

# Public Document Pack



An Etraordinary meeting of the **Health & Social Care Integration Joint Board** will be held on **Monday, 5th March, 2018** at **10.00 am** in Committee Room 2, Scottish Borders Council, Newtown St Boswells

## **AGENDA**

<b>Time</b>	<b>No</b>		<b>Lead</b>	<b>Paper</b>
10:00	<b>1</b>	<b>ANNOUNCEMENTS &amp; APOLOGIES</b>	Chair	<i>Verbal</i>
10:01	<b>2</b>	<b>DECLARATIONS OF INTEREST</b> <i>Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.</i>	Chair	<i>Verbal</i>
10:03	<b>3</b>	<b>MINUTES OF PREVIOUS MEETING</b> 12.02.2018	Chair	(Pages 3 - 8)
10:05	<b>4</b>	<b>MATTERS ARISING</b> Action Tracker	Chair	(Pages 9 - 12)
10:10	<b>5</b>	<b>FOR DECISION</b>		
	5.1	Integrated Care Fund	Chief Officer	(Pages 13 - 56)
11:55	<b>6</b>	<b>ANY OTHER BUSINESS</b>	Chair	<i>Verbal</i>
12:00	<b>7</b>	<b>DATE AND TIME OF NEXT MEETING</b> Monday 23 April 2018 at 2.00pm in Committee Room 2, Scottish Borders Council, Newtown St Boswells	Chair	<i>Verbal</i>

This page is intentionally left blank



Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 12 February 2018 at 2.00pm in the Committee Room 2, Scottish Borders Council.

**Present:**

(v) Cllr D Parker	(v) Dr S Mather (Chair)
(v) Cllr J Greenwell	(v) Mr D Davidson
(v) Cllr T Weatherston	(v) Mrs K Hamilton
(v) Cllr H Laing	(v) Mr T Taylor
Mrs J Smith	Dr C Sharp
Mr D Bell	Mrs C Pearce
Mr M Leys	Mr R McCulloch-Graham
Mr C McGrath	

**In Attendance:**

Miss I Bishop	Ms S Bell
Mrs J Stacey	Mr D Robertson
Mr P Barr	Ms D Rutherford

### 1. Apologies and Announcements

Apologies had been received from Cllr Shona Haslam, Mr John Raine, Dr Angus McVean, Ms Lynn Gallacher, Ms Susan Swan, Mrs Jane Davidson, Mrs Tracey Logan, Mrs Carol Gillie and Mr John McLaren.

The Chair confirmed the meeting was quorate.

The Chair welcomed Mrs Debbie Rutherford who was deputising for Mrs Lynn Gallacher and Mr Philip Barr who was deputising for Mrs Tracey Logan.

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 18 December 2017 were amended at page 5, paragraph 4, line 2, delete "(set up by acute and primary care colleagues)" and replace with "by the partnership organisations", and with that amendment the minutes were approved.

### 4. Matters Arising

**4.1 Minute 7: Appointment of Chief Financial Officer:** Mrs Karen Hamilton enquired of the outcome of the Chair's consideration of writing to the Cabinet Secretary. The Chair advised that he had considered the matter and had decided given an internal resolution was underway he would not be writing to the Cabinet Secretary.

**4.2 Minute 6: Inspection: Joint Older People's Services Report:** The Chair noted that there was an expectation that the Joint Older People's Services Report was likely to change. Mr Murray Leys confirmed that a meeting with the Care Inspectorate had been held and they were currently reviewing the improvement plan that had been submitted. Work continued to progress on the improvement plan even though formal feedback was awaited. Mr Colin McGrath sought a copy of the full improvement plan and evidence of progress. Mr Leys and Mr Robert McCulloch-Graham confirmed that the Board had previously received the full improvement plan which contained all the evidence gathered and the intention was to bring a final report to the Board once formal feedback from the Care Inspectorate had been received. They also confirmed that the documentation was available in the public domain.

**4.3 Action Tracker:** It was agreed that historic scheduling dates should be included in the progress box on the action tracker.

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

## **5. Chief Officer's Report**

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted: the pressures on systems over the winter period; the opening of the Craw Wood facility and the turnover of patients within the facility and potential expansion of that facility; progress with hospital to home across the region; difficulties with private guardianship orders; piloting the opening of some GP surgeries over 4 weekends; regional work; GP Quality clusters; Strategic Plan; Leadership Team training; performance/finance group progress and a delay with the recruitment to the Chief Financial Officer post.

Cllr John Greenwell enquired if there would be an opportunity to look at the Andrew Lang Unit under the Mental Health Transformation programme. Dr Cliff Sharp confirmed that the unit required consideration in terms of the estate as well as a potential possibility of a co-location of all childrens services, both health and social care, into one place.

Cllr David Parker enquired why the GP Saturday surgeries pilot had not encompassed the central Borders area. Mr McCulloch-Graham advised that it had been an optional pilot for GP practices. Dr Cliff Sharp confirmed that a similar pilot had been tried in Lanarkshire and had worked successfully, and from the feedback received there had been lessons learned locally. He commented that in preparation for next year the initiative would be planned further ahead with specific Saturdays identified and potentially GP surgeries targeted for opening.

Mr Tris Taylor wished to pass on thanks to the staff involved in progressing the Craw Wood initiative.

Cllr Helen Laing enquired if there was an opportunity to include welfare rights within the GP surgeries. Mr McCulloch-Graham confirmed that welfare rights was offered in the community hubs and it was for GPs to make referrals to the hubs.

Further discussion highlighted: role of GPs in moving to locality hub models; Quality Cluster leads; refresh of the strategic plan; provision of 10 reablement step down beds within Waverley for a maximum of 6 week periods; impact of Craw Wood and Waverley on reducing the need for surge beds in the acute setting; and resolution to the delay in advertising the Chief Financial Officer post.

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

## **6. Inspections Update**

Mr Murray Leys advised the Board that all of the recommendations within the Joint Older People's Services report had been responded to. In regard to adult protection services, he had been tasked by the Critical Services Oversight Group (CSOG) to deliver a public protection service across the whole of Scottish Borders to ensure similar processes and procedures across systems were in place and to ensure the most vulnerable across the Borders were secure and safe. Work was currently underway to formulate a public protection service and overarching governance group with current representation from the Integration Joint Board via the Chief Officer.

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.

## **7. The Integration Joint Budget 2017/18**

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

Mr David Davidson enquired about the potential to review the continuation or withdrawal of funding and grants to various charitable bodies and whether there was likely to be any further national funding made available.

Mr McCulloch-Graham clarified that there were a number of projects within the Integrated Care Fund that were due to conclude at the end of March, except for the Community Capacity Team project that the Board agreed to extend the funding for at the last meeting. There was an intention to review the projects at the Development session to be held on 19 March. He further advised that the Integration Care Fund had now been included as part of the NHS funding allocation uplift, with no further funding being made available nationally. Mr David Robertson advised that £66m had been added to Local Authority funding settlements for Health & Social Care Integration.

Mr Tris Taylor asked for a copy of the Risk Management Strategy.

Mr Tris Taylor sought clarification on ring fenced resources and any consideration attached to the budget. Mr Robertson confirmed that the Integrated Care Fund was made up of £6.3m in total allocated over 3 years to be used as a lever for change. Mr McCulloch-Graham clarified

that it was to support integration and each partnership in conjunction with the third sector, health and local authority were to use the funding to develop integrated projects.

Further discussion focused on: the intricacies of budget setting in regard to targets and forecasting, financial estimates, assumptions and managing risks; stratified information available to be able to provide oversight; measuring the activity set against the provision and cost of resource to enable effective commissioning; lobbying government for additional funding to deal with pressures; urgency to review integration care fund projects; no designation around the integration care fund monies within the NHS allocation; funding sought to offset costs against increased bed numbers in care home, increased carer hours; potential to utilise some of the £407k balance of the Older People's Change Fund; potential for future funding for a mental health older adult outreach service into care homes; financial budget for 2018/19; and confirmation that the transformation programme would be responsible for all of the required savings to be achieved in 2018/19.

Mrs Jenny Smith raised a concern that the monies allocated by the Scottish Government for the implementation of the Carers Act, within the Social Care Fund might be allocated elsewhere. Mr Robertson advised that the bulk of the £7.4m had been allocated to date on various issues associated with the Carers Act, such as the living wage. Mrs Smith enquired if the £40k had been protected. Mr Robertson advised that he would investigate and provide clarification.

Mr Robertson advised that in the current financial year there had been £7.54m given to Scottish Borders Council on a recurrent basis and in the current year Scottish Borders Council had not required to utilise all of that funding and had left £1m with the Integration Joint Board who had allocated it to NHS Borders to assist with the surge bed pressures experienced throughout the year. For the following year Scottish Borders Council would again receive £7.54m and expected £1m to be made available to the Integration Joint Board to redirect. He clarified that the intention was that Scottish Borders Council were building a budget for services such as Craw Wood for next year. In addition he further reiterated that £66m was being made available nationally to Local Authorities for health and social care to enable the implementation of various initiatives including the living wage and Carers Act. He envisaged that across both areas there would be £2.5m unallocated to bring to the Integration Joint Board for delegation in the next financial year. Mr David Davidson welcomed the clarification.

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the request in principle for the direction of the balance of social care funding of £127k to Scottish Borders Council to address the pressures in social care.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the request in principle for the direction of £443k of Integrated Care Fund to Scottish Borders Council to address the pressures in social care. The Chief Officer would make enquiries about the state of the Older Peoples' Change Fund and the Social Care Fund to see if the balance could be taken from those sources. The voting members instructed the Chair and Chief Officer to use their discretion as to where those monies would be taken from.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested a full and detailed report on the Integrated Care Fund projects to be presented at an Extra Ordinary meeting.

## **8. Transformational Programme Update**

Mr Robert McCulloch-Graham gave an overview of the content of the report and advised that it would be updated in terms of savings.

Cllr Helen Laing enquired about the 2018/19 provision of funding for dementia services. Mr McCulloch-Graham advised of the projected 60% increase in the over 65s over the next 10 years and that SB Cares were required to deliver against that as well as a number of beds and hours. On the acute side the sum of £4.8m capital had been agreed and would be put towards developing dementia resources and buildings and conversations with private providers and he was hopeful that Scottish Borders Council might be able to increase capacity, however he was not sure at this stage of the impact on revenue.

Cllr Laing enquired if existing buildings would be converted. Mr Philip Barr commented that SB Cares were currently exploring a strategic plan on what the future need would be for adult social care, care homes and dementia care. Discussions were taking place to look at what was required and how it would be delivered, with commissioning helping to inform the strategic decisions and broad strategic proposals.

Further discussion focused on: further information was required in regard to items 4 and 6; provision of an equality impact assessment; request for an updated project gantt chart; failure of delivery against the plan with no recovery plans for projects; deadlines to measure against; and format to be revised and include milestones, financial savings and any mitigating actions.

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

## **9. Festive Period Report**

Mr Rob McCulloch-Graham gave an overview of the content of the report and highlighted, more people attending the Borders Emergency Care Services; increase in attendances at the Emergency Department mainly due to respiratory conditions; reduction in admissions however those admitted were more acutely ill; lower discharges across the festive period (24-26 December); access to Craw Wood and Waverley throughout the period; mainstream care homes unavailable; and cancellation of elective procedures increased.

Mr David Davidson noted that during the festive period nobody had waited longer than 20 minutes to be triaged.

Mr Davidson further suggested the Chair might consider sending a letter to the partnerships involved to thank them for their support over the festive period.

Mr Tris Taylor noted that despite the increase in the acuity of patients admissions continued to be avoided and he suggested the same performance might be achieved throughout the year to reduce admissions.

Ms Debbie Rutherford noted that carers were not mentioned in the report and asked that the carers national helpline be mentioned in the final winter period report.

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

## **10. Strategic Planning Group Report**

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

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

## **11. Any Other Business**

**11.1 Borders Alarms:** The Chair advised Mr Colin McGrath that any issues with Border Alarms would be a matter for Scottish Borders Council and not the Integration Joint Board.

**11.2 Melrose Health Centre:** The Chair advised Mr Colin McGrath that any issues in regard to the Melrose Health Centre would be a matter for NHS Borders and not the Integration Joint Board.

**11.3 Development Session:** Mr Robert McCulloch-Graham reminded the Board of the proposed content for the forthcoming development session to be held on 19 March 2018.

**11.4 Extra Ordinary Meeting:** The Chair advised that an Extra Ordinary meeting would be held to discuss the Integration Care Fund projects and 2018/19 Budget.

**11.5 Performance:** The Chair advised that he would write to the partnerships in regard to performance over the winter period.

## **12. 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 4.10pm.

Signature: .....  
Chair






## 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 <b>HEALTH &amp; SOCIAL CARE INTEGRATION JOINT BOARD</b> agreed that it would undertake a Development session on clinical and care governance.	Robert McCulloch-Graham, Claire Pearce, Cliff Sharp	2017	<b>In Progress:</b> Item scheduled for 27 November 2017 Development session. Session cancelled due to apologies received. <b>Update:</b> Item rescheduled to 19 March 2018 Development session.	


Meeting held 27 February 2017

Agenda Item: Health & Social Care Delivery Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
13	8	Tracey Logan advised that there were already strong links to Live Borders in place and she would be happy to provide an update to the IJB if it wished.	Tracey Logan	June 2017	<b>In Progress:</b> Item scheduled for 12 February 2018. <b>Update:</b> 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 <b>HEALTH &amp; SOCIAL CARE INTEGRATION JOINT BOARD</b> noted the progress to date and welcomed hearing more at a later date.	Robert McCulloch-Graham	April 2018	<b>In Progress:</b> Item scheduled for April 2018 meeting agenda.	

## 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 <b>HEALTH &amp; SOCIAL CARE INTEGRATION JOINT BOARD</b> sought an update at a future meeting on progress against the various recommendations.	Robert McCulloch-Graham	April 2018	<b>In Progress:</b> Item scheduled for April 2018 meeting agenda.	


**Agenda Item:** Community Capacity Building – Transformation Proposal

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
23	8	The <b>HEALTH &amp; SOCIAL CARE INTEGRATION JOINT BOARD</b> agreed 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	Michael Curran	June 2018	<b>In Progress:</b> Item scheduled for 11 June 2018 meeting agenda.	


		months time.				
--	--	--------------	--	--	--	--

## Meeting held 12 February 2018




### Agenda Item: Inspection Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
24	6	The <b>HEALTH &amp; SOCIAL CARE INTEGRATION JOINT BOARD</b> 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	<b>In Progress:</b> Item scheduled for 19 November 2018.	

### Agenda Item: The Integration Joint Budget 2017/18

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
25	7	The <b>HEALTH &amp; SOCIAL CARE INTEGRATION JOINT BOARD</b> requested a full and detailed report on the Integrated Care Fund projects to be presented at an Extra Ordinary meeting.	Rob McCulloch-Graham	March 2018	<b>Complete:</b> Integrated Care Fund sole item on Extra Ordinary Meeting agenda on 5 March 2018.	

#### KEY:

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

This page is intentionally left blank

Scottish Borders Health & Social Care  
Integration Joint Board



Scottish Borders  
Health and Social Care  
PARTNERSHIP

Meeting Date: .Monday 5 March 2018.....

Report By	Robert McCulloch-Graham
Contact	Jane Robertson
Telephone:	01835 825080

**INTEGRATED CARE FUND**

<b>Purpose of Report:</b>	The purpose of this report is to provide the Integration Joint Board (IJB) with an update on the position of the Integrated Care Fund (ICF) as well as seek decisions regarding the future of a number of ICF funded projects which are facing end of project by March 2018.
---------------------------	--

<b>Recommendations:</b>	<p>The Health &amp; Social Care Integration Joint Board is asked to:</p> <p>The Integration Joint Board is asked to <b>note</b> the current position of the ICF.</p> <p>The Integration Joint Board is asked to <b>agree</b> proposals for exception ICF funding in respect of Community Led Support, the Matching Unit and Crawood.</p> <p>The Integration Joint Board is asked to consider each of the projects funded by ICF due to end between February and April 2018 and <b>decide</b> whether these projects should be mainstreamed, ended or extended via the ICF.</p>
-------------------------	--

<b>Personnel:</b>	A number of projects facing end of project by March 2018 currently employ staff therefore a decision regarding the future of these projects is required urgently.
-------------------	---

<b>Carers:</b>	A number of projects have positive outcomes for carers.
----------------	---

<b>Equalities:</b>	Related to EIA for Strategic Plan. There are no equality implications associated with the proposals
--------------------	--

<b>Financial:</b>	A number of projects are facing end by end of March 2018 and decisions regarding the future of these project including future funding is required urgently. The proposals approved within the programme to date will be
-------------------	--

	funded from the ICF grant allocation over its life.
Legal:	Potential issues regarding end of project and notice required for staff.
Risk Implications:	<p>Risk of not delivering on strategic priorities if those projects which are clearly supporting delivery are not supported to continue.</p> <p>The prevalent risk associated with the report is in relation to the 13 projects for which the direction of funding is due to end during the period from March to April. Whilst some of these projects are of a fixed life and transformational nature, others are new tests to change and a decision is required for each in terms of its continuation, mainstreaming and funding options.</p>

## **INTEGRATED CARE FUND UPDATE** **March 2018**

### **Integrated Care Fund – Allocation and Spend to Date**

- 1.1 The ICF was first allocated to the shadow partnership in 2015/16 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of **£6.39m** over the 3 years of the programme. Since then, a number of projects have been ratified by the IJB with a combined spend to date of **£3.141m**. Analysis of resource directed and projected spend to 31<sup>st</sup> March 2018 is detailed in **Table 1** below.
- 1.2 Whilst **£5.687m** of the **£6.390m** total ICF resource has been directed by the IJB, at 31 January 2018, only **£3.141m** (55%) has been recorded as spent. Projected total spend across all projects to end of March 2018 is **£3.912m**.
- 1.3 A decision was ratified by the IJB to re-focus the fund to new proposals which support the Partnerships key priorities. These included developing health and social care services which prevent avoidable hospital admission, and to ensure timely discharge from hospital.
- 1.4 Scottish Borders Council have a projected overspend to the 31<sup>st</sup> March 2018 on the level of Home Care hours and Care Home Beds as part of the work to improve the rate of discharge from hospital, and supporting more people within the community, as part of admission avoidance. This amounts to £443k above base allocation. This has been included as a pressure for the ICF within the 2017/18 budget. The remaining ICF balance at 31<sup>st</sup> March 2018 is therefore projected to be **£0.703m**.
- 1.5 Three projects previously ratified by the IJB have incurred additional unforeseen expenditure to the value of £73,313 as detailed in 3.1 below.
- 1.6 Nine projects ending by March / April 2018 with an allocation of £942,295 are forecasting an underspend of £168,488 as detailed in Table 2 below.
- 1.7 Thirteen projects are continuing beyond March 2018 with an original allocation of £3,360,945 as detailed in Table 3 below. No further allocation is requested for these projects.
- 1.8 Eight projects are continuing beyond March 2018 with an original allocation of £1,485,970 as detailed in Table 4 below. These projects are requesting a further allocation of £428,240 to complete.

**Table 1 – Summary of ICF Projects Approved to Date with Resources Directed / Spent**

	Resource Directed £	Expenditure to 31 January £	Projected Spend to 31 March £
<b>IJB Approved Projects</b>			
1 Community Capacity Building	562,660	292,739	313,523
2 Independent Sector representation	93,960	75,330	93,960
3 Community Transport Hub	139,000	89,892	139,000
4 Mental Health Integration	37,393	37,393	37,393
5 My Home Life	71,340	71,340	71,340
6 Delivery of the Autism Strategy	99,386	36,896	43,826
7 BAES Relocation	241,000	224,568	224,568
8 Delivery of the ARBD pathway	102,052	20,206	50,206
9 Health Improvement ( <i>phase 1</i> ) and extension	38,000	16,000	16,000
10 Stress & Distress Training	166,000	58,945	70,000
11 Transitions	65,200	37,199	37,500
12 Delivery of the Localities Plan (18 mths)	310,318	288,694	310,318
13 Locality Managers x 1 locality for 1 year	80,818	0	0
14 H&SC Coordination x 1 locality for one year	49,238	0	0
15 Community Led Support	101,216	93,610	101,216
16 The Matching Unit	133,227	97,795	120,000
17 RAD	132,755	132,755	132,755
18 Transitional Care Facility	846,600	395,556	500,000
19 Pharmacy Input	97,000	569	24,000
20 GP Clusters Project	50,000	27,000	32,500
21 Pathways of Care:			
Domestic Violence Pathway	120,000	67,935	67,935
22 Alcohol & Drug Partnership Transition	46,000	0	46,000
23 Buurtzorg Project Management	52,000	0	0
25 Discharge to Assess:			
(a) Craw Wood	495,966	126,107	210,350
(b) Hospital to Home	160,283	14,585	52,499
(c) Haylodge	245,751	7,127	245,751
Programme Delivery	706,458	486,058	528,386
<b>Social Care Allocation 2017/18#</b>	<b>443,000</b>	<b>443,000</b>	<b>443,000</b>
<b>Total</b>	<b>5,686,621</b>	<b>3,141,299</b>	<b>3,912,056</b>
Total 3-Year Allocation	<b>6,390,000</b>		
Undirected Resources Remaining	<b>703,379</b>		



## Exception Requests

2.1 Three projects which were previously ratified by the IJB have incurred a number of unforeseen costs within the 17/18 financial year. These are:

- 15. Community Led Support
- 16. The Matching Unit
- 25. Discharge to Assess: Craw Wood

The IJB is recommended to direct further ICF funding to address these additional in year costs.

2.2 Further detail on costs incurred are detailed below:

<b>15. Community-Led Support</b>	£
<b>Further resources required</b>	<b>21,216</b>
Additional costs to 31 March 2018 not included in the original proposals for the project have been / will be incurred to the 31 March 2018 in relation to venue hire and travel costs (£14,216) together with the costs of a further 2018 subscription to NDTi (£7,000).	

<b>16. The Matching Unit</b>	£
<b>Further resources required</b>	<b>7,700</b>
Due to maternity leave the Matching Unit has been operating with only 3 full time staff since 02/10/17 and as a result absence, training, meetings and annual leave have had an impact on service provision. To mitigate the impact of this the unit has required to recruit temporary cover to maintain optimum function of the service at a cost of £7,700 to the end of March 2018.	

<b>25. (a) Discharge to Assess: Craw Wood</b>	£
<b>Further resources required</b>	<b>44,397</b>
Costings for Craw Wood have increased as a result of additional refurbishment and set-up consultancy costs and refinement to the required staffing model including the role of the General Manager for Patient Flow having oversight of the service. Taking into account the original contingency a further £44,397 is required to ensure affordable provision to the end of April 2018.	

2.3 Should the IJB ratify the direction of further ICF funding to these three projects above, it will leave **£0.630m** of the ICF uncommitted and available for carry over for future direction in 18/19.

## Projects Requiring Decision

3.1 Of the 25 projects included within the ICF Programme detailed in Table 1 a number are now approaching the end of their funding lives (31<sup>st</sup> March or 30<sup>th</sup> April). These are summarised in **Table 2** below and are reporting an underspend of £168k

Table 2

Projects Ended or Ending by March/April 2018					
	Project	End-Date	Allocated Fund	Project Spend	Underspend
4	Mental Health Integration	31 March 2016	37,393	37,393	0
5	My Home Life	31 March 2018	71,340	71,340	0
7	BAES Relocation	31 July 2017	241,000	224,568	16,432
9	Health Improvement ( <i>phase 1</i> ) and extension	31 December 2016	38,000	16,000	22,000
13	Locality Managers x 1 locality for 1 year	IJB decision not to progress December 2016	80,818	0	80,818
14	H&SC Coordination x 1 locality for one year	IJB decision not to progress December 2016	49,238	0	49,238
17	RAD ( <i>need to put in full</i> )	30 September 2017	132,755	132,755	0
22	Alcohol & Drug Partnership Transition	31 March 2018	46,000	46,000	0
25c	Haylodge	30 April 2018	245,751	245,751	0
Total			942,295	773,807	168,488

The following projects were agreed and allocated a fixed resource that will continue into 18/19.

Table 3

Projects continuing with carry-over of existing allocation 18/19								
	Project	Original Allocation	Date	Additional Allocation	Date	Spend to end of March 18	Carry Over	End Date
1	Community Capacity Building	400,000	November 2015	162,660	December 2017	313,523	249,137	31 July 2019
6	Delivery of the Autism Strategy	99,386	December 2015	0		43,826	55,560	28 February 2019
8	Delivery of the ARBD pathway	102,052	February 2016	0		50,206	51,846	31 March 2019
10	Stress & Distress Training	166,000	October 2015	0		70,000	96,000	31 March 2020
11	Transitions	65,200	October 2015	0		37,500	27,700	31 March 2019
18	Transitional Care Facility	846,600	December 2016	0		500,000	346,600	31 December 2018
19	Pharmacy Input	97,000	December 2016	0		24,000	73,000	31 December 2018
20	GP Clusters Project	50,000	March 2017	0		32,500	17,500	31 December 2018
21	Domestic Violence Pathway	120,000	March 2017	0		67,935	52,065	30 June 2020
23	Buurtzorg Project Management	52,000	June 2017	0		0	52,000	31 March 2019
25a	Craw Wood	495,966	December 2017	0		210,350	285,616	30 June 2018
25b	Hospital to Home	160,283	December 2017	0		52,499	107,784	30 June 2018
	Programme Delivery	706,458	April 2015	0		528,386	178,072	31 December 2018
	Total	3,360,945		162,660		1,930,725	1,592,880	

The following projects request further funding and are recommended for consideration by the IJB.

Table 4

Projects requesting additional funding 18/19						
	Project	Original Allocation	Date	Existing End Date	Request for Additional Funding	Projected End Date
2	Independent Sector representation	93,960	September 2015	31 March 2018	28,165	31 March 2019
3	Community Transport Hub	139,000	October 2015	31 March 2018	65,900	31 March 2019
12	Delivery of the Localities Plan	310,318	May 2016	31 March 2018	79,652	31 March 2019
15	Community Led Support	101,216	August 2016	31 March 2018	56,673	31 March 2019
16	The Matching Unit	133,227	August 2016	31 March 2018	152,850	31 March 2019
23	Buurtzorg Project Management	52,000	June 2017	31 March 2018	45,000	31 March 2019
25a	Craw Wood	495,966	December 2017	30 June 2018	to be confirmed	to be confirmed
25b	Hospital to Home	160,283	December 2017	30 June 2018	to be confirmed	to be confirmed
Total		1,485,970			428,240	

3.2 It is expected that Projects 5, 22 and 25(c) will not require any further consideration following the conclusion of their fixed life. For the projects outlined in the table above, funding will end in March or April and the IJB is required to consider:

- Which of these projects should be mainstreamed.;
- Which of these projects require temporary extension of ICF resource, to continue the delivery of their outcomes or to further test change;
- Which of these projects should end.

The total of these requests is £428,240, with £630,000 available there is sufficient resource for the IJB to allocate for all projects should they all be agreed. This would however limit any ability to continue to fund the Discharge to Assess programme or future initiatives within the forthcoming financial year.

3.3 Projects 25a and 25b, Craw Wood and Hospital to Home, are both part of the response from the Health and Social Care Partnership to the IJB Direction "Discharge to Assess". These projects have sufficient funding already agreed by the IJB, to carry on until the end of June 2018. This should provide sufficient time for evaluation and further consideration for continuation by the IJB at a later date. If future funding is agreed, this would be a pressure on the base budget.

3.4 To assist with decision making, End of Project Reports can be seen in **Attachment One** for each project that requires consideration. The reports gives detail on outcomes and benefits achieved, strategic fit, details of any current staffing commitments and an outline of future funding requirements should the decision be taken to mainstream or extend the life of the project.

## Recommendations

The Health & Social Care Integration Joint Board is asked to **note** the current position of the ICF (Table 1).

The Health & Social Care Integration Joint Board is asked to **agree** requests for additional ICF funding in respect of Community Led Support, the Matching Unit and Craw Wood (paragraph 2.2).

The Health & Social Care Integration Joint Board is asked to consider each of the projects funded by ICF due to end March and April 2018 (Attachment 1 and Table 4) and **decide** whether projects should be mainstreamed, extended or ended.

This page is intentionally left blank

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	1 - Community Led Support		
<b>Project Owner</b>	Murray Leys	<b>Main Contact Telephone</b>	01835 826 594
<b>Main contact email</b>	<a href="mailto:Murray.Leys@scotborders.gcsx.gov.uk">Murray.Leys@scotborders.gcsx.gov.uk</a>		

## Guidance on End of Project Report

The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018

<b>1</b>	<b>Outline project description</b> <i>Please summarise the project in no more than 250 words</i>
----------	---

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

Community Led Support (CLS) aims to provide locally based hubs which can be easily accessed by local people as the first point of contact for health and social care services.

The programme builds on existing access such as through Customer Services and Social Work Duty Teams and relies on working together in local communities, voluntary groups and organisations that already connect with people.

This model has been successful in other areas in terms of eliminating waiting lists, improved customer satisfaction, increased staff morale and motivation as well as savings in Council budgets, and the intention is to replicate that success here in the Scottish Borders.

<b>2</b>	<b>Project's strategic fit with key priority areas for the Scottish Borders H&amp;SCP</b> (Refer to strategic plan and annual performance report for key priorities)
----------	---

CLS is a strategic fit with both the majority of the Partnerships Local Objectives and the Scottish Government's National Health & Wellbeing Outcomes, with the projects focus on prevention and early intervention, improving choice and control and the effective and efficient use of resources just a few examples. This strategic alignment is visually demonstrated in the tables included below. Community Led Support is also strategically aligned with the Localities Approach, identified as a key priority for transformation by the Integration Joint Board (IJB).

### Mapping of CLS Project against the H&SC Partnerships Local Strategic Objectives

	Objective 1	Objective 2	Objective 3	Objective 4	Objective 5	Objective 6	Objective 7	Objective 8	Objective 9
	Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide care close to home	Deliver services within an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
CLS	★	★			★	★	★		★

★-High Impact

# Integrated Care Fund End of Project Report

March 2018

## Mapping CLS Project against the Scottish Government’s National Health and Wellbeing Outcomes

	Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5	Outcome 6	Outcome 7	Outcome 8	Outcome 9
	People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC’s 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to achieving health equalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
CLS	★	★	★	★		★		★	★

★-High Impact

### 3 Original Project Aims

The original aims of the project were to:

- Transform Social Work access arrangements and ensure more efficient use of staff and resources;
- Streamline access to services through the development of locally based community hubs with community led with support from volunteers and staff.

### 4 Project outcomes and benefits achieved

The original project outcomes are listed below:

- Satisfied ‘customers’ due to easier access to services
- Focus on self-management and prevention
- Increased staff morale and motivation within social work teams
- Demand is managed effectively
- User expectations are managed effectively
- Significant savings on health and social care budgets
- Improved access to services
- Streamlined and proportionate support
- Culture change
- Improved wellbeing of service users
- Reduced bureaucracy
- Reduced waiting lists

Project data is currently being collated and analysed for the official evaluation which is due at the end of March. Initial findings however show that the Hubs have already started to have a real impact on achieving a number of the identified key benefits, including a reduction in waiting lists and times and a reduction in the need for formal care services which will deliver the expected savings in the health and social care budget.

The total number of people on Social Work waiting lists has reduced from 449 in June 2017 (when the first hub commenced) to 294 in January 2018 (35% reduction).



# Integrated Care Fund End of Project Report

March 2018

In the Eildon locality in 2017, 100% of hub visitors who completed a user feedback form said they were satisfied with the outcome of their visit.

In 2017 there were 43 people seen through the hubs in the Teviot locality, 121 in the Eildon locality and 11 in the Tweeddale.

The results from hubs have varied depending on whether they were by appointment only or drop in sessions. For example, in Galashiels there is a drop in hub where none of the attendees have required a social work service and were all signposted to other appropriate services. In Burnfoot however, where the service was mainly by appointment from the existing waiting list, 90% of attendees went on to receive a Social Work service. This reflects the difference between the preventative and waiting list elements of the hubs. It is important to note that many of the attendees in Burnfoot was also signposted to other Third Sector and community solutions further increasing the preventative and early intervention elements of the hubs.

The hubs use a shorter, more simplified version of the Social Work assessment known as the What Matters documentation. This reduces unnecessary bureaucracy and streamlines the hub appointment process.

Health and Social Care staff, Third Sector, Independent Sector and local community group representatives were invited to take part in ‘Effective Conversation’ training prior to the start of hubs in their area. 71% felt that the training would be beneficial to their role in CLS. 80% felt able to support their service users and 68% felt they had a good knowledge of how to access services available in their area. Knowledge of how to access services has been reported to have increased once hubs are running in an area.

Initial feedback from Hub staff has also been positive.

*“Since our change of venue I feel very positive about our What Matters Hub, we are in the right place. The balance between Social Work, OT and voluntary sector works well. It is empowering to work in this environment, providing advice, signposting and support timeously to people just when they need it. Feedback we have had is that people are delighted at the quick response from Social Work and that it can alleviate their worries. We have had people returning just to let us know what they have taken forward or how our intervention has made their lives better. There is no greater testimony.”*

Social Work Team Member

The What Matters Hubs have been widely publicised and there has been significant engagement with the Third and Voluntary Sectors, local Communities and staff. In addition to this the Scottish Borders has joined the national network for areas who have adopted this model and funds have been allocated for this. A decision to not continue to resource CLS would mean that the benefits of this existing investment would not be fully realised and there would also be a real risk of reputational damage both locally and more widely.

This is a decisive time for the What Matters Hubs and a decision to not continue support would have an adverse impact on the successful delivery of the service moving forward and the outcomes detailed above.

**5 What areas of the Borders does the project cover**

All five Localities within the Scottish Borders.

**6 What care groups does the project affect?**

# Integrated Care Fund End of Project Report

March 2018

Older people and adults with lower level health and social care needs.					
<b>7</b>	<b>Current project end date</b>				
31 March 2018.					
<b>8</b>	<b>How much ICF Fund allocated</b>				
<table border="1"> <thead> <tr> <th>Original ICF Allocation</th> <th>Predicted Spend to end of March 18</th> </tr> </thead> <tbody> <tr> <td>£90,000 + £11,216 approved by exception report in December 17 + <b>£101,216</b></td> <td>£101,216</td> </tr> </tbody> </table>		Original ICF Allocation	Predicted Spend to end of March 18	£90,000 + £11,216 approved by exception report in December 17 + <b>£101,216</b>	£101,216
Original ICF Allocation	Predicted Spend to end of March 18				
£90,000 + £11,216 approved by exception report in December 17 + <b>£101,216</b>	£101,216				
<b>9</b>	<b>Staff recruited to support delivery of the project</b>				
1 x Full-time Project Support Officer for a year which is now coming to an end.					
<b>10</b>	<b>Invest to save proposals identified for the project</b>				
<p>The more efficient use of resources is a specified outcome of the CLS programme. A reduction in waiting lists and the need to offer a full assessment for example, are associated with savings that offset the cost of set up and delivery.</p> <p>While the limited length of time the What Matters Hubs have been operational in the Scottish Borders means that it is not possible at this time to conduct a detailed cost analysis, it would be the responsibility of the Community Hub Facilitator funded by this application to demonstrate the expected savings to the Health &amp; Social Care Budget.</p>					
<b>11</b>	<b>Project support requirements beyond end of March 2018</b>				
<ul style="list-style-type: none"> <li>• Venue hire for a year - £22,432 ( costs with partner agencies have been negotiated to the minimum amount)</li> <li>• Costs for staffing to support delivery - £1 x Full-time Community Hub Facilitation Officer Band 7a £34,241.12 for a full year, including on costs. Responsibilities would include facilitation, administrative tasks, booking of venues, data collation and payment of invoices and continued networking to build Third Sector and Health participation across all localities</li> </ul> <p><b>Total funds requested: £56,673</b></p>					
<p>Please return this form to the Programme Team by Friday 23 March 2018  Email: <a href="mailto:IntegratedCareFund@scotborders.gov.uk">IntegratedCareFund@scotborders.gov.uk</a>  Phone: 01835 82 5080</p>					

# Integrated Care Fund End of Project Report

March 2018

<b><u>Project Name</u></b>		<u>No 2 - Local Integration and Improvement Lead – Independent Sector</u>	
<b><u>Project Owner</u></b>	<u>Margaret McGowan</u>	<b><u>Main Contact Telephone</u></b>	<u>07919315590</u>
<b><u>Main contact email</u></b>	<u>Margaret.mcgowan@scottishcare.org</u>		
<b><u>Guidance on End of Project Report</u></b>			
<u>The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018</u>			
<b>1</b>	<b><u>Outline project description</u></b> <u>Please summarise the project in no more than 250 words</u>		
<p><u>The independent sector is the largest provider in health and social care delivery in Scotland and this development has meant more choices for people, more savings for the public purse but correspondingly the need for a more highly skilled workforce. The major shift in service delivery over the past 10 years has been in many local authority areas, the decline in the public sector as a direct provider, with a corresponding increase in independent sector provision. Independent care and support services in Scotland have an annual turnover of over £1bn. Some 117,110 (59.4%) of Scotland’s total social services workforce of 210,000 work in care homes, care at home and housing support services (Source: Care Commission and Scottish Government 2010). Reshaping care for older people, change fund and now the Integration Agenda activity, personalisation and self-directed support means the independent sector requires the enabling support of a Local Integration Lead to meet current, changing and future demand. The Scottish Government sees care at home increasing in the next 10 years and care homes delivering new care models. There is an opportunity for new provision to be developed in Borders driven by the future need for more cost-efficiencies, savings, shared risk and best value from within the independent sector. The Local Integration Lead will represent Scottish Care and the Local Independent Sector Providers within the partnership area.</u></p>			
<b>2</b>	<b><u>Project’s strategic fit with key priority areas for the Scottish Borders H&amp;SCP</u></b> <u>(Refer to strategic plan and annual performance report for key priorities)</u>		
<p><u>We will make services more accessible and develop our communities</u>  <u>We will improve prevention and early intervention</u>  <u>We will reduce avoidable admissions to hospital</u>  <u>We will provide care close to home</u>  <u>We will deliver services within an integrated care model</u>  <u>We will seek to enable people to have more choice and control</u>  <u>We will further optimise efficiency and effectiveness</u>  <u>We will seek to reduce health inequalities</u>  <u>We want to improve support for unpaid Carers to keep them healthy and able to continue in their caring role</u></p> <p><u>This project has an indirect impact on all 9 of the National Health and Wellbeing outcomes. To ensure that providers are effectively communicated with and supported</u></p>			

# Integrated Care Fund End of Project Report

March 2018

<b>3</b>	<b><u>Original Project Aims</u></b>
	<p><u>Identify appropriate health care modules for enhanced support worker roles</u></p> <p><u>To improve quality of life in care homes</u></p> <p><u>To develop care homes to provide different models of care</u></p> <p><u>To help facilitate a timely discharge</u></p> <p><u>The development of different models of care and support will support the discharge agenda and prevention of admission to hospital</u></p> <p><u>To develop a Rapid Reaction service which functions to capacity</u></p> <p><u>To consider outreach models with care homes</u></p> <p><u>To support with changes to Medication and introduction to Mar charts, and training in administration of medication</u></p> <p><u>Work with providers in engagement of MHL programme</u></p> <p><u>Source appropriate Dementia Training</u></p> <p><u>Improve activities in care homes</u></p> <p><u>Work with Partners for Dementia</u></p> <p><u>Workforce Development</u></p> <p><u>To source and assist providers in Reablement</u></p> <p><u>Increase number of SDS related services</u></p> <p><u>Work with Palliative Group to improve services in community</u></p>
<b>4</b>	<b><u>Project outcomes and benefits achieved</u></b>
	<p><u>Independent Sector Care Providers were surveyed in February 2017 to determine their level of engagement within the partnership. The aim was to increase engagement within the independent sector and increase provider awareness of local activity from 10% to around 75%, as well as reduce the feeling of isolation of the care home managers and encourage partnership working.</u></p> <p><u>55% of those surveyed felt engaged with others in their sector.</u></p> <p><u>Of the 4 examples of local partnership activities given, 78% of providers were aware of all 4, 100% were aware of at least 2. (Locality Working Groups, Community Led Support, My Home Life, Stress and Distress Training)</u></p> <p><u>Providers noted good relationships and communication with the Independent Sector Rep but some difficulties with communication at locality level. A further survey of providers is currently being conducted in February 2018.</u></p> <p><u>The overarching aim of the 'Engaging the Independent Sector' project, is to 'ensure that the sector is a full partner at both national strategic policy level and at a local level, engaged fully across Integration, future joint commissioning strategies, health and social care integration and other key policy drivers such as self-directed support.' We believe that meaningful involvement of the Independent Sector in the Integration agenda is pivotal to ensuring that local plans are informed by an understanding of current service provision and the reality for service providers in developing and delivering future service</u></p> <p><u>The Independent Sector is represented as a full partner, effectively contributes to decision making and promotes the appropriate inclusion of independent services in national strategy and policy</u></p> <p><u>is represented as a full partner, effectively contributes to shaping relevant policies and decisions, promotes the appropriate inclusion of independent services and has a joint ownership of the agenda at a local level, is better informed, grows provider capacity to manage change and has an increased number of organisations effectively contributing to the aims and the implementation of the programme at a local level</u></p>

# Integrated Care Fund End of Project Report

March 2018

	<p><u>has developed feasible options to effectively sustain participation in national and local programmes</u>  <u>has improved opportunities for and is engaged in the development of its workforce. This has been part on</u>  <u>role, lead has been a conduit of information for the I.S sharing ideas, tools, resources, pathways, experience</u>  <u>and guidance. MHL programme, connected care, Training consortium, SVQ Training Centre, updated</u>  <u>policies and procedures, assisted with increased grades in CI Inspections. Local Partnership Profile, improved</u>  <u>communication, high level representation, governance, improved decision making, attribution and clearer</u>  <u>intelligence about the impact of the role of the sector, increased partnership working,</u></p>	
<b>5</b>	<b><u>What areas of the Borders does the project cover</u></b>	
	<p><u>Project covers Borders wide.</u></p>	
<b>6</b>	<b><u>What care groups does the project affect?</u></b>	
	<p><u>Was predominantly older people now includes all adults currently</u></p>	
<b>7</b>	<b><u>Current project end date</u></b>	
	<p><u>31/03/1/2018</u></p>	
<b>8</b>	<b><u>How much ICF Fund allocated</u></b>	
	<b><u>Original ICF Allocation</u></b>	<b><u>Predicted Spend to end of March 18</u></b>
	<p><u>£93,960</u></p>	<p><u>£75,330</u></p>
<b>9</b>	<b><u>Staff recruited to support delivery of the project</u></b>	
	<p><u>1 x Local Integration and Improvement Lead - for 17.5 hrs pw</u></p>	
<b>10</b>	<b><u>Invest to save proposals identified for the project</u></b>	
	<p><u>Not applicable to this project</u></p>	
<b>11</b>	<b><u>Project support requirements beyond end of March 2018</u></b>	

# Integrated Care Fund End of Project Report

March 2018

Local Integration and Improvement Lead for 17.5 hours per week for 12 months at £28,165

Support will be needed to oversee the My Home Life Project, also a support for providers for someone attending meetings and being a conduit of information for them, providers will need to be supported in the community and to be seen as working in a partnership and not be left on the outside. Providers will need support in setting up of their 'Training consortium' this is a group of providers getting together to share training, good practice, tools, resources and staff, continuation of the set up of an SVQ Centre,

The Independent Provider engagement would be detrimental to the sector and area if post is discontinued.

Please return this form to the Programme Team by Friday 23 March 2018

Email: [IntegratedCareFund@scotborders.gov.uk](mailto:IntegratedCareFund@scotborders.gov.uk)

Phone: 01835 82 5080

DRAFT

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	No 3 - Community Transport Hub		
<b>Project Owner</b>	British Red Cross	<b>Main Contact Telephone</b>	01361 884652
<b>Main contact email</b>	Allister.hart@bavs.org.uk		
<b>Guidance on End of Project Report</b>			
The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018			
<b>1</b>	<b>Outline project description</b> <i>Please summarise the project in no more than 250 words</i>		
<p>Scottish Borders Council, NHS Borders, The Bridge, The Red Cross, Berwickshire Association of Voluntary Services and the RVS have been partners in this Community Transport Hub (CTH) project with the aim of putting in place a co-ordinated, sustainable approach to community transport provision.</p> <p>Rather than all providers working in a silo based manner, Borders Community Transport providers have worked together and aligned their systems to make best use of available transport and reduced duplication of journeys. The project has facilitated an integrated solution for older people accessing health and social care services. A single point of contact booking system has been utilised to allow service users to simply call one number where staff will co-ordinate transport for the user by engaging with a variety of transport providers.</p> <p>A web based booking system has been utilised with staff booking journeys in a way that better suits the service user. The service user is asked a series of questions at point of booking tailored in such a way as to ensure that whoever is dealing with the booking can ensure the correct mode of transport is booked e.g. accessible vehicle allowing staff to provide a form of transport that is most suited to the users' needs.</p> <p>The Community Transport Hub has:-</p> <ul style="list-style-type: none"> <li>• engaged citizens &amp; customers;</li> <li>• provided a single point of contact and information;</li> <li>• facilitated one number for all;</li> <li>• hosted a single vehicle booking system;</li> <li>• built a volunteer base; ensured service quality;</li> <li>• reported on performance; and</li> <li>• contributed to the wider aims of the Strategic Transport Board.</li> </ul>			
<b>2</b>	<b>Project's strategic fit with key priority areas for the Scottish Borders H&amp;SCP</b> (Refer to strategic plan and annual performance report for key priorities)		
<b>Health and Social Care Plan</b>			
<i>Objective 1 We will make services more accessible and develop our communities.</i>			
The CTH does exactly what objective 1 requires in providing a single point of contact for accessible transport. The majority of transport is provided by volunteers providing volunteering opportunities for members of the community developing strong communities.			
<i>Objective 2 We will improve prevention and early intervention – ensuring that people struggling to manage independently are quickly supported through a range of services that meet their individual needs.</i>			
The CTH single point of contact supports people to be independent by enabling easy access for their transport needs. Hub Operators negotiate changes to appointment times and dates to ensure transport is available. In addition they identify individuals who need additional support and signpost to other services. The single number also gives individuals access to transport for their social needs e.g. attendance at social centres and lunch clubs.			
<i>Objective 3 We will reduce avoidable admissions to hospital – by appropriate support in the right place at the</i>			

# Integrated Care Fund End of Project Report

March 2018

*right time, we will ensure people are supported to remain in their own homes.*

CTH assists people to make their way through the health and social care system by ensuring attendance for appointments thus reducing the need for hospital admissions and move to residential care.

*Objective 4 We will provide care close to home – accessible services which meet the needs of local communities, allows people to receive their care close to home and build stronger relationships with providers.*

The CTH supports people to live independently and healthily in local communities. By facilitating transport that enables people with physical disability to fully engage in their local community. Many clients suffer with dementia. Hub staff are experienced in supporting them to remain independent within their own home with easy access to transport when required.

*Objective 5 We will deliver services within an integrated care model – through working together we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.*

The CTH is the point of contact for a range of accessible transport providers operating across the Scottish Borders. The single point of contact is available to the Scottish Ambulance Service and all other statutory services providing an integrated approach to transport requirements. This approach has increased the satisfaction of staff, reduced time and relieved anxiety.

*Objective 6 We will seek to enable people to have more choice and control. - ensuring people have more choice and control means they have the health and social care support that works best for them.*

The CTH as a single point of contact for accessible transport enables people to have choice as to their means of attending appointments and social activities. They do not need to rely on relatives, neighbours or friends. The Hub provides an integrated, high quality service.

*Objective 7 We will further optimise efficiency and effectiveness – strategic commissioning requires us to constantly analyse, plan, deliver and review services which give us flexibility to change what we do and how we do it.*

Before the establishment of the CTH, Scottish Ambulance Service and other services were provided with a confusing range of contact points for Community Transport Services. The analysis of this confusion led to the original ICF application and the development of the single point of contact. To return to the previous situation will increase the confusion and anxiety. The Hub has an oversight of all community transport provision and is able to provide data and analysis identifying need in particular communities.

*Objective 8 We will seek to reduce health inequalities – ensuring people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.*

The development of the CTH is one of the changes that ICF enabled putting in place a coordinated approach to providing community transport. The Hub has ensured openness and consistency around access to services. It has worked with community transport providers across all sectors to provide appropriate, affordable and accessible transport services. It has helped to reduce health inequalities and supported those who are vulnerable in our communities.

*Objective 9 We want to improve support for Carers to keep them healthy and able to continue in their caring role.*

The CTH provides a single point of contact relieving anxiety that Carers might otherwise experience in securing accessible transport for those they care for. They are reassured that the transport provided will deliver a door to door service enabling them to have respite from their responsibilities.

## **Scottish Borders Locality Plans**

*Each Locality Plan include in it an action plan to develop links with the CTH.*

## **Health and Social Care Annual Report performance against key priorities 16/17**

*Develop integrated and accessible transport.*

The CTH has put in place a coordinated, sustainable approach to community transport provision.



**3 Original Project Aims**

**Strategic Objectives**

- 1) Statutory and third sector partners will be involved in the development and running of the project which build upon earlier work carried out by the Red Cross and the Bridge.
- 2) The project will be part of a bigger review of transport provision in the Borders
- 3) The Project will operate Borders wide and services will be developed to suit the needs of each locality.
- 4) All partners will be fully involved in developing the project and the views and suggestions of service users will be taken on board to aid continual improvement and to ensure service provision is user centred.
- 5) To meet the aims of the Strategic Transport Board’s Transport Commissioning Strategy.
- 6) The project will link the use of the funds to the delivery of integrated health and wellbeing outcomes for adult health and social care

**Project Objectives**

- 1) All partners will work together to provide a co-ordinated transport service across the Borders.
- 2) Voluntary Sector Partners will work to align service provision to create a consistent service level for the CTH.
- 3) Efficiencies will be generated from reduction in duplicate journeys across all partner organisations.
- 4) There will be one borders number.
- 5) Flexi route will be piloted and upon demonstration of success, a plan developed for roll out.
- 6) A robust volunteer base will be available to meet demand.
- 7) A reduction in taxi spend across NHS and SBC
- 8) A full evaluation will be available and mainstreaming achieved.

**4 Project outcomes and benefits achieved**

Between 1 October 2015 (CTH start date) and 31 January 2018 the CTH facilitated 8,962 journeys, of this number 4,366 were for hospital appointments. 80% of service users agreed that the service has increased independence.

Since the beginning of the project 1,049 service users, not previously known to Community Transport providers registered with the CTH.

A survey in early 2017, (100 survey forms sent, 82 returned) resulted:

1. How do you rate the booking system 95% good or excellent
2. Ease of use 93% good or excellent
3. Friendliness and approachability 100% good or excellent
4. Efficiency 100% good or excellent

A recent survey of 90 new registered service users resulted in a return of 42 survey forms;

1. How would you rate the booking system? 81% good or excellent. The remainder marked adequate.
2. The service helped me be independent? 83% agreed or strongly agreed. One disagreed. Remainder no answer.
3. The service boosted my confidence? 86% agreed or strongly agreed. No answer 14%
4. The service helped me feel less stressed about travel? 88% agreed or strongly agreed. No answer 12%
5. I arrived at a time that suited me? 93% agreed or strongly agreed. No answer 7%

Because the CTH coordinators have a Borders wide view of transport provision, they have been able on many occasions to arrange shared journeys reducing costs and unnecessary or duplication of journeys. The coordinators have become skilled at negotiating with hospital departments and health providers’ changes to appointment times to ensure missed appointments do not occur.

When further support is needed for individuals the operators signpost to other services.

In 2016 CTH received The Transport Times Accessibility Project of the year award against stiff competition from Edinburgh Airport and Glasgow Central Station.

# Integrated Care Fund End of Project Report

March 2018

<b>5</b>	<b>What areas of the Borders does the project cover</b>	
Borders wide service. Delivery of transport is provide by Berwickshire Wheels, British Red Cross, Gala Wheels, Teviot Wheels, Tweed Wheels and The Royal Voluntary Service.		
<b>6</b>	<b>What care groups does the project affect?</b>	
Residents of the Scottish Borders who are elderly or disabled and do not have access to a family car and limited in their ability to access public transport.		
<b>7</b>	<b>Current project end date</b>	
31 <sup>st</sup> March 2018		
<b>8</b>	<b>How much ICF Fund allocated</b>	
<b>Original ICF Allocation</b>		<b>Predicted Spend to end of March 18</b>
£139.000		£139,000
<b>9</b>	<b>Staff recruited to support delivery of the project</b>	
<p>Two Hub Co-ordinators currently employed and line managed by the British Red Cross (not to continue after 31 March 2018).</p> <p>One Project Development Office in year 2, contract ended. Project Development Officer seconded from BAVS since 1 October 2017 (not to continue after 31 March 2018) Not funded by ICF.</p> <p>Dedicated driver in post from August 2017 to help meet the excess demand for the community transport generated by the CTH.</p>		
<b>10</b>	<b>Invest to save proposals identified for the project</b>	
<p>The CTH has sight of all community transport provided across the Borders that has enabled many shared journeys reducing the costs of duplication and CO2 emissions and improving efficiencies.</p> <p>CTH coordinators have built working relationships with hospital departments and local health providers negotiating changes to appointment times to a time when transport is available reducing missed appointments.</p> <p>Hub operators identify individuals requiring additional support to retain their independence and signpost to other services.</p> <p>The service relieves anxiety around transport requirements helping people to retain their independence and remain in their own homes reducing the need for hospital admissions and residential care.</p> <p>The single number increases efficiency for agency staff.</p>		
<b>11</b>	<b>Project support requirements beyond end of March 2018</b>	
<p>To mainstream the Borders Community Transport Service Hub (CTH) and to provide sustainability for the future.</p> <p>The British Red Cross currently host and manage the CTH. This will not continue after 31 March 2018. Berwickshire Association for Voluntary Service could potentially take on this role if a budget could be secured to cover one-off start-up costs and funding agreed for 3 years with the option to extend after that period. The first year budget (2018/19) is estimated at £65,900. Annual cost for the following years is estimated at £55,100. There will need to be an agreed annual inflation element. Payment to be made annually in advance.</p>		
<p><b>Please return this form to the Programme Team by Friday 23 March 2018</b>  <b>Email: <a href="mailto:IntegratedCareFund@scotborders.gov.uk">IntegratedCareFund@scotborders.gov.uk</a></b>  <b>Phone: 01835 82 5080</b></p>		

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	No 12 - Health and Social Care Locality Coordinator		
<b>Project Owner</b>	Jane Robertson	<b>Main Contact Telephone</b>	01835825080
<b>Main contact email</b>	Trish.wintrup@scotborders.gov.uk		

## Guidance on End of Project Report

The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018

### 1 Outline project description *Please summarise the project in no more than 250 words*

Under Scottish Government Legislation (Public Bodies (Joint Working) Act 2014, Local Authorities and Area Health Boards are required to integrate planning for, and delivery of, certain Adult Health and Social care services.

The Locality Coordinators (3 appointed April 2016) will develop plans for each Locality, through which they will facilitate effective partnership working across all local agencies as well as promoting integrated working on a locality basis. As well as the development of locality plans, the coordinators will play a role in the implementation of the plans.

Since September 2017 one Locality Coordinator has continued to support the facilitation of the Locality working groups, bringing together information to inform the groups on projects designed to deliver a community focused approach to health and social care both at a national and local level.

The Locality Coordinator role is to:

- Utilise the national objectives/local outcomes documented in the Strategic Plan 2016-19 to inform the development of all five H&SC locality plans.
- Build relationships with existing community groups and partners at locality level, including housing, independent and third sector organisations.
- Work co-productively with GP practices across the Borders to redesign services to support more effective communications between stakeholders and also to improve timely access to appropriate services.
- Capture what is already happening to promote and provide appropriate community based health and social care; use and build upon this work with the relevant partnerships and community groups across each of the localities.
- Clearly define what can be developed/planned to deliver care closer to home by the right person, at the right time, with the right information in the short, medium and long term.
- Maximise integrated financial resources to benefit all localities in the Scottish Borders in delivering timely, safe and effective care to improve outcomes and reduce health inequalities.
- Keep the Scottish Borders population informed by communicating effectively and in a timely manner.

### 2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP *(Refer to strategic plan and annual performance report for key priorities)*

This project is considered to be high impact across all 9 of the strategic objectives but in particular:

#### Make Services More Accessible and Develop Our Communities

- Establishment of 'What Matters' Hubs across all localities in the Scottish Borders – single point of contact, supports access to signposting and services at an earlier point – early intervention and prevention

# Integrated Care Fund End of Project Report

March 2018

- Matching Unit – matching care needs identified with available providers
- Support further development of ‘Healthy Living Networks’ supporting health literacy and enhancing health and wellbeing of individuals and addressing health inequalities
- Support further development of Community Capacity Building – for adults and older people, building resilience and supporting a reduction in issues such as loneliness and isolation
- New Community Equipment Service opened October 2017 – provides opportunities to make necessary equipment available at an earlier stage – supports early intervention and prevention and reduction in harm
- Community Transport Hub – provides a coordinated approach to accessible transport across the region – single point of contact
- Live Borders Health and fitness programmes
- Work with transport providers – to help address issues of loneliness and isolation across rural area and towns in the Scottish Borders

## Provide care close to home

- Reshape Allied Health Professional Services to support community care
- Transform Day Services
- Improve support for Unpaid Carers to stay well and continue their caring role – supports a reduction in health related issues and recognises the important role in supporting the cared for person
- Review Community Hospital and Day hospital services to support health care provision closer to home and support a reduction in avoidable attendance and admission to the BGH
- Hospital to Home – support a reduction in delayed discharges which are attributed to lack of home care support – this new service is designed with reablement in mind – increasing the wellbeing of those who need support to live safely at home

## Deliver services with an integrated care model

- Redesign Locality based Health and Social Care teams to provide a community focus to health and social care.

Localities Approach was noted as a key priority for 2017/18 in last years’ Annual Performance Report

g3

## Original Project Aims

- The postholder will be expected to continue to facilitate effective partnership working across all agencies in all five localities of the Scottish Borders(including the Third and Independent sector), facilitate integrated working with the District General Hospital, ensure effective joint working with other Council Departments and encourage and support the involvement of independent contractors in the delivery of the integrated health and social care services.
- The locality coordinator will assist in the engagement and involvement of local communities, service users and carers in the design and delivery of services
- The postholder will also report to the Local Authority Area committees on the progress of the locality plans which is a subset of the Scottish Borders Health and Social Care Strategic Plan for 2017 - 2019. This will provide opportunity for reporting performance and provide scrutiny, contributing to the oversight of the Joint Strategic Plan
  - Increase the utilisation of community services (planned Care)
    - Anticipatory care planning for Long term conditions;
    - Maximising the capacity of currently available services to deliver care (locally);
    - Identify new ways of working together to support improvement in health and wellbeing outcomes
  - Assist people and communities to help and support themselves
    - Increase community capacity;

- Provide community-based education;
  - Support people towards self –management of conditions.
- Reduce unplanned/unscheduled admissions to hospital
  - Reduce unnecessary demand for hospital care;
  - Maximise capacity to deliver/optimize opportunity to those patients who require secondary care interventions
  - Appropriate resource management within community, primary and secondary care providers;
- Support people to live independently and well within local communities
- Develop relationships and work closely with the third and independent sector locally to improve access to services and coordination between services
- Work coproductively with GP Practices – GMS contract to develop ‘clusters of GP practices’ across regions
  - ensure effective communication and timely access for people who use services
  - Utilise all members of the multidisciplinary team to provide – care right person/right time
  - Free up GP Capacity within the community to address complex care
- Ensure effective joint working with other council departments and ongoing locality projects
- Provide a robust reporting mechanism on performance

4

## Project outcomes and benefits achieved

- Improved communications and coordination of services
- Easier access to local services for service users, their families and GP Practices
- Improved linkages with the Third and Independent sector locally to improve access and coordination between the services
- Redesigned services locally to meet the needs of the local adult population, local communities in line with the improved outcomes
- Ongoing recommendations to the SPG on the future arrangements to support locality planning and integrated organisational arrangements
- Co-productively design, develop and consult on the Health and Social Care Locality Plans for all five localities across the Scottish Borders
- Data gathering to support the design and implementation of integrated health and social care teams
- Supported the development of the “What Matters” Hubs across all SB localities – which in turn are proving beneficial in reducing social work waiting lists, signposting members of the public to appropriate services to support an individual’s health, wellbeing and social care needs.
- Engagement with GPs in the health and social care agenda at locality level – supports the new GMS contract to develop the role of the GP as the ‘Expert Medical Generalist’ and lead for multidisciplinary team
- Improves outcomes for people and reduces risk
- Reduce avoidable attendance and admission to the Borders General Hospital
- Locality Working Group established in all localities. Engagement with community via the Locality Working Groups. Group members were asked if they agreed with the following statement ‘I feel engaged with the service users that I am in contact with’ 94% agreed at the end of the first year compared with 80% at the beginning of the process which demonstrates an increase in engagement with service users from an already high level.

The group reported no increase in their knowledge of local services, however the level of knowledge in this area was already high (80% felt they had a good knowledge of local

# Integrated Care Fund End of Project Report

March 2018

<p>services).</p> <p>The group reported a low level of consultation with communities on services which may indicate a need for further work in this area.</p> <p>The number of group members who felt there was strong engagement between H&amp;SC Partners and the community increased from 33% at the beginning to 56% after the first year.</p>					
<b>5</b>	<b>What areas of the Borders does the project cover</b>				
<p>Berwickshire, Cheviot, Eildon, Teviot &amp; Liddesdale and Tweeddale</p>					
<b>6</b>	<b>What care groups does the project affect?</b>				
<p>All care groups within Adult health and social care</p>					
<b>7</b>	<b>Current project end date</b>				
<p>31 March 2018</p>					
<b>8</b>	<b>How much ICF Fund allocated</b>				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; background-color: #00838f; color: white;">Original ICF Allocation</th> <th style="width: 50%; background-color: #00838f; color: white;">Predicted Spend to end of March 18</th> </tr> </thead> <tbody> <tr> <td style="background-color: #e6f2ff;">£259,500 + £50,818 agreed to extend project from October 2017 - £310,318</td> <td style="background-color: #e6f2ff;">Approximately £300,000</td> </tr> </tbody> </table>		Original ICF Allocation	Predicted Spend to end of March 18	£259,500 + £50,818 agreed to extend project from October 2017 - £310,318	Approximately £300,000
Original ICF Allocation	Predicted Spend to end of March 18				
£259,500 + £50,818 agreed to extend project from October 2017 - £310,318	Approximately £300,000				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="width: 50%; background-color: #e6f2ff;">£259,500 + £50,818 agreed to extend project from October 2017 - £310,318</td> <td style="width: 50%; background-color: #e6f2ff;">Approximately £300,000</td> </tr> </tbody> </table>		£259,500 + £50,818 agreed to extend project from October 2017 - £310,318	Approximately £300,000		
£259,500 + £50,818 agreed to extend project from October 2017 - £310,318	Approximately £300,000				
<b>9</b>	<b>Staff recruited to support delivery of the project</b>				
<p>3 Locality Coordinators to September 2017. One Locality Coordinator from October 2017 end of March 2018</p>					
<b>10</b>	<b>Invest to save proposals identified for the project</b>				
<p>Invest in this single point of contact for monitoring, implementation of Health and Social Care Locality Action Plans across all 5 localities, this will ensure progress is sustained and Scottish Government guidance for ongoing locality engagement is successfully achieved</p>					
<b>11</b>	<b>Project support requirements beyond end of March 2018</b>				
<p>Locality Coordinator extension to contract for 12 months and administrative support for the same period, to allow transition to health and social care operations in the long term. Total cost £79,652.</p>					
<p><b>Please return this form to the Programme Team by Friday 23 March 2018</b>  <b>Email: <a href="mailto:IntegratedCareFund@scotborders.gov.uk">IntegratedCareFund@scotborders.gov.uk</a></b>  <b>Phone: 01835 82 5080</b></p>					

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	No 16 - The Matching Unit		
<b>Project Owner</b>	Murray Leys	<b>Main Contact Telephone</b>	01835 824000
<b>Main contact email</b>			

## Guidance on End of Project Report

The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018

### 1 Outline project description *Please summarise the project in no more than 250 words*

The ' Matching Unit' is a small central administrative team created to match a service to the assessed needs of the client.

They complete the matching process by undertaking a number of administrative tasks previously completed by the care manager, freeing up the care managers time to focus on assessment and care management.

The Matching Unit focus on building positive and effective relationships with both home care agencies and care managers to enhance the quality of communication with customers.

The Matching Unit perform a critical role in ensuring that the service required by a client is sensitively matched with a Care at Home provider. The new provider needs to be made fully aware of the care requirements of each individual client.

Until the introduction of the Matching Unit, Care Managers would call round all the providers in their area to secure a service for their client. This meant that on any one day a provider could receive several calls from different care managers from various teams requesting a service. Care managers then had a number of time consuming admin tasks following the sourcing of care. These tasks are now undertaken by the Matching Unit and the availability of the provider is determined within one phone call. This simplifies the process and provides opportunities to more efficiently deliver the service.

It is clear from evaluation that the implementation of the Matching Unit has been an overwhelming success – reducing the amount of time care managers spend sourcing care and improving the efficiency and effectiveness of sourcing care.

If the Matching Unit was not to continue then the full potential of the Matching unit would not be realised. The continuation of the Matching Unit is essential to streamline access to services and support care managers to facilitate hospital discharges.

### 2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP *(Refer to strategic plan and annual performance report for key priorities)*

#### **We will reduce avoidable admissions to hospital by:**

- Sourcing care at home quickly and efficiently for those people in crisis at home
- Freeing up care managers time to undertake assessment and care management
- All care at home requests come through the Matching Unit they are able to prioritise
- Maintaining a care at home waiting list which identifies those that are in need of care at home both in hospital and in the community. This list is prioritised and sent out to providers twice weekly. This ensure that all care continually sourced by Matching Unit staff.

**We will provide care close to home by:**

- Maintaining knowledge as well as good working relationships with all the care at home providers in the Borders area and their boundaries. The Matching Unit use this knowledge to approach the correct provider to request care which is useful given the very rural nature of the Borders.

**We will deliver services with an integrated care model by:**

- The Matching Unit work with private home care providers within the borders and are also able to support district nursing colleagues in the future. They liaise on a daily basis with social work staff based in both the community and hospital teams.

**We will further optimise efficiency and effectiveness by:**

- Facilitating hospital discharges and freeing up beds by prioritising requests for care and sourcing care at home quickly and efficiently
- Freeing up care managers time to undertake assessment and care management tasks
- Undertaking admin tasks usually undertaken by care managers to complete the matching process
- Improving the accuracy of budget information by completing all social work managed initiation/variation forms which ensures accurate information goes to finance and care resource team.

**3 Original Project Aims**

The original aim of the project was to establish a successful Matching Unit within Health & Social Care. The success of this unit was based on the delivery of the measures set out below

- 1) Reduction in the percentage of Care Manager time used to identify & secure provision for clients.
- 2) Increase in the caseload held per Care Manager
- 3) Care Manager Staff Satisfaction
- 4) Matching Unit Staff Satisfaction
- 5) Care Provider Satisfaction

**4 Project outcomes and benefits achieved**

- 1) Reduction in the percentage of Care Manager time used to identify & secure provision for clients.

Staff were surveyed before the introduction of the Matching Unit and again after. They reported a reduction in the time spent securing care at home for clients from 20% to 9% of working week.

- 2) Increase in the caseload held per Care Manager

There has been no significant increase in caseload held by Care Managers at this stage. There are many variables to this measure including staffing vacancies, work patterns and complexity mix of cases. Further analysis to take place to look at the turnover of cases as it may be that this has increased due to the release of Care Manager time by the Matching Unit.

- 3) Care Manager Staff Satisfaction

Staff satisfaction with the new matching process is 90% compared with 6% for the previous process (before the unit was introduced).

Some staff feedback:



# Integrated Care Fund End of Project Report

March 2018

- The Matching Unit has been able to source better times for clients that I had tried for several months to get. They were also able to source an increase in care packages.
- The Matching Unit has enabled us to concentrate more on face to face work with clients and taken away much of the admin work relating to finding suitable care packages

#### 4) Matching Unit Staff Satisfaction

Matching Unit staff were asked to provide feedback on their role in summer 2017. They all said they intended to still work there in 12 months (if the unit continues). They all felt able to do their job a standard

they were pleased with and felt they had received the training they need for the role.

#### 5) Care Provider Satisfaction

Prior to the introduction of the Matching Unit, Care Providers were asked for their feedback on the previous matching process. They welcomed the new matching process, particularly the single point of contact. No feedback from Care Providers have been received on the new process. We intend to gather this in the near future.

### What areas of the Borders does the project cover

The Matching Unit cover the whole of the Scottish Borders.

### 6 What care groups does the project affect?

All clients of Social Care & Health Teams who have or require social work managed care packages. There are a number of additional tasks that the matching unit have the potential to undertake:

- Direct payment
- Individual service fund
- Respite
- Interim care home placements to facilitate discharge from Hospital

The Matching Unit also have the potential to extend the service to include additional client groups:

- District Nurse access to the Matching Unit to source care at home for patients receiving end of life care, for care managed, direct payment and individual service fund options.
- All clients of the Learning Disability Team, for social work managed, direct payment and individual service funds. Respite and care home placements can also be considered in consultation with the LD Team.
- All clients of the Mental Health Team, social work managed, direct payment, individual service fund. Respite and care home placements can also be considered in consultation with the MH Team.

### 7 Current project end date

The Matching Unit project is due to end on 31<sup>st</sup> March 2018. This would be a great loss to the health can social care teams who currently use the service and would undoubtedly result in a return to completing cumbersome admin processes in order to source care.

The loss of the matching unit would also mean that the unit would not be able to reach its full potential and support the care matching process for other teams and services.

# Integrated Care Fund End of Project Report

March 2018

The full impact of the service on facilitating hospital discharges is yet to be realised.

**8 How much ICF Fund allocated**

Original ICF Allocation	Predicted Spend to end of March 18
<p>£133,227</p> <p>This includes 2 approved exception report amounts of £10,500 in August 17 and £7,727 in December 17.</p>	<p>£120,000</p>

**9 Staff recruited to support delivery of the project**

It was identified that 4.0FTE staff, 1 Team Leader and 3 Care Co-ordinators would provide capacity to deliver home care matching, including cover for holidays & absence and management / supervision.

- Matching Unit started with 4.0FTE staff in place from April 2017
- From 2<sup>nd</sup> October 2017 the Matching Unit operated with 3.0FTE staff due to maternity leave (1 Team Leader and 2 Care Co-ordinators)
- One member of staff left 14<sup>th</sup> Feb 2018 for a permanent post.
- The Matching Unit had a period of sickness during Nov/Dec 2017 and additional funding was agreed Dec 2017 to recruit a temporary care co-ordinator. 2 temporary Co-ordinators were appointed at this time to also cover the above vacancy. Due to delays in the recruiting process no additional staff are yet in post.

Moving forward, if the Matching Unit Service is to continue then a significant amount of work can potentially be undertaken by the team. I would suggest the Matching Unit require 1 Team Leader and 4 care co-ordinators to fulfil the full potential of the Matching Unit.

Team leader Grade 8 Full time for 12 months - £35,000

Team member Grade 7 Full time for 12 months x4 - £29,000 x 4 - £116,000

Office Supplies - £250

Travel - £600

Set up for 4th Team member - £1000 (desk, phone, computer)

Total £152,850

**10 Invest to save proposals identified for the project**

Investment in the Matching Unit service reduces the time spent on administrative tasks by Care Managers, releasing them to participate in more client facing time. This should increase the turnover of the waiting list and increase the size of caseload which can be held at one time.

**11 Project support requirements beyond end of March 2018**

# Integrated Care Fund End of Project Report

March 2018

From 31<sup>st</sup> March 2018 the Matching Unit will require a half time project manager for one year to support the development of the service.

**Please return this form to the Programme Team by Friday 23 March 2018**

**Email: [IntegratedCareFund@scotborders.gov.uk](mailto:IntegratedCareFund@scotborders.gov.uk)**

**Phone: 01835 82 5080**

DRAFT

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	No 25(a) - Discharge to Assess at Craw Wood		
<b>Project Owner</b>	Jane Prior	<b>Main Contact Telephone</b>	01896 826271
<b>Main contact email</b>	Jane.prior@gmail.com		
<b>Guidance on End of Project Report</b>			
The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018			
<b>1</b>	<b>Outline project description</b> <i>Please summarise the project in no more than 250 words</i>		
Craw Wood, owned by Eildon Housing, has been re-furnished to provide facilities for up to 15 adults, opening with 8 beds at the start of December 2017, which increased to 15 at the start of January 2018, to be discharged from BGH for a residentially based assessment of critical needs and to await any required package of care prior to returning to their own home. Craw Wood is staffed 24 hours a day and registered with the Care Commission to provide short term care and support. A team of care managers from START complete assessments and request any POC and/or equipment required for discharge home. The project is supported by input as required by GP and DN from Waverley Practice.			
<b>2</b>	<b>Project's strategic fit with key priority areas for the Scottish Borders H&amp;SCP</b> (Refer to strategic plan and annual performance report for key priorities)		
Craw Wood is part of the new policy of discharging patients from hospital to undertake an assessment of need at home or in a homely setting. This project will help inform medium and long term strategy development on discharge to assess through the collection of quantitative and qualitative data.			
The project has high impact against the following strategic objectives:			
Reduce avoidable admissions to hospital Deliver services within an integrated care model Further optimise efficiency and effectiveness			
This project also delivers against the key priorities for 2017/18 set out in the last Annual Performance Report in terms of redesigning care pathways.			
<b>3</b>	<b>Original Project Aims</b>		
To introduce a new policy of discharging patients from hospital to undertake an assessment of need in a homely setting.			
For evaluation of the Craw Wood pilot to instruct and direct the Social Care Partnership with regard to the optimal operational model for Discharge to Assess.			

# Integrated Care Fund End of Project Report

March 2018

## 4 Project outcomes and benefits achieved

### Key Outcomes/Outputs

Outcomes/Outputs	Baseline	Target	Actual	Comments
Occupancy of Facility (expressed in Occupied Bed Days)		90%	75%	Data taken from 11th Dec 2017 – 29th Jan 2018. Week beginning 4 <sup>th</sup> Dec was used to 'ramp-up'.

Week Commencing	Average Occupancy	Available beds	Ave' bed occupancy
04.12.2017	39%	8	3
11.12.2017	73%	8	6
18.12.2017	88%	15	7
25.12.2017	88%	15	7
01.01.2018	64%	15	10
08.01.2018	78%	15	12
15.01.2018	64%	15	10
22.01.2018	68%	15	10
29.01.2018	tbc	23	tbc

Outcomes/Outputs	Baseline	Target	Actual	Comments
Individuals stay in Facility no longer than 2 weeks		Zero	3	
Individuals that stay in the Facility are able to be discharged home		100%	75%	7 of 27 patients that have been discharged have been re-admitted to the BGH
Individuals who return home, stay at home (BGH Readmission Rate <28 days)		TBC	TBC	Targets to be agreed.
Service Users Feedback is positive		100%	TBC	Data capture under development. Anecdotal feedback has been positive.
Staff Feedback is positive		100%	TBC	Data capture under development

# Integrated Care Fund End of Project Report

March 2018

<b>5</b>	<b>What areas of the Borders does the project cover</b>	
Patients are discharged from the BGH to Craw Wood from any area of Scottish Borders.		
<b>6</b>	<b>What care groups does the project affect?</b>	
Adults over 50 years of age who have had an admission to the BGH and who either have capacity to make an informed decision to consent to a move to Craw Wood or, who have a legal proxy for welfare decisions who is willing to work with the START team to ensure that the person is discharged to their own home within a maximum of two weeks of admission to Craw Wood.		
<b>7</b>	<b>Current project end date</b>	
March 31 <sup>st</sup> 2018.		
<b>8</b>	<b>How much ICF Fund allocated</b>	
<b>Original ICF Allocation</b>		<b>Predicted Spend to end of March 18</b>
£441,683 + Contingency fund £54,283		£210,350
<b>£495,966</b>		No SB Cares costs included for duration of project
<b>9</b>	<b>Staff recruited to support delivery of the project</b>	
1 x Occupational Therapist (agency contract) 2 x FTE care managers from core START team with backfill to START by agency social worker.		
<b>10</b>	<b>Invest to save proposals identified for the project</b>	
By discharging to assess from BGH as soon as person fit for discharge a contribution has been made to reducing delayed discharges and bed occupancy days.		
<b>11</b>	<b>Project support requirements beyond end of March 2018</b>	
To be agreed.		
<p><b>Please return this form to the Programme Team by Friday 23 March 2018</b>  <b>Email: <a href="mailto:IntegratedCareFund@scotborders.gov.uk">IntegratedCareFund@scotborders.gov.uk</a></b>  <b>Phone: 01835 82 5080</b></p>		

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	Hospital to Home		
<b>Project Owner</b>	Erica Reid	<b>Main Contact Telephone</b>	01896 828267
<b>Main contact email</b>	Erica.reid@borders.scot.nhs.uk		

## Guidance on End of Project Report

The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018

### 1 Outline project description *Please summarise the project in no more than 250 words*

This is a 6 month project which facilitates discharge home from hospital as well as preventing hospital admissions.

A small team of health care support workers are working within the district nursing team and their role is to provide a period of short-term care and programme of activities at home to individuals for up to six weeks.

The support provided by the team has a “re-abling” focus to build confidence and promote independence to maximise the early rehabilitation potential during the first six weeks of care. It is tailored to suit the needs of the individual to reach their rehab potential.

This involves integrated working of social work, the Knoll Community hospital, AHPs and district nursing teams to identify patients who are medically fit for discharge and will benefit from this approach.

Without a service such as this, the outcome for individuals may be increased dependency, an extended period of time in hospital, increased packages of care and potentially residential care.

### 2 Project’s strategic fit with key priority areas for the Scottish Borders H&SCP (Refer to strategic plan and annual performance report for key priorities)

#### Priority: Re-imagining Health and Social Care Teams

#### We will reduce avoidable admissions to hospital by:

- Providing short term care and support at home in a crisis or period of ill health to prevent an admission to hospital
- Being able to respond quickly in a crisis and put care in place without delay

#### We will improve prevention and early intervention by:

- Providing a re-ablement approach with the aim to maximise the early rehabilitation potential of the person
- Being able to react quickly to provide a service and prevent further deterioration in the persons health/abilities

#### We will deliver services with an integrated care model by:

- Close working relationships between the district nursing team, social work, the Knoll Community Hospital and AHPs to identify and provide the appropriate support for people who are ready for discharge.

# Integrated Care Fund End of Project Report

March 2018

- Working jointly with SB Cares and the hospital social work team (START) to provide care packages.
- Liaising with GP's and community social work teams for people living at home.

## **We will seek to enable people to have more choice and control by:**

- Enabling people to receive care in their own home where their condition does not require a hospital admission.
- Encouraging and promoting independence at home and the ability to undertake tasks as independently as possible,
- Enabling those receiving end of life care to have the choice to be cared for at home

## **We will further optimise efficiency and effectiveness by:**

- Facilitating hospital discharges reducing delayed discharge numbers
- Providing care and support at home rather than in hospital bed
- Providing a re-ablement approach with the aim to maximise the early rehabilitation potential
- Supporting a return to independence therefore requiring a reduced package of care.

### 3 Original Project Aims

To complete a test of change and evaluate the model of 'Hospital to Home' plus increase the capacity within home care.

### 4 Project outcomes and benefits achieved

The outcomes for this project are:

- Reduction in the number of service users awaiting care in Berwickshire
- Reduction in size of care packages
- Reduction in hospital readmission rate
- Reduction in patients staying in hospital when they are medically fit for discharge.
- Facilitate effective discharge.
- Package of care prior to hospital admission
- Improved independence, patient wellbeing and confidence to return home.
- Improved individual and staff satisfaction

The service has only been operational for 6 weeks so it is too early to determine whether these outcomes have been achieved.

### What areas of the Borders does the project cover

The hospital to home project became operational on 12<sup>th</sup> Jan 2018 in the Berwickshire locality.

### 6 What care groups does the project affect?

The project currently provides support to adults over 65 or those receiving end of life care.

### 7 Current project end date

The original project end date was set at March 2018. This has now been extended to a 6 month pilot to end in June 2018.



# Integrated Care Fund End of Project Report

March 2018

<b>8</b>	<b>How much ICF Fund allocated</b>	
	<b>Original ICF Allocation</b>	<b>Predicted Spend to end of March 18</b>
	£108,283	£25,000 (Berwickshire phase only)
<b>9</b>	<b>Staff recruited to support delivery of the project</b>	
	2.7 WTE staff are employed as Health Care Support workers for this project in Berwickshire. There is also a 37.5hr post to backfill the district nurses who are providing line management for the team.	
<b>10</b>	<b>Invest to save proposals identified for the project</b>	
<b>11</b>	<b>Project support requirements beyond end of March 2018</b>	
	<p>The pilot has been agreed to be extended the Berwickshire Pilot to end of June 2018. The pilot has also been agreed to be expanded to Hawick and Central Localities to provide a more robust sample to test and evaluate the model.</p> <p>To fully understand and evaluate the impact of this model it will require a further 12 months funding as this is radically changing the model of service provision for the local population. Proposal to carry forward remaining £83k of allocated fund to 18/19 to support project going forward.</p>	
<p><b>Please return this form to the Programme Team by Friday 23 March 2018</b>  <b>Email: <a href="mailto:IntegratedCareFund@scotborders.gov.uk">IntegratedCareFund@scotborders.gov.uk</a></b>  <b>Phone: 01835 82 5080</b></p>		

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	Stress and Distress Training		
<b>Project Owner</b>	Brian Paterson	<b>Main Contact Telephone</b>	01896 827156
<b>Main contact email</b>			

## Guidance on End of Project Report

The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018

### 1 Outline project description *Please summarise the project in no more than 250 words*

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.

### 2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP *(Refer to strategic plan and annual performance report for key priorities)*

Mapping of Stress and Distress project against the H&SC Partnership Local Strategic Objectives

Objective 1	Objective 2	Objective 3	Objective 4	Objective 5	Objective 6	Objective 7	Objective 8	Objective 9
Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide care close to home	Deliver services within an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
	★	★		★				★

★ High Impact

This project also links into dementia care pathways which is listed as a key priority for 2017/18 in the Annual Performance Report.

# Integrated Care Fund End of Project Report

March 2018

## 3 Original Project Aims

**Aim:**  
 To Provide access to Stress and Distress therapeutic interventions within all Health and Social Care Establishments Across Scottish Borders Area  
 To Provide access to Stress and Distress therapeutic interventions within all Care inspectorate registered facilities provided by third sector and for profit organisations

**Objectives:**  
 To deliver Stress and Distress training two day training to 500 staff  
 To deliver Bite size Stress and distress training to 200 plus staff  
 To impact positively on commitment 10 (on behalf of OPAH)  
 To impact positively on Commitment 11 (Mental Health )  
 To positively impact on outcomes for people with Dementia  
 Through reduction in:

- admissions into care
- admissions /re-admissions into hospital (Acute and Psychiatric)
- prescribing of neuroleptic medication

(all above objectives are quantitatively measurable)

- To positively impact on health and wellbeing of receivers of therapeutic intervention (quantitative and qualitative ,enabled through evaluation, measurement)

## 4 Project outcomes and benefits achieved

Outcomes/ Outputs	Baseline	Target	Actual	Comments
Deliver 2 day training	16	200 staff	217 <i>(Up to end Feb 2018)</i>	It should be noted that in total <b>352</b> training places have been offered for this training. The smaller number of people trained is reflective of a significant number of cancellations and participants not attending on the day.
Deliver bite size training	20	500 staff	433 <i>(Up to end Feb 2018)</i>	
Reduction in admission into care				This data is being collected as routine audit data for NHS Borders and will be available at the end of March 2018 as part of the final evaluation of the project.
Reduction in Antipsychotic and 'As Required (PRN)' prescribing				
Reduction in length of patient stay				
Reduction in readmission to hospital				
Datix incidences of violence and aggression				
Improvement in receiver health and wellbeing				

# Integrated Care Fund End of Project Report

March 2018

Forty Health Care Support workers from within Nurse Bank, the General and Community Hospitals have been trained in 'Bitesize' Stress and Distress Training. In addition, 15 trained staff from Wards 9, 10, 12 and the Community Hospitals have been trained in the two day Stress and Distress training. The attendance of these acute hospital staff at this training has been promoted by the organisation including both associate directors of nursing (mental health and the acute hospital), the medical director and the Prevention and Management of Violence and Aggression (PMAV) Team.

Although it is progress that these staff have attended the training, this represents a relatively small number of staff within Borders General and Community Hospitals. It has required the duration of the project thus far to recruit these staff to training, therefore we would anticipate it taking longer to recruit sufficient staff in order to bring about significant culture change within this environment.

Outcome data for both forms of S&D training suggest changes in attributions relating to distress in this population. The data suggests that following completion of training, staff are more likely to attribute distressed behaviours to cognitive, emotional and environmental factors rather than diseased or intentional factors.

Mental Health Units in NHS Borders Specialising in Care of people with dementia received support from the stress and distress project. This was provided through access to training, support, consultation and supervision.

The most significant addition associated with the S&D project in the Dementia Units has been the introduction of S &D care plans. These are now in place for all patients in these units and their use and implementation is regularly audited by senior nursing staff within the units and the operational manager. The purpose of this document is to help staff identify areas of potential unmet social, environmental or psychological need.

A further significant addition to organisational process has been the addition by the Mental Health Inpatient Operational Manager of S & D as a contributing factor to incidents of violence and aggression and falls in our incident reporting system. When incidents are reported via this system they are then reviewed by management and risk health and safety to consider whether any further changes to care or the environment could be made to prevent these instances occurring again. In terms of patient care, this provides further feedback into S & D care plans and reinforces the use of this model in terms of understanding and responding to patient need.

A database of all staff attending training is maintained.

<b>5</b>	<b>What areas of the Borders does the project cover</b>
Whole of Borders	
<b>6</b>	<b>What care groups does the project affect?</b>
Adults with Dementia co- morbidity with mental health issues people with learning disability, functional mental health issues, physical conditions and long term neurological conditions.	
<b>7</b>	<b>Current project end date</b>
31 <sup>st</sup> March 2018	

# Integrated Care Fund End of Project Report

March 2018

<b>8</b>	<b>How much ICF Fund allocated</b>	
	<b>Original ICF Allocation</b>	<b>Predicted Spend to end of March 18</b>
	£166,000	£70,000
<b>9</b>	<b>Staff recruited to support delivery of the project</b>	
	Project Lead Psychologist 18.75 hours per week	
<b>10</b>	<b>Invest to save proposals identified for the project</b>	
	N/A	
<b>11</b>	<b>Resources required to sustain the project</b>	
	Lead Psychologist – 18.75 hours per week Administrator – 4 hours a week	
<b>12</b>	<b>Project support requirements beyond end of March 2018</b>	
	Request to carry over approximately £96,000 from April 2018 until March 2020. This will allow continued delivery of training and ongoing support for the implementation and supervision of staff delivering Stress and Distress in Care Homes and mental health wards across Borders. This will allow the model to be embedded into practice and ensure sustainability. NHSB and SBC are developing an Older Adults Outreach Service and the model of service delivery will be based around Stress and Distress. Ongoing supervision of the model by a Clinical Psychologist is essential to this work. NHSB will review the ongoing funding of this post beyond 2020 as part of the current service transformation work.	
<p><b>Please return this form to the Programme Team by Friday 23 March 2018</b>  <b>Email: <a href="mailto:IntegratedCareFund@scotborders.gov.uk">IntegratedCareFund@scotborders.gov.uk</a></b>  <b>Phone: 01835 82 5080</b></p>		

# Integrated Care Fund End of Project Report

March 2018

<b>Project Name</b>	Buurtzorg in the Borders		
<b>Project Owner</b>	Erica Reid	<b>Main Contact Telephone</b>	01896 828267
<b>Main contact email</b>	Erica.reid@borders.scot.nhs.uk		
<b>Guidance on End of Project Report</b>			
The purpose of this report is to give a brief outline on key outcomes achieved for Integrated Care Funded Projects approaching funding end March/April 2018			
<b>1</b>	<b>Outline project description</b> <i>Please summarise the project in no more than 250 words</i>		
This project aims to bring the principles of the Buurtzorg model of neighbourhood nursing to a new model of integrated health and social care in Coldstream. The district nursing team and SB cares team in Coldstream are using this model to guide them in approaching care as a multi-agency team with a person-centred approach. This is a holistic approach to providing integrated care in the individual's home, through teams that will be self-organising and linking into the assets of the local community.			
<b>2</b>	<b>Project's strategic fit with key priority areas for the Scottish Borders H&amp;SCP</b> (Refer to strategic plan and annual performance report for key priorities)		
<b>The strategic fit is with the IJB priority of 're-imagining health and social care teams'.</b>			
<b>3</b>	<b>Original Project Aims</b>		
The project aims to provide a radically different model of teamworking in a local community. This will lead to improvements in care co-ordination and reducing the footfall of people providing health and care services that go into people's homes. It also aims to reduce the amount of care people require in their homes by providing a co-ordinated approach to care for those who receive both health and social care services.			
<b>4</b>	<b>Project outcomes and benefits achieved</b>		
<b>This model is enabling the Coldstream team to move towards truly integrating care in people's homes. We have established IT to enable the SB Cares team leader to be co-located on Thursdays. We have set up a weekly multi-agency meeting where people receiving care in the local community to ensure their care needs are being met in the most effective manner.</b>			
<b>5</b>	<b>What areas of the Borders does the project cover</b>		
It currently covers the Coldstream area, but it is anticipated to spread this to other localities once this has been tested.			
<b>6</b>	<b>What care groups does the project affect?</b>		
The affects patients who are on the District Nurse caseload in the Coldstream area, and it also affects people in the locality who are receiving care from SB Cares.			
<b>7</b>	<b>Current project end date</b>		
The current project end date is March 2018.			
<b>8</b>	<b>How much ICF Fund allocated</b>		

# Integrated Care Fund End of Project Report

March 2018

Original ICF Allocation	Predicted Spend to end of March 18
£52k	0
<b>9 Staff recruited to support delivery of the project</b>	
<p>The District Nurse team lead has been provided with 22.5 hours backfill to provide leadership to the project. There have been two Healthcare Support Workers recently appointed to enable flexibility of care provision and an enabling approach to return people to as much independence as possible.</p>	
<b>10 Invest to save proposals identified for the project</b>	
<p>N/A</p>	
<b>11 Project support requirements beyond end of March 2018</b>	
<p>This is a radically different model of working from our current practice. To enable this to continue in its development this will require project management support, data analyst for evaluation, funds to allow carers employed by SB Cares to attend a weekly hour long huddle on patient/service user priorities and the continued employment of the two HCSWs.</p> <p>It also requires the appointment of a ‘coach/heat shield’ individual to facilitate the team to self-organise and work with the team to reduce the organisational bureaucracy that reduces the service user facing time for the teams.</p> <p>It is proposed existing allocation of £52k is carried over to fund project support for 18/19 and that an additional £45k is allocated to fulfil the heat shield function.</p> <p>A Project Board has been set up to oversee implementation plans and progress.</p>	
<p style="text-align: center;"><b>Please return this form to the Programme Team by Friday 23 March 2018</b>  <b>Email: <a href="mailto:IntegratedCareFund@scotborders.gov.uk">IntegratedCareFund@scotborders.gov.uk</a></b>  <b>Phone: 01835 82 5080</b></p>	

This page is intentionally left blank