Scottish Borders Health and Social Care PARTNERSHIP

HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD MONDAY, 15TH AUGUST, 2016

A meeting of the **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** will be held in COMMITTEE ROOM 2, COUNCIL HEADQUARTERS, NEWTOWN ST BOSWELLS on **MONDAY, 15 AUGUST 2016** at **2.00 pm**.

	BUSINESS		
1.	**ANNOUNCEMENTS & APOLOGIES**		
2.	**DECLARATIONS OF INTEREST**		
3.	**MINUTES OF PREVIOUS MEETING** (Pages 1 - 12) Monday 20 June 2016		
4.	**MATTERS ARISING** (Pages 13 - 14) Action Tracker		
5.	**STRATEGIC**		
	5.1 **GP Contract Update and Cluster Approach** General Manager Primary & Community Services	(Pages 15 - 26)	
	5.2 **Integrated Care Fund Update** Interim Chief Financial Officer	(Pages 27 - 52)	
	5.3 **Prescribing Efficiencies** Director of Pharmacy	(Pages 53 - 66)	
	5.4 **Performance Management Framework** Chief Officer	(Pages 67 - 90)	
6.	**GOVERNANCE**		
	6.1 **Health & Social Care Public Governance Arrangements** Chief Officer	(Pages 91 - 98)	
7.	**FINANCE**		
	7.1 **Monitoring of the Health and Social Care Partnership Budget 2016/17**	(Pages 99 - 120)	

	Interim Chief Financial Officer	
8.	**FOR INFORMATION**	
	8.1 **Chief Officer's Report** (Pages 121 - 126) Chief Officer	
	8.2 **Delayed Discharges** (Pages 127 - 142) Chief Officer	
9.	**ANY OTHER BUSINESS**	
	9.1 **Awayday Evaluation 23.05.16** (Pages 143 - 154) Chief Officer	
10.	**DATE AND TIME OF NEXT MEETING** Monday 17 October 2016 at 2.00pm in Committee Room 2, Scottish Borders Council	

Please direct any enquiries to Iris Bishop, NHS Board Secretary
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Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 20 June 2016 at 2.00pm in the Board Room, NHS Borders, Newstead

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
	(v) Cllr J Torrance	(v) Mrs K Hamilton
	Mrs S Manion	Mrs E Rodger
	Mr D Bell	Dr A McVean
	Miss J Miller	Ms L Jackson
	Ms A Trueman	Ms I Clark
In Attendance:	Miss I Bishop	Ms S Campbell
	Mr P McMenamin	Mrs J Stacey
	Mrs J McDiarmid	Mrs K McNicoll
	Dr E Baijal	Mr S Barrie
	Mr P Barr	Mrs A Wilson
	Ms F Doig	Mr C Svensson
	Ms S Donaldson	Ms T Wintrup
	Ms J Robertson	Mr A Pattinson
	Mr D Robertson	Mrs C Gillie

1. Apologies and Announcements

Apologies had been received from Dr Andrew Murray, Mr John McLaren, Mrs Elaine Torrance, Mrs Jane Davidson, Mrs Tracey Logan, Mrs June Smyth and Ms Lynn Gallacher.

The Chair confirmed the meeting was quorate.

The Chair welcomed a range of attendees to the meeting.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

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

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

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Integration Shadow Board held on 18 April 2016 were amended at page 8, line 8 and replace £2,663m with £2.663m and with that amendment the minutes were approved.

4. Matters Arising

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

5. Integrated Care Fund Update

Mr Paul McMenamin gave an overview of the content of the paper. Mr McMenamin highlighted the partnerships integration programme work and the wider financial resources delegated to the partnership. He further highlighted potential areas for investment and disinvestment and advised that the Integrated Care Fund was a transitional resource.

Mrs Susan Manion reported that a review of all existing pieces of work had been undertaken as well as the governance sub structure. She confirmed that the agreed pieces of work that were being taken forward were in line with the Strategic Plan.

Dr Stephen Mather enquired if in the unlikely event that the integrated care fund was not completely spent, if the balance of funds would be carried forward. Mrs Manion confirmed that funding would be rolled over as it was a 3 year fund.

Mr David Davidson noted that on page 1 of the report there was no comment on how much was already spent. He further suggested the 14 projects be listed in priority order of what could be achieved quickly. Mrs Manion advised that all projects had been previously agreed and were mapped against the national outcomes and had their own timescales.

Mr Davidson enquired if all the bus operators were included in the transport hub discussions and what the outcome was. Mrs Manion reported that the subject of transport was being taken forward through the Community Planning Partnership (CPP) and the funding was a contribution made towards that piece of work. The Chair advised that a paper was being submitted to the next CPP meeting on the outcomes and Cllr John Mitchell added that he expected the paper to address issues of subsidy and strategic direction for public transport.

Further discussion focused on: Eildon Community Ward and prevention of admission funding; and the narrative and layout of Appendix 2.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted 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** noted there would 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.

6. Revised Governance Arrangements for Integrated Care Fund

Mr Paul McMenamin gave an overview of the content of the paper, highlighting the input of the Executive Management Team and a number of key high level roles across key stakeholder groups. Mr McMenamin described the flow of business within the revised governance arrangements and clarified that the Health & Social Care Integration Joint Board (IJB) would be asked to ratify proposals.

Mr John Raine welcomed the move towards a simpler form of governance. He also welcomed the inclusion of statements in the report that the IJB was ultimately responsible for the effective use of the Integrated Care Fund (ICF) and also the reference to the role of the IJB being to set the strategic intent of the partnership. He also emphasised that the Board was responsible and accountable for the success or otherwise of the whole enterprise of integration. There were however some contradictions in the report. It stated that the Executive Management Team (EMT) would be responsible for refining and approving proposals and that once approved they could be implemented. However, the report also stated that the Board would be asked to ratify proposals approved by the EMT and might refer proposals back.

Mr Raine stated the definition of `ratify` was to formally approve which could present difficulties if proposals were already being implemented. Board approval of proposals would not delay implementation if work was effectively programmed and also because the Board met frequently.

Mr Raine indicated that the process should be simple and clear with schemes supporting the delivering of the ICF programme going to EMT for endorsement and then on to the Board for final approval with an explanation as to what the schemes were intended to achieve, at what cost, over what timescale and how sustainable they would be. The Board would then ratify or refer back. Worked in this way, the governance would be simple and clear and support the fact that the Board was ultimately accountable.

Mrs Susan Manion advised that the role of the EMT was in terms of delivery. She explained that the EMT was the place where the Chief Executives as decision makers in commissioning services would agree to the delivery of the services requested by the IJB. The IJB on strategic matters was itself advised by the Strategic Planning Group. The role of the Chief Officer was to make the recommendation to the IJB to commission the services. She commented that the advantage in the setting up of the EMT was that it converged into a single group and was easier to then take a collective decision and collective view on the way forward in line with the IJBs requirements.

Ms Jenny Miller enquired if there would be third sector representative on the proposed Service Redesign Steering Group. Mr McMenamin advised that the membership and terms of reference for the working groups would be redefined with the intention that the former membership, form the main membership of the Service Redesign Steering Group plus other stakeholders.

Mr David Davidson suggested the second sentence in paragraph 4.6 was contradictory as per Mr Raine's earlier comments. Mr McMenamin advised that he would be content to remove that sentence from the report as it added little value by way of explanation.

Discussion further focused on: the purpose of the proposed new groups; description of the whole system in terms of the use and totality of resource; streamline process and provide assurance that funds were being spent in appropriate areas; and potential routes for appeal.

Mrs Karen Hamilton questioned whether any proposals not agreed by the EMT would be seen by the IJB. Mrs Jeanette McDiarmid explained that the EMT would provide the IJB with assurance that the recommendations submitted to it met the outcomes in the strategic plan, enabling the IJB with its decision making. She further advised that if the IJB did not approve a recommendation it would be referred back to the EMT.

Towards the end of the discussion Mr Raine said he was happy to support the proposals following the assurances given by the Chair and Mrs McDiarmid that the governance process was intended to run in the way he had earlier outlined.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the revised governance arrangements for the Integration Care Fund subject to the deletion of sentence 2 at paragraph 4.6 on page 4 of the paper.

7. The Localities Framework

Dr Eric Baijal gave an overview of the content of the paper and highlighted several elements including: engagement of local communities, alignment of localities and GP clusters, resourcing, support for GP practices and long term conditions proposals.

Several items were highlighted during discussion including: locality working will only succeed with ongoing necessary resource; locality engagement and partnership groups; in review of existing partnership and engagement forums; flexibility of localities; review of quality controls; expectation that GP cluster arrangements would be known by 30 June; and the use of technology for sharing patient information to ensure the patient remains at the centre of the care package.

Dr Angus McVean commented that the GP community was in a current state of flux in regard to converting to clusters and discussions continued. He suggested there may be a potential outcome of 3 clusters instead of 5. He echoed Dr Stephen Mather's concerns that investment in the community was required to prevent admissions and allow support to be put in place early to support people in their own homes.

Dr McVean suggested GPs were moving away from chronic disease management and investment would be required to enable them to lead the delivery of those types of services if that was the expectation of the IJB.

Mrs Susan Manion commented that the Patient Partnership Forum (PPF) was originally accountable to the Scottish Borders Community Health & Care Partnership that had been concluded. Discussions had been taking place regarding a revision of the PPF to ensure the

governance of patient and public involvement requirements for the IJB were met. She advised a paper on the PPF would be brought to a future meeting.

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

8. Equality Mainstreaming report.

Mrs Susan Manion reported that the Health & Social Care Integration Joint Board was obliged to provide and publish an equality mainstreaming report. The report was submitted to the IJB for comment and agreement and to highlight that both NHS Borders and Scottish Borders Council had already agreed equality outcomes (Appendix 1). She assured the IJB that the equality outcomes matched across to those within the Strategic Plan as well as the local outcomes. She reiterated that paragraph 8.2 within the report would ensure the IBJ met the equalities legislation requirements.

Discussion focused on: paragraph 5.8 should read paragraph 8.2; aspirational changes; how to make practical changes in areas such as discrimination; training; and how will people see change.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the equality outcomes outlined in paragraph 8.2 and Appendix 1 and noted the review by April 2017 to inform the development of the revised outcomes for 2017 onwards.

9. Delayed Discharges

Mrs Susan Manion advised that a formally agreed performance framework for the IJB was still under construction. She was keen to ensure that the future report would including monitoring and actions across all of the health and social care remit. She was further keen to collectively address delayed discharges and ensure duplication was removed. Mrs Manion further reported that the move to the 72hour target would take place on 1 July.

Dr Angus McVean commented that he was keen to see data on readmission rates (especially those presenting 2 or 3 times in quick succession) as potentially those discharged too quickly could be readmitted if their problems had not been resolved. Mrs Evelyn Rodger advised that she was very mindful of the potential issues of discharging patients too early in their care pathway and a focus and attention was being paid to readmission rates to ensure patients were not being disadvantaged.

Mr Alasdair Pattison commented that work was being progressed in identifying the 2% of the population in Borders who were high resource individuals to ensure they were appropriately resourced in the community to prevent admission and readmission.

Cllr John Mitchell enquired where the 2% figure originated. Mr Pattinson advised that it was a percentage taken from national data and he was keen to view the profile for the 2% in Scottish Borders and reasons for admission and readmission.

The Chair suggested that the arbitrary 72hour target wasn't necessarily best for the patient. Mrs Rodger advised that in terms of the target, it was no different to the Accident &

Emergency (A&E) target, in that it was a proxy measure for how the system was behaving. In terms of data intelligence in Scottish Borders, she advised that Scottish Borders had the lowest number of care packages, and the message received from Health Improvement Scotland was that health and social care wasn't functioning as well as it might in Scottish Borders. She advised that currently there were 5-6 patients who could not be moved to where they needed to be for their care needs due to delayed discharges in the system. Mrs Rodger suggested the IJB might want to see the trajectory to get to 72 hours and then a regular update on progress against the target.

Mrs Manion advised that the trajectories for future delays had yet to be confirmed and she suggested identifying what the likely impacts were going to be for the proposals in the action plan.

Dr Stephen Mather commented that there were areas of concern in regard to care home placement and patient choice for care home placement. He suggested a key measure of success for the IJB was to make a difference to delayed discharges and enquired if the ICF could be used to specifically target delayed discharges and improve care at home and choice of care home placement to make a tangible difference to individuals.

Mrs Manion reiterated that the ICF would be funding a range of initiatives which were in the action plan for delayed discharges, such as reablement, access to home care, rapid resource and other initiatives sitting within the context of the ICF.

Cllr Jim Torrance reiterated that it was a whole system approach that was required as historically there had always been an issue with delayed discharges in Scottish Borders, due to a lack of social care availability; lack of residential care nursing home placements; pressure on beds in the Borders General Hospital; and potential readmissions. He reminded the IJB that Waverly House had been purchased for the provision of fast tracking people and that facility had been blocked with long term clients and he emphasised the need to ensure there were appropriate services and equipment available to people to safely return to their own homes.

Mr David Davidson suggested he would be keen to see a detailed list of the obstacles to see what the interconnections were and whether they were assumed to be real or not. He was also keen to know the current status against the 72 hour target.

Mr Pattinson commented that it was a complex arrangement to manage people through the health and social care pathway and that delayed discharges were managed at the margins. Progress had been made in terms of occupied bed days but it was becoming more difficult.

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

10. Draft Corporate Services Support Plan Update

Mrs Susan Manion gave a brief overview of the content of the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and confirmed to proceed with the approach to develop the longer term Corporate Services plan.

11. Clinical & Care Governance Framework

Mrs Karen McNicoll updated the IJB on the work that had been undertaken to ensure the IJB would be provided with assurance on clinical and care governance matters. She suggested the IJB receive a report on clinical and care governance at each meeting moving forward.

Dr Stephen Mather commented that he welcomed the attendance of the Chief Social Work Officer at the NHS Borders Clinical Governance Committee. He also enquired how the information on clinical care in care homes would be brought to the attention of the IJB. Mrs McNicoll advised that information on clinical care in care homes was now being gathered as part of the care standards and would be submitted to Scottish Borders Council. That information would also be drawn together with information from the Clinical Governance Committee into a report for the IJB to ensure the IJB received appropriate information assurance.

Cllr Jim Torrance commented that a survey on pressure sores in hospitals and care homes had been carried out previously and had identified it was a 50/50 split. Mrs Manion reported that she was aware of the data for the acute setting but not for care homes. Mrs Evelyn Rodger advised that Datix was the system used by staff to record pressure ulcers and the district nurses captured that information for the community setting.

Further discussion focused on: streamlining systems and managing information more transparently; removal of duplication; ensuring qualitative information was monitored; information sharing; a clinical and care governance reporting timetable to be established for the IJB in due course: and clarifying high level governance arrangements.

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

12. Appointments to Sub Committees and Groups

The Chair suggested nominees for membership of the 3 groups:-

Audit Committee: Cllr John Mitchell, Cllr Jim Torrance, Mr John Raine, Mr David Davidson. Cllr Frances Renton seconded the nominations.

Strategic Planning Group (Chair): Mrs Pat Alexander. Mr John Raine seconded the nomination.

SB Cares Governance Group: Mrs Karen Hamilton. Cllr Frances Renton seconded the nomination.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and agreed that membership for the Audit Committee be Cllr, John Mitchell, Cllr Jim Torrance, Mr John Raine, Mr David Davidson.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and agreed that the Chair of the Strategic Planning Group be Mrs Pat Alexander.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and agreed that the member for the SB Care Governance Group be Mrs Karen Hamilton.

13. Annual Report

Mrs Susan Manion suggested that in future the Annual Report would include a chart of what had been achieved in line with the outcomes in the Strategic Plan on the performance of the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Health & Social Care Integration Joint Board Annual Report 2015/16.

14. Monitoring of the Joint Integration Budget

Mr Paul McMenamin reported the provisional outturn position to 31 March 2016 as an adverse variance of £932k. He advised that pressures had been experienced during the year and had been met by savings in other related areas of the budget. Overspends at the financial year end would be addressed by the respective partner organisations. He further advised that the majority of savings achieved were non recurring.

Mr David Davidson sought assurance that the vacancy freeze did not impact on delivery. The IJB was assured that essential frontline posts were not subject to the vacancy freeze.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the reported projected provisional outturn position of £923k net adverse variance within the delegated joint budget at 31 March 2016.

15. Delegated Functions

Mr Paul McMenamin introduced the paper and gave an outline of the content. He highlighted the detail on savings and investments in order to provide assurance to the IJB on the sufficiency of resources. He further commented that the 2016/17 financial plan addressed the financial challenges experienced in 2015/16.

Mr John Raine commented on the fact that this report, like the previous financial report and the following financial report, had no apparent sign-off or input from the Director of Finance of the Health Board and asked if there was an explanation for this.

The Chair commented that the report did not require sign off by the Chief Financial Officer for Scottish Borders Council or the Director of Finance for NHS Borders.

Mrs Carol Gillie advised that there had been a number of points of detail and clarity that had not been included in the report and due to the tight timescales involved in signing off the report she was unable to sign it off on that occasion.

Mr David Davidson enquired where the social care funding had been used in relation to the range of items shown in the social care budget table on page 4. Mr McMenamin reminded

the IJB that the social care fund had been allocated to the partnership for the partnership to direct the use of the funding. He advised that Scottish Borders Council had assumed the funding would be utilised for social care to address the pressures they had identified (living wage, gap in home care, demographics) which when added together the assumptions came to slightly more than the social care fund itself. If the costs did not materialise the funding would not be required to the same degree. He suggested the next report on the agenda gave more detail on actual and projected costs and how the IJB may wish to direct the use of the social care fund.

Mr Davidson enquired if the £12k pay uplift in SBC on page 9 was correct. Mr McMenamin clarified that the pay uplift figure was correct as it reflected pay awards and increments only, give that the majority of care staff had transferred to SB Cares.

Mr Raine returned to the earlier issue saying he felt it to be important, for the assurance of the IJB, for there to be an input from the Health Board Director of Finance, particularly in respect of factual matters and bearing in mind the particular report was also about the planned efficiency and savings targets within NHS Borders, and the IJB would have greater confidence knowing there was close co-operation between the finance officers.

Mr McMenamin commented that cooperation from the finance teams within the partner organisations was vital to the success of the partnership and he echoed Mrs Gillie's comments.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted 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** noted the further detail provided on each partner's 2016/17 efficiency/savings programme on which their Financial Plans were based and the full delivery of which was required in order to ensure that the 2016/17 delegated budget was 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.

16. Alcohol & Drugs Partnership Funding 2016/17

Mr Paul McMenamin introduced the report and explained that Fiona Doig coordinated the work of the Alcohol and Drugs Partnership (ADP) who were commissioned by the Scottish Government to deliver treatments, support families, protect the vulnerable and provide preventative medicine. It was noted that there was a proposed reduction in national funding for ADPs for 2016/17.

The Chair enquired who the other partners in the ADP were and it was confirmed they included NHS Borders, Scottish Borders Council, Police Scotland, Third Sector and the Scottish Drugs Forum.

Mrs Evelyn Rodger enquired if there were proposals to make a reduction to allocations to the voluntary sector. Mrs Fiona Doig reported that the ADPs preferred option was not to make any savings, should a 20% saving be implemented across the over all budget then it would impact on all budget streams.

Further discussion focused on: contributions from all partners to the ADP; sustainability of services; potential for non recurrent funding; identified efficiency savings; targeting services to those most in need; quality of the paper presented to the meeting; Chief Executives view and Executive Management Team view.

Cllr J Torrance, Cllr John Mitchell left the meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the direction of £220k of 2016/17 social care funding on a non recurring basis to the Alcohol and Drug Partnership and noted the proposals for reducing spend in 2016/17 by £51k across non supported and treatment areas of budget.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** further requested that the ADP engage with other partners in regard to on-going funding.

17. 2016/17 Financial Plan – Social Care Funding

Mr Paul McMenamin outlined the proposals for the direction of the funding allocated to the partnership in line with social care funding of £2.048m in 2016/17 increased to £2.861m in 2017/18 assuming no other changes and reflecting the full year effect of the living wage.

Discussion highlighted several key issues including: living wage already paid by SB Cares; would SB Cares remain as the provider of last resort?; assurance sought that reablement would be looked at; and consideration of pressures on the acute sector in order to achieve the objectives of the Strategic Plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the direction of £2.048m of 2016/17 social care funding in order to meet the commitments outlined above

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved 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 was made by 1st April 2017.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the full year impact of those commitments from 2017/18 would be £2.861m and that further proposals for directing the remaining uncommitted social care funding would be brought to the Board when developed for consideration and approval.

18. Communications Quarterly Report

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

19. Chief Officer's Report

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

20. Committee Minutes

It was noted that Mrs Elaine Torrance had been appointed as President of Social Work Scotland.

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

21. NHS Pharmaceutical Care Services Plan

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the NHS Borders Pharmaceutical Care Services Plan 2016/17.

22. Any Other Business

22.1 Emergency Department: Mrs Susan Manion distributed the "Welcome to your Emergency Department" leaflet to members for information.

23. 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 15 August 2016 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 4.47pm.

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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 to be included as part of a Commissioning discussion at a future H&SC IJB Development Session.	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 17 October 2016.	A

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 15 August 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

GP CONTRACT UPDATE AND CLUSTER APPROACH

Aim

1.1 This paper aims to provide the Scottish Borders Integrated Joint Board with an update on the Transitional Quality Arrangements (TQA) for the new General Medical Services (GMS) Contract 2016/17 and the progress in relation to the development of local GP cluster arrangements.

1.2 Following receipt of a Scottish Government Circular on 26th February 2016 work is underway locally to support the implementation of its stated recommendations.

1.3 The GP contract arrangements are agreed by the Health Board. This paper is intended to give some background to the Integration Joint Board particularly in relation to the link with the Health & Social Care localities.

Background

2.1 Changes to the way in which general practice contributes to patient outcomes as expressed in the current GMS Contract arrangements are being implemented. At their heart it means moving away from the bureaucratic "top down" approach of the previous Quality Outcomes Framework (QOF) and relying more fully on the professionalism of GPs and maximising the benefits from promoting that professionalism in a structured collaborative context.

2.2 This is to be a "peer-led, values driven" approach.

2.3 Between now and April 2017 the introduction of a comprehensive national approach to GP "cluster working" will take place. Clusters are to be small groups of practices – perhaps up to 6-8 practices – agreeing with relevant local partners a clear set of outcomes and a means to review those outcomes collaboratively; improving outcomes through further cycles with those same outcomes, or moving on to other outcomes across the patient pathway in a repeating pattern. This is to be underpinned by an evidence based approach to improvement, including clear measures of success and promoting a more deeply collaborative way of working with others in the local health and social care system.

2.4 This principle, of practices working more closely together to the benefit of patients, practices and the wider health and social care system, is also reflected in the Localities Guidance issued to support health and social care integration.

2.5 This is not a change that will happen overnight. Iit's a journey not an event. However, by the Scottish Government removing QOF from April 2016 this is felt to be a very positive start.

2.6 By April 2017 the new model of Cluster working is to be be established. Through this transitional year practices need to align themselves into clusters, establish a practice quality lead (PQL) and then in liaison with the Local Medical Committee (LMC), the Integrated Joint Board (IJB) and the NHS Board, are to choose and appoint a Cluster Quality Lead (CQL).

2.7 The role of the Cluster Quality Lead (CQL) has been deliberately left as a "non – prescriptive" role in order to allow local regions to develop a system of engagement which best suits their needs.

2.8 The February circular describes a four stage approach to the implementation of the TQA for 2016/17.

Stage 1 – first quarter of 2016/17 (1.4.16 to 30.6.16)
Practices agree who will fulfil the Practice Quality Lead (PQL) role and that person will work with the local partnership liaison person and LMC representatives to agree the cluster arrangements i.e. which practices are in which cluster.

The practices will also start to consider the issues outlined in Annex A of the circular, with a view to agreeing what actions arising from them, or other agreed cluster alternatives, will be taken forward in stage/quarter 4. These were described as the following:

1. Registers, coding and lifestyle advice
2. Flu immunisations
3. Quality, safety and prescribing
    - Access – review last 2 PAAR reports; the practice must have access to a cluster access report
    - Complex patients and anticipatory care plans – ACP's for those considered to benefit most, review existing ones as appropriate; assessment of quality using a template (latter not yet agreed)
    - Quality prescribing – continue to work with prescribing advisors, support pharmacists etc. to decide appropriate actions for the practice.

Stage 2 – second quarter (1.7.16 to 30.9.16)
PQLs and the partnership/board and LMC, identify, appoint and empower a Cluster Quality Lead and agree the time commitment to which this role will need to be resourced and how it will operate locally. ***The CQL role will be resourced by the partnership/board.***

Stage 3 – third quarter (1.10.16 to 31.12.16)
The PQLs and CQLs begin to build relationships locally via the clusters, between and across practices, primary and secondary care, health and social care and between the public and third/voluntary sectors.

Practices and the local system start to consider the issues arising from the activities outlined in Annex A of the circular, and any the other issues that might be local priorities, and agree by the end of this quarter which to take action on in quarter 4.

Stage 4 – fourth quarter (1.1.17 to 31.3.17)
Practices and the local system take action on the priorities agreed at the end of quarter 3 and agree evaluation/outcome measures that will demonstrate quality improvement.

2.9 Current Position

As required, practices have been identifying their Practice Quality Leads and to date all bar 4 practices have completed this requirement. Early discussions are now taking place to identify the role and remit of the Cluster Quality Leads and to agree how they will integrate in to the wider partnership arrangements.

2.10 With regards to cluster developments and with reference to the agreed locality boundaries in Scottish Borders, the LMC has agreed with practices the creation of 4 GP Clusters. The proposed structure seeks to makes each cluster an appropriate functional size to be able to both effect change and manage themselves cohesively. The detailed workings of this proposal are attached in embedded as an attachment in **appendix 1.**

2.11 The proposed GP clusters for the Borders are:
West Cluster incorporating the following practices: West Linton, Neidpath (Peebles) Tweed (Peebles) and Innerleithen with a population of 17,814.

South Cluster incorporating the following practices: Selkirk, Teviot (Hawick), O'Connell Street (Hawick) and West Linton with a population of 26,568.

Central Cluster incorporating the following practices: Roxburgh Street, Waverley, Glenfield, Ellwyn, Braeside (all Galashiels), Eildon (Melrose / Newtown St Boswells), Earlston and Stow & Lauder with a population of 31,778.

East Cluster incorporates the following practices: Eyemouth, Duns, Merse (Duns), Coldstream, Greenlaw, Kelso and Jedburgh with a population of 38,775.

2.12 The Borders LMC has highlighted a range of concerns and risks, as agreed by the Scottish School of Primary Care, around the Transitional Quality Arrangements and summarised that the principal risks through this process relate to drift due to the loss of the previous QOF arrangements and a subsequent lack of focus on the potential of the clusters. A lack of capacity in primary care to support local developments and to meet all expectations, and as a consequence disengagement by the key stakeholders involved is also a risk.

2.13 A key message for the SSPC was that if the CQL role is not quickly developed, there is a risk of new operating arrangements within health and social care partnerships moving forward without robust GP involvement, negatively impacting on the essential engagement of general practice with the rest of the NHS and Health and Social Care Partnerships.

2.14 Therefore the establishment of CQLs is the critical next step in this process to ensure continued engagement with all appropriate stakeholders

2.15 The Scottish General Practice Committee define this role as: *A GP nominated by the cluster with responsibility and protected time to provide a Continuous Quality Improvement leadership role in the GP cluster. The role will liaise between practices and the NHS Board/Health and Social Care Partnership on quality improvement issues.*

2.16 A challenge for us locally and reflected nationally, is defining this role in a way that ensures optimal recruitment as well as ensuring the appropriate level of resource is available in terms of funding and support to allow them to function effectively.

2.17 In essence, therefore, we now need to focus and agree on three main actions:

1. **Remit of CQLs** - the LMC would offer a view that they are to engage with the GP Cluster on areas of clinical and organisational quality whilst liaising between those practices and the HB / IJB. They will agree outcome measures that will show quality improvement and collate data related to suggested quality areas of focus e.g. complex patients and anticipatory care planning, or quality prescribing.

2. **Capacity of CQLs** – the current allocation of 2 hours a month for the Practice Quality Lead this year may need review. The CQL will need to be able to engage with all practices in their cluster. This will require time for practice to practice liaison and engagement, as well as additional time for meeting with the other cluster leads as well as other key governance structures e.g. GP Sub Committee, LMC, Locality Planning arrangements.

   The LMC therefore are proposing that the CQL role is likely to need **at least 2 sessions a week** for each of the four GP Clusters in the first instance to make the new arrangements viable.

   As discussed at a previous Integrated Joint Board one of the most challenging aspects of this position and development will be being able to find appropriate cover to allow the CQLs to fulfil their function effectively.

3. **Recruitment process for CQLs** - The LMC has articulated a strong view on this matter and feels the individuals selected are required to have a certain stature / gravitas to be able to perform across practice clusters in an effective manner. They are very keen to be actively involved in the appointment process.

Summary

3.1 Good progress has been made locally in response to the Transitional Quality Arrangements for the new General Medical Services (GMS) Contract 2016/17 and we are broadly on track in relation to the 4 stage approach described.

3.2 Further work and support is required to maintain the impetus needed to fully meet the timescales set out in the TQA and specifically, agreement between the LMC and partnership organisational structures with regards to the role of the Cluster Quality Lead, the recruitment process, and any associated resource, requires to be finalised.

3.3 Formal arrangements in support of the delivery of the new contract will be negotiated and agreed by NHS Borders. The links at a locality level between the GP practices and partners through the cluster approach allows the opportunity for real engagement that will facilitate the planning and delivery of outcomes that will be jointly owned. In addition, there is an opportunity to synchronise quality and service improvement through the cluster leads within the context of the Strategic Plan with a collective drive towards the delivery of the national outcomes. The IJB will be updated on progress.

Recommendation

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

Policy/Strategy Implications	Compliance with the new GP contract arrangements for NHS Borders.
Consultation	With the formal and informal GP networks
Risk Assessment	Will be carried out by NHS Borders as the new contractual arrangements are agreed.
Compliance with requirements on Equality and Diversity	Applicable in the context of the IJB equalities compliance in relation to the Strategic Plan.
Resource/Staffing Implications	To be clarified by NHS Borders.

Approved by

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

Author(s)

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Borders LMC

Proposed GP Clusters June 2016

GP CLUSTERS - Borders LMC Overview and Proposals June 2016

Introduction.

There has been much discussion (and confusion) round the formation of **GP clusters groups**, and how they differ from **localities**. The following outlines some of the guidance and debate to date and is intended to inform and guide practices about cluster formation, rather than be definitive or instructive. It may be useful simply to have all the guidance in one place (see appendices), and we do anticipate further national guidance in due course. The rapid changes in legislation round Integrated Joint Boards has not been easy to follow, so there is an element of 'beginner's guide' here too, with apologies to the many of you who are already very familiar with this. A reminder that:

☐ Each IJB receives funding from its Council and the Health Board (and also 'directs' them in return)

☐ Each IJB has one Health and Social Care Partnership, led by its 'Chief Officer'

☐ The Borders Integrated Joint Board (IJB) is has **five localities** (historical geographic area divisions).

LOCALITIES – what they are and what they are not!

- Localities have a defined role in determining service provision – and are to contribute to the IJBs Strategic Commissioning Plans (and conversely, if an IJB's strategic commissioning plan will have a significant impact on service provision, then that IJB should involve and consult with that locality).
- In Borders there are the 5 localities based around the historic geographical splits - Tweeddale, Teviot, Cheviot, Berwickshire and Central
- Localities are very multi-disciplinary and the intention is that there is input from secondary care, SW, housing and so on.
- Membership of the Locality is determined by the IJB s – but in conjunction with the LMC
- ***Previously*** QOF determined that a liaison GP from each practice was to link with HSCP staff (QS001).
- ***Instead, now***, the localities legislation outlines that localities are meant to have practice input – but that can take different formats: representation can be by other practice members, or be from the cluster rather than individual practices (further details, Appendix 1).

CLUSTER Groups – what they are and what they are not!

- Cluster Groups are ***NOT*** IJB or HSCP bodies, but rather GP organisations defined by the Transitional Quality Arrangements (TQA) for our 2016-17 contract.
- Every practice – as a minimum - has to identify a Practice Quality Lead (PQL) who has to spend at least 2 hours per month *in the practice* undertaking quality work. This requires the PQL to review the extracted national data set and any other material agreed locally, and as a minimum should involve (per month) one hour reflection and one hour of discussion and agreement with the practice.
- ***ANY work outwith this needs to be funded*** separately; as does the full Cluster Quality Lead (CQL) post.

- Cluster Group membership and workings have to be established this year, but groups do not necessarily have to meet before April 2017. However, there are many advantages to an earlier start and this is encouraged in the TQA. The Cluster Group timetable (see below) encourages PQLs to liaise early to decide on their CQL.
- Cluster groups are where are new quality activity will take place, including review of national data sets (these have still to be agreed) and local data determined by the groups themselves. It is therefore crucial – *because of this core quality work including mutual examination, feedback and review, which may feel sensitive to some* – that GP clusters feel comfortable and right to practices. Reflecting this, the national guidance is for groupings of 6-8 practices.
- However it is very much up to GPs to choose what they would prefer – many are opting for larger groups than this, and there are advantages to that too, particularly in terms of feeding back about local services. Cluster Groups may wish to involve others - but Dr Alan McDevitt (Chair, Scottish GP Committee and GP negotiating lead) - has made it clear that GPs should retain control of this work: this is *our* forum. There will inevitably be a process of negotiation with existing localities and other local fora, where relationships are already established: we do not want to lose those, where they are embedded and working well.
- Some GPs may want to largely limit their activities to the narrower requirements round quality review (noting that that work requires cycles of quality improvement), not least as GPs and practices are so pushed for time.
- Others may want to also focus on the next level of engagement – contributing to service reform. It is hoped that cluster groups will feed back both to IJBs and the GP Sub-Committee about local services and how deficiencies could be improved. The TQA does make it clear that the Cluster Quality Lead should liaise with, and influence, the wider health and social care partnership setting.
- This will be the foundation of our future work with wider systems: it is in all our interests, from the start, to get Cluster Group working right.

There are 4 stages to cluster development:
Stage 1 – first quarter of 2016/17 (ie to 30 June 2016)
Practices choose their Practice Quality Lead and agree with the locality liaison person and LMC representatives as to which practices are in which cluster. Start considering issues outlined in Annexe A of Richard Foggo's letter:

1. Registers, coding and lifestyle advice
2. Flu immunisations
3. Quality, safety and prescribing
    a. Access – review last 2 PAAR reports; the practice must have access to a cluster access report
    b. Complex patients and anticipatory care plans – ACP's for those considered to benefit most, review existing ones as appropriate; assessment of quality using a template (latter not yet agreed)
    c. Quality prescribing – continue to work with prescribing advisors, support pharmacists etc. to decide appropriate actions for the practice.

Stage 2 – second quarter (to 30.9.16)
PQLs and the partnership/board and LMC, identify, appoint and empower a Cluster Quality lead: that post is funded separately. Continue to consider issues in Annex A (see box above) and agree other cluster alternatives for quality review.

Stage 3 – third quarter (to 31.12.16)
The PQLs and CQLs begin to build relationships locally via clusters, between and across practices, primary and secondary care, health and social care and between the public and third/voluntary sectors. Continue to work on Annex A issues.

Stage 4 – fourth quarter (to 31.3.17)
Practices and the local system take action on the priorities agreed at the end of quarter 3 and agree evaluation/outcome measures that will demonstrate quality improvement.

Borders LMC
There has been some discussion of Cluster Groups at the LMC – where it was felt that there were multiple possible approaches to this, but that the key thing was for GPs to be happy with their group composition. The LMC is very willing to have discussions with practices where this is not the case – but also recognises that for reasons of practicalities, it is likely that accommodation with others will have to be made to some extent.
Dr McDevitt has made it clear that we are not aiming for 'super-practices' as we see in some parts of England, but instead Clusters should support our current partnership models. Dismantling QOF means that we are now professionally responsible for our quality, so we need to demonstrate that we are doing that adequately, if we want to avoid the risk of unnecessarily prescriptive approaches in the future.

Our main areas of discussion have been:
Group size. The TQA document outlines a group of 6-8, and practices may wish to argue for this if they feel that proposed groups are too big. However others will feel that we are now used to sharing data, that larger groups can be more powerful in terms of wider change, but also that each Cluster Group will need a CQL working at least a day a month initially. We are very short of GPs with the time to take on this leadership role: more groups means more GPs involved in this activity, but also less HSCP funding for other work.

Cluster Group Activity. A balance will need to be struck between very essential core business (quality work) and wider reform of services (development work) and each Group will be able to decide its own priorities and approaches. Early word from the Inverclyde Pilot schemes is that involving other professionals was very helpful – allowing new models of care to develop more quickly and appropriately, and that group membership need not be static.

That in the longer term, this represents a key route for change in secondary care and other services too, giving chances for Scottish innovation, with new ways of working including co-operative approaches.

After taking local opinion, asking for feedback and discussing this matter at various meetings we have arrived at a proposal we would like to suggest. We are very aware that this will not "tick every box" for everyone but there needs to be a balance between arranging practices into groups that are practical, workable and literally in the same area. This last point may seem obvious but we need the Borders is a large area and PQL's beed to physically be able to get to the other practices to meet.

The proposal.

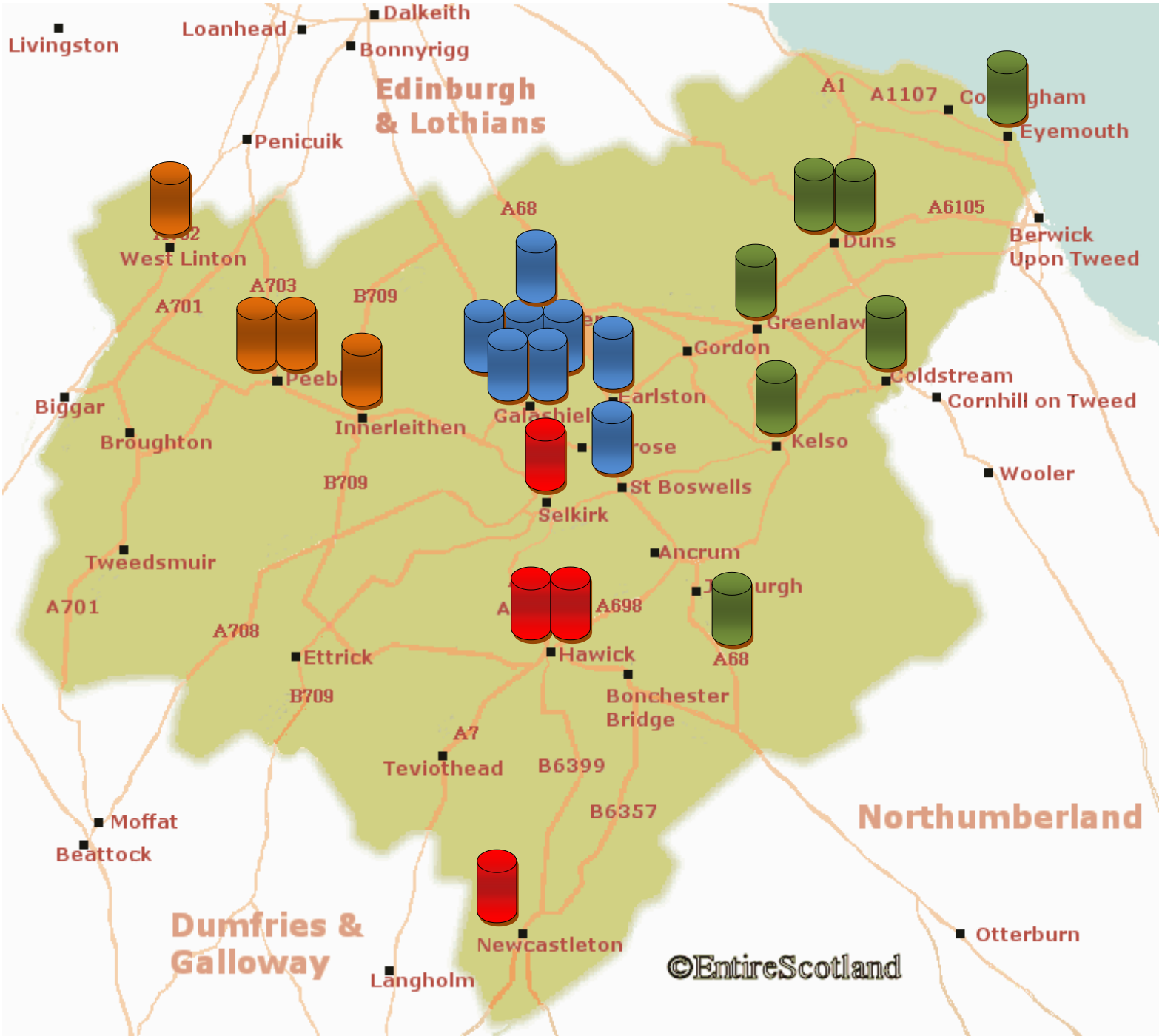
We are suggesting there should be FOUR Borders Gp Clusters, with the following practices aligned to each practice.

- **West Cluster** **Total = 17814**
  - West Linton (Population 2375)
  - Neidpath (5715)
  - Tweed (5348)
  - Innerleithen (4376)

- **South Cluster** **Total = 26568**
  - Selkirk (7443)
  - Teviot (10973)
  - O'Connell St (6609)
  - Newcastleton (1543)

- **Central Cluster** **Total = 31778**
  - Roxburgh St (3247)
  - Waverley (4956)
  - Glenfield (2039)
  - Ellwyn (3109)
  - Braeside (4619)
  - Eildon (6555)
  - Earlston (3009)
  - Stow/Lauder (4244)

- **Eastern Cluster** **Total = 38775**
  - Eyemouth (6227)
  - Duns (2921)
  - Merse (6387)
  - Coldstream (3707)
  - Greenlaw (1294)
  - Kelso (11744)
  - Jedburgh (6495)



Proposed Clusters

East

(pop 38775)

Central

(pop 31778)

West

(pop 17814)

South

(pop 26568)

INTEGRATED CARE FUND UPDATE

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 **£132k** to date in 2016/17, a combined total of **£356k** over the life of the programme to date. Analysis of the spend to date on those projects approved by the IJB is detailed in **Appendix 1**. Each project has also been classified as a partnership priority, non-priority or enabler, based on they degree that they are deemed to support the delivery of new, improved pathways of care or the implementation of a locality model for health and social care services.

Current Position

3.1 Overall, 19 projects, projected to cost **£2.401m** 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 by Steering Group to date

1	Programme delivery	£	219,563
2	Community Capacity Building	£	400,000
3	Independent Sector representation	£	93,960
4	Transport Hub	£	139,000
5	Mental Health Integration	£	38,000
6	My Home Life	£	71,340
7	Community Ward delivery(18mth pm, pso)	£	53,655
8	Health Care & Co-ordination (18mth pm, pso	£	53,655
9	Delivery of the Autism Strategy	£	99,386
10	BAES Relocation	£	241,000
11	Delivery of the ARBD pathway	£	102,052
12	Health Improvement (phase 1) and extension	£	38,000
13	Stress & Distress Training	£	166,000
14	Transitions	£	65,200
15	Delivery of the Localities Plan 18 mths)	£	300,000
16	Locality Managers x 1 locality for 1 year	£	65,818
17	H&SC Coordination x 1 locality for one year	£	49,238

18	Community Led Support	£	90,000
19	The Matching Unit	£	115,000
		£	**2,400,867**

3.2 This represents further Steering Group-approved spend of **£620k** since the last report to the IJB in June and the board is now asked to ratify the five further projects to which this further direction of funding relates and an increase in the allocation to two of the existing projects based on the ICF Steering Group / EMT review of updated briefs.

Update

3.3 Five projects have been approved by the ICF Steering group since the last IJB report. These are:

1 - The Development of Localities Plans

The redesign of services to meet needs within each locality (£300k).

Scottish Borders Council and NHS Borders have committed to developing an infrastructure to support planning and delivery at a locality level, as outlined in Scottish Government legislation.

Building on the existing work by SBC to devolve services to localities supported by a Locality Planning Group, it has been recognised that by using the opportunities afforded by the health and social care strategic plan and the potential for joining up delivery arrangements locally, a truly integrated locality approach can be taken forward. The intent is to translate the national health and wellbeing outcomes into local targets based on need.

So far in Borders we have:-

- Established a localities planning group to be a focus for change linking the existing initiatives, the integrated care funded projects e.g. health and care coordination and the virtual ward and the emerging strategic plan priorities.
- Collated and mapped information on a locality basis relating to local demographics and needs.
- Reviewed previous locality management initiatives to build on what works.
- Set up local working groups responsible for the development of locality plans.
- Developed proposals for the implementation of co-located, locality based multidisciplinary teams.
- Given a focus to localities in the strategic planning consultation, seeking views from GPs, the third sector, the independent sector and local communities, helping us shape future arrangements.

Through Locality Co-ordinators leading the development and delivery of locality plans this project will bring about the redesign of services in each locality to meet the needs of the local population and local communities. This will result in better integration, communication and coordination of services and easier access to local services for service users, their families and GP's. This will also make recommendations to the Localities Group on future planning arrangements.

This project has a high impact across all of the Local Strategic Objectives and all of the National Health and Wellbeing Outcomes. The key outcome being outcome 4 “Health and social care services are centred on helping to maintain or improve the quality of life for the people that use those services” by providing the relevant services within the individuals locality. The key local strategic objective for this project is objective 5 “Deliver services with an integrated care model”. This will be achieved by the creation of integrated teams within each locality.

This project has requested £300k over 18 months.

2 - Locality Management

Pilot Scheme: Overall management and strategic development of Adult Health and Social Care services within one locality for one year (£66k).

Scottish Borders Council and NHS Borders have committed to developing an infrastructure to support planning and delivery at a locality level, as outlined in Scottish Government legislation.

The Locality Manager will be responsible for the overall management and strategic development of Adult Health and Social Care services within each locality. They will direct, lead and be accountable for the effective management and delivery of high quality, cost effective clinical and non-clinical services within the Locality. They will manage multi-disciplinary staff from health and social care including Community Hospitals, community nursing, a range of adult social work services, care staff, local commissioners, health centres and a range of other professional disciplines and services.

They will establish effective partnership working across all agencies within the Locality (including the Third and Independent sector), facilitate integrated working with the District General Hospital, ensure effective joint working with other Local Authority departments and encourage and support the involvement of independent contractors in the delivery of the integrated services. The locality manager will also lead the engagement and involvement of local communities and service users and carers in the design and delivery of services. This will be aligned with the model for GP clusters.

This project supports the delivery of a localities approach across the Health & Social Care Partnership to enable the implementation of locality plans linked to the key outcomes for integration.

This project will contribute to a number of the local strategic objectives and national health and wellbeing outcomes. The key outcome being outcome 4 “Health and social care services are centred on helping to maintain or improve the quality of life for the people that use those services” by providing the relevant integrated services within each locality.

The key local strategic objective of this project is objective 5 “Deliver services with an integrated care model”. This will be achieved by the creation of integrated teams co-located within each locality/community.

This project has requested £66k for a one year pilot in one locality.

3 - Health and Social Care Coordination

Pilot scheme: The Introduction of a Health and Social Care Coordination approach through an integrated team, within one locality for one year (£49k).

Currently referral pathways have separate routes for each service/profession, level of need/urgency, and some are unnecessarily complex and some are unsupported by information technology.

This project will develop the role of a Duty Co-ordinator who will streamline and control a new referral process and screening functions at a local level providing a single local point of access for health and social care services, similar to the Torbay model. The Torbay model has been identified as the best practice model with regards to integrated health and social care teams.

The Health and Care Co-ordinator role will facilitate liaison between newly developed integrated teams. It will also provide the main point of contact for GPs, patients and carers at a local level and will take on the initial assessment function to provide small packages of care to prevent crisis. If a patient's needs change, where a nurse would previously have had to make a referral to the local social work office for a social work assessment; under the new system, the co-ordinator would introduce changes based on the assessment of the nurse.

The project will also provide a link with the discharge coordination function in the acute hospital settings to help facilitate supported hospital discharges. The project will improve the overall outcomes for people within the locality who are frequently exposed to health and social care systems.

This project maps strongly to the majority of the local strategic objectives and the national health and wellbeing outcomes. The strongest impact being against outcome 7 "People using health and social care services are safe from harm" by streamlining services, providing a single point of access and providing small packages of care to prevent crisis.

This project maps to local strategic objective 5 "to deliver services with an integrated model". This is by the creation of integrated teams at a local level.

This project has requested £49k to test in one locality for one year.

4 - Community Led Support

To transform arrangements for access to Social Work staff and ensure more efficient use of staff and resources (£90k for 18 months).

The Social Care (Self-Directed Support) (Scotland) Act aims to ensure that care and support is delivered in ways that support choice and control over one's own life and which respect the person's right to participate in society.

The Community Led Support model provides a real opportunity to embed the Statutory Principles outlined in the Act of participation, involvement and

collaboration by providing a direct link between communities and health and social work practice.

The National Development Team for inclusion have developed a Community Led Support model which aims to remodel initial access to Social Work Services by developing a Community Hub model, in local community settings.
These are manned by the local community/volunteers who meet and greet customers with Voluntary Organisations supporting delivery. These will provide signposting to local services and advise on self-directed support.
Customers will also have the option of a pre-booked slot with a Social Worker/or other professional but drop-ins can also be organised. Recording needs to be minimal and a full needs assessment is only undertaken if required at a later time.

The model also provides a focus for the locality planning groups to deliver change at a tangible, local level.

This will result in a change of culture, creating a different conversation at each stage of the process. Conversations will focus on prevention and will promote aspiration and independence. The process will be more efficient, timely, proportionate and light touch and pathways will be simple, efficient and effective.

The project will increase customer satisfaction and increase staff morale and motivation. The focus will be on prevention, access to social care will be improved and there will be reduced waiting times for service users and carers. Demand and expectations will be managed effectively and there will be significant savings on health and social care budgets.
This project maps strongly to the majority of local strategic objectives. The key objective being objective 1 “Make services more accessible and develop our communities” by providing easily accessible drop in social care sessions and services to promote self-directed support in local communities. The key national health and wellbeing outcome that this project supports is outcome 1 “People are able to look after and improve their own health and wellbeing and live longer”. This will be delivered by the provision of self-directed support within the community.

This project is requesting £90k over 18 months.

5 - Matching Unit

The creation of a small central administrative team “Matching/Brokerage Unit”, to match clients, assessed by care managers as needing care at home services (£115k for 1 year).

A significant part of care managers time is taken up in trying to find external provision for clients (i.e.) rather than having full focus on assessment, managers are also spending time identifying and securing a service for clients. The creation of a small central administrative team (i.e.) Matching/Brokerage Unit, to match clients, assessed by care managers as needing care at home services will improve the productivity of the Care Managers and the quality of communication with customers.

The Matching Unit will perform a critical role in ensuring that the client needs are met quickly and efficiently by a Care at Home provider and that there is a handover period to ensure the new provider is fully aware of the care requirements of the

individual client. The focus for the Matching Unit will initially be Care at Home, however the remit of the Matching Unit could be developed over time to cover other services such as respite, day services, placement in care home, befriending and volunteering.

This project will –

- Reduce the time that care home managers spend trying to identify and secure provision for clients.
- Give a borders wide overview and resource.
- Provide a more consistent and effective approach to securing provision.
- Increase the amount of successful matching, which will have an impact on readmissions.
- Reduce long term home care hours required per client.

This project will impact on a number of the local strategic objectives, the key objective being objective 7 "We will further optimise efficiency and effectiveness" and outcome 9 "Resources are used effectively and efficiently in the provision of health and social care services" by creating a central matching unit, which will streamline the matching process.

This project is requesting £115k for the creation of a three person matching unit for six months focusing on care at home matching, and then increasing this to a five person unit for the remaining six months. If the six month evaluation shows capacity the five person team will extend their remit beyond care at home matching. If successful, the function will be mainstreamed and a permanent and sustainable source of funding put in place for this service.

3.4 Each of the approved projects is outlined in in **Appendix 2** to this report where further detail of their planned timeframes, aims and objectives, progress in their delivery to date and funding requirement is provided.

3.5 Supplementing the addition of these 5 new projects to the programme, 2 existing projects have been approved by the Steering Group for further funding allocations and endorsed by the Executive Management Team:

- **Borders Ability and Equipment Store (BAES)** – Following the outcome of the recent tender exercise and a robust process of due diligence over the cost of the preferred option in terms of opportunity, timescale and value for money, a further £141k is required to enable the relocation (£141k)

- **Health Improvement (phase 1)** – an extension of this project was agreed by the Steering Group for 6 months to 31st December to enable development of the community aspect of the remodelling pathways of care project and evaluation of how this project will contribute to its outcomes. (£19k)

3.6 **Appendix 3** 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.

3.7 **Appendix 4** of the report shows where the approved, recommended and pending projects sit along the care pathway.

Development Plans

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 models of care.

This includes two projects which EMT have requested more information:

- Access to information - To improve online and offline access to information by the creation of a directory style website.
- Palliative care - To provide specialist palliative care, that patients currently receive in the Margaret Kerr Unit in patients' homes and other community settings.

Four further projects are in the process of developing briefs:

- IT integration – Putting in place an information sharing solution to enable practitioners to access full patient/client information so that they can operate in an integrated way and deliver more joined up care to the individuals along the whole care pathway.
- Transitional care – A discharge to assess model of care to be provided at Waverley Care Home.
- Remodelling pathways for older people - The development of seamless pathways for acutely ill older people requiring a hospital level of care.
- Enablement - The creation of a unified approach to mainstream the enablement approach and take a lead role on enablement activities

4.3 Following approval by the IJB, planning is underway for the implementation of the revised governance structure and the reorganisation of the associated groups/boards.

4.4 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 **£2.401m** of the ICF has been approved by the Steering Group, although of this, only **£356k** 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, funding sources 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 **ratify** approval by the Steering Group 5 new projects (**Table 1 Projects 15,16,17,18 & 19**) and a further increase in funding to 2 existing projects (**Table 1 Project 10 & 12**).

Policy/Strategy Implications	The programme is being developed in order to enable transformation to new models of care and achieve the partnership's objectives expressed within its Strategic Plan and national health and wellbeing outcomes
Consultation	The recommendations to the IJB have been made following consultation with a wide range of stakeholder representatives through the ICF Steering Group and Executive Management Team.
Risk Assessment	There are no risk implications associated with the proposals
Compliance with requirements on Equality and Diversity	There are no equality implications associated with the proposals
Resource/Staffing Implications	The proposals approved within the programme to date will be funded from the ICF grant allocation over its life

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer	David Robertson	Scottish Borders Council Chief Financial Officer

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Interim IJB Chief Financial Officer	Clare Richards	Project Manager

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APPENDIX 1

INTEGRATED CARE FUND - APPROVED PROJECTS

		Total Spend 15-16	YTD Actual June 16	Total 3-Year Approved
1	**Project Management Team**	87,721	18,409	219,563
2	**Community Capacity Building**	337	34,336	400,000
3	**Independent Sector Representation**	19,000	28,165	93,960
4	**Transport Hub**	70,600	1,600	139,000
5	**Mental Health Integration**	37,393	0	38,000
6	**My Home Life**	1,631	34,389	71,340
7	**Community Ward (PM, PSO)**	0	1,296	53,655
8	**Health Care & Co-ordination (PM, PSO)**	0	1,296	53,655
9	**Autism Strategy**	0	0	99,386
10	**BAES Relocation**	0	0	241,000
11	**ARBD**	0	0	102,052
12	**Health Improvement (*phase 1*)**	8,000	0	38,000
13	**Stress & Distress Training**	0	0	166,000
14	**Transitions**	0	0	65,200
15	**Delivery of the Localities Plan**	0	12,317	300,000
16	**Locality Management Pilot**	0	0	65,818
17	**Health & Social Care Co-ordination Pilot**	0	0	49,238
18	**Community Led Support**	0	0	90,000
19	**The Matching Unit**	0	0	115,000
		224,682	**131,808**	**2,400,867**

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Appendix 2 – 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. In the first year the transport hub has facilitated 482 journeys by using 56 volunteers. In June the Transport Hub received an award for the Accessibility project of the year.	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	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	Objective 2 by • Equipping practitioners to build health improving measures into their assessments • Integrated anticipatory, treatment and recovery/re-ablement care	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.)

	experience and maximising the use of short-term funding.	• Supporting and enabling carers to look after their health	plans • Supporting people to live well with their conditions			
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 towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education.	Outcome 3 • Ensuring people receive the correct information at the right time • Giving timely collaborative assessment and support plans	Objective 7 • Creating a clear transitions pathway, accessible to all partners including young people and their carers.	Planning is underway for the delivery of this project, which should commence fully in June 2016. Recruitment is underway (interviews took place on 23rd June).	The project would specify that recommendations must be achieved within the existing resources across 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	£65,200
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 –	The transition from a dedicated social work team to having social	Outcome 9 • Integrating social work into the	Objective 5 • Providing support to admin staff and	This project is now complete and has reported improvement in the service	One off cost to implement a new integrated model of	£37,500

April 2015 – October 2015 **Project now complete**	work functions such as care management and assessment and use of IT software such as Frameworki embedded within the integrated teams.	community • Reduce duplication • Ensuring referrals are managed effectively	team managers • Ensuring effective and efficient delivery of social work services within an integrated model.	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.	service delivery.	
My Home Life January 2016 – February 2017	A fourteen month programme of leadership support and training to help improve quality of life in care homes.	Outcome 4 • Educating and 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	Objective 3 • Providing different models of care supporting the discharge agenda and prevention of admission to hospitals	This project is underway and delivering training to care home Managers. A full evaluation against their identified outcomes will be undertaken in January 2017.	One off project – no ongoing costs.	£71,340
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	A project initiation document has been produced and the project delivery planned. Recruitment is currently underway.	One off cost to deliver the Autism Strategy.	£99,386

			earliest opportunity			
Delivery of Stress and Distress Training July 2015 – April 2018	Stress & Distress Training provides training in an individualised, formulation driven approach to understanding and intervening in stress and distressed behaviours in people with dementia.	Outcome 8 • Providing training to over 700 staff • Improve the experience, care, treatment and outcomes for people with dementia, their families and carers	Objective 3 • Reducing the likelihood of situations becoming exacerbated and resulting in residential or hospital care	Work has been undertaken to train stress and distress trainers and plan the training sessions. 16 staff have attended the 2 day training and 20 have completed the bite size training.	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 prescribing alone it is expected that a £47k saving will be realised year on year.	£166,000
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. Recruitment is currently underway.	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	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	Objective 4 - as outcome 2.	This project requested an additional £141,000 when tenders were recieved which were over budget. This was approved in July 2016. The project is currently in the process of accepting a tender.	One off cost.	£100,000 £141,000 Total £241,000

2016		home setting.				
Community Ward Pilot Programme Management and Support	Programme Management and Support to develop, plan and deliver alternative proposal to replace Community Ward pilot	• The outcomes and objectives of this work package will be determined when the development of the alternative options is complete		Project Support Officer in post.	One off project – no ongoing costs.	£54,000
Health and Care Coordination Programme Management and Support	Programme Management and Support to develop, plan and deliver Health and Care Coordination project	• This workpackage is an enabler to delivery of the outcome and objective detailed below in relation to the wider Health & Social Care Coordination project		Project Support Officer in post.	One off project – no ongoing costs.	£54,000
Delivery of the Localities Plan April 2016 – October 2017	Development of locality plans. The redesign services to meet needs. Make recommendations to the localities group. Link to GP services, the third and Independent sector.	Outcome 4 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model	Objective 5 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model.	This project is in the initial stage of developing the project brief, PID and work plans.	One off cost.	£300,000 for 18 months
Health & Social Care Coordination September 2016- August	Introduction of a Health and Social Care Coordination approach through integrating teams within one locality to test the change and consider scaling up across the	Outcome 7 • Providing one point of access for health and social care services • More streamlined service • More efficient	Objective 5 • Improving access to health and social care services • Improving referral and waiting times • Reducing	This project was approved in July 2016.	One off cost, for a 1 year test.	£49,238

2017	remaining localities.	response times	unnecessary admissions to hospital • Improving discharge from hospital Improving co-ordination of multiple services			
Locality Management September 2016- August 2017	Overall management and strategic development of Adult Health and Social Care services within one locality to test the change and consider scaling up across the remaining localities.	Outcome 4 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model	Objective 5 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model.	This project was approved in July 2016.	One off cost, for a 1 year test.	£65,818
Community Led Support September 2016 – March 2018	To develop a community hub model, promoting self directed support and setting up social work drop ins.	Outcome 1 • Providing self directed support and drop in social work sessions within the community.	Objective 1 • Providing self directed support and drop in social work sessions within the community.	This project was approved in August 2016	One off cost, for 18 months.	£90,000
The Matching Unit September 2016 – September 2017	The creation of a small central administrative team "Matching/Brokerage Unit", to match clients, assessed by care managers as needing care at home services.	Outcome 9 • A Borders-wide overview of resource and capacity will be in place resulting in a consistent and more effective	Objective 7 • Care managers time is significantly reduced in trying to identify & secure provision for clients.	This project was approved in August 2016	The running cost of the matching unit will come from the efficiencies created from the more effective use of practitioner time (e.g.) increased productivity	£115,000

		approach to securing provision.			resulting in reduced requirement to either hire additional care managers or to reduce the existing number of care managers	

Appendix 3

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	★		■			●		■	●
BAES relocation	■	●	●	★	★	■	●	■	■
H&SC Coordination	★	★	★	★	★	★	★	●	●
Locality Managers	★	●	●	★	★	★	★	●	●
Locality Coordinators	★	★	★	★	★	★	★	★	★
Community Led Support	★	★	■	★	★	★	★	★	★
Matching/brokerage Unit	★	●	★	★	●	★	★	●	★

★-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 equalities	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	■	★	★	■	■	●	■	■	★
H&SC Coordination	●	★	★	★	●	★	★	★	★
Locality Managers	●	★	★	★	★	●	★	★	★
Locality Coordinators	★	★	★	★	★	★	★	★	★
Community Led Support	★	★	★	★	★	●	★	★	★
Matching/brokerage Unit	●	★	★	★	●	★	★	●	★

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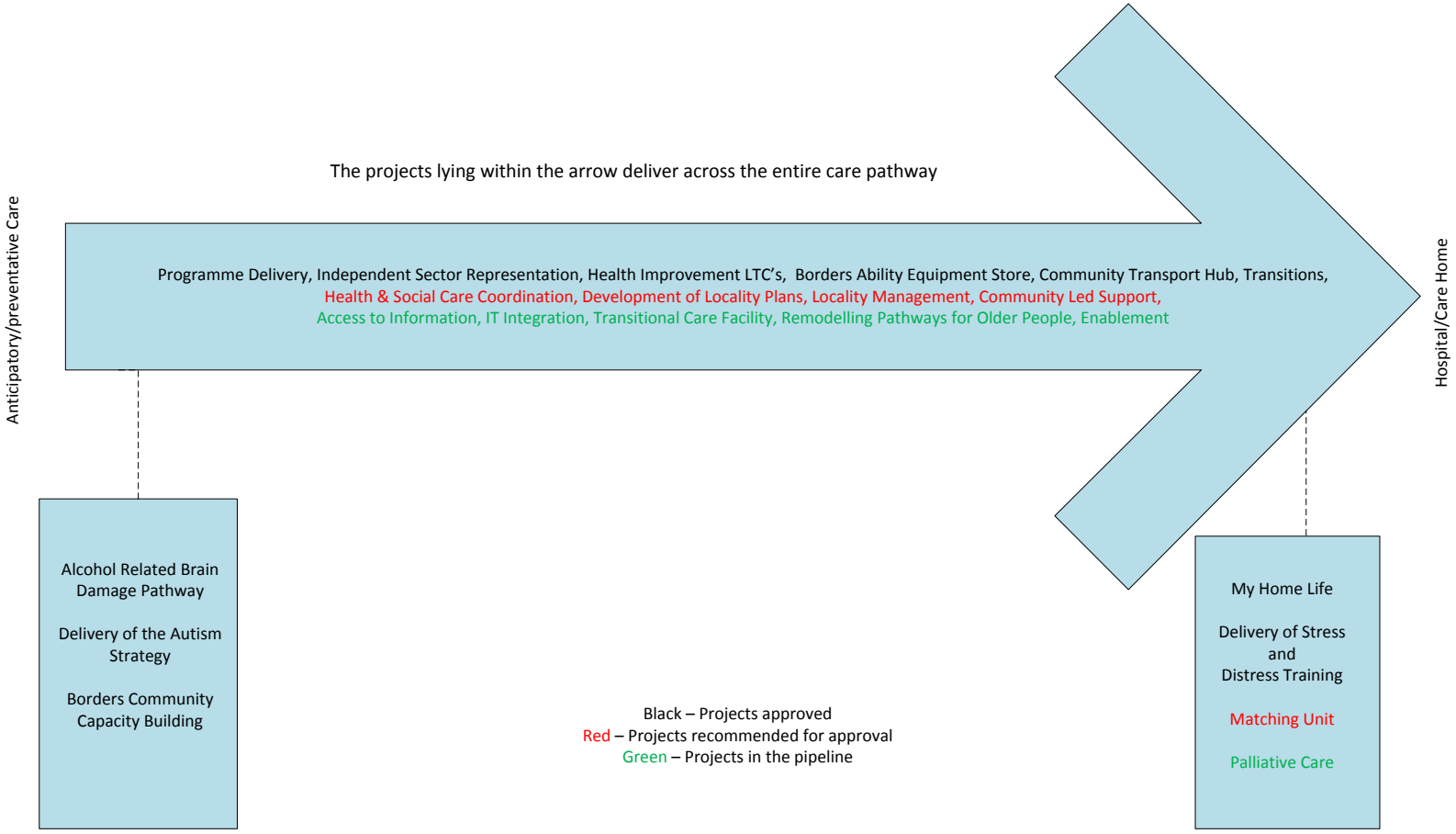
Appendix 4

The Care Pathway



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PRESCRIBING EFFICIENCIES – PAST, PRESENT AND FUTURE

Aim

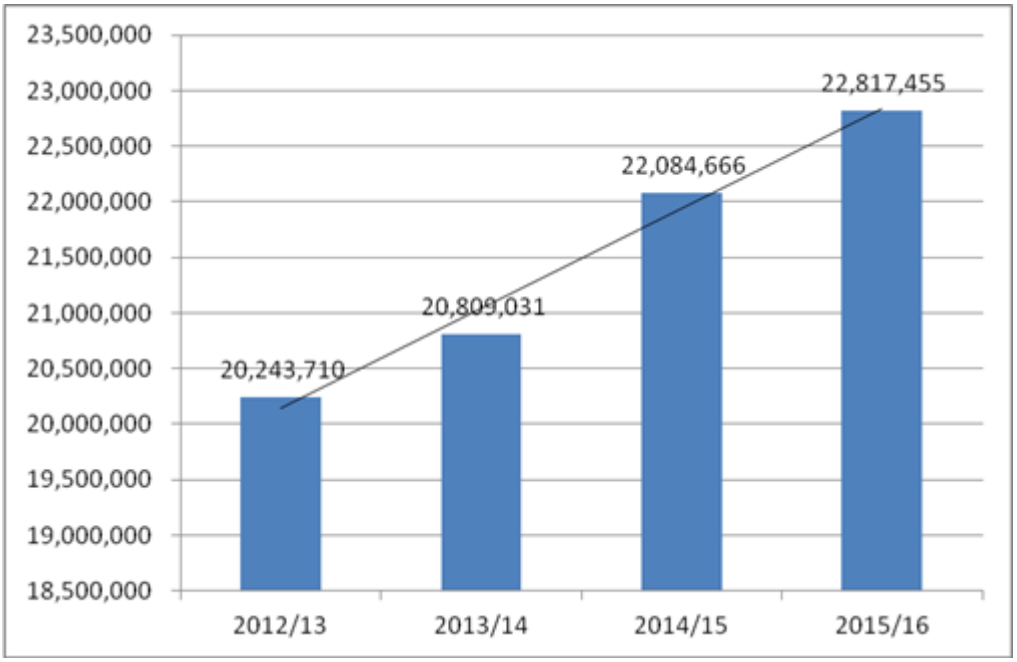
1.1 To inform the Integration Joint Board on Prescribing Efficiencies and show how, in 2016/17, proposed projects aim to achieve the £1m target set. Work to the beginning of March 2016 had achieved a gross saving of £616,000, excluding the GP Local Enhanced Service, primary care rebates and patent expiries. A longer Group chaired by Stephen Mather during 2015/16.

Background

2.1 The Medicines Resource Group (MRG) submits a budget proposal to the Clinical Executive Strategy Group annually in January and monitors expenditure against it throughout the year. All budget areas are expected to work to a savings plan and for the prescribing budget overall the savings target is £1M.

2.2 The GP prescribing budget for 2016-17 is 22,769,872; an uplift of 6.56% from 2015- 16.

Drug Growth in Primary Care



2.3 A number of cost pressures have been identified as likely to affect primary care prescribing:

- The continued move away from warfarin to alternative oral anticoagulants will have considerable impact on the drug budget (see MRG Budget prediction 2013-14). The growth in clinical use of new oral anticoagulants leads to a reduction in the requirement for laboratory monitoring of anticoagulants, reduces length of stay in hospital for patients who are being anticoagulated and reduces GP and community nurse time commitment for INR monitoring.
- Supply chain problems and changes in manufacturer

- Increasing elderly population and the corresponding increase in spend on drugs for treatment of long term conditions and cancer.

2.4 A series of documents are attached shows how the MRG is planning to achieve the savings target. The pharmacy teams will continue to work with clinicians to identify other opportunities for efficiencies. NHS Borders was fortunate to have benefitted from the patent expiry of a number of high volume drugs in the past. There are no significant drug patent expiries expected in 2016-17.

APPENDIX 1 – Past Present and Future – showing historical, current and potential efficiency projects.
APPENDIX 2 – Efficiency Savings 2016/17 – estimated savings proposed for 2016/17.
APPENDIX 3 – Prescribing Efficiency Schemes - in progress and proposed for 2016/17.

Summary

3.1 Integration Joint Board should note the estimated gross savings of £1,029,000 and the likelihood of achieving this saving.

3.2 Some elements of this paper have been presented at the Financial Position Oversight Group in June.

Recommendation

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

Policy/Strategy Implications	Supports financial management
Consultation	Appendices 2 and 3 reviewed monthly at MRG
Risk Assessment	N/A
Compliance with requirements on Equality and Diversity	Complies
Resource/Staffing Implications	Financial implications

Approved by

Name	Designation	Name	Designation
Andrew Murray	Medical Director		

Author(s)

Name	Designation	Name	Designation
Alison Wilson	Director of Pharmacy		

APPENDIX 1 - Past Present and Future

Repeat or not viable?	BNF Chapter area	Specific project
Repeat	general projects	Care home reviews
No	general projects	LES - Chronic Medication Service promotion
ongoing	general projects	Dose optimisation (minimising no of tabs)
Repeat	general projects	Effervescent/dissolvable med reviews
Repeat	general projects	Effective Feedback to Improve Primary Care Prescribing Safety (EFIPPS) reviews
no	general projects	Formulary compliance markers - GI CV, Resp, CNS, Muscul
ongoing	general projects	Non formulary to formulary and formulation switches
ongoing	general projects	Generic prescribing
no	general projects	LES - General Practice Improvement Programme (GPIP) style switches
Repeat	general projects	Liquid med reviews
ongoing	general projects	Non SMC approved drugs
ongoing	general projects	National Therapeutic Indicators
ongoing	general projects	Obsolete drugs (cancelling unused meds from patients' Repeat lists)
ongoing	general projects	Polypharmacy reviews
No	general projects	LES: Practice budgets - Reduction in relative growth
ongoing	general projects	Scriptswitch
ongoing	general projects	Authorisation of Unlicensed Medicines
Repeat	general projects	LES: Waste week - promotion and PR
No	Difficult decision that've been rejected	Paracetamol - would need a change in legislation
No	Difficult decision that've been rejected	Toothpaste, Sunscreens, shampoo etc - spend too low to justify project
No	Difficult decision that've been rejected	NRT - national scheme - public health message/benefit
No	Difficult decision that've been rejected	Homeopathy - spend too low to justify project
ongoing	Anaesthesia	Lidocaine patches
no	Cardiovascular	Amlodipine
no	Cardiovascular	Antihypertensive review
no	Cardiovascular	Dipyridamole & Aspirin to Clopidogrel (SIGN guideline)
no	Cardiovascular	Doxazosin MR/Cardura XL to normal release
no	Cardiovascular	Ezetimibe
no	Cardiovascular	Non formulary to formulary ~sartans
no	Cardiovascular	Ramipril tabs to caps
	Cardiovascular	Statin switches
repeat	CNS	Antidepressant review
	CNS	Antipsychotic load
repeat	CNS	Hypnotics & Anxiolytic review
repeat	CNS	Opioids
repeat	CNS	Simple & Co-analgesic optimisation
repeat	CNS	Pregabalin
repeat	Dressings	Wound management products - Silver

repeat	Endocrine	Bisphosphonate switches	
repeat	Endocrine	Blood Glucose Test Strips	Test Strip reductions; Strips to TrueResult; -Test Strip reductions -True Result to True You
no	Endocrine	Omnican Needles	
repeat	Endocrine	Prednisolone	High cost Prednisolone forms
no	ENT	Fluticasone nasal spray to Avamys	
no	Gastro-intestinal	Loperamide tabs to caps	
no	Gastro-intestinal	Movicol to Laxido	
repeat	Gastro-intestinal	PPI reviews and efficiency projects	
ongoing	Infections	"4C's" (Antibiotics linked with C.difficille)	Quinolones; Overall antibacterial use; SAPG Antibiotic review
no	Infections	Antibiotic measures - included in NTI's now	
no	Infections	Infections formulary compliance markers - included in NTI's now	
no	Infections	UTI prophylaxis audit	
no	Malignant Disease	Goserelin to Triptorelin	
no	Musculoskeletal	NSAID prescribing	Diclofenac MR to Naproxen
repeat	Musculoskeletal	Quinine use reduction	
ongoing	Nutrition & Blood	Gluten Free Food Service development	
ongoing	Nutrition & Blood	Oral Nutritional Sip-feeds	
no	Obs & Gynae	Mirabegron use review	
no	Obs & Gynae	Solifenacin to Tolterodine MR for <65's	
no	Obs & Gynae	Tadalafil to Sildenafil	
no	Obs & Gynae	Tamsulosin MR tabs to caps	
	Respiratory	Antihistamine switches	
ongoing	Respiratory	inhaled corticosteroids reviews	

APPENDIX 1 - Past Present and Future			Saving	RAG	
General projects					
Prescribing policy - "Realistic Medicine"	Y	Yes	Yes		
Repeat Prescribing System Review LES 16/17	Y	Yes	No		
Non-Clinical Medication Reviews - LES 16/17 - housekeeping within GP practices - includes deleting timed out drugs, ID of over/under ordering, Quantity alignment, Dose optimisation, brand to generic switching, inclusion of complete dosage instructions.	Y	Yes	Yes		
EMIS Formulary - maintenance	Y	Yes	Yes		
Scriptswitch	Y	Yes	Yes		
Chronic Medication Service (CMS) promotion	Y		No		
Reporting work	Y		Yes		
Practice Variation - National Therapeutic Indicator chart publication	Y	Yes	Yes		
DUMMY chapter - mainly Flu vacs?	Y				
Secondary Care specific projects					
Biosimilars - Infliximab		=	Y		
Biosimilars - Etanarcept		=	Y		
IV Fluids - best practice	Y	Yes	Y		
High Cost drugs - supply route	Y	=	Y		
Price& supply management		=	Y		
Cardiovascular					
Hypertension - KM & Public Health stearing group in development	Y	Yes	N		*Unlikely to make savings in-year. Data collection*
Statins	Y	Yes	N		*Likely cost , rather than saving*
Simva & Amlodipine interaction	Y	Yes	N		
Respiratory					
Trying to reduce the high use of Reliever (SABA) inhalers	Y	Yes	Y		
Reviewing the high users of Combination Steroid inhalers - part of LES16/17	Y	Yes	=		
CNS					
METHYLPHENIDATE - Consultants are changing brand for cost efficiency	=	=	Y		
Oxycodone - LES16/17	=	Yes	Y		
Antidepressant review	Y	Yes	=		
Antibiotics					
UTI -audits at GP Practices	Y	Yes	=		
SAPG therapeutic indicators	Y	Yes	=		
Endocrine					
Diabetes - BGTS over-use in Type 2	Y	Yes	Y		
Bisphosphonate holiday	Y	Yes	Y		
Anaesthesia					
Bring LIDOCAINE use down to National Average - NTI & Local comparisons & work with specialties...	Y	Yes	Y		
Nutrition & Blood					
Dietitian - Gluten-free Food Service review - bring local Formulary inline with other Boards	Y		Y		

Dietitian - Sip feeds	Y	Y	Y	

delayed

APPENDIX 1 - Past Present and Future

Area	Specific Drug	Progress		Quality	Safety	Saving
Respiratory	SALMETEROL WITH FLUTICASONE PROPIONATE	Seretide reviews	Airflusal?			
Analgesia	PREGABALIN	(Lyrica spend is included here - will reduce pending high court case				
	Chronic Pain Pharmacy LES?					
	Paracetamol prescribing?					
	Analgesia review	qty reviews? What do GP's want fixed?				
NRT						
Diabetes/Biosimilar	INSULIN GLARGINE -> Abasaglar	once established, can existing patients switch?				
Cardiology	DOAC's - which one is best? Pick & switch?					
ILEOSTOMY BAGS						
King's fund paper	dementia drug variation					
WOUND MANAGEMENT DRESSINGS	Silver and other antimicrobial dressings	Holding steady (NTI's) & new Formulary due in next 6months should help reduce...				

CATHETERS - URETHRAL - Formulary development - Mark Clark & KM

Endocrine - lancets?

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Estimated savings for 16-17	Liklihood of Achieving Estimate	Gross savings £000's	Investment £000's	Net Savings £000's	Actual Savings £000's	Full Year Effect	Unavoidable Spending Increases	Estimated gross Increase £000's
Primary Care:								
General Prescribing Support input.	High	31	0	31			Price Increases	
Scriptswitch (all practices)	Medium	120	40	60	20.01		Ropinirole (shortage)	TBC
Prescribing Efficiency LES - Non Clinical Med Review	Medium	84	36	48				
Prescribing Efficiency LES - Oxycodone brand change	High	60	13	47				
Prescribing Efficiency LES - Combination inhaler review	High	18.7	20.6	-1.9				
Prescribing Efficiency LES - repeat prescribing system review	Low	42	41.4	0.6				
PST Technicians reviews	High	45	45	0				
Flu vaccine reduced cost	High	55.76	0	55.76				
Patent Expiries	Medium	39.3	0	39.3				
Polypharmacy	Medium			0				
Primary Care Rebates	Medium	6.5	0	6.5		9.5		
Blood glucose meter and Insulin needle swap	High	56.5	0	56.5				
Sub total		**558.76**	**196**	**342.76**	**20.01**	**9.5**		
Waste Programme	Low							
Sub total		**0**	**0**	**0**	**0**	**0**		
Secondary Care - aim £60k								
Rituximab biosimilar	Low	100	0	100			Rifampicin capsules shortage	TBC
Etanercept biosimilar	Medium	240	50	190			Zoledronic acid 5mg contract shortage	TBC
IV fluids - new clinical guidance	High			0				
Infliximab biosimilar Introduction	High	33.41	0	33.41	13.22			
Patent Expiry	Medium			0				
High Cost Drugs to HBP	High			0	17.55			
pegfilgrastim to Lipegfilgrastim (formulary change)	High	8.26	0	8.26				
Apixaban reduced price	High			0				
Bendamustine reduced price	High	30		30				
Linezolid reduced price	Medium	7.5	0	7.5				
Rituximab ready made bags - reduced price	High	3.74	0	3.74				
Golimumab outcome rebate	High		0	0	8.85			
HIV Drugs	High		0	0	3.32			
Off Contract Recovery	High		0	0	31			
Adrenaline pen brand change	High	40	0	40				
Oxycodone brand change	High			0				
Secukinemab FOC initiation	High			0	8.24			
Dexamethasone product change	High	7.33	0	7.33		11		
Sub total		**470.24**	**50**	**420.24**	**82.18**	**11**		
Total		**1029**	**246**	**763**	**102.19**	**20.5**		
Non Cash Efficiencies		**Length of Stay**	**Patients Admitted**					
Updated 19.07.16								

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APPENDIX - NHS Borders Prescribing Efficiency Schemes 2016/17

Overall Projects

Ongoing Formulary Review
Prescribing policy - "Realistic Medicine"

Waste Reduction

Primary Care Specific Projects

Repeat Prescribing System Review LES 16/17

Non-Clinical Medication Reviews - LES 16/17 - housekeeping within GP practices
- includes deleting timed out drugs, ID of over/under ordering, Quantity alignment, Dose optimisation, brand to generic switching, inclusion of complete dosage instructions.

EMIS (GP) Formulary - maintenance
Scriptswitch
Chronic Medication Service (CMS) promotion
PST Reporting work
Practice Variation - National Therapeutic Indicator chart publication
DUMMY chapter - mainly Flu vacs?
PAS and rebates

Secondary Care Specific Projects

Biosimilars - Infliximab
Biosimilars - Etanercept
IV Fluids - best practice
High Cost drugs - supply route
Price& supply management

Cardiovascular

Hypertension - KM & Public Health stearing group in development
Statins

Respiratory

Trying to reduce the high use of Reliever (SABA) inhalers

Reviewing the high users of Combination Steroid inhalers - part of LES16/17

CNS

METHYLPHENIDATE - Consultants are changing brand for cost efficiency
Oxycodone brand change - LES16/17

Antibiotics

UTI -audits at GP Practices
SAPG therapeutic indicators

Endocrine

Diabetes - BGTS over-use in Type 2

Anaesthesia

Bring LIDOCAINE patch use down to National Average
- NTI & Local comparisons & work with specialties...

Nutrition & Blood

Dietitian - Gluten-free Food Service review - bring local Formulary inline with other Boards

Dietitian - Sip feeds

Catheters - Urethral - Formulary development

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PERFORMANCE MANAGEMENT FRAMEWORK

Aim

1.1 To provide an update to the Integration Joint Board on the development of the Performance Management Framework including current performance against measures as we progress delivery of the integrated services as outlined within the Strategic Plan.

Background

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

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

2.3 The IJB is responsible for planning and ensuring the delivery of a wide range of health and social care services, to ensure the achievement of the national outcomes. The Strategic Plan set out how this should be achieved at a strategic level and the commissioning and implementation plan gives more detail in relation to the specific expectations for change, delivering the National Health and Wellbeing Outcomes. The IJB are also required to publish an annual performance report which will set out how we are improving the National Health and Wellbeing Outcomes. These reports will include information about the core suite of integration indicators as set by the Scottish Government, supported by local measures and contextualising data to provide a broader picture of local performance.

Summary

3.1 NHS Borders and Scottish Borders Council both have organisational performance frameworks already in place. The intention locally is to minimise / avoid duplication with these and the IJB performance framework as far as possible. A “Core Suite” set of 23 Integration Indicators has been set by the Scottish Government, developed from national data sources so that the measurement approach is consistent across all Health and Social Care Partnership areas. This set of core indicators underpin the 9 National Health and Wellbeing Outcomes.

3.2 During the IJB in April It was agreed that the framework will consist of three reporting levels. These are detailed in the paper.

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

3.4 It was therefore agreed during the April Board that performance reports to the IJB, for the first 12 months, include only level 1 and level 2 measures.

3.5 It should be noted that the framework will require to remain flexible over the first 12 months as it will be subject to amendment as discussions progress within the Partnership moving forward. The Strategic Planning Group will provide direction and leadership to ensure progress and delivery against the Strategic Plan can be monitored through this framework.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the further development of the Performance Management Framework.

Members are asked to **consider** the current level 2 local indicators and **identify** and **agree** further indicators that members would wish to have included within the framework in moving forward.

Policy/Strategy Implications	Compliance with the Public Bodies (Joint Working) Act 2014
Consultation	Scottish Borders Council and Borders Health Board Directors of Finance, Chief Executives and the Chief Officer.
Risk Assessment	As detailed within the Scheme of Integration.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	N/A

Approved by

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

Author(s)

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Sandra Campbell	Programme Manager		

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Scottish Borders Health & Social Care partnership
Proposed Integrated Performance Management Framework
At 27th July 2016

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Purpose

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

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

The IJB is responsible for planning and ensuring the delivery of a wide range of health and social care services, to ensure the achievement of the national outcomes. The Strategic Plan set out how this should be achieved at a strategic level and the commissioning and implementation plan gives more detail in relation to the specific expectations for change, delivering the National Health and Wellbeing Outcomes. The IJB are also required to publish an annual performance report which will set out how we are improving the National Health and Wellbeing Outcomes. These reports will include information about the core suite of integration indicators as set by the Scottish Government, supported by local measures and contextualising data to provide a broader picture of local performance.

Following the initial Proposed Integrated Performance Management Framework (7th April 2016) it has been agreed that an integrated Performance Management Framework needs to be developed and progressed.

This paper therefore sets out an outline for a Performance Monitoring Matrix which will become the core monitoring for the Performance Management Framework and will also outline the work which is required in order to further develop and progress the framework.

Background

NHS Borders and Scottish Borders Council both have organisational performance frameworks already in place. The intention locally is to minimise / avoid duplication with these and the IJB performance framework as far as possible. A “Core Suite” set of 23 Integration Indicators has been set by the Scottish Government, developed from national data sources so that the measurement approach is consistent across all Health and Social Care Partnership areas. This set of core indicators underpin the 9 National Health and Wellbeing Outcomes.

The performance framework must highlight progress and delivery against the achievement of the commitments outlined within the Strategic Plan. It is therefore proposed that the best way to do this is that the initial performance framework is based on current and existing measures including the National Health and Wellbeing Outcomes. A framework consisting of three reporting levels is therefore a sensible way forward as outlined in the following diagrams.

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

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

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

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

Level 2 **Publicly Accountable Indicators and Targets**

23 Health and Social Care "Core Suite" Indicators have been set by the Scottish Government, against which every Health and Social Care Partnership is required to publicly report on. These measures need to be monitored to allow performance management and improvement to take place within the partnership. These Indicators each map to one or more of the 9 National Health and Wellbeing Outcomes. In addition we already have mandatory reporting measures such as HEAT.

Level 3 **Local Management Information**

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

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

Key Issues

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

- How the delivery arrangements are contributing to the delivery of the Strategic Plan
- Progress on the delivery of national outcomes and indicators
- Transformation of individual outcomes and experience
- Transformation of local health, care and support systems
- Change in local process including:
    - Effective engagement of housing and other services including the third sector and independent sector
    - in care models
    - in whole systems planning and investment
    - Evidence based models of care.

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

Currently we have local performance data which is gathered regularly and can be used as sub-sets for the indicators. There is also potential locally sourced information which can be used as sub-sets for the indicators if they are judged to directly contribute to the outcome of the indicator. This is evident in the level 2 indictors that have been included within this report. It should be noted that what has been provided within level 2 is what NHS Borders and Scottish Borders Council currently report on within their retrospective organisations therefore the IJB must consider if these are appropriate and if members would wish to receive these.

As the Core Suite of 23 indicators are primarily measured on an annual or Biennial basis the local Level 3 data will be required more frequently and must demonstrate a direct causal link to the indicator.

Recommendation

It is therefore proposed we work with the Performance Monitoring Matrix (as per Appendix 1) for the next 12 to 24 months. This matrix encompasses principally level 1 and level 2 measures and the table currently shows the source of information and frequency of publication. To augment this information, local information currently gathered can be used as the starting point for level 3 measures.

The Performance Monitoring Matrix must set out measures which inform the decision making process. To further progress this framework we need to fully understand what it is managers required to direct the operation of the IJB.

Priority measures for 2016/17

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

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

How this will be managed

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

Appendix 1 Draft Performance Management measures against National Health and Wellbeing Outcomes

Notes:

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

LEVEL 1		LEVEL 2						LEVEL 2/3	
H&WO No.	National Health and Wellbeing Outcome	Core Suite Indicator No.	Core Suite Indicator	Source	Core (Y/N)	Frequency of publication	Produced by	Additional Local Information Gathered	Potential Local Information Required
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	1	Percentage of adults able to look after their health very well or quite well	Scottish Government Health and Care Experience Survey	Y	Biennial	SG	Dementia: Registration - HEAT Standard Detect Cancer Early - HEAT Standard IVF Treatment Waiting Times – HEAT Standard Smoking Cessation - HEAT Standard	
		11	Premature mortality rate	NRS - European Age-Standardised mortality rate per 100,000 for people aged under 75 in Scotland.	Y	Annual	NRS		
		12	Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		

2	People, including those with disabilities, long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home in a homely setting in the community.	2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	Scottish Government Health and Care Experience Survey	Y	Biennial	SG	% of people aged 65 or over with intensive needs receiving care at home Dementia: Post-Diagnosis Support - HEAT Standard Increase the number of telecare clients	Number of people aged 65+ receiving homecare Percentage of homecare clients 65+ (receiving a service at weekends, receiving personal care, receiving service during evenings/overnight) Total number of homecare hours per 1,000 pop'n aged 65+ New Clients receiving a community care assessment New personal care clients receiving a new service Number of internal homecare service users (65+) Number of external homecare packages (65+) Number of internal and external homecare hours delivered per week (65+) Total homecare hours per week (65+) Number of people on waiting list (TPL) for homecare assessment / referral (All Ages) Number of homecare service users (under 65) Number of under 65s waiting on a homecare service
		12	Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		
		18	Percentage of adults with intensive care needs receiving care at home						
		3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	Scottish Government Health and Care Experience Survey	Y	Biennial	SG		
		13	Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		
		14	Readmission to hospital within 28 days	ISD - SMR01	Y	Annual	ISD		
		15	Proportion of last 6 months of life spent at home or in a community setting	ISD Scotland. SMR01 (Acute hospitals), SMR01-E (Geriatric Long Stay beds), SMR04 (Acute psychiatric hospitals) and NRS death registrations	Y	Annual	ISD		
		16	Falls rate per 1,000 population aged 65+	ISD - SMR01	Y	Annual	ISD		
		18	Percentage of adults with intensive care needs receiving care at home	SG - Social Care return	Y	Annual	SG		

		19?	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	ISD - EDISON	Y	Annual	ISD		
		20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency - adults 18+	ISD Health and Social Care/IRF team.	Y	Annual	ISD		
		21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Indicator under development	Y	TBC	TBC		
		22	Percentage of people who are discharged from hospital within 72 hours of being ready	Indicator under development	Y	Annual	ISD		
		23	Expenditure on end of life care	Indicator under development	Y	Annual	ISD		
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	Scottish Government Health and Care Experience Survey	Y	Biennial	SG	% ofadults feeling safe A&E Waiting Times: 4-Hour Waits - HEAT Standard Drugs & Alcohol Waiting Times - HEAT Standard	Percentage of users satisfied with the Community Alarm Service, Telecare provision % of adults satisfied with social care or social work services
		4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	Scottish Government Health and Care Experience Survey	Y	Biennial	SG		
		5	Percentage of adults receiving any care or support who rate it as excellent or good	Scottish Government Health and Care Experience Survey	Y	Biennial	SG		
		6	Percentage of people with positive experience of the care provided by their GP practice	Scottish Government Health and Care Experience Survey	Y	Biennial	SG		
		14	Readmission to hospital within 28 days	ISD - SMR01	Y	Annual	ISD		

		15	Proportion of last 6 months of life spent at home or in a community setting	ISD Scotland. SMR01 (Acute hospitals), SMR01-E (Geriatric Long Stay beds), SMR04 (Acute psychiatric hospitals) and NRS death registrations	Y	Annual	ISD		
		17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	Care Inspectorate	Y	Annual	ISD/SG/Locally TBC (indicator under development)		
		19?	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	ISD - EDISON	Y	Annual	ISD		
		22	Percentage of people who are discharged from hospital within 72 hours of being ready	Indicator under development	Y	Annual	ISD		
		23	Expenditure on end of life care	Indicator under development	Y	Annual	ISD		
4	Health and social care services are centred on helping to maintain or improve the quality of life of service users.	7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	Scottish Government Health and Care Experience Survey	Y	Biennial	SG	18 Weeks Referral To Treatment - HEAT Standard Alcohol Brief Interventions - HEAT Standard All Inpatient Services – Admissions, Discharges, Length of Stay Allied Health Professionals Musculoskeletal waiting times* CAMHS Waiting Times - HEAT Standard Cancer Waiting Times: 31-Day Decision To Treat - HEAT Standard, 62-Day Referral To Treatment - HEAT Standard Community hospital inpatient - Admissions, Discharges, Length of Stay Diagnostics Waiting > 6 Weeks - HEAT Standard Palliative Care - Admissions, Discharges, Length of Stay Patient Treatment Time Guarantee (12 Weeks) - HEAT Standard Proportion of care services graded 'good' (4) or better in Care	
		12	Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		
		13	Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		
		16	Falls rate per 1,000 population aged 65+	ISD - SMR01	Y	Annual	ISD		

		17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	Care Inspectorate	Y	Annual	ISD/SG/Locally TBC (indicator under development)	Psychological Therapies Waiting Times - HEAT Standard Time interval between first contact and completion of community care assessment - All Clients, Critical Risk Eligibility Criteria Clients, Substantial Risk Eligibility Criteria Clients, Moderate Risk Eligibility	
		19?	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	ISD - EDISON	Y	Annual	ISD		
		20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency - adults 18+	ISD Health and Social Care/IRF team.	Y	Annual	ISD		
5	Health and social care services contribute to reducing health inequalities	11	Premature mortality rate	NRS - European Age-Standardised mortality rate per 100,000 for people aged under 75 in Scotland.	Y	Annual	NRS	Antenatal Access - HEAT Standard	
		12	Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		
6	People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing.	8	Percentage of carers who feel supported to continue in their caring role	Scottish Government Health and Care Experience Survey	Y	Biennial	SG		Percentage of carers who feel supported to continue in their caring role. Total respite in weeks for adults (aged 18-64) Total respite in weeks for older people (aged 65+)
7	People who use health and social care services are safe from harm	9	Percentage of adults supported at home who agree they felt safe	Scottish Government Health and Care Experience Survey	Y	Biennial	SG	% of Looked After Children Health Assessments (of those requested) completed on time Hospital-Acquired Infection: C Diff - HEAT Standard, Sabs - HEAT Standard Learning disability - Admissions, Discharges, Length of Stay Mental Health including Forensic - Admissions, Discharges, Length of Stay Number of residents aged 65+ (internal	Number of people in long term care (65+) Number of residents under 65 in independent care homes
		12	Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		

		13	Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	ISD - SMR01/SMR01-E/SMR04	Y	Annual	ISD		
		14	Readmission to hospital within 28 days	ISD - SMR01	Y	Annual	ISD		
		16	Falls rate per 1,000 population aged 65+	ISD - SMR01	Y	Annual	ISD		
		17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	Care Inspectorate	Y	Annual	ISD/SG/Locally TBC (indicator under development)		
		20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency - adults 18+	ISD Health and Social Care/IRF team.	Y	Annual	ISD		
8	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.	10	Percentage of staff who say they would recommend their workplace as a good place to work	NHS Staff Survey (No equivalent yet for SBC staff)	Y	Annual/TBC	SG		Average number of working days per employee lost through sickness absence for Adult Services Average number of working days per employee lost through sickness absence for Older People Services* Percentage of staff who say they would recommend their workplace as a good place to work.* Sickness Absence (measured on a 12 month rolling basis) - HEAT Standard Total number of days lost through long term sickness absence as a percentage of total working days available for all SWS employees for Adults* Total number of days lost through long term sickness absence as a percentage of total working days available for all SWS employees for Older People*
9	Resources are used effectively in the provision of health and social care services, without waste.	4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	Scottish Government Health and Care Experience Survey	Y	Biennial	SG	All Inpatient Services - Bed Occupancy Rates Community hospital inpatient - Bed Occupancy Rates Delayed Discharge (Number of patients waiting for more than 2 weeks for discharge to an appropriate setting).	Number of residents aged 65+ (internal care homes) Number of residents aged 65+ (independent care homes) Net Residential Costs Per Capita per Week for Older Adults (65+) Direct payments spend on adults 18+ as a
		14	Readmission to hospital within 28 days	ISD - SMR01	Y	Annual	ISD		

		15	Proportion of last 6 months of life spent at home or in a community setting	ISD Scotland. SMR01 (Acute hospitals), SMR01-E (Geriatric Long Stay beds), SMR04 (Acute psychiatric hospitals) and NRS death registrations	Y	Annual	ISD	HEAT Standard. Learning disability - Bed Occupancy Rates Mental Health including Forensic - Bed Occupancy Rates Net Residential Costs Per Capita per Week for Older Adults (65+) Palliative Care - Bed Occupancy Rates	% of total social work spend on adults 18+ Home care costs for people aged 65 or over per hour £
		16	Falls rate per 1,000 population aged 65+	ISD - SMR01	Y	Annual	ISD		
		19?	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	ISD - EDISON	Y	Annual	ISD		
		20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency - adults 18+	ISD Health and Social Care/IRF team.	Y	Annual	ISD		
		22	Percentage of people who are discharged from hospital within 72 hours of being ready	Indicator under development	Y	Annual	ISD		
		23	Expenditure on end of life care	Indicator under development	Y	Annual	ISD		

Appendix 2 - 2015/16 Performance against measures

a) National (Core Suite) Indicators based on survey data. Priority indicators for focus in 2016/17 are highlighted in yellow

Health & Wellbeing Outcome No(s)	Core Suite Indicator	Latest Available Period	Previous Available Period	Borders target (as per Strategic Plan)	Latest Indicator Borders	Latest Indicator Scotland	Absolute change from Previous	Trend
1	Percentage of adults able to look after their health very well or quite well.	2015/16	2013/14	At least 96%	95%	93%	-1%	↓
2	Percentage of adults supported at home who agree that they are supported to live as independently as possible.	2015/16	2013/14	85%	85%	84%	2%	↑
2, 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	2015/16	2013/14	85%	85%	83%	5%	↑
3, 9	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	2015/16	2013/14	85%	75%	75%	-4%	↓
3	Percentage of adults receiving any care or support who rate it as excellent or good	2015/16	2013/14	85%	84%	81%	1%	↑
3	Percentage of people with positive experience of the care provided by their GP practice.	2015/16	2013/14	90%	90%	87%	0%	↑
4	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	2015/16	2013/14	86%	87%	84%	4%	↑
6	Percentage of carers who feel supported to continue in their caring role.	2015/16	2013/14	50% by 2018/19, rising thereafter	41%	41%	0%	↑
7	Percentage of adults supported at home who agree they felt safe.	2015/16	2013/14	86%	90%	84%	9%	↑
8	Percentage of staff who say they would recommend their workplace as a good place to work.	2015	2015	At least 61%, rising to 70%	57% (NHS Borders only)	59% (NHS Borders only)	1%	↑

b) National (Core Suite) Indicators based on organisational/system data. Priority indicators for focus in 2016/17 are highlighted in yellow, table c outlines the most up to date data against these measures.

Health & Wellbeing Outcome No(s)	Core Suite Indicator	Latest Available Period	Previous Available Period	Borders target (as per Strategic Plan)	Latest Indicator Borders	Latest Indicator Scotland	Absolute change from Previous	Trend
1, 5	Premature mortality rate (per 100,000 population)	2014	2013	Maintain downward trend. No specific target set.	321.7	423.2	-1.2	↓
1, 2, 4, 5, 7	Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	2013/14	2012/13	General target to reduce overall rate by 10%. Baseline year to be formally agreed by IJB. 10% reduction on 2013/14 figure would be to a rate of 12,930 per 100,000, still considerably higher than Scottish average	14,368	7,780	826.2	↑
2, 4, 7	Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	2013/14	2012/13	Reduce this rate over time. Exact target not set; baseline year to be set by IJB.	127,536	97,266	33,611	↑
2, 3, 7, 9	Readmission to hospital within 28 days – Borders residents (treated within and outwith Borders)			General target to reduce overall rate by 10% (based on known figures for BGH as hospital of treatment). Baseline year to be formally agreed by IJB.	Official figure for all Borders residents TBC	Official figure for all Borders residents TBC		
2, 3, 9	Proportion of last 6 months of life spent at home or in a community setting	2013/14	2012/13	91.6%. NB This target was based on a related indicator (Quality Outcome Measure 10) produced to a different definition - using data for acute hospitals only (SMR01).	85.5%	86.6%	0.3	↑

Note: Premature mortality rate for 2015 expected to be published by NRS by end August 2016. For the other indicators we expect to receive official figures for 2014/15 within the next 3 months, date TBC by Scottish Government/ISD.

Health & Wellbeing Outcome No(s)	Core Suite Indicator	Latest Available Period	Previous Available Period	Borders target (as per Strategic Plan)	Latest Indicator Borders	Latest Indicator Scotland	Absolute change from Previous	Trend
2, 4, 7, 9	Falls rate per 1,000 population aged 65+	2014/15	2013/14	General target to reduce overall rate by 10%. Baseline year to be formally agreed by IJB. 10% reduction on 2013/14 figure would be to a rate of 19.1 per 1,000.	21.0	20.5	-0.2	↓
3, 4, 7	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2014/15		No target yet. Indicator under development and these figures are provisional.	73.9% (pending final indicator definition)	81.2% (pending final indicator definition)		
2	Percentage of adults with intensive care needs receiving care at home	2013/14	2012/13	Increasing from 65%. NB This measure does not reflect clients on Self Directed Support, which reduces apparent % for this indicator.	64.6%	59.9%	-6.3%	↓
2, 3, 4, 9	Number of days people (aged 75+) spend in hospital when they are ready to be discharged, per 1,000 population	2014/15	2013/14	Target not set for this specific indicator. Associated target to reduce delayed discharge bed days for patients aged 75+ to 73% of total DD bed days, down from 84%.	627.8	1044	23.8	↑
2, 4, 7, 9	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency - adults 18+	2013/14	2012/13	Reduce this proportion over time. Exact target not set; baseline year to be set by IJB.	21.0%	22.8%	3.7%	↑

Note: For the indicators listed above as latest available year 2013/14 we expect to receive official figures for 2014/15 within the next 3 months, date TBC by Scottish Government/ISD.

Health & Wellbeing Outcome No(s)	Core Suite Indicator	Latest Available Period	Previous Available Period	Borders target (as per Strategic Plan)	Latest Indicator Borders	Latest Indicator Scotland	Absolute change from Previous	Trend
2	Percentage of people admitted to hospital from home during the year, who are discharged to a care home			No target yet. National indicator under development.	Indicator under development			
2, 3, 9	Percentage of people who are discharged from hospital within 72 hours of being ready			No target yet. National indicator under development.	Indicator under development			
2, 3, 9	Expenditure on end of life care			No target yet. National indicator under development.	Indicator under development			

Note: Work to develop the 72-hour delayed discharge measure is in progress locally. Publication of nationally consistent measure TBC.

c) Latest available data - Priority indicators for focus in 2016/17

Health & Wellbeing Outcome No(s)	Core Suite Indicator	Target	Trajectory	Apr 2016	May 2016	Jun2016	Performance Direction
8	Percentage of staff who say they would recommend their workplace as a good place to work.[1]	TBC	TBC	N/A	N/A	N/A	-
1, 2, 4, 5, 7	Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)[2]	TBC	TBC	943.6 (Feb16)	910.3 (Mar16)	807.7 (Apr16)	↑
2, 3, 7, 9	Readmission to hospital within 28 days – Borders residents (treated within and outwith Borders)[3]	TBC	TBC	211 (Feb 16)	226 (Mar 16)	125 (Apr 16)	↑
2, 4, 7, 9	Falls rate per 1,000 population aged 65+[4]	TBC	TBC	0.75 (Feb16)	0.75 (Mar16)	0.64 (Apr16)	↑
2, 3, 4, 9	Number of days people (aged 75+) spend in hospital when they are ready to be discharged, per 1,000 population[5]	TBC	TBC	6.71	6.40	6.98	↓
2, 3, 9	Percentage of people who are discharged from hospital within 72 hours of being ready[6]	TBC	TBC	N/A	N/A	N/A	-

[1] Not available monthly as the Staff Survey is an annual publication

[2] Data has a lag time as the source is SMR01, 01E and 04 national returns

[3] Data has a lag time as the source is Discovery using SMR01 national returns

[4] Indicator is measured as the number of patients who have been admitted with an ICD10 diagnosis of fall in any position. Data has a lag time as the source is SMR01 national returns.

[5] Data includes both regular and complex case delayed days

[6] Data not currently collected

d) Other Level 2 (and some level 3) Indicators already monitored locally

Health & Wellbeing Outcome No(s)	Current Collection	Previous Collection	Standard Descriptor	Current Standard	Current Performance	Performance Last Month	Performance Compared to Last Month	Status
1	May-16	Apr-16	Diagnosis of dementia	1116	1029	1030	↓	▲
1, 4	Apr-16	Mar-16	Treatment within 62 days for Urgent Referrals of Suspicion of Cancer	95%	95.80%	100%	↓	●
1, 4	Apr-16	Mar-16	Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer	95%	100%	100%	-	●
1	Dec-15	Sep-15	Smoking cessation 12 week successful quits in most deprived areas (cumulative)	72	96	67	↑	●
2	Jun-16	May-16	% of Adults 65+ receiving care at home to sustain an independent quality of life as part of the community compared to those in a care home.	70%	72.8%	71.7%	↑	●
2	Q1 2016/17	Q4 2014/15	Number of people able to maintain themselves at home through the receipt of Telecare services (with support)	600	577	581	↓	▲
3	Jun-16	May-16	% of adults feeling safe	90%	61%	72%	↑	⬢

3	May-16	Apr-16	4-Hour Waiting Target for A&E	95%	92.8%	94.6%	↓	▲
3	May-16	Apr-16	Alcohol/Drug Referrals into Treatment within 3 weeks	95%	88%	100%	↓	▲
3	Jun-16	May-16	Adults with self-directed care arrangements per 1,000 population	7	10.1	8.8	↑	●

Status key: ● Improved performance / On target ▲ Minor change in performance / Just off target ⯃ Area for improvement / Off target

Health & Wellbeing Outcome No(s)	Current Collection	Previous Collection	Standard Descriptor	Current Standard	Current Performance	Performance Last Month	Performance Compared to Last Month	Status
4	May-16	Apr-16	18 Wk RTT: 12 wks for outpatients	0	359	316	↓	●
4	May-16	Apr-16	18 Wk RTT: 12 wks for inpatients	0	1	4	↑	●
4	May-16	Apr-16	Alcohol Brief Interventions	220	188	73	↑	●
4	May-16	Apr-16	CAMHS % of patients seen within 18 weeks	95%	87.5%	79.3%	↑	▲
4	May-16	Apr-16	6 Week Waiting Target for Diagnostics	0	84	54	↓	●
4	May-16	Apr-16	Psychological Therapy % of patients seen within 18 weeks	95%	83%	89%	↓	●
4	Q1 2016/17	Q4 2015/16	Proportion of new service users who receive a service within 6 weeks of assessment (year to date)	95%	98%	95%	↑	●
7	Jun-16	May-16	Number of residents aged 65+ (internal care homes, independent care homes)	-	656	658	↓	
8	May-16	Apr-16	Sickness Absence Reduced (NHS Borders)	4%	5%	5%	-	▲
8	Apr-16	Mar-16	Percentage of Working Days Lost per Department - People	4%	3.5%	3.5%	-	●
9	May-16	Apr-16	No Delayed Discharges over 72 hours (3 days)	-	8	6	↓	-
9	May-16	Apr-16	No Delayed Discharges over 2 wks	0%	4	3	↓	●
9	Q1 2016/17	-	Number of Single Shared Assessments undertaken across the Community Health and Care Partnership (Year to date)	200	206	-	-	-

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HEALTH AND SOCIAL CARE – PUBLIC GOVERNANCE ARRANGEMENTS

Aim

1.1 To ask the Integrated Joint Board to agree the reporting arrangements for the Public Partnership Forum.

Background

2.1 Finance, clinical and care governance, public governance and staff governance are the key elements of governance necessary to give assurance to the Integrated Joint Board. A Governance framework should be in place for each element of governance to ensure that the appropriate arrangements are in place across the Partnership respect to the responsibilities of the Integrated Authority.

2.2 The Public Partnership Forum played a key part in facilitating and overseeing public, patient and service user involvement in joint work between the Council and the NHS in planning services in support of the Community Health and Social Care Partnership. It was used as a reference point for staff developing and forming plans and service redesign for adults services across health and social care

Summary

3.1 The attached paper outlines proposals for the role of the group, suggested membership and how it will operate to support public, patient and service user involvement across the Health and Social Care Partnership.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the Terms of Reference for the proposed Public Partnership Forum, **approve** the formal establishment of that group and that we proceed in making the necessary arrangements for the PPF to commence regular meetings and participate in further development of the Partnership.

Policy/Strategy Implications	Key to the delivery of the Strategic Plan
Consultation	With the Public Partnership Forum members and key Council and NHS staff.
Risk Assessment	N/A
Compliance with requirements on Equality and Diversity	Compliance linked to the decisions of the IJB and to the delivery of the Strategic Plan
Resource/Staffing Implications	N/A

Approved by

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

	Integration		

Author(s)

Name	Designation	Name	Designation
Sandra Campbell	Programme Lead		

PUBLIC PARTNERSHIP FORUM – TERMS OF REFERENCE

Aim

1.1 To provide the Integration Joint Board (IJB) with the proposed Terms of Reference for the Public Partnership Forum (PPF) and to seek agreement that the IJB should formally link to this by embedding it within the overall governance structure for the Scottish Borders Health & Social Care Partnership.

Background

2.1 The purpose of this paper is to describe the working arrangements to be agreed between Scottish Borders Public Partnership Forum (PPF) and the Scottish Borders Health and Social Care Partnership and the IJB. These arrangements are intended to maximise the effectiveness of the PPF as the main way in which the IJB engages, communicates and maintains a meaningful dialogue with the public, and is based on the current arrangements that were put in place under the former Community Health and Care Partnership (IJB).

2.2 Throughout this document the term "PPF" will refer to the whole membership of Scottish Borders PPF. The term "PPF Planning Group" will refer to the small group of PPF members who advise and support staff on issues relating to the development of the PPF.

2.3 Following approval by the IJB, members of the PPF will be asked to confirm their agreement with the principles contained within the Terms of Reference.

Terms of Reference

Aims of the PPF

3.1 The aim of the PPF is to enable the IJB to develop and maintain an effective dialogue with the community, paying particular attention to those who could be socially excluded or face discrimination when accessing services by:

- Ensuring the public is informed about the range and location of health related services;
- Involving the public, local service users and carers in discussions about how to improve health services for the local community;
- Supporting wider public involvement in planning and decision making and assisting the IJB in breaking down the barriers that prevent equal access to services.

Vision Statement

4.1 The PPF strives to ensure that health and social care services are provided in a fair way to people in the Borders. We believe that patient care should be as close to people's homes as possible and we will do our best to ensure that safe and good quality services are available for the Borders Community. As a group we will aim to

be open and honest with health and social care services and we will challenge decisions that we do not agree with.

4.2 The relationship between the PPF and the IJB will be based on the following key principles:

- Openness and honesty;
- Listening to and having respect for each others views and opinions;
- Giving and receiving feedback;
- Learning from each other;
- A commitment to improving services and better health for all.

4.3 The IJB will:

- Ensure that the PPF is involved from the beginning of planning and decision making processes.
- Ensure that meetings are accessible and inclusive.
- Use plain English and avoid acronyms.
- Ensure that the PPF is provided with relevant, accessible and timely information
- Work with the PPF to support its development.
- Provide appropriate induction and training to members.
- Provide an opportunity for members to set the agenda.
- Value and respect the input of the PPF.
- To be open and honest.
- Ensure that NHS Borders, the Borders Voluntary Community Care Forum (on behalf of the voluntary sector) and Scottish Borders Council all table items for discussion at each meeting.
- Let everybody have their say and be respectful of different views.

4.4 The PPF members will:

- Be a means of communicating between the IJB and the public by facilitating engagement and meaningful dialogue with individuals, groups and communities.
- Respect sensitive information and the need for confidentiality when it is required.
- Provide updates and share information with other members.
- Speak one at a time and allow less confident members the time to express their views.
- Prepare for meetings and seek clarification when unsure about anything.
- Let everybody have their say and be respectful of different views.
- Commit and communicate, including giving apologies for meetings if unable to attend.
- Access other people's views especially minority groups and people that might find it harder to have their views heard.
- Encourage members to challenge, sense check and ask questions for clarification.

Roles and Responsibilities

IJB

5.1 The IJB will ensure that the PPF has the necessary support and resources required to develop and undertake its role and responsibilities. This will include any

requirements that relate to professional support, training and development. As and when required a PPF planning group will be established to ensure that the PPF is in receipt of the support required and to facilitate the development of agreed work plans.

PPF

6.1 The PPF will build upon existing methods of public involvement to establish and maintain an effective partnership with the IJB and to ensure that the community is represented in the decision-making process of the IJB.

6.2 The PPF will:

- help promote positive change in the health of the local community and in the service provided by the Scottish Borders Health & Social Care Partnership, commissioned and governed by the IJB;
- where possible, represent the views of the communities in Scottish Borders paying particular attention to those who could be socially excluded or face discrimination when accessing services;
- provide a way for the IJB to inform local people about the range and location of services it provides throughout Borders;
- support the involvement of local people, service users and carers in discussions about how to improve services provided by the IJB;
- assist the IJB to promote equal access to services by respecting equality, diversity and transparency in all aspects of its work;
- assist the IJB to engage with local communities either directly or through existing groups/organisations;
- offer insights from local communities regarding the planning and delivery of services. Raise issues, concerns and other comments from local communities in relation to services provided by the IJB;
    - support the IJB to meet the National Standards for Community Engagement as adopted by Scottish Borders Council, NHS Borders and other partners;
    - act responsibly, in an appropriate manner without bias or discrimination.

NHS Borders Public Governance Committee

7.1 The PPF will report directly to the NHS Borders Public Governance Committee on relevant matters of joint interest.

Membership of the PPF

8.1 Membership of the PPF is open to anyone who receives, or has the potential to receive services provided by the IJB in Borders

OR

- receives health services delivered in Scottish Borders;
- cares for someone who receives these services;
- is a potential user of these services and
- who lives in, works in, or has a substantial connection with the area that is serviced by Scottish Borders Health and Social Care Partnership.

8.2 Group membership is also open to:

- voluntary sector organisations;
- community groups;
- support groups;
- self-help groups;
- community councils;
- local community planning/other partnership forums; and
- any other group with a presence in the Borders, having an interest in health services provided in Scottish Borders and how they are delivered to local communities.

8.3 Members of the PPF, who represent the above groups, are responsible for communicating information to and from their groups. These representatives are also accountable to their own group for their expressed views when participating in any involvement activities. A group representative is there to voice their group's views and not their own individual view unless otherwise stated.

Meetings of the PPF

9.1 The PPF will hold approximately six meetings a year (bi-monthly). An agenda and any papers will be distributed 5-7 days in advance of the meeting and minutes produced within 2 weeks.

9.2 Papers will be available on request in different formats.

9.3 A PPF Development Day will be held once a year to which all PPF members will be invited and supported to attend.

Roles and responsibilities of the PPF Representative serving on the IJB

10.1 A PPF Planning Group member will serve as PPF Representative on the IJB.

10.2 In the event of absence, the nominated PPF representative will seek to ensure that the PPF is always represented at the IJB meetings.

10.3 This member will have voting rights on behalf of the PPF.

10.4 This member will have the mandate of the PPF to represent the views of the PPF and therefore should not be presenting their own personal views. Any conflict of interest must be declared.

10.5 Where the IJB considers all the facts and then makes a decision that does not reflect the views of the PPF the IJB should ensure that the reasons why such decisions were taken are shared openly.

10.6 Appointment of PPF Chair, Vice Chair and PPF Representative to the IJB.

10.7 PPF Chair, Vice Chair and PPF member on the IJB. Members will be able to put themselves forward for re-election if they so wish, with a limit of two consecutive terms.

- Self nominations are invited from the PPF Planning Group membership.
- A personal statement from candidates will be sent out to all members of the PPF Planning Group prior to meeting.
- A private vote of the public members will take place at the meeting if there are more candidates than positions.

Scottish Health Council

11.1 The Scottish Health Council will provide ongoing support to the development, review and evaluation of the Scottish Borders PPF.

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MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2016/17 AT 30 JUNE 2016

Aim

1.1 The aim of this report is to provide an overview of the monitoring position of the Health and Social Care Partnership Budget at 30 June 2016, together with any pressures therein and proposed actions for mitigation.

Background

2.1 On the 30th March 2016, the Integration Joint Board (IJB) agreed the delegation of **£139.150m** of resources supporting integrated health and social care functions for financial year 2016/17.

2.2 At the same time, assurance over the sufficiency of resources was given to the board and approved. Since 1st April however, a number of additional factors have emerged including the requirement to implement a living wage from 1st October 2016 for all social care staff. At its meeting of 20th June, the IJB agreed the direction of social care funding to meet these pressures in 2016/17 and beyond. This amounted to £2.268m in 2016/17 increasing to £2.861m when the full-year impact of the living wage would be experienced. Beyond this initial direction, further pressures have emerged or have become more certain in terms of timing and cost as a result of a range of factors which are discussed later in this report.

2.3 This report aims to identify:

- Current pressures and variances within the integrated budget
- The requirement to deliver efficiencies and other savings within the functions which are delegated to the partnership
- Proposed mitigating actions

Overview of Monitoring Position at 30 June 2016

3.1 The current projected outturn position is based on the delivery in full of all planned efficiency and other savings measures by NHS Borders and Scottish Borders Council, in line with partners' Financial Plans for 2016/17. However, as previously reported to the board, the total value of these targets amounts to **£7.373m**, with the majority at the time of reporting, having been assessed as being of medium to high risk.

3.2 As a result therefore, close scrutiny, challenge and reporting of progress made in the delivery of all savings proposals to the IJB will be required going forward and it is fully anticipated that all future monitoring reports will, in addition to reporting the overall monitoring position on the partnership's budget, specifically report on progress made against delivery of each individual savings proposal.

3.3 This will enable the board to consider specific issues regarding delivery as they arise and agree how mitigation of financial impact will be planned actioned. Currently, both organisations are working to implement plans for the delivery of savings plans with varying degrees of progress to date and during August and

September, the Chief Officer and Chief Financial Officer of the IJB will work closely with partners to ensure that delivery is maximised and where full delivery is not possible, alternative actions are agreed and implemented in partnership with NHS Borders and Scottish Borders Council.

3.4 A summary of the projected variance position at 30 June 2016 across NHS Borders and Scottish Borders Council is detailed below, with full detail on the reported position at 30 June on the partnership's revenue budget attached as **Appendix 1**:

Overall, there are projected pressures across the total delegated budget to 31 March 2016 of **£1.433m**

3.5 Within the Joint Learning Disability service, additional clients requiring both health and social care, primarily young people who have entered the service this year from Children's Services, have put additional pressure on the budget resulting in a projected adverse variance of £200k. This is further compounded by a range of rate increases resulting from contract renegotiation with external provider organisations which is projected to now cost a further £310k above the budgeted level.

3.6 Within the Older People's service, the impact of the final COSLA residential care home contract uplift for 2016/17 has resulted in further additional costs above budgeted levels having been projected for 2016/17 (£172k). Earlier in the financial year, Scottish Borders Council retendered its Care at Home contracts resulting in additional cost increases across all contracts and providers, in excess of budget provision available (£494k). Demand in the system has also resulted in the requirement to continue to operate flex beds during 2016/17, which when added to a number of other smaller pressures results in a further unfunded budget pressure (£137k).

3.7 A small number of additional new high tariff clients within the Physical Disability Service have resulted in a further demand-led projected pressure for 2016/17 (£107k).

3.8 Generic Services is reporting a small net overspend of £34k. This is attributable to a range of factors however and is largely offset by savings across the planning and locality teams. In relation to GP Prescribing specifically, which has been an area of substantial pressure in recent financial years, a breakeven position is currently projected. Underlying this however is a pressure of £100k which has yet to be addressed and further discussion is required between NHS Borders and the partnership's Chief Officer as to what remedial actions or funding availability is possible.

Delivery of Efficiencies and Savings

4.1 Current and emerging pressures aside, total affordability of the budget supporting health and social care functions delegated to the partnership is dependent on the delivery, in full, of all planned efficiency and saving projects on which it is predicated. Where this is not possible, alternative permanent or temporary mitigating remedial actions are required.

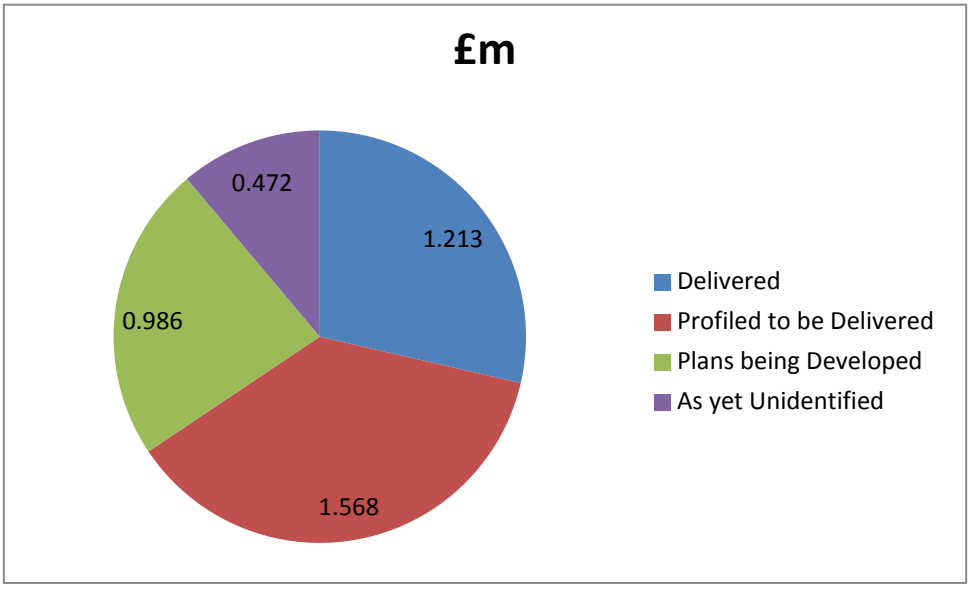
4.2 Within the partnership's Financial Plan, total efficiency and savings requirements amount to **£7.373m** in 2016/17, split between those to be delivered by NHS Borders (£4.239m) and those to be delivered by Scottish Borders Council (£2.663m). In addition, there is a further affordability gap within the budget delegated by NHS Borders to the partnership in respect of a reduction in ringfenced funding (£471k).

NHS Borders – Devolved Budget Efficiencies

4.3 Within the budget delegated to the partnership, NHS Borders requires to deliver **£4.239m** of efficiency savings, of which £3.3m (77%) is required on a recurring basis. At 30 June 2016, **£1.213m** has been delivered. Within this, £933k is recurring and £280k is non-recurring.

4.4 Of the remaining **£3.026m** gap, **£0.568m** is profiled for delivery over the remainder of the year. Total efficiency savings therefore of **£1.781m** have been or are in the process of being delivered. Additionally, plans are in development currently to deliver a further **£1.986k**, although these have not yet been formally agreed. This leaves **£472k** of unidentified and unplanned measures requiring immediate addressing.

4.5 Clearly risk of non-delivery of a significant element of NHS Borders efficiency programme is high and it should now be highlighted that a range of alternative measures will now be delivered on whatever basis is possible, permanent or temporary, to ensure the risk of overspend through non-delivery of planned savings at 31 March 2017 is minimised. The current position in terms of delivery / planned delivery is detailed below:

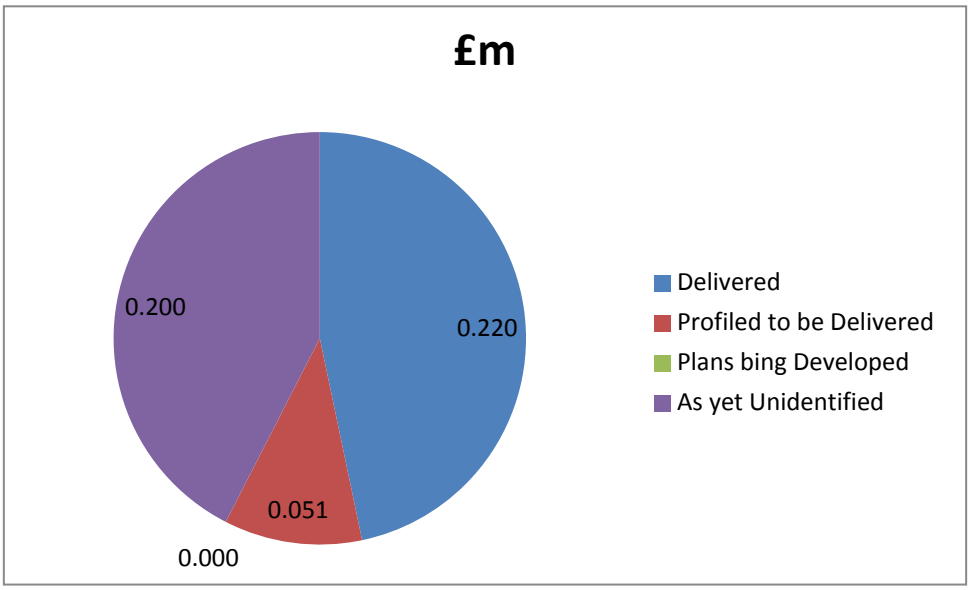


4.6 Work is still being undertaken within NHS Borders to develop plans as outlined in 4.4 above. This means that a detailed analysis of all projects' progress against delivery of targeted savings cannot be currently be provided but will be reported to the next and all future IJB meetings.

NHS Borders – Devolved Budget Efficiencies (Ringfenced Funding)

4.7 Within the budget delegated to the partnership by NHS Borders, a further gap of **£0.471m** was delegated in respect of reductions in ringfenced grant funding through NHS Borders by the Scottish Government. At the IJB meeting of 20 June, the partnership approved direction of £220k of social care funding to mitigate the forecast reduction allocated to the Alcohol and Drug Partnership (ADP), with a further plan for efficiencies of £51k having been developed by the partnership. This arrangement is non-recurring and only applies in 2016/17 with the expectation that the full £271k reduction will be addressed in full by the partnership by 2017/18.

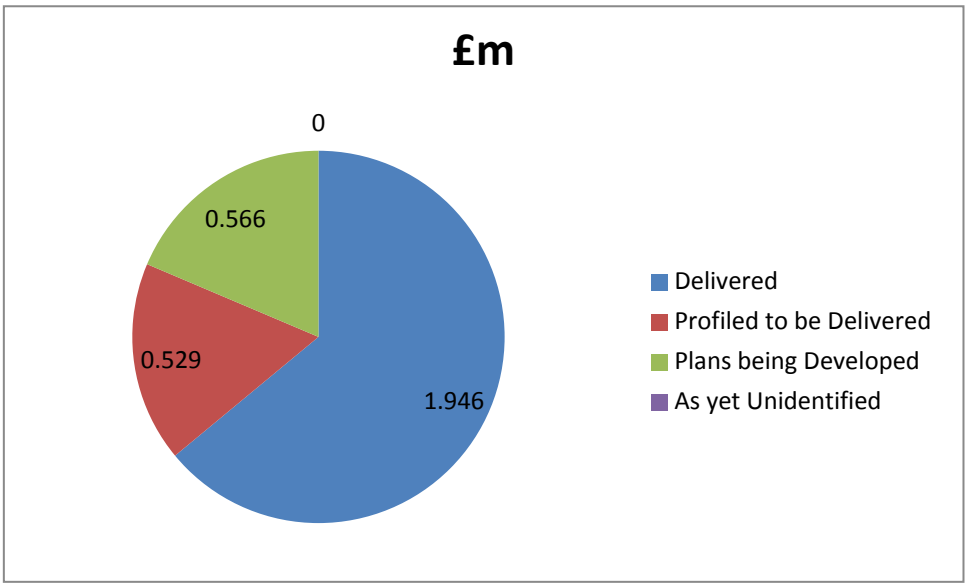
4.8 Beyond the ADP reduction, plans are being developed in partnership between NGS Borders and IJB officers to address the remaining savings gap of **£0.200m** which again is highlighted to the board requires urgent addressing. A summary therefore of the 2016/17 ringfenced grant savings / funding delivery is detailed below:



Scottish Borders Council – Devolved Budget Efficiencies

4.9 Within the budget delegated to the partnership, Scottish Borders Council requires to deliver **£2.663m** of efficiency savings all of which are on a recurring basis. On top of this there is an additional recurring **£378k** saving to be made, carried forward from 2015/16, where this saving was made by non-recurring means, a total target of **£3.041m**. At 30 June 2016, a total of **£1.946m** has been delivered.

4.10 Of the remaining **£1.095m** gap (including carry-forward), **£529k** is profiled for delivery over the remainder of the year. Total efficiency savings therefore of **£2.475m** have been or are in the process of being delivered. Additionally, plans are in development currently to deliver the remaining **£566k**, including utilisation of ICF and Social Care Funding.



4.11 A further report will be brought to the next IJB with regard to financial risk arising from any proposed efficiency and savings plans, in terms of non-delivery and following joint discussions between IJB, NHS Borders and Scottish Borders Council officers, recommendations will be made to the board in regard to remedial action to mitigate this risk.

Remediation of Social Care Pressures – Proposed Direction of Social Care Funding

5.1 As outlined in 3.4 – 3.6 above, inherent within the projected partnership position are a range of un/under-budgeted additional pressures. These can be broadly summarised as:

- Increases in 2016/17 care-provider rates not related to the implementation of the living wage
- Additional non-living wage related COSLA Residential Care Home contract uplift
- Increased demand for services / client numbers / package complexity beyond assumed financial planning levels
- Housing with Care demand exceeding budget
- A range of emerging pressures within Generic Services

5.2 The Scottish Borders Health and Social Care Partnership was allocated £5.267m social care funding on a recurring basis by the Scottish Government from 1st April 2016. A copy of the letter from the Deputy First Minister to local authorities in regard to the funding allocation and its intended use is detailed in **Appendix 2** for information.

Approved Direction of Social Care Funding to Date

5.3 At the 20 June meeting, the Integration Joint Board approved direction of part of this resource for 2016/17 and future financial years, in line with the terms of the Deputy First Minister's letter to partnerships on how the funding should be used. This direction related to:

	Year £'000	2016/17 £'000
Living Wage	1,626	813
Current Demographic Pressures	1,081	1,081
Change to Charging Threshold	154	154
Non-recurring transitional ADP funding	0	220
	2,861	**2,268**

5.4 By directing these resources, the remaining uncommitted social care funding allocation has reduced to **£2.999m** in 2016/17 and **£2.406m** in future years.

Requirement for Further Direction of Social Care Funding

5.5 Each area of further pressure summarised in 4.1 has been reviewed, evidenced and costed and the financial impact of each has been summarised below. In total, they amount to permanently recurring social care pressures of **£1.427m**:

	2016/17 £'000
Non-living wage provider rate increases for 2016/17	955
Additional non-living wage COSLA RCH uplift	172
AWLD Increased Demand	200
Demand for Housing with Care above block contract	100
	1,427

Provider rate increases

5.6 Since 2016/17 Financial Plans were approved, a number of social care providers have increased contract rates for the provision of social care services in the new financial year, over and above what the cost of implementing the living wage will be from 1st October. These are entirely market-driven cost increases across all care services, partly resulting from the new care at home contract tender for Older People, negotiations with other providers, particularly those providing services to Adults with Learning Disabilities and contract uplift agreements with SB Cares, the local authority's largest provider and care provider of last resort.

Additional non-living wage COSLA RCH uplift

5.7 As part of the financial planning process, it has been traditionally assumed that the COSLA-imposed uplift to the residential care home contract will generally be made at the level of inflation at the current time. At the time of setting the plan, the Consumer Price Index was 0.5% which formed the uplift assumption. Following approval of the plan however, COSLA wrote out to all local authorities proposing an initial uplift of 2.9% from April 2016 and a further increase from 1st October 2016, the latter specifically relating to the implementation of the living wage of 3.4%. This pressure relates to the non-living wage element and the full-year impact of the 2.9% initial uplift above the assumed level. The latter living wage impact was considered as part of the direction approved by the IJB on the 20 June 2016.

Increased Demand for AWLD care

5.8 The cost of caring for an additional number of clients in transition from Children's services to young adulthood is now projected to exceed the level of budget available and historic demographic growth invested into the service. To be affordable, based on the projected cost of named individual clients for 2016/17, it has been calculated that a further £200k of additional demographic budget is required.

Housing with Care

Scottish Borders Council commissions Housing with Care provision from a range of registered social landlords. As the service has grown, block contracts with a number of providers have now been maximised and in some cases, exceeded. The current level of service provision in terms of the cost/volume of hours delivered is projected to cost an additional £100k above existing budget provision.

5.9 In his letter to partnerships, the Deputy First Minister stated that the intended use of social care funding should, amongst other things, target helping meet a range of existing costs faced by local authorities and expand capacity to accommodate growth in demand for services as a consequence of demographic change. The view is held therefore that further direction of social care funding to meet these pressures by the IJB is not only legitimate therefore, but wholly required.

5.10 If the board agree to allocate further social care funding as proposed, this will reduce the overall level of uncommitted resource remaining to **£1.572m** in 2016/17 and **£0.979m** in future years. In any further direction of the remaining resource, the IJB must retain awareness that a further **£0.813m** will be required to fund the full-year impact of the living wage implementation (noting that £220k has already been directed on a non-recurring basis for 2016/17).

Uncommitted Social Care Funding

5.11 In addition to the four areas where it has been recommended that social care funding should be directed (5.4-5.9 above), further areas of potentially imminent financial pressure across both the partnership's delegated budget and the large hospital set-aside budget require to be recognised. These relate to:

- Transition from a nightly Night Support rate payment to hourly payment as a result of further emerging impacts of the Employment Tribunal verdict
- The potential requirement to ensure all personal assistants of clients currently in receipt of a self-directed support Direct Payment are paid the living wage with effect from 1st October 2016
- The risk potential for emerging high-value financial pressure within GP Prescribing
- Ongoing pressure within NHS Borders as a result of the demand-led requirement to continue surge bed availability, flex beds, increased demand / acuity of need driving additional costs across the Borders General Hospital and delayed discharge

Delegated Budget:

Transition from a nightly Night Support rate

5.12 Transition from a nightly Night Support rate payment to hourly payment as a result of further emerging impacts of the Employment Tribunal verdict will place a further and possibly considerable financial pressure. Work is ongoing to identify and cost the implications of this, but initial scoping shows historic nightly rates to be considerably less than the costs of an hourly rate (at a minimum or living wage) x number of hours.

Direct Payment Personal Assistants

5.13 The potential requirement to ensure all personal assistants of clients currently in receipt of a self-directed support Direct Payment are paid the living wage with effect from 1st October 2016 will increase the overall costs of the living wage implementation. Currently, the need to do so is not formally part of the social care funding settlement and partnerships will not be held to account for failure to do so, but the Deputy First Minister's letter states that if this is not implemented, then authorities may face challenge on equality grounds. Work has commenced to identify the potential financial impact of this.

GP Prescribing

5.14 In 2015/16, the highest area of risk and financial pressure across the aligned budget was within GP Prescribing where an adverse position of £1.2m was experienced. This was primarily due to specific volatile and escalating pharmaceutical costs and in particular, market prices of new drugs. This is likely to be an area of ongoing pressure financially and will require to be rigorously monitored and where further pressures do arise, further mitigation will be required.

Large Hospital Set-Aside Budget:

NHS Borders large-hospital pressures

5.15 The change in demography and the increasing complexity of care required is well documented, as is the resultant impact on the whole system. The Health and Social Care Partnership Strategic Plan has an emphasis on improving the whole pathway of care. However, there are stages along that pathway where the interdependencies between health and social care are particularly complex, which can lead to specific tensions and difficulties for people and for the relevant services.

5.16 Patient flow through the hospital following the admission of an older person with complex care is one area where there can be a significant impact on the hospital if there are issues with delays in discharge including increased bed occupancy, impact on the ability to admit for care, impact on A and E and boarders. These result in additional financial pressure such as flex beds so, as an IJB, we will consider how best to ensure the costs are managed across the system.

5.17 At the current time, the financial impact of over 20 delayed discharge beds is considerably compounded by approximately 5 flex beds and all surge beds being open over the majority of the financial year to date, in addition to those costs driven by the need to meet increased demand and acuity of need across hospital wards, Accident & Emergency and Acute Admissions Unit totalling pressures beyond budget of over £1.0m for the first quarter of the financial year. This will form a key

element of a further report brought to the next IJB on all partnership pressures and potential remedial actions.

5.18 In addition, the aspiration to fulfil all directions by the Scottish Government in terms of how the additional funding to partnerships may be used and in particular, in supporting additional spend on expanding social care to support the objectives of integration (i.e. additionality) and not just meet existing or emerging pressures requires consideration. Specifically, using any remaining resources to assist in funding the transition to, and mainstreaming of, new models of health and social care in the Scottish Borders should be an aim of the partnership.

5.19 Information is still being collected and analysed in relation to the above issues and when this work is complete and the projected financial impact known and evidenced, then a further report will be brought to the board in due course. Partners are working together to identify in full the impact of these emerging financial risks and following joint discussions and planning, recommendations will be made to the board in terms of the implementation of appropriate solutions, which may include a range of measures including further direction of social care funding and/or further remedial savings measures.

Next Steps

6.1 The budget supporting the functions delegated to the partnership, without further direction of social care funding, is under considerable pressure already during 2016/17. Further discussions are underway in relation to the pressures identified in 5.10 above and how they can be mitigated, either by the identification of further remedial savings or further targeted use of other funding tools such as Integrated Care Fund or social care funding to facilitate change.

6.2 These pressure will be fundamentally compounded however, if a robust plan for the achievement in full of the level of efficiencies (**£7.373m**) is not put in place and delivered. In order to mitigate the impact of any area of non-delivery, the Chief Officer is now considering a number of remedial actions across delegated functions, in conjunction with key NHS Borders and Scottish Borders Council officers. Working together, a number of discussions will now take place in order to develop a plan for the delivery of further savings. Following this, at the next meeting of the IJB, specific directions to facilitate recovery to a balanced budget will be reported to the IJB for approval.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and the monitoring position on the partnership's 2016/17 revenue budget.

The Health & Social Care Integration Joint Board is asked to **approve** the further direction of £1.427m recurrent social care funding to meet the further additional pressures outlined in paragraphs 5.5 to 5.10

The Health & Social Care Integration Joint Board is asked to **note** that the partnership's Chief Officer and Chief Financial Officer are working in partnership with NHS Borders' Director of Finance, Scottish Borders Council's Chief Financial Officer and other senior managers across delegated services, in order to identify and implement a remedial action

plan to mitigate the residual reported pressure within Generic Services and to address identified non-delivery of efficiency and other savings within partners' Financial Plans.

Policy/Strategy Implications	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	The report has been considered by the Executive Management team and approved by NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer in terms of factual accuracy. Both partner organisations have contributed to its development and will work closely with IJB officers in delivering its outcomes.
Risk Assessment	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.
Compliance with requirements on Equality and Diversity	There are no equalities impacts arising from the report.
Resource/Staffing Implications	No resourcing implications beyond the financial resources identified within the report.

Approved by

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

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer IJB		

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget | **2016/17** | **AT END OF MTH: June**

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,268**	**4,495**	**3,410**	**1,085**	**18,591**	**19,101**	**-510**	**52**	**20**	**20**	
Joint Mental Health Service	**15,977**	**3,728**	**3,775**	**-47**	**15,995**	**15,991**	**4**	**352**	**316**	**315**	
Joint Alcohol and Drug Service	**948**	**149**	**127**	**22**	**948**	**948**	**0**	**3**	**3**	**3**	
Older People Service	**28,126**	**5,674**	**6,648**	**-974**	**27,344**	**28,010**	**-666**	**23**	**0**	**0**	
Physical Disability Service	**3,180**	**825**	**598**	**227**	**3,208**	**3,315**	**-107**	**0**	**0**	**0**	
Generic Services	**72,651**	**18,734**	**18,592**	**142**	**73,064**	**73,218**	**-154**	**604**	**516**	**520**	
Total	**139,150**	**33,605**	**33,150**	**455**	**139,150**	**140,583**	**(1,433)**	**1034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	11,417	10,776	641	51,798	53,231	(1,433)				
NHS Funding from Sgovt etc	87,352	22,188	22,374	(186)	87,352	87,352	0				
Total	**139,150**	**33,605**	**33,150**	**455**	**139,150**	**140,583**	**(1,433)**				

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget | **2016/17** | **AT END OF MTH: June**

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,268**	**4,495**	**3,410**	**1,085**	**18,591**	**19,101**	**-510**	**52**	**20**	**20**	
Residential Care	4,181	1,020	1,210	-190	4,182	4,215	-33	0	0	0	
SBC Carers	0	0	0	0	0	0	0	0	0	0	
Homecare	2,582	910	513	397	4,154	4,604	-450	0	0	0	
Day Care	2,091	485	54	431	2,096	2,113	-17	3	0	0	
Community Based Services	7,139	1,506	1,084	422	5,821	5,805	16	0	0	0	
Respite	200	42	56	-14	201	233	-32	0	0	0	
Other	2,075	532	493	39	2,137	2,131	6	49	20	20	
Joint Mental Health Service	**15,977**	**3,728**	**3,775**	**-47**	**15,995**	**15,991**	**4**	**352**	**316**	**315**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	190	43	14	29	187	230	-43	0	0	0	
Day Care	186	46	33	13	186	181	5	5	0	0	
Community Based Services	788	43	144	-101	700	657	43	0	0	0	
Respite	15	4	4	0	16	3	13	0	0	0	
SDS	102	27	45	-18	110	149	-39	0	0	0	
Mental Health Team	14,696	3,543	3,518	25	14,728	14,703	25	347	316	315	
Choose Life	0	22	17	5	68	68	0	0	0	0	
Joint Alcohol and Drug Service	**948**	**149**	**127**	**22**	**948**	**948**	**0**	**3**	**3**	**3**	
D & A Commissioned Services	820	121	99	22	820	820	0	0	0	0	
D & A Team	128	28	28	0	128	128	0	3	3	3	
Older People Service	**28,126**	**5,674**	**6,648**	**-974**	**27,344**	**28,010**	**-666**	**23**	**0**	**0**	
Residential Care	11,422	2,162	409	1,753	11,518	11,717	-199	0	0	0	
Homecare	8,025	1,742	202	1,540	7,276	7,605	-329	0	0	0	
Day Care	1,001	232	-33	265	998	1,008	-10	0	0	0	
Community Based Services	999	350	330	20	2,164	2,481	-317	16	0	0	
Extra Care Housing	545	135	-220	355	541	558	-17	0	0	0	
Housing with Care	409	102	82	20	409	492	-83	0	0	0	
Dementia Services	37	-217	13	-230	-95	-95	0	0	0	0	
Delayed Discharge	267	14	107	-93	267	262	5	0	0	0	
Other	5,421	1,154	5,758	-4,604	4,266	3,982	284	7	0	0	
Physical Disability Service	**3,180**	**825**	**598**	**227**	**3,208**	**3,315**	**-107**	**0**	**0**	**0**	
Residential Care	566	71	71	0	506	278	228	0	0	0	
Homecare	1,747	429	204	225	1,528	1,531	-3	0	0	0	
Day Care	201	50	-2	52	200	200	0	0	0	0	
Community Based Services	666	275	325	-50	974	1,306	-332	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget | **2016/17** | **AT END OF MTH: June**

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**72,651**	**18,734**	**18,592**	**142**	**73,064**	**73,218**	**(154)**	**604**	**516**	**520**	
Community Hospitals	4,802	1,149	1,239	-90	4,802	4,802	0	115	122	123	
GP Prescribing	22,436	5,534	5,634	-100	22,436	22,436	0	0	0	0	
AHP Services	5,658	1,408	1,480	-72	5,658	5,658	0	144	139	140	
General Medical Services	16,933	4,102	4,102	0	16,933	16,933	0	4	4	4	
Community Nursing	4,387	1,084	1,069	15	4,387	4,387	0	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	69	0	0	
SB Carers	0	0	0	0	0	0	0	0	0	0	
BAES	732	214	64	150	730	730	0	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	56	14	0	14	56	53	3	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	(107)	(110)	3	0	0	0	0	0	0	
OT	0	0	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	11	9	2	43	34	9	0	0	0	
Out of Hours	2,131	542	502	40	2,131	2,131	0	0	0	0	
Community Based Services	0	8	23	(15)	115	257	(142)	0	0	0	
Sexual Health	558	153	147	6	558	558	0	7	6	6	
Public dental Services	3,324	965	902	63	3,324	3,324	0	78	78	79	
Community Pharmacy Services	3,933	1,006	1,006	0	3,933	3,933	0	0	0	0	
Continence Services	441	112	110	2	441	441	0	3	3	3	
Smoking Cessation	209	62	51	11	209	209	0	4	5	5	
Primary & Community Management	1,684	366	482	(116)	1,684	1,684	0	34	44	42	
Health Promotion	438	102	90	12	438	438	0	8	12	12	
Opthalmic Services	1,591	408	408	0	1,591	1,591	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	0	0	0	0	0	0	0	0	0	0	
Resource Transfer	2,609	652	651	1	2,609	2,609	0	0	0	0	
Other	5,243	949	733	216	5,543	5,567	(24)	28	0	0	
Health and Social Care Fund	0	0	0	0	0	0	0	0	0	0	
Savings	(4,557)	0	0	0	(4,557)	(4,557)	0	0	0	0	
Total	**139,150**	**33,605**	**33,150**	**455**	**139,150**	**140,583**	**(1,433)**	**1,034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	11,417	10,776	641	51,798	53,231	(1,433)				
NHS Funding from Sgovt etc	87,352	22,188	22,374	(186)	87,352	87,352	0				
Total	**139,150**	**33,605**	**33,150**	**455**	**139,150**	**140,583**	**(1,433)**				

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Healthcare) | **2016/17** | **AT END OF MTH: June**

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**3,599**	**905**	**931**	**(26)**	**3,599**	**3,599**	**0**	**20**	**20**	**20**	
Residential Care	2,689	672	704	(32)	2,689	2,689	0	0	0	0	
SB 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	910	233	227	6	910	910	0	20	20	20	
Joint Mental Health Service	**14,015**	**3,418**	**3,347**	**71**	**14,015**	**14,015**	**0**	**327**	**316**	**315**	
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	14,015	3,418	3,347	71	14,015	14,015	0	327	316	315	
Joint Alcohol and Drug Service	**749**	**88**	**88**	**0**	**749**	**749**	**0**	**3**	**3**	**3**	
D & A Commissioned Services	621	60	60	0	621	621	0	0	0	0	
D & A Team	128	28	28	0	128	128	0	3	3	3	
Older People Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Housing with Care	0	0	0	0	0	0	0	0	0	0	
Dementia Services	0	0	0	0	0	0	0	0	0	0	
Delayed Discharge	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	
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	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Healthcare) | **2016/17** | **AT END OF MTH: June**

	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	**68,989**	**17,777**	**18,008**	**(231)**	**68,989**	**68,989**	**0**	**507**	**516**	**520**	
Community Hospitals	4,802	1,149	1,239	(90)	4,802	4,802	0	115	122	123	
GP Prescribing	22,436	5,534	5,634	(100)	22,436	22,436	0	0	0	0	
AHP Services	5,658	1,408	1,480	(72)	5,658	5,658	0	144	139	140	
General Medical Services	16,933	4,102	4,102	0	16,933	16,933	0	4	4	4	
Community Nursing	4,387	1,084	1,069	15	4,387	4,387	0	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	250	61	64	(3)	250	250	0	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	2,131	542	502	40	2,131	2,131	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Sexual Health	558	153	147	6	558	558	0	7	6	6	
Public dental Services	3,324	965	902	63	3,324	3,324	0	78	78	79	
Community Pharmacy Services	3,933	1,006	1,006	0	3,933	3,933	0	0	0	0	
Continence Services	441	112	110	2	441	441	0	3	3	3	
Smoking Cessation	209	62	51	11	209	209	0	4	5	5	
Primary & Community Management	1,684	366	482	(116)	1,684	1,684	0	34	44	42	
Health Promotion	438	102	90	12	438	438	0	8	12	12	
Opthalmic Services	1,591	408	408	0	1,591	1,591	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	0	0	0	0	0	0	0	0	0	0	
Resource Transfer	2,609	652	651	1	2,609	2,609	0	0	0	0	
Other	2,162	71	71	0	2,162	2,162	0	0	0	0	
Health and Social Care Funding	0	0	0	0	0	0	0	0	0	0	
Savings	(4,557)	0	0	0	(4,557)	(4,557)	0	0	0	0	
Total	**87,352**	**22,188**	**22,374**	**(186)**	**87,352**	**87,352**	**0**	**857**	**854**	**857**	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Social Care) | **2016/17** | **AT END OF MTH: June**

Scottish Borders Health and Social Care PARTNERSHIP

	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
Joint Learning Disability Service	**14,669**	**3,590**	**2,479**	**1111**	**14,992**	**15,502**	**(510)**	**32**	
Residential Care	1,492	348	506	(158)	1,493	1,526	(33)	0	
SB Cares	0	0	0	0	0	0	0	0	
Homecare	2,582	910	513	397	4,154	4,604	(450)	0	
Day Care	2,091	485	54	431	2,096	2,113	(17)	3	
Community Based Services	7,139	1,506	1,084	422	5,821	5,805	16	0	
Respite	200	42	56	(14)	201	233	(32)	0	
AWLD Staff Teams	1,165	299	266	33	1,227	1,221	6	29	
Joint Mental Health Service	**1,962**	**310**	**428**	**-118**	**1,980**	**1,976**	**4**	**25**	
Residential Care	0	0	0	0	0	0	0	0	
Homecare	190	43	14	29	187	230	(43)	0	
Day Care	186	46	33	13	186	181	5	5	
Community Based Services	788	43	144	(101)	700	657	43	0	
Respite	15	4	4	0	16	3	13	0	
SDS	102	27	45	(18)	110	149	(39)	0	
MH Staff Teams	681	125	171	(46)	713	688	25	20	
Choose Life	0	22	17	5	68	68	0	0	
Joint Alcohol and Drug Service	**199**	**61**	**39**	**22**	**199**	**199**	**0**	**0**	
Drug and Alcohol Commissioned Services	199	61	39	22	199	199	0	0	
Drug and Alcohol Team	0	0	0	0	0	0	0	0	
Older People Service	**28,126**	**5,674**	**6,648**	**(974)**	**27,344**	**28,010**	**(666)**	**23**	
Residential Care	11,422	2,162	409	1753	11,518	11,717	(199)	0	
Homecare	8,025	1,742	202	1540	7,276	7,605	(329)	0	
Day Care	1,001	232	-33	265	998	1,008	(10)	0	
Community Based Services	999	350	330	20	2,164	2,481	(317)	16	
Extra Care Housing	545	135	-220	355	541	558	(17)	0	
Housing with Care	409	102	82	20	409	492	(83)	0	
Dementia Services	37	-217	13	(230)	-95	-95	0	0	
Delayed Discharge	267	14	107	(93)	267	262	5	0	
OP Staff Teams	847	261	176	85	882	815	67	7	
Other	4,574	893	5582	(4689)	3,384	3167	217	0	
Physical Disability Service	**3,180**	**825**	**598**	**227**	**3,208**	**3,315**	**(107)**	**0**	
Residential Care	566	71	71	0	506	278	228	0	
Homecare	1,747	429	204	225	1,528	1,531	(3)	0	
Day Care	201	50	-2	52	200	200	0	0	
Community Based Services	666	275	325	(50)	974	1,306	(332)	0	
Other	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Social Care) | **2016/17** | **AT END OF MTH: June**

	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	**3,662**	**957**	**584**	**373**	**4,075**	**4,229**	**-154**	**97**	
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	0	0	0	0	0	0	0	0	
Group Managers	0	0	0	0	0	0	0	0	
Service Managers	0	0	0	0	0	0	0	0	
Planning Team	0	0	0	0	0	0	0	0	
Locality Offices	0	0	0	0	0	0	0	69	
SB Cares	0	0	0	0	0	0	0	0	
BAES	482	153	0	153	480	480	0	0	
Duty Hub	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	14	0	14	56	53	3	0	
Respite	0	0	0	0	0	0	0	0	
SDS	0	-107	(110)	3	0	0	0	0	
OT	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	11	9	2	43	34	9	0	
Out of Hours	0	0	0	0	0	0	0	0	
Community Based Services	0	8	23	-15	115	257	-142	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	
GS Staff Teams	3,515	918	835	83	3,410	3,399	11	0	
Other	(434)	(40)	(173)	133	(29)	6	-35	28	
Total	**51,798**	**11,417**	**10,776**	**641**	**51,798**	**53,231**	**-1,433**	**177**	

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Deputy First Minister and Cabinet Secretary for Finance, Constitution and Economy
John Swinney MSP

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The Scottish Government
Riaghaltas na h-Alba

LEGACY 2014
XX COMMONWEALTH GAMES
SCOTLAND

Councillor David O'Neill
President
COSLA
Verity House
19 Haymarket Yards
Edinburgh
EH12 5BH

Copy to: The Leaders of all Scottish local authorities

27 January 2016

Dear David

I write now to confirm the final details of the Local Government Finance settlement for 2016-17, following the conclusion of our partnership discussions to consider the package of measures contained in my initial letter of 16 December 2015.

This funding package is focussed on delivery of our joint priorities to deliver sustainable economic growth, protect front-line services and support the most vulnerable in our society.

I have considered the representations made to me by COSLA and this is reflected in the detail of the settlement and the package of measures included in this letter. My aim throughout our extensive discussions has been to reach an agreement with councils around the implementation of these commitments. I invite local authorities to agree the terms of the settlement.

The measures set out in the settlement offer must be viewed as a package to protect shared priorities and intensify a journey of reform. In order to access all of the funding involved, of £408 million, local authorities must agree to deliver all of the measures set out below and will not be able to select elements of the package.

Integration Fund

The offer being made is 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. 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.

Teacher Numbers

The Scottish Government has been consistent that the protection of teacher numbers is a central part of our priority to raise attainment. Following our discussions and the further representations COSLA has made, the Scottish Government have agreed that the measure for the implementation of that target, against a forecast that pupil numbers will increase over the coming academic year, will be the maintenance at a national level of the pupil teacher ratio.

The objective will be to maintain the pupil teacher ratio nationally at a value of 13.7 (the same level as in 2015) in local authority schools as shown in the Teacher and Pupil Census published in December 2016 and the teacher and probationer commitments in 2016-17. In order to support delivery, the Scottish Government will continue to monitor these commitments throughout the year.

Council Tax Freeze

The Scottish Government was elected on a commitment to freeze the council tax for the entirety of this Parliamentary session and is committed to delivering this policy. Many local authorities have a commitment to freeze the Council Tax over a similar timescale. Against the questions of the wider revenue-raising challenges raised in the Budget the Scottish Government believes that it is important to provide protection for household incomes in what has been a very financially challenging period for many households.

The Scottish Government has now received the report from the Commission on Local Tax Reform and the Government believes now is not the time to dispense with the protection the freeze offers. Looking ahead we will be bringing forward plans for reform of the present Council Tax, reflecting the principles of the report, and we are committed to working in partnership with local government on the implementation of that.

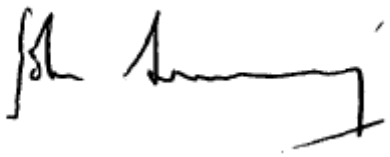
For 2016-17 individual local authorities will again require to agree to work with the Scottish Government to deliver a council tax freeze for the ninth consecutive year.

Any council that does not sign up to the complete package will not receive their share of the Integration Funding (£250 million), support for teachers (£88 million) and the council tax freeze support (£70 million). Should that be the case, steps will be taken to recover the latter two elements that have been distributed from the individual council's allocations in the local government finance settlement in-year.

If in the event, however, a council that does sign up then does not deliver any of the remaining specific commitments on council tax freeze, social care spend, including delivery of the £8.25 per hour Living Wage or national teacher targets then the Scottish Government reserves its position to take action to remove access to or recover that element of the additional funding support earmarked to deliver each of the remaining specific measures. In the case of pupil teacher ratio not being maintained nationally then the Scottish Government reserves its position to recover monies allocated to individual authorities whose pupil teacher ratio rises. This action will be proportionate and apply only to that element of the funding for a specific measure that a local authority subsequently does not deliver as set out in the paragraph above.

I will require those Council Leaders who intend to take up the offer and agree the full package of measures to write to me to set out their position, including on the council tax. Given that I am setting out changes to the proposals we previously discussed, I want to give local authorities every opportunity to consider these issues in full. Leaders should therefore provide their response to me by no later than Tuesday 9 February 2016.

I fully understand the pressures on budgets, which is being felt across the whole of the public sector, but I firmly believe that the funding proposals I have set out for local government protects our shared priorities and delivers practical financial support to intensify the pace of reform. I hope you and your fellow Council Leaders can agree that in the circumstances the proposals deliver a strong but challenging financial settlement. The key to addressing this challenge is reform and local government is a key partner in our programme to reform and improve public services.



JOHN SWINNEY

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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 In July Gwyneth Johnstone was appointed as the Group Manager for Social Work. Gwyneth has operational responsibility for the local social work teams previously managed by Jane Douglas. Murray Leys has been appointed on an interim basis as a senior manager in the social work service to work on service redesign and commissioning

3.2 23 June: Attended a national event looking at the strategic issues facing primary Care across the country with a specific focus on the transformation fund being made available to Partnerships.

3.3 6 July: A meeting with senior colleagues in the Scottish Government and the NHS and Council to discuss issues relating to Delayed Discharges. Key action and will be included in our action plan.

3.4 Associate Director for AHPs Karen McNicoll left her post in early August to take up a General Management role in Highland. Anne Suttle is acting into the post as we look to review the role. This is a joint post across health and social care.

3.5 In July meeting were held with key representative of the third sector to consider how to maximise joint working. It was agreed that this will come back to a future development session for discussion and with a formal proposal to the IJB later in the year.

Recommendation

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

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

Resource/Staffing Implications	As detailed within the report.

Approved by

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

Author(s)

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

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**

Meeting	Date, Time and Venue	Session Items
H&SC Integration Joint Board	Monday 20 June 2016 2pm – 4pm Board Room Newstead **(1pm to 2pm Networking Lunch – Discussion on Localities)**	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) 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) ELAINE TORRANCE**	Chief Officer Report (Susan M) Monitoring Integration Joint Budget 16/17 (Paul M) GP Contract Update and Cluster approach (Annabel Howell/Angus McVean) ICF Update and Proposals (Paul McMenamin) Public Governance Arrangements - Public partnership Forum (Susan M) Update on prescribing (Alison Wilson/Annabel Howell) Performance Framework (Steph Errington/June Smyth/Sandra Campbell)
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) CATHY FANCY**	Chief Officer Report (Susan 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) Draft Winter Plan 2016/17 (For info as awaiting approval by NHS Borders on 27.10.16 - Philip Lunts) Third Sector Interface (Jenny Miller) Corporate Plan (Sandra Campbell) Update on ICT (Sandra Campbell) Staff Governance Arrangements – Joint Staff Forum (Susan M) Delayed Discharges (Alasdair Pattinson) Annual Accounts (Paul M) Scottish Borders Professional Assurance Framework (Evelyn, Elaine, Andrew)
H&SC Integration Joint	Monday 21 November 2016	**Berwickshire Locality – THIRD SECTOR INTERFACE - Listen to staff,**

Meeting	Date, Time and Venue	Session Items
Board **Development Session**	9.30am – 4.00pm Eyemouth	**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) 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 (discussion) (Susan M/Alasdair P) Train to Care (discussion) (June S) Winter Plan 2016/17 (approved version for noting) Alcohol & Drug Partnership Funding 2017/18 (Tim Patterson) Scottish Borders Autism Strategy Update (Simon Burt) Draft Mental Health Strategic Plan (Simon Burt) Update on Dementia Services (Simon Burt/Murray Leys)
H&SC Integration Joint Board **Development Session**	30 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	27 February 2017	Chief Officer Report (Susan 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**	27 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**
H&SC Integration Joint Board	24 April 2017	Chief Officer Report (Susan M) Monitoring Integration Joint Budget 17/18 (Paul M) Code of Corporate Governance – Annual Refresh
H&SC Integration Joint Board Development Session	29 May 2017 9.30am – 4.00pm	
H&SC Integration Joint Board	26 June 2017	Chief Officer Report (Susan M) Monitoring Integration Joint Budget 17/18 (Paul M) Communications Quarterly Report (Carin P) Annual Accounts (Paul M)

Meeting	Date, Time and Venue	Session Items
H&SC Integration Joint Board	28 August 2017	Chief Officer Report (Susan M) Monitoring Integration Joint Budget 17/18 (Paul M)
H&SC Integration Joint Board Development Session	25 September 2017 9.30am – 4.00pm	
H&SC Integration Joint Board	23 October 2017	Chief Officer Report (Susan M) Monitoring Integration Joint Budget 17/18 (Paul M) Communications Quarterly Report (Carin P) Draft Winter Plan 2017/18 (Susan M)
H&SC Integration Joint Board Development Session	27 November 2017 9.30am – 4.00pm	
H&SC Integration Joint Board	18 December 2017	Chief Officer Report (Susan M) Monitoring Integration Joint Budget 17/18 (Paul M)
H&SC Integration Joint Board Development Session	January 2018	

DELAYED DISCHARGES

Aim

1.1 To provide the Health & Social Care Integration Joint Board with the Delayed Discharges presentation given to the Borders NHS Board on 4 August 2016.

Background

2.1 The presentation highlights:

- Introduction and context of current performance
- Changes to both definition and reporting from 1st July 2016
- 2016 Performance to date
- What has been done to improve performance and achieve the new targets (1st July)
- Review of the Action Plan and what is to happen next

Recommendation

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

Policy/Strategy Implications	As per the presentation
Consultation	As per the presentation
Risk Assessment	As per the presentation
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	As per the presentation

Approved by

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

Author(s)

Name	Designation	Name	Designation
Alasdair Pattinson	General Manager Primary & Community Services	Warwick Shaw	Head of Delivery Support

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Delayed Discharges Update

Board Development Session

4th August 2016

Aim

To provide to the Board:

- Introduction and context of current performance
- Changes to both definition and reporting from 1st July 2016
- 2016 Performance to date
- What has been done to improve performance and achieve the new targets (1st July)
- Review of the Action Plan and what is to happen next

Introduction

- Delays affect people.
- Delays at any point in Patient pathway are bad for the individual and cause friction in the system.
- Delays to discharge are rarely simple to solve, require imagination, determination and often funding too.

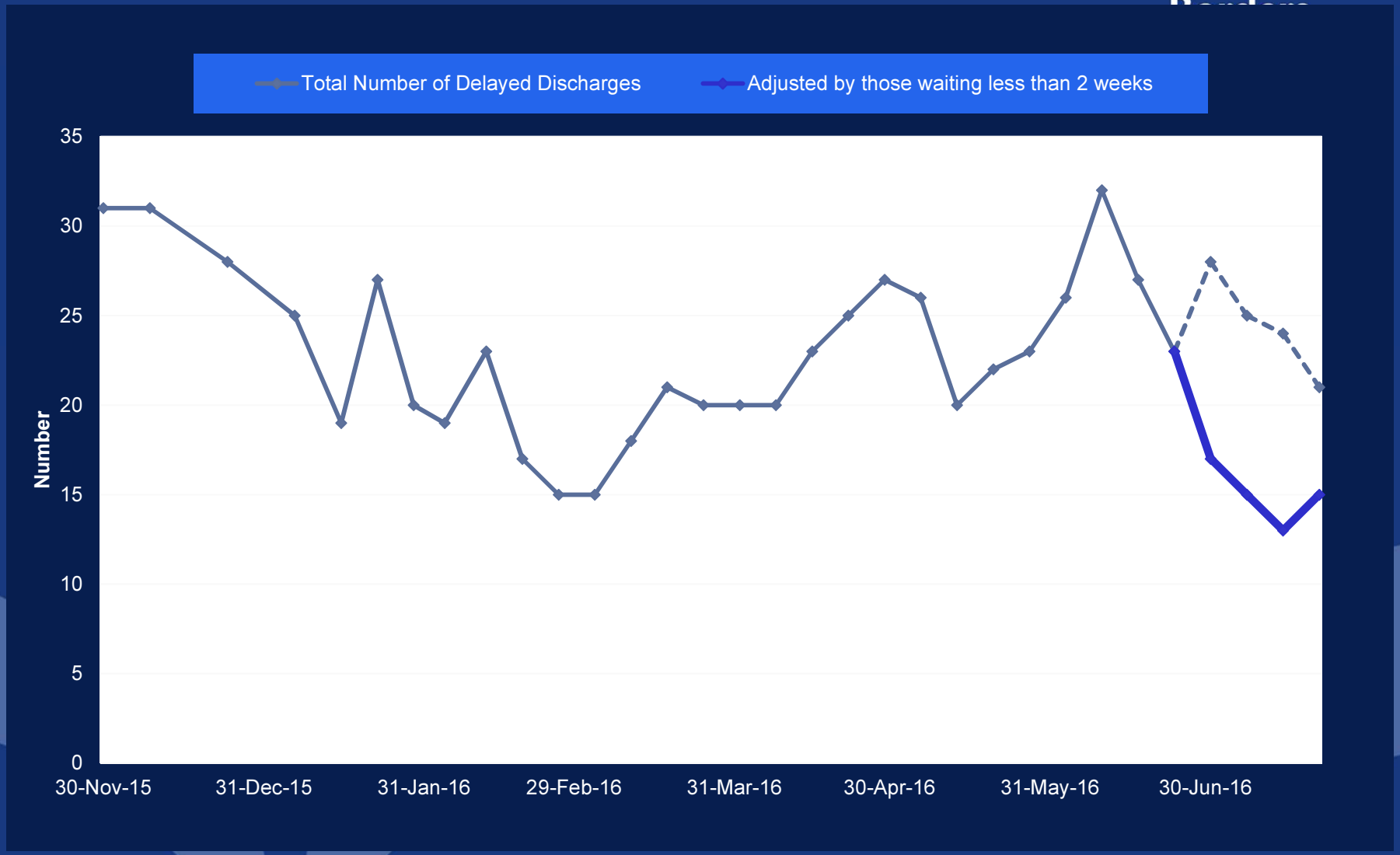
Introduction (2)

- Costs are not just financial.
- It has been an enduring problem.
- Issues and challenges:
  - Reduce admissions
  - Step up/down facilities
  - Knoll medical staffing
  - Surge capacity
  - Flex beds
  - Self Directed Support (SDS)

July Definition Changes

- Why 72 hours?
- Report will not be numbers of DDs but percentage discharged within 72 hrs.
- Metric will become occupied bed days.
- Exclusion of those “for one move only”.
- If unfit for 3 days removed from list and then back on when fit, re-start at 0 days.
- Guardianship and AWIA processes completed the patient will revert to another reason code and delay calculated from new RDD

2016 Performance and effect of excluding those between 72 hrs and 14 days



Action Plan

Already Implemented in 2016

- Reorganisation of membership and purpose of meetings:
  - Joint Operational DD Group – Thursdays
  - Joint Strategic/Escalation Group - Fridays
  - Ongoing daily review at START Hub meeting
- Improved visibility of vacancies in 24hr Care
- Community Hospital weekly Discharge Plans
- JIT facilitated Discharge (Mar) planning session
- Process Mapping session (Aug) 24 participants
- A “Discharge flat” available within Cornmill Court

Short Term (June/July)

Review Rapid Response availability and use	AP and ML Aug
Salt Greens & Waverley and reopening	Waverley October
Focus on CH MDT meetings	
Implement Matching Unit	October
Redesign Discharge Hub meetings	5 PDSA cycles
Host advisory visit from Prof John Bolton	11th August
Revise NHS Discharge Policy and Processes	Review current
Implement 72hr approach	1st July
Visibility of Home Care hours	14th July

Medium Term (September)

Initiatives to reduce admissions: projects, leads and timeframes to be developed	Tim Patterson workstream
Criteria for packages of care and assessments	
Development of Transitional unit at Waverly	October
Communication Plan with Medical, Nursing and AHP staff around revised Discharge Policy and responsibilities	Develop in September
Recycling home care/review small packages	In progress
Continue to review other areas lessons	SG, Lothian and Glasgow

Longer Term ICF Projects

- Community based models of care, in-patient and virtual
- Developing models of care and self care to avoid admission
- Earlier supported Discharges
- Increased uptake of Anticipatory Care Plans

The 72hr Target

NHSB and SBC will work to achieve an initial target of 95% of discharges being achieved within 72hrs by December 2016

Comments and Questions

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EVALUATION OF HEALTH & SOCIAL CARE IJB DEVELOPMENT AWAYDAY – KELSO, MONDAY 23 MAY 2016

Aim

To provide feedback on the evaluation of the Health & Social Care Integration Joint Board following the Development Awayday held on 23 May 2016.

Summary

Elaine Torrance presented on the Social Care & Health Inspection which will take place within the next 6 months.

Susan Manion provided updates on progress so far within integration.

There were also poster presentations on the currently available information specific to Cheviot, showing demographics, statistics and quotes for people through the engagement process.

Cheviot health team - presented on their team and how it works; and the outcomes form a Multidisciplinary team approach to managing people in their own home. They presented facts and figures on service delivery in an enthusiastic way. Questions were taken after this and the discussions were wide ranging and very helpful to people in the audience.

Speaker Highlights - Morning Session:

Elaine Torrance: Health inspection, 12 weeks' notice. Several phases: inspections, research, interviews of staff and patients.

Catriona Bhatia: work to improve our services and identify gaps. This is an opportunity, not a threat.

Susan Manion:

- essential to focus on the opportunity that we have to improve.
- work in partnership, building on what we have and what has happened already
- need to make sure we get the delivery right. How to develop a locality plan to ensure we reach the outcomes as an organisation. How we deliver care at home? We know that part of reducing admissions to hospitals is about how we develop care at home.
- work in partnership with the third and independent sector and with communities. We have to demonstrate that they are truly partners.
- need to understand that localities are not lines on a map, it's about communities and we need to build in enough flexibility to handle that.
- GPs are essential and we need to find out the best way to support them and work with them..

Alasdair Pattinson: Addressing challenges to access services. Link everything up. People are getting frustrated by delays in the system and we know this. We will address these issues. For example, there are many services which are making the same assessments of the same person. We aim to stop that.

Gillian Mitchell, physical therapist, CCHT: CCHT are co-located in the medical practice with GPs Social Care & Health which helps facilitate better working practices and smoother communication, therefore aiding positive response time to patients and improved outcomes.

Jeanette Forbes : Management is important for supervision and education.

Susan Manion: We need to understand the impact over time. We need to identify the baseline to do that.

Catriona Bhatia: Our job is to direct and commission services. If the Board decides that this is the model we are going to use, then that is what we are going to do.

Simon Burt:

- We are in a new world now, and I would like to see an IJB plan that delivers the best services and outcomes
- Locality citizen panels have been in place a year or so and they are doing really well.
- Early intervention model
- Informal communication even without shared management is a step forward.
- We are developing a mental health strategy.
- At the moment, feels like he is reporting to three organisations: the Council, the NHS and the IJB.

Afternoon - Walk and Talk Tour

After lunch, the Localities Co-ordinators led IJB member on a tour of three local facilities:

Kelso Community Hospital

Queens House – Private 32 bedded purpose built care home

Grove House –SB Cares Residential Care home which incorporates the Intermediate care unit

See Appendix D for summaries of each visit

Discussion Points – Afternoon Session

Linda Jackson: We need to get this right. To be seen as partners in care, we still have a ways to go yet.

Angus McVean: Sharing patient information. We are not good at that. There is sharing and there is sharing, but be careful what you wish for. There is info out there that I need to know, but you don't. I hear what you say and I do understand, but there is sharing and there is sharing.

Susan Manion: There are pieces of work going forward on this because it is very important.

Trish Wintrup: How do you replicate the good work? We have to see the whole picture.

Linda Jackson : All our resources are going into firefighting.

Susan Manion: Some things might be about how to bring resources into the system, some things might be to manage them in a different way.

Catriona Bhatia: Sometimes we just need to stop overthinking things.

Susan Manion: We need to think of the whole, not just focus on avoidable admissions and discharges. It is a whole system approach. It's about health and social care teams. Issues connected to reality.

Stewart Barrie: We have started engagement with different key stakeholders. Contacts have been essential. There are commonalities for all localities and there will be differences.

Shona Donaldson: We are building up that 3D picture in order to get a complete picture of what is out there. Let's not reinvent the wheel, let's use the good ideas that are out there. We need to fit those pieces into the jigsaw puzzle. It seems to me that one of the essential parts of this is that the IT systems are not compatible.

Linda Jackson – We are realizing that we are not as well organised as we should be. We need to look at that.

Susan – confirmed in response to Linda that we have some discussions on that. There is the government stuff, but we need to make sure that we use the PPF. They can feed directly into the IJB.

Catriona – Hopefully we can make a difference, some in the short time, and others over the longer term. The time is now.

Appendix A

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD DEVELOPMENT AWAYDAY

Monday 23 May 2016
9.30am – 4.30pm
Lesser Hall, Tait Hall, Kelso, TD5 7BS

ITINERARY

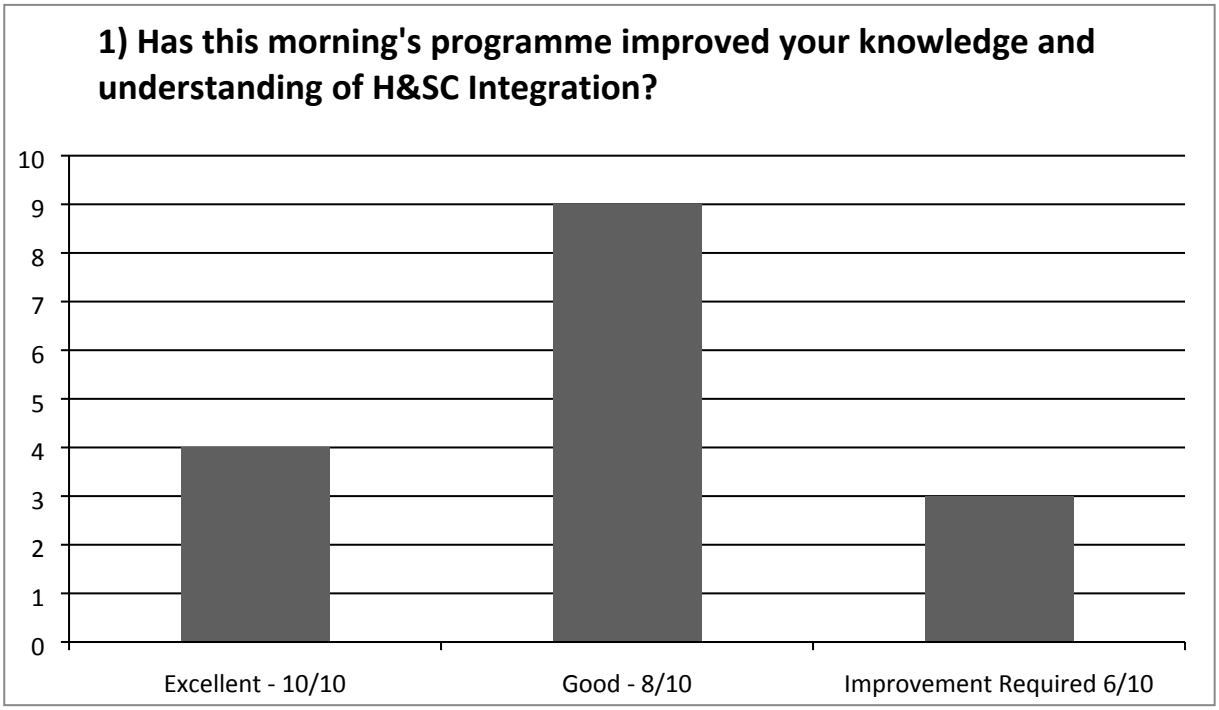
9.15am	Coffee and Welcome	Cllr Catriona Bhatia	
9.30am	Inspection of Adult Services Update	Chief Social Work Officer	Discussion
10.00am	• Localities – Background	Susan Manion	Discussion
	• Community Teams ▪ Health & Social Care ▪ Mental Health	Alasdair Pattinson Simon Burt	
	• The Locality Model Approach	Locality Coordinators	
11.00am	Staff Open Session • What can we build on? • Top priorities for integration?	Chief Officer	Discussion
12.00	Lunch		IJB Board members
1.00pm	Walk and Talk Tour of:- • Kelso Hospital • Intermediate Care Home • Nursing Home	Locality Co-ordinators	IJB Board members
4.00pm	Return to Day Room, Kelso Hospital Reflections from staff	Chief Officer	Discussion
4.30pm	Conclusion and Next Steps	Cllr Catriona Bhatia	

Appendix B – IJB Away Day Evaluation Template

Has this morning's programme improved your knowledge and understanding of Health & Social Care Integration? A. Yes – very much so B. Yes - to some extent C. No – I'm still unsure Comments
How effective has this morning's programme been in defining what we can build on? A. Yes – very effective B. Yes – to some extent C. No – I'm still unsure Comments
How effective has this morning's programme been in defining your top priorities for Integration? A. Yes – very clear B. Yes – better clarity C. No - no further forward Comments
Was adequate time allocated to each of the topics covered this morning or would you have preferred more time/less time spent on some topics? A. Yes – just right B. Yes – with the exception of C. No – could have been condensed Comments

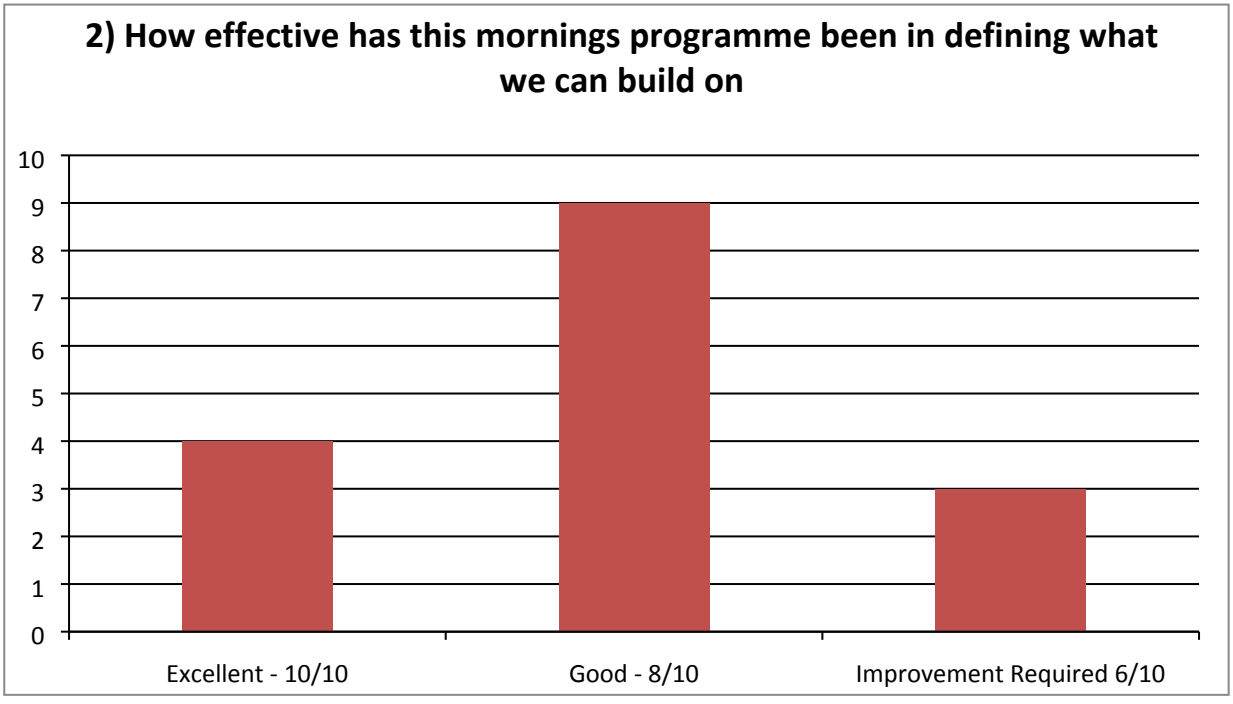
Was the Lesser Hall, Tait Hall a suitable venue for the event? A. Yes – just right B. Yes – with the exception of C. No- unsuitable Comments
How would you rate the organisation of this morning's event A. Excellent - 10/10 B. Good – 8/10 C. Improvement required 6/10 D. Needs further organisational preparation before similar events planned 4/10 Comments
Is there anything you would like to see covered in future events? A. Yes B. No Comments
Any additional comments below

Appendix C – IJB Development Awayday – Evaluation Summary



Comments

- *Really enjoyed hearing about Cheviot project from Practitioners (very well delivered)*
- *Would prefer to look at whole day*



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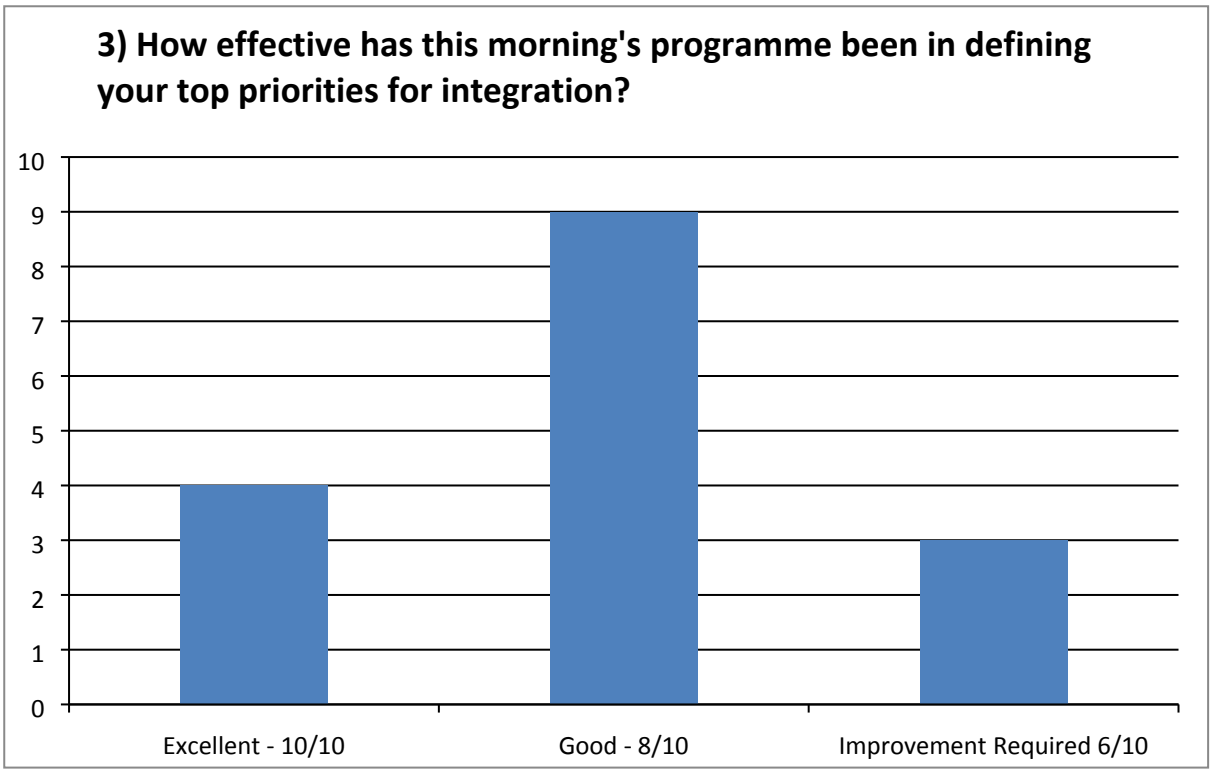

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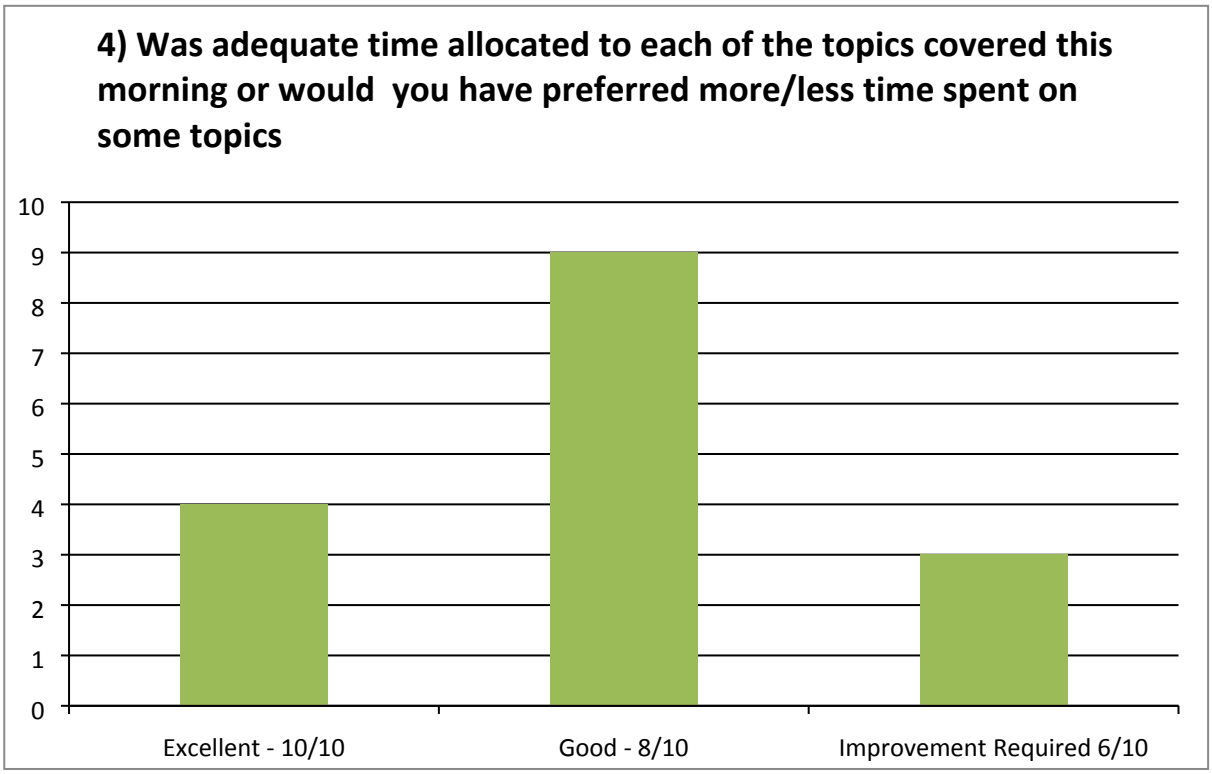

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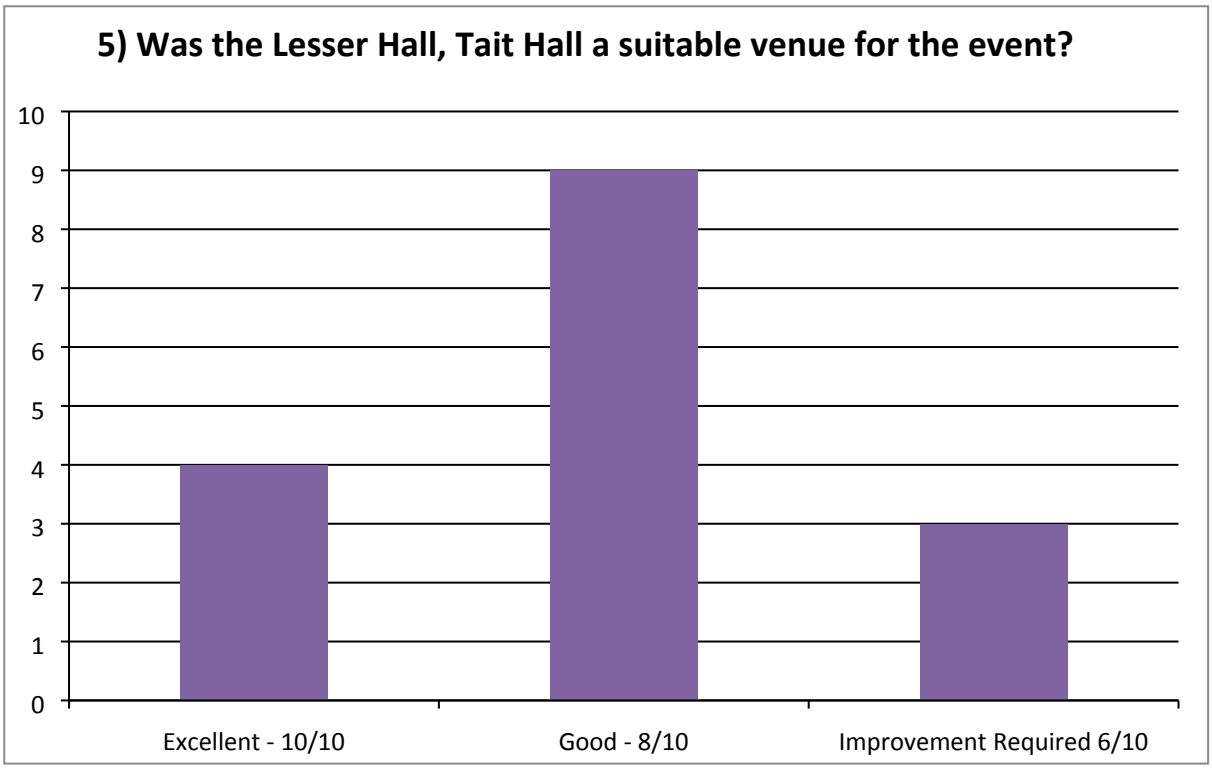

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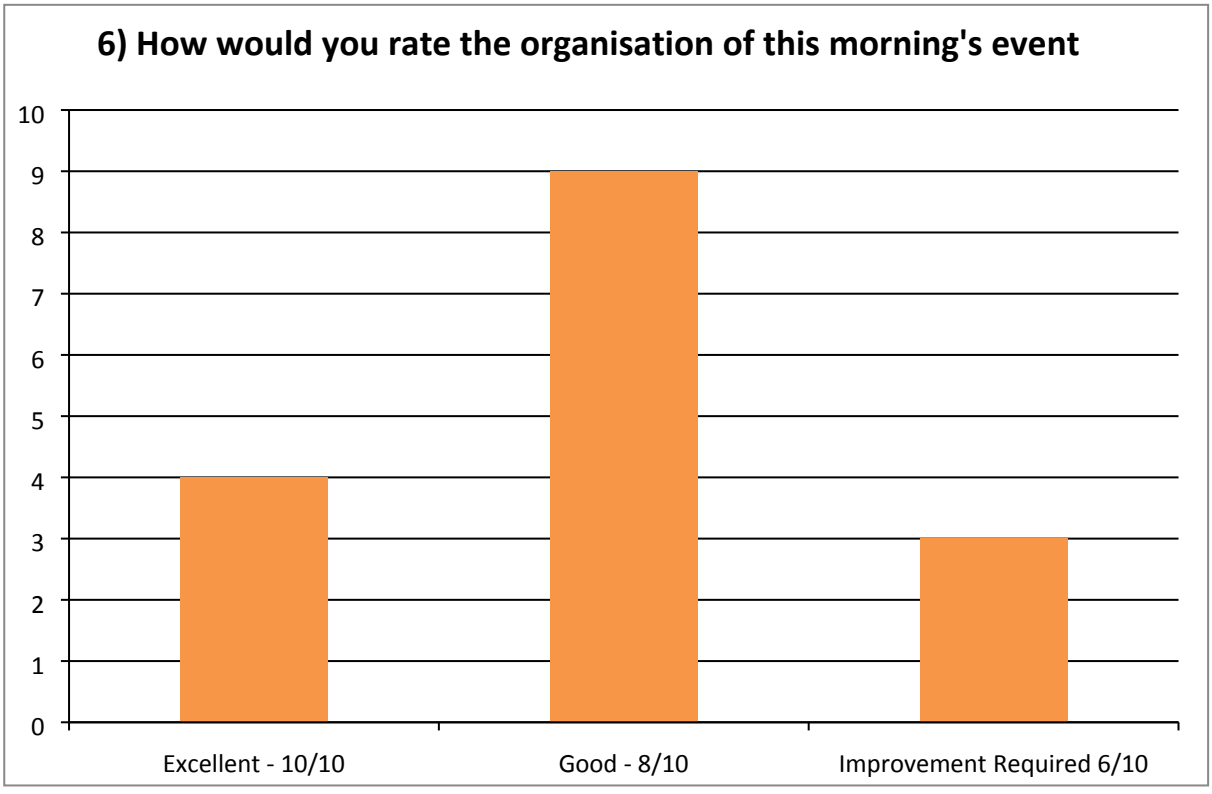

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Appendix D – Walk and Talk Tour Site Summaries

Kelso Community Hospital with Stewart Barrie and the staff nurse from the Day hospital:

- Met with staff throughout visits
- Slightly different format each time but all included Poynder View, Day Centre and co-located SC&H team.
    - One visit identified some potential under-utilised space
- Poynder View
    - Mental Health. *Service user needs?*
    - Manager gave tour for 3 sessions during afternoon
        - Nice clean, airy space
        - Own Garden prepared/looked after by Scouts
        - Craft facilities; murals, paintings
        - Met Service Users
            - Hour "quiet time" after lunch (1st visit)
            - Domino game (2nd visit)
            - Met them in good spirits as they were leaving on our way to 3rd visit/
        -
- SBC Day Centre/Day Hospital –
    - can be two way traffic of service users between PV and Day Centre.
    - met service users at 2/3 visits during afternoon
- Social Care and Health Team- example of Co-location (not integrated yet)
    - Met with staff

Queens house with Trish Wintrup, Miss Plasting:

Queens house a private 32 bedded purpose built care home. Which provides both residential and nursing care for the Cheviot area: the IJB were given a tour of the facilities by Matron, Miss Plasting. Discussions took place throughout the tour, giving the IJB a flavour for the services provided, e.g. if a resident who initially required residential care needs intensify, which is often the case, the resident will remain within Queen's House, in the same room, but the care needs will increase to meet the residents requirements. Miss Plasting stressed that this is a home from home, visiting is welcomed and there are facilities available to provide accommodation to visiting families so that the family can spend for example weekends together.

There is always a large waiting list for Queens House, which has 10 social care beds, with the remainder under private occupancy.

Queens House has plans to add a dedicated Dementia Unit to the facility within the near future.

Grove House Intermediate care unit which is managed by SB Cares with Shona Donaldson and Mary Stuart the unit manager: Members heard how the unit had been designed to provide re ablement as a stepping stone for people going home form hospital and those from the community who did not require hospital care but required bed based rehab to allow them to get back home. They heard how the unit's beds had reduced due to long stay patients using the short stay beds to manage the flow from BGH and delayed discharge targets. They were made aware of the lack of AHP resources within the unit due to lack of resources within current services and how the Cheviot health care team do not provide rehab to people within the unit unless they have placed them there.

Approved by

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

Author(s)

Name	Designation	Name	Designation
Locality Coordinators			

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