Scottish Borders
Health and Social Care
PARTNERSHIP

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Scottish Borders Health & Social Care Partnership

Annual Performance Report 2016/2017

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

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Foreword

Updated photo of Elaine to go here

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

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

Executive Summary

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

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The year at a glance

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

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

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Spotlight: Localities Planning

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

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

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

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

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

Source: National Records of Scotland 2012-based population projections

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

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

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

- Build relationships with established community groups, partners across the localities, such as other leads working at locality level, for example in Community Learning and Development.
- Map out what is already happening; use and build upon the mapping work already in existence across relevant partnerships - established community groups, many of which are linking up through the Community Learning Partnership approach.
- Identify existing services, where there are gaps and develop action plans.
- Clearly define what is happening in the short, medium and longer term, how these priorities have been identified and what the consultation process has been/is going to be.
- Co-ordinate action plans and develop proposals for the redesign of health and social care services.

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

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

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

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

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

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

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

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

Trish Wintrup – Locality Coordinator

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

Jeanette Forbes -District Nurse

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

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Spotlight: Community-Led Support

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

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

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

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

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

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

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

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Progress

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

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

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

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

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

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

"In other areas CLS has proved to be a really effective and efficient use of resource. In fact some areas have seen waiting lists for social work services disappear"

Murray Leys – Chief Officer – Adult Social Work SBC

"By listening to people and focusing on what matters to them we can really make a difference"

Shirley Cusack – NDTi

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

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

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

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Spotlight: Buurtzorg - Neighbourhood Care

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

Progress

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

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

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

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

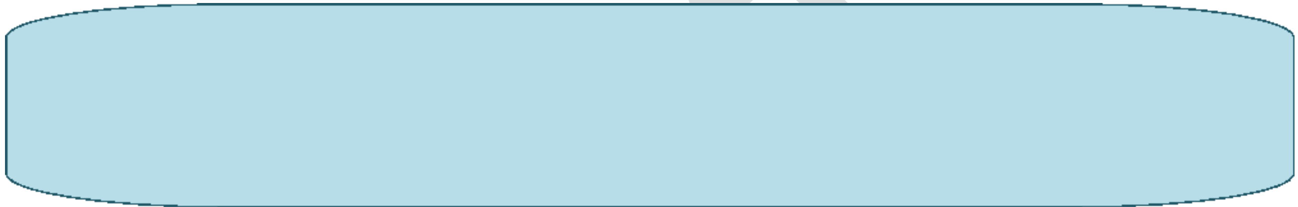
Next Steps

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

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

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

Awaiting Quote....



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

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Performance against key priorities for 2016/17

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

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

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

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

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

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

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

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Progress against our local strategic objectives

The Nine National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through improving quality across health and social care.

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5	Health and social care services contribute to reducing health inequalities.
Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
Outcome 7	People using health and social care services are safe from harm.
Outcome 8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services.

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

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

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

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

National Outcomes	1	2	3	4	5	6	7	8	9
Local objective 1									
Local objective 2									
Local objective 3									
Local objective 4									
Local objective 5									
Local objective 6									
Local objective 7									
Local objective 8									
Local objective 9									

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

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OBJECTIVE 1 - We will make services more accessible and develop our communities

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

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

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

Voluntary Sector

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

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

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

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Case Studies

Burnfoot Community Hub

22 Volunteer opportunities provided

6 Hours per week of promoting health and social activity, including a weekly senior café.

Project Search case study

Project search case study – details to follow.

OBJECTIVE 2 - We will improve prevention and early intervention

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

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

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

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

Voluntary Sector

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

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

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Case studies/stats (example)

90%

of those people within the mental health older adults service with Dementia have completed a version of "Getting To Know Me" as part of their anticipatory care plan.

This document has been developed by Alzheimer Scotland's network of Dementia Nurse Consultants and the Scottish Government. It aims to give hospital staff a better understanding of patients with dementia who are admitted either for planned treatment, such as an operation, or in an emergency.

50%

52% 52% reduction in falls with harm 2015 (SG standard 20%). Evidence of sustained progress was seen across all sectors.

21% Improved in wellbeing recorded for service users

31% Reduction in the need for contact in GP practices involved in the project

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Long term conditions project case study

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

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

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

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

OBJECTIVE 3 - We will reduce avoidable admissions to hospital

By appropriate support in the right place at the right time, we will ensure people are supported to remain in their own homes.

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

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

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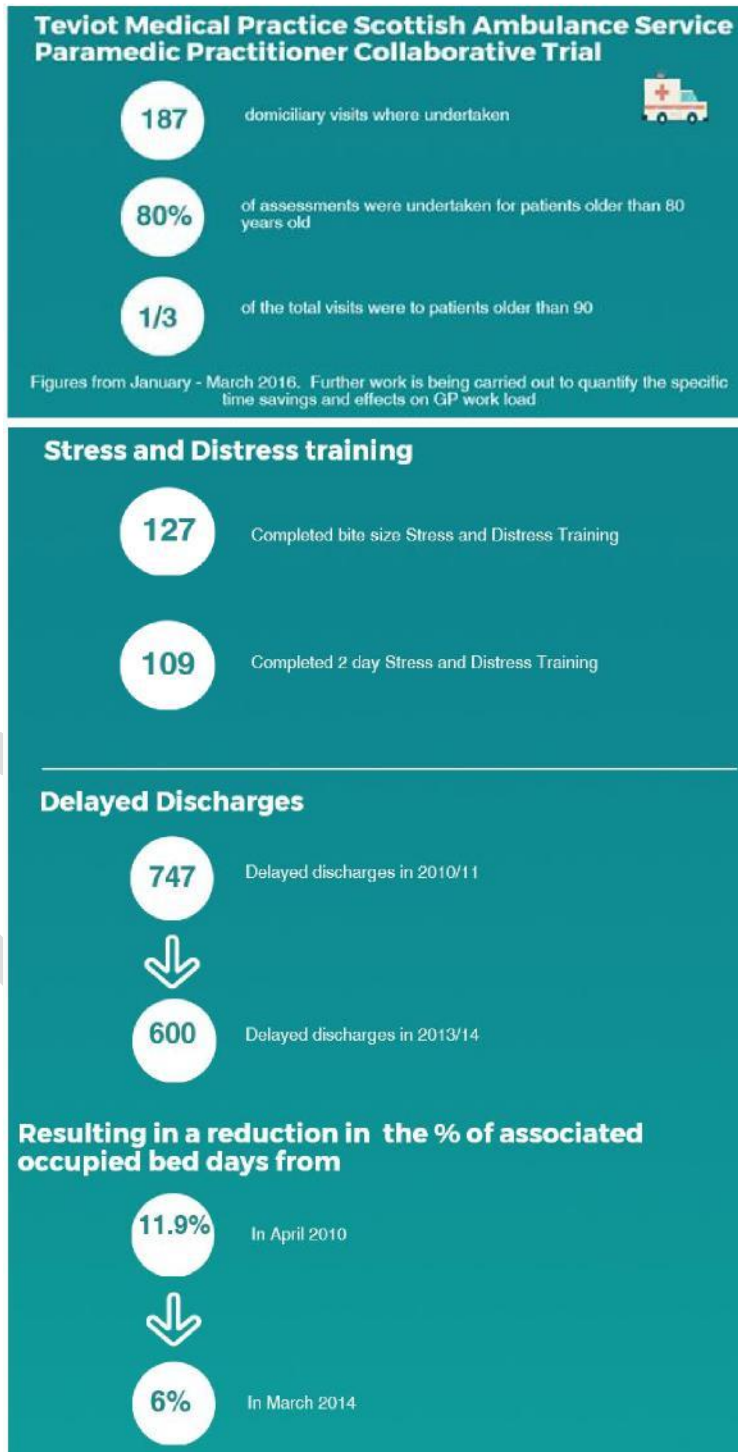
improvements and adaptations and staff are trained to identify and will offer to remove trip hazards and other dangers if requested by their clients.

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

Case studies/Data (example)



OBJECTIVE 4 - We will provide care close to home

Accessible services which meet the needs of local communities, allows people to receive their care close to home and build stronger relationships with providers.

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

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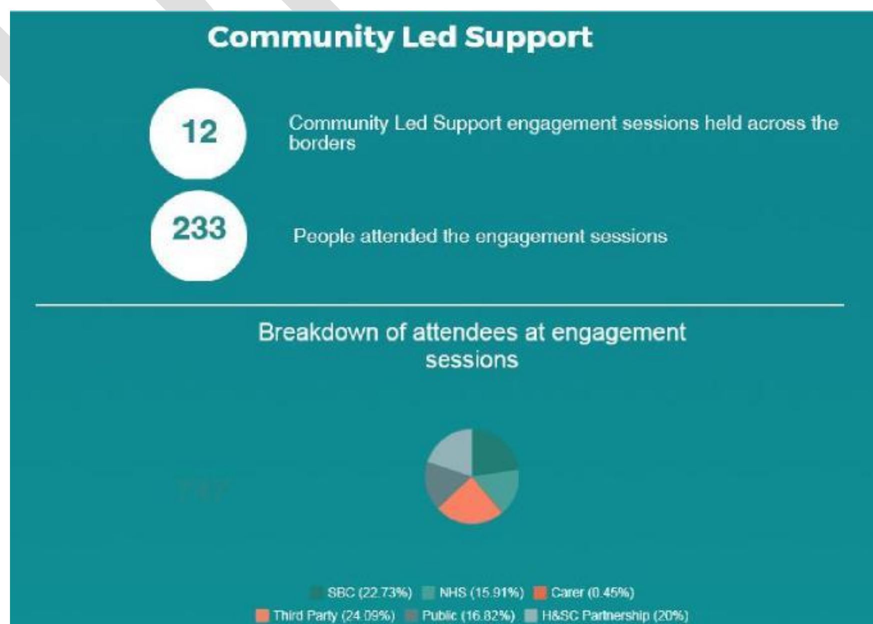
- The relocation of the Borders Ability Equipment Store is underway which will result in more efficient provision of equipment which will support people to remain in their homes and reducing the number of inappropriate hospital and care home admissions.
- The mental health service have developed a joint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

Voluntary Sector

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

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

Case Studies/Data



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OBJECTIVE 5 - We will deliver services within an integrated care model

Through working together, we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.

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

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

Voluntary Sector

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

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

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

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

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

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

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

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

OBJECTIVE 6 - We will seek to enable people to have more choice and control

Ensuring people have more choice and control means that they have the health and social care support that works best for them.

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

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

Voluntary Sector

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

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

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

Case studies/Quotes

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OBJECTIVE 7 - We will further optimise efficiency and effectiveness

Strategic Commissioning requires us to constantly analyse, plan, deliver and review our services which give us flexibility to change what we do and how we do it.

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

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

Voluntary Sector

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

APR. **Case studies/Quotes**

OBJECTIVE 8 - We will seek to reduce health inequalities

Ensuring that people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.

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

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

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

    - The supply of housing meets the needs of our communities
    - More people live in good quality, energy efficient homes
    - Fewer People are affected by Homelessness
    - More people are supported to live independently in their own homes

Voluntary Sector

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

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Case studies (example)

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

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

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

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

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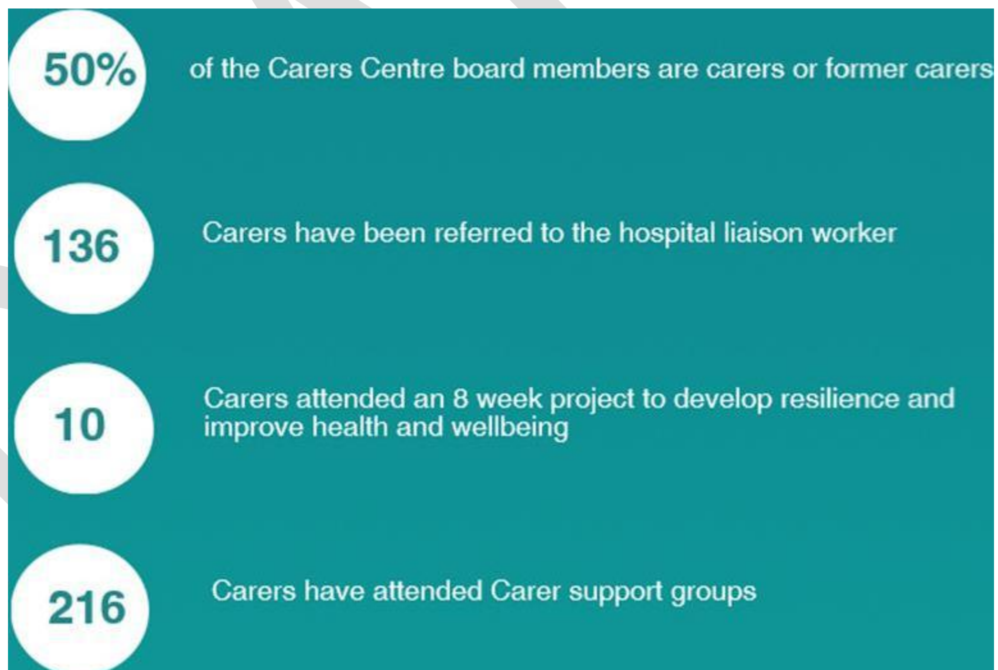
Quotes/Case studies. (Sample data based on Carers Centre Managers report for April 16 – Sept 16.)



Inspection of Services

Joint Inspection of Services for Older People in the Scottish Borders

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

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

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

Older People in Acute Hospitals Inspection – April 2016

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

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

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

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

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The following recommendations were made:

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

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

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

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Financial Performance and Best Value: Summary

Financial Arrangements

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

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

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

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

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

Financial Management

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

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

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

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

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

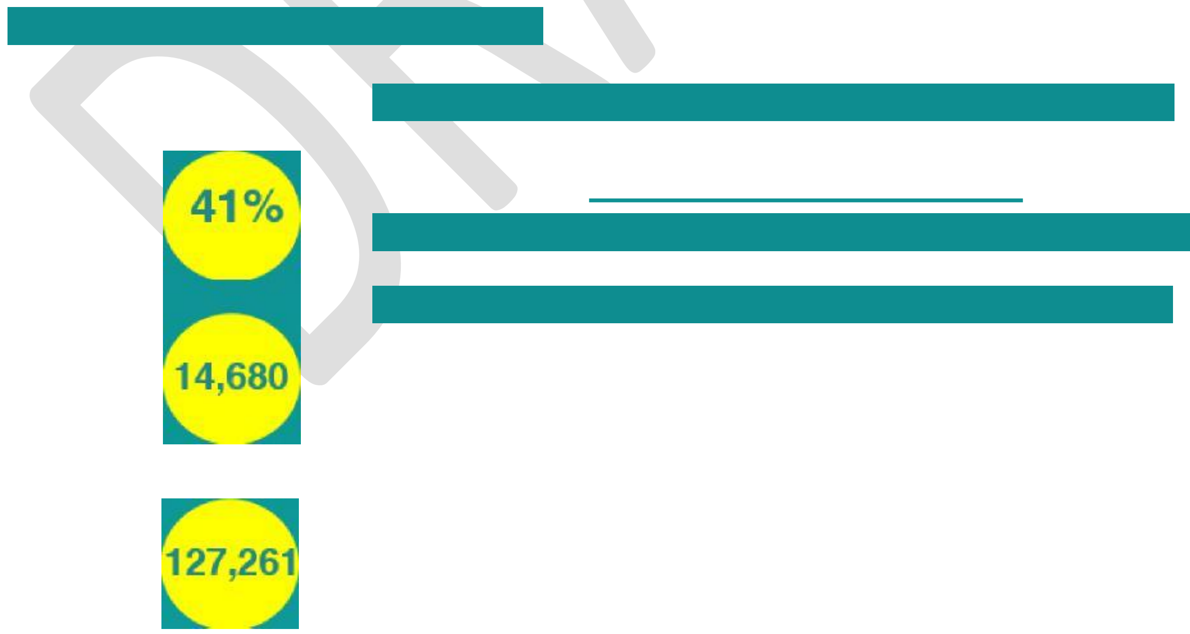
The extent of the pressures experienced above required the implementation of an in-year recovery plan by the partnership, part of an NHS Borders-wide recovery plan which aimed to deliver £13.7m of mitigating actions in total of which £4.2m related to those functions delegated to the IJB and £1.6m within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

- Insert progress update following known year end position

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

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

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



Key priorities for 2017/18

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

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

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

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

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

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

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

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APPENDIX A: Financial Performance and Best Value

i) Financial Performance

Legislative and Governance Framework

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

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

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

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

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

Statutory Reporting Requirements

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

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

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

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

2016/17 - Resources Delegated to the IJB

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

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

The IJB approved its medium-term financial plan – "the Financial Statement" for the period 2016/17-2017/18 on the 30th March 2016. This followed a process of due diligence over the previous 3-years' budget, risk analysis and the provision of assurance over the sufficiency of resources. As per the Integration Scheme, neither partner may reduce the payment in-year to the Integration Joint Board to meet exceptional unplanned costs within the constituent authorities, without the express consent of the Integration Joint Board and constituent authorities for any such change.

The process of determining the total level of resources to be delegated to the partnership complied with the provisions contained within its Scheme of Integration and the 2016/17 delegated budget was based on previous years' budget levels, adjusted incrementally to reflect:

- Partners' absolute level of funding by the Scottish Government
- Past performance and known areas of financial pressure arising due to cost, demand, legislative and other factors
- Efficiencies and other required savings delivery to ensure overall affordability
- New priorities as expressed within partners' plans and the Integration Joint Board's Strategic Plan
- Other emerging areas of financial impact

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

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

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

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

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

2016/17 - Cost of Service Provision

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

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

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

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partnership’s budget remains predicated

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

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

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

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

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

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Recovery Planning and Delivery during the Financial Year

Within the partnership's Scheme of Integration, it is specifically provided that where there is a forecast

outturn overspend against an element of the operational budget ,the Chief Officer and the Chief Financial Officer of the Integration Joint Board must agree a recovery plan to balance the overspending budget with the relevant finance officer of the constituent authority. Should the recovery plan be unsuccessful the Integration Joint Board may request that the payment from Borders Health Board and Scottish Borders Council be adjusted, to take account of any revised assumptions. It will be the responsibility of the

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authority who originally delegated the budget to make the additional payment to cover the shortfall. In this context therefore, it will be the responsibility of NHS Borders to cover any residual year-end pressure across the budget for healthcare functions. Similarly, any residual pressure on social care functions will be covered by Scottish Borders Council.

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

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

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

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

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

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

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

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

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

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

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

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

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

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Funding Priorities

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

Social Care Funding

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

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

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

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Integrated Care Funding

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

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

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

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2016/17 Final Statement of Income and Expenditure

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

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

ii) Best Value

Introduction

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

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

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

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

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

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

Leadership, Partnership Working and Inclusion

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

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

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

Transformation and Redesign

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

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

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

Examples of transformation and redesign currently underway include:

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

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

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

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

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

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

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

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

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

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

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

Use of Resources

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

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

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

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

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

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

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Governance

>Insert – see Jane

Performance Management

C&I Plan – need to put something in here

Impact of recovery on performance – see Appendix 1

Forward Planning

Integrated Financial Planning

Joint Transformation

SeRCOP (BVACOP)

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

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APPENDIX B: Performance Management

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

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

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

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

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

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

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

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

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

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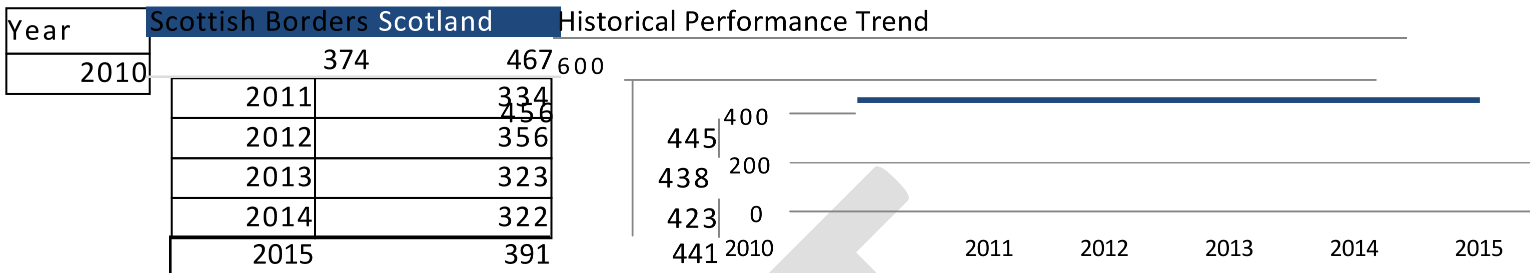
National "Core Suite" Indicators 11-20: Indicators based on organisational/system data

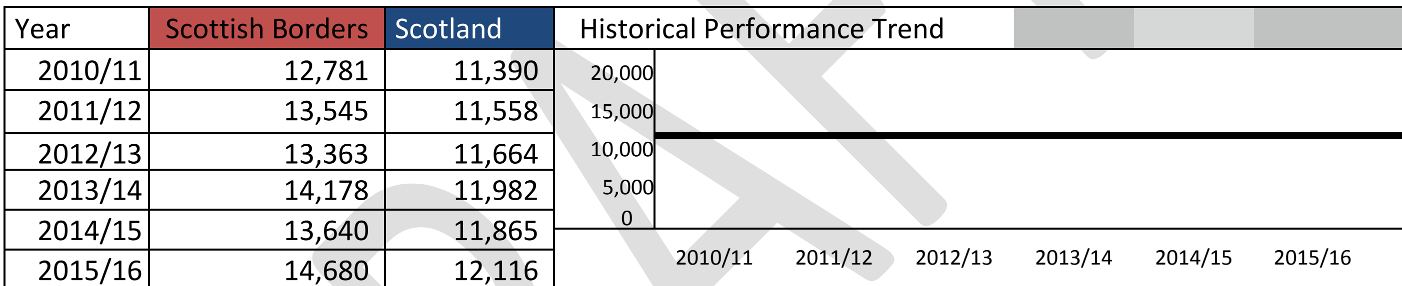
NI - 11 Premature mortality rate per 100,000 persons
(Age-Standardised mortality rate for people aged under 75)



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

Source: National Records for Scotland (NRS).

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

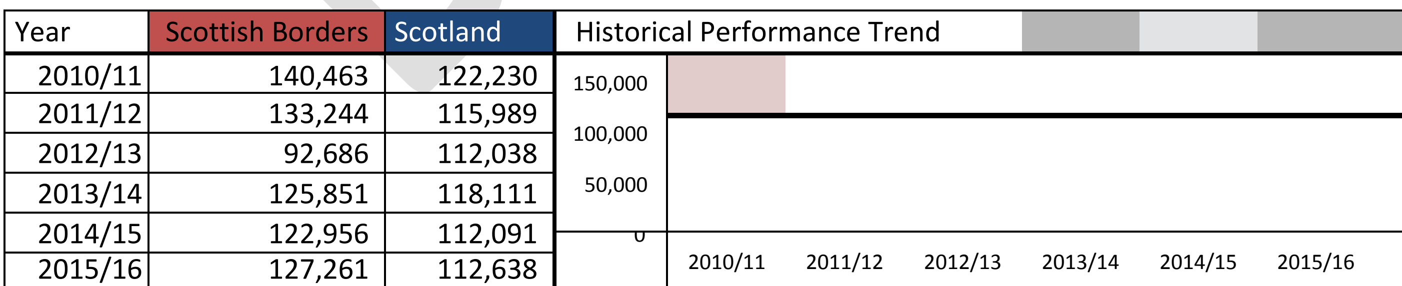


Year	Scottish Borders	Scotland
2010/11	12,781	11,390
2011/12	13,545	11,558
2012/13	13,363	11,664
2013/14	14,178	11,982
2014/15	13,640	11,865
2015/16	14,680	12,116

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

Source: ISD Scotland.

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



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

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

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NI - 14 Readmission to hospital within 28 days – rate per 1,000 discharges.

Note: Borders figure is for Borders residents (treated within and outwith Borders).

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

Historical Performance Trend

150
100
50
0
2010/11 2011/12 2012/13 2013/14 2014/15 2015/16

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

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

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

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

Historical Performance Trend

88
86
84
82
80
2011/12 2012/13 2013/14 2014/15 2015/16

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

Source: ISD Scotland.

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

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

Historical Performance Trend

30
20
10
0
2010/11 2011/12 2012/13 2013/14 2014/15 2015/16

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

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

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

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

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

Source: Care Inspectorate (indicator in development).

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

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

Historical Performance Trend

Source: Scottish Government Health and Social Care Statistics.

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

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

Historical Performance Trend

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

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

Source: ISD Scotland Delayed Discharge Census.

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

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

Historical Performance Trend

30%
20%
10%
0%
2010/11 2011/12 2012/13 2013/14 2014/15 2015/16

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

Source: ISD Scotland.

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

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

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

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

NI-23: Expenditure on end of life care.

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APPENDIX C: Services that are the responsibility of the HSCP

Our Health and Social Care Partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The partnership has a key relationship with acute services in relation to unplanned hospital admissions and will continue to work in partnership with Community Planning Partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, we can also work in partnership with our communities.

ADULT SOCIAL CARE SERVICES*	ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*	COMMUNITY HEALTH SERVICES*
• Social Work Services for adults and older people; • Services and support for adults with physical disabilities and learning disabilities; • Mental Health Services; • Drug and Alcohol Services; • Adult protection and domestic abuse; • Carers support services; • Community Care Assessment Teams; • Care Home Services; • Adult Placement Services; • Health Improvement Services; • Re-ablement Services, equipment and telecare; • Aspects of housing support including aids and adaptations; • Day Services; • Local Area Co-ordination; • Respite Provision; • Occupational therapy services.	• Accident and Emergency; • Inpatient hospital services in these specialties: o General Medicine; o Geriatric Medicine; o Rehabilitation Medicine; o Respiratory Medicine; o Psychiatry of Learning Disability; • Palliative Care Services provided in a hospital; • Inpatient hospital services provided by GPs; • Services provided in a hospital in relation to an addiction or dependence on any substance; • Mental health services provided in a hospital, except secure forensic mental health services.	• District Nursing; • Primary Medical Services (GP practices)*; • Out of Hours Primary Medical Services*; • Public Dental Services*; • General Dental Services*; • Ophthalmic Services*; • Community Pharmacy Services*; • Community Geriatric Services; • Community Learning Disability Services; • Mental Health Services; • Continence Services; • Kidney Dialysis outwith the hospital; • Services provided by health professionals that aim to promote public health; • Community Addiction Services; • Community Palliative Care; • Allied Health Professional Services

***Adult Social Care Services for adults aged 18 and over. *Acute Health Services for all ages – adults and children. *Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (*), which also include services for children.**

Glossary

Coproduction

Commissioning

Reablement

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