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A meeting of the Health & Social Care Integration Joint Board will be held on Monday, 19 December 2016 at 2.00pm in Committee Room 2, Scottish Borders Council.

	BUSINESS		
1.	**Announcements & Apologies**		1 mins
2.	**Declarations of Interest**		1 mins
3.	**Minutes of Previous Meeting** (Pages 1 - 4) Monday 21 November 2016		3 mins
4.	**Matters Arising** (Pages 5 - 6) Action Tracker		5 mins
5.	**Strategic**		30 mins
	(a) **Integrated Care Fund Update**	(Pages 7 - 20)	
	(b) **Annual Performance Reporting Requirements**	(Pages 21 - 34)	
6.	**Clinical & Care Governance**		10 mins
	(a) **Inspections Update**		
7.	**Governance**		10 mins
	(a) **Code of Conduct**	(Pages 35 - 56)	
	(b) **Staff Governance Arrangements**	(Pages 57 - 66)	
8.	**Finance**		45 mins
	(a) **Recovery Plan**		
	(b) **Monitoring of the Health & Social Care Partnership Budget 2016/17**	(Pages 67 - 74)	
	(c) **Further Direction of Social Care Funding - Borders Ability & Equipment Service**	(Pages 75 - 80)	
9.	**For Information**		10 mins
	(a) **Chief Officer's Update**		
	(b) **Joint Winter Plan 2016/17**	(Pages 81 - 114)	
10.	**Any Other Business**		
	(a) **Health & Social Care Integration Joint Board Development Session - 30 January 2017**		
11.	**Date and Time of Next Meeting** Monday 27 February 2017 at 2.00pm in Committee Room 2, Scottish Borders Council		

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

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Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of an Extra Ordinary meeting of the Health & Social Care **Integration Joint Board** held on Monday 21 November 2016 at 9.30am in the Board Room, NHS Borders, Newstead.

Present:	(v) Cllr C Bhatia (Chair)	(v) Mr D Davidson
	(v) Cllr J Mitchell	(v) Dr S Mather
	(v) Cllr F Renton	(v) Mrs K Hamilton
	(v) Cllr S Aitchison	Dr C Sharp
	Mrs E Torrance	Mrs E Rodger
	Mr D Bell	Ms A Trueman
	Mrs J Smith	Ms L Gallagher
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mr P McMenamin	Mrs T Logan
	Mrs A Wilson	Dr E Baijal
	Mrs J Stacey	Mr D Robertson

1. Apologies and Announcements

Apologies had been received from Mrs Pat Alexander, Mr John Raine, Cllr Graham Garvie, Mr Andrew Murray, Mrs S Manion, Mr John McLaren, Mrs Jeanette McDiarmid, Mrs Carol Gillie and Dr Angus McVean.

The Chair confirmed the meeting was quorate.

The Chair welcomed members of the public to the meeting.

The Chair advised that Mrs Elaine Torrance had been appointed as Interim Chief Officer with effect from 1 December 2016.

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 17 October 2016 were approved.

4. Matters Arising

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

5. Efficiency Savings and Recovery Action Plans

Mr Paul McMenamin gave a presentation on the current financial position. He spoke of the Health & Social Care Integration Joint Boards' delegated budget responsibility; the set aside budget; the projected financial position previously presented in August and the emerging delegated budget pressures, as well as other pressures in both NHS Borders and Scottish Borders Council.

Mr David Davidson enquired if there was a sense of priorities for action from the Executive Management Team (EMT). Mr McMenamin confirmed that the EMT had discussed in detail a number of areas under consideration and he was assured of their commitment to work in partnership to resolve the financial situation through minimising impact and maximising mitigation.

Mrs Jane Davidson commented that the matter was an in year situation and the bigger priority was to think ahead about budgeting into 2017/18 and she emphasised the commitment from EMT to ensure the right services were provided and sustained in the future.

Mrs Davidson also suggested there was a need to focus on a quicker delivery of the Strategic Plan objectives for health and social care. The Chair suggested the Health & Social Care Integration Joint Board would require advice on the issue of directions to facilitate such delivery through the EMT.

Mrs Jenny Smith reminded the Health & Social Care Integration Joint Board that the Strategic Planning Group should be engaged with in terms of seeking advice on the Strategic Plan. Mrs Smyth also suggested engaging with the third sector by seeking their thoughts on solutions to make efficiencies as she was mindful that there would be repercussions for the third sector in terms of commissioned services.

Dr Stephen Mather suggested squeezing spending further would put patient care at risk and he enquired if there was an identified point at which that squeezing would need to stop. Mrs Davidson assured the Health & Social Care Integration Joint Board that she would not compromise patient safety and she commented that she believed there were still efficiencies to be made and services that could be provided better together.

Mrs Tracey Logan echoed the commitment of a partnership approach to sustainable future services and the need to pursue the joint budgeting exercise.

Dr Cliff Sharp arrived.

Dr Mather pursued the question of there being an identified point at which patient safety would be compromised? The Chair reminded the Health & Social Care Integration Joint Board that the aim of the Strategic Plan was to shift the balance of care from acute to the community. She reminded the Health & Social Care Integration Joint Board that it was the professionals that assessed the risk to patients and therefore suggested the question could not be answered at that time.

Mrs Elaine Torrance commented that as the Chief Social Work Officer she would ask if the care being sought was absolutely necessary and suggested the broader issues would be how that was managed. She reiterated that it was a position for professionals on a daily basis to balance care requirements whilst being mindful of the financial consequences.

Mrs Karen Hamilton enquired about the next steps should the planned savings and efficiencies not be achieved. Mr McMenamin commented that whilst it was a volatile area the focus remained on what needed to be delivered against the risks and issues with partners and individuals managing their budgets and mitigating actions in order to minimise any additional pressures.

Cllr Sandy Aitchison noted that there had been a failure to deliver on the savings and efficiencies planned for the 16/17 period, and he sought clarity on the consequences of further savings and efficiencies being identified and delivered in terms of personnel, range of services offered, reduction in services, longer waiting lists for services, etc.

Mrs Davidson commented that the efficiency plan for 16/17 had contained a number of high risk areas and some of the failure of delivery had been about efficiencies and savings taking longer to realise with some not being available until the 17/18 financial period. She suggested that the EMT would be looking at pathways of care within the community setting to reduce the level of admissions to the acute sector and acknowledged that delayed discharges, surge beds remaining open and drugs costs had contributed to the difficult financial position for NHS Borders. She further commented that the EMT were committed to looking more carefully at progressing things jointly in terms of pathways, services and opportunities for efficiencies.

Cllr Aitchison urged swift action to resolve matters. Mrs Davidson commented that NHS Borders had a Mid Year Review meeting with the Scottish Government the following week and she expected to be able to furnish Mr McMenamin with more detailed information to work from following that session.

Further discussion focused on: the Health & Social Care Integration Joint Board's recovery plan; seeking assistance from the Scottish Government; ring fenced funding; funding of local government; special measures; transfer of capital to revenue; transformational approach to funding; and joined up budgeting for future years.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to append the presentation to the minutes.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation and the proposals to be brought to the next meeting in December around the integration care fund, social care fund, working together to deliver efficiencies and other savings, and agreement on the directions to be issued to partners.

6. Any Other Business

There was none.

7. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Monday 19 December 2016 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 10.40am.

Signature: ……..
Chair

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.	Elaine Torrance	2017	**Update:** Item rescheduled for 29 May 2017 Development session.	A

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	Elaine Torrance	2017	**Update:** The decision making process is being streamlined and the IJB will be made aware of the outcome when complete. It is suggested this item is removed from the Action	A

		ensure connections were made and that there was clarity as to the separate roles.			Tracker.	

Meeting held 17 October 2016

Agenda Item: Clinical & Care Governance – Integrated Joint Board Reporting

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that it would undertake a Development session on clinical and care governance.	Elaine Torrance Evelyn Rodger Andrew Murray	2017	**In Progress:** Development session to be identified.	A

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

Scottish Borders
Health and Social Care
PARTNERSHIP

INTEGRATED CARE FUND UPDATE – DECEMBER 2016

Aim

1.1 The aim of this report is to provide IJB members with an update on the partnership's Integrated Care Fund (ICF) Programme as well as seek IJB ratification of three projects.

Background

2.1 Integrated Care Funding was first allocated to the shadow partnership in 2015/16. The ICF commenced on the 1st April 2015 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of **£6.39m** over the 3 years of the programme. During this year, a number of projects were approved by the partnership through the governance structure in place at that time. Of the £2.13m allocated for 2015/16, **£224k** was spent by the partnership in 2015/16 and a further **£318k** to date in 2016/17, a combined total of **£542k** over the life of the programme to date. Analysis of the spend to date on those projects approved by the IJB is detailed in **Table 1**.

Current Position

3.1 Overall, 25 projects, projected to cost **£3,682m** have been approved as part of the ICF programme to date. In summary, these are:

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

Approved Projects		
1. Community Capacity Building	£	400,000
2. Independent Sector representation	£	93,960
3. Transport Hub	£	139,000
4. Mental Health Integration	£	38,000
5. My Home Life	£	71,340
6. Community Ward delivery(18mth pm, pso)	£	-
7. Health Care & Co-ordination (18mth pm, pso	£	-
8. Delivery of the Autism Strategy	£	99,386
9. BAES Relocation	£	241,000
10. Delivery of the ARBD pathway	£	102,052
11. Health Improvement (*phase 1*) and extension	£	38,000
12. Stress & Distress Training	£	166,000
13. Transitions	£	65,200
14. Delivery of the Localities Plan 18 mths	£	259,500
15. Locality Managers x 1 locality for 1 year	£	65,818
16. H&SC Coordination x 1 locality for one year	£	49,238

17. Community Led Support	£	90,000
18. The Matching Unit	£	115,000
19. Programme Delivery Team	£	469,626
	£	**2,503,120**

For IJB Approval		
20. RAD	£	140,000
21. Transitional Care Facility	£	941,600
22. Pharmacy Input	£	97,000
	£	**1,178,600**

Total	**£**	**3,681,720**

3.2 This represents further approved spend of **£1,178,600** since the last report to the IJB in August and the board is now asked to ratify the three further projects.

3.3 The projects that are already approved are constantly under review and scrutiny to ensure that they continue to deliver outcomes in line with the strategic plan. A programme support team is in place to support the delivery of all approved projects. The intention is to review the role of the team to enable it to continue to support the work of the ICF but also more broadly support the work regarding Integration.

3.4 Work is underway with the approved projects to ensure that their outcome monitoring is robust.

3.5 The Executive Management Team (EMT) recently reviewed all approved and pending ICF projects. EMT recommends that the Integrated Care Fund is now closed to future bids for funding and that all projects in development are placed on hold. This would leave the remaining £2.7m of the fund available for key priority areas including dementia and improving care pathways.

Update

4.1 Three projects have been approved through the ICF governance process since the last IJB report. These are:

1 – Rapid Assessment and Discharge Team (RAD)

To ensure that all patients who are frail, elderly and/or complex in functional and social care needs presenting as an emergency at the front door of the hospital (Emergency Department, Acute Assessment Unit) and who do not have a medical need for admission will be reviewed and wherever possible discharged home (£140k)

The service will provide 6-day/week rapid assessment and discharge service for patients who are frail, elderly and require functional and social care needs assessment. It will provide a consistent and robust screening and assessment process for appropriate patients and will discharge all patients who do not require admission.

- All patients will receive next-day follow-up phone call or check to prevent readmission

- The service will be fully sustainable, with 52-week cover and rotation of staff across AHP services
- The service will work to the following standards;
    - Access to RAD will be 0800-1800 Monday-Friday and 0830-1400 on Sunday
    - No patient who does not require admission is admitted due to a lack of access to appropriate therapist review
    - No patient should wait longer than 2 hours for review when service is operational and no more than 48 hours when service is not operational
    - All patents identified as able to return home through RAD assessment should be discharged home the same day
    - Readmission rates for patients discharged by AD should be 5% or less

The service to date has demonstrated the following outcomes;

- Most referrals reviewed within 2 hours
- A consistent 45% same-day discharge rate for patients referred to RAD
- An average 3 discharges per day of patients seen by RAD
- RAD is considered an integral part of the multidisciplinary front door assessment team, as per guidance from Society for Acute Medicine

There are three further expected outcomes:

- Reduce length of stay
- Increased discharges at the weekend by approximately 3 per day (this figure may be higher as there is currently no provision for assessment).
- Reduction in the number of older people for whom a hospital admission results in a loss of independence and a requirement for 24-hour care or nursing home placement

This project has requested £140k for 1 year. The project brief can be seen in **Appendix 1.**

2 - Transitional Care Facility

A Transitional Care Facility to provide short-term, directed support to individuals (over a maximum 6 week period) to enable them to return to their homes (£941,600)

The purpose of a Transitional Care Facility is to provide short-term, directed support to individuals (over a maximum 6 week period) to enable them to return to their homes. Without a facility such as this, the outcome for individuals may be increased dependency, increase packages of care and potentially residential care. A transitional unit of 16 beds is being created at Waverley Care Home (Galashiels), with works due to be completed by 31st December 2016 – these works will create 16 modern en-suite bedrooms, along with upgraded kitchen facilities, sluice facilities and nurse call system.

This project will provide the model of care for this facility for a fixed term of 24 months, commencing January 2017; a multi-disciplinary team, whose primary focus is to ensure that any individual admitted to the unit receives all the support required, enabling discharge to their own home within 6 weeks.

The multidisciplinary team will consist of GP cover, District nurses, AHP support, Social workers and care home staff.

In addition to the new model of care implementation, interim funding is requested for 2016/17 to fund the costs of maintaining 5 additional beds across each of 4 community hospitals until the new facility opens. This will cost approximately £2,300 per bed month. Whilst planned as part of the 2016/17 service and financial planning process, delayed implementation of the new facility and the maintaining of the additional community hospital beds to January 2017 will require non-recurring ICF allocation of an additional £410k.

This project has requested £482,100 in year 1 and £266,000 in year 2 and £193,500 in year 3 (Total £941,600). The project brief can be seen in **Appendix 2.**

3 - Pharmacy Input

The strategic and operational support of a Pharmacist and Pharmacy Technician to three ICF projects (Transitional Care Facility, Matching Unit and Enablement) within the Eildon Locality (£97k)

Through the development of joint training and guidelines with SBC it has become apparent that many of the issues for carers are around medicines and that advice from a member of pharmacy staff who understands the issues related to Care providers is necessary to reduce risk to patients and staff administering medicines.

The pressure on Social Care services is also felt by Pharmacy, the increasing elderly population on multiple medications results in more patients who require support to take their medicines and support reablement, promote independence and self-care. Many patients receive social care visits to support them with their medicines, currently there is no review of patient's medicines which may lead to a reduction in the number and/or need for visits and the length of visits due to the number of medicines.

Our frailest patients outside of the Hospital environment are looked after either in their own homes or in Care Homes yet this is the only location where patients do not receive regular pharmaceutical care input tailored to them as an individual.

The aim of this project is to demonstrate the benefits of providing Strategic and Operational support by a pharmacist and pharmacy technician into the following bids: Transitional Care facility, Matching Unit and Enablement within the Eildon locality. The project will also identify the resources needed to develop the support beyond the Eildon locality.

The project has identified the following outcomes:

- Reduced need for carer visits
- Reduced risk of medication errors
- Reduce in the use of compliance aids
- Ensure consistency of training and support to staff
- Reduce the risk of medicines related harm
- Link with GP's, GP staff, Practice nurses, Pharmacists in the community and hospital to deliver seamless care

This project is requesting £97k. The project brief can be seen in **Appendix 3.**

Summary

5.1 A total of **£3,682m** of the fund has been approved to date. It is proposed that the remainder of the fund be used to facilitate work on key priorities including dementia and improved care pathways. Work is progressing to ensure a more streamlined process for managing the fund is put in place for the future.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the position of the Integrated Care Fund.

The Health & Social Care Integration Joint Board is asked to **support** the closing of the fund to new bids, until further planning work is undertaken.

The Health & Social Care Integration Joint Board is asked to **ratify** approval by the Executive Management Team of 3 new projects detailed in 4.1 of this report.

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

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author(s)

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

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Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Project Name	Rapid Assessment and Discharge Team		
Project Owner	Phillip Lunts/Anne Suttle	**Application Main Contact**	Phillip Lunts
Main contact email	Liz Duffell	**Main Contact Telephone**	

Guidance on Project Brief

The purpose of this form is to give a brief outline on the key aspects of the proposal to the Integrated Care Fund 2015-18

Please refer to the accompanying guidance notes for more information on the Integrated Care Fund (ICF) when completing this document.

1	**Outline project description** *Please summarise the project in no more than 250 words*

To ensure that *all patients who are frail, elderly and / or complex in functional and social care needs* presenting as an emergency at the front door of the hospital (Emergency Department, Acute Assessment Unit) and who do not have a medical need for admission will be reviewed and wherever possible discharged home.

2	**Project's strategic fit** (see guidance notes section 2) *Which ICF local four priority areas and Scottish Government ICF principles will it meet?*

Four priority areas
(mark 'x')

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

Scottish Government ICF principles
(please describe how your project will address these)

Co-production	The service is produced in conjunction with service providers across health and social care. User feedback is an integral part of the development of the project.
Sustainability	A business case to divert resource to sustain the team function is in development
Locality	All – operates from BGH
Leverage	The model enables 30% of patients presenting to the BGH as acute medical conditions to be discharged directly home. This reduces demand for inpatient facilities and reduces potential demand for social care. The model of assessment contributes towards the development of a model of inpatient AHP support as assessment only which would allow some AHP resource to be relocated into the community.
Involvement	The model of care provision is person-centred and develops individual plans for each patient and their carers
Outcomes	Pilot work has demonstrated the ability to turn around 3 patients per day who would otherwise be admitted. The project addresses 8 of the 9 national outcomes

3	**Project Aims/ Achievements** *Please give a high level description of what will success look like?*

To provide a 6-day/week rapid assessment and discharge service for patients who are frail, elderly and require functional and social care needs assessment

Proposal

-

4 Project outcomes and benefits (see guidance notes section 3)
Please be specific about project benefits and outcomes – outcomes should be measurable

- The service will provide a consistent and robust screening and assessment of appropriate patients and will discharge all patients who do not require admission.
- All patients will receive next-day follow-up phone call or check to prevent readmission
- The service will be fully sustainable, with 52-week cover and rotation of staff across AHP services
- The service will work to the following standards;
  - Access to RAD will be 0800-1800 Monday-Friday and 0830-1400 on Sunday
  - No patient who does not require admission is admitted due to a lack of access to appropriate therapist review
  - No patient should wait longer than 2 hours for review when service is operational and no more than 48 hours when service is not operational
  - All patents identified as able to return home through RAD assessment should be discharged home the same day
  - Readmission rates for patients discharged by RAD should be 5% or less

5 What areas of the Borders will the project cover
Will the project affect the whole of the Borders or a specific locality, if so please state?

All Areas

6 Which care groups will the project affect? (see guidance notes section 4)

Frail Elderly or people with complex functional and social care needs

7 Estimated duration of project
Please provide high level milestones and including planning and evaluation time

1 year (from April 2016)

Move to 6-days/week working from November

Project completion and mainstreaming April 2017

Full evaluation April 2017

8 How much funding would the project need and how would it be spent? (see guidance notes section 5) *Please break down into individual costs*

The request is to fund:

Band 7	Team Leader	1	wte	46000	
Band 6		2	wte	76682	
Sunday Band 6 cover		0.31	wte	16539	(incl unsocial hours enhancements)
TOTAL				139221	

9 What would happen if ICF didn't invest in the project?

The service would need to be reduced or terminated	
10	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*
Reduction in demand for inpatient facilities. This forms part of the pathway for older people with acute medical illness	
11	**How would you identify/ recruit staff to support the project?**
Some staff already in post on short-term contracts. Recruitment for remaining staff.	
12	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)
No	

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

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Scottish Borders

Integrated Care Fund Project Brief

2016 – 2017

Project Name	Transitional Care Facility		
Project Owner	Murray Leys	**Application Main Contact**	Murray Leys
Main contact email	Murray.leys@scotrborders.gov.uk	**Main Contact Telephone**	

Guidance on Project Brief

The purpose of this form is to give a brief outline on the key aspects of the proposal to the Integrated Care Fund 2015-16 following discussions at the Integrated Care Fund Workshop on 27th January 2015.

Please refer to the accompanying guidance notes for more information on the Integrated Care Fund (ICF) when completing this document.

1 Outline project description

Please summarise the project in no more than 250 words

The majority of individuals leaving hospital will return to their own homes and do so without issue. However, individuals with more complex care or support needs may have experienced delirium, loss of confidence and loss of independence in hospital, making it more difficult to return home.

The Scottish Government is committed to significantly reducing the number of people awaiting a move from hospital wards to more appropriate settings. Delays in discharge from hospital can occur for a variety of reasons, but are usually due to a lack of appropriate care or services available. In order to improve outcomes for people who have been hospitalised, it is necessary to have robust systems in place to facilitate a safe and timely transition from hospital to home (e.g.) a Transitional Care Facility.

The purpose of a Transitional Care Facility is to provide short-term, directed support to individuals (over a maximum 6 week period) to enable them to return to their homes. Without a facility such as this, the outcome for individuals may be increased dependency, increase packages of care and potentially residential care. A transitional unit of 16 beds is being created at Waverley Care Home (Galashiels), with works due to be completed by 31st December 2016 – these works will create 16 modern en-suite rooms, along with upgraded kitchen facilities, sluice facilities and nurse call system.

The purpose of this ICF bid is to secure the funding to staff the transitional facility with a multi-disciplinary team, whose primary focus is to ensure that individuals admitted to the unit receive all the support required enabling discharge to their own home within 6 weeks.

2 Project's strategic fit (see guidance notes section 2)

Which ICF local four priority areas and Scottish Government ICF principles will it meet?

Four priority areas

(mark 'x')

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

Scottish Government ICF principles

(please describe how your project will address these)

Co-production	The creation of a Transitional Care Facility has been discussed at length by SBC, NHS and SB Cares colleagues and a preferred approach identified.
Sustainability	In large part, this proposal will contribute to achievement of discharge targets, but the aim is to also produce improved outcomes for individuals, increased independence and reduced levels of care packages required for them to remain in their own homes.

Locality	A Central Borders location is proposed, but this will cover the entire Borders population. It can also be used as a test of change to establish any future requirement for local provision of this nature.
Leverage	There are strong links between this proposal and the Enablement ICF bid
Involvement	The proposed 'Model of Care' has been developed by a group comprising reps from SBC, NHS and SB Cares.
Outcomes	Successful implementation will result improved outcomes for individuals, where independence is increased and long-term care requirements are reduced. Successful delivery of transitional care will also contribute to the achievement of discharge targets.

3 Project Aims/ Achievements

Please give a high level description of what will success look like?

The 'Model of Care' for the transitional facility has been developed by representatives form SBC. NHS and SB Cares. The aim of the project is to ensure that there is sufficient staffing in place within the facility to deliver this model. The facility will cater for individuals who have received hospital treatment, who now no longer need hospitalisation, but who have assessment and/or rehabilitation requirements preventing them from immediately returning to their own homes. In summary :

- Prior to submission to the facility, all individuals must have a care plan in place.
- This plan must demonstrate that each client (with support) is capable of returning to their own homes within 6 weeks.
- The care plan will be available to transitional facility staff from Day 1.
- Admission to the Transitional Facility will be controlled by the Facility manager
- Discharge form the Facility will be by agreement of the multi-disciplinary staffing team

The full detail of the 'Model of Care' will be presented separately, but the staffing requirement for the facility includes:

- GP cover
- District Nurse - [2.0 FTE]
- AHP support (OT, Physio and speech therapy) – [2.25 FTE]
- Additional care home staff
- Additional equipment from OT store

…at an estimated cost of **£258,500** per annum, and total cost to ICF, over a two-year period including project resource, of £532.0k

4 Project outcomes and benefits (see guidance notes section 3)

Please be specific about project benefits and outcomes – outcomes should be measurable

The critical success factors are:

4.1) That individuals admitted to the facility can transition back to their own homes
(Measure : % of individuals returning to their own homes within 6 weeks of admission)

4.2) That individuals who return home, stay at home
(Measure : % of transitional unit individuals readmitted to hospital within 6 months discharge)

4.3) That individuals remain as independent as they were prior to their admission to hospital
(Measure : % of transitional unit individuals requiring more care than was required prior to their admission to hospital)

5 What areas of the Borders will the project cover

Will the project affect the whole of the Borders or a specific locality, if so please state?

The Transitional facility will be based in central-Borders but will cater for individuals from Borders-wide. Proportionately central-Borders has higher hospital admissions and discharge rates than other Borders localities, making Waverley (Galashiels) an ideal location for a facility such as this.

6 Which care groups will the project affect? (see guidance notes section 4)

All adults, but particularly older people.

7 Estimated duration of project

Please provide high level milestones and including planning and evaluation time

- ICF/IJB approval : September 2016
- Staffing/recruitment : November 2016
- Full completion of Waverley (16 bedrooms) : January 2017
- Transitional Care Facility up and running : from January 2017
- Review of unit : March 2018

8 How much funding would the project need and how would it be spent? (see guidance notes section 5) *Please break down into individual costs*

The project requires revenue funding for staffing to cover:

Funding Type	2016/17 (£'000) *3mths*	2017/18 (£'000) *12mths*	2018/19 (£'000) *9mths*	
Model of care staffing	64.6	258.5	193.5	
Project Resource	7.5	7.5	0	
	72.1	**266.0**	**193.5**	**531.6k**

Notes :

- Project resource is required for initiation, communications, implementation and review.

9	What would happen if ICF didn't invest in the project?

If funding is not secured then the long-term outcomes for individuals will not improve, requiring additional resource to fund increased packages of care. There may also be risks to achievement of the Government discharge targets.

10	How would the project release resources in order to sustain the project? *What services would longer be provided or would be provided in different ways*

There are already many claims to proposed savings across Health and Social Care. However, if the Transitional Unit project delivers successfully it will impact on the budget required for commissioning flex-beds during the winter 'surge', it will impact on the budget required to fund long-term, complex packages of care and it will impact on delayed discharge. The proposed review of the unit in March 2018 will determine exactly how it has impacted on each of these areas. On the back of this, a strategic decision will be required to either allocate defined budget for the unit or to close the unit down (i.e.) to return the upstairs of Waverley to residential care.

11	How would you identify/ recruit staff to support the project?

Murray Ley's is leading on defining the 'Model of Care' and will also lead on the recruitment of staff.

12	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)

Yes - it is anticipated that project resource is required for implementation and communications

Please return this form to the Programme Team by 12pm, Friday 27th February 2015
Email: ReshapingCare@scotborders.gov.uk
Phone: 01835 82 5080

Scottish Borders
Health and Social Care
PARTNERSHIP

ANNUAL PERFORMANCE REPORTING REQUIREMENTS

Aim

1.1 The aim of this paper is to raise/increase awareness amongst IJB members of the statutory requirement for each Health and Social Care Partnership to produce and publish an Annual Performance Report.

Background

2.1 Each Health and Social Care Partnership must produce and publish an Annual Performance Report. Scottish Government Guidance (Guidance for Health and Social Care Integration Partnership Performance Reports, March 2016) notes that the purpose of the performance report is "to provide an overview of performance in planning and carrying out the integrated functions and is produced for the benefit of Partnerships and their communities".

2.2 The presentation accompanying this paper summarises the required elements of content as prescribed in The Public Bodies (Joint Working) (Scotland) Act 2014 and associated regulations.

Summary

3.1 The presentation has been given to the Strategic Planning Group (May 2016), members of the Health and Social Care Management Team (November 2016), the Localities Planning Group (6th December 2016), distributed to the Executive Management Team, and is scheduled to be given to the Transformation and Redesign Steering Group (14th December 2016), to raise awareness of this statutory requirement.

3.2 The timescales for sourcing and bringing together all the required content for the first Annual Performance Report for Scottish Borders Health and Social Care Partnership, which must be published by the end of July 2017 are tight and it is important that all Key Managers and Support Services will need to contribute to the content for the report.

3.3 The outline plan for preparation and sign off of the report has been fitted around the current schedule for IJB, EMT and other governance group meetings in 2017 and there is little slippage against key milestones

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the requirement to produce and publish an Annual Performance Report.

Policy/Strategy Implications	Compliance with the Public Bodies (Joint Working) Act 2014 and The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014.
Consultation	Scottish Borders HSCP Interim Chief Officer; and Director of Strategy for Integration.
Risk Assessment	Significant risk to publication by statutory deadline. Managers and Support Staff will need to provide key data and narrative to meet the deadline.
Compliance with requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	Resource needs to be identified and brought together to deliver this.

Approved by

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Chief Officer, Integration	Eric Baijal	Director of Strategy, Integration

Author(s)

Name	**Designation**	**Name**	**Designation**
Julie Kidd	Principal Information Analyst, NHS National Services Scotland.		

Scottish Borders
Health and Social Care
PARTNERSHIP

Statutory Annual Performance Reporting by Health and Social Care Partnerships

Summary of Requirements as set out in Law and Guidance

Key Points

Every HSCP **must** Publish an Annual Performance Report.

1st report must be **published no later** than 31 July 2017.

Required contents are set out in *The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014*

http://www.legislation.gov.uk/ssi/2014/326/contents/made

Key staff across the HSCP need to work together to produce it

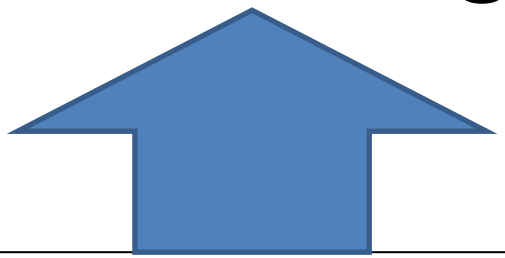
- Requires knowledge and expertise across the breadth of HSCP activities.

- It is a key opportunity to highlight both successes and challenges.

Required Report Contents: Outline

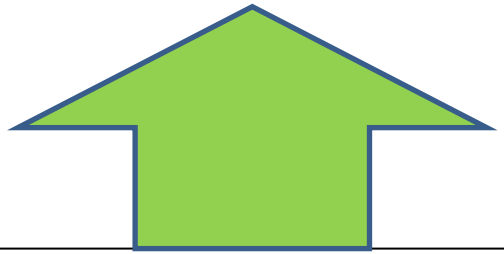
	Assessment of Performance in relation to the 9 National Health and Wellbeing Outcomes
	Financial Performance and Best Value
	Reporting on Localities
	Inspection of Services
	Review of Strategic Commissioning Plan (if applicable)

Delivery of the 9 Health & Wellbeing Outcomes



- Arrangements as set out in Strategic / Commissioning Plans (Service Delivery)
- Expenditure
- Performance against the 23 “Core Suite” Indicators set by Scottish Government
- Performance against additional Indicators set locally as part of the Performance Management Framework
- Any “significant” decisions taken by the HSCP

Financial Performance and Best Value

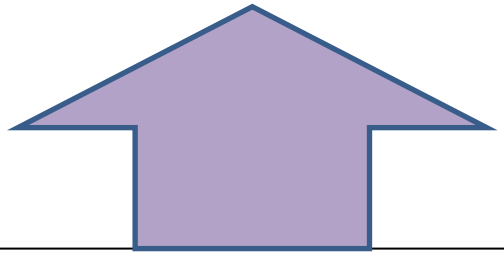


- Total spend by the Partnership.
- Spend by Service Grouping, and assessment of any under/overspend.
- Amount paid to, or set aside for, each locality.
- Has Best Value been achieved?
- Were there opportunities for further efficiencies?

Reporting on Localities

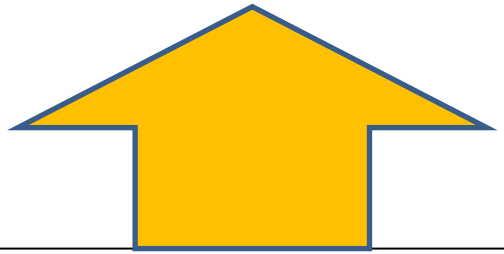
- Arrangements made for consulting and involving localities.
- Assessment of how these arrangements have contributed to the provision of services.
- Proportion of total Partnership budget spent in relation to each locality.

Inspection of Services



- Details of any inspections carried out relating to the functions delegated to the Partnership.
- For 2016/17: The Joint Inspection of Older People's Services January 2017.
- Any recommendation(s) made, alongside the actions taken by the Partnership.

Review of Strategic (Commissioning) Plan



- Required every 3 years as minimum, but a Partnership may choose to review more frequently and/or at a particular point in time.

- Performance Report to include a statement as to why the review was carried out, and describing any changes as a result.

Key Milestones

What	By When
Create APR delivery group (key managers and other staff from service delivery, finance, performance and communications)	ASAP
Prepare draft APR	Early February
Review & feedback on draft APR by groups in governance structure	Mid February – End March
Prepare final Word version of APR	Early May
EMT and IJB sign off final Word version of APR	Mid May [NB no formal IJB meeting in May]
Create graphics version of APR	End May
EMT and IJB sign off graphics version of APR	9th and 26th June (no IJB in July)
Preparation for publication incl. associated communications	No later than 31/07/2017 Statutory deadline

Links to the formal documents

- The Public Bodies (Joint Working) (Scotland) Act 2014 http://www.legislation.gov.uk/asp/2014/9/contents

- The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 http://www.legislation.gov.uk/ssi/2014/326/contents/made

- Guidance for Health and Social Care Integration Partnership Performance Reports (Scottish Government, published Wednesday, March 23, 2016) http://www.gov.scot/Publications/2016/03/4544

- Core Suite of Integration Indicators http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators

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Scottish Borders
Health and Social Care
PARTNERSHIP

CODE OF CONDUCT

Aim

1.1 To adopt the Code of Conduct for Scottish Borders Health & Social Care Integration Joint Board members.

Background

2.1 The Ethical Standards in Public life etc. (Scotland) Act 2000 provides for Codes of Conduct for local authority councillors and members of relevant public bodies. IJBs are devolved public bodies and therefore required to produce a Code of Conduct setting out how members should conduct themselves in undertaking their duties.

2.2 The Commissioner for Ethical Standards and the Standards Commission worked together to produce a template Code of Conduct for all IJBs to adopt, as per the attached. Only in exceptional circumstances can amendments be made to the Code.

Summary

3.1 On approval of the Code by the IJB, it will be submitted to the Scottish Government for formal Ministerial approval. Once Ministerial approval has been received the IJB will be required to hold and publish a Register of Interests for its members.

3.2 A Declaration of Interests Form and Guidance Notes have been worked up and will be sent to members on an annual basis for completion and return to the Board Secretary for recording and publication.

3.3 Any changes to members declarations (Section 4, paragraph 4.1) are to be notified to the Board Secretary within one month of the change.

3.4 The Code of Conduct will form part of the Code of Corporate Governance for the IJB. The current section on Codes of Conduct and Conflicts of Interest within the Standing Orders will be revised in light of the adoption of this Code of Conduct and as part of the annual refresh of the Code of Corporate Governance.

Recommendation

The Health & Social Care Integration Joint Board is asked to **adopt** the Code of Conduct for Scottish Borders Health & Social Care Integration Joint Board members.

Policy/Strategy Implications	Requirement of the Ethical Standards in Public Life, etc (Scotland) Act 2000.

Consultation	Formulated by the Commissioner for Ethical Standards and the Standards Commission.
Risk Assessment	Potential non compliance with legislative requirement.
Compliance with requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	Managed by the Board Secretary

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

CODE of CONDUCT

for

MEMBERS

of

Scottish Borders Health & Social Care Integration Joint Board

CODE OF CONDUCT for MEMBERS of
Scottish Borders Health & Social Care Integration Joint Board

CONTENTS

SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the 2000 Act", provides for Codes of Conduct for local authority Councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant Code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the Codes.

1.3 The 2000 Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councillors and a Model Code for Members of Devolved Public Bodies. The Model Code for members was first introduced in 2002 and has now been revised in December 2013 following consultation and the approval of the Scottish Parliament. These revisions will make it consistent with the relevant parts of the Code of Conduct for Councillors, which was revised in 2010 following the approval of the Scottish Parliament.

The Public Bodies (Joint Working) (Scotland) Act 2014 (Consequential Amendments & Savings) Order 2015 has determined that Integration Joint Boards are "devolved public bodies" for the purposes of the 2000 Act.

1.4 This Code for Integration Joint Boards has been specifically developed using the Model Code and the statutory requirements of the 2000 Act. As a member of Scottish Borders Health & Social Care Integration Joint Board, "the IJB", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the IJB.

This Code applies when you are acting as a member of Scottish Borders Health & Social Care Integration Joint Board and you may also be subject to another Code of Conduct.

Appointments to the Boards of Public Bodies

1.5 Whilst your appointment as a member of an Integration Joint Board sits outside the Ministerial appointment process, you should have an awareness of the system surrounding public appointments in Scotland. Further information can be found in the public appointment section of the Scottish Government website at http://www.appointed-for-scotland.org/.

Details of IJB membership requirements are set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and further helpful information is contained in the "Roles, Responsibilities and Membership of the Integration Joint Board" guidance, which also includes information on Equality Duties and Diversity.

Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present**.** In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is

crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the IJB on which you serve and of wider diversity and equality issues.

1.6 You should also familiarise yourself with how the Scottish Borders Health & Social Care Integration Joint Board policy operates in relation to succession planning, which should ensure that the IJB has a strategy to make sure they have the members in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

1.7 You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

1.8 The Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should in the first instance seek advice from the Chair of the IJB. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.9 You should familiarise yourself with the Scottish Government publication "On Board – a guide for board members of public bodies in Scotland" and the "Roles, Responsibilities and Membership of the Integration Joint Board" guidance. These publications will provide you with information to help you in your role as a member of an Integration Joint Board, and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the 2000 Act sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that will be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex A**.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

Duty
You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of Scottish Borders Health & Social Care Integration Joint Board and in accordance with the core functions and duties of the IJB.

Selflessness
You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity
You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity
You must make decisions solely on merit and in a way that is consistent with the functions of Scottish Borders Health & Social Care Integration Joint Board when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that Scottish Borders Health & Social Care Integration Joint Board uses its resources prudently and in accordance with the law.

Openness
You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

Honesty
You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of Scottish Borders Health & Social Care Integration Joint Board and its members in conducting public business.

Respect
You must respect fellow members of Scottish Borders Health & Social Care Integration Joint Board and employees of related organisations supporting the operation of the IJB and the role they play, treating them with courtesy at all times. Similarly you must respect

members of the public when performing duties as a member of Scottish Borders Health & Social Care Integration Joint Board.

2.2 You should apply the principles of this Code to your dealings with fellow members of Scottish Borders Health & Social Care Integration Joint Board, employees of related organisations supporting the operation of the IJB and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of Scottish Borders Health & Social Care Integration Joint Board.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of the IJB.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of related organisations supporting the operation of the IJB in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings. You should familiarise yourself with the Standing Orders for Scottish Borders Health & Social Care Integration Joint Board, which govern the Board's proceedings and business. The "Roles, Responsibilities and Membership of the Integration Joint Board" guidance, will also provide you with further helpful information.

Relationship with IJB Members and Employees of Related Organisations

3.3 You will treat your fellow IJB members and employees of related organisations supporting the operation of the IJB with courtesy and respect. It is expected that fellow IJB members and employees of related organisations supporting the operation of the IJB will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation and the Health Board or local authority of the IJB should be able to provide this information to any IJB member on request.

Public bodies should promote a safe, healthy and fair working environment for all. As a member of Scottish Borders Health & Social Care Integration Joint Board you should be familiar with any policies of the Health Board and local authority of the IJB as a minimum in relation to bullying and harassment in the workplace, and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules applying to the IJB regarding remuneration, allowances and expenses.

Gifts and Hospitality

3.5 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership

of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in your IJB. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;

(b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or

(c) gifts received on behalf of the IJB.

3.8 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision that Scottish Borders Health & Social Care Integration Joint Board may be involved in determining, or who is seeking to do business with your IJB, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of Scottish Borders Health & Social Care Integration Joint Board then, as a general rule, you should ensure that your IJB pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 As a member of a devolved public body, you should familiarise yourself with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of Scottish Borders Health & Social Care Integration Joint Board in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

3.12 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain or for political purposes or used in such a way as to bring Scottish Borders Health & Social Care Integration Joint Board into disrepute.

Use of Health Board or Local Authority Facilities by Members of the IJB

3.13 Members of Scottish Borders Health & Social Care Integration Joint Board must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with the Health Board or local authority policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of Scottish Borders Health & Social Care Integration Joint Board.

Appointment to Partner Organisations

3.14 In the unlikely circumstances that you may be appointed, or nominated by Scottish Borders Health & Social Care Integration Joint Board, as a member of another body or organisation, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 Members who become directors of companies as nominees of their IJB will assume personal responsibilities under the Companies Acts. It is possible that conflicts of interest can arise for such members between the company and the IJB. It is your responsibility to take advice on your responsibilities to the IJB and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the IJB's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. Annex B contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

4.3 You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

This requirement also applies where, by virtue of your employment in a particular post, you are required to be a member of the IJB.

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

4.5 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, “Related Undertakings”.

4.6 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

4.7 When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

4.8 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

4.9 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

4.10 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

4.11 Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

4.12 You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

4.13 You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

4.14 The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with the IJB of which you are a member:

(i) under which goods or services are to be provided, or works are to beexecuted; and

(ii) which has not been fully discharged.

4.16 You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) the body to which you are appointed and (b) the **nominal value** of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or

(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Code.

Category Seven: Non–Financial Interests

4.21 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the IJB to which you are appointed. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. This requirement also applies where, by virtue of your membership of a particular group, you have been appointed to the IJB.

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

5.1 The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the IJB. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions. For further detail on the declaration requirements of Scottish Borders Health & Social Care Integration Joint Board, you can refer to the IJB's Standing Orders.

5.2 IJBs inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in Scottish Borders Health & Social Care Integration Joint Board and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the **objective test** ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of Scottish Borders Health & Social Care Integration Joint Board. You will wish to familiarise yourself with your IJB's standing orders and the "Roles, Responsibilities and Membership of the Integration Joint Board" guidance.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the board chair in the first instance.

5.5 As a member of Scottish Borders Health & Social Care Integration Joint Board you might also serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between your IJB and another body. Keep particularly in mind the advice in paragraph 3.15 of this Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

5.7 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of an IJB. In the context of any particular matter you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of an IJB as opposed to the interest of an ordinary member of the public.

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest as a

- Councillor or a Member of another Devolved Public Body where the Council or other Devolved Public Body, as the case may be, has nominated or appointed you as a Member of the IJB, or you have been appointed to the IJB by virtue of your position under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;

you do not, for that reason alone, have to declare that interest.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

A member must disclose any direct or indirect pecuniary or other interest in relation to an item of business to be transacted at a meeting of the integration joint board, or a committee of the integration joint board, before taking part in any discussion on that item.

Where an interest is disclosed under the above terms the onus is on the member declaring the interest to decide whether, in the circumstances, it is appropriate for that member to take part in the discussion of, or voting on the item of business.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non-Financial Interests) of Section 4 of the Code; or

(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You do not have to declare an interest solely because you are a Councillor or Member of another Devolved Public Body or you have been appointed to the IJB by virtue of your position under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

A member must disclose any direct or indirect pecuniary or other interest in relation to an item of business to be transacted at a meeting of the integration joint board, or a committee of the integration joint board, before taking part in any discussion on that item.

Where an interest is disclosed under the above terms the onus is on the member declaring the interest to decide whether, in the circumstances, it is appropriate for that member to take part in the discussion of, or voting on the item of business.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons.

You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;

(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Code does not attempt the task of defining "relative" or "friend" or "associate". Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the IJB and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses.

There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

5.13 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

5.14 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words “I declare an interest”. The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

Frequent Declarations of Interest

5.15 Public confidence in an IJB is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss this at the earliest opportunity with their chair.

Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your IJB and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

6.1 In order for Scottish Borders Health & Social Care Integration Joint Board to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which Scottish Borders Health & Social Care Integration Joint Board conducts its business.

6.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups. You should also familiarise yourself with the “Roles, Responsibilities and Membership” guidance for members of an Integration Joint Board.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of Scottish Borders Health & Social Care Integration Joint Board or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon Scottish Borders Health & Social Care Integration Joint Board.

6.5 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of Scottish Borders Health & Social Care Integration Joint Board.

6.6 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation that is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

6.7 You should not accept any paid work relating to health and social care:-

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the IJB and its members.

This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the IJB, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

Members of Integration Joint Boards are appointed because of the skills, knowledge and experience they possess. The onus will be on the individual member to consider their position under paragraph 6.7.

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the chair of Scottish Borders Health & Social Care Integration Joint Board in the first instance.

ANNEX A

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the public body;

ii) all meetings of one or more committees or sub-committees of the public body;

(iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of that public body for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of that public body be reduced, or not paid.

Where the Standards Commission disqualifies a member of a public body, it may go on to impose the following further sanctions:

(a) Where the member of a public body is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from their public body and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(b) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX B

DEFINITIONS AND EXPLANATORY NOTES

"Chair" includes Board Convener or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking**.**

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"**Public body"** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

"Spouse" does not include a former spouse or a spouse who is living separately and apart from you.

"Undertaking" means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

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Scottish Borders
Health and Social Care
PARTNERSHIP

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
Elaine Torrance	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 joint working across NHS Borders and Scottish Borders Council on areas of integrated working, and to support relevant joint Workplace Policies as agreed by the appropriate governance bodies in both NHS Borders and SBC.

1.2 Working together will enable shared understanding, engagement with outcomes and effective service delivery. The success of integrated 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 integrated working between the Integration Joint Board (IJB) and the Trade Unions 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 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' 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 working together 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 integrated working at all levels of the organisation to assist the process of devolved decision making;
- Monitor the application 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 Health & Social Care 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 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 there is an effective risk management arrangement 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 and staff;
- 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.

6.2 A nominated deputy should be sent for each full member if that member cannot attend. Management and Staff Side representatives may attend as observers and only with prior 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 programmes, members of the Forum 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 any subgroups of the IJB in discussion with the Forum.

7.2 The Occupational Health and Safety advisors will communicate directly to the Forum on matters agreed through joint 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 the 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 joint 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 out with its terms if reference but may fall within the remit of the IJB or requires approval by individual organisations, 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 (Area Staff Side Chair, CSP, RCN, SCP, UNISON & Unite)

Management Representation:

6 Representatives from Scottish Borders Council

6 Representatives from NHS Borders

These can include HR, OH and OD

Attendees: (Ex Officio)

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

Scottish Borders
Health and Social Care
PARTNERSHIP

MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2016/17 AT 31 OCTOBER 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 October 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 This report sets out the current monitoring position on both the delegated and set-aside budgets at 31 October 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 forming a recovery plan, in addition to a recommendation for directing further non-recurring social care funding.

Overview of Monitoring Position at 30 June 2016

Delegated Budget

3.1 At 31 October 2016, the delegated budget is reporting a projected outturn of **£144.760m** against a current budget of **£139.150m** resulting in a projected adverse variance of **£5.610m** in total.

3.2 The projected financial position reports a considerable variance across the healthcare functions delegated to the Integration Joint Board, part of wider financial pressures that NHS Borders is currently projecting across its budget. For those functions delegated to the IJB, £5.232m of pressure is now being reported.

3.3 NHS Borders has developed and implemented a recovery plan in order to mitigate over £14.0m of projected financial pressure across the organisation including the £5.232m projected within the delegated budget. The delivery of this recovery plan clearly carries a significant degree of risk and accompanying this report is a

presentation on progress made to date in developing and implementing the recovery plan. Risks inherent relate in particular to the the scale of the financial savings requiring delivery, the winter timeframe over which these actions are required to continue to effect savings and the requirement to identify further actions in order to ensure that the projected variance is mitigated in full - the current recovery plan remains unbalanced by around £1.8m across NHS Borders. More strategically, the non-recurring nature of a significant proportion of targeted savings compounds this risk further.

3.4 Social care functions are currently projecting an adverse variance of £378k. It is intended that this variance will be addressed by a combination of direction of further social care funding to the Borders Ability and Equipment Service (£145k) and further management actions to reduce projected spend during the remainder of the financial year.

Older People Service

£0.376m Net

3.5 Residential care bed numbers continue to exceed the level for which there is sufficient budget although total numbers have decreased by 15 beds net since the last reported position, reducing the level of projected pressure overall.

Generic Services

£2.000m GP Prescribing

3.6 The highest single area of risk and largest adverse service variance across the delegated budget continues to be within GP Prescribing where the function is reporting an overspend of £1.027m at the end of October and a projected overspend of **£2.000m** to the year end. The current projection is based on five months' price and six months' volume information and is primarily attributable to the increased prices arising from the global short supply of certain drugs which has been particularly volatile in recent months. This financial pressure is despite considerable work to manage delivery of efficiencies and remains a significant risk going forward.

£2.406m Delivery of Efficiencies

3.7 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 on a recurring and sustainable basis. Within Generic Services, a number of targeted efficiencies are not currently projected to be delivered this financial year within the healthcare budget. Further detail is provided in section 4.

£0.658 m Other (Net)

3.8 A number of other pressures across Generic Services have emerged during 2016/17. These include staffing pressures within Allied Health Professional Services (£254k) and Primary & Community Management, including the use of flex beds, (£317k) and the further requirement to purchase more equipment for the Borders Ability Equipment Store (£145k). Pressure is also projected within Community Hospitals (£200k) due to the cost of agency nurses required currently. An element

of these pressures and other less significant pressures across this service area have been part-mitigated by savings within Community Nursing (£150k).

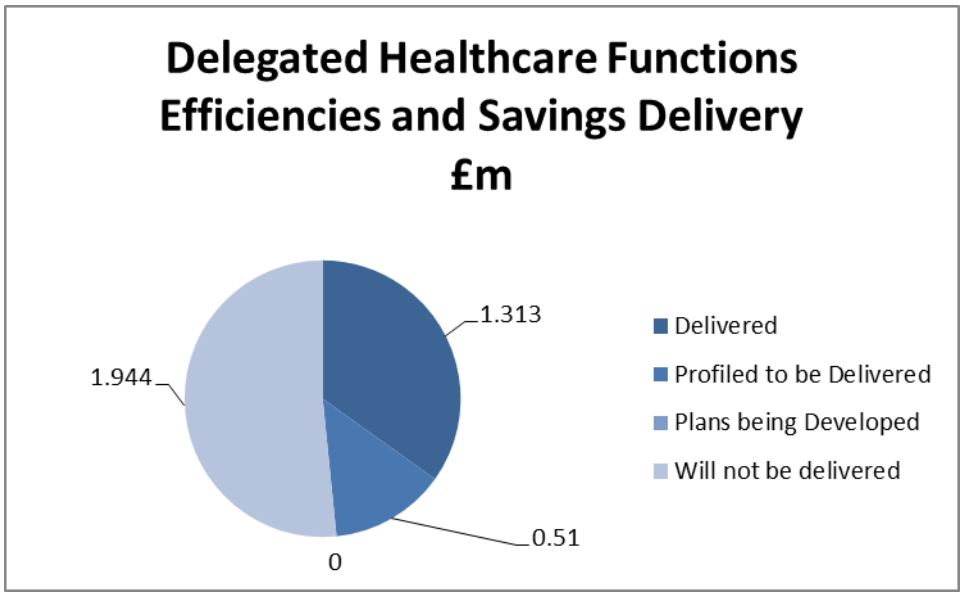
Set-Aside Budget

3.9 As previously reported in August and October, 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. These pressures continue and relate to a range of factors including the costs of continued provision of Surge Beds (£1.200m), Patient Flow (£900k), Acute Admissions Unit and Emergency Department staffing (£500k) and the non-delivery of planned efficiencies similar to the challenge over those supporting the delegated budget.

Delegated Budget Efficiency and Savings Delivery

Healthcare – Delegated Budget

4.1 Within the budget delegated to the partnership, NHS Borders needs to deliver £4.239m of efficiency savings. £3.767m of the savings was targeted within savings plans with an unidentified element of £472k. Overall, £3.3m of this total (77%) is required on a recurring basis. Progress against these targets at 31 October is summarised below:



4.2 At 31 October 2016, £1.313m has been delivered. Within this, £1.033m is recurring and £0.280m is non-recurring.

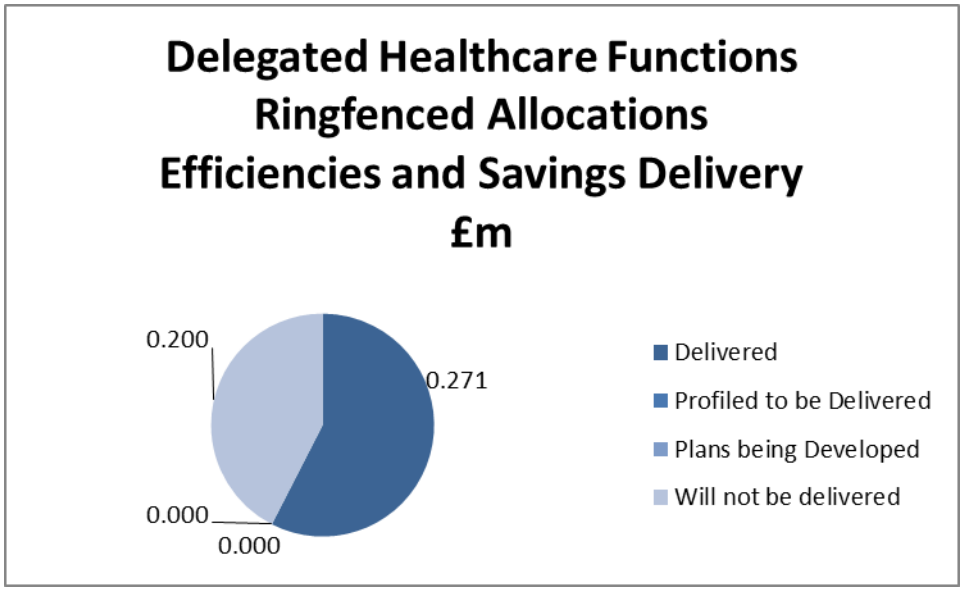
4.3 Of the remaining £2.454m gap, £0.510m is profiled for delivery over the remainder of the year:

	£'000
Step up/down	410
Service Management	100
	510

4.4 Of the £3.767m, total efficiency savings therefore 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 are now being developed as part of the NHS Borders recovery plan. Notably however, permanent recurring solutions will require development and implementation beyond the in-year actions in order to ensure future years' financial plans are deliverable. This will include an assessment of those schemes which have failed to deliver in the current year, and an evaluation of their likely delivery in the future

Health Care – Devolved Budget Efficiencies (Ringfenced Funding)

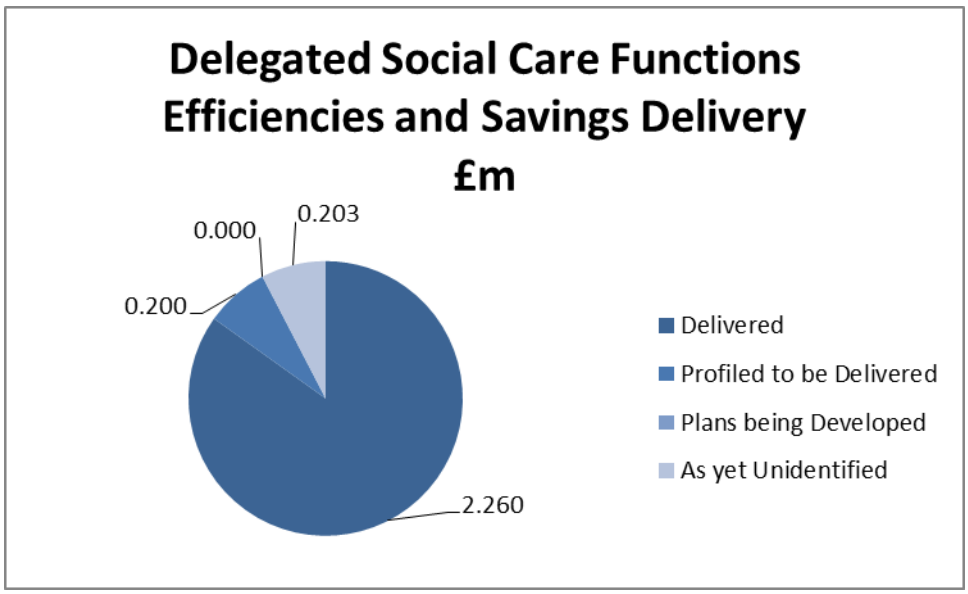
4.5 Within the budget delegated to the partnership by NHS Borders, a further gap of £0.471m was delegated in respect of reductions in ringfenced grant funding through NHS Borders by the Scottish Government. At the IJB meeting of 20 June, the partnership approved direction of £220k of social care funding to mitigate the forecast reduction allocated to the Alcohol and Drug Partnership (ADP), with a further plan for efficiencies of £51k having been delivered by the partnership. This arrangement is non-recurring and only applies in 2016/17. The ADP is continuing to work on how this reduction can be managed recurrently. .



4.6 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

4.7 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 October, £2.260m of savings have been delivered, with a further £0.200m profiled to be delivered during the remainder of 2016/17. The balance of undelivered planned savings will be met by the delivery of remedial savings identified during the financial year which will be delivered over the remaining 5 months of the financial year.



4.8 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 be delivered permanently also from this year. (*Please note: this is a different "£378k" from the figure projected as the current adverse social care position per appendix and relates to historic savings targets unmet*). Plans are now in place for their delivery which is now projected in full during the remainder of the year.

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 at 31st October 2016.

The Health & Social Care Integration Joint Board is asked to **note** NHS Borders recovery plan presented alongside this report

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 2016

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 in order that the recovery plan implemented is fully balanced

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
Elaine Torrance	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	IJB Chief Financial Officer		

MONTHLY REVENUE MANAGEMENT REPORT

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

	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**	**11,283**	**10,717**	**566**	**18,678**	**18,648**	**30**	**52**	**20**	**20**	
Joint Mental Health Service	**15,977**	**9,146**	**9,276**	**(130)**	**16,019**	**16,291**	**(272)**	**352**	**316**	**315**	
Joint Alcohol and Drug Service	**948**	**419**	**444**	**(25)**	**948**	**928**	**20**	**3**	**3**	**3**	
Older People Service	**28,126**	**14,275**	**9,431**	**4,844**	**26,735**	**27,111**	**(376)**	**23**	**0**	**0**	
Physical Disability Service	**3,180**	**1,929**	**1,974**	**(45)**	**3,321**	**3,269**	**52**	**0**	**0**	**0**	
Generic Services	**72,651**	**43,626**	**44,893**	**(1,267)**	**73,449**	**78,513**	**(5,064)**	**604**	**516**	**520**	
Total	**139,150**	**80,678**	**76,735**	**3,943**	**139,150**	**144,760**	**(5,610)**	**1034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	29,148	24,023	5,125	51,798	52,176	(378)				
NHS Funding from Sgovt etc	87,352	51,530	52,712	(1,182)	87,352	92,584	(5,232)				
Total	**139,150**	**80,678**	**76,735**	**3,943**	**139,150**	**144,760**	**(5,610)**				

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Scottish Borders
Health and Social Care
PARTNERSHIP

FURTHER DIRECTION OF SOCIAL CARE FUNDING – BORDERS ABILITY AND EQUIPMENT SERVICE

Aim

1.1 The aim of this report is to seek agreement by the Integration Joint Board (IJB) of a proposal to direct further social care funding to meet ongoing projected financial pressure within the partnership's joint Borders Ability and Equipment Service budget, on a one-off, non-recurring basis.

Background

2.1 The Borders Ability and Equipment Service (BAES / "the store") is a joint service which is included within those functions that have been delegated to the partnership. The annual recurring budget for the operation of 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 just over £300k, with the remainder (£467k) meeting staffing costs, premises expenses, transport and other operational costs such as equipment sterilisation.

2.2 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. This has been the case also this financial year and the IJB has already agreed the direction of a further £150k of social care funding at its meeting of 17 October.

2.3 Average monthly equipment purchases totalling almost £50k per month has continued since the additional funding was directed. The base budget therefore was largely consumed during the first 6 months of the year and at the current projected expenditure profile, the additional funding directed is projected to be fully utilised shortly. As a result therefore, IJB members are asked to consider further additional funding in order to sustain the activity of the store until a number of actions are undertaken and implemented during the remainder of the financial year aimed at reducing this expenditure profile.

Store Operation

3.1 The base budget for equipment in the store is £301k. This has been temporarily increased to £451k this year by the non-recurring direction of £150k social care funding. A profile of the levels of actual and committed expenditure against this budget is detailed below:

	2016						
	Apr	May	Jun	Jul	Aug	Sep	
	£	£	£	£	£	£	
Actual expenditure	15,181	78,278	40,037	30,097	87,893	57,142	
Commitments (orders placed)							
Total actual and committed expenditure	15,181	78,278	40,037	30,097	87,893	57,142	

	2016			2017			
	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£	£	£	£	£	£	£
Actual expenditure	32,041	23,500					364,169
Commitments (orders placed)		33,762	11,491	11,491	11,490	11,490	79,724
Total actual and committed expenditure	32,041	57,262	11,491	11,491	11,490	11,490	443,893
Total budget allocation							451,356
Remaining uncommitted budget as at 30/11/2016							7,463
Average spend per month Apr to Nov							**49,741**
Estimated annual spend to March 2017							**596,897**
Estimated additional budget allocation required to end Mar							**145,541**

3.2 In 2015/16, the equipment budget required £233k of additional resource to be made available in-year. An increase of £295k in-year as required for 2016/17 represents further increased financial pressure on this budget.

3.3 The stock ordering system used to order BAES equipment is ELMS. Currently, there are over 400 users set up within ELMS who have access and ability to make orders. These users come from a variety of professional and organisational backgrounds including district nurses, occupational therapists, physiotherapists, community care assessors, para-professionals and social workers.

3.4 During 2015/16, 13,819 items were ordered by BAES. This, and prior year trends, can be summarised as:

			Total Value			
	No. of Orders		NHSB	SBC	Total	
Year	NHSB	SBC	£	£	Orders	£
2012/13	10,428	5,091	920,719	491,568	15,519	1,412,287
2013/14	10,362	4,279	851,716	515,434	14,641	1,367,150
2014/15	9,445	4,418	667,009	461,452	13,863	1,128,461
2015/16	9,736	4,083	605,140	449,920	13,819	1,055,060

3.5 As can be seen from above, the proportionate split in terms of orders made is consistently around 2:1 NHSB/SBC. In cost terms, there is a closer correlation towards a 50/50 position, although still weighted towards NHS Borders issues costing more in total. In general, there are a lower number of orders made on behalf of social care staff, at a higher average cost per item. NHS staff tend to generally order more standard items of equipment, particularly in relation to enable patients to be discharged from hospital, whereas social care staff will order items, some requiring adaptation which may be of a higher value, e.g. to enable a client to return to or remain at home. The average cost of an NHS-ordered item has fallen from £88

in 12/13 to £62 in 15/16 whilst the average cost of an SBC-ordered item has risen from £97 to £110 over the same period.

3.6 It is also worth noting that the above relates to all equipment including recycled equipment and not just new equipment, hence the significantly higher order numbers compared to the level that the budget can afford for new purchases.

3.7 At the present time, around 45,000 items of equipment are on issue from BAES across the Scottish Borders. These items of equipment have been acquired over many years at a total cost of £3.6m and are provided to over 12,000 clients. 80% of the volume of these items are “core” (generally lower value, commonly used items which don’t require specific adaptation such as crutches, Zimmer frames and commodes) whilst 20% are “non-core. In terms of value however, the cost split is nearer 50/50 between core and non-core items due to the general specialist nature and higher average cost of the latter type of item which includes things like specialist ceiling-mounted hoists, stair-lifts, specialist chairs and paediatric equipment.

3.8 Non-core stock may not always be held in store. There may be a lead time in receiving non-core items and making them ready for use in a particular setting. The key distinction is that BAES will always maintain available stock for core items. This will not always be the case for non-core items.

3.9 In addition to the main BAES store, there are 18 satellite stores situated mainly within NHS Borders’ facilities. Satellite stores tend to hold small volumes of low-value equipment totalling £300-£500 per store, although there are 5 larger stores which hold equipment of around £2-3k in value. Anecdotal concern has regularly been raised with regard to stock control and issue across satellite stores. Given the relatively low value of stock held within them however, whilst any control weaknesses will still require improvement, this does not appear to be a key driver of the ongoing financial pressure experienced within the equipment budget.

Areas for Consideration Going Forward

4.1 The service provided by the Borders Ability and Equipment Store is a fundamental enabler to the Health and Social Care Partnership’s Strategic Plan. Many people live in the Scottish Borders with one or more long-term conditions or with disability or sensory impairment. Flexible support to these people in order that they maintain and improve their quality of life through supporting their independence and their ability to live at home can only be achieved through the provision of an effective and affordable ability and equipment store. Providing the right equipment, at the right time to clients who need it has a direct impact on reducing avoidable admissions to hospital and supports prevention and early intervention where people are struggling to manage independently.

4.2 With this focus therefore, coupled to a growing ageing population, demand for the BAES will continue to increase which puts further financial pressure on limited resources, exacerbated by ongoing constraint over public-sector funding. Against this increasing demand and cost backdrop therefore, it is vital that the cost-effectiveness of the store is maximised, that it is adequately resourced and that its service provision becomes more affordable and that its ongoing operation is

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sustainable, if the partnership is to achieve the aims it has expressed within its Strategic Plan.

4.3 Review of the service is clearly required however 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 current levels of demand, demand which is likely to increase further in the future. Until the outcomes of the review are known however, it is not proposed to recommend direction of funding any permanent increase in the equipment budget.

4.4 At present, an officer working group is reviewing some immediate areas concerning the store's operation including levels of authorisation and how equipment is currently issued and its recording. NHS National Shared Services has been commissioned by this group to undertake a wider review of the operation of the store and a report is expected in January 2017. Key areas of focus of the review which have been agreed include:

- Recycling equipment – evaluation against best practice
- Financial control best practice and models from other areas
- Stock control
- Systems and processes
- Authorisation
- Managing demand in the Scottish Borders whilst meeting expectation
- Provision of high cost equipment and therapeutic benefit

4.5 On completion, the review findings will form part of a wider report to the IJB in early 2017 in order that a new, more affordable model of delivery underpinned by more effective and efficient processes and controls is implemented before the start of the new financial year.

4.6 This report will build on the work currently being undertaken and will include other considerations. Some of these are specific in their detail such as the outcome from an equipment amnesty or the cost-effectiveness of renting beds as opposed to outright purchase or more general in nature such as the impact of the newly implemented protocol for the issue of non-core stock equipment from the store. How remaining funding options such as Integrated Care Fund can be utilised on a spend-to-save basis to enable greater cost-effective service delivery will also be a key consideration.

Social Care Funding

5.1 To date, the IJB has directed £4.445m of the partnership's 2016/17 social care funding allocation (£5.267m). On a permanently recurring basis, £5.088m has been committed. How the partnership has directed funding to date is summarised 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**
17-Oct-16						
Surge Beds	0	0	500	0	500	0
Night Support Sleep-ins	0	750			0	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 Directed to Date	**3,945**	**5,088**	**500**	**0**	**4,445**	**5,088**
2016/17 Allocation					**5,267**	**5,267**
Remaining Resources					**822**	**179**

5.2 If the IJB approve direction of a further **£145k** of social care funding towards the BAES equipment budget, then this will leave **£677k** of funding uncommitted this year, of which £179k is available on a recurring basis:

2016/17 Allocation	**5,267**	**5,267**
Remaining Resources	**677**	**179**

5.3 It is anticipated that further implications of the implementation of the living wage from 1st October 2016 and the uncertain outcome of the work currently being undertaken in respect of re-provisioning the night support sleep-in service will fully utilise this remaining uncommitted funding going forward.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and **approve** the direction of a further £145k non-recurring allocation of social care funding to the BAES equipment budget for utilisation during the remainder of 2016/17.

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**
Elaine Torrance	Chief Officer		

Author(s)

Name	**Designation**	**Name**	**Designation**
Paul McMenamin	IJB Chief Financial Officer		

Scottish Borders
Health and Social Care
PARTNERSHIP

JOINT WINTER PLAN 2016/17

Aim

To present the approved NHS Borders and Scottish Borders Council Joint Winter Plan 2016-17 to the Board for noting.

Background

The final Winter Plan was required to be submitted to Scottish Government by 31st October 2016.

Summary

The Joint Winter Plan outlined the range of measures proposed to manage predicted increased activity during the winter period.

The Scottish Government issued a self-assessment template for Boards to test winter planning preparedness. This was undertaken.

A risk assessment was completed and highlighted risks to delivery of the Winter Plan and mitigating actions to minimise those risks.

The implementation plan which underpins the Winter Plan is well underway. It should be noted the implementation plan is a dynamic document and will be amended in light of emerging issues and operational constraints. The delivery of the Winter Plan is overseen by a Winter Planning Board, chaired by the Chief Officer.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the final approved Joint Winter Plan 2016/17.

Policy/Strategy Implications	Request from the Scottish Government that a whole system Winter Plan is developed and 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 Clinical Executive Operational Group, Strategy and Performance Committee, SNC Corporate Management Team and Integrated Joint Board.
Risk Assessment	Completed

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	The Winter Plan presents no additional financial implications. Staffing requirements within the Winter Plan have been progressed.

Approved by

Name	Designation	Name	Designation
Evelyn Rodger	Director of Nursing, Midwifery and Acute Services	Elaine Torrance	Chief Officer

Author(s)

Name	Designation	Name	Designation
Phillip Lunts	General Manager for Unscheduled Care		

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Winter Plan 2016/17

Status: Approved

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
    - 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	Weekend Discharge project underway with target of matching	G

discharge team	weekend admissions and discharges by October 2016	
Build on the proactive recruitment strategies to minimise staffing vacancies going into winter	Nurse recruitment events 2-monthly.	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 physiotherapists and occupational therapists 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
- Make provision to 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. There will however be contingency plans in place to create additional capacity in times of extreme pressure.

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. 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 fill the staff vacancies that are predicted to occur between November and March due to normal staff turnover and to be in a position to cover any additional staffing demands. 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 subject to approval of a separate business case. 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,

- Review and redesign 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
- Review daily patients who have been in hospital for more than 28 days as a focus for complex discharges

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 20 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
- Provide similar intensive monitoring and support to Community Hospitals in managing complex discharges as will be provided in the BGH

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 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.

Pro-active recruitment has been developed and staffing is now being monitored on a daily basis to more effectively utilised.

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 restricted annual leave allocated during the 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.

Details of festive period arrangements are being compiled together with details of how each service will address any increased demand as a result of the festive period.

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. The scorecard will be based on data that reports on demand for services across the whole system and the resource available to deliver these services
- 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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