highlighted in the following graph:-

Figure 3: Projected Population of Borders (2012 Based) for 2012 and 2035 by Age



Source: National Records for Scotland 2012-based population projections

Population Density

The Scottish Borders has 24 persons per square kilometre, compared to 66 persons per square kilometre for Scotland. The population density of the Scottish Borders is the fourth lowest in mainland Scotland.

Neighbourhoods

Definition – 'A **neighbourhood** is a geographically localised community within a larger city, town or suburb'. Neighbourhoods are often independent social communities with considerable face-to-face interaction among members.

Within the Scottish Borders there are several identifiable neighbourhoods but there are three which stand out as large enough to be considered communities in their own right; Langlee (Galashiels), Burnfoot (Hawick) and Tweedbank (Galashiels).

Table 1 – Population of Identified Neighbourhoods in Scottish Borders

Area	Town Population	Neighbourhood Population
Langlee, Galashiels	12,365	2,717
Burnfoot, Hawick	13,833	2,954
Tweedbank, Galashiels	12,365	2,097

Source – Scottish Borders Council; Strategic Policy Unit – Mid_Year Population Estimates 2012

Town/Village Populations

Table 2 - 2012 Mid-year Population Estimate Scottish Borders settlements
(Denotes = at least one Community Pharmacy)

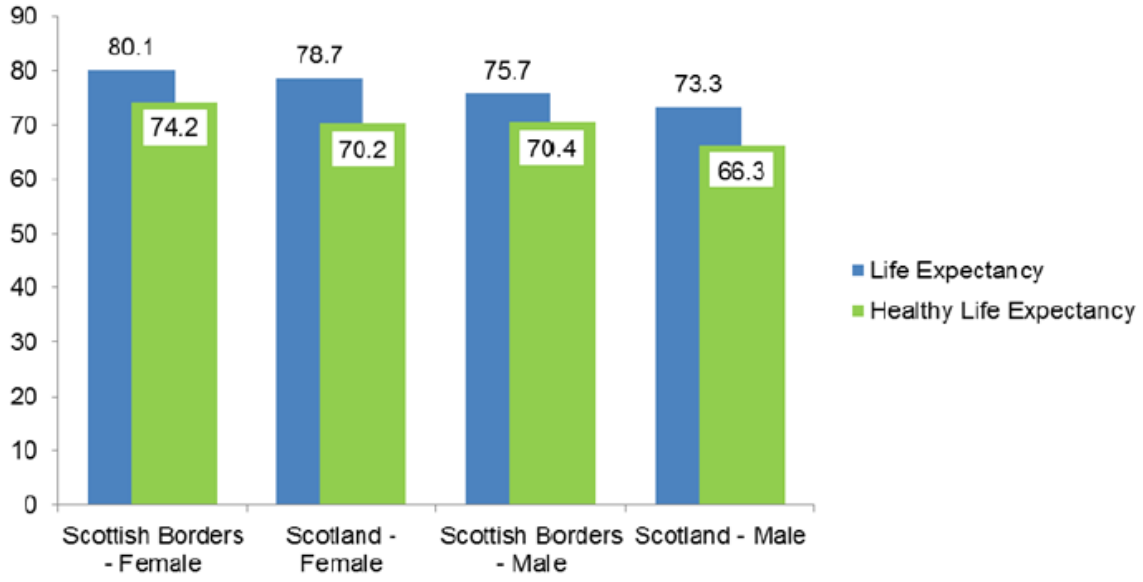
Settlement	Population	Settlement	Population
Hawick	13,833	Newtown St Boswells	1,284
Galashiels	12,365	Chirnside	1,244
Peebles	7,853	Lauder	1,109
Kelso	6,192	St Boswells	1,058
Selkirk	5,640	Eddleston	940
Jedburgh	3,946	Newcastleton	762
Eyemouth	3,155	Walkerburn	720
Melrose, Darnick, Gattonside, Newstead	3,127	Greenlaw	639
Innerleithen	3,004	Denholm	630
Duns	2,479	Stow	630
Tweedbank	2,097	Coldingham	572
Coldstream	1,839	Ayton	559
Earlston	1,793	Kirk Yelthom	552
West Linton	1,457		

Source – Scottish Borders Council; Strategic Policy Unit – Mid_Year Population Estimates 2012

Health

Healthy life expectancy is an estimate of how many years a person might live in a "healthy" state. In Scottish Borders both men and women are expected to have higher life and healthy life expectancy compared to Scotland. Figure 4 shows the gaps between healthy life expectancy and overall life expectancy. There are areas where life expectancy within Scottish Borders is lower than for Scotland (Galashiels West, Langlee, Galashiels South and Galashiels North)

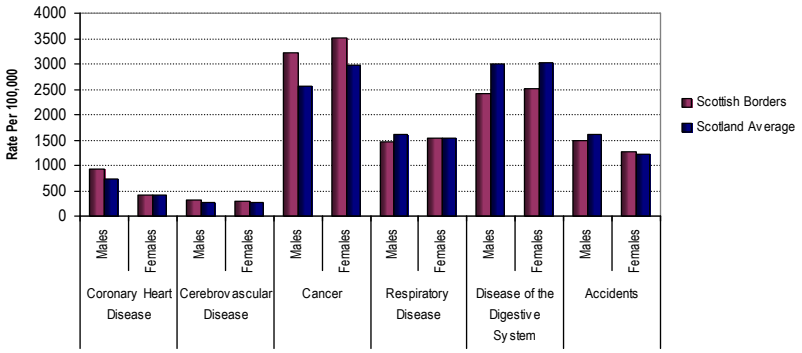
Figure 4: Life Expectancy and Healthy Life Expectancy (Years) at Birth, 5-Year Period 1999-2003



Source: ScotPHO Profiles www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/nhs-boards

A good indicator of ill health is the rate of admission to hospital for various conditions. The graph below shows the hospital admissions for selected conditions for Scottish Borders and the Scottish average. It is evident that both coronary heart disease and cancer in the Scottish Borders are above the Scottish national average, cerebrovascular disease is comparable and respiratory disease and disease of the digestive system below Scottish average.

Figure 5: Hospital Admissions for Selected Conditions all Ages (2008)



Source: Scottish Borders in Figures (2010) SBC

Deprivation

The Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland in a consistent way. It allows effective targeting of policies and funding where the aim is to wholly or partly tackle or take account of area concentrations of multiple deprivation.

An analysis of inequalities in the Scottish Borders was carried out using the SIMD coupled with additional local data collection tools. The ranking matrix shows the rank (1 to 29) for each of the small area geographies and for 46 inequality indicators. There are 9 Intermediate Geographies (small areas) in the Scottish Borders with 20% (9 of the 46) of indicators ranked between 1 and 5 shown in Figure 6 below.

Figure 6: Intermediate Geographies Inequalities Ranks

INTERMEDIATE ZONE	NUMBER OF INDICATORS RANKING 1 TO 5 OF 29	% OF INDICATORS RANKED 1 TO 5 OUT OF 29
Langlee	31	67%
Burnfoot and area	28	61%
Eyemouth	22	48%
Galashiels West	22	48%
Hawick Central	15	33%
Galashiels North	14	30%
Hawick North	11	24%
Coldstream and area	10	22%
Hawick West End	10	22%

Source: Scottish Borders Council

In relation to areas of deprivation or of high populations of the elderly continuity of pharmacy services and pharmaceutical care is important. Many people will take multiple medications which can lead to adverse effects and, on occasion, hospital admissions. It is essential to keep an oversight of polypharmacy to maximise the benefits of medication.

Introduction

In a modern NHS, Community Pharmacists provide an accessible and convenient contact point for patients, offering high levels of expertise on the best use of medicines and drug technologies, vital to ensure best patient care and best use of resources. The community pharmacy contract underpins the approach to modernising community pharmacy services both in the way that services are delivered by community pharmacists and planned and secured by NHS Boards.

Prescription for Excellence, the Scottish Governments vision and action plan for pharmaceutical care, will support community pharmacy to evolve and ensure that all patients regardless of their setting should receive high quality pharmaceutical care. Prescription for Excellence complements the Scottish Government's 2020 Vision Route Map and Quality Strategy ambitions as pharmaceutical care is a key component of safe and effective healthcare.

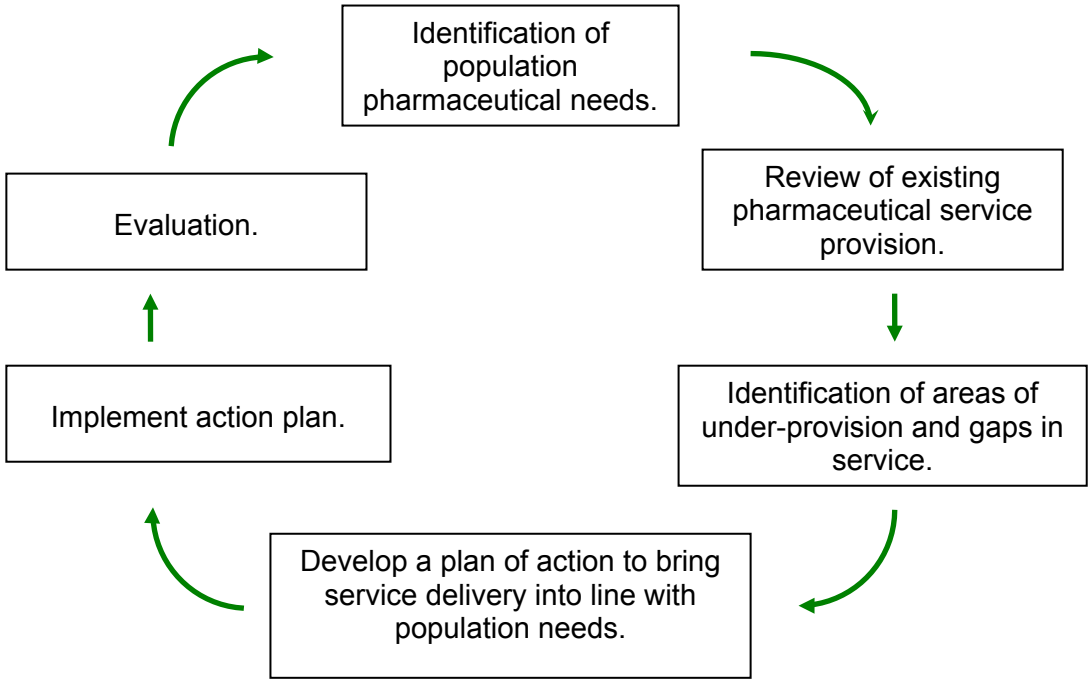
There is a statutory duty on NHS Boards to provide or secure the provision of pharmaceutical services they consider necessary to meet local needs and publish plans for where and what pharmaceutical care services are to be provided in their area. The Pharmaceutical Care Services Plan (PCSP) aims to improve the planning process for establishing and securing Pharmaceutical Care Services by ensuring that provision is based on locally identified care needs and patients have a convenient access to a full range of appropriate patient-centred and holistic services.

The aim of this pharmaceutical care services plan is to identify the current and anticipated needs of the Borders population with reference to pharmaceutical care services and is subject to extensive consultation with professional and public partners. The plan should be embedded within the planning processes of NHS Borders in order that the necessary resources for implementation can be identified in subsequent health plans.

Pharmaceutical Care Service Planning Process

The overarching aim of the Pharmaceutical Care Service planning process is to assess local needs for community pharmaceutical services and identify where there is a mismatch with current provision in order to inform service development that is both clinically effective and cost effective. This PCS planning cycle is summarised in *Figure 7* below*:*

Figure 7: PCS Planning Cycle.



Source: Adapted from Scottish Needs Assessment programme (SNAP) – Needs assessment in primary care: a rough guide.

A PCSP describes the health needs of the population and the pharmaceutical services which are in place, or could be commissioned to meet identified health needs. This is not a standalone document and the plan should be embedded within the planning processes of NHS Borders in order that the necessary resources for implementation can be identified in subsequent health plans.

The PCSP will therefore contribute to achievement of key strategic targets for example keeping people out of hospital; support for those with long term condition(s) and improvement of access within primary care. It will be used to:

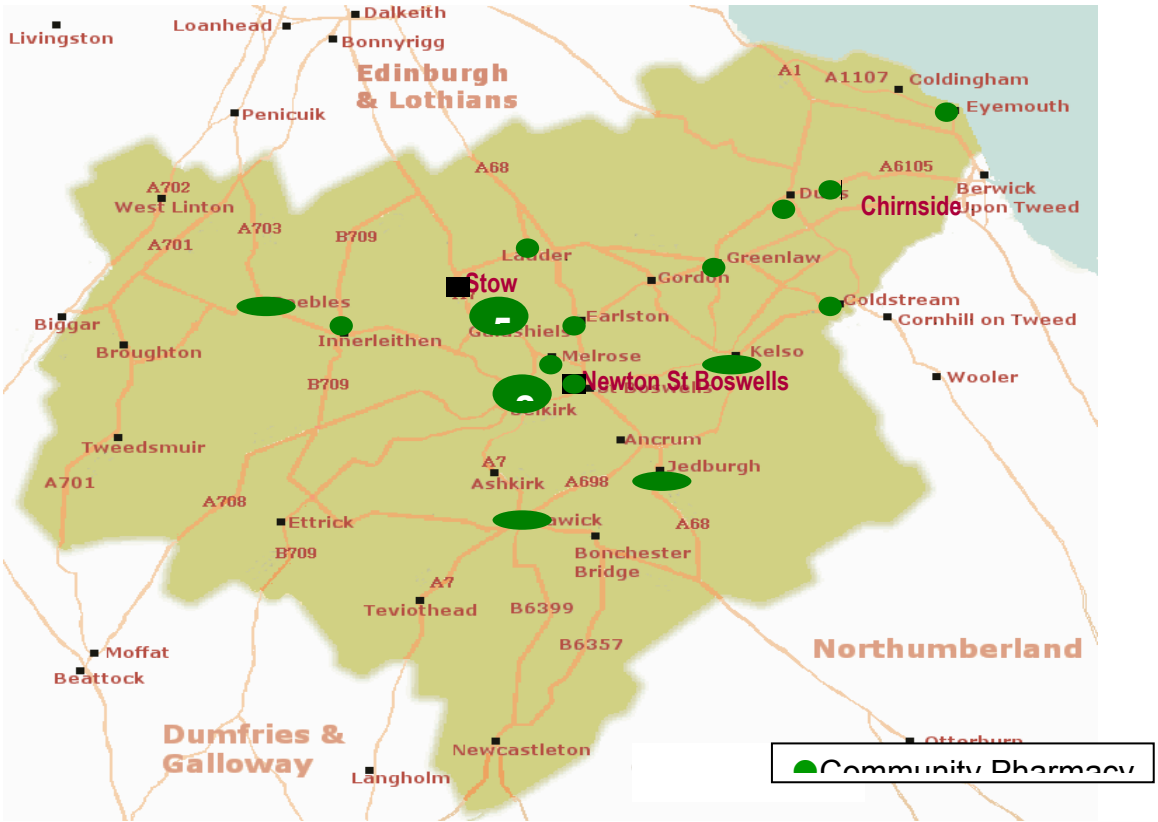
- Inform planning processes about pharmaceutical services that could be provided by community pharmacists and other providers to meet local need.
- Commission high quality pharmaceutical services.
- Ensure pharmaceutical and medicines management services reflect the health needs of the region.
- Facilitate opportunities for pharmacists to make a significant contribution to the health of the population of the Scottish Borders.
- Ensure we have robust and relevant information on which to base decisions about applications for market entry for pharmaceutical services.

Current Pharmaceutical Service Provision

Community Pharmacy

Pharmaceutical care services are currently provided by 29 community pharmacies. These are distributed across the region as illustrated in *Figure 8* below. They represent approximately 1 community pharmacy for each 4,030 of population compared to 1 community pharmacy for each 4270 Scottish Average (2010 population estimates).

Figure 8: Community Pharmacy Locations (2010).



Community pharmacies are independent contractors who provide a service to NHS Scotland in accordance with national regulation and locally negotiated contracts. These contractors may be individuals/independents with one or more outlets, partnerships/consortium with one or more outlets or multiples that generally have many outlets. The table below gives the breakdown of community pharmacies in these groups.

Table 3 - Pharmacy Contractor Ownership Breakdown

Category	Number
'Multiple' Pharmacies	10
Smaller Group Pharmacies	11
Independent Pharmacies	7
Consortium Pharmacies	1
TOTAL	**29**

Dispensing Practices

In addition to the community pharmacy network 3 GP practices hold dispensing doctor contracts (Stow, Newcastleton & Coldingham). These practices are contracted to dispense medicines for some or all of their patients. Dispensing doctors play an essential role in the dispensing and supply of medicines to patients in rural communities. Pharmaceutical care provision should complement and support dispensing doctors' services and their patients. In line with Prescription for Excellence two of the dispensing practices (Stow and Newcastleton) are supported by pharmacist independent prescribers providing disease specific clinics.

Figure 9: Dispensing Practice Locations with 10 and 20 minute travel isochrones (2010).

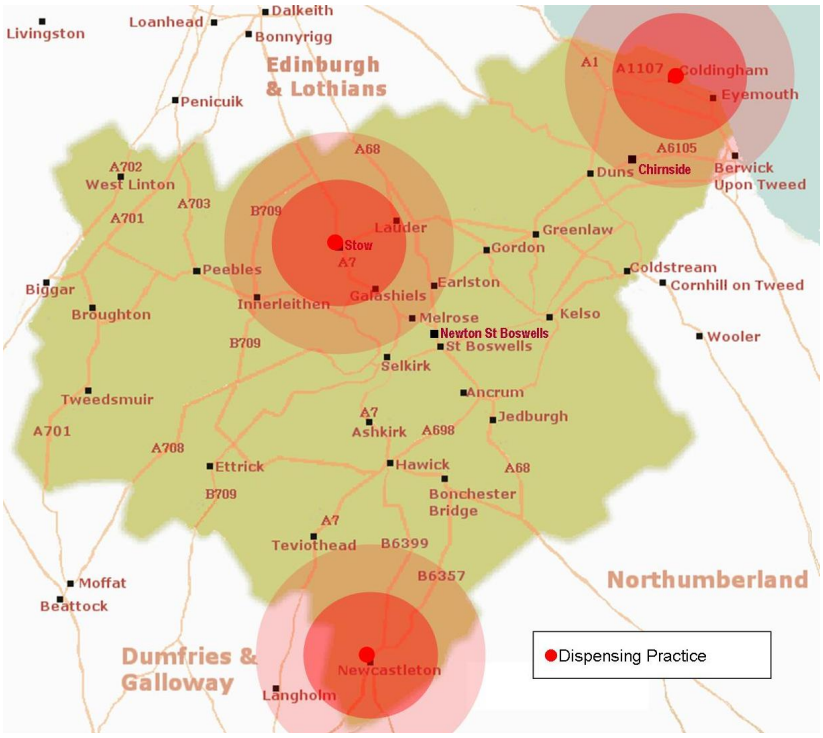


Table 4 - Dispensing Practice Statistics as at 1st October 2013

Practice	Dispensing Population	Nearest Community Pharmacy	
		Distance	Time (Car)
Coldingham	1,954	3.5 miles (Eyemouth)	8 Mins
Newcastleton	1,567	20 miles (Hawick)	30 Mins
		10.5 miles (Langholm)	18 Mins
Stow	1,441	5.5 miles (Lauder)	12 Mins
		8 miles (Galashiels)	15 Mins

Source: ISD Scotland 2010

Access to Pharmaceutical Care Services

The population of the Scottish Borders access pharmaceutical care services in line with the hours of service scheme. Most GP practices are closed by 6pm, Monday to Friday. The hours of Service Scheme means that all community pharmacies are open for most of this period. The flexibility within the scheme means that pharmacies may be able to open slightly earlier and remain open for slightly longer at their own discretion.

Normal hours of service for pharmacies are laid out as: *All places of business on the Pharmaceutical List shall be open for the supply of drugs and prescribed appliances (as the case may be), on the days and at the hours following:*

On five week days in the week (less any public holidays in the week).	9am to 5.30pm (during which time they may be closed for a maximum of one hour in the middle of the day).

Additionally at any other time when a pharmacist's place of business is open for the purpose of supplying drugs or appliances they shall supply drugs or prescribed appliances, which are ordered under the regulations.

This effectively means that each contracted pharmacy must open five and a half days per week and the opening hours should reflect local surgery times.

However there are variations to these hours depending upon individual circumstances and applications for slightly shorter or longer hours have been made at various times to suit the local situation.

During public holidays all community pharmacies operate within a rota system to ensure emergency cover is maintained. Fees for providing this service are agreed as part of the Boards locally agreed services.

Table 5 - Community Pharmacy Opening Times (January 2016)

Code	Pharmacy	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
8005	Eildon Pharmacy – Newton St Boswells	9 – 6 lunch 1-2pm	9 – 5:30 lunch 1-2pm	9 – 5:30 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 5:30 lunch 1-2pm	9 – 12	
8006	Boots UK Ltd – Galashiels	8:30 – 8	8:30 – 8	8:30 – 8	8:30 – 8	8:30 – 8	8:30 – 6	10 – 6
8007	Boots UK Ltd – Hawick	8:30 - 6	8:30 - 6	8:30 - 6	8:30 - 6	8:30 - 6	9 - 5	
8008	Boots UK Ltd – Peebles	9-6	9-6	9-6	9-6	9-6	9 – 5:30	
8009	Boots UK Ltd – Kelso	8:30 - 5:30	8:30 - 5:30	8:30 - 5:30	8:30 - 5:30	8:30 - 5:30	8:30 - 5:00	
8013	T N Crosby – Hawick	9 - 6	9 - 6	9 - 6	9 - 6	9 - 6	9 - 12	
8019	Lloyds Pharmacy Ltd – Kelso	8:30 - 5:30	8:30 - 5:30	8:30 - 5:30	8:30 - 5:30	8:30 - 5:30	9 – 5:00	
8020	Lloyds Pharmacy Ltd – Galashiels	9 – 5:30	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	9 – 5:00	
8034	G L M Romanes Ltd – Duns	9 - 6	9 - 6	9 - 5	9 - 6	9 - 6	9 - 5	
8035	G L M Romanes Ltd - Greenlaw	9 - 5.30 lunch 1-2pm	9 - 5.30 lunch 1-2pm	9 – 1	9 - 5.30 lunch 1-2pm	9 - 5.30 lunch 1-2pm		
8039	HHCC (Pharmacy) Ltd - Hawick	9 – 6 lunch 12.30-13.30	9 – 6 lunch 12.30-13.30	9 – 8.30 lunch 12.30-13.30	9 – 6 lunch 12.30-13.30	9 – 6 lunch 12.30-13.30		
8059	West Linton Pharmacy	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 - 1	
8044	A A Weir – L& G Selkirk	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 1	
8045	Lindsay & Gilmour - Hawick	9 – 6	9 - 5	9 - 6	9 - 6	9 - 6	9 - 5	
8048	Lindsay & Gilmour – Selkirk	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 5 lunch 1-2pm	
8050	Tesco Stores Ltd – Galashiels	8 - 8	8 - 8	8 - 8	8 - 8	8 - 8	8 - 8	9 - 6
8051	G L M Romanes Ltd - Eyemouth	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 5 lunch 1-2pm	9 – 6 lunch 1-2pm	9 - 3	
8052	M Farren Ltd – Galashiels	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:00	
8053	Lloyds Pharmacy Ltd - Peebles	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5	
8054	Boots UK Ltd – Melrose	8:30 - 6	8:30 - 6	8:30 - 6	8:30 - 6	8:30 - 6	9 - 5	
8055	Boots UK Ltd – Jedburgh	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 4	
8056	Lauder Pharmacy Ltd	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 - 1	
8057	Willow Health Care - Jedburgh	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	9 - 1	
8058	A G & S J Gray – Chirnside	9 – 6 Lunch 12-13.30	9 – 6 Lunch 12-13.30	9 – 6 Lunch 12-13.30	9 – 6 Lunch 12-13.30	9 – 6 Lunch 12-13.30	9 - 12	
8060	Borders Pharmacy - Galashiels	9 - 5.30	9 - 5.30	9 - 5.30	9 - 5.30	9 - 5.30	9 - 5	
8061	Borders Pharmacy – Hawick	8 - 6	8 - 6	8 - 6	8 - 6	8 - 6	9 - 5	10 - 5
8062	G L M Romanes Ltd - Coldstream	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	8:45 – 5:30	8:45 – 12:30	
8063	M Farren Ltd – Innerleithen	9 – 5:30 lunch 1-2.15pm	9 – 5:30	9 – 5:30 lunch 1-2.15pm	9 – 5:30 lunch 1-2.15pm	9 – 5:30 lunch 1-2.15pm	9 -12:30	
8064	M Farren Ltd – Earlston	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 - 1	9 – 6 lunch 1-2pm	9 – 6 lunch 1-2pm	9 - 1	
	Boots UK Ltd – Berwick Upon Tweed	8:30 - 6	8:30 - 6	8:30 - 6	8:30 - 6	8:30 - 6	8:30 – 5:30	11 – 4:30
	Castlegate Pharmacy – Berwick Upon Tweed	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 – 5:30	9 - 5	
	Lloyds Pharmacy – Berwick Upon Tweed	8:30 - 6	8:30 – 6	8:30 – 6	8:30 – 6	8:30 - 6		

To help guide understanding of accessibility to community pharmacies consideration has to be given to the travel time to a pharmacy. With the size and geography of the Scottish Borders a travel time of 20 minutes is deemed to represent reasonable access to community pharmacy. The travel time is based on a patient accessing a pharmacy via motorised transport (Car, Bus, Taxi etc) on an average journey time. *Figure 10* shows the resultant access coverage using 20 minute travel isochrones.

The information provided does not take into consideration access to public transport, bus routes and numbers of changes or the time required for this. Delivery services from community pharmacies help provide easier access to dispensed medicines but not pharmaceutical care. This delivery service is not a direct NHS funded service nor a contractual obligation and may be withdrawn at any time.

Figure 10: Community Pharmacy - 20 Minute travel Isochrones in NHS Borders Area

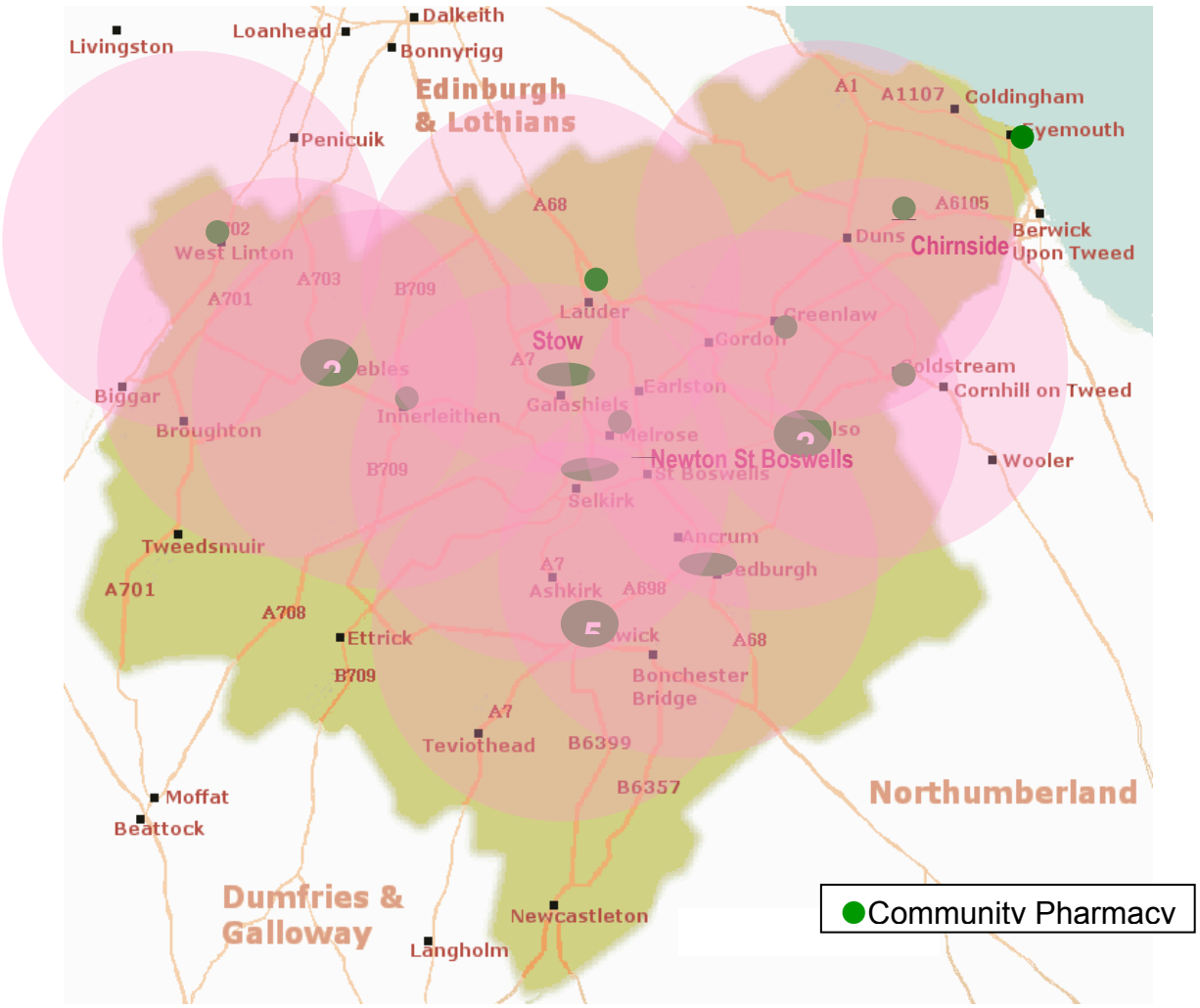


Figure 11 illustrates access (20 minute travel isochrones) to pharmaceutical care services during a Saturday pre 13:00hrs. It would appear that there is an even spread of cover and that the current service provision is adequate for the populations needs.

Figure 11: Community Pharmacy Saturday Pre 13:00hrs Service Provision.

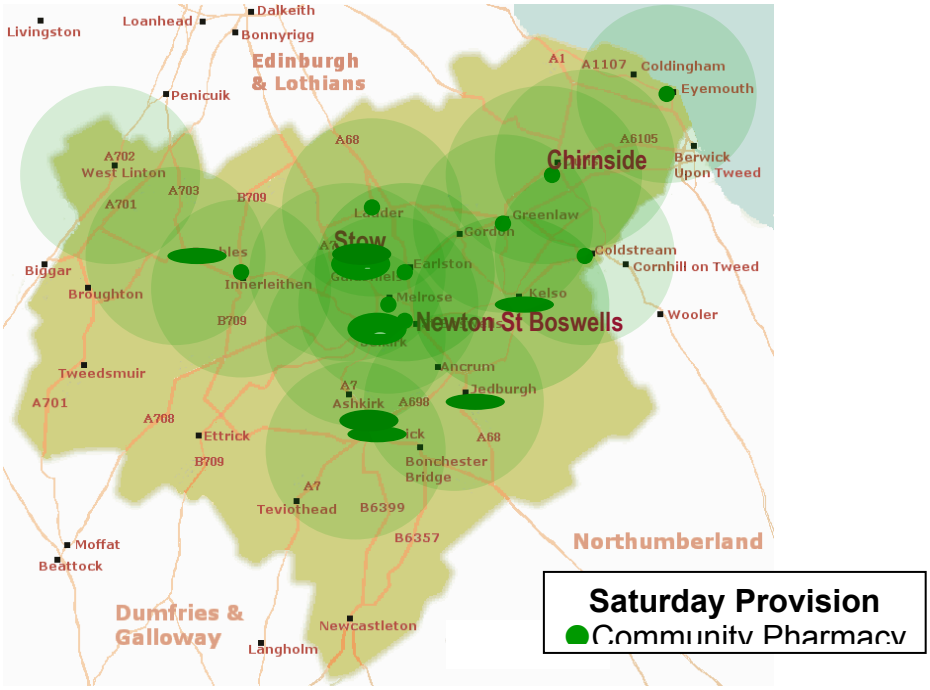


Figure 12 below illustrates access (20 minute travel isochrones) to pharmaceutical care services during a Saturday post 13:00hrs. It would appear that although there is less availability than pre 13:00hrs, it is still an even spread of cover and is adequate for the populations needs.

Figure 12: Community Pharmacy Saturday Post 13:00hrs Service Provision.

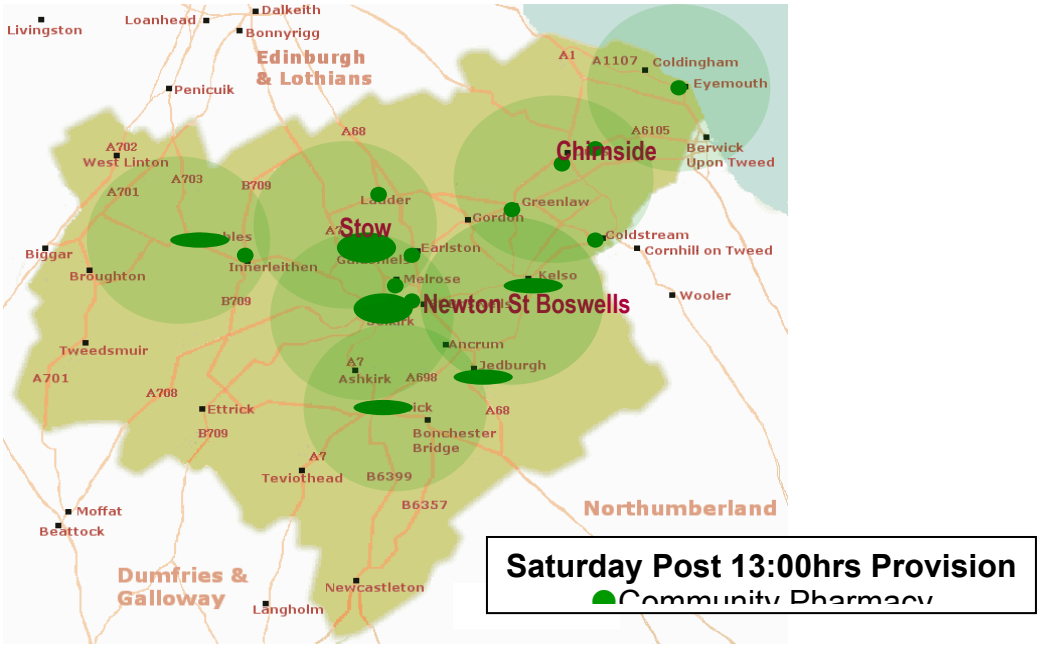
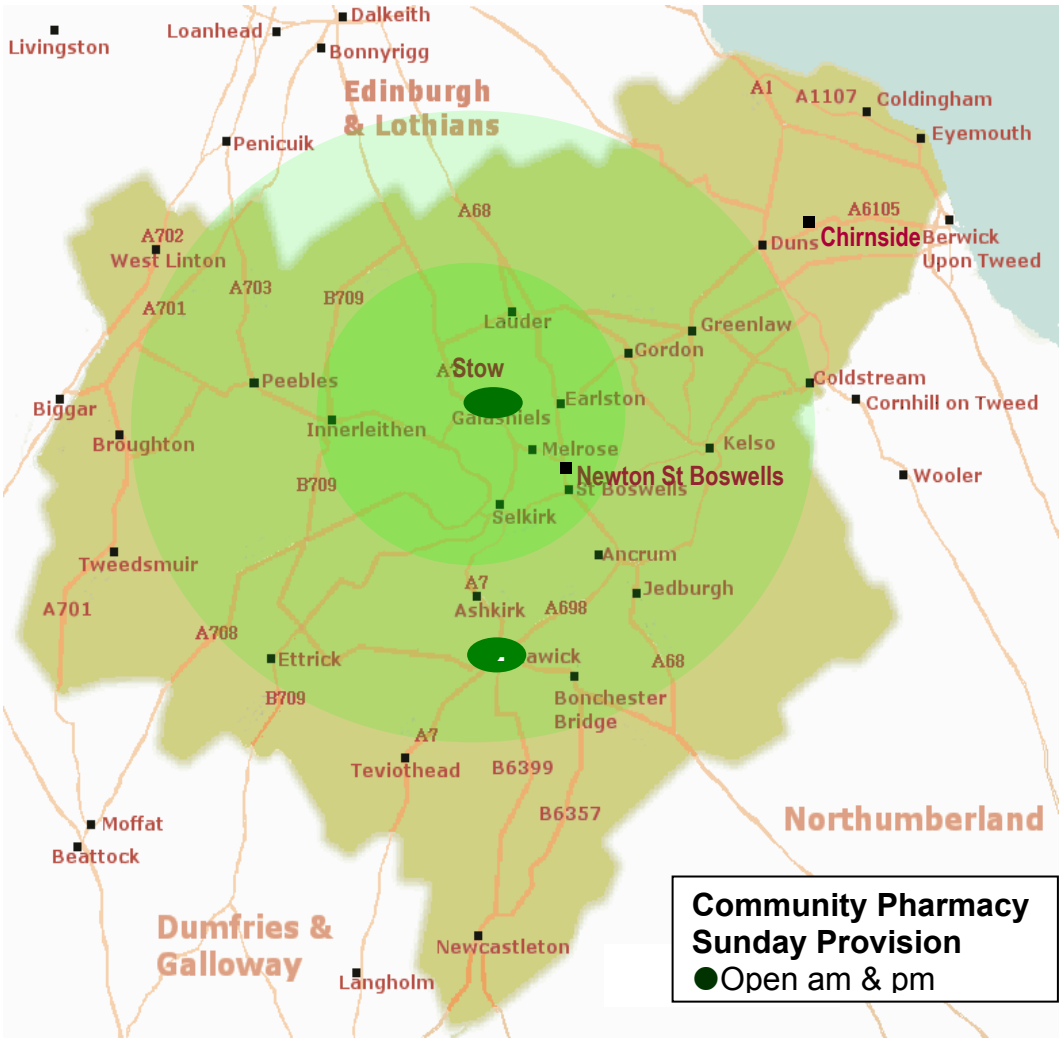

Livingston
Loanhead
Dalkeith
Bonnyrigg
Edinburgh & Lothians
Penicuik
A1
A1107
Coldingham
Eyemouth
A68
A6105
Ghirnside
Berwick Upon Tweed
A702
West Linton
A703
A701
B709
Lauder
Greenlaw
Gordon
Stow
Goldstream
Cornhill on Tweed
Biggar
Broughton
Innerleithen
Earlston
Melrose
Kelso
Newton St Boswells
Wooler
B709
Tweedsmuir
Ancrum
A7
Jedburgh
A701
Ashkirk
A698
A708
Ettrick
A68
B709
Bonchester Bridge
A7
Teviothead
B6399
B6357
Northumberland
Moffat
Beattock
Dumfries & Galloway
Newcastleton
Langholm
Saturday Post 13:00hrs Provision
Community Pharmacy

Figure 13 below illustrates access (20, 40 & 60 minute travel isochrones) to pharmaceutical care services during a Sunday. There is service provision on a Sunday from Boots and Tesco in Galashiels and Borders Pharmacy in Hawick. Outwith the Borders, Sunday services are available in Lothian and Berwick Upon-Tweed (Northumberland).

Figure 13: Community Pharmacy Sunday Service Provision.



Travel/Transport

Transport plays a key role in the access to all services in the Scottish Borders due to the rural nature of the area and the distances that people need to travel.

Scottish Borders Councils Transport Strategy 2007/08 highlighted that the Scottish Borders does have relatively good public transport and social transport services; more so in centres of larger population density.

Some services are under threat due to national cuts and a reduction in subsidy funding locally. These service reductions are identified as a potential risk to access health services including community pharmacy.

Table 6 - Road Transport Statistics (2007/2008)

	Scottish Borders	Scotland
% of households without access to a car	20	26
% of households with access to one car	47	46
% of households with access to two or more cars	33	28
% of roads needing maintenance (Red & Amber Classification)	37	35
Average rate of road usage (million vehicle km) per head of population	11	9
Rate of total government expenditure (£1,000) on roads per 100,000 population (2006)	12	9
Rate of petrol & diesel consumption (1,000 tonnes) per 100,000 population (2006)	88	61
% of children walking or cycling to school	55	51

Source: SBC/SNS Local Authority average

Contractor Premises

Access - Under the Disability Discrimination Act 1995 (DDA), it is unlawful to treat a person less favourably for a reason related to that person's disability (unless it can be justified). Pharmacies that have fewer than 15 employees are exempt from the employment regulations of the Act, but everyone providing "services", regardless of size, must follow the provisions of the Act. Pharmacies are specifically included in this section because they provide health services.

- Pharmacies must take reasonable steps to provide auxiliary aids or services, which will enable disabled people to make use of their service.
- Where physical barriers make it impossible for disabled people to use a service, the pharmacy is expected to facilitate the provision of the service by an alternative method. This could involve directing the patient to a nearby alternative pharmacy with the appropriate facilities.

Table 7 below shows a breakdown of the facilities currently available to ensure equality of access for all patients (January 2011).

Table 7 - Equality of Access Audit (January 2011; updated March 2016)

Pharmacy	Door width 800mm or wider	Aisle Width 800mm or wider	Counter Height between 750mm - 800mm from floor	Suitable Waiting Area Inc Wheelchair /Pushchair	Hearing Induction Loop	Ramps and Level access throughout	Automatic/Semi automatic Door Opening
Eildon – Newton St Boswells	✓	✓	✓	✓	✓	✗	✗
Boots - Galashiels	✓	✓	✓	✓	✓	✓	✓
Boots - Hawick	✓	✓	✗	✓	✓	✓	✓
Boots - Peebles	✓	✓	✓	✓	✓	✓	✗
Boots - Kelso	✓	✓	✗	✓	✓	✗	✓
T N Crosby – Hawick	✓	✓	✗	✓	✓	✓	✗
Lloyds – Kelso	✓	✓	✓	✓	✗	✓	✓
Lloyds – Galashiels	✓	✓	✓	✓	✓	✓	✓
D & E Ogilvie – Innerleithen	✓	✓	✗	✓	✓	✓	✗
GLM Romanes - Duns	✓	✓	✓	✓	✓	✓	✗
GLM Romanes – Greenlaw	✓	✗	✓	✗	✗	✓	✗
R G Turnbull - Earlston	✓	✓	✓	✓	✓	✓	✗
HHCC – Hawick	✓	✓	✗	✗	✓	✓	✓
West Linton Pharmacy	✓	✓	✗	✓	✗	✓	✗
A A Weir – Selkirk	✓	✓	✗	✓	✗	✓	✗
Lindsay & Gilmour - Hawick	✓	✓	✓	✓	✗	✓	✓
Coldstream Pharmacy	✓	✓	✗	✓	✓	✓	✗
Lindsay & Gilmour - Selkirk	✓	✓	✓	✓	✗	✗	✓
Tesco - Galashiels	✓	✓	✗	✓	✓	✓	✓
GLM Romanes - Eyemouth	✓	✓	✓	✓	✓	✓	✗
M Farren - Galashiels	✓	✓	✓	✓	✗	✓	✗
Lloyds - Peebles	✓	✓	✓	✓	✓	✓	✗
Boots - Melrose	✓	✓	✓	✓	✓	✓	✓
Boots - Jedburgh	✓	✓	✓	✓	✓	✓	✓
Lauder Pharmacy	✓	✓	✗	✓	✗	✓	✗
Jedburgh Pharmacy	✓	✓	✓	✓	✓	✓	✗
Grays Pharmacy - Chirnside	✓	✓	✓	✓	✓	✓	✗
Borders Pharmacy - Langlee	✓	✓	✓	✓	✓	✓	✓
Borders Pharmacy - Burnfoot	✓	✓	✓	✓	✓	✓	✓

Confidential Services

In order to provide many of the additional services community pharmacies must have a suitable environment that offers the patient the privacy expected of such services. NHS Circular: PCA(P)(2007)28 Pharmaceutical Services Remuneration Arrangements For 2007-2008: Contract Preparation Payments Premises Guidance and Assessment Tool provided guidance on the premises requirements under the new community pharmacy contract. This guidance also aids the planning of any future pharmacy premises or potential relocations.

Four community pharmacies do not have sufficient space to provide private areas, which can be utilised for the provision of counselling and/or advice. These areas in the pharmacies enable patients to have personal discussions with some privacy and to enable other private services such as emergency hormonal contraception to be provided in a confidential manner.

This will hamper these pharmacies providing some of the new enhanced services from within the pharmacy. The table below outlines the results of the most recent consultation area audit. (February 2016)

Table 8 - Consultation Room Audit (February 2016)

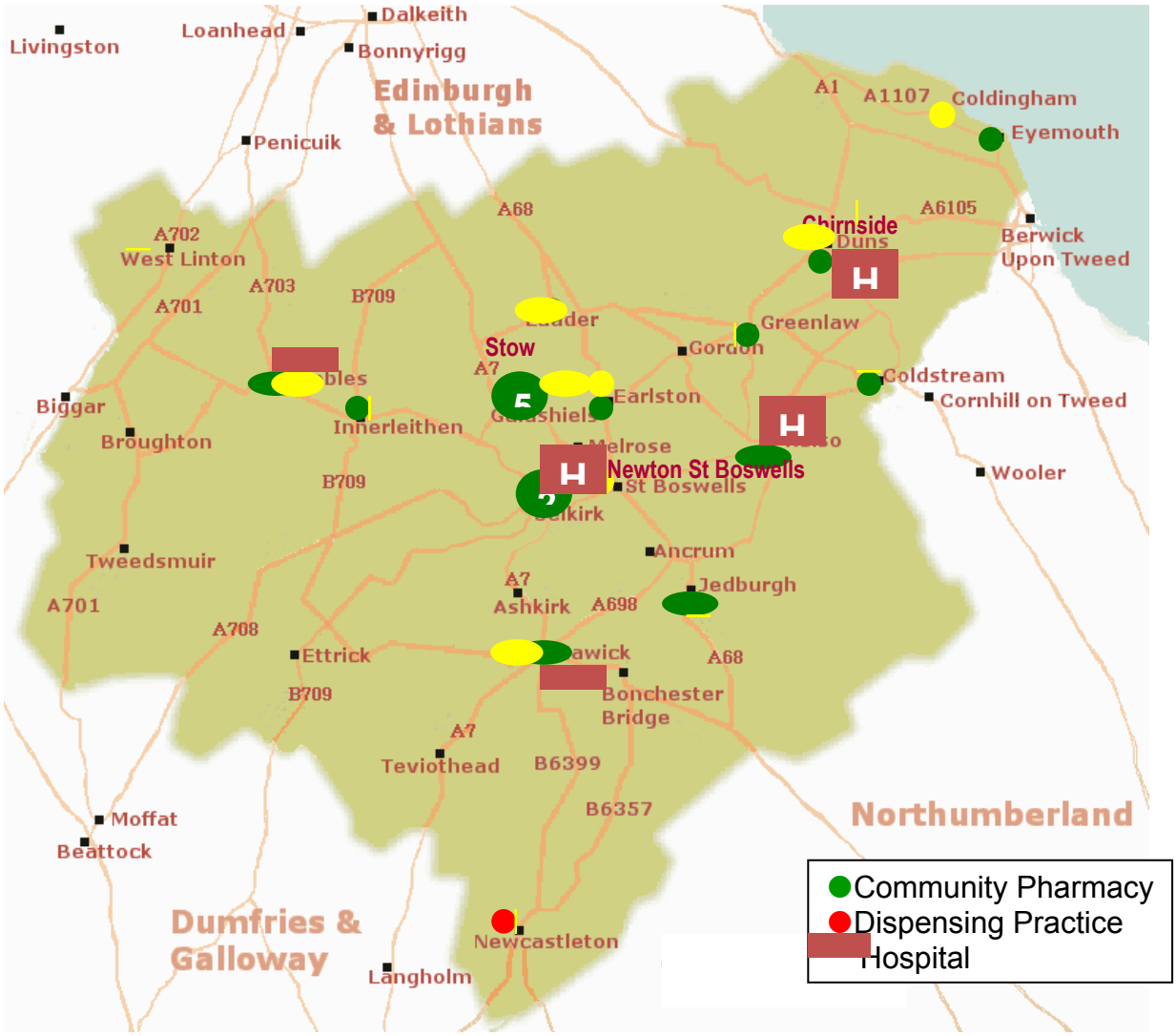
Pharmacy	Sound proof & private.	Located close to, or part of main counter.	Screened from main retail area	Wheelchair Accessible	Large enough for 2 people plus Pharmacist	Is a separate enclosed room available if complete privacy is required	Worktop / Desk	Hand Washing facilities
Eildon – Newton St Boswells	✓	✗	✓	✗	✓	N/A	✓	✓
Boots - Galashiels	✓	✓	✓	✓	✓	✓	✓	✓
Boots - Hawick	✓	✓	✓	✓	✓	✓	✓	✗
Boots - Peebles	✗	✓	✓	✗	✓	✓	✓	✓
Boots - Kelso	✗	✓	✓	✓	✓	N/A	✓	✗
T N Crosby – Hawick	✓	✓	✓	✓	✓	N/A	✓	✗
Lloyds – Kelso	✓	✓	✓	✓	✓	✓	✓	✓
Lloyds – Galashiels	✓	✓	✓	✓	✓	✓	✓	✗
D & E Ogilvie – Innerleithen	✗	✓	✓	✓	✓	✗	✓	✗
GLM Romanes - Duns	✓	✓	✓	✓	✓	✓	✓	✓
GLM Romanes – Greenlaw	✗	✗	✗	✗	✗	✗	✗	✗
R G Turnbull - Earlston	✓	✓	✓	✓	✓	✓	✓	✓
HHCC – Hawick	✓	✓	✓	✓	✓	N/A	✓	✗
West Linton Pharmacy	✓	✓	✓	✗	✗	N/A	✓	✗
A A Weir – Selkirk	✓	✗	✓	✓	✓	N/A	✓	✓
Lindsay & Gilmour - Hawick	✓	✓	✓	✓	✓	N/A	✓	✓
Coldstream Pharmacy	✓	✓	✓	✓	✓	N/A	✓	✓
Lindsay & Gilmour - Selkirk	✓	✓	✓	✓	✓	N/A	✓	✓
Tesco - Galashiels	✓	✓	✓	✓	✓	✓	✓	✓
GLM Romanes - Eyemouth	✓	✓	✓	✓	✓	✓	✓	✓
M Farren - Galashiels	✓	✗	✓	✓	✓	N/A	✓	✓
Lloyds - Peebles	✓	✓	✓	✓	✓	✓	✓	✓
Boots - Melrose	✓	✓	✓	✓	✓	N/A	✓	✓
Boots - Jedburgh	✓	✓	✓	✓	✓	N/A	✓	✓
Lauder Pharmacy	✓	✗	✓	✓	✓	N/A	✓	✓
Jedburgh Pharmacy	✓	✓	✓	✓	✓	N/A	✓	✗
Grays Pharmacy - Chirnside	✓	✓	✓	✓	✓	N/A	✓	✓
Borders Pharmacy – Galashiels	✓	✓	✓	✓	✓	✓	✓	✓
Borders Pharmacy – Hawick	✓	✓	✓	✓	✓	✓	✓	✓

Community Pharmacy Contract

The National Community Pharmacy Contract encompasses four core essential services. These four core services – Minor Ailment Service, Public Health Service, Acute Medication Service and Chronic Medication Service - underpin the contractual arrangements for the provision of pharmaceutical care services which all community pharmacy contractors are required to provide.

Acute Medication Service (AMS)
AMS is the provision of pharmaceutical care by community pharmacists for acute episodes of care. The process begins when a GP prints a prescription for a patient (GP10). The patient then presents this prescription in a community pharmacy or dispensing GP practice of their choice. The map shown in *Figure 14* depicts the co-location between Community pharmacies and the GP Practices.

Figure 14: Community Pharmacy, Hospital & GP Practice Locations.



Chronic Medication Service (CMS)
The Chronic Medication Service (CMS) aims to further develop the contribution of community pharmacists in the management of patients with long-term conditions. CMS supports patients to manage the medications they take for their condition. It is broken down in to three parts:

- ***Reviewing patient's medicines*** – the pharmacist looks at how a patient uses their medicines. They then discuss with the patient any problems they have with their medicines and decide on the need for a care plan. Recent additional elements include support for patients on new medicines and high risk medicines.
- ***CMS Care Plan*** – This plan helps pharmacists give the patient more regular care and advice about their medicines. The care plan is shared with the patient and their GP.
- ***Serial prescriptions*** – A serial prescription is a prescription for a medicine(s) a patient needs to treat a stable long-term condition and lasts for 24 or 48 weeks. The GP issues the prescription and the patient then takes it to the pharmacy where they are registered for CMS. The GP will decide how often the medicines should be dispensed. The GP is informed each time part of a prescription is issued to a patient. At the end of the term the pharmacy will inform the GP and the GP decides whether to re-issue another prescription or arrange a consultation with the patient. Serial prescribing has been rolled out to all practices. Only Kelso Medical Group Practice has declined from making use of serial prescriptions. Ongoing work is in place to ensure CMS is fully supported by pharmacies and GP practices.

Minor Ailment Service (MAS)
Patients who are registered with a Scottish GP and who come under the previous prescription exemption classification (with the exception of people who are resident in a care home, temporary residents) must register with a community pharmacy to receive the service. A pharmacist can provide advice, treatment or a referral to another health care professional according to the patients' needs. Minor ailments can include:

- Acne
- Athlete's foot
- Backache
- Cold sores
- Constipation
- Cough
- Diarrhoea
- Earache
- Eczema and allergies
- Haemorrhoids
- Hay fever
- Headache
- Head lice
- indigestion
- Mouth ulcers
- Nasal congestion
- Pain
- Period pain
- Thrush
- Sore throat
- Threadworms
- Warts and verrucae

The table below shows the figures for MAS in Scottish Borders compared to Scotland for November 2014.

Table 9 - Figures for Minor Ailments Service (November 2015)

Area	Number of Registrations.	Number of Prescriptions Dispensed.	MAS Capitation Payment.	Average MAS Prescription Value
Scottish Borders	19,888	4,293	£28,273	£2.31
Scotland	935,118		£1,264,696	

Source: ISD Scotland.

Although MAS is provided by all community pharmacies the level of engagement can vary across the area. The table below highlights the range of activity for all 29 community pharmacies for November 2015.

Table 10 - Service Activity– November 2015

Number of Patients Registered per Pharmacy	Number of Prescriptions Issued (Nov)	Value of Prescriptions Issued per Pharmacy
1730	345	£713.98
1485	212	£473.19
1420	249	£555.66
1411	333	£850.30
1341	372	£921.91
1135	212	£570.32
1056	213	£354.09
902	255	£637.21
804	200	£421.33
758	127	£322.95
740	124	£288.98
726	127	£269.26
720	199	£432.03
681	176	£369.18
587	59	£113.14
550	154	£385.29
511	186	£502.77
509	114	£245.91
483	99	£207.95
406	161	£295.63
323	137	£379.32
314	60	£157.21
291	31	£60.60
261	28	£83.31
212	39	£76.50
200	28	£105.14
150	37	£88.01
138	9	£18.25
44	7	£9.82

Source: ISD Scotland

Public Health Service (PHS)
The PHS aims to develop the role of community pharmacy contractors and their staff in public health through:

- providing a health promoting environment in their Community Pharmacies
- promoting healthy lifestyles
- offering opportunistic interventions in areas such as alcohol, self care, smoking cessation and sexual health services and emergency hormonal contraception

The Public Health Service comprises the following services:

(a) The provision of advice to patients or members of the public on healthy living options and promotion of self care in circumstances where in the professional opinion of the pharmacist it is appropriate to do so or by request from a patient or member of the public.

(b) Making available for use by patients and members of the public a range of NHS or NHS approved health promotion campaign materials and other health education information and support material.

(c) Participation in health promotion campaigns, each campaign being on display and visible within a pharmacy for a set period, determined nationally by Scottish Ministers following consultation with a body deemed to be representative of community pharmacy contractors. Between these campaigns generic display material will be made available by Scottish Ministers for use by PHS providers if they wish.

(d) Where agreed between a PHS provider and the Health Board, community pharmacies can participate in locally agreed health promotion campaigns in the intervals between the national campaigns referred to above.
Community pharmacies must have a designated Health Promotion Area clearly identified within the pharmacy premises for leaflet display and other promotional materials.

(e) **(i) the provision of a Smoking Cessation Service;**
Community pharmacies provide extended access through the NHS national programme to a smoking cessation support service, including the provision of advice and smoking cessation products.

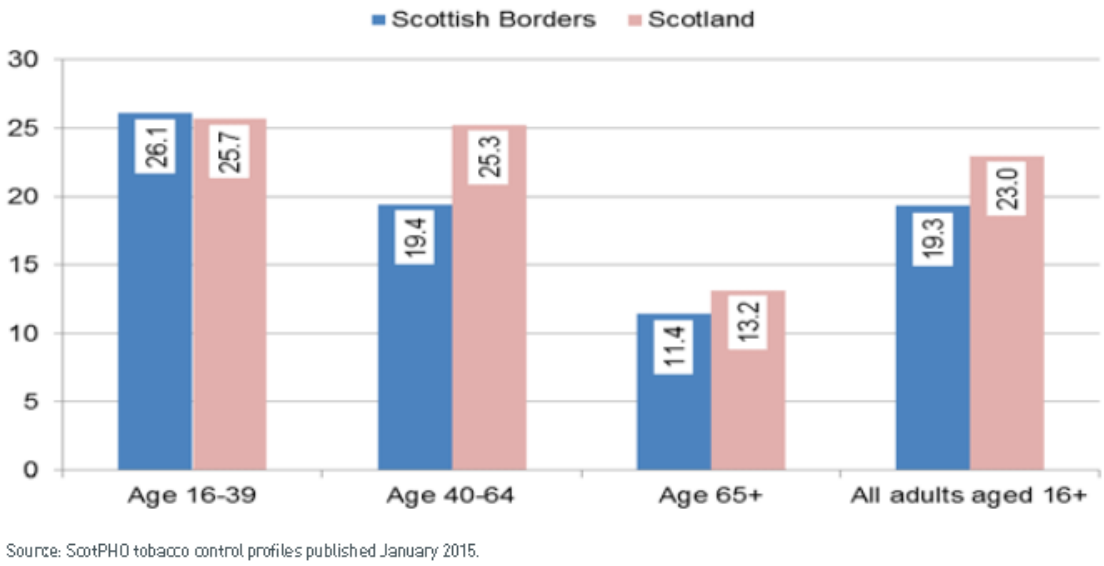
The aim of the service is to contribute to the number of smokers successfully giving up smoking by:

- Providing consistent smoking cessation advice to people considering quitting smoking.
- Providing smoking cessation products and motivational support to people engaged in a quit attempt.
- Referring people presenting who are not eligible for provision of the community pharmacy based service to the NHS Borders ‘Quit 4 Good service.

Community pharmacies also support the NHS Borders local 'Quit 4 Good' smoking cessation programme, by providing Nicotine Replacement Therapy (NRT) products to patients via voucher (prescription) service. Patients in receipt of the vouchers can access any community pharmacy and have their prescription for NRT dispensed.

The following graph outlines the total smoking prevalence in Scotland in tandem with the prevalence of smoking in pregnant women broken down into NHS Board area. It is evident from the data that although the Scottish Borders has an average percentage of smoking population, we do have a higher than average percentage of smoking during pregnancy.

Figure 15: Proportion of Scottish Household Survey Respondents who Smoked, By Age Band, 2012+2013



Source: ScotPHO tobacco control profiles published January 2015.

The following table outlines the Top 10 geographic areas of smoking prevalence in the Scottish Borders. These tie in with the previously identified areas of deprivation.

Table 11 - Smoking Prevalence Top 10 Localities (2003/04).

	Males (16+)		Females (16+)		Persons (16+)	
Intermediate Zone Name	Smokers	as % of male population	Smokers	as % of female population	Smokers	as % of population
SCOTLAND	542684	28.1	570313	26.5	1112997	27.2
Burnfoot and area	421	30.6	483	31.2	904	30.9
Langlee	303	30.8	321	29.4	624	30.1
Hawick North	421	30.4	461	28.6	882	29.5
Galashiels North	406	30.6	408	28.2	813	29.4
Newcastleton and Teviot area	422	28.9	422	27.3	844	28.1
Hawick West End	380	29.3	387	26.3	767	27.7
Galashiels West	343	28.9	369	25.9	713	27.3
Hawick Central	453	27.9	414	23.7	867	25.7
Eyemouth	339	26.4	356	24.8	695	25.6
Innerleithen and Walkerburn area	411	25.8	426	24.3	837	25.0

Source: Scot PHO 'An Atlas of Tobacco Smoking Scotland'

Table 12 Outlines the success ratio of smoking quits by Board area from 1st April 2014 to 31st March 2015.

Table 12 - Total number of quit attempts made and quit attempts made in the most deprived areas, by NHS Board; 2014/15

NHS Board of treatment	Total quit attempts	Quit attempts made in the most deprived areas	
		Number	Percentage
Ayrshire & Arran	4,524	2,592	57%
Borders	1,099	643	59%
Dumfries & Galloway	1,742	938	54%
Fife	3,763	2,232	59%
Forth Valley	2,536	1,449	57%
Grampian	6,252	3,790	61%
Greater Glasgow & Clyde	18,183	11,257	62%
Highland	3,204	1,681	52%
Lanarkshire	10,601	5,910	56%
Lothian	9,450	6,013	64%
Orkney	143	87	61%
Shetland	197	137	70%
Tayside	4,897	2,928	60%
Western Isles	165	89	54%
SCOTLAND	**66,756**	**39,746**	**60%**

Source: NHS Smoking Cessation Service Statistics (Scotland) 1st April 2014 to 31st March 2015 (ISD Scotland)

(ii) The provision of a sexual health service; emergency hormonal contraception;

Pharmacists supply Levonorgestrel or Ulipristal Emergency Hormonal Contraception (EHC) where appropriate to clients in line with the requirements of the NHS Borders Patient Group Direction (PGD). The PGD specifies that supplies should be made to clients over the age of 13.

Pharmacies offer a user-friendly, non-judgemental, client-centred and confidential service. This service is delivered in a consultation room to ensure client confidentiality.

Pharmacists are expected to link into existing networks for community services so that women who need to see either Family Planning or GP can be referred rapidly. Clients whom fail to meet the criteria laid out in the PGD are referred to another local service such as Family Planning, OOH or GP as soon as possible to ensure contraceptive needs are met.

Aims, Objectives and Service Outcomes:

- To increase the knowledge, especially among young people of the availability of emergency contraception and contraception from pharmacies.
- To improve access to emergency contraception and sexual health advice.
- To increase the use of EHC by women who have had unprotected sex and help contribute to a reduction in the number of unplanned pregnancies in the population.
- To refer clients especially those in the hard to reach groups into mainstream contraceptive services.
- To increase knowledge and awareness of the risks of Sexually Transmitted Infections (STIs).
- To refer clients who may have been at the risk of STIs to the Sexual Health Service.
- To strengthen the local network of contraceptive and sexual health services to help ensure easy and swift access to advice.

From October, pharmacists were able to supply ulipristal as well as levonorgestrel. The following table highlights the EHC supply via direct access of the service during 2015.

Table 13 - EHC Supply Statistics By Month, NHS Borders 2015

NHS Borders 2015			
Month	**Monthly Dispensing**	**Month**	**Monthly Dispensing**
JANUARY	67	**JULY**	53
FEBRUARY	57	**AUGUST**	87
MARCH	58	**SEPTEMBER**	71
APRIL	68	**OCTOBER**	50
MAY	83	**NOVEMBER**	70
JUNE	60	**DECEMBER**	no data

Source ISD Scotland 2015

It is worth noting that the areas with the highest rates of EHC supply are also the areas identified as containing the lowest SIMD scoring and identified as areas of deprivation. A new sexual health service has been established in Boots, Galashiels run by a pharmacist independent prescriber. The uptake has been slow initially and the pharmacist is reviewing consultation times to increase service availability.

Unscheduled Care Supply (CPUS)
Unscheduled care can be described as:
"*NHS care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional, or is care which, unavoidably, is out with the core working period of NHS Scotland. It follows that such demand can occur at any time and that services to meet this demand must be available 24 hours a day."*

Community pharmacists have several options to ensure continuity of treatment when patients run out of their repeat medication and to arrange medical care if required in the 'out of hours' period'. Options include:

- A National PGD for urgent provision when the prescriber is unavailable for patients registered with a Scottish GP who receives medication on a repeat prescription.
- Emergency supply – Available to all patients across the EU and Switzerland to receive medication for a treatment period of up to 30 days.
- Direct Referral to out of hours GP at local Borders Emergency Care Service – when medical care is required in the out of hours period or pharmacist is unable to use the national PGD or provide an emergency supply of medication.

Additional National Services

Gluten Free Food (GFF)
The GFF service enables community pharmacy contractors to dispense items for individual patients registered for the service from a published local formulary determined by the NHS Board on whose Pharmaceutical List they are. Each local formulary will reflect existing good clinical practice and embrace only certain 'generic' staple GFF items. Each Board will be responsible for maintenance of its own formulary. The scope of products and conditions are covered within existing ACBS advice.

Stoma Service
Registered Community pharmacies provide a stoma appliance service to anyone who requires access to the service. This service has Government guidance on what patients can expect by way of service. This includes timely orders, delivered if needed (within 48hours) with sufficient disposal bags and a cutting service if required by the patient. Pharmacies offer a discreet and supportive service to patients, they offer advice on a range of issues that aim to improve the patient's quality of life, and help them to get back to living as normally as possible.

Additional Locally Agreed Services

Additional Pharmaceutical Services are available in NHS Borders based on the local need for each specific service. All community pharmacy contractors who are named on the Pharmaceutical Services list of NHS Borders are eligible to apply to participate in the provision of additional services under the National Health Services (Pharmaceutical Services) (Scotland) Regulations 1995, as amended.

NHS Boards negotiate payment and delivery of these services with Local Pharmacy Contractors Committees. Each service has a 'Service Specification' that defines the service that is to be provided to the patient.

NHS Borders pharmacy contractors currently provide additional services from the following list:

Advice to Care Homes
Pharmacy contractors provide advice and support to the residents and staff within care homes, over and above the normal dispensing service. This is to ensure the proper and effective ordering of drugs and appliances, their clinical and cost effective use, their safe storage, supply and administration and proper record keeping. The aim is to improve patient safety within the care home with a particular focus on the ordering, storage, administration and disposal of medicines and appliances and use of residents' own medicines (prescribed and purchased).

Carers Medicine Administration Records
To help tackle the problems of non-compliance and non-adherence with prescribed medication community pharmacies provide qualifying patients with a monitored dosage system (compliance aid). Certain vulnerable patients in the community benefit from having their medication dispensed into compliance aids to assist them in identifying when and how many drugs they are taking as part of the national contract. Where a device is not necessary the pharmacist may offer alternative advice as to how the patient's compliance may be addressed.

If patients are unable to manage their medicines themselves a carer may be required to support administration. Under this service, community pharmacists assess the needs of patients and consider whether dispensing their medication with an appropriate supporting device is necessary.

If a carer is required they will be issued with a Medicines Administration Record (MAR) produced by the pharmacy.

Table 14 - Medical Compliance Aid Audit (September 2014)

Contractor Code	Pharmacy	Town	Number of MCA's 2014
8005	Eildon Pharmacy	Newton St Boswells	61
8006	Boots UK	Galashiels	60
8007	Boots UK	Hawick	65
8008	Boots UK	Peebles	84
8009	Boots UK	Kelso	76

8013	T N Crosby	Hawick	54
8019	Lloyds Pharmacy	Kelso	160
8020	Lloyds Pharmacy	Galashiels	99
8032	M Farren Ltd	Innerleithen	52
8034	G L M Romanes	Duns	100
8035	G L M Romanes	Greenlaw	29
8038	M Farren Ltd	Earlston	22
8039	H H C C (Pharmacy)	Hawick	35
8059	West Linton Pharmacy	West Linton	45
8044	A A Weir	Selkirk	74
8045	Lindsay & Gilmour	Hawick	71
8047	G L M Romanes	Coldstream	96
8048	Lindsay & Gilmour	Selkirk	90
8050	Tesco Stores Ltd	Galashiels	No data provided
8051	G L M Romanes	Eyemouth	96
8052	M Farren Ltd	Galashiels	80
8053	Lloyds Pharmacy Limited	Peebles	105
8054	Boots UK	Melrose	83
8055	Boots UK	Jedburgh	38
8056	Lauder Pharmacy	Lauder	33
8057	Jedburgh Pharmacy	Jedburgh	75
8058	Grays Pharmacy	Chirnside	27
8060	Borders Pharmacy	Langlee, Galashiels	Opened Oct 2014
8061	Borders Pharmacy	Burnfoot, Hawick	Opened July 2015

Substance Misuse Services:

(i) Buprenorphine and Suboxone Dispensing/Supervision

Pharmacy contractors dispense and supervise the self-administration of buprenorphine in a community pharmacy setting for the management of opioid dependence. The service is available where capacity allows, to any individual who presents a valid prescription for buprenorphine that specifies supervised administration.

A user-friendly, non-judgemental, client-centred and confidential service is provided by the pharmacist or a suitably trained member of staff to supervise the consumption of the prescribed dose.

(ii) Methadone Dispensing/Supervision

Pharmacy contractors dispense and supervise the self-administration of methadone in a community pharmacy setting for the management of opioid dependence. The service is available, where capacity allows, to any individual who presents a valid prescription for methadone that specifies supervised consumption and/or dispensing.

Community pharmacy contractors are requested to hold adequate stocks of methadone and will dispense and supervise the self-administration of

methadone in accordance with the directions on the prescription requested by the prescriber.

A user-friendly, non-judgemental, client-centred and confidential service is provided by the pharmacist or a suitably trained member of staff to supervise the consumption of the prescribed dose.

(iii) Needle Exchange

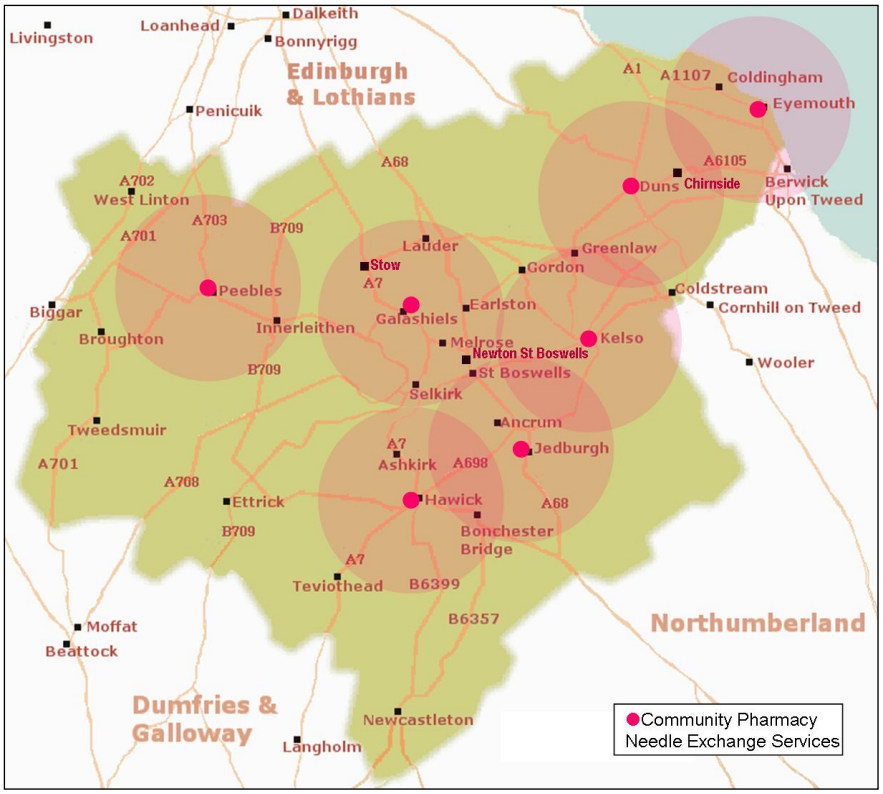
The aim of the service is to protect both individual and public health by reducing the incidence of blood-borne infection and drug-related deaths amongst service users by:

- Providing sterile injecting equipment and related paraphernalia as agreed locally.
- Reducing the rate of sharing and other high-risk injecting behaviours.
- Promoting safer injecting practices.
- Providing and reinforcing harm reduction messages including safe sex advice and advice on overdose prevention.

In addition to the provision of injecting equipment the community pharmacy contractor is responsible for offering a user-friendly, non-judgemental, client-centred, confidential service, providing information in a variety of formats on blood-borne viruses, safer injecting techniques, wound management and overdose prevention.

They also provide information on local treatment and care services, including referral routes for blood-borne virus testing. *Figure 16* shows the current Needle Exchange provision (January 2011).

Figure 16: Needle Exchange provision including 20minute isochrones.



(iv) Naloxone Take Home Supply.

The Minister for Community Safety wrote out to Alcohol & Drug Partnership Chairs and Co-ordinators, along with NHS Chief Executives, Local Authority Chief Executives and Police Chief Constables, on 2 November 2010 highlighting the priority the Scottish Government is placing on the roll out of the National Naloxone Programme.

The aim of this national programme is to increase the availability of naloxone and to improve the chance of it being available for use during an opiate overdose situation. The intention is that those deemed to be at risk of opiate overdose will be provided with a take home naloxone supply once they have received training in recognising the signs of overdose, safe administration of naloxone, basic first aid skills, and the importance of calling an ambulance.

It is hoped that, over time, this programme will have an impact on the number of fatal opiate overdoses in Scotland, enabling more people to move towards recovery.

Supplementary and Independent Prescribing

Health and Social Care Act 2001 allowed for the introduction of independent and supplementary prescribing status for non medical healthcare professionals. Supplementary and independent prescribing enables pharmacists working in community pharmacy to prescribe medicines for patients either to enable improved management and support for long term conditions or to make dosage adjustments on repeat prescriptions as a result of, for example, therapeutic drug monitoring. This is convenient for patients and eases the workload of their GP colleagues and makes use of the pharmacists' expertise in medicines.

Pharmacist independent prescribers currently provide substance misuse, respiratory and hypertension clinics as well as supporting stoma services. A review of the prescribing done by pharmacist prescribers is currently underway. This will inform how resources are directed in future. It is likely that the additional funding provided by Scottish Government will stop at the end of March and Boards will need to use the funding allocated to Prescription for Excellence instead.

During 2015, the Scottish Government announced funding for primary care pharmacists to provide patient focussed pharmaceutical care in general practices. These pharmacists will be trained as independent prescribers. Recruitment is currently underway in Borders.

Treatment of Uncomplicated Urinary Tract Infections in Women Aged 16-64
In December 2015 a service was set up to enable community pharmacists to assess and treat women aged 16-64 with uncomplicated lower urinary tract infections with Trimethoprim. The service was set up in 15 pharmacies and will be extended to other pharmacies once they have successfully completed the NES training pack. Little data is available on uptake so far.

Medicine Review Service
Prescription for Excellence (PfE) sets out a vision for the delivery of pharmaceutical care. A key part of the action plan is that people accessing pharmacy services should expect regular reviews of their medicines, which can be achieved through the new medicines review service started in January. The aim is to provide a pharmaceutical service to undertake a Medicines Review for patients within priority groups. The first group to be identified is those receiving 4 or more dispensed medicines where at least one is listed on the NHS Scotland 'Sick Day Rules' cards. The service will be reviewed after 9 months with a view to extending it to another clinical area.

Table15 – Breakdown of Additional Service Provision (January 2016)

Contractor	Advice to Care Homes	Diabetic Screening Service	Blood Pressure Testing	Consulting/Quiet Area	Prescription Collection	Prescription Delivery	Private Flu Jab	Compliance Support	Emergency Contraception	Gluten Free	Healthy Start Vitamins	Smoking Cessation	Stoma	Urinary Tract Infection	Medicines Review	Substance Misuse Services: Supervised Consumption	Substance Misuse Services: Needle Exchange	Substance Misuse Services: Oral Fluid Testing	Substance Misuse Services: Naltrexone/Disulfiram	Supplementary Prescribing
Grays Pharmacy - Chirnside				✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓			✓	✓
G L M Romanes Ltd -Coldstream	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
GLM Romanes – Duns	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M Farren – Earlston				✓	✓			✓	✓	✓	✓	✓	✓		✓	✓			✓	
GLM Romanes – Eyemouth	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Boots the Chemist – Galashiels				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
M Farren – Galashiels	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓			✓		✓	✓	
Lloyds Pharmacy – Galashiels	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Tesco Pharmacy – Galashiels	✓			✓	✓		✓	✓	✓	✓	✓	✓	✓			✓			✓	

Borders Pharmacy - Galashiels	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	
GLM Romanes – Greenlaw					✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Borders Pharmacy – Hawick	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	
T N Crosby – Hawick			✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	
Boots the Chemist – Hawick	✓				✓			✓	✓	✓	✓	✓	✓			✓			✓	
Lindsay & Gilmour – Hawick				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
HHCC Pharmacy – Hawick				✓	✓			✓	✓	✓	✓	✓	✓	✓		✓			✓	
M Farren – Innerleithen				✓	✓			✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	
Jedburgh Pharmacy			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Boots the Chemist – Jedburgh						✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Lloyds Pharmacy –Kelso	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Boots the Chemist – Kelso					✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Boots the Chemist – Melrose	✓				✓			✓	✓	✓	✓	✓	✓		✓	✓			✓	
Lauder Pharmacy		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Eildon Pharmacy – Newton St. Boswells				✓	✓			✓	✓	✓	✓	✓	✓			✓			✓	
Lloyds Pharmacy – Peebles	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	
Boots the Chemist – Peebles					✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Lindsay & Gilmour - Selkirk	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓			✓	
A A Weir – Selkirk								✓	✓	✓	✓	✓	✓	✓		✓			✓	
West Linton Pharmacy	✓			✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	

Non Commissioned Services

Non-commissioned pharmaceutical services are services provided by community pharmacies that are neither part of the core pharmacy contract with the NHS, nor are part of the additional services agreement. These services are often very valuable for special patient groups e.g. patients who are housebound.

The decision to provide these services lies directly with the community pharmacies as they are not funded by the NHS. The decision to provide these services is often a commercial decision, especially when the service increases the pharmacies overhead costs. Some of the services may incur a charge which the patient has to pay for the service.

NHS Borders pharmacy contractors currently provide non-commissioned services from the following list:

Blood Cholesterol Checks
Some pharmacies offer this service on a payment basis. The aim is to offer both screening for concerned individuals or to offer monitoring as part of supporting patients with related long term conditions.

Blood Glucose Checks
Some pharmacies offer this service on a payment basis. The aim is to offer both screening for concerned individuals or to offer monitoring as part of supporting patients with related long term conditions.

Blood Pressure Checks
Some pharmacies offer this service as part of a monitoring program aimed at supporting patients with a related long term condition.

Palliative Care Medication provision
Some pharmacies in partnership with their local GP practice currently provide a stock and checking service for a palliative care box within a medical practice. This is currently done on an ad-hoc basis and although the list of drugs available is fairly consistent the service in not managed or controlled by the Board. The aim is to allow access to palliative care drugs 24 hours a day 7 days a week for patients being cared for at home.

Pharmaceutical Waste
Community pharmacy contractors providing this service act as a drop-off point for medicines waste for the general public. Patients may return any unused or un-required medicines to a pharmacy for destruction. Pharmacies store this waste in dedicated containers provided by NHS Borders. This waste is then collected on a three monthly basis by the NHS Borders courier service, replacement containers issued and the medicines destroyed according to national guidelines.

Prescription Collection & Delivery
Most community pharmacy contractors provide this service on an ad-hoc and unpaid basis. It is considered to be a part of good customer service and support and is especially valuable to those patient groups who are housebound or have

difficulty in accessing the pharmacy. Access to pharmaceutical care is not available from this service as delivery is generally by a driver who has no or limited knowledge of pharmacy.

Travel Clinic
Some pharmacies offer a travel clinic to patients who are preparing to travel abroad and are looking for advice on any vaccinations they may require prior to their trip. They can also offer advice and supply of travel related health products.

Weight Management Service
Several pharmacies offer their own individualised weight management support service. The aim is to offer a tailored advice and support program to help patients reach their weight low goal. These services usually involve a free initial consultation followed by ongoing support and some offer discounts on selected weight management products.

Vaccination Service
Some pharmacies offer this service on a payment basis. The aim is to offer patients who may not qualify or be in the national targeted at risk groups the opportunity to receive a flu vaccination. Vaccination may include:

- Influenza
- Human Papilloma Virus

Conclusion

From the evidence gathered and outlined within this plan it is apparent that the current service provision is adequate for the populations immediate needs. No major gaps have been identified and the changes to the pharmacy contract and its associated care services has provided the platform for community pharmacy services to develop significantly enabling them to make a fundamental contribution to the health of the population.

The future of community pharmacy services will be shaped by both the projected increase and ageing of the population. This may provide further opportunities for pharmacy services to develop to meet these changing needs. Following the outcome of the consultation on the Control of Entry Arrangements and Dispensing GP Practices additional pharmaceutical care services are now provided alongside dispensing practices. Further work is required to confirm controlled localities in areas served by dispensing practices.

Both NHS Borders and the pharmacy contractors should be mindful of the potential for a reduction in the public services, in particular transport, due to the ongoing financial pressures. Community pharmacies may be directly affected by such reductions in service and will need to consider adapting to meet the changing needs of the community. This creates particular problems at weekends.

In addition to the future opportunities for community pharmacy growth the evidence also highlights some potential risks and challenges in the short to medium term. These challenges need to be addressed as part of ongoing service development, with the focus on equal opportunities and meeting the changing needs of the population. The following sections highlight these areas and suggest both some recommendations and opportunities that may be considered as part of the continuous improvement and development programme.

Recommendations

Service Provision:
The current distribution of general pharmaceutical care provision is deemed to be adequate for the immediate needs of the population. There are however several areas where access to service could be revisited in future. These are:

- **Saturday coverage** - relating to pharmacies that do not currently provide a full day Saturday service in an area with only one pharmacy.
- **Saturday coverage** – relating to two pharmacies that do not provide any service on a Saturday
- **Sunday coverage** – three pharmacies provide a service on a Sunday. Most patients can access a service within an hour's drive. Should a need be demonstrated or local unscheduled care arrangements change the Sunday coverage could be reviewed.
- **Dispensing Practices**. – A review of the current service provision to dispensing practices is required.
- **Identified Neighbourhoods** – It should be noted that if the predicted growth and ageing of the population become a reality there may be future opportunities for pharmaceutical care services.

When considering new pharmacy contract applications it will be necessary to take into account the pharmaceutical care services to be provided by the applicant and their plans to provide holistic patient-centred care. Pharmacists should demonstrate how they will undertake an enhanced role in preventing ill-health, co-production and minimise health inequalities. By 2023 all pharmacists providing NHS pharmaceutical care will be NHS accredited clinical pharmacist independent prescribers.

Contingency/Business Continuity Planning:
It is recommended that following on from work done prior to the H1N1 flu pandemic and in response to the lessons learned during the severe weather encountered in 2010, all community pharmacies develop and test contingency/business continuity plans. The plans should highlight and address the potential consequences of both internal and external threats to service continuity and to identify means of protecting the core functions of the Service. Any pharmacy wishing to be included in the Boards pharmaceutical list should have a contingency plan in place as a matter of good practice.

Governance Arrangements in Pharmacies
It is recognised that both the quality and range of services being provided vary between pharmacies and it should be the aim of NHS Borders to develop governance arrangements that will ensure that a patient can expect the same high standard of service in all the pharmacies regardless of location.

Opportunities

Medicine Compliance Aids/Initiatives
It is acknowledged as a risk to ongoing service provision that the current level of medicine compliance aids being issued by community pharmacies may soon become unmanageable. It is recommended that alternative compliance initiatives are investigated as a measure to reduce the impact from the anticipated rising age of the population before it puts further pressure on an already stressed service.

Areas of consideration could include:

- Medicines Administration Charts (MAR) - A service for home carer administration of medicines.
- Review and standardisation of the current process of 'making up' and supplying patients with compliance aids, by sharing good practice.
- Improved joint working within the multi-disciplinary team to ensure only those who need to be are issued with a medicine compliance aid and those who are capable are offered other alternatives to support them to continue to be independent.

Clinical Medication Reviews in Care Homes
The currently some pharmacies provide an advisory service to care homes. There is a need to review this in line with recommendations made by Pharmaceutical Care to Patients in Care Homes (PCCH) National Short Life Working Group and from the Polypharmacy Guidelines.

Discharge Support
Following ongoing work within secondary care it has been identified that there can be risks in the continuity of patient care during the discharge process, when a patient moves from a hospital environment back into the community. A newly appointed discharge technician funded through PfE will work with community pharmacy to support more integrated approach to the discharge process.

Carers Support
It has been highlighted that carers can be 'left out of the loop' or not fully involved in a patient's health care, especially when they are discharged from hospital back into the community. An Integrated Care Fund bid could be used to develop links and ensure that community pharmacy works with carers to develop clear communication pathways, particularly during the discharge process.

Support for Cost Effective Prescribing Initiatives and Waste Reduction
It is suggested that the Board/Community Pharmacy consider joint cost effective prescribing initiatives, similar to those already developed within primary care. The aim would be to ensure the medicines budget is maximised and that everyone plays a part in both improving efficiency in the system and maximising the service to patients. This is particularly important given the expected increase in elderly population and long term conditions.

Formulary Support
The Borders Joint Formulary (BJF) is an evidence-based formulary based on local expert opinion and practice in NHS Borders, and encompasses prescribing in both

primary and secondary care. In conjunction with cost effective prescribing initiatives community pharmacy has a key role to play in the adherence with the Borders Joint Formulary.

Oral Contraception/PIL Follow-Up Service
A new sexual health service has been set up in Boots, Galashiels. Depending on the uptake of this service there may be potential to hold clinics in other pharmacies.

Supply of Specialist Treatments (e.g. HIV, Rheumatology & oral chemotherapy)
Pharmacists are uniquely positioned to provide expert medication advice and education, thus creating a specialised role within the health care team providing both end-of-life and long term condition care, dedicated to rational medication use.

Consideration should be given to the development of a service which is focused around detecting and resolving drug-related problems, advising providers on appropriate medication use, medication reconciliation, creating medication guidelines and providing both patient and carer education. An example of this was the service to support Hepatitis C treatments and this model could be extended to cover other complex medicines.

Palliative Care Support
Some pharmacies in partnership with their local GP practice currently provide a stock and checking service for a palliative care box within a medical practice. This is currently done on an ad-hoc basis and although the list of drugs available is fairly consistent the service in not managed or controlled by the Board.

It is recommended that this service is formalised and developed to cover the entire region. The emphasis should be on providing access to palliative care drugs 24 hours a day 7 days a week for patients being cared for at home and to provide information regarding palliative care drugs to patients, carers and other health care professionals.

Telehealth
NHS Borders is working with NHS24 as part of a pilot for prescription for excellence looking at opportunities for pharmacists to support patients through telehealth. It is proposed to trial this with around 5 pharmacists initially.

Out of Hours / Unscheduled Care
Opportunities exist for community pharmacy to support out of hours services, particularly on Saturdays which tend to be a quieter day for pharmacy. This is currently being discussed with Borders Emergency care service (BECS).

Medicine Reviews
This new service will be extended to other clinical conditions, e.g. respiratory and hypertension, as funding allows.

Independent/Supplementary Prescribing
The board should review the opportunities currently provided with the aim of developing this service in response to the changing needs of the population. It is envisaged that a greater percentage of the population will live longer and live with health conditions that need to be managed by pharmaceutical care. This service is considered both convenient for patients and eases the workload of their GP. It also makes use of the pharmacists' expertise in medicines.

Acknowledgements

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The following documents are acknowledged as providing essential information in the completion of this plan:

NHS Borders PCS Plan 2014/15	NHS Borders Pharmacy
Scottish Borders in Figures 2010	Scottish Borders Council
Scottish Borders social Atlas 3rd Edition 2009	Scottish Borders Council
Scottish Borders Strategic Assessment 2014	Scottish Borders Council
Scottish Borders Demographic Fact sheet	General Register Office for Scotland (GRO(S)
Scottish National Statistics	Scottish Government
Pharmacy Data	Information Services Division (ISD Scotland)
An Atlas of Tobacco Smoking Scotland	Scottish Public Health Observatory

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