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

AGENDA		
1.	**ANNOUNCEMENTS & APOLOGIES**	1 mins
2.	**DECLARATIONS OF INTEREST**	1 mins
3.	**MINUTES OF PREVIOUS MEETING** (Pages 1 - 12) 19 December 2016 30 January 2017	3 mins
4.	**MATTERS ARISING** (Pages 13 - 16) Action Tracker	5 mins
5.	**STRATEGIC**	60 mins
	(a) **Partnership Performance Reporting** (Pages 17 - 38)	
	(b) **Transformational Programme**	
	(c) **Updated arrangements for managing the Integrated Care Fund (ICF)** (Pages 39 - 48)	
	(d) **Health & Social Care Delivery Plan** (Pages 49 - 92)	
	(e) **Locality Planning Progress Report** (Pages 93 - 98)	
	(f) **NHS Borders 2016/17 Festive Period Report** (Pages 99 - 120)	
6.	**CLINICAL & CARE GOVERNANCE**	10 mins
	(a) **Inspections Update**	
7.	**FINANCE**	30 mins
	(a) **Monitoring of the Health and Social Care Partnership Budget 2016/17 at 31 December 2016** (Pages 121 - 134)	
	(b) **Health and Social Care - Medium-Term Joint Financial Planning Strategy and Reserves Policy** (Pages 135 - 144)	
8.	**FOR INFORMATION**	5 mins
	(a) **Chief Officer's Report** (Pages 145 - 146)	
9.	**ANY OTHER BUSINESS**	5 mins
	(a) **Health & Social Care Integration Joint Board Development Session: 29 May 2017**	
10.	**DATE AND TIME OF NEXT MEETING**	

	Monday 27 March 2017 at 2.00pm in the Committee Room 2, Scottish Borders Council	

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 19 December 2016 at 2.00pm in Committee Room 2, Scottish Borders Council

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

1. Apologies and Announcements

Apologies had been received from Cllr John Mitchell, Mrs Pat Alexander, Mr Paul McMenamin, Mrs J McDiarmid and Mrs June Smyth

The Chair confirmed the meeting was quorate.

The Chair welcomed Mrs Elaine Torrance, Interim Chief Officer.

The Chair welcomed Mr Murray Leys, Chief Officer for Adult Social Work who was covering the adult social work element of the Chief Social Work Officer role.

The Chair welcomed Mrs Erica Reid, Hospital Director.

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 Extra Ordinary meeting of the Health & Social Care Integration Joint Board held on 21 November 2016 were approved.

4. Matters Arising

The Chair advised that she would discuss with the Chief Officer the topics for future Board Development sessions.

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

5. Integrated Care Fund Update

Mrs Elaine Torrance provided an overview of the content of the paper. She highlighted the range of projects that had been approved and their projected costs. She advised that the Executive Management Team had taken forward work to review the projected pathway and part of that review had led to a closing of the fund to new bids to enable more substantial planning work to take place to speed up the process and eliminate blockages in the system.

A discussion ensued which highlighted several key points including: development of ideas to prioritise pathways for delivery in the community setting; Rapid Assessment and Discharge (RAD) Team six day cover; the pause providing the ability to focus on the gaps in the system on admission and discharge; further opportunities to look at projects contributing to an integrated approach; and the timetabling of projects requiring approval by the Health & Social Care Integration Joint Board that might already be underway.

Mr John Raine enquired to what extent it represented additionality and whether the timeline for completion of the RAD project was realistic. Mrs Torrance confirmed that it was likely the timeline would be extended. In terms of additionality, she advised that one of the issues was how much the fund could be used for transformation. One of the learning elements was around the bids and how realistic it was to do shorter pieces of work which would lead to rapid change.

Mr Raine suggested it would be helpful to see if the Integrated Care Fund (ICF) was being used as additional money and to what extent against posts already funded by both Scottish Borders Council and NHS Borders.

Dr Angus McVean welcomed the RAD project but cautioned that the frail elderly would be admitted with a range of issues and potentially the target might miss a bit of the problem as there would be some who might not fit the medical model however the hospital might actually be the safest place for them at that specific point in time. He suggested undertaking audits on what was required at admission and on discharge.

Mr Andrew Murray agreed with Dr McVean's concerns and urged that the focus be person centred with the individual being the key component. Mrs Jane Davidson suggested collecting the data on what would have prevented the admission as it might give a slightly different picture and more insight into preventing admissions or enabling timely discharge.

Mrs Jenny Smith reflected that the RAD projects felt process orientated as opposed to person centred and she noted that whilst some pieces of work would be about getting the system right there was a need to think about what that change in process would make for the person using the service.

Mrs Lynn Gallacher suggested strengthening the references to carers, signposting and the Carers Act.

Cllr Graham Garvie suggested a future development session be organised to understand what the projects actually implied.

Dr Stephen Mather reminded the Health & Social Care Integration Joint Board (IJB) that it had discussed quick wins at the start of its formation back in 2015 and one of those targets suggested had been delayed discharges. He suggested the IJB should be disappointed that limited progress had been made since that time. Mrs Tracey Logan commented that more recently work had been undertaken on delayed discharges and change had now been effected with some success being seen. The matter was being tackled jointly at a senior level.

Mrs Davidson commented that over the previous 6-8 weeks there had been a cultural shift in addressing delayed discharges with both herself and Tracey Logan meeting and empowering their staff to make decisions to prevent delays, such as employing health care support workers instead of home carers, working with district nurses and attending GP Practices. She agreed that whilst progress had been limited in the past the new joint approach was focused on addressing the pathway to reduce and ultimately end delayed discharges.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the position of the Integrated Care Fund.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** supported the closing of the fund to new bids, until further planning work was undertaken.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified the recommendations of the Executive Management Team to approve 3 new projects detailed in 4.1 of the report.

6. Annual Performance Reporting Requirements

Mrs Elaine Torrance reiterated to the Board the statutory requirement for each Health and Social Care Partnership to produce and publish an Annual Performance Report. She emphasised that there would be limited data available for the first year. The final report would be submitted to the Health & Social Care Integration Joint Board for sign off ahead of submission to the Scottish Government by 31 July 2017.

Mr David Davidson enquired if sufficient resource was available to meet the key milestones. Mrs Torrance commented that the programme team and associated resources working on integration were being reviewed to ensure they worked across the whole integrated system. She added that it was helpful to have the two Chief Executives engaged and to be able to pull on the staff in both organisations to deliver.

Mrs Jenny Smith gave feedback from the Transformational Steering Group highlighting that they had been looking for guidance and support to move ahead with various ideas. Mrs

Torrance confirmed that she had spoken with them and identified key people to support therm.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the requirement to produce and publish an Annual Performance Report.

7. Inspections Update

Mr Murray Leys gave an update on the current status of the Joint Older Peoples Inspection highlighting that the self assessment questionnaire had been completed, and a list of files for reading and reviewing had been compiled. The Inspectors were due to arrive on site on 13 January.

Mrs Evelyn Rodger advised that in terms of the unannounced Healthcare Associated Infection (HAI) Inspection held in November 2016, the verbal feedback received had been positive and no major issues had been raised during the inspection. The first draft of the report was due to be shared with NHS Borders in January 2017.

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

8. Code of Conduct

The Chair advised of the requirements for the Health & Social Care Integration Joint Board to adopt a Code of Conduct.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** adopted the Code of Conduct for Scottish Borders Health & Social Care Integration Joint Board members.

9. Staff Governance Arrangements

Mr David Bell introduced the staff governance arrangements for the Health and Social Care Integration Joint Board. He advised that in line with the Scheme of Integration the partnership was required to have in place appropriate arrangements to oversee staff engagement and involvement across the employing authorities.

Cllr Graham Garvie noted the Joint Staff Forum had a large membership. Mr John McLaren commented that whilst the membership was large the quorum required was small.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the staff governance arrangements for the Health & Social Care Integration Joint Board.

10. Recovery Plan

Mrs Carol Gillie presented the recovery plan to the Board and highlighted several key elements including: financial pressures; recurring projects to be brought forward; £5.6m overspend at the year end on the delegated budget; operational pressures; efficiency/savings within the delegated budget; and the NHS wide recovery plan of £13.5m.

Mrs Jane Davidson highlighted that the Health & Social Care Integration Joint Board had been made aware of the situation previously and whilst the presentation contained more detail the situation had not changed.

Several points were raised during discussion including: Volatility of drug costs; supply and demand for junior doctors and locums; agency nursing staff are from premium rate agencies as the Scottish Government contract agency walked away from the local contract; work underway on a regional nurse bank facility; advance recruitment to permanent staff in anticipation of staff turnover and to avoid agency costs; skill mix of nursing staff to reduce reliance on junior doctors; difficulties in staffing the whole unscheduled care pathway; working hours for junior doctors are controlled and monitored and a cost is attached to anyone who breaches their contracted hours; and consultants are restricted to the 48 hours a week working time directive.

Cllr Graham Garvie commented that whilst Scottish Borders Council had met their savings target NHS Borders still had an issue. Mrs Gillie commented that the Health & Social Care Integration Joint Board had been aware from an early stage that there would be financial difficulties for NHS Borders in the current year and that mitigating actions had taken place, including, slippage on the capital programme, underwriting the revenue position; slippage on the Local Delivery Plan commitments; ring-fenced allocations; social care funding; and increased financial controls.

Cllr Garvie enquired what the Health & Social care Integration Joint Board could do to help the financial position? Mrs Gillie commented that whilst the pressures were roughly 50:50 the focus had to be on the recurring position and that she and David Robertson were trying to do more joined up financial planning for the future. For the current year it was clear a breakeven position would not be achieved and she enquired if the Social Care Fund or integrated Care Fund might be used to support the financial position.

The Chair commented that the Health & Social Care Integration Joint Board needed to have capacity to issue directions in relation to funding or a restructure to generate the required savings. She suggested full information be available for the Health & Social Care Integration Joint Board on 30 January for it to be able to issue appropriate directions.

Mr David Davidson agreed that fuller information was required and suggested the Executive Management Team provide a series of recommendations, risks and choices to the Health & Social Care Integration Joint Board so that it could make informed decisions on the issue of appropriate directions.

The Chair suggested there was a need to concentrate on investment funding and recurring savings, with difficult choices being made on what would be stopped from being done and what might be done differently to mitigate the same situation arising in the future.

Mrs Torrance commented that she was committed to working with Mr Robertson and Mrs Gillie to see what could be put in place to manage projects more effectively, to take difficult decisions and to achieve the changes required. She further commented that Prof John Bolton had agreed to work with the partnership early in the new year and that he would be able to give an objective view which might help with the difficult decisions to be made in the future.

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to hold an Extra Ordinary meeting on 30 January 2017 to focus on resolution of the financial situation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** (IJB) agreed to receive a report in advance of the Extra Ordinary meeting setting out the directions the IJB should issue to achieve a breakeven situation at the end of March and the associated risks involved.

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

Mr David Robertson provided an overview of the monitoring position of the Health and Social Care Partnership Budget to 31 October 2016, together with detail over the range of pressures that were being experienced and the proposed mitigating actions. He further advised that the report also included the monitoring position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and that relating to large-hospitals set aside for the population of the Scottish Borders (the "set-aside budget").

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted NHS Borders recovery plan presented alongside the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to call an Extra Ordinary meeting to discuss how to support NHS Borders with remedial action in order to deliver an affordable outturn position across the delegated budget at 31 March 2016.

12. Further Direction of Social Care Funding – Borders Ability & Equipment Services

Mrs Elaine Torrance sought agreement to the proposal to direct further social care funding to meet on-going projected financial pressure within the partnership's joint Borders Ability and Equipment Service (BAES) budget, on a one-off, non-recurring basis.

Dr Stephen Mather enquired if the use of the social care fund to fund extra for the BAES was good value? He enquired if there were other things available that might be better for the user and also if any rental was charged for the equipment or purchase to the users.

Mrs Torrance confirmed that discussions had taken place previously in regard to charging for equipment. Charging had not been put in place due to several factors including: how to put a new system in place; increased admin burden; and timely availability of equipment. Mrs Torrance confirmed that work needed to be undertaken, to control the spend around the BAES, the governance arrangements and sign off of budgets. She further advised that there were currently around 400 people able to access the system to order equipment. Significant controls had been put in place to ensure a balance for equipment availability to prevent hospital admissions and to support hospital discharges.

Further discussion focused on: prevention of admissions; amnesty on return of equipment; storage in new facility; reuse of larger pieces of equipment; potential for a deposit system; fundraising for equipment; seek a 90% return rate of equipment to reduce overall costs; and potential for a register of equipment going out and when due for return.

Mrs Torrance advised that the SB Cares initiative was for people to order equipment directly from them and they would transport and check the delivery to the individual. She suggested some people might find that more helpful in terms of being sign posted to order smaller items.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and approved the direction of a further £145k non-recurring allocation of social care funding to the BAES equipment budget for utilisation during the remainder of 2016/17.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a further report on the operation of the BAES at a future meeting.

13. Chief Officer's Update

Mrs Elaine Torrance advised that she had taken on the role of Chief Officer from 1 December and in regard to her substantive Chief Social Work Officer role had delegated responsibility for Adults to Murray Leys as Chief Officer for Adult Social Work. She was working from both Scottish Borders Council and NHS Borders and was meeting regularly with Sandra Pratt, Simon Burt and Murray Leys. Her initial focus had been on streamlining the Integrated Care Fund arrangements, structures and meetings as well as reviewing staffing levels, efficiencies and budgets.

Mrs Karen Hamilton enquired how long the interim arrangement would for and it was noted that it would be for six months in the first instance.

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

14. Joint Winter Plan 2016/17

Mrs Elaine Torrance highlighted that there had been lots of work on the festive plan taking place in terms of staffing arrangements and on-going focus on delayed discharges. In regard to the transitional care facility she advised that it was open with 11 beds and was being used to improve patient flow. She assured the Health & Social Care Integration Joint Board that the winter plan was progressing.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Joint Winter Plan 2016/17 had been formally approved by Borders NHS Board at its meeting on 27 October 2016 and submitted to the Scottish Government.

15. Any Other Business

Development Session: 30 January 2017: Mrs Elaine Torrance reminded the Board that the next development session was due to take place on Monday 30 January at 9.30am. The

Chair suggested the first hour be used as a short extra ordinary meeting to discuss the recovery plan.

16. Date and Time of next meeting

The Chair confirmed that there would be an Extra Ordinary meeting of the Health & Social Care Integration Joint Board held on Monday 30 January at 9.30am, and that the following scheduled meeting of the Health & Social Care Integration Joint Board would take place on Monday 27 February 2017 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 4.00pm.

Signature: ……
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of an Extra Ordinary meeting of the Health & Social Care **Integration Joint Board** held on Monday 30 January 2017 at 9.30am in Committee Room 2, Scottish Borders Council

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

1. Apologies and Announcements

Apologies had been received from Mr John Raine, Dr Annabel Howell, Mrs Lynn Gallacher, Mrs June Smyth, Mr Andrew Murray, Mrs Evelyn Rodger, Mrs Jenny Smith and Mrs Alison Wilson.

The Chair confirmed the meeting was quorate.

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. 2016/17 Integrated Budget Monitoring Position – Recovery Plan

Mr Paul McMenamin gave an overview of the content of the paper and highlighted that the adverse variance for the budget delegated was £5.6m with a variance of £3m for the large hospital budget (set aside). He advised that in order to mitigate the social care element of the projected pressure (£378k) £145k was directed towards this pressure for the purchase of additional equipment by BAES. Scottish Borders Council remained committed to the identification of further management actions to address the social care financial pressures.

Mr McMenamin commented that the overall projected pressure of £5.2m and set aside of £3m were part of NHS Borders wider financial pressures of £13.9m in the current financial year. NHS Borders had committed to the application of £2m of contingency to reduce the overall

financial cost pressure to £11.9m. Work had been undertaken on a recovery plan for the residual pressure which included £11.7m of mitigating savings, however further cost pressures across NHS wide functions of £1.6m had been projected as recently as the previous week, due to a range of emerging factors.

Mr McMenamin drew attention to section 4.6 in the report and commented that following the application of the £2m contingency, the residual financial pressure amounted to £11.9m in NHS Borders, of which just over £4m related to the budget delegated with the rest related to the large hospital budget and other NHS functions. He emphasised that section 4.7 of the report detailed the summary of how the recovery actions would deliver the mitigating savings.

Mr McMenamin advised that the partnership Executive Management Team had met and discussed the mitigating actions to be taken forward in December and January and had recommended that £677k of remaining Social Care funding be directed to mitigate the forecast outturn pressure on the delegated budget. Although it would not address the wider set aside pressures the Executive Management Team had also agreed to explore further funding sources and proposals to address the outstanding pressures and had committed to bring those back to a future meeting.

Mr McMenamin reiterated that social care was also under further pressure in the current financial year and work was underway to identify further remedial actions. He was keen that a more sustainable basis to take heath and social care functions forward with recurring savings be identified and agreed.

Mrs Elaine Torrance assured the Health & Social Care Integration Joint Board that a lot of actions had been taken in regard to adult social care and by NHS Borders to bring the financial position back into balance. She suggested there was a need for an integrated transformational programme for 2017/18 and the longer term, with clear direction in terms of actions to be taken, regular reporting, and close monitoring of actions and outcomes.

Mr David Davidson enquired if the Executive Management Team (EMT) were able to provide any additional information that they thought might be helpful to the Health & Social Care Integration Joint Board in order for it to make a well informed decision? Mrs Torrance advised that the EMT had looked at all of the partnerships resources to date that were not actually allocated such as social care funding and any other uncommitted budgets that might be available ie the Integrated Care Fund (ICF). She commented that the EMT viewed the financial pressure as a joint problem and were keen to find joined up solutions and were actively considering and working on remedial actions to jointly reduce the deficit as much as possible.

The Chair noted that the intention to bring a balanced position appeared to be predicated on predominantly non recurring savings. She advised that she was reluctant to apply the £677k to address the NHS Borders delegated budget pressures at that point in time, as she viewed the monies as a reserve that the partnership had.

The Chair suggested directing Scottish Borders Council and NHS Borders to try and bring the budget back into balance and bear in mind that the £677k could be applied at a later date. She further suggested asking the EMT and Chief Officer to continue to work together to

mitigate the pressures in the system, given there was every possibility that a worse financial position would be likely by April 2017.

Cllr John Mitchell sympathised with the recurring savings challenges faced by both Scottish Borders Council and NHS Borders.

Mr Davidson enquired what the alternative would be if the Health & Social Care Integration Joint Board (IJB) did not accept the recommendation provided by the EMT? Mrs Tracey Logan suggested it made little difference at what point in time the IJB decided to direct the monies prior to April 2017 as the same effort would be made to mitigate the financial pressures. She clarified that if the monies were directed and not required they would be returned and she reiterated that time and effort had been spent on ensuring the financial year was delivered in budget and a joint budget process would be undertaken for the following year.

The Chair suggested a revised recommendation of: The Health & Social Care Integration Joint Board (IJB) issue the direction that NHS Borders continue to work with partners and Scottish Borders Council to deliver a balanced outturn for the IJB in 2016/17, and notes that £677k of the Social Care Fund remains uncommitted and gives consideration to its application at the IJB meeting on 27 March 2017.

Mrs Jane Davidson agreed that it did not make a significant difference when the funding was to be directed to NHS Borders. She commented that the key issues were to keep the financial gap minimised, and look at transformational change and performance across the year.

Cllr Garvie supported the revised recommendation and commented that paragraph 5.3 within the report referred to finding other kinds of savings, which he suggested was the most critical point in moving forward and enquired how that would be achieved. Mrs Logan highlighted that the Development session later that morning would be addressing the budget for the following financial year and emerging pressures.

Mrs Linda Jackson enquired if the remedial actions taken were impacting on direct service provision? Mrs Logan confirmed that they were not at that point in time. Mr Murray Leys commented that there was continued purchasing of beds and services which added to the pressures on the budget.

Dr Stephen Mather commented that the principle was that the IJB had a budget and was able to direct that budget to where it was required the most and from the EMT recommendation that appeared to be the NHS delegated functions budget. The Chair agreed with the principle and suggested it was a timing issue as potentially at the year end there would be either a deficit or a surplus and the £677k was the only money available to the IJB to use to plug any financial gap at that time.

Mrs Gillie reminded the IJB that an overspend on the NHS delegated functions budget had been forecast from an early point in the financial year and whilst action was being taken to mitigate financial pressures the outturn position would not change significantly. Whilst she accepted that there could be a delay in directing funds she reminded the IJB that the outturn forecast would remain as a deficit as a result.

Further discussion focused on: delegation to the EMT to manage the best way possible to contain pressures; social care fund provided to address the living wage issue with the exact amount spent to implement the living wage; potential risks in making negative changes of service provision to individuals which might not be necessary if the £677k were allocated; investing to reduce blocked beds; joint working approach at a senior level to address delayed discharges and ensure that individuals were in the right place at the right time with the right health and care package; and support the EMT with their recommendation.

The Chair commented that her preference was to delay the commitment of the funds until the year end as the financial forecast was only as good as it was at that point in time.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and agreed to issue the direction that NHS Borders continue to work with partners and Scottish Borders Council to deliver a balanced outturn for the IJB in 2016/17.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to delay the approval of issuing a direction for the remaining 2016/17 uncommitted social care funding (£677k) to NHS Borders in order to support mitigation of the overall forecast pressures across the delegated budget until its meeting on 27 March 2017.

4. Any Other Business

5. Date and Time of Next Meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Monday 27 February 2017 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 10.10am.

Signature: ……
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 27 April 2015

Agenda Item: Draft Strategic Plan – A conversation with you

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
1	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to have a Development session later in the year dedicated to revising Commissioning and Implementation Plan and considering plan for 2017/18.	Elaine Torrance	2017	**Update:** Item rescheduled for 29 May 2017 Development session.	A

Meeting held 17 October 2016

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

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

Meeting held 19 December 2016

Agenda Item: Recovery Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
9	10	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to hold an Extra Ordinary meeting on 30 January 2017 to focus on resolution of the financial situation.	Elaine Torrance, Iris Bishop	January	**Complete:** Meeting held 30.01.17	G

Agenda Item: Recovery Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
10	10	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** (IJB) agreed to receive a report in advance of the Extra Ordinary meeting setting out the directions the IJB should issue to achieve a breakeven situation at the end of March and the associated risks involved.	Paul McMenamin	January	**Complete:** Report received and discussed at the meeting.	G

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

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

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

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Scottish Borders
Health and Social Care
PARTNERSHIP

PARTNERSHIP PERFORMANCE REPORTING - UPDATE ON PROGRESS

Aim

1.1 This report sets the context for measuring and reporting Health and Social Care Partnership performance both nationally and locally as well as providing the IJB with key performance data in line with Scottish Government reporting requirements.

Progress Report

2.1 The landscape for monitoring and reporting on performance for Health and Social Care Partnerships is complex and there are a number of key drivers and measures which have particular influence on what requires to be reported where.

2.2 There are currently 23 indicators set by the Scottish Government as mandatory for all Health and Social Care Partnerships (HSCP) to report on. Indicators 1-10 focus on patient/carer and staff experience reported via surveys and indicators 11-23 are derived from organisational/system data. A more detailed breakdown of indicators can be seen in page 1 of **Appendix One**. The 23 indicators set by the Scottish Government require to be supported by local measures to provide a broader picture of local performance and all HSCP's are required to publish an Annual Performance Report in July 2017 to report publicly on performance. Work is currently underway in the Scottish Borders to develop a draft Annual Performance Report for presentation to the IJB on 27 March 2017 which will include a report on these indicators.

2.3 The Ministerial Strategy Group (MSG) has recently defined 6 themes under which a range of measures should be reported by Health and Social Care Partnerships on a quarterly basis. These themes are:

1. unplanned admissions;
2. occupied bed days for unscheduled care;
3. A&E performance;
4. delayed discharges;
5. end of life care;
6. balance of spend between institutional and community care.

2.4 In addition to existing reporting requirements, work has been underway in the Scottish Borders to develop a performance reporting scorecard for the IJB. The scorecard has been developed in line with the six themes above defined by the MSG with an additional theme which allows for reporting on more localised measures which have a primary, community or social care focus. A breakdown of themes and selected measures for reporting to the IJB can be seen in page 2 of **Appendix One.**

2.4 **Appendix Two** offers the first quarterly report on performance for the IJB based on the themes and measures detailed above and **Appendix Three** provides an explanation of the performance information presented in the scorecard. Given the many elements of integrated care and the wide range of services delegated to Health and Social Care Partnerships it is important to note that performance reporting to the IJB will develop over time to include reporting at locality level and more specific reports on particular groups of service users.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the 23 indicators set by the Scottish Government and the requirement to publish an Annual Performance Report by July 2017.

The Health & Social Care Integration Joint Board is asked to **note** the six themes for reporting recently defined by the Ministerial Strategy Group.

The Health & Social Care Integration Joint Board is asked to **endorse** the IJB reporting scorecard.

The Health & Social Care Integration Joint Board is asked to **comment** on performance to date.

Policy/Strategy Implications	Scottish Government reporting requirements.
Consultation	N/A
Risk Assessment	N/A
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	N/A

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer for Integration		

Author(s)

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Scottish Borders Health and Social Care Partnership
National Performance Reporting

23 Health and Social Care "Core Suite" Indicators have been set by the Scottish Government, against which every Health and Social Care Partnership is required to publicly report on. These measures need to be monitored to allow performance management and improvement to take place within the partnership. These Indicators each map to one or more of the 9 national Health and Wellbeing Outcomes.

Annual Performance Report from each Health & Social Care Partnership (must be published by July each year)

Must include 23 Health and Social Care "Core Suite" Indicators, set by the Scottish Government

Survey Feedback (patients, care recipients, carers, staff)	Organisational / System data
1. % of adults able to look after their health very well or quite well. 2. % of adults supported at home who agree that they are supported to live as independently as possible. 3. % of adults supported at home who agree that they had a say in how their help, care or support was provided. 4. % of adults supported at home who agree that their health and care services seemed to be well co-ordinated. 5. % of adults receiving any care or support who rate it as excellent or good. 6. % of people with positive experience of care at their GP practice. 7. % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. 8. % of carers who feel supported to continue in their caring role. 9. % of adults supported at home who agree they felt safe. 10. % of staff who say they would recommend their workplace as a good place to work.*	11. Premature mortality rate. 12. Rate of emergency admissions for adults. 13. Rate of emergency bed days for adults. 14. Readmissions to hospital within 28 days of discharge. 15. Proportion of last 6 months of life spent at home or in community setting. 16. Falls rate per 1,000 population in over 65s. 17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.* 18. Percentage of adults with intensive needs receiving care at home. 19. Number of days people spend in hospital when they are ready to be discharged. 20. % of total health and care spend on hospital stays where the patient was admitted in an emergency. 21. % of people admitted from home to hospital during the year, who are discharged to a care home.* 22. Percentage of people who are discharged from hospital within 72 hours of being ready.* 23. Expenditure on end of life care.*

***** Indicator under development

Also must include additional performance measures, **defined locally** + narrative to demonstrate impact

In addition to the Core Suite of 23 Integration Indicators, we already have other mandatory reporting measures such as HEAT standards, some of which are likely to be factored into future performance reports for the Partnership as we progressively develop integrated performance reporting.

How will our Integrated Joint Board know that progress is being made?
Local Performance Reporting

On a quarterly basis, the Integration Joint Board will receive a performance report across a range of measures. An initial range of measures has been established but we expect that this will change and develop over time.

Quarterly Performance Report

- The Scottish Government Ministerial Strategic Group (MSG) for Health and Community Care has defined 6 themes (1-6 below) under which it expects each Health and Social Care Partnerships to report a range of measures. Each partnership is required to set *objectives* for each of the 6 themes, based on local data, comparisons to national etc.

- In addition to the 6 themes defined by Ministers, locally we have defined a 7th theme, to capture locally important issues, which at the moment focus on social care. These themes are expected to develop over time (and will likely grow in number) as local and national discussions evolve.

1: Unplanned admissions	2: Occupied bed days for unscheduled care	3: A&E Performance	4: Delayed discharges	5: End of Life care	6: Balance of spend	7: Social Care

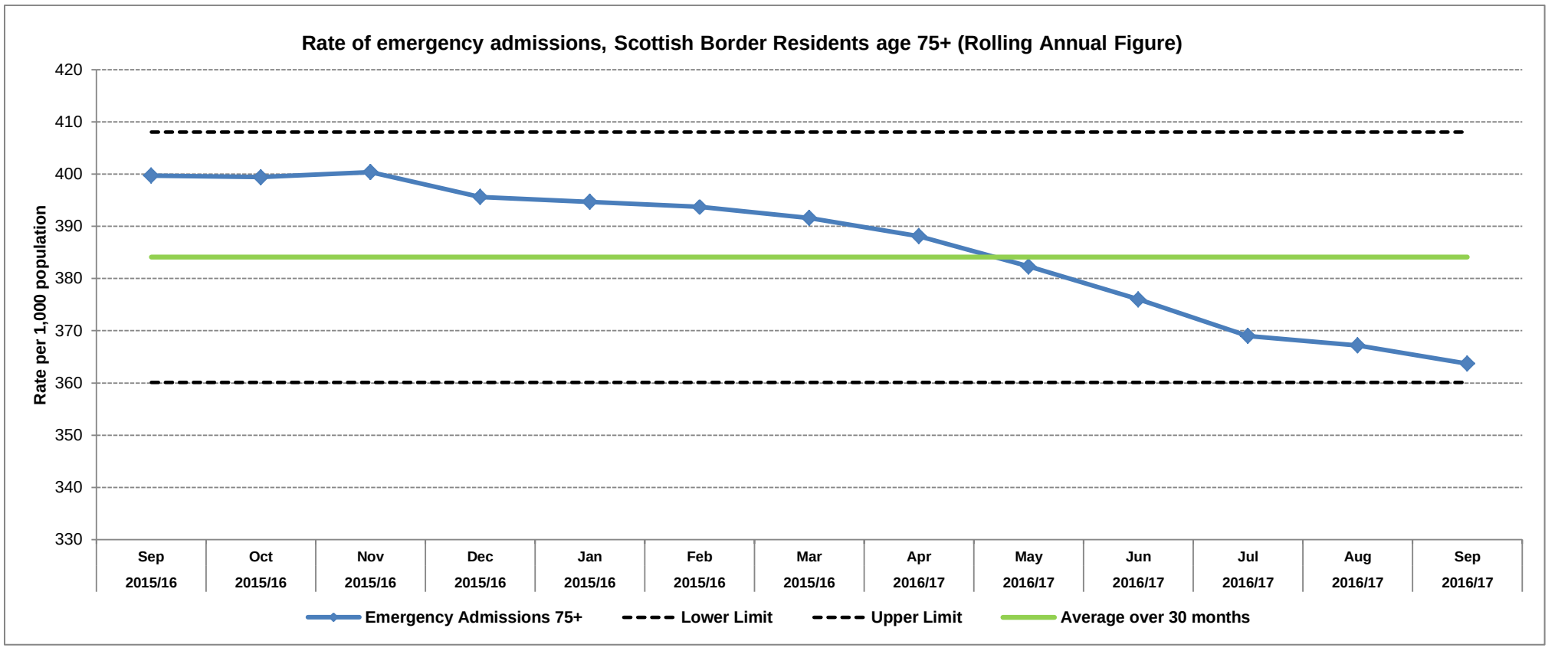
Themes and measures as applicable to this (February 2017) report

Theme	Measures
1. Unplanned admissions	• Number of emergency admissions, persons aged 75+ • Rate of emergency admissions per 1,000 population aged 75+ • *[In addition, local quarterly reporting of emergency admissions due to falls is to be developed using a method consistent with official annual statistics on falls.]*
2. Occupied bed days for unscheduled care	• Number of Occupied bed days for emergency admissions, persons aged 75+ • Rate of occupied bed days for emergency admissions, per 1,000 population aged 75+
3. A&E Performance	• Number of A&E attendances seen within 4 hours • % of A&E attendances seen within 4 hours
4. Delayed Discharges	• Number of delayed discharge over 2 weeks • Number of delayed discharge over 72 hours
5. End of Life Care	• Proportion of last 6 months of life spent at home or in a community setting. *[This is an annual rather than quarterly measure].*
6. Balance of spend	• Percentage of total Health and Social Care Spend on Community-based services. *[This is an annual rather than quarterly measure]* • Percentage of total Health and Social Care Spend in adults (aged 18+) that was on hospital stays where the patient was admitted in an emergency. *[This is an annual rather than quarterly measure]*
7. Social Care	• Number of people feeling safe. • % of adults aged 65+ receiving care at home to sustain an independent quality of life as part of the community compared to those in care. • Carer Assessments Offered and Completed
As we develop integrated performance reporting further, regularly reported measures will be supplemented by information on a more "*as and when*" basis, for example when Integrated Care Fund (ICF) project evaluations become available, or other important data sets become available (that cannot be reported on a quarterly basis).	

1. Unplanned Admissions

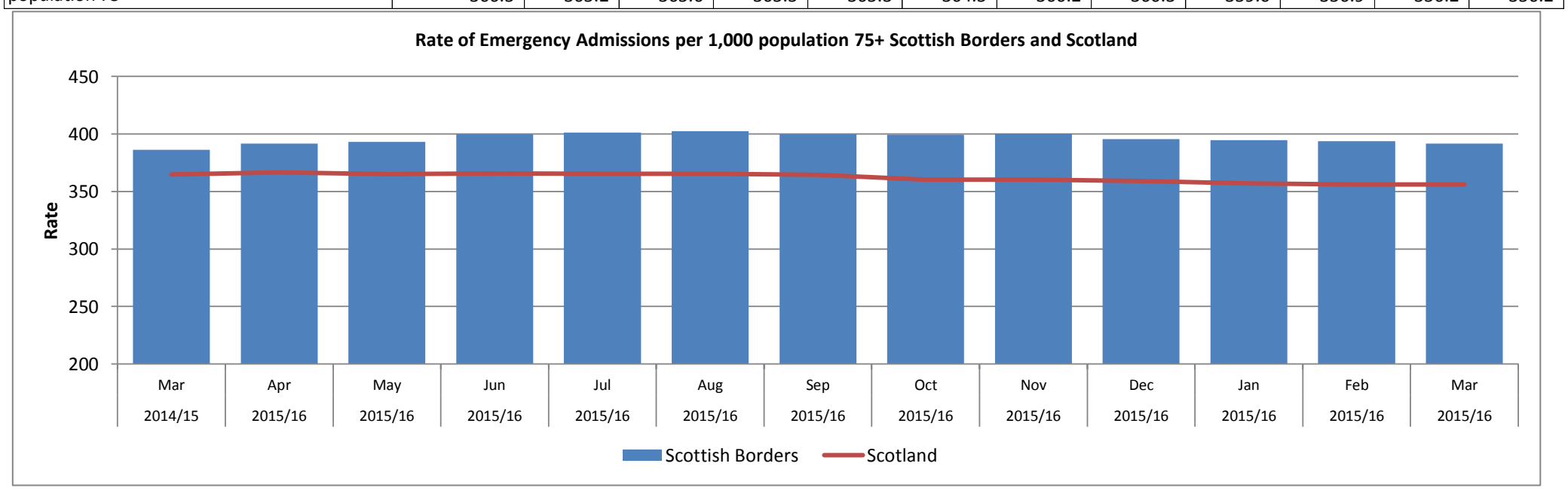
Emergency Admissions, Scottish Borders residents age 75+

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Emergency Admissions, 75+	4,524	4,457	4,383	4,302	4,280	4,240						
Rate of Emergency Admissions per 1,000 population 75+	388.1	382.3	376.0	369.0	367.2	363.7						



Emergency Admissions, Scotland residents age 75+

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Number of Emergency Admissions, 75+	158,770	158,228	158,380	158,330	158,263	157,923	157,684	157,707	157,150	156,222	155,922	155,916
Rate of Emergency Admissions per 1,000 population 75+	366.5	365.2	365.6	365.5	365.3	364.5	360.2	360.3	359.0	356.9	356.2	356.2



How are we performing?

The rate of emergency admissions for the over 75 age group in Scottish Borders is decreasing. The rate was increasing gradually to August 2015 but from that point has seen a gradual decrease, in line with the Scottish trend. The Borders rate at March 2016 (latest published data point for Scotland) is higher than the national average. There is a lag time in data points as rates are produced from a nationally available source from ISD, based on data submitted by the Health Board that has been validated.

What are we doing to improve or maintain performance?

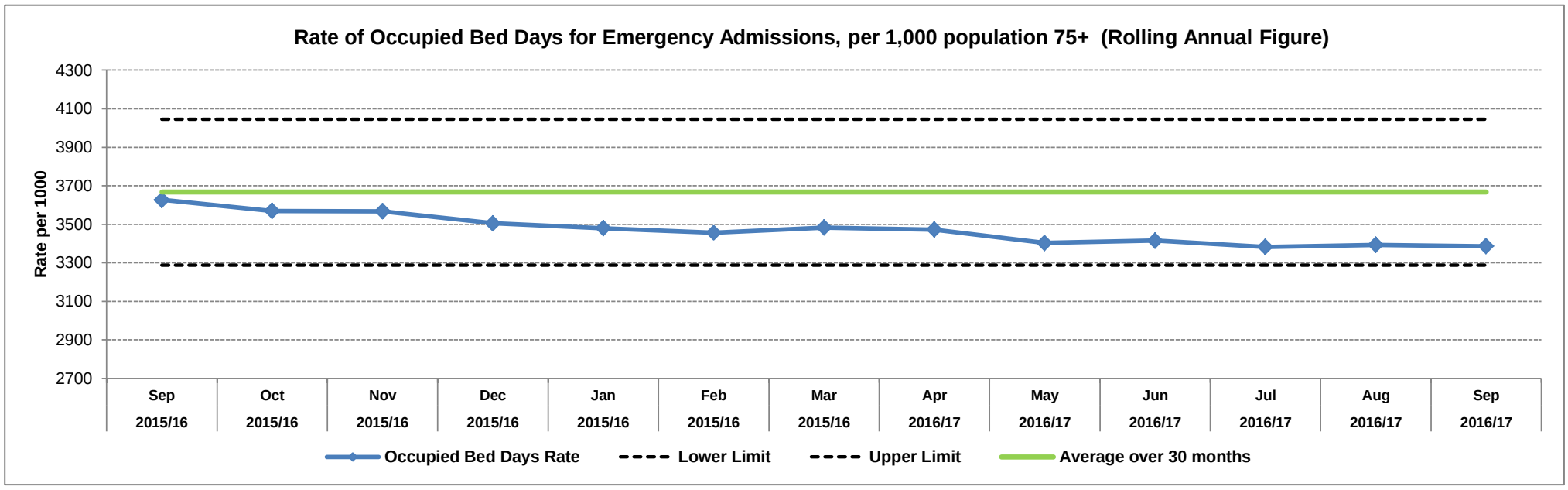
We are undertaking work to reduce emergency admissions for common conditions, focusing on developing pathways for patients with common respiratory and cardiac conditions to be reviewed and managed within their own homes and on reducing readmission rates.

Use of the Acute Assessment Unit has improved our emergency admission rate allowing patients to receive tests and monitoring then discharge rather than being admitted into the hospital (Medical Assessment Unit) for this.

2. Occupied Bed Days

Occupied Bed Days for emergency admissions, Scottish Borders Residents age 75+

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Occupied Bed Days for emergency Admissions, 75+	40,483	39,669	39,809	39,431	39,554	39,475						
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	3473	3403	3415	3383	3393	3386						



How are we performing?

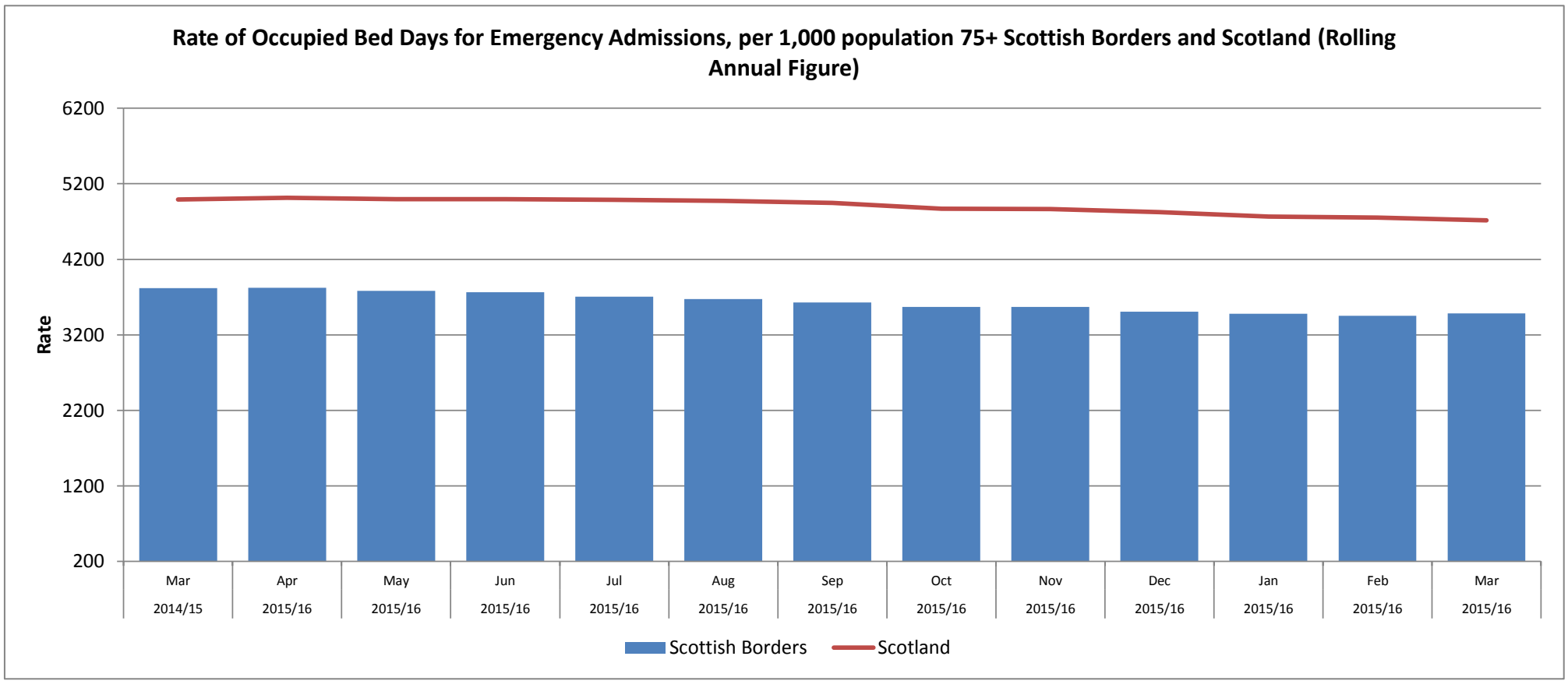
Emergency Occupied bed days for over 75s have been on the whole reducing since September 2014, following redesign work to reduce waits for patients requiring rehabilitation and elderly care beds.

What are we doing to improve or maintain performance?

The medical inpatient floor was remodelled in October to create one acute medical ward and two acute elderly care wards. This change is intended to stream frail elderly patients who are acutely unwell directly to an elderly care ward and avoid delays in medical wards. The redesign is intended to reduce overall length of stay by 0.6 days within the medical unit. There is also an increase in partnership working across health and social care to reduce delays for people requiring support on discharge home. The outcomes of this remodelling will be reviewed by end of March 2017. There continue to be delays in transitions of care and we are working closely with partners to address these.

Occupied Bed Days for emergency admissions, Scottish Borders and Scotland Residents age 75+

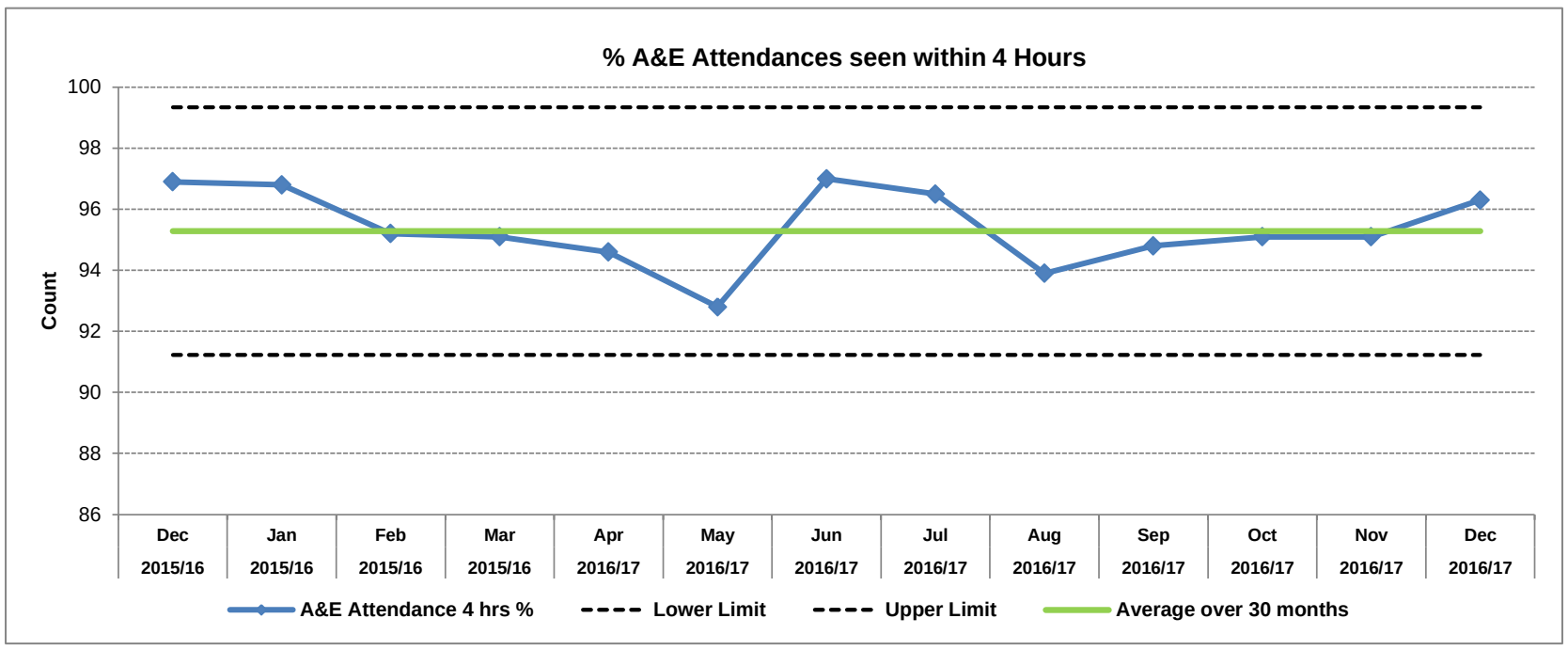
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	5,013	4,998	4,996	4,989	4,976	4,948	4871.62	4866.16	4824	4764.4	4750.2	4713.73
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	3,824	3,782	3,765	3,707	3,675	3,627	3,570	3,567	3,505	3,480	3,454	3,483



3. Accident and Emergency Performance

Accident and Emergency attendances seen within 4 hours

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of A&E Attendances seen within 4 hours	2409	2757	2460	2423	2572	2520	2487	2267	2339			
% A&E Attendances seen within 4 hour	94.60%	92.80%	97.00%	96.50%	93.90%	94.80%	95.10%	95.10%	96.30%			



How are we performing?

Patients attending A&E and the Acute Assessment Unit (AAU) are routinely discharged within 4 hours. NHS Borders is working towards consistently achieving the 98% local stretched standard.

Delivery of the EAS standard (95%) has been challenging over the summer. The standard was achieved in June, July and October, but missed in April, May, August and September. Performance recovered to 95% in October, November and December.

Winter planning is in place for the Festive Period and Winter. Performance will be closely monitored from 1st January 2017 to address any issues that have the potential to compromise performance as they arise.

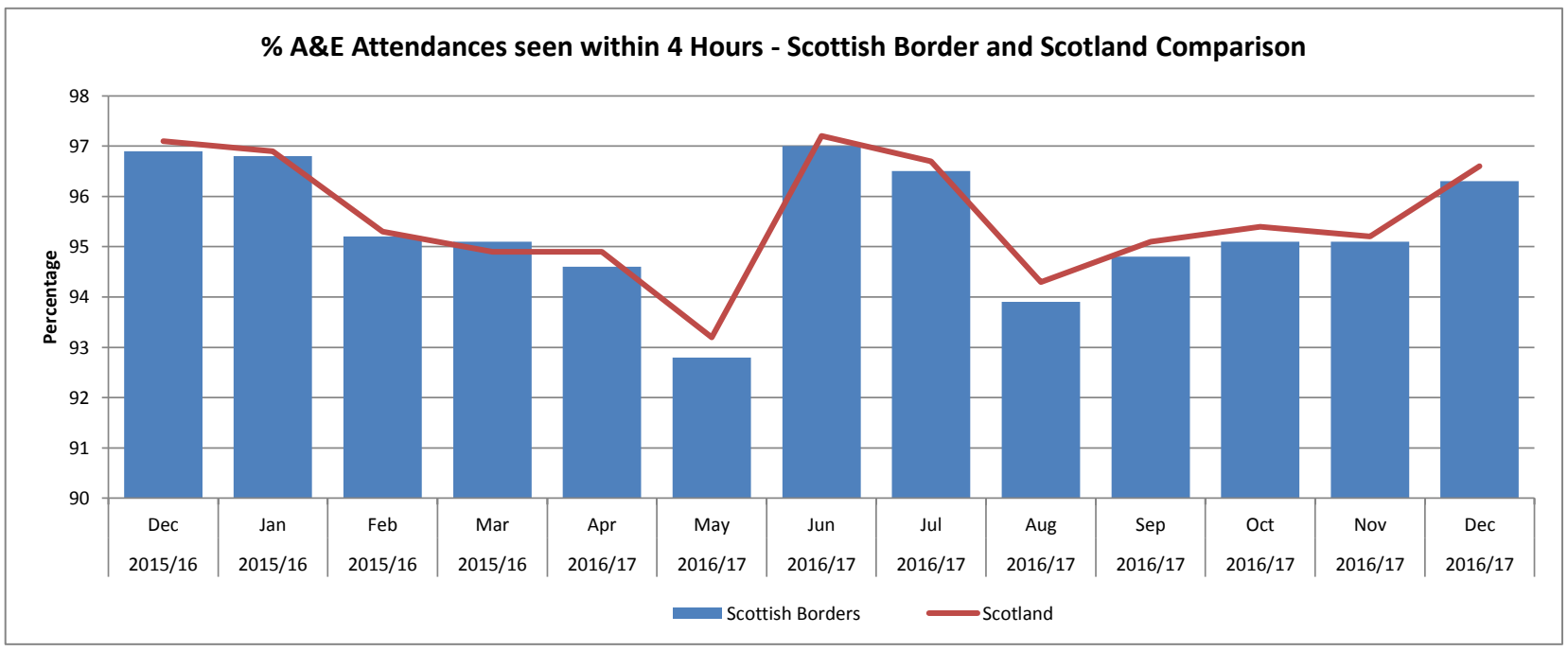
What are we doing to improve or maintain performance?

Delays in transitions of care were rising towards the end of December 2016 and we will be working closely with partners to address these delays.

We are also ensuring there is careful planning in place for patients with Lengths of Stay of over 28 days.

% A&E Attendances seen within 4 Hours - Scottish Border and Scotland Comparison

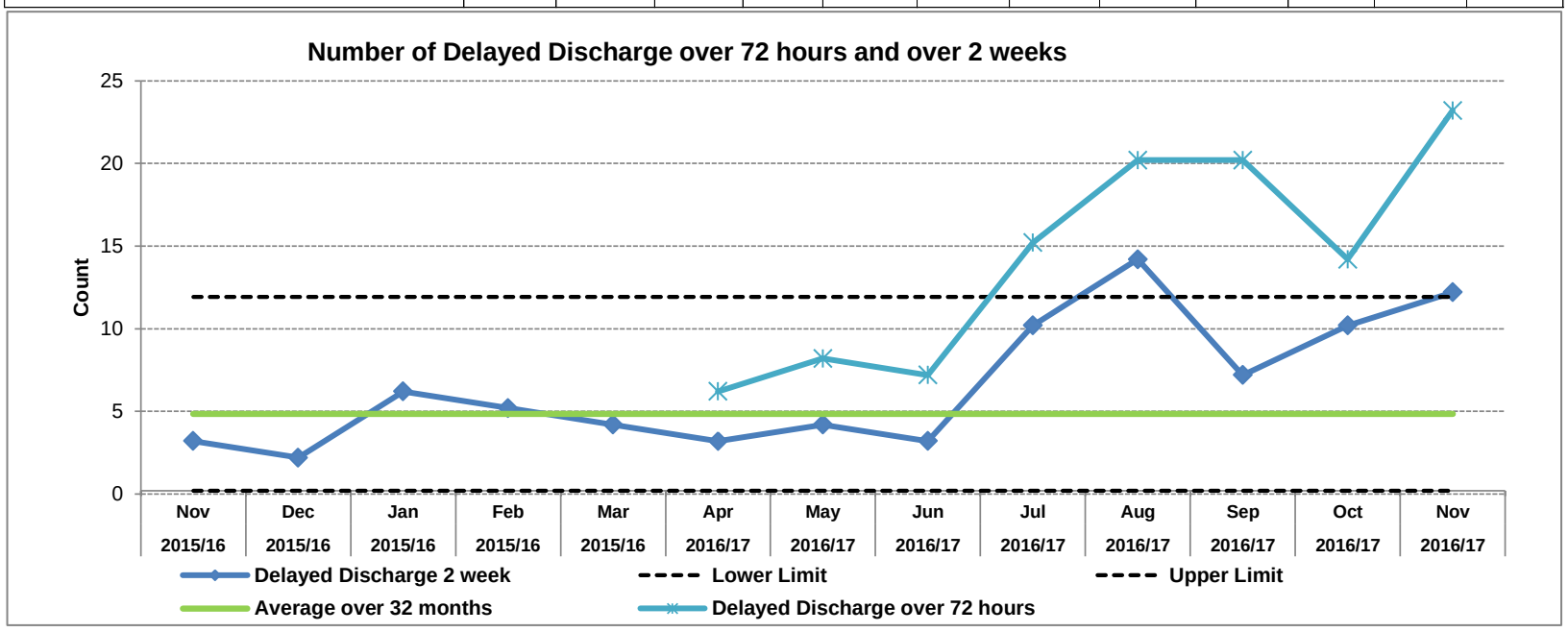
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
% A&E Attendances seen within 4 hour Scottish Borders	94.6%	92.8%	97.0%	96.5%	93.9%	94.8%	95.1%	95.1%	96.3%			
% A&E Attendances seen within 4 hour Scotland	94.9%	93.2%	97.2%	96.7%	94.3%	95.1%	95.5%	95.2%	96.6%			



4. Delayed Discharge

Delayed Discharge

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Delayed Discharge over 2 weeks	3	4	3	10	14	7	10	12				
Number of Delayed Discharge over72 hours	6	8	7	15	20	20	14	23				



Please note the Delayed Discharge over 72 hours measurement has only recently been implement from April 2016.
It has been overlayed on this graph as an indicator of the new measurement (light blue line) however as data is limited to less than one year we cannot provide a statistical run chart for this.
The Delayed Discharge over 2 weeks measurement has several years of data and has been plotted on a statistical run chart (with upper, lower limits and an average) to provide additional statistical information to complement the more recent 72 hour

How are we performing?

A new national target of zero delays over 72 hours came into force on 1st April 2016. New definitions for recording delayed discharges were introduced on the 1st July 2016.
NHS Borders is facing significant challenges with delayed discharges, which continues to impact on patient flow within the Borders General Hospital and our four Community Hospitals.
The key reasons for delay experienced by patients are currently being influenced by challenges relating to the following issues:
- Care at home – we continue to be challenged in sourcing care at home across the Borders.
- Choices of care home placements and availability thereof and total capacity in Care Homes in Borders, particularly for more complex cases.
- A number of complex cases with a significant length of stay.

Ongoing focus is being placed upon supporting the discharge of delayed patients awaiting their next stage of care across the system. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 Hour ED Standard, quality of care and ensuring people are in the right care setting, and the avoidance of disruption to planned surgical admissions.
There are weekly delayed discharge meetings with senior managers and senior colleagues from Scottish Borders Council and SB Cares, Chief Officer for Health and Social Care, and General Managers for Primary & Community Services and Unscheduled Care. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring and to implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

What are we doing to improve or maintain performance?

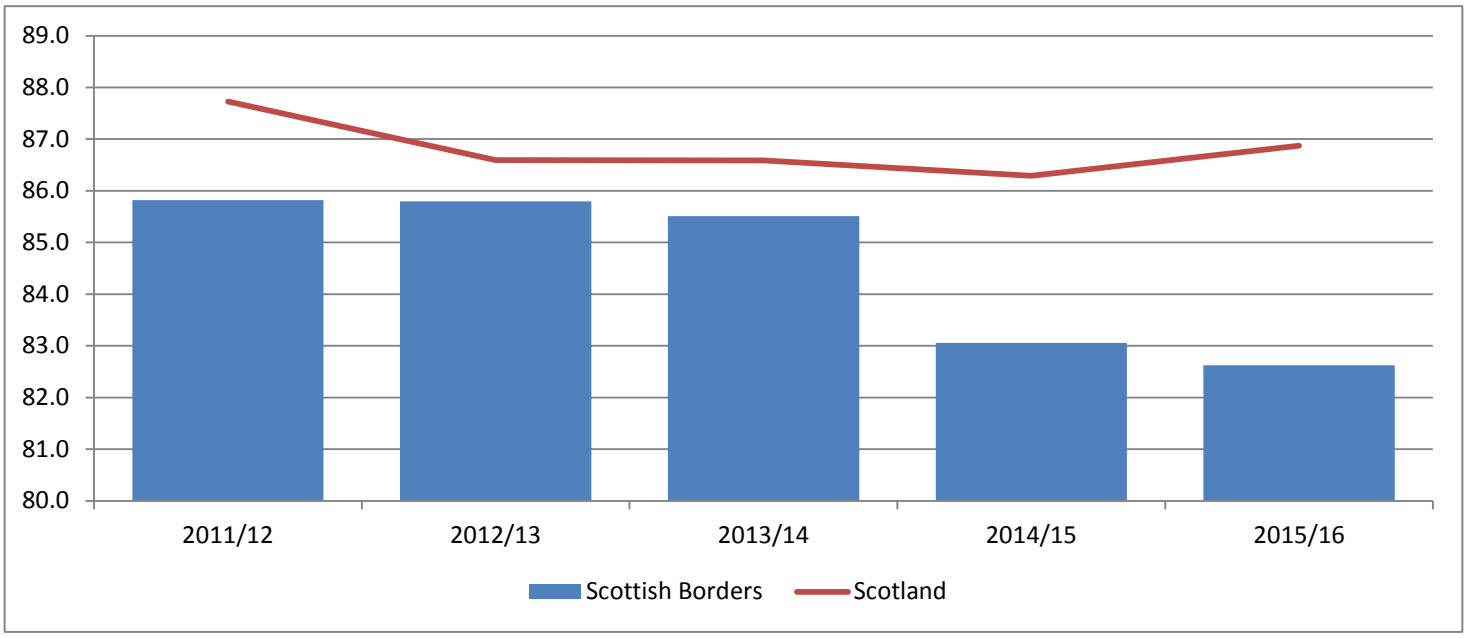
The Action Plan focuses on actions to address the main reasons for the delays currently experienced by patients across the hospital system. The key actions include:
- Senior Management attendance and support to Community Hospital Multi Disciplinary Meetings where anticipated delays are identified.
- Challenge to current assumptions for standard packages of care for people with high level needs.
- Development of a co-ordination function to identify and direct care home resources. (brokerage visit)
- Additional Telecare Support - development of a plan to introduce more technology to support aspects of community based care.
- Introduction of a transitional care facility to support step down care - Waverly Care Home has been redesigned to introduce 16 further step down beds supported by ICF. Work is underway to spread models across other care homes.
-The review of current practice for discharging patients who lack capacity which includes undertaking an appreciative enquiry approach to understand local challenges and create an improvement plan.

Numbers of delayed discharges at a census date each month are difficult to compare with national information. To compare our Delayed Discharge performance with other areas we would suggest including additional measures around this theme in future performance reports for the IJB.

5. End of Life Care

Proportion of last 6 months of life spent at home or in a community setting.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders %	85.8%	85.8%	85.5%	83.1%	82.6%	
Scotland %	87.7%	86.6%	86.6%	86.3%	86.9%	



How are we performing?

The percentage of last 6 months of life spent at home or in a community setting has fluctuated in the Borders from year to year but in each case remains slightly below the Scottish average.

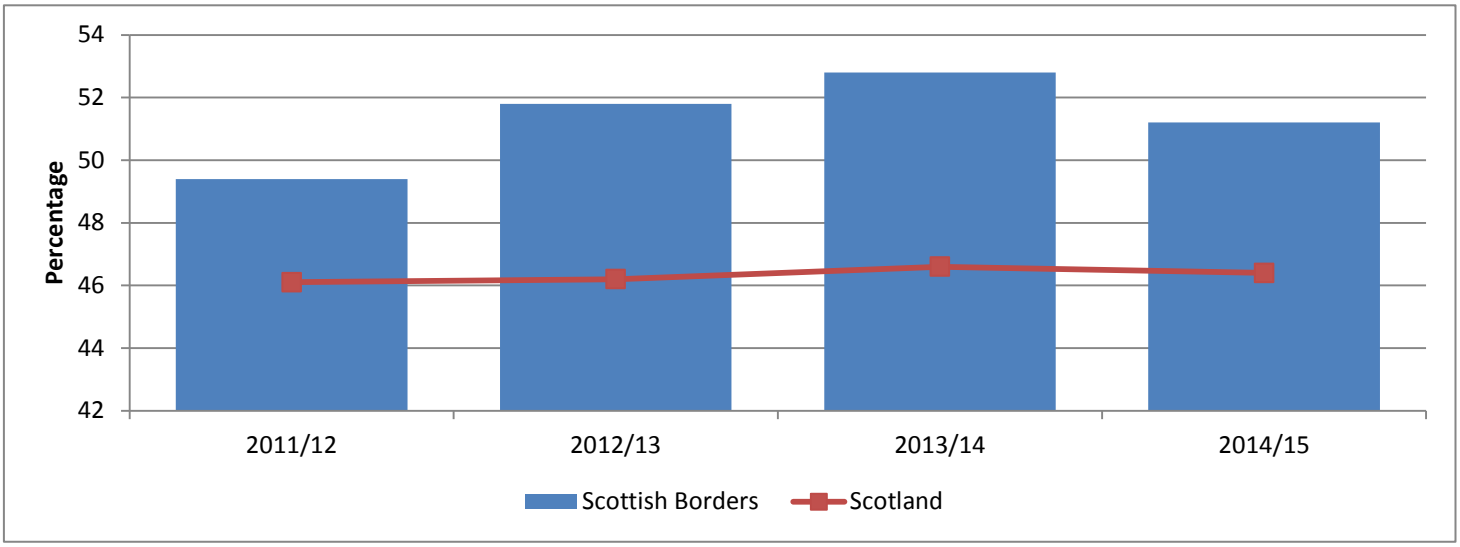
What are we doing to improve or maintain performance?

There is significant work underway to support people who choose to remain at home or in a community setting in the last 6 months of life. The opening of the Margaret Kerr Unit has provided another option and the impact of this will be monitored. The service is looking at opportunities to broaden the range of options for support in community settings.

6. Balance of Spend

Total Health and Social Care Expenditure

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders Total Spend (£ millions)	248.7	247.7	257.8	267.2		
Scottish Borders % spent on Community-Based care	49.40%	51.80%	52.80%	51.20%		
Scottish Total Spend (£ millions)	11,675	11,782	12,109	12,620		
Scottish % spent on Community-Based care	46.10%	46.20%	46.60%	46.40%		

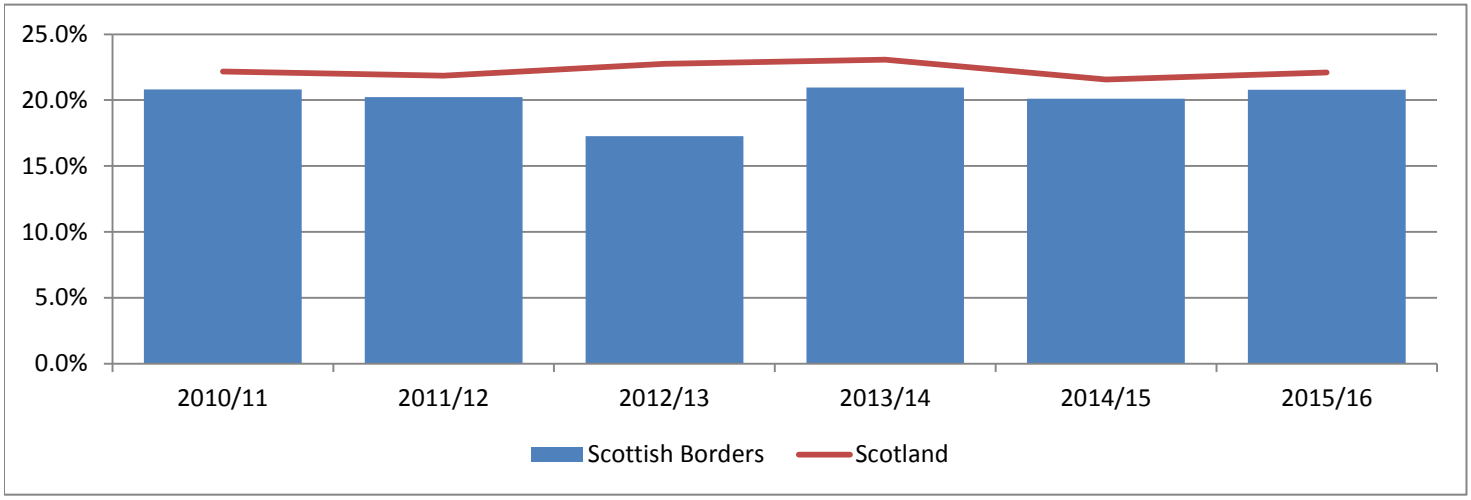


How are we performing?

In the four years 2011/12 to 2014/15 the percentage of total health and care spend in the Borders that was accounted for by community-based services has been consistently higher than the Scottish average. Whilst this is a good baseline position for the Health and Social Care Partnership relative to Scotland, it will be important to ensure that the community service share is maintained/improved. The share for 2014/15 dropped relative to that for 2013/14. We are expecting data for 2015/16 to be available to us in March 2017.

Percentage of health and care resource spent on hospital stays where the patient was admitted in an

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Scottish Borders	20.8%	20.2%	17.3%	21.0%	20.1%	20.8%
Scotland	22.2%	21.9%	22.7%	23.1%	21.6%	22.1%



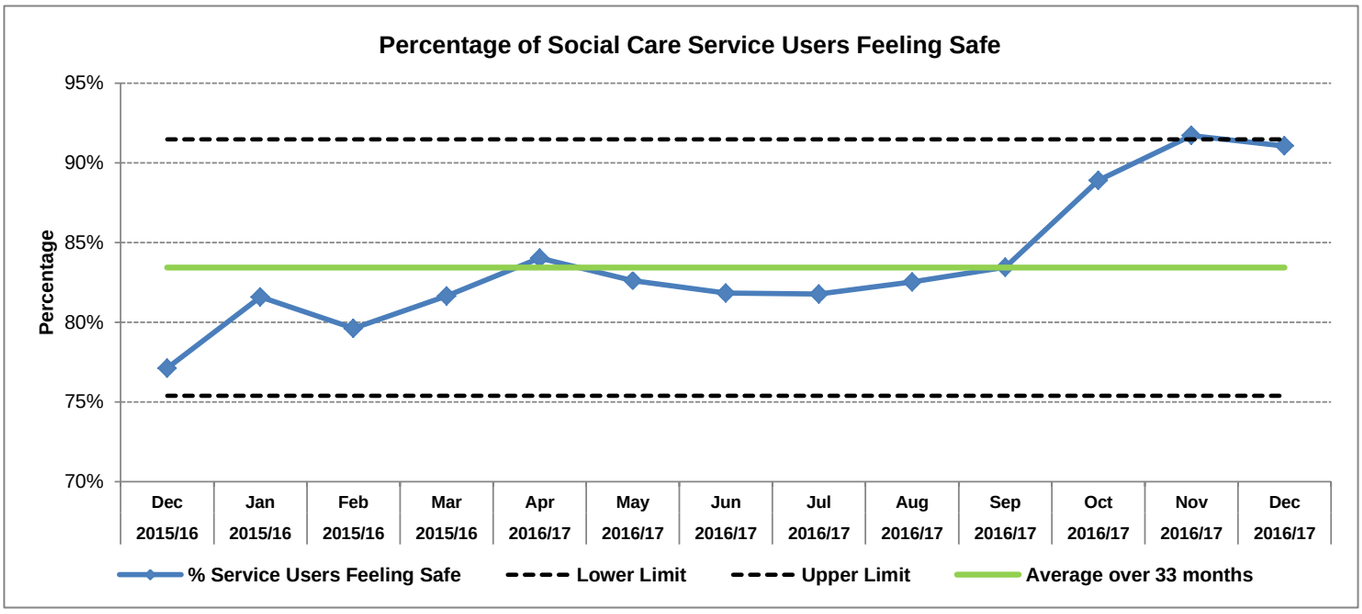
6. Balance of Spend

How are we performing?
Over all the years for which this indicator is available, Scottish Borders has consistently performed slightly better than Scotland. However, there is no obvious downward (improving) trend, and as with other Health and Social Care Partnerships, Scottish Borders is expected to work to reduce the relative proportion of spend attributed to unscheduled stays in hospital.
What are we doing to improve or maintain performance?
The Strategic Plan sets out the Framework to support a shift in resources from the acute sector to the community.

7. Social Care

Social Care Survey - Do you feel safe?

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of People Feeling Safe	205	209	171	139	170	136	152	177	173			
% of People Feeling Safe	84%	83%	82%	82%	83%	83%	89%	92%	91%			



How are we performing?

Fluctuating within the expected limits of this indicator shows over 80% of those asked if they feel safe following a Social Care Adult Assessment answered yes. This information is in recovery from some recent changes to the survey which allowed the question to be left blank. Recent changes have ensured that this option no longer occurs and this question can only be answered yes or no.

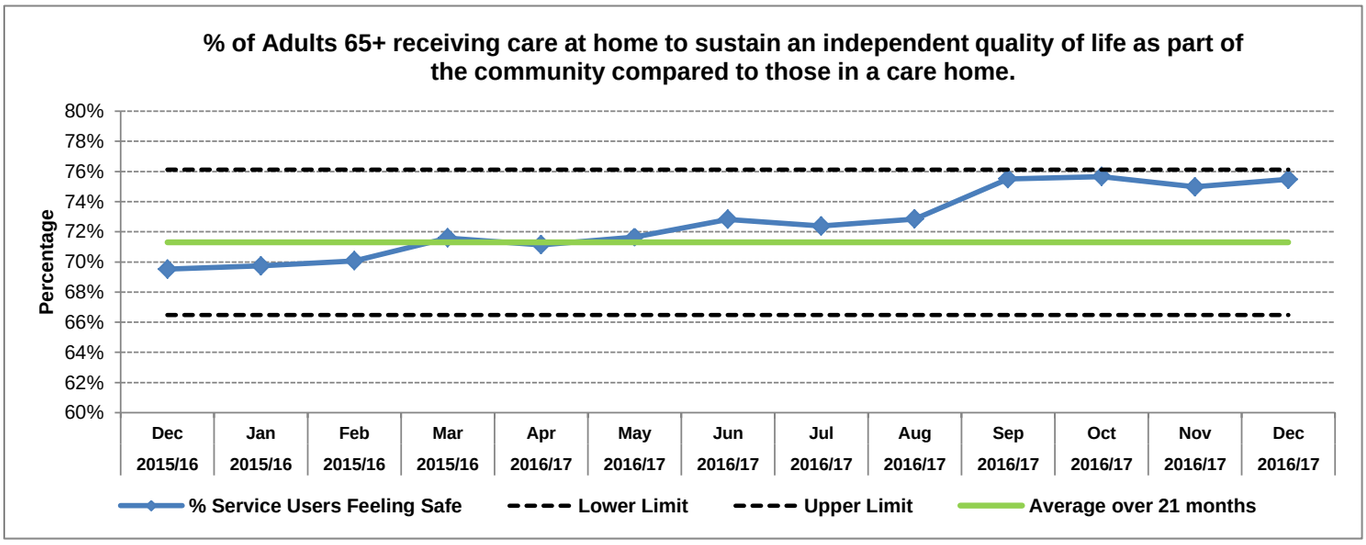
What are we doing to improve or maintain performance?

Amendments to the survey have ensured that all those who have an assessment will be asked the question and can only respond yes or no. This will ensure consistency in Reponses and reliable data recording to give an overall outcome response to the work of Social Care.

The SDS approach within Social Care is now well established with emphasis on client information and choice. This ensures a more informed and appropriate outcome for the client which ensures their needs are met.

People within the Scottish Borders with intensive care needs receiving support in a community setting rather than a care home.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Adults 65+ within co	1563	1619	1716	1710	1766	2032	2019	1988	2018			
% of Adults 65+ receiving care at home compared to those in	71%	72%	73%	72%	73%	76%	76%	75%	75%			

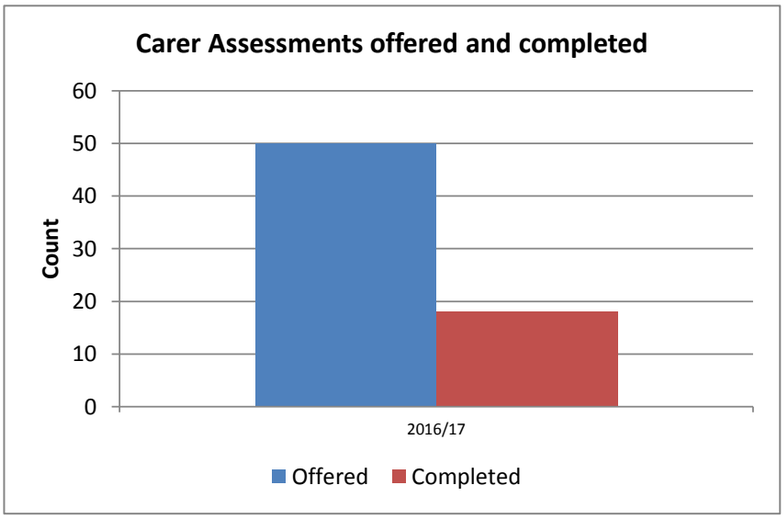


7. Social Care

How are we performing?
Consistently on or above average for the past 7 months. This indicator shows we are actively supporting a large percentage of adults over 65 within a homely, community setting rather than a residential environment.
What are we doing to improve or maintain performance?
Locality based teams monitoring and assessing the needs of our clients ensure a more community based outcome for clients. Further emphasis on locality management of client with further maintain and improve this measure.

Carers offered and completed assessments.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Assessments offered during Adu										**50**		
Carers Centre					New measure. Recording started in 2017					18		



How are we performing?
This information shows that during the month of January we offered 50 assessment to individuals who were identified as carers during a Social Work Adult Assessment. Within the same month the Carers Centre completed 18 assessment. Although these measurement are taken within the same month they may not relate to the same individuals, eg a person offered an assessment in January may not actually undergo an assessment until some time later. We expect over a year the total offered will be similar to the total completed.
What are we doing to improve or maintain performance?
Although the offering of an assessment to a carer identified during an adult assessment is not a new action, we have no regular recording or monitoring of the take up of the offer. With regular monitoring and review of this measure we can identify improvement we can make in the service to ensure uptake of the carers assessment is maintain or improved.

The measurements above are difficult to compare with national information as there are no identical measurements. To allow us to compare this performance with other areas we would suggest including additional measures around this theme in future performance reports for the IJB.

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Unplanned Admissions

What is this information and why is important to measure it?

Excellent emergency services are necessary when people are at a point of crisis or suffer serious injury. But many people who come to hospitals in emergencies could potentially have been offered better support or services earlier on, which would have
prevented the need for them to go to hospital, or may have involved a planned visit to hospital instead.

Rates of emergency admissions in people aged 75 and over are of particular concern and are higher in Scottish Borders than across Scotland as a whole. Existing work within the Borders to reduce emergency admission rates needs to continue and be built on.

A reduction in this indicator should demonstrate improved partnership working. It should represent a shift from a reliance on hospital care towards proactive and coordinated care and support in the community. It should demonstrate the effectiveness of anticipatory care, identifying people who are at risk of emergency hospital admission, supporting people to be more confident in managing their long term conditions and providing coordinated care and support at home where safe and
appropriate. Safe and suitable housing for people will also be important.

Data Source(s)
1. Hospital admissions are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.
2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

Occupied Bed Days for unscheduled care

What is this information and why is important to measure it?

It is possible for the number of emergency admissions to increase and whilst emergency bed days reduce, and vice versa, so this measure is included to ensure a balanced view. Once a hospital admission has been necessary in an emergency, it is important for people to get back home as soon as they are fit to be discharged to avoid the risk of them losing their confidence and ability to live independently.

Health and Social Care Partnerships have a central role in this by providing community-based treatment and support options, "step down" care and home care packages to enable people to leave hospital quickly once they are well enough. Additionally, care homes should where appropriate be able to support people with a wider range of physical and mental frailty and needs.

Hospitals also have a role to play, by streamlining their processes and sharing best practice to ensure more people can leave hospital quickly once they are well enough. This will include improving rehabilitation and also reducing the possibility of infections, harm and injury all of which can result in longer stays.

Data Source(s)

1. Hospital bed-days are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.
2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

Accident and Emergency Performance

What is this information and why is important to measure it?

The national standard for Accident & Emergency waiting times is that 95% of people arriving at an A&E Department in Scotland (including Minor Injury Units) should be seen and then admitted, transferred or discharged within 4 hours. NHS Boards are to work towards achieving 98% performance.

Although the standard is measured in the A&E Department, NHS Boards and Health and Social Care Partnerships are required to ensure that best practice is installed throughout the whole system, including health and social care, supporting joined up work to address wider issues of patient flow through each hospital that will safeguard timely access to services across the patient's journey and ensure the whole system works together effectively.

Data Source(s)
A&E2 Dataset, ISD (Note the data reported is for the Emergency Department at the BGH only and does not include the Minor Injury Units. The national data is also for the Emergency deparments only.)

Delayed Discharges

What is this information and why is important to measure it?

A delayed discharge (often referred to in the media as "Bed Blocking") occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible. For example, a person's house may first need to be altered to help them get around, or there may not be a place available in a local care home.

A long delay increases the risk of the patient falling ill again, or losing vital life skills, independence or mobility. It could ultimately result in the patient having to be admitted to a care home due to the deterioration in their health and mobility.

Data Source(s)
Monthly Delayed Discharge Census, ISD Scotland. This shows a snapshot of the number of patients waiting to be discharged, on a single day in each month.

End of Life Care

What is this information and why is important to measure it?

This indicator measures the percentage of time spent by people in their last 6 months of life at home or in a community setting. It is derived by linking recorded deaths data with hospital bed day data to calculate the percentage of time spent outside hospitals in the last 6 months of people's lives. Accidental deaths are excluded.

It is now possible to predict the progress of many diseases, enabling a planned approach to palliative and end of life care in ways which reflect best practice and which, as far as is practicable, in accordance with the needs and wishes of patients, carers and their families. Health and Social Care Partnerships are expected to be able to influence this by commissioning high quality end of life services, and working with communities, families and staff to enable discussion about planning for end of life. As more people have anticipatory care plans and as electronic palliative care summaries are rolled out throughout the country, then we should see a gradual increase in this measure in the medium to long term.

The indicator should ideally represent the wishes and choices for patients and their carers and also demonstrate the effectiveness of having a planned approach to end of life care. For an individual, the preferred place of care can change as their condition and/or family circumstances change over time, making this very difficult to measure and track. Therefore this indicator has been chosen by the Scottish Government as an alternative. The last six months of life was chosen as this is the period when most hospital admissions occur, and the period when clinicians would tend to plan end life care if the patient was not expected to live longer than 6 months.

Data Source(s)
This is the "Core Suite Integration Indicator" number 15, taken from Core Suite Indicator Workbooks for Health and Social Care Partnerships, ISD Scotland. Data taken from National Records for Scotland (deaths) and SMR records for acute/general hospitals, geriatric long stay beds, and acute psychiatric hospitals.

Balance of Spend

Part 1 - % spent on community based care.

What is this information and why is important to measure it?

Health and Social Care Integration should allow Health and Social Care Partnerships to commission changes in the health and social care pathway that will optimise (where appropriate) community based care. For example, through intermediate care, anticipatory and preventative care. This ensures that emergency/non elective resources (staff, beds, equipment) are used for those who need acute medical and trauma care.

Under integration it is expected that an increasing proportion of total health and social care spend should be on community-based services.

Data Source(s)

"Source" reporting system for Health and Social Care Partnerships, ISD Scotland. Please note:-

1. All NHS services are included in total spend, including health services that are not covered by integration (such as planned outpatient and inpatient care).
2. Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation based social care services.
3. Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.
4. Figures shown here for 2013/14 differ from those shown in the Scottish Borders HSCP Strategic Plan as they have since been updated to incorporate Community Dental Services and Community Ophthalmic Services.

Part 2 - % of total spend on hospital stays where the patient (age 18+) was admitted as an emergency.

What is this information and why is important to measure it?

Health and Social Care Integration should allow Health and Social Care Partnerships to commission changes in the health and social care pathway that will optimise (where appropriate) community based care. For example, through intermediate care, anticipatory and preventative care. This ensures that emergency/non elective resources (staff, beds, equipment) are used for those who need acute medical and trauma care.

Under integration it is expected that a decreasing proportion of total health and social care spend should be on unscheduled hospital care.

Data Source(s)

This is the "Core Suite Integration Indicator" number 20, taken from Core Suite Indicator Workbooks for Health and Social Care Partnerships, ISD Scotland.

Social Care

Part 1 - People with in SB with intensive care needs receivieng support in a community setting rather than a care home.

What is this information and why is important to measure it?

This measurement considers how we are managing to support elderly clients to remain within the community rather than move into residential care. It reviews our ability to support clients to sustain an independent quality primarily through home care, however it considers other areas:

- Homecare service (irrespective of hours)
- Direct payment or SDS payment
- Living within an extra care housing facility (Dovecot)
- The number of clients age 65 or older supported within a community setting is then compared to those age 65 or older in a residential setting (Care Home).

Home care is one of the most important services available to local authorities to support people with community care needs to remain at home. Increasing the flexibility of the service is a key policy objective for both central and local government, to ensure that people receive the type of assistance which they need, when they need it.

The measurement only captures 'home care services' which are provided on an hourly basis. Other services which support people at home, such as laundry services, home shopping, community alarms and meals-on-wheels, are not included**.**

The measurement will be affected by the pattern of need and demand within the area, influenced by the age-structure of the elderly population, the distribution of poverty and ill health, household composition and other factors.

It will become increasingly important that we maximise our ability to support the elderly within the community as budget and financial considerations impact our service.

Data Source(s)

1. Report from SBC Framework System provided monthly for internal monitoring via the current reporting structure.

Part 2 - Social Care Survey - Do you feel safe?

What is this information and why is important to measure it?

All adults who require support receive a care assessment by an occupational therapist, social worker or a nurse. A care assessment looks at the emotional and social side of an individuals life as well as any physical difficulties they may be experiencing.

At the end of a care assessment the individuals views are recorded to give an indication of how they feel the support discussed during the assessment will make them feel.

Ensuring our assessments and social care provision allow an individual to remain at home and feel safe in thier environment is a fundemental requirement for care within a community setting. If this care is correctly administered it will allow individuals to remain within the community and in their own homes for longer. By increasing our ability to successfully support individuals in the community, we reduce the impact on other services over time.

Data Source(s)
1. Do you feel safe?, is a Social Care Survey measurement taken during a social care adult assessment . It is recorded on the SBC Framework System and collated on a monthly basis. The questions applies to any adult who has received (and completed) an adult social care assessment

Part 3 - Carers Assessments offered and completed.

What is this information and why is important to measure it?

It is estimated that around 788,000 people are caring for a relative, friend or neighbour in Scotland. This includes around 44,000 people under the age of 18. A large percentage of these are currently not recognised as carers and are unpaid. Thier contribution to caring within the community is substantional and could not be replaced.

The Carers (Scotland) Act will commence on April 1, 2018. There is a package of provisions within the Act designed to support carers' health and wellbeing. Local Authorities have a requirement to identify and support carers needs and personal outcomes.

Any carer who appears to have a need for support should be offered an assessment. The assessment is provided regardless of the amount or type of care provided, financial means or level of need for support.

Improving our methods of identifying and offering support to carers will ensure thier contribution is recognised and complements the social care system currently in place.

Data Source(s)
1. Offered assessment data is extracted from the SBC Framework System and is a question asked during a Adult Assessment.
2. The Carer Centre provides a monthly count of all completed assessments for the Scottish Borders.

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UPDATED ARRANGEMENTS FOR MANAGING THE INTEGRATED CARE FUND (ICF)

Aim

1.1 The aim of this report is to provide the Integration Joint Board (IJB) with an update on the partnership's Integrated Care Fund (ICF) Programme and proposed updated arrangements for the management of the fund.

Background

2.1 The ICF is a 3 year government funding initiative designed to support change and transformation in Health and Social Care Services in line with integration legislation and the local strategic plan. A key focus is to improve outcomes for people using services and their carers.

To date the ICF has funded individual projects and has had a detailed approval process. All projects, therefore, have been subject to ratification and approval by numerous groups resulting in some substantial delays in progressing projects and a large amount of time being required from staff to complete and process paperwork. In addition it has been difficult to determine what the impact will be across the system. This paper, therefore, sets out a more streamlined process for the remaining budget.

2.2 A list of current approved projects is set out below:

1. Community Capacity Building
2. Independent Sector representation
3. Transport Hub
4. Mental Health Integration
5. My Home Life
6. Delivery of the Autism Strategy
7. BAES Relocation
8. Delivery of the ARBD pathway
9. Health Improvement (phase 1) and extension
10. Stress & Distress Training
11. Transitions
12. Delivery of the Localities Plan
13. Community Led Support
14. The Matching Unit
15. Programme Delivery Team
16. Rapid Assessment & Discharge Team
17. Transitional Care Facility
18. Pharmacy Input

These projects are at various stages of implementation and will continue to be reviewed to ensure they are progressing in line with strategic priorities and evaluated to measure the impact each project has on the care pathway. The projects produce monthly reports detailing their progress against their set milestones, outcome targets and budget. They are also required to complete an annual evaluation showing progress against outputs, outcomes and benefits as well as a full final project evaluation with a key focus being on sustainability. A progress summary rating of projects as red, green and amber in relation to outcomes, milestones and financial progress for overall project status can be seen in **Appendix One**. Future reports on evaluations will be reported to the IJB via quarterly performance reports.

2.3 Work has been undertaken to streamline the governance process for the remaining ICF budget which will be used to support a number of Partnership priorities including improving care pathways and delivering efficiencies. The proposed, streamlined governance process can be seen in **Appendix Two**.

2.4 It is proposed that small scale tests of change/and/or service redesign initiatives will be identified by the Executive Management Team (EMT) supported by a brief proposal which details how these initiatives will address gaps or deliver improvements required. A draft pro-forma has been developed for presentation and consideration of future proposals and can be seen in **Appendix Three**. It is proposed that responsibility for defining, commissioning and delivering tests of change and service redesign will rest with EMT. This will allow rapid change and maximise flexible, agile working. Quarterly progress and performance reports will be provided to the IJB in line with key priority areas and targets recently identified by the Ministerial Strategy Group and as summarised in the Health & Social Care Delivery Plan. Key to these will be streamlining care pathways and delivering strategic service change as well as achieving efficiencies.

2.5 It is important that all key stakeholders are kept updated and involved. A review of the role and membership of the SPG is currently underway to ensure maximum effectiveness of the group in its advisory capacity to the IJB.

2.6 In addition to individual ICF project evaluations the overall impact of all projects on the care pathway and the delivery of strategic objectives will be presented in an overarching impact report at the end of the lifespan of the fund. Qualitative feedback from service users will form an integral part of evaluation and the overarching impact report and will be used to improve the delivery of health and social care services in line with the outcomes, aims and objectives of the strategic plan.

Recommendation

The Health & Social Care Integration Joint Board are asked to **ratify** the above proposals.

Policy/Strategy Implications	The programme is being developed in order to enable transformation to new models of care and achieve the partnership's objectives expressed within its Strategic Plan and national health and wellbeing outcomes

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Consultation	The recommendations to the IJB have been made following consultation with a wide range of stakeholder representatives through the Executive Management Team and other key stakeholders.
Risk Assessment	There are no risk implications associated with the proposals
Compliance with requirements on Equality and Diversity	There are no equality implications associated with the proposals
Resource/Staffing Implications	The proposals approved within the programme to date will be funded from the ICF grant allocation over its life

Approved by

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Chief Officer for Integration		
Carol Gillie	NHS Borders Director of Finance	David Robertson	Scottish Borders Council Chief Financial Officer

Author(s)

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Chief Officer for Integration	Jane Robertson	Strategic Planning and Development Manager

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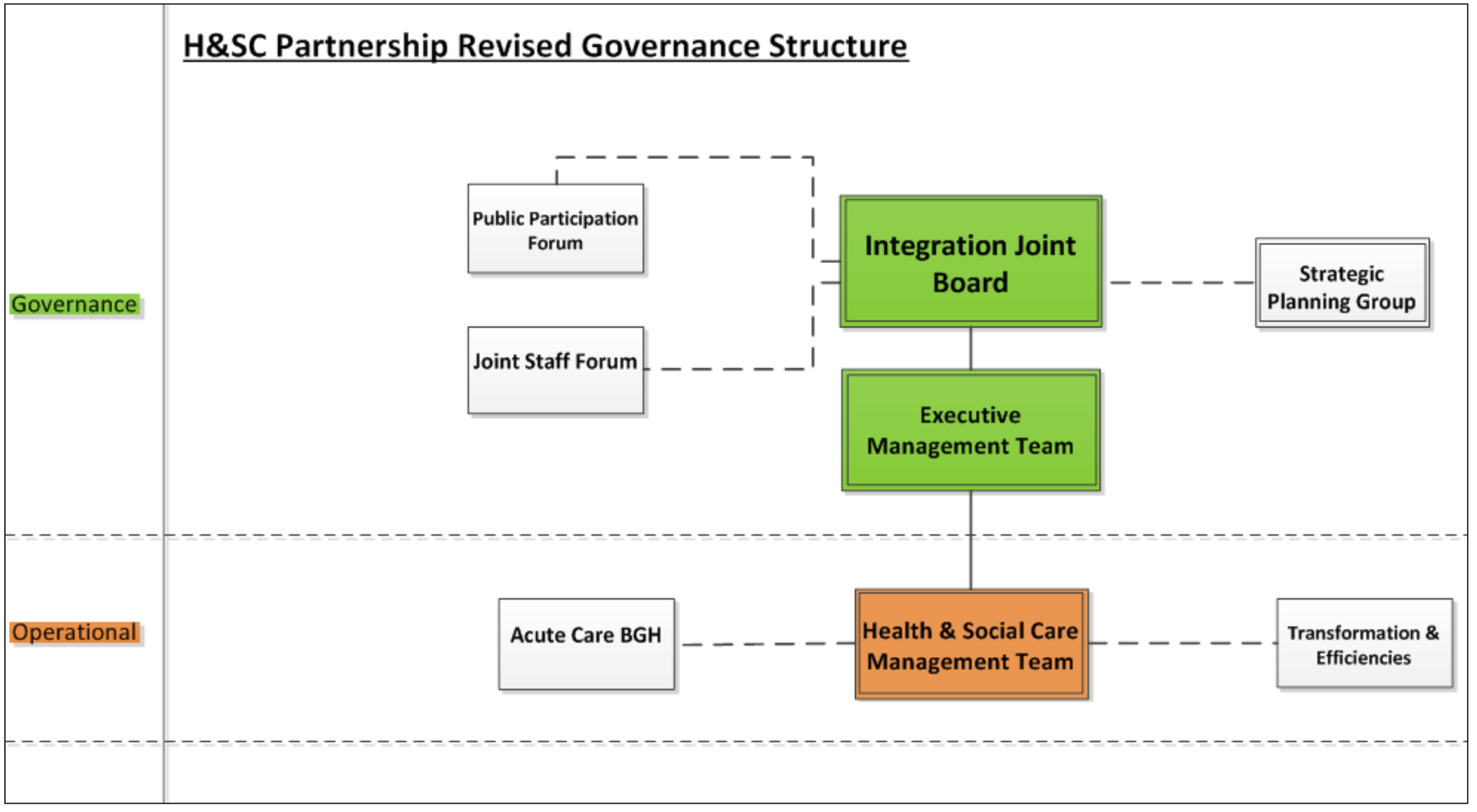
Proposed Revised Governance Structure



Appendix 2

Integrated Care Fund Project RAG Status

Outcomes, milestones, financial status and overall project status.

	Programme Delivery	Community Capacity Building	Independent Sector Representation	Transport Hub	Mental Health Integration	My Home Life	Delivery of the Autism Strategy	BAES Relocation	Delivery of the ARBD pathway	Health Improvement	Stress and Distress	Transitions	Delivery of the Localities plan	CLS	Transitional Care Facility	Matching Unit	RAD & Pharmacy
Outcome Status					2.				4.	5.							6.
Milestone Status			1.				3.										
Financial Status																	
Overall project Status																	

Notes:

1. Some delays in moving forward with case of change for the revised nurse role in care homes, meeting booked with managers during Feb to progress but consultation also needed with Care Inspectorate. Delays in implementing medicines policy as policy still requires NHS and SBC approval.
2. Project complete.
3. Timescales have been amended.
4. Awaiting NHS Remuneration Committee review for secondment.
5. Project complete.
6. These projects have been recently approved – so will be updated in subsequent reports.

Key:

Red – Off Track

Amber – At Risk

Green – On Track

Integrated Care Fund

Progress:

- 18 projects have been approved.
- An Outcome toolkit has been developed for the projects and project leads have been taken through its use.
- A monitoring and evaluation framework for each project is in the process of development.
- Projects are regularly reporting progress via monthly highlight reports and will be taken through the annual evaluation expectations and an evaluation template at a workshop in February 2017.
- In the first year the Community Transport Hub facilitated 482 journeys by using 56 volunteers.
- The final evaluation for the Long terms condition project showed a 21% improvement in wellbeing for service users and a 31% reduction in the need for contact in GP practices involved in the project.
- The Borders Community Capacity Building project has shown the following outcomes -
    - 86% of participants stated that gentle exercise classes had improved their fitness
    - 98% of participants stated that the gentle exercise class had given them an increased opportunity to socialise
    - 45% felt that the gentle exercise class had increased their confidence
    - Reduced isolation
    - 67% of men said that walking football had increased their fitness
    - 100% of men said that walking football had increased their opportunity to socialise.
- To date 99 staff have attended the 2 day stress and distress training and 87 have completed the bite size training (Dementia).
- 12 Community Led Support Events have been held across the borders followed by an evaluation day and a planning day. The first hubs are planned to be operational by the beginning of April.

Challenges:

- The recruitment of Joint roles that need approval via both NHS and SBC system – this will be tackled via workforce planning.

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Appendix 3

Proposal: **Title & Author**

1 Summary

[Highlight the key points, which should include important benefits and the return on investment]

2 Reasons

[An explanation of the reasons why the project is required]

3 Strategic Alignment

4 Options

[Brief description of the different options considered for the project] if relevant

5 Expected benefits

[Expressed in measurable terms against today's situation and indication of scale of impact]

6 Expected dis-benefits

[Outcomes perceived as negative by one or more stakeholders]

7 Risk

[Summary of any key risks of the project]

8 Cost

9 Timescales

10 Sustainability

11 Equality Impact Assessment

Scottish Borders
Health and Social Care
PARTNERSHIP

HEALTH & SOCIAL CARE DELIVERY PLAN

Aim

1.1 This report provides the Integration Joint Board with an overview of the Health & Social Care Delivery Plan which was published by the Scottish Government in December 2016.

Background

2.1 The delivery plan sets out the Scottish Government's programme to further enhance Health & Social Care Services so the people of Scotland can live longer, healthier lives at home or in a homely setting. The aim is to have a Health & Social Care System that is:

- Integrated
- Focuses on prevention, anticipation and support of self management.
- Will make day case treatment the norm
- Focuses on care being provided to the highest standards of quality and safety
- Ensures people get back to their home or community environments as soon appropriate with minimal risk of readmission.

2.2 The full plan is attached at Appendix 1.

Summary

3.1 The plan focuses on 3 key areas (the triple aims)

- "better care", "better health" and "better value"

3.2 To meet the triple aim the plan sets out 4 major programmes of activity:

- Health and Social Care Integration
- The National Clinical Strategy
- Public Health Improvement
- NHS Board reform

3.3 In each area there are key areas of focus and targets, summarised below.

The Four Programmes

a) Integration of Health & Social Care focuses actions around reducing inappropriate use of hospital services, shifting resources to primary and community care and supporting capacity of community care. The plan sets out clear aims and targets.

By 2017

- To reduce inappropriate use of hospital care

- Raising performance around delayed discharges
- Providing new models of care and support in home care

By 2018

- To reduce unscheduled bed days by 10%

By 2021

- Majority of health budget being spent in the community
- Everyone who needs palliative care will get hospice or end of life care

b) The National Clinical Strategy sets out a framework for developing Health Services across Scotland for the next 10-20 years aiming to:

- Strengthen primary and community care
- Improve secondary and acute care and
- Focus on realistic medicine

There is a commitment to build up capacity in primary and community care and support the development of new models of care.

c) The third strand is Public Health Improvement. Key public health priorities are set out including addressing issues of alcohol and tobacco misuse, diet and obesity and a new approach to Mental Health. A further priority is to support Scotland by embedding a new physical activity pathway.

d) Finally the report details NHS Board Reform actions including scope for more effective and consistent delivery of national services and a programme for leadership and talent management.

Workforce

4.1 The report stresses the importance of a skilled flexible workforce to deliver the aims of the plan. A national workforce plan is to be published by Spring 2017 which will inform our local planning in this area.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the Report which will inform local progress.

Policy/Strategy Implications	This report summarises the Scottish Government Delivery Plan.
Consultation	The report has been widely circulated to professionals and is in the public domain.
Risk Assessment	There are no risks associated with this report.
Compliance with requirements on Equality and Diversity	The report has been published by the Scottish Government.
Resource/Staffing Implications	None directly connected to this report.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Interim Chief Officer,		

	Health & Social Care		

Author(s)

Name	Designation	Name	Designation
Elaine Torrance	Interim Chief Officer, Health & Social Care		

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Health and Social Care Delivery Plan

December 2016

Healthier Scotland
Scottish Government

Introduction

1. Our aim[1] is a Scotland with high quality services, that have a focus on prevention, early intervention and supported self-management. Where people need hospital care, our aim is for day surgery to be the norm, and when stays must be longer, our aim is for people to be discharged as swiftly as it is safe to do so.
2. This delivery plan sets out our programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
   - is integrated;
   - focuses on prevention, anticipation and supported self-management;
   - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
   - focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
   - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

3. To realise these aims, we will continue to evolve our health and care services to meet new patterns of care, demand, and opportunities from new treatments and technologies. Since 2007 we have ensured that NHS funding has not only been protected but has increase to record high levels, supporting NHS frontline staffing to substantially increase. There have also been significant improvements in treatment times, reductions in mortality rates, and reductions in healthcare associated infections. As a consequence of these improvements, delivered by committed health and care staff across the country, patient satisfaction has also increased to record highs.

4. To meet the changing needs of our nation, investment, while necessary, must be matched with reform to drive further improvements in our services. Our services will increasingly face demands from more people with long-term conditions needing support from health and social care. These challenges were recognised in the Audit Scotland report[2], NHS in Scotland 2016, and underline the importance of bringing together the different programmes of work to improve health and social care services.

1 http://www.gov.scot/Topics/Health/Policy/2020-Vision.
2 http://www.audit-scotland.gov.uk/report/nhs-in-scotland-2016.

5. This plan is not an exhaustive list of all the actions being taken to improve our health and our health and social care system. While it concentrates on health services, our aspirations will only be delivered through a wider focus on the support provided by a range of services. It acknowledges that change must take place at pace and in collaboration with partners across and outside of the public sector, and that partnership working is essential for the planning that will deliver the actions described here.

How Will We Deliver Our Plan?

6. This plan will help our health and social care system evolve, building on the excellence of NHS Scotland, recognising the critical role that services beyond the health sector must play and is ultimately fit for the challenges facing us. What that will look like for individuals is described in more detail in **Appendix 1**. We must prioritise the actions which will have the greatest impact on delivery. We will focus on three areas, often referred to as the 'triple aim':
    - we will improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all ('**better care**');
    - we will improve everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management ('**better health**'); and
    - we will increase the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention ('**better value**').

Better care

7. We need to ensure that everyone receives the right help at the right time, not just now, but in the years to come as our society continues to change. That requires a change in our approach to medicine and in how and where the services that support our health are delivered. First, we need to move away from services 'doing things' to people to working with them on all aspects of their care and support. People should be regularly involved in, and responsible for, their own health and wellbeing.

8. Ultimately, individuals and where appropriate, their families – should be at the centre of decisions that affect them. They should be given more freedom, choice, dignity and control over their care. Care planning should anticipate individuals' health and care needs – both by helping those with chronic and other complex conditions to manage their needs more proactively, and by focusing on a prevention and early intervention approach to supporting health throughout people's lives. This is not always a question of 'more' medicine, but making sure that support fits with, and is informed by, individual needs. Success should be measured by better outcomes for individuals, not simply on whether processes and systems have been followed. As set out in the Healthcare Quality Strategy for Scotland[3], it is an approach to health rooted in the principles of care that is person-centred, safe and effective.

9. We need services that have the capacity, focus and workforce to continue to address the increasing pressures of a changing society. Our approach to primary and community care on the one hand, and acute and hospital services on the other, should support the critical health challenges our society faces, not least with respect to an ageing population. For our Community Health Service, that will mean everyone should be able to see a wider range of professionals more quickly, working in teams. For acute and hospital services, it will mean thinking differently about how some health and care services are delivered if we are to ensure people receive high-quality, timely and sustainable support for their needs throughout their lives.

Better health

10. To improve the health of Scotland, we need a fundamental move away from a 'fix and treat' approach to our health and care to one based on anticipation, prevention and self-management. The key causes of preventable ill health should be tackled at an early stage. There must be a more comprehensive, cross-sector approach to create a culture in which healthy behaviours are the norm, starting from the earliest years and persisting throughout our lives. The approach must acknowledge the equal importance of physical and mental health as well as the need to address the underlying conditions that affect health.

11. This can only be done by health and other key public sector services (such as social care and education) working together systematically. All services must be sensitive to individual health and care needs, with a clear focus on early intervention. Moreover, it will not just be what services can provide, but what individuals themselves want and what those around them – not least families and carers – can provide with support. Services need to be designed around how best to support individuals, families and their communities and promote and maintain health and healthy living.

3 http://www.gov.scot/Resource/Doc/311667/0098354.pdf.

Better value

12. Better value means more than just living within our means; it means improving outcomes by delivering value from all our resources. It is not just about increasing the efficiency of what we currently do, but doing the right things in different ways. This will demand an integrated approach to the components of the delivery plan so that the whole approach and its constituent parts are understood and joined up.

13. Critical to this will be shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment.

14. Taking full account of the current pressures on primary and community services, we need to redesign those services around communities and ensure that they have the right capacity, resources and workforce. At the same time, people should look to improved and sustainable services from hospitals.

15. We need to free up capacity in hospitals and acute care, allowing for specialist diagnostic and elective centres to provide better-quality services to people and potentially changes to be made to the location of some services. Services should be organised and delivered at the level where they can provide the best, most effective service for individuals. Regional – and in some case, national – centres of expertise and planning should develop for some acute services to improve patient care. The governance structures of all our NHS Boards should support these changes and maximise 'Once for Scotland' efficiencies for the kind of functions all health services need to deliver. That doesn't mean structural change to NHS Boards responsible for the delivery of services to our patients but it does mean that they must work more collaboratively and across boundaries.

16. Evolving our services must also be rooted in a widespread culture of improvement. Sustainable improvements in care, health and value will only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce.

17. Our health and care system has achieved a great deal in the last ten years using improvement methods which are data rich, engaging of leaders and frontline staff, and outcome driven. The Scottish Patient Safety Programme[4] is a good example of what this approach can deliver. While work in safety, efficiency and person-centred care has been planned and led centrally, the improvement has been local. The NHS Scotland workforce is crucial to this, and teams released to test and measure have already produced globally recognised improvements for Scotland's patients, families and carers.

4 http://www.gov.scot/Resource/Doc/311667/0098354.pdf.

18. We will build on the extensive investment in improvement skills and capacity across the health service to continue testing and measuring changes to improve care, supported by the dedicated expertise of Healthcare Improvement Scotland.

19. In meeting the triple aim, our ambition is not about a single strand of work or necessarily about commissioning a new series of projects. Indeed, much of the work is already underway. It is about making sure the different components of change work together to achieve the interlinked aims of better care, better health and better value at pace. Across those different aims, our actions are being driven by four major programmes of activity:

    - health and social care integration;
    - the National Clinical Strategy[5];
    - public health improvement; and
    - NHS Board reform.

20. Taken together, these changes in health and social care will bring long-term sustainability of our services and the continuing improvement of the nation's health and wellbeing. They are underpinned by a series of cross-cutting, thematic programmes of activity, which are also set out below.

Health and social care integration

21. Optimising and joining up balanced health and care services, whether provided by NHS Scotland, local government or the third and independent sectors, is critical to realising our ambitions. Integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. The people most affected by these developments, and for whom the greatest improvements can be achieved, are older people, people who have multiple, often complex care needs, and people at the end of their lives. Too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs.

5 http://www.gov.scot/Resource/0049/00494144.pdf.

22. For better integrated care to become a reality, the new Health and Social Care Partnerships must plan and deliver well-coordinated care that is timely and appropriate to people's needs. We are integrating health and social care in Scotland to ensure people get the right care, at the right time and in the right place, and are supported to live well and as independently as possible. An important aspect of this will be ensuring that people's care needs are better anticipated, so that fewer people are inappropriately admitted to hospital or long-term care. Consequently, we are focusing actions around three key areas: **reducing inappropriate use of hospital services**; **shifting resources to primary and community care**; and **supporting capacity of community care**.

Health and social care integration: actions

Reducing inappropriate use of hospital services

In **2017**, we will:

- Ensure Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. This will be a key lever in shifting the focus of care across health and social care services.
- Agree with partners how to deliver an ambition of raising the performance of the whole of Scotland on delayed discharges from hospitals to the performance of the top quartile of local areas. This will be done as a step to achieving our wider commitments of eliminating delayed discharges, reducing unscheduled hospital care and shifting resources into primary and community care.
- By **2018**, we aim to: Reduce unscheduled bed-days in hospital care by up to 10 percent (ie. by as many as 400,000 bed-days) by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. A range of actions will be taken to achieve this, including improving links between secondary, primary and community care under integration, supported by further work to understand better and take action on the extent to which emergency admissions are currently inappropriate and avoidable. As a result, people should only stay in hospital for as long as necessary and get more appropriate care in a more homely setting. It will reduce growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by **2021** (as set out below). The annual reports produced by Health and Social Care Partnerships and regular monitoring data will enable progress to be tracked.

Health and social care integration: actions – continued

- By **2021**, we aim to: Ensure that everyone who needs palliative care will get hospice, palliative or end of life care. All who would benefit from a 'Key Information Summary' will receive one – these summaries bring together important information to support those with complex care needs or long-term conditions, such as future care plans and end of life preferences. More people will have the opportunity to develop their own personalised care and support plan. The availability of care options will be improved by doubling the palliative and end of life provision in the community, which will result in fewer people dying in a hospital setting.

Shifting resources to the community

- By **2021**, we will: Ensure Health and Social Care Partnerships increase spending on primary care services, so that spending on primary care increases to 11 percent of the frontline NHS Scotland budget. Again, the annual reports produced by Health and Social Care Partnerships and regular monitoring data will be used to assess progress.

Supporting the capacity of community care

- In **2017**, we will: Continue to take forward a programme of work to deliver change in the adult social care sector, together with COSLA and other partners. This has begun with work to reform the National Care Home Contract, social care workforce issues and new models of care and support in home care. Reform of the National Care Home Contract will maintain the continuity, stability and sustainability of residential care provision while embedding greater local flexibility, maximising efficiency, improving quality, enhancing personalisation and promoting innovation. This national, consensus-based approach to improving social care will reinforce the ability of Health and Social Care Partnerships to match care and health support for individuals more quickly and more appropriately.

National Clinical Strategy

23. The National Clinical Strategy sets out a framework for developing health services across Scotland for the next 10-20 years. It envisages a range of reforms so that health care across the country can become a more coherent, comprehensive and sustainable high-quality service – one that is fit to tackle the challenges we face. At its heart is a fundamental change in the respective work of acute and hospital services and primary and community care, and a change in the way that medicine is approached. As a result, the Strategy aims to:
    - strengthen primary and community care;
    - improve secondary and acute care; and
    - focus on realistic medicine.

Primary and community care

24. Community and hospital-based care needs to be integrated and rebalanced to ensure that local health services are more responsive and supportive to the needs of individuals, not least those with chronic conditions who would be better supported in primary and community care. That requires reforming the latter to deliver a stronger, better resourced and more flexible service for people. We are also working to address the current workload pressures and recruitment challenges facing many GP practices and cannot simply result in a crude redistribution of pressures between different parts of the health service. To do this, we must:

    - support individuals, families and carers to understand fully and manage their health and wellbeing, with a sharper focus on prevention, rehabilitation and independence;
    - expand the multi-disciplinary community care team with extended roles for a range of professionals and a clearer leadership role for GPs;
    - develop and roll out new models of care that are person- and relationship-centred and not focused on conditions alone;
    - enable those waiting for routine check-up or test results to be seen closer to home by a team of community health care professionals, in line with the work of the Modern Outpatient Programme[6] in hospitals (as detailed later);
    - ensure the problems of multiple longer-term conditions are addressed by social rather than medical responses, where that support is more appropriate; and
    - reduce the risk of admission to hospital through evidence-based interventions, particularly for older people and those with longer-term conditions.

    We will achieve this by **building up capacity in primary and community care** and **supporting development of new models of care**.

6 http://www.gov.scot/Publications/2016/12/2376.

Primary and community care: actions

Building up capacity in primary and community care

- In **2017**, we will: Continue the investment in recruitment and expansion of the primary care workforce which began in 2016, and which will mean that, by **2022**, there will be more GPs, every GP practice will have access to a pharmacist with advanced clinical skills and 1,000 new paramedics will be in post. This will reinforce the workforce and the capacity of primary and community care to support our services for the future and will be done in line with our National Health and Social Care Workforce Plan (as discussed later).

By **2018**, we aim to:

- Have increased health visitor numbers with a continued focus on early intervention for children through addressing needs identified through the Universal Health Visiting Pathway[7], which started in 2016. As a result of this, every family will be offered a minimum of 11 home visits including three child health reviews by **2020**, ensuring that children and their families are given the support they need for a healthier start in life.
- Have commenced Scotland's first graduate entry programme for medicine. This will focus on increasing the supply of doctors to rural areas and general practices more generally.
- By **2020**, we aim to: Have implemented the recommendations of the Improving Practice Sustainability Short Life Working Group, the GP Premises Short Life Working Group and the GP Cluster Advisory Group. These actions will support more sustainable GP practices over the long term and build stronger links to Health and Social Care Partnerships, ensuring that the changes in primary care are both effective and sustainable.

By **2021**, we aim to:

- Have strengthened the multi-disciplinary workforce across health services. We will agree a refreshed role for district nurses by **2017**, train an additional 500 advanced nurse practitioners by **2021** and create an additional 1,000 training places for nurses and midwives by **2021**. This will build on four successive increases in student nursing and midwifery intakes to meet additional demand, especially in primary and community settings.
- Have increased the number of undergraduates studying medicine by 250 as a result of the 50 additional places in Scotland's medical schools introduced in **2016**.
- Have increased spending on primary care and GP services by £500 million by the end of the current parliament so that it represents 11 percent of the frontline budget. This is a fundamental change in how health resources are directed and will enable the critical shift in balance to primary and community care.

7 http://www.gov.scot/Resource/0048/00487884.pdf.

Primary and community care: actions – continued

Supporting new models of care

In **2017**, we will:

- Negotiate a new landmark General Medical Services contract, as a foundation for developing multi-disciplinary teams and a clearer leadership role for GPs.
- Test and evaluate the new models of primary care in every NHS Board, which will be funded by £23 million, and disseminate good practice with support from the Scottish School of Primary Care. These new models of care will include developing new, effective approaches to out-of-hours services and mental health support, and are essential for moving to a more person- and relationship-centred approach to individual care across the whole of Scotland.
- Taken forward the recommendations from the Review of Maternity and Neonatal Services[8] and progress actions across all aspects of maternity and neonatal care.
- Launch Scotland's Oral Health Plan, following consultation, as part of a comprehensive approach to modernise dentistry and improve the oral health of the population through a prevention and early intervention approach.

By **2018**, we will:

- Have rolled out the Family Nurse Partnership programme nationally to provide targeted support for all eligible first-time teenage mothers. This will give intensive support to mothers and their children and give their health and wellbeing a strong start.

Secondary and acute care

25. People should only be in hospital when they cannot be treated in the community and should not stay in hospital any longer than necessary for their care. This will mean reducing inappropriate referral, attendance and admission to hospital, better signposting to ensure the right treatment in a timely fashion, and reducing unnecessary delay in individuals leaving hospital. Addressing admission to, and discharge from, hospitals will be the responsibility of Health and Social Care Partnerships; but all partners will need to work together to reduce the levels of delayed discharges, ensure services are in place to facilitate early discharge and avoid preventable admissions in the first place.

26. At the same time, within hospitals, more needs to be done to ensure better outcomes for people, while making a more effective use of resources. There is increasing evidence that better outcomes are achieved for people when complex operations are undertaken by specialist teams and some services are planned and delivered on a population basis. This might mean some services currently delivered at a local level would produce better outcomes for people if delivered on a wider basis. This kind of service change needs to be accompanied by investment in new, dedicated facilities to ensure that the capacity for high-quality, sustainable services can be delivered at the appropriate level.

8 http://www.gov.scot/Topics/People/Young-People/child-maternal-health/neonatal-maternity-review.

27. To achieve this we will take intensive and coordinated action in several key areas of secondary and acute care: **reducing unscheduled care**; **improving scheduled care**; and **improving outpatients**.

Secondary and acute care: actions

Reducing unscheduled care

In **2017**, we will:

- Complete the roll out of the Unscheduled Care Six Essential Actions[9] across the whole of acute care. Through improving the time-of-day of discharge, increasing weekend emergency discharges and a more effective use of electronic information in hospitals, we will enhance a patient's journey at each stage through the hospital system and back into the community without delay.
- Undertake a survey on admission and referral avoidance opportunities. This will give a strong evidence base to target modelling for how to reduce unscheduled care through integrated primary and secondary care services.

Improving scheduled care

In **2017**, we will:

- Put in place new arrangements for the regional planning of services. The National Clinical Strategy sets out an initial analysis of which clinical services might best be planned and delivered nationally and regionally, based on evidence supporting best outcomes for the populations those services will serve. This is a critical first step towards strengthening population-based planning arrangements for hospital services, working across Scotland. NHS boards will work together through three regional groups. In **2018**, the appropriate national and regional groups will set out how services will evolve over the next 15 to 20 years, in line with the National Clinical Strategy.
- Reduce cancellations and private care spend in scheduled care by rolling out the Patient Flow Programme from the current pilots across all NHS Boards. The Programme builds on the success of previous programmes – such as Day Surgery, Enhanced Recovery for Orthopaedics and Fracture Redesign – by increasing national and local capacity to use operations management techniques to improve care for patients. Four pilot boards are implementing improvement projects covering emergency and elective theatre operations, elective surgery planning and emergency medical patient flow. As this is expanded, it will introduce more responsive and efficient secondary care and reduce wastage and the unnecessary use of resources.

9 http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/UnscheduledCare/6-Essential-Actions-To-Improving-Unscheduled-Care.

Secondary and acute care: actions – continued

By **2021**, we will:

- Complete investment of £200 million in new elective treatment capacity and expanding the Golden Jubilee National Hospital. Overall, this investment will ensure that there is high-quality and adequate provision of elective care services to meet the needs of an ageing population.
- Complete investment of £100 million in cancer care to ensure: earlier detection with more rapid diagnosis and treatment; more and better care during and after treatment, taking account of what matters most to people with cancer; increased entry to clinical trials/research; and an evidence driven cancer intelligence system for clinicians and patients with access to near-to-real time information through care pathways. Addressing cancer in such a comprehensive way will target one of the critical health issues facing the population.

Improving outpatients

- By **2020**, we aim to: Have reduced unnecessary attendances and referrals to outpatient services through the recently-published Modern Outpatient Programme. The aim is to reduce the number of hospital-delivered outpatient appointments by 400,000, reversing the year-on-year increase of new appointments. It will draw on the existing Delivering Outpatient Integration Together (DOIT) Programme and other activities such as the Technology Enabled Care Programme to:
  - give GPs greater access to specialist advice to reduce the time people wait to get appropriate treatment;
  - use clinical decision support tools to reduce the amount of time people wait to get the right treatment;
  - reduce the number of attendances for people with multiple issues through a holistic approach to their support and care;
  - enable GPs to have more access to hospital-based tests so that people can be referred to the right clinician first time; and
  - facilitate more return or follow-up appointments in non-hospital settings through virtual consultation from their own home.

Realistic medicine

28. We need to change our long-term approach to the role of medicine and medical interventions in our health and wellbeing. A new clinical paradigm, based on a 'realistic medicine' approach and backed by clinical leadership, will support people through informed, shared decision-making that better reflects their preferences and what matters most to them. There needs to a greater focus on the discussions that medical practitioners have with people about their care, and what different types of medical intervention can entail. Relationships between individuals and practitioners should be based on helping people understand options about their care and choose treatment according to their preferences.

29. At the same time, we must get better value out of medicine and medical interventions and find ways to reduce any unnecessary cost. Waste and variation in clinical practice need to be addressed, and we should also support the reliable implementation of effective interventions that are not currently being made available to people.

30. Consequently, we need to take forward actions that will strengthen **relationships between professionals and individuals** as well as **reduce the unnecessary cost of medical action**.

Realistic medicine: actions

Strengthening relationships between professionals and individuals

In **2017**, we will:

- Refresh our Health Literacy Plan, Making It Easy[10], to support everyone in Scotland to have the confidence, knowledge, understanding and skills we need to live well with any health condition we have.
- Review the consent process for patients in Scotland with the General Medical Council and Academy of Medical Royal Colleges and make recommendations for implementation from **2018** onwards. This is a key element in transforming the relationship between individuals and medical professionals.

10 http://www.gov.scot/Topics/Health/Support-Social-Care/Health-Literacy.

Realistic medicine: actions – continued

By **2019**, we aim to:

- Commission a collaborative training programme for clinicians to help them to reduce unwarranted variation. This will support a workforce that can find more effective and valued ways of delivering medicine.
- Refresh the Professionalism and Excellence in Medicine Action Plan[11] and align high-impact actions to realistic medicine.

Reducing the unnecessary cost of medical action

By **2018**, we aim to:

- Incorporate the principles of realistic medicine as a core component of lifelong learning in medical education and mainstream the principles of realistic medicine into medical professionals' working lives at an early stage.

By **2019**, we aim to:

- Develop a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost and reduce the overall cost of medicine.

Public health improvement

31. Scotland's ability to respond to infectious diseases and other risks to health matches and, in some cases, exceeds that of much of the developed world. But in common with many developed societies, we face greater challenges to public health arising from lifestyle behaviours, wider social-cultural factors that prevent positive health choices being made and a modern environment that impacts on the health and wellbeing of individuals, families and communities. There are many social determinants which impact on health and wellbeing, including those that can affect us from our earliest years throughout our lives, such as Adverse Childhood Experiences. We need to increase public and service knowledge and awareness of where avoidable harm can be reduced, including a wider understanding of both physical and mental health and the right actions to promote and strengthen healthy lifestyles.

11 http://www.gov.scot/Publications/2014/01/8967.

32. This requires a concerted, sustained and comprehensive approach to improving population health through targeting particular health behaviours, acting to reduce avoidable harm and illnesses and taking a population- and lifetime-wide approach to prevention and early intervention treatment. We will:
    - create a clear set of **national public health priorities** for Scotland as a whole and streamline the currently cluttered **public health landscape**;
    - develop and build on our sustained approach to addressing the **key public health issues** of alcohol and tobacco misuse and diet and obesity;
    - drive forward a new approach to **mental health** that ensures support and treatment are mainstreamed across all parts of the health service – and beyond – and is not simply the responsibility of specialist services, working within the framework of a new 10-year mental health strategy to be published in early 2017; and
    - support a **More Active Scotland**[12].

Public health improvement: actions

Supporting national priorities

- In **2017**, we aim to: Set national public health priorities with SOLACE and COSLA, that will direct public health improvement across the whole of Scotland. This will establish the national consensus around public health direction that will inform local, regional and national action.
- By **2019**, we aim to: Support a new, single, national body to strengthen national leadership, visibility and critical mass to public health in Scotland. Such a body will have a powerful role in driving these national priorities and providing the evidence base to underpin immediate and future action.
- By **2020**, we aim to: Have set up local joint public health partnerships between local authorities, NHS Scotland and others to drive national public health priorities and adopt them to local contexts across the whole of Scotland. This will mainstream a joined-up approach to public health at a local level.

12 http://www.gov.scot/Resource/0044/00444577.pdf.

Public health improvement: actions – continued

Supporting key public health issues

In **2017**, we will:

- Continue delivery of the ambitious targets set out in our 2013 Strategy, Creating a Tobacco Free Generation[13], including reducing smoking rates to less than 5 percent by 2034. We will implement legislation to protect more children from secondhand smoke and reduce smoking in hospital grounds.
- Refresh the Alcohol Framework[14], building on the progress made so far across the key areas of: reducing the harms of consumption; supporting families and communities; encouraging positive attitudes and choices; and supporting effective treatment. A key part of the Framework is the introduction of a minimum unit price for alcohol and we will work towards its implementation at the earliest opportunity, subject to the current legal proceedings. This will combine into a highly ambitious approach to reducing alcohol harm in Scotland.
- Consult on a new strategy on diet and obesity. There are huge preventable costs to NHS Scotland and society associated with poor diet, as one of the critical health issues we are facing, and it requires a different approach to diet and obesity.
- Introduce the Active and Independent Living Improvement Programme which will support people of all ages and abilities to live well, be physically active, manage their own health conditions, remain in or return to employment, and live independently at home or in a homely setting.
- By **2021**, we will: Deliver the Maternal and Infant Nutrition Framework with a focus on improving early diet choices and driving improvements in the health of children from the earliest years. This will include: by **2017**, rolling out universal vitamins to all pregnant women; by **2019**, consolidating best practice and evidence on nutritional guidance for pregnancy up to when children are aged 3, and developing a competency framework to promote and support breastfeeding; and by **2020**, have integrated material into training packages for core education and continuing professional development.

13 http://www.gov.scot/resource/0041/00417331.pdf.

14 http://www.gov.scot/Publications/2009/03/04144703/14.

Public health improvement: actions – continued

Supporting mental health

- By **2018**, we will: Improve access to mental health support by rolling out computerised cognitive behavioural therapy services nationally.

By **2019**, we will:

- Have evaluated the most effective and sustainable models of supporting mental health in primary care, and roll these out nationally by **2020**.
- Have rolled out nationally targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder.

By **2020**, we will:

- Have improved access to mental health services across Scotland, increased capacity and reduced waiting times by improving support for greater efficiency and effectiveness of services, including Child and Adolescent Mental Health Services and psychological therapies. This will be accompanied by a workforce development programme and direct investment to increase capacity of local services.
- Have delivered new programmes promoting better mental health among children and young people across the whole of Scotland.
- By **2021**, we will: Have invested £150 million to improve services supporting mental health through the actions set out in the 10-year strategy.

Supporting a More Active Scotland

- In **2017**, we will: Publish a new delivery plan to support the Active Scotland Outcomes Framework and the Vision for a More Active Scotland, with greater action to address inequalities in physical activity across Scotland and a refocusing of resources.
- By **2019**, we will: Have embedded the National Physical Activity Pathway in all appropriate clinical settings across the health care system, ensuring that:
  - hospitals routinely support patients and staff to be more physically active;
  - we build on our success in schools, creating a culture of being active within children and young people. This will include rolling out the Daily Mile, extending the number of school sports awards, strengthening the Active Schools network creating more quality opportunities and supporting more active travel to and from school;
  - all partners stay on track for delivering 200 Community Sports Hubs, providing local places for communities to be active designed by themselves around their own needs; and
  - we continue to build on the legacy of the 2014 Commonwealth Games using the European Championships in Glasgow in 2018 to encourage more Scots to be active.

NHS Board reform

33. As the NHS moves into this new and changing delivery environment, we need our health bodies and governance models to reflect those changes and support the delivery for the people of Scotland. Our reform focus will continue to be on providing quality care for people, a shift towards prevention and early intervention, and making best use of our resources, rather than on structures and bureaucracy. Governance arrangements will only adjust to support this shift if required – i.e. the 'form' of governance would follow the 'function' of service planning and delivery. Any such changes would have to meet two tests. Firstly, that the changes were better able to respond to the needs of local communities. Secondly, that the changes would have to ensure better collaboration between NHS boards and, additionally, improve how our NHS works with providers of other public services to secure better outcomes for people.

34. We will also build on the work that has already taken place through a 'Once for Scotland' approach to provide efficient and consistent delivery of functions and prioritise those non-patient facing services which make sense to be delivered on a national basis. The approach will consider the differing needs across Scotland, and will be, for example, 'island-proofed' as part of the Scottish Government's wider commitment on recognising the distinct nature of island communities. Our territorial and patient facing national boards such as the Ambulance Service and NHS 24 must be allowed to focus on delivery of the "triple aim" of better care, better health and better value.

NHS Board reform: actions

In **2017**, we will:

- Review the functions of existing national NHS Boards to explore the scope for more effective and consistent **delivery of national services** and the support provided to local health and social care system for service delivery at regional level. As part of this, clear guidance will be put in place to NHS Boards that their Local Delivery Plans for 2017/18 must show their contributions to driving the work of this delivery plan, not least their contributions in support of the regional planning of clinical services.
- Ensure that NHS Boards expand the **'Once for Scotland' approach** to support functions – potentially including human resources, financial administration, procurement, transport and others. A review will be completed in **2017**, and new national arrangements put in place from **2019**.
- Start a comprehensive programme to look at **leadership and talent management** development within NHS Scotland. This will ensure that current leaders are equipped to drive the changes required in health and social care, but it will also ensure sustainability of approach by identifying the next cohort of future leaders of NHS Scotland.

Cross-cutting actions

35. Improvements will be driven by the key components set out above, but they will need to be supported by a series of cross-cutting sets of actions. These are the key programmes of work which will inform all the change set out here:
    - our approach to improving the services for children and young people through Getting It Right For Every Child;
    - the National Health and Social Care Workforce Plan;
    - the review of health and social care targets.
    - a focus on research and development, innovation and digital health; and
    - a robust approach to engagement.

Getting It Right For Every Child

36. The principles of our Getting It Right For Every Child[15] approach to improving services for children and young people are simple: more effective and widespread prevention and early intervention; better cooperation amongst professionals and between them, the child or young person, and their family; and a holistic approach to addressing a child's wellbeing. In addition to actions included in the main components of work above, we will drive this agenda through: continued implementation of Children and Young People (Scotland) Act 2014[16], in particular, the Named Person and the Child's Plan; and developing a new Child and Adolescent Health and Wellbeing Strategy in **2017**. This will form the cornerstone for a comprehensive approach to ensuring that all the factors affecting a child's or young person's health are regularly identified and supported with the individual, their family and, where appropriate, services.

15 http://www.gov.scot/Topics/People/Young-People/gettingitright/what-is-girfec/foundations.

16 http://www.legislation.gov.uk/asp/2014/8/contents/enacted.

National Health and Social Care Workforce Plan

37. Reform that delivers improved outcomes for patients can only happen with a committed, supported workforce that has the right skills, flexibility and support. Everyone Matters: 2020 Workforce Vision[17] sets out the health and social care workforce policy for Scotland, and a vision and values. The National Health and Social Care Workforce Plan will take forward the commitment to a sustainable workforce by establishing the priorities for action, assess current resources, and detail the actions to close the gap between what we have and what we will need to deliver high-quality, integrated and transformed services to those who need them. To be published in Spring **2017**, the Plan will:

    - align workforce planning more effectively with the different components of the delivery plan so that capacity challenges are identified at an early stage; and
    - improve workforce planning practice to make clearer what should be planned at national, regional and local levels.

    A short discussion paper outlining these arrangements, produced in consultation with key stakeholders, is attached at **Appendix 2**.

Review of health and social care targets

38. Targets can be instrumental in driving improvements in performance, but we need to ensure that performance is focused on improving outcomes for individuals and communities. Chaired by Sir Harry Burns, a national review is being conducted into the present suite of targets and indicators for health and social care. The review will work with service users, staff, professional bodies, and providers to ensure targets and performance indicators lead to the best outcomes for people being cared for, whether in hospital, primary care, community care or social care services. The interim report is expected in the Spring and the final report later in **2017**.

Research and development, innovation and digital health

39. Research is central to all high-performing health systems, leading to better targeted and more personalised treatment and improved patient outcomes. Scotland has a solid track record as a health research nation and in winning competitively awarded research funds. Research and development (R&D) and innovation are core activities for our health and social care services in Scotland and development in health and social care will depend on the science and discovery that underpins it. Through NHS Research Scotland (NRS), there is already a firm foundation of collaborative R&D partnership working successfully across NHS Scotland, academia and life-science industries. We will continue to invest in NRS to support health-related R&D, building on its model to drive a renewed effort in health innovation, as well as in Scottish Health Innovations Ltd to encourage, develop and appropriately commercialise innovative ideas and new technologies arising from within the health services. By **2018**, we will also:

17 http://www.workforcevision.scot.nhs.uk.

- create governance structures to support a new, coherent and concerted effort on the promotion and exploitation of health-related innovation and new technologies for the benefit of the whole health service;
- develop regional innovation clusters to translate cutting-edge research and innovation into excellent individual health care; and
- support innovation and technology capacity-building at national, regional and local levels by facilitating, encouraging and empowering those who work in health and care to identify innovation challenges and develop partnerships to deliver solutions.

40. Digital technology is key to transforming health and social care services so that care can become more person-centred. Empowering people to more actively manage their own health means changing and investing in new technologies and services, by, for example enabling everyone in Scotland to have online access to a summary of their Electronic Patient Record. The time is right to develop a fresh, broad vision of how health and social care service processes in Scotland should be further transformed making better use of digital technology and data. There is an opportunity to bring together all IT, digital services, tele-health and tele-care, business and clinical intelligence, predictive analytics, digital innovation and data use interests in health and social care. This will be taken forward through:

    - a review led by international experts of our approach to digital health, use of data and intelligence, to be completed in **2017**, which will support the development of world-leading, digitally-enabled health and social care services; and
    - a new Digital Health and Social Care Strategy for Scotland, to be published in **2017**, that will support a digitally-active population, a digitally-enabled workforce, health and social care integration, whole-system intelligence and sustainable care delivery.

Engagement

41. Engagement with patients, service users, staff and their representatives, key stakeholders and volunteers is vital in delivering our plans. The public and all stakeholders must not only be aware of the broader context within which decisions about any service changes are taken over the coming years, but inform how those decisions are taken from a position of understanding both the challenges and opportunities facing us.

42. There has already been huge engagement in developing health and social care integration, realistic medicine and through the National Conversation on Creating a Healthier Scotland[18]. The latter alone reached over 9,000 people through 240 events and engagements and with over 360,000 inputs through digital and social channels. Building on this work, the Our Voice framework[19] has been developed in partnership with NHS Scotland, COSLA, the ALLIANCE and other third sector partners to support people to engage, with purpose, in improving health and social care. The framework builds on much of the good work already underway at individual and local level to hear the voices of patients, their families, carers and unpaid carers, and involve them in improvement. We will explore ways in which Our Voice can support engagement on the work of this delivery plan through use of methods such as the national citizens' panel and citizens' juries.

43. Key to this will also be building on existing engagement mechanisms to ensure that all those who will be critical in delivering this change are fully involved in planning how it will take place. Work will continue with delivery partners across the public sector on how to take forward the different existing components of the delivery plan's activity, and this will be accelerated in the context of ensuring that the links between different activities are identified and opportunities for joint working maximised.

44. At the same time, it will be essential that engagement with the NHS Scotland workforce around this agenda is robust and makes full use of the potential of the workforce to drive this change. Through developing the National Health and Social Care Workforce Plan and as part of wider professional engagement, we will work with relevant organisations and bodies to ensure that the workforce needs of the future are identified early and fully and the contributions of the workforce to these workstreams are properly supported. In recognition of the established partnership working model in NHS Scotland, we will develop this work further in collaboration with trade union and professional organisations.

18 https://healthier.scot/.

19 http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice_framework.aspx#.WEk5e7lDTEo.

How Will Delivery Of Our Plan Be Funded?

45. Achieving long-term financial sustainability of our health and care system and making the best use of our total resources is critical to this delivery plan. We will need to deliver transformational change while managing increasing demand for services, inflationary pressures and the growing needs of an ageing population. This will require a short-, medium- and long-term focus on sustainability and value of services alongside reform.

46. Over the next five years, we will invest £70 billion of resources in our health and social care system. At the same time the impact of our demographics and inflation in pay and in prices means that we must increase our overall productivity. Health funding is expected to grow in resource terms by the end of this Parliament, with significant planned investment in areas such as primary care, mental health, social care, cancer and new elective capacity. Spending on primary care services is set to increase by £500 million so that it accounts for 11 percent of the frontline NHS Scotland budget by May 2021.

47. A financial plan will support this delivery plan, creating the environment and incentives for change, and supporting transition. This will ensure stability to maintain the quality of care, health of the population and best value from resources through:
    - providing dedicated funding to invest in the levers of change;
    - putting in place arrangements to support sustainable financial balance across the whole of NHS Scotland;
    - creating short-term financial capacity to allow time to deliver change through efficiencies in current ways of working;
    - supporting clinicians to make best use of resources through investment in costing and value tools to support shared decision making on clinical and financial evidence;
    - driving an early intervention and prevention approach across services; and
    - developing an approach to infrastructure and digital that supports the shift from hospital to community and primary care and works across the public sector estate.

48. The components within the delivery plan will be financially and economically assessed at key stages in their development, from initial scoping through to implementation, to create a comprehensive assessment of affordability and sustainability.

How Will Delivery Be Tracked?

49. It is crucial that the delivery plan does not remain a simple statement of intent, but a continuing process of monitoring, challenge and review. Every component of the delivery plan will continue to be tested for its fit with our strategic aims and how it supports shifting the balance of care towards community settings, managing demand, reducing waste, harm and variation, and delivering value from our total resources. We will challenge the expected levels of investment and levels of efficiencies in local, regional and national plans to ensure delivery of the aims of the delivery plan.

50. As part of this, a robust, integrated performance framework for the different components of the delivery plan will be developed for early **2017**. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated outcomes can be fully realised, but that the delivery plan is updated with new measures as appropriate. It cannot remain a static document, but a way of continually assessing whether the measures and approach being taken are appropriate and sufficient to secure our Vision.

Appendix 1: What Will Be Different in a Transformed Health and Social Care System in Scotland?

What will be different for individuals

- People will be equal partners with their clinicians, working with them to arrive at decisions about their care that are right for them. They will be supported to reflect on and express their preferences, based on their own unique circumstances, expectations and values. This might mean less medical intervention, if simpler options would deliver the results that matter to them.
- People will be supported to have the confidence, knowledge, understanding and skills to live well, on their own terms, with whatever conditions they have. They will have access to greater support from a range of services beyond health, with a view to increasing their resilience and reinforcing their whole wellbeing.
- Health and social care professionals will work together to help older people and those with more complex needs receive the right support at the right time, and where possible, live well and independently by managing their conditions themselves.
- Hospitals will focus on the medical support that acute care can and should provide, and stays in hospital will be shorter. Individuals will benefit from more care being delivered in the community, and where possible, at home.
- Everyone will have online access to a summary of their Electronic Patient Record and digital technology will underpin and transform the delivery of services across the health and social care system.
- Children, young people and their families will benefit from services across the public sector – including health, education, social care and other services – working together to support prevention and early intervention of any emerging health issues.
- The diet and health of children from the earliest years will improve from coordinated and comprehensive nutritional support for children and families.
- There will be a significant reduction in the harmful impact on health of alcohol, tobacco and obesity, and our approach to oral health will be founded on prevention.
- People will have access to more and more effective services across the health system to support mental health, including the specialist services for children and young people. Mental health will be considered as important as physical health.
- People will lead more active, and as a result, healthier lifestyles.
- People will receive more sensitive, end of life support that will aim to support them in the setting that they wish. All those who need hospice, palliative or end of life care will receive it and benefit from individual care and support plans. Fewer people will die in hospitals.

What will be different for communities

- Most care will be provided locally through an expanded Community Health Service, avoiding the need to go into hospital.
- People will benefit from local practices and other community care with a wider range of available support. Practices will typically consist of complementary teams of professionals, bringing together clusters of health support and expertise. Communities will have access to quicker and joined-up treatment – this might be the GP, but supported by a team including highly-trained nurses, physiotherapists, pharmacists, mental health workers and social workers. GPs will take on a greater leadership role.
- Local practices will be able to provide more information and secure better advice for people locally without the need to attend hospitals to get specialist consultancy advice. That advice will be increasingly delivered locally.
- Families will receive more integrated and extended primary and community care for their children. There will be more home visits from health care professionals, including three child health reviews, and teenage mothers will receive more intensive and dedicated maternal support.

What will be different regionally

- Some clinical services will be planned and delivered on a regional basis so that specialist expertise can deliver better outcomes for individuals, services can be provided quicker and stays will be shorter. This will ensure that the services provided to people are high quality and the expertise remains as effective as possible.
- More centres will be provided to help NHS Scotland handle the growing demand for planned surgery, particularly from an ageing population. Such centres will allow medical professionals to become extremely skilled and have facilities to the highest standards. This will take pressure off other hospitals so there are fewer delays when urgent or emergency care is needed.

What will be different nationally

- There will be a national set of health priorities giving clear, consistent direction for how to improve public health across the whole of Scotland and a single national body to drive the priorities.
- Services and functions of the health service which can be delivered more efficiently at national level will be done on a 'Once for Scotland' basis.

Appendix 2: National Health and Social Care Workforce Plan: Outline Discussion Paper

Introduction

1. This document sets out the initial arrangements for the production, in early 2017, of a National Discussion Document on workforce planning in health and social care. A consultation exercise undertaken at this stage will report back and a final version of a National Health and Social Care Workforce Plan will be published in Spring 2017. There are three distinct stages:
   - **Outline Discussion Paper:** setting out initial arrangements prior to –
   - the **National Discussion Document:** to be published in early 2017, leading to –
   - the **National Health and Social Care Workforce Plan**, to be published by Spring 2017.

2. This is a complex area which will need time for all relevant stakeholders to have an opportunity for real engagement in order fully scope the landscape, issues and levers in order to 'get it right'. The production of the Workforce Plan by Spring 2017 should be seen as an **intermediate** step and part of a developing and iterative approach, not an end in itself. The Workforce Plan will be the first in an **annual series** aimed at improving workforce planning practice, as well as developing more effective and informed intelligence.

3. The Workforce Plan will present an opportunity to: a) refresh guidance for production of NHS Scotland workforce plans; and b) introduce workforce planning to which provides an overall picture for health and social care staff. The current position is different for NHS Scotland and Health and Social Care Partnerships, but the two will become increasingly interdependent in delivering care across Scotland, linking back to the recent Audit Scotland report recommendations. This outline discussion paper, the forthcoming National Discussion Document and the Workforce Plan, therefore, seek to achieve a balance in referring to working planning as it applies across NHS Scotland, and social work and social care interests.

4. Health and Social Care Partnerships are expected to develop integrated workforce plans to ensure people get the right support at the right time from staff who not only have the skills but are working in the most appropriate setting. The Workforce Plan should, therefore, look to support this agenda.

5. The need for the Workforce Plan derives from the national and international context within which workforce planning in health and social care needs to take place. The incremental approach reflects the timelines required to deliver a changed workforce and the effects of changing demand, demography and generational perspectives on work/life balance and careers. While the Workforce Plan and subsequent annual Plans will be practically focused and useable, they must also read across to and be able to adjust to strategic areas of health and social care reform.

6. This paper describes outline arrangements, processes around engagement, and some of the context for this work.

Aim of the Outline Discussion Paper

7. The aim of this paper is to set out the intended actions reflecting the Scottish Government's Programme for Government commitment on workforce planning and to assure organisations within health and social care – including NHS Boards and the full range of employers in the social service sector – of their full involvement in the work being undertaken to realise this commitment.

Objectives

8. We are working to develop national and regional workforce planning through a Workforce Plan which helps deliver the direction set out in a range of strategic developments – among them this delivery plan as well as the National Clinical Strategy – while also reflecting progress in key areas of health and social care such as integration and self-directed support. To do this, we must ensure that all key stakeholders are able to contribute to and help to shape the Workforce Plan, so that it addresses their interests and issues.

9. As we work towards a Workforce Plan in 2017, we want to ensure a clear view for those responsible for workforce planning within health and social care services, on:

   - roles and responsibilities with regards to workforce planning, and in the production of the Workforce Plan itself, as well as current arrangements already in place;
   - Ministers' intentions to ensure better coordination of national, regional and local workforce planning against a complex and shifting health and social care background; and
   - how more consistent and coordinated workforce planning can help deliver better services and outcomes for Scotland's people.

   The Workforce Plan will also provide an opportunity to consider integrated workforce planning arrangements, recognising differences in workforce planning practice between NHS Scotland, local authorities and other social service employers.

Context

10. The need for a Workforce Plan stems from the Programme for Scotland commitments in relation to health and social care, as well as from Audit Scotland recommendations on workforce planning in relation to its recent findings on the public sector workforce[20], health and social care integration[21] and on the NHS in 2016[22].

11. It is important that the Workforce Plan should apply in an integrated context, covering the social care services sector, comprising a wide range of support and services and employing 130,000 NHS Scotland staff and over 200,000 staff across the third, independent and public sectors[23]. There is a statutory duty on NHS Boards to undertake workforce planning and this will continue to apply. We, therefore, expect the Workforce Plan to be:

    - **a strategic document**, setting out the workforce vision for health and social care services, the priorities to be taken forward, the assessment of current resources to deliver the vision, and actions to close the gap between what we have and what we will need;
    - **apply at a national level**, linking, as appropriate, to regional and local levels; and
    - **active and useable**, making coherent workforce planning links between national and regional activity and offering frameworks for practical workforce planning in both the NHS Scotland and social services sectors.

12. The Workforce Plan will consider how workforce planning is influenced by the following developments in health and social care:

    - public service reform and integration of health and social care, allowing space for NHS Boards, local authorities and Health and Social Care Partnerships to plan for the workforce for the health and social care system that Scotland needs, now and in future;
    - Progr.5ng plans for elective centres;
    - recommendations on workforce planning from Audit Scotland[24];
    - the NHS Scotland Workforce 2020 Vision, Everyone Matters; and
    - approaches and methodologies in use which support development of services delivered by multi-disciplinary teams – for example, the Workforce Planning Guide by the Scottish Social Services Council, the NHS Scotland 6 Step Model, and local authority tools and guidance.

20 http://www.audit-scotland.gov.uk/report/scotlands-public-sector-workforce.

21 http://www.audit-scotland.gov.uk/report/health-and-social-care-integration.

22 http://www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_161027_nhs_overview.pdf.

23 http://data.sssc.uk.com/data-publications/22-workforce-data-report/128-scottish-social-service-sector-report-on-2015-workforce-data.

24 "The Scottish Government, in partnership with NHS Boards and integration authorities, should share good practice about health and social care integration, including effective governance arrangements, budget-setting and strategic and workforce planning". [Audit Scotland – NHS in Scotland 2016-17].

13. In relation to meeting the challenging health and social care needs required, the Workforce Plan will:
    - set out a useable framework to improve current workforce planning practice;
    - clarify how workforce planning should take place nationally, regionally and locally across health and social care;
    - map and coordinate similarities and differences in workforce planning practice; and
    - harmonise, reconcile and share approaches where appropriate, while preserving what works well.

Intended outcomes

14. The Workforce Plan will help to bring about:
    - clearer understanding about respective roles and responsibilities on workforce planning;
    - clearer understanding about the changes and improvements which need to be made and why;
    - improved consistency, allowing for sharing of best workforce planning practice across Scotland;
    - clearer evidence that robust workforce planning helps to deliver effective, efficient delivery of services and better patient/ service user/ client outcomes; and
    - a longer-term view of the challenges in regard to capacity and capability of this workforce and the solutions we need to design now in response to these.

Process for developing the Workforce Plan

15. An important first step will be to define and articulate the scale of the challenge and the scope of the Workforce Plan. Though NHS Boards are required to follow a single methodology, workforce planning practice can vary significantly. There is also considerable diversity in workforce planning practice between NHS Boards and employers in the social services sector. However, there are indications that workforce challenges are common to both, including: an ageing workforce and the need to provide care for a larger proportion of the population; increasing activity and demand on services; difficulties in recruitment for some hard-to-fill posts; the need to design multi-professional approaches to service challenges; and the availability and suitability of training and career pathways. Starting to be clearer about what can/should be dealt with nationally, regionally and locally will help.

16. Some workforce planning issues will require more pressing action. For the short to medium term, the Workforce Plan will need to:

    - for NHS Scotland, align workforce planning objectives with strategic policies, enabling capacity challenges to be identified before they become an issue;
    - improve workforce planning practice and issue more useable guidance to assist employers. This will apply across health and social care and, for NHS Scotland, will be specific about how this can be done at national, regional and local levels, recognising the key interest of Health and Social Care Partnerships in this development; and
    - examine how collecting, reporting and triangulating workforce planning information might be undertaken more efficiently, so we ensure it embeds with strategic and financial planning issues and translates into planned rather than reactive action. This might also be explored in an integrated context, given the range of different tools and resources available.

17. For the longer term, the Workforce Plan will need to develop a series of actions, perhaps set within a framework of tools accessible by different employers, allowing them to use these to build sufficient numbers of appropriately trained and qualified staff. This will involve exploring how to develop better intelligence through workforce analysis – being clear how a range of demand factors impact on supply. We will want to describe this in more detail as we move to publish the National Discussion Document in early 2017.

Timescale

18. Designing a framework for workforce planning which can apply successfully to different sectors will take time. The arrangements for publishing the National Discussion Document and the Workforce Plan are:

- in **December 2016**, issue this Outline Discussion Paper, seeking input in parallel from key stakeholders and consulting with COSLA and other key local government partners, NHS Management Steering Group, the Scottish Partnership Forum, the Human Resources Working Group on Integration and employer representative bodies such as Scottish Care and the Coalition of Care and Support Providers in Scotland. There will also be discussions with NHS Scotland and Health and Social Care Partnerships, professional bodies, representatives from the primary care sector and other professional stakeholders;
- in **early 2017**, publish the National Discussion Document, aligning with other relevant publications/releases at that time; and
- in **Spring 2017**, publish the National Health and Social Care Workforce Plan, which NHS Boards and employers in the social care sector can use to support development of their local plans, working with Health and Social Care Partnerships as appropriate.

Approach

19. The proposed new approach in the Workforce Plan will require roles and responsibilities in respect of workforce planning activity to be clarified and will involve:

i. forging closer links between and among:

- senior managers in NHS Boards, local government and the social services sector responsible for strategic planning;
- planners in NHS Boards, local government and the social services sector involved with implementing robust, progressive workforce plans, and aligning them with those for financial and service planning;
- service managers, in a unique position to know the strengths and weaknesses of services to patients, service users and clients provided locally;
- groups of health and social care professionals, whose views on achieving an optimum workforce balance will help build a workforce which will meet the future needs of health and social care;
- trade unions across health and social care, whose input is key to creating the right working conditions for those professionals; and

ii. equipping NHS Boards, local government and the social care sector with the means to plan ahead effectively to ensure they have the right staff in the right place at the right time to provide safe, high-quality health and social care services for Scotland's people.

Next steps

20. We want as far as possible to use the **existing** infrastructure to work towards a Workforce Plan by:
    - using this Discussion Paper and the National Discussion Document to invite constructive input, views and comment; and
    - visiting NHS Boards, Health and Social Care Partnerships, COSLA, local authorities and other social services employers to seek views, intelligence and support; and consulting the full range of stakeholders across the health, social care sectors, independent sector, trade unions and professional/regulatory organisations, educational institutions and other interested parties.

21. Arrangements covering governance, data and risks are currently being put in place to underpin the development of the Workforce Plan. These will ensure priority issues faced by the health and social care sector are addressed in a fully inclusive way. Once agreed, these arrangements will be shared with relevant parties.

Challenges

22. Some of the workforce planning challenges specific to NHS Boards and social services sector are outlined below.

NHS Boards

23. Building a more effective workforce planning network with NHS managers, including HR Directors and workforce planners in NHS Boards, is urgently required.
    - **Nationally:** we will hold early discussions with HR Directors about the establishment of a national workforce planning group, to be taken forward in partnership between Scottish Government and the service, to ensure there is clarity of responsibility, governance and expectation. Dialogue to facilitate and establish this will involve membership from the wider medical and non-medical professions. This group will also need to consider how best to involve Health and Social Care Partnerships and social care representatives on practical workforce planning issues. The group will require a work programme that is solution-driven, and will need an active and dynamic agenda that prioritises workforce planning challenges, linked clearly to national priorities.
    - **Regionally:** regional workforce planning already takes place in the North, West and South East/Tayside – but it is variable in scope. A more inclusive approach is needed to allow solutions to be designed across individual NHS Board boundaries. The discussions above could also consider how work should be grouped at regional level, to evolve regional approaches to particular capacity challenges.

- **Locally:** we need to maintain links with individual NHS Boards, local authorities and Health and Social Care Partnerships to ensure they are aware of and able to respond to the challenges in the Workforce Plan.

Social care employers

24. The Workforce Plan will need to recognise and address the challenges faced by the social services sector in recruiting and retaining the staff needed to deliver social care services. It will need to be relevant in different contexts, and achieve a 'fit' between existing workforce plans within health and social care (including NHS Boards, Health and Social Care Partnerships and local authorities).

25. Opportunities for joint working on this topic should be explored to minimise duplication of effort. It may be possible in future, for example, to consider the scope of Health and Social Care Partnership and NHS Board workforce plans so that they apply in more focused ways to different parts of the workforce – for example, the workforce delivering community health and social care services, and the workforce which delivers acute sector services. There will be opportunities to look at these issues in the National Discussion Document in early 2017.

26. It may be appropriate for the social care services sector to consider: whether it might build national and regional approaches into its workforce planning; and how local flexibility can best operate (particularly in the context of local government). Discussion on this will require further engagement within the social care sector, specifically involving local government and its representative organisations. In the social services sector it is understood that most, if not all, organisations take decisions about workforce planning at senior level and collect data on current:

    - staff numbers and costs;
    - vacancies; and
    - training activity.

    Most organisations use this data for budget setting, day to day management and planning for short term needs. However relatively few use workforce planning tools – the most widely used being the Scottish Social Services Council Workforce Planning Guide[25].

25 http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=25.

27. There is acknowledgement within the social service sector[26] about the urgency of workforce planning issues in light of demographic effects (such as ageing workforce) which influence the ability to plan ahead, the reliance of forecasting on available budgets and the daily effects of service changes (with consequences in planning for workforce). There are strong interconnections between workforce planning and pay, recruitment and retention and a range of other factors. It is clear that this will require an integrated approach not only to planning for services but also to workforce planning. This will require a systematic approach informed by accurate, coordinated and relevant data, allowing available capacity to be deployed flexibly.

Health and Social Care Partnerships

28. Although Health and Social Care Partnerships are required to complete integrated workforce development plans, not all have yet been completed and there is some variance in their contents. The position of Health and Social Care Partnerships is relevant here too. Although Health and Social Care Partnerships are not employers themselves, they are tasked with managing joint budgets to provide integrated health and community care services in the most effective way possible. They will play a key role in shaping workforce demand and in supporting 'intelligent forecasting', which should be reflected in both NHS Scotland and social care services workforce planning.

Discussion

29. We plan to contact all NHS Boards, COSLA and Health and Social Care Partnerships as we engage on developing the National Discussion Document. While aims and expectations depend on effective communication, we are realistic about the audience we can achieve in the limited time available. All are important and will need good reason to invest in facilitated time.

26 "Recruitment and Retention in the Social Service Workforce in Scotland" – Shona Mulholland, Jo Fawcett and Sue Granville (Why Research).

30. We will aim to involve the following professional staff groupings, principally through their existing representative bodies but also, where possible, individually:
    - staff side representatives – including Scottish Partnership Forum, the Society for Personnel and Development Scotland, Unison, Unite, GMB, the Royal College of Nursing, the Royal College of Midwives, and the British Medical Association;
    - the HR Working Group on Integration;
    - COSLA;
    - NHS Boards and local government (through SOLACE);
    - Health and Social Care Partnerships;
    - HR and SP Directors;
    - Medical Directors;
    - Nursing Directors;
    - Chief Social Work Officers;
    - Finance Directors;
    - service managers;
    - workforce Planners in NHS Boards – regional and local – and in local authorities;
    - recruitment managers;
    - service planners, including for acute and elective services, as well as representatives from local cancer planning groups and other condition-specific groups (such as the National Advisory Committee on Stroke);
    - clinicians and health and social care professionals;
    - NHS Education in Scotland, Scottish Social Services Council and other regulatory and educational interests;
    - the Royal Colleges; and
    - social care employer representatives bodies – the Coalition of Care Providers in Scotland, Scottish Care and others.

31. We will communicate with the groups outlined above in various ways, including:
    - tapping into planned meetings of existing committees, boards and other gatherings as appropriate, rather than setting up new structures;
    - assessing whether 'roadshow'-type events – with regional/board variations taking account of local issues – may be useful;
    - holding specific small events or workshops – informal and flexible, with few attendees but lively discussion;
    - organising more formal meetings, with presentations followed by discussion; and
    - facilitated discussion, at events such as Strengthening the Links.

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Scottish Borders
Health and Social Care
PARTNERSHIP

LOCALITY PLANNING PROGRESS REPORT

Aim

1.1 The aim of this report is to update the Integration Joint Board (IJB) on work progressed by the Locality Co-ordinators on the development of locality plans and to propose the next steps for consultation and engagement.

1.2 Following consultation with frontline staff this report also proposes options for co-location of staff across the five localities to enable closer joint working and future options for Integrated Teams.

Background

2.1 In line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and subsequent Localities Guidance the Scottish Borders Partnership is committed to establishing a joint responsibility at a local level to improve the health and well-being of the residents of the Scottish Borders.

2.2 In May 2016 three Locality Co-ordinators were recruited with responsibility for developing locality plans across the five localities as well as supporting the redesign of locality based health and social care services.

Progress Report

3.1 **Locality Mapping –** locality data and information has been collated for each of the five localities and has been used to develop a summarised locality action plan for each locality. The action plans offer a summary of the demographics of each locality as well as highlighting what currently exists in terms of health and social care, third sector and independent sector services.

3.2 **Locality Plans –** in line with the principles of co-production five local working groups were established with the primary function of developing a locality plan for each locality. Led by the Locality Co-ordinators the working groups have been meeting monthly since September 2016 and comprise of local representatives from the following stakeholder groups: Service user, Carer, Community Nursing, Social Work, Pharmacy, Third Sector, Housing, Community Hospital Ward Manager and AHP. Despite ongoing attempts to secure GP representation on all five working groups, this has not been achieved to date and remains a significant issue. The Locality Working Groups have successfully contributed to the development of the summary action plans and are in the process of developing draft Locality Plans for all five localities for presentation to the IJB 27 March 2017. An example of a summary action plan can be seen in **Appendix One.**

3.3 **Co-location –** work has already been progressed to determine the feasibility of co-located integrated teams within each locality taking into consideration the required professional mix of teams and the opportunities for co-location within existing buildings. A number of workshops led by the Locality Co-ordinators and involving senior operational managers from across the partnership have been held to identify any practical issues related to the implementation of co-location of staff. Key groups of frontline staff across the partnership have been consulted regarding proposals for co-location and the following options have been identified:

Berwickshire Locality

- Base 1: Knoll Hospital/Health Centre, Duns
- Base 2: Health Centre, Eyemouth

Cheviot Locality

- Base 1: Community Hospital/Health Centre, Kelso
- Base 2: Health Centre, Jedburgh

Eildon Locality

- Base 1: Currie Road Health Centre, Galashiels
- Base 2: Health Centre, Selkirk
- Base 3: Health Centre, Melrose

Teviot Locality

- Base 1: Community Hospital/Teviot Medical Practice, Hawick

Tweeddale Locality

- Base1: Haylodge Hospital/Health Centre, Peebles

It should be noted that not all staff can be fully co-located in one site locality. Further work will be needed to consider IT requirements and address any practical arrangements to support any moves along with ongoing engagement with staff.

3.4 **Communication and Engagement –** since April 2016 the Locality Co-ordinators have engaged in extensive engagement activities with all key stakeholders. A key component has been the establishment of the five Locality Working Groups which provide a local forum for updating on progress and seeking views and comment from a wide range of local stakeholders - including social care and health staff, service users, carers, members of the public and third and independent sector representatives - to inform the development of local planning and service redesign. In addition to this the Locality Co-ordinators are due to attend Local Area Forums and the Patient Participation Forum between February and September 2017 to ensure stakeholders are fully updated on progress and have the opportunity to comment on developments to date. It should be noted that it has been difficult to secure formal GP representation on Locality Working Groups apart from an informal arrangement via one local GP who attends the Cheviot Group bi-monthly. The Locality Co-ordinators continue to try and engage with GP's through informal networks however this presents a risk to future locality planning and engagement.

Work Plan for Locality Co-ordinators Feb-Sept 2017

4.1 **Feb-March 2017:** Produce drafts of all five Locality Plans – fully populate with information, agree graphics and consult with all key stakeholders including Local

Area Forums. Present draft plans to the IJB on 27 March 2017. Secure venue and date for launch of plans. Present more detailed options for integrated teams to the Executive Management Team on 17 March and the IJB on the 27 March.

4.2 **April – May 2017:** Finalise all five Locality Plans for approval at the IJB on 29 May 2017. Plan and prepare for launch event. Consult with frontline staff on more detailed proposals for integrated teams and collate and analyse feedback received. Develop detailed implementation and communication plans for actions identified within Locality Plans as well as all options for integrated teams across the five localities.

4.3 **May – Sept 2017:** Support and co-ordinate the delivery of local implementation plans reporting on progress and issues arising to the EMT and IJB as required. It is worth noting that there is no current dedicated resource identified to support implementation beyond September 2017.

Summary

5.1 During the last 3 months the Locality Co-ordinators have produced summary action plans for all five localities as well as drafted an outline Locality Plan for Berwickshire, with a view to finalising drafts of all five Locality Plans by end of March 2017.

5.2 In consultation with key stakeholders options for co-location in all five localities have been developed and key actions in order to progress options have been identified. Future work will include progress on options for Integrated Teams at locality level.

5.3 A detailed work plan for the Locality Co-ordinators has been developed which outlines their priorities between February and September 2017.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the progress made by Locality Co-ordinators in relation to Locality Plans, integrated teams and communication and engagement.

The Health & Social Care Integration Joint Board is asked to **note and comment on** the summary Locality Action Plan.

The Health & Social Care Integration Joint Board is asked to **endorse** the proposal to hold a launch event following final approval of the Locality Plans.

The Health & Social Care Integration Joint Board is asked to **note** the Locality Co-ordinators work plan and timescales for implementation.

Policy/Strategy Implications	As detailed within the report.
Consultation	As detailed within the report.
Risk Assessment	N/A
Compliance with requirements on Equality and Diversity	Compliant

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Resource/Staffing Implications	As detailed within the report

Approved by

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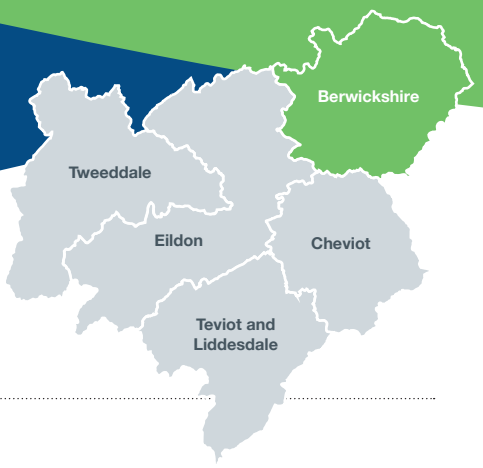
DRAFT LOCALITY ACTION PLAN
BERWICKSHIRE



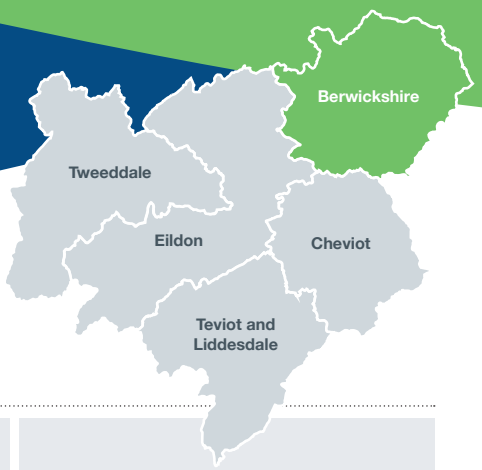
ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

NATIONAL OUTCOME	LOCAL OBJECTIVE	KEY PRIORITIES	ACTION PLAN
1, 2, 3, 7,8, 9	1,2 ,3, 4,5, 6, 7	To integrate services at a local level	• Bring together staff from NHS, SBC and the Third sector to work together within an integrated team • To establish weekly meetings between H&SC staff and third sector to improve communication and reduce the duplication for service users • Establish joint education sessions between H&SC staff to improve outcomes and experience for service user • Ensure staff available across the Locality to provide services when and where required • Work with staff and the community to devise new ways of working
1, 2, 3, 4, 7, 8, 9	1,2, 3, 4, 5, 6, 7, 9	To roll out care coordination to provide a single point of access to local services	• Establish Community Led Support model as a 'new Front door' for the access to services and information • Easier access to H& SC and third sector services to support the persons needs • Referrals are dealt with by the most appropriate person • Waiting lists will be reduced • Reduced number of people collecting the same information
1, 2, 3, 4, 5, 6, 7, 8, 9	1,2, 3,4,5, 6, 7, 9	Work with communities to develop local solutions	• Work with the local community to design and action the Local Health and Social Care plan • Day services review working with the community to find Local solutions • Identify Community led support premises within the Locality • Easier access to information at a Local level • Increase accessible transport
1,2,3, 4, 5, 6, 7, 9	1, 2,3, 6, 8,9	To promote healthy living and active ageing	• Ensure all people feel safe within their own environment • Identify housing to meet the local needs • Ensure community aware of Healthy Living Network Locality activity plan. • Ensure Locality aware of sport and leisure activities available across the locality • Promote activities, awareness and knowledge sharing across generations
1, 2, 3, 4, 5, 6, 7, 8	1,2,3, 4, 6, 8, 9	To improve the quality of life for people with long term conditions	• Adopt the National Anticipatory Care plan Locally • Develop integrated teams within the Locality-to improve outcomes for the people of Berwickshire • Increase early interventions to support people to remain at home and reduce the need for ED/GP intervention • Support the discharge from hospital at an appropriate stage with the right service intervention. • Early identification of people who have support needs to help manage their condition
1,2, 3, 4, 6, 7, 8, 9	1,2,3,4, 5, 6,7, 9	Promote support for independence and reablement so that all adults can live as independent lives as possible	• People can receive re ablement within their own home with appropriate staff including AHPs and carers • People can be discharged home from hospital earlier with the right support in place • Investigate whether Transitional care beds within Saltgreens can be established • Equipment is available locally when it is needed

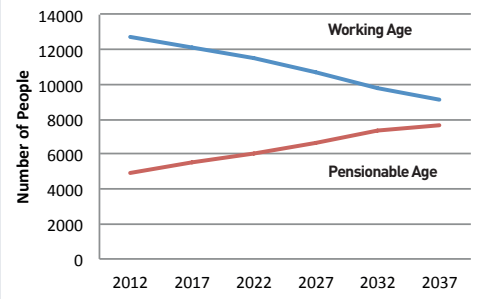
Scottish Borders **Health & Social Care** Partnership

DRAFT LOCALITY ACTION PLAN
BERWICKSHIRE



AREA PROFILE 2016

PROJECTED POPULATION 2012-2037 FOR BERWICKSHIRE



57.2% increase in **pensionable age**

28.1% decrease in **working age**

POPULATION

20,657 **population (est 2014*)**
(19% of the Scottish Borders)

15.1% aged **0-15**
(Scottish Borders = 16.7%)

60.4% aged **16-64**
(Scottish Borders = 60.2%)

24.5% aged **65+**
(Scottish Borders = 23.1%)

9.9% provide **unpaid care**

AREA

45.3% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

85% Remote rural 30% and Accessible rural 55%

Settlements with **more than 500 people:**

TOWN	POPULATION
Eyemouth	3,540
Duns	2,722
Coldstream	1,867
Chirnside	1,426
Greenlaw	629
Ayton	573
Coldingham	549

HEALTH & WELLBEING

LIFE EXPECTANCY RANGE

78.3 to **83 yrs** **men**
(Scottish Borders = 78.1%)

81.5 to **87.5 yrs** **women**
(Scottish Borders = 82%)

Higher rate of **of new cancer diagnosis**
(compared to Scottish Borders)

Lower rate of **early cancer deaths**
(compared to Scottish Borders and Scotland)

Lower rate of **suicide**
(compared to Scottish Borders and Scotland)

A&E ATTENDANCE

47.5% non-emergencies could be cared for within Locality of which **75+ age group represent the highest proportion**
(last year 43.5%)

52.5% **emergencies require hospital care**
(last year 56.5%)

7.67 **rate** of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

1,107 **on Diabetes Register**
17+ yrs

183 **on Dementia Register**

NEIGHBOURHOOD AND COMMUNITY

20.5% report **public transport** as an accessibility issue

People in Berwickshire place a **higher priority** on:

providing **sustainable transport links** including **demand responsive transport**

HOUSEHOLD PROFILE

aged 65+

26.8% **Berwickshire**
(Scottish Borders = 25.4%)
(Scotland = 20.7%)

7.9% **feel lonely** or **isolated**
(Scottish Borders = 6.1%)

12 **culture and sport facilities** operated by the public sector
(Scottish Borders = 69)

SAFETY

9.92 **rate** of **road** and **home safety incidents** per 1,000
(Scottish Borders = 7.65)

0.81 **rate** of **Fires** in **Homes** per 1,000
(Scottish Borders = 0.74)

8.1% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)

Scottish Borders
Health and Social Care
PARTNERSHIP

NHS BORDERS 2016/17 FESTIVE PERIOD REPORT

Aim

1.1 To update the Health and Social Care Partnership on NHS Borders' performance over the festive period: 16th December 2016 until 3rd January 2017. This period was 19 days long with 3 weekends, which is the same as covered last year, 17th December 2015 until 4th January 2016, making the periods comparative.

Background

2.1 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. The 2016/17 plan was discussed and subsequently approved at the 27th October 2016 NHS Borders Board meeting.

2.2 After each winter period the Winter Planning Group 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 2017.

Summary

3.1 The NHS Borders Festive Report has been attached as **Appendix 1**.

3.2 The report is being presented to the NHS Borders Strategy and Performance Committee on the 2nd March 2017. It has been reviewed by the NHS Borders Executive Team and approved by both the Director of Nursing, Midwifery and Acute Nursing Services for NHS Borders and the Interim Chief Officer for the Scottish Borders Health and Social Care Partnership.

Recommendation

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

Policy/Strategy Implications	Request from Scottish Government that all Health Boards produce a Winter Plan signed of by their Board in support of quality patient care. This report will inform the Winter Planning Process 2017/18
Consultation	Feedback was provided by the Winter Planning Group, Clinical Services and

	Managers and Partner organisations
Risk Assessment	The Winter Plan is designed to mitigate the risks associated with the winter and festive periods
Compliance with requirements on Equality and Diversity	The Report complies with requirements on Equality and Diversity
Resource/Staffing Implications	Resource and staffing implications were addressed within the Winter Plan

Approved by

Name	**Designation**	**Name**	**Designation**
Evelyn Rodger	Director of Midwifery, Nursing & Acute Services NHS Borders	Elaine Torrance	Chief Officer Scottish Borders Health and Social Care Partnership

Author(s)

Name	**Designation**	**Name**	**Designation**
Phillip Lunts	General Manager, Winter Planning Lead NHS Borders		

NHS BORDERS 2016/17 FESTIVE PERIOD REPORT

Aim

To update the Board on performance over the festive period only: 16th December 2016 until 3rd January 2017. This period was 19 days long with 3 weekends, which is the same as covered last year, 17th December 2015 until 4th January 2016, 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. The 2016/17 plan was discussed and subsequently approved at the 27th October 2016 NHS Borders Board meeting.

After each winter period the Winter Planning Group 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 2017.

Assessment

Strengths:

The following initiatives appeared to support the strong performance over the festive period 2016/17:

1. A focus on managing patient flow
    a. Repeat of cover arrangements for front door (BECS/ED) festive period that were implemented last year
    b. Robust patient flow management infrastructure – regular patient flow meetings, Hospital Safety Brief, Weekend and public holiday duty management team
    c. Cover at festive period – medical cover, support services
2. Staffing
    a. The proactive and pre-emptive recruitment of additional nursing staff through recruitment events along with HR working with Managers as early as possible have meant that vacancies have been filled quickly helping ensure staffing levels are adequate for the festive period
    b. The decision not to roster ward nursing staff annual leave over the festive period provided resilience in supporting areas of high demand. There was little dependence on bank or agency staffing.

3. Medical staffing arrangements were effective over the festive period (16th December to 3rd January), including additional senior medical staff presence at weekends and public holidays to enable senior decision-making and patient progress

What didn't work well from previous years - recommendations

Last year, the following actions were recommended that were not achieved this year:

- It was recommended that whole system work was undertaken to manage delayed discharges. Delayed discharges increased this year compared to last year
- It was recommended that elective operating should be reviewed for the first week in January. Elective operating was planned to recommence the first week in January this year, as it was felt that the impact of the Planned Care redesign would minimise the demand for elective beds.

Recommendations for Future Winter 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 need for all services to be operational over the New Year weekend and public holidays. Although there was a higher level of clinical support service provision (specialist nurses, AHPs etc) than in previous years on 3rd January, this was too late to support timely discharge. Enhanced services over the New Year public holidays next year would help maintain patient flow into January
- Increased social work services over the festive period, including access to both home care and care home providers
- A sustained Community Hospital Length of Stay of 18 days should be delivered.
- Implement learning from the project on discharge flow, including Delayed Discharges, working with Professor John Bolton.
- Consideration should be given in planning for the festive period next year as to whether elective operating should be restricted for the first 2-3 weeks of January based on the experience of elective operating that has occurred over previous festive periods
- Review of arrangements for annual leave allocation for all services, not just nursing staff over the festive period; and a review of the allocation of staff annual leave for the period immediately after the festive period – this year, there were significant staffing gaps from 4th January, as staff took annual leave. This needs to be agreed early in 2017 to allow time to plan rosters, annual leave allocation and ensure level loading.
- Although feedback suggests that messages about winter pressures were picked up well within social media, reach could be increased by working more closely with GP practices, community pharmacies and social work to ensure effective communication of winter messages

Emergency Department (ED) Activity Summary

Attendances at the Emergency Department over the festive period rose by 10.3% (130) this period compared to last year (Table 1). There was a small increase in Flow 1 (minor injuries and illness) patients this year of 5% (35) reflecting a similar increase the previous year. There was a combined increase in Flow 2 & 3 attendances through ED and AAU compared to last year of 10%. This breaks down as an increase of 20% (29) for attendances in Flow 2 (acute assessment) and 26% (65) for attendances in Flow 3 (medical admissions) seen in ED, with a 39% (68) reduction in Flow 2 & 3 patients seen in the Acute Assessment Unit (Table 5).

The busiest days for ED this festive period were Wednesday 28th December (89 attendances) and the public holidays following New Year: Monday 2nd January (101 attendances) and Tuesday 3rd January (96 attendances).This compares with the previous year, when the busiest 2 days were the Mondays immediately following Christmas and New Year.

There was a decrease of 42 (9%) in attendances at the weekends this year. 6% of this reduction is accounted for by the fact that Christmas Day, when there are traditionally lower attendances, fell on a Sunday, but there were also lower attendances on each Saturday compared to the previous year.

Attendances during the public holidays increased by 52 (17.1%) compared to last year. This year the public holidays landed on the days immediately after Christmas and New Year, when higher levels of activity are expected and did not include Christmas Day, which was a public holiday the previous year.

Table 1: ED Attendances

Year	Total Attendance		Total Breaches		Weekend Attendance[2]		Weekend Breaches[2]		Public Holiday Attendance		Public Holiday Breaches	
2012/13	1,266		72		454		10		248		7	
2013/14	1,320	(+54) 4.3%	16[1]	(-56) -77.8%	439	(-15) -3.3%	6	(-4) -40.0%	297[1]	(+53) 19.8%	1	(-6) -85.7%
2014/15	1,484	(+164) 12.4%	176	(+160) 1000%	475	(+36) 8.2%	54	(+48) 800%	309	(+12) 4.0%	22	(+22) 2200.0%
2015/16	1,259	(-225) -15.2%	36	(-140) -79.5%	468	(-7) -1.47%	12	(-42) -77.78%	304	(-12) -1.62%	7	(-15) -68.18%
2016/17	1,389	(+130) 10.3%	51	(+15) 41.7%	426	(-42) -8.97%	15	(+3) 25%	356	(+52) 17.1%	20	(+13) 185.7%

*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.

Table 2: ED Attendances by Flow

	Attendances					Percentage Difference on Previous Year			
Patient Flow Description	2012/13	2013/14	2014/15	2015/16	2016/17	2013/14	2014/15	2015/16	2016/17
Flow 1: Minor Injury & Illness	685	538	692	729	764	-21%	29%	5%	5%
Flow 2: Acute assessment - includes major injuries	102	249	192	146	175	144%	-23%	-24%	20%

Flow 3: Medical Admissions	361	371	466	248	313	3%	26%	-47%	26%
Flow 4: Surgical Admissions	118	162	134	136	137	37%	-17%	1%	1%
Total	**1266**	**1320**	**1484**	**1259**	**1389**	**4%**	**12%**	**-15%**	**10%**

There were 18 more breaches in ED this year compared to last year (Table 3). 28 (60%) of all breaches were related to bed availability. There were no increases in the number of breaches related to delays in assessment in ED. This suggests that measures taken to ensure adequate staffing within ED were effective.

Table 3: ED Breaches by Reason for Wait Description

Breach Reason for Wait Description	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Wait for bed	31	1	137	2	28
Wait for 1st ED Assessment	20	5	17	11	4
Other reason	2	2	6	8	3
Wait for Senior Review			6	1	1
Wait for treatment to end	5	1	5	1	1
Wait for transport	5	4	2	3	3
Clinical reason(s)	2		1	5	6
Wait for diagnostics test(s)	4	1	1	3	2
Wait for a specialist	3	2	1	2	3
Total	**72**	**16**	**176**	**36**	**51**

Despite the increase in breaches, ED performance against Emergency Access Standard for ED remained above the national standard of 95% (Table 4). Combined AAU and ED performance over this period was 95.05% compared to 95.7% last year.

Table 4: EAS Performance

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%

[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.

Acute Assessment Unit and Ambulatory Care Unit Summary

There were 68 fewer attendances through the Acute Assessment Unit during this period compared to last year - a 39% reduction. Almost half of this reduction was due to the earlier closure of AAU compared to last year. During this festive period, AAU closed at 18:00 hours compared to a 24hour service last year. There were 39 attendances after 1800 hours in 2015/16.

Of the patients seen in the Acute Assessment Unit this year, 45% of them were discharged home, compared to a 39% discharge rate in 2015/16.

Table 5: Acute Assessment Unit Attendances

Year	Total Attendances		Total Breaches		Weekend Attendance		Weekend Breaches		Public Holiday Attendance		Public Holiday Breaches	
2015/16	175		25		40		3		20		3	
2016/17	107	(-68) -39%	17	(-8) -32%	18	(-22) -55%	15	(+12) +400%	18	(-2) -10%	6	(3) 100%

There was an increase of 18 attendances through the Ambulatory Care Unit during this period with a 91.8% discharge rate. This compares to 81 patients attending Ambulatory Care in 2015/16 with a 92.6% discharge rate.

Table 6: Acute Assessment Unit Admissions

Year	Total Admissions		Weekend Admissions		Public Holiday Admissions	
2015/16	107		22		13	
2016/17	61	(146) -43%)	14	(-8) -36%	11	(-2) -15%

Table 7: Ambulatory Care Unit Attendances

Year	Total Attendances		Weekend Attendance		Public Holiday Attendance	
2015/16	81		14		14	
2016/17	98	(+17) 21.0%	17	(+3) 21.4%	20	(+6) 42.9%

Table 8: Ambulatory Care Unit Admissions & Discharges

Year	Total Admissions from ACU into Hospital		Total Discharges from ACU (not admitted)		Weekend Admissions from ACU into Hospital		Weekend Discharges from ACU (not admitted)		Public Holiday Admissions from ACU into Hospital		Public Holiday Discharges from ACU (not admitted)	
2015/16	6		75		0		14		2		12	
2016/17	6	(0) 0%	90	(+15) 20.0%	0	(0) 0%	16	(+2) 14.3%	1	(-1) -50%	19	(+7) 58.3%

There was a reduction in overall number of breaches of the Emergency Access Standard in AAU of 5, from 25 to 20, over this period compared to last year.

Table 9: AAU EAS Performance

Year	Total EAS Performance	Weekend EAS Performance	Public Holiday EAS Performance
2015/16	85.7%	92.5%	85.0%
2016/17	95.5%	96.5%	93.0%

BECS Activity Summary

The 2016-17 Festive Period for BECS showed a slight increase in volumes of patient care episodes compared to last year, with 28% activity as telephone advice, 45.9% patient attends and 26.2% home visits.

81.2% 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). 22.49% of patients seen were children.

87.1% of patients requiring a home visit were seen within their designated triage times. This sees a deterioration in performance from last year when the service was less busy. The geographical spread of home visits (Central 30.41%, South 18.36%, West 21.37%, East 28.49%) presented a challenge in light of peak workload between 9am and 1pm, and unpredicted reduced driver availability/staff sickness.

It is likely that reduced performance against time priorities, compared to last year, is a direct consequence of 5% increased overall service activity. Detailed festive planning meant that the service entered the festive period with full staffing, and additional clinician resource for the predicted busiest days (data provided by NHS24). However, when the flu-like cough virus hit it was evident that there was going to also be increased demand over the New Year, and for this reason additional clinician shifts were also added in response to this, to improve resilience that weekend.

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

Attends -

4 hours	92.9%
2 hours	63.6%
1 hour	31.8%

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. This can obviously be a challenge with our large geographical area.

Home visits -

4 hours	86.7%
2 hours	70.9%
1 hour	66.7%

Unforeseen driver shortages and staff illness meant that there were several key shifts when only 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.

BECS performance can also be measured against admission rates. Total admissions (includes 999 and refer to ED) for the festive period were 205 = 14.4% which compares favourably with the overall 2016 mean of 15.6%.

The top 10 conditions seen were coded as lower respiratory tract infection (141), urinary tract infection (115), upper respiratory infection (67), abdominal pain (67), attention to urinary catheter (65), medication requested (44), palliative care (41), skin infections (39), sepsis (36) and medication advice (34).

Table 10: 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%

*Variance from previous year

BGH Activity Summary

Total emergency admissions to the BGH increased by 1.4% (9) compared to the previous year (data excluding AAU attendances). Weekend admissions decreased by 14% (30), partially due to the fact that Christmas Day, with low numbers (27) of admissions, fell on a Sunday this year. There was an increase of 15.3% (20) in Public Holiday admissions, due to the fact that the immediate post-new year days, which traditionally have high levels of admissions, fell on public holidays. See Table 11 below.

The number of discharges increased by 4.8% (29), compared to the previous year; weekend discharges fell by 2.1% (3) and Public Holiday discharges increased by 37.4 % (34). However, the actual percentage of patients discharged compared to numbers admitted increased from 68% in 2015/16 to 78% this period for weekends and from 75% to 83% performance for Public Holidays. Patients' average length of stay for this period increased by 0.4 days to 3.32 days compared to 2.95 days last year, see Table 13 below.

There were 14 fewer emergency discharges than emergency admissions over this period, but an increase of 29 discharges compared to the 2015/16 festive period. Although total weekend discharges fell by 3 from the previous year, the actual percentage of patients discharged compared to numbers admitted increased from 68% to 78% for weekends and from 69% to 83% performance for Public Holidays. Patients' average length of stay for this period increased by 0.4 days to 3.32 days compared to 2.95 days last year, see Table 13 below.

Table 11: BGH Emergency Admissions & Discharges

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2012/13	742		758		233		192		153		161	
2013/14	732	(-10) -1.4%	761	(+3) 0.4%	119	(-114) -48.9	123	(-69) -35.9	156	(+3) 2.0%	113	(-48) -29.8%
2014/15	760	(+28) 3.8%	759	(-2) -0.3%	230	(+111) +93.3%	185	(+62) 50.4%	159	(+3) 1.9%	128	(+15) 13.3%
2015/16 Inc AAU	745	(-15) -2.0%	685	(-74) -9.7%	234	(+4) 1.7%	167	(-18) -9.7%	142	(-17) -10.7%	102	(-26) -20.3%
2016/17 Inc AAU	754	(+26) 3.6%	751	(+135) 21.9%	200	(-31) -13.4%	164	(+15) 10.1%	169	(+42) 33.1%	150	(+59) 64.8%

Figures below exclude AAU activity (which opened 02/12/2015) that is now reported separately												
2015/16 (exc AAU)	638		604		212		145		131		91	
2016/17 (exc AAU)	647	(+9) 1.4%	633	(+29) 4.8%	182	(-30) -14.2%	142	(-3) -2.1%	151	(+20) 15.3%	125	(+34) 37.4%

* 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 12: Emergency Admissions and Discharges by ward

Ward	Total Admissions	Total Discharges	Weekend Admissions[1]	Weekend Discharges[1]	Public Holiday Admissions	Public Holiday Discharges
MAU	303	110	96	30	69	19
ITU	6	3	3	1	1	
Ward 5	42	26	12	3	9	11
Ward 7	122	120	26	32	26	26
Ward 9	43	37	9	10	13	10
MKU	1	9		2		
Ward 12		25		3		5
Ward 15	98	101	28	30		18
Ward 16	24	39	5	6	25	11
Ward 17	1	1			7	1
SCBU	2	2			1	
Ward 4	2	58	1	16		9
BSU	2	18	1	4		2
Discharge Lounge		62				10
DME	1	22	1	5		3
Total	647	633	182	142	151	125

Table 13: BGH December 2016 Activity

	December Activity				Percentage Increase on Previous Year		
Month	Admissions	Discharges	Occupied Bed Days	ALoS (Days)	Admissions	Discharges	Occupied Bed Days
Dec-12	1661	1758	6090	3.46	-	-	-
Dec-13	1751	2050	6800	3.32	5.4%	16.6%	11.7%
Dec-14	1807	2115	7006	3.31	3.2%	3.2%	3.0%
Dec-15	1893	2213	6528	2.95	4.8%	4.6%	-6.8%
Dec-16	1647	1953	6477	3.32	-13.0%	-11.7%	-0.8%
Percentage Increase December 2016 compared with 2012					**-0.8%**	**11.1%**	**6.4%**

To improve patient flow in the BGH the aim is to discharge as many patients as possible before 11am and 12 mid day. The number discharged before both 11am and 12am was lower this year compared to last, at 22 (3.5%) and 46 (7.3%) respectively (Table 14).

Table 14: 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%)

An indicator that beds are under pressure is the number of boarders that are in the hospital at any one time. There were between 5 and 6 more boarders in the BGH on the days before Christmas this year compared to last year, with 17 more boarders in the days after Christmas. This reflects the pressure experienced after the Christmas public holidays. Please note that this data is based on weekly snapshots only (Table 15).

Table 15: 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 16: Boarders by Ward

Total Boarders	As at 16/12/2016	As at 23/12/2016	As at 30/12/2016	As at 04/01/2017
Ward 4	**1**	**1**		
Ward 5				
Ward 7	**2**	**1**	**5**	**12**
Ward 9	**2**	**1**	**4**	**3**
MKU		**1**		
Ward 16	**6**		**11**	**12**
Ward 15			**1**	
BSU	**1**	**2**	**6**	**3**
DME	**3**	**2**	**2**	
Total	**15**	**8**	**29**	**30**

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

There were 146 days of surge beds used during this period compared to 170 bed days for 2015/16, a fall of 14%.

Table 17: Overnight Transfers (8pm – 8am) by Ward

Total Boarders	As at 16/12/2016	As at 23/12/2016	As at 30/12/2016	As at 04/01/2017
MAU	**4**	**6**	**3**	**4**
Ward 4	**1**	**1**		
Ward 5			**2**	
Ward 7		**1**		**1**
Ward 9	**1**			**1**
MKU				
Ward 16				
BSU				
Ward 12-DME				
Ward 10-DME				
Total	**6**	**8**	**5**	**6**

Please note: these data show a snapshot of overnight transfers on each day as specified

Infection Control

During the festive period (16th December 2016 – 3rd January 2017), Kelso and Hay Lodge community hospitals were affected by bed closures due to influenza. During this period, Hay Lodge had one bay closed for 13 days and Kelso had two bays closed for 2 days. This equates to 90 blocked bed days in total of which 22 were blocked empty bed days. During the festive period in 2015/16, there were no closures for infection control reasons.

Elective Theatre Cancellations

9 patients' procedures were cancelled over the festive period. 3 of these were for a non-clinical reason (2.3%) which is over the local target set of 1.5% however is an improvement on the performance from the previous year (5.5%). This local target is based on the Scottish Board average for May – August 2015. Two cases were cancelled in order to accommodate an emergency and one was cancelled as there were no ITU beds available.

Table 18: Cancellations by type

Cancellation Type (Scottish Average)	Total Procedures	Total cancellations	Hospital (Target 1.5%)	Clinical (Target 2.8%)	Patient (Target 3.7%)	Other (Target 1%)
Cancellation Numbers (17/12/15–04/01/16)	**110**	**11**	**6**	**2**	**3**	**0**
Cancellation Numbers (16/12/16–03/01/17)	**133**	**9**	**3**	**1**	**5**	**0**
Cancellation Rate (17/12/15–04/01/16)	**-**	**10.0%**	**5.5%**	**1.8%**	**2.7%**	**0%**
Cancellation Rate (16/12/16–03/01/17)	**-**	**6.8%**	**2.3%**	**0.8%**	**3.8%**	**0%**

Table 19: Cancellations by Reason

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

Waiting Times

Treatment Time Guarantee/ Referral To Treatment / Stage of Treatment

There was reduced elective activity during the festive period due to the public holidays and consultant availability between Christmas and New Year. Orthopaedic joint operating was stopped from Tuesday 20th December for the festive period due to lack of AHP cover required for patient recovery and discharge over the weekend and public holidays. 4 full days of elective operating were lost due to public holidays and there were reduced lists on the 29th and 30th December.

There were 10 inpatient cancellations during November due to lack of bed capacity. In a normal month we would have expected to be able to accommodate most of these patients however the reduction in elective capacity over the festive period contributed to the 15 patients waiting over 12 weeks at the end of December.

18 Week Referral to Treatment performance is continuously over 90% for combined activity. There was reduced outpatient activity over the festive period due to the public holidays and consultant leave but this did not have a significant impact on patient journeys and the Referral to Treatment Target.

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

Total community hospital admissions decreased by 7 (12%) for the festive period 2016/17 compared to 2015/16. Overall numbers of discharges fell by 4 (7.5%). Weekend admissions decreased by 5 and there were increases in weekend discharges (up by 4) and public holiday admissions (up by 13) and discharges (up by 5). All these changes reflect low numbers.

Table 20: Community Hospital Admissions & Discharges

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%

* 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 21: Community Hospital December 2016 Activity

	December Activity				*Percentage Increase on Previous Year*		
Month	**Admissions**	**Discharges**	**Occupied Bed Days**	**ALoS (Days)**	***Admissions***	***Discharges***	***Occupied Bed Days***
Dec-12	109	106	2448	23.1	-	-	-
Dec-13	80	82	2529	30.8	*-26.6%*	*-22.6%*	*3.3%*
Dec-14	118	122	2517	20.6	*47.5%*	*48.8%*	*-0.5%*
Dec-15	101	99	2439	24.6	-14.4%	-18.9%	-3.1%
Dec-16	88	94	2572	27.4	-12.9%	-5.1%	5.5%
Percentage increase December 2016 compared with 2012					-19.3%	-11.3%	5.4%

This performance reflects the low number of discharges within community hospitals and the increasing length of stay. The average length of stay for patients in December 2016 increased by 3 days to 27.4 days compared to December 2015, with wide variations in length of stay between community hospitals. Some of this increase reflects the increased number of standard delayed discharges (from 16 in 2015/16 to 25 in 2016/17, an increase of 56%) within the hospitals.

External consultancy work has been commissioned through the Health & Social Care Partnership to improve Delayed Discharges and Patient Flow across the system; this will include reviewing community hospital activity and will support planned work to reduce Length of Stay. The learning from this will be used in the year ahead to plan for the festive period in 2017/18.

Table 22: Community Hospital December Length of Stay Comparison

Hospital	December 2015 Average Length of Stay (Days)	December 2016 Average Length of Stay (Days)
Hawick	15.5	19.3
Hay Lodge	30.7	20.4
Kelso	32.1	40.0
The Knoll	27.3	56.4
Total	24.6	27.4

Delayed Discharges

There was a 73% increase in average delayed discharge cases over the festive period in 2016 (27) compared to 2015 (16). The number of cases over 2 weeks as at 6th January 2017 was 23, compared to 12 in 2016. 14 of these delays were in Community Hospitals, but there were increases in the numbers delayed in the BGH and Mental Health. The numbers over 72 hours as at 6th January 2017 was 28, compared to 17 in 2016.

The top 3 reasons for delay were:

- wait for care package (average 6.75 patients per week - unchanged since last year)
- completion of social work assessment (11 compared to 4.25 last year)
- wait for care home placements (5 compared to 0.25 last year). This latter issue may be due to the cessation in use of flex beds this winter. 6 patients were in flex beds during the 2015/16 festive period, with occupied bed days of 98 days.

There was a significant reduction in the number of complex cases on the list from an average of 12.5 in 2015/16 to an average of 4.25 this year.

Actions currently being undertaken to reduce delayed discharges include:

1. Revised, action-focused and time-bound Delayed Discharge review process, including action tracker and escalation
2. Senior Manager allocated to manage each delayed discharge
3. Tests of change to develop systems for addressing delays in patient pathways to prevent individual patients becoming delayed discharges and at key points once delayed
4. Range of work to increase homecare capacity, including testing of the use of Health Care Assistants to support rapid access to home care
5. Establishment of transitional care capacity to support patients not yet ready to return home

Learning from these actions will be taken forward to inform festive period planning for 2017/18.

Table 23: Delayed Discharges comparison by week

Total Delayed Discharges	As at 16/12/2016			As at 23/12/2016			As at 29/12/2016			As at 06/01/2017		
	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks
BGH	6	2	2	6	6	1	4	4	2	6	6	3
Community Hospitals	14	8	7	16	10	5	18	18	7	17	16	14
Mental Health	4	2	2	6	1	0	6	6	1	6	6	6
Total	**24**	**12**	**11**	**28**	**17**	**6**	**28**	**28**	**10**	**29**	**28**	**23**

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

Table 24: Delayed Discharges by reason for delay

Total Delayed Discharges	As at 16/12/2016			As at 23/12/2016			As at 29/12/2016			As at 06/01/2017		
	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks
Delay reasons												
11B Awaiting completion of post-hospital social care assessment (including transfer to another area team)	8	2	1	10	4	1	12	12	3	14	13	9
24B Awaiting place availability in Independent Residential Home	1	1	1	2	2	0	5	5	1	4	4	4
24C Awaiting place availability in Nursing Home (not NHS funded)	6	4	4	9	7	4	2	2	1	3	3	2
25D Awaiting completion of social care arrangements to live in their own home - awaiting social support (non-availability of services)	7	5	5	5	2	1	8	8	4	7	7	7
25F Awaiting completion of social care arrangements - Re-Housing provision (including sheltered housing and homeless patients)	2	0	0	2	2	0	1	1	1	1	1	1
Total	**24**	**12**	**11**	**28**	**17**	**6**	**28**	**28**	**10**	**29**	**28**	**23**

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

Overall bed days lost to delayed discharges rose from 480 for the festive period in 2015/16 to 573 for this festive period, an increase of 19%. There were 26 more breaches due to waits for beds this period compared to last year.

Table 25: Delayed Discharge Occupied Bed Days – Comparison between festive period 2015/16 and 2016/17

Delayed Discharge Occupied Bed Days	Festive Period 2015/16			Festive Period 2016/17		
	Standard	Complex	Total	Standard	Complex	Total
BGH	14	51	65	93	0	93
Community Hospitals	155	160	315	307	54	361
Mental Health	83	17	100	81	38	119
Total	252	228	480	481	92	573

Table 26: Complex Delayed Discharges by area

Delayed Discharges	As at 16/12/2016	As at 23/12/2016	As at 29/12/2016	As at 06/01/2017
	Complex	Complex	Complex	Complex
BGH	0	0	0	0
Community Hospitals	3	3	3	3
Mental Health	2	1	1	1
Total	**5**	**4**	**4**	**4**

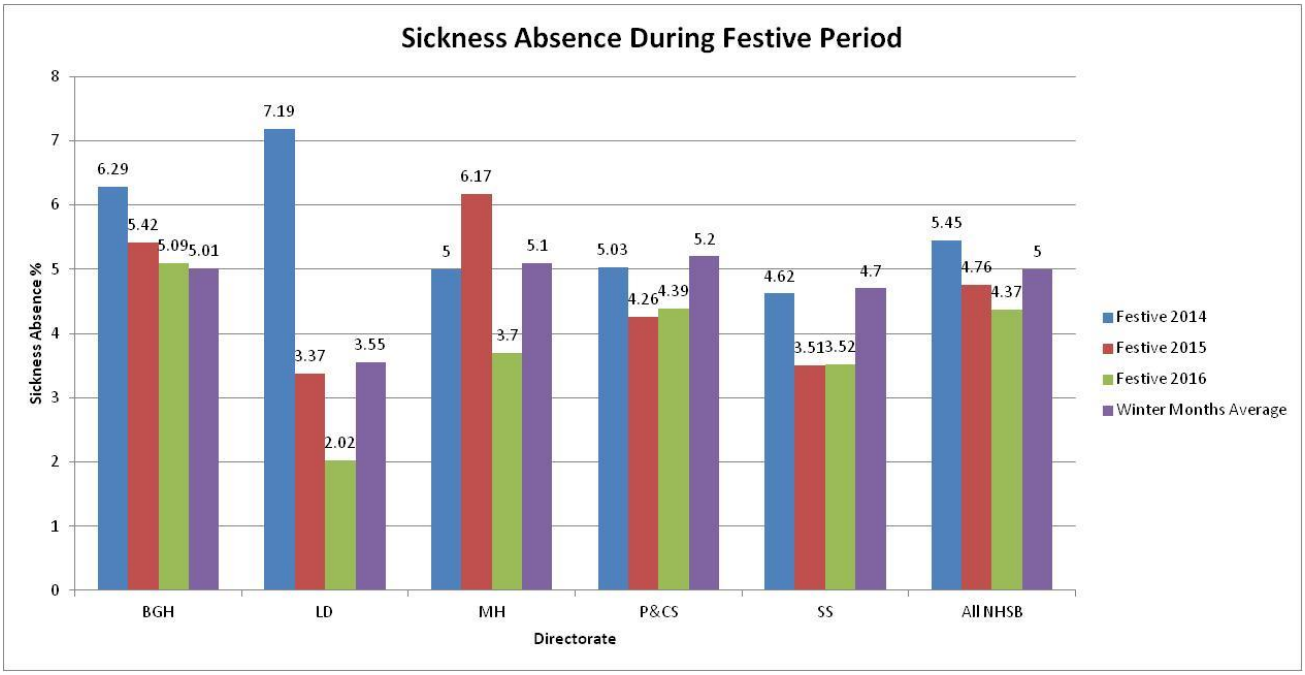
Please note: these data show a snapshot of current delayed discharges on each day as specified

Most delayed discharges continued to be in Community Hospitals – 60% compared to 76% last year; with a rise in numbers of delayed discharges in Mental Health (20% compared to 9%) and BGH (20% compared to 15%).

Staff Sickness Absence

The sickness absence rate over the festive period for 2016/17 was 4.37%. This rate saw a decrease of 8.2% of the sickness absence rate from the festive period of the previous year (2015/16) where the rate was 4.76%. On average over the winter months the absence rate sits at approximately 5.00%.

This Festive period saw BGH, LD, and MH all have a decrease in their rate of absence and P&CS and SS saw a slight increase in their level of sickness absence (<0.2%) when compared with the same period last year. The Learning Disabilities and Mental Health Services both saw a significant decrease in their rates from 3.37% to 2.02% and 6.17% to 3.7% respectively. See the chart above. All clinical boards reported a lower rate of sickness absence during this period compared to their average rate of sickness absence during the winter months. The one exception was the BGH whose rate was 0.08% higher than the winter month average.



During this festive period 7 departments (headcount > 14) report a sickness absence rate greater than 10% compared to the previous year where there were 9 departments with a sickness absence rate of greater than 10% (Table 27).

Table 27: Teams (>14 headcount) with sickness absence > 10 % during Festive 2016/17 period

Department	Headcount %	Festive 2016 %	Festive 2015 %	Festive 2014 %	Winter Months Average %
Ward 16	19	16.28	6.57	7.92	8.09
Ward 4	39	15.97	8.45	10.59	6.98
Hawick Hospital	35	14.65	3.76	4.65	6.91
Ward 12	42	12.67	2.52	3.68	4.42
Ward 9	38	12.41	7.07	8.83	6.39
Ward 7 and PSAU	48	11.51	10.91	7.32	6.93
Ward 5 - Cardiology	25	10.34	2.55		7.38

This Festive period there has been a noticeable increase of '*cold, cough, flu'* from last year although the rate was similar to that of the 2014 festive period and also the winter average rate. The *'other unknown causes'* reasons used when recording absence on SSTS was 5% lower when compared to the same period last year. Generally, the distribution of sickness absence reasons during this year's festive period is similar to the pattern evidenced during the winter months (Table 28).

Table 28: Most common reasons of sickness absence during 2016/17 Festive period

Absence Reason	Festive 2016 %	Festive 2015 %	Festive 2014 %	Winter Months Average %
Anxiety/stress/depression	21.60	23.8	23.8	20.98
Other musculoskeletal problems	9.73	8.33	13.13	9.4
Gastro-intestinal problems	9.06	8.06	5.63	7.17
Cold, cough, flu - influenza	8.76	4.19	8.02	8.39
Other known causes	8.01	13.41	4.63	10.24
Unknown causes/not specified	6.84	7.82	3.1	7.69
Back problems	6.64	5.66	6.05	5.62
Injury, fracture	6.40	6.93	10.3	6.44
Chest & respiratory problems	6.06	5.4	6.08	5.38
Pregnancy related disorders	5.27	4.31	1.49	2.97

There was no Medical Locum cover for the period for Sickness Absence.

Media Focus on Festive Period

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 stock up on the prescription medicines that they would require over the festive period. These messages were enhanced by the national activity co-ordinated by NHS24 which utilised once again the 'Doctor Owl' character. The other key message was the 'know who to turn to' message, fronted by the 'Meet Ed' campaign, the key message of which is to only present at the Emergency Department in an emergency situation, and utilise instead support and advice available from GPs, Pharmacies and Minor Injury Units.

Our communications focussed on media messaging through print (primarily local press) and SB Connect (delivered to every household across the Borders), NHS Borders website and social media. There was no paid for activity by NHS Borders over the festive period. A 'Weekly Winter Update' (WWU) template was tested over the festive period which carried our key messages in a visual and easy to read format. This had a new and significant reach on social media over the period, was widely shared, and picked up by other health boards who communicated it to their followers. We also saw a near three fold increase in the number of visits to the 'know who to turn to' page on the NHS Borders website over the festive period http://www.nhsborders.scot.nhs.uk/patients-and-visitors/know-who-to-turn-to/winter/

Weekly Winter Update – December 21st 2016

There are many instances of diarrhoea and vomiting in schools, nurseries and care homes across the Borders. Please remember to stay away from hospitals and other healthcare settings for 48 hours if you have had d&v and practice good hand hygiene to help prevent the spread of infection.

Your Pharmacist can provide expert advice and treatment for a range of common illnesses such as coughs, colds and sore throats. Most pharmacies are open on Christmas Eve (Saturday opening hours apply). Please remember to keep your medicine cabinet adequately stocked up over the festive period.

The A&E department is usually very busy between Christmas and New Year. Sometimes patients who come to A&E could be treated elsewhere, for example at a minor injury unit or at their pharmacy. Please remember to save the Emergency Department for emergencies only.

Summary

Although the festive period 2016/2017 was more challenging than the same period last year (increased breaches of the Emergency Access Standard, increased boarders, increased delayed discharges), NHS Borders continued to achieve over 95% on the Emergency Access Standard, numbers of surge beds open reduced and elective cancellations decreased compared to the previous year.

However, although numbers of admissions did not increase, low numbers of discharges in community hospitals and an increased number of delayed discharges resulted in a reduction in available bed capacity, leading to delays in admitting patients as demonstrated by increased numbers of breaches of the Emergency Access Standard.

The key areas of success built on the successful changes made last year

- the effective nurse staffing arrangements. Proactive recruitment to staffing for additional bed capacity, and the agreement not to schedule leave for nursing staff meant that there was very good availability of staff over this period. This gave flexibility in managing patient flow
- the medical staffing arrangements. There was additional senior medical staffing over the weekends and public holidays to avoid delays and meant that senior medical decision-making continued throughout the festive period
- ED staffing. The enhanced staffing meant that very few patients breached the Emergency Access Standard as a result of delays to assessment.

- the support service arrangements. There was increased availability of support service staff, including diagnostic and specialist nurse staffing on the public holidays after Christmas and New Year, which assisted in progressing patient care and discharge
- the patient flow management arrangements. The consistent presence of a duty management team across the weekends and public holidays provided strong direction each day and ensured that patient flow was effectively managed.

There was improved and closer working with both social work and Scottish Ambulance Service. There was a limited social worker presence on the weekends and the public holiday on Tuesday 3rd January. Scottish Ambulance Service provided an enhanced out of hours service on public holidays and additional vehicles on the normal working days before and after public holidays

However, there were particular challenges due to lack of any Patient Transport Service on New Years Day. The limited social work service was not able to access homecare or care homes during the public holidays. Although there was good support service presence on Tuesday 3rd January, there was very limited support at the weekends and on 2nd January, when it would have helped with progressing discharges, including social work and the Scottish Ambulance Service. A recommendation for next year is to seek to establish as far as possible, normal service availability for this period.

Projects to sustainably deliver and maintain reduced Community Hospital Length of Stay and reduced delayed discharges should be progressed and fully completed by August 2017.

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
Alasdair Pattinson, General Manager, Primary and Community Services
Sam Whiting, Infection Control Manager
Clare Oliver, Communications Manager
Karen Shakespeare, Planning and Performance Manager
Meriel Smith, Planning and Performance Officer

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Scottish Borders
Health and Social Care
PARTNERSHIP

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

Aim

1.1 The aim of this report is to provide an overview of the monitoring position of the Health and Social Care Partnership Budget at 31 December 2016. This includes an update on the range of pressures being experienced within Health and Social Care and proposed actions for mitigation.

Background

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

2.2 On the 30th March 2016, the Integration Joint Board (IJB) agreed the delegation of **£139.150m** of resources supporting integrated health and social care functions for financial year 2016/17. At the same time, it noted the proposed budget of **£18.128m** relating to the large hospitals budget set-aside.

2.3 This report sets out the current monitoring position on both the delegated and set-aside budgets at 31 December 2016, identifying key areas of financial pressure. Mitigating actions are in place to address these pressures and in aggregate, form a recovery plan for the partnership. Given the updated financial position, IJB members are recommended at this juncture, to direct remaining social care funding on a non-recurring basis to enable full financial balance on the delegated budget to be planned for and delivered.

Overview of Monitoring Position at 31 December 2016

Delegated Budget

3.1 At 31 December 2016, the delegated budget is now reporting a projected outturn of **£139.893m** against a current budget of **£139.150m** resulting in a projected adverse variance of **£0.743m** in total. This accounts for the projected impact of the recovery plan which has been implemented across healthcare functions. As previously reported to the IJB at the meeting in January, the total projected value of the recovery plan across delegated healthcare functions is **£4.154m.** This is a significant achievement in the contexts of substantial financial pressure and limited flexibility.

3.2 Excluding the impact of recovery, the projected financial position comprises considerable adverse variance across a range of healthcare functions delegated to

the Integration Joint Board which in total amount to **£4.615m**. This represents a favourable movement from the position previously reported to the IJB at the meeting in December and reflects the agreed actions within the NHS Borders recovery plan, together with other delivered efficiencies such as through the redesign of the Out of Hours service and allocated savings targets in Mental Health. There remain however, a number of key drivers of consider financial pressure across healthcare functions within and beyond those delegated to the IJB. Ongoing, the partnership's Executive Management Team continue to work to mitigate these pressures, particularly across areas such as patient flow and unscheduled hospital stay, through implementing solutions to minimising adverse impact such as delayed discharge.

3.3 Whilst many actions have been or are being delivered currently, the delivery of this recovery plan by NHS Borders continues to carry a significant degree of risk particularly linked to the remaining winter months and Prescribing costs. The highest element of risk to partnership finances over the medium-term continues to relate to the non-recurring nature of a significant proportion of targeted savings within the recovery plan.

3.4 Social care functions are currently projecting an adverse variance of £282k which require mitigating actions or additional funding sources prior to the end of the financial year.

3.5 It is also worth noting that the reported position is based on the December 2016 month-end. There are a number of service areas where further pressures have being experienced since. Across social care for example, an increased number of residential care beds commissioned together with other pressures appears to have further compounded the pressure reported above by an additional £100k. Other areas of risk include Prescribing, where based on latest available information, there has been a significant increase in the volume of prescriptions and the cost of certain drugs, and the pressures on patient flow across both health and social care. .

3.6 The position regarding the projected delivery of planned efficiencies across healthcare and social care functions delegated to the IJB remains largely unchanged from that reported to the IJB in December 2017.

Large Hospital Budget Set-Aside

3.6 As previously reported during 2016/17, NHS Borders is currently experiencing the impact of a range of pressures across the large-hospitals budget set-aside for the population of the Scottish Borders. These pressures have increased since the last report attributable to nurse agency spend across wards, surge capacity costs into elective areas of the hospital and ongoing unprecedented medical locum costs. Supplies and equipment costs have also shown an increase linked to activity increases.

3.7 **£1.623m** of the overall NHS Borders recovery plan actions are targeted at mitigating the projected adverse pressure on the set-aside budget. This has resulted in **£2.905m** of a residual financial pressure on this budget area, which will be part-mitigated, as previously reported, by over-delivery of financial savings within wider-non-delegated healthcare functions, against current projected pressures.

Further Action

4.1 The partnership's Executive Management Team (EMT) continues to work together to identify further remedial actions / efficiencies in order to address the residual adverse pressure within the delegated and set-aside budgets. Whilst a number of transformational and efficiency targeting initiatives are being developed, at this late stage of the financial year however, it is unlikely that they will impact on the current projected financial position. Based on current information the projected year end position is unchanged with three months of the financial year remaining and pressures increasing across the health and social care system.

4.2 It should be recognised that considerable work has been undertaken during 2016/17 across both healthcare and social care functions in order to address pressures experienced. Nevertheless, the IJB continues to forecast an overspend position. It is again recommended therefore that the IJB uses the resources at its disposal to ensure financial targets are delivered.

4.3 In order to give certainty in planning and delivery in 2016/17, the Executive Management Team has agreed to recommend to the IJB the direction of remaining 2016/17 social care funding now. In the unlikely event of the funding, in whole or part, not being required however, the partnership now has a Reserves Policy under which it may carry forward the unutilised resource alongside any uncommitted Integrated Care Fund monies.

4.4 EMT is also seeking to identify how other funding sources can be utilised in a supporting way this financial year. A number of other partnerships, as a result of considerable overspend across healthcare functions, have already directed underspends / slippage in the 2016/17 ICF allocation from the Scottish Government directly to funding shortfalls in their delegated budget affordability. Whilst this comes at the opportunity cost of using this resource to enable and pump-prime transformational activity, given the lack of other options currently available, it has been a clear requirement for these partnerships in order to help them mitigate the unprecedented and challenging affordability gap they face. Depending on the pressures encountered in the remaining months of the financial year, this approach may also be required in Scottish Borders.

Risk

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

- The level of efficiency and savings required in order to ensure the affordability of health and social care services. For the delegated budget, £4.710m of planned healthcare functions efficiencies required delivery during 2016/17 and £2.663m relating to social care – this has been a key challenge this financial year, primarily in relation to the former;
- In terms of the recovery plan for 2016/17, given the level of remedial savings required, a fully funded plan across all of delegated health and social care functions, set-aside functions and wider NHS Borders functions has yet to be achieved;

- Assumptions made that all factors which drive the costs of health and social care service provision remain stable during the remainder of the year remains a risk. This is in the context of significant or volatile demand and price levels, particularly in relation to unplanned admissions to hospital, social care including residential care home demand and the retendering of care at home, the implementation of the living wage and prescribing;
- The significant level of non-recurring efficiency and savings actions on which the partnership's budget remains predicated poses a significant threat to the medium-term sustainability of health and social care functions. The development of a large-scale strategic transformation programme for the medium-term will address this however;
- Future financial allocations and government settlements against the backdrop of likely increasing demand and price factors will also challenge sustainability and medium-term affordability.

Recommendation

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

The Health & Social Care Integration Joint Board is asked to **note** the reasons for recommending the direction of the remaining social care funding allocation for 2016/17 in order to enable certainty and assurance over the planning to mitigating remaining healthcare and social care pressures during the remainder of the year

The Health & Social Care Integration Joint Board is asked to **approve** the direction of the balance of the social care funding £677k in order to mitigate the current projected residual pressure within the healthcare and social care delegated budgets

Policy/Strategy Implications	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	The report has been considered by the Executive Management team and approved by NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer in terms of factual accuracy. Both partner organisations have contributed to its development and will work closely with IJB officers in delivering its outcomes.
Risk Assessment	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.
Compliance with requirements on Equality and Diversity	There are no equalities impacts arising from the report.
Resource/Staffing Implications	No resourcing implications beyond the financial resources identified within the report.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer IJB		

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MONTHLY REVENUE MANAGEMENT REPORT

Joint Health and Social Care Budget - Delegated	2016/17				AT END OF MTH: December						
	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	18,268	14,731	13,592	1,139	18,894	18,808	86	52	20	20	
Joint Mental Health Service	15,977	11,896	11,894	2	16,038	15,995	43	352	316	315	
Joint Alcohol and Drug Service	948	555	551	4	918	866	52	3	3	3	
Older People Service	28,126	19,152	16,319	2,833	26,127	26,644	(517)	23	0	0	
Physical Disability Service	3,180	2,578	2,481	97	3,426	3,346	80	0	0	0	
Generic Services	72,651	55,639	57,042	(1,403)	73,747	74,234	(487)	604	516	520	
Total	139,150	104,551	101,879	2,672	139,150	139,893	(743)	1034	854	857	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	38,736	34,512	4,224	51,798	52,080	(282)				
NHS Funding from Sgovt etc	87,352	65,815	67,367	(1,552)	87,352	87,813	(461)				
Total	139,150	104,551	101,879	2,672	139,150	139,893	(743)				

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**18,268**	**14,731**	**13,592**	**1,139**	**18,894**	**18,808**	**86**	**52**	**20**	**20**	
Residential Care	4,181	2,966	3,200	(234)	3,973	3,969	4	0	0	0	
Homecare	2,582	4,542	3,258	1,284	5,382	5,405	(23)	0	0	0	
Day Care	2,091	1,213	1,229	(16)	1,664	1,667	(3)	3	0	0	
Community Based Services	7,139	4,278	4,174	104	5,529	5,454	75	0	0	0	
Respite	200	148	170	(22)	209	229	(20)	0	0	0	
Other	2,075	1,584	1,561	23	2,137	2,084	53	49	20	20	
Joint Mental Health Service	**15,977**	**11,896**	**11,894**	**2**	**16,038**	**15,995**	**43**	**352**	**316**	**315**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	190	147	120	27	200	195	5	0	0	0	
Day Care	186	138	107	31	184	196	(12)	5	0	0	
Community Based Services	788	484	527	(43)	729	677	52	0	0	0	
Respite	15	12	3	9	16	3	13	0	0	0	
SDS	102	86	100	(14)	115	130	(15)	0	0	0	
Mental Health Team	14,696	10,978	10,986	(8)	14,726	14,726	0	347	316	315	
Choose Life	0	51	51	0	68	68	0	0	0	0	
Joint Alcohol and Drug Service	**948**	**555**	**551**	**4**	**918**	**866**	**52**	**3**	**3**	**3**	
D & A Commissioned Services	820	555	551	4	790	738	52	0	0	0	
D & A Team	128	0	0	0	128	128	0	3	3	3	
Older People Service	**28,126**	**19,152**	**16,319**	**2,833**	**26,127**	**26,644**	**(517)**	**23**	**0**	**0**	
Residential Care	11,422	8,479	8,998	(519)	11,579	12,198	(619)	0	0	0	
Homecare	8,025	5,171	5,370	(199)	7,092	7,002	90	0	0	0	
Day Care	1,001	668	625	43	913	912	1	0	0	0	
Community Based Services	999	2,254	1,688	566	3,004	3,046	(42)	16	0	0	
Extra Care Housing	545	409	360	49	545	548	(3)	0	0	0	
Housing with Care	409	382	333	49	509	517	(8)	0	0	0	
Dementia Services	37	(222)	(91)	(131)	(209)	(212)	3	0	0	0	
Delayed Discharge	267	100	201	(101)	267	262	5	0	0	0	
Other	5,421	1,911	(1,165)	3,076	2,427	2,371	56	7	0	0	
Physical Disability Service	**3,180**	**2,578**	**2,481**	**97**	**3,426**	**3,346**	**80**	**0**	**0**	**0**	
Residential Care	566	340	224	116	506	279	227	0	0	0	
Homecare	1,747	1,054	1,035	19	1,425	1,393	32	0	0	0	
Day Care	201	50	49	1	67	67	0	0	0	0	
Community Based Services	666	1,134	1,173	(39)	1,428	1,607	(179)	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**72,651**	**55,639**	**57,042**	**(1,403)**	**73,747**	**74,234**	**(487)**	**604**	**516**	**520**	
Community Hospitals	4,802	3,462	3,644	(182)	4,802	5,072	(270)	115	122	123	
Prescribing	22,436	16,747	18,192	(1,445)	22,436	24,436	(2,000)	0	0	0	
AHP Services	5,658	4,276	4,330	(54)	5,658	5,708	(50)	144	139	140	
General Medical Services	16,933	12,932	12,932	0	16,933	16,933	0	4	4	4	
Community Nursing	4,387	3,319	3,331	(12)	4,387	4,437	(50)	110	103	105	
Assesment and Care Management	0	0	0	0	0	0	0	0	0	0	
Group Managers	0	0	0	0	0	0	0	0	0	0	
Service Managers	0	0	0	0	0	0	0	0	0	0	
Planning Team	0	0	0	0	0	0	0	0	0	0	
Locality Offices	0	0	0	0	0	0	0	69	0	0	
SB Carers	0	0	0	0	0	0	0	0	0	0	
BAES	732	706	927	(221)	1,021	1,032	(11)	0	0	0	
Duty Hub	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	42	26	16	56	55	1	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	36	(104)	140	96	96	0	0	0	0	
OT	0	0	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	32	24	8	43	34	9	0	0	0	
Out of Hours	2,131	1,626	1,355	271	2,131	1,819	312	0	0	0	
Community Based Services	0	176	(95)	271	234	285	(51)	0	0	0	
Sexual Health	558	471	501	(30)	558	602	(44)	7	6	6	
Public dental Services	3,324	2,784	2,777	7	3,324	3,324	0	78	78	79	
Community Pharmacy Services	3,933	3,017	2,984	33	3,933	3,933	0	0	0	0	
Continence Services	441	337	311	26	441	433	8	3	3	3	
Smoking Cessation	209	187	144	43	209	179	30	4	5	5	
Primary & Community Management	1,684	1,333	1,588	(255)	1,684	1,982	(298)	34	44	42	
Health Promotion	438	356	327	29	438	405	33	8	12	12	
Opthalmic Services	1,591	1,223	1,278	(55)	1,591	1,591	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	0	0	
Accomodation Costs	0	0	0	0	0	0	0	0	0	0	
Resource Transfer	2,609	1,972	1,972	0	2,609	2,609	0	0	0	0	
Other	5,243	2,846	2,839	7	5,720	5,664	56	28	0	0	
Health and Social Care Fund	0	0	0	0	0	0	0	0	0	0	
Savings - Planned	(4,557)	(2,241)	(2,241)	0	(4,557)	(2,241)	(2,316)	0	0	0	
Savings - Recovery (unallocated)	0	0	0	0	0	(4,154)	4,154	0	0	0	
Total	**139,150**	**104,551**	**101,879**	**2,672**	**139,150**	**139,893**	**(743)**	**1,034**	**854**	**857**	
Financed By:											
AEF, Council Tax and Fees & Charges	51,798	38,736	34,512	4,224	51,798	52,080	(282)				
NHS Funding from Sgovt etc	87,352	65,815	67,367	(1,552)	87,352	87,813	(461)				
Total	**139,150**	**104,551**	**101,879**	**2,672**	**139,150**	**139,893**	**(743)**				

MONTHLY REVENUE MANAGEMENT REPORT

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

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Joint Learning Disability Service	**3,599**	**2,724**	**2,626**	**98**	**3,599**	**3,569**	**30**	**20**	**20**	**20**	
Residential Care	2,689	2,019	1,947	72	2,689	2,689	0	0	0	0	
Homecare	0			0	0	0	0	0	0	0	
Day Care	0			0	0	0	0	0	0	0	
Community Based Services	0			0	0	0	0	0	0	0	
Respite	0			0	0	0	0	0	0	0	
Other	910	705	679	26	910	880	30	20	20	20	
Joint Mental Health Service	**14,015**	**10,461**	**10,480**	**(19)**	**14,015**	**14,015**	**0**	**327**	**316**	**315**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Respite	0	0	0	0	0	0	0	0	0	0	
SDS	0	0	0	0	0	0	0	0	0	0	
Choose Life	0	0	0	0	0	0	0	0	0	0	
Mental Health Team	14,015	10,461	10,480	(19)	14,015	14,015	0	327	316	315	
Joint Alcohol and Drug Service	**749**	**461**	**461**	**0**	**749**	**749**	**0**	**3**	**3**	**3**	
D & A Commissioned Services	621	461	461	0	621	621	0	0	0	0	
D & A Team	128	0	0	0	128	128	0	3	3	3	
Older People Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	0	0	
Housing with Care	0	0	0	0	0	0	0	0	0	0	
Dementia Services	0	0	0	0	0	0	0	0	0	0	
Delayed Discharge	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	
Physical Disability Service	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Residential Care	0	0	0	0	0	0	0	0	0	0	
Homecare	0	0	0	0	0	0	0	0	0	0	
Day Care	0	0	0	0	0	0	0	0	0	0	
Community Based Services	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Generic Services	**68,989**	**52,169**	**53,800**	**(1,631)**	**68,989**	**69,480**	**(491)**	**507**	**516**	**520**	
Community Hospitals	4,802	3,462	3,644	(182)	4,802	5,072	(270)	115	122	123	Nursing, Medical & Equipment
Prescribing	22,436	16,747	18,192	(1,445)	22,436	24,436	(2,000)	0	0	0	Prescribing pressures
AHP Services	5,658	4,276	4,330	(54)	5,658	5,708	(50)	144	139	140	Savings targets
General Medical Services	16,933	12,932	12,932	0	16,933	16,933	0	4	4	4	
Community Nursing	4,387	3,319	3,331	(12)	4,387	4,437	(50)	110	103	105	Some nursing presures
Assesment and Care Management	0			0	0	0	0	0	0	0	
Group Managers	0			0	0	0	0	0	0	0	
Service Managers	0			0	0	0	0	0	0	0	
Planning Team	0			0	0	0	0	0	0	0	
Locality Offices	0			0	0	0	0	0	0	0	
SB Carers	0			0	0	0	0	0	0	0	
BAES	250	184	191	(7)	250	250	0	0	0	0	
Duty Hub	0			0	0	0	0	0	0	0	
Extra Care Housing	0			0	0	0	0	0	0	0	
Joint Health Improvement	0			0	0	0	0	0	0	0	
Respite	0			0	0	0	0	0	0	0	
SDS	0			0	0	0	0	0	0	0	
OT	0			0	0	0	0	0	0	0	
Grants to Voluntary	0			0	0	0	0	0	0	0	
Out of Hours	2,131	1,626	1,355	271	2,131	1,819	312	0	0	0	Service redeign
Community Based Services	0			0	0	0	0	0	0	0	
Sexual Health	558	471	501	(30)	558	602	(44)	7	6	6	Drugs pressures
Public dental Services	3,324	2,784	2,777	7	3,324	3,324	0	78	78	79	
Community Pharmacy Services	3,933	3,017	2,984	33	3,933	3,933	0	0	0	0	
Continence Services	441	337	311	26	441	433	8	3	3	3	
Smoking Cessation	209	187	144	43	209	179	30	4	5	5	
Primary & Community Management	1,684	1,333	1,588	(255)	1,684	1,982	(298)	34	44	42	Flex beds, Savings not delivered
Health Promotion	438	356	327	29	438	405	33	8	12	12	
Opthalmic Services	1,591	1,223	1,278	(55)	1,591	1,591	0	0	0	0	
Patient Transport	0			0	0	0	0	0	0	0	
Accomodation Costs	0			0	0	0	0	0	0	0	
Resource Transfer	2,609	1,972	1,972	0	2,609	2,609	0	0	0	0	
Other	2,162	184	184	0	2,162	2,162	0	0	0	0	
Health and Social Care Funding	0			0	0	0	0	0	0	0	
Savings - Planned	(4,557)	(2,241)	(2,241)	0	(4,557)	(2,241)	(2,316)	0	0	0	Balance on savings 17/18
Savings - Recovery (unallocated)	0	0	0	0	0	(4,154)	4,154	0	0	0	
Total	**87,352**	**65,815**	**67,367**	**(1,552)**	**87,352**	**87,813**	**(461)**	**857**	**854**	**857**	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget (Social Care)	2016/17	AT END OF MTH: December						
	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE
Joint Learning Disability Service	**14,669**	**12,007**	**10,966**	**1,041**	**15,295**	**15,239**	**56**	**32**
Residential Care	1,492	947	1,253	(306)	1,284	1,280	4	0
Homecare	2,582	4,542	3,258	1,284	5,382	5,405	(23)	0
Day Care	2,091	1,213	1,229	(16)	1,664	1,667	(3)	3
Community Based Services	7,139	4,278	4,174	104	5,529	5,454	75	0
Respite	200	148	170	(22)	209	229	(20)	0
AWLD Staff Teams	1,165	879	882	(3)	1,227	1,204	23	29
Joint Mental Health Service	**1,962**	**1,435**	**1,414**	**21**	**2,023**	**1,980**	**43**	**25**
Residential Care	0	0	0	0	0	0	0	0
Homecare	190	147	120	27	200	195	5	0
Day Care	186	138	107	31	184	196	(12)	5
Community Based Services	788	484	527	(43)	729	677	52	0
Respite	15	12	3	9	16	3	13	0
SDS	102	86	100	(14)	115	130	(15)	0
MH Staff Teams	681	517	506	11	711	711	0	20
Choose Life	0	51	51	0	68	68	0	0
Joint Alcohol and Drug Service	**199**	**94**	**90**	**4**	**169**	**117**	**52**	**0**
Drug and Alcohol Commissioned Services	199	94	90	4	169	117	52	0
Drug and Alcohol Team	0	0	0	0	0	0	0	0
Older People Service	**28,126**	**19,152**	**16,319**	**2,833**	**26,127**	**26,644**	**(517)**	**23**
Residential Care	11,422	8,479	8,998	(519)	11,579	12,198	(619)	0
Homecare	8,025	5,171	5,370	(199)	7,092	7,002	90	0
Day Care	1,001	668	625	43	913	912	1	0
Community Based Services	999	2,254	1,688	566	3,004	3,046	(42)	16
Extra Care Housing	545	409	360	49	545	548	(3)	0
Housing with Care	409	382	333	49	509	517	(8)	0
Dementia Services	37	(222)	(91)	(131)	(209)	(212)	3	0
Delayed Discharge	267	100	201	(101)	267	262	5	0
OP Staff Teams	847	669	542	127	875	815	60	7
Other	4,574	1,242	(1,707)	2,949	1,552	1,556	(4)	0
Physical Disability Service	**3,180**	**2,578**	**2,481**	**97**	**3,426**	**3,346**	**80**	**0**
Residential Care	566	340	224	116	506	279	227	0
Homecare	1,747	1,054	1,035	19	1,425	1,393	32	0
Day Care	201	50	49	1	67	67	0	0
Community Based Services	666	1,134	1,173	(39)	1,428	1,607	(179)	0
Other	0	0	0	0	0	0	0	0

Scottish Borders Health and Social Care PARTNERSHIP

Summary Financial Commentary

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	Summary Financial Commentary
Generic Services	3,662	3,470	3,242	228	4,758	4,754	4	97	Additional £145k PO BAES
Community Hospitals	0	0	0	0	0	0	0	0	
Prescribing	0	0	0	0	0	0	0	0	
AHP Services	0	0	0	0	0	0	0	0	
General Medical Services	0	0	0	0	0	0	0	0	
Community Nursing	0	0	0	0	0	0	0	0	
Assesment and Care Management	0	0	0	0	0	0	0	0	
Group Managers	0	0	0	0	0	0	0	0	
Service Managers	0	0	0	0	0	0	0	0	
Planning Team	0	0	0	0	0	0	0	0	
Locality Offices	0	0	0	0	0	0	0	69	
SB Cares	0	0	0	0	0	0	0	0	
BAES	482	522	736	(214)	771	782	(11)	0	
Duty Hub	0	0	0	0	0	0	0	0	
Extra Care Housing	0	0	0	0	0	0	0	0	
Joint Health Improvement	56	42	26	16	56	55	1	0	
Respite	0	0	0	0	0	0	0	0	
SDS	0	36	(104)	140	96	96	0	0	
OT	0	0	0	0	0	0	0	0	
Grants to Voluntary	43	32	24	8	43	34	9	0	
Out of Hours	0	0	0	0	0	0	0	0	
Community Based Services	0	176	(95)	271	234	285	(51)	0	
Sexual Health	0	0	0	0	0	0	0	0	
Public dental Services	0	0	0	0	0	0	0	0	
Community Pharmacy Services	0	0	0	0	0	0	0	0	
Continence Services	0	0	0	0	0	0	0	0	
Smoking Cessation	0	0	0	0	0	0	0	0	
Primary & Community Management	0	0	0	0	0	0	0	0	
Health Promotion	0	0	0	0	0	0	0	0	
Ophthalmic Services	0	0	0	0	0	0	0	0	
Patient Transport	0	0	0	0	0	0	0	0	
Accommodation Costs	0	0	0	0	0	0	0	0	
GS Staff Teams	3,515	2,565	2,459	106	3,336	3,286	50	0	
Other	(434)	97	196	(99)	222	216	6	28	
Total	**51,798**	**38,736**	**34,512**	**4,224**	**51,798**	**52,080**	**(282)**	**177**	

MONTHLY REVENUE MANAGEMENT REPORT

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

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Profiled to Date £'000	Actual to Date £'000	To date Variance £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Base WTE	YTD WTE	Current Month WTE	Summary Financial Commentary
Large Hospital Set Aside	**18,128**	**15,128**	**18,018**	**(2,890)**	**18,128**	**21,033**	**(2,905)**	**0**	**0**	**0**	
Accident & Emergency	1,806	1,506	1,952	(446)	1,806	2,376	(570)	0	0	0	Medical & Nursing pressures
Medicine & LTC	11,330	9,295	11,184	(1,889)	11,330	13,606	(2,276)	0	0	0	Locum and surge cappacity
Medicine of the Elderly	6,080	4,565	5,120	(555)	6,080	6,912	(832)	0	0	0	Locum,Nursing & Surge costs
Savings - Planned	(1,088)	(238)	(238)	0	(1,088)	(238)	(850)				
Savings - Recovery (unallocated)	0	0	0	0	0	(1,623)	1,623				
Total	**18,128**	**15,128**	**18,018**	**(2,890)**	**18,128**	**21,033**	**(2,905)**	**0**	**0**	**0**	

Scottish Borders
Health and Social Care
PARTNERSHIP

HEALTH AND SOCIAL CARE – MEDIUM-TERM JOINT FINANCIAL PLANNING STRATEGY AND RESERVES POLICY

Aim

1.1 The aim of this report is to set out the framework for future effective joint financial planning arrangements and timescales for the IJB and its partners and to seek approval of its policy for maintaining reserves and the carrying forward of resources.

Background

2.1 2017/18 will represent the second year of operation of the Scottish Borders Health and Social Care Partnership Integration Joint Board (IJB). Across Scotland, the development of a joint or integrated financial planning process between Integration Joint Boards (IJBs) and their partner health board and local authority remains embryonic at the current time, with further development towards a more cohesive approach across all partnerships still a requirement. This has been a key issue raised by IJB Chief Financial Officers in regular discussions with the Scottish Government. Presently, the development and publication of guidance on how partnerships should approach joint Financial Planning remains outstanding and whilst believed to be imminent, is unlikely to influence how 2017/18 Financial Plans across partnerships, health boards and local authorities are developed.

2.2 Within the Scottish Borders, as in 2016/17, the method for determining the allocations by partners to the integrated budget will largely be contingent on the respective financial planning and budget-setting processes of NHS Borders and Scottish Borders Council. A key aim of these processes is to provide indicative medium-term allocations to the IJB, in line with the objectives of the Strategic Plan, subject to annual approval through partners' respective budget-setting processes.

2.3 A more joined-up approach is therefore required in order to ensure that an indicative partnership medium-term financial plan not only underpins its Strategic and Commissioning Plans, but its affordability, robustness and sustainability. Its component provisions and assumptions must also be transparent and consistent. Key elements of this approach therefore include:

- A review of both NHS Borders' and Scottish Borders Council's current health and social care financial plans (which when combined form the partnership's "Financial Statement") for delegated and set-aside functions
- Detailing and agreement of funding assumptions
- Agreement of key uplift, inflationary and pressures assumptions
- Assessment of the level of new savings proposals required to fund the resulting affordability gap and permanently address recurring 2016/17 and historical shortfalls

- Engage with key stakeholders to produce additional robust proposals in order to close identified gaps and deliver strategic priorities

2.4 This paper outlines the process through which an integrated financial planning process for the IJB will deliver an affordable financial plan over the medium-term as partnership working, holistic and cohesive service planning and an integrated transformation programme all develop during this time.

Integration Scheme

Baseline Payment

3.1 As laid out in the Health and Social Care Partnership's Scheme of Integration, the baseline payment made to the IJB in 2016/17 was established by reviewing recent past performance and existing plans for Borders Health Board and Scottish Borders Council for the functions to be delegated, adjusted for known and assumed material items. The partnership's Financial Statement was then subject to due diligence and comparison to recurring actual expenditure in the previous three years adjusted for any planned changes in order to ensure that budgets were realistic and that the level of resources was sufficient to deliver the first year of the Strategic Plan.

3.2 The Integration Scheme states specifically that there will be an opportunity in the second year of operation to adjust baseline budgets to correct any inaccuracies.

Future Years

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

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

Key Principles and Other Factors for Consideration

4.1 There are a number of key principles on which a medium-term financial plan for the Scottish Borders Health and Social Care Partnership should be founded. These principles will be consistently applied across both NHS Borders' and Scottish Borders Council's financial planning process and can be summarised as being:

- To set a prudent, sustainable budget for health and social care, taking account of available resources

- To recognise the impact of existing investment and continue to invest through capital and other sources of funding (e.g. Integrated Care Fund) in transformation and redesign projects in order to improve outcomes and efficiency and deliver longer-term financial savings
- To maximise (social care) income whilst maintaining a fair, equitable, affordable and consistently applied charging policy
- To prioritise the aims and objectives of the Health and Social Care Partnership's Strategic Plan
- Where possible, to take a data-driven approach to reviewing cost-effectiveness, including variation and benchmarking
- To seek opportunities for improved efficiency through sharing services between partners at a regional or national level
- To consider how, in line with strategic priorities, resources can be shifted along the care pathway through disinvestment in lesser priorities in order to fund new priority models of care
- To identify and deliver efficiency and other savings schemes jointly between partners
- To be informed by and enable the delivery of the Scottish Borders Strategic Housing Investment Plan

4.2 Each annual partnership financial plan will require risk-assessment and sufficient actions to mitigate identified risks will require to be put in place prior to the start of the financial year. A key feature of this will be the application of the partnership's Reserves Policy. A draft Reserves Policy is detailed as **Appendix 1** to this report. Clearly for this policy to be fit for purpose, provision requires to be made within the Financial Statement to create and fund a reserve as part of risk-mitigation measures going forward. In a time of financial constraint and increasing demand and cost-pressures however, this will be a major challenge.

4.3 The key objective of a joint/more integrated financial planning process will be the delivery of a balanced, affordable and sustainable medium-term financial plan for the Health and Social Care Partnership which will be presented to members of the IJB as its Financial Statement. In order for this to be achieved, a number of considerations require to be made:

- To identify the impact of the current planned transformation and redesign programme in terms of resource realignment, efficiency opportunities and ongoing sustainability requirements beyond transitional funding arrangements
- To identify further joint opportunities for service redesign and agree a joint plan for any associated capital or revenue investment requirements
- To implement a medium-term solution for addressing the recurring efficiency gap across the partnership's devolved and large hospital budget set-aside resulting from non-recurring savings delivered in current and historic years
- To identify any additional investment requirements associated with the delivery of the partnership's approved Strategic Plan and how these investment requirements can be met

Timetable and Engagement

5.1 In order to comply with the statutory guidance accompanying the legislation for integration, the Health and Social Care Partnership is required to approve its

medium-term Financial Statement before the 01 April each year. For 2016/17, this was achieved on 30 March 2016. For 2017/18, it will be presented to IJB members on 27 March 2017.

5.2 To realise this in any given financial year, there are a number of key milestones which will require to be reached:

Overview of Health and Social Care Partnership Financial Planning Cycle - September to June	
September	*Executive Management Team agree medium-term financial planning assumptions for health and social care*
October to December	*Executive Management Team agree health & social care resource envelope following discussions with NHS Borders and Scottish Borders Council*
October to December	*Executive Management Team identify investment requirements and efficiency and savings proposals for submission to NHS Borders and Scottish Borders Council*
Mid-January	*Executive Management Team agree draft Health & Social Care Partnership Draft Medium-Term Financial Plan*
Mid-February	*Draft NHS Borders Financial Plan submitted to the Scottish Government*
Early February	*Scottish Borders Council approves its Financial Plan*
Late March	*Approval of the Draft IJB Medium-Term Financial Statement*
Late March	*Final NHS Borders Financial Plan submitted to the Scottish Government*
1st week in April	*NHS Borders Board approves its financial plan*
June	*Approval of the Revised IJB Medium-Term Financial Statement (if required)*

5.3 It is expected that a Financial Planning update report will be made to IJB members periodically during each annual cycle.

5.4 Presently, the arrangements for partnership working and in particular, integrated financial planning are still in development. For 2016/17, the partnership's financial statement was effectively formed of the outcome of partners' respective and discreet financial planning processes. For 2017/18, whilst a fully formed integrated process has not yet been achieved, a number of developments have been made which have been discussed with IJB members at previous meetings / development sessions in order to help enable an understanding of the key principles before either partner organisation submits / agrees its health function / social care function budget for the medium-term.

Priority Areas for Consideration 2017/18 – 2019/20

6.1 It is recommended that the Health and Social Care Partnership sets and agrees at least a 3-year Financial Plan on an annual rolling basis. In March of each year therefore, IJB members will be asked to approve a Financial Statement for the

Health and Social Care Partnership for the period 2017/18 to 2019/20. In line with the national position the budget from 2018/19 should be considered indicative

6.2 Following the principles outlined in this report therefore, a number of key financial planning areas have been as part of the current joint financial planning process including:

- The robustness of partners' funding assumptions and potential impact of draft Scottish Government funding allocation and settlements as these become known
- The adequacy of current assumptions in respect of investment requirements, demographic pressures, allocation of uplift and the identification of any other likely-to-emerge legislative, demand/activity or price-driven pressures over the medium-term (this should specifically recognise partnership pressures which have been addressed by the partnership during the financial year on a non-recurring basis
- What the Health and Social Care Partnership and its partners are required to do to address that the substantial recurring budget gap from current and prior financial years over the medium-term in order to ensure that the functions its delegated budget support are financially sustainable
- Assessment of the likely impact of efficiency and savings proposals planned for the medium-term partnership budget, in terms of the delivery of the Strategic Plan – (going forward, regular reports to the IJB will be made in-year supplementing those on the forecast monitoring position, specifically relating to progress made in delivering the integrated transformation, efficiency and savings programme)
- Identification of the financial impact of the current programme of health and social care transformation and redesign in terms of how any efficiency and savings arising is reflected in the partnership's Financial Statement
- Identify forward options to ensure financial sustainability of the new models of health and social care currently being planned and implemented through disinvestment and realignment of resources towards priorities

6.3 Whilst work continues on these currently for the 2017/18 financial plan, developing a more integrated financial planning process is clearly not just a cyclic, annual process and therefore work across these areas will continue through and beyond the formal process leading to the approval of the partnership's Financial Statement in March 2017 and for each annual medium-term financial plan thereafter.

6.4 The work of the Executive Management Team, Chief Officer, Chief Financial Officer and respective senior Finance Officers from both NHS Borders and Scottish Borders Council will be vital to the delivery of the above plan and joint Financial Planning will be a standing agenda item at each EMT meeting as required in order to ensure the above objectives are achieved.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** medium-term financial planning strategy proposed

The Health & Social Care Integration Joint Board is asked to **approve** the policy outlining the arrangements for the maintenance of IJB reserves

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Policy/Strategy Implications	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Consultation	The report has been considered by the Executive Management team and approved by NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer in terms of factual accuracy. Both partner organisations have contributed to its development and will work closely with IJB officers in delivering its outcomes.
Risk Assessment	To be reviewed in line with agreed risk management strategy.
Compliance with requirements on Equality and Diversity	There are no equalities impacts arising from the report.
Resource/Staffing Implications	No resourcing implications beyond the financial planning resources identified within the report.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author

Name	Designation	Name	Designation
Paul McMenamin	Interim Chief Financial Officer IJB		

APPENDIX 1

RESERVES POLICY

Introduction

Reserve Funds are established as part of good financial management. The purposes of reserve funds are as:

a) As a working balance to help cushion the impact of uneven cash flows
b) As a contingency to cushion the impact of unexpected events or emergencies
c) As a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities

The Scottish Borders Health and Social Care Partnership Integration Joint Board (IJB) is a legal entity in its own right created by Parliamentary Order following Ministerial approval of the Integration Scheme and has been formally constituted under a body corporate model. The IJB is expected to operate under public sector best practice governance arrangements. The revenue budget for the functions for which the Partnership has responsibility is delegated by Scottish Borders Council and NHS Borders (the Parties) and the Partnership subsequently commissions services from these two partner organisations.

The Scottish Borders Partnership Integration Scheme was approved by Scottish Ministers and became live with effect from 06 February 2016. Section 8.8.1 of the Scheme states that *"in line with (IRAG) guidance, a process for jointly agreeing, reporting and carrying forward any unused balances at the end of the financial year will operate".*

Within the Scheme, section (8.6.7) on reserves and balances states:

"Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve."

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

This Reserves Strategy should be read in conjunction with the Financial Regulations for the IJB, approved as part of the Partnership's local Code of Governance on 07 March 2016.

Categorisation of Reserve Funds
There are 3 main categories of reserve fund which are:

- Committed Balances/Carry forwards
- Financial Planning Balances
- Uncommitted balances

APPENDIX 1

Committed Balances/Carry Forwards

Balances which are essential to the IJB to enable it to meet definite commitments, these will include:

- Funding received from external organisations with spending conditions attached and where expenditure has yet to be incurred or conditions satisfied
- Previous policy decisions of the IJB / Council / NHS Board, i.e. approval to commit the Health and Social Care Partnership to future spend on specific initiatives
- A defined commitment made prior to 31st March where services were not provided (or goods received) prior to the financial year-end

Financial Planning Balances

Financial planning balances may be held by the IJB to plan ahead to meet the cost of potential commitments which may occur in the short to medium term. Such balances can be held to fund capacity within service priorities as set out in the Strategic Plan.

These balances may be generated through specific management action during the financial year or at the financial year-end following a review of the Partnership's final outturn position by the Chief Officer in conjunction with the Chief Financial Officer of the Partnership.

Where additional expenditure / reduced income offset against financial planning balances is of a recurring nature the Chief Officer and CFO should ensure a plan is established to enable the commitment to be financed in subsequent financial years.

Such balances need to be agreed in advance with the Director of Finance (NHS Borders) and the Chief Finance Officer (section 95) of Scottish Borders Council, to confirm that they should not be considered as windfall. Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve. If an underspend arises from a material error in the assumptions made to determine the initial budget, the methodology of the payment may need to be recalculated using the revised assumptions. Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to.

Uncommitted Balances

Previously, balances may have been earmarked for a specific purpose which no longer exists and therefore the balances remain uncommitted. These should be subject to annual review by the IJB.

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Types of Reserves

Three main types of reserve may be held by the IJB if required:

- General Fund (earmarked and general)
- Repairs and Renewal

- Insurance

At present, it is expected that only a general fund reserve will be required within the Scottish Borders Partnership, which can be used to manage the financial strategy of the IJB. Only a small element of the budgets for premises-related costs are currently delegated to the IJB and as a result the potential requirement to defray expenditure on repairing or maintaining property-related assets is low. Similarly, no specific separate insurance arrangements have yet been put in place for the IJB. It is proposed therefore that the two types of reserves that will operate currently are:

- General Fund earmarked: earmarked for specific commitments, primarily uncommitted Integrated Care Fund or social care funding
- General Fund general: general reserve for the carrying of planned IJB underspends to meet unforeseen or identified future IJB financial commitments

Level of Balances Held

CIPFA recommends that the level of reserves which require to be established and carried should be determined by an estimate of the potential impact of identified strategic and operational risks faced by the Partnership. Additionally, it has been stated that within unallocated reserves, balances should be between 2% and 4% of revenue expenditure.

The IJB should therefore, in total, hold no more than 4% of revenue expenditure as reserve balances, although in reality, the actual level is likely to be considerably less given the financial magnitude of the delegated and set-aside budgets. Assessment and quantification of the financial risks to which the Partnership is exposed will play a key role in the determination of acceptable level of reserves.

Where unallocated balances are significantly in excess of this or not identified for future anticipated liabilities or projects, the IJB may consider transfer of the excess to fund specific projects. In the event that the IJB is unable to identify appropriate projects, excess balances may, with IJB approval, transfer to partners in the same proportion as individual parties contribute to joint pressures unless it can be clearly demonstrated that the reserve is directly attributable to an individual partner's contribution.

Per the Scheme of Integration 8.6.2-8.6.3, *"where there is a forecast outturn overspend against an element of the operational budget the Chief Officer and the Chief Financial Officer of the Integration Joint Board must agree a recovery plan to balance the overspending budget with the relevant finance officer of the constituent authority. Should the recovery plan be unsuccessful the Integration Joint Board may request that the payment from Borders Health Board and Scottish Borders Council be adjusted, to take account of any revised assumptions. It will be the responsibility of the authority who originally delegated the budget to make the additional payment to cover the shortfall."*

This recovery plan will require taking cognisance of any reserves and balances available to the IJB.

Review of Balances

This Scottish Borders Health and Social Care Partnership IJB's Reserves Policy requires the Board to review balances on an annual basis following the external audit of the Statement of

APPENDIX 1

Accounts to allow examination of the level and detail of balances held. The Reserves Policy will be reviewed annually as part of both the Financial Planning and processes for the IJB, following the closure of the previous year's accounts. This will include the level of both earmarked and unallocated IJB general reserves.

The annual report will provide details of and the reason for retaining existing balances.

Utilisation of Balances

Where a balance has been committed for a specific purpose and expenditure has been incurred or grant conditions met a request should be made to the CFO in order that the balance is drawn down and matched against expenditure incurred. The subsequent Financial Management Report to the IJB will note the IJB's direction of reserves.

In order to demonstrate movement in specific balances it is important that drawdowns are requested even on occasions where the IJB is reporting an in-year underspend.

Where the balance exceeds the expenditure incurred then the remaining balance will be reclassified as an uncommitted balance and treated accordingly.

Financial Management and Financial Reporting Arrangements

The Integration Scheme also states that the IJB will record all financial information in respect of the Integration Joint Board in an integrated database (which is currently being developed), and use this information as the basis for preparing regular, comprehensive reports to the Integration Joint Board. Underpinning this however will be the recording of all financial information in respect of the delivery of functions delegated to the IJB in the financial ledger of the partner which is delivering services on behalf of the IJB. The two key factors influencing this are:

- NHS Boards do not have the facility locally to carry-forward reserves and require the support of Scottish Government Health and Social Care Directorate.
- IJBs have been classified as local authority bodies for the purposes of their annual accounts and committed balances and financial planning balances require to be transferred to Scottish Borders Council for earmarking as part of the closure of accounts process for the IJB.

Paul McMenamin

Interim Chief Financial Officer
Scottish Borders Health and Social Care Partnership Integration Joint Board

February 2017

Scottish Borders
Health and Social Care
PARTNERSHIP

CHIEF OFFICER'S REPORT – FEBRUARY 2017

Aim

1.1 To provide the Health & Social Care Integration Joint Board with an overview of activity undertaken by the Chief Officer in relation to Health and Social Care Integration.

Background

2.1 The Health & Social Care Integration Joint Board will receive a report from the Chief Officer at each of its meetings.

Summary

3.1 January and February have been busy months with considerable progress being made in the following key areas.

- Workshop held to review performance data and agree performance reporting in line with Scottish Government requirements
- Ongoing work to deliver financial recovery plan to ensure break even position for IJB delegated budgets
- Locality Planning – progress on the development of locality plans and ongoing engagement at local level
- Continued focus on delayed discharge planning and reducing admissions. Fieldwork by Professor John Bolton has been completed with report to be available by end of March.
- Review of strategic planning group. Two meetings have been held with the strategic planning group to review the role and function of the strategic planning group which will be presented to the next meeting of the IJB
- Joint staff forum – a recent meeting was held and a comprehensive update /discussion held with members attending
- Inspection activity – this has been a considerable undertaking for all concerned, with over sixty meetings arranged for the final scoping week to take place from 20 – 25th February 2017
- Workforce planning – the workforce planning group has been re-invigorated and support provided to begin work to develop a joint workforce plan

Recommendation

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

Policy/Strategy Implications	As detailed within the report.

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Consultation	As detailed within the report.
Risk Assessment	As detailed within the report.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	As detailed within the report.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		