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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Monday, 12th February, 2018** at **2.00 pm** in Committee Room 2, Scottish Borders Council

AGENDA

Time	No		Lead	Paper
14:00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	
14:01	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non-financial interest they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	Chair	
14:03	**3**	**MINUTES OF PREVIOUS MEETING** 18 December 2018	Chair	(Pages 3 - 10)
14:05	**4**	**MATTERS ARISING** Action Tracker	Chair	(Pages 11 - 14)
14:10	**5**	**CHIEF OFFICER'S REPORT**	Chief Officer	(Pages 15 - 18)
14:15	**6**	**FOR DECISION**		
	6.1	The Integration Joint Budget 2017/18	Interim Chief Financial Officer	(Pages 19 - 28)
14:45	**7**	**FOR NOTING**		
	7.1	Transformational Programme Update	Chief Officer	(Pages 29 - 36)
	7.2	Festive Period Report	General Manager Unscheduled Care	(Pages 37 - 60)
	7.3	Strategic Planning Group Report	Chief Officer	(Pages 61 - 62)

	7.4	Inspections Update	Chief Social Work Officer	*Verbal*
15:55	**8**	**ANY OTHER BUSINESS**		
	8.1	Health & Social Care Integration Joint Board Development Session: 19 March 2018	Chief Officer	*Verbal*
16:00	**9**	**DATE AND TIME OF NEXT MEETING** Monday 23 April 2018 at 2.00pm in Committee Room 2, Scottish Borders Council	Chair	*Verbal*

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 18 December 2017 at 2.00pm in the Committee Room 2, Scottish Borders Council.

Present:	(v) Cllr J Greenwell	(v) Dr S Mather (Chair)
	(v) Cllr S Haslam	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	(v) Mr J Raine
	Mr R McCulloch-Graham	(v) Mr T Taylor
	Mrs J Smith	Dr C Sharp
	Mr D Bell	Mrs E Reid
	Ms L Gallacher	Dr A McVean
	Mrs Y Chapple	
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mrs T Logan	Mr P Lunts
	Mr M Curran	Mr J Lamb
	Mrs C Gillie	Mrs D Rutherford
	Ms S Holmes	

1. Apologies and Announcements

Apologies had been received from Cllr David Parker, Cllr Helen Laing, Mrs Susan Swan, Mrs Claire Pearce, Mr Murray Leys, Mr John McLaren, Mr David Davidson, Mrs Jill Stacey and Mr Colin McGrath.

The Chair confirmed the meeting was quorate.

The Chair welcomed Mrs Erica Reid, Lead Nurse for Community to the meeting who was deputising for Mrs Claire Pearce.

The Chair welcomed Mrs Yvonne Chapple, Staff Side Representative to the meeting who was deputising for Mr John McLaren.

The Chair welcomed a range of other attendees to the meeting including Mr Philip Lunts, Mr Michael Curran, Mrs Debbie Rutherford and Mr James Lamb.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

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

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

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 8 November 2017 were approved.

4. Matters Arising

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

5. Chief Officer's Report

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted the opening of Craw Wood; hospital to home support; visit to the Cheviot model and the work already undertaken there by a multi-disciplinary team; reablement function; regional work, workstreams, sharing innovation across the health and social care partnerships; career pathways and recruitment; new GP contract; looking at diabetes services; the drug issue locally involving a fake opiate which involved both NHS Borders, Scottish Borders Council and partners; and the Leadership Team across the partnership jointly forward planning, with facilitation from the Scottish Government, to review the existing commissioning plan and look at how the team works together across the organisations.

Cllr Shona Haslam enquired if there were any known impacts yet, on implementing the mechanics of the discharge to assess policy. Mr McCulloch-Graham advised that it was too early to provide any substantial evidence.

Cllr Haslam was keen to understand if the current level of funding was making a difference. Mr McCulloch-Graham commented that he had agreed to stay within the envelope of funding agreed, however, should the Hay Lodge funding not be fully utilised he was keen to divert it to other areas such as Berwickshire, central Borders and Hawick to expand the roll out further.

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

6. Inspection: Joint Older People's Services Report

Mr Robert McCulloch-Graham gave an overview of the content of the report.

Mrs Karen Hamilton enquired if the staff survey sent to all staff across the partnership was the imatter survey. Mr McCulloch-Graham confirmed that it was.

Mrs Hamilton enquired about Action 13 on page 21 and what the evidence of completion actually was. Mr McCulloch-Graham confirmed that it was the workforce strategy.

Mr Tris Taylor was concerned at the quality of the report and highlighted several elements that were marked as both "on going" and "complete". Mr McCulloch-Graham assured Mr Taylor that the Inspectors would be looking for evidence of activity and the action plan had been designed to capture that evidence, hence the classifications used.

Mr Taylor sought assurance around the adequacy of the evidence and learning gleaned. Mr McCulloch-Graham assured Mr Taylor that the actions within the action plan were cross

referenced across several of the recommendations, as a consequence of the Inspectors being unclear in their recommendations.

Mr Taylor suggested the documentation and attachments should have been provided to the Board in a more completed state to enable members to make better informed decisions.

Dr Angus McVean commented that he would expect to see a greater percentage of anticipatory care plans updated and completed as a consequence of the early warning pressure sores system, which was different to anticipatory care plans in care homes and not part of the GP primary care remit.

Mr John Raine recognised the difficulty of providing evidence against recommendations that were unclear. He commented that the action plan was classified as draft and he recognised that it would evolve further once the meeting with the Inspectors had taken place. He was content to support it as a work in progress.

Mrs Jenny Smith enquired if learning and good practice was being gleaned from the other national partnerships as listed on page 4. Mr McCulloch-Graham advised that nationally the Chief Officers and Directors of Finance met and shared good practice.

Mrs Smith suggested references to the third sector should be included in relation to workforce planning.

Mrs Lynn Gallacher suggested references to carers should also be included in regard to the delivery of care, early intervention and prevention, and diagnosis of dementia.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** accepted the report subject to it being a work in progress and recognised that it would change following a response from the Joint Inspectorate Team.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought an update at a future meeting on progress against the various recommendations.

7. Appointment of the Chief Financial Officer - Integration Joint Board

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted that the overall budget for the partnership was in the region of £160m. He therefore felt it essential that the Integration Joint Board should have its own professional financial support as well as the continued professional financial support from both NHS Borders and Scottish Borders Council.

Mr John Raine supported the recommendation of a joint permanent appointment and questioned the difference in the salaries scope. Mrs Carol Gillie confirmed that the job description had been through due process and evaluated by both organisations and the gradings and salaries quoted were correct.

Further discussion focused on: how remuneration for the post would be decided for a successful candidate; staffing across the partnership; individual choice on employing body;

and lobbying for one single set of terms and conditions for a joint model; raising difficulties around recruitment with the Cabinet Secretary.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to the permanent joint appointment for a Director for Finance for the IJB, by NHS Borders and Scottish Borders Council.

The Chair advised that he would consider writing to the Cabinet Secretary on behalf of the Integration Joint Board to point out the difficulties and anomalies with recruitment.

8. Community Capacity Building – Transformation Proposal

Mr Michael Curran gave an overview of the content of the report and highlighted, the makeup of the team, zero background costs and suggested it was critical in terms of the delivery of some of the transformation programmes to be able to continue with community based support mechanisms.

A discussion took place that focused on several issues including: modelling of activity to push money out to the community; return on investment; compliments the early intervention and engagement outcomes within the Strategic Plan; expectation of further engagement with local communities to expand the proposal to combat loneliness for people; builds on the work of the Dementia working group in communities; success of various initiatives under the proposals such as men's sheds and soup clubs; evolved into a 3 phase project; exit strategy and self sustaining activities; collation of all community lead hub initiatives over the next 12 months to assist communities to look after themselves; and this is the first of similar projects funded through the Integrated Care Fund totalling £500k that might return to the Board to seek further funding.

Mrs Carol Gillie reminded the Board that the source of funding for the proposal to date had been non recurring funding from the Integrated Care Fund. She commented that it would be essential if the proposal were to be agreed, to have a plan on the sustainability of services in the future either through other sources of funding or volunteer services.

Dr Cliff Sharp welcomed the initiative to assist communities, but challenged it as a measure in terms of outcomes and was keen to see evidence to support the proposal in terms of fewer admissions to hospital and less activity in primary care services.

Cllr Shona Haslam commented that the scope for evidence was about transforming peoples' lives and given the wider understanding of social impacts, she therefore supported the proposal.

Dr Angus McVean suggested there were assumptions being made in terms of outcomes and a lack of evidence to support those assumptions, he highlighted that there was no evidence to support such a high level of funding. He further commented that the proposal did not decrease the number of people needing to see their GP and reminded the Board of the pressures on services for people ending up in Borders General Hospital as there were not enough carers available or care home places available. He suggested a significant difference could be made to those issues by diverting that level of funding.

Mrs Lynn Gallacher commented that she had met the community capacity team and welcomed the work they undertook. She was aware that there was little evidence to support the proposal and she reminded the Board of the immense pressure placed on carers and the need to support them.

Mrs Tracey Logan commented that it was a modest amount of money and the Board should not be solely focused on keeping people out of hospital as it also had a responsibility to engage with communities around their whole wellbeing. She suggested the proposal was about ultimately mainstreaming some of the activities whilst providing initial short term funding to get them established and moving towards self sustainability. She commented that once the framework was properly joined up there would be scope to disinvest in the proposal and suggested the funding be agreed for a 12 month period and during that 12 month period, evidence of the impact on clinical services in secondary care and primary care could be gathered.

Mr John Raine commented that he could see the arguments from both sides and was supportive of Mrs Logan's suggestion to agree to fund the proposal for a further 12 months whilst looking at the potential to mainstream activities and to see if any clinical evidence could be brought forward.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to continue with the project for 12 months with the proviso that there was an evaluation (set up by acute & primary care colleagues) on the projects listed within the document within 12 months and an interim update provided in 6 months time.

9. Discharge to Assess – Hospital to Home Pilot

Mr Robert McCulloch-Graham gave an overview of the content of the report and advised that since the last meeting he had engaged with other professionals across the region and he explained that the ethos of hospital to home was to focus on re-enablement of people in both the hospital and community settings. He commented that he was keen to appoint 5 healthcare workers to be led by District Nurses, to cover areas of particular concern in regard to delayed discharges and for an evaluation to take place after 4 months. He emphasised that the throughput of patients leaving hospital and going through re-ablement was based on a minimum of 3 patients per HCSW every 3 weeks. Over the period of 4 months it equated to offering capacity for 255 patients leaving hospital. The cost per patient would therefore be £680.

Mrs Karen Hamilton enquired if the 4 month evaluation would commence in January 2018. Mr McCulloch-Graham confirmed that it would.

Mrs Jenny Smith enquired what healthcare support worker progress would look like. Mrs Erica Reid advised that the model described had been tested and within 3 weeks reablement had been achieved together with clear outcomes.

Mrs Lynn Gallacher was supportive of the changed professional responsibility and was keen to strengthen and signpost to the carers support plan to gain a cultural shift and ensure family carers had support and intervention.

Mrs Jane Davidson suggested such a change could be incorporated now in the approach and Mrs Reid confirmed that that was the intention.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the extension of the "Hospital to Home" pilot across the Hawick, and Central localities in addition to the Berwickshire locality.

10. Scottish Borders Health & Social Care Winter Plan 2017/18

Mr Philip Lunts presented the joint winter plan presentation.

Mrs Lynn Gallacher enquired about the effect of readmission figures on length of stay. Mr Lunts commented that historically NHS Borders had higher readmission rates than other areas of NHS Scotland, however he was confident that it was a data issue and confirmed that changes had been made and there had been no increase in readmission rates as a consequence.

Mrs Jane Davidson suggested the next update on the winter plan should present by locality and capacity building plans going forward.

Cllr John Greenwell enquired about the level of flu vaccination uptake. Mr Lunts confirmed that the figures quoted were for NHS staff uptake and suggested that the public uptake level would be about 70%.

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

11. The Carers Act (Scotland) 2016

Mrs Debbie Rutherford presented the Carers Act (Scotland) 2016 presentation.

Mr Tris Taylor enquired if there were any areas of concern not being addressed by the new legislation. Mrs Lynn Gallacher advised that some national organisations had been keen to see the scope of the Act encompass more. She was aware that full guidance on eligibility criteria was still awaited and there remained some issues with regard to funding for the implementation of the Act. She further commented that there were areas of work to be progressed in regard to Learning Disabilities referrals and signposting for Dementia carers and it was anticipated that the Act would support that work in the Scottish Borders.

Mr Taylor enquired if it was confirmation of or extension to the eligibility criteria. Mrs Gallacher advised that it was still the responsibility of the professional regardless of the eligibility criteria.

Mr John Raine enquired if there was local discretion around eligibility criteria. Mrs Gallacher advised that it was a complicated area and explained that, if a carer had a support plan and the plan identified a high level need, then they might be entitled to a budget in their own right to meet that need, but only if the crucial need could not be met by the care support plan.

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

Ms Jenny Smith left the meeting.
Mrs Tracey Logan left the meeting.
Mrs Lynn Gallacher left the meeting.

12. Performance Report - Transformational Programme Tracker

Mr James Lamb gave an overview of the content of the report and highlighted: building base services; alcohol and drugs service co-location; integrated teams IT solutions; and efficiency and productivity gains.

Mrs Karen Hamilton observed that a great deal of discussion at the meeting had been around the community capacity building item and she suggested ensuring the "re-imagining" project be included in the data evaluation discussion to ensure both projects came together.

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

13. Monitoring of the Integration Joint Budget 2017/18

Mrs Carol Gillie gave an overview of the content of the report.

Cllr Shona Haslam enquired about the allocation of social care fund monies to Scottish Borders Council to cover a predicted overspend. Mrs Gillie advised that a request had been received by the partnership and further follow up information had been requested so that a fully informed recommendation could be made to the Integration Joint Board at its next meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and the monitoring position on the partnership's 2017/18 revenue budget at 30th September 2017.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a recovery plan had been developed by the NHS which based on a number of assumptions and risks forecast a break even position on NHS budgets would be delivered.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted social care services were projecting a £130k overspend and work was ongoing to identify the issues and key actions to address the situation.

14. Any Other Business

Mr Robert McCulloch-Graham reminded the Board of the proposed content for the forthcoming development session to be held on 29 January 2018.

- 2018/19 Financial Plan Budget – Delegated Functions
- Financial Planning
- Draft Strategic Commissioning Plan Review

15. 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 12 February 2018 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 4.07pm.

Signature: ……
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 17 October 2016

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that it would undertake a Development session on clinical and care governance.	Robert McCulloch-Graham, Claire Pearce, Cliff Sharp	2017	**In Progress:** Item scheduled for 27 November 2017 Development session. Session cancelled due to apologies received. **Update:** Item rescheduled to 19 March 2018 Development session.	G

Meeting held 27 February 2017

Agenda Item: Health & Social Care Delivery Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
13	8	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.	Tracey Logan	June 2017	**In Progress:** Item rescheduled to 20 August 2018 meeting.	G

Meeting held 28 August 2017

Agenda Item: Monitoring of the Health & Social Care Partnership Budget 2017/18 at 30 June 2017

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
16	12	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** asked the Chief Officer to bring forward a plan for the delivery of remedial savings to address the shortfall attributable to the part-year only impact of the Integrated Transformation Programme in 2017/18.	Robert McCulloch-Graham Susan Swan James Lamb	December 2017	**Complete:** This action is superceded by Action 20 below.	G

Meeting held 23 October 2017

Agenda Item: Update on Buurtzorg in the Borders

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
19	13	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress to date and welcomed hearing more at a later date.	Robert McCulloch-Graham	April 2018	**In Progress:** Item scheduled for April 2018 meeting agenda.	G

Agenda Item: Interim Transformation and Efficiencies Programme Tracker

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
20	17	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and requested an update on the delivery of efficiencies in 2017/18 and future years from the Transformation Programme.	Robert McCulloch-Graham Susan Swan James Lamb	December 2017	**Complete:** The NHS 2017/18 Financial Recovery Plan was shared with the IJB at its meeting on 18.12.17. A presentation on financial planning for 2018/19 would	G

					be provided to the IJB at its Development session on 29 January 2018.	

Agenda Item: Monitoring of the Health & Social Care Partnership Budget 2017/18

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
21	18	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and the monitoring position on the partnership's 2017/18 revenue budget at 31st August 2017 and requested details of the financial recovery plan for 2017/18 at the next meeting.	Susan Swan	December 2017	**Complete:** The NHS 2017/18 Financial Recovery Plan was shared with the IJB at its meeting on 18.12.17. A presentation on financial planning for 2018/19 would be provided to the IJB at its Development session on 29 January 2018.	G

Meeting held 18 December 2017

Agenda Item: Inspection: Joint Older People's Services Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
22	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought an update at a future meeting on progress against the various recommendations.	Robert McCulloch-Graham	April 2018	**In Progress:** Item scheduled for April 2018 meeting agenda.	G

Agenda Item: Community Capacity Building – Transformation Proposal

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
23	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to continue with the project for 12 months with the proviso that there was an evaluation (set up by acute & primary care colleagues) on the projects listed within the document within 12 months and an interim update provided in 6 months time.	Michael Curran	June 2018	**In Progress:** Item scheduled for 11 June 2018 meeting agenda.	

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

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 12 February 2018

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Robert McCulloch-Graham, Chief Officer
Telephone:	01896 825528

CHIEF OFFICER'S REPORT

Purpose of Report:	To inform the Health & Social Care Integration Joint Board of the activity undertaken by the Chief Officer since the last meeting.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note the report.

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

This period has been dominated by pressures within our hospitals. The Health and Social Care Partnership has lead on the introduction of provision to support the IJB's Direction – "Discharge to Assess Policy for the Council and NHS Borders.

Winter Pressures: Craw Wood interim care facility is operating to capacity and there has been a good flow of patients which has been maintained since November. We are now examining the possibility of expanding its use beyond the planned 15 bed base.

The Hospital to Home service has taken its first clients in Berwickshire; we have included the work of the Cheviot Pilot which has been operational for a couple of years now, and we are expecting Central and Hawick localities to begin later this month.

Additional provision has been introduced to reduce the attendances at Borders General Hospital through opening 7 GP surgeries over four Saturdays and increasing weekend capacity within the BECs teams. This initiative, at the time of writing has opened two Saturdays between 9.00am and 1.00pm. Take up has been slow but increasing not all the data has been collected as yet but there have been over 120 contacts with patients over the two Saturdays. BECs has not been able to strengthen its capacity due to the difficulty of recruiting.

Patients awaiting Private Guardianship Orders remain a difficulty and we are looking to see how the Council can support families' access to solicitors and to speed up the allocation of Mental Health Officers to support the process. We have seen some improvement over the last two weeks with the number of patients awaiting Guardianship falling from 10 to 7 on Friday the 2nd of February.

Regional Work: The Partnership is supporting the East Region in its plans to deliver the Health and Social Care Plan. The Borders, with leadership from Chief Executive Officers, Jane and Tracey are promoting the development of an extensive work stream to reduce the prevalence of Type 2 Diabetes (T2D). Several presentations have been made to the regional groups and there is now acceptance that the work stream should be supported by all parties within the region. Next week a further debate will take place to identify a resource to develop plans and provision to significantly reduce the rate of T2D.

Mental Health Transformation Programme – The Mental Health service is entering stage 3 of its 4 stage transformation programme. A round a locality initial staff/service user/stakeholder consultations have been completed. The next stage is to look at new models of service provision that will aim to improve/maintain quality as well as, wherever possible, achieve financial efficiencies. Any proposed new models of delivery will be consulted upon and recommendation's will be presented to the IJB for consideration.

GP Sub Committee: I attended my first meeting in December. It was helpful to put some names to faces. The major issues discussed were the forth coming GP Contract, funding and de-registration of patients. Those present raised their concerns that the forth coming new contract would provide little support for GOPs within the Borders. There was a wish that the committee would invite Richard Froggo to address the committee. (The Board has also made a similar request and we will try to organise these together.)

There was some frustration regarding the allocation of funds within the Primary Care Transformation work. These were in the main due to a lack of understanding as to the decision making process for the final allocation. I will undertake to keep them informed with regards to future allocations.

The last issue related to difficult patients where practices have as a last resort removed them from their lists. The Committee's concern regarded how these individuals were then allocated to other practices. We agreed that the collective of GPs would examine how they might address the issue.

Finance: The last IJB agreed that the process for the recruitment of a Director of Finance for the IJB should proceed. There had been a delay with internal processes, however adverts are now ready for release and we anticipate interviews being held in early April.

IJB Leadership Team: Scottish Government has made funds available for leadership training for Health and Social Care Partnerships. The IJB Leadership team had the first of four sessions on the 21st of December. The next session will have a focus on the review of the Strategic Plan; thereafter we will expand the sessions to involve the next management tier and the work of the localities.

Strategic Plan: An extended Strategic Planning Group (SPG) meeting largely dedicated to the review of the Partnership's Strategic Plan was held on 10 January. This meeting marked the beginning of the work of the SPG in developing a revised Strategic Plan and included discussions around the rationalisation of objectives and enhancement of the vision. Work is now underway to develop an advanced draft to be presented to the SPG at the next meeting scheduled for 7 March. The aim is to produce a revised draft Strategic and Commissioning Plan for ratification by the IJB in April 2018.

Performance/Finance Group.
This group met for the first time in January. The group will report to the Executive Management Team through the IJB Leadership Team. The group was considering the 6 indicators requested by Scottish Government for the Ministerial Steering Group for Health and Social Care Partnerships. These are;

1. Emergency Admissions
2. Unscheduled Care
3. A&E Attendances
4. Delayed discharge by bed days
5. Percentage of time spent in settings within the last 6 months of life
6. Balance of Care

The trajectories for these indicators will be agreed through the Executive Management Team.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 12th February 2018

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Carol Gillie, Director of Finance David Robertson, Chief Financial Officer
Telephone:	01896 825501 01835 824000

MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2017/18 AT 31 DECEMBER 2017

Purpose of Report:	To provide an overview of the monitoring position of the Health and Social Care Partnership Budget at 31 December 2017 and an update on the partnerships' resources.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the report and the monitoring position on the partnership's 2017/18 revenue budget at 31st December 2017. b) **Approve** the request for the direction of the balance of social care funding of £127k to Scottish Borders Council to address the pressures in social care. c) **Approve** the request for the direction of £443k of Integrated Care Fund to Scottish Borders Council to address the pressures in social care. d) **Request** a full and detailed report on the Integrated Care Fund projects to be presented at the next Board meeting.

Personnel:	No resourcing implications beyond the financial resources identified within the report.

Carers:	N/A

Equalities:	There are no equalities impacts arising from this report.

Financial:	As detailed within the report.

Legal:	This report is in line with legislation.

Risk Implications:	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.

Background

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

1.2 On the 30th March 2017, the Integration Joint Board (IJB) agreed the delegation of £146.288m of resources supporting integrated health and social care functions for financial year 2016/17. At the same time, it noted the proposed budget of £18.978m relating to the large hospitals budget set-aside.

1.3 Since the Financial Statement was approved by the IJB in March 2017, a number of factors have resulted in the revisions to the base budgets supporting delegated and set-aside functions. These factors include final grant allocation settlements having been made, intra-organisational budget realignments and additional funding provisions by the Scottish Government. The revised budget positions are currently:

	2017/18 Revised Budget £m
Healthcare Functions - Delegated	99.477
Social Care Functions - Delegated	46.408
Total Delegated	**145.885**
Healthcare Functions - Set-Aside	**20.696**

1.4 This report sets out the current monitoring position on both the delegated and set-aside budgets at 31 December 2017 and details the key areas of financial pressure and proposals for their mitigation.

1.5 The partnership has two further sources of ring-fenced resources at its disposal namely the social care fund and the integrated care fund. It has also assumed a monitoring role for the balance of the Older People's Change Fund. This report provides an update on each of these funding sources.

Overview of Monitoring Position at 31 December 2017

Delegated Budget

Healthcare Functions

2.1 As in 2016/17, delegated healthcare functions continue to experience considerable financial pressure. Currently, an adverse outturn projection of almost £4.7m is

forecast, representing 4.8% of the overall budget. The prime service area where this pressure is being experienced is Generic Services within which a range of miscellaneous functions such as community hospitals, dental, pharmacy and nursing, prescribing and general medical services and primary staffing and management are managed. Generic Services is also where any unallocated savings target are reported.

2.2 Within Generic Services, significant overspends relate in the main to the shortfall in, and non-delivery of, planned efficiency and savings targets. These include:

- £1.5m related to shortfall on projected savings target in prescribing – a considerable savings target (£3.2m) was applied at the start of the financial and year and currently, £1.7m of schemes have been identified although delay in releasing savings on particular schemes is also impacting on the realisable savings available.
- £0.398m related to the overall unachieved balance on the operational budgets 3% savings targets.
- £1.239m of £1.922m recurring savings that were carried forward from 2016/17 that will not be delivered in year and for which no mitigating action has been identified.

2.3 This forecast position was considered as part of 2017/18 financial recovery plan which was agreed by NHS Board at its meeting in December 2017.

Social Care Functions

2.4 Social care functions are currently projecting a year end overspend position of £0.570m. A number of areas of pressures exist, particularly the provision of additional care home beds and the ongoing level of care at home hours provided. This relates primarily to Older People and Physical Disability services and is driven by further increases in demand/need for care and support.

2.5 The Chief Officer has received budget line detailed financial information, although to date no activity information, on the £570k forecast overspend.

2.6 SBC has no plans in place to offset this forecast overspend and request that additional resources are directed by the IJB to address these pressures.

Large Hospital Budget Set-Aside

3.1 Set Aside budgets are reporting a projected £3.5m overspend position.

3.2 The key pressure areas continue to be:

- The use of both agency medical and nursing staff to support the continuing provision of surge bed capacity to address the high number of delayed discharges across the health system.
- The requirement for additional staff in A&E to deal with increased activity, vacancies and mitigate clinical risks.
- Additional staff to support patient acuity and vacancies in medicine for the elderly.
- The non delivery of savings.

3.3 This forecast position was considered as part of 2017/18 financial recovery plan which was agreed by NHS Board at its meeting in December 2017.

Recovery Planning and Delivery

4.1 Section 3 and 5 above clearly outlines significant ongoing financial pressures across healthcare delegated services and set aside budgets.

4.2 NHS Borders Board has agreed a financial recovery plan for 2017/18. This puts in place a number of actions and controls, many of which are non recurring, which will offset the operational overspends across the organisation including the IJB health delegated and set aside budgets. Based on a number or assumption and caveated by a number of risks a break even position on health budgets at 31st March 2018 is forecast by NHS Borders Board. The plan proposes that additional resources will provided to the IJB on a non recurring basis for 2017/18 to meet the operational pressures and offset unachieved efficiency savings targets in the health delegated and set aside budgets.

4.3 Although this will allow the IJB to breakeven in 2017/18 a priority for the IJB is to ensure a sustainable approach to financial planning and management within the partnership in line with the Board's approved Financial Strategy.

4.4 For social care functions after incorporating the anticipated mitigating actions by the Scottish Borders Council-wide savings programme an overspend position continues to be forecast. SBC has requested that additional funding should be directed to address the balance of forecasted pressures.

IJB Ring Fenced Resources

Social Care Funding

5.1 As part of the 2017/18 Health Board and Local Authority funding settlements, the Scottish Government announced an additional £107m of Social Care Funding to health and social care partnerships in order to fulfil a range of commitments. £100m of this funding has been baselined on a recurrent basis. The £7m was allocated on a non recurring basis. This supplemented the additional £250m Social Care Funding made to partnerships in 2016/17 which was baselined on a recurring basis. The total 2017/18 allocation to the Scottish Borders Partnership was £7.547m consisting of £5.267m 2016/17 and £2.130m 2017/18 allocation now baselined with £6.135m delegated on a permanent basis. In 2017/18 £150k was allocated on a non recurring basis.

5.2 During 2017/18, the IJB also directed £1.285m of Social Care Funding on a non-recurring basis in order to meet the cost of implementing a number of policy initiatives and address other primarily demand-led cost pressures which had emerged in-year. These are summarised in the table below.

Table 1 – 2017/18 Social Care Funding directed by the Integration Joint Board to date

	2016/17			2017/18		
	Temporary £'000	Permanent £'000	Total £'000	Temporary £'000	Permanent £'000	Total £'000
Directed during 2016/17:						
Living Wage £8.25	0	813	813	0	1,626	1,626
Social Care Demographic/Demand	220	2,508	2,728	0	2,508	2,508
Night Support Sleep Ins*	0	0	0	0	0	0
Community Mental Health Worker	0	25	25	0	50	50
Charging Threshhold	0	154	154	0	154	154
Surge Beds	500	0	500	0	0	0
Prescribing	677	0	677	0	0	0
BAES Equipment	295	0	295	0	0	0
Night Support Review	75	0	75	0	0	0
Mar-17						
COSLA Uplift	0	0	0	0	261	261
Living Wage £8.45	0	0	0	0	829	829
Aug-17						
Residential Care	0	0	0	0	407	407
Housing With care	0	0	0	0	100	100
Adults with Learning Disabilities	0	0	0	0	200	200
Oct-17						
Community Equipment Store	0	0	0	285	0	285
NHS Borders Surge Beds*	0	0	0	1,000	0	1,000
Total Directed to Date	**1,767**	**3,500**	**5,267**	**1,285**	**6,135**	**7,420**
Total Allocation			**5,267**			**7,547**
Remaining Resources			**0**			**127**

£750k remains indicatively directed on a recurring basis to Night Support from 2018/19. This will be clarified once final agreements and costings are complete.

5.3 As Table 1 shows, currently £127k of the allocation remains uncommitted.

5.4 Social care functions are projecting an adverse outturn variance of £570k. This report seeks Board approval for direction of the remaining 2017/18 Social Care funding allocation of £127k towards mitigation of this pressure on a non recurring basis.

Integrated Care Fund (ICF)

6.1 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. Since then, a number of projects have been approved by the IJB with full cost commitment of £5.225m. Following a request by the Board a full

report on each of the projects detailing the spend to date, forecast spend and the outcomes delivered will be presented at the next IJB meeting. This will give the Board the opportunity to consider its commitment to the projects with a view to continuing or ceasing the funding contributions that are currently in place.

6.2 At this point prior to this review the remaining ICF balance is currently £1.165m. This report seeks Board approval for direction of £443k of this balance to support the forecast pressures within social care.

Older People's Change Fund

7.1 The Older People's Change Fund was a 4-year Scottish Government-funded transformation programme that ran from 2012/13 to 2015/16. The IJB has agreed to take on a monitoring role for the balance of this fund. As reported to the Board in October, the residual funding is held within a Scottish Borders Council designated reserve fund and was earmarked and agreed by the Reshaping Care Board for the connected care project. As at 31st March 2017 a balance of £557k was held. Estimated commitments for 2017/18 against this project are £150k leaving a forecast balance of £407k as at 31st March 2018. Due to contractual arrangements (a DME consultant and Red Cross contract) that are in place this project will continue in the new financial year.

Risk

8.1 A number of risks associated with the IJB's monitoring position have been historically reported, including the extent of the NHS financial recovery required, the challenge over ensuring the recovery plan is delivered, the assumptions used to project the financial position and any change to those assumptions from the present time to the year end.

8.2 The most significant strategic risk relates to the partner financial plans in future years and the significant level of non-recurring efficiency and savings actions on which the partnership's budget remains predicated. The Chief Officer together with EMT are working to develop and implement a large-scale strategic transformation programme which will underpin the ability of partners and, as a consequence the IJB, to achieve financial sustainability.

8.3 Any adverse variance at the end of the financial year will be dealt with as per the partnership's Integration Scheme which requires a number of actions to be taken but ultimately will be supported from partner organisations.

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MONTHLY REVENUE MANAGEMENT REPORT

Summary	2017/18	At end of Month:	December

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	19,396	13,576	20,338	20,249	89	
Joint Mental Health Service	16,023	11,593	15,835	15,726	109	
Joint Alcohol and Drug Service	1,006	560	721	690	31	
Older People Service	24,448	13,379	18,798	19,407	(609)	
Physical Disability Service	6,160	2,806	3,300	3,502	(202)	
Generic Services	80,502	65,084	86,893	91,613	(4,720)	
Large Hospital Functions Set-Aside	18,978	18,365	20,696	24,163	(3,467)	
Total	166,513	125,363	166,581	175,350	(8,769)	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions	2017/18	At end of Month:	December

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	15,753	10,895	16,780	16,752	28	A number of areas of pressure, in particular the ongoing level of care at home hours compared to delivery of targeted financial plan savings is causing further pressure across the Older People's service. Budgets remain requiring realignment in Business World across social care services in line with funding directed and targeted savings. Actual Generic spend includes carry forward of ICF from 2016/17. Main driver of reported variance is concern over the delivery of savings from previous year's financial plan, which still require delivery actions to be identified and actioned. Assumes delivery in full of £170k recovery plan in development."
Joint Mental Health Service	2,142	1,403	2,134	1,981	153	
Joint Alcohol and Drug Service	173	103	170	139	31	
Older People Service	24,448	13,379	18,798	19,407	(609)	
Physical Disability Service	6,160	2,806	3,300	3,502	(202)	
Generic Services	4,369	985	5,226	5,197	29	
Total	53,045	29,571	46,408	46,978	(570)	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions	2017/18	At end of Month:	December

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,643	2,681	3,558	3,497	61	The outturn variance relate to 4 key issues : Nursing overspends in Community Hospitals related to agency spend covering vacant posts, patient dependancy issues and sickness absence. AHP overspend related to non delivery of savings, both prior and current year targets. A shortfall on the projected savings in GP prescribing represented by a shortfall in schemes identifed and slippage on offpatent tarriff reductions and the completiong of drug reviews. Recurring savings carried forward from 2016/17 and elements of the in year 3% savings target which will not be delivered in year account for the balance.
Joint Mental Health Service	13,881	10,190	13,701	13,745	(44)	
Joint Alcohol and Drug Service	833	457	551	551	0	
Generic Services	76,133	64,099	81,667	86,416	(4,749)	
Total	94,490	77,427	99,477	104,209	(4,732)	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2017/18	At end of Month:	December

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	1,997	1,909	2,004	2,981	(977)	Key issues are as follows : A&E overspends relate to the management of risk and associated medical staffing costs. In Medicine & long term conditions Nursing and Medical costs due to the additional cost of surge beds/delayed discharge occupied bed days offset by £1m contribution from IJB. In medicine for the elderly the additional staffing costs is linked to gaps in rota and the acuity of patients. Non delivery/slippage on delivery of in year savings targets across all specialities is impacting adversely on the financial position. Savings and planned actions relate to the unmet target from last financial year
Medicine & Long-Term Conditions	11,633	11,114	12,975	14,204	(1,229)	
Medicine of the Elderly	6,020	5,342	6,434	6,978	(544)	
Savings and Planned Actions	(672)	0	(717)	0	(717)	
Total	18,978	18,365	20,696	24,163	(3,467)	

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: ...12 February 2018.....

Report By	*Robert McCulloch-Graham*
Contact	*James Lamb*
Telephone:	*01835 824000*

IJB TRANSFORMATION PROGRAMME TRACKER

Purpose of Report:	To update the Integration Joint Board on progress in developing and delivering the transformation programme.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: Note the report.
Personnel:	Resource and staffing implications are being developed as part of both the development of the project briefs and the service redesigns that will be addressed through the projects.
Carers:	
Equalities:	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.
Financial:	Resource and staffing implications are being developed as part of both the development of the project briefs and the service redesigns that will be addressed through the projects.
Legal:	This Programme will support the delivery of the Partnership's Strategic Plan. Programme Proposals are being developed through the Joint H&SC Management Team and with service leads. A workshop was held on 5th September to ensure all key managers in the programme are aware of and engaged in the programme.
Risk Implications:	The risks relating to each project are being developed as part of the project briefs. Overall, there is a risk that without a robust programme, the Partnership will be unable to address the current – and future – affordability gap.

1.1 A progress report on the development and delivery of the programme was presented to the IJB at its December meeting.

1.2 There are currently 10 projects that comprise the IJB Transformation Programme. These are:

I. Community & Day Hospitals
II. Care at Home (including Re-ablement)
III. Allied Health Professionals
IV. Dementia
V. Mental Health Redesign
VI. Re-Imagining Day Services
VII. Carers Strategy
VIII. Alcohol & Drug Services
IX. IT & Telehealth Care
X. Re-Imagining Integrated Health & Social Care Teams

1.3 A high level Programme Plan is set out in Appendix 1 and a Programme Tracker which sets out activity in the current reporting period to the end of November – as well as planned activity in the next – is provided at Appendix 2.

Summary

2.1 As shown in the attached appendices, 3 of the 10 projects are shown as being on track:

- Home Care, Including enablement
- Allied Health Professionals
- Carers Strategy

2.2 7 of the 10 projects are shown as Amber these are:

- **Community & Day Hospitals** – Project resources are now in place to deliver this project. The initial review of the service, which is being led by Anne Hendry is progressing well and an interim report is being prepared. Some slippage in timescales is anticipated, however, this is not expected to be significant.

- **Dementia** – The project is being re-scoped as the original project brief was drafted ahead of the publication of the National Dementia Strategy and the drafting of the Scottish Borders Dementia Strategy which is currently out for consultation. A £4.8m provision is included under the Council's Capital Programme for a specialist residential dementia unit and an associated feasibility study is being developed for a Dementia Village.

- **Mental Health** – There have been delays in consultation due to low turnout of clinicians and ward staff at consultation events. This has meant that additional events have had to be arranged. Similarly, attendance at engagement events for those with lived-experience have been poorly attended. Online methods of engaging with clinicians and ward staff (Survey Monkey) and service users (Citizenspace) are being used to supplement engagement.

- **Re-Imagining Day Services** – the project is making good progress in terms of decommissioning underutilised/inefficient services. However, the project is shown as amber as there is an ongoing risk in terms of the management of interdependencies. Three projects, Day Services, Dementia and Community & Day Hospitals, are looking at buildings-based day-services and the links between them need to be managed carefully to ensure that use of buildings or

alternative arrangements are seen in the wider context. Meetings are being held between project leads to address this.

- **Alcohol & Drugs** – A cost effective solution for co-location has still to be agreed. Again there will be some slippage while this is resolved.

- **IT & Telehealth Care** – Good progress is being made in terms of the roll-out of Attend Anywhere (effectively a skype-like video phone application that enables virtual surgeries) and with practical IT problem-solving with integrated teams at various locations. However, the project is shown as amber as a detailed roadmap for a wider IT project has still to be finalised and agreed. A visit is being arranged to NHS Cumbria in early March to look at a workflow system in practice. All being well, a proposal will be scoped for a proof-of-concept project to look at how the system could be used to improve patient pathways and realise efficiencies here in the Borders.

- **Re-imagining Health & Social Care Teams** – The project is still to be formally scoped although there are a number of related initiatives (e.g. the Buurtzorg pilot in Coldstream, Transitional Care at Waverly Care Home, Discharge to Assess and Social Care Productivity Review) which are already informing models of integrated working.

2.3 The current programme does not yet include the indicative financial savings which may be possible from each of the individual projects. Discussions had been planned over October/November with project leads, Chief Financial Officer, Chief Officer and Programme Manager to review the financial context and savings opportunities from each project. However, these meetings are unlikely to take place until a new Chief Financial Officer is in post.

2.4 As can be seen from the programme plan at Appendix 1, projects remain at a relatively early stage and new models of service delivery are still in the process of being determined or scoped. As these models are clarified and established, the potential financial and non-financial benefits from each project will be identified. The financial information on the programme will therefore show the delivery timescale of the partnerships' objectives and resultant efficiency gains over future years.

2.5 As part of the discussions with project leads, additional resource requirements to deliver projects will be fully established. It is anticipated that additional resource will be required. A clear business case, based in achievement of outcomes against resources required, will be included in each funding application.

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	IJB Transformation Programme		Impact			Project Lead	Project Manager Assigned	Project Stages	RAG Status	2017-18												2018-19												2019-20			2020-21			2021-22		
	Project	Purpose	Improved Quality & Outcomes	Improved Pathways	Productivity & Efficiency					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1	**Community & Day Hospitals**	Implement best practice service models in Community Hospitals to improve patient pathway and make best use of resources.	X	X	X	Kenny Mitchell	Stewart Barrie	Planning & Data Gathering	Amber																																
								Establish & Cost Service Models																																			
								Agree & Develop Preferred Option																																			
								Implement Test of Change																																			
2	**Care at Home (Including Reablement)**	Targeted enablement within a homecare setting to deliver improved outcomes and help reduce the average hours of long-term care required.	X	X	X	Murray Leys	Lesley Horne	Develop Proposal	On Track																																
								Pilot & Evaluate																																			
								Roll Out																																			
3	**Allied Health Professionals**	Reshape AHP services in order to support the emerging community services "Out of Hospital Care" model	X	X	X	Kenny Mitchell	Sonia Borthwick	Management Review	On Track																																
								Clinical Productivity Programme																																			
								Service Redesign & Roll-Out																																			
4	**Dementia**	Redesign the care and support service to deliver improved outcomes for clients who suffer from dementia.	X	X	X	Murray Leys	Graeme McMurdo	Establish specialist dementia centre	Amber																																		
								Improve post-diagnosis support																																			
								Improve care home liaison																																			
								Improve training & support																																			
5	**Mental Health Redesign**	Service redesign in line with Mental Health Needs Assessment Recommendations, MH Strategy and to achieve identified Financial Savings	X	X	X	Simon Burt	Haylis Smith	Planning/Preperation	Amber																																
								Development																																		
								Transformation Planning																																		
								Refine & Agree																																		
								Implement From																																		
6	**Re-imagining Day Services**	Review of Day Services to identify and deliver a more effective and efficient service options	X	X	X	Murray Leys	Michael Curran	Planning & Data Gathering	Amber																																
								Implementation																																		
								Completion																																		
7	**Carers Strategy**	Work co-productively to implement the legislation effectively.	X			Murray Leys	Susan Henderson	Planning & Evaluation	On Track																																		
								Deliver Action Plan																																			
								Act Requirements Met																																			
8	**Alcohol & Drug Services**	To work with Borders Addiction Service (BAS) and Addaction to confirm potential co-location to improve joint working			X	Tim Patterson	Fiona Doig	Identify & Agree Location	Amber																																		
								Implementation																																			
								New Arrangements go live																																			
9	**IT & Telehealth Care**	Delivery of a video conferencing (Attend Anywhere) capability in care homes to support Out of Hours Emergency Care, Diabetes Services and Orthopaedics avoiding the need for expensive travel (time) and hospital visits - including avoidance of missed appointments.	X	X	X	Murray Leys	Bill Edwards/ Jackie Stephen	Attend Anywhere Pilot	Amber																																		
								Evaluation & Roll-Out																																			
								Draft wider IT Project Proposals																																			
								Agree & Implement IT Proposals																																			
10	**Re-imagining Integrated H&SC Teams**	Design and Implementation of Integrated Health & Social Care Teams across the 5 localities	X	X	X	Murray Leys	TBC	Plan to be developed	Amber																																

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IJB Transformation Programme High Level Delivery Summary Tracker (February 2018)

February 2018

Corporate Lead / *Project Manager*		Programme/ Project	Purpose	Work / Milestones Achieved / Comments on Status – this period to end January 2018		Work / Milestones to be achieved – next period to 30 April 2018
				RAG Progress	Progress on work and reasons for RAG Status	Comments
1	**Kenny Mitchell**/ Stewart Barrie	**Community & Day Hospitals**	Implement best practice service models in Community Hospitals to improve patient pathway and make best use of resources.	**Amber**	**Status is Amber:** as first joint Project Board/Team meeting rescheduled from January 19th to February 19th Key points of review by Professor Anne Hendry to be presented at this meeting **Highlights** ▪ Project Board membership finalised ▪ Project Team membership identified and finalised ▪ Review of the Clinical Model for Community Hospitals by Professor Hendry (first draft) delivered mid-January 2018 o Review currently being evaluated and; o Discussion paper for Project Board being prepared	• Develop project workstreams from Professor Anne Hendry Review(discussion paper to be presented to Project Board) • Joint Project Board/Team meeting to be held in February 19th • Develop PID/detailed Project Plan • Service Models to be progressed/confirmed • Establish criteria for appraisal options
Page 35 **Murray Leys**/Lesley Horne		**Care at Home (incl. Enablement)**	Targeted and appropriate Enablement within a homecare setting to deliver improved outcomes for individuals and contribute to reductions in the average hours of long-term care required. Links with Technology Enabled Care (TEC) to enhance or replace direct contact time by carers	**Green**	**Status is green as the project is on track** • Proposal for a pilot enablement project was taken to EMT on 10th November • EMT has requested that CO Health & Social Care Integration leads on a revised proposal utilising Health Care Support Workers (HCSWs) in localities. • Discharge to assess work is progressing at Craw Wood to create a 15-bed capacity. Unit will be operational from 4th December. • Outline target is that patients will only remain in the facility for a maximum of 2 weeks. Care staff will be supported by OT/Physio staff to deliver enablement activity.	Reablement • Revise pilot proposal Enablement • Continue to develop the proposed Care at Home model.
3	**Kenny Mitchell**/ Sonia Borthwick.	**Allied Health Professionals**	The overall project aim is to reshape AHP services in order to support the emerging community services "Out of Hospital Care" model	**Green**	• 3 month data validation started in October 2017 across some services • New Data reports are being used • MSK now running a 3 month data validation period to finish end of February	• Vacancy and remodelling across services will finish • Recurring benefit realisation activity commences
4	**Murray Leys**/ Graeme McMurdo	**Dementia**	Redesign the care and support service to deliver improved outcomes for clients who suffer from dementia.	**Amber**	**Status is amber as there is a need to rescope the project – it's priorities and timescales – in the light of both the draft dementia strategy and recent capital funding bid**: • Draft Scottish Borders Dementia Strategy is now out for consultation (National Dementia Strategy has been published and underpins current consultation on development of Borders Dementia Strategy) • £4.8m capital is in the draft SBC Capital Programme for a 15 – 24-bed residential dementia unit (locations being explored) • Report being prepared exploring options in support of residential dementia unit including a feasibility for a Scandinavian-style "dementia village", options for dementia care in localities within new extra-care housing and bolstering/enhancing dementia care within the community.	• Continue to engage with stakeholders on the draft Dementia Strategy • Complete report on options for residential care • Clarification of the direct costs of the current dementia care pathway
5	**Simon Burt**/Hayliss Smith	**Mental Health Redesign**	Service redesign in line with Mental Health Needs Assessment Recommendations, MH Strategy and to achieve identified Financial Savings	**Amber**	**Status is amber due to delays in consultation as detailed below.** • Information and Data Gathering is underway • Workshops held with stakeholders, lack of ward staff and clinicians attending has meant additional sessions have had to be arranged in order to enable their input along with survey monkey surveys. • Service user workshops were also planned for December to ensure those with lived experience are able to influence future service provision, unfortunately, information had not been sent by BVCV and therefore no service users attended, further sessions were then planned for January with poor uptake, now working with SBC to send out questions via citizenspace • Project support identified to undertake benchmarking and desk-based research, information has been gathered from a number of other health boards. Also awaiting project support from Better Borders team	• Aim to produce redesign plan by end March 2018 • Request for project and transition support made to Better Borders • Implementation of redesign plan by end of 2019/20 financial year

Corporate Lead / *Project*	Programme/ Project	Purpose	Work / Milestones Achieved / Comments on Status – this period to end January 2018	Work / Milestones to be achieved – next period to 30 April 2018

	Manager			RAG Progress	Progress on work and reasons for RAG Status	Comments
6	**Murray Leys**/ Michael Curran	**Re-Imagining Day Services**	Review of Day Services to identify and deliver a more effective and efficient service options	**Amber**	**Status is amber as mitigating action is needed in other projects to ensure that interdependencies are not missed** • Interdependency mapping session being held on 29th January • Former Ability Centre clients already pursuing alternatives in the community • Part of the Ability budget (40K) will be reinvested in community connectors link workers to facilitate other centres to become community based. • Job recruitment paperwork all in place awaiting approval • Reimaging day service transformation proposal was discuss at IJB leadership group and agreed in principle. Revised paper to go to EMT • Resource request for project officer and assessment capacity to be requested from IJB • Contract discussions underway with SBCares the main provider of day services • Delays in both the approval of the transformation plan and application for project resources will delay the project delivery dates. Next EMT is not until 5th March, This builds in a two month delay to the proposed delivery timescale.	• Proposing & Discussing an alternative model for adults & older peoples day services with key strategic managers continues • Seeking approval for implementation plan and resources • Managing interdependencies remains a key risk/opportunity to maximising efficiency and effectivity • Recruitments process for link workers underway
7	**Murray Leys**/ Susan Henderson	**Carers Strategy**	Work co-productively, through the Health and Social Care Partnership and children and young people's services, with carer representative organisations and with carers, to implement the legislation effectively.	**Green**	**Status is Green because project is on track** • In conjunction with the Borders Carers Centre a new draft carers support plan has been tested, with positive response from staff and carers to date. • Draft eligibility criteria have been agreed by Carers Act Board. • The young carers implementation group has met to plan progress to meet the legislation. • Options appraisal on the pathways to provide support completed and preferred option agreed by the Carers Act Board.	• Test out draft eligibility criteria and consult with carers groups. • Scope work required for performance reporting to Scottish Government • Plan work and timescales for carers strategy • Progress work on pathway • Continue to roll out Carers Act awareness training
8	**Tim Patterson**/ Fiona Doig	**Alcohol & Drug Services**	To undertake work with Borders Addiction Service (BAS) and Addaction to confirm potential development of a single management structures and/or co-location to improve joint working	**Amber**	**Status is amber as there is no agreement yet re relocation and associated capital costs** A visit took place to potential co-location site of Galavale on 3.8.17. Addaction have, however, negotiated a reduction in rent which would mitigate savings.	• Costings expected from NHS Borders Estates by 17.8.17. Depending on outcome will inform discussions with services. • Awaiting meeting with Chief Officer re potential alternative site following cancellation. • Awaiting confirmation of additional 2018 funding from Scottish Government.
9	**Murray Leys**/ Graeme Dobson (Attend Anywhere) Bill Edwards & Jackie Stephen (IT)	**IT & Telehealthcare**	Delivery of a video conferencing (Attend Anywhere) capability in care homes to support Out of Hours Emergency Care, Diabetes Services and Orthopaedics avoiding the need for expensive travel (time) and hospital visits - including avoidance of missed appointments.	**Amber**	**Status is amber as the project plan is still to be finalised:** **Attend Anywhere** – video conferencing facility. This is a TEC (the national Technology Enabled Care) funded project – a skype-like browser-based facility. • Orthopaedics Dept. trialled Attend Anywhere. Options for future use are being reviewed. • Diabetes Dept. will look pilot Attend Anywhere from January for hard-to-reach younger patients • GP clusters – scoping a pilot with Tweeddale GPs & Nursing/Care Homes in January 18. • MH Services are to be part of a national Distress Brief Intervention (Suicide Prevention) pilot. • • Wifi being installed in care homes in Tweeddale • Pharmacy services exploring use with community pharmacies and Out of Hours Service. • Out of Hours preparing to pilot with health professionals in Tweeddale. **Wider Integrated Technology Programme** • Draft roadmap to develop integrated IT solutions has been presented to EMT based on: • Collaborative Working – Communications(email/telephony)/Calanders/File-sharing • Person-Centric Data – a single view and single updating of people's records • Workflow – automation of processes and pathways • Assistive Technologies – enabling independent living and avoid unnecessary admissions. Further work continues to refine and agree the roadmap and identify resources to deliver it. • Presentation by Strata on workflow solution.	• Visit to Cumbria being arranged (9th of March) to view STRATA workflow system in practice (Proof of Concept project to be developed thereafter) • Attend Anywhere – Tweeddale GP Cluster/Care Home/Borders Emergency Care Service pilot to commence • Continued work on developing the road map (capacity permitting) • Smartcare launch • Secure PM resource to continue scoping work/subsequent implementation and deliver the STRATA proof of concept project
10	**Murray Leys**/ TBC	**Re-Imagining Integrated Health & Social Care Teams**	Design and Implementation of Integrated Health & Social Care Teams across the 5 localities	**Amber**	**Status is amber as the project is still in development. A number or pieces of work including the Coldstream Buurtzorg Pilot are already starting to shape the model of Integrated Social Care. These initiatives need to be brought together for visibility and to enable effective co-ordination.**	• Complete scoping of project.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .....12 February 2018.....

Report By	*Robert McCulloch-Graham*
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NHS BORDERS FESTIVE PERIOD REPORT 2017/18

Purpose of Report:	*To update the Integration Joint Board on performance over the festive period only: 15.12.17 to 02.01.18.*
Recommendations:	The Health & Social Care Integration Joint Board is asked to: note the 2017/18 Festive Period Report.
Personnel:	Staffing implications were addressed within the Joint Winter Plan 2017/18.
Carers:	N/A
Equalities:	N/A
Financial:	Resource implications were addressed within the Joint Winter Plan 2017/18.
Legal:	N/A
Risk Implications:	The Joint Winter Plan is designed to mitigate the risks associated with the winter and festive periods.

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Borders NHS Board

NHS BORDERS 2017/18 FESTIVE PERIOD REPORT

Aim

To update the Board on performance over the festive period only: 15th December 2017 until 2nd January 2018. This period was 19 days long with 3 weekends, which is the same as covered last year, 16th December 2016 until 3rd January 2017, making the periods comparative.

Background

NHS Borders like all Health Boards are required on an annual basis to produce a Winter Plan which outlines potential risks and contingency planning relevant to the winter season, with a particular focus on the festive period. This year the plan was developed jointly with the Scottish Borders Health and Social Care partnership as a whole system plan. The 2017/18 plan was discussed at both the Health Board and Integrated Joint Board and subsequently approved at the 26th October 2017 NHS Borders Board meeting.

After each winter period the Winter Planning Board convenes to assess what worked well, what could have been improved, the learning from the period, and key recommendations are taken forward in preparation for the next winter period. A full report on the winter period will come to the Board in April 2018.

Executive Summary

The 2017/18 Festive Period was the most challenging period for 3 years, with performance against the Emergency Access Standard of 89.9% dropping below 95% for the first time since 2014/15.

There appear to be three main reasons for the pressures experienced in NHS Borders:

1. Acuity of patients. There was a large increase in people with medical conditions attending primary care out of hours (12%) and the Emergency Department/Acute Assessment Unit (13.5%). Indications are that a significant element of this increased acuity was related to an increase in respiratory conditions, with a 60% increase in respiratory-related consultations at BECS and 24% in ED. In spite of this, emergency admissions reduced by 7.3%, indicating that arrangements to avoid admissions were successful. However, as a result, patients admitted to hospital appeared to be more acutely unwell than in previous years, with length of stay increasing by 9.3%, equivalent to an additional 23 beds over the period compared to the previous year.

2. Low discharge rates over Christmas period. The hospital system was placed under greater pressure early in the festive period compared to previous years. Discharges

in the period immediately around Christmas (24th-26th December) fell by 42% compared to last year. As a result, 36 more patients were admitted than discharged; compared to 8 more last year.

3. Delayed Discharge numbers. There was a 30% increase in delayed discharges compared to last year. Mental Health delayed days reduced by 57%, Community Hospital delayed days increased by 15% and BGH delayed days increased by 201%. Although allowance was made within the plans for up to 34 additional beds to replace beds unavailable due to delayed discharges, the numbers increased more rapidly than expected. As a result, a peak of 42 beds were occupied by people delayed in their discharge over this period (10 more beds in the BGH and 3 more in community hospitals than last year), reducing the numbers of beds available to admit patients.

The effect of these pressures was to place significant pressure on health and social care services.

- BECS experienced particularly high demand over the New Year period (12% increase) and as a result 4-hour performance fell from 90% to 88%. However, staffing plans coped well with this increased demand.
- The Emergency Department experienced the highest number of breaches of the Emergency Access Standard for 4 years, with 37 patients waiting over 8 hours and 19 patients waiting overnight for greater than 12 hours in the department due to a lack of beds to admit to (compared to 0 last year). There were further increases in breaches waiting first medical assessment because the department had no space to see other patients. Despite these pressures, the average time from arrival to triage increased by just 8 minutes and the average time to medical review by 23 minutes. Planned additional medical and nursing staffing again worked well.
- Activity to avoid admission appeared to be effective. The percentage of patients admitted from ED fell from 32.4% to 31.5% and the number of patients managed through the ambulatory care urgent outpatient and treatment service increased by 44%.
- An additional 15 beds were opened to accommodate patient admissions, impacting on the maintenance of normal services, including the loss of the Acute Assessment Unit (for 7 days), with all A&E attendances going through the Emergency Department, and the loss of the Planned Surgical Assessment Unit (3 days), with a subsequent knock-on cancellation of day case procedures. Although the Winter Plan identified these two areas as contingency beds, the Plan was designed to avoid their use except in extreme situations due to their impact on services.
- During the New Year public holiday period, as last year, additional nurse specialist, AHP, diagnostic services and social work staff were on duty. There was an increase in numbers and range of specialties available to support patient review and discharge. However, as the Winter Plan did not clarify the level of clinical support services required over the festive period, service provision was based on availability of staff rather than service need. Earlier planning for next year would be beneficial.
- Early and relentless nurse recruitment and the plans for additional staffing across wards and hospitals helped ensure availability of staff – there were 18wte vacancies this festive period compared to 21 vacancies in December last year. However, staff sickness and the need to open additional beds meant that there was an increase in agency hours over the period from 274.75 to 311 hours.
- Additional medical staff were rostered, including an additional consultant to review boarders, meaning that all boarded patients were reviewed daily.

- The Winter Plan aimed to maintain access to care homes and home care provision over the festive period, including during public holidays and weekends. There was social work availability over weekends and public holidays, and access for transfers to Craw Wood and Waverley step down facilities during this period, which was not available last year. However, access to mainstream homecare and care homes places was not available at all during the public holidays or weekends. There should be earlier planning to contract with care providers to ensure both capacity and access to services.
- Despite a planned reduction in elective activity and a switch to day surgery to reduce demand for inpatient beds, there was an increase from 2.7% to 17.9% in hospital-related cancellations. This was due to availability of beds.

There was close working between health and social care in the two months leading up to the Festive Period and a range of measures to reduce the number of delayed discharges, including new step-down beds and additional intermediate care beds. However, actions to support social care capacity over the festive period, including the block-booking of care home capacity and the establishment of additional specialist dementia care beds, as well as arrangements for social care services to be operational over the public holidays were not in place for this festive period.

BECS Activity Summary

The 2017-18 Festive Period for BECS showed a 12% increase in volumes of patient care episodes compared to last year, with a total of 1589 patient contacts (+12.0% variance from last year), 372 telephone advice contacts (-6.3%), 715 patient attendances (+9.8%) and 502 home visits (+35.3%).

Table 1: BECS Activity Summary

Year	Telephone Advice Provided			Attendances			Visits			Total		
2012/13	293			763			432			1488		
2013/14	321	(+ 28)	+9.6%	559	(-204)	–26.7%	313	(-119)	–27.5%	1193	(-295)	-19.8%
2014/15	429	(+108)	+33.6%	650	(+91)	+16.3%	411	(+98)	+31.3%	1490	(+297)	+24.9%
2015/16	334	(-95)	–22.1%	620	(-30)	–4.6%	363	(-48)	-11.6%	1346	(-144)	-9.6%
2016/17	397	(+63)	+18.9%	651	(+31)	+5%	371	(+8)	+2.2%	1419	(+73)	+5.4%
2017/18	372	(-25)	-6.3%	715	(+64)	+9.8%	502	(+131)	+35.3%	1589	(+170)	+12.0%

*Variance from previous year

85.4% (-4.2%) of patients requiring a face to face consultation within the Primary Care Emergency Centre at Borders General Hospital were seen within the timeframe advised from NHS24 triage (includes patient travel time into BGH). 36.1% of patients seen were children.

However only 64.1% (-12.4%) of patients requiring a home visit were seen within their designated triage times. This unfortunately sees a deterioration in performance against last year, almost certainly due to increased volumes. The wide geographical spread of home visits (Central 32.5%, South 20.9%, West 14.5%, East 29.1%) always presents a challenge, especially in bad/snowy weather.

Performance data against time priorities set by NHS24 is shown below:

Attends:

Year	1 hour		2 hour		4 hour		Total	
2015/16	39.1%		69.1%		93.2%		88.4%	
2016/17	35.7%	-3.4%	64.6%	-4.5%	92.7%	-0.5%	89.6%	+1.2%
2017/18	50.0%	+14.3%	61.5%	-3.1%	94.3%	+1.6%	85.4%	-4.2%

Home visits:

Year	1 hour		2 hour		4 hour		Total	
2015/16	55.6%		82.7%		94.7%		80.7%	
2016/17	65.4%	+9.8%	65.6%	-17.1%	87.2%	-7.5%	76.5%	-4.2%
2017/18	27.1%	-38.3%	65.4%	-0.2%	82.4%	-4.8%	64.1%	-12.4%

*Variance from previous year

It should be noted that timeframes for assessment are set by NHS24 triage, and the clock starts running from that point. So, for example, a 2-hour urgent priority call would require the patient to travel in to BGH (from wherever they live in the Borders) and have been seen by a BECS doctor within that time frame.

The service provided 131 more home visits (+35.3%) than during the same Festive period last year, probably as a result of large numbers of elderly patients presenting with flu-like respiratory illness. In addition, unforeseen driver shortages and staff illness meant that there were several key shifts (including one on Christmas Day) when only one or two vehicles were able to go out to do visits instead of the usual three and this will have impacted on waiting times for visits. 1-hour visits to the periphery of our area (e.g. Eyemouth, Newcastleton, West Linton) are always a challenge even in the best circumstances.

It is likely that the overall reduced performance against time priorities, compared to last year, is a direct consequence of the 12% increased overall service activity. Detailed festive planning meant that the service entered the festive period with full staffing, with additional clinician resource for the predicted busiest days, but unfortunately these assumptions were made on the basis of NHS24 predicted activity figures, and these have subsequently shown to have significantly underestimated demand, by as much as 60% during the two long festive 4-day weekends. In response to the Christmas pressures we added additional clinician shifts for the New Year, to improve resilience that weekend.

BECS performance can also be measured against its impact on secondary care services i.e. admission rate which includes referrals to 999, ED and secondary care specialities (-3.3% variance from last year), and its impact on primary care i.e. number of patients referred back to their own GP to contact for subsequent review (-3.5%). BECS also supports the front door of the hospital and relieves pressures on the Emergency Department by accepting appropriate walk-ins (+4.5%). At time of writing there have been no patient complaints and only one adverse event (relating to staff absence due to illness) recorded by Datix for this period.

BECS impact on other services:

Year	Refer to 999/ED/speciality			Own GP to contact patient for review		
2015/16	202			74		
2016/17	216	(+14)	+0.2%	57	(-17)	-1.5%
2017/18	189	(-27)	-3.3%	24	(-33)	-3.5%

*Variance from previous year

Top 10 conditions seen:

	2017/18		2016/17		2015/16	
1	Lower respiratory tract infection	205	Lower respiratory tract infection	152	Urinary tract infection	120
2	Urinary tract infection	146	Urinary tract infection	119	Upper respiratory tract infection	84
3	Upper respiratory tract infection	112	Upper respiratory tract infection	72	Lower respiratory tract infection	76
4	Skin infection	55	Medication requested	52	Abdominal pain	56
5	Palliative care	55	Palliative care	49	Skin infection	55
6	Vomiting	53	Abdominal pain	48	Palliative care	44
7	Medication requested	52	Attention to urinary catheter	45	Medication requested	42
8	Abdominal pain	49	Skin infection	39	Advice about treatment given	35
9	Advice about treatment given	47	Sepsis	37	Acute tonsillitis	33
10	Flu-like illness	40	Advice about treatment given	36	Sepsis	32

Emergency Department (ED) and Acute Assessment Unit (AAU) Activity Summary

Attendances at the Emergency Department and Acute Assessment Unit over the festive period rose by 13.5% (202) this period compared to last year (Table 1). This comprised an increase in Flow 1 (minor injuries and illness) patients this year of 9.9% (76), and a combined increase in Flow 2 & 3 attendances (i.e. mostly people with significant medical illness) compared to last year of 32.6%. Flow 2 (acute assessment) attendances increased by 49.1% (86) and Flow 3 (medical admissions) by 23.3% (73). There was a fall in Flow 4 (Surgical Admissions). This suggests a large increase in medically unwell patients attending ED and AAU this year, compared to last year. There were 185 more breaches in ED this year compared to last year (Table 5). As a result, performance against Emergency Access Standard dipped well below the national standard of 95% (Table 6). Combined AAU and ED performance over this period was 89.9% compared to 96.3% last year.

Although there were increases in most categories of breaches, 78% of the rise in breaches was related to significantly increased numbers of breaches due to bed availability (139 (55%) of all breaches) and an increase of 43 cases of breaches related to delays in assessment in ED. A major contributory factor to breaches related to delays in assessment was capacity within ED to review patients.

Throughout this period, there was close to attention to ensuring that patient in ED were assessed and appropriately treated in a timely fashion. Average time to triage, which is the initial point of review by a clinician, increased by just 8 minutes from 12 minutes to 20 minutes, and the maximum wait to triage was 224 minutes. Average time to first medical assessment increased by 18 minutes from 62 minutes to 80 minutes. Total average wait from arrival to discharge increased from 141 to 164 minutes. The largest proportion (44%)

of breaches due to wait for first assessment were for Flow 1 patients (i.e. patients with minor injury or illness). All patients waiting more than 8 hours were nursed on beds, where appropriate and additional nursing was provided to ensure appropriate nursing care was provided for patients waiting to access beds within the hospital.

AAU activity fell by 16% (Table 5). This reflects the fact that the Acute Assessment Unit was bedded and therefore not functional for 7 of the 18 days during this period.

Table 2: ED and AAU Total Attendances

Year	Total Attendance		Total Breaches		Weekend Attendance[2]		Weekend Breaches[2]		Public Holiday Attendance		Public Holiday Breaches	
2015/16	1,444		60		512		14		325		10	
2016/17	1,496	(+52) 3.6%	68	(+8) 13.3%	444	(-68) -13.3%	19	(+5) 35.7%	374	(+49) 15.1%	26	(+16) 160.0%
2017/18	1,698	(+202) 13.5%	253	(+185) 272.1%	542	(+98) 22.1%	61	(+42) 221.1%	372	(-2) -0.5%	62	(+36) 138.5%

*Figures in grey show the variance from previous year
[1] Previously reported data to the board included dates out with the reporting period which have now been updated.
[2] Please note: Weekend figures have adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Chart 1: Total ED and AAU Attendances by Day in the Festive Period

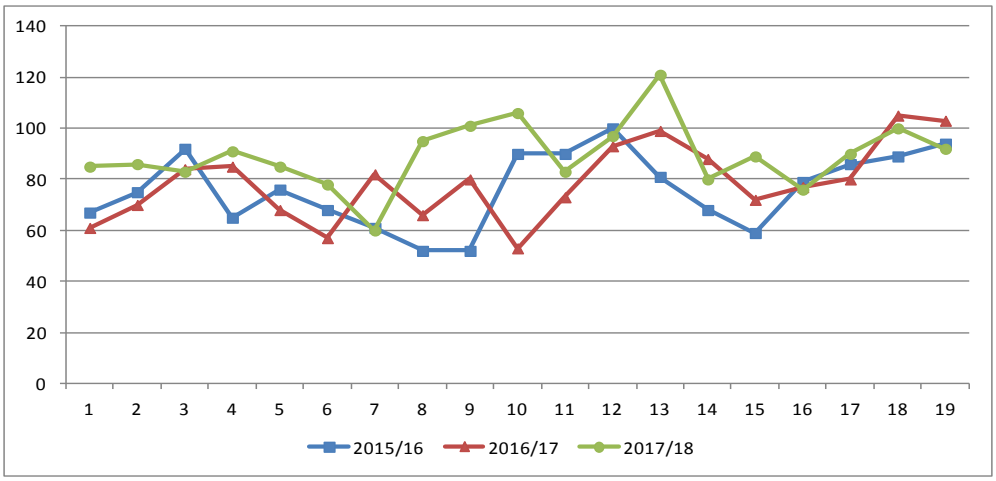


Table 3: ED and AAU Split of Total Attendances

Area	Total Attendance	Total Breaches	Weekend Attendance	Weekend Breaches	Public Holiday Attendance	Public Holiday Breaches
ED	1608	232	527	57	366	61
AAU	90	21	15	4	6	1
Total	1698	253	542	61	372	62

Table 4: ED Attendances by Flow

Patient Flow Description	Total Attendances			Percentage Difference on Previous Year	
	2015/16	2016/17	2017/18	2016/17	2017/18
Flow 1: Minor Injury & Illness	727	764	840	5.1%	9.9%
Flow 2: Acute assessment - includes major injuries	145	175	261	20.7%	49.1%
Flow 3: Medical Admissions	248	313	386	26.2%	23.3%
Flow 4: Surgical Admissions	136	137	121	0.7%	-11.7%
Total	**1256**	**1389**	**1608**	**10.6%**	**15.8%**

Table 5: Acute Assessment Unit Attendances

Year	Total Attendances		Weekend Attendances		Public Holiday Attendances	
2015/16	188		44		22	
2016/17	107	(-81) -43.1 %	18	(-26) -59.1%	18	(0) 0.0%
2017/18	90	(-17) -15.9%	15	(-3) -16.7%	6	(-6) - 54.5%

Table 6: ED and AAU Breaches by Reason for Wait Description

Breach Reason for Wait Description	2016/17	2017/18
Wait for bed	38	130
Wait for 1st ED Assessment	7	63
Other reason	3	17
Wait for Senior Review	6	4
Wait for treatment to end	1	6
Wait for transport	3	6
Clinical reason(s)	7	13
Wait for diagnostics test(s)	3	14
Total	**68**	**253**

There was an increase in overall number of breaches of the Emergency Access Standard in AAU of 1, from 20 to 21, over this period compared to last year.

Table 7: EAS Performance (ED and AAU)

Year	Total EAS Performance	Weekend EAS Performance[1]	Public Holiday EAS Performance
2012/13	94.3%	97.8%	97.2%
2013/14	98.8%	98.6%	99.9%
2014/15	88.1%	88.6%	92.9%
2015/16	97.1%	97.4%	97.7%
2016/17	96.3%	96.5%	94.4%
2017/18	89.9%	88.7%	83.3%

[1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Ambulatory Care Unit Summary

The Ambulatory Care service provides urgent outpatient access for people who do not require to be admitted but need to be seen or receive treatment urgently. The Ambulatory Care Unit relocated to a larger location during 2017. There were 140 attendances through the Ambulatory Care Unit during the festive period, (44% increase) with a 93% discharge rate. This compares to 97 patients attending Ambulatory Care in 2016/17 with a 91.8% discharge rate (Table 8).

The increased emphasis on the use of Ambulatory Care to avoid admission may partially explain why the increase in ED attendances did not translate to an increase in admissions. Further work is underway to confirm whether this was the case.

Table 8: Ambulatory Care Unit Attendances

Year	Total Attendances		Weekend Attendance		Public Holiday Attendance	
2015/16	81		14		14	
2016/17	97	(+16) 19.8%	17	(+3) 21.4%	20	(+6) 42.9%
2017/18	140	(+43) 44.3%	30	(+13) 76.5%	22	(+2) 10.0%

BGH Activity Summary

Total adult emergency admissions to the BGH decreased by 7.3% (44) compared to the previous year. Medical admissions remained unchanged (400 admissions in 16/17 and 403 admissions in 17/18). Emergency surgical admissions fell by 47% (205 in 16/17 and 158 in 17/18). Due to the short timescale to publication of this report, corrections and amendments to coding may cause these figures to change slightly.

Weekend admissions decreased by 10.1% (17 admissions). There was also a decrease in Public Holiday admissions of 13.8% (19).

The number of discharges decreased by 7.8% (45), compared to the previous year. However, weekend discharges increased by 22.9% (27). This is mainly due to the low number of discharges on Sundays last year, when both Christmas Day and New Years

Day fell on a Sunday. Public Holiday discharges decreased by 36.9 % (41) with an average of 19 discharges per day compared to a normal weekday discharge rate averaging 32 discharges.

There were 32 fewer emergency discharges than emergency admissions over this period, similar to the 2016/17 period where there were 31 fewer discharges. However, over the period 24th – 26th December, there was a mismatch between discharges and admissions totalling -37 (i.e. 37 more admissions than discharges) compared to a -8 mismatch in 2016. This mismatch has resulted in an ongoing deficit in admitting beds, leading to pressure across the BGH for the remaining festive period and beyond.

Patients' average length of stay for the festive period 2017/18 increased by 0.4 days to 4.7 days compared to 4.3 days last year, see Table 11 below.

There was a large increase in paediatric admissions of 42.9% (42) this festive period (Table 10), balanced by the same number of discharges. Paediatric average length of stay decreased for the festive period 2017/18 at 0.9 days (compared to 1.2 for 2016/17, see Table 11).

Table 9: BGH Adult Emergency Admissions & Discharges

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2015/16	657		529		203		120		124		80	
2016/17	605	(-52) -7.9%	574	(+45) 8.5%	168	(-35) -17.2%	118	(-2) -1.7%	138	(+14) 11.3%	111	(+31) 38.8%
2017/18	561	(-44) -7.3%	529	(-45) -7.8%	151	(-17) -10.1%	145	(+27) 22.9%	119	(-19) -13.8%	70	(-41) -36.9%

* Figures in grey show the variance from previous year [1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Table 10: BGH Paediatric Emergency Admissions & Discharges

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2015/16	89		86		30		27		17		12	
2016/17	98	(+9) 10.1%	100	(+14) 16.3%	27	(-3) -10.0%	29	(+2) 7.4%	25	(+8) 47.1%	18	(+6) 50.0%
2017/18	140	(+42) 42.9%	140	(+40) 40.0%	41	(+14 51.9%	50	(+21) 72.4%	26	(+1) 4.0%	19	(+1) 5.6%

Table 11: BGH Length of Stay for Festive Period 2016/17 compared to 2017/18

Year	Adults				Paediatrics			
	Occupied Bed Days	ALoS (Days)	Occupied Bed Days Variance	ALoS Variance	Occupied Bed Days	ALoS (Days)	Occupied Bed Days Variance	ALoS Variance
2016/17	3657	4.3			123	1.2		
2017/18	4076	4.7	11.5%	8.4%	125	0.9	1.6%	-23.7%

Figures exclude obstetrics.

To improve patient flow in the BGH the aim is to discharge as many patients as possible before 11am and 12 midday. The number discharged before both 11am and 12pm was slightly higher this year compared to last, at 48 (8.0%) and 69 (11.5%) respectively (Table 12).

Table 12: 11am and 12 midday discharges achieved

Year	Total Discharges		Weekend Discharges		Public Holiday Discharges	
	11am	12 midday	11am	12 midday	11am	12 midday
2012/13	56 (7.4%)	95 (12.5%)	9 (1.2%)	15 (7.8%)	8 (5.0%)	21 (13.0%)
2013/14	78 (10.2%)	127 (16.7%)	14 (1.8%)	24 (19.5%)	25 (22.1%)	35 (31.0%)
2014/15	55 (8.0%)	103 (15.0%)	18 10.8%)	30 (18.0%)	9 (8.8%)	16 (15.7%)
2015/16	48 (7.9%)	71 (11.8%)	20 13.8%)	28 (19.3%)	6 (4.6%)	7 (5.3%)
2016/17	22 (3.5%)	46 (7.3%)	14 (9.9%)	22 (15.5%)	2 (1.6%)	5 (4.0%)
2017/18	48 (8.0%)	69 (11.5%)	19 (9.1%)	29 (13.9%)	7 (11.3%	7 (11.3%)

Indicators that beds are under pressure are the number of boarders that are in the hospital at any one time and the number of overnight transfers. There were more boarders each day over the festive period than in previous years (Chart 2). Overnight transfers were similar to 2016/17.

Chart 2: Boarders Comparison 2015/16, 2016/17 and 2017/18

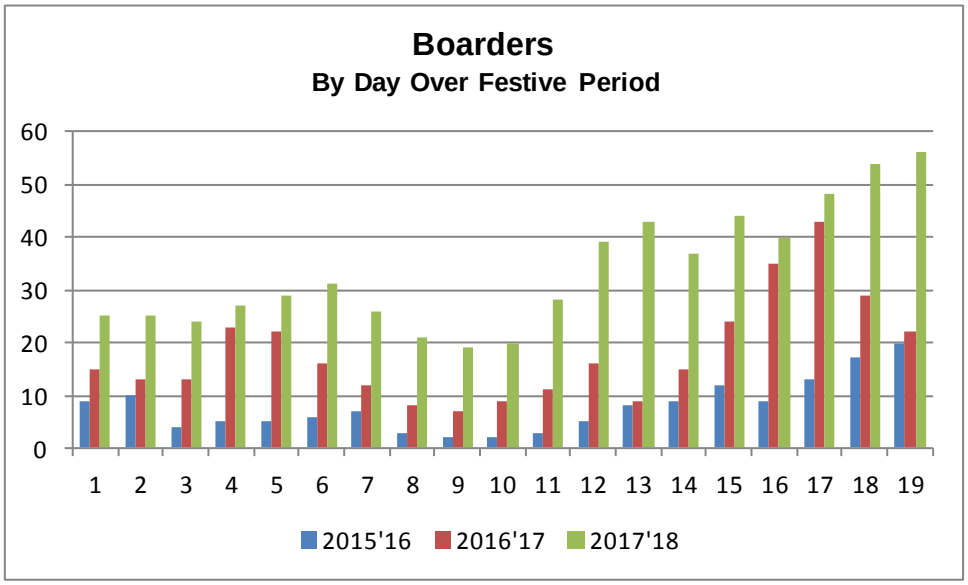


Table 13: Boarders Comparison 2016/17 with 2015/16

Total Boarders	As at 16/12/2016	As at 23/12/2016	As at 30/12/2016	As at 04/01/2017
Total	**15**	**8**	**29**	**30**

Please note: these data show a snapshot of current boarders on each day as specified

Total Boarders	As at 17/12/2015	As at 24/12/2015	As at 31/12/2015	As at 04/01/2015
Total	**9**	**3**	**12**	**20**

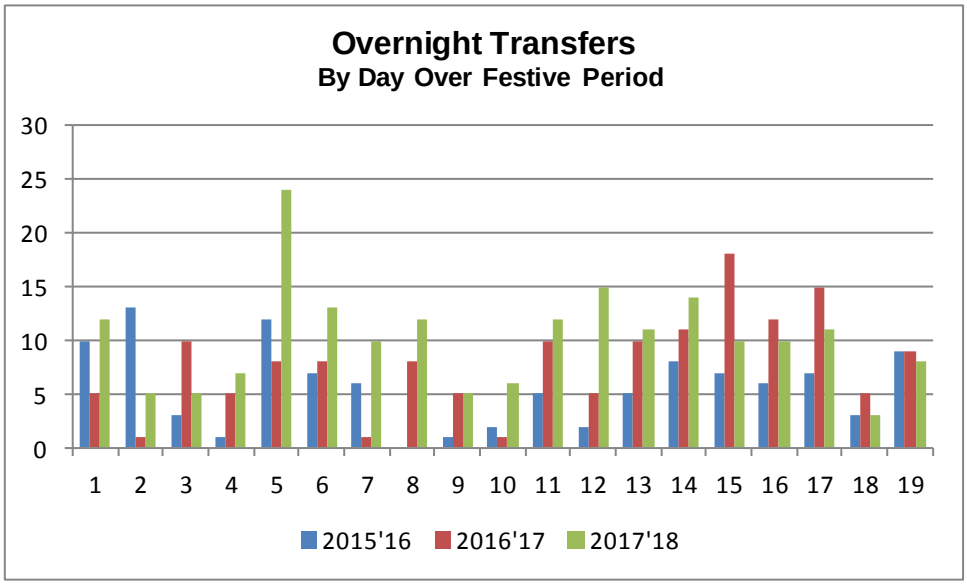
Please note: these data show a snapshot of current boarders on each day as specified

Table 14: Boarders by Ward 2017/18

Total Boarders	As at 15/12/2017	As at 22/12/2017	As at 29/12/2017	As at 02/01/2017
Ward 4	1	0	0	0
Ward 5	0	1	0	0
Ward 7	5	4	15	12
Ward 9	3	2	4	9
MKU	1	3	0	0
Ward 16	9	5	13	14
BSU	1	4	4	4
PSAU	0	0	1	3
Total	**20**	**19**	**37**	**42**

Please note: these data show a snapshot of current boarders on each day as specified

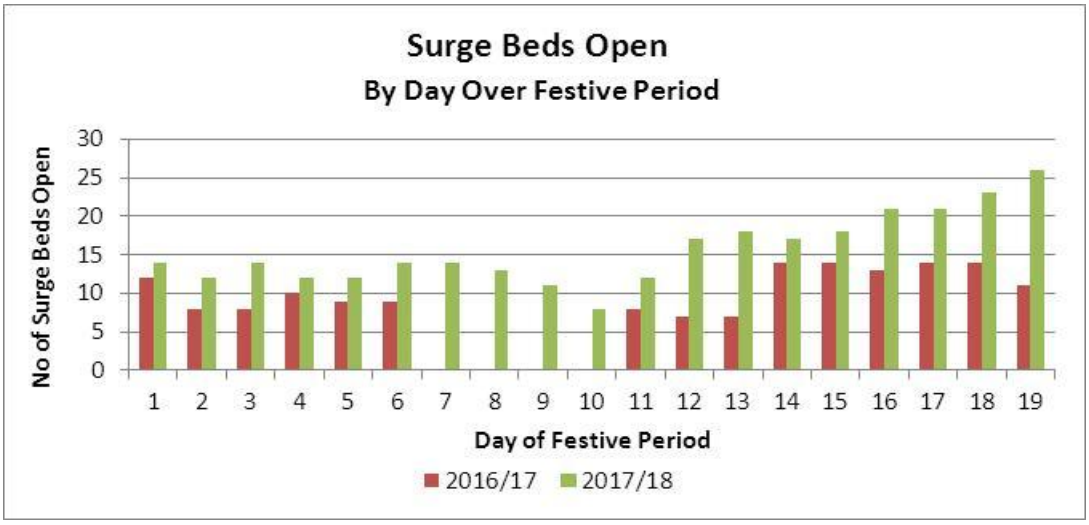
Chart 3: Overnight Transfers (8pm – 8am) by Ward



Surge Beds

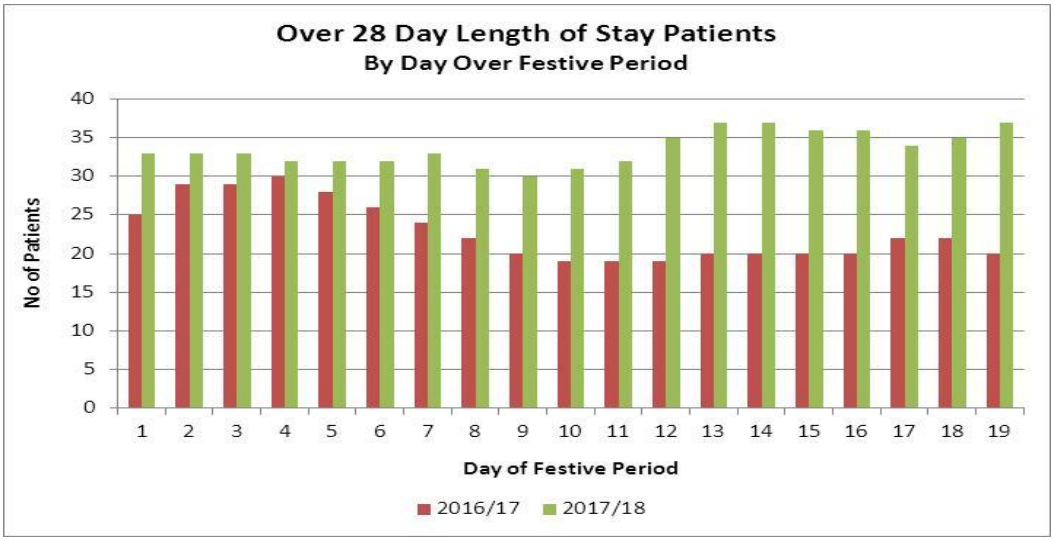
There were 297 days of surge beds used during this period compared to 158 bed days for 2016/17, an increase of 88% (Chart 4). This included the unplanned use as inpatient areas of Acute Assessment Unit (7 days) and the Planned Surgical Assessment Unit (PSAU) (3 days). This data does not include the 4 days when a total of 6 patients were held overnight in the Emergency Department due to a lack of beds to admit them that were then discharged from ED the next morning without becoming an inpatient.

Chart 4: Surge Beds Open over Festive Period



Delayed Discharges

Chart 5: Patients with a length of stay over 28 days



There was a 30% increase in bed days lost to delayed discharges from 573 for 2016/17 to 747 in 2017/18. The largest increase in bed days lost is due to the significant rise in complex cases, which rose from 92 bed days lost to 172 bed days lost.
Average delayed discharge cases over the festive period also rose by 30% in 2017 (35) compared to 2016 (27). This is reflected in a similar 30% rise in numbers of patients with length of stay over 28 days (see Chart 5 above).

The number of delayed discharge cases over 2 weeks as at 4th January 2018 was 27, compared to 23 in the same week in 2017.

There was a significant increase in the number of complex cases on the list from an average of 4.25 in 2016/17 to an average of 10 this reporting period. However, this is a return towards the average of 2015/16, which was 12.5. It is not felt that the festive period contributed to this increase.

The top three reasons for being recorded as a delayed discharge are:

- Awaiting a package of care, with an average of 12 over the period and representing 33% of all delays
- Currently being assessed by social work, with an average of 6 over the period
- For 'Adults requiring a placement in 24 hour care settings', there is a weekly average of 10, or 30% of all delays (categories 24B, 24C and 24F). These cases account for 31% of the standard delayed bed days in the festive period in 2017/18.

Table 15: Delayed Discharges comparison by week

Total Delayed Discharges	As at 14/12/17			As at 21/12/2017			As at 28/12/2017			As at 04/01/2018		
	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks
BGH	7	7	7	7	4	3	10	10	3	9	9	7
Community Hospitals	22	20	16	23	12	10	19	19	10	19	17	16
Mental Health	6	6	5	5	5	5	5	5	5	5	4	4
Total	**35**	**33**	**28**	**35**	**21**	**18**	**34**	**34**	**18**	**33**	**30**	**27**

Please note: these data show a snapshot of current delayed discharges on each day as specified, excludes complex cases.

Table 16: Delayed Discharges by reason for delay

Delayed Reason	As at 14/12/17			As at 21/12/2017			As at 28/12/2017			As at 04/01/2018		
	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks
11A Awaiting commencement of post-hospital social care assessment (including transfer to another area team)	1	1	1							1	1	1
11B Awaiting completion of post-hospital social care assessment (including transfer to another area team)				9	1	1	8	8	1	7	7	7
24B Awaiting place availability in Independent Residential Home	5	5	5	4	1	1	3	3	1	5	4	3
24C Awaiting place availability in Nursing Home (not NHS funded)	4	4	2	2	1	1	2	2	2	2	2	2
24F Awaiting place availability in care home (EMI/Dementia bed required)	4	4	4	4	4	3	4	4	3	2	2	2
25D Awaiting completion of social care arrangements to live in their own home - awaiting social support (non-availability of services)	18	16	13	12	11	9	13	13	8	12	10	8

25F Awaiting completion of social care arrangements - Re-Housing provision (including sheltered housing and homeless patients)	1	1	1	1	1	1	1	1	1	1	1	1
51 Legal issues (including intervention by patient's lawyer), - e.g. informed consent	1	1	1	1	1	1	1	1	1	1	1	1
67 Disagreement between patient/carer/family and health/social care	1	1	1	2	1	1	2	2	1	2	2	2
Total	**35**	**33**	**28**	**35**	**21**	**18**	**34**	**34**	**18**	**33**	**30**	**27**

Please note: these data show a snapshot of current delayed discharges on each day as specified

Table 17: Delayed Discharge Occupied Bed Days – Comparison between festive periods 2015/16, 2016/17 and 2017/18

Delayed Discharge Occupied Bed Days	**Festive Period 2015/16**			**Festive Period 2016/17**			**Festive Period 2017/18**		
	Standard	Complex	Total	Standard	Complex	Total	Standard	Complex	Total
BGH	14	51	65	93	0	93	210	70	280
Community Hospitals	155	160	315	307	54	361	348	68	416
Mental Health	83	17	100	81	38	119	17	34	51
Total	**252**	**228**	**480**	**481**	**92**	**573**	**575**	**172**	**747**

Table 18: Complex Delayed Discharges by area - Comparison between festive periods 2016/17 and 2017/18

Delayed Discharges	**As at 16/12/2016**	**As at 23/12/2016**	**As at 29/12/2016**	**As at 06/01/2017**	**As at 14/12/17**	**As at 21/12/2017**	**As at 28/12/2017**	**As at 04/01/2018**
	Complex	Complex	Complex	Complex	Complex	Complex	Complex	Complex
BGH	0	0	0	0	3	3	2	3
Community Hospitals	3	3	3	3	5	4	4	4
Mental Health	2	1	1	1	4	3	3	3
Total	**5**	**4**	**4**	**4**	**12**	**10**	**9**	**10**

Please note: these data show a snapshot of current delayed discharges on each day as specified

Overall, the largest proportion of recorded delays (for 2016/17 and 2017/18 festive periods) are in community hospitals, with a small increase in actual numbers from 14 in January 2017 to 16 in January 2018. There has been an increase in proportion of BGH delayed discharges from 16% of total delayed discharges in 2016/17 to 37% in 17/18, with an equivalent reduction in proportion of delayed discharges in Mental Health (Tables 17 and 18).

Elective Theatre Cancellations

33 patients' procedures were cancelled over the festive period. 24 of these were for a non-clinical reason (17.9%) which is over the local target set of 1.5% and is a deterioration in performance from the previous year (2.3%). This local target is based on the Scottish Board average for May – August 2015. The majority (12 patients) were cancelled due to no ward or ITU bed being available. Exceptional pressures over this period meant that our elective footprint was turned over to unscheduled demand (including PSAU) from 27th December.

Table 19: Cancellations by type

Year (Scottish Average)	Total Procedures	Total cancellations	Cancellation Type			
			Hospital (Target 1.5%)	Clinical (Target 2.8%)	Patient (Target 3.7%)	Other (Target 1%)
2015/16	110	11	6	2	3	0
2016/17	133	9	3	1	5	0
2017/18	134	33	24	4	5	0
Cancellation Rate 15/16	-	10.0%	5.5%	1.8%	2.7%	0%
Cancellation Rate 2016/17	-	6.8%	2.3%	0.8%	3.8%	0%
Cancellation Rate 2017/18	-	24.6%	17.9%	3.0%	3.7%	0%

Table 20: Cancellations by Reason

Reason	2015/16	2016/17	2017/18
No surgeon/anaesthetist to cover list			
Emergency took priority		2	4
Out of time	2		3
Inappropriately listed			
Scheduling Issue			1
No theatre staff			
No nursing staff – DPU			
No beds (inc ITU beds)	3	1	16
Equipment Issue	1		
Total	**6**	**3**	**24**

Waiting Times

Treatment Time Guarantee (TTG)/ Referral To Treatment / Stage of Treatment

There was a planned reduction in elective activity during the festive period due to the public holidays, consultant availability and expected bed availability between Christmas and New Year. Additionally, a large number of patients were cancelled mainly due to bed availability which has had a significant impact on the TTG waits especially within Orthopaedic Surgery.

There were 24 cancellations over the festive period, 16 of these were due to a lack of bed capacity. This combined with a reduction in elective activity due to public holidays and consultant availability has seen lower than normal numbers of patients treated, with a total of 47 elective patients treated over the two festive weeks. This has significantly increased the TTG Breach numbers over this period with a total of 136 patients reported as breaching on the 7th January 2018 within Orthopaedic Surgery, General Surgery, Oral Surgery, ENT and Urology. This compares to 16 TTG breaches on 6th January 2016 (15 within Orthopaedic Surgery and 1 General Surgery).

18 Week Referral to Treatment performance has been continuously below 90% mainly due to long waits in Outpatients for a first appointment. We are currently organising extra activity for at risk specialties until the end of March 2018 to rectify this. There was reduced outpatient activity over the festive period due to the public holidays and consultant leave that will have a small impact on patient journeys and the Referral to Treatment Target.

Table 21 Festive Period TTG Breaches - 2016/17 and 2017/18 Comparison

Date 2016/17	Number of TTG Breaches	Date 2017/18	Number of TTG Breaches
02/12/2016	21	03/12/2017	71
09/12/2016	20	10/12/2017	79
16/12/2016	14	17/12/2017	82
23/12/2016	14	24/12/2017	94
30/12/2016	14	31/12/2017	123
06/01/2017	16	07/01/2018	136

31 and 62 day Cancer Waiting Times

The festive period has not had an impact on Cancer Waiting Times performance; targets continue to be met.

Community Activity Summary

During the Festive Period Community Hospital admissions decreased by 3 (6%) and discharges increased by 1 (2%) when compared with the same period last year. Due to the small numbers this may reflect normal levels of variation in this data and does not indicate a significant shift (Table 22).

Table 22: Community Hospital Admissions & Discharges over the Festive Period

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2012/13	68		63		6		10		9		7	
2013/14	54	(-14) -20.6%	55	(-8) -12.7%	5	(-1) -16.7%	5	(-5) -50.0%	3	(-6) -66.7%	5	(-2) -28.6%
2014/15	61	(+7) 13.0%	67	(+12) 21.8%	10	(+5) 100%	13	(+8) 160.0%	3	0 0.0%	9	(+4) 80%
2015/16	59	(-2) -3.3%	53	(-14) -20.9%	11	(+1) 10%	8	(-5) -38.5%	5	2 66.7%	4	(-5) -55.6%
2016/17	52	(-7) -11.9%	49	(-4) -7.5%	5	(-6) -54.5%	12	(+4) 50%	13	(+8) 160%	5	(+1) 25%
2017/18	49	(-3) -5.8%	50	(+1) +2.0%	10	(+5) +100%	5	(-7) -58.3%	2	(-11) -84.6%	4	(-1) -20.0%

* Variance from previous year given in grey

[1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Table 23: Community Hospital Activity for December 2016 and December 2017

	December Activity				*Percentage Increase on Previous Year*		
Month	**Admissions**	**Discharges**	**Occupied Bed Days**	**ALoS (Days)**	***Admissions***	***Discharges***	***Occupied Bed Days***
2016/17	88	94	2572	27.4			
2017/18	83	86	2740	31.9	-5.7%	-8.5%	+6.5%

During December the average length of stay was up by 4 days when comparing with December last year, and occupied bed days have increased correspondingly by 6.5%. Due to the nature of individual patient length of stay in Community Hospitals this probably reflects a pattern of normal variation. This is also reflected in the length of stay of the different hospitals (Table 24).

The Community Hospitals were prepared to open 5 additional beds from 2nd January 2018. Due to pressures on beds in the BGH these were opened from 28th December 2017.

Allied Health Professionals covered key periods during the public holidays to ensure timely assessment and treatment in the BGH.

The first stage of Hospital at Home pilot was introduced in Berwickshire with staff going through induction during the Festive Period ready to commence in January.

Table 24: Community Hospital Festive Period Length of Stay Comparison

Hospital	December 2016/17 Average Length of Stay (Days)	December 2017/18 Average Length of Stay (Days)
Hawick	19.3	30.9
Hay Lodge	20.4	26.8
Kelso	40.0	51.3
The Knoll	56.4	27.8
Total	27.4	31.9

Infection Control

During the festive period (15th December 2017 – 2nd January 2018), there were no closures for infection control reasons.

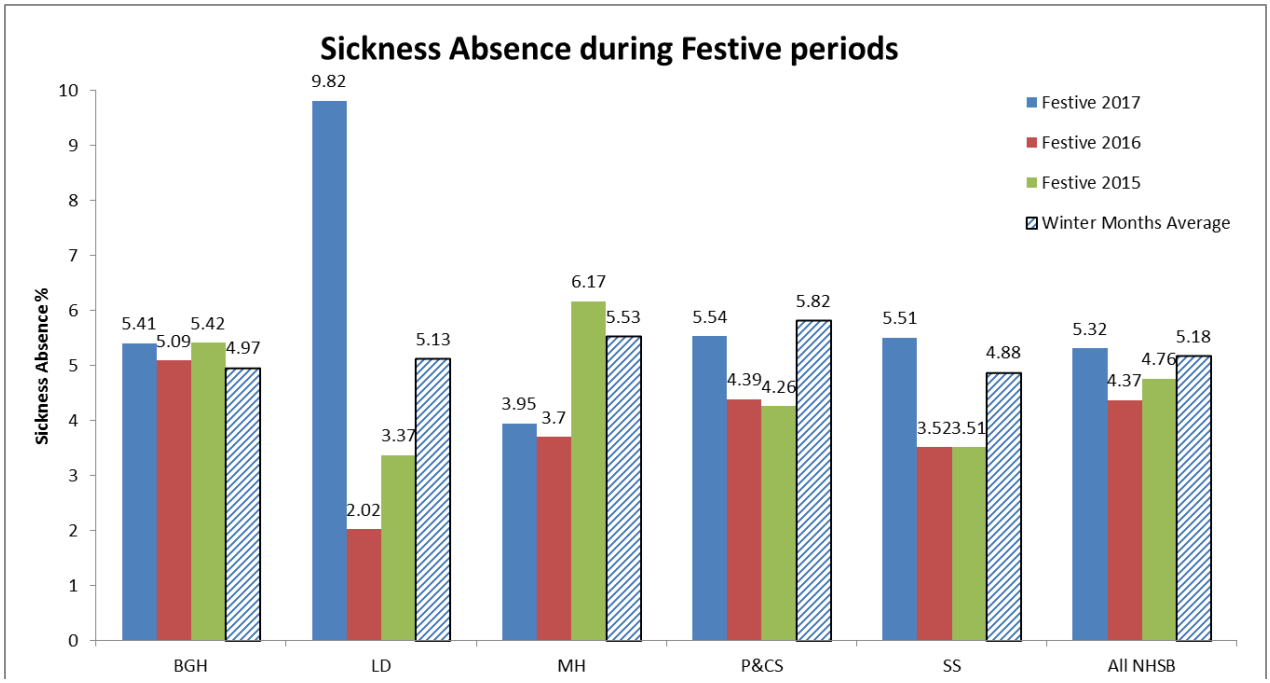
Staff Sickness Absence

The sickness absence rate over the festive period for 2017/18 was 5.32%. This rate saw an increase of 0.95 % on the sickness absence rate from the previous year (2016/17) when the rate was 4.37%. On average over the winter months the absence rate sits at approximately 5.18%.

This Festive period saw an increase in rate of absence for all directorates compared to last year's festive period. Mental Health and P&CS reported a lower rate of sickness absence during this period compared to their average rate of sickness absence during the winter months.

The total absence rate for NHS Borders over this festive period was 0.15% higher when compared to the average rate of sickness absence during the winter months. Please see the chart below.

Chart 6 Sickness Absence comparison by area, 2015/16 to 2017/18



During this festive period 8 departments (headcount > 14) report a sickness absence rate greater than 10% compared to the previous year where there were 7 departments (Table 25 below).

Table 25: Teams (>14 headcount) with sickness absence > 10 % during Festive 2017/18 period

Headcount	Sub-Department	Festive 2017	Festive 2016	Festive 2015	Winter Months Average %
19	District Nursing Tweeddale	15.06	4.62		
37	Hawick Hospital	14.42	14.65	3.76	10.21
38	Ward 4	13.27	15.97	8.45	9.72
40	Ward 12	12.92	12.67	2.52	7.90
19	Health Visiting Eildon	12.74	1.13		
48	Ward 7 and PSAU	11.16	11.51	10.91	8.23
24	Training Development	11.07	0.00	0.00	7.30
37	Ward 9	10.47	12.41	7.07	11.23

This Festive period has seen a noticeable increase (4%) of '*cold, cough, and flu' related absences* from last year. The *'other unknown causes'* reasons used when recording absence on SSTS was almost 5% higher when compared to the same period last year. With the exception of the two reasons outlined above, the distribution of sickness absence reasons during this year's festive period is similar to the pattern evidenced during the winter months (Table 26 below).

Table 26: Most common reasons of sickness absence during 2016/17 Festive period

SA Reason	Festive 2017	Festive 2016	Festive 2015	Winter Months Average %
Anxiety/stress/depression/other psychiatric illnesses	19.86	21.60	23.80	20.11
Cold, cough, flu - influenza	12.86	8.76	4.19	8.87
Unknown causes/not specified	11.77	6.84	7.82	8.00
Other known causes - not otherwise classified	9.95	8.01	13.41	9.44
Back problems	9.80	6.64	5.66	7.07
Injury, fracture	8.66	6.40	6.93	7.45
Other musculoskeletal problems	7.97	9.73	8.33	9.86
Gastro-intestinal problems	6.21	9.06	8.06	7.36

As reported through SSTS, during this festive period there were 404 occasions of sickness absences within NHS Borders. 7 members of staff had more than one episode of sickness absence within this period.

No external locums were required for sickness during the period, however due to the sudden absence of an ED doctor, nights in the Emergency Department over Christmas Day and Boxing Day public holidays were covered at short notice through a rota swap by a trainee in orthopaedics.

In accordance with the Winter Plan, the rotas at middle grade and training grade level in the key acute specialties of general medicine, general surgery, orthopaedics and the Emergency Department were modified for the festive period specifically to ensure safe cover on the public holidays and adjoining weekends. The cover ranged from a level of weekend cover + 1 to normal staffing on Tuesday 2nd January. Through rota planning

additional medical cover was in place from our substantive doctors, between the period 22nd December 2017 – 6th January 2018

In addition for the Emergency Department, 6 extra "surge" shifts were filled by well known external locums on priority days (between 26th December 2017 – 2nd January 2018), taking account of historical activity trends. There were 60 hours of external locum appointed for this purpose at a cost of £5,000.

Communications Focus over Festive Period

Once again, both weeks of the festive period had a four day weekend so the focus of local communications activity was information on GP surgery and pharmacy opening hours and reminding the public in advance to endure they had adequate supplies of prescription medicines that they would require. The emphasis was placed on when surgeries and pharmacies were open (rather than closed) in an attempt to encourage people to plan ahead. These messages were enhanced by the national activity co-ordinated by NHS24 which again featured the 'Doctor Owl' character under the strap-line 'be healthwise this winter'.

The other key message was 'know who to turn to' message, using the 'Meet Ed' campaign, reminding people only to at the Emergency Department in a real emergency situation, and utilise instead support and advice available from GPs, Pharmacies and Minor Injury Units. The 'Weekly Winter Update' format was used again, both for internal and external audiences and this year included a focus on 'Winter Stars' – staff members who go the extra mile to keep services running over the Winter period. This was well received.

With flu having a significant impact across Scotland this season we also continued to reinforce the vaccination message, as well as more general 'keep well' advice for those suffering with cold and flu like symptoms.

In common with other health boards the communications focus has shifted significantly towards social media, supported by local print and broadcast media informed by press releases and statements. We also use the NHS Borders website, SB Connect publication and information screens in our hospitals and GP surgeries.

Due to the exceptional pressures over the Christmas holiday period, on 28 December 2017 our emergency response communications were activated and the public were advised that we were experiencing unprecedented demand, and told that if they did need

to attend the hospital that their waits would be longer etc. The statement published on our NHS Borders facebook page was shared more than 400 times on the 28th alone. The communications response continued into the New Year as the volume of attendances and resulting admissions and system pressures continued.

Initial Recommendations for Future Festive Period Planning

Feedback has been sought from managers, clinicians and front-line staff on issues identified over the festive period. Although these are still being discussed, early suggestions for further work to build upon are:

- The focus for the Winter Plan was the New Year period, based on an expectation that there would be sufficient capacity over the Christmas period, as in previous years. Early and detailed planning should be applied to the Christmas period as well as the New Year period, including the modelling of the impact of different admission and discharge levels to ensure that adequate services are available
- The ongoing work to reduce delayed discharges and ensure improved access to community hospitals and alternatives to hospital care should be completed in good time to ensure that new ways of working are tested and established before the festive period
- A further review of elective operating arrangements should be undertaken to determine whether maintenance of elective operating is feasible during this period
- A dedicated additional medical ward may be helpful to ensure appropriate allocation of staff and to reduce boarders. This may involve the redesignation of an existing ward
- Work to explore other areas for establishing additional beds should be undertaken as a matter of urgency to allow time for early planning to prepare these for winter
- The Duty and Site Team arrangements for the festive period should be reviewed. Rotas should allow for adequate site team support across both daytime and night times and sufficient capacity to ensure resilience amongst the site management team
- Staff based in non-clinical areas should receive training in skills useful to be able to support wards (e.g. ward-based admin tasks) and have clearly defined roles when deployed to support clinical areas
- Patient Flow escalation policies should be reviewed and action taken to ensure they are followed consistently

Thanks to the following people for the compilation of this report:

Rebecca Green, GP Clinical Lead BECS
Heather Tait, Clinical Services Manager, Planned Care and Commissioning
Erica Reid, Lead Nurse, Community
Jane Prior, General Manager, Patient Flow
Steven Litster, Waiting Times Manager
Sam Whiting, Infection Control Manager
Clare Oliver, Communications Manager
Karen Shakespeare, Planning and Performance Manager

Recommendation

The Strategy and Performance Committee to **note** the 2017/18 Festive Period Report, the performance of the system during this period and the outline recommendations for future winter planning.

A full Winter Period Report is to be brought to the next Board meeting.

Rationale for submission to Strategy & Performance Committee	To note the performance of the system during this period and the outline recommendations for future winter planning.
Policy/Strategy Implications	Request from Scottish Government that all Health Boards produce a Winter Plan signed off by their Board in support of quality patient care. This report will inform the Winter Planning Process 2018/19
Consultation	Feedback was provided by the Winter Planning Group, Clinical Services and Managers and Partner organisations
Consultation with Professional Committees	The original Winter Plan was approved by the NHS Borders Board.
Risk Assessment	The Winter Plan is designed to mitigate the risks associated with the winter and festive periods
Compliance with Board Policy requirements on Equality and Diversity	
Resource/Staffing Implications	Resource and staffing implications were addressed within the Winter Plan

Approved by

Name	**Designation**	**Name**	**Designation**
Claire Pearce	Director of Midwifery, Nursing & Acute Services	Rob McCulloch-Graham	Chief Officer

Author(s)

Name	**Designation**	**Name**	**Designation**
Phillip Lunts	General Manager, Winter Planning Lead	Meriel Carter	Planning and Performance Officer

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .12/02/18.....

Report By	Robert McCulloch Graham
Contact	Jane Robertson
Telephone:	01835 825080

STRATEGIC PLANNING GROUP REPORT

Purpose of Report:	The purpose of the report is to update the Integration Joint Board (IJB) on key actions and issues arising from the Strategic Planning Group (SPG).

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note the key actions of the SPG.

Personnel:	N/A

Carers:	Carers are represented on the SPG and have therefore contributed to the development of this report.

Equalities:	N/A

Financial:	N/A

Legal:	The revision of the Strategic Plan meets the legal requirements of the Public Bodies (Joint Working) Scotland Act 2014.

Risk Implications:	Risk that proposed timescale for presentation of revised Strategic Plan will not be met due to capacity issues.

SPG Key Actions & Issues

Strategic Plan

An extended SPG meeting largely dedicated to the review of the Partnership's Strategic Plan was held on 10 January. This meeting marked the beginning of the work of the SPG in developing a revised Strategic Plan and included discussions around the rationalisation of objectives and enhancement of the vision. Work is now underway to develop an

advanced draft to be presented to the SPG at the next meeting scheduled for 7 March. The aim is to produce a revised draft Strategic and Commissioning Plan for ratification by the IJB in May 2018.

SPG Workplan 2018

In addition to the Strategic Plan there will be a range of Partnership strategies which will be required to be refreshed in the coming year and beyond. It was agreed by the SPG to populate a Workplan for 2018 in order to ensure effective oversight and scheduling of all Partnership Strategies. The workplan will be made available to the IJB Board Secretary at the earliest opportunity.