Public Document Pack

Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health And Social Care Integration Joint Board** will be held on Monday, 27 March 2017 at 2.00 pm in Committee Room 2, Scottish Borders Council.

AGENDA

1. **ANNOUNCEMENTS AND APOLOGIES**

2. **DECLARATIONS OF INTEREST**

3. **MINUTES OF PREVIOUS MEETING**
   27 February 2017.

4. **MATTERS ARISING**
   Action Tracker.

5. **STRATEGIC**

   5.1 **Transformational Programme**
   Verbal Report by Chief Officer.

   5.2 **Integrated Care Fund Update**
   Report by Chief Officer.

   5.3 **Annual Performance Report 2016/17**
   Report by Chief Officer.

   5.4 **NHS Borders Local Delivery Plan 2017/18**
   Report by Chief Officer.

6. **CLINICAL AND CARE GOVERNANCE**

   6.1 **Inspections Update**
   Verbal Report by Chief Social Work Officer.

7. **GOVERNANCE**

   7.1 **Review of Strategic Planning Group**
   Report by Chief Officer.

8. **FINANCE**

   8.1 **Monitoring of the Health and Social Care Partnership Budget 2016/17**
   Report by Interim Chief Financial Officer.

8.2 **Scottish Borders Health and Social Care Partnership Financial Plan 2017/18**

Report by Interim Chief Financial Officer.

9. **FOR INFORMATION**

9.1 **Chief Officer's Report**

Verbal report by Chief Officer.

10. **ANY OTHER BUSINESS**

10.1 **Health and Social Care Integration Joint Board Development Session: 29 May 2017**

Verbal Report by the Chief Officer.

11. **DATE AND TIME OF NEXT MEETING**

Monday 26 June 2017 at 2.00pm in Committee Room 2, Scottish Borders Council.

Minutes of a meeting of the **Health & Social Care Integration Joint Board** held on Monday 27 February 2017 at 2.00pm in Committee Room 2, Scottish Borders Council

Present:	(v) Cllr C Bhatia (Chair)	(v) Mrs P Alexander
	(v) Cllr G Garvie	(v) Mr J Raine
	(v) Cllr F Renton	(v) Mr D Davidson
	(v) Cllr S Aitchison	(v) Dr S Mather
	Mrs E Torrance	(v) Mrs K Hamilton
	Mr M Leys	Dr A McVean
	Mr D Bell	Mr J McLaren
	Mrs J Smith	Ms A Trueman
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mr P McMenamin	Mrs T Logan
	Mrs J Stacey	Mrs C Gillie
	Mr C McGrath	

1. Apologies and Announcements

Apologies had been received from Cllr John Mitchell, Dr Cliff Sharp, Mrs Evelyn Rodger, Ms Lynn Gallacher, Dr Annabel Howell and Alison Wilson.

The Chair confirmed the meeting was quorate.

The Chair welcomed Mr Colin McGrath, Kelso Community Council, 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 19 December 2016 were approved.

The minutes of the previous meeting of the Extra Ordinary Health & Social Care Integration Joint Board held on 30 January 2017 were approved.

4. Matters Arising

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

5. Partnership Performance Reporting

Mrs Elaine Torrance gave an overview of the content of the report and highlighted the population of the 23 indicators and the 6 themes that had been defined by the Ministerial Steering Group.

A discussion ensued which highlighted several areas including: improvement required in offer and take up of carer assessments; appendices to be numbered; inclusion of data on risk; missing text on page 11, section 6; evolution of the report over time; time lag of national statistics; report format agreed with the inclusion of page numbers; balance of spend; and the shift in balance of spend into primary care and GP services representing 11% of the front line budget.

Mrs Karen Hamilton enquired if the narrative would be part of the submission to the Scottish Government. If it was she suggested in terms of delayed discharges that the wording be reviewed as it was too simplistic to say care at home and suggested including the word "majority" as there were other reasons for delayed discharges.

Mr John McLaren enquired of the relevance of including the 4 hour Accident & Emergency (A&E) performance target as opposed to outcomes. Mrs Torrance commented that it would be helpful to understand what was useful, such as how many patients attended A&E and were returned home directly from A&E.

Cllr Sandy Aitchison commented that he was disappointed with the 82.5% spend on the last six months of life compared to the Scottish average of 87% and enquired when quantified in numbers of people what did it actually mean? Mrs Jane Davidson commented that the outcome being pursued was for an increase in the number of people being able to stay in their own homes by being supported by district and community nurses. She reminded the Board that the Margaret Kerr Unit was a specialised palliative care facility.

Dr Stephen Mather also commented that in his experience in the majority of cases people were keen not to die on their own, they wished to be with relatives and in comfort and for some that was not always in their own homes. He suggested the focus should be on where people wanted to die and how that requirement could be supported.

Mr Murray Leys commented that the data collected was in relation to the community setting and within many other Council areas it included hospices of which there were none within the Scottish Borders.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the 23 indicators set by the Scottish Government and the requirement to publish an Annual Performance Report by July 2017.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the six themes for reporting recently defined by the Ministerial Strategy Group.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** endorsed the IJB reporting scorecard.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** commented on performance to date.

6. Transformational Programme

Mrs Elaine Torrance presented the proposed integration transformation programme and highlighted several key elements including: the financial context for 2017/18; drivers for change; proposed outcomes and objectives; challenges and risks; and the next steps.

Dr Stephen Mather suggested one of the key issues was the demand led rather than budget led situation and he suggested changing the culture of the population and the service deliverers to provide something that was sufficient rather than luxury.

Mrs Karen Hamilton echoed Dr Mather's suggestion and commented that there was a need to support and empower those making decisions.

Mr John McLaren commented that communication and engagement were key to the success of the transformational programme and he enquired if the programme was being taken forward separately to the programmes within NHS Borders and Scottish Borders Council.

Mrs Torrance concurred that communication and engagement were key elements to success and commented on the delivery of work being taken forward in partnership and areas that could be improved such as home carers using medication dispensers, investment in developing technological solutions to create savings and efficiencies.

Mrs Jane Davidson commented on the need to pool resources and the transformational plans between the three bodies to ensure the Health & Social Care Integration Joint Board (IJB) could successfully commission and direct change in the delegated functions of both NHS Borders and Scottish Borders Council.

The Chair commented that the overlaps with transformational programmes into core services within Scottish Borders Council and NHS Borders would also need to be taken into account. She gave the example of changes to bus transportation, which was not within the delegated functions to the IJB, but any changes would have an effect on the IJB in terms of people getting to hospital appointments.

Mr John Raine commented that transformational change programmes were designed to do more with less and he urged that both NHS Borders and Scottish Borders Council's programmes be taken into account in formulating and finalising the IJB commissioning plan and monitoring thereof.

Mrs Torrance agreed that both bodies transformational programmes would be taken into account to ensure that the overarching commissioning plan would be achievable.

Mr Murray Leys also urged that both bodies transformational programmes be brought together to ensure they were complimentary and he suggested co-location at an operational level be pursued.

Mr David Davidson commented that it was up to the partner bodies to work together to deliver the commissioned services within the agreed budget envelope. He suggested that it would be the Executive Management Team that produced the final plans and recommendations for the IJB to approve.

Mrs Jenny Smith suggested there should be third sector input to the Executive Management Team as both commissioning and decommissioning decisions would be made at that level. She further enquired where the Clinical Boards would link into the transformational agenda.

Mrs Torrance commented that as the programme was developed a supporting communication and engagement plan would form part of the underpinning process and provide the opportunity to link to the Clinical Boards, Joint Staff Forum and a range of other areas. She suggested providing a progress update to the next meeting of the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation and agreed to receive an update at the next meeting.

7. Updated arrangements for managing the Integrated Care Fund (ICF)

Mrs Elaine Torrance introduced the paper and highlighted that it contained both an update on current projects and a proposal for the £2m balance to be demitted to the Executive Management Team to determine that spend aligned to streamlining care pathways and achieving efficiencies. Regular updates would be provided to the Health & Social Care Integration Joint Board (IJB) on progress, mainstreaming of decision making and any tests of change to support the efficiency programme.

Mr John Raine enquired if there had been any change in the governance approach previously agreed? Mrs Tracey Logan commented that there had been confusion previously. She advised that the intention was to streamline the process feeding into the Executive Management Team (EMT) level to enable more rapid progress to be made.

Mr David Davidson commented that he was concerned in regard to the Ministerial Strategy Group and enquired if further documents would be released by them. Mrs Torrance responded that she understood there would be no further documents released however, with the new Mental Health Bill being released shortly there was a need for the IJB to be able to be flexible.

Mrs Logan reiterated that in simplistic terms the intention was to focus the £2m on the agreed themes around the pathways and delivering efficiencies, and within those broad themes there was much activity and staff engagement taking place.

Mrs Jane Davidson echoed that it was about changing the approval levels from the IJB down with the EMT being able to approve spend on projects and the IJB ratifying that approval over a certain level, and holding the EMT to account. She reiterated that it was essentially about taking away layers of bureaucracy at the lower levels.

Mr Raine commented that he was supportive of reducing layers of bureaucracy below the EMT, but had not found that to be clear within the paper. Provided the IJB retained the ability to ratify the schemes proposed by the EMT as had been previously agreed he was content to support the recommendation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified the proposals.

8. Health & Social Care Delivery Plan

Mrs Elaine Torrance gave an overview of the content of the paper and highlighted the 4 programmes: Health and Social Care Integration; The National Clinical Strategy; Public Health Improvement; NHS Board reform; and their key targets.

Discussion focused on: the reorganisation of territorial health boards; regional delivery of acute services; local planning and delivery of primary and community services; potential for both regional and local back office shared services; publication of a workforce plan in the spring of 2017; ageing workforce; and creation of generic roles across the health and care system.

Dr Stephen Mather suggested the biggest impact on peoples' lives was public health and he urged commitment and support for public health to achieve the aims set out on page 27 within the national report.

Mr David Davidson enquired if commitment were given to support the public health agenda, if Live Borders should be involved with the IJB? Mrs Tracey Logan advised that there were already strong links to Live Borders in place and she would be happy to provide an update to the IJB if it wished.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Report which would inform local progress.

Cllr Graham Garvie left the meeting.

9. Locality Planning Progress Report

Mrs Elaine Torrance presented the report advising that it detailed progress made by the 3 locality coordinators in their areas and in relation to the locality action plan. She sought comments from the IJB on the draft info graphic.

Mr David Davidson suggested there needed to be more of an interface with the GP community as they were the gateway into the NHS. Dr Angus McVean suggested the locality coordinators attend the GP Cluster meetings and connect with the Quality Cluster Leads when appointed. In the meantime he advised that there were Practice Quality groups in each

cluster and to date there had been very limited engagement from the locality coordinators. He urged attendance of the locality coordinators at the GP cluster meetings.

Cllr Frances Renton commented on the disparity of data between Berwickshire and the Scottish Borders on the info graphics. Mrs Torrance advised that sometimes the data reflected the general population as well as the more local data and that it would be used to inform the work in the locality areas. Mrs Jane Davidson welcomed the info graphics and capture of locality data to help understand and change the shape of the Borders where required.

Mrs Karen Hamilton enquired about co-location in terms of sharing electronic information and systems. Mrs Tracey Logan advised that Information Technology remained a challenge to the partnership. She assured the IJB that IT was a focus of the EMT and significant work was underway to bring together both the NHS and Framework systems.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made by Locality Co-ordinators in relation to Locality Plans, integrated teams and communication and engagement.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and commented on the summary Locality Action Plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** endorsed the proposal to hold a launch event following final approval of the Locality Plans.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Locality Co-ordinators work plan and timescales for implementation.

10. NHS Borders 2016/17 Festive Period Report

Mr John Raine commented that when the report had been considered by the Health Board the previous week it had recognised the good analysis that had taken place and the further lessons to be learnt for the future.

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

11. Inspections Update

Mr Murray Leys reported that the on site inspection scrutiny week had concluded at the end of the previous week. The next critical date was 17 March when the inspectors would return for professional discussions and feedback. The overall impressions received from staff had been that the Inspectors had been open to listening and had some good things to say about practice. The Inspectors had acknowledged the support that staff had given to them, especially in terms of admin and business support from both Scottish Borders Council and NHS Borders.

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

12. Monitoring of the Health & Social Care Partnership Budget 2016/17 at 31 December 2016

Mr Paul McMenamin gave an overview of the content of the paper and reported that at 31 December 2016, the delegated budget was reporting a projected outturn of £139.893m against a budget of £139.150m resulting in a projected adverse variance of £0.743m in total. It accounted for the projected impact of the recovery plan which had been implemented across healthcare functions. As previously reported to the IJB in January, the total projected value of the recovery plan across delegated healthcare functions was £4.154m. That was a significant achievement in the contexts of substantial financial pressure and limited flexibility.

Mr McMenamin further advised that in order to give certainty in planning and delivery in 2016/17, the Executive Management Team had agreed to recommend to the IJB that it direct the remaining 2016/17 social care funding without delay. In the unlikely event of the funding, in whole or part, not being required however, the partnership may wish to agree a Reserves Policy under which it may carry forward the unutilised resource alongside any uncommitted Integrated Care Fund monies.

The Chair clarified that it was not the intention to use any unused Integrated Care Fund monies to balance the budget. Mr McMenamin confirmed that was not the intention.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and the monitoring position on the partnership's 2016/17 revenue budget at 31st December 2016.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the reasons for recommending the direction of the remaining social care funding allocation for 2016/17 in order to enable certainty and assurance over the planning to mitigate the remaining healthcare and social care pressures during the remainder of the year

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the direction of the balance of the social care funding £677k in order to mitigate the current projected residual pressure within the healthcare and social care delegated budgets

Jane Davidson left the meeting.
Tracey Logan left the meeting.
Cllr Graham Garvie returned.

13. Health & Social Care Medium Term Joint Financial Planning Strategy and Reserves Policy

Mr Paul McMenamin gave an overview of the content of the paper advising that the report set out the framework for future effective joint financial planning arrangements and timescales for the IJB and its partners and to seek approval of its policy for maintaining reserves and the carrying forward of resources.

The Chair enquired if there would be a supporting risk register. Mr McMenamin confirmed that the IJB had both a strategic risk register and a supporting financial risk register.

The Chair noted the level of balances quoted was between 2%-4% and suggested there should be no lower level and it should be up to a maximum of 4%.

Mrs Jill Stacey confirmed that the IJB Audit Committee would review both the strategic risk register and the supporting financial risk register.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the medium-term financial planning strategy proposed.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the policy outlining the arrangements for the maintenance of IJB reserves.

Cllr Sandy Aitchison left the meeting.

14. Chief Officer's Report

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

15. Any Other Business

15.1 Health & Social Care Integration Joint Board Development session: 29 May 2017: Mrs Elaine Torrance advised that Professor John Bolton had offered to present his report to the Board ahead of the next scheduled Development session. She advised that she would seek a suitable date.

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

16. 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 27 March 2017 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 4.05pm.

Signature: ……..
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 27 April 2015

Agenda Item: Draft Strategic Plan – A conversation with you

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
1	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to have a Development session later in the year dedicated to revising Commissioning and Implementation Plan and considering plan for 2017/18.	Elaine Torrance	2017	**Update:** Item rescheduled for 25 September 2017 Development session.	A

Meeting held 17 October 2016

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that it would undertake a Development session on clinical and care governance.	Elaine Torrance Evelyn Rodger Cliff Sharp	2017	**In Progress:** Item scheduled for 27 November 2017 Development session.	A

Meeting held 19 December 2016

Agenda Item: Further Direction of Social Care Funding – Borders Ability & Equipment Services

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
11	12	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a further report on the operation of the BAES at a future meeting.	Elaine Torrance	March 2017	**In Progress:** Item scheduled for 27 March 2017 meeting agenda. **Update:** Item rescheduled to 26 June meeting as the report is with NHS National Services Scotland for review.	A

Meeting held 27 February 2017

Agenda Item: Transformational Programme

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
12	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation and agreed to receive an update at the next meeting.	Elaine Torrance	March 2017	**In Progress:** Item scheduled for 27 March 2017 meeting agenda.	A

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

	Integration Joint Board meeting

This page is intentionally left blank

Scottish Borders
Health and Social Care
PARTNERSHIP

INTEGRATED CARE FUND UPDATE - March 2017

Aim

1.1 The aim of this report is to provide the Executive Management Team (EMT) with a brief update on the Integrated Care Fund (ICF) as well as seek approval for funding for three further proposals.

Background

2.1 The ICF was first allocated to the shadow partnership in 2015/16 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of **£6.39m** over the 3 years of the programme. Between 2015 and 2017 a number of projects have been approved with a combined spend of **£683k** over this time. Analysis of the spend to date is detailed in **Table 1**.

Table 1 – Summary of ICF Projects Approved to Date

	Approved Projects		Approved
1	Community Capacity Building	£	400,000
2	Independent Sector representation	£	93,960
3	Transport Hub	£	139,000
4	Mental Health Integration	£	38,000
5	My Home Life	£	71,340
6	Delivery of the Autism Strategy	£	99,386
7	BAES Relocation	£	241,000
8	Delivery of the ARBD pathway	£	102,052
9	Health Improvement (*phase 1*) and extension	£	38,000
10	Stress & Distress Training	£	166,000
11	Transitions	£	65,200
12	Delivery of the Localities Plan (18 mths)	£	259,500
13	Locality Managers x 1 locality for 1 year	£	65,818
14	H&SC Coordination x 1 locality for one year	£	49,238
15	Community Led Support	£	90,000
16	The Matching Unit	£	115,000
17	RAD	£	140,000
18	Transitional Care Facility	£	941,600
19	Pharmacy Input	£	97,000
*	Programme Delivery	£	580,458
	Total	**£**	**3,792,552**

*Please note: additional resources have been required in order to provide data analysis for the development of the Strategic Commissioning Plan, Annual Performance Reporting and to complete the Pathways Analysis

Update

3.1 The remaining ICF balance is **£2.597m.** A decision was ratified by the Integration Joint Board (IJB) in December 2016 to close the ICF to new bids in order to enable the EMT, with IJB ratification, to direct funding to deliver transformational and strategic priorities – primarily focusing on the care pathway, dementia and transformation. Proposals for funding to support these key priority areas will be presented to the IJB for ratification over the coming months.

3.2 Subsequent to this, there are three further proposals for ICF funding which are in line with the Partnership's key priorities and which represent a further spend approval of **£223k**. A summary of these proposals is detailed in **Table 2** below:

Table 2

	Proposed for Approval		
20	**GP Clusters Project**	£	50,000
21	**Pathways**		
	Domestic Violence Pathway Project	£	120,000
	Care Pathways and Delayed Discharge consultancy	£	7,000
22	**Alcohol & Drug Partnership Transitional Funding**	£	46,000
	Total Additional Funding Requirement to 31.03.17	**£**	**223,000**
	Budget	**£**	**6,390,000**
	Resource Remaining Uncommitted	**£**	**2,374,448**

GP Clusters Project

3.3 In October 2015 the Scottish Government announced that the Quality and Outcomes Framework which had been a fundamental part of the Scottish GP Contract was to be dismantled. In its place, Scottish Government has introduced Transitional Quality Arrangements (TQAs) – at the core of this approach is the establishment of GP "cluster working" which will be closely linked to the health and social care integration agenda. Indeed the expectation is that GP practices and GP clusters will have oversight and direct involvement in improving the quality of all health and social care services provided to patients registered within their locality.

3.4 Local GP practice, professional and advisory structures in liaison with health and social care were tasked with identifying appropriate cluster formation and in Scottish Borders the proposal is for 4 clusters – East, West, South and Central. Each GP Practice is required to have a Practice Quality Lead (PQL) which, apart from any work requested beyond what is specified in the GP contract, will be funded as part of core GMS resource.

3.5 Partnerships are also required to have Cluster Quality Leads (CQLs) in place and operational by 1st April 2017. This role is critical in terms of filling the existing gap in GP engagement and participation as the Health and Social Care Partnership makes progress towards delivering its strategic objectives and locality plans.

3.6 The national guidance states that the CQL posts will not be funded through core GMS resource and will require funding from out with the GMS funding envelope.

Enquiries have been made to Scottish Government about opportunities to use the Primary Care Transformation Fund (PCTF) to support these roles in Borders but the response has confirmed that the PCTF cannot be used for this purpose, although it has been confirmed that training and development support to the posts can be provided by it.

3.7 It is proposed to utilise ICF funding to establish the CQL posts at 2 hours per week per post and to assess capacity levels against their remit over the initial 12 month period. The cost of this would be circa £50k over one year.

Domestic Abuse Service Pathway

3.8 The Pathway Project brings together the key services required to develop a coordinated community response (CCR) to addressing domestic abuse in the Scottish Borders.

3.9 The project has three main elements:

1) Domestic Abuse Advocacy Support (DAAS) service;
2) Domestic Abuse Community Support (DACS) service ;
3) CEDAR Groupwork programme.

3.10 The DAAS service receives referrals for all victims but actively works and case manages the highest risk victims working to risk assess and safety plan with victims, providing crisis intervention, advocacy and referral on to DACS.

3.11 The DACS service is the long term support, community outreach service, commissioned to Children1st and provides practical and emotional support to adults and children. This service works with the medium to low risk cases, across the five localities in the Scottish Borders

3.12 The CEDAR Workgroup programme delivers a 12 week group-work programme for mothers and their children to recover from and rebuild their lives after domestic abuse

3.13 The main funded outcome for the Pathway:
More individuals who are affected by domestic abuse in the Scottish Borders have increased access to a more comprehensive range of support services.

There are two key outcomes for service users of this project:

- Survivors of domestic abuse feel safer, better supported and more resilient by having increased access to new and improved support services.
- Survivors of domestic abuse feel more supported and empowered to influence and shape services to meet their needs.

3.14 The current funding for the Pathway project ends in March 2017. A Big Lottery Funding application is in process and initial feedback is positive, but this requires confirmation of match funding. This project has requested £40k in 2016/17and in each of the following 2 years to contribute to the match funding required for the Big Lottery Application. The total funding requested is £120k.

3.15 It is recognised that further work is required to redesign domestic abuse services to ensure a sustainable service will be available at the end of this funding period.

Alcohol and Drug Partnership (ADP) Transitional Funding

3.16 In 2017/18, the Alcohol and Drug Partnership forecasts recurring commitments of £1.283m against a Scottish Government allocation of £1.050m, a shortfall of £0.261m. This pressure is directly attributable to a reduction in the ADP funding to partnerships as part of the Scottish Government's Health Board allocation. Over the last year, the ADP has put in place a range of measures aimed at reducing its expenditure profile. In 2016/17, the IJB agreed to the direction of £220k to fund on a non-recurring basis, the shortfall on resources pending redesign of the service. This followed a programme of savings identified by the partnership itself being implemented.

3.17 The ADP has identified and implemented additional savings to further mitigate the current gap and following a number of discussions with the Executive Management Team, has committed to implementing a redesign programme that will deliver £136k savings next financial year. To enable this, EMT has recommended the non-recurrent direction of a further £46k of transitional funding from the ICF in order to allow further work to be taken forward by the ADP to work with commissioned service providers in developing a new model of delivery following service redesign. A report will be brought back to the EMT in early June 2017 on the outcome of this redesign work and reported to the IJB thereafter. If unsuccessful, a more radical programme of savings through service rationalisation will require consideration.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the current expenditure position of the ICF.

The Health & Social Care Integration Joint Board is asked to **ratify** proposals for further ICF funding.

Policy/Strategy Implications	The programme is being developed in order to enable transformation to new models of care and achieve the partnership's objectives expressed within its Strategic Plan and national health and wellbeing outcomes
Consultation	The recommendations to the IJB have been made following consultation with a wide range of stakeholder representatives through the ICF Executive Management Team.
Risk Assessment	There is a risk that if funding for the domestic abuse project is not provided, then significant external funding will be lost to the Health and Social Care Partnership. Without funding for the Drug and Alcohol Partnership's transitional period of redesign, there is a risk that outcomes will be

	adversely impacted and targets will not be met.
Compliance with requirements on Equality and Diversity	There are no equality implications associated with the proposals
Resource/Staffing Implications	The proposals approved within the programme to date will be funded from the ICF grant allocation over its life

Approved by

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Chief Officer for Integration	Paul McMenamin	IJB Chief Financial Officer

Author(s)

Name	**Designation**	**Name**	**Designation**
Jane Robertson	Strategic Planning and Development Manager	Clare Richards	Project Manager
Paul McMenamin	Chief Financial Officer Integration Joint Board		

This page is intentionally left blank

Scottish Borders
Health and Social Care
PARTNERSHIP

Proposal: **PATHWAY PROJECT (Domestic Abuse Service) March 2017**

Project Lead: **Andrea Beavon**

1 Summary

The Pathway Project ('Pathway') brings together in a coordinated way the key services required to develop a "coordinated community response" (CCR) to addressing domestic abuse in the Scottish Borders.

The project has three main elements –
1) the Domestic Abuse Advocacy Support (DAAS) service
2) the Domestic Abuse Community Support (DACS) service
3) the CEDAR Groupwork programme.

The DAAS service receives referrals for all victims but actively works and case manages the highest risk victims working to risk assess and safety plan with victims, providing crisis intervention, advocacy and referral on to DACS.

The DACS service is the long term support, community outreach service, commissioned to Children1st and provides practical and emotional support to adults and children. This service works with the medium to low risk cases, across the five localities in the Scottish Borders

The CEDAR Workgroup programme delivers a 12 week groupwork programme for mothers and their children to recover from and rebuild their lives after domestic abuse

The main funded outcome for the Pathway:
More individuals who are affected by domestic abuse in the Scottish Borders have increased access to a more comprehensive range of support services.

The current funding for the Pathway project ends in March 2017.

The Big Lottery have agreed in principle to consider a Stage 2 application from Scottish Borders Council with a clear set of criteria to support a successful award:
- A funding bid no more than £449,000, over a minimum of three years
- An increase in partner agency contributions and a clear direction of travel in moving to a more sustainable funding model for the Pathway project

This funding must be match funded. It was requested that the ICF provide part of this match funding. Executive Management Team agreed to support the funding allocation from the Integrated Care Fund as per their discussion on 2nd December 2016.

Update: 9th March 2016 – CONFIDENTIAL – Big Lottery have verbally confirmed that they will award SBC £449,000 over three years

2 Reasons

There is clear evidence of continued need for the DAAS and DACS services to enable Scottish Borders to maintain a coordinated community response to addressing domestic abuse. Domestic

abuse incidents reported to Police Scotland have increased year on year, with 904 incidents reported in 2015/16.

Referrals to the DAAS service have also increased year on year with 60% of all referrals coming from Police Scotland. There were a total of 1544 referrals (2012-16) with 30% of these assessed as high risk. DAAS delivered a children/young people's service till 2015, and this supported, face to face, 179 children.

DACS supported 138 adult victims and 67 children/young people over the same period. There were 64 children and their mothers attending and completing CEDAR Groupwork between 2012 and 2016.

The current funding for the Pathway project ends in March 2017.

3 Strategic Alignment

We will make services more accessible and develop our communities.
The Pathway project delivers support via a range of interventions, including telephone based support, face to face, groupwork. Support can take the form of risk assessments, safety plans, information, advice and signposting. Supporting victims with multiple and complex needs is a core tenet of the Pathway in recognition that not all victims can access support due to factors such as age, disability, rural isolation, ethnicity, sexuality etc. Face to face work is delivered in a locality easily accessed by victims and their families.

We will improve prevention and early intervention.
All referrals received by DAAS are responded to within a 24hour period of any police incident, or 48 hours of any partner agency referrals. Standardised risk assessments and safety planning identifies quickly ways to ensure victims are safer, and these are reviewed weekly. Early engagement with services has been shown to significantly reduce further risk of harm as it avoids minimisation of risk by the victim

We will reduce avoidable admissions to hospital.
There is no direct evidence that engaging with pathway services directly avoids hospital admissions but victims report less physical violence and therefore potentially fewer visits to hospital. There is no data collection that ties up admissions to hospital directly with the impact of support from Pathway services

We will provide care close to home.
Pathway services strive to ensure that travel for victims is minimised and often accessing support is risky for some victims, therefore good partnership working with health/GP surgeries enables creativity in planning face to face meetings

We will seek to enable people to have more choice and control.
All support work in the Pathway is delivered from the ethos of empowerment, choice and taking control, these are the key principles of advocacy and domestic abuse work

We will further optimise efficiency and effectiveness.

An external evaluation of Pathway detailed ways in which more effective use of time, resources can be achieved e.g. use of database, telephone support, groupwork. Training staff to increase resilience within small teams improves efficiency in light of resilience issues

We will seek to reduce health inequalities.
Pathway services are delivered from an understanding that gender inequality is both a cause and consequence of domestic abuse, and that in order for recovery to begin, victims and their families are afforded safety in the first instance and then within a trauma recovery model, are supported to move on, reconnect and reintegrate into their communities. The health inequalities that exist are clearly identified in support plans, safety plans and long term goals for victims

We want to improve support for Carers to keep them healthy and able to continue in their caring role
Domestic abuse victims in a caring role have significantly complex and multiple needs, whether caring for a child, parent or the person causing risk. Long term work, helping the carer "see" the difference between abuse, control and caring impact can improve their coping mechanisms.

4 Options

The funding model created for Pathway 2 (2017-20) has been designed to ensure funders are clear about their contribution, we move reliance away from external funding, and build a strong foundation for sustaining services long term. The Pathway 2 model for the next three years is also based on an External Evaluation, which identified gaps in the current provision.
Exit strategies for services are developed, and until a final decision is received from Big Lottery (March 2017) and Scottish Government (May/June 2017), current service provision will continue on a month –on-month basis.

Use the Integrated Care Fund to part fund the match funding required - £120k over 3 years

5 Expected benefits

Outcome 1
Survivors of domestic abuse feel safer, better supported and more resilient by having increased access to new and improved support services.

Outcome 2
Survivors of domestic abuse feel more supported and empowered to influence and shape services to meet their needs.

6 Expected dis-benefits

There are no expected dis-benefits

7 Risk

The big lottery funding and Scottish Government funding may not be approved, however, there is potential to use ICF funding and other partner agency funding to continue elements of Pathway 2.

8 Cost

A Pathway Project Board, established in August, proposed the following funding arrangements which have been submitted with the Stage 2 application:

Integrated Care Fund NHS)	**£120,000 over 3 years (this equates to £20k a year for both SBC &**	
Borders Housing Alliance	£30,000	
Police Scotland	£45,000	
Children1st	£51,000	
Scottish Government	£120,000	application March 2017
Big Lottery	£449,000	confirmed

9 Timescales

Funding decisions expected in March 2017. The project is already running, so will continue and run for the following 3 years.

10 Sustainability

A full scale review of domestic abuse services will commence in 2017/18 with the aim of ensuring sustainable funding solutions for the range of services at local level.

11 Equality Impact Assessment

No changes to services currently provided.

Scottish Borders
Health and Social Care
PARTNERSHIP

ANNUAL PERFORMANCE REPORT 2016/17 - UPDATE

Aim

1.1 To update the Integrated Joint Board (IJB) on the progress of the development of the Partnership's Annual Performance Report.

Background

2.1 It is a requirement for every Health and Social Care Partnership to publish an Annual Performance Report for 2016/17 by 31 July 2017. The required contents are set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 and must include reports on the following:

- Assessment of performance in relation to the 9 National Health and Wellbeing Outcomes;
- Financial performance and best value;
- Performance monitoring;
- Reporting on localities;
- Inspection of services;
- Review of strategic commissioning plan (if applicable).

Summary

3.1 Following extensive engagement with Senior Managers across the Partnership an initial draft report has been produced (see **Appendix One**). The content includes all of the legally required elements and the structure and feel of the report is similar to the Partnership's Strategic Plan.

3.2 There are some elements of the report that are incomplete - partly due to challenges in accessing information however mainly due to information not being available until the end of March 2017 i.e. the year end accounts. Other sections of the report cannot be finalised until all sections of the report are fully populated i.e. the Executive Summary. The case studies and infographics within the report are shown as examples so are subject to change and there is still work to be undertaken to reduce the text in the objectives section.

3.3 The timeline for the development and publication of the report is detailed below:

- Initial draft report feedback from EMT and IJB – end of March 2017;
- Final word version sign off by EMT - end of April 2017;
- Final word version sign off by IJB – by email – early May 2017;
- Financial information added – mid May 2017
- Sign off by EMT – mid May 2017;

- Graphics version development – end of May 2017;
- Final PDF version sign off by EMT - early June 2017;
- Final PDF sign off by IJB – end of June 2017;
- Publish – end of July 2017;
- Launch – August 2017.

3.4 The timeline is tight and any slippage in achieving sign off at any stage will risk the report not being finalised and ready for publication by end of July 2017. This will contravene the requirement for publication of the report as laid out in the legislation.

Recommendation

The Health & Social Care Integration Joint Board is asked to **comment** on the content, structure and format of the draft Annual Performance Report.

The Health & Social Care Integration Joint Board is asked to **note** the timeline for the development and publication of the report.

Policy/Strategy Implications	This report gives an update on progress of the delivery of the Partnerships strategic objectives as laid out in the Strategic Plan.
Consultation	The document has been developed with colleagues from across the partnership and third sector.
Risk Assessment	There is a risk of delay and not meeting the statutory publication date if the approval dates for the final versions of the document are not met.
Compliance with requirements on Equality and Diversity	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.
Financial Implications	This will be covered in the final report.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer for Integration		

Author(s)

Name	Designation	Name	Designation
Jane Robertson	Strategic Planning and Development Manager	Clare Richards	Project Manager

DRAFT

Scottish Borders Health & Social Care Partnership

Annual Performance Report 2016/2017

Scottish Borders Health and Social Care Partnership Annual Performance Report 2016/17

Contents

Foreword

Updated photo of Elaine to go here

1 page Foreword to be written once main body of report is populated.

Elaine Torrance
Interim Chief Officer, Health and Social Care Integration
Month 2017

Executive Summary

1-2 page Executive Summary to be written once main body of report is populated.

The year at a glance

1-2 page infographics section to go here. This will contain some key points/highlights/performance data for 2016/17, which will be drawn from across the main body of the report once it is populated.

Suggested items – Continued roll out of SDS stats (Gwyneth)
Joint Older Peoples Inspection good practice areas (Sandra)

Spotlight: Localities Planning

There are five commonly recognised localities in the Borders, these were based on five existing area forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale.

Map showing our five Area Forum Localities (with all towns and villages with a population of 500 or more).

Source: © Crown Copyright, All rights reserved, Scottish Borders Council, Licence 100023423, 2015

There is a need to change the way that Health and Social care Services are delivered across the localities of the Borders. The need to change is due to three key issues:

- The increasing demand for services - due to an ageing population

- Increasing pressure on limited resources – due to the rise in the demand
- Improving services and outcomes for service users – due to changing service user expectations and the desire to provide a better experience.

Locality planning is a key tool in the delivery of the changes required to meet the changing service demands within the Borders.

Since April 2016 Locality Coordinators have been working within the 5 localities to:

- 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 existing services, where there are gaps and develop action 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 and develop proposals for the redesign of health and social care services.

In the past year significant progress has been made in all of these areas. Initially the Locality Coordinators spent time within each of their localities, engaging with local communities, gaining local knowledge and gaining interest and representation for their working groups.

Since September 2016 five locality working groups have been meeting on a monthly basis. The members of these groups have the responsibility for planning and delivery related to health and social care integration and improved well-being at an operational level. Their primary function is to be responsible for the planning, design and delivery of the locality plan for each Locality, in line with the Partnership's Strategic Plan and Scottish Government Locality Guidance. Their secondary function is to lead their staff within each service/ organisation towards service redesign in line with agreed action plans. The locality working groups have clear terms of reference and agreed memberships, which covers a broad cross section of the identified key stakeholders.

A communications plan is in place with a clearly defined stakeholder list and action plan. Communications activity has been wide ranging covering an extended distribution list ranging from partnership staff to community councils, area forums and participation networks.

From December 2016 there has been an extensive period of consultation with frontline health and social care staff regarding the co-location of teams. The feedback from the sessions was positive with staff stating that they were ready and willing to change their ways of working, that the staff on the ground want to progress with co-located teams and that they are not discouraged by identified challenges.

The next step for the Locality Coordinators is to finalise their locality plans and support the implementation of them.

Overall, the locality coordinators have contributed to the provision of services in the localities by:

- Contributing to the design/planning of co-located integrated teams.
- Developing locality plans.
- Contributing to other integrated redesign activity including the Community Led Support Projects and the development of a pilot of the nursing led Buurtzorg programme.

"These Draft Health and Social Care Locality Plans are the blueprint for the Health and Social Care Delivery Plans which will be written for the five localities, specifically tailored to local needs. These plans are outcome focused looking at what these services are going to bring to the communities not only in terms of services but also in terms of better well-being and quality of life."

Trish Wintrup – Locality Coordinator

"If carers and nurses could work together in one team then care could be provided in a more seamless way to deliver person centred care"

Jeanette Forbes -District Nurse

For more information on Locality Planning within Borders please contact Christopher Svensson (H&SC Partnership Project Support Officer) Christopher.Svensson@scotborders.gov.uk

Spotlight: Community-Led Support

Since September 2016 the Health and Social Care Partnership have been working with the National Development Team for Inclusion (NDTi) to deliver an 18 month programme of change in the way that health and social care services are provided across the Scottish Borders.

The Community Led Support model works on the principle that frontline community health and social care support and services can be delivered from "Hubs" based in our local communities. The aim being that this will make the first point of contact for services more visible and accessible for local people. The programme will further develop existing access such as Customer Services and Social Work Duty Teams; build capacity amongst the community and voluntary groups and organisations that already connect with people and establish new places within the communities where people can both drop in and have booked appointments with professionals.

The concept is that at these "hubs" members of the public will be able to have an effective conversation with someone about their life, what matters most to them and things they may be struggling with. They will be able to obtain information and advice about how to get back on track, places and people who might be able to help and where required, have quick and efficient access to Health and Social Care services.

By adopting this approach we will: put what matters to people first; make health and social care more visible in communities; build on people's skills and on community assets; remove waiting lists; increase early intervention and prevention; simplify pathways and processes and better target professional's time.

In summary, Community Led Support seeks to change the culture and practice of community health and social work delivery so that it becomes more clearly value driven, community focussed in achieving outcomes, empowering of staff and a true partnership with local people. This model strives to **support people to live their lives, their way.**

By working in this way: It will enable us to work together which is better for our communities and our staff; allow us to follow The Public Bodies (Joint Working) (Scotland) Act 2014 – which sets the framework for integrating adult health and social care services; ensure Health and social care services are planned and delivered seamlessly from the perspective of the service user or carer and enable a greater focus on prevention, early intervention, building resilient communities whilst using a locality based approach.

Experience of delivering this model in England and Wales has resulted in reduced bureaucracy, better outcomes for individuals and cost savings. Feedback from staff so far is overwhelmingly positive, with professionals talking about increased job satisfaction through staff having the time to get back to "good old fashioned social work".

Progress

Throughout November, we have worked with NDTi to run engagement sessions across the Scottish Borders. The aim of these sessions was to introduce the idea of Community Led Support, to show how this programme will bring health and social care services into local communities so that they are more accessible to all. In total 233 people attended these sessions with representation from staff, various organisations, the voluntary sector and members of the public. Attendees were asked where they feel the "heart" of their community is; where communities meet and if they are any key "go to" people. They were also asked what they thought the "challenges" were in taking this programme forward in their locality.

These engagement sessions were followed by a planning Day which was attended by a range of individuals from across the Partnership, Housing, Customer Services, Third Party and Voluntary Organisations as well as members of the public. The purpose of this session was to begin detailed planning for how the Community Led Support model is to be implemented locally – what is it actually going to look like on the ground throughout the communities of the Scottish Borders. The session was shaped around the four most prominent challenges gathered from the engagement sessions: rurality, communication, processes and mind-set.

The planning day also covered what skills, resources and support people would need to have in order to have an effective conversation in the "hubs". The session also touched on where we would like the project to be in a year's time.

The third step in the process was an evaluation day to agree; what good looks like, in relation to our vision for and outcomes from community led support arrangements; the changes that need to happen to get there; how we will know when we've got there; how we will measure and communicate what's working and for whom; what's not working so well so we can 'test and learn' and who will do what, how and when.

This enabled the creation of working groups which were tasked with the delivery of certain aspects of the plan.

This programme of change is still in its infancy, and is expected to take 18 months to fully embed but it is expected that changes will be seen by local communities within the coming months.

> "In other areas CLS has proved to be a really effective and efficient use of resource. In fact some areas have seen waiting lists for social work services disappear"
>
> Murray Leys – Chief Officer – Adult Social Work SBC

> "By listening to people and focusing on what matters to them we can really make a difference"
>
> Shirley Cusack – NDTi

A short video outlining the Community Led Support project in the Scottish Borders can be found at https://www.youtube.com/watch?v=9pLDWoqx0Kk

If you would like more information on this project please contact Nicki Tait (H&SC Partnership Project Support Officer) at NTait@scotborders.gov.uk

Scottish Borders is one of three Councils in Scotland embarking on this programme of change, for more information see http://www.ndti.org.uk/major-projects/current/community-led-support/

Spotlight: Buurtzorg - Neighbourhood Care

Buurtzorg is a model for community care that was started in the Netherlands. In the Netherlands the model is based on self-organising teams of no more than 12 community nurses who manage a case load in a specific community. The ethos is an enabling approach where their aim is to support self-management through the use of both formal and informal networks that the client has access to. In the Borders we are aiming to pilot this in partnership where we can meet the needs of health and social care with a holistic and enabling approach in our communities.

Progress

We have held events to raise awareness of the model and also engage with local communities to assess their willingness to test this new way of working. We have held four events so far: on the 29th of September in Coldstream Community Centre; 30th of November in Burnfoot Community Hub and in the Mac Arts Centre in Galashiels; and a meeting with the team in Newcastleton. Over 150 people attended altogether from different agencies, the voluntary sector and members of the local community.

At each event we asked all participants if they would like to see Buurtzorg trialled in the Scottish Borders and it was a majority yes from every area. Some attendees also suggested that we adopt the principal of Buurtzorg Plus which would enable us to tailor the model to each community's needs.

Some of the positive thoughts and questions asked are noted below:

Positive Thoughts	Queries and Concerns
The patient is at the core of this model not the tasks.	How do we finance this?
Staff will feel valued and increased job satisfaction	How would this work in Scotland?
Solution based	NHS Borders is very hierarchal, how would this work with "banding"
Holistic care vision.	What are the roles of the carers, social workers and Allied Health professionals?
An exciting model to test and support in the Borders.	Wi-Fi connection in the Borders is problematic in some rural areas. IT in general.
Trust and respect amongst colleagues	How will shift patterns work?
When can we start!	

Next Steps

We held a Buurtzorg Design Group on the 27th of January with colleagues from NHS Borders, Scottish Borders Council and SB Cares to discuss future plans. This also gave attendees a platform in which to raise

some unanswered questions. We are in the process of scheduling another planning meeting with key stakeholders to talk more about implementation and where our test site will be.

Training will be provided for the pilot team/s on the model in March/April. We are progressing a plan for implementation which includes a Design Day with partners. This will outline how we can support a self-organising approach that reduces bureaucracy to enable teams to deliver improvements in a person-centred holistic model to both health and social care in the community.

Awaiting Quote....

More information on the Buurtzorg approach can be found at https://www.rcn.org.uk/about-us/policy-briefings/br-0215

Performance against key priorities for 2016/17

The partnership has continued to focus on reducing the number of delayed discharges and reducing the number of inappropriate admissions to hospital. A key focus of this work has been mapping care pathways from hospital to community to identify any potential blocks in the system and seek solutions. This will continue to be a priority over the coming year as further redesign is undertaken to streamline the pathway, provide a wider range of intermediate care/enablement approaches and also make best use of resources.

A number of specific priorities for the partnership were identified for 2016/17. The Integrated Care Fund (ICF) of £2.13m per year has been used to assist, support and develop the integration of Health and Social care services and below is a summary of progress on key priority actions.

- The transport hub - Scottish Borders Council, NHS Borders, The Bridge, The Red Cross, Berwickshire Association of Voluntary Services and the RVS are partners in this project to put in place a co-ordinated, sustainable approach to community transport provision. The Community Transport Hub has provided a single point of contact, provided a single vehicle booking system and has developed a volunteer base. In its first year the hub facilitated 482 journeys, facilitated 150 journeys to hospital appointments and reported improvements in wellbeing of service users and volunteers.
- To integrate services at a local level. Three locality co-ordinators have been recruited to develop locality plans and consult with professionals and local communities. Progress has been made to identify opportunities for co-location and mapping of resources.
- To roll out care co-ordination to provide a single point of access to services. The Community Led Support programme commenced in September 2016.The aim being to make health and social care services more accessible within local communities. The project has to date delivered 12 engagement sessions across the borders, gathered the information provided and is now planning how to implement and evaluated the programme. Significant progress has been made in consulting with communities and key stakeholders to establish community hubs to enable easier access to advice and services. The first two of these are to open in April 2017.
- To improve communication and accessible information across groups with differing needs. Local area co-ordinators for mental health, learning disability and older people have enabled more people to access local community activities and to provide good local information.
- Work with communities to develop local solutions. The ICF fund has supported a community capacity building team who have worked with communities to develop local solutions. A toolkit on co-production has been developed through the CPP supported by an e-learning package to enhance staff skills in this area and promote this approach.
- Stress and distress project – The Stress & Distress Project provides training in an individualised, formulation driven approach to understanding and intervening in stress and distressed behaviours in people with dementia. Since April 2016 this project has provided training to 186 staff from the

hospital and care home setting. Over the 2 year term of the project training will be provided to 700 staff, including those from care homes, the third sector and not for profit organisations.

- Further develop our understanding of housing needs for people across the borders. A housing strategy for older people is now under development following a robust business case detailed planning is now in place to build a new extra care housing development in Duns, scheduled to be completed in 2018.
- To promote healthy and active living. The Borders Healthy Living Network works in three of our deprived communities, with community members and other partners to develop a range of activities: cooking skills sessions, food coops, activities such as walking football, reminiscence groups, and volunteering development. The Healthier Me network of learning disability service providers continues to work with service users on health eating and active living. Pathways and formal referral routes from health care to physical activity sessions in the community are now in place. Routes from hospital services to smoking cessation advice and to the Lifestyle Adviser Support have been improved. A comprehensive equality impact assessment of screening services is being undertaken to identify improvements required to extend reach and uptake in key vulnerable groups. Borders Community Capacity Building Team - Projects range from Curling and walking football to lunch clubs and have reported significant increases in wellbeing and physical activity as well as providing opportunities for older people to socialise. Further work is underway to develop intergenerational projects around IT. 86% of participants stated that the gentle exercise classes had improved their fitness and 67% of men said that walking football had increased their fitness.
- To improve the transition process for young people with disabilities moving into adult disability services. A project manager has been appointed and mapping workshops have been held to review the pathway and produce an improvement plan to be implemented.
- To improve the quality of life of people with long term conditions by supporting self-management and promoting healthy living. The evaluation of an Integrated Care Fund funded pilot initiative on supported self-management has provided valuable learning on the development required in pathways and in staff knowledge and skills. This is being integrated into the planning of our locality services. A new initiative is being trialled on diabetes prevention that provides health coaching support and subsidised exercise for those newly diagnosed. Mental health rehab services have developed standardised health assessment and care planning tools to support the health and wellbeing of clients with significant mental health issues.
- To improve support for carers within our communities. The partnership has continued to support the Carers' Centre who offer practical support and advice to carers as well as undertaking carer's assessments. The transitions work has also focused on carers/parents as a key partner in this work.
- Promote support for independence and re-ablement so that all adults can live as independently as possible. The ICF fund has supported the upgrading of a local care home and opening of 11 intermediate care/transitional care beds focusing on improving the skills and confidence of older people with the key aim of returning home. In addition, two care homes in other localities have identified the potential to provide 9 transitional care beds and work is now underway to establish them fully. In order to improve the efficiency of the supply of equipment to allow people to live

independently in their own homes the Borders Ability Equipment Store is being relocated to a purpose built building. This will have an impact of reducing preventable hospital and care home admissions.

- Should we say anything around the development of GP clusters?

Progress against our local strategic objectives

The Nine 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:

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: www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

In order to deliver the 9 National Health and Wellbeing Outcomes, the partnership in 2016, agreed 9 Local Strategic Objectives:

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

The table below demonstrates how these local objectives map to the national health and wellbeing outcomes.

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									

When reviewing the activities of the partnership over the past year, we have listed the activities under the objective on which they have had the greatest impact. However, many activities deliver across the range of objectives.

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.

- Development of GP Cluster model and Custer Quality Leads – in line with the Transitional Quality Arrangements in the revised GMS contract. A 4 cluster model has been identified and all Practice Quality Leads are in place. The Cluster Quality Lead appointments are underway. This overall model will work in partnership with the localities and locality planning processes.
- Throughout Scottish borders and across services there are community capacity and Local Area Coordinators teams. These teams work within communities to build relationships, increase resilience and develop the capacity of local communities.
- Improvements in the access, range and quality of information across all partnership services are being made for example development of easy read leaflets and information.
- A range of training is provided to staff and partnership organisations to improve accessibility and develop community capacity, one example is the delivery of a training programme that offers a whole range of training from basic introductory training for front line reception staff all the way to specialist champion training for those working directly with people hearing and sight loss.
- Community Led Support Project will give easier access to health and social care services and information by providing hubs/ talking points across the five localities.
- A long term conditions project was developed working in two GP practices. This provided a generic pathway to support those with a new diagnosis of a Long Term conditions which included better information, sign-posting or referral for additional advice and support.
- Early work in the reimagining day services project has identified the need for good information and support for people to make community connections effectively
- Integrated mental health teams provide locality based health and social care community mental health teams. The teams are co-located and are currently developing working practices to improve support to patients/clients.
- Promotion of mental health awareness and literacy through community based activities and capacity building through Healthy Living Networks and Community Learning & Development.
- There is a strong commitment to work in partnership with communities in order to continue to deliver high quality and improved services. For example service users and carers can get involved in the design and development of services locally through local citizens panels.
- A key priority for the partnership is to improve care pathways across services. For example the development of the Transitions Pathway for young people who will require support from the Adult Learning Disability service.
- Improved opportunities for employment and volunteering through initiatives such as a 1 year pilot program called Project Search. This supports 8 interns to gain employability skills by working in real work environments.

- The older adult mental health services are delivered via locally based health and social work teams across the Borders. The teams promote, support and deliver a range of services which engage with people with dementia and other mental health needs within their own locality.
- There are a range of support available in community settings including dementia clinics, neuro psychiatric assessment clinics, home based memory rehab service and dementia cafes.
- The Borders Dementia Working Group is a service user led group, which is key in campaigning, raising awareness, reducing prejudice and stigma, influencing policies, and providing a voice for people with dementia.
- Within the localities across the Borders "Lifestyle matters" groups run supporting the regaining of skills and groups improving and maintaining mood, anxiety management and improving self-esteem for people with dementia or with problems related to mood, anxiety or depression.
- Work has been undertaken with a wide range of partners to assess local housing needs, agree priorities and define ideas and solutions to deliver a shared vision for housing in the Borders.
- Significant efforts made and improvements in the warmth and comfort of many homes across the Scottish Borders.

Voluntary Sector

Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the APR.

Key Challenges faced by the partnership when delivering against objective 1 are:

- Ongoing fuel poverty
- Challenging budgets and changes to living wage implications, looking to provide support differently to traditional models e.g. day centres, employment and volunteering opportunities and reviewing current arrangements e.g. social enterprises and Opportunities for people (Learning Disabilities team)
- Access to volunteers for community led activities.

Case Studies

Project Search case study

Project search case study – details to follow.

OBJECTIVE 2 - We will improve prevention and early intervention

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

- The Lifestyle Advice Support Services (LASS) support people to make healthy behaviour changes such as smoking, diet, alcohol consumption and physical activity.
- Individual GP practices have worked as partners with the Long Term Conditions Self-Management project, supporting people to be more involved with and responsible for their care management. The project has shown a 21% improvement in wellbeing for service users and a 31% reduction in the need for contact in GP practices involved in the project.
- Red Cross Neighbourhood Links workers signpost and enable people to understand what support networks are available within their local communities.
- Caring for Smiles – this is a dental programme which offers older people information and support in looking after their teeth and dental health.
- "Meet Ed" pocket guides have been developed and distributed through a range of venues and organisations across the region. They offer the public information and guidance about where to find the support they need e.g. when to go to the pharmacist, when to contact a GP, self-help guidance, when to go to the Emergency Department.
- Podiatry has developed a public website where resources and advice are available to support people to manage their foot care.
- Developed and delivered initiatives on physical activity, on food in local communities through the Healthy Living Network to help people improve their health and reduce isolation.
- Expanded the "small change big difference" campaign to SBC to encourage staff to make changes towards healthier lifestyles and to access health checks.
- Actively promoted referrals from specialist services to services that support lifestyle change (e.g. LASS, quit for good).
- Actively promoted uptake of health screening opportunities, particularly cervical screening.
- A joint project which reflects the national programme to develop anticipatory care planning, is starting to roll out across the Borders. The completion of anticipatory care plans will be user led.
- Transforming Care After Treatment (TCAT) has been piloted in Tweeddale, using a reablement approach to enable people to live as independent a life as possible in their local community following their treatment and recovery from cancer.
- The Borders Falls Steering Group is currently undertaking a shared self-assessment exercise using the 'Prevention and Management of Falls in the Community' tool to inform their 2017-18 Action Plan and identify practice gaps and innovation. We are also planning a consultation framework to involve the public in falls prevention.
- Borders Community Capacity Building have introduced gentle exercise classes (participants aged 40s to 90s), promotion of cycling for older people through Just Cycle charity, establishment of Walking football in the Borders. These activities support people to live at home for longer without reliance upon statutory services.

- Community Led Support will support the objective of early intervention and prevention by providing easily accessible services, which will efficiently signpost people to support services or provide access to health and social care staff.
- The Alcohol and Drug partnership are working to reduce the amount of drug and alcohol use through early intervention and prevention, for example through performing alcohol brief interventions (ABI's) and through regulation of alcohol through the Licensing Board.
- The mental health strategy was developed in partnership with service users, Carers and other stakeholders. It identifies areas of work which ensures a focus on mental health improvement, early intervention and prevention through commissioning and service delivery.
- The local area co-ordinator service (LAC) in the learning disability service works in a range of ways to promote and enable people with LD to live healthier lives and improve their quality of life through addressing the broader determinants of health, such as tackling social isolation and exclusion and developing supportive social networks.
- A key priority within care pathways across services is to improve prevention and early intervention. For example:-
    - A healthier me pathway promotes health behaviour change in people with learning disabilities and their Carers. The LD nursing team continue to progress the projects in their work plan to address health inequalities including: work with the Oral Health team, work to improve diabetes care and support to access screening programmes.
    - A proactive dementia diagnosis pathway for people with Down's syndrome which promotes people with Down's syndrome to take part in screening and assessment from the age of 30 years.
- Post-diagnostic support ensures a focus on early intervention and prevention for people diagnosed with dementia. For example understanding good health and considering lifestyle changes is part of the post diagnostic support pathway, which is available to all those diagnosed with dementia for one year post diagnosis.
- The Homelessness Service:
    - Provides Housing Options advice
    - Provides Short term targeted support via its dedicated Housing Support Team
    - Commissions Penumbra Support Living Service

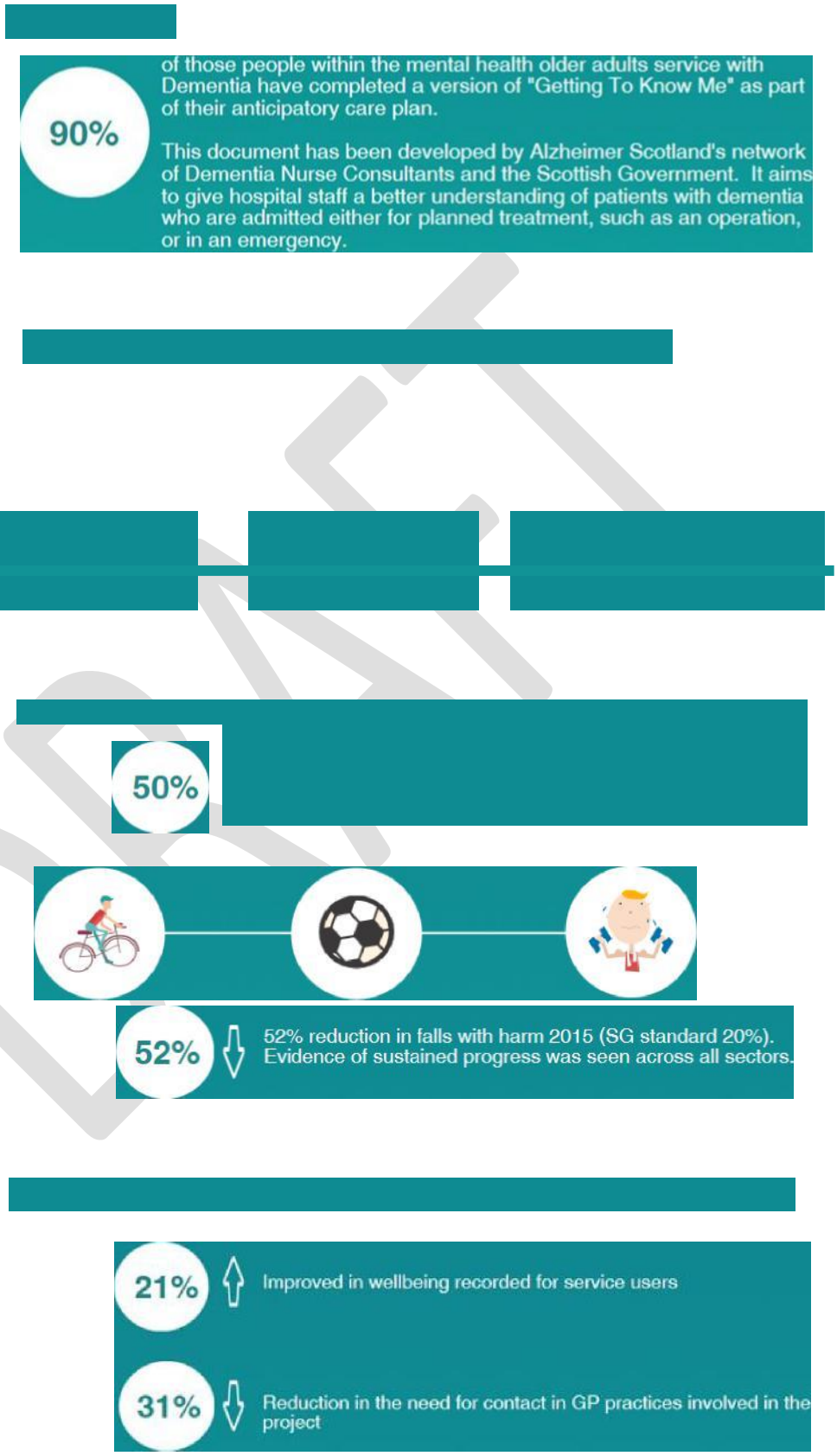
  For people and families at risk of losing or not sustaining their accommodation.

Voluntary Sector

Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the APR.

A key challenge faced by a number of areas in the delivery of this objective is the capacity of their staff and short-term funding arrangements for some projects.

Case studies/stats (example)



Long term conditions project case study

A client was referred by the GP Practise Nurse. They had poor mobility and Arthritis which was affecting their daily life. They were depended on their partner to support them with all aspects of daily life. They declined a referral to carer centre.

A home visit was arranged but the client had a fall outside and was admitted to the BGH, once discharged they were contacted within 24 hours to arrange a home visit with them and their daughter. Leaflets were left regarding Welfare benefits, Borders Care and Repair and Border Care Alarm and discussions held with the family around options of support. Family were left to discuss this.

Daughter contacted Red Cross worker and advised they would like to proceed with a referral for a welfare benefit check. This was processed and they are now in receipt of attendance and carer allowance. During the next few visits we discussed any other issues and they wanted a grab rail on front door to help them get in and out, they also looking for advice about purchasing a 2nd hand rail down the side of their home which they would fund privately. Referral made to Borders Care and repair for Grab rail and also advice about 2nd rail down the side of the home. The grab rail at front door has now been fitted and they have decided not to pursue the private handrail but have an indication of cost.

The client has a positive attitude in regards to their problems and remains very independent but their home life is safer, with no more falls to date, and they have information that may be of use to them in the future with contact details.

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.

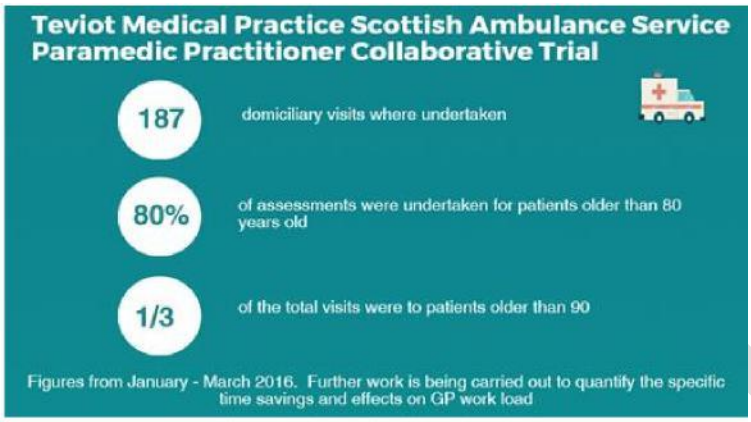
- A review of community & day hospitals is planned following an initial data gathering and analysis exercise commissioned from Professor John Bolton and subsequently from Dr Anne Hendry. This work will help to define the future role of community & day hospitals within the overall patient pathway and will identify the appropriate model of care.
- In Hawick local GP practices are working with the Scottish Ambulance Service to trial and evaluate a model of in-hours response to emergency calls to GPs. This involves specially trained paramedics responding to triaged emergency calls and treating a patient at home which in turn releases GP clinical time to attend more complex cases.
- Lifestyle Advisor Support Service has identified key areas of work for 2017/18 to improve wellbeing and aid prevention of ill health, which includes:
    a. With support and agreement from GPs, offer opportunistic health checks in all GP surgeries.
    b. Following a successful trial, fully implement the new adult weight programme Weigh 2 Go Borders which combines a number of evidenced based approaches offering wider options to the clients.
- The Buurtzorg model of care will be trialled and evaluated in specific locations. It will see primarily nurse-led services supporting people to receive care and manage their own care within their local communities.
- Funding provided for the implementation of Prescription for Excellence has been used to establish a medicine review service in community pharmacies and is currently available in 28 out of 29 pharmacies. The aim of this service is to increase the clinical role of the community pharmacist and deliver direct patient-centred care which will support more people to be seen within a community setting rather than attending or being admitted to hospital or attending GP surgeries for these aspects of care.
- Initial work is underway to redesign pathways for within hospital, through the discharge process and in the community. This work will establish gaps or blockages in the pathways and put in place processes/services to improve the patient flow along the pathway.
- A Rapid Assessment Discharge team is in place at the front door of the Borders General Hospital. The team arrange functional support for patients in order to prevent admission.
- Work is underway in partnership with NHS Borders to develop collaborative leadership which will address the care and support provided during transition from hospital to home.
- The Short Term Assessment Reablement Team continue to support patients during the transition from hospital to home.
- A Joint Delayed Discharge Action Plan forms part of the Joint Winter Plan 2016/17 which identifies a range of measures to meet predicted increase in demand. There is a short life working group to prevent avoidable re-admissions.

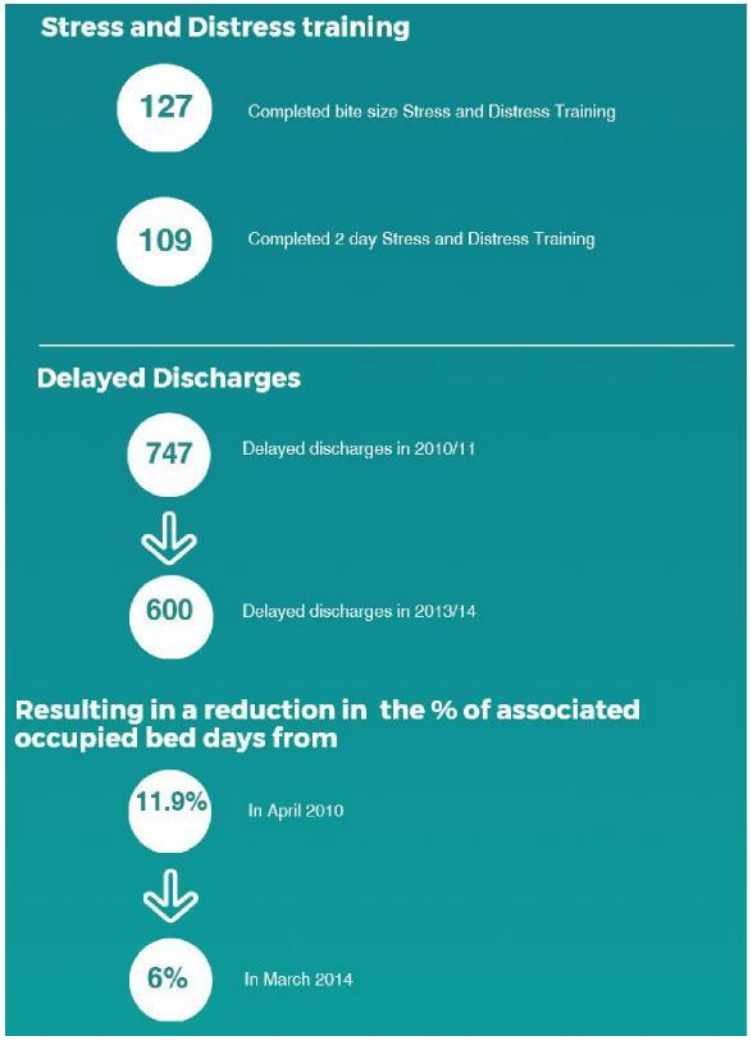
- The Older People's Liaison Service team manages and supports complex and non-complex caseloads within acute and community settings, ensuring holistic planning to meet individual outcomes.
- The Transitional Care Facility provides short-term, directed support to individuals, over a maximum 6 week period, to enable them to maintain independence and return to their homes with reduced or minimal packages of care.
- The Long Term Conditions Project, which supports improvements in the shared management of long term conditions in two localities, is supported by the Red Cross who provide home visits and support to patients so that they can remain in their own homes.
- The commissioning of services ensures that a broad range of options aimed at supporting independence in the community are provided.
- Work has been undertaken to ensure there is clear referral criteria for mental health services, information is available about services in the community and self-management programmes through the third sector are delivered
- A range of support options for clients is available through Self Directed Support.
- The Learning Disability Service works in a range of ways to promote and enable people with learning disabilities to live healthier lives and improve their quality of life through addressing the broader determinants of health, such as tackling social isolation and exclusion and developing supportive social networks. It is currently exploring different models for people who may require specialist in-patient support for learning disability.
- The Dementia team work to keep people engaged with primary health care services and with people and activities which will support them to stay well and reduce the likelihood of admission to hospital
- The dementia service are developing a physical health check tool which will help patients assess when they are well
- Stress and Distress in Dementia training for health, social care and private sector carers has been provided and further training has been developed to provide stress and distress interventions for carers and relatives.
- The mental health older adult teams work with people in hospital known to them in order to facilitate earliest discharge and participate in discharge planning.
- The Home Energy Advice Service provides information, advice and practical help on energy matters to all households within the Council area. The advice helps to provide well insulated and comfortable homes and alleviate health concerns.
- Information & Advice and in some cases practical assistance regarding property maintenance, repair and improvement is available to private sector homeowners or tenants.
- Scottish Borders Council contracts the Borders Care & Repair Service. The service enables older people and people with disabilities to have warm, well maintained and safe homes. The Care and Repair service helps achieve this by providing advice and assistance regarding repairs,

improvements and adaptations and staff are trained to identify and will offer to remove trip hazards and other dangers if requested by their clients.

Voluntary Sector - Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the APR.

Case studies/Data (example)





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.

- Four "Band 1" highest priority Health Centre sites (Selkirk, Eyemouth, Melrose and Knoll) and two "Band 1a" less significant development sites (Earlston and West Linton) were identified through the Primary Care Premises Modernisation Programme. Improvements across these sites will allow increased local access for patients to the range of services provided from these health centre sites, not only from services based "on site" but also from visiting services such as consultant clinics, psychology, mental health services etc.
- A pilot of the Buurtzorg nursing approach via integrated nursing and social work teams is in development. (see Objective 3)
- The Public Dental Service (PDS) have identified that in the coming months they will explore opportunities to offer and support annual programme of dental assessments and treatment within care establishments.
- The Sexual Health Service plan to:
    - Enhanced presence in secondary schools and Borders College to better support young people's access to Sexual Health services
    - Reinstate pop up clinics in identified areas of need to better support young people's access to Sexual Health services.
- Diabetic retinal screening continues to be delivered by local opticians.
- Podiatry services are trialling the use of a simple Office Communication System so that patients and their local podiatrist can communicate directly with a specialist podiatrist in another location and can show them via the camera their particular condition e.g. diabetic ulcer. Immediate advice is then given. This avoids patients having to be referred and travel to BGH for additional advice and input and avoids delays in treatment for the patient.
- Current review of services to ensure that the right services are provided to meet local needs. Work is underway to develop Locality Plans which identify local variations in need of health and social care services.
- Recommissioning of care at home.
- Ability Borders works with individuals and the wider partnership to identify and meet people's information needs and identify gaps and issues.
- An older persons housing strategy is being developed which will inform the partnership of the volume and placement of future Extra care housing and housing with care developments. Providing this type of accommodation will enable people to remain in their homes.
- Community Led support will provide accessible health and social care services in local communities.
- The Borders Community Capacity Building team are supporting people to come together to create local opportunities to socialise and to offer help to those most in need. This project empowers older people to create new opportunities themselves and to challenge existing provision.

- The relocation of the Borders Ability Equipment Store is underway which will result in more efficient provision of equipment which will support people to remain in their homes and reducing the number of inappropriate hospital and care home admissions.
- The mental health service have developed a joint approach to commissioning which will achieve the best outcomes for service users, foster recovery, social inclusion and equity and achieve a balanced range of services.
- The Learning disabilities service works with people with learning disabilities, family carers and service providers to commission appropriate person centred support packages within their local communities
- A mental health Occupational Therapist, the mental health Physiotherapy Team, the mental health older adult service or the mental health older Adult Liaison service each work responsively with people to sustain them in their home where that is practical and possible.
- Within the localities across the borders "Lifestyle matters" groups run supporting the regaining of skills and groups improving and maintaining mood, anxiety management and improving self-esteem for people with dementia or with problems related to mood, anxiety or depression.
- A Borders-wide needs assessment exercise was carried out by consultants which identified 6 priority areas for future housing developments.

Voluntary Sector

Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the APR.

A key challenge faced by the Primary and Community Care is the lack of suitable clinical space in our communities.

Case Studies/Data

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.

- The Scottish Borders Health and Social Care Partnership Strategic Plan 2016 links closely to the Community Planning Partnership and sets out the joint commitment to delivering a set of local objectives in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and the national wellbeing outcomes. The local objectives are heavily influenced by consultation findings with local people.
- Weekly meetings of Senior Management Team where service development, issues, challenges and solutions are discussed across health & social care.
- Joint management of delayed discharge processes across health and social care and with engagement with independent care providers.
- The Care Home Group is an interagency group considers and discusses issues, contracts and supports required for care home providers within Borders.
- A pilot of the Buurtzorg nursing approach via integrated nursing and social work teams is in development. (see Objective 3)
- Work is underway to design frailty pathways and a multi-disciplinary meeting is now in place. The meeting brings together doctors, nurses, AHP and social work staff to discuss the needs of frail older people who have been admitted within the past 24 hours.
- An integrated Joint Workforce Planning Framework is in place to ensure staff are equipped with the right skills and experience, this will include review of the joint recruitment process.
- The Partnership's staffing Forum' takes place on a quarterly basis and consists of staff, Trade Union and Management. It is responsible for facilitating and evaluating the operation of partnership working and supporting joint workplace policies.
- Integrated working practices in Learning Disability and Mental Health are providing the template for further development across all joint services.
- House of Care model promotes good conversations in person-centred care and supports improvements in the shared management of long term conditions in older people.
- Adult Protection service user questionnaires enable Scottish Borders to understand and improve support services.
- Learning Disabilities commissioning strategy and Mental Health strategy (Draft) provide an integrated approach to commissioning and deployment of resources.
- A new development is the Low Vision Clinic – an integrated approach to fund development of the service.
- Community-Led Support project (featured in the Spotlight) section of this report.
- Scottish Borders Community Planning Partnership has produced a co-production toolkit and eLearning module.
- A sensory service strategy initial draft has been developed.

- As part of integrated services work will be undertaken to integrate H&S care teams within localities and create more shared assessments and care planning.
- Health and Social Care services work effectively together to support people with dementia including regular joint appointments and referral discussions. The teams work closely with primary care partners to accurately assess, diagnose and support people with dementia. This integrated working has resulted in reduced duplication and streamlined the way in which care is provided.
- Evaluation of statutory and voluntary mental health services to ensure we deliver the right support at the right time
- Mental health service health & social care staff are now co-located in three locality based community teams and a rehab team which covers the whole of Scottish Borders.
- A service specification for a local recovery college model which will deliver a mental health service using an education approach rather than a therapeutic approach.
- The Learning Disability Service and mental health service has been integrated in Scottish Borders since 2006, its Governance structure ensures that people with Learning Disability and their carers are key partners in decision making processes.
- The Learning Disability service hosts events for a wide range of stakeholders, tackling key developments and or issues important to people with learning disabilities.

Voluntary Sector

Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the APR.

Key challenges facing the Learning Disability team are the implications of challenging budgets and changes to the living wage, looking to provide support differently to traditional models e.g. day centres, employment and volunteering opportunities, and reviewing current arrangements e.g. social enterprises and opportunities for people.

Low Vision Aid Clinic Case Study **(maybe this case study should be under a different objective - is this is more about providing care close to home than integrated services)**

A referral was received from the Low Vision Aid Clinic at BGH to the Low Vision Services - Sensory Services Team for a care home visit to assess an individual for a suitable Low Vision Aid. The individual was unable to attend the Low Vision Aid Clinic at BGH due to poor general health and limited mobility. A care home visit took place by the Low Vision Services - Sensory Services Team rehabilitation worker.

The worker found that the individual had been previously issued with a relatively strong stand illuminated magnifier by the Low Vision Aid Clinic at BGH but, due to deteriorating central vision, this was no longer functioning / focussing well. The individual was struggling to read large print unaided. It was decided that near vision spectacles would not really benefit.

The individual was disappointed and understandably frustrated at being unable to read any printed material. The individual stated that they would particularly like to read their personal CD collection and to identify artists and individual songs on covers which usually present with poor colour contrasting and very small print. They also stated that they would like to be able to be able to independently read mail/correspondence.

The individual was assessed and issued a higher strength, high colour temperature, stand illuminated magnifier which allowed recognition of the CD information and also allow for relatively easy reading of standard letter print size.

This change of Low Visual Aid will help retain and promote basic independence by allowing the individual the fundamental need of being able to read for one's self and to no longer rely on other/s to act as a 'reader'. This simple intervention will help improve quality of life with associated wellbeing as the individual was delighted with the outcome of the Rehabilitation workers' visit.

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.

- Public involvement is routinely sought for planning and strategic development at all levels and at most decision-making for a there are public members and third sector representatives.
- There are proactive processes and systems in place to gather patient and public feedback on services across the partnership e.g. a cohort of patient feedback volunteers has been established within NHS Borders.
- The Public Partnership Forum (PPF) meets bi-monthly to provide a public perspective on services provided by NHS Borders, Scottish Borders Council and the Voluntary Sector.
- The SDS Forum of users and carers is helping to develop information to ensure people are informed and better able to participate in their assessment.
- A Local Area Co-ordinator has been established for a one year pilot to support older people and people with a physical disability to make connections and choices in their local area.
- Work with the Carers Advisory Group on the new Carers Strategy and planning for the implementation of the Carers Act in 2018.
- 50% of service users have been offered the self-directed support options (Jan 2017), a significant increase in people using self- directed support in the last year i.e. from 377 to 1187 people Dec '15-Dec '16.
- Assessments have been updated recently to ensure an outcome based, person focused assessment and review.
- Reimaging day services project is developing an inclusive model for reimaging how people are supported during the day.
- The Dementia working group consists of service users who are actively defining the service needs.
- There are a wide range of training opportunities available for people seeking a greater understanding of dementia. NHS Borders has supported a number of staff to develop themselves professionally with three staff from the MH service completing MSc in Dementia in the last year and a number of others working their way through the course. 83% of NHS Borders staff have received some form of training in dementia as part of their statutory or mandatory training. The training aims increase understanding of dementia, empower patients to do what they want to do, manage their own lives and improve confidence.
- Dementia champions are being promoted throughout NHS Borders and in development within the Social work team.
- Provide options for support through self-directed support approach.
- New commissioned service specifications include a requirement to implement outcome and recovery focussed assessment and support plans.
- Mental health management attend mental health forum to hear views of service users and carers and to provide timely feedback on service developments.

- The 5 local citizens' panels continue to meet 5 times a year as part of the Learning Disability Governance Structure. They provide input to the Learning Disability service when planning developments and improvements. They contributed significantly to the LD Strategic Commissioning Plan and the development plans within that.
- Almost half of people with Learning Disability have had their support packages reviewed using an SDS approach.
- Learning Disability Local area co-ordinators work with people to gain/improve skills in travelling independently. This enables people to travel more widely and opens up potentially more opportunities for people.
- There is information available in accessible formats regarding the options within Self Directed Support to enable people with Learning Disability to have a better understanding of their options.
- Care & Repair ensure that the client is at the centre of their project. Making decisions on who carries out the works, what the work should look like and when this all should take place. Care & Repair help guide the client with decisions on design and quality to ensure that they get the best outcome and value for money for their anticipated long term needs. This is all planned within the constraints of funding and grants regulations.

Voluntary Sector

Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the

APR. The key challenges that the partnership have faced in the delivery of this objective are:

- Reviewing people's packages of support in line with SDS approach. The impact for people still needs to be assessed.
- Recruitment of care staff by providers is difficult. This can restrict the choice people have about who provides their support and when.

Case studies/Quotes

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.

- A Primary Care Strategy is currently under development which will see the identification of agreed priorities and direction of travel across primary care services. It will link with the Health & Social Care Partnership's Strategic Plan and NHS Borders' emerging Clinical Strategy.
- The remodelling of acute medicine has provided a greater level of senior medical input for all medical patients. The process has increased the opportunity for geriatricians to see patients from the outset ensuring that the right staff are in place at the right time.
- The work that is underway to review care pathways will also result in improved efficiency and effectiveness.
- Partners have an H&SC Strategic Plan (2016-19); a more detailed Commissioning and Implementation Strategy, and a Commissioning and Implementation Delivery group is being developed for the whole of Scottish Borders partnership. This gives the partnership direction for the next 2 years. The Strategy is informed by a local needs assessment and projections of need.
- The partnership has built on experience of current collocated teams e.g. Learning Disability and the Kelso team and seek further opportunities for colocation to make the more efficient use of staff skills and properties.
- Our established programme of leadership now includes a SSSC support programme enabling leadership and a mentoring programme for newly qualified social workers delivered by specially trained peers. Our aim is to achieve sustainable improvements through resilient, knowledgeable staff.
- My home LIFE The first cohort of managers has completed this training with the following outcomes realised… (awaiting Stats)
- A matching unit is being set up to maximise efficiencies across care at home and release carer capacity. A future development for the unit could be the promotion and matching of personal carers through direct payments and matching of befriending services.
- Joint Financial Planning – more detail required.
- "Two Minutes of Your Time" questionnaire is used consistently in the NHS as a feedback tool to improve services.
- The dementia training programme has resulted in staff across the services having a better understanding of how to care for people effectively. This is turn improved efficiency and reduces length of stay in hospital.
- Programme of service evaluation demonstrating improvement areas.
- Re-commissioning of services using evidence gathered.
- Partnership working across third sector.
- Involving service users and carers in service developments and recruitment.

- LD services employed a Transitions Development Officer for 1 year to develop the transitions pathway, compile information packs and develop other areas within transition for young people and their families moving from children and young people services to adulthood.
- The Learning Disabilities Service has written its strategic commissioning plan for LD identifying key areas for development over the next 3 years.

Voluntary Sector

Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the APR. **Case studies/Quotes**

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.

- Amongst a range of planned developments, the Sexual Health Service plan to reinstate pop up clinics in identified areas of need to better support young people's access to Sexual Health services.
- Lifestyle Advisor Support Service plan to increase partnership working to ensure their support for all communities with additional support to those in the most vulnerable groups though targeted partnership work and direct input with users of Criminal Justice Services, Carers Services, Mental Health services, Drug and Alcohol services and services supporting the small homeless population.
- The Public Dental Service plans to:
    a. Continue to provide Enhanced services to Special needs/ additional needs with core tooth brushing in all schools with special needs units
    b. Through more effective communication and interagency work increase the emphasis on ensuring improved access for patients identified as having mental health challenges, drug and alcohol dependencies, the homeless and ex-offenders
    c. Improve bariatric dental facilities within PDS
- Health Inequalities Impact Assessments are routinely carried out and there is a proactive inter-agency Equalities Steering Group in place.
- Development of the Public Health Inequalities Plan, to be produced in Spring 17
- Diabetes prevention: a pilot intervention with Live Borders, Health Improvement and the Diabetes Service commenced in January to offer health coaching to a group of recently diagnosed patients.
- Healthy Living Network is supporting the development of diabetes peer support groups in several localities, led by a third sector partner, Scottish Borders Senior Networking Forum.
- Health Impact Assessment of local health screening programmes to identify priorities and actions to improve reach and uptake among vulnerable groups.
- A full programme of Mental Health prevention activities are planned for Mental Health awareness week in May. This includes the launch of a resource guide and programme of community awareness and staff training sessions, to enable people to manage their own mental health and facilitate access to what's available in the community.
- Community based initiatives are being developed by the Health Improvement team, Community Learning and Development and the third sector to support women's mental health and to promote volunteering for wellbeing.
- A mental health programme for offenders is being explored through the community justice framework. The needs of families of offenders are also being developed as part of the joint parent support strategy.
- Initiatives are being developed to promote awareness and uptake of health screening programmes with harder to reach groups.
- Health literacy is being promoted with a range of staff groups and through focused work in one Learning Community Partnership.

- The Borders Community Planning Partnership (CPP) 'Reducing Inequalities strategy' sets the priorities and high level outcomes that are being aligned with the plans and priorities of relevant strategy groups in health and social care.
- The See Hear Strategy group is in the process of delivering hearing and sight loss training to frontline staff (Introductory training) and champion training for those support staff working with children and adults with complex needs.
- A range of multi-agency training is available to adult social care staff including eLearning tools on dementia and adult and child protection.
- Carers representation is being enhanced via the planned programme of work with the National Development Team for Inclusion with carers on the steering group and other working groups.
- The team are targeting the issue of carer ill-health in the new 'Health Inequalities Plan' as research shows that this increases with the amount of care provided.
- The Community Transport hub has been developed in partnership with the third sector it provides an accessible, coordinated, sustainable approach to providing community transport.
- The Alcohol and Drugs Partnership are working to reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reduce related deaths.
- The Alcohol and Drugs Partnership continue to work with Child Protection to deliver briefing sessions to staff on 'children affected by parental substance misuse'.
- During 2016-17 there has been a considerable growth in opportunities for people, their families and friends, with alcohol and drugs problems to be supported after treatment through participation in recovery groups and other activities.
- Naloxone is a medication which, that in the event of an overdose, can be given to temporarily reverse the effects of overdose and allow time for emergency services to arrive. Borders had the highest number of kits issued per 1,000 estimated people with drug use problems in Scotland. The Alcohol and Drug Partnership are also working with partners in reviewing 'Staying Alive in Scotland' good practice baseline tool which will inform further actions to reduce drug related deaths.
- The mental health service has developed a nutrition and healthy eating programme for mental health service users in key settings.
- Community Capacity building is continuing through the Local Area Coordinators.
- Peer support worker role has been established in Gala Resource Centre which will enable employment opportunities for people with experience of mental ill health.
- There have been a number of developments to improve the care of people with learning disabilities across primary care, accessing the Borders General Hospital and community hospitals, including the recent implementation of link nurses in each area, introduction of hospital passports alongside the development of e-learning covering health needs and communication. There is a learning disabilities Liaison nurse employed during the week to support people in the Borders General Hospital.
- Services are commissioned for people with learning disabilities to provide support to people with learning disabilities to access mainstream healthcare.

- The learning disabilities nursing team progress projects in their work plan to address health inequalities including: work with the Oral Health team, work to improve diabetes care and support to access screening programmes.
- Learning Disabilities nurse continue to measure outcomes for individuals using the Health Equalities Framework.
- Borders Dementia working group are providing training to community health councils about challenging stigma and prejudice by education in schools, shops, colleges etc. in order to create dementia friendly communities.
- An early onset dementia group has been established in Berwickshire which provides a service for younger people with dementia; this reduces the inequality that younger dementia patients normally find.
- The Mental health Older Adults Team have been promoting and developing the National Education Scotland "Living with Dementia Programme" which following diagnosis, enables patients to understand what they can do independently
- The fifth and final year of the Local Housing Strategy 2012-2017 has now been implemented and we have seen some significant progress in achieving this vision, and delivering on the strategic priorities.
- The Local Housing Strategy 2017 – 2022 has been in development throughout 2016. The vision has been agreed through consultation with stakeholders as "every person in the Scottish Borders lives in a home which meets their needs". The draft LHS contributes across all three Single Outcome Agreement Priorities, but in particular to Priority 2 on reducing inequalities. The following four priorities have been defined:
    - The supply of housing meets the needs of our communities
    - More people live in good quality, energy efficient homes
    - Fewer People are affected by Homelessness
    - More people are supported to live independently in their own homes

Voluntary Sector

Jenny Smith to liaise with voluntary sector colleagues to offer updates and examples for the APR.

Case studies (example)

OBJECTIVE 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role

The activity detailed below specifically relates to the Carers; however it should be noted that Carers will also benefit from work which relates to objectives 1-8.

- The partnership is committed to increasing referrals for Carers Assessments through the Borders Carers Centre. Some examples of support provided are:
    - Specialist support for young adult carers to assist with access to employment, education and training.
    - "Staying afloat" is a new 8 week project for carers that develops resilience and improved health and wellbeing Respite
    - Carers Awareness Training though Adult Protection Training - a bespoke video designed in collaboration with carers is used for this purpose.
    - Carers support groups run monthly across all 5 localities of the Borders.
    - Additional respite hours are secured for carers through the time to live fund, days out and other charitable grants.
- 417 professionals have received Carers Awareness Training through Flying Start, induction training and talks and visits. This training is delivered in partnership with carers.
- A peer support network for carers caring for someone with a mental illness has also been developed along with providing increased respite and training opportunities for carers. Carers are involved in the planning and delivery of services by increased representation at meetings.
- Carers play a key role in planning and decision making through their representation on local citizens panels on the Learning Disability Policy and Strategy Group and Learning Disabilities Partnership board.
- A dementia liaison service provides support for people with Dementia and their Carers whilst they are in hospital.
- A Carers support group runs in Gala Day Unit and we are working with Alzheimer's Scotland to redevelop other carers groups around the Borders. **Check with Peter Lerpiniere – awaiting feedback 15.03.17**
- Stress and distress training is being delivered to Carers of people with Dementia across the borders, to support carers and enable them to continue in their caring role.

One of the key challenges faced by the partnership is the ability to free up carers from their caring role in order to attend development sessions.

Quotes/Case studies. (Sample data based on Carers Centre Managers report for April 16 – Sept 16.)

Inspection of Services

Joint Inspection of Services for Older People in the Scottish Borders

A joint inspection of the Health and Social Care Partnership's older people's services has been undertaken by the Care Inspectorate and Healthcare Improvement Scotland. The inspection consisted of several phases between November 2016 and February 2017.

In November and December an initial self-evaluation report with accompanying evidence was sent to the inspection team. A staff survey was also undertaken. This was followed in January and February by three weeks of onsite inspection. The inspection team completed case file audits, and had extensive discussions with service users, carers, and provider, third sector, and social care and health staff. The inspection has been an opportunity to showcase partnership working, and to identify the areas that require improvement to achieve better outcomes for older people.

It is anticipated that the inspection findings and recommendations will be published in summer 2017 and will therefore be reported in subsequent Annual Performance Reports.

Older People in Acute Hospitals Inspection – April 2016

The review of Borders General Hospital took place over a day on Tuesday 26 April 2016. We interviewed a range of staff, including the executive team, non-executives and frontline staff.

The review was conducted by Healthcare Improvement Scotland staff, which included both quality assurance and improvement staff, along with the Scottish Health Council, clinical partners and public partners.

The review followed an unannounced inspection to Borders General Hospital which was conducted on Tuesday 12 to Thursday 14 April 2016. The following areas were inspected:

- Ward 4 (general medicine)
- Ward 5 (general medicine)
- Ward 6 (medical assessment unit)
- Ward 7 (general surgery)
- Ward 9 (orthopaedic surgery)
- Ward 12 (general medicine)
- Ward 16 (gynaecology)
- Department of medicine for the elderly, and
- Borders stroke unit.
- The emergency department and the discharge lounge

The following recommendations were made:

	Recommendations made:	Action taken to implement each recommendation
1	NHS Borders should further develop its governance and communication structures to support better sharing of learning across the organisation	Shared learning at Senior Charge Nurse and Head of Service meetings as an additional vehicle for onward dissemination and emphasis of the link between learning and changes that are made. Introduced a "Patients Said, We Did" monthly communication to all staff
2	NHS Borders should further develop the process for sharing learning from feedback and complaints across Borders General Hospital and in particular to the wards.	
3	NHS Borders must ensure clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR).	
4	NHS Borders must ensure it has robust documentation and record keeping in place.	NHS Borders introduced a daily quality review to check compliance with completion of clinical documentation and rectify any issues identified. This review is conducted in all wards to check the clinical documentation including evidence that patient assessments have been completed to standard. Feedback is given to clinical staff of any gaps with support and advice to remediate the issues that have been identified. Within 24 hours, the quality reviewers return to the ward to check that the issues that had been identified have been addressed. This information is used to measure compliance and drive improvement. This is intended to underpin a shift in clinical practice and quality of care, and will evolve over the next year.
5	NHS Borders must ensure all patients receive appropriate screening assessments within the standard timeframes.	NHS Borders is participating with national patient safety work on medicines reconciliation and will identify the learning and best practice, and draw up a plan to implement. NHS Borders has included the requirement to complete medicines reconciliation in the Code of Practice for the Control of Medicines. Medicines reconciliation was presented and discussed at the Medical Grand Round Continuing Professional Development (CPD) event in May 2016. Medicines reconciliation was presented and discussed at the next non-medical prescribing CPD event in October

		2016. See action in response to Area for Improvement 4
6	NHS Borders must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. This includes consulting any appointed power of attorney or guardian. When legislation is used, this must be fully documented in the patient health record, including any discussions with the patient or family.	The Medical Director has written to all doctors about the requirement to comply with current legislation in relation to capacity. NHS Borders will establish an ongoing process for reviewing consistency of recording consultation with any appointed power of attorney or guardian
7	NHS Borders must ensure that capacity assessments are carried out for all patients where a cognitive impairment has been identified. This should be done by fully embedding its policy for consent to treatment. This includes AWI and power of attorney.	A training tool relating to capacity assessments and AWI has been circulated to all Heads of Service for mandatory use by consultants. This will fully embed the Consent to Treatment Policy. See action in response to Area for Improvement 4
8	NHS Borders must ensure mealtimes are managed in a way that is co-ordinated and ensures maximum staff input.	At the time of the inspection we met with Senior Charge Nurses to give clarity on the expectation of planning patient and staff mealtimes to ensure consistency across NHS Borders. Clinical Nurse Managers continue to quality assure compliance.
9	NHS Borders must ensure that staff have access to expert tissue viability advice.	Agreements have been put in place with two other Health Boards for staff access to very specialist advice for complex cases. An escalation process has been developed, shared and discussed with Senior Charge Nurses. Clinical Nurse Managers now review the plan of care for every pressure injury ensuring that appropriate care and documentation is in place.
10	NHS Borders must ensure that once a patient is identified as requiring a SSKIN bundle, these are commenced and that each individual patient is individually assessed for interventions that are clearly documented.	See action in response to Area for Improvement 4
11	NHS Borders must ensure that care plans are in place for all patients' identified needs found on assessment, and that these inform the comfort rounding on those wards where it is in place.	See action in response to Area for Improvement 4 At the time of the inspection, Senior Charge Nurses were advised of the expectation of the standards. This is included in a monthly audit of documentation conducted by Senior Charge Nurses.

12	NHS Borders should consider capturing and publicising the learning from the changes it has implemented in relation to complaints and culture change.	NHS Borders is considering the best way to publicise the learning from changes it has implemented

Financial Performance and Best Value: Summary

Financial Arrangements

Specific to the establishment of an integration model for the Scottish Borders – delegation to a (body corporate) Integration Joint Boar d – there are a number of key provisions / recommendations within the statutory Integrated Resources Advisory Group guidance that require to be addressed from a financial arrangements. These provisions covered a range of core areas of financial governance and management:

- Governance Structure
- Assurance and Governance
- Financial Reporting
- Financial Planning and Financial Management
- VAT
- Capital and Asset Management
- Accounting Standards

During 2016/17, assessment of compliance was twice undertaken and reported to both the partnership and its partners' audit committees. Progress made was identified in order to ensure that all required provisions in relation to the financial arrangements required by the Act or desired locally were in place. These arrangements ensured all partners received sufficient assurance over:

- The robustness of governance over the operations of the IJB following its establishment
- The overall affordability of its Strategic Plan and any financial risks inherent
- The adequacy of levels of delegated resources and controls over how these resources are managed
- Any impact on NHS Borders and Scottish Borders Council that may have arisen as a result of the establishment of the IJB

Overall, performance in ensuring full compliance with legislation and recommended best practice has been strong during the first year of the partnership's operation, evidenced by the robust financial governance arrangements in place, the approval of the partnership's 2016/17 budget in March 2016, following assurance and due diligence, regular and frequent financial management and monitoring reports to the board during the financial year and a robust set of accounts for the period following the partnership's establishment on the 6th of February 2016 to the end of the financial year.

Financial Management

The partnership has experienced considerable financial pressure beyond the level of budget delegated to it during 2016/17. Mid-financial year, the partnership reported pressures beyond budget totalling over £5.6m across key areas of its delegated budget and over £3.0m within the large hospital budget set-aside. These reported pressures were primarily experienced across healthcare functions. Social care functions also experienced pressure during the year arising from factors such as increased demand from services,

increased cost as a result of market pressures and the introduction of a living wage of £8.25 for all social care staff, but in the main, these were funded by the Scottish Government allocation of social care funding to partnerships during 2016/17.

In terms of the pressures across healthcare functions, both those delegated to the partnership and those retained by NHS Borders, the highest single area of risk and largest adverse service variance across the delegated budget relates to Prescribing where the function experienced projected pressure of over £2.0m to the year end.

Risk to the affordability of the delegated budget and overall sufficiency of resources available to the partnership has been of prime focus, both at the time of approving the financial statement on 30 March 2016 and in subsequent monitoring reports to the IJB. In order to be affordable, delivery in full of all planned efficiencies was required on a recurring and sustainable basis. Across healthcare functions – and the budget delegated to the partnership, retained by NHS Borders and set-aside and those supporting wider non-partnership functions – a significant shortfall on the delivery of the health board's efficiency programme was experienced, resulting in considerable additional budget pressure. For the delegated budget, around £2.4m of the total programme was undelivered.

NHS Borders experienced the impact of a range of pressures across the large-hospitals budget set-aside for the population of the Scottish Borders. These pressures related to a range of factors including the costs of continued provision of Surge Beds (£1.200m), Patient Flow (£900k), Acute Admissions Unit and Emergency Department staffing (£500k) in addition to the non-delivery of planned efficiencies outlined above.

The extent of the pressures experienced above required the implementation of an in-year recovery plan by the partnership, part of an NHS Borders-wide recovery plan which aimed to deliver £13.7m of mitigating actions in total of which £4.2m related to those functions delegated to the IJB and £1.6m within the large hospital budget set-aside.

- Insert progress update following known year end position

Recovery and mitigation is accompanied by risk to the partnership, although the majority of actions undertaken during 2016/17 are in the immediacy, of a relatively low risk-nature. Going forward however, a combination of factors – not least the one-off and non-recurring nature of much of the recovery plan – is likely to lead to higher risk to the partnership unless further, more sustainable and targeted management actions are put in place.

A key component of this will be the planning and delivery of an integrated transformation programme for the partnership building on the efficiency and savings programmes already in place within each of the partner organisations and the basis on which each's financial plan is predicated. In terms of the partnership's Strategic Plan, it is critical that as the partnership moves into year 2 of its operation, maximum efficiency in service provision and delivery is achieved and the prioritised and targeted investment of scarce partnership resources is made.

Performance Monitoring Framework: Summary (example – content to be determined by Elaine's management team)

Key priorities for 2017/18

The Scottish Borders Health and Social Care Partnership Business Plan for 2016/17- 2018/19 outlines the following key priorities for the partnership.

Local Objective 1 Accessible services & develop our communities	• Develop innovative, locality based community approaches through an agreed action plan, developed & governed through the IJB, including older people Local Area Co-ordination & the Building Community Capacity Team Community Led Support, Buurtzorg and integrated health and social care teams. • Increase the Extra Care Housing services by 2-4 units by 2023. Develop a programme of action that includes scoping current provision & placement thresholds; revenue implications; workforce requirements. • Shape service development more effectively through stronger connections between the Public Partnership Forum & the IJB.
Local Objective 2 Improve prevention & early intervention	• Develop/ implement a' Falls Strategy' (with 'Action Plan'), 2017-19, informed by shared self-assessment; using the 'Prevention & Management of Falls in the Community' tool. • Improve responses to people at risk through new, innovative anticipatory care planning. • Manage risk intelligently & empathetically through a new join protocol for risk & its' governance. • Provide locally based community led hubs to improve access to health and social care services.
Local Objective 3 Reduce avoidable admissions to hospital	• Develop and implement a joint Delayed Discharge Plan, reducing rates & % of associated occupied beds —supporting the agenda with smart technology. • Reduce re-admissions. Working as a test site for assessing/monitoring frailty pathways, we will develop a co-produced, transition —friendly care pathway, articulated in a new 'Frailty Improvement Plan'. • Reduce bed blockage through evaluating & further improving the early supported discharge programme.
Local Objective 4 Provide care close to home	• Enable vulnerable adults to live safely at home through improved Adult Protection practices; undertaking a review of Large Scale Inquiries, making necessary changes; evaluating outcomes. • Develop a matching unit to improve access to locally based care at home. • Support integration & independence in people with dementia by developing a clear diagnostic pathway through Mental Health Older People's services as

	described within the updated Dementia Strategic Plan. • Maintain independence & quality of life through increased use of Technology Enabled Care. • Support the pathway to care at home through the development of a joint protocol for intermediate care/ short term placements.
Local Objective 5 Integrated Care Model	• Increase the pace of change towards integrated approaches including through joint financial planning underpinned by joint strategic commissioning; sharing workforce supports; joint governance etc. • Support informed integrated planning through Integrated Care Fund measurements of common themes across multiple projects using a locally developed outcome focused tool • Develop integrated health and social care teams in all five localities. • Improve inclusion & re-ablement approaches in palliative care/through the TCAT (Phase 2) programme; using learning across the services.
Local Objective 6 More choice & control	• Improve shared management of Long Term Conditions in older people through extended application of the 'House of Care' model, measured through the new outcome focused, Self-Evaluation Calendar. • Increase the number of people accessing all SDS options by streamlining financial & other processes, removing barriers to change. • More choice & control for the public through the development of a 'People Involvement Strategy'. • Increased role for service users & stakeholders in service planning through the application of the Partnership Board approach, learning from LD & MH developments.
Local Objective 7 Efficiency & Effectiveness	• Shared aims & language across the partnership through developing & aligning performance activities across the partnership, identifying opportunities for integrated approaches & shared use of the SA Calendar. • Drive forward collaborative change through the 'You Said We Did 'Improvement Plan. • Through improved communication & organisation-wide engagement, develop a widely-shared, persuasive vision of integrated services & of better support in the community through additional extra care housing. Align strategic and operational priorities and support innovations so that ambitions for service expansion can be achieved, emphasising the maintenance of quality, essential services within a context of efficiency savings.

Local Objective 8 Reduce health inequalities	• Deliver post diagnostic support (PDS) to a higher proportion of people with dementia & increase appropriate GP referrals. Improve outcomes when a dual diagnosis exists by piloting an assessment tool of physical health for people with mental health conditions. • Establish a single information access; improve communication internally & externally Development of locality plans to identify how to include those who are hard to reach within our communities and implement change. •
Local Objective 9 Support for Carers	• Improve carer health, strengthening Public Health input to a refreshed 'Carers Strategy'. • Align recording of carer assessments with Frameworki & Carers Centre data. • Increase the number of carer assessments • Develop a partnership programme of improvement &s elf -evaluation between carers, SBC/NHSB & the local service provider.

In order the deliver these priorities, efficiencies must be made in other areas. The areas identified by the IJB as transformation priorities are: (more detail required on each)

- Care Pathways
- Day Services
- Mental Health Services
- Localities Approach
- Staffing and Management Arrangements
- Technology Enabled Care
- Prescribing
- Alcohol & Drug Redesign
- Implementation of Carers Legislation

The redesign of these services will result in savings that reduce the partnerships budget deficit and enable the priorities to be delivered.

APPENDIX A: Financial Performance and Best Value

i) Financial Performance

Legislative and Governance Framework

Integration Joint Boards (IJBs) are required to prepare financial statements in compliance with:

- the Local Government (Scotland) Act 1973
- CIPFA Code of Practice on Local Authority Accounting (updated annually)
- Scottish Government Finance Circular 7/2014
- the Local Authority Accounts (Scotland) Regulations 2014
- Integrated Resource Advisory Group (IRAG) guidance
- Local Authority (Scotland) Accounts Advisory Committee (LASAAC) Additional Guidance for the Integration of Health and Social Care 2015/16

In complying with this legislative framework, the IJB must prepare and submit for audit set of unaudited accounts by the 30th June following the close of each financial year which must be also be considered by the IJB or a relevant committee by the 31st August . Subsequently, the independently audited accounts must be signed-off by the 30th September and published no later than 1 month thereafter.

The IJB's approved Integration Scheme sets out a range of provisions relating to the financial arrangements of the Scottish Borders Health and Social Care Partnership. These provisions specifically include:-

- How the partnership's baseline payment will be calculated and assurance over its sufficiency will be provided
- The process for recalculating payment in subsequent years
- The method through which the amount set-aside for hospital services will be determined
- The process for dealing with in-year variations
- Definition of financial planning, management accounting and reporting requirements
- Treatment of year-end balances

Statutory Reporting Requirements

Draft shadow year accounts for the Health and social Care Partnership were approved by the IJB at its meeting of 15th August 2016. These accounts covered the period from the partnership's date of legal establishment, 6th February 2016 to 31st March 2016, the end of the financial year.

The independent auditor's report to IJB members and the Accounts Commission was received on 29th September 2016. The report held opinion over the true and fair view of the financial statements and their proper preparation in accordance with the required professional and legislative frameworks. No additional

matters requiring reporting were found. The final audited Health and Social Care Partnership accounts for the period to the 31 March 2016 were approved by the IJB on 17th October 2016.

For 2016/17, the first full year of operation of the IJB following its establishment, draft unaudited accounts will be prepared by 30th June 2017 and submitted to the IJB for approval on 28th August 2017. Final audited accounts will be submitted to the IJB on 25th September 2017.

2016/17 - Resources Delegated to the IJB

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the framework for the integration of health and social care in Scotland and requires that the Integration Joint Board produces a Strategic Plan setting out the services for the population over the medium-term. It also stipulates that the Strategic Plan incorporates a medium-term financial plan (3-years) for the resources within its scope comprising of:

- The Delegated Budget: the sum of payments to the Integration Joint Board
- The Notional Budget: the amount set-aside by NHS Borders, for large hospital services used by the IJB population

The IJB approved its medium-term financial plan – "the Financial Statement" for the period 2016/17-2017/18 on the 30th March 2016. This followed a process of due diligence over the previous 3-years' budget, risk analysis and the provision of assurance over the sufficiency of resources. As per the Integration Scheme, neither partner 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.

The process of determining the total level of resources to be delegated to the partnership complied with the provisions contained within its Scheme of Integration and the 2016/17 delegated budget was 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 Integration Joint Board's Strategic Plan
- Other emerging areas of financial impact

A summary of the approved indicative, medium-term, Integrated (Delegated + Set-aside) Budget is detailed below:

	2016/17	**2017/18**	**2018/19**
		indicative	**indicative**
	£'000	**£'000**	**£'000**

Budget Delegated from NHS Borders	92,619	92,539	92,952
Budget Delegated from Scottish Borders Council	46,531	46,583	47,083
Total Delegated Budget	139,150	139,122	140,035
NHS Borders Large Hospital Budget Set-Aside	18,128	18,160	18,325
Total Integrated Budget	157,278	157,282	158,360

- Insert Final outturn position – until then, the following applies:

At the meeting of the Scottish Borders Health and Social Care Partnership Integration Joint Board (IJB) on 19th December 2016, the 2016/17 budget (£139.150m) in respect of services delegated to the Health and Social Care Partnership was forecasting a net projected adverse outturn pressure of £5.4650m (following direction of £145k social care funding / £5.610m gross). Additionally, the large hospital budget, set-aside for the population of the Scottish Borders ("the set-aside budget") (£18.128m) was also forecasting a projected adverse outturn pressure of £3.070m.

2016/17 - Cost of Service Provision

In terms of the delegated budget, the above level of projected expenditure represents the running costs of the IJB and indicates the significant size and complexity of the organisation. The partnership's Scheme of Integration lays out the expectations on the partnership as to how the significant projected adverse variance will be mitigated.

In the IJB report accompanying the Financial Statement a full financial risk matrix was reported to and approved by the partnership. Subsequent reports during the financial year also have identified a number of key financial risks to the partnership. These have included:

- The level of efficiency and savings required in order to ensure the affordability of health and social care services. For the delegated budget, £4.710m of planned healthcare functions efficiencies required delivery during 2016/17 and £2.663m relating to social care
- In terms of the recovery plan for 2016/17, given the level of remedial savings required, a fully funded plan across all of delegated health and social care functions, set-aside functions and wider NHS Borders functions had yet to be developed and agreed
- Assumptions made that all factors which drive the costs of health and social care service provision remain stable, in the context of significant or volatile demand and price levels, particularly in relation to unplanned admissions to hospital, social care including residential care home demand and the retendering of care at home, the implementation of the living wage and prescribing.
- The significant level of non-recurring efficiency and savings actions on which the

partnership’s budget remains predicated

- Future financial allocations and government settlements against the backdrop of likely increasing demand and price factors

At 31st October, the projected level of expenditure across the partnership's delegated functions, relative to its approved budget was £144.760m: This and the projected adverse outturn variance of £5.610m can be summarised as follows:

	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	18,678	18,648	30
Joint Mental Health Service	16,019	16,291	(272)
Joint Alcohol and Drug Service	948	928	20
Older People Service	26,735	27,111	(376)
Physical Disability Service	3,321	3,269	52
Generic Services	73,449	78,513	(5,064)
Total	**139,150**	**144,760**	**(5,610)**

In addition, the projected position on the large-hospital budget set-aside was reported as:

	Revised Budget	Projected Outturn	Outturn Variance
Large Hospital Set Aside			
Accident & Emergency	£'000	£'000	£'000
Medicine & LTC	1,806	2,318	(512)
Medicine of the Elderly	11,330	13,456	(2,126)
	6,080	6,512	(432)
Savings (Planned and Recovery)	(1,088)	(1,088)	0
Total	**18,128**	**21,198**	**(3,070)**

Recovery Planning and Delivery during the Financial Year

Within the partnership's Scheme of Integration, it is specifically provided that 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. 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. In this context therefore, it will be the responsibility of NHS Borders to cover any residual year-end pressure across the budget for healthcare functions. Similarly, any residual pressure on social care functions will be covered by Scottish Borders Council.

Overall, £0.233m of adverse pressure was projected for social care functions at 31st October. The overall projected pressures on the healthcare functions delegated (£5.232m) and set-aside (£3.070m) are part of an NHS Borders-wide projected financial pressure of £13.920m this financial year. This is offset by the utilisation of a £2.0m operational contingency held by NHS Borders leaving a residual pressure of £11.920m which required addressing.

The recovery actions identified to date, when analysed over each element of NHS Borders' budget are:

	IJB	Set Aside	Other	Total
	£k	£k	£k	£k
Slippage on Capital Programme	(796)	(215)	(1,140)	(2,150)
NHS Control Measures	(1,147)	(310)	(1,643)	(3,100)
Slippage on LDP/Reserves	(1,073)	(290)	(1,537)	(2,900)
Release Ring Fenced Allocations	(365)	(99)	(523)	(987)
IJB Agreed Surge Capacity		(500)		(500)
Balance Sheet Flexibility	(773)	(209)	(1,108)	(2,090)
	(4,154)	**(1,623)**	**(5,950)**	**(11,727)**

When delivered, then this will achieve a positive surplus of £83k on the delegated budget. The set-aside budget however, will remain in deficit however with an adverse variance of £2.487m although other NHS' functions will forecast £2.211m of a favourable variance. The total net residual position for NHS Borders when delivered is therefore forecast to be £193k adverse. Further compounding this position however are further forecast pressures projected across health functions which were presented to the IJB in December:

	IJB	Set Aside	Other	Total
	£k	£k	£k	£k
Emerging Pressures	800	400	400	1,600

Accounting for these emerging pressures therefore results in an updated adverse residual position of:

	IJB	Set Aside	Other	Total
	£k	£k	£k	£k
Revised Outturn Variance	**717**	**2,887**	**(1,811)**	**1,793**

This remains unaddressed currently at February 2016 although the partnership have considered a number of options including use of the residual social care funding allocation this financial year on a non-recurring basis.

The direct impact in 2016/17 of the in-year recovery plan on the partnership's Strategic Plan has been assessed as low to medium. The main positive factors which determine this are:

- Securing Scottish Government endorsement and financial support to ensure that adverse impact is minimised
- Improved efficiency and control measures which form part of the recovery plan
- Utilisation of contingency
- Technical financial adjustments which have a low impact directly on front-line functions
- One-off nature of a significant proportion of the plan

Conversely however, the wider medium-term impact is, without further action, likely to be higher as a result of:

- The opportunity cost of directing £500k of social care funding and £410k of integrated care fund, both on a non-recurring basis, to meet pressures across surge and community hospital beds
- The non-recurring nature of much of the recovery plan actions requiring permanent addressing going forward
- The requirement to still deliver previously planned efficiency savings in future financial years
- The continued pressures across key functions which have yet to be mitigated e.g. prescribing

Establishing this impact and reviewing the Strategic Plan in light of prevalent financial pressures is now a key work package for the partnership. Underpinning this will be the implementation of an integrated medium-term transformation programme for all health and social care aimed at improving performance and delivering the partnership's strategic priorities and in particular, targeting significant cashable efficiencies in order to reinvest in new models of care and achieve overall affordability in the provision of health and social care.

Funding Priorities

During 2016/17, in addition to the delivery of core functions, the partnership has directed both its social care funding and integrated care fund allocations towards a range of new requirements and planned priorities.

Social Care Funding

The IJB has directed £4.590m of the partnership's 2016/17 social care funding allocation (£5.267m). On a permanently recurring basis, £5.088m has been committed. How the partnership has directed funding to date is summarised below:

Delegated Budget		Set-Aside Budget		Total	
2016/17	2017/18	2016/17	2017/18	2016/17	2017/18
£'000	£'000	£'000	£'000	£'000	£'000

20-Jun-16							
	Living Wage	813	1,626			813	1,626
	Demand Pressure	1,081	1,081			1,081	1,081
	Charging Threshold	154	154			154	154
	Unplanned Efficiencies	220	0			220	0
		2,268	**2,861**	**0**	**0**	**2,268**	**2,861**
30-Aug-16							
	Provider Costs	1,127	1,127			1,127	1,127
	Demand Pressure	300	300			300	300
		1,427	**1,427**	**0**	**0**	**1,427**	**1,427**
17-Oct-16							
	Surge Beds	0	0	500	0	500	0
	Night Support Sleep-ins	0	750			0	750
	Night Support Redesign	75	0			75	0
	BAES Equipment	150	0			150	0
	Community MH Worker	25	50			25	50
		250	**800**	**500**	**0**	**750**	**800**
17-Oct-16							
	BAES Equipment	145	0	500	0	145	0
		145	**0**	**500**	**0**	**145**	**0**
Total Directed to Date		**4,090**	**5,088**	**1,000**	**0**	**4,590**	**5,088**
2016/17 Allocation						**5,267**	**5,267**
Remaining Resources						**677**	**179**

Integrated Care Funding

The Scottish Borders Health and Social Care Partnership's Scottish Government Integrated Care Fund allocation is £2.13m in each of financial years 2015/16 to 2017/18, a total programme value of £6.39m. To date, £3,681,720 has been directed by the IJB to meet the costs of a range of transformational initiatives:

	Approved Projects		Approved
1	Programme delivery	£	469,626
2	Community Capacity Building	£	400,000
3	Independent Sector representation	£	93,960
4	Transport Hub	£	139,000
5	Mental Health Integration	£	38,000
6	My Home Life	£	71,340
7	Delivery of the Autism Strategy	£	99,386
8	BAES Relocation	£	241,000

9	Delivery of the ARBD pathway	£	102,052
10	Health Improvement (*phase 1*) and extension	£	38,000
11	Stress & Distress Training	£	166,000
12	Transitions	£	65,200
13	Delivery of the Localities Plan 18 mths)	£	259,500
14	Locality Managers x 1 locality for 1 year		£
15	H&SC Coordination x 1 locality for one year	£	49,238
16	Community Led Support	£	90,000
17	The Matching Unit	£	115,000
18	RAD	£	140,000
19	Transitional Care Facility	£	941,600
20	Pharmacy Input	£	97,000
	Total	**£**	**3,681,720**
	Budget	**£**	**6,390,000**

2016/17 Final Statement of Income and Expenditure

This can only be inserted following the completion of the draft unaudited accounts, but a final "cost/income" and "financed by" schedule requires to be inserted.

The Statement of Income and Expenditure within the annual Accounts is £xxxxx for 2016/17.

ii) Best Value

Introduction

All public organisations have a duty to secure best value. The duty of best value in public services is defined as:

- To make arrangements to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost; and in making those arrangements and securing that balance
- To have regard to economy, efficiency, effectiveness, the equal opportunities requirements, and to contribute to the achievement of sustainable development

Best Value ultimately is about creating an effective organisational context from which Public Bodies can deliver their key outcomes. It provides the building blocks on which to deliver good outcomes by ensuring that they
are delivered in a manner which is economic, efficient, sustainable and supportive of continuous improvement.

There are a number of best value themes that public service organisations are expected to demonstrate including:

- Vision and Leadership;
- Effective Partnerships;
- Governance and Accountability;
- Use of Resources; and
- Performance Management
- Equality and Sustainability

Since its establishment on 6th February 2016, the Scottish Borders Health and Social Care Partnership has worked to embed the key themes of best value in how it plans and delivers models of health and social care across the Scottish Borders with specific focus on its leadership, strategic and financial governance, joint working, inclusion and co-production / consultation and the sound management of resources in a variety of ways and in particular the development and implementation of its Strategic Plan.

Leadership, Partnership Working and Inclusion

The Scottish Borders Health and Social Care Partnership is a co-terminus partnership between the health board, the local authority and their partners in care. Whilst the partnership is young, its working supports the full participation of the range of health and social care partners across the Scottish Borders at all levels. The partnership's Executive Management Team (EMT), consists of a number of senior officers from each of NHS Borders and Scottish Borders Council and the partnership's Chief Officer and Finance Officer and is directly responsible for supporting the IJB in setting the strategic direction of the partnership and in both planning and delivering existing and future models of health and social care across the Scottish Borders.

A number of other supporting partnership groups provide a range of support to the IJB across its transformation and redesign agenda, commissioning and implementation and strategic planning, all of which are formed by key officers from the health board, the local authority, GP representation and voluntary and independent sectors. Formal terms of reference exist for all groups which have been approved by the IJB.

In developing its Strategic Plan, the partnership engaged in > insert something about the process of inclusion and co-production. – anything else?

Transformation and Redesign

In early 2016/17, partnership established a team to specifically support the programme of transformation and redesign of health and social care. The programme is extensive and its component elements are led by officers across partners, including the independent sector. A key financial, but not only, enabler to the programme of transformation and redesign is the Integrated Care Fund, which is a £6.39m source of

funding across a 3-year period 2015/16 – 2017/18. In the development of the programme, recognition has been given to a range of factors forming evaluation criteria including:

- Key outcomes targeted within the strategic plan
- Efficiency and savings plans across partners's medium-term budgets
- Sustainability

Examples of transformation and redesign currently underway include:

- Insert examples both ICF and non-ICF e.g. Joint Day Opportunities

The component elements of the partnership's redesign > insert relevant role of TRSG, EMT, CIDG and IJB in terms of the formation and governance over redesign.

Fundamental to the transformation and redesign of health and social care is the requirement to deliver a programme of efficiency and savings on which the overall affordability of the partnership's medium-term financial plan is predicated. For the delegated budget, £4.710m of planned healthcare functions efficiencies required delivery during 2016/17 and £2.663m across its social care functions. A summary of the efficiency plans underpinning the partnership's 2016/17 financial statement is detailed below:

Healthcare	**2016/17 £'000 recurring**	**2016/17 £'000 n/recurring**	**2016/17 £'000 total**
Nursing Skill Mix Review	(93)	0	(93)
Non Support Service Admin	(118)	0	(118)
Supplies Uplift 2016/17	(235)	0	(235)
Travel Costs	0	(95)	(95)
Suspend Clinical Excellence Fund 2016/17	0	(186)	(186)
Clinical Productivity	(750)	0	(750)
Borders Wide Day Hospitals Review	(200)	0	(200)
Drugs & Prescribing	(600)	0	(600)
Review Step Down Facilities	(200)	(350)	(550)
Improving Pathway of Care	(640)	0	(640)
MH & LD Management Costs	(100)	0	(100)
AHP Models of Care	(100)	0	(100)
Review Public Health	0	(150)	(150)
Other Schemes	(100)	0	(100)
Total Savings Proposed	**(3,136)**	**(781)**	**(3,917)**
Target Savings	3,261	979	4,239
Net (deficit)/surplus	**(125)**	**(198)**	**(322)**
Ringfenced Allocations	(471)	0	(471)

Total savings (deficit)/surplus on delegated budget	(596)	(198)	(793)

Social Care	2016/17 £'000 recurring	2016/17 £'000 n/recurring	2016/17 £'000 total
Supporting Independence when providing Care at Home	(316)	0	(316)
Further contribution of surplus from SB Cares	(547)	0	(547)
Reduction in the costs of Commissioning	(378)	0	(378)
Residential and Home Care Efficiencies and Income	(235)	0	(235)
Assessment and Care Management	(100)	0	(100)
Staffing	(300)	0	(300)
Adults with Learning Disabilities Efficiencies	(549)	0	(549)
Older People Efficiencies	(234)	0	(234)
Other	(4)	0	(4)
	(2,663)	0	(2,663)

> Insert overview of the programme with some further details
> progress against the delivery from pie charts

To support future years, the partnership is working to implement an integrated approach to transformation of health and social care.

Both NHS Borders and Scottish Borders Council have put in place a strategic and corporate approach to financial planning which in turn, takes both account of partnership priorities and demand for resources and informs the partnership's medium term financial plan. To deliver this, strategically themed programmes of review are being undertaken by partners focussing on key themes including:

- Our People and achieving maximum cost-effectiveness
- Partnership working – locally, regionally and nationally
- Maximising Resources
- Control and Governance
- Transformation and Redesign

This both informs and delivers the integrated Transformation and Redesign programme for the Health and Social Care Partnership.

Use of Resources

The Integration Joint Board financial officer is responsible for the administration of the financial resources delegated to it. Part of this role is to ensure that the Strategic Plan meets the requirement for best value in the
use of the Integration Joint Board's financial resources. Balancing control and compliance with value creation and performance is important. Better value for money releases resources that can be recycled into higher
priorities helping to secure positive social outcomes within affordable funding.

On an annual basis, the Integration Joint Board requires to seek assurance from NHS Borders and Scottish Borders Council over the financial arrangements and resources through which it will discharge its responsibilities and deliver its required performance outcomes within the Strategic Plan. This process of assurance is grounded on principles of mutual trust and confidence between NHS Borders and Scottish Borders Council, working in partnership with a complete open-book approach, information-sharing and clear cross-referencing of impacts across all former-NHS and Council service areas. For 2016/17, in order to provide the IJB with assurance over the sufficiency of the resources included within the Financial Statement approved on 30th March 2016, specific scrutiny was made in relation to:

- Due diligence: in determining payment to the IJB in the first year (2016/17) for delegated functions, delegated baseline budgets were subject to due diligence and comparison to recurring actual expenditure in the previous three years adjusted for any planned changes to ensure they were realistic
- Risk assessment: an assessment was made, following due diligence, of any recurring areas of financial risk to which the IJB was exposed and where appropriate, the robustness of the arrangements put in place to mitigate them

The outcomes from both these processes were reported to the IJB as part of and following the approval of the 2016/17 medium-term Financial Statement.

Regular and frequent monitoring reports have been made to the IJB during 2016/17. These have highlighted the financial pressures to which health and social care functions are exposed this financial year and have resulted in the direction of resources by the IJB when required, in addition to the planning and delivery of a remedial recovery plan. Recovery Plan Recovery Plan – minimisation of front-line impact, key focus on patient and client safety

In order to further consolidate the robustness of how scarce financial resources are utilised and governed by the partnership, financial planning and management has featured specifically on a number of occasions as part of Integration Joint Board member development sessions.

Governance
>Insert – see Jane

Performance Management
C&I Plan – need to put something in here
Impact of recovery on performance – see Appendix 1

Forward Planning
Integrated Financial Planning
Joint Transformation

SeRCOP (BVACOP)

In preparing the Health and Social Care Partnership's accounts, reference to CIPFA's Service Reporting Code of Practice, which establishes proper practice for consistent financial reporting below the statement of accounts level is required.

APPENDIX B: Performance Management

Text on this page is to be developed further as the draft progresses.

Scottish Borders Health and Social Care Partnership is progressively developing its Performance Management Framework so that the measures that we monitor and report on reflect both national and local priorities.

- This Appendix sets out current and historical performance against a set of measures set by the Scottish Government for all Health and Social Care Partnerships. This "Core Suite" of 23 Integration Indicators was set by the Scottish Government, developed from national data sources so that the measurement approach is consistent across all Health and Social Care Partnership areas. This set of core indicators underpin the 9 National Health and Wellbeing Outcomes. Further information on the Core Suite Indicators and the rationale for their selection is available at http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators

- Within the Partnership we are also reporting on a series of measures identified locally as priorities to be monitored to help manage and improve services. This series of measures will develop further over time. More information on performance against locally set measures is available at **INSERT LINK TO MAY 2017 IJB QUARTERLY PERFORMANCE REPORT ONCE IT HAS BEEN PRODUCED, AND ENSURE THAT IT IS PUBLISHED ALONGSIDE THIS ANNUAL PERFORMANCE REPORT FOR COMPLETENESS.**

National "Core Suite" Indicators 1-10: Outcome Indicators based on survey feedback

National Indicator Number	Indicator Description	Scottish Borders	Scotland
NI - 1	Percentage of adults able to look after their health very well or quite well	95%	94%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	84%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	85%	79%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	75%	75%
NI - 5	Percentage of adults receiving any care or support who rated it as excellent or good	84%	81%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	90%	87%
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	87%	84%
NI - 8	Percentage of Carers who feel supported to continue in their caring role	41%	41%
NI - 9	Percentage of adults supported at home who agreed they felt safe	90%	84%

Source: Scottish Government Health and Care Experience Survey 2015/16
http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey.
This national survey is next due to be run in 2017/18 with results published in Spring 2018.

National Indicator Number	Indicator Description	Scottish Borders	Scotland
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	57% (NHS Borders only)	59%

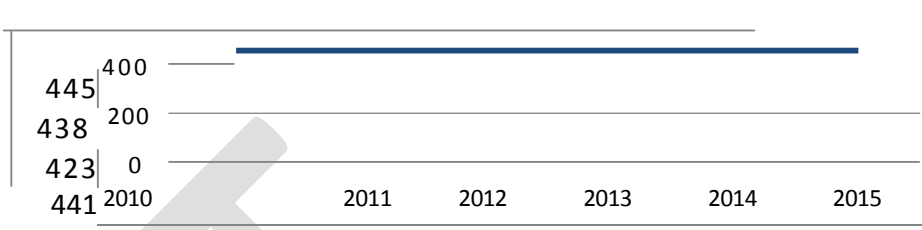
Source: NHS Scotland Staff Survey 2015 http://www.gov.scot/Publications/2015/12/5980. To date, equivalent information across the entire workforce of all Health and Social Care Partnerships is not available. Further work is required nationally and within Partnerships to collate and calculate this information.

National "Core Suite" Indicators 11-20: Indicators based on organisational/system data

NI - 11 Premature mortality rate per 100,000 persons
(Age-Standardised mortality rate for people aged under 75)

Year	Scottish Borders	Scotland
2010	374	467
2011	334	456
2012	356	445
2013	323	438
2014	322	423
2015	391	441

Historical Performance Trend

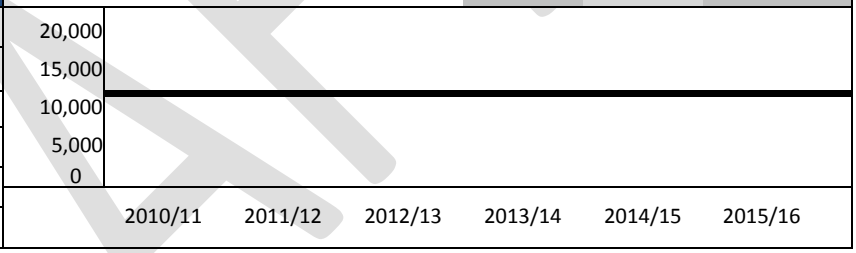


Source: National Records for Scotland (NRS).

NI - 12 Emergency admissions rate per 100,000 population aged 18+
(to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)

Year	Scottish Borders	Scotland
2010/11	12,781	11,390
2011/12	13,545	11,558
2012/13	13,363	11,664
2013/14	14,178	11,982
2014/15	13,640	11,865
2015/16	14,680	12,116

Historical Performance Trend



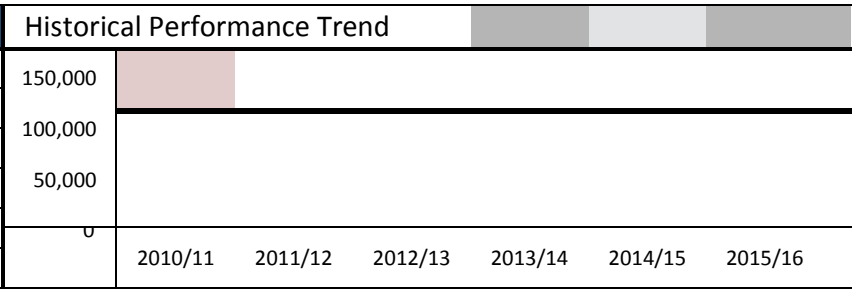
Quarterly data for Scottish Borders to appear here in future draft (equivalent to layout shown for NI-14) – pending receipt from ISD.

Source: ISD Scotland.

NI - 13 Emergency bed day rate per 100,000 population aged 18+
(to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)

Year	Scottish Borders	Scotland
2010/11	140,463	122,230
2011/12	133,244	115,989
2012/13	92,686	112,038
2013/14	125,851	118,111
2014/15	122,956	112,091
2015/16	127,261	112,638

Historical Performance Trend

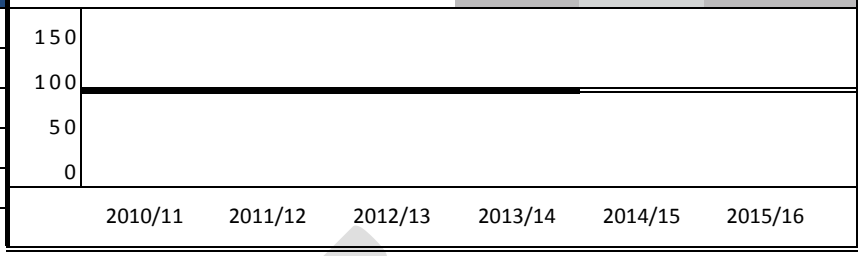


Quarterly data for Scottish Borders to appear here in future draft (equivalent to layout shown for NI-14) – pending receipt from ISD. Source: ISD Scotland.

NI - 14 Readmission to hospital within 28 days – rate per 1,000 discharges.
Note: Borders figure is for Borders residents (treated within and outwith Borders).

Year	Scottish Borders	Scotland
2010/11	100	88
2011/12	101	91
2012/13	104	92
2013/14	110	92
2014/15	105	94
2015/16	106	94

Historical Performance Trend



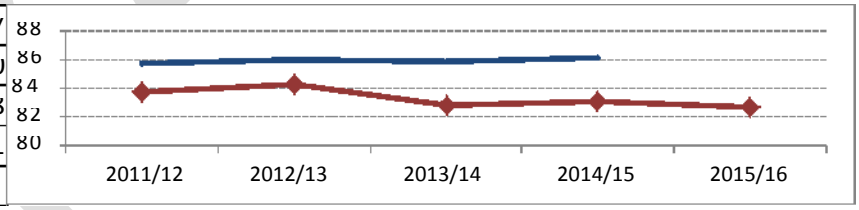
Quarterly data for Scottish Borders (N/A = figure not yet available for all H&SCPs)

Year	Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
2013/14	114	115	111	100
2014/15	100	108	108	103
2015/16	105	103	118	99
2016/17	92	N/A	N/A	N/A

Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges.

Year	Scottish Borders	Scotland
2011/12	83.8	85.7
2012/13	84.3	86.0
2013/14	82.8	85.8
2014/15	83.1	86.1
2015/16	82.7	

Historical Performance Trend



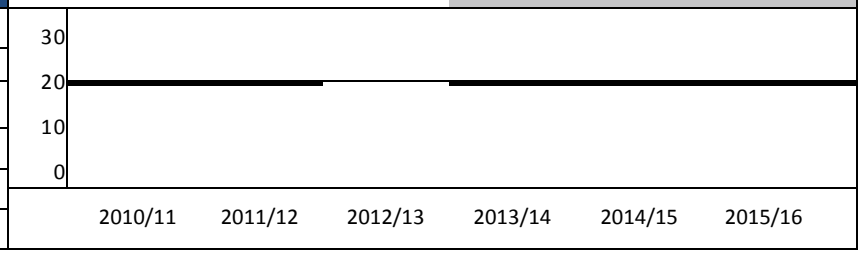
NI-15 Proportion of last 6 months of life spent at home or in a community setting (%)

Source: ISD Scotland.

NI-16 Emergency hospital admissions due to falls - rate per 1,000 population aged 65+

Year	Scottish Borders	Scotland
2010/11	17.7	19.8
2011/12	23.0	19.7
2012/13	20.5	20.7
2013/14	21.2	20.6
2014/15	21.0	20.5
2015/16	20.9	21.0

Historical Performance Trend



Quarterly data for Scottish Borders (N/A = figure not yet available for all H&SCPs)

Year	Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
2013/14	5.0	4.8	6.3	4.9
2014/15	5.0	5.2	4.8	5.9
2015/16	5.0	5.6	4.5	5.8
2016/17	4.9	N/A	N/A	N/A

Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges

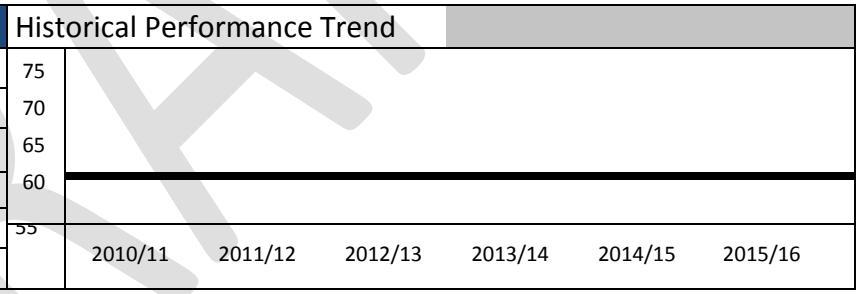
NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

Year	Scottish Borders	Scotland
2014/15	73.9%	81.2%
2015/16	74.6%	82.9%

Source: Care Inspectorate (indicator in development).

NI-18 Percentage of adults with intensive care needs receiving care at home

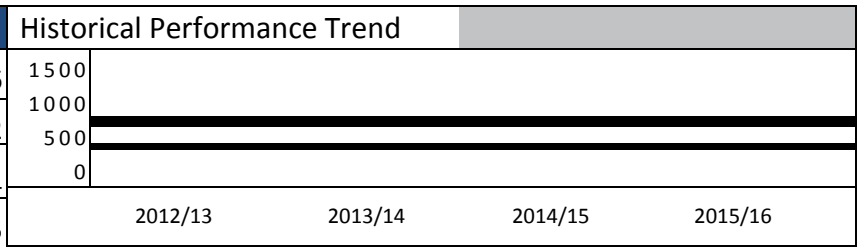
Year	Scottish Borders	Scotland
2010/11	65.9	60.6
2011/12	67.6	60.5
2012/13	70.8	61.8
2013/14	64.8	61.4
2014/15	63.3	61.3
2015/16	64.1	61.6



Source: Scottish Government Health and Social Care Statistics.

NI-19 Number of days people spend in hospital when they are ready to discharged (rate per 1,000 population)

Year	Scottish Borders	Scotland
2012/13	575	886
2013/14	604	922
2014/15	628	1,044
2015/16	522	915



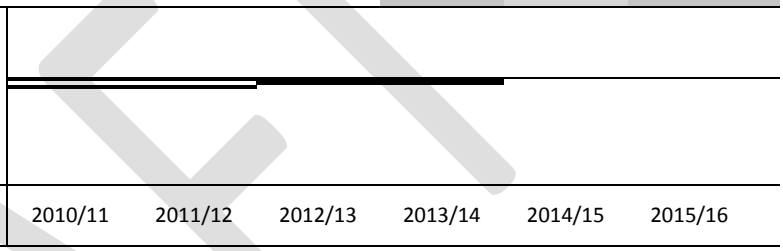
Quarterly data for Scottish Borders (N/A = figure not yet available for all H&SCPs)

Year	Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
2013/14	121	151	162	170
2014/15	191	154	153	131
2015/16	110	134	154	124
2016/17	161	N/A	N/A	N/A

Source: ISD Scotland Delayed Discharge Census.

NI-20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (adults aged 18+)

Year	Scottish Borders	Scotland	Historical Performance Trend
2010/11	21%	22%	
2011/12	20%	22%	
2012/13	17%	23%	
2013/14	21%	23%	
2014/15	20%	22%	
2015/16	21%	22%	



Quarterly data for Scottish Borders to appear here in future draft (equivalent to layout shown for NI-14) – pending receipt from ISD.

Source: ISD Scotland.

National "Core Suite" Indicators 21-23: Indicators based on organisational/system data

The last three of the Core Suite Indicators identified by the Scottish Government to be reportable for and published by all Health and Social Care Partnerships in Scotland remain under development as further work is required with regard to data sources and/or methodology in order to report these measures in a nationally consistent way. These measures are:-

NI-21: Percentage of people admitted from home to hospital during the year, who are discharged to a care home.

NI-22: Percentage of people who are discharged from hospital within 72 hours of being ready.

NI-23: Expenditure on end of life care.

APPENDIX C: Services that are the responsibility of the HSCP

Our Health and Social Care Partnership is 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*	ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*	COMMUNITY HEALTH 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.
	• 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.
		• 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.**

Glossary

Coproduction

Commissioning

Reablement

This page is intentionally left blank

Scottish Borders
Health and Social Care
PARTNERSHIP

NHS BORDERS LOCAL DELIVERY PLAN 2017/18

Aim

1.1 This paper is to update members of the Integrated Joint Board on the draft 2017/18 NHS Borders' Local Delivery Plan (LDP) and invite comments and feedback on this draft. The attached draft LDP will be submitted to the Scottish Government Health Department as a draft on 31st March 2017, with the final copy to be submitted on 29th September 2017, recognising the Health Board will review for final approval at its meeting on 26th October 2017.

Background

2.1 LDPs were introduced during 2006/07 and have been required for the last 10 years. The LDP acts as a corporate contract between NHS Boards and the Scottish Government, outlining priority outcomes and deliverables. NHS Borders' performance against LDPs will be discussed at the Annual Review.

2.2 As with previous years, NHS Borders is required to produce and submit an LDP which forms a performance and delivery agreement between NHS Borders and the Scottish Government Health and Social Care Department. Supporting guidance was issued on 16th January to all NHS Boards which outlined a requirement for the Plan to detail work towards the 2020 Vision for health and social care in Scotland and how we are working across the Health and Social Care Partnership and with members of the public to achieve this. It recommended that particular cognisance should be taken of the 'triple aim' of better health, better care, and better value as outlined in the National Delivery Plan for Health and Social Care that was published in December 2016.

2.3 The supporting guidance sets the expectation that Boards and regional planning partnerships ensure that their objectives and plans are consistent with Integration Authority plans. Similarly, given the interaction with the hospital system, Integration Authorities should ensure that their objectives and plans are consistent with NHS Board and regional plans for 2017/18.

2.4 Using last year's format as a guide, the attached draft LDP is in the format of an Improvement Plan covering the priority areas of the 2020 Route Map to deliver the 2020 Vision, with separate sections on workforce and LDP standards:

1. Improvement Plan
    a. Health Inequalities and Prevention
    b. Person-Centred Care
    c. Safe Care
    d. Primary Care
    e. Integrated Care

Page 1 of 3

f. Unscheduled Care
g. Scheduled Care
h. Mental Health

2. Workforce section
3. LDP Standards

An underpinning Financial Plan is also prepared and submitted as part of the LDP process.

2.5 The 2020 Vision was set out by the Cabinet Secretary in 2011 to achieve sustainable quality in the delivery of healthcare services across Scotland, improve efficiency and achieve financial sustainability. Service leads have produced a short narrative containing the work undertaken and planned for each area, referencing how improvements will be measured.

2.6 The LDP incorporates the key standards, plans, and levels of performance that NHS Borders will have to achieve with partners during 2017/18. This in turn will inform discussions about performance at the Annual Review and Mid Year Review with Scottish Government. Also, during 2017/18 Scottish Government will be tracking 6 key indicators for Partnerships which span across health and social care. These will be monitored locally through the quarterly IJB performance report.

2.7 In previous years the primary focus has been given to the LDP Standards that each Health Board and Partnership is required to achieve. However, a review of targets and indicators for health and social care is currently underway, led by Sir Harry Burns and will report later this year. Once the outcome of the review is known any required amendments to the LDP Standards can be made to the final version of the LDP, assuming timescales allow such changes to be accommodated.

2.8 The draft has been created by narrative received from service leads and managers across the organisation and collaboratively across the Health and Social Care Partnership. The Planning and Performance team will be liaising with national leads to receive feedback and to finalise the draft from April 2017 onwards. Narrative covering regional planning, a key area in the National Delivery Plan for Health and Social Care, will be collated in this period. Discussions within the South, East and Tayside (SEAT) Regional Group regarding this requirement within the LDPs have already commenced.

2.9 The attached draft LDP is the same document which was presented for review to the Health Board's Strategy &Performance Committee recently. Comments and feedback received from that review are currently being incorporated into the draft which will be submitted at the end of March.

Summary

3.1 There has been engagement across the service as the draft Local Delivery Plan has been developed. Feedback has been sought on this draft plan from the Strategy and Performance Committee, members of the Board Executive Team, the Area Partnership Forum, Public Reference Group and wider stakeholders, which will include staff who work in services that fall under the partnership.

3.2 NHS Borders is keen that members of the IJB have an opportunity to review and comment on the current LDP.

3.3 The draft LDP will remain a working document subject to further changes until the final version is approved and submitted.

3.4 The final version will be submitted to Scottish Government on 29th September 2017 and the Health Board will review for final approval on the 26th October 2017.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the draft LDP and **provide any feedback/comments** on the attached draft.

Policy/Strategy Implications	The LDP will be the primary mechanism for monitoring the performance of NHS Boards by the Scottish Government.
Consultation	The LDP 2017/18 has been developed in conjunction with the service, the Clinical Executive, Board Executive Team and service leads.
Risk Assessment	See Above
Compliance with requirements on Equality and Diversity	The risks for delivery of LDP actions have been factored into the plan. Performance will be monitored proactively throughout 2017/18 through reporting to allow remedial actions to be taken.
Resource/Staffing Implications	The LDP has been developed to be fully compliant with NHS Borders' Equality and Diversity requirements.

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Workforce and Planning, NHS Borders		

Author(s)

Name	Designation	Name	Designation
Meriel Smith	Planning and Performance Officer, NHS Borders		

This page is intentionally left blank

NHS Borders

Local Delivery Plan 2017/18

Planning & Performance

Contents

Glossary

ADP	Alcohol and Drugs Partnership
AHP	Allied Health Professional
BECS	Borders Emergency Care Service
BHIH	Borders Health in Hand
BI	Brief Intervention
BME	Black and Minority Ethnic Communities
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Service
CDI	Clostridium Difficile Infection
CEA	Community Empowerment Act
CEL	Chief Executive Letter
CHCP	Community Health and Care Partnership
CHW	Child Healthy Weight
CPC	Child Protection Committee
CPP	Community Planning Partnership
CYP	Child and Young Person
DCE	Detect Cancer Early
DMARDs	Disease-modifying antiheumatic drugs
DNA	Did Not Attend
ED	Emergency Department
ENP	Emergency Nurse Practitioner
EY	Early Years
GCCAM	Good Corporate Citizenship Assessment Model
GIRFEC	Getting it right for every child
GRFW	Get Ready for Work
HAI	Healthcare Acquired Infection
HLN	Healthy Living Network

HSMR	Hospital Standardised Mortality Rate
IRIO	Integrated Research and Innovation Office
ISD	Information and Statistics Division of National Services Scotland
IUCD	Intrauterine Contraceptive Device
JIT	Joint Improvement Team
KSF	Knowledge and Skills Framework
LASS	Lifestyle Advisor Support Service
LD	Learning Disability
LES	Local Enhanced Service
LTC	Long Term Conditions
LUCAP	Local Unscheduled Care Action Plan
MAU	Medical Admissions Unit
MCN	Managed Care Network
MIU	Minor Injury Unit
NES	NHS Education Scotland
P&CS	Primary and Community Services
QPQOF	Quality and Productivity Quality and Outcomes Framework
SAB	Staphylococcus aureus bacteraemia
SAS	Scottish Ambulance Service
SBC	Scottish Borders Council
SEAT	Regional Planning Area for South East Scotland
SGHD	Scottish Government Health Department
SIGN	Scottish Intercollegiate Guidelines Network
SIMD	Scottish Index of Multiple Deprivation
SME	Substance Misuse Education
SOA	Single Outcome Agreement
SPSI	Scottish Patient Safety Indicator
SWHMR	Scottish Women Hand Held Medical Record

TNA	Training Needs Analysis
VAP Bundle	Ventilation-Associated Pneumonia Bundle
VAW	Violence Against Women
VSM	Value Stream Mapping

Section 1: Improvement Plan

The following Improvement Plan sets out how we will deliver on the 2020 Vision for NHS Scotland over the next year, 2017/18. We have focused this around the priority areas of the 2020 Route Map. This plan is structured around 9 key areas of work undertaken and planned that will help us achieve our 2020 Vision for NHS Borders, but it should be noted that this Plan is not inclusive of all the improvement work that is ongoing. We have taken account of the aims of Health and Social Care National Delivery Plan, published in December 2016, within the following narrative to deliver high quality services and further enhance health and social care services in the local area. To do this the narrative covers work in three areas referred to as the triple aim: delivering better care, better health and better value.

The 2020 Vision for NHS Borders reiterates and emphasises the commitment to patient safety, and sets out how we want to make things even safer to drive up the quality of our local services and improve the experience of patients, families, carers and our staff.

NHS Borders is committed to maintaining financial balance through integrated and focused working as well as seeking out efficiencies. This is becoming increasingly challenging given the economic environment and the high level of efficiencies to be achieved whilst sustaining the range of services currently provided, ensuring accessible healthcare across remote and rural areas; managing increased demand generated through population growth and public expectations and delivering LDP Standard trajectories.

Over time the LDP will be closely aligned to the Commissioning Plan developed by the Integration Joint Board for Health and Social Care that will set out how services will be planned and delivered for the Scottish Borders.

The **executive leads** for each priority area in the plan are as follows:

	Priority Area	**Executive Lead**
1	Health Inequalities	Dr Tim Patterson, Interim Joint Director of Public Health
2	Prevention	Dr Tim Patterson, Interim Joint Director of Public Health
3	Person-Centred Care	Claire Smith, Director of Nursing, Midwifery and Acute Services
4	Safe Care	Dr Cliff Sharp, Medical Director
5	Primary Care	Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership
6	Integrated Care	Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership
7	Scheduled Care	Claire Smith, Director of Nursing, Midwifery and Acute Services
8	Unscheduled Care	Claire Smith, Director of Nursing, Midwifery and Acute Services
9	Mental Health	Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership

Priority Area 1: Health Inequalities **Executive Lead: Dr Tim Patterson** **Interim Joint Director of Public Health**	
Improvement aim	**Actions and Measures**
Health inequalities planning	
NHS Borders as a partner in the Community Planning Partnership	**Action:** NHS Borders plays an active role in implementation of the Scottish Borders Reducing Inequalities strategy to achieve better health **Measure:** Participation in relevant groups by NHS Board and staff
	Action: Promote awareness of Community Empowerment Act (CEA) within NHS Borders **Measure:** Increase in understanding of CEA within NHS
Health inequalities key priorities are embedded in Health & Social Care locality plans	**Action:** Engagement with locality planning processes, including community engagement **Measure:** Locality plans show how will address priorities
Health inequalities priorities are embedded in Integrated Children and Young People's (CYP) plan	**Action:** Public Health supports children and families services and with maternal and child health services to deliver effective interventions to improve outcomes **Measure:** Performance framework for Integrated CYP Plan
Child Health services planning	**Action:** NHS Borders Clinical Strategy drives improvement in child health services **Measure:** Strategy and implementation plan in place
Reducing preventable ill health	
Locality plans have identified improvement actions relating to prevention and reducing inequalities	**Action:** Learning and development for Health & Social Care staff to support self management and address health inequalities **Measure:** Locality plans show how will address priorities **Action:** Improved processes and pathways are developed to enable access to: • Support for healthy living and self management for individuals and carers • Information and advice, including welfare benefits, CAB • Health screening • Peer support **Measure:** Pathways in place **Action:** Awareness raising with wider community on risk factors for preventable ill health, signs and symptoms and getting checked early

Improvement aim	Actions and Measures
	Measure: Community engagement plan in place to promote dialogue and communicate key messages **Action:** Develop health literacy within communities with wider partners: pilot starting in 2017 in one learning community board. **Measure:** Evaluation of pilot
Community based health improvement activities	**Actions:** Community food programme delivered in targeted communities Food Alliance project established **Measure:** Food networking activities held in targeted communities
Mental health	
Promote community wellbeing	**Action:** Develop and deliver programme of awareness raising and training to develop mental health literacy with frontline staff and wider community and to promote access to activities & opportunities for arts, culture, physical activity that improve mental heath and wellbeing **Measure:** Collaborative programme in place
Promoting health and wellbeing for mental health service users	**Action:** Physical Health Check Tool developed to ensure patients have an assessment for physical health and an action plan for health improvement. Tool is being piloted for people with severe and enduring mental health problems. **Measure:** Wellbeing and Mental Health Steering Group responsible for implementing, monitoring and evaluating actions. Number of Physical Health Checks/Health Improvement plans completed. **Action:** Smoke free mental health settings-Development post supporting mental health service staff to develop smoke free mental health services policy, increase referrals from mental health to smoking cessation support and training for staff to raise the issue of smoking with patients. **Measure:** Referral pathway in place. Monitor referrals from mental health to smoking cessation support
Inclusion and vulnerable groups	
Learning Disability	**Actions:** Maintain delivery of 'A Healthier Me' project with partner agencies Expand reach of 'I am Me and Keep Safe' Continuation of Project SEARCH in partnership with Scottish Borders Council, and Borders College Local Areas Coordination Team continue to support people with a

Improvement aim	Actions and Measures
	learning disability to live healthier lives and improve their quality of life through developing supportive social networks, and supporting/developing Health Champions roles Employability European funding received till December 2018 to employ 2 staff to support people to engage in voluntary work with a view to broaden employment pathways Weekly weight management group to tackle obesity, which started as a pilot in October 2016, will be evaluated for future delivery/roll out **Measures:** Programmes and pathways in place, activities planned with targeted groups
Carers	**Action:** Public Health input to development of new Carers Strategy that prioritises health and wellbeing of carers **Measure:** Strategy and action plan in place
Physical Disability	**Action:** Development with Public Health input of new Physical Disability Strategy that prioritises health and wellbeing **Measure:** Strategy and action plan in place
Offenders	**Action:** Develop pathways to support offenders health **Measure:** Pathways developed **Action:** Promote awareness of support needs of offenders who are parents **Measure:** Included in scope of new Parent Support Strategy
Migrant health	**Action:** Collaboration with Migrant Support group to address health and housing issues **Measure:** Improved information sharing
Homelessness	**Action:** Public Health involvement in development of housing and homelessness strategy **Measure:** Housing and Homelessness strategy group established with Public Health Input
Capacity building	
Workforce are equipped to recognize and mitigate health inequalities	**Action:** Joint health improvement team deliver training plan in generic health behaviour change; health literacy programme; and topic based and bespoke training for H&SC workforce. **Measures:** Participants in training Qualitative feedback via evaluation

Improvement aim	Actions and Measures
Targeting resources	
Data on deprivation and vulnerability are used to inform resource allocation to improve outcomes achieve better value and	**Action:** Health Improvement programme delivery, including: Smoking cessation Nutrition and healthy weight Mental health Healthy Living Network **Measure:** Programme evaluation **Action:** Improve reach of screening programmes **Measure:** Uptake by vulnerable groups
	Action: Health inequalities impact assessment of health service planning **Measure:** HIIA completed on key service development

Priority Area 2: Prevention **Executive Lead: Dr Tim Patterson** **Interim Joint Director of Public Health**	
Improvement aim	**Actions and Measures**
Supporting healthy living	
Improve care and health outcomes for people with Type 2 Diabetes	**Actions:** Implement physical activity and health behaviour change service in low-activity people with Type 2 Diabetes Support development of diabetes peer support groups in local areas, with key partners **Measures:** Participation and completion rate Physiological and psychological outcomes Number of groups established
Increase in participation in physical activity	**Action:** Development of signposting/referral pathways from NHS settings to community-based physical activity opportunities. **Measures:** National prevalence data, uptake and outcomes in health classes. Monitor number of referrals to Live Borders from NHS
Reduction in prevalence of smoking and exposure to second hand smoke	**Actions:** Delivery of Tobacco Control Action Plan- Prevention actions. Prevention work targeted at Early Years, Children and youth work settings including vulnerable groups **Measures:** SALSUS data, local SHS data, national prevalence data Tobacco Control Plan/JHIT Performance indicators.
Improved sexual health of people in Borders	**Actions:** Delivery of Borders Sexual Health Strategy including: expanding reach of CCard; school drop-ins; supporting school based education. Workforce training opportunities (1.5) **Measures:** Ccard service information; teenage pregnancy and STI rates
Reduction in alcohol and drugs related harm	**Actions:** Alcohol brief interventions (ABI) continue in priority and wider settings. Support to school based education. Provision of Take Home Naloxone (THN). Workforce training opportunities (1.5) **Measure:** Number of ABI performed and THN kits distributed.

Improvement aim	Actions and Measures
Prevention of mental ill health	**Actions:** Develop sustainable approaches to support mental health in primary care, through better coordination and integration of current services Improve supported signposting to sources of advice and support **Measures:** Reach and engagement Service evaluations WEMWBS in SHeS
	Action: By 2018, redesign an integrated early intervention approach to support the mental health of children young people in schools and community **Measure:** New model in place and monitoring information
Suicide prevention	**Action:** Continuation of Suicide prevention training programme **Measure:** Training uptake **Action:** Development of support for this bereaved by suicide **Measure:** Support initiative in place
Maternal and infant nutrition and child healthy weight	**Actions:** Continue to promote Healthy Start uptake and vitamin use Support to maternity and early years settings to improve early diet choices Improve pathways to support for families with overweight / obese children **Measures:** Breastfeeding rates Healthy Start uptake 27 month Body Mass Index (BMI) P1 Body Mass Index (BMI)

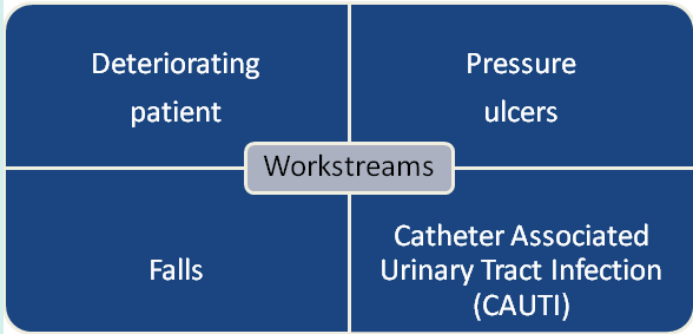
Improvement aim	Actions and Measures
GIRFEC implementation	**Actions:** Continue to implement the new HV pathway to improve support for families Strengthen HV service with expanded staffing and improved management and support **Measure:** Pathway in place **Actions:** Continue to provide specialist Public Health / Health Improvement advice and support to child health services Continue to embed the recently expanded FNP programme to support young parents **Measure:** FNP indicators

Priority Area 3: Person-Centred Care **Executive Lead: Claire Smith** **Director of Nursing, Midwifery and Acute Services**	
Patients and Carers	As part of our three year Public Involvement and Community Engagement Strategy 2016 - 2019 we continue to look at ways in which we can further involve the public in developing channels of communication with our patients, families, carers and communities. We are aiming to embed a culture of listening within the organisation ensuring that people have a strong voice when it comes to the design and delivery of services as well as their own care. Our objectives in this priority area are: • Through the introduction of the Supervisory Senior Charge Nurse (SCN) programme in inpatient areas we will focus on collecting real time feedback from patients. Supervisory SCNs will have daily conversations with patients and their families and, where issues arise, work with staff, using a coaching and mentoring approach, to implement immediate changes • Gathering patient, carer and family member feedback on their experience of care and treatment. Using volunteers to help us gather this feedback and extending the use of hand held devices cutting down on administration and speeding up the feedback process to frontline areas to drive improvements • Continue to provide an open and transparent process for formal complaints and feedback, encouraging supported dialogue between patients, carers, families and staff • Testing a new approach to complaints handling which encourages active listening, dialogue and reflective practice with patients, families and staff • Developing our approach to the use of Patient Opinion to provide independent patient led virtual feedback • Continue to commission independent advocacy services and refresh our joint Independent Advocacy Plan with our partners including Scottish Borders Council and the Third Sector identifying any gaps in provision and articulating plans to address these gaps • Work with Scottish Borders Council and the third sector to refresh our Carers strategy identifying any gaps in provision and articulating plans to address these gaps

Public Involvement and Community Engagement	NHS Borders continues to strive to provide services that match the needs of our local population and in a way that is accessible to all. In order to achieve this we are committed to involving our public and communities in designing, planning and developing our services. Our key priorities over the next 3 years are: • To ensure that the key principles of public involvement and community engagement are embedded in the day to day work of the organisation with individuals and communities encouraged and supported to contribute to the design, planning and delivery of our services. • To reach out to seldom heard groups and individuals to ensure that we collect and receive feedback and input that is representative of our population as a whole. • To develop and strengthen our relationships with our third sector partners in order to support the delivery of existing services and to provide or supplement services not provided by NHS Borders. • To ensure that advocacy services are available and accessible for service user groups, our communities and individuals. • Continue to develop channels of communication with our patients, families, carers and communities to embed a culture of listening within the organisation ensuring the public have a strong voice when it comes to the design and delivery of services as well as their own care. • To expand the membership of our public involvement groups, particularly the Public Partnership Forum, focusing on the localities that have very little or no public representation. • Working alongside our colleagues in the Scottish Health Council to take forward and develop the Our Voice national project to support improvements and empower people to be equal partners in their care.
Volunteering	We received the Investing in Volunteers Award in 2014 and as an organisation we are recognised as having achieved this award for 3 years. This is now up for renewal and we have been doing a lot of work to ensure that we continue to meet the required standards. Volunteering continues to play an important role within NHS Borders, our current volunteer roles work to enhance patient experience and help us to gather feedback. We are committed to continuing to expand the number and type of volunteering roles available offering

	more people from our communities the opportunity to become involved with the work of NHS Borders and to use the skills they have, gain others and satisfaction from their volunteering role. Ongoing financing of this project support is currently provided by the Endowment Funds. A paper is currently escalating to continue with this funding. If accepted then our objectives in this priority area are: • Evaluate the impact of volunteering on patient experience and outcomes • Continue to grow our cohort of volunteers to enhance patient experience by working with departments to explore new volunteering opportunities, support growth in existing volunteer roles and maintain levels when volunteers move on • To continue to ensure that volunteers feel well supported and valued in their roles and have a positive experience while volunteering by building the infrastructure to support and guide volunteers. Also to strengthen and optimise the support to and from volunteers during the year. • Explore and test the use of service user volunteers in the recruitment process, giving the public a strong voice and ensuring openness and transparency • Explore working with the local High Schools to develop a schools programme and engage senior pupils in volunteering giving pupils the opportunity to enhance and develop their knowledge of NHS Borders and the healthcare sector
Staff	Our staff are our most valuable assets, they deliver our services on the front line and behind the scenes and are the first point of contact for people using our services. By recognising our staff to be assets we also recognise NHS Borders responsibility to listen and learn from their experience as well as develop and support them to embed the values of public involvement and community engagement in day to day service delivery. Our objectives in this priority area are: • Develop and implement values- based recruitment: recruitment process and induction programme designed around our core organisational values • Review how we engage and communicate with staff currently and look to develop innovative ways of communicating and

	listening to staff – we are currently testing an approach to learning from adverse events. • Ensure we retain our Carers Positive Award which assesses how we support carers in the workplace • Continue to roll out the iMatter staff experience tool to measure and improve staff experience and well-being • Continue to encourage and support staff to complete the bi-annual Staff Survey and work with partnership to formulate an action plan based on the results • Continue to promote an open and collective leadership culture at all levels of the organisation
Frailty pathway for older people	Within the Health Foundation funded Measurement and Monitoring of Safety programme, a workstream was established to test the Framework on a pathway for frail patients within secondary care. To date objectives have been: • Establish a reliable care pathway • A frailty screening tool, adapted from the national screening tool has been developed, tested, embedded into the new rapid risk assessment document and implemented within all admitting areas • Ensuring reliable implementation of the local version of the national 'getting to know me' booklet that reflects needs of frail patients In addition we are now working with HIS to implement the new national Anticipatory Care Plan, being launched spring 2017. For 2017/18, the aim is to establish a multi-disciplinary frailty team to manage the care and flow of frail patients. • A multi-disciplinary frailty team meet daily (Monday – Friday) in MAU to plan care for recently admitted frail older patients, following a medical pathway. • We are currently testing a 'frailty coordinator' operating Monday to Friday, at the front door of the hospital; supporting staff to manage care for frail individuals not being admitted. This individual can be a nurse, physiotherapist or geriatrician. We are currently testing a frailty screening 'sticker' completed by SAS crews for elderly patients being conveyed to BGH.

Priority Area 4: Safe Care	**Executive Lead: Dr Cliff Sharp Medical Director**
Improvement aims	The provision of safe care has many elements to it but by far the most comprehensive programme of work is the Scottish Patient Safety Programme (SPSP). SPSP is one of a family of national improvement programmes developed over recent years in relation to the national Healthcare Quality Strategy. These programmes draw on improvement methodology advocated by the Institute for Healthcare Improvement. SPSP now contains four distinctly identified workstreams as follows: • Acute Adult • Primary Care • Mental Health • MCQIC (incorporating Paediatrics, Maternal Care & Neonatal)  The SPSP has subsequently reorganised itself to focus on the workstreams identified above, plus continued work in: • VenousThromboembolism (VTE), • Heart failure, • Medicines and • Surgical site infections.
Scottish Patient Safety Programme	The Scottish Patient Safety Programme (SPSP), led and coordinated by Healthcare Improvement Scotland, is a unique national programme that aims to improve the safety of healthcare and reduce the level of harm experienced by people using healthcare services. SPSP aims support outcome 7 of the National health and Wellbeing Outcomes *"People using health and social care services are free from harm".*

Adult Acute SPSP	**ADULT ACUTE** This acute programme has been refreshed to focus on the following patient safety essentials as the system has matured: 1 Hand washing 2 Leadership walkrounds 3 Intensive care unit daily goals 4 General ward safety brief 5 Surgical pause and brief 6 Ventilator associated pneumonia (VAP) bundle 7 National early warning score 8 Central venous catheter (CVC) insertion 9 CVC maintenance 10 Peripheral venous cannula (PVC) bundle Please see below a synopsis of the measures that we will prioritise locally in support of the 10 safety essentials: Leadership Walkrounds: The walkrounds and inspections will continue as per the current format with named executive leadership for each clinical area across NHS Borders. These will continue to be prioritised locally with Non-Executive Director attendance included, although we may not be required to report to Health Improvement Scotland. Critical Care: Process measures are showing reliability and outcome measures will continue to be monitored. Theatre Measures: Local safety priorities have identified that an improvement programme on the quality of the safety briefs and pauses matches the national approach General Ward Measures: Four of the ten essential measures of safety apply to the general ward workstream. These are: • Hand hygiene • General Ward Safety Brief • Peripheral Vascular Cannula Maintenance Bundle, and • National Early Warning Scores These measures will continue to be collected in 2017/18 to ensure the processes are reliably embedded in clinical teams. Deteriorating Patient Workstream: The outcome measure for deteriorating patient is a 50% reduction in cardiac arrests (or 300 days between events). This is achieved through a

	collection of measures such as identification, escalation and treatment of the deteriorating patient, with one of the main causes of deterioration being sepsis. Communication: The focus of safety improvement work will continue for 2017/18 focusing on ensuring SBAR communication is implemented reliably, with particular emphasis on handovers. As part of the deteriorating patient workstream we will continue incorporating debriefs on cardiac arrests in to the daily hospital huddle, with an emphasis on sharing the learning across sites. This will facilitate improved understanding of cardiac arrest incidence and esclation of deteriorating patient. Sepsis: Sepsis forms a key component of the deteriorating patient workstream. It is recommended that 'Sepsis Six' bundle and the use of visual cues and equipment to prompt reliable delivery of the bundle is developed. Medicines: Nationally, a medicines workstream has been created spanning all specialities. NHS Borders plan to continue to reflect that model locally in 2017/18 with an improvement focus on medicines reconciliation on admission and discharge. This will link with the emerging national Excellence in Care approach when the measures are developed. Venous thromboembolism (VTE): The success of the demonstrator project on VTE hosted by NHS Borders will be considered and a plan to take the interventions to scale developed. Falls: The second phase of the Scottish Patient Safety Programme (SPSP) aims to achieve a 25% reduction in all falls and 20% reduction in falls with harm by the end of 2015, while promoting recovery, independence and rehabilitation. Falls measures form an integral part of the revised measurement plan and the local delivery plan for 2017/18. As one of the four priority areas for the Nursing Directorate and of the Older People In Acute Hospitals (OPAH) workstream, the Clinical Improvement Facilitators will continue to undertake tests of change and quality improvement in the areas with the highest numbers of falls, whilst triangulating the outcome data with process data and reported events. Pressure Ulcers: As one of the four priority areas for the Nursing Directorate, the clinical improvement facilitators will continue to undertake quality improvement in this area, whilst triangulating the outcome data with process data and reported events.

	<u>Catheter Acquired Urinary Tract Infection (CAUTI):</u> Testing and innovation work will continue on the patient catheter passport, containing the insertion and maintenance bundles have been rolled out in BGH and Primary Care. <u>2017/18</u> For the adult acute workstream we will focus and prioritise improvement support in to distinct areas: • Frailty (including falls) • Communications (transitions of care, handovers, multi disciplinary team working) • Deteriorating patient • Medicines
Mental Health	The SPSP for Mental Health has a focus on the workstreams identified below, including NHS Borders Acute (Huntlyburn) being a pilot site for Improving Observation in Practice. Early work suggests high level of therapeutic activity benefits and early identification of risks.  Outcome data continues to be collected on a monthly basis via the reporting template from the Brigs and Huntlyburn. Medicines reconciliation has been introduced to Cauldshiels, which is also nurse led.
Maternity, Paediatrics and Neonates (McQIC)	Work continues to embed process measures in the deteriorating patient and infection control workstreams in 2017/18. The reporting was person dependant and moving towards a team approach to further embed the reporting of all measures. Recently the team have a focus on reducing still birth with CTG monitoring.
Primary Care	The national team are currently scoping the future of the programme.
Healthcare Acquired Infections	Every SAB case and CDI case is subject to a rigorous review which includes a feedback process to the clinicians caring for the patient as well as the wider organisation through monthly Infection Control Reports. Any learning is translated into specific actions which are added to the Infection Control Work Plan with progress critically reviewed by the Infection Control Committee.

	SABs are reported by cause to highlight themes and support targeted interventions. During 2015/16, there has been a reduction in each of the top recurring themes identified in 2014/15. Through this approach, NHS Borders has achieved a 33% reduction in SAB cases in 2015/16 compared with 2014/15. This approach will be maintained during 2016/17.
Adverse Event Management	NHS Borders continue to develop the process of reviewing adverse events in a timely manner, with a focus on identifying learning and driving improvements in practice. A focus of this work in 2016/17 will be on working with front line clinical teams to ensure a learning system is developed and that a robust system of support can be offered to patients and staff.
Safety Measurement and Monitoring – Health Foundation Award	In April 2014 the Health Foundation published a Safety Measurement and Monitoring Framework prepared by Charles Vincent. Healthcare Improvement Scotland (HIS) was specifically invited to submit a proposal with two delivery partners. NHS Borders was approached to be one of the delivery partners in recognition of the progress the Board has made in the use of data to drive quality, safety and improvement, along with NHS Tayside and the combined proposal from the three organisations was successful. NHS Borders has begun testing the Framework at Board level and across a frailty pathway for older people. This has offered the opportunity to accelerate our local improvement work in patient safety and the care of older people by establishing a pathway, using a multi disciplinary approach and by liaising with national partners. Several test of change have been undertaken to establish a reliable pathway for the frail population of NHS Borders. From a Board perspective, the Framework is being tested at the Joint Executive meeting, such as at the hospital wide safety huddle. Qualitative feedback has been positive, and descriptions about the way safety is discussed and anticipated is evolving.

Priority Area 5: Primary Care **Executive Lead: Elaine Torrance** **Interim Chief Officer**	
Improvement aims	This section includes work underway and planned within Primary Care that will support increased capacity through increased physical capacity in terms of development of premises and facilities; clinical capacity through service redesign and efficiency initiatives and also through improvements in infrastructure and support networks.
Leadership and Workforce	The senior clinical and management arrangements and working practices have continued to support a whole system approach across primary and secondary care and aim to further build upon the positive collaborative relationships across the health and social care partnership. An Associate Director for Primary and Community Services has been appointed to further strengthen the development of the integration agenda across health and social care will support the continuation and development of shared leadership and working practices across a range of services in both the day time and out of hours periods. As part of its Clinical Strategy development, NHS Borders has committed to developing a Primary Care Strategy that will initially inform and shape the requirements regarding redesign of primary care and community based services, including General Practice, Dental Services, Optometry and Pharmacy. The contribution of these independent contractor services alongside NHS Borders nursing and allied health professional services, for example, will be explored in order to ensure the challenges of providing high quality and resilient services can be addressed. We are currently engaging with services to establish priorities around a range of issues, for example; GP Relations, Recruitment and Retention, Contracts and Independent Contractors, Primary and Secondary care interfaces, Primary Care Safety and Governance arrangements. Further to the options appraisal work undertaken in 2015/16 to develop a suitable model for medical cover across community hospitals a project has been agreed with the support of Professor John Bolton and Dr Anne Hendry to review the existing arrangements for transitional or intermediate care across NHS Borders and the health and social care partnership. Through this project we aim to agree the future role of the Community Hospital in an integrated Health and Social Care system and design an appropriate clinical and non-clinical workforce to support its delivery. Progress in relation to the Transitional Quality Arrangements set out in the new GMS contract for 2016/17 has been slower than desired. Specifically, there has been limited interest to date from the GP community in relation to the role of the Cluster Quality Lead. The senior management team continue to work on this in order to ensure

	arrangements are in place by April 2017. Following a successful submission to participate in the introduction of Buurtzorg model of Neighbourhood Care in Scotland we embarked on a programme of community engagement across the region in order to establish interest and commitment from a range of statutory, independent and voluntary care providers, as well as members of the public and the communities themselves. We have identified two communities that will support us as early adopters for the approach and we will monitor and evaluate the impact as part of the test phase. This will be further supported through the 3 Locality Coordination roles introduced to support locality based engagement and planning as well as the development of locality needs assessments and locality plans.
Service Planning and Interfaces	<u>Urgent Care/Out of Hours Care</u> A local implementation plan will be developed by the Integrated Joint Board during 2016/17 which will support the delivery of the recommendations highlighted in Sir Lewis Ritchie's review of out of hours primary care services. This was detailed in our Integrated Joint Board response letter earlier this year. Sir Lewis is due to visit NHS Borders again on 11 April to review progress to date. The large geographical area and lengthy journeys between home visits will remain a challenge for our Borders Emergency Care Service (BECS). Taking into account concerns about winter resilience and mileage tolerance in light of repeated mechanical issues, the three BECS vehicles were replaced In January 2017. The Joint Clinical Board and IMT approved the purchase of Adastra Aremote software and ruggedised laptops to support electronic transfer of patient information and record keeping by BECS clinicians working in the community. The system is expected to be in operation by the end of March 2017. An Unscheduled Care Project was established to progress a range of key work streams. The Project concluded in December 2015 at which point the work had progressed to a sufficient degree to mainstream within local services. The work now sits with the operational services and a brief description of progress is listed below; • <u>Urgent Care</u> - Job descriptions are being developed for both an Urgent Care Clinical Lead and Project Manager, and it is hoped to have people in post by April 2017, with the aim of implementing and delivering the project plan during 2017/18. • <u>Community Response</u> – this is being taken forward as the Hawick Paramedic Practitioner Pilot. Two GP Practices are working directly with the Scottish Ambulance Service (SAS) to test a

	different model of in-hours response to emergency calls to GPs. BECS continue to support the training of paramedic practitioners by offering clinical experience of acute illness, under GP supervision. • Patient re-education - the "Meet ED" pocket guides have been developed (using the NHS D&G template) and printed. They offer the public information and guidance about where to find the support they need e.g. when to go to the pharmacist, when to contact a GP, self help guidance, when to go to the Emergency Department. The guides have now been distributed through a range of venues and organisations across the region. There is currently a small pilot running to redirect afternoon ED patients who present with primary care problems to BECS at 6pm, with the aim of improving patient expectation and appropriate use of services. • Emergency Department Redesign - including a review of the medical model. This redesign programme will continue to move forward during 2017/18 now that ED Consultants have been appointed. • Overnight Governance in the Emergency Department - arrangements have now been established within the specialties to address this. • Ambulatory Care and Acute Assessment - A new Ambulatory Assessment Unit has been established and the model is being evaluated in line with agreed improvement methodologies. • Review Mental Health Crisis Team input to the Emergency Department – discussions are underway to identify the most appropriate location for the team to ensure timely access and support for patients attending in crisis. Resource has been identified within Urgent Care budgets to explore the possibility of an urgent care Mental Health practitioner. • Accommodation – BECS and ED – an initial scoping exercise has been done in the light of potential changes in approach, in particular issues arising from the requirement to ensure joint working with Social Care and the third sector. These requirements have been placed on the Board capital register and will be reviewed within the standard local capital planning processes. NHS24 Interface: • BECS will also continue to offer direct access for professional-to-professional advice and patient assessment where appropriate for District and Evening Nurses, Paramedics, Nursing and Residential Homes, and Community Hospital staff i.e. bypassing the NHS24 111 call and subsequent wait for a call back. • BECS have regular partners meetings with NHS24 to discuss service issues, and this route could be used in planning urgent

	care service delivery. The National OOH Delivery Plan is highly likely to include the development of regional Urgent Care Resource Hubs (linking professionals from primary care OOH, NHS24, SAS and social care directly, or by suitable IT provision, to allow collaboration in the direction of each patient to the most appropriate professional within the most appropriate timescale and in the most appropriate setting). • BECS clinicians are encouraged to continue to engage in NHS24 triage discrepancy feedback to improve the patient pathways. • BECS communicates and negotiates with NHS24 to provide cover for PLT sessions etc. A salaried GP is now in post in BECS financed by the SG Recruitment & Retention (R&R) initiative who is contracted to provide clinical cover for the four central PLT sessions in 2017. BECS will continue to offer direct out of hours access to palliative care patients, without the need to telephone 111 NHS24. The BECS hub number is given directly to palliative care patients by local District Nursing Teams and GPs. We will also look at how to improve access to community based care facilities for palliative care patients who are not coping at home in line with the review of Community Hospital functionality as described above. BECS clinicians, District Nurses and Community Hospital Nursing Staff have all participated in the Deteriorating Patient Project and are now all routinely using National Early Warning Scores (NEWS) and SBAR communication to improve colleague-to-colleague discussion and decision making re the safest place of care for patients. Ongoing collaboration with local GPs and District Nurses to ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract. The new R&R BECS GP is undertaking a project as part of their role in both BECS and daytime primary care to improve the quality and content of ACPs. Focus within the plan will also improve arrangements for key groups of people, for example those presenting with mental health crises, Frail elderly, children, and those with special access requirements. We will also develop strategies that consider raising public awareness of the out of hours arrangements and appropriate self-management strategies through a number of mechanisms including social media, the NHS Borders website, local press articles, engagement with local volunteers and community groups. We will be looking to review our sustainable plan for the out of hours

clinical workforce in line with our Strategic Plan. A BECS Band 7 Advanced Nurse Practitioner has been appointed and started in post as a supernumerary pilot project in January 2017, to scope the benefits of using ANPs as part of multidisciplinary urgent care delivery in the future.

In line with the Transitional Quality Arrangements in the revised GMS contract each GP practice will nominate Practice Quality Leads and each cluster of GP practices will have a Cluster Quality Lead appointed by the practices and overarching services which will have a developing key role in leading clinical or professional groups and the community in planning high quality integrated services at locality level. This will have to take account of existing resources such as Minor Injury Units and Community Hospitals and looking at how best these services/facilities can best serve the people of the Scottish Borders which may not be their current format. Enhanced Services will continue to be discussed and agreed in liaison with the Local Negotiating Committee, GP Sub Committee and local GP practices.

<u>Public Dental Services (PDS)</u>

Work has progressed and in the next year the intention is to:

- Continue to provide Enhanced services to Special needs/ additional needs with core tooth brushing in all schools with special needs units
- Continue to expand of core tooth brushing to all pre-school and school age children in primary schools
- E-Referral process to be established to support improve clients access specialised dental treatment and domiciliary visits.
- Offer and support annual programme of dental assessments and treatment within care establishments.
- Through more effective communication and interagency work increase the emphasis on ensuring improved access for patients identified as having mental health challenges, drug and alcohol dependencies, the homeless and ex-offenders
- Develop an action plan to decommission one mobile dental units (MDU) by August 2017
- Train additional clinicians to ensure anxiety management services are fully supported within the community and in secondary care
- Improve bariatric dental facility within PDS

<u>GDP Service</u>

Work continues in the following areas:

- Dental Practice Advisor and Dental Clinical Lead liaise with the Directorate of Pharmacy regarding prescribing patterns, particularly antibiotics, and monitor prescribing. Performance is

encouraging for Borders

- Long Term Conditions – GDPs continue to manage their LTC patients with PDS supporting in terms of mentorship, for example for anxiety and sedation training, where necessary
- Patient safety – there are a number of strands of work progressing in this area, including antibiotic audits, monitoring of bed figures, patient scrutiny by Dental Reference Officers where requested, monitoring of outliers at payment verification meetings etc. National Education Scotland (NES) are in the process of devising dental specific programmes and NHS Borders will engage with these when finalised.

LASS - Supporting your Lifestyle change

With reduction in core budgets and central funding ceasing for Keep Well from April 2017 a sustainable model for the future delivery of LASS has been adopted retaining the most effective elements of the existing service and maximise cost effectiveness.

- Increase partnership working to ensure LASS services support for all communities with additional support to those in the most vulnerable groups though targeted partnership work and direct input with users of Criminal Justice Services, Carers Services, Mental Health services, Drug and Alcohol services and services supporting the small homeless population.
- With support from GP's offer opportunistic health checks in all GP surgeries.
- Following trial fully implement the new adult weight programme Weigh 2 Go Borders that combines a number of evidenced based approaches offering wider options to the clients.
- Further develop strong relationships with key services within the Borders General Hospital to ensure effective referral pathways are utilised to support patients and reduce the numbers of readmissions.

Sexual Health

- Consistent >90% recording of alcohol and GBV in all attendees
- Continue to link with Lothian to ensure sustainability and succession planning within Sexual Health services
- HIV and Hepatitis testing over 5 years to be fed back to individual GP practices in to encourage consideration of appropriate testing and early diagnosis
- Review of drug regimes for HIV patients to include first line use of generic antiretrovirals to address costs
- Enhance links with all school nurses to further develop the condom distribution scheme, C-card.
- Enhanced presence in secondary schools and Borders College to

	better support young people's access to Sexual Health services • Reinstate pop up clinics in identified areas of need to better support young people's access to Sexual Health services. Links continue with optometry services delivered in the community to ensure care is in line with local initiatives as they are developed. Diabetic retinal screening continues to be delivered by local opticians. <u>Primary Care Premises Modernisation Programme</u> Progress has continued in 2016/17 with our primary care premises developments. Four "Band 1" highest priority Health Centre sites (Selkirk, Eyemouth, Melrose and Knoll) and two "Band 1a" less significant development sites (Earlston and West Linton) were identified through the Primary Care Premises Modernisation Programme. The scheme at Eyemouth Health Centre will be completed within the first quarter of 2017/18 and the development at The Knoll is scheduled to begin early February 2017 with a 16 week programme of works. The development plans for Melrose are currently being reviewed and finalised; detailed specifications are being developed for Earlston and West Linton. In each of the proposed schemes the aim has been to "future-proof" as far as possible the health centre facilities, bearing in mind the projected population figures and patient activity trends which were used to inform the review and prioritisation process. The works will allow increased local access for patients to the range of services provided from these health centre sites, not only from services based "on site" but also from visiting services such as consultant clinics, psychology, mental health services etc. Increasing the available bookable clinical space which can be used flexibly by the wider multi-disciplinary and multi-agency teams and providing additional GP consulting rooms will allow more consultations with GP and other professional staff groups to take place thereby increasing patient activity and reducing patient waits. Improvements to the physical layout and the provision of "safe" interview rooms, accessible WCs and patient showers will improve equality of access issues and will contribute to improved patient and staff safety and the overall patient experience of services provided by NHS Borders. The proposed provision of a designated paediatric therapy suite at the Knoll will allow Berwickshire families to access an appropriate and child-centred therapeutic space within the locality rather than having to travel to central Borders for more specialised therapy intervention.
Technology and Data	Funding from the Primary Care Digital Services fund is being used to enhance parts of the desktop infrastructure within General Practices. This will help improve experience and productivity in practices and give a firm

	platform for other technologies. All practices have had new servers installed and some are also in line for SWAN bandwidth increases over the next 12 months. This improves resilience in the practices. GPs now have the ability to remotely access their systems from home or any other internet enabled location which has greatly improved their working. We are running a project to re-provide IT systems for Community multi-disciplinary teams. The business case is complete and the contract has been awarded to EMIS. We expect that the new system will deliver functionality that supports staff in their work, facilitates better information sharing across sectors, including General Practice and Social Work, and provides access to information both about individual patients but also for performance and planning purposes. There is a pressing need to replace key parts of the aging IT infrastructure within Primary Care. Desktop PCs still run Windows XP and will need to be upgraded before a new Community IT system can be deployed. Community locations are not Wi-Fi enabled which will restrict our ability to deliver newer ways of working. These issues are being considered for prioritisation through our capital investment prioritisation process. In support of new models of care and Buurtzorg we have finalised a design for a Clinical Bridge application. This will allow the community teams to manage their workload and cohort of patients more effectively. This is essentially a view of all the patients on the caseload across a geographic area / locality. We will test this in a couple of areas in a live environment and then after reviewing our learning implement in the remaining settings. The exact timetable Is not yet firmed up. All independent optometrists now have the capability to refer to the Borders Eye Centre electronically using SCI Gateway. In 2016/17 there was an increase in electronic referrals to 80% compared to 70% the previous year. We have developed a solution which requests the GP summary direct from GPS and reconciles this to the referral prior to it being reviewed in secondary care. On-going support and equipment refresh for this programme remains an issue with local IT teams not funded to provide this. There will also be some work to be considered nationally to renew and support the remote connectivity currently provided by VPN tokens which will expire within a year The introduction of EMIS Web and Clinical Bridge will offer us the opportunity to better report on and analyse our activity and workload. This will help inform further service changes and improvements.

	Electronic Document Transfer – Hub2Hub – we are now connected with the majority of Health Boards across Scotland, allowing traffic both ways. This has helped with costs, time, and manpower at both the BGH and at the Practice end. Laboratory results/letters/X-rays reports now go electronically to GP systems. The ever–increasing reliance on electronic systems brings with it increasing maintenance, installation and educational issues which impact on the capacity of IM&T support services.
Contracts & Resources	The imminent development of a Primary Care Strategy, the ongoing implementation of the Health and Social Care Partnership Strategic Plan and the requirements of the 2017/18 efficiency programme will influence the shape of future primary care services. Primary Care GPs continue to be well represented on both the Integration Joint Board and Strategic Planning Groups and are involved in decision making across a range of existing governance structures. We are continuing to work with GP colleagues to determine very specifically how we wish to see the ongoing joint working with GPs at a practice, locality and strategic level. We recognise that GPs will be critical in that process and are working closely with local GP groups to manage the Transitional Quality Arrangements in the revised GMS Contract.
Pharmacy services	The Scottish Government has invested in pharmacist support to GP practices through the Primary Care Fund. A new pharmacist took up this post in July 2016 to work with a number of practices in a patient facing role that will free up GP time. Additional funding was announced in March 2016 and the pharmacy team have now recruited to this post. The postholder will work alongside the senior Prescribing Support team pharmacists to free them up to take on the role of the advances GP practice pharmacist. Discussions took place with the GP-Sub Committee and practices have now been allocated this additional resource. A plan is in place for the pharmacists working in primary care with GPs to be trained as independent prescribers. Community pharmacy prescribing clinics will continue for a further year. The focus of the work in the coming year will be polypharmacy reviews and reviews of patients using compliance aids. Work is ongoing with care workers to move away from using compliance devices to administer medicines from original packs and using medicine administration record charts. This will improve the safety of medicine administration by care workers. Funding provided for the implementation of Prescription for Excellence has been used to establish a medicine review service in community pharmacy and is currently available in 28 out of 29 pharmacies. Initially the service was to support the introduction of the Sick Day Rules card but

	will be extended to pain from April 2017. The aim of this service is to increase the clinical role of the community pharmacist and deliver direct patient-centred care. NHS Borders has used the additional funding that was allocated for PfE in Autumn 2015 to appoint a discharge technician. The technician, who started in April 2016, works with complex vulnerable patients at discharge to support safe and effective medicines management and improve medicines reconciliation. Pharmacy submitted 2 bids to the Integrated Care Fund to look at redesigning services in the community. The first bid, which was successful, will look at how pharmacy can work with social care to support medicines safety checks for patients referred for a package of care; the second bid, which was unsuccessful, will review the management of respiratory patients to help prevent readmission to hospital and GP consultations.

Priority Area 6: Integrated Care **Executive Lead: Elaine Torrance** **Interim Chief Officer**	
Overview	The Integration Joint Board (IJB) agreed the content of the Strategic Plan for 2016-19 and the accompanying financial statement was also approved in March 2016. The Strategic Plan sets out nine local strategic objectives for the Health and Social Care Partnership and this year we have developed Over the past 12 months key performance information has been collated to evidence progress made in relation to the objectives. Detailed implementation plans have also been developed related to key work areas and strategies including dementia, mental health and older people. It has also been important to take into account the work taken as a partnership to provide a break even position for the IJB delegated budget whilst maintaining front line services.
National and local standards/targets	The Health & Social Care Delivery Plan sets out the three key areas for Integrated Services: reducing inappropriate use of hospital services; shifting resources to primary and community care; and supporting capacity of community care. Mapping of the patient pathway from home to hospital has been identified as a key priority to identify improvement actions and ensure that any delays from hospital are kept to a minimum. Work is progressing to introduce new intermediate models of care and in 2016 a new step up/step down/transitional care facility was opened with 11 available places increasing to 16 in 2017. Further models to establish more community based re-ablement services will be implemented in 2017. A review has been undertaken to focus on actions to reduce avoidable admissions to hospital in line with the strategic plan including work with the third sector. This, coupled with the above, will assist in reducing unscheduled bed days in hospital. A performance scorecard has been developed to monitor progress against key targets which is being reported regularly to the IJB. The importance of early intervention and prevention strategies is recognised. Two new initiatives will be implemented in 2017 including the introduction of a more flexible service response by developing closer joint working with district nurses, social care and communities (Buurtzorg model) and Community Led Support where introduction of community hubs will be set up which will make better use of resources including staff, finances and community resources. Key to both of these is the promotion of self care and having a

	different conversation with individuals to build on their own strengths and resilience. Work is also underway to develop proposals to integrate health and social care staff in locally based teams across the five localities. This development will improve access to community based health and social care services within communities as well as prevent duplication of assessment by different professionals and greater information sharing amongst professionals at a local level. In support of new models of care and Buurtzorg we have finalised a design for a Clinical Bridge application. This will allow the community teams to manage their workload and cohort of patients more effectively. This is essentially a view of all the patients on the caseload across a geographic area / locality. We will test this in a couple of areas in a live environment ac then after reviewing our learning implement in the remaining settings. The exact timetable Is not yet firmed up. There is a focus on palliative care and there is close joint working to provide support to people at home for as long as possible. The opening of the Margaret Kerr Unit has also provided another choice for people at the end of life and their families. The partnership is committed to shifting resources to the community and there is continued investment planned for social care. In 2016 a plan was implemented that all social care staff in the Borders are now paid a minimum wage of £8.25 and this will increase to £8.45 in April 2017. This coupled with a successful care at home tender and a focus on joint recruitment and retention strategies which will help to maintain the continuity, stability and sustainability of both care home and care at home services. A joint integration workforce plan is being developed during 2017 to ensure that Health, Social Care and the third independent sector have a well trained workforce working together to provide quality services across the pathway.
Locality planning	Significant progress has been made in providing locality plans for the 5 agreed localities in the Borders. Three locality co-ordinators were appointed in April 2016 who have built relationships with established community groups including housing, learning and development, the third sector, carers as well as service users and patient representatives. Each area has a local planning group in place and by working with communities we have co-produced draft action plans for each area which will be further developed with clear agreed actions.

Priority Area 7: Scheduled Care **Executive Lead: Claire Smith** **Director of Nursing, Midwifery and Acute Services**	
Local improvement aims	Achieve 98% compliance with urgency classification timeframe (for patient access to emergency theatre). Achieve 100% reduction in our sendaways (patients who are currently sent to the Golden Jubilee or private hospitals for their surgery). Achieve a reduction in our elective hospital cancellation rate from our current 4.65% weekly average for 2016 to below the Scottish national average of 2.1%. Increased elective theatre utilisation rates from an average of 61% to 85%. Reduce patient boarding, ensuring patients are placed in the appropriate place and receive the optimal level of care. Reduce pre-admissions for major orthopaedic elective surgery.
Summary of local work to be carried out under the National Scheduled Care Programme (sustainability) in 2017/18	As part of the Planned Care Surgical Flow Programme, supported by the Institute for Healthcare Optimization (IHO), some improvements in patient care have already been agreed and implemented, these are as follows: • Reduced pre-admissions for orthopaedics from week commencing 15 August 2016. • Smoothed inpatient elective procedures across the week from week commencing 26 September 2016. • Combined/interchangeable elective surgical ward implemented from Wednesday 7 December 2016. The following is still to be implemented with timescales for implementation still to be finalised: • Provide a 1.5 combined emergency theatre resource & 3.5 elective theatre resource. This will provide increased emergency theatre resource and better separation from our elective theatres which will result in more timely access for patients to emergency theatre and less cancellations of elective cases due to an emergency taking priority. In order to achieve the increased theatre resource, additional theatre nurses and consultant anaesthetists need to be recruited.

Measures which will be used to assess improvements made	Monthly monitoring of performance metrics as defined by IHO which are as follows: • Elective and emergency case volume • Elective theatre list utilisation • Emergency theatre list utilisation • Theatre list overruns & associated costs • Average waiting time for emergency cases to get into theatre • Compliance rate for patients accessing emergency theatre within their urgency classification timeframe • Reason for non compliance if patients are unable to access emergency theatre within their urgency classification timeframe • Elective case cancellations • Median post op length of stay • Number of smoothable inpatient elective admissions • Patient census • Average theatre recovery area wait • Number of elective surgical patients boarded outwith specialty

Priority Area 8: Unscheduled Care Executive Lead: Claire Smith Director of Nursing, Midwifery and Acute Services	
NHS Borders Clinical Strategy and Unscheduled Care	Improvements to Unscheduled and Emergency Care are being taken forward through the 6 Essential Actions steering group, led by the Head of Service for Unscheduled Care. The actions focus on the areas identified by the Scottish Government as the key contributors to improved Emergency Access Standard performance and areas identified as opportunities for improvement within the Board. These measures are focused on ensuring effective management of patients flow and prevention of admission. Work to reduce length of stay in Community Hospitals and Delayed Discharges is described elsewhere in this plan, but will be significant contributors to delivery of effective unscheduled care. **EA1 Clinically Focussed and Empowered Hospital Management** **Improvement Aim** – To ensure that patient flow is led at ward, hospital and Board level by clinical staff, supported by management The Hospital Safety Brief is the key daily focus for sharing information on demand and capacity at Board, Hospital and ward level. The HSB is attended by a wide range of clinical and non-clinical staff, ranging from Executive Directors, through senior consultants and nurse leaders to Senior Charge Nurses and ward staff. The Hospital Safety Brief has been developed and now robustly includes a suite of clinical measures as well as visibility of expected demand and required discharges at ward level. This will be further developed: • Attendance daily of community hospital representative and social care to ensure a whole system approach • Addressing patient safety issues will continue to be developed to ensure robust follow up • Ensure attendance from support services, e.g. estates and general services. Clinically-led patient flow management processes continue to be developed; • Providing information on expected demand and required discharges at ward level with support and feedback to address constraints in delivering this capacity • Consolidating the role of the Duty Manager to take the lead in patient flow at hospital level, supporting a whole system approach and enabling early decisions regarding onward patient movement and improving 'pull' systems to take patients out of wards when ready (e.g. from discharge lounge, community hospitals etc). • We have increased medical input to patient flow, building on the

clinical presence at the Hospital Safety Brief, by ensuring senior consultant presence at daily Board Rounds in each ward so that medical staff are integral to planning for patient flow on a daily and ward basis. We will review and streamline the Board Round process to ensure effective use of time and information sharing.

- There is now a twice daily combined medical handover of all patients at risk of deterioration and a focus on discharge pathways. This will be reviewed to ensure a robust process for follow through of actions identified.

The delivery of operational change is being managed through the 6 Essential Actions steering group, led by the Unscheduled Care Clinical Lead. The remit and membership of this group is under review to ensure delivery and monitoring of improvements.

The wider transformational changes in the management of inpatients will be delivered through a number of larger redesign projects in both the acute hospital and the community.

EA2 Hospital Capacity & Patient Flow Realignment

Improvement Aim – Hospital Capacity and Patient Flow Realignment
To ensure that hospital footprint enables the safe, timely and appropriate accommodation of all patients at all times.

We will deliver a programme of work to increase morning discharge rates. This is focused around:

- Advocate and medical presence at all Board Rounds
- Review of IDL process for junior doctors including timetables for ward processes for the team.
- To ensure boarding does not impact on length of stay through early review of boarded patients. In parallel work towards eliminating boarding.
- Discharge bundle of measures for wards to plan morning discharges effectively

We are working to a trajectory to increase morning discharges to 30% by the end of August 2017 and to 40% by the end of December 2017. Performance will be monitored daily at the Hospital safety Brief and Patient flow meetings and reported monthly through performance scorecards

EA3 Patient rather than Bed Management – Operational Performance

Improvement Aim –To provide effective patient flow through BGH by creating early capacity in inpatient areas.

We will continue to develop improved clinical review of patients to increase

	earlier decision-making and planning for discharge. The aim will be to ensure all patients receive a medical review daily that is either led by a consultant or is carried out under the auspices of a consultant: • All medical admissions are now reviewed directly by a senior clinician either in the Acute Assessment Unit or the Medical Assessment Unit, with a focus on opportunities for discharge or triage to most appropriate area. All patients in MAU receive a daily consultant review across the seven days. • We have introduced a model of dedicated consultant cover for downstream medical patients. This will increase continuity of care for inpatients and mean patients receive direct or delegated consultant review on a daily basis. • We will be evaluating the revised medical model in March 2017 to identify further areas for improvement • We are exploring the use of the IHO methodology for medical pathways • We will work on high volume pathways identified through the Effective Care workstream, e.g. chest pain of non-cardiac origin. • We have implemented IHO methodology in surgical elective pathways. We continue to develop the unscheduled surgical pathways to ensure effective use of surgical footprint. • We will increase the availability of Nurse Practitioners out of hours to support medical staff in reviewing and managing patients We intend to reduce boarding to no more than 5% of all occupied bed days. This will be delivered through: • improved patient flow management, including increased morning discharges • Working in partnership with social care colleagues to reduce delays. • Work to improve community hospital length of stay **<u>EA4 Medical & Surgical Clinical Processes arranged for optimal care</u>** **Improvement Aim** – Improve systems for pulling patients from ED in a timely fashion We will continue to consolidate and improve on the now established pathway for GP referrals to medicine. This involves a direct conversation between GP and senior clinician within the medical unit, all patients being assessed within a dedicated Acute Assessment Unit, and the establishment of an Ambulatory Care Unit for patients who require investigation or treatment but do not require admission. We will work to improve pathways for GP referrals to General Surgery and Gynaecology following a similar model. We will: • Develop an approach for ambulatory care for surgical pathways.

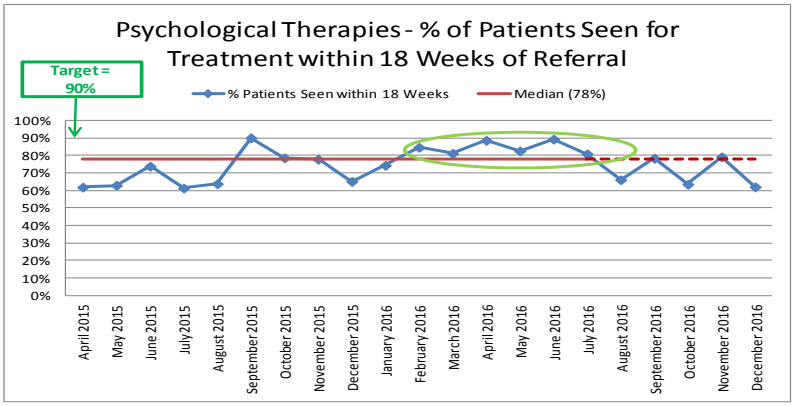
	• Develop improved scheduling of acute GP admissions to smooth and level-load activity arrival times into hospital • Complete improved pathways for GP referral into orthopaedics. • Reinforce escalation systems to ensure beds available in MAU at all times, to improve pull from ED • Maintain and embed current Rapid Assessment and Discharge (RAD) team within core AHP and social work services to increase sustainability and extend coverage to pull patients home from ED **EA5 7 day services – to smooth variation across 'out of hours' and weekend working** **Improvement Aim** - to maintain discharge numbers at consistent level throughout the week. We have established a weekend duty team including an on-site senior duty manager. We will: • Establish robust process for identifying patients with an Estimated Date of Discharge (EDD) on Fridays for the weekend. • Continue to develop 'Transforming Urgent Care' and local need and develop new model of Out-of-Hours primary care within NHS Borders. This will include linking closely with NHS24, SAS and social work out of hours services • Review and develop more effective access to social care out of hours and particularly at weekends. This work will be taken forward in conjunction with partners through the Whole System Winter Planning Group. **EA6 Ensuring Patients are cared for in their own homes** **Improvement Aim** – To ensure no patients in hospital who can be cared for in their own home • We will undertake active work to reduce emergency admissions for common conditions, focusing on developing pathways for patients with common respiratory and cardiac conditions to be reviewed and managed within their own homes and on reducing readmission rates • Extension of Day Of Care Audit (DoCA) to Community Hospitals and Mental Health and active use of DoCA data to manage discharge planning • Package of actions to reduce average length of stay in Community Hospitals to 18 days • Development of a community model of care, including hospital at home, discharge to assess facilities and the development of health and social care coordinators to arrange access to social and third

<table>
<tr>
<td></td>
<td>
sector support
• Review readmissions for areas of improvement.

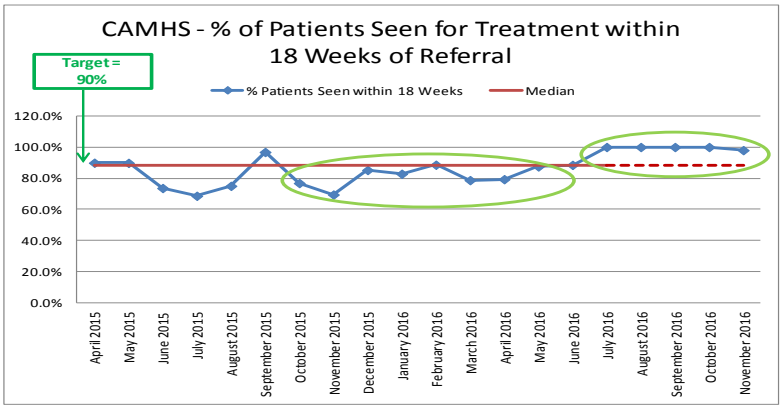
Measures for Assessment

• Achieving the 4 hour 95% Emergency Access Standard and NHS Borders stretch target of 98%
• Reduction in Emergency Access Standard breaches due to lack of beds
• Reduction in number of patients transferred overnight (for non-clinical reasons) to a stretch aim of zero
• Increase in numbers of patients being discharged on same day through Acute Assessment Unit to 35% of all presentations
• Reduction in admissions to Medical Assessment Unit by 5 per day
• Reduction in length of stay in General Medicine to 3.8 days and overall BGH length of stay to 3.32 days
• Increase in number of patients being discharged before midday with a stretch aim of achieving 40% discharges by 12 midday and 30% by 11am
• No reduction in discharge rate at weekend compared to weekdays
• Reduction in number of patients boarding out of speciality to less than 5% of occupied bed days
• No cancellations of planned procedures due to lack of bed availability
• Patients requiring urgent surgery treated within agreed clinical timescales
• Reduction in acute admissions, especially in target conditions
• Increase in patients cared for at home
• Reduction in Community Hospital length of stay to 18 days average
</td>
</tr>
<tr>
<td>Compliance with 4 hour LDP Standard</td>
<td>
Over the last year NHS Borders has met the 95% standard in every month apart from August 2016 and January 2017. We will strive to achieve the 98% target during 2017/18. NHS Borders' current performance can be seen below:

<table>
<tr><th>4 Hour Compliance</th><th>Oct-16</th><th>Nov-16</th><th>Dec-16</th><th>Jan-17</th></tr>
<tr><td>Borders</td><td>95.3%</td><td>95.0%</td><td>96.3%</td><td>90.3%</td></tr>
</table>
</td>
</tr>
</table>

Priority Area 9: Mental Health **Executive Lead: Elaine Torrance** **Interim Chief Officer**	
1. **Psychological Therapies LDP Standard: 90% of Patients will be seen for Treatment within 18 Weeks of Referral**	
Background	This LDP Standard states that 90% of patients referred for a Psychological Therapy (PT) should be seen for treatment within 18 weeks of referral. This was introduced in December 2014. Scottish Government Improving Access funding has been made available for four years from 1st April 2016 to 31st March 2020. This has been used to increase clinical capacity in year 1 – plans for additional years are currently being considered and a project plan for Improving Access to Psychological Therapies is being developed.
Current Performance	The Mental Health Service has not consistently met the standard since it was introduced in December 2014 despite additional capacity being put in place on an ad hoc basis. The chart below shows performance against the standard from April 2015 to December 2016 for information. From February 2016 to July 2016 there was a shift (circled) in performance above the median line of 78%. There is no clear reason for this. However, this shift was not sustained and performance at the end of December 2016 was 62%. 
Local improvement aims	The Improving Access to Psychological Therapies project plan aims to achieve the standard by focussing on two main improvement areas: a. Reduce Did Not Attend (DNA) and Cancelled by patient (CP) Rates b. Management of Available Appointment Slots

Improvement Actions	The following actions will be undertaken as part of these two improvement areas: a. <u>Reduce DNA/CP Rates</u> i. Review and re-launch the Mental Health Service DNA policy ii. Ensure consistent application of the DNA policy across all Mental Health Teams iii. Introduce a text reminder service for Psychological Therapy appointments b. <u>Management of Available Appointment Slots</u> i. Reviewing clinician job plans ii. Clarify expected number of appointment slots per clinician per week iii. Populating clinician diaries with expected number of appointment slots per week iv. Admin staff to manage bookings directly into clinician diaries using the pre-populated appointment slots
Improvement Measures	The following improvement measures will be monitored to ensure the actions being put in place are effective: • Outcome Measure: percentage of patients seen for PT treatment within 18 weeks of referral • Process Measure: percentage of DNA/CP appointments • Balancing Measure: additional administrative time (in hours) spent populating diaries and sending text reminders
2. **Child & Adolescent LDP Standard: 90% of Patients will be seen for Treatment within 18 Weeks of Referral**	
Background	This LDP Standard states that 90% of Child & Adolescent patients referred to the Mental Health Service should be seen for treatment within 18 weeks of referral. This was introduced in December 2014. Scottish Government Improving Access funding has been made available for four years from 1st April 2016 to 31st March 2020. A plan was developed to use this to fund a nurse-led ADHD Clinic, releasing other clinical capacity to meet waiting times; however we have been unable to recruit to the ADHD Nurse post. Future plans are now being considered.
Current Performance	The chart below shows performance against the standard from April 2015 to December 2016 for information. The standard was not consistently met between April 2015 and April 2016 and in fact during this time there was a shift below the median line. However performance then increased and the service has achieved 100% performance from July onwards. This is a

	positive shift (circled) and indicates an improvement. This improvement is due to a review and subsequent revision of the internal recording, monitoring and management process. Performance dropped slightly in both November and December 2016 to 98%, and this was due to a known and unavoidable case in each month. It is anticipated that performance will continue above the standard of 90% on an ongoing basis. 
Local Improvement Aims	The service aims to continue to meet the standard on an ongoing monthly basis. We will introduce a local aim of maintaining 95% performance on an ongoing monthly basis from 1st April 2017 onwards.
Improvement Actions	The following actions will be undertaken in the next year to ensure performance continues above 90%: • Continue with revised internal recording, monitoring and management processes • Review and consider an alternative to ADHD Nurse post • Work with HIS to review Neurodevelopmental pathways • Consider developing a CAMHS Service Specification to ensure the appropriate resource is focussed on the most appropriate patients
Improvement Measures	We will continue to monitor performance against the standard on a monthly basis, and address any change in performance on a case by case basis.

Section 2: Workforce

The key principle of our approach to workforce development and people management is to focus on our staff, our most valuable asset, who are central to the delivery of person centred, safe and sustainable healthcare. Included below is the approach we are taking to implementing Everyone Matters: 2020 Workforce Vision and how we plan to engage with our workforce. In partnership we have combined the Staff Governance Action Plan (SGAP) and the 2020 Workforce Vision Implementation Plan (Everyone Matters) to ensure better coordination and resilience of our plans to improve employee experience.

In this last year we have published a 3-year Local Workforce Plan to support evidence based approach to planning and developing the workforce. The key aim is to ensure we can deliver the highest quality of care by having the right workforce which is available, adaptable and affordable. NHS Borders, in common with all public sector organisations, is currently undergoing significant change in response to national policy, local policy and financial restraints. A number of workforce issues and risks are identified including recruitment, workforce supply, age profile of the workforce/demographics and affordability.

We work to a common set of corporate objectives and values which guide the work we do, the decisions we take and the way we treat each other. By promoting excellence in organisational behaviour (our number one action in our Staff Governance Action Plan) we believe we can improve patient experience and the quality of care we provide.

The focus of our Continuing Action Plan is based five priorities as outlined in *Everyone Matters: 2020 Workforce Vision*.

The five priority areas are as follows:

- Healthy Organisational Culture (local priority)
- Sustainable Workforce (Everyone Matters priority)
- Capable Workforce (local priority)
- Workforce to Deliver Integrated Services (Everyone Matters priority)
- Effective Leadership and Management (local priority)

Summary of the Action Plan

Priority Area	NHS Borders will:	Specific Actions
Healthy Organisational Culture "Creating a healthy organisational culture in which our NHS values are embedded in everything we do, enabling a health	Ensure the delivery of iMatter implementation plans, involve staff in decision making and take meaningful action on staff experience for all staff.	Support the Corporate Objective "Excellence in Organisational Behaviour" Complete the implementation and roll out of the diagnostic tools and staff experience indicators of "iMatter".

engaged workforce".		All staff to be given the opportunity to complete iMatter questionnaire. Ensure associated team action plans at all levels from local team to executive director are in place. Publish an overall Employee Engagement score for NHS Borders. Fully implement and mainstream Values Based Induction Fully implement and mainstream Values Based recruitment, assessment and selection. Establish a feedback loop for new recruits who have been recruited and inducted via the values based process. A Line Managers' Value in Action session established and a requirement for all line managers to attend. Hold an annual multi disciplinary workforce conference in partnership, with a values theme.
Priority Area	**NHS Borders will:**	**Specific Actions**
Sustainable workforce "ensuring that the right people are available to deliver the right care, in the right place, at the right time"	Take action to promote health, well being and resilience of the workforce, to ensure that all staff are able to play an active role throughout their careers and are aware of the support available to them.	Publication of a revised process for Personal Development Review. All staff will have an annual meaningful conversation about their performance, their development and career aspirations. Establish a retirement policy supporting staff to work longer and seeking to change cultural attitudes to

		make flexible working part of normal career development. Establish a Returning Process promoting NHS Borders as an organisation that supports to Return to Practice. Implement quality measures to support the Personal Development Plan (P.D.P.) process building on recommendations from a recent quality audit. Establish a recruitment and retention strategy to ensure continuity of services and reduced long term vacancies. Revised monitoring and reporting of turnover rates/trends to inform projections of recruitment and succession planning. Support the planning, roll-out and feedback of Nursing and Midwifery Workload and Workforce Planning tools
Priority Area	**NHS Borders will:**	**Specific Actions**
Capable Workforce "ensuring everyone has the skills needed to deliver safe, effective, person-centred care"	Build confidence and competence among staff in using technology to make decisions and deliver care and encouraging active participation in learning. Work across boundaries (between professions, between primary and secondary care, between sectors and so on) to share good practice I learning and development, evidence informed practice and	Establish an effective Statutory and Mandatory Training process with agreed protocols for release of staff to participate. E-learning available to all staff and requirement to undertake specific core courses related to KSF dimensions (including dimensions IK1, IK2, IK3 – Information and Knowledge).

	organisational development.	
Priority Area	**NHS Borders will:**	**Specific Actions**
Workforce to Deliver Integrated Services "developing a health and social care workforce across NHS Boards, local authorities and third party providers to deliver integrated services"	Working with partners, develop workforce planning capacity and capability in the integrated setting.	Joint Workforce Planning within the Scottish Borders Health and Social Care Partnership to improve understanding of workforce planning issues across organisational boundaries. Establish shared workforce information and methodologies with Scottish Borders Council.
Priority Area	**NHS Borders will:**	**Specific Actions**
Effective leadership and management " leaders and managers lead by example and empower teams and individuals to deliver the 20:20 Vision"	Implement a new development programme for board level leadership and talent management.	Support the Corporate Objective "Excellence in Organisational Behaviour" Develop multi source feedback for our leaders. Programme of leader's patient safety "walk-rounds"

Local Workforce Plan and Workforce Risks

During 2016 NHS Borders published a 3-year Local Workforce Plan in line with the guidance for submission and timetable for workforce planning and workforce projections issued by SGHD.

Our Local Workforce Plan detailed a range of workforce plans across service areas tested by using accepted methodologies for workforce planning and workload measurement (including the use of Nursing and Midwifery Workload and Workforce Planning tools). We utilise six step workforce planning methodology for line managers and staff involved in a service redesign so a consistent framework applies for the development of the future workforce. All services (clinical and non clinical support services) have either completed or are working on their optimum workforce model through service redesign and option appraisal processes. A workforce risk assessment model is incorporated in all service redesign plans and all plans are subject to the affordability test.

We are providing some high level examples below of workforce risks, utilising a workforce risk assessment methodology developed in partnership with our colleagues across the SEAT region.

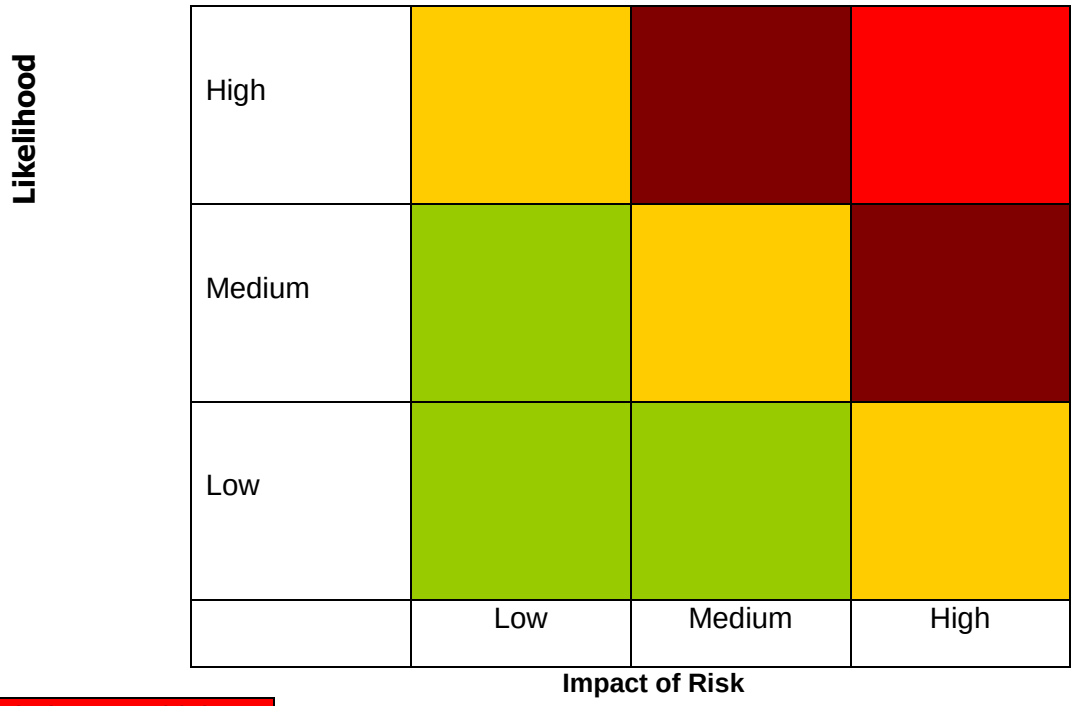
Source of Risk:	**Reduction in Training Grade Doctors Across Key Specialties** **Requirement to Achieve Financial Targets Despite Loss of Income**
Risk:	• Patients do not receive appropriate care within NHS Borders • Hospital or individual service closure • High cost replacement – agency staff
Managed by:	• Role Development Framework for Advanced Practice • Model for Alternative Medical Roles e.g. Consultant delivered services, CDFs. • Locum Appointment Policy with scrutiny on supplementary staffing
Risk Level:	• **MEDIUM** Caution: Moderate risk, needs regular monitoring

Source of Risk:	**Recruitment Shortages to Key Specialties (e.g. Theatre Nursing, Intensive Care, Consultant Anaesthetists)** **Financial Plan Does not Reflect Capacity and Demand** **Reliance on Agency and Supplementary Staff to Provide Core Services**
Risk:	• Core Services are not sustained or affordable • Patient Safety not at optimal level • Staff Morale deteriorates, sickness absence increases, staff engagement deteriorates • Financial pressures on existing plans
Managed by:	• Recruitment and retention strategy • Joint working across SEAT to support sustainability – joint appointments e.g. Haematology on-call • Locum Appointment Policy with scrutiny on supplementary staffing
Risk Level:	• **HIGH** Action: High risk, needs immediate attention

Source of Risk:	**Ageing Workforce** **Demographics in Borders**
Risk:	• Adverse effect on service delivery and workforce • Increased complexity of co-morbidities and patient care needs • Loss of key skills
Managed by:	• Recruitment and retention strategy • Return to Practice schemes across relevant staff groups e.g. AHPs, Nursing and Midwifery • Monitoring and reporting of turnover rates/trends to inform projections of recruitment and succession planning
Risk Level:	• **MEDIUM** Caution: Moderate risk, needs regular monitoring

Assessment of risk

What can be done to reduce the likelihood of a risk occurring?
What can be done to reduce the impact of the risk should it occur?



Priority: Very high risk, needs immediate action

Action: High risk, needs immediate attention

Caution: Moderate risk, needs regular monitoring

Low risk, needs monitoring

Nursing and Midwifery Workload Tools	NHS Borders has utilised the nationally developed Workload and Workforce Planning tools to inform service redesign. All Nursing Ward Areas have implemented a workforce establishment review and Adult Inpatient and Professional Judgement tools have been used to inform redesigned skill mix. Where a national tool was not available (e.g. Outpatients), locally developed tools, based on a Timed Task Analysis approach, have been used to determine Workload. Since revised shift patterns were implemented in 2012, when there is an opportunity to recruit to a post, this is matched much more closely with the hours required by the rota, e.g. a full time member of staff would be recruited to do 37.5 hours, but we would recruit to 34.5 hours when this is the rota requirement. As part of our Nursing & Midwifery Workforce Planning, there was scheduled follow up time aligned to the dates the workload tools were run, to ensure that appropriate analysis was conducted against findings. This includes clinical discussions which will inform the requirement for a business case if seeking additional staff, or reallocation of resources if the tools show an oversupply in a particular area.

Section 3: LDP Standards

NHS Borders aims to maintain the performance against the LDP standards as set out below. Performance will be monitored on an ongoing basis. 23 core suite indicators, showing performance towards the 9 outcomes for Health and Social Care Partnerships, continue to be developed. Once these are in place they will become part of the performance management cycle for NHS Borders and the Partnership.

NHS Borders looks forward to the findings of the national review of targets and indicators for health and social care being led by Sir Harry Burns and will incorporate any modifications to LDP standards within the final version of this Local Delivery Plan 2017/18.

Identifier	Standard
Cancer	People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
CWT	Cancer Waiting Times: 31 days from decision to treat (95%) 62 days from urgent referral with suspicion of cancer (95%)
Dementia	People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support
TTG	12 weeks Treatment Time Guarantee (TTG 100%)
18WKRTT	18 weeks Referral to Treatment (RTT 90%)
12Week	12 weeks for first outpatient appointment (95% with stretch 100%)
Antenatal Services	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation
IVF	Eligible patients commence IVF treatment within 12 months (90%)
CAMHS	18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
PsyTher	18 weeks referral to treatment for Psychological Therapies (90%)
CDI	Clostridium difficile infections per 1000 occupied bed days (0.32)
SAB2	SAB infections per 1000 acute occupied bed days (0.24)
Drug&Alc	Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
Alcohol	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings
Smoking	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas
GPAccess	48 hour access or advance booking to an appropriate member of the GP team (90%)
Sickness	Sickness absence (4%)
4HourA&E	4 hours from arrival to admission, discharge or transfer for A&E treatment (95%

	with stretch 98%)
Breakeven	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

Although significant investment has been made the delivery of waiting times and A&E targets remains a challenge for NHS Borders. The achievement of TTG remains challenging for NHS Borders for a number of specialities.

LDP standard performance will be monitored through the LDP Standard Performance Scorecard presented to each Borders Health Board public meeting. These will be available after the meetings on the NHS Borders website as part of the public board meeting papers.

This page is intentionally left blank

Scottish Borders
Health and Social Care
PARTNERSHIP

REVIEW OF STRATEGIC PLANNING GROUP - UPDATE MARCH 2017

Aim

1.1 The aim of this report is to update the Integration Joint Board (IJB) on the recent review of the role, function and remit of the Strategic Planning Group (SPG).

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 clearly states that the SPG is required to act as an advisory committee to the IJB. As such a SPG was established in the Scottish Borders in April 2016 with the primary function of supporting the IJB to develop the Strategic Plan and set local objectives for the Partnership. In line with Scottish Government guidance membership of the group was representative of all key stakeholders including service users, carers and representatives from localities.

2.2 Since the SPG was established, and the Strategic Plan was published, the focus of the group has become unclear and frequency of meetings and attendance has declined. Guidance from the Scottish Government regarding the role and remit of the group does not clarify the role beyond supporting the development of the Partnership's Strategic Plan.

2.3 The decision was taken in January 2017 to review the role, function and membership of the SPG with a view to revitalising meetings and ensuring that members of the group were clear regarding the importance of their role in terms of supporting the IJB going forward.

Update

3.1 Two meetings of the SPG have taken place since January 2017 and the focus of meetings has been to review the Terms of Reference of the group as well as the membership. A revised Terms of Reference and membership list can be seen in **Appendix One.** It has been recognised that if the group is to fulfil its advisory role to the IJB the timing and frequency of meetings require to be aligned to IJB meetings to ensure that SPG members have the opportunity to comment on all reports being presented to the IJB. Dates for SPG meetings for 2017 have now been confirmed in line with IJB meetings.

3.2 The Chief Officer for Integration and the Strategic Planning and Development Manager for the Partnership have met with the Scottish Government Policy Lead for Strategic Commissioning to discuss the revised Terms of Reference and membership list for the SPG. Reassurance has been given that the revisions made regarding the role, function and membership of the SPG in the Scottish Borders are in line with Scottish Governments expectations of the group. The importance of the

role of the SPG to act not only as an advisory group to the IJB but as a forum for ongoing consultation and community engagement in relation to the Partnerships plans for change and transformation has been highlighted.

3.3 A development session for SPG members, facilitated by the Scottish Government Policy Lead for Strategic Commissioning, is planned for 15 May 2017. The aim of this session is to provide SPG members with the opportunity to explore the revitalised role and function of the SPG and understand the importance of their advisory and consultative role.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the progress made in reviewing the role, function and membership of the SPG.

The Health & Social Care Integration Joint Board is asked to **endorse** the revised Terms of Reference.

Policy/Strategy Implications	
Consultation	
Risk Assessment	
Compliance with requirements on Equality and Diversity	
Resource/Staffing Implications	

Approved by

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Chief Officer for Integration		

Author(s)

Name	**Designation**	**Name**	**Designation**
Jane Robertson	Strategic Planning and Development Manager		

Page 162

Appendix One

Strategic Planning Group – Terms of Reference

Background

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

Integration will see NHS Borders, Scottish Borders Council and the Third and Independent sectors work together to deliver services which focus around the needs of the person, their Carers and family members. The key aims of integration are:

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

Strategic Planning Group (SPG)

The Strategic Planning Group acts as an advisory committee to the Integration Joint Board (IJB). The role of the SPG is to identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan and against the agreed national outcomes. The group provides a forum for initial consultation and community engagement.
Members will be expected to:

- Act in an advisory capacity to the IJB;
- Represent their sector or professional area;
- Comment on and contribute to Partnership change programmes;
- Ensure the interests of the five localities are represented;
- Contribute to any formal updates of the Strategic Plan.

Membership

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

Frequency of Meetings

Meetings will be aligned to Integration Joint Board meetings.

Quorum

No business shall be transacted at a Strategic Planning Group meeting unless there are present the Chair and at least 6 Members of the Strategic Planning Group.

Members of the Strategic Planning Group

Prescribed Group/Title	Role	Name and Deputy
Health Professional	Chair of Area Clinical Forum	Anne Livingstone Deputy: ACF Committee Member
GP	GP Sub-Committee Representative	Tim Young Deputy: tbc
User of Health Care	Representative from NHS Public Participation Network	Caroline Green Deputy: tbc by Susan Hogg
Carers of Users of Health Care	Manager, Borders Carers Centre	Lynn Gallacher Deputy: Linda Jackson
Social Care Professional	Chief Officer for Social Care Group Manager, Social Care and Health	Murray Leys Deputy: Gwyneth Johnstone
Users of Social Care	Co-ordinator, Borders Voluntary Care Voice	Jenny Smith Deputy: Kathleen Travers
Carers of Users of Social Care	Manager, Borders Carers Centre	Lynn Gallacher Deputy: Linda Jackson
Commercial Providers of Social Care	Local integration Lead, Scottish Care	Margaret McGowan Deputy: Margaret McKeith
Statutory Housing Authority	Housing Strategy Manager, SBC	Gerry Begg Deputy: Donna Bogdanovic
Non-Commercial Social Housing Providers	Director of Housing and Care Services, Eildon Housing Association	Amanda Miller Deputy: tbc
Third Sector Bodies whose activities relate to Health and Social Care	Executive Officer, The Bridge	Morag Walker Deputy: tbc
Staff Representative SBC	Staff Officer, SBC	David Bell
Staff Representative NHS Borders	Mental Health and Learning Disability Services Partnership Chair	Shirley Burrell
Non-Commercial/Not for Profit Providers of Health Care	Marie Curie	tbc
Non-Commercial Providers of Social Care	Operations Director SB Cares	Lynne Crombie Deputy: tbc
Integration Joint Board (IJB) Member	IJB Member	tbc Deputy: tbc
Interim Chief Officer for Health & Social Care	Chair SPG	Elaine Torrance Deputy: Murray Leys
Strategic Planning & Development Manager	Locality Co-ordinators' Manager	Jane Robertson Deputy: tbc
Community Council Network	Community Councillor	Colin McGrath Deputy: tbc

In attendance

Tim Patterson	Joint Director of Public Health
Paul McMenamin	Interim Chief Financial Officer for Integrated Joint Board
Alasdair Pattinson	General Manager Primary & Community Services NHS Borders
Steph Errington	Head of Performance and Planning NHS Borders
Gillian Young	Function Manager, Business Management
Julie Watson	Organisational Design & Change Business Partner

Page 164

Scottish Borders
Health and Social Care
PARTNERSHIP

MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2016/17 AT 31 JANUARY 2017

Aim

1.1 The aim of this report is to provide an overview of the monitoring position of the Health and Social Care Partnership Budget at 31 January 2017. This includes an update on the range of pressures being experienced within Health and Social Care and implemented actions for mitigation.

Background

2.1 The report relates to the monitoring position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and that relating to large-hospitals set aside for the population of the Scottish Borders (the "set-aside budget").

2.2 On the 30th March 2016, the Integration Joint Board (IJB) agreed the delegation of **£139.150m** of resources supporting integrated health and social care functions for financial year 2016/17. At the same time, it noted the proposed budget of **£18.128m** relating to the large hospitals budget set-aside. The delegated budget has subsequently been increased in respect of delegation of Community Dental Services and other relevant budget adjustments, equating to £4.581m budget now included within the report.

2.3 This report sets out the current monitoring position on both the delegated and set-aside budgets at 31 January 2017, identifying key areas of financial pressure. Mitigating actions are in place to address these pressures and in aggregate, form a recovery plan for the partnership. A small projected adverse pressure, within Social Care functions, currently remains unaddressed.

Overview of Monitoring Position at 31 January 2017

Delegated Budget

3.1 At 31 January 2017, the delegated budget is now reporting a projected outturn of **£143.786m** against a current budget of **£143.720m** resulting in a projected adverse variance of **£0.066m** in total. This accounts for the projected impact of the healthcare functions recovery plan which has been implemented. This is a significant achievement in the contexts of both substantial financial pressure and limited flexibility which should be commended, although the IJB require to be aware that due to the non-recurring nature of many aspects of recovery this year, addressing future years' recurring impacts will require significant planning and management in order to implement permanently recurring and sustainable measures.

3.2 Reports to the IJB this financial year have previously reported a projected adverse variance across a range of healthcare and social care functions delegated to the Integration Joint Board. For healthcare functions, these totalled over £4.8m, whilst there has been a regular variance of £200k-£300k across social care functions reported to each meeting. By way of mitigation, NHS Borders implemented the following recovery plan across the functions delegated to the IJB, including the direction of £677k social care funding by the IJB in February.

	IJB
	£k
Slippage on Capital Programme	(796)
NHS Control Measures	(1,147)
Slippage on LDP/Reserves	(1,073)
Release Ring Fenced Allocations	(365)
IJB Agreed Surge SCF	
IJB Agreed Non-Recurring SCF	(677)
Balance Sheet Flexibility	(773)
	(4,831)

3.3 This has considerably reduced this position to that reported herein and the partnership's Executive Management Team continue to work to deliver the healthcare recovery plan and to seek opportunity for further efficiency, particularly across areas such as patient flow and unscheduled hospital stay.

3.4 Whilst many actions have been or are being delivered currently, the implementation of this recovery plan by NHS Borders continues to carry a degree of risk. Other pressures may emerge during the remainder of the year and specifically in relation to Prescribing, the highest risk delegated function financially, as per normal processing timescales there is a two month delay in the availability of information Additionally, the highest element of risk to partnership finances over the medium-term continues to relate to the non-recurring nature of a significant proportion of targeted savings within the recovery plan upon which the majority of the recovery is predicated.

3.5 Social care functions are currently projecting an adverse variance of £66k which requires further mitigating action. This is an improving picture from previous reports however and is the result of a small reduction in the volume of residential care beds commissioned, turnover within care at home, a seasonal effect of December and early January and other management savings actions.

3.6 The position regarding the projected delivery of planned efficiencies across healthcare and social care functions delegated to the IJB remains largely unchanged from that reported to the IJB at its meeting in February 2017 with additional but largely non-recurring alternative mitigation actions having been put in place.

Large Hospital Budget Set-Aside

3.7 As previously reported during 2016/17, NHS Borders is currently experiencing the impact of a range of pressures across the large-hospitals budget set-aside for the

population of the Scottish Borders. These pressures have increased since the last report attributable to nurse agency spend across wards, surge capacity costs into elective areas of the hospital and ongoing unprecedented medical locum costs. Supplies and equipment costs have also shown an increase linked to activity increases.

3.8 **£4.528m** of the overall NHS Borders recovery plan actions are now targeted at mitigating the projected adverse pressure on the set-aside budget. If successfully delivered, the NHS Borders recovery plan will deliver a board-wide breakeven position at the end of the financial year.

Risk

4.1 A number of risks have previously been reported to the IJB. These have included the extent of recovery required, the lack of full balance before the current reported position and the assumption of price/demand stability between now and the end of the financial year. The most significant risk however which arises as a result of the mitigating actions in place relates to the medium-term and the significant level of non-recurring efficiency and savings actions on which the partnership's budget remains predicated. Whilst EMT are working to develop and implement a large-scale strategic transformation programme for the medium-term this will require to be targeted at not only addressing permanently the recurring impact of pressures met in 2016/17 temporarily, but also in enabling the partnership to fund the forecast 2017/18 financial planning pressures not yet addressed which in combination is a substantial challenge that may require other non-recurring actions be implemented meantime to enable the overall transition to affordability.

4.2 Any adverse variance at the end of the financial year will, as per the partnership's Integration Scheme, be met from managed underspends elsewhere across partner organisations. In respect of the projected position detailed within this report, the residual pressure across social care functions (£66k) if unaddressed by the 31st March, will be met by Scottish Borders Council.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and the monitoring position on the partnership's 2016/17 revenue budget at 31st January 2017.

The Health & Social Care Integration Joint Board is asked to **support** management teams within both organisations as they continue to make every effort to ensure the IJB returns a balanced position for 2016/17.

Policy/Strategy Implications	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	The report has been considered by the Executive Management team and approved by NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer in terms of factual accuracy. Both

	partner organisations have contributed to its development and will work closely with IJB officers in delivering its outcomes.
Risk Assessment	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.
Compliance with requirements on Equality and Diversity	There are no equalities impacts arising from the report.
Resource/Staffing Implications	No resourcing implications beyond the financial resources identified within the report.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer IJB		

Page 168

MONTHLY REVENUE MANAGEMENT REPORT

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

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,268**	**16,601**	**15,008**	**1,593**	**19,027**	**18,926**	**101**	**52**	**20**	**20**	
Joint Mental Health Service	**15,977**	**13,306**	**13,271**	**35**	**16,047**	**15,954**	**93**	**352**	**316**	**315**	
Joint Alcohol and Drug Service	**948**	**625**	**611**	**14**	**918**	**859**	**59**	**3**	**3**	**3**	
Older People Service	**28,126**	**21,489**	**22,261**	**(772)**	**25,962**	**26,435**	**(473)**	**23**	**0**	**0**	
Physical Disability Service	**3,180**	**2,915**	**2,872**	**43**	**3,449**	**3,341**	**108**	**0**	**0**	**0**	
Generic Services	**77,232**	**65,962**	**67,468**	**(1,506)**	**78,317**	**78,271**	**46**	**604**	**516**	**520**	
Total	**143,731**	**120,898**	**121,491**	**(593)**	**143,720**	**143,786**	**(66)**	**1034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	43,538	42,414	1,124	51,787	51,853	(66)				
NHS Funding from Sgovt etc	91,933	77,360	79,077	(1,717)	91,933	91,933	0				
Total	**143,731**	**120,898**	**121,491**	**(593)**	**143,720**	**143,786**	**(66)**				

MONTHLY REVENUE MANAGEMENT REPORT

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

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,268**	**16,601**	**15,008**	**1,593**	**19,027**	**18,926**	**101**	**52**	**20**	**20**	
Residential Care	4,181	3,387	3,370	17	3,991	3,987	4	0	0	0	
Homecare	2,582	5,135	3,734	1,401	5,466	5,526	(60)	0	0	0	
Day Care	2,091	1,352	1,491	(139)	1,664	1,667	(3)	3	0	0	
Community Based Services	7,139	4,804	4,508	296	5,564	5,455	109	0	0	0	
Respite	200	167	176	(9)	209	230	(21)	0	0	0	
Other	2,075	1,756	1,729	27	2,133	2,061	72	49	20	20	
Joint Mental Health Service	**15,977**	**13,306**	**13,271**	**35**	**16,047**	**15,954**	**93**	**352**	**316**	**315**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	190	163	148	15	200	194	6	0	0	0	
Day Care	186	153	126	27	185	196	(11)	5	0	0	
Community Based Services	788	556	563	(7)	735	659	76	0	0	0	
Respite	15	13	3	10	16	3	13	0	0	0	
SDS	102	97	107	(10)	117	122	(5)	0	0	0	
Mental Health Team	14,696	12,269	12,268	1	14,726	14,712	14	347	316	315	
Choose Life	0	55	56	(1)	68	68	0	0	0	0	
Joint Alcohol and Drug Service	**948**	**625**	**611**	**14**	**918**	**859**	**59**	**3**	**3**	**3**	
D & A Commissioned Services	820	625	611	14	790	731	59	0	0	0	
D & A Team	128	0	0	0	128	128	0	3	3	3	
Older People Service	**28,126**	**21,489**	**22,261**	**(772)**	**25,962**	**26,435**	**(473)**	**23**	**0**	**0**	
Residential Care	11,422	9,723	10,330	(607)	11,579	12,129	(550)	0	0	0	
Homecare	8,025	5,775	6,448	(673)	7,092	6,933	159	0	0	0	
Day Care	1,001	744	751	(7)	913	912	1	0	0	0	
Community Based Services	999	2,511	2,013	498	3,011	3,128	(117)	16	0	0	
Extra Care Housing	545	454	488	(34)	545	551	(6)	0	0	0	
Housing with Care	409	424	373	51	509	518	(9)	0	0	0	
Dementia Services	37	(219)	(217)	(2)	(209)	(213)	4	0	0	0	
Delayed Discharge	267	115	231	(116)	267	262	5	0	0	0	
Other	5,421	1,962	1,844	118	2,255	2,215	40	7	0	0	
Physical Disability Service	**3,180**	**2,915**	**2,872**	**43**	**3,449**	**3,341**	**108**	**0**	**0**	**0**	
Residential Care	566	393	250	143	506	279	227	0	0	0	
Homecare	1,747	1,173	1,220	(47)	1,425	1,359	66	0	0	0	
Day Care	201	56	62	(6)	67	67	0	0	0	0	
Community Based Services	666	1,293	1,340	(47)	1,451	1,636	(185)	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**77,232**	**65,962**	**67,468**	**(1,506)**	**78,317**	**78,271**	**46**	**604**	**516**	**520**	
Community Hospitals	4,802	3,847	4,035	(188)	4,802	5,040	(238)	115	122	123	
Prescribing	22,436	18,615	20,286	(1,671)	22,436	24,436	(2,000)	0	0	0	
AHP Services	5,658	4,750	4,803	(53)	5,658	5,722	(64)	144	139	140	
General Medical Services	16,933	14,368	14,367	1	16,933	16,933	0	4	4	4	
Community Nursing	4,387	3,689	3,707	(18)	4,387	4,409	(22)	110	103	105	
Assesment and Care Management	0	0	0	0	0	0	0	0	0	0	
Group Managers	0	0	0	0	0	0	0	0	0	0	
Service Managers	0	0	0	0	0	0	0	0	0	0	
Planning Team	0	0	0	0	0	0	0	0	0	0	
Locality Offices	0	0	0	0	0	0	0	69	0	0	
SB Carers	0	0	0	0	0	0	0	0	0	0	
BAES	732	804	894	(90)	1,021	1,032	(11)	0	0	0	
Duty Hub	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	42	26	16	56	55	1	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	56	(92)	148	96	96	0	0	0	0	
OT	0	0	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	43	32	11	43	34	9	0	0	0	
Out of Hours	2,131	1,807	1,513	294	2,131	1,819	312	0	0	0	
Community Based Services	0	198	(33)	231	238	293	(55)	0	0	0	
Sexual Health	558	524	537	(13)	558	574	(16)	7	6	6	
Public dental Services	3,324	3,093	3,084	9	3,324	3,324	0	78	78	79	
Community Dental	4,581	3,828	3,782	46	4,581	4,581	0	0	0	0	
Community Pharmacy Services	3,933	3,353	3,377	(24)	3,933	3,933	0	0	0	0	
Continence Services	441	374	344	30	441	433	8	3	3	3	
Smoking Cessation	209	207	157	50	209	149	60	4	5	5	
Primary & Community Management	1,684	1,523	1,772	(249)	1,684	1,983	(299)	34	44	42	
Health Promotion	438	425	399	26	438	402	36	8	12	12	
Opthalmic Services	1,591	1,359	1,381	(22)	1,591	1,591	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	0	0	0	0	0	0	0	0	0	0	
Resource Transfer	2,609	2,192	2,192	0	2,609	2,609	0	0	0	0	
Other	5,243	3,106	3,146	(40)	5,705	5,567	138	28	0	0	
Health and Social Care Fund	0	0	0	0	0	0	0	0	0	0	
Savings - Planned	(4,557)	(2,241)	(2,241)	0	(4,557)	(2,241)	(2,316)	0	0	0	
Savings - Recovery (unallocated)	0	0	0	0	0	(4,503)	4,503	0	0	0	
Total	**143,731**	**120,898**	**121,491**	**(593)**	**143,720**	**143,786**	**(66)**	**1,034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	43,538	42,414	1,124	51,787	51,853	(66)				
NHS Funding from Sgovt etc	91,933	77,360	79,077	(1,717)	91,933	91,933	0				
Total	**143,731**	**120,898**	**121,491**	**(593)**	**143,720**	**143,786**	**(66)**				

MONTHLY REVENUE MANAGEMENT REPORT

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

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**3,599**	**3,027**	**2,930**	**97**	**3,599**	**3,563**	**36**	**20**	**20**	**20**	
Residential Care	2,689	2,243	2,178	65	2,689	2,689	0	0	0	0	
Homecare	0			0	0	0	0	0	0	0	
Day Care	0			0	0	0	0	0	0	0	
Community Based Services	0			0	0	0	0	0	0	0	
Respite	0			0	0	0	0	0	0	0	
Other	910	784	752	32	910	874	36	20	20	20	
Joint Mental Health Service	**14,015**	**11,685**	**11,705**	**(20)**	**14,015**	**14,015**	**0**	**327**	**316**	**315**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	0	0	0	0	0	0	0	0	0	
Choose Life	0	0	0	0	0	0	0	0	0	0	
Mental Health Team	14,015	11,685	11,705	(20)	14,015	14,015	0	327	316	315	
Joint Alcohol and Drug Service	**749**	**511**	**511**	**0**	**749**	**749**	**0**	**3**	**3**	**3**	
D & A Commissioned Services	621	511	511	0	621	621	0	0	0	0	
D & A Team	128	0	0	0	128	128	0	3	3	3	
Older People Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Housing with Care	0	0	0	0	0	0	0	0	0	0	
Dementia Services	0	0	0	0	0	0	0	0	0	0	
Delayed Discharge	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	
Physical Disability Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Healthcare) | **2016/17** | **AT END OF MTH: 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	**73,570**	**62,137**	**63,931**	**(1,794)**	**73,570**	**73,606**	**(36)**	**507**	**516**	**520**	
Community Hospitals	4,802	3,847	4,035	(188)	4,802	5,040	(238)	115	122	123	
Prescribing	22,436	18,615	20,286	(1,671)	22,436	24,436	(2,000)	0	0	0	
AHP Services	5,658	4,750	4,803	(53)	5,658	5,722	(64)	144	139	140	
General Medical Services	16,933	14,368	14,367	1	16,933	16,933	0	4	4	4	
Community Nursing	4,387	3,689	3,707	(18)	4,387	4,409	(22)	110	103	105	
Assesment and Care Management	0			0	0	0	0	0	0	0	
Group Managers	0			0	0	0	0	0	0	0	
Service Managers	0			0	0	0	0	0	0	0	
Planning Team	0			0	0	0	0	0	0	0	
Locality Offices	0			0	0	0	0	0	0	0	
SB Carers	0			0	0	0	0	0	0	0	
BAES	250	205	213	(8)	250	250	0	0	0	0	
Duty Hub	0			0	0	0	0	0	0	0	
Extra Care Housing	0			0	0	0	0	0	0	0	
Joint Health Improvement	0			0	0	0	0	0	0	0	
Respite	0			0	0	0	0	0	0	0	
SDS	0			0	0	0	0	0	0	0	
OT	0			0	0	0	0	0	0	0	
Grants to Voluntary	0			0	0	0	0	0	0	0	
Out of Hours	2,131	1,807	1,513	294	2,131	1,819	312	0	0	0	
Community Based Services	0			0	0	0	0	0	0	0	
Sexual Health	558	524	537	(13)	558	574	(16)	7	6	6	
Public dental Services	3,324	3,093	3,084	9	3,324	3,324	0	78	78	79	
Community Dental	4,581	3,828	3,782	46	4,581	4,581	0	0	0	0	
Community Pharmacy Services	3,933	3,353	3,377	(24)	3,933	3,933	0	0	0	0	
Continence Services	441	374	344	30	441	433	8	3	3	3	
Smoking Cessation	209	207	157	50	209	149	60	4	5	5	
Primary & Community Management	1,684	1,523	1,772	(249)	1,684	1,983	(299)	34	44	42	
Health Promotion	438	425	399	26	438	402	36	8	12	12	
Opthalmic Services	1,591	1,359	1,381	(22)	1,591	1,591	0	0	0	0	
Patient Transport	0			0	0	0	0	0	0	0	
Accomodation Costs	0			0	0	0	0	0	0	0	
Resource Transfer	2,609	2,192	2,192	0	2,609	2,609	0	0	0	0	
Other	2,162	219	223	(4)	2,162	2,162	0	0	0	0	
Health and Social Care Funding	0			0	0	0	0	0	0	0	
Savings - Planned	(4,557)	(2,241)	(2,241)	0	(4,557)	(2,241)	(2,316)	0	0	0	
Savings - Recovery (unallocated)	0	0	0	0	0	(4,503)	4,503	0	0	0	
Total	**91,933**	**77,360**	**79,077**	**(1,717)**	**91,933**	**91,933**	**0**	**857**	**854**	**857**	

MONTHLY REVENUE MANAGEMENT REPORT

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

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Joint Learning Disability Service	**14,669**	**13,574**	**12,078**	**1,496**	**15,428**	**15,363**	**65**	**32**	
Residential Care	1,492	1,144	1,192	(48)	1,302	1,298	4	0	
Homecare	2,582	5,135	3,734	1,401	5,466	5,526	(60)	0	
Day Care	2,091	1,352	1,491	(139)	1,664	1,667	(3)	3	
Community Based Services	7,139	4,804	4,508	296	5,564	5,455	109	0	
Respite	200	167	176	(9)	209	230	(21)	0	
AWLD Staff Teams	1,165	972	977	(5)	1,223	1,187	36	29	
Joint Mental Health Service	**1,962**	**1,621**	**1,566**	**55**	**2,032**	**1,939**	**93**	**25**	
Residential Care	0	0	0	0	0	0	0	0	
Homecare	190	163	148	15	200	194	6	0	
Day Care	186	153	126	27	185	196	(11)	5	
Community Based Services	788	556	563	(7)	735	659	76	0	
Respite	15	13	3	10	16	3	13	0	
SDS	102	97	107	(10)	117	122	(5)	0	
MH Staff Teams	681	584	563	21	711	697	14	20	
Choose Life	0	55	56	(1)	68	68	0	0	
Joint Alcohol and Drug Service	**199**	**114**	**100**	**14**	**169**	**110**	**59**	**0**	
Drug and Alcohol Commissioned Services	199	114	100	14	169	110	59	0	
Drug and Alcohol Team	0	0	0	0	0	0	0	0	
Older People Service	**28,126**	**21,489**	**22,261**	**(772)**	**25,962**	**26,435**	**(473)**	**23**	
Residential Care	11,422	9,723	10,330	(607)	11,579	12,129	(550)	0	
Homecare	8,025	5,775	6,448	(673)	7,092	6,933	159	0	
Day Care	1,001	744	751	(7)	913	912	1	0	
Community Based Services	999	2,511	2,013	498	3,011	3,128	(117)	16	
Extra Care Housing	545	454	488	(34)	545	551	(6)	0	
Housing with Care	409	424	373	51	509	518	(9)	0	
Dementia Services	37	(219)	(217)	(2)	(209)	(213)	4	0	
Delayed Discharge	267	115	231	(116)	267	262	5	0	
OP Staff Teams	847	738	620	118	879	836	43	7	
Other	4,574	1,224	1,224	0	1,376	1,379	(3)	0	
Physical Disability Service	**3,180**	**2,915**	**2,872**	**43**	**3,449**	**3,341**	**108**	**0**	
Residential Care	566	393	250	143	506	279	227	0	
Homecare	1,747	1,173	1,220	(47)	1,425	1,359	66	0	
Day Care	201	56	62	(6)	67	67	0	0	
Community Based Services	666	1,293	1,340	(47)	1,451	1,636	(185)	0	
Other	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Social Care) | **2016/17** | **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	**3,662**	**3,825**	**3,537**	**288**	**4,747**	**4,665**	**82**	**97**	
Community Hospitals	0	0	0	0	0	0	0	0	
Prescribing	0	0	0	0	0	0	0	0	
AHP Services	0	0	0	0	0	0	0	0	
General Medical Services	0	0	0	0	0	0	0	0	
Community Nursing	0	0	0	0	0	0	0	0	
Assesment and Care Management	0	0	0	0	0	0	0	0	
Group Managers	0	0	0	0	0	0	0	0	
Service Managers	0	0	0	0	0	0	0	0	
Planning Team	0	0	0	0	0	0	0	0	
Locality Offices	0	0	0	0	0	0	0	69	
SB Cares	0	0	0	0	0	0	0	0	
BAES	482	599	681	(82)	771	782	(11)	0	
Duty Hub	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	42	26	16	56	55	1	0	
Respite	0	0	0	0	0	0	0	0	
SDS	0	56	(92)	148	96	96	0	0	
OT	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	43	32	11	43	34	9	0	
Out of Hours	0	0	0	0	0	0	0	0	
Community Based Services	0	198	(33)	231	238	293	(55)	0	
Sexual Health	0	0	0	0	0	0	0	0	
Community Dental	0	0	0	0	0	0	0	0	
Public dental Services	0	0	0	0	0	0	0	0	
Community Pharmacy Services	0	0	0	0	0	0	0	0	
Continence Services	0	0	0	0	0	0	0	0	
Smoking Cessation	0	0	0	0	0	0	0	0	
Primary & Community Management	0	0	0	0	0	0	0	0	
Health Promotion	0	0	0	0	0	0	0	0	
Ophthalmic Services	0	0	0	0	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	
Accommodation Costs	0	0	0	0	0	0	0	0	
GS Staff Teams	3,515	2,785	2,688	97	3,321	3,240	81	0	
Other	(434)	102	235	(133)	222	165	57	28	
Total	**51,798**	**43,538**	**42,414**	**1,124**	**51,787**	**51,853**	**(66)**	**177**	

MONTHLY REVENUE MANAGEMENT REPORT

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

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Large Hospital Set Aside	**18,128**	**17,217**	**20,235**	**(3,018)**	**18,128**	**18,128**	**0**	**0**	**0**	**0**	
Accident & Emergency	1,806	1,676	2,167	(491)	1,806	2,376	(570)	0	0	0	
Medicine & LTC	11,330	10,681	12,564	(1,883)	11,330	13,606	(2,276)	0	0	0	
Medicine of the Elderly	6,080	5,098	5,742	(644)	6,080	6,912	(832)	0	0	0	
Savings - Planned	(1,088)	(238)	(238)	0	(1,088)	(238)	(850)				
Savings - Recovery (unallocated)	0	0	0	0	0	(4,528)	4,528				
Total	**18,128**	**17,217**	**20,235**	**(3,018)**	**18,128**	**18,128**	**0**	**0**	**0**	**0**	

Scottish Borders
Health and Social Care
PARTNERSHIP

SOCIAL CARE: ADDITIONAL FUNDING ALLOCATION TO PARTNERSHIPS 2017/18

Aim

1.1 This report aims to summarise for the Integration Joint Board (IJB) the forecast impact of the conditions accompanying the indicative 2017/18 Scottish Government allocations and financial settlements to NHS Borders and Scottish Borders Council. The report seeks approval for direction of additional funding allocation to meet the projected additional costs arising and recommends direction towards other partnership priorities in 2017/18 where there are projected financial implications.

Background

2.1 Each of the health and social care integration partners in the Scottish Borders received Scottish Government letters announcing an additional £107m of funding to health and social care partnerships in order to fulfil a range of commitments, in particular, its continued commitment to delivering and sustaining the Living Wage in care.

2.2 For the Scottish Borders partnership, this equates to an additional £2.130m core funding and a further £0.150m in respect of delivering wider commitments of changing the basis of charging in respect of veteran war pensions and preparing for the implementation of impending carers' legislation. The basis of the additional allocation is indicatively broken down as below:

Total Scottish Govt. Allocation £'m		**Scottish Borders Allocation £'m**
50	Full Year Living Wage £8.25 impact	1.06
20	Increase in LW to £8.45	0.43
10	Further Night Support Sleep-ins	0.21
20	Sustainability of commitments made	0.43
100	**Sub-Total**	**2.13**
5	Charging disregard – Veteran War Pensions	0.11
2	Preparation for Carers' Legislation	0.04
107		**2.28**

2.3 As the above table highlights, £100m (£2.130m Scottish Borders) has been made available to "*support continued delivery of the Living Wage, sleepovers and sustainability in the care sector and £7m to disregarding the value of war pensions from financial assessments for social care and pre-implementation work in respect of the new carers' legislation*".

2.4 This supplements the additional £250m 'social care funding' to partnerships in 2016/17 which has now been baselined on a recurring basis – "*This is additional to the £250m added in the 2016/17 budget, bringing the total support available from the NHS through Integration Authorities to protect social care to £357m*".

2.5 Since the announcement that the Scottish Government intended to implement a Living Wage of £8.25 from 01 October 2016, work has been ongoing to identify the financial consequences of this commitment and implement the required arrangements across all social care providers. In 2016/17, the IJB agreed to direct £813k to meet the part-year effect of known implications of this commitment and £1.626m on a recurring basis. This was part of a range of measures to which the IJB directed social care funding during 2017/18:

	Delegated Budget		Set-Aside Budget		Total	
	2016/17 £'000	2017/18 £'000	2016/17 £'000	2017/18 £'000	2016/17 £'000	2017/18 £'000
20-Jun-16						
Living Wage	813	1,626			813	1,626
Demand Pressure	1,081	1,081			1081	1,081
Charging Threshold	154	154			154	154
Unplanned Efficiencies	220	0			220	0
	2,268	**2,861**	**0**	**0**	**2,268**	**2,861**
30-Aug-16						
Provider Costs	1,127	1,127			1127	1,127
Demand Pressure	300	300			300	300
	1,427	**1,427**	**0**	**0**	**1,427**	**1,427**
17-Oct-16						
Surge Beds	0	0	500	0	500	0
Night Support (*)	0	750			0	750
Night Support Redesign	75	0			75	0
BAES Equipment	295	0			295	0
Community MH Worker	25	50			25	50
	395	**800**	**500**	**0**	**895**	**800**
27-Feb-17						
Reported Pressures	677	0	0	0	677	0
	677	**0**	**0**	**0**	**677**	**0**
Total Directed to Date	**4,767**	**5,088**	**500**	**0**	**5,267**	**5,088**
2016/17 Allocation					**5,267**	**5,267**
Remaining Resources					**0**	**179**

2.6 Work has continued to identify the cost of fulfilling all further commitments directed by the Scottish Government for 2017/18 in addition to identifying how any remaining

Page 178

additional funding can be directed to maximum benefit in order to sustain social care services in line with the Scottish Government's directive.

2.7 In addition to the £2.130m additional allocation, £0.179m of the original £5.267m 2016/17 social care funding allocation remains undirected on a recurring basis. The 2016/17 was directed in full**.**

2.8 **It is proposed that this 2017/18 recurring uncommitted resource is consolidated with the £2.130m to provide a total 2017/18 resource of £2.309m, for direction by the IJB.**

What financial commitments / priorities require the IJB's consideration for funding?

(A) A universal Living Wage of £8.45 for all social care staff

3.1 £2.130m of additional funding has been allocated to the Scottish Borders Health and Social Care partnership in order to meet the cost of full implementation of the Living Wage in 2017/18. Specifically, this should be used to:

- Implement a Living Wage of £8.45 (an increase from £8.25 and extension across all providers) for all social care staff, with effect from 01 May 2017
- Ensure that all on-costs associated with the implementation of the Living Wage of £8.45 such as national insurance and pension contributions are met
- Evaluate the impact of the implementation of a Living Wage of £8.45 for lowest-grade care staff, in terms of grade differential erosion arising as a result and address this financially
- Address the financial consequences of the implementation of the Living Wage in relation to care staff providing Night Support Sleep-ins, following the EU Working Time Directive
- Ensure all Personal Assistants employed by staff in receipt of a Direct Payment for their care are paid an hourly rate at the Living Wage of £8.45
- In line with Scottish Government direction, no longer seek provider organisation contribution towards the cost of implementing the Living Wage commitment
- Fund the cost of the implementation of the yet-to-be-agreed Cost of Care Calculator that will uplift the contract fee for independent residential care homes part of the COSLA contract. This will include full implementation of the Living Wage of £8.45 for all residential care home staff

3.2 Based on survey and analysis undertaken across the range of areas outlined above, the projected costs of the above factors at the current time are:

		Projected Lower Cost £'000	Projected Higher Cost £'000
1	Living Wage £8.45, on-costs and differential erosion	829	829
2	Night Support Sleep-ins*	0	800
3	Personal Assistants Living Wage £8.45	0	0
4	Remove any Provider Contribution	0	0
5	COSLA Residential Care Home Uplift	250	672
	Total Scottish Government Allocation Commitments	**1,079**	**2,301**

3.3 Further detail supporting the above analysis is provided in Appendix 1 including the reason for the lower and higher cost estimates currently.

(B) Other social care current service pressures

3.4 In addition to the direct Living Wage-related factors above which require addressing, in order to *'protect social care'* and ensure the continued sustainability of its provision across the Scottish Borders, it is necessary to review key areas of risk across social care functions and, if required, increase the level of resources available to ensure they are sufficient to meet current levels of price and in particular demand.

3.5 Monitoring reports to the IJB during 2016/17 have consistently referred to ongoing affordability pressures within residential social care and the Borders Ability and Equipment Service, where the cost of meeting the current level of demand has consistently exceeded available budget. In respect of the latter, the partnership twice directed social care funding during 2016/17 in order to meet this pressure.

3.6 The projected investment required within these two social care service areas is detailed below. Further information is again included in Appendix 1.

		Projected Cost £'000
6	Residential Care Home - 20 additional beds	372
7	Borders Ability and Equipment Store - Increased Equipment Budget	249
	Other Current Partnership Social Care Financial Requirements	**621**

(C) Other forecast demand pressures

3.7 Within the indicative allocation / financial settlement correspondence, the Scottish Government has stated that *"To reflect this additional support (the additional £100m) local authorities will be able to adjust their allocations to integration authorities in 2017/18 by up to their share of £80m below the level of budget agreed…for 2016/17"*. For the Scottish Borders, this could equate to a potential reduction in the budget delegated for social care functions by up to £1.680m. Having not reduced its contribution by the allowable amount, the local authority has highlighted to the IJB that it expects any demand or demographic pressures, both

Page 180

existing and new that are forecast and required to be addressed financially in 2017/18, to be funded by the IJB, in terms of how it directs the additional funding allocation made available by the Scottish Government. The demographic pressure arising from increased demand for social care services during 2017/18 is forecast to be:

		Projected Cost £'000
8	2017/18 Demographic Increases - Older People, Learning Disability	486
	Total Demographic Pressure Forecast 2017/18	**486**

3.8 A further £150k has been allocated to the partnership to meet the costs/income foregone by disregarding the value of war pensions when assessing clients' means to determine any contribution towards the cost of their care (£110k) and to undertake preparation for the implementation of the Carers' Act in 2018. The impact of the former action will be known only when full assessment of all clients for 2017/18 is complete. This will be in late spring 2017. No decision has yet been taken as to how the partnership will undertake its preparation for the implementation of the Carers' Act. When both these impacts become clearer, a further report will be made to the IJB.

Recommended Direction of Funding 2017/18 at March 2017

4.1 In order to comply with the Scottish Government's commitment to the implementation of a Living Wage of £8.45, it is recommended that the IJB direct £829k of the additional funding allocation now.

4.2 It is also recommended that the IJB direct an element of its additional funding allocation to meet the demand-driven pressures within residential social care and the Borders Ability and Equipment Service. Together, these require £621k of additional resource.

4.3 In summary therefore, the following direction of resource is recommended currently:

		Required Funding Allocation £'000
1	Living Wage £8.45, on-costs and differential erosion	829
6	Residential Care Home - 20 additional beds	372
7	Borders Ability and Equipment Store - Increased Equipment Budget	249
		1,450

This will enable negotiations with all external providers to commence and provide local authority commissioners with the required financial resources to reach contractual agreement. Additionally, it will enable a re-baselining of key social care budgets that are currently or forecast to be under financial pressure yet again.

4.4 **This requires a total of £1.450m to be directed by the IJB now. Following this direction, a balance on the additional allocation (£2.130m) and social care**

funding carried forward (£0.179m) combined of £0.859m will be left for direction in 2017/18.

Next Steps

4.5 Until the outcomes of the negotiations between COSLA, the Scottish Government and independent care homes are known and agreement reached, a final forecast of the expected financial consequences is not possible. However, it is recommended that for now, £373k (4%) of the additional funding is 'earmarked' by the partnership and when known, a recommendation for final direction will be made.

4.6 Similarly, until further clarity over the expected costs relating to Night Support Sleep-ins emerges, then no direction of further funding by the IJB can take place. A further report on this area and the expected financial implications will be brought forward, when this becomes known.

4.7 This therefore leaves meeting the forecast demographic increases from any remaining available funding. At the current time however, until the likely implications outlined in 4.5 and 4.6 above are known, it is not possible to direct any of the remaining £0.859m (or £0.486m net of the earmarked balance for COSLA residential care home settlement) and this will only be considered once the partnership's affordability of both these further commitments is assured.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the report and direct £1.450m to enable the local authority to fulfil the Scottish Government's commitment to the implementation of the Living Wage of £8.45 and to meet identified partnership social care pressures and identified priorities in 2017/18.

The Health & Social Care Integration Joint Board is asked to **note** the outstanding factors pertaining to the implementation of the living wage and forecast demand pressures in 2017/18 and the remaining balance on the combined remaining allocation (£0.859m) from which these pressures, when known, will require to be funded.

Policy/Strategy Implications	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	The report has been considered by the Executive Management team.
Risk Assessment	To be reviewed in line with agreed risk management strategy. Any financial risks associated with any areas of the report will be reported to the Integration Joint Board during 2017/18 when they arise.
Compliance with requirements on Equality and Diversity	There are no equalities impacts arising from the report. The report proposes to meet the Scottish Government's commitment to implementing the Living Wage of £8.45 and to preserve basic grading differentials

	arising for lowest-paid care staff.
Resource/Staffing Implications	No resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2017/18 will be reported to the Integration Joint Board.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Chief Financial Officer – Integration Joint Board		

APPENDIX 1 IDENTIFIED SOCIAL CARE FINANCIAL IMPLICATIONS

	Projected Costs of Required Social Care Price/Demand Investment	Projected Lower Cost £'000	Projected Higher Cost £'000
1	Living Wage £8.45, on-costs and differential erosion	829	829
2	Night Support Sleep-ins	0	800
3	Personal Assistants Living Wage £8.45	0	0
4	Remove any Provider Contribution	0	0
5	COSLA Residential Care Home Uplift	250	672
6	Residential Care Home - 20 additional beds	372	372
7	2017/18 Demographic Increases - Older People, Learning Disability	486	486
8	Borders Ability and Equipment Service - Increased Equipment Budget	249	249
		2,186	**3,408**

(1) *Living Wage £8.45, on-costs and differential erosion*

In late 2016, work commenced to identify the impact of implementing a Living Wage of £8.45. This was a considerable project and involved a range of discussions, surveys and analysis with all external providers from whom a care and support service is currently commissioned by the local authority, excluding SB Cares who will already pay their staff at a level equal to or in excess of the planned living wage of £8.45 by April 2017. In forecasting the estimated cost of the Living Wage, consideration has been given to the increase required from current hourly pay rates, on-cost impact and the requirement to preserve basic low-grade pay differentials. The majority of this work has now been completed and it is now possible to forecast the required additional resources required to address the financial impact of the proposed implementation. For 2017/18, it is recommended that the IJB direct £829k of the additional funding allocation to meet the financial impact of each calculated required component element of implementing the living wage of £8.45 for all social care staff working within provider care organisations across the Scottish Borders.

(2) *Night Support Sleep-ins*

Transition from a nightly Night Support rate payment to hourly payment as a result of further emerging impacts of the Employment Tribunal verdict will create considerable financial pressure. Initial scoping shows historic nightly rates to be considerably less than the costs of an hourly rate (at a living wage) x number of hours worked. Resulting from the EU Working Time Directive, the requirement that all care staff providing night support are paid an hourly rate (taking account of holiday pay and a living wage) instead of a nightly fee will result in a considerable cost increase. Prior to this legislative change, the cost of a sleep-in was on average £36 and following implementation of the change it is projected that each nightly sleep over will now cost £157, an increase of 435%. Without action to redesign how night support is provided and thereby mitigate this expenditure increase, it is estimated that over a full financial year, this change will cost an additional £1.55m per annum.

The impact of this pressure clearly requires to be mitigated through a combination of reducing the number of night-time supports and a redesign of the service in order to improve both efficiency and effectiveness, a process which whilst deliverable, is also complex and will involve a range of undertakings such as service user reassessment and agreeing new support plans. Work has yet to be undertaken to undertake a project which will develop and implement a new redesigned service. The IJB previously directed £75k of social care funding to enable this work to be undertaken, but this has been put on hold and the funding will be carried forward to 17/18, pending Scottish Government further direction.

The IJB previously directed £750k in 2017/18 to help mitigate the impact of the proposed change. Until further direction is received from the Scottish Government, the exact impact financially will not be known. Potentially, this could cost an additional £800k. A number of factors however require to be considered before this can be ascertained:

- The impact of any redesign
- A potential change in Scottish Government policy with regard to Living Wage
- Slippage in the implementation which will mean that in 2017/18, any impact will only be part-year
- The opportunity for further Scottish Government funding – within the Local Authority allocation/settlement correspondence the Scottish Government have stated that *"The provision included for sleepovers…will be reviewed in-year to consider its adequacy, with a commitment to discuss and agree how any shortfall should be addressed".*

On the basis of the above therefore, it is not proposed to direct any further funding beyond that already held in reserve (£750k), towards the potential additional cost of night support sleep-ins until further certainty over its implementation, impact, redesign options and funding opportunities is established.

(3) Personal Assistants

The current Direct Payment (DP) rate is £13.00 per hour plus an additional weekly allowance to clients. This increased rate (previously £11.50 p.h.) was implemented following £450k of additional investment at the beginning of 2016/17. Following analysis across a range of clients in receipt of a direct payment and discussion with Encompass Borders, which supports clients in receipt of a direct payment with services such as recruitment, payroll and care service liaison, it is forecast that payment of £8.45 per hour plus on-cost implications for personal assistants will be accommodated within the existing DP cost structure and not require any further additional investment at this time.

(4) Remove Provider Contribution

In implementing the Living Wage of £8.25 from October 2016, the approach taken in the main, was to individually negotiate with all social care providers, other than those who had tendered (e.g. Care at Home), and agree a rate fully inclusive of the implementation of the new pay rate. As a result, no provider contribution was explicitly sought and therefore, as long as the increased hourly rate and associated

lower-grade differentials are preserved, then no further funding will be required to ensure any future provider contribution is unrequired.

(5) COSLA Residential Care Home Uplift

Negotiations continue between the Scottish Government, COSLA and Scottish Care / Independent Care Home providers following the work undertaken by COSLA and Scotland Excel around the Cost of Care calculator. No agreement of uplift to the COSLA contract has yet been agreed. Initial direction from COSLA is that this would likely be in the region of 2.6% inclusive of all living wage of £8.45 implications. The current position however is less than positive and agreement appears to be far from being reached in the immediacy. Based on current information, it is estimated that the potential increase to the contract could be between the COSLA target of 2.6% and the aspiration of providers of 7%. These amount to additional resource requirements of £250k and £672k respectively. It is expected that some middle ground will be found and in terms of earmarking resource towards meeting the expected costs, a 4% provision amounting to £373k per annum would be a prudent measure.

(6) Current Residential Care Affordability Gap

The IJB has received regular and frequent revenue monitoring reports since its shadow year in 2015/16. Whilst significant pressures have been reported across a number of health and social care functions, there has been a consistently reported overspend position within Older People residential care. It has been calculated that to maintain the existing level of service provision and meet the ongoing demand for placements of this nature where no home-based alternative is appropriate or safe, particularly when a client is leaving hospital, that the budget requires increasing to support a further 20 bed spaces, to the average actual bed number level over the last 18 months which is also the current bed number level. Taking account of the average contribution a client makes to their cost of residential care, this is forecast to require a further £372k per annum.

(7) Borders Ability and Equipment Service

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

As in previous financial years, the equipment budget has yet again been insufficient to meet demand and the IJB has twice been required to direct further resources to increase it in line with activity, with average monthly equipment purchases totalling almost £50k per month, against a budgeted profile of £25k. This resulted in a 2016/17 total forecast equipment spend of £586k, against the original £300k base budget.

Provision of enabling equipment is a key strategy that enables the partnership to promote independence of individuals, enable them to remain in their own home whilst feeling safe and expedite their discharge from hospital when appropriate and

it is critical to the achievement of partnership objectives that sufficient equipment provision is available amongst a number of other social care resources that enable adequate care and support to individuals who require it to be provided as effectively and efficiency as is possible.

A short review of the Borders Ability and Equipment Service was recently undertaken by NHS National Services Scotland which examined the demand for social care and how the demand for assistive equipment is currently being managed and support delivered. A small number of recommendations have been made and whilst further work is required to develop key areas of control and management, it has been generally acknowledged that the equipment budget is insufficient to meet both current and forecast future need, which is critical to the partnership better improving outcomes for clients, particularly older people, along their care pathway. It is therefore proposed that the IJB direct a further £249k on a recurring basis, in line with current projected demand and based on a detailed analysis and forecast of expected cost requirement in 2017/18, in order to ensure that there is sufficient provision of equipment supporting the care and support of a number of clients representative of social care need, across the Scottish Borders.

(8) Projected 17/18 Demographic Increases

As part of its 2017/18 financial planning process, Scottish Borders Council, following its annually applied methodology, has calculated the forecast cost of increased numbers of clients requiring care and support within the Older People's service, together with an increased number of young people with learning disabilities in transition to adulthood requiring care by Adult Services. This is forecast to cost an additional £237k and £249k respectively, a combined total of £486k and it is proposed that the IJB direct additional funding from its increased Scottish Government allocation to meet this.

Summary

Whilst welcome, the additional allocation of resource by the Scottish Government to the partnership is clearly limited and in addition, is accompanied by a commitment to implement a living wage of £8.45 for social care staff and address any associated impacts arising. The extent of its direction therefore is both influenced and constrained by ensuring the partnership fulfil its living wage commitments. This in turn limits what remaining further may be available to meet non-living wage cost pressures which when addressed, is unlikely to leave any remaining resource available for additionality or transformation purposes.

This page is intentionally left blank