

Annual Performance Report 2017-18

*Working together for the best possible health and
wellbeing in our communities*



CONTENTS

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP ANNUAL PERFORMANCE REPORT 2017/18

INTRODUCTION	4
EXECUTIVE SUMMARY	5
THE YEAR AT A GLANCE	6
PERFORMANCE AGAINST KEY PRIORITIES FOR 2017/18	8
KEY PARTNERSHIP DECISIONS 2017/18	12
SPOTLIGHT: CRAW WOOD – DISCHARGE TO ASSESS	13
SPOTLIGHT: MATCHING UNIT	15
SPOTLIGHT: TRANSITIONAL CARE FACILITY	18
SPOTLIGHT: HOSPITAL TO HOME	20
GOVERNANCE AND ACCOUNTABILITY	22
PROGRESS AGAINST OUR LOCAL STRATEGIC OBJECTIVES	24
OBJECTIVE 1 - We will make services more accessible and develop our communities	26
OBJECTIVE 2 - We will improve prevention and early intervention	30
OBJECTIVE 3 - We will reduce avoidable admissions to hospital	37
OBJECTIVE 4 - We will provide care close to home	45
OBJECTIVE 5 - We will deliver services within an integrated care model	48
OBJECTIVE 6 - We will seek to enable people to have more choice and control	51
OBJECTIVE 7 - We will further optimise efficiency and effectiveness	55
OBJECTIVE 8 - We will seek to reduce health inequalities	58
OBJECTIVE 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role	55

INTEGRATED CARE FUND	61
INSPECTION OF SERVICES	62
FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY	63
PERFORMANCE MONITORING FRAMEWORK: SUMMARY	67
DELIVERY OF KEY PRIORITIES FOR 2018/19	68
CONCLUSION	69
APPENDIX A: Financial Performance and Best Value	70
APPENDIX B: Inspection of Services	81
APPENDIX C: Performance Management	84
APPENDIX D: Services that are the responsibility of the Health and Social Care Partnership	88

INTRODUCTION



This is the Second Annual Performance Report for the Scottish Borders Health and Social Care Partnership and it reports on our performance between April 2017 and March 2018. I joined the partnership in October of 2017 and I am privileged to have entered a partnership of colleagues and a community which is determined to provide the best of care for the population of the Scottish Borders.

The Borders is a wonderful and beautiful place to both live and work within. It does however present several challenges that are particular to the region in terms of getting from A to B and ensuring all our citizens have access to the services they need, when they need them. This report outlines our progress in meeting the aspirations outlined within our strategic plan for the Health and Social Care Partnership of the Borders.

This Annual Performance Report presents how the Partnership has:

- worked towards delivering against our strategic priorities;
- performed in relation to the National Health and Wellbeing Outcomes;
- performed in relation to our local objectives;
- performed financially within the current reporting year;
- progressed locality planning arrangements;
- performed in inspections carried out by scrutiny bodies.

Among our key achievements to date is Discharge to Assess; a group of projects including Craw Wood and Hospital to Home which are helping to reduce delayed discharges and support individuals in returning home sooner. This complements the work of the Transitional Care Facility which supports individuals to remain as independent as they can after a stay in hospital and the Matching Unit where home care is matched to individual needs.

This financial year just gone has seen the Integration Joint Board introduce a new Direction to both the Council and NHS Borders to introduce a new policy of Discharging Patients from Hospital and to assess their needs within the community. In this way we will get people back to their homes quicker and can assess their needs in their home, making the assessment more relevant to their needs and more accurately identifying their requirements. This new direction has spurred a great deal of new work and a new direction from both Council and Health Services. The future priorities for 2018/19 are also set out in the report and we will continue to work hard to deliver responsive health and social care services which are focused on the needs of the people who use them and their local communities.

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

Robert McCulloch-Graham

Chief Officer for Integration

Scottish Borders Health and Social Care Partnership May
2018

EXECUTIVE SUMMARY

The Scottish Borders Health and Social Care Partnership's Strategic Plan was published in April 2016 following a period of public consultation. The Strategic Plan sets out the Partnership's objectives for improving health and social care services for the people in the Scottish Borders for 2016 – 2019.

The Strategic Plan will be refreshed for 2018/19, however this Annual Performance Report outlines the Partnership's performance between April 2017 and March 2018 in relation to the progress made against the delivery of the 9 Local Objectives identified in the current Strategic Plan.

Included in the report are four spotlight sections, reflecting some of the key work that has taken place in the last year. These spotlights focus on the Matching Unit, Transitional Care Facility and two elements of the Discharge to Assess programme – Craw Wood and Hospital to Home. Each of these services demonstrate the new approaches taken by the Partnership in addressing key challenges and managing resources.

The report also identifies the key priorities for the Partnership for the coming year, setting out the efficiencies/service transformation/changes that must be made across the Partnership in order to fund the delivery of these priorities.

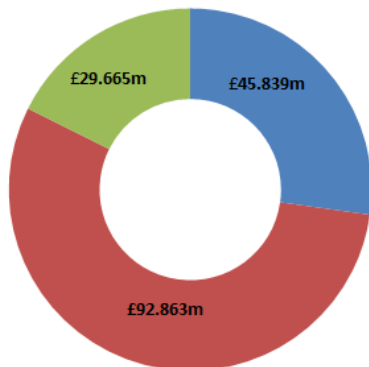
A statement is also provided of the financial performance of the Partnership and its performance against the National "Core Suite" of Integration Indicators identified by the Scottish Government.

Wherever possible 2017/18 data has been provided. Where this is not possible 2016/17 figures have been included. Where the 2017/18 data is provisional, this is denoted as 2017/18 p.

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

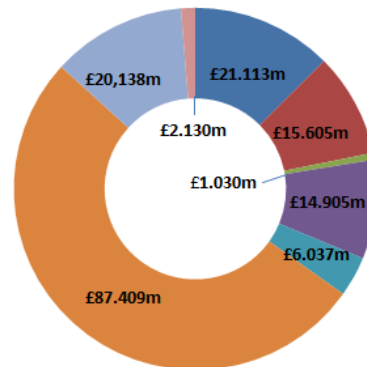
THE YEAR AT A GLANCE 2017/18

SPLIT OF BUDGET



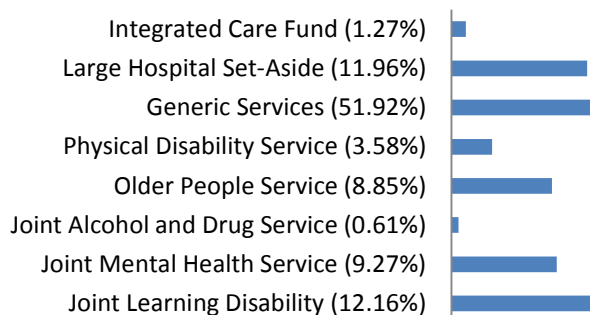
■ Social Care Delegated 45.839m (27.23%)
 ■ Health Care Delegated £92.863 (55.16%)
 ■ NHS Set-Aside £29.665 (17.62%)
 (including Social Care and ICF Funding)

SPEND BY EACH SERVICE AREA OVERSEEN BY THE INTEGRATED JOINT BOARD



■ Joint Learning Disability (12.16%)
 ■ Joint Mental Health Service (9.27%)
 ■ Joint Alcohol and Drug Service (0.61%)
 ■ Older People Service (8.85%)
 ■ Physical Disability Service (3.58%)
 ■ Generic Services (51.92%)
 ■ Large Hospital Set-Aside (11.96%)
 ■ Integrated Care Fund (1.27%)

PARTNERSHIP HEALTH AND SOCIAL CARE FUNCTIONS TOTAL



COMMUNITY SERVICES

51.4%

of total health and social care expenditure in Scottish Borders was on community based services

DISCHARGE TO ASSESS

74%

of admissions to Craw Wood are discharged home

328

home visits by the Berwickshire Hospital to Home team

BORDERS COMMUNITY CAPACITY BUILDING

40+

activity sessions
now running in local
communities per
week

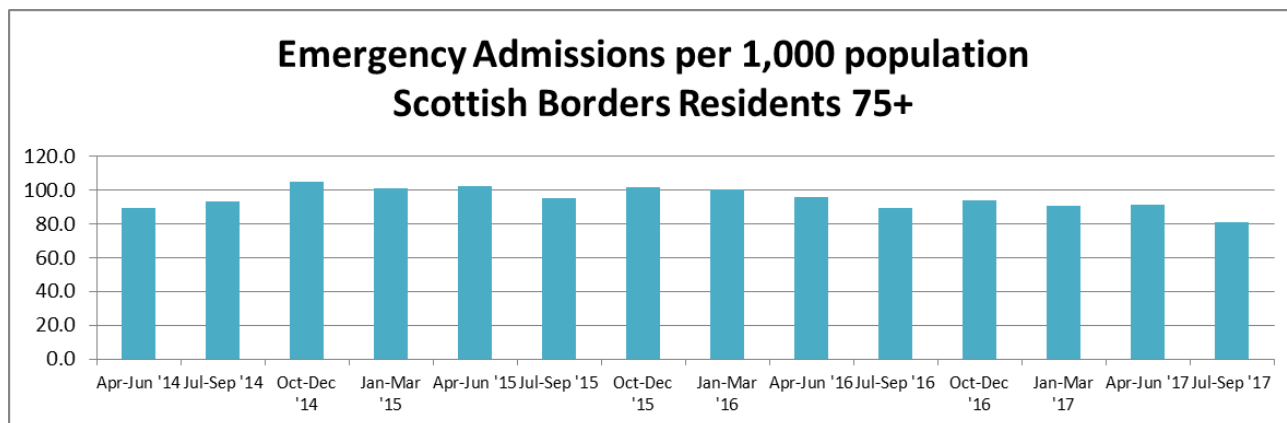
£41,000

volunteering contributions to the
community – cost of equivalent
paid staff

75%

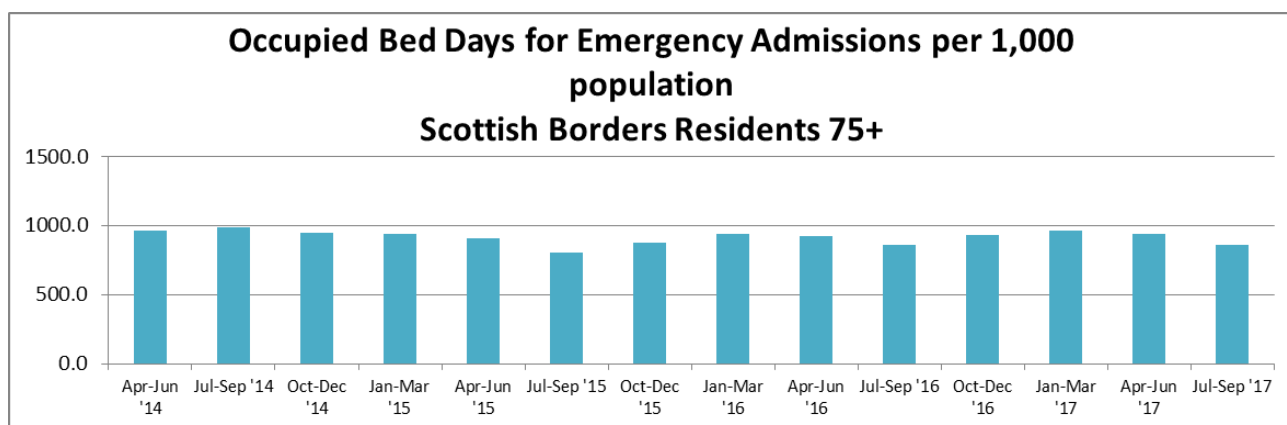
of older people reported
being more socially active
as a result of taking part
in Community Capacity
Building activities

NUMBER OF EMERGENCY ADMISSIONS TO HOSPITAL*



* Acute/general hospitals. Does not include geriatric long stay beds, or psychiatric hospitals.

NUMBER OF BED DAYS IN HOSPITAL* AFTER EMERGENCY ADMISSION BORDERS RESIDENTS AGED 75+



* Acute/general hospitals. Does not include geriatric long stay beds, or psychiatric hospitals.

899 PEOPLE WERE DELAYED
FROM BEING DISCHARGED
FROM HOSPITAL

10.5% OF ASSOCIATED
OCCUPIED BED DAYS

PERFORMANCE AGAINST KEY PRIORITIES FOR 2017/18

Detailed below is a summary of activity and performance for the key priorities detailed in the Strategic Plan.

There has been a continued focus on reducing unplanned admissions to hospital as well as reducing delayed discharges. This has resulted in the development of a number of discharge to assess initiatives, pathway redesigns and enablement approaches in 2017/18.

The key priorities identified by the Partnership for 2016/17 continued to be the focus in 2017/18. The Integrated Care Fund (ICF) has remained central in supporting and developing many of these priorities. Below is a summary of progress in 2017/18.

1	To Develop integrated and accessible transport The Community Transport Hub (CTH) run in partnership by Scottish Borders Council, NHS Borders, The Bridge, The Red Cross, Berwickshire Association of Voluntary Services and the Royal Voluntary Service (RVS) is coming to the end of its third year of operation. In 2017/18 alone the hub facilitated 22506 journeys and 92% of services users said the booking system was easy to use
2	To integrate services at a local level Locality working groups have been established and Locality Plans developed in each of the 5 localities in the Scottish Borders. This will support the redesign of health and social care services at a local level
3	To roll out care co-ordination to provide a single point of access to services Community Led Support 'What Matters' Hubs are now operational in all 5 localities, providing local communities with more accessible health and social care services. Additional outreach hubs are also run in rural communities when required. There have been over 300 attendances at the hubs since June 2017 and 95% of attendees said that the hubs were easy to access

4	<p>To improve communication and accessible information across groups with differing needs</p> <p>Local Area Co-ordinators for Mental Health, Learning Disability and Older People have enabled more people to access local community activities and to provide good local information. In 2017/18 Local Area Coordinators were identified as a contact point for young people with learning disabilities during transition between children and adult services</p>
5	<p>Work with communities to develop local solutions</p> <p>The Community Capacity Building team continues to work with communities to develop local solutions. This year the team was expanded to cover more local communities and to support the redesign of day services. 10% of participants in Community Capacity Building activities go on to volunteer within their community, further strengthening the local solutions available</p>
6	<p>Provide additional training and support for staff and for people living with dementia</p> <p>The Stress and Distress training project provides training to those working with people with dementia. It uses an evidence based approach to improve the experience, care and outcomes for people with dementia. To date, 433 bite size training sessions and 217 2 day training sessions have been delivered</p>
7	<p>Further develop our understanding of housing needs for people across the Borders</p> <p>The Integrated Strategic Plan for Older People's Housing, Care and Support Needs has been finalised and will be launched in June 2018 at the "Time to Re-think Housing for Older People Event". Analysis undertaken in the development of the strategic plan pointed to both improvements and efficiencies arising from service reform proposals. These include:</p> <ul style="list-style-type: none"> • Better outcomes through the discharge to assess model, as well as a reduction in delayed discharge and reduced likelihood of returns to hospital in the short term • Increased ability to remain in an independent living environment for longer as a result of the Care & Repair services and associated adaptations • Improved outcomes and reduced costs associated with the introduction of assistive technologies (such as telecare) • Reduced costs and an increase in resilience associated with a change in the service commissioning balance • Enhanced logistics and better resource scheduling through the adoption of a locality-based hub and spoke mode • Potential to layer these benefits through a coherent approach to service reform implementation. <p>Work has been commissioned to carry out an assessment on the housing needs and aspirations of young people through 2018. This includes</p>

	robust local assessment on housing support and housing for young people with particular health needs.
8	<p>To promote healthy and active living</p> <ul style="list-style-type: none"> • The Borders Community Capacity Building Team has developed a range of over 40 activities across the Scottish Borders including gentle exercise, walking football, lunch clubs and Men's sheds. 86% of older people reported improvements to core strength and balance as a result of attending exercise activities, reducing their risk of falls and admission to hospital. • The Healthier Me network of learning disability service providers continues to work with service users on healthy eating and active living.
9	<p>To improve the transition process for young people with disabilities moving into adult services</p> <p>A transitions pathway has been developed as well as an information pack for young people with a learning disability, to allow a smooth transition process into adult services. A key contact person has also been established</p>
10	<p>To improve the quality of life of people with long term conditions by supporting self-management and promoting healthy living</p> <ul style="list-style-type: none"> • The learning from the Long Term Conditions Self-Management project has been used to inform further work to support those with long term conditions and improve pathways to access prevention and lifestyle assistance through the more effective integration of service delivery. • A Diabetes Prevention Partnership has been developed to look at prevention, raising awareness, community support and more intensive intervention.
11	<p>To improve support for Carers within our communities</p> <ul style="list-style-type: none"> • The Partnership continues to support the Carers' Centre, which offers practical support and advice to Carers as well as undertaking Carer's assessments. In 2017/18, 453 new Carers have been referred to the Carers Centre service and 488 Carer Support Plans developed. • The Transitions and Autism pathways have also focused on Carers/parents as a key partner in this work

12

Promote support for independence and reablement so that all adults can live as independently as possible

- The Transitional Care Facility based within Waverley Care Home is a 16 bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. 81% of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is 6% which is low given that the average age of service users is 83 years old.
- A number of 'discharge to assess' projects have been piloted to allow adults to return home sooner and remain as independent as possible. These include:
 - Craw Wood Discharge to Assess – a 15 bed unit where adults can have their rehabilitation needs assessed.
 - Hospital to Home – Teams of Healthcare Support Workers facilitate discharge home from hospital and prevention of admission to hospital with a re-ablement focus. A pilot is currently running in Berwickshire, with further pilots due to commence in Teviot & Liddesdale and Eildon.
- The Borders Ability Equipment Store provides community loan equipment to people across the Borders. The facility moved to a new building in summer 2017 which allows increased capacity for stock to support hospital discharges and prevent admissions. Additionally, the new facility supports improved infection control procedures and is able to better respond to increased demands in service



KEY PARTNERSHIP DECISIONS 2017/18

For the period 2017/18 the Integration Joint Board has met regularly both as a formal meeting to transact business and also through Development sessions to raise its understanding of the more complex issues it will deal with as the partnership continues to evolve.

During this period the Integration Joint Board has focused on governance and operating arrangements as well as performance and resource planning.

Examples of key governance decisions it has made during the financial year include:-

- Welcoming new voting members to the Board;
- Appointment of its Chief Officer, Mr Robert McCulloch-Graham;
- Review and approval of its Terms of Reference;
- Approval of the Mental Health Service Strategy;
- Approval of the Learning Disability Strategic Commissioning Plan;
- Issuing Directions for a Discharge to Assess Policy;
- Agreement to pilot a Hospital to Home initiative;
- Approval of its Climate Change Report;
- Approval of its Integrated Complaints Handling Procedures;
- Approval of its Model Publication Scheme;
- Instigating a refresh of its Strategic Plan through the Strategic Planning Group.

Examples of key performance and resources decisions it has made during the financial year include:-

- Approval of its Commissioning and Implementation Plan for 2017/19;
- Review of the Integrated Care Fund Schemes and Direction of funding.
- Directed the use of Social Care Funding;
- Approved and delivered its 2017/18 financial plan;
- Directed resources to assist with Joint Winter Planning performance;
- Review of progress with the development of the Transformation and Efficiencies programme.

SPOTLIGHT: Craw Wood – Discharge to Assess Facility

In December 2017 Craw Wood opened initially as a 15 assessment bed facility at Tweedbank, in the heart of the Scottish Borders.

Craw Wood is a short term facility to which a person can be admitted in order to better understand their strengths and on-going critical needs for rehabilitation and support.

Length of stay is typically between 48 hours and two weeks. During this time a rehabilitation team assess how best to improve rehabilitation opportunities and promote independence and wellbeing of a person when it is not clear how best to achieve this. The facility is designed to ensure that a person retains as much independence as possible and does not become institutionalised.

Key Achievements

(December to end March 18)

72

Patients have used
the facility

69%

Average Occupancy

Outcomes for Discharged Service Users

43

Left Craw Wood
Discharged to Home

9

Left Craw Wood
Discharged to BGH

6

Left Craw Wood to other
destinations
i.e. private care

Craw Wood primarily opened in December 2017 as 15 bed facility with an aim to improve hospital flow over the winter of 2017/18.

However, its success has been proven in the initial months and it the facility was expanded to a capacity of 23 beds. This will continue to support the model of "Discharge to Assess" for patients in the Scottish Borders throughout 2018.

<PICTURE>

Service User Feedback

'Felt comfortable and safe'

'Friendly staff, willing to spend time which makes me relaxed and comfortable'

'Everyone has been very helpful. I can't praise Craw Wood enough and would recommend it to anyone'

'Can't fault the facility'

"In December 2017 we opened an assess-to-discharge unit within Craw Wood in Tweedbank. This service works with all Scottish Borders hospitals, but mostly with BGH to help improve outcomes for individual patients who need some extra support to regain skills on discharge from an acute hospital bed. We aim to always discharge people home from hospital as quickly as possible and to promote on-going independence at home. It has 15 assessment beds, where we are successfully providing rehabilitation support and building on each person's strengths. Most people are staying in the unit between two and two weeks. So far, 72 people have used the facility, saving over 1000 occupied bed days in the BGH"

Robert McCulloch-Graham – Chief Officer Health & Social

For more information on this project please contact Sonia Borthwick (Project Change Manager, Better Borders) Sonia.Borthwick@borders.scot.nhs.uk

SPOTLIGHT: MATCHING UNIT

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

The focus for the Matching Unit at this point is sourcing Care at Home. Prior to the introduction of the Matching Unit, Care Managers would call round all the providers in their area to secure a home care 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.

The diagram below shows how the process has been streamlined and the availability of the provider is determined within a phone call. This simplifies the process and provides opportunities to more efficiently deliver the service.

The Matching Unit ensure the new provider is made fully aware of the needs of the client, and complete the process by undertaking a number of administrative tasks. By undertaking these tasks the Matching Unit staff free up the care managers time to focus on assessment and care management.

The Matching Unit was rolled out to all Social Care and Health Teams during 2017 and the number of care packages sourced in each month is shown in the diagram below.

Matching Unit Key Figures

4444

Total home care hours
sourced in 2017

1083

Care packages
sourced in 2017/18

90%

Care Managers
satisfied with
new Matching
Unit process



The total number of care packages sourced by the Matching Unit per month

MONTH	CARE PACKAGES SOURCED
APRIL	4
MAY	45
JUNE	38
JULY	80
AUGUST	83
SEPTEMBER	91
OCTOBER	86
NOVEMBER	101
DECEMBER	113
JANUARY	138
FEBRUARY	133
MARCH	171

Within a short space of time the MU has promoted a significant number of positive matches of support packages for service users both at home and to support hospital discharge. Matching Unit staff are building expertise and efficiency around matching care needs and freeing up care managers to focus on other aspects of assessment and support planning. This along with other initiatives is helping reduce waiting list and with achieving quicker turnover of work. To date the Matching Unit has been very successful in promoting positive outcomes and with an enhanced role will work to increase efficiency across other practice areas.

Gwyneth Lennox, Social Work Group Manager

'Again the Matching Unit has come up trumps. I had an urgent duty request for an assessment this morning, and following my duty visit it was clear that she not only needed a small piece of equipment, more importantly, she needed a package of care today. She had fallen at the weekend and fractured her right dominant hand and humerus. The Matching Unit have just confirmed they can start the package of care tonight, how cool is that? Not only have I not had to waste my day going round and round endless care providers but a service that is needed critically today has been provided.....result.'

Occupational Therapy Care Manager

The focus for the Matching Unit at this point is Care at Home which is social work managed. Their remit can be further developed to include other services:

- Direct payment
- Individual service fund
- Respite
- Care home placements

The Matching Unit also has 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.

<PICTURE>

For more information about the Matching Unit please contact Elena Hendry, Project Manager, Health and Social Care Partnership Team.

Elena.Hendry@scotborders.gcsx.gov.uk

SPOTLIGHT: TRANSITIONAL CARE FACILITY

The Transitional Care Facility is a 16 bed unit based within the Waverley Care Home in Galashiels. It provides short term care for patients leaving hospital to enable them to return to their own homes within 6 weeks. The facility is run by a multi-disciplinary team of Support Workers, Allied Health Professionals and Social Workers.

The purpose of the service is to:

- Support individuals who have received hospital treatment but no longer need to be in hospital, who have rehabilitation requirements which prevent them from immediately returning to their own homes.
- Provide a period of short-term rehabilitation to individuals (over a maximum 6 week period)
- Support service users to return to their own homes as independently as possible.
- Maximise independence of service users
- Undertake an assessment of need prior to discharge home
- Ensure service users have any care and equipment required for a safe discharge home.

TRANSITIONAL CARE FACILITY

In 2017:

- 99 BGH Discharges supported
- 6% Readmission Rate within 28 days – this is significantly lower than the BGH over 65s readmission rate
- 81% Service Users were discharged to their own home
- 87% Service Users were satisfied with the service provided

Quotes from Service Users

'It gave me time to consolidate my exercise programme and get back my independence following my reactions to infections and medications'

'The unit is very well laid out, enabling me to be as independent as I can. The staff were very friendly and efficient when supporting me'

The Transitional Facility at Waverley has made a real impact for some of the most vulnerable people who live in the Borders. By having some time in the Unit people have regained skills and developed strategies which help them to move back to their own homes and communities.

Murray Leys, Chief Social Work Officer

<PICTURE>

For more information about this project please contact Elena Hendry, Project Manager, Health and Social Care Partnership Team Elena.Hendry@Scotborders.gcsx.gov.uk

SPOTLIGHT:

Hospital to Home - Berwickshire

The Integration Joint Board of NHS Borders and Scottish Borders Council approved a proposal to introduce a new direction of "Discharge to Assess" late in 2017.

To meet this new direction and to support the easing of pressures within the secondary care the Hospital to Home pilot was initiated.

This project is a test of change and is the first step to developing a Hospital to Home service to support the provision of care in people's homes. It started in the Berwickshire locality on 15th January 2018.

This has a re-ablement approach with the aim to maximise the early rehabilitation potential of the person during the early weeks of care. Its aim is to develop their confidence and skills so that they can carry out activities themselves to enable them to continue to live at home.

This service is for adults, aged 65 and over who require support at home following:

- Discharge from hospital
- A period of ill health such as a fall or other illness

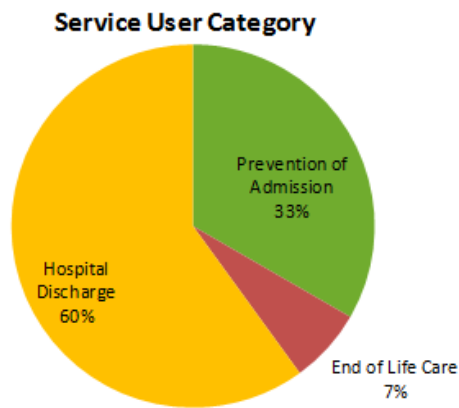
This service will also be available to anyone requiring end of life care. This service is carried out by Health Care Support Workers, under the guidance of District Nurses.

Progress – 10 pilot weeks

The pilot has been able to accommodate 15 service users to date.

From 15th January – 28th March 2018, a total of 328 visits have been carried out.

- 186 Morning Visits
- 28 Lunch Time Visits
- 16 Tea Time Visits
- 98 Evening Visits



Since 15th January:

- 60% have been a Hospital Discharge
- 33% of patients have been a Prevention of Admission
- 7% of patients have received End of Life Care

The Average Duration individuals have received care for is 18 days.

18% of service users became independent

36% have a reduced care requirements

6% of service users care requirements remained the same

Feedback from a Service User

"The caring team who visited me during the "Hospital to Home" period were very patient focused and attentive."

"I can find no fault with the care I have received,"

<PICTURE>

For more information about this project please contact Erica Reid, Lead Nurse for Community, NHS Borders Erica.Reid@Borders.scot.nhs.uk

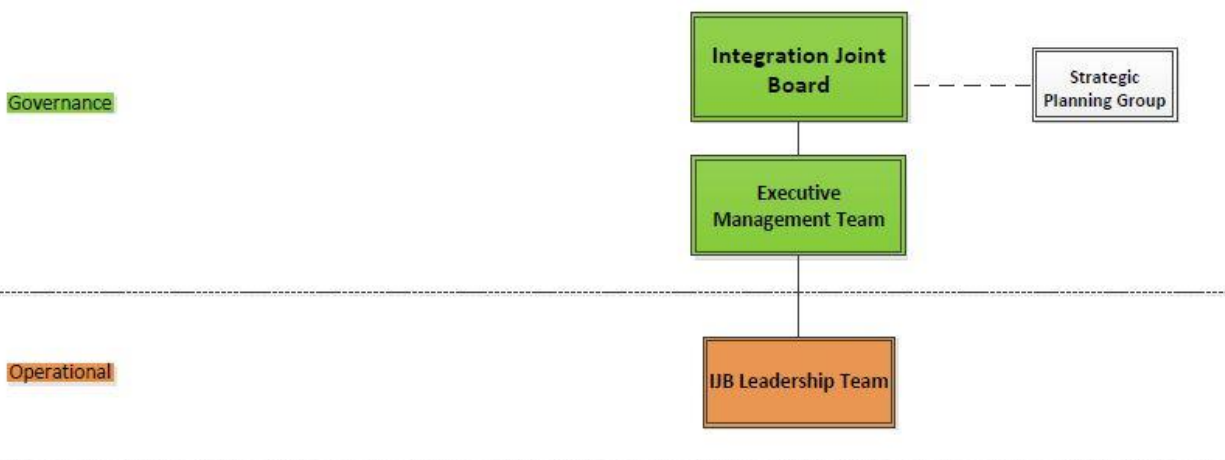
GOVERNANCE AND ACCOUNTABILITY

During 2017/18 the governance structure for the Partnership has remained the same and provides a robust and streamlined process for efficient and effective Partnership decision making. The Partnership has continued to work to fulfil its commitment to ongoing and continuous improvement. A range of activities continue to be developed in order that the Integration Joint Board identifies and understands its key strengths and areas for improvement across all aspects of its governance, operations and performance.

The governance structure has two decision making levels – the Integration Joint Board and the Executive Management Team – which are closely linked to Health and Social Care operations via the IJB Leadership Team. The governance structure for the Health and Social Care Partnership is illustrated in the diagram below:

H&SC Partnership Revised Governance Structure

H&SC Partnership Revised Governance Structure



Whilst the IJB has ultimate decision making and commissioning authority for the Partnership the Executive Management Team provides a useful assurance function to the IJB ensuring that all reports and proposals being prepared for the IJB are fit for purpose and are clearly aligned to Partnership's priorities identified within the Strategic Plan.

The focus of the Strategic Planning Group has been refreshed in 2017/18 resulting in amended Terms of Reference and Membership to ensure an improved understanding of function and role and more effective links to each of the five Localities in the Scottish Borders. The relationship between the IJB and the SPG has been strengthened in 2017/18 with the Vice Chair of the IJB now chairing the SPG and the work plan for the Strategic Planning Group being directly aligned to the work plan of the IJB.

The Integration Joint Board Chief Internal Auditor will present to the IJB Audit Committee in June 2018 the findings, conclusions and audit opinion for each of the areas of Corporate Governance, Financial Management, Performance Management, Risk Management and Follow-Up on Previous Recommendations delivered as part of its 2017/18 Internal Audit Annual Plan to provide the required assurance. The Internal Audit Annual Assurance Report 2017/18 will also include recommended actions that are designed to improve internal control and governance to assist the Integration Joint Board to achieve its strategic objectives. The IJB Audit Committee also agreed the 2018/19 Internal Audit Annual Plan for the Integration Joint Board at its meeting in March 2018.

A quarterly performance report for the Integration Joint Board continues to be produced in line with the themes defined by the Ministerial Strategic Group for Health and Social Care. In addition to these themes, the report allows for performance information relating to more localised measures which have a primary, community or social care focus.

A newly formed Integration Finance and Performance Group has been established which has responsibility for the development of Partnership Performance reporting locally and nationally and is made up of performance leads from across Scottish Borders Council and NHS Borders.

The report on the joint inspection of the Health and Social Care Partnership's older people's services undertaken by the Care Inspectorate and Healthcare Improvement Scotland was published in September 2017. An action plan based on the recommendations in the report provides assurance and a clear strategy for further improvement across the Partnership.

The Internal Audit planned work in 2017/18 included a review of the effectiveness of the Integration Joint Board's system of internal control and governance arrangements against its approved Local Code of Corporate Governance that sets out the systems and processes, and cultures and values that are used by the IJB to discharge its responsibilities to ensure that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. The review outcomes and any required improvements was incorporated into the Annual Governance Statement within the draft Statement of Accounts which was reported to the Audit Committee in June 2017 to fulfil its scrutiny and oversight role. The Integration Joint Board's Local Code of Corporate Governance will be revised to reflect current practice and up-to-date requirements, and will be submitted for approval to ensure it continues to be fit for purpose.

PROGRESS AGAINST OUR LOCAL STRATEGIC OBJECTIVES

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through improving quality across health and social care.

By working with individuals and local communities, Integration Authorities will assist people to achieve the following **Nine National Health and Wellbeing Outcomes**:

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

Source: Scottish Government: www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

In order to enable the delivery of the Nine National Health and Wellbeing Outcomes, the Partnership agreed **Nine Local Strategic Objectives**:

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

The table below demonstrates how these local objectives map to the national health and wellbeing outcomes.

National Outcomes	1	2	3	4	5	6	7	8	9
Local objective 1	•	•	•	•		•		•	
Local objective 2	•	•		•	•			•	
Local objective 3	•	•							•
Local objective 4	•	•	•	•	•	•			•
Local objective 5				•				•	•
Local objective 6	•	•	•	•	•	•	•		
Local objective 7								•	•
Local objective 8	•	•	•		•	•	•		
Local objective 9	•	•	•	•	•	•	•		

When reviewing the activities of the Partnership over the past year, we have listed the activities under the objective on which they have had the greatest impact. However, many activities deliver across multiple objectives.

OBJECTIVE 1

We will make services more accessible and develop our communities

Strong communities are a real asset of the Borders. Community capacity building makes a big improvement to the health and independence of people.

Key achievements during 2017/2018:

- GP Cluster Quality Leads have been established and are involved in the development of the new General Medical Services contract. The Cluster Quality Leads are integral to a number of projects modernising the delivery of primary care locally, for example home based rehab services, continued development of practice based paramedic model and healthcare hub. This role will be key to the Primary Care Improvement Plan.
- The Local Area Coordinators and Community Capacity teams work across the Scottish Borders and services. These teams work within communities to build relationships, increase resilience and develop the capacity of local communities.
- Key Health and Social Care information is available across the Partnership in a wide range of formats, including easy read, to improve access to information and services.
- A range of training is provided to staff and Partnership organisations to improve accessibility to Health and Social Care services and develop community capacity.
- Community Led Support provides locally based 'What Matters' Hub which can be easily accessed by people as the first point of contact for Health and Social Care Services. This involves working together in local communities with Third Sector and voluntary organisations to connect people to locally based solutions that work for them.
- The Learning Disabilities team held workshops with service users and Carers asking people what makes good support. This was used to develop a new Supported Living Framework and the basis of a revised contract for commissioning services for people with learning disabilities.
- Use of video conferencing to enable patients to have on-line, virtual appointments with clinicians and service providers is being piloted via the "Attend Anywhere" project. The main focus is on providing the capability within care homes and support Out of Hours Emergency Care, Diabetes Services and Orthopaedics avoiding the need for expensive travel and hospital visits and helping to reduce missed appointments.
- Integrated Community Mental Health Teams provide locality-based mental health and social care services. The teams are co-located and are currently developing working practices to improve assessment, treatment and psychological therapies to patients/clients. The teams deliver a range of medical psychological services and social interventions for people with mental health conditions in their own communities.
- There is promotion of mental health awareness and literacy through community based activities and capacity building through Healthy Living Networks and Community Learning & Development, with a commitment to develop and support volunteering as part of the 3 year Community Learning and Development Strategy.
- There is a strong commitment to work in partnership with communities in order to continue to deliver high quality and improved services. For example service users and Carers can get involved in the design and development of services locally through local learning disabilities citizens' panels.
- Improving care pathways across services remains a key priority. For example the continued development of the Transitions Pathway for young people who will require assistance from the Adult Learning Disability service.
- An Autism Coordinator was appointed to take forward the requirements of the Autism Strategy, ensuring that people with autism have access to all of the services they require including healthcare, education and housing.

- Project Search is now in its second year and supports interns to gain skills which will allow them to improve their opportunities for employment.
- There is a range of support available in community settings including dementia clinics and home based memory rehabilitation service.
- The Borders Dementia Working Group continues to promote a service user-led group, which is key in campaigning, raising awareness, reducing prejudice and stigma, influencing policies, and providing a voice for people with dementia.
- "Lifestyle Matters" groups assist people with dementia in anxiety management, improving self-esteem and regaining skills.
- Work has been undertaken with a wide range of partners to assess local housing needs, agree priorities and define ideas and solutions to deliver a shared vision for housing in the Borders.
- Significant improvements have been made in the warmth and comfort of many homes across the Scottish Borders through partnership working with Changeworks, Home Energy Scotland and Housing Associations. A Home Energy Forum has been established and will be producing a strategy to deliver on national objectives for energy efficiency and affordable warmth.
- There are monthly Carers support groups held in all five localities.
- Interest Link Borders continues to use 100s of community volunteers to assist children, young people and adults with learning disabilities to access community activities and improve social networks.
- Several Third Sector providers have increased opportunities for learning and sharing about good nutrition and cooking for people with dementia and their Carers.
- SB Cares has relocated the Hawick Older Peoples Day Services to the Katherine Elliot Centre, co-located with the local Home Care team and Hawick Community Support Centre. This co-location has resulted in a community hub of services within the Katherine Elliot Centre.
- SB Cares have relocated the Borders Ability Equipment Service into new, state of the art premises in Tweedbank. The new building allows better access to equipment for communities.
- There are a number of activities within Burnfoot Community Futures including:
 - Regular input from NHS Borders Quit You Way, screening services and from Hawick-wide partnership initiatives on health and wellbeing.
 - Development of volunteering, participatory budgeting and local action plan.
 - Support a reminiscence group and a recent life stories pilot
 - Delivery of meals to older people who regularly attend drop in lunch facilities during adverse weather conditions to ensure they continue to receive a hot meal.

Key Challenges faced by the Partnership when delivering this objective are:

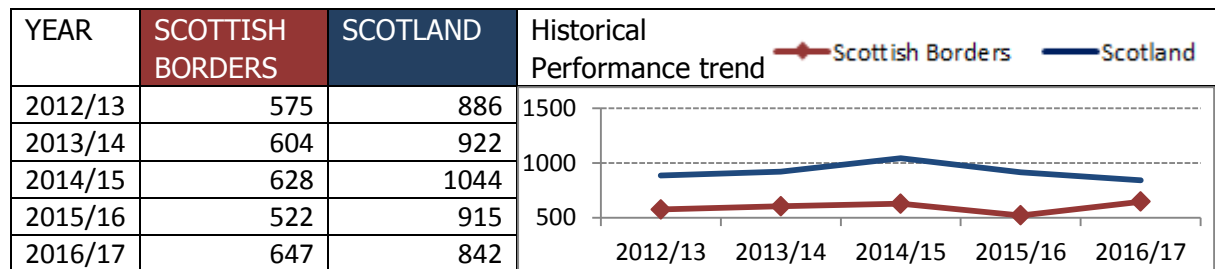
- Ongoing fuel poverty.
- Challenging budgets and changes to living wage implications.
- Access to volunteers for community led activities.

Performance - National "Core Suite" Indicators

NI-1 94% of adults able to look after their health very well or quite well (Scotland 93%).

Source: Scottish Government Health and Care experience survey 2017/18.

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



Source: ISD Scotland Delayed Discharge Census.

In terms of overall rates of occupied bed-days associated with delayed discharge, which have fluctuated from year to year, Borders has performed consistently better than the Scottish averages. However, delays in discharging patients from hospital remains a significant challenge for us. More detail on delayed discharges is given in the June 2018 quarterly performance report for the Integration Joint Board.

Performance – Specific programmes



BORDERS COMMUNITY CAPACITY BUILDING

75%

Of older people reported being more social active as a result of taking part in activities

95

Volunteers have invested their time into projects. They report increased self-esteem and pride in giving back to the community

The team won silver in the Creating Community Capacity category at the Improvement and Efficiency Social Enterprise Public Sector Transformation Awards 2018. The award recognises initiatives that create greater resilience in local communities



5 of the 8
Participants in
Project Search in
in 2017/18 gained
employment.

PROJECT SEARCH CASE STUDY

My name is Euan Aikman and I was an Intern with Project SEARCH 2017/18 which I really enjoyed. I did 2 rotations, one in ward 15 as a Domestic Assistant and the other in the RVS shop, I enjoyed both rotations and learning new skills.

Catering is something I have always wanted to do, Project SEARCH helped to build my confidence and apply for a Cook Modern Apprenticeship, I was successful with the application and have now left Project SEARCH to start my MA, I am only a few weeks in and really enjoying it.

I enjoyed Project Search and the people I met there; I would like to thank them all for helping me achieve my dream.

Partnership Priorities for 2018/19

- Establish the Attend Anywhere programme using technology to improve access to care.
- Develop innovative, locality based community approaches through an agreed action plan, developed and governed through the Integration Joint Board, including older people Local Area Co-ordination and the Building Community Capacity Team, Community Led Support, Buurtzorg and integrated health and social care teams.
- Increase Extra Care Housing by 2-4 additional developments by 2023. Develop a programme of action that includes scoping current provision and placement thresholds; revenue implications; workforce requirements.
- Shape service development more effectively through stronger connections between the Public Partnership Forum and the Integration Joint Board.

OBJECTIVE 2

We will improve prevention and early intervention

Ensuring that people are encouraged to manage independently and are quickly supported through a range of services that meet their individual needs.

Key achievements during 2017/2018:

- The Lifestyle Advice Support Services assist people to make healthy behaviour changes in relation to smoking, diet, alcohol consumption and physical activity. LASS increasingly working closely with other services such as Quit 4 Good to encourage lifestyle change in areas where needs are greater.
- Work has commenced in improving pharmacy input into social care services. The aim of this is to reduce medication errors and help people to maintain their independence with self-administration of medicines for as long as possible.
- The learning from the Long Term Conditions Self-Management project has been used to inform further work to support those with long term conditions and improve pathways to access prevention and lifestyle assistance through the more effective integration of service delivery.
- An Alcohol Related Brain Damage (ARBD) coordinator was appointed to develop an integrated care pathway for people with ARBD. One of the key aims of this work is to ensure that individuals receive the right treatment at the right time, and increase opportunities for early intervention.
- The initial development of a Diabetes Prevention Partnership has been undertaken, to include awareness raising and prevention, community support and more intensive intervention.
- Red Cross Neighbourhood Links workers signpost and enable people to understand what support networks are available within their local communities.
- Caring for Smiles is a national dental programme which offers older people and their Carers information help in looking after their teeth and oral health. Within the Scottish Borders Caring for Smiles continues to be led by the Public Dental Service in hospital and care home settings. Training for carers and staff is delivered by the Public Dental Service. This is key to the success of the programme and to supporting dependent older people improve their oral health.
- "Meet Ed" pocket are available in a range of venues and organisations across the region. They offer the public information and guidance about where to find the help that they need e.g. when to go to the pharmacist, when to contact a GP, self-help guidance, when to go to the Emergency Department.
- Podiatry has a public website where resources and advice are available to assist people to manage their foot care.
- The Health Living Network has developed and delivered initiatives to reduce health inequalities by promoting good mental health, inclusion and preventing avoidable illness (diabetes). Regular activities happen in partnership in a range of settings that increase community based peer support and volunteering opportunities/development.
- Health screening opportunities have been actively promoted, particularly cervical screening, to increase uptake.
- Anticipatory care planning is a key element of support for patients across the Borders.

- Following a successful pilot in Tweeddale of Transforming Care After Treatment (TCAT) – a multi-agency initiative between Scottish Borders Council, NHS Borders, Red Cross and MacMillan- the programme is to be rolled out across the Borders with the Central Borders area as the next stage. This service offers a reablement approach to enable people to live as independent a life as possible following their treatment and recovery of cancer.
- The Borders Falls Steering Group is developing a strategy in line with self-assessment using the 'Prevention and Management of Falls in the Community' Tool and Older People in Acute Hospital standards.
- A Falls Prevention Working Group has been formed with stakeholders from acute services, community hospitals and inpatient mental health wards to review current guidance and drive forward improvement work.
- The Borders Community Capacity Building team promote and run a range of exercises classes for older adults with a variety of ability levels, for example Walking Football, New Age Kurling and Gentle Exercise classes. By increasing basic health and fitness levels, as well as general wellbeing, these activities reduce the need for formal social care services.
- Community Led Support offers access to help and advice, and allows individuals to remain in their own home, get involved in their community and find the support they need to stay independent. The 'What Matters' Hubs promote early intervention and prevention and assist individuals in sourcing equipment, transport and help at home.
- The Alcohol and Drug Partnership are working to reduce the amount of drug and alcohol use through early intervention and prevention, for example through performing alcohol brief interventions, providing evidence to support the Licensing Board in policy development and supporting multiagency partners in 'Don't Buy/Don't Supply' campaign to reduce the number of over 18's buying or supplying alcohol to young people.
- The Mental Health Strategy identifies areas of work to ensure a focus on mental health improvement within local communities, early intervention and prevention through commissioning, partnership working and service delivery.
- The Learning Disability Transitions Steering Group has developed a high level pathway and information pack to support young people in transitioning from children's to adults services.
- A key priority within care pathways across services is to improve prevention and early intervention. For example:-
 - A "healthier me" pathway promotes health behaviour change in people with learning disabilities and their Carers.
 - The Learning Disabilities nursing team continue to progress the projects in their work plan to address health inequalities including: work with the Oral Health team, work to improve diabetes care and assist people to access screening programmes.
 - A proactive dementia diagnosis pathway for people with Down's syndrome which promotes people with Down's syndrome to take part in screening and assessment from the age of 30 years.
- Post-diagnostic support pathway is available to all those diagnosed with dementia for one year post diagnosis, and focuses on early intervention and prevention by increasing understanding of good health and considering lifestyle changes.
- The Homelessness Service:
 - Provides Housing Options advice for people and families at risk of losing or not sustaining their accommodation.
 - Provides Short term targeted support via its dedicated Housing Support Team;
 - Commissions Penumbra Support Living Service.
- The Carers Centre has completed work to redesign the Carers Support Plan in partnership with carers and the statutory and third sectors. This includes 5 key areas – Health and Wellbeing, Managing the Caring Role, How you are valued by Service, Planning for the Future , Finances and Benefits.

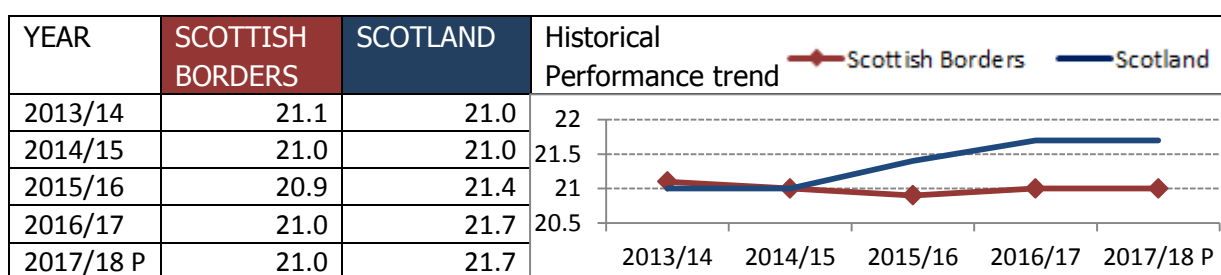
- A programme of training is in place for professionals to improve Carer awareness, and to encourage early identification and preventative assistance for Carers. A programme of Carers Act training is also available for professionals and Carers.
- A dedicated hospital liaison worker is in post to help Carers at the point of admission through to discharge.
- New Horizons Borders have employed an emotional support worker based in mental health peer support groups across each locality and introduced self-management techniques and training into the Eildon and Teviot groups.
- The Transitional Care Facility use a rehabilitation focused approach to ensure that individuals discharged from hospital are able to return to their own homes and remain there as independently as possible.
- The Scottish Ambulance Service, as part of the wider Frailty Multi-disciplinary team, has ensured that ambulance crews in the Borders complete a Frailty Screening Tool for all older adults. This provides key information to the receiving nurse at Borders General Hospital and helps to prevent falls while driving improvements for frail elderly patients.
- SB Cares offers direct provision of Personal Alarms and Ability Equipment to clients who are not eligible for Social Work-funded services, enabling earlier intervention/ prevention.

Key Challenges faced by the Partnership when delivering this objective are:

- A key challenge faced by a number of areas in the delivery of this objective is the capacity of staff to invest in prevention.
- Short term funding of initiatives
- Measurement of impact of preventative outcomes

Performance - National “Core Suite” Indicators

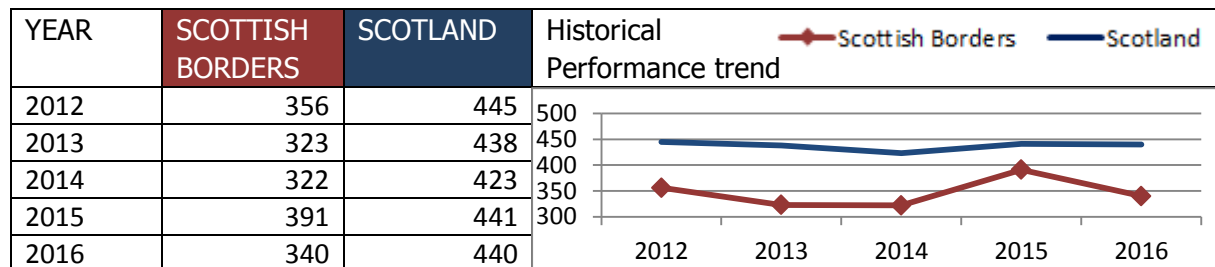
NI-16 Emergency hospital admissions due to falls - rate per 1,000 population aged 65+



Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

Since 2013/14 the rate of admissions due to falls in Borders residents aged 65+ has been very close to the Scottish average, with very little variation from year to year. More detail on this indicator is given in the June 2018 quarterly performance report for the Integration Joint Board.

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



Source: National Records for Scotland (NRS).

Annual premature mortality rates in Scottish Borders residents have been consistently lower than Scottish averages.

Performance – Specific programmes

Inpatient Falls Prevention



28%

Decrease in inpatient falls in 2017/18 compared with 2012/13



32%

Decrease in falls resulting in harm in 2017/18 compared with 2012/13

TRANSITIONAL CARE FACILITY

CASE STUDY

Mrs B was admitted to the Borders General Hospital after a fall at home where she fractured her ankle. She had no formal support at home prior to her fall.

Mrs B's recovery was complex and she was admitted to the Transitional Care Facility for a period of rehabilitation. She required the support of one staff member with all transfers, and whilst using a zimmer. She also required assistance with personal care and for her medication to be administered. Her goal once the cast was off was to be independent with a 4 wheeled walker.

The Physiotherapist provided an exercise programme which support staff followed with Mrs B until she was able to undertake stair practice with the Physiotherapist. Mrs B was keen to manage her medication independently and staff supported her to self-administer. She had kitchen practice with the Occupational Therapist and then support staff followed the rehab plan to support Mrs B until she was able to prepare her own breakfast independently.

After 3 weeks in the facility Mrs B was independent with personal care and medication, and a home visit was arranged. Mrs B was very anxious about going home however once there she became more relaxed. It was identified that additional equipment would be required to support Mrs B to remain independent at home and the Occupational Therapist arranged this.

Mrs B continued to do well and was discharged home after 6 weeks with no care package. While Mrs B was still in the hospital, the opinion was that this lady she would require a full care package of 4 times per day.

COMMUNITY LED SUPPORT

CASE STUDY

Mrs T attended a "What Matters" hub appointment following an appointment made through Customer Services. She was struggling to manage personal care due to arthritis and low blood pressure but wanted to remain as independent as possible. It was identified that a small package of care to assist with washing 3 times per week would be sufficient (1.5 hours), and that she would benefit from a hand rail to assist her safe transfer in and out of the bath. The paperwork was completed at the hub and sent to the Matching Unit. Mrs T telephoned the hub back about an hour after her appointment to say that care had been matched and would be starting the following Monday. The Occupational Therapy Assistant carried out an environmental visit and identified a rail and raised toilet seat which were arranged.

Partnership Priorities for 2018/19

- Continue to develop Community Led Support 'What Matters hubs', extending the service to more communities to improve access to Health and Social Care services for all Scottish Borders residents.
- Improved pathways for prevention and early intervention

OBJECTIVE 3

We will reduce avoidable admissions to hospital

By providing appropriate support in the right place at the right time, we will ensure people are supported to remain in their own homes.

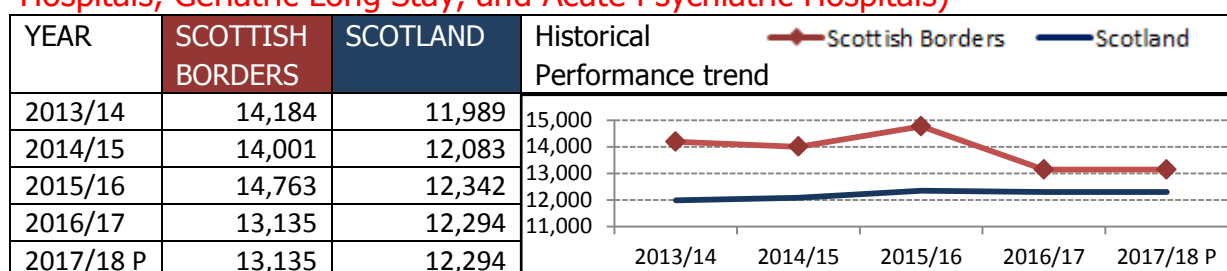
Key achievements during 2017/2018:

- A review of community and day hospitals is ongoing following an initial data gathering in 2017/18. This work will help to define the future role of community and day hospitals within the overall patient pathway and will help to identify the appropriate model of care for redesign.
- A trial with the Scottish Ambulance Service and local GP practices in Hawick, testing a model of in-hours response to emergency calls to GPs, has been extended due to its continued success. The model involves specially trained paramedics responding to triaged emergency calls and treating a patient at home, which in turn releases GP clinical time to attend more complex cases. This is supported through Primary Care Transformation resources.
- The Lifestyle Advisor Support Service continues to improve wellbeing and aid prevention of ill health, which includes:
 - Support and agreement from GPs, offering opportunistic health checks in all GP surgeries.
 - Adult weight programme "Weigh 2 Go Borders" which combines a number of evidenced based approaches offering wider options to the clients.
- The pilot site for the Buurtzorg neighbourhood care project and a clear plan for extending the model across the Borders has been identified. This is a nurse led approach to integrated and holistic care which allows people to be supported in their own homes.
- A patient flow project continues to redesign pathways within hospital, through the discharge process and in the community. This work will establish gaps or blockages in pathways and put in place processes/services to improve the patient flow.
- A Rapid Assessment Discharge team is in place at the front door of the Borders General Hospital. The team arrange functional assistance for patients in order to prevent admission.
- Work is underway to develop collaborative leadership which will address the care and assistance provided during transition from hospital to home.
- Reablement principles are embedded in the social work department's adult/older people business plans and are at the heart of the commissioning process.
- The Older People's Liaison Service team manages and assists complex and non-complex caseloads within acute and community settings, ensuring holistic planning to meet individual outcomes.
- The Transitional Care Facility provides short-term, directed support to individuals being discharged from hospital, over a maximum 6 week period, to enable them to maintain independence and return to their homes with reduced or minimal packages of care.
- The commissioning of services ensures that a broad range of options aimed at enabling independence in the community are provided.
- There are clear referral criteria for Mental Health services, information is available about services in the community, and self-management programmes are delivered through the third sector.
- A range of support options for clients is available through Self Directed Support.

- The Learning Disability Service works to promote and enable people with learning disabilities to live healthier lives and improve their quality of life through addressing the broader determinants of health, such as tackling social isolation and exclusion and developing supportive social networks.
- The Mental Health Older Adult Team work to reduce the likelihood of admission to hospital by keeping people engaged with primary health care services and with activities which will enable them to stay well.
- The dementia service is developing a physical health check tool which will help patients assess when they are well.
- Stress and Distress in Dementia training for health, social care, private sector, Carers and relatives is being provided to improve interventions with people with Dementia.
- The Mental Health Older Adults Service works with patients in the community and in hospital to avoid admission where possible and to facilitate discharge at the earliest opportunity, with prompt and high quality discharge planning.
- Scottish Borders Council works in partnership with Home Energy Scotland to provide information, advice and practical help on energy matters to all households within the Council area. The advice helps to provide well insulated and comfortable homes and alleviate health concerns.
- Information and Advice, and in some cases practical assistance regarding property maintenance, repair and improvement is available to private sector homeowners or tenants through the Scheme of Assistance.
- Scottish Borders Council contracts the Borders Care and Repair Service. The service enables older people and people with disabilities to have warm, well maintained and safe homes. The Care and Repair service helps achieve this by providing advice and assistance regarding repairs, improvements and adaptations and staff are trained to identify and will offer to remove trip hazards and other dangers if requested by their clients.
- New Horizons Borders have an emotional support worker to help reduce the number of people reaching crisis and requiring hospital care or admission. A range of self-management workshops have also been provided.
- Borders Carers Centre provide discharge support and support post discharge to reduce potential for readmission.
- Borders Carers Centre provides preventative assistance for Carers, by providing assessment and support they allow the Carers to plan ahead to prevent burnout and ill health.
- SB Cares have changed staffing model in local home care teams to provide packages of care with shorter notice and in a more flexible manner.

Performance - National “Core Suite” Indicators

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

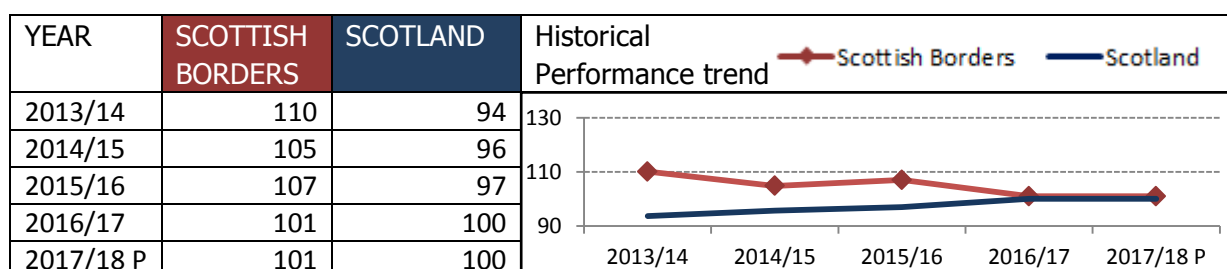


Source: ISD Scotland. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

Rates of emergency hospital admissions for Scottish Borders residents have fluctuated from year to year but whilst they have started to reduce, they remain above averages for Scotland. We will need to revisit the provisional figure for 2017/18 in later reporting, once the data submissions for all Scottish Hospitals are 100% complete.

NI-14 Readmission to hospital within 28 days – rate per 1,000 discharges.

Note: Borders figure is for Borders residents (treated within and out with Borders).



Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland, such as Borders General Hospital). This excludes discharges from Geriatric Long Stay (meaning that discharges from any of the Borders Community Hospitals do not contribute to these figures). Note: Figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

Overall rates of emergency readmission to hospital within 4 weeks of discharge have historically been higher in the Borders than across Scotland as a whole. Provisional figures for 2017/18 appear to have reversed this (which would reflect work done to reduce local readmission rates), although as the data for the latter part of the year are not yet 100% complete we will need to revisit this figure in later reporting.

Partnership Priorities for 2018/19:

- Enhance the role of Allied Health Professionals to support the Modernising Community Hospital/Healthcare programme and develop AHP role with the long term conditions pathway
- Reduce delayed discharge rates and percentages of associated occupied beds.
- Reduce delayed discharges from hospital through evaluating and further improving the early supported discharge programme and reducing readmission.
- Provide an out of hospital care pathway to improve flow across the system.

OBJECTIVE 4

We will provide care close to home

Accessible services which meet the needs of local communities, enables people to receive their care close to home and build stronger relationships with providers.

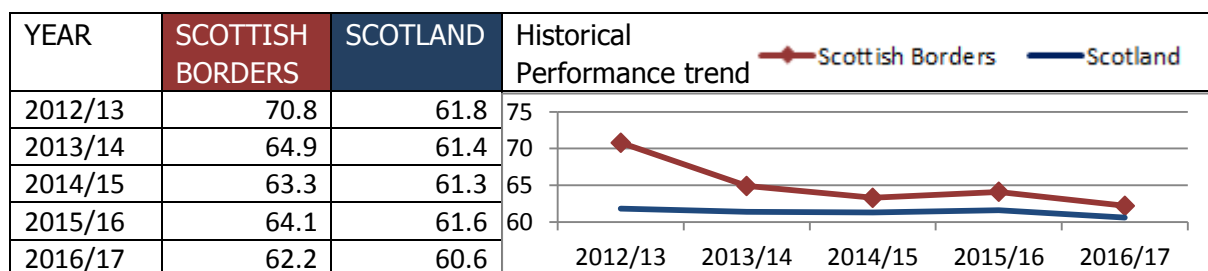
Key achievements during 2017/2018:

- A pilot of the Buurtzorg nursing approach via integrated nursing and social work teams, and a plan for extending the model across the Borders is in development.
- The Public Dental Service offers and enables an annual programme of dental assessments and treatment within care establishments.
- The Sexual Health Service continues to build on an enhanced presence in secondary schools and Borders College to improve young peoples' access to sexual health services and improve access to services for people living in postcodes associated with multiple deprivation through increasing the availability of walk in services.
- Diabetic retinal screening continues to be delivered by local opticians.
- Locality Plans for all localities have been produced after consultation with local communities. These identify local variations in need of health and social care services and will be implemented to ensure that the right services are provided.
- Technology is offering new opportunities for transforming the health outcomes and experiences of people and helping them to continue living independently at home. A Technology Enabled Care Strategy is being developed to co-ordinate and maximise these opportunities and to build on local, national and international good practice.
- Ability Borders works with individuals and the wider partnership to identify and meet people's information needs and identify gaps and issues.
- The Integrated Strategic Plan for Older People's Housing, Care and Support Needs has been finalised and will be formally launched on the 1st June 2018. Over the next 10 years the Scottish Borders Health and Social Care partners will invest close to £130m to enable increased specialist dementia care, increased housing adaptations and investment in telecare and telehealth.
- Community Led Support 'What Matters hubs' provide access to Health and Social Care services in a local community setting.
- The Hospital to Home service supports individuals to return home from hospital as soon as they are able to and provides a re-ablement approach using Healthcare Support Workers under the direction of the District Nurse.
- Smartcare, a web based self-management system which enables people to access advice, information and self-help assessment to identify equipment solutions, has recently been launched
- The Mental Health service use a joint approach to commissioning which will achieve the best outcomes for service users, foster recovery, social inclusion and equity and achieve a balanced range of services.
- The learning disabilities service works with service users, family Carers and service providers to commission appropriate person centred support packages within their local communities.
- A Mental Health Occupational Therapist, the Mental Health Physiotherapy team, the Mental Health Older Adult service and the Mental Health Older Adult Liaison service each work responsively with people to sustain them in their home where that is practical and possible.

- Within the localities across the Borders, “Lifestyle Matters” groups run enabling the regaining of skills and groups improving and maintaining mood, anxiety management and improving self-esteem for people with dementia or with problems related to mood, anxiety or depression.
- The Low Vision Services assess and provide equipment for people within their home.
- The Local Area Coordination Service covers all areas of the Scottish Borders. The key function of this service is:
 - Support self-assessment, establish personal life plans and support people to implement those plans
 - To support adults with a disability find volunteering or employment opportunities
 - Help people to access low cost and no cost services, and reduce the need for formal services

Performance - National “Core Suite” Indicators

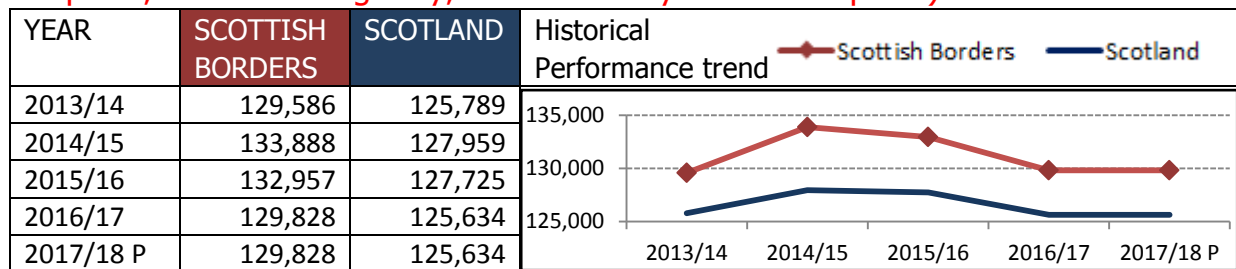
NI-18 Percentage of adults with intensive care needs receiving care at home



Source: Scottish Government Health and Social Care Statistics.

Historically, a higher proportion of Scottish Borders’ residents requiring care have received it at home, compared with Scotland as a whole. Official statistics for Borders versus Scotland in 2017/18 have yet to be published. However, we have included local reporting for a similar indicator 2017/18 in the June 2018 quarterly performance report for the Integration Joint Board.

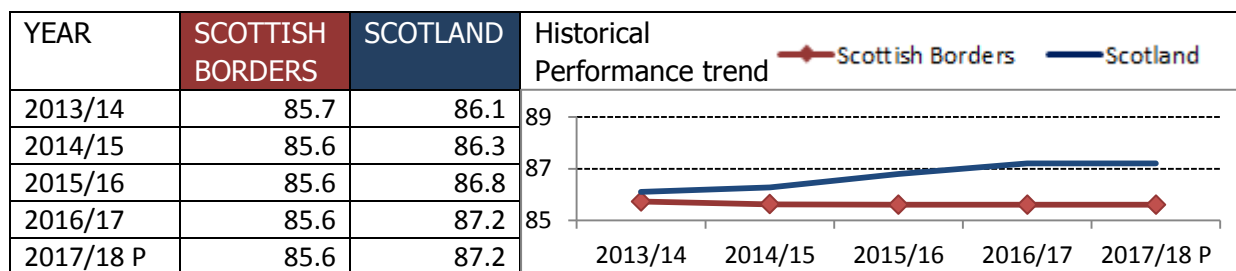
NI-13 Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)



Source: ISD Scotland. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

Emergency bed-day rates for Scottish Borders residents have fluctuated from year to year and have usually been a little higher than the averages for Scotland. We will need to revisit the provisional figure for 2017/18 in later reporting, once the data submissions for all Scottish Hospitals are 100% complete.

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



Source: ISD Scotland.

Note: Figures for 2017/18 are provisional, as deaths and hospital records are incomplete for this year.

The percentage of last 6 months of life spent at home or in a community setting has appeared fairly consistent in the Borders from year to year since 2013/14 but in each case remains a little below the Scottish average, which is gradually increasing. More detail on this indicator is given in the June 2018 quarterly performance report for the Integration Joint Board.

Performance – Qualitative data

THE MATCHING UNIT

CASE STUDY

Mr J lives with his wife Mrs J and has a diagnosis of Multiple Sclerosis. He mobilises with a zimmer frame but has poor mobility and he is at high risk for falls. He has had several falls in recent months in which he has been unable to get up from the floor. Mr J also has a recent dementia diagnosis and feels safest when Mrs J is at home.

Mrs J suffers from back pain and acknowledges that her caring role has increased since Mr J was diagnosed with dementia. She admits that she is suffering from considerable carers stress but is reluctant to accept any help at home.

Mr J was admitted to hospital after a fall at home. The Care Manager had identified a support plan for him previously but had not sent this to the Matching Unit because Mr and Mrs J had not been agreeable to accepting help. Nursing staff at the hospital were concerned about Mrs J's ability to care for her husband and contacted the Care Manager.

The Care Manager discussed a care package with Mrs J, and with her agreement made a call to the Matching Unit to advise of the situation and the urgency of sourcing care as soon as possible. The Care Manager received a call from the Matching Unit 2 hours later to advise that the package of care would start that evening. The Care Manager felt that if the care provision had not been provided as quickly Mrs J may have changed her mind.

Without the Matching Unit to provide this service, it is unlikely that the care could have been sourced as quickly.

Key Partnership Priorities for 2018/19

- Following reviews by Professor A Hendry and John Bolton, the Community Hospital/Healthcare Modernisation Programme will progress the recommendations made. This will include:
 - Development of an Intermediate Care Framework
 - Development of revised structure for community nursing
 - Development of ANP led community hospital model
 - Development of an alternative Clinical model for Community Hospitals
 - Develop hospital to home models
 - Develop hospice at home models
- Enable vulnerable adults to live safely at home through improved Adult Protection practices; undertaking a review of Large Scale Inquiries, making necessary changes; evaluating outcomes.
- Expand the Matching Unit to improve access to locally based care at home for more service user groups.
- Improve integration and independence in people with dementia by developing a clear diagnostic pathway through Mental Health Older Adults' services as described within the updated Dementia Strategic Plan.
- Maintain independence and quality of life through increased use of Technology Enabled Care.
- Support the pathway to care at home through the development of a joint protocol for intermediate care/ short term placements.

OBJECTIVE 5

We will deliver services within an integrated care model

Through working together, we will provide more efficient, effective and quality services to people and improve outcomes for people using these services.

Key achievements during 2017/2018:

- The Integrated Joint Board Leadership Team meets weekly and is made up of key senior operational, strategic and financial leaders who represent the Health and Social Care Partnership. The role of the Leadership Team is to support the delivery of outcomes as outlined in the Strategic Plan, support the integrated delivery arrangements for Health and Social Care, implementation of a change programme to improve outcomes and manage within available resources.
- There is joint management of the delayed discharge processes across health and social care and with engagement of independent care providers.
- The Care Home Group is an interagency group which provides a forum to monitor contracts and provide assistance for care home providers within Borders.
- Frailty pathways and a multi-disciplinary meeting is now in place. The meeting is used to discuss the needs of frail older people who have been admitted to Borders General Hospital within the past 24 hour period.
- A range of 'Discharge to Assess' pilots are currently underway including Craw Wood and Hospital to Home. The aim of these services is to work together across Health and Social Care services to ensure individuals are supported in the most efficient and effective way.
- An integrated Joint Workforce Planning Framework is in place to look at the current workforce and what is required going forward, as well as to ensure staff are equipped with the right skills and experience.
- An Independent Sector Rep communicates across all Health and Social Care groups to ensure representation of the independent sector in local decision making and awareness of key local activities in the Health and Social Care sector.
- A joint IT Road Map is being developed and progressed with an aim to enable and exploit convergence between the NHSB's and SBC's ICT strategies. The joint road map is built around 4 themes:
 - Collaboration - addresses electronic communications (email, diaries, telephony, connectivity and sharing of information),
 - Person-centric data - developing a joined-up view of the patient and avoiding duplication of data entry
 - Workflow – looking at how technology can be used to improve and simplify patient pathways
 - Technology Enabled Care – how technologies in the home can be used to improve health outcomes for people and enable them to live independently and safely at home
- The Partnership's Staffing Forum takes place on a quarterly basis and involves staff, Trade Union members and Management. It is responsible for facilitating and evaluating the operation of Partnership working and supporting joint workplace policies.
- Joint services continue to develop integrated working plans based on the Mental Health and Learning Disabilities model.
- Adult Protection service user questionnaires enable Scottish Borders to understand and improve support services.
- The Learning Disabilities Commissioning Strategy and Mental Health Strategy provide an integrated approach to commissioning and deployment of resources.

- Community-Led Support brings together health and social care, third sector and the independent sector to deliver services to local communities.
- The Transitional Care Facility is a multidisciplinary unit bringing health and social care staff together
- Work has commenced on the development of an integrated care pathway, commissioning strategy and action plan across Health and Social Care for individuals with a suspected or diagnosed Alcohol Related Brain Damage (ARBD). A multi-agency conference was held to identify local challenges and requirements.
- Scottish Borders Community Planning Partnership has produced a co-production toolkit and eLearning module.
- Work is underway to integrate Health and Social Care teams within localities, to improve the sharing of information and ensure seamless integrated care planning.
- Health and Social Care services and primary care partners work effectively together to accurately assess, diagnose and assist people with dementia. This integrated approach has resulted in reduced duplication and has streamlined the way in which care is provided.
- An evaluation of statutory and voluntary mental health services is ongoing to ensure we deliver the right support at the right time.
- Colocation of Mental health service Health & Social Care staff in three locality based community teams and a rehabilitation team which covers the whole of Scottish Borders.
- The Learning Disability service undertook a people planning process in 2017 which identified the need to reorganise resources to support parts of the service under the greatest pressure.
- SB Cares has established the first single care registration for a co-located older people and learning disabilities day service in Peebles which has resulted in improved outcomes and experiences for clients in both services.
- A review of the model currently utilised in the delivery of community hospitals and community health care has been completed. The review considered best practice locally and nationally and identified options and recommendations for improvement. Plans for implementing these recommendations are being developed.
- Buurtzorg Model of neighbourhood care allows a multi-agency and person-centred approach to providing integrated care in people's homes.

Key Challenges faced by the Partnership when delivering this objective are:

- Partnership IT systems
- Delivering quality services with reducing resources.

Performance - National “Core Suite” Indicators

NI-4 75% of adults supported at home strongly agreed or agreed that their health and social care services seemed to be well co-ordinated (Scotland 74%).

Source: Scottish Government Health and Care experience survey 2017/18.

NI-10 57% of NHS Borders staff said they would recommend their workplace as a good place to work (Scotland 59%).

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

Key Priorities for the Partnership for 2018/19

- Continue to develop joint financial planning underpinned by joint strategic commissioning; sharing workforce supports; joint governance etc.
- Support informed integrated planning through Integrated Care Fund measurements of common themes across multiple projects using a locally developed outcome focused tool.
- Develop integrated health and social care teams in all five localities.
- Improve inclusion and reablement approaches in palliative care; using learning across the services.
- Implement a joint workforce plan for integrated services.

OBJECTIVE 6

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

Ensuring people have more choice and control means that they can plan health and social care support that works best for them.

Key Achievements for 2017/18:

- Public involvement is routinely sought for planning and strategic development at all levels and for most decision-making.
- There are proactive processes and systems in place to gather patient and public feedback on services across the Partnership e.g. a cohort of patient feedback volunteers has been established within NHS Borders.
- The Public Partnership Forum meets bi-monthly to provide a public perspective on services provided by NHS Borders, Scottish Borders Council and the Voluntary Sector.
- The Self Directed Support Forum of Users and Carers is helping to develop information to ensure people are informed and better able to participate in their assessment. Providers, support organisations and partnership representatives have joined the Self Directed Support Working Group.
- 75% of people receiving social care support have had an assessment using a self-directed support approach and 326 people are managing their support through direct payment.
- An interim Carers Strategy and planning for the implementation of the Carers Act in 2018 has been developed with the Carers Advisory Board. Work is underway on the new 2017-1019 strategy.
- Work continues on the Reimagining day services project, developing an inclusive model for reimagining how people are supported during the day.
- The Dementia working group consists of service users who are actively defining the service needs.
- Dementia champions are being promoted throughout NHS Borders with three new staff having commenced training this year.
- Mental health managers attend the mental health forum to hear views of service users and Carers and to provide timely feedback on service developments.
- The 5 local citizens' panels continue to meet 5 times a year as part of the learning disability governance structure. They provide input to the learning disability service when planning developments, improvements, policy and strategy.
- There is information available in accessible formats regarding the options within self-directed support to enable people with learning disability to have a better understanding of their options.
- Care & Repair ensure that the person is at the centre of their project, making decisions on who carries out the works, what the work should look like and when this all should take place. Care & Repair help to guide the client with decisions on design and quality to ensure that they get the best outcome and value for money for their anticipated long term needs and provide access to an environmental Occupational Therapist assessment in relation to function and provision of adaptations.

- Borders Carers Centre provides training for Carers including assertiveness training and how to build resilience.
- SB Cares offers direct provision of Personal Alarms and Ability Equipment to clients who are not eligible for Social Work funded services, thereby offering more choice to all client groups.
- Locally based Community Led Support 'What Matters Hubs' provide an additional flexible option for those seeking to access information and advice on Health and Social Care services, allowing them to make informed choices and live their life the way they want.
- Locality Working Groups have been established in all 5 localities with representation from Health and Social care, third sector, independent sector and members of the local community. These groups allow participation in locality planning and more choice and control in local communities.

Key Challenges faced by the Partnership when delivering this objective are:

- Reviewing people's packages of assistance in line with self-directed support approach. The impact for people still needs to be assessed.
- Recruitment of care staff by providers is difficult. This can restrict the choice people have about who provides their support and when.

Performance - National "Core Suite" Indicators

NI-2 83% of adults supported at home strongly agreed or agreed that they are supported to live as independently as possible (Scotland 81%).

NI-3 74% of adults supported at home strongly agreed or agreed that they had a say in how their help, care, or support was provided (Scotland 76%)

Source: Scottish Government Health and Care experience survey 2017/18.

Key Priorities for the Partnership for 2018/19

- Increase the number of people accessing all self-directed support options by streamlining financial and other processes, removing barriers to change.
- Increased role for service users and stakeholders in service planning through the application of the Partnership Board approach, learning from Learning Disabilities and Mental Health developments.

Performance – Specific programme

SELF DIRECTED SUPPORT

1 3 2 0

people were using self directed support at the end of March 2017



1 6 6 7

people using self directed support at the end of March 2018



7 7 . 6 %

of service users have been offered self directed support options (up from 59% in 2016/17)

OBJECTIVE 7

We will further optimise efficiency and effectiveness

Strategic Commissioning requires the Partnership to constantly analyse, plan, deliver and review our services which give us flexibility to change what we do and how we do it.

Key Achievements for 2017/18:

- To date, the Partnership has delivered over £6.5m of permanent recurring savings. In addition, emerging financial pressures required the implementation and delivery of over £8m of in-year remedial actions across delegated and set-aside functions in order to ensure financial balance of resources.
 - The Health and Social Care Strategic Plan is currently being refreshed and sets the strategic direction and framework for the Partnership for 2018/19. The Strategy is informed by a local needs assessment and projections of need.
 - The Joint Commissioning and Implementation Plan has been refreshed as part of the refresh of the Strategic Plan.
 - An Information Analyst from the Local Intelligence Support Team has been working in collaboration with the Partnership over the past year and continues to look at ways that data can be used to improve efficiency.
 - There is an established programme of leadership including a Scottish Social Services Council support programme, enabling leadership and a mentoring programme for newly qualified social workers delivered by specially trained peers. Our aim is to achieve sustainable improvements through resilient, knowledgeable staff.
 - The Partnership continues to build on experience of co-located teams through existing teams e.g. Learning Disability and the Kelso team and seek further opportunities for co-location to make the more efficient use of staff skills and properties.
 - A second cohort of 'My Home Life' training has taken place enabling Care Home Managers to develop transformational leadership skills and relationship-centred care. Participants of both cohorts felt that the training had enabled them to make an improvement in the quality of practice in the care home.
 - A Matching Unit is in operation to maximise efficiencies across care at home and release paid Carer capacity. The unit plans to expand the services provided by developing a matching service for direct payments and District Nursing teams.
 - The "Two Minutes of Your Time" questionnaire is used consistently in the NHS as a feedback tool to improve services.
 - The dementia training programme has resulted in staff across the services having a better understanding of how to care for people effectively. This in turn improves efficiency and reduces length of stay in hospital.
 - The Pharmacy Input project is working to improve the way in which medications are administered in peoples' homes to reduce the unnecessary use of compliance aids and ensure the most efficient use of home care services.
 - Service users and Carers are involved in service developments and recruitment.
-
- The Learning Disability Transitions Steering Group has made progress towards a Transitions Pathway by developing a high level pathway and information pack for young people in transition from children's into adult services. This is part of a 3 year project which continues to 2019.

- SB Cares has delivered £2.6m of reduced costs of service since inception in 2015 through improved deployment of staff, efficient procurement, and reduced staff travel and improved financial management processes. £1m of this has been delivered as permanent annual cost reductions in our services.
- SB Cares continued to improve the quality care with 85% of their registered care services receiving Care Inspectorate grades of Good or above.
- The Community Led Support 'What Matters Hubs' use a simplified version of the social work assessment which reduces bureaucracy and streamlines the assessment process.
- The IJB Transformation Programme comprises of a number of projects aimed at improving service delivery and the realization of efficiencies. Current projects include Mental Health, Day Services, Carers Strategy and IT Integration.

Performance - National "Core Suite" Indicators

NI-5 83% of adults receiving any care or support rated it as excellent or good (Scotland 80%).

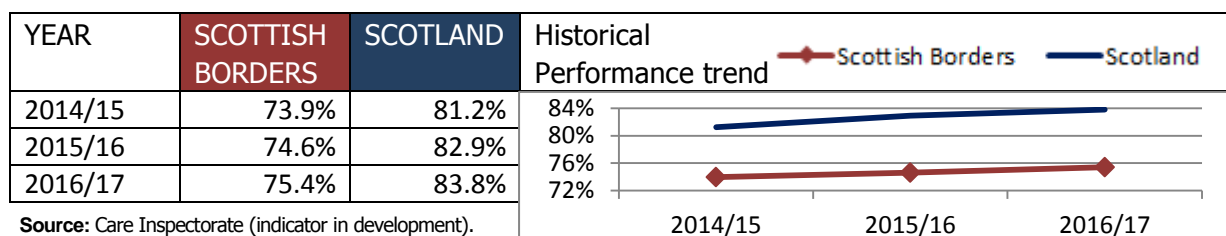
NI-6 88% of people rated the experience of the care provided by their GP practice as excellent or good (Scotland 83%).

NI-7 80% of adults supported at home strongly agree or agree that their services and support had an impact on improving or maintaining their quality of life (Scotland 80%).

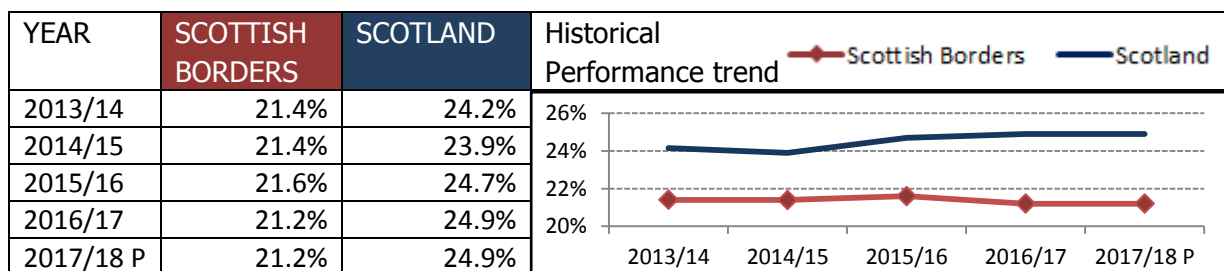
NI-9 86% of adults supported at home strongly agree or agree they felt safe (Scotland 83%).

Source: Scottish Government Health and Care experience survey 2017/18.

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



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



Source: ISD Scotland. Note: Underlying costs data for 2016/17 have been used as a proxy for 2017/18 costs in the calculation of this indicator. These figures are therefore provisional and will be refreshed once updated costs data become available.

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

Performance – Specific programmes

MATCHING UNIT



30%

Drop in Social Work waiting list numbers between April and December 2017

1083

Care Packages sourced by the Matching Unit in its first year of operation

Data April 2017 – March 2018

"TWO MINUTES OF YOUR TIME" SURVEY

96%

of hospital patients, carers and relatives surveyed were satisfied with the care and treatment provided

97%

of hospital patients, carers and relatives surveyed reported that staff providing their care understood what mattered to them

95%

of hospital patients, carers and relatives surveyed reported that they had the information and support needed to help make decisions about their care or treatment

Data April 2017 – March 2018

Key Priorities for the Partnership for 2018/19

- Shared aims and language across the partnership through developing and aligning performance activities across the Partnership, identifying opportunities for integrated approaches.
- Drive forward collaborative change through the 'You Said We Did 'Improvement Plan.
- Through improved communication and organisation-wide engagement, develop a widely-shared, persuasive vision of integrated services & of better support in the community through additional extra care housing.
- Align strategic and operational priorities and enable innovations so that ambitions for service expansion can be achieved, emphasising the maintenance of quality, essential services within a context of efficiency savings.
- Primary Care Improvement Plan which will address a number of key priorities.

OBJECTIVE 8

We will seek to reduce health inequalities

Ensuring that people do not miss out on services due to, for example, a health condition, or lack of easy access to transport. Ensuring that people in all communities are encouraged to take care of their own health and are supported to access appropriate services.

Key Achievements for 2017/18:

- Community Learning Disability Nurses work on an individual basis with people with learning disabilities to access mainstream healthcare, and provide additional support and guidance for those who struggle with this. They also work with Public Health to promote access to the main health screening programmes.
- The Public Dental Service continue to deliver the Childsmile programme and provide enhanced services to special needs/ additional needs children with core tooth brushing in all schools with special needs units. The service also continues to encourage early dental registration of children by working closely with key partners in health and social care.
- Public Dental Services work in partnership with independent dental practitioners to improve access to NHS Dental Care across the Scottish Borders, with an emphasis on patients identified as having mental health challenges, drug and alcohol dependencies, the homeless and ex-offenders.
- The Borders Community Planning Partnership 'Reducing Inequalities Strategy' sets the priorities and high level outcomes for health, care and wellbeing to address inequalities.
- The Learning Disability Liaison Nurse service supports people with learning disabilities access hospital services by working with them and their Carers prior to admission, during admission and discharge. The service works closely with the Borders General Hospital to develop training and raise awareness of learning disabilities. A Hospital Passport is now used by people with learning disabilities access the hospital. It carries important information for staff to know about the person.
- The Pathway 2 project continues to deliver high quality, responsive services to victims of domestic abuse and their children across the Scottish Borders.
- Service leaflets are available in a variety of formats to allow all people to access the information they require in a way that is most appropriate for them.
- Interagency and cross sectoral work to tackle health inequalities, focusing on prevention, mental health and inclusion.
- Implementation of the Six Steps to Being Well guide through a programme of capacity building, following the launch of the guide in Mental Health Awareness Week in May 2017.
- Further development of healthy lifestyle supports for vulnerable groups.
- Effective piloting of intervention with Live Borders, Health Improvement and the Diabetes Service to offer health coaching to a group of recently diagnosed diabetes patients.
- The Healthy Living Network is assisting with the development of diabetes peer support groups in several localities, led by a third sector partner, Scottish Borders Senior Networking Forum. Health Living Network staff chair locality support groups and act as a conduit to the Diabetes Prevention Steering Group.
- Continuing to build on the priorities and actions arising from the Health Inequalities Impact Assessment of local health screening programmes to improve reach and uptake among harder to reach and vulnerable groups.

- Following the launch of the Six Ways to Be Well guide, tailored resources have been developed for children and young people, jobseekers, parents and other groups.
- An Autism Coordinator has been appointed to take forward the recommendations of the Autism Strategy including ensuring that people with autism are able to access mainstream services.
- The Carers team are targeting the issue of Carer ill-health in the new Health Inequalities plan.
- Community based initiatives are being developed by the Health Improvement team, Community Learning and Development and the third sector to support women's mental health and to promote volunteering for wellbeing.
- Health literacy is being promoted with a range of staff groups and through focused work in one Learning Community Partnership, generating the 'Healthy Hawick' initiative.
- The See Hear Strategy group is delivering introductory hearing and sight loss training to frontline staff and champion training for those staff working with children and adults with complex needs.
- A range of multi-agency training is available to adult social care and health staff including eLearning tools on dementia and adult and child protection.
- The Community Transport hub provides a coordinated and accessible transport service across the Scottish Borders, bringing together the resources of a number of third sector organisations.
- The Alcohol and Drugs Partnership are working to reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reduce related deaths.
- The Alcohol and Drugs Partnership continue to work with Child Protection to deliver briefing sessions to staff on "children affected by parental substance misuse".
- There has been an increase in opportunities for people, their families and friends, with alcohol and drugs problems to be helped following treatment through participation in recovery groups and other activities such as the Serendipity Recovery Café and Mutual Aid Partnership Groups in Addaction.
- The Alcohol and Drug Partnership held a multiagency workshop to identify ideas for preventing drug related deaths and an action plan is being implemented.
- The Alcohol and Drugs Partnership has carried out a review of alcohol related deaths to improve understanding of the patient journey, identify services provide to individuals and learning points to inform potential interventions.
- The learning disabilities nursing team address health inequalities by working with the Oral Health team, working to improve diabetes care and enabling access to screening programmes.
- Borders Dementia working group provide training within the community in order to create dementia friendly communities.
- An early onset dementia group provides a service for younger people with dementia reducing the inequality that younger dementia patients normally find.
- The Mental health Older Adults Team have been promoting and developing the "Living with Dementia Programme" which following diagnosis enables patients to understand what they can do independently.
- The Carers Centre offers a comprehensive programme of training for carers to maintain health and well-being including building resilience, managing stress and coping strategies.
- The Local Housing Strategy 2017 – 2022 was finalised in 2017 and the first year of the strategy has been implemented.
- In 2017/18 an additional £1.73m has been allocated by the Scottish Government to improving energy efficiency in homes across the Borders with around 1000 measures expected to be installed by June 2018.

- Interest Link Borders provide transport to enable people to access services.
- Borders Carers Centre provide assistance to enable people to maximise their personal budgets and provide help for individuals to access grants.

Performance – Specific programmes

LOCALITY PLANS

In 2017/18 consultation with local communities across the Scottish Borders took place. As a result of this Locality Plans were produced for each of the 5 localities. These plans were coproduced through Locality Working Groups each representing the needs and priorities of the local community.

Each Locality Plan was produced in an easy read format as well as full and summary versions.

Key Priorities for the Partnership for 2017/18

- Deliver post diagnostic support to a higher proportion of people with dementia and increase appropriate GP referrals.
- Improve outcomes when a dual diagnosis exists by piloting an assessment tool of physical health for people with mental health conditions.
- Establish a single information access; improve communication internally and externally.

OBJECTIVE 9

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

Key Achievements for 2016/17:

The activity detailed below specifically relates to the Carers; however it should be noted that Carers will also benefit from work which relates to objectives 1-8.

- New Carer Support Plan developed with Carer involvement.
- Planning underway for the implementation of the Carers Action with the development and implementation of new eligibility criteria designed in partnership with Carers.
- The Partnership is committed to increasing referrals for Carers Support Plans through the Borders Carers Centre. Some examples of support provided are:
 - Specialist support for young adult Carers to assist with access to employment, education and training.
 - "Staying Afloat" is a new 8 week project for Carers that develops resilience and improved health and wellbeing respite.
 - Carers Awareness Training through Adult Protection Training - a bespoke video designed in collaboration with Carers is used for this purpose.
 - Carers support groups run monthly across all 5 localities of the Borders.
 - Additional respite hours are secured for Carers through the time to live fund, days out and other charitable grants.
- A Carers Health Needs Assessment has been carried out led by Public Health and informs the Carer Strategy for the next 2 years.
- A peer support network for Carers caring for someone with a mental illness has also been developed along with providing increased respite and training opportunities.
- Carers play a key role in planning and decision making through their representation on local citizens 'panels, on the Learning Disability Policy and Strategy Group and Learning Disabilities Partnership board. Training and assistance are provided to enable Carers to fulfil these obligations.
- A dementia liaison service provides information and assistance for people with Dementia and their Carers whilst they are in hospital.
- A Carers support group runs in Gala Day Unit and work is ongoing with Alzheimer's Scotland to redevelop other Carers groups around the Borders.
- Stress and Distress training is being delivered to Carers of people with Dementia across the Borders, to support Carers and enable them to continue in their caring role.
- Carers Liaison Workers offer one-to-one assistance across the five localities.
- Borders Additional Needs Group have offered face to face advice and help, signposting to other services and to family respite services where needed.
- Interest Link Borders have provided respite through befriending for families that care for someone with learning disabilities, assisting in the sustainability of the caring relationship.
- Carers can access advice on support available in their area at their local Community Led Support 'What Matters Hub'.

Key Challenges faced by the Partnership when delivering this objective is:

- Identifying Carers to ensure they get timely and appropriate support
- Support Carers to maintain their health and wellbeing
- Making sure information is easily accessible by Carers
- Ensure Carers are aware of and can access their Carers Rights

Performance - National “Core Suite” Indicators

NI-8 36% of Carers strongly agree or agree they feel supported to continue in their caring role (Scotland 37%).

Source: Scottish Government Health and Care experience survey 2017/18.

Performance – Specific programmes

- 1032 professionals have received Carers Awareness and Carers Act Training through Flying Start, induction training and talks and visits. This training is delivered in partnership with Carers.

CARERS

453

new Carers have been referred to the Carers Centre service

278

Carers have been referred to the hospital liaison worker

488

Carers Support Plans have been offered

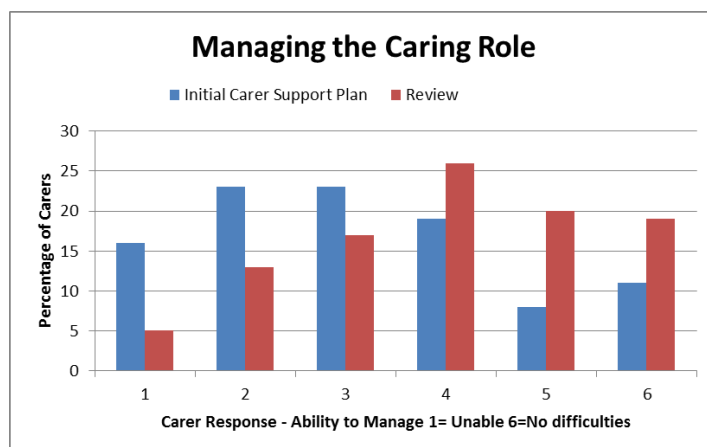
442

Carers attending Carer support groups

1811

Carers have received on-going support and guidance

Data from April 2017 - March 2018



Successful Support of Carers

Carers report less difficulty in managing their caring role on review of the Carer Support Plan at 3-6 months.

Key Priorities for the Partnership for 2017/18

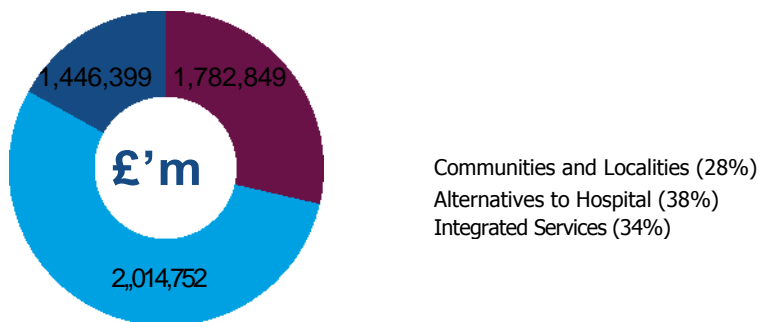
- Increase the identification of Carers
- Prepare and consult on a Carers strategy to be published in 2019.
- Improve Carer health, using the recommendations from the Carers Health Needs assessment.
- Prepare a Carers Health Needs Assessment based on the Carers survey and implement an action plan based on the recommendations.
- Align recording of Carer Support Plan with Frameworki/MOSAIC Social Care database and Carers Centre data.
- Increase the number of Carer Support Plans.
- Develop a Partnership programme of improvement and self-evaluation between Carers, Scottish Borders Council, NHS Borders and the local service provider.

INTEGRATED CARE FUND

The Integrated Care Fund has been pivotal in the delivery of the partnership's objectives.

The Scottish Borders Health and Social Care Partnership's Scottish Government Integrated Care Fund allocation is £2.13m in each of financial years 2015/16 to 2017/18, a total programme value of £6.39m. To date, £5,244,000 has been directed by the Integration Joint Board to meet the costs of a range of transformational initiatives.

INTEGRATED CARE FUND DIRECTED BY KEY THEMES



For the purpose of this report the Integrated Care Fund projects have been categorised into three key themes which are detailed below:

Communities and Localities – Covering projects such as: Locality Plans, Community Led Support and Borders Community Capacity Building. All of which are working to provide services and assistance within local communities.

Alternatives to Hospital – Includes projects such as: Transitional Care Facility, Craw Wood, Hospital to Home and Buurtzorg. All of these projects work prevent admissions to hospital and to reduce time spent in hospital.

Integrated Services – Includes: Programme Team, Autism Strategy, Alcohol Related Brain Damage, Transitions and Independent Sector Representation. These projects bring together services across Health and Social Care, and include pathway projects and integrated teams.

INSPECTION OF SERVICES

Joint Inspection of Services for Older People in the Scottish Borders

The Care Inspectorate and Healthcare Improvement Scotland undertook an inspection of the Partnership's older people's services between October 2016 and February 2017. The inspection report¹ was published on 28th September 2017. Across the nine key indicators of performance, inspectors found one i.e. 'impact on the community' to be 'good', five to be 'adequate' and three to be 'weak,' including 'delivery of key processes'; 'strategic planning and plans to improve services'; 'leadership and direction.'

An action plan is in place to meet the thirteen recommendations, with 60 actions to meet the thirteen recommendations. The inspection started when the Health and Social Care Partnership was at an early stage of development and the Partnership was already committed to an ambitious plan that is transforming the approach to meeting the needs of older people. The inspection action plan consolidates a range of these plans.

The partnership is working very hard to address the challenges outlined within the report and are not complacent about the changes required to improve the aspects of our work highlighted by the inspectorate. We do also welcome their acknowledgement of the progress already made in bringing the partnership together and in meeting our local challenges.

All services within the Health and Social Care arena within the Borders are now part of an improvement programme reporting to the Performance and Finance Group ultimately to the full Integration Joint Board. We have embarked on an ambitious plan to reduce demand, make our services more efficient and to improve quality of provision throughout. The commitment of our staff teams towards this goal is evident within all our services.

More information on how we are meeting the recommendations is within Appendix B



FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Arrangements

The Integration Joint Board agreed a joint budget and provides financial governance for the Partnership.

The statutory Integrated Resources Advisory Group Guidance provided a number of recommendations for financial governance and management:

- Governance Structure
- Assurance and Governance
- Financial Reporting
- Financial Planning and Financial Management
- VAT
- Capital and Asset Management
- Accounting Standards

Assessment of compliance was undertaken prior to the establishment of the Integration Joint Board and then again at six and twelve month intervals during 2016/17, this ensured that all required provisions in relation to the financial arrangements were in place.

These arrangements ensured all partners received sufficient assurance over:

- The robustness of governance
- The overall affordability
- The adequacy of levels of delegated resources and controls over how these resources are managed
- Any impact on NHS Borders and Scottish Borders Council

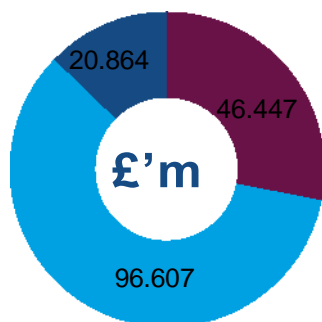
At the end of its first year the Partnership is well established in terms of financial governance, planning, management and statutory reporting evidenced by:

- Full local code of governance compliance
- Approved financial strategy and plans
- Regular and frequent financial monitoring reports
- Publication of approved Statements of Accounts

Financial Management

In 2016/17 £163.918m was available to the Partnership for direction to support the delivery of its strategic objectives. Of this, £143.054m (including £5.267m of Social Care Funding) was delegated directly to the Integration Joint Board, whilst £20.864m was retained by NHS Borders in respect of large hospitals and set-aside.

THE PARTNERSHIP'S BUDGET 2016/17



Social Care Delegated £46.447m (28.33%)
Health Care Delegated £96.607m (58.94%)
Large Hospital Set-Aside £20.864m (12.73%)
(including £5.267m Social Care Funding)

The Partnership has experienced considerable financial pressure beyond the level of original budget delegated to it during 2016/17. Whilst a breakeven position is reported at 31st March 2017, pressures of £3.879m on the delegated budget and £4.481m on set-aside functions required mitigation action during the year and additional contributions from partners, primarily in relation to healthcare functions.

FINANCIAL PRESSURE EXPERIENCED DURING 2016/17



£4.481m

large hospital
budget set-aside



£3.879m

Delegated budget

These pressures were primarily experienced across healthcare functions. Social care functions also experienced pressure during the year arising from factors such as increased demand from services, increased cost as a result of market pressures and the introduction of a living wage of £8.25 for all social care staff. In the main however these were funded by the Scottish Government allocation of social care funding to Partnerships during 2016/17.

In terms of the pressures across healthcare functions the highest single area of risk and largest adverse service variance across the delegated budget relates to prescribing where projected pressure of over £2.0m to the year end was experienced.

Risk to the affordability of the delegated budget and overall sufficiency of resources available to the Partnership has been the prime focus of the Integration Joint Board. In order to be affordable, full delivery of all planned efficiencies was required on a recurring and sustainable basis. Across healthcare functions a significant shortfall on the delivery of the health board's efficiency programme was experienced, resulting in considerable additional budget pressure. For the delegated budget, around £2.4m of the total programme was undelivered, much of which requires delivery next year.

NHS Borders experienced the impact of a range of pressures across the large-hospitals budget set-aside for the population of the Scottish Borders.

FINANCIAL PRESSURES FACED BY NHS BORDERS ACROSS THE LARGE HOSPITAL BUDGET



£1.2m

surge beds



£900k

patient flow



£500k

acute admissions
and emergency
department staffing



£2.4m

non delivery of
planned efficiencies

Due to the pressures noted above the Partnership implemented an in-year recovery plan which was part of a NHS Borders wide recovery plan aiming to deliver mitigating actions amounting to £13.7m in total.

The recovery plan and mitigating actions come with inherent risk, although the majority of actions undertaken in the year have been relatively low risk by nature. However going forward, due to the temporary nature of the recovery plan actions, ongoing risks to the overall affordability and financial sustainability will remain prevalent until addressed.

A key component of this will be the planning and delivery of an integrated transformation programme for the Partnership. This will build on the efficiency and savings programmes already in place within each of the partner organisations planned budget for 2017/18. In terms of the Partnership's Strategic Plan, it is critical that as the Partnership moves into year 2 of its operation, maximum efficiency in service provision is achieved and the prioritised and targeted investment of scarce Partnership resources is made.

PERFORMANCE MONITORING FRAMEWORK: SUMMARY

Scottish Borders Health and Social Care Partnership is progressively developing its Performance Monitoring Framework so that the measures that we monitor and report on reflect both national and local priorities.

- Appendix C sets out current and historical performance against a set of measures set by the Scottish Government for all Health and Social Care Partnerships. This “Core Suite” of 23 Integration Indicators was set by the Scottish Government, developed from national data sources so that the measurement approach is consistent across all Health and Social Care Partnership areas. This set of core indicators underpin the 9 National Health and Wellbeing Outcomes. Further information on the Core Suite Indicators and the rationale for their selection is available at <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators>
- Within the Partnership we are also reporting on a series of measures identified locally as priorities to be monitored to help manage and improve services. This series of measures will develop further over time. More information on performance against locally set measures is available at www.scotborders.gov.uk/integration

Performance areas that have been challenging for the Partnership have helped to determine the strategic priorities for 2018 – 2019.

DELIVERY OF KEY PRIORITIES FOR 2018/19

The Scottish Borders Health and Social Care Strategic Plan has been refreshed for 2018/19.

3 Strategic Objectives have been identified as follows:

- We will improve the health of the population and reduce the number of hospital admissions;
- We will improve patient flow within and out with hospital;
- We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

These three high level strategic objectives are underpinned by the following seven Partnership Principles which feed into and inform the local objectives:

1. Prevention & early intervention
2. Accessible services
3. Care close to home
4. Delivery of services with an integrated care model
5. Greater choice & control
6. Optimise efficiency & effectiveness
7. Reduce health inequalities

The key priorities identified for 2018/21 are:

- Promote healthy living and active ageing
- Improve communication and access to information
- Work with communities to develop local solutions
- Improve support for Carers within our communities
- Integrate services at a local level
- Promote support for independence and reablement so that all adults can live as independent lives as possible
- Provide alternatives to hospital care
- Improve the efficiency of the hospital experience
- Improve the use of technology enabled care

Conclusion



So the second year of the partnership closes and we embark on our third. The challenges have not abated and if anything they have increased. Our elderly population continues to grow and our available resources diminish.

We do however have a great deal of opportunity within our communities to improve everyone's health and well-being and to reduce demand across the whole range of Health and Social Care Services.

I look forward to reporting back to you next year on the progress through 2018/19.

I wish you every success.

Robert McCulloch-Graham

APPENDIX A

FINANCIAL PERFORMANCE AND BEST VALUE

I) FINANCIAL PERFORMANCE

Legislative and Governance Framework

Integration Joint Boards are required to prepare financial statements in compliance with:

- the Local Government (Scotland) Act 1973
- Chartered Institute of Public Finance and Accounting Code of Practice on Local Authority Accounting (updated annually)
- Scottish Government Finance Circular 7/2014
- the Local Authority Accounts (Scotland) Regulations 2014
- Integrated Resource Advisory Group (IRAG) guidance
- Local Authority (Scotland) Accounts Advisory Committee (LASAAC) Additional Guidance for the Integration of Health and Social Care 2015/16

In complying with this legislative framework, the Integration Joint Board must prepare and submit for audit a set of unaudited accounts by the 30th June following the close of each financial year which must be also be considered by the Integration Joint Board or a relevant committee by the 31st August . Subsequently, the independently audited accounts must be signed-off by the 30th September and published no later than 1 month thereafter.

The Integration Joint Boards' approved Integration Scheme sets out a range of provisions relating to the financial arrangements of the Scottish Borders Health and Social Care Partnership.

These provisions specifically include:

- How the Partnership's baseline payment will be calculated and assurance over its sufficiency will be provided
- The process for recalculating payment in subsequent years
- The method through which the amount set-aside for hospital services will be determined
- The process for dealing with in-year variations
- Definition of financial planning, management accounting and reporting requirements
- Treatment of year-end balances

Statutory Reporting Requirements

Draft shadow year accounts for the Health and Social Care Partnership were approved by the Integration Joint Board at its meeting of 15th August 2016. These accounts covered the period from the Partnership's date of legal establishment, 6th February 2016 to 31st March 2016.

The independent auditor's report to Integration Joint Board members and the Accounts Commission was received on 29th September 2016. The report held opinion over the true and fair view of the financial statements and their proper preparation in accordance with the required professional and legislative frameworks. No additional matters requiring reporting were found. The final audited Health and Social Care Partnership accounts for the period to the 31 March 2016 were approved by the Integration Joint Board on 17th October 2016.

For 2016/17, the first full year of operation of the Integration Joint Board following its establishment, draft unaudited accounts were prepared by 30th June 2017 and were approved by the Integration Joint Board Audit Committee. Final audited accounts will be submitted to the Integration Joint Board on 25th September 2017. Despite a challenging year the Integration Joint Board, following mitigating recovery actions and additional payment by partners, achieved a balance outturn.

2016/17 - Resources Delegated to the Integration Joint Board

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the framework for the integration of health and social care in Scotland and requires that the Integration Joint Board produces a Strategic Plan setting out the services for the population over the medium-term.

It also stipulates that the Strategic Plan incorporates a medium-term financial plan (3-years) for the resources within its scope comprising of:

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

The Integration Joint Board approved its medium-term financial plan – “the Financial Statement” for the period 2016/17-2017/18 on the 30th March 2016. This followed a process of due diligence over the previous 3-years' budget, risk analysis and the provision of assurance over the sufficiency of resources. As per the Integration Scheme, neither partner may reduce the payment in-year to the Integration Joint Board to meet exceptional unplanned costs within the constituent authorities, without the express consent of the Integration Joint Board and constituent authorities for any such change.

The process of determining the total level of resources to be delegated to the Partnership complied with the provisions contained within its Scheme of Integration and the 2016/17 delegated budget was based on previous years' budget levels, adjusted incrementally to reflect:

- Partners' absolute level of funding by the

Scottish Government

- Past performance and known areas of financial pressure arising due to cost, demand, legislative and other factors
- Efficiencies and other required savings delivery to ensure overall affordability
- New priorities as expressed within partners' plans and the Integration Joint Board's Strategic Plan
- Other emerging areas of financial impact

The financial position at the 31st March 2017 on the healthcare and social care functions delegated to the Integration Joint Board is summarised below:

DELEGATED HEALTHCARE FUNCTIONS	BASE BUDGET £'000	REVISED BUDGET £'000	PROVISIONAL OUTTURN £'000	OUTTURN VARIANCE £'000
Joint Learning Disability Service	3,599	3,634	3,690	(56)
Joint Mental Health Service	14,015	14,190	14,173	17
Joint Alcohol and Drug Service	749	634	635	(1)
Older People Service	0	0	0	0
Physical Disability Service	0	0	0	0
Generic Services	73,570	78,149	78,109	40
	91,933	96,607	96,607	0

DELEGATED SOCIAL CARE FUNCTIONS	BASE BUDGET £'000	REVISED BUDGET £'000	PROVISIONAL OUTTURN £'000	OUTTURN VARIANCE £'000
Joint Learning Disability Service	14,671	15,448	15,261	187
Joint Mental Health Service	1,962	1,963	1,911	52
Joint Alcohol and Drug Service	199	169	103	66
Older People Service	22,843	20,635	20,979	(344)
Physical Disability Service	3,180	3,448	3,343	105
Generic Services	3,642	4,784	4,850	(66)
	46,497	46,447	46,447	0

In addition to the delegated budget the outturn position on those healthcare functions retained by NHS Borders and set aside for the population for the Scottish Borders is also summarised below:

SET ASIDE HEALTHCARE FUNCTIONS	BASE BUDGET £'000	REVISED BUDGET £'000	PROVISIONAL OUTTURN £'000	OUTTURN VARIANCE £'000
Accident & Emergency	1,806	2,043	2,043	0
Medicine & Long-Term Conditions	11,330	13,029	13,029	0
Medicine of the Elderly	6,080	6,142	6,142	0
Planned Savings	(1,088)	(350)	(350)	0
	18,128	20,864	20,864	0

The Integration Joint Board experienced a number of significant finance-related challenges during its first year of operation.

These included or related to:

- There was a considerable shortfall on the delivery of planned efficiencies and savings, particular across healthcare functions – (£4.710m healthcare functions efficiencies 2016/17 and £2.663m social care 2016/17)
- The requirement for a recovery plan to deliver significant remedial savings across delegated health and social care, set-aside and wider NHS Borders functions during 2016/17
- Significant and volatile demand and price levels experienced during the year E.g. unplanned admissions to hospital, social care including residential care home demand and the retendering of care at home, the implementation of the living wage and prescribing
- The significant level of non-recurring efficiency and savings actions on which the Partnership's budget remains predicated
- Austere financial allocations and Scottish Government settlements against the backdrop of increasing demand and price factors

At the time of publication of this Annual Performance Report, a number of areas of financial risk remain prevalent including:

- The partnership's Medium-Term Financial Plan has yet to be balanced
- Implementation and delivery of a significant Transformation Programme during 2017/18
- Impact of 2016/17 and the financial plan and transformation programme in 2017/18 on the partnership's Strategic Plan has yet to be assessed
- Historic and current financial pressures experienced to date will need to be addressed
- Extensive savings and efficiencies require delivery during 2017/18 in order the partnership's plans remain affordable
- Further cost pressures may emerge during 2017/18 that remain currently unidentified
- Further Legislative and Regulatory Requirements such as the Carers' Act implementation may have additional financial consequences
- The care provider market supply in the Borders needs to be supported.
- Following the local government election in May, membership of the Integration Joint Board will change – 4 out of the previous 5 local authority members, including the chair, are no longer in the service of the council, whilst the former vice-chair has retired from NHS Borders' board.

Recovery Planning and Delivery during the Financial Year



The direct impact in 2016/17 of the in-year recovery plan on the Partnership's Strategic Plan has been assessed as low to medium. The main positive factors which determine this are:

- Securing Scottish Government endorsement and financial support to ensure that adverse impact is minimised
- Improved efficiency and control measures which form part of the recovery plan
- Utilisation of contingency
- Technical financial adjustments which have a low impact directly on front-line functions
- One-off nature of a significant proportion of the remedial actions

Conversely however, the wider medium-term impact is, without further action, likely to be higher as a result of:

- The opportunity cost of directing £500k of social care funding and £410k of Integrated Care Fund, both on a non-recurring basis, to meet pressures across surge and community hospital beds
- The non-recurring nature of much of the recovery plan actions requiring permanent addressing going forward
- The requirement to still deliver previously planned efficiency savings in future financial years
- The continued pressures across key functions which have yet to be mitigated e.g. prescribing

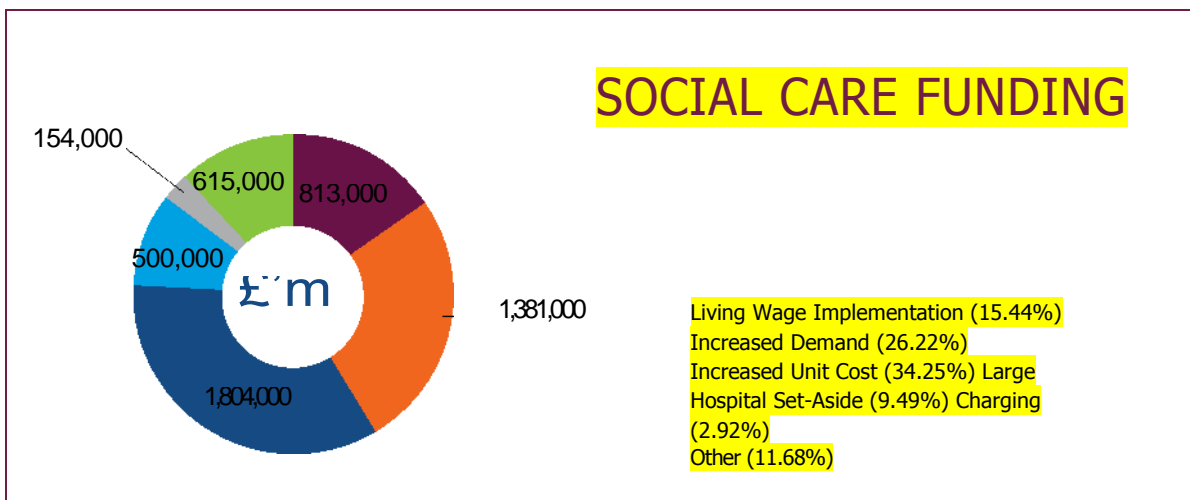
Establishing this impact and reviewing the Strategic Plan in light of prevalent financial pressures is now a key work package for the Partnership. Underpinning this will be the implementation of an integrated medium-term transformation programme for all health and social care aimed at improving performance and delivering the Partnership's strategic priorities and in particular, targeting significant cashable efficiencies in order to reinvest in new models of care and achieve overall affordability in the provision of health and social care.

Funding Priorities

During 2016/17, in addition to the delivery of core functions, the Partnership has directed both its social care funding and integrated care fund allocations towards a range of new requirements and planned priorities.

Social Care Funding

The Integration Joint Board has fully directed the Partnership's 2016/17 social care funding allocation (£5.267m). On a permanently recurring basis, £5.088m has been committed. How the Partnership has directed funding to date is summarised below:



Integrated Care Fund

The Scottish Borders Health and Social Care Partnership's Scottish Government Integrated Care Fund allocation is £2.13m in each of financial years 2015/16 to 2017/18, a total programme value of £6.39m.

To date, £4,015,552 has been directed by the Integration Joint Board to meet the costs of a range of transformational initiatives:

INTEGRATED CARE FUND PROJECTS

Pathways

Mental Health Integration	£38,000
Delivery of the Autism Strategy	£99,386
Delivery of the ARBD pathway	£102,052
Stress and Distress	£166,000
Transitions	£65,200
Domestic Violence pathway project	£120,000
Care pathways/delayed discharge consultancy	£7,000
ADP Transitional Funding	£46,000
My Home Life	£71,340
BAES Relocation	£241,000
Health Improvement	£38,000
The Matching Unit	£115,000
RAD	£140,000
Transitional Care Facility	£941,600

Communities and Localities

Community Capacity Building	£400,000
Transport Hub	£139,000
GP Clusters Project	£50,000
Delivery of the Localities Plan	£259,500
Locality Manager	£65,818
H&SC Coordinator	£49,238
Community Led Support	£90,000
Pharmacy Input	£97,000

Other

Programme delivery	£580,458
Independent Sector representation	£93,960

ICF remaining resource

£2.374m

II) BEST VALUE

Introduction

All public organisations have a duty to secure best value. The duty of best value in public services is defined as:

- To make arrangements to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost; and in making those arrangements and securing that balance
- To have regard to economy, efficiency, effectiveness, the equal opportunities requirements, and to contribute to the achievement of sustainable development

Best Value ultimately is about creating an effective organisational context from which Public Bodies can deliver their key outcomes. It provides the building blocks on which to deliver good outcomes by ensuring that they are delivered in a manner which is economic, efficient, sustainable and supportive of continuous improvement.

There are a number of best value themes that public service organisations are expected to demonstrate including:

- Vision and Leadership;
- Effective Partnerships;
- Governance and Accountability;
- Use of Resources; and
- Performance Management
- Equality and Sustainability

Since its establishment on 6th February 2016, the Scottish Borders Health and Social Care Partnership has worked to embed the key themes of best value in how it plans and delivers models of health and social care across the Scottish Borders with specific focus on its leadership, strategic and financial governance, joint working, inclusion and co-production / consultation and the sound management of resources in a variety of ways and in particular the development and implementation of its Strategic Plan.

Leadership, Partnership Working and Inclusion

The Scottish Borders Health and Social Care Partnership is a co-terminus partnership between the health board, the local authority and their partners in care. Whilst the Partnership is young, its working supports the full participation of the range of health and social care partners across the Scottish Borders at all levels. The Partnership's Executive Management Team, consists of a number of senior officers from each of NHS Borders and Scottish Borders Council and the Partnership's Chief Officer and Finance Officer and is directly responsible for supporting the Integration Joint Board in setting the strategic direction of the Partnership and in both planning and delivering existing and future models of health and social care across the Scottish Borders.

A number of other Partnership groups provide a range of support to the Integration Joint Board across its transformation and redesign agenda, commissioning and implementation and strategic planning, all of which are formed by key officers from the health board, the local authority, GP representation and third and independent sectors. Formal terms of reference exist for all groups which have been approved by the Integration Joint Board.

In developing its Strategic Plan, using a co-productive approach, the Partnership learned by listening to local people, service users, Carers, members of the public, staff, clinicians, professionals and partner organisations. From April to December 2015 the Partnership engaged on the first and second consultation drafts of the plan through workshops and local events across the Borders.

Transformation and Redesign

In early 2016/17, the Partnership established a team to specifically assist with the programme of transformation and redesign of health and social care. The programme is extensive and its component elements are led by officers across partners, including the independent sector. A key financial, but not only, enabler to the programme of transformation and redesign is the Integrated Care Fund, which is a £6.39m source of funding across a 3-year period 2015/16 – 2017/18.

Fundamental to the transformation and redesign of health and social care is the requirement to deliver a programme of efficiency and savings on which the overall affordability of the Partnership's medium-term financial plan is predicated. For the delegated budget, £4.710m of planned healthcare functions efficiencies required delivery during 2016/17 and £2.663m across its social care functions.

To support future years, the Partnership is working to implement an integrated approach to transformation of health and social care.

The Integration Joint Board and its partners have put in place a strategic and corporate approach to financial planning which in turn, takes both account of Partnership priorities and demand for resources and informs the Partnership's medium term financial plan.

To deliver this, strategically themed programmes of review are being undertaken by partners focussing on key themes including:

- Care Pathways
- Redesign of Day Services
- Redesign of Mental Health services
- Localities Approach
- Redesign of Staffing and Management Arrangements
- Use of Technology
- Prescribing
- Alcohol and Drug Redesign
- Implementation of Carers Legislation

This both informs and delivers the integrated Transformation and Redesign programme for the Health and Social Care Partnership.

Use of Resources

The Integration Joint Board Financial Officer is responsible for the administration of the financial resources delegated to it. Part of this role is to ensure that the Strategic Plan meets the requirement for best value in the use of the Integration Joint Board's financial resources. Balancing control and compliance with value creation and performance is important. Better value for money releases resources that can be recycled into higher priorities helping to secure positive social outcomes within affordable funding.

On an annual basis, the Integration Joint Board requires to seek assurance from NHS Borders and Scottish Borders Council over the financial arrangements and resources through which it will discharge its responsibilities and deliver its required performance outcomes within the Strategic Plan. This process of assurance is grounded on principles of mutual trust and confidence between NHS Borders and Scottish Borders Council, working in Partnership with a complete open-book approach, information-sharing and clear cross-referencing of impacts across all former-NHS and Council service areas.

For 2016/17, in order to provide the Integration Joint Board with assurance over the sufficiency of the resources included within the Financial Statement approved on 30th March 2016, specific scrutiny was made in relation to:

- Due diligence: in determining payment to the Integration Joint Board in the first year (2016/17) for delegated functions, delegated baseline budgets were subject to due diligence and comparison to recurring actual expenditure in the previous three years adjusted for any planned changes to ensure they were realistic
- Risk assessment: an assessment was made, following due diligence, of any recurring areas of financial risk to which the Integration Joint Board was exposed and where appropriate, the robustness of the arrangements put in place to mitigate them

The outcomes from both these processes were reported to the Integration Joint Board as part of and following the approval of the 2016/17 medium-term Financial Statement.

Regular and frequent monitoring reports have been made to the Integration Joint Board during 2016/17. These have highlighted the financial pressures to which health and social care functions are exposed this financial year and have resulted in the direction of resources by the Integration Joint Board when required, in addition to the planning and delivery of a remedial recovery plan.

In order to further consolidate the robustness of how scarce financial resources are utilised and governed by the Partnership, financial planning and management has featured specifically on a number of occasions as part of Integration Joint Board member development sessions.

Performance Management

The significant level of non-recurring efficiency and savings actions on which the Partnership's budget remains predicated, restricted levels of Scottish Government funding and a host of pressures across health and social care budgets both existing and emerging, poses a significant threat to the medium-term sustainability of health and social care functions. The development of a large-scale strategic transformation programme for the medium-term will be critical to mitigating this risk. A partnership approach to developing and delivering improved and more efficient health and social care services is now starting to have an effect, with a number of key areas of work delivered or now in progress. This has already had an impact on helping the services delegated to the Integration Joint Board move closer to achieving financial balance in 2016/17 and in developing an affordable Financial Plan for 2017/18. The impact on the Health and Social Care Partnership's ability to deliver its Strategic Plan has also yet to be assessed. Clearly, with £6m of in-year recovery actions requiring delivery in 2016/17, coupled to a further £9m of savings across delegated and set-aside budgets being required to deliver the Partnership's 2017/18 Financial Plan, there is likely to be an impact on its performance and a review of the Strategic Plan, not least in the financial context, is once again due.

Forward Planning

The Partnership agreed its medium-term joint financial planning strategy and reserves policy on 27 February 2017. This strategy sets out the framework for future effective joint financial planning arrangements and timescales for the Integration Joint Board its policy for maintaining reserves and the carrying forward of resources.

The key objective of a joint/more integrated financial planning process will be the delivery of a balanced, affordable and sustainable medium-term financial plan for the Health and Social Care Partnership which:

- Improves outcomes and efficiency
- Delivers longer term financial savings improving sustainability
- Prioritises the aim and objectives of the strategic plan
- Enables resources to be shifted along the care pathway in line with new models of care

Service Reporting Code of Practice (Best Value Accounting Code of Practice)

In preparing the Health and Social Care Partnership's accounts, reference to Chartered Institute of Public Finance and Accountancy's Service Reporting Code of Practice, which establishes proper practice for consistent financial reporting below the statement of accounts level is required.

APPENDIX B

Inspection of Services

The recommendations for improvement in the report are as follow

	Recommendations Made	Action Taken to Implement Recommendations
1.	The partnership should deliver more effective consultation and engagement with stakeholders on its vision, service redesign and key stages of its transformational change.	We have a clear communication plan which outlines the Partnership's vision and how the Partnership will engage and consult with key stakeholders in service design, joint plans and policies. The locality working groups are a positive and recent example of a regular forum for engagement and consultation.
2.	The partnership should ensure its revised governance framework provides more effective performance reporting and an increased pace of change.	Quarterly performance reports are presented to the IJB and managers across the Partnership managers engage in dialogue about these.
3.	The partnership should further develop and implement its joint approach to early intervention and prevention services so that it continues to improve the range of services working together that support older people to remain at home and help avoid hospital admission.	'What matters' hubs are now in place across the Borders and work jointly with the third sector, signposting people to healthy living activities. A strategic delivery plan is in progress. to identify the current landscape of early intervention and prevention services, and the gaps, in order to make recommendations to address this.
4.	The partnership should further develop and implement its joint approach to early intervention and prevention services so that it continues to improve the range of services working together that support older people to remain at home and help avoid hospital admission.	'What matters' hubs are now in place across the Borders and work jointly with the third sector, signposting people to healthy living activities. A strategic delivery plan is in progress. to identify the current landscape of early intervention and prevention services, and the gaps, in order to make recommendations to address this.
5.	The partnership should review its delivery of care at home, care home and intermediate care services to better support a shift in the balance of care towards more community based support.	This complex piece of work in a challenging market environment is progressing. An older person's housing strategy has been drafted, a commissioning plan will be in place by summer 2018 as will a plan for development of telecare
6.	The partnership should update its carers strategy to have a clear focus on how carers are identified and have their	The Carers Advisory Group- a group of carers- has led on a Carers Strategy for 2017-19. There has been an extensive

	needs assessed and met. The partnership should monitor and review performance in this area.	programme to raise awareness about carers through staff training and through SBConnect, sent to every Borders household.
7.	The partnership should ensure that people with dementia receive access to a timely diagnosis.	Awareness raising sessions have been held on the importance of diagnosis and discussions with GP practices to ensure that people with a diagnosis of dementia are recorded.
8.	The partnership should take action to provide equitable access to community alarm response services for older people.	A telecare strategy is in development for summer 2018 to ensure best use is made of telecare and telehealth care options to assist people to remain at home.
9.	<p>The partnership should provide stronger accountability and governance of its transformational change programme. It should ensure that:</p> <ul style="list-style-type: none"> • progress of the strategic plan priorities are measured and evaluated; • service performance and financial monitoring are linked • locality planning is implemented and leads to changes at a local level • independent needs assessment activity is included in the joint strategic needs assessment • there is appropriate oversight of procurement and commissioning work • a market facilitation strategy is developed and implemented. 	<p>There is quarterly performance reporting to the IJB; a long term sustainable financial plan will be agreed by summer 2018.</p> <p>A commissioning plan and market facilitation plan will be in place by autumn 2018.</p> <p>Locality working groups have recently published their plans and there is regular reporting to the IJB.</p>
10.	The Integration Joint Board should develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved.	<p>The 2017/18 financial recovery plan was agreed. This required additional non-recurring monies to be approved to health and social care delegated functions.</p> <p>The IJB is progressing a transformation and efficiency programme which will contribute a level of efficiency savings.</p>
11.	The partnership should ensure that there are clear pathways for accessing services and that eligibility criteria are consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.	A What Matters hub has now been established in each area of the Borders-with more hubs in some rural areas like Ettrick/Yarrow. The impact has been to significantly reduce waiting lists for social care support. The matching unit, to link people with available providers, has speeded up access to services.

12.	<p>The partnership should work together with the critical services oversight group and adult protection committee to ensure that:</p> <ul style="list-style-type: none"> • risk assessments and risk management plans are completed where required • quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve • improvement activity resulting from quality assurance processes is well governed. 	<p>Quarterly file audits are undertaken to ensure that appropriate action and recording are in place. Performance is reported on quarterly to the Adult Protection Committee and Critical Services Oversight Group. These reports are subject to peer scrutiny.</p>
13.	<p>The partnership should develop and implement a tool to seek health and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services.</p>	<p>Health and Social Care are using the IMatter tool to seek staff feedback. A survey has just been completed within social care and feedback is being analysed and reported to the IJB.</p>
14.	<p>The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and providing a skills mix that delivers high quality services.</p>	<p>A workforce plan has been drafted. In stage one this includes NHS Borders and SBC. Stage two will include the third and independent sectors and will be completed in 2018.</p>

APPENDIX C

PERFORMANCE MANAGEMENT

National “Core Suite” Indicators 1-10: Outcome Indicators based on survey feedback

NATIONAL INDICATOR NUMBER	INDICATOR DESCRIPTION	SCOTTISH BORDERS	SCOTLAND
NI - 1	Percentage of adults able to look after their health very well or quite well	94%	93%
NI - 2	Percentage of adults supported at home who strongly agreed or agreed that they are supported to live as independently as possible	83%	81%
NI - 3	Percentage of adults supported at home who strongly agreed or agreed that they had a say in how their help, care, or support was provided	74%	76%
NI - 4	Percentage of adults supported at home who strongly agreed or agreed that their health and social care services seemed to be well co-ordinated	75%	74%
NI - 5	Percentage of adults receiving any care or support who rated it as excellent or good	83%	80%
NI - 6	Percentage of people who rated the experience of the care provided by their GP practice as excellent or good	88%	83%
NI - 7	Percentage of adults supported at home who strongly agreed or agreed that their services and support had an impact on improving or maintaining their quality of life	80%	80%
NI - 8	Percentage of Carers who strongly agreed or agreed they feel supported to continue in their caring role	36%	37%
NI - 9	Percentage of adults supported at home who strongly agreed or agreed they feel safe	86%	83%

Source: Scottish Government Health and Care Experience Survey 2017/18

<http://www.isdscotland.org/Products-and-Services/Consultancy/Surveys/Health-and-Care-Experience-2017-18/>

This national survey is run every two years with 2019/20 results due to be published spring 2020.

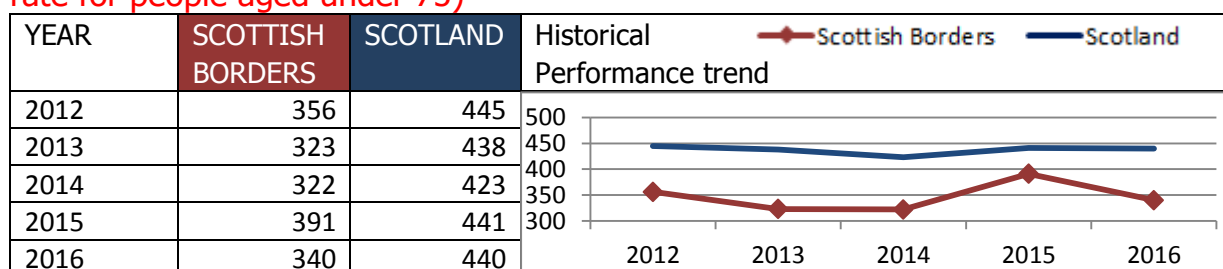
NATIONAL INDICATOR NUMBER	INDICATOR DESCRIPTION	SCOTTISH BORDERS	SCOTLAND
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	57% (NHS Borders only)	59%

Source: NHS Scotland Staff Survey 2015

<http://www.gov.scot/Publications/2015/12/5980>. To date, equivalent information across the entire workforce of all Health and Social Care Partnerships is not available. Further work is required nationally and within Partnerships to collate and calculate this information.

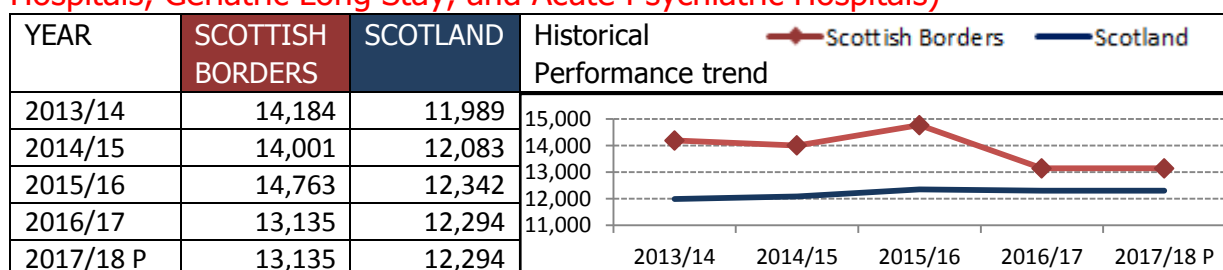
National “Core Suite” Indicators 11-20: Indicators based on organisational/system data

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



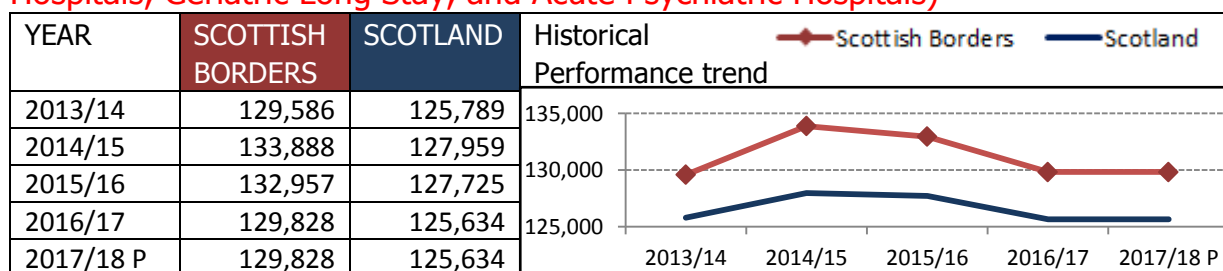
Source: National Records for Scotland (NRS).

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



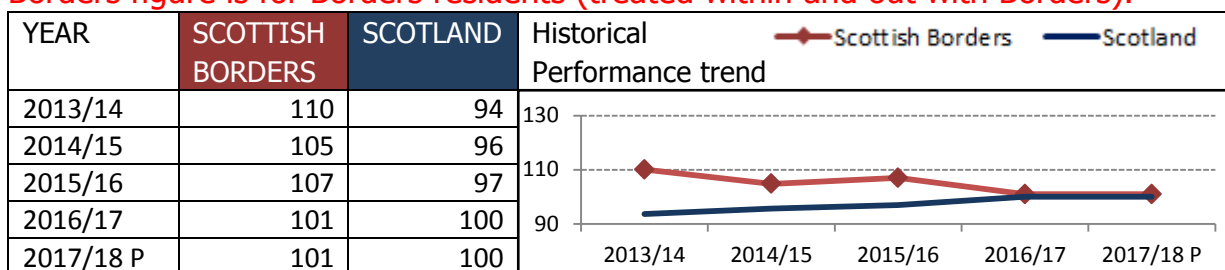
Source: ISD Scotland. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

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



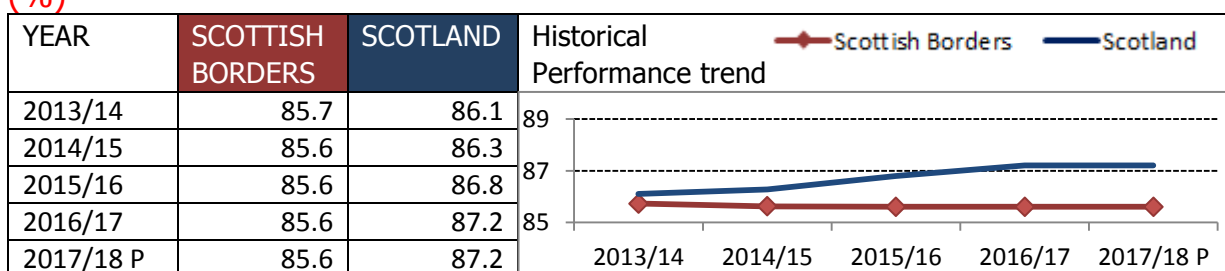
Source: ISD Scotland. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year

NI-14 Readmission to hospital within 28 days – rate per 1,000 discharges. Note: Borders figure is for Borders residents (treated within and out with Borders).



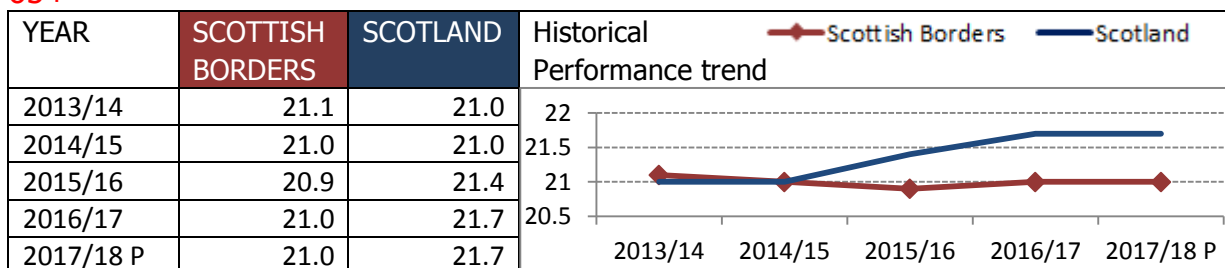
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland, such as Borders General Hospital). This excludes discharges from Geriatric Long Stay (meaning that discharges from any of the Borders Community Hospitals do not contribute to these figures). Note: Figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

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



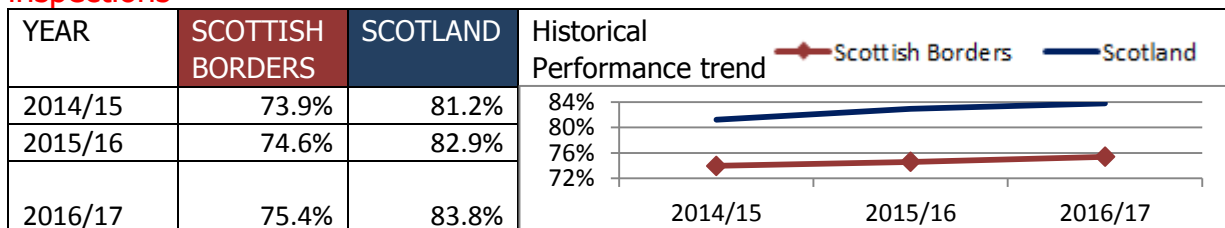
Source: ISD Scotland. Note: Figures for 2017/18 are provisional, as deaths and hospital records are incomplete for this year.

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



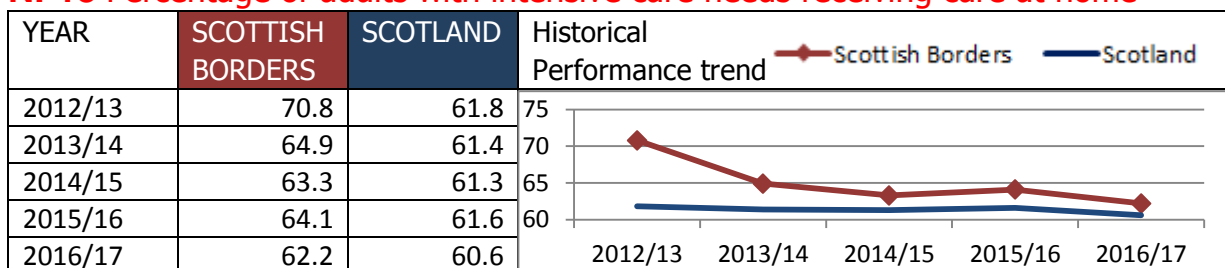
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges. Note: figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

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



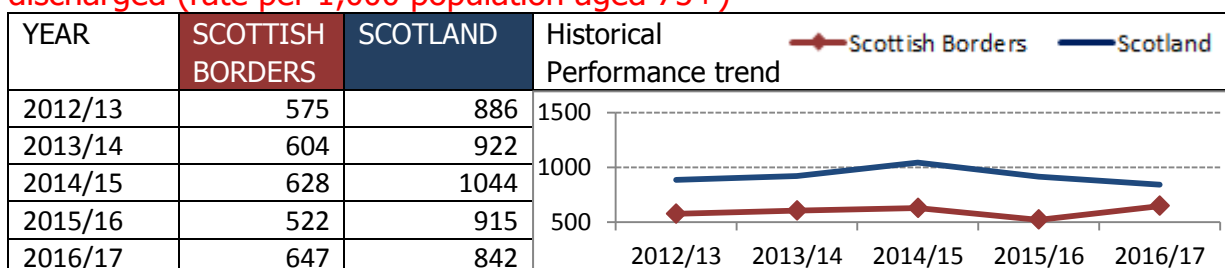
Source: Care Inspectorate (Indicator in development)

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



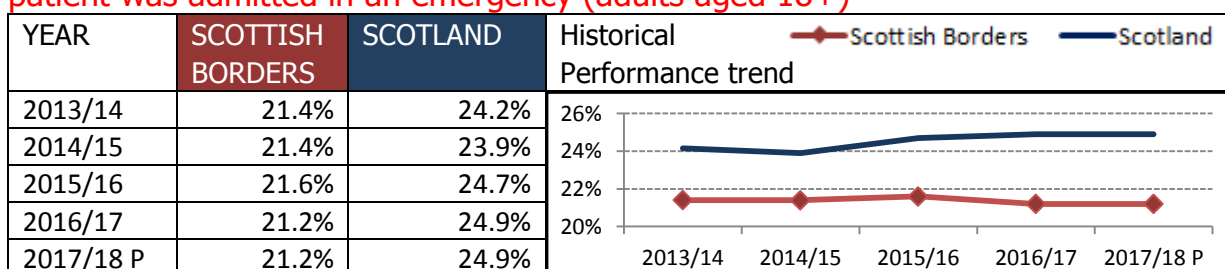
Source: Scottish Government Health and Social Care Statistics.

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



Source: ISD Scotland Delayed Discharge Census.

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



Source: ISD Scotland. Note: Underlying costs data for 2016/17 have been used as a proxy for 2017/18 costs in the calculation of this indicator. These figures are therefore provisional and will be refreshed once updated costs data become available.

National “Core Suite” Indicators 21-23: Indicators based on organisational/ system data

The last three of the Core Suite Indicators identified by the Scottish Government to be reportable for and published by all Health and Social Care Partnerships in Scotland remain under development as further work is required with regard to data sources and/ or methodology in order to report these measures in a nationally consistent way. These measures are:-

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

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

NI-23 Expenditure on end of life care.

APPENDIX D

SERVICES THAT ARE THE RESPONSIBILITY OF THE HEALTH AND SOCIAL CARE PARTNERSHIP

Our Health and Social Care Partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The Partnership has a key relationship with acute services in relation to unplanned hospital admissions and will continue to work in partnership with Community Planning Partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, we can also work in partnership with our communities.

Health and Social Care Services which are integrating

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES

(PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

*Adult Social Care Services for adults aged 18 and over.

*Acute Health Services for all ages – adults and children.

Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (), which also include services for children.

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