Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Autism - Borders Autism Strategy and Delivery Plan

Date Start: February 2017

Date End: February 2019

Project Description & Scope:

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

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

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

Project Outcome

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

	the sub group that has been established.

Project Achievements - Outputs

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

Project spend to date

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

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

Project projected spend to end of project

Projected spend to 28 February 2019 - £99,386

Autism Coordinator Salary - £84,000

Other staffing costs - £7,056

Other expenditure (Travel, Purchased services, equipment) - £8,330

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

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

Date Start: April 2017

Date End: 31 March 2019

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

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

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

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

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

Project Outcome

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

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

Project Achievements - Outputs

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

Project spend to date

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

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

Project projected spend to end of project

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

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

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Stress & Distress Training

Date Start: April 2016

Date End: March 2020

Project Description & Scope:

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

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

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

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

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

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

Project Outcome

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

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

Project Achievements - Outputs

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

Project spend to date

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

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

Project projected spend to end of project

Projected spend to March 2020 - £166,000

Breakdown of how this will be spent

Project Summary Document

Scottish Borders
Health and Social Care
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Project Name: Transitions for young people with a Learning Disability

Date Start: October 2016

Date End: September 2019

Project Description & Scope:

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

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

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

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

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

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

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

Project Outcome

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

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

Project Achievements - Outputs

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

Project spend to date

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

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

Project projected spend to end of project

Project spend to September 2019 - £56,949

Year 2 2018-19

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

Year 3 2019-20

Evaluation	£10,000

Original ICF funding awarded: £65,200

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

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Transitional Care Facility

Date Start: January 2017

Date End: December 2018

Project Description & Scope:

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

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

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

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

Project Outcome

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

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

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

Project Achievements - Outputs

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

Project spend to date

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

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

Project projected spend to end of project

Projected spend to end of project - £827,411

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

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

Project Summary Document

Scottish Borders
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Project Name: Pharmacy Input to Social Care

Date Start: January 2018

Date End: December 2018

Project Description & Scope:

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

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

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

Project Outcome

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

Project Achievements – Outputs

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

Project spend to date

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

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

Project projected spend to end of project

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

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

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

Project Summary Document

Scottish Borders
Health and Social Care
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Project Name: GP Cluster Project

Date Start: March 2017

Date End: December 2018

Project Description & Scope:

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

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

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

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

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

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

Project Outcome

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

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

Project Achievements - Outputs

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

Project spend to date

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

Details of spend eg. salaries, equipment, travel

Project projected spend to end of project

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

Projected spend of remaining funds with detail

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Pathway 2 Project – domestic abuse

Date Start: July 2017

Date End: June 2020

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

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

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

Project Outcome

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

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

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

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

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

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

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

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

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

Project Achievements - Outputs

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

Project spend to date

Spend to 31st March 2018 - £67,935

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

Project projected spend to end of project

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

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

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Buurtzorg (neighbourhood care) in the Borders

Date Start: October 2017

Date End: March 2019

Project Description & Scope:

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

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

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

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

Project Outcome

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

Project Achievements - Outputs

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

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

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Craw Wood refurbishment and staffing

Date Start: December 2017

Date End: September 2018

Project Description & Scope:

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

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

Project Outcome

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

Target 100%	

Project Achievements - Outputs

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

Project spend to date

Projected spend to end April 2018 - £667,802

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

Project projected spend to end of project

Projected Annual Cost - £885,525

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

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

Project Summary Document

Scottish Borders
Health and Social Care
PARTNERSHIP

Project Name: Hospital to Home

Date Start: January 2018

Date End: June 2018

Project Description & Scope:

A pilot has been running in Berwickshire, where Health Care Support Workers (HCSW) have been recruited to support care provision in that community. Delivery involves close partnership working with Social Work, District Nursing, SB Cares and community hospitals. The HCSW are employed by and work under the governance of the NHS, working closely with SB Cares colleagues to compliment the provision of care at home. The 18 December 2017 IJB meeting approved the extension of the "Hospital to Home" pilot beyond Berwickshire to Hawick and Central Localities. This will allow more patients to be supported, and as well as providing greater care capacity over the winter period, it will offer a more robust sample to test and evaluate the model. The Hospital to Home proposal offers the opportunity for individuals delayed in hospital to go home where they will be provided with a "Re-ableing" programme of activities, provided by a HCSW, under the guidance of a District Nurse and/or an Allied Health Professional.

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

Project Outcome

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

Project Achievements - Outputs

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

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