Public Document Pack

Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Wednesday, 14th August, 2019** at **10.00 am** in Council Chamber, SBC HQ

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	**Chair**	Verbal
10.01	**2**	**REGISTER OF INTERESTS**	**Chair**	(Pages 3 - 12)
10.10	**3**	**MINUTES OF PREVIOUS MEETING**	**Chair**	(Pages 13 - 22)
10.15	**4**	**MATTERS ARISING** Action Tracker	**Chair**	(Pages 23 - 30)
10.20	**5**	**FOR DECISION**		
	5.1	Integration Joint Board 2019/20 Financial Plan Addendum	**Interim Chief Financial Officer**	(Pages 31 - 32)
	5.2	2018/19 H&SC IJB Annual Performance Report	**Programme Manager**	(Pages 33 - 102)
	5.3	Redesign of Dementia Services	**Chief Officer**	(Pages 103 - 222)
	5.4	Bi-Annual Review of Risk Register	**Chief Internal Auditor**	(Pages 223 - 228)
	5.5	2018/19 Integration Joint Board Annual Audit Report	**Interim Chief Financial Officer**	(Pages 229 - 270)
11.30	**6**	**FOR NOTING**		

6.1	Financial Outlook Update • NHS Borders (Presentation) • Scottish Borders Council (Verbal report) • IJB (Verbal Report)	**Directors of Finance**	
7	**ANY OTHER BUSINESS**	**Chair**	Verbal
8	**DATE AND TIME OF NEXT MEETING** Wednesday 18 September 2019 at 10.00am in the Council Chamber, Scottish Borders Council	**Chair**	Verbal

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 14 August 2019

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

REGISTER OF INTERESTS

Purpose of Report:	To seek approval of the remaining declarations for inclusion in the Register of Interests as approved by the Health & Social Care Integration Joint Board on 19 June 2019.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the Register of Interests.

Personnel:	N/A

Carers:	N/A

Equalities:	Compliant

Financial:	N/A

Legal:	Statutory requirement.

Risk Implications:	N/A

Description of interests to be registered – pages 2-4

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

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

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

1. REMUNERATION

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

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

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

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

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

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

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

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

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

2. RELATED UNDERTAKINGS

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

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

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

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

3. CONTRACTS

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

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

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

4. HOUSES, LAND AND BUILDINGS

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

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

5. INTERESTS IN SHARES AND SECURITIES

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

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

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

6. GIFTS AND HOSPITALITY

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

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

7. NON FINANCIAL INTERESTS

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

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

Page 64

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	*John McLaren*
Category of Membership	*Voting Member*
Date of Declaration	22nd July 2019
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	Paid salary by NHS Borders and Honorarium from Scottish Government for being Non Executive Director
2	**Related Undertakings**	Work for NHS Borders
3	**Contracts**	Full time employment NHS Borders
4	**Houses, Land and Buildings**	Nil
5	**Shares and Securities**	Nil
6	**Gifts and Hospitality**	Nil
7	**Non Financial Interests**	Member of Labour Party, Member of Trade Union Unite and registered with NMC.

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

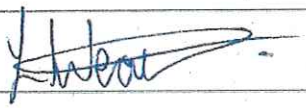
Members Name	*Shona Haslam*
Category of Membership	*Voting Member*
Date of Declaration	18/6/19.
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	
2	**Related Undertakings**	
3	**Contracts**	
4	**Houses, Land and Buildings**	Office Building cawalry Park Peebles Courthouse, High St. Peebles.
5	**Shares and Securities**	
6	**Gifts and Hospitality**	
7	**Non Financial Interests**	

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

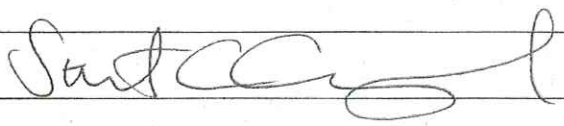
Members Name	*Tom Weatherston*
Category of Membership	*SBC voting member*
Date of Declaration	21 07 2019
Member's Signature	

	Registerable Interest	**Description of Interest**
1	**Remuneration**	SBC Elected member
2	**Related Undertakings**	none
3	**Contracts**	none
4	**Houses, Land and Buildings**	Part owner 60 Oakfield Court Kelso Part owner 60 Inchmyre Kelso
5	**Shares and Securities**	none
6	**Gifts and Hospitality**	none
7	**Non Financial Interests**	none

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	*Stuart C. Easingwood*
Category of Membership	*Non-Voting Member / Professional Advisor*
Date of Declaration	19/06/2019
Member's Signature	

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

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	Yvonne Smith
Category of Membership	
Date of Declaration	22/07/19.
Member's Signature	YSmith

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

Scottish Borders Health & Social Care
Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

REGISTER OF INTERESTS

Members Name	*Lynn Gallacher*
Category of Membership	*Non voting*
Date of Declaration	28/06/2019
Member's Signature	L C Gallacher

Registerable Interest		**Description of Interest**
1	**Remuneration**	Employed as Centre Manager by Borders Carers Centre
2	**Related Undertakings**	-
3	**Contracts**	-
4	**Houses, Land and Buildings**	-
5	**Shares and Securities**	-
6	**Gifts and Hospitality**	-
7	**Non Financial Interests**	-

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Wednesday 19 June 2019 at 10.00am in the Council Chamber, Scottish Borders Council.

Present:	(v) Cllr D Parker	(v) Dr S Mather (Chair)
	(v) Cllr J Greenwell	(v) Mr M Dickson
	(v) Cllr S Haslam	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	(v) Mr T Taylor
	(v) Cllr E Thornton-Nicol	Mr R McCulloch-Graham
	Ms L Jackson	Dr C Sharp
	Mrs N Berry	Mrs V MacPherson
	Mr S Easingwood	Mr M Porteous
	Mrs S Aspin	
In Attendance:	Miss I Bishop	Mr R Roberts
	Mrs T Logan	Ms S Douglas
	Mrs C Gillie	Mr G McMurdo
	Mrs S Bell	

1. Apologies and Announcements

Apologies had been received from Mr J McLaren, Ms L Gallacher, Mrs J Smith, Mr D Bell, Dr A McVean, Mrs J Stacey, Mrs S Holmes and Mr D Robertson.

The Chair confirmed the meeting was quorate.

The Chair welcomed Ms Linda Jackson who was deputising for Ms L Gallacher.

The Chair welcomed a range of attendees to the meeting.

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** approved the Register of Interests.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 8 May 2019 were approved.

4. Matters Arising

4.1 Action 7: Mr Tris Taylor enquired if the overall programme performance management framework was in place for the Strata Project so that assurance could be provided that there were adequate levels in place for escalation and tolerance.

Mr Rob McCulloch-Graham advised that the Strata Project was being supported by a Programme Management Board through Scottish Borders Council and it had been agreed that an evaluation report would come to the Integration Joint Board (IJB) in 6 months time to confirm whether the project should carry on for a further 12 month period. Mr McCulloch-Graham advised that he Chaired the Programme Management Board and was able to provide assurance to the IJB on the status of the project.

Mrs Tracey Logan commented that in September the full digital strategy for Health and Social Care would be brought to the IJB.

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 formation of the new GP Executive which was putting pace to the development of the Primary Care Improvement Plan (PCIP); Community Hospitals inspection and the Inspectors being accompanied by the Health Care Support Workers; and visit to the Netherlands to look at a Care Village and consideration being given to how that could be replicated for the Scottish Borders.

Initial discussion focused on the format and purpose of the Chief Officer's report.

The Chair enquired about the Dundee Discharge model and enquired if the partnership should be cognisant of it. Mr McCulloch-Graham explained that the model had targeted those who were due to move to a Care Home facility from the acute setting and gave them the option of trying to move back to their Homes with wrap around care. He further advised that it had been operational for 8 months and the data was not yet verified. Early findings were very positive and the Chief Officer was keen to pursue the model.

Cllr Shona Haslam enquired about progress in regard to pulmonary rehabilitation services. Mr Ralph Roberts commented that a couple of physiotherapists had presented to the GP Sub Committee earlier in the week and had reported that they had commenced sessions in a number of towns across the Borders.

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to remove the Chief Officer's Report as a standing item on the agenda and instead to receive a newsletter format report on a monthly basis to also include what was happening around the partnerships across Scotland.

6. Deputation

Mr Colin McGrath spoke to the deputation.

Cllr Tom Weatherston enquired about the average attendance at Community Councils' Network (CCN) meetings. Mr McGrath advised that each meeting had a core membership of 10 members with each representing their respective area. He said meetings averaged 25 members in attendance and at the Annual General Manager he suggested there had been 60 members in attendance. He further advised that Berwickshire had it's own forum.

Mr Tris Taylor clarified that the IJB required service user input and with the demise of the Public Partnership Forum a service user vacancy had been created on the IJB. He was clear that potentially anybody could be a service user and suggested it was not accurate to say that the CCN was specifically a service user organisation. Appointment of a service user to the IJB was at the discretion of the IJB, however he was mindful that the CCN were willing to be involved to fill that current void.

The Chair commented that under the Scheme of Integration the IJB were obliged to have a service user and there was no strict definition as to what or where that service user might come from.

Mrs Karen Hamilton commented that potentially there could be room for more than 1 service user to join the IJB and she was keen to know what other groups might be formulated and better suited to represent service users. She also noted that the number of people involved in the CCN whilst looking impressive in reality provided poor attendance figures at meetings, especially in Peebles.

Cllr Shona Haslam echoed Mrs Hamilton's comments and also questioned the demographic make up of the CCN. Further she suggested it may prove more beneficial to the IJB in being able to fulfil the needs of service users, if a proactive call for service user representation was put out to the public and any interested people or groups were then put through an interview process to ensure anyone appointed would bring a service user mandate of views and knowledge to the table.

Mr Malcolm Dickson commented that he agreed with the comments made by both Cllr Haslam and Mrs Hamilton and he wished to commend Mr McGrath for his public spiritedness in bringing the deputation to the IJB. He further suggested that a more structured approach be adopted to ensure the IJB was seen as providing a fair opportunity for service users to be represented.

Mr Taylor commented that whatever process was adopted it should be set up as a matter of urgency to ensure service users were fairly appointed and represented and he also wished to ensure that people with opposing points of view were not marginalised through the process.

Cllr David Parker agreed with Mr Taylor's comments and referred to item 8.2 on the agenda which was a paper in regard to Locality Working Groups and the provision of service user representatives. He also thanked Mr McGrath for his public spiritedness and like others suggested there may be other groups that should be approached for representation. He also suggested the CCN was not a representation of all the Community Councils as he was aware that a number had made it clear that the CCN did not speak for them and therefore it was not

a body in itself that would find its way naturally into the IJB. He suggested he work with Mr McCulloch-Graham to bring a process back to a future meeting.

Ms Linda Jackson commented that she agreed with Cllr Parker in regard to the CCN it was not a place where service users would go to get their views heard. She suggested that there were a large number of bodies in the Borders that catered for service users and that they should be approached to collate the views of service users and represent them at the IJB.

Mrs Tracey Logan echoed Ms Jackson's views and suggested the various carers groups and people receiving services be approached about who they would want to represent them at the IJB.

The Chair suggested as item 8.2 on the agenda provided an alternative view point a decision on the deputation was not made at that time.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a wider approach to service user representation should be taken and Mr McGrath's submission should be considered as part of that wider approach and a report would be brought back to the next meeting.

The Chair asked Mr McGrath if he wished to make comment. Mr McGrath commented that if the CCN were not allowed to join the IJB he would put in a participation request to the IJB under the regulations of the Community Empowerment Act.

7. Finance

Mrs Carol Gillie and Ms Suzy Douglas presented the financial position from their respective organisations.

Mrs Gillie spoke of the increased complexity of financial planning with the formation of the IJBs as well as impacts of pay pressures, uplifts, savings targets and drug expenditure.

Discussion focused on: brokerage and continuing requirement to make savings; both predictable and unpredictable cost pressures; realistic target of 4% recurring savings per year; opportunities around drug budgets - pulmonary rehabilitation was a good example of where savings could be made and there would be better outcomes for patients; benchmarking against other Boards to flush out targeting savings areas; poly pharmacy beneficial to the patient; and potential workforce savings – not doing like of like replacements – up skilling health care support workers – high turnover of staffing; and concern that the deliver of change would meet the anticipated timescales.

Mrs Tracey Logan commented that both the NHS and Local Authority needed to undertake joint delivery planning and joint financial planning in order to ensure there was a successful shift in the balance of care from acute to community services.

Mr Ralph Roberts echoed Mrs Logan's comments and reiterated that joint working would be the only way to ensure success for patients, clients and the organisations involved. He said the IJB had 50% of the NHS budget and therefore the NHS would only achieve financial

Page 16

balance if the IJB was successful and he was keen to get into the detail of the planning assumptions.

Cllr Shona Haslam enquired what that would look like and Mr Roberts suggested a 3 year financial plan across all of Health and Social Care be produced. A plan would be produced for the resources currently available and a plan for how that shift in the balance of care would be achieved and those plans required to be formulated jointly. He gave an example of joint working in action being the change to dementia beds and how the resources were being utilised.

Mrs Logan advised that work was underway to formulate a "joint transformation" across both organisations in order to deliver the IJB Strategic Plan and financial planning would sit behind that transformation plan. The intention was to present the joint transformation plan to the IJB in the autumn.

Mrs Gillie assured the IJB that the NHS would work with the IJB on its savings targets and to get back into financial balance.

Mr Roberts advised the IJB that the in year financial plan was predicated on brokerage that had now been agreed with Scottish Government and would require to be paid back to Scottish Government.

Mrs Douglas set out the Local Authority budget process and how it was working within a reduced Scottish Government funding position. She highlighted the risk, demand and demographic pressures facing the local authority.

Discussion focused on: roll out of Hospital to Home and anticipated savings and shift in balance of care; reduction in packages of care required from SBCares; open and transparent planning and delivery of services; and supporting communications engagement strategy.

Mrs Logan advised the IJB that she was confident the local authority financial plan would deliver for the IJB from the SBC perspective.

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

Mr Tris Taylor left the meeting.
Mrs Tracey Logan left the meeting.

8. Integration Joint Board 2019/20 Financial Plan

Mr Mike Porteous provided a detailed account of the content of the paper and presented the budget allocations from partners. He highlighted the financial implications of accepting the allocations and the progress made in reducing the financial gap of the IJB.

He outlined the current position on page 4 of the report where the focus was on the NHS element of the financial gap of £11.8m before savings plans were identified. He advised that recurring savings targets had been delegated to the IJB through a workstream approach and applied by the Turnaround Team in NHS Borders. The savings target equated to £7.2m with £1.9m of savings identified against the target with some being non recurring savings which

left a gap of £10m against forecast spend. He further advised that the IJB would require additional funding at the end of the financial year and after writing the report he had received confirmation from the Director of Finance at NHS Borders that the Scottish Government had agreed to brokerage which provided comfort that if savings continued to be delivered a breakeven position could be achieved at the financial year end through the draw down of brokerage monies from NHS Borders. He reminded the IJB that there remained risks and challenges in regard to the delivery of savings and asked the IJB if given the position in regard to brokerage if the IJB would be content to accept the budget allocation.

Cllr Shona Haslam commented that the paper did not seek acceptance of the budget by the IJB. Mr Porteous clarified that at the time of writing the report he wished the IJB to acknowledge the financial situation and the unlikely outcome of achieving a break even position unless brokerage could be obtained. Given that position had changed he was keen to ask the IJB if they wished to receive a revised paper seeking their acceptance of the proposed budget or if they wished to propose to accept the budget at the meeting.

Cllr Haslam proposed in light of the revised position that Recommendation 3 of the paper be revised to read "The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed the IJB Officers to continue to work with NHS Borders and SBC to develop a Joint Turnaround Programme and a Joint Financial Recovery Plan to address the financial gap and mitigate the risks relating to Health and Social Care services." Mrs Karen Hamilton seconded the proposal.

After some discussion the Chair agreed that the paper as it stood would be circulated to the IJB voting members along with an addendum qualifying the position to achieve a balanced budget before September 2019, for approval.

Mr Malcolm Dickson commented that the IJB Audit Committee had met with the external auditors, and the auditors had made the observation that there was not the same cognizance to agree the budget as in other IJBs. There was a reticence to agree the budget until the IJB was sure it would achieve financial balance and he suggested the current handling of the position was the correct way to take the matter forward.

Mr Ralph Roberts commented that as part of the addendum he suggested it should be clear in regard to the additional resources and non recurrent resources provided to the IJB, to recognised the NHS had no more money to put into the IJB and to ensure that all parties were clear that the success of the IJB would be through committed joint working.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the budget allocations from Scottish Borders Council and NHS Borders.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the forecast financial gap of (£10.2m) for 2019/20.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed the IJB Officers to continue to work with NHS Borders and SBC to develop a Joint Turnaround Programme and a Joint Financial Recovery Plan to address the financial gap and mitigate the risks relating to Health and Social Care services.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed IJB Officers to bring a paper to a future IJB outlining progress towards delivering a balanced budget for 2019/20.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive the paper as it stood along with an addendum qualifying the position to achieve a balanced budget before September 2019, for approval.

9. Health & Social Care – Localities Approach

Mr Robert McCulloch-Graham provided an overview of the content of the paper and it's rationale for consideration by the IJB. He suggested the 5 locality working groups be supported by a single administration post and receive input from attendance at their meetings by a member of his management leadership team. He further advised that the intention had been that 1 member from the local working groups would be elected as a representative to join the Strategic Planning Group and also one would be appointed to the IJB as the service user representative.

Mrs Karen Hamilton enquired if there were any discussions taking place in regard to merging the Community Planning Partnership with the Locality Working Groups. Mr Graham McMurdo advised that it had been given consideration previously but no action had been taken to date.

Mr McCulloch-Graham advised that the locality working groups had a diverse membership including third sector and carers and he was mindful of the earlier discussion about an advertising campaign to enable representation from service users.

Cllr Haslam enquired how GPs would be involved given they had formed four localities. Mr McCulloch-Graham clarified that everything would operate from 5 localities with input being garnered from the specific GP surgeries within those 5 localities.

Mrs Hamilton enquired if there were any specific financial consequences. Mr McCulloch-Graham commented that he was looking to strengthen the back office function with admin support being sought from within existing resources.

The Chair enquired if the intention was that the locality lead selected to join the IJB would become the service user representative. Mr McCulloch-Graham confirmed that was the intention.

Mr Malcolm Dickson interjected that it had been agreed earlier to undertake a wider approach to service user representation. Mr McCulloch-Graham suggested he could use that wider approach to service user representation to recruit to the locality working groups. Mr Dickson suggested if service users were specifically sought out then it fitted in with the earlier agreed approach.

Ms Linda Jackson commented that the whole point of representation was to improve the input and outcomes for service users and she commented that Mrs Jenny Smith's organisation represented and interfaced with a whole range of different service users and 1 or 2 representatives with a broader base could be gleaned through that route. Mr McCulloch-Graham agreed.

The Chair summarised that in principle the IJB were in favour of increased service user representation on the IJB and were content to have more than 1 service user as a member.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the H&SC Locality Plans and actions should be aligned to CPP themes and outcomes (and also aligned under the 3 H&SC Strategic Objectives).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed each locality had an identified 'Locality Lead', responsible for the planning and delivery of the H&SC actions. It was anticipated that the bulk of those would align under the 'Our health, care and wellbeing' CPP theme.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed identified members of IJB Leadership Team be allocated to specific localities. Their role to work with each 'Locality Lead' to plan and deliver the H&SC actions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed an admin resource be put in place to support the Locality Leads and IJB Leadership Team members in the delivery of H&SC actions and activity across all 5 localities and to ensure the coordination of relevant papers and updates for SPG, Area Partnership and CPP meetings.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed all 5 Locality Leads should be members of the Strategic Planning Group (SPG)

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed 1 Locality Lead be selected to represent the others when attending the IJB (that could be on a rotational basis).

Cllr Shona Haslam left the meeting.

The Chair commented that in returning to the matter of the Deputation received earlier in the meeting, given the fact that a decision had been reached in regard to the Locality Working Groups the options available to the IJB were as per the Standing Orders, which were: the issue did not merit further action or the issue could be referred to an Officer.

The Chair proposed that the matter be referred to the Executive Management Team for further discussion in light of the outcome of the Locality Working Groups item. Cllr David Parker seconded the proposal.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to refer the matter of the Deputation to the Executive management Team for further discussion.

10. Scottish Borders Health & Social Care Integration Joint Board Audit Committee Annual Report 2018/19

Cllr Tom Weatherston commented that as Chair of the IJB Audit Committee he felt more comfortable in the role now that he had undergone training and gleaned more experience. He advised that the Committee had always performed well due to the expertise around the table and in moving forward the Committee would be seeking more information to scrutinise and

review. He thanked the Committee members for their hard work during the year and also the input of the external lay member.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered the IJB Audit Committee Annual Report 2018/19 (Appendix 1) on the performance in relation to its Terms of Reference and the effectiveness of the Committee in meeting its purpose and the assurances therein.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD a**greed to the amended IJB Audit Committee Terms of Reference (Appendix 2) which incorporated the proposed changes set out in the IJB Audit Committee Annual Report 2018/19.

11. Health and Social Care Partnership Performance Management Framework

Mr Malcolm Dickson commented that during development of the framework he was pleased to see there had been a concentration on outcomes and he welcomed any learning about cause of effect through the performance management route.

The Chair commented that at the last national IJB Chairs and Vice Chairs meeting it had looked at a performance outcomes matrix for IJBs.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the performance management framework.

12. Long Term Conditions Update

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

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

13. Dryburgh Development Session Outcomes

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the intended areas of development for the partnership following the Dryburgh event.

14. Quarterly Performance Report

Mr Graeme McMurdo provided an overview of the content of the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and approved any changes made to performance reporting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the key challenges highlighted.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed actions to address challenges and to mitigate risk.

15. NHS Borders Annual Operational Plan 2019-20

Mrs Nicky Berry provided an overview of the content of the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the final draft NHS Borders Annual Operational Plan 2019/20, which would be presented for formal approval to the NHS Borders Board on 27 June 2019.

16. Strategic Planning Group Report

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

Mr Malcolm Dickson enquired about the last bullet point. Mr McCulloch-Graham advised that it referred to a possible facility that was not contained within the acute sector for short term referrals from GPs and whether such a facility could or should be provided by SB Cares or other providers. Such a facility was not available at present.

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

17. Any Other Business

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

18. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Wednesday 14 August 2019 at 10am in Council Chamber, Scottish Borders Council.

The meeting concluded at 12.32.

Signature: ……
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 12 February 2018

Agenda Item: Inspection Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
24	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and agreed to receive a presentation on the Public Protection Service at a Development session later in the year.	~~Murray Leys~~ Stuart Easingwood	~~December 2018~~ ~~May 2019~~ November 2019	**In Progress:** Item scheduled for 19 November 2018. **Update:** Session cancelled. Item scheduled to 27 May 2019 Development session. **Update:** Rescheduled to November Development session as a consequence of changing the IJB meeting dates.	G

Meeting held 23 April 2018

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
29	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD**	~~Claire Pearce,~~	~~December 2018~~	**In Progress:** Item scheduled for 17 December 2018.	G

		welcomed the opportunity to receive a report at a future meeting on Quality and Governance from Mrs Claire Pearce, Director of Nursing, Midwifery & Acute Services and Dr Angus McVean, GP Clinical Lead.	Nicky Berry, Angus McVean	~~April 2019~~ December 2019	**Update:** Item rescheduled to April 2019 meeting. **Update:** Item rescheduled to June 2019 meeting due to reconfiguration of IJB meeting dates. **Update 08.05.19:** Agreed that Clinical Governance Annual Report will be submitted to the IJB annually to provide assurance on this item. Awaiting final report from Clinical Governance Committee.	

Meeting held 28 May 2018

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
30	6	Mr Murray Leys to provide a presentation to a future Development session on Demographics	~~Murray Leys~~ Stuart Easingwood	~~2018~~ November 2019	**In Progress:** Item scheduled for 19 November 2018. **Update:** Session cancelled. Item rescheduled to 25 November 2019 Development session.	G

Meeting held 8 May 2019

Agenda Item: Matters Arising

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
6	4.1	**Chairs Action: Integrated Care Fund Update:** In regard to COPD, Mr Robert McCulloch-Graham advised that the COPD project had not yet commenced and would be part of the work being taken forward in regard to Long Term Conditions (LTCs). He advised that it was also part of the Turnaround Programme of work within the NHS and he would bring an update to the next meeting.	Rob McCulloch-Graham	June 2019	**Complete:** Item discussed at 19 June 2019 meeting.	

Agenda Item: Strata PathwaysTM – Proposed Extension of the Project

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
7	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the proposed extension and expansion of the Strata Prototyping Project (Phase 2) relating to the Discharge Management Process for 6 months – with a full evaluation in 6 months to be brought to the September IJB meeting.	Rob McCulloch-Graham, James Lamb	September 2019	**In Progress:** Item added to September meeting agenda.	

Agenda Item: Primary Care Improvement Plan (April 2019-March 2020)

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	7	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a future Development session be led by service users and primary care leads in regard to long term conditions.	Rob McCulloch-Graham, Kenny Mitchell	November 2019	**In Progress**: Item added to November Development session schedule.	G

Agenda Item: Integration Joint Board 2019/20 Financial Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
9	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** requested the NHS Borders Director of Finance and Scottish Borders Council Section 95 Officer attend the next meeting of the IJB on 12 June to present the absolute facts of where the finances were and what would and would not plug the gap, that would then enable the IJB to make a decision as to whether it could accept the budget or not.	David Robertson, Carol Gillie	June 2019	**Complete:** Item discussed at 19 June 2019 meeting.	G

Agenda Item: Outcomes from Development Session

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
10	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the item was deferred to the next meeting and Mr McCulloch-Graham	Rob McCulloch-Graham	June 2019	**Complete:** Item discussed at 19 June 2019 meeting.	G

		would circulate a discussion paper on the outcomes of the development session which would lead to the issuing of directions later in the year.				

Meeting held 19 June 2019

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
11	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to remove the Chief Officer's Report as a standing item on the agenda and instead to receive a newsletter format report on a monthly basis to also include what was happening around the partnerships across Scotland.	Louise Ramage	August 2019	Communications colleagues across NHS Borders and SBC to support the monthly newsletter.	A

Agenda Item: Deputation

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
12	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a wider approach to service user representation should be taken and Mr McGrath's submission should be considered as part of that wider approach and a report would be brought back to the next meeting.	Rob McCulloch-Graham	September 2019	Discussions with members of the Locality Working Groups have started and a further summit meeting id being planned for September.	A

Agenda Item: Integration Joint Board 2019/20 Financial Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
13	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed the IJB Officers to continue to work with NHS Borders and SBC to develop a Joint Turnaround Programme and a Joint Financial Recovery Plan to address the financial gap and mitigate the risks relating to Health and Social Care services.	Mike Porteous	September 2019	Planning is underway and dates for joint planning will be discussed at the upcoming EMT. As a financial gap remains, further work and agreements are required.	

Agenda Item: Integration Joint Board 2019/20 Financial Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
14	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive the paper as it stood along with an addendum qualifying the position to achieve a balanced budget before August 2019, for approval.	Mike Porteous	August 2019		

Agenda Item: Health & Social Care – Localities Approach

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
15	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to refer the matter of the Deputation to the Executive Management Team for further discussion.	Rob McCulloch-Graham	September 2019		

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

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 14 August 2019

Report By	Mike Porteous, Chief Finance Officer
Contact	Mike Porteous, Chief Finance Officer
Telephone:	07973981394

INTEGRATION JOINT BOARD 2019/20 FINANCIAL PLAN ADDENDUM

Purpose of Report:	The purpose of this paper is to present an addendum to the June IJ B Financial Plan paper which recommends that then IJB approve the 2019/20 resource allocations from the Partners.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the budget allocations from Scottish Borders Council (£49.078m) and NHS Borders (£134.016m) for the delegated functions. **b) Acknowledge** the revised savings targets which NHS Borders has calculated for their delegated functions. **c) Note** that any expenditure in excess of these delegated budgets in 2019/20 will require to be funded by additional contributions from the partners in line with the approved scheme of integration.

Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2019/20 will be reported to the Integration Joint Board.

Carers:	N/A

Equalities:	The equalities impact of the contents of this report are not known at this stage. As the detailed outcomes of the settlements become apparent equalities impact assessments will be carried out.

Financial:	No resourcing implications beyond the financial resources identified within the report. The report draws on information provided in the finance reports

	presented to NHS Borders (NHSB) and Scottish Borders Council (SBC). Both partner organisations' Finance functions have contributed to its development.

Legal	N/A

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

Introduction and Background

2.1 The Partners are operating in an increasingly challenging financial environment. Scottish Government settlements are only partially addressing existing and new pressures arising from an aging population, pay agreements and workforce challenges, and the need to deliver savings at the same time driving forward with strategic transformation is impacting on delivering financial balance.

2.2 There is an expectation from Scottish Government that IJB's will agree and approve their Financial Plan by 31st March of each year. To date the IJB has not been able to agree its budgets for 2019/20 because of the shortfall in funds available.

2.3 This paper builds on the partner presentations to the last IJB and follows the confirmation of up to £9.3m brokerage from the Scottish Government (SG) which has allowed NHSB to allocate in year support to its Business Units, reducing their savings targets for 2019/20. This action has a significant impact on the resource allocation made for delegated health functions and on their related savings targets.

Revised Resource Allocations and Savings Targets

3.1 The impact of the above action is presented in **Appendix 1** which shows the revised savings targets for 2019/20 for delegated health functions. The table below summarises the implications for IJB delegated health functions.

Revised Health Savings Targets	**2019/20**		**2020/21**
	Original savings Target £m	**Revised In Year Savings Target £m**	**Revised Recurring Savings Target £m**
Set Aside	1.460	0.627	2.145
Mental Health Services	1.280	0.550	1.881
Primary & Community Services	5.130	2.203	7.537
Total Delegated Health Functions	**7.870**	**3.380**	**11.563**

3.2 The revised savings target of £3.38m is a significant reduction from the original target of £7.87m. The non recurrency of support allocated in 2019/20 means the recurring savings target for delegated health functions increases to £11.563m for 2020/21.

3.3 The overall impact on the Financial Plan is a reduction in the savings target for delegated health functions and an increased resource allocation from Health. The resource allocation and savings target for SBC delegated functions remains unchanged at £1.596m. The table below summarises the resource allocations for the delegated functions, and the level of savings identified to date against the savings targets for 2019/20.

		NHSB		
Financial Summary 2019/20	**SBC**	**Core**	**Set Aside**	**Total**
	£m	**£m**	**£m**	**£m**
Resource Allocations	49.078	110.039	23.976	183.093
In Year Savings Target	1.596	2.753	0.627	4.976
In Year Savings Schemes Identified	1.406	1.404		2.810
Resultant Savings Requirement	(0.190)	(1.349)	(0.627)	(2.166)

3.4 Areas of further savings are being developed to address the remaining gap of £2.2m including a reduction in acute beds through improvements to the Older People's pathway, a move to locality working, greater influence on Prescribing spend, and rationalising operational productivity across services.

Delivering Financial Balance

4.1 Whilst an overall gap remains against the in year savings targets the size of the gap is greatly reduced from previous financial plans and significant progress has been made in identifying and delivering in year and recurring savings across the partnership:

- Provision of Day services within SBC
- Redesign of Dementia Care services within NHSB

4.2 However further work is required to generate additional savings in key areas such as Prescribing within Health and commissioned services within Social Care. The Turnaround programme underway with NHSB continues to bring greater focus to existing spend through deconstruction workshops and increased scrutiny to planned service redesigns through the mandate process. Within SBC regular meetings are established to monitor and review savings plans and ensure any slippage in delivery is identified and remedial action taken to generate alternative solutions.

4.3 The above measures may not generate sufficient savings to close the gap and manage any in year pressures. Delivering in year financial balance may require additional allocations from NHSB and SBC as afforded by the Scheme of Delegation.

4.4 The greater challenge lies in delivering ongoing financial balance through sustainable modern services. SBC and NHSB are now working jointly to agree a longer term Financial Plan for the partnership which will respond to the need to transform services and invest in initiatives which will prevent unnecessary hospital admissions, reduce lengths of stay and delayed discharges, thus reducing bed numbers to assist the return to financial balance.

Risk

5.1 There is a risk that the in year savings target will not be met. The reduction in the current year target for delegated health functions and the continuation of the Turnaround work within NHSB should generate further savings. The early identification of any slippage in existing schemes will enable alternative solutions to be generated and reduce any adverse impact.

5.2 There is an ongoing risk that new pressures emerge or existing pressures change adversely and generate an overspend. The regular monitoring reports will provide a year to date and forecast position for the delegated services and highlight actions being taken to manage these pressures.

5.3 Across the partnership there is a risk that the demographic challenges posed by an aging population exceed the funding available to meet their needs. It is therefore imperative that the partners work together to identify opportunities for shifting the balance of care and implementing change.

5.4 The non recurrency of the brokerage means it may not be available in the future. The work underway to produce a longer term Joint FP will highlight the financial challenges facing the partnership and enable plans to be drawn up jointly to address the risk of financial imbalance.

Page 34

APPENDIX 1

Reallocation of Savings Tragets, Brokerage and Non recurring Savings

	Financial Plan	Reallocation Board Recurring	Sub total pre Brokerage	Allocation Brokerage	Sub total pre Non Recurring savings	Allocation Non Recurring Savings	2019/20 Remaining Target
Business Unit							
Acute	-£3,790,000	-£1,778,453	-£5,568,453	£2,421,236	-£3,147,217	£1,519,563	-£1,627,654
Set Aside	**-£1,460,000**	**-£685,103**	**-£2,145,103**	**£932,719**	**-£1,212,384**	**£585,372**	**-£627,012**
Mental Health Services	**-£1,280,000**	**-£600,638**	**-£1,880,638**	**£817,726**	**-£1,062,912**	**£513,203**	**-£549,709**
Primary & Community Services	**-£5,130,000**	**-£2,407,246**	**-£7,537,246**	**£3,277,294**	**-£4,259,953**	**£2,056,823**	**-£2,203,130**
Corporate	-£810,000	-£380,092	-£1,190,092	£517,467	-£672,624	£324,761	-£347,863
External Providers	-£310,000	-£145,467	-£455,467	£198,043	-£257,424	£124,291	-£133,133
Subtotal	-£12,780,000						
Board General Recurring	-£5,997,000	£5,997,000	£0	£0	£0		£0
Board General Non Recurring	-£2,611,500		-£2,611,500	£1,135,514	-£1,475,986	£1,475,986	£0
Total Savings	**-£21,388,500**	**£0**	**-£21,388,500**	**£9,300,000**	**-£12,088,500**	**£6,600,000**	**-£5,488,500**

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 14 August 2019

Report By	Robert McCulloch-Graham, Chief Officer for Integration
Contact	Graeme McMurdo, Programme Manager, Scottish Borders Council
Telephone:	01835 824000 ext. 5501

HEALTH & SOCIAL CARE PARTNERSHIP
ANNUAL PERFORMANCE REPORT

Purpose of Report:	To seek approval for the 2018/19 HSCP Annual Performance Report (APR)

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Approve the 2018/19 Annual Performance Report (APR).

Personnel:	The 2018/19 APR has been developed by the HSCP Leadership Team with key stakeholders

Carers:	One of the 'spotlight' sections within the APR focuses on Carers

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

Financial:	n/a

Legal:	The report provides an update on progress of the delivery of the HSCP strategic objectives

Risk Implications:	Under legislation, every HSCP must publish an Annual Performance Report by 31st July each year.

Background

1.1 It is a requirement for every Health & Social Care Partnership to publish an Annual Performance Report (APR) by 31st July each year. The required contents of the report are set out in the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014.

1.2 It is required that performance and financial information contained in the report covers the reporting year and includes comparison data with the preceding 5-years (or with all years if less than 5-years).

1.3 As a minimum, APRs must:

- Assess performance in relation to the National Health & Wellbeing outcomes.
- Include information on financial performance and Best Value
- Include information on Localities
- Include information on Inspection of Services

1.4 The attached Scottish Borders Health & Social Care Partnership Annual Performance Report 2018/19 was developed by the HSCP Leadership Team and uses our three strategic objectives as the basis for its layout. Each strategic objective section:

- Includes a 'spotlight' to detail a specific area of work delivered.
- Recaps the priorities that we set out in our previous APR (2017/18).
- Highlights work delivered in the current reporting year (2018/19)
- Outlines key priorities for the coming reporting year (2019/20)

1.5 Our draft APR was published to the HSCP website on 31st July, on the proviso that any required changes requested by IJB will be incorporated into the final published document.

1.6 There is one appendix to this report:

Appendix 1: Scottish Borders Health & Social Care Partnership Annual Performance Report 2018/19
https://www.scotborders.gov.uk/downloads/file/6719/annual_performance_report_201819

Scottish Borders **Health & Social Care** Partnership

ANNUAL PERFORMANCE REPORT 2018-2019

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

Scottish Borders
Health and Social Care
PARTNERSHIP

CONTENTS

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP ANNUAL PERFORMANCE REPORT 2018/2019

INTRODUCTION

This is the third Annual Performance Report for the Scottish Borders Health and Social Care Partnership. It focuses and reports on our performance between April 2018 and March 2019, but also outlines our priorities moving forward and reflects back on performance from April 2016 onwards. I joined the partnership in October 2017 and I am privileged to have entered a partnership of colleagues and a community which is determined to provide the best of care for the population of the Scottish Borders.

The Borders is a fabulous and beautiful place to both live and work. It does however present several challenges that are particular to the region in terms of geographical and transport challenges in getting from [a] to [b] and ensuring all our citizens have access to the services they need, when they need them. This report outlines our progress in meeting the aspirations outlined within the Scottish Borders Health & Social Care Partnership Strategic Plan.

This Annual Performance Report presents how the Partnership has:

- worked towards delivering against our three strategic objectives.
- performed in relation to the National Health and Wellbeing Outcomes.
- performed in relation to our key priorities.
- performed financially.
- progressed locality planning arrangements.
- performed in inspections carried out by scrutiny bodies.

Among our key achievements to date is the Older People's Pathway programme of work. This covers a group of projects designed to improve patient flow, reduce delayed discharges and support individuals in returning home from hospital. Work on improving the Older People's Pathway will be a focus for the Partnership in the coming year as well.

The Integration Joint Board introduced a direction in 2017/18 to both the Council and NHS Borders to introduce a new policy of discharging patients from hospital and to assess their needs within the community. In this way people can return to their homes more quickly and their needs can be assessed in their home, making the assessment more relevant to their needs and more accurately identifying their support requirements. This direction has spurred a great deal of new work around the 'pathway' for Older People during 2017/18 and 2018/19. The 2019/20 priorities for the Partnership, which are also set out in this Annual Performance Report, continue to focus on improvements to the pathway for Older People. We will continue to work hard to deliver responsive health and social care services which are focused on the needs of the people who use them and their local communities.

Communities within the Borders are rich in terms of assets, from our exciting scenery, our wide and vibrant social calendar, and our supportive and caring local population. Our job is to ensure everyone can access these facilities and opportunities, and in doing so, provide health and wellbeing for all.

Robert McCulloch-Graham
Chief Officer Health and Social Care
Scottish Borders Health and Social Care Partnership
July 2019

EXECUTIVE SUMMARY

The Scottish Borders Health and Social Care Partnership's Strategic Plan was first published in April 2016, following a period of public consultation. It set out the Partnership's objectives for improving health and social care services for the people of the Borders.

The Strategic Plan has been reviewed to cover the period 2018 to 2021 – where the refreshed version focuses on the delivery of three local strategic objectives and the associated challenges in delivering these. This Annual Performance Report (APR) sets out the Partnership's performance between April 2018 and March 2019. It also outlines our priorities for 2019/20 and reflects back on performance from April 2016. Delivery on the progress made is structured under our 3 Strategic Objectives:

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

Included in the report are 'Spotlight' sections, reflecting on some of the key work that has taken place during 2018/19.

The spotlights cover:

- Community Led Support ('What Matters Hubs').
- Older People's Pathway.
- Unpaid Carers

The most up to date financial and performance data has been included in the report. Where it is not possible to show the 2018/19 data, 2017/18 figures have been used. Where the 2018/19 data is provisional, this is denoted as 2018/19(p).

In regard to performance, data covering Quarterly reporting to Integration Joint Board (IJB), performance against the National 'Core Suite' of Integration indicators that are identified by the Scottish Government and performance against Ministerial Strategy Group (MSG) indicators is shown. Financial information, consistent with our Annual accounts is also included.

This report has been prepared in line with the Guidance for Health and Social Care Integration Partnership Performance Reports.

2017/18 AT A GLANCE

OLDER

2018 mid-year population estimates* show that **24.4%** of the Scottish Borders population are now **65+**, well above the Scottish average of **18.9%**.

Out of the 32 Scottish Local Authorities, the Borders has the **fifth highest** proportion of people aged 65+.

Between 1998 and 2018:

- The population of the Scottish Borders grew by **8.7%**. Over the same period, the Scotland population grew by **7.1%**.
- The **64 to 74** Borders age group increased by **48.1%** compared to **28.3%** for Scotland.

Source: National Records of Scotland

COLDER

The 2018 'Beast of the East' storm was thankfully not repeated over Winter 2018/19, but it is still very important that our Winter Plan planned for the worst.

We needed to ensure that contingency measures were in place for things like a flu epidemic or extreme weather events, that the impact of these can be mitigated and that our full range of services can continue to be delivered.

BOLDER

We are continuing to focus on improving the Older Person's Pathway and the flow into and out of hospital.

STRATA

over **130 referrals** per month made through **Strata**

GARDEN VIEW

from December 2017 to June 2019, **243 patients accommodated** at Garden View, with an **average stay of 20 days**

TRANSITIONAL CARE

80% of **individuals** have been **discharged** from **transitional care** back to their **own homes**

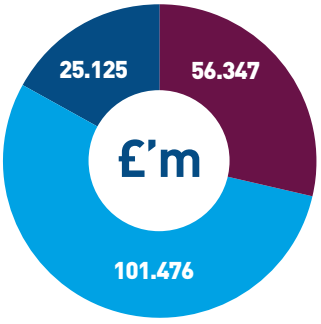
HOSPITAL TO HOME

70 patients per week are **receiving H2H care**

OUR PARTNERSHIP SPEND IN 2018/19

DURING 2018/19 THE INTEGRATION JOINT BOARD SPENT £182.948M

THIS WAS SPLIT:



- Social Care (£56.347m)
- Health Care (£101.476m)
- Set-aside (£25.125m)

£ ON EMERGENCY HOSPITAL STAYS

19.3% of **total health and care resource**, for those **age 18+** was **spent on emergency hospital stays** (Jan – Mar 2019)

+ve trend over 4 periods
Better than Scotland (24.6% - 2017/18)
Better than target (21.5%)

#yourpart

2018/19 PARTNERSHIP PERFORMANCE AT A GLANCE

• +ve trend over 4 reporting periods • compares well to Scotland average • compares well against local target	• trend over 4 reporting periods • comparison to Scotland average • comparison against local target	• -ve trend over 4 reporting periods • compares poorly to Scotland average • compares poorly to local target
KEY		
EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES) **27.7 admissions** per **1,000 population** (Jan – Mar 2019)	**ATTENDANCES AT A&E** **59.6 attendances** per **1,000 population** (Jan – Mar 2019)	**RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)** **883 bed days** per **1,000 population Age 75+** (Jan – Mar 2019)
+ve trend over 4 periods **Worse than Scotland (27.2 – Q4 2017/18)** **Close to target (27.5)**	**+ve trend over 4 periods** **Better than Scotland (65.88 – Q4 2017/18)** **Better than target (70)**	**+ve trend over 4 periods** **Better than Scotland (1,250 Q4 2017/18)** **Better than target (min 10% better than Scottish average)**
More work is required to prevent emergency hospital admissions	*The number of attendances at A&E is showing positive progress*	*Beds occupied by emergency admissions shows positive progress*
A&E WAITING TIMES (TARGET = 95%) **96.1%** of **people** seen **within 4 hours** (Mar 2019)	**NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)** **17 over 72 hours** (Mar 2019)	**"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS** **96.5% overall satisfaction rate** (Oct - Dec 2018)
+ve trend over 4 periods **Better than Scotland (86.4% - Mar 2018)** **Better than target (95%)**	**+ve trend over 4 periods** **Better than target (23)**	**-ve trend over 4 periods** **Better than target (95%)**
A&E waiting times are above target (95%) and better than the National average	*Whilst positive we need to continue work to reduce delayed discharges further*	*Surveys indicate a high satisfaction rate with hospital care*
EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES) **10.7** per **100 discharges** from **hospital** were **re-admitted within 28 days** (Jan – Mar 2019)	**END OF LIFE CARE** **85.9%** of **people's last 6 months** was **spent at home** or in a **community setting** (2018/19)	**CARERS SUPPORT PLANS COMPLETED** **31%** of **carer support plans offered** that have been **taken up** and **completed** in the **last quarter** (Oct - Dec 2018)
-ve trend over 4 Qtrs **Worse than Scotland (10.2 - Q4 2017/18)** **Worse than target (10.5)**	**+ve trend over 4 Qtrs** **Worse than Scotland (87.9% - 17/18)** **Worse than target (87.5%)**	**Little change over 4 Qtrs** **Worse than target (40%)**
More work is required to reduce readmission rates	*This is improving, but more work is required to ensure that individuals can spend their last months of life in their chosen setting*	*Support for carers is identified as critical in the Strategic Plan. Support for carers has been put in place and will continue to be developed.*

STRATEGIC OVERVIEW (HOW THINGS FIT TOGETHER)

The legislation for integration, the Public Bodies (Joint Working) (Scotland) Act 2014, sets out the principles that services should:

- Be integrated from the point of view of service-users.
- Take account of the particular needs of different service-users.
- Take account of the particular needs of service-users in different parts of the area in which the service is being provided.
- Take account of the particular characteristics and circumstances of different service users.
- Respect the rights of service-users.
- Take account of the dignity of service-users
- Take account of the participation by service-users in the community in which service users live
- Protect and improve the safety of service-users
- Improve the quality of the service
- Be planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- Best anticipate needs and prevents them arising, and
- Makes the best use of the available facilities, people and other resources.

Underpinning this are a set of nine National Health and Wellbeing Outcomes. These are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

To embed the principles and to contribute to the delivery of the National Health & Wellbeing Outcomes, the Scottish Borders Health and Social Care Partnership (H&SCP) has identified three strategic objectives in the Integration Strategic Plan 2018-21.

The three strategic objectives are:

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

Our own Strategic Objectives are underpinned by the principles of:

- Prevention and early intervention
- Accessible services
- Care close to home
- Delivery of services with an integrated care model
- Greater choice and control
- Optimise efficiency and effectiveness
- Reduce health inequalities.

The Integration Strategic Plan 2018-21 also identifies the key priorities of the Partnership to:

1. Promote healthy living and active ageing
2. Improve communication and access to information
3. Work with communities to develop local solutions
4. Improve support for carers within our communities
5. Integrate services at a local level
6. Promote support for independence and reablement so that all adults can live as independent lives as possible
7. Provide alternatives to hospital care
8. Improve the efficiency of the hospital experience
9. Improve the use of technology enabled care

This is a complicated 'landscape'. The table below shows how the **9 National Health & Wellbeing Outcomes** align to our **3 Strategic Objectives** and our **9 Key Priorities**.

NATIONAL OUTCOMES	STRATEGIC OBJECTIVES	KEY PRIORITIES
Outcome 1: people are able to look after and improve their own health and wellbeing and live in good health for longer	**We will improve the health of the population and reduce the number of hospital admissions** **How** • By supporting individuals to improve their health • By improving the range and quality of community based services and reducing demand for hospital care • Ensuring appropriate supply of good quality and suitable housing **Links** National Outcomes: **1,2,3,5** Key Prioirites: **1, 6, 7, 9**	1. Promote healthy living and active ageing
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live as far as reasonably practicable, independently and at home or in a homely setting in their community		2. Improve communication and access to information
Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected		3. Work with communities to develop local solutions
Outcome 4: Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services	**We will improve the flow of patients into, through and out of hospital** **How** • By reducing the time that people are delayed in hospital • By improving care/patient pathways to ensure a more coordinated, timely and person centered experience/approach • By ensuring people have a greater choice of different housing options which meet their long-term housing, care and support needs **Links** National Outcomes: **3,4,5,7** Key Priorities: **2, 5, 8, 9**	4. Improve support for carers within our communities
Outcome 5: health and social care services contribute to reducing health inequalities		5. Integrate services at a local level
Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their role on their own health and wellbeing		6. Promote support for independence and reablement so that all adults can live as independent lives as possible
Outcome 7: People using health and social care services are safe from harm	**We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.** **How** • By supporting people to manage their own conditions • By improving access to health and social care services in local communities • By improving support to carers • By building extra care homes, including amenity and mixed tenure provision **Links** National Outcomes: ALL Key Priorities: All except 8	7. Provide alternatives to hospital care
Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide		8. Improve the efficiency of the hospital experience
Outcome 9: Resources are used effectively and efficiently in the provision of health an and social care services		9. Improve the use of technology enabled care.

The Health and Social Care Partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services are adult social care, primary and community health care services and elements of hospital care. The Partnership has a pivotal role in regard to acute services in relation to unplanned hospital admissions and works with key Community Planning Partners, including charities, voluntary and community groups to deliver flexible, locally based services. The table below details the Health & Social Care Partnership service areas of responsibility.

Health and Social Care Services which are integrated

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

- Accident and Emergency;
- Inpatient hospital services in these specialties:
  - General Medicine;
  - Geriatric Medicine;
  - Rehabilitation Medicine;
  - Respiratory Medicine;
  - Psychiatry of Learning Disability;
- Palliative Care Services provided in a hospital;
- Inpatient hospital services provided by GPs;
- Services provided in a hospital in relation to an addiction or dependence on any substance;
- Mental health services provided in a hospital, except secure forensic mental health services.

COMMUNITY HEALTH SERVICES*

- District Nursing;
- Primary Medical Services (GP practices)*;
- Out of Hours Primary Medical Services*;
- Public Dental Services*;
- General Dental Services*;
- Ophthalmic Services*;
- Community Pharmacy Services*;
- Community Geriatric Services;
- Community Learning Disability Services;
- Mental Health Services;
- Continence Services;
- Kidney Dialysis out with the hospital;
- Services provided by health professionals that aim to promote public health;
- Community Addiction Services;
- Community Palliative Care;
- Allied Health Professional Services

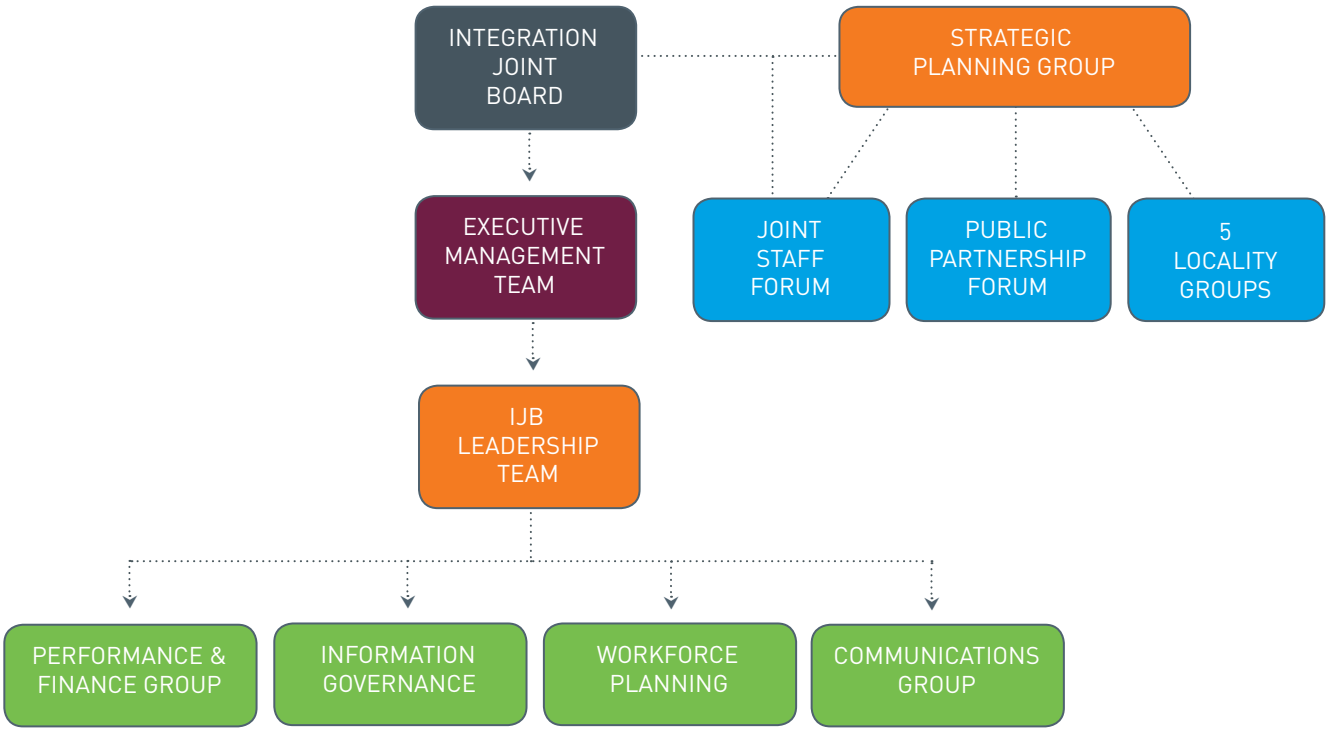
*Adult Social Care Services for adults aged 18 and over.
*Acute Health Services for all ages – adults and children.
*Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (*), which also include services for children.

GOVERNANCE AND ACCOUNTABILITY

For 2018/19, the governance structure for the Health & Social Care Partnership has remained unchanged since the last Annual Performance Report. The structure provides a robust and streamlined process for efficient and effective Partnership decision making. The Partnership works to fulfil its commitment to ongoing and continuous improvement and a range of activities continue to be developed in order that the Integration Joint Board identifies and understands its key strengths and areas for improvement across all aspects of its governance, operations and performance.

Our governance structure has two decision making levels – the Integration Joint Board (IJB) and the Executive Management Team (EMT). Both are closely linked to health and social care operations, via the Integration Joint Board Leadership Team.

H&SC Partnership Governance Structure



Whilst the IJB has the ultimate decision making and commissioning authority for the Partnership, the EMT provides a useful assurance function, by ensuring that all reports and proposals being prepared are fit for purpose and clearly aligned to the Strategic Objectives.

The function of the Strategic Planning Group (SPG) is to ensure effective links to each of the five Scottish Borders localities.

These localities are:

- Berwickshire
- Cheviot
- Eildon
- Teviot & Liddesdale
- Tweeddale

The relationship between the IJB and SPG is strengthened by the vice-Chair of the IJB chairing the SPG. The work plan for the SPG is also been directly aligned to the IJB work plan. The quarterly performance report for IJB contains a range of Health & Social Care performance measures aligned to the 3 Strategic Objectives. Quarterly performance reporting has been developed to include a red, amber or green (RAG) status for each performance measure. The RAG status is based on a combination of performance against target, performance trend and performance in comparison to National results. The Integration Performance Group (IPG) is responsible for the development of Partnership performance reporting locally and nationally, it is made up of performance leads from across the Council and NHS Borders.

The action plan resulting from the Joint Inspection of the 2017 Health and Social Care Older People's Services (undertaken by the Care Inspectorate and Healthcare Improvement Scotland) has been developed and delivery against the action plan can be seen in Appendix 1 of this report.

The Internal Audit planned work in 2018/19 included:

- the operation of IJB's corporate governance and risk management arrangements.
- a follow-up of progress on areas of improvement recommended in 2017/18 Internal Audit assurance work relating to corporate governance, financial management and performance management.
- assessment of the financial governance of the Integrated Care Fund and its use to achieve outcomes linked to Strategic Plan priorities.

Within the Internal Audit Annual Assurance Report 2018/19 the IJB's Chief Internal Auditor presented to the IJB Audit Committee in June 2019 the statutory Internal Audit opinion on the effectiveness of the IJB's governance arrangements, risk management and internal controls, findings and conclusions from specific audit activity during the year, and recommendations for improvements. The IJB Audit Committee approved the Internal Audit Annual Plan 2019/20 which will have a specific focus on the IJB's Directions to Partners and workforce development as part of transformation and change in service delivery to meet the Strategic Plan objectives.

KEY PARTNERSHIP DECISIONS 2018/19

For the period 2018/19, the Integration Joint Board has met regularly both as a formal meeting to transact business and also through Development sessions to raise its understanding of the more complex issues it will deal with as the Partnership continues to evolve.

During this period, the Board has focused on governance, operating arrangements, performance and resource planning.

Examples of key Governance decisions it has made during the 2018/19 financial year include:

- Production of the Integration Strategic Plan 2018-21.
- Appointment of a Chief Finance Officer.
- Welcoming new voting members to the Board.
- Approval of the Local Code of Corporate Governance.
- Approval of its Communications Strategy.
- Agreement to receive a review of the Strategic Risk Register twice yearly.
- Updated Model Publication Scheme.
- Updated Mainstreaming report and Equality Outcomes.

Examples of key Performance and Resources decisions it has made during the financial year include:

- Approval of its refreshed Strategic Plan 2018/19 – 20/21.
- Review of the Integrated Care Fund projects and subsequent re-direction of funding.
- Re-direction of the remaining Social Care Funding.
- Approval and delivery of its 2018/19 financial plan.
- Direction of resources to assist with Joint Winter Planning performance.
- Approval of the allocation of additional Drug & Alcohol funding received from Scottish Government.
- Expansion of the capacity within step-down facilities.
- Expansion of Hospital to Home initiative across the whole of the Borders.
- Increased the capacity within our high-end dementia care.
- Agreement to pilot the STRATA initiative.

PROGRESS AGAINST STRATEGIC OBJECTIVE 1

OBJECTIVE 1

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

Objective 1: Background and Challenges

We are committed to helping older people to manage their own health better, improving fitness and reducing social isolation. We know the number of older people in the Borders is increasing, and that the proportion of older people in the Borders is increasing at a faster rate than the Scotland average. It is crucial therefore that we continue our promotion of 'active ageing'. We know that many older people in Scottish Borders report poor health, therefore we must continue to promote healthier lifestyles, earlier detection of disease and support to individuals to recover and manage their conditions. We know that the population of the Scottish Borders is spread over a large geographical area with many people living in rural locations, therefore services must continue to be provided locally with accessible transport arrangements in place.

Key to achieving positive change is by:

- Supporting individuals in making positive changes in their health-behaviour and lifestyle, such as smoking, diet, alcohol consumption and physical activity; through patient education, encouraging the appropriate use of services and promoting personal responsibility through public information and signposting.
- Adopting preventative and early intervention approaches, promoting the uptake of screening opportunities and immunisation programmes, raising awareness of signs and symptoms of health conditions and ensuring staff and carers have the necessary knowledge, skills and equipment to provide care at home

Objective 1: Spotlight – Community Led Support ("What Matters Hubs")

The example given below details how our Community Led Support ("What Matters Hubs") work has contributed to the delivery of Strategic Objective 1.

Community Led Support

Community Led Support is a community hub model for accessing Social Work services and signposting clients to community solutions. In the Borders these are called 'What Matters Hubs'. The hubs use a conversational approach to ask an individual what matters to them, rather than what is the matter with them. It then looks at what resources are available to deliver this.

The hubs:

- have the involvement of the 3rd Sector
- use customer services as the 1st point of contact
- are active in each locality
- have a number of 'pop-up' hubs in rural locations

The Community Led Support approach encourages individuals to use community-based solutions, where possible, to address their needs. By September 2018, there were 527 signposts made to community solutions (i.e.) diverting people away from what may be considered traditional Social Work Services to alternative community services, more appropriate for the individual's specific situation.

The hubs utilise a simplified version of the Social Work assessment process called the 'What Matters' Assessment. This reduces the amount of information collected and the time taken to complete each assessment. Over a third of all social work assessments are now completed using this 'What Matters' approach. It encourages hub staff to consider community solutions where appropriate before initiating a package of care. In the year April 2018 to March 2019 a total of 1,230 What Matters assessments were completed.

Hubs have been used to tackle Social Work waiting lists. The total waiting list numbers across the social work local offices peaked at 449 in June 2017, reduced to approx. 200 by October 2018 and were at 135 in February 2019. As a result of reduced waiting lists individuals should not have to wait as long before receiving the services that they require. From a governance and operational perspective this has also resulted in a significant reduction in the percentage of breaches to the target times for Priority 1 and Priority 2 waiting lists. In February 2018, 28.7% of P1&2 cases breached target times. By November 2018 this had reduced to 17.5%.

As well as tackling waiting lists, individuals can also attend a drop-in hub session where a re-assessment of their existing package of care can be undertaken. Traditionally, a review of existing packages of care has resulted in an assessed requirement to increase the package by 9.2 hours per week. By using the 'What Matters' approach, the average increase has been 5.4 hours per week (i.e.) still an assessed increase, but less than would have been the case traditionally, therefore making a significant financial contribution via cost avoidance.

With regard to new packages of care, the average new package of care prior to the Community Led Support approach was 5.6 hours per individual. The average new package of care required using the 'What Matters' hub assessment is 4 hours.

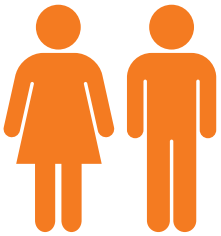
Using the 'What Matters' approach should mean that individuals receive the level of care that they require, but that already stretched Partnership resources can be used efficiently to ensure that effective care can continue to be delivered for our growing, ageing population.

FEEDBACK FROM HUB USERS INDICATES THAT

89% received the information, guidance and support that they needed

96% were satisfied with the outcome of their visit

98% would recommend the What Matters Hub



Objective 1: Priorities 2018/19 - What we said / What we did

Last year's Annual Performance Report contained a number of Partnership Priorities to be delivered in 2018/19. The table below details these and the key successes and achievements delivered.

Partnership Priorities for 2018/19 – What we said

1. Establish the Attend Anywhere virtual clinic, that uses technology to improve access to care.
2. Shape service development more effectively through stronger connections between the Public Partnership Forum and the Integration Joint Board.
3. Enable vulnerable adults to live safely at home through improved adult protection practices; undertake a review of large scale enquiries, making necessary changes; evaluate outcomes.
4. Increase the number of people accessing all self-directed support options by streamlining financial and other processes, removing barriers to change.
5. Implement the Primary Care Improvement Plan (PCIP) to address a number of key priorities.
6. Deliver post diagnostic support to a higher proportion of people with dementia and increase appropriate GP referrals.
7. Improve outcomes when a dual diagnosis exists by piloting an assessment tool of physical health for people with mental health conditions.

Key Achievements/Successes : What we did

- In October 2018, we launched a campaign to build upon the existing playing #yourpart aspect of our Strategic Plan. A video and promotional materials were developed all focusing on 'making the right choices'. The video and toolkit is available online. The campaign was launched at an event in Galashiels Transport Interchange where over 60 stakeholders attended. This event kick-started the Partnerships first ever Scottish Borders 'Healthy Lives Week' which brought together a wide-range of staff from across the Partnership and the Third Sector. Over 100 people took part in our Pledge Challenge, making a commitment to look after their health and wellbeing. Pledges ranged from drinking more water, eating more fruit, cycling more and entering a half marathon. All reinforcing the message that small changes can make big differences.
- Funding from Scottish Government was obtained to support a 2-year project to encourage access to bowel, breast and cervical cancer screening for people with learning disabilities and mental health service patients.
- A range of tools have been developed as part of the Scottish Borders Autism Strategy action plan to aid in communication and understanding. These have been developed in consultation with members of the Borders autism community.
- The PCIP was submitted to Scottish Government on 31st August 2018. It set out our intentions over the coming 3-years for primary care settings. Key focus areas include vaccinations, community treatment and community link workers.
- We have successfully tested our Physical Health Screening Tool within the Mental Health Rehabilitation Service and it will be rolled out to all patients with a Severe and Enduring Mental Illness from July 2019.
- We held our inaugural 'Living with and caring for Dementia' event in November 2018. This was attended by over 100 staff, people with dementia and their carers. It was an opportunity to listen and learn – as who better to explain what it is really like to live with dementia than the very people who are going through it?
- Attend Anywhere provides an alternative to patients or service users travelling to their appointment. It creates a 'virtual' waiting area accessible from a web browser or app on the individual's computer, smartphone, or tablet. The service is notified when the patient/service users 'arrive' and the consultation then takes place online via a video call. During 17/18 a pilot of AA was underway in 7 care homes and planning has been undertaken for pilots for Child Health, GI and diabetes. A trial is also in being planned for a link between a Peebles GP Practice and an extra care housing site.
- By March 2019, 85.2% of health and social care clients were accessing self-directed support (80.3% March 2018). The number of people accessing SDS options 1,3, and 4 has increased, option 2 has remained static.

Objective 1: Partnership Priorities for 2019/2020

Development sessions of the IJB, coupled with events attended buy a range of senior professionals have considered the challenges facing the partnership. As a result, the following priorities have been identified for 2019/20. These are continuing to be progressed through the Partnership governance structure, but in summary, the Priorities under Strategic Objective 1 are:

1.1) Develop Local "Wellness Centres"
We will look to expand the use of community hubs and drop-in centres to create 'one-stop shops'. Part of this work will also require ensuring that appropriate and adequate community space is available – covering both social care and clinical needs.

1.2) Introduce Single Assessments and Reviews
We will look to remove duplicate care assessments, develop more flexibility in regard to which professionals undertake assessments and increase Social Worker and Occupational Therapist involvement at daily ward rounds.

1.3) Introduce Local Multi-Disciplinary Teams across all 5 Localities(MDTs)
We will introduce multi-disciplinary teams across the localities to triage individuals within the community to ensure that they can access services and receive appropriate Health & Social Care interventions ahead of any acute provision they may require. We will expand the 'Cheviot' model that currently covers Kelso, Jedburgh, Coldstream and Greenlaw areas, where physiotherapists, occupational therapists, staff nurses and healthcare support workers work together to provide access to domiciliary occupational therapy, physiotherapy and nursing services - linked with medical practices. This supports prevention of hospital admission for identified patients who require therapy services at home, supports safe and timely discharge from BGH to community hospitals, supports anticipatory care and supports falls prevention. We will commission a Learning Disability 'Shared Lives Scheme' to provide high quality and affordable services and set up a 'Community Outreach Team' to specialize in meeting the needs of older adults with mental illness and dementia, working within care homes and community hospitals across the Scottish Borders.

PROGRESS AGAINST STRATEGIC OBJECTIVE 2

OBJECTIVE 2

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

Objective 2: Background and Challenges

We are committed to reducing the time that people are delayed in hospital. People should also have a greater choice of different housing options available meeting their long-term housing, care and support needs. We know that we must continue to involve and listen to our communities in planning and delivering services across the five localities. We know that housing and supported accommodation options have an important role to play in regard to the flow of patients. We know that a number of people need flexible support arrangements to maintain and improve their quality of life.

K**ey to achieving positive change is by:**

- Ensuring that people are admitted to acute services only when required.
- Ensuring that those who do require hospital stays have a seamless and timely patient experience and journey; and that discharge from hospital uses an integrated/joined-up approach enabling patients to return home quickly and safely.
- Providing short-term care and reablement support options to facilitate a safe and timely transition from an acute setting to home.
- Ensuring the reablement and hospital to home services align with housing providers, equipment providers and care and repair services.
- Reviewing our approach to housing adaptations to ensure a holistic approach is taken to meeting longer term needs/conditions of older people.
- Ensuring that assessing and caring for people is done in the in the most appropriate setting.

Objective 2: Spotlight – Older People's Pathway

Older People's Pathway covers a range of projects designed to improve the flow of patients into and out of hospital. The projects currently underway focus on the flow out of hospital and include:

STRATA

Strata is a web-based system that matches the patient's needs to available resources. It enables care providers to set up a live directory of capacity, vacant rooms and services. Health and Social Work teams can view the data in real time and place the patient, quickly, into an appropriate care setting. Once a place is identified, the Strata system can securely send the personal and medical details to the provider so that the necessary information precedes the patient's arrival. From November 2018 to May 2019, 608 referrals for a total of 219 individuals have been made; 119 of those to Residential and Nursing Care providers and 489 to Care At Home providers. Over 130 referrals per month are currently being made using STRATA.

Hospital to Home

Hospital to Home (H2H) is a District Nurse led model of care that is transforming care for our older people as they transition from hospital to home after a period of illness. The approach focuses on supporting individuals, who no longer require acute care, but are not yet capable of living independently at home. The service also supports people who are at high risk of being admitted to hospital if they do not receive support at home. It utilises a re-ablement approach with the aim to maximise the potential of the person during the early weeks of care, to develop their confidence and skills so that they can carry out activities and live independently at home. Hospital to Home reduces delayed discharges, improves patient flow, reduces long-term care package requirements, reduces re-admissions and improves outcomes for individuals.

H2H is a Borders-wide service. It started on a small scale in Berwickshire in January 2018, extending to Teviot in March 2018, Central Borders/Tweeddale in August 2018 and, more recently, to Cheviot in late 2018. Evaluation of H2H indicates:

- Positive feedback from patients, carers and staff
- Reduced requirement for ongoing packages of care. To December 2018, H2H has contributed to a reduction of 3,869 occupied bed days, 25% of users have required a reduced package of long-term care and a similar percentage have required no long-term package of care.
- For patients who have received H2H support, A&E attendances post-H2H have decreased (in comparison to pre-H2H), emergency admissions have decreased and unplanned hospital bed days have decreased. Data indicates:
- 61% reduction in number of H2H users attending A&E
- 62% reduction in those A&E attendances resulting in hospital admission.
- 47% reduction in H2H users number of unplanned bed day

Garden View / Transitional Care

Waverley Care Home in Galashiels provides 10 long-stay residential beds and 16 transitional care beds. The transitional beds deliver short-term rehabilitation for up to 6-weeks for individuals who no longer need to be in hospital, but require some additional support to regain their independence before ideally returning home. The average age of individual's admitted to transitional care is 83. Over the duration of transitional care service, the average length of stay has been 34 days, over 7,300 bed days have been provided and in excess of 80% of individuals have been discharged from transitional care back to their own homes – with the remainder either being readmitted to BGH or moved to supported accommodation.

The Discharge to Assess Unit, based at Garden View in Tweedbank is closely aligned to the Waverley Transitional unit and both are managed by SB Cares. Garden View provides capacity outwith BGH to assess patients prior to them moving home or to supported accommodation. Over the period 4th december 2017 to 1st July 2019, there were 243 patients accommodated at Garden View, with an average stay of 20 days and over 4,500 bed days being made available at BGH. SB Cares Operations Director says "Garden View and Waverley are fantastic examples of successful partnership working. Both facilities are improving the flow of patients through the hospital and is delivering improved outcomes for patients and their families".

Matching Unit

The Matching Unit is a small, central administrative team created to match a service to the assessed needs of the client. The Unit performs a critical role in ensuring that the service required by a client is matched with a provider and that the provider is fully aware of the care requirements of each individual client. The organisational and administrative process undertaken by the Matching Unit enables care managers to focus on assessment and care management. The Matching Unit team collate and maintain a list of clients waiting for care at home. In September 2018 the Matching unit service remit was extended to District Nurse teams looking to source end of life care.

The unit:

- manages the delivery of over 200 referrals per month.
- has reduced care manager time to secure packages of care.
- has reduced waiting lists for people awaiting assessment and care in their community.

Objective 2: Priorities 2018/19 - What we said / What we did

Last year's Annual Performance Report contained a number of Partnership Priorities to be delivered in 2018/19. The table below details these and the key successes and achievements delivered.

Partnership Priorities for 2018/19 – What we said

8. Improved pathways for prevention and early intervention.
9. Provide an out of hospital care pathway to improve flow across the system.
10. Enhance the role of allied health professionals to support the Modernising Community Hospital/Healthcare programme and develop their role within the long term conditions pathway.
11. Improve integration and independence in people with dementia by developing a clear diagnostic pathway through Mental Health Older Adults' services as described within the updated Dementia Strategic Plan.
12. Support the pathway to care at home through the development of a joint protocol for intermediate care and short-term placements.
13. Reduce delayed discharge rates and percentage of associated occupied beds.
14. Reduce delayed discharges from hospital through evaluating and further improving the early supported discharge programme and reducing readmission.
15. Following reviews by Professor A Hendry and John Bolton, the Community Hospital/ Healthcare Modernisation Programme will progress the recommendations made:
    - Development of an Intermediate Care Framework
    - Development of revised structure for community nursing
    - Development of ANP-led community hospital model
    - Development of an alternative clinical model for community hospitals
    - Develop hospital to home models
    - Develop hospice at home models
16. Expand the Matching Unit to improve access to locally based care at home for more service user groups.
17. Support informed integrated planning through Integrated Care Fund measurements of common themes across multiple projects using a locally developed outcome focused tool.
18. Improve inclusion and reablement approaches in palliative care using learning across the services.
19. Shared aims and language across the partnership through developing and aligning performance activities across the Partnership, identifying opportunities for integrated approaches.
20. Drive forward collaborative change through the You Said We Did Improvement Plan.
21. Establish a single information access; improve communication internally and externally.
22. Develop a Partnership programme of improvement and self-evaluation between carers, Scottish Borders Council, NHS Borders and the local service provider.

Key Achievements/Successes : What we did

- Hospital to Home (H2H) has helped develop peoples' confidence and skills so that they can carry out activities themselves, enabling them to continue living at home. So far H2H has been able to accommodate over 200 patients.
- The STRATA project went live. This automates and improves the process of discharging patients from hospital into residential care or care at home providers. The system uses a real-time directory of available care home beds, capacity and specialist services allowing these to be matched to patients.
- Work is progressing on the Older People's Pathway. To look at what changes and improvements can be made to prevent admission, improve flow and provide community capacity. An operational review of review patient pathway is underway. This seeks to identify ways in which logistical management and coordination of local services can be improved. Services include Homecare, treatment rooms and community nursing.
- The START team, based at Borders General Hospital, hold a daily, multi-disciplinary huddle meeting focusing on identifying potentially delayed patients. START work with hospital wards and service areas to improve flow through and out of hospital.
- The START team also review delayed discharges on a two-hourly basis and report daily to management on each of people delayed and the reasons for that delay. This focus has resulted in people experiencing long-term delays being transferred and assessments being allocated and undertaken in a timely way.
- Co-working with Queen's House Care Home in Kelso has seen the allocation of additional beds at Queen's new Murray House facility. These beds cater for individuals with substantial care and nursing needs. This commission has already substantially reduced pressure across both Cauldshiels ward and Melburn Lodge at BGH. The arrangement has also opened up the opportunity for further co-working with Queen's House with regards to training and research for our most vulnerable, within the Borders.
- The Mental Health Service, Public Health and Primary Care colleagues have collaborated to redesign the Doing Well Service, Lifestyle Advisory Service and Smoking Cessation service. These services have now been combined and staffing resources increased, using Action 15 Mental Health Act funding, to provide an improved early intervention and prevention service.
- The Mental Health Service has commissioned and launched the new Wellbeing College designed to support and promote peoples coping strategies.
- NHS Borders is a pilot area for national quality standards in the delivery of Post Diagnostic Support (PDS) we are currently benchmarking and will be implementing new pathways for the delivery of PDS as part of the transformation agenda. The team have developed a clear pathway for diagnosis which is contained within our standard operating procedure.

Objective 2: Partnership Priorities for 2019/2020

Development sessions of the IJB, coupled with events attended buy a range of senior professionals have considered the challenges facing the partnership. As a result, the following priorities have been identified for 2019/20. These are continuing to be progressed through the Partnership governance structure, but in summary, the Priorities under Strategic Objective 2 are:

2.1) Introduce a renewed discharge hub

We will have a more consistent approach to managing people's progress through hospital. The "Moving-on" policy involves patients earlier in the process and enables joint health & social care decisions to be made when prioritising patient transfers and resources.

2.2) Develop shared Out-of-Hours coordination

Through work with partners and our geographical neighbours, we will aim to streamline Out-of-Hours provision across a number of services.

2.3) Promote Healthier lifestyles within the Borders

Working across the entire Health and Social Care Partnership and with direct links to our Public Health provision, we will direct a number of events and campaigns, coupled with our communications strategy, to encourage Borders residents to be healthy and make healthy choices. We will look at ways to promote a career in care, make greater use of community pharmacies and engage with local communities regarding what services the HSC Partnership can and cannot provide. We will promote personal responsibility and continue to provide public health education on diet, exercise and mental health.

2.4) Commission the correct bed base mix

We will further develop community capacity, including residential care and home care. We will commence a series of commissioning exercises, including setting the strategic direction for future contracting arrangements. We will look at the bed-base mix at Borders General Hospital, Community Hospitals and Mental Health beds across the estate with a view to further develop community capacity. We will look at options for Community Hospitals to function as step-up from home facility as well as a step-down from BGH facility.

PROGRESS AGAINST STRATEGIC OBJECTIVE 3

OBJECTIVE 3

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

Objective 3: Background and Challenges

We are committed to supporting people to manage their own conditions, by improving access to health and social care services in local communities, by improving support to carers and by delivering more supported accommodation, including extra care homes, dementia care and mixed tenure provision. We know that a range of support is required to support for people with dementia and their carers. We know that we need high quality support for the 12,500 people aged 16 and over who are providing unpaid care in the Scottish Borders.

Key to achieving positive change is by:

- Piloting and evaluating different approaches to the delivery of care and support in the community.
- Developing integrated, accessible transport options.
- Developing the use of technology to promote independence and enable prevention, through monitoring and 'early-warning' of an impending problem.
- Using technology to improving access and signposting to services and information
- Developing community-based mental health care
- Supporting carers and implementing the requirements of the Carers (Scotland) Act 2016
- Investing in physical and social infrastructure, looking to harness the strengths of our own communities in developing capacity in care and support for family members and friends

Objective 3: Spotlight - Unpaid Carers

The way health and social care is delivered locally is changing and it is vitally important that the growing number of unpaid carers are supported. There are at least 759,000 carers aged 16 and over in Scotland and 29,000 young carers. Three out of five of us will become carers at some stage in our lives. With the number of carers set to increase as people live longer with long-term health conditions and disabilities, the pressure on families to care in their own homes, particularly for spouses and partners, is growing significantly and could double over the next 30 years.

An unpaid carer is anyone who looks after a friend or family member who cannot cope alone due to illness, disability, a mental health problem or an addiction. A young unpaid carer is a child or young person (under 18 years of age) who has a significant role in looking after someone in their family. They can have practical caring responsibilities or be emotionally affected by a family member's care needs.

In financial terms, unpaid carers saves the Government a lot of money. The economic value of the contribution made by carers in the UK is in the region of £10 billion per year, because many carers support people who would otherwise need services and support provided by the NHS and the Health & Social Care Partnership. Without unpaid carers, the health and social care system would quickly collapse.

Caring for someone though, can often impact negatively on health and wellbeing. Caring for a loved one who is ill can take a serious toll on the carers mental and physical health, their personal relationships and family finances. It may also impact the educational attainment of young carers and can lead to social isolation.

Carers data suggests that:

- 6 in 10 carers have been pushed to breaking point.
- 25% of those who had reached breaking point have required medical treatment as a result.
- 46% of carers said they had fallen ill but just had to continue caring.
- 1 in 9 said the person they cared for had to be rushed into hospital, emergency care or that social services had to step in to look after them while the carer recovered.
- 1 in 5 were forced to give up their jobs because their caring role had reached a crisis point.

Services for carers and the people they care for should be joined up, delivered locally, tailored to individual needs, and person-centred to meet individual outcomes. To do this effectively, services must be developed in partnership with people and communities. Carers should be involved in all aspects of planning health and social care in the Scottish Borders. Carers should have a strong voice and strong representation to ensure that decision makers fully understand the wide ranging impact of caring on physical and mental well-being, social interactions, finances and future planning.

To recognise the huge contribution made by carers we have developed a Carers Strategy entitled 'Carers: Living Well in the Scottish Borders 2019-22'. This covers Adult carers, but a separate strategy for Young Carers is also being developed and will be consulted on during 2019. The Carers Advisory Group and Borders Carers Centre have been key partners in developing these strategies. This strategy recognises the huge contribution made by carers, addresses some of the potential negative impacts and ensures that carers can be involved in service planning.

The 'Carers: Living Well in the Scottish Borders 2019-22' strategy has five key ambitions all of which have actions and indicators of success attached to them.

The ambition is that carers will:

- Will feel that they have improved health and wellbeing
- Can manage their caring role
- Feel valued by services
- Are able to plan for the future
- Have information and support to manage their finances and benefits.

Objective 3: Priorities 2018/19 - What we said / What we did

Last year's Annual Performance Report contained a number of Partnership Priorities to be delivered in 2018/19. The table below details these and the key achievements delivered.

Partnership Priorities for 2018/19 – What we said

23. Develop innovative, locality based community approaches through an agreed action plan, developed and governed through the Integration Joint Board, including older people local area co-ordination and the building community capacity, community led support, Buurtzorg and integrated health and social care teams.
24. Develop a programme of action that includes scoping current provision and placement thresholds; revenue implications; workforce requirements.
25. Continue to develop Community Led Support 'What Matters Hubs' extending the service to more communities to improve access to health and social care services for all Scottish Borders residents.
26. Develop integrated health and social care teams in all five localities.
27 Continue to develop joint financial planning underpinned by joint strategic commissioning, sharing workforce supports, joint governance etc.
28. Implement a joint workforce plan for integrated services.
29. Maintain independence and quality of life through increased use of Technology Enabled Care.
30. Increase extra care housing by two to four additional developments by 2023.
31. Increased role for service users and stakeholders in service planning through the application of the Partnership Board approach, learning from Learning Disabilities and Mental Health developments.
32. Through improved communication and organisation-wide engagement, develop a widely-shared, persuasive vision of integrated services and of better support in the community through additional extra care housing.
    Align strategic and operational priorities and enable innovations so that ambitions for service expansion can be achieved, emphasising the maintenance of quality, essential services within a context of efficiency savings.
33. Increase the identification of carers.
34. Prepare and consult on a Carers Strategy to be published in 2019.
35. Improve carer health, using the recommendations from the carers health needs assessment.
36. Prepare a carers health needs assessment based on the carers survey and implement an action plan based on the recommendations.
37. Align recording of carer support plan with Frameworki/MOSAIC social care database and Borders Carers Centre data. Increase the number of carer support plans.

Key Achievements/Successes : What we did

- Our 'Carers: Living Well in the Scottish Borders 2019-22' plan has been developed.
- A service that provides one-to-one personal support for people with cancer has been rolled out across the Borders. The 'TCAT' service is free; it provides tailored advice, information and support to help people regain a sense of control over their lives. It is being delivered in partnership between The Partnership, MacMillan Cancer Support, NHS Borders and the British Red Cross.
- World Mental Health Day in October 2018 was celebrated through a number of events across the Borders.
- An innovative mountain biking project for people currently experiencing mental ill health was delivered by the Partnership, Developing Mountain Biking in Scotland (DMBinS) and Napier University. It promoted the therapeutic benefits of cycling in improving mental health, increased personal resilience, social skills and confidence.
- The digital 'Wellbeing Point' on the NHS Borders website has lots of valuable resource to help people look after their mental health and wellbeing.
- The 'iMatters' NHS and SBC staff survey was undertaken to help the Partnership understand and improve the experience of staff.
- St Ronan's residential care home in Innerleithen was awarded a Grade-6 "Excellent" by the Care Inspectorate for the way in which the staff team supports the wellbeing of residents, as well as a Grade-5 "Very Good" for how well care and support is planned.
- The IJB Technology Enabled Care (TEC) Strategy is in place. This strategy sets the direction of travel for the Partnership use of TEC and identifies the priorities in trialing different pieces of TEC, such as:

- Florence: is a health monitoring system, allowing individuals to monitor their health condition from home. It uses text messages to allow Health clinical staff to collect readings or symptom information remotely from patients. Florence can alert clinicians if a patient's condition worsens to allow them to intervene appropriately. Florence is being trialed in the West GP Cluster for Blood Pressure, COPD and Asthma.
- ARMED (Advanced Risk Modelling for Early Detection) uses of wearable devices to monitor, predict and therefore prevent falls. If a person's normal state/pattern of sleep, body composition or grip strength changes then the system raises an alert. A pilot of Armed is underway in Deanfield residential care home, Dovecot extra care home and within the Cheviot hospital to home team.

- Extra Care Housing planning permission has been granted and developments are progressing in Duns (Todlaw) and Galashiels (Langhaugh), via Trust Housing and Eildon Housing respectively, two of our Registered Social Landlords (RSL) partners. 32 Extra Care Housing units are being constructed at Todlaw, with an anticipated opening date of Autumn 2020 and 39 Extra Care Housing units are being constructed at Langhaugh, with an anticipated opening date of Spring 2021.

Key Achievements/Successes : What we did

- Over the last 4 years there has been a dramatic decrease in people attending older people's day services and an increase in people taking a direct payment to take part in activities of more interest to them, in their own communities. By disinvesting in fixed buildings-based services and investing in community based approaches, the Partnership will be better placed to meet the growing need and desire for flexible, community-based provision. To do this, we have Local Area Coordinators (LACs). The LACs engage with older people and discuss what interests they have and what activities they would like to be involved in. With their knowledge of the local area the LACs build up a range of opportunities for older people to get involved in and contribute to their local community. The Partnership will continue to fund a number of 'building-based' services, but the intention is that LACs will help to facilitate a move from the traditional buildings-based approach to a more flexible, community-based approach that better meets the expectations of older people evidenced in recent trends.
- During 2018/19 Borders Carer Centre offered twice as many support plans to carers than during 2016/17.

Objective 3: Partnership Priorities for 2019/2020

Development sessions of the IJB, coupled with events attended buy a range of senior professionals have considered the challenges facing the partnership. As a result, the following priorities have been identified for 2019/20. These are continuing to be progressed through the Partnership governance structure, but in summary, the Priorities under Strategic Objective 3 are:

3.1) Enable further support for Carers
We will improve signposting and support for unpaid and paid carers and also expand the reablement functions we offer.

3.2) Improve Technology Enabled Care (TEC) and Data Sharing
Individuals expect more choice and more control over their care and TEC can play an important role in this to support individuals with complex needs, so that they can better manage their conditions and lead healthy, active and independent lives for as long as possible. We will continue to pilot and implement TEC products across the partnership and continue to promote the use of TEC with professionals and the public. We will follow up our June 2019 'TEC Fest' event with another event planned for December 2019.

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Performance Summary

The Integrated Joint Board (IJB) agrees a joint budget and commissions a range of health and social care partnership services within the functions delegated to it.

IJB financial governance includes:

- Approval of high level strategies and plans
- Quarterly financial monitoring reports
- Publication of the annual Statement of Accounts'

In 2018/19 the IJB controlled the direction of £182.948m of financial resource to support the delivery of its three strategic objectives.

The split of the resource is shown below:

IJB SERVICE AREA	BASE BUDGET £'000	REVISED BUDGET £'000	ACTUAL £'000	VARIANCE £'000
1. SOCIAL CARE SERVICES				
Joint Learning Disability Service	16,644	17,592	17,516	76
Joint Mental Health Service	2,108	2,022	1,999	23
Joint Alcohol and Drug Service	173	162	136	26
Older People Service	19,281	20,772	20,762	10
Physical Disability Service	3,322	3,677	3,599	78
Generic Services	12,105	12,374	12,335	39
Over-allocation (returned to SBC)		-252		-252
Social Care sub-total:	**53,633**	**56,347**	**56,347**	**0**
2. HEALTH SERVICES				
Joint Learning Disability Service	3,572	3,564	4,010	-446
Joint Mental Health Service	13,314	14,753	14,974	-221
Joint Alcohol and Drug Service	357	608	608	0
Generic Services	77,750	77,311	81,884	-4,573
NHS Contribution		5,240		5,240
Health sub-total:	**94,993**	**101,476**	**101,476**	**0**
3. SET-ASIDE HEALTHCARE SERVICES				
Accident & Emergency	2,003	2,742	2,912	-170
Medicine & Long-Term Conditions	11,847	14,491	15,571	-1,080
Medicine of the Elderly	6,288	6,509	6,642	-133
NHS Contribution		1,383		1,383
Set-aside sub-total:	**20,138**	**25,125**	**25,125**	**0**
Overall:	**168,764**	**182,948**	**182,948**	**0**

Note: The 'set-aside' budget covers the in-scope integration functions of the NHS that are carried out in a large hospital setting. In our case, Borders General Hospital (BGH).

Many of the financial pressures and challenges experienced by the Partnership in 2018/19 will continue to impact on the ability to deliver a break-even financial position in 2019/20. A key focus will therefore be on delivering savings and on developing more efficient and effective ways of providing services in the context of increasing demand and demographic growth.

Proportion of spend by reporting year, broken down by service

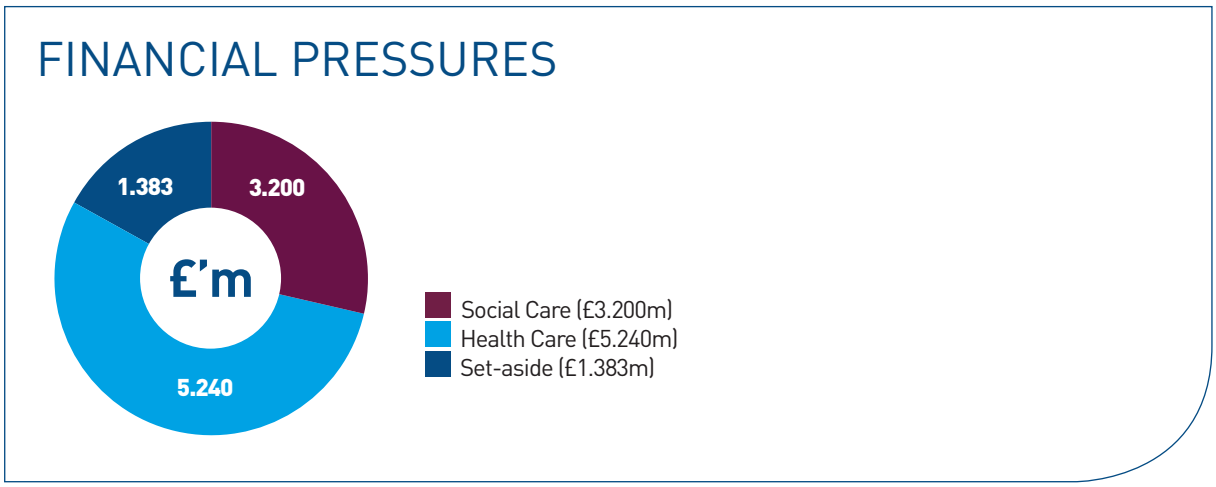
The table below shows the actual budget for 2016/17, 2017/18, 2018/19 – and the forecast budget for 2019/20.

IJB SERVICE AREA	ACTUAL 2016/17 £'000	ACTUAL 2017/18 £'000	ACTUAL 2018/19 £'000	FORECAST 2019/20 (£'000)
1. SOCIAL CARE SERVICES				
Joint Learning Disability Service	15,261	16,730	17,516	tbc
Joint Mental Health Service	1,911	1,962	1,999	tbc
Joint Alcohol and Drug Service	103	173	136	tbc
Older People Service	20,979	18,685	20,762	tbc
Physical Disability Service	3,343	3,570	3,599	tbc
Generic Services	4,850	12,011	12,335	tbc
Social Care sub-total:	**46,447**	**53,131**	**56,347**	**tbc**
2. HEALTH SERVICES				
Joint Learning Disability Service	3,690	3,520	4,010	tbc
Joint Mental Health Service	14,173	13,725	14,974	tbc
Joint Alcohol and Drug Service	635	597	608	tbc
Generic Services	78,109	77,645	81,884	tbc
Health sub-total:	**96,607**	**95,487**	**101,476**	**tbc**
3. SET-ASIDE HEALTHCARE SERVICES				
Accident & Emergency	2,043	2,004	2,912	tbc
Medicine & Long-Term Conditions	13,029	12,905	15,571	tbc
Medicine of the Elderly	6142	6,434	6,642	tbc
Generic Services	-	3,075		tbc
Planned savings	(350)	-	-	tbc
Set-aside sub-total:	**20,864**	**24,418**	**25,125**	**tbc**
Overall:	**163,918**	**173,036**	**182,948**	**189,622**
	-	**+5.6%**	**+5.7%**	**+3.6%**

Overspend / Underspend

From the table above, it can be seen that the required budget has increased year on year and the Partnership continues to experience significant financial pressures. During 2018/19 the Partnership required additional resources of £6.623m from NHS Borders and £3.2m from Scottish Borders Council to enable it to deliver a financial break-even position at year end.

A high-level breakdown of where the main financial pressures were is shown below:



Whilst the pressures were more significant in Health services, common drivers include demographic growth, staff recruitment and retention and increased demand for services across the Partnership.

Specifically:

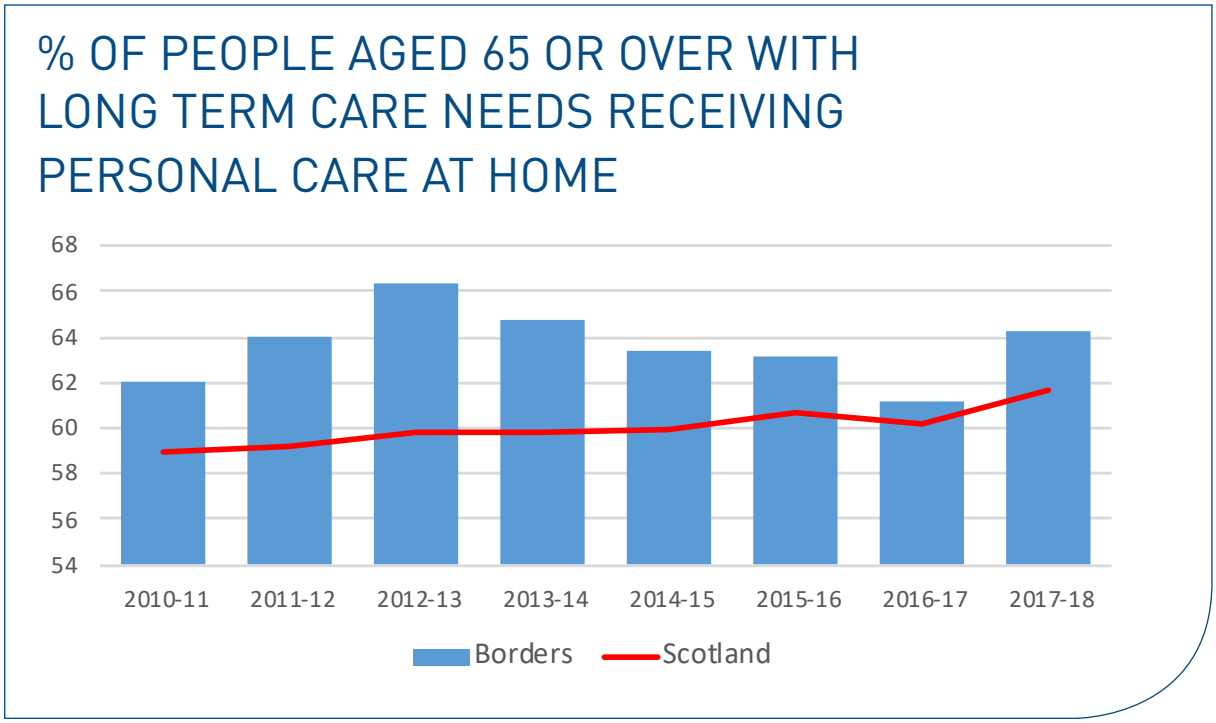
- significant increased demand for services associated with an increasing ageing population and increased complexity of care needs.
- pressures coming from challenges in recruitment and retention of staff resulting in the need for higher cost locum or agency staff to cover services.
- the non-delivery or temporary delivery of planned financial savings
- increased costs of service provision in areas such as care at home and in relation to individuals transitioning from children's services into adult specialist services.

Balance of care

The Partnership Strategic Plan is based on developing community capacity in a way that helps prevent unplanned hospital admissions and improves the flow of patients out of the acute hospital setting (i.e.) using resources more effectively on prevention, rather than treatment.

This will help us to invest in new integrated ways of working, particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting carers and supporting independent living.

The Borders has made some progress towards the aim of providing more care in the community, but this needs more improvement. In 2010/11 the percentage of people aged 65 and over with long-term care needs who receive personal care at home" was **62.0%**. In 2017/18 this was **64.2%**.



Source: Local Government Benchmarking Framework, April 2019 refresh

Best Value

Best Value ensures that we put services in place that are efficient, economic, sustainable and will deliver improved outcomes for Borders residents.

It is underpinned by having effective organisational, governance and financial arrangements in place. In the Borders, Scottish Borders Council and NHS Borders delegate budget to the Integration Joint Board (IJB). The IJB decides how to use these resources to achieve the objectives of the Strategic Plan. The IJB then directs the Health & Social Care Partnership via the constituent authorities to deliver services in line with this plan.

The governance framework is the rules, policies and procedures by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The Board has legal responsibilities and obligations to its stakeholders, staff and residents of the Borders area. The Chief Officer Health & Social Care chairs the HSCP Leadership Team and the IJB ensures proper administration of its financial affairs by having a Chief Finance Officer in place.

At the start, middle and end of the financial year, the IJB and its partners undertake a full review and evaluation of its degree of compliance with legislation and recommended best practice in relation to the Partnership's financial governance, planning, management and reporting arrangements. A number of positive outcomes have been reported following these processes and clear forward planning is in place to continue to provide full assurance to the Partnership going forward.

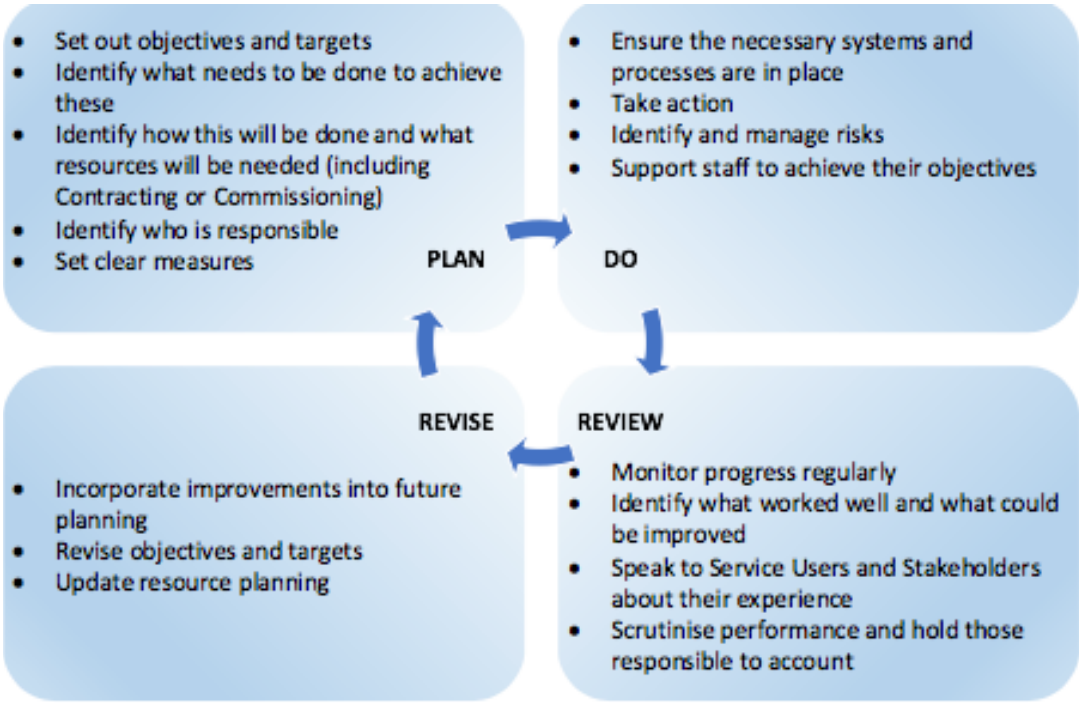
The unaudited Annual Accounts have been approved through the IJB governance process. In accordance with legislation, the audited accounts will be signed off no later than 30th September and published no later than one month thereafter.

PERFORMANCE MONITORING FRAMEWORK SUMMARY

Performance Management Framework

The Partnership has developed a Performance Management Framework (PMF) with Council and Health colleagues to assist in assessing the effectiveness of the work it commissions (including key transformation programmes and projects) and in directing future work. The PMF sets out the current strategic context and performance reporting arrangements for the Health & Social Care Partnership to increase transparency and enable closer scrutiny of performance, for services across the partnership.

The Partnership aspires to be "best in class" and seeks to promote a culture of continuous improvement, to deliver better outcomes for individuals and communities. The PMF provides the structure by which the partnership can make informed decisions on future priorities, using performance information to identify and drive improvement work. It can also be used to assess the effectiveness of transformation and change projects. The PMF gives a structure to help build continuous improvement by setting out a logical approach to driving performance improvement.



Source: Adapted from Audit Scotland

Our performance measures

We report on a quarterly basis on a number of performance measures. These measures are aligned under the 3 Strategic Objectives and are designed to show the progress being made in delivery of the strategic objectives and therefore the contribution being made by the Partnership to the National Health and Wellbeing indicators. Each performance has a 'RAG' status. This Red/Amber/Green, classification is based, wherever possible, on a combination of performance against target, performance trend and performance against National data. The RAG status helps to highlights areas of good performance and also areas where action is required.

Our quarterly measures are shown below:

HOW ARE WE DOING?

OBJECTIVE 1

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

EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES)	EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS AGE 75+)	ATTENDANCES AT A&E	£ ON EMERGENCY HOSPITAL STAYS
27.7 **admissions** per 1,000 population (Jan – Mar 2019)	**89.8** **admissions** per 1,000 population **Age 75+** (Jan – Mar 2019)	**59.6** **attendances** per 1,000 population (Jan – Mar 2019)	**19.3%** of **total health and care resource**, for those **Age 18+ was spent** on **emergency hospital stays** (Jan – Mar 2019)
+ve trend over 4 periods Worse than Scotland (27.2 – Q4 2017/18) Close to target (27.5)	-ve trend over 4 periods Worse than Scotland (97.7 – Q4 2017/18) Close to target (90.0)	+ve trend over 4 periods Better than Scotland (65.88 – Q4 2017/18) Better than target (70)	+ve trend over 4 periods Better than Scotland (24.6% - 2017/18) Better than target (21.5%)

Main Challenges

The rate of emergency admissions fluctuates with seasonality, but over the long-term (3 year period) it demonstrates an improving trend. Similarly, the rate of emergency admissions for those residents aged 75+ can demonstrate an improving trend over the long-term, but performance has declined over the 4 quarters. The number of A&E attendances has generally fluctuated between 7,000-8,000 per quarter (equivalent to approx. 60-70 per 1,000 population, per quarter). It is better than the Scotland average but follows a similar seasonal trend to Scotland. In relation to the percentage of the budget spent on emergency hospital stays, Borders has consistently performed better than Scotland and can also demonstrate a positive trend over the last 4 quarters. As with all Health and Social Care Partnerships, we are expected minimise the proportion of spend attributed to unscheduled stays in hospital.

Our plans during 2019/20 to support this objective

We are continuing to develop Local Area Co-ordination; redesigning of day service provision; Community Link Worker pilot in Central and Berwickshire areas; expanded remit of the Matching Unit; expansion of Hospital to Home – to enable timely hospital discharge and support for frail elderly patients in their own homes. Changes have been made to the unscheduled care model to ensure that more health service needs can be met outside hospitals through providing treatment alternatives to hospital admission. Continued development of the Distress Brief Interventions Service to reduce re attendance of people in mental distress at A&E.

OBJECTIVE 2

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

A&E WAITING TIMES (TARGET = 95%)	RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)	NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)	RATE OF BED DAYS ASSOCIATED WITH DELAYED DISCHARGE	"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS
96.1% of **people seen within 4 hours** (Mar 2019)	**883** **bed days** per 1000 population **Age 75+** (Jan – Mar 2019)	**17** **over 72 hours** (Mar 2019)	**171** **bed days** per 1000 population **Age 75+** (Jan – Mar 2019)	**96.5%** **overall satisfaction rate** (Oct - Dec 2018)
+ve trend over 4 periods Better than Scotland (86.4% - Mar 2018) Better than target (95%)	+ve trend over 4 periods Better than Scotland (1,250 Q4 2017/18) Better than target (min 10% better than Scottish average)	+ve trend over 4 periods Better than target (23)	+ve trend over 4 periods Better than Scotland (191 - 17/18 average) Better than target (180)	-ve trend over 4 periods Better than target (95%)

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

Main Challenges

Over the long-term (3 years) there has been an improving trend in regard to A&E waiting times. Borders is now performing above target and is consistently better than the Scottish Average. Occupied bed day rates for emergency admissions (age 75+) has seasonal fluctuations but performance trend is positive – both long-term (over 3-years) and short-term (over 4 quarters) – and we perform better than the Scottish average (although see note above*). Delayed discharge rates vary and are erratic for 'snapshot' data, but the quarterly bed day rate associated with delayed discharges is currently 171. A target (for 2019/20) to reduce delayed discharges by 30% has been set. The percentage of patients satisfied with care, staff & information in BGH and Community Hospitals remains high, although there has been a slight reduction in satisfaction rates over last 4 quarters.

Our plans during 2019/20 to support this objective

We are continuing to support a 'Discharge' programme of work, including Hospital to Home and Transitional Care projects, aimed at reducing delays for adults who are clinically fit for discharge. There is continuing development of "step-up" facilities to prevent hospital admissions and to increase opportunities for short-term placements, as well as a range of transformation programmes to shift resources and re-design services. There is continuing use of the Matching Unit to match care provision to assessed need; commissioning of specialist dementia places; increased use of technology enabled care to improve patient flow; and development of Community Outreach Team to support early discharge and admission prevention.

OBJECTIVE 3

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

EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES)	END OF LIFE CARE	CARERS SUPPORT PLANS COMPLETED	SUPPORT FOR CARERS: change between baseline assessment and review. Improvements in self- assessment
10.7 per **100 discharges from hospital** were re-admitted within 28 days	**85.9%** of **people's last 6 months** was spend at home or in a community setting	**31%** of **carer support plans offered** that have been **taken up and completed completed** in the **last quarter**	**Health and well-being** **Managing the caring role** **Feeling valued** **Planning for the future** **Finance & benefits**
(Jan – Mar 2019)	(2018/19)	(Oct - Dec 2018)	(July - Sep 2018)
-ve trend over 4 Qtrs **Worse than Scotland (10.2 - Q4 2017/18)** **Worse than target (10.5)**	**+ve trend over 4 Qtrs** **Worse than Scotland (87.9% - 17/18)** **Worse than target (87.5%)**	**Little change over 4 Qtrs** **Worse than target (40%)**	**+ve impact** **No Scotland comparison** **No local target**

Main Challenges

The quarterly rate of emergency readmissions within 28 days of discharge (all ages) is now 10.7 per 100 discharges, increasing from just under 10 during 2016/17. This is currently worse than the Scottish average and below target for this measure. Borders data in relation to end of life care shows relatively static performance but has been gradually improving over the longer term (3 years). However, end of life care figures for 2018/19 show Borders performed under target and worse than the Scottish average. The latest available data for Carers demonstrates positive outcomes as a result of completed Carer Support Plans.

Our plans during 2019/20 to support this objective

Mainstreaming of Community Led Support ("What Matters" hubs); redesign of homecare services to focus on re-ablement; increase provision of Extra Care Housing; roll-out of Transforming Care after Treatment programme; ongoing commissioning of Borders Carers Centre to undertake Carer Support Plans. The remit of the Matching Unit has been expanded to cover end of life care. Continued development of a Hospice to Home team and of the Marie Curie Nursing Service.

Performance Change

The table below gives a summary of the long-term trend for a range of performance measures used in the Quarterly reporting. Full detail can be found in the Integration section of the Council's website (Appendix 2 of the Quarterly Reports).

KEY

▲ Improving Performance ▼ Declining Performance ◄ ► Little change

MEASURE	DATA RANGE	LONG-TERM TREND	NOTES
Emergency admissions in Scottish Borders residents - all ages	Q1 2016/17 – Q4 2018/19(p)	▲	The rates fluctuate but over the long-term there has been a general decrease in volume of emergency admissions.
Rate of emergency admissions, Scottish Borders Residents age 75+	Q1 2016/17 – Q4 2018/19(p)	▲	
Number of A&E Attendances per 1,000 population	Q1 2016/17 – Q4 2018/19(p)	▲	As above, the rate fluctuates but the general long-term trend is that there is an increasing volume of A&E attendance.
% of H&C resource spent on hospital stays where the patient was admitted in an emergency – age 18+	Q1 2016/17 – Q4 2018/19(p)	▲	General decrease in the long-term trend for percentage spend on emergency hospital stays.
A&E % of patients seen within 4 hours	Mar 17 – Mar 19(p)	▲	General increase in the percentage of A&E attendees seen within 4hrs.
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	Q1 2016/17 – Q4 2018/19(p)	▲	Again, the rate fluctuates but generally there has been little change over the period.
Numbers of Delayed Discharges over 72 hours ("snapshot")	Mar 18 – Mar 19(p)	◄ ►	Delayed discharge data is erratic but performance is generally flat/slight decline.
Bed days associated with delayed discharges in residents aged 75+, per 1,000 population	Q1 2016/17 – Q4 2018/19(p)	▼	As performance with delayed discharges declines, the number of occupied bed days associated with delayed discharge increases.
Patient satisfaction	Q1 2016/17 – Q4 2018/19(p)	▲	Patient satisfaction (based on the '2 minutes of your time surveys' declined in the last quarter of 2018/19, but remains high.
Emergency readmissions within 28 days of discharge from Hospital (all ages)	Q1 2016/17 – Q4 2018/19(p)	▼	The rate of emergency readmissions within 28 days of discharge is increasing (i.e.) performance is declining.
% of last 6 months of life spent at home or in a community setting	Q1 2016/17 – Q4 2018/19(p)	▲	The percentage of people able to spend their last 6 months of life at home or in a community setting is increasing.
Support for Carers	Dec 17 – Dec 18	▲	Generally more Unpaid Carer Support Plans are being offered and completed.

Based on the range of measures above, the overall performance trend is positive (i.e.) more improving performance measures then declining. Work must continue to ensure that performance improvements continue to be driven by Partnership priorities and actions.

Core suite

The table below summaries our performance against the 23 National core suite indicators. Full details are shown in Appendix 2.

The results for indicators 1-10 are based on the 2017/18 Scottish Government Health and Care Experience Survey (i.e.) recording peoples' perceptions. The results for indicators 11-23 are based on data. From the results below, it can be seen that Borders performance based on the data measures appears stronger than those measures based on people's perception.

National core suite indicators 1-10: outcome indicators based on survey feedback for year 2017/18

OUTCOME INDICATORS

INDICATOR	TITLE	2015/16	2017/18	TREND	SCOTLAND*
NI - 1	Percentage of adults able to look after their health very well or quite well	96%	94%	▼	93%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	83%	▼	81%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	84%	74%	▼	76%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	72%	75%	▲	74%
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	82%	83%	▲	80%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	89%	88%	▼	83%
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	86%	80%	▼	80%
NI - 8	Total combined % carers who feel supported to continue in their caring role	41%	36%	▼	37%
NI - 9	Percentage of adults supported at home who agreed they felt safe	89%	89%	◀ ▶	83%
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	-	-	-	-

Source: (1-9) Scottish Government Health and Care Experience Survey 2017/18
http://www.isdscotland.org/Products-and-Services/Consultancy/Surveys/Health-and-Care-Experience-2017-18/
This national survey is run every two years with 2019/20 results due to be published spring 2020.

Source: : (10) NHS Scotland Staff Survey 2015
http://www.gov.scot/Publications/2015/12/5980. To date, equivalent information across the entire workforce of all Health and Social Care Partnerships is not available. Further work is required nationally and within Partnerships to collate and calculate this information.

DATA INDICATORS

INDICATOR	TITLE	2016/17	2017/18	2018/19(p)	TREND	SCOTLAND*
NI - 11	Premature mortality rate per 100,000 persons	340	324	-	▲	425
NI - 12	Emergency admission rate (per 100,000 population)	13,132	12,366	12,297	▲	11,492
NI - 13	Emergency bed day rate (per 100,000 population)	130,954	74%	127,593	▲	123,160
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	107	104	104	▲	103
Bespoke	Emergency readmissions within 28 days of discharge from hospital, Scottish Borders residents incl. Community Hospital beds (all ages, per 100 discharges)	10.2	10.4	11.0	▼	10.2
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	86%	◀ ▶	88%
NI - 16	Falls rate per 1,000 population aged 65+	21.0	22.3	19.0	▲	22.7
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	75%	81%	79%	▲	85%
NI - 18	Percentage of adults with intensive care needs receiving care at home	55%	62%	-	▲	61%
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	647	855	777	▼	762
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	21.3%	23.6%	21.7%	◀ ▶	25%
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	-	-	-	-	-
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	-	-	-	-	-
NI - 23	Expenditure on end of life care, cost in last 6 months per death	-	-	-	-	-

*SCOTLAND figure is latest full year available (2017/18)

Source: ISD Core Suite Indicator Updates

MSG measures

A summary of the Ministerial Strategy Group (MSG) measures we use are shown below. Additional detail is shown in Appendix 3.

MSG MEASURE		BASELINE YEAR	BASELINE TOTAL	% TARGET CHANGE	2019/20 TARGET
1. Emergency admissions		2017/18	10,701	1% decrease	10,594
2. A&E attendances		2017/18	25,159	1% decrease	24,907
3. Delayed discharges bed days (18+)		2017/18	14,246	30% decrease	9,972
4. Percentage of last 6 months of life spent in community (all ages)		2017/18	87.0%	0.5% increase	87.5%
5. Proportion of 65+ population living at home (supported and		2017/18	96.9%	no change	96.9%
6. Unplanned bed days	Acute	2017/18	76,318	1% decrease	75,555
	Geriatric Long Stay	2017/18	32,483	1% decrease	32,158
	Mental Health	2017/18	16,701	1% decrease	16,534

LOCALITY ARRANGEMENTS

Locality planning is a key tool in delivery of the change required to meet new and existing demands in the Borders. The IJB has developed locality arrangements, where professionals, communities and individuals can inform locality planning and redesign of services to meet local need in the best way.

This is achieved through having 'Locality Working Groups' in each of the five localities of:

- Berwickshire
- Cheviot
- Eildon
- Teviot & Liddesdale
- Tweeddale.

Each Locality has a Locality Plan. In the long-term, there are opportunities to further integrate the Locality Plans within Community Planning Partnership (CPP) arrangements, but in the short-term the Partnership will strengthen and bolster Locality Working Group arrangements by ensuring that:

1. Each Locality Plan is aligned to CPP themes and outcomes – as well as being aligned under the three Health & Social Care Strategic Objectives.
2. Each Locality has an identified 'Locality Lead', responsible for the planning and delivery of the H&SC actions. It is anticipated that the bulk of these will align under the 'Our health, care and wellbeing' CPP theme.
3. Identified members of IJB Leadership Team are allocated to specific localities. Their role to work with each 'Locality Lead' to plan and deliver the H&SC actions.
4. Admin resource is in place to support the Locality Leads and IJB Leadership Team members in the delivery of H&SC actions and activity across all 5 localities and to ensure the coordination of relevant papers and updates for Strategic Planning Group, Area Partnership and CPP meetings.
5. All 5 of the Locality Leads are permanent members of Strategic Policy Group (SPG)
6. 1x Locality Lead is selected to represents the others to attend Integration Joint Board.

INSPECTION OF SERVICES

Joint Inspection Action Plan – Update

The September 2017 Joint Inspection of Services for Older People in Scottish Borders identified areas of strength but also identified 13 areas for improvement. An action plan was put in place by the Partnership to. Delivery against the action plan is shown in Appendix 1.

Best Value Audit

A Best Value Review of Scottish Borders Council was undertaken by Audit Scotland during spring 2019. Whilst the focus of this audit was Council activity, one area being examined was how well the Council delivers services through partnership and collaborative working, including the Integration Joint Board. The results of the audit are not yet known but they will be reported in next year's Annual Performance Report.

Health Inspections

Borders General Hospital serves the Scottish Borders region. It contains 273 staffed beds and has a full range of healthcare specialties. Kelso Community Hospital has 23 beds and delivers a range of healthcare services, such as rehabilitation, assessment and palliative care. Hay Lodge Hospital, Peebles, supports acute hospital services and provides additional services to meet local healthcare needs - this includes acute medical care for the elderly, terminal care, convalescent care, respite care and rehabilitation. Hawick Community Hospital serves Hawick and the local area. It is a multidisciplinary health resource with 23 inpatient beds for GP acute services. The hospital also has a consultant outpatient department. Knoll Community Hospital supports acute hospital services and provides services to meet local healthcare needs. This includes acute medical care for the elderly, terminal care, respite care and rehabilitation.

Health Improvement Scotland (HIS) inspections of our community hospitals shows:

HOSPITAL	INSPECTION TYPE	DESCRIPTION & FINDINGS
Borders General	Unannounced	Inspection carried out from Tuesday 6 to Thursday 8 November 2018 in the areas of Borders Stroke Unit (stroke care), Ward 4 (general medicine), Ward 9 (orthopaedics), Ward 12 (department of medicine for the elderly) and A&E. Identified areas of good practice included screening and initial assessment and food, fluid & nutrition. Areas for improvement included person-centred care planning, falls and pressure area care.
Community Hospitals (Kelso, Hay Lodge, Hawick, Knoll)	Announced	An announced inspection of all our Community Hospitals is to be undertaken by Health Improvement Scotland on 21 & 22 May 2019. A report containing details of the findings will be published to the Health Improvement Scotland website. The report is expected to be published by August 2019.

Service/Facilities Inspections

A number of inspections by audit and scrutiny bodies, such as the Care Inspectorate, are carried out every year. The tables below show how these agencies have rated our care at home and residential care facilities and service provision. The Care Inspectorate use the following grading system:

- (6): Excellent - Outstanding or sector leading.
- (5): Very Good – Major strengths.
- (4): Good – Important strengths, with some areas for improvement.
- (3): Adequate – Strengths just outweigh weaknesses.
- (2): Weak – Important weaknesses. Priority action required.
- (1): Unsatisfactory – Major weaknesses. Urgent remedial action required.

St Ronan's care home in Innerleithen was awarded a coveted Grade 6 – 'Excellent', by the Care Inspectorate. This was awarded for the way in which the staff team supports the wellbeing of their residents. St Ronan's also received a Grade 5 – 'Very Good' for how well care and support is planned. Among the positive comments highlighted in the report was praise from residents for the caring and professional approach of staff and the fact that St Ronan's was a good home. One resident commented that St Ronan's didn't feel like a care home; to them it was simply their house where they enjoyed living.

The latest results for the 5-Council owned residential care homes is shown below:

1. RESIDENTIAL CARE HOMES

RESIDENTIAL CARE HOME	INSPECTION DATE	CARE & SUPPORT	ENVIRONMENT	STAFFING	MANAGEMENT & LEADERSHIP	WELLBEING
Deanfield, Hawick	4th May 2018	4	4	3	3	
Grove, Kelso	20th Sept 2018	4	4	-	-	4
Saltgreens, Eyemouth	23rd Nov 2018	4	4	4	4	5
St Ronan's, Innerleithen	30th Nov 2018	5	-	-	-	6
Waverley, Galashiels	24th Aug 2018	5	4	5	-	

2. CARE AT HOME

HOME CARE AREA	INSPECTION DATE	CARE & SUPPORT	ENVIRONMENT	STAFFING	MANAGEMENT & LEADERSHIP
West	12th Feb 2019	4	-	4	3
East	18th Jan 2019	4	-	4	3
South	29th Oct 2018	3	-	4	3

MSG Report on IJBs

The Ministerial Strategic Group for Health and Community Care February 2019 report on the 'Review of Progress with Integration of Health and Social Care' concluded that the pace and effectiveness of integration needs to increase. The report draws together the group's 25 proposals for ensuring the success of integration. All partnerships, across Scotland, have completed a self-evaluation on the 25 proposals. This will feed into improvement actions, with delivery against these reported on in the 2019/20 Annual Performance Report.

APPENDIX 1
JOINT INSPECTION ACTION PLAN

NO'	TITLE	REF	WHAT GOOD LOOKS LIKE	INDICATOR DESCRIPTION	RESPONSIBLE PERSON	BASELINE	RAG
1.	1. Deliver more effective consultation and engagement with stakeholders on the vision, service redesign and key stages of transformational change.	1.1	Locality Planning is working	Local Planning Groups are meeting regularly	Graeme McMurdo		Amber – proposals for change approved by IJB June 2019
		1.2	Regular Staff engagement meetings	6 monthly Staff engagement Meetings	Graeme McMurdo	Engagement	Amber To be further developed
		1.3	Staff Feel Consulted	From the 'iMatters' Staff Survey	Graeme McMurdo		Green 2019 Survey completed
2.	Ensure the revised governance framework provides more effective performance reporting and an increased pace of change	2.1	Governance Reporting is working	¼ly reports to IJB and action plan objectives are progressed	Graeme McMurdo	¼ ly reports	Green In operation
5.	Update the carers' strategy to have a clear focus on how carers are identified and have their needs assessed and met. Monitor and review performance in this area.	5.1	Carers Strategy is completed and is being an implemented Plan	Implementation actions are achieved within timescales. Reported to IJB Performance group	Susan Henderson		Green - Complete
		5.2	Carers are offered an assessment	Carers offered an assessment (and those who take it up) as a proportion of carers that the IJB is in contact with	Susan Henderson	the % of carers offered and taken up CSP increased from 27.6% to 31.3% (2017 -2018)	Green - Complete
		5.3	Carers Satisfaction	How satisfied are carers with our support	Susan Henderson	The majority of carers feel valued by services	Green - Complete

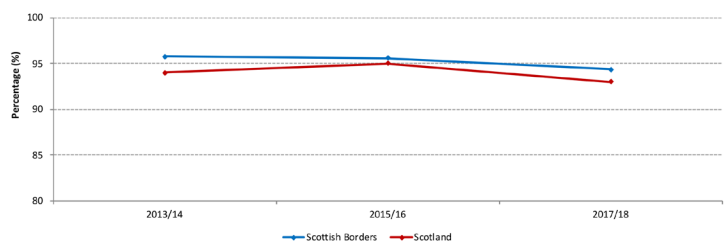
NO'	TITLE	REF	WHAT GOOD LOOKS LIKE	INDICATOR DESCRIPTION	RESPONSIBLE PERSON	BASELINE	RAG
8.	Provide stronger accountability and governance of transformational change programme. Ensure that: progress of the strategic plan priorities are measured and evaluated; service performance and financial monitoring are linked; locality planning is implemented and leads to changes at a local level; independent needs assessment activity is included in the joint strategic needs assessment; There is appropriate oversight of procurement and commissioning work; A market facilitation strategy is developed and implemented	8.1	The IJB operates to Strategic Plan	Strategic Plan Implementation plan is delivered on time	Graeme McMurdo		Green - On Track
		8.2	IJB Performance is reported and acted on	Performance reports and actions plans are routinely reported on.	Graeme McMurdo		Green - On Track
		8.3	Locality Planning is working	See 1.1	Graeme McMurdo		Amber – proposals for change agreed by IJB June 2019
		8.4	Needs are understood	Joint Strategic needs Assessment is completed and enacted	Tim Patterson		Complete
		8.5	Access to all Care Services is timely	See 4.1	Rob MG /Michael Murphy	See 4.1	
9.	Develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved	9.1	Financial Plan in Place and operating	Progress on Financial Plan is reported to the IJB	Rob McCulloch-Graham		Green On Track

NO'	TITLE	REF	WHAT GOOD LOOKS LIKE	INDICATOR DESCRIPTION	RESPONSIBLE PERSON	BASELINE	RAG
11.	Work together with the critical services oversight group and adult protection committee to ensure that: risk assessments and risk management plans are completed where required; quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve; and improvement activity resulting from quality assurance processes is well governed	11.1	Risk Assessment are timely and of good quality	Monitoring of completion of risk assessments	Gwyneth Lennox	Performance Clinic thru to Public Protection Committee	Amber - Awaiting Review
		11.2	Case File Audits indicates the Risk Assessments and files are of good quality	Monitoring of Case File Audits and improvement actions	Gwyneth Lennox	Performance Clinic thru to Public Protection Committee	Amber - Volume of Audits is currently underperforming target Remedial Action being taken
		11.3	Critical Services Oversight Group(CSOG) is sighted on the quality of Adult Protection work	QA reports go to CSOG	Stuart Easingwood	Reported To CSOG and then Public Protection Committee	Green
		11.4	Remedial actions are timely	QA action plan progress is reported to CSOG	Stuart Easingwood	Reported to CSOG and then Public Protection Committee	Green

Red = Significant Performance Issue/Delay needs remedial action
Amber = Minor Performance issue/ Delay but still within margins
Green = Completed/On track

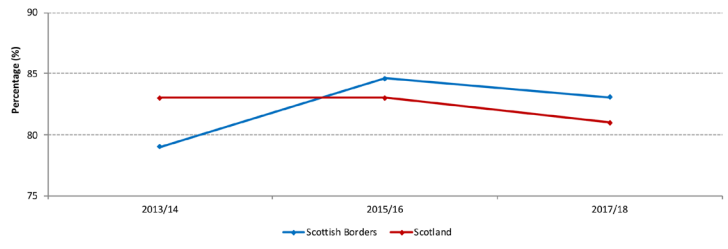
APPENDIX 2
CORE SUITE OF INDICATORS

NI-1 Percentage of adults able to look after their health very well or quite well

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	We will continue to improve information and advice available, and to promote Healthy Living.

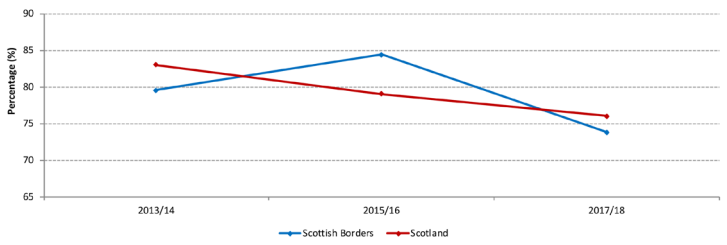
Source: Q52 - 2013/14 Health and Care Experience Survey, Q51 2015/16 Health and Care Experience Survey, Q40 2017/18 Health and Care Experience Survey

NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We are continuing to develop technology enabled care and support as one method of enabling people to remain as independent as possible.

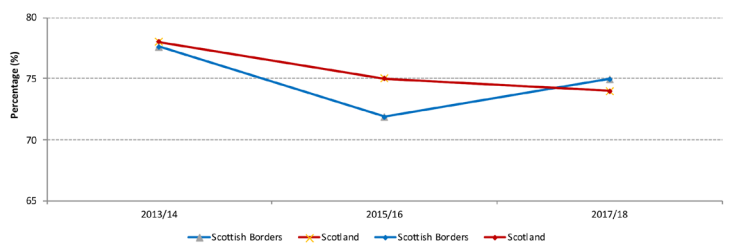
Source: Q36f - 2013/14 Health and Care Experience Survey, Q36g 2015/16 Health and Care Experience Survey, Q27f 2017/18 Health and Care Experience Survey

NI-3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Borders has a relatively high rate of Self-Directed Support in Scotland and we will continue to promote this.

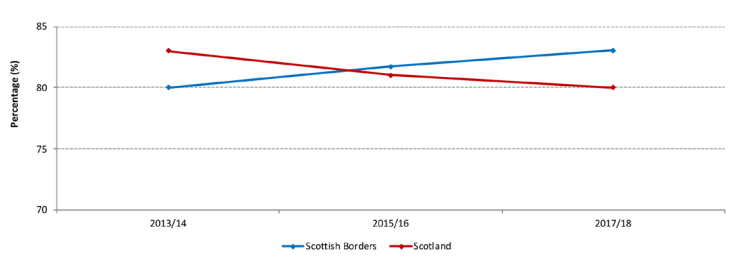
Source: Q36b - 2013/14 Health and Care Experience Survey, Q36b 2015/16 Health and Care Experience Survey, Q27b 2017/18 Health and Care Experience Survey

NI-4 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Work is progressing to improve the 'Older People's Pathway'. This will focus on joint working to prevent admissions, but where this is unavoidable to improving the flow through hospital and back into communities.

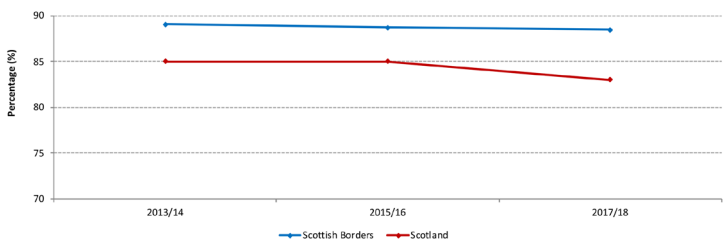
Source: Q36e - 2013/14 Health and Care Experience Survey, Q36f 2015/16 Health and Care Experience Survey, Q27g 2017/18 Health and Care Experience Survey

NI-5 Total % of adults receiving any care or support who rated it as excellent or good

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to seek the views of people receiving care (such as 2 minutes of your time survey) and will act to deliver improvements.

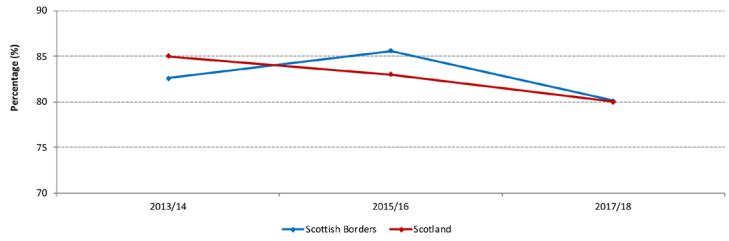
Source: Q37 - 2013/14 Health and Care Experience Survey, Q37 2015/16 Health and Care Experience Survey, Q28 2017/18 Health and Care Experience Survey

NI-6 Percentage of people with positive experience of the care provided by their GP practice

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	◀ ▶	The Primary Care Improvement Plan (PCIP) and improvements to our Locality arrangements should help to develop this.

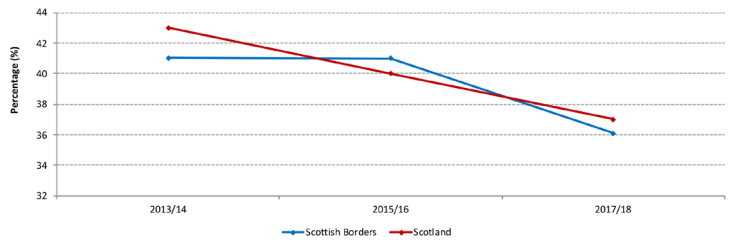
Source: Q27 - 2013/14 Health and Care Experience Survey, Q25 2015/16 Health and Care Experience Survey, Q8d 2017/18 Health and Care Experience Survey

NI-7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	We will continue to seek the views of people receiving care and will act to deliver improvements.

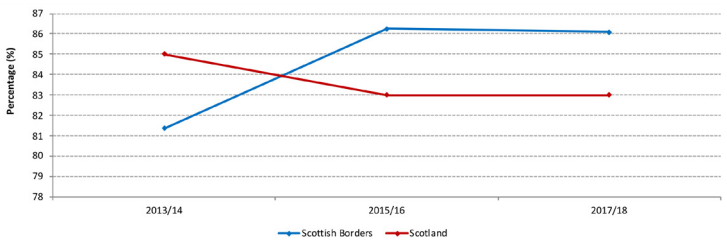
Source: Q36h - 2013/14 Health and Care Experience Survey, Q36i 2015/16 Health and Care Experience Survey, Q27h 2017/18 Health and Care Experience Survey

NI-8 Percentage of carers who feel supported to continue in their caring role

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Support for Carers is a key Partnership priority.

Source: Q45f - 2013/14 Health and Care Experience Survey, Q45e 2015/16 Health and Care Experience Survey, Q32e 2017/18 Health and Care Experience Survey

NI-9 Percentage of adults supported at home who agree they felt safe

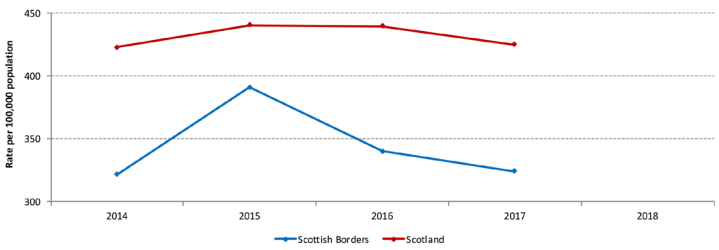
PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to seek the views of people receiving care and will act to deliver improvements.

Source: Q36g - 2013/14 Health and Care Experience Survey, Q36h 2015/16 Health and Care Experience Survey, Q27e 2017/18 Health and Care Experience Survey

NI-10 Percentage of staff who say they would recommend their workplace as a good place to work

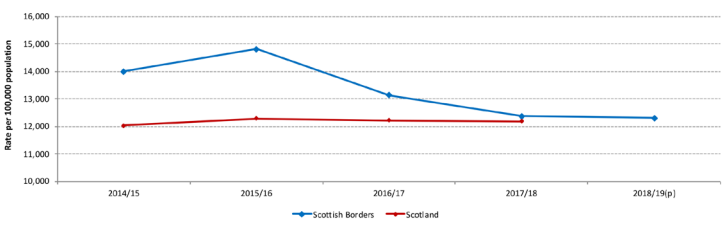
Indicator under development.

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to look at ways to improve care and support for Older People.

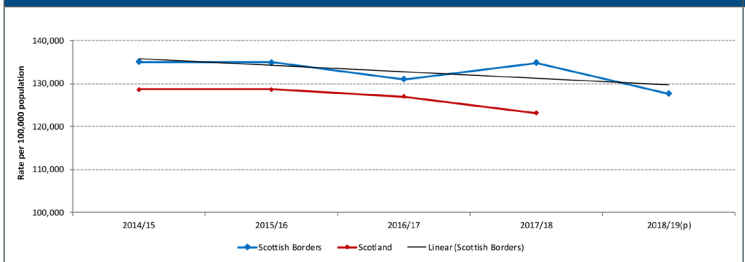
Source: National Records for Scotland (NRS)

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Work focused on preventing unplanned admissions, through creation of community capacity.

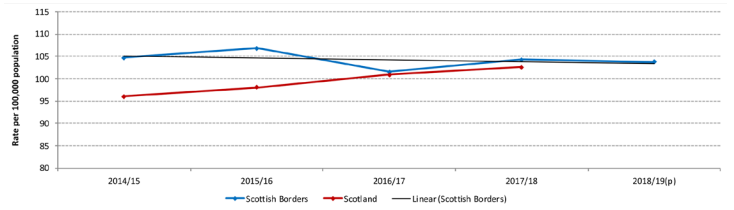
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Work at Locality level in communities will focus on admission prevention.

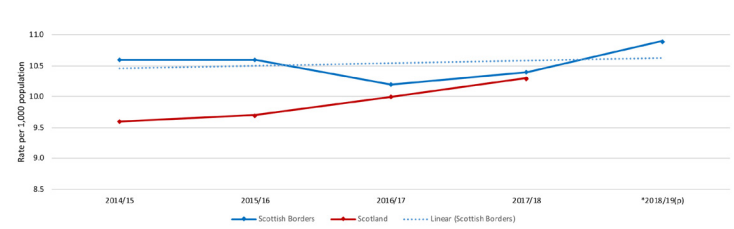
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

NI-14 (a) Readmissions to hospital within 28 days of discharge (per 100,000 population)

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	◀ ▶	Work progressing to reduce readmissions through increased community capacity and joined up care via multi-disciplinary teams.

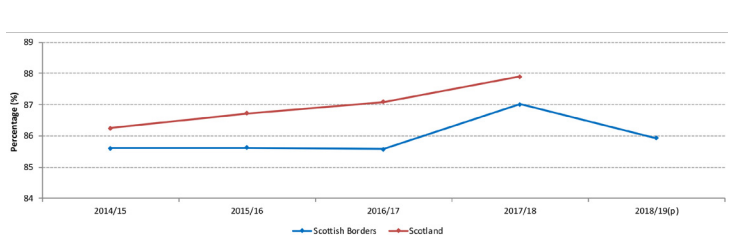
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

NI-14 (b) Emergency readmissions within 28 days of discharge from hospital, Scottish Borders residents (all ages) (per 1,000 population) Bespoke Indicator to include Borders Community Hospital beds

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Work progressing to reduce readmissions through increased community capacity and joined up care via multi-disciplinary teams.

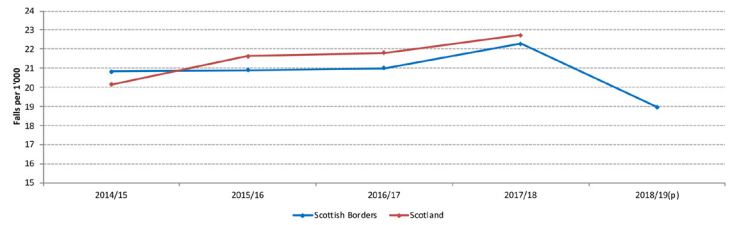
Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but also adding in Borders Community Hospital beds).

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Improving data quality to allow hospice beds to be distinguished from acute beds and also commissioning additional care beds.

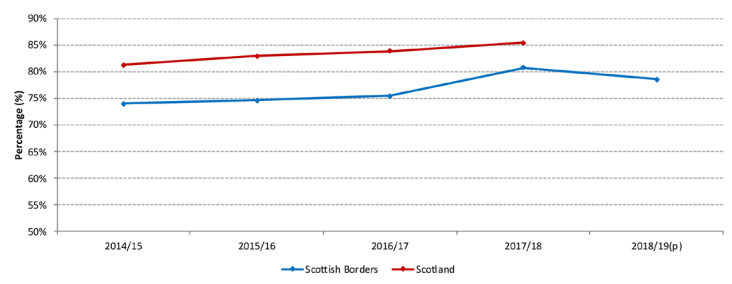
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) records
ISD Scotland: SMR04 (mental health inpatient records)
National Records for Scotland

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Trialing TEC solutions including to predict and prevent falls.

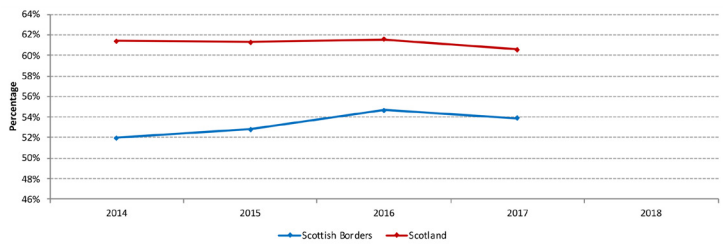
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Capital provision agreed for creation of extra care housing and residential dementia.

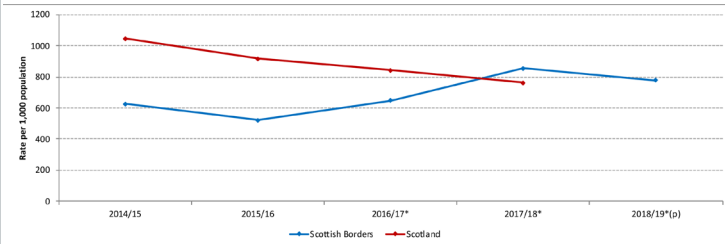
Source: Care Inspectorate

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Changes to Locality arrangements and further development of Hospital to Home will support this.

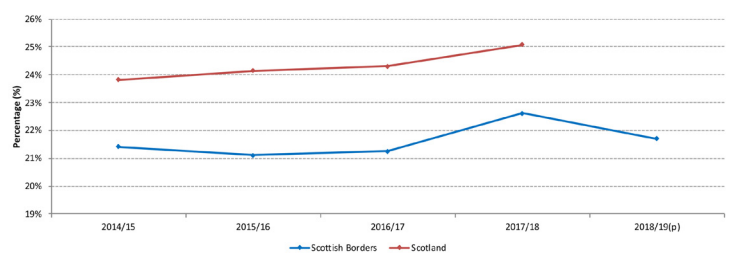
Source: Care Inspectorate

NI-19 Number of days people aged 75+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 75+)

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Implementation of new discharge hub to facilitate discharge from hospital. Challenges include identifying suitable accommodation and having sufficient carers in place.

Source: ISD Scotland Delayed Discharge Census

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Work focused on preventing unplanned admissions, through creation of community capacity.

Source: SMR04 (mental health inpatient records from NHS hospitals in Scotland

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

Indicator under development.

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

Indicator under development.

NI-23 Expenditure on end of life care

Indicator under development.

APPENDIX 3
MSG MEASURES

EMERGENCY ADMISSIONS	BASELINE YEAR	BASELINE TOTAL	% TARGET CHANGE	2019/20 TARGET
Data	2017/18	10,701	decrease	10,594

Actions to achieve target

1. Changes made to the unsheduled care model to ensure that more health services needs can be met outside hospitals through providing treatment alternatives to hospital admission.

A&E ATTENDANCES	BASELINE YEAR	BASELINE TOTAL	% TARGET CHANGE	2019/20 TARGET
Data	2017/18	25,159	decrease	24,907

Actions to achieve target

We have an overarching communications and engagement strategy is in place for the H&SCP with a focus on supporting the delivery of the Strategic Plan Objectives. As part of this we have developed the yourpart to keep healthy; access the right services and the right time; and make use of services in your community.

1. Development of the Distress Brief Interventions Service to reduce re attendance of people in mental distress at A&E.
2. As with Emergency Admissions, the changes to the unsheduled care model should ensure that more health service needs can be met outside hospitals, through providing treatment alternatives to hospital admission.

DELAYED DISCHARGE BED DAYS (18+)	BASELINE YEAR	BASELINE TOTAL	% TARGET CHANGE	2019/20 TARGET
Data	2017/18	14,246	30% decrease	9,972

Actions to achieve target

1. Expansion and roll-out across the Borders of the Hospital to Home (H2H) Service (in 2018, 60 patients were part of the H2H service).
2. Continued use of Discharge to Assess (DTA) facilities.
3. Continued use of Transitional Care facilities (TCF) for rehabilitation and reablement.
4. Continued use of Matching Unit to match care provision to assessed need.
5. Commissioning of specialist dementia provision.
6. Use of technology, such as STRATA, to improve patient flow.
7. Development of the Community Outreach Team to provide support for early discharge and prevention of admission to hospital.

PERCENTAGE OF LAST 6 MONTHS OF LIFE SPENT IN COMMUNITY (ALL AGES)	BASELINE YEAR	BASELINE TOTAL	% TARGET CHANGE	2019/20 TARGET
Data	2017/18	87.0%	0.5% increase	87.5%

Actions to achieve target

1. The remit of the Marketing unit was recently expanded to include matching for end of life care.
2. Development of a Hospice to Home team.
3. Continued development of the Marie Curie Nursing Home.

PROPORTION OF 65+ POPULATION LIVING AT HOME (SUPPORTED AND UNSUPPORTED)	BASELINE YEAR	BASELINE TOTAL	% TARGET CHANGE	2019/20 TARGET
Data	2017/18	96.9%	no change	96.9%

Actions to achieve target

The measure may not change by the end of 2019/20 as although some hospital beds may be decommissioned, these will be offset by additional commissioned beds for older adults requiring specialist dementia care.

1. Development of the Community Outreach team to prevent hospital admission and support people to live longer in the community.

UNPLANNED BED DAYS		BASELINE YEAR	BASELINE TOTAL	% TARGET CHANGE	2019/20 TARGET
Data	Acute	2017/18	76,318	1% decrease	75,555
	Geriatric Long Stay	2017/18	32,483	1% decrease	32,158
	Mental Health	2017/18	16,701	1% decrease	16,534

Actions to achieve target

Acute

1. Continued focus on the 6 Essential Actions to ensure there are no delays for patients by early discharge planning.
2. Co-ordinating this work with our Community, Social Services and Third and Independent sector.
3. Strengthening the weekend service, aiming to deliver 7-day services.
4. Specific improvements to optimising Ambulatory Care, refining Daily Dynamic Discharge, and implementing and integrated Discharge Hub.

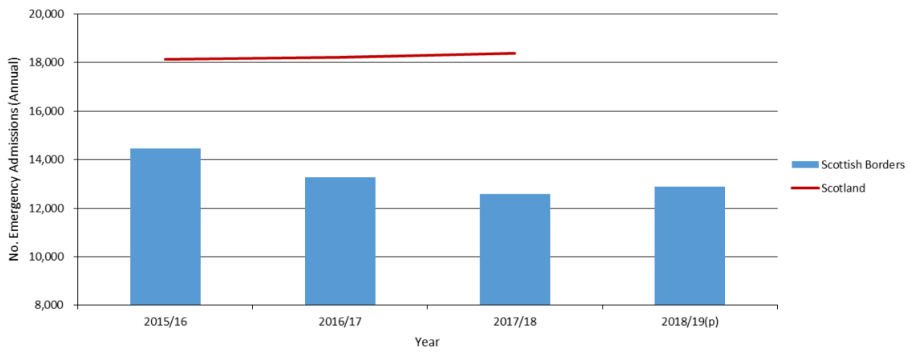
Geriatric Long Stay

1. Transformation Programme has a specific workstream for Frail Older people with one of their aims to reduce unplanned bed days.

Mental Health

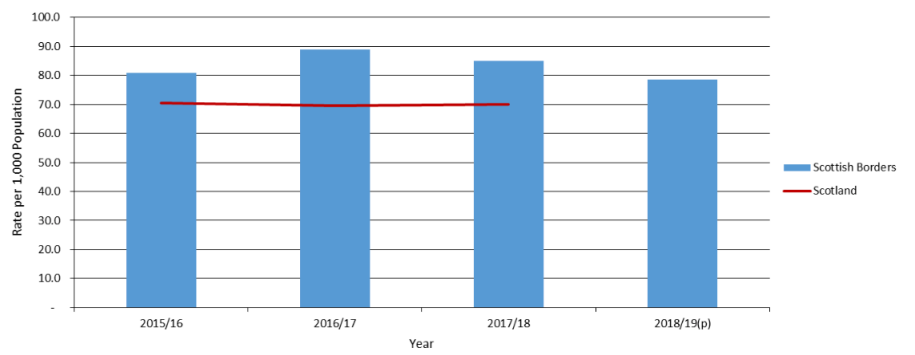
1. Outcome focussed consistent Care Planning across the community teams and in patients services.
2. Investment of Action 15 funding in Primary Care Mental Health services to provide more robust community support eg Distress Brief Interventions, Well Being Advisors, more accessible psychological therapies and expansion of local Area Coordination.

1a Number of emergency admissions (All Ages)

PERFORMANCE	BORDERS TREND
	▲

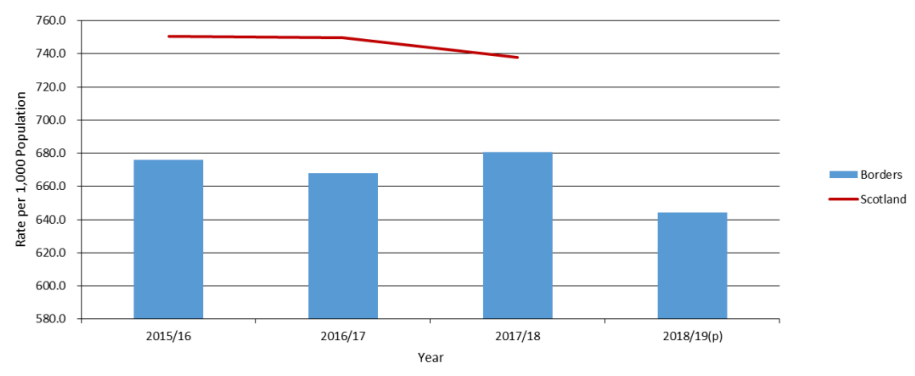
Source: SMR01, ISD

1b Admissions from A&E (All Ages)

PERFORMANCE	BORDERS TREND
	▲

Source: A&E datamart, ISD

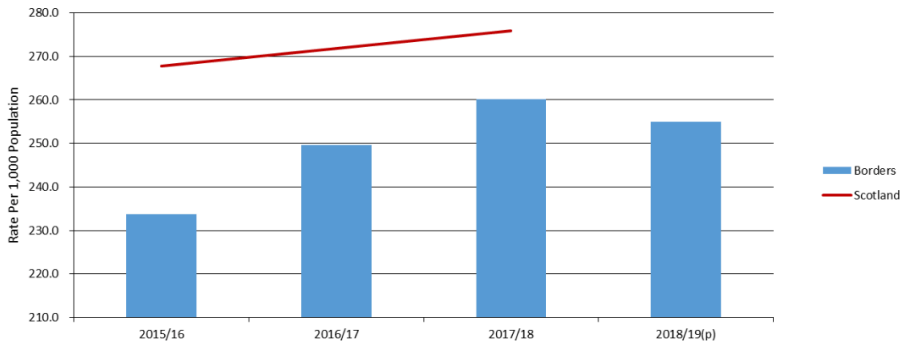
2 Number of unscheduled hospital bed days; acute specialties (All Ages)

PERFORMANCE	BORDERS TREND
	▲

Source: SMR01, ISD

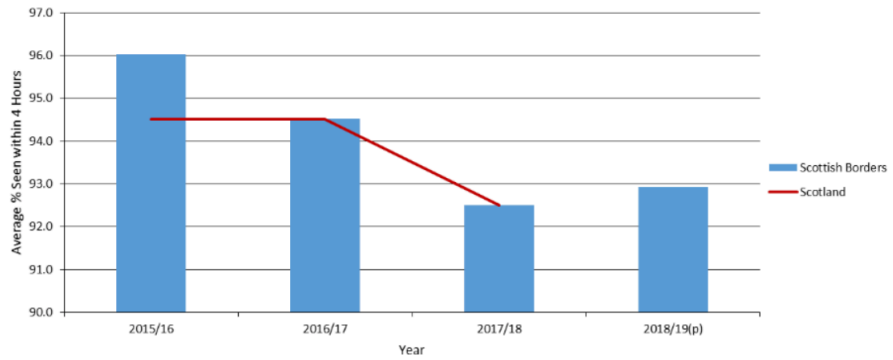
Source: A&E datamart, ISD

3a A&E attendances (All Ages)

PERFORMANCE	BORDERS TREND
	▼

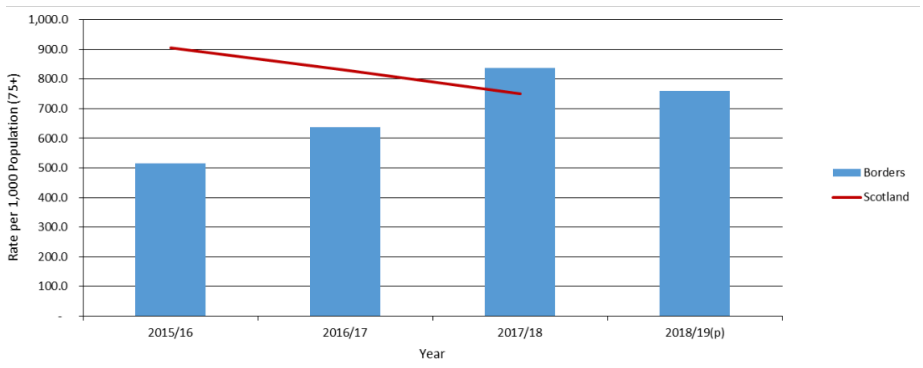
Source: A&E datamart, ISD

3b A&E % seen within 4 hours (All ages)

PERFORMANCE	BORDERS TREND
	▼

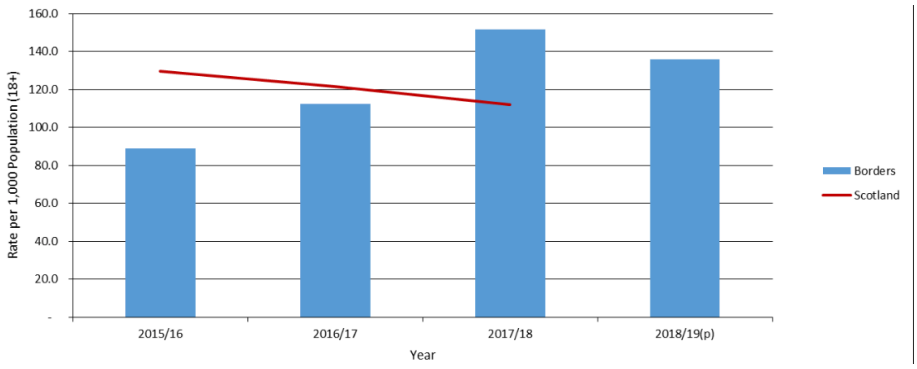
Source: A&E datamart, ISD

4a Delayed discharge bed days (i. 75+, ii. 18+)

PERFORMANCE	BORDERS TREND
	▼

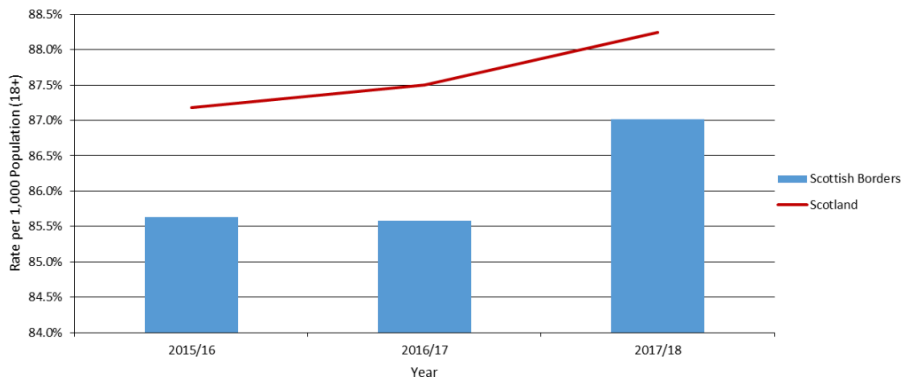
Source: Delayed Discharges, ISD

4b Delayed discharge bed days (i. 75+, ii. 18+)

PERFORMANCE	BORDERS TREND
	▼

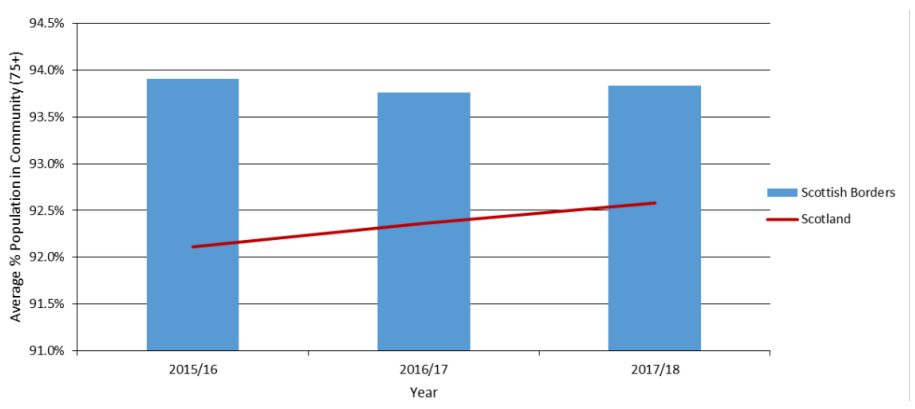
Source: Delayed Discharges, ISD

5 Percentage of last six months of life spent at Home or Community Setting

PERFORMANCE	BORDERS TREND
	▲

Source: Death records, NRS; SMR01, ISD; SMR04, ISD

6 Balance of care: Percentage of population in community or institutional settings (75+)

PERFORMANCE	BORDERS TREND
	◀ ▶

Source: SMR01, ISD; SMR04, ISD; Care Home Census, ISD; Social Care Census, SG; Population estimates, NRS

APPENDIX 4
PARTNERSHIP VISION

The diagram below sets out the Partnership vision for delivery of Health and Social Care.

In regard to delivering our three strategic objectives, our vision is that:

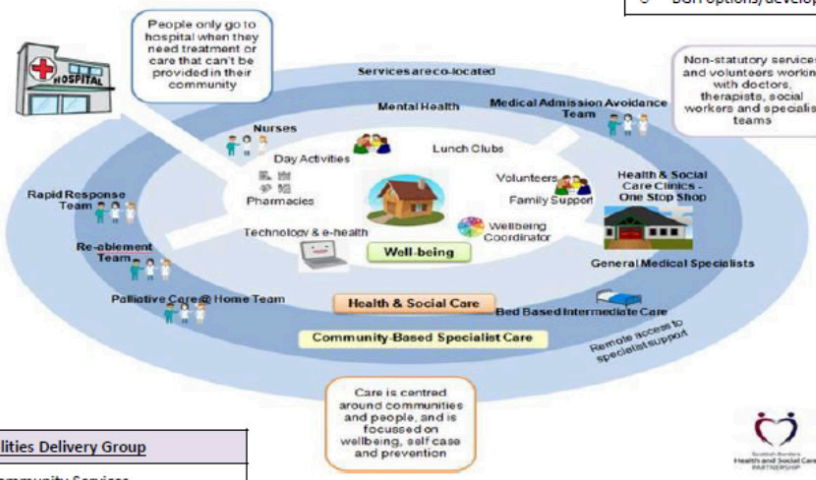
- People are only admitted to hospital when it is absolutely necessary.
- Care is centered around communities and individuals.
- Staff and volunteers work together within communities.
- With work being taken forward under a number of Groups.

Accommodation Group

- Care Village development
- Dementia/Mental Health accommodation development
- Existing care home development
- New care home development
- ECH development
- Community Hospital options/development
- BGH options/development

TEC, Aids & Adaptations Group

- Development of TEC
- Development of Care & Repair
- Development of Aids & Adaptations



Commissioning Group

- Commissioning the services and staff required to deliver the strategy
- Re-commissioning existing contracts
- New contracts
- Monitoring contractual delivery
- Policies, procedures, processes required to support the contracts
- Out of hours

H&SC Localities Delivery Group

- Development of Community Services
- Improved Community Co-ordination
- Development of the Workforce (i.e. To care for Older People)
- Development of information and advice
- Development of care at home, including reablement, transitional care and hospital to home
- Intermediate care
- Respite
- Step up/down discharge
- Single assessment
- MDTs

Community Group

- Support Locality Working Groups
- Support Carers, Local Area Co-ordinators and Community Capacity Building
- Campaigns and Communication

Alternative format/language

You can get this document on audio CD, in large print, and various other formats by contacting us at the address below. In addition, contact the address below for information on language translations, additional copies, or to arrange for an officer to meet with you to explain any areas of the publication that you would like clarified.

其他格式 / 外文譯本

這份資料冊另備有錄音帶、大字體版本以及多種其他格式。你可以透過以下地址與我們聯絡，索取不同版本。此外，你也可以聯絡以下地址索取本資料的中文和其他外文譯本或索取更多拷貝。亦可要求我們做出安排，由我們的工作人員當面為你解釋你對這份出版物中的不明確之處。

[Alternatywny format/język]

Aby uzyskać kopię niniejszego dokumentu w formacie audio, dużą czcionką, oraz innych formatach prosimy o kontakt na poniższy adres. Uzykać tam można również informacje o tłumaczeniach na języki obce, otrzymaniu dodatkowych kopii oraz zaaranżowaniu spotkania z urzędnikiem, który wyjaśni wątpliwości i zapytania związane z treścią niniejszej publikacji.

Parágrafo de formato/língua alternativos

Pode obter este documento em cassete audio, impressão aumentada e vários outros formatos contactando a morada indicada em baixo. Pode ainda contactar a morada indicada em baixo para obter informações sobre traduções noutras línguas, cópias adicionais ou para solicitar uma reunião com um funcionário para lhe explicar quaisquer áreas desta publicação que deseje ver esclarecidas.

Параграф об альтернативном формате/языковой версии

Чтобы получить данный документ в записи на пленке, в крупношрифтовой распечатке и в других различных форматах, вы можете обратиться к нам по приведенному ниже адресу. Кроме того, по данному адресу можно обращаться за информацией о переводе на различные языки, получении дополнительных копий а также с тем, чтобы организовать встречу с сотрудником, который сможет редставить объяснения по тем разделам публикации, которые вам хотелось бы прояснить.

SCOTTISH BORDERS COUNCIL
Council Headquarters | Newtown St Boswells | MELROSE | TD6 0SA
tel: 0300 100 1800
email: integration@scotborders.gov.uk
www.scotborders.gov.uk/integration

Scottish Borders COUNCIL

NHS Borders

Scottish Borders Health and Social Care PARTNERSHIP

Printed in the Scottish Borders. Designed by Scottish Borders Council Graphic Design Section. KG/06/19.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 14 August 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Rob McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 828290

REDESIGN OF DEMENTIA SERVICES

Purpose of Report:	To seek approval for the proposal to redesign dementia services, by investing in community services with a consequent reduction in the need for inpatient beds from 26 to 12, and as a result enhancing the care of dementia patients in the community.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Approve the reduction of the number of dementia inpatient beds from 26 to 12; b) Approve reinvestment in appropriate community resources; c) Agree to establish an IJB reserve of £338,000 of recurrent funding. This reserve will be earmarked for the purchase of additional dementia care home beds, as required. Should the beds not be required the balance of the reserve would be used by the IJB to contribute to the delivery of efficiencies within the health arm of the IJB budget; d) Agree to review the impact of the new model by no later than March 2021, including the effectiveness of the Care Home and Community Assessment team, the need for NHS Inpatient beds and the ongoing requirement for the earmarked reserve.

Personnel:	If staff teams are to be reduced, the normal NHS Borders redeployment process will apply.

Carers:	Further advice and support for Carers will be available through the Care Home and Community Assessment Team.

Equalities:	An Equality Impact Assessment will be carried out as part of the project.

Financial:	Within the paper, financial consequences and impacts are considered.

Legal:	N/A

Risk Implications:	See attached risk assessment within Cauldshiels mandate (**Appendix 6**).

1 PURPOSE AND SUMMARY

1.1 The Health and Social Care Partnership working with Scottish Borders Council (SBC) and NHS Borders are exploring how together we can respond to the growing demographic of people with dementia. In addition to evaluating current practice within the Borders and commissioning support to provide more accurate predictors for the demographics, officers and members of the Integration Joint Board (IJB) have been examining other models both within the UK and abroad.

1.2 Two major development sessions have been held focussing on the future provision for Health and Social Care within which provision for the elderly is a priority. Details of this work have been discussed at SBC's Corporate Management Team, NHS Borders' Board Executive Team, Strategic Planning Group and the Executive Management Team.

1.3 Previous reviews conducted by external consultants including Anna Evans, Anne Hendry and John Bolton, have identified a need for a step change in the scale and scope of service provision for older people with dementia in the Borders.

1.4 A further report 'Transforming Specialist Dementia Hospital Care' by Alzheimer's Scotland recommended that acute hospital beds for dementia patients should be transferred to more appropriate residential provision within the community.

1.5 In response the Partnership is now developing an overarching Dementia Care Strategy to govern future provision of services. In the meantime, there are a range of early responses which are being advanced in line with the early development work already undertaken and the evolving strategy. These developments aim to progress a shift in the balance of care for medicine of the elderly. The Council invested £500k in securing 7 specialist dementia care nursing beds within Queens House.

1.6 The first opportunity is the transfer of patients currently being cared for in the acute wards of Cauldshiels and Melburn Lodge at the BGH. Provision at Cauldshiels is viewed as being unfit for purpose for dementia care. The unit is currently operating significantly under capacity, with less than 50% of the beds across the two units currently being occupied. Consequently, an opportunity has arisen to transform this service by closing the Cauldshiels ward and relocating patients to the homelier setting of Melbourne Lodge. The closure of Cauldshiels ward and the resetting of the model of care within Melburn Lodge will enable a significant improvement in quality of dementia care facilities, save significant annual revenue resources and avoid the need for substantial investment in the fabric of the Cauldshiels facility.

1.7 The paper outlines in detail how this will be achieved and the necessary investment required to transfer from NHS Borders to SBC, for them to commission

the appropriate provision.

2 MAIN REPORT

2.1 **Current Provision -** The current provision of Dementia inpatient care in Scottish Borders is provided across two wards on the BGH site; Cauldshiels (a 14 bed assessment ward) and Melburn Lodge (a 12 bed ward). In addition, Lindean provides a specialist inpatient facility for older adults with acute mental health problems.

2.2 Following investment from SBC, the service is experiencing reduced demand for inpatient beds. We currently have six patients on Cauldshiels (including four delayed discharges) and seven patients on Melburn (including one delayed discharge). Across the 26 beds in the two units, there are currently 13 patients, of which five are delayed discharges and could more appropriately be cared for in an alternative setting.

2.3 A Day of Care Audit (DOCA) (attached **Appendix 3**) was undertaken across all inpatient settings within the Borders, BGH and Community Hospitals in July 2018, and Melburn, Cauldshiels and Lindean in November 2018. The DOCA completed for older adults with an organic and/or functional mental illness, which includes Melburn, Cauldshiels and Lindean, reinforced the national estimation that there is a need for a significant reduction in the number of specialist inpatient beds for this patient group. Locally of the 28 patients included in the audit only seven required a specialist inpatient bed. 21 patients could be cared for in a range of alternative settings such as nursing or residential home or with a package of care at home.

2.4 The DOCA completed in July 2018 for the BGH and Community hospitals identified no patients requiring specialist inpatient dementia care, it also identified that in the Community Hospitals the majority of patients could be managed out of hospital in an alternative care setting or at home with enhanced support.

2.5 The Mental Welfare Commission's (MWC 2014) review of dementia continuing care units identified serious concerns with quality of care, environments, access to multidisciplinary professionals and adherence to legal requirements for providing care.

2.6 Cauldshiels ward has been highlighted in successive Mental Welfare Commission reports as providing an unsuitable physical environment for dementia care. Rectifying this in the long term would require a substantial rebuilding programme and significant capital investment (**Appendix 4** MWC reports and **Appendix 5** Architects report). The estimated cost of doing this work ranges from over £1m to an architect assessed cost of £400k for essential non structural work. This capital cost will be avoided if the ward is no longer required.

2.7 Specialist dementia wards are frequently located in environments that do not support person-centred care and can increase the distress of the person with dementia and their family. There is a lack of access to the multi-disciplinary professionals required to support the complex care required in dementia. There is difficulty with transition, resulting in the largest proportion of patients in the specialist dementia wards being those who do not have a clinical need to be in hospital. This makes it difficult to provide appropriate care for the current wide range of differing needs. It also means that resources are not being targeted effectively.

2.8 There is a lack of integration between these specialist hospital environments and the wider health and social care systems. This results in specialist dementia hospital units sitting in isolation, without the same focus on discharge to more appropriate care environments that are the case with acute hospitals. This often results in the window of opportunity being missed for safe transition to a more appropriate community setting to enhance quality of life.

2.9 Staff within specialist care are committed to providing good quality care, but are hindered by the current obstacles.

2.10 **Proposed Redesign -** The Scottish government "Transforming Specialist Hospital Dementia Care" report (**Appendix 1**) sets out a model of modern specialist hospital units based on quality of care for people with dementia who have intensive and complex clinical care needs and require high level expert care. It also provides an approach to build community capacity to support the safe transition of those who do not have a clinical need to remain in specialist hospitals and can be cared for in more homely settings in the community.

2.11 Specialist dementia hospital care is required for people with dementia who have an acute psychological presentation as a result of dementia or co-morbid mental health illness. The clinical needs of this group can only be met in a hospital environment. Whilst a psychological presentation may necessitate being admitted to hospital, the person will also have additional physical, emotional and social care needs. This requires a highly skilled multi-disciplinary workforce that can deliver therapeutic interventions, care and treatment; with the appropriate level of multi-disciplinary professional input to support those providing day-to-day care.

2.12 Most people with dementia can be cared for in the community throughout the illness. This requires a multi-disciplinary coordinated and planned approach to support those providing day-to-day care. There will be a small number of people with dementia who have acute clinical care needs that require specialist hospital care for a period of time. It is estimated that up to one percent of people with dementia will require management in a specialist dementia hospital environment at any one time. This will result from severe psychological symptoms of dementia or the combined influence of a co-morbid mental health condition.

2.13 The Scottish Government report recommends a 50% reduction in specialist dementia inpatient beds for all Health Boards. Melburn lodge already provides an appropriate environment to support the above recommendations for an inpatient "centre of excellence" for dementia care and will therefore require little alteration. Melburn provides 12 inpatient beds approximately meeting the estimated requirement for an overall 50% reduction in specialist dementia inpatient beds. Due to the physical environment on Cauldshiels ward not being fit for purpose, closing this ward would allow a suitable reduction in line with the national recommendation.

2.14 Day of care audits for Borders General Hospital, the Community Hospitals and specialist dementia in patient wards confirm that the local demand for beds supports the reduction in inpatient beds by 50%.

2.15 In line with recommendations made in the Scottish Government report, the Health and Social Care Partnership should reduce the number of dementia inpatient beds from 26 to 12 and reinvest in appropriate community resources (**Appendix 6** Cauldshiels Mandate). The proposal is to phase the reduction in inpatient beds in Cauldshiels whilst developing the community services to facilitate this shift in the balance of care. The current assessment function undertaken in Cauldshiels will

be incorporated into Melburn.

2.16 Preliminary bed modelling has been undertaken, this indicates that the number of inpatient dementia beds can safely be reduced through the existing changes and the development of the Care Home and Community Assessment Team without the need to purchase additional specialist dementia beds in the community. The report is contained in **Appendix 7**.

3 NEXT STEPS

3.1 The Health and Social Care Partnership are in the process of developing a local Dementia Strategy and our Mental Health Services are in the midst of a transformation programme. It is clear that reducing inpatient beds and reinvesting in community resources is consistent with the National and local drive to shift the balance of care from hospital to the community and the Scottish government report "Transforming Specialist Hospital Dementia Care". It will also compliment local ambitions to develop increased suitable housing and support models for people diagnosed with dementia.

3.2 A local Dementia Strategy is likely to include the redesign of services and the development of an appropriate commissioning strategy. It is clear that reducing inpatient beds and reinvesting in community resources is consistent with the national drive to shift the balance of care from hospital to the community and the Scottish Government report. It will also compliment local ambitions to develop increased suitable housing and support models for people diagnosed with dementia.

3.3 A project team has been established to take forward this proposal which will be part of the Mental Health Transformation Programme, but will also work alongside the NHS Borders Financial Turnaround Programme.

3.4 This proposal includes the introduction of a Care Home and Community Assessment Team. Modelling suggests that this team could reduce the number of admissions from care and nursing homes by 50%. If this modelling is correct, the additional 5 specialist Dementia Nursing Beds might not be required. It is therefore proposed that the £338k identified for the specialist beds be ear marked as an IJB reserve until the actual impact of the Care Home and Community Assessment Team is realised or not. This reserve would therefore be utilised if the pressure for admissions to acute services remain at a level which would jeopardise the ability to cater for people with high level dementia needs.

3.5 The Cauldshiels steering group will monitor progress across both wards in Cauldshiels and Melburn Lodge. A review will be produced for the IJB to determine the impact of the ward closure.

3.6 Investment in additional social work capacity (£45,000) has also been identified as a key requirement to ensure continued flow through the inpatient bed capacity and maintenance of the reduced level of specialist inpatient beds. This will be funded from the disinvestment from Cauldshiels.

4 IMPLICATIONS

4.1 Financial

The proposed recurring reinvestment, funded by the reduction in Cauldshiels beds will enable: -

(a) Development of a Care Home and Community Assessment Team to support patients in the community.

(b) Investment in a dedicated Social Worker to ensure flow through hospital into the community.

(c) The proposed £338,000 initially identified for the commissioning of five specialist dementia beds in the community to be ear marked as an IJB reserve and only to be invested in nursing beds should this be required.

4.2 The table below summarises the saving anticipated from the closure of Cauldshiels, and proposed reinvestment in new dementia services. This will require the redirection of resources by the IJB from acute services funded by NHS Borders to community settings funded by SBC. In the process a net saving of £474,202 will be realised, please see **Appendix 8** for further breakdown:

Cauldshiels Savings	**Recurring £ (Excl MHOAT)**
Total Budget for Cauldshiels Ward	1,102,455
Total Funding	**1,102,455**
Total estimated investment (excl beds)	
Staffing (inclusive of Care Home and Community Assessment Team and 1 FTE Social Work post)	266,253
Travel	24,000
Cost of new provision (excl beds)	290,253
Interim Saving (excl beds)	**812,202**
Ear Marked Investment for 5 Specialist Beds	**338,000**
Forecast Savings (incl beds)	**474,202**

4.3 In order to reduce the number of specialist inpatient beds there needs to be reinvestment to develop further community capacity in health and social care services (estimating this at £1,300 per week per patient, a reduction of 14 beds on Cauldshiels ward would equate to a reinvestment of £946,400 pa). With this in mind our Health and Social Care Partnership has already agreed to: -

- Develop a Care Home and Community Assessment Team to provide specialist support to Community Hospitals and the Care Home sector to

Page 117

reduce the need for hospital admission. This should be operational by September 2019. This will support more robust community resources to provide outreach to care homes and Community Hospitals which would be flexible and responsive to individual needs.

- Commission 5 specialist Dementia Nursing Beds to accommodate existing inpatients suitable for discharge from inpatient care or to prevent such an admission.
- Place a concerted focus on timely discharge, we have experienced a reduced demand for suitable admissions to Cauldshiels ward.

4.4 As a result, we have chosen to staff the ward to meet demand reducing the number of beds from 14 to 10. Currently we have six patients on Cauldshiels ward of which four are delayed discharges. As the demand has reduced further we are now considering reducing beds to six from the end of September 2019. Melburn ward has also seen a reduction in demand and currently has seven patients with one delayed discharge (on a ward with 12 beds).

This page is intentionally left blank

Transforming Specialist Dementia Hospital Care

Alzheimer Scotland
Action on Dementia

Scottish Government
Riaghaltas na h-Alba
gov.scot

This report is part of the consensus-based stakeholder response to the Mental Welfare Commission's report into specialist NHS dementia care in 2014. It is an independent review of the sector commissioned by The Scottish Government, and makes recommendations on the modernisation of specialist NHS dementia care. This work was led by Alzheimer Scotland's National Dementia Nurse Consultant, a post that was jointly funded by Alzheimer Scotland and the Scottish Government.

The development of this report was led by Maureen Taggart, Alzheimer Scotland National Dementia Nurse Consultant

This report was researched and written by:
Maureen Taggart and Lindsay Kinnaird, Research Manager, Alzheimer Scotland

Report design by Andrew Palfreyman, Alzheimer Scotland

Please cite as: "Transforming Specialist Dementia Hospital Care, Alzheimer Scotland, 2018"

Published June 2018

With grateful acknowledgment to:
Our NHS colleagues who made this unique insight possible
Alzheimer Scotland colleagues
Alzheimer Scotland Carers Reference Groups
Care Inspectorate
Health Care Improvement Scotland
Knowledge Services, NHS Lanarkshire
Mental Welfare Commission
National Dementia Carers Action Network
National Nurse and Allied Health Professionals Consultants Group
NHS National Education for Scotland
Scottish Dementia Working Group

Table of contents

Executive summary

Introduction:

- This report sets out a model of specialist hospital care for people with dementia who have intensive and complex clinical care needs that require high level expert care.
- Specialist dementia hospital care is required for people with dementia who have an acute psychological presentation as a result of dementia or co-morbid mental health illness. The clinical needs of this group can only be met in a hospital environment.
- Whilst a psychological presentation may necessitate being admitted to hospital, the person will also have additional physical, emotional and social care needs. This requires a highly skilled multi-disciplinary workforce that can deliver therapeutic interventions, care and treatment.
- It also provides an approach to the safe transition of people who do not have a clinical need to remain in hospital and can be cared for in more homely settings in the community, with the appropriate level of multi-disciplinary professional input to support those providing day-to-day care.
- The findings and recommendations of this report were made possible by the overwhelming enthusiasm of staff working in this area to welcome the Alzheimer Scotland National Dementia Nurse Consultant to visit their unit and share their practice. This included staff within the specialist dementia units, mental health leads for quality excellence in specialist dementia care, executive directors of nursing and allied health professionals, consultant psychiatrists and psychologists, pharmacology and social work.
- This collaborative approach also included people with dementia and their families, Chief Nursing Officer's Directorate, Commitment 11 Excellence in Specialist Dementia Care Group of the National Dementia Strategy and the Mental Welfare Commission.

Background:

- The Mental Welfare Commission's (MWC 2014) review of dementia continuing care units identified serious concerns with quality of care, environments, access to multi-disciplinary professionals and adherence to legal requirements for providing care.
- A roundtable discussion[a] was hosted by Alzheimer Scotland in 2014 following on from the above report to develop a better understanding of the issues and challenges and identify what could be done to remedy these.
- The key outcome of this roundtable was the appointment of an Alzheimer Scotland National Dementia Nurse Consultant to undertake a review of NHS specialist dementia care environments. This post was jointly funded by Alzheimer Scotland and the Scottish Government.
- Ten NHS Boards were included in this review, with 63 individual specialist care environments visited from a total of 92 with the purpose of 1) evaluating the quality

a Chaired by Professor Graham Jackson and attended by representatives from Scottish Government, NHS Health Boards and Royal College of Psychiatrists

and appropriateness of specialist hospital care in dementia and 2) developing an understanding of the issues around transition and discharge from hospital.

- During these visits staff demonstrated how they were delivering person-centred care within challenging circumstances and environments. These challenges included unsuitable buildings, design and layout that hindered the delivery of person-centred care, lack of access to multi-disciplinary professionals and the needs of patients ranging from acute psychological symptoms to end-of-life care.
- The Alzheimer Scotland National Dementia Nurse Consultant also brought her own in-depth understanding of the context of these environments and the needs of people who require specialist dementia hospital care. This specialist knowledge and understanding, combined with the extensive consultation enabled the Nurse Consultant to provide the recommendations within this report.

Issues with current provision:

- The Alzheimer Scotland National Dementia Nurse Consultant found:
  - Specialist dementia wards are frequently located in environments that do not support person-centred care and can increase the distress of the person with dementia and their family.
  - There is a lack of access to the multi-disciplinary professionals required to support the complex care required in dementia.
  - There is difficulty with transition, resulting in the largest proportion of patients in the specialist dementia wards being those who do not have a clinical need to be in hospital.
  - This makes it difficult to provide appropriate care for the current wide range of differing needs. It also means that resources are not being targeted effectively.
  - Staff within specialist care are committed to providing good quality care, but are hindered by the current obstacles.
- There is a lack of integration between these specialist hospital environments and the wider health and social care systems.
- This results in specialist dementia hospital units sitting in isolation, without the same focus on discharge to more appropriate care environments that is the case with acute hospitals.
- This often results in the window of opportunity being missed for safe transition to a more appropriate community setting to enhance quality of life.
- Most people with dementia can be cared for in the community throughout the illness. This requires a multi-disciplinary coordinated and planned approach to support those providing day-to-day care.
- There will be a small number of people with dementia who have acute clinical care needs that require specialist hospital care for a period of time.

- It is estimated that up to one percent of people with dementia will require management in a specialist dementia hospital environment at any one time[b]. This will result from severe psychological symptoms of dementia or the combined influence of a co-morbid mental health condition.

Moving forward:

- This report sets out a model of modern specialist hospital units based on quality of care for people with dementia who have intensive and complex clinical care needs and require high level expert care.
- It also provides an approach to build community capacity to support the safe transition of those who do not have a clinical need to remain in specialist hospitals and can be cared for in more homely settings in the community.
- Going forward, the Advanced Dementia Practice Model (Alzheimer Scotland 2015) provides the integrated and comprehensive evidence-based approach to support people in the community and ensure that people with dementia do not remain in hospital unnecessarily.
- Based on the evidence presented in this report, there is an urgent need for widespread redesign of specialist dementia hospital provision across Scotland. This will enable current resources to be used more effectively.
- The decommissioning and re-design process can be delivered as a one-time transformational change.

Recommendations:

- That specialist NHS dementia care is modernised, providing high quality, human rights-based care, specifically for individuals who cannot be cared for in the community.
- Integration Joint Boards develop a transition plan and a local engagement strategy with their partners, including NHS Boards and people living with dementia, for any necessary de-commissioning process and re-investment in specialist dementia units and to develop further community capacity in health and social care services.
- That the Scottish Dementia Working Group and National Dementia Carers Action Network provide the representative groups for this local engagement.
- Integration Joint Boards and NHS Boards assess the proportion of people with dementia that can be safely transitioned to more appropriate community settings.
- The Alzheimer Scotland National Dementia Nurse Consultant provides expert guidance at both a national and local level.
- Integration Joint Boards and NHS Boards build strong and strategic local engagement on:
    - Any necessary de-commissioning and re-directing of resources to the development of specialist dementia hospital units and
    - building further community health and social care services.

b Brodaty et al (2003) "Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery" Medical Journal of Australia https://www.mja.com.au/journal/2003/178/5/behavioural-and-psychological-symptoms-dementia-seven-tiered-model-service

- NHS National Procurement to commission the design of a blueprint for a specialist dementia unit that can be implemented by each NHS Board.
- There should be no financial detriment for families as part of the decommissioning process, with the financial cost of the care and treatment of the person with dementia being transitioned to the community continuing to be met by the NHS Board.
- The legal status of patients being transitioned to the community is reviewed and the appropriate legal documentation put in place.
- The creation of modern specialist dementia units that will provide centres of excellence to treat the small number of people with dementia who have a clinical need to be in hospital.

  The estimated 45[c] specialist dementia units required across Scotland will provide a highly skilled practice area and make it an attractive specialism for ambitious and talented practitioners to deliver highly skilled therapeutic interventions.

  Promoting Excellence Framework the foundation for evidence based care for all practitioners. Leaders and senior practitioners ensuring that everyone working within the unit are trained at the appropriate level to ensure a high quality therapeutic approach.

  They will be underpinned and supported by the Charter of Rights for People with Dementia and their Carers in Scotland, the Promoting Excellence Framework, the AHP Framework Connecting People, Connecting Support and the Standards of Care for Dementia in Scotland.
- The timeframe for this process will extend beyond the end-point of Scotland's 2017-2020 National Dementia Strategy

c This is based on an estimated 560 people with dementia who require care and treatment in a specialist dementia unit.

1. Introduction

1.1 Introduction

This report is part of the consensus-based stakeholder response to the Mental Welfare Commission's report into specialist NHS dementia care in 2014. The independent review of the sector was commissioned by the Scottish Government, and makes recommendations on the modernisation of specialist NHS dementia care. This work was led by Alzheimer Scotland's National Dementia Nurse Consultant, a post that was jointly funded by Alzheimer Scotland and the Scottish Government.

Most people with dementia can be cared for in the community[d] throughout the illness. This requires a multi-disciplinary, professional, coordinated and planned approach to support those providing day-to-day care[e]. There will be a relatively small number of people with dementia at any one time who have acute clinical care needs that require specialist hospital care for a period of time. This will result from severe psychological symptoms of dementia or the combined influence of a co-morbid mental health condition.

However, an estimated 60 percent of current patients with dementia do not have this clinical need and could be more appropriately cared for in the community. This means the specialist dementia hospital population has a wide range of needs that cannot be appropriately accommodated alongside each other. It also results in resources being used inefficiently and does not facilitate skilled practitioners to deliver highly specialised interventions for people with an acute clinical need.

This report sets out a model of a modern specialist hospital unit based on quality of care for people with dementia who have intensive and complex clinical care needs and require high level expert care. It also provides an approach to building community capacity to support the safe transition for those who do not have a clinical need to remain in hospital and can be cared for in more homely settings in the community.

Going forward, the Advanced Dementia Practice Model (Alzheimer Scotland 2015)[f] provides the integrated and comprehensive evidence-based approach to support people in the community and ensure that people with dementia do not remain in hospital unnecessarily.

d Continuing to live at home or in a care home

e This includes family carers, care homes, care at home service and day care

f Alzheimer Scotland (2015) "Advanced dementia practice model: understanding and transforming advanced dementia and end-of-life care" https://www.alzscot.org/campaigning/advanced_dementia_model

1.2 Background to report

The Mental Welfare Commission's (MWC 2014)[g] review of dementia continuing care units identified serious concerns with quality of care, environments, access to multi-disciplinary professionals and adherence to legal requirements for providing care. A roundtable discussion[h] was hosted by Alzheimer Scotland in 2014 following on from this report to develop a better understanding of the issues and challenges and identify what could be done to remedy these.

The key outcome of this roundtable was the appointment of an Alzheimer Scotland National Dementia Nurse Consultant to undertake a review of NHS specialist dementia care environments. Ten NHS Boards[i] were included in this review, with 63 specialist care environments visited from a total of 92 with the purpose of:
1) evaluating the quality and appropriateness of specialist hospital care in dementia; and
2) developing an understanding of the issues around transition and discharge from hospital.
The Nurse Consultant also carried out extensive consultation with key stakeholders, including people with dementia and families, as part of this process. The findings from this review are presented in full in Appendix 1 of this report.

The recommendations of this report are based on the findings of the review by the Alzheimer Scotland National Dementia Nurse Consultant. Improvements since the review have been explored in a smaller number of NHS Boards and are incorporated into the recommendations within this report.

The recommendations are also informed by the improvement programme of work from the Commitment 11 Quality and Excellence Specialist Dementia Care Group. This work has been ongoing since September 2014, with NHS Boards submitting their self-assessment and improvement plans to the Commitment 11 Group. This work has been continued through a programme led by Focus on Dementia[j] that is working with four individual specialist dementia hospital units across Scotland. Additional improvement has been delivered through the Promoting Excellence Framework (2011), with the Dementia Specialist Improvement Leads Programme being introduced to cascade enhanced and expert education and training to support change and improvement.

g Mental Welfare Commission (2014) "Dignity and respect: dementia continuing care visits" http://www.mwcscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf
h Chaired by Professor Graham Jackson and attended by representatives from Scottish Government, NHS Health Boards and Royal College of Psychiatrists
i Review took place between April 2015 and March 2016 and included Ayrshire and Arran, Dumfries and Galloway, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian, Scottish Borders and Tayside.
j Health Improvement Scotland

1.3 Context and legal framework for specialist dementia hospital care

The National Dementia Strategy for Scotland[k] is underpinned by the "Charter of Rights for People with Dementia and their Carers in Scotland" (2009)[l]. This includes ensuring that the human rights of people with dementia are respected, protected and fulfilled. The Charter also stipulates that people with dementia have the right to health and social care services provided by people with an appropriate level of training on dementia and human rights.

The Promoting Excellence Framework (2011)[m] takes this forward into practice through outlining the knowledge and skills required by health and social care practitioners. This is set out in four different levels of skill and knowledge determined by a practitioner's role and level of responsibility. There has also been focused attention and improvements in specialist dementia hospital provision through the Commitment 11 Group of the National Dementia Strategy (2013 to 2016)[n].

Specialist hospital care in dementia sits within the principles and provisions of the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act[o]. The review by the Alzheimer Scotland National Dementia Nurse Consultant found that only a small number of patients are subject to a compulsory treatment order under the Mental Health (Care and Treatment) (Scotland) Act.

Whilst legislation and guidelines provide the framework for staff to work within, there is also a need for ongoing training and support in ethical decision making. There is unlikely to be a single right answer in any given situation and staff within specialist dementia hospital care require support in the complex ethical dilemmas that can arise (Nuffield Council on Bioethics 2009)[p].

k The first National Dementia Strategy was published in 2010, with subsequent updates published in 2013 and 2017

l "Charter of Rights for People with Dementia and their Carers in Scotland" (2009) https://www.alzscot.org/assets/0000/2678/Charter_of_Rights.pdf

m NHS Education for Scotland and Scottish Social Services Council (2011) "Promoting Excellence Framework" http://www.gov.scot/Resource/Doc/350174/0117211.pdf

n Commitment 11: "We will set out plans for extending the work on quality of care in general hospitals to other hospitals and NHS settings."

o Mental Health (Care and Treatment) (Scotland) Act 2003 and updated provisions in Mental Health (Scotland) Act 2015.

p Nuffield Council on Bioethics (2009) "Dementia ethical issues" http://nuffieldbioethics.org/wp-content/uploads/2014/07/Dementia-report-Oct-09.pdf

1.4 Outline of report

Section 2: People with dementia who need specialist hospital care

This section provides an understanding of when people with dementia may require specialist hospital care. It also presents current data on the number of people with dementia in specialist hospital environments and an outline of the Advanced Dementia Practice Model (Alzheimer Scotland 2015).

Section 3: Current approaches to specialist dementia hospital care

This section provides an understanding of current approaches to specialist hospital care in dementia. It provides a summary of the key findings of the review by the Alzheimer Scotland National Dementia Nurse Consultant. It also provides a synopsis from recent findings from the Mental Welfare Commission's visits to specialist dementia hospital environments.

Section 4: Transforming specialist dementia care

This section takes forward the issues and challenges outlined in the report and presents a blueprint for a specialist dementia unit through outlining the core specialisms and approach required. It also puts forward a case for a one-off transformational change through decommissioning and re-design of specialist dementia care across Scotland.

Section 5: Conclusion and recommendations

This section provides the concluding remarks and sets out a series of recommendations to guide the decommissioning and transformation process.

2. People with dementia who need specialist hospital care

2.1 Introduction

This section will demonstrate that most people with dementia can continue to be cared for in the community throughout the illness. It will show that only a small proportion of people with dementia require specialist hospital care. As the number of people with dementia increases, recognising and responding to these factors will be of key importance in reshaping dementia hospital provision with the essential component of specialist community support to ensure resources are used efficiently.

2.2 People with dementia who will require specialist hospital care

The experience of dementia is unique to each individual and dependent on factors relating to underlying health, personality, biography and social context. As dementia progresses, the physical nature of the illness becomes more to the fore – the influence of social and psychological aspects will also continue to be prominent.

People will often have co-morbid physical or mental health conditions that will combine with dementia in a complex way. The possible range of physical, psychological and social issues in dementia requires a bio-psychosocial holistic approach in providing appropriate care and treatment for the individual.

Health care practitioners will have a key role in responding to the increasing physical nature of advancing dementia, the impact of co-morbid conditions and supporting psychological wellbeing. This specialist support can be provided in the person's current place of residence[q] for most people with advanced dementia. Section 2.4 outlines how people can continue to be supported in the community to avoid unnecessary hospital admissions.

There will be a small proportion of people who will require specialist dementia hospital care and treatment. This group will experience very severe and persistent psychological distress and behaviours that would be too challenging to be managed in mainstream settings, irrespective of how much specialist support is provided.

The types of issues include aggression and physical violence, self-harm, high risk to self and/or others and ongoing extreme disinhibited behaviours, with lack of recognition of inappropriateness. They will often be physically mobile and possibly younger. It also includes people with dementia who have acute mental health conditions such as psychosis, schizophrenia and severe depression with suicidality.

This group will also have complex physical health care needs, along with the requirement for meaningful occupation and social stimulation. This requires a multi-disciplinary professional approach in addition to the nursing and specialist clinical care support who will provide day-to-day caring.

Brodaty et al (2003)[r] provide a "seven-tiered model of management of behavioural and psychological symptoms of dementia". They estimate that up to one percent of people

q Continuing to live at home or in a care home

r Brodaty et al (2003) "Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery" Medical Journal of Australia https://www.mja.com.au/journal/2003/178/5/behavioural-and-psychological-symptoms-dementia-seven-tiered-model-service

will be within the highest tiers and require management in a psychogeriatric or neuro-behavioural unit. This will include people with acute psychiatric illness and severe behavioural problems complicating their dementia.

The intensity of experience is likely to continue for a relatively short period of time until the presentation changes. This may be ongoing for a period of around 18 months and will diminish as the illness progresses and physical robustness reduces. The person can then be safely transitioned to being cared for in a community setting, once this clinical need to remain in hospital no longer exists.

2.3 Specialist dementia hospital population

There were 1,886 NHS Old Age Psychiatry specialist beds for people with dementia in Scotland in June 2014[s]. The work carried out by the Alzheimer Scotland National Dementia Nurse Consultant suggests that this number is likely to have reduced to some extent since the audit was carried out.

Official statistics provide approximately 1,850 as the number of NHS Old Age Psychiatry beds in 2016 (ISD 2017)[t]. Official statistics also show that there are 4,400 Geriatric Medicine beds in 2017. These official statistics includes people with an organic illness (dementia) and those with a functional illness (mental ill health conditions such as depression, bi-polar and schizophrenia). It is therefore difficult to provide a precise number of patients with dementia, given the frequency of co-morbid conditions and under-diagnosis of dementia.

2.4 Advanced Dementia Practice Model and Advanced Dementia Specialist Team

Those providing day-to-day support require specialist support in responding to the complex physical, psychological and social issues that occur in advanced dementia. The Advanced Dementia Practice Model (Alzheimer Scotland 2015) provides an integrated and comprehensive approach to respond to this most complex phase of the illness and support people to remain in the community.

The Advanced Dementia Specialist Team provides the specialist input required to support those already providing care. They will provide expert assessment, medical interventions and guidance on skilled, person-centred approaches to care. These specialist practitioners are located within this team on a full, part-time or consultancy basis. It includes specialist consultants, psychologists, allied health professionals and mental health and general nursing practitioners.

The care plan provides a planned and coordinated approach to support the person through advanced dementia and end-of-life. It will identify the practitioners required to support the person's care, bringing in specialist support where this is not already being provided. This approach will enable most people to remain within the community. It will also provide the multi-disciplinary professional team necessary to enable people to safely transition from hospital to the community when they no longer have a clinical need to remain.

s Scottish Government audit of NHS Boards for National Dementia Strategy Commitment 11 Working Group

t 1,160 long stay beds and 3,235 in units other than long stay https://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/

2.5 Current practice

Current practice is not consistent with this optimum approach to specialist care in dementia. The following section will demonstrate that people are currently being admitted to hospital who can be cared for in community settings and are then unable to be safely transitioned out because of lack of appropriate care in the community.

3. Current approach to specialist dementia hospital care

3.1 Introduction

This section provides an understanding of current approaches to specialist hospital care in dementia. Evidence presented comes from the extensive and in-depth review by the Alzheimer Scotland National Dementia Nurse Consultant[u]. This review included consultation with a wide range of key stakeholders such as practitioners and people living with dementia. It outlines the key problems in the quality and appropriateness of provision. It also highlights that many people do not have a clinical need to be in hospital, but that challenges with transitioning from these environments means that the number of people remaining in hospital is much higher than necessary.

A synopsis of the findings of the Mental Welfare Commission's reports[v] in specialist dementia care environments is provided. The good practice examples from the review by the Alzheimer Scotland National Dementia Nurse Consultant are then presented along with an understanding of some of the improvements since that time.

3.2 Findings of review by the Alzheimer Scotland National Dementia Nurse Consultant

3.2.1 Hospital population

Admission to assessment units was often not because of clinical need to be in hospital. It could broadly be defined as relating to a lack of appropriate care and support in the community. This included the lack of an appropriate care plan for the person to remain in their current place of residence, and distress in dementia not being adequately supported by specialists in the community. The range of needs within specialist units and transition units varied widely from psychological symptoms of dementia and co-morbid mental health illness to end-of-life. Occupancy levels varied across the NHS Boards. Low occupancy was noted in three Boards with occupancy levels around 70 percent.

3.2.2 Workforce skills and knowledge and access to multi-disciplinary professionals

The skill mix and ratio of professional staff in these environments was lower than that of all other mental health areas. In most areas there was a lower ratio of registered mental health nurses to clinical support staff. A small number of NHS Boards had higher ratios of professional staff, with 55 to 60 percent registered mental health nurses.
Access to multi-disciplinary professionals in assessment units was at a higher level compared with specialist dementia units. However, the level varied between NHS Boards. Only two wards had dedicated social worker time, with all others having a referral system. Most of the specialist and transition units for people with complex needs associated with

u A full report on the review is provided in Appendix 1
v Inspections that took place during 2016 and 2017

advanced dementia had no access to the multi-disciplinary professional team including psychology, pharmacy and allied health professionals.

Half of the assessment units had access to allied health professionals and there was very limited access to pharmacy and psychology. The specialist and transition units had virtually no access to these professionals – access to pharmacy was minimal and they were not participating in medication management or multi-disciplinary reviews. Access to other professionals could be available through a referral approach, but length of waiting time was an issue. Due to increased referrals from community teams, very few people with dementia in the specialist and transition units were supported by the psychological service.

The cost of beds varied widely. Higher costs did not equate to quality of care and access to a greater number of specialists compared with the less costly beds. Whilst many of the specialist beds are in mental health services, some are managed within community hospitals and others within primary care, where there is limited access to specialist dementia professionals. Two Boards had transferred the care and treatment of patients with dementia to a specialist unit in England because of the lack of a hospital environment that could provide specialist care within Scotland.

3.2.3 Environments

Older facilities were in use in many areas which required significant investment for upgrade and maintenance. Specialist dementia units continue to be located on upper floors with no easy access to outdoor areas. These can be old, institutional environments in locations that are difficult for families to visit using public transport.

In many cases the built environment presented challenges for staff in providing person-centred quality care and added to the distress of patients and families. There was a lack of privacy, with bed and toilet areas being shared by up to six people with no personal shower or wash areas.

Purpose-built dementia units had been developed in some areas, with others to be completed by 2019. At the time of the review, four NHS Boards were implementing a bed remodelling plan, driven by low occupancy and units being housed in outdated buildings.

3.2.4 Transitions

The length of stay within assessment units was an average of eight to 12 weeks. However, it could be up to two years in some instances and increased significantly when there were legal issues such as lack of specific relevant powers through power of attorney or guardianship. Discharge from these environments was often to a care home or NHS specialist bed either in hospital or in a contracted-out location. Delays in discharge were attributed to lack of funding for a care package and the availability of appropriate care settings within the community.

The length of stay within specialist and transition units ranged from one year to 15 years, with an average of four and a half years. The specialist dementia units exist in isolation and are disconnected from wider health and social care services commissioned by Integration

Joint Boards. Challenges to discharge included social work considering it to be a low priority as the person was in a place of safety. Families were apprehensive about care being provided outwith the specialist hospital environment and there was a lack of knowledge about alternative appropriate accommodation and support. Failed previous discharge to a care home was a common reason why people remained in NHS care.

3.3 Good practice examples and changes implemented since the time of review

There was evidence of good practice at the time of the initial review and follow-up visits by the Alzheimer Scotland National Dementia Nurse Consultant. It was evident throughout the review that staff were committed to providing a high standard of care. However, they were often frustrated and hindered by the issues outlined in the previous section.
The Promoting Excellence Framework (2011) had been implemented in every NHS Board visited. Most assessment units held reviews once or twice weekly, with families invited as appropriate.

Good practice in pre-discharge was noted in two Boards. In one, hospital staff and family would visit the care home to offer support to care home staff. The other had consultant-led clinics within care homes which successfully reduced admissions to the ward with outreach working. Two Boards reported a significant reduction in admission where psychiatric liaison teams had been established to support the care homes in their areas.

At the time of the review, there had been a number of recent improvements, including an activity room and areas for family to use or stay overnight. Some units had activity coordinators, with volunteers and community groups providing support for activity and connection. Many of the units visited had activity programmes planned.
Although some units had excellent facilities and activity rooms, staff shortages and lack of time meant the majority were locked, with no therapeutic activity going on within the unit at the time of the visit. When activity was carried out it was provided by nurses, with few units having access to specialist allied health professionals.

3.4 Mental Welfare Commission reports

Around 30 Mental Welfare Commission reports on specialist dementia care environments were reviewed. The visits took place throughout 2016 and 2017 across NHS Board areas in Scotland. The issues identified by the Commission were consistent with the extensive review conducted by the Alzheimer Scotland National Dementia Nurse Consultant.
Reports noted recommendations from previous visits – this highlighted that improvements are being made in areas of concern previously raised by the Commission. However, significant issues remained across many of the environments recently visited.

Most frequently occurring was a failure to evidence person-centred care planning and lack of access to multi-disciplinary specialists. A need for meaningful activity and tailored or person centred activity for patients was also recognised in many areas. There were

some instances of a failure to record documentation in relation to the relevant Acts[w] in the patient's file and to consult proxy decision makers and involve family members. Environmental concerns included overly clinical settings, unsuitable buildings and dignity and privacy being compromised.

3.5 Moving forward

This section has demonstrated that specialist dementia units are frequently located in environments that do not support person-centred care and can increase the distress of the person with dementia and their family. It has also shown a lack of access to the multi-disciplinary professionals required to support the complex care required in dementia. There is a disconnection between these specialist services and the wider health and social care commissioned by Integration Joint Boards. This creates difficulties with transition and results in a significant proportion of patients in the specialist dementia wards having no clinical need to be in hospital. This makes it difficult to provide appropriate care for the current wide range of differing needs. It also means that resources are not being targeted effectively. Staff within specialist care are committed to providing good quality care, but are hindered by the current obstacles.

The following section provides a model of specialist dementia care for those who have a clinical need to be in hospital. It also outlines an approach to the safe transitioning of the current group of people with dementia in specialist hospital environments who would be more suitably cared for in community settings.

w Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000

4. Transforming specialist dementia care

4.1 Introduction

Based on the evidence presented in this report, there is an urgent need for widespread redesign of specialist dementia hospital provision across Scotland. This includes the transition of most patients to the community, so they can be cared for in more appropriate settings to enhance their quality of life.

The decommissioning and re-design process can be delivered as a one-time, transformational change. This will require NHS Boards and Integration Joint Boards to review their community provision and capacity; making investments as required to provide the specialist support for those providing care in the community[x]. Moving forward, the Alzheimer Scotland Advanced Dementia Practice Model (2015) provides an approach to ensure that people with dementia are supported within the community.

Our vision is that the modern specialist dementia unit provides a centre of excellence to deliver quality treat and care for the small number of people with dementia who will have a clinical need to be in hospital. This will provide a highly skilled practice area and make it an attractive specialism for ambitious and talented practitioners to deliver therapeutic interventions.

4.2 Collaborative approach of the review

This vision was made possible by the overwhelming enthusiasm of staff working in this area in welcoming the Alzheimer Scotland National Dementia Nurse Consultant to visit their unit and sharing their practice. It included staff within the specialist dementia units, mental health leads for quality excellence in specialist dementia care, executive directors of nursing and allied health professionals, consultant psychiatrists and psychologists, pharmacology and social work.

This collaborative approach also included people with dementia and their families, the Chief Nursing Officer's Directorate, Commitment 11 Excellence in Specialist Dementia Care Group of the National Dementia Strategy, and the Mental Welfare Commission.

x To provide specialist support to care homes and people with dementia who continue to live at home.

4.3 Transformational change: decommissioning and re-investment

The review carried out by the Alzheimer Scotland Dementia Nurse Consultant identified that most patients did not have a clinical need to be in hospital and could be cared for in a community setting. The modest estimation of the proportion of people with dementia who do not have a clinical need to remain in hospital is 60 percent[y].

This estimate is based on extensive consultation by the Alzheimer Scotland National Dementia Nurse Consultant with the multi-disciplinary professional teams and managers across the 63 units included in the review. The Alzheimer Scotland Dementia Nurse Consultant is also aware of work done by some NHS Boards in this area to assess the needs of patients to remain within these units. Whilst this work is not within the public domain, it is the understanding of the Alzheimer Scotland Dementia Nurse Consultant that this work is consistent with the evidence collected throughout the review.

There is also an urgent need for a widespread redesign of specialist dementia hospital provision across Scotland for the estimated 40 percent of people who have a clinical need to be cared for in these environments. This is essential to ensure access to multi-disciplinary professional specialists, provide an environment that supports person-centred care and deliver the required highly skilled therapeutic care and treatment.
It is not possible to provide a precise number of people with dementia in specialist dementia hospital units[z]. The most recent figure available is that of 1,886 NHS Old Age Psychiatry beds for people with dementia in 2014[aa]. This number will have reduced in light of the redesign that has taken place since that time. For the purposes of this report, we estimate a current figure of 1,400 beds.

Based on this figure, 840 people with dementia could be safely transitioned to the community with appropriate support, with 560 specialist dementia hospital beds required across Scotland. The estimated 560 people who need to be cared for in a specialist care unit is less than one percent of the estimated number of people with dementia[bb]. This is consistent with the estimate provided by Brodaty et al (2003)[cc] in the "seven-tiered model of management of behavioural and psychological symptoms of dementia". This would require 45 12-bedded specialist dementia units across Scotland for the estimated 560 people.

The average cost of providing a specialist dementia hospital bed is £2,520 per inpatient week[dd]. This equates to an annual cost of £183 million per year – £110 million of which is on the 60 percent of patients who do not have a clinical need to be in hospital. This £110 million per year could be re-invested in providing highly specialised dementia hospital care and supporting community provision, so that people with dementia are not admitted to hospital unnecessarily.

y There was general consensus throughout the review that between 60% to 80% of these beds are not required and that the care of this client group could be met within alternative care environments (Appendix 1).

z Outlined in Section 2.3

aa Scottish Government audit of NHS Boards for National Dementia Strategy Commitment 11 Working Group

bb There is an estimated 90,000 people with dementia in Scotland in 2017 – 560 is 0.6 percent of this total.

cc Brodaty et al (2003) "Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery" Medical Journal of Australia https://www.mja.com.au/journal/2003/178/5/behavioural-and-psychological-symptoms-dementia-seven-tiered-model-service

dd Based on average cost of inpatient bed per week for geriatric psychiatry ISD (2016) "Speciality group costs: inpatients in long-stay specialities National Statistics release"

The potential savings can be demonstrated by using a current 30-bedded unit as an example. The current average cost for 30 patients is £3.9 million, based on the £2,520 average weekly cost. Implementing a 12-bedded unit with additional multi-disciplinary input will result in the weekly cost per patient rising – we have estimated this would rise to £3,500 per patient for this example, which would cost £2.2 million per year for 12 patients. If £1,000 cost per week followed each person being transitioned to the community, this would be an annual cost of approximately £936,000 per year. This indicative example shows a potential overall saving of £800,000 per year for the decommissioning and transformation of a 30-bedded unit

An average of 60 people with dementia per NHS Board can be safely transitioned to the community with the appropriate level of multi-disciplinary support for those providing day-to-day care. This varies across areas, from an estimated 22 in NHS Borders to 164 in NHS Greater Glasgow and Clyde[ee]. Similarly, the number of specialist hospital beds required across Scotland will vary according to population size and need. Again, this will vary from 15 in NHS Borders to 109 in NHS Greater Glasgow and Clyde[ff].

The review by the Alzheimer Scotland Dementia Nurse Consultant took place between April 2015 and March 2016. We therefore recommend that NHS Boards re-assess the proportion of people with dementia that can be safely transitioned to more appropriate community settings as an initial task in the de-commissioning and transition process.

4.3.1 Transition to community and health board planning

An integrated and comprehensive approach is required to support people living with dementia in the community. A coordinated and planned approach is necessary to tackle the acute issues that can arise and enable the delivery of optimum care. Those providing day-to-day care[gg] require specialist support in responding to the complex issues that can arise in dementia. They have a need for advice and guidance on caring to support the reduction of unnecessary hospital admissions.

The decommissioning process will require NHS Boards and Integration Joint Boards to evaluate the level and capacity of community resources to facilitate safe transition. There will be a need to invest where the required multi-disciplinary specialist support is not sufficient to support care homes and people living at home. A proportion of the resources released from reducing the hospital population can be re-invested in building community capacity. The example under section 4.3 shows that there can be savings on current resources, even with £1,000 per week following each person being transitioned to the community.

The review by the Alzheimer Scotland Dementia Nurse Consultant found the financial implications to be part of the reluctance from families in transitioning the person to the community. There should be no financial penalty for families as part of the decommissioning process. The care and treatment of the person with dementia being transitioned as part of the decommissioning process should continue to be met by the NHS Board.

ee This is based on the overall estimated number of people with dementia in Scotland and the proportional breakdown across each NHS Board according to population age and size.

ff A breakdown by NHS Board is provided in Appendix 2

gg This includes family carers, care homes, care at home service and day care

The appropriate legal documentation would be required to transition a person who does not have capacity to consent to the move to a community setting. Welfare power of attorney or guardianship may be held by a family member giving them specific relevant powers.

Where guardianship or power of attorney does not exist, the legal protection required to move a person who lacks capacity should be adhered to, which may delay transition on occasions. Moving forward, the process of seeking guardianship would be commenced when a person is admitted to the specialist dementia unit.

4.3.2 Supporting and involving families

The review by the Alzheimer Scotland National Dementia Nurse Consultant identified that the family may be anxious about the person being transitioned to a community setting. The circumstances that led to the person with dementia being admitted to hospital may have been a crisis; once the situation had stabilised, the family may continue to consider hospital to be the most appropriate environment. They may be unaware that there are more appropriate community environments that could provide a better quality of life for the person. It is important to engage closely with the family to work through any apprehension in a supportive manner to reach a resolution.

The family should be fully involved in the transition planning process, with their views listened to and concerns addressed. They should be assured that the ongoing bio-psychosocial needs of the person with dementia will be reviewed and met within the community setting. They should also be certain that there will be no financial penalty as a result of the transition to a community setting.

Where the person is moving to a care home, the family should have the opportunity to visit and meet with staff who will be providing care. There should be a room prepared and opportunity for the family to personalise it. It is likely that most people would be moving to a care home, but there may be occasions when the person is returning home. In these instances, close family members will have had a significant input into this decision.

Moving forward, the family would be part of the ongoing assessment process within the specialist dementia unit. They would be aware that the person's presentation and care needs had evolved over time and there would be an incremental approach to safe transition planning within the multi-disciplinary team. Furthermore, there would have been no expectation that the person would have remained in the unit beyond the intensive clinical need; a well-planned safe transition to the community would be the aim.

4.4 Specialist dementia care unit

The specialist dementia unit is designed to provide care and treatment to 12 people with dementia who have a clinical need to be in hospital and who are unable to be supported in a community setting, no matter the level of specialist support provided. The unit will deliver highly skilled care and treatment focused on the therapeutic relationship, delivered by a multi-disciplinary team responding to acute and intensive psychological conditions. The multi-disciplinary team within the unit will have additional support from specialist practitioners, as well as voluntary and community organisations in providing holistic care and treatment in response to the physical, psychological and social needs of each patient.

4.4.1 Patient profiles

Guidance on the appropriateness of hospital care in this area is based on a single eligibility question "Can the individual's care needs be met in any setting other than hospital" (Scottish Government 2015)[hh]. The care, treatment and support of most people with dementia can be provided in settings other than a hospital - this includes continuing to live at home or in a care home. Whilst there will be fluctuations in a person's health and the pattern of declining cognitive and physical function is neither fixed nor predictable, care and treatment for most people can be provided in community settings.

There will be a small proportion of people with dementia at any one time who will require specialised hospital care because of acute psychological symptoms resulting from their dementia and the complex interplay of co-morbid mental health conditions, necessitating substantial health care input. This requirement for specialist hospital care is not condition specific. It requires a holistic assessment of the individual, based on the person's overall needs and presentation.

People requiring specialised hospital care are likely to be in the advanced phase of dementia, as determined by the complexity and severity of symptoms. In addition to this, underlying health is a key factor and the influence of co-morbid mental health illness may result in a person with moderate dementia being admitted to the unit.

This group will experience severe behavioural and psychiatric symptoms. This will relate to people with enduring mental health conditions such as chronic schizophrenia, psychosis and severe depression with suicidality. It will also include people who demonstrate extreme behaviours that are harmful to themselves and others, including physical violence. The level of risk involved can require three people to provide care and support at any one time.

The specialised and multi-disciplinary professional approach within the unit will provide the care and treatment required to improve or stabilise the medical condition over a period of time, which may be around 18 months for many patients. The person will then be safely transitioned, once their condition has stabilised for a sufficient period of time and presentation has changed so that it is possible for care to be provided in a community setting.

hh Scottish Government (2015) "Hospital based complex clinical care http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf

4.4.2 Multi-disciplinary assessment

Many people being admitted to the specialist care unit will have an existing care plan, as they may be transferred from an assessment unit or have been receiving intensive support in a community setting. This may include a detailed formulation plan given the presence of psychological symptoms.

The initial step will be for the multi-disciplinary team to review any existing plan and identify where changes or additions should be made. This may include bringing in additional specialist practitioner/s to review a particular aspect of a patient's presentation.

Each specialist practitioner will conduct their individual assessment of the patient's presentation and needs. They will then take part in the multi-disciplinary review for each patient.

Ongoing regular review will then be required on a weekly basis with the multi-disciplinary team in evaluating care, managing medication and making appropriate changes to the care plan of each patient.

Whilst the person with dementia will be admitted to the specialist care unit as a result of severe psychological symptoms, they will also be experiencing a range of physical health care problems. In addition to this, there will be a need for social stimulation and meaningful occupation. The range of physical, psychological and social issues will require a bio-psychosocial approach to assessment and care planning in understanding and responding to individual experience.

The range of assessment tools utilised by the multi-disciplinary team in their evaluation of the individual's needs should be based on providing a holistic, person-centred approach. This would also include formulation such as the Newcastle Model (James 2011)[ii] in using a bio-psychosocial approach to understand the potential causes of psychological distress. Additional tools would be utilised in the assessment and responses to depression, anxiety and medication review.

Dementia Care Mapping (Bradford University)[jj] provides a structured action cycle approach to assessing and reviewing the ongoing needs of the unit and individual patients. This includes person-centred planning, staff training needs and monitoring and implementing improvements to care.

4.4.3 Multi-professional care and treatment

The table below outlines the core group of health and social care specialists who will be located within the unit on a full-time or part-time basis.

ii James (2011) "Understanding behaviour in dementia that challenges" Jessica Kingsley Publisher London

jj University of Bradford "Dementia care mapping" https://www.bradford.ac.uk/health/research/dementia-care-mapping/

Table 1: Specialist dementia care unit multi-disciplinary team

Practitioner	Description
Registered Mental Health Nurses	Directly involved in all care and treatment of each patient. Direct advanced statements and anticipatory care planning.
Registered General Nurses	To respond to and treat physical health care needs.
Clinical Support Workers	Deliver person-centred care under the direction of the nurse professionals.
Nurse Consultant	Provide expert advice in dementia care and treatment. Provide supervision of nursing within unit.
Advanced Nurse Practitioner	Support the mental health nursing and provide medication input
Consultant Psychologist	Assessment and prescribing of individualised interventions, formulation plans and neuropsychiatric assessment and treatment.
Consultant Psychiatrist	Formal diagnosis of dementia and other mental health illness. Involvement in the management and ongoing review of care and treatment.
Specialist Registrar Old Age Psychiatry	Substantive time on the ward and oversee care and treatment in deputising for Consultant Psychiatrist
Junior Doctor	Assigned to unit as part of training to develop understanding of specialism – provide support for physical health.
Occupational Therapist	Work with the person to develop and maintain a routine of everyday activities that creates a sense of purpose and supports a good quality of life. They can advise on changes to the everyday environment and equipment and adaptions.
Physiotherapist	Help restore movement and function through exercise, manual therapy, education and advice. Physiotherapy uses physical approaches to promote, maintain and restore physical, psychological and social well-being.
Speech and Language Therapist	Assess, diagnose and manage a range of communication and swallowing needs. The role also encompasses environmental adaptations to support communication, eating and drinking.
Dietitian	Assess, diagnose and treat diet and nutrition problems using the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate food choices.
Activities Coordinator	Develop person-centred care planning for activities of interest delivered individually and as part of group work.
Mental Health Social Worker	Carry out needs assessment, pre-discharge and discharge planning and community care assessment.
Pharmacist	Assist in the review and management of medication.

Additional specialist health care support

There will also be a need to access a wider range of specialist practitioners in response to the specific requirements and wellbeing of each patient. This will be determined by the assessed bio-psychosocial needs of each individual patient. It will include specialist consultants, such as a geriatrician for complex physical conditions and a cardiologist for heart and vascular health.

Additional allied health professional support will be important, including podiatry to help people stay mobile and independent, and arts therapies delivering highly specialist psychological therapies for difficulty in communication and expressing emotions verbally. Patients may reach end-of-life in the specialist dementia care unit because of a co-morbid condition such as cancer. Access to palliative care specialists will be key to managing pain and other distressing symptoms experienced at end-of-life.

Social and community connections

It will be important to provide social stimulation and meaningful occupation, so that people remain connected and engaged. This includes supporting continued involvement in the person's existing hobbies, interests and spiritual practices. This will involve utilising connections with external agencies, voluntary organisations and community networks. It will include patients being supported to take part in activities outwith the hospital and community resources coming into the unit to provide social engagement.

The activities coordinator will work with the person and those closest to them to identify opportunities to link with supports within the community. The activities coordinator will also develop person-centred care planning for activities of interest delivered individually and as part of group work.

4.4.4 Staff quota

The table below outlines the staffing level within the specialist dementia care unit. This will be the basic level of cover provided by the multi-disciplinary team. This will be under continual review according to the needs of patients and may be increased for particular needs, such as those requiring continuous observation of a patient for their wellbeing and the safety of others.

The multi-disciplinary team is split into the different staff groups and disciplines. Total nursing and clinical care workers equates to 29.8 whole time equivalent staff. An additional 5.4 whole time equivalents will include consultant psychologist, consultant psychiatrist, junior doctor, allied health professionals and additional practitioners including nurse consultant, advanced nurse practitioner, pharmacy and social worker with Mental Health Officer status. The unit should also take students of each profession in order to make this an attractive career choice for the future workforce.

Table 2: Specialist dementia unit staffing for seven-day week

Practitioner	Level of staffing full time equivalent	Grade
Nursing and clinical care workers		
Senior Charge Nurse	1.0	Band 7
Charge Nurses	3.0	Band 6
Registered Mental Health and General Nurses	15.4	Band 5
Clinical Support Workers	10.4	Band 3
Additional nursing staff		
Nurse Consultant	0.1	Band 8B
Advanced Nurse Practitioner	0.4	Band 7
Consultants		
Psychologist	1.0	Band 8
Psychiatrist	0.5	
Additional doctors Specialist Registrar Old Age Psychiatry	0.5	
Junior Doctor	0.5	
Allied health professionals		
Occupational Therapist	0.5	Band 7
Physiotherapist	0.3	Band 6
Speech and Language Therapist	0.3	Band 6
Dietitian Additional practitioner	0.3	Band 6
Pharmacist	0.5	Band 7
Social Worker with Mental Health Officer status	0.5	

4.4.5 Knowledge and understanding of dementia

A sound understanding of dementia is essential for all those providing care and treatment within the specialist dementia unit. The Promoting Excellence Framework (2011) provides a structured approach to understanding the level of knowledge and skill required by staff in health and social care services to provide human rights based care and support in accordance with the Charter of Rights (2009)[kk].

kk "Charter of Rights for People with Dementia and their Carers in Scotland" (2009) https://www.alzscot.org/assets/0000/2678/Charter_of_Rights.pdf

The level of knowledge and skill required by each practitioner will be determined by their role and level of responsibility within the multi-disciplinary team. The Promoting Excellence Framework provides four levels[ll] of knowledge and skills that staff require to support people with dementia and their family at different phases of the illness[mm]. It also provides "key quality of life indicators" that staff should be supporting people to achieve.

As a minimum, all **ancillary and non-clinical staff** supporting the units should have the knowledge and skills set out in the "Informed" level of Promoting Excellence.
As a minimum, all **clinical staff** should have the knowledge and skills set out in the "Skilled" level of Promoting Excellence, inclusive of clinical support workers and wider team members including roles such as volunteers.

All **professionally registered staff** including medical, clinical psychology, nursing and allied health professionals, will as a minimum have the knowledge and skills set out at the "Enhanced" level of Promoting Excellence.

Specialist dementia units should also receive multi-disciplinary support from practitioners operating at the **"Expertise"** level of Promoting Excellence – noting that this level of practice becomes role and discipline specific. These practitioners should include clinical psychologist, nurse consultant, advanced nurse practitioner, psychiatrist, activity coordinator and a range of allied health professionals.

In addition, there will be a minimum of one practitioner who has completed the NHS Education for Scotland intensive capacity and capability building Dementia Specialist Improvement Leads programme (DSILS). There should be strategic and organisational support and leadership to maximise the role of staff who have completed the training to enable DSILS', to cascade enhanced and expertise education and training to support change and improvement.

4.4.6 Working with families

Close family members are partners in care and it is essential that these key relationships are recognised and respected. Staff within the unit should be aware of the powers held by the family member/s, such as power of attorney or guardianship. The family carers have their own rights in addition to those assumed when acting for the person with dementia to "full participation in care needs assessment, planning, deciding and arranging care, support and treatment, including advanced decision making" (Charter of Rights 2009).

The family member/s should be encouraged to be active participants in the care of the person with dementia, including treatment discussions and being invited to multi-disciplinary team reviews. This should be ongoing throughout the person with dementia's stay in the unit and during discharge planning. Whilst attending the multi-disciplinary team review will be appropriate for some, others will be more comfortable in having more informal discussions with those providing care and for their views to be listened to and taken into account in this way. As the family will have been integral to care planning throughout the stay in the unit, the discussion around possible transition will occur gradually and not be presented suddenly.

ll Informed, skilled, enhanced and expertise levels.
mm Staff are most likely to be working with people at the "Living well with increasing help and support" and "End-of-life and dying well" phase of illness.

Visiting times should be flexible, with the family member/s encouraged to remain as long as they wish. They should be encouraged and supported to continue to make the contribution to care that is important to them and of which they are capable. Family members should be made aware of the possible financial support to enable them to visit the unit, depending on their personal circumstances.

4.4.7 Environment and physical space

It is essential that the specialist dementia unit is a purpose built physical environment. It is not appropriate or acceptable for this highly specialised care and treatment to be provided in an adapted building. The specialist built environment provides the opportunity to maximise the therapeutic potential of the space and supports the comfort, safety and activity of patients. It can also act to reduce the occurrence of distress.

Design features that respond to the experience of the illness as well as age-related impairments, can support person-centred care. It provides an enhanced working environment for staff to deliver person-centred care and a welcoming and supportive environment for people visiting the unit, who may spend a large part of their time with their family member, supporting their care. Some important features in dementia design are outlined in Table 3 below.

Table 3: Some examples of key design features

Built environment	Purpose built environment that maximises therapeutic potential through layout, design and key features.
Sound	Absorbance from ceilings, floors, window covering and soft furnishing to support audible communication. Quiet ambience with noise minimised.
Corridors	All corridors lead to meaningful places, with endings avoided or made into an interesting feature for engagement and activity.
Signage	Clear signage to help wayfinding for everybody, with pictures and graphics in addition to words.
Bedrooms	Individual en-suite facilities, room recognisable with easy visibility of bed and personal items on display.
Meaningful occupation	Facilities that support engagement in occupation, activity and social stimulation.
Outside space	Access to outside space during the day from communal areas.
Safety	Environment to minimise risk of self-harm and injury.

The specialist dementia unit requires an innovative approach to design that delivers maximum therapeutic potential. NHS National Procurement is well positioned to commission the design of a blueprint for the optimal environment to support specialised dementia hospital care. Through this competitive process, an innovative and creative design team can be appointed to create a blueprint that can be used by all NHS Boards to build the specialist dementia unit that provides a living and working environment and supports maximum therapeutic potential and enhances the full potential of each individual patient.

5. Conclusion and recommendations

There is an urgent need for extensive improvement of specialist dementia hospital provision in Scotland. This specialist area of practice has been overlooked for too long. There is a lack of the multi-disciplinary specialist care and treatment required and there are environments that are not conducive to person-centred care. Most people in specialist dementia hospital environments can be more appropriately cared for in community settings.

A decommissioning and re-design process would enable the development and roll-out of centres of excellence that would provide the small proportion of people with highly complex psychological needs the care and treatment they need. It would also allow resources to be transferred to the community so that care homes and those providing day-to-day care can receive specialist support and people with dementia are not admitted to hospital, unless it is essential to their clinical care needs. This would provide an efficient re-commissioning of current resources and tackle inappropriate admissions and unnecessarily lengthy stays in hospital.

Recommendations:

- That specialist NHS dementia care is modernised, providing high quality, human rights-based care, specifically for individuals who cannot be cared for in the community.
- Integration Joint Boards develop a transition plan and a local engagement strategy with their partners, including NHS Boards and people living with dementia, for any necessary de-commissioning process and re-investment in specialist dementia units and to develop further community capacity in health and social care services.
- That the Scottish Dementia Working Group and National Dementia Carers Action Network provide the representative groups for this local engagement.
- Integration Joint Boards and NHS Boards assess the proportion of people with dementia that can be safely transitioned to more appropriate community settings.
- The Alzheimer Scotland National Dementia Nurse Consultant provides expert guidance at both a national and local level.
- Integration Joint Boards and NHS Boards build strong and strategic local engagement on:
    - Any necessary de-commissioning and re-directing of resources to the development of specialist dementia hospital units and
    - building further community health and social care services.
- NHS National Procurement to commission the design of a blueprint for a specialist dementia unit that can be implemented by each NHS Board.
- There should be no financial detriment for families as part of the decommissioning process, with the financial cost of the care and treatment of the person with dementia being transitioned to the community continuing to be met by the NHS Board.
- The legal status of patients being transitioned to the community is reviewed and the appropriate legal documentation put in place.

- The creation of modern specialist dementia units that will provide centres of excellence to treat the small number of people with dementia who have a clinical need to be in hospital.

  The estimated 45[nn] specialist dementia units required across Scotland will provide a highly skilled practice area and make it an attractive specialism for ambitious and talented practitioners to deliver highly skilled therapeutic interventions.
  Promoting Excellence Framework the foundation for evidence based care for all practitioners. Leaders and senior practitioners ensuring that everyone working within the unit are trained at the appropriate level to ensure a high quality therapeutic approach.
  They will be underpinned and supported by the Charter of Rights for People with Dementia and their Carers in Scotland, the Promoting Excellence Framework and the Standards of Care for Dementia in Scotland.
- The timeframe for this process will extend beyond the end-point of Scotland's 2017-2020 National Dementia Strategy

nn This is based on an estimated 560 people with dementia who require care and treatment in a specialist dementia unit.

Appendix 1: Key findings – Review of NHS specialist dementia care (April 2015 to March 2016)

Introduction

This report outlines the key findings from the review of NHS specialist dementia care environments. This review was conducted by Maureen Taggart, Alzheimer Scotland National Dementia Nurse Consultant, between April 2015 and March 2016. It included 10 NHS Health Boards, over 60 individual dementia specialist care environments and a wide range of stakeholders, including senior managers and executive leads, practitioners and people living with dementia. This unique insight was made possible by the engagement and commitment of NHS colleagues, for which our warmest gratitude is extended.

This report sets out the key issues identified through visits to care environments, discussions with NHS Boards staff and meetings with people with dementia and their families.
A more detailed report will follow outlining recommendations for action and a model of safe transition for people who do not need to remain in these care environments.

Background

The review of NHS specialist care environments resulted from:

1. Themed visits by the Mental Welfare Commission of dementia continuing care units which outlined 17 key areas for improvement (Mental Welfare Commission (2014) "The Dignity and Respect Report: Dementia Continuing Care Visits"
www.mwcscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf

2. A roundtable discussion on NHS continuing care hosted by Alzheimer Scotland and University of West of Scotland in September 2014. This event was chaired by Professor Graham Jackson and attended by representatives from the Scottish Government, Royal College of Psychiatrists and NHS Boards.

The purpose of the round table meeting was to develop a better understanding of the issues and challenges within NHS continuing care and specialist dementia care settings and identify what could be done to remedy these.

- The discussion highlighted:
- The static nature of the population within these settings was a significant issue that causes pressure on resources.
- Estimates that around 40%[oo] of this population had no clinical need to be in hospital.
- The difficulty in organising and supporting discharge to appropriate alternative care settings.

oo This estimate was put forward as part of the roundtable discussion – the review by the Alzheimer Scotland National Dementia Nurse Consultant found this to be much higher in practice.

The reasons for the issues outlined above are complex, but were thought to include:

- Financial costs (social versus healthcare), leading to a resistance to move to an alternative setting.
- Continuing healthcare criteria not being applied in many cases (new guidance published in June 2015)[pp].
- Criteria being poorly understood among public and professionals.
- The expectation that NHS continuing healthcare is a "bed for life".
- Lack of alternative accommodation and support.

Approach to review

Ten NHS Boards have been included in this review, with over 60 individual specialist care environments visited by the Alzheimer Scotland Dementia Nurse Consultant with the purpose of developing understanding of the issues around transition and discharge.

Initial contact was made with the Executive and Operational Leads for Commitment 11. Visits were set up with a range of professionals involved in the care and treatment of people with dementia in specialist dementia units[qq] in the following NHS Boards:
Ayrshire and Arran
Dumfries and Galloway
Fife
Forth Valley
Grampian
Greater Glasgow and Clyde
Lanarkshire
Lothian
Scottish Borders
Tayside

Meetings within NHS Boards included: Directors of Nursing, Clinical Leads for Old Age Psychiatry, Consultant Psychiatrist, Associate Directors of Nursing, Senior Nurses, Senior Charge Nurses, Allied Health Professionals (Occupational Therapists, Dietitians and Physiotherapists), Consultant Psychology, Social Work, Nurse and Allied Health Professionals Consultants, Community Psychiatric Liaison Teams, Pharmacy, Service Managers and Professional Leads.

Additional discussion was held with people with dementia within assessment and specialist care units and their families. Staff within these care environments were also included in this review. Visits to NHS contracted bed locations in private sector care homes were conducted. Other key stakeholders were also consulted: Scottish Dementia Working Group, National Dementia Carers Action Network, Healthcare Improvement Scotland, Care Inspectorate, Mental Welfare Commission, Nurse and Allied Health Professional National Group, Alzheimer Scotland Dementia Advisors, Alzheimer Scotland Policy and Engagement Managers, Alzheimer Scotland Carers Reference Groups, Scottish Government Focus on Dementia Team, Advocacy Services, Alzheimer Scotland's Head of Operations and National Education for Scotland.

pp Scottish Government (2015) Guidance on NHS complex clinical care http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf
qq The term unit is used throughout the findings section to describe the range of environments where assessment, transition and specialist dementia care is delivered.

Key findings

1. Admission Units

The main reasons for admission were 1) increase in distressed behaviour in the person with dementia 2) carer distress 3) failed discharge to a care home 4) risk behaviours that meant care could not be safely managed at home and 5) lack of a care package to support the person with dementia to remain at home.

Length of stay varied greatly across NHS Boards, with an average of 8 to 12 weeks – this was up to two years in some instances. Most discharges from assessment units (estimated 90-95%) were to a care home or NHS specialist beds in a hospital or contracted beds. The application for power of attorney and guardianship increased the length of stay significantly – this was generally by nine months.

Some NHS Boards transferred people to "transition units" as they were not clinically ready for discharge. These transitions could last two to three years, with subsequent move to a care home. There was a higher level of access to multi-professionals within assessment units compared with specialist dementia units. However, this higher level of access was not available in every NHS Board.

Most units held reviews once or twice weekly, with families invited as appropriate. Only two areas had a social worker attached to the ward, with all others having a referral system.

Each area attributed delayed discharges to lack of funding and care packages. A lack of care home places was evident for one NHs Board.

There was good practice in relation to pre-discharge noted in two Boards. In one Board, staff and the family would visit the care home to offer support to care home staff – with community mental health staff or liaison psychiatry attending the pre-discharge meeting.

Another NHS Board had consultant-led clinics within care homes which successfully reduced admissions to the ward. The new "Hospital Based Complex Clinical Care Guidance" (2015) was being used in three Boards. In these areas, the review team met with the family one week after admission to discuss the plan of care, hear their views or concerns and provide a copy of the guidance for patients and their relatives.

2. Specialist beds and transitions

Consultant psychiatrists and managers highlighted that they had experienced an increase in complaints in response to attempts to transition patients. Families sought the support of their local MSP, who issued a letter of complaint to the NHS Board.

There were issues around charging policy when provision comes from social care as opposed to health – the financial impact of transition and families viewing specialist dementia units as a "bed for life". In some instances, when the person had been moved from another unit or hospital, families were given a letter to say the person would remain there for the rest of their life.

In cases where discharge to another care setting was proposed, formal appeals from the family were lodged, requiring further review to be carried out by an independent consultant psychiatrist.

In many cases, staff knew the patients well and the family were happy with the care provided – this could result in a lack of motivation for the person to be moved from the unit. Failed discharge to a care home was a common reason why many people remained in NHS care. Length of stay varied from one year to up to 15 years, with an average of 4.5 years. There were diverse needs within the same unit – this ranged from psychological and behavioural issues to end-of-life.

Discharging people with dementia is perceived to be a low priority for social workers, who view the person as being in a place of safety. The local authority insisted on transfer of resources if the person had been in a unit for over a year, as this was classed as long-term care.

When consultants have attempted to discharge people on several occasions without success, it can be seen as a waste of their valuable time to continue to attempt discharge. Many of the NHS contracted out beds have been in place for 20-30 years, with limited reviews of the initial contract. Whilst many of the specialist beds are in community hospitals, some are managed within mental health services and others are primary care, where the GP has limited access to specialist dementia professionals.

There was a general consensus that between 60% and 80% of these beds are not required – the care of this client group could be met within alternative care environments.

Most of these specialist units for people with complex clinical care associated with advanced dementia had no access to the multi-professional team of psychology, pharmacy, AHP, advocacy, etc. The main people involved in care were nurses and the consultant – staff recruitment and retention is a significant challenge for many NHS Boards.

One NHS Board had successfully closed many of their specialist beds and reinvested into community services to support people with dementia and their families to remain in their place of choice. At present four NHS Boards are reviewing and implementing a bed remodelling plan – this is driven in part by low occupancy and units being housed in outdated buildings.

There is real concern, and some evidence, that savings will not be re-invested back into specialist dementia care but utilised instead as efficiency savings.

A further two Boards reported a significant reduction in admissions where psychiatric liaison teams had been established to support the care homes in their areas. The three Boards using the new guidance have noticed a change, with families being much more engaged in the planning and discharge of their family member. One Board had also been reducing their beds due to low occupancy.

3. Specialist bed costs

There was significant variation in the cost of providing a specialist bed – costs of units ranging from £525 - £1,450 were highlighted. It should be noted that although a bed may cost £1,000 per week, this did not equate to access to a greater number of specialist dementia professionals than the less costly beds.

Low occupancy was noted in three Boards of 67% to 71%, which was consistent with the 2014 bed census.

NHS contracted beds were visited in three independent care home providers. There were various models used in these environments such as private sector beds with NHS management and staff, or private sector beds and staff with no NHS management but who could attend NHS Clinical Governance and Quality Monitoring meetings.

Of the NHS Boards visited, two had transferred the care and treatment of a patient to a dementia specialist unit in England, at a significant cost.

Most of the contracted beds visited are involved with the Commitment 11 local groups and have completed self-assessment and improvement plans. One NHS Board is to bring the specialist dementia care beds back into the acute sector from next year, under mental health management.

4. Environments and therapeutic activity

There has been a marked improvement since the Mental Welfare Commission's "Dignity and Respect" report (2014). Many of the units visited by the Commission have been closed, with new dementia friendly units developed and others to be completed by 2019.

However, a significant level of investment is required to upgrade/maintain some of the older facilities. Specialist dementia units continue to be located on upper floors with no easy access to outdoor areas. Features such as long corridors mean these buildings are not fit for purpose, even with adaptations.

It was evident that Commitment 11 improvement plans are making a difference in relation to activities within units. Some NHS Boards have developed an activity room and areas for family to use or stay overnight. One unit evidenced a reduction in falls since the environmental improvements and increased therapeutic activity over the previous year. Some areas had activity coordinators, with volunteers and community groups providing support for activity and connection.

Although some units had some excellent facilities and activity rooms, the majority were locked, with no activity going on in the unit whatsoever at the time of the visit. Staff shortages and lack of time was normally the reason given for this lack of therapeutic stimuli. When activity was carried out, it was provided by nurses, with few units having access to specialist AHPs to offer support.

Some areas highlighted how healthcare associated infection regulations hampered activity due to the concern over cross infection – this was a huge frustration for staff.

Bed and toilet areas could be shared by up to six people, with no showers or personal wash areas.

Some units had lots of personal effects on display for the people with dementia - this included pictures and soft furnishing. There was also some good evidence of life story work and person-centred care. However, other units were very stark, with no personal affects and presented as very clinical areas.

The private sector units visited have upgraded some of their areas to be more dementia friendly, with the majority providing en-suite single room accommodation. There are also improved dining and lounge areas and access to garden and outdoor areas.

Many of the units visited had activity programmes planned. This included Playlist for Life, baking, pet therapy, gardening, art work, exercise and movement, cognitive stimulation therapy, reminiscence, social outings to places of interest and doll therapy. Some of these activities were supported by volunteers, local primary or secondary school children and nurses or occupational therapists. A few of the areas were in the process of evaluating the effectiveness of therapeutic activity in their units.

5. Specialist AHP, Pharmacy and Psychology

There was great variation between NHS Boards in relation to access to AHP specialists, pharmacy and psychology. Only 50% of the assessment units had access to AHPs and there was very limited access to pharmacy and psychology. The specialist and complex needs units had virtually no access at all.

Most health care was provided by the consultant psychiatrist and the nursing team. All areas could access an occupational therapist from an acute service; however, there was a waiting time issue. When a falls risk assessment highlighted further intervention and referral to occupational therapy or physiotherapy, this was made to acute or primary care teams for further assessment and management.

There was a process to be followed for access to dietitians, speech and language therapists, geriatrician, Macmillan nurses, dentists and podiatrists to mention a few. Only three Boards had access to psychology via a referral process. However, due to increased referrals from community teams, very few people with dementia in the specialist units were ever supported by the extremely limited psychological services.

Access to pharmacy was minimal and normally only to top-up, as opposed to review, medication. No area had a pharmacist who was present at the multi-disciplinary reviews. However, staff could telephone a pharmacist for advice. Dementia assessment units based within the acute general hospital site did tend to have quicker access to AHPs and geriatricians - units outwith acute had a significant wait for assessment.

The Alzheimer Scotland Dementia Nurse Consultant held a multi-professional meeting in each NHS Boards. During these, there was a general consensus that improving dementia care was a priority. However, it was evident that they still received the lowest budget compared with other mental health services.

NHS Boards have highlighted some improvements in investment since Commitment 11 was implemented in September 2014. There was additional funding in two Boards, with appointments to additional psychology and pharmacy welcomed.

6. Skills and knowledge and workforce

The Promoting Excellence Framework had been implemented in every NHS Board visited. The majority had an implementation plan that sat with self-assessment and improvement plans. These were reported to the Chief Nursing Officer Directorate - reporting had taken place in December 2014 and in February 2016.

Skill mix and staff ratio to patients was lower than all other mental health areas – in most areas there were 40% to 45% registered mental health nurses with 60% to 55% untrained staff. A small number of Boards had a skill mix of 55% to 60% registered mental health nurses with 45% to 40% untrained staff.

Not all staff within the community hospitals hosting the specialist dementia beds were registered mental health nurses; however, some did have Dementia Champions on site. Whilst there were Dementia Ambassadors in some of the NHS contracted bed units, there were low numbers of registered mental health nurses, with only three covering a 90-bedded area. NHS contracted bed care homes did evidence training in the Promoting Excellence Framework. This was particularly strong at the informed practice level and they were progressing with plans at the skilled practice level.

All areas visited agreed that staff required their skills and knowledge to be at a higher level –the enhanced and expertise practice levels of the Promoting Excellence Framework were considered to be appropriate. However, this was considered challenging to achieve because of being unable to release staff as staff ratios were too low. Training in responding to stress and distress was highlighted as a priority in all areas. Some areas provided additional resources to assist with the training needs, but many had utilised the "bite size" models from NHS Education for Scotland only and highlighted a lack of support and supervision from psychology as a major issue.

Limited knowledge and skills to support people with advanced dementia and other co-morbidities affecting physical health was a challenge in many areas. Those who had undertaken the "Quality and Excellence in Specialist Dementia Care" programme with NES demonstrated greater knowledge and confidence in caring for complex physical health and delivering end-of-life care.

Some Boards did not have Practice and Improvement Development Support – thus creating an additional obstacle to supporting training. A small number of Boards did train large numbers of staff in "The Journey of Care for Dementia" and had recently trained "Dementia Care Mappers". Some areas had supported staff to train in "The Best Practice for Dementia Care" with Dementia Service Development Centre at the University of Stirling.

7. Experience of people with dementia and their families

Meeting with the families of people with dementia who were resident within the specialist assessment units was, in the main, a positive experience. They talked about being included in care and treatment decisions and being encouraged to offer care and support to their family member. They were invited to review meetings with the consultant and nurse, had completed "Getting to know me" or life story work and enjoyed the freedom in most wards to open visiting times.

This was in stark contrast to the comments provided by family members where the person was within a specialist care environment or had been recently discharged from a specialist complex needs unit (transition and what was previously referred to as long term care). They had expressed concern about the attitude of some staff, lack of empathy and compassion, feeling that they were not actively listened to or that their views were not valued. Many of these wards did not have flexible visiting times and families were not supported to engage and support the person with dementia. They did not have access to specialist multi-professional teams and when attending a review or pre-discharge meeting, they stated that "decisions were made before they were invited to speak".

An issue raised by a number of families was the lack of support and services for younger-onset dementia. When assessment was required, younger people with dementia were admitted to acute adult mental health wards where staff had very little skills and knowledge of dementia care. Families did not consider old age psychiatry wards to be appropriate for younger people with dementia. A few areas did have specialist community services that are multi-professional.

Appendix 2: Transitioning and Specialist Dementia Hospital estimated numbers by NHS Health Board

Health Board	Estimated number of people who can be transitioned to community	Estimated number of specialist hospital beds required
Ayrshire and Arran	67	44
Borders	22	15
Dumfries and Galloway	31	21
Fife	60	40
Forth Valley	46	31
Grampian	86	58
Greater Glasgow and Clyde	164	109
Highland	59	40
Lanarkshire	94	63
Lothian	121	81
Orkney	4	3
Shetland	4	2
Tayside	76	50
Western Isles	6	4

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78781-027-3 (web only)

Published by The Scottish Government, June 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS433766 (06/18)

Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Project Name	Mental Health - Community Outreach Team (COT)		
Project Owner	Irene Thomson	**Application Main Contact**	Irene Thomson
Main contact email	Irene.thomson@borders.scot.nhs.uk	**Main Contact Telephone**	01896 827152

Guidance on Project Brief

The purpose of this form is to give an outline on the key aspects of the proposal to the Integrated Care Fund 2015-18

Please refer to the accompanying guidance notes for more information on the Integrated Care Fund (ICF) when completing this document.

1 Outline project description

Please summarise the project in no more than 250 words

Mental health conditions are common among the elderly. NICE(2013)estimastes that around 2 in 5 older people living in care homes have depression, and an estimated 4 out of 5 people in care hoses live with dementia or sever memory problems. Despite the high prevalence of these conditions, NICE advises that these mental health issues are often not recognised, diagnosed or treated. Scottish Borders has the lowest number of care home beds in Scotland but has the highest proportion of people with dementia in care homes (69%)

The Community Outreach Team (COT) would specialise in meeting the needs of older adults with mental illness and dementia, working within care homes and community hospitals across the Scottish Borders

It would aim to provide proactive and responsive support to care homes and community hospitals to help them better meet the needs of their residents and inpatients with mental illness and dementia. Interventions would include carrying out mental health and memory assessments for residents, advising on the best type of treatment for the individual and advising staff on managing the symptoms and behaviours of people with mental illness and memory problems, like dementia, may experience.

The service would also provide training and education for care home and community hospital staff to provide them with the skills and knowledge to provide effective care for residents and inpatients with mental illness and memory problems.

The project would build on the current set up, skills and support offered by the current Liaison nursing staff and would work closely with the existing Community Mental Health Teams, Primary Care and Acute Medical Services

2.	**Project's strategic fit** (see guidance notes section 2) *Which local strategic objectives and Scottish Government ICF principles will it meet?*

Borders IJB Strategic Plan objectives

1. Improve the health of the population and reduce the number of hospital admission
2. Improve the flow of patients into, through and out of hospital
3. Improve the capacity for people to better manage their own conditions and support those who care for them

This project would meet all three of the IJB strategic objectives listed above.

Scottish Government ICF principles

1. Co-production
2. Sustainability
3. Locality
4. Leverage
5. Involvement
6. Outcomes

3	**Project Aims/ Achievements** *Please give a high level description of what will success look like?*

How to access the service

- Referrals to the service can be made by GPs, or senior care home/community hospital staff.
- All referrals sent to a COT referral inbox (email or sky gateway)
- Referrals are screened on the same day and the referrer is informed of the outcome. If the referral is appropriate COT will contact the care home or community hospital by phone to arrange an appointment
- If the referral is inappropriate contact will be made and advice given on how to proceed
- The service will also be open to more informal contact and discussion about possible referrals
- The COT will then assess the individual looking at:
    - Advice and treatment regarding specific mental health issues
    - A person-centred care plan that will ideally involve the individual, family, carers and staff in maximising quality of life, physical health and comfort
    - Offer advice and training where necessary to staff to support them in meeting an individual's care needs and maintain them in their current care setting

Aims:

- To provide prompt access to a specialist mental health service for patients in care homes & community hospitals, who have or are suspected of having a mental health need
    - Emergency referrals will be responded to on the same day
    - Urgent referrals will be responded to within 2 working days
    - Routine referrals will be responded to within 7 days

- To promote good practice and develop personalised care plans to maximise an individual's quality of life, in order to maintain them within their current care setting
- To promote the use and consideration of anticipatory care planning for individuals
- To provide a bio-psychosocial model of care in which both non-pharmacological approaches and medication are considered. This may include:
    - Modelling and implementing Stress and Distress techniques – the team will work with an evidence based, psychological model for identifying and treating unmet needs in dementia patients called the Newcastle Clinical Model. This model is used in a number of projects throughout Scotland with the aim of supporting care homes maintain residents within their own environment. It aims to reduce admissions to hospital by supporting staff to develop a better understanding of dementia as well as building a range of skills to enable staff to work with residents in a way that limits stress and distress in those individuals with a diagnosis of dementia
- Signposting to other services or organisations for further support e.g Palliative care
- Assessment and management of risks to an individual, staff or other residents
- To consider the involvement of other professional groups following the assessment of an individual's needs
    - Physiotherapy
    - Occupational Therapy
    - Consultant psychiatrist
    - Psychology
- The service will provide training and education to care home and hospital staff based on best practice and/ or individual needs
- To work with an individual, carers and staff to facilitate a successful transition into a care home environment from hospital and home

Expected outcomes:

- Improved detection, assessment and treatment of common mental health conditions
    - In particular to increase dementia diagnosis rates within the care home population with the aim of finally reaching the Scottish Government's national Local Delivery Plan (LDP) standard for dementia diagnosis in The Borders
- Reduction in antipsychotic prescriptions
- Reducing hospital admissions, facilitating earlier discharge (reduction in delayed discharge days) and the need for care home moves
- Raise awareness of mental health in care homes and community hospitals
- Increased confidence and skills in caring for older people with mental health difficulties and dementia in care home and community hospital staff

	4 What areas of the Borders will the project cover *Will the project affect the whole of the Borders or a specific locality, if so please state?*

The project aims to work across the entirety of the Borders but initially it will begin roll out in the South and East (Berwickshire across to Jedburgh, Hawick and Newcastleton) An increase in the areas covered will continue as the staffing has been recruited to and feedback from care homes/ community hospitals in respect of what is or isn't working well has been considered.

It will cover all 92 community hospital beds and provide a service to the 695 care home beds within Scottish Borders. Therefore, it will provide a service to potentially 787 individuals.

The project would anticipate having capacity to assess, plan treatment and intervene (where necessary) for 60-70 individuals per week, with capacity for support workers to work with around 40 individuals and staff teams implementing care plans, etc. In addition a rolling programme of training and implementation of stress and distress techniques will be undertaken with each care home and community hospital throughout the year.

The project will employ QI methodology in order to ensure its practice and service delivery is effective and of good quality

5	**Which care groups will the project affect?** (see guidance notes section 4)

Adults of any age within 24 hour care setting who have a dementia diagnosis or adults over the age 70 with a suspected mental illness eg psychosis or depression.

6	**Estimated duration of project** *Please provide high level milestones and including planning and evaluation time*

While this funding request is for 2 years the anticipation is that this becomes a permanent project and that costs saved by the reduction of inpatient beds and a reduction in occupied bed days (compared to the current base line) will fund the costs of the service.

7	**How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs*

The funding will be spent on the following areas

<u>Staff</u>
0.2 Team Manager time Provided through current MHOAS management time
2 x sessions of medical time per week (£24,394)
1 x WTE clinical psychologist (8a - £58,205)
0.5 x Band 6 Occupational therapist(£19,966)
2 x Band 6 nurses These posts currently exist and will be part of the project (£46,464 per WTE)
4 x Band 5 nurses 2 x Band 5 post currently available to recruit to. (£31,746 per WTE)
4 x Band 3 nurses 2.26 WTE Band 3 Posts currently available to recruit to (£24,423 per WTE)

<u>Travel</u>
Travel costs for all of the above average of approx £200 per month per employee (£24,000 per year)

Training
Training in the Newcastle model for the qualified members of staff in train the trainer. (£2,000) (one off)

Hardware
Laptops and telephones approximate total (£11,000)(one off)

Total recurring costs £444,169
Total existing resources to be put into the project £211,616
Total additional funding required £232,553 (Plus additional one off costs of £13,000)

8 What would happen if ICF didn't invest in the project?

The current service will continue. At present there are 2 nurses who cover the whole of the Borders visiting care homes and community hospitals. The current service has no resilience and there is no back up or cover for holidays, sickness absence etc there is little ability to respond to more than one crisis at a time unless in the same or nearby location.

The current service is as responsive as it can be but generally picks up cases at a late stage in the journey by which time staff working with the individual find it difficult to remain positive or see any potential for a positive outcome for them or the resident. It has been difficult to build relationships or build on previous training/educational opportunities e.g. stress and distress because of the now stretched services due to crisis admissions from community hospitals and care homes and continued delayed discharges.

Care provided to people with dementia may not readily meet their needs without advice and guidance from a service with expertise in the care and treatment of older adults with mental health difficulties. As a result care homes may feel unable to meet the needs of individuals, and struggle to provide care at the standard they would wish to do so.

It is anticipated that if there are fewer in-patient beds within Scottish Borders care homes and community hospitals will need to be supported to be able to continue to care for individuals as their illness progresses. Without this type of service if would not be unrealistic to suggest that admission to acute care in times of crisis is more likely. Care home's ability to tolerate challenges may become depleted if they are not supported to manage in times of difficult and responded to in times of crisis. The proposed service will aim to support care homes and community hospitals to avoid admission to acute sites wherever possible.

By working with community based colleagues the proposed project will develop an ethos and culture which enables care providers feel supported and responded to when necessary and ensure there is easy access to expert advice, guidance, support and intervention as required. Alongside this practice individuals will be supported to transition into care home placements, reducing the number of failed admissions and helping care homes to feel more able to meet the needs of individuals expressing stressed and distressed behaviours. The anticipated outcome is this will bring about earlier discharge from older adult mental health wards, community hospitals and community based individuals. The relationship and interaction between the project and the community mental health team will facilitate planned and emergency transitions into care home placements from home, thus avoiding potential hospital admission in crisis.

The result being a reduction in bed days lost due to delayed discharge and reduced avoidable admissions.

While the figures below focus only on older adult mental health inpatient beds it is anticipated that the service will have a positive impact on the whole of the hospital inpatient system, given the demographics of the Scottish Borders and that Dementia is the primary cause of death in females over 70 years of age area and the second highest cause of death (behind heart disease) in males of 70 years locally.

9	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*

The project will release resources by supporting care homes to develop and sustain knowledge and skills to work with people with dementia and other mental illnesses throughout their journey; We anticipate shifting beliefs and culture to enable managers and charge nurses to be confident about providing care to this group of people. The potential impact on hospital admission and early discharge is significant. The project would help to facilitate the recommendations within the "Transforming Specialist Dementia Hospital Care" report to be implemented if carried out in conjunction with commissioning of services, to enable the closure of NHS Borders older adult mental health beds.

Over the past year there has been a rise in the number of bed days lost to care home waits across all inpatient facilities within NHS Borders. In 2017 – 166 individuals were delayed in hospital waiting for care home facilities, occupying 4429 days, the average length of delay per person in 2017 was 26.68 . In 2018, (to November) the number of individual delays dropped to 133 with 4227 bed days lost an average of 31.78 days delayed per person. The numbers for individuals awaiting specialist dementia beds also fell from 22 in 2017 to 20 in 2018 (although this figure does not include December 2018) however, the average length bed days delayed rose from 42.8 days to 54.9 days in 2017 and 2018 respectively.

The bed days lost within the older adult mental health wards is considerably higher. In 2017 there were 13 delays for care homes with 881 bed days lost (average 67.7 days per person) in 2018 while the number of delays remained the same (December figures not included) at 13 the bed days lost rose to 910 an average of 70 bed days lost per person. The team would anticipate having a significant impact on these figures. Clearly any savings made as a result of any reduction in specialist dementia in-patient beds could be transferred to support the project in the longer term. The average cost of older adult inpatient beds within NHS Borders is £473.85 per day, delays costing NHS Borders £417,461.85 and £431,203.50 in 2017 and 2018 respectively, in two wards alone which relates to only 13 patients.

The service would anticipate a positive impact on reducing length of stay across all wards across the acute site, mental health and community hospitals. Investment in the service would ultimately save funds from a whole system perspective but would also result in achieving the aims of the fund. The figures below show the potential savings that could be made by reducing admissions and lost bed days across NHS Borders :

Across all inpatient areas

- In 2017 there were 165 individuals whose discharge was delayed waiting for care home placements totalling - 4425 bed days lost.
- In 2018 (to November) there were 132 individuals whose discharge was delayed waiting for a care – totalling 4215 bed days lost.

The average length of delay rose from 26.82 bed days lost to 31.93 in 2017 and 2018 (to November).

SAVINGS

Reducing the bed days lost (across all inpatient beds)

- By 10% would produce a saving of **£201,518.93**,
- By 20% would result in savings of **£399,455.55** *based on Jan to Nov 2018 figures

It is not possible to determine the savings produced by admission avoidance accurately. We are representing this saving by removal of all bed days lost *(as above).

The project will aim to avoid 10% of admission at a saving of a further £199,716.40.

When admission avoidance is added to reduction in lost bed days potential savings are:

- **£401,235.33** for a 10% reduction of lost bed days
- **£599,171.95** for a 20% reduction to bed days lost.

10	How would you identify/ recruit staff to support the project?

Section 7 above identifies the staffing proposal. The following posts are currently vacant or occupied by members of the current team and would transfer to the new service they are

2 WTE Band 6

2 WTE Band 5

2.26 WTE Band 3

We would need to recruit to the remainder of posts on a temporary basis.

11	Would the project require dedicated project support from the programme team (see guidance notes section 6)

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

This page is intentionally left blank

ALTERNATIVES TO HOSPITAL DAY OF CARE AUDIT (DoCA+)

July 2018

What was the DoCA+

A snapshot audit of every patient in the Borders General Hospital and Community Hospitals undertaken in July 2018, to assess which patients would be able to receive care in a non hospital setting and what services would be required to achieve this.

The team

The DOCA+ was carried out by a team of experienced clinicians:

- Consultant Geriatrician – Jenny Inglis
- Consultant in Acute Medicine – Lynn McCallum
- Lead Social Worker – Jane Prior
- AHP – Liz Duffell (Team Leader, RAD)/ Lynn Morgan Hastie – Head of Physiotherapy

Community Nursing – Fiona Houston (Clinical Nurse Manager)/ DN leads Margaret Richardson (Hawick) and Mary Hayes (Peebles)

- GP Superintendent for Community Hospitals (CH visits) (apart from Knoll). Dr Kevin Buchan (Hawick), Dr James Millar (Kelso) and Dr Declan Hegarty (Peebles)

The Methodology

The existing national DOCA audit tool was used with additional 21 options for non-hospital services identified within reports by John Bolton and Anne Hendry.

DoCA+ was undertaken on:
BGH: Mon. 9th July 2018 (Wards MAU, 6, 16, 7, 9 and BSU) and Wed. 18th July 2018 (Wards 12, 14 and 5)
Community Hospitals: Mon 23rd July 2018 (Hawick, Haylodge) and Thurs. 26th July 2018 (Knoll and Kelso).

Combined BGH and Community Hospital Results

Combined Results DoCA+ July 2018			
	Combined Total	**BGH**	**Community Hospitals**
Total Number of patients in survey:	**301**	**218**	**83**
Patients identified as going home on day of survey:	20	20	0
Patient notes missing at survey time:	5	5	0
Number of patients meeting criteria (appropriately placed in acute hospital):	**131**	**104**	**27**
Number of patients with an alternative place of care:	**145**	**89**	**56**

Alternate place of care - by theme	**Total**
Home Care	79
Nursing Home	24
Assessment	15
Discharge to Residential/Extra Care Housing	9
Discharge Home	8
Other (process delays)	6
Awaiting guardianship/other legal issues	4
	145

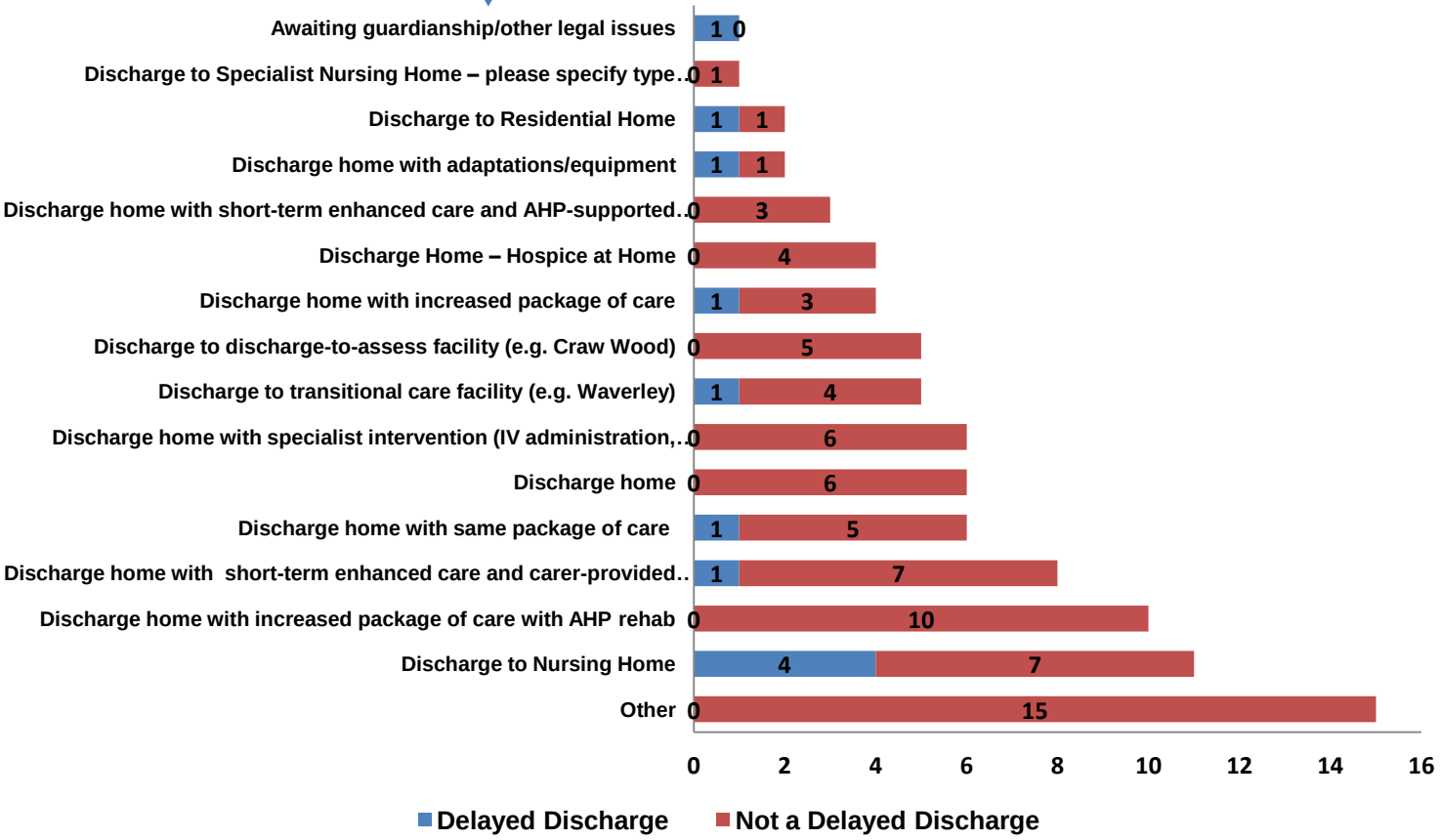
BGH

- 89 patients (46%) could be managed out of hospital
- 12.4% identified as delayed discharges
- 54 patients could be managed at home with appropriate care
- 15 patients required nursing home care
- 12 patients suitable for step-down residential care in Craw Wood (awaiting assessment/residential care)

BGH results and figures –

Total number of patients assessed 193
Total delayed discharges 12
Patients meeting criteria 54%
Patients not meeting criteria 46%
Number of patients with an alternative place of care 89

Alternate place of care - by theme	Total
Home Care	49
Nursing Home	15
Assessment	10
Discharge Home	6
Other (process delays)	6
Discharge to Residential/Extra Care Housing	2
Awaiting guardianship/other legal issues	1
	89



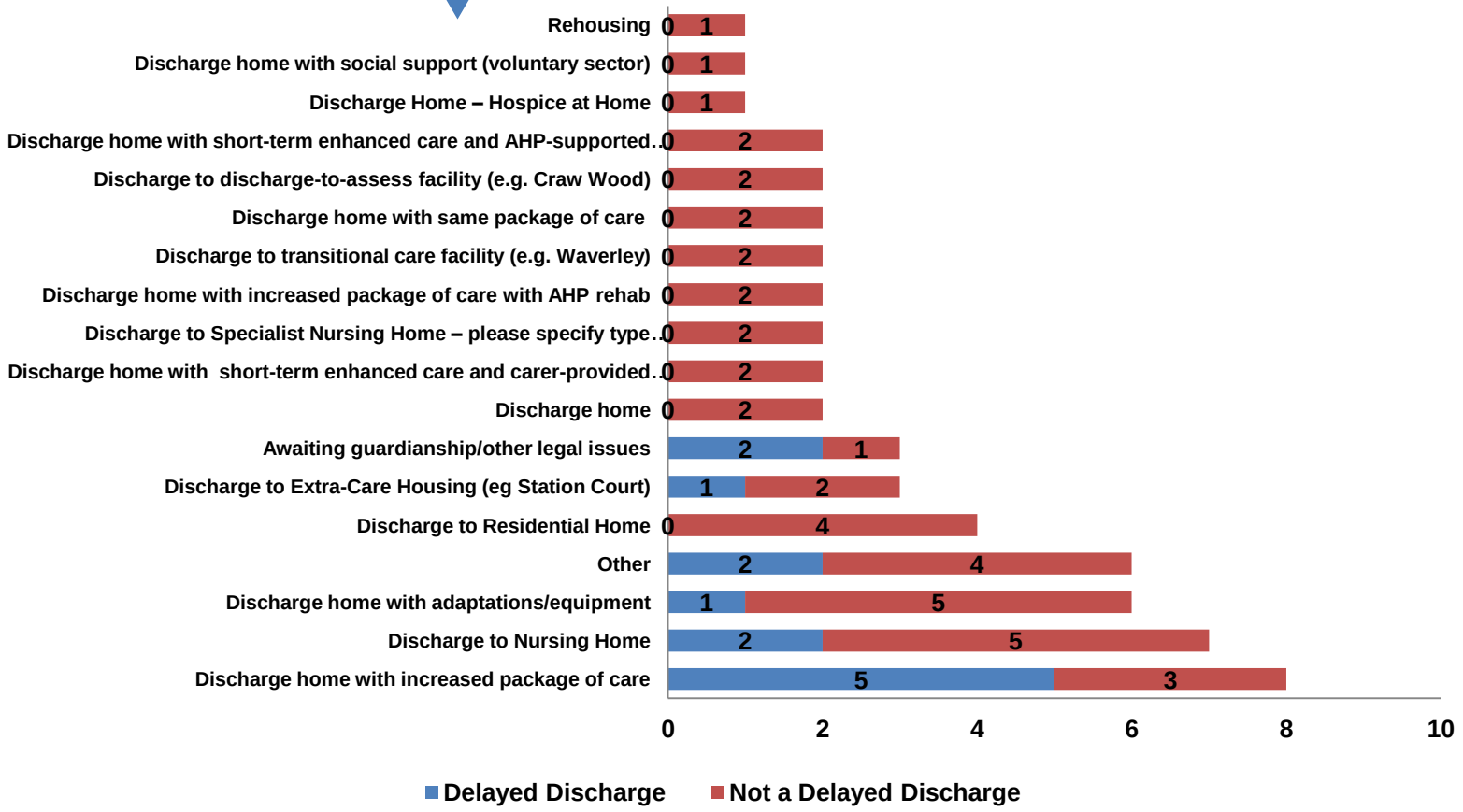
Community Hospitals

- 56 patients (68%) could be managed out of hospital
- 21.4% identified as delayed discharges
- 32 patients could be managed at home with appropriate care
- 9 patients required nursing home care
- 12 patients suitable for step-down residential care in Craw Wood (awaiting assessment/residential care)

CH results and figures –

Total number of patients assessed 83
Total delayed discharges 13
Patients meeting criteria 32%
Patients not meeting criteria 68%
Number of patients with an alternative place of care 56

Alternate place of care - by theme	Total
Home Care	30
Nursing Home	9
Discharge to Residential/Extra Care Housing	7
Assessment	5
Awaiting guardianship/other legal issues	3
Discharge Home	2
	56



Older Peoples Mental Health DoCA+

A snapshot audit of patients in NHS Borders Older Peoples Inpatient Mental Health facilities (Cauldshiels, Melburn Lodge and Lindean) undertaken 15th November 2018, to assess which patients would be able to receive care in a non hospital setting and what services would be required to achieve this.

The team

The DOCA+ was carried out by a team of experienced clinicians:

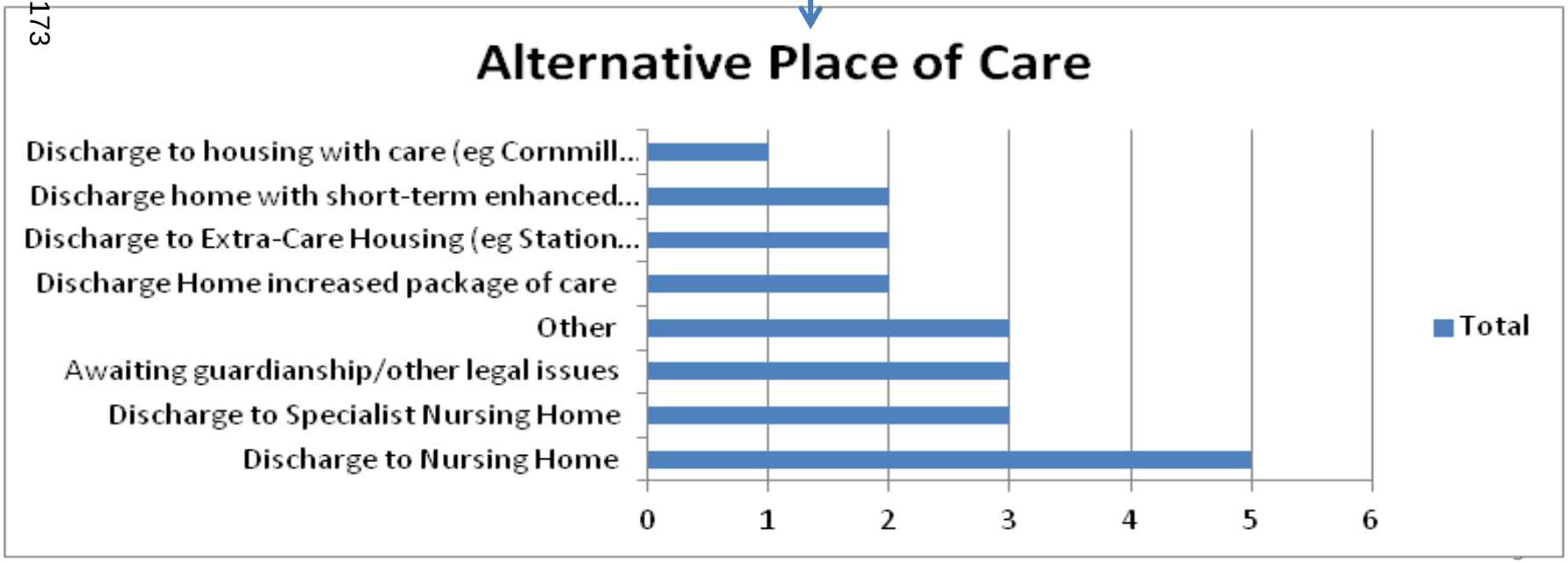
Christine Proudfoot, Alzheimer Scotland Dementia Nurse Consultant, Mental Health
Lisa Clark, Operational Manager, Mental Health
Mrs Rianda du Preez, Professional Lead MH OT, Mental Health
Mrs Stacy Patterson, Social Work
Mrs Diane Keddie, Lead Nurse Excellence in Care
Anne Palmer, Clinical Governance & Quality Facilitator
Gina Allen, Project Support Officer

The Methodology

The existing national DOCA audit tool was used with an additional set of criteria for non-hospital services.

Combined BGH and Community Hospital Results

Combined Results DoCA+ July 2018			
	Combined Total	BGH	Community Hospitals
Total Number of patients in survey:	28	218	83
Number of patients meeting criteria (appropriately placed in acute hospital):	7	104	27
Number of patients with an alternative place of care:	21	89	56



Older Peoples Mental Health

- 21 patients (75%) could be managed out of hospital
- 62% identified as delayed discharges
- 5 patients could be managed at home with appropriate care
- 9 patients required nursing home care
- 4 patients required residential/extra-care housing
- 3 patients were awaiting guardianship and other legal measures


Community Hospital
short term
residential
Hospice at home
AHP
Delayed discharge
criteria
home
GPs
Alternative Place
self care
delays
discharge to assess
Intervention
DOC
enhanced
coding
BGH
Specialist
Waverly
audit
results
social care
appropraiately placed
adaptions
consultant
package of care
Craw Wood
nursing home
information
equipment

Enhanced Homecare

- DOCA+ - 79 patients

- Identified by
  - Professor John Bolton (Report for Scottish Borders Council and Borders NHS on care pathways and delayed discharges 2017)
  - Professor Anne Hendry (Review of the Clinical Model for Community Hospitals in Scottish Borders, 2018)

- Existing/Tested models
  - Cheviot Healthcare Team
  - Neighbourhood Care Team (Coldstream)
  - Hospital to Home
  - Community-based AHP services
  - Teviot Project (2102-2104)

- Models of care
  - Carers as enablers
  - District Nurses as coordinators of care
  - AHP-led community care model

Strategic Intent

"undertake a review and development process to provide an agreed and comprehensive model of home-based step up and step down services"

- detail the level of services and the resource required from:
  - Home care staff
  - Community nursing staff
  - AHPs
- Model the impact of the new services over time
- Provide a business case including cost-benefit analysis and potential to release resources

Would provide the H&SCP with a commissioning plan for this tier of services.

This page is intentionally left blank

NHS Borders
Mental Health Service

Administration
The Cottages
Huntlyburn
Melrose
TD6 6BD
Telephone 01896-827152
Fax 01896-827154
www.nhsscotland.co.uk

PRIVATE & CONFIDENTIAL
Ms Alison Thomson
Executive Lead
The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh EH12 5HE

Date 21st May 2018
Your Ref
Our Ref PG/LMac

Enquiries to Philip Grieve
Direct Line 01896-827157
Email Philip.grieve@borders.scot.nhs.uk

Dear Ms Thomson

Thank you for the feedback and recommendations following the Mental Welfare Commission visit to Cauldshiels Ward, NHS Borders, in February 2018.

The Service notes the recommendations and has initiated improvements to address these as follows:

Recommendation 1:
Managers should consider how risk and nursing assessments can be added to the current system.

All patients will have a safety care plan in place and will be added to the admission check list to ensure every patient has one in place; this will be reviewed daily and will demonstrate ongoing daily risk assessment. Cauldshiels ward will introduce and reinforce the use of frequency charts, ABC charts, Neuropsychiatric Inventory Assessment to further support subjective observations of overall care.

Recommendation 2:
Managers should raise awareness of nursing and medical staff on the rights of patients who may be detained without authority.

The Associate Director of Mental Health, Peter Lerpiniere, has a Professional Mental Health Nursing session planned for the 11th June 2018 in which he will discuss "Rights in Mind – a pathway to patients' rights in mental health services" and plans a further 2 sessions specifically for Cauldshiels and Melburn Lodge staff

Recommendation 3:
Managers should review the OT input for patients in Cauldshiels ward.

Cauldshiels currently consists of an OTTI assessing all new admissions by doing a Pool Activity Level for each patient with suggested activities that can be provided by staff in the ward. The Pool Activity level assesses the level that the patient is functioning at and ensures that activities are presented at this level.

A review of OT provision will take place when the new management structure is embedded within mental health.

Recommendation 4:
Managers should ensure a review of the environment taking into account the comments in this report. Given our previous concerns have not been addressed; we will now escalate this recommendation to senior managers.

A member of the Capital planning team has an identified sum of money that will be allocated to Cauldshiels. A recent walk round took place on 14th May 2018 and a list has been compiled of potential areas that the ward staff see as priority e.g. flooring, lighting, coloured toilet seats/side rails, painting of the walls. This will be reported back to Capital Planning for progression

I trust this response is satisfactory and if you require further information, please do not hesitate to contact me

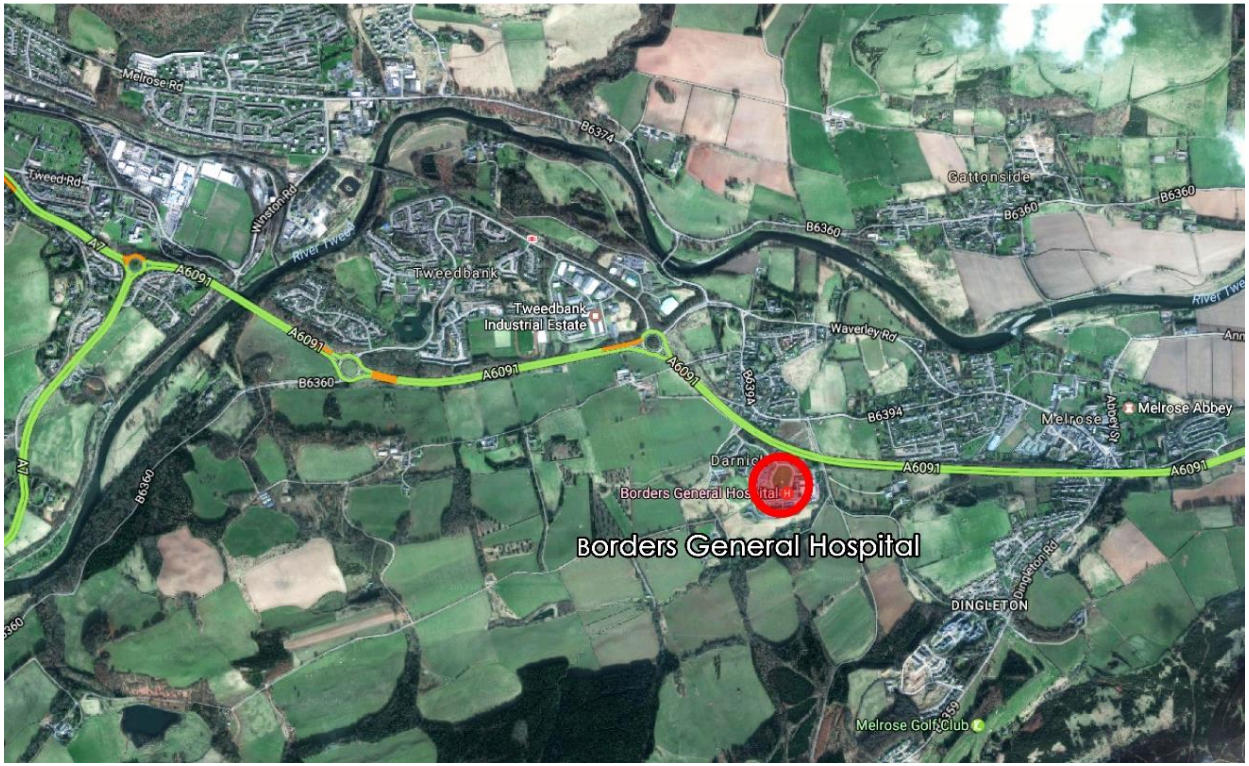
Yours sincerely

Philip Grieve
Operational Manager for Mental Health

Feasibility Study for NHS Borders

Cauldshiels – Dementia Ward

Contents



UNUM PARTNERSHIP
CHARTERED ARCHITECTS

1.0 Introduction

Unum Partnership Ltd has been commissioned by NHS Borders to produce a feasibility study on the accommodation at Cauldshiels and Lindean Wards within The Borders General Hospital Main Building, currently functioning as a 14 Bed Acute Elderly Adult Dementia Ward and a 6 Bed Functional Elderly Mental Health Ward.

The units have been converted from previous acute hospital clinical uses and extended to provide single bed accommodation to meet the needs of patients with complex and challenging physical and mental health issues. The structural features of the building and its position on the ground floor of an existing 3 storey building has led to significant compromise of layout which is further exacerbated by the provision of single bed accommodation in a floorplate designed for open multi bed wards .

Reductions in staffing levels and the increased complex needs of the patient group who use the ward have significantly hampered the ability of the service to cope with the building environment and facilities.

The requirement for this existing level of bed numbers remains, however significant issues exist for staff where the building does not comply with current guidance on facilities for Dementia Design and improvement is required.

Unum Partnership have been tasked with reviewing the current facilities within the building with the view to incorporating Dementia design best practice and designing out flash points within the building where possible.

1.0 Introduction

Through consultation with clinical staff carried out by NHS Borders Estates and Management team and a site visit by the writer, the key issues were identified as follows:

1/ The nurse call/ staff assistance system has 'blind spots'. This is an immediate and significant risk to staff safety.

2/ Loose furniture within bedrooms impedes cleaning and compromises Infection Control.

3/ A significant number of the ensuites are too small leading to significant difficulties in elderly patients being assisted with toilet and washing. The ensuites have WC and washbasin only, with 1 assisted bathroom to be used by 14 patients. The assisted bathroom itself does not comply with space standards for moving and handling. Although Lindean has 1 bathroom for 6 patients, Cauldshiels does not comply with current standards on provision of washing facilities.

4/ There is very poor opportunity for passive observation throughout the ward due to the complexity of the circulation spaces. The circulation spaces have a significant number of alcoves and dead ends which pose real problems for those with Dementia who are easily disorientated.

5/ The general environment is not 'Dementia Friendly' and is in a poor condition

- The interior colours and finishes lack visual contrast
- Lighting levels are significantly below standard
- Signage is poor and is not Dementia Friendly
- Unsatisfactory handrail provision has lead to risk to and conflicts between patients

6/ Lack of Patient day/ activity spaces makes therapeutic activities difficult. There are no designated Quiet rooms or Family visiting spaces and the internal Over night room is rarely used as it has no natural day light.

7/ Staff Clinical and support spaces including the DSR are too small and there is a general lack of storage/ space for service function. The clinical room is shared between the two wards with Controlled drugs being stored in this one location.

8/ The staff kitchen is located next to the day room that is currently not being used, at the opposite end from the main hub of the ward and has issues with ventilation and cooling.

9/ Externally, the location of the ward entrances are poorly sign posted, the entrance to Lindean is in a back service area and there is no footpath to the entrance of Cauldshiels. Additionally the only external patient space for use by both wards is at the entrance to Cauldshiels which is screened by a high fence and is not immediately obvious on arrival.
The cross circulation between patients using the garden space and visitors entering and leaving the ward poses a security risk which is currently managed by restricting access to supervised use only.

10/ Bedroom doors are currently not self closing fire doors as required by current standards, it is acceptable for this to be retained in existing buildings, however the operation hinders recovery of patients fallen behind doors and the ironmongery is poor for those with Dementia, visual impairments or dexterity issues.

11/ The staff working at the reception area have identified an issue with patients being able to approach the rear of the desk and interfere with staff or accessing computers at the open desk area. This causes staff to feel threatened and poses a risk to Patient confidentiality.

12/ Estates have identified a possible issue with capacity within the Domestic Hot Water flow and return system which may impede the ability to provide additional showering/ bathing facilities. Further investigation will be required if an upgrade to ensuites to include showering provision is included.

The following review of current facilities together with the options appraisal has led to the proposed improvements being separated in to two stages:

Stage 1

Essential non structural upgrade works, including nurse call system, lighting, decoration and security provision.

Stage 2

Many of the elements and failures of the facility require significant structural alteration to be made compliant or have been found to be unachievable within the current building. A high level review of clinical need and accommodation requirements is included which could feed into an overall appraisal of service provision throughout the Borders General Hospital site and the Borders service area.

2.0 Cauldshiels

2.1 Entrance

Cauldshiels and Lindean wards are located within the ground floor of the main Borders General Hospital Building with their own separate entrances to the rear of the building away from the car park and past Melburn Lodge. On arrival at the hospital there are signs to direct visitors to the wards however the route appears to be a service road access only which leads to a back of house services area. The location of pedestrian signage on the footpath outside Melburn Lodge appears to direct away from the facilities and pedestrians have to cut across grass or round parts of the service road to approach the entrances. There is no pedestrian or accessible footpath leading to each entrance.

Arrival at both wards is extremely poor. A lack of distinct signage and welcoming or obvious entrance to both of these wards immediately gives a sense that this is a low priority service. On a functional level, the entrance is not observed from the nurses' office other than by CCTV, whilst the visitor must pass directly next to the day room window and then enter through the garden gate to access the door entry system. This access crosses the egress from the day room to the external garden space.

There is little opportunity to change the location of the ward entrances, however additional signage and footpaths could be installed.

2.0 Cauldshields

Entrance to Cauldshiels

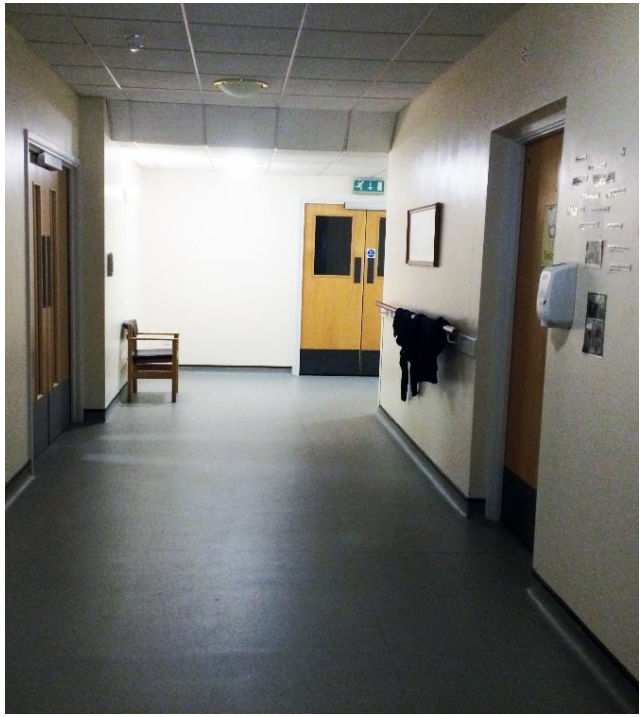
Entrance to Lindean

A pleasant garden space has been created which visually links the two large day spaces, but this is compromised by the entrance to the Cauldshiels ward which does give rise to security issues especially with Dementia patients who tend to wander.

2.0 Cauldshiels

2.2 General Layout and circulation

From the schematic plan it can be seen that there is little functional order or hierarchy to the location of the rooms within the layout. The footprint was originally designed as open multi-bed wards with a deep plan and a low ratio of perimeter wall to floor area. When originally converted to single rooms, bedrooms were by necessity located on the perimeter to obtain natural light and ventilation. The result was significant areas of circulation that cannot be integrated into functional defined areas.



The corridors do not benefit from any natural light and observation is exacerbated by the deep structural wall fins that create hiding points and alcoves along the lengths of the corridors. This also gives the sense of being in the very bowels of the hospital.

2.0 Cauldshiels

UNUM PARTNERSHIP
CHARTERED ARCHITECTS

2.0 Cauldshiels

The main nursing office and reception desk are located at the entrance but due to the spine walls previously noted, this feels quite remote from the two day areas. The reception desk is not designed to prevent patients from having access to the rear of the desk and this can be an issue with patient confidentiality.
From the entrance way, patient bedrooms, day spaces and staff spaces are intermingled. This can lead to widespread dispersion of patients and staff throughout the building during all times of the day, with management policies in place requiring a higher staff/ patient ratio than in other units of this size. This can also lead to feeling of isolation, particularly at the western end of the ward. The location of day rooms at separate ends of the deep U shaped circulation has also caused issues for nursing. The westerly day room is now only used occasionally and is generally locked off. The servery kitchen is also located at this end of the ward which then requires traversing the ward with heated trollies.

Comments from nursing staff also highlight the additional time taken to locate patients within the ward and the high level of conscious interaction required by nursing staff to ensure contact is maintained without the obtrusive measures of close observation.

2.3 Bedrooms and Ensuites

The bedrooms and ensuites within Cauldshiels vary greatly in terms of size, orientation and facilities within. This has been known to create tension between patients in other wards over the perceived hierarchy of rooms.

They are predominantly single bedrooms, although there are several that were originally sized to accommodate two beds. Only four of the bedrooms comply with current space standards set out in HBN 04-01 2010 Adult In-patient spaces regarding wheelchair accessibility and moving and handling requirements.

An issue within each of the rooms is the moveable furniture which impedes cleaning. Ideally fitted furniture would be installed. This can respond to the needs of dementia patients and provide easier to clean facilities. This was considered to be a low priority at stage 1 of this study but would be integrated into a new layout.

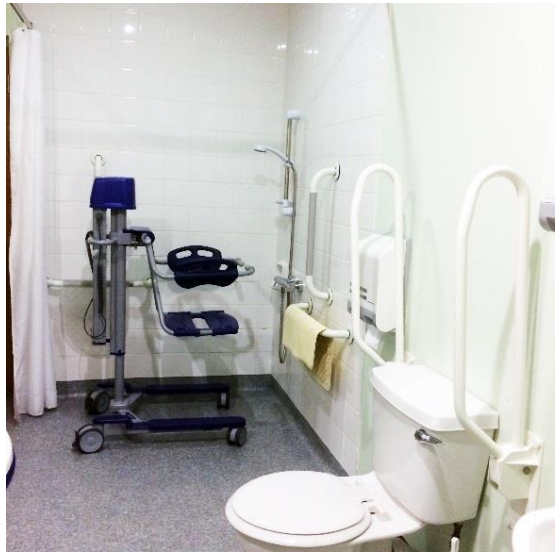
Bedrooms have been fitted out on an ad hoc basis with varying levels of compliant grab rails, colour contrasts and infection resistant surfaces.

Each bedroom has en-suite facilities; however the en-suites vary greatly in size from room to room, the largest being approximately 6 sqm and the smallest less than 3. All contain a WC and wash hand basin, with the larger rooms laid out with a peninsula WC. None of the ensuites contains showering facilities. This leaves all 14 patients having to use the showering facilities within the single assisted bathroom, which is not fully accessible.

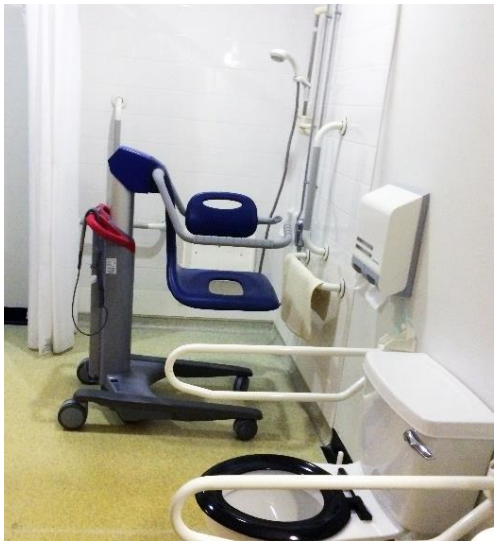
2.0 Cauldshiels

2.4 Assisted Bathrooms

There is only 1 assisted bathroom in each ward. The layout of each of these rooms impedes the use of hoists as the WC is located too close to the rise and fall bath. These rooms do not comply with the current space standards and a revision to the overall ward layout would be required to provide HBN 00-02 compliant facilities.



Lindean Assisted Bathroom



Cauldshiels Assisted Bathroom

2.5 Patient Day rooms

The two patient day rooms are very generous in size for the number of patients within the ward and exceed the provision as set out in SHPN 35. However their dispersed location and lack of proximity to staff areas can make observation difficult. These large spaces also can induce conflict between patients as there are no quiet areas within the ward or private rooms to receive visitors other than patient bedrooms.

There are no Activity or Group rooms within either ward and this has a negative impact on the therapeutic quality of the services that can be provided.

To resolve this issue a reconfiguration of the ward would require to take place.

2.0 Cauldshiels

2.6 Clinical Rooms and Service Provision

The current clinic room is of insufficient size. There is a lack of storage and no space for an examination couch. A room of 16m2 is the recommended size within HBN00-03 – Clinical and clinical support spaces, to accommodate examination couch and sufficient work surface, Controlled drugs cabinets etc. The situation is further exacerbated as Lindean shares this clinical room and controlled drugs cabinet with Cauldshiels with staff having to leave the ward to retrieve the required medicines and the potential for breaches in patient confidentiality.
A reconfiguration of both wards would include separate compliant clinical space.

2.7 Domestic Services and Storage

Domestic Services and storage space is very limited within both wards. There is limited possibility of upgrading this within the current configuration.

Domestic Service Room

2.0 Cauldshiels

2.8 Design for Dementia.

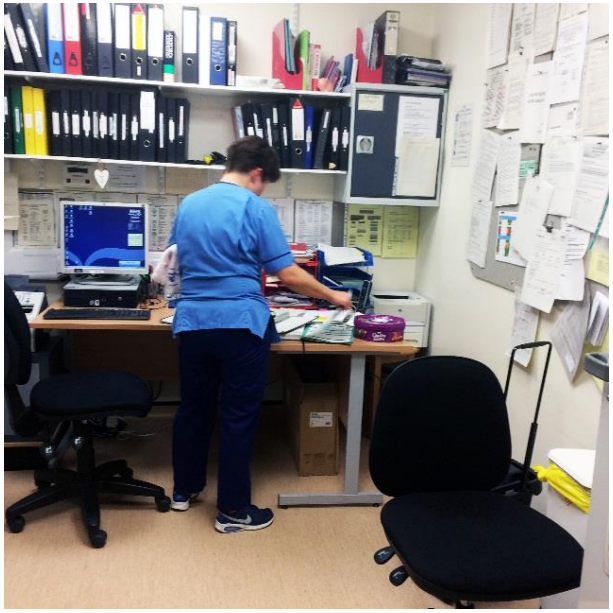
Many aspects of Dementia design are fundamentally integral to the clarity of the layout and space within a facility and cannot be tacked on as an afterthought. Complex circulation routes and lack of natural day light as well as a lack of visual links to outside make orientation and way finding difficult. The introduction of fresh finishes and specialist signage, pictures and colour contrasts should help improve the current situation and light levels can be significantly improved. It should be noted however that this only goes a small way to bring the facility up to current standards and full Dementia friendly compliance cannot be achieved without a fairly fundamental re-design of the facility.

3.1 General Layout

Lindean ward has recently been refurbished as an Elderly functional mental health ward.
Internally, doors have been upgraded to anti-barricade standards and lighting levels improved.
The decoration is fresh and in good order.

Refer to the comparison of existing area with a notional 6 bed elderly functional ward. It is clear that significant additional floor space would be required for Linden to function as an independent ward.

3.0 Lindean



Staff Office

Servery

The ward has very much been squeezed into a tight corner with several functions being borrowed from Cauldshiels, such as the clinical room and very little staff and clinical space compromising efficient provision of service. The layout and circulation are also compromised due to the proportions and nature of the existing footprint which hampers observation.

4.1 Stage 1 Essential Non Structural Works

These works are required on the basis of the Service provision continuing on the current situation of a 14 bed ward and a 6 bed ward, maintaining the status quo with regard to bedrooms/ dayrooms/ staff facilities. Actions within this stage are seen as imperative and urgent to improve the current Service provision however will not provide a solution to the physical characteristics and failings in layout and circulation of the building, alter space provision or address patient/ staff facilities.

The works identified in this stage are as follows:

1/ Upgrading of Nurse Call/ Alarm system
2/ Upgrading Door Access / Security System to swipe cards/ fobs
3/ Overhaul and replacement of lighting throughout to current standards.
4/ Full face lift of walls and floor finishes to improve visual contrast and refresh interiors.
5/ Installation of Dementia Friendly signage.

To be considered as part of this refurbishment but not currently essential:

6/ Replacement of Interior doors and ironmongery to comply with fire regulations and anti-barricade requirements.

Due to the nature of this patient group, further discussion and consideration should be given to whether carrying out refurbishment works on a rolling programme could be done without decanting of patients. It may not be possible given the serious disturbance caused and the risks posed by interaction between works and the patient group.

1/ Upgrade of Nurse Call System and personal attack alarms with possible inclusion of Telecare with integrated bed sensors. The existing panic alarms and nurse call system do not work in several areas within the building due to blind spots. Further investigation would be required to coordinate full integration of the stand alone systems and upgrade to a suitable and workable system including bed pressure pad alarms. A budget cost has been allowed in the Feasibility costs.

2/A New Secure access system would be installed to replace the current pin code access control and integrate access to staff controlled areas throughout with panic alarm fobs carried by staff.

4.0 Upgrading Works

3/ New Lighting Provision
The Lux levels recommended by the Dementia Design centre are slightly different from the EN 12464 recommendations.
Recommended lighting levels are :-

Living rooms	600lux
Bathrooms and toilets	300lux
Bedrooms	200lux
Corridors	150day/20-50night

The new lighting layout would involve an increased number of fittings as well as relocation of
several fittings which will necessitate some local remedial works to ceilings. Ceilings throughout the ward are inlay grid suspended ceilings which should alleviate the disruption of this element of the works.

4/ Redecoration to provide visual contrasts and improved wayfinding
An allowance will be made for a full re-decoration of the ward to re-fresh and re-decorate, incorporating colour defining areas and to enhance way-finding. An allowance is included for replacement of all floor finishes.

5/ Signage Review and overhaul.
New Dementia Friendly signage is proposed throughout the ward. At this stage an allowance for new signage is included as further discussion is required on wayfinding signage requirements.

6/ Replacement of internal doors with rationalisation of keys/ security strategy
Replacement of all the doors within the ward is being proposed to bring the fire resistance and separation up to current standards and to incorporate the best practice guidelines of colour contrast and designation of rooms by highlighting patient areas and reducing the visual impact of staff and non-patient areas. All doors will be colour laminate finish and a review of lock suiting to reduce the number of keys required to be carried by staff incorporated. Bedroom doors will be reconfigured to address the issue of accidental barricade from inside patient rooms.

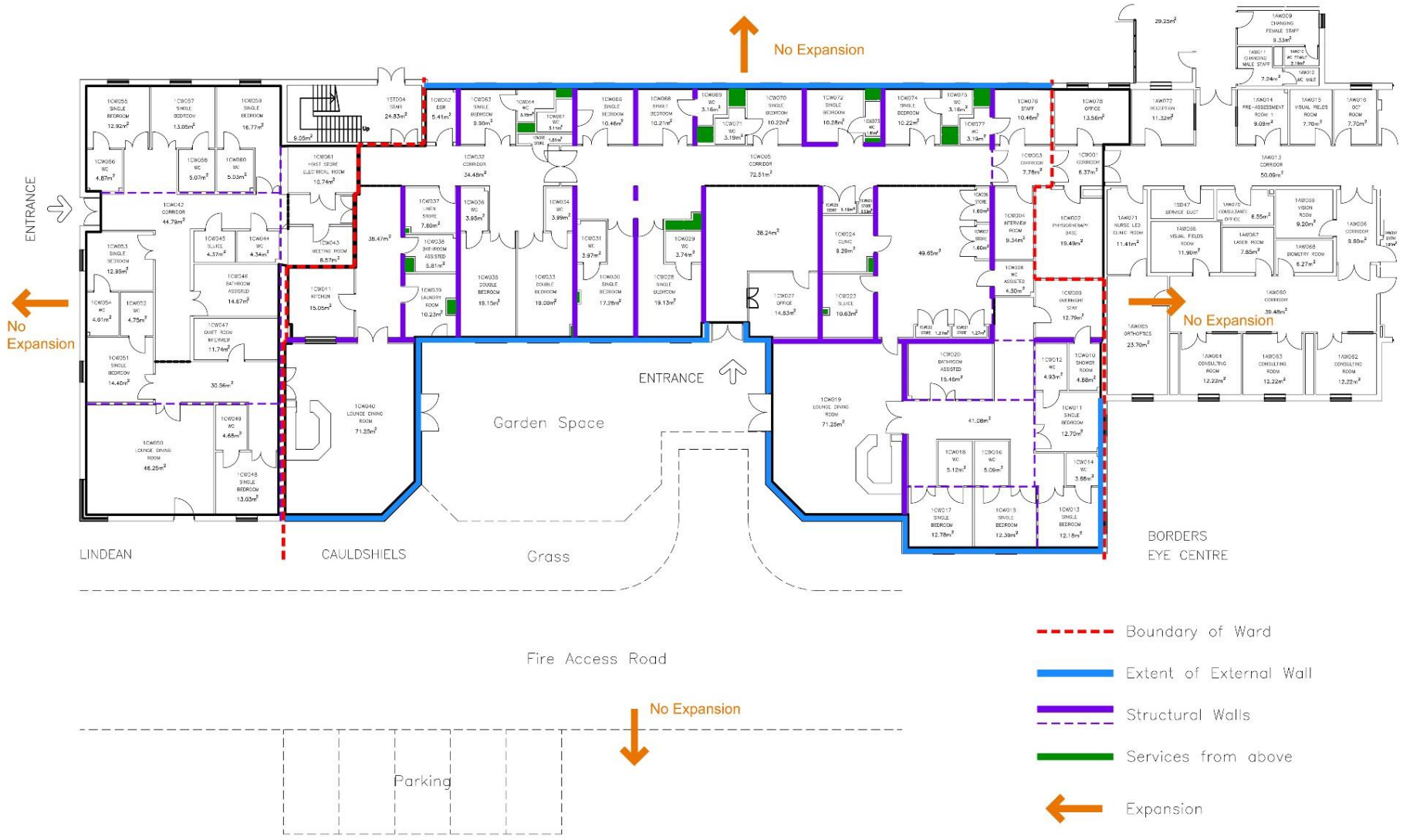
It must be stressed that these upgrades would not address many of the fundamental issues of the service provision within this facility. The purpose of stage 1 has been to identify the steps that are critical to reduce the immediate risks to staff and patients given that a solution to the longer term issues of the two wards may take a significant number of years to be resolved.

4.2 Stage 2 Reconfiguration of Service Provision

An audit of the current space provision against notional desired/ compliant wards was carried out to identify if and where space might be re-allocated to provide a compliant functioning ward. (See Appendix A)

It became apparent from early investigations that Lindean is significantly smaller in area than would be required for a fully self sufficient ward, whilst Cauldshiels appears theoretically to have sufficient floor area. However a review confirmed that the physical characteristics of the two wards and limitations caused by existing structure, services, ratio of internal floor area to external perimeter wall area and site constraints conspire to make the provision of two compliant wards within the current footprint impossible. It also became apparent that the wards are lacking space to the extent that any effort to address each of the space issues noted above resulted in further compromising a different issue or damaging an aspect of the facility that does work, such as the eastern day room or external wall provision to bedrooms. The opportunity for extension of the wards is severely restricted by the fire access road to one side and the Eye clinic and other areas of the BGH to all other boundaries.
Refer to Diagram 01

4.0 Upgrading Works



UNUM PARTNERSHIP
CHARTERED ARCHITECTS

Conclusion

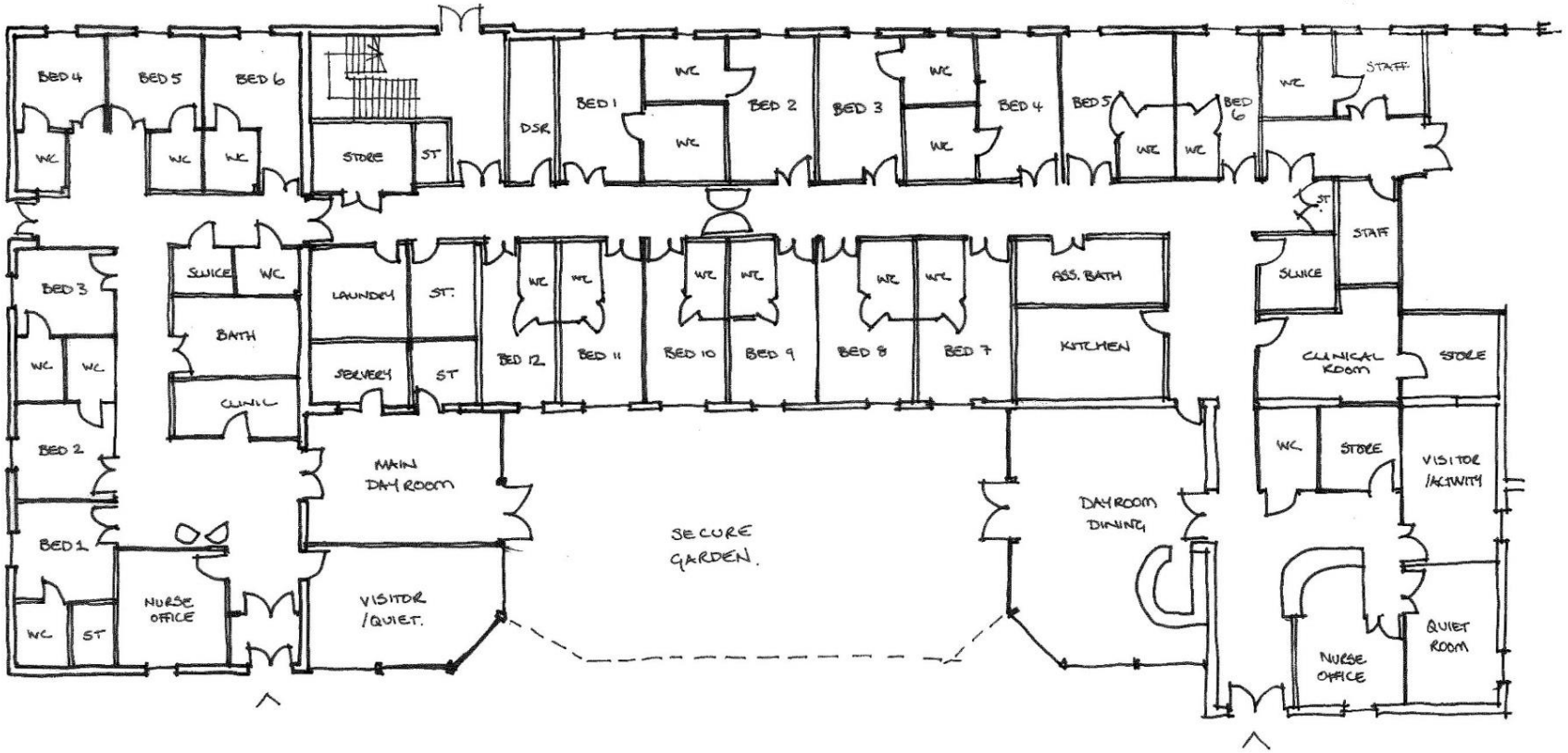
There are various options that could be considered which are listed below. Further discussions with the Finance, Estate and Clinical teams are required to determine if any of the following are worth pursuing and investigated further for their feasibility and to firm up budget costs

A/ A reduction in bedroom numbers for Cauldshiels could be considered.
See sketch option A which has 12 bedrooms. This addresses the functional arrangements of both wards and re-assigns floor area, allowing Lindean to function independently and to arrange the functional spaces in Cauldshiels in a more logical manner. It also addresses the issue of maintaining the integrity of the secure garden by moving the entrance ways. The main issues are whether a 12 bed unit would be sufficient and the major structural reconfiguration that would be required to relocate the main spine corridor. Discussion with the Mental Health Team advised that it was very unlikely a 12 bed ward would meet clinical need so this option has not been pursued further.

B/ Lindean be relocated to another part of the hospital and Cauldshiels expand into the entire space.
This option confirmed that the footprint available here would be significantly in excess of what would be required for a 14 bed ward. An improved entrance and day area can be created and significant improvement can be made to the bedroom wing and corridor. However there is significant space remaining that is surplus to requirements. There is an opportunity to create a 17-18 bed ward or to demolish a part of the existing single storey area to expand the garden space.
This option also requires major structural reconfiguration to re-align the corridor and structural spine walls, and the budget cost includes the cost or provision of Lindean ward elsewhere.

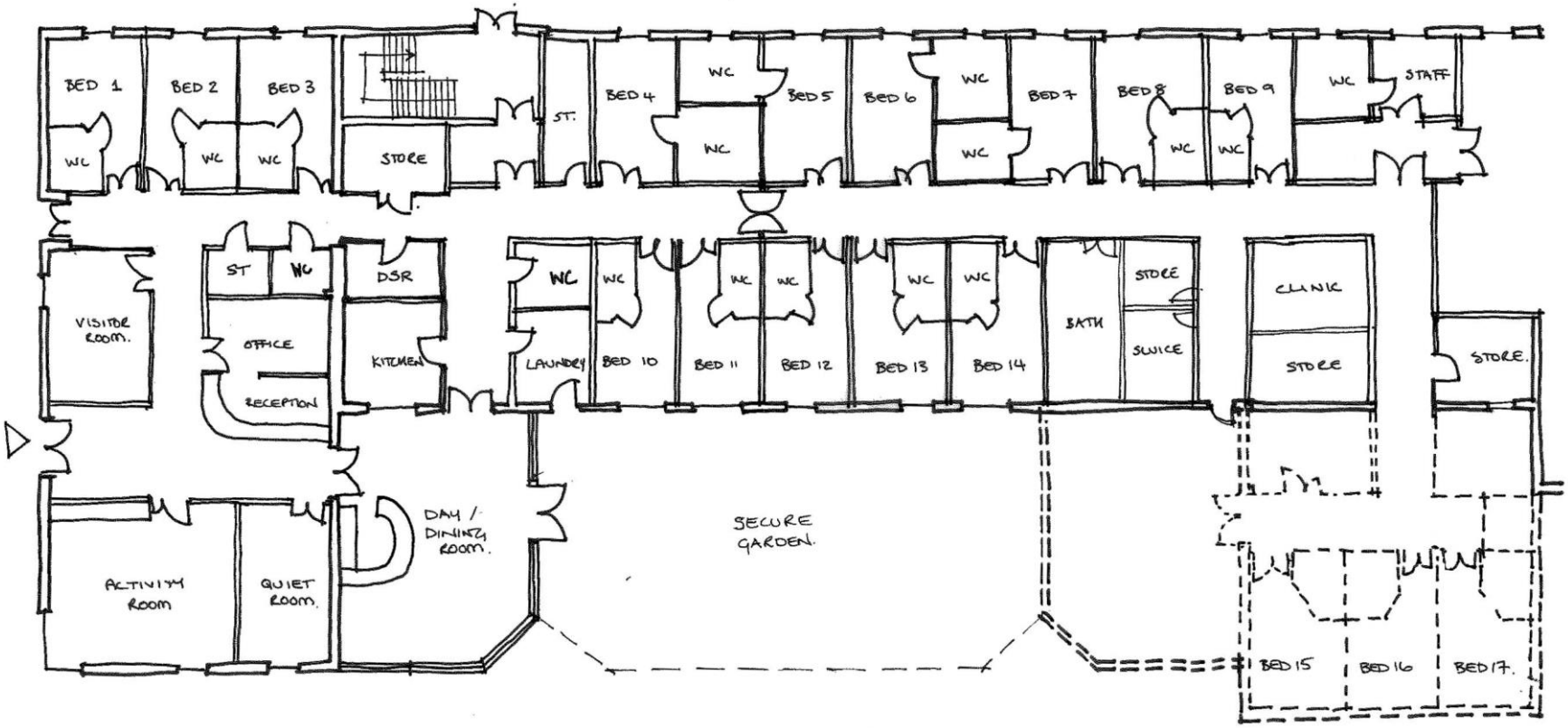
C/ Both wards be relocated elsewhere, preferably new build.

4.0 Upgrading Works



Sketch Option A
Cauldshiels 12 Bed / Lindean 6 Bed wards

4.0 Upgrading Works



Sketch Option B
Cauldshiels 14 Bed – possibly 17 bed.

5.1 Stage 1 Costs

NHS BORDERS
PROPOSED INTERNAL REFURBISHMENT
CAULDSHIELS, BORDERS GENERAL HOSPITAL

30-Jan-17

ELEMENTAL INDICATIVE COST - REFURBISHMENT

GROSS FLOOR AREA 863.00 m2

NRM ELEMENTS

	GROUP/SUB ELEMENTS	SUB ELEMENT COST	GROUP ELEMENT COST	SUB ELEMENT COST/M2	GROUP ELEMENT COST/M2	SUB ELEMENT %	GROUP ELEMENT %
0	FACILITATING WORKS						
		£0.00	£0.00	£0.00	£0.00	0.00%	0.00%
1	SUBSTRUCTURE						
		£0.00	£0.00	£0.00	£0.00	0.00%	0.00%
2	SUPERSTRUCTURE						
2.6	Windows and External Doors	£12,400.00		£14.37		3.10%	
2.8	Internal Doors	£75,650.00		£87.66		18.93%	
		£88,050.00	£88,050.00	£102.03	£102.03	22.03%	22.03%
3	INTERNAL FINISHES						
3.1	Wall finishes	£19,760.00		£22.90		4.94%	
3.2	Floor Finishes	£44,576.00		£51.65		11.15%	
		£64,336.00	£64,336.00	£74.55	£74.55	16.10%	16.10%
4	FITTINGS, FURNISHINGS AND EQUIPMENT						
4.1	General Fittings, Furnishings and Equipment	£6,000.00		£6.95		1.50%	
		£6,000.00	£6,000.00	£6.95	£6.95	1.50%	1.50%
5	SERVICES						
5.8	Electrical Installations	£105,286.00		£122.00		26.34%	
5.12	Communication, Security and Control Systems	£38,835.00		£45.00		9.72%	
5.14	Builder's Work in Connection with Services	£4,750.00		£5.50		1.19%	
		£148,871.00	£148,871.00	£172.50	£172.50	37.24%	37.24%
6	PREFABRICATED BUILDINGS AND BUILDING UNITS						
		£0.00	£0.00	£0.00	£0.00	0.00%	0.00%
7	WORK TO EXISTING BUILDING						
7.1	Minor Demolition Works and Alteration Works	£23,253.00		£26.94		5.82%	
		£23,253.00	£23,253.00	£26.94	£26.94	5.82%	5.82%
			£330,510.00		£382.98		82.69%
	Add						
	Preliminaries	12.50%	£41,313.75		£47.87		10.34%
			£371,823.75		£430.85		93.02%
	Add						
	Contingencies	7.50%	£27,886.78		£32.31		6.98%
	TO SUMMARY		£399,710.53		£463.16		100.00%

5.2 Stage 2 Costs

On the basis of recent healthcare projects carried out to completion in house at Armours Consultants, basic rates per meter have been applied to the three options to give very approximate budget costs.

Currently Ward refurbishments are achieving rates of £1200-£1400 per square meter.

New Build Hospital facilities have been costing £3000 - £3500 per square meter, not including site abnormals.

On this basis

Option A – Refurb and Reconfiguration to provide 12 bed and 6 bed units - £1.5 -£2M

Option B – Refurb to provide large 14-17 bed ward with new build 6 Bed ward - £2.8 - £3.5M

Option C – New Build 14 bed and 6 bed (not including site purchase/ abnormals - £3-£3.6M

6.0 Appendices

Cauldshields Current Schedule of Accommodation			
		Bedroom 1	19.13
		Bedroom 2	17.28
		Bedroom 3	19
		Bedroom 4	19.15
		Bedroom 5	9.9
		Bedroom 6	10.46
		Bedroom 7	10.21
		Bedroom 8	10.22
		Bedroom 9	10.28
		Bedroom 10	10.22
		Bedroom 11	12.7
		Bedroom 12	12.18
		Bedroom 13	12.39
		Bedroom 14	12.78
		Ensuite 1	3.74
		Ensuite 2	3.97
		Ensuite 3	3.99
		Ensuite 4	3.95
		Ensuite 5	3.15
		Ensuite 6	3.11
		Ensuite 7	3.16
		Ensuite 8	3.19
		Ensuite 9	1.81
		Ensuite 10	3.16
		Ensuite 11	4.93
		Ensuite 12	3.68
		Ensuite 13	5.09
		Ensuite 14	5.12
		Lounge/ Dining Room 1	71.25
		Lounge/ Dining Room 2	71.25
		Kitchen Servery	15.05
		Assisted Bathroom	15.46
		Patient WC	4.5
		Patient WC	5.81
		Clinical Room	9.29
		Office	14.63
		Staff Room	10.46
		Staff WC	3.19
		Interview Room	9.34
		Overnight Room	12.79
		Ensuite	4.88
		Sluice	10.63
		Linen Store	7.6
		DSR	5.41
		Laundry	10.23
		Stores	9.33
14 beds			**529.05**
		Planning/	
		Engineering	49.54 9.4%
		Circulation	282.21 53.3%
		Department Total	**860.8**

Notional 14 Bed Organic and Dementia Acute A&T Ward				
1	ACTIVITY ROOM	1	19.0	19.0
2	SINGLE ROOMS	14	12.5	175.0
3	Ensuite Shower Rooms	14	4.5	63.0
4	LOUNGE/ DINING ROOM	1	70.0	70.0
5	QUIET ROOM	1	16.0	16.0
6	KITCHEN / SERVERY	1	16.0	16.0
7	ASSISTED BATHROOM	1	16.0	16.0
8	Patient WC	2	6.0	12.0
9	TREATMENT ROOM	1	16.0	16.0
10	NURSES STATION	1	12.0	12.0
11	NURSING OFFICE	1	20.0	20.0
12	STAFF ROOM	1	10.0	10.0
13	STAFF WC	2	2.5	5.0
14	INTERVIEW ROOM	1	12.0	12.0
15	VISITOR/ FAMILY ROOM	1	12.0	12.0
16	VISITOR WC	1	6.0	6.0
17	DISPOSAL SLUICE	1	8.0	8.0
18	LINEN	1	8.0	8.0
19	DSR	1	8.0	8.0
20	PATIENT LAUNDRY	1	12.0	12.0
21	STORES	1	12.0	12.0
	SUB TOTAL	**14 bed**		**516.00**
	Planning/			51.6 10.0%
	Engineering			15.48 3.0%
	Circulation			206.4 40.0%
	Department Total			**789.48**

Schedule of Accommodation
Cauldshiels Comparison

6.0 Appendices

Lindean Current Schedule Of Accommodation			
		Bedroom 1	12.92
		Bedroom 2	13.05
		Bedroom 3	16.77
		Bedroom 4	12.95
		Bedroom 5	14.4
		Bedroom 6	13.03
		En-Suite 1	4.87
		En-Suite 2	5.07
		En-Suite 3	5.03
		En-Suite 4	4.61
		En-Suite 5	4.75
		En-Suite 6	4.68
		Sitting/ Dining Area	46.25
		(incl servery)	
		Assisted Bathroom	14.67
		WC	4.34
		Disposal Sluice	4.37
		Office	11.74
		Staff room/ Visitor Room	8.57
		Store	10.74
			212.81
		Planning/	
		Engineering	13.54
		Circulation	75.35
		Department Total	**301.7**

Notional 6 Bed Elderly Functional MH Ward				
6 Bed				
1	ACTIVITY ROOM	1	15.0	15.0
2	SINGLE ROOMS	6	12.5	75.0
3	WCS (ENSUITE)	6	4.0	24.0
4	DAY ROOM/ DINING	1	45.0	45.0
5	SERVERY	1	12.0	12.0
6	QUIET ROOM	1	12.0	12.0
7	ASSISTED BATHROOM	1	16.0	16.0
8	WC	1	6.0	6.0
9	TREATMENT ROOM	1	14.0	14.0
10	VISITOR ROOM	1	12.0	12.0
11	NURSING OFFICE	1	16.0	16.0
12	STAFF	1	8.0	8.0
13	STORE	1	10.0	10.0
14	DSR	1	8.0	8.0
15	LINEN ROOM	1	6.0	6.0
	DISPOSAL STORE	1	6.0	6.0
	SUB TOTAL	**6 Bed**		**285.00**
	Planning		28.5	10.0%
	Engineering		8.55	3.0%
	Circulation		99.75	35.0%
	Department Total		**421.8**	

Schedule of Accommodation
Lindean Comparison

This page is intentionally left blank

Project Reference	

FIP Project Mandate NHS BORDERS

ACCOUNTABILITY

Workstream	Productivity & Efficiency
Business Group	Mental Health
Executive Lead	Nicky Berry
Responsible Officer (Project Lead)	Simon Burt
Project Support (PMO)	Holly Hamilton-Glover
Finance Manager	Viv Buchan
Clinical Lead	Lucy Calvert
Workforce Lead	

Business Group	**£000s**	**WTE**	**COST CENTRE**	**SUBJECTIVE**	**£000s**
Mental Health (Cauldshiels)	**55**	**1.6**	BO1370	71D5	
	70	**2.71**	BO1370	71D5	
	175	**6.78**	BO1370	71D5	
	180		BO3170	various	

		£000s
Date Updated	11/06/2019	**BAU**
Updated By	**HHG**	**Cost Savings Plan**
		Turnaround Programme	**480**

		Capital £k	**Revenue £k**
Proposed Start date (Implementation)	01/05/2019	**Investment Required (if any)**		**623**
Proposed Completion date	01/01/2020	**Steering Group Approval**	

SCHEME DETAIL

Scheme Title

Specialist Dementia Hospital redesign

Project Narrative

Project Details
Project Scope
Any Connecting Departments
What will change?

Background

The Scottish Government report "Transforming Specialist Hospital Dementia Care", June 2018, sets out the recommendations from an independent review of the sector commissioned by The Scottish Government, and makes recommendations on the modernisation of specialist NHS dementia care. The recommendations are wide ranging but essentially include;

1. Creating a modern specialist dementia inpatient unit that will provide a centre of excellence to treat the small number of people with dementia who have a clinical need to be in hospital.
2. Develop a transition plan and a local engagement strategy with partners, including the NHS, Local Authority and people living with dementia, for any necessary de-commissioning process and re-investment in specialist dementia units and to develop any further community capacity in health and social care services.

Current Demand analysis

Cauldshiels:

The combined beds across Cauldshiels Ward (assessment ward) and Melburn Ward (Treatment Ward) total 26 (14 Cauldshiels and 12 Melburn).

DOCA completed for the 3 Mental Health Older Adult inpatient wards (including the functional illness ward, Lindean - 6 patients) on 15th November 2018. This audit found that overall 62% of patients were identified as Delayed Discharges (21 patients out of a bed total of 32). Of these 3 were identified as requiring "specialist Nursing Home" and 6 to a "Nursing Home". 5 patients were suitable for discharge home and 4 discharges to a suitable residential or extra care housing facility and 3 were awaiting Guardianship/other legal processes to be followed.

Project Benefits

How will the benefits be realised
Where will benefits be realised
Financial & Non Financial

The benefits will be realised by reducing the number of inpatient Dementia beds from the current 26 to 12 by January 2020. This will result in Cauldshiels ward closing and the function being transferred to Melburn ward. Melburn ward would become a specialist inpatient ward delivering both assessment and treatment to patients.

The enhanced provision of community resources and expertise will be funded by the disinvestment on Cauldshiels ward and the reinvestment in the community. An estimate reinvestment for the transition of previous inpatients into the community is £1,000 per patient (* Transforming Specialist Dementia Hospital Care report). Based upon the total reduction of 14 beds this would equate to £720,000 of the current £1,100,000 running costs for Cauldshiels ward. The investment will be required for:

CHAT – Providing permanent funding replacing the 2 years temporary funding from the ICF (50%). The remaining 50% funding has been identified from the re allocation of existing resources – Re investment £240,000

5 x additional specialist care home beds – Re investment £ 338,000 (based upon £1,300pw bed price)

1 x additional social worker – Re investment £45,000

Final Steps to Consolidate Benefits and deliver financial improvements

Cease new admissions to Cauldshiels
Undertaken implementation plan
Confirm community services operational

Risk Assessment

Y	**Required? Y/N** yes	**If No provide reason**			
Y	**Completed**		**Fully Authorised**	**Max Risk**	**8**

Any other Potential Risks / Impacts

Using Risk Assessment Template

KEY PROJECT STAGES (shade)

	A	M	J	J	A	S	O	N	D	J	F	M	A
Project Initiation & Planning													
Project Development													
Project Implementation													
Project Control													
Project Closure													

FORECAST BENEFITS

		A	M	J	J	A	S	O	N	D	J	F	M	Total
000s	***2019-20***			11	11	11	*25*	*25*	*25*	*25*	*40*	*40*	*40*	*252*
000s	***2020-21***	40	40	40	40	40	40	40	40	40	40	40	40	*479*
		A	M	J	J	A	S	O	N	D	J	F	M	**Ave.Total**
WTEs	***2019-20***			4.31	4.31	4.31	4.31	11.00	11.00	11.00	11.00	11.00	11.00	*6.94*
WTEs	***2020-21***	11.00	11.00	11.00	11.00	11.00	11.00	11.00	11.00	11.00	11.00	11.00	11.00	*11.00*

Benefit £K	%
Pay	**100**
Non Pay	
Income	

Scot Gov Analysis £	£000s
Service Redesign	**480**
Workforce	
Procurement	
Infrastructure	
Other	
Financial Manage/ Corp	
Drugs & Prescribing	

Mandatory Completion

Scheme Type	**Recurring £K**	**Non Rec £K**
FIP	480.00	
Cost Containment		

PROJECT MANDATE APPROVAL

APPROVED BY FINANCE MANAGER:	**DATE:**
APPROVED BY EXECUTIVE DIRECTOR:	**DATE:**
APPROVED BY PMO MANAGER:	**DATE:**

This page is intentionally left blank

Prepared by:
Phillip Lunts/Holly Hamilton-Glover/Bill Urquhart

Sponsored by:
Phillip Lunts

Date: July 2019

Cauldshiels and Melburn Lodge Bed and Capacity Model
Summary of findings

Summary

An Alzheimer Scotland and Scottish Government national report identified that too many people with dementia were being cared for in hospital beds and recommended reduction of inpatient beds and development of alternatives. NHS Borders currently has

- Cauldshiels Dementia Assessment Unit – 14 beds
- Melburn Lodge Dementia continuing care facility – 12 beds

The national report recommended NHS Borders should have 15 beds.

A project to develop alternative models of care has been established and is based on:

1. Establishment of a support team for Community Hospitals and Care Homes (CHAT team)
2. Provision of 5 additional specialist dementia beds

A modelling exercise was commissioned to assess the impact of these changes on numbers of inpatient beds required and the resource requirements for the alternative services.

The outputs of the modelling exercise indicate the following;

- The current admissions and discharges are in balance
- Demand for beds since January 2019 has reduced to a steady requirement of 14-16 beds
- The impact of CHAT team will reduce this requirement by 5.6 beds
- The additional specialist dementia care home beds will reduce this requirement by 5 beds
- Therefore, residual inpatients beds required are 5 beds

Methodology

The model has been developed based on the following:

1. Review of Cauldshiels and Melburn Lodge activity data for the last 3 years. During this period, the services moved from capturing data on EPEX to TrakCare. Most analysis was carried out on EPEX dataset as it was the largest data run (2 years). A sample analysis of TrakCare data showed similar activity data to the EPEX data, so confirmed this approach was valid. Data on Delayed Discharges was taken from TrakCare as EPEX did not record this data in a robust manner.

2. Development of a predictor model for future bed requirements. The model was based on activity and percentage split of admissions and discharges by source and allows these numbers to be adjusted according to predicted future admission levels and length of stay. Assumptions on the impact of the proposed new service model were provided by Dr Lucy Calvert, Consultant Psychiatrist for Older People and Irene Thomson, Service Manager and reviewed by Peter Lerpiniere, Associate Director of Nursing, Lisa Clark, Clinical Nurse Manager and Christine Proudfoot, Dementia Nurse Consultant.

3. Development of predicted resource requirements for alternative care models. Only limited work on this aspect of model has been undertaken, based on advice from clinicians and managers. Further work can be carried out once the output of the current model has been reviewed.

Analysis

Detailed data tables are attached as appendices. The bed model based on current assumptions is also included.

The summary of findings is as follows:

Review of Cauldshiels and Melburn Lodge activity data for the last 3 years.

1. The current system is in balance:
   - Numbers of patients within Cauldshiels and Melburn Lodge have been relatively stable over the past 3 years (up to January 2019), with an average of 11 patients in Cauldshiels and 10 in Melburn Lodge
   - The average occupancy in Cauldshiels is around 80%, indicating that there is not a waiting list of patients for Cauldshiels (otherwise occupancy would be closer to 100%)
   - The average admissions to Cauldshiels are 4 per month. Discharges are also 4 per month
   - There is some flow between Cauldshiels and Lindean (Elderly Functionally Mentally Ill facility) representing overflow when the ward is full. However, the clinical view was that there was similar overflow from Lindean to Cauldshiels and these two cancelled each other out
   - There is a predicted increase in demand, based on demographic data adjusted for age and sex, of 1 additional admission per year each year until 2022.

2. There has been a reduction of around 8 patients across Cauldshiels and Melburn Lodge since January 2019. (Average 23 beds (previous 3 years) falling to approximately 15 beds to date (14 on 19th July)). Professional advice indicates that this is related to the purchase of 7 Specialist Dementia beds opening in Dec 2018/Jan 2019 and some improvements in social care and social work support. Given that the data suggests a steady state, this occupancy is unlikely to change (i.e. increase) unless there are system changes.

3. Admissions to Cauldshiels split into three groups
   - Approximately 40% from home – (27% direct, 12% BGH (BGH admissions are assumed to be 50% home and 50% care home))
   - 40% from care/nursing homes (including above assumptions around source of BGH admissions)
   - Remainder from other sources
   - All Melburn Lodge admissions come from Cauldshiels

4. Current discharge pattern is
   - 50% discharged to care homes
   - 7% discharged home
   - 11% died
   - 16% transferred to Melburn Lodge

5. The split between types of care homes is difficult to calculate but estimated to be;
   - 74% to ‘specialist’ dementia homes (this includes Knowe South, Riverside etc)
   - 24% to care homes

6. 50% of patients in Cauldshiels stayed for less than 60 days and 66% for less than 90 days. Melburn length of stay is not reliably calculable due to the small numbers and very long lengths of stay.

Development of a predictor model for future bed requirements

1. The CHAT team is assumed to achieve the following;
    a. No impact on admissions from home
    b. Reducing admissions from care and nursing homes by 50%
    c. Reducing admissions for physical presentations at BGH (e.g. fractured NOF) by 50% due to improved support and education within care homes
    d. Reducing length of stay for patient discharged to care homes by 20%
    e. Reducing occupied beddays for patients who die by 50% (better support for care homes would reduce admissions of patients in terminal stages by 50%)

There would also be a 50% reduction in length of wait for Melburn Lodge beds because the two units will be combined (assumes 50% of wait was delay to access Melburn bed).

2. Modelling indicates that, based on these assumptions, the CHAT team will reduce demand for hospital beds by 2059 occupied beddays (OBDs) or the equivalent of 5.6 beds (1318 OBDs/ 3.6 beds through admission avoidance and 741 OBDs/2 beds through reduced length of stay)
3. There has been no modelling of the potential impact of the team on the level of care home required. However, professional judgement indicates that more patients could be supported in non-specialist care and nursing homes and even in residential homes.

Development of predicted resource requirements for alternative care models

1. Modelling of demand and capacity required for the new CHAT team has not been undertaken as yet. As the team has not yet commenced, the level of resource required is not fully known. At the moment, the CHAT team establishment is based on professional judgement regarding the level of staffing required to maintain a sustainable locality based model.

2. A separate modelling exercise has been undertaken to determine the demand and turnover within specialist dementia care home beds. Further work is required to firm up assumptions around likely numbers of patients requiring specialist dementia beds.

Bed Modelling summary

The bed model as outlined above indicates the following:

		Total expected bed requirements in Melburn Lodge
Average occupancy Cauldshiels/Melburn Lodge to Jan 2019	*21 patients*	*21 beds*
Murray House beds open Jan 2019	*7 patients*	*14 beds*
CHAT team	5.6 patients	9 beds
Additional specialist dementia beds to be opened	5 patients	4 beds

Appendices

- Admissions / Discharges
- Length of stay
- OBD 2017-18
- Age/Sex Mix and Population projections
- Pathways

Time period: Admissions between January 2015 to March 2018 (39 months)

Admissions / Discharges

Cauldshiels

Source of admission	BGH	BGH A&E	Care Home	Community Hospital	Home	Huntlyburn	Lindean	Melburn Lodge	Nursing Home	Grand Total
% of Admissions	20	5	16	5	27	3	11	3	10	100
Total admissions	30	7	24	8	40	4	16	5	15	149
Average per month	0.77	0.18	0.62	0.21	1.03	0.10	0.41	0.13	0.38	3.82
Min-Max	0-2	0-2	0-5	0-1	0-4	0-3	0-2	0-2	0-3	0-9

Melburn Lodge

Source of admission	Cauldshiels	Lindean	Nursing Home	Grand Total
% of Admissions	93	4	4	100
Total admissions	**25**	**1**	**1**	**27**
Average per month	0.64	0.03	0.03	0.69
Min-Max	0-4	0-1	0-1	0-5

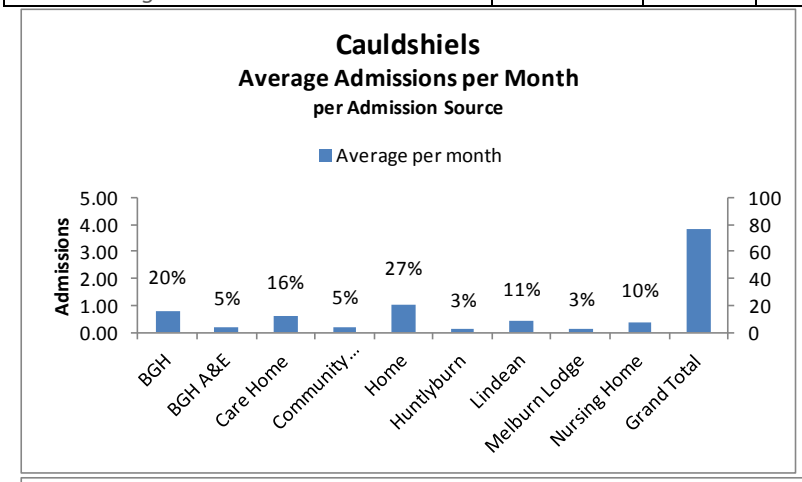
Discharge Destinations

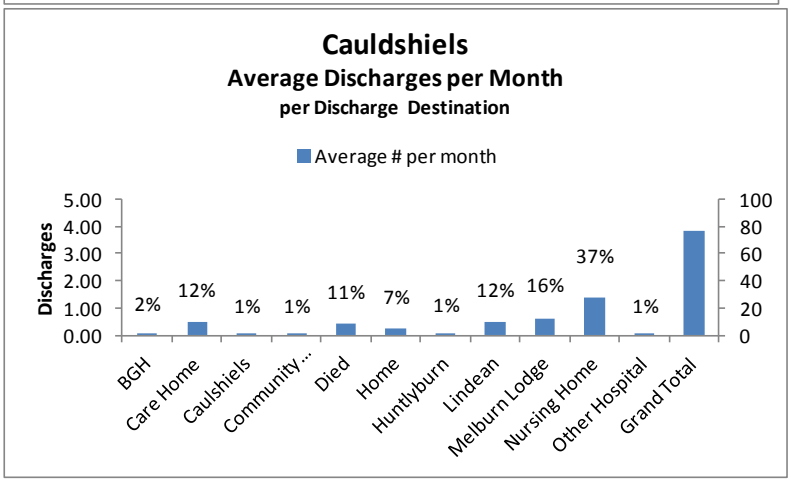
Destination	**Patients**	**%**	**Average per month**
BGH	3	2	0.08
Care Home	18	12	0.46
Cauldshiels	1	1	0.03
Community Hospital	1	1	0.03
Died	16	11	0.41
Home	10	7	0.26
Huntlyburn	2	1	0.05
Lindean	18	12	0.46
Melburn Lodge	24	16	0.62
Nursing Home	55	37	1.41
Other Hospital	1	1	0.03
Grand Total	**149**		3.82

Melburn Lodge Discharge Destinations

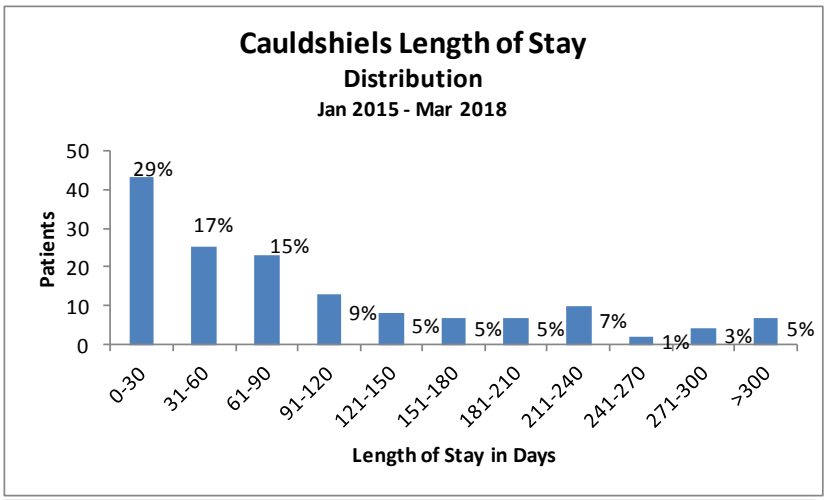
Destination	**Patients**	**%**	**Average per month**
Care Home	7	28	0.18
Cauldshiels	3	12	0.08
Died	11	44	0.28
Home	1	4	0.03
Lindean	2	8	0.05
Nursing Home	1	4	0.03

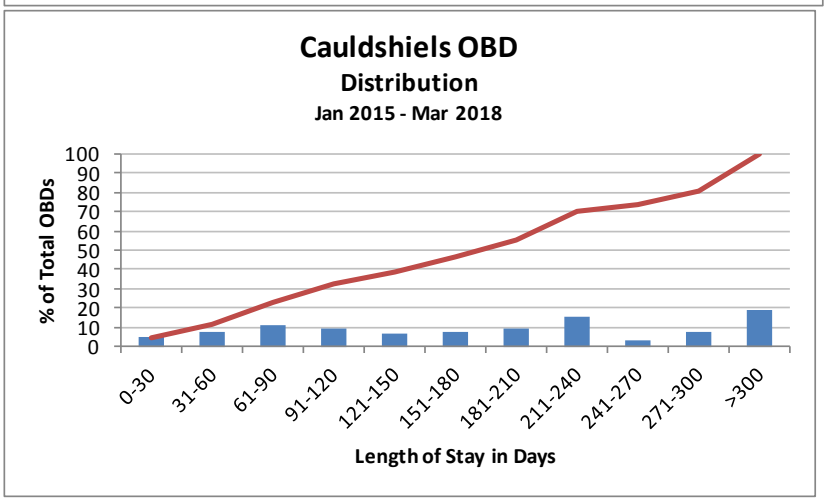
Grand Total	**25**		0.64
Not discharged Yet	*2*		





Length of Stay



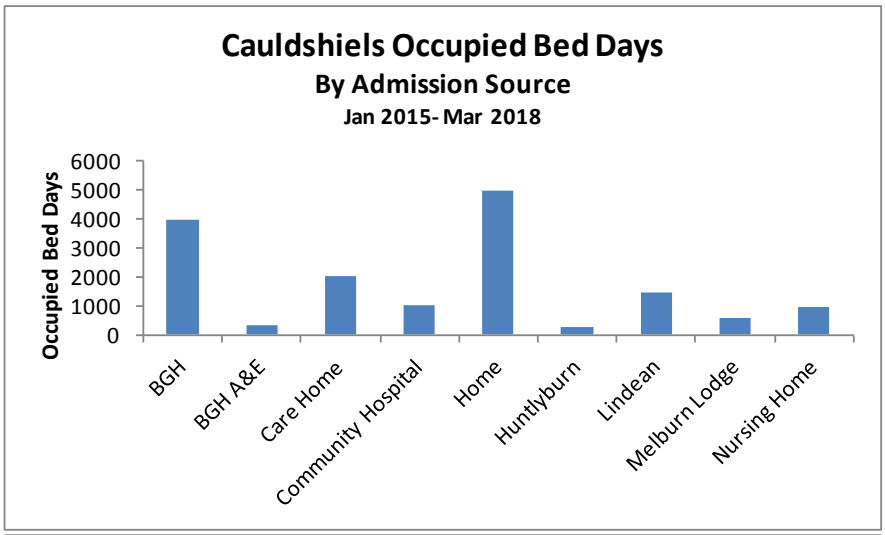


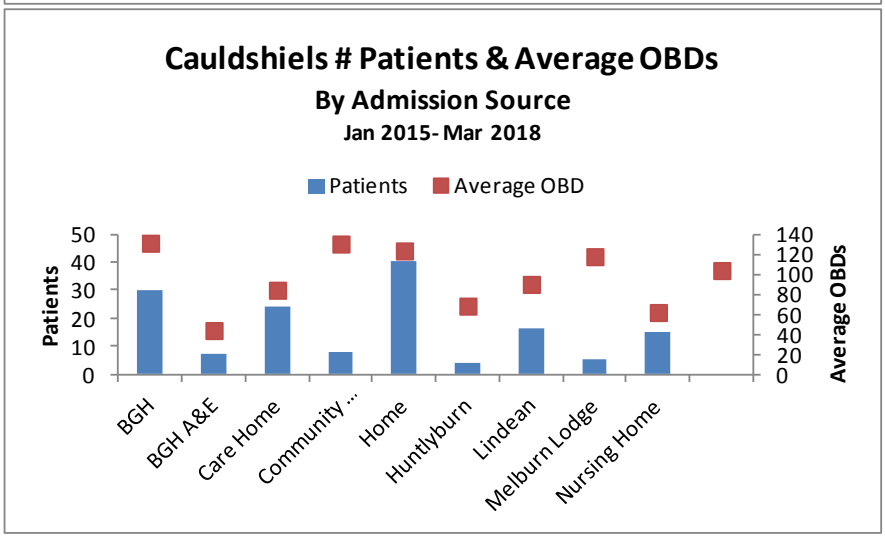
Cauldshiels Total Length of Stay by Admission Source (All 2015-2018 admissions)

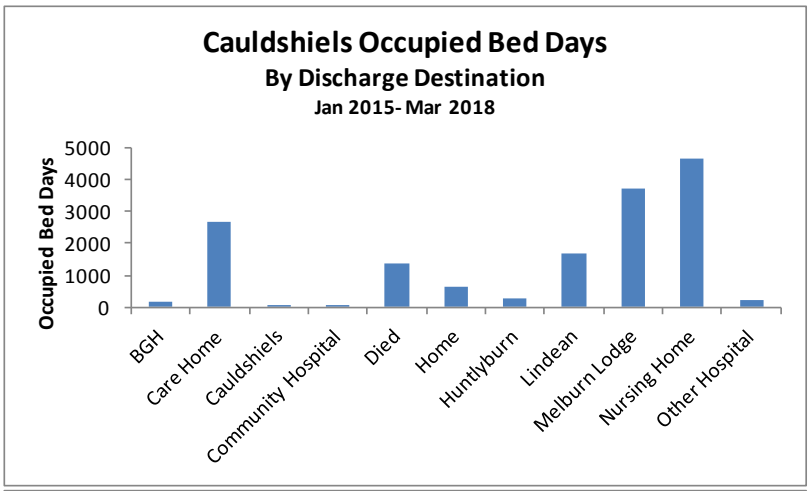
LoS by Admission Group	Patients	OBDs	Average LoS
BGH	30	3931	131
BGH A&E	7	307	44
Care Home	24	2019	84
Community Hospital	8	1042	130
Home	40	4934	123
Huntlyburn	4	273	68
Lindean	16	1439	90
Melburn Lodge	5	588	118
Nursing Home	15	928	62
Grand Total	149	15461	104

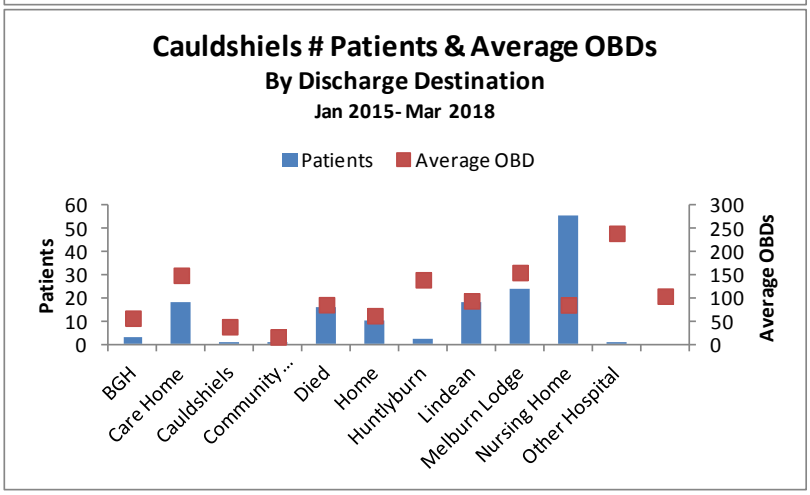
Cauldshiels Total Length of Stay by Discharge Destination (All 2015-2018 admissions)

LoS by Discharge Group	Patients	OBDs	Average LoS
BGH	3	169	56
Care Home	18	2676	149
Cauldshiels	1	38	38
Community Hospital	1	16	16
Died	16	1366	85
Home	10	617	62
Huntlyburn	2	278	139
Lindean	18	1686	94
Melburn Lodge	24	3710	155
Nursing Home	55	4666	85
Other Hospital	1	239	239
Grand Total	149	15461	104

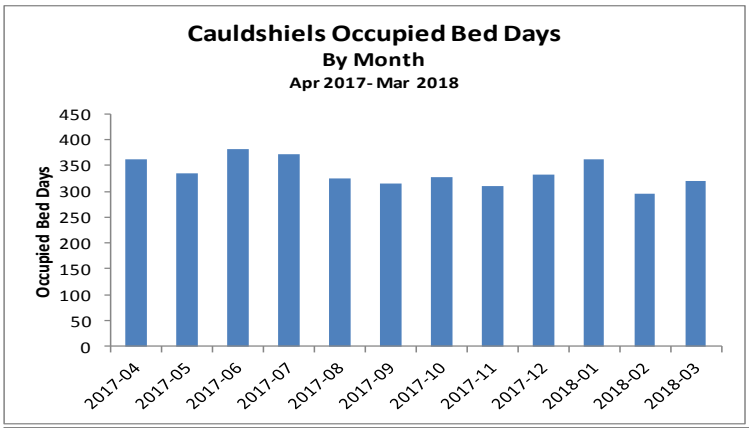


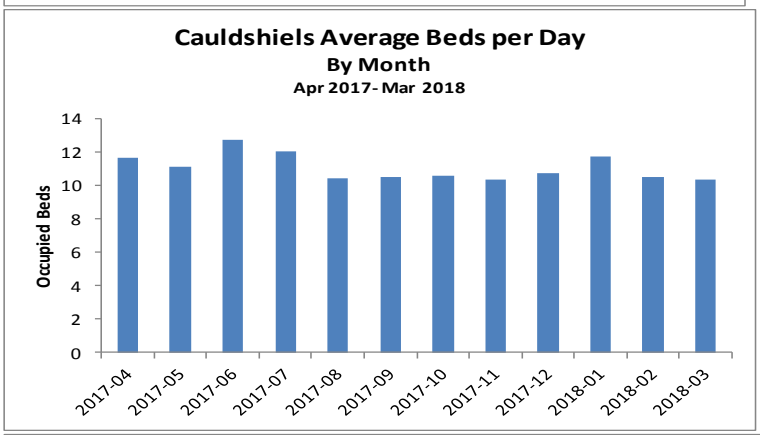


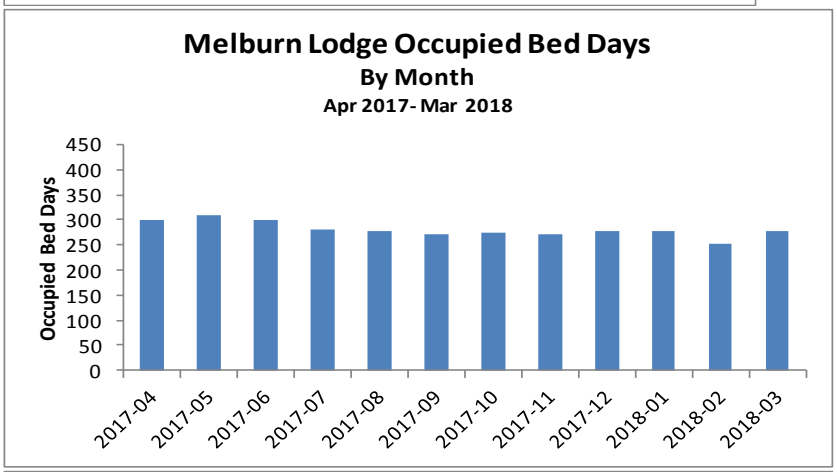


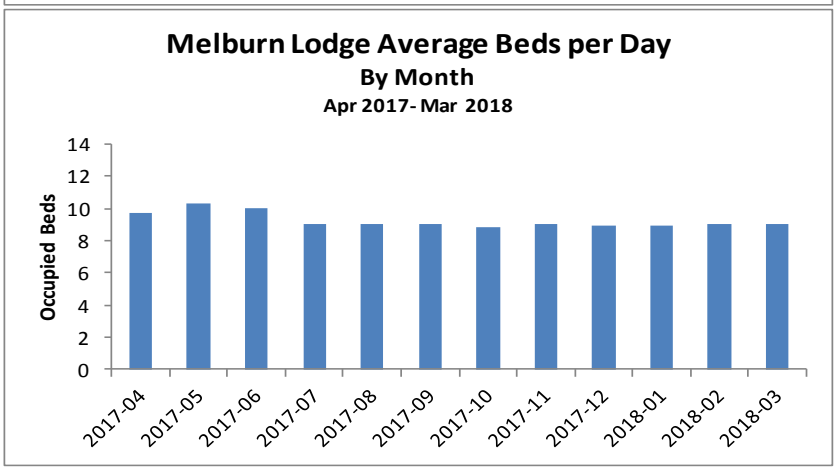


OBD 2017-18
Actual beds Occupied during each month









Age/Sex Mix and Population projections

Cauldshiels Age Group / LoS

LoS / Age Group	0-30	31-60	61-90	91-120	121-150	151-180	181-210	211-240	241-270	271-300	>300	Grand Total
Under 65	3	2			1		1	1			1	9
65-74	5	2	3	3	2	1		2		1	4	23
75-84	25	14	12	8	1	4	5	3	1	2	2	77
85+	10	7	8	2	4	2	1	4	1	1		40
Grand Total	**43**	**25**	**23**	**13**	**8**	**7**	**7**	**10**	**2**	**4**	**7**	**149**

Cauldshiels Age Group / LoS

LoS / Age Group	0-30	31-60	61-90	91-120	121-150	151-180	181-210	211-240	241-270	271-300	>300	Grand Total
Female	25	14	11	4	4	5	4	3	0	0	1	71
Female Under 65	3	1					1	1			1	7
Female 65-74	3	1			1							5
Female 75-84	12	9	7	3	1	3	2	1				38
Female 85+	7	3	4	1	2	2	1	1				21
Male	18	11	12	9	4	2	3	7	2	4	6	78
Male Under 65		1			1							2
Male 65-74	2	1	3	3	1	1		2		1	4	18
Male 75-84	13	5	5	5		1	3	2	1	2	2	39
Male 85+	3	4	4	1	2			3	1	1		19
Grand Total	43	25	23	13	8	7	7	10	2	4	7	149

Population Projections (based on Age / Gender Mix)

Patients Admitted

	Population 2017	Population 2018	Population 2019	Population 2020	Population 2021	Population 2030	Population 2040
All Patients Admitted 2015-18	149	152	155	158	162	202	243
%increase on 2017	0	2	4	6	8	35	63
Average per year	46	47	48	49	50	62	75

Projected Average Beds per day

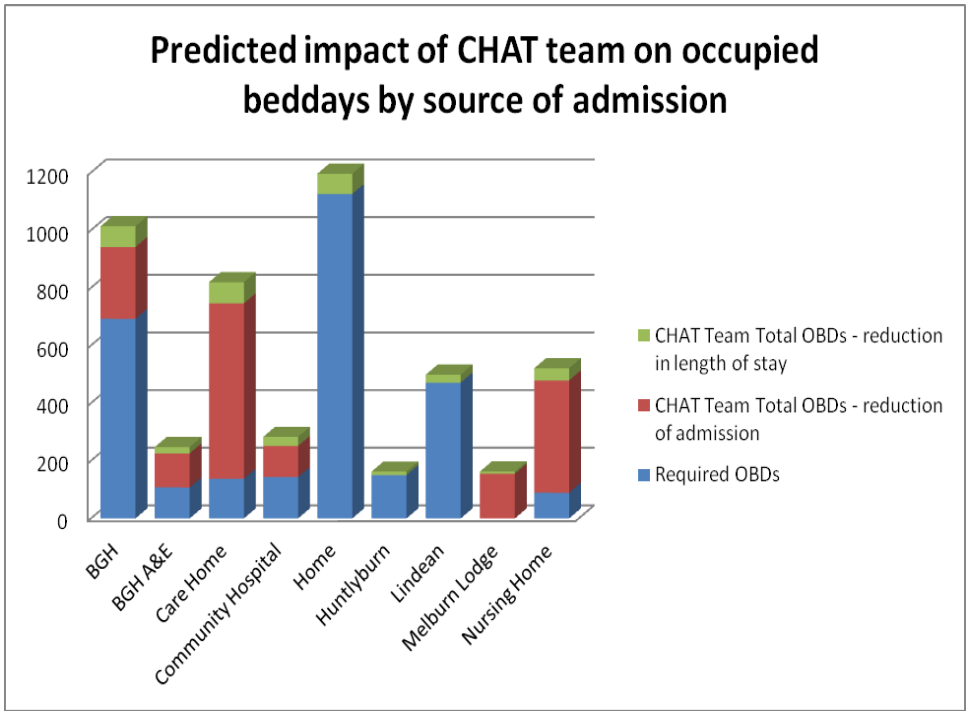
	Population 2017	Population 2018	Population 2019	Population 2020	Population 2021	Population 2030	Population 2040
2017/18 OBD	4039	4115	4202	4273	4365	5403	6413
%increase on 2017	0	2	4	6	8	34	59
Beds per day	11	11	12	12	12	15	18

Pathways

Cauldshiels Top 13 Pathways by %

Source	Destination	%
Home	Nursing Home	11
Care Home	Nursing Home	7
BGH	Care Home	5
BGH	Died	5
BGH	Nursing Home	5
Home	Lindean	5
Nursing Home	Nursing Home	5
BGH	Melburn Lodge	3
Care Home	Melburn Lodge	3
Home	Home	3
Home	Melburn Lodge	3
Lindean	Lindean	3
Lindean	Nursing Home	3
		61%

Impact of Community Hospital and Care Home Team on occupied beddays (predicted)



9th August 2019 EMT Paper Dementia Services Redesign, Supporting Information

Breakdown of Investments and Savings

A net saving of £474,202 will be realised, in summary;

Total Budget for Cauldshiels ward	£1,102,455
Investment already in place (existing staff to be redeployed)	£210,426
Total Funding	**£1,312,881**
Total estimated costs for New Care Home and Community Assessment Team (inclusive of 1 FTE Social Work post)	£500,679
Total Costs of New Provision	**£500,679**
Contingency (previously identified for 5 specialist beds)	**£338,000**
Total saving	**£474,202**

This can be broken down further;

Cauldshields Savings		**Recurring**	**Recurring (Excl MHOAT)**
Total Budget for Cauldshields Ward		1,102,455	1,102,455
Total Budget for MHOAT staff		210,426	
Total Funding		1,312,881	1,102,455
Total estimated investment			
Staffing	476,679		266,253
Travel	24,000		24,000
		500,679	0
Total Cost of new provision		500,679	290,253
Contingency	338,000	338,000	338,000
Total Saving		**474,202**	**474,202**

The posts that will be transferring from the existing MHOAT are as follows;

0.2 WTE Team Manager – provided through current MHOAS management time (£11,510)
2 WTE B6 Nurses – these currently exist and within MHOAS costs (£92,928)
2 WTE B5 Nurses – vacant posts held within MHOAS (£63,492)
2.26 WTE B3 Nurses – vacant posts held within MHOAS (£42,496)

This accounts for the £210,426.

The additional staffing can be broken down as follows;

		Existing	New	Additional
The posts that MH were going to meet for the COT project are:				
0.20 WTE Team Manager - which will be provided through the current MHOAS management time		11,510	11,510	0
2.00 WTE Band 6 Nurses – these currently exist and I believe they are within the MHOAS cost centre		92,928	92,928	0
2.00 WTE Band 5 Nurses – these are the vacant B5 posts that had been getting held within MHOAS		63,492	126,984	63,492
2.26 WTE Band 3 Nurses – these are the vacant B3 posts that had been getting held within MHOAS		42,496	97,692	55,196
		210,426	329,114	118,688
Social Worker	1.00			45,000
Indirect staffing				
Medical	0.20			24,394
Psychology	1.00			58,205
AHP	0.50			19,966
				102,565
TOTAL ADDITIONAL ESTIMATED COSTS				266,253

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 14 August 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Jill Stacey, SBIJB Chief Internal Auditor (Scottish Borders Council's Chief Officer Audit & Risk)
Telephone	01835 825036

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD STRATEGIC RISK REGISTER UPDATE

Purpose of Report:	The purpose of this report is to provide Members of the Board with an update of the most recent review of the IJB Strategic Risk Register as it is important that the Board is kept informed of the IJB's key risks and the actions undertaken to manage these risks.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: (a) Consider the IJB Strategic Risk Register to ensure it covers the key risks of the IJB; (b) Note the progress in managing one of the risks to reduce its rating from Red to Amber; and (b) Note that a further risk update will be provided in December 2019.

Personnel:	In line with their roles and responsibilities the IJB's Chief Officer and Chief Finance Officer have carried out the current review of the IJB Strategic Risk Register during late July 2019, supported by SBC's risk management service.

Carers:	There are no direct carers' impacts arising from the report.

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

Financial:	There are no direct financial implications arising from the proposals in this report.

Legal:	Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.

Risk Implications:	Risk Management arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems in line with its agreed Risk Management Strategy within its governance arrangements.

Background

2.1 The IJB, as strategic commissioner of health and social care services, gives directions to NHS Borders and Scottish Borders Council for delivery of the services in line with the Strategic Plan. The Scheme of Integration sets out how the managerial arrangements across the integrated arrangements flow back to the IJB and the Chief Officer. These arrangements are further supported by the IJB's Local Code of Corporate Governance.

2.2 Compliance with the principles of good governance requires the IJB to adopt a coherent approach to the management of risks that it faces in the achievement of its strategic objectives. A Risk Management Strategy was approved by the IJB on 7 March 2016 which includes the: reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities; and monitoring risk management activity and performance.

2.3 The Internal Audit Annual Assurance Reports for the Scottish Borders Health and Social Care Integration Joint Board 2016/17 and 2017/18 highlighted that Risk Management is not yet fully embedded into the culture of the IJB, the strategic risk register was prepared in 2016 but never finalised, and documentary evidence of risk deliberations in decision making requires improvement. In order to significantly improve the risk management process and fulfil its Risk Management Strategy by identifying, evaluating, managing and monitoring key risks and mitigations, Internal Audit made the following recommendations "The IJB strategic risk register should be finalised. Ensure IJB strategic risks are considered and reviewed regularly at IJB meetings. Risk management deliberations associated with IJB decision making should be clearly documented".

2.4 On the recommendation by the IJB Audit Committee (17 December 2018), the IJB Strategic Risk Register was approved by the full Board on 28 January 2019 with agreement that it reviews the IJB Strategic Risk Register on a six monthly basis i.e. June and December each year.

2.5 The Internal Audit Annual Assurance Report for the Scottish Borders Health and Social Care Integration Joint Board 2018/19 highlighted that progress had been made in finalising the IJB Strategic Risk Register though further improvement was required to fully embed the process. The Internal Audit recommendation is "Ensure IJB strategic risks are considered and reviewed regularly at IJB meetings".

Summary

3.1 It is important that the IJB has its own robust risk management arrangements in place because if objectives are defined without taking the risks into consideration, the chances are that direction will be lost should any of these risks materialise. Furthermore the ability to manage risk will help the Board act more confidently on future business decisions. Knowledge of the risks they face will give them various options on how to deal with potential problems.

3.2 The current review of the IJB Strategic Risk Register has taken place during late July 2019, and was supported by SBC's risk management service. The review was undertaken by the IJB's Chief Officer and Chief Finance Officer in line with their roles and responsibilities.

3.3 A high level summary of the IJB's Strategic Risk Register, which sets out the key risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan, is shown in **Appendix 1**. There are currently 10 risks on the IJB Strategic Risk Register; two Red and eight Amber rated risks. Risk IJB006 current risk score was reduced from Red to Amber during the recent risk review after reassessing the likelihood of the risk materialising and the impact due to progress with the workforce development plan which was highlighted as having had a positive effect on controlling this risk.

3.4 This report and the IJB Strategic Risk Register are intended to provide the Board with assurance that risks are being effectively managed and monitored.

3.5 The Strategic Risk Register will continue to be reviewed alongside the implementation of the Strategic Plan by the IJB's Chief Officer and Chief Finance Officer with support from SBC's risk management service, and a further update will be presented to the Board in December 2019. This will assist to address the Internal Audit recommendation on managing risks

Page 3 of 3

This page is intentionally left blank

Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 14 August 2019

Scottish Borders
Health and Social Care
PARTNERSHIP

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD STRATEGIC RISK REGISTER UPDATE
APPENDIX 1

IJB IJB	2	8			
IJB001 Failure to achieve culture change may affect strategic objectives	**12** Major - Possible		02 Aug 2019	12 –	
IJB002 Ineffective and innefficient use of resources may not achieve best value	**12** Moderate - Likely		02 Aug 2019	12 –	
IJB003 Insufficient availability of residential and home care provision	**16** Major - Likely		02 Aug 2019	16 –	
IJB004 Partnership approach to communicating and engagement with stakeholders	**9** Moderate - Possible		02 Aug 2019	9 –	
IJB005 Insufficient funding, or failure to make savings, may affect provision	**16** Major - Likely		02 Aug 2019	16 –	
IJB006 Inability to develop a workforce for the future	**9** Moderate - Possible		02 Aug 2019	9 ↓	
IJB007 Significant supplier failure	**12** Major - Possible		02 Aug 2019	12 –	
IJB008 If someone under the care of the IJB comes to harm	**12** Major - Possible		02 Aug 2019	12 –	
IJB009 Failure to manage and appropriately resource major programmes/projects	**9** Moderate - Possible		02 Aug 2019	9 –	
IJB010 If the Partners breach data protection legislation	**8** Major - Unlikely		02 Aug 2019	8 –	

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 14 August 2019

Report By	Mike Porteous, Chief Finance Officer
Contact	Mike Porteous, Chief Finance Officer
Telephone:	07973981394

2018/19 INTEGRATION JOINT BOARD ANNUAL AUDIT REPORT

Purpose of Report:	The purpose of this report is to recommend the IJB approve the independent auditor's Annual Audit Report for 2018/19.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the independent auditor's 2018/19 Annual Report. b) **Acknowledge** the key messages and actions within the report.

Personnel:	N/A

Carers:	N/A

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

Financial:	No resourcing implications beyond the financial resources identified within the report. The report has been reviewed by the Chief Officer and approved by NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer for factual accuracy. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.

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

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

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Integration Joint Board is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973. This means the IJB must prepare and publish a set of Annual Accounts at the end of each financial year.

2.2 These accounts must be reviewed by an Independent Auditor who will report their findings to the IJB Audit Committee as part of their Annual Audit Report. The report presents the Auditor's opinion of the accounts and allows them to bring any matters of concern to the committee's attention. The Code of Audit practice sets out the four dimensions which form the scope of the audit work carried out – Financial Management / Financial Sustainability / Value for Money / Governance and Transparency.

2.3 The IJB Audit Committee has recommended the IJB approve the Annual Audit Report.

2018/19 – Annual Audit Report

3.1 The 2018/19 audit of Borders IJB was undertaken by Audit Scotland. The key messages highlighted within the Annual Audit Report are:

2018/19 Annual Accounts

The Auditors have given the accounts an unqualified report which means they consider that the accounts meet the regulations and requirements of the Act and that they are a true and fair view of the IJB's financial position.

Financial Management and Sustainability

The IJB reported a breakeven position for the year. This was achieved with additional funding of £3.2m from Scottish Borders Council and £5.24m from NHS Borders for Core functions and £1.4m for Set Aside functions.

The Auditors noted the Chief Financial Officer post should be made permanent as soon as possible and that the 2019/20 resource allocations from partner bodies had not been formally approved at the time of the audit.

Governance, Transparency and Best Value

The Auditors noted that the monitoring and reporting of risks relating to the IJB has improved in 2018/19. However they indicated improvements could be made in attendance at Board meetings and that the IJB Audit Committee could expand the work it considers.

They also noted the IJB had self assessed itself as only partially established in most areas as part of the Ministerial Strategic Group for H&CC.

Action Plan and Risk

The report also included Appendices containing an Action Plan setting out recommendations for improvements for the IJB and a section on Risk which considered any risks identified in the audit planning process.

The responses of the CO and CFO to these recommendations are also presented within the Action Plan in Appendix 1. The risks noted within Appendix 2 of the AAR reflect the issues presented throughout the report and within the Action.

Summary

4.1 The IJB Audit Committee has recommended the IJB approve the 2018/19 Annual Audit Report

4.2 A copy of the 2017/18 Annual Audit Report is attached and the Annual Accounts for 2017/18 can be provided on request.

Page 285

This page is intentionally left blank

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Integration Joint Board

ANNUAL ACCOUNTS 2018/19

For the Financial Year 01 April 2018 to 31 March 2019

(Audited)

Table of Contents

Management Commentary

Purpose

Welcome to the Annual Accounts for the Scottish Borders Health and Social Care Partnership Integration Joint Board for the year ended 31 March 2019. The purpose of the Management Commentary is to inform all users of the 2018/19 Statement of Accounts and help them assess how the Integration Joint Board (IJB) has performed in fulfilling its duties over the course of the financial year.

The Scottish Borders

The Scottish Borders area is 473,614 hectares (1,827 square miles) and is located in the South East of Scotland. It has Edinburgh and the Lothians to the North, Northumberland to the South and Dumfries and Galloway to the West.

The Scottish Borders is a rural area with a population of 115,270 in 2018, an increase of 0.2% from the previous year, which is the same as the Scottish average. Scottish Borders is a medium-sized Local Authority area in terms of its population but it has a large land area and a sparse population density. The largest town is Hawick with an estimated population of 13,889, followed by Galashiels with 12,603. The latest information indicates 28% of the Scottish Borders population lives in settlements of below 500 people or in isolated hamlets.

The population of Scottish Borders has risen by 8.7% in the past 10 years, a faster rate of increase than the Scottish average of 7.1%. The population of the Scottish Borders has an older structure than average, with a lower proportion of under 25s and a higher proportion of over 25s , and especially of over 75s, than average for Scotland. In the past 10 years, the 25-44 age group in Scottish Borders saw the largest percentage decrease (a drop of 24.4%) and the 65-74 age group saw the largest increase (48.1%).

Whilst the overall population of the Scottish Borders is not projected to increase significantly over the coming years, the average age of the Scottish Borders population will continue to increase as the current older working-age cohort become pensioners, with fewer younger people to replace them, and just because everyone is expected to live longer. The 16-24 age group is projected to see the largest decrease (a drop of 8.4%) by 2026, and the 75+ age group is projected to see the largest percentage increase (33.5%). In terms of actual numbers, the 45-64 age group will remain the largest cohort.

These demographic factors have a unique and challenging impact on the models of providing levels and costs of health and social care in the Scottish Borders, both currently and in the future.

Role and Remit of the Integration Joint Board

The Scottish Borders Integration Joint Board (IJB) is a legal entity in its own right which was created following the implementation of the Joint Working Public Bodies (Scotland) Act 2014. On 6th February 2016, Ministerial approval was given to establish the Integration Joint Board between NHS Borders and Scottish Borders Council in order to integrate the planning and commissioning of health and social care services in the Scottish Borders.

The operation of the IJB is governed by its Scheme of Integration which sets out the body corporate model of integration within the Scottish Borders and details the functions delegated. These delegated functions include:

Adult Social Care Services*	Acute Health Services (**Provided in a hospital)	Community Health Services***
• Social Work Services for adults and older people; • Services and support for adults with physical disabilities and learning disabilities; • Mental Health Services; • Drug and Alcohol Services; • Adult protection and domestic abuse; • Carers support services; • Community Care Assessment Teams; • Care Home Services; • Adult Placement Services; • Health Improvement Services; • Re-ablement Services, equipment and telecare; • Aspects of housing support including aids and adaptations; • Day Services; • Local Area Co-ordination; • Respite Provision • Occupational Therapy services.	• Accident and Emergency; • Inpatients services in these specialities: - General Medicine; - Geriatric Medicine; - Rehabilitation Medicine; - Respiratory Medicine; - Psychiatry of Learning Disability; • Palliative Care Services provided in a hospital; • Inpatient hospital services provided by GPs; • Services provided in a hospital in relation to an addiction or dependence of any substance; • Mental Health services provided in a hospital, except secure forensic mental health services.	• District Nursing; • Primary Medical Services (GP Practices),*** • Out of Hours Primary Medical Services,*** • Public Dental Services,*** • General Dental Services,*** • Ophthalmic Services,*** • Community Pharmacy Services,*** • Community Geriatric Services; • Community Learning Disability Services; • Mental Health Services; • Continence Services; • Kidney Dialysis outwith the hospital; • Services provided by health professional that aim to promote public health; • Community Addiction Services; • Community Palliative Care; • Allied Health Professional Services.
*Adult Social Care Services for adults aged 18 and over. **Acute Health Services for all ages – adults and children. ***Community Health Services for adults aged 18 and over, excepting those marked with asterisks (***), which also include services for children.		

The IJB has a responsibility for the strategic planning of hospital services most commonly associated with the emergency care pathway. As such, the IJB has control of the resources supporting those associated hospital functions retained by NHS Borders and set-aside for the population of the Scottish Borders: the “Set-Aside Budget”. They are shown in the middle column above.

Strategic Plan

The IJB renewed its Strategic Plan in 2018/19, setting out its strategic objectives for 2018/19 – 2020/21. The plan sets out what the IJB wants to achieve to improve health and well-being in the Borders through integrating health and social care services.

The partnership’s Strategic Plan also describes some of the actions it is taking to make the shift towards more community-based health and social care services, the outcomes sought to achieve these and the steps being taken to deliver our local objectives. It also outlines the performance measures used to assess the progress we are making.

Within the refreshed strategic plan the number of objectives has been reduced from nine to three with a focus on keeping people healthy and well, improving service flow and managing health conditions.

The refreshed strategic objectives are:-

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

A number of key principles are outlined within the Strategic Plan which underpin all three high level objectives:

- Prevention and early intervention;
- Accessible services;
- Care close to home;
- Delivery of services within an integrated care model;
- Greater choice and control;
- Optimise efficiency and effectiveness;
- Reduce health inequalities.

This high level plan will be supported by the implementation of strategies related to specific themes such as dementia, mental health, carers and locality plans that reflect differing patterns of need across the Scottish Borders.

Operations of the IJB

Annual Performance Report 2018/19

The partnership will publish it's 2018/19 Annual Performance Report (APR) in July 2019. This will provide a comprehensive summary of the Partnership's financial performance and its performance against the Local and National Integration Indicators identified by the IJB and the Scottish Government.

The partnership's priorities for 2019/20 are also set out in the report and we will continue to work hard to deliver responsive health and social care services which are focused on the needs of the people who use them and their local communities.

A key focus for the Partnership going forward will be delivering our joint programme of transformation to ensure that we can successfully address the challenges and achieve the Partnership's objectives to ensure the best possible health and wellbeing for our communities.

A full copy of the Annual Performance Report can be requested by contacting the IJB Chief Officer, Scottish Borders Council HQ, Newtown St Boswells, Melrose. TD6 0SA or on 01835 824000.

Performance against Strategic Objectives 2018/19

The Strategic Plan 2018/19 – 2020/21 focuses on the delivery of the three local Strategic Objectives which are aligned to the health and wellbeing outcomes. Performance against these objectives is highlighted through a number of key achievements summarised under each objective.

STRATEGIC OBJECTIVE 1: **We will improve the health of the population and reduce the number of hospital admissions.**
We are committed to helping older people to manage their own health better, improving fitness and reducing social isolation. We know that the number and proportion of older people in the Borders is increasing and we therefore need to promote 'active ageing.' We know that many older people in Scottish Borders report poor health therefore we must promote healthier lifestyles, earlier detection of disease and support to recover and manage their conditions. We know that the population of the Scottish Borders is spread over a large geographical area with many people living in rural locations, therefore services need to be provided locally and accessible transport arrangements put in place.

Key Achievements:

- The Primary Care Improvement Plan was submitted to Scottish Government on 31st August 2018. It sets out our intentions over the coming 3-years to improve primary care settings through investment in key areas including vaccinations, community treatment and community link workers.

- The Action 15 Plan was also submitted to the Scottish Government in 2018. This set out our plans to invest in Mental Health services across the partnership.

- We held our inaugural 'Living with and caring for Dementia' event in November 2018. This was attended by over 100 staff, people with dementia and their carers. It was an opportunity to listen and learn – as who better to explain what it is really like to live with dementia than the very people who are going through it?

- The first Borders Healthy Lives Week brought together a wide-range of staff from across the Partnership and the Third Sector. Over 100 people took part in our Pledge Challenge, making a commitment to look after their health and wellbeing. Pledges ranged from drinking more water, eating more fruit, cycling more and entering a half marathon. All reinforcing the message that small changes can make big differences

- Funding of £98k from Scottish Government was obtained to support a 2-year project to encourage access to bowel, breast and cervical cancer screening for people with learning disabilities and mental health service patients.

STRATEGIC OBJECTIVE 2:
We will improve the flow of patients into, through and out of hospital.

We are committed to reducing the time that people are delayed in hospital. People should also have a greater and more flexible choice of different services which meet their long-term housing, care and support needs. We know that we need to continue to listen, involve, plan and deliver services across the five localities. We know that housing and supported accommodation options have an important role to play in regard to the flow of patients. We know that a number of people need flexible support arrangements to maintain and improve their quality of life.

- The Discharge Programme has been formed to bring together the linked services across the partnership focussing on preventing admissions, reducing the number of delayed discharges within the hospital system, and enabling people to remain in the community longer.

Specific changes within the Discharge Programme includes the following:

- Hospital to Home (H2H) has been expanded across all 5 localities and has helped develop peoples' confidence and skills so that they can carry out activities themselves, enabling them to continue living at home. So far H2H has been able to accommodate over 200 patients.

- The STRATA project went live in 2018/19. This automates and improves the process of discharging patients from hospital into residential care or care at home providers. The system uses a real-time directory of available care home beds, capacity and specialist services allowing these to be matched to patients.

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

We are committed to supporting people to manage their own conditions, by improving access to health and social care services in local communities, by improving support to carers and by delivering more supported accommodation, including extra care homes, dementia care and mixed tenure provision. We know that a range of support is required to support for people with dementia and their carers. We know that we need high quality support for the 12,500 people aged 16 and over who are providing unpaid care in the Scottish Borders.

- A service that provides one-to-one personal support for people with cancer has been rolled out across the Borders. The 'TCAT' service is free; it provides tailored advice, information and support to help people regain a sense of control over their lives. It is being delivered in partnership between The Partnership, MacMillan Cancer Support, NHS Borders and the British Red Cross.

- An innovative mountain biking project for people currently experiencing mental ill health was delivered by the Partnership, Developing Mountain Biking in Scotland

(DMBinS) and Napier University. It promoted the therapeutic benefits of cycling in improving mental health, increased personal resilience, social skills and confidence.

- The IJB Technology Enabled Care (TEC) Strategy is in place. This strategy sets the direction of travel for the Partnership use of TEC and identifies the priorities in trialling different pieces of TEC, such as:
  - *Florence*: is a health monitoring system, allowing individuals to monitor their health condition from home. It uses text messages to allow Health clinical staff to collect readings or symptom information remotely from patients. Florence can alert clinicians if a patient's condition worsens to allow them to intervene appropriately. Florence is being trialled in the West GP Cluster for Blood Pressure, COPD and Asthma.

  - *ARMED (Advanced Risk Modelling for Early Detection)* use of wearable devices to monitor, predict and therefore prevent falls. If a person's normal state/pattern of sleep, body composition or grip strength changes then the system raises an alert. A pilot of ARMED is underway in Deanfield residential care home, Dovecot extra care home and within the Cheviot hospital to home team.

Key Partnership Decisions 2018/19

The IJB continued to meet regularly in 2018/19 both as a formal meeting to transact business and also through Development sessions to enhance its understanding of the more complex issues it faces as the Partnership continues to evolve.

Key aspects of the IJB's business include a focus on governance and operating arrangements as well as performance and resource planning.

Examples of key governance decisions it has made during the financial year include:-

- Welcoming new voting members to the Board;
- Appointment of a temporary Chef Finance Officer, Mr Michael Porteous;
- Approval of the Local Code of Corporate Governance;
- Agreement to expand the Hospital to Home initiative;
- Agreement to pilot the STRATA initiative
- Approval of its Communications Strategy;
- Agreement to receive a review of the Strategic Risk Register twice yearly.

Examples of key performance and resources decisions it has made during the financial year include:-

- Approval of its refreshed Strategic Plan 2018/19 – 20/21;
- Review of the Integrated Care Fund Schemes and Direction of the remaining funding.
- Direction of the remaining Social Care Funding;
- Approval and delivery of it's 2018/19 financial plan;
- Direction of resources to assist with Joint Winter Planning performance;
- Approval of the allocation of additional Drug & Alcohol funding received from Scottish Government.

Locality Planning

Locality planning is a key tool in delivery of the change required to meet new and existing demands in the Borders. The IJB has developed locality arrangements, where professionals, communities and individuals can inform locality planning and redesign of services to meet local need in the best way. This is achieved through having 'Locality Working Groups' in each of the five localities of:

- Berwickshire
- Cheviot
- Eildon
- Teviot & Liddesdale
- Tweeddale.

Each Locality has a Locality Plan. In the long-term, there are opportunities to further integrate the Locality Plans within Community Planning Partnership (CPP) arrangements, but in the short-term the Partnership is planning to strengthen and bolster Locality Working Group arrangements

Governance

The governance structure of the Partnership includes the operation of the IJB and the EMT:

- **The Integration Joint Board (IJB)** as the governing body, approves all decisions of the Health and Social Care Partnership, excluding those delegated to the Executive Management Team (EMT). It receives regular progress updates from the EMT through the Chief Officer and Chief Financial Officer as well as frequent and regular financial and performance planning and management reports.

- **The Executive Management Team (EMT)** supports the **Chief Officer** to commission tests of change and/or service redesign. These are then drawn up into business cases by the operational level of the governance structure and returned to the EMT for review and decision making. The EMT also considers or supports the preparation of all reports to the IJB and advises the Chief Officer on the Partnership's governance, planning, monitoring and reporting responsibilities.

The Strategic Planning Group and the Joint Staff Forum offer advice to the Integration Joint Board whilst the Health and Social Care Joint Management Team provide operational support and delivery and progress reporting.

The Partnership continues to review performance, identify strengths and areas for improvement and work to deliver continuous improvement in its governance, operations and performance.

At the start, middle and end of the financial year, the IJB and its partners undertake a full review and evaluation of its degree of compliance with legislation and recommended best practice in relation to the Partnership's financial governance, planning, management and reporting arrangements. A number of positive outcomes have been reported following these processes and clear forward planning is in place to continue to provide full assurance to the Partnership going forward.

A quarterly performance reporting scorecard has been developed for the IJB, in line with the themes defined by the Ministerial Strategy Group. In addition to these themes, the scorecard allows for the reporting on more localised measures which have a primary, community or social care focus.

Financial Position at 31 March 2019

Delegated Budget

The partnership reported a break even position against the Delegated Budget at 31 March 2019. Additional allocations from the funding bodies were required during the year and at year end to deliver a break even position overall.

The reported position across delegated functions is summarised below:

Delegated Functions Total	Base Budget £'000	Revised Budget £'000	Actual Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	20,216	21,156	21,526	(370)
Joint Mental Health Service	15,422	16,775	16,973	(198)
Joint Alcohol and Drug Service	530	770	744	26
Older People Service	19,281	20,772	20,762	10
Physical Disability Service	3,322	3,677	3,599	78
Prescribing	21,700	22,795	22,737	58
Generic Services	68,155	66,890	71,482	(4,592)
Over allocation returned to Scottish Borders Council		(252)		(252)
Additional Allocation from NHS Borders	0	5,240	0	5,240
	148,626	**157,823**	**157,823**	**0**

Key pressures within the 2018/19 delegated function's accounts impacting on out-turn have been:

- significant increased demand for services associated with an increasing ageing population and increased complexity of care needs
- pressures arising from challenges in recruitment and retention of staff resulting in the need for higher cost locum or agency staff to cover services
- the non-delivery of savings
- meeting the increased costs of service provision in areas such as care at home and in relation to patients transitioning into adult specialist services.

Despite the above the IJB delivered significant success through savings and efficiencies made within the pharmacy service with a small underspend reported against the Prescribing budget in 2018/19.

The IJB continued to support the delivery of services such as Hospital to Home and the Matching Unit which are instrumental in reducing the number of delayed discharges and providing effective care for people in a community setting. These services contributed directly to the more effective management of patient flow across hospital and community services and a significant reduction in spend over the winter period.

However additional funding was required to deliver a break even position for 2018/19. Additional allocations of £3.2m were made during the financial year by the Scottish Borders Council to fund pressures within Social Care services resulting in a small underspend at year end which has been returned to the Council. NHS Borders required additional funding from the Scottish Government in order to meet its financial obligations. A brokerage agreement was reached with the Scottish Government which provided NHS Borders with additional in year funding and enabled them to make an additional allocation of £5.240m to fund the Health services overspend within NHS delegated functions.

Large Hospital Budget Retained and Set-Aside

Legislation sets out that Integration Authorities are responsible for the strategic planning of hospital services most commonly associated with the emergency care pathway along with primary and community health care and social care.

In relation to the Large Hospital Budget Retained by NHS Borders and Set-Aside, an overspend position has been reported at 31 March 2019, summarised as:

Set Aside Healthcare Functions	**Base Budget £'000**	**Revised Budget £'000**	**Actual Outturn £'000**	**Outturn Variance £'000**
Accident & Emergency	2,003	2,742	2,912	(170)
Medicine & Long-Term Conditions	11,847	14,491	15,571	(1,080)
Medicine of the Elderly	6,288	6,509	6,642	(133)
Planned Savings & Actions				0
Additional Allocation from NHS Borders		1,383		1,383
	20,138	**25,125**	**25,125**	**0**

Key pressures within the 2018/19 set aside accounts impacting on out-turn have been:

- the impact of vacancies and the subsequent use of agency staff to ensure rotas are supported and services are fully operational
- high patient acuity impacting on staffing levels

The brokerage secured by NHS Borders enabled it to make an additional contribution of £1.383m the year end to deliver a break even position for the Set-Aside services overall.

Other Resources

Social Care Funding

The Scottish Government funding of £7.397m is contained within their 2018/19 baseline allocation to NHS Borders and subsequently forms part of the delegated funding to the IJB. These resources have been directed in full to Scottish Borders Council to meet the costs of implementation of an increased Scottish Living Wage from 01 October 2017, increased market provider costs and increased demand for social care services, in particular care at home. In summary resources have been directed within Social Care services on the following basis:

Social Care Fund	**Directed Funding 2016/17 to 2018/19** £'000
Scottish Living Wage	2,455
Demographic Pressures	3,220
Market Provider costs	1,722
	7,397

Integrated Care Fund

The resources the IJB is allocated from NHS Borders included separate funding previously allocated under the banner of Integrated Care Fund (ICF). This funding of £2.13m was allocated annually for the 3 years to 2017/18, providing a total of £6.39m over the life of the programme. Funding was carried forward into 2018/19 to meet the residual costs of live programmes of work and a small overspend was recorded. The funding of £2.13m has now been included in the base funding allocated to the IJB and the overspend was met from this budget in 2018/19.

A summary of the ICF expenditure is detailed below, in the context of previous spend and total allocations:

	Budget Allocation 2015/16 £'000	Budget Allocation 2016/17 £'000	Budget Allocation 2017/18 £'000	Budget Allocation 2018/19 £'000	Actual Outturn over 3 year £'000	(Over) / Under Committment £'000
NHS Borders-Led	21	621	317	713	1,672	0
SBC -led	204	703	1,764	2,047	4,756	(38)
	225	**1,324**	**2,081**	**2,760**	**6,428**	**(38)**

Former Older People's Change Fund

Prior to the establishment of the Health and Social Care Partnership, NHS Borders, Scottish Borders Council and their third and fourth sector partners worked together to deliver the Reshaping Care Programme, funded by the Scottish Government Change Fund allocation over 4 years to March 2015. This programme is now complete, but a residual uncommitted balance on the funding allocation of £450k remains for carry forward to 2019/20 for use by the Partnership.

Financial Outlook

The IJB continues to face significant financial challenges and a financial recovery plan is being drawn up to identify potential solutions to the recurring service pressures and unmet savings targets. The partnership is facing a number of risks which will require management and mitigation in 2019/20 and beyond:

- the 2019/20 Financial Plan remains draft and does not currently address all historic and existing pressures
- the financial challenges facing NHS Borders will result in a requirement for further brokerage in 2019/20 to enable it to meet its statutory obligations, including funding any overspend incurred by the IJB
- the partnership's Strategic Plan has been updated and relaunched to cover the 3 years from 2018/19 to 2020/21. Both NHS Borders and Scottish Borders Council will receive only a 1-year financial settlement
- prescribing remains a high risk area due to the level of spend and volatility of price and supply
- there is an ongoing risk in relation to the sustainability of the workforce both internally and with our external care partners

- further cost pressures may emerge during 2019/20 that are not yet projected or provided for within either partner's financial plans, nor the resources delegated to the IJB
- the risk of loss of service provision as a result of market failure would result in additional costs as alternative supply is transitioned

Risk, Uncertainty and Change

Management of risk and in particular, Financial Risk is one of the key responsibilities of the Board. Strategic and Operational Risk Registers for the Partnership are now in place. Specific prevalent risks are outlined above and within the Partnership's Risk Register, these are categorised across the following strategic themes:

- Lack of change in culture to partnership approach
- Unclear direction by IJB to utilise resources efficiently and effectively
- Insufficient future market for care to meet increasing demand
- Lack of partnership approach to engagement and consultation
- Slippage in delivery by partners of efficiency savings and the ambitious programme to transform to new models of care
- Insufficient workforce skills and capacity to meet demand and transformed service delivery
- Significant supplier failure to provide services
- Reputational damage if someone comes to harm
- Lack of resources and governance to implement change and transformation programmes and projects
- Insufficient oversight of information governance

In 2018/19, the IJB chair was Dr Stephen Mather, who is an NHS Borders Non-Executive Director. The vice –chair was Councillor David Parker. In addition to the chair and vice-chair the IJB Board comprises 4 additional voting members from NHS Borders and 4 from Scottish Borders Council. During 2018/19 1 new council member joined the Board, replacing Councillor Laing

Annual Accounts

The Integration Joint Board is required to prepare Annual Accounts by the Local Authority Accounts (Scotland) Regulations 2014, which section 12 of the Local Government in Scotland Act 2003 requires preparation in accordance with proper accounting practices. These practices primarily comprise the Code of Practice on Local Authority Accounting in the United Kingdom 2018/19 supported by International Financial Reporting Standards (IFRS) and statutory guidance issued under section 12 of the 2003 Act.

Dr Stephen Mather	**Rob McCulloch-Graham**	**Michael Porteous CPFA**
Chair	**Chief Officer**	**Chief Financial Officer**

On behalf of the Integration Joint Board Members and Officers of Scottish Borders Health and Social Care Partnership Integration Joint Board

14 August 2019

Remuneration Report

Introduction

The remuneration report has been prepared in accordance with the Local Authority Accounts (Scotland) Regulations 2014. These Regulations require various disclosures about the remuneration and pension benefits of specific IJB members and senior employees in respect of earnings and pension benefits.

Remuneration

The term remuneration means gross salary, fees and bonuses, allowances and expenses, and compensation for loss of employment. It excludes pension contributions paid by the Employee. Pension contributions made to a person's pension are disclosed as part of the pension benefits disclosure below.

The information contained in the report is subject to external audit. The explanatory text within the report is reviewed by external auditors to ensure that it is consistent with the financial statements.

Remuneration of Integration Joint Board Members

The voting members of the IJB are appointed through nomination by NHS Borders and Scottish Borders Council. Nomination of the IJB Chair and Vice-Chair posts alternates between an elected member and a Health Board representative. In December 2018 the Scheme of Integration was amended from a 2 year rotation to a 3 year rotation of these posts on the basis of continuity of leadership and retention of experience. IJB Board members at 31 March 2019 are:

- Dr S Mather (Chair)
- Councillor D Parker (Vice Chair)
- Mr M Dickson
- Mrs K Hamilton
- Mr T Taylor
- Mr J Raine
- Councillor J Greenwell
- Councillor S Haslam
- Councillor T Weatherston
- Councillor E Thornton-Nicol

Additional remuneration paid to IJB members including the Chair, Vice – Chair and other Board members relating to their role on the IJB are detailed below. All IJB Board members are supplied to the IJB at zero cost to the Board by their respective organisations.

Expenses 2017/18 £	Name	Post(s) Held	Nominated By	Expenses 2018/19 £
2,601	Dr Stephen Mather	Chair	NHS Borders	2,935
Nil	Mr David Parker	Vice-Chair	Scottish Borders Council	Nil
1,020	Mrs Karen Hamilton	Member	NHS Borders	714
1,351	Mr David Davidson	Member	NHS Borders	238
Nil	Mr Malcolm Dickson	Member	NHS Borders	1,127
393	Mr Tristram Taylor	Member	NHS Borders	Nil
5,365	**Total**			**5,014**

The IJB does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting IJB members. Therefore no pension rights disclosures are provided for the Chair and Vice-Chair of the IJB as they are defined above.

Remuneration of Senior Employees

The term 'Senior Employee' means:

1. Any employee who has responsibility for the management of the Integration Joint Board to the extent that the person has the power to direct or control the major activities of the Board (including activities involving the expenditure of money), during the year to which the Report relates, whether solely or collectively with other persons;
2. Who holds a post that is politically restricted by reason of section 2(1) (a), (b) or (c) of Local Government and Housing Act 1989 (4); or
3. Whose annual remuneration, including any remuneration from a local authority subsidiary body, is £150,000 or more.

The IJB does not employ any staff in its own right. Specific post-holding officers are non-voting members of the board however.

Chief Officer: Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014, a Chief Officer for the IJB has to be appointed and the employing partner has to formally second the officer to the IJB. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the IJB.

Other Officers: The services of a Chief Finance Officer (CFO) have been secured through a secondment appointment. The CFO undertakes the statutory role of section 95 Officer for the IJB. The employment contract for the CFO will adhere to the legislative and regulatory framework of the employing partner organisation. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below.

The Chief Officer therefore has responsibility for the management of the IJB, supported by the Chief Financial Officer from a financial context. Regardless of how these posts are supplied to the partnership or funded, both are therefore deemed to be Senior Employees in line with criterion 1 above.

Total 2017/18 £	Name	Employing Organisation	Salary 2018/19 £	Fees and Allowances £	Total 2018/19 £
46,361 (FYE £99,883)	Mrs Elaine Torrance (01 March 2017 to 17 September 2017)	Scottish Borders Council			
49,920 (FYE £105,322)	Mr Rob McCulloch-Graham	Scottish Borders Council	104,094	703	104,797
96,281	**Total**	**Total**	**104,094**	**703**	**104,797**

The post of CFO was initially undertaken by the Chief Finance Officer for Scottish Borders Council within his duties as Section 95 Officer. The Chief Financial Officer role was then undertaken from 6 August 2018 to 31 March 2019 by Mr Michael Porteous on a secondment basis.

Total 2017/18 £	Name	Employing Organisation	Salary 2018/19 £	Fees and Allowances £	Total 2018/19 £
25,263 (FYE £50,526)	Mr Paul McMenamin (01 March 2017 to 30 September 2017)	Scottish Borders Council			
	Mr Michael Porteous (06 August 2018 to 31 March 2019)	NHS Borders	38,614 (FYE £59,090)	146	38,760
25,263	**Total**	**Total**	**38,614**	**146**	**38,760**

During the period, no payments were made in respect of bonuses, compensation for loss of office or any non-cash benefits. No exit packages were agreed by the Board during this period.

Rob McCulloch-Graham held an employment contract with Scottish Borders Council on Scottish Borders Council pay terms and conditions of employment and is a member of the Scottish Borders Council Local Government Pension Scheme (LGPS). This scheme became a career average pay scheme on 1 April 2015. Benefits built up to 31 March 2015 are protected and based on final salary. Accrued benefits from 1 April 2015 will be based on career average salary.

Mr Michael Porteous has an employment contract with an NHS Board and is a member of the NHS Pension Scheme (Scotland) 2015. The NHS Superannuation Scheme became a career average pay scheme from 1 April 2015. Benefits built up to 31 March 2015 are protected and based on final salary.

In respect of officers' pension benefits, the statutory liability for any future contributions to be made rests with the relevant employing partner organisation. On this basis, there is no pensions liability reflected on the IJB Balance Sheet for the Chief Officer or any other officers. The IJB however has the responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the IJB.

The following table shows the IJB's funding during the year to support officers' pension benefits and the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions:

Name	In-Year Pension Contributions For Year To		Accrued Pension Benefits At 31 March 2019	
	31 March 2018 £	31 March 2019 £	Pension £	Lump Sum £
Chief Officer Mrs Elaine Torrance (01 April 2017 to 17 September 2017)	8,241			
Chief Officer Mr Rob McCulloch-Graham (09 October 2017 to 31 March 2018)	8,986	18,737	9,195	0
	Movement from 31 March 2018 =		8,146	0
Chief Financial Officer Mr Paul McMenamin (01 April 2017 to 30 September 2017)	4,355			0
				0
Chief Financial Officer Mr Michael Porteous (06 August 2018 to 31 March 2019)	6,821	5,108	18,153	52,236 *1
	Movement from 31 March 2018 =		1,884	3,429
	Total Movement from 31 March 2018 =		**10,030**	**3,429**

*1Pro-rata for period employed as Chief financial Officer 06 August 2018 to 31 March 2019

The regulations require any officer whose remuneration for the year was £50,000 or above, to be disclosed in bandings of £5,000. For the IJB in 2018/19 this is:

Number of Employees in Band 2017/18	Remuneration Band	Number of Employees in Band 2018/19
	£95,001 - £100,000	
	£100,001 - £105,000	1

Dr Stephen Mather
Chair

Rob McCulloch-Graham
Chief Officer

On behalf of the Councillors and Officers of Scottish Borders Health and Social Care Partnership

14 August 2019

Statement of Responsibilities

Integration Joint Board

The Integration Joint Board has appointed its Chief Officer on a permanent basis.

The Integration Joint Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that the proper officer of the board has the responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this Joint Board, that officer is the Chief Financial Officer;
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003); and
- Approve the Annual Accounts.

I confirm that these Annual Accounts were approved for signature by the Integration Joint Board at its meeting on 14 August 2019.

Signed on behalf of Scottish Borders Health and Social Care Partnership Integration Joint Board

Dr Stephen Mather
Chair

14 August 2019

Chief Financial Officer

The Chief Financial Officer (CFO) is seconded at no cost to the IJB from one or other partner organisation. The post was filled from 6 August with a full time secondee from outwith the Borders. Prior to this date the role was covered by the Chief Financial Officer of Scottish Borders Council in addition to his substantive role.

The CFO is responsible for the preparation of the IJB's Annual Accounts in accordance with the proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

In preparing the Annual Accounts, the CFO is responsible for:

- selecting suitable accounting policies and then applying them consistently;
- making judgements and estimates that are reasonable and prudent;
- complying with the Code of Practice and legislation.

The CFO is also required to:

- keep adequate proper accounting records which are up to date; and
- take reasonable steps to ensure the propriety and regularity of the finances of the IJB.

I certify that the financial statements give a true and fair view of the financial position of Scottish Borders Health and Social Care Partnership Integration Joint Board as at 31 March 2019 and the transactions of the Joint Board for the year then ended.

Michael Porteous CPFA
Chief Financial Officer

14 August 2019

Annual Governance Statement 2018/19

Introduction

The Annual Governance Statement explains the IJB's governance arrangements and system of internal control and reports on their effectiveness.

Scope of Responsibility

The IJB is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

To meet this responsibility the IJB has established arrangements for governance which includes a system of internal control. The system is intended to manage risk to support the achievement of the IJB's policies, aims and objectives. Reliance is also placed on NHS Borders and Scottish Borders Council (the partners) systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the IJB.

The system can only provide reasonable and not absolute assurance of effectiveness.

The Governance Framework and Internal Control System

The Board of the IJB comprises voting members, nominated by either NHS Borders or Scottish Borders Council, as well as non-voting members including a Chief Officer appointed by the Board.

The IJB's Local Code of Corporate Governance (IJB Local Code) sets out the framework and key principles, which require to be complied with, to demonstrate effective governance. The revised IJB Local Code approved by the Board in September 2018 reflects the changing context of integration and is consistent with the principles and recommendations of the new CIPFA/SOLACE Framework 'Delivering Good Governance in Local Government' (2016) and the supporting guidance notes for Scottish authorities. The overall aim of the Framework is to ensure that: resources are directed in accordance with agreed policy and according to priorities; there is sound and inclusive decision making; and there is clear accountability for the use of those resources in order to achieve desired outcomes for service users and communities.

The main features of the governance framework and internal control system associated with the seven core principles of good governance defined in the revised Framework in existence during 2018/19 included:

A. Behaving with integrity, demonstrating strong commitment to ethical values, and respecting rule of law

The roles and responsibilities of Board members and statutory officers and the processes to govern the conduct of the Board's business are defined in the approved Scheme of Integration, Constitution and Standing Orders to make sure that public business is

conducted with fairness and integrity. The Board has a standalone Terms of Reference setting out its remit.

Reliance is placed on the values and standards set out in the codes of conduct within the employer partner organisations, which incorporate "The Seven Principles of Public Life" identified by the Nolan Committee on Standards in Public Life.

The IJB is dependent upon arrangements within the partner organisations for areas such as:

- ensuring legal compliance in the operation of services;
- handling complaints;
- ethical awareness training and whistleblowing policies and procedures;
- staff appointment and appraisal processes which take account of values and ethical behaviour;
- identifying, mitigating and recording conflicts of interest, hospitality and gifts; and
- procurement of goods and services which are sustainable, represent value of money and which reinforce ethical values.

Other areas where the IJB places significant reliance on arrangements in place within the partner organisations are set out in the remainder of the statement.

The Chief Officer is responsible for ensuring that agreed procedures are followed and that all applicable statutes and regulations are complied with.

Professional advice on the discharge of duties is provided to the Board by the IJB Chief Officer supported by Board Secretary, Chief Financial Officer, and Chief Internal Auditor as appropriate.

B. Ensuring openness and comprehensive stakeholder engagement

Board meetings are held in public unless there are good reasons for not doing so on the grounds of confidentiality.

Unless confidential, decisions made by the Board are documented in the public domain.

Community engagement was encouraged as part of the development of the Scheme of Integration and the Strategic Plan of the Health and Social Care Partnership and Locality Plans were developed following consultations with interested parties including members of the public.

C. Defining outcomes in terms of sustainable economic, social, and environmental benefits

The vision, strategic objectives and outcomes are reflected in the Scottish Borders Health & Social Care Partnership's Strategic Plan 2018-2021 and the associated Implementation Plan, as an appendix, which have been updated to reflect on-going assessment of need. This is underpinned by the Locality Plans which provide the associated implementation actions.
Implications are considered during the decision making process covering Policy/Strategy, Consultation, Risk Assessment, Compliance with requirements on Equality and Diversity, and Resource/Staffing.

D. Determining the interventions necessary to optimise the achievement of the intended outcomes

In determining how services and other courses of action should be planned and delivered the partnership has a statutory responsibility to involve patients and members of the public.

The Scottish Borders Health & Social Care Partnership's Strategic Plan 2018-2021 is based on consultation during its review and update.

The IJB has issued directions to the partners primarily to deliver business as usual with the exception of a limited amount of commissioning through ICF and Social Care funding. In future there will be more use of directions as service redesign and recommissioning in line with the transformation programme is progressed.

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

The IJB Chief Officer is responsible and accountable to the Board for all aspects of management including promoting sound governance and providing quality information/support to inform decision-making and scrutiny.

Regular meetings are held between the Chief Officer and the Chair and Vice Chair of the IJB. The IJB Chief Officer also meets regularly with the Chief Executives of the partner organisations.

Members of the IJB Board are provided with the opportunity to attend Development Sessions relevant to their role.

F. Managing risks and performance through robust internal control and strong public financial management

The IJB Chief Officer has overall responsibility for directing and controlling the partnership. The IJB Board is responsible for key decision-making.

The IJB has approved a Risk Management Strategy which includes: the reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities; and monitoring risk management activity and performance.

The IJB Chief Financial Officer is responsible for the proper administration of all aspects of the Partnership's financial affairs including ensuring appropriate advice is given to the Board on all financial matters. The IJB CFO post has been filled on an interim basis until August 2019.

The IJB's system of internal financial control is dependent upon on the framework of financial regulations, regular management information, administrative procedures (including segregation of duties), management supervision and systems of delegation and accountability within the partner organisations.

Revenue Budget Monitoring reports are presented to the Board at each meeting for monitoring and control purposes including the annual outturn. Financial reporting for the

partnership requires the application of appropriate financial regulations, codes of financial practice, and reporting standards.

The IJB also relies upon the partners for:

- pursuing a proactive, holistic approach to tackling fraud, theft, corruption and crime, as an integral part of protecting public finances, safeguarding assets, and delivering services effectively and sustainably; and
- management of data in accordance with applicable legislation.

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

The Chief Officer Audit & Risk of Scottish Borders Council is the IJB's Chief Internal Auditor to provide an independent and objective annual opinion on the effectiveness of internal control, risk management and governance. This is carried out in conformance with the Public Sector Internal Audit Standards.

The IJB responds to the findings and recommendations of Internal Audit, External Audit, Scrutiny and Inspection bodies. The IJB Audit Committee is integral to overseeing assurance and monitoring improvements in internal control and governance.

Quarterly Performance Reports were presented to the Board for monitoring and control purposes. An Annual Performance Report for 2018/19 is being prepared to outline progress against strategic objectives over the year.

The Annual Accounts and Report for 2018/19 setting out the financial position in accordance with relevant accounting regulations is also being prepared.

The IJB completed a self-assessment return in May 2019 for the Ministerial Strategic Group as part of the review of progress with health and social care integration.

Review of Adequacy and Effectiveness

The IJB is required to conduct, at least annually, a review of the effectiveness of its governance framework.

The review was informed by: an annual self-assessment against the IJB's Local Code of Corporate Governance consistent with the principles of the CIPFA/SOLACE Framework (2016), carried out by IJB Internal Audit; IJB Internal Audit reports; IJB External Audit reports; relevant reports by other external scrutiny bodies and inspection agencies; and relevant partners' (NHS Borders and Scottish Borders Council) Internal Audit and External Audit reports.

During the year a full update of the IJB's Local Code of Corporate Governance was carried out as part of Internal Audit work with evidence of how good governance is operating in practice. This demonstrates that 12 of the previous year's 15 improvement actions have been addressed.

Improvement Areas of Governance

The review activity outlined above has identified the following areas where further improvement in governance arrangements can be made to enhance compliance with the Local Code:

1 Fully embed risk management into the culture of the IJB.
2 Develop a medium-term Financial Strategy.
3 Recruit on a permanent basis to the IJB Chief Financial Officer post.

The implementation of these actions to enhance the governance arrangements in 2019/20 will be driven and monitored by the IJB Chief Officer in order to inform the next annual review. Internal Audit work planned in 2019/20 is designed to test improvements and compliance in governance and risk management arrangements, achievement of transformation and change in service delivery (and the associated workforce development), and performance management.

Conclusion and Opinion on Assurance

It is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the IJB's governance arrangements and system of internal control, while recognising that improvements are required to fully demonstrate compliance with the Local Code in order for the IJB to fully meet its principal objectives. Systems are in place to regularly review and improve governance arrangements and the system of internal control.

Dr Stephen Mather
Chair

14 August 2019

Rob McCulloch-Graham
Chief Officer

14 August 2019

Independent Auditor's Report

Independent auditor's report to the members of Scottish Borders Integration Joint Board and the Accounts Commission

Report on the audit of the financial statements

Opinion on financial statements

I certify that I have audited the financial statements in the annual accounts of Scottish Borders Integration Joint Board for the year ended 31 March 2019 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Comprehensive Income and Expenditure Statement, Movement in Reserves Statement, Balance Sheet and notes to the annual accounts, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2018/19 (the 2018/19 Code).

In my opinion the accompanying financial statements:

- give a true and fair view in accordance with applicable law and the 2018/19 Code of the state of affairs of the board as at 31 March 2019 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2018/19 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing (UK) (ISAs (UK)), as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I was appointed by the Accounts Commission on 10 April 2017. The period of total uninterrupted appointment is three years. I am independent of the board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. Non-audit services prohibited by the Ethical Standard were not provided to the board. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern basis of accounting

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the Chief Financial Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the board's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Risks of material misstatement

I have reported in a separate Annual Audit Report, which is available from the Audit Scotland website, the most significant assessed risks of material misstatement that I identified and my conclusions thereon.

Responsibilities of the Chief Financial Officer and Integration Joint Board audit committee for the financial statements

As explained more fully in the Statement of Responsibilities, the Chief Financial Officer is responsible for the preparation of financial statements that give a true and fair view in accordance with the financial reporting framework, and for such internal control as the Chief Financial Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Chief Financial Officer is responsible for assessing the board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

The Integration Joint Board audit committee is responsible for overseeing the financial reporting process.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, intentional omissions, misrepresentations, or the override of internal control. The capability of the audit to detect fraud and other irregularities depends on factors such as the skilfulness of the perpetrator, the frequency and extent of manipulation, the degree of collusion involved, the relative size of individual amounts manipulated, and the seniority of those individuals involved. I therefore design and perform audit procedures which respond to the assessed risks of material misstatement due to fraud.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other information in the annual accounts

The Chief Financial Officer is responsible for the other information in the annual accounts. The other information comprises the information other than the financial statements, the audited part of the Remuneration Report, and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon except on matters prescribed by the Accounts Commission to the extent explicitly stated later in this report.

In connection with my audit of the financial statements, my responsibility is to read all the other information in the annual accounts and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Report on other requirements

Opinions on matters prescribed by the Accounts Commission

In my opinion, the audited part of the Remuneration Report has been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014.

In my opinion, based on the work undertaken in the course of the audit:

- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with statutory guidance issued under the Local Government in Scotland Act 2003; and

- the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the Delivering Good Governance in Local Government: Framework (2016).

Matters on which I am required to report by exception

I am required by the Accounts Commission to report to you if, in my opinion:

- adequate accounting records have not been kept; or

- the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records; or

- I have not received all the information and explanations I require for my audit.

I have nothing to report in respect of these matters.

Conclusions on wider scope responsibilities

In addition to my responsibilities for the annual accounts, my conclusions on the wider scope responsibilities specified in the Code of Audit Practice, including those in respect of Best Value, are set out in my Annual Audit Report.

Use of my report

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 120 of the Code of Audit Practice, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Gillian Woolman MA FCA CPFA

Audit Director
Audit Scotland
102 West Port
Edinburgh
EH3 9DN

August 2019

Statement of Accounts

Comprehensive Income and Expenditure Statement (CIES) for the Year Ended 31 March 2019

This statement shows the cost of providing services for the year according to accepted accounting practices. Where the impact on the General Fund is amended by statutory adjustments, these would be included in both the Expenditure and Funding Analysis and the Movement in Reserves Statement. For 2018/19, there are no statutory adjustments.

Gross Expenditure 2017/18 £'000	Income 2017/18 £'000	Net Expenditure 2017/18 £'000		Gross Expenditure 2018/19 £'000	Income 2018/19 £'000	Net Expenditure 2018/19 £'000	Note
96,247	0	96,247	Health Services Delegated	102,274	0	102,274	4,7
54,475	0	54,475	Social Care Services Delegated	58,432	0	58,432	
24,418	0	24,418	Health Services Retained and Set-Aside by NHS Borders	25,125	0	25,125	
150	0	150	Corporate Services	162	0	162	
175,290	**0**	**175,290**	**Cost of Services**	**185,993**	**0**	**185,993**	
0	(175,290)	(175,290)	Taxation and Non-Specific Grant Income	0	(185,993)	(185,993)	5
175,290	**(175,290)**	**0**	**Surplus or (Deficit) on Provision of Services**	**185,993**	**(185,993)**	**0**	
		0	**Total Comprehensive Income and Expenditure**			**0**	

The Integration Joint Board came into existence in February 2016. The 2018/19 Comprehensive Income and Expenditure Statement reflects the third year of financial operation.

Movement in Reserves Statement

The IJB does not at this time have Reserves.

The Comprehensive Income and Expenditure Statement reports no net surplus or deficit on the provision of services at 31 March 2019. No statutory adjustments have been made in respect of any absence entitlement on the part of the Chief Officer which has been earned but not yet taken as at 31 March 2019.

Following these positions therefore, no net movement in reserves has been calculated for 2018/19.

Balance Sheet at 31 March 2019

The Balance Sheet shows the value of the IJB's assets and liabilities as at the balance sheet date. The net assets of the IJB (assets less liabilities) are matched by the reserves held by the IJB. At 31 March 2019, these remain nil.

31 March 2018 £'000			31 March 2019 £'000		Note
11,694		Short-Term Debtors	15,002		6
	11,694	**Current Assets**		**15,002**	
(11,694)		Short-Term Creditors	(15,002)		6
	(11,694)	**Current Liabilities**		**(15,002)**	
0		Provisions	0		
	0	**Long-Term Liabilities**		**0**	
	0	**Net Assets**		**0**	
	0	Useable Reserve: General Fund		0	
	0	Useable Reserve: Employee Statutory Adjustment Account		0	
	0	**Total Reserves**		**0**	

The unaudited accounts were issued on 10th June 2019 and the audited accounts were authorised for issue on 14 August 2019

.

Michael Porteous CPFA
Chief Financial Officer

14 August 2019

Notes to the Annual Accounts

1 – Significant Accounting Policies

1.1 General Principles

The Annual Accounts summarise the Integration Joint Board's transactions for the 2018/19 financial year and its position at the year-end of 31 March 2019.

The IJB was established under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a section 106 body as defined in the Local Government (Scotland) Act 1973.

It is therefore required to prepare Annual Accounts by the Local Authority Accounts (Scotland) Regulations 2014. Section 12 of the Local Government in Scotland Act 2003 requires these to be prepared in accordance with proper accounting practices. These practices primarily comprise the Code of Practice on Local Authority Accounting in the United Kingdom 2016/17, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

The accounting convention adopted in the Annual Accounts is historical cost. They are prepared on a going-concern basis, which assumes that the IJB will continue in operational existence for the foreseeable future.

1.2 Accruals of Income and Expenditure

Activity is accounted for in the year in which it takes place, not simply when settlement in cash occurs. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the IJB.
- Income is recognised when the IJB has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.
- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.
- Where debts may not be received, the balance of debtors is written down.

1.3 Funding

The IJB is primarily funded through funding contributions from the statutory funding partners, NHS Borders and Scottish Borders Council. Expenditure is incurred as the IJB commissions specified health and social care services from the funding partners for the benefit of service recipients in the Scottish Borders.

1.4 Cash and Cash Equivalents

The IJB does not operate a bank account or hold cash. Transactions are settled on behalf of the IJB by the funding partners. Consequently, the IJB does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to / from each funding partner, as at 31 March, is represented as a debtor or creditor on the IJB's Balance Sheet.

1.5 Employee Benefits

The IJB does not directly employ staff. Officers are formally employed by the funding partners who retain the liability for pension benefits payable in the future. The IJB therefore does not present a Pensions Liability on its Balance Sheet.

The IJB has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as Employee-Related costs. Where material, the Chief Officers absence entitlement as at 31 March will be accrued, for example in relation to annual leave earned but not yet taken. There are no charges from funding partners for other staff.

1.6 Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation, as at 31 March, due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the IJB's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March, whose existence will only be confirmed by later events. A contingent asset is not recognised in the IJB's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

No provisions or contingent liabilities or assets have been made at 31 March 2019.

1.7 Reserves

The IJB's reserves are classified as either Usable or Unusable Reserves.

The IJB's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March shows the extent of resources which the IJB can use in later years to support service provision.

The IJB's only Unusable Reserve is the Employee Statutory Adjustment Account. This is required by legislation. It defers the charge to the General Fund for the Chief Officer's absence entitlement as at 31 March, for example any annual leave earned but not yet taken. The General Fund is only charged for this when the leave is taken, normally during the next financial year.

1.8 VAT

VAT payable is included as an expense only to the extent that it is not recoverable from Her Majesty's Revenue and Customs. VAT receivable is excluded from income.

In November 2016, HMRC issued an opinion on the VAT treatment of services provided by IJB's partners. This related to the VAT treatment of the exchanges of staff between the Health Board and Local Authority, when under the direction of the Integrated Joint Board.

Relevant to the Scottish Borders, where other than the Chief Officer, the supply of these services is seen as part of the party's statutory obligation/contribution to the IJB and therefore the LA/HB have not recharged for any costs incurred, HMRC's opinion is that there is no consideration and as such no supply for VAT purposes.

HMRC has issued a final view that the secondment of the Chief Officer is outside the scope of VAT as the provision of a Chief Officer by and HB and/or LA to the IJB is done under a special legal regime. Therefore the LA/HB should not be charging VAT to the other party on this supply as it outside the scope of VAT.

2 – Events after the Reporting Period

2.1 Events after the Reporting Period / Balance Sheet Date

The unaudited Annual Accounts were authorised for issue by the Chief Financial Officer on 10th June 2019. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provide information about conditions existing at 31 March 2019, the figures in the financial statements and notes would normally be adjusted in all material respects to reflect the impact of this information. There are no identified Events after the Reporting Period to 31 March 2019.

3 – Expenditure and Funding Analysis

3.1 Expenditure and Funding Analysis

The Expenditure and Funding Analysis shows how the funding available to the IJB in the form of funding partner contributions has been used in providing services. This is compared to the cost of services on an accounting basis.

2017/18				2018/19		
Net Expenditure Chargeable to the General Fund £'000	Adjustments £'000	Net Expenditure in the CIES £'000		Net Expenditure Chargeable to the General Fund £'000	Adjustments £'000	Net Expenditure in the CIES £'000
20,025	0	20,025	Joint Learning Disability Service	21,526	0	21,526
15,597	0	15,597	Joint Mental Health Service	16,973	0	16,973
767	0	767	Joint Alcohol and Drug Service	744	0	744
19,298	0	19,298	Older People Service	20,762	0	20,762
3,535	0	3,535	Physical Disability Service	3,599	0	3,599
			Prescribing*	22,737		22,737
89,396	0	89,396	Generic Services	71,482	0	71,482
23	0	23	Older Peoples Change Fund	85	0	85
2,081	0	2,081	Integrated Care Fund	2,798	0	2,798
24,418	0	24,418	Health Services Retained and Set-Aside by NHS Borders	25,125	0	25,125
150	0	150	Corporate Services	162	0	162
175,290	**0**	**175,290**	**Cost of Services**	**185,993**	**0**	**185,993**
(175,290)	0	(175,290)	Other Income and Expenditure	(185,993)	0	(185,993)
0	**0**	**0**	**(Surplus) or Deficit on Provision of Services**	**0**	**0**	**0**

* Prescribing expenditure was shown within Generic services in 2017/18

No adjustments are required in relation to the statutory requirement to defer any charge to the General Fund for the Chief Officer's absence entitlement at 31 March 2019.

4 – Expenditure and Income Analysis by Nature

4.1 Expenditure and Income Analysis by Nature

2017/18 £'000		2018/19 £'000
120,222	Services commissioned from NHS Borders	127,399
54,918	Services commissioned from Scottish Borders Council	58,432
126	Employee Benefits Expenditure	137
24	Auditor Fee: External Audit	25
(175,290)	Partners' Funding Contributions	(185,993)
(0)	**Cost of Services**	**(0)**

The Fee charged by the Independent Auditor for 2018/19 was £25,000.

5 – Taxation and Non-Specific Grant Income

5.1 Taxation and Non-Specific Grant Income

2017/18 £'000		2018/19 £'000
(125,250)	Funding Contribution from NHS Borders	(134,050)
(50,040)	Funding Contribution from Scottish Borders Council	(51,943)
(175,290)	**Taxation and Non-Specific Grant Income**	**(185,993)**

The funding contribution from the NHS Board shown above includes £25.125m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by the NHS which retains responsibility for managing the costs of providing the services. The IJB however has responsibility for the consumption of, and level of demand placed on, these resources.

6 – Debtors and Creditors

6.1 Debtors

The IJB's Debtors include money owed to the partnership at 31 March 2019 and any payments made in respect of delegated functions in advance of the 2019/20 financial year:

31 March 2018 £'000		31 March 2019 £'000
1,432	Funding NHS Borders	3,761
10,262	Funding Scottish Borders Council	11,241
0	Funding Non-Public Sector	0
11,694	**Debtors**	**15,002**

6.2 Creditors

The IJB's Creditors include payments due by the partnership not yet made by the 31 March 2019 and any income it has received in advance of the 2019/20 financial year:

31 March 2018 £'000		31 March 2019 £'000
(1,432)	Funding NHS Borders	(3,761)
(10,262)	Funding Scottish Borders Council	(11,241)
0	Funding Non-Public Sector	0
(11,694)	**Creditors**	**(15,002)**

7 – Related Party Transactions

7.1 Related Party Transactions

The IJB has related party relationships with NHS Borders and Scottish Borders Council. In particular the nature of the partnership means that the IJB may influence, and be influenced by, its partners. The following transactions and balances included in the IJB's accounts are presented to provide additional information on the relationships.

NHS Borders

2017/18 £'000		2018/19 £'000
(125,250)	Funding Contributions	(134,050)
0	Service Income	0
120,665	Expenditure on Services Provided	127,399
0	Key Management Personnel	0
12	Support Services	13
(4,573)	**Net Transactions with NHS Borders**	**(6,638)**

Key Management Personnel: There are no non-voting Board members employed by the NHS Board and recharged to the IJB..

31 March 2018 £'000		31 March 2019 £'000
1,432	Debtors: Amounts Due from NHS Borders	3,761
(1,432)	Creditors: Amounts Due to NHS Borders	(3,761)
0	**Net Balance with NHS Borders**	**0**

Scottish Borders Council

2017/18 £'000		2018/19 £'000
(50,040)	Funding Contributions	(51,943)
0	Service Income	0
54,475	Expenditure on Services Provided	58,432
126	Key Management Personnel	137
12	Support Services	13
4,573	**Net Transactions with Scottish Borders Council**	**6,638**

Key Management Personnel: The senior officers employed by the Local Authority and recharged to the IJB include only the Chief Officer. Details of the remuneration for some specific post-holders are provided in the Remuneration Report.

31 March 2018 £'000		31 March 2019 £'000
10,262	Debtors: Amounts Due from Scottish Borders Council	11,241
(10,262)	Creditors: Amounts Due to Scottish Borders Council	(11,241)
0	**Net Balance with Scottish Borders Council**	**0**

8 – Other Notes to the Accounts

8.1 Provisions:

No provisions have been made at the 31 March 2019.

8.2 Useable Reserve: General Fund:

The IJB does not hold a balance on its General Fund Reserve at 31 March 2019. The IJB has an approved Reserves Policy which enables it over time to earmark or build up funds which are to be used for specific purposes in the future such as known or predicted future expenditure needs. This supports strategic financial management. The Policy can also enable a contingency fund to be established in order to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the IJB's risk management framework.

8.3 Unusable Reserve: Employee Statutory Adjustment Account:

Only one officer, the Chief Officer, requires to be considered in relation to absence entitlement earned but not yet taken at 31 March 2019. The value of this untaken but accrued entitlement is not considered material to the overall financial position of the IJB as presented in the Comprehensive Income and Expenditure Statement.

8.4 Agency Income and Expenditure:

The Scottish Borders Partnership IJB is co-terminus between NHS Borders and Scottish Borders Council. The IJB does not act as the lead agency / manager for any delegated health or care services nor does it commission services on behalf of any other IJBs.

8.5 Contingent Assets and Contingent Liabilities:

No Contingent Liabilities or Contingent Assets have been identified relating to any item not recognised on the IJB's Balance Sheet.