Scottish Borders **Health & Social Care** Partnership

Annual Performance Report 2016-17

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

Scottish Borders
Health and Social Care
PARTNERSHIP

CONTENTS

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP ANNUAL PERFORMANCE REPORT 2016/17

INTRODUCTION

This is the first Annual Performance Report for the Scottish Borders Health and Social Care Partnership and it reports on our performance between April 2016 and March 2017. We have worked hard over the past 12 months to meet our priorities and we know that by working together we can successfully address both the opportunities provided by integration and the challenges that lie ahead. The details of our achievements as a Partnership are presented in this report.

In line with the Scottish Government Guidance for Health and Social Care Integration Partnership Performance Reports this Annual Performance Report presents how the Partnership has:

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

Some of our key achievements to date include the formation of the Locality Working Groups across the five localities in the Borders and the co-productive development of our Locality Plans; the implementation of Community Hubs which puts communities and the people who live in them at the heart of improving access to health and social care; and the development of the Buurtzorg model of nursing care which will deliver a collaborative and integrated approach to community based health and social care services.

The priorities for 2017/18 are set out in the report and we will continue to work hard to deliver responsive health and social care services which are focused on the needs of the people who use them and their local communities. A key focus for the Partnership going forward will be delivering our joint programme of transformation to ensure that we can successfully address the challenges and achieve the Partnership's objectives to ensure the best possible health and wellbeing for our communities.

Elaine Torrance
Chief Officer for Integration
Scottish Borders Health and Social Care Partnership
May 2017

EXECUTIVE SUMMARY

In April 2016, following an extensive period of consultation with local people, the Scottish Borders Health and Social Care Partnership's Strategic Plan was published. The Strategic Plan sets out the Partnership's objectives for improving health and social care services for the people in the Scottish Borders and lays the foundation for the key priorities for improvement going forward.

This Annual Performance Report outlines the Partnership's performance between April 2016 and March 2017 in relation to the progress made against the delivery of the 9 Local Objectives identified in the Strategic Plan.

Key highlights from the past year are included, with a focus on the initiation of the Community Led Support Project, Buurtzorg and Locality Planning, along with managing the challenges for the Partnership including managing within availability of resources, ensuring staff recruitment and retention in key areas, and increasing volunteers to support community services.

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

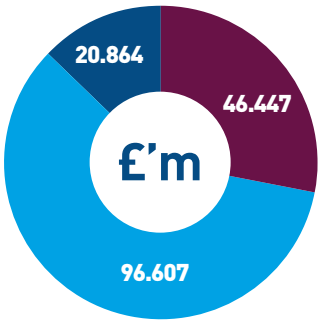
A statement is also provided of the financial performance of the Partnership and its performance against the National "Core Suite" of Integration Indicators identified by the Scottish Government.

Wherever possible 2016/17 data has been provided. Where this is not possible 2015/16 figures have been included.

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

THE YEAR AT A GLANCE 2016/17

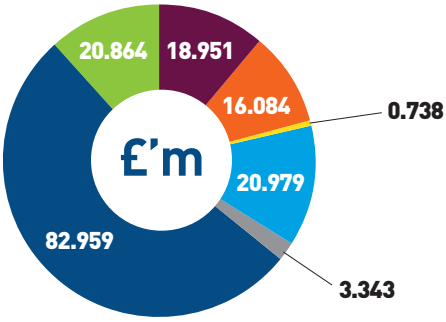
SPLIT OF BUDGET



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

(including £5.267m Social Care Funding)

SPEND BY EACH SERVICE AREA OVERSEEN BY THE INTEGRATED JOINT BOARD



- Joint Learning Disability (11.56%)
- Joint Mental Health Service (9.81%)
- Joint Alcohol and Drug Service (0.45%)
- Older People Service (12.80%)
- Physical Disability Service (2.04%)
- Generic services (50.61%)
- Large Hospital Set-Aside (12.73%)

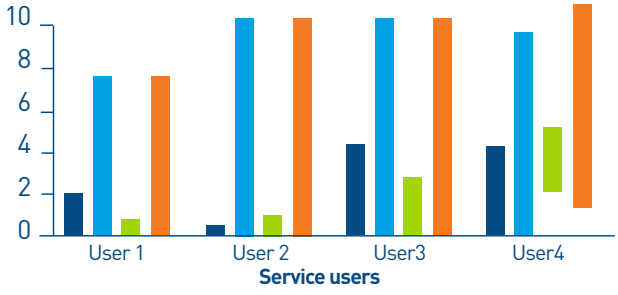
PARTNERSHIP HEALTH AND SOCIAL CARE FUNCTIONS TOTAL

LOCALITY PLANNING

5
Summary Locality Plans created

5
Locality Working Groups in operation

TRANSFORMING CARE AFTER TREATMENT (TCAT)



Evaluation covers self care, productivity and leisure

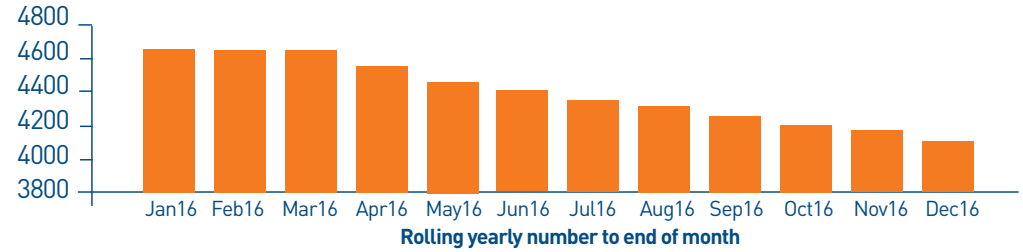
BORDERS COMMUNITY CAPACITY BUILDING

40+
activity sessions now running in local communities

67%
of participants in walking football said that walking football had increased their fitness

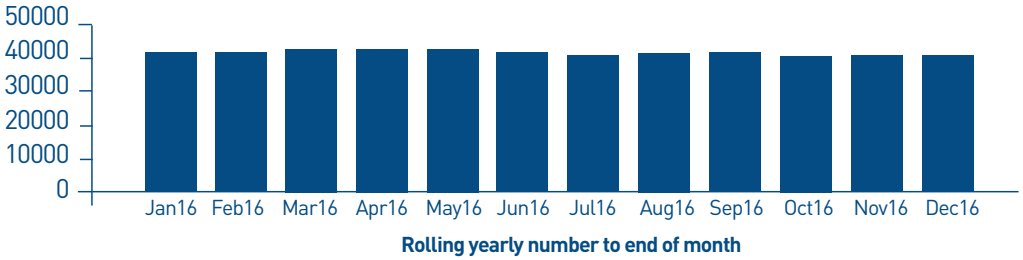
85%
of participants felt that the gentle exercise class had improved their fitness

NUMBER OF EMERGENCY ADMISSIONS TO HOSPITAL* BORDERS RESIDENTS AGED 75+



* Acute/general hospitals. Does not include geriatric long stay beds, of psychiatric hospitals. Over the past year (Dec 15 - Dec 16) there has been a significant fall in emergency admissions to the Borders General Hospital in persons over 75 years for Borders residents compared to Scotland as a whole (11% v 0.5% respectively). This is helping primary care teams access alternatives to hospital admission (including use of ambulance care services); a rigorous approach to patient triage within the Emergency department; and the introduction of a Frailty Service resulting in a more streamlined approach to patient care that ensures that patients receive the 'right care from the right person at the right time' to avoid or minimise their stay in hospital.

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



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

823 PEOPLE WERE DELAYED FROM BEING DISCHARGED FROM HOSPITAL

7.8% OF ASSOCIATED OCCUPIED BED DAYS

635 2015/16 **823** 2016/17 **&** **5.5%** 2015/16 **7.8%** 2016/17

WHERE WE PERFORMED WELL

95%
of adults are able to look after their health very well or quite well

90%
of adults supported at home feel safe

51%
of total health and social care expenditure in Scottish Borders was on community based services

ONE OF OUR KEY CHALLENGES

41%
of carers feel supported to continue in their caring role

PERFORMANCE AGAINST KEY PRIORITIES FOR 2016/17

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

The Partnership has continued to focus on reducing the number of delayed discharges and reducing the number of inappropriate admissions to hospital. A key focus of this work has been mapping care pathways from hospital to community to identify any potential blocks in the system and seek solutions. This will continue to be a priority over the coming year as further redesign is undertaken to streamline the pathway, provide a wider range of intermediate care/enablement approaches and also make best use of resources.

A number of specific priorities for the Partnership were identified for 2016/17. The Integrated Care Fund (ICF) has been used to assist, support and develop the integration of Health and Social Care services and below is a summary of progress on key priority actions.

- **To Develop integrated and accessible transport** –
- Scottish Borders Council, NHS Borders, The Bridge, The Red Cross, Berwickshire Association of Voluntary Services and the Royal Voluntary Service (RVS) are partners in the Transport Hub project to put in place a co-ordinated, sustainable approach to community transport provision. **In its first year of operation the transport hub facilitated 482 journeys and 150 hospital appointments. 80% of service users agreed that the service has increased independence.**

- **To integrate services at a local level** –
- Three Locality Co-ordinators have been recruited and produced locality plans to support the redesign of health and social care services at a local level.

- **To roll out care co-ordination to provide a single point of access to services** –
- The Community Led Support programme commenced in September 2016, the aim being to make health and social care services more accessible within local communities. **To date, 12 community engagement sessions have been held, with 2 hubs planned to be open by the end of June 2017.**

- **To improve communication and accessible information across groups with differing needs** –
- Local area co-ordinators for mental health, learning disability and older people have enabled more people to access local community activities and to provide good local information.

- **Work with communities to develop local solutions** –
- The Community Capacity Building team have worked with communities to develop local solutions. **To date 31 new activity sessions have been developed.**
- A toolkit on co-production has been developed through the Community Planning Partnership supported by an e-learning package to enhance staff skills in this area and promote this approach.

- **Provide additional training and support for staff and for people living with dementia** –
- The Stress & Distress Project provides training in understanding and intervening in stress and distressed behaviours in people with dementia. **Thus far, bite size training has been provided to 148 staff and full training to a further 177.**

- **Further develop our understanding of housing needs for people across the Borders** –
- A housing strategy for older people is now under development. Following a robust business case, detailed planning is now in place to build additional Extra Care Housing Developments in the Scottish Borders.

- **To promote healthy and active living** –
- The Borders Healthy Living Network works in three of our deprived communities, with community members and other partners to develop a range of activities: cooking skills sessions, food co-ops, activities such as walking football, reminiscence groups, and volunteering development.
- The Healthier Me network of learning disability service providers continues to work with service users on healthy eating and active living.
- Pathways and formal referral routes from health care to physical activity sessions in the community are now in place. Routes from hospital services to smoking cessation advice and to the Lifestyle Adviser Support have been improved.
- A comprehensive health inequalities impact assessment of screening services is being undertaken to identify improvements required to extend reach and uptake in key vulnerable groups.
- The Borders Community Capacity Building Team have initiated projects ranging from Kurling and walking football to lunch clubs and have reported significant increases in wellbeing and physical activity as well as providing opportunities for older people to socialise. Further work is underway to develop intergenerational projects around IT. **Evaluations to date have shown that 98% of gentle exercise participants have reported that the class has given them increased opportunities to socialise and 45% have reported an increase in confidence following participation in the class.**

- **To improve the transition process for young people with disabilities moving into adult services** –
- A project manager has been appointed and mapping workshops have been held to review the pathway and produce an improvement plan to be implemented.

- **To improve the quality of life of people with long term conditions by supporting self-management and promoting healthy living** –
- The evaluation of a pilot initiative on supported self-management has provided valuable learning on the development required in pathways and in staff knowledge and skills. This is being integrated into the planning of our locality services. **The pilot showed a 21% improvement in wellbeing for service users.**

- A new initiative is being trialled on diabetes prevention that provides health coaching support and subsidised exercise for those newly diagnosed.
- Mental health rehabilitation services have developed standardised health assessment and care planning tools to support the health and wellbeing of clients with significant mental health issues.

- **To improve support for Carers within our communities** –
- The Partnership has continued to support the Carers' Centre, which offers practical support and advice to Carers as well as undertaking Carer's assessments. **In 2016/17, 401 new Carers have been referred to the Carers Centre service.**
- The transitions work has also focused on Carers/parents as a key partner in this work.

- **Promote support for independence and reablement so that all adults can live as independently as possible** –
- 16 transitional care beds focusing on improving the skills and confidence of older people with the key aim of returning home following admission to hospital have been developed in a care home setting. **To date, 72% of patients using the service have returned to their original home and 75% have stayed in this setting for 6 weeks or less.**
- In addition, two care homes in other localities have identified the potential to provide 9 transitional care beds.
- The Borders Ability Equipment Store is being relocated to a purpose built building to improve the efficiency of the supply of equipment to allow people to live independently in their own homes. This will have an impact of reducing preventable hospital and care home admissions.

KEY PARTNERSHIP DECISIONS 2016/17

Since its establishment on 6th February 2016, the Integration Joint Board has met regularly in order to put in place sound governance and operating arrangements and to direct its performance and resource planning, management and reporting.

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

- The appointment of its Chief Officer, Chief Financial Officer and Chief Internal Auditor;
- Approval of its Strategic Plan;
- Approval of the Scheme of Integration for the Scottish Borders;
- Approval of the Local Code of Governance within which the partnership operates;
- Established its Audit Committee arrangements.

In relation to performance and resources, the IJB has:

- Approved and delivered its 2016/17 financial plan;
- Directed the successful delivery of an in-year financial recovery plan;
- Directed the use of over £5m of social care funding allocation and £4m of integrated care funding to meet new and existing priorities of the partnership;
- Had its 2015/16 Statement of Accounts approved by its External Auditor;
- Approved its Performance Monitoring Framework.

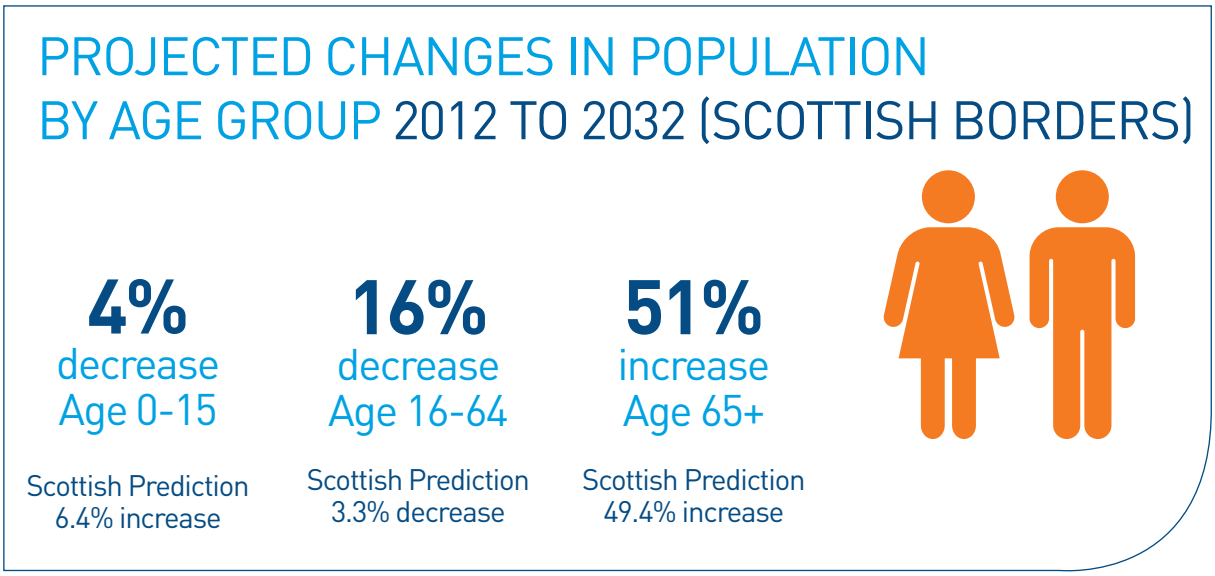
SPOTLIGHT: LOCALITIES PLANNING

There are five commonly recognised localities in the Borders which are aligned to the five existing area forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale.

The map below shows our five Area Forum Localities (with all towns and villages with a population of 500 or more).

Changes to the way in which Health and Social Care Services are delivered across the five localities of the Borders is required due to three key issues:

- Demographic change - Increasing demand for services due to an increases in people aged 65+;



Source: National Records of Scotland 2012-based population projections

- Increasing pressure on health and social care resources due to the rise in the demand;
- Changing service user expectations and the desire to improve health and social care experience.

Locality planning is a key tool in the delivery of the changes required to meet the increasing service demands within the Borders and supports the requirements of the Community Empowerment (Scotland) Act 2015.

Guidance from the Scottish Government is clear that local representatives – including health and social care professionals, third and independent sectors, housing, service users and their carers - have the opportunity to influence and inform service planning as we move towards achievement of the objectives set out in the Strategic Plan.

Since April 2016 three Locality Co-ordinators have been working across the five localities to support the development of local plans and proposals for the redesign of health and social care services. Each area has developed a summary action plan with an area profile which supports the need for change within each Locality.

Local working groups across the five localities in the Scottish Borders have been established. These working groups are made up of local representatives and they have made a significant contribution to the development of five Locality Plans. The plans focus on local needs and key priorities for improvement from the perspective of local people who use and deliver health and social care services.

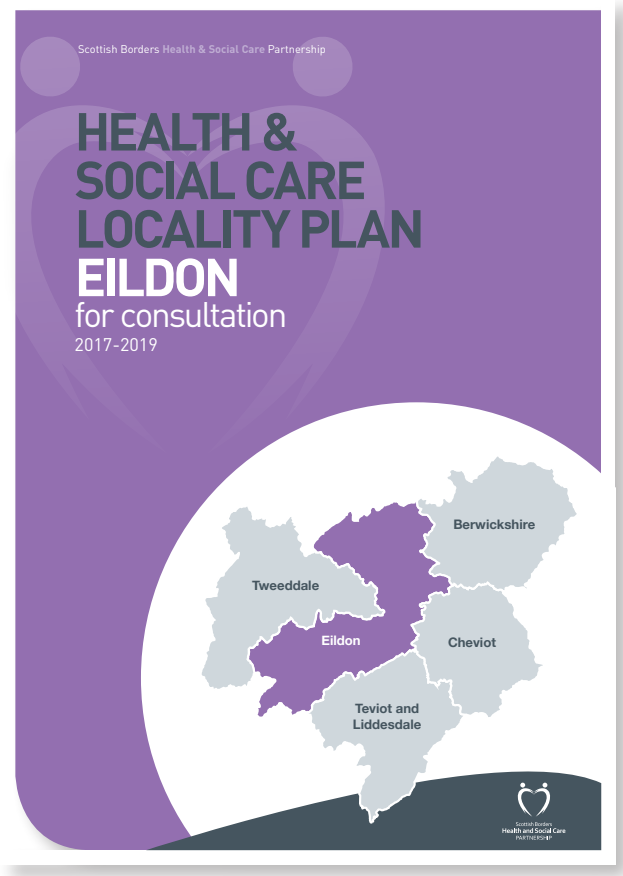
Priorities across the localities are broadly similar and can be grouped into the following categories:

- Availability and accessibility of services;
- Availability of community based rehabilitation services;
- Local housing and support options;
- Prevalence and management of long term conditions;
- Availability of transport.

Each Locality Plan identifies actions to address these challenges, who will progress these and the timescale for this.

"The Health and Social Care Locality Plans have been developed in collaboration with representatives across the five localities in the Borders. The plans are outcome focused and recommend changes to the way in which health and social care services are delivered to improve the well-being and quality of life of people living in the Scottish Borders"
Trish Wintrup – Locality Coordinator

"If Carers and nurses could work together in one team then care could be provided in a more seamless way to deliver person centred care"
Janette Forbes – District Nurse



For more information on Locality Planning within Borders please contact Christopher Svensson (H&SC Partnership Project Support Officer) **Christopher.Svensson@scotborders.gov.uk**

SPOTLIGHT: COMMUNITY-LED SUPPORT

Since September 2016 the Health and Social Care Partnership have been working with the National Development Team for Inclusion (NDTi) to deliver an **18 month programme of change** in the way that health and social care services are accessed across the Scottish Borders.

Community Led Support aims to provide locally based hubs which can be easily accessed by local people as the first point of contact for health and social care services.

The programme will build on existing access such as through Customer Services and Social Work Duty Teams and relies on working together in local communities, voluntary groups and organisations that already connect with people.

At the hubs members of the public will be encouraged to have a conversation with someone about what matters most to them and things they may be struggling with. By adopting this approach we will put what matters to people first; make health and social care more visible in communities; build on people's skills and on community assets; reduce waiting lists for social care; increase early intervention and prevention; simplify pathways and processes and better target professionals' time. This approach strives to **support people to live their lives, their way**.

Experience of delivering this model in England and Wales has resulted in reduced bureaucracy, better outcomes for individuals and cost savings. Feedback from staff so far is overwhelmingly positive, with professionals talking about increased job satisfaction.

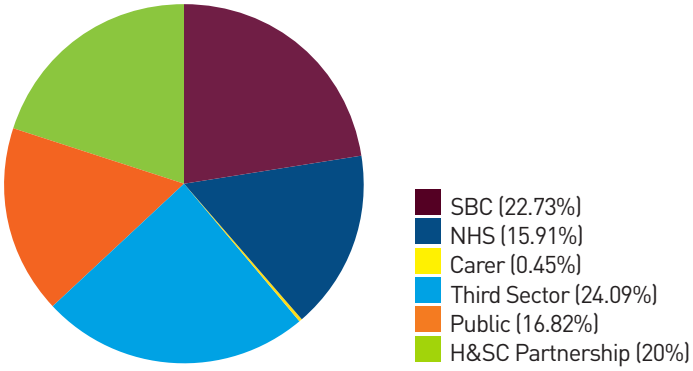
Progress

COMMUNITY LED SUPPORT

12
Community Led Support engagement sessions held across the Borders

233
People attended the engagement sessions

BREAKDOWN OF ATTENDEES AT ENGAGEMENT SESSIONS



Attendees at the engagement sessions, held as part of the NDTi process, were asked where they feel the "heart" of their community is; where communities meet and if they are any key "go to" people locally. They were also asked what they thought the "challenges" were in taking this programme forward in their locality.

These engagement sessions were followed by a Planning Day and a further evaluation day which was attended by a range of individuals from across the Partnership, Housing, Customer Services, Third Sector Organisations as well as members of the public. This enabled the creation of working groups which were tasked with the delivery of certain aspects of the plan.

This programme of change is expected to take 18 months to fully embed but it is expected that changes will be seen by local communities within the coming months.

> *"In other areas Community Led Support has proved to be a really effective and efficient use of resource. In fact some areas have seen waiting lists for social work services disappear"*
> **Murray Leys** – Chief Officer – Adult Social Work, Scottish Borders Council

> *"By listening to people and focusing on what matters to them we can really make a difference"*
> **Shirley Cusack** – NDTi

A short video outlining the Community Led Support project in the Scottish Borders can be found at **https://www.youtube.com/watch?v=9pLDWoqx0Kk**

If you would like more information on this project please contact Nicki Tait (H&SC Partnership Project Support Officer) at NTait@scotborders.gov.uk

Scottish Borders is one of three Councils in Scotland embarking on this programme of change. For more information see **http://www.ndti.org.uk/major-projects/current/community-led-support/**

SPOTLIGHT: BUURTZORG – NEIGHBOURHOOD CARE

Buurtzorg is a model for providing health and community care that was started in the Netherlands. In the Netherlands the model is based on self-organising teams of no more than 12 community nurses who manage a case load in a specific community. The ethos is an enabling approach where the aim is to support self-management through the use of both formal and informal networks that a person has access to. In the Borders we are aiming to pilot this where we can meet the needs of health and social care with a holistic and enabling approach in our communities.

Progress

We have held events to raise awareness of the model and also engaged with local communities to test this new way of working. We have held **four events** and over **150 people** attended from different agencies, the third (voluntary) sector and members of the local community.

At each event we asked all participants if they would like to see Buurtzorg trialled in the Scottish Borders and it was a yes majority from every area. Attendees also supported adopting the principal of Buurtzorg Plus which would enable us to tailor the model to each community's needs.

Some of the positive thoughts and questions asked are noted below:

POSITIVE THOUGHTS	QUERIES AND CONCERNS
The patient is at the core of this model not the tasks.	How do we finance this?
Staff will feel valued and increased job satisfaction	How would this work in Scotland?
Solution based	NHS Borders is very hierarchical, how would this work with "banding"
Holistic care vision.	What are the roles of the Carers, social workers and Allied Health professionals?
An exciting model to test and support in the Borders.	Wi-Fi connection in the Borders is problematic in some rural areas. IT in general.
Trust and respect amongst colleagues	How will shift patterns work?
When can we start!	

Next Steps

We held a Buurtzorg Design Group on the 27th of January with colleagues from NHS Borders, Scottish Borders Council and SB Cares to discuss future plans. This also gave attendees a forum in which to raise some unanswered questions. We are in the process of scheduling another planning meeting with key stakeholders to talk more about implementation and where our test site will be.

Training on the model will be provided for the pilot team/s during the summer of 2017. We are progressing a plan for implementation which includes a Design Day with partners. This will outline how we can support a self-organising approach that reduces bureaucracy and enables teams to deliver improvements in a person-centred holistic model of both health and social care in the community.

> *"The neighbourhood model aims to put individuals and families at the heart of care, building relationships that enables people to flourish. We believe that teams of community nurses and social care staff require support and coaching not management and control."*
> **Erica Reid** – Director for Hospital Care – NHS Borders

More information on the Buurtzorg approach can be found at **https://www.buurtzorg.com/**

GOVERNANCE AND ACCOUNTABILITY

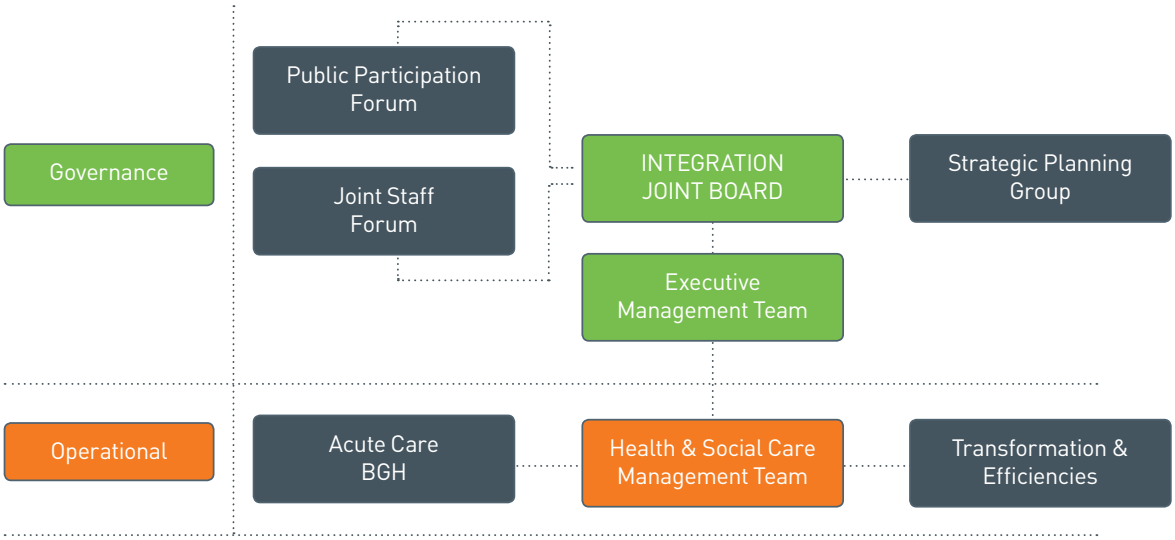
During 2016/17 the governance structure for the Partnership has been revised in order to streamline the process and clarify the decision making roles within the structure. The revised governance structure consists of two layers:

- The Executive Management Team who commission tests of change/and/or service redesign. These are then drawn up into business cases by the operational level of the governance structure and returned to the Executive Management Team for review and decision making.
- The Integration Joint Board provides ratification for the decisions made.

The Integration Joint Board receives regular progress updates from the Executive Management Team as well as quarterly performance reports.

The Strategic Planning Group, Public Participation Forum and the Joint staff Forum offer advice to the Integration Joint Board. Whilst the Health and Social Care Management Team provide the operational support, delivery and progress reporting for the approved service redesign/tests of change.

H&SC Partnership Revised Governance Structure



During 2016/17, the Partnership worked to fulfil its commitment to ongoing and continuous improvement. A range of activities continue to be developed in order that the Integration Joint Board identifies and understands its key strengths and areas for improvement across all aspects of its governance, operations and performance. In relation to governance specifically, the Integration Joint Board approved the formation and held the inaugural meetings of its Audit Committee during the year.

The Integration Joint Board Chief Internal Auditor will present to the Audit Committee in June 2017 the findings, conclusions and audit opinion for each of the areas of Corporate Governance, Financial Management and Performance Management delivered as part of its 2016/17 Internal Audit Plan to provide the required assurance. The Internal Audit Annual Report 2016/17 will also include recommended actions that are designed to improve internal control and governance to assist the Integration Joint Board to achieve its strategic objectives. The Audit Committee also agreed the 2017/18 Internal Audit Plan for the Integration Joint Board at its meeting in March 2017.

At the start, mid-point and end of the financial year, the Integration Joint Board and its partners undertook a full review and evaluation of its degree of compliance with legislation and recommended best practice (Integrated resources advisory group) 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 provide full assurance to the Partnership going forward.

A quarterly performance reporting scorecard has been developed for the Integration Joint Board, in line with the themes defined by the Ministerial Strategic Group for Health and Community Care. In addition to these themes, the scorecard allows for the reporting on more localised measures which have a primary, community or social care focus.

A joint inspection of the Health and Social Care Partnership's older people's services undertaken by the Care Inspectorate and Healthcare Improvement Scotland in early 2017 will also provide further assurance and a clear strategy for further improvement across the Partnership. As part of the enablement of the review, an initial self-evaluation report with accompanying evidence was compiled.

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

PROGRESS AGAINST OUR LOCAL STRATEGIC OBJECTIVES

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

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

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

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

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

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

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

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

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

OBJECTIVE 1

We will make services more accessible and develop our communities

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

Key achievements during 2016/2017:

- A GP Cluster model and Cluster Quality Leads have been identified in line with the Transitional Quality Arrangements in the revised General Medical Services contract. A 4 cluster model has been identified and all Practice Quality Leads are in place. The Cluster Quality Lead appointments have now been made and the induction processes are underway. This model will work in partnership with the localities and locality planning processes.
- Throughout Scottish Borders and across services there are community capacity and Local Area Coordinators teams. These teams work within communities to build relationships, increase resilience and develop the capacity of local communities.
- Improvements in the access, range and quality of information across all Partnership services are being made, for example development of easy read leaflets and information.
- A range of training is provided to staff and Partnership organisations to improve accessibility and develop community capacity. One example is the delivery of an education programme that offers a whole range of training from a basic introductory level for front line reception staff to specialist champion training for those working directly with people with hearing and sight loss.
- The Community Led Support Project will give easier access to health and social care services and information by providing hubs/ talking points across the five localities.
- A long term conditions project was developed working in two GP practices. This provided a generic pathway to assist those with a new diagnosis of a Long Term Condition which included better information, sign-posting or referral for additional advice and support.
- Integrated Community Mental Health Teams provide locality-based mental health and social care services. The teams are co-located and are currently developing working practices to improve assessment, treatment and psychological therapies to patients/clients. The teams deliver a range of medical psychological services and social interventions for people with mental health conditions or dementia in their own communities.
- There is promotion of mental health awareness and literacy through community based activities and capacity building through Healthy Living Networks and Community Learning & Development.
- There is a strong commitment to work in partnership with communities in order to continue to deliver high quality and improved services. For example service users and Carers can get involved in the design and development of services locally through local learning disabilities citizens' panels.
- A key priority for the Partnership is to improve care pathways across services. For example the development of the Transitions Pathway for young people who will require assistance from the Adult Learning Disability service.
- An Autism Strategy has been developed and is being delivered across the Borders by a newly appointed Autism Coordinator.

- There are improved opportunities for employment through initiatives such as a 1 year pilot program called Project Search. This enables 8 interns to gain employability skills by working in real work environments.
- There is a range of support available in community settings including dementia clinics, home based memory rehabilitation service and dementia cafes.
- The Borders Dementia Working Group is a service user-led group, which is key in campaigning, raising awareness, reducing prejudice and stigma, influencing policies, and providing a voice for people with dementia.
- Within the localities across the Borders, "Lifestyle Matters" groups run assisting with the regaining of skills and groups improving and maintaining mood, anxiety management and improving self-esteem for people with dementia or with problems related to mood, anxiety or depression.
- Work has been undertaken with a wide range of partners to assess local housing needs, agree priorities and define ideas and solutions to deliver a shared vision for housing in the Borders.
- Significant improvements have been made in the warmth and comfort of many homes across the Scottish Borders.
- There are monthly Carers support groups held in all five localities.
- Interest Link Borders has utilised 200 community volunteers to assist children, young people and adults with learning disabilities to access community activities and improve social networks.
- Several Third Sector providers have increased opportunities for learning and sharing about good nutrition and cooking for people with dementia and their Carers.
- SB Cares has relocated the Hawick Older Peoples Day Services to the Katherine Elliot Centre, co-located with the local Home Care team and Hawick Community Support Centre. This co-location has resulted in a community hub of services within the Katherine Elliot Centre.
- SB Cares have relocated the Borders Ability Equipment Service into new, state of the art premises in Tweedbank. The new building is designed to facilitate improved access to communities and will, in the near future, be developed to include demonstration rooms.

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

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

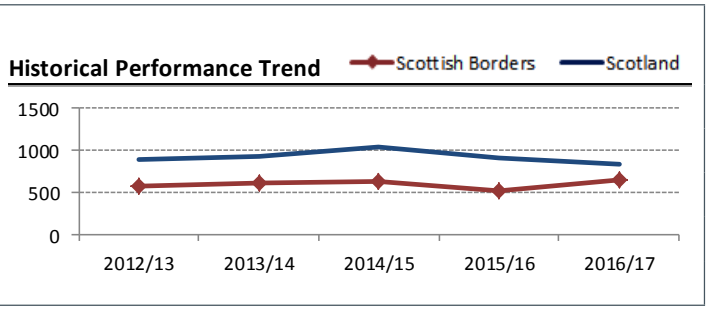
Performance - National "Core Suite" Indicators

NI-1 95% of adults able to look after their health very well or quite well (Scotland 94%).

Source: Scottish Government Health and Care experience survey 2015/16.

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+)

YEAR	SCOTTISH BORDERS	SCOTLAND
2012/13	575	886
2013/14	604	922
2014/15	628	1,044
2015/16	522	915
2016/17	647	842



Source: ISD Scotland Delayed Discharge Census.

In terms of overall rates of occupied bed-days associated with delayed discharge, which have fluctuated from year to year, Borders has performed consistently better than the Scottish averages. However, delays in discharging patients from hospital remains a significant challenge for us. More detail on delayed discharges is is given in the June 2017 quarterly performance report for the Integration Joint Board.

Performance – Specific programmes

BURNFOOT COMMUNITY FUTURES

22 volunteers engaged

6 hours a week of health promotion and social activity provided for older people, including a weekly senior cafe

134 local residents have become members of Burnfoot Community Futures

35% of Burnfoot Community Futures members are over 50 years old

PROJECT SEARCH
CASE STUDY

My name is Racquel and I have enjoyed learning new skills in the training and development department. I enjoyed working with my co-workers as a team. I am really happy to say that I have just found out that I have a job. Thank you to everyone in Project SEARCH for helping me to reach my goal of securing my employment. I am really excited to be starting work soon.

Partnership Priorities for 2017/18

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

OBJECTIVE 2

We will improve prevention and early intervention

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

Key achievements during 2016/2017:

- The Lifestyle Advice Support Services assist people to make healthy behaviour changes in relation to smoking, diet, alcohol consumption and physical activity. Actively promoted referrals from specialist services to services that encourage lifestyle change (e.g. Lifestyle Advice Support Service, quit for good).
- Individual GP practices have worked as partners with the Long Term Conditions Self-Management project, helping people to be more involved with and responsible for their care management. This project supported improvements in the shared management of long term conditions in two localities. It was partnered by the Red Cross who provided assistance and home visits to enable patients to remain in their own homes.
- Red Cross Neighbourhood Links workers signpost and enable people to understand what support networks are available within their local communities.
- Caring for Smiles is a dental programme which offers older people and their Carers information and help in looking after their teeth and dental health. Caring for Smiles is also provided in care home settings to assist staff and residents.
- "Meet Ed" pocket guides have been developed and distributed through a range of venues and organisations across the region. They offer the public information and guidance about where to find the help that they need e.g. when to go to the pharmacist, when to contact a GP, self-help guidance, when to go to the Emergency Department.
- Podiatry has developed a public website where resources and advice are available to assist people to manage their foot care.
- Improvement of pathways to access prevention and lifestyle assistance for those with long term conditions through the more effective integration of service delivery.
- Implementation of health assessment and care plans for mental health service users.
- Developed and delivered initiatives on physical activity, on food in local communities through the Healthy Living Network to help people improve their health and reduce isolation.
- The "Small Change Big Difference" campaign has been expanded to Scottish Borders Council to encourage staff to make changes towards healthier lifestyles and to access health checks.
- Health screening opportunities have been actively promoted, particularly cervical screening.
- Anticipatory care planning is a key element of support for patients across the Borders.
- Transforming Care After Treatment (TCAT) has been piloted in Tweeddale. This uses a reablement approach to enable people to live as independent a life as possible in their local community following their treatment and recovery from cancer.
- The Borders Falls Steering Group is currently undertaking a shared self-assessment exercise using the 'Prevention and Management of Falls in the Community' tool to inform their 2017-18 Action Plan and identify practice gaps and innovation.

- The Borders Community Capacity Building project has introduced gentle exercise classes (participants aged 40's to 90's), promotion of cycling for older people through Just Cycle charity and the establishment of walking football in the Borders. These activities assist people to live at home for longer without reliance upon statutory services.
- Community Led Support will provide easily accessible services, which will efficiently signpost people to local services or provide access to health and social care staff.
- The Alcohol and Drug Partnership are working to reduce the amount of drug and alcohol use through early intervention and prevention, for example through performing alcohol brief interventions and through regulation of alcohol through the Licensing Board.
- The Mental Health Strategy was developed in partnership with service users, Carers and other stakeholders. It identifies areas of work to ensure a focus on mental health improvement, early intervention and prevention through commissioning and service delivery.
- The Local Area Co-ordinator team in the Learning Disability service works in a range of ways to promote and enable people with Learning Disabilities to live healthier lives and improve their quality of life through addressing the broader determinants of health, such as tackling social isolation and exclusion and developing supportive social networks.
- A key priority within care pathways across services is to improve prevention and early intervention. For example:-
  - A "healthier me" pathway promotes health behaviour change in people with learning disabilities and their Carers.
  - The Learning Disabilities nursing team continue to progress the projects in their work plan to address health inequalities including: work with the Oral Health team, work to improve diabetes care and assist people to access screening programmes.
  - A proactive dementia diagnosis pathway for people with Down's syndrome which promotes people with Down's syndrome to take part in screening and assessment from the age of 30 years.
- Post-diagnostic support ensures a focus on early intervention and prevention for people diagnosed with dementia. For example understanding good health and considering lifestyle changes is part of the post diagnostic support pathway, which is available to all those diagnosed with dementia for one year post diagnosis.
- The Homelessness Service:
  - Provides Housing Options advice for people and families at risk of losing or not sustaining their accommodation.
  - Provides Short term targeted support via its dedicated Housing Support Team;
  - Commissions Penumbra Support Living Service.
- The Carers Centre has commenced work to redesign the Carers Support Plan in partnership with carers and the third sector.
- A programme of training is in place for professionals to improve Carer awareness, and to encourage early identification and preventative assistance for Carers.
- A dedicated hospital liaison worker is in post to help Carers at the point of admission through to discharge.
- New Horizons Borders have employed an emotional support worker based in mental health peer support groups across each locality and introduced self-management techniques and training into the Eildon and Teviot groups.
- Outside the Box have facilitated specialist discussions with existing older people's groups in several communities across the Borders on 'Happiness Habits', encouraging participants to do things that reduce poor mental health and build good mental wellbeing.

- SB Cares now offers direct provision of Personal Alarms and Ability Equipment to clients who are not eligible for Social Work-funded services, enabling earlier intervention/ prevention.

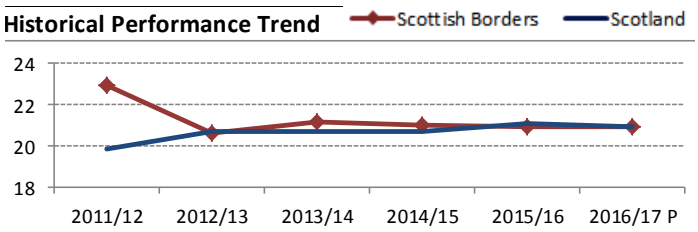
Key Challenges faced by the Partnership when delivering this objective are:

- A key challenge faced by a number of areas in the delivery of this objective is the capacity of staff to invest in prevention.
- Another challenge faced by some projects is that they are only funded on a short term basis.

Performance - National "Core Suite" Indicators

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	23.0	19.8
2012/13	20.6	20.7
2013/14	21.1	20.7
2014/15	21.0	20.7
2015/16	20.9	21.1
2016/17 P	20.9	20.9

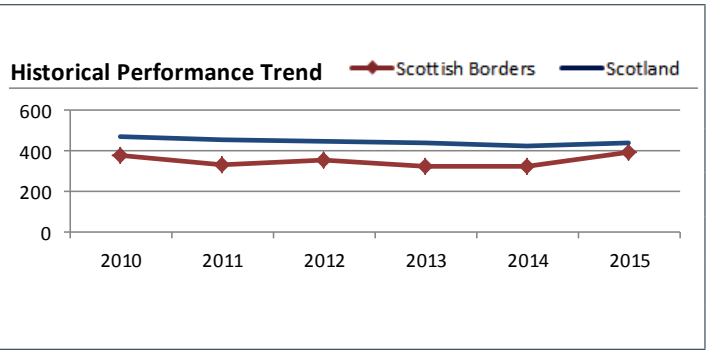


Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

Since 2012/13 the rate of admissions due to falls in Borders residents aged 65+ has been very close to the Scottish average, with very little variation from year to year. More detail on this indicator is given in the June 2017 quarterly performance report for the Intregration Joint Board.

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2010	374	467
2011	334	456
2012	356	445
2013	323	438
2014	322	423
2015	391	441



Source: National Records for Scotland (NRS).

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

Performance – Specific programmes

DEMENTIA

90% of those people within the mental health older adults service with Dementia have completed a version of "Getting To Know Me" as part of their anticipatory care plan.

This document has been developed by Alzheimer Scotland's network of Dementia Nurse Consultants and the Scottish Government. It aims to give hospital staff a better understanding of patients with dementia who are admitted either for planned treatment, such as an operation, or in an emergency.

INPATIENT FALLS PREVENTION

50%▼ As part of improving prevention and intervention partnership activities, our inpatient falls programme has out-performed Scottish Government's targets with a 50% reduction in falls (Scottish Government Standard 25%)

52%▼ There has been a 52% reduction in inpatient falls with harm 2015 (Scottish Government standard 20%). Evidence of sustained progress was seen across all sectors.

HEALTH IMPROVEMENT LONG TERM CONDITIONS PROJECT

21%▲ Improvement in wellbeing recorded for service users.

31%▼ Reduction in the need for GP contact in the practices involved in the project.

TRANSFORMING CARE AFTER TREATMENT (TCAT)

CASE STUDY

Mrs P was previously active. However, following treatment for cancer she suffered from fatigue and was unable to do things at her normal pace. This caused Mrs P anxiety. Mrs P was signposted to FitBorders and attended gentle exercise classes to prevent a decline in her physical activity and help her to regain her emotional wellbeing. As a result Mrs P has improved functional ability in everyday tasks along with increased self-esteem.

LONG TERM CONDITIONS PROJECT

CASE STUDY

Mr A had poor mobility and arthritis, which was affecting his daily life. He was dependent on his partner to support him with all aspects of daily life.

Mr A had a fall and was admitted to the Borders General Hospital. Within 24 hours of discharge he was contacted by the Red Cross to arrange a home visit. A volunteer visited and discussed options for support with Mr A and his family. Leaflets were also left regarding welfare benefits, Borders Care and Repair and Border Care Alarm.

Following the volunteer visit a referral for a welfare benefit check was processed and Mr A is now in receipt of attendance and carer allowance. A referral was also made to Borders Care and Repair for a grab rail and advice given about second rail outside of the home. Mr A is now living independently at home.

Partnership Priorities for 2017/18

- Develop/ implement a Falls Strategy (with Action Plan), 2017-19, informed by shared self-assessment; using the 'Prevention and Management of Falls in the Community' tool.
- Improve responses to people at risk through new, innovative anticipatory care planning.
- Manage risk intelligently and empathetically through a new joint protocol for risk and its governance.
- Provide locally based community led support hubs to improve access to health and social care services.

OBJECTIVE 3

We will reduce avoidable admissions to hospital

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

Key achievements during 2016/2017:

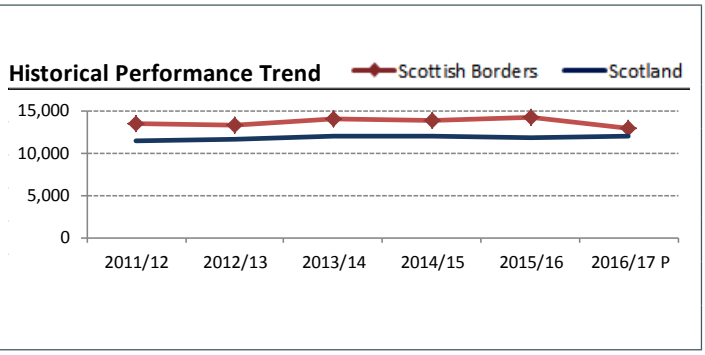
- A review of community and day hospitals is planned following an initial data gathering and analysis exercise commissioned from Professor John Bolton. This work will help to define the future role of community and day hospitals within the overall patient pathway and will identify the appropriate model of care.
- In Hawick, local GP practices are working with the Scottish Ambulance Service to trial and evaluate a model of in-hours response to emergency calls to GPs. This involves specially trained paramedics responding to triaged emergency calls and treating a patient at home, which in turn releases GP clinical time to attend more complex cases.
- The Lifestyle Advisor Support Service has identified key areas of work for 2017/18 to improve wellbeing and aid prevention of ill health, which includes:
  - Support and agreement from GPs, offering opportunistic health checks in all GP surgeries.
  - Implementing the new adult weight programme "Weigh 2 Go Borders" which combines a number of evidenced based approaches offering wider options to the clients.
- The Buurtzorg model of care will be trialled and evaluated in specific locations. It will see primarily nurse-led services enabling people to receive care and manage their own care within their local communities.
- Funding provided for the implementation of Prescription for Excellence has been used to establish a medicine review service in community pharmacies and is currently available in 28 out of 29 pharmacies. The aim of this service is to increase the clinical role of the community pharmacist and deliver direct patient-centred care which will enable more people to be seen within a community setting rather than attending or being admitted to hospital or attending GP surgeries.
- Initial work is underway to redesign pathways within hospital, through the discharge process and in the community. This work will establish gaps or blockages in pathways and put in place processes/services to improve the patient flow.
- A Rapid Assessment Discharge team is in place at the front door of the Borders General Hospital. The team arrange functional assistance for patients in order to prevent admission.
- Work is underway to develop collaborative leadership which will address the care and assistance provided during transition from hospital to home.
- The Short Term Assessment Reablement Team continue to assist patients during the transition from hospital to home.
- Reablement principles are embedded in the social work department's adult/older people business plans and are at the heart of the commissioning process.
- A Joint Delayed Discharge Action Plan forms part of the Joint Winter Plan 2016/17, which identifies a range of measures to meet predicted increase in demand. A short life working group to consider activities to prevent avoidable re-admissions.

- The Older People's Liaison Service team manages and assists complex and non-complex caseloads within acute and community settings, ensuring holistic planning to meet individual outcomes.
- The Transitional Care Facility provides short-term, directed support to individuals, over a maximum 6 week period, to enable them to maintain independence and return to their homes with reduced or minimal packages of care.
- The Long Term Conditions Project, which enables improvements in the shared management of long term conditions in two localities. It is partnered by the Red Cross who provide home visits and help for patients so that they can remain in their own homes.
- The commissioning of services ensures that a broad range of options aimed at enabling independence in the community are provided.
- Work has been undertaken to ensure there are clear referral criteria for mental health services, information is available about services in the community, and self-management programmes are delivered through the third sector.
- A range of support options for clients is available through Self Directed Support.
- The Learning Disability Service works to promote and enable people with learning disabilities to live healthier lives and improve their quality of life through addressing the broader determinants of health, such as tackling social isolation and exclusion and developing supportive social networks. It is currently exploring different models for people who may require specialist in-patient assistance for learning disability.
- The dementia team work to keep people engaged with primary health care services and with people and activities which will enable them to stay well and reduce the likelihood of admission to hospital.
- The dementia service is developing a physical health check tool which will help patients assess when they are well.
- Stress and Distress in Dementia training for health, social care and private sector Carers has been provided and further training has been developed to provide stress and distress interventions for Carers and relatives.
- The Mental Health Older Adults Service works with patients in the community and in hospital to avoid admission where possible and to facilitate discharge at the earliest opportunity, with prompt and high quality discharge planning.
- The Home Energy Advice Service provides information, advice and practical help on energy matters to all households within the Council area. The advice helps to provide well insulated and comfortable homes and alleviate health concerns.
- Information and Advice, and in some cases practical assistance regarding property maintenance, repair and improvement is available to private sector homeowners or tenants.
- Scottish Borders Council contracts the Borders Care and Repair Service. The service enables older people and people with disabilities to have warm, well maintained and safe homes. The Care and Repair service helps achieve this by providing advice and assistance regarding repairs, improvements and adaptations and staff are trained to identify and will offer to remove trip hazards and other dangers if requested by their clients.
- New Horizons Borders have introduced an emotional support worker to help reduce the number of people reaching crisis and requiring hospital care or admission. A range of self-management workshops have also been provided.
- Borders Carers Centre provide discharge support and support post discharge to reduce potential for readmission.
- Borders Carers Centre provides preventative assistance for Carers, by providing assessment and support they allow the Carers to plan ahead to prevent burnout and ill health.
- SB Cares have changed staffing model in local home care teams to provide packages of care with shorter notice and in a more flexible manner.

Performance - National "Core Suite" Indicators

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	13,560	11,570
2012/13	13,376	11,668
2013/14	14,184	11,989
2014/15	14,001	12,083
2015/16	14,719	12,138
2016/17 P	12,995	12,037

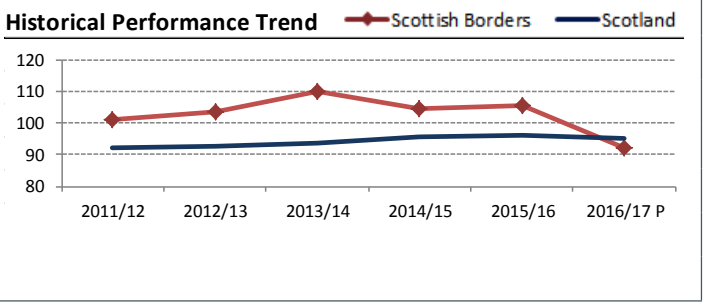


Source: ISD Scotland. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

Rates of emergency hospital admissions for Scottish Borders residents have fluctuated from year to year but whilst they have started to reduce, they remain above averages for Scotland. We will need to revisit the provisional figure for 2016/17 in later reporting, once the data submissions for all Scottish Hospitals are 100% complete.

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	101	92
2012/13	104	93
2013/14	110	94
2014/15	105	96
2015/16	106	96
2016/17 P	92	95



Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland, such as Borders General Hospital). This excludes discharges from Geriatric Long Stay (meaning that discharges from any of the Borders Community Hospitals do not contribute to these figures). Note: Figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

Overall rates of emergency readmission to hospital within 4 weeks of discharge have historically been higher in the Borders than across Scotland as a whole. Provisional figures for 2016/17 appear to have reversed this (which would reflect work done to reduce local readmission rates), although as the data for the latter part of the year are not yet 100% complete we will need to revisit this figure in later reporting.

Performance – Specific programmes

TEVIOT MEDICAL PRACTICE SCOTTISH AMBULANCE SERVICE PARAMEDIC PRACTIONER COLLABORATIVE TRIAL

187
domiciliary visits were undertaken

80%
of assessments were undertaken for patients older than 80 years old

1/3
of the total visits were to patients older than 90

Figures from January - March 2016.
Further work is being carried out to quantify the specific time savings and effects on GP work load.

STRESS AND DISTRESS TRAINING

148
people completed bite size Stress and Distress Training

117
people completed the 2 day Stress and Distress training

DELAYED DISCHARGES

People were delayed from being discharged from hospital

635
delayed discharges in 2015/16

823
delayed discharges in 2016/17

&

The % of associated occupied bed days

5.5%
in 2015/16

7.8%
in 2016/17

Partnership Priorities for 2017/18:

- Develop and implement a joint Delayed Discharge Plan, reducing rates and percentages of associated occupied beds – supporting the agenda with smart technology.
- Reduce delayed discharges from hospital through evaluating and further improving the early supported discharge programme and reducing readmission.
- Provide an out of hospital care pathway to improve flow across the system.

OBJECTIVE 4

We will provide care close to home

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

Key achievements during 2016/2017:

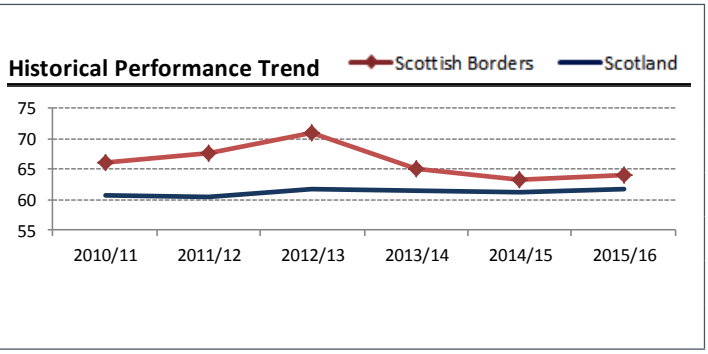
- Improvements planned and underway at local health centre sites across the Borders will improve access to a range of services provided from these.
- A pilot of the Buurtzorg nursing approach via integrated nursing and social work teams is in development. (See Spotlight section for more details)
- The Public Dental Service is exploring opportunities to offer and enable an annual programme of dental assessments and treatment within care establishments.
- The Sexual Health Service plan to:
  - Enhanced presence in secondary schools and Borders College to improve young people's access to Sexual Health services.
  - Reinstate pop up clinics in identified areas of need, to better support young people's access to Sexual Health services.
- Diabetic retinal screening continues to be delivered by local opticians.
- Podiatry services are trialling the use of a simple Office Communication System so that patients and their local podiatrist can communicate directly with a specialist podiatrist in another location for immediate advice.
- Work is underway to develop Locality Plans which identify local variations in need of health and social care services and will ensure that the right services are provided.
- Ability Borders works with individuals and the wider partnership to identify and meet people's information needs and identify gaps and issues.
- An older persons housing strategy is being developed which will inform the Partnership of the volume and placement of future Extra Care Housing and Housing with Care developments. Providing this type of accommodation will enable people to remain in or return to their homes.
- Community Led Support will provide accessible health and social care assistance in local communities.
- Smartcare, a web based self-management system which enables people to access advice, information and self-help assessment to identify equipment solutions, will bolster the Community Led Support programme.
- The mental health service have developed a joint approach to commissioning which will achieve the best outcomes for service users, foster recovery, social inclusion and equity and achieve a balanced range of services.
- The learning disabilities service works with service users, family Carers and service providers to commission appropriate person centred support packages within their local communities.
- A mental health occupational therapist, the mental health physiotherapy team, the mental health older adult service and the mental health older adult liaison service each work responsively with people to sustain them in their home where that is practical and possible.

- Within the localities across the Borders, "Lifestyle Matters" groups run enabling the regaining of skills and groups improving and maintaining mood, anxiety management and improving self-esteem for people with dementia or with problems related to mood, anxiety or depression.
- A Borders wide needs assessment exercise was carried out by consultants who identified 6 priority areas for future housing developments.
- The Low Vision Services assess and provide equipment for people within their home.
- The Carers Hospital Liaison Worker ensures Carers have all of the information, assistance and advice they require to improve discharge and avoid readmission.
- Following a consultation survey by Interest Link Borders, befriending for people with a learning disability is being delivered locally, throughout the Borders and is outcomes-focused.
- SB Cares has increased the amount of care packages provided in clients own homes, last year SB Cares delivered 821,000 home care visits.

Performance - National "Core Suite" Indicators

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2010/11	66.0	60.6
2011/12	67.6	60.5
2012/13	70.8	61.8
2013/14	64.9	61.4
2014/15	63.3	61.3
2015/16	64.1	61.6

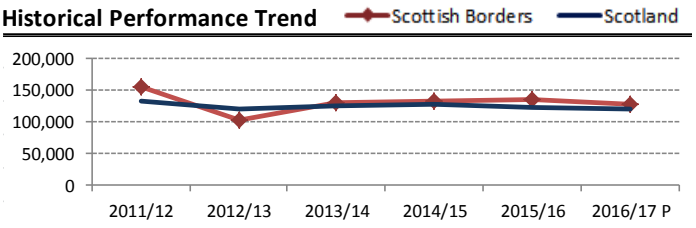


Source: Scottish Government Health and Social Care Statistics.

Historically, a higher proportion of Scottish Borders' residents requiring care have received it at home, compared with Scotland as a whole. Official statistics for Borders versus Scotland in 2016/17 have yet to be published. However, we have included local reporting for a similar indicator 2016/17 in the the June 2017 quarterly performance report for the Integration Joint Board.

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	156,604	132,560
2012/13	103,393	120,078
2013/14	129,586	125,789
2014/15	133,888	127,959
2015/16	135,078	122,713
2016/17 P	127,259	119,649

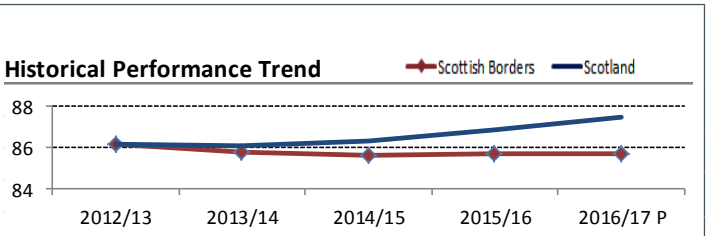


Source: ISD Scotland. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

Emergency bed-day rates for Scottish Borders residents have fluctuated from year to year and have usually been a little higher than the averages for Scotland. We will need to revisit the provisional figure for 2016/17 in later reporting, once the data submissions for all Scottish Hospitals are 100% complete.

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2012/13	86.2	86.2
2013/14	85.7	86.1
2014/15	85.6	86.3
2015/16	85.7	86.9
2016/17 P	85.7	87.5



Source: ISD Scotland.

Note: Figures for 2016/17 are provisional, as deaths and hospital records are incomplete for this year.

The percentage of last 6 months of life spent at home or in a community setting has appeared fairly consistent in the Borders from year to year since 2013/14 but in each case remains a little below the Scottish average, which is gradually increasing. More detail on this indicator is given in the June 2017 quarterly performance report for the Integration Joint Board.

Performance – Qualitative data

An elderly Person with symptoms of anxiety and mild cognitive impairment who attended seven Lifestyle Matters Group sessions showed the following improvements:

WEEK	POSITIVE THOUGHTS	QUERIES AND CONCERNS
1	Anxious	"I nearly didn't come to the group because I felt very anxious and I still do"
2	Hopeful, fortunate	"After last week I am hopeful that the group will help. It is good that there are things like this that we can go to"
3	Anxious, safe	"I was anxious coming here but I feel safe when I am here"
4	Nervous, relieved	"I was anxious again at the thought of going out but not as bad as I have been before. I feel relieved now that I am here."
5	Happy	"I feel things are going much better at the moment. I feel more confident"
6	Satisfied	"I am quite pleased with myself"
7	Positive	"I feel more positive about the things I am doing and am looking forward to planning a holiday"

LOW VISION AID CLINIC

CASE STUDY

A referral was received for the Low Vision Services requesting a care home visit to assess Miss H for suitable low vision equipment. Miss H had poor mobility and could not attend an appointment at the low vision clinic. A worker visited Miss H and assessed her low vision needs within the care home.

Miss H had been previously issued with equipment, however due to deteriorating vision this was no longer sufficient. Miss H was struggling to read large print unaided. It was recommended that Miss H user a higher strength, high colour temperature, stand illuminated magnifier which allowed relatively easy reading of standard letter print size.

This change of low visual aid has helped Miss H to read independently. This simple intervention has helped improve her quality of life and Miss H is delighted with the outcome

Key Partnership Priorities for 2017/18

- Enable vulnerable adults to live safely at home through improved Adult Protection practices; undertaking a review of Large Scale Inquiries, making necessary changes; evaluating outcomes.
- Develop a matching unit to improve access to locally based care at home.
- Improve integration and independence in people with dementia by developing a clear diagnostic pathway through Mental Health Older Adults' services as described within the updated Dementia Strategic Plan.
- Maintain independence and quality of life through increased use of Technology Enabled Care.
- Support the pathway to care at home through the development of a joint protocol for intermediate care/ short term placements.

OBJECTIVE 5

We will deliver services within an integrated care model

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

Key achievements during 2016/2017:

- The Joint Management Team meets weekly to discuss service development, issues, challenges and solutions across health & social care.
- There is joint management of the delayed discharge processes across health and social care and with engagement of independent care providers.
- The Care Home Group is an interagency group which provides a forum to monitor contracts and provide assistance for care home providers within Borders.
- Work is underway to design frailty pathways and a multi-disciplinary meeting is now in place. The meeting is used to discuss the needs of frail older people who have been admitted to Borders General Hospital within the past 24 hour period.
- An integrated Joint Workforce Planning Framework is in place to ensure staff are equipped with the right skills and experience, including a review if the joint recruitment process.
- The Partnership's staffing Forum takes place on a quarterly basis and involves staff, Trade Union members and Management. It is responsible for facilitating and evaluating the operation of Partnership working and supporting joint workplace policies.
- Integrated working practices in Learning Disability and Mental Health are providing the template for further development across all joint services.
- The House of Care model promotes good person-centred care conversations and enables improvements in the shared management of long term conditions in older people.
- Adult Protection service user questionnaires enable Scottish Borders to understand and improve support services.
- The Learning Disabilities Commissioning Strategy and Mental Health Strategy (Draft) provides an integrated approach to commissioning and deployment of resources.
- Community-Led Support project (featured in the spotlight section of this report) is a good example of future plans for integrated working.
- Scottish Borders Community Planning Partnership has produced a co-production toolkit and eLearning module.
- Work is underway to integrate Health and Social Care teams within localities, to improve the sharing of information and ensure seamless integrated care planning.
- Health and Social Care services and primary care partners work effectively together to accurately assess, diagnose and assist people with dementia. This integrated approach has resulted in reduced duplication and has streamlined the way in which care is provided.
- An evaluation of statutory and voluntary mental health services to ensure we deliver the right support at the right time.
- Mental health service health & social care staff are now co-located in three locality based community teams and a rehabilitation team which covers the whole of Scottish Borders.
- A service specification for a local recovery college model is being developed which will deliver a mental health service using an education approach rather than a therapeutic approach.
- The Learning Disability service hosts events for a wide range of stakeholders, tackling key developments and or issues important to people with learning disabilities.

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

- Delivering quality services with reducing resources.

Performance - National "Core Suite" Indicators

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

Source: Scottish Government Health and Care experience survey 2015/16.

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

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

Key Priorities for the Partnership for 2017/18

- Continue to develop joint financial planning underpinned by joint strategic commissioning; sharing workforce supports; joint governance etc.
- Support informed integrated planning through Integrated Care Fund measurements of common themes across multiple projects using a locally developed outcome focused tool.
- Develop integrated health and social care teams in all five localities.
- Improve inclusion and reablement approaches in palliative care/through the TCAT (Phase 2) programme; using learning across the services.
- Produce a joint workforce plan for integrated services.

OBJECTIVE 6

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

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

Key Achievements for 2016/17:

- Public involvement is routinely sought for planning and strategic development at all levels and for most decision-making.
- There are proactive processes and systems in place to gather patient and public feedback on services across the Partnership e.g. a cohort of patient feedback volunteers has been established within NHS Borders.
- The Public Partnership Forum meets bi-monthly to provide a public perspective on services provided by NHS Borders, Scottish Borders Council and the Voluntary Sector.
- The Self Directed Support Forum of Users and Carers is helping to develop information to ensure people are informed and better able to participate in their assessment.
- A Local Area Co-ordinator has been established for a one year pilot to help older people and people with a physical disability to make connections and choices in their local area.
- Work is underway with the Carers Advisory Group on the new Carers Strategy and planning for the implementation of the Carers Act in 2018.
- Social care and health assessments have been updated recently to ensure an outcome based, person focused assessment and review.
- Reimaging day services project is developing an inclusive model for reimaging how people are supported during the day.
- The Dementia working group consists of service users who are actively defining the service needs.
- Dementia champions are being promoted throughout NHS Borders and in development with the Social work team.
- Newly commissioned mental health service specifications include a requirement to implement outcome and recovery focussed assessment and support plans.
- Mental health managers attend the mental health forum to hear views of service users and Carers and to provide timely feedback on service developments.
- The 5 local citizens' panels continue to meet 5 times a year as part of the learning disability governance structure. They provide input to the learning disability service when planning developments, improvements, policy and strategy.
- Almost half of people with learning disability have had their support packages reviewed using a self-directed support approach.
- There is information available in accessible formats regarding the options within self-directed support to enable people with learning disability to have a better understanding of their options.
- Care & Repair ensure that the person is at the centre of their project, making decisions on who carries out the works, what the work should look like and when this all should take place. Care & Repair help to guide the client with decisions on design and quality to ensure that they get the best outcome and value for money for their anticipated long term needs and provide access to an environmental Occupational Therapist assessment in relation to function and provision of adaptations.

- Borders Additional Needs Group have established and developed "inclusion group" for Parent Carers.
- New Horizons Borders completed an internal evaluation which has informed future service provision.
- Borders Carers Centre provides training for Carers including assertiveness training and how to build resilience.
- SB Cares now offers direct provision of Personal Alarms and Ability Equipment to clients who are not eligible for Social Work funded services, thereby offering more choice to all client groups.

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

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

Performance - National "Core Suite" Indicators

NI-2 85% of adults supported at home agreed that they are supported to live as independently as possible (Scotland 84%).

NI-3 85% of adults supported at home agreed that they had a say in how their help, care, or support was provided (Scotland 79%)

Source: Scottish Government Health and Care experience survey 2015/16.

Performance – Specific programmes

DEMENTIA

83% of NHS Borders staff have received some form of training in Dementia as part of their statutory or mandatory training.

SELF DIRECTED SUPPORT

533 people were using self directed support at the end of March 2016

▲ **1320** people using self directed support at the end of March 2017

& **59%** of service users have been offered self directed support options

Key Priorities for the Partnership for 2017/18

- Improve shared management of Long Term Conditions in older people through extended application of the "House of Care" model, measured through the new outcome focused, Self-Evaluation Calendar.
- Increase the number of people accessing all self-directed support options by streamlining financial and other processes, removing barriers to change.
- More choice and control for the public through the development of a 'People Involvement Strategy'.
- 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.

OBJECTIVE 7

We will further optimise efficiency and effectiveness

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

Key Achievements for 2016/17:

- During 2016/17, the Partnership delivered over £5m of planned efficiency savings. In addition, emerging financial pressures required the implementation and delivery of over £8m of in-year remedial actions across delegated and set-aside functions in order to ensure financial balance of resources.
- The Partnership approved its medium term joint financial planning Strategy in Feb 2017. A key objective of this will be the planning and implementation of efficiencies across health and social care.
- A Health and Social Care Strategic Plan (2016-19) is in place with a more detailed Commissioning and Implementation Strategy which sets the strategic direction and framework for the Partnership for the next 2 years. The Strategy is informed by a local needs assessment and projections of need.
- A Primary Care Strategy is currently under development which will see the identification of agreed priorities and direction of travel across primary care services. It will link with the Health & Social Care Partnership's Strategic Plan and NHS Borders' emerging Clinical Strategy.
- An Information Analyst from the Local Intelligence Support Team has been working in collaboration with the Partnership over the past year and is currently looking at the use of the SOURCE database to drive the redesign of pathways in order to improve efficiency.
- Our established programme of leadership now includes a Scottish Social Services Council support programme, enabling leadership and a mentoring programme for newly qualified social workers delivered by specially trained peers. Our aim is to achieve sustainable improvements through resilient, knowledgeable staff.
- The work that is underway to review care pathways will result in improved efficiency and effectiveness.
- The Partnership has built on experience of current co-located teams e.g. Learning Disability and the Kelso team and seek further opportunities for co-location to make the more efficient use of staff skills and properties.
- The first cohort of care home managers have completed the My Home Life training, this has resulted in care home managers feeling that they are able to provide improved management and leadership, care home staff feeling that they have a greater desire to take the initiative when dealing with residents needs and that there has been an improvement in the overall quality of practice in the care home.
- A Matching Unit has been established to maximise efficiencies across care at home and release paid Carer capacity. A future development for the unit could be the promotion and matching of personal Carers through direct payments and matching of befriending services.

- The "Two Minutes of Your Time" questionnaire is used consistently in the NHS as a feedback tool to improve services.
- The dementia training programme has resulted in staff across the services having a better understanding of how to care for people effectively. This is turn improves efficiency and reduces length of stay in hospital.
- Partnership working across third sector.
- Service users and Carers are involved in service developments and recruitment.
- Learning disabilities services employed a Transitions Development Officer for 1 year to develop the transitions pathway, compile information packs and develop other areas within transition for young people and their families moving from children and young people services to adulthood.
- The Learning Disabilities Service has agreed a strategic commissioning plan identifying key areas for development for their service over the next 3 years.
- Interest Link Borders have increased administrative and operational assistance for service co-ordinators to ensure they have the resources they need to continue developing our service.
- New Horizons Borders have analysed staff skills to improve efficiency and flow in the team, and to reduce costs required by employing additional staff.
- SB Cares delivered £650k of contribution back to Social Care through improved deployment of staff, efficient procurement, and reduced staff travel and improved financial management processes.
- SB Cares continued to improve the quality care with 84% of their registered care services receiving Care Inspectorate grades of Good or above.

Performance - National "Core Suite" Indicators

NI-5 84% of adults receiving any care or support rated it as excellent or good (Scotland 81%).

NI-6 90% of people with positive experience of the care provided by their GP practice (Scotland 87%).

NI-7 87% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life (Scotland 84%).

NI-8 90% of adults supported at home who agreed they felt safe (Scotland 84%).

Source: Scottish Government Health and Care experience survey 2015/16.

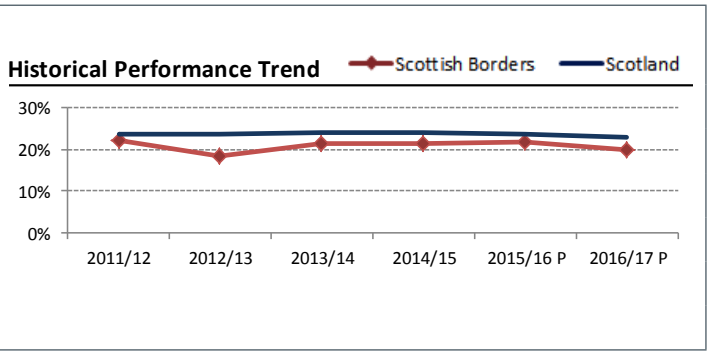
NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

YEAR	SCOTTISH BORDERS	SCOTLAND
2014/15	73.9%	81.2%
2015/16	74.6%	82.9%

Source: Care Inspectorate (indicator in development).

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	22%	24%
2012/13	18%	24%
2013/14	21%	24%
2014/15	21%	24%
2015/16	22%	23%
2016/17 P	20%	23%



Source: ISD Scotland. Note: Underlying costs data for 2014/15 have been used as a proxy for 2015/16 and 2016/17 costs in the calculation of this indicator. These figures are therefore provisional and will be refreshed once updated costs data become available.

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

Performance – Specific programmes

MY HOME LIFE PROJECT

100% self reported increase in leadership and communication skills of care managers

83% self reported increase in the quality of management and leadership of care managers

80% of attendees stated that the quality of life for residents had improved

80% of attendees stated that the quality of interactions between staff and residents had improved

Data Jan 2016 - Dec 2017

"TWO MINUTES OF YOUR TIME" SURVEY

96% of hospital patients, carers and relatives surveyed were satisfied with the care and treatment provided

96% of hospital patients, carers and relatives surveyed reported that staff providing their care understood what mattered to them

95% of hospital patients, carers and relatives surveyed reported that they had the information and support needed to help make decisions about their care or treatment

Data April 2016 - Feb 2017

Key Priorities for the Partnership for 2017/18

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

OBJECTIVE 8

We will seek to reduce health inequalities

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

Key Achievements for 2016/17:

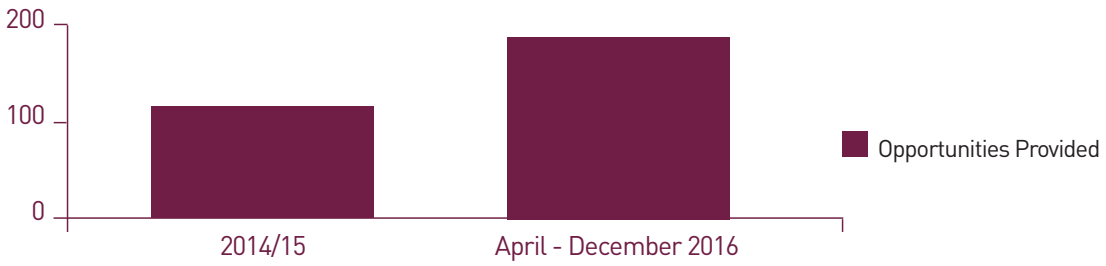
- The Public Dental Service will:
  - Continue to provide enhanced services to Special needs/ additional needs with core tooth brushing in all schools with special needs units;
  - Through more effective communication and interagency work increase the emphasis on ensuring improved access for patients identified as having mental health challenges, drug and alcohol dependencies, the homeless and ex-offenders;
  - Improve bariatric dental facilities within Public Dental Service.
- Health Inequalities Impact Assessments are routinely carried out and there is a proactive inter-agency Equalities Steering Group in place.
- Development of the Public Health Inequalities Plan is on progress.
- Enable the implementation of the Six Steps to Being Well guide through a programme of capacity building.
- Further development of healthy lifestyle supports for vulnerable groups.
- A pilot intervention with Live Borders, Health Improvement and the Diabetes Service commenced in January to offer health coaching to a group of recently diagnosed diabetes patients.
- The Healthy Living Network is assisting with the development of diabetes peer support groups in several localities, led by a third sector partner, Scottish Borders Senior Networking Forum.
- Health Inequalities Impact Assessment of local health screening programmes has taken place to identify priorities and actions to improve reach and uptake among harder to reach and vulnerable groups.
- Using a coproduction approach a full programme of mental health has been developed for Mental Health Awareness week in May 2017. This has been centred on the production of a resource guide Six Steps to Being Well in Scottish Borders which will be launched in May 2017.
- Community based initiatives are being developed by the Health Improvement team, Community Learning and Development and the third sector to support women's mental health and to promote volunteering for wellbeing.
- A mental health programme for offenders is being explored through the community justice framework. The needs of families of offenders are also being developed as part of the joint parent support strategy.
- Health literacy is being promoted with a range of staff groups and through focused work in one Learning Community Partnership.
- The Borders Community Planning Partnership 'Reducing Inequalities Strategy' sets the priorities and high level outcomes that are being aligned with the plans and priorities of relevant strategy groups in health and social care.
- The See Hear Strategy group is delivering introductory hearing and sight loss training to frontline staff and champion training for those staff working with children and adults with complex needs.

- A range of multi-agency training is available to adult social care staff including eLearning tools on dementia and adult and child protection.
- The Carers team are targeting the issue of carer ill-health in the new Health Inequalities Plan.
- The Community Transport hub has been developed in partnership with the third sector to provide an accessible, coordinated, sustainable approach to the delivery of community transport.
- The Alcohol and Drugs Partnership are working to reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reduce related deaths.
- The Alcohol and Drugs Partnership continue to work with Child Protection to deliver briefing sessions to staff on "children affected by parental substance misuse".
- There has been an increase in opportunities for people, their families and friends, with alcohol and drugs problems to be helped following treatment through participation in recovery groups and other activities.
- The Alcohol and Drug Partnership are working with partners in reviewing 'Staying Alive in Scotland' a good practice baseline tool which will inform further actions to reduce drug related deaths.
- The mental health service has developed a nutrition and healthy eating programme for mental health service users in key settings.
- A peer support worker role has been established in Galashiels Resource Centre which will enable employment opportunities for people with experience of mental ill health.
- Improvement in the care of people with learning disabilities across primary care, accessing the Borders General Hospital and community hospitals has included the implementation of link nurses in each area, a liaison nurse, introduction of hospital passports, the development of e-learning covering health needs and communication.
- The learning disabilities nursing team address health inequalities by working with the Oral Health team, working to improve diabetes care and enabling access to screening programmes.
- Borders Dementia working group are providing training within the community in order to create dementia friendly communities.
- An early onset dementia group provides a service for younger people with dementia reducing the inequality that younger dementia patients normally find.
- The Mental health Older Adults Team have been promoting and developing the "Living with Dementia Programme" which following diagnosis enables patients to understand what they can do independently.
- The Carers Centre offers a comprehensive programme of training for carers to maintain health and well-being including building resilience, managing stress and coping strategies.
- The Local Housing Strategy 2017 – 2022 has been in development throughout 2016 and agreed through consultation with stakeholders. The draft Local Housing Strategy contributes to Priority 2 on reducing inequalities. The following four priorities have been defined:
  - The supply of housing meets the needs of our communities
  - More people live in good quality, energy efficient homes
  - Fewer People are affected by Homelessness
  - More people are assisted to live independently in their own homes

- Interest Link Borders provide transport to enable people to access services.
- Borders Carers Centre provide assistance to enable people to maximise their personal budgets and provide help for individuals to access grants.
- Borders has the highest number of Naloxone kits issued per 1,000 estimated people with drug use problems in Scotland. These kits temporally reverse the effects of overdose.

Performance – Specific programmmes

DRUG AND ALCOHOL PARTNERSHIP - OPPORTUNITIES FOR PEOPLE TO BE SUPPORTED AFTER TREATMENT



SEE HEAR TRAINING

8 courses provided

88 people attended

98% rated the training as very good or good

Key Priorities for the Partnership for 2017/18

- Deliver post diagnostic support to a higher proportion of people with dementia and increase appropriate GP referrals.
- Improve outcomes when a dual diagnosis exists by piloting an assessment tool of physical health for people with mental health conditions.
- Establish a single information access; improve communication internally and externally.
- Development of locality plans to identify how to include those who are hard to reach within our communities and implement change.

OBJECTIVE 9

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

Key Achievements for 2016/17:

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

- The Partnership is committed to increasing referrals for Carers Assessments through the Borders Carers Centre. Some examples of support provided are:
  - Specialist support for young adult Carers to assist with access to employment, education and training.
  - "Staying Afloat" is a new 8 week project for Carers that develops resilience and improved health and wellbeing respite.
  - Carers Awareness Training through Adult Protection Training - a bespoke video designed in collaboration with Carers is used for this purpose.
  - Carers support groups run monthly across all 5 localities of the Borders.
  - Additional respite hours are secured for Carers through the time to live fund, days out and other charitable grants.
- Improve Carer health and undertake a Carers' health needs assessment to inform a refreshed 'Carers' Strategy'.
- A peer support network for Carers caring for someone with a mental illness has also been developed along with providing increased respite and training opportunities.
- Carers play a key role in planning and decision making through their representation on local citizens 'panels, on the Learning Disability Policy and Strategy Group and Learning Disabilities Partnership board. Training and assistance are provided to enable Carers to fulfil these obligations.
- A dementia liaison service provides assistance for people with Dementia and their Carers whilst they are in hospital.
- A Carers support group runs in Gala Day Unit and we are working with Alzheimer's Scotland to redevelop other Carers groups around the Borders.
- Stress and Distress training is being delivered to Carers of people with Dementia across the Borders, to support Carers and enable them to continue in their caring role.
- Carers Liaison Workers offer one-to-one assistance across the five localities.
- Carers Information Packs have been redesigned in collaboration with Carers.
- Borders Additional Needs Group have offered face to face advice and help, signposting to other services and to family respite services where needed.
- Interest Link Borders have provided respite through befriending for families that care for someone with learning disabilities, assisting in the sustainability of the caring relationship.
- Borders Additional Needs Group have expanded services to include assistance for young Carer siblings by working with local youth work provision.
- SB Cares are delivering improved access and coordination between social care services to aid Carers in their role.

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

- The ability to provide alternative care for Carers in order to attend development sessions.

Performance - National "Core Suite" Indicators

NI-8 41% of Carers feel supported to continue in their caring role (Scotland 41%).

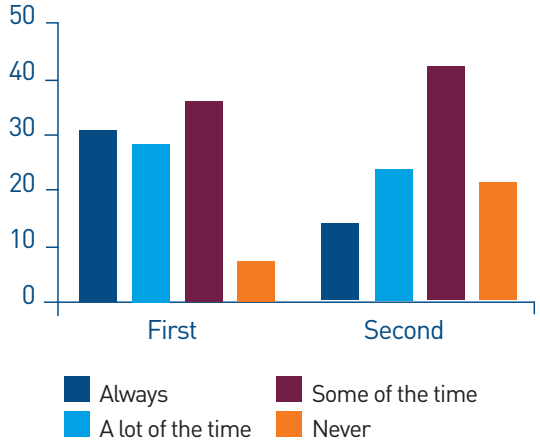
Source: Scottish Government Health and Care experience survey 2015/16.

Performance – Specific programmes

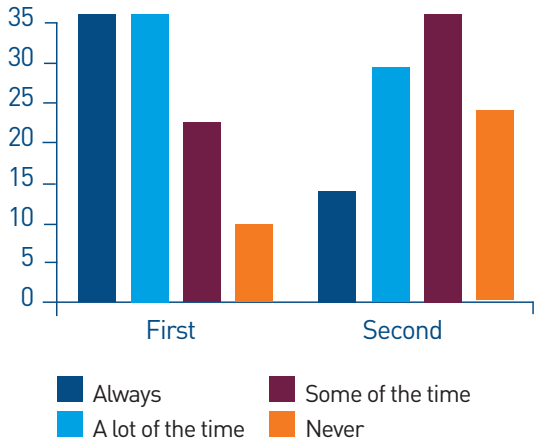
- 417 professionals have received Carers Awareness Training through Flying Start, induction training and talks and visits. This training is delivered in partnership with Carers.

CARERS

I feel stressed as a result of caring



I feel mentally exhausted as a result of caring



Data from 1 April - 30 September 2016

401 new Carers have been referred to the Carers Centre service

285 Carers have been referred to the hospital liaison worker

18 Carers attended an 8 week pilot project to develop resilience and improve health and wellbeing

430 Carers attending Carer support groups

675 Carers have received on-going support and guidance

Data from April 2016 - March 2017

Key Priorities for the Partnership for 2017/18

- Improve Carer health, strengthening Public Health input to a refreshed 'Carers Strategy'.
- Align recording of Carer Support Plan with Frameworki/MOSAIC Social Care database and Carers Centre data.
- Increase the number of Carer Support Plans.
- Develop a Partnership programme of improvement and self-evaluation between Carers, Scottish Borders Council, NHS Borders and the local service provider.

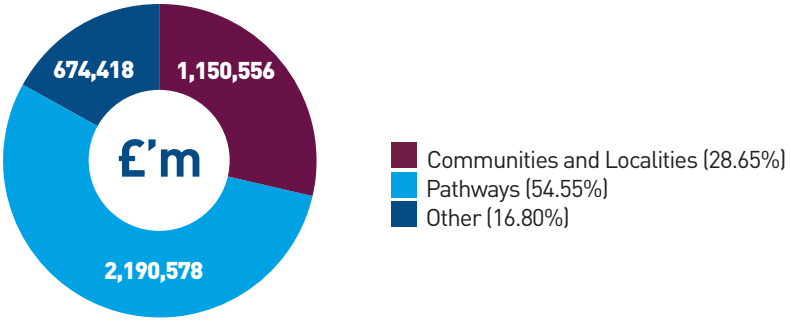
INTEGRATED CARE FUND

The Integrated Care Fund has been critical in assiting with the delivery of the Partnership's objectives.

The Scottish Borders Health and Social Care Partnership's Scottish Government Integrated Care Fund allocation is £2.13m in each of financial years 2015/16 to 2017/18, a total programme value of £6.39m. To date, £4,015,552 has been directed by the Integration Joint Board to meet the costs of a range of transformational initiatives.

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

INTEGRATED CARE FUND EXPENDITURE BY KEY THEMES



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

Pathways – Including projects such as: Mental Health Integration, My home Life training, Stress and Distress Dementia training, the delivery of the Alcohol Related Brain Damage pathway, the Autism pathway and the Transitions pathway. It also includes projects such as the Transitional Care Facility and the Rapid Assessment and Discharge Team which aim to reduce hospital admissions and delayed discharge. These projects all aim to streamline the pathways of care within the community, within hospital and during hospital discharge.

Other – Covering the delivery of the programme, performance monitoring and evaluation, along with representation by the Independent Sector.

The remaining Integrated Care Fund is being held whilst planning is undertaken to identify projects to further streamline care pathways, improve the dementia service and enable service transformation.

INSPECTION OF SERVICES

Joint Inspection of Services for Older People in the Scottish Borders

A joint inspection of the Health and Social Care Partnership's older people's services has been undertaken by the Care Inspectorate and Healthcare Improvement Scotland. The inspection consisted of several phases between November 2016 and February 2017. In November and December an initial self-evaluation report with accompanying evidence was sent to the inspection team.

A staff survey was also undertaken covering:

- Key performance outcomes
- Impact on older people and Carers
- Impact on members of staff
- Community wellbeing
- Delivery of key processes
- Policy development and partnership working
- Leadership and direction

This was followed in January and February by three weeks of onsite inspection. The inspection team completed case file audits, and had extensive discussions with service users, Carers, and provider, third sector, and social care and health staff. The inspection has been an opportunity to showcase partnership working, and to identify the areas that require improvement to achieve better outcomes for older people.

It is anticipated that the inspection findings and recommendations will be published in summer 2017 and will therefore be reported in subsequent Annual Performance Reports.

Older People in Acute Hospitals Inspection – April 2016

The review of Borders General Hospital took place over a day on Tuesday 26 April 2016. We interviewed a range of staff, including the executive team, non-executives and frontline staff.

The review was conducted by Healthcare Improvement Scotland staff, which included both quality assurance and improvement staff, along with the Scottish Health Council, clinical partners and public partners.

The review followed an unannounced inspection to Borders General Hospital which was conducted on Tuesday 12 to Thursday 14 April 2016. The following areas were inspected:

- Ward 4 (general medicine)
- Ward 5 (general medicine)
- Ward 6 (medical assessment unit)
- Ward 7 (general surgery)
- Ward 9 (orthopaedic surgery)
- Ward 12 (general medicine)
- Ward 16 (gynaecology)
- Department of medicine for the elderly, and
- Borders stroke unit.
- The emergency department and the discharge lounge

The recommendations and action plan can be seen in Appendix B.

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Arrangements

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

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

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

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

These arrangements ensured all partners received sufficient assurance over:

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

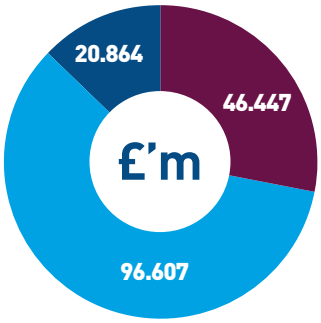
At the end of its first year the Partnership is well established in terms of financial governance, planning, management and statutory reporting evidenced by:

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

Financial Management

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

THE PARTNERSHIP'S BUDGET 2016/17



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

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

FINANCIAL PRESSURE EXPERIENCED DURING 2016/17

£4.481m
large hospital budget set-aside

£3.879m
Delegated budget

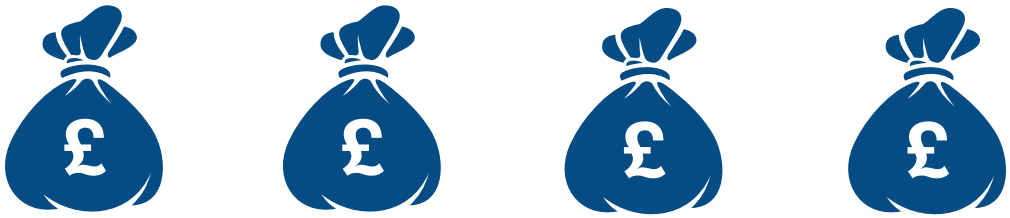
These pressures were primarily experienced across healthcare functions. Social care functions also experienced pressure during the year arising from factors such as increased demand from services, increased cost as a result of market pressures and the introduction of a living wage of £8.25 for all social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

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

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

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

FINANCIAL PRESSURES FACED BY NHS BORDERS ACROSS THE LARGE HOSPITAL BUDGET



£1.2m
surge beds

£900k
patient flow

£500k
acute admissions and emergency department staffing

£2.4m
non delivery of planned efficiencies

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

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

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

PERFORMANCE MONITORING FRAMEWORK: SUMMARY

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

- Appendix C sets out current and historical performance against a set of measures set by the Scottish Government for all Health and Social Care Partnerships. This "Core Suite" of 23 Integration Indicators was set by the Scottish Government, developed from national data sources so that the measurement approach is consistent across all Health and Social Care Partnership areas. This set of core indicators underpin the 9 National Health and Wellbeing Outcomes. Further information on the Core Suite Indicators and the rationale for their selection is available at http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators

- Within the Partnership we are also reporting on a series of measures identified locally as priorities to be monitored to help manage and improve services. This series of measures will develop further over time. More information on performance against locally set measures is available at www.scotborders.gov.uk/integration (at the time of publishing this Annual Report we are also publishing alongside it the June 2017 quarterly Performance Report to the Integrated Joint Board).

Performance areas that have been challenging for the Partnership have helped to determine the strategic priorities for 2017 – 2018.

DELIVERY OF KEY PRIORITIES FOR 2017/18

The Scottish Borders Health and Social Care Partnership Business Plan for 2016/17-2018/19 outlines the following key priorities for the Partnership, these are detailed in each objective section.

In order the deliver these priorities, efficiencies must be made in other areas. The areas identified by the Integration Joint Board as transformation priorities are:

PROJECTS	REDESIGNED SERVICES & PATHWAYS	IMPROVED OUTCOMES	MEET INCREASED DEMAND	AFFORDABILITY
Care Pathways (e.g. Hospital to home, intermediate services redesign, Community Services, diabetes, dementia)	✓	✓	✓	✓
Redesign of Day Services (Redesign of day time support across health and social care)	✓	✓	✓	✓
Redesign of Mental Health Services (Implementation of new /redesigned models of support to individuals, focussing on capacity and demand, value for money and further integrated care and support)	✓	✓	✓	✓
Localities Approach (Implementation of locality plans, embedding locality based health and social care and support in the heart of communities and developing models of nurse-led patient care is planned)	✓	✓	✓	✓

PROJECTS	REDESIGNED SERVICES & PATHWAYS	IMPROVED OUTCOMES	MEET INCREASED DEMAND	AFFORDABILITY
Redesign of Staffing & Management Arrangements (Reviewing all staffing and management arrangements across health and social care, including back office and supporting roles will be undertaken, in order to seek greater efficiency in the provision of and support to health and social care services)	✓	✓	✓	✓
Use of Technology (Investment in technology and the achievement of business process efficiency is a key objective of the programme. Greater use of assistive technology will deliver not only improved outcomes for individuals by making them feel safe and enabling their independence)	✓	✓	✓	✓
Prescribing (Implementation of an effective prescribing programme that reduces variation and promotes value for money is vital to reducing cost and ensuring the overall affordability and financial sustainability)			✓	✓
Alcohol and Drug Redesign (A review to identify funding priorities and implement changes to the alcohol and drug recovery oriented system of care focussing on recovery, productivity/ efficiency, demand /capacity and commissioning arrangements)	✓			✓
Implementation of Carers Legislation (The Carers (Scotland) Act 2016 will commence on 1 April 2018. There are many provisions within the legislation that will require implementation and influence how Carers, including young Carers, are supported in the course of their providing care. This will allow them to meet their planned and identified personal outcomes)		✓	✓	

The redesign of these services will result in savings that reduce the Partnerships budget deficit and enable the priorities to be delivered.

APPENDIX A
FINANCIAL PERFORMANCE AND BEST VALUE

I) FINANCIAL PERFORMANCE

Legislative and Governance Framework

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

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

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

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

These provisions specifically include:

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

Statutory Reporting Requirements

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

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

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

2016/17 - Resources Delegated to the Integration Joint Board

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

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

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

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

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

- Partners' absolute level of funding by the Scottish Government
- Past performance and known areas of financial pressure arising due to cost, demand, legislative and other factors

- Efficiencies and other required savings delivery to ensure overall affordability
- New priorities as expressed within partners' plans and the Integration Joint Board's Strategic Plan
- Other emerging areas of financial impact

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

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

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

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

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

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

These included or related to:

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

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

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

Recovery Planning and Delivery during the Financial Year

SIGNIFICANT PRESSURES

Prescribing
Demand for Social Care
Locum & Agency Staff
Other Staffing Pressures
Demand for Flexible Beds
Non - Delivered Efficiency

RECOVERY ACTION AREAS

Capital Slippage
Local Delivery Plan Slippage
Redirect Ringfenced Allocations
Additional Control Measures
Balance Sheet Flexibility
Temporary Funding

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

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

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

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

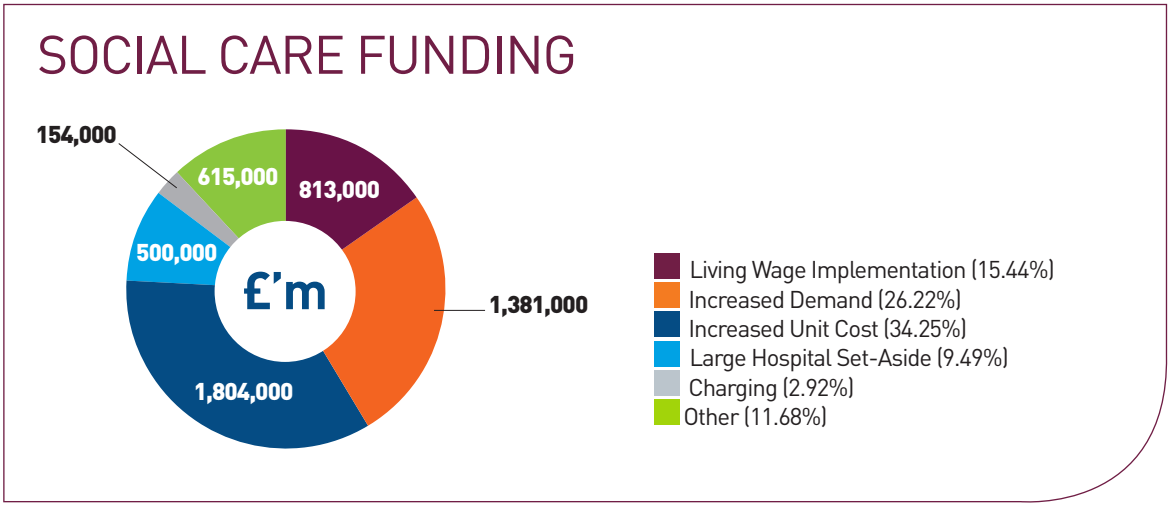
Establishing this impact and reviewing the Strategic Plan in light of prevalent financial pressures is now a key work package for the Partnership. Underpinning this will be the implementation of an integrated medium-term transformation programme for all health and social care aimed at improving performance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

Funding Priorities

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

Social Care Funding

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



Integrated Care Fund

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

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

INTEGRATED CARE FUND PROJECTS

Pathways

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

Communities and Localities

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

Other

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

ICF remaining resource

£2.374m

II) BEST VALUE

Introduction

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

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

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

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

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

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

Leadership, Partnership Working and Inclusion

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

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

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

Transformation and Redesign

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

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

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

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

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

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

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

Use of Resources

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

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

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

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

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

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

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

Performance Management

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

Forward Planning

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

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

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

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

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

APPENDIX B
INSPECTION OF SERVICES

Below are the recommendations from the Older People in Acute Hospitals Inspection from April 2016.

	RECOMMENDATIONS MADE	ACTION TAKEN TO IMPLEMENT EACH RECOMMENDATION
1	NHS Borders should further develop its governance and communication structures to support better sharing of learning across the organisation	Shared learning at Senior Charge Nurse and Head of Service meetings as an additional vehicle for onward dissemination and emphasis of the link between learning and changes that are made. Introduced a "Patients Said, We Did" monthly communication to all staff
2	NHS Borders should further develop the process for sharing learning from feedback and complaints across Borders General Hospital and in particular to the wards.	
3	NHS Borders must ensure clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR).	
4	NHS Borders must ensure it has robust documentation and record keeping in place.	NHS Borders introduced a daily quality review to check compliance with completion of clinical documentation and rectify any issues identified. This review is conducted in all wards to check the clinical documentation including evidence that patient assessments have been completed to standard. Feedback is given to clinical staff of any gaps with support and advice to remediate the issues that have been identified. Within 24 hours, the quality reviewers return to the ward to check that the issues that had been identified have been addressed. This information is used to measure compliance and drive improvement. This is intended to underpin a shift in clinical practice and quality of care, and will evolve over the next year.

	RECOMMENDATIONS MADE	ACTION TAKEN TO IMPLEMENT EACH RECOMMENDATION
5	NHS Borders must ensure all patients receive appropriate screening assessments within the standard timeframes.	NHS Borders is participating with national patient safety work on medicines reconciliation and will identify the learning and best practice, and draw up a plan to implement. NHS Borders has included the requirement to complete medicines reconciliation in the Code of Practice for the Control of Medicines. Medicines reconciliation was presented and discussed at the Medical Grand Round Continuing Professional Development event in May 2016. Medicines reconciliation was presented and discussed at the next non-medical prescribing Continued Professional Development event in October 2016. See action in response to Area for Improvement 4
6	NHS Borders must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. This includes consulting any appointed power of attorney or guardian. When legislation is used, this must be fully documented in the patient health record, including any discussions with the patient or family.	The Medical Director has written to all doctors about the requirement to comply with current legislation in relation to capacity. NHS Borders will establish an ongoing process for reviewing consistency of recording consultation with any appointed power of attorney or guardian
7	NHS Borders must ensure that capacity assessments are carried out for all patients where a cognitive impairment has been identified. This should be done by fully embedding its policy for consent to treatment. This includes adults with incapacity and power of attorney.	A training tool relating to capacity assessments and adults with incapacity has been circulated to all Heads of Service for mandatory use by consultants. This will fully embed the Consent to Treatment Policy. See action in response to Area for Improvement 4
8	NHS Borders must ensure mealtimes are managed in a way that is co-ordinated and ensures maximum staff input.	At the time of the inspection we met with Senior Charge Nurses to give clarity on the expectation of planning patient and staff mealtimes to ensure consistency across NHS Borders. Clinical Nurse Managers continue to quality assure compliance.
9	NHS Borders must ensure that staff have access to expert tissue viability advice.	Agreements have been put in place with two other Health Boards for staff access to very specialist advice for complex cases. An escalation process has been developed, shared and discussed with Senior Charge Nurses. Clinical Nurse Managers now review the plan of care for every pressure injury ensuring that appropriate care and documentation is in place.

	RECOMMENDATIONS MADE	ACTION TAKEN TO IMPLEMENT EACH RECOMMENDATION
10	NHS Borders must ensure that once a patient is identified as requiring a SSKIN (Skin Insepection) bundle, these are commenced and that each individual patient is individually assessed for interventions that are clearly documented.	See action in response to Area for Improvement 4
11	NHS Borders must ensure that care plans are in place for all patients' identified needs found on assessment, and that these inform the comfort rounding on those wards where it is in place.	See action in response to Area for Improvement 4 At the time of the inspection, Senior Charge Nurses were advised of the expectation of the standards. This is included in a monthly audit of documentation conducted by Senior Charge Nurses.
12	NHS Borders should consider capturing and publicising the learning from the changes it has implemented in relation to complaints and culture change.	NHS Borders is considering the best way to publicise the learning from changes it has implemented

APPENDIX C
PERFORMANCE MANAGEMENT

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

NATIONAL INDICATOR NUMBER	INDICATOR DESCRIPTION	SCOTTISH BORDERS	SCOTLAND
NI - 1	Percentage of adults able to look after their health very well or quite well	95%	94%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	84%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	85%	79%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	75%	75%
NI - 5	Percentage of adults receiving any care or support who rated it as excellent or good	84%	81%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	90%	87%
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	87%	84%
NI - 8	Percentage of Carers who feel supported to continue in their caring role	41%	41%
NI - 9	Percentage of adults supported at home who agreed they felt safe	90%	84%

Source: Scottish Government Health and Care Experience Survey 2015/16
http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey.
This national survey is next due to be run in 2017/18 with results published in spring 2018.

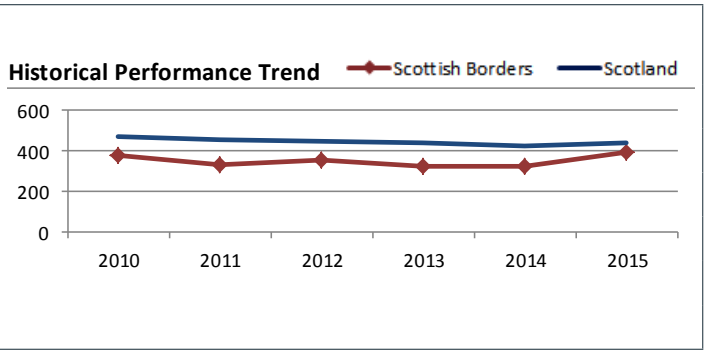
NATIONAL INDICATOR NUMBER	INDICATOR DESCRIPTION	SCOTTISH BORDERS	SCOTLAND
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	57% (NHS Borders only)	59%

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

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

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

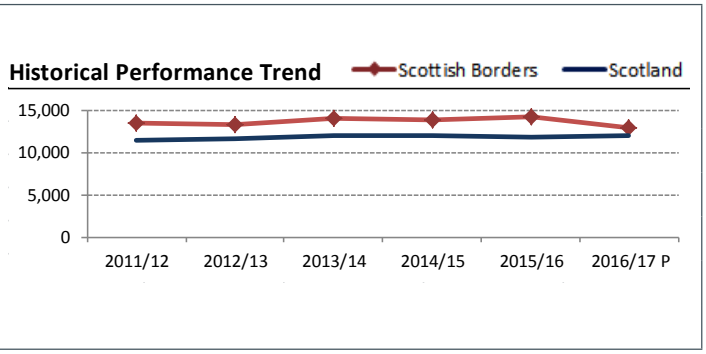
YEAR	SCOTTISH BORDERS	SCOTLAND
2010	374	467
2011	334	456
2012	356	445
2013	323	438
2014	322	423
2015	391	441



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)

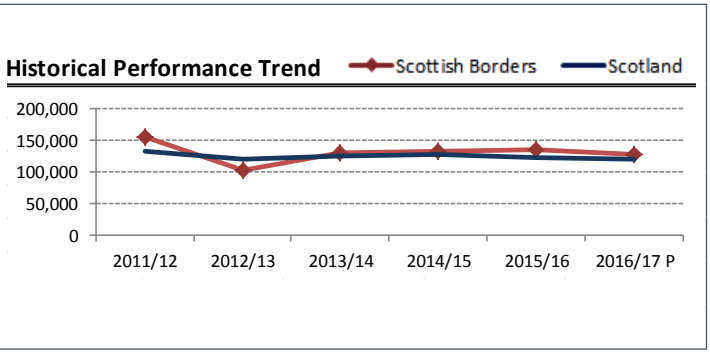
YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	13,560	11,570
2012/13	13,376	11,668
2013/14	14,184	11,989
2014/15	14,001	12,083
2015/16	14,719	12,138
2016/17 P	12,995	12,037



Source: ISD Scotland. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

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

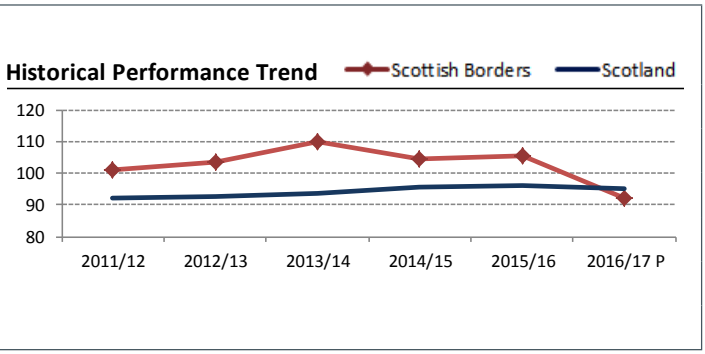
YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	156,604	132,560
2012/13	103,393	120,078
2013/14	129,586	125,789
2014/15	133,888	127,959
2015/16	135,078	122,713
2016/17 P	127,259	119,649



Source: ISD Scotland. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

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

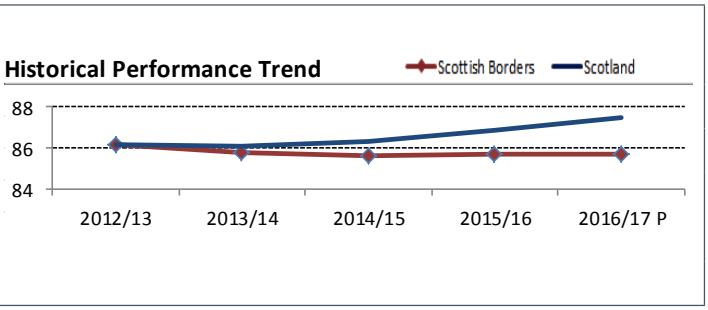
YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	101	92
2012/13	104	93
2013/14	110	94
2014/15	105	96
2015/16	106	96
2016/17 P	92	95



Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland, such as Borders General Hospital). This excludes discharges from Geriatric Long Stay (meaning that discharges from any of the Borders Community Hospitals do not contribute to these figures). Note: Figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2012/13	86.2	86.2
2013/14	85.7	86.1
2014/15	85.6	86.3
2015/16	85.7	86.9
2016/17 P	85.7	87.5

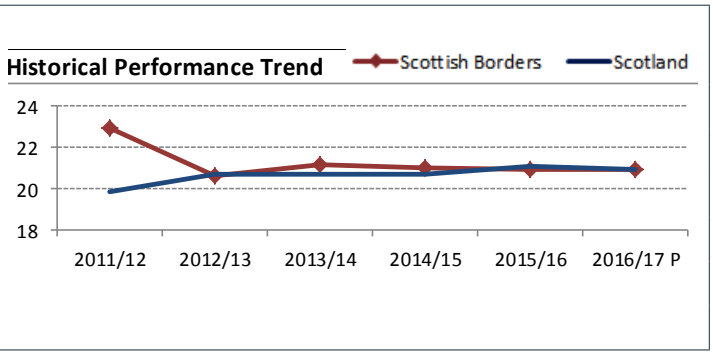


Source: ISD Scotland.

Note: Figures for 2016/17 are provisional, as deaths and hospital records are incomplete for this year.

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	23.0	19.8
2012/13	20.6	20.7
2013/14	21.1	20.7
2014/15	21.0	20.7
2015/16	20.9	21.1
2016/17 P	20.9	20.9



Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

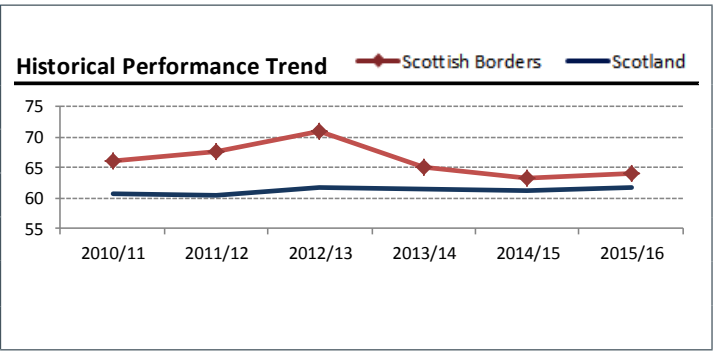
NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

YEAR	SCOTTISH BORDERS	SCOTLAND
2014/15	73.9%	81.2%
2015/16	74.6%	82.9%

Source: Care Inspectorate (indicator in development).

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

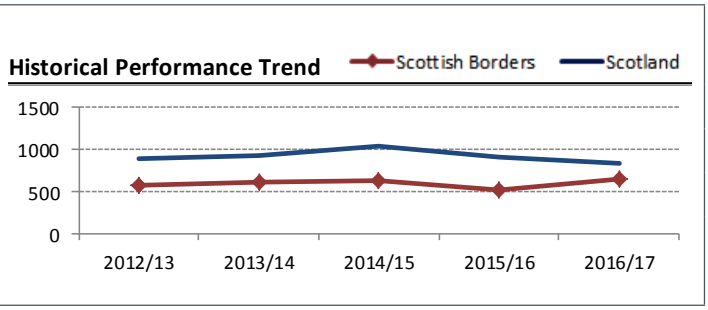
YEAR	SCOTTISH BORDERS	SCOTLAND
2010/11	66.0	60.6
2011/12	67.6	60.5
2012/13	70.8	61.8
2013/14	64.9	61.4
2014/15	63.3	61.3
2015/16	64.1	61.6



Source: Scottish Government Health and Social Care Statistics.

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

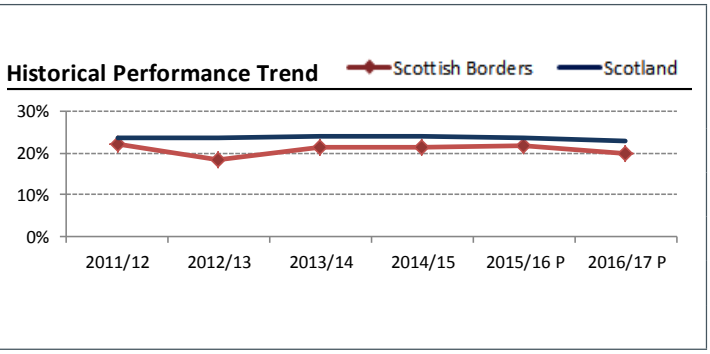
YEAR	SCOTTISH BORDERS	SCOTLAND
2012/13	575	886
2013/14	604	922
2014/15	628	1,044
2015/16	522	915
2016/17	647	842



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+)

YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	22%	24%
2012/13	18%	24%
2013/14	21%	24%
2014/15	21%	24%
2015/16	22%	23%
2016/17 P	20%	23%



Source: ISD Scotland. Note: Underlying costs data for 2014/15 have been used as a proxy for 2015/16 and 2016/17 costs in the calculation of this indicator. These figures are therefore provisional and will be refreshed once updated costs data become available.

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

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

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

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

NI-23 Expenditure on end of life care.

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

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

Health and Social Care Services which are integrating

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

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

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