Scottish Borders

Integrated Care Fund End of Project Report

March 2018

Project Name	1 - Community Led Support		
Project Owner	Murray Leys	**Main Contact Telephone**	01835 826 594
Main contact email	Murray.Leys@scotborders.gcsx.gov.uk		

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

Since September 2016 the Health and Social Care Partnership have been working with the National Development Team for Inclusion (NDTi) to deliver an 18 month programme of change in the way that health and social care services are accessed across the Scottish Borders.
Community Led Support (CLS) aims to provide locally based hubs which can be easily accessed by local people as the first point of contact for health and social care services.
The programme builds on existing access such as through Customer Services and Social Work Duty Teams and relies on working together in local communities, voluntary groups and organisations that already connect with people.
This model has been successful in other areas in terms of eliminating waiting lists, improved customer satisfaction, increased staff morale and motivation as well as savings in Council budgets, and the intention is to replicate that success here in the Scottish Borders.

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

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

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

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

★-High Impact

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

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

★-High Impact

3 Original Project Aims

The original aims of the project were to:

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

4 Project outcomes and benefits achieved

The original project outcomes are listed below:

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

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

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

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

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

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

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

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

Initial feedback from Hub staff has also been positive.

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

Social Work Team Member

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

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

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

All five Localities within the Scottish Borders.

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

Older people and adults with lower level health and social care needs.

7	Current project end date

31 March 2018.

8	How much ICF Fund allocated

Original ICF Allocation	Predicted Spend to end of March 18
£90,000 + £11,216 approved by exception report in December 17 + **£101,216**	£101,216

9	Staff recruited to support delivery of the project

1 x Full-time Project Support Officer for a year which is now coming to an end.

10	Invest to save proposals identified for the project

The more efficient use of resources is a specified outcome of the CLS programme. A reduction in waiting lists and the need to offer a full assessment for example, are associated with savings that offset the cost of set up and delivery.

While the limited length of time the What Matters Hubs have been operational in the Scottish Borders means that it is not possible at this time to conduct a detailed cost analysis, it would be the responsibility of the Community Hub Facilitator funded by this application to demonstrate the expected savings to the Health & Social Care Budget.

11	Project support requirements beyond end of March 2018

- Venue hire for a year - £22,432 (costs with partner agencies have been negotiated to the minimum amount)
- Costs for staffing to support delivery - £1 x Full-time Community Hub Facilitation Officer Band 7a £34,241.12 for a full year, including on costs. Responsibilities would include facilitation, administrative tasks, booking of venues, data collation and payment of invoices and continued networking to build Third Sector and Health participation across all localities

Total funds requested: £56,673

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Scottish Borders

Integrated Care Fund End of Project Report

March 2018

Project Name	No 2 - Local Integration and Improvement Lead – Independent Sector		
Project Owner	Margaret McGowan	**Main Contact Telephone**	07919315590
Main contact email	Margaret.mcgowan@scottishcare.org		

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

The independent sector is the largest provider in health and social care delivery in Scotland and this development has meant more choices for people, more savings for the public purse but correspondingly the need for a more highly skilled workforce. The major shift in service delivery over the past 10 years has been in many local authority areas, the decline in the public sector as a direct provider, with a corresponding increase in independent sector provision. Independent care and support services in Scotland have an annual turnover of over £1bn. Some 117,110 (59.4%) of Scotland's total social services workforce of 210,000 work in care homes, care at home and housing support services (Source: Care Commission and Scottish Government 2010). Reshaping care for older people, change fund and now the Integration Agenda activity, personalisation and self-directed support means the independent sector requires the enabling support of a Local Integration Lead to meet current, changing and future demand. The Scottish Government sees care at home increasing in the next 10 years and care homes delivering new care models. There is an opportunity for new provision to be developed in Borders driven by the future need for more cost-efficiencies, savings, shared risk and best value from within the independent sector. The Local Integration Lead will represent Scottish Care and the Local Independent Sector Providers within the partnership area.

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

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

This project has an indirect impact on all 9 of the National Health and Wellbeing outcomes.
To ensure that providers are effectively communicated with and supported

3 Original Project Aims

Identify appropriate health care modules for enhanced support worker roles
To improve quality of life in care homes
To develop care homes to provide different models of care
To help facilitate a timely discharge
The development of different models of care and support will support the discharge agenda and prevention of admission to hospital
To develop a Rapid Reaction service which functions to capacity
To consider outreach models with care homes
To support with changes to Medication and introduction to Mar charts, and training in administration of medication
Work with providers in engagement of MHL programme
Source appropriate Dementia Training
Improve activities in care homes
Work with Partners for Dementia
Workforce Development
To source and assist providers in Reablement
Increase number of SDS related services
Work with Palliative Group to improve services in community

4 Project outcomes and benefits achieved

Independent Sector Care Providers were surveyed in February 2017 to determine their level of engagement within the partnership. The aim was to increase engagement within the independent sector and increase provider awareness of local activity from 10% to around 75%, as well as reduce the feeling of isolation of the care home managers and encourage partnership working.

55% of those surveyed felt engaged with others in their sector.

Of the 4 examples of local partnership activities given, 78% of providers were aware of all 4, 100% were aware of at least 2. (Locality Working Groups, Community Led Support, My Home Life, Stress and Distress Training)

Providers noted good relationships and communication with the Independent Sector Rep but some difficulties with communication at locality level. A further survey of providers is currently being conducted in February 2018.

The overarching aim of the 'Engaging the Independent Sector' project, is to ‘ensure that the sector is a full partner at both national strategic policy level and at a local level, engaged fully across Integration, future joint commissioning strategies, health and social care integration and other key policy drivers such as self-directed support.’ We believe that meaningful involvement of the Independent Sector in the Integration agenda is pivotal to ensuring that local plans are informed by an understanding of current service provision and the reality for service providers in developing and delivering future service
The Independent Sector is represented as a full partner, effectively contributes to decision making and promotes the appropriate inclusion of independent services in national strategy and policy
is represented as a full partner, effectively contributes to shaping relevant policies and decisions, promotes the appropriate inclusion of independent services and has a joint ownership of the agenda at a local level, is better informed, grows provider capacity to manage change and has an increased number of organisations effectively contributing to the aims and the implementation of the programme at a local level

has developed feasible options to effectively sustain participation in national and local programmes has improved opportunities for and is engaged in the development of its workforce. This has been part on role, lead has been a conduit of information for the I.S sharing ideas, tools, resources, pathways, experience and guidance. MHL programme, connected care, Training consortium, SVQ Training Centre, updated policies and procedures, assisted with increased grades in CI Inspections. Local Partnership Profile, improved communication, high level representation, governance, improved decision making, attribution and clearer intelligence about the impact of the role of the sector, increased partnership working,

5	What areas of the Borders does the project cover

Project covers Borders wide.

6	What care groups does the project affect?

Was predominantly older people now includes all adults currently

7	Current project end date

31/03/1/2018

8	How much ICF Fund allocated

Original ICF Allocation	Predicted Spend to end of March 18
£93,960	£75,330

9	Staff recruited to support delivery of the project

1 x Local Integration and Improvement Lead - for 17.5 hrs pw

10	Invest to save proposals identified for the project

Not applicable to this project

11	Project support requirements beyond end of March 2018

	Local Integration and Improvement Lead for 17.5 hours per week for 12 months at £28,165 Support will be needed to oversee the My Home Life Project, also a support for providers for someone attending meetings and being a conduit of information for them, providers will need to be supported in the community and to be seen as working in a partnership and not be left on the outside. Providers will need support in setting up of their 'Training consortium' this is a group of providers getting together to share training, good practice, tools, resources and staff, continuation of the set up of an SVQ Centre, The Independent Provider engagement would be detrimental to the sector and area if post is discontinued.
	Please return this form to the Programme Team by Friday 23 March 2018 **Email: IntegratedCareFund@scotborders.gov.uk** **Phone:** 01835 82 5080

Integrated Care Fund End of Project Report

March 2018

Project Name	No 3 - Community Transport Hub		
Project Owner	British Red Cross	**Main Contact Telephone**	01361 884652
Main contact email	Allister.hart@bavs.org.uk		

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

Scottish Borders Council, NHS Borders, The Bridge, The Red Cross, Berwickshire Association of Voluntary Services and the RVS have been partners in this Community Transport Hub (CTH) project with the aim of putting in place a co-ordinated, sustainable approach to community transport provision.

Rather than all providers working in a silo based manner, Borders Community Transport providers have worked together and aligned their systems to make best use of available transport and reduced duplication of journeys. The project has facilitated an integrated solution for older people accessing health and social care services. A single point of contact booking system has been utilised to allow service users to simply call one number where staff will co-ordinate transport for the user by engaging with a variety of transport providers.

A web based booking system has been utilised with staff booking journeys in a way that better suits the service user. The service user is asked a series of questions at point of booking tailored in such a way as to ensure that whoever is dealing with the booking can ensure the correct mode of transport is booked e.g. accessible vehicle allowing staff to provide a form of transport that is most suited to the users' needs.

The Community Transport Hub has:-

- engaged citizens & customers;
- provided a single point of contact and information;
- facilitated one number for all;
- hosted a single vehicle booking system;
- built a volunteer base; ensured service quality;
- reported on performance; and
- contributed to the wider aims of the Strategic Transport Board.

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

Health and Social Care Plan

Objective 1 We will make services more accessible and develop our communities.
The CTH does exactly what objective 1 requires in providing a single point of contact for accessible transport. The majority of transport is provided by volunteers providing volunteering opportunities for members of the community developing strong communities.

Objective 2 We will improve prevention and early intervention – ensuring that people struggling to manage independently are quickly supported through a range of services that meet their individual needs.
The CTH single point of contact supports people to be independent by enabling easy access for their transport needs. Hub Operators negotiate changes to appointment times and dates to ensure transport is available. In addition they identify individuals who need additional support and signpost to other services. The single number also gives individuals access to transport for their social needs e.g. attendance at social centres and lunch clubs.
Objective 3 We will reduce avoidable admissions to hospital – by appropriate support in the right place at the

right time, we will ensure people are supported to remain in their own homes.
CTH assists people to make their way through the health and social care system by ensuring attendance for appointments thus reducing the need for hospital admissions and move to residential care.

Objective 4 We will provide care close to home – accessible services which meet the needs of local communities, allows people to receive their care close to home and build stronger relationships with providers.
The CTH supports people to live independently and healthily in local communities. By facilitating transport that enables people with physical disability to fully engage in their local community. Many clients suffer with dementia. Hub staff are experienced in supporting them to remain independent within their own home with easy access to transport when required.

Objective 5 We will deliver services within an integrated care model – through working together we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.
The CTH is the point of contact for a range of accessible transport providers operating across the Scottish Borders. The single point of contact is available to the Scottish Ambulance Service and all other statutory services providing an integrated approach to transport requirements. This approach has increased the satisfaction of staff, reduced time and relieved anxiety.

Objective 6 We will seek to enable people to have more choice and control. - ensuring people have more choice and control means they have the health and social care support that works best for them.
The CTH as a single point of contact for accessible transport enables people to have choice as to their means of attending appointments and social activities. They do not need to rely on relatives, neighbours or friends. The Hub provides an integrated, high quality service.

Objective 7 We will further optimise efficiency and effectiveness – strategic commissioning requires us to constantly analyse, plan, deliver and review services which give us flexibility to change what we do and how we do it.
Before the establishment of the CTH, Scottish Ambulance Service and other services were provided with a confusing range of contact points for Community Transport Services. The analysis of this confusion led to the original ICF application and the development of the single point of contact. To return to the previous situation will increase the confusion and anxiety. The Hub has an oversight of all community transport provision and is able to provide data and analysis identifying need in particular communities.

Objective 8 We will seek to reduce health inequalities – ensuring people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.
The development of the CTH is one of the changes that ICF enabled putting in place a coordinated approach to providing community transport. The Hub has ensured openness and consistency around access to services. It has worked with community transport providers across all sectors to provide appropriate, affordable and accessible transport services. It has helped to reduce health inequalities and supported those who are vulnerable in our communities.

Objective 9 We want to improve support for Carers to keep them healthy and able to continue in their caring role.
The CTH provides a single point of contact relieving anxiety that Carers might otherwise experience in securing accessible transport for those they care for. They are reassured that the transport provided will deliver a door to door service enabling them to have respite from their responsibilities.

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

Health and Social Care Annual Report performance against key priorities 16/17
Develop integrated and accessible transport.
The CTH has put in place a coordinated, sustainable approach to community transport provision.

3 Original Project Aims

Strategic Objectives

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

Project Objectives

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

4 Project outcomes and benefits achieved

Between 1 October 2015 (CTH start date) and 31 January 2018 the CTH facilitated 8,962 journeys, of this number 4,366 were for hospital appointments. 80% of service users agreed that the service has increased independence.
Since the beginning of the project 1,049 service users, not previously known to Community Transport providers registered with the CTH.
A survey in early 2017, (100 survey forms sent, 82 returned) resulted:

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

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

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

Because the CTH coordinators have a Borders wide view of transport provision, they have been able on many occasions to arrange shared journeys reducing costs and unnecessary or duplication of journeys.
The coordinators have become skilled at negotiating with hospital departments and health providers' changes to appointment times to ensure missed appointments do not occur.
When further support is needed for individuals the operators signpost to other services.
In 2016 CTH received The Transport Times Accessibility Project of the year award against stiff competition from Edinburgh Airport and Glasgow Central Station.

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

Borders wide service. Delivery of transport is provide by Berwickshire Wheels, British Red Cross, Gala Wheels, Teviot Wheels, Tweed Wheels and The Royal Voluntary Service.

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

Residents of the Scottish Borders who are elderly or disabled and do not have access to a family car and limited in their ability to access public transport.

7	**Current project end date**

31st March 2018

8	**How much ICF Fund allocated**

Original ICF Allocation	Predicted Spend to end of March 18
£139.000	£139,000

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

Two Hub Co-ordinators currently employed and line managed by the British Red Cross (not to continue after 31 March 2018.
One Project Development Office in year 2, contract ended. Project Development Officer seconded from BAVS since 1 October 2017 (not to continue after 31 March 2018) Not funded by ICF.
Dedicated driver in post from August 2017 to help meet the excess demand for the community transport generated by the CTH.

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

The CTH has sight of all community transport provided across the Borders that has enabled many shared journeys reducing the costs of duplication and CO2 emissions and improving efficiencies.
CTH coordinators have built working relationships with hospital departments and local health providers negotiating changes to appointment times to a time when transport is available reducing missed appointments.
Hub operators identify individuals requiring additional support to retain their independence and signpost to other services.
The service relieves anxiety around transport requirements helping people to retain their independence and remain in their own homes reducing the need for hospital admissions and residential care.
The single number increases efficiency for agency staff.

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

To mainstream the Borders Community Transport Service Hub (CTH) and to provide sustainability for the future.

The British Red Cross currently host and manage the CTH. This will not continue after 31 March 2018. Berwickshire Association for Voluntary Service could potentially take on this role if a budget could be secured to cover one-off start-up costs and funding agreed for 3 years with the option to extend after that period. The first year budget (2018/19) is estimated at £65,900. Annual cost for the following years is estimated at £55,100. There will need to be an agreed annual inflation element. Payment to be made annually in advance.

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Scottish Borders

Integrated Care Fund End of Project Report

March 2018

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

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

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

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

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

The Locality Coordinator role is to:

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

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

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

<u>Make Services More Accessible and Develop Our Communities</u>

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

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

Provide care close to home

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

Deliver services with an integrated care model

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

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

g3	Original Project Aims

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

- Provide community-based education;
- Support people towards self –management of conditions.

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

4 Project outcomes and benefits achieved

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

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

services).
The group reported a low level of consultation with communities on services which may indicate a need for further work in this area.
The number of group members who felt there was strong engagement between H&SC Partners and the community increased from 33% at the beginning to 56% after the first year.

5	What areas of the Borders does the project cover

Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale

6	What care groups does the project affect?

All care groups within Adult health and social care

7	Current project end date

31 March 2018

8	How much ICF Fund allocated

Original ICF Allocation	Predicted Spend to end of March 18
£259,500 + £50,818 agreed to extend project from October 2017 - £310,318	Approximately £300,000

9	Staff recruited to support delivery of the project

3 Locality Coordinators to September 2017. One Locality Coordinator from October 2017 end of March 2018

10	Invest to save proposals identified for the project

Invest in this single point of contact for monitoring, implementation of Health and Social Care Locality Action Plans across all 5 localities, this will ensure progress is sustained and Scottish Government guidance for ongoing locality engagement is successfully achieved

11	Project support requirements beyond end of March 2018

Locality Coordinator extension to contract for 12 months and administrative support for the same period, to allow transition to health and social care operations in the long term. Total cost £79,652.

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Scottish Borders

Integrated Care Fund End of Project Report

March 2018

Project Name	No 16 - The Matching Unit		
Project Owner	Murray Leys	**Main Contact Telephone**	01835 824000
Main contact email			

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

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

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

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

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

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

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

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

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

We will reduce avoidable admissions to hospital by:

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

We will provide care close to home by:

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

We will deliver services with an integrated care model by:

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

We will further optimise efficiency and effectiveness by:

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

3 Original Project Aims

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

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

4 Project outcomes and benefits achieved

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

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

2) Increase in the caseload held per Care Manager

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

3) Care Manager Staff Satisfaction

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

Some staff feedback:

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

4) Matching Unit Staff Satisfaction

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

5) Care Provider Satisfaction

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

What areas of the Borders does the project cover

The Matching Unit cover the whole of the Scottish Borders.

6 What care groups does the project affect?

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

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

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

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

7 Current project end date

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

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

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

8	How much ICF Fund allocated

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

9	Staff recruited to support delivery of the project

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

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

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

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

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

Office Supplies - £250

Travel - £600

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

Total £152,850

10	Invest to save proposals identified for the project

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

11	Project support requirements beyond end of March 2018

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

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Scottish Borders

Integrated Care Fund End of Project Report

March 2018

Project Name	No 25(a) - Discharge to Assess at Craw Wood		
Project Owner	Jane Prior	**Main Contact Telephone**	01896 826271
Main contact email	Jane.prior@gmail.com		

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

Craw Wood, owned by Eildon Housing, has been re-furbished to provide facilities for up to 15 adults, opening with 8 beds at the start of December 2017, which increased to 15 at the start of January 2018, to be discharged from BGH for a residentially based assessment of critical needs and to await any required package of care prior to returning to their own home. Craw Wood is staffed 24 hours a day and registered with the Care Commission to provide short term care and support. A team of care managers from START complete assessments and request any POC and/or equipment required for discharge home. The project is supported by input as required by GP and DN from Waverley Practice.

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

Craw Wood is part of the new policy of discharging patients from hospital to undertake an assessment of need at home or in a homely setting. This project will help inform medium and long term strategy development on discharge to assess through the collection of quantitative and qualitative data.

The project has high impact against the following strategic objectives:

Reduce avoidable admissions to hospital
Deliver services within an integrated care model
Further optimise efficiency and effectiveness

This project also delivers against the key priorities for 2017/18 set out in the last Annual Performance Report in terms of redesigning care pathways.

3 Original Project Aims

To introduce a new policy of discharging patients from hospital to undertake an assessment of need in a homely setting.

For evaluation of the Craw Wood pilot to instruct and direct the Social Care Partnership with regard to the optimal operational model for Discharge to Assess.

4 Project outcomes and benefits achieved

Key Outcomes/Outputs

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

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

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

5	What areas of the Borders does the project cover

Patients are discharged from the BGH to Craw Wood from any area of Scottish Borders.

6	What care groups does the project affect?

Adults over 50 years of age who have had an admission to the BGH and who either have capacity to make an informed decision to consent to a move to Craw Wood or, who have a legal proxy for welfare decisions who is willing to work with the START team to ensure that the person is discharged to their own home within a maximum of two weeks of admission to Craw Wood.

7	Current project end date

March 31st 2018.

8	How much ICF Fund allocated

Original ICF Allocation	Predicted Spend to end of March 18
£441,683 + Contingency fund £54,283 **£495,966**	£210,350 No SB Cares costs included for duration of project

9	Staff recruited to support delivery of the project

1 x Occupational Therapist (agency contract)
2 x FTE care managers from core START team with backfill to START by agency social worker.

10	Invest to save proposals identified for the project

By discharging to assess from BGH as soon as person fit for discharge a contribution has been made to reducing delayed discharges and bed occupancy days.

11	Project support requirements beyond end of March 2018

To be agreed.

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Integrated Care Fund End of Project Report

March 2018

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

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

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

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

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

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

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

2 Project’s strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

Priority: Re-imagining Health and Social Care Teams

We will reduce avoidable admissions to hospital by:

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

We will improve prevention and early intervention by:

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

We will deliver services with an integrated care model by:

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

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

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

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

We will further optimise efficiency and effectiveness by:

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

3 Original Project Aims

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

4 Project outcomes and benefits achieved

The outcomes for this project are:

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

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

What areas of the Borders does the project cover

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

6 What care groups does the project affect?

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

7 Current project end date

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

8	How much ICF Fund allocated

Original ICF Allocation	Predicted Spend to end of March 18
£108,283	£25,000 (Berwickshire phase only)

9	Staff recruited to support delivery of the project

2.7 WTE staff are employed as Health Care Support workers for this project in Berwickshire. There is also a 37.5hr post to backfill the district nurses who are providing line management for the team.

10	Invest to save proposals identified for the project

11	Project support requirements beyond end of March 2018

The pilot has been agreed to be extended the Berwickshire Pilot to end of June 2018. The pilot has also been agreed to be expanded to Hawick and Central Localities to provide a more robust sample to test and evaluate the model.

To fully understand and evaluate the impact of this model it will require a further 12 months funding as this is radically changing the model of service provision for the local population. Proposal to carry forward remaining £83k of allocated fund to 18/19 to support project going forward.

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Scottish Borders

Integrated Care Fund End of Project Report

March 2018

Project Name	Stress and Distress Training		
Project Owner	Brian Paterson	**Main Contact Telephone**	01896 827156
Main contact email			

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

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

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

This approach can improve the quality of life for individuals with dementia, their carers, families and staff. This proactive training can reduce exacerbation in situations that may result in the need for residential or hospital care.
This model has demonstrated significant results in reducing the frequency of distressed behaviour for the person with dementia and staff/carer distress (Wood-Mitchell et al, 2007).

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

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

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

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

★ **High Impact**

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

3 Original Project Aims

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

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

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

(all above objectives are quantitatively measurable)

- To positively impact on health and wellbeing of receivers of therapeutic intervention

(quantitative and qualitative ,enabled through evaluation, measurement)

4 Project outcomes and benefits achieved

Outcomes/ Outputs	Baseline	Target	Actual	Comments
Deliver 2 day training	16	200 staff	217 *(Up to end Feb 2018)*	It should be noted that in total **352** training places have been offered for this training. The smaller number of people trained is reflective of a significant number of cancellations and participants not attending on the day.
Deliver bite size training	20	500 staff	433 *(Up to end Feb 2018)*	It should be noted that in total **646** training places have been offered to date. The smaller number of people trained is reflective of a significant number of cancellations and participants not attending on the day.
Reduction in admission into care				This data is being collected as routine audit data for NHS Borders and will be available at the end of March 2018 as part of the final evaluation of the project.
Reduction in Antipsychotic and 'As Required (PRN)' prescribing				
Reduction in length of patient stay				
Reduction in readmission to hospital				
Datix incidences of violence and aggression				
Improvement in receiver health and wellbeing				

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

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

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

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

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

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

A database of all staff attending training is maintained.

5	What areas of the Borders does the project cover

Whole of Borders

6	What care groups does the project affect?

Adults with Dementia co- morbidity with mental health issues people with learning disability, functional mental health issues, physical conditions and long term neurological conditions.

7	Current project end date

31st March 2018

8	How much ICF Fund allocated

Original ICF Allocation	Predicted Spend to end of March 18
£166,000	£70,000

9	Staff recruited to support delivery of the project

Project Lead Psychologist 18.75 hours per week

10	Invest to save proposals identified for the project

N/A

11	Resources required to sustain the project

Lead Psychologist – 18.75 hours per week
Administrator – 4 hours a week

12	Project support requirements beyond end of March 2018

Request to carry over approximately £96,000 from April 2018 until March 2020. This will allow continued delivery of training and ongoing support for the implementation and supervision of staff delivering Stress and Distress in Care Homes and mental health wards across Borders. This will allow the model to be embedded into practice and ensure sustainability. NHSB and SBC are developing an Older Adults Outreach Service and the model of service delivery will be based around Stress and Distress. Ongoing supervision of the model by a Clinical Psychologist is essential to this work. NHSB will review the ongoing funding of this post beyond 2020 as part of the current service transformation work.

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Integrated Care Fund End of Project Report

March 2018

Project Name	Buurtzorg in the Borders		
Project Owner	Erica Reid	**Main Contact Telephone**	01896 828267
Main contact email	Erica.reid@borders.scot.nhs.uk		

Guidance on End of Project Report

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

1 Outline project description

Please summarise the project in no more than 250 words

This project aims to bring the principles of the Buurtzorg model of neighbourhood nursing to a new model of integrated health and social care in Coldstream. The district nursing team and SB cares team in Coldstream are using this model to guide them in approaching care as a multi-agency team with a person-centred approach. This is a holistic approach to providing integrated care in the individual's home, through teams that will be self-organising and linking into the assets of the local community.

2 Project's strategic fit with key priority areas for the Scottish Borders H&SCP

(Refer to strategic plan and annual performance report for key priorities)

The strategic fit is with the IJB priority of 're-imagining health and social care teams'.

3 Original Project Aims

The project aims to provide a radically different model of teamworking in a local community. This will lead to improvements in care co-ordination and reducing the footfall of people providing health and care services that go into people's homes. It also aims to reduce the amount of care people require in their homes by providing a co-ordinated approach to care for those who receive both health and social care services.

4 Project outcomes and benefits achieved

This model is enabling the Coldstream team to move towards truly integrating care in people's homes. We have established IT to enable the SB Cares team leader to be co-located on Thursdays. We have set up a weekly multi-agency meeting where people receiving care in the local community to ensure their care needs are being met in the most effective manner.

5 What areas of the Borders does the project cover

It currently covers the Coldstream area, but it is anticipated to spread this to other localities once this has been tested.

6 What care groups does the project affect?

The affects patients who are on the District Nurse caseload in the Coldstream area, and it also affects people in the locality who are receiving care from SB Cares.

7 Current project end date

The current project end date is March 2018.

8 How much ICF Fund allocated

Original ICF Allocation	Predicted Spend to end of March 18
£52k	0

9	Staff recruited to support delivery of the project

The District Nurse team lead has been provided with 22.5 hours backfill to provide leadership to the project. There have been two Healthcare Support Workers recently appointed to enable flexibility of care provision and an enabling approach to return people to as much independence as possible.

10	Invest to save proposals identified for the project

N/A

11	Project support requirements beyond end of March 2018

This is a radically different model of working from our current practice. To enable this to continue in its development this will require project management support, data analyst for evaluation, funds to allow carers employed by SB Cares to attend a weekly hour long huddle on patient/service user priorities and the continued employment of the two HCSWs.

It also requires the appointment of a 'coach/heat shield' individual to facilitate the team to self-organise and work with the team to reduce the organisational bureaucracy that reduces the service user facing time for the teams.

It is proposed existing allocation of £52k is carried over to fund project support for 18/19 and that an additional £45k is allocated to fulfil the heat shield function.

A Project Board has been set up to oversee implementation plans and progress.

Please return this form to the Programme Team by Friday 23 March 2018
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080