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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health And Social Care Integration Joint Board** will be held on **Monday, 18th December, 2017** at **2.00 pm** in Committee Room 2, Scottish Borders Council

AGENDA

Time	No		Lead	Paper
14:00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
14:01	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	Chair	*Verbal*
14:03	**3**	**MINUTES OF PREVIOUS MEETING** 08.11.17	Chair	(Pages 3 - 8)
14:05	**4**	**MATTERS ARISING** Action Tracker	Chair	(Pages 9 - 12)
14:10	**5**	**CHIEF OFFICER'S REPORT**	Chief Officer	(Pages 13 - 16)
14:15	**6**	**FOR DECISION**		
14:15	6.1	Inspection: Joint Older People's Services Report	Chief Officer	(Pages 17 - 38)
14:30	6.2	Appointment of the Chief Financial Officer - Integration Joint Board	Chief Officer	(Pages 39 - 48)
14:40	6.3	Community Capacity Building - Transformation Proposal	Service Development Manager	(Pages 49 - 96)
14:55	6.4	Discharge to Assess - Hospital to Home Pilot	Chief Officer	(Pages 97 - 108)
15:05	**7**	**FOR NOTING**		

15:05	7.1	Scottish Borders Health & Social Care Winter Plan 2017/18	General Manager Unscheduled Care	(Pages 109 - 128)
15:20	7.2	The Carers Act (Scotland) 2016	Borders Carer Centre	(Pages 129 - 136)
15:35	7.3	Performance Report - Transformational Programme Tracker	Portfolio Manager	(Pages 137 - 146)
15:45	7.4	Monitoring of the Integration Joint Budget 2017/18	Director of Finance/Chief Financial Officer	(Pages 147 - 166)
15:55	**8**	**ANY OTHER BUSINESS**	Chair	
15:55	8.1	Health & Social Care Integration Joint Board Development Session: 29.01.18 • 2018/19 Financial Plan Budget – Delegated Functions • Financial Planning • Draft Strategic Commissioning Plan Review • IJB Structure Review	Chief Officer	*Verbal*
16:00	**9**	**DATE AND TIME OF NEXT MEETING** Monday 12 February 2018 at 2.00 p.m. in Committee Room 2, Scottish Borders Council	Chair	*Verbal*

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of an **Extra Ordinary meeting of the Health & Social Care Integration Joint Board** held on Wednesday 8 November 2017 at 3.30pm in the Board Room, NHS Borders, Newstead.

Present:	(v) Cllr J Greenwell	(v) Dr S Mather (Chair)
	(v) Cllr S Haslam	(v) Mr D Davidson
	(v) Cllr D Parker	(v) Mr J Raine
	(v) Cllr T Weatherston	(v) Mr T Taylor
	Mr R McCulloch-Graham	Mrs Y Chapple
	Mr M Leys	Ms L Jackson
	Mr C McGrath	
In Attendance:	Miss I Bishop	Mrs T Logan
	Mrs S Swan	Mrs C Gillie

1. Apologies and Announcements

Apologies had been received from Mrs Karen Hamilton, Cllr Helen Laing, Dr Cliff Sharp, Mr John McLaren, Dr Angus McVean, Mrs Jill Stacey, Mrs Jane Davidson, Mr David Bell, Mrs Claire Pearce and Mrs Jenny Smith.

The Chair confirmed the meeting was quorate.

The Chair welcomed Linda Jackson deputising for Lynn Gallacher and Yvonne Chapple deputising for John McLaren.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

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

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

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 23 October 2017 were approved.

4. Matters Arising

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

5. Discharge to Assess – IJB Direction

Mr Rob McCulloch-Graham gave an overview of the content of the paper and advised that the pressure on the Borders General Hospital at present was at a critical level. Work had been expedited to discharge patients and find extra care home and residential home placements.

Mr McCulloch-Graham clarified that the winter plan was the Joint Winter Plan which involved all partners: NHS Borders, Scottish Borders Council and SB Cares.

Cllr Shona Haslam sought clarification on the difference between a boarding bed and a discharge to assess bed. Mr McCulloch-Graham commented that in the acute setting if the hospital was running out of capacity in a department they would move patients to another ward, which was often not appropriate to that patients condition, although they still received the appropriate care and assessment required.

Mrs Tracey Logan commented that in order to assist social work and health professionals in the discharge of patients from the acute sector, she was keen for the Health & Social Care Integration Joint Board (IJB) to issue a policy direction so that staff could be up front with patients on admission to say their expectations should be that they would not stay in a clinical setting if it was not required. She further commented that she was keen to make Crawwood a more homely setting for people to be discharged to with the intention that the environment would assist in people's reablement and outcomes, taking pressure away from the acute sector and care homes.

Mr Tris Taylor suggested the consultation phase should not wait until the Spring, given the pilot could be utilised to glean user feedback to facilitate change in behaviours and evidence positive outcomes for people. Mr McCulloch-Graham agreed that evidence should be gathered at the pilot stage to feed in to the consultation process. Mr Taylor further enquired if it was a change to both social care and NHS processes. Mrs Logan confirmed it was.

Mrs Linda Jackson sought assurance that carers would be fully involved in the process. Mr McCulloch-Graham confirmed that it was essential that carers were involved, especially at part of the assessment to leave the hospital.

Mr Murray Leys commented that consultation would be directed through the Public Partnership Forum which was the IJB's formal process.

Mr John Raine advised the IJB that the Borders General Hospital had been under severe strain the previous day and indeed that morning. He commented that it was a challenge to move any patients who no longer required medical care out of the acute setting. However it was especially difficult with certain groups of patients such as those in the Department for Medicine of the Elderly (DME), who due to their length of stay became used to certain routines, a user friendly environment and activities. Often the patient was reluctant to leave and the family were reluctant to aid the discharge.

Mr McCulloch-Graham further commented that the IJB would need to specify what it expected to receive for the funding it commissioned and how success would be measured. The primary expectation was to reduce the number of stranded patients and a performance measure would be required.

Mr Colin McGrath enquired about the adaptation of vacant properties owned by both Scottish Borders Council and NHS Borders to assist in the discharge of people to supported living environments. Mrs Logan commented that work with Housing Association partners on extra care housing and the older peoples housing strategy was nearing completion and contained a comprehensive strategy on the provision of extra care housing for those with dementia.

Mrs Carol Gillie highlighted to the IJB that the discharge to assess policy was about discharge to assess from all NHS facilities including the Community Hospitals.

Cllr David Parker commented that given the major issue with stranded patients it was fundamental that a policy change be directed and Crawwood be refurbished to assist the proposal. He suggested any further delay would lead to unrealistic pressures on services and patients. He also suggested that the consultation be done in tandem with the pilot asking patients and families for feedback as they passed through the revised system.

Cllr Haslam commented that the opening of Crawwood and other facilities in the community would require close monitoring to ensure they did not end up as another place for people to become stranded. Mr McCulloch-Graham assured the IJB that a publication had been put together for patients and their families on admission to hospital which clearly advised that whilst they would receive medical treatment in the hospital their recovery and assessment would take place outwith the hospital setting. He further advised that there was a need to ensure packages of care and vacancies in care homes were available to aid the movement of people out of the secondary care setting and into the right community environment for them as individuals.

Mr McCulloch-Graham advised the IJB that Crawwood had only given permission to operate as an assessment function until the Spring of 2018 and he was keen to demonstrate by that time that there was a longer term plan. He further spoke of the challenges in attracting people into the care profession.

The Chair concluded that year on year the acute and community hospitals contained a number of stranded patients during the winter period, who had been admitted with acute illness and then awaited assessment and were unable to move to another facility or move back to their own home. He commented that in 2017 there were on average 41 stranded patients in the wrong place each week and the IJB had the opportunity to make a difference to those patients and direct the Health Board and Local Authority to manage patient flow better through the discharge to assess policy.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the issuing of a Direction to NHS Borders and Scottish Borders Council to introduce a policy of Discharge to Assess.

Under this new “Direction” the **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested the Health and Social Care Partnership to provide a detailed and costed proposal to the IJB for the introduction of such a policy over the winter period of 17/18.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** further requested that a review of the methodology be undertaken in June 2018 and a report brought to the IJB with

further recommendations based on the experience of the first six months of "Discharge to Assess" practice.

6. Pilot for Discharge to Assess

Mr Rob McCulloch-Graham gave an overview of the content of the paper and highlighted the costs and the actions to be taken. He advised that comparing data from August 2016 to August 2017 there were some 120 more people delayed in the system. The proposal before the IJB was for a full complement of 21 beds.

Mrs Susan Swan clarified that the Crawwood costings were for refurbishment and the provision of 8 beds. The £850k also included set up costs and the provision of a small number of beds in Hay Lodge and a staffing model.

Mrs Yvonne Chapple enquired about the proposed staffing levels and Mrs Swan advised that costs were based on both trained and untrained nursing staff in Haylodge, senior support and support workers in Crawwood, and medical support was linked to salaried GP cover. Mrs Tracey Logan assured the IJB that staffing levels would be provided in accordance with professional advice. Mr McCulloch-Graham commented that discussions were also taking place with GP practices in Innerleithen and Peebles to provide medical support instead of the proposed costly salaried GP option.

Cllr John Greenwell enquired about the anticipated journey time through the new pathway. Mr Murray Leys advised that length of stay would be measured and he anticipated any period up to six weeks maximum. Mrs Logan clarified that the assessment period would be much shorter than six weeks.

Mrs Carol Gillie highlighted a risk around the provision of staffing in Haylodge. She advised of the recruitment challenges in recruiting both trained and untrained nursing staff and could not say with confidence that the model proposed could be brought to fruition.

Cllr Shona Haslam enquired about the quantum of the staffing risk. Mrs Gillie advised that recruitment at support worker level was taking place, however the Haylodge staffing model required trained nursing staff to be recruited and that might not be achieved. In order to mitigate risks an alternative plan was being explored incase recruitment to the Haylodge model was unsuccessful.

Mr Tris Taylor sought clarification that the cost of providing the model for 12 months for 21 beds was £1.8m and enquired how efficiencies would be made. Mrs Swan advised that the efficiency would be the initial set up and refurbishment costs of £150k. Mrs Logan suggested that if there was enough space there could be 25 beds provided instead of 21 for the same price.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to the implementation of discharge to assess facilities at Haylodge Community Hospital and at Crawwood.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the allocation of a Hospital to Home provision through the health care support team.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the use of Integrated Care Fund resources to cover the total estimated cost of £850k, for the discharge to assess options recommended by the Executive Management Team (EMT).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested an evaluation of this provision as part of the wider winter plan.

The Chair recorded the thanks of the Health & Social Care Integration Joint Board to all those involved in the preparation of the paper.

7. Emergency Powers

Mr Rob McCulloch-Graham provided an overview of the content of the paper.

Mr John Raine suggested it was a sensible proposal and that any public body would have a similar provision for taking emergency decisions.

Mr David Davidson proposed that the Chief Executives of Scottish Borders Council and NHS Borders be named substitutes should the Chair, Vice Chair or Chief Officer be unavailable. Cllr David Parker seconded the proposal.

The proposal was carried and would be included in the amendment to the Standing Orders.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the amendment to the Standing Orders to introduce emergency powers for decision making outside of formal Integration Joint Board meetings.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that the Chief Executives of Scottish Borders Council and NHS Borders be named substitutes should the Chair, Vice Chair or Chief Officer be unavailable on such occasions as the use of emergency powers were required.

8. Any Other Business

Mr Colin McGrath suggested providing a paper to the IJB to elucidate on section 1.2 of the Standing Orders (*Any statutory provision, regulation or direction issued by the Scottish Ministers shall have precedence if they are in conflict with the Standing Orders*).

9. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Monday 18 December 2017 at 2.00pm in the Council Chamber, Scottish Borders Council.

The meeting concluded at 4.30pm.

Signature: ……
Chair

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Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 17 October 2016

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

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

Meeting held 19 December 2016

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
11	12	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a further report on the operation of the BAES at a future meeting.	Robert McCulloch-Graham	March 2017	**Complete:** IJB agreed funding of £285k from Social Care Fund on 23.10.17	G

Meeting held 27 February 2017

Agenda Item: Health & Social Care Delivery Plan

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

Meeting held 28 August 2017

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
16	12	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** asked the Chief Officer to bring forward a plan for the delivery of remedial savings to address the shortfall attributable to the part-year only impact of the Integrated Transformation Programme in 2017/18.	Robert McCulloch-Graham Susan Swan James Lamb	December 2017	**In Progress:** The 2017/18 Financial Recovery Plan information and the 2018/19 IJB Financial Plan information to be brought to the 12 February 2018 meeting.	G

Meeting held 23 October 2017

Agenda Item: Update on Buurtzorg in the Borders

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

Agenda Item: Interim Transformation and Efficiencies Programme Tracker

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
20	17	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and requested an update on the delivery of efficiencies in 2017/18 and future years from the Transformation Programme.	Robert McCulloch-Graham Susan Swan James Lamb	December 2017	**In Progress:** The 2017/18 Financial Recovery Plan information and the 2018/19 IJB Financial Plan information to be brought to the 12 February 2018 meeting.	G

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
21	18	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and the monitoring position on the partnership's 2017/18 revenue budget at 31st August 2017 and requested details of the financial recovery plan for 2017/18 at the next meeting.	Susan Swan	December 2017	**In Progress:** The 2017/18 Financial Recovery Plan information and the 2018/19 IJB Financial Plan information to be brought to the 12 February 2018 meeting.	G

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

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 18 December 2017

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

CHIEF OFFICER'S REPORT

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

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

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

Discharge to Assess

The extra-ordinary meeting of the IJB in October agreed to issue a direction to NHS Borders and Scottish Borders Council to develop a "Discharge to Assess" policy. The same meeting then agreed to fund three interim projects; 6 beds at Hay Lodge, the opening of a step-down facility at Craw Wood and to support hospital to home work.

Since that time a great deal of work has been undertaken. Hay Lodge hospital has had small scale refurbishment to allow it to open 6 beds urgently if required. Craw Wood is now

operational and receiving its first step down clients who will stay there a short time until they can go home or enter a longer term care home.

More work and investigation has been undertaken regarding the “Hospital to Home (H2H)” project. East Lothian’s model has been examined as has our own Cheviot Model. The success of these programmes has lead us to seek an expansion of the winter project to three localities, and a paper is being discussed later on the agenda.

On my visit to the Cheviot model, I was impressed by the effective multi-agency work being undertaken and was able to witness how this work is speeding the recovery of people leaving home and clear evidence of individuals avoiding hospital admissions. We are now seeking to use the Cheviot experience within the training of the new Health Care Support workers now being appointed to the new programmes.

Regional Work

The six IJBs across the South East Region, are leading on five themes.

1. Commissioning
2. Innovation
3. Workforce
4. Primary care
5. Diabetes

Our own Chief Executives have taken a lead across the region with regards to combating Diabetes. As well as supporting this work as the Borders Chief Officer I am working with the Commissioning work stream. This is examining how we might be able to obtain better value for money from our commissions, particularly in Learning Disabilities, and Mental Health but also Care.

SOLACE / COSLA meeting

I attended a meeting of the above groups in Edinburgh in early October to examine the experience of integration so far. The meeting was lead by NHS and Council Chief Executives with little input from Integration Officers, other than questions from the floor. There was a concern that judgements were being made on the success or otherwise of Integration Joint Boards. There were suggestions that the legislation that created the IJBs should be re-examined, whereas others felt it too soon to be changing the format since the boards had been operational for less than two years.

Drug issues

A verbal update will be given.

Inspection report and actions

There is a report on the IJB agenda which gives the detail of the action planning. I stated at earlier IJB meetings that I would be seeking to gain a better insight into the evidence the inspectorate used to reach their judgements and recommendations. January 8th has now been set for this meeting.

We will also be seeking further clarity from the inspectors regarding their recommendations and the evidence they expect us to provide when they review our progress in the future.

Current Priorities

As well as work to lessen the pressures on hospitals over the winter, we will be working to prepare the 18/19 budget for the IJB approval in early spring. As yet we do not have any settlement figures from Scottish Government or NHS Scotland, however we have some expectation as to what we will receive, or not. So the leadership team will be examining proposals which will address what we expect will be a much more challenging year than the current one, which in itself is extremely difficult.

The leadership team of the Health and Social Care Partnership has been reformed, with new terms of reference and is now meeting weekly, with a set agenda and forward plan. Scottish Government has provided funds for leadership training and dates have been set into spring for four development sessions. These will be cascaded through the wider leadership team of the partnership which we intend to hold on a quarterly basis.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 18 December 2017

Report By	Mr Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Mr Warwick Shaw, Head of Delivery Support Mrs Susan Henderson, Planning Manager (Adults) Social Work
Telephone:	01896 825575 01896 824582

INSPECTION: JOINT OLDER PEOPLE'S SERVICES REPORT

Purpose of Report:	To inform the Health & Social Care Integration Joint Board of the outcome of the Joint Inspection of Older People's services and the action being taken by the Partnership.

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

Personnel:	This report has not identified any additional resource/staffing requirements.

Carers:	N/A.

Equalities:	This is an update paper so no requirement. Actions within the action plan will be subject to their own separate requirements and will be undertaken as required.

Financial:	This report has not identified any additional resource/staffing requirements.

Legal:	Consistent with current strategy. The action plan will be reported to the Care Inspectorate and Healthcare Improvement Scotland once complete.

Risk Implications:	The inspection team will agree a final action plan in January and then monitor progress.

Background

The Care Inspectorate and Healthcare Improvement Scotland undertook an inspection of the Partnership's older people's services between October 2016 and February 2017. This involved submission by the Partnership of extensive advance information in the form of a

report and documentary evidence, followed by three weeks of on-site investigation by the inspection team. This included a file reading week and two weeks of meetings with stakeholders.

The inspection report[1] was published on 28th September. Across the nine key indicators of performance, inspectors found one to be 'good', five to be 'adequate' and three to be 'weak,' including 'delivery of key processes'; 'strategic planning and plans to improve services'; and, 'leadership and direction.' An analysis of those outcomes against previous inspections is at Annex A, ours was the final inspection in the current format.

There are thirteen recommendations for improvement in our report:

1.	The partnership should deliver more effective consultation and engagement with stakeholders on its vision, service redesign and key stages of its transformational change.
2.	The partnership should ensure its revised governance framework provides more effective performance reporting and an increased pace of change.
3.	The partnership should further develop and implement its joint approach to early intervention and prevention services so that it continues to improve the range of services working together that support older people to remain at home and help avoid hospital admission.
4.	The partnership should review its delivery of care at home, care home and intermediate care services to better support a shift in the balance of care towards more community based support.
5.	The partnership should update its carers strategy to have a clear focus on how carers are identified and have their needs assessed and met. The partnership should monitor and review performance in this area.
6.	The partnership should ensure that people with dementia receive access to a timely diagnosis.
7.	The partnership should take action to provide equitable access to community alarm response services for older people.
8.	The partnership should provide stronger accountability and governance of its transformational change programme. It should ensure that: • progress of the strategic plan priorities are measured and evaluated • service performance and financial monitoring are linked • locality planning is implemented and leads to changes at a local level • independent needs assessment activity is included in the joint strategic needs assessment • there is appropriate oversight of procurement and commissioning work • a market facilitation strategy is developed and implemented.
9.	The Integration Joint Board should develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved.
10.	The partnership should ensure that there are clear pathways for accessing services and that eligibility criteria are consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists

[1] http://www.careinspectorate.com/images/documents/4030/Scottish%20Borders%20services%20for%20older%20people%20joint%20inspection%20report%20September%202017.pdf

	and that waiting times for services and support are minimised.
11.	The partnership should work together with the critical services oversight group and adult protection committee to ensure that: • risk assessments and risk management plans are completed where required • quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve • improvement activity resulting from quality assurance processes is well governed.
12.	The partnership should develop and implement a tool to seek health and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services.
13.	The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and providing a skills mix that delivers high quality services.

The Draft Action Plan is at Annex B

Summary

A draft action plan has been created to meet the thirteen recommendations. Many of actions have been completed, and the remaining reflect work that is already in progress. The Joint Inspection Executive Group monitor progress against the draft action plan which will be reported to the Executive Management Team (EMT). The Care Inspectorate and Healthcare Improvement Scotland will be meeting with us in January to agree the final format of the Action Plan.

ANALYSIS OF BORDERS AND OTHER JOPS REPORTS

ANNEX A

Partnership	Date of Publication	Key outcomes for older people and key performance outcomes	Getting the right help at the right time	Impact on staff	Impact on the community	Delivery of key processes	Strategic planning and plans to improve services	Management and support of staff	Partnership working	Leadership and direction
Borders	**27/09/2017**	**A**	**A**	**A**	**G**	**W**	**W**	**A**	**A**	**W**
Edinburgh	16/05/2017	W	W	A	A	U	W	A	A	W
Orkney	09/03/2017	G	A	G	A	A	A	G	A	G
D&G	10/10/2016	A	A	G	G	A	A	A	A	A
Aberdeen City	20/09/2016	A	G	G	VG	W	A	A	A	A
S Lanarkshire	06/06/2016	A	A	A	G	G	A	G	A	A
E Lothian	15/05/2016	A	A	G	A	A	G	A	A	G
W Isles	23/03/2016	W	A	G	A	A	W	A	A	W
Argyll and Bute	23/02/2016	G	A	A	G	A	A	A	A	A
Shetland	10/11/2015	G	G	G	A	A	A	G	A	A
Glasgow	14/08/2015	A	A	A	G	A	G	A	G	G
Falkirk	13/07/2015	G	G	A	G	A	A	A	A	A
Angus	09/03/2015	A	G	A	G	G	W	A	A	A
Fife	17/01/2015	A	A	A	G	A	W	G	A	A
Moray	19/08/2014	VG	G	G	G	A	A	G	A	A
Aberdeenshire	19/08/2014	G	G	G	G	A	A	G	G	G

ANNEX B

Scottish Borders Health and Social Care PARTNERSHIP

Inspection of Older People's Services 2017- DRAFT ACTION PLAN-

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
1. Deliver more effective consultation and engagement with stakeholders on the vision, service redesign and key stages of transformational change.	1.1 Clear communication plan which outlines the Partnership's vision and how the Partnership will engage and consult with all key stakeholders on key developments in terms of service redesign, joint plans and policies	Review and update existing Partnership communication plan	Jane Robertson, Strategic Planning and Development Manager	**August 2017**	Comms plan and updated action tracker – JR/SB HSC Comms Engagement Plan 16 ·	**Complete**	G
		Review and update Partnership stakeholder lists and distribution lists Use staff survey to evidence that staff aware of vision and consulted	Jane Robertson, Strategic Planning and Development Manager	**August 2017**	Locality offices - adultchild .msg List of all Borders GPs as at 23.06.2017 Additional Contact List APR June 2017.x APR Communications Plan v4.doc	**Complete**	G
	1.2 Evidence of increased engagement and consultation activity specifically related to	Record all partnership communication activity on overarching action tracker and individual project communication	Jane Robertson, Strategic Planning and Development Manager	**Ongoing**	TRANSFORMATION AND EFFICIENCIES P	**Complete**	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	the Partnership Transformational Programme i.e. meetings with staff, communication via newsletter	plans					
		Agree arrangements going forward to support the ongoing engagement with members of the locality working groups	Jane Robertson, Strategic Planning and Development Manager	**October 2017**	Locality Consultation Communications Plan	**Complete**	G
	1.3 Ongoing commitment to support the Locality Working Groups which offers regular forum for engagement and consultation with representatives of all relevant stakeholder groups.	Distribute Health and Social Care Locality Plans for public consultation	Jane Robertson, Strategic Planning and Development Manager	**July 2017**	https://www.scotborders.gov.uk/hscplocalityplans	**Complete**	G
		Consult staff – a) workshop to provide information on transformation projects b) Regular newsletters	James Lamb, Portfolio Manager, Chief Exec Robert McCulloch-Graham, Chief Officer H&SC Integration	**September 2017**	a) Feedback Tuesday's Workshop 2.pptx TRANSFORMATION AND EFFICIENCIES P b) Newsletter healthsocialcarenews SEP2017.pdf	**Complete**	G
		Mental Health and Dementia Strategy Workshops	Peter Lerpiniere Associate Director, Mental Health	**End Jan 2018**	Strategy. Comments collated & action plan in place		A
2. Ensure the revised governance framework provides more effective	2.1 Revised Partnership governance structure in place and evidence of more effective and timeous approval and	Implement revised governance structure.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**Feb 2017**	Revised Governance.pdf	**Complete**	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
performance reporting and an increased pace of change.	decision making processes which in turn is supporting an increased pace of change.						
	2.2 Quarterly Partnership performance reports presented to Executive Management Team and Integration Joint Board and aligned to Ministerial Strategic Group performance reporting. Operational managers across the Partnership engaged in dialogue about data, performance and impact of service redesign.	Review effectiveness of revised governance structure.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**October 2017- check**	Quarterly IJB Report - 2nd Edition 2017-06	**Complete**	G
	2.3 A better understanding of staff views across the Partnership	Provide quarterly Partnership performance reports to the IJB. Staff survey due to be sent out to all staff across the Partnership in Feb 2018	Robert McCulloch-Graham, Chief Officer H&SC Integration	**Complete** **February 2018**	Add evidence IJB Quarterly Performance Report - June 2017	**Ongoing**	A
		Report Partnership	Robert	**July 2017**	Annual	**Complete**	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
		Performance via published Annual Performance Report and to the Ministerial Strategy Group.	McCulloch-Graham, Chief Officer H&SC Integration		Performance Report		
3. Further develop and implement the joint approach to early intervention and prevention services so there is a range of services working together that support older people to remain at home and help avoid hospital admission.	3.1 A range of services work together that support older people to remain at home and help avoid hospital admission.	Hold a ½ day strategic review session to fully understand the current landscape and Identify the key components of a good EI & P approach for older people and identify gaps	Tim Patterson, Joint Director of Public Health	**February 2018**	JHIT Older People Seminars 20.10.17.dc Seminar report to be embedded	It is expected by the end of the financial year 17/18 to show a 10% reduction in falls	A
	3.2 There is a clear strategic overview of the early intervention and prevention landscape in the Borders supported by a clear understanding of the broad range of early intervention and prevention approaches required to achieve positive outcomes for older people.	Develop a strategic delivery plan to address gaps in EI & P identified at the strategic review session	Tim Patterson, Joint Director of Public Health	**March 2018**	Evidence: Delivery plan to be written Current prevention/early intervention services Patient pathway work Telecare Falls work		A
		The community hubs and customer services are signposting to healthy living activities and preventing social isolation	Gwyneth Johnston	**November 2017**	To be gained		

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	3.3 Early intervention and prevention providers understand their role and function in the broader landscape and develop complementary approaches with partners that enhance the positive outcomes experiences by older people.	Embed anticipatory care planning and plans into care assessment and planning	Robert McCulloch-Graham, Chief Officer H&SC Integration	**April 2018**	Anticipatory care plans are within MOSAIC		A
		Introduce specific software to collate and disseminate information on a range of positive activities on a locality basis.	Gwyneth Johnston??	**December 2019**	Software in place and being utilised	Contact with providers has been made	A
	3.4 Anticipatory Care Plans in Care Homes are up to date.	Ensure ACP in Care Homes are up-to-date.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**June 2018**	Early Warning Scores		A
4.Review delivery of care at home, care home, intermediate care and palliative care services to better support a shift in the balance of care towards more community based support	The older people's commissioning strategy is reviewed and strategic plans put in place based on demographic evidence across the Scottish Borders. TEC (technology enabled care) strategy informs commissioning decisions. The older	Update the older peoples commissioning strategy. Develop the TEC strategy and the Older Peoples housing strategy. Evaluate the current care at home service, including assessment	Robert McCulloch-Graham, Chief Officer H&SC Integration	**June 2018** **January – April 2018** **June 2018**	Draft strategies completed. Equality impact assessments undertaken. Consultation process with local communities Contractual documents developed along with robust evaluation and	The TEC strategy and the Older Peoples housing strategy are currently under development.	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	peoples housing strategy forms part of the older peoples commissioning strategy. All strategies are agreed by the Borders Older People's Planning Partnership. A cohesive commissioning plan that is informed by the market strategy is developed which clearly states expectation of contracted services both in the statutory sector and in the voluntary sector. All services are able to deliver choice and flexibility in line with SDS approach while integrated pathways for individuals ensure that people are able to achieve their outcomes. A contractual position is in place with care at home providers which allows for flexible care	processes. Consult with all stakeholders, including service users, carers, providers; and learn from other local authorities e.g. the review undertaken by Maggie Dowe, SW Scotland, published in Nov. Plan cohesively to ensure that specifications for services are understood and align to ensure service users experience joined up health and social care services. Commission all services in a way that ensures service users are given maximum control via revised contractual requirements with providers. Establish a contractual position with care at home providers which allows for flexible care at home delivery and			monitoring requirements The Border Older Peoples Planning Partnership will have oversight for the work: minutes and highlight reports submitted as evidence.	Estates paper completed	

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	at home delivery and reduced assessment processes	reduced assessment processes.					
	4.1 Margaret Kerr Unit is viewed as a homely setting in Scottish Government performance figures	Discuss with Scottish Government the use of Margaret Kerr Unit as a homely setting in Scottish Government performance figures	Murray Leys, Chief Officer Adult Social Work	**December 2017**	Letter to/from Scottish Government		A
5. Update the carers' strategy to have a clear focus on how carers are identified and have their needs assessed and met. Monitor and review performance in this area.	5.1 There is a clear pathway for identifying carers and ensuring their needs are assessed and met.	Develop a Carers support plan, eligibility criteria and pathway for assessing and supporting carers	Susan Henderson, Planning Manager	**April 2018**	Pathway in place with supporting documentation	Draft support plan and draft eligibility criteria are components of pathway work  Scottish Borders Carers Eligibility Fram  Carers Support Plan8817.docx	A
		Put communication and training plans in place to ensure stakeholders are aware of the legislation	Susan Henderson, Planning Manager	**December 2017**	Communication and training plans. Positive feedback from stakeholders about feeling informed	Progressing Awareness raising training trialled with Kelso sw staff Sept.	A
	5.2 A carers strategy is in place that indicates how carers needs are identified and have their needs	Carers strategy 2017-19 agreed and published that states how carers needs are identified and met.	Susan Henderson, Planning Manager	**April 2018**	Carers strategy	Progressing Draft 2017-18 Strategy to be extended to 2019	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	assessed and met. The partnership monitor and review this performance						
		A performance process in place to monitor and review progress in identifying and supporting carers	Susan Henderson, Planning Manager	**April 2018**	Reporting regularly to IJB. Carer feedback.	Progressing	A
		An assessment of the health needs of carers in Scottish Borders is produced	Tim Patterson, Joint Director of Public Health	**March 2018**	Health needs assessment report anticipated March 2018.	Project plan in place	A
6. Ensure that people with dementia receive access to a timely diagnosis	6.1 Clinicians will be supported to recognise the importance of a dementia diagnosis, make appropriate referrals, and support people through their diagnosis.	Develop and circulate a checklist of "things to consider" in relation to dementia diagnosis for GPs, Junior Doctors and Care Homes.	Peter Lerpiniere, Associate Director, Mental Health	**December 2017**		**"**Checklist" will be developed by Dementia Strategic Partnership Group.	A
	6.2 Resources will be utilised as effectively as possible to widen opportunities for access to diagnostic services.	Carry out awareness session on TiME agenda November facilitated by MHOAS	Peter Lerpiniere, Associate Director, Mental Health	**30 November 2017**	Copy of pathway:	Date requested for slot in TiME agenda.	A
		Consider increasing capacity to carry out more memory clinics	Peter Lerpiniere, Associate Director, Mental Health	**31 December 2017**		MH strategy & dementia strategy consultation events are underway and will include evaluating capacity to rebalance resources to support more clinics.	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
		Map the patient pathway from referral to diagnosis to entry on to Dementia Register to look for any challenges and areas for improvement	Peter Lerpiniere, Associate Director, Mental Health	**31 July 2017**	Diagnosis of Dementia - Pathway.pdf	Mapped and areas identified for improvement include communication with GPs to request diagnoses be added to the register (see action 7).	A
	6.3 All patients who receive a diagnosis of dementia will be recorded on the primary care register.	Discuss with GP practices in order to carry out a gap analysis of the diagnoses on MHOAS records against GP records	Peter Lerpiniere, Associate Director, Mental Health	**31 August 2017**	No evidence available – telephone calls	Already carried out with Selkirk GP practice. All other practices scheduled for w/c 21/08/2017.	G
	6.4 All people given a diagnosis have an understanding of what to expect from the service.	Write letters to GP practice to follow up on discussions in point 5 above and ask GP to add missing diagnoses on to register	Peter Lerpiniere, Associate Director, Mental Health	**30 Sept 2017**	Copy of letter being sent (following telephone calls above) to practices who have agreed to support: DoD Letter - GP Practices - Sept 17.doc	Already carried out with Selkirk GP practices. All other practices scheduled for w/c 21/08/2017.	A G
		Adjust first assessment letter used by MHOAS to include clear diagnoses & request to GP to add to dementia register	West team secretary/ Consultant Psychiatrist	**31 July 2017**	MHOAS Assessment template.docx	Discussed at Mental Health Operational Group and agreed for implementation.	G
		Develop patient awareness leaflet to set expectations of what will be offered /	Simon Burt, Joint LD Service Manager & Acting	**31 January 2018**			G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
		delivered	MH Service General Manager				
7. Take action to provide equitable access to community alarm response services for older people.	Telecare strategy written and audit in place in relation to technology enabled care, including community alarm systems. This shall ensure that older people are assisted to remain at home for longer with reduced impact/incidence of falls. Older people have access to a 24 hour response service Resilience aspects of current (Tunstall) technology (SB Cares risk owner)	Produce the strategy for telecare and telehealthcare Audit current systems through use of SWOT analysis. In conjunction with a Falls Strategy increase focus on telecare and establish feasibity of introducing a universal alarm service	Head of Adult Social Care	**March 2018** **January – April 2018** **April – December 2018**	Assistive Technology strategy that will include telecare and telehealthcare priorities. Drafted for agreement Consultation undertaken with local communities and other stakeholders Actions from strategy realised via implementation plans. BOPPP highlight reports to show scrutiny of work		**A**
8. Provide stronger accountability and governance of transformational change programme. Ensure that: progress of the strategic plan priorities are measured and evaluated;	8.1 There is clear evidence of the impact of improvements and service redesign on the delivery of local strategic objective as laid out in the Strategic Plan through: • Annual performance report	Improve the content, structure and format of the IJB quarterly performance reports	Jane Robertson	**October 2017**	Evidence The quarterly performance monitoring report to the IJB October 2017 Annual Performance Report 2018/19 Next MSG submissions -FILE,		G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
service performance and financial monitoring are linked; locality planning is implemented and leads to changes at a local level; independent needs assessment activity is included in the joint strategic needs assessment; There is appropriate oversight of procurement and commissioning work; A market facilitation strategy is developed and implemented	• Quarterly performance reports to IJB A number Ministerial Strategy Reports				Leadership Group, IJB, EMT Locality Plans – link to be added		
		Ratification of Commissioning and Implementation Plan by IJB	Robert McCulloch-Graham, Chief Officer H&SC Integration	**December 2017**	IJB agenda and minutes	THE IJB was presented with a finalised Commissioning & Implementation Plan at its meeting on 23rd October 2017	G
	8.2.1 Fully costed Commissioning and Implementation Plan and Locality Plans in place. Clear identification of financial costs/benefits and expected outcomes including all project briefs / PIDs.	Both IJB and strategic planning group bodies have timetabled development sessions throughout the year which will cover strategic planning and commissioning functions with a clear inclusion of outcomes and value for money. Further development of financial elements of Locality Plans and demonstration of "fair share"	Robert McCulloch-Graham, Chief Officer H&SC Integration	**April 2018**		The Commissioning and Implementation requires to be costed where possible. The strategic needs analysis for each of the localities will be completed by April 17 which will assist in the location of resources to meet the plan.	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	8.2.2 Comprehensive assessment of performance impacts of Financial Planning efficiency targets and in-year recovery plans.	Refer to Action Point 9	Director of Finance IJB Section 95 Officer	**December 2017**	NHS Recovery Plan NHS financial plan SBC financial plan IJB financial statement Descriptor of how strategy not impacted by above	Refer to Action Point 9	A
					IJB financial planning budgetary control reports	The IJB Financial Plan is not directly linked to performance outcomes.	A
	8.3 Clear mechanisms in place for progressing and monitoring locality implementation plans. Clear evidence of changes made at a local level	Continued support for locality working groups to take on monitoring role of progress of implementation of Locality Plans	Robert McCulloch-Graham, Chief Officer H&SC Integration	**December 2017**	Project briefs/PIDs		A
		Implementation of robust reporting mechanisms to evidence changes made at a local level	Robert McCulloch-Graham, Chief Officer H&SC Integration	**September 2017**	Extension of locality co-ordinator role until 31 March 2018 Progress reports Locality Plans	**Complete**	G
	8.4a Commissioning and Implementation Plan approved by IJB	Commissioning and Implementation plan ratified by IJB October 2017	Robert McCulloch-Graham, Chief Officer H&SC Integration	**December 2017**	IJB agenda and minute Draft commissioning and implementation plan	The Commissioning and Implementation Plan was presented to the IJB 23.10.17	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	8.4b Regular monitoring reporting over delivery. Of Commissioning and Implementation Plan					This is the ongoing monitoring as this is not yet in place so should be noted at amber.	A
	8.5 A medium-term Market Facilitation Plan and regular and frequent reports to the IJB over its delivery	Development, approval and implementation of a Market Facilitation Plan for the IJB	Robert McCulloch-Graham, Chief Officer H&SC Integration	**March 2018**	Market Facilitation Plan IJB agenda and minute	**Ongoing**	A
9. Develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved	9.1 A joined-up approach to ensure that the partnership medium-term financial plan not only underpins its Strategic and Commissioning Plans, but assures its affordability, robustness and sustainability. Its component provisions and assumptions are transparent and consistent. 9.2 The delivery of a balanced, affordable and sustainable medium-term financial plan for the Health and Social Care Partnership which will be presented to	Develop and implement a detailed financial recovery plan to ensure that a sustainable financial position is achieved and agreed by the Integration Joint Board.	Director of Finance IJB	**March 2018**	Balanced 2017/18 Outturn Balanced 2018/19 Financial Statement All recurring pressures to be addressed by recurring mitigating actions Delivery of financial planning and reserves strategy over medium-term	A Recovery Plan was implemented in late 2016 and approved by the IJB in January 2017 – total value of savings delivered in excess of £4m, enabling a breakeven outturn position The partnership's new Medium-term Joint Financial Planning and Reserves Strategy was approved by the IJB on 27 February 2017 Partnership approved its 2017/18 Financial Statement on 27 March 2018 Noting that majority of	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	members of the IJB as its Financial Statement. To achieve this: • Identification of the impact of the current planned transformation and redesign programme in terms of resource realignment, efficiency opportunities and ongoing sustainability requirements beyond transitional funding arrangements • Identification of further joint opportunities for service redesign and agree a joint plan for any associated capital or revenue investment requirements • Implementation of a medium-term solution for addressing the recurring efficiency gap across the partnership's devolved and large hospital budget set-aside resulting from non-					healthcare savings within 2016/17 recovery plan were non-recurring. Due diligence carried out at the inception of IJB confirmed the IJB had received a fair provision of resources as part of the delegated functions from the overall Health & Social Care resources available, however this was not confirmed to be adequate and had required recurring efficiency targets to achieve financial balance. 2017/18 Financial Recovery plan has again been underpinned by non-recurring measures and has required additional non-recurring monies to be approved to Health and Social care delegated functions. The IJB Financial Plan and provision	

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
	recurring savings delivered in current and historic years • Identification of any additional investment requirements associated with the delivery of the partnership's approved Strategic Plan and how these investment requirements can be met					of health and social care for 2018/19 is currently in discussion. This will confirm the level of efficiency required to achieve a breakeven financial position. The IJB is progressing a Transformation and Efficiency Programme which will contribute a level of efficiency savings from the delegated functions. The quantum of the contribution from the T&EP has yet to be confirmed.	
10. Ensure that there are clear pathways for accessing services and that eligibility criteria are developed and consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership	Accessible pathways are in place to enable people to access appropriate and timely support	Deliver community led services via hubs in localities Provide shortened 'what matters' assessments Through matching unit provide more speedy access to services Develop a more robust hospital to home process	Murray Leys , Chief Officer Adult Social Work Jane Prior, General Manager, Patient	**December 2017**	Eligibility criteria on website Leaflets Performance data for waiting list What matters assessment Community Led Support Hub Screenir		**A**

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.			Pathways		Matching unit evidence91017.docx Documents to follow: DD strategy and processes/patient pathway		
11. Work together with the critical services oversight group and adult protection committee to ensure that: risk assessments and risk management plans are completed where required; quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve; and improvement activity resulting from quality assurance processes is well governed	Risk assessment and management plans are completed and recorded in MOSAIC Quality assurance process reflects appropriate responses to Adults at risk	Quarterly Adult Protection file audits to be carried out. The Adult Protection Committee Coordinator conducts a 100% Audit of Adult Protection. All Audits are reported to the AP Audit sub group and any team remediation is captured through an individualised team improvement plan. Produce performance reporting reports for the AP Audit sub group, AP Committee & CSOG. These reports will be subject to peer scrutiny particularly in relation to Risk assessment, Protection plans, Chronologies and Case Conferences. Refresher AP training to be set up.	Murray Leys , Chief Officer Adult Social Work	**August 2017**	AP Audit format revised March 2017 2 AP Quality Assurance and Audit AP Quarterly Report Q1 June 2017.pdf 2017-18 Q1 ASP KPI Scorecard 2016-17 (L	There is now an AP Audit Tool on Mosaic which allows Teams to self-audit or audit neighbouring teams AP Level 3 Refresher Training has been set for Nov 2017 and this will further support the AP Process, Outcomes and use of Risk assessment, Protection Plans and Chronologies.	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
12. Develop and implement a tool to seek health and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services.	Health and Social Care staff feedback is sought and used to inform staff experience and support services	Implement i-matters staff survey across the Partnership	Robert McCulloch-Graham, Chief Officer H&SC Integration	**February 2018**	Provision of joint combined list to iMatter National Team iMatter (NHS)	The first iMatters questionnaire will be implemented in February 18. Health staff within the H&SC partnership have undertaken the completion of iMatter, it is expect to be rolled out across all staff within the partnership by February 18	A
		Examination of iMatter output Include feedback through Self-evaluation strategy Annual Appraisal process/PRD Report to Joint Leadership Board	Robert McCulloch-Graham, Chief Officer H&SC Integration	**Date to be gained from Jennifer Boyle**	Self-evaluation strategy		A
13. Develop and implement a joint comprehensive workforce strategy, involving the third and independent sectors. This	Draft Integrated Workforce Development Plan developed will reflect the workforce requirements of the Third and Independent Sectors	Draft Joint Workforce Plan to include third and independent sectors to incorporate plans for developing a sustainable workforce. Present Draft Workforce Plan for sign off by IJB.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**April 2018**	Sarah Halliday		A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Comment / Progress	RAG
should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and skills mix that delivers high quality services	within the Integrated Workforce Plan for the Partnership Including sustainable recruitment plans	To introduce a workforce plan for health social care for partnership		**April 2018**			A
		Work with the 3rd and independent sector to identify further staffing requirements		**April 2018**	Private and 3rd sector staff survey – Minutes of providers meeting to be added		A
		Support the 3rd and independent sector with a strategy to meet the demands of the workforce		**April 2018**			A

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 18 December 2017

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

APPOINTMENT OF THE CHIEF FINANCIAL OFFICER – INTEGRATION JOINT BOARD

Purpose of Report:	Section 13 of the Public Bodies (Joint Working) (Scotland) Act 2014 amends the Local Government (Scotland) Act 1973, by extending the application of Part 7 of the 1973 Act (with the exception of sections 101A and 105A) to Integration Joint Boards. Under that provision, the Integration Joint Board requires to appoint a "proper officer" (Chief Financial Officer) who has responsibility for the administration of the financial affairs of the Integration Joint Board (IJB) in terms of section 95 of the 1973 Act.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Agree to the permanent joint appointment for a Director for Finance for the IJB, by NHS Borders and Scottish Borders Council.

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Compliant.

Financial:	Meets the requirements to appoint a Section 95 Officer to the Integration Joint Board

Legal:	Meets the requirements to appoint a Section 95 Officer to the Integration Joint Board

Risk Implications:	As detailed within the Scheme of Integration.

Background

1.1 Interim Chief Financial Officer arrangements have been in place since March 2016, on a part time arrangement through the appointment of Mr Paul McMenamin (Scottish Borders Council) and latterly Mrs Susan Swan (NHS Borders).

Summary

2.1 The Chief Financial Officer will be the accountable officer for financial management, governance and administration of the IJB. This includes accountability to the IJB for the planning, development and delivery of the IJB's financial strategy and responsibility for the provision of strategic financial advice and support to the IJB and the Chief Officer.

2.2 The Chief Financial Officer as the IJB's designated Section 95 Officer will be a member of the IJB under the Regulations and is a key member of the Executive Management Team leading the planning, development and implementation of the financial strategy to resource and deliver the IJB's strategic objectives.

2.3 Scottish Government have stated within their publication "Roles and Responsibilities and Membership of the Integration Joint Board" Sept 2015, that; "The Integration Joint Board must also appoint the Section 95 Officer who will be the responsible officer for the financial arrangements of the Integration Joint Board".

2.4 The Chief Financial Officer (CFO) will be responsible for developing the financial strategy of the IJB and must be actively involved in and able to bring influence to bear on all material business decisions to ensure short and long term opportunities and risks are fully considered and aligned with the IJB's financial strategy. The CFO will promote sound financial management by the IJB to ensure public funds are safeguarded and used appropriately, effectively, economically and efficiently at all times.

2.5 The Chief Financial Officer will also be responsible for the development of collaborative arrangements between Scottish Borders Councils' Section 95 Officer and the NHS Borders Director of Finance and will report to the Chief Officer of the Integration Joint Board.

Process of Appointment

3.1 This will be a joint appointment across the partnership with an equal funding arrangement from the service budgets delegated to the IJB. The post has already been evaluated as requiring either an NHS Officer on Salary Scale 8c (between £57,232 and £70,559, or a Council Officer Grade 12 (between £50,424 and £52,760). Attachment A.

3.2 This will be a permanent position and the budget for the post will be contained within existing budget limits. It is most likely, taking notice periods into account that the appointment will commence within the 18/19 financial year, and will feature within the budget planning for the IJB.

3.3 Outlined below is a proposed timeline for the joint appointment which will be undertaken following the same procedures as those undertaken for the appointment of the Chief Officer.

TIMELINE FOR CHIEF FINANCIAL OFFICER HEALTH & SOCIAL CARE RECRUITMENT

Date by	Action	Who by	Comment	Status
11.12.17	CFO H&SC Job Description - (Drafted 2016)	John Cowie & Clare Hepburn	Job Description from 2016 to be reviewed and clarified if need amended or regrading	
11.12.17	FINAL CFO H&SC Job Description - approval	Rob McCulloch-Graham		
11.12.17	DRAFT CFO H&SC Advert	John Cowie & Clare Hepburn		
15.12.17	FINAL CFO H&SC Advert	Rob McCulloch-Graham		
15.12.17	Interview Date to be secured (Given Festive Break secure date in February 2018?)			
15.12.17	Interview Panel to be identified	Rob McCulloch-Graham	2 NEDs 2 Cllrs CO H&SC D of F SBC and NHSB	
18.12.17	CFO H&SC Advert & Job Description to be released on SHOW & SBC including Interview date of	John Cowie & Clair Hepburn	To agree if advert to appear in other publications/websites	
19.12.17	Interview/Assessment Centre to be arranged for w/c ..... Preference for Education Centre/BGH. Require Large Meeting Room 3-4 Desk Top Exercise Rooms			
19.12.17	Observers and timings for Stakeholder MDT sessions to be agreed.		Observer: Timetable:	
03.01.18	Invitations for stakeholder MDT to be released e.g. - GM - Assoc DN - Assoc MD - GP - Chief Pharmacist - SBC		MDT members identified and agreed by Rob. Emails drafted to go once Rob given go ahead.	
08.01.18	Draft of interview /AC schedule worked up based on expected number of shortlisted applicants to be interviewed. (Taking account of Meet and Greet, walking between appointments, prep time for applicants, comfort breaks, etc.).		A plan for max of 4 candidates	
08.01.18	Subject for Desktop Exercise to be agreed. Links to activity for MDT.	Rob McCulloch-Graham		
15.01.18	Final identity of participants for stakeholder MDT sessions agreed (based on confirmations/declines).	Rob McCulloch-Graham		
05.02.18	12 Noon Closing Date	NHS B or SBC		
06.02.18	Shortlisting arrangements to be agreed by telephone / email			
06.02.18	Candidates notified by email of interview / assessment and internet link to electronic 16 PF test. Candidate notified by letter of interview / AC, arrangements for MDT stakeholder group, and pre-			

	employment requirements (PVG/Disclosure).			
07.02.18	Car Parking spaces reserved for MDT members			
07.02.18	Timetable for interviews at.... Who doing meet and greet at.... Refreshments for interview panel at.... Lunch for interview panel members at.... Nameplates for Interview panel at.... Room set up at .... Pre Panel meeting 30 mins agree Questions.			
07.02.18	Final arrangements for MDT stakeholder group confirmed and notified to participants (ie schedule of timings, interviewees).			
07.02.18	Interview/ AC Schedule confirmed and sent to Panel members along with interview packs. Structured Interview Plan, competency and values based interview agreed and forwarded to panel members.			
12.02.18	Closing date for 16 PF test.			
19.02.18	Assessment centre takes place			
20.02.18	Interviews take place			
20.02.18	Successful candidate contacted and appointment confirmed verbally	Rob McCulloch-Graham		
20.02.18	Board members notified of successful applicant appointment (privately). Press Release agreed for successful applicant appointment.	Jane Davidson Tracey Logan		
20.02.18	Provisional start date agreed and notified to HR.	John Cowie & Clare Hepburn		
21.02.18	HR conditional offer of appointment drawn up and sent to successful applicant. References requested. OHS completed.	John Cowie & Clare Hepburn		

INTERVIEW PANEL

Name	Position	Role	Confirmed
		Chair Panel	
		Panel Member	
		Panel Member	
		Panel Member	
		Panel Member	
		Panel Member	
		Expert HR Advice	

JOB DESCRIPTION

5459C

1. JOB DETAILS

Job Title:	**Chief Financial Officer – Integration Joint Board (IJB)**
Responsible to:	Chief Officer – Integration Joint Board Professionally Accountable to: Chief Financial Officer (SBC) and Director of Finance (NHS)
Department & Base:	Finance SBC/NHS
Date this JD written/updated:	

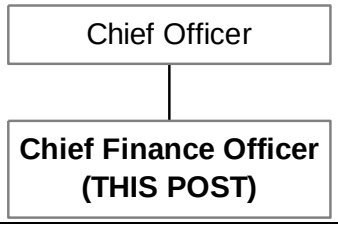
2. JOB PURPOSE

- Is a key member of the leadership team, accountable to the Integration Joint Board for the planning, development and delivery of the IJB's three year financial strategy linked to the achievement of the Strategic Plan;
- Is responsible for the provision of strategic financial advice and support to the Integration Joint Board and Chief Officer and for the financial administration and financial governance of the IJB;
- The post holder is the senior professional financial advisor to the Integrated Joint Board and is the Accountable Officer for financial management and administration of the IJB. The Chief Officer has all other accountable officer responsibilities. The Chief Financial Officer's responsibility includes assuring probity and sound corporate governance and responsibility for achieving Best Value.

3. ORGANISATIONAL POSITION

The Chief Financial Officer :

- will work with the Chief Officer to establish, plan, develop and implement a business and financial strategies to resource and deliver the IJB's strategic objectives sustainably and in the public interest;
- will in collaboration with the Chief Officer put in place arrangements to finance the agreed strategic outcomes of the IJB
- is responsible for developing the financial strategy and financial governance arrangements of the IJB;
- must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term financial implications, opportunities and risks are fully considered, and alignment with the IJB's financial strategy; and
- must lead the promotion and delivery by the IJB of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively.
- Is responsible for creating, in conjunction with related Local Authority (LA) and Health Board (HB) Directors of Finance, a collaborative arrangement with Business partners and associated Chief Financial Officers within the related Board Area(s).



4. SCOPE AND RANGE

The postholder works autonomously under the general direction of the Chief Officer on the allocation of task and the timescales to be met.

The CFO supports the effective and efficient management of public monies allocated to the IJB ensuring that Resource Limits are not exceeded. Also to put in place processes to ensure relevant approvals are obtained and all items of expenditure fall within the legal powers of the IJB and are exercised with due regard for probity and value for money.

The CFO advises the IJB on the Strategic Commissioning Plan ensuring it is affordable to enable strategic change to health and social care and health improvement to take place.

Annual Budgets

NHS	£92 million
Set Aside	£10 million
SBC	£45 million

To achieve effectiveness across the the IJB, NHS Borders & SBC organisations a matrix management approach and collaborative working will be essential.

5. MAIN DUTIES/RESPONSIBILITIES

Developing and implementing Organisational Strategy

- Ensure the delegated resources specified within the Strategic plan are deployed to deliver the outcomes agreed
- Provide a strategic financial focus and advice to the IJB
- Ensure that the directions to the Health Board and Local Authority require that the financial resources are spent in accordance with the Strategic Plan.
- Establish a process of regular monitoring of the financial performance of the IJB budget in conjunction with the Health Board and Local Authority Directors of Finance to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole
- Ensure regular comprehensive budget monitoring reports are prepared for the IJB
- Develop business cases for changes to delegated resource budget in line with the strategic plan to improve outcomes for patients carers and service users in conjunction with the Chief Officer
- Work collaboratively with the Partnership Senior Management Team to achieve the objectives of the IJB.
- Assist the Chief Officer and Senior Managers to deliver change and improvement through service redesign.
- Identify priority areas for action and contribute to policy development to address these in the short, medium and long-term in a way which draws on a sound theoretical base and personal experience and knowledge of financial management.
- Supporting the Chief Officer to ensure efforts within the Partnership are co-ordinated to improve health, reduce inequalities, improve health and social care services, and increase social inclusion

based on the user's journey.

Responsibility for Financial Strategy

- Take a lead role in the compilation of the IJBs financial strategic plan and annual revenue budget
- Prepare strategic scenario planning to allow the IJB to be able to approve a balanced financial plan/budget
- Provide expert advice on policy, legislative and accountancy developments
- Production and management of the IJB's Financial Plans in terms of processes and outcomes ensuring compliance with relevant regulations and local and national requirements and timescales.
- Liaise and provide finance advice and guidance on all aspects of planning and performance out with the partnership including statutory agencies, community planning partnerships and other Health and Social Care partnerships.
- Develop and implement Financial Planning for all areas of the IJB

Influencing Decision Making

- Responsible for ensuring effective liaison and working relationships with all financial functions within the Health Board, Council and other partnerships.
- Contribute to relevant wider NHS, Council and Community Planning Partnership Strategy.
- Contribute to the delivery of a comprehensive and coherent performance management system, facilitating real performance improvement across the Partnership, reducing duplication and delivering excellence in governance.

Financial Information for Decision Makers

- Deliver professional, consistent and appropriate financial management advice across the Partnership,in line with statutory accounting guidance and regulations

Value for Money

- Responsibility for value for money assessment contributing to the IJB's Strategic Plan, playing a key role in the production and development of the plan.
- Monitor and advise on the strategic financial implications/considerations of Best Value.

Safeguarding Public Money

- Manage all aspects and take a lead role in the development of financial governance, control and compliance, management of risk, and deliver a comprehensive financial management system for the IJB.

Assurance and Scrutiny

- Plan, monitor, co-ordinate and ensure completion of the annual closure of the Partnership's accounts and the production of the annual financial statements, ensuring compliance with statutory reporting requirements required by Local Authority/ NHS group accounts .
- Establish procedures in conjunction with the Health Board accountable officer and Local Authority Section 95 Officer to allow the best practice principles set out in the Code of Guidance on Funding External Bodies and Following the Public Pound to be followed;
- Act as point of contact with the External Auditor in respect of the audit of the IJB'sfinancial statements and liaising with them during this process.
- Receive assurance from Health Board and LA Directors of Finance re anti-fraud measures within their organisations and to develop and necessary local procedures to monitor anti-fraud measures designed to reduce risk.

Ensure that Financial Risk Management is properly addressed within the Integration Joint Board.

6. SYSTEMS AND EQUIPMENT

NHS Borders Board uses Cedar E-Financials software to provide all main financial processes. The system is used in conjunction with Business Objects which provides a sophisticated report writing mechanism. The IJB is planning to use a separate entity of the system. A knowledge of SBC's financial system is also required. . Extensive, including complex formulae, spreadsheets, graphs and charts, use is also made of Microsoft Outlook, Word and Excel and local developed systems. The Intranet is used to access organisational policies, information, procedures and Scottish Executive Circulars etc. Maintain detailed working papers for audit purposes. .

7. DECISIONS AND JUDGEMENTS

This post has a high level of autonomy, working in a self-directed manner under the general direction of the Chief Officer with professional support provided by the NHS Director of Finance and SBC Chief Finance Officer.

The work will be within the parameters of Government health and social care priorities and policies, and other frameworks such as accountancy practice and corporate governance.

The postholder is required to deal with highly complex problems involving a number of competing demands and devise solutions using prior knowledge and experience.

The postholder is actively involved in the development of policies and procedures, which will impact on the whole of NHS Borders/ SBC and the IJB eg service changes and their impact.

As an expert on health and social care integration advise the IJB in unprecedented areas of policy and procedure.

8. COMMUNICATIONS AND RELATIONSHIPS

The postholder is expected to communicate with a wide range of senior clinical and non-clinical staff across NHS Borders and SBC, and with senior officials of external organisations, including the Scottish Government, other NHS Boards and Local Authorities. Excellent communication skills are required to influence and persuade others, particularly around opportunities for efficiency, the implementation of change, health and social care integration. All of the subject areas of this post are often highly complex and sensitive. The postholder is expected to have strong presentation skills and to be able to express views convincingly and coherently, verbally and in writing to a wide range of interested parties and individuals.

9. PHYSICAL DEMANDS OF THE JOB

- The postholder is sedentary for extended periods.
- A VDU is used for a significant proportion of time both for ledger, e-mail and other software packages.
- The post holder will require positive personal behaviours and attitudes to support and encourage team working within services with staff from both the NHS and the LA and exhibit sustained concentration and ensure accuracy on complex financial problems while having to cope with interruptions.

- The demands of the post for prioritising workloads to meet fixed, pre-determined timetables, whilst remaining flexible in the approach to the order of work to meet any unscheduled demands, is stressful and physically tiring.
- The postholder deals directly with the frustration of managers over funding issues.
- The workload and pressures resulting from the workload can have a physical and mental effect on the post holder.
- A driving licence is required.

10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB

Dealing with the many varying demands on the postholder's time and prioritising task in order to meet the many competing and conflicting deadlines.

Presenting to the IJB, clinicians and senior managers highly sensitive, complex and challenging information which will be scrutinised and disputed. Influencing these key staff to redesign services in line with the data presented

Being an expert in health and social care integration which is still developing nationally and for which there are not precedents.

11. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB

- Educated to degree level or equivalent with significant financial experience at senior managemer level within a large complex organisation, preferably within the NHS or Local Authority.
- CCAB, CIMA or overseas equivalent Qualified Accountant
- Strong negotiating and communication skills
- Practical experience of applying relevant strategic business and financial support tools.
- Demonstrate a track record in collaborative working that produces results.
- Demonstrate leadership and influencing skills and have a proven track record
- in developing structures and/or systems to support the attainment of organisational goals.
- Demonstrate integrity and effective management skills necessary to enable the successful
- delivery of redesign programmes to improve services.
- Ability to develop and maintain effective, positive relationships with key partner
- organisations at a national as well as local level providing a positive role model
- for partnership, relationship and conflict management.

PERSON SPECIFICATION

Factor	Essential
Qualifications and/or experience	• Degree in a relevant subject or equivalent qualification. • Membership of a CCAB professional body, CIMA or overseas equivalent. • Evidence of continuing, relevant, professional and personal development. • Extensive experience in a senior role within a complex or • multi-agency / disciplinary financial management environment, with practical experience of applying strategic planning and performance tools. • Leadership and influencing skills. • Proven track record in collaborative working that produces results within • dynamic, and participative decision making environments. • Proven track record in developing structures and systems to • support the attainment of organisational goals.

	Desirable
Qualifications and/or experience	• Experience of overseeing the production of annual accounts for a • large/complex organisationExperience of working at a senior level in a • political environment within health service and/or local authority.
	Essential
Knowledge	• Detailed knowledge of relevant policy change in Scotland, particularly • in relation to the business support element of health and social care. • Detailed knowledge of development agenda facing Health and • Social Care Partnerships. • Comprehensive knowledge of tools and techniques for strategic financial • support and development. • Critical appraisal skills. • Highly effective numeracy/ data interpretation, analysis and presentation skills.
Attributes	• Demonstrable and facilitative leadership skills. • Excellent communication and inter-personal skills, including sensitivity, • tact and political astuteness. • Honesty, integrity and with high professional standards • Self-starter. • Values driven. • Team player. • Ability to work on own initiative.
Training	• Record of continuous professional development (CPD).

12. JOB DESCRIPTION AGREEMENT

A separate job description will need to be signed off by each jobholder to whom the job description applies.

Job Holder's Signature:

Head of Department Signature:

This job description is not definitive and may be subject to future amendments following negotiation and consultation.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 18 December 2017

Report By	Michael Curran, Service Development Manager
Contact	Michael Curran, Service Development Manager
Telephone:	01835 826682

COMMUNITY CAPACITY BUILDING - TRANSFORMATION PROPOSAL

Purpose of Report:	To outline the positive impact of the Community Capacity Building approach. To outline the contribution to the transformation and efficiency programmes. To seek approval and resources to deliver phase three of the development.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Approve the drawdown of resources to continue with the Community Capacity Building approach for two years to enable the delivery of the transformation and the current health and social care strategic plan.

Personnel:	Not continuing onto phase three would put existing community capacity workers at risk

Carers:	The report has been reviewed by the Chief Social Work Officer, Borders Council's Financial Officer. Building community capacity was an objective that was consulted on during the development of the health and social care strategy

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

Financial:	The report has been reviewed by the Chief Social Work Officer, Borders Council's Financial Officer. Building community capacity was an objective that was consulted on during the development of the health and social care strategy

Legal:	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.

Risk Implications:	To be reviewed in line with agreed risk management strategy. Inability to deliver enhanced capacity within the community will undermine the delivery of key strategic objectives

Background

1.1 The Community Capacity building approach has been used to good effect since its initiation in 2013, the first phase of the programme was to evidence that capacity could be developed and activities become self-sustaining by using a capacity building approach. This was established and approval was given to initiate the second phase and expand across all localities in 2016.

1.2 The second phase has been evaluated and the community capacity approach has lead to more sustainable outcomes within communities. For older people engaged in the physical and social activities set up means they are less likely to require health and social care supports now and into future.

1.3 A social return on investment has been carried out and has established a return of £10 for every £1 invested; this reflects the effectiveness of the staff team and the relatively high costs of older people's physical and mental ill health. Over 500 older people and 100 volunteers are actively involved in activities initiated by the Community Capacity Building team in 16/17. This grows monthly as the team initiates, support and create self-sufficient groups led by the community.

1.4 Community Capacity Building is a mechanism for early intervention, reducing health inequalities, supporting carers and supporting independent living. The team has and will continue to improve health and wellbeing through preventive and supportive community based care, this will enable the delivery of the strategic intention to move the balance of care into the community.

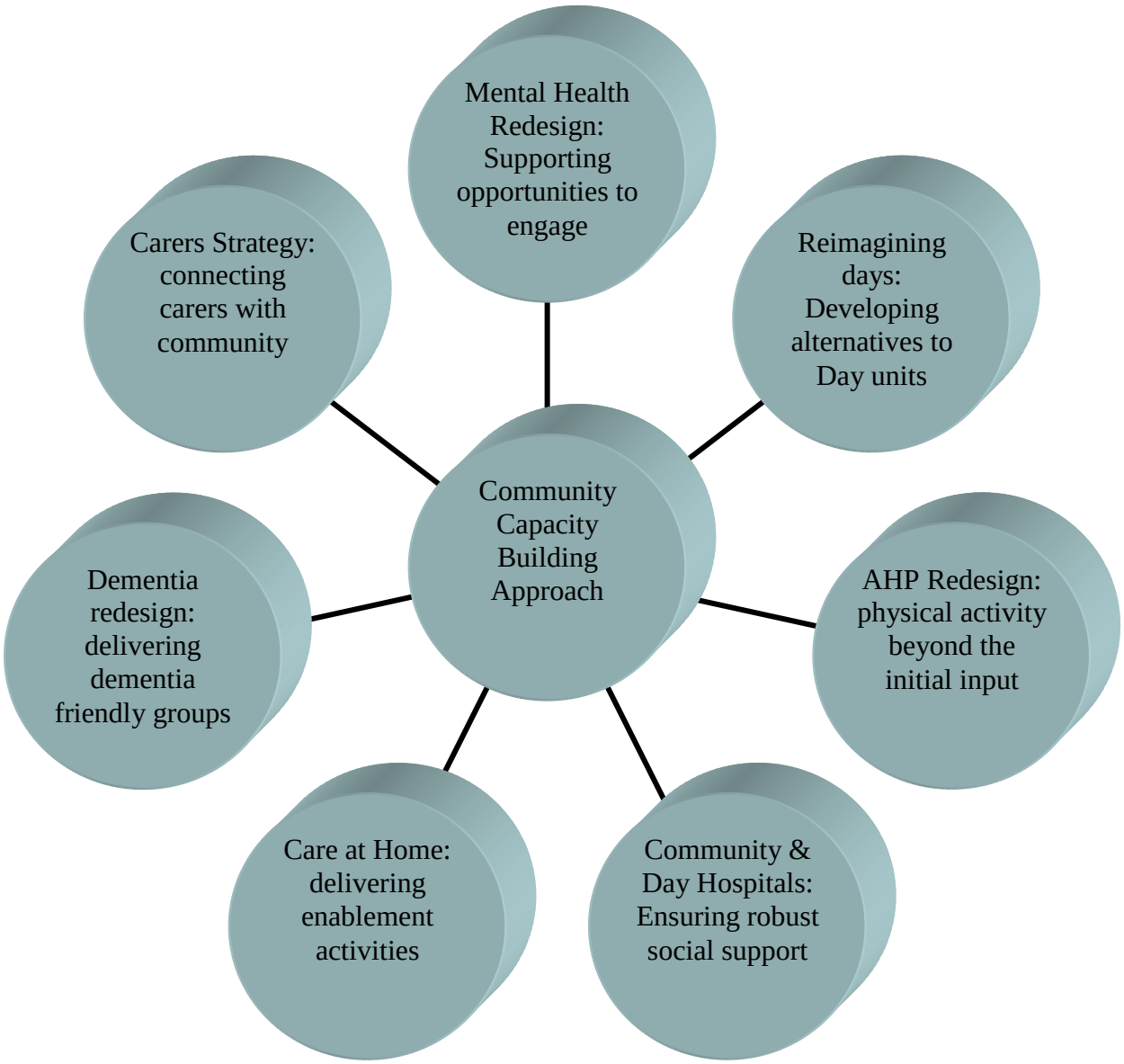
1.5 The Community Capacity Building Team have been recognised and cited as an example of good practice it is an enabler for the strategic transformations programme and is core to objective one in the Health and Social Care Strategic Plan. *"We will make services more accessible and develop our communities. Strong communities are a real asset of the Borders. Community Capacity building makes a big improvement to the health and independence of people. "*It is this enabling function that will form the focus of phase three of the project.

1.6 As public resources are tightened, those whose needs are significant but not high enough to meet eligibility criteria are at risk of being neglected, but if they receive no interventions then the risk is that as they age, their health conditions become worse than they might otherwise have been. Engagement with BCCBP activities can lengthen the time before older people need health interventions and better manage demand.

1.7 Recent research into risk factors for dementia highlights that some of the preventative activities are those the Community Capacity Building Team has specialised in: better physical activity levels, more mental stimulation and lifelong learning, reduced social isolation and less depression. It may be that more could be done by Community Capacity Building Team working specifically with people and carers with lived experience of dementia.

1.8 The Community Capacity Building team have an extant exit strategy outlined in previous funding requests (ICF & Change Fund). The exit Strategy was founded on the aspiration and realisation of groups becoming self-sufficient; this has been achieved. However it should be noted that this can stake some time and can be frail to begin with. Many groups will maintain themselves beyond the lifespan of the project with proper attention to succession planning they may last for some time.

1.9 Phase three places the Community Capacity Building approach central to the transformation agenda. All projects will rely on the creation and maintenance of robust communities. The Community Capacity Building approach will deliver this robustness. The Community Capacity Building approach has already supported the recommissioning of day units into the community; delivering specific activities to support transformation will enable other projects to deliver their strategic goals and efficiencies. The graphic below illustrates the central role for the Community Building Approach and Annex 1 describes in more detail the developments that will be supported.



Summary

2.1 Community Capacity Building has evidenced its positive contribution to the Health and Social Care agenda by delivering higher levels of engagement and activity for older people. This has in turn delivered a high level of social return as a result of a fitter more engaged elderly population who will avoid or delay the need for more costly alternatives

2.2 The most recent evaluation identified that there is a role for the community capacity building team in supporting service reform and is best thought of as a preventative resource for older people that can also be linked in to the focus of reconfigured services.

2.3 Phase three of the project development will enable and deliver clear and concrete transformation towards a community based approach. Specific projects can specify specific needs however it is believed that the generic approach around engagement, inclusion and support will deliver an advantage to all projects.

2.4 The Community Capacity Building team have already delivered transformation within the Reimagining daytime support project. The team effectively facilitated the decommissioning of the Ability Centre and creation of community based alternatives for clients to move into. Reimagining day time project transformation is scheduled to run for 18 months to two years. The role of the Community Capacity Building team in this project has been identified as critical to the delivery of the project and its efficiencies.

2.5 The Community Capacity Building team has a revenue cost of 163k, the current funding stream (ICF) finishes at the end of the financial year. The team consists of one coordinator (Grade 8) and four community capacity builders (Grade 6). The team cover all 5 localities. There are no accommodation costs as they make use of hot desking space. The table breaks down the funding requested:

Role	Grade	Annual cost	On cost	Mileage	Total
Community Capacity Team Coordinator (1)	8a	£28,329	£9,009	£2,466	£39,804
Community Capacity Builder(4)	6a	£84,484	£26,864	£11,508	£122,856
Total		£112,813	£35,873	£13,974	£162,660

Annex 1

Project	CCB contribution	Examples
Community & Day Hospitals: To implement best practice service models in Community Hospitals to improve patient pathway and make best use of resources.	By releasing capacity in other day time units (dementia day units and day centres) people not absolutely required to be in DH and struggling to move on can be accommodated Offering complementary activities to support people to access s both condition specific support groups and preventative activities,	Strength and balance Positive health activities Social opportunities
Care at Home: Targeted and appropriate Enablement within a homecare setting to deliver improved outcomes for individuals and contribute to reductions in the average hours of long-term care required. Links with Technology Enabled Care (TEC) to enhance or replace direct contact time by carers	Creating opportunities and viable alternatives to support for meals preparation Delivering complementary activities that support enablement agenda	Food train soup and sandwich clubs, alternative meals services food foundation Chair based activity strength and balance classes gentle exercise classes
Allied Health Professionals: To reshape AHP services in order to support the emerging community services “Out of Hospital Care” model	Offer complimentary activities that support the AHP role, i.e. enablement & healthy living Deliver a follow up to specific programmes of work into healthier active lifestyle and connecting people to ongoing opportunities	Chair based activity Strength and balance classes Gentle exercise classes Walking football , netball
Dementia Redesign: To deliver improved outcomes for clients who suffer from dementia.	Creating environments that are inclusive that offer safe and supportive environments. Working with business to support them to engage and understand different needs,	Dementia café Food Buddies Various social opportunities Men’s Sheds
Mental Health Redesign: To redesign services in line with Mental Health (MH) Needs Assessment Recommendations, MH Strategy and to achieve identified Financial Savings	Providing opportunities to engage and contribute to communities, both as a volunteer and participant. Building partnerships with healthier activities and a creative environments that accept and support all	Writing for well being Men’s Sheds Soup and sandwich Flourishing Borders Well-being week
Re-Imagining Day Services: To identify and deliver a more effective and efficient service options for day time support	Offering alternatives to day units and supporting people to make community connections	Vets breakfast clubs Walking football Walking netball soup and sandwich club New age curling

Carers Strategy: To work co-productively, through the Health and Social Care Partnership and children and young people's services, with carer representative organisations and with carers, to implement the legislation effectively.	Connecting carers with activities and pursuits that support their social and emotional needs To deliver activities that are specifically created with the carers in mind offering peer support and conversation	Positive health activities Social opportunities Food and Friendship meals delivery service.

Evaluation of the Borders Community Capacity Building for Older People Project

2016-2017

and estimate/forecast of the project's Social Return on Investment

'Put a ball at my feet and it becomes fun not exercise'

Sheila Durie
Haldane Associates

August 2017

Executive Summary

This evaluation was commissioned by the Scottish Borders Council to investigate the second phase of the Borders Community Capacity Building Project (BCCBP) funded by the Integrated Care Fund. The period under study was the year to May 2017.

Older people accessing the current range of BCCBP activities were interviewed individually or in focus groups, together with a cross-section of other stakeholders.

This report

- Demonstrates the impact of the expanded project in terms of increased outputs and scope
- Benchmarks the BCCBP with other similar interventions
- Explores the preventative value of the work of the project, using a Social Return on Investment approach.
- Presents a case for embedding the capacity building approach in mainstream health and social care services.

The main findings and conclusions were:

- The project works with 2 main theories of change, both of which were validated by the research

    a) That the community development approach will lead to more sustainable outcomes within communities and for individual older people, even though the approach takes longer to develop and embed in communities

    b) That engagement in the physical and social activities set up by BCCBP will mean older people are less likely to require health and social care supports in future

- The likely social return on investment in BCCBP is in the region £10 for every £1 invested, which reflects the effectiveness of the staff team and the relatively high costs of older people's physical and mental ill health

- BCCBP has involved over 500 older people in its activities during the year, but there are an estimated 26,000 physically under-active older people living in the Borders who could benefit from access to BCCBP groups, which in turn will reduce demand on services.

- BCCBP should have a long-term role to play in reform of health and social care services, particularly the pilots currently being put in place in some Borders' communities. Without community capacity building, these pilots may be less effective.

A number of practical and strategic issues have been identified which should be addressed. The aim is to realise the value of the community development approach in reforming services for older people, to ensure there is limited duplication and overlap going forward, and to ensure the BCCBP is maximising its potential.

Contents

1. Introduction

This report was commissioned by the Borders Capacity Building Project of Scottish Borders Council as part of the evaluation framework for the Integrated Care Fund, which now funds the Project.

1 a) Introduction to the project

The Borders Community Capacity Building Project (BCCBP) was set up through the Older People's Change Fund in 2013. It employed a team leader and 2 development workers, and focused on certain areas of the Scottish Borders (Tweeddale, Cheviot and parts of Berwickshire).

In November 2015, Phase Two of the project was funded by the Integrated Care Fund (ICF), and two additional development worker posts were approved in order to extend the project Borders-wide. These posts were filled in May 2016.

The project team is employed through the Scottish Border Council and has a project Board drawn from the key partner agencies of Scottish Borders Council, NHS Borders and the Third Sector Interface.

The key document the project is working to is the ICF Project Initiation Document (PID) but it is set within the Scottish Borders Health and Social Care Strategic Plan 2016-2019, as well as a range of national and local strategies and policies.

1 b) Aims of the evaluation and its scope

The aim of this evaluation is to examine the expanded project funded by the ICF, with a focus on the geographical areas of Teviot & Liddlesdale, Gala Water and Berwickshire where new activity has been established in the last year, and on newly developed activities.

The period under evaluation is from May 2016 when the new ICF posts were filled, to May 2017.

The purposes of this evaluation are to:

- Help present a case for embedding the capacity building approach in mainstream Council services
- Demonstrate the impact of the expanded project
- Benchmark the BCCBP with what is happening across Scotland and the UK
- Explore the preventative value of the work of the project, using an approach based on the principles of Social Return on Investment.

1 c) Methodology

The work has been independently produced based on research with service users, other stakeholders and partners associated with and involved in the Borders Community Capacity Building Project.

The author, Sheila Durie, is an evaluator and is experienced in the application of the Social Return on Investment methodology (SROI). She is an Accredited SROI Practitioner, a Licensed SROI Trainer and Accredited SROI Assurance Assessor.

The sources of information used were:

- Project documentation and records kept internally for the continuous evaluation framework established by the ICF evaluation team
- Semi-structured interviews with participants involved in BCCBP's activities
- Semi-structured interviews with volunteers involved in the management of activities
- Focus groups with participants involved in project activities
- Semi-structured interviews with other main stakeholders, starting with an initial list which was extended through discussion and recommendations from stakeholders
- Desk research on examples of capacity building programmes elsewhere and on current practices and thinking on community development, asset-based approaches to service development and co-production
- Desk research on the strategic context of health and social care in Scotland, and the various pilot initiatives on public service reform being developed in Scottish Borders
- Desk research to help in preparing a forecast/estimate value map using the SROI methodology using the literature around preventative health measures and well-being measurement.

The ICF evaluation support team had helped the project staff develop a set of questionnaires for use with participants, which were designed to be used over time to identify trends and outcomes for older people involved in the activities.

At the time of the survey and interview work however (May to July 2017) the questionnaires had not been in use for long enough to allow for measurement of outcomes over time, but it is suggested that they could be the basis for an evaluation of social return at a later time.

2. Context

2a) Relevant demographics in the Scottish Borders

Like every other area in Scotland, Scottish Borders has a growing population of older people, and demand on health and social care services is rising. The rise in demand is happening at a time of constraints on public expenditure.

The population of the Scottish Borders is older on average than the rest of Scotland. There are 26,000 people over the age of 65 living in Scottish Borders. By 2032, this figure is projected to increase by 51%, a faster rate than the 49% for Scotland overall. [1]

Most people do not live in concentrated urban areas, but in towns, small settlements and scattered homes. Almost half of the over 65's in the Scottish Borders live in rural areas.

The proportion of older people living alone is also much higher than the Scottish average, and this is known to be a factor which increases the risk of loneliness and social isolation.

Overall, the population of the Borders enjoys good health, but as age increases, the proportion of those reporting that their health is bad or very bad increases to more than 10% in the over 75 age group. Those aged 65 and over are also increasingly likely to be living with two or more long-term health conditions.

The numbers of people living with dementia in Scottish Borders is estimated at around 2,500, but is projected to rise. The very recent publication of research identifying 9 risk factors gives some basis

[1] The figures are taken from The Scottish Borders Health and Social Care Strategic Plan for 2016-2019

however for developing interventions which over time could slow the projected increase in the rate of older people living with dementia, some of which could be influenced by the BCCBP. [2]

Rates of physical activity are reportedly lower than average in Scottish Borders, and obesity rates are higher than average. In the age range 65-74, only 14% of men and 8% of women meet the recommended guideline for physical activity for this age group (which is at least 2.5 hours per week of moderate intensity activity in bouts of 10 minutes or more). 17% of men and 21% of women in this age range were considered to be 'completely inactive'. [3]

Thus there could be at least 20,000 people over 65 who would benefit from more physical activity, 3,000 of whom are completely inactive.

The rural and isolated nature of much of the area, the reliance on transport, the dispersed nature of services and the poorer rates of physical activity present challenges in delivering health and social care services for older people across the Scottish Borders, and in mounting interventions such as the BCCBP designed to prevent or ameliorate the impact of long-term health issues.

2b) Health and inequality issues

Deprivation is an issue in the Borders. The two most deprived areas are Burnfoot (Hawick) and Langlee (Galashiels), which are in the top 10% most deprived areas in Scotland for domains such as income, employment and health. Around 15% of the Borders datazones are in the top Scottish ones which are access deprived.

In areas of higher deprivation, it is known that hospital admissions are higher, and rates in the Borders are higher compared to the Scottish average (11% higher than Scottish average). [4]

Deprivation is not just confined to geographical areas - it applies to vulnerable groups who live in deprived circumstances, such as those with low incomes, and those living with mental health issues and disabilities.

The burden of caring is greater in more deprived areas and particularly in areas deprived because of access. 46% of carers living in the most deprived areas of the Borders provide 35 or more hours of care per week, compared with 22% of carers living in the least deprived areas.

Research also indicates that providing care for another person often affects the carer's own health. More carers (42%) than non-carers (29%) have one or more long-term conditions or health problems. Many carers are themselves older people.

The aim of the Health and Social Care Partnership is to invest in new integrated ways of working particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting carers and promoting independent living.

[2] The Lancet Commission on Dementia Intervention, Prevention and Care, at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31363-6/fulltext

[3] The Health and Well-Being of Older People in Scotland, 2001, http://showcc.nhsscotland.com/isd/files/older.pdf . Although this is an older report, physical activity levels have been very similar for some years as reported by the Scottish Health Survey

[4] Scottish Borders Health and Well-Being Profile, ScotPHO 2016 at http://www.scotpho.org.uk/opt/Reports/hwb-la/scotpho-hwb-profiles-aug2016-scottishborders-v2.pdf

2c) Social enterprise

The Social Enterprise Census conducted in 2015 revealed an estimate of 195 social enterprises in Scottish Borders, or 4% of the total number for Scotland. Scottish Borders showed 1.7 social enterprises for every 1,000 of the population, which is higher than the Scottish average of 1.0 per 1,000. [5]

The reason for identifying social enterprise as part of the context within which BCCBP operates is the Scottish Government's commitment to social enterprise, as evidenced by the 2017-2020 strategy, their belief in the role of social enterprise in public sector reform, the existing use of social enterprise within partner agencies (e.g. Fit Borders) and the scope to do more in this area, as reported by a number of interviewees.

There is however no recognisable social enterprise policy within the Health and Social Care Partnership, NHS Borders or Scottish Borders Council, but at locality level, there is a presence from the main development agency, the Scottish Borders Social Enterprise Chamber, on the relevant forums that BCCBP works with.

2d) Public service reform

The Health and Social Care Strategic Plan 2016-2019 for the Scottish Borders notes how vital service reform is to ensure that the region can meet future challenges with reducing inputs but at the same time seek to improve service quality.

The process of reform under the integration of health and social care is advancing, based on the principles of personalising care through encouraging participation, collaboration and co-production, improving communications, reducing duplication and making better use of new technologies and new models of care.

One such model is 'community led support' which is now being piloted in Scottish Borders, focused mainly on older people and adults with vulnerabilities. The community led support model provides a real opportunity to provide a direct link between communities and health and social work practice. In the Scottish Borders, community-based hubs are being established to locate social work and health and care assessment functions within communities and provide a one-stop shop to access services.

Other local initiatives that relate to community led support are the piloting on a small scale of the Buurtzog model of home care and the move towards locality planning.

In many ways, the trends are towards a return to past practices in social work and health, based on building good relationships within communities, locating services more clearly in the local community and building services around local strengths and assets.

For such models to work effectively will require an engaged and empowered community, and BCCBP is ideally placed to assist in this process.

[5] Social enterprise in Scotland: Census 2015 at http://www.socialenterprisescotland.org.uk/files/1a891c7099.pdf

3. Description of the project

3a) Aims and objectives of the BCCBP

The aims of the project, as expressed in the ICF PID are:

1. To implement a series of coordinated community support projects across the Borders
2. To adopt a person-centred approach to supporting older people
3. To encourage and support communities to create and run their own services
4. To better coordinate services and create a dynamic atmosphere in which ideas will flourish
5. To signpost people to other services
6. To work in partnership with all agencies involved in supporting older people
7. To reduce the time spent in hospitals and enable greater choice for people with long-term conditions
8. To meet unmet need in communities
9. To establish support mechanisms which improve quality of life and enable older people to live at home independently for longer.

Thus the aims of the BCCBP are a mixture of desired outcomes for different stakeholders and processes and standards for the project to meet.

The other stated aims contained in the PID are for BCCBP to:

- Integrate these community services with preventative health initiatives
- Reduce the need for day centres, GP consultations, respite care and 'even' emergency admissions.

3b) Range and scope of activities established

Project aim 1 was to extend the geographical coverage of activities to include Berwickshire, Teviotdale and Liddlesdale and other parts of Eildon, by funding additional development workers to initiate activities in these areas. The two new staff were employed in May 2016, one to focus on Berwickshire and one on Eildon. The pre-existing staff also helped develop new areas and new activities.

The towns and settlements where new activities have been developed over the last year have been:

- Berwickshire: Eyemouth; Coldstream; Greenlaw, Duns; Chirnside
- Teviotdale and Liddlesdale: Burnfoot/Hawick; Denholm; Newcastleton
- Eildon: Fountainhall; Stow; Lauder; Melrose; Selkirk
- Tweeddale: Innerleithen, Peebles; Netherurd
- Cheviot: Jedburgh.

The new activities that have been developed in Phase 2 that meet Project Aims 1, 4 and 8 are:

- Tea dances
- Soup clubs
- Mealmakers and the Food Foundation just starting
- Extending the walking football groups into other areas
- Walking netball (Peebles is only the second group set up in the whole of Scotland)
- Walking rugby (in development)

- New Age Kurling
- Mens Sheds
- Happiness Habit cafes
- Creative writing groups (just about to start in Duns)
- Events such as the Hawick Silver Sunday, Eyemough International Women's day; the Borders Shed Fest in March and the planned Health and Well-being Week in Berwickshire (September/October)
- Gala Water Directory
- Just Cycle social enterprise in Tweedbank
- Inter-generational projects such as the Jedburgh Gardening project and Eyemouth IT initiative
- The Borders Seniors Networking Forum.

Progress has been made with Project Aim 3, most obvious with the gentle exercise classes, the walking football and Men's Sheds.

Of the 8 communities where Gentle Exercise (GEx) classes have been set up so far, 4 are now self-managing and 3 are on the road to being so. Some groups have been able to attract independent funding to help with running costs.

The walking football group in Galashiels (Langlees) is now constituted, and is now part of the Gala Fairydean football club. The men involved are also helping some of their members set up clubs in other areas of the Borders.

Five Men's Sheds sheds now exist in the Borders in Galashiels, Jedburgh, Hawick, Eyemouth and Coldstream with others under development in Kelso, Selkirk and Duns. BCCBP has not been responsible for all this activity, as there are many partners, but in Berwickshire particularly, the BCCBP staff input was reported to have been absolutely vital in the development of the Coldstream Men's Shed.

Project Aims 2, 5 and 6 are reflected throughout how the BCCBP team approach their work, and the GEx case study opposite illustrates how the community development approach adopted by BCCBP works, and why it works well.

A number of activities that were established through Phase 1 of the BCCB project have been successfully replicated to other areas, which meets Project Aims 1, 4 and 6.

For example, there are now 6 walking football teams in Scottish Borders, and enough for a competition, the first of which was held in May 2016. This year's event in April attracted many more teams.

The most obvious way in which the project has met Project Aim 8 is through replication of activities into other areas. There was a lot of interest reported to the researcher in establishing Men's Sheds, soup

GEx classes case study

Class instructors are provided by Fit Borders, a local social enterprise. Fit Borders was already running GEx classes on a commercial basis. The programmes it had developed for the sessions are all scientifically based on Otago principles, and promote strength and balance for older people. Exercise can be standing or seated. The need for GEx was identified through discussions with older people, observations of older people finding Zumba Gold too hard, and being contacted by e.g. care homes to run classes.

BCCBP provided funds to subsidise classes in certain areas (e.g. Langlees) and to increase the participation rates of older people and those with health conditions, disabilities or mental health issues.

The aim at the start, with all the classes, was for them to become self-managing. This was up front during the taster sessions. Participants were involved in co-producing the classes from day one: deciding days and times of the classes, where to hold them, what level to pitch them at etc.

The partnership with Fit Borders has generated sustainable classes in areas which wouldn't otherwise have started up classes. The BCCBP budget includes funds to subsidise the costs of the instructor provided through Fit Borders where the income from class participants is low at the start. As numbers build up the classes become more self-sustaining, but fees are kept low so the classes may never become fully self-sustaining, especially in smaller communities.

clubs, tea dances and New Age Kurling in areas which didn't have them. What seems to happen as a development process is that individuals hear about classes/activities that are run in communities other than their own, they come along to them for a while, and then ask the BCCBP team to help them set up the activity in their own area.

Project Aim 8 has also been addressed by the BCCBP by supporting asset transfer discussions underway in two communities.

The Coldstream Men's Shed is constituted and in the process of taking on additional space through a negotiated asset transfer with Scottish Borders Council. The BCCBP development worker in Berwickshire has been a significant source of help to Coldstream Men's Shed in undertaking this.

She has also fulfilled the same role in Duns, where 'A Heart for Duns' Development Trust is also planning an asset transfer of a building for income generation purposes.

Project Aims 7 and 9 reflect the impact of the project's work on the situation of the older people attending the activities and getting involved in volunteering, managing and developing them. This is explored in section 4 Findings.

The activities that BCCBP has set up have therefore involved common themes: physical activities, social activities and food.

3c) Stakeholders

Social Return on Investment relies on identifying stakeholders that are materially impacted on by the activities under analysis. The main stakeholders who experience outcomes are firstly the older people who participate in the groups and activities BCCBP has helped establish.

The older people however are split into two main sub-groups: people who are attending because they gain some benefit from the groups, and people who gain benefit from the groups but who are also minded to volunteer their time to help manage and develop the groups.

Although the health issues and demographics of ageing are different for men and women, there was no clear difference in outcomes reported by older men and women. BCCBP has developed activities that appeal differently to men and women – walking football and walking netball for example – but the outcomes appeared to be similar.

Other direct beneficiaries may be the families of older people attending groups, as they feel happier that their older relatives are getting out of the house, in company, and are better connected, hence reducing their concerns. There were comments made by older people interviewed about what their families thought, but no representatives of this group were directly included in the research, so they have not been included in the analysis. This may be worth exploring in future.

The other key stakeholders are the range of health and social care services and professionals working with older people, and the range of partners helping BCCBP to develop its activities and who benefit from the increased levels of activity that BCCBP encourage and promote (e.g. the Drill Hall community association in Peebles, Fit Borders etc).

3d) Theory of change

Social Return on Investment is testing an organisation's 'theory of change' i.e. why the activities that are invested in would lead to change, and justifying a causal relationship between inputs, outputs and outcomes.

In the case of BCCBP, there are two theories of change involved:

1. That the community development approach will lead to more sustainable outcomes within communities and for individual older people, even though the approach will take longer to develop and embed

2. That engagement in the physical and social activities set up by BCCBP will mean older people are less likely to require health and social care supports in future.

To explore the first theory of change requires an agreed definition of 'community capacity building' and how it relates to the health agenda for older people.

The term 'community learning and development' acknowledges that different occupations play a role in developing local communities, and that this work encompasses not just informal learning support but also a concern for the wider development of those communities.

The United Nations defines community development as "a process where community members come together to take collective action and generate solutions to common problems." It is a broad term given to the practices of leaders, activists, involved residents and professionals to improve various aspects of communities, typically aiming to build stronger and more resilient local communities.

Community development is also understood as a professional discipline, with a set of values and practices which plays a special role in overcoming poverty and disadvantage, knitting society together at the grass roots and deepening democracy.

Community capacity building is one of the 'twin pillars' of community development, the other being community engagement. Most of the beneficial changes in communities come about through the process of engagement, whereby communities are able to respond to opportunities, or deal with problems, by bringing them to the attention of those with the ability to respond and carrying out agreed plans of action.

But such engagement cannot take place unless the community has the capacity required to engage in such discussions. Also, the most excluded groups and communities are most often the ones with the least capacity to engage. Communities with capacity are confident, organised, cohesive and influential, and mean that community

Development case study – Lauder example

Initially, it is about doing the 'market research', going along to already existing groups, local halls/venues/speaking with organisations like the Red Cross/RVS, speaking to the local community to find out what need there is in the area and what is already happening.

I also had a meeting with the local LASS (Lifestyle advisor) based in the Health Centres to discuss opportunities, what did they see was a potential 'need' in that community.

So, in Lauder, we were approached by both the Sheltered Housing Association in the area, and the Leisure Centre who had heard about some of the work we had been involved in within other areas. These meetings were initially to look at the goings on and engaging the older generation in activities/groups in the community. I fully understand that all communities have something on offer for a variety of ages, however, what's missing – who's needs are not being catered for?

Meetings are ongoing, however, we are looking to start:

- Walking football
- New age Kurling - we discovered the leisure centre already have 2 unused sets of kurling equipment.
- An afternoon drop in
- A lunch club –local businesses to assist with this
- A men's shed – initial meeting was instigated with members of the local Community Council

members are likely to enjoy a better quality of life. This means they can deal more effectively with public bodies to come up with solutions to problems or opportunities; that they can do more to set up and run projects or initiatives, and that they can encourage people to support each other.

Asset-based approaches to health improvement are becoming increasingly adopted, in recognition that communities themselves and individuals within them have some of the answers to health inequalities. These approaches involve assessing the resources, skills, and experience available in a community; organizing the community around issues that move its members into action; and then determining and taking appropriate action. This method uses the community's own assets and resources as the bases for development; it empowers the people of the community by encouraging them to utilize what they already possess.

The BCCBP staff work explicitly with a community development approach. They become visible in the community, and the community can learn to trust the staff. The first step in the process is engagement with the people in the community, and listening to what their concerns are and what could be done. Their role is facilitation, not management, and staff work alongside individuals in the community or with established groups and develop partnerships in order to set up new things. Staff can remain in the background for support but their aim is to develop individuals to take on the running of the group, get the group constituted and become sustainable in the longer term.

The interests of older people in communities and their perception of what is needed are the building blocks of activities which then go on to empower individuals to manage the activities themselves.

An example of the approach is the recent 'Re-imagining Days in Berwickshire' which were held in June in Eyemouth and Duns. Drop in events were held in both communities for anyone with an interest in making new connections in their communities. The events were supported by the National Development Team for Inclusion (NDTI) and the BCCBP, and aimed to create discussions and opportunities to explore activities suitable for all adults, including people with a learning disability, mental health issue or dementia, older people, carers groups and individuals who would like to be more engaged within their local area.

70 people altogether attended both sessions and the event had the support of the Executive Member (local Councillor) for Adult Social Care. He recognised the value of the community development approach:

"*The team has already been speaking to local people and getting their views about the types of social, leisure and learning experiences that are currently being provided across Berwickshire. They have been hearing about what is already working well and have begun to gather some ideas about other activities and ways of connecting that people might enjoy and find beneficial. They have also been listening to some of the barriers that people can face that stop them taking part in activities, such as transport, lack of choice, location or cost. I would encourage the people of Berwickshire to come along to their nearest local session so they can share their thoughts, give their suggestions and make sure their views are taken into account*."

An illustration of the difference made by the capacity building approach versus what other development practices are can be seen with some of the national sports associations. They have seen the spread of interest in walking sports and have begun promoting new groups. In Peebles, there was an idea to set up a walking rugby group associated with the local rugby club. The sports development officer did not set up taster sessions first and then invite people to come along, and did limited publicity, and it did not get off the ground as an idea. With the walking football in Peebles however, the BCCBP development worker advertised a time, brought a ball along and 4 jumpers for

goal posts, and then hooked up with the Community Association when she discovered they were also running a group at a different time. Peebles walking football is now successfully established.

Another illustration of the process concerns GEx classes. Live Borders had tried to set up GEx classes in Hawick and failed. BCCBP tried to do it as well in Hawick and it failed. Then BCCBP tried it out in Burnfoot, and it worked. The member of staff involved said that 'you need to go where the lynchpins are in the community, and find the activists and well-known people and start there'. BCCBP listened to what local people were saying, and spoke to the right people in the community in order to get it started. That requires an investment of staff time.

Thus the first theory of change is that BCCBP can contribute to public service reform by helping communities develop the capacity to specify and manage their own services to support their ageing populations.

The second theory of change the project is working with is that increasing the access to physical and mental well-being services within communities has a preventative role in reducing future demand on health and social services. The proposition is that engagement with BCCBP activities can lengthen the time before older people need health interventions and this will allow health and social care services to better manage demand in future. This proposition is supported by research evidence.

The relationship between physical exercise and avoiding chronic health conditions is evidentially strong. There is a clear causal relationship between the amount of physical activity people do and chronic health conditions:

'*Drawing from recent systematic reviews of the literature, encompassing both experimental and observational research, the evidence is strong that physically active adults aged 65 years and over have higher levels of cardio-respiratory fitness and physical function, improved disease risk factor profiles and lower incidence of numerous chronic non-communicable diseases than those who are inactive. Engaging in physical activity carries very low health and safety risks for most older adults. In contrast, the risks of poor health as a result of inactivity are very high.'* [6]

There is also good evidence that physical activity programmes which emphasise balance training, limb co-ordination and muscle strengthening activity are safe and effective in reducing the risk of falls. [7]

Physical activity can improve mental well-being e.g. the risk of depression, dementia and Alzheimer's can be reduced through physical exercise. It also shows that physical activity can enhance psychological well-being, by improving self-perception and self-esteem, mood and sleep quality, and by reducing levels of anxiety and fatigue. [8]

Conversely, there is mounting evidence that social isolation and loneliness can lead to physical illness, by making some illness more likely to occur and more serious e.g. links have been found between loneliness and heart problems and increased blood pressure. Loneliness has also been

[6] 'Start Active Stay Active 2011, Report of the four home countries Chief Medical Officers at https://www.gov.uk/government/publications/start-active-stay-active-a-report-on-physical-activity-from-the-four-home-countries-chief-medical-officers

[7] Start Active Stay Active op cit

[8] Start Active Stay Active op cit

associated with decline in functioning e.g. in performing daily activities such as bathing and dressing, and reduced physical mobility, which are of particular relevance to health and social care systems. [9]

The challenge is to show causal relationships between increased physical activity, improved mental well-being and reduced social isolation and changes in future demand for services in those individuals who have been participating in BCCBP groups. The research evidence strongly supports these interventions as being preventative and protective, but more study over time with participants would require to be done to prove the proposition.

3e) Outputs

The range of groups and numbers attending groups which have been running during the year under study are:

Name of Group	Activity	Reducing Isolation (RI)/ Physical Exercise (PE)	Participants	Volunteers	How often
Whim Hall	Kurling	PE	15	2	Monthly
Fountainhall (morning session)	Kurling	RI & PE	18	3	Weekly
Fountainhall (evening session)	Kurling	PE	10	2	Weekly
Netherurd	Kurling	RI & PE	10	2	Fortnightly – stopped until Autumn
Caddonfoot Village Hall Clovenfords	Kurling	RI & PE	10	1	Monthly to start with
Stow Lunch Club	Gala Water Directory	RI	16	4	Bi monthly for 8 months
Whim Hall	Happiness Habit Café	RI	16	2	Two sessions
Netherurd	Happiness Habit Café	RI	12	2	One off
Fountainhall	Happiness Habit Café	RI	31	2	One off
Stow Lunch Club	Happiness Habit Café	RI	16	4	Two sessions
Peebles drop-in	Soup Club	RI	10	2	Weekly
Peebles Craft Box	Crafts	RI	10	2	Weekly
Innerleithen Craft Box	Crafts	RI	6	2	Weekly
Peebles Walking Netball	Walking Netball	PE	10	1	Weekly
Senior Fellowship	Various Activities	RI	10	8	Weekly
Coldstream Soup Club	Soup Club	RI	20	6	Weekly through the winter months
Greenlaw Soup Club	Soup Club	RI	30	5	Weekly through the winter months
Eyemouth Diabetes Support Group	Diabetes Support Group	RI	4	1	Fortnightly

[9] For a literature review, see 'A Summary of Recent Research Evidence about Loneliness and Social Isolation, their Health Effects and the Potential Role of Befriending', Roberts, 2015 for ACVO, at http://acvo.org.uk/wp-content/uploads/2015/03/BEFRIENDING-REASEARCH-REPORT.pdf

Coldstream Men's Shed	Men's Shed	RI	50	5	Weekly
Eyemouth Tea Dance	Tea Dance	RI	25	5	Monthly
Eyemouth Walking Netball	Walking Netball	PE	9	2	Weekly
Get Connected	Intergeneration al IT Club	RI	5	3	Varies
Coldstream Walking Football	Walking Football	PE	12	1	Weekly
Eyemouth Walking Football	Walking Football	PE	12	2	Weekly
Duns Men's Shed	Mens' Shed	RI	6	4	Weekly
Lauder Men's Shed	Men's Shed	RI	10	1	Fortnightly Initial stages of set up
Lauder Soup Club	Soup Club	RI	0	1	Fortnightly Initial stages of set up
Burnfoot GEx class	GExc	PE	15	2	Weekly
Jedburgh	GExc	PE	30	5	Weekly
Peebles	GExc	PE	15	3	Weekly
Innerleithen	GExc	PE	20	2	Weekly
Kelso	GExc	PE	40	5	Weekly
Leitholm	GExc	PE	15	1	Weekly
Selkirk	GExc	PE	20	2	Weekly
Total			538	95	

Thus during 2016-2017, the BCCBP has stimulated some 260 older people to engage in regular physical activity, has involved over 500 people in activity which builds social contact and has engaged almost 100 older people in volunteering within their community by taking on elements of managing the groups.

3f) Inputs

The budget for the BCCBP for 2016-2017 was £160,000. The total budgeted expenditure for the 3 year period of ICF funding since 2015 was £400,000.

This budget supported a team manager and 4 development workers, their travel and other costs and the activities fund.

In the SROI analysis, volunteer time has also been costed and included as an investment.

Section 4 Findings

4a) Participant outcomes

Some 45 older people involved in the BCCBP groups were either interviewed individually or involved in focus groups. They were involved across most of the BCCBP range of activities: walking football, New Age Kurling, GEx classes, soup clubs, men's sheds, walking netball, craft boxes, lunch clubs and directories and in general community development activities.

The common outcomes being reported by group participants can be summarised as:

- Improved physical fitness
- Eating better

- More social contact with others in their community
- More prepared to get out of the house and do other things
- Keeping mentally well.

All participants talked about the fact that the activities were fun, that they all had a good laugh and that this was motivating them to come back time after time. 'Put a ball at my feet and it becomes fun not exercise' sums it up.

In the physical activities sessions, when asked what they got out of it they replied 'a lot of pleasure'; 'it's good fun'; 'it's the only physical activity I can do but it makes a real difference to my long-term condition'; 'I've lost a lot of weight'; 'it helps with my coordination, balance and reactions because I have Parkinson's'', 'lots of us have arthritis and the walking netball helps with that', 'I can't remember the last time I went to my GP'; 'the longer we do it the longer we'll last'.

For those involved in the walking football, it was a way of being involved in something they loved but had thought they had lost forever – playing football.

The walking football team in Langlees reported considerable physical benefits from the regular exercise. The researcher was shown photographs of the group members at a tournament a year before, and the amount of weight loss between then and the present day was considerable (over a stone). One member reported huge improvements in stamina, and most reported that they had taken up other physical activities like regular walking, playing golf and cycling because they now felt much fitter, and were able to do more. Most now reported they were taking the equivalent of the recommended minimum exercise.

It had taken the group members about a year to get to this point and to experience the health benefits. The walking netball group would agree with this: they had been going about 6 months and were starting to feel the difference, but felt they could go further and improve their fitness.

The walking football group in Langlees recognise that they are becoming very competitive and physical as a team. They plan to set up a second group of newer recruits, who can go on the same journey as they did and start at a gentler pace, and extend the benefits to others.

The GEx classes help less physically able people make small but vital improvements to their physical situation. The classes are designed to – and were reported to – improve core body strength, improve coordination, encourage more walking and maintain well-being. They reported doing the exercises at home – they just needed to hear the music and they'd be doing the routines. One woman reported that even after 4 months, she could now bend down to her bottom cupboards and didn't have to ask her husband to do it, one said she could cut her own toenails again and another women who had been unable to use her mobility scooter because she could not raise her head up enough due to her arthritis had now overcome that and was getting out and about again.

During the year, the walking football group relied less and less on the BCCBP but still wanted their involvement to help with sponsorship, setting up a league etc – 'they're part of the team'. The group was very motivated and self-organising and very committed to what they were doing: 'there's places where this could go that even we can't see'.

Even although the aim of the group is primarily about exercise all participants reported that the social side was just as important. People reported that by concentrating on playing the sport, even at a walking level, or doing the exercise, meant all their problems were left behind, and so the session

helped to improve well-being. Then after the exercise, there was a cup of tea and a chat as a group, and this could be just as important a part of the session.

Women involved in the walking netball talked about how keep fit classes could be quite solitary, whereas the netball involved teams. None of the group had known each other before they started attending the group.

Friendships are formed, and if someone is not at the group, then someone else might decide to check out that they were OK. In one of the GEx classes, a woman became unable to attend because of her long-term health condition, but the women from the group go round to her house after their session, so she keeps up the social contact.

The GEx classes made a real difference to the self-esteem of the women who participated – 'the class is uplifting and I always come away feeling good. I've been in tears with laughter'.

The social contact was important within the community: 'it brings people together that wouldn't normally socialise together', 'anyone can do it but it's a lot better doing it with other people' (referring to craft activity); 'I know some people have met up with folk they haven't seen for 60 years – and they were only living on the other side of town!', 'they probably wouldn't meet up with each other without the soup club'.

One commonly reported feature of the BCCBP projects was the inclusive nature of the group. The walking football group in Langlees reported that everyone was welcome, and very few new recruits to the group didn't come back, but that was 'because we actively work at it'.

The men involved in the Men's Shed in Coldstream also talked about this. They started in November 2016, with around 12 members, and now have 50. The men there talked about how they had to work at not becoming a club just for a few men, and acknowledged the key role of the development worker in taking them to task when she felt they had lost sight of this. The members in the focus group said they had the biggest membership of any shed in the Borders, and put that down to the development workers' work in making sure the inclusive ethos was kept to, and keeping reminding them when they slipped. Now it had just become second nature.

Some men came in very unsure of themselves, some came just for the company, and some had come 'just for a laugh and a giggle'. Some wives are also involved in the shed, but even if they were not directly involved, the men know that they were benefitting. All the wives had been down to 'check it out' and give their approval. The wives benefitted by having 'more me time' with the men out of the house actively involved in doing something they loved doing. It gave many wives peace of mind.

Their outcomes were the pleasure of using their brains and skills they hadn't used for years and problem solving - people in the community brought in items for repair that no one else would repair, which taxed their skills and creativity. It's engaging them in a way that other activities haven't. A story was told about a man who was assaulted in the street and was left with a hairline hip fracture. He came back to the Men's Shed 4 weeks after coming out of hospital, and those who knew him reckoned the Men's Shed gave him the motivation and focus to recover much more quickly than he would otherwise have done.

Another reported that he had retired to Coldstream but didn't know anyone, but the moment he entered the shed 'I knew I was in a community'. The walking football participants also mentioned that those who had retired to the area but didn't know anyone had found an instant network of pals

through the walking football. ‘We helped one guy pave his driveway – we just turned up and helped him out’.

A number of participants talked about the importance of knowing that the activity, whatever it was, was going to be sustained. This came mainly from older people involved with activities that were longer established and which were pretty well self-managing. They contrasted this with other projects and initiatives – ‘some things just disappear because the funding has dried up – that’s really demoralising’.

This is fact was one of the key issues for the new staff when they started in post working in new areas – the scepticism and even downright hostility that met them because they were seen as ‘the Council’ and some communities had felt let down before by short-term initiatives.

A number of respondents reported feeling let down in the past when classes had stopped. There was some discussion about the difference in policy that allowed BCCBP GEx classes to continue even with small numbers, as BCCBP supported Fit Borders financially to run them if numbers were low, whereas Live Borders could be asked in to an area to run classes, but if numbers were below the minimum level, the classes stopped.

The finding here that it could take a year to turn around older people who were physically inactive beforehand into regular exercisers who reported feeling fitter and healthier, would suggest that a long-term investment is required if the majority of the 20,000 underactive older people in Scottish Borders are to experience health benefits.

As well as physical activity and social contact/reducing isolation, the other main thematic area was food.

The two soup clubs have really taken off from a standing start, with the support of supermarkets and volunteers from within the staff group in supermarkets.

Lunch clubs have always featured as community activity to support older people but reportedly, some of these are struggling to find volunteers. Soup clubs are a new name for an old activity, and this re-branding seems to have struck a chord and galvanised communities into action – ‘as long as they don’t think they are soup kitchens’.

Their popularity may also be a reflection of the growing issue of poverty, and the growing importance of foodbanks to support low income families. The soup clubs have developed an inter-generational aspect without that being an original aim. One operates after school closes on Fridays, so it attracts women and their kids to eat with the older people. For some people, old and younger, this might be their main meal of the day, and for families, it helps without stigmatising them as living in poverty and needing food banks.

4b) Volunteers

A few of the activities and groups set up by BCCBP are inter-generational and involve the participation of young people as volunteers.

The Jedburgh Gardening project was an inter-generational example which involved young people volunteering. This project may be more challenging to maintain as young people in secondary school inevitably move on, and the young people needed supervision and so it was a time-consuming project. Pupils volunteered to help with gardening duties, but were also helping to keep isolated

older people socially connected. The older householders reported really valuing the social contact as well as the practical assistance.

One of the development workers had involved 7 secondary school pupils in evaluating activities with walking footballers. The young people reported that the experience would make them volunteer again with older people: they were surprised at how much fun the walking football was and how engaging it was. Interestingly, the walking footballers found that the young people were not working well together as a team, and they began mentoring them to do a better job.

For BCCBP, the volunteers are group members who are prepared to step up and play a role in delivering some of the activities (e.g. organising the teas and coffees, home baking etc) or in managing the group as a whole e.g. developing a constitution and sitting on a management committee. By definition, these older people are likely to be more able.

Many respondents spoke of the difficulties and many barriers in encouraging older people to volunteer. Physical and mental inactivity would be just two, but others play a role as well, for example feeling 'I've done my bit' when they had had a working life.

Most groups and staff interviewed thought that as time went on, and the groups became more established, it was more likely that volunteers would come forward to sit on management committees. With the Eyemouth Tea Dances for example, which have been going for just a few months, the last tea dance attracted 27 people and more were offering to help. The worker involved in a partner agency thought that if they could only get a volunteer to set up a bank account then that group would be self-managing.

This echoes the finding that community development and capacity building outcomes need time (and investment) in order to materialise, but can be long-lasting. The main roles and skills that staff contribute are leadership and promotion and reaching out to partners/others. 'There's more to activities than just turning up'.

The volunteers who were interviewed reported that their main outcome, over and above those reported arising from the activity itself, was about the pleasure of 'giving something back' to their community. This was particularly apparent with people who had been working at a senior level and had been very busy, or who had retired to the area and didn't really know many people, so volunteering was a way of getting involved in the community and getting to know people.

There appear to be some differences between BCCBP and other agencies in how they perceive the relationship between services and volunteers and therefore different expectations about how volunteers should be supported. It may be, as one respondent suggested, that BCCBP is attracting more able volunteers.

Other agencies e.g. NHS Borders and the Third Sector Interface have programmes of volunteer training and the trend over the last few years has been to treat volunteers increasingly as employees, with similar rights and responsibilities as employers placed on the agencies who are 'utilising' them as volunteers. BCCBP volunteers however are local older people who are participating in the activity, and who may or may not take on a role of managing activities they are interested in. BCCBP staff have to undertake risk assessments for activities etc., but the actual volunteering role is much more informal in most stages in the group's development, until they become constituted.

There is an important point here which merits further discussion. If 'the community' is going to be involved in co-production of new services that build resilience which are preventative and supportive of older people living well as they age, and local people are genuinely involved in leading them, then the definition of what a service is may have to change. Some of the formality and regulation surrounding volunteering etc may have to be relaxed. Otherwise these co-produced services will slide back into the inflexibility that integrated services are at the moment trying to get away from.

4c) Outcomes for other stakeholders

Under the SROI approach, partners and collaborators usually experience outcomes as a result of the activity's impact on participants. In this case, the statutory health and social care services could expect a gradual reduction in demand for health and social care services over time from older people as BCCBP continues to run and develop its activities.

As the older people involved in physical activity groups regain some measure of fitness and reach physical activity targets, this could translate into a reduction in GP visits, reduced need for medication, reduced falls and delay the onset of long-term health conditions, or prevent long-term health conditions worsening at the same rate as would have been the case without intervention.

There were enough reports from group participants during this research to suggest that all these outcomes are happening – the question is to what degree. The forecast of social return in section 5 below will attempt to model some answers.

All the groups however reported that social and mental well-being outcomes were just as important. Mental well-being contributes towards good physical health, whilst loneliness and isolation lead to deterioration in physical health. Mental health is one of the priority areas for the NHS in the Borders, so anything that supports mental well-being of older people could also contribute to managing demand for services.

'Meeting strategic objectives' is not generally defined as an outcome for partners as there are many ways of achieving this, but Scottish Borders Council, and specifically the CLD service, were reported to have few targets for work with older people, and therefore BCCBP is fulfilling this strategic objective. CLD were widely reported to want to work more with older people, but there are limitations on resources to allow them to do this, so the partnership with BCCBP is an important one for them.

In the view of a local Councillor involved with some of BCCBP's activities, the project has significantly enhanced the Council's reputation within some communities because of their approach. One stakeholder reported being surprised when she realised the staff were Council staff as they obviously had a different approach. Many others recognised that the community development approach as characterised by the flexible approach of the staff was important. Scottish Borders is an area that needs flexibility of approach, as every community appears to operate differently, and what works in one place will not necessarily work in another. Knowing this and being able to deliver it in practice were seen to be two different things, and BCCBP was acknowledged as being good at delivery that matched the needs of individual communities.

The BCCBP resuscitated a previous care forum as the Borders Seniors Networking Forum in 2016 and recruited an active Chair to drive it forward with admin support from one of the development workers. The Forum now has around 50 organisations on the database and meetings are well attended.

It addresses the lack of communication between statutory staff and between them and third sector workers across the Borders, and its primary aim is to bring people together to share information. There is a need for a body to understand all the policy changes that affect older people and share that information, as well as communicate vertically to represent the views of older people. It has been successful enough for there to be a discussion about the Forum standing on its own without the support of BCCBP and finding its own funding.

When asked what impact BCCBP had in developing the work of partners, there was almost universal agreement that the work proceeded much more quickly. The practical organisational and promotional skills of the staff were extremely important in moving things along rapidly. 'I would have done something myself eventually but it would have taken me much longer and I would have been less effective'.

BCCBP can help local groups do things they couldn't do themselves. The Stow Lunch Club is a very successful lunch club. The organiser had made contact with BCCBP as she was concerned however that the lunch club was not reaching out to isolated people. Conversations with lunch club members led to the idea of creating a directory for the Gala Water area. The organiser had wanted to do this for some time, but wouldn't have done it without BCCBP. The members made the decisions about the information in the Directory and the presentation of it, so the Directory was co-produced. The members had taken a while to voice their views, but the development worker listened to them and was very good at feeding back. The Directory has been well used, and all copies are circulating in the community.

BCCBP can also add value to statutory partner's activities e.g. by promotional activity, using social media, contributing own networks to get things done and giving practical assistance.

BCCBP may also be creating outcomes that are not just about health. It has helped establish one social enterprise – Just Cycle – and has been involved in a very recent partnership with another one – the Food Foundation in Peebles – to pilot provision of hot meals for older isolated people. Both of these deliver employability and training outcomes for those out of the labour market or who have difficulties in accessing mainstream employment.

Just Cycle is an emerging social enterprise, which is to say that it is still working to build up its earned income and reduce its reliance on grants. The BCCBP helped Just Cycle get started, paid for some initial expenses, helped find its own premises, supported the development of a new website and fundraised for some costs. It helped establish a relationship with Criminal Justice, where trainees are involved in the bike maintenance workshops. Most recently the Coldstream Men's Shed have been generating funds by selling bikes, and men there are being trained in bike maintenance.

Perspective of a development worker

Interestingly, I feel since my return [from maternity leave], there has been more of a steer to look at food and nutritional opportunities for older adults. For example, lunch clubs. I personally feel like this could be because other groups relating to physical activities (football/gentle exercise) become almost a necessity for a community as they have heard about them elsewhere and would like it themselves. From an internal point of view, I think looking at food and nutritional projects may impact on costs for homecare and be an advantage for costs within SBC.

Using the example of the football, it became very clear very quickly to me, that apart from some marketing costs, the core of the group can be set up for minimal cost, with 2-4 participants initially, some grass land, a football and jumpers….Word of mouth has been a great asset to the project.

Since my return, a number of the classes have sustained their numbers of people attending, however, in some cases, the numbers have increased. This without a doubt has to be down to the advertising and people becoming a lot more aware of our existence, there have been a few of the groups who have had to relocate to bigger premises due to large numbers attending.

With every project/group/activity, it is important to be aware of the financial impact, that generally, people are happy to pay no more than £2.50.

Setting up a new organisation however is almost a full-time job in its own right, and the key need for Just Cycle is to find funding to employ a full-time worker. The link with BCCBP themes however is clear: encouraging physical activity through stimulating communities to organise activities for themselves, and linking community initiatives together in order to increase capacity.

There was agreement from the agencies most involved with social enterprise that there was more scope for BCCBP to get involved in developing social enterprises but the project is restricted by its Local Authority status.

It is clear that BCCBP has had a tricky relationship with the third sector, especially in its earlier days, which may be construed as a negative outcome. Initially, the project was seen as being in direct competition to the third sector, and as resources reduce over time, this could resurface as an issue.

There also appears to be a conceptual issue over to what extent BCCBP is perceived to be about community development and the comparison with the models other agencies are using to underpin their work that are also about community development or capacity building. There appear to be perceptions of duplication or differences which are not helpful. As one respondent put it 'the whole of the community development ground has got very muddied and crowded'.

In the health field with older people, where the more recent emphasis is on the community doing more for itself and being supported to do so, there is a danger of this issue becoming less clear as more community-based initiatives are developed. There appears to be a need for some clearer leadership and definition and practice development.

4d) Process Evaluation

The view from the staff about why what they do works is that proactivity is the key. By going out into communities and initiating conversations, things happen.

Promotion appears to be one of the staff's most important project activities. The role of staff in promoting activity was mentioned by a lot of community respondents as being an extremely important role. Persistence pays off, and many people from the community reported that without this promotional effort, involving both the budget and the skills of the staff, many activities may not have got off the ground or been sustained.

Talking to community activists also highlighted creativity as a key ingredient. The researcher was struck by the enthusiasm of all those involved, and how engaged many participants were in their groups, and how they talked about their future plans and were interested in developing new things. The role of the development workers was critical in creating that atmosphere: 'she might only be in for an hour but there's such a buzz you think she's been here all day'.

The dispersed nature of the Borders and having a Borders-wide remit both places restrictions on the team and makes effective functioning more challenging.

There is no office for the development workers to be based in, they are working from their cars and using phones and tablets as IT support, team meetings are more difficult to schedule due to dispersed working, and there is just less time available to harmonise, practice and promote learning amongst team members. It appears that flexibility is a key strength in the team.

It is not surprising therefore that there appears to be subtle differences of approach discerned by the researcher between team members. This is mainly about the emphasis on sustainability of services from the outset, how up front that is in discussions with community leaders and how much responsibility is taken on by individual development workers for activities.

However the team do all learn from each other and adopt new practice, so a bit more time for discussing underpinning issues and philosophy would be a worthwhile investment.

4e) Aims and objectives not achieved

In terms of the main ICF PID aims and objectives, all appear to have been met, but those which are critically dependent on SBC and the NHS have been only partially met. These are the 2 supplementary objectives:

- Integrate these community services with preventative health initiatives
- Reduce the need for day centres, GP consultations, respite care and 'even' emergency admissions.

Staff and community respondents mentioned the need for better partnership working with NHS services (whether preventative or not) at a very local level e.g. with district nurses. Respondents said that more promotional information about activities could be handed out to more isolated people by those who could encourage them to join in. District nurses, home care providers and GP's could all help promote the activities to those least likely to find out about them through friends and family.

This is an area where the involvement of the BCCBP project in piloting the Buurtzog model could be tested on a small scale. More could be done for example visiting people discharged from hospital and/or ensuring care provider staff and district nurses give out leaflets advertising new groups aimed at helping people regain some fitness through Gentle Exercise.

Providing evidence that the BCCBP can reduce the need for mainstream primary health and social care services is outwith the scope of this evaluation, but has been looked at and modelled in Section 5 below.

4f) Best practice review

One of the most striking features of work in this field is how little work has actually been written up over the last decade in community capacity building, despite the Scottish Government still recognising that community capacity building underpins achievement of national outcomes and is one of 3 priorities for Community Learning and Development (CLD).

A survey of community capacity building [10] showed that the understanding of the different terms vary enormously, and a very extensive list of activities was presented which staff regarded as being evidence of community capacity building, from youth work to volunteering events to provision of mobile childcare services.

A quarter of CLD staff however were reported not to have much involvement with community capacity building.

[10] 'A snapshot of community capacity building in Scotland', 2011, Learning and Teaching Scotland at https://blogs.glowscotland.org.uk/glowblogs/WALT/files/2011/03/FINAL-Community-Capacity-Building-in-Scotland-survey-2011.pdf

Scottish Borders is one of the few areas in Scotland which has a dedicated Council community capacity building team [11] and Scottish Borders is unique in having a team that focuses on older people. In other areas, these functions are performed by CLD teams. Most CLD staff view community capacity building as part of what they do rather than all of what they do. The BCCBP as an entity therefore appears to be unique.

There is now however a widening scope of policy where community capacity building and community engagement are becoming recognised as necessary and effective. The National Standards for Community Engagement cite many examples where community engagement underpins effective practice, from participatory budgeting to town centre design to asset transfers to communities, all of which were mentioned in the interviews with stakeholders and partners of BCCBP as being areas where BCCBP could add further value.

The recent Community Empowerment Bill has given new impetus to community capacity building, as has the Christie Commission and the integration of health and social care.

The issues which affect delivery of community capacity building practice have been identified as:

1. Resourcing/funding
2. Commitment of the host body – is it 'mission critical' or not?
3. Staff development and training in community development practice and theory
4. Policy and practice development
5. Issues for community groups in building their capacity, e.g. involving new people
6. Accountability to the communities being worked with.

All of these issues affect BCCBP to a greater or lesser extent. What might be done to ameliorate the impact of these issue on the BCCBP and older people's integrated services, will be discussed in Section 6 below.

Section 5 Forecasted Social Return on Investment

5a) Introduction to the methodology

SROI is a principles-based approach to measuring, accounting for and managing social value. It explores what difference activities make to people's lives, examines how significant these changes are and gives an account of the importance of these changes by assigning financial values to outcomes for stakeholders. The key principles are:

- Stakeholder involvement
- Understanding change
- Valuing what matters
- Only include what is material
- Do not overclaim
- Be transparent
- Verify the result.

[11] Perth and Kinross Council, Moray Council, Shetland Islands Council and Argyll and Bute Council were found to be the only ones that have a dedicated capacity building team separate from CLD staff

The framework for developing an SROI analysis has been set out in the SROI Guide, and this analysis for the BCCBP has followed the principles and standards for SROI contained in this Guide.[12] SROI is now used across the world, in 35 countries, as a way of exploring value creation in a huge range of activities.

The key tool for SROI analysis is the value map. This records the relationship between BCCBP's activities and the changes created for the different stakeholders involved, shows how these changes have been measured and valued, and results in a calculation of the ratio of social value resulting from the investment in BCCBP's activities.

In this case, the value map is a forecast, or estimate. This means that the level of rigour required of an evaluative study could not be guaranteed due to lack of time given for the evaluation overall, and so the quantities of outcomes for each stakeholder have been based on estimates, or on desk research where it exists. The financial proxies however are likely to be those used in an evaluation study.

The value map is contained in a separate Excel spreadsheet, but elements of it are presented in the Appendix.

During the Older People's Change Fund, Scottish Borders used a scorecard system for deciding on investment, and set a benchmark of a return on 3:1, which the Joint Improvement Team thought was 'ambitious'. [13]

5b) Construction of the value map

The outcomes from this evaluation for different stakeholders were clearly expressed during the interviews and focus groups (see Sections 4a to 4c).

The project records provided information about numbers of participants, volunteers and the breakdown of physical versus mental well-being/reducing isolation aims of each activity.

We know from previous surveys conducted by the BCCBP project that 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. Applying these to the numbers of participants gives us an estimate of participant outcomes, and then an estimated range of health and social care outcomes for other stakeholders such as reduced demand.

These numbers were backed up by what the 45 participants involved in this study reported. This is a relatively small sample of the participants, and may not be representative of older people as a whole, however guidance on SROI suggests that when you stop hearing new reports from participants then there may not be anything new to uncover even if a larger sample is interviewed. This in the researcher's view is the case here.

5c) Valuation using financial proxies

SROI is different from other methods in taking valuations from different stakeholder groups and adding them together to calculate overall value. Value is perceived differently by different

[12] First produced in 2009 by the SROI Network, funded and supported by the Office of the Third Sector and the Scottish Government and subsequently updated by Social Value UK. See http://www.socialvalueuk.org/resources/sroi-guide/

[13] Change Fund report 2015, at www.jitscotland.org.uk/change-fund-report-june-2015-final/

stakeholders, but SROI principles have been developed to ensure we understand as much of the impact as possible, rather than take the perspective of one stakeholder only. The way to do this is to find financial proxies that represent the value from the stakeholder's perspective for each outcome.

This approach is also in accordance with HM Treasury's Green Book, which now recommends that stakeholder valuation should be attempted whenever possible. [14]

In a full SROI evaluation analysis, information about how some stakeholder groups value outcomes would be secured directly from engaging with that stakeholder group.

The purpose of valuing participants' outcomes is to understand how relatively important these outcomes are, in the whole scheme of things. If an intervention has really made a difference to someone's life then participants should value it more highly. When asked, Gex participants reported that on a scale of 1 to 10, where 1 was not important and 10 was hugely important, that GEx classes were scored as 10 and so were very important in their lives.

As SROI has developed over the last 10 years more commonality in valuing some outcomes has been created and there are now numerous sources of financial proxies. [15]

There are a range of methods based on existing economic evaluation approaches which are recommended for use in developing financial proxies, some of which are relevant to particular stakeholders, and some of which have been used to evaluate the outcomes here:

- Changes to unit or marginal costs (whether potential or actual cash savings)
- Changes to income
- Revealed preference i.e. the preferences of individuals can be revealed by the market price for an equivalent outcome
- Hedonic pricing, which is a type of revealed preference proxy i.e. valuing the change in the utility of something by seeing how the valuation of it changes as its characteristics change. (This approach has mainly been used to value changes in environmental amenity by seeing how they affect house prices)
- Stated preference i.e. directly asking people to give their valuations through surveys of large samples
- Contingent valuation, which is a type of stated preference proxy i.e. directly asking people to give an estimate of their willingness to pay to have something or avoid or accept something
- Travel cost method, which is a type of stated preference proxy, i.e. directly asking people to state the time and travel costs that they are willing to incur in order to have something, which can represent the value of access to something.

However, recent work[16] on Subjective Well-Being Valuation has allowed robust methods to be applied which overcome some of the limitations of some of these more traditional approaches.

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209107/greenbook_valuationtechniques.pdf

[15] Global Value Exchange, 2015, 'Discover your social value', Glasgow: Social value UK. Available from: www.globalvaluexchange.org

[16] Fujiwara, Kudrna. and Dolan, 2014. 'Quantifying and Valuing the Wellbeing Impacts of Culture and Sport', London: Department for Culture Media and Sport. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304899/Quantifying_and_valuing_the_wellbeing_impacts_of_sport_and_culture.pdf [Accessed February 2016].

Wellbeing valuation takes data on people's subjective wellbeing (SWB) from large surveys and uses statistical or econometric techniques to assess how different life events impact on SWB. The British Household Panel Survey (BHPS) for example has surveyed over 10,000 people year-on-year asking them about 500 questions on different aspects of their lives, including questions about wellbeing and happiness.

Data like the BHPS can be used to estimate the impact that a non-market good - or outcome - has on a dimension of SWB, such as improved life satisfaction. The BHPS can then be used to look at the impact that extra income has on SWB. From a comparison of these two estimates, we can then calculate the equivalent value of the particular non-market good i.e. the amount of extra income that would be required to produce the equivalent impact on life satisfaction.

So for example, having a skin condition or allergy can reduce life satisfaction. The SWB approach calculates that you would need an extra £895 in income per year to return you to the same level of life satisfaction you would have if you did not suffer from the condition. This figure could be used to value a treatment that removed the skin condition or allergy, from the perspective of the patient. [17]

Using this type of approach has found values for a range of long-term health conditions, and found that improvements in mental well-being have a very high valuation, as do increased independence. The value of volunteering has also been studied using the SWB method. [18]

5d) Deductions to avoid overclaiming

Once the quantities of outcomes multiplied by their value has been calculated for each stakeholder for each outcome, deductions are applied to get the final value. There are two main deductions: deadweight and attribution.

'Deadweight' recognises that some outcomes might happen anyway, that participants have other choices they can make to get the same outcomes and if they weren't taking part in the BCCBP activity they might be doing something else that delivered the same outcome for them.

Duplication and overlap between BCCBP and other activities (such as those of Local Area Coordinators) was mentioned by some statutory stakeholders. It may be that as resources for each initiative have reduced, there has been a greater need to develop activities in partnership, and this practical situation may be giving rise to the perception that there is duplication going on. There could also be some confusion operating about the different terminology.

Older people interviewed however did not see this. In their view, the BCCBP activities are occupying a niche that nobody else is in, so duplication is less of an issue than perceived. Even when there were other similar activities going on in a community e.g. GEx and other exercise classes for older people, participants stated that the GEx classes were different, as they were more explicitly based on addressing the health conditions they had. They would not attend the other classes because they did not explicitly help their health condition, and with GEx, there was more emphasis on the social aspects.

[17] Fujiwara, Kudrna. and Dolan, 2014, 'Valuing Mental Health: how a subjective wellbeing approach can show just how much it matter', London: UK Council for Psychotherapy. Available from: http://media.wix.com/ugd/9ccf1d_b3cfc47c5b2043ec92b32f558d15d97f.pdf

[18] 'Well-being and civil society: estimating the value of volunteering using subjective well-being data', 2013, Fujiwara et al for Department of Work and Pensions at https://www.gov.uk/government/publications/wellbeing-and-civil-society-estimating-the-value-of-volunteering-using-subjective-wellbeing-data-wp112

Other participants however reported they were quite active in their community, and if they weren't going to e.g. walking netball they might be going to a craft session. This would obviously not get them as fit, but would still reduce their risk of isolation. In an evaluation study, this would be looked at explicitly, and although each participant in this study was asked what they might do if BCCBP and its activity wasn't there, responses varied a lot, so it became difficult to estimate an average figure for deadweight.

The other factor is attribution: who else contributed to achievement of outcomes. Friends and family might be an example of another stakeholder with power to influence how people participated and the outcomes they achieved. TV advertising trends may have an effect, a GP prompting someone to do more exercise – these are all examples of attribution. This is a difficult factor to isolate, as generally speaking there is limited research in this area and individuals vary significantly. More in-depth interviewing would help, as well as knowing who else was supporting the older people involved in the activity, such as a home care worker or a district nurse. Attribution is clearer where outcomes relate to community organisations, as BCCBP works closely in partnership in different communities.

5e) Duration

Another factor which can make a huge impact on the SROI ratio is the duration of individual outcomes. Duration is about how outcomes last into the future, without the intervention being present.

The aim of the BCCBP is that the groups can sustain themselves after a period of time. The evidence from the research is that this is largely the case, but for how many years is uncertain. The groups' answer to the question varied with how long they had been established, so the only way to determine duration is to monitor this as the BCCBP continues into the future.

Judgements and estimates however can be made.

If a group stopped, then the mental well-being outcomes would presumably stop, although they might be sustained for a period, based on what respondents said in this study about developing friendships amongst the group.

The physical outcomes would last, but would drop off over time, unless the new levels of fitness were maintained by other activities, as was suggested by the walking football group.

Thus in this forecast the assumption has been a conservative one of relatively limited duration, but this may prove to be too pessimistic in reality.

5f) Estimated SROI ratio

The Appendix contains details of the estimates and judgements made in exploring the social return from the BCCBP, but the best estimate of the social return for the BCCBP is around £10 for every £1 invested.

80% of this value accrues to older people themselves, and 16% to the health and social care system in terms of reduced demand.

5g) Sensitivity analysis

Analysis suggests that the range of social return varies between £5 and £18, depending on the assumptions made about duration, deductions and quantities.

The longer term impact of improvements in fitness, exercise levels and mental well-being could lead to a delay in the onset of health conditions that require treatment and/or a better ability to self-manage health conditions.

If a delay of 5 years for the onset of conditions is modelled, then based on the average NHS spend per person at different ages, the ratio is likely to be around £14 to £1 invested.

The individual return to the health and social care system as a stakeholder would be in the region of £6 to £1.

5h) Conclusion and recommendations about the SROI method

Other SROI studies that have looked at interventions similar to BCCBP's are:

- The Paths for All study from 2012 found a return on £8 for every £1 invested in walking projects for older people [19]
- the Bums off Seats study found a £4 return [20]
- The Extra Time intervention of using football as the basis for social and physical activity for older people found a £5 return [21]
- Peer support for people with dementia designed to reduce isolation found a range between £1.15 and £5 [22]
- The Community Champions capacity building programme to promote health and well-being suggested a return of £5 and a Community Assets programme suggested returns of £6. [23]

Thus this forecast/estimate of SROI is in the same ballpark as previous studies, if not slightly higher, as BCCBP encompasses a number of aims.

The SROI analysis supports both theories of change that BCCBP works with:

- The community development approach, although more resource intensive, delivers better and more sustainable outcomes
- The return for the health and social care system in terms of reduced demand in future is likely to be well over the 3 to 1 benchmark stipulated.

The longer term impact of the BCCBP in reducing demand in the health and social care system could be significant. The theory of change is that by BCCBP setting up groups in Borders communities aimed at improving physical fitness and reducing social isolation will help older people manage their own health better and reduce the burden of ill health in later life.

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[19] 'Walk Glasgow SROI Study' 2012, Paths for All at http://www.pathsforall.org.uk/sroi

[20] 'Bums off Seats' 2011 at http://greenspacescotland.org.uk/sroi.aspx

[21] Quoted in 'Translating the evidence: What works for physical activity?, 2010, BHF at https://www.nice.org.uk/.../health-economics-4-review-of-sroi-evaluations-23682624

[22] 'Peer support for people with dementia', Semple et al 2015 at http://www.scie.org.uk/prevention/research-practice/getdetailedresultbyid?id=a11G000000CbjT1IAJ

[23] Reported in 'Community Engagement SROI review' 2015 for NICE at https://www.nice.org.uk/guidance/ng44/evidence/health-economics-4-review-of-sroi-evaluations-2368262416

This evaluation has found evidence of health improvements reported by individuals that would suggest this longer-term reduction on health and social care demand would be realised in practice, but it would be helpful if BCCBP were able to measure physical health indicators in some groups to show this linkage more clearly and gather more in-depth evidence of this effect.

Section 6 Conclusions

6a) Main Conclusions

The findings here support the following conclusions:

- BCCBP has met all its project aims and objectives 1-8
- The level of outputs has significantly increased with the expansion of the team in 2016
- The project staff are very well regarded and valued within the communities where they operate
- The staff would benefit from more support to articulate and embed the community development principles inherent in their methods
- The outcomes for older people in terms of improved health and well-being are significant, but a new group designed to increase physical activity levels needs around a year before it can be said to be generating significant health outcomes
- Groups can be set up in less time, but they are not worth investing in, as they are not sustainable, do not led to sustained outcomes and do not contribute to the aim of building community resilience and capacity
- The community development approach therefore delivers value for investors
- The BCCBP has not met its two supplementary aims as they rely on cooperation with other health and social care professionals, which has not been within the power of the project staff to influence, and this should be addressed as a strategic issue
- There are some challenges with partnership working with the third sector which should be addressed as a strategic issue
- BCCBP is not realising its full potential to contribute to the strategic development of the health and social care agenda for older people in the Scottish Borders
- There is more scope to develop local social enterprise responses to health and social care service needs and there are local partners to work with
- There is significant potential for BCCBP to provide the underpinning community development activity that will be necessary in ensuring public service reform for older people and supporting the introduction of new models such as community led support, Buurtzog care model and participatory budgeting as part of its longer-term development beyond the ICF.

6b) What's in a name?

Many respondents stated that they thought the name of the project was not right and had led to misunderstandings of what the project was trying to achieve. Many suggested the project should be re-branded, but no one could suggest a better name that encapsulated the dual focus on older people and building community capacity.

If the project is to continue beyond March 2018, it would be worth organising a workshop with stakeholders to explore a new brand identity.

6c) Opportunities

Respondents thought new activities could usefully be developed in:

- music
- creative writing
- more cultural and artistic activities
- more food projects
- more inter-generational work
- mindfulness.

One worker noted however that 'the project has slowly moved out to fill in the gaps', and so there is currently some development work going on in all the above areas.

There is a need to continue to extend the geographical coverage of existing activities especially to smaller areas and some under-represented areas such as Hawick.

The total size of the target group who need help to increase their physical activity – some 3,000 totally inactive and 20,000 under-active people - suggests the BCCBP team could justify being made permanent.

Going forward, the project may require a larger budget to subsidise classes in the smaller areas, but this would be a much cheaper option than setting up a project to say develop new transport options or in dealing with the consequences of loneliness and social isolation.

6d) Strategic role going forward

There is a role for BCCBP in supporting service reform, most clearly with the pilots of community led support, the Buurtzog model and participatory budgeting with older people. These all require community engagement, and building motivation and skills within communities to generate more services. BCCBP has proved it can do this cost effectively.

Duplication between BCCBP and other services was mentioned by some statutory stakeholders, and this could be a legitimate concern between community learning and development, local area coordinators and the LASS and HLN services. This requires some teasing out and discussion at a strategic level of where these different services fit in what is a changing landscape and what their role is going forward.

The BCCBP is best thought of as a preventative resource for older people that can also be linked in to help services gain more involvement from communities.

As public resources are tightened, those whose needs are significant but not high enough to meet eligibility criteria for assistance are at risk of being neglected, but if they receive no interventions then the risk is that as they age, their health conditions become worse than they might otherwise have been. Engagement with BCCBP activities can lengthen the time before older people need health interventions and better manage demand.

The recent research into risk factors for dementia highlights that some of the preventative activities are those BCCBP has specialised in: better physical activity levels, more mental stimulation and lifelong learning, reduced social isolation and less depression. It may be that more could be done by BCCBP working specifically with people and carers with lived experience of dementia.

Working in partnership with other agencies, BCCBP could manage a process of community engagement with older people and prospective partners around the potential for new local social enterprises in the health and social care field.

6e) Recommendations

- BCCBP could use the information that will be flowing from the outcomes questionnaires, combined with a more rigorous and extensive approach to data collection (including collecting data on physical health indicators) to do a more robust evaluation of SROI. The value map included here provides a starting point to define what additional data is needed.

- BCCBP should be mainstreamed as an important component of the reform of public services as they affect the health and social care of older people.

- Further thought should be given to BCCBP's legal status. On the one hand, being a unit of Scottish Borders Council is very helpful in terms of future involvement in the health and social care agenda as outlined above and capturing the benefits over time of reducing demand on services. On the other hand, the unit is unable to access some funding that might allow it to develop new activities more quickly, or pursue new avenues for building capacity or provide a vehicle for social enterprises in health and social care.

- The project staff should receive more promotional training and support to enhance their key strength in community development and in promotion, and specifically to help their groups access the harder to reach and more isolated older people.

- The project should take the lead and facilitate a practice forum involving staff from relevant partners to embed better understanding of the principles and practice of community development across different sectors. There are external agencies who could help with this process.

- The project should be asked to pilot a participatory budgeting exercise with older people in an appropriate area, both geographically and thematically, to build the teams' skills, allow them to work together on one project and learn from each other, and to link this with the other health pilots that are on-going.

Appendix 1. Value Map of the SROI forecast

Outcomes, Indicators and Quantities

Stakeholder: Older people who are participants in BCCBP groups	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
	Time, energy	261 older people regularly involved in physical activity groups	Reduced impact of long-term health conditions on daily life	86% of older people involved in gentle exercise and kurling groups reported their fitness had improved	Interviews and focus groups plus participant surveys and project records	187 86% of 218 people participating in New Age Kurling and Gex classes
			Taking responsibility for one's own physical health by taking more exercise and improving fitness	67% of older people involved in walking sports groups reported their fitness had improved	Interviews and focus groups plus participant surveys and project records	29 67% of 43 older people involved in walking netball and football
				Number of people who now take the recommended level of physical activity each week - estimated at 20%	Interviews and focus groups	9 20% of 43 people involved in walking sports
		202 older people regularly involved in groups which are aimed at improving mental well-bering and social contact	People are more connected in their community and doing activities and leads to improved mental well-being from the social contacts involved in groups	Proportion of older people who report that they value the social contact and it makes them feel happier and motivated to sustain the group - estimated at 85%	Interviews and focus groups	398 85% of whole group (without happiness cafe participants) i.e. 463
				Proportion of older people who report being more socially active - estimated at 75%	Interviews and focus groups	347 75% of whole group (without happiness cafe participants) i.e. 463
			Older people have access to better quality information	Number of people accessing the Gala Water Directory as a	Interviews and focus groups plus project records	375 Estimate 25% - of

			through Directory	proportion of the elderly population		approx 1500 pensioners living in isolated circumstances

Stakeholder: Older people who are also volunteering to manage groups	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
Time and energy	£41,040	95 volunteers providing an estimated1.5 hours of input to group management per week	Increased sense of personal self-esteem and a sense of giving back to the community	Proportion of participants who volunteer who sustain their involvement as volunteers	Interviews and focus groups	80 Estimated as 85%

Stakeholder: Community-based organisations who are supporting BCCBP groups	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
			Stronger and more sustainable local community organisations	Number of additional participants involved in other Community Association activities	Interviews	60
				Number of groups that BCCBP have set up that are now self-sustaining	Interviews and project records	10
			Improved sustainability of local social enterprises	Increased revenue estimated from BCCBP activities for Fit Borders and grant funds raised for Just Cycle	Interviews	1
			Better networking support for services and workers through the Borders Seniors Networking Forum	Number of regular attendees and those receiving information through the Forum	Interviews	50

Stakeholder: NHS Primary Care services	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
			Reduced demand on GP services by people who are improving their own physical health and managing their LTC	Number of older people with LTC's who have taken up physical activity and improved their fitness	Interviews and focus groups plus participant surveys and project records	187
			Reduced demand on GP's due to improved mental-well being and resilience of patients	Number of older people whose mental well-being has improved	Interviews and focus groups plus participant surveys and project records	398
			Reduction in older people needed hospitalisation for falls	Number of older people who have improved their core strength, coordination and balance through physical exercise	Interviews and focus groups plus participant surveys and project records	187
				Number of falls that would be expected amongst those doing physical exercise classes	Chartered Institute of Physiotherapits and NICE guidelines	86

Stakeholder: Scottish Borders Council	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
			Improved reputation in local communities	The number of local communities who have extensively cooperated with BCCBP	Interviews	5
			Avoided costs of strengthening CLD teams to work with older people	The cost of locating a development worker in each locality to work with older people 50% iof time	Interviews	1

Stakeholder:	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity

Health and Social Care Partnership	Funding for year 3	£160,000	Outcomes are experienced by other stakeholders			

Outcomes and financial proxies

Stakeholder: Older people who are participants in BCCBP groups	Outcome description	Financial proxy description	Value	Source
	Reduced impact of long-term health conditions on daily life	SWB valuation of the negative effect on life satisfaction of a range of LTC's and the income required to return someone to the same level of life satisfaction.	£2,160	'Valuing mental health', Fujiwara and Dolan, 2014, UK Council for Psychotherapy at https://www.simetrica.co.uk/wwwsimetricacouk-resources
	Taking responsibility for one's own physical health by taking more exercise and improving fitness	HACT valuation of indirect health impact from being in control of one's life is £3424, but older people less likely to value it so highly due to limited ability to change activity patterns or behaviour and the valuation so assumed 25% of value	£856	'Measuring the indirect impact of improved health on wellbeing', 2015, HACT at http://www.hact.org.uk
	People are more connected in their community and doing activities and leads to improved mental well-being from the social contacts involved in groups	SWB valuation of the negative effect on life satisfaction of poor mental health is £44,237, but assume 10% of this value	£4,424	Valuing mental health, Fujiwara and Dolan, 2014, UK Council for Psychotherapy
	Older people have access to better quality information through Directory	Average cost per annum for the 4 main broadband providers as a proxy for better access to information	£163	At http://www.moneysavingexpert.com/phones/cheap-broadband

Stakeholder: Older people who are also volunteering to manage groups	Outcome description	Financial proxy description	Value	Source
	Increased sense of personal self-esteem and a sense of giving back to the community	HACT valuation of indirect health impact from REGULAR volunteering is £892	£892	'Measuring the indirect impact of improved health on wellbeing', 2015, HACT at http://www.hact.org.uk

Stakeholder: Community-based organisations who are supporting BCCBP groups	Outcome description	Financial proxy description	Value	Source
	Stronger and more sustainable local community organisations	Cost of replacing volunteer labour with paid staff ONS study of 2.8 hrs nationally volunteered per week, assume for 40 wks pa Take NMW as proxy for time Assume 7 volunteers per group	£6,145	http://blogs.ncvo.org.uk/2014/06/26/its-the-economic-value-stupidbut-is-volunteering-really-worth-100bn-to-the-uk/
	Improved sustainability of local social enterprises	Additional funding input to Just Cycle as a result of BCCBP and the contribution made to Fit Borders from GEx classes	£8,200	Interviews
	Better networking support for services and workers through the Borders Seniors Networking Forum	The value of time contributed to the Borders SNF by participants, 4 quarterly meetings, 3 hours per time, £15 on average hourly rate	£180	Interviews

Stakeholder: NHS Primary Care services	Outcome description	Financial proxy description	Value	Source
	Reduced demand on GP services by people who are improving their own physical health and managing their LTC	Unit cost of a GP consultation is £65 per 17 minute consultation, assume on less consultation per month	£780	http://www.pssru.ac.uk/project-pages/unit-costs/2015/

	Reduced demand on GP's due to improved mental-well being and resilience of patients	Unit cost of a GP consultation is £65 per 17 minute consultation, assume on less consultation per month	£780	http://www.pssru.ac.uk/project-pages/unit-costs/2015/
	Reduction in older people needed hospitalisation for falls	30% of people older than 65 and 50% of people older than 80 fall at least once a year so assume 86 fewer falls, savings per fall for all types of treatment in hospital in the Borders	£1,651	Falls prevention economic model from Chartered Institute of Physiotherapists at http://www.csp.org.uk/documents/falls-prevention-economic-model

Stakeholder: Scottish Borders Council	Outcome description	Financial proxy description	Value	Source
	Improved reputation in local communities	Cost of a community engagement process to enhance reputation. Assume 5 hours per month @ £80 per hour plus 8% account fee as per Holyrood Partnership	£5,184	https://www.holyroodpr.co.uk/why-us/cost-charges/
	Avoided costs of strengthening CLD teams to work with older people	Would need 1 worker per locality. Assume average CLD salary is £29K, assume 20% travel and on costs and 50% of time spent on older people	£87,000	Salary from My Jobs Scotland

Deductions to avoid overclaiming, duration and drop off

Deadweight

For older people interviewed, reported deadweight for physical and mental well-being seemed to vary significantly between groups and areas from 0% to 50%
Only 14% of men and 8% of women meet recommended guidelines for physical activity
17% of men and 21% of women are completely inactive.
Suggests average rate of 11%

For volunteers, 19% of over 65's volunteer on elderly projects Scottish Household Survey 2016 at http://www.gov.scot/Publications/2016/09/7673/13
For community organisations, 0% deadweight where participants said activity would not have happened without BCCBP
For social enterprise, estimate of 25% deadweight

Attribution
If 50% of GP appointments are with people with LTC's (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf) then attribution to existing primary care support should be 50%.
However, participant interviews suggested attribution of 0 to anyone else.
If the average person with an LTC spends 0.05% with a health professional (http://www.nuffieldtrust.org.uk/blog/fact-or-fiction-demand-gp-appointments-driving-crisis-general-practice) then attribution should be very low.

Conclusion : use 10% to allow for interviewer bias
And 5% to allow for friends and neighbours

For non-individual outcomes - 50% to reflect partnerships with other organisations

Duration
The outcomes which are assumed to endure for longer than the activity are:

Older people who are participants in BCCBP groups:
Reduced impact of long-term health conditions on daily life
Taking responsibility for one's own physical health by taking more exercise and improving fitness
Community-based organisations who are supporting BCCBP groups:
Stronger and more sustainable local community organisations
NHS Primary Care services:
Reduced demand on GP services by people who are improving their own physical health and managing their LTC
Scottish Borders Council:
Improved reputation in local communities

Drop off
For those outcomes which endure, the value in year 2 reduces by 25%.

SROI calculation

The investment is £160,000 of funding plus £41,040 of volunteer time

	Year1	Year2	Total
Total present value of all outcomes for all stakeholders added together	£1,977,383.31	£308,301.31	£1,981,883.31
Total net present value (discounted by 3.5%)	£1,910,515.28	£287,802.57	£2,198,317.85
Investment			£201,040
SROI Ratio			10.93

Sensitivity analysis

Item	Base case	New assumption	Base result	New result	Difference	Sensitive or not
Deadweight	Average of 9.75%	Average of 25%	10.93	9.67	-12%	No
		Average of 40%	10.93	7.74	-29%	Yes
Attribution	Average of 31%	Average of 50%	10.93	7.29	-33%	Yes
		Average of 40%	10.93	8.75	-20%	Yes
Duration	1 year	2 years	10.93	18.23	67%	Yes
Quantities		25% lower	10.91	8.19	-25%	Yes
Investment figure used	2016-2017	Total for 3 years	10.93	5.49	-50%	Yes
Valuations		50% lower	10.93	5.46	-50%	Yes

All assumptions have the power to affect the result, but the most sensitive ones are attribution and duration, and these should be paid particular attention to if an evaluation is to be attempted.

If BCCBP does have a role in preventing the long-term deterioration in health status of older people, then what could be added to the value map is an outcome for the NHS, which is a reduction in the spend per person which has been avoided because older people require less services. One way to value this is to compare the average spend at different ages, and assume the spend for someone aged 75 is reduced to that of someone aged 65. This would result in a 'saving' of £1,800 per person, which over the population in the last year of 463 people would have produced a notional value to the NHS of £833,400, and a return of £5.89 to the health and social care system.

Another way to value this effect would be to look at the increased in QUALY's arising from improved physical and mental health and to apply the NICE benchmark of £20,000 cost per QUALY gained. Further work could be done on this approach.

SOCIAL RETURN ON INVESTMENT

External evaluation of Community Capacity Building work so far suggests a social return on investment in the region of £10 for every £1 invested. This reflects the effectiveness of the staff team and the relatively high cost of older peoples' physical and mental ill health.

The external evaluation analysis also supports the community development approach used by the team. Although this is more resource intensive, it delivers better and more sustainable outcomes.

COMMUNITY CAPACITY BUILDING

Community Capacity Building has a significant impact in delaying the onset of long term conditions which may require treatment or admission to hospital. If a delay of 5 years for the onset of conditions is modelled then based on the average NHS spend per person at different ages, the ration is likely to be around £14 for every £1 invested.

THE FUTURE

Increasing access to physical and mental wellbeing services in communities has been shown to have a preventative role in reducing demand upon Health and Social Care services

- Community Capacity Building work is crucial to the successful reform of health and social care services
- Existing successful pilot projects will be confirmed and new ones initiated
- Working more closely with partners in health, there are opportunities to develop social prescribing projects
- Continuing to work with our third sector partners will help to make more effective use of resources and avoid duplication

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SCOTTISH BORDERS COUNCIL
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Scottish Borders COUNCIL

Scottish Borders Health and Social Care PARTNERSHIP

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community capacity building

IN THE SCOTTISH BORDERS 2016/17

OUR AIM & VISION

"The aim of the Community Capacity Building team is to actively foster and encourage the development of resilience within communities to allow them to become stronger and more self-reliant through offering the right support at the right time."

Scottish Borders COUNCIL

COMMUNITY CAPACITY BUILDING 2016/17
HOW ARE WE DOING?

Scottish Borders Health and Social Care PARTNERSHIP

PARTICIPATION
500
people participated in **CCB activities** in the year 2016/17 **alone**

MENTAL HEALTH
398
out of **500 people** reported **improved mental wellbeing**

FALLS PREVENTION
187
people reported **improvements** to **core strength** and **balance**, **reducing** their **risk of falls** and **acute admission** to **hospital**

PHYSICAL HEALTH
86%
of **older people** reported **improved physical health** and **fitness** as a result of being **involved in physical activity**

VOLUNTEERS
95
volunteers have **invested their time** into **CBB projects**. They report **increased self-esteem** and **pride** in **giving back** to the **community**

VOLUNTEERING CONTRIBUTION
over **£41,000**
volunteering contribution to the **community - cost** of **equivalent paid staff**

SOCIAL ISOLATION
75%
of **older people** reported being **more socially active** as a result of taking part in **CBB activities**

ACTIVITIES
2428
hours of activities throughout the year for **older adults** to take part in

21
new activities created throughout the year

How did we do it

- Engage in community discussions
- Identify existing gaps
- Partnership working
- Community research
- Co-produced working relationships
- Asset based approaches
- Support communities to run their own services

From this development of..... examples include.....
- Gentle Exercise classes
- Walking football & netball
- Soup clubs
- Food & friendship
- Writing for wellbeing
- Craft classes

Why did we do it

To empower Communities

To develop positive sustainable outcomes

To meet un-met need

- Increases volunteering opportunities
- Increases different opportunities for older people
- Reduces reliance on other services
- Effective use of resources

Walking Football

"It has changed my life. I am SO glad to have the opportunity to play football again. I consider the exercise beneficial and necessary as I intend to keep playing football for as long as possible"

Gentle Exercise Class

*"**Having attended the class.....** not only has my mental health improved but I have lost a lot of weight and feel a hundred times better and fitter"*

Soup Club

"I come along for lunch as it's great to share a meal with others, it's a change from being in the house by myself. Look forward to seeing friends (old and new) – feeling loved and cared about – love the soup!!"

Men's Shed

"One of the shedders shared his story of being diagnosed with prostate cancer, this personal story prompted other shedders to book a screening test. Many of the gentlemen stated they had never had the test nor considered that it could happen to them so close to home"

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 18 December 2017

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

"DISCHARGE TO ASSESS" HOSPITAL TO HOME PILOT

Purpose of Report:	To introduce a new policy of discharging patients from hospital to undertake an assessment of need at home and provide a programme of re-ablement activities to lessen the need for on-going care.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Agree the extension of the "Hospital to Home" pilot across the Hawick, and Central localities in addition to the Berwickshire locality.

Personnel:	Introduction of a new Hospital to Home Service to work alongside existing programmes.

Carers:	Introduction of a new Hospital to Home Service to work alongside existing programmes.

Equalities:	This policy will target those patients most likely to benefit from an assessment in a specialist discharge to assess facility. The overall policy direction of discharge to assess will apply equally where possible.

Financial:	Further funding bids will need to be considered by the IJB as the Health Board and the Local Authority progress their plans.

Legal:	This proposal is for a trial period over this winter. Depending on the outcome of this test, consultation would be more appropriate in the spring of 2018.

Risk Implications:	A risk assessment will be undertaken through the plans designed to implement the "Discharge to Assess" policy.

Background

1.1 On 8th November 2017, the Integration Joint Board approved papers proposing the issuing of a Direction to NHS Borders and Scottish Borders Council to introduce a policy of "Discharge to Assess.

1.2 As part of the work to meet this new Direction and to support the easing of pressures within secondary care, the IJB agreed to the opening of:

- 6 beds at Haylodge Community Hospital - as step down beds, where patients can be moved from Borders General Hospital (BGH) to await a package of care or a Care Home place.

- up to 15-beds at Craw Wood (Tweedbank) for Discharge to Assess (DTA), where patients capable of giving consent can be moved from BGH, again to await a package of care or a Care Home place.

1.3 The paper also agreed funding of £108k to support the appointment of staff to operate a "Hospital to Home" function to increase the capacity within home care.

1.4 Further work and preparation has been undertaken since this decision, and this paper is requesting the expansion beyond Berwickshire to Hawick and Central Localities. This will allow more patients to be supported, and as well as providing greater care capacity over the winter period, it will offer a more robust sample to test and evaluate the model.

1.5 This paper outlines in greater detail the estimated costs and recommendations to introduce a pilot for Hospital to Home facilities across Hawick, Berwickshire and Central Localities.

Proposal

2.1 The following proposal has been developed, by a dedicated short-life cross Partnership Project Team, for the implementation of discharge to assess facilities within Borders.

2.2 This work is identified as one of the recommendations within John Bolton's work for the Borders Partnership and NICE guidance also states that; individuals should not be sent directly to a care home from an acute setting.

2.3 To comply with these recommendations and meet the pressures within the Borders hospitals, the partnership needs to reduce demand for care, to a level that existing capacity within home care provision, and the current number of care home beds can provide for.

2.4 The proposed activity will offer the opportunity for individuals delayed in hospital to go home where they will be provided with a "Re-ableing" programme of activities. These will be provided for by a Health Care Support Worker, under the guidance of a District Nurse and/or an Allied Health Professional. It is expected that one member of staff will cater for 2 or more clients.

2.5 These workers and the associated Nursing/AHP teams will support an assessment of the client's needs to determine their improvement and if there are any on-going needs beyond the initial 6 week duration of this work. Should there be a need for a Social Work assessment these will be undertaken by the START social work teams operating through the nearest Community Hospital. These assessments will greatly benefit from the fact they will be undertaken in the client's own familiar surroundings.

2.6 There will be a central management and administration of these teams for the allocation of cases, the coordination of rotas and the introduction of on-going care beyond the 6 weeks on the programme.

2.7 Whilst there will be central management and coordination, the workers will be professionally lead by District Nurse teams in partnership with AHPs. (A range of duties for these workers is outlined within Appendix 1.)

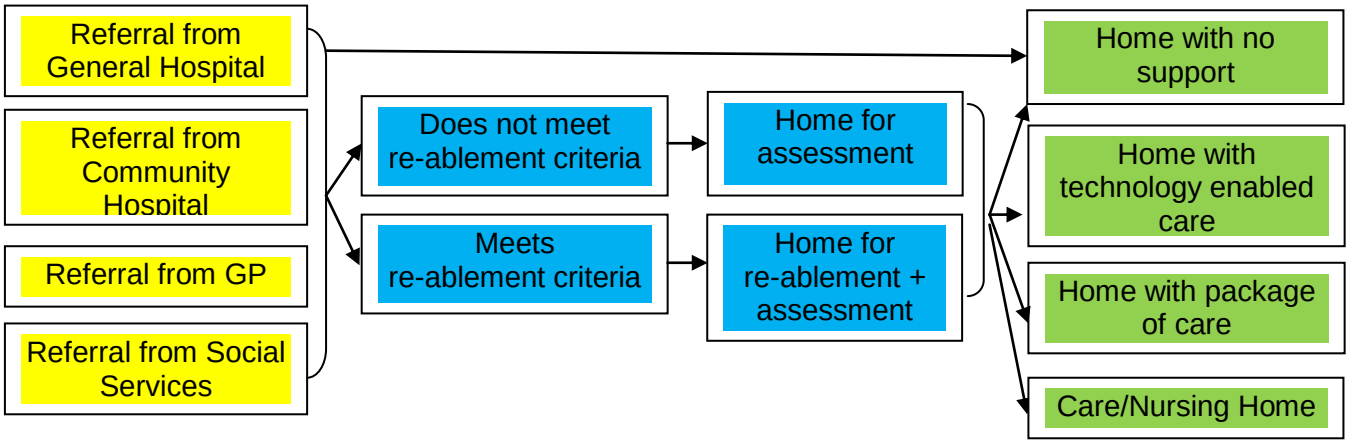
2.8 It is important that this new resource is properly targeted towards those individuals who will benefit from "re-ablement". Strict criteria need to be applied therefore at hospital discharge so only appropriate patients are referred. If such criteria are not adhered to there is a very real danger that patients will stay for long periods of time within programme, thus preventing flow and removing the opportunity for other patients to gain from the resource.

2.9 It is also important that the exit from this re-ablement service is undertaken as soon as the individual has improved within expectations. Whilst this work will ease demands on on-going care, there remains a dependency that such care will be readily available. To this end other work streams need to continue, to maintain the capacity of Care Homes and Home Care commissioned.

2.10 As yet there is little empirical evidence of the success of this type of work, however, experience from other partnerships across the UK demonstrate that we should expect reductions of between 40% and 50% in the size of packages of care required following this intervention. In many cases this work has also completely averted or substantially delayed the need of a care home place.

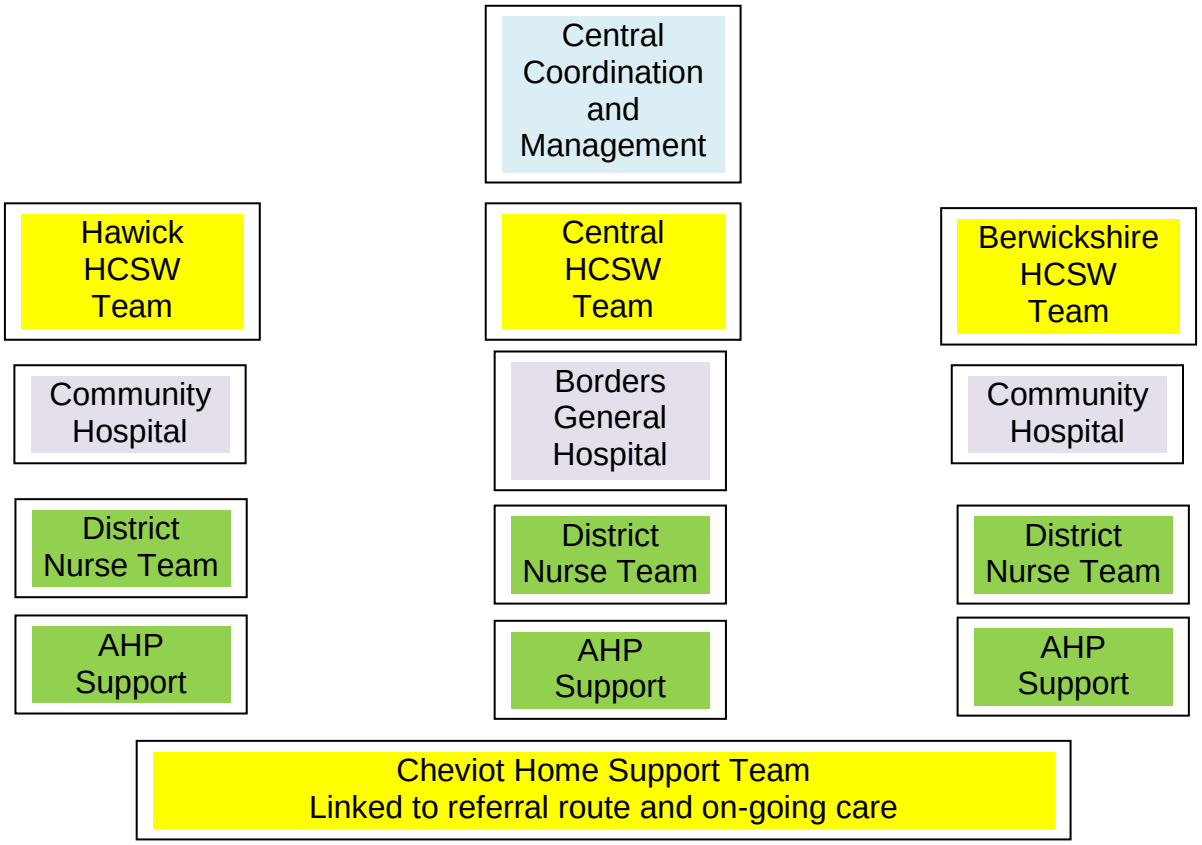
2.11 The evaluation of the re-ablement work will inform the predictions of the demand for care in future years and therefore support the commissioning plans of the partnership.

2.12 Proposed Model



2.13 The majority of individuals currently delayed within hospital are from Berwickshire, Hawick and the Central localities of the Borders. It would therefore be desirable that the pilot should target these areas. It is proposed that 15 Health Care Support Workers are appointed to these areas. Further work will be coordinated with the Cheviot Home Care provision which will be included within the referral routing from BGH and Community Hospitals.

2.14 Existing multi-agency work is being undertaken in the Cheviot Locality which will support the overall programme. The coordination of Hospital to Home will liaise with the Cheviot teams to ensure congruence of their activities.



Costs

3.1 The summarised costs of the options described above are detailed in the following table:

Number of staff	Est. Cost	Operational period
15 HSCW	£124,500	
16hrs/wk B6 Nurse	£5,427	
22.5 hrs/wk B7 Nurse	£9,150	
Supplies	£3,000	
Mobile	£1,500	
Transport	£18,300	1st Jan 2018 - 30th April 2018
Total	£161,877	

3.2 The total cost to implement all three areas, is estimated at £161,877.

3.3 The IJB agreed to support the Hospital to Home work at its meeting in November to the sum of £108,000. The request here is to expand this work across three localities, most challenged with delayed discharge from hospital. The additional funding for this expansion is therefore £53,877. The overall funding envelope already agreed by the IJB at the extraordinary meeting for “Discharge to Assess” actions was £850k. It is proposed that the additional costs of approximately £54k are found within this overall envelope as this work will lessen the needs for surge beds within community hospitals.

3.4 Expected throughput of patients leaving hospital and going through re-ablement is based on a minimum of 3 patients per HCSW every 6 weeks. Over the period of three months, this equates to offering capacity for 255 patients leaving hospital. The cost per patient would therefore be £698.

3.5 The implementation of discharge to assess facilities supports the aim of the Integration Joint Board (IJB) to ensure delayed discharge levels are reduced. The use of Integrated Care Funding (ICF) to pilot this new patient pathway is supported by the partnership Executive Management Team (EMT).

Appendix 1.

Health Care Support Worker

JOB DESCRIPTION

1. JOB IDENTIFICATION	
Job Title:	Clinical Support Worker
Responsible to:	Hospital to Home co-ordinator
Accountable to:	Hospital to Home co-ordinator
Department(s):	
Job Reference:	
No of Job Holders:	
Last Update	

2. JOB PURPOSE

In partnership with the registered nurse/HtH co-ordinator, assesses and reviews the patient's personal goal plan, using the patient's individual care plan. Implement the plan of care to ensure delivery of a high standard. Works on a regular basis without direct supervision from a registered nurse.

As part of a multidisciplinary team, the post holder will carry out personal care duties for patients, in support of the registered nurse/HtH co-ordinator and other relevant professional practitioners, where appropriate.

3. DIMENSIONS

To enhance the current care at home services by providing care for medically fit patients, waiting in a hospital bed for a Package of Care and living in the Scottish Borders. This will reduce the patient's length of stay in hospital.

The post includes morning and evening shifts and weekend working. This post requires travelling between patients.

ORGANISATIONAL POSITION

Clinical Services Manager

Lead Nurse
Hospital to Home coordinator
This post

The post is employed within NHS Borders and there will be a requirement to work flexibly across Borders Community and Hospital based services to meet service demands.

5. ROLE OF DEPARTMENT

To provide high quality nursing care to patients with a variety of clinical needs in the community setting, meeting the identified physical and psychological needs. The post holder will, when required, assist the registered nurse/other health care professionals with the management of direct and in-direct patient care.

6. KEY RESULT AREAS

1. To carry out a range of clinical duties with minimal/no supervision, including for example, washing, dressing and getting patient up, preparing meals, prompting with medication, blood pressure monitoring, oxygen saturation levels, body temperature, pulse rate and respiration rate, glucose monitoring (BM Sticks), collection and testing of urine samples/faecal samples/sputum samples and wound/MRSA swabs ensuring delivery of high quality patient care at all times. NB: this list is not exhaustive and will vary depending on area of work.

2. To carry out/administers simple dressings using both sterile and non sterile techniques, as per Treatment Plan.

3. To work in partnership with the Community Allied Health Professionals to promote patient independence.

4. To reorganise/prioritise own workload according to patient need and service needs without direct supervision.

5. To co-operate with and maintain good working relationships with both the multidisciplinary team and other Healthcare and Social Care professionals. Have an empathetic approach to patients, carers and relatives, answering any queries, suggestions or concerns they may have where possible, referring them to the registered nurse/HtH coordinator where appropriate.

6. To maintain up to date written records, reporting and escalating as required, informing the registered nurse/HtH coordinator of any changes or outcomes of clinical interventions undertaken including any observed change in the patients condition. Recording any changes/treatments administered/action taken to comply with local, Professional and Health service standards. Maintain patient confidentiality at all times.

7. To be responsible for ensuring personal on-going training as required, ensuring skills/competencies are maintained.

8. To supervise, in partnership with the registered nurse, new clinical support workers and nursing students in direct patient care.

9. To work within defined standards, protocols, policies and procedures for the community, directorate and NHS Borders including the development of risk assessments to ensure delivery of the highest level of patient care at all times.

10. To monitor stock levels of all supplies, to support and maintain the running of the service in order to promote the effective and efficient use of resources.

11. To participate in clinical audit of services provided to ensure evidence based practice is identified and implemented.

7a. EQUIPMENT AND MACHINERY

The following are examples of equipment which will be used when undertaking the role:

Manual Handling equipment:
Stand-aid, full body hoist, bath hoist, glide sheets, pat slide, banana board

Communication aids :
Telephone, computers, scanners

Medical Equipment :
Glucometer, Blood pressure and temperature monitoring system, blood collection systems, bladder scanner, 12 Lead ECG recording

Other:
Various walking aids, raised toilet seats, electric bath, electrically controlled chairs, wheelchairs, weighing scales, height measurement tool, specialist mattresses, microwave.

This list is not exhaustive

Note: New equipment may be introduced as the organisation and technology develops, however training will be provided.

7b. SYSTEMS

The following are examples of system which will be used when undertaking the role:

TRAK - maintenance of patient records.

Pecos – for ordering stores and supplies

Risk assessments – DATIX

eLearning modules – personal development

Intranet and internet – access to policies

Note: New systems may be introduced as the organisation and technology develops, however training will be provided.

8. ASSIGNMENT AND REVIEW OF WORK

Workload is allocated by the Registered nurse/ HtH co-ordinator. The member of staff is expected to be responsible for planning own workload with minimum supervision/no supervision by the Registered

nurse.

The post holder will receive their work review and annual appraisal from the Registered Nurse.

9. DECISIONS AND JUDGEMENTS

Uses own initiative to assess patient condition, pertaining to both the emotional and physical needs, making recommendations to changes to care plan to the registered nurse, improve outcomes within the bounds of existing knowledge and skills.

Recognising abnormal readings when undertaking clinical observations of patients and escalating these to the registered nurse for advice/action.

10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB

Undertaking a physically, mentally and emotionally demanding job whilst at the same time taking care to safeguard their own health and safety as well as those of colleagues and patients.

Maintain high standards of patient care within defined resources.

Working with patients who may be distressed, anxious, or terminally ill or have cognitive impairment and communication problems.

Maintaining skills and knowledge level in clinical competencies and core skills.

Travelling between patients in all weather conditions.

11. COMMUNICATIONS AND RELATIONSHIPS

The post holder will communicate on a regular basis with the patient, their relatives, the multidisciplinary team, internal and external agencies involved with the provision of care using effective verbal, non-verbal and written communication

Will communicate proficiently with regards to planning, implementation and review of workload.

Requires to communicate effectively with patients who may be distressed/worried or anxious

Communicate with the registered nurse/ HtH co-ordinator regarding their personal development needs.

12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB

Physical Skills

Venepuncture

PC skills

Manual handling skills

Physical Demands:

Manual handling on a daily basis including e.g. safely manoeuvre patients some of whom may be highly dependent, manoeuvring wheelchairs, hoists.

Activities include repeated bending, crouching, and kneeling in restricted areas as well as standing/walking for long periods during the shift.

May participate in resuscitation procedures at the direction of the registered nurse/ambulance staff.

Mental Demands:

Maintaining high levels of patient interaction on a daily basis and concentration required when observing patients conditions and undertaking clinical duties.

Maintaining high levels of concentration on a daily basis when checking documents/case notes and documentary observation whilst subject to interruptions from patients/relatives

Ability to deal flexibly with frequently changing situations and unpredictable events (e.g. falls, patient illness) prioritising demands of clinical and non-clinical workload.

Constant awareness of risk factors.

Emotional Demands:

Communicating with distressed, anxious, worried patients/relatives/carers and supporting relatives/carers following receipt of bad news

Caring for patients who are terminally ill or have a progressive illness

Supporting new staff and learners

Lone worker for the majority of the time when out in the community

Environmental:
Working in conditions, which involve daily exposure to bodily fluids including sputum, vomit, urine, faeces and occasionally wound exudates.

Patient's home environment including pets.

Potential exposure to episodes of verbal and physical aggression from patients/relatives/carers.

13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB

Effective written and verbal communication skills.

Ability to work with people and as part of a multidisciplinary team.

Ability to show initiative, take responsibility and work without supervision on a daily basis.

Organisational and time management skills

14. JOB DESCRIPTION AGREEMENT

A separate job description will need to be signed off by each jobholder to whom the job description applies. Job Holder's Signature: Head of Department Signature:	 Date: Date:

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Scottish Borders Health and Social Care Winter Plan 2017/18

Winter Plan – Aims

- Maintain normal delivery of services – no disruptions
- Work within footprint of existing bed resources– nobody cared for in an area that is not the right specialty and minimised delayed discharges
- Make transformational changes
- Flexibility to manage peaks in demand

Winter Plan – Areas of work

Implementation status

75 actions to deliver

G 50 A 10 R 2 complete 13

Category

- Reduce admissions
- Maintain Services
- Improve Flow
- Reduce delays
- Surge capacity

Winter Plan
Performance status

Aims	Risk Status
Maintain normal delivery of services – no disruptions	G
Work within footprint of existing bed resources	A
Make transformational changes	G
Flexibility to manage peaks in demand	R Current predicted deficit in surge capacity in January

Implementation Actions – Reduce admissions

Status

Highlights

- COPD – ‘winter MOT’ – project launched
- Care Home Anticipatory Care Plans – ongoing work in Central Borders
- Surgical Assessment Unit – reduced admissions by approx 6 per day

Implementation Actions – Maintaining Services

A

Status

Highlights

- Intensive recruitment programme for staff
- Staffing arrangements for festive period
- Resilience plans in place

Issues

- Confirmation of festive arrangements for all services

Implementation Actions – Improve Flow

Status

Highlights

- BECS and ED additional staffing plans in place
- Dynamic Daily Discharge rolled out
- Site and Capacity Team model launched

Issues

- Morning Discharges – plan to be firmed up
- Weekend discharges – testing Hospital at Weekend model for coordination of medical activity

Implementation Actions – Reduce Delays Status

R

Highlights

- Berwickshire supported discharge project starting early Dec
- Moving On booklet being implemented

Issues

- Planning housing cover over festive period
- Discharge transport arrangements
- Access to equipment for discharge

Risks

- Care Home capacity during Festive period/January - Currently no plan for block-booked capacity
- Dementia care home capacity – no additional capacity established

Implementation Actions – Surge Capacity

Status

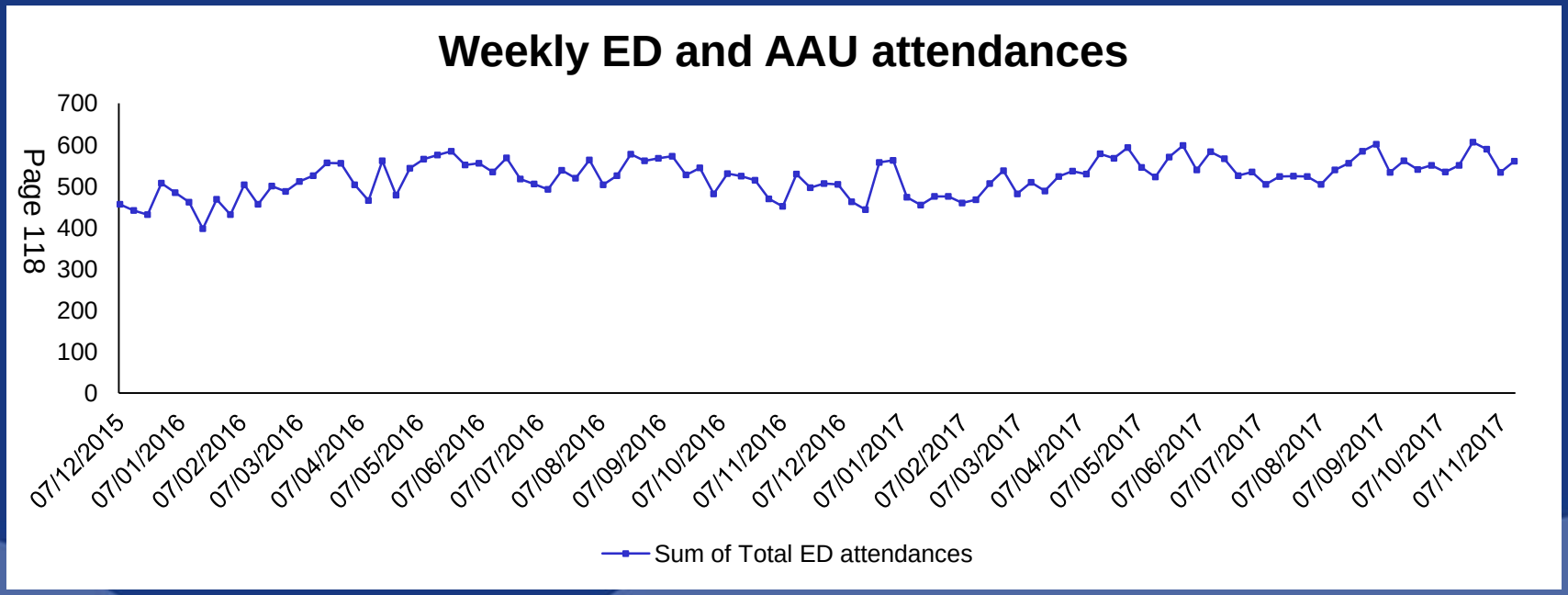
Highlights

- Craw Wood Discharge to Assess facility opening 4th December

Issues

- Developing staffing plans for Borders Stroke Unit and Knoll/Hawick extra beds
- Progress with works to Haylodge Day Hospital

Performance – Emergency Department (ED)/Acute Assessment Unit Attendances

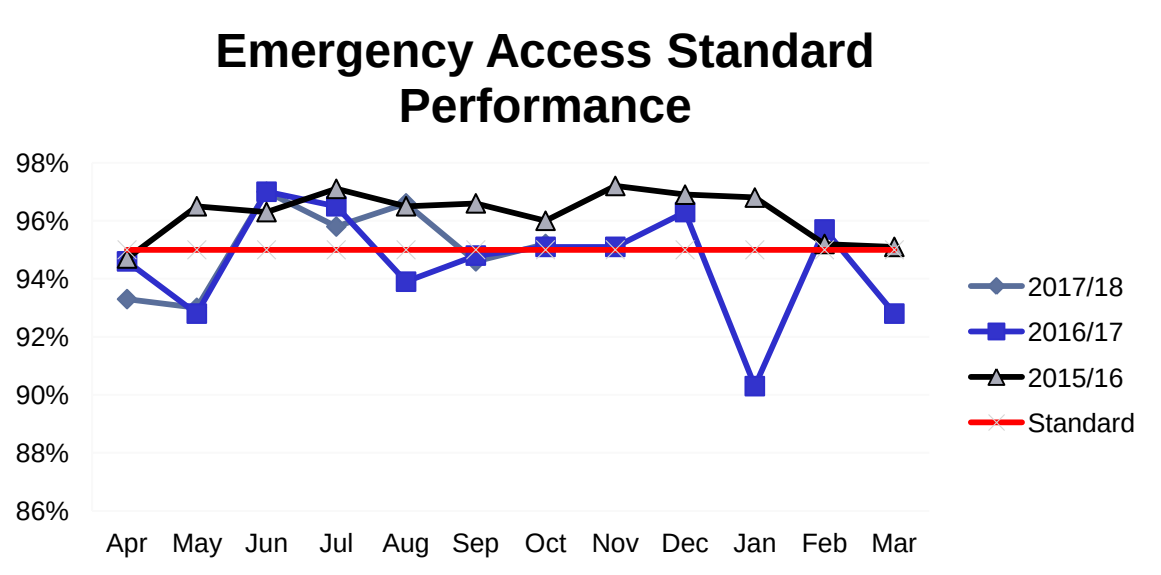


There has been a 3% increase in ED and AAU attendances between 2016 and 2017, but a 6% increase since August 2017

Performance - Emergency Department (ED)/Acute Assessment Unit Breaches

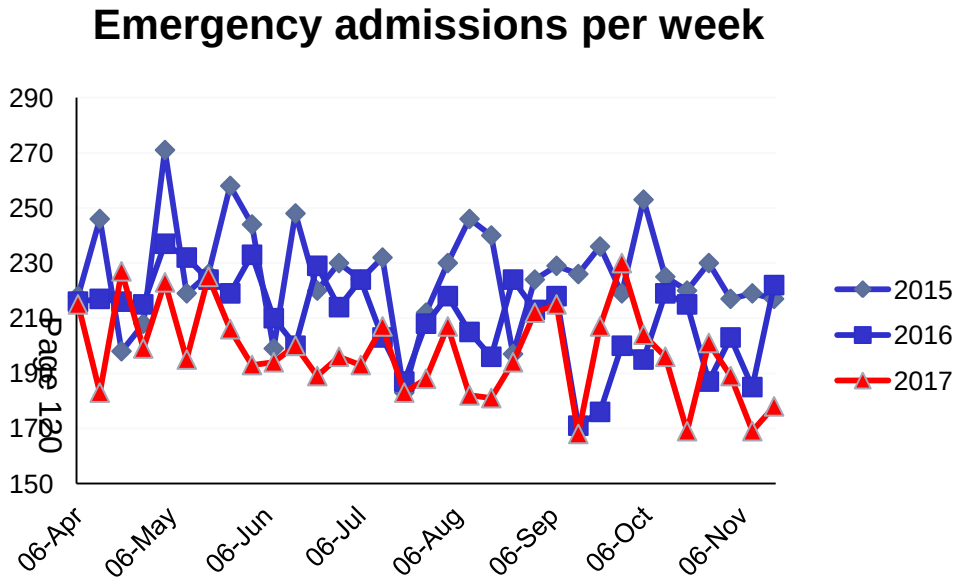
AIM: The number of patients breaching the 4-hour ED standard will not increase in the winter period compared to the previous summer.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2017/18	93%	93%	97%	96%	97%	95%	95%		
2016/17	95%	93%	97%	97%	94%	95%	95%	95%	96%
2015/16	95%	97%	96%	97%	97%	97%	96%	97%	97%



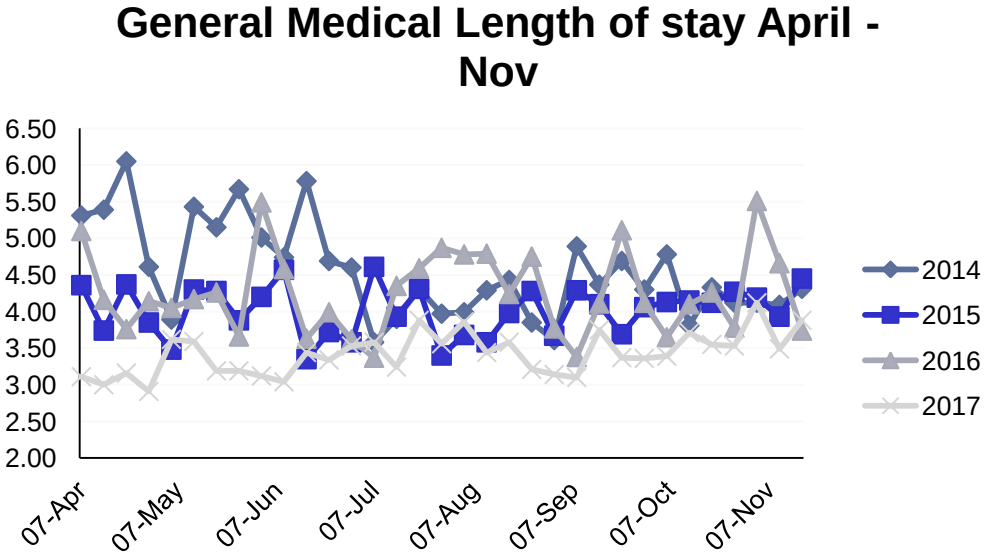
Current performance is just above the 95% standard

Admissions and Average Length of Stay



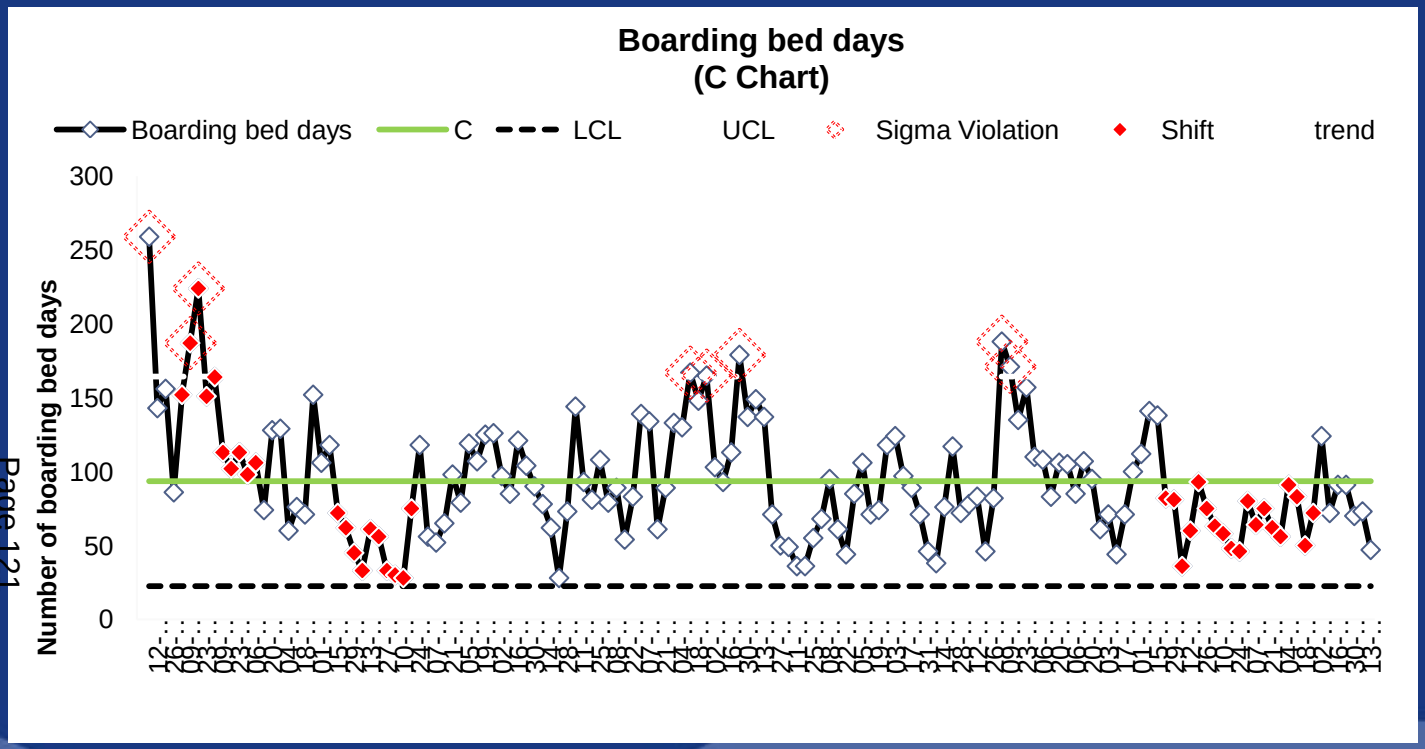
•There has been a 6% fall in emergency admissions between 2016 and 2017

•General Medical Length of stay has fallen by 12% in 2017 compared to 2016



Boarding Patients

AIM: We will intend to have zero boarding patients

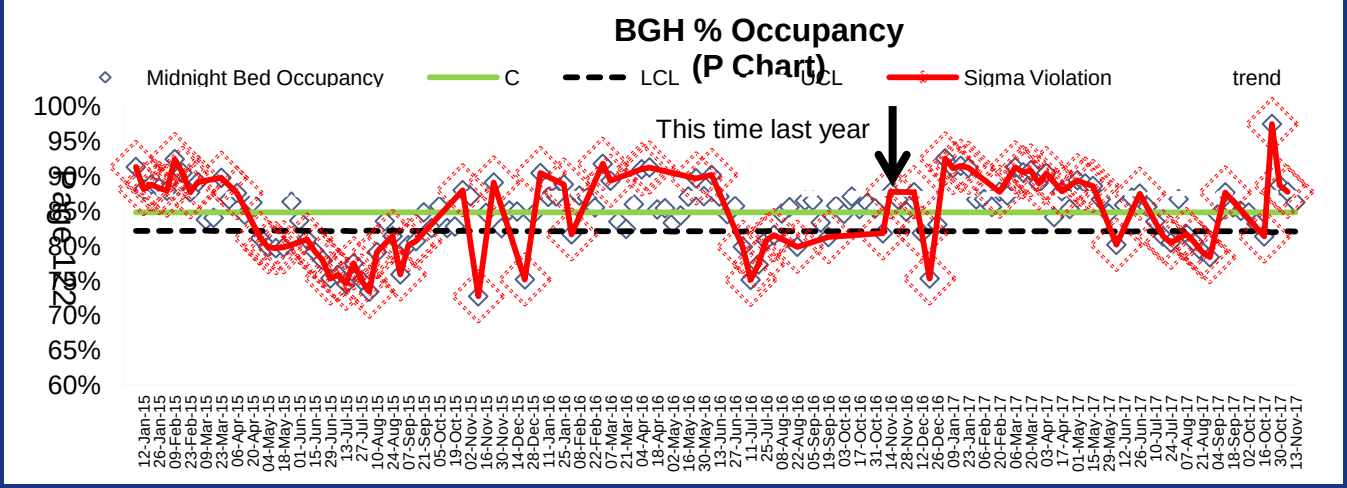


There was an average of 5% of patients boarded between August and Nov 2017. This is the same as for the same period last year.

This represents an average of 11.2 beds occupied by boarders each day

BGH Bed Occupancy and surge beds

AIM: we will maintain bed occupancy rates as close as possible to the 85% target.

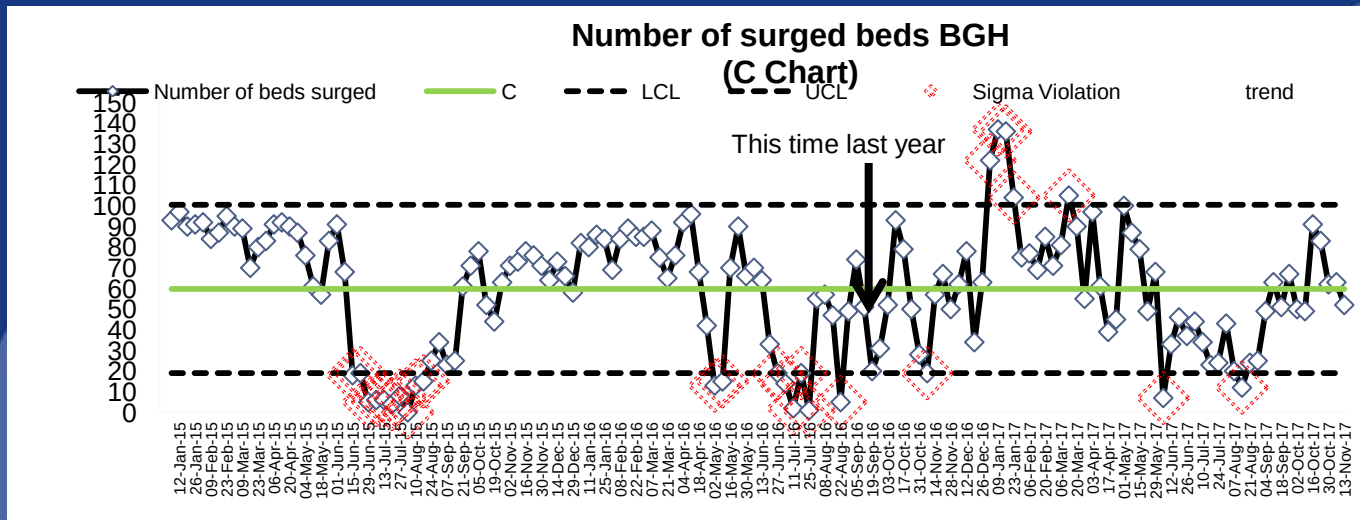


BGH Bed Occupancy has averaged **86.45%** over 2017 compared to **85.31%** for the previous year.

It is currently 87.54%

BGH surge beds have averaged **62.7** beddays/week (**9 beds**) in 2017 compared to **56.3** beddays/week (**8 beds**)in 2016.

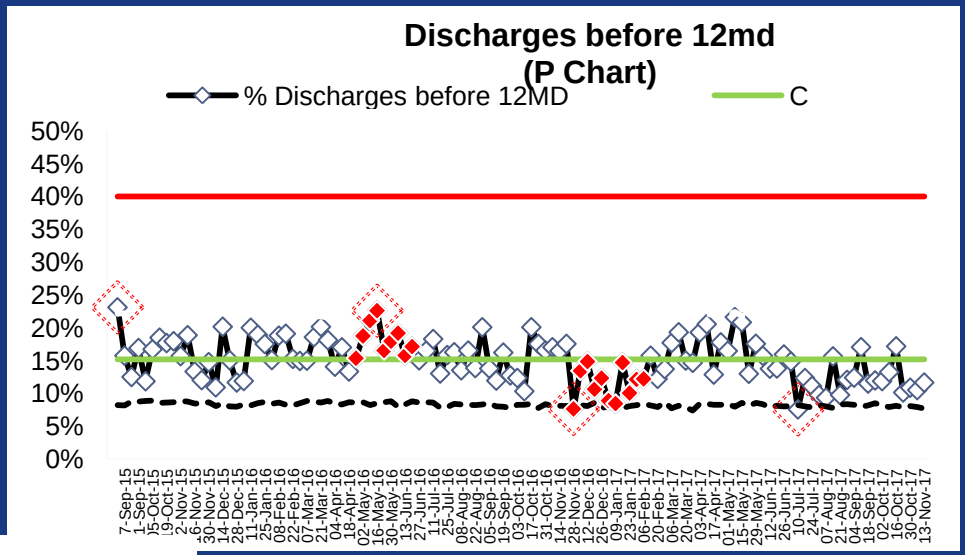
Current position: 52 beddays (7.5 beds)

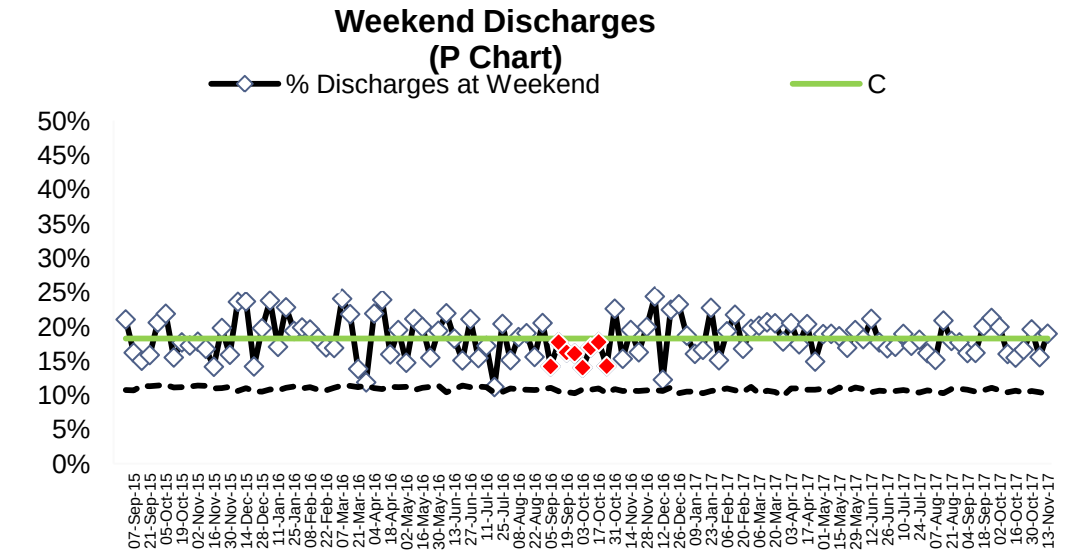


Morning and Weekend Discharges

AIM: to achieve the national standard of 40% of discharges taking place in the morning and to increase average discharges at the weekend by 25%.

Morning Discharges are running at 13% against a target of 40%.

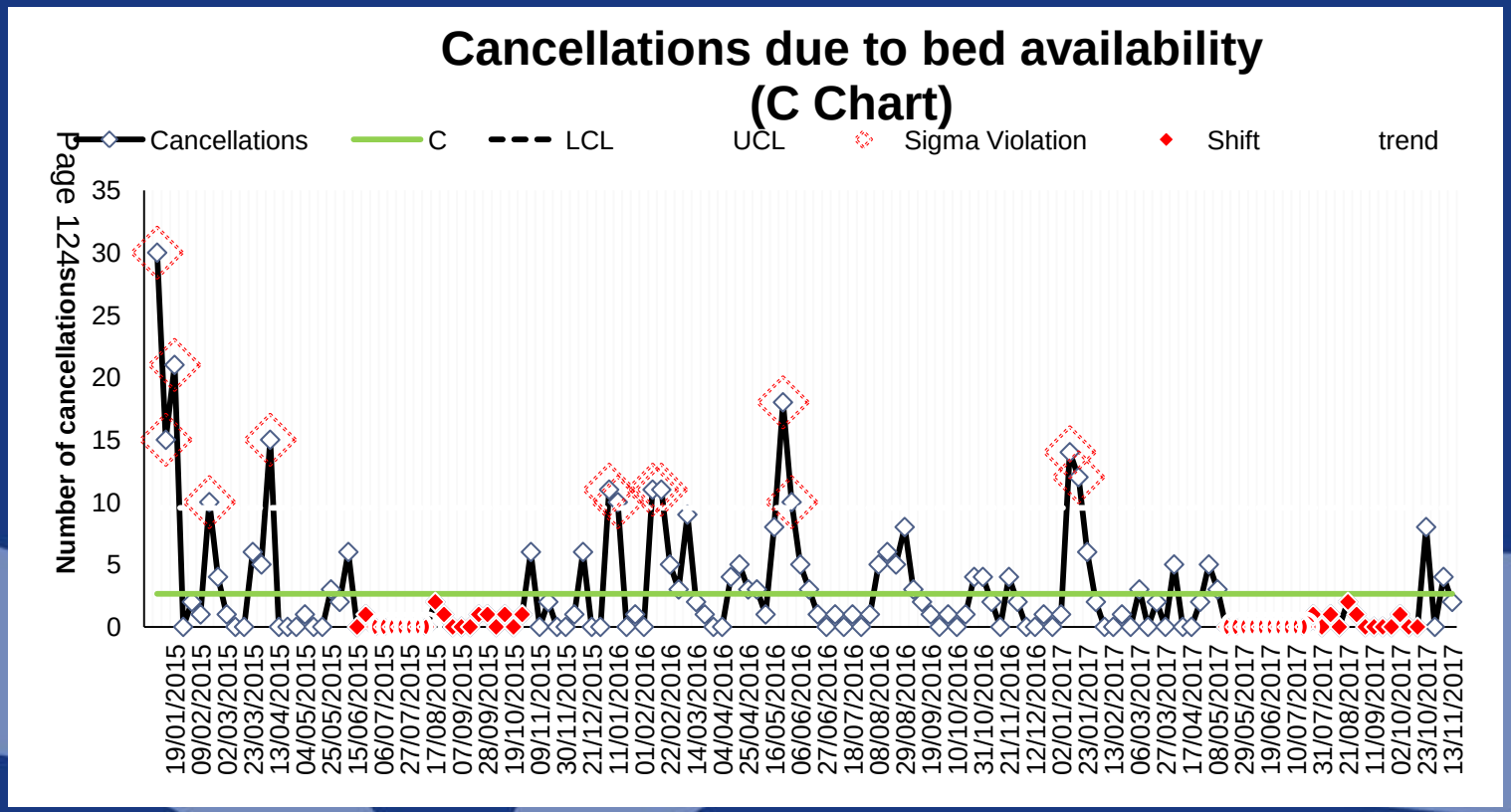




Weekend discharges are running at 18% of weekly discharges against a target of 28%

Cancellations

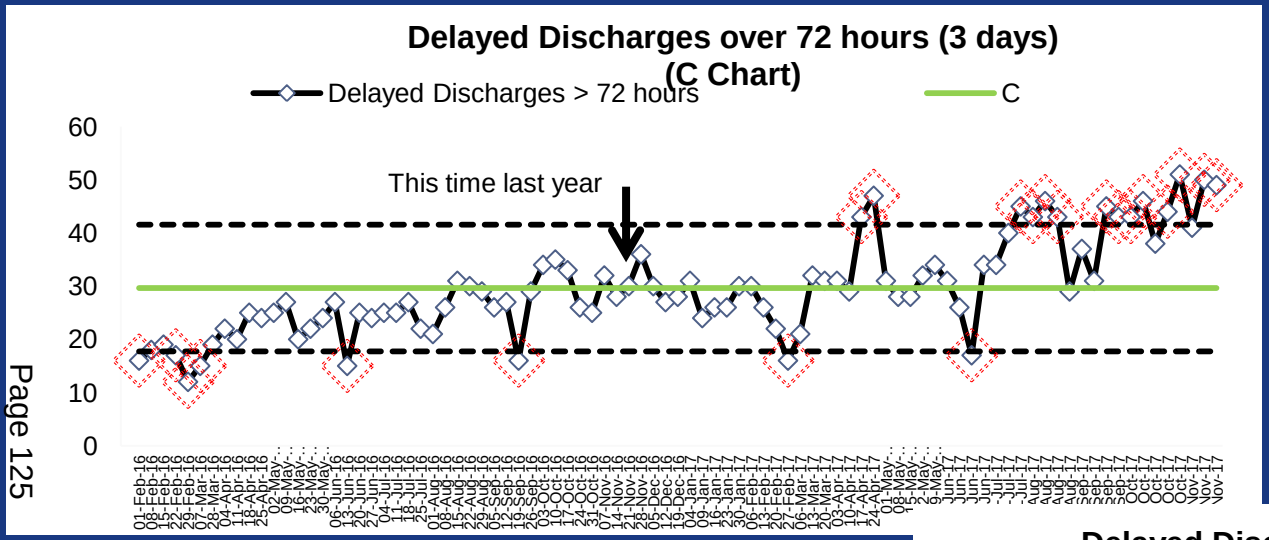
The aim of the Winter Plan is to have no elective procedures cancelled due to availability of beds.



Cancellations due to bed availability have fallen from an average 3.5 per week in 2016 to an average 1.65 per week in 2017

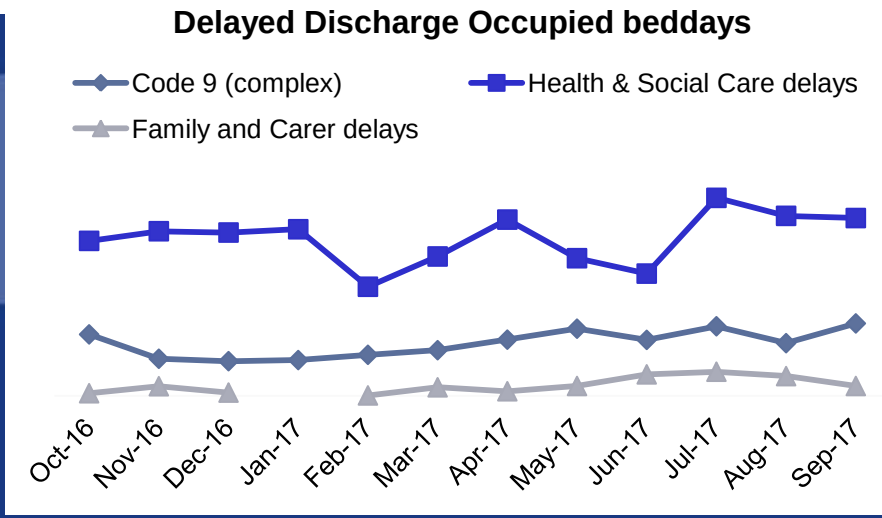
Delayed Discharges

The aim of the Winter Plan is to achieve and maintain zero delayed discharge patients over 72 hours



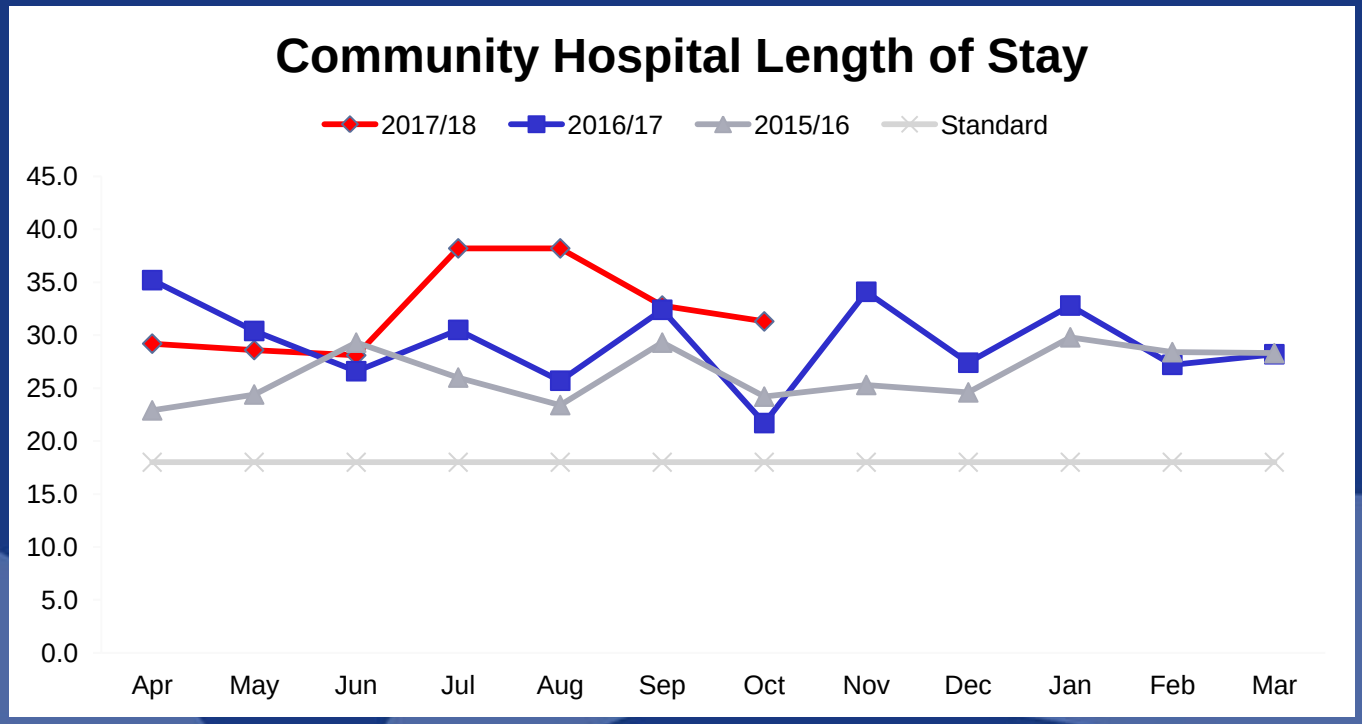
There has been a 27% increase in delayed discharge occupied beddays between Quarter 4 2016 and Quarter 3 2017. The number of beds lost has increased from 31.5 to 40 – an increase of 8.6 beds.

There has been a 46% increase in beddays lost due to complex cases.



Community Hospitals – Average Length of Stay

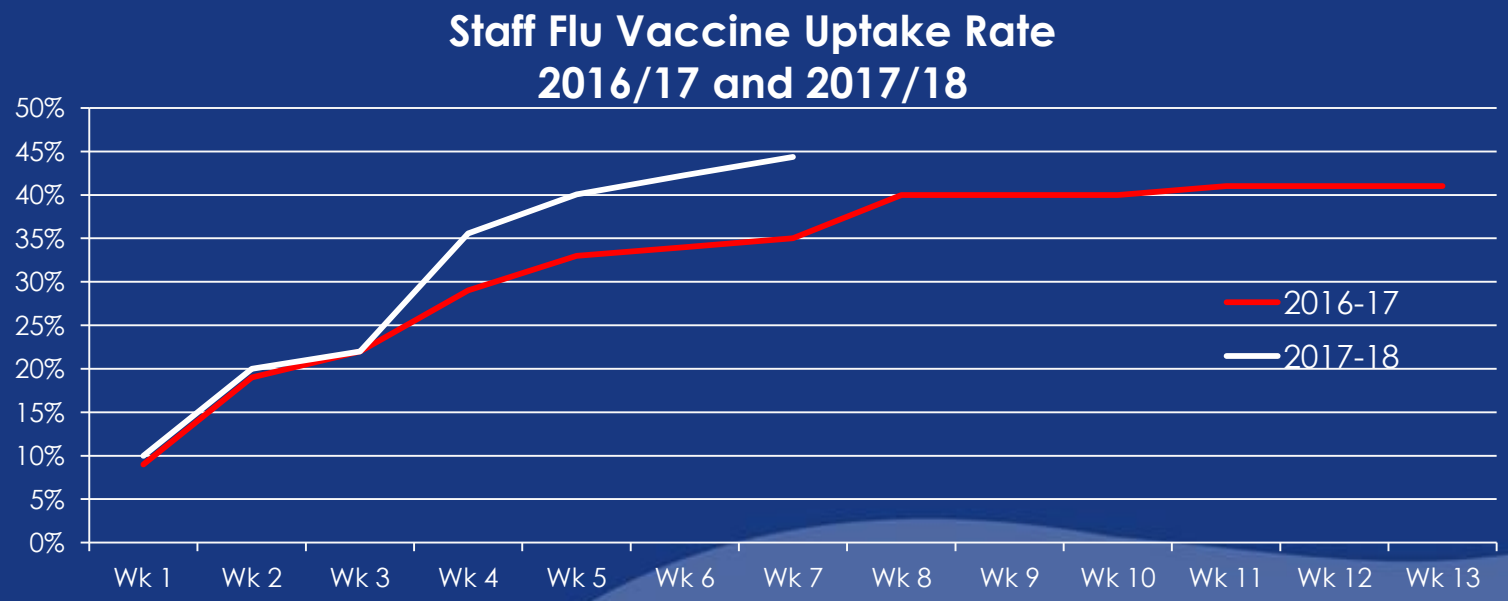
AIM: to maintain Community Hospital bed occupancy at 95% and achieve an average length of stay of 18 days.



•Average length of stay in Community Hospitals for 2017 was 32.3 day - 12% increase on the previous year

Flu Vaccination Uptake

AIM: to achieve the same or better levels of flu vaccination uptake compared to last year.



ACHIEVEMENT: As at 18th November 2017, uptake was at 44%.

Any Questions?

The Carers Act (Scotland) 2016

- Comes into force on 1 April 2018
- Intention is to ensure Scotland's carers can continue caring, have good health and a life alongside caring
- The Act defines a carer as 'an individual who provides or intends to provide care for another individual'
- Act has removed 'regular and substantial' care

Duty to prepare a carer plan or statement

- Adult Carer's Support Plan
  - Name changed from Carer's Assessment
  - CSP looks at five areas of the carer's life and must include emergency and future planning
- Young Carer's Statement for under 18s or those still a pupil at school
- To come - timescales for carers looking after someone with a terminal illness

Duty to support carers

- Local authorities have:
  - a duty to support carers who meet the local eligibility criteria
  - the power to support carers in a preventative manner who do not meet the eligibility criteria

Duty to involve carers

- Care planning
  - Local authorities and health boards have a duty to take into account the views of the carer when planning care, eg hospital discharge
- Developing services and strategies
  - Local authorities must involve carers in the development of local services and eligibility criteria
  - Local carers' strategies will be a joint responsibility for local authorities and health boards

Duty to provide information and advice

- Act places duties on local authorities to:
  - Establish and maintain an information and advice service, including existing services
  - Provide carers with a range of information
  - Publish a short breaks services statement and provide a wide range of breaks

What are the benefits for local carers?

- Increased knowledge of carers' rights
- Early intervention and crisis prevention
- Better:
  - carer engagement and involvement
  - carer health and well-being
  - personal outcomes for carers
  - income maximisation
  - emergency care planning
  - discharge planning, with reduced delays/readmission

Good progress in the Borders so far…

- Nationally:
  - Local carers' views fed into consultation on Act's regulations
  - Representation by Carers' Centre on Scot Gov's working group
- Locally:
  - Health, Social Care Partnership and third sector working group
  - Carers' Advisory Board as a forum to involve and engage carers
  - Local collaboration on eligibility criteria
  - Carer's Support Plan and eligibility criteria (being piloted)
  - Expert Carers' group to model training for professionals
  - Carers' Act training for health and social care professionals

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 18 December 2017

Report By	Robert McCulloch-Graham, Chief Officer
Contact	James Lamb, Portfolio Manager Susan Swan, Interim Chief Financial Officer
Telephone:	01835 826682 01896 825551

PERFORMANCE REPORT - TRANSFORMATION PROGRAMME TRACKER

Purpose of Report:	To update the Health & Social Care Integration Joint Board on progress in developing and delivering the transformation programme.

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

Personnel:	Resource and staffing implications are being developed as part of both the development of the project briefs and the service redesigns that will be addressed through the projects. Programme Proposals are being developed through the Joint H&SC Management Team and with service leads. A workshop was held on 5th September to ensure all key managers in the programme are aware of and engaged in the programme.

Carers:	Not Applicable

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

Financial:	Resource and staffing implications are being developed as part of both the development of the project briefs and the service redesigns that will be addressed through the projects.

Legal:	This Programme will support the delivery of the Partnership's Strategic Plan.

Risk Implications:	The risks relating to each project are being developed as part of the project briefs. Overall, there is a risk that without a robust programme, the Partnership will be unable to address the current – and future – affordability gap.

Background

1.1 A progress report on the development of the programme was presented to the IJB at its 23rd October meeting.

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

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

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

Summary

2.1 As shown in the attached appendices, 4 of the 10 projects are shown as being on track:

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

2.2 6 of the 10 projects are shown as Amber these are:

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

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

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

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

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

- **IT & Telehealth Care** – Good progress is being made in terms of the roll-out of Attend Anywhere (effectively a skype-like video phone application that enables virtual surgeries) and with practical IT problem-solving with integrated teams at various locations. However, the project is shown as amber as a detailed roadmap for a wider IT project has still to be finalised and agreed.

- **Re-imagining Health & Social Care Teams** – The project is still to be formally scoped.

2.3 The current programme does not yet include the indicative financial savings which may be possible from each of the individual projects. Discussions had been planned over October/November with project leads, Chief Financial Officer, Chief Officer and Programme Manager to review the financial context and savings opportunities from each project. However, due to diary constraints, it has not been possible to complete this. Further meetings will be scheduled in the new year to enable this.

2.4 Preliminary discussions on the transformation programme, as developed to date, will result in a targeted level of recurring savings to the IJB in future financial year. As the programme develops, the level of these targeted savings will increase.

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

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

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

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IJB Transformation Programme High Level Delivery Summary Tracker (December 2017)

December 2017

Corporate Lead / *Project Manager*		Programme/ Project	Purpose	Work / Milestones Achieved / Comments on Status – this period to 30 November July 2017		Work / Milestones to be achieved – next period to 31 January 2018
				RAG Progress	Progress on work and reasons for RAG Status	Comments
1	**Kenny Mitchell**/ Stewart Barrie	**Community & Day Hospitals**	Implement best practice service models in Community Hospitals to improve patient pathway and make best use of resources.	**Amber**	**Status is Amber: due to slippage** as key project resources have started since last Programme update (Kenny Mitchell: end of August; Anne Hendry (AH), Project Manager: October) The impact (if any) on key project deliverables will be clearer from AH report and following first Project Board meeting (see below) **Highlights** ▪ Community & Day Hospital Clinical Reference Group (CHRG) – first meeting held *on 27 Sept 2017* ▪ Project Board appointed and first meeting scheduled for December 2017 ▪ Draft Project Team membership identified subject to capacity ▪ Dr Anne Hendry (AH) progressing well with review which is due for completion in January 2018. o AH to present interim findings to next meeting of CHRG on 30th November	• Develop PID/detailed Project Plan • Develop project workstreams (produce discussion paper for Project Board) • First Project Board meeting - Dec 14th 2017 (monthly thereafter) • Project team to be agreed/confirmed o First Project team meeting – Jan 2017 • External "first phase"review process to be progressed. • Service Models to be progressed/confirmed • Establish criteria for appraisal options
2	**Murray Leys**/Lesley Horne	**Care at Home (incl. Enablement)**	Targeted and appropriate Enablement within a homecare setting to deliver improved outcomes for individuals and contribute to reductions in the average hours of long-term care required. Links with Technology Enabled Care (TEC) to enhance or replace direct contact time by carers	**Green**	**Status is green as the project is on track** • Proposal for a pilot enablement project was taken to EMT on 10th November • EMT has requested that CO Health & Social Care Integration leads on a revised proposal utilising Health Care Support Workers (HCSWs) in localities. • Discharge to assess work is progressing at Craw Wood to create a 15-bed capacity. Unit will be operational from 4th December. • Outline target is that patients will only remain in the facility for a maximum of 2 weeks. Care staff will be supported by OT/Physio staff to deliver enablement activity.	Reablement • Revise pilot proposal Enablement • Continue to develop the proposed Care at Home model.
3	**Kenny Mitchell**/ Sonia Borthwick.	**Allied Health Professionals**	The overall project aim is to reshape AHP services in order to support the emerging community services "Out of Hospital Care" model	**Green**	• 3 month data validation started in October 2017 • November/December – new Data Reports will be produced	• December/January – vacancy and resource modelling activities begin • End January – recurring benefit realisation commences
4	**Murray Leys**/ Graeme McMurdo	**Dementia**	Redesign the care and support service to deliver improved outcomes for clients who suffer from dementia.	**Amber**	**Status is amber as there is a need to rescope the project – it's priorities and timescales – in the light of both the draft dementia strategy and recent capital funding bid**: • Draft Scottish Borders Dementia Strategy is now out for consultation (National Dementia Strategy has been published and underpins current consultation on development of Borders Dementia Strategy) • A £4.8m bid to SBC's Capital Programme for a 15 – 24-bed residential dementia unit (locations being explored) • Report being prepared exploring options in support of residential dementia unit including a feasibility for a Scandinavian-style "dementia village", options for dementia care in localities within new extra-care housing and bolstering/enhancing dementia care within the community.	• Continue to engage with stakeholders on the draft Dementia Strategy • Complete report on options for residential care • Clarification of the direct costs of the current dementia care pathway
5	**Simon Burt**/Hayliss Smith	**Mental Health Redesign**	Service redesign in line with Mental Health Needs Assessment Recommendations, MH Strategy and to achieve identified Financial Savings	**Green**	**Status is green as the project is on track.** • Information and Data Gathering is underway • Workshops held with stakeholders and further workshops planned for December to ensure that as many stakeholders as possible have the chance to participate. • Service user workshops are also planned for December to ensure those with lived experience are able to influence future service provision • Survey monkey being used to provide further opportunities to input into the process • Project support identified to undertake benchmarking and desk-based research.	• Aim to produce redesign plan by end March 2018 • Plan for required project and transition support in development • Implementation of redesign plan by end of 2019/20 financial year

Corporate Lead / *Project Manager*		Programme/ Project	Purpose	Work / Milestones Achieved / Comments on Status – this period to 30 November July 2017		Work / Milestones to be achieved – next period to 31 January 2018
				RAG Progress	Progress on work and reasons for RAG Status	Comments
6	**Murray Leys**/ Michael Curran	**Re-Imagining Day Services**	Review of Day Services to identify and deliver a more effective and efficient service options	**Amber**	**Status is amber as mitigating action is needed in other projects to ensure that interdependencies are not missed** • The Ability Centre will be the first centre to be decommissioned as part of the Reimagine Day services project with full decommission complete by end of March 2018 • Clients are already pursuing alternatives in the community and will stop using the building by December this year • The lease for the building expires at the end of December and Interested parties are in discussions with estates on the future use of the building • Staffing will remain in place until the end of the financial year to support the community capacity building team to support clients establish their community based activities • Part of the efficiency (40K) will be reinvested in community connectors to facilitate other centres to become community based. • Interdependency mapping is underway with a session being called to discuss and agree the way forward	• Proposing & Discussing an alternative model for adults & older peoples day services with key strategic managers continues • Developing implementation plan and resources requirements and timescales • Managing interdependencies remains a key risk/opportunity to maximising efficiency and effectivity
7	**Murray Leys**/ Susan Henderson	**Carers Strategy**	Work co-productively, through the Health and Social Care Partnership and children and young people's services, with carer representative organisations and with carers, to implement the legislation effectively.	**Green**	**Status is Green because project is on track** • In conjunction with the Borders Carers Centre a new draft carers support plan has been tested, with positive response from staff and carers to date. • A draft eligibility criteria has been agreed by Carers Act Board. • The young carers implementation group has met to plan progress to meet the legislation. • Options appraisal on the pathways to provide support completed and preferred option agreed by the Carers Act Board.	• Test out draft eligibility criteria and consult with carers groups. • Scope work required for performance reporting to Scottish Government • Plan work and timescales for carers strategy • Progress work on pathway
8	**Tim Patterson**/ Fiona Doig	**Alcohol & Drug Services**	To undertake work with Borders Addiction Service (BAS) and Addaction to confirm potential development of a single management structures and/or co-location to improve joint working	**Amber**	**Status is amber as there is no agreement yet re relocation and associated capital costs** A visit took place to potential co-location site of Galavale on 3.8.17. Addaction have, however, negotiated a reduction in rent which would mitigate savings.	Costings expected from NHS Borders Estates by 17.8.17. Depending on outcome will inform discussions with services. Awaiting meeting with Chief Officer re potential alternative site.
9	**Murray Leys**/ Graeme Dobson (Attend Anywhere) Bill Edwards & Jackie Stephen (IT)	**IT & Telehealthcare**	Delivery of a video conferencing (Attend Anywhere) capability in care homes to support Out of Hours Emergency Care, Diabetes Services and Orthopaedics avoiding the need for expensive travel (time) and hospital visits - including avoidance of missed appointments.	**Amber**	**Status is amber as the project plan is still to be finalised:** **Attend Anywhere** – video conferencing facility. This is a TEC (the national Technology Enabled Care) funded project – a skype-like browser-based facility. • Orthopaedics Dept. trialled Attend Anywhere. Options for future use are being reviewed. • Diabetes Dept. will look pilot Attend Anywhere from January for hard-to-reach younger patients • GP clusters – scoping a pilot with Tweeddale GPs & Nursing/Care Homes in January 18. • MH Services are to be part of a national Distress Brief Intervention (Suicide Prevention) pilot. • Pharmacy services exploring use with community pharmacies and Out of Hours Service. • Out of Hours preparing to pilot with health professionals in the new year. **Wider Integrated Technology Programme** • Draft roadmap to develop integrated IT solutions has been presented to EMT based on: • Collaborative Working – Communications(email/telephony)/Calanders/File-sharing • Person-Centric Data – a single view and single updating of people's records • Workflow – automation of processes and pathways • Assistive Technologies – enabling independent living and avoid unnecessary admissions. Further work continues to refine and agree the roadmap and identify resources to deliver it. **Delivery of Practical Solutions** • Buurtzorg Pilot – Wifi connectivity at Coldstream health centre to enable access to SBC Network • Transitional Care Team – Data points provided at Waverly Care Home to enable access to SBC Network • START/Haylodge – Datapoint enabled to provide access to SBC network.	• Continue to develop Attend Anywhere pilots. • Continue to develop the Integrated Technology Roadmap and identify resources to deliver it. A further resentation will be made to EMT in December. • Continue to identify and deliver practical solutions.
10	**Murray Leys**/ TBC	**Re-Imagining Integrated Health & Social Care Teams**	Design and Implementation of Integrated Health & Social Care Teams across the 5 localities	**Amber**	**Status is amber as the project is still in development.**	•

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 18 December 2017

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Carol Gillie, Director of Finance, NHS Borders David Robertson, Chief Financial Officer, Scottish Borders Council
Telephone:	01896 825555 01835 825012

MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2017/18 AT 30 SEPTEMBER 2017

Purpose of Report:	The aim of this report is to provide an overview of the monitoring position of the Health and Social Care Partnership Budget at 30 September 2017.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) note the report and the monitoring position on the partnership's 2017/18 revenue budget at 30th September 2017; b) note that a recovery plan has been developed by the NHS which based on a number of assumptions and risks forecasts a break even position on NHS budgets will be delivered; c) note social care services are projecting an £130k overspend and work is ongoing it identify the issues and key actions to address the situation.

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

Carers:	Not Applicable

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

Financial:	No resourcing implications beyond the financial resources identified within the report. The report has been reviewed by the Chief Officer and by NHS

	Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer for factual accuracy. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.

Legal:	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.

Risk Implications:	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.

Background

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

1.2 On the 30th March 2017, the Integration Joint Board (IJB) agreed the delegation of £146.288m of resources supporting integrated health and social care functions for financial year 2016/17. At the same time, it noted the proposed budget of £18.978m relating to the large hospitals budget set-aside. Within the delegated budget, £94.490m related to healthcare functions delegated by NHS Borders and £51.978m related to social care functions delegated by Scottish Borders Council.

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

	2017/18 Revised Budget £m
Healthcare Functions – Delegated	98.620
Social Care Functions – Delegated	53.272
Total Delegated	**151.892**
Healthcare Functions - Set-Aside	**19.708**

1.4 This report sets out the current monitoring position on both the delegated and set-aside budgets at 30 September 2017 and details the key areas of financial pressure and proposals for their mitigation.

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Overview of Monitoring Position at 30 September 2017

Delegated Budget

Healthcare Functions

2.1 As in 2016/17, delegated healthcare functions continue to experience considerable financial pressure. Currently, an adverse outturn projection of almost £3.7m is forecast, representing 3.7% of the overall budget. The prime service area where this pressure is being experienced is Generic Services within which a range of miscellaneous functions such as community hospitals, dental, pharmacy and nursing, prescribing and general medical services and primary staffing and management are managed. Generic Services is also where any unallocated savings target is reported.

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

- £1.9m related to shortfall in year on projected savings target in prescribing – a considerable savings target (£3.2m) was applied at the start of the financial and year and currently, £1.7m of schemes have been identified, although delay in releasing savings on particular schemes is impacting on the realisable savings available.
- £0.411m related to the overall unachieved balance on the operational budgets 3% savings targets.
- £1.239m of £1.922m recurring savings that were carried forward from 2016/17 that will not be delivered in year and no mitigating action has been identified.

2.3 The NHS Financial Recovery Plan for 2017/18 has been discussed by the Executive Management Team (EMT) and was presented to the NHS Borders Board at its October and December meeting (Attachment 1). The NHS is projecting a breakeven financial year end position based on a number of assumptions and caveated by a number of risks.

Social Care Functions

2.4 Social care functions are currently projecting a year end overspend position of £0.130m.

2.5 The projected year end overspend level is predicated 'on yet to be defined recovery actions' totalling £0.170m which are being discussed within the Management Team.

2.6 The year end predicted overspend is the result of slippage in the assumed level of savings within Social Care Delegated Functions primarily linked to the review of care packages (£110K), care at home within Older People (£237k) and the deployment of technology in clients homes (£50k).

2.7 The IJB has been asked by Scottish Borders Council (SBC) to consider an allocation of Social Care Fund monies to cover the predicted overspend of £0.130m. Further work is being undertaken with services to understand the issues and before a recommendation is able to be made to the Board.

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Large Hospital Budget Set-Aside

2.8 Set Aside budgets are reporting a projected £4.2m overspend position.

2.9 The EMT was recently updated on the NHS Financial Recovery Plan for 2017/18, which highlighted the in year funding pressures within the Set Aside budget areas including agency costs to staff surge bed capacity and as cover for vacancies, additional staffing to address clinical risk and outstanding efficiency targets.

2.10 A main area of overspend reported by the NHS for 2017/18 is the additional costs incurred by the continuing provision of surge bed capacity to address the ongoing high number of delayed discharges occupied bed days across the health system. The reported financial position is prior to the approval given by the IJB at its 23rd October 2017 meeting to allocate £1m of Social Care Fund monies as a contribution to the costs incurred relating to surge bed capacity within the health system.

Recovery Planning and Delivery

3.1 A priority for the IJB is in ensuring a sustainable approach to financial planning and management within the partnership in line with the Board's approved Financial Strategy.

3.2 Section 3 above clearly outlines significant ongoing financial pressures across health and social care delegated services and set aside budgets.

3.3 For health the 2017/18 Financial Recovery Plan has been discussed by the EMT and been presented to the NHS Borders Board at its October and December meetings. The NHS 2017/18 Recovery Plan reports a breakeven year end position based on a number of assumptions and caveated with some significant risks. The key actions taken by the NHS within the recovery plan include:

- The use of capital funding to support revenue pressures
- Slippage on a number of planned investments
- Technical accounting adjustments

The NHS will review the level of resources provided to the IJB in line with these actions.

3.4 For social care functions by incorporating the anticipated mitigating actions by the Scottish Borders Council-wide savings programme a year end overspend of £0.130m is currently being forecast. Discussions are ongoing with services which may result in a recommendation being made to the IJB at a later date to allocate further Social Care Fund monies to social care delegated functions.

Risk

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

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

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

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Borders NHS Board

2017/18 UPDATED RECOVERY PLAN

Aim

The aim of this paper is to advise the Board of the projected 2017/18 year end financial position. This paper builds on the information previously presented to the Board at the development sessions in August and September and the Board meeting in October.

Executive Summary

The key points to note from this report are:

- As at the 31st October 2017 NHS Borders is reporting an overspend of £5.4m on revenue budgets. Based on the October position, there remains significant pressure on operational budgets and a shortfall on the delivery of the efficiency programme.
- Further to the recovery plan presented at the October Board meeting and as a result of a number of actions including the direction of £1m of resources from the Integration Joint Board (IJB) NHS Borders is projecting a break even position at 31st March 2018. The achievement of the forecast break even outturn position is not without significant risk not least of which is winter.
- Due to the significant number of non recurring measures in the 2017/18 recovery plan the recurring position of NHS Borders remains an area of significant concern.

Background

At its meeting in April the Board approved a financial plan, as part of the local delivery plan (LDP) for 2017/18 which included an efficiency savings delivery of £12.9m recurrently and £2.7m on a non recurring basis and noted a projected shortfall totalling £3.8m on this requirement.

The Board finance report has noted that the organisation has encountered significant ongoing financial pressures in 2017/18, principally linked to operational budgets and slippage on the delivery of the efficiency programme. At the Board meeting on the 26th October 2017 a recovery plan for 2017/18 was presented which projected a year end overspend position £0.965m and noted work was ongoing to deliver a break even position. The Board requested an update on the recovery plan at its December meeting.

This report considers:

- The financial position as at end of October 2017.
- An updated forecast year end position at 31st March 2018.
- The risks associated with the forecast position.
- The 2018/19 and onwards financial outlook.

Financial Position as at End of October 2017

The Board Finance report details the position to the end of October as being £5.4m overspent.

The key pressures are:

- The Acute Services, including set aside budgets, are overspent on expenditure budgets by £4.4m. This is due to increased medical (£0.9m), nursing (£1.2m) and drug (£0.7m) costs and a shortfall in the delivery of efficiency (£1.2m). A key driver for the increased costs is activity levels linked to delayed discharges, patient acuity and staff cover particularly due to the high sickness levels experienced during October in relation to Norovirus.
- External healthcare providers are £0.5m overspent linked to a increased cost of activity within NHS Lothian, UNPACS activity and ECR placements.
- Within IJB directed services a shortfall on the delivery of general and prescribing efficiency is the key reason for the reported overspend.

Updated Forecast Year End Position

The financial position at the end of October is the basis for the year end outturn.

Based on the robust management of budgets and no unforeseen events the forecast year end position is £0.2m underspent. This position must be treated with a significant degree of caution as due to the small underspend forecast any adverse event could easily cause the position to deteriorate.

	£m	**£m**	**£m**
Forecast year end position presented to October Board	**(1.0)**		
Actions			
IJB direction of resource		1.0	
Operational action/pressures		0.2	
Forecast year end position presented to December Board			**0.2**

The key reasons for the update in the year end forecast:

- At its meeting on the 23rd October 2017 the IJB agreed to direct £1m of resource to offset the increased cost of delayed discharge occupied bed days across the organisation.
- Operational pressures have been impacted on as a result of:
    - Updated information regarding out of area patients reducing the forecast overspend.
    - Management action reducing expenditure levels in support services operational budgets.
    - The positive impact of the procurement project on supplies costs.
    - An increase in the forecast nursing overspend due to the impact of norovirus on agency costs in October.

The revised forecast position is based on a number of key assumptions:

- Continued robust management of all budgets across the organisation.
- All Clinical Boards and departments achieve the revised agreed out turn position or better including any unexpected events such a medical vacancies.
- £9.1m of efficiency is delivered.
- There are no new national or local issues which impact on prescribing costs and delivery of savings.
- The spend on drugs associated with the new medicines fund is no greater than the allocations received.
- External healthcare spend is based on the current patient cohort and normal referral patterns.
- The level of spend related to the achievement of waiting times in no more than that received from Scottish Government (SG).
- No new developments are approved unless funding sources have been identified.

The following key areas are still being considered to support delivery of the financial position:

- The impact of the financial control measures which are in place and are being relaunched.
- Continued review of non recurring ring fenced allocations received in the remainder of the financial year.
- Review of accounting policies, technical adjustments and slippage on national/regional agreed LDP developments.
- Dialogue with the Scottish Government on the Board's financial position is ongoing.

The Board should not underestimate the challenge it is facing to deliver its financial targets in 2017/18. The achievement of a break even position will require senior leadership, operational management focus and continued attention. The pressures of winter and the requirement to meet performance targets will be extremely testing for the Board and the organisation.

Risks

Whilst every effort has been made to ensure all likely additional costs and national, regional and local priorities have been incorporated into the forecast year end position, there remains a number of inherent uncertainties and risks. It is not possible to eradicate all financial risks facing individual services or the wider organisation. Specific risks to be noted include the impact of:

- Management of in year run rate on operational services to deliver the agreed year end out turn position.
- Availability of the workforce.
- The level of delayed discharges in the health system.
- Winter – including a potential flu outbreak or norovirus.
- Ongoing delivery of in year savings targets including medicines and clinical productivity.
- Impact of national price changes to medicines and the introduction of new high cost medicines.
- Out of areas referrals, particularly high cost placements.

These key risks will be monitored to ensure early identification of issues and assessment of likely impact on the year end position.

2018/19 Onwards Financial Outlook

Based on current information the Board continues to forecast a year end recurring deficit estimated to be £8.8m, an increase from the £4.9m recurring deficit at the start of 2017/18. The Board must continue to consider how this deficit can be reduced and work to establish a robust financial outlook for 2018/19. It is anticipated that the Board will receive a draft allocation for 2018/19 and some indication of the prospect for future years late in December. Nevertheless it is clear that the outlook remains increasingly challenging. Not only will the Board be required to address the recurring deficit of £8.8m but will also need to deliver further efficiencies to meet future pressures.

Work will continue over the coming weeks and months as the Better Borders transformation programme develops further and individual workstreams provide greater clarity on the likely financial impact. In addition, a further assessment of the in year position will bring greater clarity on the recurring impact of any existing or emerging cost pressures. There are limited plans in place for future financial years and it is imperative that the Board remains alert to the financial challenge it faces.

It is planned to present a paper detailing the financial outlook to the Board at its meeting on the 18th January 2018.

Summary

The Board received a 2017/18 recovery plan paper at its meeting in October which forecast a year end position of £0.965m overspent. The Board requested an update on the recovery plan at its December meeting.

Based on the financial position (£5.4m overspent) at the 31st October 2017 and as a result of a number of actions taken in line with the recovery plan including the direction of £1m of resources from the Integration Joint Board (IJB) NHS Borders is projecting a break even position at 31st March 2018. The achievement of the forecast break even outturn position is not without significant risk not least of which is winter.

Due to the significant number of non recurring measures in the 2017/18 recovery plan the recurring position of NHS Borders remains an area of significant concern.

Recommendation

The Board is asked to **note** the update on the year end recovery plan and a forecast break even position at 31st March 2018.

The Board is asked to **request** a further update on the recovery plan if a break even position is no longer forecast.

Policy/Strategy Implications	Statutory requirement to deliver financial targets. Based on allocations received by the Board and spend in line with LDP. Takes account of planning/horizon scanning undertaken by the Board.

Consultation	Ongoing presentations across the organisation.
Consultation with Professional Committees	Ongoing presentations across the organisation.
Risk Assessment	The range in the paper gives an indication of the risk.
Compliance with Board Policy requirements on Equality and Diversity	Complete
Resource/Staffing Implications	As detailed in the paper.

Approved by

Name	Designation	Name	Designation
Carol Gillie	Director of Finance, Procurement, Estates & Facilities		

Author(s)

Name	Designation	Name	Designation
Janice Cockburn	Deputy Director of Finance		

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MONTHLY REVENUE MANAGEMENT REPORT

Summary	2017/18	At end of Month:	September

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	19,396	8,909	20,429	20,120	309	
Joint Mental Health Service	15,850	7,467	15,511	15,574	(63)	
Joint Alcohol and Drug Service	1,006	346	651	651	0	
Older People Service	24,448	6,624	26,255	26,424	(169)	
Physical Disability Service	6,161	1,733	3,856	3,661	195	
Generic Services	80,501	42,920	85,190	89,252	(4,062)	
Large Hospital Functions Set-Aside	18,978	12,387	19,708	24,617	(4,192)	
Total	166,340	80,386	171,600	180,299	(7,982)	

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MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	15,753	7,136	16,807	16,553	254	A number of areas of pressure, in particular the ongoing level of care at home hours compared to delivery of targeted financial plan savings is causing further pressure across the Older People's service.
Joint Mental Health Service	1,969	814	1,982	1,995	(13)	
Joint Alcohol and Drug Service	173	47	171	171	0	Budgets remain requiring realignment in Business World across social care services in line with funding directed and targeted savings.
Older People Service	24,448	6,624	26,255	26,424	(169)	
Physical Disability Service	6,161	1,733	3,856	3,661	195	Actual Generic spend includes carry forward of ICF from 2016/17. Main driver of reported variance is concern over the delivery of savings from previous year's financial plan, which still require delivery actions to be identified and actioned. Assumes delivery in full of £170k recovery plan in development.
Generic Services	4,368	(1,188)	4,201	4,598	(397)	
Total	52,872	15,166	53,272	53,402	(130)	

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MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,643	1,773	3,622	3,567	55	Within generic services the key issues are (1) Nursing in Community Hospitals related to agency spend covering vacant posts, patient dependancy and sickness absence (£250k). (2) AHP non delivery of savings, both prior and current year targets (£358k). (3) A shortfall on the projected savings in GP prescribing (£1,685k).(4) Recurring savings carried forward from 2016/17 and elements of the in year 3% savings target which will not be delivered
Joint Mental Health Service	13,881	6,653	13,529	13,579	(50)	
Joint Alcohol and Drug Service	833	299	480	480	0	
Generic Services	76,133	44,108	80,989	84,654	(3,665)	
Total	94,490	52,833	98,620	102,280	(3,660)	

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MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	**1,997**	**1,276**	**2,035**	**2,671**	**(636)**	A&E overspends are related to management of risk and increased medical staffing costs. In Medicine & long term conditions additional Nursing and Medical costs have been incurred due to the requirement for surge beds. In medicine for the elderly the additional staffing costs is linked to gaps in the medical rota and the acuity of patients on some wards. Savings and planned actions relate to the unmet element of the 3% target
Medicine & Long-Term Conditions	**11,633**	**7,574**	**12,056**	**14,978**	**(2,205)**	
Medicine of the Elderly	**6,020**	**3,537**	**6,334**	**6,968**	**(634)**	
Savings and Planned Actions	**(672)**	**0**	**(717)**	**0**	**(717)**	
Total	**18,978**	**12,387**	**19,708**	**24,617**	**(4,192)**	

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