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Scottish Borders
Health and Social Care
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A meeting of the **Health & Social Care Integration Joint Board** will be held on **Monday, 20th August, 2018** at **2.00 pm** in Committee Room 2, Scottish Borders Council

AGENDA

Time	No		Lead	Paper
14:00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
14:01	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	Chair	*Verbal*
14:03	**3**	**MINUTES OF PREVIOUS MEETING** 11 June 2018	Chair	(Pages 3 - 10)
14:05	**4**	**MATTERS ARISING** Action Tracker • Clinical & Care Governance Assurance Framework	Chair	(Pages 11 - 24)
14:10	**5**	**CHIEF OFFICER'S REPORT**	Chief Officer	(Pages 25 - 28)
14:15	**6**	**FOR DECISION**		
	6.1	Primary Care Improvement Plan	Chief Officer	(Pages 29 - 78)
	6.2	Direction - Primary Care Improvement Plan	Chief Officer	(Pages 79 - 82)
	6.3	Integrated Care Fund Conditions	Chief Officer	(Pages 83 - 84)
	6.4	Integrated Care Fund	Chief Office	*To Follow*
	6.5	Monitoring of the Integration Joint	Interim Chief	*To Follow*

		Budget 2017/18	Financial Officer	
	6.6	Integration Joint Board Local Code of Corporate Governance	Chief Officer	(Pages 85 - 104)
	6.7	Health & Social Care Partnership Communications Strategy	Chief Officer	(Pages 105 - 116)
15:20	**7**	**FOR NOTING**		
	7.1	Strategic Planning Group Report	Chief Officer	(Pages 117 - 124)
	7.2	Quarterly Performance Report	Policy, Performance & Planning Manager	(Pages 125 - 150)
	7.3	Winter Plan 2018/19	General Manager Unscheduled Care	*Presentation To Follow*
	7.4	Audit Committee Minutes	Chief Officer	(Pages 151 - 164)
15:55	**8**	**ANY OTHER BUSINESS**	Chair	
	8.1	Health & Social Care Integration Joint Board Development Session: 19 November 2018 • Look Back: Look Forward • Public Protection Service • 2019/20 Finance • Strategic Plan	Chief Officer	*Verbal*
16:00	**9**	**DATE AND TIME OF NEXT MEETING** Monday 22 October 2018 at 2.00pm in Committee Room 2, Scottish Borders Council	Chair	*Verbal*

AT THE CONCLUSION OF THE PUBLIC MEETING THE BOARD MAY RECONVENE FOR ANY MATTERS OF RESERVED BUSINESS

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 11 June 2018 at 2.00pm in the Council Chamber, Scottish Borders Council.

Present:	(v) Cllr D Parker	(v) Dr S Mather (Chair)
	(v) Cllr J Greenwell	(v) Mr M Dickson
	(v) Cllr S Haslam	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	(v) Mr J Raine
	Mr D Bell	(v) Mr T Taylor
	Mrs J Smith	Mrs C Pearce
	Mr J McLaren	Mr M Leys
	Ms L Gallacher	Dr A McVean
	Mr C McGrath	Mr R McCulloch-Graham
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mrs J Stacey	Mrs C Gillie
	Mr D Robertson	

1. Apologies and Announcements

Apologies had been received from Dr Cliff Sharp, Cllr Helen Laing and Mrs Tracey Logan.

The Chair confirmed the meeting was quorate.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

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

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

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 28 May 2018 were amended at page 2, minute 6, paragraph 4, line one to include “that he believed where” and with that amendment the minutes were approved.

4. Matters Arising

4.1 Action 8: The Clinical Governance paper previously provided to the Integration Joint Board (IJB) by the Chief Social Work Officer and Director of Nursing & Midwifery to be brought back to the IJB to enable closure of the action.

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

5. Inspection Action Plan update

Mr Murray Leys gave an overview of the content of the report and advised that: the Carers Strategy was being updated; there had been good progress made on the action plan overall; and Mr Michael Murphy had been appointed to the position of Chief Officer for Adult Social Work.

Mr Tris Taylor enquired about the methodologies used for co-production. Mr Robert McCulloch-Graham advised that co-production had taken place through the input of representatives from various locality working groups, carers, users, Strategic Planning Group representatives to a range of strategies that had been formulated and then released for consultation. Mr Taylor suggested the consultation sessions may have been used as an example of assurance on co-production, and challenged that co-production and consultation were separate entities.

Mrs Lynn Gallacher commented that the Carers Strategy had been co-produced through the Carers Advisory Board which had carers amongst its membership. She advised that it had been formulated in true co-production as carers had been fully involved in the redesign and finalisation of the strategy for release for consultation.

Mr Leys further commented that the Physical Disability Strategy had been co-produced with carers, users and a range of other individuals before it had been finalised for release for consultation.

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

6. Chief Officer's Report

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted his attendance at the Scottish Parliament Health & Sport Committee which had focused on partnership performance and the determination of set aside budgets.

Mr Malcolm Dickson enquired in regard to technological solutions if as CGI was the strategic partner for the Local Authority, would the IJB be obliged to follow that strategic partner or could it direct to go to the open market. Mr McCulloch-Graham advised that whilst there was no requirement to stay with CGI there would be potential benefit in continuing with CGI in terms of the size of contract that the Council had with them. Mr Murray Leys commented that several of the care support systems operated were supported by CGI.

Mr John Raine enquired if Scottish Borders were an outlier in terms of delayed discharges as that had been the impression he had gleaned from Mr McCulloch-Graham's appearance before the Scottish Parliament Health & Sport Committee. Mr McCulloch-Graham advised that both Scottish Borders and Lothian were outliers, with the position fluctuating. He reminded the IJB that it had been a difficult winter period with extended winter pressures across the system and in addressing the situation the IJB had commissioned the introduction of a Discharge to Assess policy, Craw Wood and Hospital to Home.

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Mr John McLaren sought assurance that the NHS Borders Information Management & Technology (IM&T) department were sighted on the position in regard to the CGI contract and potential for outsourcing. The Chair commented that the technological strategy should underpin the 3 aims within the Strategic Plan.

Mrs Karen Hamilton enquired about the community hubs and the potential for an evaluation of them in terms of efficacy, accessibility and publicity. Mr Leys advised that an evaluation had been carried out and he would make that available.

Cllr John Greenwell welcomed the prospect of virtual clinics and supported a move in that direction.

Cllr Tom Weatherston enquired why there wasn't a single system across the piece. Mr McCulloch-Graham advised that some systems operated across both organisations either through a portal or they had the ability to converse. Whilst the intention might be to move to a single system it would be piecemeal in its approach and he commented that Mr Raine's suggestion of taking 3 areas as pilot areas to test and make exemplars would be a preferable approach.

Mr Tris Taylor noted that the Learning Disability Service, whilst it had been integrated for some 8 years, the staff continued to have to work across 2 different business systems and he asked if they could be empowered to work with information technology services to effect change. Mr McCulloch-Graham commented that there was a willingness in the team to effect change and decisions needed to be made at the middle management level and he gave the example of "imatter" being rolled out across the learning disability service team covering both NHS and Local Authority staff.

Mrs Jane Davidson commented that the things that frustrated the teams were often the differences in health and safety and risk assessment processes. Whilst the separate employer situation would remain irresolvable, it was the other irritations that would be addressed.

Mr Raine commented that it was easier to reconcile differences of process in the partner organisations, but was difficult to deal with the impediment of different HR practices for staff across the health and social care partnership, especially differences in pay and terms and conditions. He suggested that there was nothing on the horizon to bring any comfort to bring people in integrated services closer and harmoniously together.

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

7. Health & Social Care Strategic Plan 2018-2021

Mr Robert McCulloch-Graham gave an overview of the content of the report and spoke of the five drivers for the review.

Mr Colin McGrath referred to page 8 of the plan and sought clarification on the identity of the services provided in locally based hubs. Mr McCulloch-Graham advised that all of the delegated services were listed in the appendices.

Further discussion focused on: the layout of the document; inclusion of hyperlinks in a paper based report; structure of Joint Staff Forum feeding into the IJB via the Strategic Planning Group; co-production; and use of #yourpart.

Mr John McLaren on behalf of the Joint Staff Forum asked that an update be given to the Forum on Buurtzorg.

Mr Tris Taylor recalled a previous conversation in regard to the use of language around involvement of service users and how prescriptive it had been. He noted the revisions within the document were more laudable, however he felt the content remained paternalistic. He suggested the document undercut itself and had not been created in full co-production, although some areas of it had been co-produced. He suggested there appeared to be difficulties in pursuing citizen participation, and although Scottish Borders was a relatively healthy region in Scotland the vision in the Strategy did not demonstrate that and he remained concerned that the document was not consistent all the way through and he was unable to support it as a strategy.

Mr McCulloch-Graham disagreed with Mr Taylor's comments and commented that in order to manage the demand on services there was a need for a different relationship with citizens to set out what the services would provide and what the citizen was expected to do. He advised the population was being asked to engage on the strategy through the #yourpart campaign.

Mr Taylor suggested his point was that in the #yourpart campaign the missing link was the ability of the citizen to suggest a better way of utilizing buildings, delivering services and coming up with solutions for local and regional services to meet their health and wellbeing needs. He suggested such a change would lead to a more meaningful and better citizen participation experience.

Mr John Raine noted the Board was asked to ratify the refreshed Strategy and he was content to do that, however he noted that one of the key principles was to reduce health inequalities and he was unsure that the Plan detailed enough on how that would be achieved. The previous plan had set out actions for reducing health inequalities which had been fairly broad and if the IJB was to make a difference in tackling inequalities then it should have an element of target within the strategy. That would also enable the IJB to commission services to achieve greater equality and outcomes.

Cllr Shona Haslam commented that conversations were on going with local communities about health and wellbeing through the Area Partnerships of the Local Authority.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** delegated to the Chair and Chief Officer to review the reporting structure and agree whether a revised structure be included in the Plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified the refreshed version of the Strategic Plan subject to the potential revision of the reporting structure chart and with the dissent of one Board member.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the proposal to launch the plan as part of the SBC **#yourpart** campaign in August 2018.

8. Monitoring of the Health and Social Care Partnership Budget 2017/18 at 31 March 2018

Mrs Carol Gillie gave an overview of the content of the report and highlighted that the report was in line with the year end forecast of a breakeven position given substantial extra funding given to the IJB. She further advised that part of the 2018/19 Financial Plan would continue to pick up the pressures.

Cllr Shona Haslam commented that given the level of emphasis placed on the Learning Disability and Mental Health services she was concerned that the most vulnerable people within the community might suffer.

Mrs Jane Davidson commented that it was a point well made and the IJB had to be mindful of the disadvantaged when looking to commission services to provide the change required.

Mr John Raine noted that the overspend on the Older People's Service had been offset by underspends in other areas including the joint Learning Disability and Mental Health service and he enquired if that had been a fortuitous windfall.

Mr David Robertson commented that predominantly underspends in services were used to effect change and on that occasion it had been fortuitous to be able to manage the pressure in the Older People's Service and it would not set a precedent for the future.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and the final outturn monitoring position on the partnership's 2017/18 revenue budget at 31 March 2018.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** asked the Chief Officer to bring forward a plan to the next meeting of the IJB for delivery of permanent remedial savings to address the recurring resource gap experienced during both 2016/17 and 2017/18 which required additional contributions from partners at the financial year-end.

9. Deliverability of Health & Social Care Partnership Financial Plan Savings for Financial Year 2018/19

Mrs Carol Gillie gave an overview of the content of the report and highlighted that each savings scheme had an identified deliverability status attached to it. In summary there were £1.1m of schemes identified. Within the schemes was £5.2m of unidentified savings which the IJB had asked the NHS to report back on and given the NHS Board did not meet until the end of June she was unable to provide an update to the meeting.

Mr Tris Taylor enquired about the status of the IJB in regard to financial direction and accountability and enquired if the IJB could make directions about limiting the spending envelope. He further enquired if the IJB was accountable for overspending on the budget given the partner organisations were required to address any overspends.

Mr David Robertson confirmed that the partner organisations would be required to address any overspends. He commented that the IJB had a responsibility to achieve a financial outturn of balance or surplus.

Further discussion focused on: delegated budget; commissioning services; setting direction of travel; issuing directions; end of first quarter with no agreed budget in place; shifting the balance of care to the community and tackling demand; 53% of NHS budget including set aside; and the Scottish Government discussing the totality of the NHS budget and being cognisant of the IJB.

Cllr Shona Haslam enquired what level of detail both financial and non financial would be made available to the IJB in order for it to be assured that any decisions it made in regard to decommissioning services were made in the round and not solely on the basis of finance.

Mr McCulloch-Graham advised that savings proposals would have already been through the robust processes of each partner organisation.

Mrs Gillie enquired of the level of detail the IJB would wish to receive in order to be assured that the decisions it made were in line its strategic plan. Mr Robertson reminded the IJB that it commissioned the partner organisations to deliver a range of services on its behalf and the partner organisations in turn might put in place arrangements to commission services from care providers, the third sector, and voluntary sector.

Mrs Jane Davidson suggested that at present the IJB was unclear on the granularity of commissioning and as it matured it would be able to commission for change.

Cllr Haslam enquired how confident the officers were that the proposals brought to the IJB in the budget would produce a balanced budget, and if not what the consequences would be.

Mrs Gillie advised the IJB that NHS Borders was in discussion with the Scottish Government in regard to the financial position and financial sustainability moving forward.

Mr Taylor enquired why in the meantime the IJB 2018/19 budget and spending could not be determined on assumptions. Mr Robertson reminded the IJB that it had been concerned previously about potentially planning on assumptions and it had been determined that a paper would come to the IJB once the NHS position had been clarified.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report on the deliverability of 2018/19 savings and efficiencies that are required in order to deliver a balanced budget for the year to 2019.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** asked the Chief Officer to bring forward a plan to the next meeting of the IJB for delivery of savings to address the resource gap in year and recurrently.

10. Integrated Care Fund Update

Mr Robert McCulloch-Graham gave an overview of the content of the report and reminded the Board that they had requested the paper. He highlighted the 3 projects that were to cease

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and explained that due to the staffing of the projects they would not conclude until the end of September.

Cllr Shona Haslam noted that the Delivery of the Autism Strategy was to be mainstreamed and she enquired how the learning would be captured. Mr McCulloch-Graham advised that he would seek further information from the Coordinator in that regard.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the timescale for ending the Autism Strategy, ARBD Pathway and Stress and Distress Training projects.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the total Integrated Care funding being returned for redirection.

11. Interim Report on Community Capacity Building

Mr Robert McCulloch-Graham gave an overview of the content of the report and advised that he had visited several of the projects and heard at first hand from those accessing the services how those services were having a direct impact on peoples health.

The Chair commented that the Scottish Borders Community Capacity Building Team had recently won silver at the finals of the Improvement and Efficiency Social Enterprise Public Sector Transformation Awards 2018. The award recognised initiatives that do the most to engage with the local community and create greater resilience, better life chances and less dependency on public services.

Cllr Tom Weatherston commented that he had attended the Awards ceremony and that Tackling Poverty in Funeral Costs had won the overall award.

Mr Tris Taylor suggested the Chairman may wish to send a letter to the staff thanking them for their hard work and congratulating them on their achievement.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the work of the Community Capacity Building Team to date.

12. Strategic Planning Group Report

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

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

13. Any Other Business

There were none.

14. 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 20 August 2018 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 3.52pm.

Signature: ……
Chair

Scottish Borders
Health and Social Care
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Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 17 October 2016

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that it would undertake a Development session on clinical and care governance.	Robert McCulloch-Graham, Claire Pearce, Cliff Sharp	2017	**In Progress:** Item scheduled for 27 November 2017 Development session. Session cancelled due to apologies received. **Update:** Item rescheduled to 19 March 2018 Development session. **Update:** Item rescheduled to 28 May session due to Extra ordinary meeting taking place on 19 March 2018. **Update:** Item rescheduled to 19 November 2018 session due to change in status of development sessions to formal meetings. **Update 11.06.18:** The Clinical Governance paper previously provided to the Integration Joint Board (IJB)	G

					by the Chief Social Work Officer and Director of Nursing & Midwifery to be brought back to the IJB to enable closure of the action. **Complete:** Clinical & Care Governance Assurance Framework attached.	

Meeting held 27 February 2017

Agenda Item: Health & Social Care Delivery Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
13	8	Tracey Logan advised that there were already strong links to Live Borders in place and she would be happy to provide an update to the IJB if it wished.	Tracey Logan	June 2017	**In Progress:** Item scheduled for 12 February 2018. **Update**: Item rescheduled to 20 August 2018 meeting. **Update:** Item rescheduled to 17 September meeting due to holidays.	G

Meeting held 23 October 2017

Agenda Item: Update on Buurtzorg in the Borders

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
19	13	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress to date and welcomed hearing more at a later date.	Robert McCulloch-Graham	April 2018	**In Progress:** Item scheduled for April 2018 meeting agenda. **Update:** Item rescheduled to 20 August meeting due to	G

					agenda business pressures (ties into Action 27). **Complete:** Chief Officer to provide a verbal update at the 20.08.18 meeting.	

Meeting held 12 February 2018

Agenda Item: Inspection Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
24	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and agreed to receive a presentation on the Public Protection Service at a Development session later in the year.	Murray Leys	December 2018	**In Progress:** Item scheduled for 19 November 2018.	G

Meeting held 23 April 2018

Agenda Item: Buurtzorg Project Management

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
27	7.9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding with a further update on progress.	Robert McCulloch-Graham	August 2018	**In Progress:** Item scheduled for 20 August 2018 meeting agenda. **Complete:** Chief Officer to provide a verbal update at the 20.08.18 meeting.	G

Agenda Item: Hospital to Home

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
28	7.11	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive an update on the impact of the decisions made, updated timescales and projects to be mainstreamed.	Robert McCulloch-Graham	June 2018	**In Progress:** Item scheduled for 11 June 2018 meeting agenda. **Update:** Item rescheduled to 20 August meeting. **Complete:** Update contained within ICF paper to the 20.08.18 meeting.	G

Agenda Item: Scottish Borders Health and Social Care Partnership 2017/18 Winter Period Evaluation Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
29	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** welcomed the opportunity to receive a report at a future meeting on Quality and Governance from Mrs Claire Pearce, Director of Nursing, Midwifery & Acute Services and Dr Angus McVean, GP Clinical Lead.	Claire Pearce, Angus McVean	2018	To be scheduled	

Meeting held 28 May 2018

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
30	6	Mr Murray Leys to provide a presentation to a future Development session on Demographics	Murray Leys	2018	To be scheduled	

Meeting held 11 June 2018

Agenda Item: Monitoring of the Health and Social Care Partnership Budget 2017/18 at 31 March 2018

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
31	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** asked the Chief Officer to bring forward a plan to the next meeting of the IJB for delivery of permanent remedial savings to address the recurring resource gap experienced during both 2016/17 and 2017/18 which required additional contributions from partners at the financial year-end.	Carol Gillie	2018	**In Progress:** Scheduled for 17 September meeting.	A

Agenda Item: Deliverability of Health & Social Care Partnership Financial Plan Savings for Financial Year 2018/19

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
32	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** asked the Chief Officer to bring forward a plan to the next meeting of the IJB for delivery of savings to address the resource gap in year and recurrently.	Carol Gillie	2018	**In Progress:** Scheduled for 17 September meeting.	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

Scottish Borders
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Scottish Borders Integration Joint Board

Clinical & Care Governance Assurance Framework

CONTENTS

1. Introduction to Clinical & Care Governance

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

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

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

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

Key Elements of effective Clinical & Care Governance

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

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

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

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

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

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

2.1 Objectives

The primary objectives of this assurance framework are to:

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

2.2 Reporting structure

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

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

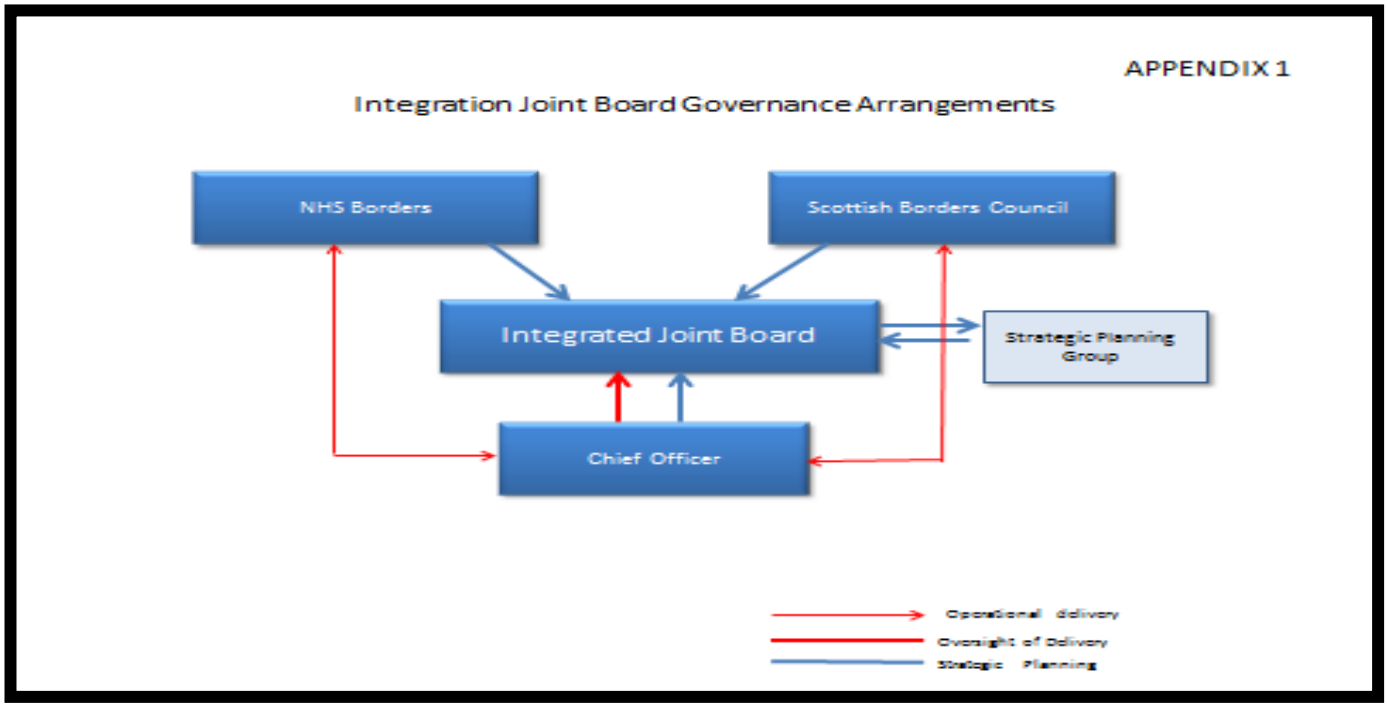

Diagram 1: Integration Joint Board Governance Arrangements Source: Scheme of Integration

2.3 Types of topics to be reported

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

2.3.1 Adverse events

2.3.2 Patient feedback

2.3.3 Clinical effectiveness

2.3.4 Infection control

2.3.5 Patient safety

2.3.6 Medicines safety

2.3.7 Adult Protection

2.3.8 Child Protection

2.3.9 Risk management (see Risk Management Strategy)

2.3.10 Claims management

2.3.11 Research governance

2.3.12 National, internal and external audit or inspection reports (Care Inspectorate and Healthcare Improvement Scotland reports)

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2.4 Clinical & Care Governance Assurance framework and process

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

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

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

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2.5 Roles and responsibilities

2.5.1 Integration Joint Board (IJB)

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

Members of the IJB are responsible for:

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

2.5.2 Chief Officer

The Chief Officer has overall accountability for the IJB's Clinical & Care Governance Assurance Framework, ensuring that suitable and effective arrangements are in place relating to the services delivered under the direction ofthe IJB. The Chief Officer will be responsible for drawing to the attention of the IJB any new or escalating clinical & care governance risks and associated mitigations to ensure appropriate oversight and action.

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

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

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

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

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

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

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

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

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

2.6 Next steps - developing clinical & care governance arrangements

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

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

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

2.6.3 Implementation of clinical & care governance reporting and monitoring arrangements

2.6.4 Identification of key reports and implementation of reporting timetable.

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

The Clinical & Care Governance Assurance Framework (version 1.00) was approved by the Integration Joint Board at its meeting on 07.03.2016

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 20 August 2018

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Robert McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 825528

CHIEF OFFICER'S REPORT

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

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

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

Chief Officer Report

Primary Care Improvement Plan (PCIP)

The Primary Care Improvement Plan is on the board's agenda for agreement and is due to be submitted to Scottish Government by the end of August 2018. The preparation of the plan has involved an extensive amount of work and discussion with a large range of stakeholders. It has been taken to the Executive Management Team on 24 July, the GP Sub Committee on 6 August, and the Clinical Executive Strategy Group on the 9th of August, prior to its presentation to the IJB.

Throughout these preparations close consort has been held with Scottish Government and with a range of IJB partners as well as neighbouring Boards. As with all partnerships our plan remains a dynamic one in that it will continue to change as funding is agreed, and as work streams gain more clarity on what will be achievable in each year. The full extent of the plan is to develop services to support the new GP contract and to develop Primary Care as a whole within our communities.

The majority of work involves Community Health Staff and GP practices however there will be an opportunity in the second year to develop specific work in partnership with Council Services through targeted work with link workers across the five localities.

Day of Care Audit

An extensive Day of Care Audit (DOCA) of inpatients in Community Hospitals and BGH wards has been undertaken within all four Community Hospitals and the BGH. This has involved a full multidisciplinary team of clinical and managerial staff reviewing every patient in each of these areas to determine whether the hospital was the correct provision for them and what they would require if they were to be cared for at home.

This exercise is now complete and the results are due to be discussed on 11 September and we expect further papers to the IJB to outline changes required to reduce delays.

Appointments

I am very pleased to say that our IJB Chief Financial Officer, Mike Porteous, started on 6 August on secondment from NHS Lothian.

We have agreed to go to advert for the posts of the Chief Officer and another Group Manager for Adult Social Care. We will be looking to recruit and anticipate having the post filled by the start of December.

Integrated Care Fund (ICF)

A report is being presented to the IJB to seek acceptance of the NHS Borders Board proposed conditions for future applications for the ICF. The report will also outline four IC funding proposals for Crawwood, Hospital to Home, Strata and COPD. Approval will be sought for three of the proposals and the fourth proposal has already been agreed through decision making by NHS Borders Chief Executive, Scottish Borders Council (SBC) Chief Executive, IJB Chair and IJB Vice Chair; therefore is for noting.

Winter Plan

The Winter Planning Board continues to meet on a bi-weekly basis.

The final draft of the Winter Plan will be presented to the NHS Board on 4 October and the IJB on 22 October. We are awaiting communication from Scottish Government, stating the final submission date but expect this to be the end of October. Discussions on preparing for the festive period will be included within the Winter Plan

Regional Work

The last diabetes steering group set out work streams for our work to reduce the number of people with type 2 diabetes. Agreement has been given for the appointment of a Director to lead on this work over the next few years. Appointments will be made this side of Christmas. With T2D taking 10% of the NHS budget, we have high hopes and aspirations that this work will serve to provide improved lives and outcomes for the population but save a significant amount of budget in the process.

Child and Adolescent Mental Health

After years of very good practice in offering timely support for young people requiring support our waiting times increased dramatically towards the end of last year. This was reported within the media. The service which is small in comparison with other partnerships, suffered from an inability to fill posts after the departure of a number of staff, at a time when the recording system was also changed. The result was an unacceptable level of performance over several months. Managers have intervened and additional support has been sourced. An improvement trajectory has been agreed and we expect to return to their normal high standard within the next 5 months. We have already seen improvements in the last month.

Older People's Inspection

The interim Chief Officer for Adult Social Care has reviewed the progress made on the improvement plan and he and I have met with the Care Inspectorate. We are pleased with progress to date but are suggesting some changes as to how we can evidence improvement.

A revised action plan will be brought to the Strategic Planning Group and further reports will be by exception from the Performance and Finance Group which will monitor progress on a six weekly basis.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: ....20 August 2018.....

Report By	*Robert McCulloch-Graham, Chief Officer Health & Social Care*
Contact	*Robert McCulloch-Graham, Chief Officer Health & Social Care*
Telephone:	*01896 825528*

PRIMARY CARE IMPROVEMENT PLAN

Purpose of Report:	To propose to the Integration Joint Board the submission to the Scottish Government of the Primary Care Improvement Plan for the Scottish Borders, and to agree its implementation.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Agree** the Primary Care Improvement Plan. b) **Agree** to issue a direction to NHS Borders to implement the Primary Care Improvement Plan.

Personnel:	There will be staffing implications within the PCIP, these will be addressed through each work stream.

Carers:	N/A

Equalities:	The overall policy direction of the Primary Care Improvement Plan will apply equally where possible. Health Inequality Impact Assessments will be undertaken at individual work stream level.

Financial:	There will be staffing implications within the PCIP, these will be addressed through each work stream and funding applied within the overall budget limit of the plan. Should further funding be required the normal decision making and governance procedures will apply.

Legal:	Introduction of a new approach to primary care provision. This proposal has been discussed at the Board Executive Team, the Executive Management Team, the Clinical Executive Strategy Group and agreed by the GP Sub Committee.

Risk Implications:	Risk Assessments will be undertaken at individual work stream level.

Background

1.1 The Primary Care Improvement Plan (PCIP) will aim to support the further introduction of the new contract for General Practitioners and improve the overall efficiency and quality of Primary Care provision within the Scottish Borders.

1.2 Integration Authorities are required to;

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Sub Committee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and

2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the Memorandum of Understanding (MoU) and the Contract document ("Blue Book") in support of the new GP contract.

1.3 The Primary Care Improvement Plan focuses on six priority work areas:

- Vaccinations
- Pharmacotherapy
- Community Treatment and Care
- Urgent Care
- Additional Professional Roles
- Community Link Workers

1.4 The GP Sub Committee of the Scottish Borders agreed the plan at its meeting held on 8 August 2018.

1.5 The plan offers a high level summary of intentions and an indication of resource allocation. Further work is required to reach agreement on the required provision for the Vaccination work stream for example. The Primary Care Division of the Scottish Government have been involved throughout our preparations and remain supportive. We expect, as do all Integration Joint Boards (IJBs), that more detail will be added to the plan as we progress further into the financial year. The plan expects delivery within three years, there is time therefore to work across the partnership of stakeholders to provide further detail on requirements. Further reports and refinements to the plan will be taken to the Strategic Planning Group of the IJB, with highlight reports being brought to the IJB.

Funding

2.1 The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Primary Care Fund:

- Primary Care Improvement Fund:
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours Fund.

2.2 An in-year NRAC allocation to Integration Authorities (IAs) (via Heath Boards) will comprise £45.750 million of the £115.5 million Primary Care Fund. For the Borders this equates to an allocation of £962,000 for 18/19, the fund must be delegated in its entirety to Integration Authorities.

2.3 Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services.

2.4 The money must be used by IAs for the purposes described by Scottish Government. The PCIF including base lined GP pharmacy funding should be:-

"treated as PCIF and cannot be subject to any general savings requirements and must not be used to address any wider funding pressures."
Directorate for Population Health, Primary Care Division, Scottish Government. 23rd May 2018.

2.5 The PCIP will enable the Health Board and the Health and Social Care Partnership, to support the continued introduction of the new GP Contract and to introduce further improvements in the primary care offer for the residents of the Scottish Borders.

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Borders Health & Social Care Partnership

Primary Care Improvement Plan

(GMS Contract)

2018 – 2021

NHS Borders

Scottish Borders Health and Social Care PARTNERSHIP

Scottish Borders COUNCIL

Contents

Foreword

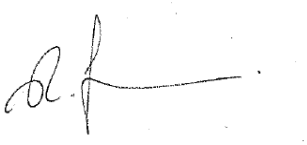
I would like to introduce Scottish Borders' first Primary Care Improvement Plan in connection to the GMS Contract as part of the Scottish Government aim to improve Primary Care Services for all.

We now operate a new contract for our GPs across the country and here in the Scottish Borders we are looking forward to a greater joining up of services supporting our local communities.

The Borders is a wonderful and beautiful place in which to live and work. It does however provide some particular challenges around access to Health and Social Care Services.

The new legislation and this new plan developed by the professions within Primary Care is intended to better utilise our resources to meet these challenges.

It is not the final statement on Primary Care in the Scottish Borders, it is however our clear statement of intent, and we will continue to work across the professions and with the people of the Borders to provide a Primary Care Service, fit for purpose, for now and for the future.



Robert McCulloch Graham

Chief Officer, Scottish Borders Health and Social Care Partnership

Primary Care Improvement Plan (GP Contract)

Scottish Borders

Financial Year: 2018/19

Introduction

This document forms the first Scottish Borders Primary Care Improvement Plan (PCIP) linked to the new GMS Contract (2018). The PCIP has been developed as a requirement of the national Memorandum of Understanding[1] between the Scottish Government, Integration Authorities (IA), the Scottish General Practitioners Committee (SGPC) of the BMA and NHS Boards, however, it is consistent with our local priorities and objectives also set out within the Scottish Borders Strategic Plan 2016 to 2019 and NHS Borders' Clinical Strategy which reflect the commitment of the Scottish Borders Health and Social Care Partnership (H&SCP) and its partner agencies to continuously improve the quality of treatment, support and community services provided to the population.

The PCIP therefore forms a crucial strand of a transformational programme for Primary Care Services overall which will be reflected in an emerging and overarching Primary Care Strategy.

This initial PCIP is a dynamic working document and through ongoing liaison with all stakeholders will be revised as the work streams progress and implementation proceeds.

Background

National Context

On 13th November 2017 the new GMS contract was published and was accepted by the GP community in January 2018 through a ballot of the profession. The new contract is underpinned by four key documents:

- The Scottish GMS Contract Offer Document[2]
- The National Code of Practice for GP Premises[3]
- The National Health Service (GMS Contracts)(Scotland) Regulations 2018[4];
- Memorandum of Understanding (MoU) – to cover the transition period between 2018 and 2021

[1] *Memorandum of Understanding between the Scottish Government, Integration Authorities, BMA and NHS Boards: GMS Contract Implementation in the context of Primary Care Service Redesign. (Nov 2017)*

[2] *The Scottish GMS Contract Offer Document 2017 (http://www.gov.scot/Publications/2017/11/1343);*

[3] *The National Code of Practice for GP Premises 2017(http://www.gov.scot/Publications/2017/11/7592);*

[4] *The National Health Service (GMS Contracts)(Scotland) Regulations 2018*

The new contract aims to refocus the role of GPs as Expert Medical Generalist's (EMG's) working within a Multi-disciplinary Team (MDT) in which the GP will focus on:

- Undifferentiated presentations;
- Complex care;
- Local and whole system quality improvement;
- Local clinical leadership for the delivery of General Medical Services (GMS).

Within the contract documents, the role of the Expert Medical Generalist is described as the following:

"Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses, physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others."

To enable the development of this EMG role, there will be a shift over time of GP workload and responsibilities - this will require a wide range of tasks currently undertaken by GPs to be completed by members of a wider primary care multi-disciplinary team where it is safe and appropriate to do so, while also demonstrating an improvement for patient care.

In support of the implementation of the new contract in the context of Primary Care Service redesign, a Memorandum of Understanding (MoU) was agreed in November 2017 between Scottish Government, Integration Authorities, the Scottish General Practitioners Committee (SGPC) and NHS Boards. This is a key document that summarises the entire process.

It is a requirement of the MoU that Integrated Authorities develop and review a local Primary Care Improvement Plan (PCIP). The aim of the plan is to identify and integrate key areas to be transformed in order to achieve the GP contract goals with the expectation that reconfigured services will continue to be provided in or near GP practices.

The MoU states six nationally agreed priorities, which are evidence-based, for transformative service redesign in Primary Care in Scotland over a three year planned transition period between 2018 and 2022. These are:

- Vaccination services;
- Pharmacotherapy services;
- Community Treatment & Care Services (CT&CS);
- Urgent Care (Advanced Practitioners);
- Additional professional roles:
    - MSK Physiotherapy;
    - Community Clinical Mental Health Professionals;
- Community Link Worker's (CLW's).

GP's will retain the lead professional role in these areas in their capacity as EMG's.

The MoU also outlines some key enablers of change linked to Premises, Information Sharing Arrangements and Workforce. Within the latter, it highlights the workforce implications of the MDT:

"As part of their role as EMG's, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas listed above will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters).

Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans. Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements"

Financial resource to support delivery of the PCIP's will be provided through the Primary Care Fund from the Scottish Government and, on the whole, will be allocated on an NRAC basis (National Resource Allocation Committee formula). Local engagement between Health Boards, GP Sub Committees and Health & Social Care Partnerships (HSCPs) is key to prioritise the work streams within the plan and subsequently agree the internal funding arrangements.

The MoU is provided on Appendix 1.

Local Context

Scottish Borders covers an area of 4,743 square kilometres (1,831 square miles), with a population of approximately 118,484 people registered with a GP practice and a population density of 25 persons per square kilometre (compared to 65 persons per square kilometre for Scotland). Thus, suggesting a less densely populated geography.

The population distribution is based mainly within 13 towns ranging in size from around 2,000 to nearly 15,000 and many smaller villages and individual houses. Cross-border flow of patients is also a consideration particularly around Newcastleton, Coldstream and Eyemouth.

Following the implementation of The Public Bodies (Joint Working) (Scotland) Act 2014, one Health & Social Care Partnership/Integrated Authority was established covering Scottish Borders as a whole and with the responsibility for the strategic planning for a range of services provided by NHS Borders. Within the Scottish Borders Integrated Authority, 5 localities have been established: namely Berwickshire, Eildon, Cheviot, Tweeddale and Teviot. Four Quality Clusters are now in place in line with the revised GMS Contract and they span across the five localities.

There are currently 23 GP practices in Borders, with 18 health centres owned by NHS Borders.

The two overarching local strategic documents are Scottish Borders Strategic Plan, developed through the IA and NHS Borders' Clinical Strategy. Both are focussed on enabling people to access the right care and support to meet their needs in the right way, in the right place and to deliver services in an integrated and person-centred way.

Scottish Borders Strategic Plan has at its core the following three objectives:

1. We will improve the health of the population and reduce the number of hospital admissions;
2. We will improve the flow of patients into, through and out of hospital;
3. We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

NHS Borders Clinical Strategy holds as its vision:

"*To provide personalised, evidence based care as close to home as possible. Working with people to define treatment goals and optimise outcomes. Supporting people to stay well; treat illness and manage crises.*"

The aims of the Clinical Strategy are as follows:

- Greater focus on prevention of ill health and reduction of health inequalities;
- Integrated community teams to provide support for prevention of illness to intensive care at home;
- Admission to hospital will only be required for specialist care;
- Proactive approach to Realistic Medicine;
- Sustainable, safe, high quality services across the care pathway informed by evidence supported by eHealth and digital technologies;
- A workforce that has the capacity, capability and adaptability to meet future demands.

Significant transformational change programmes are underway across the IA and NHS Borders with the aim of reshaping and improving resources in line with these principles and objectives in order to provide sustainable, safe service models within the means available. Part of this work will see the development and redesign of community services and will enable people to be supported within their own home and local communities wherever possible. The principles and aims of the PCIP along with its implementation are consistent with and inexorably linked to this wider Primary Care agenda.

Governance for the PCIP

A, 'GP Away Day' was held on 22nd May 2018 at which each area of the plan was explored, including the governance arrangements for the development and implementation of the Primary Care Improvement Plan (PCIP).

The draft PCIP was produced and updated through working with GPs, the Primary and Community Services (P&CS) team and a range of stakeholders. The PCIP has been widely shared with bodies including the GP Sub-Committee, the Clinical Executive Strategy Group and the NHS Borders Board amongst other groups in draft format. The final version of the PCIP will address the comments, concerns and suggestions of all stake holders and final agreement from the GP Sub Committee will be sought prior to submission to the Integration Joint Board (IJB) of the IA on the 20th of August for ratification.

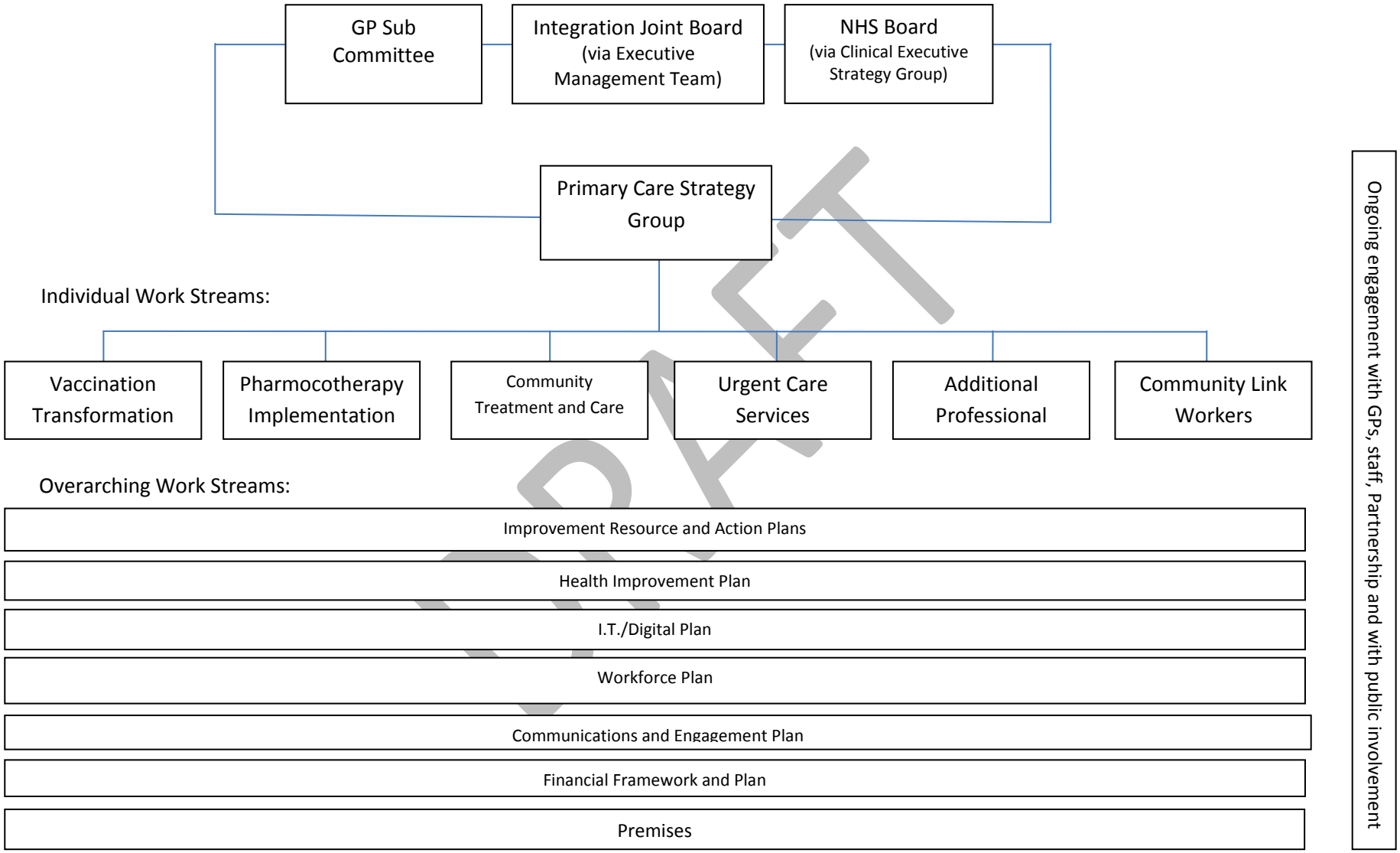
Following IA agreement, the IA will issue relevant directions to NHS Borders via the Board on the implementation of the actions from the plan. The implementation of the actions will then be the responsibility of the Primary Care Strategy Board, currently being established, which will act as a steering group (Terms of Reference on Appendix 4) to the relevant work stream project groups.

Monitoring reports will be provided to the IA, GP Sub-Committee and NHS Borders Board (through the Executive Management Team and Clinical; Executive Strategy Group).

Each work stream of the PCIP has an identified project sponsor, lead and/or practice representative with an operational group in place. These are supported by P&CS and will report into the Primary Care Strategy Board. The overall governance structure is shown overleaf.

Each strand of the programme surrounds the main delivery areas of the PCIP and will develop Key Performance Indicators (KPI's) clearly linked to outcomes, enabling shared learning and ensuring evaluation takes place.

Public representation will be progressed via the individual groups and consideration will be made to the re-establishment of Practice Patient Groups (PPG's).


GP Sub Committee
Integration Joint Board (via Executive Management Team)
NHS Board (via Clinical Executive Strategy Group)
Primary Care Strategy Group
Individual Work Streams:
Vaccination Transformation
Pharmocotherapy Implementation
Community Treatment and Care
Urgent Care Services
Additional Professional
Community Link Workers
Overarching Work Streams:
Improvement Resource and Action Plans
Health Improvement Plan
I.T./Digital Plan
Workforce Plan
Communications and Engagement Plan
Financial Framework and Plan
Premises
Ongoing engagement with GPs, staff, Partnership and with public involvement

Scottish Borders Primary Care Improvement Plan

This first PCIP covers a period of three financial years (2018/19, 2019/20 and 2020/21) focussing on the six key areas previously noted. Those underlined are to be prioritised during year one of the transformation. They are:

1. The Vaccination Transformation Programme (VTP);
2. Pharmacotherapy Services;
3. Community Treatment and Care Services;
4. Urgent Care (Advanced Practitioners);
5. Additional Professional Roles:
    - Musculoskeletal (MSK) focused physiotherapy;
    - Community Clinical Mental Health Professionals;
6. Community Link Worker's.

In Scottish Borders, the Primary Care Strategy Group will oversee the implementation of the PCIP:

1. The Vaccination Transformation Programme (VTP)

The Scottish Government announced in March 2017 the intention to develop a Vaccination Transformation Programme (VTP) this recognises both the increasing complexity of vaccine programmes and the changing role of the GP.

The VTP has different work streams including:

- Pre-school Programme;
- School based Programme;
- Travel vaccinations and travel health advice – the MoU has prioritised this for the first year of the Programme, however, a national group has been established that will drive change;
- Influenza Programme;
- At risk and specific age group Programmes (shingles, pneumococcal, hepatitis B).

Each of these work streams will be incorporated into the overall Scottish Borders programme. The aim is to achieve seamless change.

National groups have been established to oversee vaccine transformation programmes within Health Boards. These are the Scottish Immunisation Programme Group and Business Change Manager's (BCM) Group. They will develop national strategies (e.g. information, monitoring, quality, risk management etc.), blueprints and plans that will influence local decision-making.

A Scottish Borders VTP Group has been established to drive forward local transition. This requires key stakeholder engagement and consultation with the local Area Medical Committee (AMC) as well as patient representatives (for example, via the NHS Borders Public Involvement Network).

The local VTP Business Change Manager (BCM) has been recruited and work is ongoing to:

- Review the current delivery model (i.e. via GP's including LES arrangements on a payment per item basis);

- Explore Health Board provision (through centralised Hubs potentially at Kelso, Hawick, Peebles, Duns, Galashiels or the Borders General Hospital);
- Investigate a hybrid model.

A range of considerations and challenges have been identified during the early discussions regarding the delivery of transformation and these will be addressed as part of the programme. They include:

- The current complexity of immunisation programmes;
- Patient safety must be a priority;
- Existing levels of childhood and adult immunisation in General Practice is very high;
- Public and patient expectations must be considered and appropriately managed;
- Existing GP IT systems support immunisation delivery and provide a complete record of an individual's medical history, reducing risk if inappropriate immunisation;
- Recruitment of an appropriately skilled workforce to deliver an immunisation programme;
- An option's appraisal is required to agree the most appropriate service delivery model for the new programmes. It will need to be flexible and acknowledge that it may not be appropriate for all areas of the Scottish Borders;
- Immunisation locations will be identified, this will be challenging due to capacity issues within Primary Care premises;
- Delivery of the currently proposed VTP has significant financial implications.

The total programme of change is scheduled over 3 years in order to recognise the length of time required to provide robust processes ensuring the safety of the public (our main priority) with assurances that structures, roles and governance will be established within the first year. It is anticipated that years 2 and 3 will realise a greater realignment of provision outside GP practice.

Different models for each vaccination type (influenza, childhood immunisation, HPV, shingles, travel, pneumococcal etc.) will be developed. The simple timeline for the transition of the individual work streams is estimated to be:

Previously Completed		Year 1		Year 2		Year 3
• School programme (including flu vaccines)		• Pertussis/ whooping cough vaccine • 0-5 years programme		• Shingles (start) • Flu & Pneumococcal vaccines 65+ • Flu Vaccines (for those at risk)		• Travel • Shingles (completion)

Priorities for the Vaccine Transformation Programme are still under negotiation. Options will be reviewed over the next few months with discussion taking place at the GP Sub-Committee in October. More detail will be added to the plan at this time.

2. Pharmacotherapy Services

The contract states that "From April 2018, there will be a three year trajectory to establish a sustainable pharmacotherapy service which includes Pharmacist and Pharmacy Technician support to the patients of every practice. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new Pharmacists and Pharmacy Technicians to be recruited and trained."

This is a fundamental change in the delivery and management of Pharmacy services as they will be based at individual practice level. By April 2021 all practices will benefit from Pharmacy delivering key core services, with some practices receiving additional services where possible.

Core services to be delivered by 2021 include:

- Authorising and action all acute and repeat prescription requests;
- Authorising and action hospital immediate discharge letters (IDL's);
- Medicines reconciliation;
- Medicine safety reviews/recalls;
- Monitoring high risk medicines;
- Non-clinical medication reviews.

Acute and repeat medicine prescription requests is a large area (a recent audit suggests 15 hours GP time, per practice, per week) which includes the authorising and action of:

- Hospital outpatient requests;
- Non-medicine prescriptions;
- Installment requests;
- Serial prescriptions;
- Pharmaceutical queries;
- Medicine shortages;
- Review of use of 'specials' and 'off-licence' requests.

This is to be managed by Pharmacists. Beyond this Pharmacy Technicians, who are in many cases already within practices at present, will also focus on:

- Monitoring clinics;
- Medication compliance reviews (patient's own home);
- Medication management advice and reviews (care homes);
- Formulary adherence;
- Prescribing indicators and audits.

Testing elements of the Pharmacotherapy Service within a practice will be the initial stage of implementation, followed by cluster working then expansion across the Scottish Borders based on a sustainable model. This will be the challenge ahead for current Pharmacy services due to limited available resource (both financial and workforce).

Following the publication of, 'Prescription for Excellence' during 2013 and updated with, 'Achieving Excellence in Pharmaceutical Care' in 2017 the ethos of, 'Realistic Medicine' (also published in 2017) and polypharmacy have been followed.

There are a number of projects taking place within practices including:

- Regular patient facing review clinics (by an independent prescribing Pharmacist);
- Medicines Reconciliation (from hospital discharges when the Pharmacist is in the practice – in future a system is to be put into place);
- Polypharmacy and Care Home reviews;
- COPD/Pulmonary Rehabilitation/Inhaler Reviews;
- The Integrated Joint Board Care at Home-Pharmacy Project;
- Training & supporting practice administration teams to complete non-medication reviews.

Where practices already receive support this would then be included in this total. The capacity impact on practice workload will be assessed during the span of the PCIP.

Furthermore, there are services being delivered within Community Pharmacy which help reduce GP workload. These include:

- The Medicine Review Service;
- Pharmacy First, incorporating treatment for Urinary Tract Infections and Impetigo;
- The Chronic Medication Service (CMS).

At present it is the ambition of the H&SCP to increase this Pharmacy support to practices by expanding the current Pharmacy First services to include treatment of infected bites and exacerbations of COPD.

Pharmacists and Pharmacy Technicians will be employed by NHS Borders and will provide an agreed number of sessions to practices. This timetable will be shared with practices. When these employees are working within the practice they will use the practice's patient record system and work as part of the practice team. To provide daily support, it is expected that some of the time allocated to the practice will be provided remotely. This is to prevent 'batching' of work and help manage workflow.

The team will work under a single governance structure but will have different tasks in different practices as roles and practices develop at varying paces.

Additionally, it is expected that a unified repeat prescribing system across the whole of the Scottish Borders will be the first priority and responsibility of the NHS Borders Pharmacy department.

The resource required to achieve the contract requirements have been estimated on Table 2. This includes the relevant skill mix (with Pharmacists, Technicians & dietetics) necessary to deliver all elements of the plan:

Table 2:	**Baseline Primary Care Fund (£000's)**	**Pharmacy First (£000's)**	**Additional Support (PfE) (£000's)**	**Funding Total (£000's)**	**Estimated Team Costs (£000's)**	**Funding Requirement in Year 1 (£000's)**
Year 1	161	24	63	248	452	**204**

This level of resource will provide services during the working week (i.e. Monday to Friday) during core working hours with approximately one Pharmacist per 10,000 patients. This Pharmacist structure would be supported by technician staff by the end of Year 3.

The annual Scottish Borders Pharmaceutical Care Services plan will provide more detail on the transition process as it identifies the pharmaceutical care needs for both Community Pharmacy and Primary Care as a whole.

A general summary of the aims to be achieved by this enhanced team are:

Year 1	Year 2	Year 3
•Develop a unified repeat prescribing system •Ensure a sustainable process for hospital discharge letters •Establish a process for medicines reconciliations	•Embed the repeat prescribing system •Create a process for Level 2 pharmacotherapy services	•Roll out the medication review & high risk medicines processes •Develop support for the Level 3 pharmacotherapy services

A more specific timeline for year 1 is:

2018/19 (Year 1)	Apr 18 – Sept 18	Oct 18 – Mar 19
Process hospital discharge letters	Develop Team Protocol	Implementation
Medicines Reconciliations		
Unified Prescribing System	System Design	Pre-implementation planning/begin implementation

3. Community Treatment and Care Services (CT&CS)

Community Treatment and Care Services are one of the three main priorities for PCIPs stated within the MoU which is aiming to deliver change on a safe and sustainable basis over the next 3 years with the initial focus on phlebotomy during 2018/19.

CT&CS will include but is not limited to the following:

- Phlebotomy;
- Basic disease data collection and biometrics (e.g. blood pressure etc.);
- Chronic disease monitoring;
- Management of minor injuries and dressings;
- Ear syringing;
- Suture removal;
- Some elements of minor surgery.

In the Scottish Borders phlebotomy services have been revised and successfully remodelled historically therefore is not a priority of the PCIP in year 1. This may be revisited as the plan progresses. The initial focus locally will be in the other areas listed.

Currently CT&CS are provided across the Scottish Borders in a variety of ways and involve a range of clinical professions. This section also links with the local transformation programme for community services which is currently underway and will run concurrently with the PCIP. It will reshape community models of care, including community and day hospitals, rehabilitation services and community nursing services. The PCIP is an integral part of this overarching strategic direction for wider Primary Care in the Scottish Borders.

It has been identified that our local treatment rooms have an important role in the delivery of CT&CS, however, they will require a review to establish resources and suitability. There are 10 treatment rooms which provide services to 15 GP practices. Recognising the different starting points and challenges to be overcome in order to provide a consistent and safe service to patients it is important to establish a strong baseline to enable an appropriate treatment room model to be established.

During the first year the focus will be:

- Engaging with and applying national training structures and opportunities via the, 'Transforming Roles Programme';
- Agree set opening times and appropriate staffing levels/skill mix across all treatment rooms and community hospitals;
- Improve appointment booking systems (via the administration teams);
- Ensuring availability for both Primary and Secondary Care.

As noted previously, Community Treatment and Care Services are delivered across the whole primary care community, with links between GP practice's and other IA professionals/services. Community hospitals are a significant resource and redesigned care models have been considered within the recent research undertaken as part of the IA transformation programme.

The work being taken forward as part of the wider transformation programme will be linked with the delivery of this PCIP action point and together the following areas will be covered:

- Developing a Community Hospitals and Intermediate Care Framework;
- Review community employee levels (in Community Hospitals and Treatment Rooms);
- Create an improvement network across these services with connections to frailty and palliative care services;
- Support locality/cluster working through the realignment of the Department of Medicine for the Elderly (DME) Consultant sessions.

The local Minor Injury Units (MIUs) are connected to community hospitals and as such a review of their current demand and the resulting safety implications of continuing or expanding the role of these units will be considered.

Key to these changes is the evolving role of the nursing profession and their training requirements. The national transforming roles programme is currently in phase 1 which is focussing on a consistent

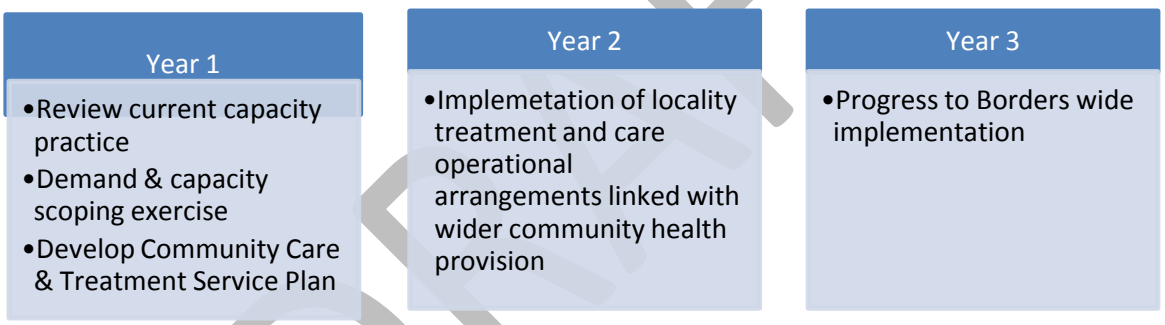
approach to Advanced Nurse Practitioners (ANP's) and developing an integrated community nursing team (containing ANP's, General Practice Nurses, District Nurses, Mental Health Nurses, Health Visitors, School Nurses etc.). The Scottish Borders are committed to being part of this process.

We therefore have the opportunity to support the education and ensuring appropriate clinical supervision is in place for ANP's in Primary Care. There is a survey of ANP education requirements underway with a plan to work to a national definition of advanced nursing practice.

There is very close linkage between the CT&CS work and urgent care with ANP's being the catalyst for change. They will be able to provide professional guidance for treatment room staff going forward as well as support the role of the EMG (see further detail in the next section).

Overall these models are a significant departure from the current process and will require developments in services, Information Technology (I.T), processes and governance in order to transfer the work from practices in a safe and sustainable manner.

The programme of work to establish new models of care is shown below:



In addition a pilot ANP led community hospital model within the Knoll and a formal Scottish Borders ANP training programme are potential developments between now and 2021.

4. Urgent Care (Advanced Practitioners)

To reduce GP workload and free up GP capacity the MoU supports the redesign of urgent and unscheduled care services. This aims at providing advanced practitioner resource (nurse or paramedic) to act as the first response to home visits or urgent call outs from patients. It is probable that these individuals will work across Clusters rather than individual practices in order to meet patient needs.

Testing of this approach has already taken place within the Scottish Borders (Hawick and Kelso) as noted on the GP contract document. During 2018/19 another pilot is in place within the South Cluster. The aim is to measure the benefits of the role and share learning from practices working collaboratively.

There are wide ranging views about how this should develop and which professional is the most appropriate to provide urgent care. As such the evidence of the impact of ANP's and paramedics within current pilots will assist with future service redesign.

Furthermore, recognising the close linkage with CT&CS the urgent care element of the PCIP will focus on ANP's initially.

To support ANP's ability to work at the required levels of clinical competence and enable GP colleagues to progress to EMG's the proposal is to appoint four additional ANP's during 2018/19 (year 1) of the PCIP, with the intention to recruit additional nurses in subsequent years. This will be to support professional leadership of this service, and enable clinical supervision. This would be at a potential cost of £211k in year 1 (see the funding elements below).

Priority for investment	Outline	Funds
Advanced Nurse Practitioners	Recruitment of 4 x Band6/7 ANP roles to support the development of ANP roles within GP practice	£191,462
	Support development of existing ANP's working with Practices	£20,000

It is proposed:

- To appoint four additional ANP's (Band 7) to act as professional leads for ANP's across Primary Care. These individuals will be involved in clinical practice with capacity (potentially 2 days per week) to provide mentorship, supervision and managing clinical competence. This will support the development of additional ANP's in subsequent years, which in turn will support General Practice;
- Once current ANP's in post have achieved the clinical competence levels as set out nationally, the plan will be to incorporate newly recruited members into a consistent approach to advanced practice nursing within the Scottish Borders. The aim will be to have all nurses, working as ANP's in Primary Care, to meet the requirements of clinical competence as described in the national definition above.

Year 1	Year 2	Year 3
•Scoping exercise to review current services •Demand and capacity work & agree 2019/20 investment	•Begin recruitment for practitioners working across practices	•Begin recruitment for practitioners working across practices

5. Additional Professional Roles

Additional professionals' role will provide services for groups of patients with specific needs that can be delivered by other professionals as the first point of contact in the practice and community setting; this would be determined by local needs. Examples of this type of role include:

- Musculoskeletal focused physiotherapy services;
- Community Mental Health Workers.

5a. Musculoskeletal focused physiotherapy services

First Contact Physiotherapy (FCP) means patients with a musculoskeletal problem who contact their local GP surgery are offered an appointment with a physiotherapist instead of a GP. An appropriately trained and experienced physiotherapist based within the practice is able to autonomously assess, diagnose and address the immediate needs of a large proportion of these patients, initiating further investigations and referrals where clinically appropriate. This approach puts physiotherapy expertise right at the beginning of the MSK pathway where patients can get the most benefit and in the place where they are most likely to first seek help.

Based on pilots in other NHS Board areas, FCP has been shown to complement the practice's approach with regard to health promotion, early intervention, use of medicines and investigations and onward referral to secondary care services such as orthopaedics. The FCP assesses diagnoses and acts upon the clinical findings, signposting to appropriate community resources and equipping people with the knowledge and advice to self manage their condition. The FCP will also request investigations where clinically relevant and refer onward to the appropriate services.

The intended outcome of FCP is to reduce the burden on stretched GP practices in the Scottish Borders and improve the patient journey through early intervention, signposting, and treatment. Assuring the patient sees the right person first time should reduce the number of steps in the clinical pathway and minimise the time it takes for a patient to receive the appropriate services for their condition ensuring optimal outcomes. A plan is being produced to implement this approach.

Priority for investment	Outline	Funds
Musculoskeletal focused physiotherapy services	Recruit 4 x Band 7 First point of contact physiotherapists	£191,462

5b. Community Mental Health Professionals

Community clinical mental health professionals, based in practices, will work with individuals and their families assessing their mental health needs. The aim is to provide support for conditions such as low mood, anxiety and depression. The subsequent outcome to be achieved is improved patient care through more swiftly accessible and appropriate mental health input.

The 2017 – 2027 Mental Health Strategy (http://www.gov.scot/Publications/2017/03/1750/0) is aiming for multi-disciplinary teams to be based within primary care ensuring practices are able to support and treat patients with mental health issues. A test of change is taking place throughout 2018 relating to first responders for those in crisis. This is Scotland-wide.

This pilot plus the commitment to recruit 800 mental health workers across Scotland (this equates to 16.5 in the Scottish Borders) will indirectly benefit General Practice. The goal for the Scottish Borders over the lifetime of the plan is to recruit these individuals in line with national guidance.

There is significant complexity around mental health presentations within primary care and as such multi-layered, evidence based interventions is required. Therefore a multi-professional mental health team is required to be integrated with both practices and other mental health teams.

The main aims relating to this plan will be to:

- Implement one single line management structure for the Public Health Advisors;
- On completion of the above assess the use of the current investment and provide a model service for the future (similar to Wellbeing Services in other areas);
- The review will evaluate and provide support for Community Psychiatric Nurses (CPN's), Lifestyle Advisors (LASS) and Counseling Services (including adolescent services);
- Clarity and general improvements to access methods and referral pathways are required;
- Make use of available technologies e.g. mobile telephone applications.

These objectives will conclude during 2018/19 (see timeline below) with active transition happening in year 2 and 3 of the overall plan. Individual plans for consideration could include the use of computerised cognitive behavioural therapy (CBT) and additional mental health professional capacity in practices.

This section will be further developed to address Action 15 of the Mental Health Strategy and has strong linkage with the Community Link Worker (CLW) role.

6. Community Link Worker's (CLW's)

The CLW programme has been established to make connections between individuals and their communities via their GP practice. The aim is to mitigate the impact of the social determinants of health in people that live in areas of high socioeconomic deprivation.

The CLW role will assist people with financial, emotional or environmental problems. These may include housing, debt, social isolation, stress or fuel poverty problems. By providing advice, direction to other organisations/activities in the community or alternatively coping strategies the CLW will ensure people feel more supported in their community.

The main objective for the Scottish Borders over the next 3 years is to access the opportunity to secure CLW's. The Scottish Government manifesto is to provide 250 CLW's over the life of the Parliament therefore the target goal for the Scottish Borders is to enable 5 such roles across the area. Funding will be accessed with an assumption that this will continue.

It is highly likely that these roles will be merged as part of the mental health/'wellbeing' service due to the close linkage with mental health issues. This will also ensure flexibility, as both are amenable to cluster working, which will provide the best coverage across the Scottish Borders.

We will continue to work closely with Scottish Borders Council (SBC) in their work with families and their own community worker schemes.

In the first year of operation this work will be led by our Mental Health Link Worker's who have already made a significant impact working alongside our GP practices. By leading with this group of new staff the IA will develop work practices, and model the approach for demand beyond mental health within the second year of the plan.

More definitive plans will follow a scoping exercise on the overall Wellbeing Service. This will be included on future review PCIP's.

7. I.T and Data/Information Collection

Given the level of technological process in recent years I.T and data provide knowledge and solutions to everyday work. In terms of the GMS contract there are 3 national groups that will influence local development; these are I.T, e-health and data and information. Their recommendations will impact upon local decision making.

Identified areas for progress are listed but not exclusively restricted to:

- Preference for EMIS web as a GP system. The community teams and hospitals are transferring to this system thereby providing good linkage. The outcome relies on the National Procurement Team which has a separate plan of implementation. There will be a standard approach to implementation and training for users etc;
- The offsite storage and back-up of data is being reviewed. One-off funding has been set aside to ensure this risk is resolved;
- Upgrading of Docman and the introduction of GP2GP will take place from August 2018;
- The new contract shares the responsibility for patient data between GPs and the Health Board. The Scottish Government will provide further guidance on the responsibilities for

each party and this is to be published during 2018, in the meantime a data sharing agreement will be developed by the NHS Borders ehealth department;

- There will be a requirement for practices to provide agreed local and national data extracts to enable intelligence led quality planning, improvement and assurance via Quality Clusters;
- Recognising the increasing level of coordination between NHS Borders and GP practices the aim is for dissolution of the I.T SLA to ensure an adequate level of service provision and contingencies provided;
- A Programme of Technology Enabled Care (TEC) with increased use of, 'Attend Anywhere' (online face-to-face consulting software) that will benefit patient interactions as a method of addressing time and travel constraints as well as assisting more remote and rural practices will be implemented;
- The use of mobile applications, websites and social media will be part of the overall Communications Strategy that will link in with the IJB and NHS Borders strategies in order to ensure information sharing;
- Upgraded technologies e.g. practice business continuity laptops via the I.T development fund;
- Added transparency to local decision making by creating space on the most appropriate website. This will include relevant meeting dates, remits, documents and minutes.

8. Premises

The National Code of Practice for GP Premises was published by the Scottish Government in November 2017. The main aim of the document is to highlight sustainability pressures around the GP workforce and premises liabilities and highlights the preference to move away from this to more Health Board owned and maintained premises. From the total 23 practices within the Scottish Borders, there is one GP owned practice and one leased practice with the remainder being within Health Board accommodation. There are also branch surgeries that need to be considered.

From Scottish Government guidance it is clear that each practice will transfer over a period of 25 years to Health Board premises.

Further work is required over the next 3 years. This includes:

a) GP Practice Premises –
   - Re-establish the Borders Primary Care Premises Group;
   - Evaluate current GP practice premises;
   - Review contract implications and create appropriate processes for the treatment of different practice types (GP owned, Health Board and leased) including applications for the Sustainability Fund;

b) Local GP Practice Issues – including exploring capacity.

9. Other Areas

Additional aspects of the contract will require revising or updating as more details become available. Operationally the Primary and Community Services (P&CS) Team within NHS Borders will evaluate these, consult with the wider stakeholder group and incorporate changes as necessary.

Identified areas include but are not restricted to:

- An annual assessment of the Enhanced Services (the level of funding will remain the same as indicated by the contract document);
- Practice boundary areas will to be reviewed and clarified (during 2018/19);
- Improving practice sustainability by promoting use of the Practice Sustainability Assessment Tool as recommended by the national group;
- An audit of the impact of temporary residents and recommendations made;
- A process to be established for the set-up of new practices (in 2019/20);
- Certificates and fee charges (Scottish Government guidance is to follow on this);
- Review the current meeting structure, remits and resources to ensure the ethos of the tripartite agreement, transparency and collaboration are achieved (a review will begin in 2018/19 and adjusted over the 3 years as appropriate);
- Local population health needs assessments will be undertaken by public health and by working closely with LIST analysts;
- Workforce planning is integral to all elements of the PCIP and key to more detailed plans is the National Health and Social Care Workforce Plan: Part 3 Primary Care (http://www.gov.scot/Publications/2018/04/3662);
- This will include the continuation of accessing the Rural GP Fellowship Programme in conjunction with National Education Scotland (NES). The successful application of Jedburgh Medical Practice for 2018/19 has the opportunity for a GP working a mix of sessions within a GP practice and Acute specialties. The programme for remote and rural classified GP practices is aimed at attracting and retaining, where possible, GPs to the Scottish Borders.

10. Cluster Working

Clusters are groups of practices working together to ensure the provision of high quality care for their patients and communities. They will drive forward continuous improvement, facilitating strong collaborative relationships across clusters and learning, developing and improving together. They will work in collaboration with the Primary & Community Services management team and NHS Borders Public Health Department.

There are currently four clusters within the Scottish Borders (East, Central, West and South – see map). This is to be reviewed within the duration of the plan particularly in terms of access and linkage to other areas and SBC services.

To maximise the potential from cluster working the Scottish Government's 'Improving Together' paper states the requirement of:

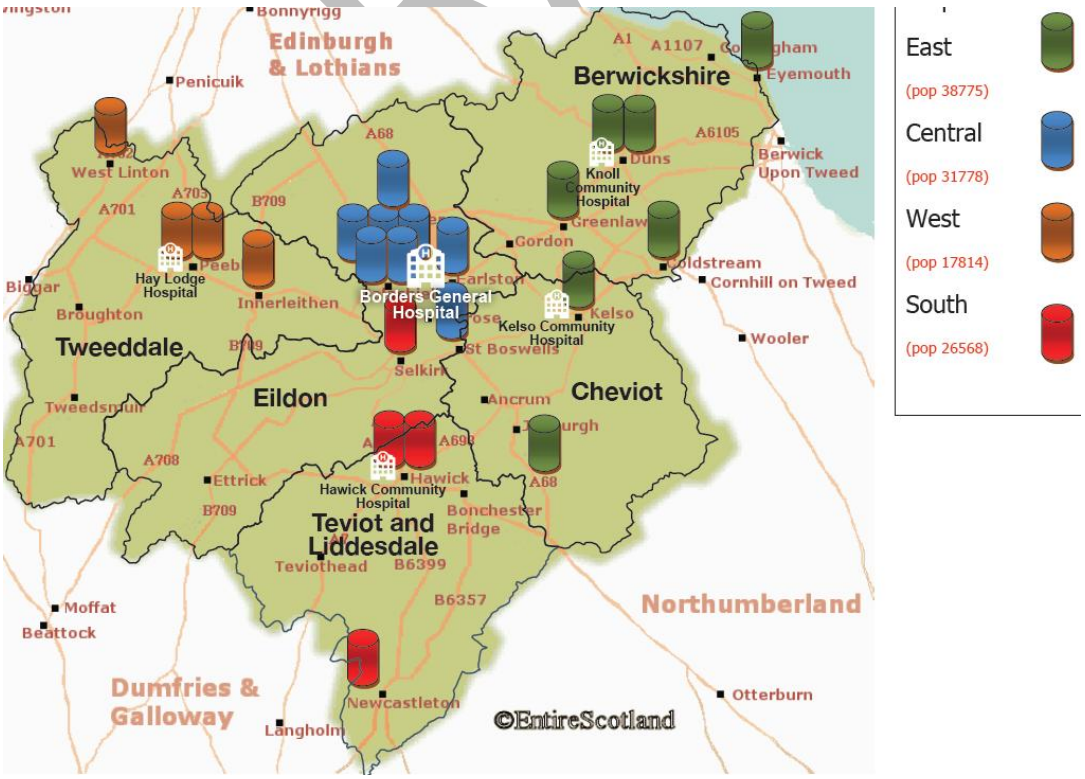
- Data (working in collaboration with the local LIST team);
- Health Intelligence Analysis;
- Facilitation (leadership provided through the clusters);
- Improvement Advice (national collaboration);
- Leadership (training to be considered for the cluster leads).

At present there are 4 GPs holding the cluster lead positions at a cost of £46,080 per annum. A recurring funding source for these will need to be found. Primary Care Improvement Fund (PCIF) resources have been used to progress pilot projects relevant to their local population. These include:

- The Community Acute Rehabilitation Team (CARE);
- The Advanced Practitioner Project;
- Here We Are (Docman Documentation Management Improvement);
- COPD Pilot;
- Medication Reconciliation in Primary Care Pilot Scheme;
- Anticipatory Planning Review – 'What Matters to Me';
- New Patient Checks Pilot Scheme.

The pilot schemes will be evaluated with the intention of continuing to support those with added benefits or to stop and invest into new opportunities for change.

The map shows the layout of the practices by IA locality and cluster in the Scottish Borders:



11. Beyond General Practice

a) Borders Emergency Care Service (BECS)/Out-of-Hours (OOH)

'Pulling Together: Transforming Urgent Care for the People of Scotland' by Sir Lewis Ritchie (released November 2015) described a new model of care where a multidisciplinary, multi-sectoral urgent care co-ordination and communication function will be provided at Urgent Care Resource Hubs, which would be configured for both service delivery and training purposes. They would be established primarily to co-ordinate urgent care for OOH services, however, should be considered on a 24/7 basis.

Following tests of change last year, BECS will permanently employ a range of clinical colleagues to support the delivery of cost effective, sustainable urgent care. The redesign is demonstrated on Appendix 3.

Funding for OOH services sits outwith the Primary Care Fund (PCF) and has been confirmed as £105k for the 2018/19 financial year.

b) Interface with Acute Services

Several strands of the PCIP have elements that span both Primary and Secondary Care Services, for example, MSK physiotherapy services, the Vaccination Transformation Programme (VTP) and Community Treatment and Care Services (CT&CS). It is essential that good communication across the care sectors continues and further develops as the PCIP progresses. Formal discussions will take place through the evolving Area Medical Committee (AMC) which will bring together clinicians from both Primary and Secondary Care.

12. Budget Planning

The process, cost and provision of adequate resource must be developed by the IA to ensure a safe transfer of workload. Service redesign will take into account the expectation that, where appropriate, the programme of delivery should continue to be conducted in or near GP practices.

In February 2018 the Scottish Budget Bill confirmed an increase of the Primary Care Fund from £72m in 2017/18 to £110 in 2018/19 (with additional funds for Mental Health and Out-of-Hours). Within this is an allocation totalling £45.75m nationally which is the Primary Care Improvement Fund (previously the Primary Care Transformation Fund, pharmacy, recruitment and retention etc.). This has been merged with the view of providing increased flexibility for individual IA priorities.

It is recognised that the level of transformation expected will be challenging given the level of new funding being invested.

Funding of the new GMS contract is, on the whole, via the Primary Care Fund (PCF). There are various programmes within this, one of which is the Primary Care Improvement Fund (PCIP). This allocation is facilitated through NHS Borders for implementation and totals £962k in 2018/19. This is estimated to increase to £1m in 2019/20 (year 2) and £2.1m in 2020/21 (year 3) as the national pot grows from £72m to £110m. This is summarised on Table 1 below:

Table 1:	**Year 1 2018/19 £000's (Confirmed)**	**Year 2 2019/20 £000's (Estimated)**	**Year 3 2020/21 £000's (Estimated)**
PCIF Allocations	962	1,050	2,100

This is to be released in two separate amounts (tranche 1 will deliver £561k, tranche 2 will be £240k). The second sum will follow the progress report to be submitted to the Scottish Government in September 2018. The assumption is that this funding will be available annually and thus necessary recruitment to progress the PCIP actions will also surmise this.

Previously agreed commitments against this resource leave a balance in the first year of £617k (see Table 2) which will support the prioritised PCIP work streams. There has been no formal confirmation of the resource allocation for 2019/20 and 2020/21, however, the Scottish Government has asked IA's and Health Boards to plan on the assumption that funding will continue.

Table 2:	**£000's**
18/19 Allocation	962
Pharmacy Commitments	
Baseline	*-161*
Pharmacy First	*-24*
Additional Support (PfE)	*-63*
VTP	-97
Remaining Allocation	**617**

The planning phase of this transformation process is still underway and four of the six priority areas are able to provide initial estimates of their requirements for the PCIP in year 1. These funding requirements are shown in Table 3. It is clear that the year 1 proposals exceed the resource envelope available; however, given that we are still in the planning stage of this transformation programme recognition is given that realistically only 6 months of the expenditure will apply during the 2018/19 financial year.

The result would be expenditure totalling £364k in 2018/19 with the expectation that the remaining allocation (£253k) is transferred into 2019/20, effectively helping resource the next stage of the plan. Discussions are ongoing with finance colleagues to consider the overall budget management of the plan.

Table 3:	Estimated Full Year Requirement Year 1 £000's	6 Months Total (Remaining 18/19) £000's
VTP (nominal)	*120*	*60*
Pharmacy	204	102
CT&CS	211	106
Urgent Care	0	0
Additional Roles:		
MSK Physiotherapy	191	96
Comm. Mental Health	0	0
Total	**727**	**364**
Funding Available		617
Remaining		253

Year 1 proposals total £727k, carrying this forward into year's 2 and 3 (taking into account the committed funding) provides a remaining balance each year for further consideration (Year 1 £253k, Year 2 £208k and Year 3 £1m). This is shown on Table 4.

Several assumptions have been made that are important to note: the first being the level of allocation increase (that has still to be confirmed), the uplift applied to the pharmacy element and lastly, the ability to carry forward remaining resources from the previous financial year. The latter should not be a major concern due to the Scottish Government's recognition that funding will, 'clearly fall within the scope of the MoU' and are, 'ring-fenced resources' [letter dated 23rd May 2018 from Richard Foggo].

After funding the full year 1 requirements of £727k this would leave a remaining balance with potential for investment. This needs further scoping work to enable the identification of key priorities and agreement with all relevant parties.

It should also be noted that these figures will change and will require regular updating due to the assumptions made, comparisons with the actual expenditure incurred and the potential for shifting priorities as the PCIP progresses.

Table 4:	Year 1 £000's	Year 2 £000's	Year 3 £000's
Funding Allocation (PCIF)	**962**	**1,050**	**2,100**
Commitments:			
Pharmacy	*-248*	*-271*	*-541*
VTP	*-97*	*-97*	*0*
Remaining Allocation	617	682	1,558
Carry Forward from the previous year		253	208
Estimated Continuing from Year Programme Expenditure	**364**	**727**	**727**
Remaining Balance for Additional Works	253	208	1,039

13. Workforce

The National Health and Social Care Workforce Plan was published in June 2017, Part 3 of that plan, subsequently published in May 2018, outlines the Scottish Government's approach to the Primary Care workforce issues (see below). The Plan sets out a range of options at a national, regional and local level for the recruitment and retention of GPs, including the expansion of the capacity and capability of MDT's. This includes plans for recruitment, training and development of specific groups and roles. As such a Scottish Borders Workforce Plan will need to be developed for Primary Care.

It has been indicated that as part of their role as EMG's, GPs will act as senior clinical leader's within the extended MDT, as outlined in the MoU.

National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for Primary Care in Scotland (May2018)

SUMMARY OF KEY RECOMMENDATIONS AND NEXT STEPS

This Plan sets out recommendations and the next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in parts one and two and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations below set out how we will enable the expansion and up-skilling of our Primary Care workforce the national facilitators available to enable this, and how this will be implemented to complement local workforce planning.

Facilitating primary care reform

Recommendations and commitments:

- Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care.
- In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover.
- The implementation of the new GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place.
- The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce.
- An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning.

Building Primary Care workforce capacity

Recommendations and commitments:

- Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing.
- Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs.
- As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and enhance opportunities for the primary care workforce to further develop rewarding and attractive careers.

Improving data, intelligence and infrastructure in primary care

Recommendations and commitments:

- More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.

- Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.
- Planning for future staffing in primary care should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning.
- The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by summer 2018.

NHS Borders Workforce Plan:

A plan is currently under development in order undertake a review of the existing workforce employed within GP Practices in the Scottish Borders. This will underpin an enhanced understanding of the existing Primary Care workforce and be utilised to inform the development of a local workforce plan. The initial phase of this work will be completed by December 2018. The information will be used to inform the development of proposals for year 2 focused on the 6 priority areas.

14. Risk

Risk assessments and Health Inequalities Impact Assessments will be undertaken across the different work streams and any required action plans will then be developed. The main areas of risk identified at this initial stage are around levels of engagement, finance, recruitment and capability.

15. Engagement and Ongoing Development

The PCIP is a dynamic working document and will be developed through ongoing dialogue and engagement with GPs, GP practice teams, wider IA colleagues, partner agencies and with patients and public involvement.

16. Summary

The updated GP contract was released in November 2017 and agreed by the GP community in January 2018. It has provided the opportunity for transformation in Primary Care services across the Scottish Borders. This 3 year Primary Care Improvement Plan (PCIP) provides a backdrop and highlights the main areas of focus for the IA in reshaping this facet of Primary Care. The key philosophies underlying the contract are communication, transparency and collaboration and the implementation of the plan will be progressed on that basis. By transforming the multi-disciplinary

team and services around the role of the Expert Medical Generalist (EMG) we will achieve a robust and sustainable community model of primary care for the people of the Scottish Borders.

This process must be carried out in an informed, measured and sustainable way. Service delivery will continue as existing practice and will evolve in a phased manner to ensure that seamless change is possible. Many projects and pilots schemes are already taking place with the opportunity to continue those that add value to services we commission.

APPENDIX 1

Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards
GMS Contract Implementation in the context of Primary Care Service Redesign

Introduction and Context

The principles underpinning the approach to general practice in Scotland were set out in a document General Practice: Contract and Context – Principles of the Scottish Approach published by the Scottish General Practitioners Committee ("SGPC") of the British Medical Association (BMA) and the Scottish Government in October 2016, noting that the Scottish Government and the SGPC are the two negotiating parties on commercial general practitioner (GP) contractual matters in Scotland. This Memorandum of Understanding ("MOU") between **the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards** builds on these arrangements and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MOU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

For the purposes of this MOU, we refer to Health and Social Care Partnerships (HSCPs) responsible for the planning and commissioning of primary care services.

As an Expert Medical Generalist (as defined in the Scottish GMS contract offer document for 2018 the "Scottish Blue Book"), the GP will focus on:

- Undifferentiated presentations,
- Complex care,
- Local and whole system quality improvement, and
- Local clinical leadership for the delivery of general medical services under GMS contracts.

Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and nonclinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others.

Delivering improved levels of local care in the community will have a clear benefit for patients and must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. This will require clear articulation of the respective roles and responsibilities of GPs and other members of the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan (see Sections F and G of this MOU).

The development of primary care service redesign in the context of delivery of the new GMS contract should accord with seven key principles:

Safe –Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

Person-Centred - Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focussed, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision making.
Having regard to the five principles underpinning the Health and Social Care Standards:

dignity and respect, compassion, to be included, responsive care and support and wellbeing.

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

Effective - The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

Sustainable – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

Affordability and value for money – Making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes.

An important determinant of success will be how the planned changes are implemented, seek to influence and depend on wider services.

This change has already started with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract. The new approach introduced by the GMS Statement of Financial Entitlements for 2016-17, sees GP practices working together in local Clusters with their HSCP and NHS Boards to identify priorities and improve the quality of services and outcomes for people.

Further key enablers for change include:

(1) Premises: The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in the risk of owning premises away from individual GPs to the Scottish Government. Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. Details on the criteria for lease transfer and for accessing interest free loans will be set out in the premises Code of Practice and summarised in the GMS contract offer document which sets out the terms of the proposed new Scottish GMS contract.

(2) Information Sharing Arrangements: The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.

The new GMS contractual provisions in Scotland will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within this joint controller arrangement. These contractual changes will support ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care.

(3) Workforce: The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multidisciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

A. Purpose and aim of the MOU

This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and is structured to set out the key aspects relevant to facilitating the statement of intent the document represents:

Section A – Purpose and aim
Section B - Parties and their responsibilities
Section C - Key stakeholders
Section D - Resources
Section E - Oversight
Section F – Primary Care Improvement Plans
Section G – Key Priorities

It provides the basis for the development by HSCPs, as part of their statutory Strategic Planning responsibilities, of clear HSCP Primary Care Improvement Plans, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. Plans will have a specific focus on the key priority areas listed at Section G of this MOU with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

Taken together with the Scottish GMS contract offer document, the National Code of Practice for GP premises, and the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018, this MOU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

In addition, The National Health and Social Care Workforce Plan: Part 3 Primary Care, to be published following agreement on the new Scottish GMS contract, will set out the context and arrangements for increasing the Scottish GP and related primary care workforce and both the

capacity and capability of the multi-disciplinary team.

This MOU will be reviewed and updated by the parties before 31 March 2021 through arrangements that will be agreed by March 2018.

B. Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Authority responsibilities (typically delivered through the Health and Social Care Partnership delivery organisations):

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met.

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the new Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board Areas;
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978;
- Delivering primary medical services as directed by HSCP as service commissioners;
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs;
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.
- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.
- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

C. Key Stakeholders

HSCPs must collaborate with NHS Boards as partners in the development and delivery of their Strategic Plan (and the associated Primary Care Improvement Plan). Local and Regional Planning arrangements will need to recognise the statutory role of the HSCP as service commissioners; and the partnership role of NHS Boards as NHS employers and parties to the GMS contracts for the delivery of primary medical services in their Board area.

In addition to this, HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals

- Third sector bodies carrying out activities related to the provision of primary care

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.
Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services, mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

D. Resources

General Practice funding – through the GMS contract funding allocated to NHS Boards, general practice funding represents a significant element of the public investment in community and primary care. The published draft Primary Medical Services budget was £821 million in 2017-18 – funding the remuneration of 4,460 General Practitioners; the c.3000 practice staff they employ, both nursing and non-clinical, and the non-staff expenses of running practices. This investment enables over 23 million healthcare interactions every year. The Primary Medical Services investment funds the part of the system that is the first port of call for most people's healthcare needs most of the time. In addition to the direct care enabled by this investment, the clinical decisions GPs make – whether to treat; how to treat; whether to refer to further specialist treatment – have a much wider impact on the health and social care system. The "GP footprint" is estimated to be as much as four times the direct investment in Primary Medical Services. This investment through the contract is, therefore, critical to the sustainability of the whole health and care system.

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was invested through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the 3 financial years from 1 April 2018 to £250 million 2021-22.

Process

Specific levels of resource will be agreed as part of the Scottish Government's Spending Review and budget processes and allocated in line with the arrangements set out in this MOU.

Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs will agree these

Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority. Key partners and stakeholders should be fully engaged in the preparation, publication and review of the plans.

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) will be set out in an annual funding letter as part of the Scottish Government's budget setting process.

The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Fund, and will feature as a key element of the National Health and Social Care Workforce Plan: Part 3 Primary Care.

E. Oversight

New oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland will be developed including:

A National GMS Oversight Group ("the national oversight group") with representatives from the Scottish Government, the SGPC, HSCPs and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS contract in Scotland and the HSCP Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working.

National issue specific groups – A range of national issue specific groups with members drawn from a range of stakeholders, including NHS Boards, HSCPs and SGPC where appropriate will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation. These may include: GP Contract Implementation Group; GP premises; GP IT, e-Health; Data and Information; Remote and Rural; Nursing; GPN Group; Vaccination Transformation Programme; Patient Groups.

As well as the requirements on the HSCP to develop a Primary Care Improvement Plan as set out in Section D, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract as set out in the Scottish GMS contract offer document. These arrangements will include the priority areas set out in Section G of this MOU and must be agreed with the LMCs.

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders as set out above. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee as set out above. HSCPs and NHS Boards will discuss and agree locally the arrangements for providing appropriate levels of support to enable this advice to

be provided.

Within HSCPs, GP clusters have a critical role in improving the quality of care in general practice and influencing HSCPs both regarding how services work and service quality. Improving Together: a new quality framework for GP Clusters in Scotland provides a framework for how that learning, developing and improving may be achieved. As GP Clusters mature, they will be expected to have a key role in proactively engaging with HSCPs, advising on the development of HSCP Primary Care Improvement Plans and working with their MDT and wider professional networks to ensure highly effective health and social care provision within and across the HSCP area and where relevant across HSCPs.

HSCPs will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement. Healthcare Improvement Scotland will work in support of HSCPs where required to ensure that GP clusters have the support they need to engage effectively in quality improvement activity.

The *Local Intelligence Support Team* (LIST) already provides support to HSCPs and has been commissioned to provide support through HSCPs to GP clusters. This support involves on-site expert analytical advice to provide local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service users.

F. Primary Care Improvement Plan

The collaborative implementation of the new GMS contract in Scotland should be set in the context of the HSCP Primary Care Improvement Plan. Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3 years from 2018 - 2021 are listed in Section G below. The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional investment is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. It will be important that GPs continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.

The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Plan should also consider how the new MDT model will align and work with community based and where relevant acute services, subject to wider stakeholder engagement to be determined by the HSCP in line with their statutory duty to consult.

Key Requirements of the Primary Care Improvement Plan:

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed in Section C;
- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;
- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs;
- To provide detail on available resources and spending plans (including workforce and infrastructure);
- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract;
- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018.

Key Priorities

Existing work to develop and test new models of care has shown benefits from the effective deployment of other professional staff working within a wider MDT aligned to general practice. The priority between 2018 and 2021 will be on the wider development of the services detailed below. Changes to services will only take place when it is safe to do so. The service descriptions and delivery timescales given here are provided for the purposes of this MOU.

(1) *The Vaccination Transformation Programme (VTP)* was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations.

In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. As indicated above, there may be geographical and other limitations to the extent of any service redesign.

(2) Pharmacotherapy services – These services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the HSCP Primary Care Improvement Plan. This is to be followed by phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

(3) *Community Treatment and Care Services* - These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the

management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

(4*) Urgent care (advanced practitioners)* - These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.
By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.
(5) Additional Professional roles - Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- *Musculoskeletal focused physiotherapy services*
- *Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice .*

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

(*6) Community Links Worker (CLW)* is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

Workforce As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas under (1) to (6) of Section G in the MOU will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

Existing practice staff will continue to be employed directly by practices. Practice Managers,

receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

Signatories
Signed on behalf of the Scottish General Practice Committee

Name: Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association
Date: 10 November 2017

Signed on behalf of Health and Social Care Partnership Chief Officers
Name: David Williams, Chief Officer, Glasgow HSCP and Chair, Chief Officers, Health and Social Care Scotland
Date: 10 November 2017

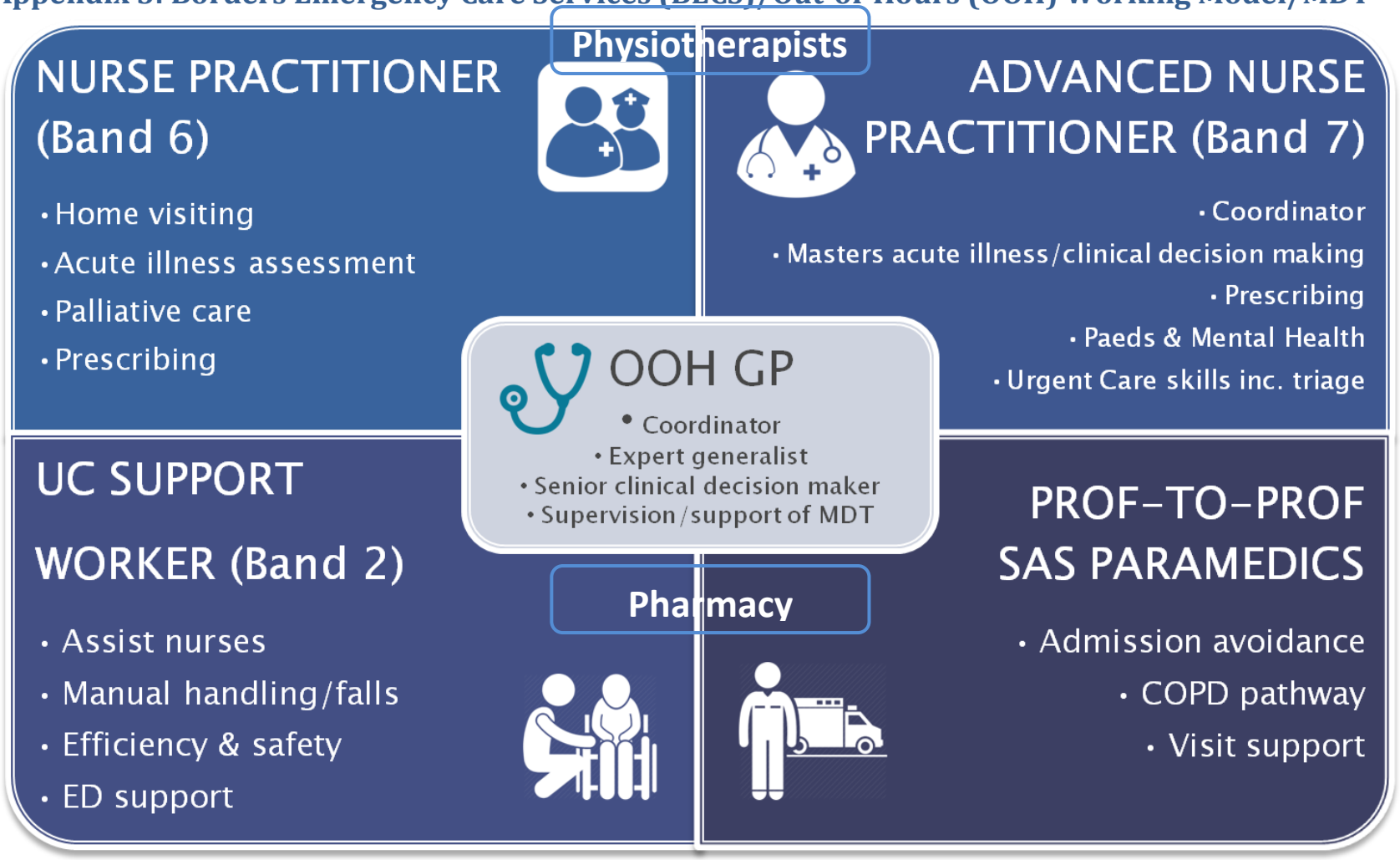
Signed on behalf of NHS Boards
Name: Jeff Ace, Chief Executive, NHS Dumfries & Galloway and Chair, Chief Executives, NHS Scotland
Date: 10 November 2017

Signed on behalf of the Scottish Government
Name: Paul Gray, Chief Executive, NHS Scotland
Date: 10 November 2017

Appendix 2: Primary Care Improvement Plan Summary Table

	Service Area	Project Sponsor	Project Lead	Target Date	RAG Status	RAG Commentary
1.	Vaccination Transformation Programme (VTP)	Tim Patterson	Trish Wintrup	March 2021		High risk/high priority
2.	Pharmacy	Alison Wilson	Keith Maclure			High priority with work programme already underway
3.	Community Treatment and Care Services	Claire Pearce	Erica Reid/Gordon Gowans			High risk/high priority
4.	Urgent Care	Nicola Lowdon	TBA			Cluster project started
5.						
a.	MSK Physiotherapy	Lynne Morgan Hastie	Janie Thomson	March 2021		Medium priority with App in post
b.	Community Mental Health Services	Amanda Cotton	Haylis Smith			Medium priority with merging process underway
6.	Community Links Worker (CLW)	Rob McCulloch-Graham	Natalie Macdonald			Medium priority with merging process underway

Appendix 3: Borders Emergency Care Services (BECS)/Out-of-Hours (OOH) Working Model/MDT



Courtesy of Dr Rebecca Green, BECS

PRIMARY CARE STRATEGY BOARD (PCSB)

Terms of Reference & Remit

Appendix 4: DRAFT

Constitution

The Primary Care Strategy Board (PCSB) has been established to oversee and direct the work programme and priorities for the Scottish Borders Health & Social Care Partnership (H&SCP) Primary Care transformation programme. It will provide the role of strategic leadership, scrutiny and review for the Primary Care Transformation Programme.

The group was constituted from July 2018 and will be reviewed on an annual basis.

Membership

IJB Chief Operating Officer (Chair)
Medical Director (Co-Chair)
GP Sub-Committee Representative (Chair of GP Sub-Committee)
Central Cluster Lead
East Cluster Lead
South Cluster Lead
West Cluster Lead
GP Representatives x2
Associate Medical Director
Director of Finance
Director of HR
Lead Nurse for Community
Director of Strategic Change & Performance
Director of Public Health
Director of Pharmacy
General Manager, Mental Health and Learning Disability Services
Public Involvement Representative
Area Service Manager, SAS
General Manager, Primary & Community Services
Contracts Manager, Primary & Community Services
Partnership Forum Representative
Primary Care Transformation Programme Manager

Timescale

The outputs of this programme are set to be completed by the end of March 2021; with 6 monthly review dates beginning from September 2018. The PCSB will meet on a bi-monthly basis though the frequency may be varied subject to agreement with the Chair. A schedule of meetings will be set out in advance.

Reporting Arrangements

Members of the Board will be collectively accountable for the delivery of the Primary Care Improvement Plan (PCIP). It is important that nominated members commit to attend the PCSB. Where it is not possible, nominated deputies are encouraged to attend with agreement from the Chair.

The Chief Officer of the Scottish Borders Integrated Joint Board (IJB) will be the overall programme Senior Responsible Officer (SRO). The IJB Leadership Group and the NHS Borders Strategy Group will be supported by the Primary Care Strategy Group. PCSG will consult with the GP Sub-Committee, liaise with Health & Social Care Management Team and negotiate with LMC.

The PCSB will ultimately report and make recommendations to the NHS Board and the IJB.

Role & Remit

Specifically the group will:

- Ensure the implementation of the 2018 General Medical Services (GMS) Contract by 31st March 2021;
- Support the vision and strategic leadership for the Primary Care Transformation Programme;
- Provide governance and scrutiny across all aspects of the Programme;
- Ensure the Primary Care Improvement Plan (PCIP) for the Scottish Borders is robust, effectively monitored with managed timetables and obstacles which may affect delivery removed;
- Ensure consistency and connection between the six priority areas for change;
- Provide regular updates to GP Sub-Committee, LMC, H&SCP, IJB, NHS Borders;
- Ensure sufficient and appropriate linkages between the Primary Care Transformation Programme and other major planning activities within the partnership e.g. efficiencies;
- Ensure that there is an integrated, comprehensive and effective Communications Strategy in place to ensure all stakeholders (patients, staff, public and partner organisations) are informed and involved throughout the process;
- Remit decisions outwith the scope of the group to the IJB Leadership Group;
- Create and monitor the Programme Risk Register;
- Ensure that all Programme Evaluation and Lessons Learned Reports are prepared.

Group Administration

The Board is supported by the Business & Project Support Manager or alternative member of the P&CS Administrative Team. Key activities of the administrative support are:

- Work closely with the Chair;
- Advise on the content of agendas, accompanying papers, minutes & actions;
- Provide advisory support to ensure that appropriate information is communicated to all GP practices & any necessary other parties.

The agenda & papers will normally be circulated one week in advance of the meeting. Urgent or late papers may be circulated by email prior to the meeting but tabled papers will be avoided except in extraordinary circumstances.

Minutes of the meetings, as well as the Work Programme & other relevant documents arising as a result of the Committee will be circulated & shared with the LMC, GP Sub-committee, Clusters, Health Board and IJB as necessary.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .....20 August 2018.....

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Robert McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 825528

DIRECTION – PRIMARY CARE IMPROVEMENT PLAN

Purpose of Report:	To direct the Health and Social Care Partnership, and in particular NHS Borders to implement the Primary Care Improvement Plan for 2018-21. (Agenda item 6.1)

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **approve** the issuing of a Direction to NHS Borders and Scottish Borders Council to implement the Primary Care Improvement Plan for 2018-21. b) **request** NHS Borders to implement the Primary Care Improvement Plan for 2018-21 and the proposed funding allocations for 18/19, under this new "Direction". c) **request** highlight reports from the Primary Care Strategy Group and the NHS Borders Clinical Executive Strategy Group on the progress and on-going development of the implementation of the PCIP.

Personnel:	There will be staffing implications within the PCIP, these will be addressed through each work stream.

Carers:	N/A

Equalities:	The overall policy direction of the Primary Care Improvement Plan will apply equally where possible.

Financial:	There will be staffing implications within the PCIP, these will be addressed through each work stream and funding applied within the overall budget limit of the plan.

	Should further funding be required the normal decision making and governance procedures will apply.

Legal:	Introduction of a new approach to primary care provision. This proposal has been discussed at the Board Executive Team, the Executive Management Team, the Clinical Executive Strategy Group and agreed by the GP Sub Committee.

Risk Implications:	Risk Assessments and Health Inequality Impact Assessments will be undertaken at individual work stream level.

Background

1.1 The Primary Care Improvement Plan (PCIP) will aim to support the further introduction of the new contract for General Practitioners and improve the overall efficiency and quality of Primary Care provision within the Scottish Borders.

Summary

2.1 Last year Scottish Government brought together the Out of Hours, Primary Care Transformation Fund and Mental Health Funds into a single funding allocation, referred to as the Primary Care Transformation Fund (PCTF).

2.2 Several key developments have taken place since then. These include:

- Scottish Government and BMA agreement to proceed with the 2018 General Medical Services contact following a poll of the GP profession – January 2018.
- Publication of the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards – draft published November 2017 and finalised 19 April 2018.
- Primary Care National Workforce Plan – published 30 April 2018.
- Passing of Scottish Government Budget Bill in February 2018 confirming increase in Primary Care Fund from £72m in 2017-18 to £110m in 2018-19.
- Wider contextual developments include; the new Oral Health Action Plan and on-going work by the Health and Justice Collaboration Improvement Board to further develop ‘Action 15’ of the Mental Health Strategy, which is committed to the appointment of 800 new mental health workers in health and justice settings.

2.3 Taken together, these set the terms of the main deliverables which are expected within the Primary Care Improvement Plan, focusing on six priority work areas:

- Vaccinations
- Pharmacotherapy
- Community Treatment and Care
- Urgent Care
- Additional Professional Roles
- Community Link Workers

Funding

3.1 The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Primary Care Fund:

- Primary Care Improvement Fund (PCIF):
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours Fund.

3.2 An in-year NRAC allocation to integration Authorities (IAs) (via Heath Boards) will comprise £45.750 million of the £115.5 million Primary Care Fund. For the Borders this equates to an allocation of £962,000 for 18/19, the fund must be delegated in its entirety to Integration Authorities.

3.3 Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services.

3.4 The money must be used by IAs for the purposes described by Scottish Government. The PCIF including base lined GP pharmacy funding should be;

"treated as PCIF and cannot be subject to any general savings requirements and must not be used to address any wider funding pressures."
Directorate for Population Health, Primary Care Division, Scottish Government. 23rd May 2018.

3.5 This paper, through this "Direction", will enable the Health Board and the Health and Social Care Partnership, to support the continued introduction of the new GP Contract and to introduce further improvements in the primary care offer for the residents of the Scottish Borders.

3.6 Should the board accept this proposal to introduce this Direction and the proposed plan; further papers will be submitted to the Strategic Planning Group with highlight reports to the Integration Joint Board (IJB) outlining the progress during this financial year with further more detailed plans to follow for the next two financial years.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 20 August 2018

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Jane Robertson, Strategic Planning and Development Manager
Telephone:	01835 825080

INTEGRATED CARE FUND CONDITIONS
August 2018

Purpose of Report:	The purpose of this report is to seek acceptance from the Integrated Joint Board (IJB) of the proposed conditions for future applications for the Integrated Care Fund (ICF).

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Agree** the proposed conditions for future applications for ICF

Personnel:	A number of projects employ staff

Carers:	A number of projects have positive outcomes for carers

Equalities:	Related to EIA for Strategic Plan

Financial:	n/a

Legal:	n/a

Risk Implications:	Risk of not delivering on strategic priorities if those projects which are clearly supporting delivery are not supported to continue.

Purpose

1.1 The purpose of this report is to seek acceptance of the NHS Borders Board proposed conditions for future applications for the ICF to the IJB.

Background

2.1 The ICF was first allocated to the shadow partnership in 2015/16 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of £6.39m over three years. To date a total of £6.169m of IC funds have been directed by the IJB leaving £0.221m undirected from the original £6.39 allocation.

2.2 A further year 4 allocation of IC funding of £2.13m for 2018/19 has been delegated from NHS Borders core funding with the following conditions for application being proposed from the Borders NHS Board for acceptance:

1. Investment of the resource must be in line with the strategic commissioning plan and weight given within that to the key priority areas of reducing delayed discharges and unscheduled admissions;
2. Projects must have a positive measurable impact on delayed discharge numbers and occupied bed days;
3. Projects must deliver change which result in reduced costs;
4. Projects must be evidenced based;
5. Funding for each project will be non-recurring and each project must have a clear exit strategy.

2.3 Taking into account the carry-over of ICF from the original three year allocation and the allocation of IC Funding for 18/19 Table 1 below outlines a total of £2.351m IC Funding remains for direction by the IJB in 18/19.

Table 1

Integrated Care Fund Update

	£k	£k
Total 3 year Allocation (3 X £2.130m)		**6,390**
Resource Directed to 31/3/2018 (See Appendix 1))	(5,854)	
Carried Forward to 2018/19		**536**
Directed to Crawwood April 2018	(474)	
Project realignments (April / Jun 2018)	160	
2018/19 ICF Allocation	2,130	
Unallocated Funding at 30/6/2018		**2,351**

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .....20 August 2018.....

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Jill Stacey, Chief Internal Auditor, Scottish Borders Health and Social Care Integration Joint Board (Scottish Borders Council's Chief Officer Audit & Risk)
Telephone:	01835 824000

INTEGRATION JOINT BOARD LOCAL CODE OF CORPORATE GOVERNANCE

Purpose of Report:	The purpose of this report is to propose that the revised Local Code of Corporate Governance of the Scottish Borders Health and Social Care Integration Joint Board (IJB), that provides the framework for the corporate governance arrangements for delivering health and social care integration in the Scottish Borders, be approved by the full IJB Board on recommendation by the IJB Audit Committee.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the revised IJB Local Code of Corporate Governance, as detailed in Appendix 1 of this report.

Personnel:	N/A

Carers:	N/A

Equalities:	It is anticipated that there are no adverse impact due to race, disability, gender, age, sexual orientation or religion/belief arising from the proposals in this report.

Financial:	There are no direct financial implications arising from the proposals in this report. Arrangements to ensure that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively is an integral part of good corporate governance and therefore financial governance and key internal financial controls are embedded within the Local Code of Corporate Governance.

Legal:	Development of its own Local Code of Corporate Governance

	and arrangements for its annual review will enable the IJB to comply with best practice. Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk. The IJB Chief Officer and IJB Interim Chief Financial Officer have been involved in the annual review of the IJB's governance framework and the revisions to the IJB's Local Code of Corporate Governance.

Risk Implications:	The Local Code of Corporate Governance provides the framework for members and officers of the IJB to conduct its affairs that are based on seven principles. The review of and revisions to the Local Code of Corporate Governance will ensure that internal controls, risk management and other governance arrangements are improved through the implementation of the framework.

Background

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

1.2 Scottish Borders Health and Social Care Integration Joint Board (IJB) aims to meet the highest standards of corporate governance to help ensure that it meets its objectives. The IJB operates through a governance framework for the conduct of its affairs which brings together an underlying set of legislative requirements, governance principles and management processes.

1.3 Authorities are urged to test their structure against the seven core principles of good governance set out in the CIPFA/SOLACE 'Delivering Good Governance in Local Government' 2016 Edition (the 2016 Framework) by:

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

1.4 A self-assessment of compliance with the IJB Local Code was carried out, using the conclusions and audit opinion from the IJB Internal Audit Annual Assurance Report 2017/18, to inform the draft IJB Annual Governance Statement 2017/18 by the Chief Officer prior to its inclusion within the unaudited IJB Statement of Accounts 2017/18, all of which were considered by the IJB Audit Committee on 25 June 2018.

1.5 During the 2017/18 review it was concluded that revisions are required to the IJB Local Code (previously approved by the IJB Board on 28 August 2017) to ensure it reflects the changing context of the IJB.

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Summary

2.1 Revisions are required to the IJB Local Code of Corporate Governance (Local Code), which is attached to this report as Appendix 1, to ensure it continues to be a value-added tool for members and officers of the IJB in the conduct of its affairs.

2.2 The main changes to the Local Code cover:

a) Updating existing and formalising new governance arrangements as these have been developed and implemented by the IJB during the year; and
b) Addressing gaps in the previous version on how the IJB demonstrates good governance in practice against each of the supporting principles that underpin the seven core principles of good governance set out in the CIPFA/SOLACE 'Delivering Good Governance in Local Government' 2016 Edition.

2.3 The approval by the IJB of its revised Local Code, on recommendation by the IJB Audit Committee 25 June 2018 (as set out in Appendix 1), which reflects the seven core principles with supporting principles, each of which in turn translates into a range of specific requirements, will ensure the IJB meets best practice. Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.

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

2.5 This process not only creates an opportunity for the IJB to set out its standard for good governance but also to ensure that its governance arrangements are seen to be sound. This is important as the governance arrangements in public services are closely scrutinised.

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Scottish Borders Health and Social Care Integration Joint Board Local Code of Corporate Governance (approved 28 August 2017)

(updated May 2018)

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

The 7 core principles of good governance are:

A. Behaving with integrity, demonstrating strong commitment to ethical values, and respecting the rule of law
B. Ensuring openness and comprehensive stakeholder engagement
C. Defining outcomes in terms of sustainable economic, social, and environmental benefits
D. Determining the interventions necessary to optimise the achievement of the intended outcomes
E. Developing the entity's capacity, including the capability of its leadership and the individuals within it
F. Managing risks and performance through robust internal control and strong public financial management
G. Implementing good practices in transparency, reporting, and audit to deliver effective accountability

Authorities are urged to test their structure against these principles by reviewing their existing governance arrangements against the Framework, developing and maintaining an up-to-date local code of governance including arrangements for ensuring its ongoing application and effectiveness and preparing a governance statement in order to report publicly on the extent to which they complies with their own code on an annual basis, including how they have monitored the effectiveness of their governance arrangements in the year, and on any planned changes for the current period.

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

A. Behaving with integrity, demonstrating strong commitment to ethical values, and respecting the rule of law
Local government organisations are accountable not only for how much they spend, but also for how they use the resources under their stewardship. This includes accountability for outputs, both positive and negative, and for the outcomes they have achieved. In addition, they have an overarching responsibility to serve the public interest in adhering to the requirements of legislation and government policies. It is essential that, as a whole, they can demonstrate the appropriateness of all their actions and have mechanisms in place to encourage and enforce adherence to ethical values and to respect the rule of law.

A1 Behaving with integrity

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring members and officers behave with integrity and lead a culture where acting in the public interest is visibly and consistently demonstrated thereby protecting the reputation of the organisation	Reliance is placed on the values and standards set out in the codes of conduct within the employer partner organisations, as well as the organisational development plans, which incorporate "The Seven Principles of Public Life" identified by the Nolan Committee on Standards in Public Life. Shared values are reflected in the Strategic Plan.
2	Ensuring members take the lead in establishing specific standard operating principles or values for the organisation and its staff and that they are communicated and understood. These should build on the Seven Principles of Public Life (the Nolan Principles)	The Integration Joint Board has an approved Constitution, Standing Orders and Terms of Reference. Reliance is placed on the values and standards set out in the codes of conduct within the employer partner organisations, as well as their organisational development plans. Shared values are reflected in the Strategic Plan.
3	Leading by example and using these standard operating principles or values as a framework for decision making and other actions	The IJB Audit Committee remit includes promotion of the highest standards of conduct and professional behaviour. Reliance is placed on the arrangements within the employer partner organisations for identifying, mitigating and recording conflicts of interest, hospitality and gifts. Declarations of Interest are set out in the IJB's Standing Orders which govern the conduct of each Committee meeting. They are also a standard agenda item at all meetings of the Board. The standard template for decision-making reports to the IJB and its Committees includes a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing Evaluation of the implications in reports could be more consistently applied The IJB's Annual Governance Statement is the outcome of the annual self-evaluation of compliance.
4	Demonstrating, communicating and embedding the standard operating principles or values through appropriate policies and processes which are reviewed on a regular basis to ensure that they are operating effectively	As A1.3 The role of the IJB Audit Committee is to have high-level oversight of internal control, governance and risk management. The IJB Audit Committee has been constituted with a Terms of Reference and has periodic meetings during the year in line with the Audit Cycle. Reliance is placed on partners' policies and processes for complaints and whistle blowing.

A2 Demonstrating strong commitment to ethical values

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Seeking to establish, monitor and maintain the organisation's ethical standards and performance	The IJB's Annual Governance Statement is the outcome of an annual self-evaluation of compliance.
2	Underpinning personal behaviour with ethical values and ensuring they permeate all aspects of the organisation's culture and operation	Reliance is placed on the arrangements within the partner organisations for: • Provision of ethical awareness training • Appraisal processes taking account of values and ethical behaviour • Staff appointments policy • Procurement policy • Ethical values feature in contracts with external service providers
3	Developing and maintaining robust policies and procedures	
4	Ensuring that external providers of services on behalf of the organisation are required to act with integrity and in compliance with high ethical standards expected by the organisation	

A3 Respecting the rule of law

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring members and staff demonstrate a strong commitment to the rule of the law as well as adhering to relevant laws and regulations	Advice and overseeing compliance on legal matters is provided by the Chief Officer supported by Board Secretary, Chief Financial Officer, and Chief Internal Auditor as appropriate.
2	Creating the conditions to ensure that the statutory officers, other key post holders and members are able to fulfil their responsibilities in accordance with legislative and regulatory requirements	The Scheme of Integration sets out the roles and responsibilities of statutory officers (Chief Officer, Chief Financial Officer) which are reflected within job descriptions and relevant governance documents. Guidance is available. As A3.1.
3	Striving to optimise the use of the full powers available for the benefit of citizens, communities and other stakeholders	The scope is set out in the Scheme of Integration in order to comply with the Public Bodies (Joint Working) (Scotland) Act 2014 which requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. Guidance is available on use of powers. As A3.1.
4	Dealing with breaches of legal and regulatory provisions effectively.	In the context of health and social care integration this is the Chief Officer; a Statutory post with a job profile. Reliance is placed on the arrangements within the partner organisations for ensuring legal compliance in operation of services. Advice and overseeing compliance on legal matters is provided by the Chief Officer supported by Board Secretary, Chief Financial Officer, and Chief Internal Auditor as appropriate.
5	Ensuring corruption and misuse of power are dealt with effectively	Reliance is placed on the arrangements within the employer partner organisations for effective anti-fraud and corruption policies and procedures.

B. Ensuring openness and comprehensive stakeholder engagement
Local government is run for the public good, organisations therefore should ensure openness in their activities. Clear, trusted channels of communication and consultation should be used to engage effectively with all groups of stakeholders, such as individual citizens and service users, as well as institutional stakeholders

B1 Openness

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring an open culture through demonstrating, documenting and communicating the organisation's commitment to openness	Corporate governance is about openness, integrity and accountability and the Local Code sets out the IJB's systems and processes through which it accounts to, engages with and, where appropriate, leads its communities. Committee Minutes and Reports are published on modern.gov website for transparency. The IJB business is held in public unless there are good reasons for not doing so on the grounds of confidentiality. Reliance is placed on the arrangements within the partner organisations to ensure compliance with Data Protection and Freedom of Information legislation.
2	Making decisions that are open about actions, plans, resource use, forecasts, outputs and outcomes. The presumption is for openness. If that is not the case, a justification for the reasoning for keeping a decision confidential should be provided	As B1.1
3	Providing clear reasoning and evidence for decisions in both public records and explanations to stakeholders and being explicit about the criteria, rationale and considerations used. In due course, ensuring that the impact and consequences of those decisions are clear	There is a Calendar of dates for submitting, publishing and distributing reports to IJB Board and Committees. Report pro-formas set out professional advice and considerations in reaching decisions. Professional advice and overseeing compliance with the legal and financial framework is provided by the Chief Officer, Chief Financial Officer, Chief Internal Auditor and Secretary to the IJB as appropriate.
4	Using formal and informal consultation and engagement to determine the most appropriate and effective interventions/ courses of action	Community engagement was encouraged as part of the development of the Scheme of Integration and the Strategic Plan of the Health and Social Care Partnership.

B2 Engaging comprehensively with institutional stakeholders

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Effectively engaging with institutional stakeholders to ensure that the purpose, objectives and intended outcomes for each stakeholder relationship are clear so that outcomes are achieved successfully and sustainably	The Strategic Plan, which was developed following consultations with interested parties including members of the public (therefore highly co-produced), is currently being reviewed and updated. Locality Plans have been produced and published (October 2017) following consultation. The Communications and Engagement Plan, which sets out the key requirements for effective communications and engagement with all relevant stakeholders, requires review and update.

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
2	Developing formal and informal partnerships to allow for resources to be used more efficiently and outcomes achieved more effectively	Scottish Borders Council and NHS Borders are partners in the Scottish Borders Health & Social Care Partnership which also involves the third sector, independent sector and user/ carer representatives. The Strategic Planning Group and the Integrated Performance Group which have representation from partners are also part of the governance arrangements.
3	Ensuring that partnerships are based on: • trust • a shared commitment to change; • a culture that promotes and accepts challenge among partners; and that • the added value of partnership working is explicit	As B2.2.

B3 Engaging stakeholders effectively, including individual citizens and service users

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Establishing a clear policy on the type of issues that the organisation will meaningfully consult with or involve individual citizens, service users and other stakeholders to ensure that service/other provision is contributing towards the achievement of intended outcomes	As B2.1.
2	Ensuring that communication methods are effective and that members and officers are clear about their roles with regard to community engagement	As B2.1
3	Encouraging, collecting and evaluating the views and experiences of communities, citizens, service users and organisations of different backgrounds including reference to future needs	As B2.1
4	Balancing feedback from more active stakeholder groups with other stakeholder groups to ensure inclusivity.	Consultation processes seek to secure opinion which is as inclusive as possible.
5	Taking account of the interests of future generations of tax payers and service users	The partnership has a statutory responsibility to involve patients and members of the public in how health and social care services are designed and delivered.

C. Defining outcomes in terms of sustainable economic, social, and environmental benefits
The long-term nature and impact of many of local government's responsibilities mean that it should define and plan outcomes and that these should be sustainable. Decisions should further the authority's purpose, contribute to intended benefits and outcomes, and remain within the limits of authority and resources. Input from all groups of stakeholders, including citizens, service users, and institutional stakeholders, is vital to the success of this process and in balancing competing demands when determining priorities for the finite resources available

C1 Defining outcomes

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Having a clear vision which is an agreed formal statement of the organisation's purpose and intended outcomes containing appropriate performance indicators, which provides the basis for the organisation's overall strategy, planning and other decisions	The vision, strategic objectives and outcomes are reflected in the Scottish Borders Health & Social Care Partnership's Strategic Plan 2016-2019 and the associated Commissioning and Implementation Plan. The Strategic Plan is currently being reviewed and updated to ensure it is based upon on-going assessment of need. The Commissioning and Implementation Plan has been updated during 2017/18.
2	Specifying the intended impact on, or changes for, stakeholders including citizens and service users. It could be immediately or over the course of a year or longer	As C1.1
3	Delivering defined outcomes on a sustainable basis within the resources that will be available	As C1.1
4	Identifying and managing risks to the achievement of outcomes	The Risk Management Strategy was approved by the IJB on 7 March 2016. It includes the: reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities; and monitoring risk management activity and performance. The IJB Strategic Risk Register is a work in progress.
5	Managing service users' expectations effectively with regard to determining priorities and making the best use of the resources available	As C1.1

C2 Sustainable economic, social and environmental benefits

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Considering and balancing the combined economic, social and environmental impact of policies, plans and decisions when taking decisions about service provision	The standard template for decision-making reports to the IJB and its Committees includes a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing.
2	Taking a longer-term view with regard to decision making, taking account of risk and acting transparently where there are potential conflicts between the organisation's intended outcomes and short-term factors such as the political cycle or financial constraints	The standard template for decision-making reports to the IJB and its Committees includes a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing. Potential conflicts between the IJB's intended outcomes and short-term factors such as the political cycle or financial constraints of the partner organisations are recognised as part of value for money considerations and medium term financial planning. Reliance is placed on the value for money arrangements within the partner organisations. The IJB has issued directions to the partners primarily to deliver business as usual, with the exception of a limited amount of commissioning through ICF and Social Care funding. As limited commissioning has taken place it follows that little in-roads has been achieved in service redesign through either disinvestment or targeted reinvestment. It is therefore unclear how value for money will be assessed in those commissioning decisions. The performance management framework does not contain any value for money metrics e.g. cost per case throughput. The performance management framework is being further developed over time by the Integrated Performance Group.
3	Determining the wider public interest associated with balancing conflicting interests between achieving the various economic, social and environmental benefits, through consultation where possible, in order to ensure appropriate trade-offs	As C2.2
4	Ensuring fair access to services	As C2.2 To promote fair access to services compliance with requirements on Equality and Diversity are considered during the decision making process and reliance is placed on the equality and diversity arrangements within the partner organisations.

D. Determining the interventions necessary to optimise the achievement of the intended outcomes
Local government achieves its intended outcomes by providing a mixture of legal, regulatory, and practical interventions. Determining the right mix of these courses of action is a critically important strategic choice that local government has to make to ensure intended outcomes are achieved They need robust decision-making mechanisms to ensure that their defined outcomes can be achieved in a way that provides the best trade-off between the various types of resource inputs while still enabling effective and efficient operations. Decisions made need to be reviewed continually to ensure that achievement of outcomes is optimised.

D1 Determining interventions

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring decision makers receive objective and rigorous analysis of a variety of options indicating how intended outcomes would be achieved and including the risks associated with those options. Therefore ensuring best value is achieved however services are provided	The standard template for decision-making reports to the IJB and its Committees include a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing. Officers attend IJB and its Committee meetings to advise as appropriate. Committee reports are published on modern.gov one week in advance of meeting dates For best value - see C2.2 above
2	Considering feedback from citizens and service users when making decisions about service improvements or where services are no longer required in order to prioritise competing demands within limited resources available including people, skills, land and assets and bearing in mind future impacts	The Scottish Borders Health & Social Care Partnership's Strategic Plan 2016-2019 is based on consultation. The Strategic Plan is currently being reviewed and updated and any update will be based upon further consultation. The partnership has a statutory responsibility to involve patients and members of the public in how health and social care services are designed and delivered.

D2 Planning interventions

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Establishing and implementing robust planning and control cycles that cover strategic and operational plans, priorities and targets	Reporting schedule for meetings and timetable for papers. Committee reports are published on modern.gov one week in advance of meeting dates.
2	Engaging with internal and external stakeholders in determining how services and other courses of action should be planned and delivered	See D1.2
3	Considering and monitoring risks facing each partner when working collaboratively including shared risks	A risk management framework is in place but risk management is not yet embedded.
4	Ensuring arrangements are flexible and agile so that the mechanisms for delivering outputs can be adapted to changing circumstances	The IJB has issued directions to the partners primarily to deliver business as usual with the exception of a limited amount of commissioning through ICF and Social Care funding. In future there will be more use of directions as service redesign and recommissioning in line with the transformation programme is progressed.

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
5	Establishing appropriate key performance indicators (KPIs) as part of the planning process in order to identify how the performance of services and projects is to be measured	Regular performance reporting is in place on identified Ministerial priority areas and other indicators which are more relevant to social care reducing the predominance of Health related indicators. The performance management framework is being further developed over time by the Integrated Performance Group.
6	Ensuring capacity exists to generate the information required to review service quality regularly	As D2.5
7	Preparing budgets in accordance with organisational objectives, strategies and the medium-term financial plan	Budgets are based on existing service configuration which will not necessary align with objectives where major service reconfiguration is required.
8	Informing by drawing up realistic estimates of revenue and capital expenditure aimed at developing a sustainable funding strategy	As D2.7. Reliance is placed on the financial strategies and planning arrangements within the partner organisations.

D3 Optimising achievement of intended outcomes

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring the medium term financial strategy integrates and balances service priorities, affordability and other resource constraints	As D2.7
2	Ensuring the budgeting process is all-inclusive, taking into account the full cost of operations over the medium and longer term	Budgeting guidance and protocols take account of the budgeting processes of the partner organisations.
3	Ensuring the medium-term financial strategy sets the context for ongoing decisions on significant delivery issues or responses to changes in the external environment that may arise during the budgetary period in order for outcomes to be achieved while optimising resource usage	As D2.7
4	Ensuring the achievement of 'social value' through service planning and commissioning *(Social Value is technically referred to as Community Benefit in Scotland)*	Reliance is placed on the arrangements for achieving community benefits within the partner organisations.

E. Developing the entity's capacity, including the capability of its leadership and the individuals within it

The integration authority needs appropriate structures and leadership, as well as people with the right skills, appropriate qualifications and mindset, to operate efficiently and effectively and achieve their intended outcomes within the specified periods. The integration authority must ensure that it has both the capacity to fulfil its own mandate and to make certain that there are policies in place to guarantee that its management has the operational capacity for the organisation as a whole. Because both individuals and the environment in which an authority operates will change over time, there will be a continuous need to develop its capacity as well as the skills and experience of the leadership of individual staff members. Leadership in entities is strengthened by the participation of people with many different types of backgrounds, reflecting the structure and diversity of communities.

E1 Developing the entity's capacity

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Reviewing operations, performance and use of assets on a regular basis to ensure their continuing effectiveness	Reliance is placed on the operational arrangements, performance and use of assets within the partner organisations relating to the services commissioned by the IJB.
2	Improving resource use through appropriate application of techniques such as benchmarking and other options in order to determine how the authority's resources are allocated so that outcomes are achieved effectively and efficiently	Reliance is placed on the arrangements for resource allocation within the partner organisations.
3	Recognising the benefits of partnerships and collaborative working where added value can be achieved	Scottish Borders Health & Social Care Partnership is a partnership specifically created to deliver agreed outcomes.
4	Developing and maintaining an effective workforce plan to enhance the strategic allocation of resources	Reliance is placed on the arrangements for managing people within the employer partner organisations.

E2 Developing the capability of the entity's leadership and other individuals

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Developing protocols to ensure that elected and appointed leaders negotiate with each other regarding their respective roles early on in the relationship and that a shared understanding of roles and objectives is maintained	The Chair and Vice Chair of the IJB are involved in the appointment process of the Chief Officer. Regular meetings are held between the Chief Officer and the Chair and Vice Chair of the IJB. The Chief Officer also meets regularly with the Chief Executives of the partner organisations.
2	Publishing a statement that specifies the types of decisions that are delegated and those reserved for the collective decision making of the governing body	The IJB's Standing Orders were amended on 8 November 2017 to include emergency powers for urgent decision making.
3	Ensuring clearly defined and distinctive leadership roles within a structure, whereby the chief officer leads the authority in implementing strategy and managing the delivery of services and other outputs set by members and each provides a check and a balance for each other's authority	The Scheme of Integration sets out the roles and responsibilities of statutory officers (Chief Officer, Chief Financial Officer) and the Board, whose standalone Terms of Reference were approved on 28 August 2017. Regular meetings are held between the Chief Officer and the Chair and Vice Chair of the IJB. The Chief Officer also meets regularly with the Chief Executives of the partner organisations.

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
4	Developing the capabilities of members and senior management to achieve effective shared leadership and to enable the organisation to respond successfully to changing legal and policy demands as well as economic, political and environmental changes and risks.	IJB Development Sessions have been held for Board members during the year relevant to their role. An Induction process is in place for any new Non-Executive Directors of NHS Borders and SBC Councillors appointed to the IJB Board.
5	Ensuring that there are structures in place to encourage public participation	The partnership has a statutory responsibility to involve patients and members of the public in how health and social care services are designed and delivered.
6	Taking steps to consider the leadership's own effectiveness and ensuring leaders are open to constructive feedback from peer review and inspections	Feedback from inspection reports have been presented to the IJB who have supported the improvement actions set out by Management.
7	Holding staff to account through regular performance reviews which take account of training or development needs	Reliance is placed on the arrangements for managing people within the employer partner organisations.
8	Ensuring arrangements are in place to maintain the health and wellbeing of the workforce and support individuals in maintaining their own physical and mental wellbeing	Reliance is placed on the arrangements for managing people within the employer partner organisations.

F. Managing risks and performance through robust internal control and strong public financial management
Local government needs to ensure that the organisations and governance structures that it oversees have implemented, and can sustain, an effective performance management system that facilitates effective and efficient delivery of planned services. Risk management and internal control are important and integral parts of a performance management system and crucial to the achievement of outcomes. Risk should be considered and addressed as part of all decision making activities. A strong system of financial management is essential for the implementation of policies and the achievement of intended outcomes, as it will enforce financial discipline, strategic allocation of resources, efficient service delivery, and accountability. It is also essential that a culture and structure for scrutiny is in place as a key part of accountable decision making, policy making and review. A positive working culture that accepts, promotes and encourages constructive challenge is critical to successful scrutiny and successful delivery. Importantly, this culture does not happen automatically, it requires repeated public commitment from those in authority.

F1 Managing risk

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Recognising that risk management is an integral part of all activities and must be considered in all aspects of decision making	The Risk Management Strategy was approved by the IJB on 7 March 2016. It includes the reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities; and monitoring risk management activity and performance. The IJB Strategic Risk Register is a work in progress, and the arrangements for managing strategic IJB risks are not yet fully embedded.
2	Implementing robust and integrated risk management arrangements and ensuring that they are working effectively	As F1.1
3	Ensuring that responsibilities for managing individual risks are clearly allocated	As F1.1.

F2 Managing performance

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Monitoring service delivery effectively including planning, specification, execution and independent post-implementation review	The Performance Management Framework exists but is not fully developed or complete. Development is ongoing. Regular performance reporting is in place on identified Ministerial priority areas and other indicators which are more relevant to social care reducing the predominance of Health related indicators.
2	Making decisions based on relevant, clear objective analysis and advice pointing out the implications and risks inherent in the organisation's financial, social and environmental position and outlook	The standard template for decision-making reports to the IJB and its Committees include a section on implications covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing.

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
3	Ensuring an effective scrutiny or oversight function is in place which encourages constructive challenge and debate on policies and objectives before, during and after decisions are made thereby enhancing the organisation's performance and that of any organisation for which it is responsible (OR, for a committee system) Encouraging effective and constructive challenge and debate on policies and objectives to support balanced and effective decision making Providing members and senior management with regular reports on service delivery plans and on progress towards outcome achievement	As F2.1
4	Providing members and senior management with regular reports on service delivery plans and on progress towards outcome achievement	As F2.1
5	Ensuring there is consistency between specification stages (such as budgets) and post-implementation reporting (e.g. financial statements)	Reliance is placed on Financial standards and guidance within the partner organisations. There are IJB Financial Regulations and Standing Orders. Arrangements are in place for the External Audit of IJB annual financial statements.

F3 Robust internal control

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Aligning the risk management strategy and policies on internal control with achieving objectives	The Risk Management Strategy was approved by the IJB on 7 March 2016, though these arrangements are not yet fully embedded. The IJB Strategic Risk Register is work in progress.
2	Evaluating and monitoring risk management and internal control on a regular basis	As F3.1
3	Ensuring effective counter fraud and anti-corruption arrangements are in place	Reliance is placed on counter fraud and anti-corruption arrangements within the partner organisations.
4	Ensuring additional assurance on the overall adequacy and effectiveness of the framework of governance, risk management and control is provided by the internal auditor	Internal Audit service is provided by Scottish Borders Council's Internal Audit team. Effective liaison with NHS Borders Internal Audit service providers.
5	Ensuring an audit committee or equivalent group or function which is independent of the executive and accountable to the governing body: • provides a further source of effective assurance regarding arrangements for managing risk and maintaining an effective control environment • that its recommendations are listened to and acted upon	The IJB Audit Committee has been constituted with a Terms of Reference and has periodic meetings during the year in line with the Audit Cycle.

F4 Managing data

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring effective arrangements are in place for the safe collection, storage, use and sharing of data, including processes to safeguard personal data	Reliance is placed on the arrangements for managing data within the partner organisations.
2	Ensuring effective arrangements are in place and operating effectively when sharing data with other bodies	
3	Reviewing and auditing regularly the quality and accuracy of data used in decision making and performance monitoring	

F5 Strong public financial management

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring financial management supports both long-term achievement of outcomes and short-term financial and operational performance	Financial management extends only to the short term. In February 2017 proposals made to extend financial management planning horizon to three years were noted and the policy outlining the arrangements for the maintenance of IJB reserves was approved by the Board. Reliance is placed on the budget setting and monitoring arrangements within the partner organisations.
2	Ensuring well-developed financial management is integrated at all levels of planning and control, including management of financial risks and controls	There is a budget monitoring process and regular reporting to IJB Board.

G. Implementing good practices in transparency, reporting, and audit to deliver effective accountability

Accountability is about ensuring that those making decisions and delivering services are answerable for them. Effective accountability is concerned not only with reporting on actions completed, but also ensuring that stakeholders are able to understand and respond as the organisation plans and carries out its activities in a transparent manner. Both external and internal audit contribute to effective accountability.

G1 Implementing good practice in transparency

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Writing and communicating reports for the public and other stakeholders in an understandable style appropriate to the intended audience and ensuring that they are easy to access and interrogate	There is a standard template for decision-making reports to the IJB and its Committees. Reports are available for transparency on the modern.gov website.
2	Striking a balance between providing the right amount of information to satisfy transparency demands and enhance public scrutiny while not being too onerous to provide and for users to understand	As G1.1

G2 Implementing good practices in reporting

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Reporting at least annually on performance, value for money and the stewardship of its resources	An Annual Performance Report is presented to the IJB Board and then published. The Annual Accounts and Report that sets out the financial position is produced in accordance with accounting regulations and is presented in draft and then final after the External Audit process to the IJB Audit Committee and then to the IJB Board.
2	Ensuring members and senior management own the results	The IJB has approved the statutory roles of Chief Officer and Chief Financial Officer.
3	Ensuring robust arrangements for assessing the extent to which the principles contained in the Framework have been applied and publishing the results on this assessment including an action plan for improvement and evidence to demonstrate good governance (annual governance statement)	The Annual Review of the Framework is reported in the IJB's Annual Governance Statement.
4	Ensuring that the Framework is applied to jointly managed or shared service organisations as appropriate	Reliance is placed on the governance arrangements within the partner organisations.
5	Ensuring the performance information that accompanies the financial statements is prepared on a consistent and timely basis and the statements allow for comparison with other similar organisations	As G2.1

G3 Assurance and effective accountability

	Behaviours and actions that demonstrate good governance	Demonstration of good governance in practice
1	Ensuring that recommendations for corrective action made by external audit are acted upon.	The Accounts Commission appoints the External Auditors of the IJB on a 5-year appointment: Audit Scotland from 2016/17 – 2020/21. Any recommendations made by External Audit are acted upon.
2	Ensuring an effective internal audit service with direct access to members is in place which provides assurance with regard to governance arrangements and recommendations are acted upon	The Board appointed Scottish Borders Council's Chief Officer Audit and Risk as Chief Internal Auditor for the Integration Joint Board on 1 February 2016 with agreement that the Internal Audit service for the IJB is provided by the Council's Internal Audit team. Compliance with CIPFA's Statement on the Role of the Head of Internal Audit (2010). Compliance with Public Sector Internal Audit Standards (2017). Any recommendations made by Internal Audit are acted upon.
3	Welcoming peer challenge, reviews and inspections from regulatory bodies and implementing recommendations	Any recommendations made by Regulatory Bodies or Inspection Agencies are acted upon.
4	Gaining assurance on risks associated with delivering services through third parties and that this is evidenced in the annual governance statement	The approved IJB Risk Management Strategy includes the: reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities; and monitoring risk management activity and performance. These arrangements are not yet fully embedded, and the IJB Strategic Risk Register is a work in progress. The IJB Annual Governance Statement is included within its Statutory Accounts.
5	Ensuring that when working in partnership, arrangements for accountability are clear and that the need for wider public accountability has been recognised and met	The Scottish Borders Health & Social Care Partnership involves partners from Scottish Borders Council, NHS Borders, the third sector, the independent sector and user/carer representatives. The IJB is made up of voting members from Scottish Borders Council and NHS Borders (Elected Members and Non-Executive Directors respectively), and other non-voting members from the partners (professional advisors). The IJB, as the strategic commissioner of health and social care services, gives directions to the Council and NHS Borders for delivery of the services in line with the Strategic Plan, and monitors performance thereon.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date**:** 20 August 2018

Report By	Robert McCulloch-Graham, Chief Officer for Integration
Contact	Tracey Graham, Communications & Marketing Manager (SBC)
Telephone:	01835 826592

HEALTH & SOCIAL CARE PARTNERSHIP COMMUNICATIONS STRATEGY

Purpose of Report:	The purpose of this report is to update the Integration Joint Board (IJB) on the Scottish Borders Health and Social Care Partnership Communications Strategy.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: • **Note** the integrated approach to Partnership communication and the launch of the refreshed Health and Social Care Strategic Plan via the #yourpart campaign. • **Agree** communication work streams and standard operating procedures and joint working principles outlined in the Partnership Communication Strategy.

Personnel:	N/A
Carers:	N/A
Equalities:	Equalities Impact Assessment
Financial:	N/A
Legal:	N/A
Risk Implications:	Ineffective communication

1	**Purpose**
1.1	The purpose of the report is to update the Integration Joint Board (IJB) on the Partnership Communications Strategy which has been developed to support the delivery of the refreshed Health & Social Care Partnership's Strategic Plan through effective and consistent communication.
2	**Background**
2.1	The IJB has no dedicated communications support however both Scottish Borders Council (SBC) and NHS Borders have communication teams. Communication support for the Partnership has previously been provided on an as and when basis via existing communication teams. This arrangement has presented some challenges in terms of clarity of roles and responsibilities and consistency for Partnership communication. In order to improve on this a Partnership Communication Strategy has been developed (Appendix A) which clearly identifies three work streams for communication support for the Partnership as well as areas of responsibility for each team to ensure effective communication across the Partnership.
3	**Update on Progress**
3.1	The Partnership Communication Strategy has been developed by communication leads and officers from both SBC and NHS Borders communication teams. The strategy focuses on key messages and work streams which support the Partnership to effectively deliver on the three strategic objectives outlined in the refreshed Health and Social Care Strategic Plan.
3.2	The three communication work streams and the lead organisation for progressing each work stream are outlined in the table below:

Workstream		**Lead**
1	Use the new #yourpart campaign effectively where appropriate	Both SBC and NHS Comms
2	Corporate Communications support, promotional activity of good news stories, case studies, and opportunities/services available when appropriate	SBC Comms Lead
3	Internal communications activity to ensure staff play their part in fully support the partnership in delivering efficiency and effectiveness going forward	NHS Borders Comms Lead

3.3	The Communication Strategy also outlines the standard operating procedures for Partnership communication and joint working principles to ensure that both communication teams have clarity regarding roles and responsibilities and are consistent in their approach to Partnership communication.
3.4	Regular Partnership communication meetings chaired by the Chief Officer for Integration are in place with representatives from both communication teams in attendance. The purpose of meetings are to review communication activity across the Partnership and highlight key areas for Partnership communication on a monthly basis.
4.	**Next Steps**
4.1	A Partnership Communications Action Plan is being developed and will be populated continuously showing all ongoing communication activity. This will be reviewed and updated at monthly Partnership communication meetings. Measures will be put in place to evaluate the medium and long term effectiveness of Partnership communication and will be reviewed at Partnership communication meetings.
4.2	The refreshed Health and Social Care Strategic Plan will be launched in August 2018 as part of the #your part campaign across a range of communication activities.

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Scottish Borders Health and Social Care Partnership

Communications Strategy

July 2018

Background

The Integration Joint Board (IJB) became a legal entity in April, 2016 and is responsible for commissioning and ensuring the delivery of health and social care services in the Scottish Borders. The Partnership includes Scottish Borders Council (SBC), NHS Borders, the Voluntary/Independent sectors and the Housing sector with the requirement to work co-productively with members of the public, service users and carers to plan and deliver integrated health and social care services.

Communications approach

Communications activity will focus on **supporting the delivery of the revised Health and Social Care Partnership's Strategic Plan objectives.** This will ensure there is a clear focus on outcomes and will allow effective evaluation to take place. The updated Health and Social Care Partnership's Strategic Plan for 2018-2021 has three key objectives.

1. We will improve the health of the population and reduce the number of hospital admissions
2. We will improve the flow of patients into, through and out of hospital
3. We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

Communications Strategy Workstreams

Existing communications teams at SBC and NHS Borders have equal responsibility for effective communications across the partnership. There are three types of communication activity required to support the Partnership to deliver on its strategic objectives, these are detailed below:

1 **Use the new #yourpart campaign effectively where appropriate (Both SBC and NHS Comms responsible)**
The #yourpart campaign is a vital Borders wide campaign which has been launched by SBC but has full support from all partners and will benefit all services/organisations within the Partnership. The aim of the campaign for the Partnership will be to encourage people to look after their own and their family's health and wellbeing to relieve pressure on vital public services.

2 **Corporate Communications support, promotional activity of good news stories, case studies, and opportunities/services available when appropriate (SBC Comms Lead)**
There are several areas and projects underway which involve corporate communications planning and input. This will include routine support for the IJB meetings, communications around performance, positive news, case studies and publicity of services available. The overarching Communications Action Planner which has been developed by the SBC Comms team will capture the communications activity per month (via a Trello Board). Whilst SBC Comms will continue to lead on this, NHS Borders input to the Action Planner will be regularly required. A particular focus should be on effectively promoting and signposting the various opportunities available to the public**.**

3 **Internal communications activity to ensure staff play their part in fully support the partnership in delivering efficiency and effectiveness going forward (NHS Borders Comms Lead)**
Internal communication is a critical requirement to promote the transformation of health and social care services. This is a particular challenging area in terms of reaching and engaging with staff across the Partnership. It is proposed that NHS Borders Comms lead on the internal communications activity including the development of an internal communications strategy.

Key messages

The following overarching key messages should be used consistently:

Refreshed Strategic Plan 2018-2022

- The Scottish Borders' Health and Social Care Partnership, which is made up of SBC, NHS Borders and the Voluntary and Independent sectors, has refreshed its Strategic Plan and continues to work to improve Health and Social Care Services in the Borders.
- The plan sets out why we want to integrate health and social care services, how this will be done (in partnership with individuals, families and communities) and what we can expect to see as a result.
- It is the aim of the H&SCP to create health and social care services that are more joined up, more personalised and can improve outcomes for all our service users, their Carers and their families.
- The aim is that we plan, commission and deliver services in a way that puts people at the heart of decision-making.
- The Health & Social Care Partnership commissions services for those who require them, but everyone in the Scottish Borders should play their part to ensuring that the limited resources we have can be focused on those who really need them.
- Why? Everyone is well aware that there is increasing demand for services at a time where public funding is reducing. In relation to Health and Social Care, we are faced with an ageing population where more people need our health and social care services and will continue to do so there simply won't be enough money to keep delivering services in the way and at the levels we currently do.
- We want to continue to have a positive impact on people's lives, despite being faced with various challenges but we can only do this if everyone in the Borders play their part.
- Even the small things everyone could do will have an impact on ensuring that we can maintain key local services.

#yourpart campaign and why we need you to play your part

- Working together, Scottish Borders Council, NHS Borders, the Voluntary and Independent sectors are encouraging members of the public, service users and carers to play their part to help us to continue to keep the Borders thriving through living healthier lives
- The #yourpart campaign aims to deliver the key message to all residents that their actions, no matter how small, can have a positive impact on key local services.
- People should take responsibility for their own health and well-being , whether that is eating more fruit and vegetables , undertaking more exercise or activities, or taking up advice and support on offer e.g. around smoking cessation. If people can stay healthier, then we can minimise time spend with a GP or in hospital.
- People should also know who to turn to and only use A&E when they need it. If you are unwell and it is not an emergency, there are a wide range of services available to provide you with appropriate treatment and care. Going directly to the correct health professional with the right skills is very important.
- The #yourpart campaign supports the Health and Social Care Partnership's refreshed Strategic Plan and also supports SBC's new approach to its Corporate Plan called 'Our Plan and Your Part in it' where the key message is that we need everyone to play their part in whatever way they can so we can continue to deliver excellent services into the future.
- We need to work differently and in partnership with our communities to allow us to continue to provide excellent Health and Social Care services into the future.
- There are many opportunities out there for people to choose to live a healthier lifestyle and we are keen to ensure communities continue to be supported to allow them to play their part.

- Fewer people in hospital means shorter waiting times and faster treatment; less people in GP surgeries means doctors can focus on providing vital care and support to those that absolutely do need it; more healthy people means fewer prescriptions.
- This approach will not only have positive benefits for residents, but should have positive impacts on public service finances, which mean we can target the limited resources we have on those services that need it most and are most valued by our communities, and maintain them in the longer term.

Target audience

The Council will engage/communicate with Public, Staff, IJB, voluntary/third Sector, Community Planning Partners, Trade Unions, Councillors, Community Councils.

Evaluation

Short term:

- Services to provide feedback regularly via the above structure to allow the Communications strategy to be reviewed on an ongoing basis. This should include feedback on numbers of people accessing services i.e. numbers attending Community Hubs, etc.
- A method of evaluating and gaining feedback from clients should be e.g. feedback on how people heard about services available.

Med-Long term

- For each of the 3 strategic objectives, a set of performance indicators has been developed and will be reviewed quarterly. These include things like number of unplanned admissions to hospital, A&E waiting times, delayed discharge etc. We should, over the longer term, hope to see a positive movement across these indicators as people take responsibility for their own health and avoid unnecessary contact with health and social care services.
- The Health and Social Care partnership produces an annual report.
- Integrated Change Fund project evaluation and mainstreaming.

Standard Operating Procedure and Joint Working Principles

In addition to above, a Standard Operating Procedure (appendix 1) is in place which clearly identifies the lead organisation for each of the joint services which fall under the Partnership – this will be adopted with immediate effect in addition to the above strategy.

Meetings structure

It is important that a clear structure is in place for meetings to ensure effective communications going forward. This will operate as follows:

- **EMT** – attended by Tracey Graham - Corporate Communications and Marketing Manager (SBC)
- **IJB** – attended by Sue Bell - Communications and Marketing Officer (SBC), Laura McIntyre – Communications Officer (NHS Comms)
- **IJB Leadership team meeting** – attended by Jane Robertson (with attendance by Comms representative as/when required)

- **Communications Project Team meetings** - once monthly, attended by:
  - Jane Robertson - Strategic Planning and Development Manager (H&SC Partnership)
  - Tracey Graham – Corporate Communications and Marketing Manager (SBC)
  - Sue Bell – Communications and Marketing Officer (SBC)
  - Laura McIntyre – Communications Officer (NHS Borders)
- **Monthly IJB Communications Meeting** – once monthly attended by:
  - Robert McCulloch Graham, Jane Robertson, Tracey Graham and Clare Oliver (or Laura McIntyre) and Louise Ramage.

Appendix 1

Standard Operating Procedure and Joint Working Principles

Health and Social Care Partnership communication activities

June 2018

The purpose of this document is to:

- clearly identify service areas that communications teams will take the lead on
- outline a set of principles that will be adopted by each team.

This applies to any of the following that relate to services delivered jointly through the H&SCP:

- communications planning
- proactive media relations
- reactive media enquiries.

As each communications team works independently from one another and has different standards and practices already in place, it is acknowledged that a set of standard principles will be mutually beneficial.

Given the nature of communications work, it is impossible to identify a prescriptive procedure for every possible situation. However, identifying clear lines of responsibilities and a set of principles will be of benefit to ensure resources are used as effectively as possible and reputational risk is minimised for both organisations.

Service Areas and Designated Lead Organisation

NHS Borders to lead on:

- District Nursing
- Primary Medical Services (GP practices)
- Out of Hours Primary Medical Services
- Public Dental Services
- General Dental Services
- Ophthalmic Services
- Community Pharmacy Services
- Community Geriatric Services
- Community Learning Disability Services
- Mental Health Services
- Continence Services
- Kidney Dialysis outwith the hospital
- Services provided by health professionals that aim to promote public health
- Community Addiction Services
- Community Palliative Care
- Allied Health Professional Services
- Public Health
- Accident and Emergency
- Inpatient hospital services in these specialties:
    - General Medicine
    - Geriatric Medicine
    - Rehabilitation Medicine
    - Respiratory Medicine
    - Psychiatry of Learning Disability
- Palliative Care Services provided in a hospital
- Inpatient hospital services provided by GPs
- Services provided in a hospital in relation to an addiction or dependence on any substance
- Mental health services provided in a hospital, except secure forensic mental health services.
- Health Improvement Services

SBC to lead on:

- Social Work Services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental Health Services
- Drug and Alcohol Services
- Adult protection and domestic abuse
- Carers support services
- Community Care Assessment Teams
- Care Home Services
- Adult Placement Services
- Re-ablement Services, equipment and telecare
- Aspects of housing support including aids and adaptations
- Day Services
- Local Area Co-ordination
- Respite Provision
- Occupational therapy services.
- Criminal Justice
- Safer Communities

Support for H&SC Partnership/Integration Joint Board (IJB)

Three workstreams have been identified in the Communications Strategy for the H&SC Partnership and leads for each strand has been identified as follows:

1 Use the new #yourpart campaign effectively where appropriate – **Both SBC and NHS Comms**

2 Routine Corporate Communications support, promotional activity of good news stories, case studies, and opportunities available when appropriate - **SBC Comms Lead**

3 Internal communications activity to ensure staff play their part in fully support the partnership in delivering efficiency and effectiveness going forward – **NHSB Comms Lead**

Principles for Joint Working

- Judgement will be made by relevant communications teams as to whether any communications work i.e. press response/release should be joint, or issued solely by the most appropriate organisation.
- All **joint** press releases and media responses will be issued from Scottish Borders Health and Social Care Partnership and approved by the Chief Officer Health and Social Care Integration (or in his absence, the relevant Service Director or Executive Management Team member).
- Joint press releases will contain a quote from one of the following, with the Chief Officer Health and Social Care Integration advising who is appropriate for each release:
  - Councillor Tom Weatherston, Executive Member for Adult Social Care
  - Dr Stephen Mather, Chair of the Integration Joint Board
  - Councillor David Parker, Vice Chair of the Integration Joint Board
- Joint press releases will be added to the SBC and NHS Borders websites. They will also be publicised through SBC and NHS Borders social media channels and if relevant, submitted for inclusion in the H&SCP newsletter, SBConnect and through other channels as appropriate.
- Communications teams will give as much advance notice as possible to their counterparts of any proactive press release in relation to a joint service. These should be captured on the Action Planner (Trello) and discussed at the Communications meetings.
- Communications teams will 'cc' their counterparts where appropriate when a media enquiry in relation to a joint service is passed to the relevant colleague for response.

- Given the complexity of joint services and the fast paced nature of emerging projects, if there is any uncertainty as to who leads on a specific piece of work, the teams will discuss and come to agreement on this.
- If a media enquiry in relation to a piece of partnership working is received by either organisation and it is deemed to have more relevance to the other organisation, it will be forwarded to them for responding.
- Requests for interviews in relation to joint services will be co-ordinated by the lead organisation's communications team as per normal processes. Communications teams will inform their counterparts of such requests when it is felt appropriate to do so.
- Journalists are within their right to approach SBC Elected Members on any issue to gain their political view on a subject matter.

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Scottish Borders Health and Social Care Partnership

Communications Strategy

July 2018

Scottish Borders
Health and Social Care
PARTNERSHIP

Background

The Integration Joint Board (IJB) became a legal entity in April, 2016 and is responsible for commissioning and ensuring the delivery of health and social care services in the Scottish Borders. The Partnership includes Scottish Borders Council (SBC), NHS Borders, the Voluntary/Independent sectors and the Housing sector with the requirement to work co-productively with members of the public, service users and carers to plan and deliver integrated health and social care services.

Communications approach

Communications activity will focus on **supporting the delivery of the revised Health and Social Care Partnership's Strategic Plan objectives.** This will ensure there is a clear focus on outcomes and will allow effective evaluation to take place. The updated Health and Social Care Partnership's Strategic Plan for 2018-2021 has three key objectives.

1. We will improve the health of the population and reduce the number of hospital admissions
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Communications Strategy Workstreams

Existing communications teams at SBC and NHS Borders have equal responsibility for effective communications across the partnership. There are three types of communication activity required to support the Partnership to deliver on its strategic objectives, these are detailed below:

1 **Use the new #yourpart campaign effectively where appropriate (Both SBC and NHS Comms responsible)**
The #yourpart campaign is a vital Borders wide campaign which has been launched by SBC but has full support from all partners and will benefit all services/organisations within the Partnership. The aim of the campaign for the Partnership will be to encourage people to look after their own and their family's health and wellbeing to relieve pressure on vital public services.

2 **Corporate Communications support, promotional activity of good news stories, case studies, and opportunities/services available when appropriate (SBC Comms Lead)**
There are several areas and projects underway which involve corporate communications planning and input. This will include routine support for the IJB meetings, communications around performance, positive news, case studies and publicity of services available. The overarching Communications Action Planner which has been developed by the SBC Comms team will capture the communications activity per month (via a Trello Board). Whilst SBC Comms will continue to lead on this, NHS Borders input to the Action Planner will be regularly required. A particular focus should be on effectively promoting and signposting the various opportunities available to the public**.**

3 **Internal communications activity to ensure staff play their part in fully support the partnership in delivering efficiency and effectiveness going forward (NHS Borders Comms Lead)**
Internal communication is a critical requirement to promote the transformation of health and social care services. This is a particular challenging area in terms of reaching and engaging with staff across the Partnership. It is proposed that NHS Borders Comms lead on the internal communications activity including the development of an internal communications strategy.

Key messages

The following overarching key messages should be used consistently:

Refreshed Strategic Plan 2018-2022

- The Scottish Borders' Health and Social Care Partnership, which is made up of SBC, NHS Borders and the Voluntary and Independent sectors, has refreshed its Strategic Plan and continues to work to improve Health and Social Care Services in the Borders.
- The plan sets out why we want to integrate health and social care services, how this will be done (in partnership with individuals, families and communities) and what we can expect to see as a result.
- It is the aim of the H&SCP to create health and social care services that are more joined up, more personalised and can improve outcomes for all our service users, their Carers and their families.
- The aim is that we plan, commission and deliver services in a way that puts people at the heart of decision-making.
- The Health & Social Care Partnership commissions services for those who require them, but everyone in the Scottish Borders should play their part to ensuring that the limited resources we have can be focused on those who really need them.
- Why? Everyone is well aware that there is increasing demand for services at a time where public funding is reducing. In relation to Health and Social Care, we are faced with an ageing population where more people need our health and social care services and will continue to do so there simply won't be enough money to keep delivering services in the way and at the levels we currently do.
- We want to continue to have a positive impact on people's lives, despite being faced with various challenges but we can only do this if everyone in the Borders play their part.
- Even the small things everyone could do will have an impact on ensuring that we can maintain key local services.

#yourpart campaign and why we need you to play your part

- Working together, Scottish Borders Council, NHS Borders, the Voluntary and Independent sectors are encouraging members of the public, service users and carers to play their part to help us to continue to keep the Borders thriving through living healthier lives
- The #yourpart campaign aims to deliver the key message to all residents that their actions, no matter how small, can have a positive impact on key local services.
- People should take responsibility for their own health and well-being , whether that is eating more fruit and vegetables , undertaking more exercise or activities, or taking up advice and support on offer e.g. around smoking cessation. If people can stay healthier, then we can minimise time spend with a GP or in hospital.
- People should also know who to turn to and only use A&E when they need it. If you are unwell and it is not an emergency, there are a wide range of services available to provide you with appropriate treatment and care. Going directly to the correct health professional with the right skills is very important.
- The #yourpart campaign supports the Health and Social Care Partnership's refreshed Strategic Plan and also supports SBC's new approach to its Corporate Plan called 'Our Plan and Your Part in it' where the key message is that we need everyone to play their part in whatever way they can so we can continue to deliver excellent services into the future.
- We need to work differently and in partnership with our communities to allow us to continue to provide excellent Health and Social Care services into the future.
- There are many opportunities out there for people to choose to live a healthier lifestyle and we are keen to ensure communities continue to be supported to allow them to play their part.

- Fewer people in hospital means shorter waiting times and faster treatment; less people in GP surgeries means doctors can focus on providing vital care and support to those that absolutely do need it; more healthy people means fewer prescriptions.
- This approach will not only have positive benefits for residents, but should have positive impacts on public service finances, which mean we can target the limited resources we have on those services that need it most and are most valued by our communities, and maintain them in the longer term.

Target audience

The Council will engage/communicate with Public, Staff, IJB, voluntary/third Sector, Community Planning Partners, Trade Unions, Councillors, Community Councils.

Evaluation

Short term:

- Services to provide feedback regularly via the above structure to allow the Communications strategy to be reviewed on an ongoing basis. This should include feedback on numbers of people accessing services i.e. numbers attending Community Hubs, etc.
- A method of evaluating and gaining feedback from clients should be e.g. feedback on how people heard about services available.

Med-Long term

- For each of the 3 strategic objectives, a set of performance indicators has been developed and will be reviewed quarterly. These include things like number of unplanned admissions to hospital, A&E waiting times, delayed discharge etc. We should, over the longer term, hope to see a positive movement across these indicators as people take responsibility for their own health and avoid unnecessary contact with health and social care services.
- The Health and Social Care partnership produces an annual report.
- Integrated Change Fund project evaluation and mainstreaming.

Standard Operating Procedure and Joint Working Principles

In addition to above, a Standard Operating Procedure (appendix 1) is in place which clearly identifies the lead organisation for each of the joint services which fall under the Partnership – this will be adopted with immediate effect in addition to the above strategy.

Meetings structure

It is important that a clear structure is in place for meetings to ensure effective communications going forward. This will operate as follows:

- **EMT** – attended by Tracey Graham - Corporate Communications and Marketing Manager (SBC)
- **IJB** – attended by Sue Bell - Communications and Marketing Officer (SBC), Laura McIntyre – Communications Officer (NHS Comms)
- **IJB Leadership team meeting** – attended by Jane Robertson (with attendance by Comms representative as/when required)

- **Communications Project Team meetings** - once monthly, attended by:
  - Jane Robertson - Strategic Planning and Development Manager (H&SC Partnership)
  - Tracey Graham – Corporate Communications and Marketing Manager (SBC)
  - Sue Bell – Communications and Marketing Officer (SBC)
  - Laura McIntyre – Communications Officer (NHS Borders)
- **Monthly IJB Communications Meeting** – once monthly attended by:
  - Robert McCulloch Graham, Jane Robertson, Tracey Graham and Clare Oliver (or Laura McIntyre) and Louise Ramage.

Appendix 1

Standard Operating Procedure and Joint Working Principles

Health and Social Care Partnership communication activities

June 2018

The purpose of this document is to:

- clearly identify service areas that communications teams will take the lead on
- outline a set of principles that will be adopted by each team.

This applies to any of the following that relate to services delivered jointly through the H&SCP:

- communications planning
- proactive media relations
- reactive media enquiries.

As each communications team works independently from one another and has different standards and practices already in place, it is acknowledged that a set of standard principles will be mutually beneficial.

Given the nature of communications work, it is impossible to identify a prescriptive procedure for every possible situation. However, identifying clear lines of responsibilities and a set of principles will be of benefit to ensure resources are used as effectively as possible and reputational risk is minimised for both organisations.

Service Areas and Designated Lead Organisation

NHS Borders to lead on:

- District Nursing
- Primary Medical Services (GP practices)
- Out of Hours Primary Medical Services
- Public Dental Services
- General Dental Services
- Ophthalmic Services
- Community Pharmacy Services
- Community Geriatric Services
- Community Learning Disability Services
- Mental Health Services
- Continence Services
- Kidney Dialysis outwith the hospital
- Services provided by health professionals that aim to promote public health
- Community Addiction Services
- Community Palliative Care
- Allied Health Professional Services
- Public Health
- Accident and Emergency
- Inpatient hospital services in these specialties:
    - General Medicine
    - Geriatric Medicine
    - Rehabilitation Medicine
    - Respiratory Medicine
    - Psychiatry of Learning Disability
- Palliative Care Services provided in a hospital
- Inpatient hospital services provided by GPs
- Services provided in a hospital in relation to an addiction or dependence on any substance
- Mental health services provided in a hospital, except secure forensic mental health services.
- Health Improvement Services

SBC to lead on:

- Social Work Services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental Health Services
- Drug and Alcohol Services
- Adult protection and domestic abuse
- Carers support services
- Community Care Assessment Teams
- Care Home Services
- Adult Placement Services
- Re-ablement Services, equipment and telecare
- Aspects of housing support including aids and adaptations
- Day Services
- Local Area Co-ordination
- Respite Provision
- Occupational therapy services.
- Criminal Justice
- Safer Communities

Support for H&SC Partnership/Integration Joint Board (IJB)

Three workstreams have been identified in the Communications Strategy for the H&SC Partnership and leads for each strand has been identified as follows:

1 Use the new #yourpart campaign effectively where appropriate – **Both SBC and NHS Comms**

2 Routine Corporate Communications support, promotional activity of good news stories, case studies, and opportunities available when appropriate - **SBC Comms Lead**

3 Internal communications activity to ensure staff play their part in fully support the partnership in delivering efficiency and effectiveness going forward – **NHSB Comms Lead**

Principles for Joint Working

- Judgement will be made by relevant communications teams as to whether any communications work i.e. press response/release should be joint, or issued solely by the most appropriate organisation.
- All **joint** press releases and media responses will be issued from Scottish Borders Health and Social Care Partnership and approved by the Chief Officer Health and Social Care Integration (or in his absence, the relevant Service Director or Executive Management Team member).
- Joint press releases will contain a quote from one of the following, with the Chief Officer Health and Social Care Integration advising who is appropriate for each release:
  - Councillor Tom Weatherston, Executive Member for Adult Social Care
  - Dr Stephen Mather, Chair of the Integration Joint Board
  - Councillor David Parker, Vice Chair of the Integration Joint Board
- Joint press releases will be added to the SBC and NHS Borders websites. They will also be publicised through SBC and NHS Borders social media channels and if relevant, submitted for inclusion in the H&SCP newsletter, SBConnect and through other channels as appropriate.
- Communications teams will give as much advance notice as possible to their counterparts of any proactive press release in relation to a joint service. These should be captured on the Action Planner (Trello) and discussed at the Communications meetings.
- Communications teams will 'cc' their counterparts where appropriate when a media enquiry in relation to a joint service is passed to the relevant colleague for response.

- Given the complexity of joint services and the fast paced nature of emerging projects, if there is any uncertainty as to who leads on a specific piece of work, the teams will discuss and come to agreement on this.
- If a media enquiry in relation to a piece of partnership working is received by either organisation and it is deemed to have more relevance to the other organisation, it will be forwarded to them for responding.
- Requests for interviews in relation to joint services will be co-ordinated by the lead organisation's communications team as per normal processes. Communications teams will inform their counterparts of such requests when it is felt appropriate to do so.
- Journalists are within their right to approach SBC Elected Members on any issue to gain their political view on a subject matter.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 20th August 2018

Report By	Robert McCulloch-Graham, Chief Officer Health& Social Care
Contact	Sarah Watters, Policy, Performance & Planning Manager, SBC
Telephone:	01835 826542

QUARTERLY PERFORMANCE REPORT, AUGUST 2018
(DATA AVAILABLE AT END JUNE 2018)

Purpose of Report:	To provide a high level summary of quarterly performance for Integration Joint Board (IJB) members, using latest data available, at the end of June 2018. The report also proposed changes to the quarterly performance report to support the IJB's revised Strategic Plan 2018 -2021

Recommendations:	Health & Social Care Integration Joint Board is asked to: a) Note and approve the changes to performance reporting; b) Note the key challenges highlighted.

Personnel:	*n/a*

Carers:	*n/a*

Equalities:	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process. Performance information supports the strategic plan.

Financial:	*n/a*

Legal:	*n/a*

Risk Implications:	*n/a*

Background

1.1 Now that the Scottish Borders Health and Social Care Partnership's Strategic Plan has been revised, members of the Integration Performance and Finance Group (IPFG) have taken the opportunity to revisit the structure and content of performance reporting for the IJB. Previously, the performance report was developed around the six themes defined by the Ministerial Strategy Group (MSG) for Health and Community Care (shown below) as well as a range of additional measures to reflect other areas important to the partnership, such as social care and carers.

MSG Themes:

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.

1.2 The inclusion of new, additional indicators under each theme each quarter meant that the performance report for the IJB has become progressively larger over the last 18 months and the opportunity has now been taken to refocus reporting down to key performance indicators (KPIs) that should provide IJB members with a sense of how effectively the partnership is addressing the 3 strategic objectives within the revised plan. Within the revised Strategic Plan, a section titled "*What will success look like*?" has been included for each of the 3 objectives and provided the starting point for the selection of the most relevant high-level KPIs.

1.3 Building on the experience of producing the last 3 quarterly reports for the IJB and using the expertise of LIST colleagues from NHS National Services Scotland (NSS), (who have been supporting the Partnership for the last 3.5 years), all currently reported data has been reviewed for its usefulness, relevance, and regular availability. By way of aligning performance reporting to the revised Strategic Plan, it is proposed that high level performance reporting for the IJB now be structured around the 3 objectives in the revised plan. Indicators chosen under each objective aim to demonstrate the impact that the work of the partnership is having on:

- keeping people healthy and out of hospital (Objective 1)
- getting people out of hospital as quickly as possible (Objective 2)
- building capacity within Scottish Borders communities (Objective 3)

1.4 It is therefore proposed that the IJB be provided with the following information quarterly, under each of the 3 objectives:

Objective 1: we will improve health of the population and reduce the number of hospital admissions

- Rate of emergency admissions to hospital, per 1,000 population (all ages);
- Rate of emergency admissions to hospital, per 1,000 population (ages 75+);
- Number of attendances at A&E;
- % of health and care resource spent on emergency hospital stays for persons aged 18+.

Objective 2: We will improve the flow of patients into, through and out of hospital

- % of people seen within 4 hours at A&E;
- Number of Occupied Bed Days for emergency Admissions, ages 75+;
- Rate of Occupied Bed Days* for emergency admissions, per 1,000 population (ages 75+);
- Number of Delayed Discharges over 72 hours; and over 2 weeks;
- Rate of Bed Days* associated with delayed discharges, per 1,000 population aged 75+;
- Summarised results for NHS Borders' "Two minutes of your time" survey (conducted on an ongoing basis at BGH and Community Hospitals).

looking at the rate of bed days per 1000 population (aged 75 and over) is necessary if we want to compare Scottish Borders performance against Scotland, and monitor trends over the longer term. For example, between October and December 2017, there were **10,587 bed days following emergency admissions for people aged 75+. That equated to a rate of 883 bed days per 1000 people aged 75 and over. The rate of occupied bed days will also reflect the fact that some people will spend a very short time in hospital, whilst for others it will be much longer.*

Objective 3: we will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

- Rate of Emergency Readmissions within 28 days of discharge from hospital (all ages), per 100 discharges;
- % of last 6 months of life spent at home or in a community setting;
- Carers offered assessments/assessments completed;
- Support for caring - change between baseline assessment and review in relation to: Health and well-being; managing the caring role; feeling valued; planning for the future; finance & benefits.

1.5 In addition to the quarterly measures outlined above, a number of annual measures will be included in either the quarterly report or the Annual Performance Report as and when updates become available (which can sometimes be mid-way through the year) and will give IJB members a sense of whether or not objectives are being achieved over the longer term. These are presented below:

- Premature mortality rate per 100,000 population
- % of adults who say they can look after their health very or quite well
- Balance of spend: % of total health and social care expenditure on community-based care;
- % of people satisfied with the care services they receive at home
- % of people who have a positive experience of the care provided by their GP
- % of care services in receipt of grade "good or better" in Care Inspectorate inspections
- % of last 6 months of life spent at home or in a homely setting (by setting e.g. Community; Hospice/Palliative Care Unit; Community Hospital; and Large Hospital)

The 2017/18 Annual Report has just been published, where members of the IJB can find these indicators updated, along with trend information and Scottish

comparators (2017/18 data has been summarised at the end of this report for convenience).

1.6 In addition to the indicators that are presented to the IJB on a quarterly basis, a broader range of indicators are collected and reviewed on a regular basis within services, at relevant partnership groups and at the Health and Social Care Leadership Group. Indicators within the IJB report, and the various "layers" that sit underneath, ensure that not only the national requirements for data and information are met e.g. when the MSG requires performance information but that services are able to be managed effectively and focused on continuous improvement.

1.7 The IPFG is currently developing its Performance Management Framework that will articulate the various reporting "layers" and should provide IJB members with the assurance that data and performance information is being used to inform continuous improvement across the wide breadth of services that sit within the Health and Social Care Partnership. Given this breadth, it would be impossible to cover all service areas in the high level IJB reporting but the IPFG will ensure that areas of strategic focus are covered as effectively as possible and this may involve the addition or amendment of indicators over time.

1.8 The IPFG will always endeavour to present the latest available data and for some measures, there may be a significant lag whilst data is checked, cleansed and then released publicly, which increases robustness and allows for national comparators. Work is ongoing within the group to improve the timeliness of data where possible and to explore the pros and cons of using unverified but timelier local data.

1.9 There are 3 appendices to this report:

Appendix 1 provides a very high level, "at a glance" summary for EMT and the IJB (for future reports, this summary will be designed to align with the revised Strategic Plan which, at the time of papers being produced, was not finished);

Appendix 2 provides the rationale for the inclusion of indicators in the summary;

Appendix 3 provides further details for each of the measures presented in Appendix 1, including performance trends and analysis.

Summary of Performance

2.1 In a number of areas, Borders is demonstrating good performance over time and when compared to Scotland, including rate of hospital admissions, % of Health & Social Care resources spent on emergency hospital stays, attendance at A&E, and rate of occupied bed days for emergency admissions (age 75+).

2.2 However, whilst the rate of emergency admissions to hospital is stable / improving, there are still around 3000 people being admitted each quarter, with a third of them over 75 years old, which places significant pressure on our hospital services. The winter period saw a slight increase in the proportion of people waiting more than 4 hours in A&E, and although Borders compares well to Scotland, achievement has been under the 95% standard for the last 5 months reported. Key challenges remain in relation to bed days associated with people being delayed in hospital and although the rate of bed days associated with delayed discharge (age 75+) has

come down during Q4 (to 189.9 bed days per 1000 population age 75+), the *annual* rate for Borders is now 869 bed days per 1000 population age 75+, compared to 772 for Scotland)- Borders has been lower than Scotland in previous years. Quarterly end of life care measure fluctuates considerably and should be treated on a "provisional" basis. Challenges remain around support for carers and completing assessments and Borders Carers Centre continue to be commissioned to undertake assesem4rnt, as part of the revised strategic plan.

2.3 The revised Strategic Plan 2018 -21 and its Implementation plan provide more details on actions and timescales, many of which go beyond 2018 due to their transformational nature.

2.4 Given the many elements of integrated care, the wide range of services delegated to the Health and Social Care Partnership, and national changes in policy and direction, it is anticipated that performance reporting to the IJB will further develop over time. Performance reporting will increasingly align to and support the revised Strategic Plan and will be overseen by the IPFG.

Updated annual figures

Indicator	Scottish Borders	Scotland
Premature mortality rate per 100,000 population	**324 in 2017**	425
% of adults who say they can look after their health very or quite well	**94% in 2017/18**	93%
Balance of spend: % of total health and social care expenditure on community-based care	**51.4% in 2015/16**	46.5%
% of people satisfied with the care services they receive at home	**83% in 2017/18**	81%
% of people who have a positive experience of the care provided by their GP	**88% in 2017/18**	83%
% of care services in receipt of grade "good or better" in Care Inspectorate inspections	**80.7% in 2017/18**	85.4%
% of last 6 months of life spent at home or in a homely setting (by setting e.g. Community; Hospice/Palliative Care Unit; Community Hospital; and Large Hospital)	**87.2 for 2017/18**	88.3%

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Changing Health & Social Care for You

Working with communities in the Scottish Borders for the best possible health and wellbeing

Summary of Performance for Integration Joint Board: AUGUST 2018

This report provides an overview of quarterly performance under the 3 strategic objectives within the revised Strategic Plan, with **latest available data at the end of June 2018**. A number of annual measures that have been updated recently are included in the Annual Performance Report 2017/18

KEY					
	+ve trend/SB compares well to previous period/to Scotland		-ve trend/some concern from previous period or when compared to Scotland		Little change/little difference over time/to Scotland

How are we doing?

Objective 1: We will improve health of the population and reduce the number of hospital admissions

Emergency Hospital Admissions (Borders residents, all ages)	Emergency Hospital Admissions (Borders residents age 75+)	Attendances at A&E	£ on emergency hospital stays
27 admissions per 1,000 population	**84.2** admissions per 1,000 population Age 75+	**7,051** attendances	**20.8%** of total health and care resource, for those Age 18+ was spent on emergency hospital stays
(Jan - March 2018)	(Jan – March 2018)	(Jan - March 2018)	(Oct – Dec 2017)
Little change over 4 Qtrs	+ve trend over 4 Qtrs	+ve trend over 4 Qtrs	Little change over 4 Qtrs
Similar to Scotland	Lower than Scotland	Trend similar to Scotland	Lower than Scotland

Main challenges:

Whilst the *rate* of emergency admissions to hospital amongst the Borders population is stable / improving as shown above, there are still over **3000** emergency admissions each quarter, with a third of them people aged 75 and over. This places significant pressure on our hospital services (particularly on BGH, but also on other hospitals to which Borders' residents can be admitted, such as Edinburgh Royal Infirmary).

Our plans during 2018 to support this objective:

Develop Local Area Co-ordination; redesign day services; Continue Community Link Worker pilot in Central and Berwickshire areas; develop the role of community pharmacist; extend scope of the Matching Unit; Use Buurtzorg model of care to plan and deliver service by locality; increase use of telecare and telehealth; delivery of Post Diagnostic Support for people with dementia, and continued focus on referral process for dementia

Objective 2: We will improve the flow of patients into, through and out of hospital

A&E waiting times (Target = **95%**)	No. of Occupied Bed Days* for emergency admissions (ages 75+)	Rate of Occupied Bed Days* for Emergency admissions (ages 75+)	Number of delayed discharges ("snapshot" taken 1 day each month)	Rate of bed days associated with delayed discharge
89% of people seen within 4 hours (March 2018)	**10,587** bed days for admissions of people aged 75+ (Oct - Dec 2017)	**883** bed days per 1000 population Age 75+ (Oct – Dec 2017)	**19** over 72 hours **19** over 2 weeks (April 2018)	**189.8** bed days per 1,000 population Aged 75+ (Jan - March 2018)
-ve trend over 4 Qtrs	+ve trend over 4 Qtrs	Little change over 4 Qtrs	-ve trend over 4 Qtrs	-ve trend over 4 Qtrs
Higher than Scotland		Lower than Scotland		Higher than Scotland

*Occupied Bed Days in general/acute hospital beds such as Borders General Hospital. This does not include bed days in the four Borders' community hospitals.

"**Two minutes of your time**" survey, conducted at BGH and Community Hospitals (Jan – March 2018)		
Satisfaction with care and treatment **97.1%**	Staff understanding of what mattered **93.8%**	Patients had info and support needed **93.5%**
Little change over 4 Qtrs	-ve trend over 4 Qtrs (although high)	Little change over 4 Qtrs

Main challenges:

The winter period saw a reduction in the percentages of people seen within 4 hours in A&E, and although Borders compares relatively well to Scotland, nonetheless achievement has been under the 95% standard for the last 5 months reported. Key challenges remain in relation to bed days associated with people being delayed in hospital.

Our plans during 2018 to support this objective:

Support a range of "Hospital to Home" and "Discharge to assess" models to reduce delays (for adults who are medically fit for discharge); develop "step-up" facilities to prevent hospital admissions and increase opportunities for short-term placements; as well as a range of longer term transformation programmes aimed at shifting resources and redesigning services

Objective 3: we will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

Emergency readmissions within 28 days (all ages)	End of Life Care	Carers offered assessments/assessments complete	Support for carers: change between baseline assessment and review. Improvements in self-assessment:
10.3 per 100 discharges from hospital were re-admitted within 28 days (Oct – Dec 2017)	**88.2%** of people's last 6 months was spend at home or in a community setting (Oct – Dec 2017)	**187** Offered **36** Completed (Jan – March 2018)	Health and well-being Managing the caring role Feeling valued Planning for the future Finance & benefits (Jan – March 2018)
Little change over 4 Qtrs	-ve Trend over 4 Qtrs	Little change over 4 Qtrs	n/a (data from Q4 17/18)
Similar to Scotland	Lower than Scotland		

Main challenges:

Quarterly "end of life care" measure fluctuates considerably and should be treated on a "provisional" basis and could be influenced by seasonal factors such as variations in hospital activity. Measure may subsequently be replaced with one that better distinguishes time spent in the Margaret Kerr Unit as distinct from time spent on general/acute hospital wards. Challenges remain around support for carers

Our plans during 2018 to support the objective:

Further development of "What Matters" hubs; Support for Transitional Care as a model of service delivery for people 50+; redesign of care at home services to focus on re-ablement; increase provision of Extra Care Housing; roll out of Transforming Care after Treatment programme (commencing with Eildon); ongoing commissioning of Borders Carers Centre to undertake assessments.

Rationale for inclusion of measures in IJB performance reporting

Objective 1: we will improve health of the population and reduce the number of hospital admissions

Indicator	Why has this been included?
Rate of emergency admissions to hospital, per 1000 population (all ages)	Reducing emergency admissions in our population 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 manage 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.
Rate of emergency admissions to hospital, per 1000 population (age 75+)	This is of particular concern and has historically been higher in the 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.
Number of attendances at A&E	Whilst this focuses on 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 ultimately prevent people having to attend A&E
% of health and care resource spent on emergency hospital stays for persons 18+	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 to see the proportion of emergency spend reduce.

Objective 2: We will improve the flow of patient into, through and out of hospital

Indicator	Why has this been included?
% of people seen within 4 hours at A&E	The national standard for Accident and Emergency (A&E) waiting times is that 95% of people arriving in an A&E Department in Scotland (including Minor Injuries Units) should be seen and then admitted, transferred or discharged within 4 hours. NHS Boards are to work towards achieving 98% performance.
Number of Occupied Bed Days for emergency Admissions, 75+	Once a hospital admission has been necessary in an emergency, it is important for people to get back home (or to another appropriate place) 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
Rate of Occupied Bed Days for	

Indicator	Why has this been included?
emergency admissions, per 1000 population (ages 75+)	needs. There is a continuing focus in the Borders on providing alternative supports for older adults, rather than keep them unnecessarily in hospital. The number and the rate have both been included to demonstrate the scale of the challenge as well as the change over time. **Note:** These measures reflect all bed days in a general/acute hospital (such as BGH) following emergency admission, including those for delayed discharges. They *do not*, however, reflect bed days in any of the Borders' Community Hospitals. This is because, in common with several others in this report, the measures are based on standard, Scotland-wide measures (to allow benchmarking), which excludes data on beds coded as "Geriatric Long Stay" (GLS). All beds in the Borders Community Hospitals are coded by NHS Borders as GLS and thus those bed days are not reflected in these measures.
Number of Delayed Discharges over 72 hours; and over 2 weeks	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. 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. Delayed Discharges (DDs) over 2 weeks; over 72 hours are snapshots - taken on a census day each month - of the numbers of patients for whom the delay has exceeded the specified period of time.
Rate of Bed Days associated with delays, per 1,000 population aged 75+	This measure is included to provide a fuller picture (not just the monthly snapshot, above) of the impact of delays. Put simply, patients who are fit to leave hospital but are delayed (for a variety of reasons) take up beds that could be used for other patients who require urgent or planned care. Integration should ultimately see a reduction in this measure.
Summarised results for NHS Borders' "Two minutes of your time" survey (conducted on an ongoing basis at BGH and Community Hospitals)	NHS Borders has introduced a proactive patient feedback system '2 minutes of your time', which comprises a brief survey of 3 quick questions. Feedback boxes are located within acute hospital (the BGH), community hospital and mental health units. In addition patient feedback volunteers have been recruited and gather feedback from patients, carers and their relatives within clinical and public areas throughout the hospital. This enables us to look at changing the way in which we do things and ensuring our work has a more person centred approach.

Objective 3: we will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

Indicator	Why has this been included?
Rate of Emergency Readmissions within 28 days of discharge from	The readmission rate reflects several aspects of integrated health and care services, including discharge arrangements and co-ordination of follow up care, underpinned by good communication. It also reflects the quality and level of care being provided within the community.

Indicator	Why has this been included?
hospital (all ages), per 100 discharges	This is a bespoke measure produced by ISD LIST (part of NHS National Services Scotland) for Scottish Borders H&SCP and includes patients discharged from the Borders' Community Hospitals as well as from general/acute beds such as BGH.
% of last 6 months of life spent at home or in a homely setting	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. This 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. 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.
Carers offered assessments /assessments complete	It is estimated that around 788,000 people are caring for a relative, friend or neighbour in Scotland (including around 44,000 people under the age of 18). A large percentage of these are currently not recognised as carers and are unpaid. Their contribution to caring within the community is substantial and could not be replaced. The Carers (Scotland) Act will commenced 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 their contribution is recognised and complements the social care system currently in place.
Support for caring-change between baseline assessment and review	A Carers Assessment includes a baseline review of several key areas including health and wellbeing, managing the carer role and planning for the future. These areas are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for Carers.

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Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the Scottish Borders Integration Joint Board August 2018

SUMMARY OF PERFORMANCE:
DATA AVAILABLE AT END JUNE 2018

Structured Around the 3 Objectives in the Revised Strategic Plan

Objective 1: We will improve health of the population and reduce the number of hospital admissions

Objective 2: We will improve the flow of patients into, through and out of hospital

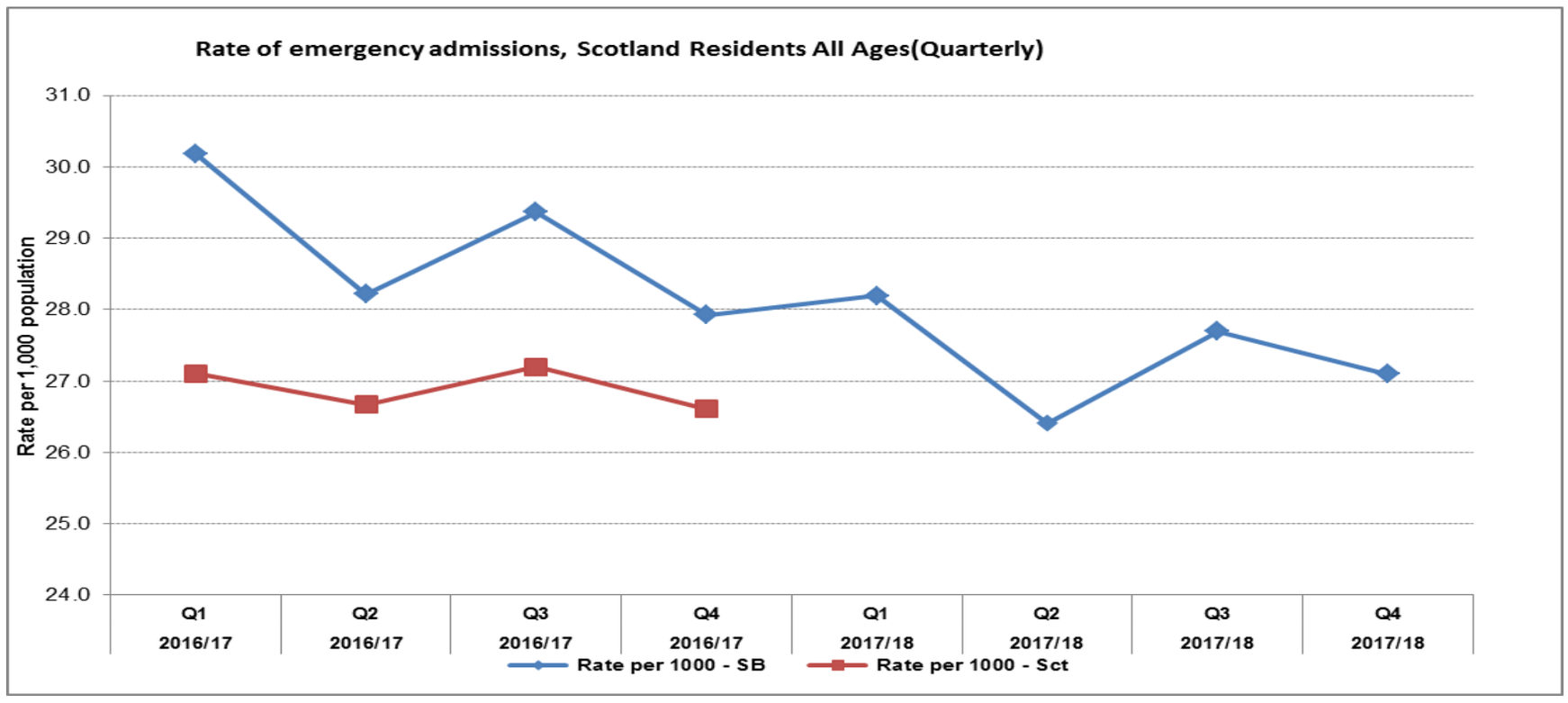
Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

Objective 1: We will improve health of the population and reduce the number of hospital admissions

Emergency Admissions, Scottish Borders residents All Ages

Source: MSG Integration Performance Indicators workbook (SMR01 data)

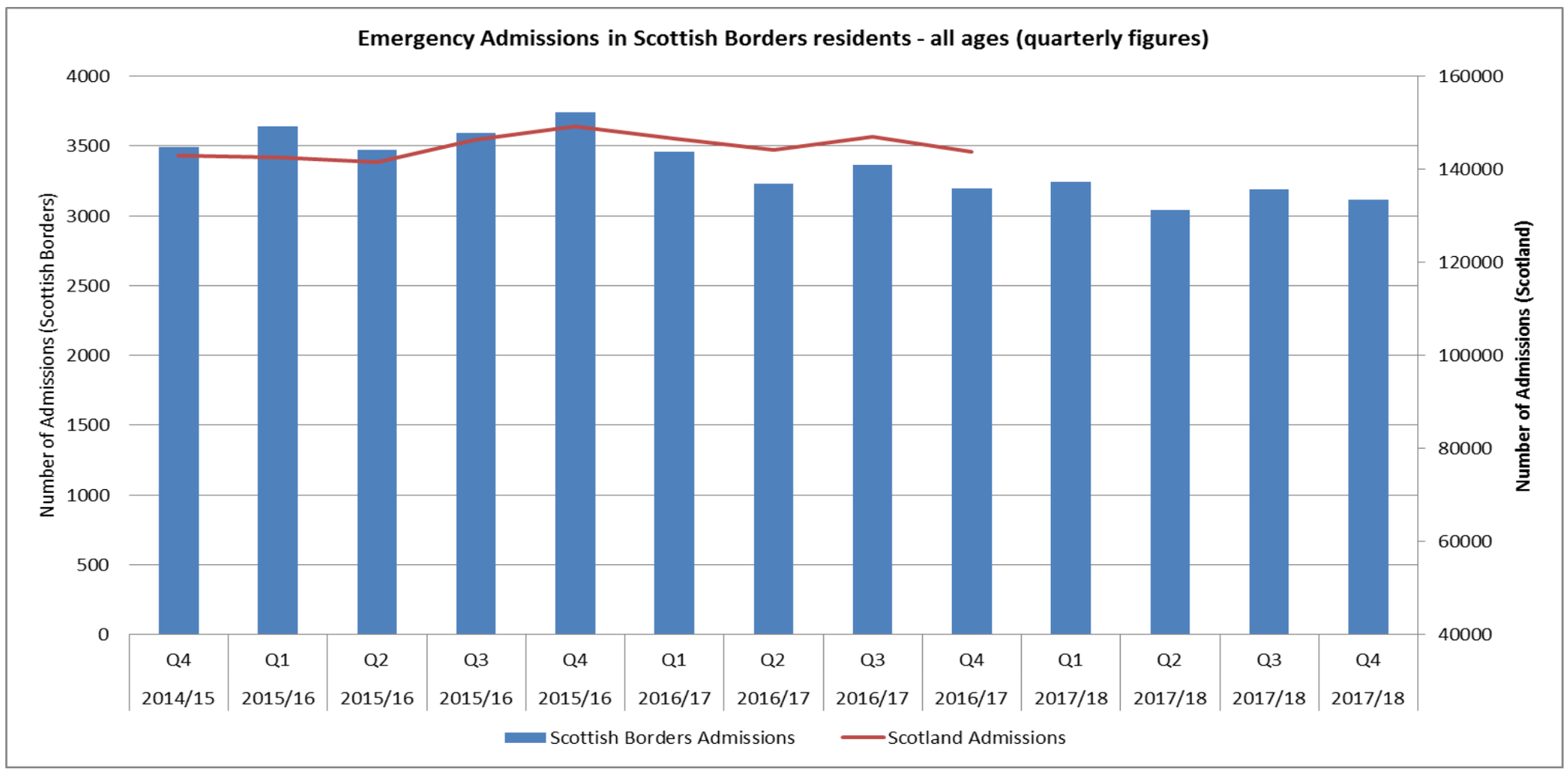
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Number of Emergency Admissions, All Ages	3,457	3,232	3,363	3,198	3,243	3,038	3,186	3,117
Rate of Emergency Admissions per 1,000 population All Ages	30.2	28.2	29.4	27.9	28.2	26.4	27.7	27.1



Emergency Admissions in Scottish Borders residents - all ages (quarterly figures)

Source: MSG Integration Performance Indicators workbook (SMR01 data)

	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Scottish Borders Emergency Admissions - All Ages	3,641	3,470	3,593	3,739	3,457	3,232	3,363	3,198	3,243	3,038	3,186	3,117
Scotland Emergency Admissions - All Ages	142,453	141,573	146,317	149,099	146,484	144,123	147,016	143,822				



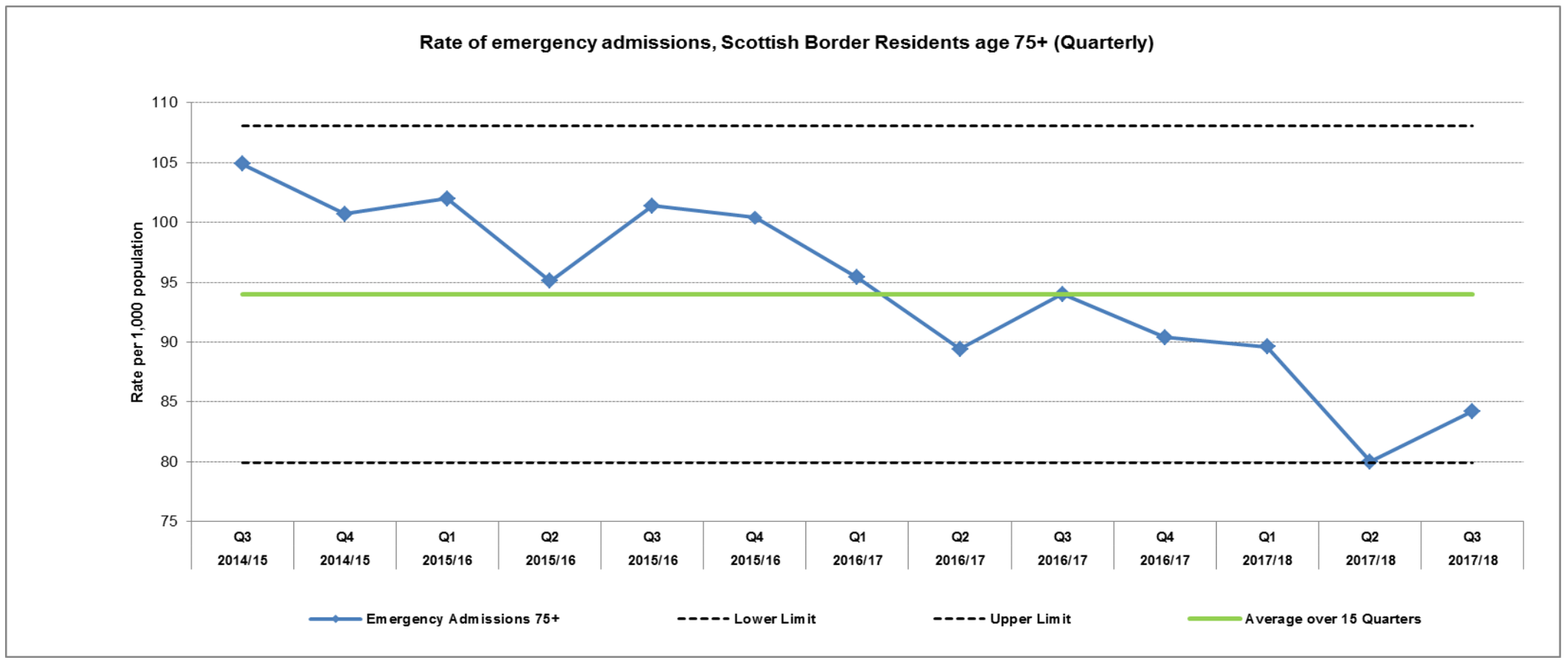
How are we performing?

The quarterly number of emergency admissions for the Scottish Borders has fluctuated since the end of the 2014/15 financial year, but has generally been decreasing. The Scottish number has also been fluctuating but the total number of emergency admissions has increased from 2015/16 to 2016/17, while it has decreased for the Scottish Borders.

Emergency Admissions, Scottish Borders residents age 75+

Source: NSS Discovery (SMR01 data)

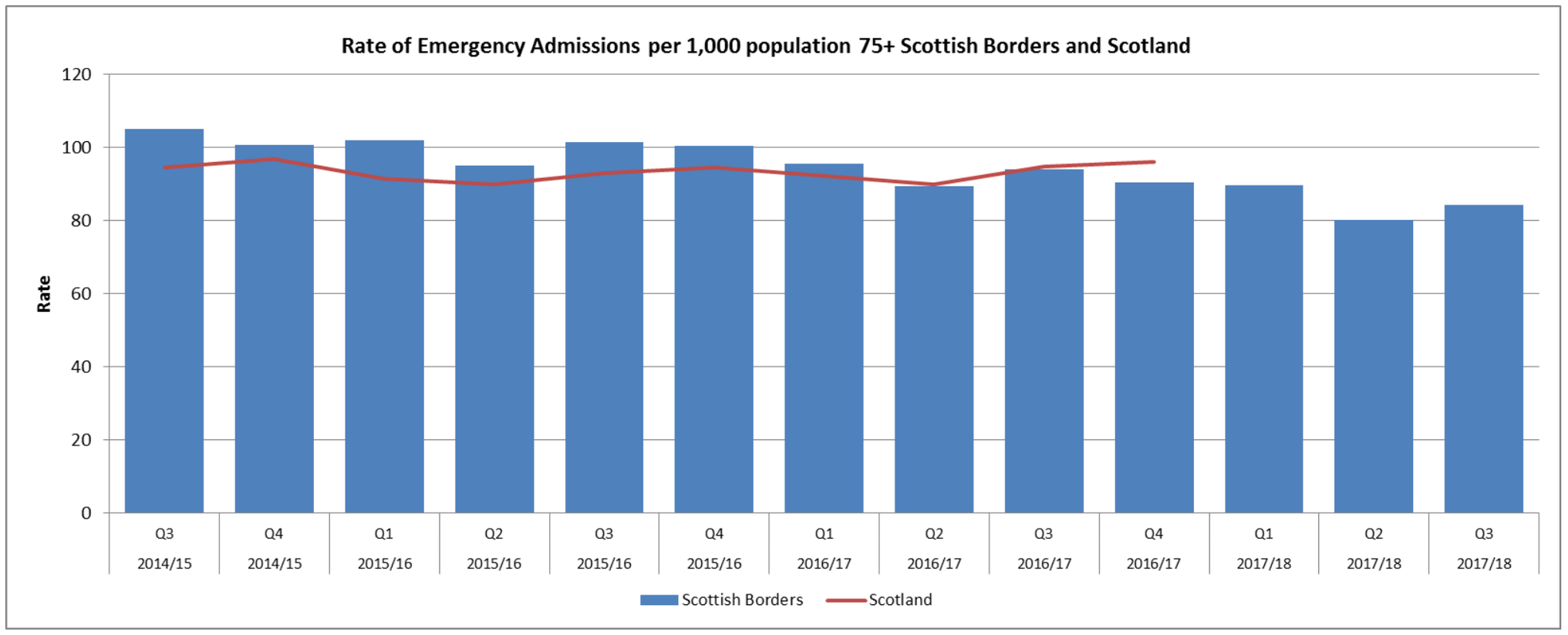
	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
Number of Emergency Admissions, 75+	1,165	1,189	1,108	1,182	1,169	1,125	1,054	1,107	1,066	1,074	959	1,009
Rate of Emergency Admissions per 1,000 population 75+	100.7	102.0	95.1	101.4	100.4	95.4	89.4	94.0	90.4	89.6	80.0	84.2



Emergency Admissions comparison, Scottish Borders and Scotland residents age 75+

Source: NSS Discovery (SMR01 data)

	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
Rate of Emergency Admissions per 1,000 population 75+ Scottish Borders	100.7	102.0	95.1	101.4	100.4	95.4	89.4	94.0	90.4	89.6	80.0	84.2
Rate of Emergency Admissions per 1,000 population 75+ Scotland	96.9	91.5	89.9	92.9	94.5	92.2	89.9	94.7	95.9			



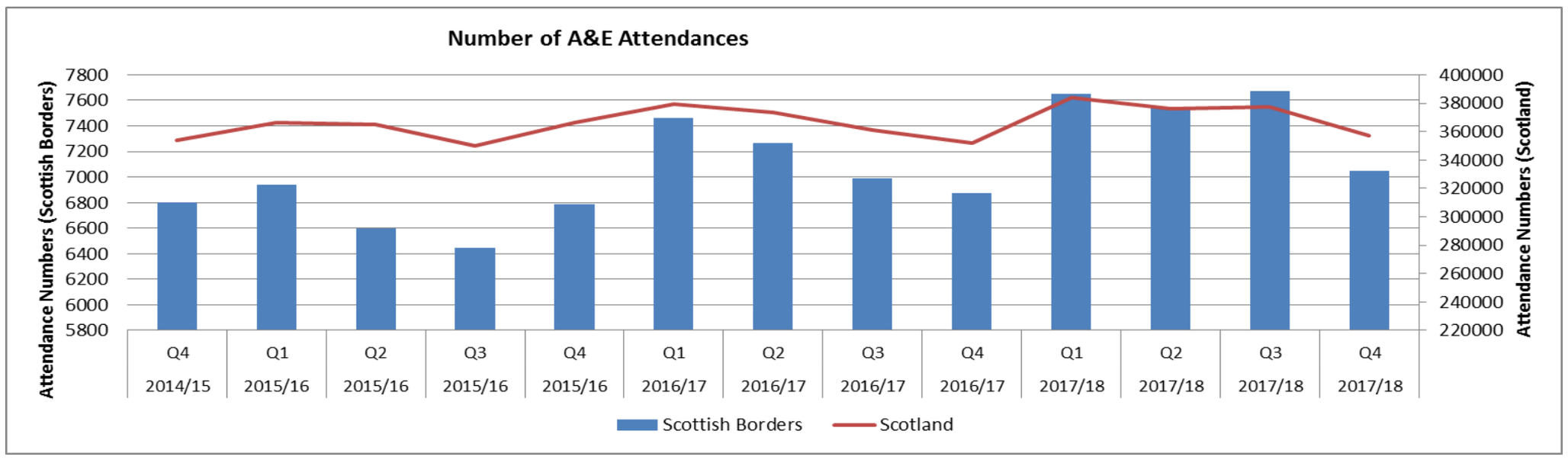
How are we performing?

The rate of emergency admissions for Scottish Borders residents aged 75 and over has generally been decreasing since late 2014. However, the Borders rate has been higher than the Scottish average until the second quarter of 2016 (July-Sept). Since October 2016, quarterly rates have been similar to or lower than the Scottish average.

Number of A&E Attendances

Source: MSG Integration Performance Indicators workbook (data from NHS Borders Trakcare system)

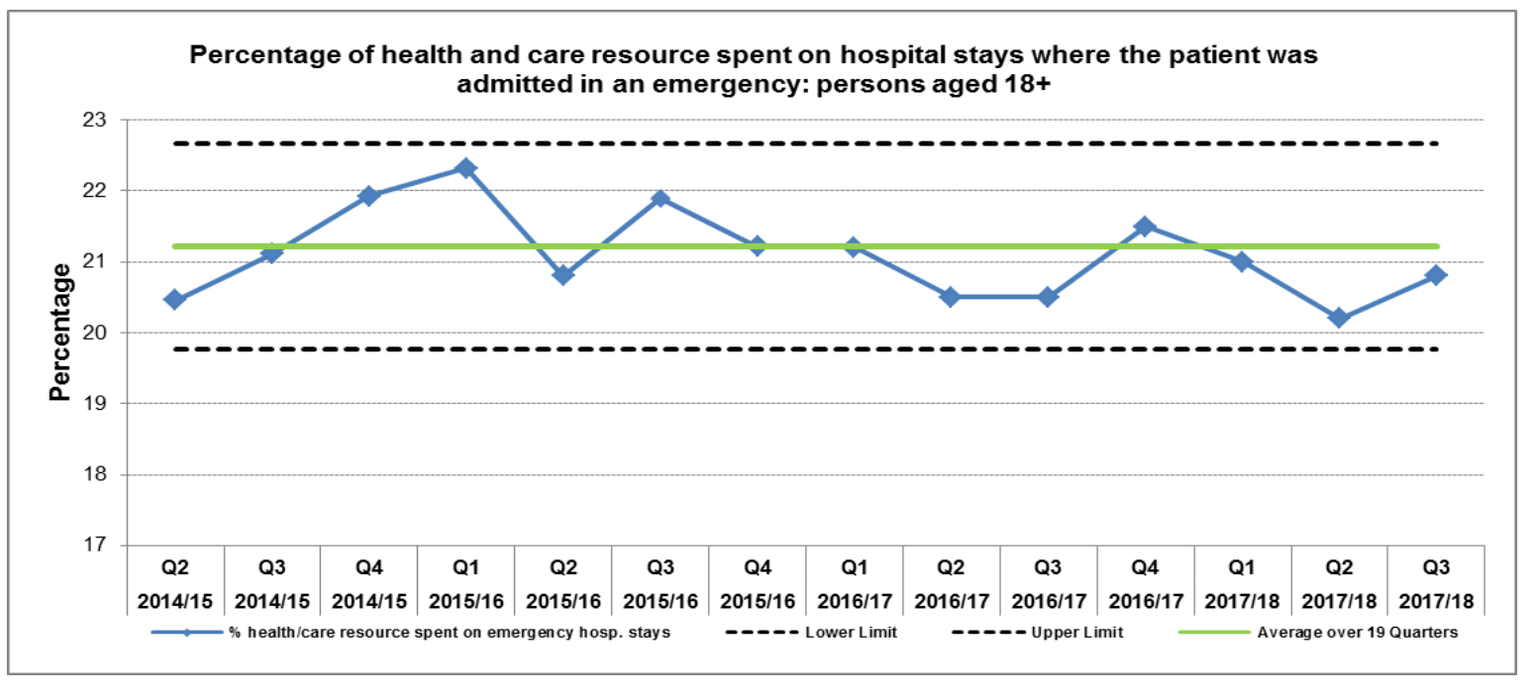
	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Number of Attendances, Scottish Borders	6,936	6,598	6,446	6,785	7,465	7,266	6,989	6,876	7,654	7,550	7,670	7,051
Number of Attendances, Scotland	366,496	364,677	349,963	366,500	379,254	373,584	360,953	352,210	384,076	376,287	377,477	357,401

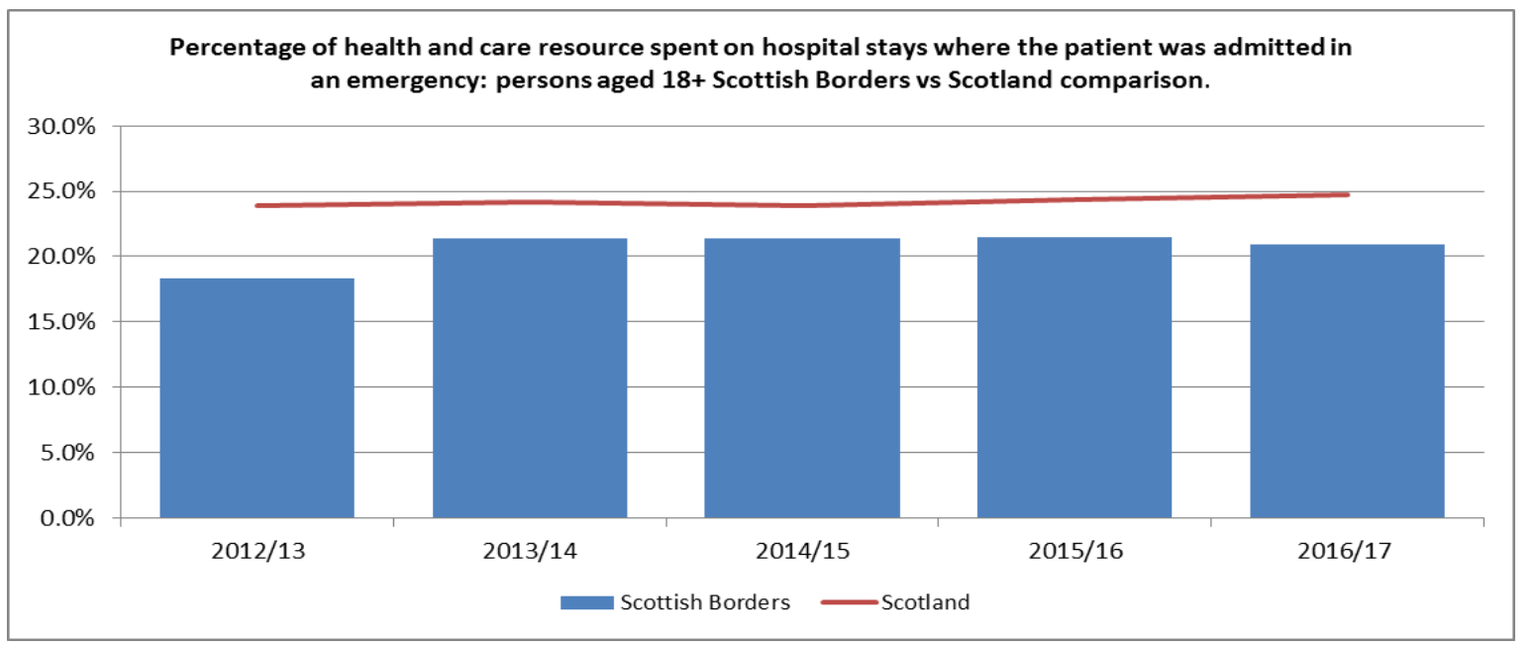


Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+

Source: Core Suite Indicator workbooks

	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18
% of health and care resource spent on emergency hospital stays (Scottish Borders)	21.9	22.3	20.8	21.9	21.2	21.2	20.5	20.5	21.5	21.0	20.2	20.8





How are we performing?

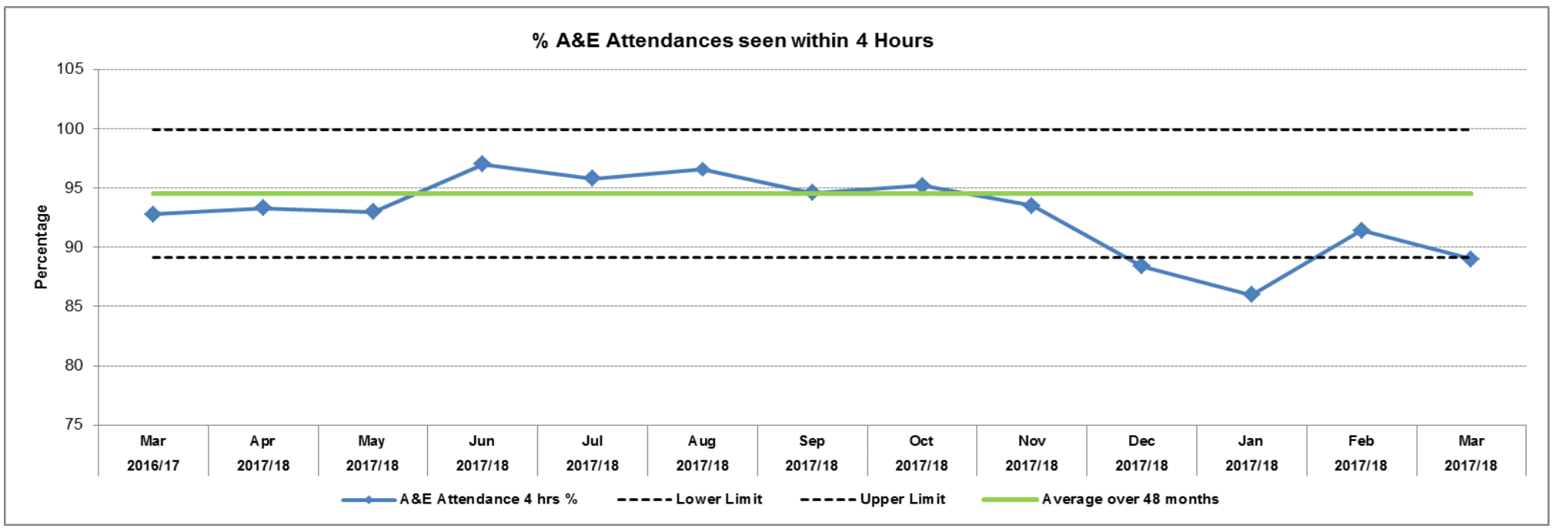
Scottish Borders has consistently performed slightly better than Scotland. However, there is no obvious downward (improving) trend, and as with other Health and Social Care Partnerships, Scottish Borders is expected to work to reduce the relative proportion of spend attributed to unscheduled stays in hospital.

Objective 2: We will improve the flow of patients into, through and out of hospital

Accident and Emergency attendances seen within 4 hours- Scottish Borders

Source: NHS Borders Trakcare system

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Number of A&E Attendances seen within 4 hours	2,567	2,679	2,556	2,515	2,571	2,661	2,599	2,405	2,624	2,395	2,143	2,455
% A&E Attendances seen within 4 hour	93.3%	93.0%	97.0%	95.8%	96.6%	94.6%	95.2%	93.5%	88.4%	86.0%	91.4%	89.0%



How are we performing?

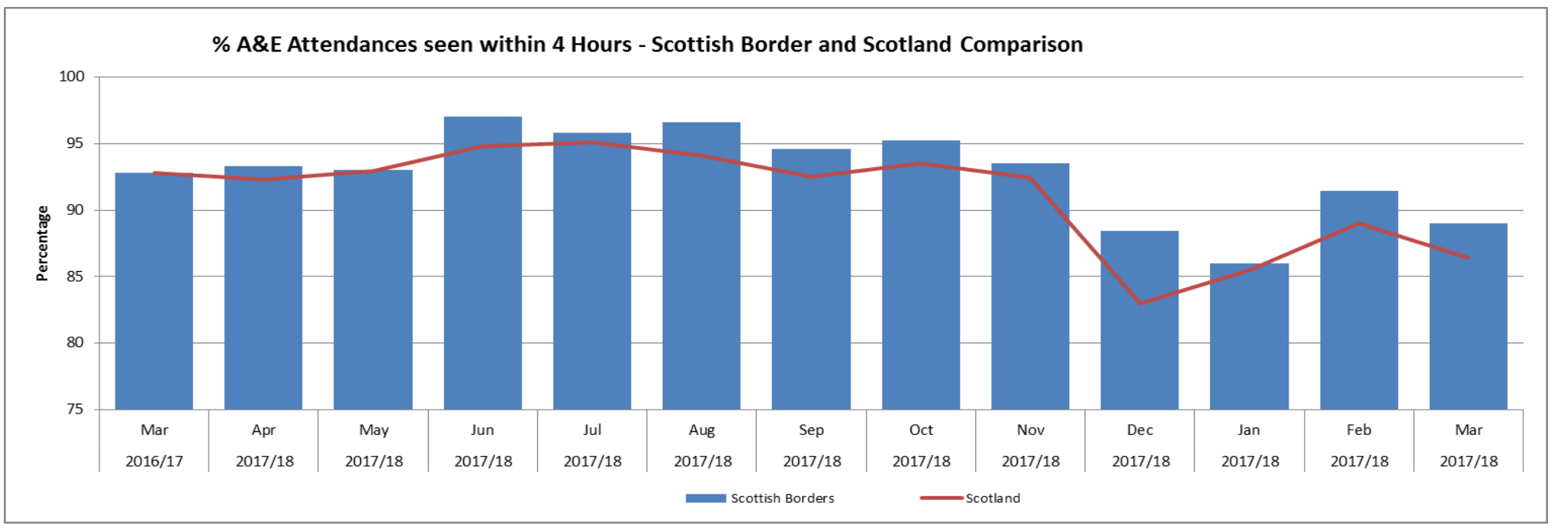
Patients attending A&E and the Acute Assessment Unit (AAU) are routinely discharged within 4 hours. NHS Borders is working towards consistently achieving the 98% local stretch standard.

The 95% standard was achieved in June, July and August 2017. The main cause of breaches has been delays waiting for bed availability and reflects ongoing challenges in the discharge of complex patients.

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

Source: NHS Borders Trakcare system

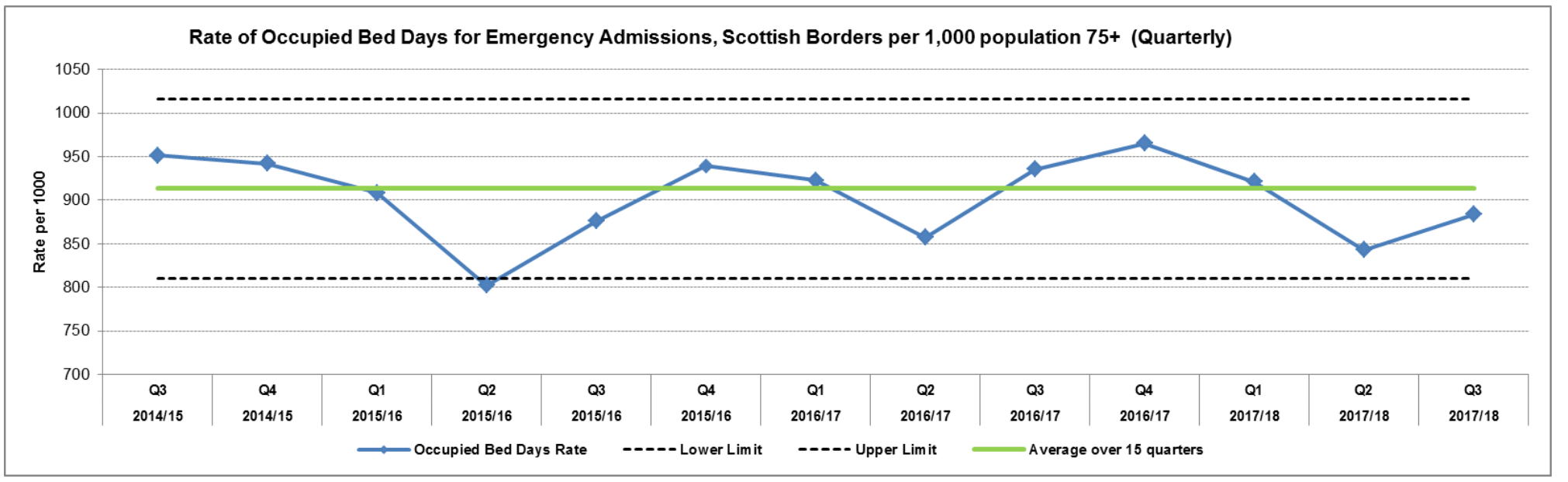
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	~~Sep-17~~	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% A&E Attendances seen within 4 hour Scottish Borders	93.3%	93.0%	97.0%	95.8%	96.6%	0.946	0.952	0.935	88.4%	86.0%	91.4%	89.0%
% A&E Attendances seen within 4 hour Scotland	92.3%	92.9%	94.8%	95.1%	94.1%	0.925	0.935	0.924	83.0%	85.5%	89.0%	86.4%



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

Source: NSS Discovery (SMR01 data)

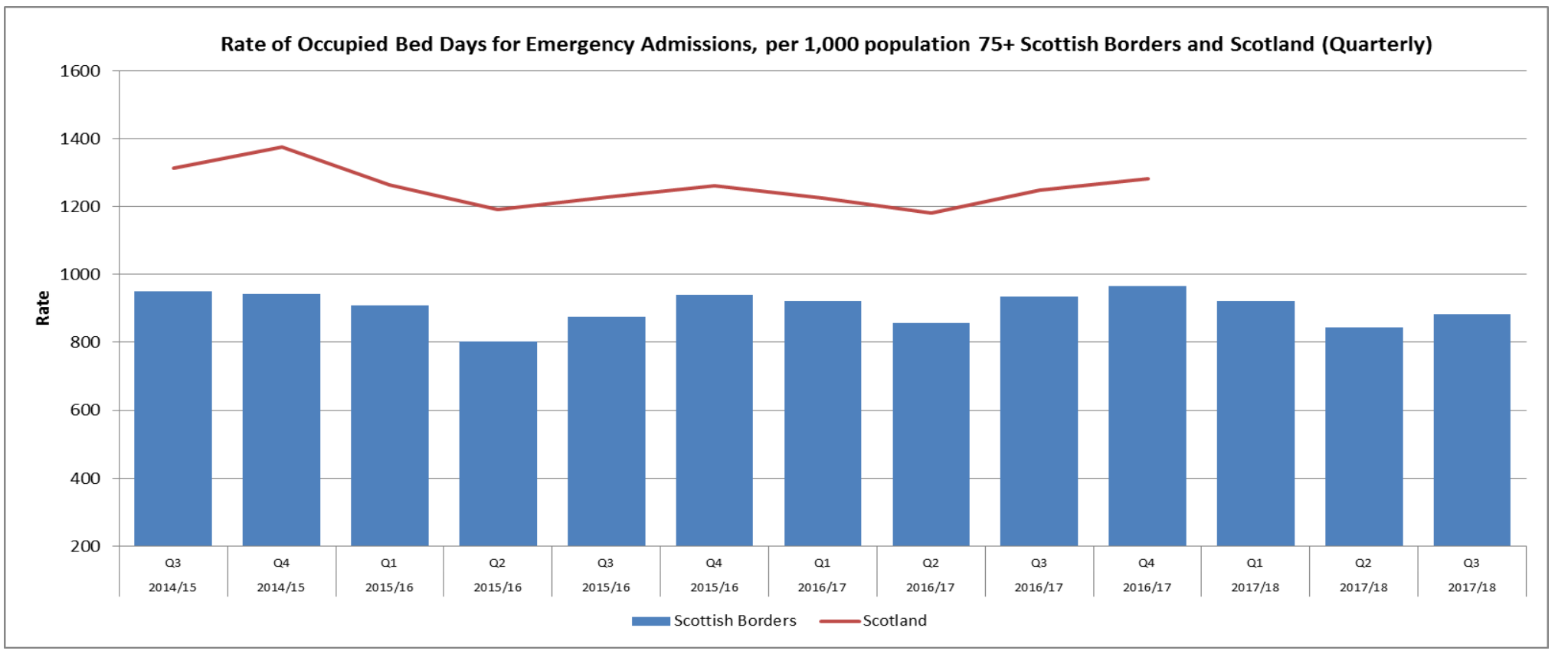
	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
Number of Occupied Bed Days for emergency Admissions, 75+	10,896	10,587	9,348	10,213	10,948	10,877	10,109	11,028	11,382	11,035	10,103	10,587
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	942	908	802	876	939	922	857	935	965	921	843	883



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

Source: NSS Discovery (SMR01 data)

	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	942	908	802	876	939	922	857	935	965	921	843	883
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1,375	1,263	1,190	1,227	1,261	1,224	1,181	1,248	1,282			



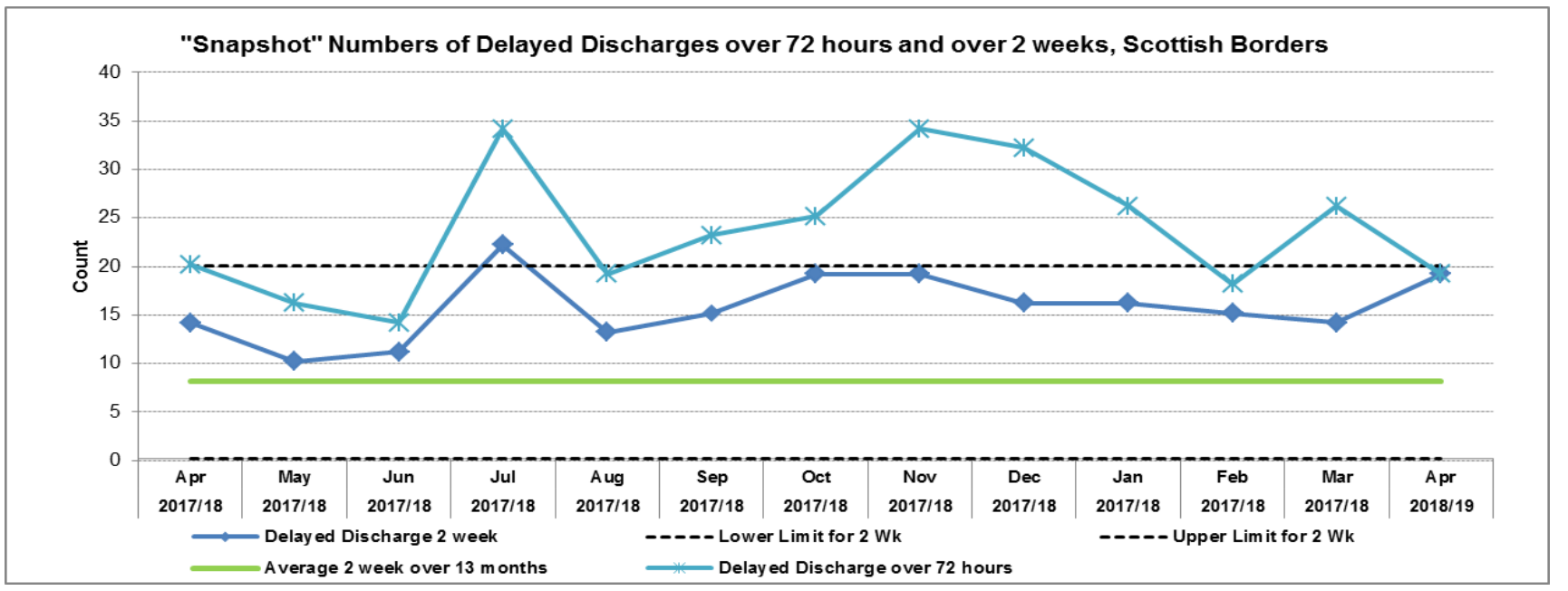
How are we performing?

The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75 and over have fluctuated over time but are lower than the Scottish averages. The Scottish rate has only twice gone below 1,200 per 1,000 population, while the Scottish Borders rate has never gone above 1,000 per 1,000 population. However, it should be noted that this nationally-derived measure does not include bed-days in the four Community Hospitals in the Borders.

Delayed Discharges (DDs)

Source: EDISON/NHS Borders Trakcare system

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Number of DDs over 2 weeks	10	11	22	13	15	19	19	16	16	15	14	19
Number of DDs over72 hours	16	14	34	19	23	25	34	32	26	18	26	19



Please note the Delayed Discharge over 72 hours measurement has recently been implemented from April 2016.

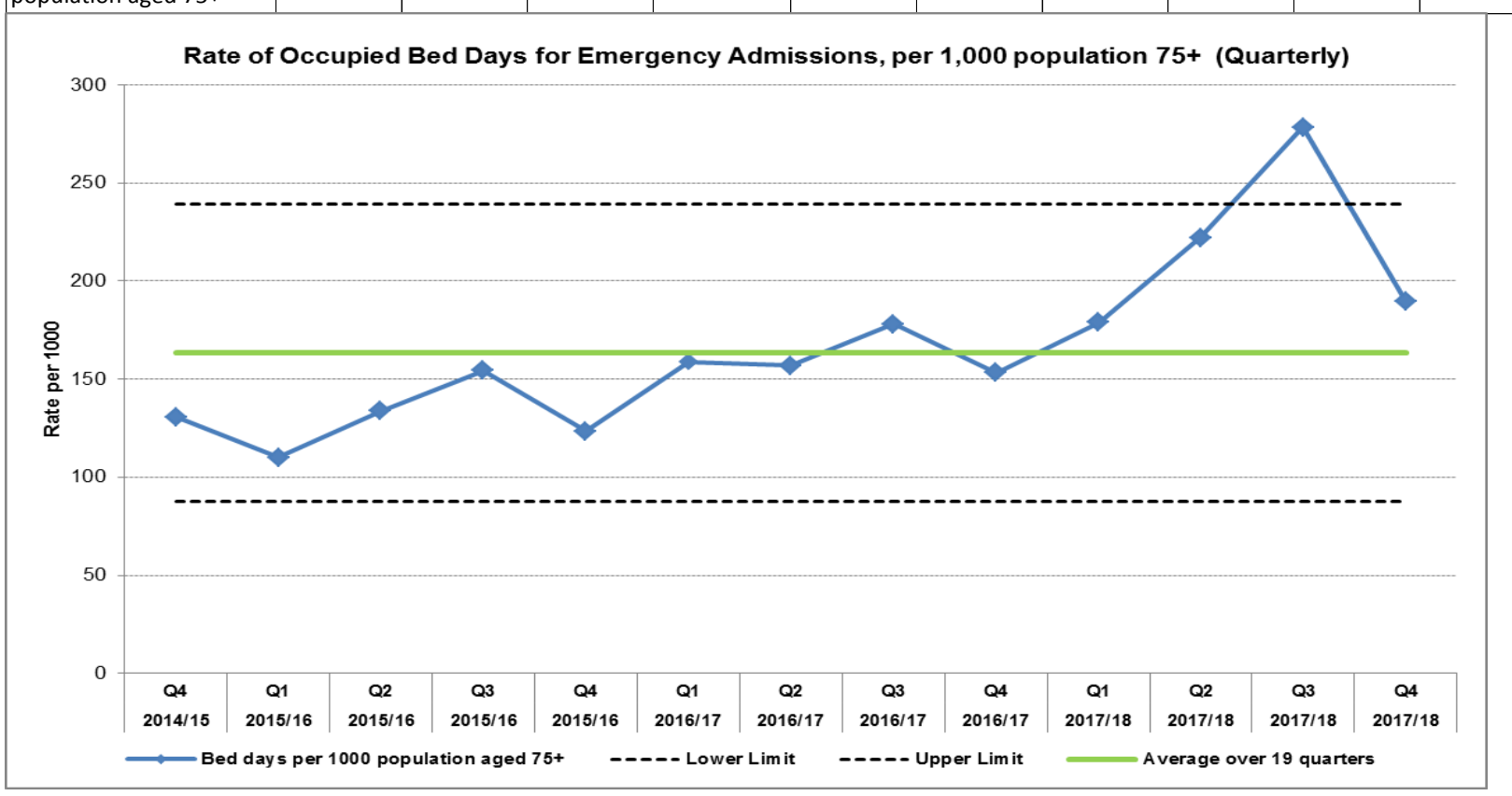
It has been overlayed on this graph as an indicator of the new measurement (light blue line) however as data is limited we cannot provide a statistical run chart for this.

The DD 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 measurement.

Bed days associated with delayed discharges in residents aged 75+; rate per 1,000 population aged 75+

Source: Core Suite Indicator workbooks

	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2015/16	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Bed days per 1,000 population aged 75+	110	134	154	124	159	157	178	153	179	222	278	190



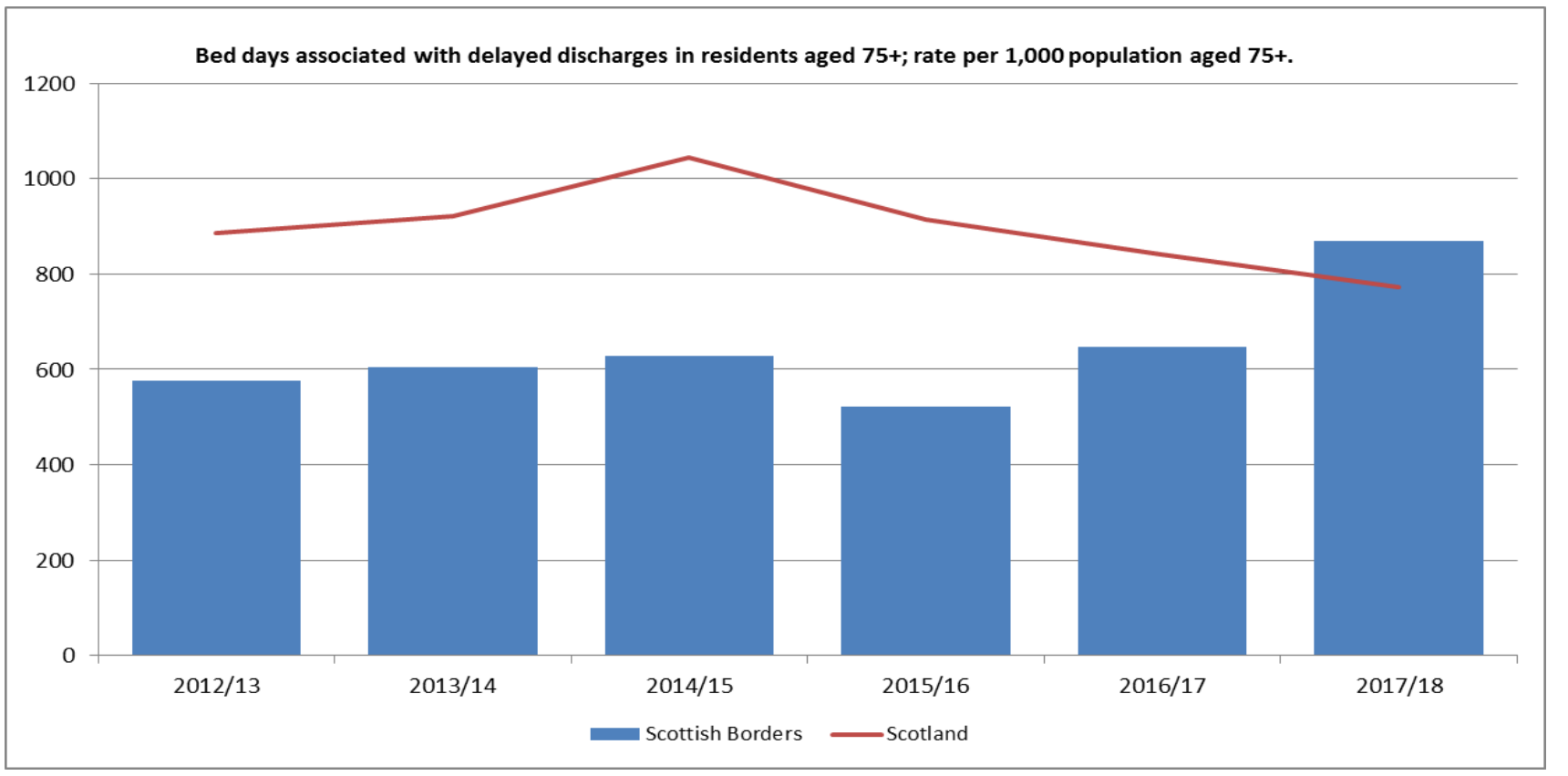
How are we performing?

The rate of bed days associated with delayed discharges for Scottish Borders residents aged 75 and over has fluctuated since the start of the 2013/14 financial year, but has generally remained around 100 to 200 per 1,000 residents. However, the rate for the middle two quarters of 2017/18 was higher than any previous quarter, increasing to over 200 per 1,000 residents for the first time.

Scotland / Scottish Borders comparison of bed days associated with delayed discharges in residents aged 75+

Source: Core Suite Indicator workbooks

	2012/13	2013/14	2014/15	2015/16	2016/17*	2017/18*
Scottish Borders	575	604	628	522	647	869
Scotland	886	922	1044	915	842	772



How are we performing?

In terms of overall rates of occupied bed-days associated with delayed discharge for residents aged 75 and over, Borders has performed consistently better than the Scottish average. However, the local rate for 2016/17 as a whole was higher than for the preceding year.

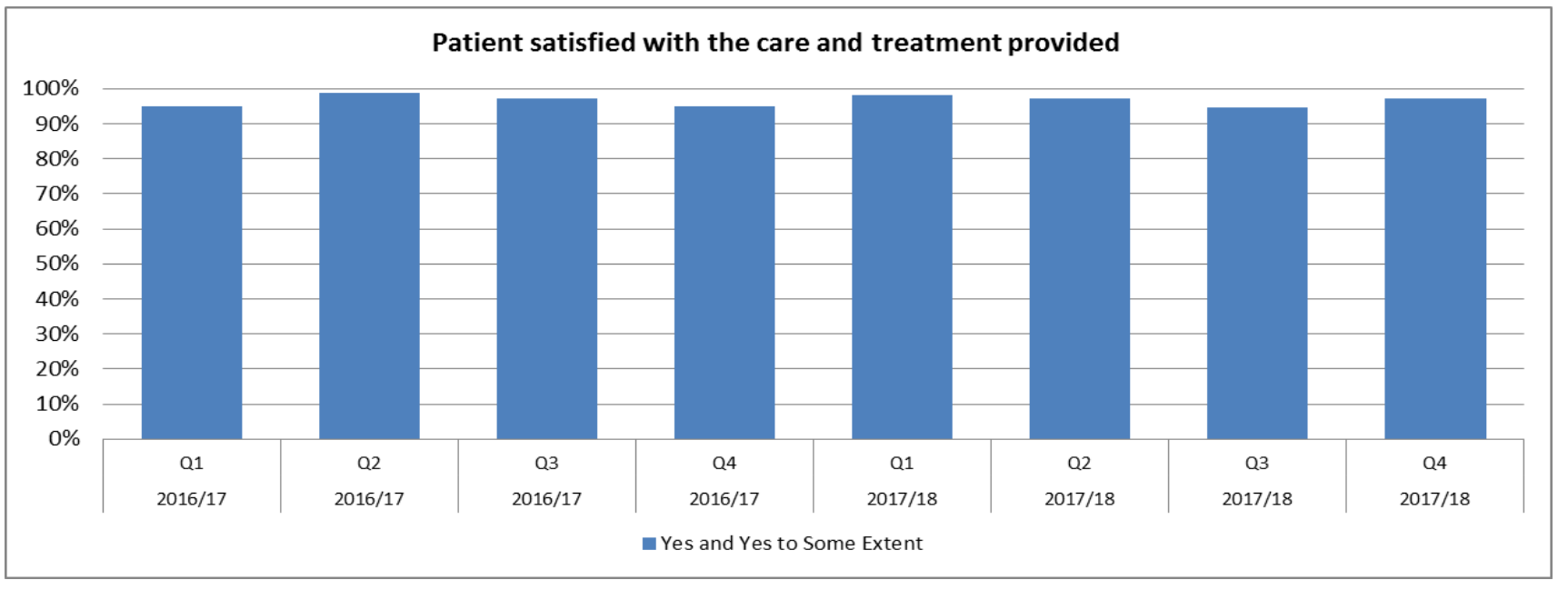
*Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for

BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

Source: NHS Borders

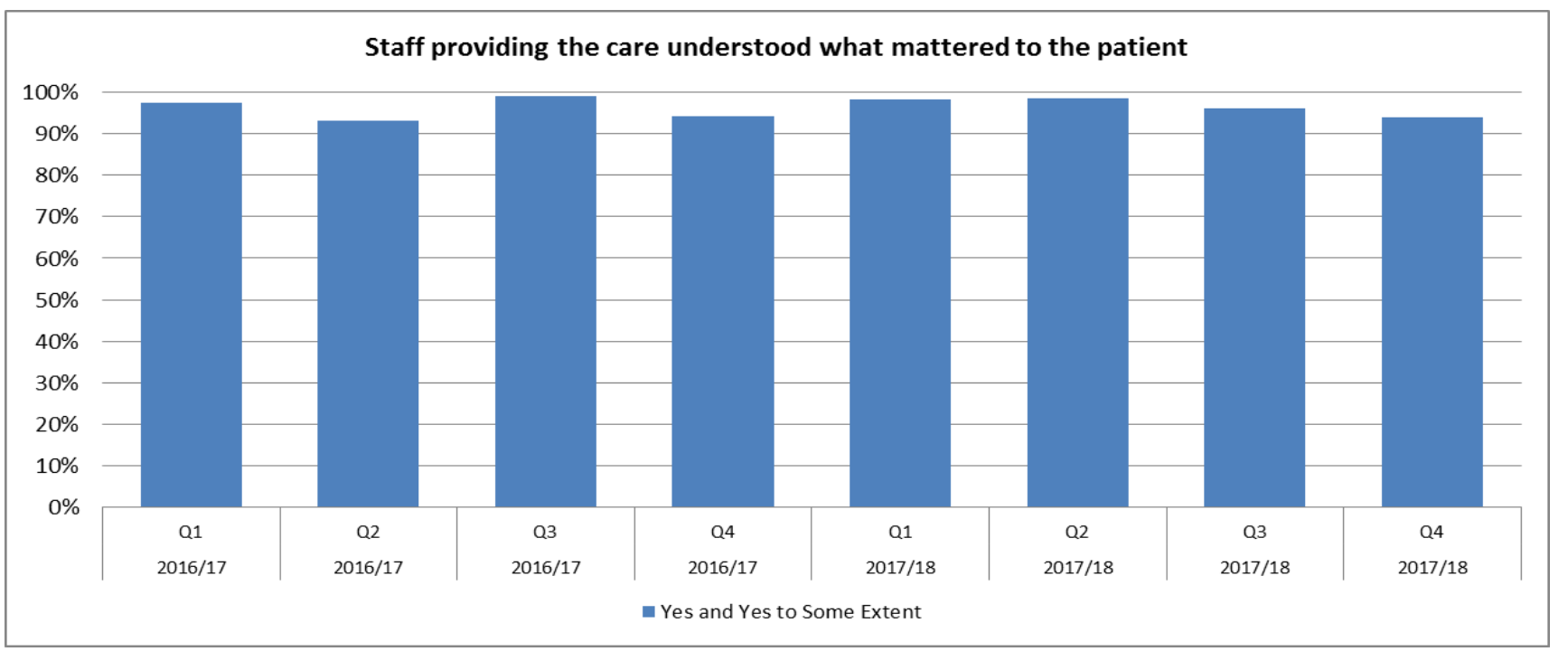
Q1 Was the patient satisfied with the care and treatment provided?

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q14 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Patients feeling satisfied or yes to some extent	232	160	105	116	105	206	141	135
% feeling satisfied or yes to some extent	95.1%	98.8%	97.2%	95.1%	98.1%	97.2%	94.6%	97.1%



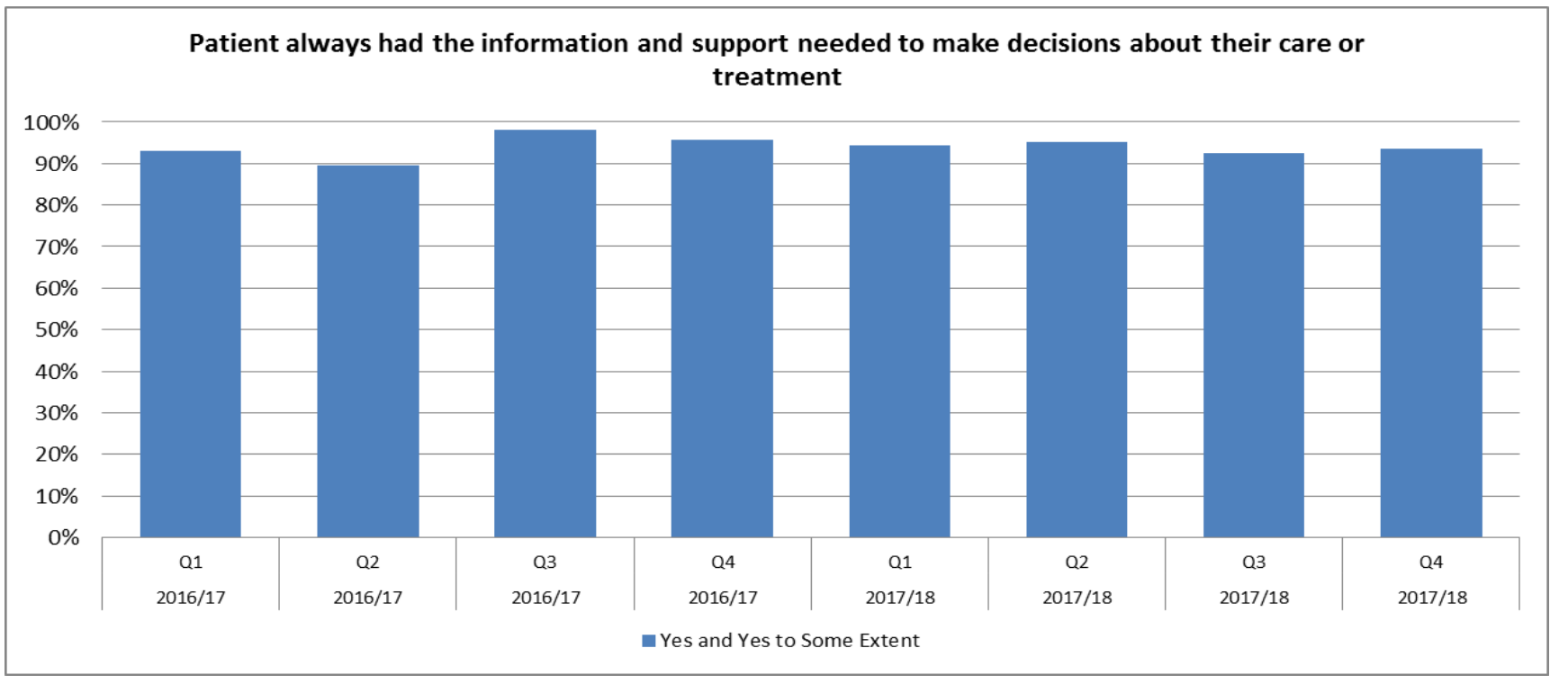
Q2 Did the staff providing the care understand what mattered to the patient?

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q14 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Staff providing the care understood what mattered to the patient, or yes to some extent	238	151	106	113	105	213	144	135
% understood what mattered or yes to some extent	97.5%	93.2%	99.1%	94.2%	98.1%	98.6%	96.0%	93.8%



Q3 Did the patient always have the information and support needed to make decisions about their care or treatment?

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q14 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Patients always had the information and support needed to make decisions about their care or treatment, or yes to some extent	226	147	101	111	99	200	137	129
% always had information or support, or yes to some extent	93.0%	89.6%	98.1%	95.7%	94.3%	95.2%	92.6%	93.5%



How are we performing?

The 2 Minutes of Your Time Survey is carried out across the Borders General Hospital and Community Hospitals and comprises of 3 quick questions asked of patients, relatives or carers by volunteers. There are also boxes posted in wards for responses. The results given here are the responses where the answer given was in the affirmative or 'yes to some extent'. Percentages given are of the total number of responses.

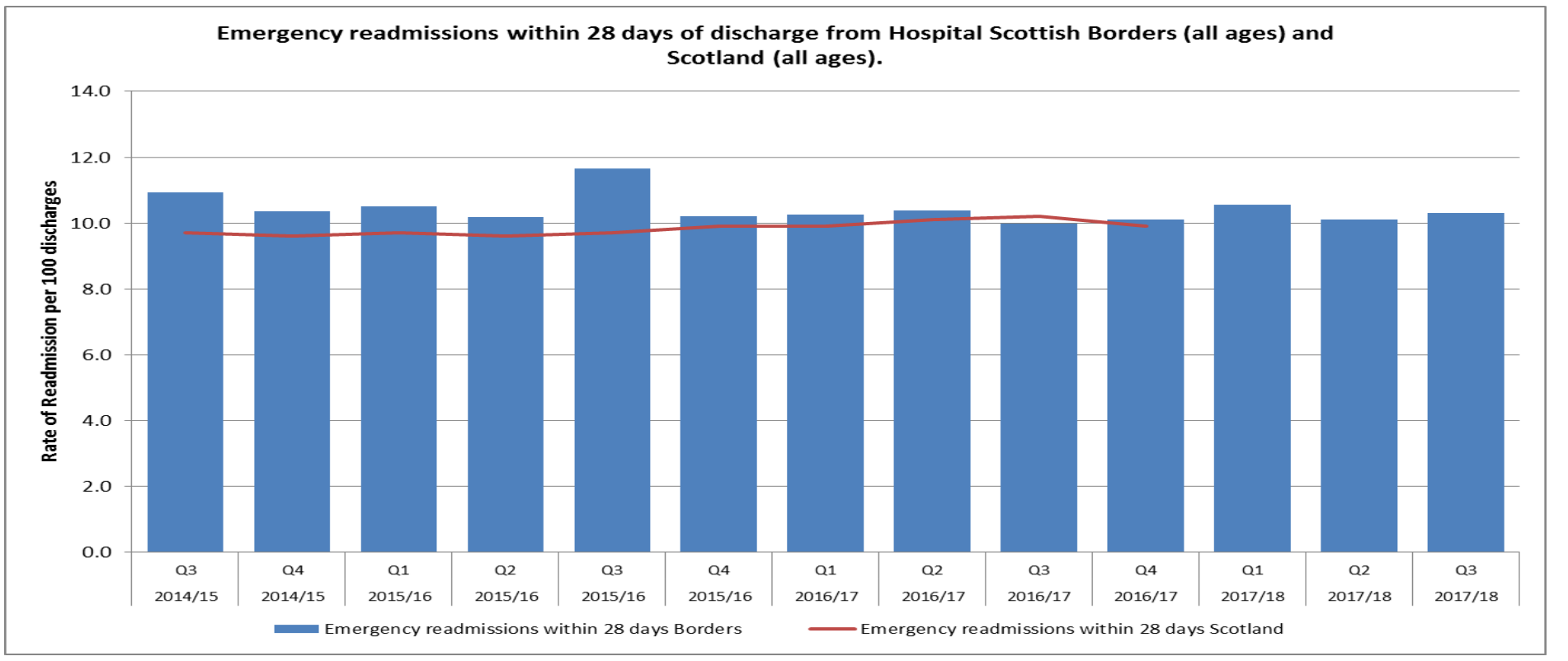
The positive response averages for the last 7 quarters are 96.5% for question 1, 96.7% for question 2 and 93.8% for question 3.

Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

Emergency readmissions within 28 days of discharge from hospital, Scottish Borders residents (all ages)

Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but here also adding in Borders Community Hospital beds).

	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
28-day readmission rate Scottish Borders (per 100 discharges)	10.4	10.5	10.2	11.7	10.2	10.3	10.4	10.0	10.1	10.6	10.1	10.3
28-day readmission rate Scotland (per 100 discharges)	9.6	9.7	9.6	9.7	9.9	9.9	10.1	10.2	9.9			



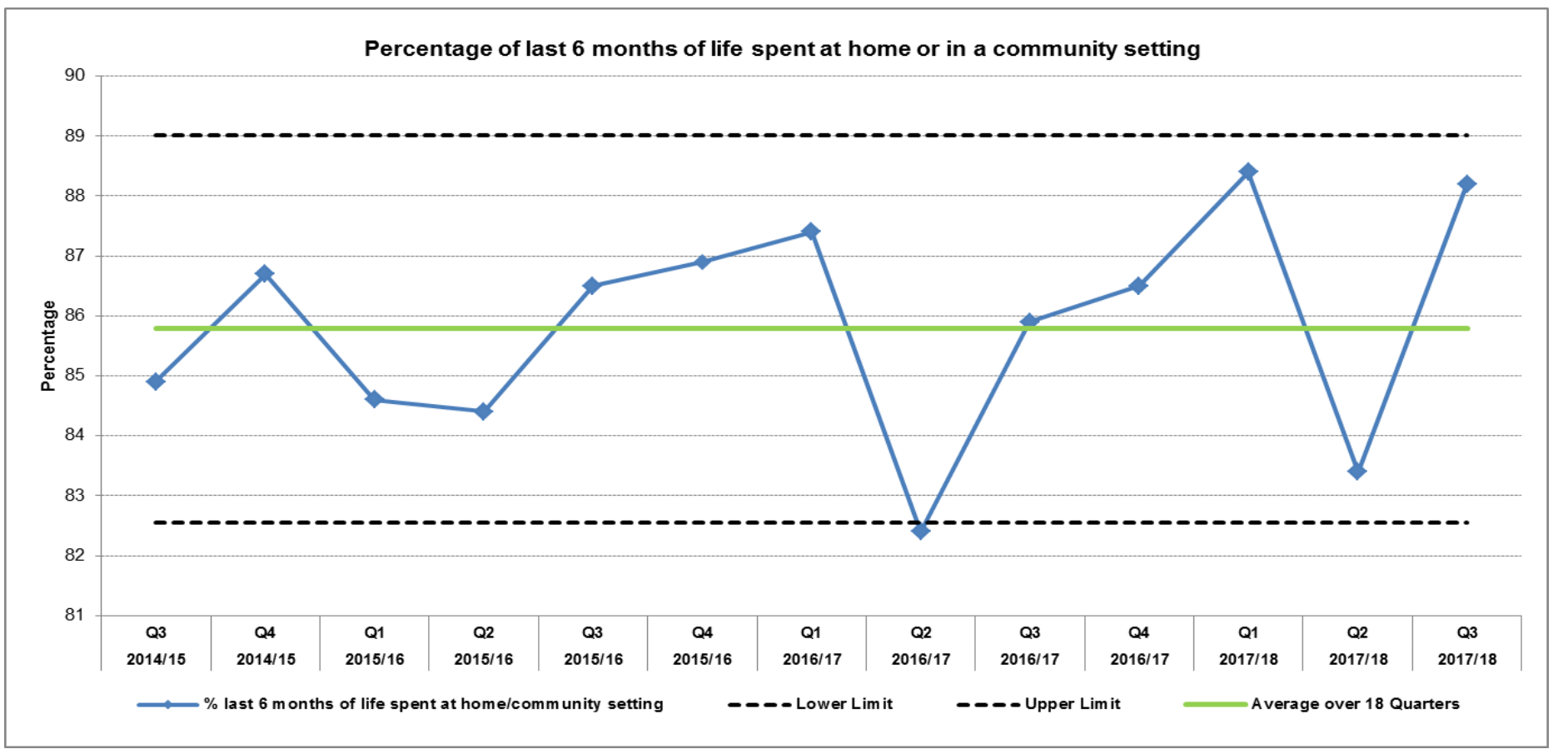
How are we performing?

The quarterly rate of emergency readmissions within 28 days of discharge for Scottish Borders residents has fluctuated since the start of the 2014/15 financial year, but has generally remained around 10 to 11 readmissions per 100 discharges. The Borders rate has usually been higher than the Scottish average. The gap has slightly narrowed over time, although at least in part this will reflect improvments in the accuracy of NHS Borders' data.

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

Source: Core Suite Indicator workbooks

	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
% last 6 months of life spent at home or in a community setting Scottish Borders	86.7%	84.6%	84.4%	86.5%	86.9%	87.4%	82.4%	85.9%	86.5%	88.4%	83.4%	88.2%



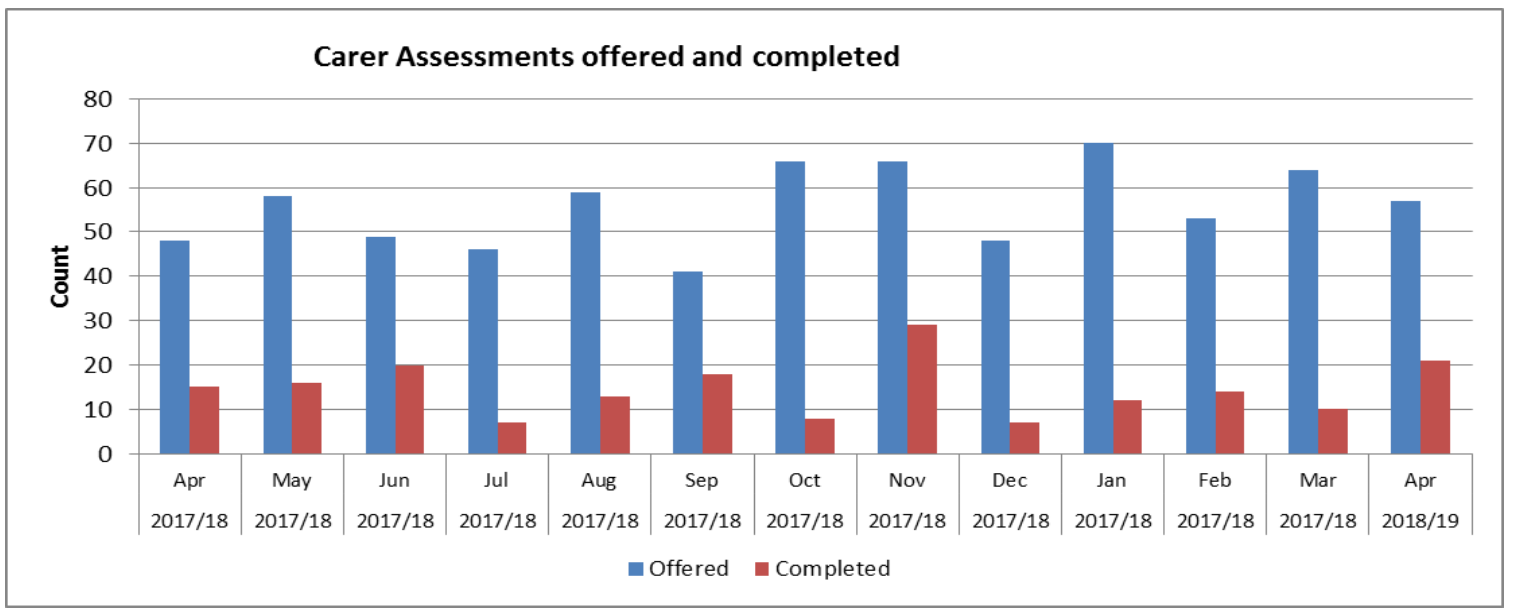
How are we performing?

The percentage of last 6 months of life spent at home or in a community setting has appeared fairly consistent in the Borders from year to year since 2013/14 but in each case remains a little below the Scottish average, which is gradually increasing.

Carers offered and completed assessments.

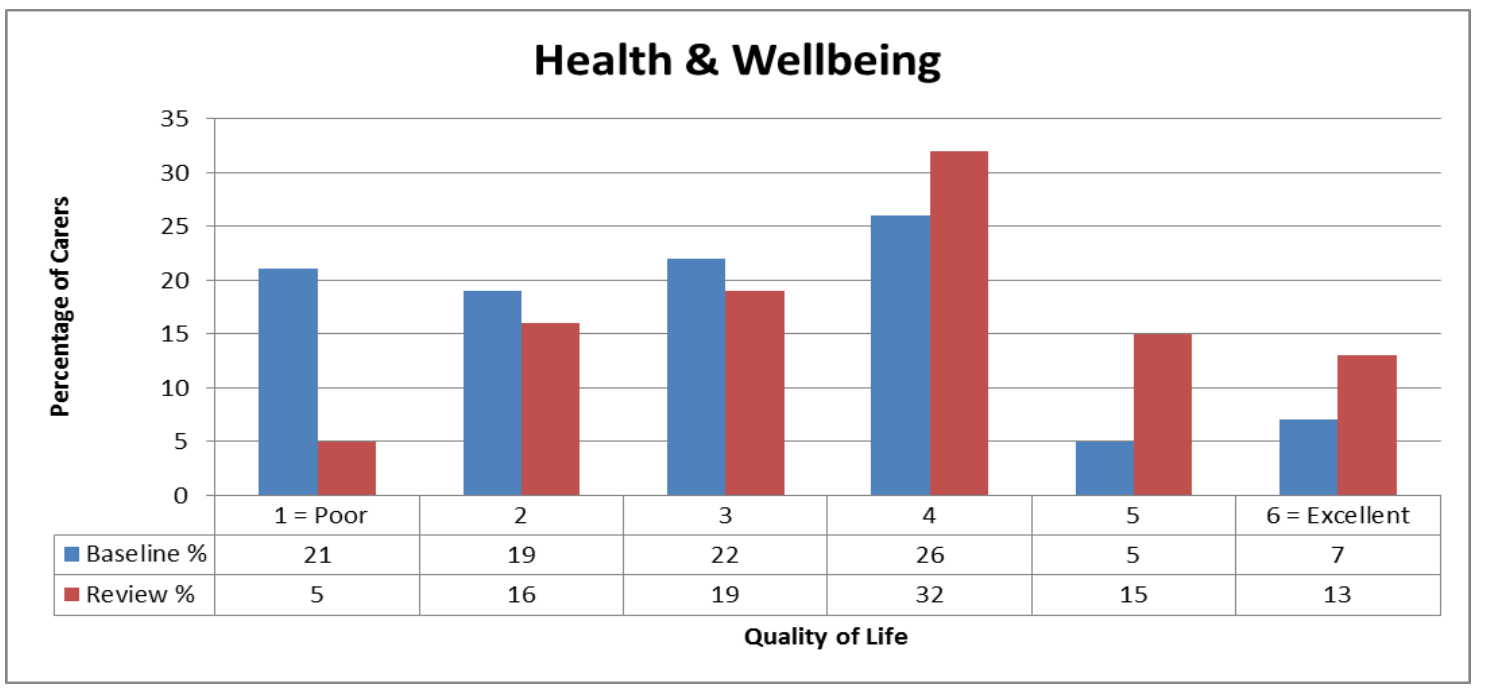
Source: Mosaic Social Care System and Carers Centre

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Assessments offered during Adult Assessment	49	46	59	41	66	66	48	70	53	64	57
Asssessments completed by Carers Centre	20	7	13	18	8	29	7	12	14	10	21



Health and Wellbeing

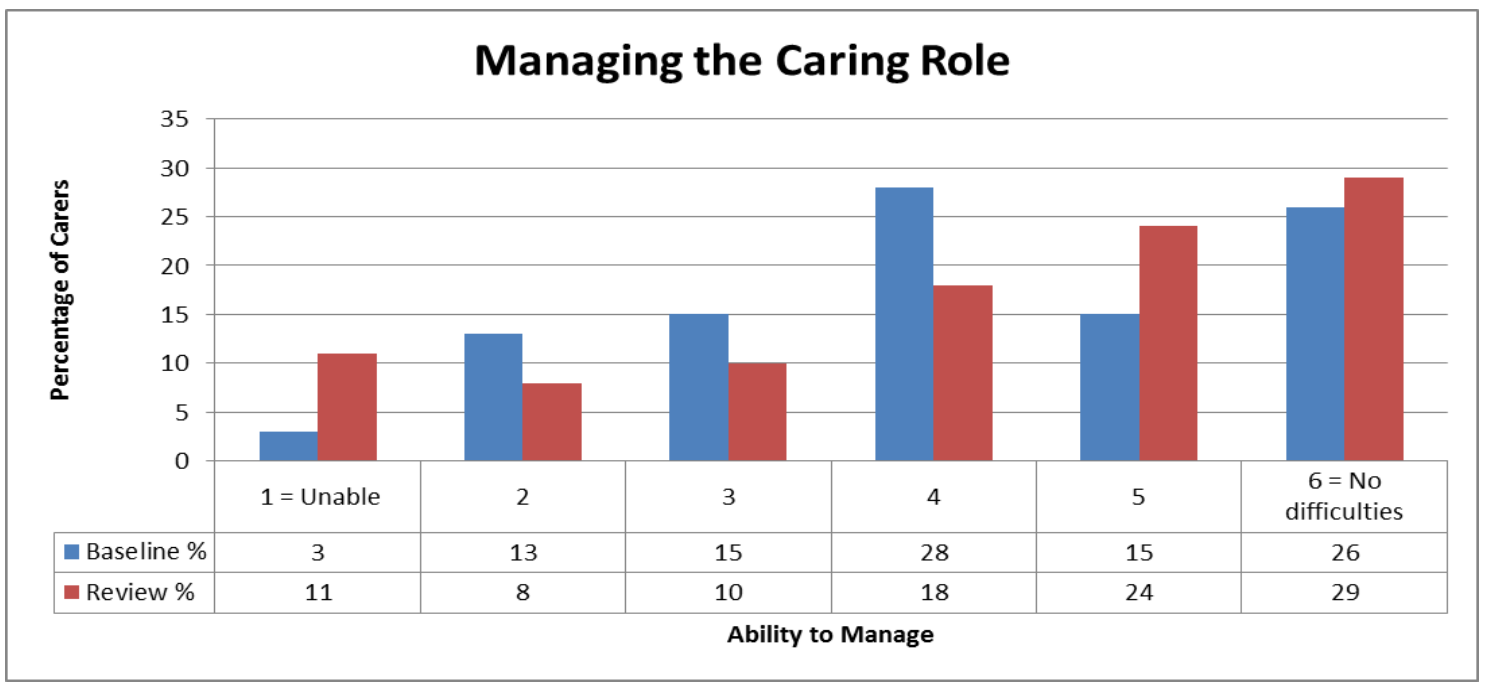
I think my quality of life just now is:



	1 = Poor	2	3	4	5	6 = Excellent
Baseline %	21	19	22	26	5	7
Review %	5	16	19	32	15	13

Managing the Caring role

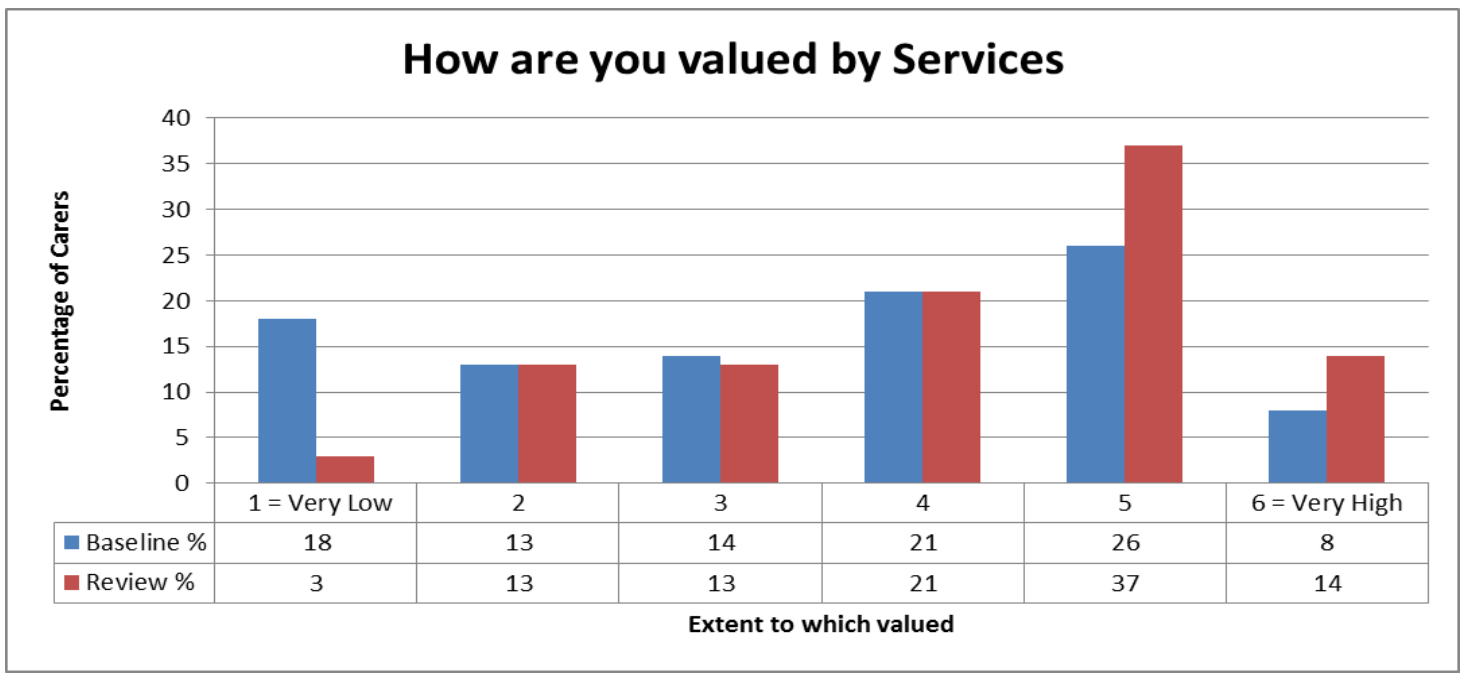
I think my ability to manage my caring role just now is:



	1 = Unable	2	3	4	5	6 = No difficulties
Baseline %	3	13	15	28	15	26
Review %	11	8	10	18	24	29

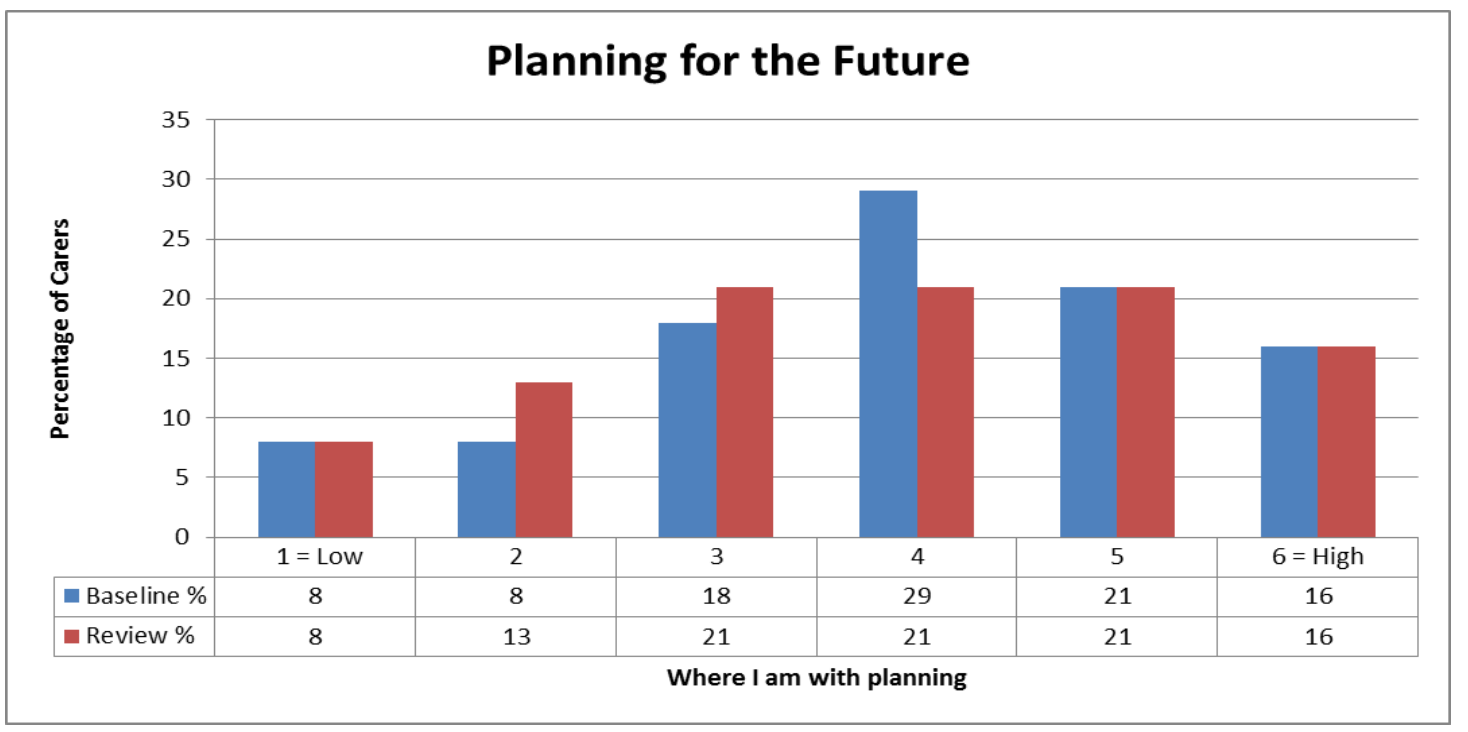
How are you valued by Services

I think the extent to which I am valued by services just now is:



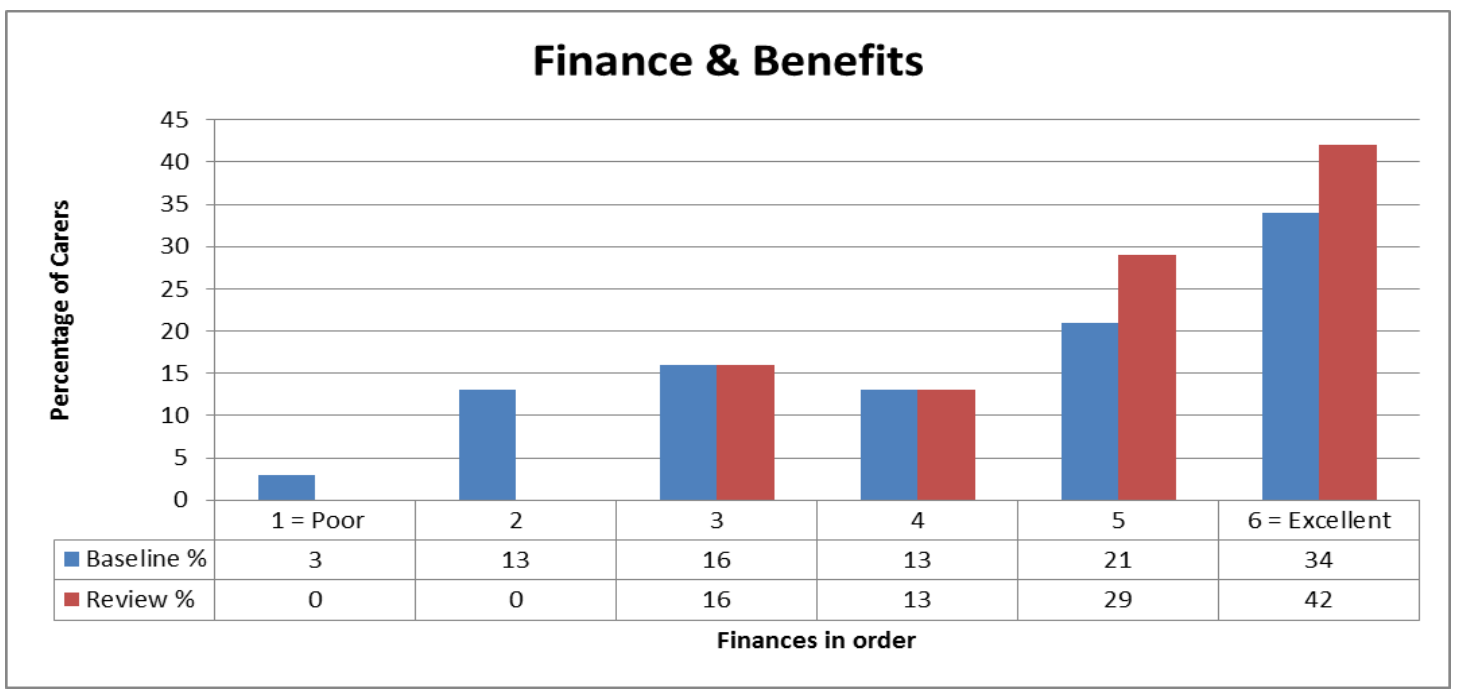
Planning for the Future

I think where I am at with planning for the future is:



Finance & Benefits

I think where I am at with action on finances and benefits is:



How are we performing?
A Carers Assessment includes a baseline review of several key areaswhich are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for carers. Data for Quarter 4 2017/18 shows improvement between the baseline and review surveys in nearly all respects. There are just two exceptions to this – the questions under caring choices around Carers' social lives and feelings as to whether their lives have been put on hold.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 20 August 2018

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Robert McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 825528

AUDIT COMMITTEE MINUTES

Purpose of Report:	To inform the Health & Social Care Integration Joint Board (IJB) of the activity undertaken by the Audit Committee.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the approved minutes of the IJB Audit Committee held on 26.06.17, 25.09.17, 19.03.18

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

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Minutes of a meeting of the **Scottish Borders Health and Social Care Integration Joint Board Audit Committee** held on **Monday 19 March 2018** at **2.00pm** in Committee Room 2, Scottish Borders Council, Newtown St Boswells.

Present:	Cllr T Weatherston (Chair)	Mr J Raine
	Cllr J Greenwell	Mr D Davidson
In Attendance:	Miss I Bishop	Mr R McCulloch-Graham
	Mrs J Stacey	Mr A Haseeb
	Mrs G Woolman	Mr G Samson
	Mrs S Holmes	

1. Apologies and Announcements

Apologies had been received from Mrs Susan Swan.

The Chair confirmed the meeting was quorate.

The Chair welcomed Mrs Gillian Woolman, Mr Graeme Samson, Mr Asif Haseeb and Mrs Sue Holmes to the meeting.

2. Declarations of Interest

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted there were none.

3. Minutes of previous meeting

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** held on 25 September 2017 were approved.

4. Matters Arising

4.1 Community Transport: Mr David Davidson sought sight of the community transport information referred to in minute 5 on page 3. Mr Robert McCulloch-Graham advised that he would chase up the matter outwith the meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted the matter identified.

5. External Audit Annual Plan 2017/18

Mrs Gillian Woolman gave an overview of the content of the annual audit plan for 2017/18 which was year 2 of a 5 year appointment process. She highlighted: risks and planned work and the code of audit practice; chief financial officer appointment; financial sustainability; care services: audit output; audit fee; and audit scope and timing.

Mr David Davidson sought qualification of the statement "There is a risk that the Integration Joint Board (IJB) is not ensuring that adequate services are being delivered" in regard to the Care Services item on page 6 of the report. Mrs Woolman qualified the statement by confirming that the statement was taken from the Care Inspectorate joint report. She advised that she had been interested in how the IJB had responded, the actions it had implemented going forward to fulfil the strategic journey and the wider reporting perspective.

Mr Davidson challenged the planned materiality level of 1%. Mrs Woolman advised that 1% was a small percentage and was relative to the size and nature of the organisation. She advised that the typical range was 0.5% to 2% with the performance materiality tending to be the figure that varied.

Mr John Raine commented that in terms of governance and transparency the IJB had met earlier that day to review a series of projects that were funded through the Integrated Care Fund to decide if they should continue or conclude. The IJB had been concerned that they had not been engaged with previously in discussions around identifying and approving projects. In terms of set aside he enquired what the Auditors would be looking for and scrutinising. Mrs Woolman advised that the Audit Team would be interested in hospital set aside and would look at the various different templates used to calculate the figures and undertake a read across to see what would be helpful to IJBs. She commented that guidance received from the Scottish Government on expectations was clear that there was no longer a transition period and partnerships had to work together on clarity and look across at practices as they evolved across the NHS, IJBs and Local Authorities.

Cllr John Greenwell noted that the audit fee was stated as £24k and he enquired if it would increase as activity from IJBs increased. Mrs Woolman advised that the £24k audit fee was a flat fee across all IJBs across Scotland.

Mr Raine suggested that external audit might in the future look at the complexities of the whole system, double handling, time commitments and cost of the structure of an IJB.

Mr Robert McCulloch-Graham enquired how the £24k fee compared to the NHS Borders audit fee. Mrs Woolman advised that the audit fee for Scottish Borders Council was £270k and Mr Asif Haseeb clarified the NHS Borders audit fee was in the region of £125k.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted the annual plan

6. Internal Audit Annual Plan 2018/19

Mrs Jill Stacey gave an overview of the content of the paper and highlighted the internal audit arrangements, resources and workplan.

Mr David Davidson enquired on page 1, Item 1.3 who was responsible for the key principles of the local code of governance. Mrs Stacey advised that there was a distinction between the overarching code of governance and the local code of governance which came from the fact that integration bodies were set up under the auspices of the local government framework. The local government framework set out what the body should be doing and from an officer perspective the lead for it was the Chief Officer with support from herself as the Internal Auditor to the IJB.

Mr John Raine enquired about duplicating internal audits and suggested in terms of ensuring skills and competencies for the future in relation to workforce planning and development, both the NHS and local authority would have internal audits undertaken and then a further audit would take place of the IJB under the commissioning arrangements. Mrs Stacey advised that the audit would be at a different level and reliance would be placed on the external auditors Pricewaterhouse Coopers (PWC) audit work of workforce and planning for both NHS Borders and Scottish Border Council.

Mr Raine enquired if it would also apply to the transformation programmes of work in NHS Borders and Scottish Borders Council. Mrs Stacey confirmed it would.

Cllr John Greenwell enquired under section 4.3 on page 3 of the report, if the assessment of decision making and performance making would be based on outcomes for value for money or for service users and if it would incorporate impact assessments within the process. Mrs Stacey advised that it would depend on the performance management framework set by the IJB and she expected it would encompass a broad range of indicators.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted the annual plan and agreed to undertake a self evaluation session at the end of the June meeting.

7. Audit Scotland Forthcoming Audit - Health and Social Care Integration: Update on progress

Mr Asif Haseeb gave an overview of the content of the paper. He advised that 4 areas had been identified as study sites which consisted of Aberdeen City Council, Shetland, South Lanarkshire, and Glasgow. There would also be a comparison to the Highland Lead Agency model and areas of best practice would be explored by looking towards Glasgow, Perth, and Angus integration partnerships.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted the update on progress

8. Any Other Business

8.1 Vetting of Information: Mr David Davidson suggested arrangements might be put in place for a Finance and Resources Committee to fully vet information before it was submitted to the IJB for decision and he sighted the quality of the Integrated Care Fund paper at the morning meeting as an example of poor quality information which did not provide the IJB with the ability to make fully informed decisions.

Further discussion ensued which focused on: conflicts of interests in terms of reliance on officers within the partnership organisations to put forward recommendations; acknowledgment that there is an issue and consider how to resolve it; role and impartiality of the Executive Management Team; and ambiguity of decision making for partnerships.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted the issue.

8.2 Meeting Cycle: Mrs Jill Stacey suggested the Audit Committee move to a quarterly cycle to enable continuity of the Committee as it evolved. Mr Robert McCulloch-Graham suggested it would also tie into financial planning cycles.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed to move to a quarterly meeting cycle and undertake an extra meeting in December.

9. Date and Time of next meeting

The Chair confirmed that the next meeting of the Scottish Borders Health and Social Care Integration Joint Board Audit Committee would be held on Monday 11 June 2018 at 10.00am in Committee Room 2, Scottish Borders Council.

The meeting concluded at .....pm.

Signature: .....
Chairman

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Health & Social Care Integration Joint Board Audit Committee** held on Monday 26 June 2017 at 10.00am in Committee Room 2, Scottish Borders Council.

Present:	(v) Cllr T Weatherston (Chair)	(v) Mr J Raine (v) Mr D Davidson
In Attendance:	Miss I Bishop Mr P McMenamin	Mrs J Stacey Mrs E Torrance

1. Apologies and Announcements

Apologies had been received from Cllr John Greenwell.

The meeting was quorate.

2. Election of Chair

The Committee elected a Chair.

Mr David Davidson nominated Cllr Tom Weatherston and Mr John Raine seconded the nomination.

Cllr Tom Weatherston was duly elected as Chair of the Integration Joint Board Audit Committee.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that the Chair of the Audit Committee should rotate on an annual basis as per the rotation of the Chair of the Integration Joint Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that when the Chair of the Integration Joint Board was from NHS Borders the Chair of the Audit Committee would be from Scottish Borders Council and vice versa.

3. Declarations of Interest

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

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

4. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board Audit Committee held on 27 March 2017 were approved.

5. Matters Arising

5.1 Action 2: Mrs Jill Stacey confirmed that the action was now complete.

5.2 Action 3: Mrs Jill Stacey confirmed that the action was now complete.

5.3 Action 4: Mrs Jill Stacey suggested the Audit Committee may wish to recommend to the Integration Joint Board that it undertake a self assessment within the next 18 months.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed to recommend that the Health & Social Care Integration Joint Board undertake a self assessment.

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

6. Internal Audit Annual Report 2016/17 for Scottish Borders Health & Social Care Integration Joint Board.

Mrs Jill Stacey gave an overview of the conclusion of Integration Joint Board Internal Audit Annual Report 2016/17 highlighting the 3 key areas that the internal audit had focused on; Corporate Governance; Financial Management; and Performance Management.

Discussion took place and focused on the membership of the Integration Joint Board; baseline information for performance management; agenda setting; Executive Management Team attendance; managing risk in decision making; risk register; sharing of Audit Committee agendas of all 3 organisations; meetings of Audit Committee chairs of all 3 organisations; exploration with other Integration Joint Boards the independence of their Audit Committees; transparency through publication of agendas and meeting papers; Executive Leadership section to be updated to recognise the changes that had occurred during 2016; consideration of wider assurances from partners; joint performance reporting; issuing of directions; partners responsibility for clinical and care governance - the commissioner requires assurance but the governance arrangements remain with the provider bodies; and induction package of documents for new members.

Mr Paul McMenamin recorded his thanks to Mrs Stacey for the substantial piece of work that had been undertaken in terms of assurance and a clear forward plan for development.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** considered the Internal Audit Annual Report 2016/17 for the Scottish Borders Health & Social Care Integration Joint Board as detailed in Appendix 1 of the report and provided commentary thereon.

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The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that the Executive Leadership section be updated to recognise the changes that had occurred during 2016.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that the audit committee chairs of all 3 organisations (NHS Borders, Scottish Borders Council, Integration Joint Board) should meet on a six monthly basis for the purposes of assurance.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that other Integration Joint Boards be approached to see how they had addressed the independence of their Audit Committees.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that a revised report be brought back to the next meeting of the Audit Committee and a summary document be produced for the next Health & Social Care Integration Joint Board meeting.

7. Statement of Accounts 2016/17

Mr Paul McMenamin gave an overview of the content of the statement of accounts for 2016/17. Since being issued the accounts had been slightly amended and the current draft would be submitted to the External Auditor. The final accounts would be submitted to the Audit Committee and Integration Joint Board later in the year.

Discussion focused on some potential rewording in regard to: independence of the audit committee; the chief officer role; and legal services in regard to CNORIS.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted the report and considered the unaudited Annual Accounts for 2016/17.

8. Integration Joint Board Local Code of Corporate Governance

Mrs Jill Stacey advised that the first version of the local code of corporate governance had been approved by the Integration Joint Board in 2016 and since that time CIPFA SOLACE had updated their good governance framework for local government. She had taken the opportunity to refresh the local code and confirmed that it was in keeping with the annual governance statement within the draft accounts. Mrs Stacey spoke of the layout which had been divided into the 7 core principles and suggested the committee may wish to consider how to disseminate the document to Board members.

Discussion took place and focused on: annual review of the local code; dissemination of the local code as part of a package of documents for Board members; terms of reference for the Integration Joint Board; identifying a development session for Board members to understand the role of voting and non voting members, the complexities of service delivery in relation to integration; working up scenario's to assist the development session; and preparation of an executive summary.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that the full Board approve its Local Code of Corporate Governance for health and social care integration as detailed in Appendix 1 of the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed to the annual review of its governance arrangements and reporting of the outcome of that review in an Annual Governance Statement scrutinised by the Integration Joint Board Audit Committee in advance of Integration Joint Board approval.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** agreed that a development session be held for Board members focusing on a suite of learning, including understanding the code of corporate governance, Board members roles and terms of reference for the Board.

9. Any Other Business

There was none.

10. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board Audit Committee would take place on Monday 25 September 2017 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 11.40am.

Signature: ……..
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Health & Social Care Integration Joint Board Audit Committee** held on Monday 25 September 2017 at 2.00pm in Committee Room 2, Scottish Borders Council.

Present:	(v) Cllr J Greenwell (Chair)	(v) Mr J Raine (v) Mr D Davidson
In Attendance:	Miss I Bishop Mr P McMenamin Mr G Samson Mrs G Woolman	Mrs J Stacey Mrs S Pratt Mr A Haseeb

1. Apologies and Announcements

Apologies had been received from Cllr Tom Weatherston.

Cllr John Greenwell chaired the meeting in Cllr Weatherston's absence.

The chair confirmed that 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 AUDIT COMMITTEE** noted there were none.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board Audit Committee held on 26 June 2017 were approved.

4. Matters Arising

4.1 Updates: Mrs Jill Stacey advised the Committee of the actions that had been taken in addressing all the actions listed on the action tracker.

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

5. Final Audited Annual Report and Statutory Accounts 2016/17 for the Scottish Borders Health & Social Care Integration Joint Board

Mr Paul McMenamin presented the final audited annual report and statutory accounts for 2016/17. He advised that the local authority annual accounting code of practice had been applied in producing the annual accounts. The draft accounts had been brought to the Audit Committee on 26 June for review, were submitted to Audit Scotland for scrutiny and the final accounts were presented to the committee and incorporated the external auditor audit opinion and the audit report.

Mr McMenamin recorded thanks to colleagues from Audit Scotland and particularly Graham Samson for his positive and supportive approach to undertaking the audit and he suggested the accompanying management report was testimony to the understanding shown and support provided.

Mr David Davidson enquired about indentifying and quantifying risk. Mr McMenamin commented that considerable work on risk had taken place although it had remained unseen and a refresh was to be commenced. He advised that the mechanism through which that refresh would take place would be through the joint management team reporting to the Chief Officer and the three practitioner managers who would be pursuing updating the strategic and operational risk registers.

Mr McMenamin further commented that Sandra Pratt had been appointed as the Interim Chief Officer and interviews for a permanent appointment were being held. It was anticipated that a new Chief Officer would take up post within the next 3-4 months. He also advised that Susan Swan would be taking over as Interim Chief Financial Officer and a plan for that transition was being put in place.

Mr John Raine enquired about governance and transparency and Mrs Jill Stacey commented that part of the external audit process had an element of placing reliance on internal audit work and there were some elements of governance identified as part of the internal audit work and a risk management strategy was one of those observations. It was in regard to having an approved strategy that was not in full effect. She further commented that risk management was a key element of risk governance and the internal audit report had identified that the Board fulfilled its remit and was clear about its strategic priorities and internal audit would support and guide the Board to fulfil its remit.

Mr Raine challenged the specifics given the Board had not expressed that view and it was the view of internal audit. He enquired if Audit Scotland had suggested improvements were identified had they also been identified by internal audit. Mrs Stacey confirmed that they had been identified by both.

Mr Raine enquired about the specific issue of the allocation of the £6m Integrated Care Fund being the responsibility of the Integration Joint Board to determine. Mr McMenamin advised that in year 1 and at an operational level, the Board had focused on building governance and financial governance arrangements, which he determined had distracted the Board from focusing on commissioning strategic outcomes. He suggested the Board had been driven by the direction of finance, both social care funding and integrated care funding. However, he suggested the Board were now identifying the strategic role that it was required to fulfil.

Mr Raine commented that if the Board decided to devote the integrated care fund to actions that would reduce delayed discharges, that it would be a strategic decision by the Board in

discharging its objectives. Mr McMenamin agreed that such a scenario would be deemed as the Board exercising its strategic responsibility.

Mr David Davidson quoted that the "2017/18 Financial Plan remains draft" and he sought assurance in regard to finalisation. Mr McMenamin commented that sustainability was a key audit dimension.

Mr Davidson noted that on page 5 the Transport Hub had received a substantial sum of funding and 150 hospital appointments had been supported. He enquired what assistance had been provided to the main bus providers to provide services to outlaying areas. Mr McMenamin commented that he would ask the Community Transport Manager to provide an update outwith the meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** approved the report and approved the 2016/17 Annual Accounts.

6. External Audit Annual Audit Report 2016/17 for the Scottish Borders Health & Social Care Integration Joint Board

Mr Asif Haseeb gave an overview of the content of the external audit report. He highlighted various elements including: identified savings; performance; and overspend.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** noted the conclusions and recommendations made within the draft Annual Audit Report for the year-ended 31 March 2017.

7. Any Other Business

There was none.

8. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board Audit Committee would take place on 19 March 2018 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 2.55pm.

Signature: ……..
Chair

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