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Scottish Borders
Health and Social Care
PARTNERSHIP

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, 17 OCTOBER 2016 at 2.00 pm.

	BUSINESS		
1.	**ANNOUNCEMENTS & APOLOGIES**		
2.	**DECLARATIONS OF INTEREST**		
3.	**MINUTES OF PREVIOUS MEETING** (Pages 1 - 6) Monday 31 August 2016		
4.	**MATTERS ARISING** (Pages 7 - 10) Action Tracker		
5.	**CLINICAL & CARE GOVERNANCE**		
	(a) **Clinical & Care Governance - Integrated Joint Board Reporting** Medical Director	(Pages 11 - 52)	
	(b) **Scottish Borders Professional Assurance Framework: Health & Social Work Professionals** Medical Director, Chief Social Work Officer, Director of Nursing, Midwifery & Acute Services	(Pages 53 - 70)	
	(c) **Inspections Update** Verbal update - Chief Social Work Officer		
	(d) **Chief Social Work Officer Annual Report 2015/16** Chief Social Work Officer	(Pages 71 - 100)	
6.	**GOVERNANCE**		
	(a) **Staff Governance Arrangements** Chief Officer	(Pages 101 - 110)	
	(b) **Health & Social Care Integration Joint Board Business Cycle 2017** Board Secretary	(Pages 111 - 114)	

7.	**FINANCE**			
	(a)	**Monitoring of the Integration Joint Board 2016/17** Interim Chief Financial Officer	(Pages 115 - 128)	
	(b)	**Delivery of Efficiencies and Savings Plans** Interim Chief Financial Officer	(Pages 129 - 134)	
	(c)	**Direction of Social Care Funding** Interim Chief Financial Officer	(Pages 135 - 140)	
	(d)	**Prescribing Efficiencies - Past, Present & Future** Director of Pharmacy	(Pages 141 - 160)	
	(e)	**Health & Social Care Integration Joint Board 2015/16 Final Audited Statement of Accounts** Interim Chief Financial Officer	(Pages 161 - 202)	
8.	**FOR INFORMATION**			
	(a)	**Chief Officer's Report** Chief Officer	(Pages 203 - 204)	
	(b)	**Committee Minutes** Chief Officer	(Pages 205 - 210)	
	(c)	**Integrated Winter Plan 2016/17** General Manager Unscheduled Care	(Pages 211 - 244)	
9.	**ANY OTHER BUSINESS**			
	(a)	**Health & Social Care Integration Joint Board Development Session - 21 November 2016** Verbal update by Chief Officer		
10.	**DATE AND TIME OF NEXT MEETING** Monday 19 December 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 an Extra Ordinary Health & Social Care **Integration Joint Board** held on Wednesday 31 August 2016 at 10.00am in Committee Room 1, Scottish Borders Council.

Present:	(v) Cllr C Bhatia (Chair)	(v) Mr J Raine
	(v) Cllr J Mitchell	(v) Mrs K Hamilton
	(v) Cllr F Renton	(v) Mr D Davidson
	(v) Cllr S Aitchison	Mrs E Rodger
	Mrs S Manion	Mrs A Trueman
	Mrs E Torrance	Mr A Murray
	Mr D Bell	Mr J McLaren
In Attendance:	Miss I Bishop	Mr P McMenamin
	Mrs J McDiarmid	Dr E Baijal
	Mr D Robertson	Mrs C Gillie
	Ms J Robertson	

1. Apologies and Announcements

Apologies had been received from Cllr Graham Garvie, Mrs Pat Alexander, Dr Stephen Mather, Mrs Jenny Smith, Ms Lynn Gallacher, Dr Angus McVean, Mrs Jill Stacey, Mrs Jane Davidson, Mrs Tracey Logan and Dr Annabel Howell.

The Chair confirmed the meeting was quorate.

The Chair recorded the thanks of the Board to Cllr Jim Torrance and Cllr Iain Gillespie who had stepped down from the Board. The Chair welcomed the appointments of Cllr Sandy Aitchison and Cllr Graham Garvie to the Board.

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 Health & Social Care Integration Joint Board held on 20 June 2016 were approved.

The minutes of the Extra Ordinary Health & Social Care Integration Joint Board meeting held on 15 August 2016 were approved.

4. Matters Arising

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a future development session would consider the relationship between the sub groups of the Health & Social Care Integration Joint Board, the Scottish Borders Council and NHS Borders to ensure connections were made and that there was clarity as to the separate roles.

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

5. Integrated Care Fund Update

Mrs Susan Manion highlighted some key points being: agreements reached so far in relation to projects; projects to be progressed in support of the Implementation Plan; mapping against outcomes and investment; and locality plans and developing resources. She further touched on Locality Management, Community Led Support and the Matching Unit.

The Chair suggested going through each of the five projects in turn and taking questions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Delivery of the Localities Plan Project.

In regard to the Locality Management Pilot, Mr John McLaren expressed his anxiety on how the pilot would be progressed given the differences in staff engagement processes within both parent bodies. Mrs Jeanette McDiarmid noted the concern and confirmed that the local authority would engage with the unions at the start of the pilot and prior to any implementation. Mrs Carol Gillie advised that she and Mrs McDiarmid would ensure due process was followed in order to address Mr McLaren concerns.

The Chair suggested any feedback and learning from Mr McLaren around the process would potentially be useful for the future.

Mrs Elaine Torrance reminded the Board of the linkages to the Joint Staff Forum and suggested all of the projects would be of interest to the Joint Staff Forum.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Locality Management Pilot.

In regard to the Health & Social Care Coordination Project, Mrs Manion advised that the project was linked to the Locality Management pilot in the sense that it was the implementation of the implementation plan for models of care, she clarified it was about individuals taking responsibility for essentially holding the strings on a number of patients pathways to ensure they were followed.

Mrs Evelyn Rodger whilst supportive of the principles of locality managers, was keen to understand how much of the resources had gone in to support managers. She suggested it would be helpful to have that mapped out, in order to be clear on what was available, what had been delivered and what might be needed in the future. The Chair further commented that it should also include release of funding from other areas to support that moving forward.

Mr McLaren questioned the sustainability of continuity of service if it related to one individual. He further queried how realistic, one year was in order to be able to demonstrate delivery against the objectives in the plan. Mrs Manion confirmed that the intention was to put 2 to 3 items together to make it as robust and sustainable and systemic as possible and not just reliant on individuals.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Health & Social Care Coordination Project.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Community Led Support Project.

In relation to the Matching Unit Project, Cllr Sandy Aitchison enquired if the £115k contained all of the expenditure for staff, etc. Mrs Manion confirmed that the infrastructure already existed and the project was about social workers moving to a brokerage for placements for individuals and support/care packages. Mrs Torrance advised that it was also about putting systems in place to be able to reallocate care packages quickly.

Mrs Karen Hamilton sought a more comprehensive breakdown of how costs were achieved to understand if it was a really good piece of work for £115k.

Mr David Davidson enquired about the risks for each of the projects in meeting the budget requirements. Mr David Robertson commented that all of the projects were listed in Appendices 2 and 3 and he suggested the inclusion of a RAG status and Risk status for each project, the Appendices could then be used as the overall monitoring report for the projects.

Mrs Jane Robertson advised that there was already in place a process for recording and reviewing risks relating to the projects which could be made available to Board members.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Matching Unit Project.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the increase in funding for the BAES relocation project, which was already underway.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the increase in funding for the Health Improvement (phase 1) and extension Project.

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.

6. Monitoring of the Health & Social Care Partnership Budget 2016/17

Mr Paul McMenamin gave a brief presentation highlighting the emergence of budgetary pressures during July and early August; risks to the overall deliverable ability of a balanced budget outturn in relation to pressures emerging in year; how the budget was funded through efficiencies and other savings plans in the partner organisations; social care funding; the monitoring position; and self directed support funding.

Mr David Davidson thanked Mr McMenamin for his realistic overview of the current position and where the Board was headed financially. He suggested documentation be produced to indicate the risks to the budget being sustainable at current levels and where savings might be made and what could be ceased in order to afford the budget. He further commented that whilst the partnership had ambitions, there were significant financial challenges and ideally, the partnership should consider a reserve. This would need to be agreed across the partner agencies. He further suggested that the Board should ensure that what was proposed to be delivered was achievable within budget and that officers be tasked with making a 2.5% saving on budgets before any investment in future projects was agreed.

The Chair suggested a separate discussion be scheduled in regard to the provision of a reserve.

Mr David Robertson commented that in regard to the COSLA discussions with the Scottish Government it had been clearly expressed that the aspirations on the living wage were not fully funded and the assumption was that 25% of the costs would be met by the Care Providers and would not be passed back to the Local Authorities. However in reality, Care Providers were renewing contracts and passing the costs (living wage, National Insurance, etc) back to the commissioners. He commented that whilst the Scottish Government had provided funding to pay for services, the pressures within Scottish Borders Council were a direct result of implementing Government policy. He also suggested a reserve was a sensible strategy to pursue, however in order to establish a reserve the budget would need to be underspent which was currently not feasible.

The Chair advised the Board that it had the authority to direct the two partner organisations to look at how they would address the financial implications coming forward and to give direction to them on the actions it wished them to take on the emerging pressures.

Mr Robertson cautioned that funding was not a defence against the equalities challenge and legal requirements.

Mrs Carol Gillie welcomed Mr McMenamin's clear presentation and reiterated that the emerging pressures would impact on each organisation unless addressed and resolved jointly.

Mr John McLaren requested that Mr McMenamin provide his presentation to the next meeting of the Joint Staff Forum. Mr McMenamin advised that he would be content to provide the presentation to the Joint Staff Forum.

Mrs Elaine Torrance suggested a joint communication strategy be worked up to highlight the challenges and plan how to advise the Joint Staff Forum, wider staff and the public.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and the monitoring position on the partnership's 2016/17 revenue budget.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved 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** noted that the partnership's Chief Officer and Chief Financial Officer were 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.

7. Any Other Business

7.1 Audit Committee Membership: The Chair advised that Cllr Gillespie had been nominated as a member of the Audit Committee and she proposed that Cllr Graham Garvie replace him as a member. Cllr Frances Renton seconded the proposal.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** duly noted Cllr Graham Garvie as a member of the Audit Committee.

7.2 Development Session: The Chair advised that she had invited Geoff Huggins, Director of Health & Social Care Integration, Scottish Government to speak to the Board at its Development session on 26 September. It was expected that discussion would focus on the national perspective and where integration was on a national basis and the pressures that were emerging and any advice he might have for the Board on managing those pressures.

8. Date and Time of Next Meeting

The Chair confirmed that the next meeting of the Health & Social Care Integration Joint Board would be held on Monday 17 October at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 12.10.

Signed: ……
Chair

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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 revising Commissioning and Implementation Plan and considering plan for 2017/18.	Susan Manion Eric Baijal	November	**In Progress:** Item scheduled for 21 November 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	**Complete:** Housing scheduled as discussion topic for networking lunch on 17 October 2016.	G

Agenda Item: Any Other Business: Inspection of Adult Services

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
6	16	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed Adult Services feature as a future Development session topic.	Susan Manion Elaine Torrance	2016	**Complete:** Inspection of Adult Services scheduled as discussion topic for networking lunch on 15 August 2016.	G

Meeting held 31 August 2016

Agenda Item: Matters Arising

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
7	4	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a future development session would consider the relationship between the sub groups of the Health & Social Care Integration Joint Board, the Scottish Borders Council and NHS Borders to ensure connections were made and that there was clarity as to the separate roles.	Susan Manion	2016		

KEY:	
R	Overdue / timescale TBA
A	<2 weeks to timescale
G	>2 weeks to timescale

Blue	Complete – Items removed from action tracker once noted as complete at each H&SC Integration Joint Board meeting

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CLINICAL AND CARE GOVERNANCE – INTEGRATED JOINT BOARD REPORTING OCTOBER 2016

Aim

1.1 To provide the Integrated Joint Board (IJB) with a summary of pertinent information relating to Clinical and Care Governance across integrated services.

Background

2.1 There is a requirement for robust and effective governance, accountability and liability arrangements in order to ensure the delivery of safe, effective, person centred and quality integrated services.

2.2 A paper was submitted to the IJB for consideration earlier this year with a suggested Clinical and Care Governance Framework and reporting approach. Appendix 1, 2, 3, 4 and 5 contain the proposed reports which would be laid before the IJB to provide assurance that Clinical and Care Governance matters for integrated services are being given appropriate scrutiny.

Summary

3.1 Reports included provide details of:

- The annual workplan of the NHS Borders Clinical Governance Committee
- Minutes of discussion at the NHS Borders Clinical Governance Committee relating to clinical and care governance of all services including integrated services
- Clinical and care governance matters for:
    - Primary and Community Services and the Borders General Hospital
    - Mental Health
    - Learning Disabilities

3.2 Where specific issues arise relating to clinical and care governance individual reports will be provided for detailed discussion with the IJB.

3.3 The content of this report has been considered by the NHS Borders Clinical Governance Committee.

Recommendations

The Health & Social Care Integration Joint Board is asked to **agree** the proposed reporting format and **note** the reports provided.

Policy/Strategy Implications	The content of the ongoing work outlined will be considered by the NHS Borders Clinical Governance Committee and Integrated Joint Board
Consultation	As above.
Risk Assessment	In compliance.

Compliance with Policy requirements on Equality and Diversity	In compliance.
Resource/Staffing Implications	Services and activities provided within agreed resource and staffing parameters.

Approved by

Name	Designation	Name	Designation
Andrew Murray	Medical Director		

Author(s)

Name	Designation	Name	Designation
Laura Jones	Head of Quality and Clinical Governance		

Appendix 1 - Clinical Governance Committee Workplan for 2016/17

Appendix 2 - Clinical Governance Committee Minutes for July 2016

Appendix 3 - Clinical Governance Committee BGH and PCS Governance Report

Appendix 4 - Clinical Governance Committee Mental Health Governance Report

Appendix 5 - Clinical Governance Committee Learning Disability Governance Report

Clinical Governance Committee (CGC)
Workplan 2016/17

Standing Items to be Received by CGC	Aim	Lead	Approver	Deadline	Status
Minutes of Previous Meeting	To record the discussion from CGC meetings	PA to Director of Nursing, Midwifery & Acute Services	Medical Director / Head of Clinical Governance & Quality	For all meetings	Document
Action Tracker	To record actions from CGC meetings and to ensure they are appropriately actioned	PA to Director of Nursing, Midwifery & Acute Services	Medical Director / Head of Clinical Governance & Quality	For all meetings	Document
Forthcoming 'Key Agenda Items' for CGC	**Aim**	**Speaker**	**Approver**	**Deadline**	**Status**
1 Patient Safety	To inform and assure CGC with respect this NHS Scotland Quality ambition - "There will be no avoidable injury or harm to patients from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times."	Clinicians and Services Leading on Patient Safety activties		To address a key issue or topic area at one of the CGC meetings in 2014/15	
	Infection Control Report (Every meeting)	Infection Control Manager	Director of Nursing, Midwifery & Acute Services	25 May 16 13 July 16 21 September 16 16 November 16 January 17	

				March 17	
	Adverse Event Overview and Thematic Reports (Every second meeting unless Exception Reporting)	Quality and Clinical Governance Facilitator and Thematic Topic Specialists	Head of Clinical Governance & Quality	13 July 16 21 September 16 January 17	
	Quarterly Hospital Standardised Mortality Report (including Annual Mortality Review Update in September 2015) (Every quarter)	Associate Medical Director (Clinical Governance & Quality)	Head of Clinical Governance & Quality	25 May 16 16 November 16 March 17	
	Annual Patient Safety Programme Report	Quality and Clinical Governance Facilitator	Head of Quality and Clinical Governance	March 17	
	Very High Risk Management Report (Twice a year)	Risk & Safety Manager	Director of Nursing, Midwifery & Acute Services	25 May 16 16 November 16	
	Occupational Health Report (Once a year unless Exception Reporting)	Head of Health & Wellbeing	Director of Workforce & Planning	November 2016	
	Claims Update (Twice a year unless Exception Reporting)	Risk & Safety Manager	Director of Nursing, Midwifery & Acute Services	May 2016 November 2016	
2 Person Centred	To inform and assure CGC with respect this NHS Soctland Quality ambition - “Mutually beneficial partnerships between patients, their families, and those delivering healthcare “services which respect individual needs and values, and	Clinicians and Services Leading on Person Centerdness activities	Approver	To address a key issue or topic area at one of the CGC meetings in 2014/15	

	which demonstrate compassion, continuity, clear communication, and shared decision making				
	Patient Feedback (Twice a year unless Exception Reporting)	Head of Clinical Governance & Quality	Head of Clinical Governance & Quality	25 May 16 16 November 16	
	Scottish Public Services Ombudsman Report updates (verbal)	N/A	General Manager for Unscheduled Care	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
3 Effectiveness	To inform and assure CGC with respect this NHS Soctland Quality ambition - “The most appropriate treatments, interventions, support, and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated”	Clinicians and Services Leading on Effectiveness	Approver	To address a key issue or topic area at one of the CGC meetings in 2014/15	
	Clinical Board Governance Reports	Associate Directors of Nursing/Service Manager/Associate Medical Director	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
	Public Health Clinical Support Report	Joint Director of Public Health	Joint Director of Public Health	13 July 16 January 17	
	Research Governance Report	Research Coordinator	Head of Clinical Governance &	21 September 16	

			Quality		
	Inspection and Review Reports	Associate Directors of Nursing and/or Head of Clinical Governance & Quality	Appropriate Director	As Required	

4 Assurance	Clinical Governance Committee Reports	Exec Director/Head of CG&Q and Clinical Governance Leads	Approver	As Required	
	Clinical Governance Work Plan	PA to Director of Nursing, Midwifery & Acute Services & Head of Clinical Governance & Quality	Head of Clinical Governance & Quality	March 17	
	Clinical Governance Annual Report	PA to Director of Nursing, Midwifery & Acute Services & Head of Clinical Governance & Quality	Chair	March 17	
	Clinical Governance Terms of Reference and Self Assessment	PA to Director of Nursing, Midwifery & Acute Services & Head of Clinical Governance & Quality	Chair	13 July 16	

Annual Agenda Items for CGC	Aiming to Inform and Assure the CGC in Relation to Specific Work Areas Including:	Speaker	Approver	Deadline	Status
Pharmacy Annual Update	Pharmacy activities relating to quality and clinical governance	Director of Pharmacy	Associate Medical Director (Mental Health & Learning Disabilities)	21 September 16	
Occupational Health Annual Update	Occupational health activities relating to quality and clinical governance	Head of Work & Wellbeing	Director of Workforce & Planning	July 2016	
Children's Services Annual Update (incl. GIRFEC)	Children's service activities relating to quality and clinical governance	Head of Children's Services/ Child Health Commissioner	Director of Nursing, Midwifery & Acute Services	16 November 16	

Director of Public Health Annual Update (incl. screening programmes)	Public health activities relating to quality and clinical governance	Consultant in Public Health Medicine	Joint Director of Public Health	13 July 16	
Child Protection Annual Update	Child protection activities relating to quality and clinical governance	Head of Children's Services/ Child Health Commissioner	Director of Nursing, Midwifery & Acute Services	13 July 2016	
Adult Protection Annual Update	Adult protection activities relating to quality and clinical governance	Associate Director of Nursing – Mental Health	Director of Nursing, Midwifery & Acute Services	January 17	
Medical Appraisal Annual Update	Medical appraisal activities relating to quality and clinical governance	Lead Appraiser	Medical Director	21 September 16	
Medical Education Annual Update including GMC survey results	Medical Education activities relating to quality and clinical governance	Director of Medical Education & Associate Medical Director	Medical Director	16 November 16	
Suicide Annual Update to Healthcare Improvement Scotland (HIS)	Suicide review and prevention activities relating to quality and clinical governance	Associate Director of Nursing – Mental Health	Director of Nursing, Midwifery & Acute Services	July 17	
Care of Older Adults in Hospital (OPAH) Annual Update	Care of older adults and dementia activities relating to quality and clinical governance (includes dementia, wound care, falls and nutritional care).	Associate Directors of Nursing – Acute and Mental Health	Director of Nursing, Midwifery & Acute Services	Update – July 16 January 17	
Maternity Services and Severe Maternal Morbidity Annual Update	Maternity services and severe maternal morbidity activities relating to quality and clinical governance.	Associate Nurse Director/Head of Midwifery and General Manager for Women and Children's Services	Director of Nursing, Midwifery & Acute Services	March 17	

End of Life Care	End of life care relating to quality and clinical governance.	Associate Medical Director (PACS)	Medical Director	May 2016	
Blood Transfusion	Blood transfusion relating to quality and clinical governance.	Consultant Anaesthetist / Transfusion Practitioner	Medical Director	January 2017	
Clinical Documentation Annual Update	To provide quality and clinical governance to the clinical documents. (Every 2 years)	Clinical Governance & Quality Facilitator	Head of Clinical Governance & Quality	16 November 16	SEE LAURA
Infection Control Annual Update	Infection control relating to quality and clinical governance.	Infection Control Manager	Director of Nursing, Midwifery & Acute Services	13 July 16	
Items for Noting					
Child Protection Committee Minutes	To inform and assure the CGC of work underway through the Committee.	Representative from Child Protection Committee	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
Adult Protection Committee Minutes	To inform and assure the CGC of work underway through the Committee.	Representative from Adult Protection Committee	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
Public Governance Committee Minutes	To inform and assure the CGC of work underway through the Committee.	Chair Public Governance Committee	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17	

				March 17	
BGH Clinical Governance Group Minutes	To inform and assure the CGC of the work underway through the Group.	Chair of the BGH Governance Group	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
PACS Clinical Governance Group Minutes	To inform and assure the CGC of the work underway through the Group.	Chair of the PACS Governance Group	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
Learning Disabilities Clinical Governance Group Minutes	To inform and assure the CGC of the work underway through the Group.	Chair of the LD Governance Group	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
Mental Health Clinical Governance Group Minutes	To inform and assure the CGC of the work underway through the Group.	Chair of the MH Governance Group	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
Public Health Clinical Governance Group Minutes	To inform and assure the CGC of the work underway through the Group.	Chair of the PH Governance Group	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	

National Audit Reports	To inform and assure the CGC of National Audits. (Exception Reports may be required)	Chair	N/A	25 May 16 13 July 16 21 September 16 16 November 16 January 17 March 17	
Developments	**Aim**	**Speaker**		**Deadline**	**Status**
Improve information shared between CGC and other sub-committees of the Board	To improve awareness and transparency and information sharing	Chairs of Board Sub Committees		Ongoing	

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Minutes of a meeting of the **Clinical Governance Committee** held on 13th July 2016 at 2pm in the Committee Room, BGH

Present:	Stephen Mather (Chair)	Doreen Steele
	David Davidson	
In Attendance:	Evelyn Rodger	Laura Jones
	Simon Burt	Dr David Love
	Sam Whiting	Phillip Lunts
	Jane Davidson	Dr Annabel Howell
	Charlie Sinclair	Dr Andrew Riley
	Lynne Morgan Hastie	Dr Andrew Murray

1. Apologies and Announcements

The Chair noted that apologies had been received from Cliff Sharp, Susan Manion, David Thomson, Sheila MacDougall, Hamish McRitchie, Karen McNicol, Tim Patterson and Nicky Berry.

Andrew Riley is attending on behalf of Tim Patterson.

It was noted that Karen McNicol is leaving NHS Borders.

2. Declarations of Interest

None.

3. Minutes of the Previous Meeting

Doreen Steele noted that on page 5 – Patient Feedback Report it should say 'compliments' and not 'complaints'.

The minutes of the previous meeting held on the 25th of May were then approved.

4. Matters Arising

The **CLINICAL GOVERNANCE COMMITTEE** noted the Action Tracker.

5. Patient Safety

5.1 Infection Control Report

Sam Whiting (SW) presented his report.

David Davidson (DD) asked about the risk associated when isolation is not possible. SW responded that the risk is difficult to quantify. The evidence of cross transmission is very rare. DD asked about visitors and infection control. SW answered that as visitors tend not to go from bed to bed and do not perform invasive procedures, the risk of cross infection associated with visitors is lower than staff.

There was prolonged discussion around infection control measures in six-bedded bays. Jane Davidson (JD) asked if are we are content that systems are operating as intended. SW responded that monitoring does confirm that systems and processes are operating as intended with generally good compliance.

With regard to hospital cleanliness monitoring, SW explained that resources for cleaning clinical areas are prioritised over non-clinical area. This would have the effect of reducing the overall compliance score at times where non-clinical areas are included in monitoring checks. SW was asked in the next report to show a split in cleanliness scores between clinical and non-clinical areas.

DS asked regarding page 9 reasons for the hand hygiene audit not being submitted or completed and was concerned that this did not support a zero tolerance approach to hand hygiene. SW answered that failure to submit an audit tended to be associated with changes in staff who had been allocated to complete audits or were on leave. In these cases, the relevant Senior Charge Nurses had confirmed that this task had now been allocated to alternative staff.

DL asked about cleaning of blood spillages and described what he had observed recently in the Emergency Department. SW advised that the spot checking process includes periodic observations of cleaning processes as they happen. The recurring theme in audits relating staff knowledge on cleaning was being addressed by training accompanying the rollout of a new cleaning agent that is easier for staff to use and will support better compliance. SW explained that in response to the feedback by DL, he would ensure that the Emergency Department is prioritised for early adoption of the new cleaning agent.

SW summarised the incident on page 7. SW explained that an outbreak report is being drafted along with a significant adverse review. No further cases have been identified.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

5.2 Adverse Event Overview and Prevention and Management of Aggression and Violence (PMAV) Thematic Report

Laura Jones (LJ) presented the Adverse Event Overview containing information on trends over the last 3.5 years since the introduction of the adverse event management policy.

Evelyn Rodger (ER) noted that graphs 1, 2, 3 showed normal variation in the numbers of adverse events reported and queried whether we should be expecting to see a reduction in these numbers based on the improvement work underway. LJ advised it is important to promote a positive culture around the reporting of errors and we would not necessarily aim to see a reduction in reporting of incidents. We should however be monitoring outcomes and seeing reductions against these based on the focused improvement work.

LJ highlighted that individual cases and learning is discussion at clinical board governance groups and can be highlighted to the committee in reports from clinical boards. JD said that it was a helpful report but not an assurance report. JD suggested that this would be positive from an assurance perspective for the committee to ensure learning and action follow significant adverse events.

Thematic Report - PMAV

Sue Keean was unable to attend the meeting so DS suggested a further discussion be scheduled for the September meeting. At the next meeting the committee would like to discuss the areas experiencing high levels of aggression and violence and training uptake in these area.

ER advised that she has been in discussion with the PMAV team to look at how training can be provided differently within clinical areas.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

5.3 Significant Adverse Event Review's (SAERs)

JD asked the committees views on making SAER reports available to the public through the NHS Borders internet site. It was suggested that this is already done in NHS Ayrshire and Arran. LJ highlighted that a lot of work has been done to involve patients and families throughout the SAER process to provide an open and transparent approach.

There was a debate around this and the need to ask permission from patients. The chair suggested that the Board be consulted on this to make a decision. AM agreed to take this for a discussion at the Board development session.

SM suggested that some detail of individual SAERs be shared through clinical board governance reports to ensure the committee can be assured that learning and actions are being addressed. JD suggested this would be useful from an assurance perspective to link the learning from SAERs to a change in outcomes over time. LJ and AM agreed to consider this for the next report to the committee.

5.4 Very High IT Risks

Jackie Stephens (JS) came to the meeting to discuss the very high IT risks that were facing NHS Borders. She gave a presentation on the following risks:

- Windows XP Desktop
- Radiology Hardware (RIS)

JS is also attending the board in September to discuss the issues further with a view to considering a plan for the resources required to address this. The committee were keen to see a phased plan to address this.

JS was asked to review the risk levels with June Smyth on the basis of the work that has been done to date.

The **CLINICAL GOVERNANCE COMMITTEE** noted the presentation.

6. Person Centred

6.1 Scottish Patient Service Ombudsman (SPSO) Reports

Philip Lunts (PL) talked to a paper summarising progress against the 5 SPSO improvement action plans. For two cases all actions are now completed and closed. The other three are ongoing and PL provided an update on the actions complete and those remaining with timescales for completion.

The Chair asked how the committee can be assured that actions have been completed where staff have been required to undertake personal reflection and practice change. Andrew Murray (AM) advised that they are ensuring that the conversation is taking place by checking the log of appraisals and monitoring feedback about individuals thereafter. ER advised that this would also apply to nursing and would be linked to their appraisal and revalidation process.

JD agreed that this is assuring for the committee and noted that some measures continue to be tracked from the SPSO cases. JD highlighted that this is about culture change and will take time and a continued focus.

JD highlighted that during a recent meeting with a family they had discussed their confidence in raising concerns whilst you are a patient in the hospital. As a result testing work is going to take place in Women's and Children's of a bedside sign advising patients and families about how to raise concerns and who they can contact outwith the ward.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

7. Clinical Effectiveness

7.1 Clinical Board Update (Borders General Hospital, Primary and Community Services)

Charlie Sinclair (CS) advised that the BGH and PCS will now use the reporting format on front of the committee at the meeting. CS has enhanced the report by adding a summary at the beginning providing an assurance position across each directorate.

CS outlined that daily monitoring of compliance with Older People in Acute Hospitals (OPAH) process measures is continuing. Some areas are now seeing sustained compliance. CS indicated that the audit processes is being reviewed to assess if a sampling process would be effective. JD will consider this with CS.

CS indicated that the SPSO cases relating to the BGH and PCS had been covered in the earlier agenda item.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

7.2 Clinical Board Update (Mental Health)

Simon Burt (SB) advised that he was happy to take questions in David Thomson's absence.

DD asked for examples of medication errors and noted that he would be happy to receive an email with this information. SB agreed to provide this.

DD enquired about what was happening with the Borders Addiction Service (BAS) in relation to IT issues they were experiencing. SB told DD that the issue holding this up is due to BAS having a preferred system which the clinical board accepted. Information Governance needs to be reviewed and this is currently happening.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

7.3 Clinical Board Update (Learning Disabilities)

SB advised the committee that he would be moving the LD report over to the format being used by the BGH and PCS for the next meeting.

SB highlighted the ongoing issues around the provision of residential units for clients with autism and challenging behaviour across the UK. At present places are sourced from England and Wales. This requires local staff to make regular visits and impacts on the service. This has been raised by Cliff Sharp at the South, East Scotland and Tayside regional planning group. and SEAT. SB advised that he was managing the risk associated with this issue and is in discussion with Lothian about future provision.

SB highlighted that this is risk which spans the integrated service. DS said that this would be appropriate to go to the IJB for future commissioning consideration.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

8. Assurance

8.1 Occupational Health Annual Report

Irene Bonnar (IB) gave a summary of occupation health activity from 201515/16. There has been a good use of the service from the staff.

It was noted that just under 25% of referrals to Occupational Health are for MSK. JD highlighted that she has asked for a drop in service to be developed for staff experiencing MSK problems. IB was asked to bring information on how this is progressing to a future meeting.

There was a discussion around uptake for classroom based training. Concern was expressed at the uptake rates and rate of cancellations but individuals and training providers. The committee requested assurance that this issue was being tackled by the group reviewing training provision. IB agreed to raise the points with John McLaren and bring an update back in the next report to the committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and supports this.

8.2 Child Protection Annual Update

ER advised that this was a historical Report from last year from the Child Protection Committee. Moving forward from the recent Joint Inspection of Children's Services the work plan for the next year will be more focused on outcomes rather than processes.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and supports this.

8.3 Care of Older Adults in Hospital (OPAH) Annual Update

Deferred until September.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and supports this.

9. Items For Noting

9.1 Minutes

The following minutes for:

- Child Protection Committee
- Adult Protection Committee
- Public Governance Committee – no minutes
- BGH Clinical Governance
- Primary and Community Services Clinical Governance
- Learning Disabilities Clinical Governance
- Mental Health Clinical Governance
- Public Health Clinical Governance

The **CLINICAL GOVERNANCE COMMITTEE** noted the minutes.

10. Any Other Business

SB told the committee that the Joint Adult Health and Social Care inspection to be carried out by the Care Inspectorate will take place soon. It is anticipated that this will start in January 2017.

11. Date and Time of Next Meeting

The Chair confirmed that the next meeting of the Clinical Governance Committee would be held on Wednesday 28th September 2016 at 10am – 1pm in the BGH Committee Room. **Please note the change of time.**

The meeting concluded at 4.20pm

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CLINICAL GOVERNANCE COMMITTEE

BORDERS GENERAL HOSPITAL (BGH) AND PRIMARY AND COMMUNITY CARE (PACS) CLINICAL GOVERNANCE REPORT – JULY 2016

Aim

To provide the Clinical Governance Committee with assurance that appropriate governance systems and processes are in place within the Borders General Hospital (BGH) and Primary and Community Care (PACS) and to demonstrate examples of this work.

Background

The 'Framework for Measuring and Monitoring safety' is now being consistently applied to support our Clinical Governance meetings within BGH and PACS. This joint report will use the framework principles to structure the report and recommendations.

The BGH Integrated Clinical Governance and Primary and Community Services meetings are monthly. This report reflects the meetings held on held on:

- BGH - 1 June and 6 July 2016
- PACS - 18 May and 15 June 2016

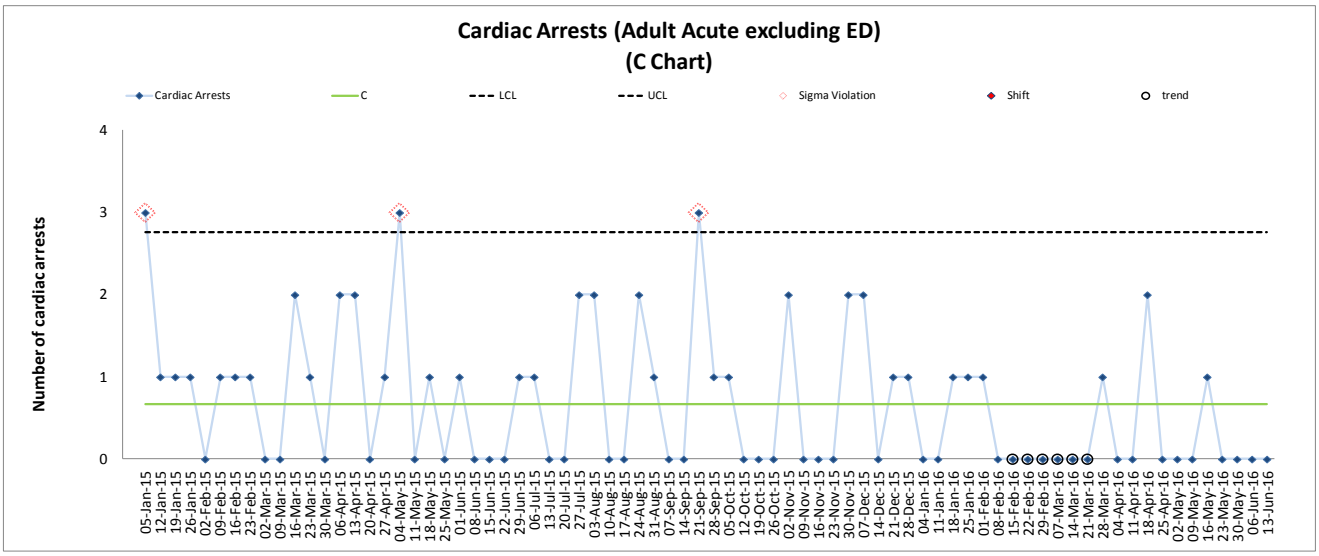
Summary

The following summary provides an overview of the main achievements, issues and improvements highlighted following the last report. Detail is contained within the Divisional reports submitted to the BGH and PACS Clinical Governance Groups.

Division	**Adverse Events** (including Significant Adverse Event reviews)	**Complaints** (including SPSO)	**Risk**
Planned Care	All SAER improvement action since 2013 reviewed 115 actions complete, 14 in progress (improvement action tracker on BGH Group agenda for noting)	All complaints and concern actions reviewed for 2015. 18 actions complete 1 action in progress and 11 new actions. (improvement action tracker on BGH Group agenda for noting)	All risks on register reviewed, action plans being finalised for end June 2016.
Unscheduled Care	88 (92 last month) events in holding 44 are overdue (78 last month) with 16 under review, 3 awaiting final review and 3 being approved.	Complaints improvement plan 33 actions with 10 complete, 5 in progress and 18 outstanding. SPSO cases 20145009 and 201404767 improvement plans progressing to timescale with ongoing review. 201502380 and 201406607 improvement plans completed and submitted to SPSO. Actions being progressed and regularly reviewed.	Following focussed work additional risks have been identified. 10 for review (3 last month), 2 being reviewed, and 18 received final approval.
Women and Child Health	Final draft of W31786 Respiratory Syncitial Virus (RSV) in Special Care Baby Unit – Complete. 3 instances of pressure ulcers under investigation – interim measures implemented pending outcome of investigation. 13 adverse events in holding with 6 currently under review.	Nil at time of writing	9 risks on risk register all have been reviewed. 3 are rated 'High'
Primary and Community Services	Community and Community Hospital: Nil at time of writing GP Adverse Events are dealt with by individual practices AHP: SAER – Speech and language Therapy missed referral – under investigation.		

Past Harm - Has Patient Care been safe in the past?

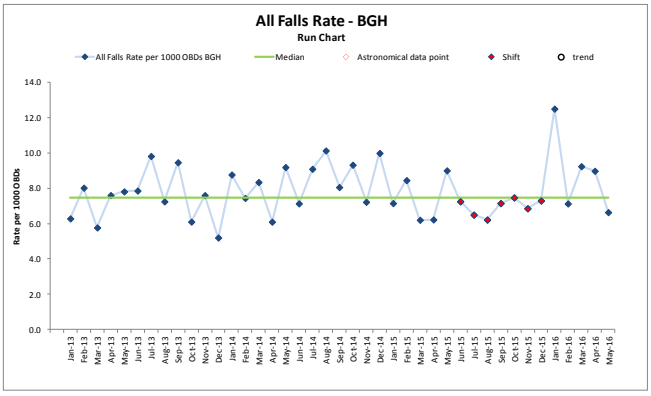
Cardiac Arrest



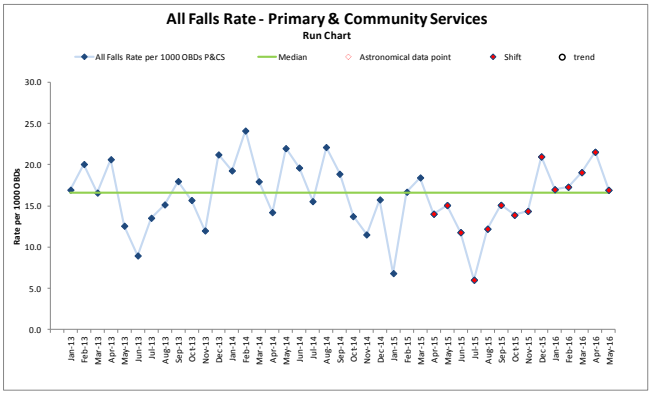
Cardiac arrests are monitored on a weekly basis and all are reviewed to monitor outcomes and assess learning. Our current data illustrates low numbers with no further astronomical data points or trends.

Falls

Our 'All Falls' data continues to show normal variation with individual areas focussing on specific actions for improvement in line with their local data.



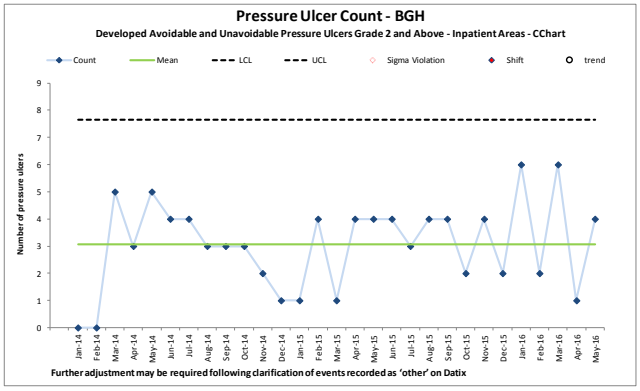
This chart shows a downward shift in the falls rate between June 2015 and December 2015, increasing in January 2016; now decreasing .



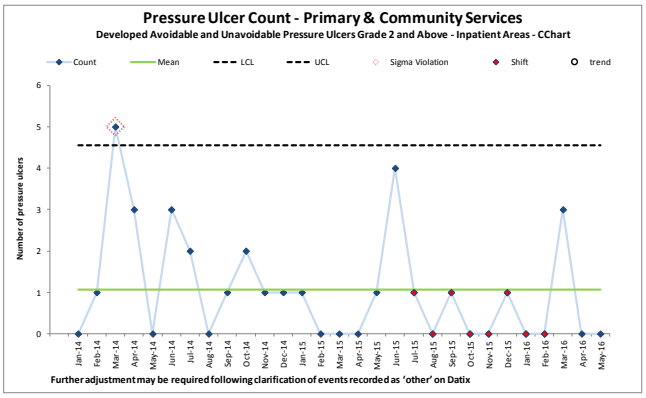
This chart shows a downward shift in the falls rate between April and November 15 and a subsequent shift above the median between December 2015 and May 2016.

Pressure Area Care

All pressure areas grade 2 – 4 are reported on Datix and a clinical review is then instigated to bring appropriate clinical expertise to the patients bedside in order to identify specific actions required for the individual.



This chart shows normal variation in pressure ulcers.



This chart shows a downward shift in the pressure ulcer count between July 2015 and February 2016.

Remote access to expert advice for complex wound management

As part of ongoing service improvement we are currently in discussion with NHS Fife to establish support for complex wound management and have also agreed the ability to access additional support from the Golden Jubilee. An escalation process and protocol is being finalised.

Reliability - Are our Clinical systems and processes reliable?

BGH and PACS Clinical Governance groups

There continues to be improvements in the quality of Divisional reports and submission from group members with plans for Unscheduled Care to reflect the same quality of narrative now consistently submitted by Planned Care and Women and Child Health.

As agreed at the May meeting this report starts with a summary of specific progress being made, action plans, learning and improvement in relation to Incidents, Significant Adverse Event Review, Risk Management and Complaints.

BGH

The Programme of Daily Monitoring and immediate rectification continues to provide a daily report for all inpatient areas within BGH, while working directly with medical staff and registered nurses to ensure that post audit feedback is actioned.

Standards expected to be achieved relate to:

1. AWI Bundle (AMT, 4AT, AWI section 47)
2. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
3. Nursing Bundle (NEWS, Food & Hydration (MUST), Tissue Viability (PURA), Falls, Patient Moving and Handling & Person Centred Care Planning).
4. A sheet specifically for documentation of 'Communication with patients, relatives and carers' has been introduced for MDT use.

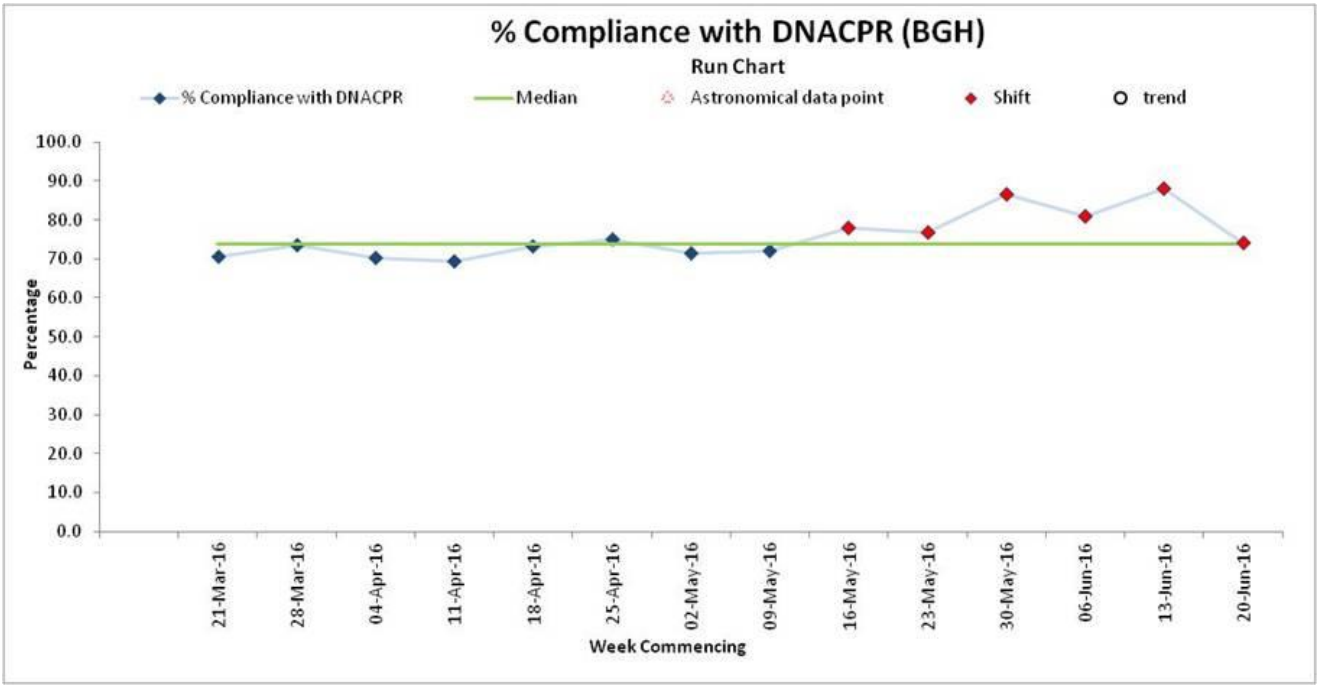
The daily report illustrated at the May meeting provides a combination of narrative about observations of auditors as well as a visual 'traffic light' summary. Run charts are provided

to individual wards for each component on a weekly basis and information illustrated across the hospital for each component are published with the daily report on a Friday.

As we are seeing extended periods of sustained improved practice we are reviewing our data to consider whether we can go to a model of sampling 5 patients per area and also involving Senior Charge Nurses in the collection and reflection of practice within their areas. From Monday 27 June auditors resumed auditing all patients within the BGH until we achieve sustained improvement.

We have also revised the methodology for assuring all issues identified are remediated immediately upon escalation or complete within 24 where this is not possible. All wards now keep their own issue logs and sign when an issue has been remediated, with a further sign-off by auditors the next day.

Work has been supported to explore whether our data is showing improvement. Initial consideration of DNACPR data, the run chart below illustrates aggregated BGH performance showing percentage compliance against DNACPR.

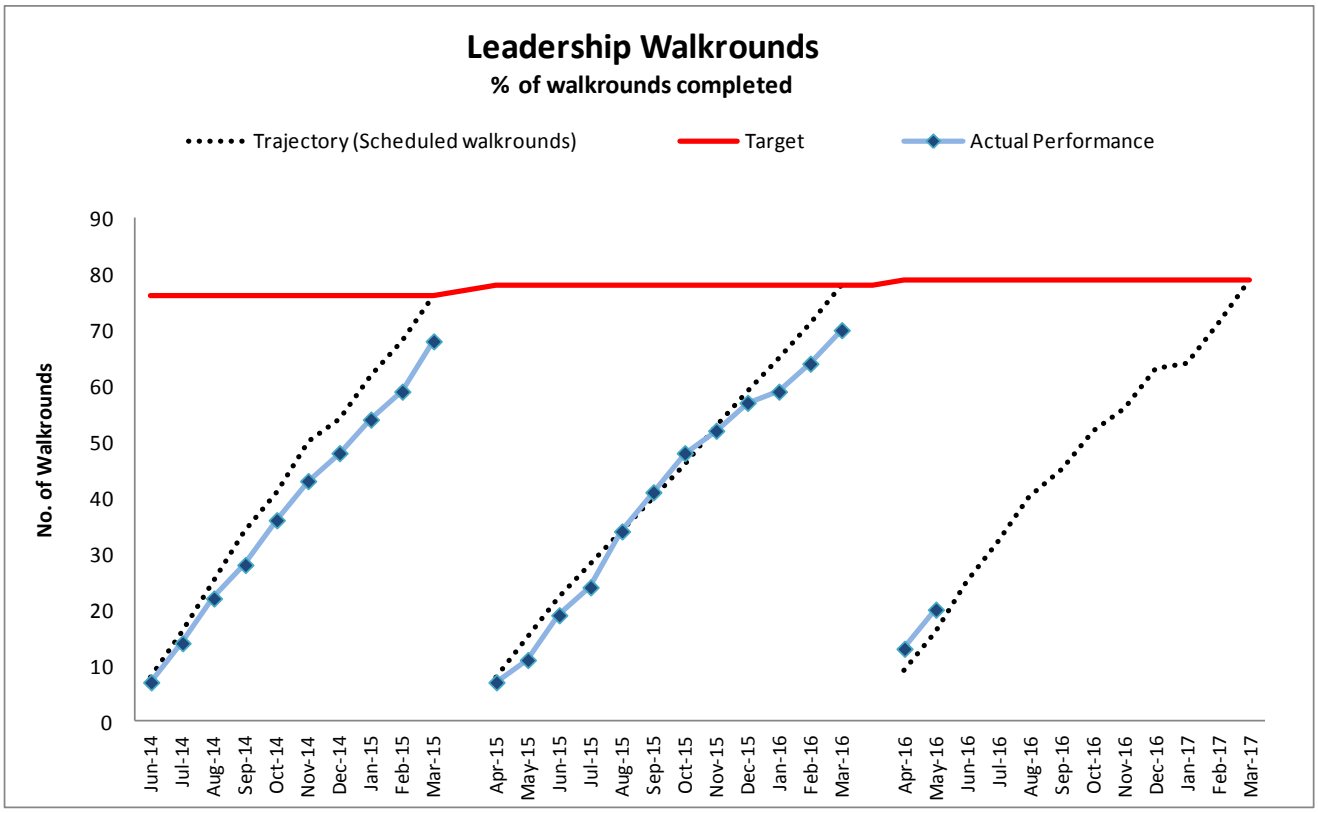


There has been a positive shift in performance over the last 6 weeks indicating improvement against this measure which was difficult to see in the daily analysis.

A copy of the Safety Measurement & Monitoring dashboard is attached as Appendix which provides an indication of performance against the remaining OPAH measures reported on a daily basis.

<u>Executive Walkabouts</u>

The programme of Leadership Walk-rounds and inspections is established with new dates programmed for the year ahead



This chart shows that performance continues to be below trajectory but has improved in August 2015

Sensitivity to Operations - Is care safe today?

Each morning a Hospital Safety Brief continues to be held in order to 'Look Back' to review safety, quality and patient flow for the past 24 hours and to 'Look Ahead' to anticipate, predict and plan for safety, quality and patient flow for the next 24 hours.

We have added Pressure Ulcer escalation to the brief with staff identifying if they have any patients in their areas with Pressure Ulcers grade two or above. This is then followed up by our Clinical Improvement Facilitators or Clinical Nurse Managers who ensure plans are in place and are being effective or whether a clinical review is required.

Anticipation and preparedness - Will care be safe in the future?

Older People in Acute Hospitals (OPAH)
As reported in May NHS Borders invited Healthcare Improvement Scotland (HIS) to undertaken a proactive inspection of Older Peoples in Acute Hospitals. This inspection consisted of 2 elements including an unannounced OPAH inspection which took place between Tuesday 12 and Thursday 14 April, looking at standards of care against the 11 outcome areas within the Care of Older People Acute Care (2002) standards. In addition HIS held a review visit on the 26 April to discuss with a range of staff NHS Borders approach to learning from feedback and complaints, adverse events and from Borders cases investigated by the Scottish Public Sector Ombudsman. During the review visit on the 26 April the HIS team met with frontline staff including Senior Charge Nurse, Nursing and Medical Leads to discuss how they learn from feedback and events in their own areas, how they share this with their staff and what improvements have been made as a result.

In the post inspection feedback session the Inspectors specifically thanked all the staff for welcoming and accommodating this inspection and highlighted that all staff have shown

compassion, dignity and respect throughout this inspection. 25 Actions were identified and have been completed following the verbal feedback with and 9 further actions developed with expected completion by September 2016.

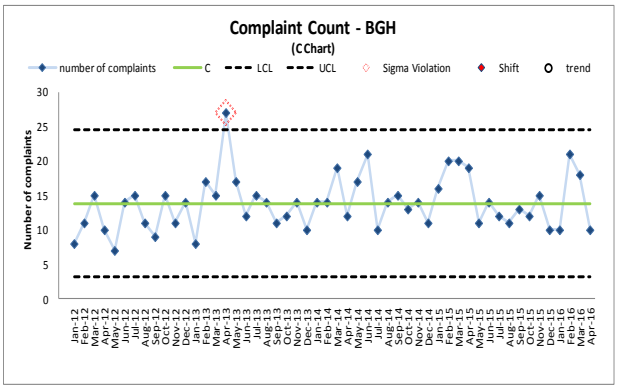
We received the Embargoed Report on Wednesday 29 June and have returned comments in relation to content and factual accuracy on Friday 1 July. We await further comment from NHS Healthcare Improvement Scotland.

Integration and learning - Are we responding and improving?

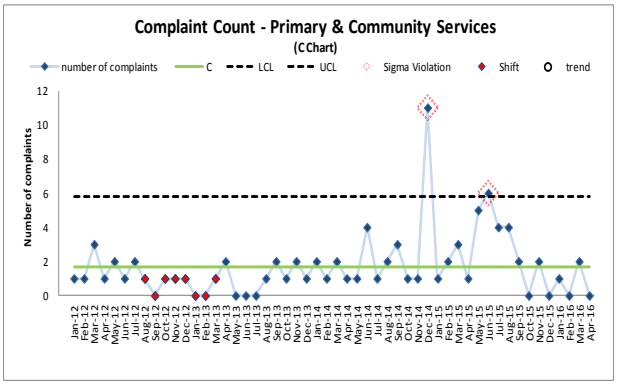
Complaints

Our last report highlighted the new complaint handling introduced from 1 November 2015 with an ongoing focus on local resolution and remediation, while aiming to reduce formal complaints.

This new approach continues to be monitored by both Clinical Governance Groups on a monthly basis.



This chart shows normal variation



This chart shows there have been 2 sigma violations in Dec 14 & Jun 15

Recommendation

The Board Clinical Governance Committee is asked to note the report and the assurance that robust governance systems are in place across Primary, Community and Acute Services.

Policy/Strategy Implications	There are no policy implications for the Clinical Governance Committee
Consultation with Professional Committees	Items have been discussed at BGH & PACS Clinical Governance Groups, with updates given to the PACS Clinical Board
Risk Assessment	There are no risk assessment implications for the Clinical Governance Committee
Compliance with Board Policy requirements on Equality and Diversity	Yes
Resource/Staffing Implications	None

Author(s)

Name	Designation
Charlie Sinclair	Associate Director of Nursing (Acute, Primary Care and Community)

Appendix 1

Safety Measurement & Monitoring dashboard

Safety Measurement
& Monitoring Weekly

When you open the dashboard if you click on the word “Reliability” you will be taken to the page containing the OPAH measures and then you can navigate to the individual charts by clicking on the grey globe next to the measure name.

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CLINICAL GOVERNANCE COMMITTEE

MENTAL HEALTH CLINICAL GOVERNANCE REPORT – JUNE 2016

Aim

To assure the Clinical Governance Committee that appropriate governance systems and processes are in place within the Mental Health Service.

Background

The 'Framework for Measuring and Monitoring Safety' continues to be used to support our governance systems and structures within Mental Health.

The Mental Health Governance meeting is held bi-monthly on the fourth Monday. This report reflects the meeting held on held on Monday 27th June 2016.

This report also includes appropriate detail from the Mental Health Performance Scorecard and Nursing Dashboard, providing an overview of relevant performance against local and national standards.

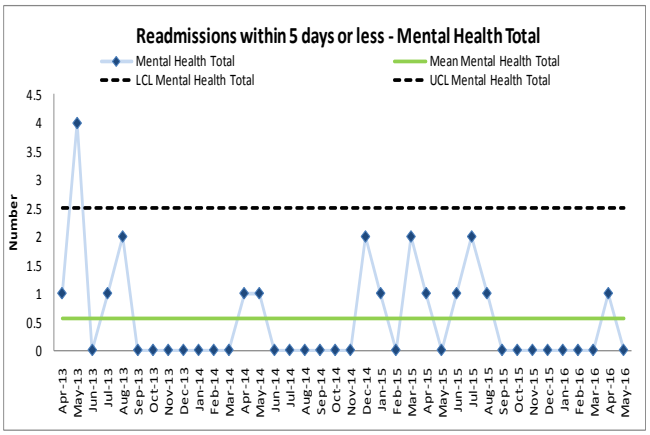
Summary

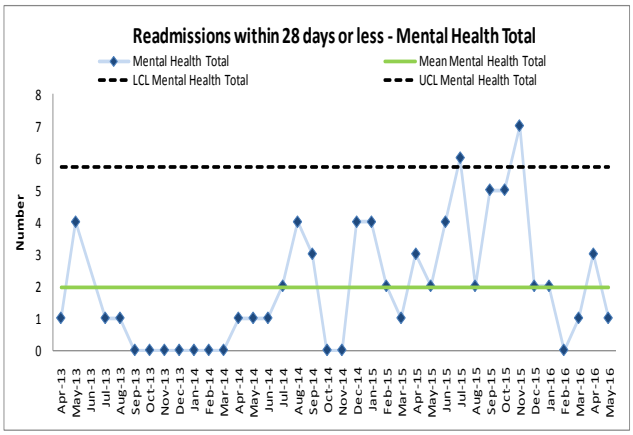
Past Harm - Has Patient Care been safe in the past?

Readmissions

There was one readmission within 5 days of discharge (or less) in Mental Health in April 2016, in Huntlyburn Ward. Appropriate discharge plans were in place for this patient and the readmission was due to the individual patient's mental health needs rather than any failings in process. No follow up actions are required.

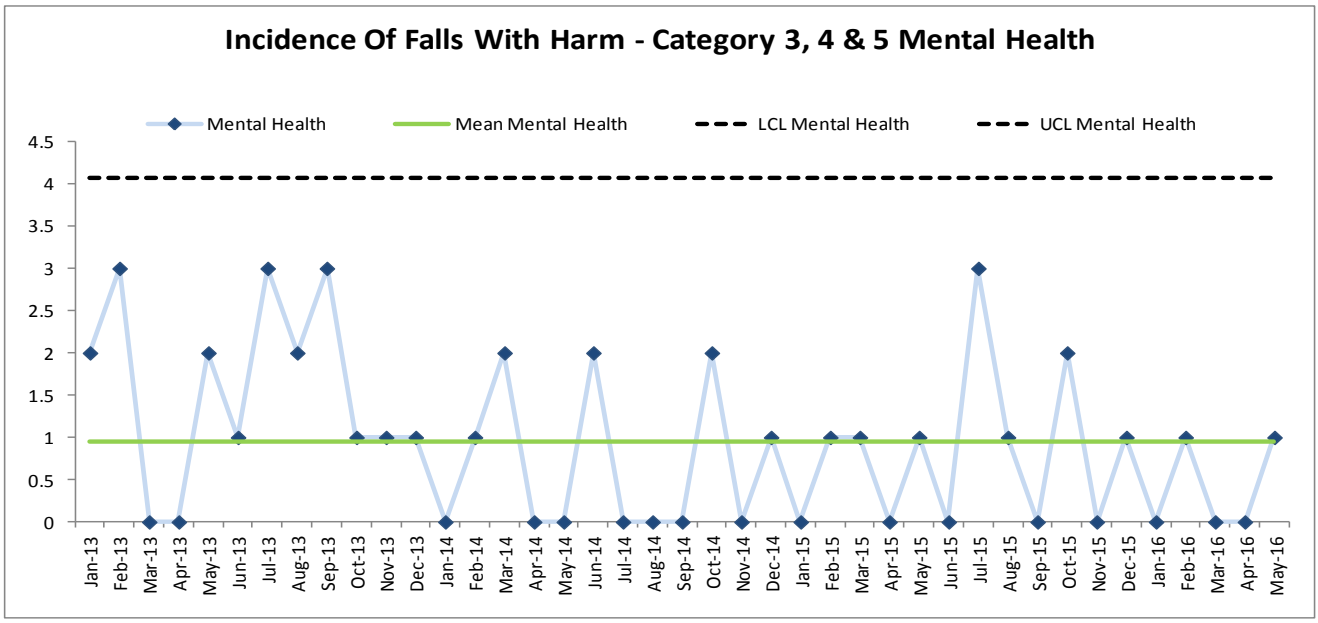
Since December 2015 the number of readmissions within 28 days has been low and is investigated on a case by case basis via the performance scorecard in Mental Health Operational and Board meetings. Pre discharge arrangements continue to be a priority in all Mental Health Wards and low numbers of readmissions would suggest these arrangements are being successfully utilised.





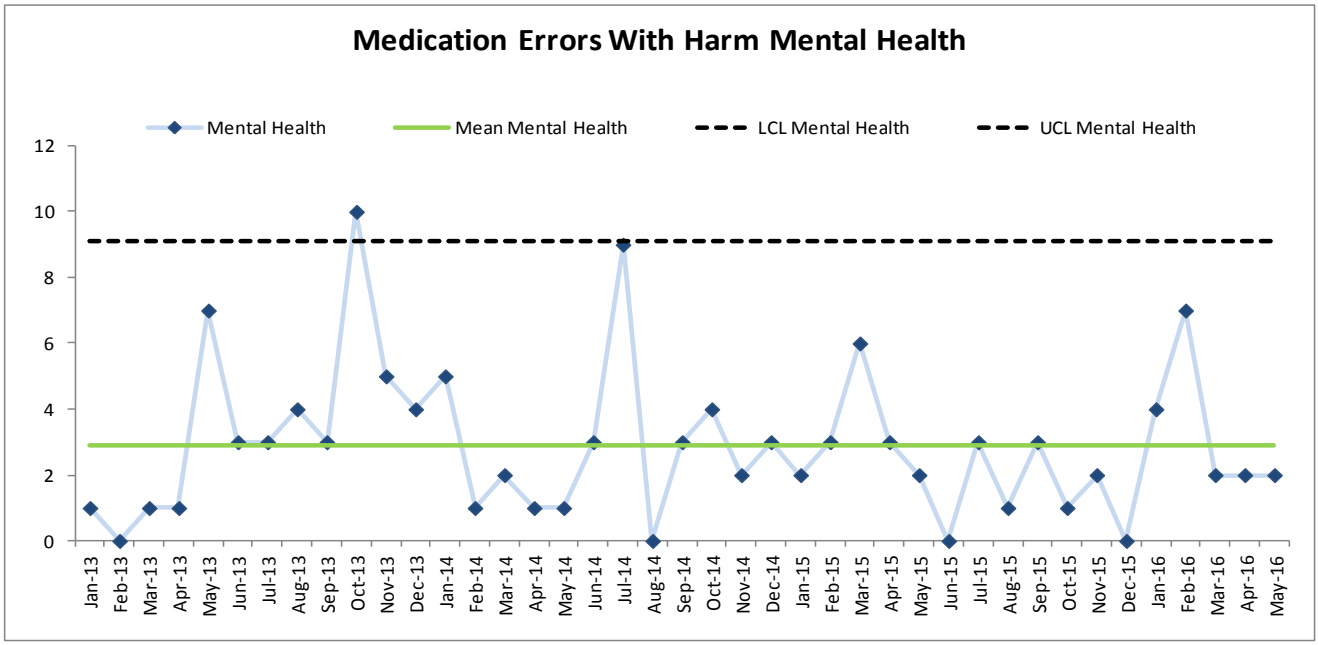
Falls

There are a low number of falls reported in Mental Health settings; 10 incidents over the last 12 months (June 2015 – May 2016 inclusive). Awareness and learning from falls investigation is shared with staff in addition to formal mechanisms, as part of the introduction of a monthly adverse event newsletter. Mental Health falls tend to happen within our older adult wards - all areas work well to prevent and manage falls and continue to explore other strategies to reduce risk and events.



Medication Errors

There were 27 medication errors reported in the last 12 months (June 2015 – May 2016 inclusive). This is highlighted as part of the monthly adverse event newsletter. Huntlyburn ward and East Brig complete a prescription audit weekly; it has been requested that all wards move to doing this. Processes are in place to review all reported medication errors and to ensure action is taken to mitigate future risk.

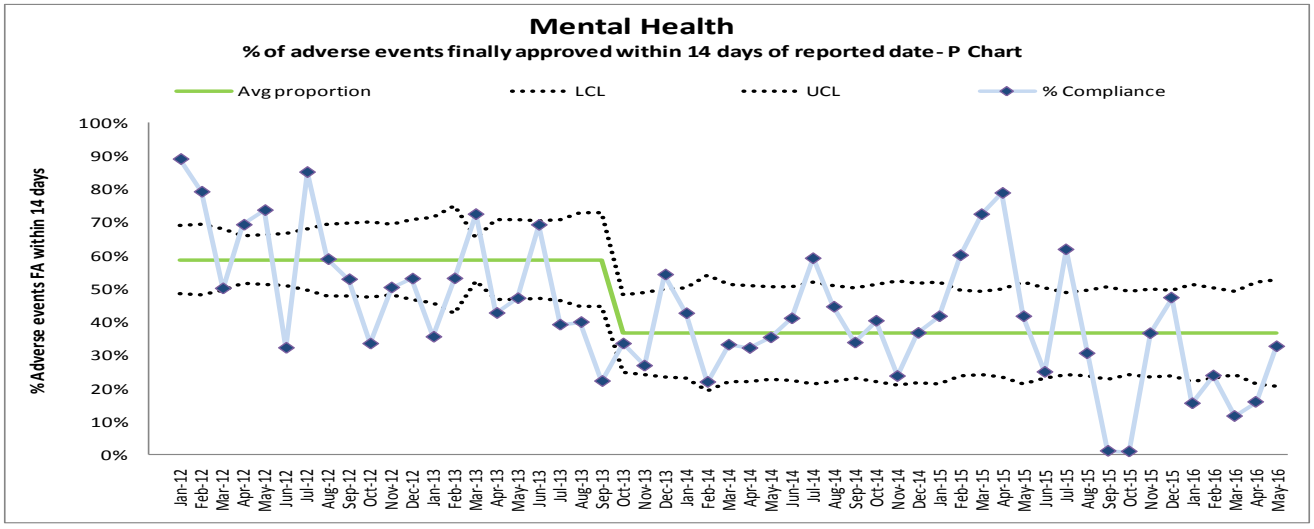


Reliability - Are our Clinical systems and processes reliable?

Adverse Events

Performance in responding to adverse events in a timely manner continues to be a focus for all members of the Mental Health Management Team.
Adverse events will be a standing item for discussion at the Mental Health Operational and Performance Review Meetings from May 2016 onwards to try to address where improvements will be made.

The Operational Manager has developed a Mental Health Adverse Events newsletter which picks up on and investigates key themes or events over time and allows more robust feedback on progress and outcomes of adverse events to staff. This is an improved communications mechanism from previous practice.



Borders Addictions Service Prescribing System

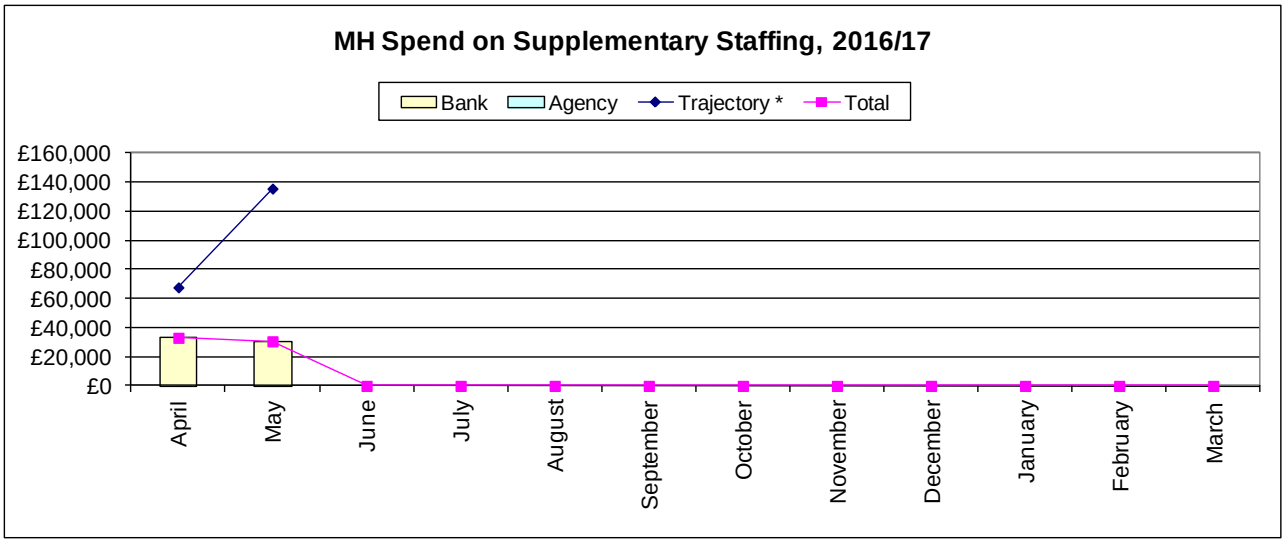
The current prescribing system used in the Borders Addictions Service (BAS), called POPPIE, has been deemed as not fit for use and is currently a very high risk on the Mental Health Risk Register. An options appraisal was undertaken to look at alternative systems and a proposal was drafted. IM&T are currently reviewing the proposal in line with the current IT infrastructure – this has been escalated to Jackie Stephen, Head of IM&T, and it is hoped that a solution will be agreed and moved towards within the coming months.

Sensitivity - Is care safe today?

Supplementary Staffing

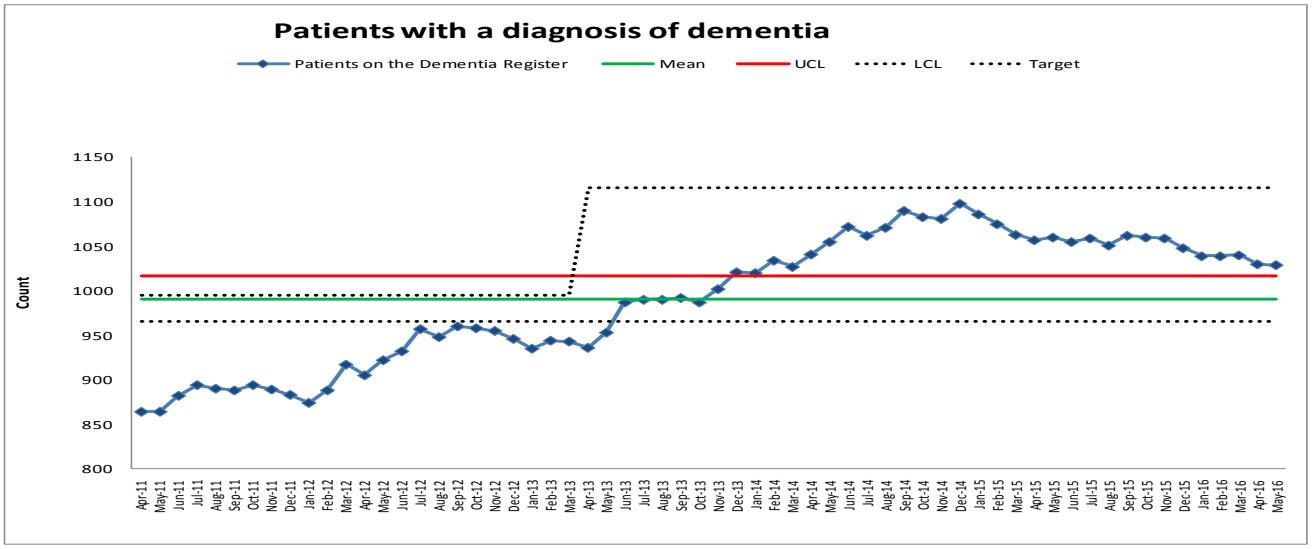
Use of supplementary staffing in Mental Health in May 2016 decreased slightly from April however is still higher than in 2015/16 due to the decant of patients from Melburn Lodge to allow refurbishment works to take place. This resulted in the need for increased staff to enhance supports given the mixture of presentations in one clinical area. The refurbishment was completed on 10th June 2016 and therefore it is anticipated that use of supplementary staffing in Mental Health will decrease in the coming months.

A robust process continues to be followed to ensure supplementary staffing requests are appropriate. There was no use of agency nursing in Mental Health throughout 2015/16 and in 2016/17 to date. The supplementary staffing report is discussed at the Mental Health Board meetings.



Dementia HEAT Standards – Dementia Diagnosis and Post Diagnostic Support

The number of patients diagnosed with dementia continues under target. The target of 1116 patients was nearly met in December 2014 but since then has continued on a downward trend. However, the percentage of patients then offered support within the first 12 months following a diagnosis of dementia was 98% at the end of April 2016 (against a target of 100%) which is an increase compared to previous months.



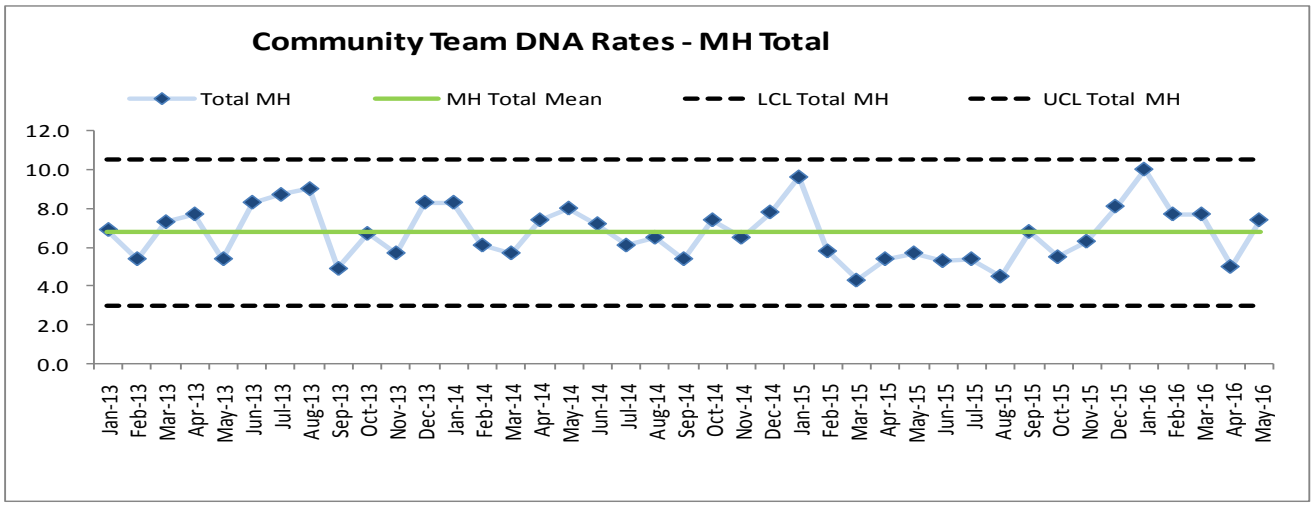
With regards to the Dementia Diagnosis target, it is thought that we are under reporting, therefore the MHOAS Service Manager and Consultant are undertaking a gap analysis with MHOAS and GP's to ensure diagnoses are entered onto the register appropriately. It is anticipated that this will mean the target is reached in the coming months.

With regards to the Post Diagnostic Support target, a pro forma has been developed to check and monitor post diagnostic support offered. In addition, we have introduced an improvement programme in relation to the use of the patient centred document, 'Getting to Know Me'. We will report on the progress and outcomes of the programme in future Governance reports.

These targets are monitored via the performance scorecard at Mental Health Operational and Board meetings.

Community Team DNA Rates

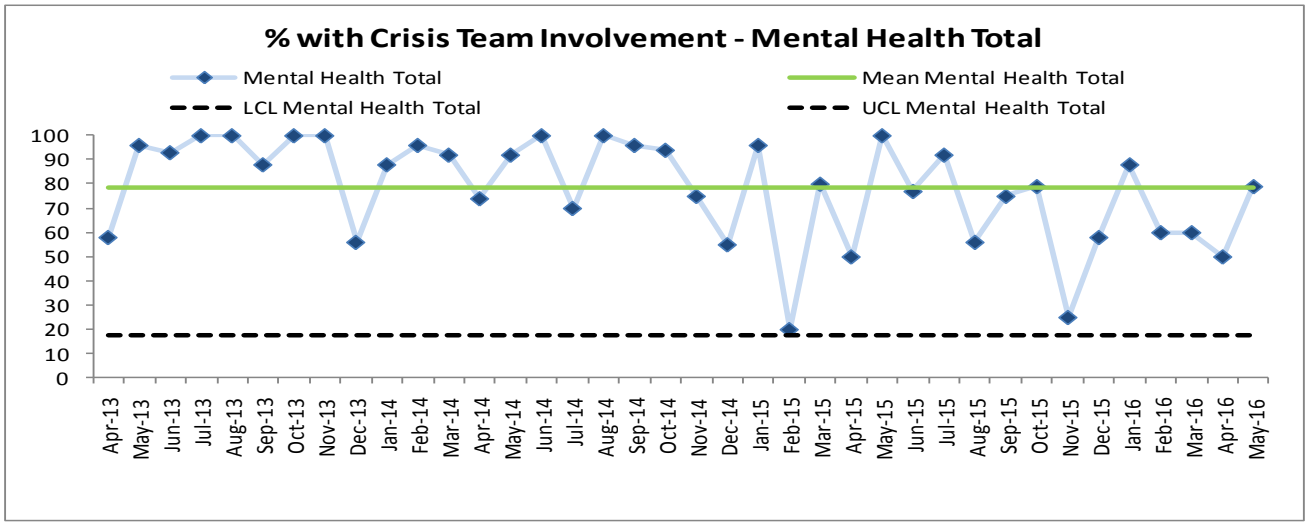
Community Team DNA Rates in Mental Health were under target overall (7.4% against a target of 8%) however the South Team and BAS DNA rates continue above target. BAS use a text reminder system however the complex nature of patients presenting to the service means there is a limited impact that any new initiatives will have on the DNA rate. The South Team are considering how alternative models of allocating appointments could be tested to reduce their DNA rate.



Crisis Team involvement in Mental Health admissions

Crisis Team involvement in admissions increased to 79% in May 2016 from 50% the previous month, however is still significantly lower than the target of 100%. The Service Manager investigates cases where the Crisis Team was not involved in admission on a case by case basis to ensure performance improves.

A list of reasonable exceptions to when crisis team involvement is appropriate will also be drafted and reported through the Mental Health Governance group.



Mental Health Waiting Times - Psychological Therapies

The percentage of patients seen within 18 weeks for a Psychological Therapy continues under the HEAT target of 90%, with performance of 89% in April 2016 and 83% in May 2016.

The following actions have been put in place to improve performance:

- additional clinics have been put in place in the team with the highest number of breaches;
- clinical space available for Psychological Therapies is currently being quantified to try and increase the space available and therefore increase clinical capacity;
- meeting with individual Team Managers and Professional Leads to look at team level data and allocate resource / plan actions accordingly;
- one member of staff having recently commenced training in EMDR.

A Clinical Psychologist is being recruited to using additional funding from the Scottish Government to improve access to Psychological Therapies. This will create extra capacity to tackle the waiting list, which a programme of work is carried out to address the underlying challenges. This funding has been granted over a four year period.

Mental Health Waiting Times - Psychological Therapies

The percentage of patients seen within 18 weeks in CAMHS also continues under the HEAT target of 90% however performance improved to 87.5% in May 2016 (from 79% the previous month) and it is anticipated that the target will be reached by July 2016.

A plan is currently being put in place as to how to best use funding from the Scottish Government to improve access to CAMHS both on a short term basis and to address underlying challenges. Again this funding has been granted over a four year period.

Anticipation and preparedness - Will care be safe in the future?

Scottish Patient Safety Programme (SPSP)

Phase 1 of SPSP, focussing on Adult Mental Health, is coming to completion. Under phase 1, initiatives introduced have been:

- Safer medicines management – as required bundle, error free prescribing audit and medication at transition admission and discharge (formally known as medication reconciliation). Huntlyburn ward was recognized nationally as only nurse led process with significant results benchmarked across Scotland;
- Risk assessment/safety planning – completed risk assessment within 2 hours of admission, risk assessment at discharge and crisis card update, safety brief, pass plans and debrief staff and patient
- Staff/patient safety climate survey and associated action plan; and
- Additional question added to all staffs appraisal/PDP “What are you going to contribute within your role to patient safety in the forthcoming year”

Performance measures are currently being developed for the work streams under phase 2 and target start date of phase 2 is September 2016.

Audit of Alcohol Detox Admissions

The BAS Consultant has started an audit of alcohol detox admissions – including admission criteria and clinical roles in the admission process – from January 2014 to January 2015. This is to ensure appropriate admission for alcohol detox and will make recommendations for future admissions. Results will be fed back to the Mental Health Governance Group and auctioned accordingly.

Mental Welfare Commission Investigation

A report has been released by the MWC regarding an investigation into the care and treatment of "Ms MN", a person with Asperger's Syndrome and challenging behaviour who committed suicide shortly after discharge from hospital into a care facility. A quality assurance audit of discharge planning will be undertaken in response to and in line with the recommendations made within the report - a short life working group, Chaired by the Operational Manager, will take this forward.

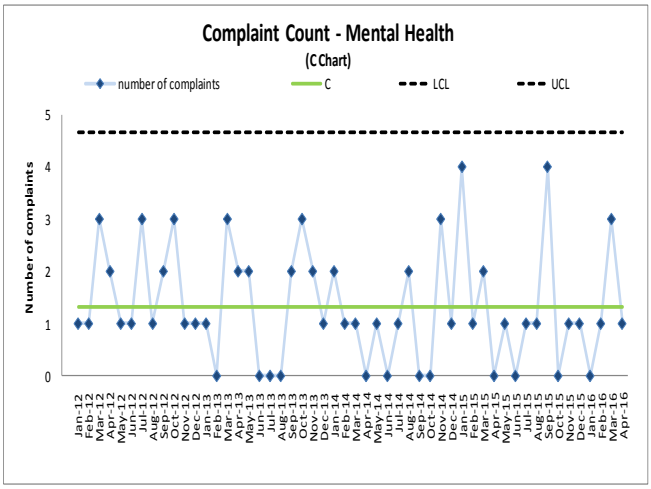
Integration and learning - Are we responding and improving?

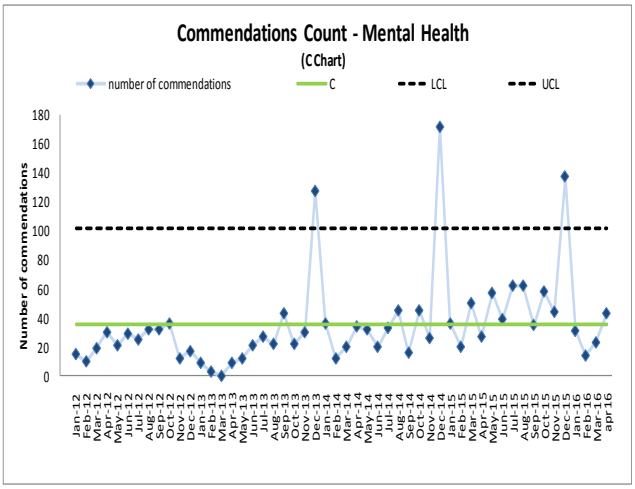
Complaints & Commendations

The number of complaints in Mental Health is low, averaging at one per month. There were three complaints received in April 2016 for which the investigations were all commenced within the 3 day target and the response letters were all sent within the 20 day target.

The new complaints handling process was introduced in November 2015, and this new approach continues to be monitored.

There were 43 commendations received in April 2016, 23 of which were received in Huntlyburn Ward. There were 23 commendations received in May 2016.





Recommendation

The Board Clinical Governance Committee is asked to **note** the report and the assurance that robust governance systems are in place across the Mental Health Service.

Policy/Strategy Implications	There are no policy implications for the Clinical Governance Committee
Consultation with Professional Committees	Items have been discussed at the Mental Health Governance group, with updates given to the Mental Health Clinical Board
Risk Assessment	There are no risk assessment implications for the Clinical Governance Committee
Compliance with Board Policy requirements on Equality and Diversity	Yes
Resource/Staffing Implications	None

Author(s)

Name	Designation
David Thomson	Associate Director of Nursing (Mental Health)

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Clinical Governance Committee

Scottish Borders
Learning Disability Service

29th June 16

Aim

The aim of this report is to provide the Governance Committee with assurance that the LD Service Clinical Governance & Quality Group has oversight of the issues within the service and can provide assurance to the board that appropriate actions and interventions are in place.

Background

The LD Service Clinical Governance & Quality Group meets bi-monthly. Standing agenda items include:- Health & Safety/Risk Management, Clinical Audit/Clinical Effectiveness, Continuing Professional Development, Patient Focus/Public Involvement, Compliments & Complaints. Membership of the group includes management representation from both NHS and SBC. Copy of the last meeting minutes attached.

Clinical Governance Minutes 01.06.2016.(

Summary

Health & Safety/Risk Management

Summary of Datix reports for the Learning Disability Service April – May 16
There were 25 incidents reported on DATIX between 1st April 2015 and 31st March 2016. The number of aggression/ violence events has increased this year. These include:-

- A neighbour being verbally aggressive to a member of admin staff
- A relative being verbally aggressive to a member of admin staff
- A patient being verbally and physically aggressive to a member of nursing staff
- A patient's wife being verbally aggressive towards a member of nursing staff
- A patients partner behaving improperly towards a member of nursing staff

All nursing staff attend Prevention and Management of Aggression and Violence Training on an annual basis. Admin staff are not required to complete this however following the above incidents training in Customer Care was booked for all admin staff via SBC Training

Department but this was subsequently cancelled. Training is now being arranged via Borders Caring Services but there are limited places on this training.

The 2 moderate risks were:-

- The improper behavior towards a member of nursing staff, which was reported to the police and the perpetrator, has been charged.
- The inability to access patient records despite repeated request due to the restricted access at Newstead

There were no major incidents. All incidents are reviewed by line managers at the time to identify any actions required to prevent further incidents. Managers actively encourage staff to report all incidents and near misses.

Risk Register (NHS) – An additional risk has been added to the risk register which is graded as a very high risk. The risk assessment was reviewed at the Clinical Board meeting on 29th June where the grading was confirmed. The risk is in relation to the lack of suitable accommodation for patients with a learning disability who have very high levels of challenging behaviour in Scotland and England. Currently we have a patient who has been given notice by his service provider and to date no alternative accommodation offers have been secured. There are also no LD NHS or private sector beds available at this time. All efforts are being made to identify a suitable provider throughout the UK. In the longer term we are looking at the possibility of commissioning a local service but due to the very high levels of staffing required it is highly likely that this would only be viable if other Boards and Local Authorities were willing to jointly commission.

In addition there are 3 medium risks and 1 high risk. The high risk is in relation to the lack of inpatient beds for adults with a learning disability within the Borders. Regarding the high risk, a further meeting has been held including NHS finance and the existing business case will be updated and submitted to the Strategy Group for consideration. We therefore continue to rely on the availability of other NHS Boards inpatient facilities or the private sector. The LDS management team is becoming increasingly concerned about the lack of availability of beds currently and as a result are reviewing this risk assessment.

Risk Register (SBC) – The ongoing social work waiting list, approximately 45 at the time of writing this report, has been assessed using the SBC risk management framework. With the control measures in place this risk rated as High and has now been recorded upon the SBC risk register. In addition social workers are not able to actively review cases at the level set by the service. An agency social worker has been appointed to increase capacity and a lean working workshop including all staff has been undertaken to identify where efficiencies can be made.

Argyll mobicare – This continues to be used and actively monitored for all appropriate staff within the service.

Provider concerns – A poor CQC report (English equivalent to Care Inspectorate) was received regarding an external provider in England where we have 2 patients residing. Increased monitoring is in place. There are particular issues in relation to 1 of our residents whom we are actively pursuing an alternative placement for as highlighted above (***Risk Register (NHS)).***

Integration and Learning

Intensive Support Service – This service was commissioned 2 years ago and is due for evaluation. An external organisation has been invited to complete this evaluation which will hopefully be completed by September/October16.

CPD – The next CPD day will be on the subject of challenging behaviour and will be held in November 16.

Learn Pro (LD module) – The learning disability service has supported the creation of a Learn Pro LD module for use by NHS staff. The service is having conversations with the Director of Nursing to consider how we can ensure the best use of this training resource.

Compliments and Complaints – In March there was 1 complaint and 3 compliments and in April 2 complaints and 1 compliment.

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Recommendation
The Board Clinical Governance Committee is asked to note the report and the assurance that robust governance systems are in place across the Integrated Learning Disability Services.

Policy/Strategy Implications	None
Consultation with Professional Committees	Not required
Risk Assessment	Not required
Compliance with Board Policy requirements on Equality and Diversity	Yes
Resource/Staffing Implications	None
Which meetings has the document been before the Clinical Governance Committee?	Not required

Approved by

Name	Designation	Name	Designation

Author(s)

Name	Designation	Name	Designation
Simon Burt	Group Manager		

SCOTTISH BORDERS PROFESSIONAL ASSURANCE FRAMEWORK: HEALTH & SOCIAL WORK PROFESSIONALS

Aim

1.1 This Framework sets out how the Medical Director, Executive Nurse Director and Chief Social Worker provide assurance to the Integrated Joint Board (IJB), NHS Board and the Local Authority in the Scottish Borders on the quality and professionalism of the health and social care professional for which they have accountability. When implemented, the Framework provides evidence that structures and processes are in place to provide the right level of scrutiny and assurance across all these professional services.

Background

2.1 The Scottish Government set out the 2020 Vision and Strategic Narrative for achieving sustainable quality in the delivery of health and social care across Scotland. This vision can only be realised if the people who deliver care in Scotland work in partnership with the people they serve. This Framework, as well as assuring the NHS Board and the Local Authority, will also demonstrate to the Scottish Government how health and social care professionals within Scottish Borders are meeting the ambitions of the Public Bodies (Joint Working) (Scotland) Bill 2013.

Summary

3.1 The components of the professional assurance framework are:

- Health & Social Care Professionals are equipped, supervised and supported according to regulatory requirements;
- There is dispersed leadership which focuses on outcomes and promotes a culture of multi-professional parity & respect
- There is clear accountability for standards & professionalism at each level & upwards to the IJB, NHS Board & Local Authority
- The IJB, NHS Board and the Local Authority have a clear understanding of the quality of the Nursing, Midwifery, Allied Health Professionals and Social Work services.

Recommendation

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

Policy/Strategy Implications	Implications on IJB, NHS Board and the Local Authority.
Consultation	N/A
Risk Assessment	N/A
Compliance with requirements on Equality and Diversity	Yes

Resource/Staffing Implications	Possibility

Approved by

Name	**Designation**	**Name**	**Designation**
Evelyn Rodger	Director of Nursing, Midwifery & Acute Services	Elaine Torrance	Chief Social Work Officer
Andrew Murray	Medical Director		

Author(s)

Name	**Designation**	**Name**	**Designation**
Evelyn Rodger	Director of Nursing, Midwifery & Acute Services	Elaine Torrance	Chief Social Work Officer
Andrew Murray	Medical Director		

Scottish Borders Professional Assurance Framework:

Health* and Social Work Professionals

2015

*(*the term 'health professional'' is used here for ease and refers to Nurses, Midwives, Allied Health Professionals, and community and hospital based Medical staff. It does not include independent contractor services for the purposes of this document as there are specific arrangements in place for these services with regard to monitoring quality within Primary and Community Care which will continue.)*

1. INTRODUCTION

Professionally registered practitioners working in health and social care across Scotland perform their roles in a diverse range of settings. The organisational context in which professionally registered health and social care practitioners fulfil their roles is complex. Lines of accountability can be convoluted and often span organisational boundaries. Fostering team working is equally important as developing the roles of any one professional group[1].

The Integrated Joint Board (IJB), NHS Board and Local Authority have corporate accountability for maintaining and improving the quality of services in the form of clinical and social care governance[2].

Accountability for the quality of our staff:

- Nursing, Midwifery and Allied Health Professionals (AHPs) are devolved to the Executive Nurse Director to ensure there is clarity of professional responsibility and robust accountability structures for professional Nurses, Midwives and AHPs. The Executive Nurse Director has overall responsibility for NMAHP practice and standards.
- Social work is the responsibility of the Chief Social Work Officer. Each local authority is required through legislation to appoint a Chief Social Work Officer, who must hold a social work qualification and has a key role in ensuring components are in place for developing good governance: culture, systems, practices, performance, vision and leadership and in overseeing compliance with these arrangements. The Chief Social Work Officer (CSWO) has overall responsibility for social work practice and standards– whether provided directly by the local authority or in partnership with other agencies.
- Medical staff are the professional responsibility of the Medical Director who holds accountability for the actions of medical staff, delivering care through health and social care integrated services.

This clarity for professional accountability and leadership is most needed in times of significant organisational and structural change and in the commissioning of services; when patients, families and service users may be more at risk if responsibilities for tasks and care are unclear.

Individually Nurses and Midwives are professionally accountable to the Nursing and Midwifery Council (NMC); social workers are professionally accountable to the Scottish Social Services Council (SSSC), with AHPs accountable to the Health and Care Professions Council (HCPC); and medical staff to the General Medical Council (GMC). Professionally registered practitioners also have a contractual accountability to their employer and are accountable in law for their actions. This is the position irrespective of the setting and context within which professionally registered practitioners perform their roles.

[1] Kings Fund (2013), Making Integrated Care Happen at Scale and Pace, The Kings Fund London
[2] RCN (2013) Clinical Governance, Available online http://www.rcn.org.uk/development/practice/clinical_governance

This Framework sets out how the Medical Director, Executive Nurse Director and Chief Social Work Officer will provide assurance to the IJB, NHS Board and the Local Authority in Scottish Borders on the quality and professionalism of the health and social care professionals for which they have accountability. When implemented, the framework will provide evidence that structures and processes are in place to provide the right level of scrutiny and assurance across all these professional services. It is one of the key methods by which clinical and care governance will be achieved across integrated health and social care. The Professional Assurance Framework can be found in Appendix 1.

1.1 The Professional Assurance Framework in Context

The Scottish Government set out the 2020 Vision and Strategic Narrative[3] for achieving sustainable quality in the delivery of health and social care across Scotland. This vision can only be realised if the people who deliver care in Scotland work in partnership with the people they serve. This Framework, as well as assuring the NHS Board and the Local Authority, will also demonstrate to the Scottish Government how health and social care professionals within Scottish Borders are meeting the ambitions of the Public Bodies (Joint Working) (Scotland) Bill 2013.

2. WHY IS THIS PROFESSIONAL ASSURANCE FRAMEWORK NECESSARY?

2.1 The Integration of Health and Social Care

The Public Bodies (Joint Working) (Scotland) Bill introduced in the Scottish Parliament in May 2013 aims to enact the Scottish Government's commitment to integrate adult health and social care. The policy memorandum to the Bill states that integration means that:

> *"…services should be planned and delivered seamlessly from the perspective of the patient, service user or carer, and that systems for managing such services should actively support such seamlessness"[4].*

The integration of health and social care has been a Government imperative for over two decades. Successful integration will require decision-making to be devolved to locality management teams where the focus will be on developing new and innovative solutions. The ability of Health and Social Care Partnerships to reshape care effectively will be crucially dependent on the willingness of the parent bodies to exercise facilitative leadership, that is "to let go"[3]. Cultural change of this magnitude will require innovation, flexibility and informed risk-taking.

2.2 The Mid Staffordshire Public Enquiry Report (The Francis Report 2012)

For the NHS the Francis Report was a landmark publication for with implications for the rest of the UK. It has important messages for all professional practitioners. Among the many recommendations the Francis Report called for a stronger nursing voice in safeguarding acceptable standards of care. So, at the same time that the integration of health and social care requires flexibility, innovation and informed risk-taking, the Mid Staffordshire Public Enquiry Report calls for fundamental standards, clearer accountability, simplified regulation and more effective external scrutiny[5]. These

[3] Scottish Government 2020 Vision Available online http://www.scotland.gov.uk/Topics/Health/Policy/2020-Vision
[4] SPICe Briefing, Public Bodies (Joint Working) (Scotland) Bill, Available online http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_13-50.pdf
[5] Francis R, The Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry Available online http://www.midstaffspublicinquiry.com/

principles require to be equally applied to Medical, AHP and social work standards of practice in order to build a strong, cohesive professional whole – which delivers high quality services with, and to, communities and families.

2.3 Transforming Care: A national response to Winterbourne View Hospital (2012)
This report had the equivalent impact on social work and Local Authorities that the Francis Report had on the NHS. It exposed wider issues in the care system. It laid out clear actions for health and local authority commissioners in order to transform care for clients with learning disabilities. The report made clear that Directors are directly accountable and responsible for the quality of care and practice taking place under their watch.

Chief Social Work Officers, Medical and Executive Nurse Directors must balance empowering facilitative leadership with absolute clarity in roles, accountabilities and expectations in order to achieve the necessary professional assurance with regard to standards of practice. The examples given here provide some context but there are obviously other reports over recent years with disappointingly similar and recurring themes, which demonstrate the need for professional assurance.

Whilst these two English reviews have been instrumental in changing the health and social care landscape there are other reports in Scotland from Mental Welfare Commission, the Scottish Public Services Ombudsman and published significant case reviews that need to influence change in Scottish Borders services.

3. WHO IS THE PROFESSIONAL ASSURANCE FRAMEWORK FOR?

This Framework applies to all health and social care professionals as set out in the integration scheme irrespective of their grade or seniority. It is closely aligned with the statutory regulatory frameworks[6][7] and professional guidance that underpin nursing, midwifery, AHP, Medical and social work practice. Crucially, it will enable health, and social care professionals to carry out their responsibilities, confident in their knowledge of accountability both for their actions and those actions which they have delegated to others.

The Framework also has wider applicability to those responsible for services and the quality of care delivered to patients/clients or service users. This may be within settings where staff from different organisations work together with a manager who may be from a different professional group or background.

The Chief Social Work Officer, Medical and Executive Nurse Director must ensure that all agencies in our Health and Social Care Partnership fulfil the responsibilities set out in the Assurance Framework. In fulfilling their role, these professional leaders must have access to people, information and existing systems and processes, for example, HR policies and procedures across the NHS and Local Authority, partner services and agencies where health and social care professionals perform their roles[8].

[6] NMC
[7] Midwives Rules & Standards
[8] NHS Highland (2012) Professional NMAHP Leadership Framework Within the Lead Agency Model

4. COMPONENTS OF THE PROFESSIONAL ASSURANCE FRAMEWORK

The Assurance Framework which has been set out in the format of a Driver Diagram (logic model) aims to ensure that there are:

> '*Explicit and effective lines of accountability from the care setting to the Executive Nurse Director, Medical Director and Chief Social Work Officer; which provide assurance on standards of care, practice and professionalism'.*

The building blocks to meeting the aim are provided as a series of Primary Drivers. Core specific actions, systems and processes needed to meet each Primary Driver are set out in separate sections from pages 9 -12. Examples of indicators to demonstrate the extent to which these requirements are in place are included. These can be converted into measures to inform improvements where required. The Primary Drivers and the rationale behind them are summarized below.

4.1 Health and Social Care Professionals are equipped, supervised and supported according to regulatory requirements

The building blocks to effective systems of assurance starts where caring takes place - at the interface between practitioners and the people they serve. As such practitioners must be fully equipped, supported and supervised. The Framework sets out what is needed in this respect and explains how to provide assurance that systems are in place and working effectively.

4.2 There is dispersed leadership which focuses on outcomes and promotes a culture of multi-professional parity and respect

The Medical Director, Executive Nurse Director and Chief Social Work Officer are professionally accountable for the quality of the medical, nursing, midwifery, AHP and social work service provided in their organisations. Given the size and complexity of most organisations they must extend their span of clinical governance and professional influence through a dispersed and devolved professional leadership structure. Hierarchies can be constraining but equally there must be easy access to professional leadership, advice and support for operational managers at the different levels throughout the organisation.

The professional leaders selected for these roles must be able to foster (and demonstrate) effective team working through a mutual respect for the contribution of other professional groups and agencies. The focus must be on achieving health and social care outcomes as well as the ones that matter to the people served. An effective nursing, midwifery, AHP and social work leadership structure can be likened to the weave of a fabric that can be tightened or loosened depending upon the circumstances and the capability of the leaders that occupy professional leadership roles. It must set clear parameters but also empower.

4.3 There is clear accountability for standards and professionalism at each level and upwards to the IJB, NHS Board and Local Authority

As well as structures there must be clearly defined roles and accountabilities in terms of the uniqueness of the registered Medical Practitioner, registered nurse, midwife, AHP or social worker roles particularly where they overlap. Practitioners and professional leaders must understand what is expected of them, how to fulfil these expectations and how to provide assurance on their effectiveness. Non-clinical managers must also be clear about what is expected when doctors, Nurses, Midwives, AHPs and social workers report to them in a line management capacity. The effectiveness of joint working will be demonstrated by effective information sharing across professions guided by a robust information sharing protocol.

4.4 The IJB, NHS Board and Local Authority have a clear understanding of the quality of the Nursing, Midwifery, Medical, AHP and social work service

The final building block in this Framework is that, for the NHS Board and Local Authority to be fully accountable, they must have a clear understanding about the quality of the medical, nursing, midwifery, AHP and social work service provided in their region. Crucially there must be transparency and dispute resolution. A combination of retrospective and real time data should be used to provide assurance that systems and processes are in place and working effectively.

5. HOW TO USE THIS PROFESSIONAL ASSURANCE FRAMEWORK

This Assurance Framework can be used in a variety of ways such as to:

- Confirm there is a system of safeguarding in place for which Chief Executives are ultimately accountable
- Review and strengthen what is already in place in relation to medicine, nursing, midwifery, AHP and social work roles and practice, leadership, governance and reporting arrangements
- Highlight where improvements are required
- Clarify what is expected of doctors, Nurses, Midwives and social workers, professional leaders and operational managers
- Provide guidance on what needs to be in place when setting up new organisational structures
- Reinforce the importance of professional conduct and competence during appraisal and personal development and review processes
- Assist managers and practitioners in ensuring that appropriate professional attitudes and behaviours are identified and in taking supportive and remedial action where required.

6. PROFESSIONAL REQUIREMENTS

As an aid to using this Professional Assurance Framework some of the underlying concepts are clarified below.

6.1 Accountability and Responsibility

The terms ‘responsibility’ and ‘accountability’ should not be used interchangeably.

Responsibility can be defined as a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand. Responsibility for completion of a set of tasks or functions can be delegated

Accountability can be defined as demonstrating an ethos of being answerable for all actions and omissions, whether to service users, peers, employers, standard-setting/regulatory bodies or oneself[9]. Accountability cannot be delegated.

6.2 Scope of Practice

Health and social care professionals must work within the parameters of their designated role and capability.

For Nurses and Midwives the NMC has incorporated into The NMC Code: Professional standards of practice and behaviour for Nurses and Midwives[10]. The pertinent statements are that Nurses and Midwives:

- Must maintain the knowledge and skills you need for safe and effective practice.
- Must work within the limits of your competence.

For social workers the SSSC has clear Codes of Practice which set out the standards of professional conduct and practice required of social workers. This document states that social workers must:

- Be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills.
- This specifically includes meeting relevant standards of practice in a lawful safe way, clear and accurate recording, seeking appropriate assistance if you are uncertain about how to proceed in a work matter and undertaking relevant training

For AHPs the Health and Care Professions Council has the Standards of Conduct, Performance and Ethics; in which duties as a registrant are stated clearly. In particular:

- You must keep your professional knowledge and skills up to date.
- You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.

For doctors, the GMC document Good Medical Practice sets out standards of professionalism.

6.3 Delegation

Some tasks are specified to be undertaken by only appropriately registered, skilled practitioners. If a registered practitioner delegates a task, then that practitioner must be sure that the delegation is appropriate. This means that the task must be necessary; and the person performing the

[9] Scottish Government (2012) Professionalism in nursing, midwifery and the allied health professions in Scotland: a report to the Coordinating Council for the NMAHP Contribution to the Healthcare Quality Strategy for NHSScotland, CNOPPP, Scottish Government.

[10] NMC (2010) The Code: Standards of conduct, performance and ethics for Nurses and midwives, Available online http://www.nmc-uk.org/Publications/Standards/The-code/Provide-a-high-standard-of-practice-and-care-at-all-times-/

delegated task must understand the task and how it is performed, have the skills and abilities to perform the task competently and accept responsibility for carrying it out[11].

Apart from a number of specific circumstances, the law does not prescribe which tasks are suitable for particular healthcare personnel. However, it does provide a crucial regulatory framework that applies to every individual practitioner, irrespective of their rank or role. The law imposes a duty of care on practitioners, whether healthcare support workers, registered professional practitioners, doctors or others, in circumstances where it is 'reasonably foreseeable' that they might cause harm to patients/clients through their actions or their failure to act[12].

If these conditions have been met and an aspect of care is delegated, the delegate becomes accountable for their actions and decisions. However, the health or social care professional remains accountable for the overall management of the person in their care, and cannot delegate this function or responsibility.

Where another, such as an employer, has the authority to delegate an aspect of care, the employer becomes accountable for that delegation. In accordance with the NMC Code[13], Nurses or Midwives must act without delay if they believe a colleague or anyone else may be putting someone at risk.

7. CONCLUSIONS AND RECOMMENDATIONS

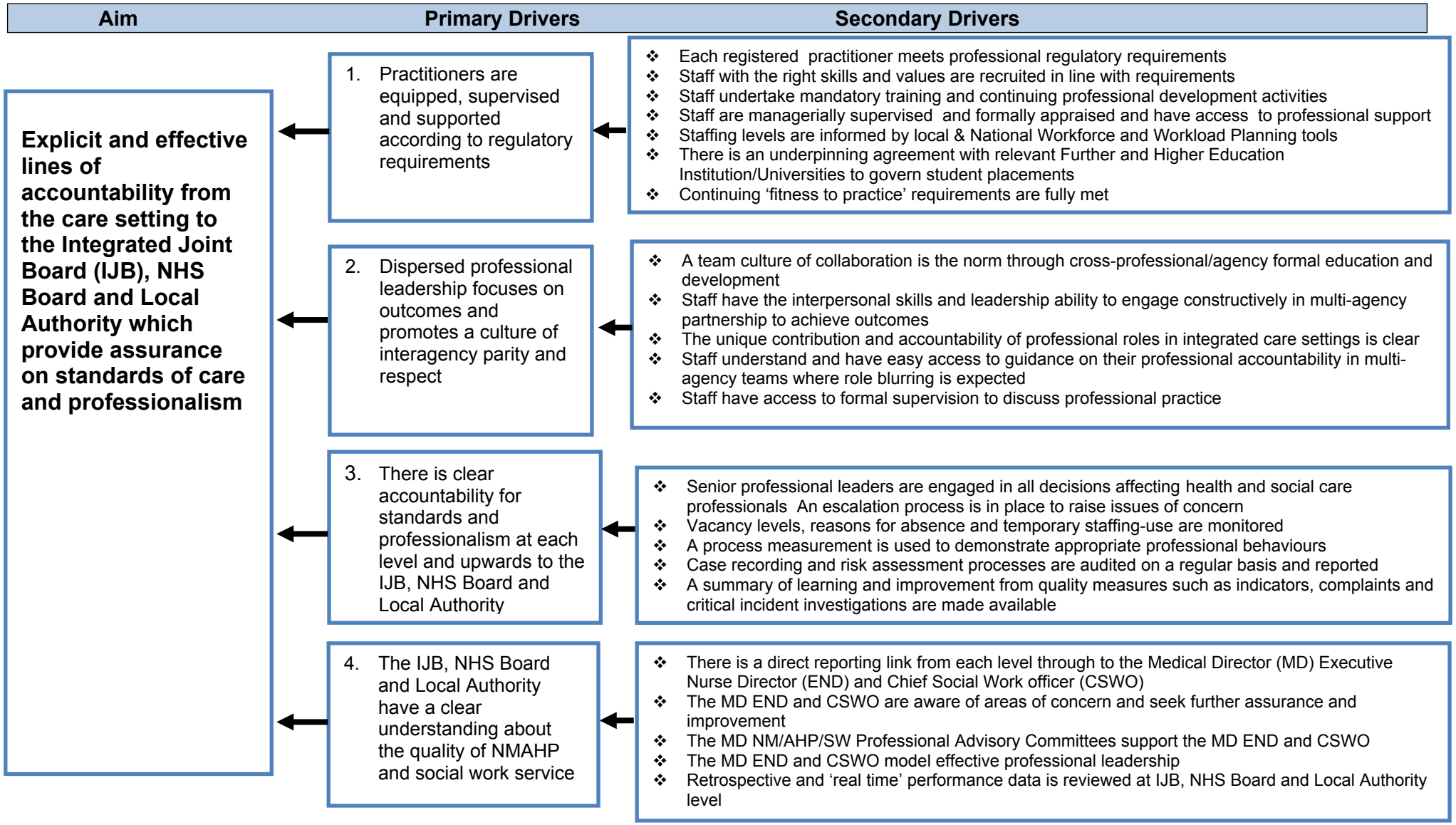
The requirement for health and social care professionals' accountability remains the same no matter where they work or who they work with. In times of organisational change and upheaval it is possible to lose sight of this. Previously accepted norms deconstruct and professional identity is challenged. Sometimes such challenge is appropriate to enable progress to be made, but the four primary drivers set out in this Framework are the fundamentals to assuring professional practice in Scottish Borders. They must not be eroded or compromised.

There will undoubtedly be rugged terrain to navigate as the IJB, NHS Board and Local Authority work more formally with other agencies to build new relationships and working practices in pursuit of integrated care. Health, and social care professionals will play their part but they need to feel confident that their organisations understand what is required of them to meet their codes of professional conduct/standards of professional practice, and work within the law. At a human level, it is often only when there are clear parameters and a concordance in approach that people feel confident enough to innovate and flourish. The following suggests how this Framework will be used to best effect.

[11] NMC (2013) Regulation in Practice, Available Online http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/
[12] RCN (2011), Accountability and Delegation, What you need to Know, Available online http://www.rcn.org.uk/__data/assets/pdf_file/0003/381720/003942.pdf
[13] NMC Code

APPENDIX 1

NMAHP AND SOCIAL WORK PROFESSIONAL ASSURANCE FRAMEWORK



HOW WE PROVIDE ASSURANCE

1. Practitioners are equipped, supervised and supported according to regulatory requirements

Steps to Meeting Secondary Drivers	Indicators
➢ An up-to-date record is held of each practitioner's registration details ➢ A relevant medical manager, NMAHP or social worker is involved in the recruitment of all medical, NMAHPs or social workers according to the appropriate profession to ensure professional robustness of the process. ➢ Professional values and attitudes are explicitly assessed as part of the interview process (values based interviews). ➢ Each practitioner holds their own training record and understands their responsibility along with their manager for meeting mandatory training requirements ➢ Appraisal is undertaken by operational managers with input from a relevant medical manager, NMAHP or social work representative informed by feedback from colleagues and patients/clients ➢ Practitioners have access to a professional supervisor (mandatory in professionally isolated multi-agency settings) ➢ Inter-agency / cross-professional formal education and development is monitored through governance arrangements ➢ Implementation of all requisite professional regulatory educational quality standards (e.g. QSPP and Standards for Learning and Assessment in Practice, Care standards)	✓ GMC, NMC, HCPC, SSSC Registration monitoring records ✓ Recruitment monitoring data ✓ Performance appraisal records ✓ Personal Development Planning and Review (PDR) statistics (including extent to which actions identified and agreed upon during PDP/PDR processes have been progressed and completed) ✓ Individual learning and development records ✓ Capacity to provide and uptake of professional supervision ✓ Practice Education Facilitator (PEF) reporting; NES performance management reports: NMC/HCPC/SSSC validation and monitoring reports ✓ Mandatory training records ✓ Service Level Agreements (SLAs) with relevant HEI/Universities to provide bespoke education when required

2. Dispersed professional leadership focuses on outcomes and promotes a culture of inter-agency parity and respect	
Steps to meeting Secondary Drivers	**Indicators**
➢ Senior practitioners have access to leadership development in partnership working and leading across organisational boundaries ➢ Protocols are in place to support and advise practitioners on delegation of activities within the NHS, Local Authority and integrated care settings ➢ A relevant medical manager/NMAHP/social worker agrees staffing levels with operational managers informed by local and national tools ➢ An explicit decision-making process underpins which professional is most appropriate to provide specific aspects of care based on assessed need and person-centred outcomes. ➢ An independent and objective relevant medical manager, NMAHP/social worker sits on disciplinary panels where professional conduct /competence is an issue ➢ A system is in place to enable all staff to raise a concern if they are asked to undertake a task for which they do not feel competent ➢ Regular reporting of outcomes form patients, service users and their carers	✓ Medical NMAHP and social work leadership and professional reporting structure ✓ % staff undertaking multi-agency leadership development programmes ✓ Compliance with protocols on: - role clarity - delegation principles in multiagency settings - Professional accountability and reporting processes ✓ Dependency/occupancy/skill mix/nurse to bed ratio reports ✓ Patient/client record audits (outcome data) ✓ Patient/client feedback data ✓ Staff feedback data ✓ Staff absence data ✓ Staffing establishments and levels ✓ Staff Experience data ✓ Feedback from service users and carers

3. There is clear accountability for standards and professionalism at each level and upwards to the IJB, NHS Board and Local Authority

Steps to Meeting Secondary Drivers	Indicators
➢ There is a formal system for involving the relevant medical manager, NMAHP or social worker in professional issues involving NMAHPs or social workers e.g. HR issues, the workforce and clinical governance implications of service design/redesign ➢ The medical manager, NMAHP or social worker reviews workforce data with operational managers e.g. actual against proposed skill mix, vacancies, absence rates ➢ A measure is used to demonstrate / improve appropriate professional behaviors ➢ Summaries of learning and improvement from quality measures (such as quality indicators, complaints and critical incident investigations) are used for organisational learning and are embedded within governance structures ➢ A recognised and well-publicised escalation process is in place to ensure Doctors, NMAHPs and social workers are able to bring concerns to the attention of senior managers and that they receive feedback ➢ PIN and relevant Local Authority Guidelines and Policies underpin practice	✓ Workforce data e.g. skill mix reviews, staff vacancies, temporary staffing use (agency and bank) ✓ Core mandatory quarterly attendance statistics, capability, disciplinary and grievance data ✓ Risk management reports ✓ Critical incident review reports ✓ Outcome of review of appropriate professional behaviours, action plans and progress reports ✓ Clinical quality indicator reports ✓ Escalation reports and outcomes

4. The IJB, NHS Board and Local Authority have a clear understanding about the quality of Medical, MAHP and social work services	
Steps to Meeting Secondary Drivers	**Indicators**
➢ There is a formal system for reporting to the Medical Director Executive Nurse Director and Chief Social Work Officer on professional issues involving NMAHPs and social workers ➢ A quality report is made to the NHS Board and Local Authority via relevant governance structures which triangulates indicators of workforce and professionalism with relevant aspects of scrutiny and review reports, feedback on professional behaviours and demonstrates evidence of the learning and continuous improvement arising from these.	✓ Independent scrutiny reports, action plans and progress reports ✓ Scottish Public Service Ombudsman reports ✓ Complaints, compliments and critical incident statistics and reports (including reports of near misses) ✓ Staffing and skill mix review reports ✓ Records of referrals to GMC, NMC/HCPC/SSSC and outcome of investigations and hearings. ✓ Pre and Post Registration Education Placement Audit reports ✓ Patient/client feedback data ✓ Staff feedback data ✓ Risk management data (e.g. DATIX reports) ✓ Specific Scottish Patient Safety Programme and joint improvement collaborative indicators ✓ Healthcare Improvement Scotland, Care Inspectorate inspection reports and audits

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CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2015/16

Aim

1.1 This is the ninth annual report on the work undertaken on behalf of the Council in the statutory role of Chief Social Work Officer**.**

1.2 The report provides the IJB with an account of decisions taken by the Chief Social Work Officer in the statutory areas of Fostering and Adoption, Child Protection, Secure Orders, Adult Protection, Adults with Incapacity, Mental Health and Criminal Justice. The report of the Chief Social Work Officer is attached as Appendix A.

1.3 It also gives an overview of regulation and inspection, workforce issues and social policy themes over the year April 2015 to March 2016, and highlights some of the key challenges for Social Work for the coming year.

Background

2.1 The requirement that every local authority should have a professionally qualified Chief Social Work Officer is contained within Section 45 of the Local Government etc (Scotland) Act 1994. This requirement was reinforced by the recommendation contained in the Changing Lives Report published by the 21st Century Social Work Review Group to strengthen the governance and leadership roles of the Chief Social Work Officer. This national guidance has recently been reviewed to take into account new partnership arrangements.

2.2 Following the review of the Corporate Management structure in Scottish Borders Council during 2014 a specific service director role was created for the Chief Social Work Officer, reporting directly to the Depute Chief Executive for People.

2.3 In 2014 the Scottish Government published a template and guidance to enable Chief Social Work Officers across Scotland to develop a more consistent approach to the production of their reports and allow summary comparison of the delivery and performance of Social Work across different areas. This template has been used to provide this report. This has provided helpful comparative data for Social Work which has been published to give a picture of Social Work across Scotland.

Summary

3.1 During 2015 the new governance arrangements for Social Work in Scottish Borders Council have become well established in the People Management Team. There has continued to be significant changes to governance arrangements in relation to the establishment of the Integration Joint Board and the strengthening of Children and Young People's leadership group, however public protection arrangements have continued to be a high priority for the Council during this period.

3.2 There have been a number of achievements during this period. There has been an ongoing focus on improving arrangements for the discharge process from hospital which have enabled people to move to appropriate care settings in a timely way. The implementation of Getting It Right For Every Child is well under way and the

Early Years agenda is well advanced. Processes for Self Directed Support have been further developed to provide service users and carers greater say in choice and the management of their care arrangements and over 530 people are now using this approach.

3.3 Key Social Work performance data is contained in the report. The number of children on the Child Protection Register remained lower that the national average during this period. There has been an increase in new foster parents but a number have also de-registered and therefore the recruitment of new foster parents remains a priority for 2016/17.

3.4 The Mental Health Officer service continues to perform well in terms of attendance at emergency detentions but the demands on the service continue to increase with a notable increase in private and welfare guardianship applications in line with national trends.

3.5 The report has summarised Care Inspectorate grades during this period and the overall quality of inspected services across the Borders has increased with 81% of services being graded at good/very good and excellent.

3.6 Challenges facing Social Work for 2016/17 are identified in the report. There are ongoing financial constraints and introducing new arrangements for children and young people including the named person remain a priority. Implementation of the actions identified following the Children and Young People's inspection this year will be a priority including improvements in recording, risk assessment and chronologies. Of particular note is the process of self evaluation across adult services as we prepare for further inspection activity in the coming year. Work is also progressing at pace as part of the implementation of the new arrangements for Community Justice.

3.7 There continues to be challenges in recruitment and retention of staff in care at home services, however, a successful tender to increase the number of Home Care providers in the Borders combined with the introduction of a minimum hourly rate of £8.25 per hour from October should improve the situation.

3.8 As a Council we continue to be well placed to face these challenges and to deliver high quality services and improve outcomes for all people who access Social Work services.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report of the Chief Social Work officer attached as Appendix A and in particular notes the elements noted in section 4 of this report.

Policy/Strategy Implications	The Chief Social Work Officer is required to provide an annual report for Council.
Consultation	The Council and key Senior Managers in the Council have received and commented on this report.
Risk Assessment	There are no specific concerns that need to

	be addressed in respect of the recommendations contained in this report. Public protection processes however need to continue to be a high priority for the Council and IJB.
Compliance with requirements on Equality and Diversity	Social Justice and equality are key values in Social Work and there are no adverse equality implications arising from the work contained in this report.
Resource/Staffing Implications	There are no specific costs attached to any of the recommendations contained in this report but managing service change and efficiencies in the light of increasing demand whilst maintaining service quality remains a challenge.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Social Work Officer		

Author(s)

Name	Designation	Name	Designation
Elaine Torrance	Chief Social Work Officer		

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CHIEF SOCIAL WORK OFFICER

ANNUAL REPORT

April 2015/March 2016

ELAINE TORRANCE

CHIEF SOCIAL WORK OFFICER

INTRODUCTION

This report provides an overview of Social Work activity, performance and achievements during the period April 2015 to March 2016. The report provides information on the statutory decisions made by the Chief Social Work Officer (CSWO) on behalf of the Council and highlights some key challenges in the forthcoming year. The report format follows the template produced by the Scottish Government's Chief Social Work Advisor to provide greater standardisation across CSWO's reports issued in April 2014.

1. Local Authority

The Scottish Borders is located in the south east of Scotland and covers an area of 4,731 square kilometres, the sixth largest local authority in Scotland. It is a rural local authority with only two towns, Galashiels and Hawick, with more than 10,000 people.

The 2011 Census showed that there were 113,870 people in the Scottish Borders, making Scottish Borders one of the least populated regions in Scotland, with a population density the sixth lowest in Scotland.

The latest estimates from National Records of Scotland project a 10.6% increase in population for the Scottish Borders between 2010 and 2035, with significant increases in the population aged 65 or more and in particular the 75+ age group which is predicted to rise by almost 100%. These are age groups that make intensive use of Social Work services.

The Scottish Index of Multiple Deprivation (SIMD) in 2012 reported that Scottish Borders contained only 5 (or 0.5%) of the most deprived data zones in Scotland (those in the most deprived 15% of all data zones). This figure was the same in 2009 but shows an increase since the SIMD started in 2002. Furthermore, the SIMD shows that the more deprived areas in Scottish Borders are still as deprived as they were in 2009, while other regions in Scotland have succeeded in decreasing inequality in their more deprived localities. This relative deprivation adds impetus for Scottish Borders to tackle deprivation and reduce inequalities with at least the same level of commitment as is being deployed in other regions.

Further information can be found in the Scottish Borders Strategic Assessment[1].

2. Partnership Structures / Governance Arrangements

The requirement that every local authority should have a professionally qualified Chief Social Work Officer (CSWO) is contained within Section 45 of the Local Government etc. (Scotland) Act 1994. This replaced the requirement in Section 3 of the Social Work (Scotland) Act 1968 for each Local Authority to appoint a Director of Social Work.

The responsibilities of the CSWO have recently been reviewed and updated guidance has been produced by the Scottish Government. The CSWO is required to ensure the provision of appropriate professional advice in the discharge of local authorities' statutory social work and the role also needs to promote values and standards of professional practice to all social services workers in relation to promoting equality, fairness and social justice.

The guidance is clear that "the CSWO's responsibilities in relation to Local Authority Social Work functions continue to apply to functions which are being delivered by other bodies under Integration arrangements".

[1] http://www.scotborders.gov.uk/downloads/file/7249/2014_strategic_assessment

The role provides professional advice to Local Authorities including elected members and officers to carry out the Local Authority's legal duties in relation to social work. The CSWO assists the Council to understand their responsibilities and the complexities involved when delivering Social Work services. Key to these are the Council's role as corporate parent, ensuring effective child and adult protection arrangements are in place, the management of high risk offenders as well as carrying out statutory mental health functions and Adults with Incapacity legislation such as guardianships and intervention orders.

It is recognised that Social Work has a key contribution to the achievement of national and local outcomes. The CSWO also has a significant role to monitor and improve the quality of service provision and to advise on the identification and management of corporate risk insofar as they relate to social work services.

Nationally, there has been significant work to raise the profile of Social Work in the current changing landscape. In 2014 a new National Strategy set out a vision for Social Work Services across Scotland:

"Our Vision is of a socially just Scotland with excellent Social Services delivered by a skilled and valued workforce which works with users to empower, support and protect people with a focus on prevention, early intervention and enablement"

There has been good progress made nationally on the vision. The principles and values of maintaining human rights, social justice and equality of citizenship are key to Social Work.

The vision re-emphasises the role of Social Work which is to:

- Empower individuals and families to take control of their lives and develop hope and aspirations for the future
- To support the most vulnerable and excluded members of our society to live fulfilling lives and play an active part in society
- To protect individuals, families and communities at risk of harm from themselves or others
- To harness and build on strengths within our communities

The key themes of professional leadership, ethics and principles, workforce development and service quality and performance are discussed in this report. Locally there has been good progress in developing social work professional workforce opportunities including practice teaching and quality assurance processes across social work.

In Scottish Borders, Social Work is embedded in the People Department which is led by the Depute Chief Executive and three Service Directors, Chief Social Work Officer, Service Director Children & Young People, and a Chief Officer for Health and Social Care Integration. This structure was developed throughout 2014/15.

In this current structure the CSWO has retained operational responsibilities for Criminal Justice Social Work and Mental Health Officer work. While direct line management of the Children & Families Social Work Service is the responsibility of the Service Director for Children and Young People, professional Social Work accountability and practice standards are reported to the CSWO. The role also leads on behalf of the Council on public protection and ensuring professional leadership for Social Work across all service areas including commissioned services as well as a key role in quality assurance and professional social work standards.

During 2015/16 the new Corporate Management Structure has become well established and the People Department Team covering Education and Social Work has strengthened.

The current structure can be found in Appendix 2.

Over the past 12 months I have, in my role as Chief Social Work Officer, ensured that Social Workers and Social Care staff across all service areas have had opportunities to meet together and ensure that professional leadership and support is available to all staff across the Council and commissioned services. Key cross cutting themes such as public protection and transitions are therefore able to be progressed. In addition all Managers responsible for Social Work tasks come together monthly in a CSWO meeting to consider practice governance including standards, quality and professional leadership and training across Social Work.

Community Planning Partnership

During 2014 the Community Planning Partnership focused on key priorities identified including reducing inequalities, early intervention prevention and building the resilience of communities. It is recognised that Social Work Services play a key role in these areas.

The Scottish Borders Community Planning Partnership has three key priorities for delivering its vision.

1. Grow our economy
2. Reduce inequalities
3. Maximise the impact from the low carbon agenda

A number of lead officers from the members of the Community Planning Partnership have formed a Community Planning Partnership Equality Group. Under this structure, the group ensures that equalities work is mainstreamed, progress towards equalities outcomes is being made, and equalities best practice is shared.

A reducing inequalities plan has been agreed which contains agreed specific actions to reduce inequalities for vulnerable groups and areas of disadvantages including reducing homelessness, increasing employment opportunities and reducing re-offending.

A range of partnership structures are in place that are key to the delivery of Social Work Services. A strong leadership group for Children and Young People's Services is now operating very effectively. The Borders Learning Disability Service, which has been integrated for 10 years, has a well established and comprehensive governance structure which has embedded in it service user, carer and Provider involvement. The Integration Joint Board is now in place to oversee Adult Services which the Chief Social Work Officer attends. This enables the IJB to receive advice on Social Work matters and ensures care governance matters and the quality of care issues are highlighted. Last year's CSWO report has been made available to the IJB as part of the Care Governance arrangements and this was considered helpful by all members

Other examples of strong partnerships are Public Protection, where multi agency Adult Protection, Child Protection and MAPPA arrangements are in place.

Corporate Parenting responsibilities are well understood and actively promoted across services. We have had a Corporate Parenting Strategy and Action plan since 2008 which has been revised 3 yearly with the current Strategy and Action Plan 2015/18.

Corporate Parenting is now firmly established across the Scottish Borders as the multi-agency approach to improving services and outcomes for Looked After Children and Young People and those in Aftercare. Developments have been enhanced over the past year with additional agencies being represented at the strategic and operational group level following the inclusions of Corporate Parenting in the Children & Young People (Scotland) Act 2014.

The Chief Strategic Oversight Group (CSOG) reviewed it's constitution/remit during this period to strengthen oversight of public protection and overview performance related to public protection matters.

The CSWO role includes establishing effective Care for People arrangements. The CSWO and social work services, including SB Cares, work closely with Emergency Planning and during the winter of 2015/16 and extensive flooding was fully involved in setting up rest centres and successfully evacuating a nursing home.

In addition, close working with Police and Emergency Planning Teams around the PREVENT agenda has been a priority during this year with awareness raising and training a key feature.

3. Engagement

Key to all of these developments is effective engagement with service users, carers and local communities. The establishment of a Community Capacity Team across the Borders has been successful in developing community responses to local need and this has been enhanced by locality co-ordinators appointed through the Integrated Care Fund to engage with local communities as part of the locality planning arrangements. This service has built on the learning and experience of the Local Area Co-ordination model which has been developed very successfully by the Learning Disability Service. A pilot of Local Area Co-ordination for older people is now underway and early results are positive reducing social isolation of older people and improving health.

Social Work continues to commission Borders Voluntary Care Voice (BVCV) to provide support to user/carer groups to participate in planning structures and ensure the voice of people using services is central to decision making. Independent Advocacy is also used to very good effect and promotes user engagement particularly ensuring that those service users with communication difficulties are supported to be as engaged as possible in their care and support. Scottish Care have continued to be supported to be a key part of the partnership agenda and a key partner in agreeing the use of the Integrated Care Fund (ICF).

A toolkit on co-production has been developed by the Community Planning Partnership to assist with meaningful engagement with localities and an e-learning package has been devised for use by all Community Planning Partners (see link below). The governance structure that underpins the Learning Disability Service is an exemplar of a co-productive approach; core to its functioning are five Locality Citizens Panels that meet regularly throughout the year and feed directly via representatives into the Learning Disability Policy and Strategy Group and the Learning Disability Partnership Board. The Citizens Panel work closely with local communities and have been instrumental in wielding real influence and achieving real change for example influencing the design of the layout of local shops to make it easier for people with a disability to get about in them.
www.scotborders.gov.uk/coproduction

4. Social Services Delivery Landscape/Market

In general, Scottish Borders has a healthy and industrious population. Scottish Borders has a lower than average population of working age; 58.49% compared to the Scottish average of 62.79%. However, there are lower levels of unemployment than the national average, although these reflect a larger proportion of part-time employment than the Scottish average.

Both men and women within Scottish Borders have a longer than average life expectancy at birth than the Scottish average, and 84.1% of people in the Scottish Borders assess their health as being good or very good compared to 82.2% for Scotland.

There are a number of pressures on the provision of Social Work services within Scottish Borders, including but not limited to:

- Demographic shifts, in particular increasing numbers of people in the older age groups, creating a need to increase capacity while maintaining quality and flexibility
- Increasing expectations and requirement to support people in their own homes and communities
- The financial pressure associated with complex or specialist service provision that cannot be provided locally within the Scottish Borders
- Ongoing developments for integrated services with partner services and organisations, across both Children's Services and Social Care services
- Managing rising complex needs of both children and young people and adults

The Integration Strategic Plan has been agreed and supported by a commissioning plan which detail priorities for investment for Adults and Older People in line with Council and Partnership priorities and these will help form the basis of the Strategic Plan for the newly formed partnership. A revised Children and Young People's plan has been agreed with agreed actions to meet improved outcomes including keeping children and young people safe, raising attainment of all children and increasing engagement and participation. Scoping of all partnership funding for Children &Young People has been completed and a new commissioning plan for these services, including service change, is being progressed.

5. Finance

Across Social Work Services as a whole, £55.220m was spent during 2015/16 on the provision of care services across the Scottish Borders, broken down across client groups as follows:

	£m
Children & Families Social Work **	15.390
Services in the Criminal Justice System*	0
Older People's Services	24.805
Adults with Learning Disabilities	14.637
People with Physical Disabilities	3.255
People with Mental Health Needs	2.187
Generic Services and Staff Teams	4.950
	55.220

*Fully funded by Scottish Government Grant to Lothian and Borders Criminal Justice Authority (£1.217m)
** Excludes Additional Special Needs service

The budget for Social Work increased by 2m with increases in Children & Young People's Services and also Adults Services. There is a slight reduction in staffing reflecting the Council's approach to transformation. During 2015/16, significant financial pressure was again experienced across adult social care services. The level of both residential care beds and care at home hours commissioned externally during 2015/16 significantly exceeded the level of budget. This was further exacerbated by other exceptional factors including the transfer of homecare contracts to SB Cares, the Council's provider of last resort following the termination of two major care at home contracts by external providers, and new night support sleep-in wage costs as a result of employment legislation changes. A number of transformational projects were completed during 15/16 assisting with these pressures. In addition these pressures were mitigated temporarily in-year by a range of actions including targeted locality team savings and managing vacancies. In order to ensure the Older People's budget is affordable going forward, investment in the 2016/17 financial plan has been aimed at

permanently addressing these and additional emerging pressures such as the increase in costs from the recent Older People care at home tender.

In addition, the costs of Business Support which provides services such as Commissioning, Contracts Management, Performance Monitoring and Administration within the People department amounted to a further £3.442m during the financial year.

Moving forward Scottish Borders Council's 2016/17 Financial Plan provides for considerable investment into Social Work services, with a total of £0.784m increased investment in Social Work Children's Services and up to £6.709m in Adult Services, including up to £5.267m of social care funding allocation from the Scottish Government to the Scottish Borders Health and Social Care partnership, as part of the 2016/17 local government financial settlement. Accompanying the funding, the Deputy First Minister has set out a range of intended purposes to which the allocation will be directed. These are:

- Support additional spend on expanding social care to support the objectives of Integration
- Make progress on charging thresholds for all non-residential services
- Expand capacity to accommodate growth in demand for services as a consequence of demographic change
- Help meet a range of existing costs faced by local authorities
- Deliver the Living Wage for all social care workers with an implementation date of 1 October (£8.25)

This investment has been targeted at addressing a range of historic and emerging pressures on social care services, including increased demographic pressure, increased market provider costs, the impact of legislative changes such as charging thresholds and the implementation of both a minimum wage of £7.20 from April 2016 and a single living wage during 2016/17.

This investment however, is set against a backdrop of restricted government funding and in order to ensure that its service provision is affordable, Scottish Borders Council plans to deliver a considerable efficiency and savings programme during 2016/17. In terms of Children's Social Work Services, £0.350m of savings targets require delivery across a range of services areas including reducing commissioned services and redesign of the management structure. Within Adult Services, £2.663m of savings also require to be delivered through the successful implementation of a range of initiatives including service redesign, staffing reductions, reductions in the cost of commissioning and the implementation of a new approach to assessment and care management and re-ablement.

Pressures continue to be experienced across social care, despite the additional investment and in particular, client numbers and external provider costs continue to outstrip available resources and close, rigorous management of budgets is required, together with the direction of additional funding by the Health and Social Care Partnership, to ensure that the provision of all social care services remains affordable and financial sustainable.

The Scottish Borders Integration Joint Board (the Board) of Scottish Borders Health and Social Care Partnership (the Partnership) was established as a body corporate by Scottish Ministers on 6 February 2016. The Partnership has prepared a Strategic Plan for 2016 – 2019 which sets out what we want to achieve to improve health and well-being in the Borders through integrating health and social care services. Work is ongoing to develop and implement new models of health and social care through which the objectives of the plan will be delivered and in financial terms, to ensure resources are directed to support their achievement. These resources include the core budget delegated to the Partnership by the Local Authority and investment / disinvestment. In addition to this and the Scottish Government's social care funding allocation to partnerships, the integrated care fund is also a key enabler to transformation and funds a £6.39m programme of change over the next 3 years.

6. Performance & Achievements during 15/16

Performance Management in Scottish Borders is firmly aligned to the themes and priorities identified in the Scottish Borders Single Outcome Agreement and the Scottish Borders Council Corporate Plan. Social Work services have a key role to play in the delivery of several national and local outcomes, and these are placed at the centre of strategic developments across the authority and in partnership planning. These reflect the national outcomes detailed below:

- Our children have the best start in life and are ready to succeed
- We live longer, healthier lives
- We have tackled the significant inequalities in Scottish society
- We have improved the life chances for children, young people and families at risk
- We live our lives safe from crime, disorder and danger.
- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it
- Our public services are high quality, continually improving, efficient and responsive to local people's needs

Performance is measured and reported at a variety of levels to senior managers within Social Work, to the Scottish Borders Council Corporate Management team, and to the Scottish Borders Council Executive Committee and relevant partnerships including the Integration Joint Board and Children & Young People's Leadership group

In Children & Young People's Services an updated Children & Young Person's Plan has been developed, consulted on and published. A multi-agency inspection was undertaken by the Care Inspectorate during January – March 2016. The report of this Inspection has recently been reported to Council and no children were considered to be at immediate risk in the Scottish Borders. There was positive commentary on engagement with Children & Young People for example the report stressed that over all, families were helped to overcome adversity through support they received from services. Social Workers worked hard to engage with families to develop positive relationships and provide valuable support. (P 15)

The Council has one residential child care unit for young people aged 12-18 years and in 2015 the staff in this unit were awarded the CELSIS Residential Team of the Year Award. In the Service Inspection in June 2015 the service was awarded Grade 6 – Excellent across all areas of the Inspection process and this was noted in the Inspection

As part of the multi-agency Children's Inspection a staff questionnaire highlighted positive comments. However, the report also commented on quality and improvements required in some of Social Work key processes including the quality of chronologies, risk assessment and care plans and this is now being progressed. A full action plan has been developed to progress improvements in these areas.

In terms of performance, there has continued to be a rise in the number of Looked After Children, however throughout 2015/16 there has been a small reduction in the number of Looked After Children being placed in externally purchased placements.

It has been recognised that throughout 2015 there were continuing improvements in educational attendance and achievement for all children including those who are looked after and those who experience deprivation. Fewer children are being excluded from school with more being skilfully supported to stay in school.

Children and Young People who are unable to live at home, experience warm and nurturing relationships and stable environments provided to them by well supported foster carers, kinship carers and residential placements. (Ref Care Inspectorate services for Children & Young People Inspection Report).

The number of children on the Child Protection Register at March 2015 remained lower than the national average but it should be noted that this rate has increased over the past few months.

In Criminal Justice services, a full service review has been undertaken and staffing adjustments made to reflect the workload demands and to ensure a clearer focus on quality assurance processes, including file audit. Improved performance data for reporting has been developed. Good progress has also been made in preparation for the new Community Justice arrangements to be established in 2017 including consultation on the new proposals and service developments.

In Adult Services there has been a continued challenge on meeting Delayed Discharge targets and a new assessment tool was introduced designed to incorporate Self Directed Support and clearer outcomes for service users and carers.

Social Work staff in Mental Health Services have become full members of multi-disciplinary teams in line with Integration which has involved co-location of staff and improving IT systems.

A new tender for care and support services was undertaken resulting in a new framework agreement and an increase in local providers resulting in 13 care at home services now operating across the Scottish Borders. A further two care at home providers are currently in contract discussions to provide additional support. This should help to address the challenges we have been experiencing regarding increased demand for care at home and recruitment and recruitment challenges.

Progress is continuing with the implementation of Self Directed Support with a total of 533 people using this approach at the end of March 2016, a 78% increase from 300 in 2014/15. A breakdown of the options chosen is detailed below:

Option 1 Direct payment	Option 2 Individual Service Fund	Option 3 Social Work Managed	Option 4 A mix of the options
168	1	328	36

This information shows the option people have chosen. Where people have chosen a mix of options they are not included under options one, two or three but under option 4. For example there are four people with an

individual service fund but two of these people have combined this with at least one other option and are therefore counted under Option 4. A survey of people using this approach was very positive. The majority of people felt that the Council was fully adhering to the duties of the Act. The principle most fully met was for always treating people with dignity and respect.

The Joint Learning Disability Service was established in 2006 and the service has further progressed and notable achievements have included:-

1. Project Search – In collaboration with Scottish Borders Council, NHS Borders and Borders College, the service is ready to support its' first set of 8 Interns through this programme. Project Search is an employment programme emanating from Cincinnati in the USA and aims at training and supporting adults with a learning disability into permanent employment. For the first years of this programme the employment rotations will be provided at Borders General Hospital.
2. Healthier Me - 'A Healthier Me' project was set up to tackle lifestyle issues leading to poor health to improve the health and well-being of people with learning disabilities and their carers through 5 key aims. The project started small in the first year with 20 people with learning disabilities supported by one organisation to 30 more in 3 organisations in the second year. In the third year, this had grown to 14 organisations and at least 86 people with learning disabilities and importantly a Key Lead network established, representing 27 organisations that support people with learning disabilities in the Scottish Borders.

   The project found that people with learning disabilities and their carers when using this approach felt on the whole more empowered, demonstrated through increased confidence, feeling more in control and being involved.
3. There is ongoing progress with the e move from Residential to Supported Living – In line with the Learning Disability National Strategy. Over the last 12 months three projects to move people out of residential care into supported housing have been completed. Two of these projects included either substantially refurbishing or building new accommodation including accommodation suiting adults who have significant physical disabilities. All projects have demonstrated increased satisfaction, independence and improved quality of life for the individuals concerned. The projects have been a successful collaboration between Health, Social Care, Housing Providers, independent sector care providers and the existing residents, their families and advocates.

In Borders there has been support for two Syrian refugee families who have been successfully resettled locally and Social Work have been involved in the planning and support arrangements for the families including children with quite complex needs.

7. Statutory Functions

The Chief Social Work Officer has statutory functions that are specific to the role and are referred to in legislation as well as Scottish Government guidance[2].

Appendix 1 of this report gives detailed statistics on these functions and associated performance.

The effective management of sex offenders under the MAPPA arrangements is a multi-agency responsibility and an Offender Management Committee is in place which oversees this process, chaired by the Chief Social

[2] http://www.scotland.gov.uk/Publications/2010/01/27154047/

Work Officer. In March 2016 a total of 36 offenders were being managed but this is likely due to increase as there has been an extension of the multi-agency arrangements to serious violent offenders.

In Mental Health the Borders continues to perform well in terms of MHO attendance at emergency assessment stage when compared with other areas. However, completion of social circumstances reports is lower and actions are in place to improve this performance.

In line with Scottish trends the numbers of private guardianship applications continue to rise reflecting demographic changes, and the number of CSWO guardianship orders has also increased along with an increase in Intervention Orders. Many of the CSWO guardianship cases are highly complex where workers are managing complex decisions balancing rights and risks and difficult decisions to restrict liberty.

In Criminal Justice Social Work there is an upward trend in relation to Diversion from Prosecution, Criminal Justice Social Work Reports, Community Payback Orders and Voluntary Prison through care.

There has been a small reduction in the percentage of Looked After Children and Young People requiring externally purchased placements. Two young people were placed in Secure Care during 2015/16 for varying periods of time. This is unusual within SBC and the placements reflected the significant risks they posed to themselves or others at that time.

In March 2015 the number of children on the Child Protection register remained lower than the national average but has seen a rise in subsequent months.

The CSWO is the Agency Decision Maker approving Fostering, Permanence and Adoption arrangements. There has been a rise in approvals of foster placements but a number of foster carers have been deregistered for a number of reasons including retirement. A recruitment drive was undertaken during this year and increasing the numbers of foster carers remains a priority particularly given the increase in Looked After Children.

8. Continuous Improvement

2014/15 has seen a range of new service initiatives introduced. Four Early Years centres are now fully operational providing an early intervention and support for families. These are being fully evaluated in terms of improved outcomes for young people and their families.

In Learning Disabilities, a Care Home has been closed as residents moved to a more inclusive supported living service in line with national policy.

Self-evaluation is embedded into all social work services though the inspection process, performance monitoring, and a self-evaluation framework to which all services contribute. Multi-agency self-evaluation of services for children and young people has been an area of development prioritised by the leadership group.

The second combined Standards & Quality Report for Children and Families services (children and families social work and additional support for learning) has been produced this year. Focused self-evaluation in both Child and Adult Protection has been very helpful in informing the business planning processes this year and in planning for the Children & Young People's Inspection.

Closer integration of service evaluation and financial monitoring has led to more robust oversight of improvement activity across the senior management team. In particular the work to integrate financial

records into the main Frameworki management information system will allow improved scrutiny, authorisation and monitoring of the financial impact of care provision.

The Council continues to have strong public protection multi disciplinary arrangements from the Chief Senior Officers Overview Group, chaired by the Council's Chief Executive through the public protection committees and sub groups. Key to this work is self evaluation, performance monitoring and audit.

Case reviews are regularly undertaken and improvement actions identified and monitored. There have been 6 Initial Case Reviews in the period April 2015 to March 2016 which highlighted some areas for improvement which are included in the Child protection business plan. Issues identified for improvement include:

- Improving quality of Chronologies and Risk Assessments
- Development of new protocols (eg a new Protocol in identifying bruising in Non Mobile Children was introduced)
- Changes to Child Protection procedures including process for reports and de-registration processes.
- Establishing an Audit and Improvement officer post
- Encouraging additional feedback from families involved in the Child protection process
- New Guidance on long term neglect and emotional abuse cases

The overall quality of Older People's Care Homes has improved during this period as reflected in the Care Inspectorate grades detailed in appendix 2.

A new charging policy was introduced in April 2015 which introduced charges for Self Directed Support. This proved to be difficult for some service users and carers to understand and resulted in a significant number of appeals and complaints. The policy was updated and simplified in April 2016 to address some of these issues following consultation with service user and carer representatives. This included the production of easy to read letters.

Adult Protection remains a priority and initial referrals have remained fairly static with 171 concerns reported during this period. Older Adults continue to be the group at most risk of harm with 61 concerns. Financial and physical harm continue to be the highest reported types of harm, there has been 60 concerns each in both of the categories. To address this there has been significant work undertaken with local banks to identify and report potential concerns relating to financial abuse.

A total of Ninety eight complaints were received regarding Social Work Services during this period, an increase of 25.64**%** from the previous year. A total of 86 complaints were investigated of which 22 were upheld, 26 partially upheld, 32 were not upheld. 4 complaints were I understand were withdrawn and 2 are currently under investigation.

Some key themes arose from the complaints including:

- Difficulty in accessing service and quality of service
- Delay in service and response times
- Actions of professionals
- Disagreements with financial assessment

When complaints have been upheld clear actions are identified to improve the quality of service provided and these are regularly reviewed to ensure continuous improvement. (see charging comments above)

9. Planning for Change

In Scottish Borders there has been significant progress in the implementation of personalisation and Self Directed Support building on the successful use of Direct Payments.

The ongoing Implementation of continuing care, aftercare and kinship care elements of the Children & Young Persons Act including the named person arrangements will be an ongoing focus.

Self Directed Support requires a fundamental shift in the way public services are delivered to ensure that people can control how the resources available to meet their needs are utilised. However, it is recognised that there are ongoing challenges in relation to culture change, developing an outcome based assessment process and changing commissioning arrangements. A clear action plan is in place to address this and numbers are increasing.

A multi-agency Community Justice group is consulting on key issues to inform reporting to the Community Planning Partnership/the transitions plan to manage the legislative changes in relation to Community Justice. Feedback from all key stakeholders is important as part of this work.

In relation to Adults Services the Integration Joint Board is now in place and the Strategic Plan has been approved by Scottish Ministers. Further progress has been made in developing Integrated Mental Health Teams. The need to ensure improved outcomes for service users and carers is a key priority along with the development of locally accessible services which are important in a rural area.

Of central importance for Social Work is to ensure that the creation of revised partnership structures does not create potential barriers with other important services and there continues to be clear linkages between Children, Adult, Substance misuse, Housing Services and Community Safety. The further development of the local Community Planning structures will be important to assist with these links.

Implementation of the changes required in the Children and Young People's Bill have been a priority. For example many young people over the age of 18 are continuing to receive support and guidance including planning for the introduction of the named person, Continuing Care, Aftercare and Kinship Care arrangements.

10. User and Carer Empowerment

The principles of collaboration and participation are key to Social Work's approach to the development of services in line with Self Directed Support.

There are many examples of engagement in Scottish Borders including:

- Commissioning of Borders Voluntary Care Voice (BVCV) to provide user/carer reference groups
- Commissioning of a specialist advocacy service for all adults
- Establishment of a Community Capacity Team across the Borders working together with local communities
- Review of the joint Learning Disability governance structures establishing local Citizens Panels
- Support for the development of Mental Health Consultation Cafes
- Children and Young People participation groups
- User/carer representation on the local SDS Project Board and other planning groups has ensured co-production approach

- Children and Families managers meeting with the Borders Parent Carers group on a regular basis

Encouraging feedback and engagement from service users, carers and families is important and arrangements are well established in directly provided services as reflected in Care Commission reports. It continues to be important to engage with people who do not currently access services and the Council have a panel in place which provides some feedback. Services regularly seek feedback from service users and carers but in some areas (eg adult protection) it has proven difficult to gain views and new approaches are being adopted to try to improve this.

11. Workforce Planning/Development

a) Professional Development

During this period responsibility for social work learning and development was transferred from the Corporate (HR) Workforce Planning & Development Team to the new Professional Development Team; the Team Leader taking up post in September 2015 and two part-time Advisors being appointed in March 2016. The primary task of the team is to ensure that the mandatory training needs of social care staff are met and there is appropriate support and funding for additional CPD and career progression opportunities. The two Practice Learning Advisors link with Group Managers and other staff from Adult Services and Children & Young People Services, each being the first point of contact for enquiries and new requests for training in each service area. The annual funding panel met early during the financial year to agree funding applications for a wide range of courses and qualifications, specific to Social Work practice and many events including; Practice Learning, Open University Modules, Mental Health Officer Award, Certificate in Management in Social Services Level 10 and 11, Graduate Certificate in Child Welfare & Protection, Graduate Certificate in Leadership and Management 11, Post Graduate Certificate in Dementia Studies and Post Graduate – Chief Social Work Officer.

Social work staff continue to benefit from the Council wide use and development of e-learning platforms; Learnpro includes modules which are specific to Social Care staff (such as Adult Support and Protection, Welfare Reform & the Impact on Health, and Dementia Informed Practice) and is constantly evolving to meet service needs.

Four priority areas of work (including numerous ongoing work strands) have been identified for the new Professional Development Team and some progress made on each as follows:

1. Alignment with the National (2020) Vision & Strategy for Scotland
2. Engagement with SSSC initiatives
3. An incremental pendulum swing towards a development culture
4. Strengthening SW identity (both as practitioner and professional & social scientist)

The National Vision & Strategy for Scotland – Alan Baird, Chief Social Work Adviser, was guest speaker at the key 'Re-visioning Social Work' event in the Scottish Borders, early July 15. Since then there has been a number of 'roadshow' events with Adult Services and Children & Young Peoples teams throughout the Borders area to both inform and update on the National Vision and Local implementation Plan, and to also engage staff in further discussion about professional learning and development. During these 'roadshow' events attention was paid to what is already working well for each staff team; a clear and consistent message from virtually every team was the quality of support/supervision, good communication amongst colleagues and positive working (multi-agency) relationships.

b) SSSC Resources – The intention over a sustained period is to highlight to staff the benefits of utilising existing SSSC resource material, such as Stepping into Leadership and the Continuous learning framework. The first focus during this period has been on mentoring, promoted by SSSC, and designing a mentoring scheme to support and promote the professional development and learning of social workers in their probationary year. The preparatory work has been completed; the training course (for mentors) will start later in 2016 and the scheme is expected to be available early in 2017. Continued individual coaching, and/or mentoring has been provided as required to staff during challenging transitions or if experiencing personal/professional challenges

In order to support individual team leadership/culture a new on-going group has been set up for team leaders, called 'Self-leadership & Resilience' which is designed and facilitated around learning from each other offering an opportunity to reflect on issues including team culture and operational dilemmas. The dynamics of getting and giving support; a reflective space has proved helpful, especially during periods of transition and uncertainty. Facilitation of team development days offering additional support and input to teams integrating with NHS colleagues is being actively progressed to further enhance collaborative working practice.

c) Strengthening SW identity

A Professional Development Group continues to be well attended and is available to all frontline staff working with SBC. To strengthen the role and importance of practice learning we ran a conference in February of this year with Mark Doel, Emeritus Professor in Social Work at Sheffield Hallam University, as our main guest. His Keynote Address, '*Practice Teaching at the Heart of Social Work*', was a reflection on what we know about the impact of practice teaching and learning not just on students and practitioners but also on host agencies and the profession in general.

12. Key Challenges for the year ahead

Social Work Services continue to face significant challenges in the year ahead including managing demand due to demographic change, maintaining service quality and supporting people with whom we work to keep safe and improve quality of life and outcomes. Managing financial challenges and the efficiency agenda remain a high priority area across all service areas. Focused Self Evaluation and Quality Assurance arrangements across services are important.

Specific key challenges are outlined below:

Children & Young People

Arrangements to ensure full implementation of continuing care and aftercare aspects of Children and Young Person's Act ae continuing to be progressed along with implication for resources including foster placements and support with housing and employment. This includes the Extension of support (including financial support) for carers of children and young people with kinship care orders.

A detailed action Plan has been developed following the Inspection and there will be close monitoring of the plan including specific social work tasks to ensure all actions are completed.

Work to increase fostering placements particularly for young people/teenagers and adoption/permanence to ensure children have secure placements remain important priorities.

Child Sexual Exploitation is a national issue and work will continue to develop a strategy with ongoing training being provided and closer links with community safety and domestic violence services will assist with this.

The outcome of the Children and Young People's Inspection has highlighted a need to focus on key social work processes and recording including chronologies and risk assessments and there will be focused work across Social Work in these areas including adult and older people's services.

Adult Services

In adult services the Integration Joint Board will be continuing to further develop closer joint working both at strategic and operational level and key to this will be overseeing care governance and quality.

Implementation of Carers legislation will need to be a key focus for the coming year and work with the Carers Centre will be an important element of this.

There continue to be challenges in recruitment and retention of care at home staff. However, a successful tender to increase the number of home care providers in the Borders combined with the introduction of a minimum hourly rate of £8.25 from October should assist in improving this.

The challenge of promoting and increasing personalised supports and increasing the take up of Self Directed Support remains a high priority particularly in Children and Young People's services.

Commissioning step-up/step-down beds for adults with learning disabilities with very complex and challenging needs. There is collaborative working with neighbouring Health Boards and Local Authorities as the solution is probably collaboration to optimise use of resources, resilience and risk.

A priority will also be the introduction of the new Community Justice arrangements and strengthening links with Community Safety and Domestic Violence. The new service structure for Criminal Justice which has been implemented will also be reviewed.

In my role as Chief Social Work Officer I will endeavour to monitor, review, update and advise the Council on key matters highlighted in this report, whilst ensuring effective leadership for all staff in Social Work and Social Care to provide high quality, safe services for people in the Borders.

APPENDIX 1

PERFORMANCE REPORT

STATUTORY FUNCTIONS

1. Fostering and Adoption

Adoption is a positive route for a child where it is apparent that the child is unlikely to be able to safely return to the immediate or extended family. There is a strong body of evidence to indicate that permanent and/or stable long term placements, including adoption, lead to better outcomes for the child where these placements can be put in place early enough to enable the child to form solid attachments with the carers. This is especially crucial in the early years of 0-3.

In the year to March 2016 there was 1 child adopted, which shows a decline to previous years. However, there has been a general positive trend in the number of Permanence Orders (legal orders which secure the long term care of children and young people) for older children and young people. Permanence Orders have risen from 2 in 2012 to 8 granted in 2016.

Between April 2015 and March 2016 there was a reduction of approved prospective adopters from 3 to 1. The reduction in approved prospective adopters had no effect on the permanent placement of children in the Scottish Borders. The primary focus of assessment of alternative carers between April 2015 and March 2016 was on foster carers and kinship carers.

Senior managers have identified a need to focus on robust decision-making for permanence cases to avoid drift and delay. A multi-agency Permanence Planning Group has been established to lead good practice in permanence planning and there is currently a multi-agency Development Plan addressing policy, procedure and practice in this area.

Timescales in permanence planning are improving (the process to legally secure permanent placements and / or adoption for children) Timescales are monitored every 6 months and the period between July 2015 and January 2016 showed an average time of 8.33 months from the S.31 Review (LAC Review) to a Permanence Order application being made to court. The previous 6 monthly figure was 20.5 months.

	2013-14	2014-15	**2015-16**
Children adopted during the reporting year	7	5	**1**
Children placed with prospective adopters at end of year	7	6	**2**

The Chief Social Work Officer is also the Agency Decision Maker (ADM) in terms of Fostering and Permanence decisions – Regulation 12 Children (Scotland) Act 1995.

It is the ADM's responsibility to make decisions based on recommendations by the Fostering and Permanence Panels. In Scottish Borders Council these panels are held on a monthly basis including a Kinship Care panel and consider the following:

- Fostering assessments
- Kinship Care Assessments (Not a statutory requirement for ADM/CSWO)
- Foster carers reviews
- Assessment of Prospective Adoptive Parents
- Children being considered for Permanence (Long term fostering and Adoption)

- Matching of children with prospective adopters or long term foster carers
- Advice & guidance on complex situations that may be considered for permanence

The ADM receives minutes of the meetings, meets regularly with the chair of the meeting and makes decisions based on the recommendations.

	2013-14	2014-15	**2015-16**
Foster Carers approved	12	6	**12**
Foster Carers de-registered	4	2	**7**
Foster/Short Breaks Carers reviewed	35	48	**31**
Long term (permanent) foster carers approved	4	4	**2**
Children registered for permanence	14	13	**8**
Prospective adopters approved	8	3	**1**
Prospective adopters not approved	0	0	**0**

Recruitment and retention of foster carers continues to be a focus of the Resources Team (Family Placement) to ensure that children and young people who require alternative care are placed within their local community in family based placements. As well as striving to increase foster carer numbers through a coordinated recruitment campaign, advertisement and awareness raising, there is a clear focus on retention with the on-going support of foster carers prioritised to ensure quality placements for looked after children.

Kinship care is a desirable outcome for children who are unable to be looked after by their birth parents, and enables children to remain and be cared for within their extended family and community, with clear benefits for their identity and sense of belonging as they develop. This reduces the need for local authority foster carers and promotes better outcomes for the children themselves. The percentage of kinship care placements in the Scottish Borders continues to grow year on year.

While workers will always consider all options for a child's care and will seek to make use of a child's family strengths and supports, at times it is not possible to place children in their own community. In particular some complex cases require us to place children in specialist placements outside the area. Each of these young people has a comprehensive care plan and a team of professionals dedicated to helping to resolve their issues and, in a controlled way, bringing them back into less specialised and resource intensive placements.

The number of children placed in externally purchased placements, most of which are outside of the Scottish Borders has remained at the same level however the overall percentage has decreased over the reporting year due to the increasing number of looked after children.

	2014	2015	**2016**
LAC placed outside areas as at 31 March	41 (25%)	31 (16%)	**31 (14%)**
Kinship placements as at 31 March	40	55	**47**

The total number of children & young people who are Looked After has increased during 2016 and currently sits at the highest value for the past 3 years.

	2014	2015	**2016**
Looked After Children as at 31 March (SBC)	199	188	**221**
Looked After Children as at 31 July (Scotland)	15,580	15,404	**tba**

To allow for comparison, these figures can be expressed as a percentage of the population aged 0-17, which shows that Scottish Borders has many fewer Looked After Children then the general population for Scotland.

% of pop. Aged 0-17	2014	2015	**2016**
Looked After Children as at 31 March (SBC)	0.9	0.8	**1.0**
Looked After Children as at 31 July (Scotland)	1.5	1.5	**tba**

2. Child Protection

The number of children on the child protection register remained low and at 23.3.16 there were 28, which is well below the national average rate per head of population. However, it should be noted that this has increased since that date.

The proportion of children who have been re-registered within 2 years has shown an increase during 2015/16. Part of this increase can be attributed to larger family groups rather than singular children being placed at risk which impacts the figures more dramatically.

The average age of children on the register has continues to show a rising trend, with 61% of registered children now being aged 4 or under.

The length of time that children spend on the register has also shown a decline this year. Over the past 3 years there has been a small fluctuation of 2 weeks however in general the average number of weeks registered averages 23.

	2013-14	2014-15	**2015-16**
Children on the Child Protection Register (*31 March*)	31	33	**28**
Children re-registered within 2 years (*31 March*)	0%	0%	**14%**
Children registered during the year	55	55	**45**
Children de-registered during the year	53	55	**50**
Children on register aged 4 or under (*31 March*)	58%	48%	**61%**
Average number of weeks registered (based on children de-registered during the year)	22	24	**22**

3. Secure Orders

There were two children subject to a Secure Order by the Children's Hearing process during 2015/16.

Secure Orders are used very infrequently in Scottish Borders, and more early-intervention and community-based support packages are considered to be a better approach to these complex cases. The use of these orders reflected the significant risk these young people placed either to themselves or others.

4. Adult Protection

One trend which continues to increase every year is the number of police and fire service Adult at Risk forms which are shared with Scottish Borders. In 2015 to 2016 we received 1556 of these forms with 514 indicated as possible adults at risk of harm. These forms have continued to rise 10% every year over the last few years. However although information sharing forms around risk increase every year, this has not resulted in an increase in work that becomes Adult Protection work. Many of the concern forms are dealt with through a social work response or shared with partner agencies.

An Adult Protection Referral occurs when a young person or adult over the age of sixteen is known or believed to be an "adult is at risk of harm" as defined under the Adult Support and Protection (Scotland) 2007 Act.

A total of 171 Adult Protection Referrals were received in 2015 – 2016, this number is almost identical to last year figure. However if we review referrals over the last four years the figures have remained consistent and have only fluctuated within a 10 % range.

	2012-13	2013-14	2014-15	**2015-16**
Adult Protection Referrals	189	190	169	**171**

Types of harm

Financial and Physical harm continue to be the largest types of principle harm reported in Scottish Borders, both of these categories have had 60 referrals recorded as the principal type of harm. These figures combined, account for two thirds of Adult Protection referrals. Psychological and Emotional harm often go alongside Physical harm, however Scottish Government have requested that we only count the principal type of harm to inform the national Adult Protection landscape.

Scottish Borders is a large rural authority which has some affluent over 65 residents, and these adults have an increased risk of financial harm. Some of these perpetrators use computer and internet technology to fraudulently target adults. As technology becomes more sophisticated older adults will continue to be more vulnerable than other groups to financial harm through technology.

In 2015 Scottish Borders undertook further work with Trading Standards, local Banks and Building societies to highlight financial harm, scams and bogus callers. There has been individual success in several cases, some of our joint intervention alongside key partners has saved some customers thousands of pounds.

Client groups

Adults over the age range of 65 years (Older adults) including clients with a dementia related illness continue to be the group, at greatest risk of harm in Scottish Borders, there have been 63 individual

concerns for all adults over the age of 65. When we review these 65 cases in terms of trends, Adults at risk who have dementia have seen figures rise from 16 last year to 21 this year. However when we review this increase over a longer timeframe, we can clarify that these figures, do fluctuate between 16 -25 depending on year. A similar pattern can be demonstrated in the wider older adult group although figures have increased this year from 35 to 42 this is again within an expected range and each year has a degree of variation. Financial harm and reports of physical harm being the greatest type of harm to older adults.

Clients with a learning disability have an assessed level of cognitive deficit, which makes some adults in the learning disability range, more vulnerable than others to harm. In many of these cases it is an adult known to the client who becomes the harmer. Sometimes this is a so called friend or acquaintance targets the client for financial or material gain. There have been 32 cases in this area.

In mental health harm figures continue to be stable over the last few years, there have been 18 cases this year. Similar to Learning disability and older adults' financial or material harm are challenges to this group.

Adults with a sensory loss have had 6 cases this year, these figures are similar over the last few years. Bogus callers or workman have been a particular challenge to these adults, with some good examples of Trading Standards and Police Scotland reacting to this type of harm.

Adults with a physical disability have increased from 11 last year to 15 this year, but this increase is small and still less than the 18 received in 2013 / 2014.

Trends

Financial harm continues to be a challenge in Scottish Borders and nationally. Scottish Borders are being very proactive in working with partners in the prevention of harm and to intervene more quickly when signs of harm come to our attention.

Allegations of harm in care home settings has featured heavily over the last few years, in 2015/ 2016 Scottish Borders embarked on bespoke adult protection training into all out care homes. This training has seen a marked decrease in large scale inquiries, but a longer timeframe is required to effectively evaluate the impact of this training, but early indications are positive.

Disability Hate crime is recognised nationally, as an area which is under reported. Some of the rationale for this is that this harm is reported as physical or financial and not a hate crime. The important factor is that harm is harm and is reported and investigated.

Disability hate crime and the term hate crime have been uncovered in Scottish Borders, these cases happen where a perpetrator targets an adult specifically because of their mental disorder or disability. Both mental health and Learning disability services are aware of these risks and working with Police Scotland and NHS Borders to address all harm.

5. Adults with Incapacity

There has been a substantial increase in the number of Private Welfare Guardianships, and Welfare Guardianships for which the Chief Social Work Officer has responsibility for.

As at 31 March	2013-14	2014-15	**2015-16**
Private Welfare Guardianships	64	71	**97**
Chief SW Officer Welfare Guardianships	22	18	**29**

6. Mental Health services

The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in October 2005. The Act enables medical professionals to detain and treat people against their will on grounds of mental disorder. This term is used to cover mental health problems, personality disorders and learning disabilities.

The Act allows for people to be placed on different kinds of compulsory order according to their particular circumstances. There are three main kinds of compulsory powers:

- Emergency detention
- Short-term detention
- Compulsory Treatment Order (CTO)

The use of emergency detention order had been on an increasing trend during 2014-2015 which was mirrored in the short-term detentions. 2015-16 has seen a decline in the use of both these orders back to the levels experienced in 2013-14.

Compulsory treatment orders have also declined however the levels have dropped below 2013-14 more significantly than the decline in other types of orders.

	2013-14	2014-15	**2015-16**
Emergency detentions	18	27	**17**
Short-term detentions	62	77	**61**
Compulsory treatment orders	43	41	**28**

7. MAPPA

Multi Agency Public Protection Arrangements (MAPPA) is the framework which brings together agencies who manage sex offenders. The fundamental purpose of MAPPA is public safety and the reduction of serious harm. The introduction of MAPPA across Scotland in April 2007 gave a consistent approach to the management of offenders, providing a framework for assessing and managing the risk posed by some of those offenders.

There are three levels at which risk is assessed and managed under MAPPA.

- Level 1: ordinary risk management

- Level 2: local inter-agency risk management
- Level 3: Multi-agency Public Protection Panels (MAPPA)

Previous MAPPA reporting considered various levels of discussion however recent modification to measurements have provided a different range of statistic which are not fully comparable to previous years. Below are the new measurements:

	2015-16
Number of Risk Management Case Conferences (RMCC)	**37**
Number of individuals considered at RMCC	**36**
Total Number of Level 2 cases discussed	**25**
Number of Level 3 meeting held	**0**

On 31 March 2016 the overall number of sex offenders subject to MAPPA within the Scottish Borders was 96. All of whom were managed at level 1 with 31 individuals subject to statutory supervision by criminal justice social work.

CARE INSPECTORATE GRADES

Quality improvement is at the core of much of the improvement work across Social Work services. We are aided in this process by the work of the Care Inspectorate who have responsibility for inspecting all Social Work services in Scotland and ensuring that care providers meet the Scottish Government's National Care Standards.

In the period April 2015 to March 2016 the Care Inspectorate carried out inspections on 3 services provided by Scottish Borders Council, as well as 46 private care services and 41 in the voluntary/not-for-profit sector. These consisted of both announced and unannounced inspections. (Please note of the 46 private care services inspected 3 were owned by Scottish Borders Cares LLP, t/a SB Cares)

The inspections covered a range of services, summarised as follows.

Service Description	**Local Authority**	**Private**	**Voluntary / Non-profit**	**Total**
Adoption Service	1			1
Fostering Service	1			1
Adult placement	1			1
Care Home Service	1	19	5	25
Nursing Agency		1	1	2
Housing Support Service	1	4	16	21
Support Service	1	9	15	25
Total	**3**	**46**	**41**	**77**

The inspections are based on quality themes and grade each service on a scale from 1 (Unsatisfactory) to 6 (Excellent).

Quality Themes:

- Care and Support
- Environment
- Staffing
- Management

Quality Grades:

1. Unsatisfactory
2. Weak
3. Adequate
4. Good
5. Very Good
6. Excellent

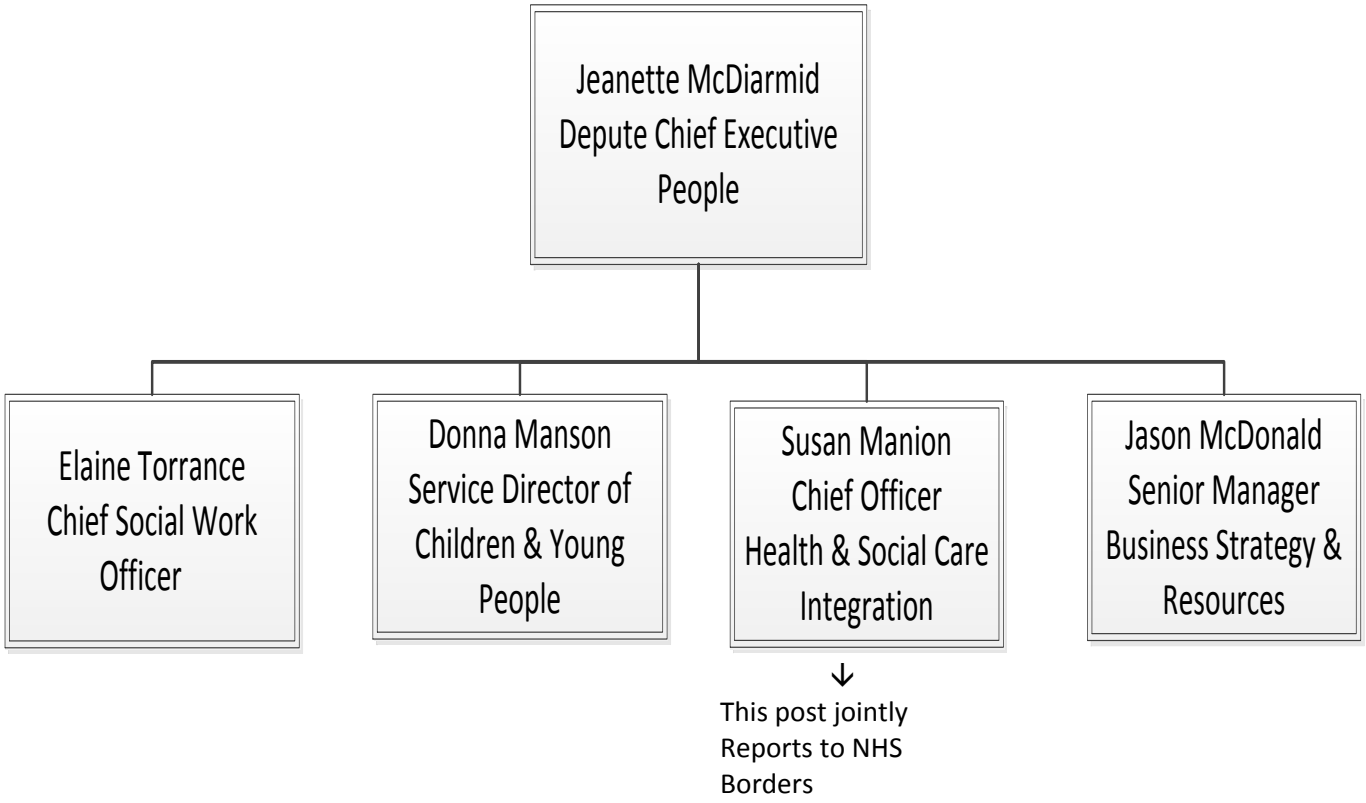
Not all services are graded for every theme. For instance, the Adoption service does not provide services in any particular premises and therefore is not graded for Environment.

Overall, 81% of services were rated as 'Good', 'Very Good' or 'Excellent'.

Quality Theme	**Quality Grading**					
	1	**2**	**3**	**4**	**5**	**6**
Care and Support	2	0	11	19	37	5
Environment	0	1	8	10	8	2
Staffing	2	0	10	24	34	4
Management and Leadership	2	0	11	30	26	5
Total	6	1	40	83	105	16
	2%	**0%**	**16%**	**33%**	**42%**	**6%**

This years inspections has seen an increase in the overall percentage of services rated as 'Good', 'Very Good' or 'Excellent' (72% in 2013/14, 79% in 2014/15 and 81%).

APPENDIX 2


Jeanette McDiarmid
Depute Chief Executive
People
Elaine Torrance
Chief Social Work
Officer
Donna Manson
Service Director of
Children & Young
People
Susan Manion
Chief Officer
Health & Social Care
Integration
Jason McDonald
Senior Manager
Business Strategy &
Resources
This post jointly
Reports to NHS
Borders

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STAFF GOVERNANCE ARRANGEMENTS

Aim

1.1 There are several key areas of governance which the Integrated Joint Board (IJB) should ensure are in place, namely clinical and care governance, financial governance, public and service user involvement and staff governance.

1.2 This paper outlines the arrangements for staff governance and the IJB will be asked to approve the arrangements outlined.

Background

2.1 Health and Social Care Services are required, as outlined in the Integration Scheme, to ensure that there are appropriate arrangements in place to oversee staff engagement and involvement across the employing authorities.

Summary

3.1 Staff providing services under the auspices of the IJB delegated functions continue to be employed by, and have accountability to, the NHS and the Council as employers. However, it is important that the IJB is assured that there is appropriate engagement and inclusion of staff using the agreed procedures within the employing authorities.

3.2 There is a strong track record of joint staff working with representatives from across the organisations participating in joint discussions. The existing group has reviewed its role and Terms of Reference and it is this that is presented to the IJB.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the staff governance arrangements for the IJB.

Policy/Strategy Implications	Part of the agreed IJB Governance arrangements.
Consultation	Consultation with the NHS Staff partnership forum and the Council Union Group as well as the existing Joint Staff Forum
Risk Assessment	n/a
Compliance with requirements on Equality and Diversity	Part of the IJB governance arrangements
Resource/Staffing Implications	n/a

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Sandra Campbell	Programme Manager, Health and Social Care		

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

HEALTH & SOCIAL CARE JOINT STAFF FORUM – PROPOSED TERMS OF REFERENCE

CONTENTS

1. Purpose

1.1 The Health & Social Care Joint Staff Forum (the Forum) as a strategic body is responsible for facilitating, monitoring and evaluating the effective operation of partnership working across NHS Borders and Scottish Borders Council on areas of integrated working, and to develop, supports relevant joint Workplace Policies for approval by the appropriate governance body.

1.2 Working in partnership will enable shared understanding, engagement with outcomes and effective service delivery. The success of partnership working can be measured by improvements in decision making, the production of enhanced outcomes and the delivery of shared goals.

1.3 The purpose of this agreement and terms of reference is to provide a framework for partnership working between the Integration Joint Board (IJB) and the Trade Unions and Professional Organisations recognised by NHS Borders and Scottish Borders Council. It is not the intention of this agreement to replace or undermine existing Joint Trade Union and management mechanisms in operation for employees of either the Health Board or the Council.

2 Roles and Responsibilities

2.1 Trade Unions and Professional Organisations recognise the IJB's responsibility to improve the wellbeing of the people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time.

2.2 The IJB recognises the Trade Unions and Professional Organisations' role in representing the interests of their members within the workplace, and in improving terms/conditions of service, promoting health and safety at work, and employment security.

2.3 It is the responsibility of all parties to demonstrate commitment to partnership working by ensuring early involvement in all activities of health and social care, in line with the agreed values.

3 Remit

3.1 The Forum will:

- Take a proactive approach in embedding partnership working at all levels of the organisation to assist the process of devolved decision making;
- Monitor the implementation of all Workplace Policies related to agreed integration programme and subsequent ongoing development;
- Consider and comment on other policies;
- Support the work of the Workforce Development Project Group as required;
- Ensure the best Workforce practice is shared across the Partnership;
- Contribute to the development of Strategies and Action Plans to inform the integration programme of care and subsequent ongoing development;

- Assist in assessing the impact of strategic decisions upon staff by monitoring and evaluating outcomes through staff surveys and other staff engagement exercises
- Contribute to responses on consultation from the Scottish Government, its sub groups and supporting infrastructure;
- Ensure that any Workforce strategies and policies are underpinned by appropriate Staff Governance, financial planning, implementation planning and evidence;
- Ensure adequate and necessary Facilities arrangements are in place.
- Ensure that the views of all recognised trade unions with an interest in improving the health and social wellbeing and health and social care services, local communities and wider staff are appropriately heard and considered.
- Ensure that an effective risk management system is in operation focusing on staff issues that identifies clinical, legislative, financial and other risks, and is focused on the safety of patients, clients and users;
- Ensure that members of the Health & Social Care Joint Staff Forum have knowledge and understanding of national health policies and local health and social care issues, and the ability to contribute to strategic leadership and to develop effective working relationships;
- Secure assurance that all staff, are effectively trained, properly supported and performance is formally reviewed on an annual basis.

3.2 The Forum will not, in the conduct of its business, seek to cut across existing joint Trade Union and management mechanisms that operate for either the Health Board or the Council. The Forum must ensure that nothing it does will impinge on the terms and conditions of staff as employees of either the Health Board or the Council.

4 Authority

4.1 In line with the agreed remit, the forum is recognised as an integral part of the Health & Social Care Partnership governance structure, to ensure that there is appropriate staff engagement and staff governance in the development and delivery of services.

5 Reporting Arrangements

5.1 The Forum will provide formal reports to the IJB as required, and be empowered to initiate and sponsor work, in addition to receiving reports from work initiated elsewhere.

5.2 Following a meeting of the Forum, the minutes of that meeting will be presented for information at the next meeting of the IJB and approval at the next Forum meeting.

5.3 The Forum should, annually and within three months of the start of each financial year, provide, approve and agree a work plan detailing the work to be taken forward by the Forum.

5.4 The Forum will produce/approve an annual report for presentation to the IJB that will describe outcomes from the Forum during the year.

6. Membership

6.1 Membership of the Forum shall comprise representatives of management and recognised trade unions from both organisations and include Employee Director for NHS Borders.

6.2 A nominated deputy can be identified for each full member. Nominated deputies may only attend in the absence of the principal member. Management and Staff Side representatives may attend as observers with the agreement of the joint Chairs. Full Time Officers for recognised trade unions may attend as an ex officio member.

6.3 Respective memberships will be formally updated annually.

6.4 Should there then be continued non-attendance of a nominated representative to the Forum, the Joint Chairs shall contact the nominated representative and/or their relevant organisation and clarify if the nominated representative wishes to continue as a member of the Forum, or if another nominated representative from that organisation will be replacing them.

7 Involvement in the Programme/Service Delivery

7.1 Throughout the development and implementation programme, member of the have been involved in and contributed to all working groups. This will continue as required as the Health & Social Care Partnership moves to business as usual operation (and through subsequent development and delivery). Trade Union Representation will continue to be given to the subgroups of the IJB in discussion with the Forum. For information, these groups have included, to date, the following;

- Workforce Development
- Finance Resources/Financial Arrangements
- Legal/Governance Group
- Information Performance and Technology
- Commissioning and Locality Planning

7.2 The Forum will also act as a resource for other groups seeking Staff Side views / opinions relating to the delivery of integrated health & social care services.

7.3 The Occupational Health and Safety advisors will communicate directly to the Forum on matters agreed through partnership working with managers and health and safety representatives.

8 Forum Meetings

8.1 Cycle of Meetings

8.1.1 The Forum will meet on an agreed basis, but routinely every 8 weeks, unless otherwise agreed by the Joint Chairs. These will be tabled in relation to the meeting schedules for the IJB.

8.1.2 Meetings only to be cancelled by mutual agreement between both Joint Chairs.

8.1.3 The Joint trade unions will meet prior to meeting of the Forum. This will be an open trade union representation allowing all appropriate trade union representatives to attend.

8.2 Chairing of Meetings

8.2.1 There will be Joint Chairs appointed from the Management and Staff Side who will chair meetings of the Forum on an alternating basis. It is the responsibility of the Joint Chairs to agree in advance any agenda items and agenda planning meetings will therefore take place between the Joint Chairs in advance of each meeting of the Forum. The Agenda should reflect the needs of both NHS Borders and Scottish Borders Council and based upon the programme of work identified through the IJB.

8.2.2 The Administrative Support will distribute an agenda and supporting papers for each Forum meeting no later than one week before the date of the meeting to all Forum members. Written reports will be required for all agenda items otherwise the matter will not be discussed unless otherwise agreed by the joint chairs in advance. These should be received by the administrative support 2 weeks before the meeting.

8.2.3 The Chair will:

- Conduct each meeting in an objective and professional manner
- Ensure that all members of the Forum are afforded the opportunity to contribute and treated with dignity and respect
- Manage the business of the meeting in an efficient and effective way

8.2.4 With the agreement of the Co-Chairs, the Forum may invite any persons whose special knowledge would be of assistance to attend and speak at its meetings.

8.3 Quorum

8.3.1 Meetings of the Forum will be deemed to be quorate when:

- A minimum of four members of the management side (must be two from each organisation)
- At least one of the joint Chairs
- A minimum of four members of the trade unions (must be two from each organisation) are present.

9. Values

9.1 To underpin the working of the Forum, the following values will be adopted and govern the approach taken to consideration of issues:

- mutual trust, honesty and respect;
- openness and transparency in communications;
- recognising and valuing the contribution of all partners;
- access and sharing of information;
- consensus, collaboration and inclusion as the “best way”;
- maximising employment security;

- full commitment to the framework and good employment practice;
- the right of stakeholders to be involved, informed and consulted;
- early involvement of all staff and their trade unions in all discussions regarding change;
- a team approach to underpin partnership working.

10. Decision of the Forum

10.1 Consultation

10.1.1 Any party may request that a matter brought before the Forum be subject to appropriate consultation with management and trade union colleagues prior to any final agreement being reached. The processes of consultation of both organisations must be assured and respected.

10.2 Referral

10.2.1 Any matter considered by the Forum which is deemed to fall outwith its terms if reference, or which is subject to Programme Board or Shadow Board or requires approval by individual organisations Boards, will be referred to the these bodies as appropriate on the basis of Forum support. Reference to the Scottish Government may also take place as appropriate.

10.3 Failure to Agree

10.3.1 In the event of any failure to agree in matters under consideration by the Forum, the matter will be referred via the Joint Chairs to the Joint Integration Board, who will endeavour to find a way forward.

11 Communication

11.1 Communication is crucial to ensure effective participation in partnership working and to promote outcomes achieved. The secretariat of the Forum will ensure that key communications are jointly agreed and disseminated. All communications will be integral to the Health & Social Care Partnership's Communications Strategy.

12. Review

12.1 These Terms of Reference will be reviewed on an annual basis.

APPENDIX 1

MEMBERSHIP FOR JOINT INTEGRATION STAFF FORUM

Union Representation:

6 Representatives from Scottish Borders Council

6 Representatives from NHS Borders

Management Representation:

6 Representatives from Scottish Borders Council

6 Representatives from NHS Borders

These can include HR, OH and OD

Attendees: (Ex Officio)

Employee Director from NHS Borders

Other Organisational Departments from both SBC and NHS invited as required through Agenda including additional trade unions not identified within membership above.

Fulltime Officers for recognised trade unions

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD BUSINESS CYCLE 2017

Aim

1.1 To provide the Health & Social Care Integration Joint Board with a focused and structured approach to the business that will be required to be conducted over the coming year.

Background

2.1 To deliver against targets and objectives, the Health & Social Care Integration Joint Board must be kept aware of progress on a regular basis.

2.2 Health & Social Care Integration Joint Board meeting agendas will be mainly focused on strategic, clinical and care governance and financial issues in order to facilitate strong debate of items.

2.3 Standing items will be submitted to the Health & Social Care Integration Joint Board in full format with verbal by exception reporting required at the meeting.

2.4 Attached is the revised Business Cycle for 2017 for the Health & Social Care Integration Joint Board and Development sessions. The business cycle will remain a live document and subject to amendment to accommodate any appropriate changes to timelines, legislative requirements, etc.

2.5 Each Health & Social Care Integration Joint Board meeting will be preceded by a networking lunch in order to facilitate a cohesiveness of the Board and an opportunity for informal discussion of items of interest to the Board.

Summary

3.1 It is proposed that the Health & Social Care Integration Joint Board meet no less than on 6 occasions throughout 2017 with 5 Development sessions scheduled.

3.2 It is proposed that there are no meetings held in July.

3.3 Both the Scottish Borders Council and the Borders Health Board schedules of meetings have been taken into account in order to maximise attendance.

3.4 All Health & Social Care Integration Joint Board meetings and development sessions will take place at Scottish Borders Council.

3.5 In order to maximise the availability of Health & Social Care Integration Joint Board (H&SC IJB) members all meetings have been arranged for Mondays as per the schedule listed below:-

Date/Event	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
H&SC IJB Networking Lunch 1pm to 2pm		27	27			26		28		23		18
H&SC IJB Meeting 2pm to 4pm		27	27			26		28		23		18

H&SC IJB Development Session 9.30am to 12noon	30			24	29				25		27	

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the proposed meeting dates and business cycle for 2017.

Policy/Strategy Implications	Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Consultation	-
Risk Assessment	Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Compliance with Board Policy requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	Resource/staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Approved by

Name	**Designation**	**Name**	**Designation**
Cllr C Bhatia	Chair	Susan Manion	Chief Officer Health & Social Care Integration

Author(s)

Name	**Designation**	**Name**	**Designation**
Iris Bishop	Board Secretary		

HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD WORKPLAN/BUSINESS CYCLE 2017

Meeting	Date, Time and Venue	Session Items	Responsible Officer(s)
H&SC Integration Joint Board **Development Session**	Monday 30 January 2017 9.30am – 12.30		
H&SC Integration Joint Board	Monday 27 February 2017 2.00pm – 4.00pm Scottish Borders Council	Chief Officer Report Monitoring Integration Joint Budget 16/17 Inspections Update Performance Report Communications Quarterly Report National IT Security – Discussion Scottish Borders Autism Strategy Update Update on Dementia Services Refresh of Communication and Engagement Plan?	Susan Manion Paul McMenamin Elaine Torrance Stephanie Errington Carin Petterson Jackie Stephen Simon Burt Simon Burt Carin Petterson
H&SC Integration Joint Board	Monday 27 March 2017 2.00pm – 4.00pm Scottish Borders Council **(10am to 12noon - Audit Committee)**	Chief Officer Report Monitoring Integration Joint Budget 17/18 Inspections Update Performance Report Delayed Discharges Quarterly Report Code of Corporate Governance – Annual Refresh	Susan Manion Paul McMenamin Elaine Torrance Stephanie Errington Susan Manion Iris Bishop
H&SC Integration Joint Board **Development Session**	Monday 24 April 2017 9.30am – 12.30	**STAND DOWN PERIOD FOR LOCAL ELECTIONS**	
H&SC Integration Joint Board **Development Session**	Monday 29 May 2017 9.30am – 12.30		
H&SC Integration Joint Board	Monday 26 June 2017 2.00pm – 4.00pm Scottish Borders Council **(10am to 12noon - Audit Committee)**	Chief Officer Report Monitoring Integration Joint Budget 17/18 Inspections Update Performance Report Communications Quarterly Report Delayed Discharges Quarterly Report Annual Accounts Annual Report of IJB ICF 6 Monthly Report	Susan Manion Paul McMenamin Elaine Torrance Stephanie Errington Carin Petterson Susan Manion Paul McMenamin Iris Bishop Paul McMenamin
	JULY NO MEETING		

Meeting	Date, Time and Venue	Session Items	Responsible Officer(s)
H&SC Integration Joint Board	Monday 28 August 2017 2.00pm – 4.00pm Scottish Borders Council	Chief Officer Report Monitoring Integration Joint Budget 17/18 Inspections Update Performance Report Draft Winter Plan 2017/18	Susan Manion Paul McMenamin Elaine Torrance Stephanie Errington Susan Manion
H&SC Integration Joint Board **Development Session**	Monday 25 September 2017 9.30am – 12.30 **(2pm to 4pm - Audit Committee)**		
H&SC Integration Joint Board	Monday 23 October 2017 2.00pm – 4.00pm Scottish Borders Council	Chief Officer Report Monitoring Integration Joint Budget 17/18 Inspections Update Performance Report Communications Quarterly Report Delayed Discharges Quarterly Report Final Winter Plan 2017/18 Chief Social Work Officer Annual Report Agree meeting dates and business cycle 2018	Susan Manion Paul McMenamin Elaine Torrance Stephanie Errington Carin Petterson Susan Manion Susan Manion Elaine Torrance Iris Bishop
H&SC Integration Joint Board **Development Session**	Monday 27 November 2017 9.30am – 12.30		
H&SC Integration Joint Board	Monday 18 December 2017 2.00pm – 4.00pm Scottish Borders Council	Chief Officer Report Monitoring Integration Joint Budget 17/18 Inspections Update Performance Report ICF 6 monthly Report Delayed Discharges Quarterly Report	Susan Manion Paul McMenamin Elaine Torrance Stephanie Errington Paul McMenamin Susan Manion
H&SC Integration Joint Board **Development Session**	Monday January 2018 9.30am – 12.30		

MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2016/17 AT 31 AUGUST 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 31 August 2016, together with detail over the range of pressures currently being experienced therein and proposed actions for mitigation. The report includes the monitoring position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and that relating to large-hospitals set aside for the population of the Scottish Borders (the "set-aside budget").

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. At the same time, it noted the proposed budget of **£18.128m** relating to the large hospitals budget set-aside.

2.2 Since approving the partnership's Financial Statement in March, the IJB has, within the delegated budget, directed a total of **£3.695m** of the social care funding allocation from the Scottish Government (full-year recurring impact of **£4.288m**). Of the **£5.267m** total allocation to the Scottish Borders partnership this financial year, this results in **£1.572m** remaining uncommitted for this year and **£0.979m** in future financial years, pending recommendations for further direction within a separate report to the IJB on 17 October 2016.

2.3 This report sets out the current monitoring position on both the delegated and set-aside budgets at 31 August 2016, identifying key areas of financial pressure. An overview of the delivery of efficiencies and other savings on which the budget is predicated is also outlined, identifying key risks. Following this mitigating actions are proposed to address these pressures, including recommendations for directing the remaining uncommitted social care funding across both the delegated and set-aside budgets.

Overview of Monitoring Position at 30 June 2016

Delegated Budget

3.1 In order for the partnership's financial plan for functions delegated to it to be affordable, **£7.373m** of efficiency and other savings require delivering during 2016/17. The challenge extended by this, in conjunction with a series of demand, price and legislative pressures which have emerged during the financial year to date, has resulted in the reporting of a projected adverse position at the 31st March, which is both considerable and requires immediate addressing.

3.2 At 31 August 2016, the delegated budget is reporting a projected outturn of **£144.565m** against a current budget of **£139.150m** resulting in a projected adverse variance of **£5.415m** in total. This adverse variance relates to projected pressures

of **£5.032m** across healthcare functions and **£0.383m** across social care functions and can be detailed as follows:

Joint Learning Disability Service

£0.075m Night Support Sleep-Ins

3.3 The largest area of projected pressure within the Joint Learning Disability Service relates to the requirement to implement the working time directive / single living wage for all care staff from 1 October 2016. Scottish Government has now confirmed that councils should continue to pay sleepover hours at a rate that is compliant with HMRC requirements. No change is now anticipated to sleepover rates from 1 October. This remains a transitional position and Scottish Government's ambition remains that Councils will move to a position where all hours, including sleepover hours, are paid at the rate of the real Living Wage. Government recognise however that it may take time for partnerships and providers to adjust to this, including through service redesign, where appropriate. As such this is an issue that will be subject to further consideration for 2017-18.

3.4 The cost of a sleep-in is currently on average £36. The introduction of the real living will see this cost increase to £153, an increase of 425%. Without action, it is estimated that over a full year, this will cost an additional £1.5m per annum.

3.5 The impact of this pressure will clearly requires to be mitigated through a combination of reducing the number of night-time supports and a redesign of the service in order to improve both efficiency and effectiveness, a process which whilst deliverable, is also complex and will involve a range of undertakings such as service user reassessment and agreeing new support plans. In order to contain the ongoing impact of this anticipated legislative change to £750k and not the projected cost of £1.500m by doing nothing, a project over the remainder of the financial year will aim to develop and implement a new redesigned service. This project is estimated to cost £75k but is targeted at realising £750k of recurring savings.

3.6 Other pressure across the Joint Learning Disability Service, in particular due to demand for homecare, has been mostly offset by a range of savings, within Community Based Services.

Joint Mental Health Service

£0.332m Staffing

3.7 £300k of projected pressure is reported within the Mental Health Team due to the use of agency medical locums to cover consultant vacancies. . Additionally, a further £30k is projected in respect of the part-year unbudgeted cost of a Community Mental Health Worker.

Older People Service

£0.034 Net

3.8 Demand for residential care beds continues to exceed the level supported by available budget resulting in projected pressure of £511k. This has been largely offset by the maintenance of a lower than budgeted level of homecare provision a reduction in projected respite costs and planned staffing savings within the Older People staff team.

Physical Disability Service

£0.048 Net

3.9 The previously reported pressure arising from a small number of additional complex and high tariff care packages this year has now been part-mitigated by a reduction in the demand for residential care.

Generic Services

£1.800m GP Prescribing

3.10 The highest single area of risk and largest adverse service variance across the delegated budget continues to be within GP Prescribing which is reporting a projected overspend of **£1.800m** attributable to the increased prices of key drugs arising from the global short supply of certain drugs. NHS Borders increased the GP prescribing budget by £1.4m in 2016/17. This provided for increased demand for drugs which has materialised as expected. However although some resource was put aside for price increase actual costs to date are significantly higher linked to nationally agreed tariffs for drugs which are in short supply. NHS Borders pharmacy staff in conjunction with GPs have proactively reviewed the drugs effected by price increases and made changes where clinically appropriate to minimise the impact on the GP prescribing budget. Many other partnerships across Scotland have experienced the same issues.

£2.406m Delivery of Efficiencies

3.11 Risk to the affordability of the delegated budget and overall sufficiency of resources has been a key focus of reports to the IJB in 2016/17, both at the time of approving the financial statement on 30 March 2016 and in subsequent monitoring reports since. In order to be affordable, delivery in full of all planned efficiencies is required. Within Generic Services, a number of targeted efficiencies which are not currently projected to be delivered this financial year within the healthcare budget have been centralised. A separate report to the IJB on the delivery of efficiencies will be reported providing fuller detail, but overall, inability to deliver the targeted savings actions in 2016/17 will result in a projected pressure of £2.406m this financial year.

£0.663m Other (Net)

3.12 A number of other pressures across Generic Services have emerged during 2016/17. These include staffing pressures within Allied Health Professional Services due to the use of agency locums to improve waiting times (£254k), the continued requirement for flex beds to support patient flow as a result of delayed discharges which is reported under the Primary and Community Services Management (£300k) and the requirement for further spend on equipment for the Borders Ability Equipment Store (£150k). An element of these and other pressures have been part-

mitigated by underspends within Community Nursing (£150k) due to short term vacancies.

Set-Aside Budget

3.13 As reported to the IJB in August, NHS Borders is currently experiencing the impact of a range of pressures across the large-hospitals budget set-aside for the population of the Scottish Borders. The key issue continues to be activity levels and the impact of discharged discharge on patient flow. This is manifested in the continued requirement for Surge Beds (£1.200m) normally only open in the winter months and additional medical staff in Acute Admissions Unit and Emergency Department. Due national and local workforce challenges NHS Borders is using high cost agency medical and nursing staff to cover gaps in rotas in order to maintain safe services.

Recovery Planning

4.1 IJB members, as part of the process of planning to mitigate the financial impact of the pressures reported in section 3 above, are asked to consider recommendations for direction of further social care funding across targeted areas of the delegated and set-aside partnership budget.

4.2 In addition to the direction of all remaining social care funding, given the scale of the adverse projected position reported in section 3, further actions to mitigate the impact of the underlying pressures are now required during the second part of the financial year.

4.3 In relation to Social Care, if following consideration of the social care funding report, IJB members agree to the direction of further funding towards meeting the costs of the living wage and Ability Store equipment budget pressures, the residual pressure of **£133k** will be met through the identification of additional savings measures over the remainder of 2016/17.

4.4 Within Healthcare, the high level of adverse financial pressure across all budgets is of a level incomparable with historic financial years due to a range of significant factors. In order to mitigate them, NHS Borders is currently implementing a Board-wide recovery plan that will seek to reduce profiled spend across all areas of the organisation including those supported by the budget delegated to the Health and Social Care Partnership, the large hospital budget retained by NHS Borders and set-aside and those supporting the wider non-delegated health board functions. It is expected that this plan will be considered and updated by NHS Borders' Board later this month and in due course will be reported to the IJB.

4.5 The key areas of action by NHS Borders in order to contain and mitigate the pressures reported (across all of its operations and not just those functions delegated to the IJB) can be summarised as follows:

Increased Financial Scrutiny

4.6 The level of financial scrutiny in overspending areas of operational budgets has increased. Some examples of these are detailed below :

- New rostering systems and processes have been put in place for nursing in the BGH
- A detailed review of areas of high levels of sickness to ensure full adherence to policy and put in place support for staff to promote attendance at work (and reduce the cost of back cover)
- Ongoing work on the process for recruiting and utilising bank staff
- Stop agency nursing staff other than those required for patient safety
- Appointment of four Clinical Development Fellows, which are out-with our current funding establishment levels, from 3rd August 2016 who will partially support service delivery and avoid the use of locums to cover junior doctor rotation gaps
- In some specialities, processes have been put in place to allow closer working with NHS Lothian to support medical pressures
- On a case by case basis, consideration is being given to the service impact of not using agency locums to cover senior medical gaps

Identification of Further Savings Potential

4.7 NHS Borders is currently reviewing all resource allocations in order to identify areas of potential saving against allocation total and redirect towards the overall financial position.

4.8 A number of financial control measures in areas of discretionary spend such as training, travel, etc. are currently being implemented in order to reduce projected costs in these areas during the remainder of the financial year. Further projected cost reductions are anticipated from the deferral of appointment across a number of non-essential vacant posts within the health board.

4.9 In line with work that is being taken forward nationally the Board is also examining the possibility of a number of technical accounting adjustments which will release resource in 2016/17.

4.10 Focus is also once again being placed on the acceleration of new and existing efficiency projects in order to release further resources this financial year.

4.11 Clearly this is not an insubstantial challenge. The plan and progress against it will be reported to the IJB on an ongoing basis. The Health and Social Care Partnership does not have direct access to sufficient resource in itself to direct funding to NHS Borders to help address the pressures reported, other than what is included within separate papers on the use of the Integrated Care Fund and social care funding. What is also required therefore, is further specific direction across delegated functions by the Partnership, with the intention of realising additional savings that can be vired to offset those areas of pressure.

Summary

4.12 Pressure across both delegated and set-aside budgets is clearly substantial. A combination of direction of additional funding and the implementation of a recovery plan is now required in order to mitigate such pressure. The requirement to deliver this latter plan, from an IJB perspective, requires to now be formalised through the issuing of a subsequent direction to NHS Borders, requiring the health board to, take appropriate remedial action in order to deliver an affordable outturn position at 31 March 2016.

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 **note** the planned high-level actions of recovery currently being developed and implemented by NHS Borders.

The Health & Social Care Integration Joint Board is asked to **approve** the issue of a subsequent direction to NHS Borders requiring appropriate remedial action in order to deliver an affordable outturn position across the delegated budget at 31 March 2017.

The Health & Social Care Integration Joint Board is asked to **consider** how it may further support NHS Borders in planning and delivering actions to mitigate the pressures across its delegated, set-aside and wider health board budgets through the use of directions proposing disinvestment opportunities.

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 - Delegated | **2016/17** | **AT END OF MTH: August**

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**	**7,810**	**7,524**	**286**	**18,678**	**18,830**	**-152**	**52**	**20**	**20**	
Joint Mental Health Service	**15,977**	**6,368**	**6,551**	**-183**	**16,019**	**16,351**	**-332**	**352**	**316**	**315**	
Joint Alcohol and Drug Service	**948**	**304**	**264**	**40**	**948**	**928**	**20**	**3**	**3**	**3**	
Older People Service	**28,126**	**10,762**	**9,651**	**1,111**	**26,885**	**26,919**	**-34**	**23**	**0**	**0**	
Physical Disability Service	**3,180**	**1,385**	**1,391**	**-6**	**3,321**	**3,369**	**-48**	**0**	**0**	**0**	
Generic Services	**72,651**	**30,027**	**28,821**	**1,207**	**73,299**	**78,168**	**-4,869**	**604**	**516**	**520**	
Total	**139,150**	**56,656**	**54,202**	**2,455**	**139,150**	**144,565**	**(5,415)**	**1034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	20,946	17,655	3,292	51,798	52,181	(383)				
NHS Funding from Sgovt etc	87,352	35,710	36,547	(837)	87,352	92,384	(5,032)				
Total	**139,150**	**56,656**	**54,202**	**2,455**	**139,150**	**144,565**	**(5,415)**				

MONTHLY REVENUE MANAGEMENT REPORT

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

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**	**7,810**	**7,524**	**286**	**18,678**	**18,830**	**-152**	**52**	**20**	**20**	
Residential Care	4,181	1,851	1,581	270	4,182	4,182	0	0	0	0	
SBC Carers	0	0	0	0	0	0	0	0	0	0	
Homecare	2,582	1,877	1,655	222	4,179	4,181	-2	0	0	0	
Day Care	2,091	657	771	-114	1,657	1,671	-14	3	0	0	
Community Based Services	7,139	2,467	2,561	-94	6,316	6,461	-145	0	0	0	
Respite	200	78	95	-17	207	231	-24	0	0	0	
Other	2,075	880	861	19	2,137	2,104	33	49	20	20	
Joint Mental Health Service	**15,977**	**6,368**	**6,551**	**-183**	**16,019**	**16,351**	**-332**	**352**	**316**	**315**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	190	84	69	15	210	197	13	0	0	0	
Day Care	186	79	63	16	192	182	10	5	0	0	
Community Based Services	788	149	246	-97	700	618	82	0	0	0	
Respite	15	6	3	3	16	3	13	0	0	0	
SDS	102	44	80	-36	105	232	-127	0	0	0	
Mental Health Team	14,696	5,978	6,070	-92	14,728	15,051	-323	347	316	315	
Choose Life	0	28	20	8	68	68	0	0	0	0	
Joint Alcohol and Drug Service	**948**	**304**	**264**	**40**	**948**	**928**	**20**	**3**	**3**	**3**	
D & A Commissioned Services	820	304	264	40	820	800	20	0	0	0	
D & A Team	128	0	0	0	128	128	0	3	3	3	
Older People Service	**28,126**	**10,762**	**9,651**	**1,111**	**26,885**	**26,919**	**-34**	**23**	**0**	**0**	
Residential Care	11,422	4,389	4,112	277	11,388	11,899	-511	0	0	0	
Homecare	8,025	2,992	3,484	-492	7,609	7,164	445	0	0	0	
Day Care	1,001	355	388	-33	895	908	-13	0	0	0	
Community Based Services	999	886	657	229	2,840	2,814	26	16	0	0	
Extra Care Housing	545	215	145	70	516	519	-3	0	0	0	
Housing with Care	409	171	164	7	409	492	-83	0	0	0	
Dementia Services	37	-237	26	-263	-209	-208	-1	0	0	0	
Delayed Discharge	267	43	137	-94	267	262	5	0	0	0	
Other	5,421	1,948	538	1,410	3,170	3,069	101	7	0	0	
Physical Disability Service	**3,180**	**1,385**	**1,391**	**-6**	**3,321**	**3,369**	**-48**	**0**	**0**	**0**	
Residential Care	566	176	94	82	506	277	229	0	0	0	
Homecare	1,747	671	686	-15	1,652	1,537	115	0	0	0	
Day Care	201	28	32	-4	67	67	0	0	0	0	
Community Based Services	666	510	579	-69	1,096	1,488	-392	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	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**	**30,027**	**28,821**	**1,207**	**73,299**	**78,168**	**(4,869)**	**604**	**516**	**520**	
Community Hospitals	4,802	1,923	2,047	-124	4,802	5,002	-200	115	122	123	
GP Prescribing	22,436	9,271	9,832	-561	22,436	24,236	-1,800	0	0	0	
AHP Services	5,658	2,325	2,439	-114	5,658	5,912	-254	144	139	140	
General Medical Services	16,933	7,183	7,183	0	16,933	16,933	0	4	4	4	
Community Nursing	4,387	1,828	1,801	27	4,387	4,237	150	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	382	490	(108)	726	876	(150)	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	1	13	56	54	2	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	(83)	(93)	10	0	31	(31)	0	0	0	
OT	0	0	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	21	17	4	43	34	9	0	0	0	
Out of Hours	2,131	902	845	57	2,131	2,131	0	0	0	0	
Community Based Services	0	46	(1,960)	2,007	256	303	(47)	0	0	0	
Sexual Health	558	261	255	6	558	591	(33)	7	6	6	
Public dental Services	3,324	1,676	1,656	20	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	187	184	3	441	433	8	3	3	3	
Smoking Cessation	209	103	82	21	209	159	50	4	5	5	
Primary & Community Management	1,684	621	811	(190)	1,684	2,001	(317)	34	44	42	
Health Promotion	438	187	173	14	438	405	33	8	12	12	
Opthalmic Services	1,591	680	680	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	1,106	1,103	3	2,609	2,602	7	0	0	0	
Other	5,243	1,601	1,482	119	5,641	5,531	110	28	0	0	
Health and Social Care Fund	0	0	0	0	0	0	0	0	0	0	
Savings	(4,557)	(1,213)	(1,213)	0	(4,557)	(2,151)	(2,406)	0	0	0	
Total	**139,150**	**56,656**	**54,202**	**2,455**	**139,150**	**144,565**	**(5,415)**	**1,034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	20,946	17,655	3,292	51,798	52,181	(383)				
NHS Funding from Sgovt etc	87,352	35,710	36,547	(837)	87,352	92,384	(5,032)				
Total	**139,150**	**56,656**	**54,202**	**2,455**	**139,150**	**144,565**	**(5,415)**				

MONTHLY REVENUE MANAGEMENT REPORT

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

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**	**1,510**	**1,448**	**62**	**3,599**	**3,569**	**30**	**20**	**20**	**20**	
Residential Care	2,689	1,122	1,065	57	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	388	383	5	910	880	30	20	20	20	
Joint Mental Health Service	**14,015**	**5,718**	**5,775**	**(57)**	**14,015**	**14,315**	**(300)**	**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	5,718	5,775	(57)	14,015	14,315	(300)	327	316	315	
Joint Alcohol and Drug Service	**749**	**197**	**197**	**0**	**749**	**749**	**0**	**3**	**3**	**3**	
D & A Commissioned Services	621	197	197	0	621	621	0	0	0	0	
D & A Team	128	0	0	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: August**

	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**	**28,285**	**29,127**	**(842)**	**68,989**	**73,751**	**(4,762)**	**507**	**516**	**520**	
Community Hospitals	4,802	1,923	2,047	(124)	4,802	5,002	(200)	115	122	123	
GP Prescribing	22,436	9,271	9,832	(561)	22,436	24,236	(1,800)	0	0	0	
AHP Services	5,658	2,325	2,439	(114)	5,658	5,912	(254)	144	139	140	
General Medical Services	16,933	7,183	7,183	0	16,933	16,933	0	4	4	4	
Community Nursing	4,387	1,828	1,801	27	4,387	4,237	150	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	102	106	(4)	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	902	845	57	2,131	2,131	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Sexual Health	558	261	255	6	558	591	(33)	7	6	6	
Public dental Services	3,324	1,676	1,656	20	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	187	184	3	441	433	8	3	3	3	
Smoking Cessation	209	103	82	21	209	159	50	4	5	5	
Primary & Community Management	1,684	621	811	(190)	1,684	2,001	(317)	34	44	42	
Health Promotion	438	187	173	14	438	405	33	8	12	12	
Opthalmic Services	1,591	680	680	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	1,106	1,103	3	2,609	2,602	7	0	0	0	
Other	2,162	137	137	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)	(1,213)	(1,213)	0	(4,557)	(2,151)	(2,406)	0	0	0	
Total	**87,352**	**35,710**	**36,547**	**(837)**	**87,352**	**92,384**	**(5,032)**	**857**	**854**	**857**	

MONTHLY REVENUE MANAGEMENT REPORT

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

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**	**6,300**	**6,076**	**224**	**15,079**	**15,261**	**(182)**	**32**	
Residential Care	1,492	729	516	213	1,493	1,493	0	0	
SB Cares	0	0	0	0	0	0	0	0	
Homecare	2,582	1,877	1,655	222	4,179	4,181	(2)	0	
Day Care	2,091	657	771	(114)	1,657	1,671	(14)	3	
Community Based Services	7,139	2,467	2,561	(94)	6,316	6,461	(145)	0	
Respite	200	78	95	(17)	207	231	(24)	0	
AWLD Staff Teams	1,165	492	478	14	1,227	1,224	3	29	
Joint Mental Health Service	**1,962**	**650**	**776**	**(126)**	**2,004**	**2,036**	**(32)**	**25**	
Residential Care	0	0	0	0	0	0	0	0	
Homecare	190	84	69	15	210	197	13	0	
Day Care	186	79	63	16	192	182	10	5	
Community Based Services	788	149	246	(97)	700	618	82	0	
Respite	15	6	3	3	16	3	13	0	
SDS	102	44	80	(36)	105	232	(127)	0	
MH Staff Teams	681	260	295	(35)	713	736	(23)	20	
Choose Life	0	28	20	8	68	68	0	0	
Joint Alcohol and Drug Service	**199**	**107**	**67**	**40**	**199**	**179**	**20**	**0**	
Drug and Alcohol Commissioned Services	199	107	67	40	199	179	20	0	
Drug and Alcohol Team	0	0	0	0	0	0	0	0	
Older People Service	**28,126**	**10,762**	**9,651**	**1,111**	**26,885**	**26,919**	**(34)**	**23**	
Residential Care	11,422	4,389	4,112	277	11,388	11,899	(511)	0	
Homecare	8,025	2,992	3,484	(492)	7,609	7,164	445	0	
Day Care	1,001	355	388	(33)	895	908	(13)	0	
Community Based Services	999	886	657	229	2,840	2,814	26	16	
Extra Care Housing	545	215	145	70	516	519	(3)	0	
Housing with Care	409	171	164	7	409	492	(83)	0	
Dementia Services	37	(237)	26	(263)	(209)	(208)	(1)	0	
Delayed Discharge	267	43	137	(94)	267	262	5	0	
OP Staff Teams	847	402	318	84	882	842	40	7	
Other	4,574	1,546	220	1,326	2,288	2,227	61	0	
Physical Disability Service	**3,180**	**1,385**	**1,391**	**(6)**	**3,321**	**3,369**	**(48)**	**0**	
Residential Care	566	176	94	82	506	277	229	0	
Homecare	1,747	671	686	(15)	1,652	1,537	115	0	
Day Care	201	28	32	(4)	67	67	0	0	
Community Based Services	666	510	579	(69)	1,096	1,488	(392)	0	
Other	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	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**	**1,742**	**(306)**	**2,049**	**4,310**	**4,417**	**(107)**	**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	280	384	(104)	476	626	(150)	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	1	13	56	54	2	0	
Respite	0	0	0	0	0	0	0	0	
SDS	0	(83)	(93)	10	0	31	(31)	0	
OT	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	21	17	4	43	34	9	0	
Out of Hours	0	0	0	0	0	0	0	0	
Community Based Services	0	46	(1,960)	2,007	256	303	(47)	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	1,480	1,397	83	3,409	3,369	40	0	
Other	(434)	(16)	(52)	36	70	0	70	28	
Total	**51,798**	**20,946**	**17,655**	**3,292**	**51,798**	**52,181**	**(383)**	**177**	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Set Aside) | **2016/17** | **AT END OF MTH: August**

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
Large Hospital Set Aside	**18,128**	**8,353**	**9,912**	**(1,559)**	**19,216**	**22,286**	**(3,070)**	**0**	**0**	**0**	
Accident & Emergency	1,806	824	1,037	(213)	1,806	2,318	(512)	0	0	0	
Medicine & LTC	11,330	5,016	6,027	(1,011)	11,330	13,456	(2,126)	0	0	0	
Medicine of the Elderly	6,080	2,513	2,848	(335)	6,080	6,512	(432)	0	0	0	
Savings	(1,088)										
Total	**18,128**	**8,353**	**9,912**	**(1,559)**	**19,216**	**22,286**	**(3,070)**	**0**	**0**	**0**	

DELIVERY OF EFFICIENCIES AND SAVINGS PLANS AT 31 AUGUST 2016

Aim

1.1 The aim of this report is to provide an overview of the progress made by NHS Borders and Scottish Borders Council in the delivery of their efficiency and savings plans, on which the delegated budget and large-hospital budget set-aside are predicated, identifying key areas of partnership financial risk.

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. At the same time, it noted the proposed budget of **£18.128m** relating to the large hospitals budget set-aside.

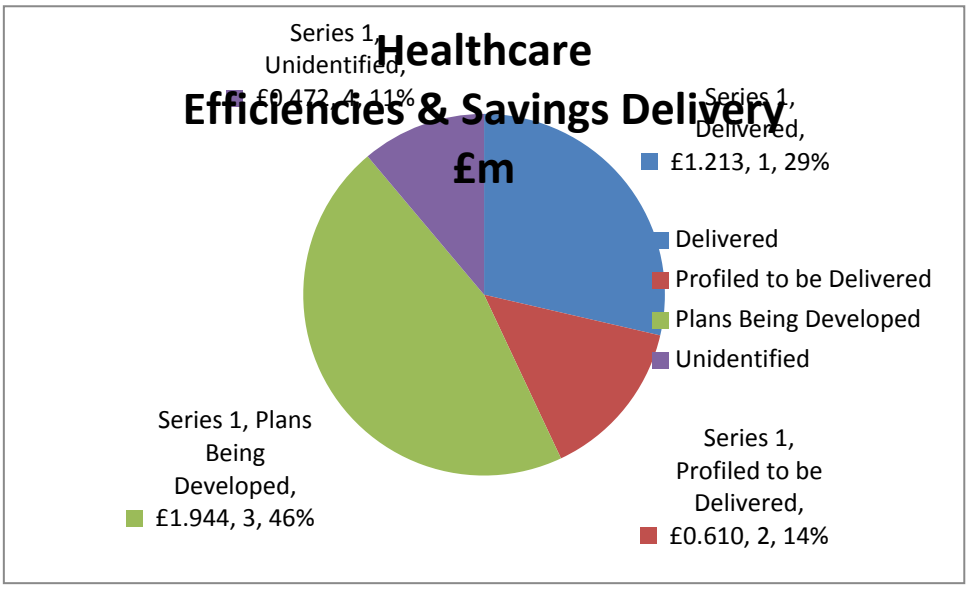
2.2 The monitoring report to the IJB at 31 August 2016 is reporting considerable financial pressure across both healthcare and social care budgets this financial year, attributable to a range of factors. These pressures will only be mitigated through a combination of implementation of a range of recovery actions and further direction of social care funding, the latter of which has, to date, been utilised only with social care.

2.3 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.

2.4 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, at the time of approving the partnership's financial statement, it was noted that there was a further affordability gap within the budget delegated by NHS Borders to the partnership in respect of a reduction in ringfenced funding (£471k). This was partially addressed by the direction of £220k of social care funding on a non-recurring basis to the Alcohol and Drug Partnership during 2016/17.

Health Care – Devolved Budget Efficiencies

3.1 Within the budget delegated to the partnership, NHS Borders is required to deliver **£4.239m** of efficiency savings, £3.255m of this total (77%) is required on a recurring basis. Progress against these targets at 31 August is summarised below:



3.2 At 31 August 2016, **£1. 213m** has been delivered. Within this, £0.933m is recurring and £280k is non-recurring. An element of the savings delivered to date relates to GP Prescribing. Whilst this is a key area of ongoing financial pressure across the partnership budget due to volatility and increased market costs for certain drugs, it is important to attribute £600m of savings delivered through managed programme of changes.

3.3 Of the remaining **£3.026** gap, **£0.610m** is profiled for delivery over the remainder of the year across a number of projects:

	£'000
Clinical Productivity	100
Community Service Cost Reviews	100
Step up/down	410
	610

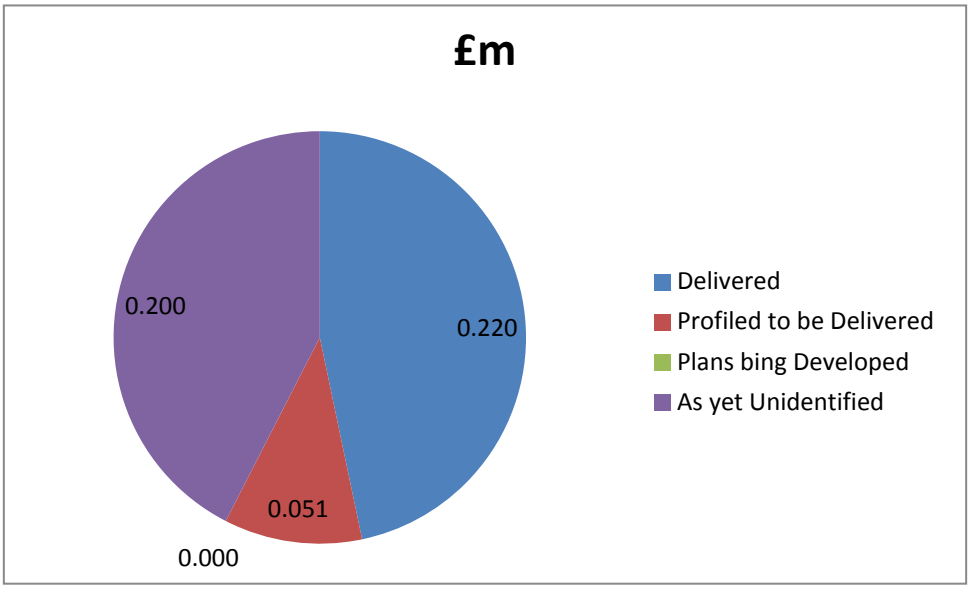
3.4 The assumptions underlying this however carry a degree of risk and uncertainty however. These include how any saving profiled within the Clinical Productivity project will be treated given ongoing re-investment requirementsand the securing of Integrated Care Funding to enable the implementation of the new Transitional Care Facility which will have an impact on the Step Up/Down care efficiency target above.

3.5 Of the **£4.239m**, total efficiency savings of **£1,823m** have been or are projected to be delivered. With no further plans in place at the current time, clearly risk of non-delivery of a significant element of NHS Borders efficiency programme is high and 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. Further detail on these recovery actions is contained within the Monitoring Report to 31 August 2016.

Health Care – Devolved Budget Efficiencies (Ringfenced Funding)

4.1 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.

4.2 Beyond the ADP reduction, plans are being developed in partnership between NHS Borders and the IJB Chief Officer to address the remaining savings gap of **£0.200m**. A summary therefore of the 2016/17 ringfenced grant savings / funding delivery is detailed below:

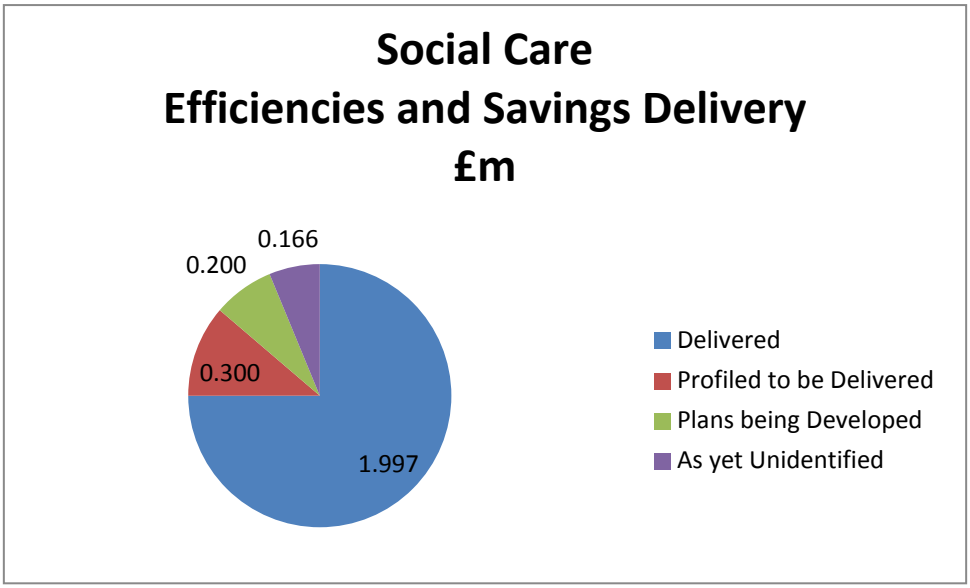


Social Care – Devolved Budget Efficiencies

5.1 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. At the end of August, **£1.997m** of savings have been delivered, with a further **£0.500m** profiled to be delivered during the remainder of 2016/17. Of this, **£0.200m** of profiled savings is dependent on approval and delivery of Integrated Care Funded projects relating to Enablement and Community Led Support, whilst the remainder relates to savings within the management structure of adult care services (**£0.100m**) and Day Services (**£0.100m).**

5.2 Further work is required to develop an alternative savings plan to deliver the remaining **£0.166m** of planned savings that remain undelivered or un-projected this year.

5.3 In addition to the **£2.663m** of savings planned within the 2016/17 delegated budget above, a further **£378k** of recurring savings targets carried forward from 2015/16 require to now be delivered permanently. Plans are now in place for their delivery which is now projected in full during the remainder of the year.



Next Steps

6.1 In terms of any financial risk arising from any proposed efficiency and savings plans and required mitigating alternative recovery actions, the IJB will be kept informed through the provision of regular reports to future meetings during the remainder of the financial year. Close monitoring of the delivery of the proposed actions across partners to directly address the reported projected pressures is a pre-requisite of ensuring overall affordability of delegated and set-aside functions this financial year.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and the progress made by NHS Borders and Scottish Borders Council in delivering their efficiency and savings plans on which the partnership's 2016/17 revenue budget is predicated.

The Health & Social Care Integration Joint Board is asked to **note** the projected level of non-delivery of efficiency savings and consider how the impact of this can be mitigated through consideration of proposals for alternative measures detailed within a recovery plan

In line with the IJB approach to the issue of dealing with pressures and overspends and supporting the NHS and Council to achieve efficiency expectations, the IJB will, through the use of directions, strengthen existing and/or develop revised efficiency 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		

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DIRECTION OF SOCIAL CARE FUNDING

Aim

1.1 The aim of this report is to provide an overview of how social care funding has been directed by the partnership to date and to provide recommendations for further direction from the partnership's remaining uncommitted funding allocation.

Background

2.1 During 2016/17, the IJB has to date directed a total of **£3.695m** of the social care funding allocation from the Scottish Government (with a full-year recurring impact of £4.288m). Of the **£5.267m** total allocation to the Scottish Borders partnership this financial year, **£1.572m** therefore remains uncommitted for this year with **£0.979m** available in future financial years.

2.2 A summary of how the funding allocation has been directed to date is detailed below:

	Delegated Budget		Set-Aside Budget		Total	
	2016/17 £'000	2017/18 £'000	2016/17 £'000	2017/18 £'000	2016/17 £'000	2017/18 £'000
20-Jun-16						
Living Wage	813	1,626			813	1,626
Demand Pressure	1,081	1,081			1,081	1,081
Charging Threshold	154	154			154	154
Unplanned Efficiencies	220	0			220	0
	2,268	**2,861**	**0**	**0**	**2,268**	**2,861**
30-Aug-16						
Provider Costs	1,127	1,127			1,127	1,127
Demand Pressure	300	300			300	300
	1,427	**1,427**	**0**	**0**	**1,427**	**1,427**
Total Directed To Date	**3,695**	**4,288**	**0**	**0**	**3,695**	**4,288**

Requirement for Further Direction of Funding

3.1 Following consideration of the pressures reported in the IJB report on monitoring of the health and social care budget at 31 August 2016, it is the considered view of the Chief Officer to recommend to members of the IJB further direction of part of the remaining social care funding allocation in order to:

- Fund a project to defray the costs of sleep-ins arising from the working time directive
- Partly mitigate financial pressures arising from ongoing increased demand across both the delegated and set-aside budgets
- Enable the appointment of a joint Community Mental Health worker

3.2 A summary of the recommended social care funding proposed direction is detailed below:

	Delegated Budget		Set-Aside Budget		Total	
	2016/17 £'000	2017/18 £'000	2016/17 £'000	2017/18 £'000	2016/17 £'000	2017/18 £'000
17-Oct-16						
Surge Beds	0	0	500	0	500	0
Night Support (*)	0	750				750
Night Support Redesign	75	0			75	0
BAES Equipment	150	0			150	0
Community MH Worker	25	50			25	50
	250	**800**	**500**	**0**	**750**	**800**
Total Proposed Directed	**3,945**	**5,088**	**500**	**0**	**4,445**	**5,088**
Remaining Uncommitted	**1,322**				**822**	**179**

3.3 Further detail over the requirement for direction of the remaining uncommitted social care funding and how it will be used is detailed in the paragraphs below.

Surge Beds

3.4 The provision of additional beds – "surge beds" – formed a key component of NHS Borders Winter Plan, which is aimed at ensuring that there is sufficient capacity across health and social care services to meet the additional demand for care normally experienced during the colder months of the year. These beds, in order to be safely opened, require a range of supporting medical and nursing staff and are an important aspect of ensuring surges in demand are able to be accommodated. . This year occupied bed days for patients whose discharge is delayed has increased significantly resulting in it not being possible to revert to non winter bed numbers. In recognising the financial impact that this has had on NHS Borders, it is recommended that the partnership approve the direction of **£500k** of non-recurring social care funding as a contribution towards mitigating the financial pressure this has put on the large hospitals budget set-aside.

Night Support

3.5 Resulting from the Working Time Directive, the requirement that all care staff providing night support be paid an hourly rate (taking account of holiday pay and a living wage) instead of a nightly fee will place a considerable financial pressure on the service. Prior to this legislative change, the cost of a sleep-in was on average £36 and following implementation of the change it is projected that each nightly sleep over will now cost £153, an increase of 425%. Scottish Government originally proposed this change be implemented from 1 October 2016. The longer term government aspiration to align sleep in payments with the real living wage remains; however, the proposal has been put on hold in the current year and it is assumed will now be implemented from 1 April 2017. Without action to contain expenditure, it

is estimated that over the full 2017/18 year, this change will cost an additional £1.5m per annum.

3.6 The impact of this pressure clearly requires to be mitigated through a combination of reducing the number of night-time supports and a redesign of the service in order to improve both efficiency and effectiveness, a process which whilst deliverable, is also complex and will involve a range of undertakings such as service user reassessment and agreeing new support plans.

3.7 It is proposed therefore to undertake a project over the remainder of the financial year which will develop and implement a new redesigned service. This will require a full team social worker and a half-time team manager, together with some assistive technology and the commissioning of an assessment tool from an external provider, at a total cost of **£75k**.

3.8 It is intended that the outcome of this project will cap the increased cost implications of the legislative changes at a total of **£750k** per annum and to achieve this cost reduction it is proposed to direct **£75k** in 2016/17 on a one-off basis to fund the required work.

BAES Equipment Budget

3.9 Borders Ability and Equipment Store is a joint service included within those functions delegated to the partnership. The current budget for the Store is £767k, which is funded by £251k by NHS Borders and £516k by Scottish Borders Council. Within this, the budget for the equipment itself is £300k, with the remainder (£467k) meeting staffing costs, premises expenses, transport and other operational costs such as equipment sterilisation.

3.10 Historically, the equipment budget has been insufficient to meet demand and during each financial year, further resources have been required to increase it from other service areas. So far during 2016/17, the budget has almost been exhausted, with average monthly equipment purchases totalling almost £50k per month, against a budgeted profile of £25k.

3.11 Review of the service is clearly required which is now underway in order to improve its overall affordability, financial management budgetary control and cost-effectiveness. Beyond this however, it is also clear that the equipment budget is insufficient to meet not just current but future requirements and it is proposed that it be increased to £450k per annum, which combined to the outcomes of the current review will make future service provision affordable ongoing. Whilst £150k of additional funding is required immediately to ensure service continuity over the remainder of the financial year, until the review is undertaken, further funding should not be directed despite perceptions of ongoing need and sustainability. To meet the immediate requirement therefore, the direction of **£150k** of social care funding on a one-off non-recurring basis is required.

Community Mental Health Worker

3.12 Following work undertaken by the Children and Young People's Leadership Group, considerable savings are now targeted in order to meet previously agreed efficiency plans. These savings will be delivered from April 2017. There remains however the

requirement to find further resources in order to finally enable the appointment to a vacant Community Health Worker post which will work with young people with high risk behaviours and provide support to schools. In order to mitigate financial impact of this on NHS Borders' and Scottish Borders service revenue budgets going forward, it is proposed that this post be funded through the direction of social care funding. This will require commitment of **£25k** for the remainder of 2016/17 and **£50**k recurring in future years.

3.13 Should IJB members approve the recommendations made above, this will result in total direction of **£750k** of social care funding this financial year and **£800k** recurring in future years. **£822k** of funding will in turn remain available for allocation this financial year on a one-off basis and **£179k** available for direction on a recurring basis in future financial years.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** how the Scottish Government allocation of social care funding to the partnership has been directed during 2016/17 to date.

The Health & Social Care Integration Joint Board is asked to **ratify** the further direction of social care funding on the proposed recurring and non-recurring bases to meet the additional pressures outlined above.

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		

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PRESCRIBING EFFICIENCIES – PAST, PRESENT AND FUTURE

Aim

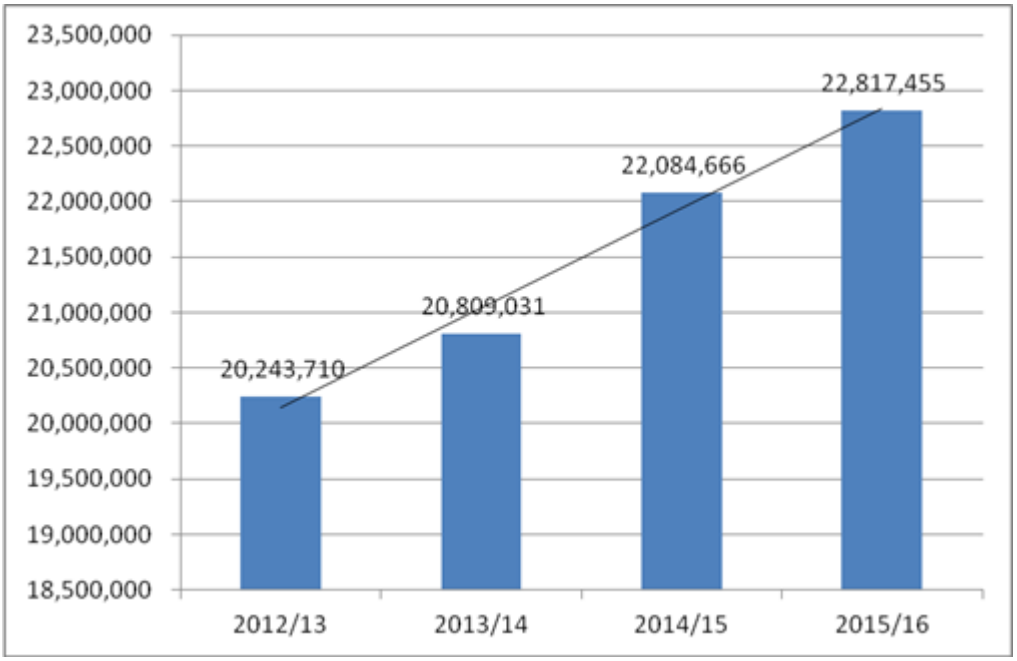
1.1 To inform the Integration Joint Board on Prescribing Efficiencies and show how, in 2016/17, proposed projects aim to achieve the £1.2m target set. Work to the beginning of March 2016 had achieved a gross saving of £616,000, excluding the GP Local Enhanced Service, primary care rebates and patent expiries.

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 £1.2M.

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 leading to increased product cost.
- 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.

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.
APPENDIX 4 – Key Issues – reports indicating drug price increases and the mechanism for identifying and watching these.

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	Vince Summers	Deputy Director of Pharmacy
Keith Maclure	Lead Prescribing Support Pharmacist		

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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APPENDIX 2 - 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	24.7		Ropinirole (shortage)	TBC
Prescribing Efficiency LES - Non Clinical Med Review	Medium	84	36	48			Spend increases from range of drug price increase (refer to Increases spreadsheet Quarter 1 Primary Care only	-258.00
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	19			
Sub total		**558.76**	**196**	**342.76**	**43.7**	**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			Nabilone shortage and price increase	TBC
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		3.74		
Golimumab outcome rebate	High		0	0	8.85			
HIV Drugs	High		0	0	6.16			
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			
Ranibizumab (Lucentis) contract	High	135	0	135	33.9			
Dexamethasone product change	High	7.33	0	7.33		11		
Sub total		**605.24**	**50**	**555.24**	**118.92**	**14.74**		
Total		**1164**	**246**	**898**	**162.62**	**24.24**		
Non Cash Efficiencies		**Length of Stay**	**Patients Admitted**					
Updated 11.08.16								

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APPENDIX 3 - 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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APPENDIX 4 – Efficiency Savings Key Issues

Key Issues highlighted in this table are undermining the efficiency savings work:-

Having no control over drug price increases	Growth Report shows the three BNF chapter areas of largest financial growth with some explanatory narrative – this is not an exhaustive list, it just highlights some of enormous price increases which the Board have no control over.	 Chart 1 in Appendix 4 16 08 growth repor
Identifying drug tariff price Increases	The attached Watch list is being developed based on intelligence gathered through national Prescribing support networks and local knowledge of the impact of some Tariff price increases. When price increases are identified, the Prescribing Support Team reviews patients as appropriate - to ensure the most cost effective treatment.	 Chart 2 in Appendix 4 16 08 drugs watch l

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Drug	Narrative	number of pts in latest yr	Latest yr's Spend
DULOXETINE	This could be an issue: need further information... (potential shortage in future?)	516	£84,559
NABILONE_CAP 1MG	shortage	5	£17,251
ROPINIROLE HCL_TAB	shortage	120	£16,783
CLONAZEPAM_TAB	Tariff price rise	206	£14,617
PROCHLorPeraZINE MAL_TAB BUCCAL 3MG	Tariff price rise	830	£13,605
TROSPIUM CHLOR_TAB 20MG	Tariff price rise	91	£11,227
NITROFURANTOIN_TAB	Tariff price rise	555	£10,748
CELECOXIB	This could be an issue: need to keep an eye on the market (Borders use more than normal after taking part in a clinical trial 5yrs ago, quantities are now decreasing)	206	£4,402
FLECAINIDE ACET_TAB	Tariff price rise	67	£3,841
DAPSONE_TAB 50MG	Tariff price rise	5	£3,630
ISOSORBIDE MONONIT_TAB	Tariff price rise	102	£3,327
RIVASTIGMINE_SKIN PATCH 9.5MG/24HRS	Tariff price rise	26	£3,272
TIBOLONE_TAB 2.5MG	shortage	34	£2,573
DESMOPRESSIN ACET_I/NSL SPY 10MCG	Tariff price rise	16	£2,565
RASAGILINE	potential shortage in future?	3	£1,460
NARATRIPTAN HCL_TAB 2.5MG	Tariff price rise	98	£1,330
EPROSARTAN	potential shortage in future?	4	£637

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Chapter	sub-chapter	Drug	Spend increase		Spend increase (%)	Volume change (%)	Narrative	indication of patient numbers (latest yr)
Central Nervous System	Analgesia	Nefopam	£	41,000	320	0.08	Original brand Accupan was discontinued followed by shortages of the generic.	850
	Anti-epileptics	Pregabalin	£	32,000	15	16	Lyrica High Court appeal due in June/July 2017. (Patent expiry expected July 2017).	1617
	Antidepressants	Trazodone	£	50,400	151	5.7	Generic shortages (particularly of the liquid version). Only ever used as 3rd or 4th line - very rarely a suitable alternative.	863
Cardiovascular	Anticoagulants	Apixaban	£	37,000	78	106	Formulary change to 1st line	358
		INR testing	£	7,000	51	44	near patient testing	
		Rivaroxaban	£	6,700	20	40	Formulary change to 2nd line	130
		Warfarin	£	1,000	7	0.9		2086
	Lipid regulating drugs	Rosuvastatin	£	6,000	18	18	Formulary change	346
		Atorvastatin	£	2,800	11	17	Formulary change	6562
Endocrine	Diabetes	New oral meds	£	46,000	59	4.4	Driven primarily by Pioglitazone generic shortage and the resultant reliance on 2nd/3rd line alternatives	412 (Pioglitazone
		Metformin	£	9,000	17	6.7		3645
		Diagnostic testing	-£	19,000	-14.4	6.5	Switch to TrueYou test strips and continuing decrease in urine testing	
	Steroids	Hydrocortisone	£	10,900	33	15	Shortages	102
		Fludrocortisone	£	4,500	848	17		102
	Thyroid therapy	Levothyroxine	£	4,000	6	5	Tariff pricing	5180
		Anti-thyroids	£	7	32	16	Tariff pricing	194

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SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 2015/16 FINAL AUDITED STATEMENT OF ACCOUNTS

Aim

1.1 The purpose of this report is to provide the Integration Joint Board (IJB) with the final audited Health and Social Care Partnership accounts for the period to the 31 March 2016, complying with its statutory responsibility to produce financial statements in respect of the period from its establishment on 06 March 2016 to this date.

1.2 The final Statement of Accounts ("the accounts") has been approved and signed off by the Chair of the IJB, the Chief Officer and the Chief Financial Officer. Accompanied by the Annual Audit Report by the partnership's External Auditor, the accounts were considered by the IJB Audit Committee on 26 September 2016 and subsequently approved.

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Integration Joint Board is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973. This means that the IJB is required to prepare and publish audited annual accounts that meet the reporting requirements specified in relevant legislation and regulation (specifically s.12 of the Local Government in Scotland Act 2003 and regulations under s.105 of the Local Government (Scotland) Act 1973).

2.2 These accounts require to be proportionate to the limited number of transactions of the IJB, yet comply with the public-sector requirement for transparency and true and fair financial reporting. Whilst these accounts formally represent the operating activities of the partnership in financial terms, NHS Borders and Scottish Borders Council are also required to report additional disclosures within their statutory accounts reflecting the formal relationship with the IJB.

2.3 The IJB accounts require to be prepared in draft by 30 June each financial year subject to audit, following which they require approval by its Audit Committee by 30 September and onward approval by the board itself thereafter. IJB's are specified in legislation as 'section 106' bodies under the terms of the Local Government (Scotland) Act 1973 as amended and as such they are expected to prepare their financial statements in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

Summary

3.1 During 2015/16, the Health and Social Care Partnership operated as a shadow board, until its 'integration start day' date on 01 April 2016, the date from which the delivery of its Strategic Plan commenced. As a result of the parliamentary process however, the date of establishment of the IJB as specified in the order and on which it became a legal entity was 06 February 2016.

3.2 The commencement date for delegation of functions to the IJB was 01 April 2016. Since this date did not occur during 2015/16, the IJB accounts do not need to include part-year contributions from NHS Borders or Scottish Borders Council or part-year payments from the IJB to respective partners for carrying out its directions.

3.3 As such, because the commencement date for delegation of functions and resources published in the Strategic Plan was 01 April 2016, the 2015/16 statutory accounts only require to include the operating costs of the IJB for the period from its establishment to 31 March 2016. This situation will obviously change for 2016/17, when fuller accounts will be required reflecting payment to / from the IJB.

3.4 Draft accounts were submitted to KPMG, the partnership's appointed External Auditor on 30 June 2016. Following a process of audit involving the supply of supplementary evidence, discussion and suggested amendments, a final draft version including the External Auditor's audit opinion has been produced. This final version of the Statement of Accounts is included as **Appendix 1** to this report.

3.5 **Appendix 2** details the External Auditor's draft Annual Audit Report to the Members of the IJB.

Statement of Accounts

4.1 Under the Code of Practice on Accounting for Local Authorities in the United Kingdom, the IJB accounts must meet a number of specific reporting requirements. These include:

- Management Commentary
- Statement of Responsibilities
- Annual Governance Statement
- Remuneration Report
- Balance Sheet
- Statement of Income and Expenditure
- Statement of Accounting Policies and Notes to the Accounts
- Audit Report

4.2 The Partnership's governance arrangements determine who is responsible for signing the financial statements, following specification in Regulations under s.105 of the Local Government (Scotland) Act 1973. This is provided for within the Statement.

External Audit Conclusions and Recommendations

5.1 A statement containing the audit opinion of the External Auditor has been received along with the final Annual Audit Report for 2015/16 and Management Representation Letter. The Statement is included in the section Independent Auditor's Report of the IJB Statement of Accounts 2015/16. There are no matters that are required to be brought to the attention of the IJB Audit Committee.

5.2 Within the Annual Audit Report for 2015/16, the External Auditor has made a number of conclusions over the Statement of Accounts 2015/16 and the wider operation of the IJB during the period to 31 March 2016, based on the audit work undertaken. In summary, these are:

Significant Risks	*There are no findings in relation to fraud risk or over-ride of controls.* *The accounts have been prepared in accordance with relevant legislation and guidance within which the remuneration report has been appropriately produced.*
Financial Sustainability	*The IJB is financially sustainable and a going concern.*
Financial Management	*The Chief Financial Officer (interim) has been appointed and has appropriate skills, capacity and experience.*
Governance and Transparency	*The IJB's governance framework is considered appropriate.*
Value for Money	*The IJB has evidenced using its resources for the purposes of meeting initial set-up and operating costs*

5.3 Specific to Financial Sustainability, recommendations have been made by the External Auditor. Again, in summary, these are:

Financial Sustainability	1. *The IJB should agree funding levels for 2017-18 and 2018-19 as soon as possible from both partners to allow for budget setting and planning.* 2. *Plans should be put in place as a matter of urgency for efficiency savings.* 3. *Budget provision should be put in place for areas of emerging financial pressures. A risk register should be maintained and regularly updated as financial risks emerge. The budget should also be updated regularly to reflect these risks so that financial plans can be amended accordingly.*

5.4 Work is already ongoing in respect of the areas covered by these external audit recommendations.

5.5 No audit adjustments required to be made to the draft annual accounts and a small number of minor presentational adjustments were made to some of the financial statement notes on advice of the External Auditor.

5.6 Both NHS Borders and Scottish Borders Council's Audit Committees have had oversight of the draft Statement of Accounts and External Auditor's management report for 2015/16. As outlined in 1.2, these were also considered by the IJB Audit Committee on 26 September 2016 and subsequently approved. The External Management Team has also had the opportunity to review both these documents prior to reporting to the IJB.

Recommendation

The Health & Social Care Integration Joint Board is asked **note** the approval of the 2015/16 Statement of Accounts by the IJB Audit Committee and to ratify its decision.

The Health & Social Care Integration Joint Board is also asked **note** the key recommendations made by the External Auditor to the IJB in its management report.

Policy/Strategy Implications	There are no direct policy/strategy implications arising from this report
Consultation	Previous versions of the report have been considered and noted by both NHS Borders and Scottish Borders Council's Audit Committees. The External Management Team has also had the opportunity to review.
Risk Assessment	There are no risks arising directly from this report.
Compliance with requirements on Equality and Diversity	There are no equality or diversity implications arising from this report.
Resource/Staffing Implications	There are no resource or staffing implications arising from this report.

Approved by

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer IJB		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer IJB		

Scottish Borders
Health and Social Care
PARTNERSHIP

ANNUAL ACCOUNTS 2015/16

For the period 6 February 2016 to 31 March 2016

(Audited)

Management Commentary

Purpose

The purpose of the Management Commentary is to inform all users of the accounts and help them assess how the Integration Joint Board (IJB) has performed in fulfilling its duties.

Strategic Plan

The Scottish Borders Integration Joint Board (the Board) of Scottish Borders Health and Social Care Partnership (the Partnership) was established as a body corporate by Scottish Ministers on 6 February 2016. The Partnership has prepared a Strategic Plan for 2016 – 2019 which sets out what we want to achieve to improve health and well-being in the Borders through integrating health and social care services.

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

The partnership's Strategic Plan describes some of the actions we will take to start to make the shift towards more community-based health and social care services, the outcomes we will seek to achieve and the steps we will take to deliver our local objectives. In addition, we describe some of the performance measures we will use to assess the progress we are making.

Our 9 Local Objectives are:

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

Key Priorities

The Partnership has set itself the following key priorities for its first year of operation following its establishment on the 06 February 2016:

- To develop integrated accessible transport.
- To integrate services at a local level.
- To roll out care coordination to provide a single point of access to local services.
- To improve communication and accessible information across groups with differing needs.
- Work with communities to develop local solutions.

- Provide additional training and support for staff and for people living with dementia.
- Further develop our understanding of housing needs for people across the Borders.
- To promote healthy living and active ageing.
- To improve the transition process for young people with disabilities moving into adult disability services.
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the Third Sector.
- To improve support for Carers within our communities.
- Promote support for independence and reablement so that all adults can live as independent lives as possible.

Locality Planning

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

Financial Performance

The Scottish Borders Health and Social Care Partnership operated only as a shadow board during 2015/16, with budgets and functions being aligned only and not delegated until 01 April 2016. These accounts relate therefore only to the operating costs of the Board from its establishment date of 6 February 2016 to 31 March 2016. During this period, the Board received income of £19,000 and incurred expenditure of £19,000. The Board had no reserves at either its establishment date or at 31 March 2016.

Financial Risks

Management of risk and in particular, Financial Risk is one of the key responsibilities of the Board. Work continues currently to develop both Strategic and Operational Risk Registers for the Partnership and in relation to Financial Risk in particular, the following key areas of risk and uncertainty have been identified:

- Real-term funding reductions
- Insufficient transformation funding
- Slippage in the ambitious programme to transform to new models of care
- Further political policy initiatives and funding conditions
- The delivery of challenging efficiency and savings programmes
- Future demographic (demand) pressures
- Increasing market / provider costs of health and social care services
- Market / provider failure
- Price volatility, in particular increased Drugs costs
- Failure of financial planning, management and governance
- Other emerging pressures

Annual Accounts

The Integration Joint Board is required to prepare Annual Accounts by the Local Authority Accounts (Scotland) Regulations 2014, which section 12 of the Local Government in Scotland Act 2003 requires to be prepared in accordance with proper accounting practices. These practices primarily comprise the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the Code) and the Service Reporting Code of Practice 2015/16 (SeRCOP), supported by International Financial Reporting Standards (IFRS) and statutory guidance issued under section 12 of the 2003 Act.

Councillor Catriona Bhatia
Chair

Susan Manion
Chief Officer

Paul McMenamin
Interim Chief Financial Officer

On behalf of the Councillors and Officers of Scottish Borders Health and Social Care Partnership

30 September 2016

Remuneration Report

Introduction

The remuneration report has been prepared in accordance with the Local Authority Accounts (Scotland) Regulations 2014. These Regulations require various disclosures about the remuneration and pension benefits of senior employees in respect of earnings etc. paid by the Board. The Board does not make payment to any member of the Board, by way of salary, enhanced pension benefits or reimbursement of expenses.

The Chief Finance Officer and Secretary to the Integration Joint Board do not receive remuneration from the IJB. The duties of these posts are covered by each post holder's substantive posts in Scottish Borders Council and NHS Borders respectively.

Remuneration

The term remuneration means gross salary, fees and bonuses, allowances and expenses, and compensation for loss of employment. It excludes pension contributions paid by the Employer. Pension contributions made to a person's pension are disclosed as part of the pension benefits disclosure below.

Remuneration of Senior Employees

The term 'Senior Employee' means:

1. Any employee who has responsibility for the management of the Integration Joint Board to the extent that the person has the power to direct or control the major activities of the Board (including activities involving the expenditure of money), during the year to which the Report relates, whether solely or collectively with other persons;
2. Who holds a post that is politically restricted by reason of section 2(1) (a), (b) or (c) of Local Government and Housing Act 1989 (4); or
3. Whose annual remuneration, including any remuneration from a local authority subsidiary body, is £150,000 or more.

Susan Manion, IJB Chief Officer is the only employee of the Board remunerated during the period. No Board employee received more than £50,000 remuneration during the period. The Chief Officer of the Board holds an employment contract with NHS Borders on NHS pay terms and conditions.

The annual remuneration of all employees of the Board is set by reference to national arrangements agreed by the Scottish Government under Ministerial Direction and in accordance with relevant NHS Pay and Conditions of Service Circulars.

Officers receive reimbursement for business mileage and subsistence allowances in accordance with nationally agreed rates which form part of the employee's contractual terms and conditions of employment. The table below details the reimbursement payment of business mileage and subsistence allowances received by the Chief Officer.

Salaries, Fees and Allowances relating to the Chief Officer for the period amounted to **£15,866.**

	Salaries, Fees and Allowances for Period to 31 March 2016 £	Total Remuneration £
Chief Officer (Full Year Equivalent = £102,749)	15,160	15,160
Other Employee Expenses	706	706
Totals	**15,866**	**15,866**

*Based on 54/366ths of £102,749 pro-rata of total annual costs representing period from 06 February to 31 March 2016

During the period, there was no payment of bonuses, taxable expenses, compensation for loss of employment or non-cash benefits. No exit packages were agreed by the Board during this period.

NHS Pension Scheme

All employees working for the Board are eligible to become members of the National Health Service Superannuation Scheme for Scotland or the Scottish Borders Local Government Pension Scheme.

The Chief Officer of the Board holds an employment contract with NHS Borders on NHS pay terms and conditions of employment and is a member of the NHS Pension Scheme. Details of the NHS Scheme are provided below. Full information on the NHS Pension Scheme can be sourced from the Scottish Public Pensions Agency website via the following link: http://www.sppa.gov.uk

The NHS Board participates in the National Health Service Superannuation Scheme for Scotland. The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations.

The National Health Service Superannuation Scheme for Scotland is a multi-employer scheme where the share of the assets and liabilities applicable to each employer is not identified. The NHS Board will therefore account for its pension costs on a defined contribution basis as permitted by IAS 19. NHS Borders has no liability for other employers' obligations to the multi-employer scheme.

The most recent actuarial valuation at 31 March 2014 discloses a liability of £39.5 billion (March 2013: £29.1 billion) with £1.4 billion to be met by employing authorities. Consequently the employer's rate of contribution increased from 13.5% to 14.9% on 1 April 2015.

Changes to the scheme were implemented from 01 April 2008 and again from 01 April 2015.

The new NHS Pension Scheme (Scotland) 2015: From 01 April 2015 the NHS Pension Scheme (Scotland) 2015 was introduced. This scheme is a Career Average Re-valued Earnings (CARE) scheme. Members will accrue 1/54th of their pay as pension for each year they are a member of the scheme. The accrued pension is re-valued each year at an above inflation rate to maintain its buying power. This is currently 1.5% above increases to the Consumer Prices Index (CPI). This continues until the member leaves the scheme or retires. In 2015/16 members paid tiered contribution rates ranging from 5.2% to 14.7% of pensionable earnings. The retirement age for members of the CARE scheme is the Employee's State Pension age. Members can access their accrued pension benefits earlier than their retirement age however an actuarial reduction is applied to the sum received. All members, unless covered by full or partial transitional protection arrangements, automatically became members of the NHS 2015 scheme on 01 April 2015.

Previous NHS Superannuation Schemes (Scotland):

Details of the two NHS Superannuation Schemes previously available to NHS employees are noted below.

The 1995 Section: Benefits are calculated on a 'final salary' basis at a normal retirement age of 60. Annual benefits are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. Members pay contributions on a tiered basis, dependent on earnings, of between 5.2% and 14.7% of pensionable earnings. Pensions are increased in line with the Consumer Price Index.

The 2008 Section: Benefits are calculated on a "final salary" basis at a normal retirement age of 65. Pension will have an accrual rate of 1/60th and be calculated on the basis of the average of the best consecutive three years pensionable pay in the ten years before retirement. There is an option to exchange part of Pension benefits for a cash lump sum at retirement, up to 25% of overall Pension Value. Members pay tiered contribution rates ranging from 5.2% to 14.7% of pensionable earnings.

Both the 1995 & 2008 schemes closed to new members on 31 March 2015. Accrued benefits in either NHS 1995 or NHS 2008 schemes are protected and will be paid at the section's normal pension age based on final pensionable pay when members leave or retire.

Pension Benefits of Senior Employees

	In-Year Pension Contributions for Period to 31 March 2016* £	Accrued Annual Pension Benefits as at 31 March 2016^ £	Accrued Pension Lump Sum as at 31 March 2016^ £
Chief Officer	1,499	10,640	27,475
Totals			

*Contributions during period 06 February to 31 March 2016 based on 54/366^{ths} of total annual contributions (£10,162.99)

^Total pension benefits / lump sum accrued as at 31 March 2016 in both '1995' and '2008' schemes (NB: '2008' scheme no lump sum entitlement – value above relates to '1995' scheme only)

Councillor Catriona Bhatia
Chair

Susan Manion
Chief Officer

On behalf of the Councillors and Officers of Scottish Borders Health and Social Care Partnership

30 September 2016

Statement of Responsibilities

Integration Joint Board

The Integration Joint Board has appointed its Chief Officer. It has also appointed its Chief Financial Officer on an interim secondment basis.

The Integration Joint Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that one of its officers has the responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this Joint Board, that officer is the Chief Financial Officer;
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003; and
- Approve the Annual Accounts for signature.

I confirm that these Annual Accounts were approved for signature by the Integration Joint Board at its meeting on 30 September 2016.

Signed on behalf of Scottish Borders Health and Social Care Partnership

Councillor Catriona Bhatia
Chair

Chief Officer

The Integration Joint Board has appointed a Chief Officer in accordance with section 10 of the Act.

The Chief Officer is accountable directly to the Integration Joint Board for the preparation, implementation and reporting on the Strategic Commissioning Plan, including overseeing the operational delivery of delegated services.

The Chief Officer is a member of the Parties' relevant Executive / Corporate Management teams and is accountable to and managed by the Chief Executives of both Parties.

The Chief Officer is seconded to the Integration Joint Board from NHS Borders.

Chief Financial Officer

The Chief Financial Officer is and will be seconded at no cost to the IJB from one or other partner organisation. Currently, this post is filled on an interim basis.

The Chief Finance Officer is responsible for the preparation of the Board's Annual Accounts in accordance with the proper practices as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Code).

In preparing the Annual Accounts, the Chief Finance Officer has:

- selected suitable accounting policies and then applied them consistently;
- made judgements and estimates that were reasonable and prudent;
- complied with legislation; and
- complied with the Code (in so far as it is compatible with legislation).

The Chief Finance Officer has also:

- kept adequate accounting records which were up to date; and
- taken reasonable steps for the prevention and detection of fraud and other irregularities.

I certify that the financial statements give a true and fair view of the financial position of Scottish Borders Integration Joint Board at the reporting date and the transactions of the Joint Board for the year ended 31 March 2016.

P. McMenamin

Paul McMenamin, BA CPFA
Interim Chief Financial Officer

Annual Governance Statement

The Scottish Borders Health & Social Care Integration Scheme was submitted to Scottish Ministers on 17 December 2015 and received Cabinet Secretary approval on 18 December 2015.

An Order to establish the Integration Joint Board was laid in the Scottish Parliament on Friday 8 January 2016 for 28 days. From Saturday 06 February 2016 the Scottish Borders Health & Social Care Integration Joint Board was legally established.

The Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively.

Chief Officer

In discharging the responsibilities of the IJB on its behalf, the Chief Officer has a reliance on the NHS and Local Authority's systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the IJB. Additionally, the IJB has through a range of instruments, put in place a system of governance over its operations.

The Chief Officer, Susan Manion, was appointed formally by the IJB on 07 March 2016.

Code of Corporate Governance

As part of the programme of preparing for the integration of health and social care, a Code of Corporate Governance was developed by the Legal and Governance work-stream.

The Partnership's Code of Corporate Governance was approved by the IJB at its meeting of 7 March 2016. The roles and responsibilities of Board members and officers are defined within a comprehensive suite of governance documents relating to the arrangements within which the partnership will operate which specifically covers:

- Scheme of Integration
- Key Principles of the Local Code of Governance
- Standing Orders
- Audit Arrangements including Terms of Reference for the Audit Committee
- Care and Clinical Governance Assurance Framework
- Risk Management Strategy
- Financial Arrangements and Financial Regulations

In addition to its own governance arrangements, the Board places reliance on the governance arrangements adopted by NHS Borders and Scottish Borders Council. Where appropriate existing mechanisms embedded within both NHS Borders and Scottish Borders Council will be used to provide assurance to the Health & Social Care Integration Joint Board to ensure unnecessary double handling of business does not occur.

Integration Joint Board

Services were delegated to the IJB on 01 April 2016. As such, 2015/2016 was a shadow year for the IJB and during this year the governance framework was established. The overarching strategic vision and local objectives of the IJB are detailed in the IJB's Strategic Plan which sets out the key outcomes the IJB is committed to delivering with its partners for the Scottish Borders. The Plan was approved at the meeting of the IJB on the 07 March 2016.

Performance management, monitoring of service delivery and financial governance is provided by the Health and Social Care Partnership to the IJB who are accountable to both the Health Board and the Local Authority. It reviews reports on the effectiveness of the integrated arrangements including the financial management of the integrated budget.

The Strategic Planning Group sets out the IJB's approach to engaging with stakeholders. Consultation on the future vision and activities of the IJB is undertaken with its health service and local authority partners. The IJB publishes information about its performance regularly as part of its public performance reporting.

The IJB's approach to risk management is set out in its risk management strategy, and the Partnership's Strategic and Operational Risk Registers which are in development. Regular reporting on risk management will be undertaken and reported regularly to the Executive Management Team and the IJB.

Audit Arrangements

Prior to the establishment of the IJB, a programme of work was undertaken to evaluate the progress made within the Scottish Borders Health and Social Care Integration (H&SCI) programme in advance of 01 April 2016. This work assessed the position against compliance with the legislative provisions within The Public Bodies (Joint Working) Scotland Act 2014 and the subsequent recommended best practice guidance issued by the Scottish Government / Integrated Resources Advisory Group (IRAG), in terms of the establishment of the arrangements for Financial Governance and Management within NHS Borders, Scottish Borders Council and the Scottish Borders Health and Social Care partnership, specific to the establishment of the Integrated Joint Board (IJB). Following the programme of work, reports were made to the IJB on 07 March 2016, NHS Borders Audit Committee on 01 February 2016 and 04 April 2016 and Scottish Borders Council's Audit Committee on 29 March 2016.

The IJB agreed to establish an Audit Committee as part of the governance arrangements of the Health & Social Care Integration Joint Board on 01 February 2016. On the same date, it approved the Terms of Reference of the IJB Audit Committee. The Audit Committee's core function is to provide the IJB with independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and governance arrangements.

At its meeting of 20 June 2016, the Board agreed the membership of its Audit Committee. At 31 March 2016, the Committee had not yet met.

The Partnership complies with the requirements of the CIPFA Statement on "The Role of the Head of Internal Audit in Public Organisations 2010". The IJB's appointed Chief Internal Auditor has responsibility for the IJB's internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit service operates in accordance with the CIPFA "Public Sector Internal Audit Standards

2013" as confirmed by self-assessment since 2014 and external peer review quality assessment during 2015 which was reported to Audit and Risk Committee and is stated within internal audit plans and reports. The Board appointed Jill Stacey, Chief Officer Audit and Risk, Scottish Borders Council as Chief Internal Auditor for the Integration Joint Board on 01 February 2016.

The Chief Internal Auditor will, from 2016/17, provide an annual report to the Audit Committee and an independent opinion on the adequacy and effectiveness of the governance framework, risk management and internal control.

Chief Financial Officer

The IJB complies with the CIPFA Statement on "The Role of the Chief Financial Officer in Local Government 2010". The IJB's Chief Finance Officer has overall responsibility for the Partnership's financial arrangements and is professionally qualified and suitably experienced to lead the IJB's finance function and to direct finance staff. The Chief Financial Officer was appointed on a 6-month interim basis by the IJB on 07 March 2016.

Responsibility for maintaining and operating an effective system of internal financial control rests with the Chief Finance Officer. The system of internal financial control is based on a framework of regular management information and financial governance arrangements.

On the 30 March 2016, the Chief Financial Officer made a full report to the IJB containing a Statement of Assurance over the sufficiency of resources prior to approval of the partnership's Financial Statement 2016/17. Supplementary reports were also made as part of the due diligence and assurance process to the IJB on 07 March 2016 and 18 April 2016.

Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the risks facing the organisation. The system aims to evaluate the nature and extent of failure to achieve the organisation's policies, aims and objectives and to manage risks efficiently, effectively and economically. As such it can therefore only provide reasonable and not absolute assurance of effectiveness.

Review

The IJB has responsibility for conducting (at least annually) a review of effectiveness of the system of internal control as part of its wider governance arrangements. The partnership's Chief Internal Auditor will facilitate an annual review of its governance arrangements against its Code of Corporate Governance, informed by the work of the Executive Management Team (who have responsibility for the development and maintenance of the internal control framework environment), the work of the internal auditors and the Chief Internal Auditor's annual report, and reports from external auditors and other review agencies and inspectorates.

Councillor Catriona Bhatia
Chair

Susan Manion
Chief Officer

On behalf of the Councillors and Officers of Scottish Borders Health and Social Care Partnership

30 September 2016

Independent Auditor's Report

Independent Auditor's Report to the members of the Scottish Borders Integration Joint Board and the Accounts Commission for Scotland

We certify that we have audited the financial statements of Scottish Borders Health and Social Care Partnership for the period ended 31 March 2016 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise of the Comprehensive Income and Expenditure Statement, Balance Sheet and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the 2015/16 Code).

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 125 of the Code of Audit Practice approved by the Accounts Commission for Scotland, we do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Respective responsibilities of the Chief Finance Officer and auditor

As explained more fully in the Statement of Responsibilities, the Chief Finance Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland) as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances of the body and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Finance Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual accounts 2015/16 to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view in accordance with applicable law and the 2015/16 Code of the state of the affairs of the body as at 31 March 2016 and of the income and expenditure of the body for the then ended;

- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 Code; and

- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Opinion on other prescribed matters

In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014; and

- the information given in the Management Commentary for the financial period for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if, in our opinion:

- adequate accounting records have not been kept; or

- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or

- we have not received all the information and explanations we require for our audit; or

- the Annual Governance Statement has not been prepared in accordance with Delivering Good Governance in Local Government; or

- there has been a failure to achieve a prescribed financial objective.

We have nothing to report in respect of these matters.

Hugh Harvie, for and on behalf of KPMG LLP
20 Castle Terrace
Edinburgh
EH1 2EG
29 September 2016

Statement of Accounts

Comprehensive Income and Expenditure Statement (CIES) for the Period Ended 31 March 2016 (06 February 2016 to 31 March 2016)

	Gross Expenditure 2015/16 £'000	Income 2015/16 £'000	Net Expenditure 2015/16 £'000	Notes Ref.
Corporate Services	20	(20)	0	2, 3
Deficit on Provision of Services	**20**	**(20)**	**0**	
Total Comprehensive Income and Expenditure	**20**	**(20)**	**0**	
Other Notes				1

Balance Sheet at 31 March 2016

	Gross Expenditure 2015/16 £'000	Notes Ref.
Short Term Debtors	4	4
Current Assets	**4**	
Short Term Creditors	(4)	5
Current Liabilities	**(4)**	
Net Assets	**0**	
Useable Reserves	0	
Total Reserves	**0**	
Other Notes		6

P. M. McMenamin

Paul McMenamin BA, CPFA
Interim Chief Financial Officer

30 September 2016

Notes to the Statement of Accounts

1 – Significant Accounting Policies

1.1 General Principles

The Annual Accounts summarise the Board's transactions for the 2015/16 financial year and its position at the year end of 31 March 2016. The Board is required to prepare Annual Accounts by the Local Authority Accounts (Scotland) Regulations 2014, which section 12 of the Local Government in Scotland Act 2003 requires these to be prepared in accordance with proper accounting practices. These practices primarily comprise the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the Code) and the Service Reporting Code of Practice 2015/16 (SeRCOP), supported by International Financial Reporting Standards (IFRS) and statutory guidance issued under section 12 of the 2003 Act. The accounting convention adopted in the Annual Accounts is historical cost.

1.2 Accruals of Income and Expenditure

Activity is accounted for in the year in which it takes place, not simply when cash payments are made or received. In particular:

- expenses in relation to services received (including services provided by employees) are recorded as expenditure when the services are received rather than when payments are made; and
- where revenue and expenditure have been recognised but cash has not been received or paid, a debtor or creditor for the relevant amount is recorded in the Balance Sheet. Where there is evidence that debts are unlikely to be settled, the balance of debtors is written down and a charge made to revenue for the income that might not be collected.

1.3 Events after the Reporting Period / Balance Sheet Date

Events after the Reporting Period / Balance Sheet Date are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the Annual Accounts are authorised for issue. Two types of events can be identified:

- those that provide evidence of conditions that existed at the end of the reporting period – the Annual Accounts are adjusted to reflect such events; and
- those that are indicative of conditions that arose after the reporting period – the Annual Accounts are not adjusted to reflect such events, but where a category of events would have a material effect disclosure is made in the notes of the nature of the events and their estimated financial effect.

Events taking place after the date of authorisation for issue are not reflected in the Annual Accounts. There are no post-balance sheet date events known currently.

1.4 Contingent Liabilities and Contingent Assets

A contingent liability is a possible future financial obligation which is reported as a specific note to the annual accounts because it cannot be judged as probable enough to warrant a provision. Contingent liabilities are not recognised in the Balance Sheet but disclosed in a note to the accounts. Similarly, a contingent asset arises where an event has taken place that gives the Board a possible asset, but where its existence will only be confirmed by the occurrence of uncertain future events over which the Board does not have full control. Again, these are not recognised in the Balance Sheet but disclosed in a note to the accounts, where there is some probability that there will be an inflow of economic benefit.

There are no probable contingent liabilities or assets known at the Balance Sheet date.

1.5 Reserves

The IJB has the authority to maintain a General Fund Reserve. No reserve existed however at the start or end of the accounting period.

Planned underspends going forward will be returned by the Health Board and Local Authority to the IJB and carried forward through the General Fund. This will require adjustments to the allocations from the IJB to these bodies for the sum of the underspend.

In future, when expenditure is to be financed from the reserve, it will be charged to the appropriate service in that year offsetting the surplus/deficit on the Provision of Services in the Comprehensive Income and Expenditure Statement.

1.6 VAT

The IJB is a non-taxable entity and therefore neither charges, nor recovers VAT on its functions.

HMRC has issued an Interim Decision on the VAT treatment of the secondment of the Chief Officer to the IJB which states that *"Secondment of the Chief Officer (CO): under Section 10(1) of the Act requires an IJB to appoint a CO; and section 10(3) can be read as meaning that the relevant authority must second that person (or, under section 10(4), employ and then second that person). Therefore, it is recognised that the requirement on the HB/LA to provide a CO is a statutory requirement, so when fulfilling this the HB/LA would be acting under a Special Legal Regime, and therefore the transaction would be an act as a public body, and in acting as such would make the transaction not taxable, and deemed as outside the scope of VAT."*

There are no known VAT implications over the supply of the Chief Officer to the IJB therefore at the current time.

2 – Related Party Transactions

Income - Payment for Integrated Functions	31 March 2016 £'000
NHS Borders	(10)
Scottish Borders Council	(10)
Total Corporate Expenditure	**(20)**

Expenditure - Payment for Delivery of Integrated Functions	31 March 2016 £'000
NHS Borders	10
Scottish Borders Council	10
Total Corporate Expenditure	**20**

The above values are based on a 50/50 cost-sharing arrangement between NHS Borders and Scottish Borders Council in respect of the operating costs incurred by the IJB during the period.

3 – Corporate Expenditure

	31 March 2016 £'000
Staff Costs	16
Audit Fee	4
Total Corporate Expenditure	**20**

4 – Short-Term Debtors

	31 March 2016 £'000
Central Government Bodies	2
Other Local Authorities	2
Total Corporate Expenditure	**4**

5 – Short-Term Creditors

	31 March 2016 £'000
Central Government Bodies	(2)
Other Local Authorities	(2)
Total Corporate Expenditure	**(4)**

6 – Events After the Reporting Period / Balance Sheet Date

The unaudited accounts were issued on 30 June 2016 by Paul McMenamin, BA, CPFA, Interim Chief Finance Officer, who is the proper officer of the IJB in accordance with Section 95 of the Local Government (Scotland) Act 1973. Where events taking place before the balance sheet date provided information about conditions existing at 31 March 2016, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

There have been no material events since the date of the balance sheet which necessitate the revision of the figures in the financial statements or notes thereto including contingent assets and liabilities.

KPMG

cutting through complexity

Scottish Borders Health and Social Care Integration Joint Board

Annual audit report to the Members of Scottish Borders Council and the Controller of Audit

For the year ended 31 March 2016

Draft: 6 September 2016

DRAFT

Contents

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About this report

This report has been prepared in accordance with the responsibilities set out within the Audit Scotland's *Code of Audit Practice* ("the *Code*").

This report is for the benefit of Scottish Borders Health and Social Care Integration Joint Board ('IJB'') and is made available to Audit Scotland and the Controller of Audit (together "the Beneficiaries"). This report has not been designed to be of benefit to anyone except the Beneficiaries. In preparing this report we have not taken into account the interests, needs or circumstances of anyone apart from the Beneficiaries, even though we may have been aware that others might read this report. We have prepared this report for the benefit of the Beneficiaries alone.

Nothing in this report constitutes an opinion on a valuation or legal advice.

We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in the introduction and responsibilities section of this report.

This report is not suitable to be relied on by any party wishing to acquire rights against KPMG LLP (other than the Beneficiaries) for any purpose or in any context. Any party other than the Beneficiaries that obtains access to this report or a copy (under the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002, through a Beneficiary's Publication Scheme or otherwise) and chooses to rely on this report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG LLP does not assume any responsibility and will not accept any liability in respect of this report to any party other than the Beneficiaries.

Complaints

If at any time you would like to discuss with us how our services can be improved or if you have a complaint about them, you are invited to contact Hugh Harvie who is the engagement leader for our services to Scottish Borders Health and Social Care Integration Joint Board, telephone 0131 527 6682, email: hugh.Harvie@kpmg.co.uk who will try to resolve your complaint. If your problem is not resolved, you should contact Alex Sanderson, our Head of Audit in Scotland, either by writing to him at Saltire Court, 20 Castle Terrace, Edinburgh, EH1 2EG or by telephoning 0131 527 6720 or email to alex.sanderson@kpmg.co.uk. We will investigate any complaint promptly and do what we can to resolve the difficulties. After this, if you are still dissatisfied with how your complaint has been handled you can refer the matter to Russell Frith, Assistant Auditor General, Audit Scotland, 4th Floor, 102 West Port, Edinburgh, EH3 9DN.

Executive summary

Audit conclusions

- We expect to issue an unqualified audit opinion on the financial statements of Scottish Borders Health and Social Care Integration Joint Board ('IJB''), following receipt of management representation letters.

Financial position

- The notional financial resources expended to support the IJB in 2015-16 have been identified and disclosed within the financial statements. However, the IJB was not charged for these services, the costs being borne in their entirety by either Scottish Borders Council or NHS Borders.

Financial statements and related reports

- We have concluded satisfactorily in respect of each significant risk and audit focus area identified. We concur with management's accounting treatment and judgements, including going concern. We have no matters to highlight in respect of: unadjusted audit differences; independence; and changes to management representations.
- Financial statements were of good quality when received; with only a few minor presentational changes required.

Wider scope matters

- We considered the wider scope audit dimensions and concluded positively in respect of financial management, governance and transparency and value for money.
- We also considered financial sustainability and have recommendations in this area.

Audit Conclusions

- The IJB is required to prepare its financial statements in accordance with International Financial Reporting Standards, as interpreted and adapted by the Code. Additional guidance on accounting for the integration of the health and social care has been created by LASAAC. Our audit confirmed that the financial statements have been prepared in accordance with the LASAAC guidance and relevant legislation.
- We did not encounter any significant difficulties during the audit. There were no other significant matters arising from the audit that were discussed, or subject to correspondence with management that have not been included within this report. There are no other matters arising from the audit, that, in our professional judgement, are significant to the oversight of the financial reporting process.

Executive summary
Scope and responsibilities

Purpose of this report

The Accounts Commission has appointed KPMG LLP as auditor of the Scottish Borders Heath and Social Care Integration Joint Board ("the IJB") under the Local Government (Scotland) Act 1973 ("the Act"). This document summarises our opinion and conclusions on significant issues arising from our audit.

Audit Scotland's Code of Audit Practice ("the Code") sets out the wider dimensions of public sector audit which involves not only the audit of the financial statements, but also consideration of areas such as financial management and sustainability, governance and transparency and value for money.

Auditor and audited bodies' responsibilities

The Code sets out the responsibilities in respect of:

- the financial statements;
- corporate governance and systems of internal control;
- prevention and detection of fraud and irregularities;
- standards of conduct and arrangements for the prevention and detection of bribery and corruption;
- arrangements for preparing and publishing statutory performance information;
- financial position; and
- Best Value, uses of resources and performance.

Scope

An audit of the financial statements is not designed to identify all matters that may be relevant to those charged with governance. Management of the audited body is responsible for preparing financial statements that show a true and fair view and for implementing appropriate internal control systems.

Weaknesses or risks identified are only those which have come to our attention during our normal audit work in accordance with the Code, and may not be all that exist.

Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.

Under the requirements of International Standard on Auditing (UK and Ireland) ('ISA') 260 *Communication with those charged with governance*, we are required to communicate audit matters arising from the audit of financial statements to those charged with governance of an entity. This annual audit report to the Board discharges the requirements of ISA 260.

Financial position

Overview

An order to establish the Integration Joint Board was laid in the Scottish Parliament on Friday 8 January 2016 for 28 days. On 6 February 2016 the Scottish Borders Health & Social Care Integration Joint Board was legally established.

Whilst the Scottish Borders Health and Social Care Partnership operated only as a shadow board during 2015-16, with budgets and functions being aligned only and not delegated until 1st April 2016, the IJB was required to prepare financial statements for 2015-16, following the 2015-16 Code. Guidance was issued by The Local Authority (Scotland) Accounts Advisory Committee ("LASAAC") in September 2015 on the expected content of the IJB accounts. The LASAAC guidance states that IJBs should comply with the Local Authority Accounts (Scotland) Regulations 2014, which includes the preparation of a remuneration report. The IJB appointed a Chief Officer and, on an interim basis, a Chief Finance Officer.

Financial position

CIES	£000
Income	19
Expenditure	(19)
Net expenditure	-
Balance Sheet	**£000**
Current assets	4
Current liabilities	(4)
Net assets	-

The IJB accounts relate only to the operating costs of the Board from its establishment date of 6 February 2016 to 31 March 2016. During this period, the Board received income of £19,000 and incurred expenditure of £19,000. The Board had no reserves at either its establishment date or at 31 March 2016.

The IJB received contributions from Scottish Borders Council and NHS Borders as income.

The remuneration report is appropriately produced to include the Chief Officer as this position is deemed to be a 'relevant position'. Per LASAAC guidance the Chief Officer costs should be allocated to the IJB from its establishment date.

The balance sheet consists of Scottish Borders Council and NHS Borders debtor and creditor amounts.

Significant risks

SECTION 3

Significant risks and audit focus areas

International Standard on Auditing (UK and Ireland) 315 (ISA): *Identifying and assessing risks of material misstatement through understanding the entity and its environment* requires the auditor to determine whether any of the risks identified as part of risk assessment are significant risks and therefore requiring specific audit consideration. Professional standards require us to make a rebuttable presumption that the fraud risk from income recognition is a significant risk. As the IJB did not direct services during 2015-16, it did not receive income for operations and therefore we do not consider the fraud risk from revenue recognition to be significant.

We summarise below the risks of material misstatement. We set out the key audit procedures to address those risks and our findings from those procedures on the following pages, in order that the IJB may better understand the process by which we arrived at our audit opinion.

SIGNIFICANT RISK	OUR RESPONSE	AUDIT CONCLUSION
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as a significant risk; as management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	We have no changes to the risk or our approach to addressing the assumed ISA risk of fraud in management override of controls. We do not have findings to bring to your attention in relation to these matters. No control overrides were identified.
FOCUS AREA	**OUR RESPONSE**	**AUDIT CONCLUSION**
First year financial statements preparation	■ As 2015-16 is the first period of the preparation of the IJB's financial statements we reviewed the disclosures in the financial statements against the 2015-16 Code, the Local Authority Accounts (Scotland) Regulations 2014 and LASAAC guidance. ■ The remuneration report was reviewed to check the officers disclosed are appropriate and that the amounts are accurate by agreeing to supporting documentation.	The accounts have been prepared in accordance with the relevant legislation and guidance. Only the Chief Officer's remuneration has been disclosed as the IJB had no other employees.

Wider scope
Audit dimensions introduction

We summarise below the work we have undertaken in the year to obtain assurances over the arrangements in place for each audit dimension and our conclusions on the effectiveness and appropriateness of these arrangements.

Financial sustainability

In considering financial sustainability of the IJB we performed the following work:

- *review of the financial position of the IJB as at 31 March 2016 and future budgets and forecasts;*
- *review of Health and Social Care Partnership financial statement 2016-17 and Assurance over the Sufficiency of Resources*; and
- *review of Due Diligence 2016-17 outturn analysis.*

Management continue to work closely with the two funding providers and Scottish Government to anticipate the impact of future local government budget allocations. We consider that the IJB is financially sustainable and a going concern.

Financial management

Our conclusion below is derived from the following audit tests, carried out to determine the effectiveness of the financial management arrangements. This included:

- *review of Financial Statement 2016-17 – Overview of Due Diligence Process;*
- *review of the financial regulations for the SBC Joint Integration Board; and*
- *consideration of the finance function and financial capacity within the IJB.*

The chief financial officer was appointed on an interim basis for six months on 7 March 2016. We noted that the chief financial officer has the appropriate skills, capacity and experience to support the IJB and effectively manage the organisation.

Best Value

Governance and transparency

In considering governance and transparency we performed the following work:

- *review of the the annual governance statement within 2015-16 accounts; and*
- *review of the Health and Social Care IJB code of corporate governance*

The IJB agreed to establish an audit committee in February 2016 and agreed the membership of the committee in June 2016. The chief internal auditor was appointed in February 2016 and will provide an independent opinion on the adequacy and effectiveness of the governance framework from 2016-17.

We consider the governance framework to be appropriate for the IJB.

Value for money

We consider value for money and Best Value throughout our testing. Areas where we had a specific focus on value for money and Best Value are:

- *reviewing the expenditure of the IJB to ensure it was only concerned with the running costs of the IJB. This identified that all expenditure was in relation to running costs; and*
- *reviewing the 2016-17 financial statements and assurance over the sufficiency of resources; ensuring the focus is delivering quality service to meet increasing demand with a clear focus on value for money.*

The IJB have evidenced using their resources for the purposes of initial set up and running costs of the IJB.

Financial sustainability

Financial sustainability looks forward to the medium and longer term to consider whether the body is planning effectively to continue to deliver its services or the way in which they should be delivered.

Our conclusion below is derived from the following audit tests, carried to determine the effectiveness of the financial sustainability arrangements.

Review of Health and Social Care Partnership financial statement 2016-17 and Assurance over the Sufficiency of Resources:

- *The report sets out the financial statement of Scottish Borders IJB for 2016-17 to 2018-19. For the year 2016-17 and 2017-18, the total integrated budget is expected to be £157.2 million in both years, it is then forecast to increase to £158.3 million in 2018-19. It should be noted that for 2017-18 and 2018-19 the budget is indicative as both NHS Borders and Scottish Borders Council's funding settlements with the Scottish Government are for 2016/17 only and will be subject to change in absolute terms for future financial years.*
- *There are considerable efficiencies and savings assumptions requiring delivery within both NHS Borders and Scottish Borders Council's respective financial plans for 2016-17, on which the proposed levels of delegated and notional resources are based. Whilst the majority of these savings have been identified and plans have been or are in the process of being developed, the majority remain high risk and, in particular, there remains £0.793 million requiring further efficiencies or service change plans to be identified.*
- *To provide the IJB with assurance over the sufficiency of the resources, scrutiny has been undertaken as part of due diligence and risk assessment.*
- *There are a number of areas of emerging or unknown financial pressures that may impact the IJB during or beyond 2016-17 for which no budget provision has been made. The IJB will work with its partners to address any pressures which may emerge in order to identify appropriate remedial action through the development of appropriate solutions, including the use of additional Social Care funding, further targeted savings on service delivery and the issuing of supplementary directions over functions to be provided and the resources accompany them.*

Recommendations

1	*The IJB should agree funding levels for 2017-18 and 2018-19 as soon as possible from both partners to allow for budget setting and planning.*
2	*Plans should be put in place as a matter of urgency for efficiency savings.*
3	*Budget provision should be put in place for areas of emerging financial pressures. A risk register should be maintained and regularly updated as financial risks emerge. The budget should also be updated regularly to reflect these risks so that financial plans can be amended accordingly.*

Conclusion: Management continues to work closely with the two partners and the Scottish Government to anticipate the impact of future local government budget and NHS allocations. We consider that the IJB is a going concern, however there are risks around the uncertainty of future funding.

Wider scope
Audit dimensions (continued)

Financial management

Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.

Our conclusion below is derived from the following audit tests, carried out to determine the effectiveness of the financial management arrangements. This included:

- *review of Financial Statement 2016-17 – Overview of Due Diligence Process;*
- *review of the financial regulations for the SBC Joint Integration Board; and*
- *consideration of the finance function and financial capacity within the IJB.*

The chief financial officer was appointed on an interim basis for six months on 7 March 2016. We noted that the chief financial officer has the appropriate skills, capacity and experience to support the IJB and effectively manage the organisation.

Conclusion:

The IJB has appropriate financial capacity for current operations. This is supported by financial directions and scrutiny by senior management and IJB members.

Wider scope
Audit dimensions (continued)

Governance and transparency

Governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision making, and transparent reporting of financial and performance information.

In considering governance and transparency we performed the following work:

- *review of the annual governance statement within 2015-16 accounts; and*
- *review of the Health and Social Care IJB code of corporate governance.*

The IJB agreed to establish an audit committee in February 2016 and agreed the membership of the committee in June 2016. The chief internal auditor was appointed in February 2016.

Conclusion:

We consider the governance framework to be appropriate for IJB. Transparency was achieved through the online publication of IJB papers and minutes.

Value for money

Value for money is concerned with using resources effectively and continually improving services.

We consider value for money and Best Value throughout our testing. Areas where we had a specific focus on value for money and Best Value are:

- *reviewing amounts disclosed in the of the IJB's financial statements to ensure they are in relation to the IJB.* This identified that all expenditure was in relation to running costs, after removing the Chief Officer's remuneration prior to the establishment date*;* and
- *reviewing the 2016-17 financial statements and assurance over the sufficiency of resources; ensuring the focus is delivering quality service to meet increasing demand with a clear focus on value for money.*

Conclusion:

The IJB has evidenced using its resources for the purposes of initial set up and running costs of the IJB. One adjustment was made to the financial statements to correctly reflect the remuneration of the Chief Officer.

Appendices

Appendix one
Auditor independence

APPENDIX 1

To the Integration Joint Board members

Assessment of our objectivity and independence as auditor of Scottish Borders Integration Joint Board (the IJB)

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the APB Ethical Standards. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity.

Independence and objectivity considerations relating to the provision of non-audit services

We have considered the fees charged by us to the IJB for professional services provided by us during the reporting period.

The audit fee charged by us for the period ended 31 March 2016 was £4,000. No other fees were charged in the period. No non-audit services were provided to the IJB and no future services have been contracted or had a written proposal submitted.

Independence and objectivity considerations relating to other matters

There are no other matters that, in our professional judgment, bear on our independence which need to be disclosed to the IJB.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the IJB and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP

Appendix two
Audit findings

APPENDIX 2

Adjusted and unadjusted audit differences

We are required by ISA (UK and Ireland) 260 to communicate all corrected and uncorrected misstatements, other than those which are trivial, to you. There were no audit adjustments required to the draft annual accounts.

A small number of minor presentational adjustments were required to some of the financial statement notes.

Appendix three
Appointed auditors responsibilities

APPENDIX 3

Area	Appointed auditors responsibilities	How we've met our responsibilities
Corporate governance	Review and come to a conclusion on the effectiveness and appropriateness of arrangements to ensure the proper conduct of the bodies affairs including legality of activities and transactions. Conclude on whether the monitoring arrangements are operate and operating in line with recommended best practice.	Page 9 sets out our conclusion on these arrangements.
Financial statements and related reports	Provide an opinion on audited bodies' financial statements on whether financial statements give a true and fair view of the financial position of audited bodies and their expenditure and income. Provide an opinion on whether financial statements have been properly prepared in accordance with relevant legislation, the applicable accounting framework and other reporting requirements.	Page 2 summarises the opinion we expect to provide.
Financial statements and related reports	Review and report on, as appropriate, other information such as annual governance statements, management commentaries and remuneration reports.	Page 2 reports on the other information contained in the financial statements, covering the annual governance statement, management commentary and remuneration report.
Financial statements and related reports	Notify the Auditor General or Controller of Audit when circumstances indicate that a statutory report may be required.	No notifications to Controller of Audit required.
Financial statements and related reports	Review and conclude on the effectiveness and appropriateness of arrangements and systems of internal control, including risk management, internal audit, financial, operational and compliance controls.	Pages 2 and 9 set out our conclusion on these arrangements.
WGA returns and grant claims	Examine and report on WGA returns. Examine and report on approved grant claims and other returns submitted by local authorities.	The IJB is below the threshold for the completion of audit work on the WGA return. We have not reported on any grant claims.

Appendix three
Appointed auditors responsibilities (continued)

APPENDIX 3

Area	Appointed auditors responsibilities	How we've met our responsibilities
Standards of conduct – prevention and detection of fraud and error	Review and conclude on the effectiveness and appropriateness of arrangements for the prevention and detection of fraud and irregularities, bribery and corruption and arrangements to ensure the bodies affairs are managed in accordance with proper standards of conduct. Review National Fraud Initiative participation and conclude on the effectiveness of bodies engagement.	Page 9 sets out our conclusion on these arrangements. Participation in the National Fraud Initiative is not relevant for the IJB in 2015-16.
Financial position	Review and conclude on the effectiveness and appropriateness of arrangements to ensure that the bodies financial position is soundly based.	Pages 4 and 7 set out our conclusions on these arrangements.
Financial position	Review performance against targets.	This is not applicable as no targets have been set in the IJB's first year.
Financial position	Review and conclude on financial position including reserves balances and strategies and longer term financial sustainability.	Pages 4 and 7 set out our conclusion on the IJB's financial position and longer term financial sustainability.
Best Value	Be satisfied that proper arrangements have been made for securing Best Value and complied with responsibilities relating to community planning.	Page 6 sets out our conclusion on these arrangements.
Performance information	Review and conclude on the effectiveness and appropriateness of arrangements to prepare and publish performance information in accordance with Accounts Commission directions.	The Annual Performance Report for 2015-16 has not yet been published.

KPMG

cutting through complexity

The contacts at KPMG in connection with this report are:

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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 Murray Leys has been appointed to a permanent post as Chief Officer Adult Social Work with the responsibility for the commissioning and delivery of adult social work services.

3.2 Attended a meeting of the Executive group of the Chief Officers network which included a discussion on social care funding and its implementation across Scotland, the draft review of Strategic Plans and the learning and development support available to the Chief Officers group.

3.3 The Scottish Borders submission to the Health and Sport Committee was submitted and published. It was a survey seeking detail on information relating to budget setting, delayed discharges and the social and community care workforce. We were written to by the Chair of the Committee and thanked for our contribution. A small number of IJBs have been invited as a witness to discuss their submission, including the Scottish Borders. The IJB Chair has agreed to attend as a witness on Tuesday 4th October.

3.4 In August Professor John Bolton led a session with key managers highlighting innovative work across the country to address the issue of delayed discharges and whole system working. Key elements will be included in the local action plan.

Recommendation

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

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

Approved by

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

Author(s)

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

COMMITTEE MINUTES

Aim

To raise awareness of the Health & Social Care Integration Joint Board on the range of matters being discussed by the Strategic Planning Group.

Background

The Health & Social Care Integration Joint Board will receive various approved minutes as appropriate.

Summary

Committee minutes attached are:-

- Strategic Planning Group: 18.05.16

Recommendation

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

Policy/Strategy Implications	As detailed within the individual minutes.
Consultation	Not applicable
Risk Assessment	As detailed within the individual minutes.
Compliance with requirements on Equality and Diversity	As detailed within the individual minutes.
Resource/Staffing Implications	As detailed within the individual minutes.

Approved by

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

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

Page 1 of 1

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Scottish Borders
Health and Social Care
PARTNERSHIP

Meeting of the Strategic Planning Group
1.30pm to 3.00pm on 18 May 2016
Committee Room 2, Scottish Borders Council Headquarters

Minute

Present: Margaret McGowan, David Bell, Peter Symms, Tim Young, Jenny Miller, Karen McNicoll, Linda Jackson, Gerry Begg, Gwyneth Johnston

In Attendance: Eric Baijal (Chair), Carin Pettersson, Clare Malster, Paul McMenamin, Trish Wintrup, Shona Donaldson, Stewart Barrie, Clare Richards, Julie Watson, Suzanne Hislop (Minutes)

1.	**Welcome** • Introductions were made and the Chair welcomed Julie Watson (Organisational Design & Change Business Partner) who was attending the Strategic Planning Group for the first time.	
2.	**Apologies**: Susan Manion, Elaine Torrance, Morag Walker, Amanda Miller, Shirley Burrell, Alasdair Pattinson, Steph Errington, Julie Kidd, Sandra Campbell, Tim Patterson, Cathie Fancy, Jane Robertson	
3.	**Minutes of the previous meeting** • The minutes of the previous meeting of 19 April were accepted as a true record. • The group went through the actions arising from the last minute and updated the action tracker.	
4.	**Matters Arising** • None noted.	
5.	**Performance Monitoring** • The Chair gave a presentation on annual performance reporting requirements that outlined the issues around performance monitoring for the Integration Joint Board (IJB). It is a legal requirement to publish annual performance monitoring report from 2016/17 onwards. The deadline is 31 July 2017 and preparation needs to begin now with a collaborative approach across the Partnership required. Quarterly performance monitoring reports are to be provided to the IJB. • The Commissioning & Implementation Plan will be required to be	

	reviewed every three years. • There are several bodies that will be auditing and reviewing performance and there are currently 19 pieces of guidance in relation to Health & Social Care. EB to circulate a link to these documents. • The importance of communicating with those involved with providing services and ensuring that they are kept informed regarding decisions was raised. This will allow staff to assess, for example, if they will be required to work in a different way or develop new skills. • The issue of Co-production and how this is assessed was raised. An approach to Co-production is being discussed at the Community Planning Joint Delivery Team meeting today and a copy of this document is to be circulated. • Presentation to be circulated.	**ACTION EB** **ACTION CM** **ACTION SH**
6.	**Integrated Care Fund – Scottish Government Submission** • The Integrated Care Fund (ICF) End of Year Submission to the Scottish Government was presented to the group. As an advisory group to the IJB, it is important that the SPG are aware of the report. • This has been to the Strategic Planning Board and minor amendments made in light of feedback received. • It was noted that some missing information had been recently supplied and an updated version of the document is available. • It was agreed that this was a useful paper and the dashboard included at the beginning for ease of reference was helpful.	
7.	**Terms of Reference** • The revised Terms of Reference were discussed. Some amendments were suggested including: o Cathie Fancy (Group Manager for Housing Strategy & Services) to be added to list of those 'in attendance'. o Order of columns in membership table to be changed to show prescribed group followed by role and name. o ACF Committee member to be added as Karen McNicoll's deputy. • It was agreed by the group to approve the Terms of Reference with the addition of the aforementioned amendments.	**ACTION SH**
8.	**Provision for Patients/Clients with Sensory Impairment** • The paper produced by PS was discussed. • The Chair emphasised that this was an issue of importance to the IJB/Partnership. • GJ is keen to involve PS in discussions around the issues to be addressed in the future planning of Sensory Services. The 'See Hear Strategy' is looking at integrated working and pathways. This is a complex piece of work that is currently focused on training, but is due to be expanded. Currently centralised sensory services approach with small numbers of people working in this area. Is going to be a challenge as to how these services are delivered locally. Will be important to engage with the Third/Voluntary Sector to capture the changes taking place in provision within these sectors. • Was agreed that it may be appropriate to present an item on the 'See Hear Strategy' to both the Strategic Planning Board (SPB) and the SPG later in the year when work has progressed. • It was suggested that it was important to focus equally on mainstream transformation and smaller group and ensure people have confidence in us to consider all groups and demonstrate that we are tackling inequality and exclusion.	

9.	**AOB** • A mock-up of the GP communication that CP and Annabel Howell (Associate Medical Director PACS and Palliative Care, NHS Borders) have been working on was presented to the group. It was emphasised that the images used are not final and the focus should be on the content. • The Strategy for Engagement and Communication was also tabled. The group were asked to feedback any comments on the Strategy by end of play on Monday. • The following suggestion were made: o Inclusion of heading titled 'Integration at a glance' o One side format in place of a pamphlet. o 3rd Sector to be replaced by Third Sector in the table. • It was suggested that this communication could go to all staff rather than only GPs. Communications Workstream to take up the issue of a general communication. Though to also be given to a separate communication for clinical staff working in acute settings. • The work of Alan Bonfield (Visual Impairment Officer) in reviewing communications was highlighted by GJ.	**ACTION ALL** **ACTION CP** **ACTION CP/CM**
10.	**Date and time of next meeting:** **The date of the next meeting was given as 11 July 2016 from 2.00pm to 3.30pm in Committee Room 2.**	

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INTEGRATED WINTER PLAN 2016/17

Aim

1.1 To present the Integrated Winter Plan 2016/17 to the Integrated Joint Board.

Background

2.1 Health and Social Care Services are required on an annual basis to produce a Winter Plan which outlines potential risks and contingency planning relevant to the winter season, with a particular focus on the festive period.

2.2 The Scottish Government has issued detailed guidance to the NHS, Local Authorities and Integrated Joint Boards on what should be included in their winter plans. The Health Board has responsibility to submit final plans by 31st October.

2.3 This year, the expectation is that the Winter Plan is developed as an integrated plan across health and social care services and that approval is through local governance structures that ensure sign-off from all parties.

2.3 The Winter Plan is an overarching plan which includes other relevant plans, which may be required over the winter period, for example severe weather plans, pandemic influenza plans and infection control policies and protocol, and encompasses service development work on integration, improving delayed discharges, 6 Essential Actions for Unscheduled Care and Transforming Urgent Care. The plan spans all health servceis, including mental health, primary and community services and child health, as well as hospital and social care services.

2.4 The overall aim of the planning process is to ensure that the Health Board and Local Authority prepares for winter pressures so as to be able to respond and deliver effectively to continue to deliver high quality care, as well as national and local standards.

Summary

3.1 This year's draft winter plan has been developed following detailed analysis of the activity and demand data for the last 3 years. This analysis indicates that the most challenging period is between December and March. There is very little variation in numbers presenting with minor injuries and illnesses and in overall admissions to the BGH or community hospitals. The length of time that patients were delayed in their discharge from hospital was a significant pressure in the last 2 years. The greatest areas of activity increase are in the management of older people with acute illnesses.

3.2 As in previous years, the Winter Plan has been developed around existing actions that are known to have been effective and planned activities that can realistically be expected to deliver changes before the commencement of the winter period.

3.3 In 2015/16, service planning was generally effective in managing increases in demand over the winter period. There were a number of areas where arrangements

were highly effective, including the planning around management of activity within the primary care out-of-hours service and the Emergency Department.

3.4 There were a number of areas where the measures within the winter plan were not delivered as intended. The rate of morning and weekend discharges did not improve; community hospital length of stay did not reduce, and delayed discharge occupied beddays increased compared to the previous year. Focused action to address these areas in time for this winter are in progress.

3.5 The main areas of development within this year's Winter Plan, compared to previous years are in

3.5.1 Additional work to reduce admissions to hospital through the more effective use of anticipatory care planning

3.5.2 The remodelling of the medical and surgical inpatient areas in the BGH in order to reduce delays in patients moving to the appropriate ward environment and to create a dedicated elective admission area for people receiving planned surgical procedures. These actions are expected to reduce length of stay within the BGH and avoid cancellations of procedures due to demand for unscheduled inpatient capacity

3.5.3 The development of services to enable patients to be discharged from hospital when clinically fit, and to ensure people are supported to return to their home environment. These include the establishment of a transitional care facility to allow people to receive ongoing reablement, assessment and care outwith the acute hospital prior to returning home; and a matching unit for homecare to ensure rapid and more effective allocation of homecare hours

3.5.4 An increased focus on the individual management of patients who are delayed or who have been in hospital for prolonged periods.

3.6 Based on this work, it is anticipated that there will be a requirement for a reduced number of surge beds to support increased demand over the winter period. It is proposed to maintain 10 surge beds in 2016/17, all of which will be within the medical unit in the BGH, where the inpatient demand will be most acute. In addition, we plan to keep the 10-bedded Ward 16 open at weekends. This is a reduction from a maximum of 23 planned surge beds last year. There will be contingencies for accessing additional beds.

3.7 A more robust and integrated governance structure for the Winter period has been established. A fortnightly Winter Planning Group, comprising relevant services, is responsible for the operational delivery of the plan. An Integrated Winter Planning Board, chaired by the Chief Officer, who has operational responsibility for Mental Health and Community Care, will oversee delivery and effective implementation of the Winter Plan. The plan will be reviewed and signed off by both the Health Board and Scottish Borders Council through appropriate governance processes.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the Winter Plan for information as this will be formally approved by Borders Health Board on 27th October.

Policy/Strategy Implications	Request from the Scottish Government that all Health Boards produce a Whole System Winter Plan signed off by the Health Board.
Consultation	The Winter Plan has been prepared by and in conjunction with stakeholders. The plan has been reviewed by NHS Borders Clinical Executive Operational Group and Strategy and Performance Committee, SBC Corporate Management Team and the Integrated Joint Board
Risk Assessment	Completed. All risks currently managed.
Compliance with requirements on Equality and Diversity	Equality and Diversity Scoping template completed. This indicates that there are no equality and diversity impacts of the Winter Plan. The Winter Plan provides enhanced and additional services to maintain access to and delivery of health services. This benefits all people within Scottish Borders.
Resource/Staffing Implications	Resource and staffing implications are addressed within the Winter Plan.

Approved by

Name	**Designation**	**Name**	**Designation**
Susan Manion	Chief Officer Health & Social Care Integration	Evelyn Rodger	Director of Nursing, Midwifery and Acute Services

Author(s)

Name	**Designation**	**Name**	**Designation**
Phillip Lunts	General Manager, Unscheduled Care		

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Winter Plan 2016/17

Status: Draft

Author: Phillip Lunts & Alasdair Pattinson

Approved: Evelyn Rodger, Director of Nursing, Midwifery and Acute Services

Version: 6.5

Version control

Version	Date	Author	Comments
1.0	31/7/16	Phillip Lunts	
2.0	14/8/16	Phillip Lunts	First draft with revisions
3.0	15/8/16	Phillip Lunts	Revised
4.0	18/8/16	Phillip Lunts/Fiona Jackson	Fully revised and all sections completed
5.0	18/8/16	Fiona Jackson	Formatted and additional information added
6.0	19/8/16	Phillip Lunts	Final draft plan completed
6.1	22/8/16	Susan Manion/Evelyn Rodger	Amendments including details of governance arrangements
6.2	1/9/16	Phillip Lunts	Revisions from NHS Borders Strategy and Performance Committee
6.3	12/9/16	Phillip Lunts/Murray Leys	Amendments to home care, care home and equipment store sections
6.4	26/9/16	Phillip Lunts	Add references to OOHs support for Pharmacy, Dental, Referrals between OOHs services, MH Crisis, documentation
6.5	5/10/16	Phillip Lunts/	Incorporated suggestions from SBC Corporate Management Team: More detail on Anticipatory Care Additional Governance and Monitoring section

CONTENTS

Winter Plan Summary

This Winter Plan has been developed as a whole system plan to address predicted increases in activity and demand for health and social care services across the winter period 2016/17.

The plan is based on data and experience over the past 3 years.

This indicates that there were reductions in attendances at BECS and an overall increase in ED and AAU attendances between January and March 2016. There continued to be bed pressures, with additional beds open within Ward 8 and the Knoll Hospital, as well as the surge beds within the MAU annexe and the Borders Stroke Unit. However, boarders within the BGH reduced by 40%. Length of stay reduced overall, but remained high in Community Hospitals with beddays lost due to delayed discharges increased by one-third compared to the previous winter. The percentage of patients over 75 years of age admitted with acute illnesses has continued to increase year on year.

The main pressures experienced over the winter of 2015/16 were in high numbers of ED attendances at weekends and on Mondays, demand for medical and orthopaedic beds, reduced but continuing high numbers of patients unable to be accommodated within medical beds (average 12.6 medical boarders – compared to 21.2 previous year) and delays in discharging patients out of hospital, both in terms of time of admission and delayed discharges.

The aim of the Winter Plan is to enable health and social care services to meet the needs of the population without a reduction in the quality and effectiveness of the services we provide. The Winter Plan therefore intends to ensure that we maintain and achieve the standards that indicate that we are achieving this. These include;

- Emergency Access Standard (98%)
- Local and National Waiting Times Targets
    - Treatment Time Guarantee (TTG)
    - 18 Weeks Referral to Treatment
    - Stage of Treatment
    - 31 and 62 Day Cancer Waiting Times
    - Stroke (Admitted to the stroke unit within one day of admission)
- No Delayed Discharges over 72 hours
- Bed Occupancy compared to target of 85%
- Zero boarders

Some surge capacity has remained open over most of the summer period, due to inpatient demand. This means that we will need to deliver effectively on all the actions outlined in this plan to ensure we have sufficient capacity to manage increased demand during the winter.

The winter plan therefore addresses;

- Prevention of admission through flu vaccination and a communication plan to signpost people to appropriate sources of advice (Knowing Who to Turn To)
- Measures to support the management of people in the community, including

    - Testing new models of community care within Eildon locality
    - Identifying and supporting those patients who have had the most frequent hospital admissions over the past year to help reduce their admission rates.
    - Identifying and supporting those patients who attended the Emergency Department over the past year to help reduce their need to attend ED.

- Enhanced services at the front door of the hospital, including
    - enhanced Borders Emergency Care Service out-of-hours staffing at times of predicted increased demand
    - A review of medical and nursing staffing within the Emergency Department and measures to plan for predicted times of increased demand
    - The maintenance of the Rapid Assessment and Discharge Team to identify and manage patients with complex needs but who do not require admission, including expansion into weekend working

- Improved pathways to specialty wards for patients requiring assessment
    - Enhancement of Ambulatory Care services to reduce numbers of patients requiring admissions
    - Ensuring all GP referrals to Medicine go direct to Medical Assessment Unit
    - Improved pathways for orthopaedic and surgical patient admission

- Improved systems for ensuring that patients requiring acute admission avoid delay and boarding. These include
    - Robust processes to ensure beds are always available on Medical Assessment Unit
    - Remodelling of medical inpatient beds to ensure correct mix of acute medical and acute elderly care beds so that patients with complex social and health needs receive care without delay in environments designed for their needs.
    - Remodelling of planned care (surgical) inpatient beds to separate patients admitted for planned surgical procedures from patients admitted as emergencies to ensure no cancellations for planned operations
    - Additional 10-bed medical surge capacity within the medical unit
    - Contingency planning for medical boarders to be accommodated in one location only if required
    - Streamlined pathways for transfer from BGH to Community Hospitals

- Active management of discharges, including
    - Measures to increase morning discharges to 40%, including increased utilisation of discharge lounge
    - 7-day services to ensure discharges at weekends match admissions

    - Increase discharge lounge staffing to take more patients
    - Redesign Discharge Hub to ensure that all complex discharges are individually managed to improve discharge planning and reduce delays

- Bundle of measures to reduce length of stay in Community Hospitals, including testing new model of medical management within Knoll Hospital
- Detailed planning for patients who are delayed in their discharge based on the new 72-hour standard to reduce time waiting for discharge
- Review of demand and capacity for homecare and targeted increase in capacity
- Establishment of a Transitional Care facility to allow patients to be discharged to a more homely environment for assessment and establishment of appropriate care packages
- Maintaining close working with voluntary sector in discharge management

- Patient Flow Management
    - Ensure effective systems for escalating and addressing any delays in the management and discharge of patients from ED
    - Standardised approach to patient flow management, including competency-based training for all Hospital Bleep Holders and Duty Managers
    - Duty Manager every day between December 2016 and April 2017

- Infection Control – robust testing of outbreak control measures and contingency planning for impact of outbreaks
- Communication Plan to maximise impact of messages, including effective use of 'Meet Ed' publicity to avoid hospital attendance, and integrated approach to winter communications
- Staffing – all nursing vacancies filled going into winter and additional staffing recruited to cover additional capacity

SECTION 1 – WINTER PERIOD PLAN

1. Introduction

NHS Boards and Local Authorities have a responsibility to undertake effective Winter Planning to ensure that the health and social care needs of the population continue to be met in a timely and effective manner regardless of any increases in demand or additional challenges associated with the winter period.

This Winter Plan is a joint plan between NHS Borders and Scottish Borders Council It has been developed as a whole system plan between NHS Borders and Scottish Borders Council based on ongoing review of demand and activity over the past 3 – 5 years and lessons learnt over the course of the last 3 winters.

The plan sets out the key actions that will be undertaken to ensure that services are prepared to manage the increased activity and other demands expected during the winter period.

This year, planning for winter is being undertaken in the context of continuing pressures on inpatient beds throughout the summer. Surge bed provision remains partially open, meaning that the delivery of the actions outlined in this plan requires to be robust.

The winter period is between 1st November 2016 and 31st March 2017

The delivery of the Winter Plan will be overseen by an Integrated Winter Planning Board, chaired by the Chief Officer for Health and Social Care. The Board will report to both the Health Board and the Council, with regular updates to the Integrated Joint Board. An operational Winter Planning Group will be responsible for implementation.

2. Key Deliverables

Safe and effective care for people requiring the health and social care measured through delivery of:

- Emergency Access Standard (98%)
- Local and National Waiting Times Targets
    - Treatment Time Guarantee (TTG)
    - 18 Weeks Referral to Treatment
    - Stage of Treatment
    - 31 and 62 Day Cancer Waiting Times
    - Stroke (Admitted to the stroke unit within one day of admission)
- No Delayed Discharges over 72 hours
- Bed Occupancy compared to target of 85%
- Zero boarders

3. Self Assessment

The Scottish Government asks Health Boards to ensure they have plans for the following

- Resilience (plans to keep services going when there are unexpected or major pressures, including adverse weather)
- Unscheduled and Elective Planning (plans to provide correct staffing levels, facilities and beds to care for both emergency patients and patients who are attending for planned operations).
- Out of Hours Services
- Norovirus
- Seasonal Flu
- Respiratory Pathway
- Management Information

We undertook a full evaluation of the implementation of our winter plan for 2015/16 against the Scottish Government self-assessment framework and this has informed the preparation of this winter plan.

4. Recommendations from Winter 2015/16

The following table outlines the key learning and recommendations from the 2015/16 Winter Period.

Lessons learned /Recommendations from Winter 2015/16

Key Requirement	Progress/Further Actions	Status
Remodel inpatient footprint to ensure appropriate allocation of specialty beds, including ensuring the correct allocation and staffing of medical beds. This will minimise boarding patients	Remodelling Medicine and Planned Care IHO remodelling underway with launch dates of 3rd October 2016	G
Develop community-based prevention strategies to avoid patients requiring admission	Top 5% of frequent admissions and top 30 ED attenders being reviewed to identify ways of reducing admissions/attendance	G G
Focus on proactive Discharge Planning at an individual patient level to reduce delayed discharges and patients waiting inappropriately in hospital beds	Redesign of Discharge Hub underway	G
Resolve the issues preventing patients being discharged in the morning	Morning Discharge Project underway with target of 40% discharges by midday by end August 2016	A
Develop more effective discharge planning and a coordinated weekend discharge team	Weekend Discharge project underway with target of matching weekend admissions and discharges by October 2016	G
Build on the proactive recruitment strategies to minimise staffing vacancies going into winter	Nurse recruitment events 2-monthly. Additional capacity recruited to in August 2016	G/A
Earlier preparation and implementation of Winter Plan for 2016/17	Working to earlier timeline for Winter Plan preparation	G

5. Resilience

This Winter Plan details the actions we will take to ensure that we are prepared to manage the extra demand for services we can expect during the winter period. NHS Borders also has a number of policies and measures that ensure we are prepared to deal with unexpected or major events. These are summarised as resilience plans.

The aim of the Winter Plan will be to ensure that all services across health and social care will have up-to-date resilience plans and staff are aware of the location of these plans

- Business Continuity plans. Each department has a plan that explains how they will continue to operate in an emergency. These plans will have been tested by November 2016
- Both NHS and Scottish Borders Council have severe weather plans that incorporate resilience arrangements for services. The SBC severe weather resilience plan covers Education, Social Work and Care Homes. The plan was well-tested last year due to the winter storms. The Severe Weather Policy for NHS Borders will have been updated and tested by November 2016.
- Pandemic Influenza Contingency Planning will be in place
- Revised Major Emergency Plan will be in place by end November
- Inter-agency emergency planning arrangements will have been updated to address winter pressures for 2016/17

6. Prevention of admission

Flu vaccination

In Winter 2015/16, the flu vaccination rate for children within the community was 58%, the second highest in Scotland. NHS staff flu vaccination achieved 44% coverage against the previous year's uptake of 54%.

The aim of the Winter Plan will be to maintain the same or better levels of flu vaccination uptake for community as last year and to improve staff vaccination uptake to above 50%.

For flu vaccinations, NHS Borders will ensure:

- All adults aged 65 years and over and adults aged 18 years and over with "at-risk" health conditions are offered flu vaccination and that we will vaccinate 75% of people within these groups, in line with WHO targets. We will also offer vaccinations to all pregnant women, at any stage of pregnancy,
- NHS Borders will offer vaccination to the same groups of children as last year. Specifically:

- All children aged 2-5 (not yet at school) through GP practices
- All primary school aged children (primary 1 to primary 7) at school.

3. Staff programme

- NHS Borders will aim to achieve the 50% target for staff vaccinated and encourage independent primary care providers such as GP, dental and optometry practices, and community pharmacists, to offer vaccination to staff
- Scottish Borders Council will ensure that flu vaccination is offered to and taken up by social care providers

- Within NHS Borders there is particular focus on improving uptake amongst staff working with high risk patients. Access to the vaccine for staff is maximised using specific OH flu clinics, on-site sessions in ward areas, roving vaccinators and a robust network of peer vaccinators. The programme is promoted via poster campaigns, information leaflets, plasma screen and intranet, team brief, staff newsletter, weekly email and videos with local promotional material used as well as nationally produced material.

Communication and Engagement with the Public

In order to help avoid unnecessary admissions to the Emergency Department or Primary Care Out-of-Hours service (BECS) over the Winter period, the objectives of the Winter Communications and Engagement plan are to;

- Encourage the public to access the right services at the right time in the right place
- Be aware of seasonal viruses such as flu and norovirus, and how to prevent against them / deal with symptoms
- Remind people to prepare for the winter period by obtaining adequate supplies of prescribed medications

These messages will be delivered through:

- The annual national campaign delivered by NHS 24 (Be Health-Wise this Winter) - details still to be received
- A local radio advertising campaign promoting the 'Meet Ed' - Know Where to Turn To message along with localised messages about flu vaccination and seasonal GP and Pharmacy Opening Hours – budget to be agreed

The use of social media will once again be a major part of the communications mix.

In addition, the Winter Planning Group will be asked to consider the use of near 'real time' communication with the public in the form of a **weekly update posted on social media** and the website detailing issues such as cold weather snaps, norovirus outbreaks, vaccination clinics etc. This forum could also be used

additionally to communicate real time issues, such as a very busy Emergency Department, bed shortages etc – the aim being to continue a conversation with people advising them when the hospital may be under pressure and signposting them elsewhere, rather than only communicating in this way when we are seen to be in crisis.
This will be a test and, if accepted by the Winter Planning Group, can be tweaked as necessary as the Winter period progresses.

We will engage with families and carers of people who may require hospital care during the winter period to develop ways of providing support to help them to maintain or provide care within the persons own home.

As part of our planning for the festive period, we will undertake an intensive review of all patients in hospital to ensure that they are not waiting unnecessarily for investigations or treatment and we will work closely with their families and carers to enable them to be discharged home safely and without delay. This will include arrangements for follow-up outpatient tests and review and arrangements for home or local provision of treatment.

Communication and Engagement with Staff

- The Winter Plan and the detail of arrangements will be disseminated through all staff groups and services within NHS Borders, Scottish Borders Council and other partners.

- A Winter Planning staff focussed microsite will be launched in early December 2016 and be live until the end of March 2017. The microsite will have links to relevant external sites, as well as to key local policies relevant to the winter period. Information from the microsite can also be made available to partner organisations to populate their own websites where this is considered of value.

7. Primary and Community Care

We know that primary and community care services are affected by specific issues;

- If the acute hospital is busy, so is primary care.
- Admissions can only be avoided if there is a better and safer alternative.
- The winter plan should build on work being planned to improve and transform services rather than put in place separate arrangements .
- We need to agree contracts with GPs for services they provide as part of winter planning.

GP practices will arrange services according to their own winter plans.

The aim of the Winter Plan will be to take measures to reduce numbers of patients being admitted to the BGH through support of patients at high risk of admissions and by testing new ways of delivering services. These actions will reduce demand for hospital beds by the equivalent of 3 beds

- Paramedics Support to Teviot locality; We will maintain the pilot aligning services of 2 paramedic practitioners to two GP Practices in Hawick. They are working with the Practices to support the management of emergency care between 8am and 6pm, allowing GPs to maintain focus on the provision of routine appointments.

- Trial Comprehensive Geriatric Assessment (CGA); We will work with General Practice to identify (at risk of frailty) patients. We will screen for unmet need with a questionnaire supported by volunteers. This will be supported by Medicine for the Elderly Team and aligned to existing Frailty Pathway developments.

- Readmission avoidance; We will review the top 5% of readmitting patients by frequency. Data analysis suggests that these patients use a high number of beds in our acute hospital. The reviews will involve primary and secondary care, social care and voluntary sector to identify interventions necessary to support patients to be managed in the community setting.

- Anticipatory Care Plans. We will review the use of anticipatory care plans within the BGH to ensure that the information within them is being accessed and used effectively to avoid admission and manage patients during their inpatient stay.

These plans are part of the development of integrated health and social care services and will inform redesign and reallocation of resources in the future.

8. Out-of-hours provision.

Primary Care Out-of-hours/Borders Emergency Care Service (BECS)
BECS performed well during the winter period, meeting all its quality standards. Although there was an increase in attendances last year compared to the previous year, there was no large increase in activity during the winter period compared to other months of the year. The most significant challenge continues to be availability of GPs to cover the BECS rotas. If there are not sufficient medical staff, many patients will have to use the Emergency Department. This will increase pressure on a busy department and increase the likelihood of Emergency Access Standard breaches.

The aim of the Winter Plan is to maintain the out-of-hours GP services achieved last year and continue to achieve the quality standards for GP out-of-hours.

Rotas are being planned in advance to ensure they are covered. BECS uses both GPs who work in practices during the day (sessional GPs) and GPs who are employed by BECS (salaried GPs). Plans for recruitment for salaried GPs continue, whilst we are actively encouraging sessional GPs to join the rota. Where we anticipate that GP cover may be limited, other plans are put in place.

As part of this process, we will be testing a nurse-led model of out-of-hours cover for the quietest periods of the night to identify whether it would be possible to run at these times without GP cover. This will be a pilot initiative and will help inform future planning for out-of-hours primary care.

BECS works closely with NHS 24 to monitor demand; when NHS 24 predicts that key dates could be particularly busy, the service looks to increase staffing availability, especially over the Christmas and New Year period.

BECS drivers will also be available to offer support to reception. BECS vehicles all have 4x4 capability. This will help service continuity throughout the winter period.

BECS provides advice directly to social work, pharmacists, district nurses and nursing homes. This means that patients receive a rapid local assessment based on anticipatory care planning.

Palliative care patients have direct access to the service which avoids delays or hospital attendance.

BECS GPs also provide professional to professional support for the Scottish Ambulance Service, thus preventing avoidable admissions and offer safe care alternatives.

A Transforming Urgent Care Steering Group has been established to develop and deliver a new strategy for the delivery of primary care out-of-hours services.

Out-of-hours dental services are planned to continue as normal. Festive period cover is detailed in the Festive Period Plan.

Out-of-hours pharmacy community pharmacy cover is as normal #

9. Unscheduled Care

9.1 Emergency Department (ED)

The ED experiences the majority of the external pressures as the fall-back option for all medical emergencies as well as delays for patients waiting to be admitted when the hospital has pressures on beds.

During the winter, arranging enough staff to ensure that care is seamless and given with minimal delay becomes more important due to the higher activity. We have used the data from previous years to predict the likely pressure points during the winter period.

The aim of the Winter Plan is to ensure that patients attending ED receive the best possible care and move to the next place for care without delay. Our

performance against the 98% 4-hour Emergency Access Standard will demonstrate how well we are achieving this.

We are reviewing both medical and nurse staffing within the Emergency Department to determine the most effective allocation of staff and the correct staffing levels required to ensure safe cover for the service. This review will be complete and measures to adjust staffing taken prior to the winter.

We will be further developing the role of the Emergency Nurse Practitioner and other advanced practice roles to develop more sustainable staffing for the future. Where it is not possible to recruit or train sufficient nurse practitioners in time for the winter we will ensure appropriate medical cover is in place instead.

We will also review the top 30 frequent attenders at ED to identify any general and specifications that can be taken to reduce the numbers of times these patients attend ED.

Flow 1 (Minor Injury and Illness)

Flow 1 was approximately 56% of all ED attendances between November 2015 and the end of April 2016. This compares with a 60% average in the summer months and reflects a seasonal drop. Measures to reduce numbers of breaches of the 4-hour standard amongst Flow 1 patients were successful with a total of 66 breaches across the whole of the period November 2015 to March 2016. This compares to 148 in the similar period the year before.
We will plan staffing so that patients in Flow 1 are treated separately from other patients so that there are no delays for these patients. The department will provide the following;

- We will test and implement models for the most effective use of Emergency Nurse Practitioners including ensuring that hours of work match demand. We will test the benefits of additional Emergency Nurse Practitioners, particularly on the days of greatest predicted activity. We will ensure that the outcomes of these tests are implemented.
- Increase medical cover according to expected demand where possible.
- Identify separate areas to treat Flow 1 patients to avoid delays due to cubicle capacity

Flow 2 (Acute Assessment) and Flow 3 (Medical Admission)

Last winter, we introduced the Acute Assessment Unit, a facility based within the Medical Assessment Unit to review acute medical admissions referred by GPs. Prior to this, most of these patients would have attended ED and be categorised as either Flow 2 or Flow 3 patients. .

Between February and May 2016, there was an 18% increase in the combined numbers of ED flow 2 & flow 3 and AAU patient attendances compared to the period

November to January. This reflects a similar increase in the previous year and demonstrates seasonal variation.

In order to maintain the improved Emergency Access Standard performance, NHS Borders is planning

- To increase medical cover according to expected demand where possible.
- To maintain the Rapid Assessment and Discharge (RAD) team. This team consists of Physiotherapy, Occupational Therapy and social work care manager who can assess suitable patients in ED and arrange for them to go home rather than be admitted to hospital.
- To further develop the Acute Assessment and Ambulatory Care Service (see below).
- Ensure there are 3 available beds on the Medical Assessment Unit at all times to take patients from ED, with a clear escalation plan to engage additional resource when this is not achieved
- Ensure that all patients referred by their GP for medical admission are reviewed directly within the Acute Assessment Unit
- increase the numbers of beds available above normal bed complement (see section 9.2)

Flow 4 (Surgical Admissions)

Flow 4 is approximately 9% of all ED attendances. There was no change in numbers of flow 4 patients attending ED during the last winter period or previous years.
To improve performance this winter, we are improving processes so that surgical admissions are transferred to the relevant ward as soon as the patient is assessed as needing admission. At the moment, patients often wait in ED to be reviewed by the surgical doctors.

9.2 Medical Unit

Last winter, NHS Borders established an Acute Assessment Unit within the medical unit for all medical patients referred for admission by their GP. This service is now fully established and continues to ensure that 30% of patients are seen, assessed and discharged without admission.

This winter, we will be remodelling the way in which we care for patients admitted to the medical unit. We will redesign the inpatient wards so that;

- Patients who are expected to remain in hospital for less than 48 hours will be cared for on the Medical Assessment unit under the care of medical and nursing staff experienced in the management of acutely ill patients
- Patients who have a medical condition that is likely to improve rapidly with treatment and who will then be fit to return home will be managed in an acute medical ward with access to appropriate medical specialities
- Patients who have more complex needs, have multiple health conditions or who require rehabilitation or additional social support will be assessed within

24 hours by a clinicians specialising in the care of elderly and frail patients and will be transferred directly to 2 acute elderly care wards, where they can receive the care appropriate to both their medical condition and their other longer-term needs

This remodelling is expected to reduce length of stay within the medical unit by an average of 0.5 days per patient and to reduce the number of patients waiting for prolonged periods of time for social care assessment and placement.

9.3 Unscheduled Patient Flow

There was a slight increase in medical patients admitted to the BGH during winter 2015/16 compared to the previous winter, although overall admissions did not increase. This reflects the pattern for the previous winter.

Work to manage medical patients more effectively, including the establishment of the acute assessment unit and the creation of a temporary additional medical ward in Ward 8, reduced numbers of patients boarding in wards outwith their admitting specialty by 26%, from 2715 boarding beddays to 1999 boarding beddays.

The aim of the Winter Plan is to ensure that patients receive care in the right place and are not delayed in admission because of availability of beds. The number of patients breaching the 4-hour ED standard will not increase in the winter period compared to the previous summer, we will intend to have zero boarding patients and we will maintain bed occupancy rates as close as possible to the 85% target.

The work described above to improve the management of medical patients is expected to reduce the demand for medical beds. A range of measures to reduce delays for both simple and complex discharges (described in section 11 below) will further reduce the requirement for medical patients to be accommodated outwith their specialty. However, as these measures will not be in place and tested before the onset of winter pressures, we believe that there will be a requirement for additional medical beds during the winter period. We therefore intend to plan to be able to open the following surge beds

- 8 additional acute medical beds within the medical Assessment Unit annexe
- 2 additional beds in the Borders Stroke Unit

We will not be planning to open any further inpatient beds.

These arrangements should be sufficient to avoid boarding patients into other wards. However, when there are occasions that will require patients to be boarded, we will ensure that all medical patients are boarded to one single area within Ward 7. This will ensure more effective medical and support service arrangements for these patients. We will also be introducing more robust processes for identifying and transferring boarders to ensure that there is minimal impact on the care of boarded patients.

We will also continue to maintain patient flow by;

- Additional nurse staffing. We will recruit extra nurses to staff the additional medical beds and to fill the staff vacancies that are predicted to occur between November and March due to normal staff turnover. These staff will be available to support areas of high activity. At times of critical bed pressures, this will allow us to open extra beds for short periods of time
- Frail Elderly Assessment Service. We will continue the new model of rapid assessment of frail elderly patients on arrival at hospital. This process reduces the length of time patients stay in hospital and improves discharge arrangements.
- The Rapid Assessment and Discharge team will undertake 6 day working to cover patients admitted at weekends. We will review the impact of weekend AHP working from last winter to determine the most effective allocation of AHPs to ensure that there are no delays to patients due to weekends.

10. Elective Care

During December and January, cancellations due to bed availability did not increase from previous months. The position worsened in February, when 35 procedures were cancelled due to lack of bed availability. Patients exceeding Treatment Time Guarantee also increased from zero to 11 patients at one point. Overall numbers of cancellations were however significantly less than the previous year.

The aim of the Winter Plan is to have no elective procedures cancelled due to availability of beds.

To achieve this, NHS Borders is remodelling the inpatient footprint and theatre scheduling of planned care. This will;

- establish a combined elective ward for all surgical specialties
- Smoothing of the scheduling of theatre lists to reduce peaks and troughs of demand for inpatient beds on any particular day
- Reduce admission the day before surgery in orthopaedics

As a result of this remodelling, elective inpatient beds will be protected during the winter period and will not be used for unscheduled care. There should therefore be no cancellations of elective procedures as a result of lack of bed availability.

11. Discharge

A major part of the delays in admitting patients over the winter period last year was due to patients being discharged late in the day and a reduction in discharges at weekends.

The aim of the Winter Plan is to achieve and maintain 40% of total patients discharged discharged before 12 midday and that the number of patents discharged at the weekend is the same as the number of patients admitted.

In order to improve morning discharge arrangements, we will;

- Ensure that each ward is aware of the number of morning discharges required each day and support wards to achieve this
- Develop a morning discharge team based within the Discharge Lounge, including additional admin and nursing support
- Review on a daily basis ward-by-ward performance against required number of morning discharges and immediately address issues identified
- Have open criteria for acceptance of patients to Discharge Lounge (all patients individually assessed for suitability, rather than blanket criteria)

In order to improve weekend discharge arrangements, we will;

- Establish a robust weekend discharge planning process, commencing early in the week, to identify patients with the potential to be discharged at the weekend and ensure that weekend medical and nursing staff are aware of these patients
- Ensure all potential weekend discharge patients have a criteria-led discharge plan. This allows nursing staff to discharge patients according to a discharge plan agreed with medical staff
- Establish a coordinated weekend discharge team, including medical, nursing, AHP, pharmacy and social work and a weekend duty manager with site management oversight of patient flow and discharge at weekends.

Patients with complex discharge needs can have prolonged lengths of stay due to the complexity in arrangements for discharge. These patients are identified and reviewed daily at a multi-agency discharge hub meeting.

The aim of the Winter Plan is to improve coordination of actions to rapidly and safely establish discharge arrangements for patients with complex discharge needs. This will result in an average reduction of 2 days in the length of stay for patients referred to the Discharge Hub. This will have the effect of reducing demand by the equivalent of 1 hospital bed per day

To achieve this we will,

- Expand the role of the Discharge Hub. This is a daily meeting of different agencies to agree and carry out actions to speed up the discharge of patients with more complex needs. A discharge hub coordinator will be appointed to ensure that all actions are being taken
- Establish integrated working between the START hospital social work team and the discharge liaison team as an integrated hub for discharge support

12. Community Hospitals

Although the 2015/16 Winter Plan ruled out the use of closed beds in the Knoll and Hawick Community Hospitals for surge capacity, there were occasions last winter when these beds were occupied, creating significant logistical challenges.

During 2015/16, there was no reduction in length of stay of patients in Community Hospitals compared to the previous winter, with average length of stay running at approx. 34 days.

The aim of the Winter Plan is to maintain Community Hospital bed occupancy at 95% and achieve an average length of stay of 23 days.

In order to best manage Community Hospital beds, NHS Borders will;

- Roll-out and embed the Community Hospital Discharge Bundle across all Community Hospitals
    - daily multidisciplinary board round review of all patients and adjustment of EDDs
    - standardised template for multidisciplinary team meetings
    - weekly discharge plan, identifying when patients will be discharged across the week
    - use of day hospitals as discharge lounges to enable patients to be ready for discharge first thing in the morning
    - standardised transfer pathway for patients between BGH and Community Hospitals, including simplified waiting list, transfer checklist and dedicated transport slots for transfer
- Establish a new model of medical management of patients within the Knoll Community Hospital, as a test of change.. This may provide a more standardised and intensive management of these patients
- Daily in-reach assessment of patients in BGH for transfer to Community Hospitals

13. Delayed Discharges

The numbers of patients delayed in their discharge over the winter of 2015/16 did not increase compared to the previous winter. However, their length of delay did increase, resulting in an additional 506 beddays lost due to delayed discharges.

We continued to use flex beds to move patients waiting for placement of choice out of hospital.

The aim of the Winter Plan is to work towards zero delayed discharge patients over 72 hours

We will;

- Provide information and education for health staff to ensure that they present a consistent message to patients and relatives that they may be discharged to transitional facilities whilst agreeing care home placements or other arrangements
- Maintain joint delayed discharge review meetings, and continue to work to resolve on an individual basis each person delayed in their discharge
- Carry out daily senior manager review of delayed discharges

- Implement weekly Day of Care Auditing in the Community Hospitals to identify patients delayed in their discharge process at an early stage and avoid Delayed Discharges.
- Establish a Transitional Care Facility will be established in Waverly Care Home (see below)
- Progress actions to address the causes of delayed discharges as described throughout this plan

14. Home Care

Social Care & Health will work closely with NHS Borders to support the actions contained within the winter plan. Delays in discharge due to lack of home care currently represent 25% of patient delays to discharge within the BGH.

The aim of the Winter Plan is to reduce the number of patients who have the discharge delayed due to unavailability of home care.

In order to ensure effective access to home care for patients being discharged from hospital, we will undertake the following measures

- Undertake demand and capacity to identify current capacity and current and predicted demand for home care services
- Encourage commissioned services to undertake proactive recruitment to increase available numbers of carers
- Establish a matching unit to review all home care hours and reallocate hours released by patients admitted to hospital at an earlier stage
- Reduce “stopped”care package times on admission to hospital from 14 to 7 days
- Introduce a transitional care facility within Waverly Care Home for patients who no longer need to be in hospital or who do not require admission to hospital but require a further period of social care or rehabilitation in order to return or remain at home. Based on models elsewhere, this facility is predicted to significantly reduce the need for social care input for this group of patients.
- Explore alternative staffing models to help in identifying additional home care support (eg, healthcare support workers)

15. 24-hour and residential care

Working in partnership with stakeholders from NHS, Scottish Borders Council, Independent and third sectors, we will review measures to support access to 24-hour care placements and resilience of care homes during the winter period.

All care homes have business continuity plans in place and a RAG system operates which advises when pressures are experienced.

16. Borders Ability and Equipment Store

The Borders Ability and Equipment Store provides rapid access to equipment essential to allow patients to be safely discharged home. At times, when demand increases, there is the potential that equipment will not be available in a timely fashion.

The Winter Plan aims to ensure that no patient is delayed in their discharge home due to lack of equipment.

In order to support this, we will

- Undertake demand and capacity analysis of equipment requirements for patients during the winter period to identify whether there is an increase in demand and the nature of the requests
- Develop a model to ensure that sufficient and appropriate equipment is ordered in a timely fashion and available to support any surges in demand during the winter period
- Review available budget for aids and adaptations
- Review and confirm that operating procedures are in place to ensure full and timely access to equipment during out-of-hours and festive periods
- Ensure that there is a robust plan for the distribution of equipment during periods of severe weather.

17. Patient Flow management

During Winter 2015/16, a planned focus on coordination of patient flow ensured rapid identification, escalation and management of potential blockages in patient flow. This meant that fewer patients were delayed in their care and more patients received care in the appropriate place.

The aim of the Winter Plan is to ensure that patients requiring hospital care are not delayed in their pathway and that they receive their care in the appropriate place. There will be daily, weekly and monthly planning to ensure that system pressures are identified in advance and that contingency plans are in place and utilised where required.

There is a well-established patient flow management system already in place, including

- Daily patient flow meetings of all areas of hospital to review current situation and make plans for that day and the next day
- Weekly planning meetings for weekend patient flow management
- Clear escalation processes that are triggered based on early warning signs of increased activity or delays in the system

Additional measures developed during 2016 to support patient flow include

- Hospital Bleepholder (person responsible for the daily operation of the hospital) established as part of Senior Charge Nurse role
- All Senior Charge Nurses have received competency-based training in the role of Hospital Bleepholder to ensure consistency of approach in managing patient flow.
- Revised escalation processes for ED, Acute Assessment Unit and Medical Assessment Unit to ensure early response to pressures in these areas
- Weekend Senior Manager on duty and responsible for the safe and effective operation of the hospital

During the winter period, we will reintroduce the Duty Manager role during weekdays. This is a senior manager responsible for oversight and direction of the operation of the hospital. In 2015/16, this role was effective in early identification of potential patient flow challenges and in taking action to avoid these.

A review of the daily hospital patient flow processes is underway which will inform further improvement

18. Infection Control

During Winter 2015/16, there was minimal disruption to health services due to Norovirus. There were 138 blocked beddays (number of patients per day who could not be moved due to bay closures as a result of norovirus), with a loss of 26 beddays (equivalent to 0.2 of a bed over this period). This is a similar experience to winter 2014/15. A small-scale tabletop exercise to review ability to sustain a significant outbreak demonstrated that there was sufficient capacity within the inpatient system to provide resilience. However, Norovirus outbreaks during April and May 2016 resulted in a number of ward closures that put strain on the acute hospital system.

The aim of the Winter Plan is to ensure that services continue as planned and are not adversely impacted as a result of Norovirus outbreaks.

To achieve this, we will;

- Plan to reduce the risk of spread of Norovirus by monitoring national information on a weekly basis to provide early warning of Norovirus, increasing levels of cleaning during the winter period and raising awareness of risks through a high profile campaign directed at staff and visitors.
- Take rapid and robust interventions when there are cases of Norovirus including rapid identification and isolation of patients, further increased cleaning in affected wards and precautionary closure of affected bays.
- Manage outbreaks of Norovirus (2 or more cases) through daily outbreak meetings and close involvement of Infection Control in the daily management of the hospitals.

- Review the Norovirus management plans. This includes ensuring accurate and up-to-date information is available to all staff, and reviewing options for cohorting patients, decision-making processes for closing and reopening affected wards and bays and risk assessments of the impact of wad closures. Review management plans for other infections that require control measures.
- develop Norovirus resilience plans for individual wards to ensure that individual hospital specialties, and overall patient flow, can be effectively maintained during significant outbreaks
- Review preparedness for other outbreaks, including influenza outbreak management

19. Respiratory

In order to maintain patients with respiratory conditions at home, there will be a national campaign to ensure that people are advised 'Keep Warm' during periods of cold weather. This will be reinforced through local media campaigns. Patients with known significant or end-stage disease have self-management plans included within anticipatory care plans. Work to ensure that these are accessed by service will be undertaken. We will review the potential for a 24-hour contact line for this group of patients to provide telephone advice and reassurance. This will form part of the work to review frequent users of hospital services. Specialist advice is available for patients during the week should they require discussion about their management plans.

The Respiratory Specialist Nursing team will continue to identify patients with known respiratory conditions at point of admission and support wards and medical staff to review and manage patients effectively.

The Respiratory Specialist Nursing service support discharge planning and decision to discharge for inpatients with respiratory conditions.

Oxygen Therapy

Oxygen therapy is available at all emergency and unscheduled care points of contact. There is also a locally agreed pathway for the assessment and prescribing of home O2 support. Procedures for obtaining/organising home oxygen services are available on the Respiratory Microsite.

20. Women and Children

Children's Services, Borders General Hospital
Children's services are currently reviewing their bed management plans to ensure that there is a focus on early safe discharge and early medical review by 4pm where a child requires a further period of observation. There is a focus on:

- The development of criteria led discharge.
- Cohorting of children with Respiratory Syncitial Virus.
- Keeping children at home wherever possible.
- Ambulatory care wherever possible.

The children's ward is able to accommodate young people up to the age of 18 years where appropriate to support the management of patient flow across the wider hospital. The children's ward cannot accommodate adults over the age of 18 years (European Association for Children in Hospital CHARTER). A revised boarding policy has been produced to ensure that criteria for admitting young people up to 18 years of age are clear and applied.

Maternity services

Maternity services will continue to focus on identifying and addressing service pressures promptly and focusing on safe and early discharge.

21. Mental Health

There are a number of areas in which mental health services will be affected by winter pressures:

- Mental health issues are likely to be a significant cause of frequent attendances in ED. Crisis Mental Health services will be operating as normal. Work to reduce the top 30 frequent attenders (see section 7) will require mental health services to review provision and potentially individualised plans for patients to reduce their need to attend ED and to assist staff in managing them when they do attend
- Older Adult mental health services will be impacted by the general pressures on older people, particularly pressures to provide social care to enable timely discharge from hospital. This will be further challenged by the need to avoid unnecessary movement of patients with dementia during their time in hospital. Delays in discharge for these patients may result in significant numbers of lost beddays in acute areas of the hospital, with a disproportionate impact on patient flow. Work to reduce delayed discharges will include a focus on patients with dementia within the mental health services
- Access to services, including housing, can be challenging for people with mental health issues, particularly over the festive period. As part of our festive plan, we will develop arrangements to ensure that access to services is readily available over this period.
- Management of patients with delirium within the BGH and Community Hospitals is a significant challenge currently within the BGH and community hospitals and this is likely to be exacerbated during the winter. The mental health service will work closely with acute and community hospitals to support the management of these patients. Models for providing additional support are being developed.

22. Learning Disabilities

There are no requirements for additional staffing or other arrangements within mental health services during the winter period. Any exceptional pressures on the service will be managed through the established business continuity and severe weather plans. Details of arrangements for cover over the festive period are contained in section 2.

23. Staffing

During winter 2015/16, recruitment to additional staffing commenced in August. However, recruitment did not match the increased demand for staffing, due to staff leaving, sickness and the requirement to staff additional beds. It also proved challenging to recruit sufficient staff. This resulted in a dependence on bank and agency staffing, which carried through into the spring and summer of 2016.

Annual leave was restricted for ward staff over the 2-week festive period and, as a result, there were few staffing issues during this time. There was a 20% reduction in bank nurse use during the festive period 2015/16 than in the previous 2 weeks.

Recruitment to staffing for this winter has commenced earlier and staffing is now being monitored on a daily basis to more effectively utilise staff.

The aim of the Winter Plan is to ensure that there are enough nurses employed to continue to safely staff our services.

We will do this by;

Nurse staffing

- Level-loading annual leave for nursing staff across 50 weeks, with no annual leave allocated during the 2-week festive period.
- Following the Sickness Absence policy consistently on every occasion.
- Introducing an 8-week electronic nurse rota to ensure improved visibility of staffing and earlier planning for staffing gaps
- Proactively recruiting to both current vacancies, the additional nurses to cover the expected vacancies that will occur as people leave over the next 6 months and other posts as required
- Maintaining Nurse Bank at full operation and reviewing the potential to operate on Saturday mornings to assist in forward planning of supplementary staffing for Sunday and Monday, and potentially reducing requirement for agency nursing
- Reminding all staff of arrangements for coming to work in periods of severe weather (see section 5: Resilience).

Medical staffing

- Early planning of festive period rotas to ensure appropriate levels of medical staffing during this period

- Identifying areas of potential pressure or risk during the winter period and proactively identifying measures for addressing these pressures, including early recruitment to additional posts
- Close management of rotas to ensure they are level-loaded

Plans for forward planning of staffing will also be developed for other clinical professions, including AHPs.

Social care staffing (see section on Homecare)

24. Data and Reporting

Although normal reporting systems provided information on service status during last winter, improved predictive information to forecast potential pressures in the system would have helped plan for surges in demand. The Easter public holiday did not have the same level of planning as the festive period.

The aim of the Winter Plan is to ensure that data is available at the times it is needed and in the right format.

To achieve this, we will;

- Bring together information on system pressures to provide a 2-week ahead forecast to predict pressure in the system. , This will include; Local Information (see section 14 for more information).
  - Systemwatch – predicted unscheduled care activity.
  - NHS 24 – for GP out-of-hours predicted activity.
  - Flu surveillance – for early warning of outbreaks.
  - Public Health – for early warning of other disease outbreaks.
  - Weather forecast
  - Staffing pressures
- Provide wards with daily predictors of expected admissions and required discharges and feedback on performance against previous days predictor
- Establish a simple system for reporting daily information to the Scottish Government.

25. Estates & Facilities

The main challenge for Estates & Facilities over the winter months is associated with the potential for severe weather. NHS Borders has a legal obligation to ensure the safety of all members of staff and members of the public when using the buildings, footpaths and car parks on their property. Snow and ice may present risks to the continuation of the provision of services which are provided by the NHS Borders.

The aim of the Winter Plan is to ensure that services continue to function seamlessly throughout the winter period.

NHS Borders will do this by;

- Undertaking a programme of routine maintenance and testing to ensure anything we are likely to need over the winter months is in workable order
- Utilising the fleet of 4x4 vehicles to support staff transport when required during periods of severe weather
- Ensuring that normal Estates services are continued throughout the winter period

26. Working with other agencies

Scottish Ambulance Service (SAS)
The Scottish Ambulance Service are currently developing their draft winter plan. Scottish Ambulance Services and NHS Borders Winter plan will be aligned to ensure provision of ambulance services fits with changes to working arrangements within the Health Board. Additional capacity will be sought during the festive period.

Voluntary Sector Provision
The British Red Cross will continue to help support discharge over the winter period and provide support to avoid readmissions. The Red Cross attend daily Discharge Hub and put support in place for patients where appropriate, including visiting patients in wards, discussing how the Red Cross can help the patient, following them home (sometimes transporting them home), making sure they have enough essential supplies and working with them to ensure they are not re-admitted.

As in previous years, in instances of severe weather proactive links will be made to co-ordinate support for essential transport from BRC to both community based NHS services and social care services.

SECTION 2 – FESTIVE PERIOD PLANNING

Festive period planning covers the period where normal working will be affected by the public holidays over the Christmas and New Year period. For this year, this will cover a 3 week period – 19th December 2016 to 8th January 2017 .

In 2015/16, arrangements for the operation of core services over the festive period worked well as demonstrated by the 41 breaches of the Emergency Access Standard compared to 205 in the previous year (performance over the period of 97% compared to 86%)

However, it was identified that delays and lost activity due to the festive period shutdown impacted on the operation of services until the end of January. There were 22 cancellations in January as a result of delays in discharging patients.

During this period, **the aim of the Winter Plan is to ensure that appropriate health services are available to meet the changed pattern of demand and to ensure that people have appropriate access to all services in a timely fashion**. In particular, services are planned to address the expected surges in activity following the public holidays. The aim of the Winter Plan is also to ensure that there is no impact on services in January as a result of lost capacity during the festive period.

A festive period summit is being held on the week commencing 10th October to determine the services that should be operating over the festive period and the additional activity that will be required to replace lost activity.

The full festive plan will be attached to the final version of the Winter Plan.

SECTION 3 – MONITORING AND GOVERNANCE

Governance

A robust and integrated governance structure for the Winter period has been established.

A fortnightly Winter Planning Group, comprising representatives from relevant operational services, will be responsible for the operational delivery of the plan.

An Integrated Winter Planning Board, chaired by the Chief Officer, who has operational responsibility for Mental Health and Community Care, will oversee delivery and effective implementation of the Winter Plan.

The plan is being reviewed and signed off by both the Health Board and Scottish Borders Council through appropriate governance processes.

The Winter Plan will be signed off by Borders Health Board in October 2016.

Monitoring

We will monitor the progress and implementation of the Winter Plan in all areas, and the success of the measures that we have taken.

This monitoring will be at 3 levels:

Implementation of the Winter Plan

- Regular reporting to Winter Planning Group and Winter Planning Board of progress with the implementation of the actions within the Winter Plan
- Regular updates to appropriate governance groups across NHS Borders, Scottish Borders Council and the Integrated Joint Board

Achievement against planned outcomes

- We will monitor key performance indicators on a daily basis through a daily integrated operational scorecard
- We will report weekly to relevant individuals and groups within NHS Borders and Scottish Borders Council through a weekly performance scorecard
- We will report monthly to the Health Board and the Integrated Joint Board on delivery against outcomes

Evaluation

- We will undertake a full evaluation of service performance over the festive period in February 2017
- We will undertake an full evaluation of the effectiveness of the entire winter plan in April 2017

These evaluations will be widely shared and will be used to help inform planning for Winter 2017/18.

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