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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Monday, 23rd April, 2018** at **2.00 pm** in Committee Room 2, Scottish Borders Council

AGENDA

Time	No		Lead	Paper
14:00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	Verbal
14:02	**2**	**REGISTER OF INTERESTS**	Chief Officer	(Pages 3 - 24)
14:03	**3**	**MINUTES OF PREVIOUS MEETING** 19 March 2018	Chair	(Pages 25 - 28)
14:05	**4**	**MATTERS ARISING** Action Tracker	Chair	(Pages 29 - 32)
14:10	**5**	**CHIEF OFFICER'S REPORT**	Chief Officer	(Pages 33 - 36)
14:15	**6**	**FOR DECISION**		
	6.1	Scottish Borders Health & Social Care Partnership Financial Plan 2018/19	Chief Financial Officer, SBC Director of Finance, NHS Borders Finance Director	(Pages 37 - 56)
	6.2	Integrated Care Fund Review of Projects 2015 - 18	Chief Officer	(Pages 57 - 92)
	6.3	Integration Joint Board Meeting Cycle	Chair	(Pages 93 - 94)
14:45	**7**	**FOR NOTING**		

	7.1	Scottish Borders Health and Social Care Partnership 2017/18 Winter Period Evaluation Report	Chief Officer	(Pages 95 - 120)
	7.2	Strategic Planning Group Report	Chief Officer	(Pages 121 - 124)
	7.3	Inspections Update	Chief Social Work Officer	
	7.4	Quarterly Performance Report	Chief Officer	(Pages 125 - 164)
	7.5	Equality Mainstreaming Progress Report	Chief Officer	(Pages 165 - 188)
15:55	**8**	**ANY OTHER BUSINESS**		
	8.1	Health & Social Care Integration Joint Board Development Session: 28 May 2018 • Strategic Commissioning & Implementation Plan 2018-2021	Chief Officer	
16:00	**9**	**DATE AND TIME OF NEXT MEETING** Monday 11 June 2018 at 2.00pm in Committee Room 2, Scottish Borders Council	Chair	

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 23 April 2018.....

Scottish Borders Health and Social Care PARTNERSHIP

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Iris Bishop, Board Secretary
Telephone:	01896 825525

REGISTER OF INTERESTS

Purpose of Report:	To seek approval of the Register of Interests
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the Register of Interests.
Personnel:	N/A
Carers:	N/A
Equalities:	Compliant
Financial:	N/A
Legal:	Statutory requirement.
Risk Implications:	N/A

Description of interests to be registered – pages 2-4

The Register of Interests for members of the Scottish Borders Health & Social Care Integration Joint Board follow on pages 5-22.

Hard copies of which can be obtained by contacting the Board Secretary, Borders NHS Board, Headquarters, Education Centre, Borders General Hospital, Melrose, TD6 9BD.

The Register of Interests has been drawn up in accordance with the Ethical Standards in Public Life etc (Scotland) Act 2000 (Register of Interests) Regulations 2003 as amended, Board Members of devolved public bodies are required to give notice of their interest under the following headings:-

1. REMUNERATION

i. You have a registerable interest where you receive remuneration by virtue of being:-
- Employed;
- Self-employed'
- The holder of an office;
- A director of an undertaking;
- A partner in a firm; or
- Undertaking a trade, profession or vocation, or any other work.

ii. In relation to the above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

iii. If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two "Related Undertakings".

iv. If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

v. When registering employment, you must give the name of the employer, the nature of its business and the nature of the post held in the organisation.

vi. When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

vii. Where you otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication and the frequency of articles for which you are paid.

viii. When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and detail of the nature of its business.

ix. Registration of a pension is not required as this falls outside the scope of the category.

2. RELATED UNDERTAKINGS

i. You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of a company (or other undertaking) in which you hold a remunerated directorship.

ii. You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

iii. The situations to which the above paragraph apply are as follows:-

- You are a director of a Board of an undertaking and receive remuneration declared under category one; and
- You are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

3. CONTRACTS

i. You have a registerable interest where you, or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 6(i) below, have made a contract with Scottish Borders Council or NHS Borders:-

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

ii. You much register a description of the contract, including its duration, but excluding the consideration.

4. HOUSES, LAND AND BUILDINGS

i. You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.

ii. The test to be applied when considering the appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

5. INTERESTS IN SHARES AND SECURITIES

i. You have a registerable interest where you have an interest which may be significant to, of relevance to, or bear upon, the work and operation of the IJB, in shares comprised in the share capital of a company or other body and the nominal value of the shares is:-

a) greater than 1% of the issued share capital of the company or other body; or
b) greater than £25,000.

ii. Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

6. GIFTS AND HOSPITALITY

i. You must register the details of any gifts or hospitality received within your current term of office, except that it is not necessary to record any gifts or hospitality as described as follows:-

a) isolated gifts of a trivial character the value of which must not exceed £50;
b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or
c) civic gifts received on behalf of the public body.

7. NON FINANCIAL INTERESTS

i. You may also have a registerable interest if you have non financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations are registered and described.

ii. In the context of non financial interest, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	STEPHEN PETER MATHER
Category of Membership	VOTING
Date of Declaration	12th FEB 2018
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	AS NON-EXEC DIRECTOR NHS
2	**Related Undertakings**	NIL
3	**Contracts**	NIL
4	**Houses, Land and Buildings**	NIL
5	**Shares and Securities**	NIL
6	**Gifts and Hospitality**	NIL
7	**Non Financial Interests**	NIL .

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	DAVID DAVIDSON
Category of Membership	VOTING – NHS NED.
Date of Declaration	12.2.18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	SELF EMPLOYED
2	**Related Undertakings**	NIL
3	**Contracts**	NIL
4	**Houses, Land and Buildings**	NIL
5	**Shares and Securities**	NIL
6	**Gifts and Hospitality**	NIL
7	**Non Financial Interests**	NIL

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	KAREN HAMILTON
Category of Membership	VOTING MEMBER - NED
Date of Declaration	12.2.18
Member's Signature	Karen Hamilton

	Registerable Interest	**Description of Interest**
1	**Remuneration**	NIL
2	**Related Undertakings**	NIL
3	**Contracts**	NIL
4	**Houses, Land and Buildings**	NIL
5	**Shares and Securities**	NIL
6	**Gifts and Hospitality**	NIL
7	**Non Financial Interests**	NIL

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	*Please insert full name* JOHN RAINE
Category of Membership	*Please state if voting or non voting member and in what capacity ie:* VOTING *Non Voting Member (Carer Representative/Staff Representative/Professional Advisor, etc)*
Date of Declaration	21/2/18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	REMUNERATION AS OFFICE HOLDER; CHAIRMAN NHS BORDERS
2	**Related Undertakings**	NONE
3	**Contracts**	NONE
4	**Houses, Land and Buildings**	N/A
5	**Shares and Securities**	N/A
6	**Gifts and Hospitality**	NONE
7	**Non Financial Interests**	TRUSTEE AND CHAIR NHS BORDERS CHARITABLE TRUST

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	TRIS TAYLOR
Category of Membership	VOTING MEMBER
Date of Declaration	12/02/2018
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	NIL
2	**Related Undertakings**	NIL
3	**Contracts**	NIL
4	**Houses, Land and Buildings**	NIL
5	**Shares and Securities**	NIL
6	**Gifts and Hospitality**	NIL
7	**Non Financial Interests**	NIL

Scottish Borders Health & Social Care
Integration Joint Board

REGISTER OF INTERESTS

Member's Name	David Parker
Category of Membership	Non Executive Director
Date of Declaration	14 February 2018
Member's Signature	

Registerable Interest	Description of Interest
1. Remuneration	Non Executive Member of NHS Borders Non Executive Member of the Scottish Local Government Pensions Agency Non Executive Member of the Scottish Teachers Pension Agency
2. Related Undertakings	Non Executive Member of NHS Borders
3. Contracts	Nil
4. Houses, Land and Buildings	Joint owner of 6 Shielswood Court, Tweedbank
5. Shares and Securities	Nil
6. Gifts and Hospitality	Monthly submission provided to SBC
7. Non Financial Interests	Non Executive Member of NHS Borders Non Executive Member of the Scottish Local Government Pensions Agency Non Executive Member of the Scottish Teachers Pension Agency

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	Helen Haig
Category of Membership	Voting Member, Elected representative.
Date of Declaration	12-1-18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	Employee of Northumbria Healthcare
2	**Related Undertakings**	
3	**Contracts**	
4	**Houses, Land and Buildings**	House owner Ayton.
5	**Shares and Securities**	
6	**Gifts and Hospitality**	
7	**Non Financial Interests**	

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	*Please insert full name* SHONA HASLAM
Category of Membership	*Please state if voting or non voting member and in what capacity ie: Non Voting Member (Carer Representative/Staff Representative/Professional Advisor, etc)*
Date of Declaration	28/3/18.
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	Leader of Scottish Borders Council.
2	**Related Undertakings**	
3	**Contracts**	
4	**Houses, Land and Buildings**	Owner - The Courthouse Residence Owner - 7 Cherry Court, Peebles (Business)
5	**Shares and Securities**	Slop.
6	**Gifts and Hospitality**	None
7	**Non Financial Interests**	Trustee Peebles Skate Park Group

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	Tom Weatherson.
Category of Membership	Elected member SBC
Date of Declaration	12-2-18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	Employed SBC
2	**Related Undertakings**	Nil
3	**Contracts**	Nil
4	**Houses, Land and Buildings**	60 Oakfield Court Kelso 60 Inchmelo Kelso
5	**Shares and Securities**	Nil
6	**Gifts and Hospitality**	Nil
7	**Non Financial Interests**	Nil

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	JOHN GREENWELL
Category of Membership	ELECTED MEMBER SBC
Date of Declaration	12 SEPT 2018
Member's Signature	JAG

	Registerable Interest	Description of Interest
1	**Remuneration**	EMPLOYED SBC
2	**Related Undertakings**	NIL
3	**Contracts**	NIL
4	**Houses, Land and Buildings**	NIL
5	**Shares and Securities**	NIL
6	**Gifts and Hospitality**	NIL
7	**Non Financial Interests**	NIL

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	Robert McCulloch-Graham
Category of Membership	None voting
Date of Declaration	12/2/18.
Member's Signature	

	Registerable Interest	Description of Interest
1	**Remuneration**	Chief Officer.
2	**Related Undertakings**	None
3	**Contracts**	None
4	**Houses, Land and Buildings**	None
5	**Shares and Securities**	None
6	**Gifts and Hospitality**	None
7	**Non Financial Interests**	None.

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
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PARTNERSHIP

REGISTER OF INTERESTS

Members Name	*Please insert full name* CLIFF SINAPP
Category of Membership	*Please state if voting or non voting member and in what capacity ie: Non Voting Member (Carer Representative/Staff Representative/Professional Advisor, etc)* NON VOTING (PROFESSIONAL ADVISER)
Date of Declaration	12/2/18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	None
2	**Related Undertakings**	None
3	**Contracts**	None
4	**Houses, Land and Buildings**	None
5	**Shares and Securities**	None
6	**Gifts and Hospitality**	None
7	**Non Financial Interests**	None

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	CLAIRE PEARCE
Category of Membership	NON VOTING
Date of Declaration	9-4-18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	EMPLOYED BY NHS BORDERS
2	**Related Undertakings**	NIL
3	**Contracts**	NIL
4	**Houses, Land and Buildings**	NIL
5	**Shares and Securities**	NIL
6	**Gifts and Hospitality**	NIL
7	**Non Financial Interests**	NIL

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	DAVID BELL
Category of Membership	Non-voting, co-chair JSF
Date of Declaration	12-2-18
Member's Signature	D J Bell

	Registerable Interest	**Description of Interest**
1	**Remuneration**	SBC EMPLOYEE
2	**Related Undertakings**	nil
3	**Contracts**	nil
4	**Houses, Land and Buildings**	nil
5	**Shares and Securities**	nil
6	**Gifts and Hospitality**	nil
7	**Non Financial Interests**	LAY OFFICIAR UNITE THE UNION.

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	JOHN MCLAREN
Category of Membership	STAFF REPRESENTATIVE - NHS
Date of Declaration	16.2.18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	Paid Employee of NHS Borders
2	**Related Undertakings**	Nil.
3	**Contracts**	Nil
4	**Houses, Land and Buildings**	Nil
5	**Shares and Securities**	Nil
6	**Gifts and Hospitality**	Nil
7	**Non Financial Interests**	member of Unite the union. registration with NMC. Member of Langlee Residents Association.

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
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PARTNERSHIP

REGISTER OF INTERESTS

Members Name	Jennifer Smith (Jenny)
Category of Membership	Non Voting Member, Third Sector
Date of Declaration	12/2/18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	
2	**Related Undertakings**	
3	**Contracts**	
4	**Houses, Land and Buildings**	
5	**Shares and Securities**	
6	**Gifts and Hospitality**	
7	**Non Financial Interests**	Chief officer of third sector org contracted by SBC + NHS Borders. - Borders Care Voice

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
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REGISTER OF INTERESTS

Members Name	*Please insert full name* COLIN F. L MCGRATH
Category of Membership	*Please state if voting or non voting member and in what capacity ie:* *Non Voting Member (Carer Representative/Staff Representative/Professional Advisor, etc)*
Date of Declaration	12.2.18
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	
2	**Related Undertakings**	
3	**Contracts**	
4	**Houses, Land and Buildings**	
5	**Shares and Securities**	
6	**Gifts and Hospitality**	
7	**Non Financial Interests**	

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	Angus McLean
Category of Membership	Non voting member
Date of Declaration	26.3.18
Member's Signature	A McLean

	Registerable Interest	Description of Interest
1	**Remuneration**	None
2	**Related Undertakings**	None
3	**Contracts**	None
4	**Houses, Land and Buildings**	None
5	**Shares and Securities**	None
6	**Gifts and Hospitality**	None
7	**Non Financial Interests**	None

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of an **Extra Ordinary Health & Social Care Integration Joint Board** meeting held on Monday 19 March 2018 at 11.25am in Committee Room 2, Scottish Borders Council.

Present:	(v) Cllr D Parker	(v) Dr S Mather (Chair)
	(v) Cllr H Laing	(v) Mr D Davidson
	(v) Cllr S Haslam	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	(v) Mr J Raine
	Mr D Bell	(v) Mr T Taylor
	Mrs J Smith	Mrs E Reid
	Dr A Howell	Mr R McCulloch-Graham
	Ms L Gallacher	Dr A McVean
	Mr C McGrath	Mr M Leys
In Attendance:	Miss I Bishop	Mrs J Robertson
	Mrs T Logan	Mr L Gill
	Mrs S Bell	Mrs S Holmes

1. Apologies and Announcements

Apologies had been received from Cllr John Greenwell, Mrs Susan Swan, Dr Cliff Sharp, Mr John McLaren, Mrs Jill Stacey, Mrs Jane Davidson, Mrs Carol Gillie and Mrs Claire Pearce.

The Chair confirmed the meeting was quorate.

The Chair welcomed Dr Annabel Howell to the meeting who was deputising for Dr Cliff Sharp, and Mrs Sue Holmes who was deputising for Mrs Jill Stacey and Mrs Erica Reid who was deputising for Mrs Claire Pearce.

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 12 February 2018 were amended at page 4, paragraph 6, inclusion of final sentence: “It was recorded that Mr Tris Taylor had expressed reservations not to support the decision.” and with that amendment the minutes were approved.

4. Matters Arising

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

Mr Tris Taylor commented that the Board needed to be sure that its governance was working well and he was assured there was an Integrated Care Fund criteria. However he reiterated the point that if the Board was asked to allocate money from a fund and had not been afforded the opportunity to scrutinise the criteria, then it was not in a position to make those decisions with the full knowledge of the facts and was therefore not discharging its duties. He acknowledged that such a position was not good governance and sought a commitment to full transparent documentation for the Board in future to allow it to make fully informed decisions.

5. Integrated Care Fund

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

A discussion on the finer points of detail had taken place in an earlier development session.

During the meeting it was recognised that better transparent financial information was required by the Board in order to enable it to make fully informed decisions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current position of the ICF.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the proposals for exception ICF funding in respect of Community Led Support, the Matching Unit, Hospital to Home and Crawwood.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered each of the projects funded by the ICF that were due to end between February and April 2018 in Table 4 and concluded the following:

Table 4 Projects

- Independent sector representation – Not Agreed
- Community Transport Hub – Agreed
- Delivery of Localities – Not Agreed
- Community Led Support – Agreed
- Matching Unit – Agreed
- Buurtzorg – Withdrawn from these recommendations
- Craw wood – Agreed to fund until 1 October and further continuation will be subject to budget agreement either carry forward or further ICF funding or mainstreaming in the future based on financial information at the next meeting.
- Hospital to Home – Agreed to fund until 1 October.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered each of the projects funded by the ICF in Table 3 and concluded the following:

Page 2 of 3

Table 3 Projects

- Agreed that the Matching Unit to be removed from Table 3 as already agreed to fund until 1 October.
- Agreed to remove Community Capacity Building from Table 3 as already agreed to funding at previous meeting with reporting back timescale.
- Agreed that all remaining projects be reviewed for decision on 23 April in regard to future funding or cessation.

6. Any Other Business

6.1 Integrated Care Funding: Neither a recommendation, nor a decision was made in regard to the presumption that £2.13m of the NHS baseline budget, might be identified as potential future ICF funding and be included in terms of financial planning purposes for the partnership.

7. 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 23 April 2018 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 12.00noon.

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. **Update:** Item rescheduled to 28 May session due to Extra ordinary meeting taking place on 19 March 2018.	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	Tracey Logan	June 2017	**In Progress:** Item scheduled for 12 February 2018.	G

		place and she would be happy to provide an update to the IJB if it wished.			**Update**: Item rescheduled to 20 August 2018 meeting.	

Meeting held 23 October 2017

Agenda Item: Update on Buurtzorg in the Borders

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
19	13	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress to date and welcomed hearing more at a later date.	Robert McCulloch-Graham	April 2018	**In Progress:** Item scheduled for April 2018 meeting agenda. **Update:** Item rescheduled to 11 June meeting due to agenda business pressures.	G

Meeting held 18 December 2017

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

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

Agenda Item: Community Capacity Building – Transformation Proposal

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
23	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed	Michael Curran	June 2018	**In Progress:** Item scheduled for 11 June 2018 meeting	G

		to continue with the project for 12 months with the proviso that there was an evaluation (set up by acute & primary care colleagues) on the projects listed within the document within 12 months and an interim update provided in 6 months time.			agenda.	

Meeting held 12 February 2018

Agenda Item: Inspection Update

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

Agenda Item:

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
26						G

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

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 23 April 2018

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

CHIEF OFFICER'S REPORT

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

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

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

Chief Officer Report 23rd April 2019

Winter

I reported at the last IJB about the winter pressures we were experiencing, these have continued and are only really abating now, and we are seeing more capacity both in BGH and within our Community Hospitals. There does however remain pressure on some services.

The winter pressures were further exasperated by the significant fall of snow. Both the Council and NHS Borders had to put emergency procedures in place to ensure their services remained open. Transporting staff to and from the hospitals became a significant issue, and a great deal of partnership work between all agencies was required.
For my sins, I was on call that particular week, it was a challenging time for us all but I can report that everyone rose to meet the challenge. I was particularly impressed by staff walking miles through snow drifts to get to work, and those staff who slept over to pick up their following shift in the morning.

There were lots of lessons learned that we will gain from in preparation for the next winter.

Finance

I have been particularly busy bringing both the Council and the NHS Borders proportions of the IJB budget together, as will be seen by the papers presented today. You will see how challenging this has been, and the pressures we are facing this financial year. It has been important that we get a clear picture of all of those resource issues so that together we can share our efforts to resolve them fairly.

The IJB and officers have been focussing on the role of the Integrated Care Fund. The board and officers have used this fund to support a fairly diverse range of issues, and as a new fund it has taken time to get the correct governance around its use. The board requested that the projects/services in receipt of funds be reviewed so that they could be properly directed within the new financial year. The last of the 17/18 funds are on the agenda for this meeting. We have drawn up a draft of new conditions for the use of the future allocations of ICF funding and these will be taken to the IJB Strategic Planning Group for approval.

Whilst on finance, I have to report that we have been unsuccessful in appointing our Section 95 Finance Director. We received insufficient interest in the position. We have now started a new recruitment campaign, and have called in further support from Scottish Government through the Integration Team. I remain hopeful this position will be filled shortly. From the effort that has been required to bring the joint finance papers to you today, I am more than ever convinced this position is essential to the Board and the Partnership's success.

Case Work

In my role as Chief Officer, I occasionally get involved in particular cases, usually where there is significant risk. In this recent period, I was involved with other senior managers, in a particularly worrying case of a 17 year old, who turned 18 a few weeks back. The case very much highlighted the continued chasm between Children's Services and Adult

Services. The legislation that exists does not support a smooth, controlled and supportive transition into adulthood and I believe this requires a national response.

This particular case for services in the Borders had to address a significant risk to this young person's life. It did raise significant differences between the approaches of professions. We did have one major incident during this last period and a high level of on-going resource has been put in place across services to support this individual, and to manage the risk as much as is possible.

A review is underway of the case, and I am hopeful that within its findings, we will see a greater focus of effort on the transition of such individuals into adulthood. I also hope the national legislation will also be addressed to give a greater level of flexibility as to how agencies can respond to such heightened needs and level of risk.

Strategic Planning

The Strategic Planning Group began the review of our current strategic plan and our commissioning plan. This has been progressing and is now supported through the new Performance and Finance Group which I mentioned in my last report to you. This group has been further supported now through the allocation of a couple of consultants from Health Improvement Scotland.

They are supporting work of how we monitor and report on our performance. They are also supporting work on determining the requirements on services to bring the overall operational capacity of our hospitals to the more manageable percentage of 85%. I am hopefully that this work will conclude in a few weeks, and expect it to support the Board's commissioning function within the forthcoming year. I will bring more updates as we progress.

Adult Social Care

The position of Chief Officer for Adult Social Care has become vacant through some changes to the operation of the Chief Social Work Officer Role and the operation of Public Protection services.

We have successfully appointed to the Adult Social Care role on an interim basis and are shortly to advertise for the permanent position. Currently there is a great deal of pressure and demand on a few senior roles, this appointment should alleviate this and allow for some greater strategic direction for Adult Social Care Services.

The interim position is due to begin early May.

Delayed Discharge

As you will know the winter period has seen our delays remain stubbornly high despite the efforts being made. To gain some better insight into the issues, I chaired a daily meeting of officers to go through the list of patients delayed across our hospitals.

The exercise revealed some insights and perhaps more importantly reassured us that we are undertaking the right actions through operating a discharge to assess policy. In particular, the need for step down facilities and for services supporting assessment at home.

New areas that the exercise did identify or indicate we needed greater effort included the issue of Guardianship, both through the local authority and through private arrangements. Although we have seen some easing in the last couple of weeks, the number patients waiting for a guardianship order remains a high percentage of those delayed. We have stepped up our efforts here to address this.

Another area of importance is the operation of the START team within BGH and our Community Hospitals. The work of this team would be supported more through closer access with the Matching Unit, access to MHOs and to Physio and Occupational Therapists. The leadership team are now examining how we can make this happen.

Regional Work

My efforts around the regional work are in support of the six chief officers in the region and the development of the work around the prevention of diabetes. Both Tracey and Jane support this work and Tracey chairs the newly formed steering group for Diabetes in the East of Scotland.
The recent meeting of the regional board agreed to fund £200k to support the appointment of a team to drive the work forward. The work has received a great deal of interest across the country and I am confident the group will make a significant difference and we can start to claw back some of the £250M spent on Diabetes within the region.

So a busy period with more to come.

Rob

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 23 April 2018

Report By	Robert McCulloch-Graham
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SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP FINANCIAL PLAN 2018/19

Purpose of Report:	This report seeks approval of the financial plan for the Scottish Borders Health and Social Care Partnership for financial year 2018/19. The proposed IJB budget for 2018/19 currently totals £168.4m, comprising £122.528m from the NHS including set aside and £45.839m from SBC. In total resources available to the IJB will increase by £0.950m from the comparable position in 2017/18, including the former ICF and Social Care Fund monies. The plan however requires a significant level of efficiency savings totalling £9.883m, of which £5.2m are currently unidentified. Proposals to bridge this gap will be submitted to the Board of NHS Borders in June 2018 and will subsequently be shared with the IJB. Scottish Borders Council & NHS Borders are liable for all expenditure incurred by the Partnership against respective budget contributions.

Recommendations:	The Health and Social Care Integration Joint Board is asked to **approve** the report on the 2018/19 Health and Social Care Financial Plan and ask that a report is brought to the June 2018 meeting with details of how the unidentified savings requirement will be addressed, recognising that plans to deliver £5.2m of savings remain unidentified.

Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2018/19 will be reported to the Integration Joint Board.

Carers:	N/A

Equalities:	There are no equalities impacts arising from the report. Equality Impact Assessments for Social Care proposals are available on the Council Website.

Financial:	As detailed within the paper.

Legal:	The report 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:	Risks facing the partnership are detailed within the report. Risks are both substantial and numerous at the current time and the Executive Management Team is working to mitigate these through robust governance, planning, managing the required actions to deliver an affordable medium-term financial plan.

Background

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

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

1.2 The 2018/19 financial plan has been prepared in line with the currently approved IJB Strategic plan. This will be reviewed during 2018/19 and future financial plans will reflect any changes subsequently agreed by the IJB

Approach to 2018/19 Financial Plan

2.1 Full transparency of the use of these resources by the IJB is paramount and the Scottish Borders Council Health and Social Care Partnership is required to publish an annual Financial Statement setting out the level of these resources and their planned use. As Scottish Government has agreed only a one year budget the focus of the financial plan is on financial year 2018/19.

2.2 IJB members approved its medium-term Financial Planning Strategy at its meeting in February 2017. The context of how partners should approach joint financial planning is largely set by two main reference documents:

- Integrated Resources Advisory Group (IRAG) Statutory Guidance.
- The partnership's approved Scheme of Integration.

Appendices 1a and 1b summarise the key provisions contained within the above reference documents.

2.3 This report sets out:

- The funding principles underlying the draft 2018/19 budget. (section 3)
- The delegated resources provided to the IJB for 2018/19. (section 4)
- The efficiencies and savings required for 2018/19. (section 5)
- Key financial risks. (section 6)

Funding –Allocations / Settlement from the Scottish Government

Key Funding Principles

3.1 On the 14th December 2017, the Scottish Government wrote to all Scottish health boards and local authorities in relation to its draft budget for 2018/19 advising of indicative allocations and funding settlements. This correspondence contained a

number of provisions, requirements and conditions pertaining to the funding allocations. Following agreement of the budget in the Scottish Parliament in February allocations/settlements were confirmed.

3.2 NHS Boards and Local Authorities are required to ensure that 2018/19 budget settlements for Integration Authorities are in place in advance of the new financial year. The IJB was advised of the draft level of resources to be provided within this timescale.

3.3 The NHS Borders guidance for 2018/19 states that there should be a commitment to shift the balance of frontline NHS spend such that:

- Any funding for mental health services will be in addition to a real terms increase to 2017/18 spending levels above 1.5%.
- Additional funding for primary care will be used to support primary care transformation.
- The continued transfer of NHS Borders share of the £350 million provided from baseline budgets to Integration Authorities to support social care (Social Care Fund).
- More than half frontline NHS spending will be in community health services by the end of this parliament.
- Plans are developed with Integration Authorities to reduce delayed discharges, avoidable admissions and inappropriately long stays in hospital, with focus to reduce unscheduled bed-days in hospital care by up to 10 per cent

3.4 Scottish Borders Council allocation to the IJB will be £45.839m including, a share of £66 million provided nationally to Local Authorities recognising a range of pressures in relation to Social Care. This funding will be allocated directly to Local Authorities from the Scottish Government. Scottish Borders Council share of this allocation is £1.537m and this sum will be passed in full to the IJB. Overall the resources provided to the IJB will increase by £0.172m (0.4%) in cash-terms after deducting required efficiency savings.

3.5 NHS Borders' indicative baseline allocation for 2018/19 is a general uplift of 1.5% from 2017/18 which results in a baseline budget of £200.6m for NHS Borders, a cash increase of £2.9m. The level of uplift provided to NHS Borders will be shared with the IJB on a pro-rata basis. This level of uplift will not fully meet the financial pressures facing the IJB therefore efficiency savings will be required. The baseline funding includes £7.397m of social care funding representing NHS Borders share of the £350m made available nationally on a recurring basis, which is unchanged from level of recurring funding provided in 2017/18.

As part of NHS Borders baseline funding NHS Borders receives £2.13m of resources which for the period 2015/16 to 2017/18 was ring-fenced to support a joint Health and Social Care transformation programme known as the Integrated Care Fund (ICF). NHS Borders Board has confirmed that £2.13m will be directed to the IJB in 2018/19 non recurrently subject to conditions around the use of the funding. Of the £2.13m funding, £450k is required to be provided and ring fenced to fund the Crawwood discharge to assess facility until the 31st March 2019 if required. Funding for the unit beyond 31st March 2019 will be addressed as part of the 2019/20 Financial Planning process. This leaves a balance of £1.68m available. Further funding will be required to fund the extension of the Hospital to Home

service and the Transitional Care Facility based at Waverly Care Home to 31st March 2019. More details on costs will be presented to a future IJB meeting as part of 2018/19 ICF proposals.

During 2018/19 as additional NHS funding becomes available through ring fenced allocations within the delegated budget, NHS Borders Board is expected to provide these resources to the IJB, as has been the case in previous financial years. It is anticipated this will include among others the following:

- Investment in Adult Mental Health Services and CAMHS.
- Primary Care investment funds.
- Additional social care funding (estimated to be £5m across NHS Scotland).
- Alcohol and Drugs Partnerships funding (estimated to be £20m across NHS Scotland).

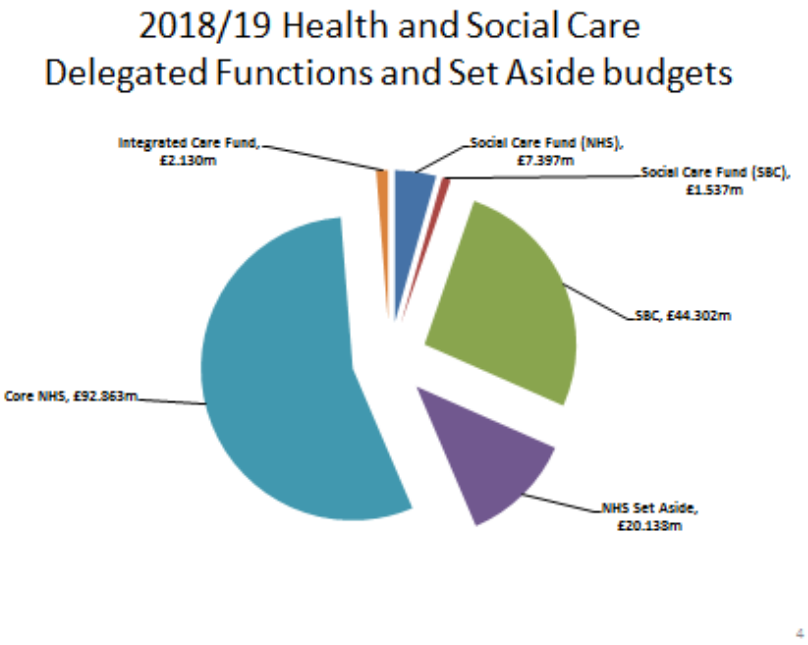
3.6 Scottish Borders Council funding for 2018/19 is based on an incremental uplift of 2017/18 budget covering pay awards and inflation, demographic growth and a detailed savings target to ensure a balanced budget is delivered.

Provision of Resources to the IJB 2018/19

4.1 Based on the principles as detailed above the following resources are proposed

	2018/19 Baseline Provision £m
Healthcare Functions – Delegated *	102.390
Social Care Functions – Delegated*	45.839
Healthcare Functions - Set-Aside	20.138
Total	**168.367**

*NHS Healthcare budget includes £7.397m of Social Care Funding (part of £350m nationally) and £2.1m of Integrated Care Funding and Scottish Borders Council budget includes £1.537m of Social Care Fund (part of £66m nationally).



The table below summarises the proposed level of resource and provides a comparison with the previous year baseline funding. This shows the proposed budget for 2018/19 and a high level operational split across functions.

Detailed 2017/18 & 2018/19 Partnership Budgets	**Joint 2017/18 £m**	**Joint 2018/19 £m**
Joint Learning Disability Service	19.396	21.113
Joint Mental Health Service	15.850	15.605
Joint Alcohol and Drug Service	1.006	1.030
Older People Service	23.395	20.489
Physical Disability Service	6.161	6.037
Generic Services	80.501	81.825
Integrated Care Fund	2.130	2.130
Large Hospital Functions Set-Aside	18.978	20.138
Total	**167.417**	**168.367**

A summary budget movement comparing 17/18 to 18/19 is shown in appendix 1e. and a detailed funding movement is shown in appendix 1f.

4.2 In line with national guidance the IJB needs to issue directions to the NHS and SBC on the level of resources and how they should be utilised in line with the strategic plan. It needs to consider how the social care fund and the integrated care fund should be utilised to support these directions. A summary of the Integrated Care Fund and Social Care Fund and current commitments and potential future commitments is attached in Appendix 1c.

4.3 Although the IJB budget has increased from 2017/18 there has also been a significant increase in demand and pressures which mean the level of budget increase will not be sufficient to fund known investments and pressures in full. Significant efficiency savings are therefore required to cover costs increases above the level of additional resources provided for new investments or pressures. Delivery of these savings is key to ensuring the services within the IJB can operate within budget in 2018/19.

Delivery of Savings and Affordability

5.1 In order to ensure that the 2018/19 IJB financial plan is both affordable and deliverable, NHS Borders, Scottish Borders Council and the Health and Social Care Partnership must work together to prepare and deliver the required programme of transformation, efficiency and other savings, targets for which have been developed and are the basis on which the provision of resources to the IJB is predicated.

The IJB has over the previous 2 financial years delivered a significant level of efficiency which is summarised in the table below.

Permanent Recurring Savings	**2016/17 & 17/18**
	£m
Establishment of SB Cares	0.915
Efficiency measures including contracts and commissioning arrangements	4.057
Service reviews to meet demand pressures	1.412
Charging Review	0.13
Total Savings	**6.514**

5.2 Based on the assumption that the IJB will direct both partners to deliver efficiencies, work has been progressing, within the context of the overall resource envelope available in 2018/19. This is a challenging target and an increase from the level delivered in previous years.

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5.3 In anticipation of the level of resources to be directed, provisional plans are being developed to deliver the above level of savings . This will include both business as usual efficiencies, as well as a longer term transformation programme in order to ensure the financial sustainability of services. At this time NHS Borders does not have an efficiency plan which delivers the level of efficiency required and therefore has an unbalanced financial plan. NHS Borders financial plan for 2018/19 was approved at the Board meeting on the 5th April 2018 subject to further review at the June 2018 Board meeting.

5.4

NHS 2018/19 Savings to be delivered	**Non Recurring**	**Recurring**	**Total**
	£m	£m	£m
Dental Services increased efficiency	0.150		0.150
Increase in level of funding in primary care	0.025		0.025
AHP Management Review		0.100	0.100
Medical Support Community Hospitals		0.075	0.075
Management Review	0.055		0.055
MHOAT & Clinical Psychology Vacancy Mgmt	0.265		0.265
MH Staff Turnover	0.330		0.330
Prescribing Benchmarking & Variation		0.250	0.250
Clinical Pathway & Prescribing Support		0.450	0.450
Patent Expiry		0.200	0.200
Formulary Management & Rebates		0.300	0.300
Total Business as Usual Savings	0.825	**1.375**	**2.200**
To be identified			**5.235**
TOTAL			**7.435**

At this point there remains a £5.235m of savings which remains unidentified. Work is ongoing to identify further projects to meet this requirement. NHS Borders board has requested that proposals are presented at its meeting in June on how financial targets will be achieved in 2018/19 and how the Board can in the longer term return to financial sustainability.

5.5 Similarly, within the context of the overall resource envelope available to Scottish Borders Council, for the delegated provision to the IJB to be affordable, £2.448m of savings require delivery in 2018/19. In order to deliver this, the following savings programme has been approved by Scottish Borders Council:

SBC 2018/19 Savings to be delivered	**Total**
	£m
Review of Day Services	0.290
Review of Non day services	0.100
Review Specialist Care & Support Services	0.250
Review Shopping Service	0.041
Review L.D. Commissioned Services	0.337
Greater Use of Technology	0.100
Adult Social Care Productivity Review	0.088
Review Adult Social Work Mgmt. Structure	0.060
Review Community Based Services	0.110
Other Efficiencies incl. £0.650m carried forward from 17/18	0.672
SBC Corporate Savings	0.400
Total	**2.448**

All of these savings are recurring.

5.5 The savings plans identified by Scottish Borders Council as part of the 2018/19 Financial Planning process are designed to ensure affordability of the social care functions delegated to the IJB without any further savings being required. This assumes demand pressures can be contained within existing budgets during 2018/19.

Inherent Risk in the current Proposed Budgets for Delegation

6.1 There are risks inherent in any budget setting process and the budget for the IJB in 2018/19 is no exception. Partnership finances, and the overall affordability of delegated functions, remain under considerable pressure. The identification of planned savings and measures to bridge the £5.235m funding gap associated with the NHS contribution to the partnership budget remains the key risk associated with the delivery of a balanced budget in financial year 2018/19.

6.2 Both IRAG guidance and the approved Scheme of Integration require a more sophisticated approach to joint financial planning across the health and social care partnership than has been adopted thus far. A more integrated approach to financial planning and the joint management or the associated resources remains a key development goal for the partnership.

6.3 Across Scotland, partnerships are struggling to deliver balanced, affordable financial plans for next year and in the medium-term for the services delegated to them. Consistently, the level of affordability gap, particularly in relation to the healthcare functions and the lack of a robust programme of efficiency and savings to bridge this gap has been cited as the main challenge facing health and social care partnerships. It is imperative therefore that the efficiency and savings plans in place within partner organisations are delivered in full and to the timescales

envisaged. Of equal critical importance, it is also fundamental that the Executive Management Team and the Integration Joint Board work to develop, approve and deliver an integrated transformation programme in order that the required level of further savings be achieved in order that the overall budget delegated to the partnership is affordable.

6.4 Risk to the IJB could be mitigated by the partnership by issuing directions to the NHS Borders and Scottish Borders Council to deliver services within a reduced budget envelope and more fundamentally, pass the risk back to the health board and Council. This would result in a breakeven position for the IJB whilst preserving strategic oversight over activity within its remit. The IJB would still have a degree of control since efficiency proposals would still require approval, but this may not be a satisfactory situation for NHS Borders or Scottish Borders Council.

6.5 A further key risk to the partnership is the impact on performance as a result of the considerable savings targets required. The partnership's Strategic Plan was approved prior to the IJB being established and accordingly, requires review as the partnership goes into year 3 of its operation, particularly in the context of such financial pressure and funding restrictions.

Wider Risk

7.1 Beyond the risks directly attributable to a lack of overall affordability of delegated functions, there are a number of other risks to which the partnership is exposed and that, regardless of the final agreed position, will require to be managed. These can be summarised as:

- The Scottish Parliament budget for 2018/19 is for one-year only. Further work is required between NHS Borders, SBC and the IJB before a medium-term 3-year Financial Statement can be produced.
- Further cost pressures exist and others may emerge during 2018/19 that are not provided for within either partner's 2018/19 financial plan, nor the resources delegated to the IJB e.g. emergence of new drugs/technology or increased demand.
- Prescribing: This is a high risk area due to the volatility of supply and price. The majority of prescriptions are written by General Practitioners who are independent contractors.
- It is also essential that maximising patient flow and minimising lost opportunity to maintain costs at budgeted levels is achieved. The ongoing provision of service at Winter Plan levels and in particular, keeping surge-beds open all year was, other than Prescribing, the largest area of pressure in 2017/18 and it is essential that this does not happen in 2018/19. This is a very real live issue as during the first few weeks of April all of the surge beds remain open for which no funding has been identified and elective procedures continue to be cancelled as a result of operational bed pressures
- Providers of social care continue to experience financial pressures and beyond the implementation of a living wage, there will undoubtedly be ongoing risks over the sustainability of care provision, particularly residential and home care across the Scottish Borders, most prevalently in those areas of limited alternative supply, including Berwickshire specifically. Any risk of loss of service provision will also result in additional costs as alternative supply is transitioned, particularly if the option of SB Cares as the provider of last resort is exercised.

- Resources delegated in 2018/19 are mainly based on the incremental approach to budgeting across NHS Borders and Scottish Borders Council, within prevalent funding constraints and as a result relate only to the ongoing provision of current type, level and model of care provided. The IJB is clearly being delegated with responsibility for the planning and delivery of efficiencies and other savings in order to meet known pressures.
- As the delivery of the Strategic Plan develops, there may be an identified requirement to realign resources in line with priorities / demand and as a result, shifts of resource across the partnership.
- Partners' financial plans assume that in the main, the partnership will mitigate against the impact of increased future demographic pressure across delegated services.

APPENDIX 1a

Integrated Resources Advisory Group (IRAG) Statutory Guidance
Financial Planning

1 The Scottish Government's Integrated Resources Advisory Group guidance and advice on financial matters for Health Boards and Local Authorities (IRAG) sets out a wide range of guidance and recommendations in order to assist partnerships to plan and manage the financial implications of the legislation and to provide a basis for the development of the local financial arrangements required to support the implementation of the integration of health and social care. This is statutory guidance and it should be used with reference to the legislation.

2 The IRAG guidance specifically states that a premise underlying the legislation is that the Integration Joint Board will, through the Strategic Plan, be able to allocate resources within the Integrated Budget and to plan and agree transfers between the notional budget and the Integrated Budget. It will be for the Integration Joint Board, through the strategic planning process and having regard to the duties in the legislation for consultation, co-production with stakeholders and co-operation with other Integration Authorities (Section 32), to decide what capacity is required from Local Authority and Health Board in order to deliver the agreed performance on outcomes.

3 The relative proportions of partners' contributions to the resources within scope of the plan will not influence the proportion of services that will be directed by the Integration Joint Board through the Strategic Plan, although it is likely that in the first years they will be similar.

4 IRAG also sets out a proposed process for calculation of subsequent (to year 1) years' payments to the IJB. The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. They should aim to be able to give indicative three year allocations to the integration joint board, subject to annual approval through the respective budget setting processes. This should be in line with the three year Strategic Plan.

5 The IJB should develop a case for the Integrated Budget based on the Strategic Plan and present it to the Local Authority and Health Board for consideration and agreement as part of the annual budget setting process. The business case should be evidence based with full transparency on its assumptions and take account of activity changes, cost inflation, efficiencies and savings, impact on performance, legal requirements and other know adjustments required. The partner Local Authority and Health Board will evaluate the case for the Integrated Budget against their other priorities and are expected to negotiate their respective contributions accordingly. The allocations will be a negotiated process based on priority and need and it should not be assumed that they will be the same as the historic or national allocations to the Health Board and Local Authority.

6 The allocations made from the Integration Joint Board to the Local Authority and Health Board for operational delivery of services will be approved by the Integration Joint Board. The value of the payments will be those set out in the Strategic Plan approved by the Integration Joint Board.

APPENDIX 1b

Scheme of Integration
Financial Planning

1 Within the Health and Social Care Integration Scheme for the Scottish Borders, provision has been made to ensure the IJB receives the assurance it requires over the sufficiency of resources to carry out its delegated functions. Following this, it will approve the initial amount delegated to it, on an annual basis. These arrangements cover the determination of the amounts paid to it by partners (or set-aside) and their variation and are specifically set out in sections 8.3-8.6 of the Scheme. These arrangements cover:

- Payment to the IJB for delegated functions in the first year of operations (2016/17).
- Payment to the IJB for delegated functions in subsequent years.
- Method for determining hospital services set-aside amount.
- How in-year variations will be dealt with by the IJB and partners.

2 In line with the Scheme, the baseline payment in 2016/17 was calculated following review of recent past performance and existing financial plans for both NHS Borders and Scottish Borders Council in respect of the functions delegated. The payment from each partner was then adjusted for material items such as demand-driven pressure, price increases, new commitments and efficiency and savings plans. A full process of due diligence was undertaken over the proposed budget and the IJB were asked to approve the financial statement for the partnership based on the provision of assurance over the adequacy of resources and a detailed analysis of the inherent risks contained therein.

3 On this basis, the delegated budget delivered through both partners' respective financial planning processes and was formed by their combined outcomes, and the recognition of a range of factors including the 2015/16 base budget for functions delegated, Scottish Government funding levels, cost and demand pressures and efficiency and other savings targeted.

4 The partnership's Scheme of Integration, within section 8.4, explicitly defines how payment from each of NHS Borders and Scottish Borders Council, in respect of delegated functions, should be calculated in subsequent years following the first year (2016/17) of its operation. The Scheme specifically states:

8.4 Payment in subsequent years to the Integration Joint Board for delegated functions

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

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

8.4.2 Borders Health Board and Scottish Borders Council should consider the following when reviewing the Strategic Commissioning Plan:

- The Local Government Financial Settlement
- The uplift applied to NHS Board funding from Scottish Government
- Efficiencies to be achieved

8.4.3 Whilst the Integration Joint Board will plan, agree and deliver the Strategic Commissioning Plan and related Financial Plan, this will follow a process of joint discussion and planning with the other parties.

Appendix 1c

Current & Future Integrated Care Fund and Social Care Fund Commitments

Use of Integrated Care Fund (2015/16 – 2017/18) - 3 yr allocation £6.39m		
Forecast Spend to 31/3/2018 - £3.912m		
	£m	£m
ICF 3 year agreed allocation		**6.390**
Previously agreed directed resource at 19/3/2018	(5.244)	
Undirected Resource at 19/3/2018		**1.146**
Less allocated resource to support SBC H & SC 17/18 budget pressures	(0.443)	
Exception requests agreed 19/3/2018	(0.066)	
Forecast underspend on ICF projects	0.174	
Sub-total		**(0.335)**
Resource available after project cost variances		**0.811**
Projects being extended agreed by Board on 19/3/2018	(0.275)	
Funding of Crawwood May – Sep 2018	(0.440)	
Sub-total		**(0.715)**
Forecast uncommitted ICF funding available		**0.096**

Use of Social Care Fund (Both NHS & SBC streams)

NHS Stream (mainstreamed by SG) – Allocation of £7.397m		SBC Stream (share of £66m) - Allocation £1.537m	
Living Wage to £8.25	£1.626m	Cosla Uplift 2018 (3.39%)	£0.402m
Demographic demand	£2.508m	Impact of Carers Act	£0.322m
Comm. Mental Health Worker	£0.050m	Living wage to £8.75	£0.758m
Charging Threshold	£0.154m	Impact of Scottish Living Wage on Sleep-overs (from mid-year)	£0.223m
Cosla Uplift 2017	£0.261m		
Living Wage to £8.45	£0.829m		
Sleep-ins to av. min. wage	£0.750m		
Residential Care	£0.407m	**Required**	**£1.705m**
Housing with care	£0.100m	**Pressure**	**£0.168m**
Adults with Learning Disabilities	£0.200m		
Permanently directed to 31/3/2018	**£6.885m**		
Demographic Growth per SBC 18/19 Financial Plan	£0.592m		
Pressure	**£0.080m**		

2018/19 IJB funding

	NHS £m 2018/19	SBC £m 2018/19	Total £m 2018/19
Baseline Funding			
Delegated Budget	100.411	45.667	146.078
Savings to be delivered in 2018/19	(5.921)	(2.448)	(8.369)
Community Nursing Staff no longer charged to IJB *	(1.084)	0	(1.084)
Primary Care Development Fund (national funding)	0.324	0	0.324
Health & Social Care Fund Continuation (£350m allocation)	7.397	0	7.397
Pay & Prices (Health 1.5%, SBC inflation)	1.263	0.549	1.812
Dementia Funding	0	0.534	0.534
Share of £66m Health & Social Care Fund	0	1.537	1.537
	102.390	**45.839**	**148.229**
Set Aside	22.915	0	22.915
Savings to be delivered in 2018/19	(3.052)	0	(3.052)
Pay & Prices (1.5%)	0.275	0	0.275
	20.138	**0**	**20.138**
Total	**122.528**	**45.839**	**168.367**
In addition historic and new cost pressures to be delivered			

* Further review of this service delegation to be undertaken in 18/19 financial year.

Appendix 1e

2018/19 IJB funding compared to 2017/18 funding levels				
	NHS Base	**NHS Set Aside**	**SBC**	**IJB**
	£m	**£m**	**£m**	**£m**
2017/18 Funding	101.887	19.863	45.667	167.417
NHS*/SBC Core Budget 2018/19	102.390	20.138	45.839	168.367
Movement from 2017/18	0.503	0.275	0.172	0.950

* NHS Budget includes Social Care Funding of £7.397m and Integrated Care Fund of £2.130m (conditions around funding yet to be agreed) and SBC funding includes £1.537m Social Care Funding.

Appendix 1F

IJB Funding Movements

SBC Contribution to IJB 2018/19		
	2017/18	**2018/19**
	£m	**£m**
Baseline Funding		
Draft Social Care Functions	46.446	45.667
Plus pay inflation	0.654	0.549
Less efficiencies to be delivered	(1.133)	(2.048)
Less allocation of corporate savings		(0.400)
Dementia Funding		0.534
Share of £66m Health & Social Care Fund		1.537
	45.667	**45.839**

NHS Contribution to IJB 2018/19

	£m	£m
Baseline Funding	**2017/18**	**2018/19**
Delegated Budget	92.360	92.360
Cost pressures to be provided for	6.163	2.507
Less efficiencies to be delivered	(6.163)	(2.507)
Community Nursing Costs no longer charged to the IJB	0	(1.084)
Primary Care Development Fund (national funding)	0	324
Pay & Prices (1.5%)	0	1.263
	92.360	92.863
Integrated Care Fund	2.130	2.130
Health & Social Care Fund Continuation (£350m allocation)	7.397	7.397
	101.887	**102.390**
Set Aside Budget	18.978	19.863
Cost pressures to be provided for	2.439	2.549
Less efficiencies to be delivered	(2.439)	(2.549)
Drugs new drugs & protocols	700	0
Patient Transport allocated to services	185	0
Pay & Prices (1.5%)	0	275
	19.863	**20.138**
Total	**121.750**	**122.528**

* Further review of this service delegation to be undertaken in 18/19 financial year.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .....23 April 2018.....

Report By	Robert McCulloch-Graham, Chief Officer for Integration
Contact	Jane Robertson, Strategic Planning and Development Manager
Telephone:	01835 825080

INTEGRATED CARE FUND
REVIEW OF PROJECTS 2015-18

Purpose of Report:	The purpose of this report is to update the Integration Joint Board (IJB) following the review of a number of Integrated Care Fund (ICF) projects which are due to carry over funding into financial period 2018-19. The report also outlines recommendations for continued investment or disinvestment of these projects following consideration of project summaries by the IJB Leadership Team

Recommendations:	The Health & Social Care Integration Joint Board is asked to: **Note** the review of ICF projects due to carry over funding in the financial period 2018-19. **Consider** recommendations from the IJB Leadership Team for continued investment or disinvestment of projects. **Decide** which projects should have continued investment or disinvestment.

Personnel:	A number of projects under review currently employ staff.

Carers:	A number of projects have positive outcomes for carers.

Equalities:	Related to EIA for Strategic Plan.

Financial:	Potential for redirection of ICF if projects disinvested.

Legal:	Potential issues regarding notice required for staff.

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

REVIEW

INTEGRATED CARE FUND PROJECTS 2015-18 (£6.39m)

April 2018

Purpose

1.1 The purpose of this report is to update the Integration Joint Board (IJB) following the review of a number of Integrated Care Fund (ICF) projects which are due to carry over funding into financial period 2018-19.

1.2 The report seeks IJB agreement for continued investment or disinvestment of those ICF projects which are due to carry over funding into 2018/19.

Background

2.1 The ICF was first allocated to the shadow partnership in 2015/16 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of **£6.39m** for the 3 years of the programme.

2.2 During this time a number of ICF projects have been ratified by the IJB with a directed resource to date of **£5.244m**. Whilst **£5.244m** of the **£6.390m** total ICF resource has been directed by the IJB, at 31 March 2018 only **£3.912m** (75%) has been recorded as spent.

2.3 At an extraordinary meeting of the IJB on 19 March 2018 decisions were made regarding a number of projects due to end between February and April 2018 which were seeking funding beyond 31 March 2018. A summary of decisions taken regarding requests for further resource from the ICF are detailed below:

Table 1 – IJB Decisions re ICF Projects 19 March 2018

Project	Decision
Independent Sector Representation	Not agreed
Community Transport Hub	One year funding agreed
Delivery of Localities	Not agreed
Community Led Support	One year funding agreed
Matching Unit Agreed	One year funding agreed
Buurtzorg	Withdrawn
Craw Wood	Funding agreed until 1 October 2018
Hospital to Home	Funding agreed until 1 October 2018

2.4 Decisions were also taken by the IJB at this meeting regarding the allocation of IC funding to meet budget pressures and a reclaim of underspend on projects. These decisions leave a forecast of uncommitted ICF funding available of £96k. A summary of all decisions taken and the impact on the ICF are detailed in Table 2 below:

Table 2 – Summary of Integrated Care Fund (2015/16 – 2017/18)

Use of Integrated Care Fund (2015/16 – 2017/18) - 3 yr allocation £6.39m		
Forecast Spend to 31/3/2018 - £3.912m	**Movement**	**Balance**
	£m	£m
ICF 3 year agreed allocation		**6.390**
Previously agreed directed resource at 19/3/2018	(5.244)	
Undirected Resource at 19/3/2018		**1.146**
Less allocated to support SBC H & SC 17/18 budget pressures	(0.443)	
Exception requests agreed 19/3/2018	(0.066)	
Forecast underspend on ICF projects	0.174	
Sub-total		**(0.335)**
Resource available after project cost variances		**0.811**
Projects being extended agreed by Board on 19/3/2018	(0.275)	
Funding of Crawwood May – Sep 2018	(0.440)	
Sub-total		**(0.715)**
Forecast uncommitted ICF funding available		**0.096**

2.5 The IJB also considered a number of projects with a fixed allocation of IC funding projected to continue into 2018/19. Following consideration the IJB requested that the current impact and benefits of these projects should be reviewed and the outcome of review be presented to the IJB on 23 April 2018 to inform a decision regarding the future of each project.

2.6 It was agreed the Borders Community Capacity Building Team would be excluded from review since the IJB previously agreed to fund the project for a further 12 months in December 2017 with the proviso that there was an evaluation within 12 months and an interim update provided to the IJB within 6 months.

2.7 Programme Delivery has also been excluded from review since this is not a project but an enabler to providing an essential support role for the delivery of the Partnership's Strategic Plan. It also provides a critical support role for Partnership finance and performance monitoring as well as ensuring that all requirements placed on the IJB from the Public Bodies Joint Working (Scotland) Act are met.

Review of Projects

3.1 Since the decision by the IJB to review those projects with a fixed allocation of ICF funding projected to continue into 2018/19 work has been underway to collate information to facilitate review of each of the projects.

3.2 A template to collate information for review of projects has been developed and all project leads have been supported to complete the template. It is worth noting that the information contained within each review document varies in terms of evidence and detail. This is due to a number of variables including duration of project to date, evaluation mechanisms used and the type of available data ie quantitative or qualitative.

3.3 Those projects included in review and review summaries (see **Appendices A to K**) can be seen in Table 3 below:

Table 3 – Review of ICF Projects with Carry Over of Funding

Projects for review						
Project	**ICF Allocation**	**Date Allocated**	**Spend to end of March 18**	**Carry Over**	**Proposed End Date**	**Project Summary**
Delivery of the Autism Strategy	99,386	December 2015	43,826	55,560	28 February 2019	Appendix A - Autism Strategy
Delivery of the ARBD pathway	102,052	February 2016	50,206	51,846	31 March 2019	Appendix B - ARBD Pathway
Stress & Distress Training	166,000	October 2015	72,284	93,716	31 March 2020	Appendix C - Stress & Distress
Transitions	65,200	October 2015	37,199	28,001	31 March 2019	Appendix D - Transitions
Transitional Care Facility	926,600	December 2016	645,344	281,256	31 December 2018	Appendix E - Transitional Care Faci
Pharmacy Input	97,000	December 2016	13,000	84,000	31 December 2018	Appendix F - Pharmacy Input
GP Clusters Project	50,000	March 2017	32,500	17,500	31 December 2018	Appendix G - GP Clusters

Domestic Violence Pathway	120,000	March 2017	67,935	52,065	30 June 2020	 Appendix H - Domestic Violence

Table 3 (Continued)

Project	ICF Allocation	Date Allocated	Spend to end of March 18	Carry Over	Proposed End Date	Project Summary
Buurtzorg Project Management	52,000	June 2017	0	52,000	31 March 2019	Appendix I - Buurtzorg
Craw Wood	540,363 440,000 980,363	December 2017	667,802 (spend to end of April 18)	312,561	30 September 2018	Appendix J - Craw Wood
Hospital to Home	160,283	December 2017	35,800	124,483	30 June 2018	Appendix K - Hospital to Home
Total	2,818,884		1,665,896	1,152,988		

Recommendations

4.1 All projects outlined in Table 3 were reviewed by the IJB Leadership Team on 3 April 2018. Consideration was given to evidence of impact and progress made against original project outcomes, project outputs achieved and clarity regarding how any funding carried over into 2018/19 would be utilised to further progress the delivery of project outcomes. The IJB Leadership Team also considered the value each project brought to improving the management of demand, the previous position, community supports, integration and value for money.

4.2 Following consideration of all the projects the IJB Leadership Team have made recommendations for the future of projects for the IJB to consider. These are outlined in Table 4 below:

Table 4 – Recommendations for the Future of Reviewed ICF Projects

Project	Carry Over	Commentary	Proposal
Delivery of the Autism Strategy	55,560	Insufficient evidence provided within the project summary to understand the impact of benefits realised and outcomes achieved. Too few individuals benefited from the project to provide value for money.	Disinvest in project with 3 months' notice.
Delivery of the Alcohol Related Brain Damage (ARBD)Pathway	51,846	Appropriate area to target resource however current project scope not felt to maximise benefits for this population or those making referrals for support for individuals with ARBD. Need for refocus of project on prevention and creation of referral routes to other relevant services.	Approve 50% carry over with a view to mainstreaming service within Alcohol and Drug Partnership at project end.

Table 4 (Continued)

Project	Carry Over	Commentary	Proposal
Stress & Distress Training	93,716	Too many gaps in information provided to demonstrate evidence of the benefits realised and outcomes achieved although there is evidence that the training programme is being successfully implemented. Project evaluation due April 2018 and project would benefit from refocus once evaluation results complete to ensure benefits are as far reaching as possible.	Approve 50% carry over with a view to mainstreaming training at project end.
Transitions	28,001	Clear from project summary that this project has achieved all preparatory work required for benefits to be realised in second phase of project.	Approve carry over.
Transitional Care Facility Waverley Care Home	281,256	Project has clearly contributed to an improved rate of discharge and patient flow. Focus on risk assessment is likely to improve efficiency further.	Approve carry over with a view to mainstreaming service at project end.
Pharmacy Input	84,000	Project started in February 2018 due to a delay in recruitment. Project outcomes are expected to improve rate of discharge and efficiency of dispensing which should contribute to significant savings target to meet with prescribing. Needs identifiable link of project outcomes with HSCP strategic objectives.	Approve carry over with a view to mainstreaming at project end.
GP Clusters Project	17,500	Limited evidence presented to identify impact and benefits realised however work underway with GP's to form clusters and quality leads have been appointed. Partnership is required to move towards a cluster operation for primary care and this should support this.	Approve carry over.
Domestic Violence Pathway	52,065	ICF funding is part of a bigger programme of funding (total funding £1.3m) for this pathway.	Approve carry over with a view to mainstreaming as part of Public Protection Review.
Buurtzorg Project Management	52,000	Area of work closely aligned with overall strategic direction and is reliant on implementation of locality plans. Evidence of impact and benefits realised still to be determined. Clear linkages to Hospital to Home Project – similar outcomes expected.	Approve carry over with further update on progress.
Craw Wood	312,561	Impact and benefits realised clearly evidenced. Project has clearly contributed to an improved rate of discharge and patient flow. Current level of expenditure likely to reduce following review of staffing rota.	Approve carry over with a review of staffing rota.
Hospital to Home	124,483	Early stages of project due to challenges with recruitment. Project is fully operational in two localities and due to begin in Central. This project fits fully within the Buurtzorg model of care and is expected to support both hospital discharge and preventative work.	Approve carry over.

4.3 Following review of the eleven projects outlined in Table 4 the IJB Leadership Team recommend approval to carry over ICF funding for ten projects. Of these ten, it is proposed that two projects carry over only 50% of funding - these are Delivery of the ARBD Pathway and Stress and Distress Training. Due to insufficient evidence of the impact and benefits realised the IJB Leadership Team recommend that one project should not be supported to carry over funding into the second phase – Deliver of the Autism Strategy

4.4 This will result in a return of funding to the ICF of circa **£122k** increasing the total uncommitted ICF funding to **£218k**.

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Autism - Borders Autism Strategy and Delivery Plan

Date Start: February 2017

Date End: February 2019

Project Description & Scope:

In response to the launch of the Scottish Strategy for Autism in 2011 and an identified need to improve the co-ordination of services for people with Autism, a multi-agency steering group in Scottish Borders developed the Scottish Borders Autism Strategy and 10 year action plan. These documents were approved by the Integrated Joint Board at its meeting on 17th November 2015. The action plan sets out seven priority areas and details a programme of work which will lead to improvements in how, services are delivered and information is provided to people with Autism and their Carers.

An Autism Co-ordinator and associated admin support have been employed to enable the implementation of the Delivery Plan as set out in the Scottish Borders Autism Strategy.

Service / Department Lead:	Haylis Smith
Project Manager:	Anita Hurding

Project Outcome

Proposed	**Actual**
Improved awareness of autism	Community Autism events held. Networking with a wide range of stakeholders and services in SBC, NHS and Third Sector.
Improved access to autism training	Online training module developed and will be available on SBLearn and LearnPro
Improved access to diagnostic assessment across the lifespan	Current diagnostic pathways have been mapped and discussions on how to make improvements are ongoing
Improving information and resources pre and post diagnosis	A wide range of resources have been amassed. Currently exploring how these can be shared in the most effective way. Discussions ongoing regarding the possibility of a web resource and who would be most appropriate to host this.
Improved access to information of local services	In discussions regarding the use of ALISS (A Local Information System for Scotland) as a tool to promote information on services
Improved inclusion and involvement for people with autism and their families in development and delivery of services	5 Autistic people and 2 parent/carers consulted with in development of the online training module. Survey developed and distributed among people with autism, their families and service providers. Survey made available to approximately 100 people and the Autism Strategy Group was encouraged to disseminate and promote this too. Unfortunately only 6 responses were received. Representatives of the autism community included in

	the sub group that has been established.

Project Achievements - Outputs

- Choice and Control Sub Group established
- Draft training framework developed
- Diagnostic pathways mapped
- Autism Awareness eModule created
- 3 Drop in events held in the community in September 2017 in Duns, Peebles and Galashiels.
- Training session held for Third Section organisations in August 2017
- Proposal for Autism Champions Pilot produced

Project spend to date

Spend to 28 February 2018 - £40,677 (Project spend to 31st March 2018 - £43,826)

Autism Coordinator Salary - £40,050
Travel expenses - £178
Miscellaneous expenditure (room hire, equipment, subscriptions) - £449

Project projected spend to end of project

Projected spend to 28 February 2019 - £99,386

Autism Coordinator Salary - £84,000
Other staffing costs - £7,056
Other expenditure (Travel, Purchased services, equipment) - £8,330

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Delivery of the Alcohol Related Brain Damage (ARBD) Pathway

Date Start: April 2017

Date End: 31 March 2019

Project Description & Scope:
(*Brief description of the project and its scope*)

Borders Alcohol and Drugs Partnership (Borders ADP) commissioned an independent needs assessment and audit of services for individuals, families and carers of individuals with Alcohol Related Brain Damage (ARBD) which was finalised in March 2013. The work focused on identifying best practice, estimating prevalence, assessing current provision, identifying gaps and identifying improvements to services and arrangements.

The summary of the report's findings identified that the current numbers of individuals with ARBD, although not high were likely to grow and that there are people currently not diagnosed and therefore not known to services or being counted: services were providing support but not in a coordinated way, no formal planned assessment approach was in place; there was a lack of proper facilities to meet the needs of individuals with an ARBD when needed as well as inconsistent referring.

An ARBD Coordinator was appointed in April 2017 to take forward the recommendations of the 2013 needs assessment and service review, and to scope best practice throughout the Borders, Scotland and Nationwide.

Service / Department Lead:	Haylis Smith
Project Manager:	Dionne Chamberlain

Project Outcome

Proposed	**Actual**
Improve access to diagnosis and assessment for people with ARBD.	A draft integrated care pathway has been developed. The Addictions Psychological Therapies team are currently reviewing the numbers of individuals assessed and re-assessment for ARBD.
People with ARBD receive the right level of treatment and support for them regardless of which setting they are in.	Training has taken place in an out of area care home to enable carers to support an individual from the Borders with an ARBD. Further training planned. An ARBD conference was held in November 2017 to bring together professionals working with people with ARBD, across all settings to ensure consistency and awareness in support received.
All staff have increased and improved awareness of ARBD across all settings of health and social Care.	A staff survey was conducted in August 2017 to determine awareness of ARBD. A leaflet about ARBD was published and distributed across all relevant services.

	41% of attendees at the ARBD Conference in November 2017 reported having a better understanding of ARBD as a result of attending.
There is better coordination of care and support for people.	An ARBD steering group has been established. Key stakeholders and services have been identified and links made. Partnership working is currently being developed with a local care home, Addaction and the Serendipity Recovery Café.
Access to dedicated ARBD Specialist Unit is improved for those that need it.	Negotiations ongoing to access a specialist ARBD service in Edinburgh.
There is improved data being held on ARBD and better use of existing resources in supporting Individuals with ARBD.	A case note audit highlighted the needs of people with ARBD and suspected ARBD. It also highlighted the gaps in information. The proposed Integrated Care Pathway should improve this.

Project Achievements - Outputs

- ARBD steering group established
- Integrated Care pathway developed and presented to the ARBD steering group. To be trialled in year 2 to improved ARBD assessment process and post diagnostic support.
- Training plan for staff – a survey was carried out in August 2017 to determine current level of knowledge and skills. This led to ARBD Conference in November 2017. Training session held out with the Borders in a care home setting. Discussion ongoing about arranging similar training in the Borders.
- ARBD casenote audit conducted in 2017 which informed the integrated care pathway.

Project spend to date

Spend to 28 February 2018 - £30,486 (projected spend to 31st March 2018 - £50,206)

Salary of ARBD Coordinator £30,458 – further charging for current financial year expected
Travel expenses £26.80 – further changes expected
Awaiting confirmation of any other additional costs to be cross charged (conference, training, costs associated with educational materials)

Project projected spend to end of project

Project spend to March 31st 2019 - £102,052

Salary of ARBD Coordinator - £84,000
Other staffing costs (administrative support for 2 years) - £11,704
Other costs (training, Conferences, travel, educational materials) - £11,648

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Stress & Distress Training

Date Start: April 2016

Date End: March 2020

Project Description & Scope:

Stress & Distress Training provides training in an individualised, formulation driven approach to understanding and intervening in stress and distressed behaviours in people with dementia. This training aims to improve the experience, care, treatment and outcomes for people with dementia, their families and carers.

This training has been developed by Dr Whitnall and Dr Thurlby as part of the dementia workstream within NHS education for Scotland. The approach is based upon the clinical model of psychological intervention for responding to distress in dementia developed by Dr Ian Andrew James and Lorna MacKenzie in Northumberland, Tyne & Wear NHS Trust.

This approach can improve the quality of life for individuals with dementia, their Carers, families and staff. This proactive training can reduce exacerbation in situations that may result in the need for residential or hospital care.

This model has demonstrated significant results in reducing the frequency of distressed behaviour for the person with dementia and staff/carer distress (Wood-Mitchell et al, 2007).

The model is used to develop hypotheses regarding the cause of a specified behaviour, which leads to the testing of interventions tailored to that individual's presentation.

Service / Department Lead:	Brian Paterson
Project Manager:	Lesley Walker

Project Outcome

Proposed	**Actual**
To deliver Stress and Distress training two day training to 500 staff	433 (up to end February 2018) – 646 places have been offered – 433 reflects the significant number of cancellations and non-attendance
To deliver Bite size Stress and distress training to 200 plus staff	217 (up to end February 2018) – 352 places have been offered
Reduction in admission into care	The outcome of this will be measured in April 2018 as part of the end of year evaluation process.
Reduction in neuroleptic use	The outcome of this will be measured in April 2018 as part of the end of year evaluation process.

	Additional measures will also be reviewed as part of the end of year including: • Reduction in length of stay • Reduction in readmission to hospital • Datix incidence of violence and aggression • Improvement in receiver health and wellbeing

Project Achievements - Outputs

- Applying new understanding of people's behaviour using an evidence based model which will impact on the outcomes for people with dementia and their kinship.
- Improvement in quality of individualised care for people with a dementia diagnosis whether in establishment (hospital, residential/ nursing care) or at home receiving care/support.
- Improving knowledgebase and skills across health, social care and third sector.

Project spend to date

Actual Spend to 28th February 2018 - £58,945 (Project spend to 31st March 2018 - £72,284)

Breakdown of how this was spent eg. staffing, equipment etc

Project projected spend to end of project

Projected spend to March 2020 - £166,000

Breakdown of how this will be spent

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Transitions for young people with a Learning Disability

Date Start: October 2016

Date End: September 2019

Project Description & Scope:

This project focuses upon young people who have a diagnosed learning disability between the ages of 14 and 18 who are moving towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education.

The project required the employment of a Transition Development Officer (TDO), full time for 12 months in Year 1, with the expertise and knowledge both of services and the needs of young people with learning disabilities.

The Officer reported to the multi-agency Transitions Steering Group (Project Board) and received support from a project officer within SBC, planning manager in LD services and expert support from Scott Reid (ARC Scotland).

The Officer scoped the current pathways across services for this group of people in transition, including the legislative duties and responsibilities before moving on to developing improved integrated pathways and processes. This includes the development of accessible information and co-ordinated assessments.

Young people with learning disabilities, their carers/advocates and people who have experienced the transitions process are included in a co-productive approach.

Year 2 and 3 of the project will involve testing and embedding the new pathway and processes.

Service / Department Lead:	Simon Burt
Project Manager:	Susan Henderson

Project Outcome

Proposed	**Actual**
Increased understanding of what Transitions means for young people and carers currently to shape new pathway	Carers have been consulted and involved through Borders carer centre and local parent carer groups. ARC Scotland gathered information from young people. Above information shaped pathway and information pack content. Participation in national information gathering to inform what a 'good transition' looks like from carers and people with learning disabilities and fed into production of Principles of Good Transitions 3. Shared learning gained so far in pathway

	developments and processes and structures surrounding this with National Transitions Forum in Nov 2017.
Improved pathway developed which can be easily navigated	Pathway developed and ready for testing in Year 2. Information booklet produced to test effectiveness. Information shared informally with schools.
Planning for transitions starts early to gain best outcomes for individuals	Pathway developed and ready for testing in Year 2. Information booklet produced to test effectiveness. Information shared informally with schools.
People navigating the pathway will have access to good information	Information pack has been drafted and will be tested in Year 2.

Project Achievements - Outputs

- 2 Workshops held in 2017 to understand needs and shape the future pathway
- Carers consulted and involved through Borders carer centre and local parent carer groups
- ARC Scotland gathered information from young people and fed into local learning
- Participation in national information gathering to inform what a 'good transition' looks like from Carers and people with learning disabilities and fed into production of Principles of Good Transitions 3.
- Above information shaped pathway and information pack content.
- Creation of a new pathway based on scoping work performed by Transitions Development Officer
- Creation of an information pack for service users and their families.
- Promotion and awareness raising of the difficulties of transition process from children to adult services
- Training needs identified across relevant staff groups. Training to be delivered in year 2
- Identification of Local Area Coordinators as appropriate named link person for transitions and training delivered to staff in this role in November 2017
- Shared learning gained so far in pathway developments and processes and structures surrounding this with National Transitions Forum in Nov 2017.

Project spend to date

Spend to 28th February 2018 - £37,199 (projected spend to 31st March 2018 - £37,500)

Transitional Development Officer Salary - £37,071
Other expenses (travel, equipment) - £128

Project projected spend to end of project

Project spend to September 2019 - £56,949

Year 2 2018-19

Travel	£1,500
Information packs and website	£5,000
Venues for workshop events and Carer expenses	£750
Letters/postage	£500
Miscellaneous	£2,000

Year 3 2019-20

Evaluation	£10,000

Original ICF funding awarded: £65,200

Return underspend to ICF at end of March 2018 = £8251 (related to underspent salary and IT costs)

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Transitional Care Facility

Date Start: January 2017

Date End: December 2018

Project Description & Scope:

The model of care for the Transitional Care Facility (TCF) has been developed by representatives from SBC, NHS and SB Cares. TCF is based in Waverley Care Home in Galashiels and provides 16 modern en-suite rooms with upgraded facilities.

The unit is staffed with a multi-disciplinary team, whose primary focus is to ensure that individuals admitted to the unit receive the support required to facilitate discharge to their own home. The environment within Transitional Care is designed to be as much like home as possible. As part of an individual's rehab plan, building confidence in normal activities of daily life is included, something that is not always possible when someone is discharged directly from hospital and may result in increased home care requirements.

The provision of a multi-disciplinary staff team to manage and staff a Transitional Care Facility (TCF). The facility will provide short term care which will enable patients to return to their homes within 6 weeks.

Service / Department Lead:	Murray Leys
Project Manager:	Elena Hendry

Project Outcome

Proposed	**Actual**
Individuals are treated in the most appropriate setting - reduction in patients staying in hospital when they are medically fit for discharge.	In 2017, a total of 3352 occupied bed days was saved in an acute hospital setting due to TCF. This is expected to increase to over 4500 occupied bed days in 2018 due to the increase from 11 to 16 beds after refurbishment was completed in 2017. 99 medically fit patients were discharged from BGH and admitted to TCF. A further 4 non-TCF patients were also discharged from hospital and stayed in the facility.
Individuals admitted to the facility are able to transition back to their own homes - % Service users who return home within 6 weeks	In 2017: • 81% of individuals discharged from TC returned to their own home. • 77% of individuals stayed for 6 weeks of less 67% of recorded TC stays resulted in the person returning home and within 6 weeks.
Individuals who return home, stay at home –	TCF had a readmission rate within 28 days of discharge of 6% (December 16 to November 17 – refers to 28

Readmission rate within 28 days	days from discharge from TC) The over 65s BGH 28 day readmission rate for 2016/17 is 11.8% which is almost double that of TC. The average age on admission to Transitional Care is 83 years old.
The service meets service user needs and improves wellbeing – User survey	To January 2018, 19 admission questionnaires and 15 discharge questionnaires were received. The average wellbeing score on admission was 25, which increased to 27 on discharge. This demonstrates that, not only was mental wellbeing maintained within Waverley, but for most service users it actually improved during their stay and subsequent discharge to home. **On discharge:** • 80% of respondents answered 'often' or 'all of the time' to the question "I've been feeling optimistic about the future" compared with 42% on admission. • 80% Agreed that the service met their individual needs and preferences. • 100% Agreed the service treated them with dignity and respect. • 87% Were satisfied overall with the service provided. Multiple respondents noted how friendly and kind the staff are, as well as appreciating the opportunity to improve their ability.
Staff are engaged with the service, understand the service and are satisfied with the service – staff survey	A staff survey will be carried out in April/May 2018. A number of activities have taken place to ensure engagement and understanding of the service including: • Team building and process mapping days workshops • Communications to Health and Social Care staff, • Attendance at various meetings and forums across the partnership. • The criteria and brochure have also been widely circulated
Care Package Requirements on Discharge	An audit of 51 TC stays found:

	22% of packages were increased 6% of packages were reduced 14% maintained the same level of package 18% had no package of care before or after 33% had no package of before TC but required one on discharge 6% required supported accommodation or permanent care on discharge A further audit will be carried out in year 2 to compare with these results.

Project Achievements - Outputs

- Multi-disciplinary team established including AHPs, support workers and social work.
- Established a person centred model of rehabilitation allowing individuals to return to their maximum functional capacity before going home. Processes, procedures and criteria put in place to facilitate this.
- Improved hospital discharge process – reduced delayed discharge by supporting 99 medically fit patients to be discharged from an acute hospital setting
- High level of service user satisfaction with the service
- Low rate of readmission to hospital for service users who successfully return home from Transitional Care

Project spend to date

Actual spend to 28th February 2018 - £475,556 (projected spend to 31st March 2018 - £645,344)

Agreed payment to Community Hospital Beds 2016 - £410,000
SB Cares Staffing Costs January 17 – March 18 - £133,176
NHS Staffing Costs - £78,373
GP Costs January 17 – March 18 - £17,235
IT & Equipment - £2,487
Community Equipment Store charges - £4,073

Project projected spend to end of project

Projected spend to end of project - £827,411

Payment to Community hospital beds 2016 - £410,000
SB Cares - £208,089
NHS Staffing Costs - £156,746
GP Costs - £27,576
IT & Equipment - £5,000
Community Equipment Store charges - £15,927

This leaves £99,189 from the original budget which was originally planned for District Nursing and Speech and Language therapy resource. The project proposes using a proportion of this to increase AHP cover to include holiday and sickness cover, as well as extending the period covered (current AHP staffing is part time) - £52,000. Consideration of a dedicated Care Manager resource is also being considered. - £46,700

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Pharmacy Input to Social Care

Date Start: January 2018

Date End: December 2018

Project Description & Scope:

This project aims to introduce Pharmacy input into social care decision making around the provision of support to patients with medicines.

The aims of this project are to reduce home care visits due to medication, reduce medication errors and reduce the improper use of compliance aids, as well as demonstrate the benefits of providing Strategic and Operational support by a pharmacist and pharmacy technician into the following ICF Projects : Transitional Care facility and Matching Unit.

Service / Department Lead:	Alison Wilson
Project Manager:	Margaret Purves

Project Outcome

Proposed	**Actual**
Impact on carer visits	Too early in project to measure impact.
Impact on Medication errors	Too early in project to measure impact. Use of Datix incident recording data to demonstrate
Appropriate use of aids to support medication use	Too early in project to measure impact
Impact on risk of harm to patients from their medicines	Too early in project to measure impact. Use of individual medication risk assessment tool to demonstrate

Project Achievements – Outputs

- Project Manager and Pharmacy Technician in post from January 2018
- Commenced work in Cheviot locality
- Working with Craw Wood and Transitional Care to improve medication processes

Project spend to date

Project spend to 31st March 2018 - £13,000

Staffing - £12,000
Other (equipment/travel) - £1,000

Project projected spend to end of project

Projected spend to 30th June 2019 - £97,000 – The project was unable to recruit against the original post profile for a Pharmacist for a one year post and agreed to recruit a part time Project Manager resource

instead of a full time Pharmacist. The proposal is to extend the project for an additional 6-8 months to allow delivery of outcomes with this alternative staffing model.

Full time Pharmacy Technician for 20 months - £52,000
Part time Project Manager for 20 months - £31,500
Other (equipment/travel) - £13,500

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: GP Cluster Project

Date Start: March 2017

Date End: December 2018

Project Description & Scope:

In October 2015, following discussions with the Scottish GP Committee, the Scottish Government announced that the Quality and Outcomes Framework (QOF) which had been a fundamental part of the Scottish GP Contract was to be dismantled. In its place, the Scottish Government has introduced, 'Transitional Quality Arrangements' (TQAs). Core to this approach is the establishment of GP "cluster working" which will be closely linked to the health and social care integration agenda. The expectation is that GP practices & clusters will have both oversight & direct involvement with improving the quality of all health and social care services provided to patients registered within their area (see NHS Circular PCA(M)(2016)(7) & General Practice: Contract and Context, Principles of the Scottish Approach – Scottish Government and BMA)).

Furthermore, during January 2017, the Scottish Government published the document "Improving together: A National Framework for Quality and GP Clusters in Scotland" in which guidance is given regarding the role and function of clusters and Cluster Quality Lead's (CQL's). The emphasis within both the National Framework & the RCGP document, "Setting the Strategy for Quality in Scotland's General Practice" is on collaborative working & a collective approach. Clusters & CQL's in particular will be expected to work together with the Health & Social Care Partnerships (H&SCP's) to jointly plan & develop appropriate local priorities as well as leading the quality improvement agenda across general practice.

Local GP practices, professional & advisory structures in liaison with health and social care were tasked with identifying appropriate cluster formation. In the Scottish Borders 4 clusters have been identified – East, West, South & Central.

Each GP Practice is required to have a Practice Quality Lead (PQL) which, apart from any work requested beyond what is specified in the GP contract, will be funded as part of the core GMS resource. All Borders GP practices have now appointed their individual PQLs.

Partnerships are also required to have Cluster Quality Leads (CQLs) from 1st April 2017. The national guidance states that these posts will be instrumental in shaping & delivering change to improve outcomes for their patients. These individuals should be identified, appointed and empowered by the cluster & wider Partnership.

Service / Department Lead:	Kenny Mitchell
Project Manager:	Zena Trendell

Project Outcome

Proposed	**Actual**
Better communication across groups of GP practices	Awaiting detail

The identification of key Primary Care health priorities within each individual cluster	Awaiting detail
A programme of work to form part of the H&SCP Primary Care Improvement Plan for 2018/19	Awaiting detail

Project Achievements - Outputs

- Individuals in post, meetings arranged with PQL's & at CQL level, information sharing
- Collaborative working with the H&SCP, Health Board, LIST & others are all outputs of the project

Project spend to date

Spend to 28th February 2018 - £27,000 (projected spend to 31st March 2018 - £32,500)

Details of spend eg. salaries, equipment, travel

Project projected spend to end of project

Project spend to 31st December 2018 - £50,00

Projected spend of remaining funds with detail

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Pathway 2 Project – domestic abuse

Date Start: July 2017

Date End: June 2020

Project Description & Scope:

The Pathway 2 project follows on from the original Pathway Project which started in 2012 and brought together a co-ordinated community response to addressing domestic abuse in the Scottish Borders. Pathway 2 continues the existing services – Domestic Abuse Advocacy Support (DAAS) and Domestic Abuse Community Support (DACS) services but has an additional has two elements – A Domestic Abuse Community Engagement Worker and Domestic Abuse Advocate (Court). These two additional elements were identified as "gaps" in the independent external evaluation and also fitted with the funding criteria for Big Lottery and Scottish Government.

Pathway 2 aims to support people who have experienced and are recovering from domestic abuse, as well as engaging with service users and the wider community in order to actively tackle domestic abuse in the Scottish Borders, providing an increased opportunity for survivors to move towards recovering from their experiences.

Service / Department Lead:	Graham Jones
Project Manager:	Andrea Beavon

Project Outcome

Proposed	Actual
People are safer	The Domestic Abuse Advocacy Support Service continues to deliver a responsive service to victims of domestic abuse referred by a range of partner agencies, and including an increase in self referrals. All referrals where contact is safely made undertake a Risk Assessment and Safety Plan. The Domestic Abuse Advocacy Support (DAAS) Service received 267 referrals in the period 1/7/17 to 31/12/17. Of these referrals, 95% were female, 5% male, and the main referral source was Police Scotland (74%)- all referrals were contacted within 24 hours of the incident. Risk assessments were conducted with all those who engaged with the service and safety plans implemented, monitored and reviewed every week (for high risk case) and every three weeks (not high risk case). DAAS continues to focus on reducing risk and increasing safety for adult victims of domestic abuse by proactive support using an empowerment/advocacy model. Working in partnership continues to be the principle by which risk is managed, and all cases are reviewed at closure to measure improved outcomes by a Severity of Abuse Grid (SOAG). This ties in the risk assessment tool (DASH-RIC) and is designed to revisit levels of abuse after advocacy intervention. At the time of writing, data to demonstrate this reduction in risk is not available due to the absence of the Service Manager who is responsible for requesting this information from the database providers. A full report on reduction in risk and increase in

safety will be available at the end of the reporting period to 30th June 2018.
The following 8 exit interviews were conducted in the reporting period, 100% of respondents felt they could contact DAAS again, and would be confident in contacting the police should further incident occur – this is a significant safety planning action which increases the potential for risk reduction.

Case	Contact DAAS Again	Confident Calling Police	Recommend DAAS	Knowledge of help if reoccurance	Anything DAAS Could have done
858	y	y	y	y	n
962	y	y	y	y	n
1318	y	y	y	y	n
1245	y	y	y	y	n
1371	y	y	y	y	n
1128	y	y	y	y	n
822	y	n	y	y	n
1376	y	y	y	y	n
1398	y	y	y	y	n
1241	y	y	y	y	n
1218	y	y	y	y	n

The outcomes for clients accessing the DACS service are recorded under the following domains; this clearly evidences the positive impact of support on safety, mental and emotional health, family relationships, and community engagement.

SHANARRI	Service Outcome (L2)	No. of individuals with this outcome in their workplan	% of individuals (13 with completed work)	No. of individuals who demonstrated an overall improvement	No. of individuals where status was maintained (i.e. no change)	No. of individuals where status deteriorated	% of success for this outcome
SAFE	01. Child is living in a safer environment	1	7.7%	1	0	0	100%
	41. Adult is living in a safer environment	10	76.9%	10	0	0	100%
HEALTHY	09. Child/young person has improved emotional	1	7.7%	1	0	0	100%
	12. Parent/carer has improved emotional	6	46.2%	5	1	0	83%

		13. Parent/carer is happier	1	7.7%	1	0	0	100%
		14. Parent/carer/adult has increased resilience	8	61.5%	8	0	0	100%
	NURTURED	24. Improved family relationships	2	15.4%	2	0	0	100%
	ACTIVE	26. Parent/carer/adult is more active within the	2	15.4%	2	0	0	100%

Risks of further harm is reduced	The Safety Plan is the tool by which action is planned to reduce the risk of further harm. Each action is aligned to a specific risk in the risk assessment and involves • installation of alarms, • stalking packs/phone applications • Personal alarms • Home security advice • Information sharing with key partners • Referrals to the Court Advocacy Service, Safe Housing Options service, • Sharing of intelligence
Perpetrator behaviour is disrupted	The framework for approaching risk management in relation to perpetrators is the Multi-Agency Risk Assessment Conference and the Multi-Agency Tasking And Coordination meeting. Both require significant partnership action to share information and take action to disrupt serial offenders. **MARAC data: for period Sept to December 2017** Referrals – 55 (54 female, 1 male) Source of referrals: DAAS – 41 Police – 6 Other - 8 Demographics of referrals BME – 4, LGBT – 0, Disability – 6 Repeat referrals to MARAC - 6 No of children affected - 62 Number of actions per partner agency DAAS – 51 DACS – 3 Police – 43 CYPS – 7 CJ – 10 Child health – 10 Mental health – 2 Addictions – 1 Adult protection – 2 SBHA – 8 Berwickshire HA – 4 Eildon – 2 Waverley – 3 Homeless – 6 Education 8 BWA – 4 Fire -5 There have been 5 referrals to the MATAC process in the same three month period, representing the 5 most high risk perpetrators in the Scottish Borders.
Better justice outcomes for victims	The new Court Advocacy service successfully recruited an experienced advocate, who started on 16th October 2017. The first referral for the service was taken on 31st October 2017 following a period of engagement with the stakeholder working group – Crown Office, Police Scotland, Victim Information Service, Witness Service and Scottish Borders Court Service.

	To date the service has received 51 referrals (direct from custody) and is currently supporting 37 client with ongoing court processes eg face to face support, organising special measures, advocating in relation to giving evidence, and follow up support to help manage expectations in relation to court outcomes. **What difference you made as a result:** The Court Advocacy service is just over six months old and still in the development phase in relation to gathering service user feedback and evidence of impact. However, some evidence exists in relation to the outcomes for victims and stakeholders: see attached presentation. There will be a suite of indicators developed (as per the funding bid) and built into the reporting framework for the end of the first year period.
Survivors have better outcomes when integrating into a community	The Community Engagement officer was successfully recruited and started in October 2017, this a 14hr/week post. In the remaining period from October to December 2017 the community engagement officer has: - Met with Border Women's Aid, Scottish Borders Rape Crisis Centre, Children1st, Reconnect to develop referral criteria and raise awareness of the service user group (SEED). - Met with equality groups eg Scottish Borders LGBT Equality to ensure all women, including trans women can access the service user group - Met with Borders Volunteer service to ascertain whether there are volunteers who may benefit from the service user group - Observed awareness raising delivery to Faculty of Law - Supported CEDAR graduate mums to deliver a session at the CEDAR Conference - Joined the Never Too Late to Tell Working Group, looking at using the animation to raise awareness of Childhood Sexual Abuse - Joined the 16 Days of Action Working Group - Developed a Communications Plan to ensure a framework for raising awareness and reporting on the project - Attended training on Responding to Trauma, Rape and Sexual Assault and Transgender Awareness - Engaged with other SEED group in the UK to learn from their journey to date - Accessed community groups in Berwickshire (Borders Association of Voluntary Services) to better understand the availability of resources - Developed materials to assist stakeholder to identify women who may benefit from the service user group - Contributed to the development of awareness raising materials, and organised delivery of the multi-agency domestic abuse half day course During the reporting period, a number of courses were delivered: Young People and Domestic Abuse training 20 participants (13 SBC, 7 others) in August 2017 16 participants (13 SBC, 3 others) in November 2017 Domestic Abuse Stalking and Honour Based Violence (DASH) Risk Assessment training 10 participants (2 SBC, 8 others) in September 2017 9 participants (5 SBC, 4 others) in December 2017 **What difference you made as a result:** The Community Engagement officer (CEO) has made a real in-roads to ensuring stakeholders are aware of the support that women can access in relation to influencing the shape of service delivery in the Scottish Borders. Four women have indicated they wish to meet as a group and progress some of their own ideas. The CEO has met them all individually and is now organising a meeting of all four women. Further evidence of impact should be available

	at the end of the first year and will be reported on in the required report.
Service review	A fully costed business and funding model is being presented to senior management in October 2018. Presently the Pathway project data is being gathered to start this process of mainstreaming the funding for domestic abuse services.

Project Achievements - Outputs

- Risk assessments – these are conducted using the Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklist (DASH-RIC) for every referral where safe contact can be made.
- Safety plans – these are created for every referral after risk assessment and are highly individualised
- Support plans – these are the plans created for each client in the Domestic Abuse Community Support (DACS) service commissioned by SBC and delivered by Children1st.
- Risk reviews- these are conducted weekly, fortnightly or monthly with DAAS clients according to the risks identified, the review is conducted using the Severity of Abuse Grid (SOAG), which measures severity, frequency and escalation of further harm
- Referral pathways – these are established with key partner agencies and are being developed with new partners eg Mental Health Elderly Team
- Court reports – these are standardised reports developed with Crown Office and Court Service and created for every referral received from Custody. They are submitted to the PF for consideration and used to create safety plans for victims going through the court process, with the support of the Court Advocate
- Community engagement events – see CEO Workplan

Project spend to date

Spend to 31st March 2018 - £67,935

Staffing – Domestic Abuse Community Engagement Worker and Domestic Abuse Advocate (Court).

Project projected spend to end of project

Project Spend to 30th June 2020 - £120,000

Staffing – Domestic Abuse Community Engagement Worker and Domestic Abuse Advocate (Court).

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Buurtzorg (neighbourhood care) in the Borders

Date Start: October 2017

Date End: March 2019

Project Description & Scope:

Buurtzorg in the Borders is a pilot exploring how the Buurtzorg Neighbourhood Care approach may be adapted to the Scottish Borders. It is based in Coldstream and is concerned with changing care "one patient at a time"

Buurtzorg involves a non-hierarchical approach using self-managing teams and its successful application will require a longer term cultural shift, to move away from traditional ways of working across Partnership organisations as well as patients and informal carers .

While it is too early for the emergence of meaningful data, it can be stated that the provision of care has reduced for all patients in the small cohort involved so far and positive patient stories have been developed. It is essentially an evolutionary approach that will take some time to embed due to the required culture shift. It is anticipated that the proposed supporting activity with enhanced project management support and heat shield (back office support) will significantly help this test of change take root and show potential for rolling out across the Borders.

Service / Department Lead:	Erica Reid
Project Manager:	Stewart Barrie

Project Outcome

Proposed	**Actual**
Increased service user facing time	Too early in project to measure improvement
Number of service users seen who receive both Health and Social Care	Too early in project to measure improvement
Hours of care per service user	Too early in project to measure improvement
Number of individuals visiting each service user per day/week	Too early in project to measure improvement
Number discharged from caseload	Too early in project to measure improvement
Decreased travel	Too early in project to measure improvement

Project Achievements - Outputs

- Coaching - enabling strong leadership from District Nurse Team Leader
- Support from Buurtzorg UK & Ireland (PublicWorld)
- Weekly team meetings with Community Nursing Team, SBC SC &H, SB Cares

• Patient stories developed • Synergies with Hospital to Home (HaH) will help it embed as well as provide data (HaH template) • Project governance structure developed March 2018
Project spend to date
No spend to date
Project projected spend to end of project
Total project spend - £52,000 Project Manager Salary costs (for 1 year) - £46,677 Other costs £5,323

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Craw Wood refurbishment and staffing

Date Start: December 2017

Date End: September 2018

Project Description & Scope:

Craw Wood, owned by Eildon Housing Association, will be used as a discharge to assess patient pathway. The Care Inspectorate are supportive of the short-term use of Craw Wood for DTA, but have been very clear that registration will only be for the short-term, to support Winter planning. The EMT supported immediate work to bring the Craw Wood premises up to acceptable standards for use and refurbishment works were completed November 2017. The proposal is to have 15-beds operational at Craw Wood to improve DTA and to mitigate Winter pressures. The Care Inspectorate have stated that they expect the use of Craw Wood to either cease by end April 2018 – or that there be a long-term plan for Craw wood, which would require significant remodelling or demolishment & reconstruction of the building.

Service / Department Lead:	Murray Leys
Project Manager:	Graeme McMurdo

Project Outcome

Proposed	**Actual**
Occupancy of Facility (expressed in Occupied Bed Days) – Target 90%	65% - Data taken from 11th Dec 2017 – 26th Feb 2018. Week beginning 4th Dec was used to 'ramp-up'. Reflects 23 bed capacity.
Individuals stay in Facility no longer than 2 weeks Target – Zero	16 exceeded the target.
Individuals that stay in the Facility are able to be discharged home.	82% - 7 of 40 patients that have been discharged have been re-admitted to the BGH.
Individuals who return home, stay at home (BGH Readmission Rate <28 days) Target - TBC	Targets to be agreed.
Service Users Feedback is positive Target 100%	Data capture under development. Anecdotal feedback has been positive.
Staff Feedback is positive	Data capture under development.

Target 100%	

Project Achievements - Outputs

- Project Steering Group established
- Patient Pathway defined and agreed
- Communication activities complete
- Facility opened on time under challenging time scale by 4th Dec for 8 beds
- Facility extended to 15 beds by 2nd Jan
- Data Capture and Monitoring Reporting agreed or being developed.
- Refurbishment of full complement of 23 beds completed January 2018

Project spend to date

Projected spend to end April 2018 - £667,802

Approximate breakdown of costs:
Refurbishment and set up costs - £181,566
Staffing (GP, support workers, AHP) - £365,927
Leasing Costs - £45,000
Equipment/Utilities/Catering - £75,309

Project projected spend to end of project

Projected Annual Cost - £885,525

Staffing - £712,324
Leasing Costs - £90,000
Equipment/Utilities/Catering - £83,201

(Projected additional cost to extend project May 2018 – September 2018 - £368,968)

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Hospital to Home

Date Start: January 2018

Date End: June 2018

Project Description & Scope:

A pilot has been running in Berwickshire, where Health Care Support Workers (HCSW) have been recruited to support care provision in that community. Delivery involves close partnership working with Social Work, District Nursing, SB Cares and community hospitals. The HCSW are employed by and work under the governance of the NHS, working closely with SB Cares colleagues to compliment the provision of care at home. The 18 December 2017 IJB meeting approved the extension of the "Hospital to Home" pilot 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. The Hospital to Home proposal offers the opportunity for individuals delayed in hospital to go home where they will be provided with a "Re-ableing" programme of activities, provided by a HCSW, under the guidance of a District Nurse and/or an Allied Health Professional.

Service / Department Lead:	Rob McCulloch-Graham / Erica Reid
Project Manager:	Sonia Borthwick / Elena Hendry

Project Outcome

Proposed	**Actual**
Reduction in average time patients spend waiting for discharge after being declared medically fit to do so	Berwickshire pilot live from 15th January 2018 Hawick pilot live from 15th March 2018 Central pilot not yet live. Too early to draw conclusions/trends from data.
Contribution towards a percentage reduction in admissions/readmissions	Berwickshire pilot live from 15th January 2018 Hawick pilot live from 15th March 2018 Central pilot not yet live. Too early to draw conclusions/trends from data.
Contribution towards a reduction in the average assessed home care hours required per client	Berwickshire pilot live from 15th January 2018 Hawick pilot live from 15th March 2018 Central pilot not yet live. Too early to draw conclusions/trends from data.

Project Achievements - Outputs

- Promoted independence (and reduced dependency)
- Improved locality arrangements, making the best use of resources
- Building capacity & assets in communities and in the Third Sector
- Deliver person-centred planning & pathways
- Successful operational launch of pilot in Berwickshire

Project spend to date
Actual spend to 28 February 2018 - £14,585 (Project spend to 31st March 2018 - £35,800) Berwickshire pilot - £25,000 Hawick pilot - £10,800
Project projected spend to end of project
Projected spend to 30 June 2018 - £160,283 HCSW Staffing - £124,500 Supervisory Staffing - £14,397 Supplies - £3,086 Travel - £18,300

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: ..23 April 2018.....

Report By	Dr Stephen Mather, Chair
Contact	Iris Bishop, Board Secretary
Telephone:	01896 825525

INTEGRATION JOINT BOARD MEETING CYCLE

Purpose of Report:	To seek approval for a change in the designation of meetings.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Approve the increase from 6 formal meetings to 8 per year and a reduction from 5 Development sessions to 3 per year.

Personnel:	Staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Carers:	N/A

Equalities:	Compliant

Financial:	Resource implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Legal:	Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Risk Implications:	Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Aim

1.1 To provide the Health & Social Care Integration Joint Board with a focused and structured approach to the business that will be required to be conducted over the coming year.

Background

2.1 To deliver against targets and objectives, the Health & Social Care Integration Joint Board must be kept aware of progress on a regular basis.

Summary

3.1 It is proposed that the Health & Social Care Integration Joint Board increase its Formal meetings to 8 per year and reduce its Development sessions to 3 per year.

3.2 The Audit Committee at its last meeting proposed that it now meet on 4 occasions each year.

3.3 It is proposed that there are no meetings held in July.

3.5 All Health & Social Care Integration Joint Board meetings, development sessions and Audit Committee meetings will continue to take place at Scottish Borders Council.

3.6 Listed below are the changes proposed to the current meeting schedule (highlighted in yellow).

Date/Event	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
H&SC IJB Meeting 2pm to 4pm		12		23	28	11		20	17	22		17
H&SC IJB Development Session 9.30am to 12.30	29		19		~~28~~				~~17~~		19	
H&SC IJB Audit Committee 2pm-4pm (March & September) 10am-12noon (June)			19			11			17			17

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: ....23 April 2018.....

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Philip Lunts, General Manager, Unscheduled Care
Telephone:	01896 826704

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERHSIP
2017/18 WINTER PERIOD EVALUATION REPORT

Purpose of Report:	To update the Board on key activity relating to the 2017/18 winter period and present the evaluation of the Winter Plan 2017/18

Recommendations:	The Health & Social Care Integration Joint Board is asked to: **note** the learning and improvement opportunities for next year which will now be taken forward by the Winter Planning Board.

Personnel:	Resource and staffing implications were addressed within the Winter Plan.

Carers:	Planning for all activity for all Groups across the Winter Period.

Equalities:	Planning for all activity for all Groups across the Winter Period. Performance against the Winter Plan has been presented at numerous committees and groups within NHS Borders and Scottish Borders Council. Debriefs of both the Festive Plan and the Winter Plan have taken place. Feedback from these sessions has influenced this evaluation.

Financial:	Resource and staffing implications were addressed within the Winter Plan.

Legal:	Request from the Scottish Government that all Health Boards produce a Winter Plan signed off by their Board. This report will inform the Winter Planning Process 2018/19.

Risk Implications:	The Winter Plan is designed to mitigate the risks associated with the winter and festive periods.

Summary

This winter has been one of the most challenging for the past 4 years. In addition to the normal winter pressures, there were 3 major challenges during the course of this winter;

- Norovirus outbreak. There was a major norovirus outbreak in October 2017, which continued into the early part of November, resulting in a loss of beds
- Flu outbreak. The flu outbreak this year was one of the most significant in recent years and this impacted on front door activity and admissions
- Snow. We experienced the worst snow weather for the past 8 years during February and into March with major disruption to health systems.

This winter, the normal provisions for additional winter activity were put in place. In addition, the following new measures were taken;

- A range of initiatives within social care to reduce delays to discharge
- A number of actions to better support patients within primary care
- An increase in assessment and ambulatory care capacity, including a test of a Surgical Assessment Unit and the expansion of the Acute Assessment Unit
- Additional surge capacity in Community Hospitals
- Planned reduction in inpatient elective operating during January 2018

Feedback from primary care suggests that GP practices were busy but made arrangements that allowed them to cope with additional demand. Activity data indicates that the front door of the BGH was much busier than in previous years. BECS activity increased by 9% and Emergency Department by 8%. Both departments saw 30% or greater increases in patients requiring urgent assessment. This suggests more patients presenting acutely unwell. Despite these challenges, both departments reported that the planning for additional activity had worked well.

Although admissions to the BGH reduced by 8% overall and by 10% for adults over the winter period, the length of stay increased by 6% from an average 4.3 days to 4.7 days, but with the greatest increase from 1st January onwards. As a result, there was a 10% increase in occupied beddays for medical patients during this period. This is likely to be due to two factors

- front-door services were very effective at managing patients to avoid admission, meaning patients who were admitted were sicker or more complex than previous years.
- There was a 30% increase in delayed discharge occupied beddays in the period up to beginning of January

This increase in length of stay outbalanced the reduction in admissions and resulted in very high demand for inpatient beds. In addition, there were a number of peaks in admissions which caused increased impact on patient flow.

The demand for acute medical beds exceeded capacity on a regular basis over this period. As a result, numbers of boarding patients increased by two-thirds. Operationally, there were major challenges in the ability to identify suitable patients to board to non-medical wards and the time and resource required to manage this resulted in delays and increased length of stay. This further exacerbated the challenges in managing patient flow.

An additional 44 surge beds were open over this period across the BGH, Community Hospitals and Social Care. However 10 of these beds were open before the winter period began. These were insufficient to accommodate demand from the New Year, resulting in

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the Planned Surgical Admissions Unit opening as inpatient beds for 28 days and the Acute Assessment Unit for 38 days. There were 16 days during this period when there were insufficient beds to accommodate all patients and some patients were cared for overnight in ED.

There was a consequent deterioration in performance against the Emergency Access Standard, with breaches increasing from 584 last year to 982 this winter. We experienced 109 eight-hour breaches during this period, of which 58 were overnight.

Elective operating was impacted with total number of procedures undertaken falling from 1457 last year to 1336 this year and numbers of patients exceeding their Treatment Time Guarantee as a result of cancellations rising from 63 at beginning of November to 254 at end of February.

On a positive note, uptake of staff flu vaccination was higher than last year at 54% and vaccination of over-65s in the community increased compared to last year.

It is a credit to staff across health and social care that delivery of care was maintained and patients were cared for appropriately and safely. Data and feedback suggests that the tried-and-tested operational provisions within the Winter Plan worked well to minimise the impact of additional activity. Although new initiatives to support the management of the increased demand, mainly additional social care capacity, had a positive impact, especially on delayed discharges, they did not have sufficient time to be established and did not address the demand for acute medical beds. As a result, there was a heavy reliance on short-term contingency arrangements, with a resulting impact on maintenance of routine services.

A range of recommendations for future winter planning are contained at the end of this report.

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Borders NHS Board

Scottish Borders Health and Social Care PARTNERSHIP

NHS Borders

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERHSIP 2017/18 WINTER PERIOD EVALUATION REPORT

Aim

To update the Board on key activity relating to the 2017/18 winter period.

Background

The Scottish Borders Health and Social Care Partnership, like all Partnerships, is required on an annual basis to produce a Winter Plan which outlines potential risks and contingency planning relevant to the winter season, with a particular focus on the festive period. The 2017/18 Winter Plan was developed as a whole system Scottish Borders Joint Winter Plan between NHS Borders and Scottish Borders Council and was approved at the October 2017 NHS Borders Board and subsequently noted by the Integrated Joint Board in November 2017.

Assessment

As in previous years the key elements of the 2017/18 winter plan were staffing resilience, unscheduled and elective capacity planning, including appropriate escalation and contingency or surge, infection control planning and procedures, and our communication strategy. However, this year's Winter Plan was a driver for the establishment of social care alternatives to hospital, in particular initiatives to enable patients to be discharged from hospital earlier whilst assessment and social care planning took place.

Data within this evaluation relates to the period November 2017 to end February 2018, unless otherwise stated.

Executive Summary

This winter has been one of the most challenging for the past 4 years. In addition to the normal winter pressures, there were 3 major challenges during the course of this winter;

- Norovirus outbreak. There was a major norovirus outbreak in October 2017, which continued into the early part of November, resulting in a loss of beds
- Flu outbreak. The flu outbreak this year was one of the most significant in recent years and this impacted on front door activity and admissions
- Snow. We experienced the worst snow weather for the past 8 years during February and into March with major disruption to health systems.

This winter, the normal provisions for additional winter activity were put in place. In addition, the following new measures were taken;

- A range of initiatives within social care to reduce delays to discharge
- A number of actions to better support patients within primary care
- An increase in assessment and ambulatory care capacity, including a test of a Surgical Assessment Unit and the expansion of the Acute Assessment Unit
- Additional surge capacity in Community Hospitals
- Planned reduction in inpatient elective operating during January 2018

Feedback from primary care suggests that GP practices were busy but made arrangements that allowed them to cope with additional demand. Activity data indicates that the front door of the BGH was much busier than in previous years. BECS activity increased by 9% and Emergency Department by 8%. Both departments saw 30% or greater increases in patients requiring urgent assessment. This suggests more patients presenting acutely unwell. Despite these challenges, both departments reported that the planning for additional activity had worked well.

Although admissions to the BGH reduced by 8% overall and by 10% for adults over the winter period, the length of stay increased by 6% from an average 4.3 days to 4.7 days, but with the greatest increase from 1st January onwards. As a result, there was a 10% increase in occupied beddays for medical patients during this period. This is likely to be due to two factors

- front-door services were very effective at managing patients to avoid admission, meaning patients who were admitted were sicker or more complex than previous years.
- There was a 30% increase in delayed discharge occupied beddays in the period up to beginning of January

This increase in length of stay outbalanced the reduction in admissions and resulted in very high demand for inpatient beds. In addition, there were a number of peaks in admissions which caused increased impact on patient flow.

The demand for acute medical beds exceeded capacity on a regular basis over this period. As a result, numbers of boarding patients increased by two-thirds. Operationally, there were major challenges in the ability to identify suitable patients to board to non-medical wards and the time and resource required to manage this resulted in delays and increased length of stay. This further exacerbated the challenges in managing patient flow.

An additional 44 surge beds were open over this period across the BGH, Community Hospitals and Social Care. However 10 of these beds were open before the winter period began. These were insufficient to accommodate demand from the New Year, resulting in the Planned Surgical Admissions Unit opening as inpatient beds for 28 days and the Acute

Assessment Unit for 38 days. There were 16 days during this period when there were insufficient beds to accommodate all patients and some patients were cared for overnight in ED.

There was a consequent deterioration in performance against the Emergency Access Standard, with breaches increasing from 584 last year to 982 this winter. We experienced 109 eight-hour breaches during this period, of which 58 were overnight.

Elective operating was impacted with total number of procedures undertaken falling from 1457 last year to 1336 this year and numbers of patients exceeding their Treatment Time Guarantee as a result of cancellations rising from 63 at beginning of November to 254 at end of February.

On a positive note, uptake of staff flu vaccination was higher than last year at 56% and remained high within community.

It is a credit to staff across health and social care that delivery of care was maintained and patients were cared for appropriately and safely. Data and feedback suggests that the tried-and-tested operational provisions within the Winter Plan worked well to minimise the impact of additional activity. Although new initiatives to support the management of the increased demand, mainly additional social care capacity, had a positive impact, especially on delayed discharges, they did not have sufficient time to be established and did not address the demand for acute medical beds. As a result, there was a heavy reliance on short-term contingency arrangements, with a resulting impact on maintenance of routine services.

A range of recommendations for future winter planning are contained at the end of this paper.

Resilience Planning

The Winter Plan this year recommended assessment of NHS and SBC joint capacity for resilience. This confirmed that plans were in place for maintaining business continuity in both organisations. These plans were tested intensively as a result of the severe weather experienced in February. A separate review of this event is taking place. However, the fact that services were maintained without any serious adverse events, and the lessons learned from this event, will be invaluable in helping to further strengthen the resilience of the Partnership for future years.

Prevention of admissions

In 2017/18 there was an increased focus on vaccination of NHS staff against influenza. As at 23rd February, 56% of staff had been vaccinated against a target set by the Scottish Government of 50%. This was an improved performance against previous years.

Vaccination of essential SBC staff and carers within home care services was also offered. 85 members of Scottish Borders Council staff were vaccinated and a drop-in clinic for SBCares staff was available. However, formal monitoring of uptake was not undertaken, so the extent of vaccination of these groups is not clear.

There was a spike in staff off sick due to flu-related conditions in January this year, but this mirrored a similar increase last year.

The community vaccination programme vaccinated three-quarters of all primary school and over 65 age groups, representing an improvement for over-65s and a slight drop for primary school age.

Other at-risk groups' percentage vaccination increased. Borders overall performance was in the top half for Scotland in all categories.

Table 1 Flu Vaccination

	2015		**2016**		**2017**		
Programme	**Borders**	Scotland	**Borders**	Scotland	**Borders**	Scotland	Position in Scotland
Primary school flu vacc	**79.3%**	71.5%	**78.11%**	72.1%	**77.1%**	71% (provisional)	Not yet released
Over 65	**75.8%**	74.5%	**74.8%**	72.6%	**75.9%**	73.7%	2nd highest
Pregnant and not in a clinical risk group	**52.7%**	49.9%	**49.8%**	46.6%	**52.4%**	47.8%	5th highest
All at risk (exc. healthy pregnant women & carers)	**50.7%**	48.0%	**49%**	44.5%	**51.0%**	44.9%	2nd highest

Communications activity was focused on supporting the national activity co-ordinated by NHS24 which aimed to highlight the appropriate services available for a wide range of ailments and conditions; including links to useful NHS Inform self-help guides. The other key message 'know who to turn to', fronted by the 'Meet Ed' campaign, aims to inform the public to only present at the Emergency Department in an emergency situation, and instead utilise support and advice available from GPs, Pharmacies and Minor Injury Units.

Our communications focussed on media messaging through print (primarily local press) and SB Connect (delivered to every household across the Borders), NHS Borders website and social media. There was no paid for activity by NHS Borders. Our 'Weekly Winter Update' (WWU) was used over the winter period which carried our key messages in a visual and easy to read format. Social media played a big part in how we communicated this year and was positively received with messages being widely shared. The key messages highlighted above were posted on our social media platforms daily. During the festive period when we experienced high demand for our services and also when we had periods of severe weather, we utilised social media more in order to get advice, service information and statements from senior management to both staff and the general public quickly which proved very effective.

Primary Care

Although GP practices report increased levels of activity over this winter period, arrangements enabled them to cope well with the demand. As in previous years, GP practices undertook a range of approaches to managing surge activity, especially after the Festive Period holidays;

- Arranging additional surgeries after the public holiday period
- Booking fewer routine patients over the festive period to increase the availability of 'on the day' appointments
- Increasing the number of Advanced Nurse Practitioners on duty
- Increasing the number of 'on the day' appointments on the Fridays immediately before the public holidays
- Having extra dispensing staff on duty immediately prior to Christmas
- Increasing the number of GPs available for emergency appointments and home visits

During a period of intense pressure at the BGH in January, 7 GP practices (out of 23) agreed to open on a voluntary basis on Saturday mornings for 4 weekends. This initiative was arranged at short notice as a test to see if it would reduce pressure on front door services at the BGH. However, data analysis and feedback suggests that it did not have a significant impact on levels of attendances at either BECS or ED. Part of the learning indicated that peak activity takes place after the practices closed (1-2 in afternoon).
The paramedic practitioners continued to operate in a number of areas within the Borders. There are now 4 qualified Paramedic Specialists and a further 2 undertaking training. The paramedic practitioners also worked closely with BECS, collaborating to support Home Visits.

Two small-scale initiatives were established to help support patients at home and avoid admissions;

- Development of anticipatory care plans for people in nursing homes
- Development of self-management plans for patients with COPD

Although both of these initiatives progressed, they were commenced too late in the year and require sufficient time to establish. They therefore did not impact significantly on activity over the winter period.

Front door activity

The Winter Plan aimed to maintain performance in Borders Emergency Care Service (BECS) and to maintain the 4–hour Emergency Access Standard above 95% and at similar levels to the rest of the year.

Borders Emergency Care Service activity

Data is for the period November 2017 to January 2018. There was a 9% increase in total BECS contacts over this winter compared to the previous winter. December saw the highest number of overall contacts. Over the festive period, BECS staffed to higher levels than normal based on NHS24 predictors, but saw an increase of 60% in activity above these predicted levels of activity. January saw a peak in patient demand for rapid contacts (1 hour attend and 1 hour visit). This indicates a significant increase in numbers of significantly unwell patients referred and is likely to be at least in part attributable to the impact of the Flu outbreak on elderly patients. The number of patients presenting with respiratory symptoms rose by 60% over the festive period compared to the previous year.

BECS performance against national standards deteriorated as a result.

In summary, although BECS saw a large increase in attendances, with the largest increase in patients with significant illness, requiring urgent attention, the service managed this extra demand within its resources. There were particular challenges on weekend afternoons and future planning should incorporate additional clinical staffing at these times.

Table 2 BECS Activity and Performance

		Nov-16	Dec-16	Jan-17		Nov-17	Dec-17	Jan-18
attend	1 hr	40	38	44		69	59	61
	2hr	92	103	96		69	130	89
	4hr	425	629	557		453	703	480
visit	1hr	27	36	34		22	37	49
	2hr	108	124	142		132	163	124
	4hr	229	327	353		232	402	370
phone	1 hr	65	95	92		90	86	100
	2hr	104	143	144		117	135	152
	4 hr	161	226	256		184	251	203
TOTAL		1251	1721	1718		1368	1966	1690

Table 3: BECS performance

	Activity compared to last year	Performance	Compared to last year
Attends			
4 hours	55%	95%	(+1.4%)
2 hours	-1%	71%	(-9.4%)
1 hour	2%	34%	(-16.7%)
Home visits			
4 hours	10%	92%	(-4.3%)
2 hours	12%	77%	(+1.8%)
1 hour	11%	59%	(-4.7%)

Emergency Department (ED) and Acute Assessment Unit

Activity in the Emergency Department increased by 8% compared to 16/17 (12% compared to 15/16). There was no increase in Flow 1 (minor) patients and an 8% decrease in Flow 4 (surgical admissions) patients attending ED. However, there was an increase of 29% in Flow 2 & 3 patients (patients presenting with major conditions, including medical admissions), with the largest increase (45%) in December. This reflects an increase in patients presenting with acute conditions.

The Acute Assessment Unit was occupied by surge beds and therefore closed to attendances for 38 days this period compared to 7 days last winter. As a result, there was a 21% reduction in AAU activity.

Combined ED and AAU activity increased by 6% this year compared to last year.

During November, a Gynaecology and Surgical Assessment Unit was established in Ward 16. This provided an assessment service for patients requiring surgical or gynaecology review who would otherwise have been seen either in ED or admitted to the ward. This service ended on 29th November, when the assessment area was bedded. This review does not include this data.

Table 4 Combined ED/AAU Activity

Flow	Nov-16	Dec-16	Jan-17	Feb-17		Nov-17	Dec-17	Jan-18	Feb-18
Flow 1: Minor Injury & Illness	1246	1259	1151	1074		1281	1309	1146	1076
Flow 2: Acute assessment - includes major injuries	210	224	307	255		379	433	409	358
Flow 3: Medical Admissions	581	631	614	559		560	673	636	525
Flow 4: Surgical Admissions	223	220	258	198		189	219	205	187
Grand Total	**2260**	**2334**	**2330**	**2086**		**2409**	**2634**	**2396**	**2146**

The Emergency Access Standard (EAS) of 95% was not achieved throughout this winter period. The highest monthly achievement was 93.5% in November 2017. Performance fell below 90% in both December and January. Flow 1 performance remained above 97% each month, but Flow 3 performance was particularly low, reflecting the demand for

medical beds. This included 16 occasions when a total of 58 patients were cared for overnight in ED, due to a lack of beds within the hospital to admit them to.

Of all attendances in ED and AAU, 33.6% were admitted. This compares with 35% of attendances admitted in the previous winter period and 31% for the period immediately preceding this winter.

The highest numbers of breaches were for patients waiting beds, comprising 54% of all breaches. 90% were waits for medical beds. Next highest cause of breaches were waits for first ED assessment, averaging 9% of breaches.

A positive is that Flow 1 performance, for patients attending with minor conditions, remained above 97% throughout this period. This indicates that ED internal ability to manage patient flow was adequate and that the cause of the low EAS performance was related to hospital-wide systems, mainly access to beds.

Table 5 EAS performance

EAS	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**
Flow 1: Minor Injury & Illness	98.9%	97.1%	97.8%	98.0%
Flow 2: Acute assessment - includes major injuries	91.6%	82.9%	83.9%	85.2%
Flow 3: Medical Admissions	83.9%	75.0%	67.5%	83.0%
Flow 4: Surgical Admissions	88.9%	88.6%	81.5%	88.8%
Total	**93.5%**	**88.4%**	**86.0%**	**91.4%**

Due to the demand for inpatient beds, the Acute Assessment Unit was used as an inpatient area for 38 days during this period or 32% of the time. As a result AAU attendances fell to 578 for this period, compared to 714 for the previous year (a fall of 19%).

Table 6: AAU Performance

	Nov-17	**Dec-17**	**Jan-18**	**Feb-18**
Attendances	214	162	48	154
Breaches	26	29	16	28
EAs Performance	87.9%	82.1%	66.7%	81.8%

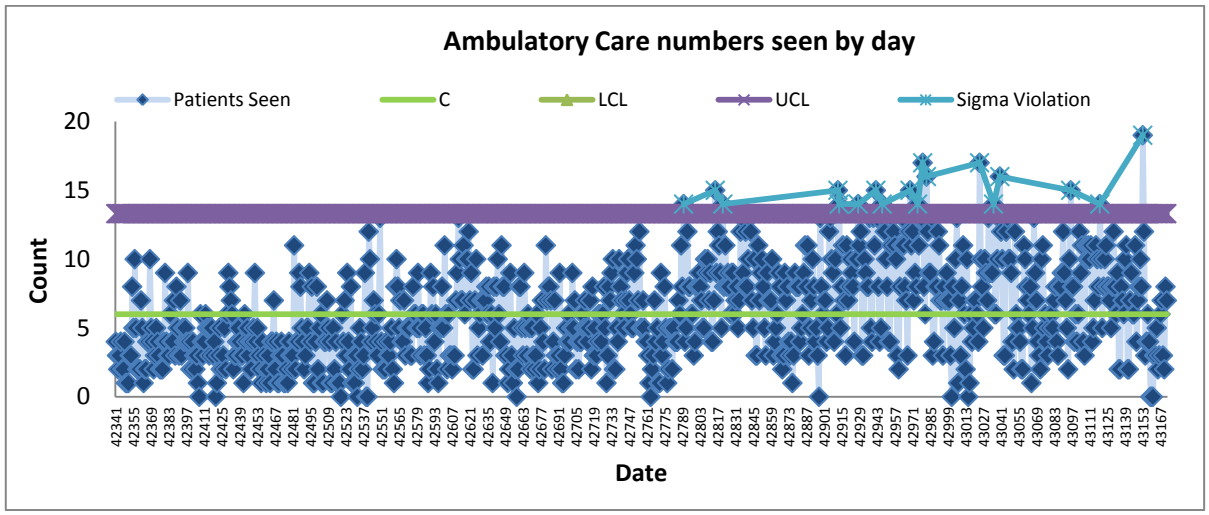
Ambulatory Care

Attendances in Ambulatory Care rose from 641 to 878 compared to last winter, an increase of 37%. Admissions from Ambulatory Care remained at 7%, unchanged from the previous year, demonstrating that selection of patients was appropriate.

Table 7 Ambulatory Care

	Nov-16	**Dec-16**	**Jan-17**	**Feb-17**	**Total**		**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Total**
Attendees	146	155	186	154	641		224	203	260	191	878
Admissions	7	11	4	14	36		14	16	10	24	64
% admissions	5%	7%	2%	9%	6%		6%	8%	4%	13%	7%

Chart 1: Ambulatory Care (ACU) attendances by week



The Rapid Assessment and Discharge (RAD) team continued to operate on 6 days/week during the winter period and increased to 7 days/week during the January peak in activity, providing rapid AHP assessment for patients, whose condition might enable immediate discharge this was arranged at short notice, impacting on the sustainability and appropriateness of the rota. Nevertheless, the service was considered invaluable by clinicians within the BGH.

Admissions

Adult Admissions to the BGH over the winter period fell from 3935 to 3532 between Nov-Feb this winter compared to last winter, a fall of 10%. There was a 5% fall in medical admissions, a 7% fall in Orthopaedic admissions, a 20% fall in General Surgical admissions and a 33% fall in Gynaecology admissions (from 249 to 167). There was a 9% increase in ITU admissions, but this only represented an increase in admissions of 4 over the period.

General Medical admissions represented 56% of all admissions in this period compared to 50% of all admissions the previous year.

The highest period for admissions were the 7 weeks from week commencing 4th December to week commencing 15th January, representing 42% of total admissions compared to 39% of total admissions for the previous year. The week commencing 25th December had the highest number of admissions overall and for General Medicine admissions this year. Last year, the week commencing 31st December had the highest number of admissions. ITU admissions were higher this year than last year during the period from 18th December to 28th January. These periods reflect the peak of flu prevalence within the community. Orthopaedic admissions were variable across the period.

There was a 5% increase in Medical Paediatric admissions (35 extra admissions). The peak additional admissions were in December.

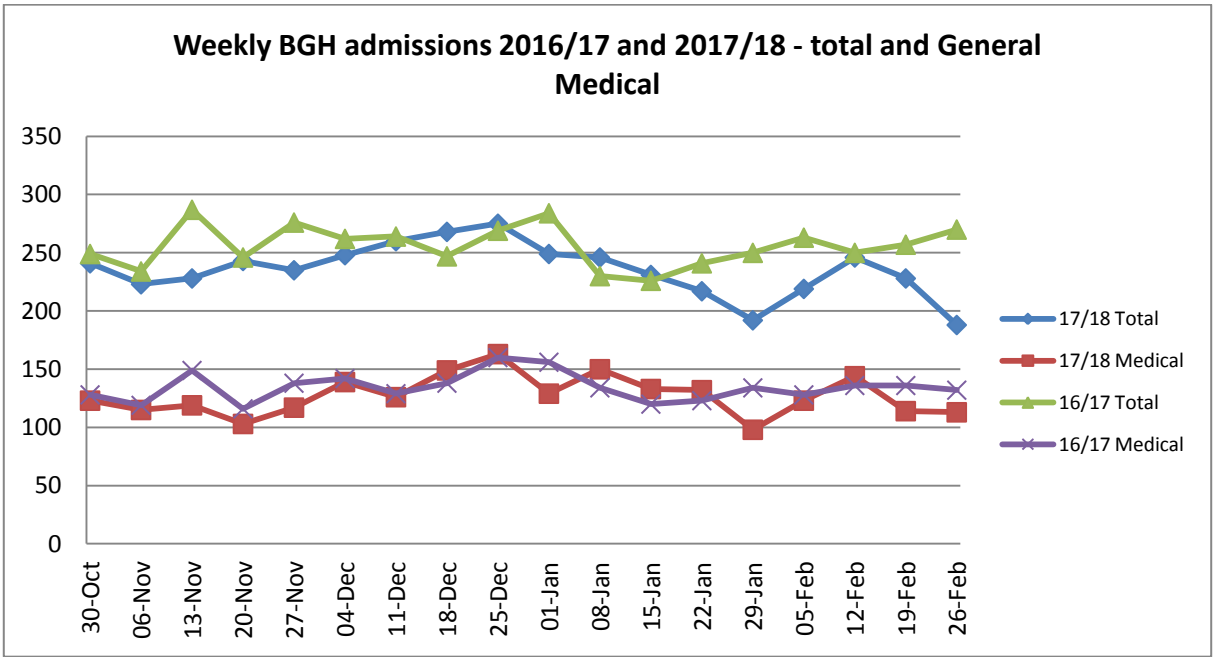
The top 50% of reasons for admission indicate that there was an increase in respiratory conditions. Data is not robust as 25% of all admissions were coded with non-specific indication of disease (codes Z0). Admissions for respiratory related conditions – J codes

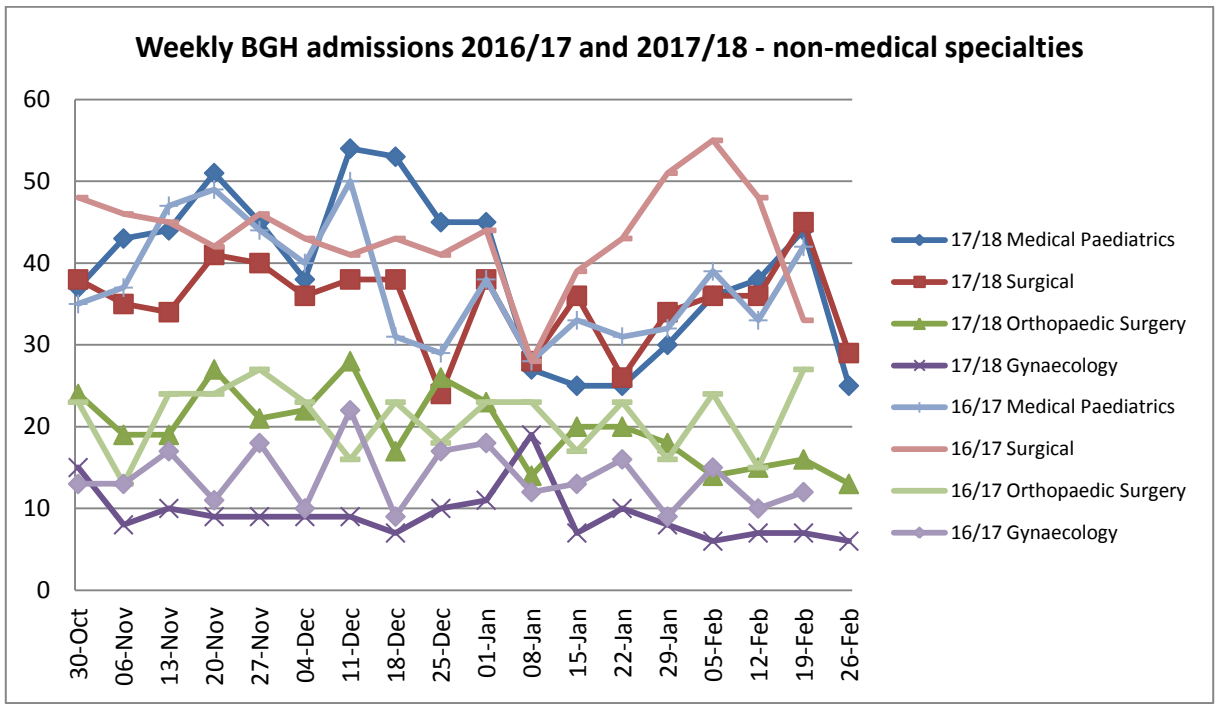
plus R0 (Symptoms and signs involving the circulatory and respiratory systems) – represented 18.2% of admissions in 2016/17 and 16.4% of admissions in 2017/18. However, there were a higher number of admissions related to respiratory conditions in the 6 weeks from 10th December to 19th January this winter compared to last winter. This matches the data on hospital-confirmed cases of Flu which increased by 118% between weeks commencing 16th December and 19th January inclusive.

Table 8 Confirmed hospital flu cases from week commencing 16th December 2017 to week commencing 19th January 2018

	Week 51 – Week 4 (2016/17)	Week 51 – Week 4 (2017/18)
Flu A	68	134
Flu B	3	21
Total	**71**	**155**

Chart 2: Weekly admissions to Borders General Hospital





Length of Stay

Average length of stay for the BGH rose over the period Nov – Feb compared to last winter, with an overall average length of stay of 4.7 days, compared to 4.3 days last year. The average LoS for General Medicine was 4.2 days compared to 4.15 days the previous winter (and 3.48 days for the period June-Oct 2017). There was a peak in increase in length of stay during January of both years.

Chart 3: BGH Length of Stay

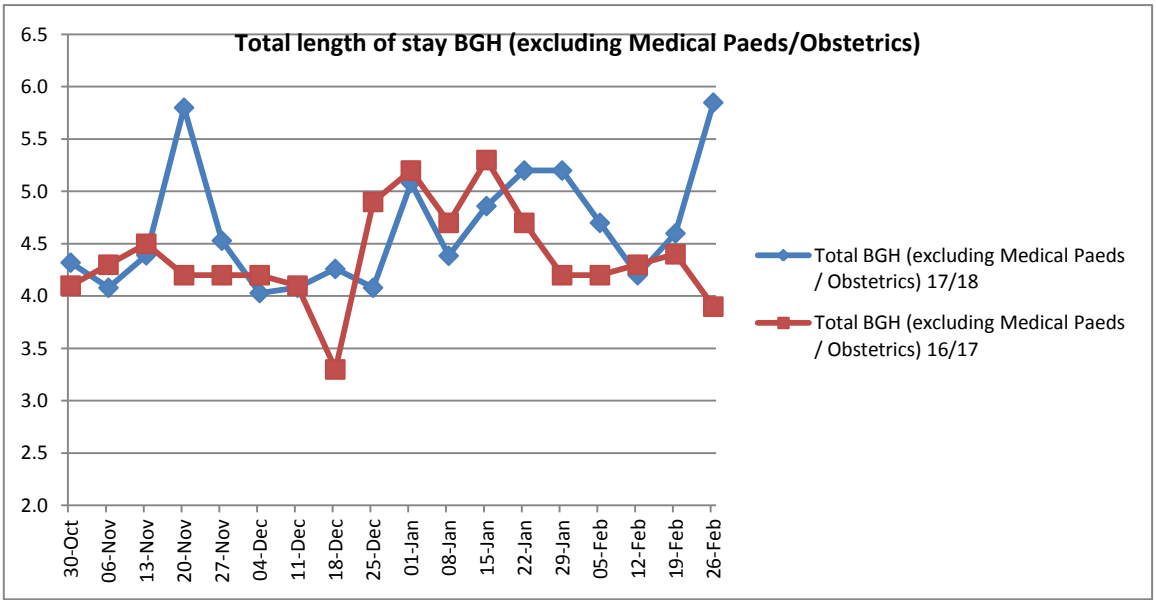


Table 9: BGH Length of Stay

	Week Beginning	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb
2017/18																			
	General Medicine	4.1	3.4	3.8	6.2	5.0	3.6	3.7	3.9	3.7	4.3	3.8	5.0	4.6	4.1	4.2	2.4	4.4	5.5
	Elderly Medicine	18.1	20.1	25.6	34.7	13.9	21.6	14.7	22.2	14.7	18.0	12.7	15.6	14.0	23.3	15.7	29.5	18.7	23.6
	General Surgery	2.3	2.6	2.6	2.7	2.1	2.3	2.4	2.6	2.4	2.9	2.7	2.0	3.0	3.9	2.6	2.4	3.1	3.7
	Ortho	3.3	2.6	3.6	4.0	3.2	3.5	3.2	3.8	3.2	5.5	8.4	3.6	8.4	6.8	5.8	3.8	3.3	5.0
	AllSpecialties	**4.3**	**4.1**	**4.4**	**5.8**	**4.5**	**4.0**	**4.1**	**4.3**	**4.1**	**5.1**	**4.4**	**4.9**	**5.2**	**5.2**	**4.7**	**4.2**	**4.6**	**5.8**
2016/17																			
	General Medicine	4.1	5.2	5.3	4.3	3.9	4.9	4.6	3.5	5.5	5.4	4.4	4.5	4.3	3.8	4.1	3.6	4.1	3.5
	Elderly Medicine	17.5	16.6	22.4	20.7	15.7	15.3	18.3	9.6	26.3	16.2	13.3	30.8	20.8	14.3	17.6	14.5	26.3	18.6
	General Surgery	2.3	2.2	2.5	2.6	2.4	2	3	1.6	2.2	2.6	3	2.5	2.9	2.5	2.1	2.7	2.3	2.3
	Orthopaedics	4.2	4	3.3	2.8	4.3	2.9	2.8	2.7	3.1	4.8	8.1	7.5	4	4.8	5.1	3.6	2.9	3
	AllSpecialties	**4.1**	**4.3**	**4.5**	**4.2**	**4.2**	**4.2**	**4.1**	**3.3**	**4.9**	**5.2**	**4.7**	**5.3**	**4.7**	**4.2**	**4.2**	**4.3**	**4.4**	**3.9**

Bed capacity

The Winter Plan aimed to establish 14 surge beds within the BGH, together with 13-18 surge beds in Community Hospitals. It also planned to establish a total of 18 social care step down beds. This was a total of 54 beds.

In fact, 44 additional beds were opened as surge capacity in the following configuration;

- 10 of the surge beds within BGH were already open at the commencement of the Winter period. The remaining beds in Ward 16 were opened at the end of November when the Surgical Assessment Unit closed.
- 9 additional community hospital beds were opened – 1 in Hawick, 2 in Knoll and 6 in Haylodge, although only 2 of these were available before the end of January.
- 21 social care step-down beds, including the 6 additional beds in Waverley, Transitional Care facility and 17 beds within Craw Wood Discharge to Assess facility, with 7 of these beds opening in early January. A further 8 beds were identified within Craw Wood but had not opened by the end of February.

Due to demand on beds, additional beds were opened in interim accommodation:

- The Planned Surgical Assessment Unit was used for inpatients on 28 days during this period. This compares to 17 days in 16/17 but 56 days in 15/16.
- the Acute Assessment Unit was used for inpatients on 38 days during this period compared to 7 days the previous year

As a result, these areas ceased to provide their core function, resulting in elective cancellations and the diversion of acute medical attendances to the Emergency Department.

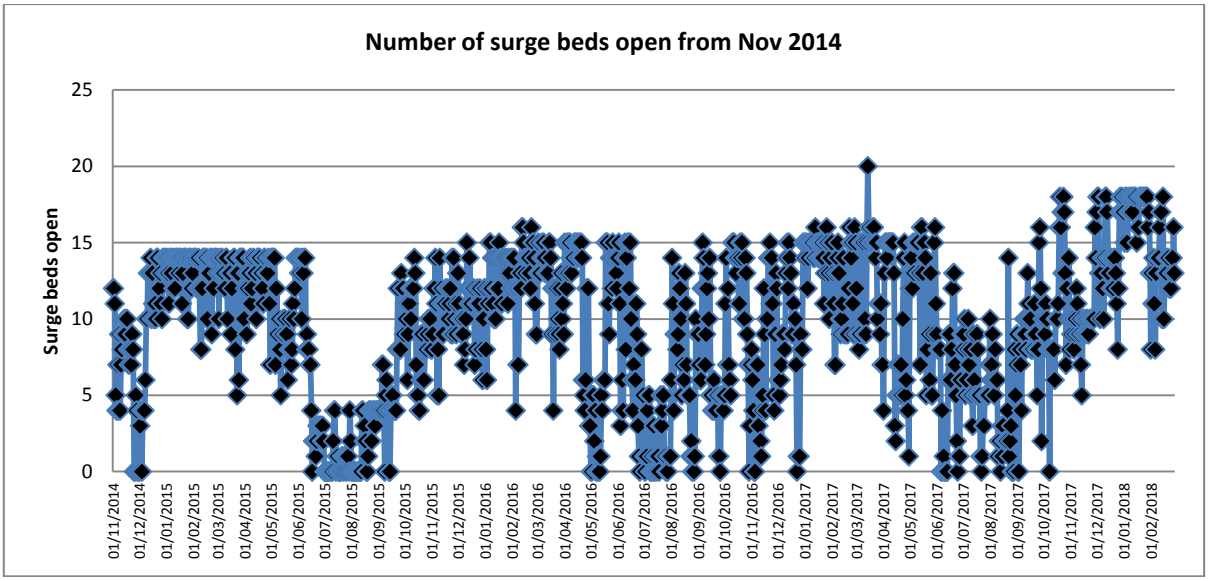
There were a further 58 patients who were held overnight for longer than 8 hours in the Emergency Department on 16 occasions during this period of which 16 were discharged from ED the next day. These patients will not be counted within the occupied bed numbers.

On average, 13.6 BGH surge beds were used each day this period, compared to an average 11 last year.

Table 10: BGH Surge Beds

	2015/16				2016/17				2017/18			
	Nov-15	Dec-15	Jan-16	Feb-16	Nov-16	Dec-16	Jan-17	Feb-17	Nov-17	Dec-17	Jan-18	Feb-18
Beddays	319	294	476	495	196	243	564	308	294	442	533	368
Average beds open	10.6	9.5	15.4	17.06	6.5	7.8	18.2	11	9.8	14.2	17.2	13.1

Chart 4: BGH surge beds

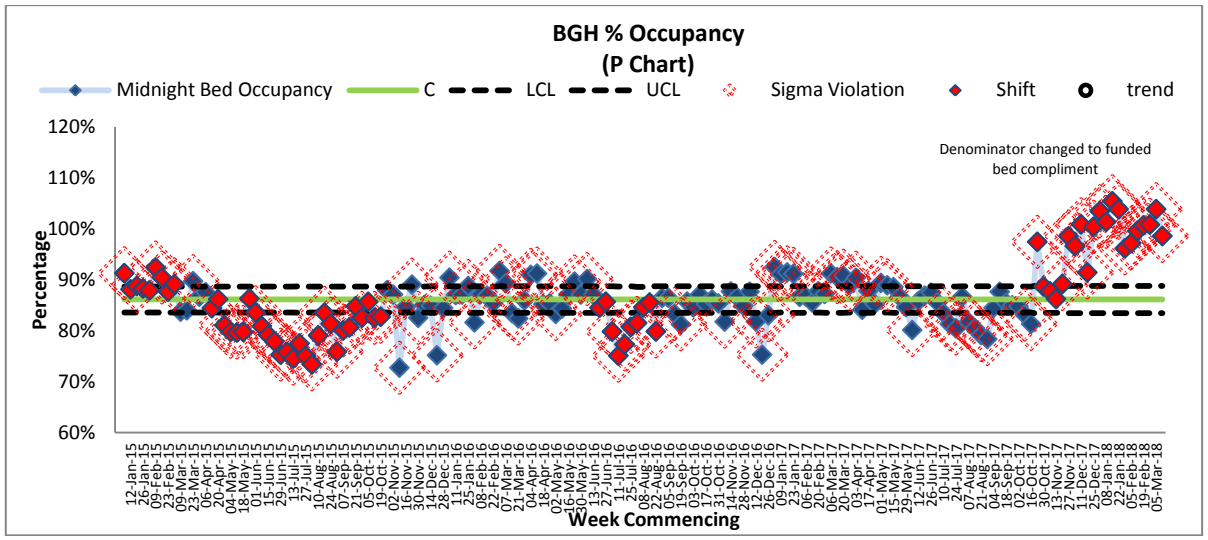


Bed occupancy

Calculations for bed occupancy were changed in early November. Previous occupancy had been based on total number of beds occupied at midnight. The new occupancy rate is based on total beds occupied as a percentage of the core bed establishment. As a result, bed occupancy can now exceed 100%. This means that comparisons with previous years are not possible.

Bed occupancy ran at 99.92% of core bed numbers throughout the winter period and exceeded 100% of core bed complement during 9 of the 16 weeks. Community Hospital bed occupancy ran at an average 102.17% against core bed capacity with 13 weeks when occupancy was over 100%.

Chart 5: BGH Percentage Occupancy



Boarding

There was a 65% increase in the number of patients boarded to wards outwith their speciality during this period compared to last winter. The vast majority of boarders were medical. Boarding included patients moved to additional bed capacity in PSAU.

Boarding numbers rose from an average 14 per day last winter to an average 24 per day this winter. Boarding numbers increased above 30 boarders per day for 38 days from 25th December onwards and remained above this level for all but one week in this period. There was a peak of 48 during New Year week.

In order to manage the extra number of medical patients, additional junior doctors and consultants were rostered from January onwards.

NB: the boarding data source changed in Nov 17. This may affect comparisons with previous data.

Chart 6: Patient Boarding

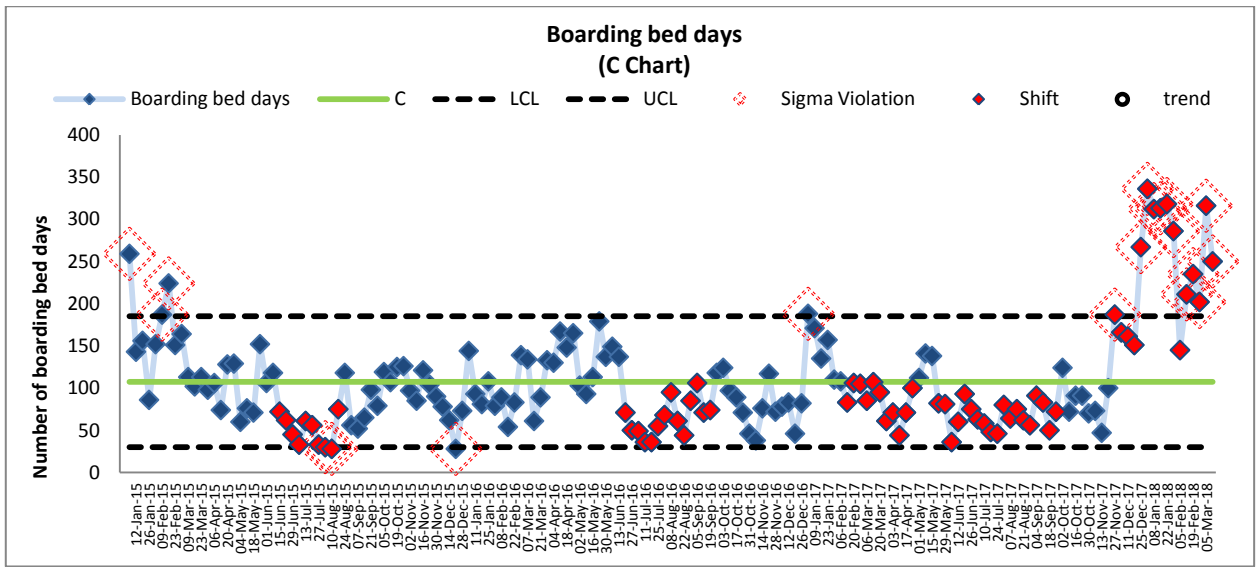


Table 11: Weekly Boarding Beddays

Week starting	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb
17/18	70	73	47	100	187	166	161	151	267	336	312	313	318	286	145	211	235	202
16/17	46	38	76	117	72	78	83	46	82	188	171	135	157	110	108	83	106	105

Discharges

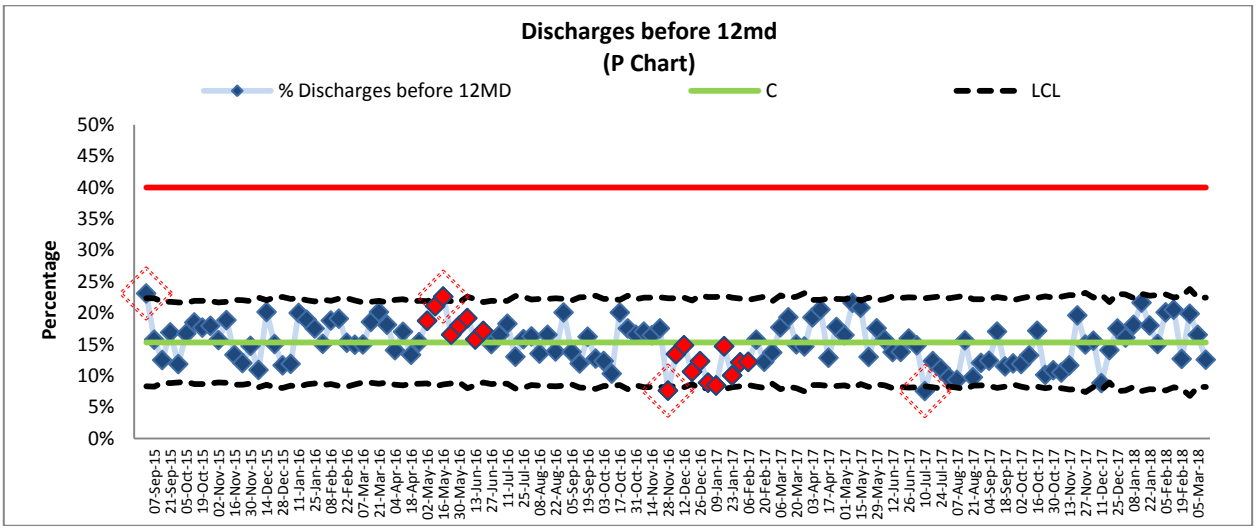
The Winter Plan set out to;

- Increase number of morning discharges to 40%
- Increase the number of weekend discharges by 25%
- Reduce delayed discharges to 10

Morning discharges

Morning Discharges increased from 13% to 15.6% against a target of 40%.

Chart 7: Morning discharges

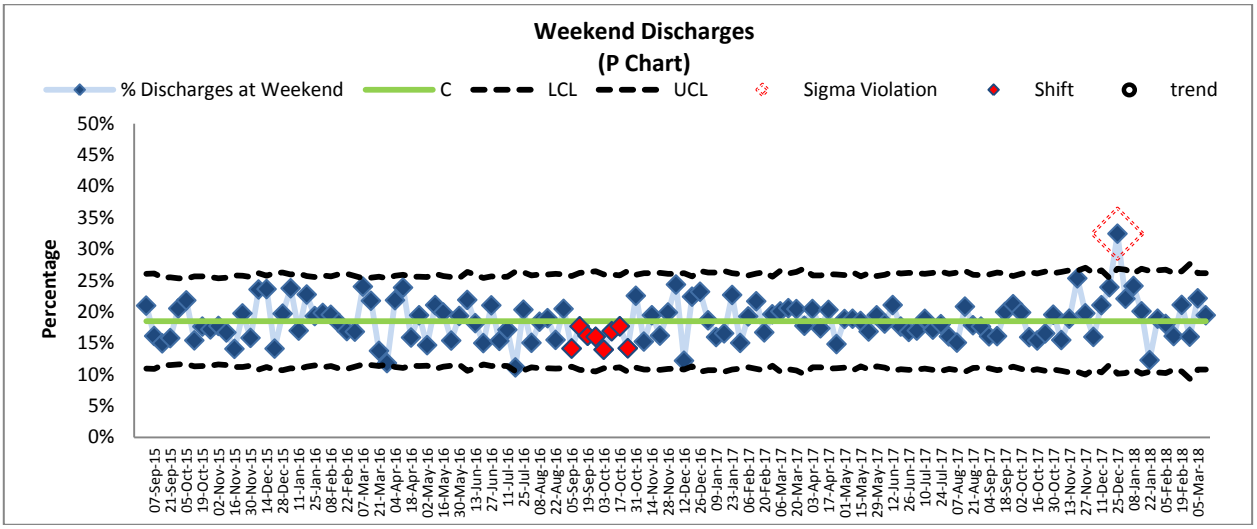


Weekend discharges

Weekend discharges increased slightly from 19% to 20.3% against a target of 28%. There was a peak of weekend discharges around the festive period (similar to last year).

From the festive period to the end of February, weekend staffing was increased to include 7-day cover from the Rapid Assessment and Discharge Team. Pharmacy was open on Sunday as well as Saturday during January, but there was low utilisation of this service.

Chart 8: Weekend Discharges



Community Hospitals

Average length of stay in Community Hospitals rose from 31.33 days last winter to an average 34.06 days this winter

An additional 9 beds were opened in Community Hospitals above core capacity to accommodate additional patient demand. Community Hospital bed occupancy ran above 100% of core capacity for the majority of this period. 83% of admissions into Community Hospitals were transfers from the BGH.

Table 12: Community Hospital LOS

	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb
Hawick	53.7	26.7	22.4	30.6	25.8	30.8	21.6	11.8	37.8	51.0	23.0	80.0	16.6	23.3	17.6	21.3	37.5	29.8
Haylodge	35.0	159.0	39.0	31.0	39.0	30.2	38.8	25.3	38.8	51.7	27.3	23.4	26.3	54.0	47.0	188.0	35.2	-
Kelso	15.4	36.5	20.4	36.8	36.3	35.8	48.3	22.4	145.0	49.0	32.6	160.0	26.5	31.8	22.6	40.0	80.5	160.0
Knoll	33.0	33.8	33.8	167.0	28.0	158.0	29.4	17.4	29.4	27.8	24.6	28.2	28.7	18.8	86.5	58.0	34.4	173.0
Total	**28.8**	**39.6**	**27.2**	**41.5**	**31.2**	**40.4**	**31.5**	**17.9**	**42.7**	**41.5**	**26.4**	**40.8**	**23.6**	**27.4**	**31.4**	**44.7**	**41.2**	**94.9**

Delayed Discharges

The winter plan focused on developing alternatives to hospital care for patients who required ongoing care. Additional measures put in place included;

- Opening of Craw Wood as a Discharge to Assess facility in December 2017 with a further 7 beds opening in January 18
- Expansion of the transitional care beds in Waverley Care Home in August 2017
- Development of a rapid access homecare team in Berwickshire and a Hospital to Home care team in Teviot.

There was an overall 39% increase in delayed discharge occupied beddays during this winter compared to the previous winter, with the numbers of delayed discharges falling sharply from January onwards. The decrease in delayed discharge numbers was in patients awaiting homecare and residential care. This reflects the opening of the additional

Craw Wood beds at the beginning of January and an improvement in availability of carers in some areas of the Borders. The numbers waiting nursing home care remained unchanged.

The time taken to establish the new alternatives to hospital meant that only Craw Wood impacted on numbers of delayed discharge and this did not come into effect fully until January. The new care models were not operational during this period.

Table 13: Delayed Discharges

	30-Oct	**06-Nov**	**13-Nov**	**20-Nov**	**27-Nov**	**04-Dec**	**11-Dec**	**18-Dec**	**25-Dec**	**01-Jan**	**08-Jan**	**15-Jan**	**22-Jan**	**29-Jan**	**05-Feb**	**12-Feb**	**19-Feb**	**26-Feb**
Number of Delayed Discharges on Sunday	43	45	46	54	51	51	50	42	40	39	36	47	34	36	34	47	34	36
DD Occupied Bed Days (includes OBDS discharges) for week	300	291	329	385	370	367	357	327	282	294	287	311	290	286	250	311	290	286

Table 14: Delayed Discharges by reason

Monthly Delayed Discharge Cases				
Reason for Delay	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**
Regular Cases				
11A Community Care Assessment - awaiting commencement	1	1	0	0
11B Community Care Assessment - awaiting completion	2	9	7	4
24B Community Care Arrangements - Place Availability Residential Home	13	13	12	6
24C Community Care Arrangements - Place Availability Nursing Home (non NHS funded)	11	8	6	7
24F Community Care Arrangements - Place Availability EMI/Dementia in Care Home	6	5	8	6
25D Community Care Arrangements - Care Arrangements own home - social support	30	26	26	15
25E Community Care Arrangements - Care Arrangements own home - procurement/ delivery of equipment	1	0	1	0
25F Community Care Arrangements - Care Arrangements Specialist Housing provision (inc sheltered housing)	2	1	2	0
51 Patient/Carer/Family-related reasons - Legal/Financial	1	1	2	2
67 Patient/Carer/Family-related reasons - Disagreements	2	2	2	2
74 Patient/Carer/Family-related reasons - Other	0	0	1	1
Total	**69**	**66**	**67**	**43**
Complex Cases				
25X Complex case arrangements in order to live in own home		1		
51X Patient/Carer/Family-related reasons - Legal/Financial Adults with incapacity act	15	14	9	9
71X Patient/Carer/Family-related reasons - Other Interim move under the choice of accommodation	2			
Total	**17**	**15**	**9**	**9**
Total Delayed Discharges	**86**	**81**	**76**	**52**
Source: EDISON				

Elective operating

A key feature of the Winter Plan was to maintain elective operating without disruption due to unscheduled pressures. In order to achieve this, it was agreed to ring-fence a reduced number of elective beds and to reduce inpatient operating during the first 3 weeks in January, increasing daycase surgery instead.

In fact, the pressures on the acute hospital during January meant that we were unable to maintain elective inpatient operating from 27th December as the elective beds were required to accommodate unscheduled patients. Although 1 elective bay was established on occasions during this period, we were unable to re-establish full elective inpatient capacity throughout the winter period. The Planned Surgical Admissions Unit was also converted at short notice into an inpatient area on two occasions in January for a total period of 28 days, requiring all daycase surgery to operate through the Day Procedure Unit.

Bed pressures also resulted in patients being delayed in leaving ITU. This led to a number of cancellations of urgent cancer and other patients requiring post-operative ITU care. All urgent patients were rescheduled for operation within 2 weeks of original date.

As a result, cancellations due to hospital-related reasons increased by 26% compared to last year. Cancellations data refers to procedures cancelled within 48 hours of planned date.

Total procedures undertaken during this winter fell by 8% from 1457 last winter to 1336 this winter.

Patients exceeding the 12-week Treatment Time Guarantee also increased from 63 to 254 patients between November and February.

Table 15: Cancellations of Elective Procedures

2015/16				**2016/17**				**2017/18**			
Nov-15	Dec-15	Jan-16	Feb-16	Nov-16	Dec-16	Jan-17	Feb-17	Nov-17	Dec-17	Jan-18	Feb-18
51	36	59	49	44	30	60	30	33	51	67	56

Sickness

Sickness absence over the winter period was higher than for the remainder of the year and 6% higher compared to the same period last year. There was a spike in absences due to cold, cough flu in January 2018.

Chart 9: Sickness Absence Rates

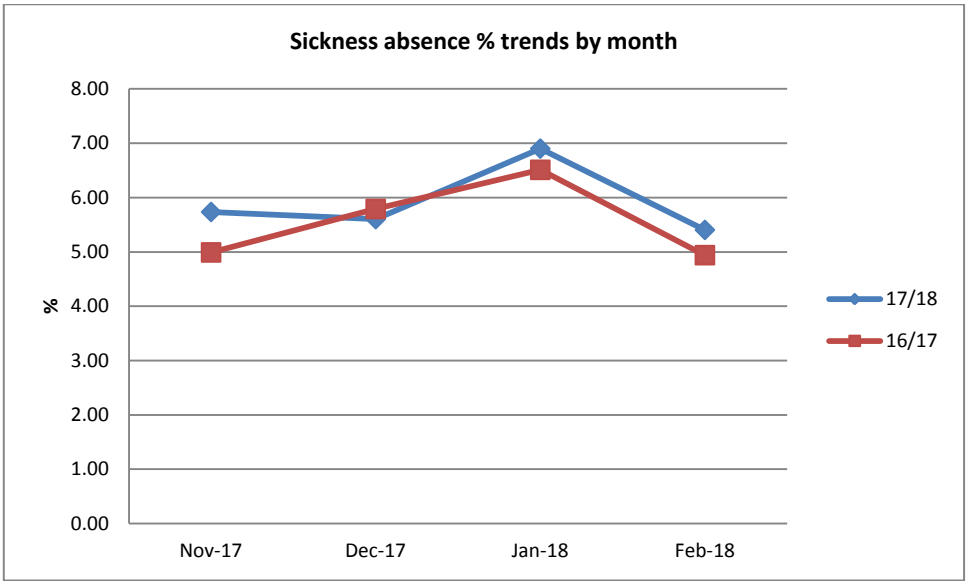
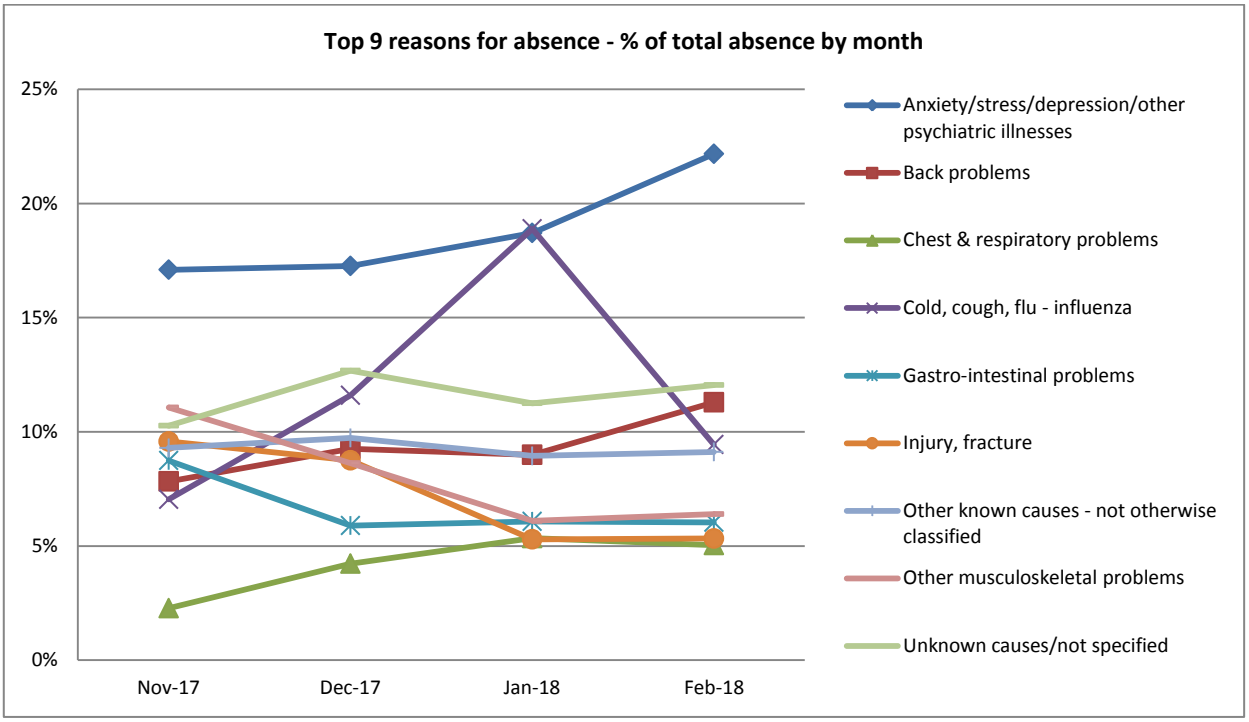


Chart 10: Reasons for absence by month



Outbreaks

The impact of flu on the availability of beds within BGH and Community Hospitals was low and less than last year. However, there was a big increase in the number of beds closed to admissions due to norovirus this winter compared to last winter, but a similar number to the previous year.
This had some impact on the management of patient flow, particularly in November 2017.

Table 17: Blocked Bed Days due to outbreaks

		Nov 13 - Feb 14	Nov 14 – Feb 15	Nov 15 – Feb 16	Nov 16 – Feb 17	Nov 17 - Feb 18
Flu	Blocked Beds	0	135	30	70	44
	Blocked Empty Beds	0	39	2	3	0
D&V	Blocked Beds	1492	60	342	66	308
	Blocked Empty Beds	246	12	67	6	46
Total	Blocked Beds	1492	195	372	136	352
	Blocked Empty Beds	246	51	69	9	46

Overall Assessment

A Winter Plan debrief was held on 14th March 2018 to consider lessons learned and develop recommendations for future planning.

The conclusions drawn from this debrief and the information contained in this report are;

- Develop a Winter Plan based on tried and tested measures.
  a) There are a range of actions that are taken each winter to manage winter pressures (eg, additional front door staffing, proactive recruitment, festive period staffing). The data suggests that these measures worked well and these should form the basis of a standard winter planning framework.

  There are a number of areas where interim or short-term measures are put in place to improve patient flow over the winter period (e.g. weekend RAD and AHP services, weekend social work, additional clinical staffing). These are seen as effective but their short-term nature and the lack of identified funding to establish them make them problematic to staff and sustain. Service feedback suggests that these could have been more effective if they were commissioned early as part of the routine planning for winter.

- Establish shared ownership of the Winter Plan. The Winter Plan has largely been developed from within NHS and predominantly focused on managing hospital flow. A positive feature of this winter period was the joint ownership of patient flow and discharge management. However, joint working was managed on an ad-hoc and informal basis and opportunities for communication and cross-agency support could have been improved.

- Deliver transformational change separately from the Winter Plan. This year, as in previous years, the winter plan has been used as a driver to develop new models of care provision. The debrief session identified a number of other areas where new ways of working may reduce inpatient demand and keep people at home. These are important initiatives that should be progressed in a robust and managed way. However, relying on these new projects to address activity demand for winter results in individual projects being progressed at too rapid a rate and, if they do not deliver, there is inadequate alternative provision within the Winter Plan to manage activity.

- Ensure that the Winter Plan is realistic. Winter Planning needs to build in sufficient buffer capacity to ensure effective unscheduled patient flow and to maintain ring-fenced elective capacity. There were insufficient acute medical beds during this winter and the boarding of patients to other wards was both operationally challenging and introduced delays in discharges The additional capacity needs to be available in the right places: these are likely to be additional acute medical beds, the maintenance of elective working through ring-fenced beds and access to social care beds that can accommodate patients waiting for nursing homes as well as those completing assessment for home.

Recommendations for Future Winter Planning:

Detailed recommendations will be published in due course and included in the planning for next winter. However, the key recommendations from the evaluation of this year's winter plan are;

1. Establish a core Winter Plan based on predicted pressures and tested actions. These should include;
    a. The implementation of the set of agreed actions that are taken each winter to manage winter pressures.
    b. The establishment of sufficient surge capacity to maintain smooth and effective patient flow. Consideration should be given to identifying additional appropriately staffed medical inpatient capacity
    c. The Winter Planning Group should be re-established with clear remits for delivering on each of the workstrands within the Winter Plan and an organisational commitment to support the Group
    d. Winter Planning should be carried out over a 2-3 year period. This would ensure that plans are in place early enough to be implemented in time, and would help identify both the timescales for changes that will shift the balance of care and the interim measures that need to be put in place to maintain services until this happens.

2. Funding should be allocated formally to the Winter Plan to allow services to plan early to recruit and support additional activity

3. A more formal joint operational management process should be established to ensure that all agencies are aware of the challenges faced across the patient pathway and to enable rapid and consistent management of pressures

4. Transformational service redesign projects should be managed through a separate mechanism and work to appropriate timescales, rather than winter timescales. The impact of these redesign projects should not be incorporated into winter planning until they are fully implemented and sustained.

Staff and services across health and social care worked extremely hard and very effectively to maintain high quality and person-centred care for patients and clients whilst dealing with the challenges of a very difficult winter. However, the need to develop contingency plans rapidly and late in the day meant that patient experience was not as good as it could have been, that staff were put under great pressure to make changes and that planned activity was disrupted. The experience from this winter is that early investment and action to establish the appropriate services would have made the delivery of care much more effective, improved patient experience and have avoided the expense of rapid and short-term operational decision-making.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: Monday 23 April 2018

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

STRATEGIC PLANNING GROUP REPORT TO INTEGRATION JOINT BOARD

Purpose of Report:	To update the Integration Joint Board on key issues and actions of the Strategic Planning Group.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: • Note the key issues and actions arising via the Strategic Planning Group, in particular progress being made in relation to the refresh of the Partnership's Strategic Plan.

Personnel:	*N/A*

Carers:	Represented on the Strategic Planning Group.

Equalities:	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process and will be revised in line with the refreshed Strategic Plan.

Financial:	*N/A*

Legal:	The Strategic Planning Group is a requirement of the Public Bodies Joint Working (Scotland) Act and acts as an advisory committee to the IJB.

Risk Implications:	Risk of disconnect between the IJB and the Strategic Planning Group without regular reporting mechanisms in place.

1. Purpose

1.1 The purpose of this report is to update the Integration Joint Board (IJB) on key issues and actions arising from the Strategic Planning Group (SPG) meeting held 16 March 2018.

2. Background

2.1 The SPG acts as an advisory committee to the IJB. The key role of the SPG is in developing and finalising the Partnership's Strategic Plan and in reviewing its progress. The SPG also provides a forum for initial consultation and community engagement with SPG members expected to:

- Act in an advisory capacity to the IJB;
- Represent their sector or professional area;
- Comment on and contribute to Partnership change programmes;
- Ensure the interests of the five localities are represented;
- Contribute to any formal updates of the Strategic Plan.

2.2 This absence of a formal reporting structure between the SPG and IJB was raised at the joint SPG and Locality Working Group (LWG) session held on 28 September 2017. It was acknowledged that communication between the SPG and IJB could be improved and ways in which to address this were discussed.

2.3 It was agreed following further discussion at the SPG meeting held 20 November 2017, that a short report for the IJB be produced following each future SPG meeting. This will contain a report on any key issues and actions arising from meetings which require to be raised with the IJB.

3. SPG Key Actions & Issues

3.1 <u>Strategic Plan</u>

3.1.1 A presentation was given on progress made on the refresh of the Partnership's Health & Social Care Strategic Plan. The changes made to date reflect discussion at the SPG held in January and focus on 4 key identified areas for revision within the Strategic Plan:

- Reduction in size to produce a more concise document;
- Reduction in the number of local objectives from 9 to 3;
- Key principles which underpin local objectives;
- Enhanced vision statement which reflects the Partnership's relationship with communities.

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3.1.2 The three proposed local objectives reflect a focus for the Partnership in reducing demand for health and social care services through early intervention, ensuring services are responsive and follow smooth processes and improve the capacity within the community to enable individuals to remain well. The proposed refreshed local objectives are detailed below:

- We will improve the health of the population and reduce the number of avoidable hospital admissions;
- We will improve patient flow within and out with hospital;
- We will improve the capacity within the community for people to better care for their own health and support how they care for others.

3.1.3 The SPG agreed with with the broad direction of the refreshed Strategic Plan. A revised draft is to be circulated ahead of the SPG meeting scheduled for 25 April before being presented to the IJB at development session on 28 May.

3.2 IJB Quarterly Performance Report

3.2.1 An overview was given of the *Quarterly Performance Report for the Scottish Borders IJB* which has been prepared for the IJB meeting scheduled for 23 April. This document was accompanied by a 2 page infographic summary which provided a snapshot of the full report and was positively received by the group as a useful addition.

3.2.2 The report was accepted by SPG members.

3.3 Carers (Scotland) Act 2016

3.3.1 A presentation was given on the Carers (Scotland) Act 2016 seeking agreement from the SPG on:

- The planned consultation on *Caring Together*, an interim strategy for adult carers with the focus on preparation/implementation of the Carers Act;
- The Eligibility Criteria and threshold for funding support to carers;
- Funding to meet the duties of the Act.

3.3.2 Approval to proceed with the consultation, Eligibility Criteria and funding was agreed by the SPG.

3.4 Physical Disability Strategy

3.4.1 A presentation was given on the *Physical Disability Strategy* with the aim of seeking approval from the SPG to initiate the planned consultation.

3.4.2 Approval to proceed with the consultation on the *Physical Disability Strategy* was agreed by the SPG.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 23rd April 2018

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

QUARTERLY PERFORMANCE REPORT UPDATE APRIL 2018
(DATA UP TO END DECEMBER 2017)

Purpose of Report:	To provide a high level summary of quarterly performance for Integration Joint Board (IJB) members, using data available at the end of December 2017. The report also highlights how the quarterly performance scorecard has evolved since the last report in Sep 2017, and now also includes a summary of progress on the *Inspection of Older People's Services 2017 Action Plan.*

Recommendations:	Health & Social Care Integration Joint Board is asked to: a) Note the additional/amended measures for reporting; b) Note the key challenges highlighted; c) Advise on any further measures to be considered for inclusion in future quarterly performance reports.

Personnel:	*n/a*

Carers:	*n/a*

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

Financial:	*n/a*

Legal:	*n/a*

Risk Implications:	*n/a*

Background

1.1 The performance reporting scorecard for the IJB was originally developed to include the six themes defined by the Ministerial Strategy Group (MSG) for Health and Community Care. These themes are:

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

1.2 The themes identified by the MSG are heavily weighted to hospital care and in recognition of this, the performance reports presented to the IJB since 2017 have included additional sections headed "Social Care", "Carers" and "Other Relevant Measures" (including local data collated via the Social Care Survey, Carers Centre Assessments, Patient feedback and evaluations of Integrated Care Fund (ICF) projects). Additionally, progress on actions with the *Inspection of Older People's Services 2017 Action Plan* have now been included under "Other Relevant Measures" and will be provided for the duration of the action plan.

1.3 Since the last quarter, the recently established 'Integration Finance and Performance Group' (IF&PG), has reviewed the availability of data and has made a few additions / amendments to the indicators under some of the themes, with details provided in the table below. This is due to new or revised data sources being developed or identified and it is anticipate that amendments will be made from quarter to quarter (but always highlighted within this report).

Theme	**Measure(s)- change/addition/amendment**
1.Unplanned admissions	*Emergency Admissions, residents 75+* A quarterly measure has replaced the monthly HEAT standard management information, which is no longer available. *Emergency re-admissions within 28 days (all ages)* This is a new quarterly measure
5. End of Life Care	*Percentage of last 6 months of life spent at home or in a community setting* A quarterly measure has been added (previously, only annual information was presented)- it should be noted that this measure shows considerable fluctuations and needs to be investigated further by the IFPG. For this reason, it has not yet been included within the Appendix 1 Infographic summary.

1.4 Due to changes in the Carer Centre Reporting Schedule, the IF&PG is awaiting updated information which will be available for the next quarterly report. There are therefore no changes to the data, graphs or commentary since the last report under the "Carers" theme.

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

1.6 There are 2 appendices to this report:

Appendix 1 provides a very high level, "at a glance" summary for EMT and the IJB, including the identification of high level challenges, and a case study from the Integrated Care Fund (ICF) projects;

Appendix 2 provides further details for each of the measures presented in Appendix 1. As well as providing the rationale for the inclusion of each indicator (i.e. what is this information and why is important to measure it?) as well as analysis of the performance trends and information on what is being done to either improve or maintain performance.

Summary of Performance

2.1 In a number of areas, Borders is demonstrating good performance over time and when compared to Scotland, including the *% of total health and care spend in the Borders accounted for by community-based services* (51.4% for Borders, compared to 46.5% for Scotland), and *% of Health & Social Care resources spent on emergency hospital stays* (17.8% compared to 24.7% for Scotland). *Emergency admissions to hospital for over 75s* has seen little change over the last 4 quarters and is lower than Scotland.

2.2 Areas of challenge where the trend over the last 4 quarters is either negative or showing some cause for concern include:-

- Emergency admissions for falls for over 65s has risen over the last 4 quarters;
- Emergency occupied bed days (75+) has increased over the last 4 quarters;
- % of A&E attendances seen within 4 hrs, whilst higher than Scotland, has dropped sharply over the last 4 quarters and especially during December, and mirrors the national trend;
- Delayed Discharge from hospital remains an ongoing challenge, fluctuating monthly and increased since last year, and remains a key strategic and operational focus for the partnership;
- Bed days because of delayed discharge has increased steadily since 2015/16 and is higher than it was at the same time in the previous two years;
- % of care users saying they feel safe has dropped since the same time last year. Work is underway to find more specific outcome measures with a more stringent collection methodology.

- In relation to the *Inspection of Older People's Services 2017 Action Plan*, work is progressing, with only 2 actions overdue, from a total of 60, and details are provided in Appendix 2.

2.3 Given the many elements of integrated care, the wide range of services delegated to Health and Social Care Partnership, and changes being proposed nationally e.g. to HEAT standards management information, it is anticipated that performance reporting to the IJB will further develop over time to include reporting at locality level and more specific reports on particular groups of service users and staff. Reporting will also need to reflect and support the refreshed Strategic Plan.

APPENDIX 1

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP

SUMMARY OF PERFORMANCE: PRODUCED MARCH 2018 (using data up to end Dec 2017)

HOW ARE WE DOING?

In 2016, we published our Health and Social Care **Strategic Plan 2016-19**, with 9 local objectives to work towards over a three year period. Underpinning these 9 objectives, Scottish Government Ministers have defined a range of themes that they wish to see all Integrated Joint Boards address and a range of performance indicators by which to monitor performance.

The themes are as follows:

- Unplanned admissions to hospital
- Occupied bed days for unscheduled care
- A&E Performance
- Delayed discharges
- End of Life care
- Balance of spend; institutional v community services

We have also defined 3 themes that are important to the Scottish Borders that we wish to see performance monitored against.

These are:

- Social Care
- Carers
- Other Relevant measures in relation to funded projects or initiatives

This report provides an overview of performance under these themes **with latest available data at the end of December 2017**. Reviewing performance information regularly is a vital part of ensuring we stay focused on *"working together for the best possible health and well-being in our communities"*

KEY

Positive trend/compares well to previous period/to Scotland	**SB** Scottish Borders	**RAA** Rolling annual average, calculated over a 12 month period	**18+ 65+ 75+** Age groups e.g. those over 75 years old	**RATE PER 1000** Number calculated as a rate per 1000 population	**"2 MINUTES OF YOUR TIME"** NHS survey done monthly in Borders General and Community hospitals
Negative trend/some concern from previous period or when compared to Scotland					
Little change/difference over 4 periods					

Scottish Borders
Health and Social Care
PARTNERSHIP

WORKING TOGETHER FOR THE BEST POSSIBLE HEALTH AND WELL-BEING IN OUR COMMUNITIES

HOW ARE WE DOING?

Summary

% of total health and care spend in the Borders accounted for by community-based services has been consistently higher than Scotland for the last 2 years- it will be important that this is maintained / improved. % of Health & Social Care resources spent on emergency hospital stays in Borders has reduced since last year and is significantly lower than Scotland which is positive. Although many of the key indicators (below) show that our performance compares favourably to Scotland, there are some areas of challenge locally, where performance over the last 4 quarters is showing a negative trend and/or cause for concern:

Challenges

- Emergency admissions for falls for over 65s has risen over the last 4 quarters
- Emergency occupied bed days (75+) has increased over the last 4 quarters
- % of A&E attendances seen within 4 hrs, whilst higher than Scotland, has dropped sharply over the last 4 quarters.
- Delayed Discharge from hospital remains an ongoing challenge, fluctuating monthly and increased since last year. This remains a key strategic and operational focus for the partnership
- Bed days because of delayed discharge has increased steadily since 2015/16 and is now at its highest level since 14/15
- % of care users saying they feel safe has dropped since Q3 16/17. An alternative measure with a more stringent collection methodology is being sought.

Details of performance information and on what we are doing to improve or maintain performance can be found in **Appendix 2**

Financial Performance

SPEND

£276.3m
SB Total Spend 15/16

51.4%
on **community based care**

SB 14/15	51.2%
Scotland 15/16	46.5%

SPENT ON EMERGENCY HOSPITAL STAYS (18+)

17.8%
of **Health & Social Care resources** spent on **emergency hospital stays (18+)**

SB Q2 16/17	20.8%
Scotland 16/17	24.7%

Operational performance

EMERGENCY ADMISSIONS (75+)
91
per **1000 75+**
(April - June 2017)
Little change over 4 Qtrs
Lower than Scotland

EMERGENCY RE-ADMISSIONS WITHIN 28 DAYS
10.6
per **100 discharges**
(April - June 2017)
Trend over 4 Qtrs
Similar to Scotland

A&E ATTENDANCES SEEN WITHIN 4 HRS
2624
88.4%
(Dec 17)
Trend over 4 months
Higher than Scotland

BED DAYS BECAUSE OF DELAYS
222
per **1000 75+**
(July - September 2017)
Trend over 4 Qtrs
Lower than Scotland

CARE USERS FEELING SAFE
81%
(Oct – Dec 2017)
Trend over 4 Qtrs
No Scottish figure

EMERGENCY ADMISSIONS FOR FALLS (65 +)
6.2
per **1000 65+**
(April - June 2017)
Trend over 4 Qtrs
Lower than Scotland

EMERGENCY OCCUPIED BED DAYS (75+)
931
per **1000 75+** (RAA)
(April - June 2017)
Trend over 4 Qtrs
Lower than Scotland

DELAYS GETTING OUT OF HOSPITAL
16 < **2 weeks**
32 < **72 hours**
(Dec17)
Fluctuating over 4 months
No Scottish figure

COMMUNITY SUPPORT
77%
of **adults 65+** receiving **care in a community setting**
(Dec17)
Little change over 4 months
No Scottish figure

CARERS
49
assessments offered
20 (41%)
completed
(June17)
No update since last report

Other relevant measures

2 minutes of your time (Oct-Dec 2017)
94.6% patients felt satisfied with care & treatment
96% felt staff understood what mattered
92.6% had the info they needed to make decisions
(down from 98.1%, 98.1%, 94.3% in April – June 2017)

Integrated Care Fund (ICF)- project example (More detail in Appendix 2)
The **Matching Unit** is a team created to match a home care service to the assessed needs of clients. Prior to this service, Care Managers spent a significant amount of time sourcing care individually.

Established in Hawick in April 2017 and rolled out to all locality teams during 2017, both staff and clients are already benefiting significantly from this new team.

FULL REPORT AVAILABLE AT **https://www.scotborders.gov.uk/info/20014/social_care_and_health/381/health_and_social_care_integration**

Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the Scottish Borders Integrated Joint Board

SUMMARY OF PERFORMANCE:
PRODUCED MARCH 2018 (using data up to end Dec 2017)

1. Unplanned Admissions

Part 1 - Emergency admissions for people aged 75+

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

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

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

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

Data Source(s)
1. NSS Discovery. Emergency admissions to hospital as sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. The 28 day readmissions figures include beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are included) .
2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

Part 2 - Emergency admissions for falls, people aged 65+

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

With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major concern.

Falls can have a significant impact on an older person's independence and quality of life, impeding a person’s mobility and confidence. However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence based practices can prevent many falls and fractures in older people in the community setting. Rehabilitation services are also key to preventing repeat falls. In addition, the safety of a person’s immediate environment as well as their prescribed medicines will be important.

An economic evaluation published in 2013 estimated the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million (http://www.ncbi.nlm.nih.gov/pubmed/24215036) and without intervention is set to rise over the next decade as our population ages and the proportion with multi-morbidity and polypharmacy grows.

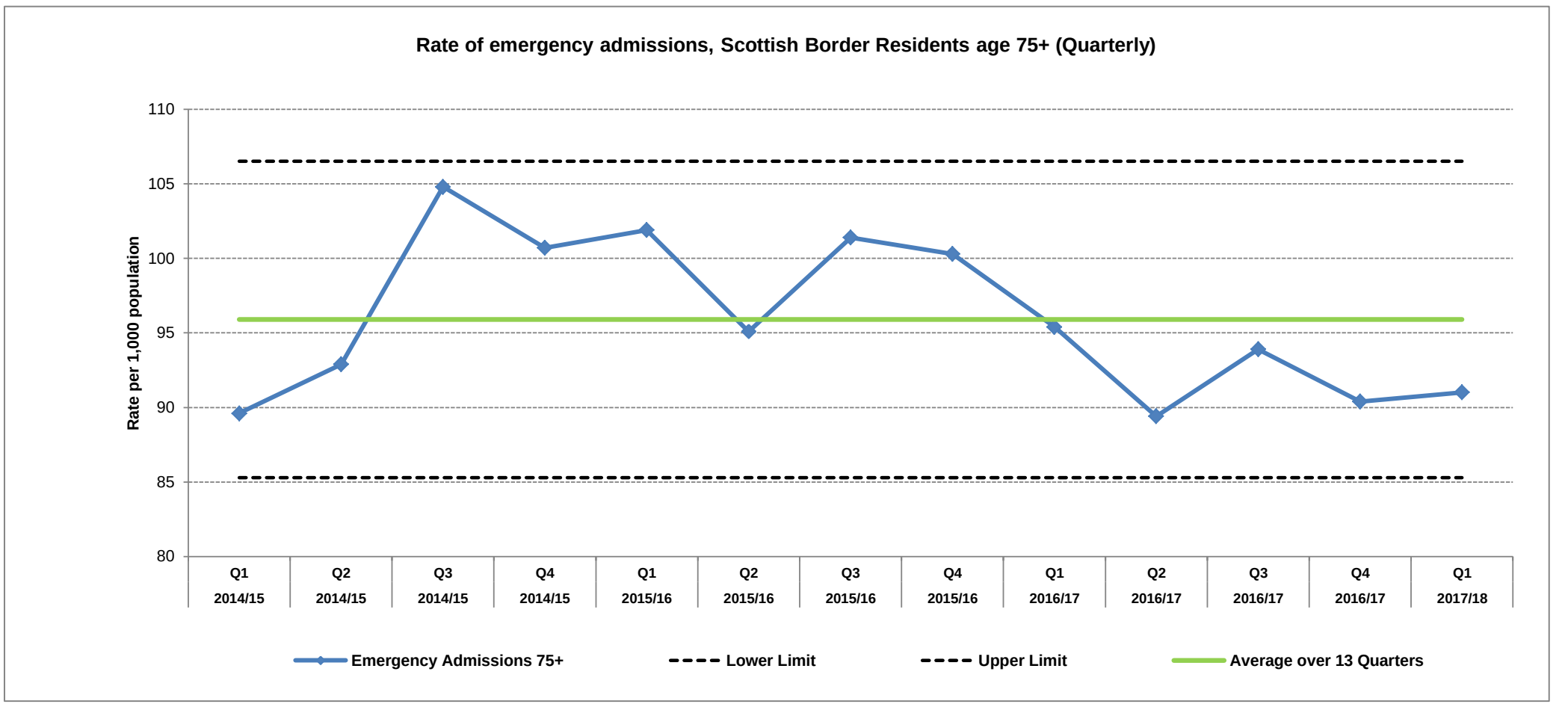
Data Source(s) and notes
1. Emergency Hospital admissions due to falls are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.
2. Diagnostic codes used to identify falls are ICD-10 codes W00-W19.
3. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

1. Unplanned Admissions

Emergency Admissions, Scottish Borders residents age 75+

New - Changed to Quarterly

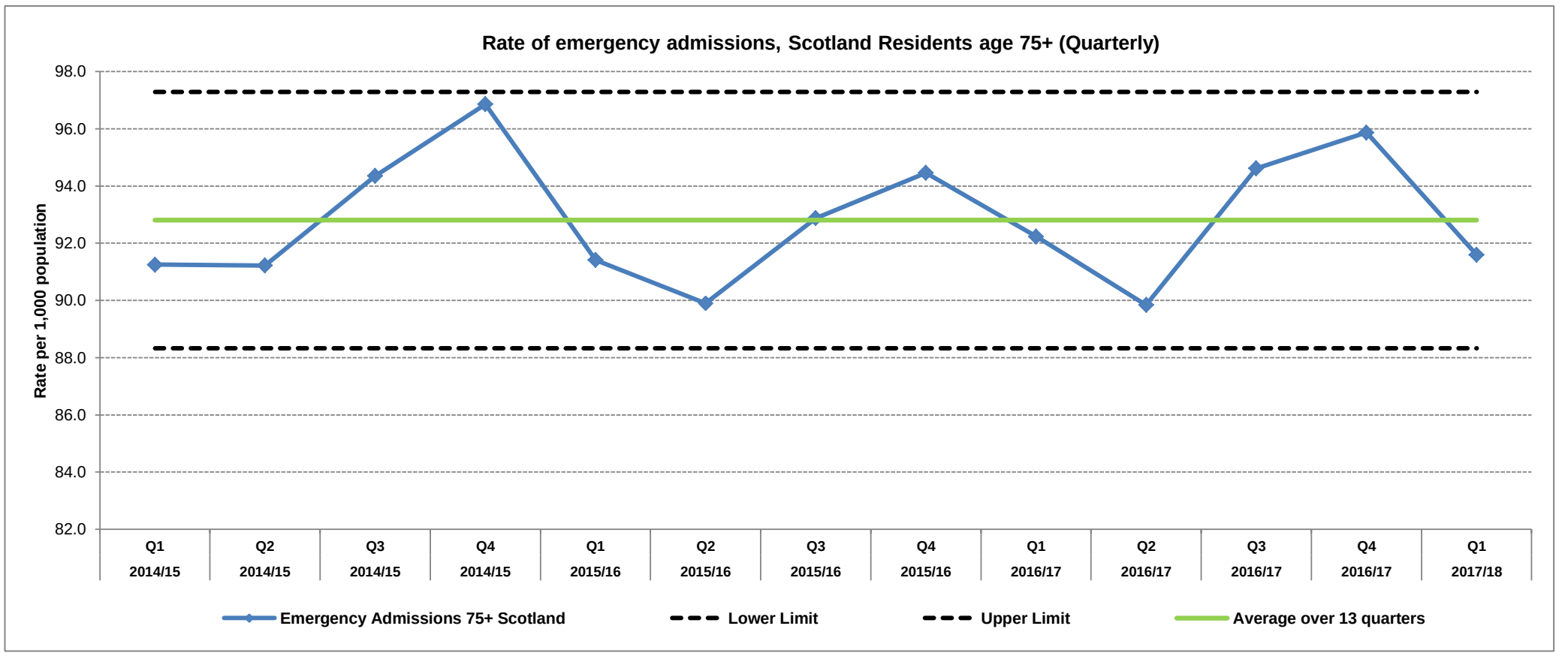
	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Number of Emergency Admissions, 75+	39,521	40,877	41,963	40,014	39,351	40,654	41,346	40,795	39,737	41,850	42,402	40,512
Rate of Emergency Admissions per 1,000 population 75+	92.9	104.8	100.7	101.9	95.1	101.4	100.3	95.4	89.4	93.9	90.4	91.0



Emergency Admissions, Scotland residents age 75+

New - Changed to Quarterly

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Number of Emergency Admissions, 75+	433,238	433,238	433,238	437,717	437,717	437,717	437,717	442,309	442,309	442,309	442,309	442,309
Rate of Emergency Admissions per 1,000 population 75+	91.2	94.4	96.9	91.4	89.9	92.9	94.5	92.2	89.8	94.6	95.9	91.6

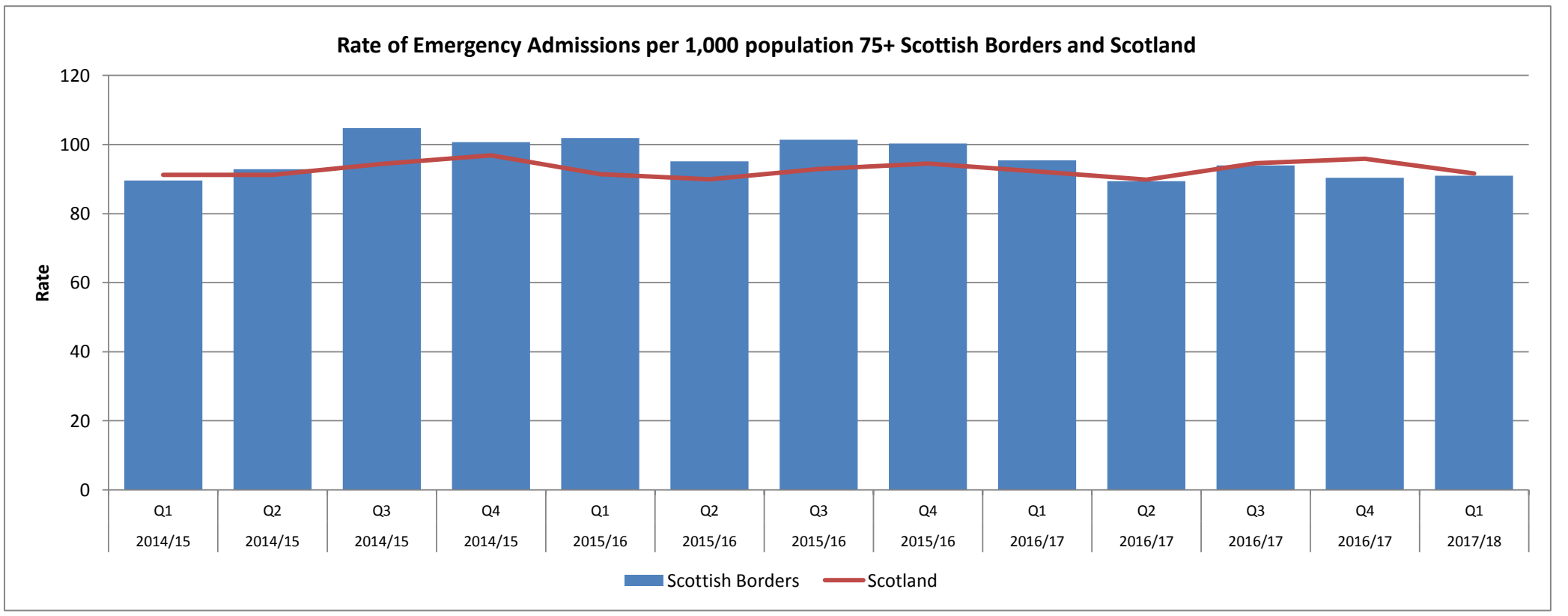


Emergency Admissions comparison, Scottish Borders and Scotland residents age 75+

New for this Quarter

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Rate of Emergency Admissions per 1,000 population 75+ Scottish Borders	92.9	104.8	100.7	101.9	95.1	101.4	100.3	95.4	89.4	93.9	90.4	91.0
Rate of Emergency Admissions per 1,000 population 75+ Scotland	91.2	94.4	96.9	91.4	89.9	92.9	94.5	92.2	89.8	94.6	95.9	91.6

1. Unplanned Admissions



How are we performing?

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

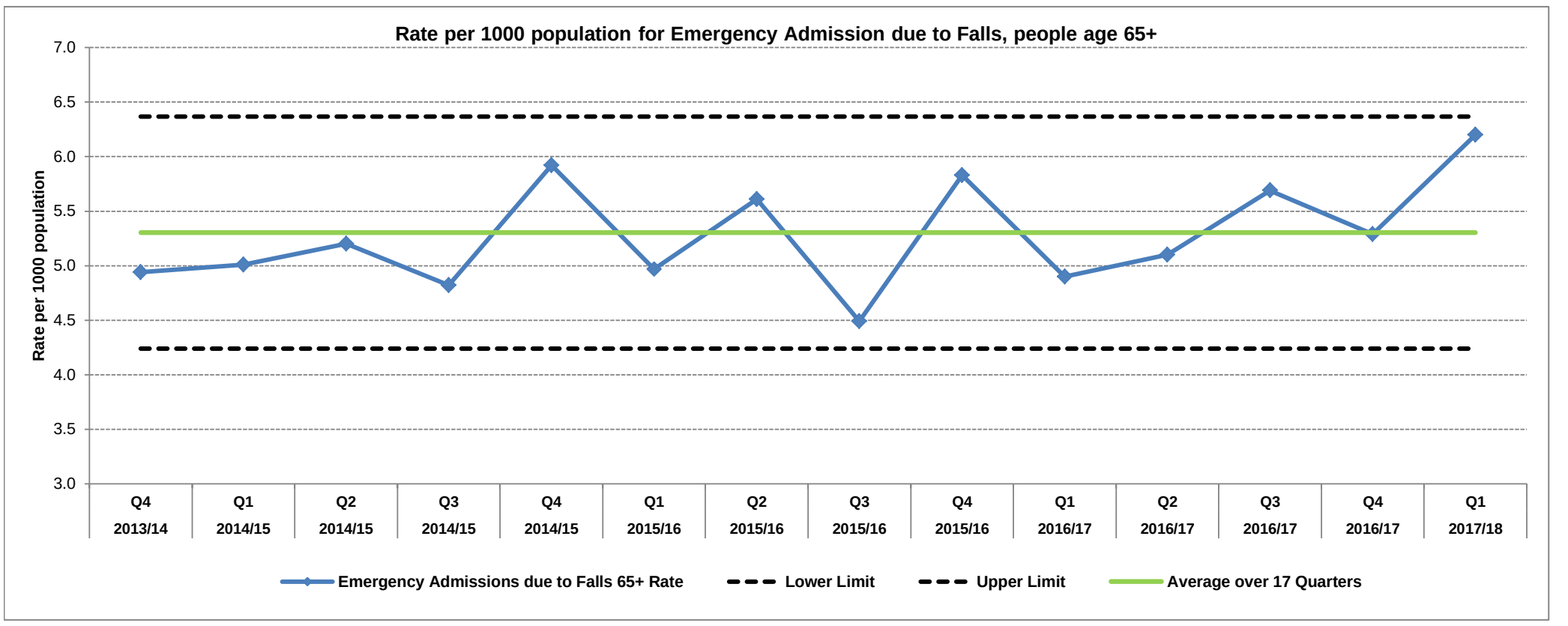
What are we doing to improve or maintain performance?

A number of improvement actions are underway which will continue to impact positively on this measure. These include the relocation of the Ambulatory Care Unit to the Medical Assessment Unit (MAU) annexe and expansion (from June 2017), work to prevent admission (especially in relation to respiratory illness), increased use of patient anticipatory care planning, the development of the Surgical Assessment Unit (autumn 2017), and work to maintain people with palliative needs at home (including hospice at home) (March 2018)

Emergency Admissions for falls, people aged 65+, rates per 1,000 population (aged 65+) in Scottish Borders residents

Updated: Apr-Jun'17

	Jul-Sep '14	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17	Apr-Jun'17
Rate of Emergency Admissions for falls per 1,000 population 65+	5.2	4.8	5.9	5.0	5.6	4.5	5.8	4.8	5.1	5.7	5.3	6.2

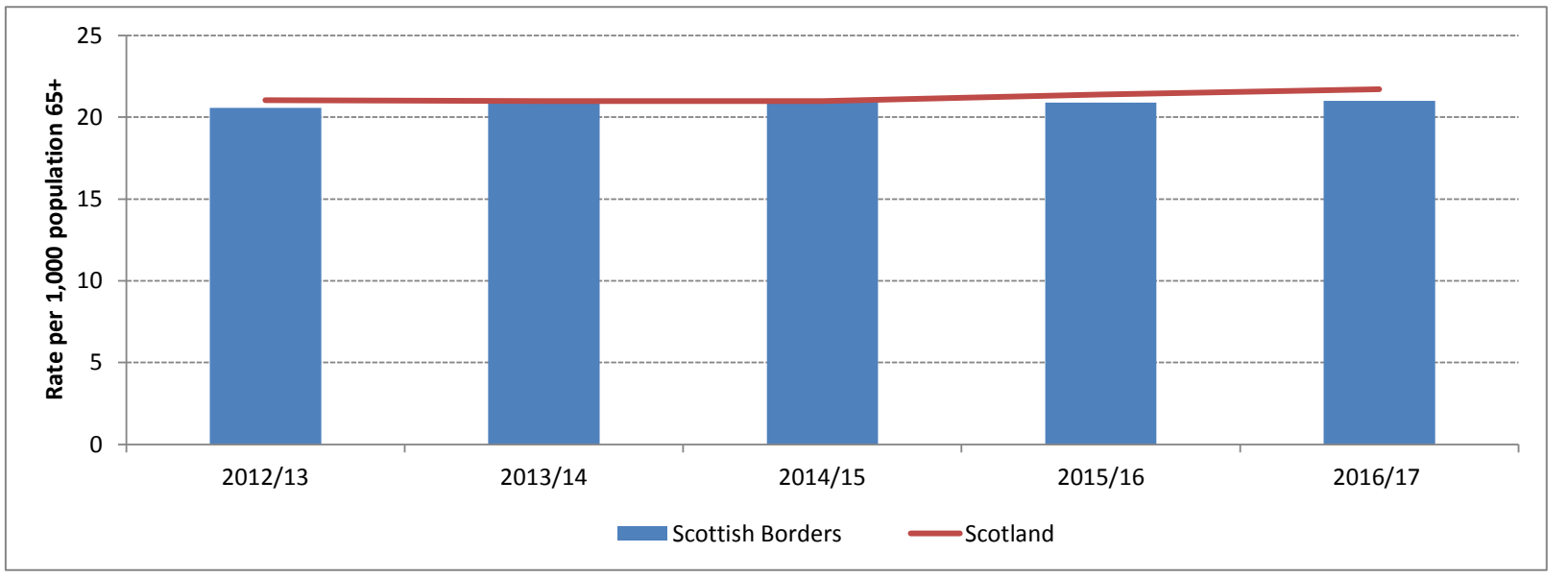


1. Unplanned Admissions

Emergency Admissions for falls, people aged 65+, rates per 1,000 population (aged 65+) in Scottish Borders and Scotland Residents

	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders	20.6	21.1	21.0	20.9	21.0
Scotland	21.0	21.0	21.0	21.4	21.6

Annual figures to 2016/17 refreshed to reflect increased completeness of national data



How are we performing?

The quarterly rate of emergency admissions for falls amongst Scottish Borders residents aged 65 and over has fluctuated since the start of the 2013/14 financial year, but has generally remained around 5 to 6 per 1,000 residents. Annual rates for the Scottish Borders 2013/14 and 2014/15 were very close to the Scottish averages, whilst in 2015/16 and 2016/17 they were slightly lower.

What are we doing to improve or maintain performance?

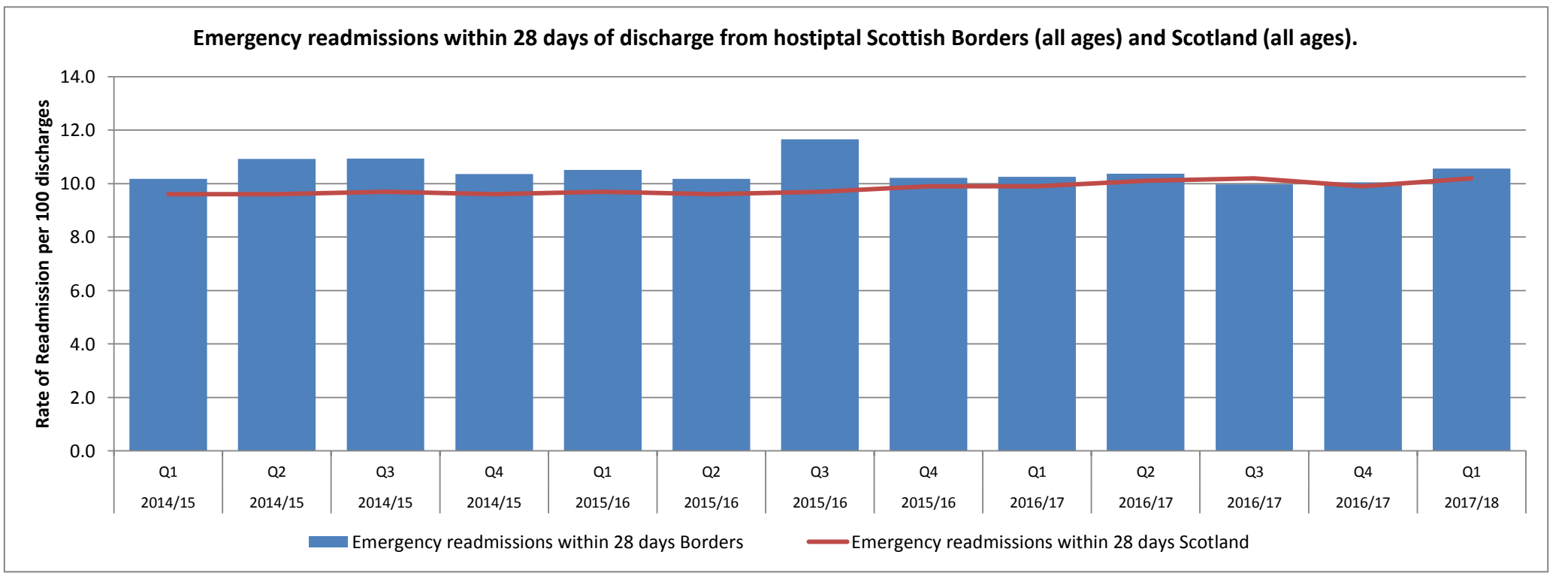
Following the publication of "The prevention and management of Falls in the Community (2014-2016) NHS Borders have been active in developing a process to implement the framework. A steering group was developed and meet monthly. This group has representation from Scottish Ambulance service and from Scottish Fire and Rescue service. In order to implement change a pilot site was selected. A single point of access has been agreed so that all calls from partner services go through a single number. A database is being developed so that over time we will have a list of vulnerable patients and repeat falls. A series of workshops for District Nurses were held in order to raise awareness of the pathway. The pathway has been introduced within a Pilot site on a phased basis and is now working in Kelso and expanding to Cheviot. We started with a target response time of a week and have reduced this to 4 days but not yet to the recommended 48 hours. This relates to staffing levels in then Out of Hours period. We will continue to roll out this pathway and strive to reduce response time over the coming year.

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

New for this Quarter

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

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
28-day readmission rate Scottish Borders (per 100 discharges)	10.9	10.9	10.4	10.5	10.2	11.7	10.2	10.3	10.4	10.0	10.0	10.6
28-day readmission rate Scotland (per 100 discharges)	9.6	9.7	9.6	9.7	9.6	9.7	9.9	9.9	10.1	10.2	9.9	10.2



How are we performing?

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

What are we doing to improve or maintain performance?

Part of the reason for the Borders rate being slightly higher than the Scottish rate can be attributed to a known local challenge in relation to the coding of re-admissions (especially in relation to gynaecology and medical oncology), and work is underway to improve the use and consistency of codes. There is also an ongoing partnership challenge around the management and prevention of re-admission rates for older adults (across general and geriatric medicine).

2. Occupied Bed Days

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

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

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

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

Data Source(s)

1. Hospital bed-days are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.

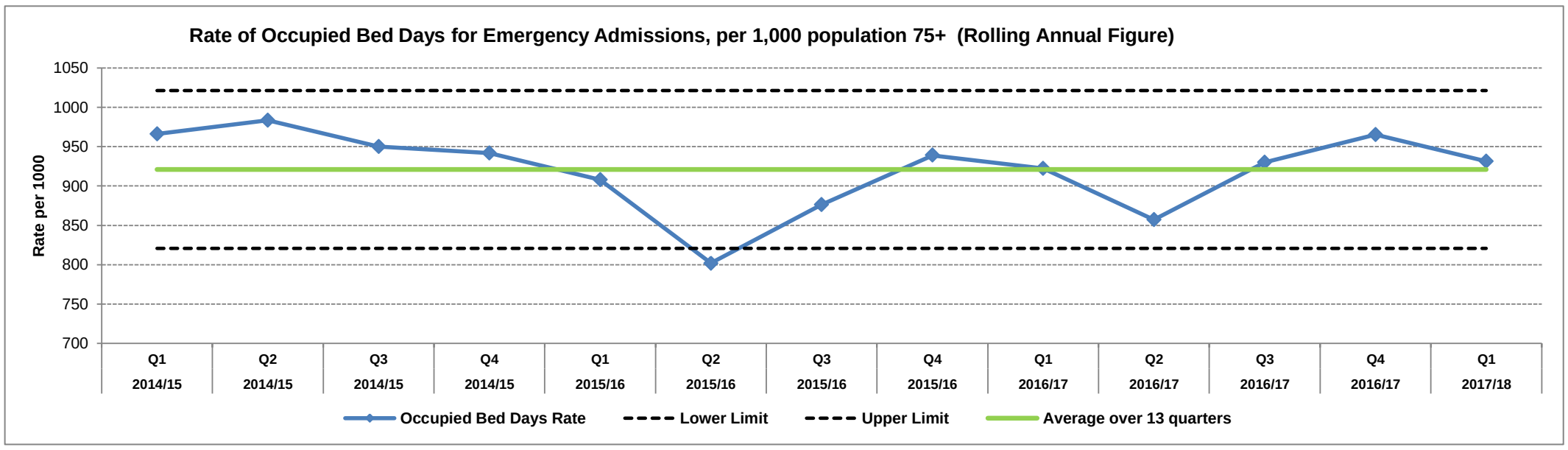
2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

2. Occupied Bed Days

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

Updated - Changed to Quarters

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Number of Occupied Bed Days for emergency Admissions, 75+	536,161	567,977	594,917	552,186	520,591	536,976	551,068	541,550	522,398	552053	567033	534754
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	984	950	942	908	802	876	939	922	857	930	965	931



How are we performing?

The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75 and over have fluctuated over time but are lower than the Scottish averages. The Scottish rate has only twice gone below 1,200 per 1,000 population, while the Scottish Borders rate has never gone above 1,000 per 1,000 population.

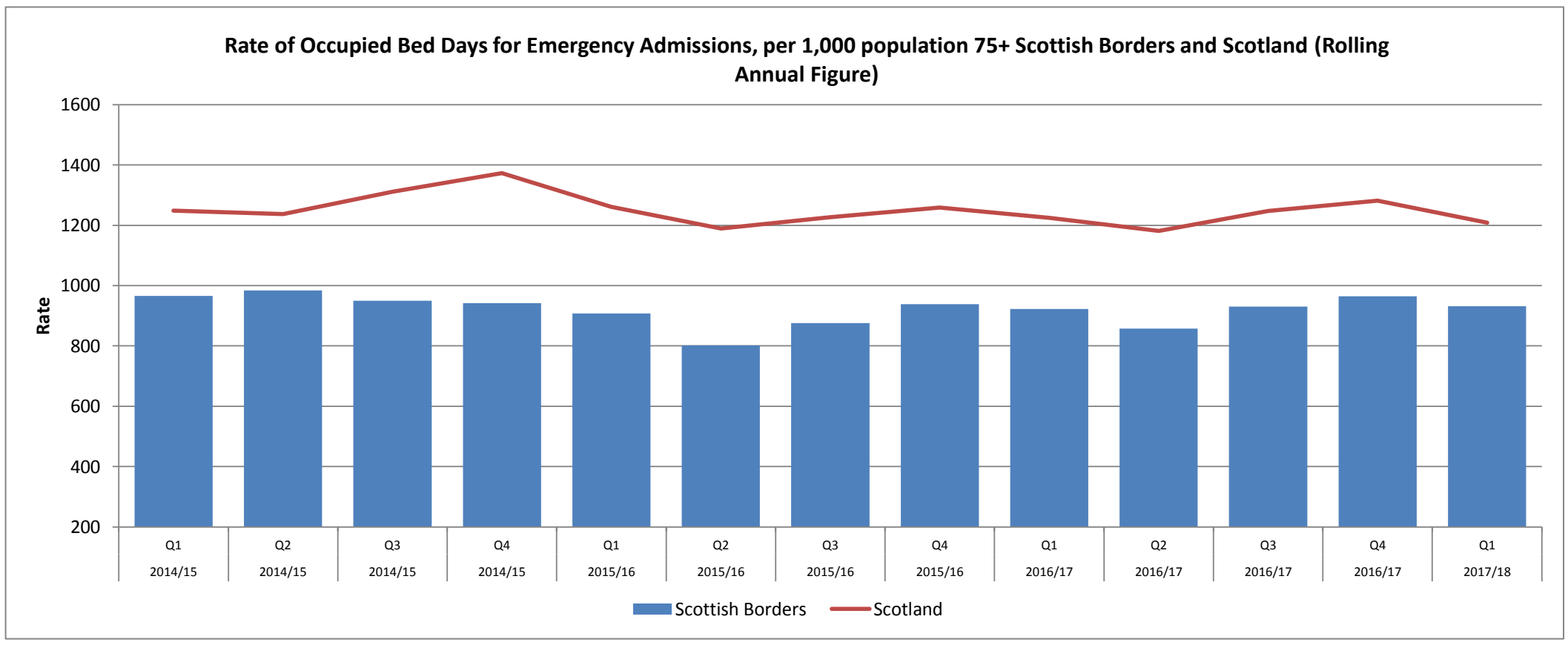
What are we doing to improve or maintain performance?

Work continues to reduce length of stay including an increase in 11am discharges, and the development of some initiatives to allow people to be discharged earlier (e.g. rapid access carers, expansion of transitional care etc. A focus on reducing delayed discharge remains a key challenge for the partnership.

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

Updated - Changed to Quarters

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish	984	950	942	908	802	876	939	922	857	930	965	931
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1,238	1,311	1,373	1,262	1,189	1,227	1259	1224.4	1181.1	1248.1	1282	1209



3. Accident and Emergency Performance

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

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

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

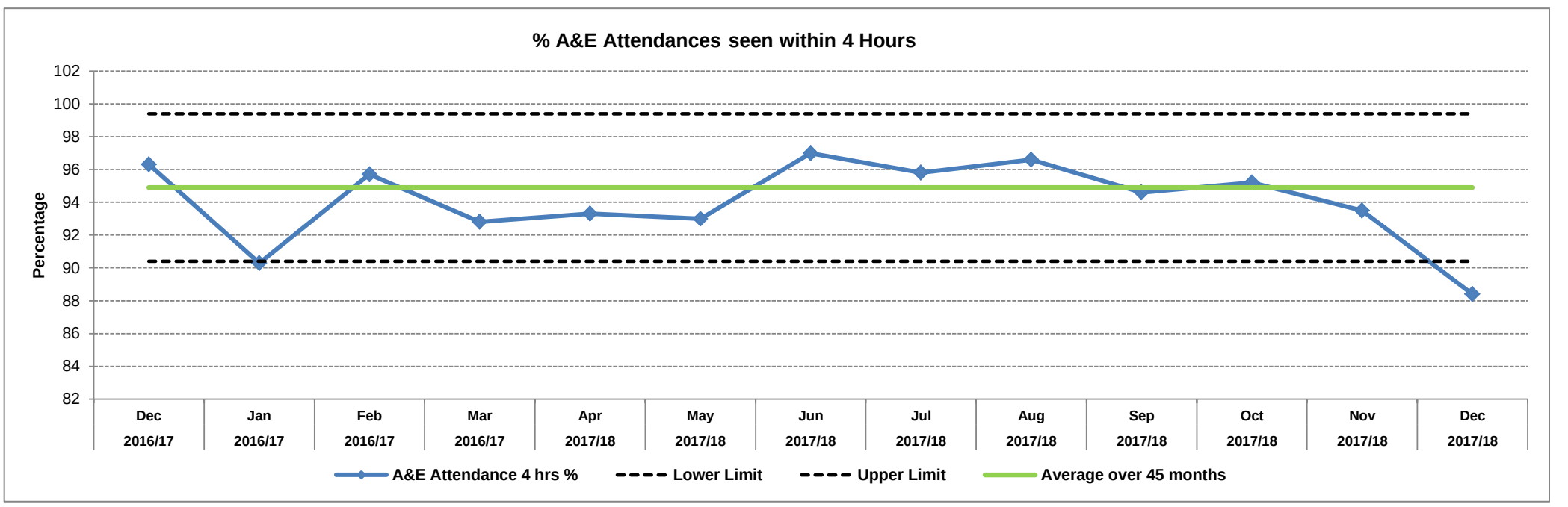
Data Source(s)
NHS Borders TrakCare system.

3. Accident and Emergency Performance

Accident and Emergency attendances seen within 4 hours

Quarter updated

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Number of A&E Attendances seen within 4 hours	2,323	2,079	2,401	2,567	2,679	2,556	2,515	2,571	2,661	2,599	2,405	2,624
% A&E Attendances seen within 4 hour	90.3	95.7	92.8	93.3	93.0	97.0	95.8	96.6	94.6	95.2	93.5	88.4



How are we performing?

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

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

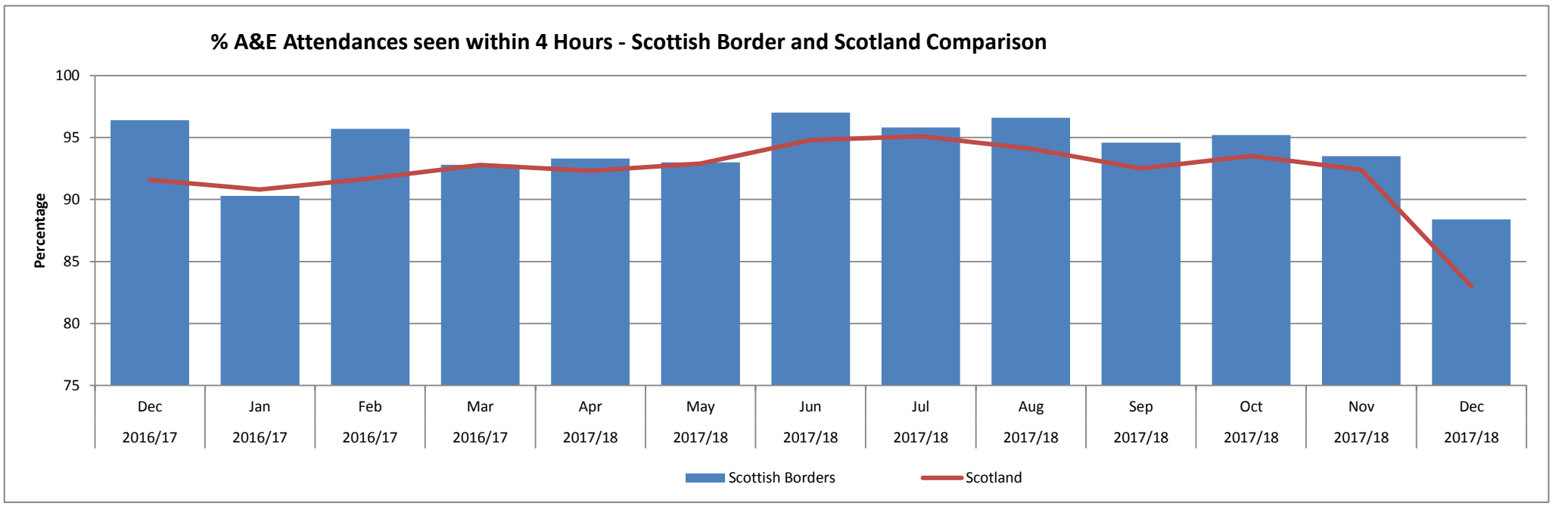
What are we doing to improve or maintain performance?

Whilst we expect total A&E attendances by end of 17/18 and 18/19 to be relatively static (albeit with anticipated seasonal fluctuation, as is reflected nationally too), the H&SCP has started working with GP clusters to increase support to people before they end up at A&E and after they have been there. We are also increasing capacity in the Borders Emergency Care Service (BECS – our "Out of Hours" service). Therefore we would expect A&E attendances to come down in the longer term as we build in more alternatives.

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

Quarter updated

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
% A&E Attendances seen within 4 hour Scottish Borders	90.3%	95.7%	92.8%	93.3%	93.0%	97.0%	95.8%	96.6%	94.6%	95.2%	93.5%	88.4%
% A&E Attendances seen within 4 hour Scotland	90.8%	91.7%	92.8%	92.3%	92.9%	94.8%	95.1%	94.1%	92.5%	93.5%	92.4%	83.0%



4. Delayed Discharge

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

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

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

Data Source(s)
Monthly Delayed Discharge Census, ISD Scotland.

1) The measures on numbers of discharges delayed by more than 72 hours/more than 2 weeks, are snapshots of the number of patients waiting to be discharged, on a single day in each month.

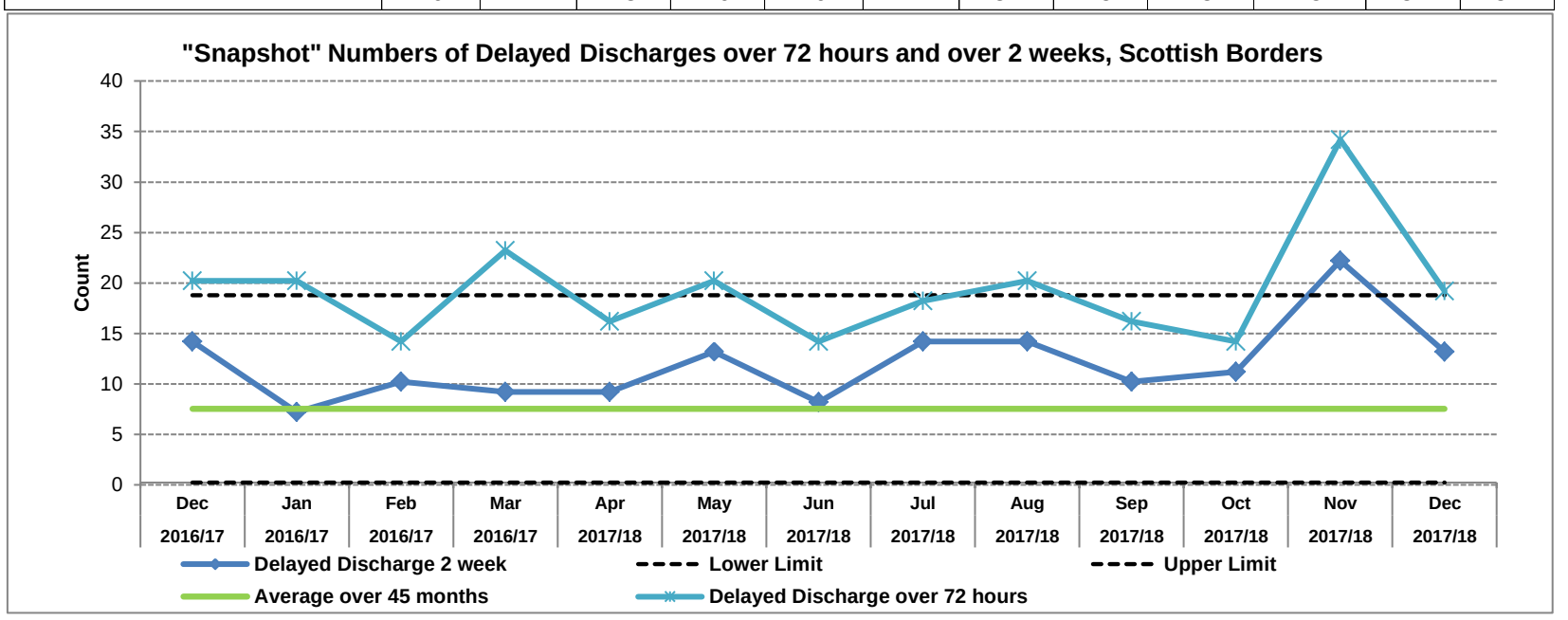
2) The measure of bed days associated with delayed discharges is based on all delayed discharges within the specified time period.

4. Delayed Discharge

Delayed Discharges (DDs)

Quarter updated

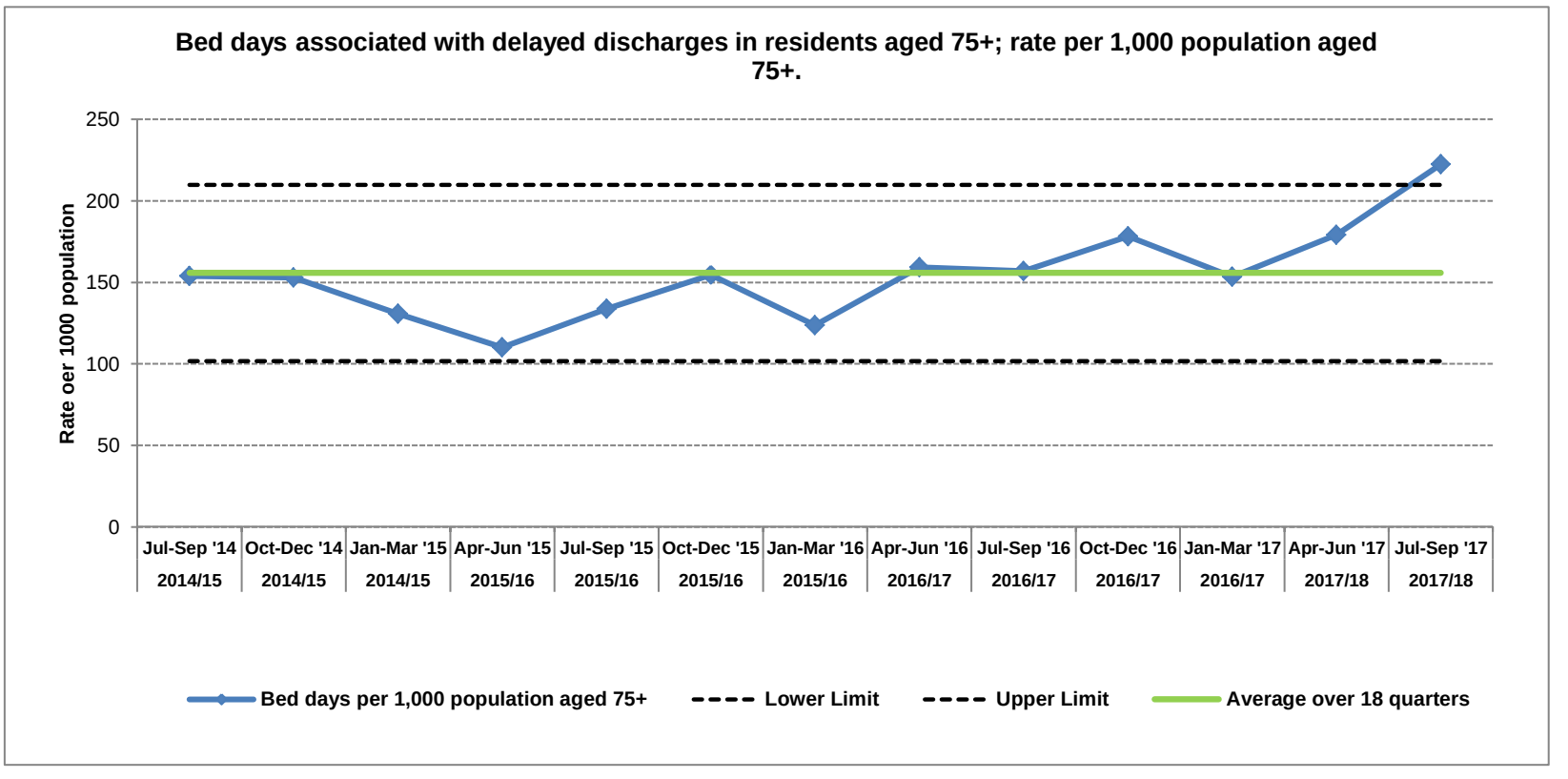
	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Number of DDs over 2 weeks	13	8	14	14	10	11	22	13	15	19	19	16
Number of DDs over72 hours	20	14	18	20	16	14	34	19	23	25	34	32



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

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

	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17	Apr-Jun '17	Jul-Sep '17
Bed days per 1,000 population aged 75+	153	131	110	134	154	124	159	157	178	153	179	222

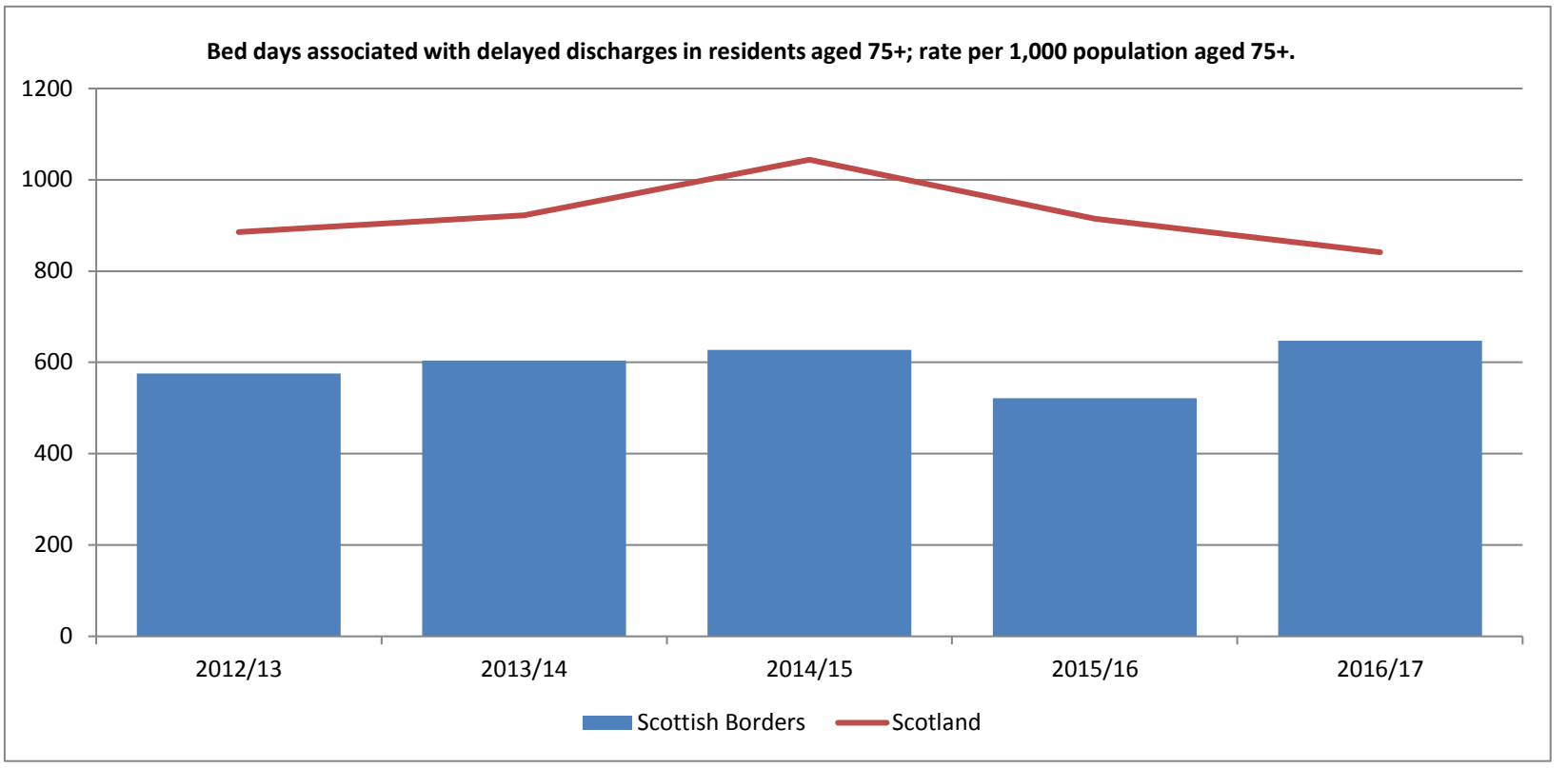


4. Delayed Discharge

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

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

No Change



Delayed Discharges at Census Point by Reason for Delay

Quarter updated

Reason for delay	2016 Jan	2017 Feb	2017 Mar	2017 Apr	2017 May	2017 Jun	2017 Jul	2017 Aug	2017 Sep	2017 Oct	2017 Nov	2017 Dec
Total delays at census point	**39**	**23**	**34**	**31**	**30**	**29**	**51**	**33**	**43**	**47**	**53**	**43**
Health and social care / patient and family related reasons	**33**	**16**	**26**	**21**	**24**	**21**	**42**	**23**	**31**	**34**	**39**	**33**
Total health and social care reasons	**32**	**16**	**25**	**21**	**22**	**18**	**37**	**21**	**30**	**31**	**36**	**30**
Assessment	1	-	2	1	-	4	1	-	1	1	2	8
Funding	-	-	-	-	-	-	-	-	-	-	-	-
Place availability	18	8	10	10	10	9	21	9	14	18	14	9
Care arrangements	13	8	13	10	12	5	15	12	15	12	20	13
Transport	-	-	-	-	-	-	-	-	-	-	-	-
Total patient and family related reasons	**1**	**-**	**1**	**-**	**2**	**3**	**5**	**2**	**1**	**3**	**3**	**3**
Disagreements	-	-	1	-	-	1	2	1	-	-	2	2
Legal/financial	-	-	-	-	2	1	1	1	1	1	1	1
Other	1	-	-	-	-	1	2	-	-	2	-	-
Total complex delays	**6**	**7**	**8**	**10**	**6**	**8**	**9**	**10**	**12**	**13**	**14**	**10**
Adults with incapacity (AWI)	4	4	5	4	3	6	7	9	11	12	14	10
Other complex reasons (not AWI)	2	3	3	6	3	2	2	1	1	1	-	-

4. Delayed Discharge

How are we performing?

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

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

Ongoing focus is being placed upon supporting the discharge of delayed patients awaiting their next stage of care across the system. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 Hour ED Standard, quality of care and ensuring people are in the right care setting, and the avoidance of disruption to planned surgical admissions.

There are weekly delayed discharge meetings with senior managers and senior colleagues from Scottish Borders Council and SB Cares, Chief Officer for Health and Social Care, and General Managers for Primary & Community Services and Unscheduled Care. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring and to implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

What are we doing to improve or maintain performance?

Following the work last year with Professor John Bolton, and aligned to winter planning, we have been continuing to grow capacity locally through the progressive implementation of three operational care facilities:

- The Transitional Care Facility in Galashiels has been operational from the start of January 2017 with 10 beds initially, rising to 16 since Dec 17.
- The "Discharge to Assess" (DTA) facility at Craw Wood (Tweedbank) has been operational from the start of December 2017 with 8 beds initially, rising to 15, with plans to increase to 23 if possible.
- The "Hospital to Home" service will be operational from the start of February 2018. This service will be able to support up to 30 people at a time.

Looking further ahead, the HSCP is working to increase capacity in community care options.

5. End of Life Care

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

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

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

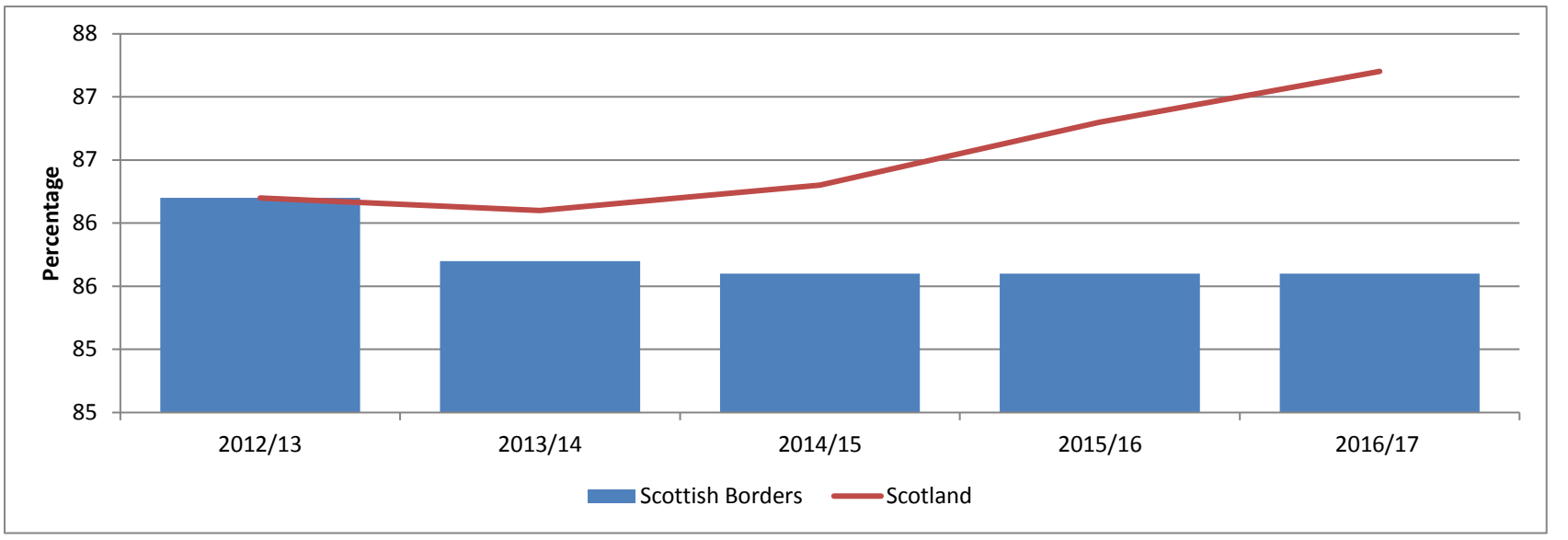
The indicator should ideally represent the wishes and choices for patients and their carers and also demonstrate the effectiveness of having a planned approach to end of life care. For an individual, the preferred place of care can change as their condition and/or family circumstances change over time,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

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

5. End of Life Care

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

	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders %	86.2%	85.7%	85.6%	85.6%	85.6%
Scotland %	86.2%	86.1%	86.3%	86.8%	87.2%



How are we performing?

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

What are we doing to improve or maintain performance?

The partnership needs to continue to focus on improved data quality to better evidence the contribution of the Margaret Kerr Unit (MKU) which is on the Borders General Hospital site but provides palliative care in a more "homely" setting than in the main hospital wards.

From 2013 (when the unit opened) to early 2017, NHS Borders' submissions of SMR01 data to ISD did not allow ready differentiation between activity on the main BGH wards and activity within the MKU. However, with effect from early 2017, episodes of care within the MKU have been recorded using the significant facility code for palliative care unit, thus allowing differentiation between it and the "Large Hospital" setting.

Areas of development by the specialist team include MKU outreach providing ward based teaching and support - practical and clinical, MKU hospice at home to deliver the same level of care in the patient's home that is within the MKU, and sourcing care home beds for palliative patients - MKU care Home. Part of the role throughout is education of a wide range of staff throughout the patient journey in palliative care skills- through communications skills courses directed at difficult conversations, deteriorating patients and dealing with complaints, and a joint project with PATCH (a charity to support palliative patients in acute care) and St Columbas Education department, encouraging cross group and joint learning. We are also contributing to Borders carers education and are developing care home education.

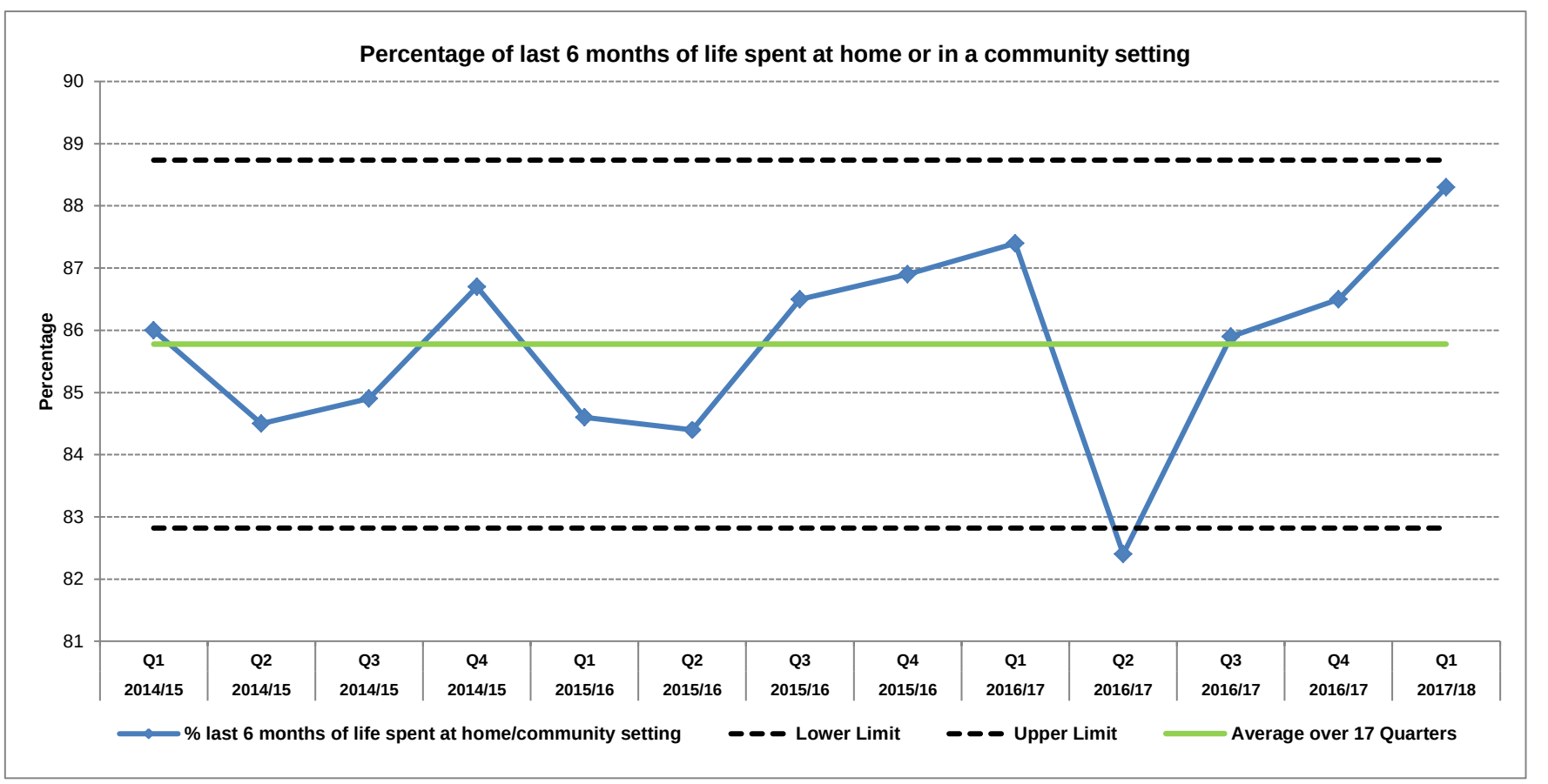
The local specialist palliative care team are in the process of developing a suite of outcome measures (including those validated through the Cicely Saunders institute) which were included in the recommendations sent in by the Scottish Partnership for Palliative Care, to the national work. These and other data the team are starting to collect will inform in greater detail the quality and extent of palliative care provision.
Overarching all of this, there is national work planned to progressively develop data recording, collection and reporting in order to gain better insight into provision of palliative care across a range of settings. We anticipate that Scottish Borders H&SCP, in common with other H&SCPs across Scotland, will be involved in discussions and work around this.

This measure has not been included on the Infographic summary as it is an annual measure only (and as such will be included in the annual report in July 2018

5. End of Life Care

Percentage of last 6 months of life spent at home or in a community setting New for this quarter

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Percentage of last 6 months of life spent at home or in a community setting Scottish Borders	84.5	84.9	86.7	84.6	84.4	86.5	86.9	87.4	82.4	85.9	86.5	88.3



How are we performing?

In addition to the annual measure around end of life care (shown on the previous page), local quarterly data has been provided in relation to last 6 months of life (for Scottish Borders only). However, the very "spikey" nature of the figures requires the Integration Performance Group to investigate this measure further to explore the reasons for the fluctuations and assess its usefulness and accuracy within this performance scorecard. It may be that figure need to be treated on a "provisional" basis.

For this reason, it has not yet been included in the "Infographic summary" (presented at Appendix 1)

What are we doing to improve or maintain performance?

See commentary under annual measure on previous page, for actions relating to improvements around end of life care

6. Balance of Spend

Part 1 - % spent on community based care.

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

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

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

Data Source(s)
Integrated Resource Framework (IRF) Official Statistics generated from the "Source" reporting system for Health and Social Care Partnerships, ISD Scotland. Please note:-
1. All NHS services are included in total spend, including health services that are not covered by integration (such as planned outpatient and inpatient care).
2. Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation based social care services.
3. Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.
4. Figures shown here for 2013/14 differ from those shown in the Scottish Borders HSCP Strategic Plan as they have since been updated to incorporate Community Dental Services and Community Ophthalmic Services.

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

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

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

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

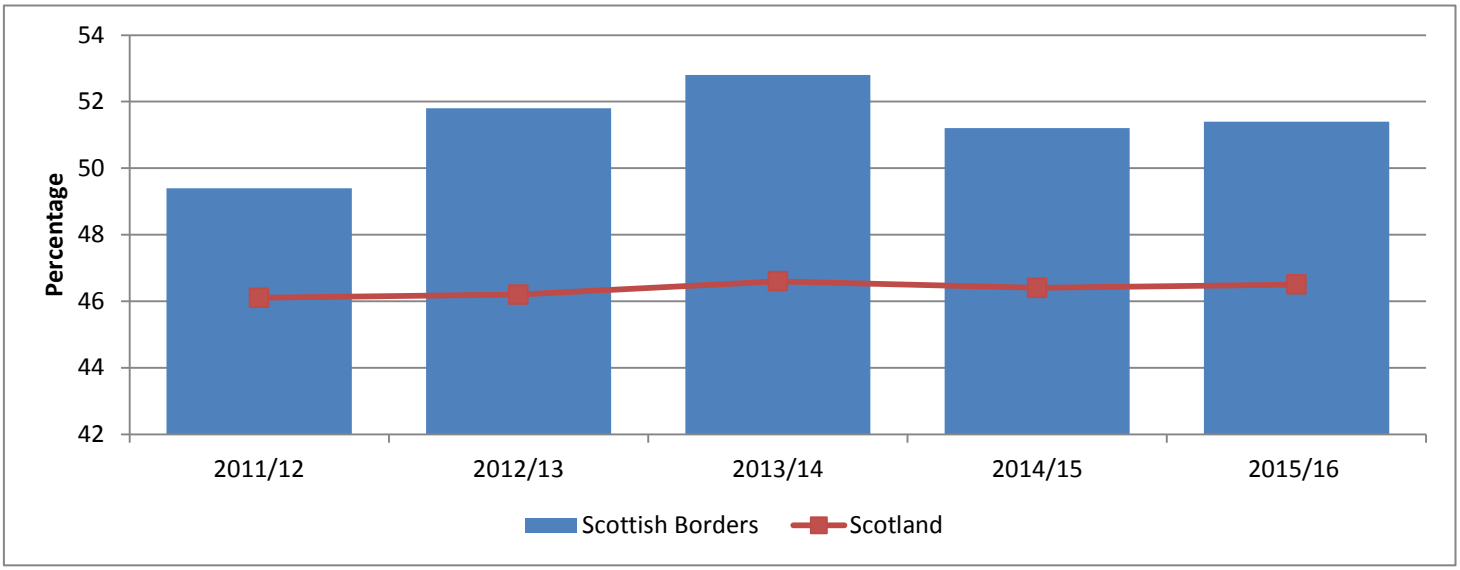
Data Source(s)
This is the "Core Suite Integration Indicator" number 20, taken from Core Suite Indicator Workbooks for Health and Social Care Partnerships, ISD Scotland.

6. Balance of Spend

Total Health and Social Care Expenditure

Updated with 2015/16 information

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders Total Spend (£ millions)	248.7	247.7	257.8	267.2	276.3	
Scottish Borders % spent on Community-Based care	49.4%	51.8%	52.8%	51.2%	51.4%	
Scottish Total Spend (£ millions)	11,675	11,782	12,109	12,620	13037	
Scottish % spent on Community-Based care	46.1%	46.2%	46.6%	46.4%	46.5%	



How are we performing?

The percentage of total health and care spend in the Borders that was accounted for by community-based services has been consistently higher than the Scottish average. Whilst this is a good baseline position for the Health and Social Care Partnership relative to Scotland, it will be important to ensure that the community service share is maintained/improved. The share for 2015/16 increased slightly relative to 2014/15.

What are we doing to improve or maintain performance?

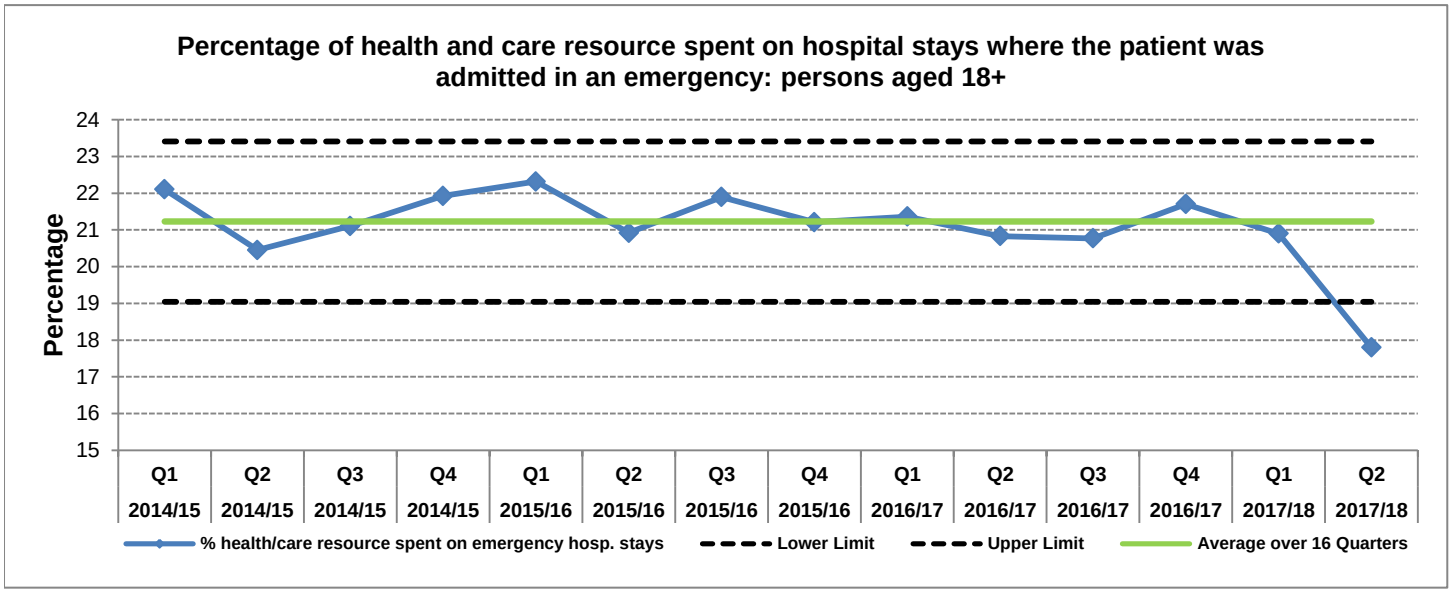
We will be examining this theme/objective as part of our review of our Strategic Plan in the first months of 2018 and the possibility and benefits of using more up to date local data on a "provisional" basis in relation to balance of spend.

6. Balance of Spend

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

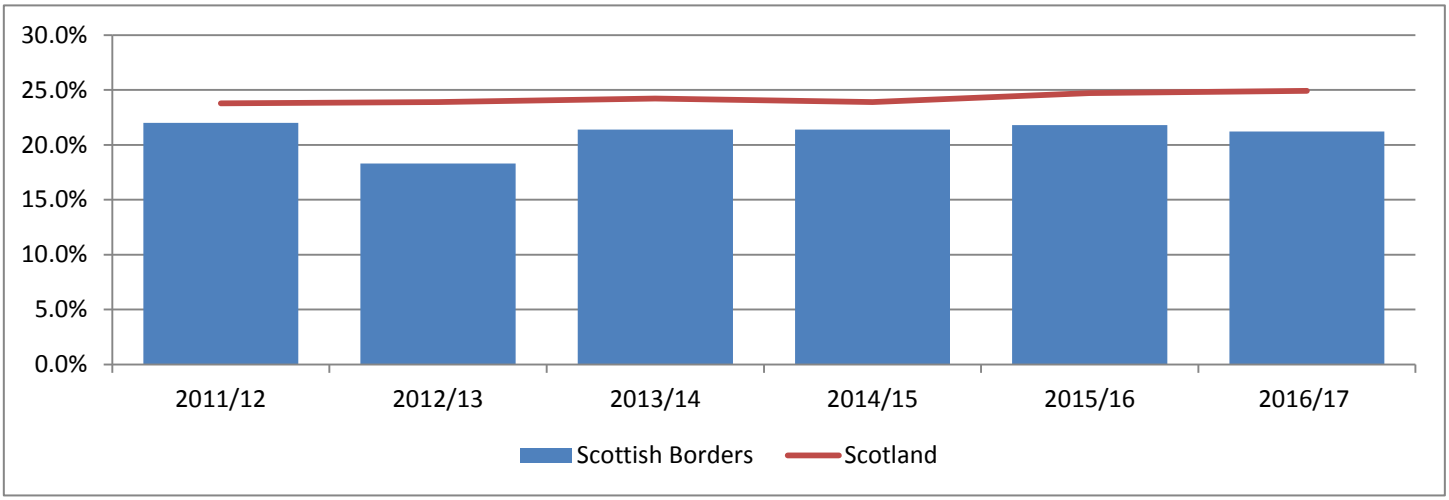
Updated - 2 new quarters

Quarter ending	Q3 2014-15	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18
% of health and care resource spent on emergency hospital stays	21.1	21.9	22.3	20.9	21.9	21.2	21.4	20.8	20.8	21.7	20.9	17.8



Figures for 2015/16 and 2016/17 revised to reflect updated costs reference data

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (P)
Scottish Borders	22.0%	18.3%	21.4%	21.4%	21.6%	21.2%
Scotland	23.8%	23.9%	24.2%	23.9%	24.7%	24.7%



How are we performing?

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

6. Balance of Spend

What are we doing to improve or maintain performance?
Work continues to reduce emergency admissions to the BGH. The Long Term Conditions self-management project helps patients with chronic conditions to support themselves in the community. Also Anticipatory Care Plans are routinely created and shared between health and social care to make sure patients receive the support that they require in their own homes.

7. Social Care

Part 1 - Percentage of social care clients reporting that they feel safe.

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

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

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

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

Data Source(s)

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

Part 2 - People within SB with intensive care needs receiving support in a community setting rather than a care home.

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

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

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

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

The measurement only captures 'home care services' which are provided on an hourly basis. Other services which support people at home, such as laundry services, home shopping, community alarms and meals-on-wheels, are not included.
The measurement will be affected by the pattern of need and demand within the area, influenced by the age-structure of the elderly population, the distribution of poverty and ill health, household composition and other factors.

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

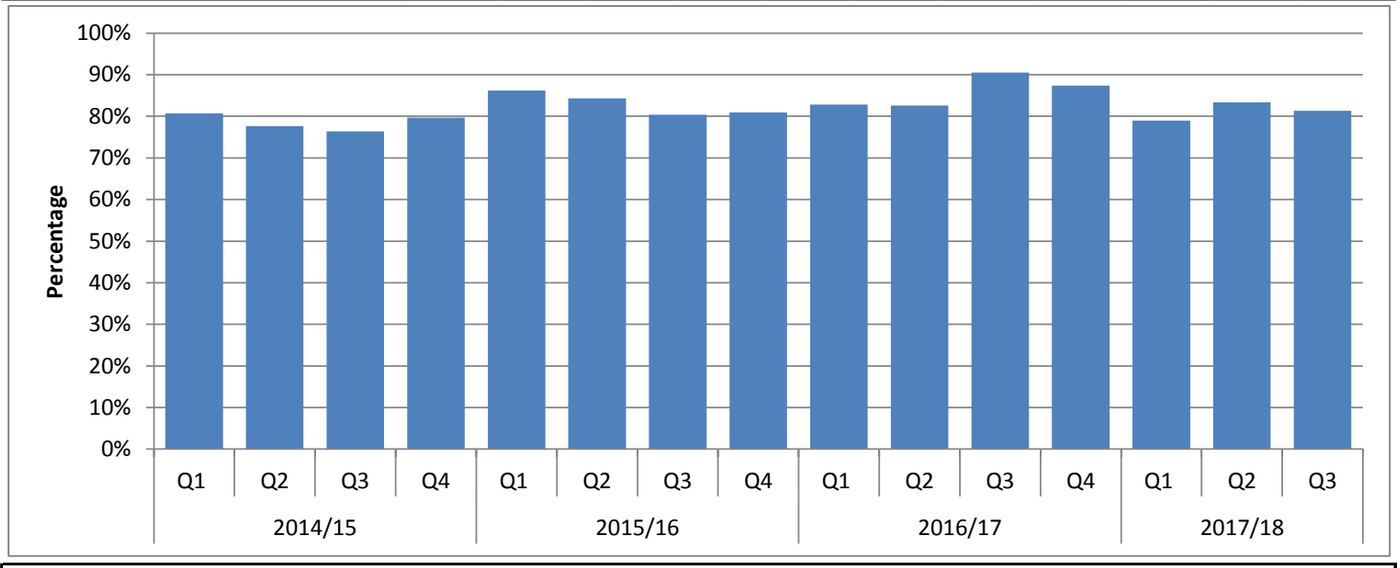
Data Source(s)

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

7. Social Care

Social Care Survey - Do you feel safe?

	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
Number of People Feeling Safe	659	690	638	624	629	585	445	502	504	514	527	458
Ave. % of People Feeling Safe	80%	86%	84%	80%	81%	83%	83%	91%	87%	79%	83%	81%



How are we performing?

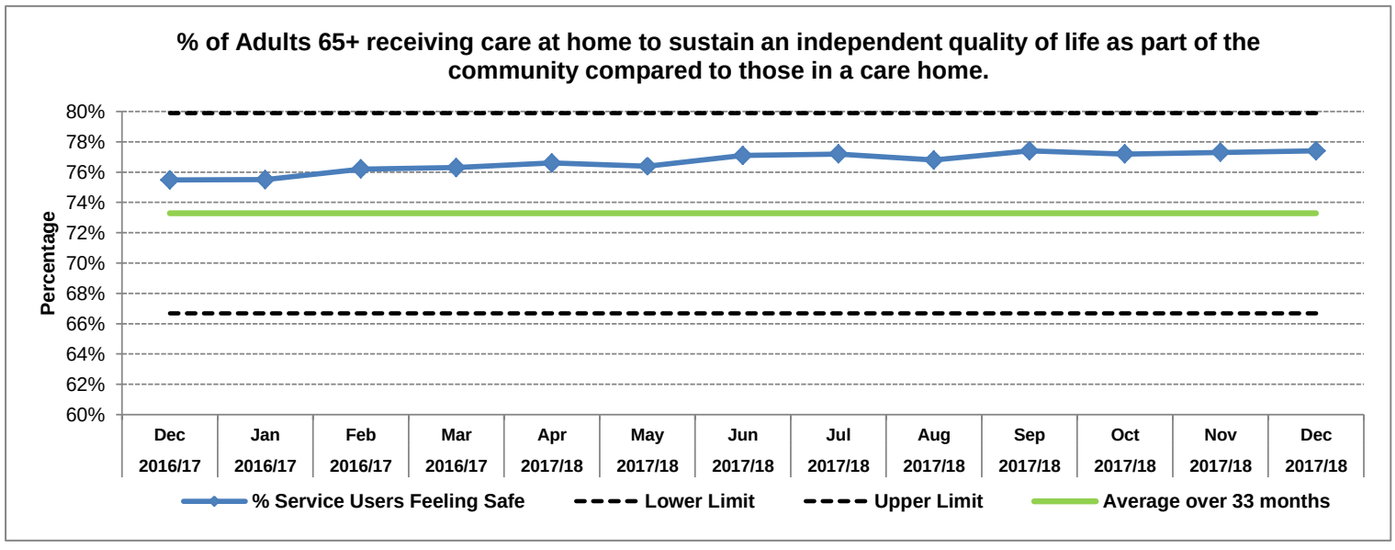
Fluctuating over the past 3 years, this indicator shows on average over 80% of those asked if they feel safe following a Social Care Adult Assessment answered yes.

What are we doing to improve or maintain performance?

This question has been consistently used to measure the outcome of a Social Care Assessment in which the clients needs are assessed and desired outcomes discussed. The methodology of collecting and measuring this outcome has changed over time and these inconsistencies may impact the measure. Further work is underway to find new and more specific outcome measures which will have more stringent collection methodology and provide a wider ranging outcome evaluation.

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

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Number of Adults 65+ within community.	2074	2126	2153	2176	2145	2291	2295	2243	2330	2311	2314	2302
% of Adults 65+ receiving care at home compared to those in a care home.	76%	76%	76%	76%	76%	77%	77%	77%	77%	77%	77%	77%



7. Social Care

How are we performing?

Since June 2016 this measure has been consistently better than the average over the past two years. This indicator shows we are actively supporting a large percentage of adults over 65 within a homely, community setting rather than a residential environment.

However, the fact that this indicator has remained at around 76/77% for the last 9 months could suggest that locally, our capacity within a community setting has been reached and should be addressed.

What are we doing to improve or maintain performance?

Locality based teams monitoring and assessing the needs of our clients ensure a more community based outcome for clients. Further emphasis on locality management of client will further maintain and improve this measure.

The current review of the Strategic Plan will include an examination of what data is available locally in relation to the theme of Social Care. The Integration Performance Group will also look at this indicator in more detail to ascertain the reasons for the apparent "plateauing" of performance.

8. Carers

Part 1 - Carers Centre Assessments - Support for Caring

A Carers Assessment includes a baseline review of several key areas including Support for Caring, Caring Choice, and Caring Stress based on the Quality of Life assessment tool. These areas are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for Carers.

Data Source(s)

1. Carer Centre Assessment responses to - Support for Caring questions
2. Carer Centre Assesment responses to - Caring Choice
3. Carer Centre Assesment responses to - Caring Stress

Part 2 - Carers Assessments offered and completed.

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

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

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

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

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

Data Source(s)

1. Offered assessment data is extracted from the SBC Framework System and is a question asked during a Adult Assessment.

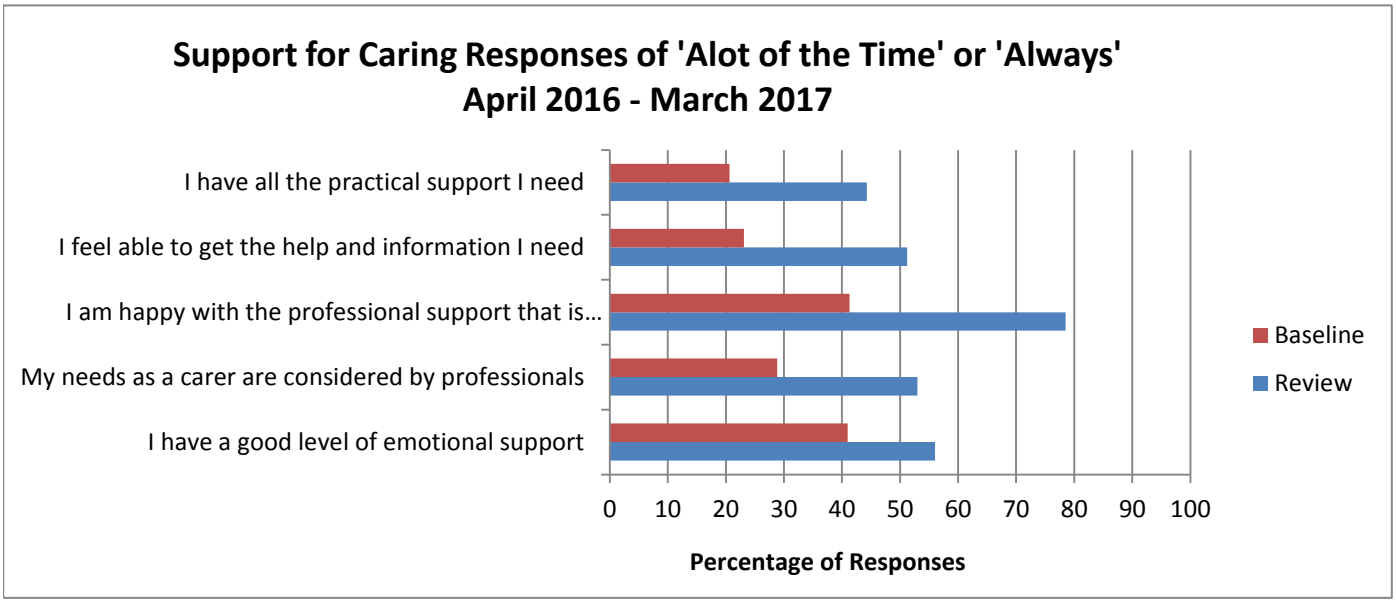
2. The Carer Centre provides a monthly count of all completed assessments for the Scottish Borders.

8. Carers

Carers Centre Assessments - Support for Caring

Due to changes in the Carer Centre Reporting Schedule we are awaiting updated information which will be available for the next Quarterly IJB report. There are therefore no changes to the data, graphs or commentary since the last report, on the next 4 pages.

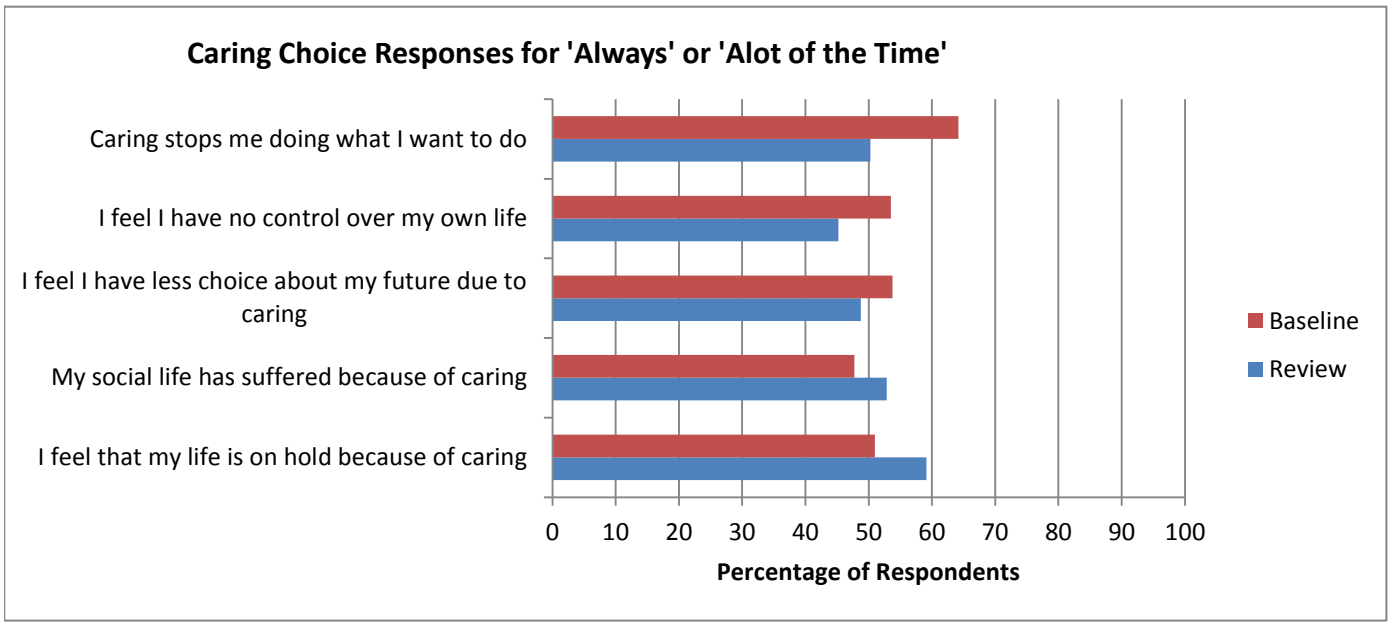
	Apr 2016 - Mar 2017									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot
I have a good level of emotional support	22	19	36	24	**41**	19	19	37	38	**38**
My needs as a carer are considered by professionals	6	24	36	36	**29**	29	24	26	28	**53**
I am happy with the professional support that is provided to me	23	19	31	29	**42**	42	37	28	26	**79**
I feel able to get the help and information I need	14	9	59	18	**23**	23	29	37	29	**52**
I have all the practical support I need	14	7	47	32	**21**	21	24	27	40	**45**



Carers Centre Assessments - Caring Choice

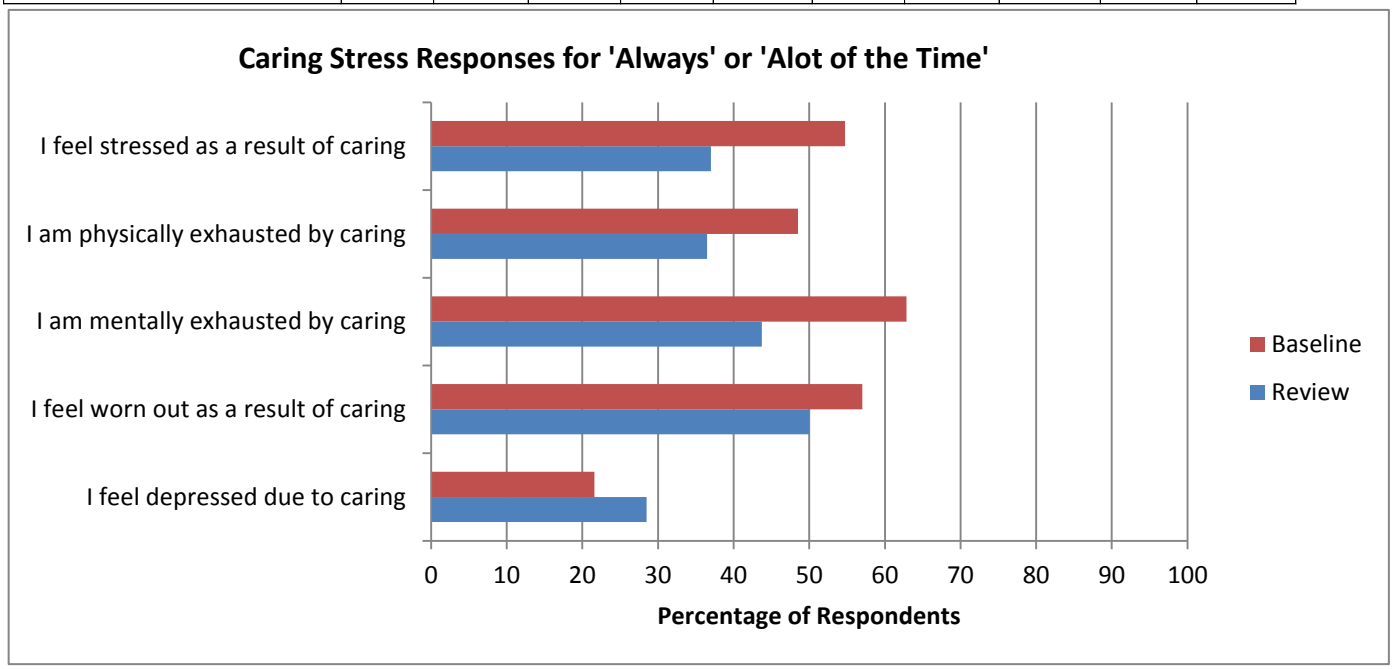
	Apr 2016 - Mar 2017									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot
I feel that my life is on hold because of caring	27	24	21	28	**51**	25	34	24	17	**59**
My social life has suffered because of caring	32	16	25	28	**48**	24	29	29	18	**53**
I feel I have less choice about my future due to caring	38	16	9	38	**54**	17	32	31	20	**49**
I feel I have no control over my own life	25	29	24	23	**54**	19	26	27	28	**45**
Caring stops me doing what I want to do	33	31	17	18	**64**	17	33	31	19	**50**

8. Carers



Carers Centre Assessments - Caring Stress

	Apr 2016 - Mar 2017									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot
I feel depressed due to caring	9	13	56	23	**22**	22	7	11	54	**29**
I feel worn out as a result of caring	45	12	38	6	**57**	16	34	39	12	**50**
I am mentally exhausted by caring	33	30	28	9	**63**	13	31	39	17	**44**
I am physically exhausted by caring	23	26	26	26	**49**	21	16	43	21	**37**
I feel stressed as a result of caring	29	25	40	5	**55**	13	25	48	15	**37**



8. Carers

How are we performing?

A Carers Assessment includes a baseline review of several key areas including Support for Caring, Caring Choice, and Caring Stress based on the Quality of Life assessment tool. These areas are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for carers.

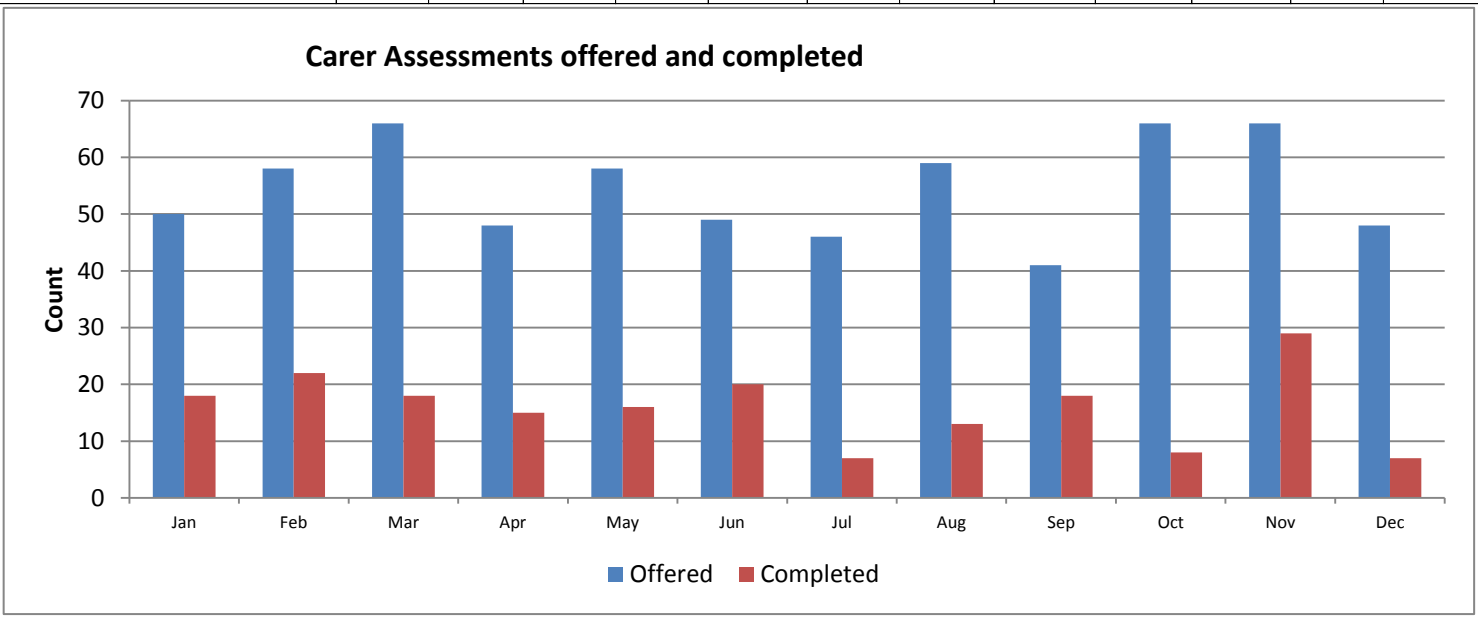
Data for April 2016 - March 2017 shows improvement between the baseline and review surveys in nearly all respects. There are just two exceptions to this – the questions under caring choices around Carers' social lives and feelings as to whether their lives have been put on hold.

What are we doing to improve or maintain performance?

The Carers (Scotland) Act 2016, which will be implemented from 1st April 2018, includes a range of duties on the Partnership and Scottish Borders Council to support Carers' health and wellbeing. These include a duty to provide support to adult and young Carers, based on the Carer's identified needs which meet the local eligibility criteria. The H&SCP is working to implement the requirements of the Act; in collaboration with the Carers Centre we have set up a Project Board and we are developing a structure to ensure Carers and Carer representatives participate in the planning process. It is anticipated that this will lead to an increase in the number of Carers who will seek support and in the range of support made available to Carers. The work of the Borders Carers Centre (commissioned by the Partnership) is a crucial component of the support offered to Carers.

Carers offered and completed assessments.

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Assessments offered during Adult Assessment	**50**	**58**	**66**	**48**	**58**	**49**	**46**	**59**	**41**	**66**	**66**	**48**
Carers Centre	18	22	18	15	16	20	7	13	18	8	29	7



How are we performing?

This information shows that during the last 12 months we offered of average 55 assessment to individuals who were identified as carers during a Social Work Adult Assessment. Within the same month the Carers Centre completed on average 16 assessments per month. Although these measurement are taken within the same month they may not relate to the same individuals, for example a person offered an assessment in January may not actually undergo an assessment until some time later. We expect over a year the total offered will be similar to the total completed.

8. Carers

What are we doing to improve or maintain performance?
Although the offering of an assessment to a carer identified during an adult assessment is not a new action, we have not regular recording or monitored the take up of the offer. With regular monitoring and review of this measure we can identify improvement we can make in the service to ensure uptake of the carers assessment is maintain or improved.

9. Other Relevant Measures

Part 1 - BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

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

NHS Borders has introduced a proactive patient feedback system '2 minutes of your time', which comprises a brief survey of 3 quick questions. Feedback boxes are located within our acute hospital (the BGH), community hospital and mental health units. In addition patient feedback volunteers have been recruited and gather feedback from patients, carers and their relatives within clinical and public areas throughout the hospital. This enables us to look at changing the way in which we do things and ensuring our work has a more person centred approach.

Data Source(s)

NHS Borders

Part 2 - Integrated Care Fund Project Evaluations

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

It was recognised nationally, and evidenced locally, that the Reshaping Care for Older People Fund had worked well in encouraging the NHS , Local Authority, the third and independent sectors to work together to begin to redesign services for the future with a focus on older people.

It has now set more ambitions challenges; to be innovative, taking preventative approaches with the express intent to reduce inequalities across all adult services. This fund (Integrated Care Fund) is allocated to parnerships to help facilitate and drive forward the changes requied, tackling collectively the challenge associated with multiple and chronic conditions for all adults.

Several project have been established to focus on specific preventitive areas and this section summerises the project evaluations as they become available. During this quarter one project evaluation was available. More detail of each project and their evaluation findings are available via their 2 page summaries.

Data Source(s)

1. Community Equipment Service/Border Ability Equipment Service Relocation

Part 3 - Inspection of Older People's Services 2017: Action Plan Update

What is this information and why is it important?

In 2016/2017, the Care inspectorate undertook an inspection of Older People's Services in the Scottish Borders. In response to the inspection findings, an action plan was drafted. The action plan contains 13 high level actions and 60 sub actions, and is overseen by the IJB Leadership Team.

It is important that the issues identified by the Care Inspectorate are addressed in line with the timescales within the action plan (generally by end 2018, some into 2019) in order that we focus our collective resources on provided the best possible services for older people, to improve outcomes and quality of life. As there are both operational and reputational risks associated with delays in progressing the actions, this overview is intended to provide the IJB with assurance and highlight any areas of concern or delay.

Data Source

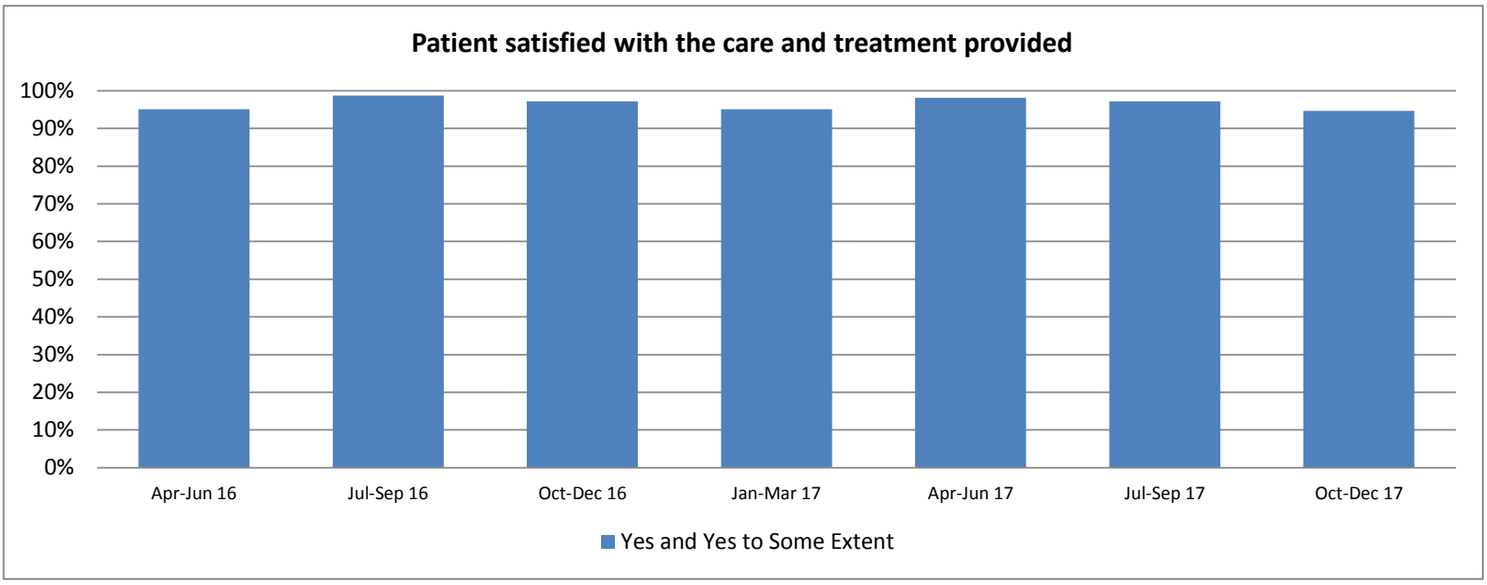
IJB Leadership Team Inspection Action Plan 2017

9. Other Relevant Measures

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

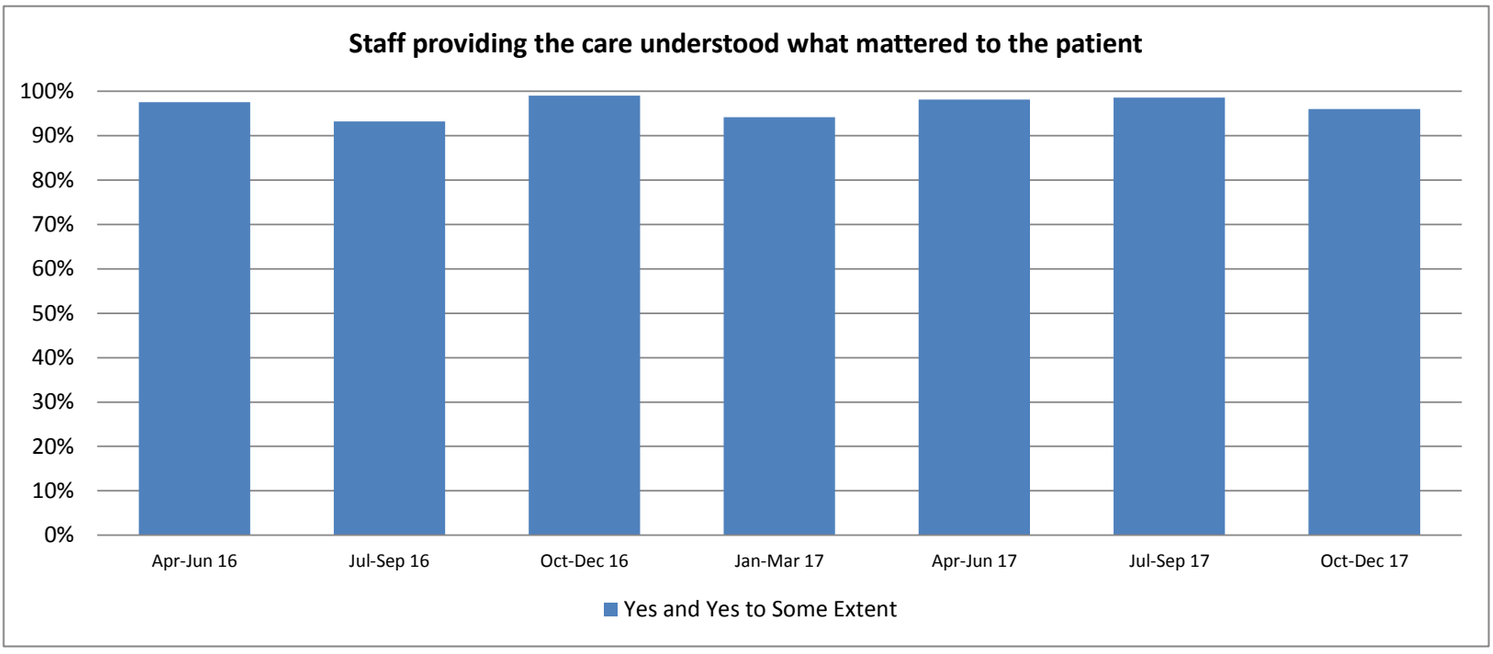
Q1 Was the patient satisfied with the care and treatment provided? Jul-Dec 2017 added

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Patients feeling satisfied or yes to some extent	232	160	105	116	105	206	141	
% feeling satisfied or yes to some extent	95.1%	98.8%	97.2%	95.1%	98.1%	97.2%	94.6%	



Q2 Did the staff providing the care understand what mattered to the patient? Jul-Dec 2017 added

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Staff providing the care understood what mattered to the patient, or yes to some extent	238	151	106	113	105	213	144	
% understood what mattered or yes to some extent	97.5%	93.2%	99.1%	94.2%	98.1%	98.6%	96.0%	



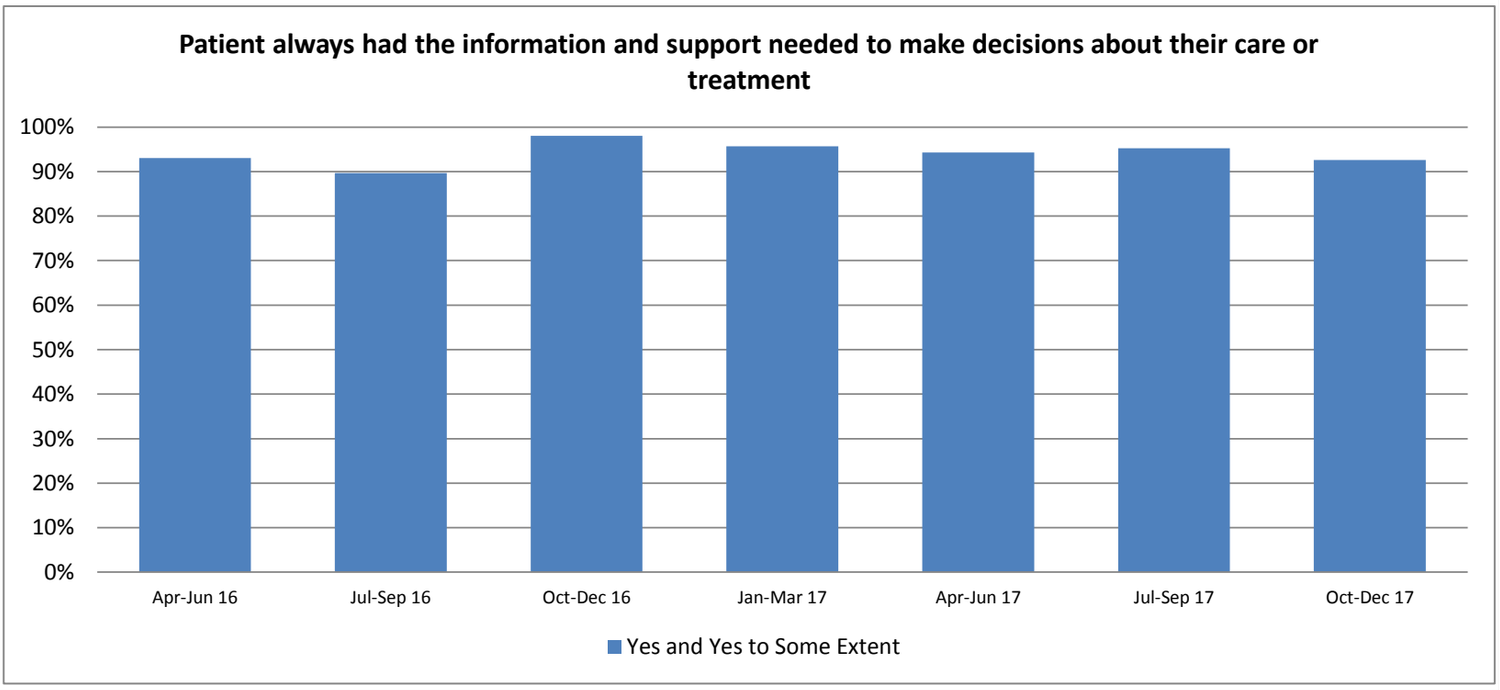
9. Other Relevant Measures

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

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

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Patients always had the information and support needed to make decisions about their care or treatment, or yes to some extent	226	147	101	111	99	113	105	
% always had information or support, or yes to some extent	93.0%	89.6%	98.1%	95.7%	94.3%	95.2%	92.6%	

Jul-Dec 2017 added



How are we performing?

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

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

What are we doing to improve or maintain performance?

The feedback collected is reported to our clinical and public areas in a timely manner. Within our clinical areas this is displayed on their quality and safety information boards and in public areas this is visible in a 'You said, We did' report. This enables the public and staff to see what changes have been made as a result of feedback. This feedback is reported across the organisation and to the Board.

9. Other Relevant Measures

Integrated Care Fund Projects

Learning Disabilities Transition

What is this project and why is important?

This project focuses upon young people who have a diagnosed learning disability between the ages of 14 and 18 who are moving towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education. A Transition Development Officer was commissioned for 12 months from October 2016 to scope current pathways and develop a more consistent and coordinated approach.

Key Achievements

In year 1 of the project a first draft of the new pathway was developed and testing of this will take place in the current year. An information pack for families and staff has been produced. A named person has been identified for each family through the Local Area Coordinators and a training programme for this developed. More detailed evaluation will be available once the new pathway has been fully adopted.

Matching Unit

What is this project and why is important?

The Matching Unit is an administrative team created to match a home care service to the assessed needs of the client. This was established in Hawick in April 2017 and rolled out to all locality teams and START by October 2017. Prior to this service Care Managers spent a significant amount of time sourcing care individually.

Key Achievements

Care Managers were surveyed before and after the introduction of the service. The time spent securing care at home by Care Managers dropped from 20% to 9% of the working week which exceeded the target set (half the time spent).
Staff satisfaction with the new process is 90%, compared with 6% for the previous process for securing home care.
An initial survey of Care Providers suggested they would welcome the changes to the home care process.

Evidence / Case Study

John is 65 years old and lives with his wife Mary, he has a diagnosis of secondary progressive Multiple Sclerosis and mobilises with a zimmer frame, he has poor mobility and requires supervision as he is a high falls risk. He has had several falls in recent months in which he has been unable to get up from the floor.

John feels safe when Mary is at home however he does not like it when she is out, often calling her or waiting near the front door. John was diagnosed with dementia in January 2017.

Mary suffers from back pain and she is John's sole carer, she supports him with all personal care and transfers. John also gets up to use the bathroom several times a night with support from Mary. Mary acknowledges that her caring role has increased since John was diagnosed with dementia and that she finds some of the care tasks very tiring. She admits that she is suffering from considerable carers stress however she is also reluctant to accept any help at home.

The allocated OT care manager (Claire) had identified that both John and Mary were at risk while undertaking some of the care tasks and should Mary not be able to continue with her caring role then John would require a large package of care to support him at home.

Claire had identified a support plan for John but had not sent to the Matching Unit as neither Mary or John were agreeable to accepting help and felt they needed time to consider this.

John was admitted to hospital after a fall at home.

9. Other Relevant Measures

Claire received a call from the hospital ward to let her know that Mary was very tearful and anxious and very distressed that John was remaining in hospital. She had decided that she was taking him home against all medical advice. The nursing staff were very concerned about Marys ability to manage the care for her husband at home and contacted Claire.

What Happened:

As Claire had already identified a support package which was not yet put in place she did the following:

- Made a telephone call to the Matching Unit to advise of the situation and of the urgency of sourcing the package of care as soon as possible.
- Sent the support plan to her line manager for authorisation on Mosaic.

The Matching Unit were able to access the support plan on Mosaic and called round the providers in the area to source the care.

• Claire received a call from the Matching Unit 2 hrs later to advise her that the care package was starting that evening.

The Matching Unit carried out all other tasks to put this care in place. Claire's view is that if the care provision had taken longer given Marys stress levels it is unlikely that she would not have accepted the care.

What Would Have Happened Without The Matching Unit:

- Call round all four providers in the area to try to source the care
- Populate the support plan with: the provider, time, complete the budget workings and the costs.
- Complete a home care alert to send this to admin.
- Print and post/email the paperwork to the provider.
- Complete a case note
- Send herself an Initiation/Variation form
- Complete initiation/variation form
- Send Initiation/Variation form to finance.

Claire's feedback on this service:

'after the scenario this morning where a client's wife took her husband home from hospital against medical and nursing advice and the care plan authorised a few weeks ago was transferred to the Matching Unit at about 12.30pm and they have just called and care can start tonight……how efficient is that and no stress to me!' (Claire - OT care manager)

9. Other Relevant Measures

Inspection of Older People's Services 2017: Action Plan Update

How are we performing?

For each of the 13 high level actions, a set of sub-actions has been established, with responsible owners and expected completions dates. Progress is being made across all 13 high level actions. Of the 60 sub actions:

- 25 (42%) are now completed
- 33 (55%) are in progress and expected to meet timescales (one exception below)
- 2 (3%) are now overdue (details below)

In progress- exception

High level Action	Sub Action	Comments
9. Develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved	Develop and implement a detailed financial recovery plan to ensure that a sustainable financial position is achieved and agreed by the Integration Joint Board. (Expected completion date 31/03/2018)	On 2nd April EMT will consider a report on the 2018/19 IJB budget, including identification of savings, with a view to reporting this to IJB on 23rd April. Timescales within the action plan should then be revised accordingly

Overdue Action

High level Action	Sub Action	Comments
3. Further develop and implement the joint approach to early intervention and prevention (EI&P) services so there is a range of services working 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 (Expected completion date 28/02/18)	There has been a delay in collating information due to staff absence and therefore to arranging the review event. Timescale to be amended. Session outputs will be used as part of future early intervention and prevention work with partners.
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 should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.	Develop a more robust hospital to home process (Expected completion date 31/01/18)	After considering various approaches, a simple "process and pathways paper" is being developed, and it is expected that this will be complete in the next 2 months (by end May 2018)

What are we doing to improve or maintain performance?

Relevant service managers and owners of the actions continue to prioritise the actions required to address the Care Inspectorate's areas of concern and the IJB Leadership Team, which meets weekly, will continue to monitor the detailed action plan.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: Monday 23rd April 2018

Report by:	Robert McCulloch-Graham, Chief Officer for Integration
Contact:	Jane Robertson, Strategic Planning and Development Manager
Telephone:	01835 825080

EQUALITY MAINSTREAMING PROGRESS REPORT

Purpose of Report:	To provide the Integration Joint Board (IJB) with an update on progress of the Health and Social Care Partnership's approach to mainstreaming equality.

Recommendations:	Health & Social Care Integration Joint Board is asked to: a) Note the Equality Mainstream Report; b) Approve the draft Progress Report for publication.

Personnel:	*n/a*

Carers:	*n/a*

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

Financial:	*n/a*

Legal:	Equality Outcomes Progress report requires to be published by end of April 2018 as per the Equality Act (2010) and (Specific Duties)(Scotland) Regulations 2012

Risk Implications:	*n/a*

Background

1.1 All public bodies across Scotland are required to comply with the three aims of the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012 which are detailed below:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act
2. Advance equality of opportunity between persons who share a relevant characteristic and persons who do not
3. Foster good relations between people who share a protected characteristic and those who do not

1.2 In April 2015 the Scottish Government added Integration Joint Boards (IJB) to Schedule 19 of the Equality Act 2010 and to The Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015.

The amendment regulations required IJB's to publish the following information by the 30 April 2016:

- A report on mainstreaming the equality duty;
- A set of equality outcomes.

1.3 The Scottish Borders Integration Joint Board (IJB) are fully committed to the values and ethos placed upon them by the Equality Act 2010 and have identified equality outcomes for the period 2016-2020 in an Equality Mainstreaming Report (Appendix 1).

1.4 The Scottish Borders IJB equality outcomes are:

- experience fair access to services that mitigate the impact of any protected characteristics under the Equality Act (2010) **Equality Outcome 1**

- be supported to access education, training and employment **Equality Outcome 2**

- have improved physical and mental wellbeing, experience fewer health inequalities and will be able to live independently **Equality Outcome 3**

- experience a workforce that feel valued, are skilled, competent, and reflect the diversity of the populace across the Scottish Borders **Equality Outcome 4**

- feel safe, be safe, healthy, achieving, respected and included **Equality Outcome 5**

- experience services that reflect the needs of the communities, address health inequalities, and which shift the balance of these services towards early intervention and prevention **Equality Outcome 6**

- be confident that the information they provide, particularly in relation to the protected characteristics, will be used to make improvements to services and the way they are planned and delivered **Equality Outcome 7**

1.5 The equality outcomes are designed to help the Partnership achieve its vision of providing the best possible health and wellbeing for our communities set out in the Strategic Plan as well as meet its duty to eliminate discrimination and harassment, promote equality of opportunity and foster good relations between groups.

Progress Report

2.1 As stated the legislation required that the IJB published a set of equality outcomes and mainstreaming report by 30 April 2016 (Appendix 1). Thereafter, at intervals of not more than 2 years a progress report on its approach to mainstreaming equality is required.

2.2 In line with this requirement work has been underway in the Scottish Borders to develop a progress report for publication by 30 April 2018, a draft of which can be seen in Appendix 2.

2.3 The progress report covers the period 2016-18 and outlines statistical information relating to equality and diversity in the Scottish Borders, the approach the Partnership has taken to mainstreaming equality across health and social care and the benefits of doing so. The report also demonstrates a number of examples of the approach taken to mainstream equality within health and social care against the equality outcomes.

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Scottish Borders
Health and Social Care
PARTNERSHIP

Appendix 1

HEALTH AND SOCIAL CARE INTEGRATION PARTNERSHIP MAINSTREAMING REPORT AND EQUALITY OUTCOMES 2016/2020

INTRODUCTION

The Scottish Borders Integration Joint Board (IJB) are fully committed to the values and ethos placed upon them by the Equality Act 2010. The Scottish Borders Health and Social Care Partnership (the Partnership) comprises of Scottish Borders Council and NHS Borders along with third and independent sector organisations who aim to work together to deliver joint up services that ultimately will be in the best interest of staff, service users, patients, families and carers. The Partnership's Equality Outcomes are directly tied into that overarching goal.

The Partnership published its strategic plan for 2016-19 'Changing Health & Social Care For You' along with supporting documents in mid-April 2016. The plan was informed by three rounds of consultations and provides an overview of why integration of health and social care services is necessary and what can be expected to be the results of integration in the Scottish Borders. The plan is a high level working document which is at the end of its lifespan and is currently being revised. Based on on-going assessment of need, the document will be reviewed at least every three years, and this process will always involve consultation with people living in the Borders. This process will also include cross referencing and benchmarking against the Partnership's equality outcomes.

This Mainstreaming Report contains our equality outcomes for the period 2016-2020. Our equality outcomes are designed to help us achieve our vision of providing the best possible health and wellbeing for our communities and meet our general duty to eliminate discrimination and harassment, promote equality of opportunity and foster good relations between groups.

LEGISLATIVE CONTEXT

All public bodies across Scotland are required to comply with the three aims of the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012.

The Equality Act (2010) is the law which bans unfair treatment and helps achieve equal opportunities in the workplace and in wider society. This single Act replaces previous anti-discrimination laws to make the legislation simpler, to remove inconsistencies and to provide specific protection to people who are discriminated against on the basis of a defined set of nine “protected characteristics”. The nine protected characteristics are:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

These characteristics cannot be used as a reason to treat people unfairly. Every person has one or more of the protected characteristics, so the Act protects everyone against unfair treatment.

The three aims of the Act’s Public Sector General Equality Duty are as follows:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act
2. Advance equality of opportunity between persons who share a relevant characteristic and persons who do not
3. Foster good relations between people who share a protected characteristic and those who do not

The Public Sector General Equality Duty replaces the previous Race Equality Duty (2002), the Disability Equality Duty (2006) and the Gender Equality Duty (2007).

The purpose of the general Equality Duty is to ensure that all public bodies, including IJBs, mainstream equality into their day to day business by proactively advancing equality, encouraging good community relations and addressing discrimination. The current duty requires equality to be considered in relation to key functions including the development of internal and external policies, decision making processes, procurement, service delivery and improving outcomes for patients/service users.

In Scotland, an additional set of specific duties were created by secondary legislation: the Equality Act (2010) (Specific Duties) (Scotland) Regulations 2012, which came into force in May 2012.

The specific duties listed below are intended to support public bodies, in their delivery of the General Equality Duty:

- Report progress on mainstreaming the public sector equality duty
- Publish equality outcomes and report progress
- Assess and review policies and practices (impact assessment)
- Consider award criteria and conditions in relation to public procurement
- Publish in a manner that is accessible

In April 2015 the Scottish Government added IJBs to Schedule 19 of the Equality Act 2010 and to The Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015.

The amendment regulations require IJBs to publish the following information by the 30 April 2016:

- A report on mainstreaming the equality duty; and
- A set of equality outcomes

The legislation required that the set of equality outcomes and mainstreaming report be published no later than 30 April 2016. Thereafter, at intervals of not more than 2 years a progress report on its approach to mainstreaming equality and at intervals of not more than 4 years for progress against its equality outcomes.

OVERARCHING OPERATIONAL CONTEXT

The IJB became a legal entity April 2016. As a consequence, the IJB is responsible for planning and commissioning services, while the Partnership is responsible for delivering those services and improving outcomes for the people of the Borders.

Heath and Social Care Partnerships must demonstrate that the services they are responsible for are delivering against the National Health and Wellbeing Outcomes identified by the Scottish Government:

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

Acknowledging that there are regional differences, the Scottish Borders Health and Social Care Partnership identified local objectives, all of which align to the National Health and Wellbeing Outcomes. There are currently 9 local objectives however this will be subject to change during the review of the Strategic Plan. The 9 current local objectives are:

1. Make services more accessible and develop our communities (Health & Wellbeing Outcomes (HWO) 1, 2, 3, 4, 6 and 8)
2. Improve prevention and early intervention (HWO 1, 2, 4, 5 and 8)
3. Reduce avoidable admissions to hospital (HWO 1, 2, and 9)
4. Provide care close to home (HWO 1, 2, 3, 4, 5, 6 and 9)
5. Deliver services within an integrated care model (HWO 5, 8 and 9)
6. Seek to enable people to have more choice and control (HWO 1, 2, 3, 4, 5, 6 and 7)
7. Further optimise efficiency and effectiveness (HWO 8 and 9)
8. Seek to reduce health inequalities (HWO 1, 2, 3, 5, 6 and 7)
9. Improve support for Carers to keep them healthy and able to continue in their caring role (HWO 1, 2, 3, 4, 5, 6 and 7)

Each Health and Social Care Partnership is required to publicly report on its performance, inclusive of 23 "Core Suite Integration Indicators" set by the Scottish Government in 2015. These indicators (where available – some are under development nationally) were included in our Annual Performance Report for 2016/17 (in the main body of the report and in Appendix C). They will also be reported on in our Annual Performance Report for 2017/18 (due to be published in July 2018).

The Partnership's priorities have continued to evolve since 2016, as have national and local influences on the indicators included in performance reporting. In 2016/17, Integration Joint Board members selected 7 of the 23 National Indicators as of particular interest during that year and in the table below is a summary of performance against that selected set of 7. In addition, the table shows if indicators related to these 7 are included in quarterly performance reports to the Integrated Joint Board.

Table showing performance against 7 Core Suite indicators selected by the IJB in 2016/17 as priorities (data shown are the latest available at early March 2018)

National Core Suite Indicator Description	Scottish Borders	Scotland	Exact measure included in quarterly integration performance reports?	If no, a related measure included in quarterly integration reports?
Percentage of staff who say they would recommend their organisation as a good place to work Source: *	71% (NHS Borders only, 2016 figure)	74% (2017 figure)	No	No
Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals Source: ISD Scotland 2016/17	13,135	12,294	No	Yes
Readmission to hospital within 28 days – rate per 1,000 discharges. Source: ISD Scotland 2016/17	101	100	No	Yes
Emergency hospital admissions due to falls - rate per 1,000 population aged 65+ Source: ISD Scotland 2016/17	21	22	Yes	
Percentage of adults with intensive care needs receiving care at home Source: Scottish Government Health and Social Care Statistic 2015/16	64%	62%	No	Yes
Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) Source: ISD Scotland Delayed Discharge Census 2016/17	647	842	Yes	
Percentage of people who are discharged from hospital within 72 hours of being ready	Not available nationally	Not available nationally	No	Yes

***** Sources: Scottish Borders figure from NHS Borders iMatter report December 2016; Scotland figure from Health and social care staff experience national report 2017, Scottish Government (data from 22 NHS Boards plus 23 Health and Social Care Partnerships). Last direct like-for-like comparison was from NHS Scotland staff survey 2015 (NHS Borders 57%, versus NHS Scotland 59%).

BENEFITS OF EQUALITY MAINSTREAMING

Mainstreaming equality means integrating equality and diversity into our day-to-day working. We aim to do this by taking equality into account as part of the process of planning, commissioning and delivering health and social care services for the people in the Scottish Borders. Ongoing stakeholder management, engagement and collaboration are critical to the delivery of equality mainstreaming, activities that the IJB and the Partnership are committed to engage in to provide the best quality service and deliver on the goals of integration.

Mainstreaming equality has a number of benefits including:

- It helps to ensure that services are fit for purpose and meet the needs of our community
- It helps to attract and retain a productive workforce, rich in diverse skills and talents
- It helps to work toward social inclusion and allows us to support the staff, service areas and the communities to improve the lives of everyone who lives in the Borders
- It helps to continually improve and better perform through growing knowledge and understanding.

HOW TO MAINSTREAM EQUALITY: OUR EQUALITY OUTCOMES

An equality outcome is the desired aim to further one or more of the general equality duties; eliminate discrimination, advance equality of opportunity and foster good relations. Outcomes are changes that result for individuals, communities, organisations or society as a consequence of action taken. Outcomes include short-term benefits such as changes in awareness, knowledge, skills and attitudes, and long-term benefits such as changes in behaviours, decision-making, or social or environmental conditions.

Both NHS Borders and Scottish Borders Council have published existing equality outcomes and they are outlined in **Appendix 1**. In mapping these outcomes against the Strategic Plan the following set of outcomes for the Health and Social Care Partnership are as follows:-

Users of health and social care services, their families and carers will:

- experience fair access to services that mitigate the impact of any protected characteristics under the Equality Act (2010) **Equality Outcome 1**

- be supported to access education, training and employment **Equality Outcome 2**

- have improved physical and mental wellbeing, experience fewer health inequalities and will be able to live independently **Equality Outcome 3**

- experience a workforce that feel valued, are skilled, competent, and reflect the diversity of the populace across the Scottish Borders **Equality Outcome 4**

- feel safe, be safe, healthy, achieving, respected and included **Equality Outcome 5**

- experience services that reflect the needs of the communities, address health inequalities, and which shift the balance of these services towards early intervention and prevention **Equality Outcome 6**

- be confident that the information they provide, particularly in relation to the protected characteristics, will be used to make improvements to services and the way they are planned and delivered **Equality Outcome 7**

Each of the outcomes will contribute towards the national health and wellbeing outcomes and local objectives outlined in our Strategic Plan.

Appendix 1

NHS Borders Equality Outcomes 2017-2021

In setting out Equality Outcomes we have considered the wider determinants of health and social inequalities including poverty, education, housing and local community. We have taken a Community Planning Partnership approach, working with Scottish Borders Council, local Police representatives, local Fire and Rescue Services representatives and Borders College. We have agreed to align our equality outcomes with the Community Planning Partnership Equality Outcomes, with our own responsibilities and actions within the outcomes to take forward.

Outcome 1: We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected and our workforce reflects our community

Outcome 2: Our services meet the needs of and are accessible to all members of our community

Outcome 3: Our staff treat all service users, clients and colleagues with dignity and respect

Outcome 4: We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process

Outcome 5: We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced

Outcome 6: We work in partnership with other agencies and stakeholders to ensure our citizens have the freedom to make their own choices and are able to lead independent, healthy lives as responsible citizens

Outcome 7: We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from under represented groups is improved

Scottish Borders Council Equality Outcomes 2017–2021

Our outcomes are designed to help us achieve our vision and meet our general duty to eliminate discrimination and harassment; promote equality of opportunity and promote good relations.

Outcome 1: We are seen as an inclusive equal opportunities employer where all staff feel valued and respected and our workforce reflects our community.

Outcome 2: Our services meet the needs of, and are accessible to; all members of our community and our staff treat all services users, clients and colleagues with dignity and respect.

Outcome 3: Everyone has the opportunity to participate in public life and the democratic process.

Outcome 4: We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty.

Outcome 5: Our citizens have the freedom to make their own choices and are able to lead independent, healthy lives as responsible citizens

Outcome 6: The difference in rates of employment between the general population and those from under-represented groups is improved.

Outcome 7: The difference in educational attainment between those who are from an equality group and those who are not is improved.

Outcome 8: We have appropriate accommodation which meets the needs of our diverse community.

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Scottish Borders
Health and Social Care
PARTNERSHIP

Appendix 2

Health & Social Care Integration Partnership
Mainstreaming Report and Equality Outcomes 2016/2020

Progress Report covering the period 2016-2018

Forward from Chair of the Partnership

1 The Equality Duty

2 Making Equality our Business

- Equality & Diversity in the Scottish Borders – Statistics
- Building on our previous work
- Our approach

3 Benefits of Equality Mainstreaming

4 Mainstreaming in Practice

5 Next Steps

Foreward from the Chief Officer of the Partnership

This document presents the Scottish Borders Health and Social Care Partnership's Equality Mainstreaming update report for the period 2016-1018.

The Partnership is fully committed to the values and ethos placed upon them by the Equality Act 2010 and aims to work together to deliver joined up services that are in the best interest of staff, service users, patients, families and carers. The Partnership's Equality Outcomes are directly tied into that overarching goal.

We first published our Equality Mainstreaming Report in April 2016 which set out the approach the Health and Social Care Partnership would take to meeting the Public Sector Equality Duty.

This report provides an update on the progress we have made alongside the next steps we will take to embed the Equality Duty within all our services.

Robert McCulloch Graham
Chief Officer for Integration
Scottish Borders Health and Social Care Partnership

The Equality Duty

1.1 All public bodies across Scotland are required to comply with the three aims of the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012. The three aims of the Act's Public Sector General Equality Duty are as follows:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act
2. Advance equality of opportunity between persons who share a relevant characteristic and persons who do not
3. Foster good relations between people who share a protected characteristic and those who do not

1.2 The purpose of the general Equality Duty is to ensure that all public bodies, including IJBs, mainstream equality into their day to day business by proactively advancing equality, encouraging good community relations and addressing discrimination. The current duty requires equality to be considered in relation to key functions including the development of internal and external policies, decision making processes, procurement, service delivery and improving outcomes for patients/service users.

1.3 The specific duties listed below are intended to support public bodies, in their delivery of the General Equality Duty:

- Report progress on mainstreaming the public sector equality duty
- Publish equality outcomes and report progress
- Assess and review policies and practices (impact assessment)
- Consider award criteria and conditions in relation to public procurement
- Publish in a manner that is accessible

1.4 In April 2015 the Scottish Government added IJBs to Schedule 19 of the Equality Act 2010 and to The Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015.

1.5 The amendment regulations require IJBs to publish the following information by the 30 April 2016:

- A report on mainstreaming the equality duty; and
- A set of equality outcomes

1.6 The legislation required that the set of equality outcomes and mainstreaming report be published no later than 30 April 2016. Thereafter, at intervals of not more than 2 years a progress report on its approach to mainstreaming equality and at intervals of not more than 4 years for progress against its equality outcomes.

1.7 This is our progress report 2016-2018.

Making Equality our Business

2.1 Equality & Diversity in the Scottish Borders - Statistics

2016 population of Scottish Borders - 114,530 (National Records of Scotland Vital Events)
1,005 **births** in the Scottish Borders (8.8 per 1,000 compared to 10.1 for Scotland)
1,277 **deaths** in the Scottish Borders (11.1 per 1,000 compared to 10.5 for Scotland)

Age Groups 2016 (National Records of Scotland)
16.6% of the Scottish Borders population is under the age of 15 (16.9% Scotland)
59.6% of the Scottish Borders population aged 16 to 64 (64.6% Scotland)
23.8% of the Scottish Borders Population is aged 65 or older (18.5% Scotland)

Gender	Male	Female
Age 0 to 15	50.7%	49.3%
Aged 16 to 64	48.8%	51.2%
65+	46.1%	53.9%
Total	48.5%	51.5%

Life Expectancy 2014-2016 (National Records of Scotland)

	Scottish Borders		Scotland	
	Male	Female	Male	Female
At Birth	78.6	82.6	77.1	81.1
At Aged 65	18.2	20.4	17.4	19.7

Workplace Earnings in the Scottish Borders (Office of National Statistics ASHE)
Gross Weekly Pay 2017
Male Full-Time Workers **= £492.2** (Scotland = £579.9)
Female Full-Time Workers = **£402.0** (Scotland = £498.3)

Disability (2011 Census)
30% of the Scottish Borders population have a long term health condition (deaf or partially hearing impaired; blind or partially vision impaired; learning disability; learning difficulty; developmental disorder; physical disability; mental health condition; or Other Long-term health condition). (Scotland = 30%)

Ethnicity (Scottish Survey Core Questions 2015)

Ethnicity	Scottish Borders	Scotland
White: Scottish	72.8%	78.4%
White: Other British	24.0%	12.4%
White: Polish	Not disclosed	1.7%
Asian	Not disclosed	2.3%
Other Ethnic Group	Not disclosed	1.4%

LGBT (Scottish Borders Council – People Dept.)
67% of young people in the Borders said they know someone who is either: Lesbian, Gay, Bisexual or Transgender.

2.6% of adults identify as "LGB & Other" (Lesbian, Gay, Bisexual or Other) (Scotland = 1.6%) (Scottish Survey Core Questions 2014)

Religion (Scottish Survey Core Questions 2015)

Religion	Scottish Borders	Scotland
None	50.1%	46.6%
Church of Scotland	32.0%	27.5%
Roman Catholic	7.0%	14.5%
Other Christian	10.3%	7.3%
Other Religion	Under 1%	3.3%

Deprivation
Low Income Families (HMRC August 2014)
14.0% of Scottish Borders live in low income households (Scotland =18.4%)
(Scottish Government Small Area Income Estimates - Income Data in Excel (2017)
16% of the households in the Scottish Borders have income under 60% of median gross income (Scotland =15%)
£633 mean gross household income per week in the Scottish Borders (Scotland = £668)

Low Income Families (continued**)**
Scottish Index of Multiple Deprivation 2016 - indicators
10% incomed deprived (12% in Scotland)
9% employment deprived (11% in Scotland)

Fuel Poverty (Scottish House Conditions Survey 2014-16)

34% of households in the Scottish Borders are in Fuel Poverty (Scotland 31%).
13% are in extreme fuel poverty (Scotland 8%)

Languages (Census 2011**)**

There are 38 spoken Languages in the Borders

2.2 Building on Our Previous Work

For a number of years both Scottish Borders Council and NHS Borders along with its remaining partners have placed a priority on meeting our equality duties through their work, policies and attitude. As a Partnership we look to continually improve and extend this through our joint mainstreaming approach to ensure that not only is the Partnership fully compliant with current legislation but that it meets the needs of its customers and clients together with the diverse communities of the Scottish Borders.

2.3 Our Approach

Scottish Borders Health and Social Care Partnership published its first Equality Mainstreaming Report in April 2016. The report sets out the approach we are taking to mainstreaming the Equality Duty and outlined our Equality Outcomes. The report also included a key recommendation to review the equality outcomes by April 2017 to ensure they are relevant and fit for purpose.

Both NHS Borders and Scottish Borders Council have published existing equality outcomes and they are outlined in **Appendix 1**. These outcomes have been mapped against the Strategic Plan.

Whilst the legislation has identified nine protected characteristics when delivering our services we also consider carers and health and equalities.

The review of the outcomes identified that they are still relevant and that we should continue towards achieving these outcomes.

In addition the review identified that in order to help us further mainstream equality in our practices the Partnership should ensure that:

- Equality duty performance indicators are established.
- We are aware of the need to implement Corporate Equality & Diversity Policies fairly and consistently.
- The Equality Impact Assessment (EIA) process is used when carrying out core business functions.
- Officers trained in the current EIA process and requirements.

Work is still ongoing to take these actions forward with particular emphasis on implementing the Equality Impact Assessment process.

Benefits of Equality Mainstreaming

3.1 Mainstreaming equality means integrating equality and diversity into our day-to-day working. We aim to do this by taking equality into account as part of the process of planning, commissioning and delivering health and social care services for the people in the Scottish Borders. Ongoing stakeholder management, engagement and collaboration are critical to the delivery of equality mainstreaming, activities that the IJB and the Partnership are committed to engage in to provide the best quality service and deliver on the goals of integration.

3.2 Mainstreaming equality has a number of benefits including:

- It helps to ensure that services are fit for purpose and meet the needs of our community
- It helps to attract and retain a productive workforce, rich in diverse skills and talents
- It helps to work toward social inclusion and allows us to support the staff, service areas and the communities to improve the lives of everyone who lives in the Borders
- It helps to continually improve and better perform through growing knowledge and understanding.

Mainstreaming in Practice

4.1 We are required to provide an update on our approach to mainstreaming equality over the last two years. To help us demonstrate our progress we are reporting against our equality outcomes with a number of examples as listed below.

4.1.1 **Equality Outcome 1**
Experience fair access to services that mitigate the impact of any protected characteristics under the Equality Act 2010.

- The rurality of the Scottish Borders presents challenges in terms of access to services. As a more flexible approach to accessing services, locally based Community Led Support 'What Matters' Hubs are currently being rolled out across the Scottish Borders. While individual Hubs are at different stages of development, they all follow the same progression which sees them start as appointment only from social work and customer service referral before moving on to offer drop in sessions. Extension of the service to more outlying areas within the Locality will then follow.
- The Hubs will offer increased opportunities for all Scottish Borders residents to access information and advice. This includes unpaid Carers who can access advice on support available in their area at their local Hub.
- An evaluation of the service is soon to be undertaken and it is envisaged that the take up of the service has proved to be successful with plans to extend to more rural communities over the course of the next year.

4.1.2 **Equality Outcome 2**
Be supported to access education, training and employment.

Health and Social Care Partnership is holding a consultation on the Scottish Borders Physical Disability Strategy, A Fairer Borders for People with a Physical Disability or Long-Term Condition and their Carers. The draft strategy has equality at its core the with a key message: by enabling and supporting people with a Physical Disability in all aspects of life, especially co production of services, the Scottish Borders will be become a fairer place to live Our six ambitions are :

Ambition 1 Support services in the Borders are designed and delivered to support all people with a disability to live the life they choose
Ambition 2 People with a physical disability are able to participate fully in education and paid employment

Ambition 3 People with a physical disability can live life to the full in homes and communities across the Borders
Ambition 4 Our system is equipped to meet the needs of people with a disability in a fair and inclusive way
Ambition 5 People with a physical disability participate as active citizens in all aspects of daily and public life in the Borders
Ambition 6 Informal carers of people with physical disabilities and long term conditions are acknowledged and supported to recognize their rights as a carer

The consultation is being held to give people the opportunity to provide additional feedback and will run from 3rd April to 2nd July 2018. A copy of the strategy and an online questionnaire are available on the Council's website at: www.scotborders.gov.uk/physicaldisability

4.1.3 **Equality Outcome 3**
Have improved physical and mental wellbeing, experience fewer health inequalities and will be able to live independently

In the last two years the number of people using self-directed support has increased from 423 to 1649 (February 16 - February 18). This includes 340 people who currently manage their support through a direct payment. SDS promotes choice and flexible, individualised support.

The Borders Community Capacity Building Project (BCCBP) project has successfully reinvented how local health and social care activities are delivered in communities and delivered a far more efficient approach to addressing social isolation, maintaining a healthy lifestyle through activity and providing community led alternatives to healthy and nutritious meals; the project has delivered a social return on investment of 1:10. This has been delivered through mediums that older people are happy to engage with and deliver themselves informally (soup club in the local community centre) or through formally constituted groups (gentle exercise class). The project continues to provide additional routes for preventative support and information to promote good health and wellbeing and to keep people safe.

The qualitative findings are also impressive; 45 older people involved in BCCBT groups were either interviewed individually or involved in focus groups. They were involved across most of the BCCBT 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

4.1.4 **Equality Outcome 4**

Experience a workforce that feel values, are skilled, competent and reflect the diversity of the populace across the Scottish Borders

The Community Capacity Building team (CCB) has been congratulated for winning silver at the finals of the iESE (Improvement and Efficiency Social Enterprise) Public Sector Transformation Awards 2018. The team made it to the shortlist of the three top nominations in the creating community capacity category, which recognises initiatives that do the most to engage with the local community and create greater resilience, better life chances and less dependency on public services, coming away from the ceremony on 6 March with a coveted silver award.

iMatter is the NHS Scotland Staff Engagement continuous improvement process being used nationally across all Boards in Scotland. It forms a key part of the Healthy Organisation Culture element of the National 2020 Workforce Vision: Everyone Matters. All NHS Borders and H&SC Partnership staff will receive a questionnaire in March 2018

The proposed result would be:

- Higher staff morale & motivation
- Less absenteeism & stress
- Greater efficiency, productivity & effectiveness
- Stronger financial management

That would allow:

- Enhanced patient experience and outcomes

4.1.5 **Equality Outcome 5**

Feel safe be safe, healthy, achieving, respected and included

The Borders Community Capacity Building Project (BCCBP) has been responsible for a substantial range of developments that have maintained older people's health and inclusion in their communities and transformed the way preventative services are delivered. The project began in January 2013 and was designed to enable older people to do more to help themselves and others in their communities. The project aims to develop social capital and through this increase the support available to older people in Scottish Borders.

Successful aspects include:

- Making better use of resources and skills already there within the community
- Encouraging and helping local communities and groups to provide networks of support, to help older people to improve their health and wellbeing
- Developing new services, including new models of service delivery, to provide support for older people to maintain their health, wellbeing and independence

4.1.6 **Equality Outcome 6**

Experience services that reflect the needs of the communities, address, health inequalities, and which shift the balance of these services towards early intervention and prevention.

- Since September 2016 the Health and Social Care Partnership have been working with the National Development Team for Inclusion (NDTi) to transform the way that health and social care services are accessed across the Scottish Borders. Community Led Support (CLS) aims to provide locally based Hubs across the five Scottish Borders Localities that can be easily accessed by local people as the first point of contact for health and social care services. The use of diverse community venues for meeting people and providing them with information, advice, signposting and conversations about what matters to them is central to many people's experience of CLS. Community Led Support relies on working together in local communities with voluntary groups and organisations to connect people to locally based solutions that work for them.
- A key focus of Community Led Support is prevention. By offering help to find information and advice quickly to allow individuals to remain in their own home, get involved in their community and find the support needed to stay independent such as equipment, transport or help at home for example, the What Matters Hubs promote early intervention and prevention.

4.1.7 **Equality Outcome 7**

Be confident that the information they provide, particularly in relation to the protected characteristics, will be used to make improvements to services and the way they are planned and delivered.

Locality Plans:

- The H&SC Locality Plans have been co-produced in line with the guidance from the SG Locality Guidance, considering what localities should look like, in terms of those who should be involved in the planning and design of future service provision.
- An extensive public consultation was undertaken in 2017 to ask staff and the public for their opinions of the plans (including Easy Read versions of all plans) – post consultation feedback saw additions to the plans to support information on the Carers Act and Mental Health care planning going forward.

- The locality plans are designed to support the delivery of health and social care, in or as near to, the persons home as practically possible, in a timely person centred manner, by the most appropriate skilled person/professional
- Make best use of resources available to support health and social care
- Reduce unnecessary attendance/admission to the district general hospital and by doing so free up capacity for those who clinically require the services delivered from that site
- Increase understanding/knowledge of the general public on self-help/services available from other health care professionals/third sector organisations – with the aim to reduce pressures on currently overstretched services across health and social care while at the same time optimising opportunities for improving the health and wellbeing of Scottish Borders residents.
- An Equality Impact assessment was undertaken to ensure equity in all areas

Next Steps

5.1 We will be working towards ensuring that:

- Equality duty performance indicators are established.
- We are aware of the need to implement Corporate Equality & Diversity Policies fairly and consistently.
- The Equality Impact Assessment (EIA) process is used when carrying out core business functions.
- Officers trained in the current EIA process and requirements.