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HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD MONDAY, 7TH MARCH, 2016

A MEETING of the HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD will be held in the COUNCIL CHAMBER, COUNCIL HEADQUARTERS, NEWTOWN ST BOSWELLS on MONDAY, 7 MARCH 2016 at 9.30 am

AGENDA			
1.	**ANNOUNCEMENTS & APOLOGIES**		2 mins
2.	**Formal Establishment of the Scottish Borders Health & Social Care Integration Joint Board** (Pages 1 - 4)		8 mins
3.	**Formal Appointment of Chief Officer** (Pages 5 - 6)		5 mins
4.	**Appointment of Interim Chief Financial Officer** (Pages 7 - 18)		10 mins
5.	**DECLARATIONS OF INTEREST**		5 mins
6.	**MINUTES OF PREVIOUS MEETING** (Pages 19 - 26) Monday 1 February 2016		5 mins
7.	**MATTERS ARISING** (Pages 27 - 28) Action Tracker		5 mins
8.	**GOVERNANCE**		
	8.1 **Code of Corporate Governance** • Standing Orders • Clinical & Care Governance • Risk Management Strategy	(Pages 29 - 122)	15 mins
	8.2 **Workforce Planning Framework**	(Pages 123 - 126)	10 mins
9.	**STRATEGIC**		
	9.1 **Health & Social Care Strategic Plan**	(Pages 127 - 188)	10 mins
10.	**FINANCE**		

	10.1 **Monitoring of the Integration Joint Budget 2015/16**	(Pages 189 - 202)	10 mins
	10.2 **Health & Social Care Integration Integrated Resources Advisory Group**	(Pages 203 - 230)	10 mins
	10.3 **Financial Statement (supporting the Strategic Plan) and Assurance over the Sufficiency of Resources**	(Pages 231 - 246)	10 mins
11.	**FOR INFORMATION**		
	11.1 **Chief Officer's Report**	(Pages 247 - 250)	10 mins
	11.2 **Committee Minutes**	(Pages 251 - 256)	5 mins
12.	**ANY OTHER BUSINESS**		5 mins
13.	**DATE AND TIME OF NEXT MEETING** Monday 18 April 2016 at 2.00 pm in Committee Room 2, Scottish Borders Council		

FORMAL ESTABLISHMENT OF THE SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

Aim

To advise the Health & Social Care Integration Joint Board of the legal establishment of the Scottish Borders Health & Social Care Integration Joint Board.

Background

The Integration scheme is the document by which the Health Board and Local Authority outline how the legislation, Public Bodies (Joint Working) Act 2014, is to be complied with. Specifically the Integration Scheme must state which model of integration the Health Board and the Local Authority have agreed to apply (delegated authority to an Integrated Joint Board or a lead agency model), the functions to be delegated in accordance with that model and the scope agreed.

The Integration Scheme is the means by which the Health Board and Local Authority give an assurance that they will meet the legislative requirements.

The agreements within the Integration Scheme are legally binding and any changes will require to be consulted upon and submitted to Scottish Ministers for approval.

Summary

The Scottish Borders Health & Social Care Integration Scheme was submitted to Scottish Ministers on 17 December 2015 and received Cabinet Secretary approval on 18 December 2015 (Attachment 1).

An Order to establish the Integration Joint Board was laid in the Scottish Parliament on Friday 8 January 2016 for 28 days. From Saturday 6 February 2016 the Scottish Borders Health & Social Care Integration Joint Board was legally established.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the legal establishment of the Scottish Borders Health & Social Care Integration Joint Board.

Policy/Strategy Implications	Compliance with the Public Bodies (Joint Working) Act 2014
Consultation	As detailed within the scheme
Risk Assessment	A risk register is kept as part of the overall programme of work.
Compliance with Board Policy requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	As detailed within the scheme.

Approved by

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

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

Health and Social Care Integration Directorate
Integration and Reshaping Care Division

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To:
Jane Davidson
Chief Executive, NHS Borders

Tracey Logan
Chief Executive, Scottish Borders Council

CC:
Susan Manion
Chief Officer, Scottish Borders Integration Joint Board

21 December 2015

Dear Colleagues

Approval of integration scheme under section 7(2)(a) of the Public Bodies (Joint Working) (Scotland) Act 2014 ('the Act')

I write to provide notification that the Cabinet Secretary for Health, Wellbeing and Sport has approved your Integration Scheme and the responsibilities of the Chief Officer in terms of section 10(7) of the Act, as set out in your Scheme.

The Order to establish the Integration Joint Board will be laid in the Scottish Parliament on Friday 8 January and will lie in Parliament for 28 days before coming into force on Saturday 6 February 2016. From Saturday 6 February 2016 the Integration Joint Board for the area of Scottish Borders Council will be legally established.

I would like to take this opportunity to thank you for working with us to reach this milestone, and I look forward to continuing to work with you over the coming months.

Yours faithfully

Frances Conlan
Policy and Strategy Team Leader

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FORMAL APPOINTMENT OF CHIEF OFFICER

Aim

1.1 To formally appoint the Chief Officer, Health & Social Care Integration.

Background

2.1 The order to establish the Scottish Borders Health & Social Care Integration Joint Board has now been approved. The Integration Joint Board is now asked to formally appoint to the Chief Officer post.

2.2 The Chief Officer, Health & Social Care Integration remains as a permanent employee of the substantive employing organisation in terms of employment terms and conditions.

Summary

3.1 The current incumbent, Susan Manion, is technically seconded from Borders Health Board to the Health & Social Care Integration Joint Board to fulfil the role of the Chief Officer.

Recommendation

The Health & Social Care Integration Joint Board is asked to formally **approve** the appointment of Susan Manion as Chief Officer, Health & Social Care Integration.

Policy/Strategy Implications	Compliance with the Public Bodies (Joint Working) Act 2014
Consultation	N/A
Risk Assessment	As detailed within the Scheme of Integration.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	N/A

Approved by

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

Author(s)

Name	Designation	Name	Designation

Iris Bishop	Board Secretary		

APPOINTMENT OF INTERIM CHIEF FINANCIAL OFFICER

Aim

1.1 To appoint the Interim Chief Financial Officer to the Scottish Borders Health & Social Care Integration Joint Board.

Background

2.1 The order to establish the Scottish Borders Health & Social Care Integration Joint Board has now been approved. The Integration Joint Board is now asked to appoint to the Interim Chief Financial Officer, Health & Social Care Integration Joint Board post.

2.2 A copy of the Job Description for the role is enclosed at attachment 1. The Job Description has been approved by both Scottish Borders Council and Borders Health Board, Human Resources Departments.

Summary

3.1 It is proposed that Paul McMenamin be seconded from Scottish Borders Council to the Interim Chief Financial Officer, Health & Social Care Integration Joint Board post for a period of six months with effect from 01.03.16 to 31.08.16.

3.2 During the six month secondment period, the formal recruitment and appointment process will be carried out, so that a substantive appointment can be made in the autumn.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the appointment of Paul McMenamin to the role of Interim Chief Financial Officer, Health & Social Care Integration Joint Board on a six month secondment basis.

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

Approved by

Name	Designation	Name	Designation
Cllr Catriona Bhatia	Chair, Health &		

	Social Care Integration Joint Board		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

INTEGRATION JOINT BOARD (IJB) – CHIEF FINANCIAL OFFICER ROLE

1. JOB IDENTIFICATION	
Job Title:	**Chief Financial Officer – Integration Joint Board (IJB)**
Reporting to:	Chief Officer – Integration Joint Board
Accountable to :	Integration Joint Board
Professionally Accountable to:	Chief Financial Officer (SBC) and Director of Finance (NHS)

2. JOB PURPOSE

- Is a key member of the leadership team, accountable to the Integration Joint Board for the planning, development and delivery of the IJB's three year financial strategy linked to the achievement of the Strategic Plan;
- Is responsible for the provision of strategic financial advice and support to the Integration Joint Board and Chief Officer and for the financial administration and financial governance of the IJB;
- The post holder is the senior professional financial advisor to the Integrated Joint Board and is the Accountable Officer for financial management and administration of the IJB. The Chief Officer has all other accountable officer responsibilities. The Chief Financial Officer's responsibility includes assuring probity and sound corporate governance and responsibility for achieving Best Value.

3. DIMENSIONS

The Chief Financial Officer :

- will work with the Chief Officer to establish, plan, develop and implement a business and financial strategies to resource and deliver the IJB's strategic objectives sustainably and in the public interest;
- will in collaboration with the Chief Officer put in place arrangements to finance the agreed strategic outcomes of the IJB
- is responsible for developing the financial strategy and financial governance arrangements of the IJB;
- must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term financial implications, opportunities and risks are fully considered, and alignment with the IJB's financial strategy; and
- must lead the promotion and delivery by the IJB of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively.
- is responsible for creating, in conjunction with related Local Authority (LA) and Health Board (HB) Directors of Finance, a collaborative arrangement with Business partners and associated Chief Financial Officers within the related Board Area(s).

The Budget under direct financial management is £136m, and the funding under control of the strategic plan is £156M.

4. KEY RESULT AREAS

Developing and implementing Organisational Strategy

- Ensure the delegated resources specified within the Strategic plan are deployed to deliver the outcomes agreed
- Provide a strategic financial focus and advice to the IJB
- Ensure that the directions to the Health Board and Local Authority require that the financial resources are spent in accordance with the Strategic Plan.
- Establish a process of regular monitoring of the financial performance of the IJB budget in conjunction with the Health Board and Local Authority Directors of Finance to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole
- Ensure regular comprehensive budget monitoring reports are prepared for the IJB
- Develop business cases for changes to delegated resource budget in line with the strategic plan to improve outcomes for patients carers and service users in conjunction with the Chief Officer
- Work collaboratively with the Partnership Senior Management Team to achieve the objectives of the IJB.
- Assist the Chief Officer and Senior Managers to deliver change and improvement through service redesign.
- Identify priority areas for action and contribute to policy development to address these in the short, medium and long-term in a way which draws on a sound theoretical base and personal experience and knowledge of financial management.
- Supporting the Chief Officer to ensure efforts within the Partnership are co-ordinated to improve health, reduce inequalities, improve health and social care services, and increase social inclusion based on the user's journey.

Responsibility for Financial Strategy

- Take a lead role in the compilation of the IJBs financial strategic plan and annual revenue budget
- Prepare strategic scenario planning to allow the IJB to be able to approve a balanced financial plan/budget
- Provide expert advice on policy, legislative and accountancy developments
- Production and management of the IJB's Financial Plans in terms of processes and outcomes ensuring compliance with relevant regulations and local and national requirements and timescales.
- Liaise and provide finance advice and guidance on all aspects of planning and performance out with the partnership including statutory agencies, community planning partnerships and other Health and Social Care partnerships.
- Develop and implement Financial Planning for all areas of the IJB

Influencing Decision Making

- Responsible for ensuring effective liaison and working relationships with all financial functions within the Health Board, Council and other partnerships.
- Contribute to relevant wider NHS, Council and Community Planning Partnership Strategy.
- Contribute to the delivery of a comprehensive and coherent performance management system, facilitating real performance improvement across the Partnership, reducing duplication and delivering excellence in governance.

Financial Information for Decision Makers

- Deliver professional, consistent and appropriate financial management advice across the Partnership, in line with statutory accounting guidance and regulations

Value for Money

- Responsibility for value for money assessment contributing to the IJB's Strategic Plan, playing a key role in the production and development of the plan.
- Monitor and advise on the strategic financial implications/considerations of Best Value.

Safeguarding Public Money

- Manage all aspects and take a lead role in the development of financial governance, control and compliance, management of risk, and deliver a comprehensive financial management system for the IJB.

Assurance and Scrutiny

- Plan, monitor, co-ordinate and ensure completion of the annual closure of the Partnership's accounts and the production of the annual financial statements, ensuring compliance with statutory reporting requirements required by Local Authority/ NHS group accounts .
- Establish procedures in conjunction with the Health Board accountable officer and Local Authority Section 95 Officer to allow the best practice principles set out in the Code of Guidance on Funding External Bodies and Following the Public Pound to be followed.;
- Act as point of contact with the External Auditor in respect of the audit of the IJB's financial statements and liaising with them during this process.
- Receive assurance from Health Board and LA Directors of Finance re anti-fraud measures within their organisations and to develop and necessary local procedures to monitor anti-fraud measures designed to reduce risk.
- Ensure that Financial Risk Management is properly addressed within the Integration Joint Board.

4. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB

- Educated to degree level or equivalent with significant financial experience at senior management level within a large complex organisation, preferably within the NHS or Local Authority.
- CCAB, CIMA or overseas equivalent Qualified Accountant
- Strong negotiating and communication skills
- Practical experience of applying relevant strategic business and financial support tools.

- Demonstrate a track record in collaborative working that produces results.
- Demonstrate leadership and influencing skills and have a proven track record in developing structures and/or systems to support the attainment of organisational goals.
- Demonstrate integrity and effective management skills necessary to enable the successful delivery of redesign programmes to improve services.
- Ability to develop and maintain effective, positive relationships with key partner organisations at a national as well as local level providing a positive role model for partnership, relationship and conflict management.

PERSON SPECIFICATION

Factor	Essential
Qualifications and/or experience	• Degree in a relevant subject or equivalent qualification. • Membership of a CCAB professional body, CIMA or overseas equivalent. • Evidence of continuing, relevant, professional and personal development. • Extensive experience in a senior role within a complex or multi-agency / disciplinary financial management environment, with practical experience of applying strategic planning and performance tools. • Leadership and influencing skills. • Proven track record in collaborative working that produces results within dynamic, and participative decision making environments. • Proven track record in developing structures and systems to support the attainment of organisational goals.
	Desirable
Qualifications and/or experience	• Experience of overseeing the production of annual accounts for a large/complex organisationExperience of working at a senior level in a political environment within health service and/or local authority.
	Essential
Knowledge	• Detailed knowledge of relevant policy change in Scotland, particularly in relation to the business support element of health and social care. • Detailed knowledge of development agenda facing Health and Social Care Partnerships. • Comprehensive knowledge of tools and techniques for strategic financial support and development. • Critical appraisal skills. • Highly effective numeracy/ data interpretation, analysis and presentation skills.
Attributes	• Demonstrable and facilitative leadership skills. • Excellent communication and inter-personal skills, including sensitivity, tact and political astuteness. • Honesty, integrity and with high professional standards • Self-starter.

	• Values driven. • Team player. • Ability to work on own initiative.
Training	• Record of continuous professional development (CPD).

ROLE OF THE CHIEF FINANCIAL OFFICER FOR AN INTEGRATION JOINT BOARD

INTRODUCTION

This paper outlines the background to the **role** of the Chief Financial Officer for an Integration Joint Board and describes the proposed role that the Chief Financial Officer must fulfil to meet their professional obligations. Each Integration Joint Board will be responsible for the appointment of its Chief Financial Officer.

This paper has been prepared from two main sources:

1. CIPFA Statement on the Role of the Chief Financial Officer in Local Government. There have been amendments to this following discussion with IRAG to ensure that they are focussed on the requirements of the Integration Joint Board.

2. Professional Guidance, Advice and Recommendations for Shadow Integration Arrangements – as approved by IRAG. IRAG paper of May 20, 2014 outlined these core financial duties which have been included in the role of the Chief Financial Officer.

Following the discussion of this role at the May IRAG meeting, areas which required policy clarification based on IRAG views were identified. IRAG recommendations on the following were:

- Chief Financial Officer should be professionally qualified.
- It would be inappropriate for Chief Executives to fulfil the role.
- In most cases the role of Chief Financial Officer should not be filled by either the Director of Finance of the Health Board or the S.95 officer of the Local Authority. However, there may be local circumstances that would allow this to happen. Any potential issues of conflict would need to be carefully considered in this instance.
- It is possible for one person to be the Chief Financial officer for more than one IJB.

From the work outlined above a Role Outline/Job Description for a Chief Financial Officer has been prepared. This has been reviewed by the Head of Health & Social Care Workforce Integration and the NHS Head of Pay & Conditions.

The impact that these roles will have on existing Directors of Finance in both Health and Local Authority has been considered. The scale of funds that will flow through the Health Board and Local Authority will be unchanged because of integration. The close working relationship that Directors of Finance will have to have with the Chief Financial Officer(s) in their area cannot be understated.

These are based on the Roles and responsibilities of the IJB on Day 1 and would need to be amended if the IJB became a trading/employment organisation.

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CIPFA STATEMENT ON THE ROLE OF THE CHIEF FINANCIAL OFFICER IN LOCAL GOVERNMENT

The Chief Financial Officer in a public service organisation:

- is a key member of the Leadership Team, helping it to develop and implement strategy and to resource and deliver the authority's strategic objectives sustainably and in the public interest;
- must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term implications, opportunities and risks are fully considered, and alignment with the authority's financial strategy; and
- must lead the promotion and delivery by the whole authority of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively.

To deliver these responsibilities the Chief Financial Officer:

- must have access to appropriate financial information and analysis.

Core CFO responsibilities:

Developing and implementing organisational strategy

- Contributing to the effective leadership of the authority, maintaining focus on its purpose and vision through rigorous analysis and challenge.
- Contributing to the effective corporate management of the authority, including strategy implementation, cross organisational issues, integrated business and resource planning, risk management and performance management.
- Supporting the effective governance of the authority through development of corporate governance arrangements, risk management and reporting framework; and
- Leading development of a medium term financial strategy and the annual budgeting process for the Integration Joint Board to ensure financial balance and a monitoring process to ensure its delivery.

Responsibility for financial strategy

- Agreeing the financial framework with sponsoring organisations and planning delivery against the defined strategic and operational criteria.
- Maintaining a long term financial strategy to underpin the authority's financial viability within the agreed performance framework.
- Implementing financial management policies to underpin sustainable long-term financial health and reviewing performance against them.
- Co-ordinating the planning and budgeting processes.

Influencing decision making

- Ensuring that opportunities and risks are fully considered, decisions are aligned with the overall financial strategy. and appropriate briefings are provided to the Integration Joint Board.
- Providing professional advice and objective financial analysis enabling decision makers to take timely and informed business decisions. (This will require a strong working relationship with Directors of Finance and related Chief Financial Officers).
- Ensuring that clear, timely, accurate advice is provided to the Chief Officer/Integration Joint Board in setting the funding plan/budget.
- Ensuring that advice is provided to the scrutiny function in considering the funding plan/budget.

Financial information for decision makers

- Monitoring and reporting on financial performance that is linked to related performance information and strategic objectives that identifies any necessary corrective decisions.
- Responsibility for the consolidation of appropriate management accounts information received from Health Board and Local Authority.
- Ensuring the reporting envelope reflects partnerships and other arrangements to give an overall picture.

Value for money

- Challenging and supporting decision makers, especially on affordability and Best Value, by ensuring policy and operational proposals with financial implications are signed off by the finance function.
- Reporting to the IJB on the efficiency programmes being delivered within the Operational Units
- Co-ordinating appropriate Benchmarking Exercises.

Safeguarding public money

- Implementing effective systems of internal control that include standing financial instructions.
- Ensuring that the authority has put in place effective arrangements for internal audit of the control environment and systems of internal control as required by professional standards and in line with CIPFA's Code of Practice.
- Ensuring that delegated financial authorities are respected.
- Promoting arrangements to identify and manage key business risks,-risk mitigation and insurance.
- Implementing appropriate measures to prevent and detect fraud and corruption.
- Ensuring that any partnership arrangements are underpinned by clear and well documented internal controls.

Assurance and scrutiny

- Reporting performance of both the authority and its partnerships to the board and other parties as required.
- Ensuring that financial and performance information presented to members of the public, the community and the media covering resources, financial strategy, service plans, targets and performance is accurate, clear, relevant, robust and objective.
- Supporting and advising the Audit Committee and relevant scrutiny groups. This now needs to include a review of the Statement of Internal Controls.
- Ensuring that clear, timely, accurate advice is provided to the Chief Officer/ Integration Joint Board and the scrutiny functions on what considerations can legitimately influence decisions on the allocation of resources, and what cannot.
- Ensuring that the financial statements are prepared on a timely basis, meet the requirements of the law, financial reporting standards and professional standards as reflected in the Code of Practice on Local Authority Accounting in the United Kingdom developed by the CIPFA/LASAAC Joint Committee.
- Certifying the annual statement of accounts.
- Ensuring that arrangements are in place so that other accounts and grant claims (including those where the authority is the accountable body for community led projects) meet the requirements of the law and of other partner organisations and meet the relevant terms and conditions of schemes
- Liaising with the external auditor.

Leading and Directing the Finance Function - arrangements *will depend on local agreement*

- To receive assurance from Directors of Finance that efficient and effective professional services from the finance staff in both Health and Local Authorities is being delivered.
- Identifying and equipping managers and the Leadership Team with the financial competencies and expertise needed to manage the business both currently and in the future.

PROFESSIONAL GUIDANCE, ADVICE AND RECOMMENDATIONS FOR SHADOW INTEGRATION ARRANGEMENTS

IRAG paper - Role of the Integration Joint Board Chief Financial Officer

The integrated Joint Board financial officer will have to fulfil the following tasks. However local consideration may add other duties to the post.

Tasks that the **Integration Joint Board financial officer** will have to undertake:

- Be Responsible for the financial administration of the IJB;
- Establish financial governance systems for the proper use of the delegated resources;
- Ensure that the Strategic Plan meets the requirement for best value in the use of the Integration Joint Board's financial resources;

- Ensure that the directions to the Health Board and Local Authority require that the financial resources are spent according to the allocations in the Strategic Plan;

- Establish a process of regular in-year reporting and forecasting in conjunction with the Health Board and Local Authority Directors of Finance to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole;

- Develop a business case for the resources of the Integrated Joint Board in line with the method set out in the Integration Scheme in conjunction with the Chief Officer;

- Develop financial regulations which incorporate a minimum set of controls. It is recommended that the financial regulations are approved by the Integration Joint Board;

- Establish procedures in conjunction with the Health Board accountable officer and Local Authority Section 95 Officer to allow the best practice principles as set out in the Code of Guidance on Funding External Bodies and Following the Public Pound to be followed.;

- Authorise the relevant financial statements for the IJB;

- Determine the appropriate accounting policies for the Integration Joint Board

- In conjunction with the Chief Officer develop a case for the Integrated Budget based on the Strategic Plan and present it to the Local Authority and Health Board for consideration and agreement as part of the annual budget setting process.

Lynne Hollis

Scottish Government Health Finance

July 2014

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

Present:	(v) Cllr Catriona Bhatia (Chair)	(v) Mrs Pat Alexander
	(v) Cllr John Mitchell	(v) Mr David Davidson
	(v) Cllr Jim Torrance	(v) Mrs Karen Hamilton
	Mrs Susan Manion	Dr Cliff Sharp
	Mr Paul McMenamin	Mrs Evelyn Rodger
	Mr David Bell	Mr John McLaren
	Mrs Linda Jackson	Dr Angus McVean
	Mrs Jenny Miller	Mrs Angela Trueman
In Attendance:	Miss Iris Bishop	Mrs Jane Davidson
	Mrs Jill Stacey	Mrs Carol Gillie
	Dr Eric Baijal	Dr Annabel Howell
	Ms Sandra Campbell	Mrs Carin Petterson

1. Apologies and Announcements

Apologies had been received from Dr Stephen Mather, Mr John Raine, Cllr David Parker, Cllr Frances Renton, Mrs Tracey Logan, Mrs Elaine Torrance, Mrs Jeanette McDiarmid, Mrs June Smyth, Mrs Clair Hepburn, Mrs Fiona Morrison and Mr David Robertson.

The Chair confirmed the meeting was quorate.

The Chair welcomed Mrs Angela Trueman to the meeting, who was replacing Mr Andrew Leitch as the User Carer Representative, non voting member of the Health & Social Care Integration Joint Board.

The Chair welcomed Dr Cliff Sharp, Interim Medical Director.

The Chair advised that Cllr David Parker was intending standing down from the Health & Social Care Integration Joint Board. Subject to Scottish Borders Council approval the intention was that Cllr Iain Gillespie might join the Health & Social Care Integration Joint Board as the replacement for Cllr Parker. The Chair welcomed Cllr Gillespie to the meeting as an observer.

The Chair welcomed Ms Linda Jackson to the meeting who was deputising for Mrs Fiona Morrison.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

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

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

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 14 December 2015 were amended at page 3 last paragraph, line 1, to read ...."post diagnostic dementia...", page 5, second to last paragraph to read "Mr David Davidson..." and page 8, third paragraph, line 2 to read "..spend of £470k.." and with those amendments the minutes were approved.

4. Matters Arising

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker and agreed that the session that had taken place on 20 January 2016 had not fully accommodated the commissioning suggestion and the action would therefore return to amber.

5. Health & Social Care Strategic Commissioning Plan

Dr Eric Baijal gave an overview of the content of the plan and the next steps to be taken. The Chair clarified that the document before the meeting was the Strategic Plan and a separate Commissioning and Implementation Plan would be drawn up.

Mrs Susan Manion advised the meeting that it could not formally approve the Strategic Plan until the Health & Social Care Integration Joint Board had been legally established. The date of legal establishment was 6 February 2016, she therefore proposed that the Strategic Plan be brought back to the next meeting for homologation.

The Chair confirmed that it was the content of the Strategic Plan that required approval as opposed to the finalised document.

Cllr John Mitchell requested the population figures for Hawick and Galashiels be checked.

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

6. Integrated Care Fund – Progress Update

The paper was tabled at the meeting and Mrs Susan Manion reminded the Health & Social Care Integration Joint Board (H&SC IJB) that an update report had been presented at the last meeting which had given a reassurance around governance arrangements and decision making processes.

Mrs Pat Alexander commented that she was keen to have sight of all the appendices.

The Chair advised that the H&SC IJB was noting the progress made against the projects that had already been approved.

Mr David Davidson reiterated that the H&SC IJB should receive their meeting papers seven days in advance to allow the members the time to read and scrutinise all of the content within the papers.

Cllr John Mitchell commented that all officials and staff were working hard and it was difficult to be kept up to date all of the time.

Cllr Jim Torrance commented that it was important that the paper was noted by the H&SC IJB.

Mrs Evelyn Rodger suggested that it might be helpful for the next report to look at stress and distress, how many staff had been trained, were going to be trained, what difference it had made to front line staff, etc. She suggested that level of granularity would have been detailed within the bid and it would be helpful for the H&SC IJB to view progress being made.

Mr Davidson further commented that it would be critical for the H&SC IJB to receive progress reports for each project on how it was progressing against each stage in its timeline. Progress reports would give the H&SC IJB the ability to be able to scrutinise where any issues might lie and offer direction.

Mrs Manion advised that the H&SC IJB would receive a full report on the Integrated Care Fund after the end of the financial year.

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

7. Chief Officer's Report

Mrs Susan Manion gave an overview of the content of the report highlighting the anticipated final approval of the Scheme of Integration on 6 February 2016, formal appointment of the Chief Officer and Chief Financial Officer on 7 March. She suggested the forthcoming Development session scheduled for 7 March would need to become a formal meeting to allow the H&SC IJB to recognise its' legal establishment and requirements ahead of 1 April 2016.

A discussion ensued which encapsulated several issues including: the huge amount of work that had been undertaken by Mrs Manion and her team in order to address the delayed discharges situation in extreme circumstances; achievements to date against the 72 hours target, possibly through a graphic detailing target, trajectory, etc; information on the GP contract and their input to design localities and clusters; status of the Physiotherapy 9 week target as a local stretched target; request for more detail within the categories of reporting, such as graphical trends, so that it would be easier to assimilate and compare; ongoing work on the performance monitoring framework; and oversight of performance.

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

8. Communications Update

Ms Carin Petterson gave an update.

Dr Angus McVean commented that he would be more than happy to provide GP input to future newsletters.

During discussion several issues were raised including: staff engagement; information technology issues; integration website; reinstatement of the Communications Group to look at information available to the staff and public and links to existing websites; make the newsletter balanced and give a preview of items for the following issue; emphasis that primary care is about a whole range of services and teams and not just GPs;

Ms Linda Jackson commented that she would be willing to provide information and stories for the newsletter form the carers sector.

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

9. Integration Joint Board Audit Committee Arrangements

Mrs Susan Manion suggested taking both the Audit Committee and Internal Auditor papers together as one single discussion. She highlighted that within the Scheme of Integration it was clear that the H&SC IJB may wish to establish an Audit Committee and in order to ensure the Audit Committee functioned appropriately the of a Chief Internal Auditor would be vital.

Mrs Jill Stacey confirmed that a key part of any organisation was to have effective governance arrangements in place and in order to ensure transparency, scrutiny and assurance an Audit Committee would be required.

Mrs Stacey advised of a slight revision to the wording of point 7 in Appendix 1 of the Audit Committee paper.

A discussion followed which highlighted: membership of the Audit Committee and skill sets required; risk management strategy for the H&SC IJB to take account of commissioning risks and be shared with the Joint Staff Forum;

The Chair suggested voting members of the H&SC IJB consider if they wished to be a member of the H&SC IJB Audit Committee.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to establish an Audit Committee as part of the governance arrangements of the Health & Social Care Integration Joint Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Terms of Reference of the IJB Audit Committee as detailed at Appendix 1 with the suggested revision.

10. Appointment of Chief Internal Auditor

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** appointed Jill Stacey, Chief Officer Audit and Risk, Scottish Borders Council as Chief Internal Auditor for the Integration Joint Board.

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

11. Monitoring of the Integration Joint Budget 2015/16

Mrs Carol Gillie introduced the report 9 months into the financial year reminding the H&SC IJB that the budget was on an aligned basis and any pressures were the responsibility of the respective partner organisations.

Mrs Gillie advised that the projected year end position was that the partnership would end the year with a £466k expense over budget. It was an improved position following projected breakeven position for Scottish Borders Council services within the delegated functions. The projected overspend at the year end was linked to NHS services, principally GP prescribing and dental services.

Discussion focused on several elements including: reduction in number of clients in residential care; impact of the living wage on the care sector; Scottish Government settlement for Local Authorities; understanding the impact of underspends against delivery of services; and the shift in budget alignment to assist integration of services.

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

12. Integrated Joint Board Governance – Draft Financial Regulations

Mrs Carol Gillie reminded the H&SC IJB that a more detailed session had been undertaken at the Development session in January.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the content of the report and agreed the content of the Draft Financial Regulations.

13. Committee Minutes

The Chair noted that the previous two meetings of the Strategic Planning Group had been inquorate and a discussion took place on how to strengthen the group with suggestions including: reducing the quorum number; support from H&SC IJB members; virtual working through email discussion, input and approval of items; OD plan; financial representative to be included in the group membership; nursing input to the group; deputies to be nominated; terms of reference and membership to be shared; meetings to be planned across the year;

Dr Eric Baijal advised that he would circulate to the H&SC IJB the Terms of Reference, Membership, Remit and Governance arrangements.

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

14. Audit Scotland Report

Mrs Carol Gillie commented that it was a good background information document and she advised that there were 2 further follow up reports to be released.

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

15. Chief Financial Officer

Mrs Susan Manion advised that a draft job description had been drawn up with the agreement of both Scottish Boarders Council and NHS Borders and it had been agreed that an appointment would be made on an Interim basis for a period to be identified.

Mr Paul McMenamin had been identified as an Interim appointee on a secondment basis to ensure the H&SC IJB was assured around its financial arrangements from 1 April 2016 onwards.

Mrs Manion proposed the detail of the process to be followed to recruit, timeline and secondment period be shared with the H&SC IJB at its next meeting.

The Chair suggested speaking to other H&SC IJBs regarding sharing the Chief Financial Officer post.

Mrs Carol Gillie confirmed that both she and Mr David Robertson would fully support Mr Paul McMenanmin in the role of Chief Financial Officer for the H&SC IJB.

Mrs Karen Hamilton suggested costing the resourcing and staffing implications in other areas as she was aware there were a number of staff across both organizations providing support to the H&SC IJB through their professional roles.

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

16. Any Other Business

16.1 Development: Mrs Susan Manion highlighted that Mr George Hunter had moved on. He has provided a written report which would be fed into the OD work.

16.2 Meeting: The Chair confirmed that the next meeting of the H&SC IJB would be held on 7 March at 9.30am as alluded to earlier in the meeting.

16.3 National H&SC IJB Chairs & Vice Chairs: The Chair gave feedback from the national H&SC IJB Chairs and Vice Chairs meeting held on 28 January. She highlighted: national indicators and what success will look like; key indicators; whole system approach; delayed discharges; political aspirations; shifting resources; and commissioning services.

Cllr John Mitchell enquired if there was any feedback on the Highland partnership that had gone Lead Agency. The Chair advised that those from Highland had advised it had been a painful process but they felt it was now working well. Mrs Jane Davidson reminded the meeting that in Highland there were two partnerships and one had been the Lead Agency model and the other had been the Body Corporate model.

17. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Monday 7 March 2016 at 9.30am in the Council Chamber, Scottish Borders Council.

The meeting concluded at 3.50pm.

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Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 27 April 2015

Agenda Item: Draft Strategic Plan – A conversation with you

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
1	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to have a Development session later in the year dedicated to Commissioning (the commissioning cycle, review of the Manchester model and lessons learned).	Susan Manion/ Iris Bishop	October	**In Progress:** Item included as part of the Commissioning discussion scheduled for the 20 January 2016 H&SC IJB Development Session. **Update:** The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that the session that had taken place on 20 January 2016 had not fully accommodated the commissioning suggestion and the action would therefore return to amber.	A

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

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD – CODE OF CORPORATE GOVERNANCE

Aim

1.1 To gain approval of the Health & Social Care Integration Joint Board Code of Corporate Governance.

Background

2.1 The Health & Social Care Integration Joint Board is required to approve its Strategic Plan before 1 April 2016. The Strategic Plan will contain the date on which functions and resources are to be delegated to the Health & Social Care Integration Joint Board, which must be by 1 April 2016 at the latest.

2.2 Although the Health & Social Care Integration Joint Board exists as an entity from 1 April 2015, the Council and the Health Board cannot formally delegate their functions to the Health & Social Care Integration Joint Board until the Strategic Plan is agreed.

Summary

3.1 On agreement of the Strategic Plan and the delegation of functions and resources to the Health & Social Care Integration Joint Board, the Health & Social Care Integration Joint Board will require its own Code of Corporate Governance.

3.2 The Code of Corporate Governance will be made up of a suite of documents, some of which you will have already seen. We have included some cover papers to the individual documents to assist in explaining their purpose.

3.3 It should be noted that the financial documents will also be included in the Code of Corporate Governance once approved.

3.4 The Code of Corporate Governance will be a live document subject to amendment and revision as the Health & Social Care Integration Joint Board matures. It is proposed that as a minimum the Code of Corporate Governance be reviewed on an annual basis.

3.5 Where appropriate existing mechanisms embedded within both NHS Borders and Scottish Borders Council will be used to provide assurance to the Health & Social Care Integration Joint Board to ensure unnecessary double handling of business does not occur.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the current suite of documents which form the Code of Corporate Governance for the Health & Social Care Integration Joint Board.

The Health & Social Care Integration Joint Board is asked to **approve** an annual review of the Code of Corporate Governance.

Policy/Strategy Implications	In compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	Not applicable.
Risk Assessment	As detailed within the papers.
Compliance with requirements on Equality and Diversity	An equality impact assessment will be undertaken on the arrangements for Joint Integration when agreed.
Resource/Staffing Implications	It is anticipated that the Integration Joint Board will oversee services which have a budget of over £100m, within the existing scope. The budget will change as other functions are brought within the scope of the Integration Joint Board.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

Code of Corporate Governance

Approved	
Review Date	April 2017

INDEX

Health and Social Care Integration Scheme for the Scottish Borders

CONTENTS

Preface

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

The Act requires that the Local Authority and the Health Board jointly prepare, consult and then agree an Integration Scheme for the Local Authority Area, prior to them submitting it to Scottish Ministers for final approval. The Act states that the purpose of an integration scheme is to set out:

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

The Act also requires that the Health Board and the Local Authority undertake a joint consultation as part of the preparation of their integration scheme. This Integration Scheme describes how the new Act will be applied within the Scottish Borders.

Individuals and communities in the Scottish Borders have benefited from the integration of designated Health and Social Care services already. This Integration Scheme has been informed by considerable local experience of developing and delivering integration in practice; and also benefitted from a considerable amount of on-going dialogue and positive interaction with a range of stakeholders over recent years. The Health Board and the Local Authority are committed to continuing that constructive engagement.

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

In line with the legislation, the Integration Joint Board will not only plan but also oversee the delivery of the integrated services for which it has responsibility. In line with its Strategic Commissioning Plan, the Integration Joint Board will require that the Local Authority and Health Board provide services to match what is required and it will oversee performance and targets to ensure that delivery is in line with the outcomes.

Introduction

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

The Act requires them to prepare jointly an Integration Scheme setting out how this joint working is to be achieved. There is a choice of ways in which they may do this: the Health Board and Local Authority can either delegate .between each other, or can both delegate to a third body called the Integration Joint Board. Delegation between the Health Board and Local Authority is commonly referred to as a "lead agency" arrangement. Delegation to an Integration Joint Board is commonly referred to as a "body corporate" arrangement.

This document uses the model Integration Scheme where the "body corporate" arrangement is used and sets out the detail as to how the Health Board and Local Authority will integrate services. Section 7 of the Act requires the Health Board and Local Authority to submit jointly an Integration scheme for approval by Scottish Ministers.

Once the scheme has been approved by the Scottish Ministers, the Integration Joint Board (which has distinct legal personality) will be established by Order of the Scottish Ministers.

The Act requires that an Integration Scheme, once approved, must be re-submitted and follow the consultation process set out in the regulations if it is to be amended. Changes to documents referred to within the Integration Scheme (eg Workforce Plan) do not require the Integration Scheme to go through this process – only changes to the Integration Scheme itself.

As a separate legal entity the Integration Joint Board has full autonomy and capacity to act on its own behalf and can, accordingly, make decisions about the exercise of its functions and responsibilities as it sees fit. However, the legislation that underpins the Integration Joint Board requires that its voting members are appointed by the Health Board and the Local Authority, and consists of Councillors and NHS Non-Executive Directors. Whilst serving on the Integration Joint Board its members will carry out their functions under the Act on behalf of the Integration Joint Board itself, and not as delegates of their respective Heath Board or Local Authority.

The Integration Joint Board is responsible for the strategic planning of the functions delegated to it and for ensuring oversight of the delivery of its functions set out within the Integration Scheme in Section 4. This scheme covers the health and wellbeing of all adults including older people and universal children's health services in accordance with Section 29 of the Act. Further, the Act gives the Health Board and the Local Authority, acting jointly, the ability to require that the Integration Joint Board replaces their Strategic Commissioning Plan in certain circumstances. In these ways, the Health Board and the Local Authority together have significant influence over the Integration Joint Board, and they are jointly accountable for its actions.

Vision, Aims and Outcomes of the Integration Scheme

Scottish Borders Council and Borders Health Board will build on a history of partnership working. By maximising the opportunities presented through legislation we aim to achieve the highest outcomes for the people of the Scottish Borders. By creating our new integrated arrangements across health and social care we will enhance, strengthen and develop the formerly separate services for the provision of adult health and social care. By integrating service delivery and fulfilling the expectations of our Strategic Commissioning Plan we seek to enhance and promote the health and wellbeing of the people of the Scottish Borders.

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

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

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

INTEGRATION SCHEME

The parties:

Scottish Borders Council, established under the Local Government (Scotland) Act 1994 and having its principal offices at Newtown St Boswells, Melrose, Roxburghshire, TD6 OSA ("the Council");

and

Borders Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Borders") and having its principal offices at Borders General Hospital, Melrose, Roxburghshire, TD6 9BS ("NHS Borders") (together referred to as "the Parties")

1. Definitions and Interpretation

1.1 In this Integration Scheme, the following terms shall have the following meanings:-

- "The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;
- "Integration Joint Board" means the Integration Joint Board to be established by Order under section 9 of the Act;
- "Outcomes" means the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act
- "The Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014
- "Integration Joint Board Order" means the Public Bodies (Joint Working) (Proceedings, Membership and General Powers of Integration Joint Boards) (Scotland) Order 2014
- "Scheme" means this Integration Scheme;
- "Strategic Commissioning Plan" means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults and universal children's health services in accordance with section 29 of the Act.
- "Universal children's health services" refers to the functions exercisable in relation to the health care services set out in paragraphs 11-15 of Appendix 2, Part 2, Section 3, which are delegated in relation to persons of any age.
- "Payment" means the term used in legislation to describe the integrated budget contribution to the Integration Joint Board. This payment does not require a cash transaction to be made. The term is also used to describe the non cash transaction the

Integration Joint Board makes to the Health Board and Local Authority for carrying out the directed functions.

1.2 In implementation of their obligations under the Act, the Parties hereby agree as follows:

- In accordance with section 1(2) of the Act, the Parties have agreed that the integration model set out in sections 1(4)(a) of the Act will be put in place for Scottish Borders, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. This Scheme comes into effect on the date the Parliamentary Order to establish the Integration Joint Board comes into force.

2. Local Governance Arrangements

2.1 Part of the remit of the Integration Joint Board is to prepare and implement a Strategic Commissioning Plan in relation to the provision of such health and social care services to people in their area in accordance with the requirements of the Act.

2.2 The regulations of the Integration Joint Board's procedure, business and meetings form the Standing Orders which may be considered at the first meeting of the Integration Joint Board.

2.3 Borders Health Board, Scottish Borders Council and the Integration Joint Board are all responsible for the achievement of the outcomes. (Appendix 1). The Integration Joint Board has oversight of the functions delegated to it and of the performance of the services related to those functions. The Chief Officer is responsible for reporting to the Integration Joint Board on performance of those services in the context of a performance framework agreed by the Integration Joint Board via the Chief Officer.

2.4 The Chief Officer will prepare an annual report on performance on delivery of the Strategic Commissioning Plan to the Integration Joint Board and share it with Borders Health Board and Scottish Borders Council.

2.5 The Integration Joint Board will have a distinct legal personality and the autonomy to manage itself. There is no role for Scottish Borders Council or Borders Health Board to, acting separately, sanction or veto decisions of the Integration Joint Board. In the event of a dispute arising between Borders Health Board and Scottish Borders Council the dispute resolution mechanism will be followed as set out at Section 14.

2.6 The Integration Joint Board may create such Committees that it requires to assist it with the planning and oversight of delivery of services which are within its scope. This is provided for in legislation. The Integration Joint Board may establish an Audit Committee, to seek and secure assurance over effective governance.

2.7 As agreed by Borders Health Board and Scottish Borders Council, the Integration Joint Board shall comprise five NHS Non-Executive Directors appointed by Borders Health Board, and five Elected Councillors appointed by Scottish Borders Council. The Integration Joint Board will include non-voting members as prescribed by Regulation 3 of the Public Bodies (Joint Working) (Proceedings, Membership and General Powers of Integration Joint Boards) (Scotland) Order 2014.

2.8 The term of office of voting Members of the Integration Joint Board shall last as follows:

(a) for Local Government Councillors, three years, thereafter Scottish Borders Council will identify its replacement Councillor(s) on the Integration Joint Board,

(b) for Borders Health Board nominees, three years, thereafter Borders Health Board will identify its replacement Non Executive(s) on the Integration Joint Board.

2.9 At the first meeting of the Integration Joint Board it will elect a Chairperson and Vice Chairperson from the voting membership of the Integration Joint Board. The Chair and Vice–Chair posts shall rotate annually between Borders Health Board and Scottish Borders Council, with the Chair being from one body and the Vice-Chair from the other. The first Chair of the Integration Joint Board will be from Scottish Borders Council.

2.10 The initial appointment of the Chair and Vice Chair will be for a period of 12 months.

2.11 The terms of office for the Chair and Vice Chair shall rotate on an annual basis.

2.12 All appointments, including the appointment of the Chair and Vice Chair, will be reviewed every 3 years. Members can be reappointed.

3. Delegation of Functions

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

3.2 Each function listed in column A of Part 1 of Appendix 2 is delegated subject to the exceptions in column B and only to the extent that:

(a) There are a number of functions delegated at Section 3 of Part 2 of Appendix 2 which are delegated in relation to persons of any age (universal children's health services)); and

(b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed in Section 1 of Part 2 of Appendix 2; or

(c) The function is exercisable in relation the health and care services listed in Section 2 of Part 1 of Appendix 2.

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

3.4 Each function listed in column A of Part 1 of Appendix 3 is delegated subject to the exceptions in column B and only to the extent that it is exercisable in relation to persons of at least 18 years of age.

4. Local Operational Delivery Arrangements

4.1 The Integration Joint Board is responsible for the strategic planning and oversight of the delivery of the services related to the functions delegated to it. This will be carried out by the development of a Strategic Commissioning Plan as per section 29 of the Act. This plan will set out the arrangements for carrying out the integration functions and how these will contribute to achieving the nine National Health and Well-Being outcomes. As per Section 26 of the Act, the Integration Joint Board will give direction to Borders Health Board and Scottish Borders Council to carry out each function delegated to it. Assurance to the Integration Joint Board over the performance of services delivered by Borders Health Board and Scottish Borders Council will be provided by regular and frequent monitoring to the Integration Joint Board by the Chief Officer.

4.2 The Integration Joint Board will have provided to it, the necessary resources to undertake the functions delegated by Borders Health Board and Scottish Borders Council.

4.3 Borders Health Board and Scottish Borders Council Executives responsible for the delivery and management of any services within the scope of the Integration Joint Board, will report on performance on a regular basis to the Integration Joint Board through the Chief Officer.

4.4 The Integration Joint Board will:-

a. Appoint its Chief Officer.

b. Appoint its Chief Financial Officer.

c. Convene a Strategic Planning Group specifically to enable the preparation of Strategic Commissioning Plans in accordance with section 32 of the Act; inform significant decisions outside the Strategic Commissioning Plan in accordance with section 36 of the Act; and review the effectiveness of the Strategic Commissioning Plan in accordance with section 37 of the Act, in line with the obligations to meet the engagement and consultation standards.

d. Prepare, approve and implement a Strategic Commissioning Plan for all of its delegated functions, in accordance with the Act; supported by an integrated workforce and organisational development plan.

e. Establish arrangements for locality planning in support of key outcomes for the agreed localities in the context of the Strategic Commissioning Plan.

f. Approve the Strategic Commissioning Plan as presented by the Chief Officer, before the integration start date in accordance with the Act.

g. Approve the allocation of resources to deliver the Strategic Commissioning Plan within the specific revenue budget as delegated by each Party (in accordance with the standing financial instructions/orders of both Parties), and where necessary to make recommendations to either or both Parties.

h. Prepare and publish an annual financial statement that sets out the amount that the Integration Joint Board intends to spend in implementation of the Strategic Commissioning Plan in accordance with the Act.

i. Share an Annual Report with Borders Health Board and Scottish Borders Council.

j. Have oversight of the performance of all the services referred to in 3.1, 3.2, 3.3 and 3.4 above, through the Chief Officer.

4.5 The Integration Joint Board may consider the following:

a. Maintaining and routinely reviewing an integrated risk management strategy, including (where necessary) to make recommendations to either or both Parties.

b. Establishing a standing Audit Committee to focus on financial audit and governance matters, including (where necessary) making recommendations to either or both Parties.

c. Establishing a Joint Staff Forum to focus on applying the principles of staff governance across services in partnership with trade unions, and where necessary to make recommendations to either or both Parties without impacting or undermining the consultation and bargaining mechanisms for staff employed by Borders Health Board and Scottish Borders Council.

4.6 Targets and Performance Management

4.6.1 Borders Health Board and Scottish Borders Council will establish a Performance Management Framework which meets the obligations set out in legislation and will take account of targets, measures and objectives which are in force at any given time for integrated and non integrated functions. The Integration Joint Board will receive frequent and regular monitoring reports on the agreed performance framework in pursuit of the delivery of the Strategic Commissioning Plan, including all delegated and set-aside budgets.

4.6.2 Both parties will develop for the Integration Joint Board a Performance Management Framework with a list of all relevant targets, measures and arrangements which relate to the integration functions and for which responsibility is to transfer, in full or in part, to the Integration Joint Board. Scottish Borders Council and Borders Health Board have existing performance management processes and the Integration Performance Management Framework will align with those processes to avoid duplication and streamline reporting and will as far as possible, draw on existing data sets and reporting mechanisms.

4.6.3 In meeting the delivery requirements of the national health and wellbeing outcomes, consideration will need to be given to any additional resource requirements for collecting and reporting information that is not currently collected, both in operational and support terms.

4.6.4 The Integration Joint Board will receive regular reports for the delegated functions from Borders Health Board and Scottish Borders Council on the delivery of integrated services and issue directions in response to those reports to ensure improved performance.

4.6.5 The Chief Officer will provide regular Strategic Commissioning Plan Performance Reports to the Integration Joint Board for members to scrutinise performance and impact against planned outcomes and commissioning priorities. This will culminate in the production of an annual performance report to the Integration Joint Board. The Strategic Commissioning Plan Performance Report will also provide necessary information on the activity and resources that relate to the planned and actual use of services, including the consumption patterns of health and social care resources by locality. The information will provide the opportunity for the Integration Joint Board resources to be used flexibly, to provide services co-designed with local communities, for their benefit.

4.6.6 The national and local performance measures and targets as they relate to the delegated functions outlined in 3.1, 3.2, 3.3 and 3.4 will be delegated in relation to the oversight of operational delivery arrangements and in relation to the strategic planning outcomes and performance reporting. These performance measures and targets may be fully or partially delegated by both Parties to the Integration Joint Board. Responsibility for financial planning and management of integrated budgets is the responsibility of the Integration Joint Board which is accountable for the delivery of the Strategic Commissioning Plan and associated financial objectives.

4.6.7 The performance management framework will be in place by the end of March 2016.

4.7 Corporate Services Support

4.7.1 With regard to corporate services support, Scottish Borders Council and Borders Health Board will by the end of March 2016, have:-

- identified the corporate resources used to deliver the delegated functions;

- agreed the corporate support services required to fully discharge Integration Joint Board duties under the Act.

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

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

4.7.3 By end of March 2016, agreements specifying the associated support services will be in place. These agreements will be kept under review during the initial year and, thereafter, will be reviewed formally (and agreed by all parties) annually.

4.7.4 In regard to support for strategic planning there will be set out local arrangements for the preparation of the strategic commissioning plan with support from Borders Health Board and Scottish Borders Council, taking into account the relevant activity and financial data covering the services, facilities and resources that relate to the Strategic Commissioning Plan. Local arrangements will be reviewed formally on an annual basis taking account of any changes to the Strategic Commissioning Plan.

5. Clinical and Care Governance

5.1 Assurance to the Integration Joint Board and subsequently, Scottish Borders Council and Borders Health Board in respect of the key areas of governance will be achieved through explicit and effective lines of accountability. This accountability begins in the care setting within an agreed clinical and care governance framework established on the basis of existing key principles embedded in the governance and scrutiny arrangements for Borders Health Board and Scottish Borders Council.

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

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

5.4 As part of the integration arrangements the Chief Social Work Officer will provide oversight and advice to the Integration Joint Board on the quality of social work

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

5.5 The Integration Joint Board, and where required the Strategic Planning Group and Localities, will receive Clinical and Care Governance reports from the parties on matters relating to the delegated functions.

5.6 As part of the regular monitoring process the Integration Joint Board may, as required, also take advice from other appropriate professional forums and groups as outlined in Scottish Government guidance, including the Adult Protection Committee, Child Protection Committee (for universal childrens health services), Area Clinical Forum and Area Drug and Therapeutics Committee.

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

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

6. Chief Officer

6.1 The Integration Joint Board shall appoint a Chief Officer in accordance with section 10 of the Act.

6.2 The Chief Officer will be accountable directly to the Integration Joint Board for the preparation, implementation and reporting on the Strategic Commissioning Plan, including overseeing the operational delivery of delegated services as set out in Appendices 2 and 3.

6.3 Where the Chief Officer does not have operational management responsibility for services included in integrated functions, the parties will ensure that appropriate communication and liaison is in place between the Chief Officer and the person/s with that operational management responsibility.

6.4 The Chief Officer will be a member of the Parties relevant senior management teams and be accountable to and managed by the Chief Executive's of both Parties.

6.5 The Chief Officer is seconded to the Integration Joint Board from the employing body.

6.6 Where there is to be a prolonged period where the Chief Officer is absent or otherwise unable to carry out their responsibilities, the Scottish Borders Council's Chief Executive and Borders Health Board's Chief Executive will jointly propose an appropriate interim arrangement for approval by the Integration Joint Board's Chair and Vice-Chair at the request of the Integration Joint Board.

7. Workforce

7.1 Borders Health Board and Scottish Borders Council will jointly develop and put in place for their employees delivering integrated services, by the end of March 2016, a Joint Organisational Development Plan (which will cover the learning and development of staff and the development of an effective collaborative culture) and an outline Workforce Plan (to support the implementation of the strategic commissioning plan).

7.2 Core HR services will continue to be provided by the appropriate corporate HR functions in Scottish Borders Council and Borders Health Board.

7.3 The corporate HR functions in Scottish Borders Council and Borders Health Board will provide the necessary resources to ensure the development and implementation of the joint organisational development plan and the outline workforce plan and will, where appropriate, consult with stakeholders.

7.4 Both the joint organisational development plan and the outline workforce plan will be refreshed periodically by the parties and the Integration Joint Board.

7.5 Borders Health Board and Scottish Borders Council professional/clinical supervisions arrangements for professional and clinical staff will continue until superseded by any jointly agreed arrangements.

8. Finance

8.1 The Integration Joint Board will seek assurance from Borders Health Board and Scottish Borders Council over the sufficiency of resources to carry out its delegated duties and adjust its performance accordingly, following which it will approve the initial amount delegated to it. This will continue in future years following negotiation with the other parties.

8.2 The arrangements in relation to the determination of the amounts paid, or set aside, and their variation, to the Integration Joint Board by Borders Health Board and Scottish Borders Council are set out below at sections 8.3, 8.4.8.5 and 8.6:-

8.3 Payment in the first year to the Integration Joint Board for delegated functions

8.3.1 The baseline payment will be established by reviewing recent past performance and existing plans for Borders Health Board and Scottish Borders Council for the functions to be delegated, adjusted for material items.

8.3.2 Delegated baseline budgets will be subject to due diligence and comparison to recurring actual expenditure in the previous three years adjusted for any planned changes to ensure they are realistic. There will be an opportunity in the second year of operation to adjust baseline budgets to correct any inaccuracies.

8.4 Payment in subsequent years to the Integration Joint Board for delegated functions

8.4.1 In subsequent years the Chief Officer and the Integration Joint Board Chief Financial Officer will develop a case for the Integrated Budget based on the Strategic Commissioning Plan. The financial plan will be presented to Borders Health Board and Scottish Borders Council for consideration as part of the annual budget setting process. The case should be evidenced, with full transparency demonstrating the following assumptions:-

- Performance against outcomes
- Activity changes
- Cost inflation
- Price changes and the introduction of new drugs/technology
- Agreed service changes
- Legal requirements
- Transfers to/from the amounts made available by Borders Health Board for hospital services
- Adjustments to address equity of resource allocation

8.4.2 Borders Health Board and Scottish Borders Council should consider the following when reviewing the Strategic Commissioning Plan:

- The Local Government Financial Settlement
- The uplift applied to NHS Board funding from Scottish Government
- Efficiencies to be achieved

8.4.3 Whilst the Integration Joint Board will plan, agree and deliver the Strategic Commissioning Plan and related Financial Plan, this will follow a process of joint discussion and planning with the other parties.

8.5 Method for determining the amount set aside for hospital services

8.5.1 This should be determined by the hospital capacity that is expected to be used by the population of the Integration Joint Board area.

8.5.2 The capacity should be given a financial value using the data from the latest Integrated Resources Framework (IRF).

8.5.3 It will be the responsibility of the Council Section 95 Officer and the NHS Board Accountable Officer to comply with the agreed reporting timetable and to make available to the Integration Joint Board Chief Financial Officer the relevant financial information required for timely financial reporting to the Integration Joint Board. This will include such details as may be required to inform financial planning of revenue expenditure. The Integration Joint Board's Chief Financial Officer will manage the respective financial plan so as to deliver the agreed outcomes within the Joint Strategic

Commissioning Plan viewed as a whole. Monitoring arrangements will include the impact of activity on set aside budgets.

8.6 In-year variations

8.6.1 Neither Borders Health Board nor Scottish Borders Council may reduce the payment in-year to the Integration Joint Board to meet exceptional unplanned costs within the constituent authorities, without the express consent of the Integration Joint Board and constituent authorities for any such change. Where appropriate supplementary resources are identified or received by Borders Health Board or Scottish Borders Council e.g. as a result of RSG redetermination, these will be passed on to the Integration Joint Board through increasing the level of budgets delegated to it.

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

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

8.6.4 In the case of joint services any additional payment will be agreed pro rata in line with the original budget level.

8.6.5 The Integration Joint Board should make repayment in future years following the same methodology as the additional payment. If the shortfall is related to a recurring issue the Integration Joint Board should include the issue in the Strategic Commissioning Plan and financial plan for the following year.

8.6.6 Additional adjustments may be required, for example, when errors in the methodology used to determine the delegated budget are found. In these circumstances the payment for this element should be recalculated using the revised methodology.

8.6.7 Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve. If an underspend arises from a material error in the assumptions made to determine the initial budget, the methodology of the payment may need to be recalculated using the revised assumptions.

8.6.8 Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to.

- The Integration Joint Board will have financial accountability for the funding received as payments from Borders Health Board and Scottish Borders Council. This financial accountability will not apply to notional funding for Set Aside Budgets included within the Strategic Commissioning Plan.

- The Integration Joint Board will follow best practice guidelines for audit;

  - The Integration Joint Board and their Chief Financial Officer will receive financial management support from Borders Health Board and Scottish Borders Council who will:

  - Record all financial information in respect of the Integration Joint Board in an integrated database, and use this information as the basis for preparing regular, comprehensive reports to the Integration Joint Board.

  - Support the Chief Financial Officer of the Integration Joint Board to allow them to carry out their functions in preparation of the annual accounts, financial statement prepared under section 39 of the Act, the financial elements of the Strategic Commissioning Plan and other reports that may be required.

  - Ensure monthly financial monitoring reports relating to the performance of the Integration Joint Board against the delegated budget will be submitted to the Chief Officer within 15 working days of the month end for reporting to the Integration Joint Board.

  - Ensure regular reports will be prepared on the financial performance against the Strategic Commissioning Plan.

  - Provide a schedule of payments to the Integration Joint Board following approval of the Strategic Commissioning Plan and its related financial plan. It is intended that this will be a one-off payment made during April/May of each financial year. This payment may be subject to in-year adjustments.

  - In advance of each financial year a timetable of financial reporting will be submitted to the Integration Joint Board for approval.

8.7 Capital Assets:

8.7.1 The Integration Joint Board will not own any capital assets but will have use of such assets which will continue to be owned by Borders Health Board and Scottish Borders Council who will have access to sources of funding for capital expenditure. In line with guidance, the Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure.

8.7.2 The Chief Officer will consult with Borders Health Board and Scottish Borders Council to identify need for asset improvement owned by either party and where investment is identified, will submit a business case to the appropriate party which will be considered as part of each party's existing capital planning and asset management arrangements.

8.8 Year-end balances:

8.8.1 In line with guidance, a process for jointly agreeing, reporting and carrying forward any unused balances at the end of the financial year will operate.

9. Participation and Engagement

9.1 Section 6(2)(a) of the Public Bodies (Joint Working) (Scotland) Act 2014 requires Local Authorities and Health Boards to prepare an Integration Scheme. Before submitting the Integration Scheme to Scottish Ministers for approval, the Local Authority and Health Boards have consulted with:-

- Staff of the Local Authority likely to be affected by the Integration Scheme;
- Staff of the Health Board likely to be affected by the Integration Scheme;
- Health professionals;
- Users of health care;
- Carers of users of health care;
- Commercial providers of health care;
- Non-commercial providers of health care;
- Social care professionals;
- Users of social care;
- Carers of users of social care;
- Commercial providers of social care;
- Non-commercial providers of social care;
- Non-commercial providers of social housing; and
- Third sector bodies carrying out activities related to health or social care.

9.2 Staff and practitioner events were held from October 2014 to January 2015. Engagement events took place in February 2015 in all 5 localities in Scottish Borders. The consultation over the Scheme of Integration was launched on 22 December 2014 (closing on 13 March 2015 – 12 week statutory consultation period) with a press release and emails to all identified stakeholders. The Draft Scheme of Integration was posted on both the Scottish Borders Council and Borders Health Board websites along with details of how people could respond or provide their comments and feedback. This included electronic forms and an email address as well as telephone and postal address.

9.3 Feedback from all of the above has been used to inform the final Scheme of Integration.

9.4 There are national standards for community engagement and participation which underpin how Scottish Borders Council and Borders Health Board operate. A

framework has been developed to take into account these requirements, specifically Scottish Government Planning Advice note 2010 and CEL 4(2010) 'Informing, engaging and consulting people in developing health and community care services'

9.5 Communication and Engagement is vital to the success of integrated services and the reputation of all partners involved. The Parties will support the Integration Joint Board to develop a Communications and Engagement Plan that incorporates the continuing role of the Strategic Planning Group in the development, review and renewal of the Strategic Commissioning Plan. To do this, the Parties will provide appropriate resources and support to develop both a Communications Strategy and supporting action plan. The Strategy will ensure that Communications and Engagement/co-production is effectively linked to the role of the Strategic Planning Group. The Strategy and first iteration of the Communication and Engagement Plan will be in place by April 2016.

10. Information-Sharing

10.1 The PAN Lothian and Borders General Information Sharing Protocol update was agreed by the Pan Lothian and Borders Data Sharing Partnership December 2014.

10.2 Scottish Borders Council, the Borders Health Board and the Integration Joint Board agree to be bound by the Information Sharing Protocol

10.3 This protocol describes the key principles the parties must adhere to for information to be shared lawfully, securely and confidentially. Other signatories will be added as appropriate.

10.4 Procedures for sharing information between Scottish Borders Council, Borders Health Board, and, where applicable, the Integration Joint Board will be drafted as Information Sharing Agreements and procedure documents, as required. This will be undertaken by a sub group (the Borders Data Sharing Partnership) on behalf of the PAN Lothian and Borders Data Sharing Partnership, and will detail the more granular purposes, requirements, procedures and agreements for the Integration Joint Board and their delegated function.

10.5 The national protocol on information sharing – Scottish Accord for the Sharing of Personal Information (SASPI) – will be adopted in due course.

10.6 **Information-Sharing and Confidentiality** All staff are bound by the data confidentiality policies of their employing organisations and the requirements of the Information Sharing Protocol that is in place.

10.7 **Information Sharing and data handling** With respect to person identifiable material, data and information will be held in both electronic and paper format and only be accessed by authorised personnel in order to provide the service user with the appropriate service within the partnership. It may be necessary to share information with external agencies and in that case consent will be sought from the service user if no statutory requirement to share information exists. In order to comply with the Data

Protection Act 1998 all parties will always ensure that any personal data that is processed will be handled fairly, lawfully and with justification.

10.8 Scottish Borders Council and Borders Health Board will continue to be Data Controller for their respective records (electronic and manual), and will detail arrangements for control and access. The Integration Joint Board may require to be Data Controller for personal data where it is not held by either Scottish Borders Council or Borders Health Board.

10.9 Roles and responsibilities for Third party organisations will be detailed in contracts with respective commissioning bodies, and access to shared records agreed in advance.

10.10 Procedures will be based on a single point of governance model through the Data Sharing Partnership. This allows data and resources to be shared, with governance standards, and their implementation, the separate responsibility of each partner. Shared datasets governance will be agreed by all contributing partners prior to access.

10.11 Following consultation, Information Sharing Protocols and procedure documents will be recommended for signature by the Chief Executives of Borders Health Board and Scottish Borders Council and the Integration Joint Board.

10.12 Once established, Agreements and Procedures will be reviewed every two years by the Borders Data Sharing Partnership, or more frequently if required.

10.13 The Borders Integration Joint Board Information Sharing Agreements and procedures will be agreed by end of March 2016.

10.14 The Public Records (Scotland) Act: Both parties are scheduled Public Authorities under the Public Records (Scotland) Act and have a duty to create and have approved a records management plan. The Integration Joint Board will become a body under the duties of the Act and will comply with the requirements of the Act. Reference to information management procedures of the integrated service will be recorded in both plans, including information sharing and other record keeping arrangements and duties that pertain to services contracted out to third party service providers or external agencies will also be included.

10.15 Record keeping: The parties will work towards common records and templates that are readily available for staff to use, in particular:

- Data sharing agreement template
- Consent forms for data sharing
- A data sharing log (this will be a public document)
- Data sharing agreement Review form

10.16 Responsibility for the maintenance and distribution of joint service templates, logs and Borders Health Board and Scottish Borders Council records sits with the Chief Officer. File plans and records retention schedules for records created solely by the Integrated Services will be devised and approved by the Integration Joint Board.

10.17 Responsibility for records created, retained and disposed by each organisation remains with that organisation. Each party will maintain their existing records according to their own policies and disposal schedule.

10.18 **Security:** The success of information sharing relies on a common understanding of security. The information sharing protocol refers to the expected standard but each party must maintain its own guidance to ensure it meets that standard and that controls to manage the following elements are included:-

- Safe storage of documents transported between work and site. Access to electronic and physical records. Use of laptops, memory sticks and other portable data devices when working off site (including at home);

- Confidential destruction;

- Security marking on electronic communications when applicable

10.19 **Access to information - Freedom of Information (FOI):** Both Borders Health Board and Scottish Borders Council will receive Freedom of Information requests and will manage these requests through their own existing processes. Both parties process involves a central FOI Co-ordinator for each organisation, a 10 day timescale for departments to respond to the FOI Co-ordinator and Service Director sign off prior to the response being returned to the requestor. The Co-ordinators of both organisations will work closely together and communicate regularly in relation to FOI.

10.20 Where an FOI relates to a joint service, the receiving organisation will forward the FOI to the relevant Service Manager who will provide the requested information on behalf of both organisations. The receiving organisation will undertake the progress monitoring, responsibility for redacting, quality checking and responding to the applicant. A list of services that are in scope for Integration and their Managers will be developed and shared between the two organisations. All FoI's that relate to integrated services will be signed off by the Chief Officer.

10.21 Should one organisation receive a request that also relates to the other, this request will be managed by the receiving organisation by partnership working of both organisations' FoI Co-ordinators.

10.22 Both organisations will use the same performance measures and report regularly to the Integration Joint Board and to the Office of the Scottish Information Commissioner (OSIC).

10.23 FOI requestors will be logged. Requests for review will be administered by the organisation who dealt with the request and will include review panel members from both organisations.

10.24 **Subject Access Requests:** The differing charging regimes in each organisation for Subject Access and Access to Medical Records requests prevents a joint approach

being adopted for gathering of personal information. Therefore, each party will manage its requests following that organisation's procedures.

10.25 If a subject access request refers to the integrated service it may be necessary to send out two responses. The requestor should be informed at the outset that this will happen. There will be no change to the process for managing access to deceased persons records.

10.26 **Privacy and confidentiality:** Most of the information the integrated services will handle will be personal and confidential in nature. All staff with access to shared information will

1. receive regular training in handling personal data compliantly;

2. have access to systems and records removed as soon as they leave the post that allows them to share information;

3. be subject to appropriate level of vetting by HR. This particularly applies to existing staff that may not have been subject to checks in their current role but require it in their integrated services post.

10.27 **Information Governance:** The Information Governance reporting arrangements for each party are as follows:

1. Borders Health Board: The Information Governance Committee reports to the Borders Health Board's Audit Committee.

2. Scottish Borders Council: The Information Governance Group reports to the Corporate Management Team.

11. Complaints

11.1 The Parties agree that complaints in relation to the delegated functions as set out in Part 2 Appendix 2, and Part 2 Appendix 3, will be received, managed and responded to by the appropriate lead organisation and agree to the following arrangements in respect of this:-

- Complaints in relation to integrated services or Scottish Borders Council services can be made to Scottish Borders Council, Headquarters.

- Complaints in relation to integrated services or Borders Health Board services can be made to NHS Borders, Borders General Hospital.

- Each organisation will have a clearly defined description of what constitutes a complaint contained within their organisations complaints handling documentation.

- A framework has been developed that clearly shows the lead organisation for each integrated service and the contact details for those who will be responsible for

progressing any complaints received. The lead organisation will take responsibility for the triage of the complaint, and liaise with the other organisation to develop a joint response where required.

- Where the complaint is multi-faceted and has a multi-agency dimension to it, the Chief Officer will designate one of the existing processes to take the lead for investigating and coordinating a response. The Chief Officer will have an overview of complaints related to integrated services and will provide a commitment to joint working, wherever necessary, between the parties when dealing with complaints about integrated services.

- If a complaint remains unresolved through the defined complaints-handling procedure, complainants will be informed of their right to go either to the Scottish Public Services Ombudsman for services provided by Borders Health Board, or to the Social Work Complaints Review Committee following which, if their complaint remains unresolved, they have the right to go to the Scottish Public Services Ombudsman for services provided by Scottish Borders Council.

- There will be three established processes for a complaint to follow depending on the lead organisation.

    1. Statutory Social Work.
    2. NHS.
    3. Independent Contractors – All Independent Contractors involved with the Integration Joint Board, will be required to have a Complaints Procedure in place. Where complaints are received that relate to a service provided by an Independent Contractor, the lead organisation will refer the complainant to the Independent Contractor for resolution of their complaint. This may be done by either provision of contact details or by the lead organisation passing the complaint on, depending on the approach preferred by the complainant.

- The current process for gathering service user/patient/carer feedback within Borders Health Board and Scottish Borders Council, how it has been used for improvement, and how it is reported will continue.

12. Claims Handling, Liability & Indemnity

12.1 Borders Health Board will continue to follow their CNORIS programme for their services and Scottish Borders Council will continue with their current insurance processes. This will be applied to all integrated services.

12.2 Where there is a shared liability negotiations will take place as to the proportionality of each parties liability on a claim by claim basis.

13. Risk Management

13.1 The Corporate Risk functions in Borders Health Board and Scottish Borders Council will support the Chief Officer to develop a risk management strategy by the end of

March 2016. In the context of the risk management strategy the initial list of risks to be reported will be outlined in the first formal meeting of the Integration Joint Board from 1 April 2016.

13.2 The risk management strategy will include: risk monitoring and risk management framework; the integrated management risk register; and the strategic risk register.

13.3 As part of the risk management strategy the Chief Officer will be responsible for drawing to the attention of the Integration Joint Board any new or escalating risks and associated mitigations to ensure appropriate oversight and action.

13.4 Business Continuity plans will be in place and tested on a regular basis for the integrated services.

14. Dispute resolution mechanism

14.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, then they will follow the process as set out below:

(a) The Chief Executives of Borders Health Board and Scottish Borders Council, will meet to resolve the issue;

(b) If unresolved, the Borders Health Board, and Scottish Borders Council will each prepare a written note of their position on the issue and exchange it with the others;

(c) In the event that the issue remains unresolved, the Chief Executives (or their representatives) of Borders Health Board and Scottish Borders Council will proceed to mediation with a view to resolving the issue.

(d) A professional independent mediator will be appointed. The mediation process will commence within 28 calendar days of the agreement to proceed.

(e) The Mediator shall have the same powers to require any Partner to produce any documents or information to him/her and the other Partner as an arbiter and each Partner shall in any event supply to him such information which it has and is material to the matter to be resolved and which it could be required to produce on discovery; and

(f) The fees of the Mediator shall be borne by the Parties in such proportion as shall be determined by the Mediator having regard (amongst other things) to the conduct of the parties.

14.2 Where the issue remains unresolved after following the processes outlined above, the Parties agree the following process to notify Scottish Ministers that agreement cannot be reached.

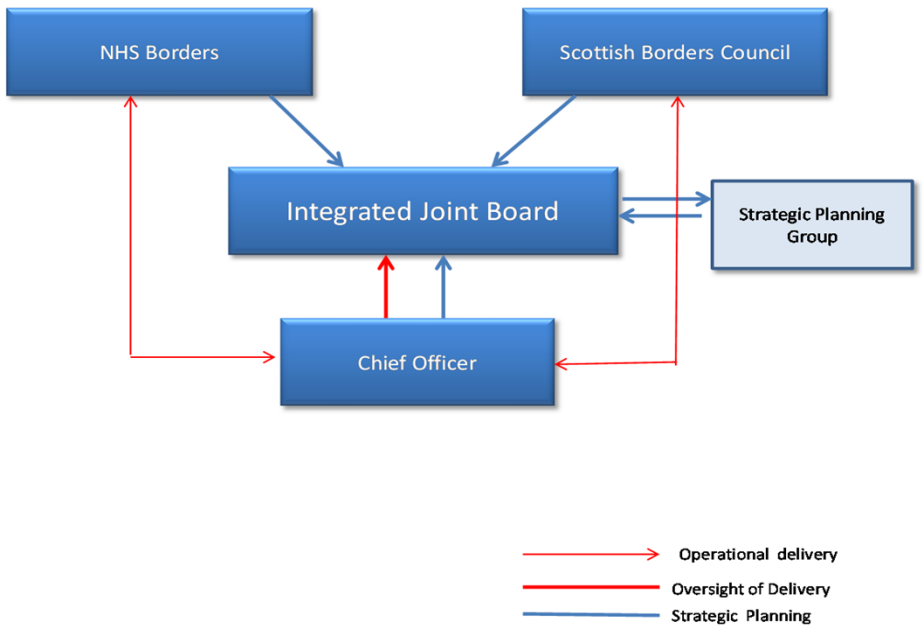
14.3 The Chief Executives shall write to Scottish Ministers detailing the unresolved issue, the process followed and findings of the mediator and seek resolution from Scottish Ministers.

APPENDIX OF DOCUMENTS – HEALTH AND SOCIAL CARE SCHEME OF INTEGRATION

Appendix No	Document
1 HSC Integration Scheme 151215 diagr	Integration Joint Board Governance Arrangements The Integration Joint Board may establish its own Audit Committee. The chairs of all 3 Audit Committees would, in such circumstances, (Borders Health Board, Scottish Borders Council and the Integration Joint Board) be expected to work in an integrated way.
2 APPENDIX 2 Functions Delegated I	Functions delegated by the Health Board to the Integration Joint Board
3 APPENDIX 3 Functions Delegated I	Functions delegated by the Local Authority to the Integration Joint Board

APPENDIX 1

Integration Joint Board Governance Arrangements



APPENDIX 2

Part 1

Functions delegated by the Health Board to the Integration Joint Board

Note

In accordance with paragraphs 3.1 and 3.2 of the Integration Scheme, each function listed in column A is delegated subject to the exceptions in column B and only to the extent that:

(d) It is exercisable in relation to persons of at least 18 years of age (other than functions exercisable in relation to the health care services set out in paragraphs 11-15 of Section 3 of Part 2 of Appendix 2 which are delegated in relation to persons of any age); and

(e) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed in Section 1 of Part 2 of Appendix 2; or

(f) The function is exercisable in relation the health and care services listed in Section 2 of Part 1 of Appendix 2.

Functions prescribed for the purposes of section 1(8) of the Act

Column A	*Column B*
The National Health Service (Scotland) Act 1978	
All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of— section 2(7) (Health Boards); section 2CB (Functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS Contracts); section 17C (personal medical or dental services); section 17I (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38 (care of mothers and young children);

section 38A (breastfeeding);

section 39 (medical and dental inspection, supervision and treatment of pupils and young persons);

section 48 (provision of residential and practice accommodation);

section 55 (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);
section 64 (permission for use of facilities in private practice);

section 75A (remission and repayment of charges and payment of travelling expenses);

section 75B(reimbursement of the cost of services provided in another EEA state);

section 75BA (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);

section 79 (purchase of land and moveable property);

section 82 use and administration of certain endowments and other property held by Health Boards);

section 83 (power of Health Boards and local health councils to hold property on trust);

section 84A (power to raise money, etc., by appeals, collections etc.);

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);

section 98 (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ;

The Health Boards (Membership and

	Procedure) (Scotland) Regulations 2001/302; The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54; The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114; The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004; The National Health Service (Discipline Committees) Regulations 2006/330; The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183; The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55.
Disabled Persons (Services, Consultation and Representation) Act 1986	
Section 7 (Persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002	
All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003	
All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (Approved medical practitioners); section 34 (Inquiries under section 33: co-operation); section 38 (Duties on hospital managers: examination notification etc.);

	section 46 (Hospital managers' duties: notification);
	section 124 (Transfer to other hospital);
	section 228 (Request for assessment of needs: duty on local authorities and Health Boards);
	section 230 (Appointment of a patient's responsible medical officer);
	section 260 (Provision of information to patients);
	section 264 (Detention in conditions of excessive security: state hospitals);
	section 267 (Orders under sections 264 to 266: recall);
	section 281 (Correspondence of certain persons detained in hospital);
	and functions conferred by—
	The Mental Health (Safety and Security) (Scotland) Regulations 2005;
	The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005;
	The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and
	The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008.

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23
(other agencies etc. to help in exercise of functions under this Act**)**

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by—
	section 31(Public functions: duties to provide information on certain expenditure etc.); and
	section 32 (Public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36.

Part 2

Services currently provided by the Health Board which are to be integrated

SECTION 1

Interpretation of Schedule 3

1. In this schedule—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004; and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

SECTION 2

2. Accident and Emergency services provided in a hospital.

3. Inpatient hospital services relating to the following branches of medicine—

(a) general medicine;

(b) geriatric medicine;

(c) rehabilitation medicine;

(d) respiratory medicine; and

(e) psychiatry of learning disability.

4. Palliative care services provided in a hospital.

5. Inpatient hospital services provided by General Medical Practitioners.

6. Services provided in a hospital in relation to an addiction or dependence on any substance.

7. Mental health services provided in a hospital, except secure forensic mental health services.

SECTION 3

8. District nursing services.

9. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

10. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

11. The public dental service.*

12. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978.*

13. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978.*

14. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978.*

15. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978.*

16. Services providing primary medical services to patients during the out-of-hours period.

17. Services provided outwith a hospital in relation to geriatric medicine.

18. Palliative care services provided outwith a hospital.

19. Community learning disability services.

20. Mental health services provided outwith a hospital.

21. Continence services provided outwith a hospital.

22. Kidney dialysis services provided outwith a hospital.

23. Services provided by health professionals that aim to promote public health.

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

APPENDIX 3

Part 1

Functions delegated by the Local Authority to the Integration Joint Board

Note

In accordance with paragraphs 3.3 and 3.4 of the Integration Scheme, each function listed in column A is delegated subject to the exceptions in column B and only to the extent that it is exercisable in relation to persons of at least 18 years of age.

PART 1

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958	
Section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 12AA (Assessment of ability to provide care.)	
Section 12AB (Duty of local authority to provide information to carer.)	
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Local Government and Planning (Scotland) Act 1982	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986	
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions
The Housing (Scotland) Act 2001	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002	
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
The Housing (Scotland) Act 2006	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013	
Section 3 (Support for adult carers.)	Only in relation to assessments carried out under integration functions.
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013 .
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4 The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002	

Part 2

Services currently provided by the Local Authority which are to be integrated

Scottish Ministers have set out in guidance that the services set out below must be integrated.

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptions
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare

INTEGRATION JOINT BOARD LOCAL CODE OF CORPORATE GOVERNANCE

Aim

1.1 The purpose of this report is to gain approval to the Local Code of Corporate Governance of the Scottish Borders Health and Social Care Integration Joint Board (IJB) that provide the framework for the governance arrangements for delivering health and social care integration in the Scottish Borders.

Background

2.1 The public sector has adopted Corporate Governance principles. Fundamentally Corporate Governance is about openness, integrity and accountability. It comprises the systems and processes, and cultures and values, by which organisations are directed and controlled and through which they account to, engage with and, where appropriate, lead their communities.

2.2 The six core principles of good governance[1] are:

- Focusing on the purpose of the authority and on outcomes for the community and creating and implementing a vision for the local area;
- Members and Officers working together to achieve a common purpose with clearly defined functions and roles;
- Promoting the values for the authority and demonstrating the values of good governance through upholding high standards of conduct and behaviour;
- Taking informed and transparent decisions which are subject to effective scrutiny and managing risk;
- Developing the capacity and capability of members and officers to be effective; and
- Engaging with local people and other stakeholders to ensure robust public accountability.

2.3 Authorities are urged to test their structure against these principles by:

- Reviewing their existing governance arrangements against the Framework;
- Developing and maintaining an up-to-date local code of governance including arrangements for ensuring its on-going application and effectiveness; and
- Preparing a governance statement in order to report publicly on the extent to which they comply with their own code on an annual basis, including how they have monitored the effectiveness of their governance arrangements in the year,

[1] The CIPFA/SOLACE 2007 framework 'Delivering Good Governance in Local Government'

and on any planned changes for the coming period.

Proposal

3.1 In order to demonstrate that robust Corporate Governance procedures are in place for health and social care integration and to comply with best practice, it is proposed that the Integration Joint Board (IJB) has its own Local Code of Corporate Governance ('Local Code') that will be available to be viewed by all stakeholders including partners, service users and the local community.

3.2 The approval by the IJB of its Local Code (as set out in Appendix 1) which reflects the six core principles with supporting principles and specific requirements will ensure the IJB meets the requirements of the best practice good governance framework. Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk. Some mechanisms are in place, some are approved and some are under development so the Local Code will evolve as health and social care integration progresses.

3.3 The Local Code of Corporate Governance will be scrutinised by the IJB's Audit Committee which will receive an annual report in the form of an Annual Governance Statement from the Chief Officer on compliance with the Local Code and whether the Local Code requires to be updated.

3.4 The basis of the Annual Governance Statement will be an overview of and opinion on the IJB's arrangements contained in the approved Local Code. The Annual Governance Statement will provide assurance that internal control and governance arrangements are adequate and operating effectively in practice or, where reviews of the internal control and governance arrangements reveal gaps, it will identify planned actions that will ensure effective internal control and governance in future.

3.5 The annual review, scrutiny and reporting processes will be in alignment with the publication of the Annual Accounts and Performance Information, which will include the Annual Governance Statement signed by the Chief Officer and the Chair of the IJB. An Annual Performance report on Health and Social Care Integration will be prepared by the Chief Officer, presented to the IJB for approval and submitted as laid out in regulations.

Recommendations

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

(a) **Approve** its Local Code of Corporate Governance for health and social care integration as detailed in Appendix 1 of this report; and

(b) **Agree** to the annual review of its governance arrangements and reporting of the outcome of that review in an Annual Governance Statement scrutinised by the IJB Audit Committee in advance of IJB approval.

Policy/Strategy Implications	Development of its own Local Code of Corporate

	Governance and arrangements for its annual review will enable the IJB to comply with best practice. Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.
Consultation	Members of the Integration Programme Board have been consulted on the report. The report has also been reviewed by and approved by relevant Management Teams within both partner organisations.
Risk Assessment	The Local Code of Corporate Governance provides the framework for members and officers of the IJB to conduct its affairs that are based on six principles. The review of and revisions to the Local Code of Corporate Governance will ensure that internal controls, risk management and other governance arrangements are improved through the implementation of the framework.
Compliance with requirements on Equality and Diversity	It is anticipated that there are no adverse impact due to race, disability, gender, age, sexual orientation or religion/belief arising from the proposals in this report.
Resource/Staffing Implications	There are no direct financial implications arising from the proposals in this report. Arrangements to ensure that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively is an integral part of good corporate governance and therefore financial governance and key internal financial controls are embedded within the Local Code of Corporate Governance.

Approved by

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

Author

Name	Designation	Name	Designation
Jill Stacey	SBC Chief Officer Audit and Risk and IJB Chief Internal Auditor		

The public sector has adopted Corporate Governance principles. Fundamentally Corporate Governance is about openness, integrity and accountability. It comprises the systems and processes, and cultures and values, by which organisations are directed and controlled and through which they account to, engage with and, where appropriate, lead their communities.

The six core principles of good governance are:

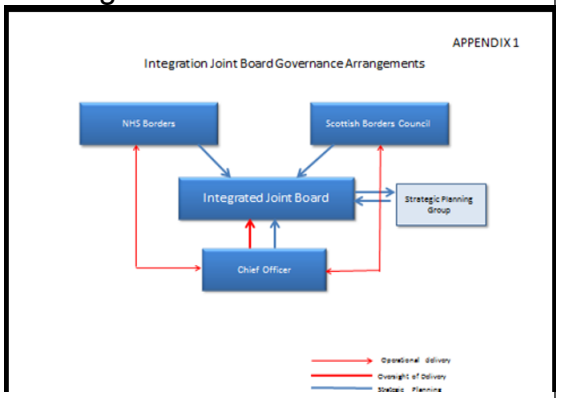
(i) Focusing on the purpose of the authority and on outcomes for the community and creating and implementing a vision for the local area;
(ii) Members and Officers working together to achieve a common purpose with clearly defined functions and roles;
(iii) Promoting the values for the authority and demonstrating the values of good governance through upholding high standards of conduct and behaviour;
(iv) Taking informed and transparent decisions which are subject to effective scrutiny and managing risk;
(v) Developing the capacity and capability of members and officers to be effective; and
(vi) Engaging with local people and other stakeholders to ensure robust public accountability.

Authorities are urged to test their structure against these principles by:
Reviewing their existing governance arrangements against the Framework

- Developing and maintaining an up-to-date local code of governance including arrangements for ensuring its ongoing application and effectiveness

<u>Reporting structure</u>

The Integration Joint Board (IJB) is responsible for the strategic planning of the functions delegated to it. The partner organisations Scottish Borders Council and NHS Borders will engage in the partnership via the reporting structures by having oversight of delivery and/or governance routes:



The preparation and publication of an Annual Governance Statement in accordance with the Framework fulfils the statutory requirement for the authority to conduct a review at least once in each financial year of the effectiveness of its system of internal control and to include a statement reporting on the review with its Statement of Accounts. This process not only creates an opportunity for the Integration Joint Board to set out its standard for good governance but also to ensure that its governance arrangements are seen to be sound. This is important as the governance arrangements in public services are closely scrutinised.

1 The CIPFA/SOLACE 2007 framework 'Delivering Good Governance in Local Government'

CORE PRINCIPLE 1

Focusing on the purpose of the authority and on outcomes for the community and creating and implementing a vision for the local area

Supporting Principle	The Local Code should reflect the requirements to:	Demonstration of Compliance
1.1 Exercising strategic leadership by developing and clearly communicating the authority's purpose and vision and its intended outcomes for citizens and service users	Develop and promote the authority's purpose and vision	The vision, strategic objectives and outcomes are reflected in the Scottish Borders Health & Social Care Partnership's Strategic Plan 2016-2019 and the associated Commissioning and Implementation Plan.
	Review on a regular basis the authority's vision for the local area and its implications for the authority's governance arrangements	
	Ensure that partnerships are underpinned by a common vision of their work that is understood and agreed by all partners	The Strategic Assessment underpins the strategic vision for the Scottish Borders including Scottish Borders Council, NHS Borders and other community planning partners.
	Publish an annual report on a timely basis to communicate the authority's activities and achievements, its financial position and performance	The Annual Accounts and Report that sets out the financial position and performance will be produced in accordance with accounting regulations. Regular performance monitoring reports are scrutinised by the IJB.
1.2 Ensuring that users receive a high quality of service whether directly, or in partnership, or by commissioning	Decide how the quality of service for users is to be measured and make sure that the information needed to review service quality effectively and regularly is available	The Commissioning and Implementation Plan and the associated Performance Management Framework will establish the mechanism for measuring quality and performance of all services within scope of health and social care integration.
	Put in place effective arrangements to identify and deal with failure in service delivery	The Clinical and Care Governance framework will set out the key roles to monitor and review service delivery standards and performance of all services within scope of health and social care integration. Audit and Inspection activity will be presented as relevant to the IJB or one of its Committees including improvement action plans.
1.3 Ensuring that the authority makes best use of resources and that tax payers/service users receive excellent value for money	Decide how value for money is to be measured and make sure that the authority or partnership has the information needed to review value for money and performance effectively. Measure the environmental impact of policies, plans and decisions	Reliance will be placed on the value for money arrangements within the partner organisations. The standard template for decision-making reports to the IJB and its Committees includes a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing.

CORE PRINCIPLE 2

Members and Officers working together to achieve a common purpose with clearly defined functions and roles

Supporting Principle	The Local Code should reflect the requirements to:	Demonstration of Compliance
2.1 Ensuring effective leadership throughout the authority and being clear about executive and non-executive functions and of the roles & responsibilities of the scrutiny function	Set out a clear statement of the respective roles and responsibilities of the executive and authority's approach towards putting this into practice.	The Integration Joint Board has approved the constitution, terms of reference and reporting arrangements for its formal committees to date e.g. Strategic Planning Group and Audit Committee.
	Set out a clear statement of the respective roles and responsibilities of members generally and of senior officers.	The Integration Joint Board has approved the statutory roles of Chief Officer and Chief Finance Officer.
2.2 Ensuring that a constructive working relationship exists between authority members and officers and that the responsibilities of authority members and officers are carried out to a high standard	Determine a scheme of delegation and reserve powers within the constitution, including a formal schedule on those matters specifically reserved for collective decision of the authority, taking account of relevant legislation, and ensure that it is monitored and updated when required	The Integration Joint Board is responsible for the strategic planning of the functions delegated to it by the partners and for ensuring oversight of the delivery of its functions set out within the Scheme of Integration.
	Make a Chief Executive responsible and accountable to the authority for all aspects of operational management	In the context of health and social care integration this is the Chief Officer Health and Social Care Integration which is a Statutory post with job description.
	Develop protocols to ensure that the Leader and Chief Executive negotiate their respective roles early in the relationship and that a shared understanding of roles and objectives is maintained	Regular meetings are held between the Chief Officer Health and Social Care Integration and the Chair and Vice Chair of the IJB. The Chief Officer also meets regularly with the Chief Executives of the partner organisations.
	Make a senior officer (the Section 95 officer) responsible to the authority for ensuring that appropriate advice is given on all financial matters, for keeping proper financial records and accounts, and for maintaining an effective system of internal financial control	In the context of health and social care integration this is the Chief Financial Officer which is a Statutory post with job description. Responsibilities are set out within the Financial Regulations (approved) which is the framework for financial rules and regulations.
Supporting Principle	**The Local Code should reflect the requirements to:**	**Demonstration of Compliance**
2.2 (cont'd)	Make a senior officer (usually the monitoring officer) responsible to the authority for ensuring that agreed procedures are followed and that all applicable statutes and regulations are complied with	In the context of health and social care integration this role will be fulfilled by the Chief Officer supported by Board Secretary, Chief Financial Officer, and Chief Internal Auditor.
2.3 Ensuring relationships between the authority, its partners and the public are clear so that each knows what to expect of the other	Develop protocols to ensure effective	The Chief Officer is the bridge enabling good communication from the IJB to

	communication between members and officers in their respective roles	those working in and associated with health and social care integration and vice versa. The partner organisations Scottish Borders Council and NHS Borders will engage in the partnership via the reporting structures as set out in Scheme of Integration.
	Ensure that an established scheme for remuneration of members and officers and an effective structure for managing the process, including an effective remuneration panel (if applicable) are in place	n/a
	Ensure that effective mechanisms exist to monitor service delivery	The Commissioning and Implementation Plan and the associated Performance Management Framework will establish the mechanism for measuring quality and performance of all services within scope of health and social care integration.
	Ensure that the authority's vision, priorities, and targets are developed through robust mechanisms, and in consultation with the local community and other key stakeholders, and that they are clearly articulated and disseminated	The vision, strategic objectives and outcomes are reflected in the Scottish Borders Health & Social Care Partnership's Strategic Plan 2016-2019 and the associated Commissioning and Implementation Plan. Consultation and engagement events were undertaken during the development of the Scheme of Integration and the Strategic Plan.
	When working in partnership, ensure that members are clear about their roles and responsibilities both individually and collectively in relation to the partnership and to the authority	The Scheme of Integration states that whilst serving on the Integration Joint Board its members will carry out their functions under the Act on behalf of the Integration Joint Board itself, and not as delegates of their respective Health Board or Local Authority. Approved terms of reference for the IJB.
	When working in partnership, ensure that there is clarity about the legal status of the partnership; and ensure that representatives of organisations both understand and make clear to all other partners the extent of their authority to bind their organisation to partner decisions	The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. The partner organisations Scottish Borders Council and NHS Borders will delegate functions to the Integration Joint Board (using the "body corporate" arrangement) and will engage in the partnership via the reporting structures as set out in the Scheme of Integration.

CORE PRINCIPLE 3

Promoting the values for the authority and demonstrating the values of good governance through upholding high standards of conduct and behaviour

Supporting Principle	The Local Code should reflect the requirements to:	Demonstration of Compliance
3.1 Ensuring authority members and officers exercise leadership by behaving in ways that exemplify high standards of conduct and effective governance	Ensure that the authority's leadership sets a tone for the organisation by creating a climate of openness, support and respect	Reliance will be placed on the values and standards set out in the codes of conduct within the employer partner organisations, as well as organisational development plans.
	Ensure that standards of conduct and personal behaviour expected of members and staff, of work between members and staff and between the authority, its partners and the community are defined & communicated through codes of conduct and protocols	Reliance will be placed on the values and standards set out in the codes of conduct within the employer partner organisations, as well as the organisational development plans, which incorporate "The Seven Principles of Public Life" identified by the Nolan Committee on Standards in Public Life.
	Put in place arrangements to ensure that members and employees of the authority are not influenced by prejudice, bias or conflicts of interest in dealing with different stakeholders and put in place appropriate processes to ensure that they continue to operate in practice	Reliance will be placed on the arrangements within the employer partner organisations for identifying, mitigating and recording conflicts of interest, hospitality and gifts. Declarations of Interest are set out in the IJB's Standing Orders which govern the conduct of each Committee meeting.
3.2 Ensuring that organisational values are put into practice and are effective	Develop and maintain shared values including leadership values for both the organisation and staff reflecting public expectations, and communicating these with members, staff, the community and partners	Shared values are reflected in the Strategic Plan.
	Put in place arrangements to ensure that systems and processes are designed in conformity with appropriate ethical standards, and monitor their continuing effectiveness in practice	The Annual Governance Statement will be the outcome of the annual self-evaluation of compliance.
	Develop and maintain an effective standards committee	The IJB Audit Committee remit includes role to promote the highest standards of conduct and professional behaviour.
	Use the organisation's shared values to act as a guide for decision making and as a basis for developing positive and trusting relationships within the authority	The standard template for decision-making reports to the IJB and its Committees includes a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing.
Supporting Principle	**The Local Code should reflect the requirements to:**	**Demonstration of Compliance**
3.2 (cont'd)	In pursuing the vision of a partnership, agree a set of values against which decision making and actions can be judged. Such values must be demonstrated	

	by partners' behaviour both individually and collectively	

CORE PRINCIPLE 4

Taking informed and transparent decisions which are subject to effective scrutiny and managing risk

Supporting Principle	The Local Code should reflect the requirements to:	Demonstration of Compliance
4.1 Being rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny	Develop and maintain an effective scrutiny function which encourages constructive challenge and enhances the authority's performance overall and that of any organisation for which it is responsible	The health and social care partnership's scrutiny arrangements are established through the Scheme of Integration, the IJB's committee structures and specified remits, and the governance of partner organisations through the reporting structure.
	Develop and maintain open and effective mechanisms for documenting evidence for decisions and recording the criteria, rationale and considerations on which decisions are based	Minutes and committee reports are published on modern.gov. IJB business is only held in private if required by legislation. The standard template for decision-making reports to the IJB and its Committees include a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing.
	Put in place arrangements to safeguard members and employees against conflicts of interest and put in place appropriate processes to ensure that they continue to operate in practice	Reliance will be placed on the arrangements within the employer partner organisations for identifying, mitigating and recording conflicts of interest, hospitality and gifts. Declarations of Interest are set out in the IJB's Standing Orders which govern the conduct of each Committee meeting.
	Develop and maintain an effective audit committee (or equivalent) which is independent of the executive and scrutiny functions or make other appropriate arrangements for the discharge of the functions of such a committee	The role of the IJB Audit Committee is to have high-level oversight of internal control, governance and risk management.
	Ensure that effective, transparent and accessible arrangements are in place for dealing with complaints	Reliance will be placed on the complaints and comments policy and procedures within the partner organisations. The Clinical and Care Governance framework will set out the key requirements.
Supporting Principle	**The Local Code should reflect the requirements to:**	**Demonstration of Compliance**
4.2 Having good quality information, advice and support to ensure that services are delivered effectively and are what the community wants/needs	Ensure that those making decisions whether for the authority or the partnership are provided with information that is fit for the purpose – relevant, timely and gives clear explanations of technical issues and their implications	The standard template for decision-making reports to the IJB and its Committees include a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing. Committee reports are published on modern.gov one week in advance of meeting dates. Officers attend IJB and its Committee meetings to advise as appropriate.
	Ensure that professional advice on matters that have legal or financial implications is available and	Professional advice and overseeing compliance with the legal and financial framework will be provided by the Chief Officer, Chief Financial

	recorded well in advance of decision making and used appropriately	Officer, Chief Internal Auditor and Secretary to the IJB as appropriate. The Clinical and Care Governance framework will set out the key requirements.
4.3 Ensuring that an effective risk management system is in place	Ensure that risk management is embedded into the culture of the authority, with members and managers at all levels recognising that risk management is part of their jobs	The Risk Management Strategy, to be approved by the IJB, includes the: reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities; and monitoring risk management activity and performance. The Chief Officer will be responsible for drawing to the attention of the IJB any new or escalating risks and associated mitigations to ensure appropriate oversight and action.
	Ensure that arrangements are in place for whistle-blowing to which staff and all those contracting with the authority have access	Reliance will be placed on the arrangements within the employer partner organisations for reporting and responding to such reports.
4.4 Using their legal powers to the full benefit of the citizens and communities in their area	Actively recognise the limits of lawful activity place on them by, for example, the ultra vires doctrine but also strive to utilise powers to the full benefit of their communities	The scope is set out in the Scheme of Integration in order to comply with the Public Bodies (Joint Working) (Scotland) Act 2014 which requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services.
	Recognise the limits of lawful action and observe both the specific requirements of legislation and the general responsibilities placed on authorities by public law	Reliance will be placed on the arrangements within the partner organisations for ensuring legal compliance.
	Observe all specific legislative requirements placed upon them, as well as the requirements of general law, and in particular to integrate the key principles of good administrative law – rationality, legality and natural justice – into their procedures and decision-making processes	Advice and overseeing compliance on legal matters will be provided by the Chief Officer supported by Board Secretary, Chief Financial Officer, and Chief Internal Auditor as appropriate.

CORE PRINCIPLE 5

Developing the capacity and capability of members and officers to be effective

Supporting Principle	The Local Code should reflect the requirements to:	Demonstration of Compliance
5.1 Making sure that members and officers have the skills, knowledge, experience and resources they need to perform their roles well	Provide induction programmes tailored to individual needs and opportunities for members and officers to update their knowledge on a regular basis	IJB Development Sessions have been held during the pre-planning phases of the health and social care programme.
	Ensure that the statutory officers have the skills, resources and support necessary to perform effectively in their roles and that these roles are properly understood throughout the authority	The Scheme of Integration sets out the roles and responsibilities of statutory officers (Chief Officer Health and Social Care Integration, Chief Financial Officer) which are reflected within job descriptions and relevant governance documents.
5.2 Developing the capability of people with governance responsibilities and evaluating their performance, as individuals and as a group	Assess the skills required by members and officers and make a commitment to develop those skills to enable roles to be carried out effectively	IJB Development Sessions have been held to cover relevant topics. There has been informal development of officers from NHS Borders and Scottish Borders Council as part of their participation and engagement in the health and social care programme working groups.
	Develop skills on a continuing basis to improve performance, including the ability to scrutinise and challenge and to recognise when outside expert advice is needed	IJB Development Sessions are scheduled on alternate months from IJB meetings during 2016.
	Ensure that effective arrangements are in place for reviewing the performance of the executive as a whole and of individual members and agreeing an action plan which might, for example, aim to address any training or development needs	Annual self-evaluation will be part of the Performance Management framework. Any improvement actions will be reflected in the Organisational Development Plan and / or Communications and Engagement Plan as appropriate.
5.3 Encouraging new talent for membership of the authority so that best use can be made of individuals' skills and resources in balancing continuity and renewal	Ensure that effective arrangements are in place designed to encourage individuals from all sections of the community to engage with, contribute to and participate in the work of the authority	Community engagement was encouraged as part of the development of the Scheme of Integration and the Strategic Plan.
	Ensure that career structures are in place for members and officers to encourage participation and development	Reliance will be placed on the workforce planning arrangements within the employer partner organisations.

CORE PRINCIPLE 6

Engaging with local people and other stakeholders to ensure robust public accountability

Supporting Principle	The Local Code should reflect the requirements to:	Demonstration of Compliance
6.1 Exercising leadership through a robust scrutiny function which effectively engages local people and all local institutional stakeholders, including partnerships, and develops constructive accountability relationships	Make clear to themselves, all staff and the community to whom they are accountable and for what	The vision, strategic objectives and outcomes are reflected in the Scottish Borders Health & Social Care Partnership's Strategic Plan 2016-2019 and the associated Commissioning and Implementation Plan. The Strategic Assessment underpins the strategic vision for the Scottish Borders including Scottish Borders Council, NHS Borders and other community planning partners.
	Consider those institutional stakeholders to whom the authority is accountable and assess the effectiveness of the relationships and any changes required	The Scheme of Integration sets out the governance arrangements of the health and social care partnership including the reporting structure for the IJB, Scottish Borders Council and NHS Borders.
	Produce an annual report on the activity of the scrutiny function	
6.2 Taking an active and planned approach to dialogue with and accountability to the public to ensure effective and appropriate service delivery whether directly by the authority, in partnership or by commissioning	Ensure clear channels of communication are in place with all sections of the community and other stakeholders, and put in place monitoring arrangements and ensure that they operate effectively	The ability to communicate with discrete groups in an appropriate manner was demonstrated as part of the development of the Scheme of Integration and the Strategic Plan of the health and social care integration partnership. The Communications and Engagement Plan will set out the key requirements for effective communications and engagement with all relevant stakeholders, using existing structures in partner organisations NHS Borders and Scottish Borders Council as appropriate.
	Hold meetings in public unless there are good reasons for confidentiality	Minutes and committee reports are published on modern.gov website. The IJB business is only held in private if required by legislation.
	Ensure that arrangements are in place to enable the authority to engage with all sections of the community effectively. These arrangements should recognise that different sections of the community have different priorities and establish explicit processes for dealing with these competing demands	Community engagement was encouraged as part of the development of the Scheme of Integration and the Strategic Plan of the health and social care integration partnership. The Communications and Engagement Plan will set out the key requirements for effective communications and engagement with all relevant stakeholders, using existing structures in partner organisations NHS Borders and Scottish Borders Council as appropriate.
Supporting Principle	**The Local Code should reflect the requirements to:**	**Demonstration of Compliance**
6.2 Taking an active and planned approach to dialogue with and	Establish a clear policy on the types of issues they will meaningfully consult on or engage with the public and service users about including a feedback	The Communications and Engagement Plan will set out the key requirements for effective communications and engagement with all relevant stakeholders, using existing structures in partner organisations

accountability to the public to ensure effective and appropriate service delivery whether directly by the authority, in partnership or by commissioning (cont'd)	mechanism for those consultees to demonstrate what has changes as a result	NHS Borders and Scottish Borders Council as appropriate.
	On an annual basis, publish a performance plan giving information on the authority's vision, strategy, plans and financial statements as well as information about its outcomes, achievements and satisfaction of service users in the previous period	An Annual Report setting out performance against the strategic plan will be produced as well as the Annual Accounts and Report that sets out the financial position in accordance with accounting regulations. Regular performance monitoring reports are scrutinised by the IJB.
	Ensure that the authority as a whole is open and accessible to the community, service users and its staff and ensure that it has made a commitment to openness and transparency in all its dealings, including partnerships, subject only to the need to preserve confidentiality in those specific circumstances where it is proper and appropriate to do so	Corporate governance is about openness, integrity and accountability and the Local Code sets out the IJB's systems and processes through which it accounts to, engages with and, where appropriate, leads its communities. Reliance will be placed on the arrangements within the partner organisations to ensure compliance with Data Protection and Freedom of Information legislation.
6.3 Making best use of human resources by taking an active and planned approach to meet responsibility to staff	Develop and maintain a clear policy on how staff and their representatives are consulted and involved in decision making	Reliance will be placed on the HR Policies and Procedures, and arrangements for communicating and consulting with staff and trades unions within the employer partner organisations.

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

STANDING ORDERS

Version	**4**
Date	**22.02.16**
Author	**Iris Bishop, Board Secretary**

1. General

1.1 The Standing Orders of the Scottish Borders Health & Social Care Integration Joint Board are set up in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014.

1.2 Any statutory provision, regulation or direction issued by the Scottish Ministers shall have precedence if they are in conflict with the Standing Orders.

2. Membership

2.1 The Integrated Joint Board shall comprise five NHS Non-Executive Directors appointed by Borders Health Board, and five Elected Councillors appointed by Scottish Borders Council. In addition, there will be non-voting representatives drawn from health and social care professionals, staff, the third sector, users, the public and carers as identified by the Integration Joint Board. The Chief Officer of the Integration Joint Board, Chief Financial Officer and the Chief Executives of NHS Borders and Scottish Borders Council, and any other senior officers as appropriate, will be invited to attend the Integration Joint Board as non-voting members.

2.2 The term of office of voting Members of the Integration Joint Board shall last as follows:

(a) for Local Government Councillors, three years, thereafter Scottish Borders Council will identify its replacement Councillor(s) on the Integration Joint Board,

(b) for Borders Health Board nominees, three years, thereafter Borders Health Board will identify its replacement Non Executive(s) on the Integration Joint Board.

2.3 Where a Voting Member resigns or otherwise ceases to hold office, the person appointed in his/her place shall be appointed for the unexpired term of the Voting Member they replace.

2.4 On expiry of a Voting Member's term of appointment the Voting Member shall be eligible for re-appointment provided that he/she remains eligible and is not otherwise disqualified from appointment.

2.5 Any Voting Member appointed to the Integration Joint Board who ceases to fulfil the requirements for membership detailed in the Scheme of Integration approved by the Scottish Ministers shall be removed from membership on the serving by the Board Secretary of notice to that effect.

2.6 A Voting Member of the Integration Board may resign his/her membership in writing at any time during their term of office by giving notice to the Board Secretary or the Clerk to the Council. The resignation shall take effect from the date notified in the notice or on the date of receipt if no date is notified.

2.7 If a Voting Member has not attended three consecutive Ordinary Meetings of the, Integration Joint Board, the Board Secretary shall, by giving notice in writing to that

Voting Member, remove that person from office unless the Integration Joint Board are satisfied that :-

(a) The absence was due to illness or other reasonable cause; and

(b) The Voting Member will be able to attend future Meetings within such period as the Integration Joint Board consider reasonable.

2.8 The acts, meetings or proceedings of the Integration Joint Board shall not be invalidated by any defect in the appointment of any Member.

3. Chair

3.1 The first Chair of the Integration Joint Board shall be from the body not employing the Integration Joint Board's Chief Officer, with the Vice-Chair from the body employing the Chief Officer. The Chair and Vice –Chair posts shall rotate annually between the NHS Board and the Council, with the Chair being from one body and the Vice-Chair from the other.

3.2 The Vice-Chair may act in all respects as the Chair of the Integration Joint Board if the Chair is absent or otherwise unable to perform his/her duties.

3.3 At every Meeting of the Integration Joint Board the Chair, if present, shall preside. If the Chair is absent from any Meeting the Vice-Chair, if present, shall preside. If both the Chair and the Vice-Chair are absent, a chair shall be appointed from within the voting members present for that meeting.

3.4 Powers, authority and duties of Chair and Vice-Chair.

The Chair shall specifically:-

(a) Preserve order and ensure that every Member has a fair Hearing;

(b) Decide on matters of relevancy, competency and order, and whether to have a recess during the Meeting, having taken into account any advice offered by the Chief Officer or other relevant officer in attendance at the Meeting;

(c) Determine the order in which speakers can be heard;

(d) Ensure that due and sufficient opportunity is given to Members who wish to speak to express their views on any subject under discussion;

(e) If requested by any Member ask the mover of a motion, or an amendment, to state its terms;

(f) Maintain order and at his/her discretion, order the exclusion of any Member of the public who is deemed to have caused disorder or misbehaved;

(g) The decision of the Chair on all matters within his/her jurisdiction shall be final;

(h) Deference shall at all times be paid to the authority of the Chair. When he/she rises to speak, the Chair shall be heard without interruption and

(i) Members shall address the Chair while speaking.

4. Meetings

4.1 The Integration Joint Board shall meet at such place and such frequency as may be agreed by the Integration Joint Board and no less than four times per year.

4.2 The Chair may convene Special Meetings if it appears to him/her that there are items of urgent business to be considered. Such Meetings will be held at a time, date and venue as determined by the Chair. If the Office of Chair is vacant, or if the Chair is unable to act for any reason the Vice-Chair may at any time call such a Meeting.

4.3 If the Chair refuses to call a Meeting of the Integration Joint Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least one third of the whole number of voting Members, has been presented to the Chair or if, without so refusing, the Chair does not call a Meeting within seven days after such requisition has been presented, those Members who presented the requisition may forthwith call a Meeting provided no business shall be transacted at the Meeting other than specified in the requisition.

5. Notice of Meeting

5.1 Before every Meeting of the Integration Joint Board a Notice of the Meeting, specifying the time, place and business to be transacted at it shall be delivered to every Member or sent by post to the usual place of residence of such Members or delivered by electronic means so as to be available to them at least seven clear days before the Meeting. Members may opt in writing addressed to the Chief Officer to have Notice of Meetings delivered to an alternative address. Such Notice will remain valid until rescinded in writing. Lack of service of the Notice on any Member shall not affect the validity of a Meeting.

5.2 In the case of a Meeting of the Integration Joint Board called by Members in default of the Chair, the Notice shall be signed by those Members who requisitioned the Meeting. The meeting will consider the business specified in the notice. Such meeting shall be held within fourteen days of receipt of the notice by the Chief Officer.

5.3 At all Ordinary or Special Meetings of the Integration Joint Board, no business other than that on the Agenda shall be discussed or adopted except where by reason of special circumstances, which shall be specified in the Minutes, the Chair is of the opinion that the item should be considered at the Meeting as a matter of urgency.

5.4 The Board Secretary shall be responsible for giving public notice of the time and place of each Meeting of the Integration Joint Board by posting within the main offices of the Integration Joint Board not less than three clear days before the date of each Meeting.

6. Quorum

6.1 No business shall be transacted at a Meeting of the Integration Joint Board unless there are present, and entitled to vote both Council and NHS Board members. Three Elected Members from Scottish Borders Council and three Non Executive members from NHS Borders shall constitute a Quorum.

7. Codes of Conduct and Conflicts of Interest

7.1 Members of the Integration Joint Board shall subscribe to and comply with both the Standards in Public Life - Code of Conduct for Members of Devolved Public Bodies and Councillors Code of Conduct and Guidance made in respect thereto which are incorporated into the Standing Orders. All members who are not already bound by the terms of either Code shall be obliged before taking up membership, to agree in writing to be bound by the terms of the Code of Conduct for Members of Devolved Public Bodies.

7.2 If any Member has a financial or non-financial interest as defined in the Councillors' Code of Conduct or the Code of Conduct of Members of Devolved Public Bodies and is present at any Meeting at which the matter is to be considered, he/she must as soon as practical, after the Meeting starts, disclose that he/she has an interest and the nature of that interest and if he/she is precluded from taking part in consideration of that matter.

7.3 If a Member or any business associate, relative or friend of theirs has any pecuniary or any other interest direct or indirect, in any Contract or proposed Contract or other matter and that Member is present at a Meeting of the Integration Joint Board, that Member shall disclose the fact and the nature of the relevant interest and shall not be entitled to vote on any question with respect to it. A Member shall not be treated as having any interest in any Contract or matter if it cannot reasonably be regarded as likely to significantly affect or influence the voting by that Member on any question with respect to that Contract or matter.

7.4 A Member who has an interest in service delivery may participate in the business of the Integration Joint Board, except where they have a direct and significant interest in a matter, unless the Integration Joint Board formally decides and records in the Minutes of the Meeting that the public interest is best served by the Member remaining in the Meeting and contributing to the discussion. During the taking of a decision by the Integration Joint Board on such matter, the Member concerned shall absent him/herself from the Meeting.

8. Adjournment of Meetings

8.1 A Meeting of the Integration Joint Board may be adjourned by a motion, which shall be moved and seconded and put to the Meeting without discussion. If such a motion is

carried by a simple majority of those present and entitled to vote, the Meeting shall be adjourned to another day, time and place specified in the motion.

9. Disclosure of Information

9.1 No Member or Officer shall disclose to any person any information which falls into the following categories:-

- Confidential information within the meaning of Section 50(a)(2) of the Local Government (Scotland) Act 1973.

- The full or any part of any document marked not for publication by virtue of the appropriate paragraph of Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973.

- Any information regarding proceedings of the Integration Joint Board from which the Public have been excluded unless or until disclosure has been authorised by the Council or the NHS Board or the information has been made available to the Press or to the Public under the terms of the relevant legislation.

9.2 Without prejudice to the foregoing no Member shall use or disclose to any person any confidential and/or exempt information coming to his/her knowledge by virtue of his/her office as a Member where such disclosure would be to the advantage of the Member or of anyone known to him/her or which would be to the disadvantage of the Integration Joint Board, the Council or the NHS Board.

10. Recording of Proceedings

10.1 No sound, film, video tape, digital or photographic recording of the proceedings of any Meeting shall be made without the prior approval of the Integration Joint Board.

11. Admission of Press and Public

11.1 Members of the public and representatives of the Press will be admitted to every formal meeting of the Board but will not be permitted to take part in discussion (Public Bodies (Admission to Meetings) Act 1960; Local Government (Scotland) Act 1973)

11.2 The Board may exclude the public and press while considering any matter that is confidential. (Local Government (Scotland) Act 1973, Schedule 7; Freedom of Information (Scotland) Act 2002 (the Act) and Environmental Information (Scotland) Regulations 2004 (the Regulations)

11.3 The terms of any resolution specifying the part of the proceedings to which it relates and the categories of exempt information involved shall be specified in the minutes.

11.4 Members of the public and representatives of the press admitted to meetings shall not be permitted to make use of photographic or recording apparatus of any kind unless agreed by the Board. (Local Government (Scotland) Act 1973; Public Bodies (Admission to Meetings) Act 1960)

11.5 Members of the public and press should leave when the meeting moves into reserved business. It is at the discretion of the Chair of that meeting if officers can remain.

11.6 Subject to the extent of the accommodation available and subject to the terms of Sections 50A and 50E of the Local Government (Scotland) Act 1973, and Public Bodies (Admission to Meetings) Act 1960 meetings of the Integration Joint Board shall be open to the public.

11.7 Every Meeting of the Integration Joint Board shall be open to the public but these provisions shall be without prejudice to the Integration Joint Board's powers of exclusion in order to suppress or prevent disorderly conduct or other misbehaviour at a Meeting. The Integration Joint Board may exclude or eject from a Meeting a member or members of the Press and Public whose presence or conduct is impeding the work or proceedings of the Integration Joint Board.

12. Reception of deputations

12.1 Every application for the receiving of a deputation must be in writing, duly signed and delivered or e-mailed to the Board Secretary at least seven clear working days prior to the date of the meeting at which the deputation wish to be received. The application must state the subject and the action which it proposes the Integration Joint Board should take.

12.2 The deputation shall consist of not more than ten people.

12.3 No more than two members of any deputation shall be permitted to address the meeting, and they may speak in total for no more than ten minutes.

12.4 Any member of the Integration Joint Board may put any relevant question to the deputation, but shall not express any opinion on the subject matter until all questions have been asked. If the subject matter relates to an item of business on the agenda, no debate or discussion shall take place until the relevant minute or other item is considered in the order of business.

12.5 The Integration Joint Board may make the following decisions regarding any deputation:

(i) refer the petition to another organisation or Officer of another organisation, with or without a recommendation or comment. That Organisation or Officer shall then make the final decision which could include taking no further action;

(ii) that the issue(s) raised do not merit or do not require further action.

13. Receipt of petitions

13.1 Every petition shall be delivered to the Board Secretary at least seven clear working days before the meeting at which the subject matter may be considered. The Chair will be advised and will decide whether the contents of the petition should be discussed at the meeting or not.

13.2 The Board may make the following decisions regarding any petition:

(i) refer the petition to another organisation or Officer of another organisation, with or without a recommendation or comment. That Organisation or Officer shall then make the final decision which could include taking no further action;

(ii) that the issue(s) raised do not merit or do not require further action.

14. Alteration, Deletion and Rescission of Decisions of the Integration Joint Board

14.1 Except insofar as required by reason of illegality, no motion to alter, delete or rescind a decision of the Integration Joint Board will be competent within six months from the decision, unless a decision is made prior to consideration of the matter to suspend this Standing Order.

15. Suspension, Deletion or Amendment of Standing Orders

15.1 Any one or more of the Standing Orders in the case of emergency as determined by the Chair upon motion may be suspended, amended or deleted at any Meeting so far as regards any business at such Meeting provided that two thirds of the voting Members of the Integration Joint Board present and voting shall so decide. Any motion to suspend Standing Orders shall state the number or terms of the Standing Order(s) to be suspended.

16. Order of business

16.1 For ordinary meetings of the Board or its Committees, the business shown on the agenda shall normally proceed in the following order:

- Business determined by the Chair to be a matter of urgency by reason of special circumstances
- Reception of deputations, followed by consideration of any items of business on which the deputations have been heard
- Petitions
- Minutes of the previous meeting for approval
- Minutes of Sub-Committees
- General Business
- Questions and motions of which due notice has been given

16.2 No item of business shall be transacted at a meeting, unless either:

- It has been included on the agenda for the meeting; or
- It has been determined by the Chair to be a matter of urgency by reason of special circumstances

17. Motions, Amendment and Debate

17.1 It will be competent for any voting Member of the Integration Joint Board at a Meeting of the Integration Joint Board to move a motion directly arising out of the business before the Meeting.

17.2 No Member, with the exception of the mover of the motion or amendment, will speak supporting the motion or amendment until the same will have been seconded.

17.3 Subject to the right of the mover of a motion, and the mover of an amendment, to reply, no Member will speak more than once on the same question at any Meeting of the Integration Joint Board except:-

- On a question of Order
- With the permission of the Chair
- In explanation or to clear up a misunderstanding in some material part of his/her speech.

In all of the above cases no new matter will be introduced.

17.4 The mover of an amendment and thereafter the mover of the original motion will have the right of reply for a period of not more than 5 minutes. He/she will introduce no new matter and once a reply is commenced, no other Member will speak on the subject of debate. Once these movers have replied, the discussion will be held closed and the Chair will call for the vote to be taken.

17.5 Amendments must be relevant to the motions to which they relate and no Member will be at liberty to move or second more than one amendment to any motion, unless the mover of an amendment has failed to have it seconded. The mover and seconder of the motion will not move an amendment or second an amendment, unless the mover of the motion has failed to have it seconded.

17.6 It will be competent for any Member who has not already spoken in a debate to move the closure of such debate. On such motion being seconded, the vote will be taken, and if a majority of the Members present vote for the motion, the debate will be closed. However, closure is subject to the right of the mover of the motion and of the amendment(s) to reply. Thereafter, a vote will be taken immediately on the subject of the debate.

17.7 Any Member may indicate his/her desire to ask a question or offer information immediately after a speech by another Member and it will be the option of the Member to whom the question would be directed or information offered to decline or accept the question or offer of information.

17.8 When a motion is under debate, no other motion or amendment will be moved except in the following circumstances:

- to adjourn the debate; or
- to close the debate.

17.9 A motion or amendment once moved and seconded cannot be altered or withdrawn unless with the consent of the majority of those present.

18. Voting

18.1 Every effort shall be made by Members to ensure that as many decisions as possible are made by consensus.

18.2 Only the five Members nominated by the NHS Board, and the five Members appointed by the Council shall be entitled to vote. Those Members drawn from health and social care professionals, staff, the third sector, users, the public and carers shall not be entitled to vote.

18.3 Every question at a Meeting shall be determined by a majority of votes of the Members present and who are entitled to vote on the question. In the case of an equality of votes the Chair shall not have a second or casting vote. In the event of an equality of votes, the matter shall be referred to the NHS Borders Board and to Scottish Borders Council for final decision.

19. Minutes, agendas and papers

19.1 The Board Secretary is responsible for ensuring that Minutes of the proceedings of a meeting of the Integration Joint Board or its Committees, including any decision or resolution made at that meeting, shall be drawn up. The minutes shall be submitted to the next meeting of the Integration Joint Board, or relevant Committee, for approval by members as a record of the meeting subject to any amendments proposed by members and shall be signed by the person presiding at that meeting. A Minute purporting to be so signed shall be received in evidence without further proof.

19.2 The names of members present at a meeting of the Integration Joint Board or of a Sub-Committee of the Board shall be recorded in the Minute, together with the apologies for absence from any member.

19.3 Minutes of Meetings shall be submitted by the Chief Officer or an officer so designated by him/her to the Council and the NHS Board for noting.

19.4 The Freedom of Information (Scotland) Act 2002 gives the public a general right of access to all recorded information held. Therefore, when minutes of meetings are created, it should be assumed that what is recorded will be made available to the public. This does not apply to Minutes of a private section of any meeting.

19.5 The Minute of a meeting being held where authority or approval is being given by the Integration Joint Board and the Minutes are intended to act as a record of the business of the meeting, then the Minute should contain:

- A summary of the Integration Joint Board's discussions
- A clear and unambiguous statement of all decisions taken

- If no decision is taken, a clear and unambiguous statement of where the matter is being referred or why the decision has been deferred
- Where options are presented, a summary of why options were either accepted or rejected
- Reference to any supporting documents relied upon
- Any other relevant points which influenced the decision or recommendation
- Any recommendations which require approval by a higher authority

19.6 The contents of a Minute will depend upon the purpose of the meeting. If the meeting agrees actions they will be recorded in an Action Tracker:

- A description of the task, including any phases and reporting requirements
- The person accepting responsibility to undertake the task
- The time limits associated with the task, its phases and agreed reporting

19.7 The agendas and papers for all Integration Joint Board, Committee and Sub-Committee meetings shall be circulated to members by post or electronic means at least seven days before any given meeting.

19.8 The draft minutes and action trackers from all Integration Joint Board, Committee and Sub-Committee meetings shall be issued as soon as possible following a meeting, ideally within five working days.

20. Freedom of Information (Scotland) Act 2002

20.1 The Freedom of Information (Scotland) Act 2002 (FOI(S)A) was introduced by the Scottish Parliament to ensure that people have the right to access information held by Scottish public authorities. The Act states that any person can receive information that they request from a public authority, subject to certain exemptions such as protection of personal data and commercial interests, or national security. It came into force on 1 January 2005 and is retrospective.

Under FOI(S)A NHS Borders and Scottish Borders Council are required to:

- Provide applicants with help and assistance in finding the information they require within a given timescale
- Maintain a publication scheme of information to be routinely published
- Put in processes for responding to enquiries and undertaking appeals against decisions to withhold information

20.2 Information as defined under FOI(S)A includes copies or extracts, including drafts, of any documents such as:

- reports and planning documents
- committee minutes and notes
- correspondence including e-mails
- statistical information

20.3 The FOI(S)A provides a range of exemptions which may be applied allowing the public authority to withhold information. Exemptions must be considered on a case by case basis and may be applied to all or only part of the information requested.

- All documents will be scrutinised for information which may be withheld under an exemption to the Act prior to release.
- Full details of the FOI(S)A exemptions and how to apply them can be found in the Freedom of Information (Scotland) Act 2002.
- Briefings on how to apply exemptions can be found on the Scottish
- Information Commissioners website http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp.

21. Records management

21.1 Under the Freedom of Information (Scotland) Act 2002, NHS Borders and Scottish Borders Council must have comprehensive records management systems and process in place which must give clear guidance on time limits for the retention of records and documents.

22. Reserved Business

22.1 A Private meeting of the Integration Joint Board may be called at any time by the Chair, or one third of the Members. Generally a minimum notice period of three days should be observed. However, in exceptional circumstances and provided the majority of Integration Joint Board members are present and given the opportunity to attend, appropriate matters pertaining to a Private session may be conducted at the conclusion of an Integration Joint Board meeting. To allow for appropriate notice periods to be observed the wording “At the conclusion of the Board meeting, the board will reconvene for any matters of reserved business.” should be clearly stated at the bottom of each Integration Joint Board meeting agenda.

23. Suspension and Disqualification

23.1 Any Member of the Integration Joint Board may on reasonable cause shown be suspended from the Integration Joint Board or disqualified from taking part in any business of the Integration Joint Board in circumstances specified for NHS Board appointed nominees by the NHS Board, and for Council appointed nominees by the Council.

24. Working Groups

24.1 The Integration Joint Board may establish any Sub-Committee or Working Group as may be required from time to time but each Working Group shall have a limited time span as may be determined by the Integration Joint Board.

24.2 The Membership, Chair and quorum of any Sub-Committee or Working Groups will be

determined by the Integration Joint Board.

24.3 The Terms of Reference of the Sub-Committee or Working Group will be determined by the Integration Joint Board.

24.4 A Sub-Committee or Working Group does not have any delegated powers to implement its findings and will prepare a Report for consideration by the Integration Joint Board.

24.5 Agendas for consideration at a Sub-Committee or Working Group will be issued by electronic means to all Members no later than seven working days prior to the start of the Meeting.

Scottish Borders
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Scottish Borders Health & Social Care Integration Joint Board

AUDIT COMMITTEE TERMS OF REFERENCE

CONSTITUTION

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

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

Chair

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

Quorum

Three members of the Committee will constitute a quorum.

Functions Referred

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

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

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

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

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

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

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

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

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

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

CLINICAL & CARE GOVERNANCE ASSURANCE FRAMEWORK

Aim

1.1 To outline the Clinical & Care Governance Assurance Framework for the Integration Joint Board (IJB).

1.2 To support the development of next steps:

- Communication of IJB key messages relating to clear and transparent understanding of clinical & care governance requirements

- Implementation of clinical & care governance reporting and monitoring arrangements and timetable.

Background

2.1 Clinical & care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality care and support is understood to be the responsibility of everyone working in and with the organisation – built on partnership and collaboration within and between health and social care professionals and managers.

2.2 There are five key elements to clinical & care governance within the Scottish Borders Health and Social Care Partnership which have been identified and are listed below:

1. Quality and effectiveness of care;
2. Professional standards and regulation;
3. Safety and risk assessment;
4. Leadership and culture;
5. Learning, audit and continuous improvement.

Summary

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

3.2 This paper has been developed from the outline arrangements already agreed and described in the Scheme of Integration.

Recommendation

The Health & Social Care IJB is asked to **approve** the key principles and next steps to implement the Framework.

Policy/Strategy Implications	This framework and the plans to develop it further, will be sponsored by the Strategic Planning Group. Within NHS Borders the Healthcare Governance Steering Group and Clinical Strategy Group will be kept fully engaged as will the Health & Social Care Management Group.
Consultation	As above.
Risk Assessment	In compliance.
Compliance with requirements on Equality and Diversity	In compliance.
Resource/Staffing Implications	Services and activities provided within agreed resource and staffing parameters.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Karen McNicoll	Associate Director AHPs		

Scottish Borders
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Clinical & Care Governance Assurance Framework

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1. Introduction to Clinical & Care Governance

1.1 Clinical & care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality care and support is understood to be the responsibility of everyone working in and with the organisation – built on partnership and collaboration within and between health and social care professionals and managers.

1.2 The Scottish Borders Integration Joint Board (IJB) is committed to a culture where the workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of robust clinical & care governance arrangements

1.3 In doing so the IJB aims to provide safe and effective, person centred care and treatment for patients and clients, and a safe environment for everyone working within (and others who interact with) the services delivered under the direction of the IJB.

Key Elements of effective Clinical & Care Governance

Five key elements to clinical & care governance within the Scottish Borders Health and Social Care Partnership has been identified and are listed below:

- Quality and effectiveness of care;
- Professional standards and regulation;
- Safety and risk assessment;
- Leadership and culture;
- Learning, audit and continuous improvement.

1.4 The IJB believes that appropriate application of clinical & care governance assurance processes will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical & care outcomes, the achievement of objectives and targets, and a learning and improvement approach to service planning and delivery.

1.5 The IJB purposefully seeks to promote an environment that puts clinical & care governance at the heart of key decisions. This means that the IJB can take an effective approach to leading health and social care integrated services in a way that both addresses significant challenges and enables positive outcomes.

1.6 The IJB promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan. Opportunity-related risk must be carefully evaluated in the context of the anticipated benefits for patients, clients, the IJB and other stakeholders.

1.7 The IJB will receive internal and external clinical & care governance assurance reports. These assurance reports will be submitted by the partner organisations Scottish Borders Council and NHS Borders and provider organisations and will pertain to the relevant work streams under the strategic control of the IJB.

2. Clinical & Care Governance Assurance Framework - Implementing Health & Social Care Integration for the Scottish Borders

2.1 Objectives

The primary objectives of this assurance framework are to:

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

2.2 Reporting structure

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

The partner organisations Scottish Borders Council and NHS Borders will report any relevant clinical & care governance issues via the reporting structures by having oversight of delivery and/or governance routes:

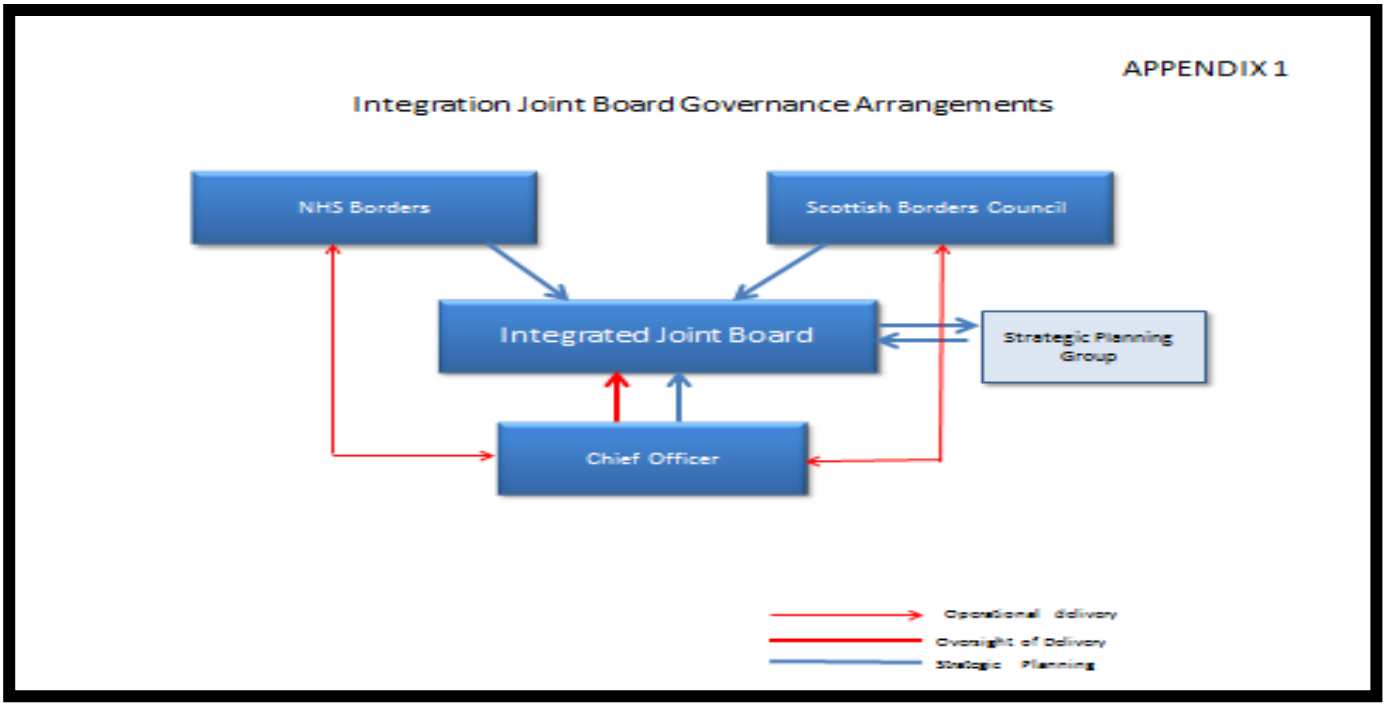

Diagram 1: Integration Joint Board Governance Arrangements Source: Scheme of Integration

2.3 Types of topics to be reported

This assurance framework takes a positive and holistic approach to clinical & care goverance assurance.

2.3.1 Adverse events
2.3.2 Patient feedback
2.3.3 Clinical effectiveness
2.3.4 Infection control
2.3.5 Patient safety
2.3.6 Medicines safety
2.3.7 Adult Protection
2.3.8 Child Protection
2.3.9 Risk management (see Risk Management Strategy)
2.3.10 Claims management
2.3.11 Research governance
2.3.12 National, internal and external audit or inspection reports (Care Inspectorate and Healthcare Improvement Scotland reports)

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2.4 Clinical & Care Governance Assurance framework and process

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

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

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

.

2.5 Roles and responsibilities

2.5.1 Integration Joint Board (IJB)

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

Members of the IJB are responsible for:

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

2.5.2 Chief Officer

The Chief Officer has overall accountability for the IJB's Clinical & Care Governance Assurance Framework, ensuring that suitable and effective arrangements are in place relating to the services delivered under the direction ofthe IJB. The Chief Officer will be responsible for drawing to the attention of the IJB any new or escalating clinical & care governance risks and associated mitigations to ensure appropriate oversight and action. The Chief Officer will keep the IJB and the Chief Executives of the partner organisations informed of any significant existing or emerging clinical & care governance risks that could seriously impact the IJB's ability to deliver the outcomes and objectives of the Strategic Plan or the reputation of the IJB or the partner organisations.

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

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

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

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

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

2.5.8 As part of the regular monitoring process the IJB may, as required, also take advice from other appropriate professional forums and groups as outlined in Scottish Government guidance, including the Adult Protection Committee, Child Protection Committee (for universal children's health services), Area Clinical Forum and Area Drug and Therapeutics Committee.

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

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

2.6 Next steps - developing clinical & care governance arrangements

Clinical & care governance is key to the effective delivery of the objectives within the Strategic Plan.The following activities and outputs will be developed. Timescales for these are being planned and progress in this will be reported through the implementation programme arrangements.

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

2.6.2 Communication of IJB key messages relating to clear and transparent understanding of clinical & care governance requirements

2.6.3 Implementation of clinical & care governance reporting and monitoring arrangements

2.6.4 Identification of key reports and implementation of reporting timetable.

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

The Clinical & Care Governance Assurance Framework (version 1.00) was approved by the Integration Joint Board at its meeting of **[00/00/0000**

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Integration Joint Board

Risk Management Strategy

CONTENTS

1. Introduction to Strategic Approach

1.1 The Scottish Borders Integration Joint Board (IJB) is committed to a culture where the workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of good risk management practice.

1.2 In doing so the IJB aims to provide safe and effective care and treatment for patients and clients, and a safe environment for everyone working within and others who interact with the services delivered under the direction of the IJB.

Key benefits of effective risk management:

- appropriate, defensible, timeous and best value decisions are made;
- risk 'aware' not risk 'averse' decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward;
- high achievement of objectives and targets;
- high levels of morale and productivity;
- better use and prioritisation of resources;
- high levels of user experience/ satisfaction with a consequent reduction in adverse incidents, claims and/ or litigation; and
- a positive reputation established for the Integration Joint Board.

1.3 The IJB believes that appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, the achievement of objectives and targets, and fewer unexpected problems.

1.4 The IJB purposefully seeks to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions. This means that the IJB can take an effective approach to managing risk in a way that both addresses significant challenges and enables positive outcomes.

1.5 The IJB promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan. Opportunity-related risk must be carefully evaluated in the context of the anticipated benefits for patients, clients, the IJB and other stakeholders.

1.6 The IJB will receive assurance reports (internal and external) not only on the adequacy but also the effectiveness of its risk management arrangements. These assurance reports will be submitted by the partner organisations Scottish Borders Council and NHS Borders and will pertain to the relevant work streams under the strategic control of the IJB.

2. Risk Management Strategy - Implementing Health and Social Care Integration for the Scottish Borders

2.1 Objectives

The primary objectives of this strategy are to:

- Identify how risk information will be reported to the Integration Joint Board (IJB).
- Make clear what strategic and operational risks require to be reported to the IJB.
- Ensure that the risk management framework facilitates the identification of the key risks affecting the delivery of the Health and Social Care Strategic Plan and supporting Strategic Commissioning Plan.
- Establish standards and principles for the efficient and effective management of risk, including regular monitoring, reporting and review.

2.2 Reporting structure

The Integration Joint Board (IJB) is responsible for the strategic planning of the functions delegated to it and the risks arising from that undertaking.

The IJB will identify any high level strategic risks.

The partner organisations Scottish Borders Council and NHS Borders will report any relevant risks via the reporting structures by having oversight of delivery and/or governance routes:

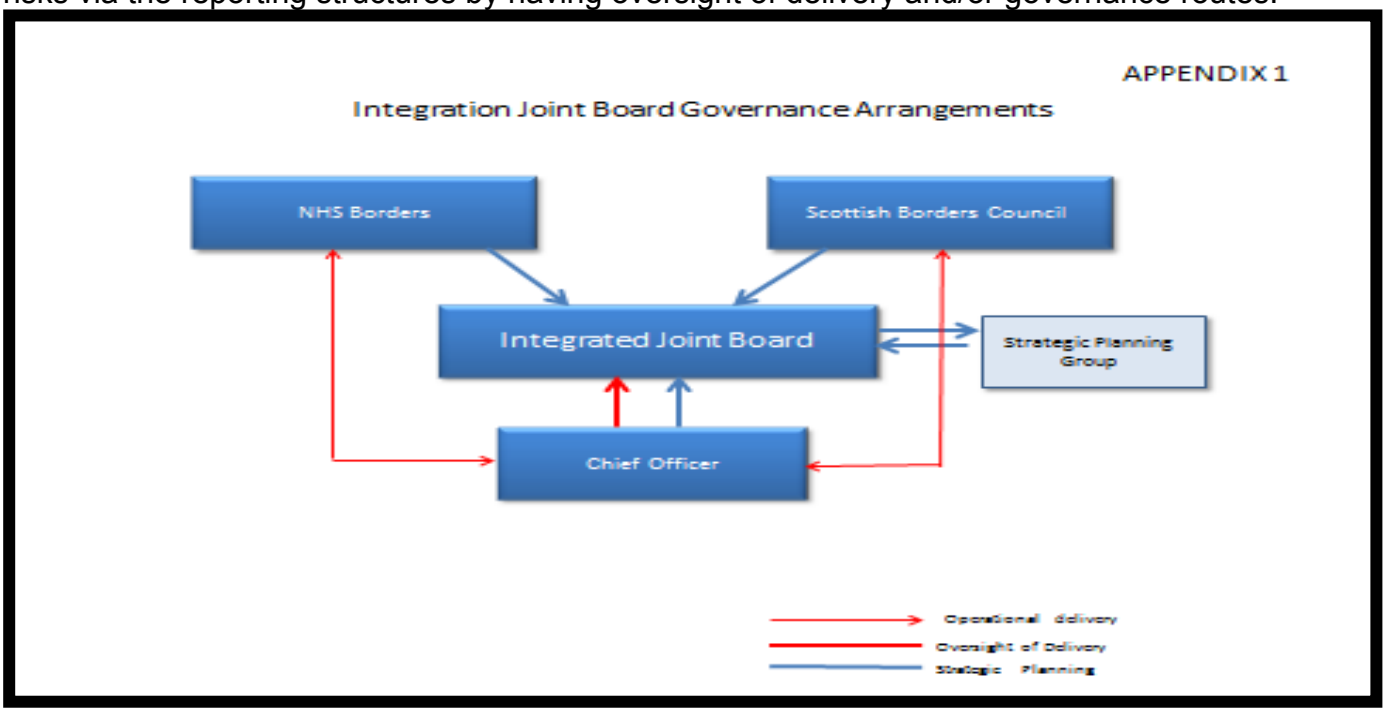

Diagram 1: Integration Joint Board Governance Arrangements Source: Scheme of Integration

2.3 Types of risk to be reported

This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business objectives, opportunities or threats.

2.3.1 Strategic risks represent the potential for the Integration Joint Board (IJB) to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risks.

2.3.2 Operational risks represent the potential for impact (opportunity or threat) within or arising from the activites of an individual service area or team operating within the scope of the IJB's activities which are more 'front-line' in nature. The development of actions and controls to respond to these risks will be led by local managers and team leaders which will be overseen by the Chief Officer. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership or significantly impact on the delivery of the strategic plan, then these will be proposed for escalation to 'strategic risk' status for the IJB.

2.3.3 Business continuity and resilience risks will be the responsibility of the partner organisations to identify and manage. Each partner organisation must have business continuity / resilience plans in place which are developed and tested in accordance with respective Scottish Borders Council and NHS Borders internal corporate policies and arrangements.

2.4 Risk management framework and process

This document represents the risk management framework to be implemented across the services delivered under the direction of the Integration Joint Board (IJB) and will contribute to the IJB's wider corporate governance arrangements.
Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

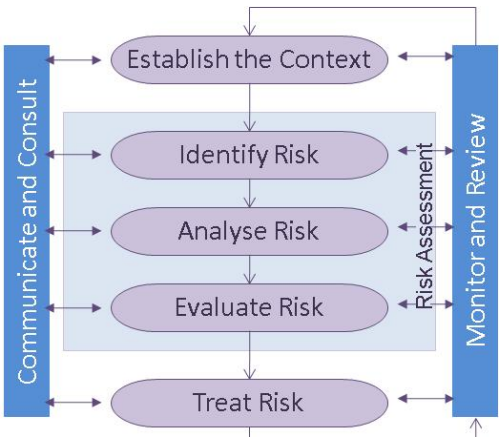

Diagram 2: Standard risk management process

For consistency the IJB will **adopt the standard risk management process** shown in the diagram on the right.

This reflects the processes currently used in both partner organisations.

Risk management tools for the purpose of identification and **risk scoring will be as used by each partner organisation**.

The integrated management risk register and the strategic risk register will be held by the IJB with risk information from partner organisations being utilised in identifying the relevant risks to the strategic objectives of the IJB.

Effective communication of risk management information across the services delivered under the direction of the Integration Joint Board is essential in developing a consistent and effective approach to risk management.

Copies of this strategy will be widely circulated within the partner organisations.

2.5 Roles and responsibilities

2.5.1 Integration Joint Board (IJB)

Members of the Integration Joint Board are responsible for:

- Collective ownership of all the risks within the integrated management risk register and the strategic risk register.
- Ensuring that each risk has a lead risk owner identified to ensure risks are being adequately and appropriately managed.
- Having oversight of its risk management arrangements;
- Receiving and reviewing of risk reports on strategic risks and any key operational risks that require to be brought to its attention; and,
- Ensuring awareness of any risks linked to recommendations from the Chief Officer concerning new priorities, policies and decisions.

2.5.2 Chief Officer

The Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the services delivered under the direction of the IJB. The Chief Officer will be responsible for drawing to the attention of the IJB any new or escalating risks and associated mitigations to ensure appropriate oversight and action.

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

2.5.3 Chief Financial Officer

The Chief Financial Officer will be responsible for promoting arrangements to identify, analyse, evaluate and manage key financial risks, risk mitigation and insurance for the IJB.
The Chief Financial Officer will be responsible for ensuring financial implications and risks are considered within decision making in alignment with the financial strategy of the IJB.

2.5.4 Partner Organisations

It is the responsibility of the partner organisations to provide risk information as required by the IJB as part of monitoring arrangements and/or highlight any significant single risk arising

that requires immediate notification to the IJB. This risk information will be communicated via the reporting structures and when necessary by the Chief Officer.

2.6 Monitoring risk management activity and performance

Measuring, managing and monitoring risk management performance is key to the effective delivery of the objectives within the Strategic Plan.

The Integration Joint Board (IJB) operates in a dynamic and challenging environment. A suitable system is required to ensure risks are monitored for change in context and scoring so that appropriate response is made.

Monitoring will include review of the risk profile as defined by the content of the IJB risk registers. Any new or emerging risks will be identified and escalated as appropriate to the IJB at any time.

It is expected that partner organisations will use IJB risk registers to keep their own organisations updated on the management of the risks, highlighting any IJB risks that might impact on the partner organisation.
As the IJB risk management processes mature and embed it is planned to introduce key risk indicators (KRIs) linked where appropriate to specific risks to provide assurance on the performance of certain control measures. The performance data linked to the Strategic Plan will also inform the identification of new risks or highlight where existing risks require more attention.

Reviewing the IJB's risk management arrangements and delivery of this Risk Management Strategy will be done on a yearly cycle until the arrangements are fully embedded. Once embedded it is envisaged a 3 yearly cycle will be sufficient.

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

The Strategy (version 1.10) was approved by the Integration Joint Board at its meeting of **[00/00/0000**

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WORKFORCE PLANNING FRAMEWORK – NHS BORDERS/SCOTTISH BORDERS COUNCIL

Aim

1.1 The aim of this paper is to provide the Integration Joint Board (IJB) with an update on how workforce planning is undertaken within NHS Borders and Scottish Borders Council (SBC), then outline how we are/will integrate in future to support the integrated services.

Background

2.1 Effective workforce planning ensures that we have the necessary information, capability, capacity and skills to plan for current and future workforce requirements. This includes planning a sustainable workforce of the right size, with the right skills and competencies, which is responsive to health and social care demand and ensures effective and efficient service delivery across a broad range of services and locations.

Overview of NHS Workforce Planning Methodology and Timescale for Production of Local Workforce Plan

CEL 32 (2011) which was issued by Scottish Government Health Department provides NHS Borders with a framework to support the development of workforce plans at service, NHS Board and regional level. All NHS Boards in Scotland are required to follow this approach.

The guidance reflects the 6 Step Methodology to Integrated Workforce Planning and contains workforce planning checklists at each step of the process which sign-post to other data and information sources that will help ensure that workforce plans are evidence based. We use this as part of the service improvement methodology to identify key workforce issues that support future models of care/service delivery.

We also use the tool to:

- Ensure closer integration between NHS Boards and social care providers in planning the wider workforce.
- Identify the key learning and educational needs of the existing and future workforce
- Support the development of our local workforce projections to inform annual student intake to the “controlled” groups (Medical, Dental and Nursing and Midwifery), and develop a national picture of likely trends across all staff groups. (Using professional, validated workload measurement and workforce configuration tools where appropriate).
- Ensure our plans are in line with the ambitions of the Quality Strategy.
- Consider demographic influences, and demonstrate how changes in future service demand and workforce supply based on population need can be managed.

A key requirement set out to Chief Executives within the guidance is to ensure Workforce Plans have been developed in line with local Partnership and staff

governance arrangements as well as reflect an integrated approach with other planning agendas. This is particularly important in demonstrating the integration with social care providers.

We are required to publish our Local Workforce Plan on NHS Borders website by 30th June each year and submit workforce projections to the Scottish Government.

Overview of Scottish Borders Council's People Plans

Scottish Borders Council is working towards aligning how departments plan for employees to reflect the way they think about their business and finance plan. The people plan is designed to help use our most valuable assets to deliver our objectives.

The people plan is a cycle of activities which guides managers depending on the needs of the service and ensures that informed decisions are made about how to plan for the future.

Underpinning the people plan is change management and the two key elements are:

- People will be responsible for the success or failure. Engaging stakeholders and involving staff in planning and decision making and communication effectively are vital throughout process
- Learning and providing feedback makes sure the change is fit for purpose and people are engaged and committed to new ways of working.

Management teams will be guided through a series of analysis using current workforce data. Typically, this planning process takes place over 2-3 sessions and is facilitated by an OD Business partner looking at:

- Environmental Analysis - identifying internal and external factors that may affect the service
- Scenario Planning – what are the potential workforce implications of strategic plans for the next year, in 3 years and 5 years
- Demand Forecasting – estimating the number of people and the types of skills needed in the department in the future, using the scenarios generated above
- Supply Forecasting - estimating the numbers and types of employees likely to be available within the department in the future, should current trends continue
- Gap Analysis - developing strategies to address identified gaps between the supply and demand
- Strategy Development – developing longer term strategies and principles in order to make decisions
- Monitor and Evaluate – Reviewing, assessing and amending implementation of the strategies impacting on people.

Shared Workforce Planning Principles

As illustrated above it is evident that NHS Borders and SBC share a joint understanding regarding the principles of Workforce Planning and a similar approach to how local workforce/people plans are developed. The Six Step Methodology matches very closely to the facilitated sessions described above, and the workforce information reviewed as part of the process is very similar across both organisations.

Planned/Existing Integrated Services

The integrated services means all health and social care services contained within the Scheme of Integration. There will be no changes to existing terms and conditions of staff or any transfer from one employer to another. The focus is on working more effectively together in joined up teams. While there may be co-locating and changes to the make-up and management of teams, including potential changes of duties and roles, there is no intention or requirement to transfer staff into a "new" joint organisation.

3.1 Summary of Actions and Timescales

Workforce planning leads from NHS Borders and SBC will work together to ensure future workforce planning across these services becomes more aligned during 2016/17 and into future years.

Specific actions are outlined below, which will be built into the Integrated Workforce Project plan for 2016/17 that is currently being developed.

Actions

March 16	April - May 16	June 16	October 16	Longer Term
Initial discussions between Workforce Planning Leads to identify areas where Joint Workforce Planning is appropriate.	Scope and develop joint actions to be progressed as part of Workforce/People Plans with support from identified leads across NHS Borders and SBC	Publish NHS Borders Local Workforce Plan 30th June 2016 highlighting integrated services and initial actions to progress Joint Workforce Planning.	People Plans developed for all departments then reviewed on Annual Basis	Progress Joint Actions once signed off by IJB and work towards Joint Workforce Planning where appropriate.

.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the Workforce Planning Framework report and the planned actions for 2016/17.

Policy/Strategy Implications	The work outlined will ensure that workforce planning is in place to support the delivery of the Strategic Plan.
Consultation	HR representatives within NHS Borders and Scottish Borders Council. Integration Workforce Project members. Chief Officer for Integration. As they are produced Workforce plans / People plans will continue to be developed in line with set guidance within both organisations and comply with their specific consultation requirements.
Risk Assessment	Risk assessments relating to workforce are a fundamental part of workforce planning and will be embedded within the workforce planning activities during 2016/17 and beyond.
Compliance with requirements on Equality and Diversity	All plans developed will undertake Equality Impact Assessments to ensure compliance with requirements on Equality and Diversity.
Resource/Staffing Implications	Through existing HR teams within NHS Borders and Scottish Borders Council.

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Workforce & Planning, NHS Borders	Clair Hepburn	Chief Officer Human Resources, Scottish Borders Council

Author(s)

Name	Designation	Name	Designation
Claire Smith	HR Team Manager – Workforce Planning & Resourcing, NHS Borders	Julie Watson	Organisation Design & Change Business Partner, Scottish Borders Council

HEALTH AND SOCIAL CARE STRATEGIC PLAN

Aim

1.1 The aim of this paper is to seek homologation by the Integration Joint Board (IJB) of its decision at its last meeting to approve the Health and Social Care Strategic Plan. This will allow dependent pieces of work to be concluded.

Background

2.1 The Health and Social Care Strategic Plan (Appendix 1) was approved for formal consultation on 12 October 2015; there was a period of consultation from 20 October 2015 to 11 December 2015. Both staff and public were targeted with engagement activities, specifically designed to overcome the challenges of the Borders such remoteness and rurality and a huge number of staff dispersed across different environments. A full report on the communications and engagement activity was provided at the last Board meeting.

2.2 At the previous meeting of the Integration Joint Board on 1 February 2016, the process of approval of the Scheme of Integration was not complete, necessary for the Board to make a formal decision. Consequently the Strategic Plan was approved, with the intention of homologating that decision at the Board meeting on 7 March 2016.

2.3 The Strategic Plan provides the route map for the Commissioning and Implementation Plan currently being developed. The Commissioning and Implementation Plan will encapsulate the “directions” to providers. “Directions” are a mechanism to action the strategic commissioning plan. In the first year the “directions” will be clear on business as usual for the partners based on their existing plans but there will be a number of key priorities identified which will help focus and facilitate the transformation described in the Strategic Plan.

2.4 This will guide the development of a financial plan for use of the Integrated Care Fund to drive work in these priority areas.

Next Steps

3.1 Following formal approval by the IJB a number of pieces of work currently underway required to be completed:

- Easy- Read Version
- Equality Outcomes
- Communication and Engagement Plan
- Commissioning/Implementation Plan
- Financial Statement
- A framework for Locality Planning
- Collaborative planning of appropriate acute services
- Performance Monitoring Framework

Summary

4.1 Following approval of the Health and Social Care Strategic Plan at the IJB meeting on 1 February 2016, it is now presented for homologation of that decision. Formal approval will allow dependent pieces of work to be concluded.

Recommendation

The Health & Social Care Integration Joint Board is asked to homologate the decision to **approve** the Health and Social Care Strategic Plan.

Policy/Strategy Implications	This document sets the direction for the delivery of better outcomes from more integrated health and social care services and a better client/patient service experience thought the Commissioning and Implementation Plan and the Integrated Care Fund.
Consultation	Formal consultation as described. Discussion with the Strategic Planning Group. Previous discussion at the IJB
Risk Assessment	The significant risks relate to delay in follow through of dependent work, particularly in production of the Commissioning and Implementation Plan and a financial plan for the Integrated Care Fund.
Compliance with requirements on Equality and Diversity	A three stage Equality and Diversity Impact Assessment is in progress.
Resource/Staffing Implications	None

Approved by

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

Author(s)

Name	Designation	Name	Designation
Dr Julie Kidd	Principal Information Analyst	Dr Eric Baijal	Director of Strategy (Integration)

Scottish Borders **Health & Social Care** Partnership

Scottish Borders
Health and Social Care
PARTNERSHIP

changing health & social care for you

Working together for the best possible health and wellbeing in our communities

strategic plan 2016 -19

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SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP STRATEGIC PLAN

*This document is referred to in our legal "Scheme of Integration" document as the Strategic Commissioning Plan.

FOREWORD

People are living longer than ever and this trend is set to continue. This is something that we should all celebrate. It means that we need to plan ahead, both as communities and as individuals, to ensure that we, in the Borders, make the most of the benefits and positive experiences of a long healthy life. This Plan sets out why we want to integrate health and social care services, how this will be done and what we can expect to see as a result. We want to create health and social care services that are more personalised and improve outcomes for all our service users, their Carers and their families.

This is our first Strategic Plan as a new Health and Social Care Partnership (HSCP). This Plan builds on the progress that has already been made by NHS Borders, Scottish Borders Council and our partners to improve services for all people in the Scottish Borders.

This Plan is based on what we have learned from listening to local people; service users, Carers, members of the public, staff, clinicians, professionals and partner organisations. From April to December 2015 we engaged on the first and second consultation drafts of the Plan through workshops and local events across the Borders.

We believe that through strong leadership, innovative thinking, robust planning and by putting the views of patients, service users and Carers at the heart of all that we do, we can achieve our ambition of "Best Health, Best Care, Best Value" for our communities. We will make sure that strong and effective relationships continue to develop between Scottish Borders Council and NHS Borders, colleagues in the Third and Independent sectors and with other key partner organisations. The aim is that we plan, commission and deliver services in a way that puts people at the heart of decision-making.

Together, with you, we know we can make a real difference.

Susan Manion
Chief Officer Health and Social Care Integration
March 2016

EXECUTIVE SUMMARY

This Plan sets out what we want to achieve to improve health and well-being in the Borders through integrating health and social care services.

The case for changing the way we deliver health and social care services in the Borders is compelling. We have a growing number of people needing our services, but limited resources with which to deliver them. These services could be provided more effectively and efficiently if they are integrated. We want to achieve better outcomes for all our communities. The Borders is largely a remote and rural area. There are five Area Forum localities in the Borders, which have individual characteristics and therefore different needs. This makes delivery of services complex. About a quarter of the households in the Borders are composed entirely of people aged 65 and over. This age group has a greater need for our services. The growing number of people with dementia is a big challenge.

Deprivation is an issue in the Borders. Although it may only seem to affect a small number of communities, it is often hidden in rural areas. Research indicates that people from deprived areas are more likely to make greater use of hospital and other health and social care services. Health inequalities exist beyond deprivation and we need to take into account that some people have different health outcomes. As an example, people with mental health issues or a learning disability tend to have poorer health outcomes. This plan contains actions to address such issues. It also sets out our local objectives, which will enable us to achieve the nine national health and well-being outcomes.

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

CASE FOR CHANGE: WHY WE NEED TO CHANGE

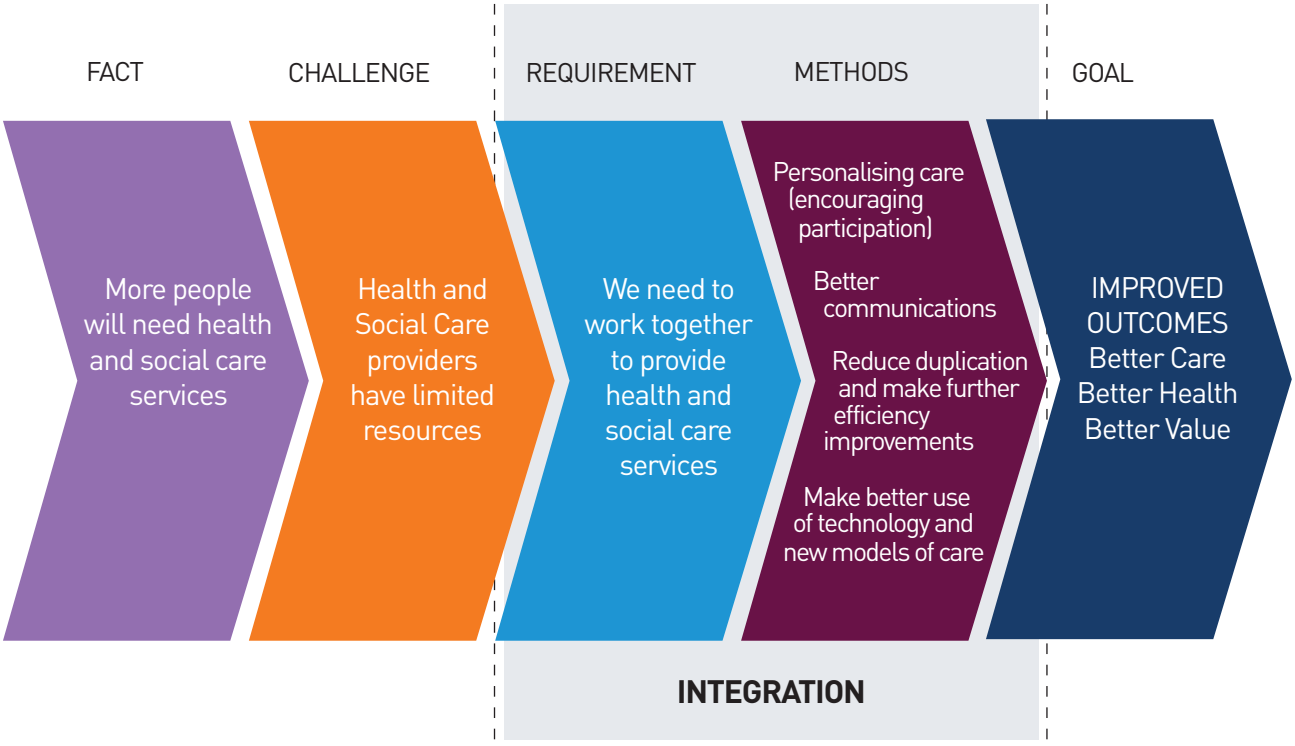
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in the figure below and include:

- **Increasing Demand for Services** – with a growing ageing population, more people need our health and social care services and will continue to do so.
- **Increasing Pressure on Limited Resources** – the rise in demand puts pressure on our limited resources and this is happening at a time of constraint on public sector funding and rising costs of health and social care services.
- **Improving Services and Outcomes** – service users expect – and we want to provide – a better experience and better results.

We need to make better use of the people and resources we have by working more effectively together. If we do not change, we will not be able to continue the high quality services the people of the Borders expect to meet their needs.

FIGURE 1 – THE CASE FOR CHANGE



THE SCOTTISH BORDERS: A SUMMARY PROFILE AND SOME OF OUR KEY CHALLENGES

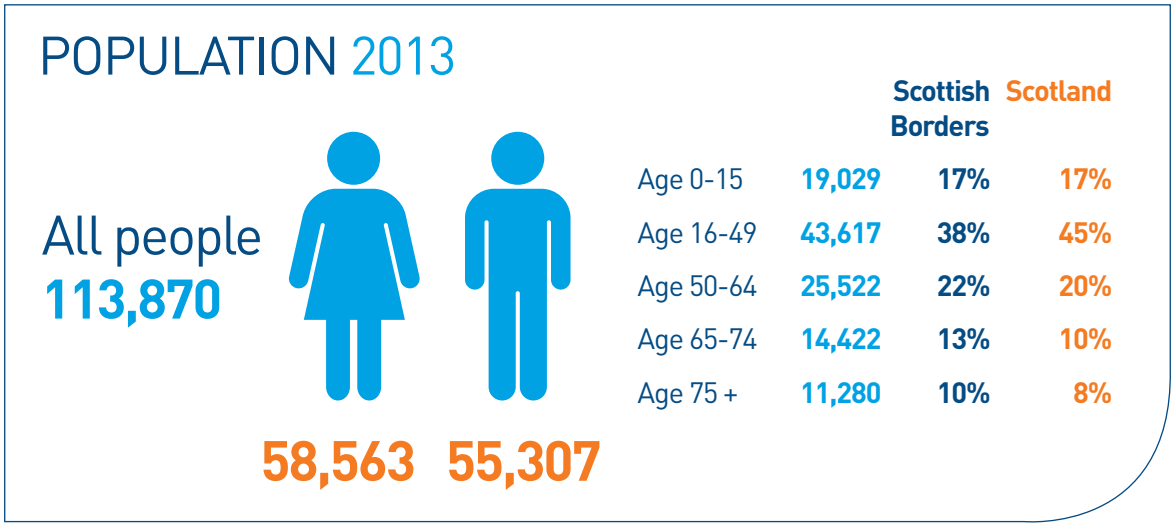
This section of the Plan gives a high level summary profile of the Scottish Borders and some of our key challenges. More detailed information is also available in two further documents published alongside this Plan – Facts and Statistics, and the Joint Strategic Needs Assessment.

Who Lives in the Borders?

Understanding the needs and issues of people and communities across the Borders is critical in the planning and provision of better health and social care services. In this section, we look at how the population structure and characteristics impact on health and social care services. This highlights some of the challenges we need to address.

As the figure below shows, we have a higher percentage of older people than the rest of Scotland.

FIGURE 2

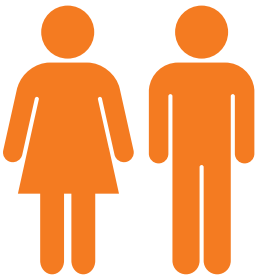


Source: National Records of Scotland, mid-year population estimates.

By the year 2032, the number of people aged 65 and over is projected to increase by 51%, a faster rate than the 49% for Scotland overall. The number of people under 65 is also projected to decrease in the Scottish Borders. Age is strongly related to patterns of need for health and social care. These changes will influence how we deliver services in the future. Integration will enable us to work more effectively and efficiently to achieve "Best Health, Best Care, Best Value".

FIGURE 3

PROJECTED CHANGES IN POPULATION BY AGE GROUP 2012 TO 2032



4% decrease Age 0-15

16% decrease Age 16-64

51% increase Age 65+

Source: National Records of Scotland 2012-based population projections

WHAT THIS MEANS...

This is a priority. We need to promote active ageing and address the range of needs of older people.

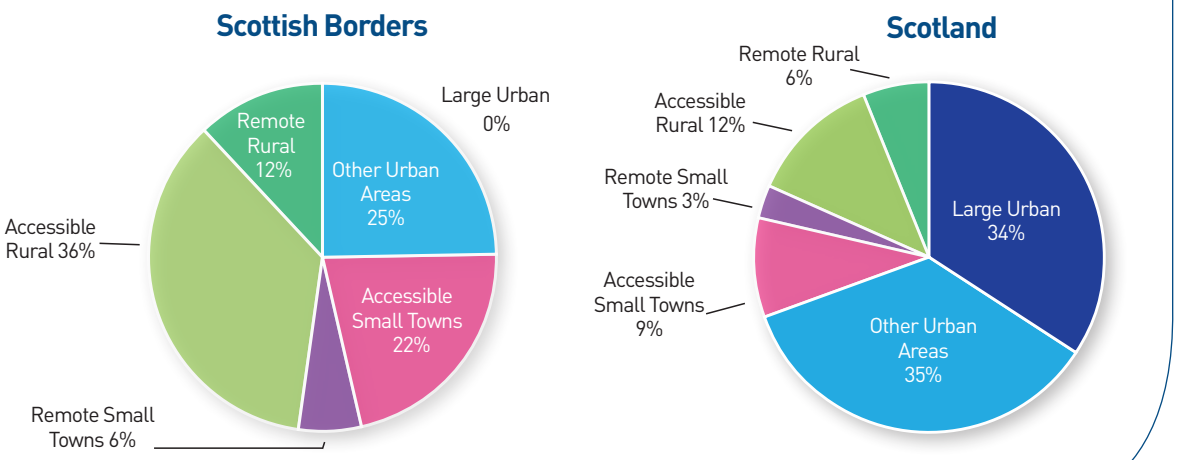
Where do people live?

The Urban/Rural profile of the Borders presents challenges in terms of both the accessibility and cost of services. The challenges are different in nature to those facing densely populated cities such as Glasgow, Edinburgh and Dundee.

In the Borders nearly half (48%) of the population live in rural areas, as shown in Figure 4. Just under one-third of people live in settlements of fewer than 500 or in remote hamlets, in contrast to 34% of the Scottish population who live in "Large Urban" areas (part of towns/ cities with populations of more than 125,000). Our main towns are Hawick (with a population of 13,696 in 2013) and Galashiels (population 12,394), which come under the Scottish Government classification of "Other Urban Areas". Peebles, Kelso and Selkirk are the only other towns with a population of more than 5,000. As people in the Borders do not live close together in cities, planning services is more challenging.

FIGURE 4

POPULATION SHARES (%) BY URBAN/RURAL AREA 2012



Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland

Category	Description
1 Large Urban Areas	Settlements of 125,000 or more people.
2 Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or

WHAT THIS MEANS...

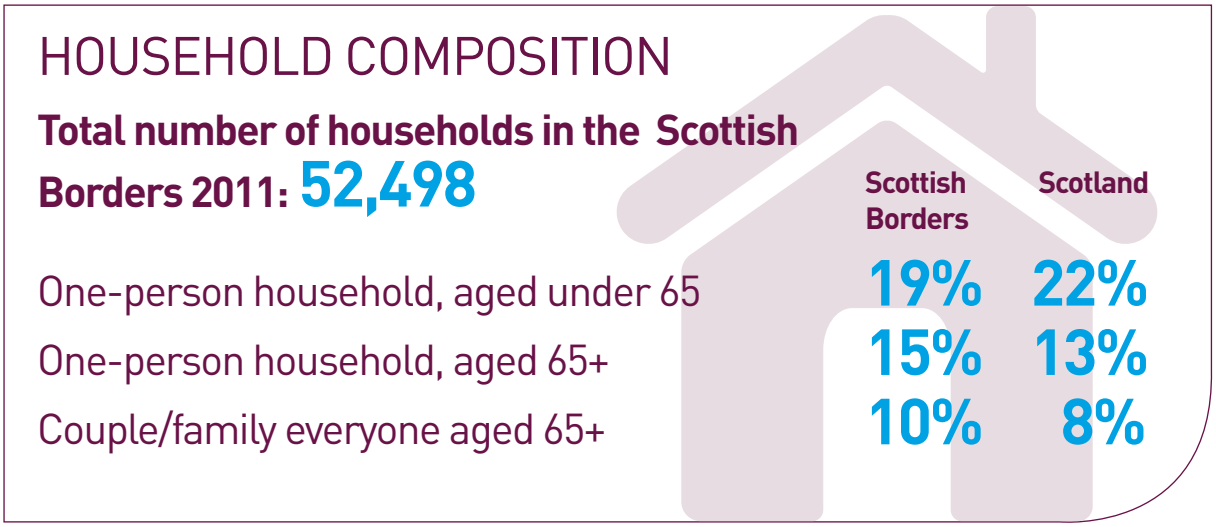
Services therefore need to be provided locally whenever possible and accessible transport arrangements put in place.

Borders Households

With the changes predicted in the population (see Figure 3 on page 7), we expect an increase in the numbers of older people living alone with complex needs. This will have major implications for housing, health and social care.

More than one third of households in the Borders are made up of one adult. The number of households in the Borders in which one or all occupants are aged over 65 is 25%, higher than the 21% for Scotland as a whole.

FIGURE 5



Source: Scotland Census 2011

The number of single adult households is projected to increase by 24% between 2012 and 2037, whilst the number of larger households is projected to decline. Households headed by people aged 60-74 are projected to increase by 9% and those headed by a person aged over 75 are projected to increase by 90%.

WHAT THIS MEANS...

Housing options need to be a key feature of our integrated health and social care services. Our existing Local Housing Strategy (2012-2017) and Housing Contribution Statement (2016) set out our work in relation to housing in more detail. An updated strategy will be in place in 2017.

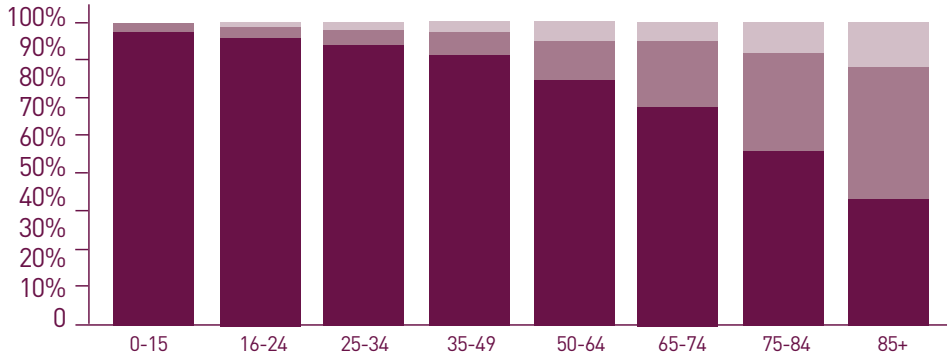
How Do People in the Borders View Their Health?

In general, people in the Scottish Borders enjoy good health, with 84% considering their health to be 'very good or good'; 12% of respondents consider themselves in 'fair' health, while 4% think their health is 'bad or very bad'.

The graph below shows that the number of people who consider their health to be 'very good or good' decreases with age. For example, more than 1 in 10 people aged over 75 reported their health as being 'bad or very bad', compared with only around 1 in 100 people aged 16-24.

FIGURE 6

SELF REPORTED GENERAL HEALTH
AMONGST SCOTTISH BORDERS RESIDENTS



Source: Scotland Census 2011

WHAT THIS MEANS...

We must enable people to keep well as long as possible through promoting healthier lifestyles, earlier detection of disease, and support to recover and manage their conditions.

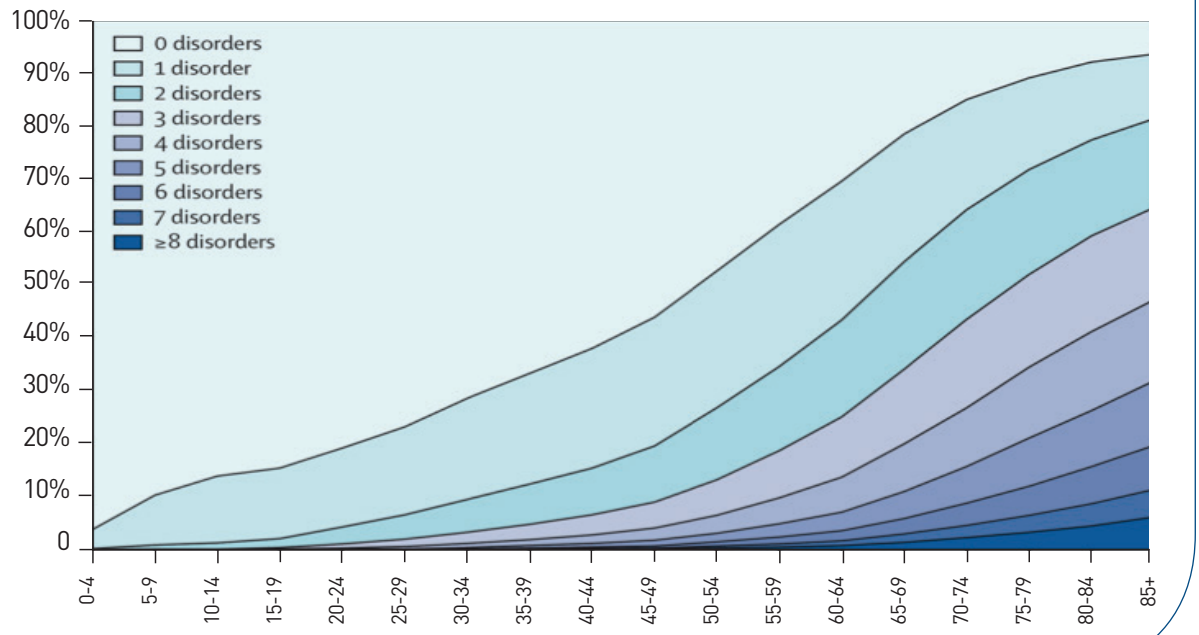
People Living with Multiple Long Term Conditions

We know that many people in the Borders live with one or more long-term conditions. This may affect how they access and use services. We need to make sure that services are integrated to support individuals with complex needs, to enable them to manage their conditions to lead healthy, active and independent lives as long as possible.

The number of people living with two or more long-term conditions rises with age as illustrated in Figure 7. For example, nearly two thirds of patients aged 65-84 and more than 8 in 10 patients aged over 85 had multi-morbidity. This presents a significant challenge to plan and deliver health and social care services.

FIGURE 7

PERCENTAGES OF PEOPLE HAVING ONE OR MORE LONG-TERM CONDITIONS, BY AGE GROUP, SCOTLAND 2007



Source: Barnett et al (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/abstract

Disability

The needs of people living with disabilities and sensory impairments are distinct from those who live with one or more health conditions. According to the 2011 Scotland Census, 6,995 people in Borders live with a physical disability. We have at least 555 people aged over 16 in our population who have a learning disability. About 2,300 people are estimated to have severe sensory impairment.

WHAT THIS MEANS...

People with a disability need flexible support arrangements to maintain and improve their quality of life.

It is estimated that around 500 people in our population are blind or have severe sight loss, while 1,800 people have severe or profound hearing loss. The National Health and Wellbeing Outcomes focus on people having a positive experience and their dignity respected when in contact with health and social care services, and that services are to be centred on helping maintain and improve the quality of life of people who use those services. This means that we must ensure services are accessible and easy to use by people with sensory impairment.

At the time of the 2011 Scotland Census, 612 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Learning Disability. 485 people in this group (81%) were aged 16 or over in 2011. Meanwhile, the total number of adults with Learning Disabilities known to Scottish Borders services is higher than the figures captured through the Census. As at March 2014, 599 people aged over 16 with Learning Disabilities were known to Scottish Borders services, of which 555 had confirmed addresses in the area.

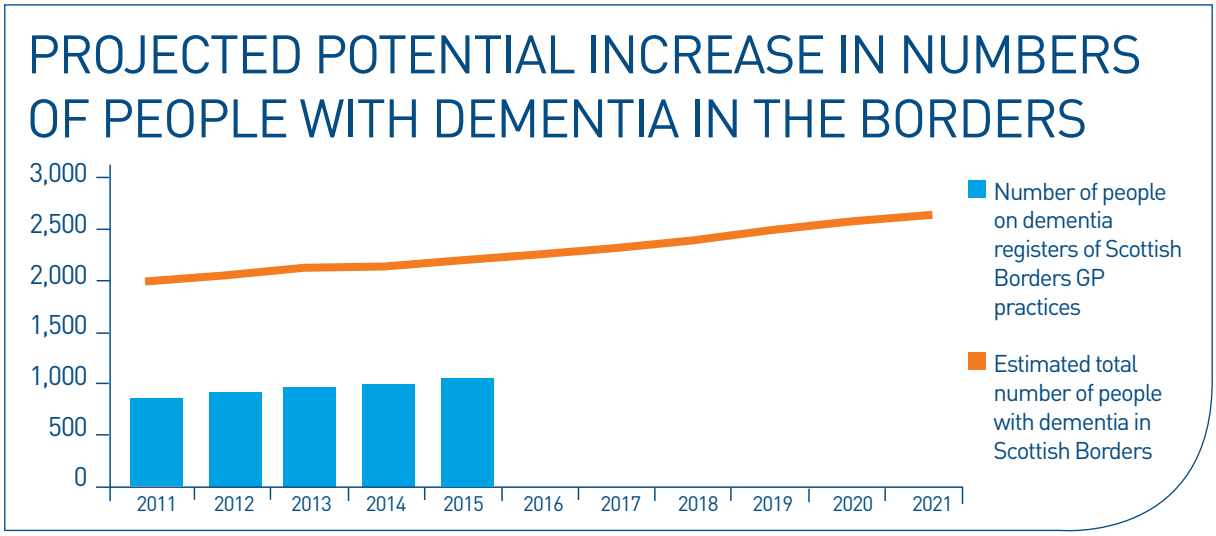
Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than that provided by mainstream Health and Social Care services. As part of the Learning Disability governance structure, people with learning disabilities and family Carers have places at the Partnership Board table to help inform decision making and strategic direction. Locality citizens' panels throughout the Borders provide opportunities for conversations between the Learning Disability Service and people directly affected by learning disabilities. A local area coordination service supports people to be more involved in their local communities.

Around one in four Scottish adults will experience at least one diagnosable mental health problem every year, and we are all likely to experience poor mental wellbeing at some point in our life. Due to the stigma related to mental illness, many will not access treatment and tend to have poorer health outcomes. Mental Health Services are in the process of developing integrated teams to provide easy access and multi-agency support to people with mental health needs. A full mental health needs assessment has been completed and this will help shape how we plan services in the future.

Dementia

Dementia is a growing issue and represents a challenge for planning and providing appropriate integrated care. The number of people living with dementia is projected to increase across Scotland, however the rate of increase in the Borders may be faster than the Scottish average as our population is older. Figure 8 below shows the number of people diagnosed with dementia in the Borders (shown in blue bars). For a number of reasons, including difficulties in diagnosis, the actual figures of people living with dementia are likely to be higher. The red line shows the likely number of people and how this number is predicted to increase over time as the population ages.

FIGURE 8



Source: 1. Diagnosed cases: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof 2. Estimated overall numbers of cases: Scottish Government projection, based on 'Eurocode' prevalence model used by Alzheimer's Scotland, and 2010 - based population projections.

WHAT THIS MEANS...

A range of support needs to be provided for people with dementia and their Carers, with appropriate training for all involved, to provide care across all settings.

People Living with Complex and Intense Needs

Health and Social Care resources are not utilised evenly across the population, as illustrated in the box below. As a Partnership, we need to develop a better understanding of the people who use very high levels of resource and use this knowledge to help plan our services more effectively. For example, where someone has had multiple hospital admissions and/or visits to A&E, it might have been more appropriate to deliver more of their care at home or in another community setting and reduce the risk of them having an avoidable admission to hospital. Changes in how care is provided to these people could produce better outcomes for them and allow us to treat more people more effectively.

Work to support people living with complex and intense needs will include:

- Identification of the main factors that increase the risk of emergency admission or re-admission to hospital;
- Use of this information to help strengthen our responses to patients and service users earlier on, and
- Exploration of alternative models of care.

USE OF HEALTH AND SOCIAL CARE RESOURCES: AN EXAMPLE

Analysis of expenditure in 2012/13 showed that:

- 2,332 people (2.5% of all Scottish Borders residents using selected major health services*) accounted for half of all expenditure on those services.
- 1,451 people aged 65 and over (7% of Scottish Borders residents aged 65+ who used any of the selected health services) accounted for half all expenditure on people aged 65 and over across those services.

*Health Services included in the analysis were: A&E attendances, inpatient and day case hospital admissions (all specialties), new attendances at consultant-led outpatient clinics, and community prescribing.

Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

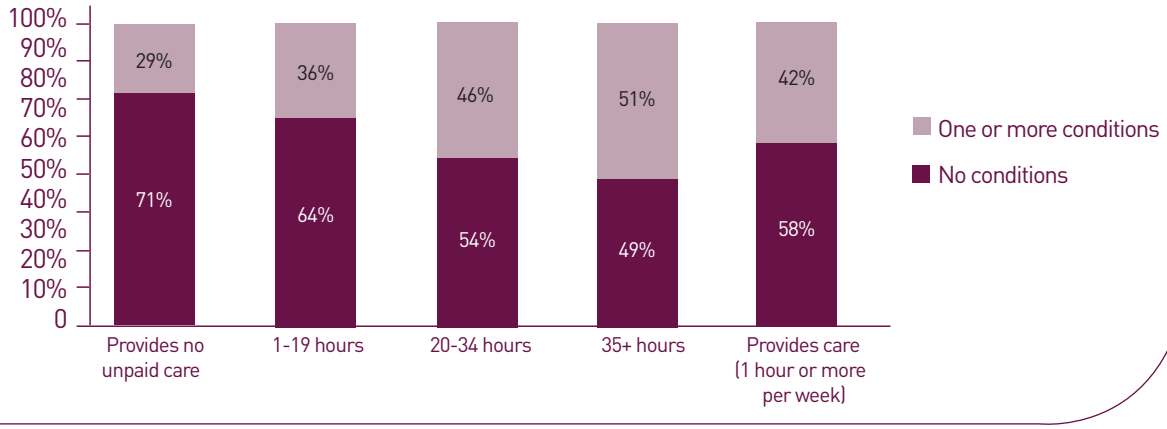
Carers in the Borders

Health and Social Care Services are dependent on the contribution of Carers*. In the Borders, approximately 12,500 people aged 16 and over provide unpaid care, around 13% of people in this age group.

The burden of caring is greater in more deprived areas. 46% of Carers living in the most deprived areas of the Borders provide 35 or more hours of care per week, compared with 22% of Carers living in the least deprived areas. Research also indicates that providing care for someone else often affects the Carer's own health – and Carers are often themselves older people with one or more long term conditions. More Carers (42%) than non-Carers (29%) have one or more long-term conditions or health problems. Of people providing more than 50 hours of unpaid care per week, 13% rated their own health as 'bad or very bad' compared with 4% of people who were not Carers.

FIGURE 9

PERCENTAGE OF CARERS WITH ONE OR MORE LONG-TERM HEALTH CONDITIONS, 2011, BY WEEKLY HOURS OF CARE THEY PROVIDED



Source: Scotland Census 2011 / Scotland's Carers (Scottish Government, March 2015).

WHAT THIS MEANS...

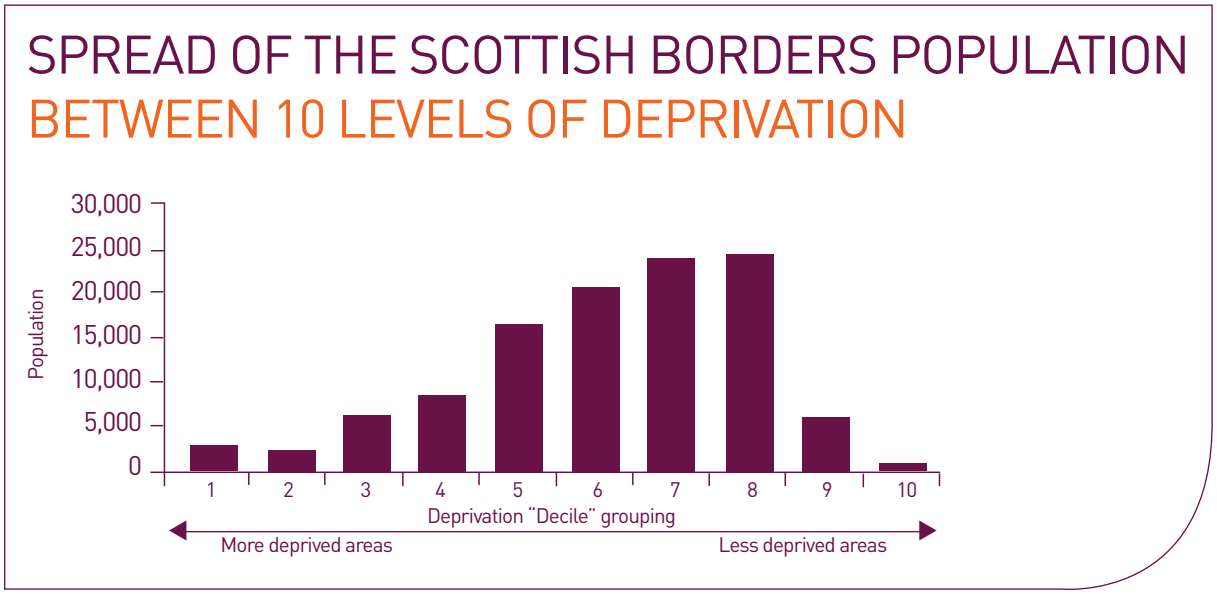
A range of easily accessible information and available support needs to be a key priority to ensure the wellbeing of Carers.

*Carers are individuals who care for a friend, relative or neighbour without receiving paid income in addition to income received through the benefits system. (Definition source: Care 21 Report: The future of unpaid care in Scotland. www.gov.scot/Publications/2006/02/28094157/0).

Deprivation in the Scottish Borders

Deprivation has a big effect on the need for, and use of, health and social care services. Taken as a whole, levels of deprivation in the Borders' population are relatively lower in comparison to Scotland. Figure 10 below shows the spread of our population between 10 different categories of deprivation (with 1 being the most deprived and 10 being the least deprived). If our deprivation profile were the same as Scotland's, we would see about 10% of our population in each category. What we see instead is an uneven distribution, with clearly less than 10% of our population living in the most deprived areas. However, some of our more urban areas - in Burnfoot (Hawick) and Langlee (Galashiels) - continue to show as amongst the most deprived in Scotland.

FIGURE 10



Source: Scottish Borders Strategic Assessment 2014

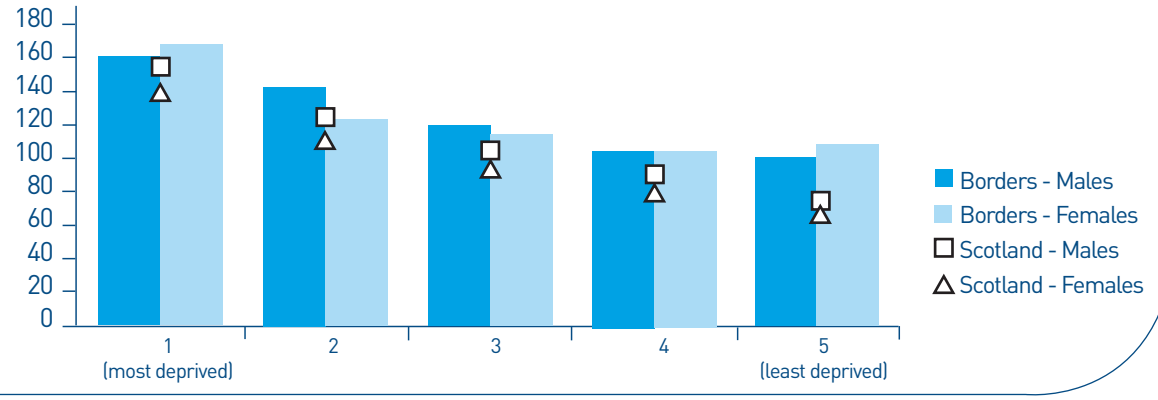
We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

An example of how the use of health and care services varies by deprivation is shown in Figure 11 below. The Borders follows the national pattern of having higher emergency hospital admission rates for people living in areas of higher deprivation. The figure also shows that emergency admission rates in the Borders are higher than the Scottish average within any given deprivation grouping.

A report on deprivation-related hospital activity noted: "Given that people at increased risk of health inequalities make proportionately greater use of acute and community health services, hospitals offer an important opportunity for health improvement actions to reduce health inequalities". The need for health and social care services to contribute to reducing health inequalities is the focus of the Scottish Government's National Health and Wellbeing Outcome number 5 (see Appendix B).

FIGURE 11

EMERGENCY HOSPITAL AGE-STANDARDISED ADMISSION RATES PER 1,000 POPULATION, BY 5 DEPRIVATION LEVELS 2011/12



Source: NHS Health Scotland (March 2015) Hospital discharges and bed days in Scotland by deprivation 2011-12.

WHAT THIS MEANS...

The Strategic Plan and Locality Plans that we will be developing in 2016 must reflect the local needs of communities, recognising patterns of deprivation and inequality. These plans will cross-reference with work already being developed under our Reducing Inequalities Strategy.

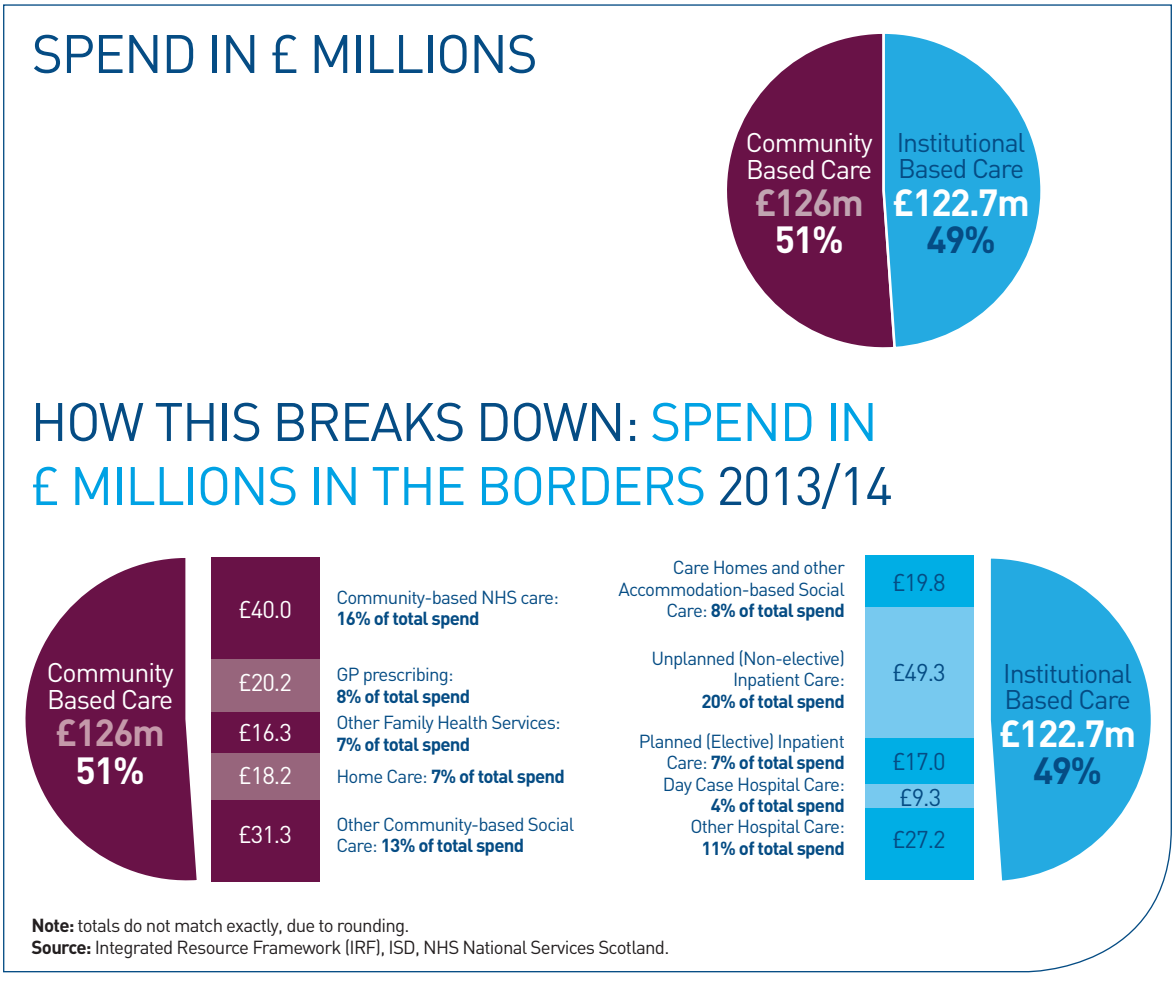
HEALTH AND SOCIAL CARE SPENDING

The total NHS and social care spending in the Borders in 2013/14 was £248.7m. All NHS services are included in this total – including health services that are not covered by integration (such as planned outpatient and inpatient care). The overall spending was split 51% Community-Based Care versus 49% Institutional Care.

- Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.
- Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.

The Borders has already made significant progress towards the aim of providing more care in the community compared with Scotland as a whole, where the split was 44% on Community-Based Care versus 56% on Institutional care.

FIGURE 12



Note: totals do not match exactly, due to rounding.
Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

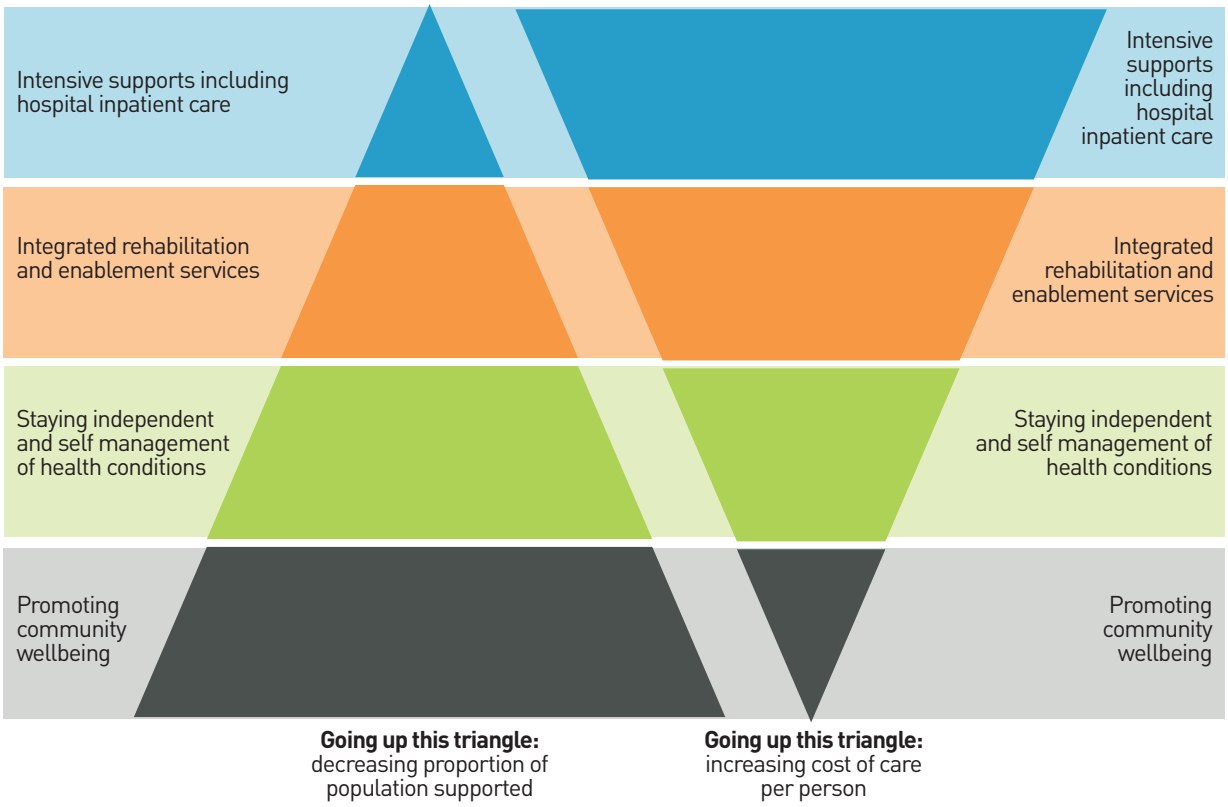
Shifting the Balance of Care Towards Prevention and Early Intervention

The aim of integrated health and social care services is to shift the balance of care towards prevention and early intervention to ensure that individuals have better health and well-being. Services need to be redesigned around the needs of the individual, to:

- Ensure that their journey through their care and treatment is as integrated and streamlined as possible;
- Enable them to remain independent for as long as possible; and
- Support them to recover after illness and at times of crisis.

In Figure 13 below, services that promote health and well-being are shown at the bottom of each triangle, whilst intensive support services (such as acute hospital inpatient care) are shown at the top. The triangle on the left shows that a small number of people need the intensive support and care provided within hospital. However the triangle on the right shows that this small group of people use a large amount of total resource available for health and social care.

FIGURE 13
CURRENT CARE MODEL

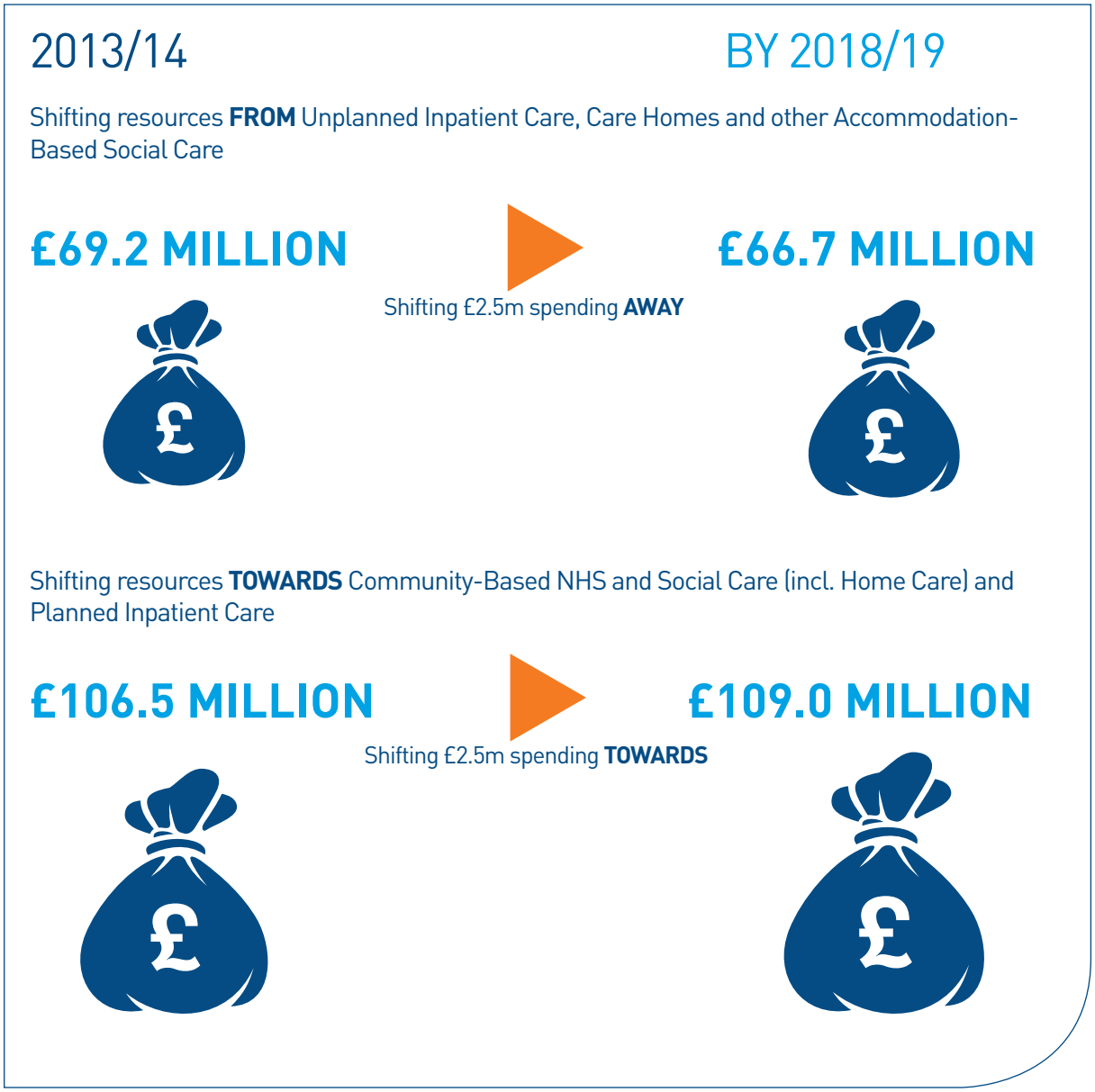


If we are able to improve health and wellbeing through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in Figure 14.

What shifts do we need to make?

By shifting just 1% of our total spend of approximately £250m FROM Unplanned Inpatient Care and Institutional-Based Social Care TOWARDS Community-based NHS and Social Care and Planned Inpatient Care, we will use our resources more effectively. This will help us invest in new integrated ways of working particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting Carers and independent living.

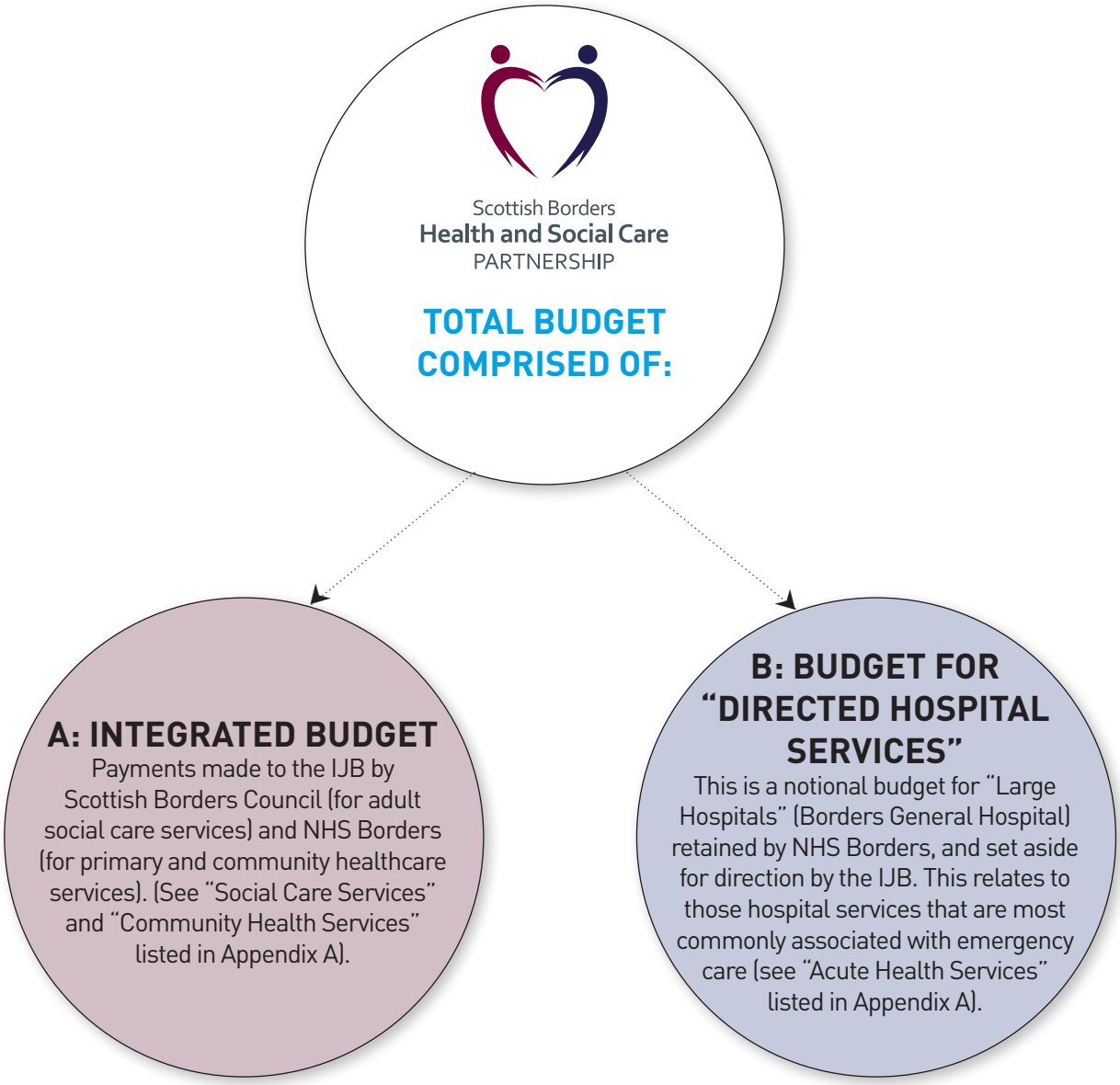
FIGURE 14



The Health and Social Care Partnership's budget

We have shown above that total NHS and social care expenditure in the Borders in 2013/14 was £248.7m. The budget the new Health and Social Care Partnership will be responsible for will represent a high proportion (about two thirds) of total spend on Health and Social Care. The use of this budget will be directed by the Partnership's Integration Joint Board (IJB), which is a separate legal entity from either the Council or the NHS Board, and is responsible for directing and overseeing the delivery of integrated health and social care services in the Borders. Details of our final budget for 2016/17, once formally approved in March 2016, will be published in our first annual Financial Statement at www.scotborders.gov.uk/integration. The Financial Statement will support the delivery of this Strategic Plan.

FIGURE 15



WHAT YOU SAID AND WHAT WE PLAN TO DO

This section of this document describes some of the actions we will take to start to make the shift towards more community-based health and social care services, the outcomes we will seek to achieve and the steps we will take to deliver our local objectives. We describe some of the performance measures we will use to assess the progress we are making. This has been influenced by what you have told us was important to you.

Each of our 9 Strategic Objectives is set out on the following pages with:

- A reflection of some of your feedback relating to each objective.
- An outline of how we intend to deliver what is needed to achieve the objective.
- Examples of activities identified in our current service strategies which relate to the objective. Although many examples give the name of a particular service or strategy in brackets, all of the objectives apply to all of our client/patient groups and we intend that they all benefit from these approaches.
- Related projects which are already underway.
- What people can expect to see in terms of targets and outcomes against each objective over the next 3 years.

Objective 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role - was added as a Strategic Objective following the round of consultation in May and June 2015. This reflects the way in which engagement with the people who use and provide our services is central to the development of our Strategic Plan and the activities that underpin it.

The information given on the following pages is not exhaustive. This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

As a Health and Social Care Partnership, we also have a Public Sector Equality Duty under the Equality Act (2010). We have a duty to:

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a characteristic that is protected under the Act, and those who don't.
- Foster good relations between people who share a characteristic and those who don't. This involves tackling prejudice and building understanding.

The characteristics that are protected under the Act are:

AGE Younger people, older people, or any specific age group	**DISABILITY** Including physical, sensory, learning, mental health and health conditions	**GENDER** Male, Female and Transgender
MARRIAGE AND CIVIL PARTNERSHIP Including single, divorced, civil partnership, married, separated	**PREGNANCY AND MATERNITY** Including breastfeeding	**RACE** People from ethnic minorities including Gypsy Travellers and Eastern European immigrants
RELIGION OR BELIEF Including people who have no belief	**SEXUAL ORIENTATION** Bisexual, Gay, Heterosexual and Lesbian	**CARERS** Both formal and informal carers

In taking forward the work of the Health and Social Care Partnership, we will embrace these duties and ensure that all requirements are met, through the implementation of the Business and Commissioning Plans for the Service and Strategic areas that are Integrating.

OBJECTIVE 1

We will make services more accessible and develop our communities

Strong communities are a real asset of the Borders. Community capacity building makes a big improvement to the health and independence of people.

What we heard you say is important to you:

- Ensure information is up-to-date, accessible both off- and on-line and improve how people are directed to and can access services.
- Build on existing work to increase to community capacity throughout the Borders.
- Use community-based education from an early age to encourage better lifestyles.

We want to:

- Improve access and signposting to our services and information, and assist people to help themselves.
- Develop local responses to local needs.
- Communicate in a clear and open way.

Some examples of how we intend to do this through our current services and strategies:

- Improve co-ordination for individuals and build capacity in communities to support older people at home. (Older People).
- Put people with dementia at the centre of planning and providing services and ensure they are able to live independently within their own homes and community. (Dementia).
- Improve information and advice to Carers. (Carers).
- Strengthen partnership and governance structures. (Drugs and Alcohol).
- Achieve best outcomes for service users, foster recovery, social inclusion and equity. (Mental Health and Wellbeing).
- Ensure that people with sensory loss receive seamless provision of assessment, care and support. This will be provided by local partnerships, which will identify local priorities and approaches. This will include a review of the local sensory loss strategy in the light of the publication of the national "See Hear" Strategy. (Sensory Services).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- Health literacy training (delivered by Health Improvement Team) for staff to improve the accessibility of information about keeping well and services.
- Delivering affordable housing across the Scottish Borders; working with local housing associations to provide housing which is warm, in good condition and fit for purpose.

These are some of the changes that we have started to make:

- **Burnfoot Community Hub** – supporting the creation of a Community Hub facility to allow delivery of a range of community services and activities.
- **Borders Community Capacity Building** – supporting older people in Cheviot, Tweeddale and Berwickshire to establish or create new activities and support in their local communities – initiated through co-production and involving local residents.
- **Learning Disabilities** – Involve service users in the design and delivery of services. Local area co-ordinators are available to support people in accessing support and services in their local communities.
- **Locality Citizens Panels** – providing forums for people with learning disabilities and their Carers to meet and discuss local issues affecting them, and to contribute as part of the Learning Disabilities governance structure.
- **Locality Planning/Locality Management** – Taking into account the varying needs of the Borders population, we will have local plans and will devolve some services accordingly.

We will measure performance against this objective over the next three years by measures including:

- We would like to maintain 90% of adults in the Borders rating the overall care provided by their GP as "Excellent" or "Good" (higher than 87% overall for Scotland) in 2013/14. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We want to increase the proportion of adults who received support and care services in the Borders and rated the services as "Excellent" or "Good" in 2013/14 from 83% to 85%.
- We want to see the number of adults who agree that the support or care services they had received improved or maintained their quality of life from 83% (lower than the Scottish average of 85%) to 86%.

OBJECTIVE 2

We will improve prevention and early intervention

Ensuring that people struggling to manage independently are quickly supported through a range of services that meet their individual needs.

What we heard you say is important to you:

- Be proactive about providing early intervention and prevention: support people better/ earlier, and promote existing services e.g. health checks at GP surgeries.
- More Anticipatory Care Planning for people, their families or Carers.
- Work with other organisations, staff and people to develop integrated approaches to prevention and promote personal responsibility.
- More acute care and community services in local communities.
- Local wheelchair-friendly housing options.
- A good transition into adult services that ensures young adults with disabilities can live as independently as possible and can prevent/reduce reliance on services.

We want to:

- Prioritise preventative, anticipatory and early intervention approaches.
- Focus services towards the prevention of ill health, to identify problems earlier on, to anticipate the need for support, to offer care and support at an early stage, and to respond where possible to prevent crisis.
- Improve supports for people to manage their health conditions, improve access to healthcare when required, and make best use of recovery models.
- Ensure that young people with disabilities transition from children's to adult services in a seamless way.

Some examples of how we intend to do this through our current services and strategies:

- Help the growing pool of 'young old' people to stay well through prevention measures. (Older People).
- Reduce the amount of drug and alcohol use through early intervention and prevention. (Drugs and Alcohol).
- Promote healthier lifestyles for patients, staff and visitors through our health improvement campaign 'Small changes, big difference'.
- Increase referrals to services that support lifestyle change, such as Lifestyle Advice & Support Services (LASS) and Quit4Good (smoking cessation services) in primary care; and signpost to community resources such as 'Walk It' groups to promote physical activity.
- Strengthen falls prevention work.
- Deliver the Long Term Conditions project to support people to manage their conditions better.
- Promote uptake of health screening opportunities and immunisation programmes.
- Raise awareness of signs and symptoms of health conditions (physical and mental health) and encourage people to get checked early (e.g. Detecting Cancer Early campaign; Suicide prevention training).

OBJECTIVE 2 - continued

Examples of how we intend to do this through our current services and strategies (continued):

- Provide Housing Options and Housing Support, directly and with partners, to help people remain in their own home and prevent homelessness. This includes Housing Officers visiting vulnerable households on a regular basis – identifying the needs of those people.
- Promote social contact with local resources to reduce isolation and loneliness.
- Develop a mechanism to ensure that anticipatory care plans are used effectively.
- Implement the recommendations in the Mental Health Needs Assessment.
- We will work with all partners to raise awareness about dementia and improve diagnosis rates.
- Review the support mechanisms for transition into adult services (Physical Disability).

These are some of the changes that we have started to make:

- **Telehealth Care** – look at how technology can be used to provide better home-based health care services.
- **Lifestyle Advice and Support Services (LASS)** – strengthen pathways from acute care to these services.
- **Bowel Screening** - Improve uptake in deprived areas.
- **Long Term Conditions** - Test out new ways of working to support the shared-management **of long term conditions.**
- **Targeted health improvement projects for people with learning disabilities**. For example 'A healthier me'.

We will measure performance against this objective over the next three years by measures including:

- We want to maintain and improve on the 96% of Scottish Borders GP practice patients who felt that they were able to look after their own health 'very well' or 'quite well' (a little higher than the Scottish average of 94%) (Source: Health and Care Experience Survey 2013/14, Scottish Government).

OBJECTIVE 3

We will reduce avoidable admissions to hospital

By appropriate support in the right place at the right time, we will ensure people are supported to remain in their own homes.

What we've heard you say is important to you:

- Ensure essential equipment is easily accessible at all times for people, staff, families and Carers.
- Improve discharge planning to ensure it is clearly communicated and coordinated.
- Ensure there is an integrated response to prevent admissions.
- Increase self-referral and reduce waiting list times so that people can be supported as quickly as possible before their needs change.

We want to:

- Reduce unnecessary demand for services including hospital care. If a hospital stay is required we will minimise the time that people are delayed in hospital.

Some examples of how we intend to do this through our current services and strategies:

- Help older people to stay well through prevention measures; improve coordination and help them in making their way through the health and social care system.
- Build capacity in communities to support older people at home.
- Holistic assessments and personalised care planning that addresses broader health and social care issues important to individuals, such as welfare benefits/financial issues, housing issues, and social connectedness.
- Stronger links with community based support services/resources.
- Housing - Provide well insulated, comfortable homes to help prevent existing health problems from becoming worse. Ensure adaptations to homes, such as grab rails, are in place to help prevent falls or other injuries, and to help keep people independent.

These are some of the changes that we have started to make:

- Connected Care – aims to create improved community support to prevent hospital admission and ensure timely discharge. We are working with other organisations to develop new and improved approaches to make this happen.

OBJECTIVE 3 - continued

We will measure performance against this objective over the next three years by measures including:

- We would like to reduce overall rates of emergency hospital admissions by 10%, by improving health and care services for people in other settings.
- We would like to reduce the rate of multiple emergency hospital admissions in people aged 75 and over, by 10%, by improving health and care services for people in other settings.
- We will reduce instances of patients being readmitted to hospital within 28 days of discharge by 10%.
- We will reduce falls amongst people aged 65 and over by 10%.

OBJECTIVE 4

We will provide care close to home

Accessible services which meet the needs of local communities, allows people to receive their care close to home and build stronger relationships with providers.

What we've heard you say is important to you:

- Ensure there are appropriate and accessible services in the community to support prevention.
- Ensure that the right staff are in place to support people who need to access services.
- Work more closely with our communities and organisations and make better use of local knowledge.
- Make the care profession a more attractive career.

We want to:

- Support people to live independently and healthily in local communities.
- Improve care pathways to ensure more co-ordinated, timely and person-centred care.
- Ensure the right services are in place to meet people's needs.
- Ensure staff (and Carers) have the necessary knowledge, skills and equipment to provide care at/close to home.
- Move to outcome-focussed delivery of care and support.

Some examples of how we intend to do this through our current services and strategies:

- Work with other organisations so people with a physical disability can live as independently as possible; develop opportunities for people with a physical disability to fully engage in their local community; and improve access to public transport. (Physical Disability).
- Build capacity in communities to support older people at home.
- Have appropriate housing in place to keep people independent. (Older People).
- Ensure people with dementia have access to services which enable them to remain independent within their own homes and community as long as practical. (Dementia).
- Develop a joint approach to commissioning; achieve the best outcomes for service users; foster recovery, social inclusion and equity; and achieve a balanced range of services. (Mental Health and Wellbeing, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.
- Use Locality Planning to inform service development based on the needs of people in each of our localities.

OBJECTIVE 4 - continued

These are some of the changes that we have started to make:

- **Health Improvement** – To support people to live well with long term conditions – we will promote self-management to empower people and their Carers to actively engage in creating individualised care.
- **Borders Ability Equipment Store** – Ensure provision meets the future demands of a growing elderly population which will require additional equipment, technology options **and support.**
- **Introduction of local area co-ordination services for Learning Disabilities**.
- **Change models of support** – reduce the number of people with Learning Disabilities living in a care home setting to living in a Supported Living Model of support.

We will measure performance against this objective over the next three years by measures including:

- We would like to see more people supported and cared for in their own homes or another homely setting, currently 65% in the Borders and 62% in Scotland overall.
- We would like to maintain the average proportion of the last six months of a person's life that they spent at home at 91.6%, a little higher than the Scottish average of 91.2%. (Source: Health and Care Experience Survey 2013/14, Scottish Government).

OBJECTIVE 5

We will deliver services within an integrated care model

Through working together, we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.

What we've heard you say is important to you:

- More integrated and proactive local teams, sharing responsibility and enabling faster decision making.
- Recognise and clarify the roles of all organisations involved in providing health and care services and make better use of each other's skills and experience.
- Integrate IT systems between organisations to improve communications and information sharing.
- Ensure communities are considered individually when planning health and care services.

We want to:

- Ensure robust and comprehensive partnership arrangements are in place.
- Pro-actively integrate health and social care services and resources for adults.
- Integrate systems and procedures.
- Ensure that our workforce are equipped to provide good quality, effective, integrated services with the person at the centre.

Some examples of how we intend to do this through our current services and strategies:

- Improve the coordination and help for individuals making their way through the health and social care system. (Older People).
- Develop an integrated approach to commissioning, and achieve a balance of services. (Mental Health and Wellbeing, Older People).
- Improve access and develop effective and integrated quality services. (Sensory Impairment).
- The housing sector in the Borders has a range of partnership mechanisms to enhance the level of staff engagement, including the Local Housing Strategy Partnership, Borders Housing Hub, New Borders Alliance and the Strategic Housing Investment Plan Working Group.

OBJECTIVE 5 - continued

These are some of the changes that we have started to make:

- **Mental Health Integration** – build on existing arrangements in Mental Health Service to integrate community teams.
- **Improve integration of health and social care provision**. (Learning Disability, Older People).
- **Co-production approach** – professionals and patients/clients working together to review, redesign and deliver integrated services.

We will measure performance against this objective over the next three years by measures including:

- We would like to see the proportion of adults who agreed that their health and care services seemed to be well co-ordinated rise from 79% (the average for Scotland) to 85% (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We would like to reduce the number of bed-days occupied by adults due to delayed discharge across all ages, but particularly for those aged 75 and over, from 84% to the Scottish average of 73%.
- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. We will aim to improve our rating to a minimum of 61%, preferably higher at 70%. The same question will be included in future council staff surveys.

OBJECTIVE 6

We will seek to enable people to have more choice and control

Ensuring people have more choice and control means that they have the health and social care support that works best for them.

What we heard you say is important to you:

- Ensure services are flexible to address short- and long-term needs and as close to 24/7 as possible, to enable people to access the services they need when they need them.
- Provide more housing options, giving people more freedom and choice.
- Increase availability of self-referral to access services and ensure consistency across services.
- Encourage more people to self-manage their conditions.

We want to:

- Ensure the principles of choice and control, as exemplified in Self Directed Support legislation, are extended across all health and social care services. This includes the participation and involvement of people in their care and support.

Some examples of how we intend to do this through our current services and strategies:

- Enable people with a physical disability to have choice and control over how they are supported to live independently. (Physical Disability).
- Borders Care & Repair services help disabled homeowners or private sector tenants with adaptations that will enable them to stay in their own home. Borders Care & Repair offer help and assistance and can project manage the entire adaptation process. (Housing).
- Ensure the needs of people with dementia are at the centre of all planning and provision of services specific to them. (Dementia).
- Improve the provision of information and advice to Carers, improve quality of Carer assessments/ support plans and involvement of Carers in care planning. (Carers).
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment, Older People).

OBJECTIVE 6 - continued

These are some of the changes that we have started to make:

- **Self-Directed Support (SDS)** – is now being implemented across health and social care services. SDS is an approach across health and social care services that ensures people have choice over their support and over how it is arranged and paid for.
- **Dementia** – The Scottish Borders Dementia Strategy is being updated to align it with national strategies. One area of focus is Post Diagnostic Support for people who are recently diagnosed. New models of care are being explored. Another area of development is a local Dementia Working Group which, with support from Alzheimer Scotland, will ensure people with dementia have their voices heard and are involved in service development. The group will link to the Scottish Dementia Working Group and will have opportunities to be involved with strategic developments at a national level.

We will measure performance against this objective over the next three years by measures including:

- Amongst adults who received support and care services in the Borders in 2013/14, 83% agreed that they were supported to live as independently as possible (a little lower than the Scottish average of 84%). We want to increase this to 85% (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We want to increase the number of people who agreed that they had a say in how their support or care was provided, from 80% to 85% (the Scottish average was 83%) (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We will ensure that everyone eligible for social care support will have choice and control through the Self-Directed Support approach.

OBJECTIVE 7

We will further optimise efficiency and effectiveness

Strategic Commissioning requires us to constantly analyse, plan, deliver and review our services which give us flexibility to change what we do and how we do it.

What we've heard you say is important to you:

- Improve clarity of decision making process and enable decisions to be made more quickly.
- Ensure that we make the most of our staff through training and flexibility and create more opportunities to offer additional support.
- Acknowledge and address changes required for a more flexible and responsive workforce.
- Value and support our volunteers.
- Make better use of our existing resources and assets, including buildings, people, and finance to ensure that they are sufficient and used as effectively and efficiently as possible.

We want to:

- Transform the way we provide and deliver services.
- Efficiently and effectively manage resources to deliver "Best Health, Best Care, Best Value".
- Support and develop our staff to be confident and reach their full potential.
- Deliver effective support and care through a mixed economy of care, utilising all key partners in the voluntary and private sector.

Some examples of how we intend to do this through our current services and strategies:

- Work to improve the energy efficiency of homes; providing adaptations to enable people to stay at home rather than move someone at higher cost.
- Make efficient use of the funding and other resources available. (Dementia, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.

These are some of the changes that we have started to make:

- **Transitions** – focusing on improving the transition pathway for young people with learning disabilities as they move from children's to adults' specialist services.
- **My Home Life** – offer training to managers to help improve quality of life in care homes.
- **Focus on Outcomes Training** – deliver a new outcome-focused assessment for social care and associated training.

OBJECTIVE 7 - continued

We will measure performance against this objective over the next three years by measures including:

- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. (Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. The same question will be included in future council staff surveys.)
- We would like a higher proportion of our budget to be spent on community-based health and social care and planned hospital care. In the Borders, 20% of all NHS and Social Care expenditure in 2013/14 was in relation to hospital stays, where the patient was admitted as an emergency. This is lower than the Scottish average of 22%. (Source: Integrated Resource Framework, www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/index.asp)

OBJECTIVE 8

We will seek to reduce health inequalities

Ensuring that people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.

What we've heard you say is important to you:

- Ensure openness and consistency around access to services.
- Work with communities to address loneliness, deprivation and inequality and empower them to develop their own solutions.
- Work with local transport providers across all sectors to provide appropriate and accessible transport services.
- People with learning disabilities are more likely to have more undiagnosed health conditions, die younger than the general population and need more support to access health care.

We want to:

- Reduce inequality, in particular health inequality and support and protect those who are vulnerable in our communities.

Some examples of how we intend to do this through our current services and strategies:

- Develop a Carers Rights Charter, ensure Carer representation on Health and Social Care Partnership. (Carers).
- Reduce the amount of drug and alcohol use through early intervention and prevention, reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reduce related deaths. (Drugs and Alcohol).
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- The four outcomes of the Local Housing Strategy (2012-2017) aim to tackle the inequalities in our society – this includes health inequalities.

OBJECTIVE 8 - continued

These are some of the changes that we have started to make:

- **Transport Hub** – Scottish Borders Council, NHS Borders, The Bridge, Red Cross, Berwickshire Association of Voluntary Services and Royal Voluntary Service are working as partners to put in place a coordinated, sustainable approach to providing community transport.
- **Community Learning Portal** – provide free access to the Community eLearning Portal for staff in partner organisations.
- **Stress & Distress Training** – provide training in a personalised way to understanding and intervening in stress and distressed behaviours in people with dementia. This training aims to improve the experience, care, treatment and outcomes for people with dementia, their families and carers.
- **Deaf Awareness E-learning** – create an e-learning training resource focusing on the needs of older people with hearing loss. Initially the training will be available to Scottish Borders Council and NHS staff, but the intention is to ensure that partner organisations have access to it in the future.
- **Community nurses and social care staff** support people with Learning Disabilities to access mainstream healthcare.
- **Liaison nurses** are based in Borders General Hospital (Learning Disabilities, Mental Health).

We will measure performance against this objective over the next three years by measures including:

- We want to improve and increase the percentage of adults who received support and care services in the Borders who agreed that they felt safe from 81% (lower than the Scottish average of 85%) to 86%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We would like to maintain the downward trend in the Borders in death rates in people aged under 75.
- We will address the recommendations within "The Keys to Life" (2013) National Strategy for people with learning disabilities, through local action plans for people with learning disabilities, to improve their health.

OBJECTIVE 9

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

What we've heard you say is important to you:

- Improve support for Carers to avoid deterioration in their own health and wellbeing and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.

We want to:

- Improve support for Carers so they can avoid deterioration in their own health and wellbeing and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.
- Improve access to respite care.

Some examples of how we intend to do this through our current services and strategies:

- Ensure the needs of Carers are considered alongside those of the person living with dementia. (Dementia).
- Develop a Carers Rights Charter, improve communication and advice to Carers, improve quality of Carer assessments and support plans, ensure Carer representation on health and social care partnership and produce a resource on issues relating to stress and caring. (Carers).
- Improve identification of Carers at an earlier stage and signpost/refer them for their own assessment.
- All staff will be provided with training around Carers and their needs.
- Carers will be consulted and included in all aspects of their relative's care needs, on planning and delivering the care need, during any hospital stays, on discharge, and in the community.
- Implement requirements set out within the new Carers legislation in 2017.

OBJECTIVE 9 - continued

These are some of the changes that we have started to make:

- **Carers** - We have commissioned the Carers Centre to be the first point of contact for Carers' Assessments. This model has been extremely successful and reduced the length of time for Carers waiting for assessment. However not all Carers are accessing the Centre. Work is underway to consider how we can promote the service and additionally how the Carers Centre can be supported to meet increased demand.

We will measure performance against this objective over the next three years by measures including:

- We want to increase the percentage of Carers reporting that they feel supported to continue caring from 41% (lower than the Scottish average of 44%) to 50%. We will review this target with a view to improving it further if possible.
- We want to support Carers in the Borders so that fewer Carers feel caring has had a negative impact on their health and well-being and reduce this figure from 30% to 20% (Source: Health and Care Experience Survey 2013/14, Scottish Government).

Planning for Change – Key Priorities

Below are the Partnership priorities identified so far for 2016/17. A fund of £2.13m per year has been provided to assist, support and develop the integration of Health and Social Care Services until March 2018.

- To develop integrated accessible transport.
- To integrate services at a local level.
- To roll out care coordination to provide a single point of access to local services.
- To improve communication and accessible information across groups with differing needs.
- Work with communities to develop local solutions.
- Provide additional training and support for staff and for people living with dementia.
- Further develop our understanding of housing needs for people across the Borders.
- To promote healthy living and active ageing.
- To improve the transition process for young people with disabilities moving into adult disability services.
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the Third Sector.
- To improve support for Carers within our communities.
- Promote support for independence and reablement so that all adults can live as independent lives as possible.

LOCALITY PLANNING

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

Map showing our five Area Forum Localities (with all towns and villages with a population of 500 or more).

We have set up a group to oversee the development of planning in each of the five localities. We expect to appoint locality co-ordinators to act as a focus for planning in each locality.

They will:

- Build relationships with established community groups, partners across the localities, such as other leads working at locality level, for example in Community Learning and Development.
- Map out what is already happening, use and build upon the mapping work already in existence across relevant partnerships - established community groups, many of which are linking up through the Community Learning Partnership approach.
- Identify where existing funding is coming from, where there are gaps and where there are ideas or plans.
- Clearly define what is happening in the short, medium and longer term, how these priorities have been identified and what the consultation process has been/is going to be.
- Co-ordinate action plans, planned expenditure and how these fit with local priorities.

Planning at this level will need to take account of existing local plans such as Community Action Plans or Neighbourhood Plans as well as cross-Borders strategies, such as the reducing inequalities strategy and health inequalities action plan. It will also need to address cross-border issues (between Borders localities, and between Borders and neighbouring areas of Scotland and England). Some priorities are the same across localities but others are different. Locality plans will also need to take account of projects starting at the moment. For example, we are beginning to develop care coordination, which will be undertaken by care coordinators which will be rolled out across the localities in a phased way. This will help us provide more person centred care. Another current project is to provide a means for Borders Community Transport providers to work together to make best use of available transport and reduce duplication of journeys. Some other projects are specific to a locality such as "the Eildon Community Ward".

Service users, Carers, families, communities and professionals – particularly GPs – must be actively involved in locality planning, so that they can influence how resources are spent in their area – genuine co-production. Co-production is where people using services, their families and their neighbours work as equals with professionals to plan and deliver services. We are rolling out a "Borders Community Capacity Building Project" which will provide communities with support and ability to do this. We want communities to use the collective resources (assets) which they have at their disposal, to protect against poor health and improve health.

Assets are the strengths that people and communities have such as relationships, networks, enthusiasm, social cohesion and resilience as well as plans, land, buildings and funding. The people of the Scottish Borders are perhaps our single biggest asset. The networks and relationships that exist within and across communities are invaluable in themselves and they are health-improving. They provide a solid foundation for any work to improve health and wellbeing alongside the strong volunteer ethic and a natural commitment to supporting others. There is growing evidence of the combination of local people, community

groups, partners and physical assets in action across localities, such as the Borders Healthy Living Network, Langlee Residents Association, Burnfoot Community Futures, Eyemouth Community Development Trust and the relationships and activities these community based groups/organisations have been developing with agencies and local people.

In addition to people, other assets within the Scottish Borders include land and buildings. The Scottish Borders is a stunning place to live and this applies to all localities, with some of the most breath-taking views, areas of green space and outdoor walks available right on our doorstep. The Scottish Borders is steeped in history and this could be brought to life through social projects that involve communities and people who have experience of the changes influencing health and wellbeing in the Borders. We know that older people are living longer, healthier lives and they have a wealth of knowledge, skills and experience to share with others. We should make every effort to capitalise on this and positively influence the next generation of children and young people by connecting up these assets.

The Scottish Borders is made up of 'can do' communities and this is very much seen through their actions to support others on a day to day basis, as well as in times of crisis. If these assets are nurtured and harnessed in everyday life, this culture of support could be further enhanced. This has been referred to as an assets approach, which at its simplest turns what we know on its head and questions what we think in a positive way, for example, instead of asking about what is not going well, we ask about what is going right and do more of this. This is very much the current thinking influencing some local groups and networks. This can also be applied in practice through training and development to ensure that people are viewed in this way and seen for their strengths and the contribution they have to make. An assets approach therefore presents a significant shift in the way we engage with people and communities, from a deficit model that emphasises need and problems to an asset model that values active participation and sees people and communities as co-producers of long term sustainable solutions. Focusing particularly on health, the fundamental shift from what makes us ill to what makes us well and doing more of this is at the heart of an asset approach.

Where appropriate, we will devolve resources towards the delivery of particular local outcomes. For example, we will strengthen the work of the healthy living network in areas of disadvantage to improve the health and well-being of those communities. We will prioritise engagement with vulnerable groups, isolated residents and people who are not already accessing existing groups and local services. We will make the best use we can of community capacity and capability to do this.

Some illustrative Facts and Statistics about our Area Forum Localities

Tweeddale

- Estimated population in 2013: 19,192.
- 41% of live in its largest settlement, Peebles (population 7,908), whilst 59% live in smaller settlements or rural areas.
- The locality with the highest proportion of its population aged under 16 (18.7%). 60.1% of the population are aged 16-64 and a further 21.2% are aged 65+.
- In 2014/15 there were 16.6 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 80 per 1,000 population.

Eildon

- Estimated population in 2013: 38,798. Our largest locality in population terms (over one third of Scottish Borders residents live here).
- Nearly one third of residents live in Galashiels (estimated population 12,394) and another 14% in Selkirk (estimated population 5,608).
- The locality with the highest proportion of its population aged 16-64 (62.3%) and the lowest proportion aged 65+ (20.5%). A further 17.2% of the population are aged under 16.
- In 2014/15 there were 27.3 attendances at Borders General Hospital A&E for every 100 population – this is the highest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 93 per 1,000 population; this is the highest rate across our localities.

Berwickshire

- Estimated population in 2013: 20,862.
- No large towns; most people live in small settlements or rural areas. Eyemouth (population 3,152) and Duns (population 2,444) are the largest settlements here.
- 15.8% of the population are aged under 16, 60.0% are aged 16-64, 24.2% are aged 65+.
- In 2014/15 there were 15.8 attendances at Borders General Hospital A&E for every 100 population – this is the lowest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 79 per 1,000 population.

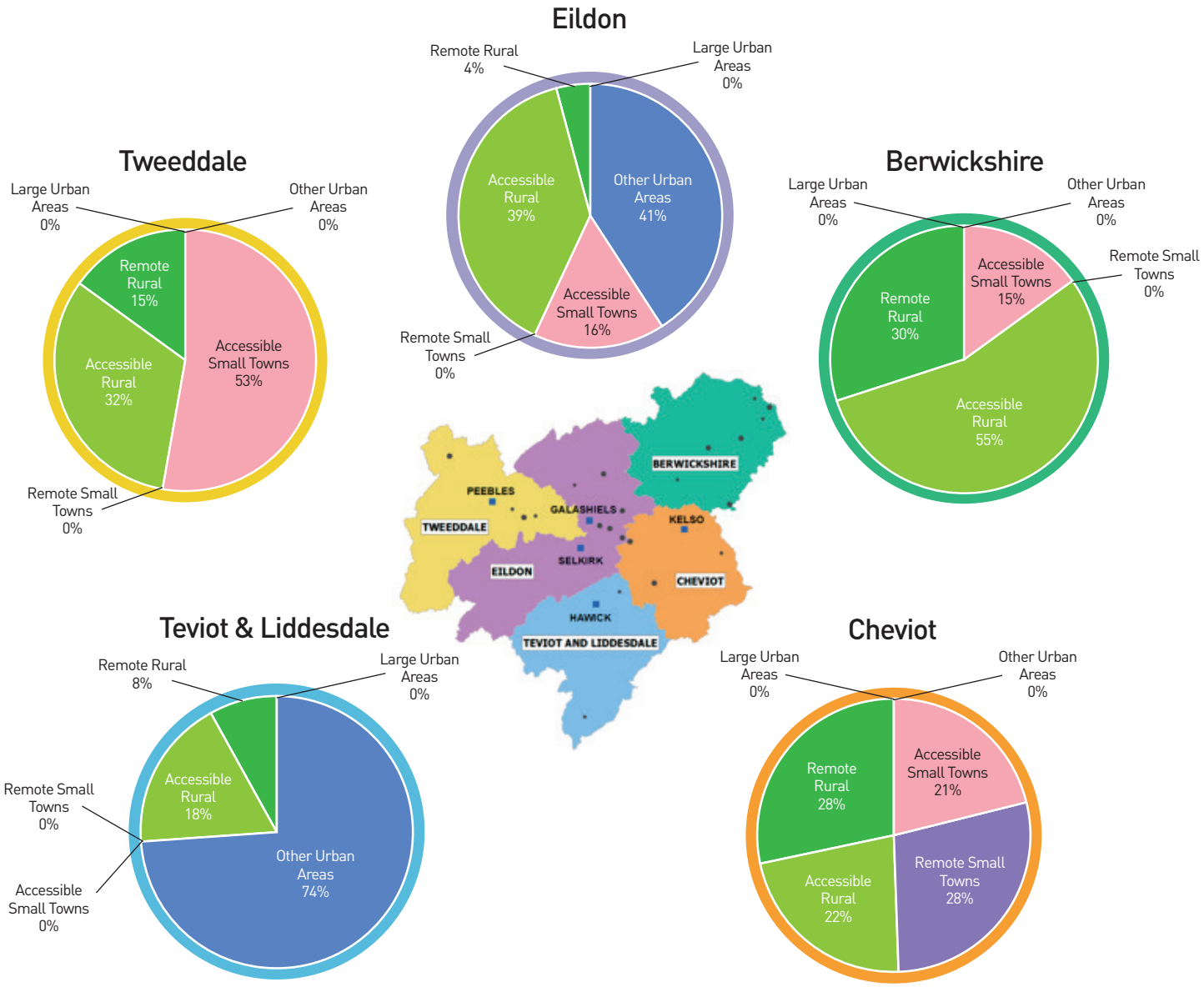
Cheviot

- Estimated population in 2013: 16,407. Our smallest locality in population terms.
- More than 60% of residents live in Kelso and Jedburgh, which have estimated populations of 6,139 and 3,959, respectively.
- The locality with the highest proportion of its population aged 65+ (25.6%). It also has the lowest proportions of children aged under 16 (15.6%) and people aged 16-64 (58.8%).
- In 2014/15 there were 19.7 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 75 per 1,000 population; this is the lowest rate across our localities.

Teviot & Liddesdale

- Estimated population in 2013: 18,611.
- Nearly three-quarters of the population live in the town of Hawick (estimated population 13,696).
- 15.7% of the population are aged under 16, 60.6% are aged 16-64, 23.7% are aged 65+.
- In 2014/15 there were 23.4 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 87 per 1,000 population.

OUR AREA FORUM LOCALITIES AND THEIR URBAN/ RURAL POPULATION PROFILES



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Category	Description
1 Large Urban Areas	Settlements of 125,000 or more people.
2 Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland. www.gov.scot/Publication/2014/11/2763/downloads

WHAT WILL SUCCESS LOOK LIKE

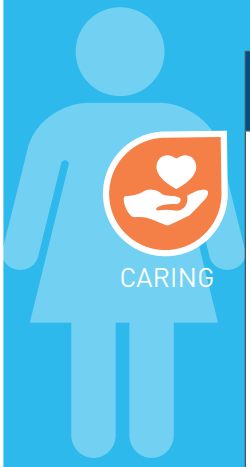
- Services are integrated and there is less duplication
- There is easier access to services through a single point of contact
- People with multiple long term conditions are supported
- Carers will feel better supported and have improved health and well-being
- Make best use of staff
- People participate in planning their own care and support
- The benefits of new technology improve people's health and well-being
- There is a shift to early intervention and prevention for children and young people, families and carers
- There will be a reduction in health inequalities
- Spend money wisely

PLANNING FOR INTEGRATED SERVICES

The two case studies here illustrate how ordinary people should experience a better integrated health and social care service.

PAMELA AGE 57

I'm Pamela and I've lived in Innerleithen most of my life. I live with my husband Owen and our daughter Jane. My 83 year old Father lives in sheltered housing nearby and our eldest daughter Jillian lives 7 miles away in Peebles. I have a lot of friends who live in the area.



MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
I look after my 3 year old grandson, Jack, 3 times a week. I visit my elderly father every day and I am the first responder to his Bordercare alarm. I recently had a Carer Assessment carried out.	I recently realised how much I've been looking after my Father. I love my Father and I want to care for him, but sometimes, I resent being his first responder and I feel I sacrifice things that are important to me to look after him. I feel guilty for thinking these things. Sometimes I don't understand what's happening with his care. I worry a lot about him.	• Clear information on available support and services. • Health and care co-ordinated services. • A single number to access services. • More support for me as a Carer.
I live in a modern, rented house. My husband Owen and I don't drive so we rely on public transport.	I love where I live and I like that I can walk to shops and the bus stop. But I find organising transport to get my Father to appointments can be really difficult.	• A single number to book transport. • Easier access to more coordinated services.
Owen recently retired for health reasons. My Father has dementia and is prone to falling. Jane is taking her higher exams. I love looking after Jack and seeing Jillian. Her partner Bill is nice too.	Owen is eight years older than me. He struggles with depression and I feel I need to be with him, which can result in me not being able to spend enough time with my Father or Jane. My Father falls occasionally. He has been recommended to attend gentle exercise classes but he says no.	• More opportunities to meet other people in the local community. • Supporting local communities to connect people and interests.

HOME

FAMILY

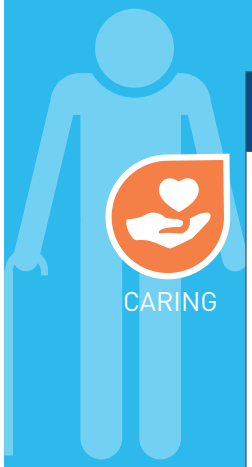
PAMELA
AGE 57

Continued ...

	MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
WORK	I work part-time in a shop in nearby Galashiels.	I've considered reducing my hours to spend more time with my Father and my family, but I can't for financial reasons. I often have calls to make or receive about my Father when I'm at work which is challenging as I've limited flexibility. I sometimes have to take leave to take him to appointments.	• More options to enable me to take my father to appointments. • Longer opening hours for services.
HEALTH	I've high blood pressure, arthritis and anxiety. I'm a cancer survivor. I take many prescription drugs. I've been a heavy smoker for years.	I don't take the best care of myself because by the time I've looked after my Father, grandson, Owen, daughter, been to work and volunteered at Church I'm often too tired. I tend not to tell Owen about my worries because of his depression. Smoking helps me feel more relaxed, but I've noticed I smoke more now. I'm quite anxious so I was grateful that the Carer's Assessment lady listened to me.	• Locally available acute health and care services. • Forward (Anticipatory) care planning for my Father, Owen and me. • A named person that I can speak to.
COMMUNITY	Owen and I have many friends here. I enjoy volunteering at my local church.	We have a good community with neighbours and friends helping out. I've school friends and friends at Church, so every once in a while, if things are ok, I meet them for lunch. My Father is isolated and he would really like visits from people as he has trouble going out.	• Supporting local communities to connect people and interests.

CHARLIE AGE 78

I'm Charlie. I've lived in Kelso since I retired here 15 years ago with my wife, Sandra, who died 5 years ago. I've been alone since. My two children live far away. They come for visits, but they have busy lives and their own families. I love Kelso, I feel safe and happy here, apart from being so far from my family.



MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
CARING I am a widower. I don't need health and care services at the moment.	I feel capable, but having recently had a fall, I had a bit of a fright and I was admitted to hospital for a short while. It was sad as I had no visitors which made me start to think about what would happen to me when I do need more help. I don't want to be a burden to my children. I always thought I would grow old with Sandra. There are home carers who can help me, but I would prefer to have someone I could rely on, not a lot of different people.	• I can choose the staff I want to support me at home. I will get support if I want to employ my own staff. • A single number to access services.
HOME I live in a 3 bedroom house with a large garden, on the outskirts of the town. I drive, but I'm less confident now so I don't like driving.	I know my house is too big and I cannot manage the garden alone, but I don't want to move and start over with a new house and neighbours. I'm a 10 minute walk to the bus stop and buses are regular but if I need to go to the Hospital, I have to change buses. I feel I need to drive more and more.	• Better co-ordinated local transport • Bigger range of locally based housing options
FAMILY My son Paul lives in England. My daughter Steph and her family moved to Florida 3 years ago.	Paul visits every couple of months. I can see he's worrying about me and I know Steph feels guilty for being so far away. I want to be able to reassure them I have a plan for any future needs and that I can support myself. Paul wants me to move near him but I don't deal with change very well.	• Forward (Anticipatory) Care Planning. • I am in control of planning for the future.

CHARLIE
AGE 78

Continued ...

MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
WORK I'm retired. I had to step back from my voluntary work at my bowls club which I enjoyed.	I liked being Treasurer of my local bowls club. My friend introduced me to bowls and she takes me when she can, but she can't make it every week. I had to give up being Treasurer as it became too much. I don't feel as fulfilled as I did. I would love to do more voluntary work.	• Appropriate volunteering opportunities for older people
HEALTH I'm slowing down and finding things harder. I've many medications, I'm not sure what they are and why I take them.	I like to keep active and I do drive when I need to, usually to appointments and shops. It was scary when I fell, but I don't think I needed to go to the emergency department, but I couldn't be checked locally. I felt very overwhelmed by the number of people asking me the same questions – surely the staff can look it up on my medical notes?	• Locally based services • Better information sharing across organisations
COMMUNITY When Sandra was alive we did lots of things together, but it's not the same without her.	I feel lonely without my wife and not as confident to socialise with people. My neighbours are lovely, but I don't see them as often as I used to. I wish there were more activities and groups for older people like me.	• Community based groups and activities

PLANNING INTO THE FUTURE

The Strategic Plan will only be the beginning. It will be a living working document which will change and grow throughout its life. It will build on feedback from people living in the Borders. It will be reviewed at least every three years, based on on-going assessment of need. In the future, we will focus particularly on how to meet the needs of people who use services in local communities.

Throughout the last 12 months we held a number of engagement events for both the public and staff. The information we received from these events has been used to inform this document. For example, the 9th local objective on support for unpaid carers was added as a direct result of your feedback. Thank you to all who gave us feedback in person or in writing throughout the process of developing this Plan. We have been able to act on some of your comments at this stage whilst others will be retained to help us in our ongoing planning and engagement work.

APPENDIX A
SERVICES THAT ARE INTEGRATING

Which health and social care services are we integrating?

Our partnership will be responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The Partnership has a key relationship with acute services in relation to unplanned hospital admissions and will continue to work in partnership with Community Planning Partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, we can also work in partnership with our communities.

ADULT SOCIAL CARE SERVICES*

- Social Work Services for adults and older people;
- Services and support for adults with physical disabilities and learning disabilities;
- Mental Health Services;
- Drug and Alcohol Services;
- Adult protection and domestic abuse;
- Carers support services;
- Community Care Assessment Teams;
- Care Home Services;
- Adult Placement Services;
- Health Improvement Services;
- Re-ablement Services, equipment and telecare;
- Aspects of housing support including aids and adaptations;
- Day Services;
- Local Area Co-ordination;
- Respite Provision;
- Occupational therapy services.

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

- Accident and Emergency;
- Inpatient hospital services in these specialties:
  - General Medicine;
  - Geriatric Medicine;
  - Rehabilitation Medicine;
  - Respiratory Medicine;
  - Psychiatry of Learning Disability;
- Palliative Care Services provided in a hospital;
- Inpatient hospital services provided by GPs;
- Services provided in a hospital in relation to an addiction or dependence on any substance;
- Mental health services provided in a hospital, except secure forensic mental health services.

COMMUNITY HEALTH SERVICES*

- District Nursing;
- Primary Medical Services (GP practices)*;
- Out of Hours Primary Medical Services*;
- Public Dental Services*;
- General Dental Services*;
- Ophthalmic Services*;
- Community Pharmacy Services*;
- Community Geriatric Services;
- Community Learning Disability Services;
- Mental Health Services;
- Continence Services;
- Kidney Dialysis outwith the hospital;
- Services provided by health professionals that aim to promote public health;
- Community Addiction Services;
- Community Palliative Care;
- Allied Health Professional Services

*Adult Social Care Services for adults aged 18 and over.
*Acute Health Services for all ages – adults and children.
*Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (*), which also include services for children.

APPENDIX B
THE NATIONAL HEALTH AND WELLBEING OUTCOMES

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through improving quality across health and social care.

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

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

Source: Scottish Government

APPENDIX C
OUR LOCAL OBJECTIVES AND THE NATIONAL OUTCOMES CROSS-REFERENCED

Our Local Objectives are:

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

The National Outcomes cross-referenced with Our Local Objectives

National Outcomes	1	2	3	4	5	6	7	8	9
Local objective 1	★	★	★	★		★		★	
Local objective 2	★	★		★	★			★	
Local objective 3	★	★							★
Local objective 4	★	★	★	★	★	★			★
Local objective 5				★				★	★
Local objective 6	★	★	★	★	★	★	★		
Local objective 7								★	★
Local objective 8	★	★	★		★	★	★		
Local objective 9	★	★	★	★	★	★	★		

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Scottish Borders COUNCIL

NHS Borders

Scottish Borders Health and Social Care PARTNERSHIP

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MONITORING OF THE SHADOW INTEGRATED BUDGET 2015/16

Aim

1.1 To provide the Health & Social Care Integration Joint Board with a report, by exception, of any significant pressures within the Partnership's Integrated Budget based on the projected outturn as at 31st January 2016.

Background

2.1 The total Shadow Revised Integrated Budget stands currently at £137.460m.

2.2 The services contained within this report related to the latest prescribed services for delegation within the Regulations to the bill and it is anticipated that these will form the basis of the delegated budget on 1st April 2016.

2.3 It was agreed that 2015/16 will be a shadow year and the integrated budget will be on an aligned basis. As a result, any cost pressures remain the responsibility of the partner organisations which has been the basis for remedial action taken for the year to date and how any adverse or favourable variances will be addressed at the end of the financial year.

Key Issues

3.1 At the end of January 2016, the partnership's shadow delegated budget is reporting a position of projected year end pressures of £403k. This position is net of considerable of both permanent and temporary investment into key areas of budget and will require further remedial actions to address these pressures between now and over the financial year-end. The investment of additional resources to meet emerging pressures (eg the drawing down of reserves to fund the additional costs of night support/homecare provision) was previously reported to the Board as they arose during 2015/16.

3.2 Total projected spend on the shadow budget at the 31st January 2016 therefore is £137.858m

3.3 There are a number of areas where cost and demand factors are driving increased total spend pressures. These include:

Older People's Service – The higher then anticipated level of both residential care beds and care at home hours commissioned during 2015/16, exacerbated by factors including the transfer of homecare contracts to SB Cares, provider of last resort and night support sleep-in wage costs. These pressures have been met temporarily by a range of actions including vacancy freeze, targeted locality savings and savings through the reorganisation of the dementia care team and an overall net position of £23k is projected with further investment in the 2016/17 financial plan aimed at permanently addressing these drivers and other pressures. Notably however, the position has improved considerably since the last reported position due to a significant reduction in these service areas and lower demand during the December / January period.

Generic Services – The highest area of risk and financial pressure continues to be on the

GP Prescribing budget where a projected position of £1.0m overspend remains due to specific volatile and escalating pharmaceuticals. This pressure has been part-mitigated by planned savings across other generic services including Dental Services and Sexual Health although there are other service areas which vary also. The position is also assisted by the delivery of additional remedial savings targets across locality offices and rigorous management of staff turnover, resulting in overall pressures of £638k being projected within these areas of service.

3.4 Planned savings of £200k are also projected within the joint Mental Health Service.

3.5 As a shadow year with budgets aligned only, any year-end overspends will be the responsibility of the host organisation. NHS Borders will manage its element of any overspend by taking appropriate action. In anticipation of any unforeseen pressures NHS Borders has set aside a small contingency in its financial plan and will make continued use of a number of financial control measures. Discussions have already taken place within Scottish Borders Council's corporate management team and an agreed plan for funding these pressures within the shadow delegated budget from elsewhere across the Council and in particular, the People Department (non-delegated services) is in place.

3.6 The Board will be informed should any further pressures arise and of any management action being taken to mitigate the pressure. .

Recommendation

It is recommended that the Health & Social Care Integration Joint Board:

- **Note** the above reported projected position of £403k net pressures at 31st January 2016 and notes that both partner organisations are working to minimise any adverse variance at year-end but should this not be possible the responsible organisation will ensure that resources are available to ensure a break even out turn.

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

Policy/Strategy Implications	In compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	Members of the Integration Programme Board have been consulted on the report and the position reported to the Shadow Board. The report has also been reviewed by and approved by relevant Management Teams within both partner organisations.
Risk Assessment	A full risk assessment and risk monitoring process for the Integration Programme is being developed as part of the Integration Programme arrangements.
Compliance with requirements on	An equality impact assessment will be

Equality and Diversity	undertaken on the arrangements for Joint Integration when agreed.
Resource/Staffing Implications	It is anticipated that the Integration Shadow Board will oversee services which have a budget of over £130m, within the existing scope. The budget will change as other functions are brought within the scope of the Integration Shadow Board.

Approved by

Name	Designation	Name	Designation
David Robertson	Chief Financial Officer	Carol Gillie	Director of Finance

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Business Partner	Janice Cockburn	Deputy Director of Finance

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MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Joint Learning Disability Service	**14,488**	**11,720**	**11,848**	**(128)**	**14,746**	**14,746**	**0**	**32**	
Residential Care	1,492	1,285	1,617	(332)	1,566	1,571	(5)	0	
SBC Cares	2,065	1,723	1,885	(162)	2,062	2,060	2	0	
Homecare	667	2,244	1,599	645	2,734	2,717	17	0	
Day Care	791	480	507	(27)	632	656	-24	3	
Community Based Services	8,181	4,835	5,207	(372)	6,365	6,370	(5)	0	
Respite	200	159	146	13	200	215	(15)	0	
Other	1,092	994	887	107	1,187	1,157	30	29	
Joint Mental Health Service	**1,988**	**950**	**1,119**	**(169)**	**1,887**	**1,884**	**3**	**25**	
Residential Care	21	0	0	0	0	0	0	0	
Homecare	227	161	165	(4)	200	200	0	0	
Day Care	182	150	127	23	181	175	6	5	
Community Based Services	835	538	685	(147)	720	692	28	0	
Respite	15	13	49	(36)	15	30	(15)	0	
SDS	44	88	93	(5)	107	113	(6)	0	
Choose Life	69			0	0	0	0	0	
Mental Health Team	595			0	664	674	(10)	20	
Joint Alcohol and Drug Service	**197**	**143**	**69**	**74**	**203**	**186**	**17**	**0**	
D & A Commissioned Services	177	138	60	78	177	155	22	0	
D & A Team	20	5	9	(4)	26	31	(5)	0	
Older People Service	**24,148**	**19,065**	**19,384**	**(319)**	**24,442**	**24,465**	**(23)**	**23**	A considerable decrease during December and January in the number of external residential care home beds and homecare hours commissioned, offset by a projected decrease in income from client contributions has improved the position considerably from previous reports.
Residential Care	5,557	5,306	5,623	(317)	6,353	6,541	(188)	0	
Homecare	8,107	6,464	6,273	191	7,928	7,825	103	0	
Day Care	198	121	4	117	210	234	(24)	0	
Community Based Services	1,018	1,181	1,162	19	1,403	1,365	38	16	
Extra Care Housing	6,792	6,138	7,365	(1227)	7,478	7,462	16	0	
Housing with Care	283	366	299	67	439	439	0	0	
Delayed Discharge	267	115	208	(93)	267	262	5	0	
Other	1,926	(626)	(1550)	924	364	337	27	7	
Physical Disability Service	**3,250**	**2,766**	**2,985**	**(219)**	**3,258**	**3,255**	**3**	**0**	
Residential Care	503	401	381	20	503	362	141	0	
Homecare	1,801	1,379	1,393	(14)	1,671	1,669	2	0	
Day Care	192	163	180	(17)	195	196	(1)	0	
Community Based Services	682	763	965	(202)	817	956	(139)	0	
Other	72	60	66	(6)	72	72	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Generic Services	**3,497**	**3,478**	**3,453**	**25**	**3,698**	**3,622**	**76**	**97**	The majority of any adverse variances relates to savings / income initiatives included in the Financial Plan which have not been delivered. The remaining remedial Action Plan savings have been centralised here in order that progress against their delivery in totality can be clearly reported during the remainder of the financial year, which is on-track and particularly positive across locality officers and as a result of management of staff turnover.
Community Hospitals	0	0	0	0	0	0	0	0	
GP Prescribing	0	0	0	0	0	0	0	0	
AHP Services	0	0	0	0	0	0	0	0	
General Medical Services	0	0	0	0	0	0	0	0	
Community Nursing	0	0	0	0	0	0	0	0	
Assesment and Care Management	238	201	247	(46)	300	296	4	0	
Group Managers	263	124	135	(11)	150	164	(14)	0	
Service Managers	160	3	1	2	4	1	3	0	
Planning Team	247	188	119	69	226	132	94	0	
Locality Offices	2,636	2,159	2,008	151	2,587	2,444	143	69	
SB Cares	471	471	626	(155)	473	463	10	0	
BAES				0					
Duty Hub	51	0	8	(8)	0	13	(13)	0	
Extra Care Housing	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	42	2	40	56	55	1	0	
Respite	42	9	5	4	12	7	5	0	
SDS	96	57	(61)	118	97	97	0	0	
OT	58	69	61	8	84	76	8	0	
Grants to Voluntary	43	43	24	19	43	34	9	0	
Out of Hours	110	38	1	37	117	67	50	0	
Community Based Services	7	5	99	(94)	35	136	(101)		
Sexual Health	0	0	0	0	0	0	0	0	
Public dental Services	0	0	0	0	0	0	0	0	
Community Pharmacy Services	0	0	0	0	0	0	0	0	
Continence Services	0	0	0	0	0	0	0	0	
Smoking Cessation	0	0	0	0	0	0	0	0	
Primary & Community Management	0	0	0	0	0	0	0	0	
Health Promotion	0	0	0	0	0	0	0	0	
Ophthalmic Services	0	0	0	0	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	
Accommodation Costs	0	0	0	0	0	0	0	0	
Resource Transfer	0	0	0	0	0	0	0	0	
Other	(501)	69	178	(109)	(6)	112	(118)	28	
SB Cares Contribution to General Fund	-480	0	0	0	(480)	(475)	(5)		Reduction of £63k in projected SB Cares Surplus from position previously reported at the end of December due to a retrospective reassessment of accrued holiday pay for care staff relating to public holidays worked during 2015/16.
Total	**47,088**	**38,122**	**38,858**	**-736**	**47,754**	**47,683**	**71**	**177**	

MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget -SBC	2015/16			AT END OF MTH: January			
Financed By:							
AEF, Council Tax and Fees & Charges	47,088	38,122	38,858	(736)	47,754	47,683	71
NHS Funding from Sgovt etc							
Total	**47,088**	**38,122**	**38,858**	**-736**	**47,754**	**47,683**	**71**

0

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**3,585**	**2,986**	**2,904**	**82**	**3,585**	**3,545**	**40**	**21**	**19**	**19**	
Residential Care	2,689	2,241	2,194	47	2,689	2,689	0	0	0	0	Fluctuating demand for assessment & treatment
SBC Cares	0	0	0	0	0	0	0				
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
Same as You	0	0	0	0	0	0	0	0	0	0	
Other	896	745	710	35	896	856	40	21	19	19	Staffing vacancies
Joint Mental Health Service	**13,807**	**11,512**	**11,327**	**185**	**13,850**	**13,650**	**200**	**319**	**311**	**309**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	0	0	0	0	0	0	0	0	0	
Choose Life	0	0	0	0	0	0	0	0	0	0	
Mental Health Team	13,807	11,512	11,327	185	13,850	13,650	200	319	311	309	Staffing vacancies
Joint Alcohol and Drug Service	**879**	**520**	**520**	**0**	**879**	**879**	**0**	**3**	**3**	**3**	BAS reported under mental health
D & A Commissioned Services	768	408	408	0	745	745	0	0	0	0	
D & A Team	111	112	112	0	134	134	0	3	3	3	
Older People Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Housing with Care											
Dementia Services	0	0	0	0	0	0	0	0	0	0	
Delayed Discharge	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	
Change Fund	0	0	0	0	0	0	0	0	0	0	
Physical Disability Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

Joint Health and Social Care Budget	NHS	2015/16	0	AT END OF MTH:	January

0

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**70,435**	**57,851**	**58,341**	**(490)**	**70,912**	**71,626**	**(714)**	**502**	**498**	**494**	
Community Hospitals	4,593	3,866	3,881	(15)	4,651	4,672	(21)	125	128	124	
GP Prescribing	21,349	17,681	18,474	(793)	20,935	21,935	(1000)	0	0	0	Increased drug prices
AHP Services	5,445	4,609	4,592	17	5,555	5,585	(30)	146	137	137	
General Medical Services	16,132	14,107	14,049	58	16,959	16,908	51	4	4	4	
Community Nursing ex HV/SN	4,232	3,557	3,522	35	4,284	4,247	37	110	103	105	
Assesment and Care Management	0	0	0	0	0	0	0	0	0	0	
Group Managers	0	0	0	0	0	0	0	0	0	0	
Service Managers	0	0	0	0	0	0	0	0	0	0	
Planning Team	0	0	0	0	0	0	0	0	0	0	
Locality Offices	0	0	0	0	0	0	0	0	0	0	
SB Carers	0	0	0	0	0	0	0	0	0	0	
BAES	246	205	213	(8)	246	255	(9)	0	0	0	
Duty Hub	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Joint Health Improvement	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	0	0	0	0	0	0	0	0	0	
OT	0	0	0	0	0	0	0	0	0	0	
Grants to Voluntary	0	0	0	0	0	0	0	0	0	0	
Out of Hours	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Sexual Health	599	519	454	65	624	549	75	7	6	6	
Public dental Services	3,992	3,080	2,843	237	3,667	3,402	265	81	79	78	
Community Pharmacy Services	3,856	3,357	3,357	0	3,933	3,933	0	0	0	0	
Continence Services	435	371	407	(36)	444	487	(43)	3	3	3	Increased demand for service
Smoking Cessation	255	203	146	57	243	171	72	4	4	5	Reduction in patient numbers
Primary & Community Management	1,617	1,435	1,567	(132)	1,696	1,836	(140)	15	21	19	Use of flex beds higher than funded
Health Promotion	508	409	384	25	522	498	24	8	12	12	
Opthalmic Services	1,605	1,360	1,360	0	1,591	1,591	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	878	731	731	0	823	823	0	0	0	0	
Resource Transfer	2,563	2,174	2,174	0	2,609	2,604	5	0	0	0	
Other	2,130	187	187	0	2,130	2,130	0	0	0	0	
Total	**88,706**	**72,869**	**73,092**	**(223)**	**89,226**	**89,700**	**(474)**	**845**	**830**	**825**	
Financed By:											
AEF, Council Tax and Fees & Charges											
NHS Funding from Sgovt etc	88,706	72,869	73,092	(223)	89,226	89,700	(474)				

Joint Health and Social Care Budget	NHS	2015/16		0	AT END OF MTH:	January					
Total	88,706	72,869	73,092	(223)	89,226	89,700	(474)	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,073**	**14,706**	**14,752**	**(46)**	**18,331**	**18,291**	**40**	**53**	**19**	**19**	
Residential Care	4,181	3,526	3,811	(285)	4,255	4,260	(5)	0	0	0	
SBC Carers	2,065	1,723	1,885	(162)	2,062	2,060	2	0	0	0	
Homecare	667	2,244	1,599	645	2,734	2,717	17	0	0	0	
Day Care	791	480	507	(27)	632	656	(24)	3	0	0	
Community Based Services	8,181	4,835	5,207	(372)	6,365	6,370	(5)	0	0	0	
Respite	200	159	146	13	200	215	(15)	0	0	0	
Other	1,988	1,739	1,597	142	2,083	2,013	70	50	19	19	
Joint Mental Health Service	**15,795**	**12,462**	**12,446**	**16**	**15,737**	**15,534**	**203**	**344**	**311**	**309**	
Residential Care	21	0	0	0	0	0	0	0	0	0	
Homecare	227	161	165	(4)	200	200	0	0	0	0	
Day Care	182	150	127	23	181	175	6	5	0	0	
Community Based Services	835	538	685	(147)	720	692	28	0	0	0	
Respite	15	13	49	(36)	15	30	(15)	0	0	0	
SDS	44	88	93	(5)	107	113	(6)	0	0	0	
Choose Life	69	0	0	0	0	0	0	0	0	0	
Mental Health Team	14,402	11512	11327	185	14514	14324	190	339	311	309	
Joint Alcohol and Drug Service	**1,076**	**663**	**589**	**74**	**1082**	**1065**	**17**	**3**	**3**	**3**	
D & A Commissioned Services	945	546	468	78	922	900	22	0	0	0	
D & A Team	131	117	121	(4)	160	165	(5)	3	3	3	
Older People Service	**24,148**	**19065**	**19384**	**(319)**	**24442**	**24465**	**(23)**	**23**	**0**	**0**	
Residential Care	5,557	5,306	5,623	(317)	6,353	6,541	(188)	0	0	0	
Homecare	8,107	6,464	6,273	191	7,928	7,825	103	0	0	0	
Day Care	198	121	4	117	210	234	(24)	0	0	0	
Community Based Services	1,018	1,181	1,162	19	1,403	1,365	38	16	0	0	
Extra Care Housing	6,792	6,138	7,365	(1227)	7,478	7,462	16	0	0	0	
Housing with Care	283	366	299	67	439	439	0	0	0	0	
Delayed Discharge	267	115	208	(93)	267	262	5	0	0	0	
Other	1,926	(626)	(1550)	924	364	337	27	7	0	0	
Physical Disability Service	**3,250**	**2,766**	**2,985**	**(219)**	**3,258**	**3,255**	**3**	**0**	**0**	**0**	
Residential Care	503	401	381	20	503	362	141	0	0	0	
Homecare	1,801	1,379	1,393	(14)	1,671	1,669	2	0	0	0	
Day Care	192	163	180	(17)	195	196	(1)	0	0	0	
Community Based Services	682	763	965	(202)	817	956	(139)	0	0	0	
Other	72	60	66	(6)	72	72	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**73,932**	**61,372**	**61,794**	**(465)**	**74,610**	**75,248**	**(638)**	**599**	**498**	**494**	
Community Hospitals	4,593	3,866	3,881	(15)	4,651	4,672	(21)	125	128	124	
GP Prescribing	21,349	17,681	18,474	(793)	20,935	21,935	(1000)	0	0	0	Risk area for the partnership due to price volitility and currently little information
AHP Services	5,445	4,609	4,592	17	5,555	5,585	(30)	146	137	137	
General Medical Services	16,132	14,107	14,049	58	16,959	16,908	51	4	4	4	
Community Nursing	4,232	3,557	3,522	35	4,284	4,247	37	110	103	105	
Assesment and Care Management	238	201	247	(46)	300	296	4	0	0	0	
Group Managers	263	124	135	(11)	150	164	(14)	0	0	0	
Service Managers	160	3	1	2	4	1	3	0	0	0	
Planning Team	247	188	119	69	226	132	94	0	0	0	
Locality Offices	2,636	2,159	2,008	151	2,587	2,444	143	69	0	0	
SB Carers	471	471	626	(155)	473	463	10	0	0	0	
BAES	246	205	213	(8)	246	255	(9)	0	0	0	
Duty Hub	51	42	8	(8)	0	13	(13)	0	0	0	
Extra Care Housing	0	9	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	57	2	40	56	55	1	0	0	0	
Respite	42	69	5	4	12	7	5	0	0	0	
SDS	96	43	(61)	118	97	97	0	0	0	0	
OT	58	38	61	8	84	76	8	0	0	0	
Grants to Voluntary	43	5	24	19	43	34	9	0	0	0	
Out of Hours	110	38	1	37	117	67	50	0	0	0	
Community Based Services	7	5	99	(94)	35	136	(101)	0	0	0	
Sexual Health	599	519	454	65	624	549	75	7	6	6	
Public dental Services	3,992	3,080	2,843	237	3,667	3,402	265	81	79	78	
Community Pharmacy Services	3,856	3,357	3,357	0	3,933	3,933	0	0	0	0	
Continence Services	435	371	407	(36)	444	487	(43)	3	3	3	
Smoking Cessation	255	203	146	57	243	171	72	4	4	5	
Primary & Community Management	1,617	1,435	1,567	(132)	1,696	1,836	(140)	15	21	19	
Health Promotion	508	409	384	25	522	498	24	8	12	12	
Opthalmic Services	1,605	1,360	1,360	0	1,591	1,591	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	878	731	731	0	823	823	0	0	0	0	
Resource Transfer	2,563	2,174	2,174	0	2,609	2,604	5	0	0	0	
Other	1,629	256	365	(109)	2,124	2,242	(118)	28	0	0	
SB Cares Contribution to General Fund	(480)	0	0	0	(480)	(475)	(5)	0	0	0	
SB Cares Surplus Contribution	**(480)**	**0**	**0**	**0**	**(480)**	**(475)**	**(5)**				
Total	**135,794**	**111,034**	**111,950**	**(959)**	**136,980**	**137,383**	**(403)**	**1022**	**830**	**825**	
Financed By:											
AEF, Council Tax and Fees & Charges	47,088	38,122	38,858	(736)	47,754	47,683	71	0	0	0	
NHS Funding from Sgovt etc	88,706	72,869	73,092	(223)	89,226	89,700	(474)	0	0	0	
Total	**135,794**	**110,991**	**111,950**	**(959)**	**136,980**	**137,383**	**(403)**	**0**	**0**	**0**	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,073**	**14,706**	**14,752**	**(46)**	**18,331**	**18,291**	**40**	**53**	**19**	**19**	Staff vacancies and review and management of care packages a have created underspend
Joint Mental Health Service	**15,795**	**12,462**	**12,446**	**16**	**15,737**	**15,534**	**203**	**344**	**311**	**309**	
Joint Alcohol and Drug Service	**1,076**	**663**	**589**	**74**	**1,082**	**1,065**	**17**	**3**	**3**	**3**	
Older People Service	**24,148**	**19,065**	**19,384**	**(319)**	**24,442**	**24,465**	**(23)**	**23**	**0**	**0**	A very small further decrease during January in the number of external residential care home beds (8) and homecare hours (57 per week) commissioned, more than offset by a projected decrease in income from client contributions. Small compensating reduction in average homecare hours p.w. but overall, level of activity still exceeding budgeted for both residential and homecare, despite additional temporary investment.
Physical Disability Service	**3,250**	**2,766**	**2,985**	**(219)**	**3,258**	**3,255**	**3**	**0**	**0**	**0**	
Generic Services	**73,932**	**61,372**	**61,794**	**(465)**	**74,610**	**75,248**	**(638)**	**599**	**498**	**494**	Risk continues around GP Precribing due to drug prices as volumes are as expected. Concern regarding the robustness of prediction due time lag in data.
SB Cares Contribution	**(480)**	**0**	**0**	**0**	**(480)**	**(475)**	**(5)**	**0**	**0**	**0**	Reduction of £63k in projected SB Cares Surplus from position previously reported at the end of December due to a retrospective reassessment of accrued holiday pay for care staff relating to public holidays worked during 2015/16.
Total	**135,794**	**111,034**	**111,950**	**(959)**	**136,980**	**137,383**	**(403)**	**1022**	**830**	**825**	
Financed By:											
AEF, Council Tax and Fees & Charges	47,088	38,122	38,858	(736)	47,754	47,683	71				
NHS Funding from Sgovt etc	88,706	72,869	73,092	**(0)**	89,226	89,700	(474)				
Total	**135,794**	**110,991**	**111,950**	**(736)**	**136,980**	**137,383**	**(403)**				

HEALTH AND SOCIAL CARE INTEGRATION INTEGRATED RESOURCES ADVISORY GROUP

PROFESSIONAL GUIDANCE, ADVICE AND RECOMMENDATIONS FOR SHADOW INTEGRATION ARRANGEMENTS

COMPLIANCE ASSESSMENT AND PROGRESS TO DATE WITHIN THE SCOTTISH BORDERS PARTNERSHIP

Aim

1.1 The aim of this report is to provide an assessment of the progress made within the Scottish Borders Health and Social Care Integration (H&SCI) programme in establishing the finance-related arrangements recommended by the Integrated Resources Advisory Group (IRAG). This was a body established by the Scottish Government to develop and promote best practice in relation to a range of financial matters relating to preparation for integration, the shadow procedures required and the financial governance arrangements which require to be in place prior to the 1st April 2016. Scottish Borders were represented as part of this group and contributed to the development of the guidance and recommendations.

Background

2.1 During 2015, the Scottish Government issued Regulations, secondary legislation to The Public Bodies (Joint Working) Scotland Act 2014. These Regulations included a number of detailed recommendations in relation to the financial planning, management, reporting and governance arrangements, largely drawing on the work of the Integrated Resources Advisory Group undertaken during 2014. This is consistent in full with the guidance and recommendations published by IRAG which comprehensively references the requirements of the Public Bodies Act.

2.2 Whilst not all financial matters within the guidance, those both mandatory and recommended, have been addressed in full at this stage with work still in progress for some areas, as the end of the IJB shadow year approaches, an assessment of the state of readiness of financial matters, specific to the recommendations issued, has been undertaken. This provides assurance over the appropriateness and comprehensiveness of work to date and identifies any areas where further work requires delivery and agreement, prior to the 1st April 2016 or in the first full year of the Integration Joint Board. This report provides a summary of the work completed and identifies those areas where remaining work packages require completion, and where necessary, require agreement and approval by the IJB.

2.3 Specific to the establishment of an integration model for the Scottish Borders – delegation to a (body corporate) Integration Joint Board – there are 69 key provisions/recommendations within the IRAG guidance that require addressing from a financial arrangements perspective and against which progress has been evaluated. These considerations cover a number of key matters relating to sound governance and robust financial management including the model of integration proposed, assurance and governance over it, delegation of functions to it and the use of resources supporting it to deliver its objectives expressed within the Strategic

Plan, Financial Planning and Management processes and Statutory and Management Reporting.

2.4 Fundamental to the establishment of good financial governance are arrangements for financial/performance planning, management and reporting processes of the partnership's medium-term Strategic Plan and the robustness of the provisions agreed within the Partnership's Scheme of Integration approved by the Scottish Government. These form a key part of the review of overall progress made in establishing proper and effective financial management and governance arrangements during the shadow year leading to full integration on 1st April 2016 and the establishment of the Integration Joint Board.

Summary

3.1 The Scottish Borders Integration Joint Board is a legal entity in its own right created by Parliamentary Order following Ministerial approval of its Integration Scheme. It will operate under public sector good practice governance arrangements which are proportionate to its transactions and responsibilities.

3.2 The IJB's Scheme of Integration sets out the detail of the integration arrangement, as agreed by NHS Borders and Scottish Borders Council. It covers a number of matters provided for by Regulations supplementing the legislation. For finance-related matters, these include:

- Financial management arrangements including budget variances;
- Reporting arrangements between the Integration Joint Board, Health Board and Local Authority;
- The method for the determination of the resources to be made available by the NHSB and SBC to the Integration Joint Board; and
- The functions which are to be delegated to the Integration Joint Board by NHSB and SBC

3.3 In addition to the specific provisions included within the Scheme of Integration, a considerable amount of work has been completed, or is in progress, to ensure a full framework of financial governance, planning, management and reporting is in place for the IJB by 1st April 2016. Since the inception of the Finance workstream of the programme a number of key milestones have been reached and provisions and processes implemented following approval by the Board. A summary of the progress made and key deliverables is contained within this report.

3.4 In order to provide full assurance to members of the Board over this progress, a compliance review has been undertaken against the recommended best practice which formed the basis of the Regulations supplementing the legislation. A summary of compliance by the Scottish Borders partnership with the recommended requirements is detailed in *Appendix 1* to this report. Progress made to date has been specifically identified to ensure that all the required provisions in relation to the financial arrangements required by the Act, or desired locally, will ensure robust governance over the operations of the IJB. This includes the affordability of the Strategic Plan, the adequacy of levels of delegated resources and controls over how they are managed and assessment of the impact on NHS Borders and Scottish Borders Council that may have arisen as a result, have all been considered.

3.5 Following this compliance review, the Finance Workstream Action Plan has been updated and a number of further deliverables (financial statement and assurance on sufficiency of resources) will be reported to the IJB prior to the 1st April 2016 in order to ensure that all required arrangements are approved and established, supplemented by an ongoing programme of development during the first year of operation of the IJB. The updated Action Plan is detailed in *Appendix 2* to this report.

Progress to-date

4.1 Since the inception of the H&SC Integration Programme during 2014, the Finance workstream has progressed the development and implementation of a range of provisions, processes and governance arrangements supporting the establishment of the IJB and its state of readiness for 1st April 2016. This work has been fully incorporated across other workstreams within the programme and in leading to the development of the Strategic Plan and the Scheme of Integration for the Scottish Borders partnership.

4.2 The Finance workstream in the Scottish Borders programme has also been represented on the IRAG committee which developed the national guidance over the 18 months leading up to its launch in 2015 and the publication of supplementary Regulations to the legislation, in addition to contributing to the development of specific recommendations for inclusion therein. Information and knowledge sharing as part of a wider network of NHS, Local Authority and CIPFA Directors of Finance and H&SCI workstream leads has also informed the development of proposed arrangements for the Scottish Borders partnership

4.3 Building on the arrangements in place supporting the Scottish Borders Community Health and Care Partnership, a number of pieces of work were completed as a preliminary stage of the Finance workstream. These work packages included:

- Identification and agreement of budgets for which it is proposed form part of the shadow integrated budget
- Development of a schedule of joint financial management reporting to the shadow IJB and the H&SCI Programme Board / Executive Management Team
- Development of a single joint monitoring report to the IJB and exception report to the H&SCI Programme Board / Executive Management Team
- Defining all integrated budget holders and budget responsibilities

4.4 Further work has been completed since, or remains ongoing, to ensure that adequate financial governance, planning, management and reporting systems are in place prior to the 1st April 2016, the key elements of which can be summarised within the following 7 headings:

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

- Accounting Standards

A full analysis of the assessment of progress made to date against the recommended provisions within the professional guidance forms *Appendix 1* to this report and a summary of the progress made and remaining planned actions is detailed below, with the latter forming the basis of an Action Plan for delivery contained in *Appendix 2*.

Governance Structure

4.5 The recommended practice contains a number of provisions relating to the structure of governance within the IJB and partner organisations. These specifically relate to the Scheme of Integration and the Strategic Plan, the appointment and roles and responsibilities of the Chief Officer, the Integration model established and strategic Financial Governance.

4.6 Many of the provisions relating to the structure of governance are covered by the Scottish Borders partnership's Scheme of Integration which received ministerial approval in February 2016 and within which the functions to be delegated, how resources supporting them have been calculated, including the proportion of large hospitals set-aside and financial management and reporting arrangements have been specified. These also explicitly define which budgets are delegated to the IJB and support the delivery of the Strategic Plan and although not currently relevant, provide for the Chief Officer to manage non-integrated budgets should the situation be required in future.

4.7 Work is continuing on a number of elements in this area and the key actions which require to be completed prior to the start of the new financial year and during year one of the IJB relate to:

1. The appointment to the role of Chief Financial Officer by the IJB (prior to 1 April 2016)
2. During year one the publication of written Directions from the IJB to NHS Borders and Scottish Borders Council detailing the duties of the IJB and partners and amount of delegated budget/set-aside and how it will be used, a description of services together with any supplementary provisions
3. The development, publication and approval by the IJB of a Financial Statement (1 year + 2 indicative years) outlining the resources delegated to support the Strategic Plan
4. Assurance to the IJB over the 'sufficiency of resources' included within the Financial Statement, relative to the Strategic Plan's projected requirements and any inherent risks and mitigating arrangements put in place (prior to 1 April 2016).

These actions are included in more detail within the Action Plan in *Appendix 2*.

Assurance and Governance

4.8 A significant number of the financial provisions contained within the Scheme of Integration, Financial Regulations and professional guidance relate to the areas of assurance and governance. This is an area of particular importance, since it requires the clear setting out of the arrangements through which confidence over all

aspects of the IJB's operations can be demonstrated. This covers a number of areas including financial assurance, risk management and insurance, the arrangements for internal and external audit, including the establishment of an audit committee and the need to demonstrate best value in the use of public resources.

4.9 To date, a number of work packages across assurance and governance have been completed, including ensuring a number of provisions are specified within the Scheme of Integration including performance monitoring systems and processes and the provisions for the IJB addressing key risks identified. KPMG, Scottish Borders Council's External Auditors have also been appointed as External Auditors to the IJB.

4.10 A number of further pieces of work remain ongoing and requiring completion by the end of this financial year, both in relation to the IJB itself and to NHS Borders and Scottish Borders Council. In summary, these are:

5. NHS Borders and Scottish Borders Council are in the process of reviewing their respective organisation's own Financial Regulations to ensure they are consistent with and complement the new proposed Financial Regulations of the IJB
6. Completion of the risk analysis process (for both the IJB and NHSB/SBC – updated risk registers for both the latter organisations) is required and a Risk Register and Risk Management Strategy both require completion
7. A proposed strategy for Insurance over the activities of the IJB still requires agreement and approval
8. The Chief Internal Auditor's appointment to the IJB requires formal approval *
9. The IJB's Internal Audit Plan for 2016/17 still requires developing and approval by the IJB
10. The arrangements over the establishment and operations of an IJB Audit Committee require to be defined *
11. A report to the IJB over the approach taken to provide the board with assurance over the sufficiency of resources for 2016/17-18/19 is still required

* Actions 8 and 10 have now been approved by the IJB at its meeting of 1st February 2016.

Financial Reporting

4.11 In relation to Financial Reporting, there are no immediate outstanding issues requiring action. For noting however, it is likely that 2015/16 accounts will have to be produced to accompany the 2016/17 accounts for comparative purposes due to the 1st April being the establishment date of the Integration Joint Board and accordingly, no transactions will be formally undertaken in respect of its operations prior to this date.

Financial Planning and Management

4.12 Defined processes are in place for the calculation of partners' respective contributions to the Integrated Budget although the calculation of the large hospitals

budget set-aside remains a work in progress, although the IJB will be asked to review and approve an initial draft financial statement in March 2016:

12. Refinement of and quality assurance over large hospitals budget set-aside remains ongoing following and will be incorporated into any revised financial statement

4.13 The key Financial Management work package requiring approval is the production of the Financial Statement to support the Strategic Plan. This has been produced approaching the conclusion of both NHS Borders and Scottish Borders Council's 2016/17 Financial Planning process and the finalisation of the medium-term Integrated Budget for the IJB 2016/17-2018/19, the duration of the IJB's first Strategic Plan.

13. Production of the Financial Statement for the IJB 2016/17 is complete and to be approved at the March meeting, accompanied by a due diligence report providing assurance over the sufficiency of resources made available to the IJB to support the delivery of the Strategic Plan. The allocation of resources within the outcomes of the Strategic Plan requires to be developed further also

4.13 There is defined provision within the Scheme of Integration and Financial Regulations for how the Integrated Budget is calculated and the IJB has been operating in a shadow year with a shadow Integrated Budget developed within this prescription since 1st April 2015. Monthly monitoring reports, either in full or by exception, have been prepared and approved by the IJB/Integration Programme Board to date respectively and where significant variances have arisen in year, these and their required remedial actions have also been reported in detail with full agreement by the Chief Officer who takes responsibility for all budget areas within the Integrated Budget. Moving forward, a more structured and inclusive approach specific to the development of the IJB's budget is required across all 3 entities. Financial Regulations also include specific provisions for spending limits and the process and limits for budget virement.

14. An integrated Financial Planning process, involving the IJB Chief Officer, within each organisation, which takes account of priorities and results in a negotiated contribution from each partner to the IJB's Integrated Budget, must further be developed for 2017/18.
15. Further development of an IT single entity reporting solution is required in order to simplify and make the production of monitoring reports to joint-budget holders and the IJB more consistent and streamlined

Written Directions over how the resources should be used will also be issued by the IJB during the first year.

16. Further work is also required in relation to clear identification of the nature, value, source and services supported by current Health Board Resource Transfer which will then require to be accounted for in the method of calculating the Integrated Budget of the IJB. Similarly, further work is also required in relation to hosted services.

4.14 Agreement and clear definition of the treatment of variances within the Integrated Budget in-year has been made both within the SOI and the Financial Regulations. This will be subject to review going forward and where appropriate, these arrangements may change as flexibility within the Integrated Budget evolves and managing risk within it develops.

17. At an operational financial management level, a policy on the application of monthly accrual accounting requires further discussion and agreement

4.15 Work will continue in 2016/17 to further develop robust financial arrangements for the IJB, following the appointment of the Chief Financial Officer.

18. A Financial Strategy will be developed which will cover a number of key areas including forecast funding levels for the Integrated Budget, priority areas for investment and disinvestment and identification of financial risks and an approach to a strategy for building and managing IJB reserve levels

VAT

4.16 It is fully anticipated that there will be no specific impact on the IJB or NHSB/SBC from a VAT perspective as a result of any arrangements put in place. Any VAT risks identified will be addressed through the development of an appropriate solution to ensure that all transactions and the supply of services remain VAT neutral.

Capital and Asset Management

4.17 The Strategic Plan considers all of the resources available to deliver the objectives approved within the Integration Scheme including non-current assets owned by the Health Board and Local Authority. In the short term the Integration Joint Board will not be empowered to own capital assets and the VAT regimes of the Local Authority and Health Board will apply to capital assets used to provide the delegated services.

19. The Integration Joint Board, going forward, will identify the asset requirements to support the Strategic Plan. This will enable the Chief Officer to identify capital investment projects, or business cases to submit to NHSB/SBC for consideration as part of each organisation's capital financial planning processes
20. The Integration Joint Board, NHS Borders and Scottish Borders Council continue to identify all non-current assets which will be used in the delivery of the Strategic Plan

Recommendation

It is recommended that the Health & Social Care Integration Joint Board **note** the progress made to date in the development and implementation of the key financial arrangements following recommended best practice and compliance with legislation which require to be in place prior to the 1st April 2016 and beyond and agree the plan of actions for the remaining work requiring completion and approval.

Policy/Strategy Implications	The recommendation made within the report is wholly consistent with professional

	guidance and the partnership's Scheme of Integration and is intended to provide assurance over the deliverability of the Strategic Plan through robust financial governance, planning, management and reporting.
Consultation	The Scheme of Integration has been consulted widely in line with the Public Bodies Act and where
Risk Assessment	A detailed risk log is maintained for the Integration Programme and reported through the Executive Management Team. The approach to risk management is set out in the Scheme of Integration.
Compliance with requirements on Equality and Diversity	The integration of health and social care aims to overcome some of the current barriers between health and social care services, to improve pathways of care and outcomes to the population of the Scottish Borders
Resource/Staffing Implications	None

Approved by

Name	Designation	Name	Designation
Carol Gillie	Director of Finance (NHSB)	David Robertson	Chief Financial Officer (SBC)

Author

Name	Designation	Name	Designation
Paul McMenamin	IJB Chief Financial Officer		

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

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

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

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
4	22/1.2.1	The Integration Joint Board must make arrangements for the proper administration of its financial affairs and appoint an officer with this responsibility, (the Integration Joint Board financial officer)	Job Description for IJB CFO post has now been finalised and job evaluated with recruitment process pending	CFO post will be filled prior to 31st March 2016	The Chief Financial Officer will be responsible for developing a number of further governance and operational planning, management and reporting arrangements post-appointment
1.3 FINANCIAL MODEL					
5	23/1.3.0.1	The Health Board and Local Authority will delegate functions and make payments to the Integration Joint Board in respect of the delegated functions and the Health Board will also set aside amounts in respect of large hospitals for use by the Integration Joint Board.	This is set out in section 8 of the SOI. Specifically, 8.3/8.4 set out the provisions for making payments to the IJB whilst 8.5 sets out the method for determining the amount set aside for large hospital services.	None	Amount delegated / Set-aside is subject to due dilligence process and assessment of sufficiency of resources when compared to current spend levels and current and future risks
6	23/1.3.0.1	The Integration Joint Board will produce the Strategic Plan for the use of these resources and give direction and make payment where relevant to the Health Board and Local Authority for delivery of the services in line with the Strategic Plan.	Strategic Plan launched November 2015 Formal directions yet to be developed	Directions require to be developed and published prior to 31st March 2016.	Strategic Plan requires finalisation and approval
7	23/1.3.1.1	Resources within the scope will comprise: • The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services (A); • The payment made to the Integration Joint Board by the Health Board for delegated primary and community healthcare services and for those delegated hospital services which will be managed by the Chief Officer (B); and • The amount set aside by the Health Board for delegated services provided in large hospitals for the population of the Integration Joint Board (C).	This is explicitly stated within the SOI 3.3 and sections 8.3-8.5 clearly reflect that this will be the case. Figure 1 P24 of the FOI does graphically reflect this also as does Appendices 2 and 3.	In the report to IJB in March which will agree, subject to an assessment of the sufficiency of resources and any inherent risks therein, resources delegated, this should be preambled with the statement on the left.	3 areas of resource (A+B+C) constitute all available resources supporting the delivery of the Strategic Plan, whilst only A+B form part of the delegated budget

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

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

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

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

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

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

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

SCOTTISH BORDERS INTEGRATED JOINT BOARD
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
20	28/2.2.2	The participating authorities should identify and manage within their own risk management arrangements any risks they consider to have retained under the integration arrangements.	Requires to be further reviewed within both NHSB and SBC following establishment of the IJB.	Requires to be further reviewed within both NHSB and SBC following establishment of the IJB.	Risk registers within SBC and NHSB require updating and reporting in respect of new and retained risks
21	27/2.2.3	The Integration Scheme should consider provisions to address the key risks inherent in integration and include: • Governance, management and strategy; • Financial management; • Asset management; • Information management; • Performance management; and • Customer management.	Arrangements/provisions for control and governance across each of these areas is provided for within the Scheme of Integration, including complaints handling, etc, primarily within sections 10 to 13	None	
22	27/2.2.4	It is also recommended that the provisions for risk management in the Integration Scheme include: • Leadership/lines of accountability; • Arrangements for recording, updating, monitoring and reporting of risk management information; and • Arrangements for accessing professional risk management support.	None of this is explicitly defined in detail within the Scheme of Integration.	A report to the IJB on all Risk Management arrangements, including the Risk Management Strategy, is required prior to the 1st April 2016 - 7th March 2016	Jill Stacey leading
2.3 INSURANCE					
23	29/2.3.1	Integration Joint Boards should make appropriate provision for insurance according to the risk management strategy.	Risk Management strategy is still in development and remains unapproved.	Requires inclusion and finalisation.	Interim insurance options are currently being considered
24	29/2.4.1	It is the responsibility of the Integration Joint Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. This will include determining who will provide the internal audit service for the Integration Joint Board and nominating a Chief Internal Auditor.	SBC's CIA will be appointed to the role of CIA to the IJB. Audit committee will be established. Internal Audit plan to be develoepd. Etc.	Work ongoing.	There are a number of pressing items requiring reporting to both the IJB and NHSB/SBC audit committees with regard to audit arrangements for the IJB

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

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
Further work will be undertaken during 2016/17 to ensure full compliance with IRAG in relation to Financial Reporting					
4. FINANCIAL MANAGEMENT					
4.1 RESOURCES WITHIN THE SCOPE OF THE STRATEGIC PLAN					
33	38/4.1.1	The legislation requires that the Integration Joint Board produce a Strategic Plan, which sets out the services for their population over the medium term (3 years)	Updated Strategic Plan published and launched in November 2015.	Currently being refined	
34	38/4.1.2	The Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan which will comprise: • the Integrated Budget, i.e. the sum of the payments to the Integration Joint Board (see 4.2); plus • the notional budget, ie the amount set aside by the Health Board, for large hospital services used by the Integration Joint Board population (see 4.4).	This is not explicitly within the Strategic Plan although the services to be integrated are defined in Appendix A. These resources within scope will be formally defined within the 2016/17 Financial Statement which will be approved by the IJB in March 2016 and which will support the delivery of the Strategic Plan. This will also include large hospital set-aside notional budget. Formal Written Directions, including the value of specific integrated budget, will also be issued prior to the 1st April from the IJB to NHSB and SBC.	Report to IJB in March	Set-aside=hospital capacity that is expected to be used by the population of the IJB area, financial value based on latest IRF
35	38/4.1.4	The relative proportions of partners' contributions to the resources within scope of the plan will not influence the proportion of services that will be directed by The Integration Joint Board through the Strategic Plan, although it is likely that in the first years they will be similar.	This is not specifically referred to within either the SOI or the Strategic Plan but has been a working principle of the financial planning work to date as proposed at a member development session in 2015.	None	2016/17 initial delegated budget is essentially the sum of the outcomes from 2 component financial planning processes within SBC/NHSB
4.2 THE INTEGRATED BUDGET					
36	39/4.2.1	The legislation requires that Health Boards and Local Authorities make payments to the integration joint board for the delegated functions and that the method for determining the value of the payments is included in the Integration Scheme	8.3.1 of the SOI states that "the baseline payment will be established by reviewing recent past performance and existing plans for NHSB and SBC for the functions delegated adjusted for material items" and 8.1-8.2 provides for the mechanism of value determination.	None	

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

SCOTTISH BORDERS INTEGRATED JOINT BOARD

COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
37	39/4.2.2	The legislation also requires that where the Integration Joint Board gives direction for the partner Local Authority and Health Board for the operational delivery of services, that the value of the payment or the method of agreeing the value of the payment be included in the direction	Directions not yet developed within the Scottish Borders.	To be issued prior to 1st April 2016	See background document - "Note: minimum contents of Directions" Need to develop clarity of understanding amongst key managers and IJB as to what form and content such directs require
38	39/4.2.3	Integration authorities should undertake a shadow period in 2014-15. The allocations in the shadow period should be based on the existing financial plans of the Local Authority and Health Board including the planned efficiencies and consideration of recent financial outturn and trends in expenditure; this process must be transparent and the assumptions underlying the budgets must be available to all partners.	Shadow period commenced 1st April 2016 - aligned budgets reflected approved 2015/16 Financial Plans for both NHSB and SBC, including planned efficiencies, savings/income proposals and service pressures/growth. Financial Plans between both partners shared and published.	None	
39	39/4.2.4	The financial performance of the Integrated Budget is monitored during the shadow period with full transparency so that all partners have a clear understanding of the cause and type (recurrent/non-recurrent) of variances and the remedial actions taken by the Local Authority and Health Board. They should have a clear understanding of the adequacy of the budgets in the financial plan for the following year and the assumptions on which they are based.	Monthly aligned financial monitoring reports by exception to Programme Implementation Board / Executive Management Team, with a full quarterly report to IJB detailing current and projected position to date and key areas of pressure/savings variances with detailed explanation where required, including proposed remedial action across integrated and non-integrated budget heads. Financial Plan process paper to be developed for IJB.	Financial Statement to IJB 07 March 2016	Financial Planning paper to IJB in addition to Financial Statement Due dilligence paper over sufficiency of resources to deliver Strategic Plan

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
40	39/4.2.5	The initial payments to the Integration Joint Board should be based on analysis of the shadow period in 2014-15 to provide the Local Authority, Health Board and Integration Joint Board with reassurance that the delegated resources are sufficient to deliver the delegated functions. It should also consider the respective financial plans of the Local Authority and Health Board including full transparency on the budget assumptions and planned efficiency savings. These allocations should be tested against the actual performance in the shadow period and adjusted if necessary. Although not included in the payment, the analysis in the shadow period should include the notional budget for hospital services.	This is the planned approach which takes account of both organisations existing financial plans. Assurance over the sufficiency of resources will take place during February and be reported to the IJB in March. Both organisations are experiencing significant pressures presently on functions which will be delegated so on the outcome of the financial planning processes, how these services will be sustained over the medium-term and the assumptions built into plans, will be a particular area where scrutiny and assurance is required.	Assurance over the sufficiency of resources is a key work package, requiring completion and approval prior to 1st April 2016 - 07 March 2016		
41	40/4.2.7	The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. They should aim to be able to give indicative three year allocations to the integration joint board, subject to annual approval through the respective budget setting processes.	Section 8.4 of the SOI clearly lays out the detailed method through which payment in subsequent years to the IJB for delegated functions will be made. Reference is also made to the IJB agreeing and delivering the Strategic Plan/Financial Plan but through a process of joint discussion and planning with partners.	None presently	Integrated Financial Planning process to be developed for 17/18 onwards	
42	40/4.2.8	The Chief Officer, and the Integration Joint Board financial officer where such is appointed separately, should develop a case for the Integrated Budget based on the Strategic Plan and present it to the Local Authority and Health Board for consideration and agreement as part of the annual budget setting process.	This hasn't been the case for 2016/17 budget directly. Will require to be the case for 2017/18 however. In the interim, the CO also acts as manager of services within both organisations and is therefore part of the management team and financial planning process within each respective partner's organisation.	None prior to April 2016	2017/18 Financial Planning process	

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
43	40/4.2.9	Local Authority and Health Board will evaluate the case for the Integrated Budget against their other priorities and are expected to negotiate their respective contributions accordingly. The allocations will be a negotiated process based on priority and need and it should not be assumed that they will be the same as the historic or national allocations to the Health Board and Local Authority.	Whilst little reference has been made to specifically 'integrated' services as part of NHSB's/SBC's financial planning process for 2016/17, budgets, pressures and requirement for proposed savings have been recognised as part of a prioritisation process. This has the impact of increasing/decreasing certain budgets supporting integrated services.	None prior to April 2016	A clearer approach to prioritisation of integrated services' budgets as part of a wider approach to financial planning in partner organisations will require development for 2017/18.	
44	40/4.2.9	The method for determining the contributions is required to be included in the Integration Scheme.	SOI 8.3-8.5	None		
45	41/4.2.10	The allocations made from the Integration Joint Board to the Local Authority and Health Board for operational delivery of services will be approved by the Integration Joint Board. The value of the payments will be those set out in the Strategic Plan approved by the Integration Joint Board	Report to IJB in March 2016, accompanied by Financial Statement.	07-Mar-16	Not yet complete - a final resource statement requires appending to Strategic Plan and final integrated and notional budget positions require reflecting in the Strategic Plan	
46	41/4.2.11	The legislation will require that a direction should be in writing and must include information on (Section 26): • The integrated function/(s) that are being directed and how they are to be delivered; and • The amount of and method of determining the payment to carry out the delegated functions.	Formal Written Directions, including the value of specific integrated budget, will also be developed durign the year and issued to NHS Borders and SBC	Pending		
47	41/4.2.12	It anticipated that a direction from the Integration Joint Board will take the form of a letter from the Chief Officer to the Health Board or Local Authority referring to the arrangements for delivery set out in the Strategic Plan and/or other documentation. Once issued they can be amended or varied by a subsequent direction	Initial directions to be agreed April 2016	Pending	Clarity of understanding of Directions is required and form/content requires agreeing.	

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
48	41/4.2.14	Some social work expenditure budgets will be funded by resource transfer payments. It is recommended that partners identify these and adopt a transparent and consistent approach to their inclusion in the payment to the Integration Joint Board. The options for this are: • For the Health Board to stop paying resource transfer to the Local Authority and instead to include it in its payment to the Integration Joint Board. The Local Authority would need to make a corresponding reduction in its payment to the Integration Joint Board to cover the loss of resource transfer income from the Health Board; or • For the Health Board to continue paying resource transfer to the Local Authority and to exclude it from its payment to the Integration Joint Board. The Local Authority would include in its	Work has yet to take place to analyse resource transfer and adjust as necessary.	This work will require to be undertaken prior to the publication of the Financial Statement, within which a grossed-down position will require showing.	
49	41/4.2.15	It is recommended that the local decision on treatment of resource transfer be set out in the Integration Scheme.	Resource transfer is not referred to within the SOI. This will therefore require local agreement and may require reporting to IJB.	Further work and agreement required	
50	42/4.2.17	Resources used by the population of an Integration Joint Board for delegated services that are provided on a hosted arrangement, should be included in the respective Integrated Budget	Further work required	Further work required	
4.3 MANAGING FINANCIAL PERFORMANCE					
51	42/4.3.0.1	The partners should include in the Integration Scheme provisions for managing in-year financial performance of the Integrated Budget. This will require that the Chief Officer receive financial performance information for both her/his operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	SOI 8.6 outlines how any in-year variations will be addressed. Within the Shadow Year, the CO receives financial performance information for both her operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	None	Single entity reporting still in development

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
52	42/4.3.0.2	It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole.	A monthly management report is presented to the CO for discussion and approval covering all functions delegated. This is also reported to her management team on a monthly basis where detailed discussion and (if required) remedial actions are planned and approved.	None	Single entity reporting still in development	
53	42/4.3.0.2	It is also recommended that a joint appointment from the senior finance teams of the Health Board and Local Authority provide the Chief Officer with financial advice for the respective operational budgets. This would allow for the same person carry out both this role and the role of financial officer for the joint board, but this is a matter for local determination.	Job Description for IJB CFO post has now been finalised and job evaluated with recruitment process pending	CFO post interim appointment March 2016, permanent appointment August 2016		
54	42/4.3.0.3	It is recommended that the Health Board and Local Authority agree a consistent basis for the preparation of management accounts, i.e. accruals vs. cash basis; this is a matter for local decision.	This is a matter for further discussion. Whilst an accruals basis is consistently applied for statutory reporting, there is inconsistency between the partners in terms of monthly accrual accounting for management reporting purposes.	Ongoing work package		
55	43/4.3.0.4	Integration Joint Board will allocate the resources it receives from the partner Health Board and Local Authority in line with the Strategic Plan; in doing this it will be able to use its power to hold reserves	This will be undertaken as part of the work developing the Financial Statement prior to 1st April 2016.	Costed Strategic Plan		
56	43/4.3.0.5	In her/his operational role, the Chief Officer will manage the respective operational budgets so as to deliver the agreed outcomes within the operational budget viewed as a whole. The Chief Officer will be responsible for the management of in-year pressures and will be expected to take remedial action to mitigate any net variances and deliver the planned outturn	This is currently happening to a degree. The CO takes full responsibility for the management of in-year pressures during 2015/16. Whilst in shadow year and budgets only as aligned presently, the operational budget is not viewed as a whole for the purposes of such remedial action however.	None	Shift from aligned to fully integrated budgets, supported by Financial Regulations / Virement rules from 1st April 2016	

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
57	43/4.3.0.7	It is recommended that the Integration Joint Board has a reserves policy and reserves strategy, which include the level of reserves required and their purpose. This should be agreed as part of annual budget setting and reflected in the Strategic Plan agreed by the Integration Joint Board.	This has yet to be developed and be approved during 2016/17 in preparation for 2017/18 financial planning process.	CFO will develop and seek agreement from CO/IJB and respective partners	Will form part of IJB Financial Strategy
58	43/4.3.0.9	The Chief Officer will not be able to vire between the operational Integrated Budget and those budgets that are managed by the Chief Officer, but are outside of the scope of the Strategic Plan, unless agreed by the partner Local Authority and Health Board.	The arrangements for this are defined in s8.6 of the SOI	None	Specifically stated in 8.6.4 - 8.6.6 of SOI
59	43/4.3.0.9	The arrangements for the virement of budgets should be specified in the scheme of delegation within the partner authorities.	Outstanding - partners' Financial Regulations require review and if appropriate, updating	Schemes of administration in NHSB and SBC require review and update accordingly.	
60	44/4.3.1.1	The Integration Scheme should include provisions for the treatment of in-year under and overspends.	s8.6 of SOI clearly defines these provisions	None	
61	44/4.3.1.5	In-year underspends on either arm of the operational integrated budget should be returned from the Local Authority and Health Board to the Integration Joint Board and carried forward through the general fund.	8.6.8 of the SOI states "Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to. " 8.6.7 states "Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve."	None	Treatment of planned overspends defined in SOI 8.6.7, unplanned overspends in 8.6.8

4.4 NOTIONAL BUDGET FOR DIRECTED HOSPITAL SERVICES

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS /	STATUS>
62	46/4.4.0.3	Legislation requires that the method for determining the amount to be set aside by the Health Board should be included in the Integration Scheme	This is defined in s8.5 of the SOI, specifically referencing IRF. The work to calculate this however remains outstanding.	To be completed and reported within Financial Statement to March IJB in draft, subject to further work and analysis		
63	.	Where material; the notional budget should include the resources for the in scope hospital services used by the partnership population in all Health Boards.	Not relevant within Scottish Borders			
64	46/4.4.1.4	It is recommended that partners should establish a process for the Chief Officer and the hospital sector to jointly monitor in year actual demand against plan and provide for virements, if required, based on practical thresholds.	t.b.a.	t.b.a.		
5. VAT						
5.1 REVENUE						
5.2 CAPITAL						
65	50/5.2.1	In the short term the Integration Joint Board will not be empowered to own capital assets and the VAT regimes of the Local Authority and Health Board will apply to capital assets used to provide the delegated services.	8.7.1 of SOI states "The Integration Joint Board will not own any capital assets but will have use of such assets which will continue to be owned by Borders Health Board and Scottish Borders Council who will have access to sources of funding for capital expenditure". The SOI does not refer to VAT regimes, however, following national recommended practice (HSCI Finance Leads recommendations, existing partners' VAT regimes will apply.	None	VAT approach should be simple and pragmatic - watching brief presently to ensure all decisions proposed and implemented are VAT neutral	
6. CAPITAL AND ASSET MANAGEMENT						
6.1 ASSET MANAGEMENT						

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

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

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS /	STATUS>
66	51/6.1.1	The Integration Joint Board should identify the asset requirements to support the Strategic Plan. This will enable the Chief Officer to identify capital investment projects, or business cases to submit to the Health Board and Local Authority for consideration as part of the capital planning processes, recognising that partnership discussion would be required at an early stage if a project was jointly funded.	SOI 8.7.2 states "The Chief Officer will consult with Borders Health Board and Scottish Borders Council to identify need for asset improvement owned by either party and where investment is identified, will submit a business case to the appropriate party which will be considered as part of each party's existing capital planning and asset management arrangements." Following the IRAG guidance therefore, a formal process will be in place to consider IJB capital requirements as part of both organisations' wider capital planning process".	None		
67	51/6.1.3	The Integration Joint Board, Health Board and Local Authority are recommended to undertake due diligence to identify all non-current assets which will be used in the delivery of the Strategic Plan.	This is not stipulated in SOI, nor has any work been undertaken to identify fixed assets specifically.	An audit of all fixed assets supporting the functions delegated will be require undertaking and a report to the IJB, linking them to the delivery of the Strategic Plan will be made during 2016/17	2016/17	
6.2 CAPITAL FUNDING						
68	52/6.2.1	The Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure. The Health Board and Local Authority will continue to own any property and assets used by the Integration Joint Board and have access to sources of funding for capital expenditure.	SOI s8.7.1 states that "In line with guidance, the Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure." Asset ownership will be retained by each partner and a formal process for accessing sources of capital funding from either organisation will be develoepd".	Capital Planning process		
6.3 R&M						
69	53/6.3.1	The Integrated Budget may include payments from the Local Authority and Health Board to cover the revenue costs of assets e.g. rents, repairs and maintenance, rates, cleaning, property insurance etc.	Locally, we have decided not to include property repairs, maintenance and servicing within the Integrated Budget and both partners' will retain the responsibility for this function.	None		

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SCOTTISH BORDERS INTEGRATION OF HEALTH AND SOCIAL CARE

SUMMARY OF OUTSTANDING FINANCE WORKSTREAM 2015/16 AT OCTOBER 2015

Action	Report to IJB	Theme	Report No	Description	Responsibility	Timescale	Notes
1	Mar-16 (a)	**Governance Structure**	**3**	Development and Approval of Annual Financial Statement of resources supporting the delivery of the Strategic Plan	NHS DoF / SBC CFO	Feb-16	On outcome of NHSB / SBC respective financial planning processes
2	Mar-16(a)	**Financial Reporting**	**12**	Specific calculation of large hospital budgets set-aside requires finalisation	NHS DoF	Feb-16	
	Mar-16(a)	**Financial Planning and Management**	**13**	All resources within the Financial Statement require allocation in line with the Strategic Plan	NHS DoF / SBC CFO	Feb/Mar-16	
4	Mar-16 (b)	**Governance Structure**	**4**	Due dilligence analysis of the sufficiency of delegated and notional resources supporting the delivery of the Strategic Plan	NHS Dof / SBC CFO	Mar-16 draft Jun-16 full	Following completion of Financial Statement
5	Mar-16 (a)	**Financial Planning and Management**	**16**	Analysis and incorporation into Financial Statement of impact of Resource Transfer is outstanding, including uplift process	NHS DoF / SBC CFO	Mar-16	
6	Mar-16 (a)	**Financial Planning and Management**	**16**	Analysis and incorporation into Financial Statement of impact of Hosted Services is outstanding	NHS DoF / SBC CFO	Feb/Mar-16	
7		**Assurance**	**-**	Report to NHSB and SBC Audit Committees over progress made to date and remaining Action Plan	NHS DoF / SBC CFO	Feb/Mar-16	
8	Mar-16 (c)	**Assurance**	**8**	The Chief Internal Auditor's appointment to the IJB requires formal approval by the IJB	NHS Dof / SBC CFO	Feb-16	Approved

SCOTTISH BORDERS INTEGRATION OF HEALTH AND SOCIAL CARE

SUMMARY OF OUTSTANDING FINANCE WORKSTREAM 2015/16 AT OCTOBER 2015

Action	Report to IJB	Theme	Report No	Description	Responsibility	Timescale	Notes
9	Mar-16 (d)	**Assurance**	**6**	A report to the IJB for approval on the arrangements that will be put in place for Risk Management within the IJB	Chief Internal Auditor	Mar-16	
10	Mar-16 (e)	**Assurance**	**9**	Risk-based Internal Audit Plan for 2016/17 to be developed and approved by IJB	Chief Internal Auditor	Mar-16	
	Mar-16 (f)	**Assurance**	**10**	Arrangements for the IJB's Audit Committee requires approval	Chief Internal Auditor	Feb-16	Approved
12		**Assurance**	**6**	NHS Borders' and Scottish Borders Council's Risk Management Strategies require review and updating in context of Integration	Risk Management	Mar-16	Designated owners of Risk Registers within NHSB and SBC
13	Mar-16 (a)	**Assurance**	**-**	Clear statement of financial accountability of Chief Officer to Director of Finance NHSB and Chief Financial Officer (SBC)	NHS Dof / SBC CFO	Mar-16	Will be included as part of Action 1 above
14	N/A	**Governance Structure**	**1**	Appointment of Chief Financial Officer	-	Mar-16	
15	Mar-15	**Governance Structure**	**2**	Development and Issue of Written Directions by the IJB to NHS Borders and Scottish Borders Council	Chief Officer	Mar-16	
16		**Assurance**	**5**	A review of NHS Borders and Scottish Borders Council Financial Regulations to ensure consistency and provide for IJB	NHS DoF / SBC CFO	Mar-16	

SCOTTISH BORDERS INTEGRATION OF HEALTH AND SOCIAL CARE

SUMMARY OF OUTSTANDING FINANCE WORKSTREAM 2015/16 AT OCTOBER 2015

Action	Report to IJB	Theme	Report No	Description	Responsibility	Timescale	Notes
17		**Assurance**	**7**	Agreement of Insurance arrangements for the IJB	NHS DoF / SBC CFO	Jun-16	
18	Sep-16	**Financial Planning and Management**	**18**	Development of a Financial Strategy for the IJB including risk-based Reserves Strategy	CFO	Jun-16	
19	Jun-16	**Assurance**	**6**	Development and Approval of IJB Risk Management Strategy	Chief Officer	Jun-16	Initial draft to IJB Mar-16
20		**Financial Planning and Management**	**17**	Policy on the application of monthly accrual accounting requires further discussion and agreement	NHS DoF / SBC CFO	Jun-16	
21		**Capital and Asset Management**	**20**	Agree list of all capital fixed assets	NHS DoF / SBC CFO / CFO	Jun-16	
22	Sep-16	**Financial Planning and Management**	**14**	An integrated priority-based Financial Planning process must further be developed for 2017/18 (Revenue AND Capital)	NHS DoF / SBC CFO / IJB CFO	Apr-16-Sep 16	
23		**Financial Planning and Management**	**15**	Development of a single-entity IT reporting solution for the production of budget monitoring reports	NHS DoF / SBC CFO	Sep-16	

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HEALTH AND SOCIAL CARE PARTNERSHIP DRAFT FINANCIAL STATEMENT 2016/17 AND ASSURANCE OVER THE SUFFICIENCY OF RESOURCES

Aim

1.1 To provide the Shadow Board with a position statement in relation to the 2016/17 Health and Social Care Partnership's Financial Statement and Assurance report, detailing the level and sufficiency of resources supporting the first and future years' delivery of the partnership's Strategic Plan.

Background

2.1 Under the legislation, NHS Borders and Scottish Borders Council must make payment to the Integrated Joint Board for the delegated functions at the start of each financial year. In addition, NHS Borders must calculate and present the notional budget for large hospitals set-aside for the population of the Scottish Borders. These two elements form the overall integrated budget.

2.2 Within the Health and Social Care Integration Scheme for the Scottish Borders, it is defined that in the first year of operation of the Integrated Joint Board, the baseline payment made to it for delegated functions will be established by reviewing past performance and existing plans for NHS Borders and Scottish Borders Council for the functions delegated, adjusted for material items.

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

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

Draft Financial Statement

3.1 In summary, the proposed delegated budget for the Scottish Borders Health and Social Care Partnership at this point in development is **£144.426m**, whilst the budget retained for large hospital set-aside is **£18.128m**. Based on a range of factors, it will be for the IJB to agree whether to accept this proposed level of resourcing is sufficient to deliver both the functions delegated to it and its first year of progressing towards delivery of its medium-term Strategic Plan.

3.2 The draft delegated budget is based on the proposed/agreed budget for former NHS Borders and Scottish Borders Council functions delegated to the IJB from 1st April taking account of the adjustment factors above, together with the large hospitals budget set aside for the population of the Scottish Borders. In reality however, whilst this is the basis for the calculation of the Integrated Budget, the relevance is in the absolute value of the delegated and notional budgets and not on the component elements of how or within which organisation they were calculated.

3.3 A summary breakdown of each element of the partnership's budget is detailed in Appendices 1-3 of this report:

1. Draft budget delegated by NHS Borders
2. Budget delegated by Scottish Borders Council
3. Draft budget retained by NHS Borders in respect of large-hospitals budget set-aside for the population of the Scottish Borders

3.4 In summary terms, this amounts to:

	2016/17	2017/18 indicative	2018/19 indicative
	£'000	£'000	£'000
1. NHS Borders Delegated Functions	92,622	92,622	92,622
2. Scottish Borders Council Delegated Functions	51,805	51,856	52,356
Total Delegated Budget	**144,426**	**144,477**	**144,977**
3. Large Hospital Budget Set-Aside	18,128	18,128	18,128
Total Integrated Budget	**162,555**	**162,606**	**163,106**

Assurance

4.1 There are primarily two areas over which financial assurance is required by the IJB:

- Financial Governance
- Financial Assurance and Risk Assessment for Integrated and in particular, Delegated Resources

4.2 In terms of the former, the IJB has and will receive a number reports over progress regarding establishing robust financial governance arrangements including a view from the Board's Chief Internal Auditor, in addition to a progress report over compliance with best practice recommendations. Of equal importance and current priority is the latter area of assurance over the sufficiency of resources and any risks inherent in order to enable a view to be formed by the IJB as to whether the resources delegated to the it are adequate for it to carry out its functions, including the large hospitals budget set-aside for the population of the Scottish Borders.

Financial Risk

5.1 Risks over the sufficiency of resources delegated to the Partnership to robustly deliver its strategic plan can be categorised into 3 main types of ascending criticality:

A. Assurance Arrangements Going Forward
B. Mitigation of Inherent Financial Risks

C. Absolute Affordability

A. Assurance Arrangements Going Forward

1. *The basis, regularity and frequency of periodic financial performance monitoring reports to the Partnership going forward*

This reporting arrangement will enable clear understanding of the affordability of existing service provision and where variances arise, how they will be treated or addressed, either by partners or where appropriate, by the IJB, enabled by virement provision the Financial Regulations.

2. *Agreement of Risk Sharing*

Financial Regulations and the overall Scheme of Integration provide clarity over agreement for sharing risks between the IJB and its partners and how any in-year variations will be dealt with, during the first and future years of operation of the Integration Joint Board.

3. *The agreed basis of calculation of future years delegated budget levels and representation of IJB priorities and targets within partners' financial planning processes*

Going forward, adjustments in respect of budget variances, where appropriate and taking account of their root causes and options for addressing, will be made through future years' allocations to the IJB and in the directions from the IJB to its partners. The IJB will plan and allocate resources within the overall integrated budget, including transfers to/from the delegated and notional budgets and in future years, will present a business case for the integrated budget to its partners for consideration and agreement as part of the annual financial process and based on clear evidence in respect of activity, costs, efficiencies, performance and other factors which NHS Borders and Scottish Borders Council will evaluate this and negotiate respective contributions to the integrated budget accordingly

4. *Audit and Risk Management Arrangements*

.
The establishment of the IJB Audit Committee has an important role to play in the assurance process going forward and its role in assessing the IJB's objectives, risks and post-integration performance results will help demonstrate the IJB's effectiveness of delivering the Strategic Plan in an affordable manner and that its activities are founded on robust and effective governance arrangements. Similarly, each partner will seek and be provided with assurance over the arrangements both prior and post-integration and the roles of Chief Internal Auditors of both NHSB and SBC will enable this on an ongoing basis. In the immediacy, key areas of governance and assurance are in place through:

- The appointment of a Chief Internal Officer to the IJB
- Agreement over the establishment of the IJB Audit Committee Arrangements
- The development of a draft IJB Local Code of Corporate Governance
- The development of a draft IJB Risk Management Strategy

B. Mitigation of Inherent Financial Risks

1. *Due diligence over how partners have addressed historic financial risks*

experienced over the years leading up to the 1st April 2016

Both partners have undertaken considerable due diligence work, following best-practice methodology, in order to identify, quantify and where possible address recurring pressures within budgets to be delegated to the IJB by examining historic budget and spend profiles over the years 2013/14 – 2015/16. A more detailed analysis will be reported to the Board prior to the 1st April in order to provide fuller assurance over the sufficiency of overall proposed level of resources delegated.

2. ***Whether partners have identified and evidenced existing and emerging pressures and provided for either appropriate remedial action to address them or sufficient additional funding to meet their cost within the 2016/17-2018/19 Financial Plan***

Again, the due diligence work undertaken has identified a range of pressures to which the integrated budget has been delegated and both partners' draft financial plans for 2016/17 demonstrate a commitment to investing in the areas at a sufficient level to ensure meeting their cost are met going forward, further analysis over which will be reported to the Board prior to the 1st April.

3. ***The deliverability of planned efficiency and other savings measures on which partners' financial plans are predicated and the degree over which the delegated budget can be assessed as being robust and affordable***

As a result of the issues outlined in C below, without full clarity over the identification of fully identified and sufficient efficiency measures within the proportion of delegated budget from NHS Borders, then assurance over the deliverability of all savings required cannot be provider at the current time. However, as work progresses to identify and agree these measures, an assessment of any risks associated with them will be presented to the Board prior to 1st April in order to further provide assurance over both this area of risk specifically and the overall affordability of the Partnership's financial plan for 2016/17.

4. ***Certainty over the level of external/government funding for each financial year covered by the Strategic Plan***

The draft budget to be delegated in totality remains provisional at the current time. Whilst Scottish Borders Council approved its financial plan, including the Health and Social Care Partnership's proposed delegated budget, on 11th February 2016, NHS Borders Budget remains unapproved at this point in time. Additionally, no final funding settlement from the Scottish Government to NHS Borders, has yet been agreed and any variance from assumed levels on which the draft budget is based, may have a further impact on both the absolute level of proposed delegated budget and also on any view over the sufficiency of resources available to support the Strategic Plan delivery next year.

C. Absolute Affordability

1. ***The absolute level of resources and a fully funded Partnership Financial Statement***

This risk relates to the extent that the budget delegated by both partners to the partnership is wholly affordable, in respect of whether it is sufficient in financial terms to fully support

ongoing activity. Primarily, assurance is required that the assumptions on which the level of budget delegated are robust. In particular, it is critical that a view be formed in relation to how any budget gap will be addressed and that sufficient planned savings measures which require delivery in order for the budget to be 'balanced' and therefore functions delegated will be affordable, are both in place and clear.

In line with the proposed methodology above, the draft budget delegated by both partners is based on the 2015/16 baseline budget for functions to be delegated, adjusted incrementally by a number of factors. These include a range of growths/pressures to address historic, current and emerging pressures driven by increased costs, demand, legislative changes or Scottish Government funding conditions. In order to ensure overall affordability however, efficiency and other cost savings/increased income require to be identified in order to ensure the proposed budget delegated in 2016/17 is affordable in absolute terms and therefore fully funded.

Both NHS Borders and Scottish Borders Council have experienced or are experiencing considerable challenge in delivering balanced and affordable financial plans for 2016/17 as a result of a combination of further additional pressures arising from inflationary and other cost pressures or demographic increases in demand. In particular, the extent of the impact of Scottish Government funding settlements to both organisations has resulted in unprecedented resource gaps requiring to be addressed and the achievement of a balanced budget.

For 2016/17, NHS Borders total draft resource gap is **£11.451m**, whilst Scottish Borders Council's is **£11.155m**. For those functions delegated to the IJB or retained and set-aside, NHS Borders resource gap is **£5.327m** (£4.239m & £1.088m respectively), excluding a further £471k relating to specific earmarked allocations, whilst Scottish Borders Council's is **£2.663m**. Work is ongoing to critically challenge and quality assure the process through which both partners have calculated total resource gaps within the financial plan and their allocation of efficiencies and other savings to the Health and Social Care partnership.

Draft Budget delegated by NHS Borders

A summary of the proposed draft budget (at 29th February 2016) delegated by NHS Borders for 2016/17 is detailed below:

	2016/17
	£'000
Baseline Budget	**89,408**
Social Care Fund	5,270
Uplift	1,138
Other Agreed Uplifts	1,515
Efficiency	(4,239)
Other Savings	(471)
Proposed Budget	**92,621**

Draft Budget retained by NHS Borders and set-aside for large hospital services

In addition to delegated budget, the proposed draft budget (at 29th February 2016) for large hospitals retained by NHS Borders and set-aside for 2016/17 is:

	2016/17

	£'000
Baseline Budget	**18,158**
Social Care Fund	0
Uplift	309
Other Agreed Uplifts	749
Efficiency	(1,088)
Other Savings	0
Proposed Budget	**18,128**

NHS Borders, in order to fully fund its financial plan in 2016/17, requires the delivery of a considerable level of efficiency savings. For functions that will be delegated to or held notionally for large hospitals in relation to the Health and Social Care Partnership's Strategic Plan next year, these amount to:

	2016/17 £'000
Delegated Budget:	
Efficiency	(4,239)
Other Savings	(471)
Retained Large Hospitals Budget Set-Aside:	
Efficiency	(1,088)

Within NHS Borders financial plan presently, only **£2.572m** of the **£4.239m** apportioned to the IJB currently has draft identified plans proposed for delivery. These are outlined in *Appendix 4* to this report. Further work is required to secure agreement over these proposals and their targeted efficiency savings. Even if accepted and approved, this leaves **£1.667m** of savings requirement unidentified. Additionally, there is also **£471k** of unidentified savings requirement relating to the functions and services specifically funded by earmarked Scottish Government grant in 2016/17 which have been reduced within the provisional NHS settlement by the government and which could require additional investment in order to sustain existing levels of services next year.

There are also **£1.088m** of efficiency savings relating to the notional large hospitals set-aside budget which requires further clarity at the current time. This results in a total efficiency requirement of **£5.798m** for Partnership services across delegated and notional budgets. In relation to the proposed efficiency targets and work undertaken to identify options for their delivery, further analysis and appraisal is required and, in particular, due diligence over this, before agreement can be reached. This will be undertaken during March and its outcome will be incorporated into the wider final financial statement and assurance report to the board, prior to 1st April 2016. Until full assurance and agreement over plans to deliver the required level of efficiency savings within both delegated and notional budgets is in place, this fundamental risk to the sufficiency of resources to the IJB remains high and will require to be considerably mitigated or eliminated before it can be recommended that the Board accept the level of budget proposed.

Draft Budget delegated by Scottish Borders Council

A summary of the proposed budget (approved 11th February 2016) delegated by Scottish Borders Council for 2016/17 is detailed below:

	2016/17 £'000
Baseline Budget	**47,088**
Social Care Fund	5,270
Pressures/Growths	1,439
Other corporately Pressure/Growths (e.g. manpower increments, inflation etc)	671
Efficiency and Other Savings	(2,663)
Proposed Budget	**51,805**

The baseline budget for functions to be delegated by Scottish Borders Council in 2015/16 was **£47.088m**. In 2016/17, it has been assumed that this will be supplemented by the transfer of resource from NHS of £5.270m through the Social Care Fund. In addition, a number of areas of investment have been made corporately or specifically within social care services to meet a range of pressures arising, which in total amount to £2.110m. However, in order to ensure the overall level of budget delegated is affordable, a range of efficiency and other savings have been identified which require delivery before or during 2016/17 amounting to **£2.663m** relating to Partnership services. Again, the robustness and deliverability of all proposals within the plan for savings is currently undergoing due diligence and assurance over this will be reported to the Board prior to 1st April.

A summary of how Scottish Borders Council will deliver its **£2.663m** of efficiency and other savings is detailed in *Appendix 5*.

At the present time therefore, assuming appropriate assurance over the deliverability of the proposed savings plans, their associated financial targets and the sufficiency of level of investment to meet pressures identified, the Council-delegated component of the overall delegated budget is, prima-facie, affordable and funded.

Conclusion

6.1 Following a number of steps taken to date, including:

- robustness of structure of and governance over both partners' respective financial planning processes
- due diligence over proposed delegated budgets
- management arrangements over the delivery of transformation and associated savings in place within NHS Borders and Scottish Borders Council
- the development of wider governance and financial planning and management arrangements pertaining to the IJB

6.2 With agreed resolution over the level and plans for delivery of required savings and a fully funded integrated budget subsequently arising, the Board will be able to form a clear picture over the overall sufficiency of resources available and accept the proposed budget to be delegated and the element retained by NHS Borders for large hospital set-aside.

6.3 Until further progress is made in order to identify sufficient and appropriately robust savings proposals which will enable a balanced and fully funded budget to be delegated to the IJB, assurance over the sufficiency of resources cannot be provided at this time and further work is required before a fully

assured 2016/17 Financial Statement can be presented to the Board prior to the 1st April.

6.4 At 7th March therefore, the Chief Officer and Chief Financial Officer to the IJB do not recommend acceptance of the draft delegated and notional budgets until this further work is undertaken and full assurance can be provided.

6.5 It is critical that both partners work to enable the successful establishment of the Partnership and delivery of its Strategic Plan during its first year of operation in particular, but failure to fully fund the draft budget delegated to it or that notional budget retained by NHS Borders for large hospitals set-aside will result in significant risks to the delivery of the Partnership's Strategic Plan outcomes and / or the risk of overspending during its first year of operation, which under the Scheme of Integration will fall on the responsibility of the partner delegating the budget to make additional payment to cover the shortfall, if no delivery or recovery plan can be agreed.

6.6 If a plan cannot be agreed to fully fund the budget proposed for delegation to the IJB within the required timescale, then the IJB may be required to direct partner(s) to reduce spend within specific functions. Such a scenario, whilst wholly legitimate should circumstances dictate, would only be required if NHS Borders cannot / does not bring forward further proposals during March and is an option of last resort. In the first year following its establishment, it is important that the IJB is provided with maximum enablement to be successful both in its performance and financially and if this latter scenario was to apply, it would undoubtedly be with increased reputational and financial risks to both the IJB and its partners than the former.

6.7 In order to achieve this therefore, a further, more detailed report will be brought forward to the Partnership board, in advance of the 1st April seeking approval of the outcomes of the assurance process and acceptance of the proposed delegated and notional integrated budgets calculated and reported at that time.

Recommendation

It is recommended that the Health & Social Care Integration Joint Board:

- **Note**: the current position in relation to the production and agreement of a fully evidenced and funded joint delegated and notional budget for 2016/17 for the Scottish Borders Health and Social Care Partnership

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

- **Agree**: that a final financial statement accompanied by a full assurance report be presented to the Board prior to the 1st April 2016 for approval, requiring the convention of an extra-ordinary meeting in late March 2016

Policy/Strategy Implications	In compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any

	consequential Regulations, Orders, Directions and Guidance.
Consultation	The report has been reviewed by both NHS Borders Director of Finance and SBC Chief Financial Officer and further consultation will be undertaken across all key stakeholders as part of the wider report to the IJB prior to the 1st April 2016.
Risk Assessment	A full risk assessment and risk monitoring process for the Integration Programme is in place as part of the Integration Programme arrangements.
Compliance with requirements on Equality and Diversity	An equality impact assessment will be undertaken on the arrangements for Joint Integration when agreed, including the Integrated Budget in particular. The pressures / savings proposals within the Council component element of the budget have already been subjected to Equality Impact Assessment.
Resource/Staffing Implications	The report provides an interim position statement over the level of and sufficiency of draft Partnership resources for 2016/17, which will be further developed and presented to the board with full financial assurance by 1st April 2016.

Approved by

Name	Designation	Name	Designation
Susan Manion	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Chief Financial Officer - IJB		

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Appendix 1
Draft Budget delegated by NHS Borders

Draft NHS Borders Budget Delegated	2016/17 £'000	2017/18 indicative £'000	2018/19 indicative £'000
	92,621	92,621	92,621
	92,621	92,621	92,621

More detailed analysis of the NHS Draft Budget Delegated is being undertaken and will be presented to the Board on completion.

Appendix 2
Budget delegated by Scottish Borders Council

Scottish Borders Council Budget Delegated	2016/17 £'000	2017/18 indicative £'000	2018/19 indicative £'000
Adults with Learning Disabilities	14,674	14,909	15,175
Older People	28,124	27,862	27,906
Generic Services	3,659	3,663	3,762
People with Mental Health Needs	2,168	2,177	2,201
People with Physical Disabilities	3,180	3,245	3,312
	51,805	51,856	52,356

Appendix 3
Draft Large-Hospitals Budget Set-Aside

Draft Large-Hospitals Budget Set-Aside	2016/17 £'000	2017/18 indicative £'000	2018/19 indicative £'000
	18,128	18,128	18,128
	18,128	18,128	18,128

More detailed analysis of the NHS Draft Budget Retained in relation to large hospital budgets set-aside is being undertaken and will be presented to the Board on completion.

Appendix 4
Summary of NHS Proposed Savings within Delegated Budget

	16/17 £'000
IJB Share Carried Forward Schemes (estimated)	
Skill Mix (Nursing)	-96
Non-support Service Admin	-122
Supplies Uplift 2016/17	-114
Travel Costs	-98
Suspend Clinical Excellence Fund 2016/17	-192
Schemes Carried Forward	-622
New Local Schemes 2016/17 (estimated)	
Clinical Productivity	-750
Day Hospital Review	-100
Drugs/Prescribing	-600
Community Hospital LoS	-400
Other Small Schemes	-100
New Local Schemes	-1,950
Total	**2,572**
Savings Target 2016/17	**(4,239)**

Appendix 5
Summary of SBC Proposed Savings within Delegated Budget

	16/17 £'000	17/18 £'000 (indicative)	18/19 £'000 (indicative)
Supporting Independence when providing Care at Home	(316)	0	0
Further contribution of surplus from SB Cares	(547)	(177)	(162)
Reduction in the costs of Commissioning	(378)	(160)	0
Residential and Home Care Efficiencies and Income	(235)	0	0
Assessment and Care Management	(100)	0	0
Staffing	(300)	(50)	0
Adults with Learning Disabilities Efficiencies	(549)	0	0
Older People Efficiencies	(234)	(237)	0
Other	(4)	(4)	(4)
	(2,663)	**(628)**	**(166)**

Savings Target 2016/17	**(2,663)**

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CHIEF OFFICER'S REPORT February 2016

Aim

1.1 To provide the Health & Social Care Integration Joint Board with an overview of activity undertaken by the Chief Officer in relation to the Integration Joint Board.

Background

2.1 The Health & Social Care Integration Joint Board will receive a report from the Chief Officer at each of its meetings.

Summary

3.1 Primary Care

Locality coordinators have been appointed recently to support locality planning arrangements and delivery through work with front line staff, local communities, the third sector and primary care contractors. A framework for a locality approach in line with the Strategic Plan is programmed to return to the IJB at a future meeting.

3.2 IJB Business

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

3.3 Delayed Discharges

Significant focus has been maintained on delayed discharges over the last period with close monitoring and oversight across the partnership. A representative from the Joint Improvement Team has spent time reviewing how we operate across the partnership arrangements and, while endorsing our overall approach and infrastructure of support, has made some helpful suggestions for improvement which we will action. Work is taking place to put the detail on some specific changes across the system which will lead to longer lasting and sustainable improvement including discharge to assess facilities and rapid reaction to facilitate discharge and prevent admission. These will be highlighted in the revised plan to achieve the 72 hour target.

3.4 Communication

The latest Health and Social Care integration newsletter has been approved and will be released shortly. We will issue a newsletter aimed at all staff every two months with occasional targeted news bulletins for specific groups such as GPs, Carers, the independent sector etc. Website links will be established to ensure the information on health and social care is easily accessible. For the public, there will be regular bulletins in SB Connects which goes to all households. The communications team are working on a press release for the launch of the Health and Social Care arrangements on the 1st April.

3.5 Health and Social Care Scotland (Chief Officers network)

The Chief Officers across Scotland have formed an association, meeting formally every two months to discuss areas of common interest and learning. Each time, we meet senior representatives from the Scottish Government to discuss national issues. At its meeting on Friday 19th February we will be discussing, among a number of

items, the National Clinical Strategy, the National Care Home contract and OD support for Chief Officers.

Recommendation

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

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

Approved by

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

Author(s)

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

HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD WORKPLAN/BUSINESS CYCLE 2016

Meeting	Date, Time and Venue	Session Items
H&SC Integration Joint Board **Development Session**	Wednesday 20 January 2016 9.30am – 12.30 Board Room, NHS Borders, Newstead	Financial Governance Update on strategic plan and locality approach (capacity building) – Eric and Elaine Commissioning Plan Delayed Discharges IJB Development – George Hunter
H&SC Integration Joint Board	Monday 1 February 2016 2pm - 4pm Committee Room 2 Scottish Borders Council	Chief Officer Report Budget Monitoring Communications Update Integrated care fund Update Financial Regulations Strategic Plan
H&SC Integration Joint Board	Monday 7 March 2016 **9.30am – 12.30** Council Chamber, Scottish Borders Council	Formal establishment of IJB Appoint Chief Officer Appoint Chief Financial Officer Code of Corporate Governance Formal Adoption of Standing Orders Approval of Strategic Plan Risk Management Strategy Clinical & Care Governance
H&SC Integration Joint Board	Monday 18 April 2016 2pm – 4pm Committee Room 2, Scottish Borders Council	Chief Officer Report Chief Financial Officer Report Integrated Care Fund Update Scottish Borders Autism Strategy Update (S Burt) Dementia Strategy Update (Jane Douglas)
H&SC Integration Joint Board **Development Session**	Monday 23 May 2016 9.30am – 12.30 Board Room, NHS Borders, Newstead	**FULL DAY AWAYDAY OF DEVELOPMENT – POTENTIALLY OUT TO EYEMOUTH OR THE EAST OF BORDERS SOMEWHERE – SM TO WORK UP GO TO LOCALITY – CURRENT VIEW – ASPIRATIONAL VIEW – JB IS THE TOOL TO ACHIEVE – VOTING AND NON VOTING MEMBERS ONLY TO ATTEND**
H&SC Integration Joint Board	Monday 20 June 2016 2pm – 4pm Council Chamber, Scottish Borders Council	Chief Officer Report Chief Financial Officer Report Integrated Care Fund 6 monthly report Communications Report Integrated Care Fund Update
H&SC Integration Joint Board	Monday 15 August 2016 2pm – 4pm Committee Room 2,	Chief Officer Report Chief Financial Officer Report Communications Report

Meeting	Date, Time and Venue	Session Items
	Scottish Borders Council	Integrated Care Fund Update
H&SC Integration Joint Board **Development Session**	Monday 26 September 2016 9.30am – 12.30 Board Room, NHS Borders, Newstead	Consequences and pace of change in terms of commissioning Prescribing – Alison Wilson Community Ward – Annabel Howell and Sandra Pratt
H&SC Integration Joint Board	Monday 17 October 2016 2pm – 4pm Committee Room 2, Scottish Borders Council	Chief Officer Report Chief Financial Officer Report Integrated Care Fund Update
H&SC Integration Joint Board **Development Session**	Monday 21 November 2016 9.30am – 12.30 Board Room, NHS Borders, Newstead	
H&SC Integration Joint Board	Monday 19 December 2016 2.00pm – 4pm Committee Room 2 Scottish Borders Council	Chief Officer Report Chief Financial Officer Report Integrated Care Fund 6 monthly report Communications Report Integrated Care Fund Update

COMMITTEE MINUTES

Aim

To raise awareness of the Health & Social Care Integration Joint Board on the range of matters being discussed by the Strategic Planning Group.

Background

The Health & Social Care Integration Joint Board will receive various approved minutes as appropriate.

Summary

Committee minutes attached are:-

- Strategic Planning Group: 13.01.16

Recommendation

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

Policy/Strategy Implications	As detailed within the individual minutes.
Consultation	Not applicable
Risk Assessment	As detailed within the individual minutes.
Compliance with requirements on Equality and Diversity	As detailed within the individual minutes.
Resource/Staffing Implications	As detailed within the individual minutes.

Approved by

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

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

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Scottish Borders Health and Social Care PARTNERSHIP

Meeting of Strategic Planning Group
13 January 2016
Committee Room 2, Scottish Borders Council Headquarters

Minute

Attendees: Eric Baijal (Chair), Amanda Miller, Carin Pettersson, Margaret McGowan, Tim Patterson, Tim Young, Julie Kidd, Linda Jackson, Clare Malster, Jenny Miller, Elaine Torrance, Dr Peter Symms, Jane Douglas, David Bell, Suzanne Hislop (Minutes)

		Action
1.	**Apologies**: Susan Manion, Morag Walker, Shirley Burrell, Steph Errington, Alasdair Pattinson, Sandra Campbell, Fiona Morrison	
2.	**Minutes of the previous meeting** • The minutes of the previous meeting of 24 November were accepted as a true record. SPG Minutes 24 November 2015.docx • The group went through the actions arising from the last minute and updated the action tracker. Action Tracker SPG 13 January updated.dc	
3.	**Matters Arising** • As the meeting held on 24 November was not quorate, the minutes from the meeting held 14 October were therefore also approved by the group. SPG Minutes 14 October 2015.doc	

4.	**Draft Terms of Reference and Membership - Strategic Planning Group** • The Chair explained that there had not been any real change to the Terms of Reference but the membership of the Strategic Planning Group has been revisited. This was reviewed to address the overlap that existed between the Strategic Planning Project Board and this group. The original intention of the SPPB was to be a small tight group which would write and progress the Strategic Plan through the correct administrative processes. The SPPB also had a role in the Integrated Care Fund. We have now reconstituted what was the SPPB to form the Strategic Planning Board which is a small group of action takers supplemented by a couple of other key people to take forward the actual work. There were number of people on the original Strategic Planning Project Board who held a more consultative role and would be better placed on the Strategic Planning Group. The main change is therefore to the membership of the Strategic Planning Group to include people who were originally on the Strategic Planning Project Board but are now not on the newly formed Strategic Planning Board. • The Chair asked for thoughts and comments from the group before pointing out that we still require a Health Professional representative. Karen McNicoll (Chair of the Area Clinical Forum) has been previously contacted regarding this and forwarded the meeting details after agreeing to identify an appropriate person. The Chair took an action to follow up on the previous correspondence with Karen McNicoll. The Chair also highlighted that the Chief Financial Officer is to be added to the membership of the SPG. The issue of a Locality Representative was discussed at the previous Strategic Planning Board and it was agreed that it would be best to ask the new Locality Co-ordinators when in post. The Chair also took the opportunity to apologise for having failed to welcome Dr Peter Symms as a new member to the group. The Chair welcomed Dr Symms and thanked him for his participation. • CM informed the group that the Community Councils feel outwith this process and the Chair asked CM if it was therefore appropriate to ask a member of the Community Council Network to attend SPG meetings. It was agreed to invite a representative from the Community Council Network to future meetings. The Chair to write to the Chair of the CCN. • TP asked where the acute sector was represented on the SPG membership. The Chair explained that the need for an appropriate professional from the acute sector has been taken up with the Area Clinical Forum. TP was thinking about representation at a more managerial level and someone who would have an overview of issues such as reducing emergency admissions and preventing delayed discharges. The Chair suggested that he and TP discuss this issue outwith this meeting. • The issue of deputies was raised and it was agreed that SH would contact all of those on the revised membership list who do not already have a deputy and ask for nominations in advance of the next meeting with outstanding action to be updated on tracker. • The issue of a quorum for the SPG was raised. The Chair is to look into this and report back to the group. • Linda Jackson who was attending the meeting on behalf of Fiona Morrison asked about incorporating a mechanism for identifying gaps or feeding back when things are not working. The Chair is to come up with a form of words and amended the Terms of Reference to reflect this. It was agreed that the changes discussed are to be made to the document which will be reviewed at the next meeting.	**Chair** **Chair** **Chair** **Chair/TP** **Chair** **Chair**

5.	**Draft Terms of Reference and Membership - Strategic Planning Board** • The Chair explained that the Terms of Reference for the Strategic Planning Board reflect his earlier comments regarding the intention to have a small group with responsibilities for the Integrated Care Fund funding with no projects going onto the Executive Management Team without first being approved by the SPB. • ET questioned whether the SPB had enough members with suitable seniority to make these decisions. The Chair explained that we are trying hard to keep the membership down to people who are directly involved with the Strategic Plan. It was agreed that the Chair, ET and relevant others to have a discussion outwith the meeting about the membership of the SPB and inform the SPG of the outcome. • ET suggested that a diagram setting out the structure of the groups and how they relate to each other would be welcome to provide clarity. The Chair sketched out a basic diagram for members showing the structure of some of the programme groups and instructed SH to contact SC and ask for the diagram she is currently working on around the structure of groups for circulation when available. EB asked that bullet points be included as this would be helpful. • The revised version of the Strategic Planning Board Terms of Reference and membership and a chart that sets out clearly the governance, information flow of the various programme groups is to be brought to the next meeting. • Linda Jackson expressed concern that Carers and the Third Sector are not represented on the SPB and asked if these groups could have a champion on the SPB or alternatively submit papers. Thought is to be given to Voluntary and Carer representation on the SPB. • TP suggested that it would be useful to explain where the ICF projects are generated from, where they come from and what the process is around this. • DB suggested Organisational Development be represented on the SPB. DB requested that the SPB minutes be sent to the Joint Staff Forum. • There is therefore to be a discussion outwith the meeting in relation to the SPB and the following: o Appropriately senior managers being represented on the SPB. o Voluntary and Carer representation on the SPB. o Organisational Development representation on the SPB. o The request from DB that the minutes of SPB meetings be sent to the Joint Staff Forum for information. • The Chair is to write to absent members to summarise the changes to the SPG and SPB and explain that we are looking forward to their regular attendance.	**SH** **Chair/ET** **Chair**
6.	**Strategic Plan Update** • A presentation was given by the Chair, JK, and CP on the progress made with the Strategic Plan to date. • The Chair was hopeful that we will have the opportunity to give this presentation to the Integrated Joint Board at the development session being held on 20 January. We feel it is important to do this and is also a good opportunity to feedback the views of this group to the IJB on the 20th. • The Chair asked that comments from members today be carefully recorded in the minutes so that this can form the feedback to the IJB. • The Chair went on to explain that the Equalities Commission have instructed all partnerships to produce an equalities action plan. Partnerships have however suggested that this is not appropriate as have they no employees and would expect that services commissioned would cover this requirement and this would be part of the commissioning process. This has	

	not been settled to date and wider discussions are taking place around this issue. • AM wanted to understand the risk around the implementation of the Strategic Plan. JK explained that locality planning is a good example of where the risk is and we have to be mindful of not focusing on the Strategic Plan in isolation but to consider the other pieces of work that are required. • ET highlighted that in the past when we have done consultation we have had a summary of the key themes and suggested that it might be useful to see what the key themes are which would also be useful for audit purposes. JK explained that we have an audit trail of the feedback received and what has been included in the document. After further discussion the SPG agreed that the IJB should see a summary of the themes that came out of the engagement. This is to be added to the paper produced by CP for the IJB development session on the consultation on the second draft of the Strategic Plan. • CP's paper was discussed and the figures included within. CP described this as quantitative and was unsure how useful this was in obtaining an accurate picture of how many people we reached. The Chair agreed that it was difficult to calculate reach. JD stated that the IJB were clear that they wanted to know how many people had responded to the consultation and this was echoed by DB. • AM raised the subject of the Housing Contribution Statement. A Housing Workshop was held in December and used as an engagement vehicle to inform the Strategic Plan. • TP asked if the GP Sub-Committee had fed back to the process. TY informed the group that this has been discussed at the meetings which the Chief Officer attends and this was reflected in the minutes. TY confirmed that the GP's are signed up to the process. • DB stated that as an advisory group it is important that we raise our concerns about the potential reputational damage that would be caused should there be a delay in the IJB signing off the Strategic Plan on 1 February. This was agreed by the group who also agreed that they are supportive of the work that has taken place to date and have confidence in the plans to take this forward.	
7.	**Integrated Care Fund** • The Chair introduced the Integrated Care Fund Paper which gives an overview of programmes and projects. Due to time constraints the paper was noted and there is to be a fuller discussion of the ICF at a later meeting when a paper on governance will be made available.	**Chair**
8.	**AOCB** • TY provided an updated on the comments made by Sandy Morris in the minutes from the meeting held on 14 October relating to the Quality and Outcomes Framework for GP's. QOF has been disbanded and there is an evolving prospect of GP practices collaborating in clusters moving forward. • The Chair highlighted that the minutes of this meeting are unlikely to be ready for the IJB session on 20 January, but feedback will be provided from today's meeting.	
9.	**Date and time of next meeting:** **The date of the next meeting was given as 9 February from 2 to 3.30pm in the Ruberslaw Room, Tweed Horizons**	