Scottish Borders **Health & Social Care** Partnership

ANNUAL PERFORMANCE REPORT 2018-2019

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

Scottish Borders
Health and Social Care
PARTNERSHIP

CONTENTS

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

INTRODUCTION

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

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

This Annual Performance Report presents how the Partnership has:

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

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

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

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

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

EXECUTIVE SUMMARY

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

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

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

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

The spotlights cover:

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

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

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

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

2017/18 AT A GLANCE

OLDER

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

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

Between 1998 and 2018:

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

Source: National Records of Scotland

COLDER

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

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

BOLDER

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

STRATA

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

GARDEN VIEW

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

TRANSITIONAL CARE

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

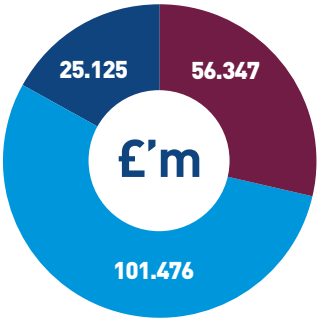
HOSPITAL TO HOME

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

OUR PARTNERSHIP SPEND IN 2018/19

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

THIS WAS SPLIT:



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

£ ON EMERGENCY HOSPITAL STAYS

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

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

#yourpart

2018/19 PARTNERSHIP PERFORMANCE AT A GLANCE

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

STRATEGIC OVERVIEW (HOW THINGS FIT TOGETHER)

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

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

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

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

The three strategic objectives are:

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

Our own Strategic Objectives are underpinned by the principles of:

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

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

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

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

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

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

Health and Social Care Services which are integrated

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

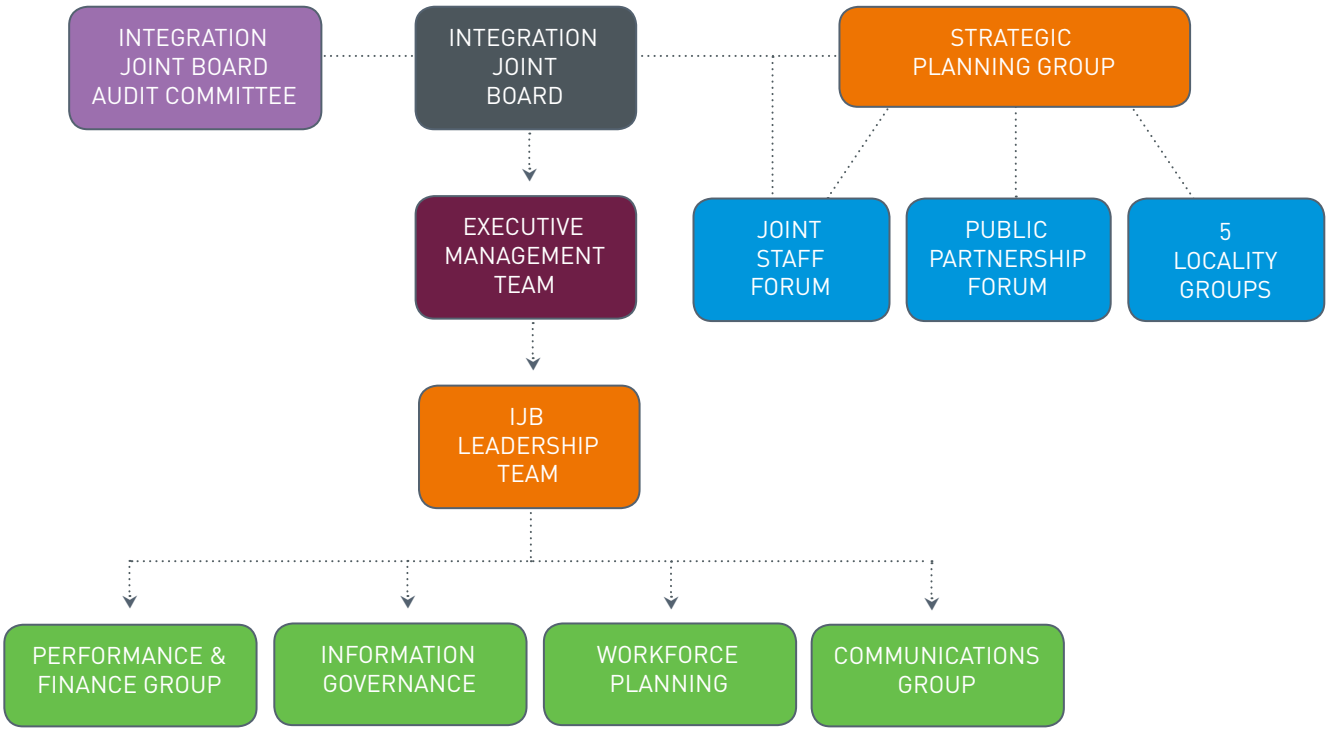
*Adult Social Care Services for adults aged 18 and over.
*Acute Health Services for all ages – adults and children.
*Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (*), which also include services for children.

GOVERNANCE AND ACCOUNTABILITY

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

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

H&SC Partnership Governance Structure



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

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

These localities are:

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

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

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

The Internal Audit planned work in 2018/19 included:

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

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

KEY PARTNERSHIP DECISIONS 2018/19

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

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

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

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

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

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 1

OBJECTIVE 1

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

Objective 1: Background and Challenges

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

Key to achieving positive change is by:

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

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

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

Community Led Support

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

The hubs:

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

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

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

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

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

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

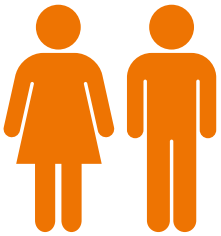
Using the 'What Matters' approach should mean that individuals receive the level of care that they require, but that already stretched Partnership resources can be used efficiently to ensure that effective care can continue to be delivered for our growing, ageing population.

FEEDBACK FROM HUB USERS INDICATES THAT

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

96% were satisfied with the outcome of their visit

98% would recommend the What Matters Hub



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

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

Partnership Priorities for 2018/19 – What we said

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

Key Achievements/Successes : What we did

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

Objective 1: Partnership Priorities for 2019/2020

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

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

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

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 2

OBJECTIVE 2

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

Objective 2: Background and Challenges

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

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

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

Objective 2: Spotlight – Older People's Pathway

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

STRATA

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

Hospital to Home

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

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

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

Garden View / Transitional Care

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

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

Matching Unit

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

The unit:

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

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

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

Partnership Priorities for 2018/19 – What we said

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

Key Achievements/Successes : What we did

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

Objective 2: Partnership Priorities for 2019/2020

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

2.1) Introduce a renewed discharge hub

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

2.2) Develop shared Out-of-Hours coordination

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

2.3) Promote Healthier lifestyles within the Borders

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

2.4) Commission the correct bed base mix

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 3

OBJECTIVE 3

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

Objective 3: Background and Challenges

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

Key to achieving positive change is by:

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

Objective 3: Spotlight - Unpaid Carers

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

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

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

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

Carers data suggests that:

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

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

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

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

The ambition is that carers will:

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

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

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

Partnership Priorities for 2018/19 – What we said

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

Key Achievements/Successes : What we did

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

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

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

Key Achievements/Successes : What we did

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

Objective 3: Partnership Priorities for 2019/2020

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

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

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

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Performance Summary

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

IJB financial governance includes:

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

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

The split of the resource is shown below:

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

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

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

Proportion of spend by reporting year, broken down by service

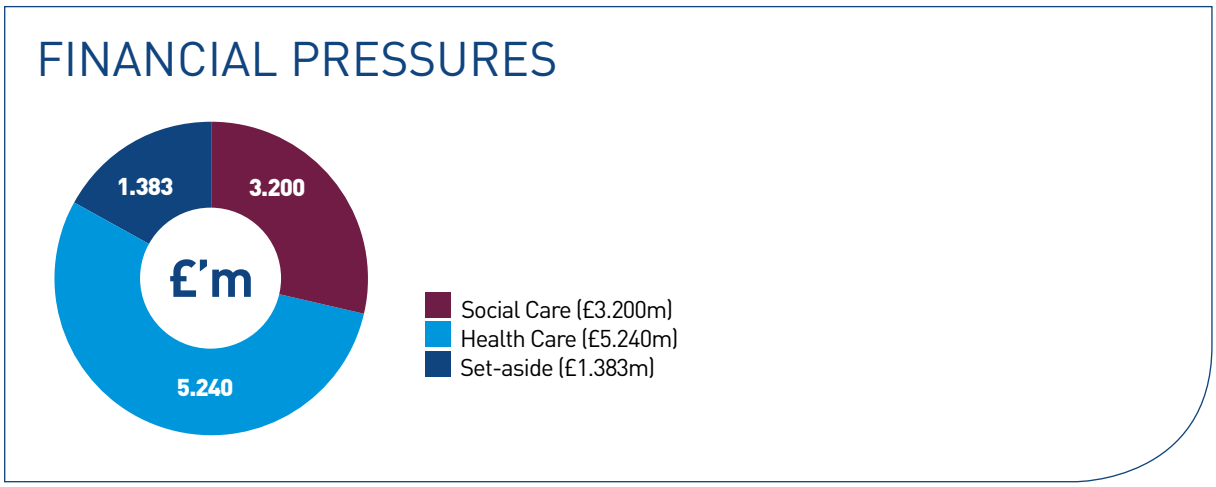
The table below shows the actual budget for 2016/17, 2017/18, 2018/19 – and the forecast budget for 2019/20.

IJB SERVICE AREA	ACTUAL 2016/17 £'000	ACTUAL 2017/18 £'000	ACTUAL 2018/19 £'000	FORECAST 2019/20 (£'000)
1. SOCIAL CARE SERVICES				
Joint Learning Disability Service	15,261	16,730	17,516	17,463
Joint Mental Health Service	1,911	1,962	1,999	1,977
Joint Alcohol and Drug Service	103	173	136	175
Older People Service	20,979	18,685	20,762	20,682
Physical Disability Service	3,343	3,570	3,599	3,326
Generic Services	4,850	12,011	12,335	5,257
Social Care sub-total:	**46,447**	**53,131**	**56,347**	**48,880**
2. HEALTH SERVICES				
Joint Learning Disability Service	3,690	3,520	4,010	4,243
Joint Mental Health Service	14,173	13,725	14,974	16,061
Joint Alcohol and Drug Service	635	597	608	379
Generic Services	78,109	77,645	81,884	89,356
Health sub-total:	**96,607**	**95,487**	**101,476**	**110,039**
3. SET-ASIDE HEALTHCARE SERVICES				
Accident & Emergency	2,043	2,004	2,912	2,748
Medicine & Long-Term Conditions	13,029	12,905	15,571	15,747
Medicine of the Elderly	6,142	6,434	6,642	6,696
Generic Services	-	3,075		-
Planned savings	(350)	-	-	-624
Set-aside sub-total:	**20,864**	**24,418**	**25,125**	**24,567**
Overall:	**163,918**	**173,036**	**182,948**	**183,486**
	-	**+5.6%**	**+5.7%**	**0.3%**

Overspend / Underspend

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

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



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

Specifically:

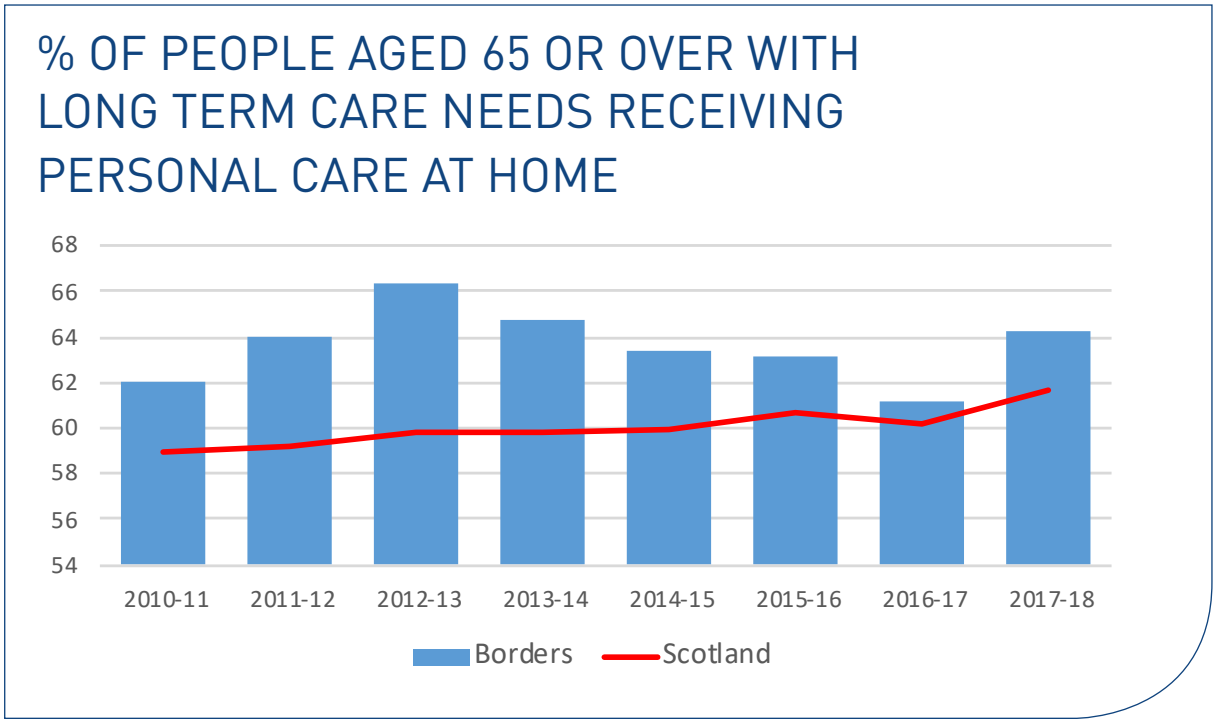
- significant increased demand for services associated with an increasing ageing population and increased complexity of care needs.
- pressures coming from challenges in recruitment and retention of staff resulting in the need for higher cost locum or agency staff to cover services.
- the non-delivery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

Balance of care

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

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

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



Source: Local Government Benchmarking Framework, April 2019 refresh

Best Value

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

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

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

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

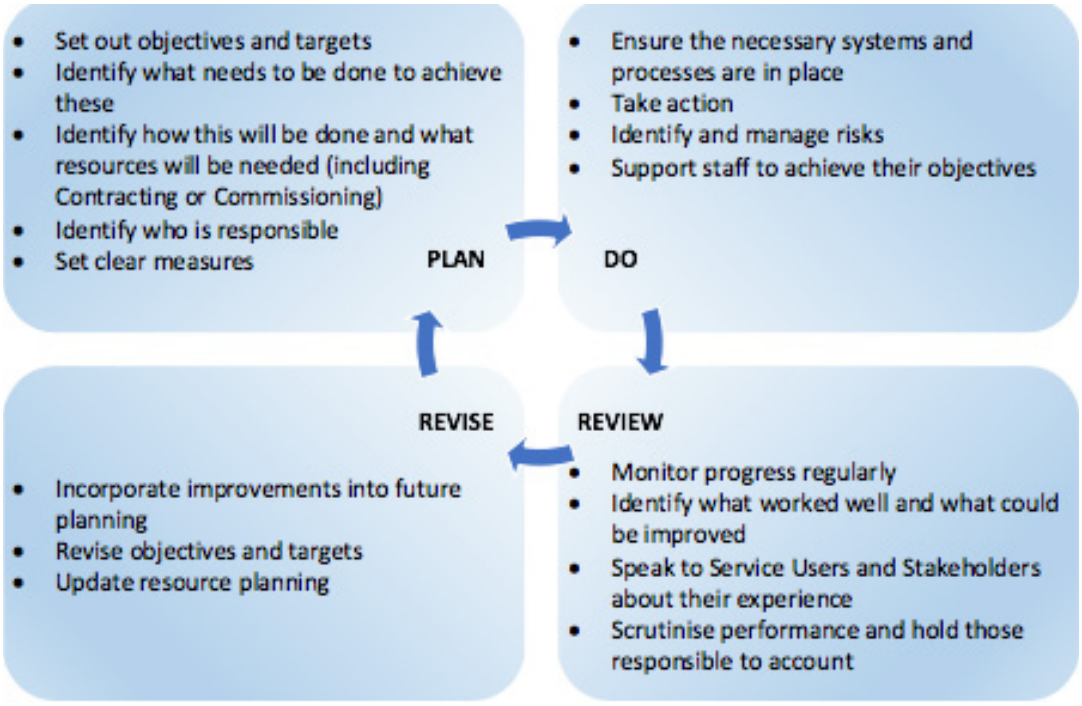
The unaudited Annual Accounts have been approved through the IJB governance process. In accordance with legislation, the audited accounts will be signed off no later than 30th September and published no later than one month thereafter.

PERFORMANCE MONITORING FRAMEWORK SUMMARY

Performance Management Framework

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

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



Source: Adapted from Audit Scotland

Our performance measures

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

Our quarterly measures are shown below:

HOW ARE WE DOING?

OBJECTIVE 1

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

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

Main Challenges

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

Our plans during 2019/20 to support this objective

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

OBJECTIVE 2

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

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

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

Main Challenges

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

Our plans during 2019/20 to support this objective

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

OBJECTIVE 3

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

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

Main Challenges

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

Our plans during 2019/20 to support this objective

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

Performance Change

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

KEY

▲ Improving Performance ▼ Declining Performance ◄ ► Little change

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

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

Core suite

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

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

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

OUTCOME INDICATORS

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

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

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

DATA INDICATORS

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

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

Source: ISD Core Suite Indicator Updates

MSG measures

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

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

LOCALITY ARRANGEMENTS

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

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

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

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

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

INSPECTION OF SERVICES

Joint Inspection Action Plan – Update

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

Best Value Audit

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

Health Inspections

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

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

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

Service/Facilities Inspections

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

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

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

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

1. RESIDENTIAL CARE HOMES

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

2. CARE AT HOME

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

MSG Report on IJBs

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

APPENDIX 1
JOINT INSPECTION ACTION PLAN

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

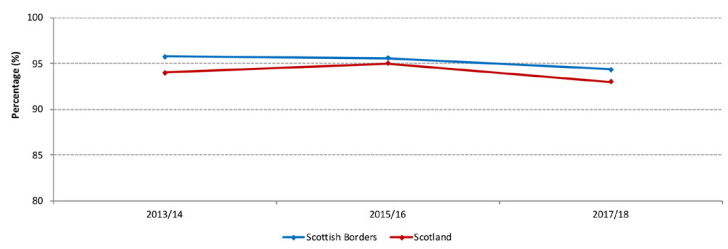
NO'	TITLE	REF	WHAT GOOD LOOKS LIKE	INDICATOR DESCRIPTION	RESPONSIBLE PERSON	BASELINE	RAG
8.	Provide stronger accountability and governance of transformational change programme. Ensure that: progress of the strategic plan priorities are measured and evaluated; service performance and financial monitoring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

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

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

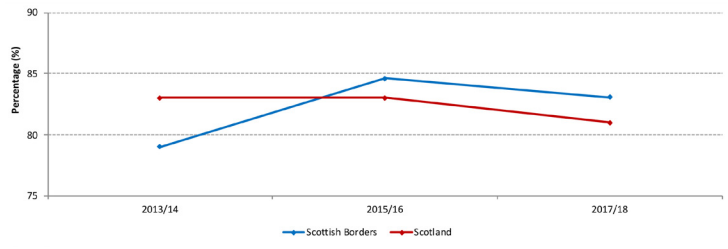
APPENDIX 2
CORE SUITE OF INDICATORS

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

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

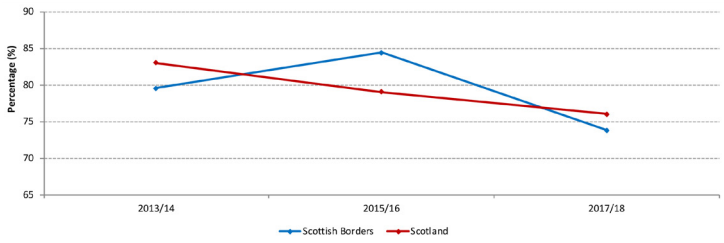
Source: Q52 - 2013/14 Health and Care Experience Survey, Q51 2015/16 Health and Care Experience Survey, Q40 2017/18 Health and Care Experience Survey

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

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

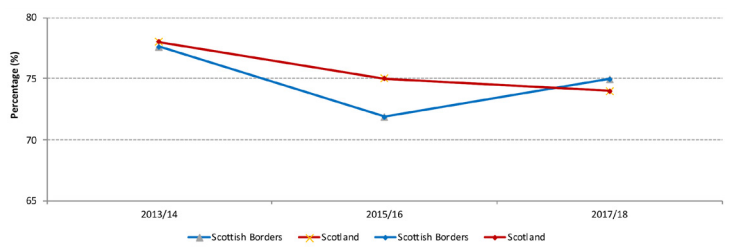
Source: Q36f - 2013/14 Health and Care Experience Survey, Q36g 2015/16 Health and Care Experience Survey, Q27f 2017/18 Health and Care Experience Survey

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

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

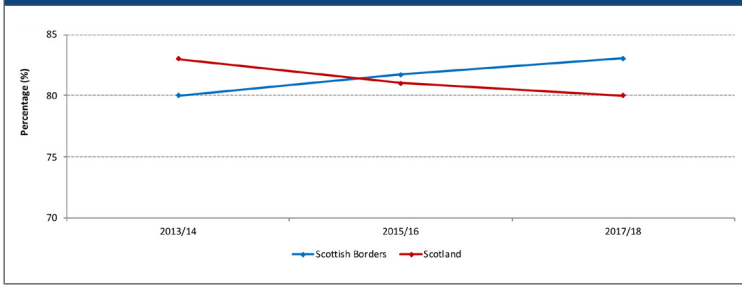
Source: Q36b - 2013/14 Health and Care Experience Survey, Q36b 2015/16 Health and Care Experience Survey, Q27b 2017/18 Health and Care Experience Survey

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

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

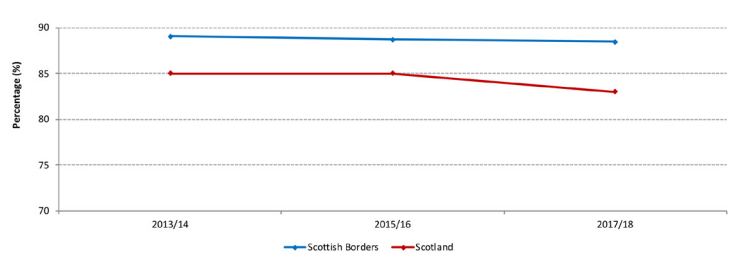
Source: Q36e - 2013/14 Health and Care Experience Survey, Q36f 2015/16 Health and Care Experience Survey, Q27g 2017/18 Health and Care Experience Survey

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

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

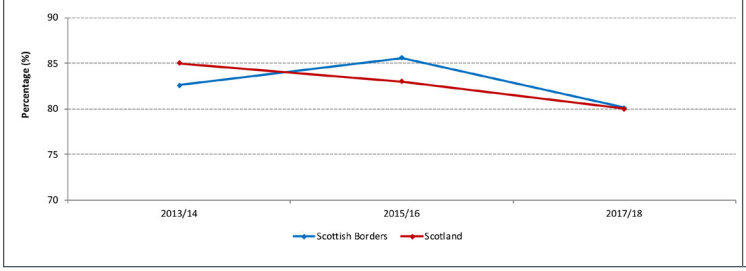
Source: Q37 - 2013/14 Health and Care Experience Survey, Q37 2015/16 Health and Care Experience Survey, Q28 2017/18 Health and Care Experience Survey

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

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

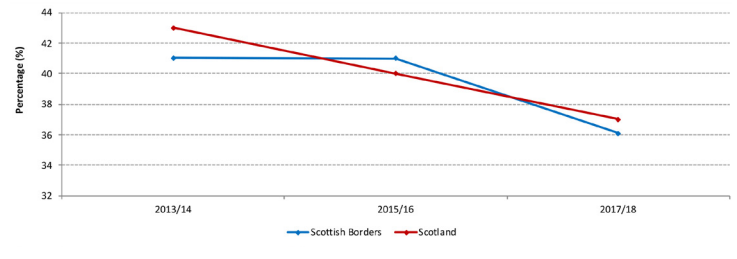
Source: Q27 - 2013/14 Health and Care Experience Survey, Q25 2015/16 Health and Care Experience Survey, Q8d 2017/18 Health and Care Experience Survey

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

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

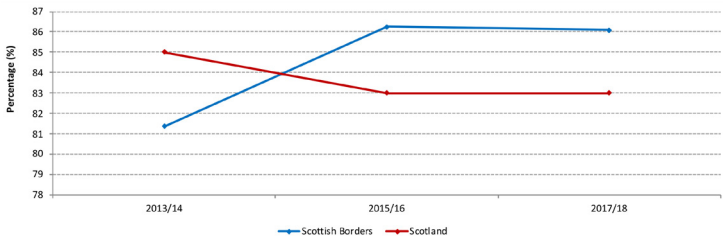
Source: Q36h - 2013/14 Health and Care Experience Survey, Q36i 2015/16 Health and Care Experience Survey, Q27h 2017/18 Health and Care Experience Survey

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

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

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

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

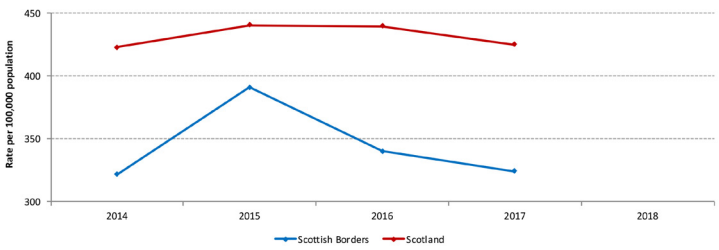
PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to seek the views of people receiving care and will act to deliver improvements.

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

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

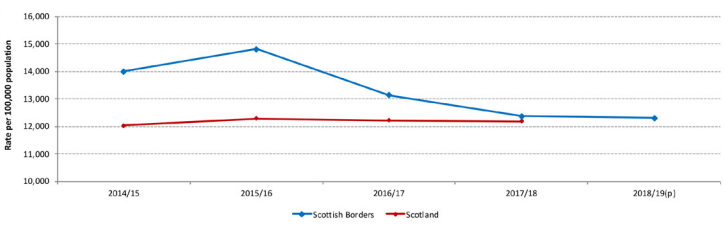
Indicator under development.

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

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

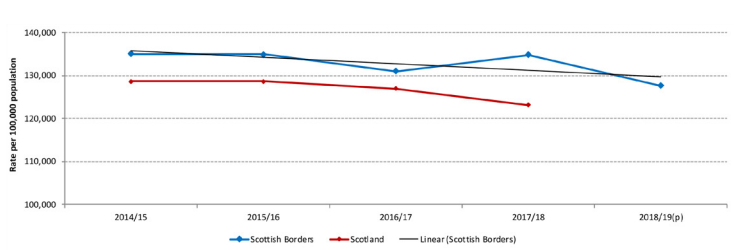
Source: National Records for Scotland (NRS)

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

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

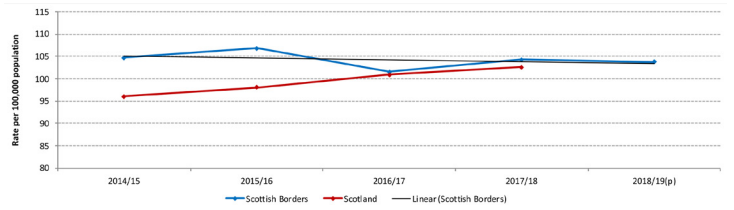
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

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

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

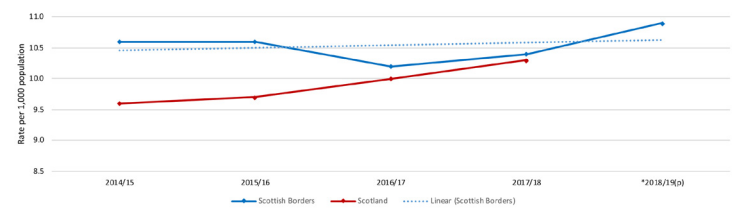
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

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

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

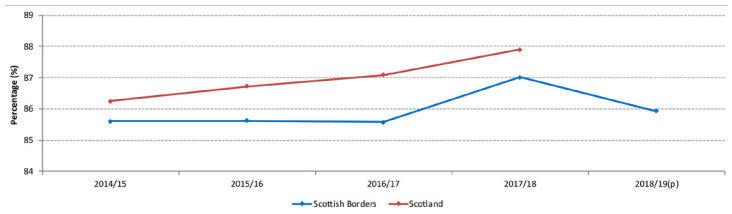
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

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

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

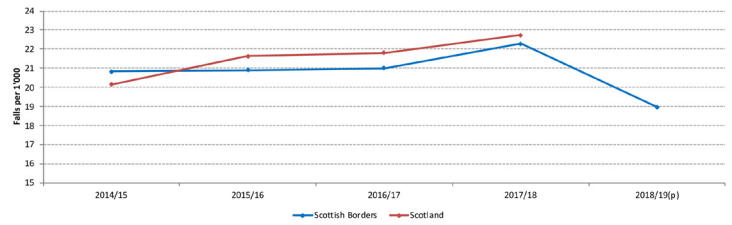
Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but also adding in Borders Community Hospital beds).

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

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

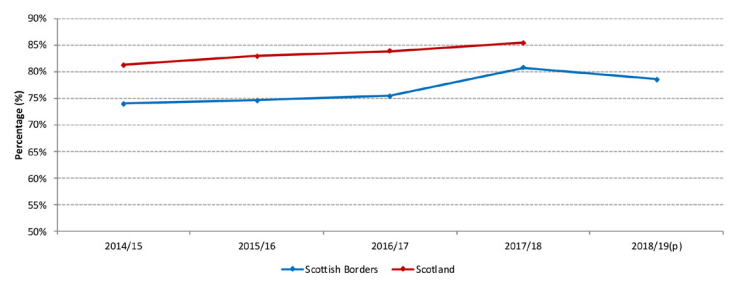
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) records
ISD Scotland: SMR04 (mental health inpatient records)
National Records for Scotland

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

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

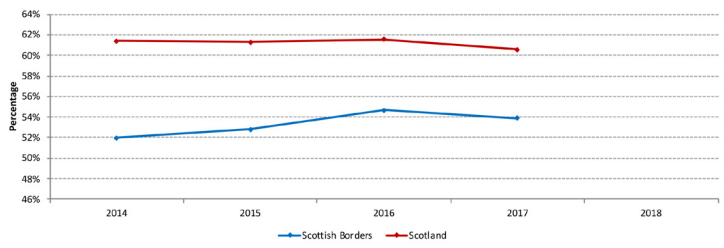
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges

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

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

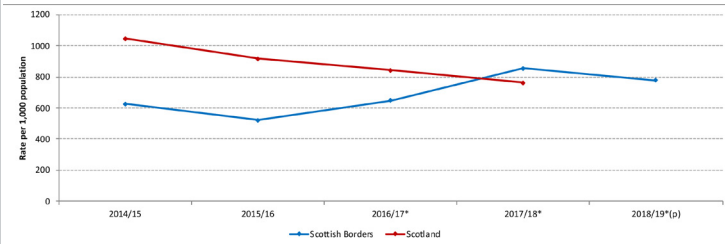
Source: Care Inspectorate

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

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

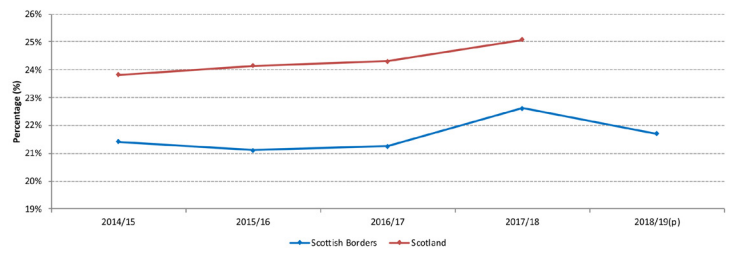
Source: Care Inspectorate

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

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

Source: ISD Scotland Delayed Discharge Census

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

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

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

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

Indicator under development.

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

Indicator under development.

NI-23 Expenditure on end of life care

Indicator under development.

APPENDIX 3
MSG MEASURES

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

Actions to achieve target

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

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

Actions to achieve target

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

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

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

Actions to achieve target

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

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

Actions to achieve target

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

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

Actions to achieve target

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

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

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

Actions to achieve target

Acute

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

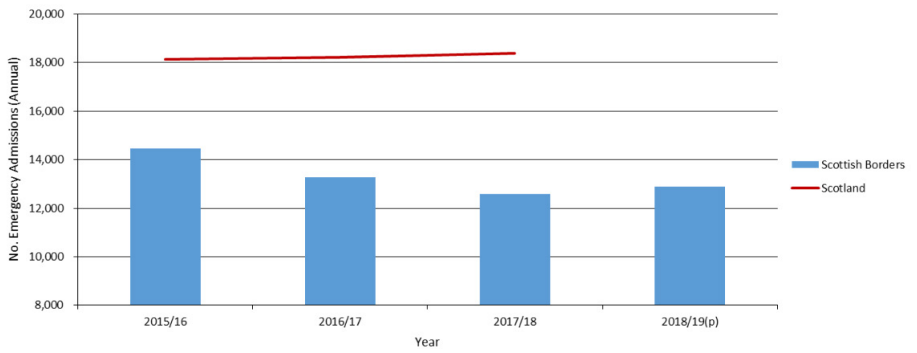
Geriatric Long Stay

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

Mental Health

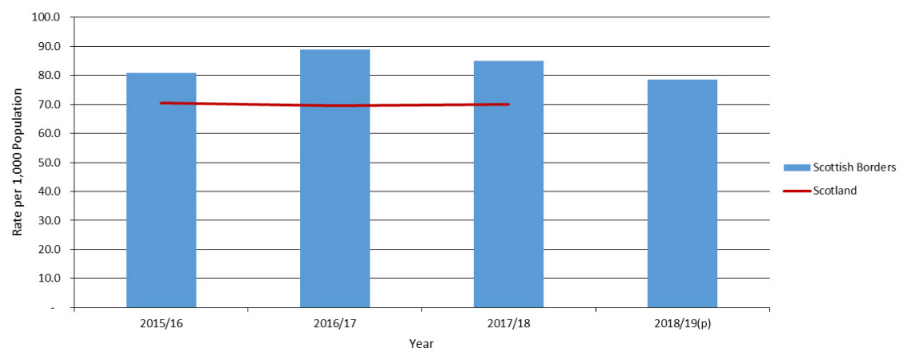
1. Outcome focussed consistent Care Planning across the community teams and in patients services.
2. Investment of Action 15 funding in Primary Care Mental Health services to provide more robust community support eg Distress Brief Interventions, Well Being Advisors, more accessible psychological therapies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

1a Number of emergency admissions (All Ages)

PERFORMANCE	BORDERS TREND
	▲

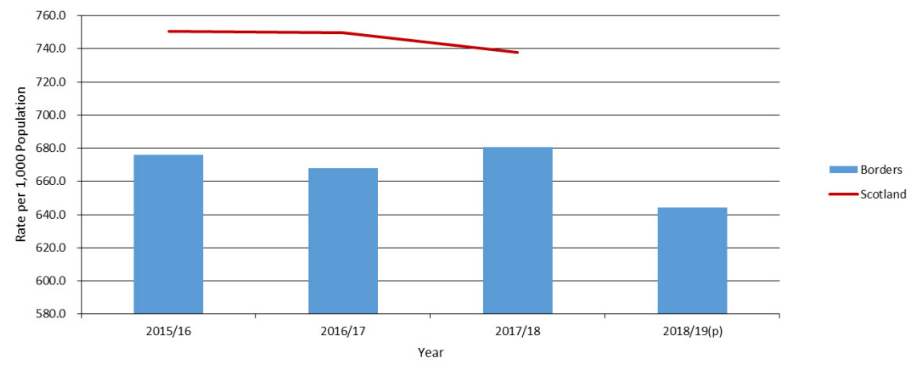
Source: SMR01, ISD

1b Admissions from A&E (All Ages)

PERFORMANCE	BORDERS TREND
	▲

Source: A&E datamart, ISD

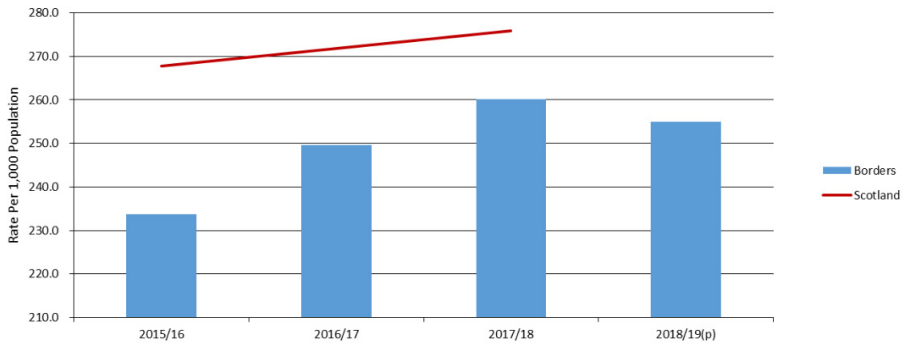
2 Number of unscheduled hospital bed days; acute specialties (All Ages)

PERFORMANCE	BORDERS TREND
	▲

Source: SMR01, ISD

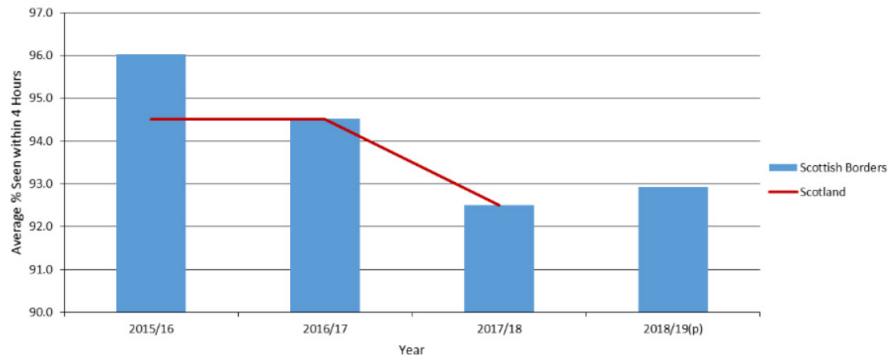
Source: A&E datamart, ISD

3a A&E attendances (All Ages)

PERFORMANCE	BORDERS TREND
	▼

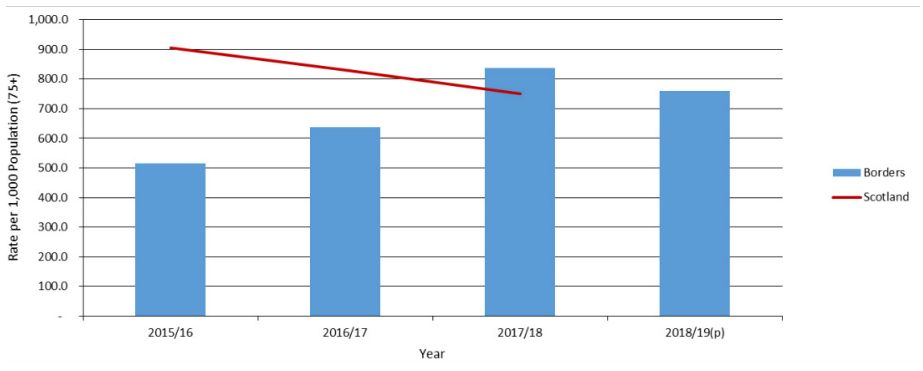
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▼

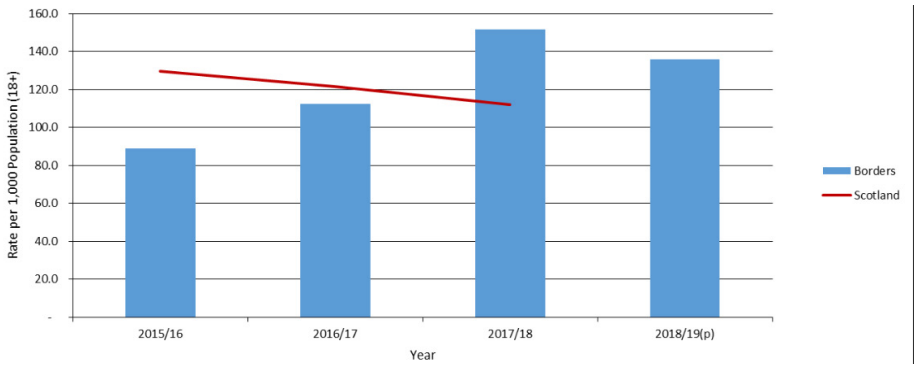
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▼

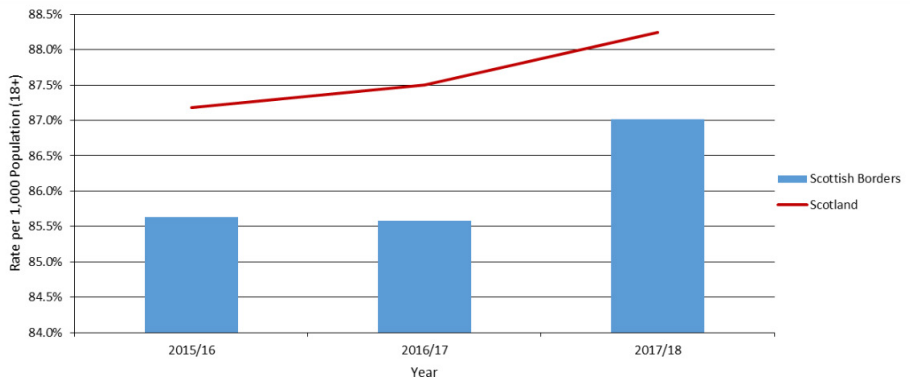
Source: Delayed Discharges, ISD

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

PERFORMANCE	BORDERS TREND
	▼

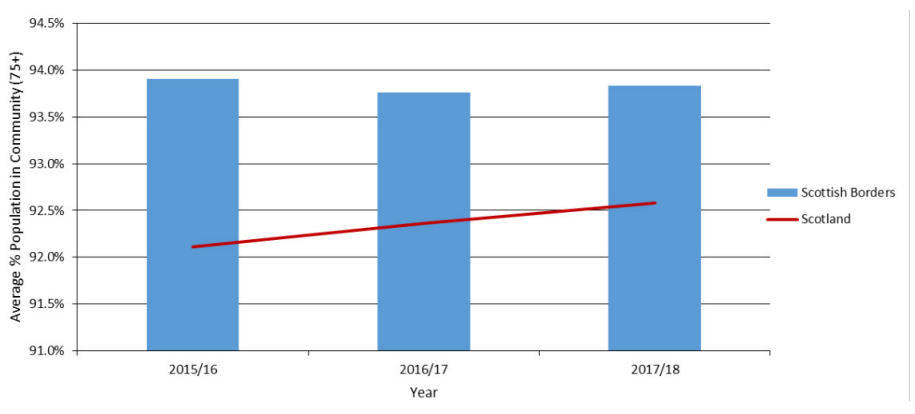
Source: Delayed Discharges, ISD

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

PERFORMANCE	BORDERS TREND
	▲

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

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

PERFORMANCE	BORDERS TREND
	◀ ▶

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

APPENDIX 4
PARTNERSHIP VISION

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

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

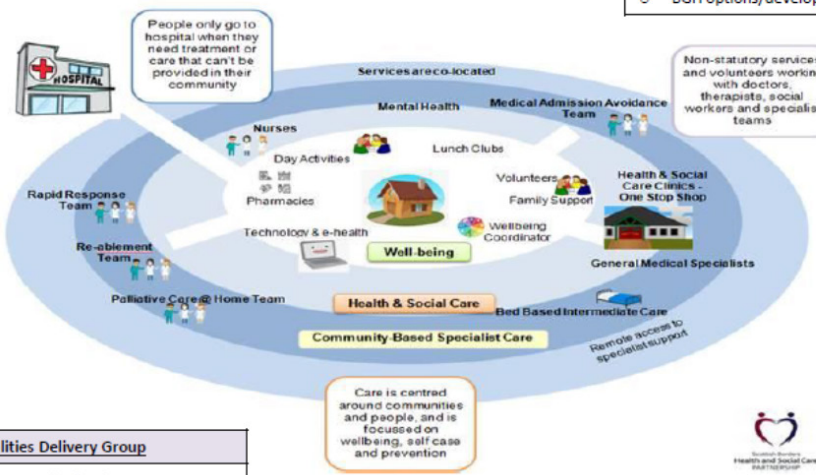
- People are only admitted to hospital when it is absolutely necessary.
- Care is centered around communities and individuals.
- Staff and volunteers work together within communities.
- With work being taken forward under a number of Groups.

Accommodation Group

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

TEC, Aids & Adaptations Group

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



Commissioning Group

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

H&SC Localities Delivery Group

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

Community Group

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

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[Alternatywny format/język]

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