Public Document Pack

Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Monday, 11th June, 2018** at **2.00 pm** in Council Chamber, Scottish Borders Council

AGENDA

Time	No		Lead	Paper
14:00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
14:01	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	Chair	*Verbal*
14:03	**3**	**MINUTES OF PREVIOUS MEETING** 28.05.18	Chair	(Pages 3 - 8)
14:05	**4**	**MATTERS ARISING** Action Tracker	Chair	(Pages 9 - 14)
14:10	**5**	**CHIEF OFFICER'S REPORT**	Chief Officer	(Pages 15 - 18)
14:15	**6**	**FOR DECISION**		
	6.1	Health & Social Care Strategic Plan 2018 - 2021	Chief Officer	(Pages 19 - 174)
	6.2	Monitoring of the Health and Social Care Partnership Budget 2017/18 at 31 March 2018	Chief Financial Officer	(Pages 175 - 186)
	6.3	Deliverability of Health & Social Care Partnership Financial Plan Savings for Financial Year 2018/19	Chief Financial Officer	(Pages 187 - 200)
15:15	**7**	**FOR NOTING**		

	7.1	Integrated Care Fund Update	Chief Officer	(Pages 201 - 202)
	7.2	Interim Report on Community Capacity Building	Chief Officer	(Pages 203 - 212)
	7.3	Strategic Planning Group Report	Chief Officer	(Pages 213 - 214)
	7.4	Inspection Action Plan update	Chief Officer	(Pages 215 - 248)
15:55	**8**	**ANY OTHER BUSINESS**	Chair	
16:00	**9**	**DATE AND TIME OF NEXT MEETING** Monday 20 August 2018 at 2.00pm in Committee Room 2, Scottish Borders Council.	Chair	*Verbal*

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 28 May 2018 at 9.30am in the Council Chamber, Scottish Borders Council.

Present:	(v) Cllr D Parker	(v) Dr S Mather (Chair)
	(v) Cllr J Greenwell	(v) Mr D Davidson
	(v) Cllr S Haslam	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	(v) Mr J Raine
	Mrs J Smith	(v) Mr T Taylor
	Ms L Jackson	Dr C Sharp
	Mr M Leys	Mr J McLaren
	Dr A McVean	Mr R McCulloch-Graham
	Mr C McGrath	
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mrs T Logan	Mrs J Stacey
	Mrs C Gillie	Mr L Gill
	Mrs J Robertson	Mrs S Bell

1. Apologies and Announcements

Apologies had been received from Cllr Helen Laing, Mrs Claire Pearce, Ms L Gallagher, Mr David Bell and Mr David Robertson

The Chair confirmed the meeting was quorate.

The Chair welcomed Ms Linda Jackson who was deputising for Mrs Lynn Gallagher.

The Chair welcomed members of the public to the meeting.

2. Declarations of Interest

The Chair sought any verbal declarations of interest pertaining to items on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. Authorisation to Sign Off Annual Accounts 2017/18

Mr Robert McCulloch-Graham gave an overview of the content of the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and agreed that Mr David Robertson as Chief Financial Officer of Scottish Borders Council should sign off the

Integration Joint Board (IJB) Annual Accounts 2017/18 in the current absence of a Section 95 Officer for the IJB.

4. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 23 April 2018 were amended at page 5 to read “Mr Tris Taylor declared a potential conflict of interest in the autism item due to a close relationship with someone who may have autism” and at page 7, item 7.9, paragraph 2, line 2, to read “... slow. The project ...” and with those amendments the minutes were approved.

5. Matters Arising

5.1 Minute 6: Scottish Borders Health & Social Care Partnership Financial Plan 2018/19: Mr Colin McGrath noted that 100% of the social services budget for adult services was allocated to the partnership and he enquired what percentage that was of the total social services budget. Mr Robert McCulloch-Graham advised that he would pick up the matter with Mr McGrath outwith the meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

6. Chief Officer’s Report

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted several elements including: continued pressures on the Borders General Hospital and Community Hospitals; utilisation of the Craw wood facility; external auditors review of inspection action plan; Scottish Parliament Health and Sport Committee review of partnerships; appointment of an Adult Social Care Chief Officer; update on regional work; and on going work on the primary care improvement plan.

Discussion focused on: usage of Craw wood and the set criteria for the facility; 10 days average length of stay at Craw wood; presentation on population demographics to a future Development session; analysis of care home beds and care hours; future provision of specialist dementia beds; 6 inspections of adult support and protection services currently underway across Scotland; and commonality across partnerships in regard to set aside.

Mr Murray Leys confirmed he would be happy to provide a presentation to a future development session on demographics and the empirical number of beds and care hours to be commissioned in the future along with a rationale as to how such numbers were identified and if the numbers were unaffordable some suggested options to worked through.

Mr John Raine commented that where there was a coterminous Local Authority and Health Board there was no need for a set aside budget and he was keen to have that point clarified for both the Integration Joint Board and the Health Board.

Mr McCulloch-Graham also highlighted the formation of the primary care improvement plan.

Mr John McLaren commented that he was aware that the GPs had been involved in the early formulation of the plan and he enquired how and when the organisations would have the

Page 2 of 4

opportunity to input to the plan. Mr McCulloch-Graham advised that there was a timetable of various meetings and groups that the plan would be presented to.

Dr Angus McVean advised that an awayday had been held the previous week with those likely to be impacted by the proposed changes. Views had been expressed at the event in regard to how to take the plan forward, how to match the money to the plan, and an engagement strategy with stakeholders.

Mrs Jane Davidson reminded the Board that the formation of the plan was a joint responsibility between the partnership and the Health Board with a need for a joined up planning approach as the aim of the plan should be to direct change in how primary care and community services might be provided moving forward.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

Mrs Tracey Logan arrived.

7. Refresh of Health & Social Care Strategic Plan 2018-2021- Update on Progress

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted the work of the strategic planning group in producing the refreshed draft and the revision of objectives from 9 to 3.

Discussion focused on: language; shared objectives; inclusion of hyperlinks; unclear on what we are asking the audience; seek more information on the detail of the governance structure and how it works; be clear in Appendix 2 that all services listed have been delegated to the partnership; what has been removed from the original strategy and why; what are the fundamental changes between the 2 documents; is it a yearly refresh or a final strategy for the next 3 years; work to be done on co-production with stakeholders; are we listening to the local population and doing what they want or are we telling them what they can have; spending diagram is paternalistic and does not show any funding/commissioning going to the third sector; difficulties of commissioning in remote and rural areas; meaningful engagement in shaping our services for the future; marrying up initiatives with the provision of services instead of promoting something and then removing the funding; language around being a carer; and providing a realistic strategy for the future; and to help the public make realistic choices, provide them with the choices and ask them to prioritise them.

Mr Malcolm Dickson welcomed the easy read format, commented that parent bodies should be changed to partnership bodies and noted several of the timescales had already passed. He suggested inclusion of the results of the actions that had been completed and sought assurance that exit strategies and mainstreaming plans had been instigated accordingly.

Mrs Jane Davidson welcomed sight of the early draft and highlighted the importance of setting out the partnership ambition.

Mr John Raine welcomed the strategy and enquired when the move would be made from being aspirational to measuring success, against targets, resources and timescales.

The Chair thanked the Board for a valuable discussion and in summary suggested the document provided a good sign post of where the partnership had been and its aspirations for the future. He commented that over the past 3 years the partnership had continued to mature and evolve. He further reminded the Board that the Strategic Plan was a live document that should be reviewed annually and it was apparent that demographic changes were already impacting earlier than forecast.

The Chair acknowledged the wide range of comments that had been made and advised that they would be taken on board and the document revised to better reflect co-production and meaningful language for the public.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made on refreshing the Strategic Plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** commented on the content and format of the refreshed Strategic Plan.

8. Annual Performance Report 2017/18 – Update

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted that the Board had issued directions in regard to Hospital to Home and Discharge to Assess.

Mrs Jenny Smith commented that the wording around the matching unit was unclear as it suggested the unit would not be subject to the usual integrated care fund evaluation process. Mr McCulloch-Graham acknowledge the need to revise the wording and commented that the intention was to mainstream the matching unit funding.

Mr John Raine suggested as the contribution of volunteers was included and quantified the contribution of carers should also be included and quantified.

Mr Tris Taylor enquired of the intended audience of the document. Mr McCulloch-Graham advised that the audience would be the public, staff and Scottish Government.

Mr Taylor commented on several elements of the document including: inconsistent numbers and percentages; no page numbers; inconsistent indicators; lack of assurance on performance data; inconsistent measures; no comparators; no underlying logic or indicators to measure against; quality of evidence was missing; and being opaque by omission.

Mr Taylor further sought evidence that public involvement was routinely sought.

Mr McCulloch-Graham welcomed the scrutiny provided and suggested meeting with Mr Taylor outwith the meeting to explore those comments in greater depth.

Mr John McLaren suggested an explanation of generic services also be included in the document.

Ms Linda Jackson advised that she had already fed back comments however she highlighted that the spot lights were on Scottish Borders Council and NHS Borders and she would welcome the inclusion of a spotlight on the Third Sector.

The Chair welcomed the scrutiny provided to the document and the comments received. He reminded the Board of the directions that it had made over the past year and commented that at a recent national meeting of Integration Joint Board (IJB) Chairs he had been surprised to find out that several other IJBs had yet to make any directions. He observed that the Board should remember that it had achieved progress and would continue to strive to achieve more.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted progress made on the development of a draft Annual Performance Report and Summary Report.

Cllr David Parker suggested given the timescale for approval of the report was end of July and the Board did not meet in July, authority to approve the report for publication be delegated to the Chair and Chief Officer. The motion was seconded by Mrs Karen Hamilton.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that the Chair and Chief Officer be delegated authority on behalf of the Board to approve the report for publication by the end of July.

9. Any Other Business

9.1 Update on the Finance Officer: Mr Robert McCulloch-Graham advised the Board that there would be a readvertisement of the position and support would also being utilised from employment agencies.

10. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Monday 11 June 2018 at 2.00pm in Committee Room 2, Scottish Borders Council.

The meeting concluded at 11.00am.

Signature: ……
Chair

This page is intentionally left blank

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 17 October 2016

Agenda Item: Clinical & Care Governance – Integrated Joint Board Reporting

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that it would undertake a Development session on clinical and care governance.	Robert McCulloch-Graham, Claire Pearce, Cliff Sharp	2017	**In Progress:** Item scheduled for 27 November 2017 Development session. Session cancelled due to apologies received. **Update:** Item rescheduled to 19 March 2018 Development session. **Update:** Item rescheduled to 28 May session due to Extra ordinary meeting taking place on 19 March 2018. **Update:** Item rescheduled to 19 November 2018 session due to change in status of development sessions to formal meetings.	G

Meeting held 27 February 2017

Agenda Item: Health & Social Care Delivery Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
13	8	Tracey Logan advised that there were already strong links to Live Borders in place and she would be happy to provide an update to the IJB if it wished.	Tracey Logan	June 2017	**In Progress:** Item scheduled for 12 February 2018. **Update**: Item rescheduled to 20 August 2018 meeting.	G

Meeting held 23 October 2017

Agenda Item: Update on Buurtzorg in the Borders

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
19	13	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress to date and welcomed hearing more at a later date.	Robert McCulloch-Graham	April 2018	**In Progress:** Item scheduled for April 2018 meeting agenda. **Update:** Item rescheduled to 20 August meeting due to agenda business pressures (ties into Action 27).	G

Meeting held 18 December 2017

Agenda Item: Community Capacity Building – Transformation Proposal

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
23	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to continue with the project for 12	Michael Curran	June 2018	**In Progress:** Item scheduled for 11 June 2018 meeting agenda.	G

		months with the proviso that there was an evaluation (set up by acute & primary care colleagues) on the projects listed within the document within 12 months and an interim update provided in 6 months time.				

Meeting held 12 February 2018

Agenda Item: Inspection Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
24	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and agreed to receive a presentation on the Public Protection Service at a Development session later in the year.	Murray Leys	December 2018	**In Progress:** Item scheduled for 19 November 2018.	G

Meeting held 23 April 2018

Agenda Item: Scottish Borders Health & Social Care Partnership Financial Plan 2018/19

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
26	6	The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** accepted the report on the 2018/19 Health and Social Care Financial Plan and asked that a report be brought to the June 2018 meeting with details of how the unidentified savings requirement would be addressed, recognising that plans to deliver £5.2m of savings remain unidentified.	David Robertson, Carol Gillie	June 2018	**In Progress:** Item scheduled for 11 June 2018 meeting agenda.	G

Agenda Item: Buurtzorg Project Management

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
27	7.9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding with a further update on progress.	Robert McCulloch-Graham	August 2018	**In Progress:** Item scheduled for 20 August 2018 meeting agenda.	G

Agenda Item: Hospital to Home

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
28	7.11	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive an update on the impact of the decisions made, updated timescales and projects to be mainstreamed.	Robert McCulloch-Graham	June 2018	**In Progress:** Item scheduled for 11 June 2018 meeting agenda. **Update:** Item rescheduled to 20 August meeting.	

Agenda Item: Scottish Borders Health and Social Care Partnership 2017/18 Winter Period Evaluation Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
29	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** welcomed the opportunity to receive a report at a future meeting on Quality and Governance from Mrs Claire Pearce, Director of Nursing, Midwifery & Acute Services and Dr Angus McVean, GP Clinical Lead.	Claire Pearce, Angus McVean	August 2018	To be scheduled	

Meeting held 28 May 2018

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
30	6	Mr Murray Leys to provide a presentation to a future Development session on Demographics	Murray Leys	2018	To be scheduled	

KEY:	
R	Overdue / timescale TBA
A	<2 weeks to timescale
G	>2 weeks to timescale
Blue	Complete – Items removed from action tracker once noted as complete at each H&SC Integration Joint Board meeting

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 11 June 2018

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Robert McCulloch-Graham, Chief Officer
Telephone:	01896 825528

CHIEF OFFICER'S REPORT

Purpose of Report:	To inform the Health & Social Care Integration Joint Board of the activity undertaken by the Chief Officer since the last meeting.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note the report.

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

Chief Officer Report 5th June 2019

Parliament Health and Sport Committee

Five IJB Chief Officers attended a meeting of this committee to examine the work in preparing our IJB budgets. The questioning mainly focused on shifting the balance of care from Acute to Partnership, and in particular how the Set Aside arrangements are supporting this or otherwise.

It was evident that each of the IJB's had their set aside budgets calculated in different ways, and that the amount identified was a notional amount. It is intended that the set-aside would serve the purpose of providing a mechanism of measuring the shift in the balance of health care from acute to community and primary care. We are in effect measuring apples and oranges, as each IJB cannot be compared effectively with another whilst we employ different ways of calculating the set-aside. Scottish Government are attempting to bring more rigour to this process in an attempt to unify our processes which arrive at the set aside estimate.

The committee also examined progress within our partnerships, which nationally are positive regarding delayed discharges, whilst here in the Borders and across Lothian we remain challenged. We were however able to offer some good news from our own IJB in that our admission figures have continued to reduce in spite of the rising pressures within our over 65 population.

Technology Enabled Care

I met with the Council's strategic partner CGI to meet with their global lead on health care. The meeting was exciting in that we were able to hear of a wide range of examples of where technology could transform the offer of health and social care.

I was particularly struck by the simplicity of some of the solutions to problems and issues we have been facing for years. One area in particular that could deliver a huge improvement on the number of people awaiting health services, consultation and triage, through "attend anywhere" technology. Our Care Homes could be using this, through linked cameras with diagnostic equipment to negate the need for a call out to a care home or to a distant homestead of a patient. COPD and other interactions such as speech and language therapy, counselling, occupational therapy, medicine prompts, even gp consultations can now all be offered on a telephone line or via satellite.

CGI were able to give many examples worldwide as to where these solutions have been tried and tested.

We will be meeting again in August which will give us time to decide which areas we would like to prioritise to take forward with CGI's help. We are asking our housing colleagues to join us at this follow up.

Learning Disabilities Review

I participated in the latest quarterly review of our learning disability services. It was a pleasure to discuss the successes of this team which hosts both Council and NHS staff and operate a fully integrated service provision.

This success has not been aided however by our continuing separation of processes and decision making between NHS and the Council. Leaders within this team, described how, although being integrated for over 8 years, they still need to follow separate SBC and NHS processes. These include, managing budgets, HR issues, performance reporting and the list goes on. Even though permission has been granted at a senior level to undertake processes just once, the organisation is such, that they are still required to do things twice in all cases.

We agreed that as a result of the review we would look into these issues to see if they can be resolved.

Hospital to Home

I have managed to get some time with the leadership of the Hospital to Home pilot and have been really encouraged by the work and its potential for the future.

The Integration Joint Board approved a proposal to introduce a new direction of "Discharge to Assess". One of the components of this was to test and implement a Hospital to Home pilot in 3 localities. The **Berwickshire Pilot** started on the 15th January and has now been operational for 19 weeks. The **Teviot pilot** commenced on the 5th March and has now been operational for 10 weeks. These services are carried out by 2.7 WTE Health Care Support Workers, under the guidance of District Nurses, working in partnership with a multi-agency team.

The Pilots have been able to accommodate 39 people to date and over 1,300 visits have been provided. The average duration individuals have received care for is 19 days before clients have moved on to the next stage of their recovery.

Based on the 14 patients who have remained at home:

- 2 Patients have become Independent
- 10 Patients Care Requirements decreased
- 5 Patients Care Requirements have remained the same

Based on the data so far the care needs at the end of the service are 40% less than the original assessment plan. This is in line with other IJBs that have tested similar models.

The next stage of the pilot will focus on the **Central** locality and will commence at the end of July 2018. This model proposed to enhance the existing model by have an integrated multi-disciplinary team of AHP's, Health Care Support Workers and Social Workers supporting people at home. This model will be targeting patients within the BGH who are resident within the Central Locality.

A report on hospital to home, will be brought to the August IJB, along with further update on both Craw Wood and Waverley Care Home step down models.

A short report this time as the last IJB was only a couple of weeks ago, but a busy couple of weeks.

Rob

Page 3 of 3

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: ..11 June 2018.....

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Jane Robertson, Strategic Planning and Development Manager
Telephone:	01835 825080

HEALTH AND SOCIAL CARE STRATEGIC PLAN 2018 - 2021

Purpose of Report:	The purpose of this report is to outline to the Integration Joint Board (IJB) the key changes made to the Health and Social Care Strategic Plan following review as well as seek IJB ratification of the refreshed version of the Strategic Plan (see Appendix 1).
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Ratify the refreshed version of the Strategic Plan. b) Agree the proposal to launch the plan as part of the SBC #yourpart campaign in August 2018.
Personnel:	None.
Carers:	Consultation with representatives from all key stakeholder groups via the Strategic Planning Group, Locality Working Group and other relevant Partnership fora.
Equalities:	Equality and Diversity Impact Assessment to be updated.
Financial:	None.
Legal:	This document proposes changes to the existing Health and Social Strategic Plan in line with proposals made by the Strategic Planning Group.
Risk Implications:	Risks are identified with the IJB Risk Register.

Background

In January 2018 the Strategic Planning Group (SPG) reviewed the existing Health and Social Care Strategic Plan (Appendix 2) and proposed a number of changes to the Plan. Proposed changes included:

- Produce a more concise document;
- Enhance the vision statement to reflect the relationship with communities;
- Reduce the number of local strategic objectives;
- Outline the key principles underpinning the objectives;
- Include commissioning and implementation as part of the Strategic Plan.

Update on Progress

Following identification of proposals for changes by the SPG, work has been progressed to refresh the Strategic Plan in line with these proposals. The IJB reviewed an initial draft of the refreshed Strategic Plan on 28 May 2018 and further changes have been made following receipt of comments received by IJB members on this date.

In summary, the document has been considerably reduced in size. This has been achieved by removing the following detailed information from the body of the document into a number of appendices:

- National Health and Wellbeing Outcomes;
- Services that are Integrated;
- Implementation Plan;
- Housing Contribution Statement 2018;
- The Scottish Borders - Profile and Key Challenges;
- Equalities;
- Partnership Governance - Summary of Role and Function;
- Health and Social Care Spending.

All appendices to the refreshed Strategic Plan can be seen in Appendix 3 of this report.

The number of objectives has been reduced from nine to three with a focus on keeping people healthy and well, improving service flow and managing health conditions. The refreshed strategic objectives are detailed below:

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

A number of key principles are outlined within the Strategic Plan which underpin all three high level objectives:

- Prevention and early intervention;
- Accessible services;
- Care close to home;

- Delivery of services within an integrated care model;
- Greater choice and control;
- Optimise efficiency and effectiveness;
- Reduce health inequalities.

The vision statement has been re-worded to reflect a stronger link with communities as well as emphasise the important role communities and the people living in them have to remain resilient, healthy and well. The refreshed vision statement is detailed below:

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

The latter section of the refreshed Strategic Plan includes information regarding how the Partnership will commission services to deliver the strategic objectives as well as detailing the Partnership resources available to support this.

Next Steps

Following ratification of the refreshed Health and Social Care Strategic Plan by the IJB the document will be produced graphically before publication on all Partnership websites.

It is proposed the refreshed plan is officially launched as part of Scottish Borders Council's #yourpart campaign in August 2018.

This page is intentionally left blank

Changing Health & Social Care for You

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

Draft Revised Strategic Plan 2018 – 2021

Scottish Borders Health & Social Care Partnership
Strategic Plan 2018-2021

Contents

Foreword

Whilst we should celebrate the fact that we are all living longer, we know we will all be putting more pressure on the services that look after us and our families.

Here in the Borders our over 65yr old population is due to increase by 47% in the next 14 years, and 121% for our over 85 year olds, hugely increasing demand on our health and social care services. We need to change the way in which we operate our services and help our citizens to help keep themselves in good health.

I am delighted to introduce this revision to our existing strategic plan. We have sought to offer a vision of a future where our health and social care services will be working in a new partnership with our communities and residents.

Joining NHS services with Council and third sector providers will eliminate duplication and support much more efficient use of resources for which demand is increasing. There is a great deal such a closer partnership can provide.

The bigger prize however is in the partnership between services and our citizens. We have a responsibility for ourselves, our children and our neighbours. To help create a healthier population, we all need to engage in improving health outcomes for our communities as well as ourselves. We can achieve this through good diet, exercise, early diagnosis and swift access to services all increases our likelihood of living longer and living well.

The Scottish Borders offers great opportunities for involvement in the widest ranges of activities which directly improve our health and the quality of our lives. This plan seeks to help everyone to gain access to these resources and in so doing reduce the strain on our services from an ageing population.

Type 2 Diabetes can be prevented through a healthy lifestyle. At present over 10% of NHS resource is spent on treating the symptoms that equates to more than £20,000,000 just here in the Borders. There is a great deal we can all do as individual citizens, to improve our own health outcomes. Working together and in partnership with our services, citizens can create a whole new health economy and promote healthier outcomes for the whole of the Border's population.

I look forward to joining with you in our challenge to create the Healthiest Region in Scotland.

Robert McCulloch-Graham
Chief Officer, Health and Social Care Integration
May 2018

Executive Summary

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

The Scottish Borders Health and Social Care Partnership first published its Strategic Plan in April 2016 following extensive consultation with people and communities across the geographical area to identify key priorities for health and social care in the Borders.

Following consultation nine local objectives were identified which reflected the health and social care priorities of the population in the Borders as well as supporting the delivery of the nine national health and well-being outcomes (Appendix 1).

Since then work has been underway to transform and target those health and social care services delegated to the Integration Joint Board (Appendix 2) to deliver on the local objectives within the context of a growing demand for services and increasing financial constraints.

Following the publication of the five Health and Social Care Locality Plans in April 2018 it was identified that the Scottish Borders Health and Social Care Strategic Plan would benefit from a refresh to ensure that the strategic objectives were fit for purpose and continued to reflect the priorities of the population and communities of the Scottish Borders.

This refreshed Strategic Plan outlines three refocused local strategic objectives and the key challenges on delivering these. The strategy also presents a high level summary of the continued case for transforming the way in which health and social care services are delivered in the Scottish Borders before outlining a plan for the resource and delivery of the strategic objectives (Appendix 3).

The Local Housing Strategy and The Housing Contribution Statement (Appendix 4) sets out the significant role of housing partners across the Borders in supporting the delivery of the Strategic Plan priorities.

Local Strategic Objectives

This document describes some of the actions we will take to start to make the shift towards more community-based NHS and social care services, the outcomes we will seek to achieve and the steps we will take to deliver our local objectives. We will describe some of the performance measures we will use to assess the progress we are making.

We have identified 3 Strategic Objectives:

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

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

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

The Partnership's local strategic objectives are shown in detail below and the information is not exhaustive. They are also aligned and contribute to the delivery of the nine National Health and Wellbeing Outcomes listed in Appendix 1.

Details of the Partnership's duties under the Equality Act 2010 can be seen in Appendix 5.

This high-level Plan will be supported by the implementation of Strategies related to specific themes such as Dementia, Mental Health, Carers and Locality Plans that reflect differing patterns of need across the Scottish Borders. The full Implementation Plan ("Plan and "Do" components of the Commissioning Cycle) is shown as Appendix 3.

OBJECTIVE 1: We will improve health of the population and reduce the number of hospital admissions

How?
• By supporting individuals to improve their health • By improving the range and quality of community based services and reducing demand for hospital care • Ensuring appropriate supply of good quality and suitable housing

We are committed to	Your part
• Helping older people manage their own health better, improve fitness and reducing social isolation • Supporting positive changes in health behaviour and lifestyle, such as smoking, diet, alcohol consumption and physical activity. • Adopting preventative and early intervention approaches where possible • Ensuring staff and carers have the necessary knowledge, skills and equipment to provide care at home. • Through patient education, encouraging the appropriate use of services and promote personal responsibility through public information and signposting. (Patient Education) • Continue to promote uptake of screening opportunities and immunisation programmes and raise awareness of signs and symptoms of health conditions • Implementing the Integrated Strategic Plan for Older People's Housing, Care and Support 2018-28	✓ Find out about health improvement programmes and initiatives in your area ✓ Use our Lifestyle Advisory Support Service ✓ Use our What Matters Hubs ✓ Comment on our draft Physical Disability Strategy ✓ Consider whether or not simple equipment could help a family member remain at home. Find out how to purchase or hire equipment. ✓ Get a copy of our Pocket Guide ✓ When offered ensure you take up Screening opportunities

What will success look like?

More adults say that they can look after their health very well or quite well	We see a reduced premature mortality rate per 100,000	We will see more projects that are funded through the integrated care fund evaluate positively and become mainstreamed
Less people are admitted to hospital as an emergency	Less people attend A&E	We spend more of our resources in the community (as opposed to on hospital stays)

OBJECTIVE 2: We will improve the flow of patients into, through and out of hospital

How?
• By reducing the time that people are delayed in hospital • By improving care/patient pathways to ensure a more co-ordinated, timely and person-centred experience/approach • By ensuring people have a greater choice of different housing options which meet their long-term housing, care and support needs

We are committed to	Your part
• Ensuring that people are admitted to acute services only when required and embedding the Rapid Assessment and Discharge (RAD) Team to ensure patients can return home quickly • Ensuring that those requiring hospital stays have a seamless and timely patient experience/journey • Providing short-term care and reablement to facilitate a safe and timely transition • Caring for and assessing people in the most appropriate setting • Providing an integrated approach to facilitating discharge • Review approach to housing adaptations to ensure a holistic approach is taken to meeting longer term needs of older people • Ensuring the reablement and hospital to home service development aligns with housing providers and care and repair services.	✓ Use our Pocket Guide to find out when to go to the Pharmacist, when to contact a GP and when to go to A&E ✓ Use the Voluntary Sector support that is available within your community ✓ Use our Hospital to Home service to get help and the support you need to regain your independence following a stay of hospital or a period of ill health ✓ Use the resources listed above to keep as fit, healthy and active as you can within your own community

What will success look like?

More people are seen within 4 hours at A&E	There are less unplanned admissions to hospital	More patients are satisfied with care and treatment, felt that staff understood what mattered and felt they had the information they needed to make decisions
Delayed Discharges		
Less people wait • over 72 hours • over 2 weeks	We analysed the reasons for delay to make improvements	The rate of occupied bed days (associated with delayed discharge) will reduce

OBJECTIVE 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them

How?

- By supporting people to manage their own conditions
- By improving access to health & social care services in local communities
- By improving support to carers
- Building extra care homes, including amenity and mixed tenure provision

We are committed to	Your part
• Piloting and evaluating the Buurtzorg Neighbourhood Care Model in Coldstream and extending it to other areas • Providing locally based Hubs which can be easily accessed by the community as the first point of contact for health and social care services • Develop integrated accessible transport • Use technology where appropriate to provide better home based health care services • Develop community based mental health care • Ensuring people have choice of control over the support they need and are supported to live independently in their own homes • Supporting carers and implementing the requirements of the Carers (Scotland) Act 2016 • Invest in social infrastructure, looking to harness the strengths of our own communities in developing capacity in care and support for family member and friends • Supporting an outcome-focussed approach across all areas • Improve access and signposting to services and information	✓ Use our What Matters Hubs as the first point of contact for health and social care services ✓ Community Transport Hub and SBC Community Transport ✓ As we develop the use of technology could you help us pilot new equipment within your own home ✓ Community Mental Health ✓ Use the Care and Repair Service provided in partnership with Eildon Housing Association to create a safer living environment ✓ Comment on our draft Physical Disability Strategy ✓ Borders Learning Disability Service ✓ Carers

What will success look like?

More people • are satisfied with the services they receive at home • have a positive experience of the care provided by their GP	More carers • feel supported • have a carers support plan	Increased proportion of care services will receive graded good (4) or better in Care Inspectorate Inspections
The rate of people readmitted to hospital within 28 days of discharge reduces	A high proportion of the last 6 months of life is spent at home or in a homely setting	The percentage of overall health and social care resource spent on community based services is maintained or increased

Key Priorities

Below are the Partnership priorities identified so far for 2018-21

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

Case for Change: Why we need to change

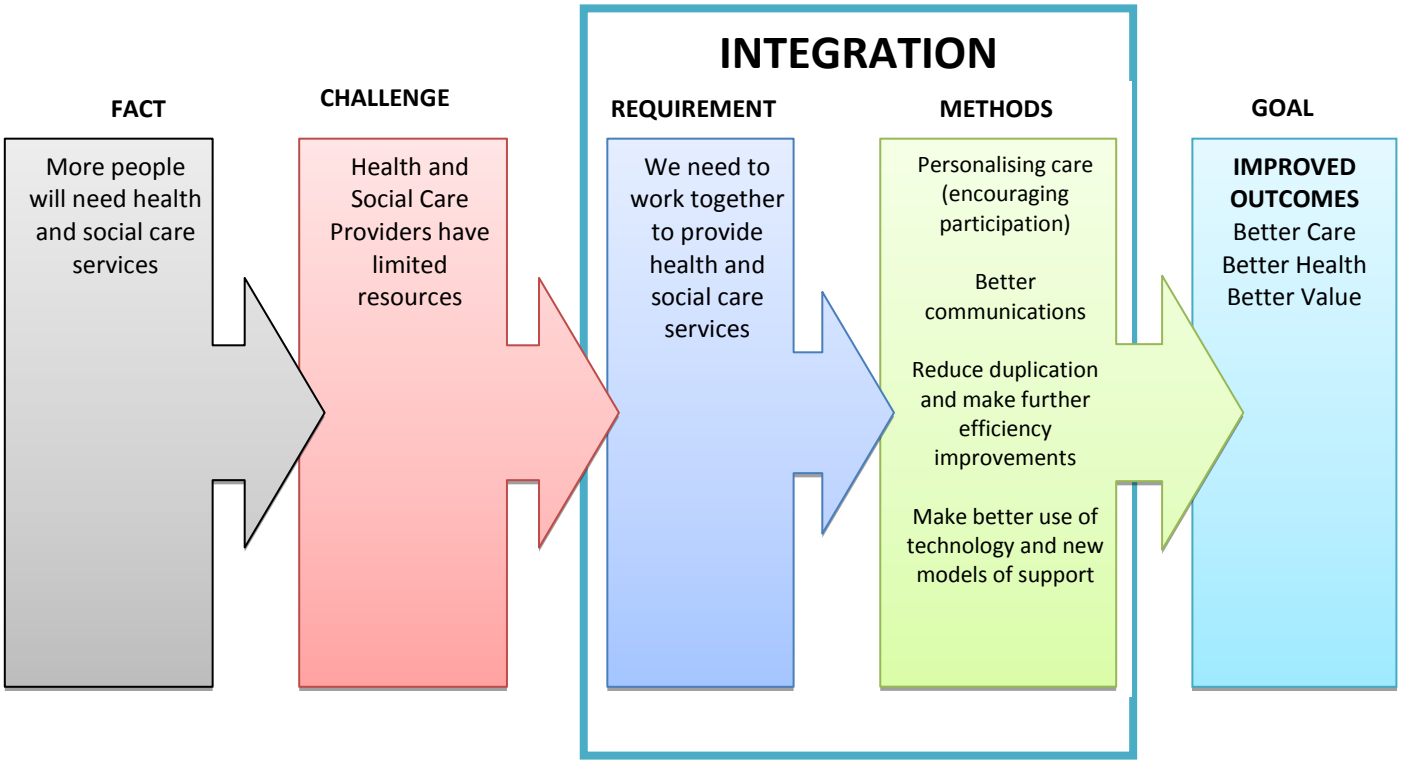
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in Figure 1 below and include:

- **Increasing Demand for Services** – with a growing ageing population, more people need our health and social care services and will continue to do so.
- **Increasing Pressure on Limited Resources** – the rise in demand puts pressure on our limited resources and this is happening at a time of constraint on public sector funding and rising costs of health and social care services.
- **Improving Services and Outcomes** – service users expect – and we want to provide – a better experience and better results.

We need to make better use of the people and resources we have by working more effectively together. If we do not change we will not be able to continue the high quality services the people of the Borders expect to meet their needs.

Figure 1 – The Case for Change



Key Challenges

In order to meet the challenges we face in terms of a growing population and greater demands on health and social care services the Partnership wish to support the people of the Scottish Borders to play their own part in staying healthy and well for as long as possible. Table 1 below outlines some of the ways in which individuals can take responsibility for their own health and wellbeing and support others to do the same.

Table 1

CHALLENGES	YOUR PART
We know the number of older people in the Borders is increasing therefore we need to promote active ageing.	You could you take up more gentle exercise in your local community.
The population of the Scottish Borders is spread over a large geographical area with many people living in rural locations therefore services need to be provided locally and accessible transport arrangements put in place.	You could find out about services at a local What Matters Hub.
Housing has an important role to play in the delivery of our integrated health and social care services.	You could choose to live in a house which meets your future needs and will help you to live independently for longer.
Many older people in Scottish Borders report poor health therefore we must promote healthier lifestyles, earlier detection of disease and support to recover and manage their conditions.	You could you eat healthier food, exercise more and reduce the amount of alcohol you drink in order to improve your health.
People with a disability need flexible support arrangements to maintain and improve their quality of life.	You could volunteer to help support someone with a disability.
We need to provide a range of support for people with dementia and their Carers, with appropriate training for all involved.	You could help to raise awareness of dementia within your local community.
We need to ensure there is high quality support available for the12,500 people aged 16 and over who are providing unpaid care in the Scottish Borders.	You could offer some support to an unpaid carer.
We need to continue to listen, involve, plan and deliver services across the 5 localities.	You could attend a local area partnership and participate in discussions on issues that affect you and your family.

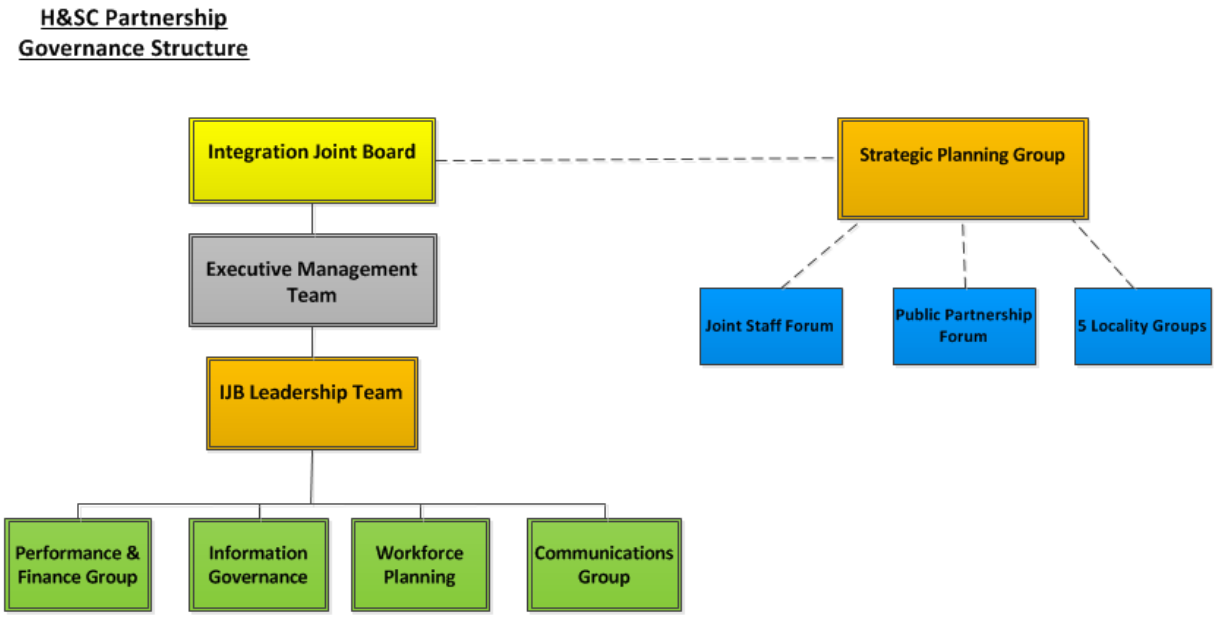
These challenges are supported by evidence related to the Scottish Borders area profile and key challenges presented in **Appendix 6.**

Commissioning

In order to successfully deliver the objectives of the Strategic Plan it is critical that required conditions for change are in place.

Leadership and Governance

Leadership and effective governance with the Integration Joint Board (IJB) and across the partner organisations is an essential factor in the successful integration of health and social care services. In the Scottish Borders the work of the IJB is informed by, and in turn informs, the strategic priorities of the two partnership bodies – Scottish Borders Council and NHS Borders.

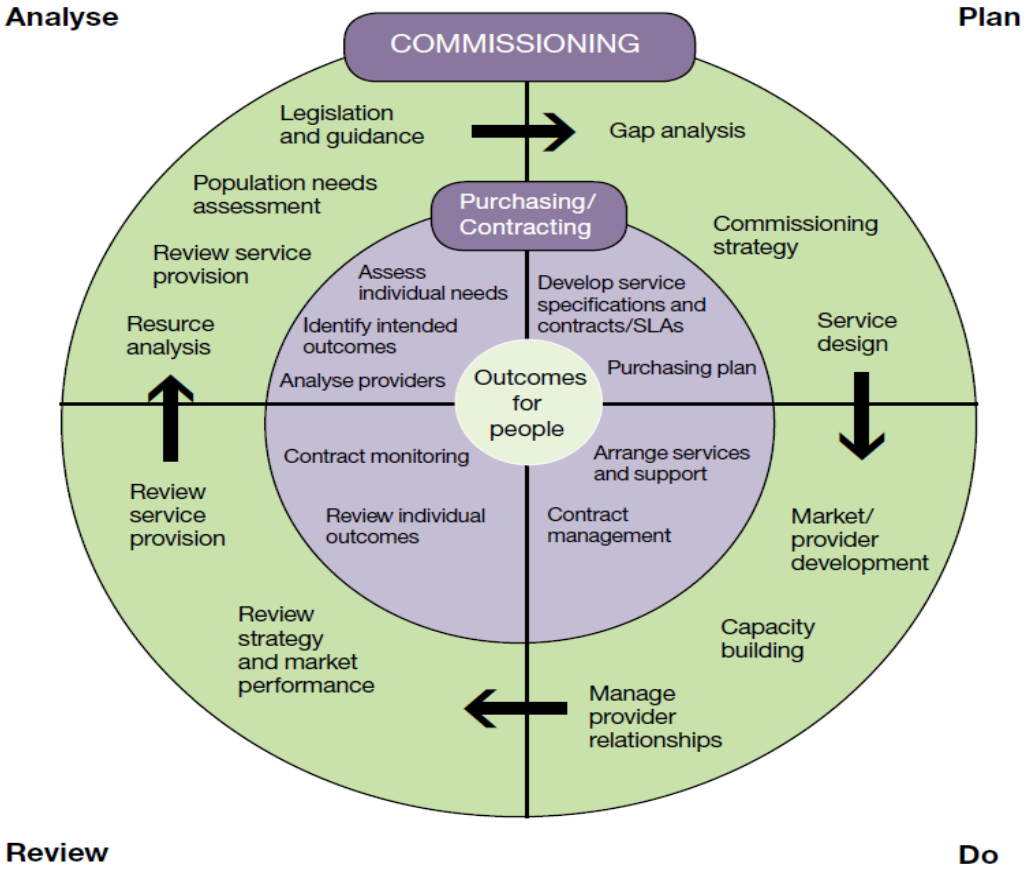


A summary of the role and function of each group can be seen in Appendix 7.

Strategic Procurement of Commissioned Services

Strategic procurement will support the delivery of commissioned services where delivery will be provided by a third party. In the Scottish Borders a clear emphasis will be placed on a number of key procurement ambitions including:

- procuring sustainbable, quality and affordable services through innovative approaches;
- engaging service users and providers in related activities and opportunities;
- building strong relationships with existing and new service providers;
- using available resources from partners and associated Centres of Expertise.



Strategic Commissioning Cycle

Locality Planning

Locality planning is a key tool in the delivery of change required to meet new and existing demands in the Borders. The IJB is required by the Scottish Government to undertake this activity through the development of locality forum arrangements, where professionals, communities and individuals can inform locality planning and redesign of services to meet local need in the best way. In the Borders we co-produced Locality Plans and established Locality Working Groups in each of the five localities.

Transformational Planning

Transformational change and a short, medium and longer term view is needed to meet the increasing pressures on health and social care services due to unprecedented and escalating demand within the context of financial constraints and legislative change. In the Borders we are delivering a Partnership Transformation Programme which outlines the transformation required across health and social care services now and in the future. The key identified areas for transformation currently include:

- out of hospital care programme focussing on
- community hospitals
- enablement
- allied health professionals and
- dementia
- strategic planning for older people housing, care and support

Also included in the transformation programme are:

- mental health redesign
- reimagining day services
- carers strategy
- redesign of alcohol and drugs services,
- ICT and telehealthcare
- localities and workforce planning

The Programme is currently under review to ensure that it is aligned not only to the revised Strategic Plan 2018 – 2021 and the delivery of the associated Financial Plan, but also with emerging ICF-funded projects and the Transformation Programmes of both NHSB and SBC.

Workforce Planning and Development

Improvements are dependent upon best workforce planning. Staff must be deployed in the right places, with the correct skills and in appropriate numbers. Importantly, there must be a shared vision across the partnership organisations of what integration will look like and why it is important. In the Scottish Borders we have developed a draft Joint Workforce Plan.

Evidencing Improvement

A robust appraisal process is essential to ensure services are efficient and cost effective and that resource decisions are equitable and justifiable. A key component of this is an evidence based review programme. In the Scottish Borders we have developed an Integrated Performance Management Reporting process, which continues to evolve and develop over time.

Communication and Engagement

Sustainable change requires robust communication within and outside of the key organisations. In the Scottish Borders, our aproach to communication is clearly described within our Health and Social Care Partnership Communication Strategy with meaningful engagement and consultation with people living and working in the Scottish Borders underpinning the approach to communication.

Strategic Priorities

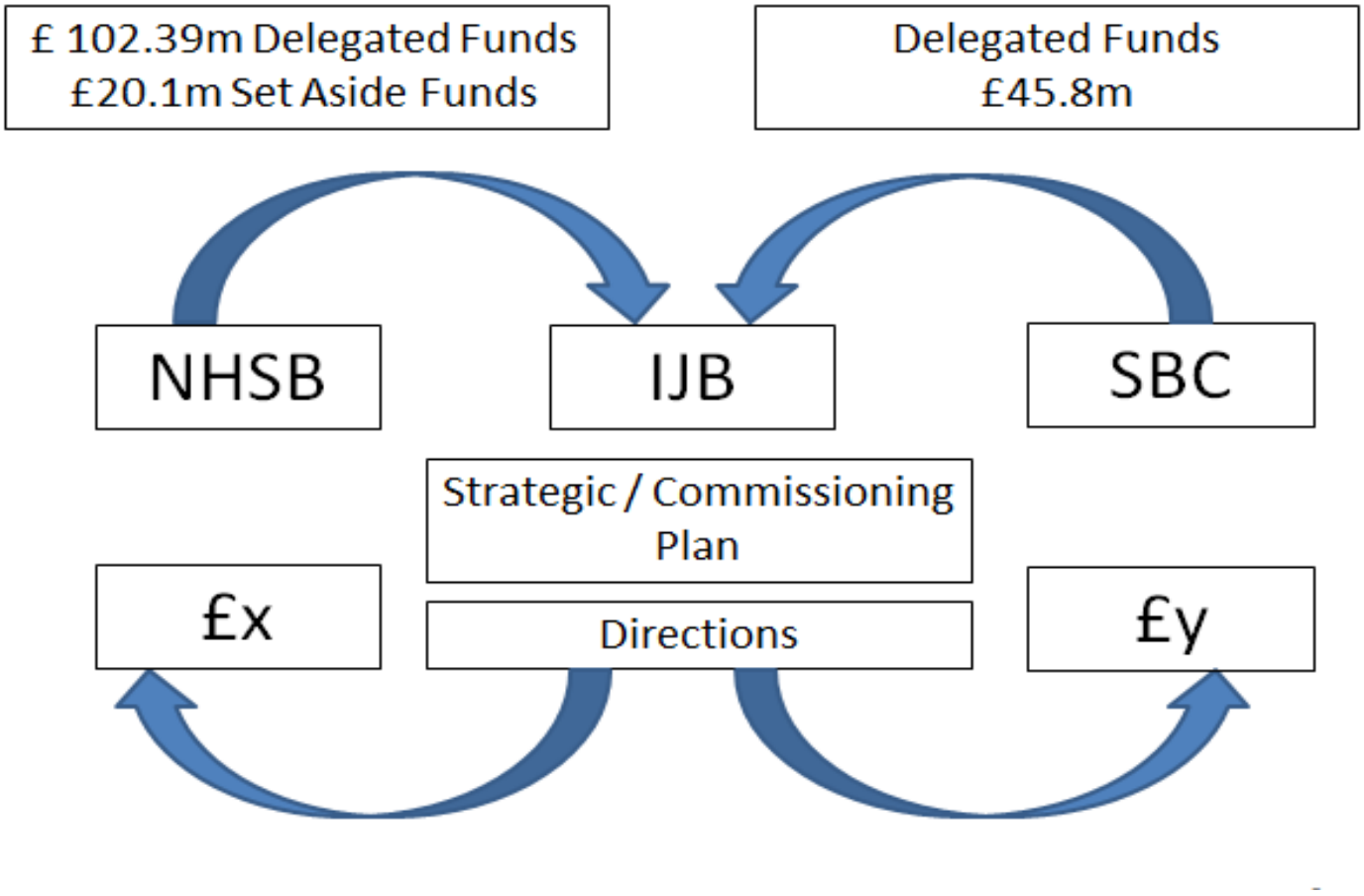
Strategic priorities - or areas for action to achieve sustainable quality in service delivery - do not sit independently and improvement in one area will positively impact upon another. Whilst there is no material increase in main stream budgets over the life of the plan additional investment has been enabled by the Scottish Government Integrated Care Fund Allocation. The overarching goal of the IJB is to create a single system for the planning and delivery of services with a locality focus in order to drive home change across identified priority areas.

Partnership Spending

In April 2018 the Scottish Borders Health and Social Care Partnership agreed its Financial Plan for 2018/19 comprising of:

- The Delegated Budget i.e. the sum of payments to the Integration Joint Board from (IJB) partners (SBC £45.8m, NHSB £102.39m)
- The amount set aside by NHS Borders for large hospital services used by the IJB population (£20.1m Set Aside Funds)

The IJB agrees its Strategic Commissioning Plan and decides how it should allocate funds to NHS Borders and SBC. Where there is significant change the IJB will issue a new Direction alongside a budgetary allocation to either or both NHSB and SBC. The diagram below illustrates this:



Whilst the IJB budget of £168m has increased by almost £1m from 2016/17, a significant increase in demand and pressures will mean efficiencies are required to be delivered in 2017/18 to live within the delegated resource.

Based on the known demographics of the Scottish Borders, the estimated future need for health and social care services, the expressed local ambitions for health and social care services and the knowledge of available resources, funding for the following strategic objectives for the Scottish Borders Health and Social Care Partnership have been identified:

Local Strategic Objectives	Planned Spend 2018/19
1. **We will improve the health of the population and reduce the number of hospital admissions**	
2. **We will improve patient flow within and out with hospital**	
3. **We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them**	
	**Integrated Care Fund**

The integrated Care Fund (ICF) has been used to enable the shift in health and social care services from hospital to community and outreach. This has resulted in a decrease in hospital admissions and increase in alternatives to hospital care. A detailed on plan on how the partnership will deliver on its strategic objectives within agreed resource can be seen in Appendix 8.

This page is intentionally left blank

Scottish Borders **Health & Social Care** Partnership

Scottish Borders
Health and Social Care
PARTNERSHIP

changing health & social care for you

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

strategic plan 2016 -19

CONTENTS

SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP STRATEGIC PLAN

*This document is referred to in our legal "Scheme of Integration" document as the Strategic Commissioning Plan.

FOREWORD

People are living longer than ever and this trend is set to continue. This is something that we should all celebrate. It means that we need to plan ahead, both as communities and as individuals, to ensure that we, in the Borders, make the most of the benefits and positive experiences of a long healthy life. This Plan sets out why we want to integrate health and social care services, how this will be done and what we can expect to see as a result. We want to create health and social care services that are more personalised and improve outcomes for all our service users, their Carers and their families.

This is our first Strategic Plan as a new Health and Social Care Partnership (HSCP). This Plan builds on the progress that has already been made by NHS Borders, Scottish Borders Council and our partners to improve services for all people in the Scottish Borders.

This Plan is based on what we have learned from listening to local people; service users, Carers, members of the public, staff, clinicians, professionals and partner organisations. From April to December 2015 we engaged on the first and second consultation drafts of the Plan through workshops and local events across the Borders.

We believe that through strong leadership, innovative thinking, robust planning and by putting the views of patients, service users and Carers at the heart of all that we do, we can achieve our ambition of "Best Health, Best Care, Best Value" for our communities. We will make sure that strong and effective relationships continue to develop between Scottish Borders Council and NHS Borders, colleagues in the Third and Independent sectors and with other key partner organisations. The aim is that we plan, commission and deliver services in a way that puts people at the heart of decision-making.

Together, with you, we know we can make a real difference.

Susan Manion
Chief Officer Health and Social Care Integration
March 2016

EXECUTIVE SUMMARY

This Plan sets out what we want to achieve to improve health and well-being in the Borders through integrating health and social care services.

The case for changing the way we deliver health and social care services in the Borders is compelling. We have a growing number of people needing our services, but limited resources with which to deliver them. These services could be provided more effectively and efficiently if they are integrated. We want to achieve better outcomes for all our communities. The Borders is largely a remote and rural area. There are five Area Forum localities in the Borders, which have individual characteristics and therefore different needs. This makes delivery of services complex. About a quarter of the households in the Borders are composed entirely of people aged 65 and over. This age group has a greater need for our services. The growing number of people with dementia is a big challenge.

Deprivation is an issue in the Borders. Although it may only seem to affect a small number of communities, it is often hidden in rural areas. Research indicates that people from deprived areas are more likely to make greater use of hospital and other health and social care services. Health inequalities exist beyond deprivation and we need to take into account that some people have different health outcomes. As an example, people with mental health issues or a learning disability tend to have poorer health outcomes. This plan contains actions to address such issues. It also sets out our local objectives, which will enable us to achieve the nine national health and well-being outcomes.

This Plan sets out a high level summary of some of what we will do when working together to deliver more personalised care, making best use of advancing technology to achieve "Best Health, Best Care, Best Value". This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

CASE FOR CHANGE: WHY WE NEED TO CHANGE

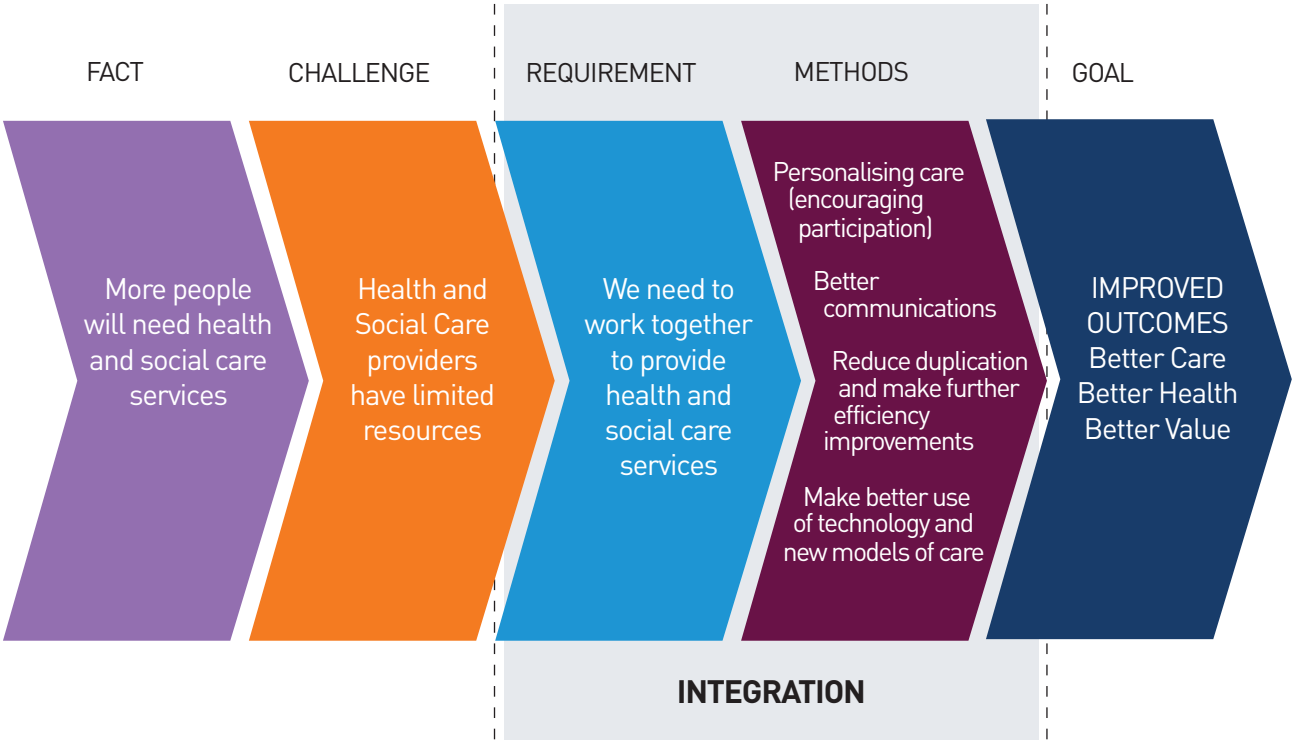
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in the figure below and include:

- **Increasing Demand for Services** – with a growing ageing population, more people need our health and social care services and will continue to do so.
- **Increasing Pressure on Limited Resources** – the rise in demand puts pressure on our limited resources and this is happening at a time of constraint on public sector funding and rising costs of health and social care services.
- **Improving Services and Outcomes** – service users expect – and we want to provide – a better experience and better results.

We need to make better use of the people and resources we have by working more effectively together. If we do not change, we will not be able to continue the high quality services the people of the Borders expect to meet their needs.

FIGURE 1 – THE CASE FOR CHANGE



THE SCOTTISH BORDERS: A SUMMARY PROFILE AND SOME OF OUR KEY CHALLENGES

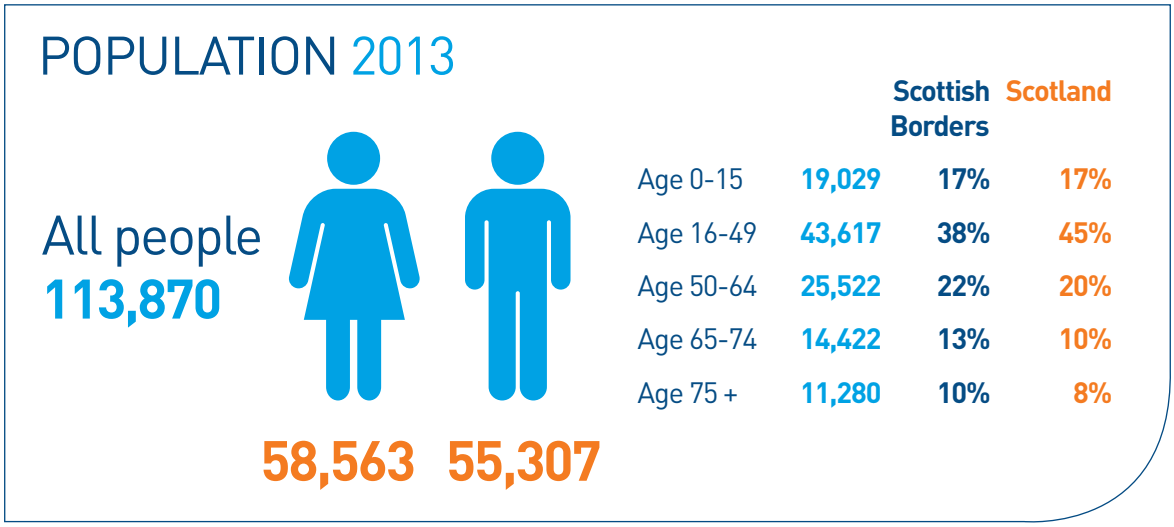
This section of the Plan gives a high level summary profile of the Scottish Borders and some of our key challenges. More detailed information is also available in two further documents published alongside this Plan – Facts and Statistics, and the Joint Strategic Needs Assessment.

Who Lives in the Borders?

Understanding the needs and issues of people and communities across the Borders is critical in the planning and provision of better health and social care services. In this section, we look at how the population structure and characteristics impact on health and social care services. This highlights some of the challenges we need to address.

As the figure below shows, we have a higher percentage of older people than the rest of Scotland.

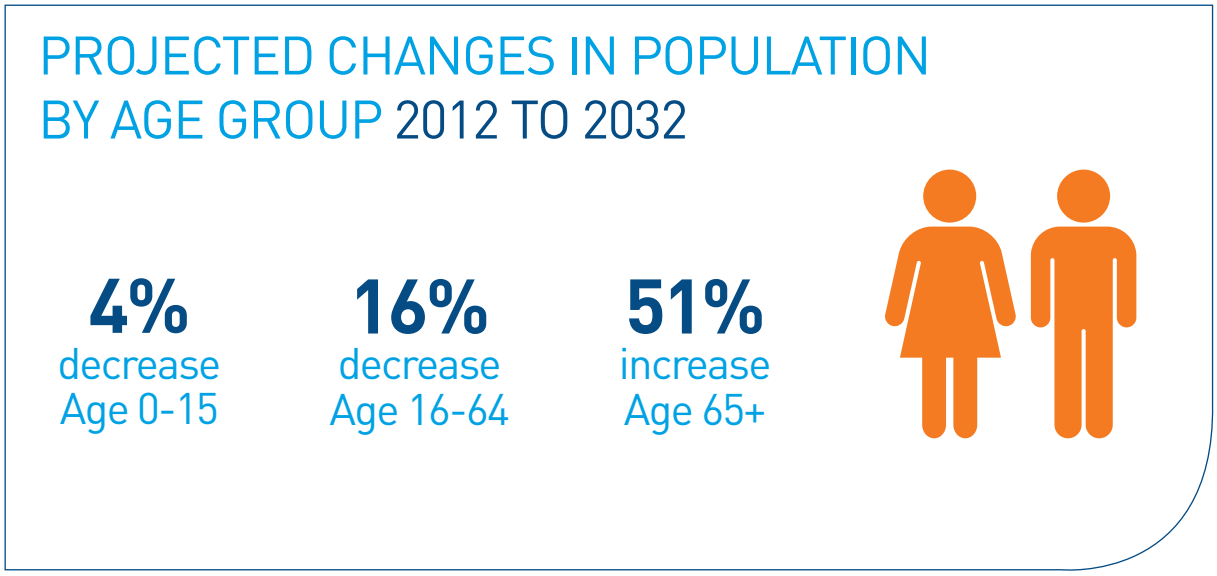
FIGURE 2



Source: National Records of Scotland, mid-year population estimates.

By the year 2032, the number of people aged 65 and over is projected to increase by 51%, a faster rate than the 49% for Scotland overall. The number of people under 65 is also projected to decrease in the Scottish Borders. Age is strongly related to patterns of need for health and social care. These changes will influence how we deliver services in the future. Integration will enable us to work more effectively and efficiently to achieve "Best Health, Best Care, Best Value".

FIGURE 3



Source: National Records of Scotland 2012-based population projections

WHAT THIS MEANS...

This is a priority. We need to promote active ageing and address the range of needs of older people.

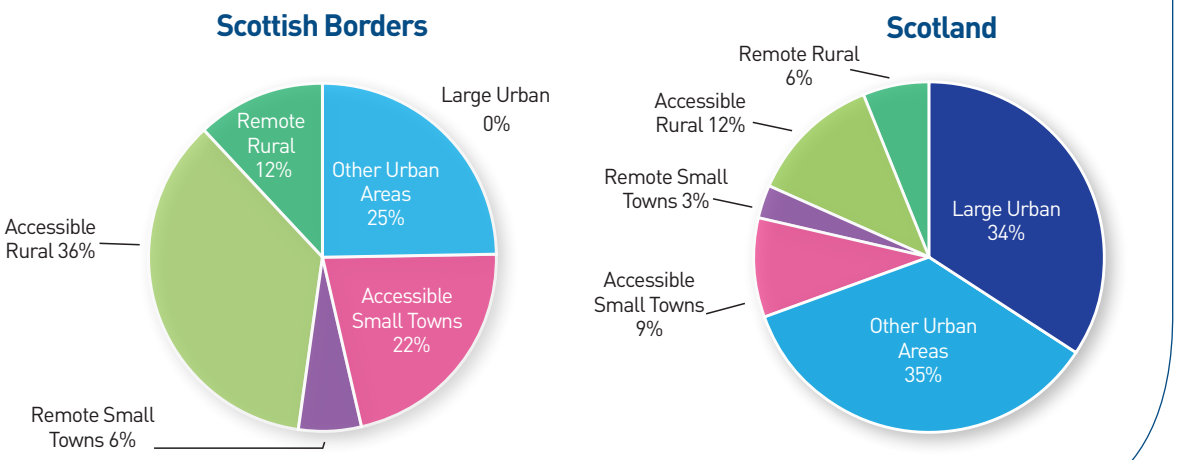
Where do people live?

The Urban/Rural profile of the Borders presents challenges in terms of both the accessibility and cost of services. The challenges are different in nature to those facing densely populated cities such as Glasgow, Edinburgh and Dundee.

In the Borders nearly half (48%) of the population live in rural areas, as shown in Figure 4. Just under one-third of people live in settlements of fewer than 500 or in remote hamlets, in contrast to 34% of the Scottish population who live in "Large Urban" areas (part of towns/ cities with populations of more than 125,000). Our main towns are Hawick (with a population of 13,696 in 2013) and Galashiels (population 12,394), which come under the Scottish Government classification of "Other Urban Areas". Peebles, Kelso and Selkirk are the only other towns with a population of more than 5,000. As people in the Borders do not live close together in cities, planning services is more challenging.

FIGURE 4

POPULATION SHARES (%) BY URBAN/RURAL AREA 2012



Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland

Category	Description
1 Large Urban Areas	Settlements of 125,000 or more people.
2 Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or

WHAT THIS MEANS...

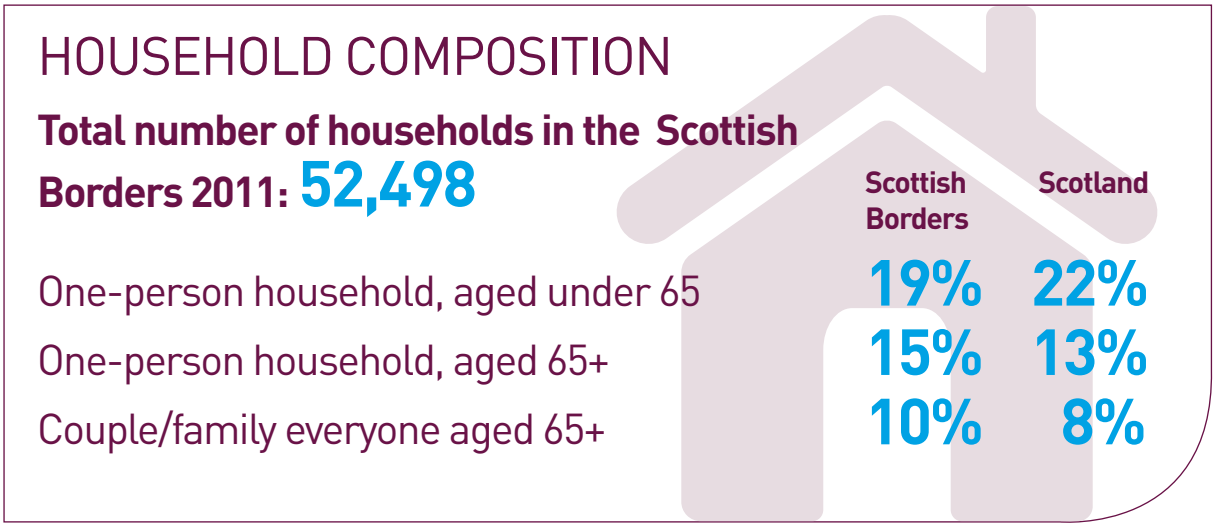
Services therefore need to be provided locally whenever possible and accessible transport arrangements put in place.

Borders Households

With the changes predicted in the population (see Figure 3 on page 7), we expect an increase in the numbers of older people living alone with complex needs. This will have major implications for housing, health and social care.

More than one third of households in the Borders are made up of one adult. The number of households in the Borders in which one or all occupants are aged over 65 is 25%, higher than the 21% for Scotland as a whole.

FIGURE 5



Source: Scotland Census 2011

The number of single adult households is projected to increase by 24% between 2012 and 2037, whilst the number of larger households is projected to decline. Households headed by people aged 60-74 are projected to increase by 9% and those headed by a person aged over 75 are projected to increase by 90%.

WHAT THIS MEANS...

Housing options need to be a key feature of our integrated health and social care services. Our existing Local Housing Strategy (2012-2017) and Housing Contribution Statement (2016) set out our work in relation to housing in more detail. An updated strategy will be in place in 2017.

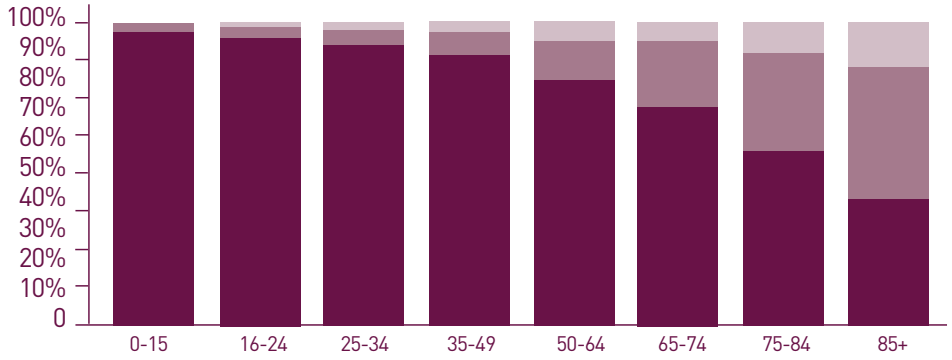
How Do People in the Borders View Their Health?

In general, people in the Scottish Borders enjoy good health, with 84% considering their health to be 'very good or good'; 12% of respondents consider themselves in 'fair' health, while 4% think their health is 'bad or very bad'.

The graph below shows that the number of people who consider their health to be 'very good or good' decreases with age. For example, more than 1 in 10 people aged over 75 reported their health as being 'bad or very bad', compared with only around 1 in 100 people aged 16-24.

FIGURE 6

SELF REPORTED GENERAL HEALTH
AMONGST SCOTTISH BORDERS RESIDENTS



Source: Scotland Census 2011

WHAT THIS MEANS...

We must enable people to keep well as long as possible through promoting healthier lifestyles, earlier detection of disease, and support to recover and manage their conditions.

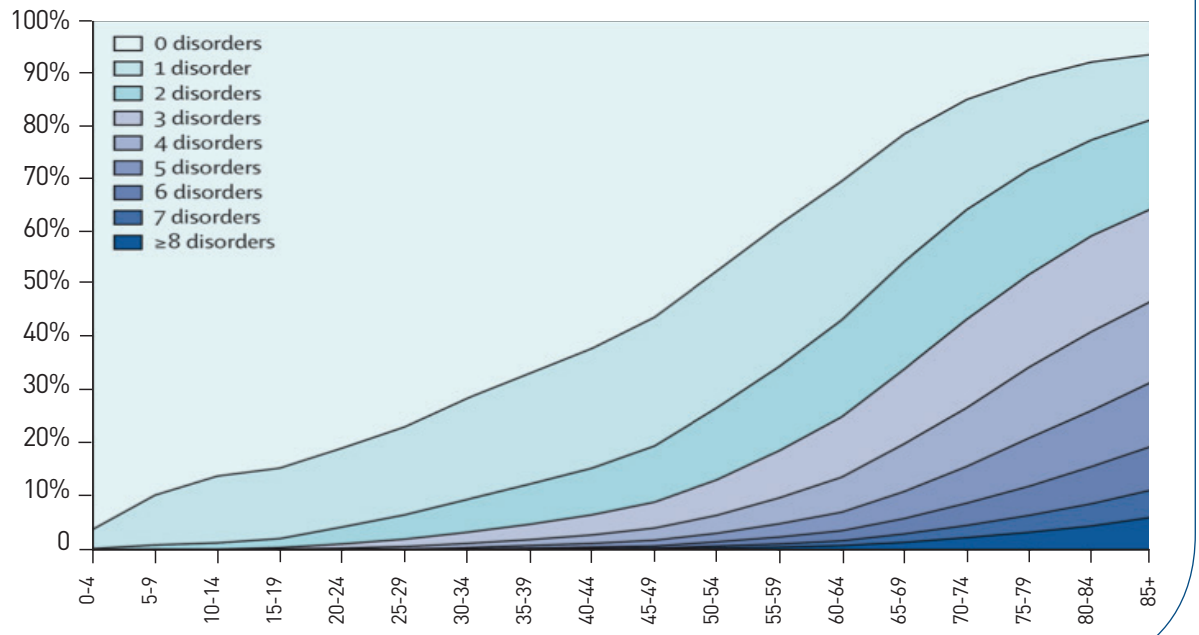
People Living with Multiple Long Term Conditions

We know that many people in the Borders live with one or more long-term conditions. This may affect how they access and use services. We need to make sure that services are integrated to support individuals with complex needs, to enable them to manage their conditions to lead healthy, active and independent lives as long as possible.

The number of people living with two or more long-term conditions rises with age as illustrated in Figure 7. For example, nearly two thirds of patients aged 65-84 and more than 8 in 10 patients aged over 85 had multi-morbidity. This presents a significant challenge to plan and deliver health and social care services.

FIGURE 7

PERCENTAGES OF PEOPLE HAVING ONE OR MORE LONG-TERM CONDITIONS, BY AGE GROUP, SCOTLAND 2007



Source: Barnett et al (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/abstract

Disability

The needs of people living with disabilities and sensory impairments are distinct from those who live with one or more health conditions. According to the 2011 Scotland Census, 6,995 people in Borders live with a physical disability. We have at least 555 people aged over 16 in our population who have a learning disability. About 2,300 people are estimated to have severe sensory impairment.

WHAT THIS MEANS...

People with a disability need flexible support arrangements to maintain and improve their quality of life.

It is estimated that around 500 people in our population are blind or have severe sight loss, while 1,800 people have severe or profound hearing loss. The National Health and Wellbeing Outcomes focus on people having a positive experience and their dignity respected when in contact with health and social care services, and that services are to be centred on helping maintain and improve the quality of life of people who use those services. This means that we must ensure services are accessible and easy to use by people with sensory impairment.

At the time of the 2011 Scotland Census, 612 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Learning Disability. 485 people in this group (81%) were aged 16 or over in 2011. Meanwhile, the total number of adults with Learning Disabilities known to Scottish Borders services is higher than the figures captured through the Census. As at March 2014, 599 people aged over 16 with Learning Disabilities were known to Scottish Borders services, of which 555 had confirmed addresses in the area.

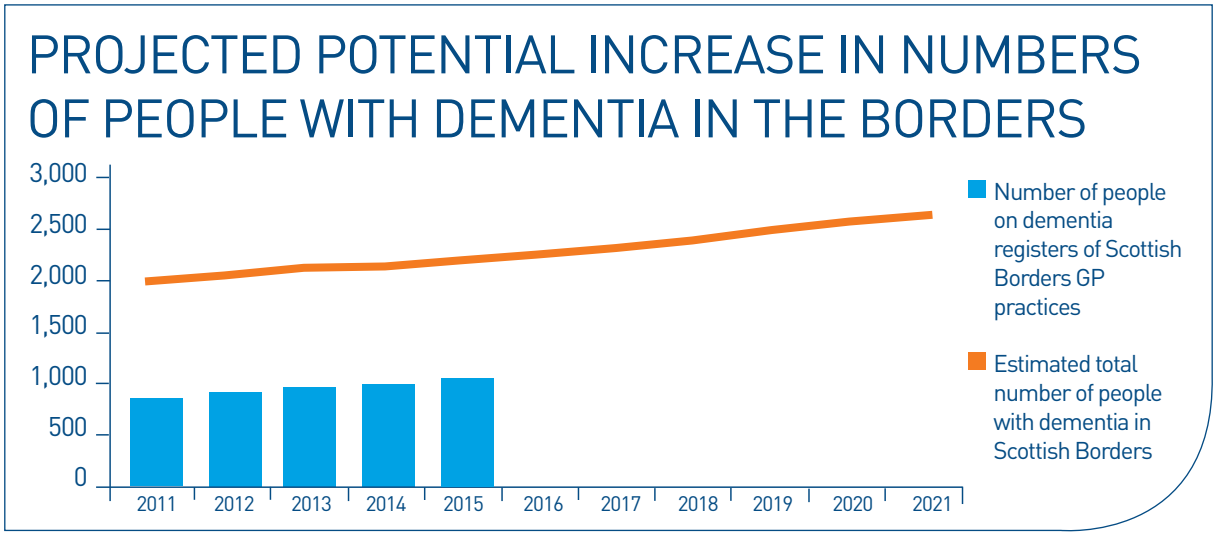
Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than that provided by mainstream Health and Social Care services. As part of the Learning Disability governance structure, people with learning disabilities and family Carers have places at the Partnership Board table to help inform decision making and strategic direction. Locality citizens' panels throughout the Borders provide opportunities for conversations between the Learning Disability Service and people directly affected by learning disabilities. A local area coordination service supports people to be more involved in their local communities.

Around one in four Scottish adults will experience at least one diagnosable mental health problem every year, and we are all likely to experience poor mental wellbeing at some point in our life. Due to the stigma related to mental illness, many will not access treatment and tend to have poorer health outcomes. Mental Health Services are in the process of developing integrated teams to provide easy access and multi-agency support to people with mental health needs. A full mental health needs assessment has been completed and this will help shape how we plan services in the future.

Dementia

Dementia is a growing issue and represents a challenge for planning and providing appropriate integrated care. The number of people living with dementia is projected to increase across Scotland, however the rate of increase in the Borders may be faster than the Scottish average as our population is older. Figure 8 below shows the number of people diagnosed with dementia in the Borders (shown in blue bars). For a number of reasons, including difficulties in diagnosis, the actual figures of people living with dementia are likely to be higher. The red line shows the likely number of people and how this number is predicted to increase over time as the population ages.

FIGURE 8



Source: 1. Diagnosed cases: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof 2. Estimated overall numbers of cases: Scottish Government projection, based on 'Eurocode' prevalence model used by Alzheimer's Scotland, and 2010 - based population projections.

WHAT THIS MEANS...

A range of support needs to be provided for people with dementia and their Carers, with appropriate training for all involved, to provide care across all settings.

People Living with Complex and Intense Needs

Health and Social Care resources are not utilised evenly across the population, as illustrated in the box below. As a Partnership, we need to develop a better understanding of the people who use very high levels of resource and use this knowledge to help plan our services more effectively. For example, where someone has had multiple hospital admissions and/or visits to A&E, it might have been more appropriate to deliver more of their care at home or in another community setting and reduce the risk of them having an avoidable admission to hospital. Changes in how care is provided to these people could produce better outcomes for them and allow us to treat more people more effectively.

Work to support people living with complex and intense needs will include:

- Identification of the main factors that increase the risk of emergency admission or re-admission to hospital;
- Use of this information to help strengthen our responses to patients and service users earlier on, and
- Exploration of alternative models of care.

USE OF HEALTH AND SOCIAL CARE RESOURCES: AN EXAMPLE

Analysis of expenditure in 2012/13 showed that:

- 2,332 people (2.5% of all Scottish Borders residents using selected major health services*) accounted for half of all expenditure on those services.
- 1,451 people aged 65 and over (7% of Scottish Borders residents aged 65+ who used any of the selected health services) accounted for half all expenditure on people aged 65 and over across those services.

*Health Services included in the analysis were: A&E attendances, inpatient and day case hospital admissions (all specialties), new attendances at consultant-led outpatient clinics, and community prescribing.

Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

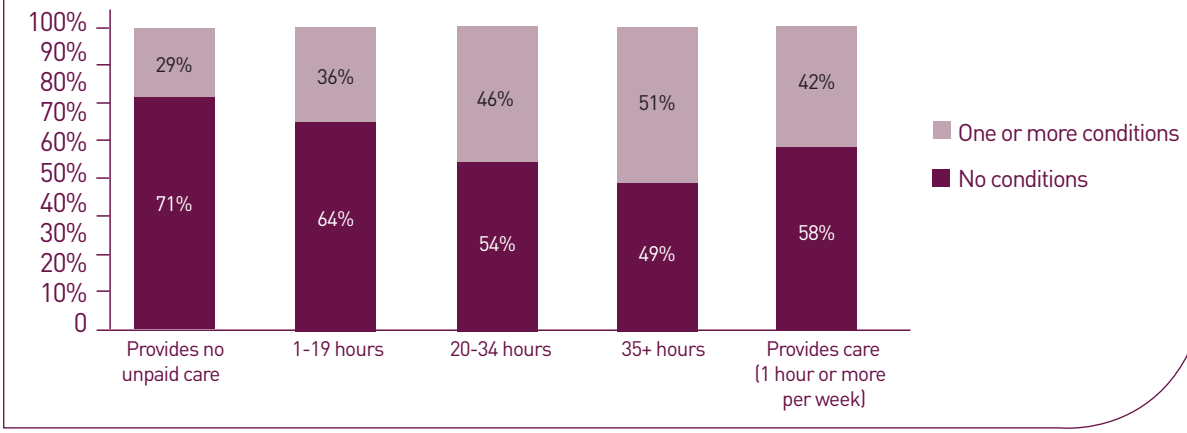
Carers in the Borders

Health and Social Care Services are dependent on the contribution of Carers*. In the Borders, approximately 12,500 people aged 16 and over provide unpaid care, around 13% of people in this age group.

The burden of caring is greater in more deprived areas. 46% of Carers living in the most deprived areas of the Borders provide 35 or more hours of care per week, compared with 22% of Carers living in the least deprived areas. Research also indicates that providing care for someone else often affects the Carer's own health – and Carers are often themselves older people with one or more long term conditions. More Carers (42%) than non-Carers (29%) have one or more long-term conditions or health problems. Of people providing more than 50 hours of unpaid care per week, 13% rated their own health as 'bad or very bad' compared with 4% of people who were not Carers.

FIGURE 9

PERCENTAGE OF CARERS WITH ONE OR MORE LONG-TERM HEALTH CONDITIONS, 2011, BY WEEKLY HOURS OF CARE THEY PROVIDED



Source: Scotland Census 2011 / Scotland's Carers (Scottish Government, March 2015).

WHAT THIS MEANS...

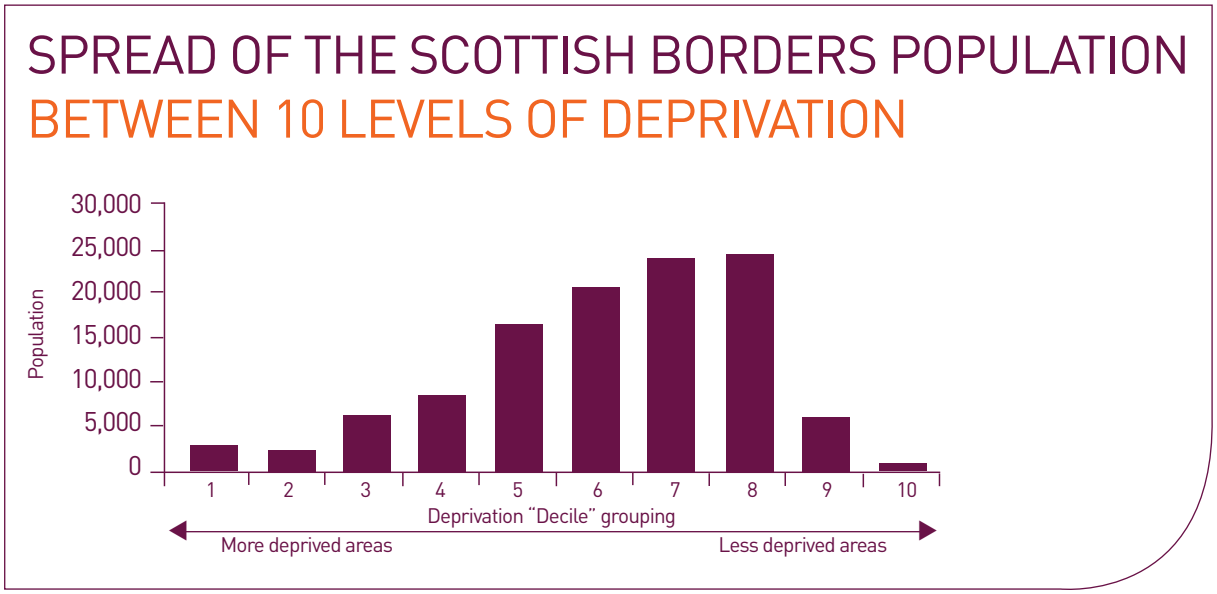
A range of easily accessible information and available support needs to be a key priority to ensure the wellbeing of Carers.

*Carers are individuals who care for a friend, relative or neighbour without receiving paid income in addition to income received through the benefits system. (Definition source: Care 21 Report: The future of unpaid care in Scotland. www.gov.scot/Publications/2006/02/28094157/0).

Deprivation in the Scottish Borders

Deprivation has a big effect on the need for, and use of, health and social care services. Taken as a whole, levels of deprivation in the Borders' population are relatively lower in comparison to Scotland. Figure 10 below shows the spread of our population between 10 different categories of deprivation (with 1 being the most deprived and 10 being the least deprived). If our deprivation profile were the same as Scotland's, we would see about 10% of our population in each category. What we see instead is an uneven distribution, with clearly less than 10% of our population living in the most deprived areas. However, some of our more urban areas - in Burnfoot (Hawick) and Langlee (Galashiels) - continue to show as amongst the most deprived in Scotland.

FIGURE 10



Source: Scottish Borders Strategic Assessment 2014

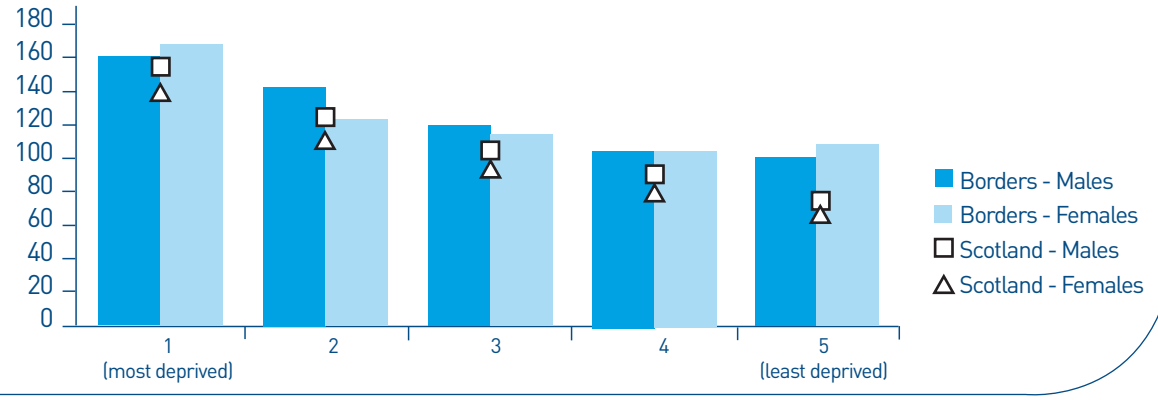
We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

An example of how the use of health and care services varies by deprivation is shown in Figure 11 below. The Borders follows the national pattern of having higher emergency hospital admission rates for people living in areas of higher deprivation. The figure also shows that emergency admission rates in the Borders are higher than the Scottish average within any given deprivation grouping.

A report on deprivation-related hospital activity noted: "Given that people at increased risk of health inequalities make proportionately greater use of acute and community health services, hospitals offer an important opportunity for health improvement actions to reduce health inequalities". The need for health and social care services to contribute to reducing health inequalities is the focus of the Scottish Government's National Health and Wellbeing Outcome number 5 (see Appendix B).

FIGURE 11

EMERGENCY HOSPITAL AGE-STANDARDISED ADMISSION RATES PER 1,000 POPULATION, BY 5 DEPRIVATION LEVELS 2011/12



Source: NHS Health Scotland (March 2015) Hospital discharges and bed days in Scotland by deprivation 2011-12.

WHAT THIS MEANS...

The Strategic Plan and Locality Plans that we will be developing in 2016 must reflect the local needs of communities, recognising patterns of deprivation and inequality. These plans will cross-reference with work already being developed under our Reducing Inequalities Strategy.

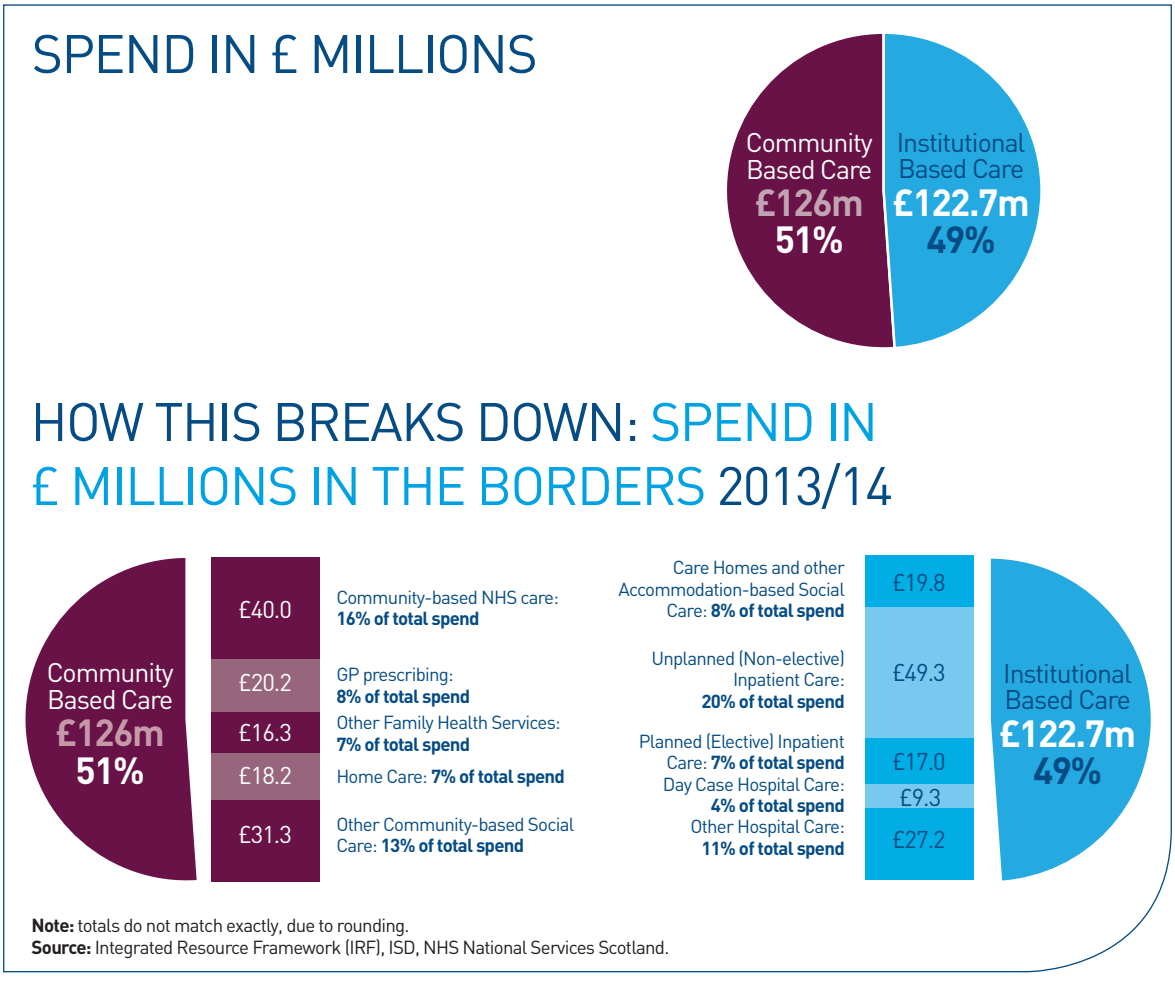
HEALTH AND SOCIAL CARE SPENDING

The total NHS and social care spending in the Borders in 2013/14 was £248.7m. All NHS services are included in this total – including health services that are not covered by integration (such as planned outpatient and inpatient care). The overall spending was split 51% Community-Based Care versus 49% Institutional Care.

- Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.
- Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.

The Borders has already made significant progress towards the aim of providing more care in the community compared with Scotland as a whole, where the split was 44% on Community-Based Care versus 56% on Institutional care.

FIGURE 12



Note: totals do not match exactly, due to rounding.
Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

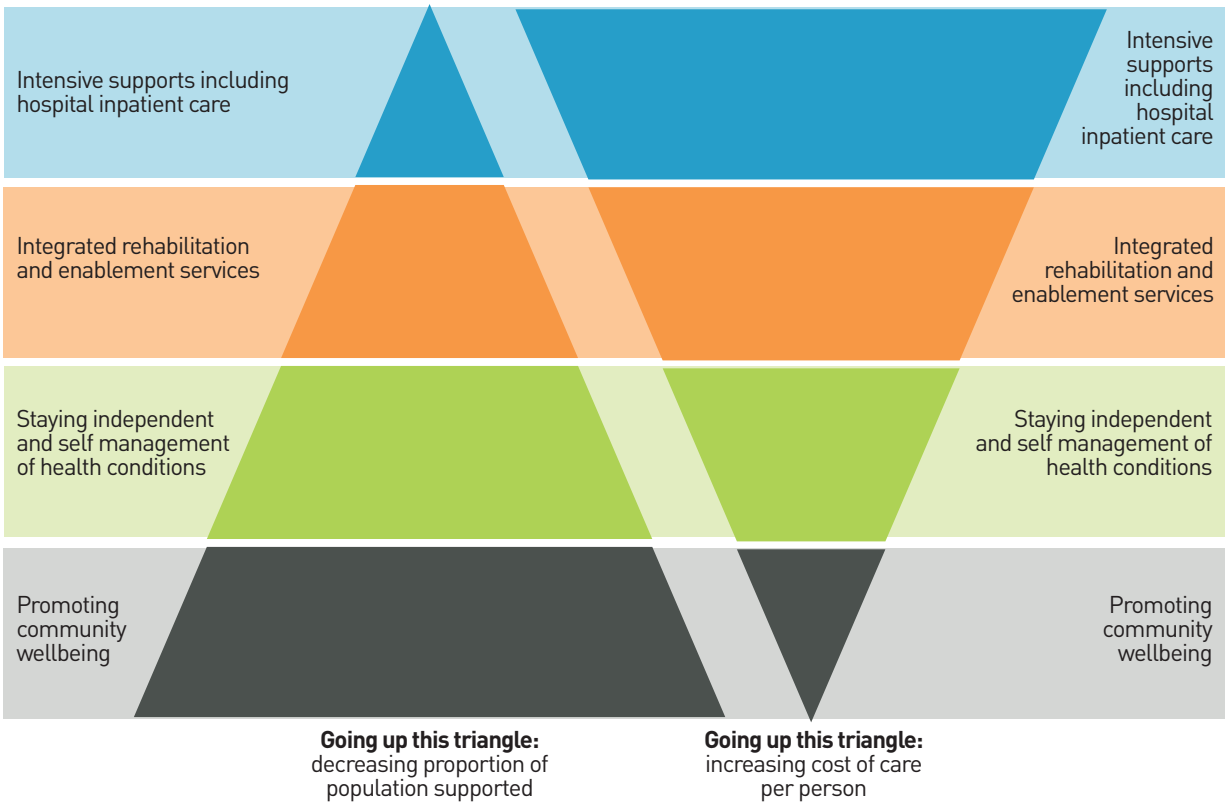
Shifting the Balance of Care Towards Prevention and Early Intervention

The aim of integrated health and social care services is to shift the balance of care towards prevention and early intervention to ensure that individuals have better health and well-being. Services need to be redesigned around the needs of the individual, to:

- Ensure that their journey through their care and treatment is as integrated and streamlined as possible;
- Enable them to remain independent for as long as possible; and
- Support them to recover after illness and at times of crisis.

In Figure 13 below, services that promote health and well-being are shown at the bottom of each triangle, whilst intensive support services (such as acute hospital inpatient care) are shown at the top. The triangle on the left shows that a small number of people need the intensive support and care provided within hospital. However the triangle on the right shows that this small group of people use a large amount of total resource available for health and social care.

FIGURE 13
CURRENT CARE MODEL

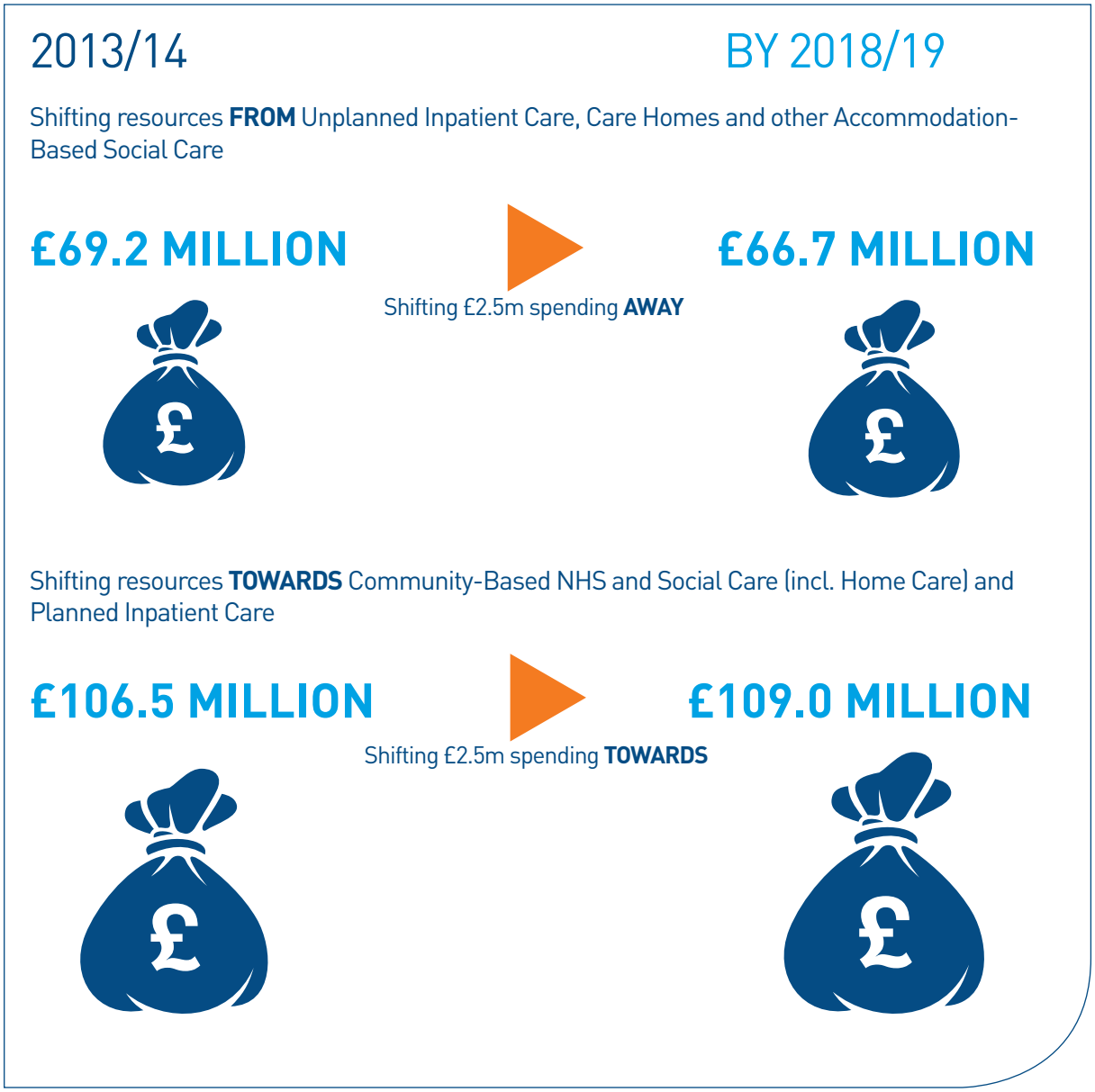


If we are able to improve health and wellbeing through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in Figure 14.

What shifts do we need to make?

By shifting just 1% of our total spend of approximately £250m FROM Unplanned Inpatient Care and Institutional-Based Social Care TOWARDS Community-based NHS and Social Care and Planned Inpatient Care, we will use our resources more effectively. This will help us invest in new integrated ways of working particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting Carers and independent living.

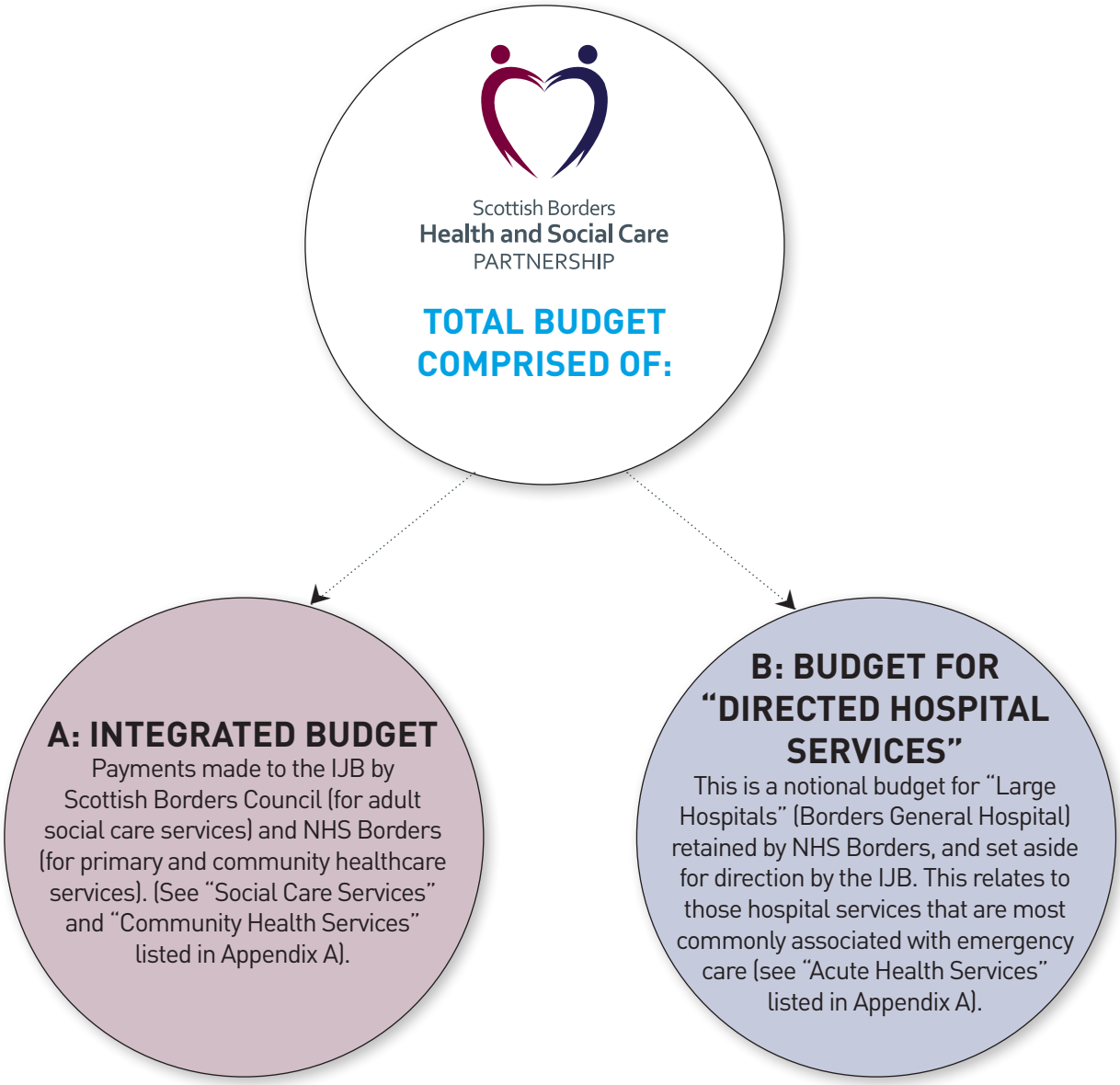
FIGURE 14



The Health and Social Care Partnership's budget

We have shown above that total NHS and social care expenditure in the Borders in 2013/14 was £248.7m. The budget the new Health and Social Care Partnership will be responsible for will represent a high proportion (about two thirds) of total spend on Health and Social Care. The use of this budget will be directed by the Partnership's Integration Joint Board (IJB), which is a separate legal entity from either the Council or the NHS Board, and is responsible for directing and overseeing the delivery of integrated health and social care services in the Borders. Details of our final budget for 2016/17, once formally approved in March 2016, will be published in our first annual Financial Statement at www.scotborders.gov.uk/integration. The Financial Statement will support the delivery of this Strategic Plan.

FIGURE 15



WHAT YOU SAID AND WHAT WE PLAN TO DO

This section of this document describes some of the actions we will take to start to make the shift towards more community-based health and social care services, the outcomes we will seek to achieve and the steps we will take to deliver our local objectives. We describe some of the performance measures we will use to assess the progress we are making. This has been influenced by what you have told us was important to you.

Each of our 9 Strategic Objectives is set out on the following pages with:

- A reflection of some of your feedback relating to each objective.
- An outline of how we intend to deliver what is needed to achieve the objective.
- Examples of activities identified in our current service strategies which relate to the objective. Although many examples give the name of a particular service or strategy in brackets, all of the objectives apply to all of our client/patient groups and we intend that they all benefit from these approaches.
- Related projects which are already underway.
- What people can expect to see in terms of targets and outcomes against each objective over the next 3 years.

Objective 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role - was added as a Strategic Objective following the round of consultation in May and June 2015. This reflects the way in which engagement with the people who use and provide our services is central to the development of our Strategic Plan and the activities that underpin it.

The information given on the following pages is not exhaustive. This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

As a Health and Social Care Partnership, we also have a Public Sector Equality Duty under the Equality Act (2010). We have a duty to:

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a characteristic that is protected under the Act, and those who don't.
- Foster good relations between people who share a characteristic and those who don't. This involves tackling prejudice and building understanding.

The characteristics that are protected under the Act are:

AGE Younger people, older people, or any specific age group	**DISABILITY** Including physical, sensory, learning, mental health and health conditions	**GENDER** Male, Female and Transgender
MARRIAGE AND CIVIL PARTNERSHIP Including single, divorced, civil partnership, married, separated	**PREGNANCY AND MATERNITY** Including breastfeeding	**RACE** People from ethnic minorities including Gypsy Travellers and Eastern European immigrants
RELIGION OR BELIEF Including people who have no belief	**SEXUAL ORIENTATION** Bisexual, Gay, Heterosexual and Lesbian	**CARERS** Both formal and informal carers

In taking forward the work of the Health and Social Care Partnership, we will embrace these duties and ensure that all requirements are met, through the implementation of the Business and Commissioning Plans for the Service and Strategic areas that are Integrating.

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.

What we heard you say is important to you:

- Ensure information is up-to-date, accessible both off- and on-line and improve how people are directed to and can access services.
- Build on existing work to increase to community capacity throughout the Borders.
- Use community-based education from an early age to encourage better lifestyles.

We want to:

- Improve access and signposting to our services and information, and assist people to help themselves.
- Develop local responses to local needs.
- Communicate in a clear and open way.

Some examples of how we intend to do this through our current services and strategies:

- Improve co-ordination for individuals and build capacity in communities to support older people at home. (Older People).
- Put people with dementia at the centre of planning and providing services and ensure they are able to live independently within their own homes and community. (Dementia).
- Improve information and advice to Carers. (Carers).
- Strengthen partnership and governance structures. (Drugs and Alcohol).
- Achieve best outcomes for service users, foster recovery, social inclusion and equity. (Mental Health and Wellbeing).
- Ensure that people with sensory loss receive seamless provision of assessment, care and support. This will be provided by local partnerships, which will identify local priorities and approaches. This will include a review of the local sensory loss strategy in the light of the publication of the national "See Hear" Strategy. (Sensory Services).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- Health literacy training (delivered by Health Improvement Team) for staff to improve the accessibility of information about keeping well and services.
- Delivering affordable housing across the Scottish Borders; working with local housing associations to provide housing which is warm, in good condition and fit for purpose.

These are some of the changes that we have started to make:

- **Burnfoot Community Hub** – supporting the creation of a Community Hub facility to allow delivery of a range of community services and activities.
- **Borders Community Capacity Building** – supporting older people in Cheviot, Tweeddale and Berwickshire to establish or create new activities and support in their local communities – initiated through co-production and involving local residents.
- **Learning Disabilities** – Involve service users in the design and delivery of services. Local area co-ordinators are available to support people in accessing support and services in their local communities.
- **Locality Citizens Panels** – providing forums for people with learning disabilities and their Carers to meet and discuss local issues affecting them, and to contribute as part of the Learning Disabilities governance structure.
- **Locality Planning/Locality Management** – Taking into account the varying needs of the Borders population, we will have local plans and will devolve some services accordingly.

We will measure performance against this objective over the next three years by measures including:

- We would like to maintain 90% of adults in the Borders rating the overall care provided by their GP as "Excellent" or "Good" (higher than 87% overall for Scotland) in 2013/14. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We want to increase the proportion of adults who received support and care services in the Borders and rated the services as "Excellent" or "Good" in 2013/14 from 83% to 85%.
- We want to see the number of adults who agree that the support or care services they had received improved or maintained their quality of life from 83% (lower than the Scottish average of 85%) to 86%.

OBJECTIVE 2

We will improve prevention and early intervention

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

What we heard you say is important to you:

- Be proactive about providing early intervention and prevention: support people better/ earlier, and promote existing services e.g. health checks at GP surgeries.
- More Anticipatory Care Planning for people, their families or Carers.
- Work with other organisations, staff and people to develop integrated approaches to prevention and promote personal responsibility.
- More acute care and community services in local communities.
- Local wheelchair-friendly housing options.
- A good transition into adult services that ensures young adults with disabilities can live as independently as possible and can prevent/reduce reliance on services.

We want to:

- Prioritise preventative, anticipatory and early intervention approaches.
- Focus services towards the prevention of ill health, to identify problems earlier on, to anticipate the need for support, to offer care and support at an early stage, and to respond where possible to prevent crisis.
- Improve supports for people to manage their health conditions, improve access to healthcare when required, and make best use of recovery models.
- Ensure that young people with disabilities transition from children's to adult services in a seamless way.

Some examples of how we intend to do this through our current services and strategies:

- Help the growing pool of 'young old' people to stay well through prevention measures. (Older People).
- Reduce the amount of drug and alcohol use through early intervention and prevention. (Drugs and Alcohol).
- Promote healthier lifestyles for patients, staff and visitors through our health improvement campaign 'Small changes, big difference'.
- Increase referrals to services that support lifestyle change, such as Lifestyle Advice & Support Services (LASS) and Quit4Good (smoking cessation services) in primary care; and signpost to community resources such as 'Walk It' groups to promote physical activity.
- Strengthen falls prevention work.
- Deliver the Long Term Conditions project to support people to manage their conditions better.
- Promote uptake of health screening opportunities and immunisation programmes.
- Raise awareness of signs and symptoms of health conditions (physical and mental health) and encourage people to get checked early (e.g. Detecting Cancer Early campaign; Suicide prevention training).

OBJECTIVE 2 - continued

Examples of how we intend to do this through our current services and strategies (continued):

- Provide Housing Options and Housing Support, directly and with partners, to help people remain in their own home and prevent homelessness. This includes Housing Officers visiting vulnerable households on a regular basis – identifying the needs of those people.
- Promote social contact with local resources to reduce isolation and loneliness.
- Develop a mechanism to ensure that anticipatory care plans are used effectively.
- Implement the recommendations in the Mental Health Needs Assessment.
- We will work with all partners to raise awareness about dementia and improve diagnosis rates.
- Review the support mechanisms for transition into adult services (Physical Disability).

These are some of the changes that we have started to make:

- **Telehealth Care** – look at how technology can be used to provide better home-based health care services.
- **Lifestyle Advice and Support Services (LASS)** – strengthen pathways from acute care to these services.
- **Bowel Screening** - Improve uptake in deprived areas.
- **Long Term Conditions** - Test out new ways of working to support the shared-management **of long term conditions.**
- **Targeted health improvement projects for people with learning disabilities**. For example 'A healthier me'.

We will measure performance against this objective over the next three years by measures including:

- We want to maintain and improve on the 96% of Scottish Borders GP practice patients who felt that they were able to look after their own health 'very well' or 'quite well' (a little higher than the Scottish average of 94%) (Source: Health and Care Experience Survey 2013/14, Scottish Government).

OBJECTIVE 3

We will reduce avoidable admissions to hospital

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

What we've heard you say is important to you:

- Ensure essential equipment is easily accessible at all times for people, staff, families and Carers.
- Improve discharge planning to ensure it is clearly communicated and coordinated.
- Ensure there is an integrated response to prevent admissions.
- Increase self-referral and reduce waiting list times so that people can be supported as quickly as possible before their needs change.

We want to:

- Reduce unnecessary demand for services including hospital care. If a hospital stay is required we will minimise the time that people are delayed in hospital.

Some examples of how we intend to do this through our current services and strategies:

- Help older people to stay well through prevention measures; improve coordination and help them in making their way through the health and social care system.
- Build capacity in communities to support older people at home.
- Holistic assessments and personalised care planning that addresses broader health and social care issues important to individuals, such as welfare benefits/financial issues, housing issues, and social connectedness.
- Stronger links with community based support services/resources.
- Housing - Provide well insulated, comfortable homes to help prevent existing health problems from becoming worse. Ensure adaptations to homes, such as grab rails, are in place to help prevent falls or other injuries, and to help keep people independent.

These are some of the changes that we have started to make:

- Connected Care – aims to create improved community support to prevent hospital admission and ensure timely discharge. We are working with other organisations to develop new and improved approaches to make this happen.

OBJECTIVE 3 - continued

We will measure performance against this objective over the next three years by measures including:

- We would like to reduce overall rates of emergency hospital admissions by 10%, by improving health and care services for people in other settings.
- We would like to reduce the rate of multiple emergency hospital admissions in people aged 75 and over, by 10%, by improving health and care services for people in other settings.
- We will reduce instances of patients being readmitted to hospital within 28 days of discharge by 10%.
- We will reduce falls amongst people aged 65 and over by 10%.

OBJECTIVE 4

We will provide care close to home

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

What we've heard you say is important to you:

- Ensure there are appropriate and accessible services in the community to support prevention.
- Ensure that the right staff are in place to support people who need to access services.
- Work more closely with our communities and organisations and make better use of local knowledge.
- Make the care profession a more attractive career.

We want to:

- Support people to live independently and healthily in local communities.
- Improve care pathways to ensure more co-ordinated, timely and person-centred care.
- Ensure the right services are in place to meet people's needs.
- Ensure staff (and Carers) have the necessary knowledge, skills and equipment to provide care at/close to home.
- Move to outcome-focussed delivery of care and support.

Some examples of how we intend to do this through our current services and strategies:

- Work with other organisations so people with a physical disability can live as independently as possible; develop opportunities for people with a physical disability to fully engage in their local community; and improve access to public transport. (Physical Disability).
- Build capacity in communities to support older people at home.
- Have appropriate housing in place to keep people independent. (Older People).
- Ensure people with dementia have access to services which enable them to remain independent within their own homes and community as long as practical. (Dementia).
- Develop a joint approach to commissioning; achieve the best outcomes for service users; foster recovery, social inclusion and equity; and achieve a balanced range of services. (Mental Health and Wellbeing, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.
- Use Locality Planning to inform service development based on the needs of people in each of our localities.

OBJECTIVE 4 - continued

These are some of the changes that we have started to make:

- **Health Improvement** – To support people to live well with long term conditions – we will promote self-management to empower people and their Carers to actively engage in creating individualised care.
- **Borders Ability Equipment Store** – Ensure provision meets the future demands of a growing elderly population which will require additional equipment, technology options **and support.**
- **Introduction of local area co-ordination services for Learning Disabilities**.
- **Change models of support** – reduce the number of people with Learning Disabilities living in a care home setting to living in a Supported Living Model of support.

We will measure performance against this objective over the next three years by measures including:

- We would like to see more people supported and cared for in their own homes or another homely setting, currently 65% in the Borders and 62% in Scotland overall.
- We would like to maintain the average proportion of the last six months of a person's life that they spent at home at 91.6%, a little higher than the Scottish average of 91.2%. (Source: Health and Care Experience Survey 2013/14, Scottish Government).

OBJECTIVE 5

We will deliver services within an integrated care model

Through working together, we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.

What we've heard you say is important to you:

- More integrated and proactive local teams, sharing responsibility and enabling faster decision making.
- Recognise and clarify the roles of all organisations involved in providing health and care services and make better use of each other's skills and experience.
- Integrate IT systems between organisations to improve communications and information sharing.
- Ensure communities are considered individually when planning health and care services.

We want to:

- Ensure robust and comprehensive partnership arrangements are in place.
- Pro-actively integrate health and social care services and resources for adults.
- Integrate systems and procedures.
- Ensure that our workforce are equipped to provide good quality, effective, integrated services with the person at the centre.

Some examples of how we intend to do this through our current services and strategies:

- Improve the coordination and help for individuals making their way through the health and social care system. (Older People).
- Develop an integrated approach to commissioning, and achieve a balance of services. (Mental Health and Wellbeing, Older People).
- Improve access and develop effective and integrated quality services. (Sensory Impairment).
- The housing sector in the Borders has a range of partnership mechanisms to enhance the level of staff engagement, including the Local Housing Strategy Partnership, Borders Housing Hub, New Borders Alliance and the Strategic Housing Investment Plan Working Group.

OBJECTIVE 5 - continued

These are some of the changes that we have started to make:

- **Mental Health Integration** – build on existing arrangements in Mental Health Service to integrate community teams.
- **Improve integration of health and social care provision**. (Learning Disability, Older People).
- **Co-production approach** – professionals and patients/clients working together to review, redesign and deliver integrated services.

We will measure performance against this objective over the next three years by measures including:

- We would like to see the proportion of adults who agreed that their health and care services seemed to be well co-ordinated rise from 79% (the average for Scotland) to 85% (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We would like to reduce the number of bed-days occupied by adults due to delayed discharge across all ages, but particularly for those aged 75 and over, from 84% to the Scottish average of 73%.
- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. We will aim to improve our rating to a minimum of 61%, preferably higher at 70%. The same question will be included in future council staff surveys.

OBJECTIVE 6

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

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

What we heard you say is important to you:

- Ensure services are flexible to address short- and long-term needs and as close to 24/7 as possible, to enable people to access the services they need when they need them.
- Provide more housing options, giving people more freedom and choice.
- Increase availability of self-referral to access services and ensure consistency across services.
- Encourage more people to self-manage their conditions.

We want to:

- Ensure the principles of choice and control, as exemplified in Self Directed Support legislation, are extended across all health and social care services. This includes the participation and involvement of people in their care and support.

Some examples of how we intend to do this through our current services and strategies:

- Enable people with a physical disability to have choice and control over how they are supported to live independently. (Physical Disability).
- Borders Care & Repair services help disabled homeowners or private sector tenants with adaptations that will enable them to stay in their own home. Borders Care & Repair offer help and assistance and can project manage the entire adaptation process. (Housing).
- Ensure the needs of people with dementia are at the centre of all planning and provision of services specific to them. (Dementia).
- Improve the provision of information and advice to Carers, improve quality of Carer assessments/ support plans and involvement of Carers in care planning. (Carers).
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment, Older People).

OBJECTIVE 6 - continued

These are some of the changes that we have started to make:

- **Self-Directed Support (SDS)** – is now being implemented across health and social care services. SDS is an approach across health and social care services that ensures people have choice over their support and over how it is arranged and paid for.
- **Dementia** – The Scottish Borders Dementia Strategy is being updated to align it with national strategies. One area of focus is Post Diagnostic Support for people who are recently diagnosed. New models of care are being explored. Another area of development is a local Dementia Working Group which, with support from Alzheimer Scotland, will ensure people with dementia have their voices heard and are involved in service development. The group will link to the Scottish Dementia Working Group and will have opportunities to be involved with strategic developments at a national level.

We will measure performance against this objective over the next three years by measures including:

- Amongst adults who received support and care services in the Borders in 2013/14, 83% agreed that they were supported to live as independently as possible (a little lower than the Scottish average of 84%). We want to increase this to 85% (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We want to increase the number of people who agreed that they had a say in how their support or care was provided, from 80% to 85% (the Scottish average was 83%) (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We will ensure that everyone eligible for social care support will have choice and control through the Self-Directed Support approach.

OBJECTIVE 7

We will further optimise efficiency and effectiveness

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

What we've heard you say is important to you:

- Improve clarity of decision making process and enable decisions to be made more quickly.
- Ensure that we make the most of our staff through training and flexibility and create more opportunities to offer additional support.
- Acknowledge and address changes required for a more flexible and responsive workforce.
- Value and support our volunteers.
- Make better use of our existing resources and assets, including buildings, people, and finance to ensure that they are sufficient and used as effectively and efficiently as possible.

We want to:

- Transform the way we provide and deliver services.
- Efficiently and effectively manage resources to deliver "Best Health, Best Care, Best Value".
- Support and develop our staff to be confident and reach their full potential.
- Deliver effective support and care through a mixed economy of care, utilising all key partners in the voluntary and private sector.

Some examples of how we intend to do this through our current services and strategies:

- Work to improve the energy efficiency of homes; providing adaptations to enable people to stay at home rather than move someone at higher cost.
- Make efficient use of the funding and other resources available. (Dementia, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.

These are some of the changes that we have started to make:

- **Transitions** – focusing on improving the transition pathway for young people with learning disabilities as they move from children's to adults' specialist services.
- **My Home Life** – offer training to managers to help improve quality of life in care homes.
- **Focus on Outcomes Training** – deliver a new outcome-focused assessment for social care and associated training.

OBJECTIVE 7 - continued

We will measure performance against this objective over the next three years by measures including:

- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. (Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. The same question will be included in future council staff surveys.)
- We would like a higher proportion of our budget to be spent on community-based health and social care and planned hospital care. In the Borders, 20% of all NHS and Social Care expenditure in 2013/14 was in relation to hospital stays, where the patient was admitted as an emergency. This is lower than the Scottish average of 22%. (Source: Integrated Resource Framework, www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/index.asp)

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.

What we've heard you say is important to you:

- Ensure openness and consistency around access to services.
- Work with communities to address loneliness, deprivation and inequality and empower them to develop their own solutions.
- Work with local transport providers across all sectors to provide appropriate and accessible transport services.
- People with learning disabilities are more likely to have more undiagnosed health conditions, die younger than the general population and need more support to access health care.

We want to:

- Reduce inequality, in particular health inequality and support and protect those who are vulnerable in our communities.

Some examples of how we intend to do this through our current services and strategies:

- Develop a Carers Rights Charter, ensure Carer representation on Health and Social Care Partnership. (Carers).
- Reduce the amount of drug and alcohol use through early intervention and prevention, reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reduce related deaths. (Drugs and Alcohol).
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- The four outcomes of the Local Housing Strategy (2012-2017) aim to tackle the inequalities in our society – this includes health inequalities.

OBJECTIVE 8 - continued

These are some of the changes that we have started to make:

- **Transport Hub** – Scottish Borders Council, NHS Borders, The Bridge, Red Cross, Berwickshire Association of Voluntary Services and Royal Voluntary Service are working as partners to put in place a coordinated, sustainable approach to providing community transport.
- **Community Learning Portal** – provide free access to the Community eLearning Portal for staff in partner organisations.
- **Stress & Distress Training** – provide training in a personalised way to understanding and intervening in stress and distressed behaviours in people with dementia. This training aims to improve the experience, care, treatment and outcomes for people with dementia, their families and carers.
- **Deaf Awareness E-learning** – create an e-learning training resource focusing on the needs of older people with hearing loss. Initially the training will be available to Scottish Borders Council and NHS staff, but the intention is to ensure that partner organisations have access to it in the future.
- **Community nurses and social care staff** support people with Learning Disabilities to access mainstream healthcare.
- **Liaison nurses** are based in Borders General Hospital (Learning Disabilities, Mental Health).

We will measure performance against this objective over the next three years by measures including:

- We want to improve and increase the percentage of adults who received support and care services in the Borders who agreed that they felt safe from 81% (lower than the Scottish average of 85%) to 86%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We would like to maintain the downward trend in the Borders in death rates in people aged under 75.
- We will address the recommendations within "The Keys to Life" (2013) National Strategy for people with learning disabilities, through local action plans for people with learning disabilities, to improve their health.

OBJECTIVE 9

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

What we've heard you say is important to you:

- Improve support for Carers to avoid deterioration in their own health and wellbeing and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.

We want to:

- Improve support for Carers so they can avoid deterioration in their own health and wellbeing and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.
- Improve access to respite care.

Some examples of how we intend to do this through our current services and strategies:

- Ensure the needs of Carers are considered alongside those of the person living with dementia. (Dementia).
- Develop a Carers Rights Charter, improve communication and advice to Carers, improve quality of Carer assessments and support plans, ensure Carer representation on health and social care partnership and produce a resource on issues relating to stress and caring. (Carers).
- Improve identification of Carers at an earlier stage and signpost/refer them for their own assessment.
- All staff will be provided with training around Carers and their needs.
- Carers will be consulted and included in all aspects of their relative's care needs, on planning and delivering the care need, during any hospital stays, on discharge, and in the community.
- Implement requirements set out within the new Carers legislation in 2017.

OBJECTIVE 9 - continued

These are some of the changes that we have started to make:

- **Carers** - We have commissioned the Carers Centre to be the first point of contact for Carers' Assessments. This model has been extremely successful and reduced the length of time for Carers waiting for assessment. However not all Carers are accessing the Centre. Work is underway to consider how we can promote the service and additionally how the Carers Centre can be supported to meet increased demand.

We will measure performance against this objective over the next three years by measures including:

- We want to increase the percentage of Carers reporting that they feel supported to continue caring from 41% (lower than the Scottish average of 44%) to 50%. We will review this target with a view to improving it further if possible.
- We want to support Carers in the Borders so that fewer Carers feel caring has had a negative impact on their health and well-being and reduce this figure from 30% to 20% (Source: Health and Care Experience Survey 2013/14, Scottish Government).

Planning for Change – Key Priorities

Below are the Partnership priorities identified so far for 2016/17. A fund of £2.13m per year has been provided to assist, support and develop the integration of Health and Social Care Services until March 2018.

- To develop integrated accessible transport.
- To integrate services at a local level.
- To roll out care coordination to provide a single point of access to local services.
- To improve communication and accessible information across groups with differing needs.
- Work with communities to develop local solutions.
- Provide additional training and support for staff and for people living with dementia.
- Further develop our understanding of housing needs for people across the Borders.
- To promote healthy living and active ageing.
- To improve the transition process for young people with disabilities moving into adult disability services.
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the Third Sector.
- To improve support for Carers within our communities.
- Promote support for independence and reablement so that all adults can live as independent lives as possible.

LOCALITY PLANNING

There are five commonly recognised localities in the Borders as the maps in this section show. These are based on the five existing Area Forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale. Summary profiles for each of the five localities show some of the differences between them. As part of the planning process, we will build more detailed locality profiles, including a wider range of measures relevant to health and social care. This will allow us to target need most appropriately.

Map showing our five Area Forum Localities (with all towns and villages with a population of 500 or more).

We have set up a group to oversee the development of planning in each of the five localities. We expect to appoint locality co-ordinators to act as a focus for planning in each locality.

They will:

- Build relationships with established community groups, partners across the localities, such as other leads working at locality level, for example in Community Learning and Development.
- Map out what is already happening, use and build upon the mapping work already in existence across relevant partnerships - established community groups, many of which are linking up through the Community Learning Partnership approach.
- Identify where existing funding is coming from, where there are gaps and where there are ideas or plans.
- Clearly define what is happening in the short, medium and longer term, how these priorities have been identified and what the consultation process has been/is going to be.
- Co-ordinate action plans, planned expenditure and how these fit with local priorities.

Planning at this level will need to take account of existing local plans such as Community Action Plans or Neighbourhood Plans as well as cross-Borders strategies, such as the reducing inequalities strategy and health inequalities action plan. It will also need to address cross-border issues (between Borders localities, and between Borders and neighbouring areas of Scotland and England). Some priorities are the same across localities but others are different. Locality plans will also need to take account of projects starting at the moment. For example, we are beginning to develop care coordination, which will be undertaken by care coordinators which will be rolled out across the localities in a phased way. This will help us provide more person centred care. Another current project is to provide a means for Borders Community Transport providers to work together to make best use of available transport and reduce duplication of journeys. Some other projects are specific to a locality such as "the Eildon Community Ward".

Service users, Carers, families, communities and professionals – particularly GPs – must be actively involved in locality planning, so that they can influence how resources are spent in their area – genuine co-production. Co-production is where people using services, their families and their neighbours work as equals with professionals to plan and deliver services. We are rolling out a "Borders Community Capacity Building Project" which will provide communities with support and ability to do this. We want communities to use the collective resources (assets) which they have at their disposal, to protect against poor health and improve health.

Assets are the strengths that people and communities have such as relationships, networks, enthusiasm, social cohesion and resilience as well as plans, land, buildings and funding. The people of the Scottish Borders are perhaps our single biggest asset. The networks and relationships that exist within and across communities are invaluable in themselves and they are health-improving. They provide a solid foundation for any work to improve health and wellbeing alongside the strong volunteer ethic and a natural commitment to supporting others. There is growing evidence of the combination of local people, community

groups, partners and physical assets in action across localities, such as the Borders Healthy Living Network, Langlee Residents Association, Burnfoot Community Futures, Eyemouth Community Development Trust and the relationships and activities these community based groups/organisations have been developing with agencies and local people.

In addition to people, other assets within the Scottish Borders include land and buildings. The Scottish Borders is a stunning place to live and this applies to all localities, with some of the most breath-taking views, areas of green space and outdoor walks available right on our doorstep. The Scottish Borders is steeped in history and this could be brought to life through social projects that involve communities and people who have experience of the changes influencing health and wellbeing in the Borders. We know that older people are living longer, healthier lives and they have a wealth of knowledge, skills and experience to share with others. We should make every effort to capitalise on this and positively influence the next generation of children and young people by connecting up these assets.

The Scottish Borders is made up of 'can do' communities and this is very much seen through their actions to support others on a day to day basis, as well as in times of crisis. If these assets are nurtured and harnessed in everyday life, this culture of support could be further enhanced. This has been referred to as an assets approach, which at its simplest turns what we know on its head and questions what we think in a positive way, for example, instead of asking about what is not going well, we ask about what is going right and do more of this. This is very much the current thinking influencing some local groups and networks. This can also be applied in practice through training and development to ensure that people are viewed in this way and seen for their strengths and the contribution they have to make. An assets approach therefore presents a significant shift in the way we engage with people and communities, from a deficit model that emphasises need and problems to an asset model that values active participation and sees people and communities as co-producers of long term sustainable solutions. Focusing particularly on health, the fundamental shift from what makes us ill to what makes us well and doing more of this is at the heart of an asset approach.

Where appropriate, we will devolve resources towards the delivery of particular local outcomes. For example, we will strengthen the work of the healthy living network in areas of disadvantage to improve the health and well-being of those communities. We will prioritise engagement with vulnerable groups, isolated residents and people who are not already accessing existing groups and local services. We will make the best use we can of community capacity and capability to do this.

Some illustrative Facts and Statistics about our Area Forum Localities

Tweeddale

- Estimated population in 2013: 19,192.
- 41% of live in its largest settlement, Peebles (population 7,908), whilst 59% live in smaller settlements or rural areas.
- The locality with the highest proportion of its population aged under 16 (18.7%). 60.1% of the population are aged 16-64 and a further 21.2% are aged 65+.
- In 2014/15 there were 16.6 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 80 per 1,000 population.

Eildon

- Estimated population in 2013: 38,798. Our largest locality in population terms (over one third of Scottish Borders residents live here).
- Nearly one third of residents live in Galashiels (estimated population 12,394) and another 14% in Selkirk (estimated population 5,608).
- The locality with the highest proportion of its population aged 16-64 (62.3%) and the lowest proportion aged 65+ (20.5%). A further 17.2% of the population are aged under 16.
- In 2014/15 there were 27.3 attendances at Borders General Hospital A&E for every 100 population – this is the highest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 93 per 1,000 population; this is the highest rate across our localities.

Berwickshire

- Estimated population in 2013: 20,862.
- No large towns; most people live in small settlements or rural areas. Eyemouth (population 3,152) and Duns (population 2,444) are the largest settlements here.
- 15.8% of the population are aged under 16, 60.0% are aged 16-64, 24.2% are aged 65+.
- In 2014/15 there were 15.8 attendances at Borders General Hospital A&E for every 100 population – this is the lowest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 79 per 1,000 population.

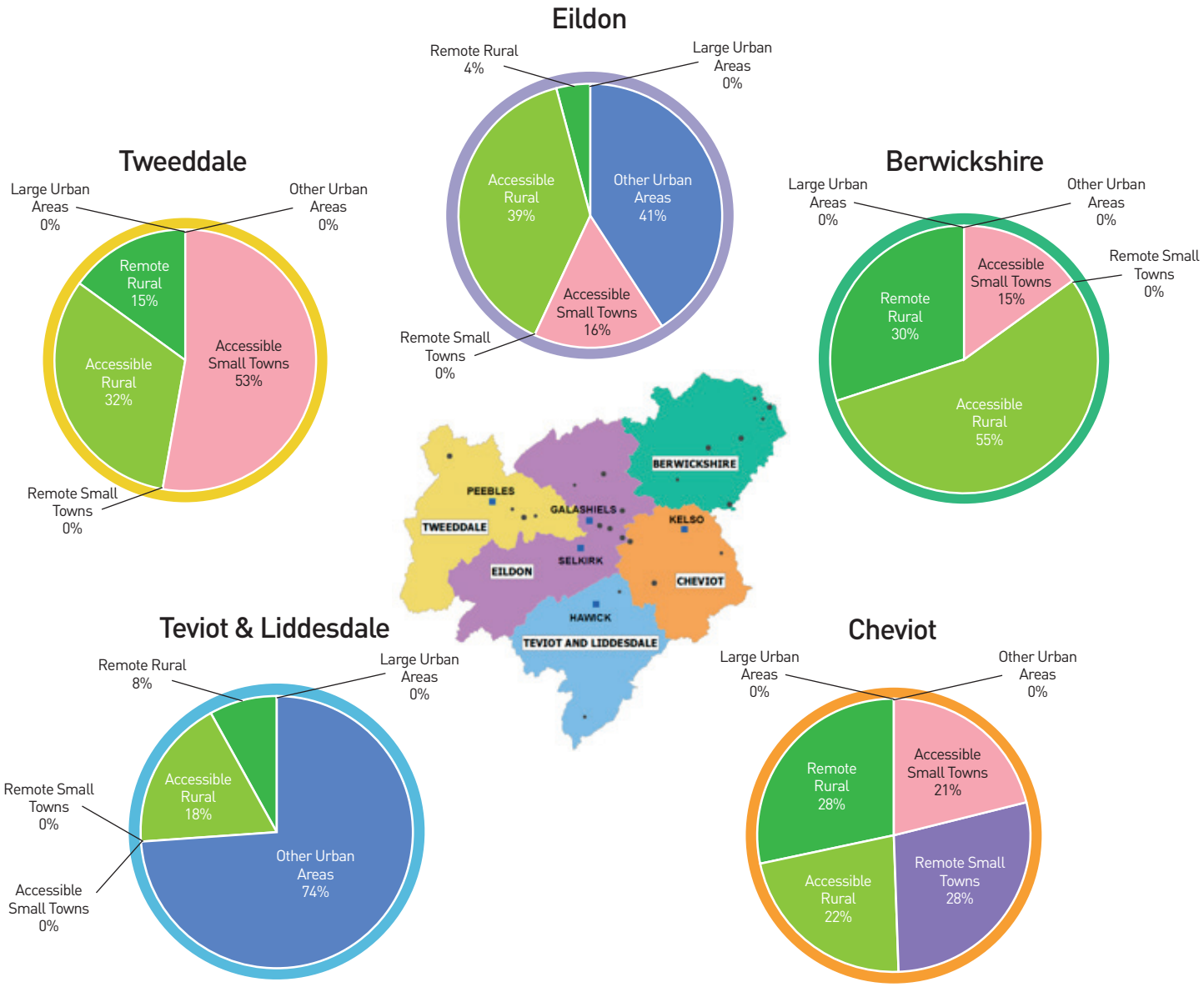
Cheviot

- Estimated population in 2013: 16,407. Our smallest locality in population terms.
- More than 60% of residents live in Kelso and Jedburgh, which have estimated populations of 6,139 and 3,959, respectively.
- The locality with the highest proportion of its population aged 65+ (25.6%). It also has the lowest proportions of children aged under 16 (15.6%) and people aged 16-64 (58.8%).
- In 2014/15 there were 19.7 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 75 per 1,000 population; this is the lowest rate across our localities.

Teviot & Liddesdale

- Estimated population in 2013: 18,611.
- Nearly three-quarters of the population live in the town of Hawick (estimated population 13,696).
- 15.7% of the population are aged under 16, 60.6% are aged 16-64, 23.7% are aged 65+.
- In 2014/15 there were 23.4 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 87 per 1,000 population.

OUR AREA FORUM LOCALITIES AND THEIR URBAN/ RURAL POPULATION PROFILES



Source: © crown copyright, All rights reserved, Scottish Borders Council, Licence 100023423, 2015

Category	Description
1 Large Urban Areas	Settlements of 125,000 or more people.
2 Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland. www.gov.scot/Publication/2014/11/2763/downloads

WHAT WILL SUCCESS LOOK LIKE

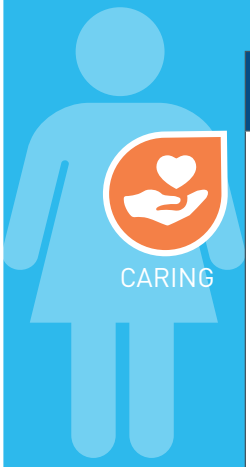
- Services are integrated and there is less duplication
- There is easier access to services through a single point of contact
- People with multiple long term conditions are supported
- Carers will feel better supported and have improved health and well-being
- Make best use of staff
- People participate in planning their own care and support
- The benefits of new technology improve people's health and well-being
- There is a shift to early intervention and prevention for children and young people, families and carers
- There will be a reduction in health inequalities
- Spend money wisely

PLANNING FOR INTEGRATED SERVICES

The two case studies here illustrate how ordinary people should experience a better integrated health and social care service.

PAMELA AGE 57

I'm Pamela and I've lived in Innerleithen most of my life. I live with my husband Owen and our daughter Jane. My 83 year old Father lives in sheltered housing nearby and our eldest daughter Jillian lives 7 miles away in Peebles. I have a lot of friends who live in the area.



MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
I look after my 3 year old grandson, Jack, 3 times a week. I visit my elderly father every day and I am the first responder to his Bordercare alarm. I recently had a Carer Assessment carried out.	I recently realised how much I've been looking after my Father. I love my Father and I want to care for him, but sometimes, I resent being his first responder and I feel I sacrifice things that are important to me to look after him. I feel guilty for thinking these things. Sometimes I don't understand what's happening with his care. I worry a lot about him.	• Clear information on available support and services. • Health and care co-ordinated services. • A single number to access services. • More support for me as a Carer.
I live in a modern, rented house. My husband Owen and I don't drive so we rely on public transport.	I love where I live and I like that I can walk to shops and the bus stop. But I find organising transport to get my Father to appointments can be really difficult.	• A single number to book transport. • Easier access to more coordinated services.
Owen recently retired for health reasons. My Father has dementia and is prone to falling. Jane is taking her higher exams. I love looking after Jack and seeing Jillian. Her partner Bill is nice too.	Owen is eight years older than me. He struggles with depression and I feel I need to be with him, which can result in me not being able to spend enough time with my Father or Jane. My Father falls occasionally. He has been recommended to attend gentle exercise classes but he says no.	• More opportunities to meet other people in the local community. • Supporting local communities to connect people and interests.

HOME

FAMILY

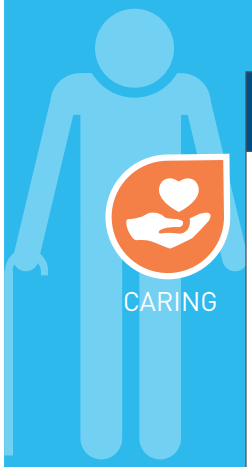
PAMELA
AGE 57

Continued ...

MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
I work part-time in a shop in nearby Galashiels.	I've considered reducing my hours to spend more time with my Father and my family, but I can't for financial reasons. I often have calls to make or receive about my Father when I'm at work which is challenging as I've limited flexibility. I sometimes have to take leave to take him to appointments.	• More options to enable me to take my father to appointments. • Longer opening hours for services.
I've high blood pressure, arthritis and anxiety. I'm a cancer survivor. I take many prescription drugs. I've been a heavy smoker for years.	I don't take the best care of myself because by the time I've looked after my Father, grandson, Owen, daughter, been to work and volunteered at Church I'm often too tired. I tend not to tell Owen about my worries because of his depression. Smoking helps me feel more relaxed, but I've noticed I smoke more now. I'm quite anxious so I was grateful that the Carer's Assessment lady listened to me.	• Locally available acute health and care services. • Forward (Anticipatory) care planning for my Father, Owen and me. • A named person that I can speak to.
Owen and I have many friends here. I enjoy volunteering at my local church.	We have a good community with neighbours and friends helping out. I've school friends and friends at Church, so every once in a while, if things are ok, I meet them for lunch. My Father is isolated and he would really like visits from people as he has trouble going out.	• Supporting local communities to connect people and interests.

CHARLIE AGE 78

I'm Charlie. I've lived in Kelso since I retired here 15 years ago with my wife, Sandra, who died 5 years ago. I've been alone since. My two children live far away. They come for visits, but they have busy lives and their own families. I love Kelso, I feel safe and happy here, apart from being so far from my family.



MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
CARING I am a widower. I don't need health and care services at the moment.	I feel capable, but having recently had a fall, I had a bit of a fright and I was admitted to hospital for a short while. It was sad as I had no visitors which made me start to think about what would happen to me when I do need more help. I don't want to be a burden to my children. I always thought I would grow old with Sandra. There are home carers who can help me, but I would prefer to have someone I could rely on, not a lot of different people.	• I can choose the staff I want to support me at home. I will get support if I want to employ my own staff. • A single number to access services.
HOME I live in a 3 bedroom house with a large garden, on the outskirts of the town. I drive, but I'm less confident now so I don't like driving.	I know my house is too big and I cannot manage the garden alone, but I don't want to move and start over with a new house and neighbours. I'm a 10 minute walk to the bus stop and buses are regular but if I need to go to the Hospital, I have to change buses. I feel I need to drive more and more.	• Better co-ordinated local transport • Bigger range of locally based housing options
FAMILY My son Paul lives in England. My daughter Steph and her family moved to Florida 3 years ago.	Paul visits every couple of months. I can see he's worrying about me and I know Steph feels guilty for being so far away. I want to be able to reassure them I have a plan for any future needs and that I can support myself. Paul wants me to move near him but I don't deal with change very well.	• Forward (Anticipatory) Care Planning. • I am in control of planning for the future.

CHARLIE
AGE 78

Continued ...

MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
WORK I'm retired. I had to step back from my voluntary work at my bowls club which I enjoyed.	I liked being Treasurer of my local bowls club. My friend introduced me to bowls and she takes me when she can, but she can't make it every week. I had to give up being Treasurer as it became too much. I don't feel as fulfilled as I did. I would love to do more voluntary work.	• Appropriate volunteering opportunities for older people
HEALTH I'm slowing down and finding things harder. I've many medications, I'm not sure what they are and why I take them.	I like to keep active and I do drive when I need to, usually to appointments and shops. It was scary when I fell, but I don't think I needed to go to the emergency department, but I couldn't be checked locally. I felt very overwhelmed by the number of people asking me the same questions – surely the staff can look it up on my medical notes?	• Locally based services • Better information sharing across organisations
COMMUNITY When Sandra was alive we did lots of things together, but it's not the same without her.	I feel lonely without my wife and not as confident to socialise with people. My neighbours are lovely, but I don't see them as often as I used to. I wish there were more activities and groups for older people like me.	• Community based groups and activities

PLANNING INTO THE FUTURE

The Strategic Plan will only be the beginning. It will be a living working document which will change and grow throughout its life. It will build on feedback from people living in the Borders. It will be reviewed at least every three years, based on on-going assessment of need. In the future, we will focus particularly on how to meet the needs of people who use services in local communities.

Throughout the last 12 months we held a number of engagement events for both the public and staff. The information we received from these events has been used to inform this document. For example, the 9th local objective on support for unpaid carers was added as a direct result of your feedback. Thank you to all who gave us feedback in person or in writing throughout the process of developing this Plan. We have been able to act on some of your comments at this stage whilst others will be retained to help us in our ongoing planning and engagement work.

APPENDIX A
SERVICES THAT ARE INTEGRATING

Which health and social care services are we integrating?

Our partnership will be 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.

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;
- Re-ablement 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 outwith 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.

APPENDIX B
THE NATIONAL HEALTH AND WELLBEING OUTCOMES

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 support people to achieve the following outcomes:

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

Source: Scottish Government

APPENDIX C
OUR LOCAL OBJECTIVES AND THE NATIONAL OUTCOMES CROSS-REFERENCED

Our Local Objectives are:

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 National Outcomes cross-referenced with Our Local Objectives

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	★	★	★	★	★	★	★		

Alternative format/language

You can get this document on audio CD, in large print, and various other formats by contacting us at the address below. In addition, contact the address below for information on language translations, additional copies, or to arrange for an officer to meet with you to explain any areas of the publication that you would like clarified.

其他格式 / 外文譯本

這份資料冊另備有錄音帶、大字體版本以及多種其他格式。你可以透過以下地址與我們聯絡，索取不同版本。此外，你也可以聯絡以下地址索取本資料的中文和其他外文譯本或索取更多拷貝。亦可要求我們做出安排，由我們的工作人員當面為你解釋你對這份出版物中的不明確之處。

[Alternatywny format/język]

Aby uzyskać kopię niniejszego dokumentu w formacie audio, dużą czcionką, oraz innych formatach prosimy o kontakt na poniższy adres. Uzykać tam można również informacje o tłumaczeniach na języki obce, otrzymaniu dodatkowych kopii oraz zaaranżowaniu spotkania z urzędnikiem, który wyjaśni wątpliwości i zapytania związane z treścią niniejszej publikacji.

Parágrafo de formato/língua alternativos

Pode obter este documento em cassete audio, impressão aumentada e vários outros formatos contactando a morada indicada em baixo. Pode ainda contactar a morada indicada em baixo para obter informações sobre traduções noutras línguas, cópias adicionais ou para solicitar uma reunião com um funcionário para lhe explicar quaisquer áreas desta publicação que deseje ver esclarecidas.

Параграф об альтернативном формате/языковой версии

Чтобы получить данный документ в записи на пленке, в крупношрифтовой распечатке и в других различных форматах, вы можете обратиться к нам по приведенному ниже адресу. Кроме того, по данному адресу можно обращаться за информацией о переводе на различные языки, получении дополнительных копий а также с тем, чтобы организовать встречу с сотрудником, который сможет редставить объяснения по тем разделам публикации, которые вам хотелось бы прояснить.

SCOTTISH BORDERS COUNCIL
Council Headquarters | Newtown St Boswells | MELROSE | TD6 0SA
tel: 0300 100 1800
email: integration@scotborders.gov.uk
www.scotborders.gov.uk/integration

Scottish Borders Council | NHS Borders | Scottish Borders Health and Social Care Partnership

Printed in the Scottish Borders. Designed by Scottish Borders Council Graphic Design Section. KG/02/16.

Appendix 1

The National Health and Wellbeing Outcomes

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.

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

Source: Scottish Government

This page is intentionally left blank

Appendix 2

Services that are Integrated

Which health and social care services have we integrated?

Our 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.

ADULT SOCIAL CARE SERVICES*	ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*	COMMUNITY HEALTH 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;
• Re-ablement Services, equipment and telecare;
• Aspects of housing support including aids and adaptations;
• Day Services;
• Local Area Co-ordination;
• Respite Provision;
• Occupational therapy services.
	• 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.
		• 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 outwith 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.

This page is intentionally left blank

Implementation Plan ("Plan" and "Do" components of the Commissioning Cycle

Objective 1: We will improve the health of the population and reduce the number of hospital admissions

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
People will be informed and have access to the right support at the right time.	We will develop Local Area Co-ordination (LAC) for adults and older people.	July 2017 – October 2018	Reduced demand on statutory services through increased local alternatives. Reduced Waiting Lists. Increased access to Information and Community Support. Reduced Revenue Costs from reduced demand.
	After an analysis of demand the additional funding was utilised to recruit 2 part-time Local Area Co-ordinators and 2 part-time Community Link Workers. This has enabled an improved geographical spread for the Local Area Co-ordination Service in mental health across the Borders. ***(Core Funding Investment)***	April 2017 – March 2020	
Health and Social Care Services reduce admission to hospital, improve health and wellbeing and reduce demand for statutory services.	We will redesign day services with a focus on early intervention and prevention. ***(Transformation Programme)***	April 2017 – October 2018	Reduced admissions to hospital. Improved health and wellbeing. Reduction in demand for statutory services. Reduced demands on GPs. Improved access to advice on minor health complaints. Reduced Revenue Costs from reduced demand.
	We are building on the work and expanding the Community Capacity Team and have introduced Community Link Workers from April 2018 to support people to access alternatives to statutory services. This is being piloted in the Central and Berwickshire Areas. ***(Integrated Care Fund)***	April 2018 – July 2019	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	1 Pharmacy teams are taking on new responsibilities within GP surgeries in line with the new GMS contract pharmacotherapy service. This includes case management, supporting long term conditions (particularly respiratory disease and diabetes), care homes and polypharmacy reviews. The work should help prevent medication-related admissions and improve the quality of disease management. 2 A clinical technician is in place to support medicines management at discharge and an ICF project (using a project manager and pharmacy technician) is testing pharmacy input to patients receiving care packages. A change in the way pharmacy services are provided to the wards is speeding up the discharge process by helping to ensure medicines are ready in advance and increasing patient contact to discuss medicine issues. Medicine reviews of patients on certain medicines know to cause acute kidney injury was set up 2 years ago (Sick Day Rules). This has been shown in another Board to reduce admissions. We will continue to promote this service. 3 Increased funding for pharmacy services through the Primary Care Transformation Fund is support and increase in capacity within GP surgeries. The ICF project will free up capacity within community pharmacies by reducing carer's reliance on medicines compliance aids (MCAs), which are timely to prepare and provide a safer system to support medicines management by carers. We continue to develop the role of the community pharmacist to improve health and wellbeing, reduce admissions and demand for other services, eg. BECS	April 2017 – March 2019	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	through Pharmacy First, medicines review, carer support and using quality improvement techniques ***(Integrated Care Fund)***		
Resources are used effectively and efficiently in the provision of health and social care services.	We will deliver on our partnership information our Integrated Transformation and Integrated Care Fund programmes. **(Transformation Programme)** **(Integrated Care Fund)**	April 2017 – March 2019	Reduced costs through management of demand, reduced unit costs and elimination of duplication and waste. Scarce resources will be directed to those most in need and secure best value. Health and social care will continue to be affordable within a context of constrained funding, increased cost and greater demand. Improved outcomes for patients, clients and carers.
	We will deliver our three year Workforce Plan. **(Core Funding Investment)**	October 2016 – March 2019	
	We will shift resources from acute health and social care to community settings. **(Transformation Programme)** **(Integrated Care Fund)**	April 2017 – March 2019	
	We will demonstrate best value in the commissioning and delivery of health and social care. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	
	We will invest in and realign resources to deliver our strategic priorities and disinvest from services not required. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will design and implement cost-effective alternatives to traditional, costly models of care. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	
People are able to access the information they require within their own community.	We will extend the scope of the Matching Unit to source care and respite care at home to meet assessed need. ***(Integrated Care Fund)***	June 2017 – December 2018	Quicker and more efficient planning of care and support. More people at home or in a homely setting including when at the end of their life. Reduced demand for care at home and other health and social care services. Reduced Revenue Costs from reduced demand and greater efficiency
	We will plan and deliver health and social care services by locality area, using the Buurtzorg model of care. ***(Integrated Care Fund)*** ***(Transformation Programme)***	April 2017 – March 2019	
	We will increase the use of telecare and telehealthcare. ***(Transformation Programme)***	October 2017 – June 2018	
	We will increase the provision of Housing with Care and Extra Care Housing. ***(Core Fund Investment)***	April 2017 – March 2020	
Health and social care services will reduce health inequalities.	We will continue to review the standard of our health centres as part of the Primary Care Modernisation Programme. This is directly linked to the new GMS Contract. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a 3 year plan from 2018/19 to 2020/21. ***(Core Fund Investment)***	April 2018 – March 2021	All people newly diagnosed with dementia are offered at least one year post-diagnostic support. Local health and social care services which are designed to meet local need.

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	The Cluster Leads is concluded, as we have to have cluster leads as part of the new contract. This is directly linked to the new GMS Contract. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a 3 year plan from 2018/19 to 2020/21. ***(Integrated Care Fund)***	April 2018 – March 2021	Improved standard of health centre premises. Increased community support work form improved health centres. Improved GP services. Greater focus on prevention will result in reduced Revenue costs from reduced demand and increased efficiency.
	We will continue to deliver Post Diagnostic Support to a higher proportion of people with dementia. In the last year the NHS Mental Health Older Adult service has moved from paper to electronic records (EMIS) affording the opportunity for revision of our Post Diagnostic Support pathway which is under way. At beginning of May 2018 a revised recording template will be implemented to provide a live and interactive template for each person with a diagnosis of dementia and will allow direct national reporting and local audits to be conducted which will result in improved PDS going forward. **(Core Funding Investment)**	October 2017 – October 2018	
	We will continue to increase appropriate GP referrals for people with dementia. Over the last year primary care colleagues have been alerted to the importance of referrals of people with a suspected diagnosis of dementia through a variety of means. Including at the November Medical Education session and a data cleansing process matching diagnoses known in mental health with the primary care dementia register. **(Core Funding Investment)**	October 2017 – October 2018	

Objective 2: We will improve the flow of patients into, through and out of hospital

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
Resources are used effectively and efficiently in the provision of health and social care services.	We will deliver on our partnership information our Integrated Transformation and Integrated Care Fund programmes. **(Transformation Programme)** **(Integrated Care Fund)**	April 2017 – March 2019	Reduced costs through management of demand, reduced unit costs and elimination of duplication and waste. Scarce resources will be directed to those most in need and secure best value. Health and social care will continue to be affordable within a context of constrained funding, increased cost and greater demand. Improved outcomes for patients, clients and carers.
	We will deliver our three year Workforce Plan. **(Core Funding Investment)**	October 2016 – March 2019	
	We will shift resources from acute health and social care to community settings. **(Transformation Programme)** **(Integrated Care Fund)**	April 2017 – March 2019	
	We will demonstrate best value in the commissioning and delivery of health and social care. **Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	
	We will invest in and realign resources to deliver our strategic priorities and disinvest from services not required. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will design and implement cost-effective alternatives to traditional, costly models of care. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	
Health and social care services will reduce health inequalities.	We will continue to review the standard of our health centres as part of the Primary Care Modernisation Programme. This is directly linked to the new GMS Contract. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a 3 year plan from 2018/19 to 2020/21. **(Core Funding Investment)**	April 2018 – March 2021	All people newly diagnosed with dementia are offered at least one year post-diagnostic support. Local health and social care services which are designed to meet local need. Improved standard of health centre premises. Increased community support work form improved health centres. Improved GP services. Greater focus on prevention will result in reduced Revenue costs from reduced demand and increased efficiency.
	The Cluster Leads is concluded, as we have to have cluster leads as part of the new contract. This is directly linked to the new GMS Contract. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a 3 year plan from 2018/19 to 2020/21. **(Integrated Care Fund)**	April 2018 – March 2021	
	We will continue to deliver Post Diagnostic Support to a higher proportion of people with dementia. In the last year the NHS Mental Health Older Adult service has moved from paper to electronic records (EMIS) affording the opportunity for revision of our Post Diagnostic Support pathway which is under way. At beginning of May 2018 a revised recording template will be implemented to provide a live and interactive template for each person with a diagnosis of dementia and will allow direct national reporting and local audits to be conducted which will result in improved PDS going forward. **(Core Funding Investment)**	October 2017 – October 2018	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will continue to increase appropriate GP referrals for people with dementia. Over the last year primary care colleagues have been alerted to the importance of referrals of people with a suspected diagnosis of dementia through a variety of means. Including at the November Medical Education session and a data cleansing process matching diagnoses known in mental health with the primary care dementia register. **(Core Funding Investment)**	October 2017 – October 2018	

Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
People will be able to access a range of community-based health and social care services.	Weekly 'What Matters' hubs are now operational in all five Scottish Borders Localities, with additional less frequent more rural satellite hubs being considered for future development. ***(Integrated Care Fund)***	October 2016 – April 2019	Reduced demand on statutory services through increased local alternatives. Reduced Waiting Lists. Increased access to Information and Community Support. Reduced Revenue Costs from reduced demand.
People will be informed and have access to the right support at the right time.	We will develop Local Area Co-ordination (LAC) for adults and older people.	July 2017 – October 2018	
	After an analysis of demand the additional funding was utilised to recruit 2 part-time Local Area Co-ordinators and 2 part-time Community Link Workers. This has enabled an improved geographical spread for the Local Area Co-ordination Service in mental health across the Borders. ***(Core Funding Investment)***	April 2017 – March 2020	
Health and Social Care Services reduce admission to hospital, improve health and wellbeing and reduce demand for statutory services.	We will redesign day services with a focus on early intervention and prevention. ***(Transformation Programme)***	April 2017 – October 2018	Reduced admissions to hospital. Improved health and wellbeing.

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We are building on the work and expanding the Community Capacity Team and have introduced Community Link Workers from April 2018 to support people to access alternatives to statutory services. This is being piloted in the Central and Berwickshire Areas. ***(Integrated Care Fund)***	April 2018 – July 2019	Reduction in demand for statutory services. Reduced demands on GPs. Improved access to advice on minor health complaints.
	1 Pharmacy teams are taking on new responsibilities within GP surgeries in line with the new GMS contract pharmacotherapy service. This includes case management, supporting long term conditions (particularly respiratory disease and diabetes), care homes and polypharmacy reviews. The work should help prevent medication-related admissions and improve the quality of disease management. 2 A clinical technician is in place to support medicines management at discharge and an ICF project (using a project manager and pharmacy technician) is testing pharmacy input to patients receiving care packages. A change in the way pharmacy services are provided to the wards is speeding up the discharge process by helping to ensure medicines are ready in advance and increasing patient contact to discuss medicine issues. Medicine reviews of patients on certain medicines know to cause acute kidney injury was set up 2 years ago (Sick Day Rules). This has been shown in another Board to reduce admissions. We will continue to promote this service. 3 Increased funding for pharmacy services through the Primary Care Transformation Fund is support and increase in capacity within GP surgeries. The ICF project will free up capacity within community pharmacies by reducing carer's	April 2017 – March 2019	Reduced Revenue Costs from reduced demand.

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	reliance on medicines compliance aids (MCAs), which are timely to prepare and provide a safer system to support medicines management by carers. We continue to develop the role of the community pharmacist to improve health and wellbeing, reduce admissions and demand for other services, eg. BECS through Pharmacy First, medicines review, carer support and using quality improvement techniques ***(Integrated Care Fund)***		
Provide people with alternatives to hospital care.	We will support Transitional Care as a model of service delivery for people over the age of 50 who no longer require in-patient care but who do require up to 6 weeks rehabilitation outside of a hospital environment in order to regain and retain maximum levels of independence in their own home. ***(Integrated Care Fund)***	December 2017 – December 2018	Reduced emergency admissions and associated bed days. Reduce re-admissions to hospital. Reduced Revenue Costs from reduced demand.
	We will support a range of models of Discharge to Assess in order to reduce delays to hospital discharge for adults who are medically fit for discharge and have not yet regained sufficiently to live independently at home. The models we are currently support includes: (a) Craw Wood Discharge to Assess residential facility for up to 15 adults. (b) Berwickshire Hospital to Home Pilot Project. (c) Hawick Hospital to Home Pilot Project. (d) Central Discharge to Asses at Home Project. ***(Integrated Care Fund)***	December 2017 – October 2018	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will develop "step-up" facilities to prevent hospital admissions and increase opportunities for short-term placements. ***(Integrated Care Fund)***	April 2017 – March 2019	
	A review has been completed by Prof Anne Hendry regarding the existing model for community hospital and day hospital provision in the Borders. Work is now being progressed to link this with previous work undertaken by John Bolton to under a modernisation programme for the delivery of primary and community health care models. This forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a 3 year plan from 2018/19 to 2020/21. ***(Transformation Programme)***	April 2018 – March 2021	
	We will redesign the way care at home services are delivered to ensure a re-ablement approach. ***(Transformation Programme)***	March 2018 – October 2018	
	The Distress Brief Intervention Service has now been commissioned and commenced a role out in October 2017. ***(Integrated Care Fund)***	April 2017 – March 2020	
People are able to access the care and support they require within their own community.	We will extend the scope of the Matching Unit to source care and respite care at home to meet assessed need. ***(Integrated Care Fund)***	June 2017 – December 2018	Quicker and more efficient planning of care and support. More people at home or in a homely setting including when at the end of their life. Reduced demand for care at home and other health and social care services.

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will plan and deliver health and social care services by locality area, using the Buurtzorg model of care. ***(Integrated Care Fund)*** ***(Transformation Programme)***	April 2017 – March 2019	Reduced Revenue Costs from reduced demand and greater efficiency
	We will increase the use of telecare and telehealthcare. ***(Transformation Programme)***	October 2017 – June 2018	
	We will increase the provision of Housing with Care and Extra Care Housing. ***(Core Fund Investment)***	April 2017 – March 2020	
The delivery of health and social care services is improved through more integration at a local level.	We will develop integrated locality management. ***(Core Funding Investment)***	June 2017 – October 2018	Decreased duplication and more streamlined and efficient delivery of health and social care services at a local level. Reduced demand on statutory services through increased local alternatives. Increased access to Information and Community Support. Reduced Revenue Costs from reduced demand and greater efficiency.
People who use health and social care services have their dignity and right to choice respected.	We will continue to increase the number of people assessed for all Self Directed Support options. **(Core Funding Investment)**	April 2016 – March 2019	Improved care pathways for all care groups. Increased opportunities to have greater choice and control over planned care and support.

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	The pilot phase of the Transforming Care after Treatment Programme is complete. It will continue in Tweeddale and a rollout to the rest of the Borders is commencing with Eildon. **(Other External Funding)**	March 2018 – December 2018	Improved consistency and equity in the application of the Resource Allocation System. Responsibility for spend of allocated personal budget is transferred to individuals.
Resources are used effectively and efficiently in the provision of health and social care services.	We will deliver on our partnership information our Integrated Transformation and Integrated Care Fund programmes. **(Transformation Programme)** **(Integrated Care Fund)**	April 2017 – March 2019	Reduced costs through management of demand, reduced unit costs and elimination of duplication and waste. Scarce resources will be directed to those most in need and secure best value. Health and social care will continue to be affordable within a context of constrained funding, increased cost and greater demand. Improved outcomes for patients, clients and carers.
	We will deliver our three year Workforce Plan. **(Core Funding Investment)**	October 2016 – March 2019	
	We will shift resources from acute health and social care to community settings. **(Transformation Programme)** **(Integrated Care Fund)**	April 2017 – March 2019	
	We will demonstrate best value in the commissioning and delivery of health and social care. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	
	We will invest in and realign resources to deliver our strategic priorities and disinvest from services not required. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will design and implement cost-effective alternatives to traditional, costly models of care. **(Transformation Programme)** **(Integrated Care Fund)** **(Core Funding Investment)**	April 2017 – March 2019	
Health and social care services will reduce health inequalities.	We will continue to deliver Post Diagnostic Support to a higher proportion of people with dementia. In the last year the NHS Mental Health Older Adult service has moved from paper to electronic records (EMIS) affording the opportunity for revision of our Post Diagnostic Support pathway which is under way. At beginning of May 2018 a revised recording template will be implemented to provide a live and interactive template for each person with a diagnosis of dementia and will allow direct national reporting and local audits to be conducted which will result in improved PDS going forward. **(Core Funding Investment)**	October 2017 – October 2018	All people newly diagnosed with dementia are offered at least one year post-diagostic support. Local health and social care services which are designed to meet local need. Improved standard of health centre premises. Increased community support work form improved health centres. Improved GP services. Greater focus on prevention will result in reduced Revenue costs from reduced demand and increased efficiency.
	We will continue to increase appropriate GP referrals for people with dementia. Over the last year primary care colleagues have been alerted to the importance of referrals of people with a suspected diagnosis of dementia through a variety of means. Including at the November Medical Education session and a data cleansing process matching diagnoses known in mental health with the primary care dementia register. **(Core Funding Investment)**	October 2017 – October 2018	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will continue to review the standard of our health centres as part of the Primary Care Modernisation Programme. This is directly linked to the new GMS Contract. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a 3 year plan from 2018/19 to 2020/21. **(Core Funding Investment)**	April 2018 – March 2021	
	The Cluster Leads is concluded, as we have to have cluster leads as part of the new contract. This is directly linked to the new GMS Contract. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a 3 year plan from 2018/19 to 2020/21. **(Integrated Care Fund)**	April 2018 – March 2021	
People who provide unpaid care are supported to look after their own health and wellbeing in order to fulfil their caring role.	We will continue to commission the Borders Carers Centre to undertake all carers' assessments. **(Core Funding Investment)**	April 2017 – March 2019	Improved and more consistent support for carers. Better understanding of the numbers of people providing informal care.
	We will meet all identified carer needs which are assessed as critical. **(Core Funding Investment)**	April 2017 – March 2019	

Scottish Borders Health & Social Care Partnership
Strategic Plan 2018-2021

Housing Contribution Statement

Scottish Borders COUNCIL

CONTENTS

1. INTRODUCTION

The Integration of Health and Social Care and the Public Bodies (Joint Working) Act (2014) is the most substantial reform to the National Health Service and social care services in decades. Health Boards and local authorities must integrate services to provide a more joined-up and person-centred approach to health and social care, enabling independent living where appropriate. National health and wellbeing outcomes and associated joint strategic commissioning plans / housing contribution statements, provide a practical framework and set an ambitious agenda to improve the health and wellbeing of people across Scotland, within a challenging context of an ageing population, public sector budget constraints, technological change and increasing expectations.

The Scottish Borders Health and Social Care Partnership first published its Strategic Plan in April 2016 following extensive consultation with people and communities across the Borders. Nine local objectives were identified which reflected the identified priorities and supported the delivery of the nine national health and well-being outcomes.

Following the publication of the five Health and Social Care Locality Plans in April 2018 it was identified that the Scottish Borders Health and Social Care Strategic Plan would benefit from a refresh to ensure that the strategic objectives were fit for purpose and continue to reflect the priorities of the population and communities of the Scottish Borders.

The refreshed Strategic Plan sets out a high level summary of the continued case for transforming the way in which health and social care services are delivered in the Scottish Borders as well as considering the significant role Housing has to play in the delivery of our integrated health and social care services.

Poor or inappropriate housing can contribute to a wide range of physical and mental health problems. Actions relating to housing have the potential to produce significant benefits in the health and well-being of individuals and the wider community, and generate savings in public and private expenditure on health, housing and social services.

This updated Housing Contribution Statement sets out the role of the housing sector in achieving the Health and Social Care Integration objectives in the Scottish Borders and builds on the previous statement and strategic plan produced in 2016.

2. LOCAL HOUSING STRATEGY

The Housing (Scotland) Act 2001 places a statutory requirement on local authorities to prepare a Local Housing Strategy (LHS) every five years, setting out a vision for the supply, quality and availability of housing in their local area.

The LHS is the key planning document, providing a framework of action, investment and partnership-working to deliver these local priorities. The new Local Housing Strategy sets strategic outcomes and a delivery plan framework for the period 2017 – 2022. Local Housing Strategy 2017-2022

LHS VISION

Every person in the Scottish Borders lives in a home that meets their needs

In order to deliver this vision successfully and contribute to the Borders Community Plan and Health and Social Care Integration, as well as the Scottish Government's National Outcomes and National Health and Wellbeing Outcomes; the following four LHS priorities have been defined:

The supply if housing meets the needs of our communities	**More people live in good quality, energy efficient homes**	**Less people are affected by homelessness**	**More people are supported to live independently in their own homes**

The LHS has a key role to play in contributing to the effective integration of health and social care. The clear aim of the integrated health and social care services is to shift the balance of care towards prevention and early intervention to ensure that individuals have better health and well-being. As a consequence, services are being redesigned around the needs of the individual. Critically, work is being undertaken to enable the balance of resources shift from acute to preventative services; and away from inpatient/institutional settings and towards in-home/community settings.

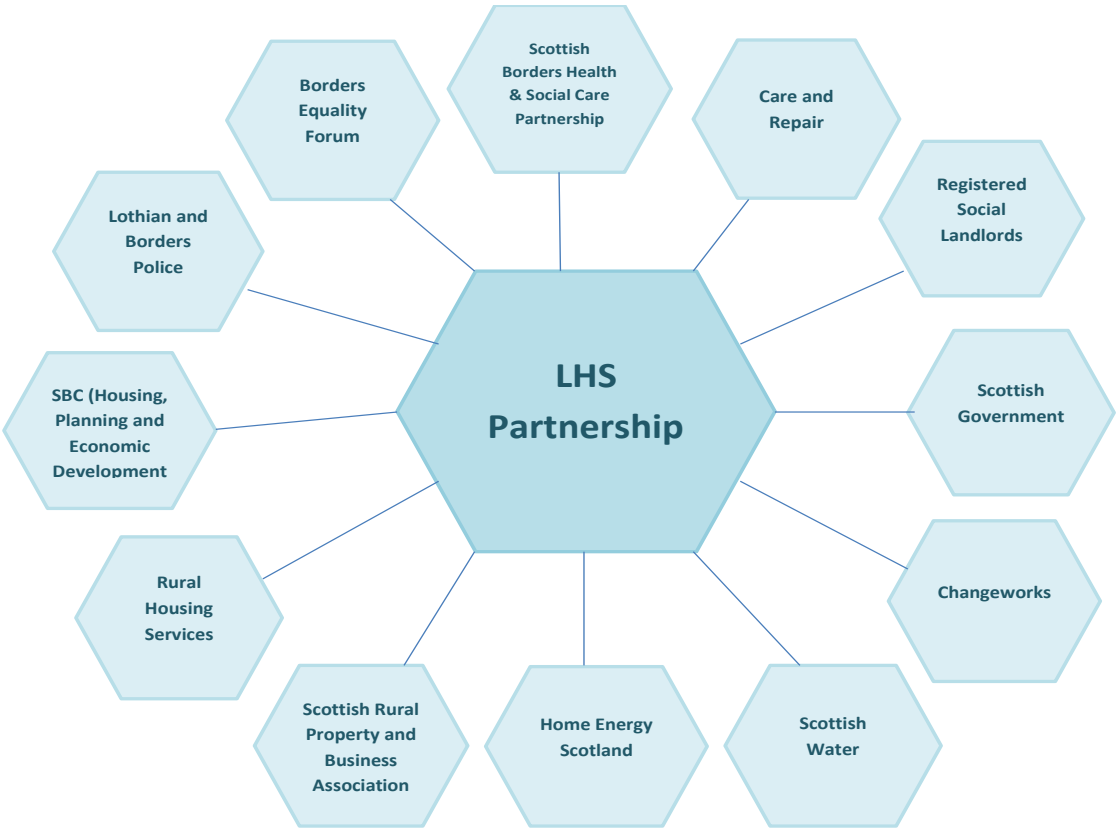
The refreshed strategic plan, the LHS, and this Housing Contribution Statement sets out clearly the contribution that housing can make in support of this agenda, through the design and delivery of housing and housing related services, that are capable of responding to the needs of individuals as and where they arise. The new LHS 2017-22 sets out in more detail what the integration of health and social care means in terms of providing suitable accommodation and the care and support required to fully support this agenda, whilst enabling people to live independently within their own home for as long as possible.

Local Housing Strategy Partnership

The Scottish Borders LHS Partnership is the housing market partnership for Scottish Borders. Figure 1 on page 5 highlights all of the representatives on the partnership. A range of issues from commissioning, new supply, SESPlan and the Housing Need and Demand Assessment (HNDA) are reported and discussed at the Partnership and the new Borders Housing Alliance.

Over and above the Housing Market Partnerships, the Council is hugely reliant on a range of partners to ensure that the ambitions of the LHS are realised and the range of partnership groups responsible for development and delivery of LHS objectives is set out in figure 1:

Figure 1: LHS Partnership



The LHS strategic outcomes and delivery plans are reviewed annually by the LHS Partnership Groups. Key LHS indicators will also be reviewed in a number of areas: in particular, annually through the Community Plan and within Partners' returns to the Annual Return on the Scottish Social Housing Charter.

In addition to strategic monitoring, partners are also responsible for the monitoring of their operational functions as they relate to the LHS outcomes; for example, housing management, housing investment/capital programme, and homelessness.

3. HOUSING PROFILE

Figure 2 below highlights some of the key information in regards in housing in the Scottish Borders. This information is also captured in the Scottish Borders Health & Social Care Partnership Joint Strategic Needs Assessment document to support the development of the Strategic Commissioning Plan 2015 – 2018. This document provides a wide range of evidence which will be continually built on to inform decision making in the future.

Figure 2: Housing Profile

Population
- 115,020 total population, 27,699 aged 65 and over – 24% of the population

Households
- 53,787 total households in 2016 (peercentage change of 13.4% since 2001)

Household Composition
- 35% one adult, 36% two adults, 5% one adult, one or more children, 18% two or more adults, one or more children and 6% three or more adults

Tenure
- 59% owner occupied, 27% social rent and 14% private rent (2014-16 SHCS)

Dwellings
- 57,940 total dwellings – 13% increase since 2011

Rurality
- 47% of the population live in rural areas (2016) – 36% Accessible Rural, 11% Remote Rural

House Building
- 2017/18 – 144 affordable housing, 512 average market completions per year

Empty Homes
- 2017 - 1,419 long term empty homes, 960 second homes in the Scottish Borders

Adaptations
- 2015/16 – more than 750 adaptations and 4,200 handyperson jobs for older people completed by the Borders Care & Repair Services in 2016/17 (81 of those being major adaptations

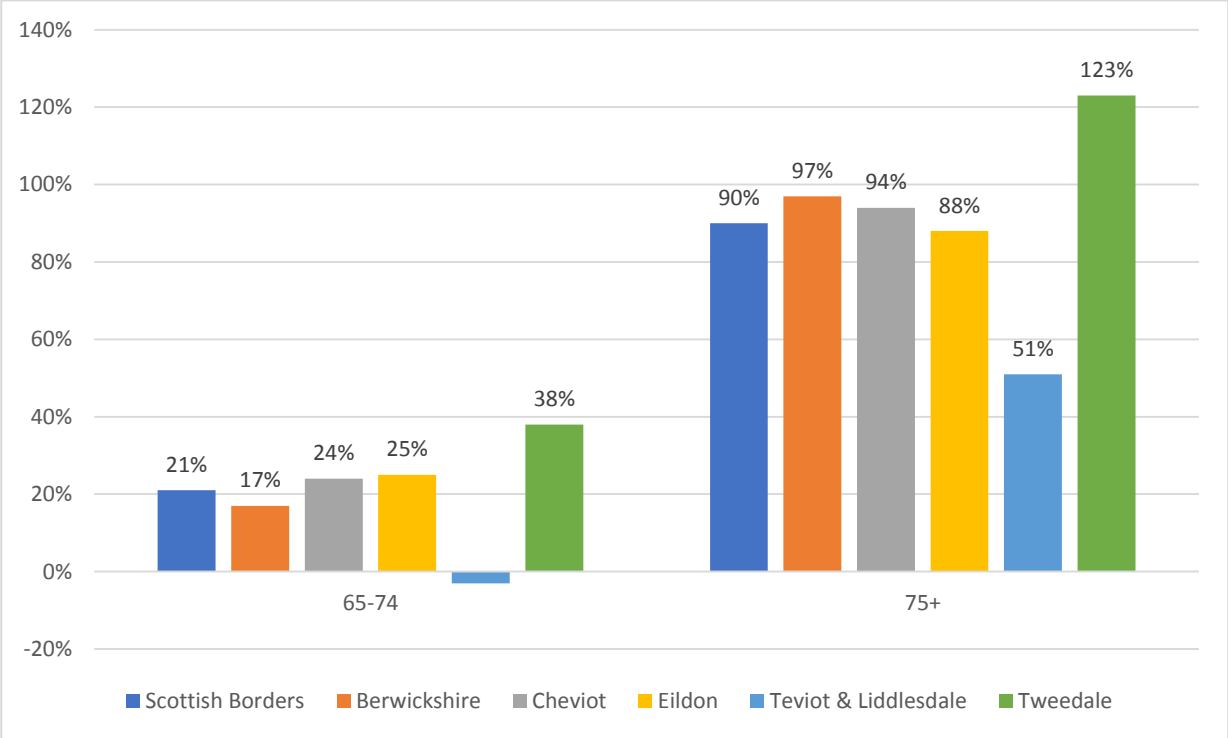
Specialist Provision
- 19 residential care/nursing homes providing 700 places
- more than 170 extra care housing/housing with care spaces
- over 400 sheltered and 52 very sheltered houses, with over 2,000 different types of specialist social rented housing targeted for older people
- more than 750 adaptations and 4,200 handyperson jobs for older people completed by the Borders Care & Repair Services in 2016/17
- 2 Care Homes, 975 Medium Dependency/ Amenity, 614 Sheltered, 56 Very Sheltered/ Extra Care housing, 131 Wheelchair housing and 64 housing with care clients across 4 venues

Older people in the Scottish Borders

The Scottish Borders household population is growing slower compared to Scotland as a whole - 7% increase to 2037, compared to 17% for Scotland. But households over 75 years are growing at one of the highest rates across Scotland – Scottish Borders projects a 90% increase to 2037, compared to Scotland's 82%. All households over 65+years are predicted to increase by 54%, at the same rate as Scotland overall. Currently just over a third of the total household population in the Scottish Borders are aged over 65 years - in 20 years, nearly half of all households (46%) will be aged over 65 years.

The projected increases by age varies considerably by locality with Tweeddale showing the greatest increase of older people aged over 75 years, followed by Berwickshire – the two areas where the provision of Home Care is already under greatest pressure. Teviot is showing a small decrease in number of household 65-74 years, and the smallest proportional growth of households aged over 75 years.

Figure 3: Increase in older households in the Scottish Borders 2012-2037



Most older people (68%) in the Borders own their homes, and most of these people own their properties outright. The level of equity held by many of these households is considerable, but we also know that there are very few options in the private sector for older people wishing to move from their current home to a more suitable housing option to meet their longer-term needs.

Scottish Borders Council new housing supply target over the next 12 years is 348 new homes each year, made up of 128 new affordable homes and 220 new private homes per annum. Comparing this against the current households living in the Borders this is only 2% new addition to the housing stock each year. While renewal and refreshment of the housing stock is important to meet a range of needs, the new Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028 recognises that the majority of housing, care and support needs will be met in people's existing homes. While the housing annual supply

target is 128 new affordable homes, Scottish Borders current Strategic Housing Investment Plan (2018-2023) sets out more ambitious plans for over 200 new affordable homes each year for the next four years.

Housing Need and Demand Assessment

Revised guidance for housing need and demand assessment (HNDA) was provided by the Scottish Government in 2014, emphasising the need for housing practitioners to engage with health and social care planners to share evidence, identify needs and plan for solutions across health, social care and housing. One of the key aspects of the HNDA is to provide evidence to inform policies related to the provision of specialist housing and housing-related services.
The second SESplan (Scottish Borders, Edinburgh, East Lothian, West Lothian, Midlothian and part of Fife) Housing Need and Demand Assessment received robust and credible status in March 2015. One of the purposes of this assessment is to provide evidence to inform policies related to the provision of specialist housing and housing-related services.

Housing is at the heart of independent living with the term 'social care' associated with certain housing functions which can improve the lives of vulnerable and older people and significantly reduce health and care costs. Typically, such housing functions can be categorised as follows:

- Provision of 'fit for purpose' housing – this includes provision of sheltered; very sheltered and extra care housing and repairs and adaptations
- Provision of information and advice – on housing options; welfare advice; training and employment support; advocacy support; befriending services and assistance in finding alternative housing
- Provision of low level support and preventative services – this includes housing support; community alarms; tele-care and tele-health; care and repair services; small repair services; handyperson services and garden maintenance.
- Community capacity building – with housing organisations promoting tenant participation in local activities and development of community led social enterprises

Based on the demographic and health profiles, the current level of health and social care provision is unlikely to keep up with the levels that will be required in future, particularly for an ageing population. Not only are people living longer, but a significant number of these people are projected to live beyond 85 years. Despite relatively good health and life expectancy, this will mean increased frailty and complex health needs, with increased housing, health and social care services required, particularly in areas where there are a high proportion of older people living alone.

The SESplan HNDA estimated 6,423 households in the Scottish Borders were in housing need. (31st March 2013) comprising a requirement for adaptations (47%); households living in poor quality housing (25%); overcrowding households (17%); special forms of housing (5%); concealed households (4%) and homeless households (3%). Most of this can be resolved in-situ or by the market (5,204) leaving 1,219 households remaining in need. The housing needs of these households cannot be met in-situ using existing social housing and they cannot afford a market solution. Instead they will require additional (including new) social housing.

4. HEALTH AND SOCIAL CARE PARTNERSHIP

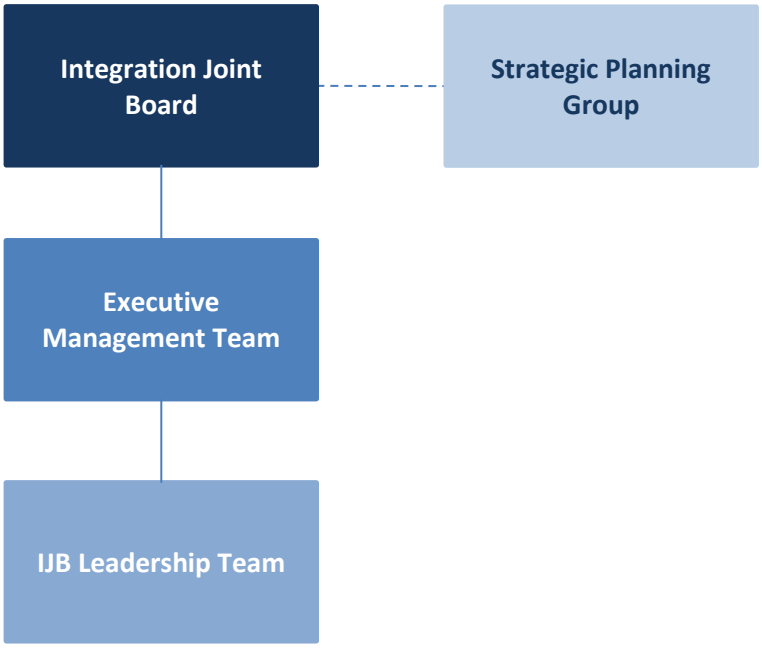
The Scottish Borders Health and Social Care Partnership launched in April 2015. The partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The total NHS and social care spending in the Borders in 2015/16 was £276.3m. 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, and we can also work in partnership with our communities.

The implementation of the Health & Social Care Partnership Strategic Plan will be supported by supplementary plans related to specific themes (for example Dementia, Mental Health, and the Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028), and Locality Plans that reflect differing patterns of need across the Borders.

Governance

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The legislation supporting Health and Social Care Integration, through the Integration Joint Board, offers the opportunity for Councillors, Health Board Non-Executive Directors, the Third Sector and Independent Sector to work together to plan for a future health and care service able to meet the demands of the future. The Integration Joint Board will plan and commission services to ensure that the national and local outcomes are all based on providing a more person centred approach with a focus on supporting individuals, families and communities. Figure 4 below shows the current structure of the Integration Joint Board process.

Figure 4: Integration Joint Board Governance Arrangements



The legislation also requires the Partnership to set up a Strategic Planning Group (SPG) to support the development of the new integrated arrangements. The Borders SPG was established in May 2015.

Reflecting the range and diversity of health and social care stakeholders in the Borders, the group is made up of representatives from a range of organisations including representatives from both the Statutory and social housing sector as shown in Table 1 below.

Table 1: Strategic Planning Group

Role	Organisation
Health professional	The area clinical forum
GP	GP sub-committee
Commercial providers of social care	Scottish Care
Scottish Borders Council	Health and Social Care, Housing
Third sector bodies	The Bridge
Staff representatives	SBC, NHS Borders
Non-Commercial providers of social housing, health care, and social care	Eildon HA, SBCares
Carers of users of health care and users of social care	Borders Carers Centre
Users of health care and of social care	NHS Public Participation Network, Borders Voluntary Care Voice

Housing's Key Role in Locality Planning within Health and Social Care Partnership

This Strategic Plan (2018-2021) recognises the role of housing in the context of health and social care in the Borders. In particular, it stresses the importance of housing options, giving people more freedom and choice; of developing the supply of appropriate housing to meet changing needs as the populations ages; of building capacity in communities to support older people at home and having housing in place to keep people independent. It specifically highlights the integrated housing functions of aids and adaptations.
The new Strategic Plan (2018-21) identifies 3 Strategic Objectives:

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

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

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

The Partnership's local strategic objectives are also aligned and contribute to the delivery of the nine National Health and Wellbeing Outcomes.

The delivery strategy for the Strategic Plan (2016-19) and now this refreshed plan has been more fully developed in the Locality Plans (undertaken at the five localities: Berwickshire, Cheviot, Eildon, Teviot and Liddesdale, and Tweeddale). Groups were established in each of the five localities to oversee the development of these locality plans.

Service users, carers, communities and health and social care professionals, including housing representatives, must be actively involved in locality planning so that they can influence how resources are spent in their area.

Figure 5: Area Forum Localities

The LHS sets out in more detail the role of the housing sector in achieving the Health and Social Care Integration outcomes at a local level in the Scottish Borders, for example by:

- undertaking effective strategic housing planning
- providing information and advice on housing options
- identifying, facilitating and delivering suitable housing that gives people choice and an appropriate home environment
- providing low level, preventative services which can prevent the need for more expensive interventions at a later stage
- building capacity in local communities

5. DELEGATED AND NON-DELEGATED FUNCTIONS

In March 2016 the Integration Joint Board approved the Strategic Plan 2016-19 and Scottish Borders Council and NHS Borders delegated functions to the new Scottish Borders Health and Social Care Partnership. The Act sets out a range of health and social care functions, including functions under housing legislation, which 'must' or 'may' be delegated to an integration authority.

The housing functions that were delegated by Scottish Borders Council to the Health and Social Care Partnership are:

- Adaptations – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living.
- Housing Support – housing support is defined in housing legislation as any service which provides support, assistance, advice and counselling to an individual with particular needs to help that person live as independently as possible in their own home or other residential accommodation such as sheltered housing.

There are some housing functions which are not delegated functions but which provide a resource to support health and Social Care Integration and the outcome it is seeking to achieve:

- RSL adaptations – providing adaptations to their tenants to enable them to live independently, for example providing , a handrail or ramp at the entrance, or a shower in place of a bath
- Care and Repair – providing independent advice and assistance to older and disabled homeowners or private tenants with services that enable them to continue to live independently in their own homes. The service provides adaptations, home improvements and a handy person service
- Housing support services for homeless people – providing housing and tenancy support to vulnerable homeless people
- New supply housing – the Strategic Housing Investment Plan (SHIP) 2018-23 sets out proposals for up to 1,177 new affordable Borders homes and a total investment of up to £174.5m over the next 5 years.

6. THE ROLE OF HOUSING IN THE INTEGRATION OF HEALTH AND SOCIAL CARE (SHARED OUTCOMES AND PRIORITIES)

The National Health and Wellbeing Outcomes are shown in figure 6 below. Scottish Borders Council and it partners can make a contribution to the achievement of many of the National Health and Wellbeing Outcomes. For example, Outcome 2 is of particular important in when considering the housing contribution.

Figure 6: National Health and Wellbeing Outcomes

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

In terms of Housing's contribution to the Strategic Plan 2018-21 The Local Housing Strategy (LHS) provides the strategic direction to tackle housing need and demand and to inform the future investment in housing and related services across the Scottish Borders area.

The LHS brings together the Local Authority's responses to the whole housing system including: requirements for market and affordable housing; prevention and alleviation of homelessness; meeting housing support needs; addressing housing conditions across tenures including fuel poverty and linkages with the Climate Change (Scotland) Act 2009.

It is important that the LHS links with Health and Social Care Strategic Plan and table 2 on page 14 highlights the links between the Strategic Local Objectives and the LHS Outcomes.

Table 2: Links between Strategic Objectives and LHS Outcomes

Strategic Objectives	LHS Priorities			
	1. The supply if housing meets the needs of our communities	2. More people live in good quality, energy efficient homes	3. Less people are affected by homelessness	4. More people are supported to live independently in their own homes
We will improve the health of the population and reduce the number of hospital admissions;	✓	✓	✓	✓
We will improve patient flow within and out with hospital;	✓	✓	✓	✓
We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.	✓	✓	✓	✓

Table 3 provides a further breakdown as to how housing links into the Strategic Plan's local objectives and how housing can contribute to each of the objectives of key principles.

The new Strategic Plan (2018-21) identifies 3 Strategic Objectives:

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

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

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

Table 3: Housings Contribution towards Strategic Plan Objectives and Principles

Objectives and Principles of Strategic Plan 2018-21	Housing Contribution
Objective: We will improve the health of the population and reduce the number of hospital admissions	• The vision of the LHS is to ensure "Every person in the Scottish Borders lives in a home that meets their needs". Providing safe, secure, warmer and more comfortable homes of an appropriate size, in an appropriate location and that are affordable to live in will reduce existing health problems – heart attacks, strokes, hypothermia, raised blood pressure, asthma, mental health problems, respiratory disease and also help prevent health issues occurring. • Delivery of adaptations and handyman's service (including fall prevention measures such as grab rails) • Providing housing support, directly and with partners to help people remain in their own home and prevent homelessness. Reduces stress, anxiety – keeping people in their homes

Objective: We will improve patient flow within and out with hospital	• Implementing the Older People's Housing, Care and Support Strategic Plan • Ensuring the reablement and hospital to home service development aligns with housing providers and care and repair services.
Objective: We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.	• Part of the ambitions of the Integrated Older People's Housing Care and Support Strategic Plan is to Invest in social infrastructure, looking to harness the strengths of our own communities in developing capacity in care and support for family member and friends. • Housing Representation on key partnership groups, including the SPG and the Community Led Support Steering Group • The availability of Housing related information and advice at the "What Matters Hubs"
Principle 1: Prevention & early intervention	• Preventing homelessness through the Housing Options approach • Investment in Adaptations • Expand on and develop new initiative housing with support models for particular needs groups such as transitional housing for those leaving care or institutions • Provision of welfare benefits advice and financial inclusion services • Unified, partnership working framework for assessing health and housing needs (Unified Health Assessment) • Housing Officers visiting vulnerable households on a regular basis – identifying the needs of that person • Development of Housing Information and Advice Strategy/Communications Plan for private sector households • Strategic review of Scheme of Assistance to shift activity towards preventative investment • Development of Affordable Warmth Plan and fuel poverty awareness raising activity • Expanding the Care and Repair model • Review the falls prevention strategy, working widely across all partners in the Borders to ensure consistent approach and sharing of intelligence across key health, social care and also housing staff. • The 2015 Scottish Public Health Network paper "Restoring the public health response to homelessness" identified preventing through much earlier intervention and prevention activity https://www.scotphn.net/wp-content/uploads/2015/10/Restoring-the-Public-Health-response-to-Homelessness-in-Scotland-May-2015.pdf
Principle 2: Accessible services	• Access to affordable housing – delivering affordable housing across the area • Delivering warm housing in good condition • Working with local housing associations and private sector landlords to provide housing which is fit for purpose • Deliver more accessible, barrier free housing • Tenancy sustainment and Support Services through Housing Providers
Principle 3: Care close to home	• Housing Support Services • Borders Care & Repair provide a handyman service which will carry out handyperson jobs or advise on home upgrading & grant funding
Principle 4: Delivery of services with an integrated care model	• Using the planned investment in extra care housing to drive wider service change, including using the new extra care developments as hubs in a wider 'hub and spoke' approach to delivering home care services to people in their own homes across Scottish Borders • The housing sector in the Borders has a range of partnership mechanisms to enhance the level of staff engagement: ➢ LHS Partnership ➢ Borders Housing Hub ➢ Older Persons Housing, Care and Support Steering Group ➢ Strategic Housing Investment Plan Working Group ➢ New Borders Alliance

	➢ Private Landlord Forum ➢ Community Planning Partnership ➢ New Integrated Homelessness and Wellbeing Strategic Partnership • Commitment to review and formalise commitments to Care & Repair to enable long term development of the service, enhancing the service to include a dementia service and increase capacity in prevention information and advice and falls prevention, including moving home service. • Commitment to review the spend on adaptations to consider scope for consolidation between funding streams, and continue dialogue with Scottish Government over the adequacy of funding for the RSL sector tenants / future demand.
Principle 5: Greater choice & control	• LHS Priority 4 "More people are supported to live independently in their own homes" • Implementation of the integrated Older Persons Housing Care and Support Strategic Plan • Flexible Housing Support options • Modernisation, remodelling and reprovisioning of existing sheltered housing schemes • Training and employment skills development and opportunities for employment • Aids and Adaptations • Borders Care & Repair services help disabled homeowners or private sector tenants with adaptations that will enable them to stay in their own home. • Safe Housing Options and co-ordinated services for Domestic Abuse Victims and their families • Undertaking a Housing needs and Aspirations study for Young people in the Borders – through extensive engagement and qualitative/quantitative research to help identify appropriate responses to meet those needs
Principle 6: Optimise efficiency & effectiveness	• Collaborative approaches to delivery plans and commissioning services through a range of partnership mechanisms such as: • SPG • LHS Partnership Group • Borders Housing Alliance • Integrated Older Persons Housing Care and Support Steering Group • Integrated Homelessness and Wellbeing Strategic Partnership
Principle 7: Reduce health inequalities	• The four outcomes of the LHS aim to tackle the inequalities in our society – this includes health inequalities • Building safer and thriving communities is a key priority to focus local community planning activities to assist Borders's most disadvantaged communities and improve employment and health inequalities. • Specific examples include: ➢ Significant levels of investment in improving the Energy Efficiency of homes across the Borders, as well as the provision of Home Energy Advice, helping to make homes warm and more comfortable. ➢ Activities of Housing providers in terms of the provision of information and advice to tenants on a range of issues from financial advice, eating well and keeping warm. ➢ Improving access to health and social care services for homeless people, particularly for those with complex needs by working with integration partners.

Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028

The Local Housing Strategy 2017-22 identified the development of an integrated older persons housing strategy as a strategic priority. Partners in the Scottish Borders have since produced an integrated Strategic

Plan setting out a vision for enabling older people to have greater choice of housing, support and care that meets their long-term needs. It is focused on enabling independent living but proposes an investment and service framework which tackles the logistical and market challenges experienced in the Scottish Borders. It proposes investment in housing for older people, technology-based services, and additional people capacity as a means of ensuring future needs can be met.

The Integrated Strategic Plan for Older People's Housing, Care and Support was developed through a steering group involving all Scottish Borders Health and Social Care partners, and the Scottish Borders Housing Network. Partners consulted with the Locality Planning Groups to understand perspectives from residents and staff living and working in the local areas about the challenges and possible solutions to meet the housing, support and care needs of older people living in the Scottish Borders. Working in partnership across the public, private and third sectors, the ambition of the Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028 is to:

- Enable investment in existing homes, and to invest significantly in technology (including telecare) to enable older people to continue living at home as their needs change
- Improve the availability of information and advice to enable older people to make best housing choices to meet their future housing, care and support needs, including advice and assistance on moving home if this is the best option
- Increase the housing options of newly built houses in the private and rented sectors so that people that want to move home have more choice
- Invest in extra care housing and other types of housing with on-site support so that people are living independently but have the safety and security of care and support nearby
- Use the planned investment in extra care housing to drive wider service change, including using the new extra care developments as hubs in a wider 'hub and spoke' approach to delivering home care services to people in their own homes across Scottish Borders
- Invest in social infrastructure, looking to harness the strengths of our own communities in developing capacity in care and support for family member and friends.

Over the next 10 years the Scottish Borders Health and Social Care partners will invest close to £130m to enable:

- 400 extra care houses (including 60 in a new retirement campus)
- 300 new build houses suitable for older people for sale and in the rented sector
- Existing housing, refurbished or remodeled - 300 houses in the social rented sector
- Housing support on site to be offered to 300 more older households across housing sectors
- Over 8,000[1] adaptations and small repairs to enable people to stay in their own home
- A minimum of an additional 20 specialist dementia spaces to meet the need identified in the emerging Dementia Strategy
- Investment in telecare / telehealth for over 800[2] households.

[1] Based on an extrapolation of current levels, plus unmet need, increased in line with projected need
[2] Based on assessment of the number of projected Scottish Borders home care customers who would benefit from telecare using recognised industry criteria

WHAT THIS MEANS…

- Good housing options are critical, giving people more freedom and choice;
- We need to develop the supply of appropriate housing to meet changing needs as the populations ages
- We need to continue building capacity in communities to support older people at home and having housing in place to keep people independent
- Aids and Adaptations play a crucial role in prevention activity and enabling independent living
- There is a strong link between access to good Housing and the general Health of the population
- Housing has an important role to play in the delivery of our integrated health and social care services. The Scottish Borders Local Housing Strategy (2017-2022), the Strategic Housing Investment Plan (2018-23) and the Integrated Strategic Plan for Older People's Housing Care and Support sets out our work in relation to housing in more detail.

7. PRIORITIES AND CHALLANGES

A number of workshops have been held between SBC, housing providers and colleagues from health and social care to have a focused overview on the housing dimension of integration, explore the existing provision and linkages in the Borders and to identify the key priorities and challenges for the Housing Contribution Statement.

Priorities

Housing Support and Homelessness

Since 2012, homeless prevention has been very effective in the Borders, with homeless applications remaining stable around the 650 mark per year. Homelessness prevention has been a major aspect of the national housing agenda for more than a decade. A commitment to the delivery of person-centred, preventative services which target early intervention and personal choice is an integral part of the LHS and the local housing options approach. The service redesign agenda for the Homelessness Services was guided by an ongoing strategic delivery plan framework which is and continues to be underpinned by the following objectives:

- Preventing homelessness by working in partnership with other agencies;
- Maximise access to a range of support and assistance to help people achieve or maintain independence;
- More integrated accessible housing options and advice for all customers with a focus on health and well-being and prevention

In Scottish Borders, the Housing Support Model was developed at a key time to form part of the overall commitment to tackling and preventing homelessness. The model recognises the requirement to ensure that local housing support services continue to meet the needs of individuals in the community. The model also recognises the importance of identifying the key demands/underlying needs in the Scottish Borders in order to determine how best services can be delivered to meet housing need and prevent homelessness.

SBC doesn't have access to a large range of providers although the council continuously explores new and more aligned ways to work and ensure support is person centred. A key priority for Housing and Health and Social Care partners is to continue to develop new models and expand on existing specialist housing models for older people and vulnerable client groups, such as transitional housing for young people leaving care and people with learning disabilities.

The Strategic Plan must also consider the recent HARSAG recommendations including ensuring that public bodies do not discharge people into homelessness; that "all public bodies (have) a duty to take steps to prevent homelessness"; and to "ensure plans are always agreed to prevent homelessness for people leaving public institutions", and to move to a default 'rapid rehousing' model.
https://beta.gov.scot/publications/ending-rough-sleeping-in-scotland-interim-report/

The Scottish Government Homelessness Prevention and Strategy Group also recently stressed the importance of developing "pathways for people where pathways are difficult but predictable (e.g. SHORE standards and similar for other institutions)". : https://beta.gov.scot/publications/homelessness-prevention-and-strategy-group-minutes-march-2018/.

Access to housing

Partners acknowledge that increasing access to housing supply and offering a better range of both settled and temporary options requires tailored responses to the dynamics of the housing system at a local level. In some localities even modest supply side interventions could make a significant difference to those facing or experiencing homelessness or experiencing a delay in hospital discharge. Aligned to improving access to accommodation however, is the need for proactive and person-centered Housing Options advice services that enable early action and informed decision making.

- Provide a range of housing allocation protocols for vulnerable adults and those with complex needs
- Greater early involvement of housing partners in the planning of hospital discharges to co-ordinate and ensure that safe, suitable housing is available upon discharge to prevent delays in discharge once clinical needs are met and reduce risk of re-admissions

Affordable warm and fuel poverty

Living in cold conditions is a risk to health. There is an established body of evidence that identifies direct and indirect health impacts suffered by those living in fuel poverty and cold housing, which include links to respiratory and cardiovascular disease and negative impacts on mental health.

Properly designed and implemented actions to improve housing energy performance can have major co-benefits for public health. There are a wide range of initiatives in place that aim to improve the energy efficiency of housing and reduce carbon emissions. Programmes are funded from a range of sources and are led by the Council and other partners. Work will continue to be targeted at deprived and vulnerable households who are more likely to live in energy inefficient housing, especially those who do not have access to social housing. Energy efficiency advice is also made available by housing providers and is targeted at those people most likely to be most affected by fuel poverty.

Key areas for action include:

- Providing warm, energy efficiency homes and home energy advice
- Linking fuel poverty work and health and well-being
- The establishment of the new Borders om energy Forum
- The development of a new Affordable Warmth and Energy Efficiency Strategy in 2018.

Adaptations

The projected increases in the number of older people and people with dementia, together with unmet needs from people with physical disabilities and people with learning disabilities result in increased demand for housing support, housing adaptations, and specifically designed or adaptable housing.

A 2012 study about adaptations found that:

- Adaptations generate savings and value for the health and social care budget, far in excess of the amount invested;
- adaptations bring increased independence, confidence, health and autonomy for tenants;

There is clear evidence that small changes to homes can relieve pressure on the NHS and social care and studies have shown that, for example, preventive work associated with falls on stairs would give a return of 62p for every £1 spent with a payback period of less than eight months.

Priorities include:

- Increasing investment in low level support and preventative services – such as housing support; community alarms; tele-care and tele-health; care and repair services; small repair services; handyperson services and garden maintenance
- Increase use of technology and safety measures such as telehealth and community alarms to support independent living.

Housing supply

Scottish Borders Council new housing supply target over the next 12 years is 348 new homes each year, made up of 128 new affordable homes and 220 new private homes per annum. Comparing this against the current households living in the Borders this is only 2% new addition to the housing stock each year. While renewal and refreshment of the housing stock is important to meet a range of needs, the Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028 recognises that the majority of housing, care and support needs will be met in people's existing homes. While the housing annual supply target is 128 new affordable homes, Scottish Borders current Strategic Housing Investment Plan (2018-2023) sets out more ambitious plans for over 200 new affordable homes each year for the next four years.

Priority:

- Increasing the supply of specialist housing such as wheelchair accessible, extra care, housing with support, and intermediate housing designed with and for people with particular needs, as well as emphasising the wider contribution of warm, safe, affordable housing supply

Private sector

One of the key priorities identified in the LHS is to improve the condition and management in private rented housing and a number of interventions and actions have been identified to support this, including:

- Improve the availability of information and advice to enable people to make best housing choices to meet their future housing, care and support needs, including advice and assistance on moving home if this is the best option
- Provision of Information and Advice to improve Housing Quality and standards
- Developing a new Private Sector House Condition Improvement Plan; and
- A Private Rented Sector Communications and Engagement Strategy

Sustainable places

Well-designed, sustainable places, both urban and rural, support people's physical and mental wellbeing and good health is determined by a range of factors — many of them linked to the quality, accessibility and sustainability of the physical environment. Linked priorities for future improvements include:

- Examining housing standards and link to health and well-being – condition, energy efficient and specialised aspects such as dementia-friendly
- Better joint planning on examining opportunities to re-model or find alternative uses for existing housing stock
- Encourage and support community cohesion and resilience such as facilitating cross-generational community based activities and events
- Promote visiting support services such as befriending and carers support services particularly in rural villages to prevent social isolation and increase/maintain social networks of vulnerable people and their carers
- Support local initiatives to increase training and employment opportunities

Ongoing Challenges

Since the development of the previous Strategic Plan (2016-19) and the new Local Housing Strategy in 2017 there has been significant progress and achievements realised across many priority areas, as reflected in the Annual Performance Reports and LHS Annual Reports. The development of the new Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028 in particular demonstrates the commitment to a collaborative and preventative approach in the Borders and an understanding of the inter-relationship and strong, linkages between Housing and Health and Social Care.

Looking forward, there is a projected 75% growth in different types of housing, care and support services required estimated over the next 10 years, above current supply. These needs vary between long term care and support, lower level home care, housing support on site and adaptations/small repairs. To help effectively address those needs there are still a number of areas where there are opportunities for further collaborative working and improvements to service delivery, including:

- **Improving the joint analysis of housing, health and social care needs** – ensuring that we all work jointly to identify the needs of the local community – building on work in the JSNA, Local Housing Strategy and Housing Need and Demand Assessment. There is a requirement for joint analysis and s shared evidence base and for the JSNA and HNDA to be more closely aligned in the future.
- **Improving strategic and operational planning structures** - effective working between different agencies, in particular housing, health and social service authorities with respect to strategic planning, service commissioning and service provision
- **Identifying and implementing initiatives to get a better understanding of the housing sectors role and improve outcomes** - Housing, health and adult social care services will develop closer working relationships in the commissioning arrangements of supported housing and housing support services in order that we maximise their impact for both individuals and the wider health and social care system
- **Providing support to all staff across the housing sector** – ensuring staff are kept up to date and supported through transformational changes.
- **Providing housing options advice** – continuing to provide housing options advice and widening this service to assist people as they get older - helping people stay at home for longer. Closer working

relationships with housing, health and social care will provide opportunities to prevent and intervene earlier for 'at risk' communities, including homeless people. This should consider the role of communities, the voluntary sector, and any workforce that comes into contact with 'at risk' groups, including, primary and secondary health care, allied health professionals, social care, housing and homelessness.

- **The establishment of the Homelessness and Wellbeing Partnership in 2018** and the development of the Integrated Homelessness and Wellbeing Strategy will support this activity. Strategic Housing Services will also consider what further resources may be required to ensure frontline health and social care professionals can identify appropriate services in their area to refer people at risk of homelessness.
- **Responding to the needs of the older population** - Scottish Borders HSCP and the Integrated Joint Board are aware of the challenges in health and social care for older people and has instigated a Transformational Programme. This will redesign services for older people including discharge to assess hospital at home, telehealth/telecare and What Matters Hubs. The period of new Strategic Plan will also see the early stages of the implementation of the new Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028.

8. RESOURCES

The total NHS and social care spending in the Borders in 2015/16 was £276.3m. All NHS services are included in this total – including health services that are not covered by integration (such as planned outpatient and inpatient care). The overall spending was split 51% Community-Based Care versus 49% Institutional Care.

The Borders has already made some progress towards the aim of providing more care in the community compared with Scotland as a whole, where the split was 47% on Community-Based Care versus 53% on Institutional care (further information on Health and Social Care spend in the Borders is detailed in the main body of the Strategic Plan).

There are a number of specific local authority housing functions which the legislation specifies must be delegated to the Integration Authority, these are; adaptations and housing support aspects of social care services. The Scottish Borders Council budget identified as making a direct contribution to health and social care through delivery of the delegated functions is £375k.

The Council currently budgets £375k from its Capital Budget to provide means tested grants to assist major adaptations in private sector properties. This is currently sufficient to meet the needs of cases prioritised through Occupational Therapist assessment as being "critical" or "substantial".

Scottish Borders Council is a post transfer Council, and one consequence is that the former Supporting People budget has been disaggregated and operational management spread across Social Work managers. There has been considerable work done by the Council's Social Work Department to successfully develop a range of Housing with Care services in existing RSL owned sheltered housing developments. But it is no longer easily possible to identify Housing Support funding other than that which is managed by the Council's Housing Services to commission a voluntary sector provider.

The extent of the resources that could be influenced by the health and social care agenda is less clear. Some examples of housing activities that can be influenced by health and social care (and vice versa)

include new build housing, housing improvement across all tenures, actions to address poverty and disadvantage.

New-build housing

Strategic oversight of delivery of the new supply of affordable housing is led by the Council working in partnership with locally active Registered Social Landlords (RSLs) to develop the Strategic Housing Investment Plan (SHIP) submission to Scottish Ministers. This is now submitted every two years and provides a rolling five year planning horizon to set out proposed and prioritised affordable housing projects. This is framed within Resource Planning Assumptions. RSL project proposals are considered in context of deliverability, housing need, strategic fit, and impact, which enables projects which contribute to the health and social care agenda to score highly in the prioritisation process. Examples of this include new supported housing solutions to assist the Joint Learning Disability Service and Extra Care Housing.

Scottish Government are the main provider of grant to assist delivery of affordable housing by responding to SHIP submissions through the development of 3 year Strategic Local Programme (SLP) Agreements to direct grant towards securing delivery of individual RSL projects. In 2017/18 Scottish Government allocated £11.5m to assist Scottish Borders projects through the SLP. Grant Allocation decisions are framed by benchmark grant rates set, and periodically reviewed and revised by Scottish Government. Notwithstanding grant allocations, the largest source of funding of affordable housing is raised by the RSLs themselves via their own capacity to borrow from the private sector money markets.

Scottish Borders Council can also assist delivery of affordable housing through use of its Second Homes/Council Tax budget which assumes that £715k income will be received annually for this purpose, and which is prioritised to assist delivery of projects identified through the SHIP process.

RSL affordable housing is built to Housing for Varying Need standards which are slightly larger than comparably sized housing built for market sale, which are built to comply only with Scottish Building Regulation standards. RSLs also build homes which meet the needs of people with particular needs which the private sector housing building sector typically does not address, e.g. wheelchair standard housing or Extra Care Housing, or “core and cluster” groupings to facilitate delivery of cost effect housing support or care services, provided or commissioned by the Council or NHS Borders.

Housing improvement across all tenures

New build or refurbished housing will account for only a small proportion of the overall housing stock in the Borders. The majority of people will continue to live in their own homes, whether these are owned or rented. Moving forward housing improvements, adaptations, equipment and assistive technologies will have an increasing role to play. Residents of the Borders will also continue to receive the same broad range of public services, increasingly integrated and improved through the work of the Scottish Borders HSCP.

RSLs are able to access 100% funding of costs of major adaptations in their housing stock from “Stage 3” funding from Scottish Government, which is allocated from a Scottish national budget annually to individual RSLs. In 2015/16 the following allocations were made to Borders based RSLS –

- Berwickshire Housing Association £41k

- Eildon Housing Association £68k
- Scottish Borders Housing Association £109k
- Waverley Housing £41k[3]

Scottish Borders has a nationally recognised Care and Repair service which won the Scottish Public Sector award in December 2015. This is commissioned by the Council and is funded from the Council's Housing Services revenue budget. The Care and Repair Services delivers major adaptations in private sector housing, and in those homes owned by the above mentioned 4 Borders based RSLs, thereby streamlining delivery and providing efficiencies and quality control across this activity, in addition to a range of other housing support services to enable people to live at home in the community. Currently 1 FTE Occupational Therapist is funded by the same Council budget, which is based within the Care and Repair service.

The Home Energy Efficiency Programme Scotland (HEEPS) is Scottish Government funded to offer grant funding to private households to install a range of energy efficiency measures including external wall insulation (EWI). In 2016/17 £1.7m Scottish Government grant funding helped install 1256 Energy Efficiency measures across the Borders in households suffering from fuel poverty. In 2017/18 an additional £1.73m has been allocated to improving energy efficiency in homes across the Borders with around 1000 measures expected to be installed by June 2018. The success of HEEPS: ABS relies on strong partnerships with RSLs mainly because EWI projects require coordination of social and private upgrades (such as mixed tenure blocks of flats).

The new Scottish Energy Efficiency Programme (SEEP) also aims to improve energy efficiency and reduce fuel poverty through increased support and incentives for private sector households not experiencing fuel poverty. This will also include the introduction of energy efficiency standards. The details of this new programme are still to be finalised, but there are likely to be resources made available to support this activity, and the Scottish Government has committed almost £0.5 billion to SEEP over the next ten years.

The Energy Efficiency Standard for Social Housing (EESSH) aims to improve the energy efficiency levels of social housing. All RSLs have a target compliance date of delivering EESSH by March 2020. Achieving this standard in some properties will be challenging, particularly for those of non-traditional construction and for those located in 'off gas' areas. Each RSL has prioritised investment towards meeting the standard, which will result in £12.1m being invested to meet EESSH.

Housing Support Services

There a range of non-delegated housing support services provided, which include housing and tenancy support for young people and to vulnerable homeless people. Housing support services help people to live independently in the community, regardless of their tenure. Providing a range of services to homeless people, including advice on budgeting and debt management; assistance with benefit claims; maintaining the security of the dwelling and general counselling and advice. RSLs also provide similar services, giving advice to those facing difficulties with their housing.

[3] In addition there are a number of other RSLs based out with SBC with small amounts of housing stock within the area. They also receive Stage 3 allocations, but we have no information available as to how much, if any, is spent within Scottish Borders.

Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028

The Integrated Strategic Plan for Older People's Housing, Care and Support draws on the strengths of different approaches, and proposes a way forward with a combination of investing in housing, technology and service delivery capacity, building on commitments already made by partners. It proposes new build activity, supplementing the existing mix of private and public residential provision across Scottish Borders. It also involves the remodelling, refurbishment and adaptation of existing housing, a strengthened approach to telecare, and the implementation of proposed service reforms to ensure that the breadth of independent living benefits can be grasped across all Borders localities. Scope for co-location of the new housing with other housing and non-housing developments and amenities will also be explored as part of more detailed feasibility work.

A summary of the investments included in the Integrated Strategic Plan for Older People's Housing, Care and Support are detailed in table 4 on page 25.

Table 4: Financial Plan

Care units	Units Over 10 years	To 2027	Per unit
A 20 unit specialist dementia care unit	20	£4,800,000	£240,000
A 60 unit mixed tenure campus	60	£9,000,000	£150,000
Various local extra care housing developments (30-45 units each)	360	£54,000,000	£150,000
New housing with care provision	**440**	**£67,000,000**	**£152,272**
Housing supply			
New Build	300	£39,000,000	£130,000
Refurbishment/Remodelling	300	£16,500,000	£55,000
New / remodelled housing provision	**600**	**£55,500,000**	£92,500
	1,040	**£123,000,000**	**£118,269**
Other investment to 2027			
Adaptations, small repairs	8424	£8,634,600	£1,025
Telecare	851	£255,240	£300
Total investment planned		**£132,190**	

Table 4 details investment of £132m planned across the Scottish Borders to support delivery of the integrated housing, care and support plan for older people. This includes a mix of care settings and housing tenures and will be funded by the Council, local RSLs, private developers and other strategic partners in the region (a full financial Plan is available as Appendix 5 of the integrated housing, care and support plan for older people).

Monitoring and Review

In line with the Scottish Government Guidance for Health and Social Care Integration the Partnership produces Annual Performance Report which 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.

Table 5: The Strategic Plan 2018-21 has identified what success will look like:

	People participate in planning their own care and support
Services are integrated and efficient	
	The benefits of new technology improve people's health and well-being
People with multiple long term conditions are supported	
	There is a shift to early intervention and prevention
Carers will feel better supported and have improved health and well-being	
	There will be a reduction in health inequalities

The monitoring and evaluation arrangements for the housing contribution to health and well-being will be through these Annual Performance Reports, but also through the Local Housing Strategy which is also monitored annually against the delivery plans, to ascertain progress and to enable remedial actions to be instigated promptly should they be required to ensure milestones set out in the delivery plans are achieved, and that services/partners are on track to deliver specific LHS objectives.

In addition to strategic monitoring, partners will be responsible for monitoring of their operational functions as they relate to the LHS outcomes; for example, housing management, housing investment/capital programme, and homelessness.

Future LHS annual reports will contain a specific statement on Housing's Contribution to Health and wellbeing, and to the Strategic Plan.

This Housing Contribution Statement has been approved by:

Scottish Borders Council Chief Housing Officer
Cathie Fancy
Signature

Chief Officer Health and Social Care Integration
Robert McCulloch-Graham
Signature

This page is intentionally left blank

Equalities

As a Health and Social Care Partnership, we also have a Public Sector Equality Duty under the Equality Act (2010). We have a duty to:-

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a characteristic that is protected under the Act, and those who don't.
- Foster good relations between people who share a characteristic and those who don't. This involves tackling prejudice and building understanding.

The characteristics that are protected under the Act are:

Age Younger people, older people, or any specific age group	**Disability** Including physical, sensory, learning, mental health and health conditions	**Gender** Male, Female and Transgender
Gender Reassignment Someone who proposes to go through, is going through or has gone through a process, or part of a process, to change his or her gender from man to woman or woman to man.	**Pregnancy and Maternity** Including breastfeeding	**Race** People from ethnic minorities including Gypsy Travellers and Eastern European immigrants
Religion or Belief Including people who have no belief	**Sexual Orientation** Bisexual, Gay, Heterosexual and Lesbian	**Carers*** Both formal and informal carers

*the partnership considers the impact on carers in relation to all the protected characteristics.

In taking forward the work of the Health and Social Care Partnership, we will embrace these duties and ensure that all requirements are met, through the implementation of the Business and Commissioning Plans for the Service and Strategic areas that are integrated.

This page is intentionally left blank

The Scottish Borders: Profile and Key Challenges

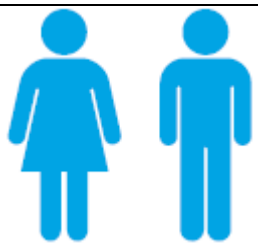
This section of the Plan gives a high level summary profile of the Scottish Borders and some of our key challenges. More detailed information is also available in two further documents published alongside the original Strategic Plan for 2016-19 – Facts and Statistics, and the Joint Strategic Needs Assessment.

Who Lives in the Borders?

Understanding the needs and issues of people and communities across the Borders is critical in the planning and provision of better health and social care services. In this section, we look at how the population structure and characteristics impact on health and social care services. This highlights some of the challenges we need to address.

As the figure below shows, we have a higher percentage of older people than the rest of Scotland.

Figure 1 Population 2017

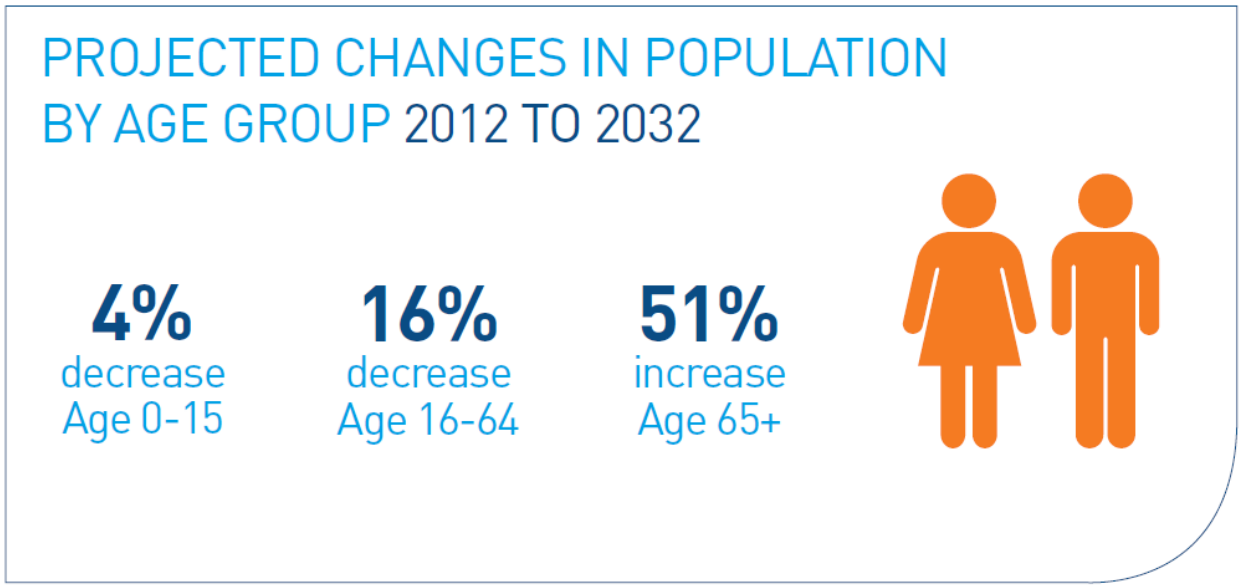
				Scottish Borders	Scotland
		Age 0-15	19,026	17%	17%
All People		Age 16-49	41,420	36%	44%
115,020		Age 50-64	26,875	23%	21%
		Age 65-74	15,715	14%	10%
	59,231 55,789	Age 75+	11,984	10%	8%

Source: National Records of Scotland, mid-year population estimates.

By the year 2032, the number of people aged over 65 is projected to increase by 51%, a faster rate than the 49% for Scotland overall. The number of people under 64 is also projected to decrease in the Scottish Borders. Age is strongly related to patterns of need for health and social care. These changes will influence how we deliver services in the future. Integration of health & social care services will enable us to work more effectively and efficiently to achieve “Best Health, Best Care, Best Value”.

The projected increases by age varies considerably by locality with Tweeddale showing the greatest increase of older people aged over 75 years, followed by Berwickshire – the two areas where the provision of Home Care is already under greatest pressure. Teviot is showing a small decrease in number of household 65-74 years, and the smallest proportional growth of households aged over 75 years.

Figure 2



Source: National Records of Scotland 2012-based population projections.

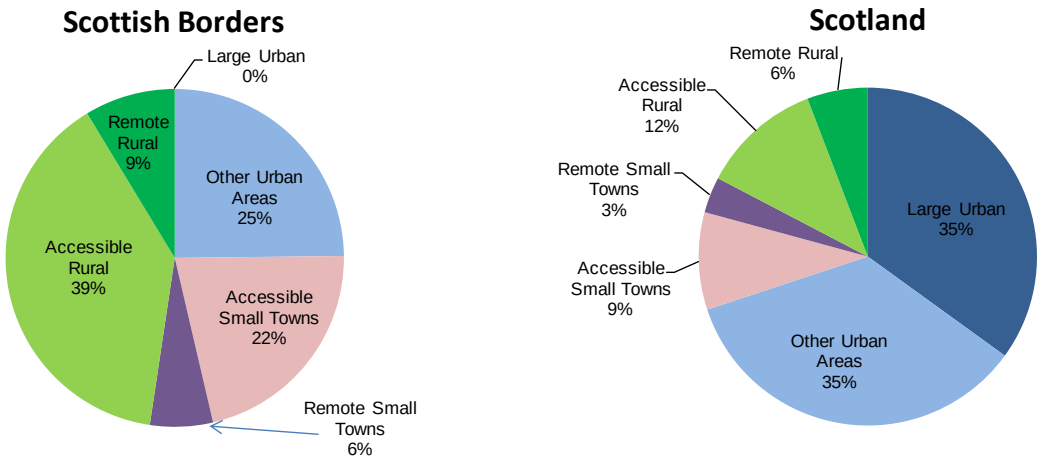
WHAT THIS MEANS…
We need to promote active ageing and address the range of needs of older people.

Where do people live?

The Urban/Rural profile of the Borders presents challenges in terms of both the accessibility and cost of services. The challenges are different in nature to those facing densely populated cities such as Glasgow, Edinburgh and Dundee.

As shown in Figure 4, in the Borders nearly half (48%) of the population live in rural areas, in contrast to 35% of the Scottish population who live in “Large Urban” areas (part of towns/cities with populations of more than 125,000). Our main towns are Hawick (with a population of 13,783 in 2016) and Galashiels (population 12,601), which come under the Scottish Government classification of “Other Urban Areas”. Peebles, Kelso and Selkirk are the only other towns with a population of more than 5,000. As people in the Borders do not live close together in cities, planning services is more challenging.

Figure 3 Population Shares (%) by Urban/Rural area 2016



Sources: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland mid-year population estimates 2016

Category	Description
1 – Large Urban Areas	Settlements of 125,000 or more people.
2 – Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 – Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 – Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 – Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 – Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

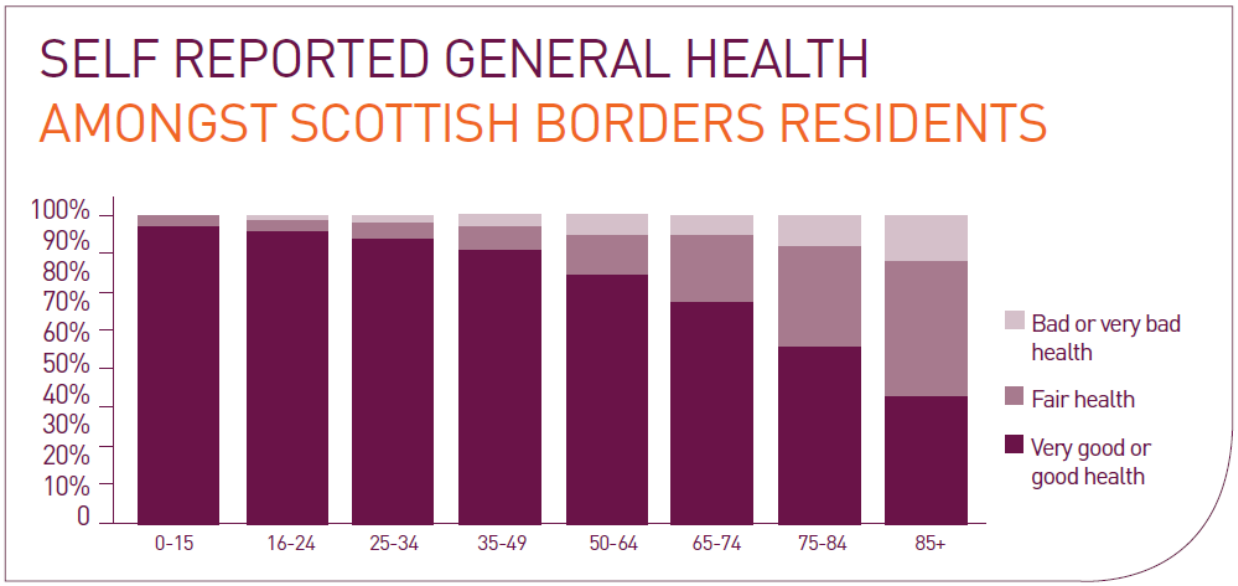
WHAT THIS MEANS…
Services need to be provided locally whenever possible and accessible transport arrangements put in place.

How Do People in the Borders View Their Health?

In general, people in the Scottish Borders enjoy good health, with 84% considering their health to be 'very good or good'; 12% of respondents consider themselves in 'fair' health, while 4% think their health is 'bad or very bad'.

The graph below shows that the number of people who consider their health to be 'very good or good' decreases with age. For example, more than 1 in 10 people aged over 75 reported their health as being 'bad or very bad', compared with only around 1 in 100 people aged 16-24.

Figure 4



Source: Scotland Census 2011

WHAT THIS MEANS…
We must enable people to keep well as long as possible through promoting healthier lifestyles, earlier detection of disease, ensuring the provision of suitable housing and support to recover and manage their conditions.

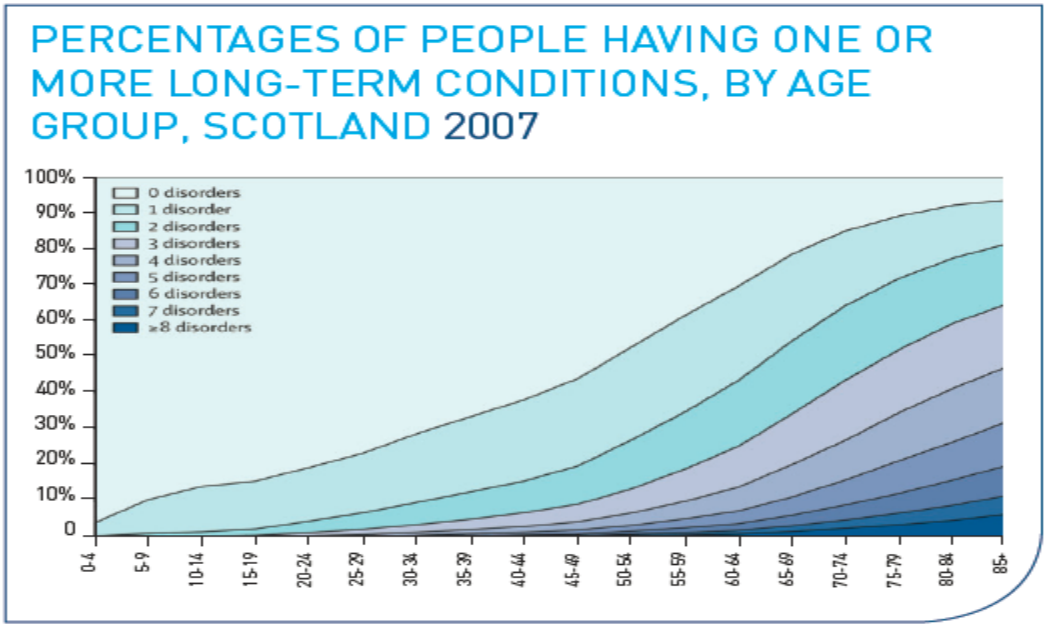
How is health affected in the Scottish Borders?

Long Term Conditions

We know that many people in the Borders live with one or more long-term conditions. This may affect how they access and use services. We need to make sure that services are integrated to support individuals with complex needs, to enable them to manage their conditions to lead healthy, active and independent lives as long as possible.

The number of people living with two or more long-term conditions rises with age as illustrated in Figure 7. For example, nearly two thirds of patients aged 65-84 and more than 8 in 10 patients aged over 85 had multi-morbidity. This presents a significant challenge to plan and deliver health and social care services.

Figure 5



Source: Barnett et al (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/abstract

There are clear benefits to people's health, wellbeing and wider social outcomes through having a permanent, well maintained and warm home throughout life. Living in cold conditions in particular is a risk to health. There is an established body of evidence that identifies direct and indirect health impacts suffered by those living in fuel poverty and cold housing, which include links to respiratory and cardiovascular disease and negative impacts on mental health. Fuel poverty is a particular issue facing households in the Scottish Borders where 38% of households are fuel poor in comparison with 34% nationally. The Local Housing Strategy sets out in more detail our plans to address fuel poverty.

The poor health of homeless people is also not a new issue. Living without a stable home can make you vulnerable to illness, poor mental health and drug and alcohol problems. Conversely, many people become homeless because of existing health needs. The longer people remain without a stable and safe place to live, the more these problems multiply and the harder they are to overcome.

For the past few years an increasing body of evidence has shown the impact of this poor health on individuals and on the NHS. Homeless people are more likely to use A&E, spend time in hospital and to be heavy users of mental health and substance misuse services. Premature rates of death and the prevalence of chronic and multiple health conditions among homeless people paint a very stark picture of the human cost to this inequality, and the scale of the challenge to overcome.

One of the recommendations from Commission identifies 'there should be a strengthening of the emphasis on the prevention of homelessness and repeat homelessness through early intervention and joint agency working involving various statutory bodies/departments and voluntary sector partners. This should be linked to an extension of the housing options approach, including identifying health and social needs as part of the same process.

Preventing homelessness has obvious benefits for people's housing outcomes, but can also support a reduction in health inequalities. Homelessness prevention activity could be further developed in response to health and wellbeing needs and we need to have a better understanding of the issues and challenges in order to develop services that are better able to respond to these needs and improve the health and well-being outcomes of people experiencing homelessness in the Borders.

Disability & Sensory Impairment

Not all physical disabilities are visible or registered. Some can be prevented, for example those related to morbid obesity.

A physical disability is unique for each individual in the way it affects their life. It is not unusual for people to be affected by more than one health condition or physical disability, or for someone with a physical disability to experience mental health problems.

Services therefore need to be person-centred, with a clear understanding of an individual's rights to independence, self-determination, dignity and respect.

Services need to take a holistic approach considering not only the individual, but also the needs of informal carers and their family.

Good quality and appropriate housing is important to help ensure those living with a disability live a good quality of life, as independently as they choose.

The Local Housing Strategy considers how appropriate and good quality accommodation can help vulnerable groups live with a good quality of life, as independently as they choose, and contribute to improving health and wellbeing. Priority clients groups do not necessarily fall into neat categories as they may have more than one disability or condition, however many housing and housing related issues are common for all vulnerable groups.

Addressing these through the development of new housing and the refurbishment of existing housing will give groups with particular needs a greater choice of where and how to live in a safe and secure environment. It follows that appropriate and good quality housing can help in the prevention of illness and improved well-being for all vulnerable groups. The physical built environment is only one part of the equation, the right location and appropriate services are also vital to achieving good outcomes for these groups

WHAT THIS MEANS…

- People with a disability need flexible support arrangements to maintain and improve their quality of life.
- People with a disability need access to good quality and appropriate housing.

It is estimated that around 600 people in our population are blind or have severe sight loss, while 1,800 people have severe or profound hearing loss. The National Health and Wellbeing Outcomes focus on people having a positive experience and their dignity respected when in contact with health and social care services, and that services are to be centred on helping maintain and improve the quality of life of people who use those services. This means that we must ensure services are accessible and easy to use by people with sensory impairment.

At the time of the 2011 Scotland Census, 612 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Learning Disability. 485 people in this group (81%) were aged 16 or over in 2011. Meanwhile, the total number of adults with Learning Disabilities known to Scottish Borders services is higher than the figures captured through the Census. As at March 2014, 599 people aged over 16 with Learning Disabilities were known to Scottish Borders services, of which 555 had confirmed addresses in the area.

Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than that provided by mainstream Health and Social Care services. As part of the Learning Disability governance structure, people with learning disabilities and family Carers have places at the Partnership Board table to help inform decision making and strategic direction. Locality citizens' panels throughout the Borders provide opportunities for conversations between the Learning Disability Service and people directly affected by learning disabilities. A local area coordination service supports people to be more involved in their local communities.

Mental Health

Mental health is a major public health challenge on a global scale. Mental disorders affect people from all walks of society regardless of gender, race or social standing, and can severely impact the quality of life of both sufferers and their families. In Scotland, one in four people will experience a diagnosable mental health problem each year. Anxiety and depression are the most common, but others include schizophrenia, personality disorders, eating disorders and dementia. However, the exact prevalence of mental health problems are difficult to estimate, primarily due to the numbers of people who do not seek treatment and difficulties in accurately recording them in a non-acute setting.

Mental Health is included in the top 5 'vulnerabilities' or reasons for engagement with the Housing Options service in the Borders. Understanding this relationship provides a good basis to guide the development of services which should be integrated into the housing options model at a local level with mental health services (ad toher services such as financial inclusion), where key partnerships will support the development of a range of options that will proactively respond to local need.

The Mental Health Strategy was published in February 2018 in response to the recommendations in the Mental Health Needs Assessment (2014). This strategy will support the delivery of Mental Health services in Scottish Borders in line with the objectives in the Strategic Plan.

Dementia

Dementia is a growing issue and represents a challenge for planning and providing appropriate integrated care. An estimated 2,468 Scottish Borders residents were living with dementia in 2017. The number of people living with dementia is projected to increase across Scotland, however the rate of increase in the Borders may be faster than the Scottish average as our population is older.

Figure 6: Estimated numbers of people with dementia / annual new diagnoses in the Scottish Borders, 2017-2020

Dementia prevalence	Dementia incidence
Estimated 2,468 Scottish Borders residents living with dementia in 2017.	Projected to be around 500 new diagnoses of dementia each year in the Borders 2018-2020.

Sources:

1. Alzheimer Scotland https://www.alzscot.org/campaigning/statistics
2. Estimated and projected diagnosis rates for dementia in Scotland 2014-2020, Scottish Government. http://www.gov.scot/Publications/2016/12/9363/0

The projected increases in the number of older people and people with dementia result in increased demand for housing support, housing adaptations, and specifically designed or adaptable housing.

Services such as Care and Repair are ideally placed to identify needs and provide services that help enable people with Dementia to stay put in their own homes.

The new Integrated Older People's Housing Care and Support Strategic Plan proposes additional investment in specialist dementia care and continued commitment to residential care homes as part of a wider strategic approach.

There will be a targeted investment in the development of approximately 20 additional specialist dementia care spaces to meet projected needs. This will supplement existing dementia care provision in residential facilities and home settings across the Borders. A sum of £4.8m has already been set aside as a contribution to this proposed capacity in Scottish Borders Council's capital programme. Alternative options (including a stand-alone dementia care unit) will be explored further as part of the business case for the project being developed in 2018/19.

WHAT THIS MEANS…

- A range of support needs to be provided for people with dementia and their Carers, with appropriate training for all involved, to provide care across all settings.
- There will be increased demand for adaptations and small repairs.
- Additional investment in specialist dementia care spaces to meet projected needs is required.
- There needs to be further investigation in to the links between homelessness and health and wellbeing in the Borders including prevention, housing options, housing support and temporary accommodation.

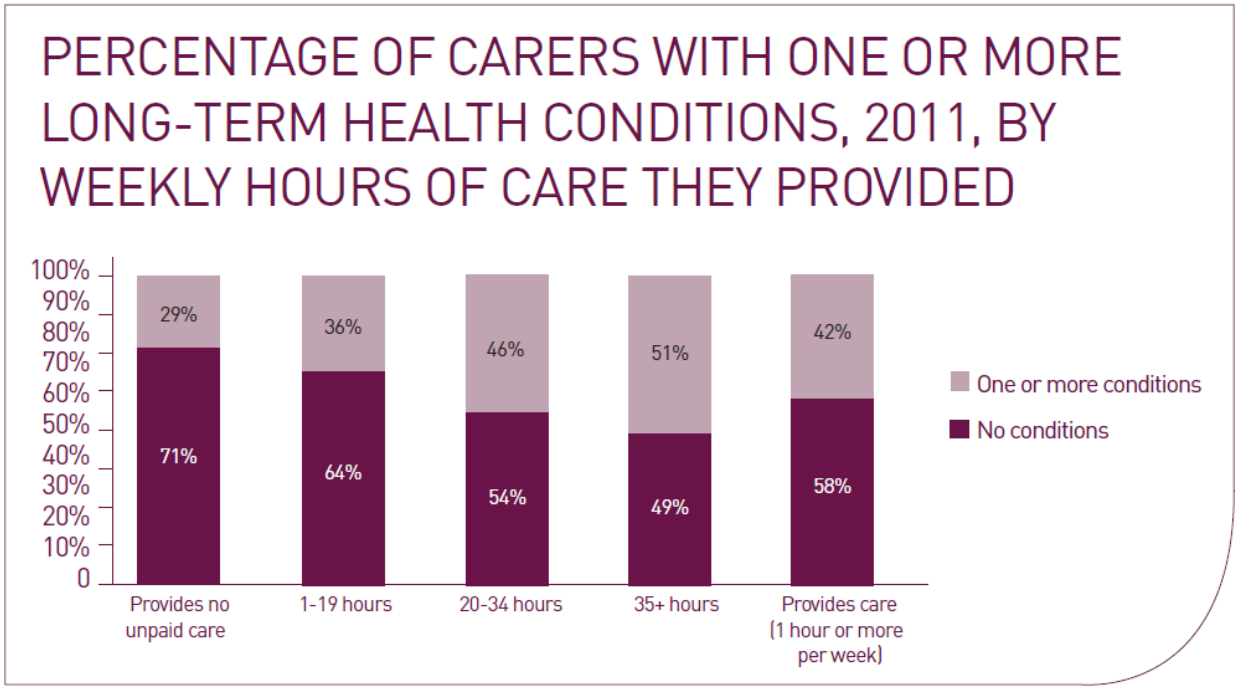
Providing a Caring Role

Health and Social Care Services are dependent on the contribution of Carers*. In the Borders, approximately 12,500 people aged 16 and over provide unpaid care, around 13% of people in this age group.

Research shows that carers in more deprived areas spend more time in a caring role. 46% of Carers living in the most deprived areas of the Borders provide 35 or more hours of care per week, compared with 22% of Carers living in the least deprived areas. Research also indicates that providing care for someone else often affects the Carer's own health – and Carers are often themselves older people with one or more long term conditions. More Carers (42%) than non-Carers (29%) have one or more long-term conditions or health problems. Of people providing more than 50 hours of unpaid care per week, 13% rated their own health as 'bad or very bad' compared with 4% of people who were not Carers.

In recognition of the need to ensure the wellbeing of carers and their important contribution the Carers (Scotland) Act 2016 is being implemented from 1 April 2018; this brings new duties for the Partnership.

Figure 9



Source: Scotland Census 2011 / Scotland's Carers (Scottish Government, March 2015).

WHAT THIS MEANS…

As required by the housing legislation, the Partnership is committed to ensuring:

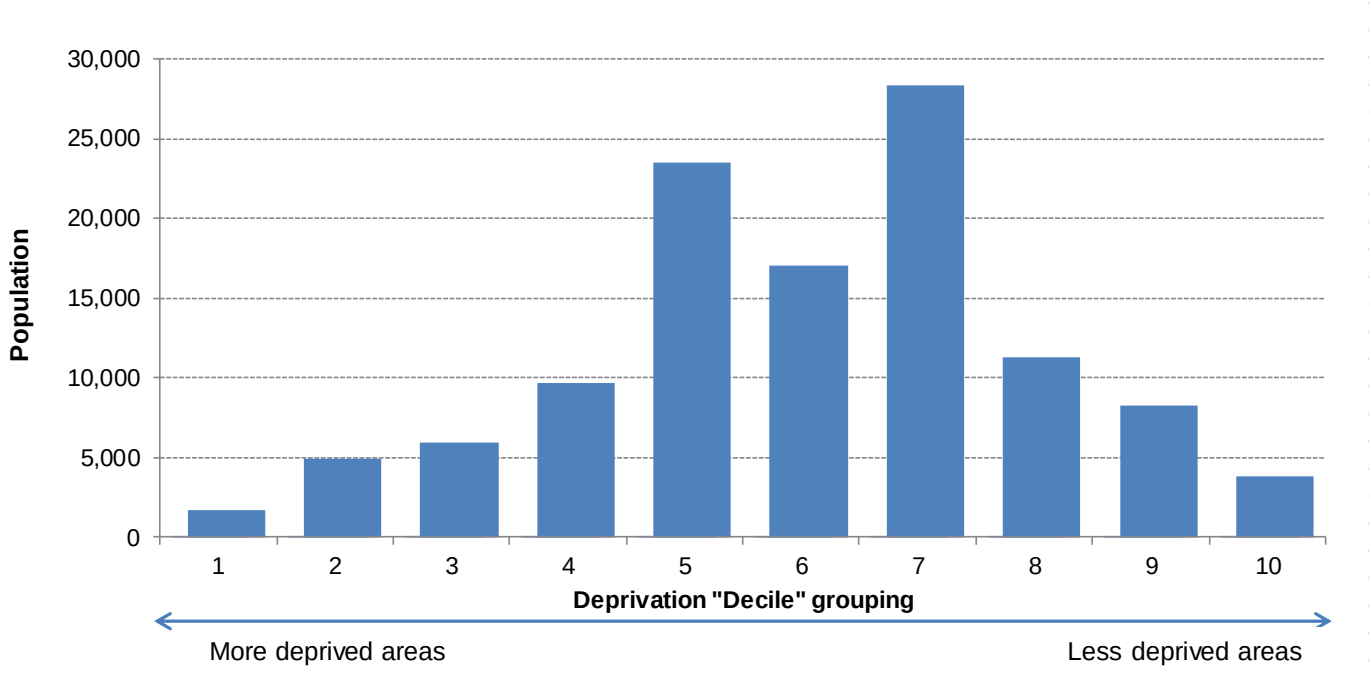
- Carers are identified early and that a range of easily accessible information is available;
- There is a clear pathway for carers to access support and a carers eligibility criteria is in place;
- Carers are informed and involved in hospital discharge planning;
- Carers have a strong voice in planning and developments that have an impact on their caring role;
- A short breaks statement is in place by the end of 2018 to provide information on local and national breaks support.

*Carers are individuals who care for a friend, relative or neighbour without receiving paid income in addition to income received through the benefits system. (Definition source: Care 21 Report: The future of unpaid care in Scotland. www.gov.scot/Publications/2006/02/28094157/0).

Deprivation in the Scottish Borders

Deprivation has a big effect on the need for, and use of, health and social care services. Taken as a whole, levels of deprivation in the Borders' population are relatively lower in comparison to Scotland. Figure 10 below shows the spread of our population between 10 different categories ("deciles") of deprivation. If our deprivation profile were the same as Scotland's, we would see about 10% of our population in each category. What we see instead is an uneven distribution, with clearly less than 10% of our population living in the most deprived areas. However, some of our more urban areas - in Burnfoot (Hawick) and Langlee (Galashiels) - continue to show as amongst the most deprived in Scotland.

Figure 10 Spread of the Scottish Borders Population Between 10 Levels of Deprivation.



Sources: Scottish Index of Multiple Deprivation (SIMD) 2016 applied to National Records of Scotland mid-year population estimates 2016.

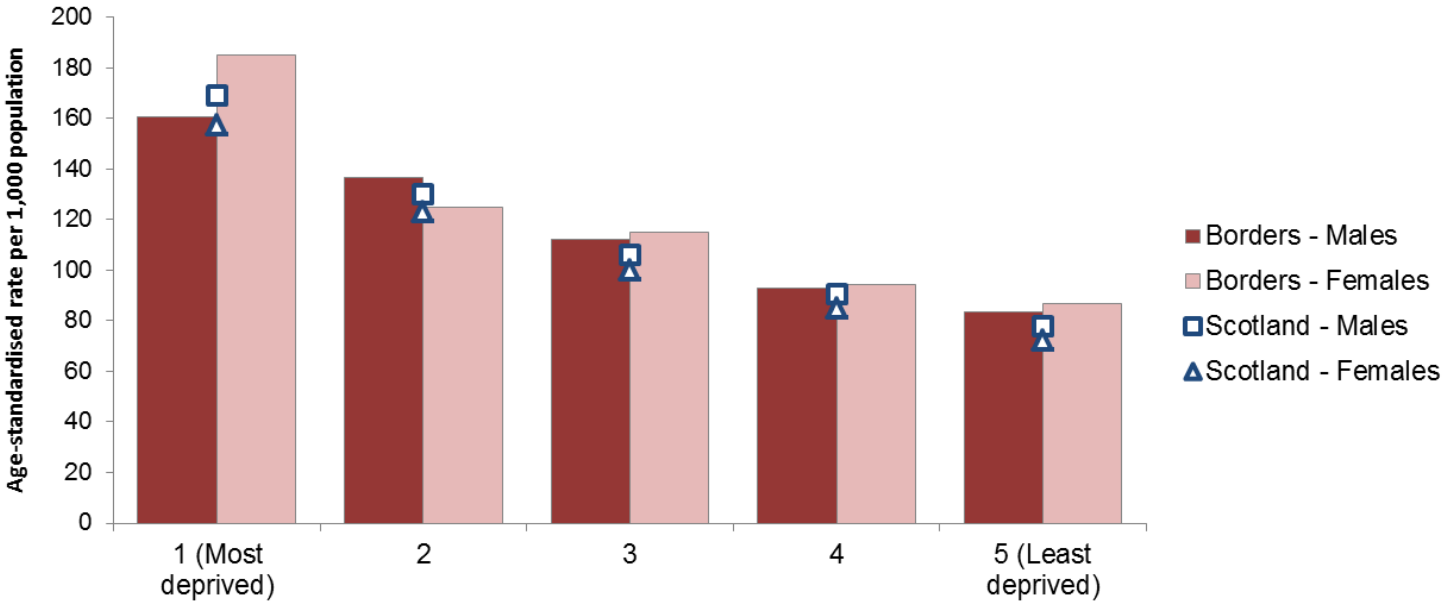
We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

An example of how the use of health and care services varies by deprivation is shown in Figure 11 below. Although work within the Borders over the past few years has reduced our overall rates of emergency admissions to hospital, we still follow the national pattern of having higher emergency hospital admission rates for people living in areas of higher deprivation.

NHS Health Scotland, in their March 2015 report on deprivation-related hospital activity noted: "Given that people at increased risk of health inequalities make proportionately greater use of acute and community health services, hospitals offer an important opportunity for health improvement actions to reduce health inequalities". The need for health and social care services to contribute to reducing health inequalities is the focus of the Scottish Government's National Health and Wellbeing Outcome number 5.

Figure 11

Emergency Hospital admission rates per 1,000 population, by deprivation quintile 2016/17



Source: SMR01 Hospital inpatient data, analysed for Scottish Borders Health and Social Care Partnership.

WHAT THIS MEANS…

- The Strategic Plan and Locality Plans that we have developed reflect the local needs of communities, recognising patterns of deprivation and inequality. These plans cross-reference with work already being developed under our Reducing Inequalities Strategy.
- A number of actions have been identified in the Local Housing Strategy that are required to reduce inequalities in housing and across neighbourhoods. These include, ensuring social housing allocations respond to housing need, measures to address fuel poverty; increasing affordable housing supply, preventing homelessness and and ensuring appropriate provision of specialist housing.

H&SC Partnership Governance Structure
Summary of Role and Function of Each Group

Integration Joint Board (IJB)

The IJB is the formal board meeting of the Scottish Borders Health & Social Care Partnership which was established on 6th February 2016 and consists of Local Authority Elected Members, Health Board Non-Executive Directors and representatives of the Third and Independent Sectors. Its establishment followed ministerial approval which makes the IJB a legal entity in its own right under the Joint Working Public Bodies (Scotland) Act 2014.

The Integration Joint Board members work together in order to plan, commission and oversee the delivery of integrated health and social care services meeting the needs of the people of the Scottish Borders whilst planning for the demands of the future.

The role of the IJB is to:-

- Strategically plan and commission health and social care services to ensure national and local outcomes are met. To enable this, the IJB convenes a Strategic Planning Group to assist in the preparation, approval and delivery of its Strategic Plan;
- Oversee the delivery of the integrated services for which it has responsibility by reviewing finance and performance against targets to ensure that delivery is in line with planned outcomes;
- Establish arrangements for locality planning in support of key outcomes for the 5 agreed localities in the context of the Strategic Plan;
- Ensure resources are sufficient and appropriately allocated to deliver the IJB's Strategic Plan within the medium-term revenue budget detailed in its annual Financial Statement;
- Publish and share with partners an annual Performance (delivery of the Strategic Plan) Report and Annual (Financial) Accounts in line with statutory guidance, codes of practice and timescales;
- Seek assurance on the robustness of clinical and care governance frameworks from NHS Borders and Scottish Borders Council respectively and ensure that clear accountability is preserved;
- Establish a plan for communication, participation and engagement to ensure that the users of health and social care services, staff, carers and all other stakeholders are involved in or aware of the development and delivery of effective models of health and social care;
- Establish arrangements for handling complaints to and requests for information from the Health and Social Care Partnership;
- Appoint its Chief Officer and Chief Financial Officer.

Integration Joint Board (IJB) Leadership Team

The IJB Leadership Team is a weekly meeting of key senior operational, strategic and financial leaders who represent the HSCP. The meeting is chaired by the Chief Officer for Integration and the group has a critical role in overseeing and ensuring the delivery of integration of health and social care in the Scottish Borders in line with the strategic intentions and priorities outlined in the Strategic Plan and on behalf of the IJB.

The role of the IJB Leadership Team is to:-

- take an overview and support the delivery of outcomes as outlined in the Strategic Plan;
- support the integrated delivery arrangements for Health and Social Care;
- contribute to the agenda for the H&SC IJB;
- support the implementation of a change programme designed to improve outcomes and manage within available resources;
- focus on achieving financial balance.

Executive Management Team (EMT)

The EMT is a meeting of key Leaders and decision makers across SBC and NHS Borders with the intent to improve outcomes through the integration of health and social care and support the delivery of the Strategic Plan.

The role of the EMT is to:-

- take an overview and support the delivery of outcomes as outlined in the strategic plan
- support the integrated delivery arrangements for Health and Social Care
- co-ordinate the agenda for the H&SC IJB
- support the implementation of a change programme designed to improve outcomes and manage within available resources
- focus on achieving financial balance
- act as the programme board for transformational redesign

Strategic Planning Group (SPG)

The Strategic Planning Group acts as an advisory committee to the Integration Joint Board (IJB). The role of the SPG is to identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan and against the agreed national outcomes. The group provides a forum for initial consultation and community engagement.

Members will be expected to:

- Act in an advisory capacity to the IJB;
- Represent their sector or professional area;
- Comment on and contribute to Partnership change programmes;
- Ensure the interests of the five localities are represented;
- Contribute to any formal updates of the Strategic Plan.

Joint Staff Forum (JSF)

The Forum will:

- Take a proactive approach in embedding integrated working at all levels of the organisation to assist the process of devolved decision making;
- Monitor the application of all Workplace Policies related to agreed integration programme and subsequent ongoing development;
- Consider and comment on other policies;
- Support the work of the Workforce Development Project Group as required;
- Ensure the best Workforce practice is shared across the Health & Social Care Partnership;
- Contribute to the development of Strategies and Action Plans to inform the integration programme of care and subsequent ongoing development;
- Assist in assessing the impact of strategic decisions upon staff by monitoring and evaluating outcomes through staff surveys and other staff engagement exercises
- Contribute to responses on consultation from the Scottish Government, its sub groups and supporting infrastructure;
- Ensure that any Workforce strategies are underpinned by appropriate Staff Governance, financial planning, implementation planning and evidence;
- Ensure adequate and necessary Facilities arrangements are in place.
- Ensure that the views of all recognised trade unions with an interest in improving the health and social wellbeing and health and social care services, local communities and wider staff are appropriately heard and considered.
- Ensure that there is an effective risk management arrangement in operation focusing on staff issues that identifies clinical, legislative, financial and other risks, and is focused on the safety of patients, clients and users and staff;
- Ensure that members of the Health & Social Care Joint Staff Forum have knowledge and understanding of national health policies and local health and social care issues, and the ability to contribute to strategic leadership and to develop effective working relationships;
- Secure assurance that all staff, are effectively trained, properly supported and performance is formally reviewed on an annual basis.

Public Partnership Forum (PPF)

The PPF will build upon existing methods of public involvement to establish and maintain an effective partnership with the IJB and to ensure that the community is represented in the decision-making process of the IJB. The PPF will:

- help promote positive change in the health of the local community and in the service provided by the Scottish Borders Health & Social Care Partnership, commissioned and governed by the IJB;
- where possible, represent the views of the communities in Scottish Borders paying particular attention to those who could be socially excluded or face discrimination when accessing services;
- provide a way for the IJB to inform local people about the range and location of services it provides throughout Borders;
- support the involvement of local people, service users and carers in discussions about how to improve services provided by the IJB;
- assist the IJB to promote equal access to services by respecting equality, diversity and transparency in all aspects of its work;
- assist the IJB to engage with local communities either directly or through existing groups/organisations;
- offer insights from local communities regarding the planning and delivery of services. Raise issues, concerns and other comments from local communities in relation to services provided by the IJB;
- support the IJB to meet the National Standards for Community Engagement as adopted by Scottish Borders Council, NHS Borders and other partners;
- act responsibly, in an appropriate manner without bias or discrimination.

Locality Groups (LG)

The five LGs comprise of key representatives with responsibility for:

- Working together with, and reporting directly to the Strategic Planning Group (SPG)
- Providing a locally based focus for the development of Locality Plans (Bottom up approach, as referred to in the legislation/guidance from Scottish Government) to support improved health and social care outcomes for local people
- Monitor the progress of the Locality Plans
- Communicate progress and delivery to all community stakeholders within each respective Locality

Communications Group

The aim of the Communications Group is to support the delivery of the revised Health and Social Care Partnership's Strategic Plan objectives through effective and consistent communication.

Information Governance

Still to be developed.

Workforce Planning

The overall aims of the strategic approach to engaging with and developing our workforce and our partnership are:

- To develop workforce plans which describe the current workforce profile, the roles, skills and competencies needed to deliver the strategic objectives and outcomes for the partnership in line with the 2016/2019 Strategic plan and the Local Government Delivery plan.
- To focus role development on the needs of service users
- To develop a multi-skilled flexible workforce, who are engaged and involved, and have the professional skills, the aptitude and drive to take a team approach to service delivery and improvement.
- To develop initiatives (internships, apprenticeships, sector based work academy) which will enable the recruitment and maintenance of the required workforce.
- To develop leadership capability and capacity at every level of the partnership
- To develop organisational structures and processes which enable the right balance of accountability and assurance, and encourage our workforce to deliver services which can change, evolve and innovate to meet the challenges ahead.

Integration Performance & Finance Group (IP&FG)
The IP&FG is a meeting of key partnership, performance and information officers across the Scottish Borders Health and Social Care Partnership (HSCP) with the intent of providing performance information and analysis that can aid decision making within the HSCP and improve outcomes for people in the Scottish Borders.

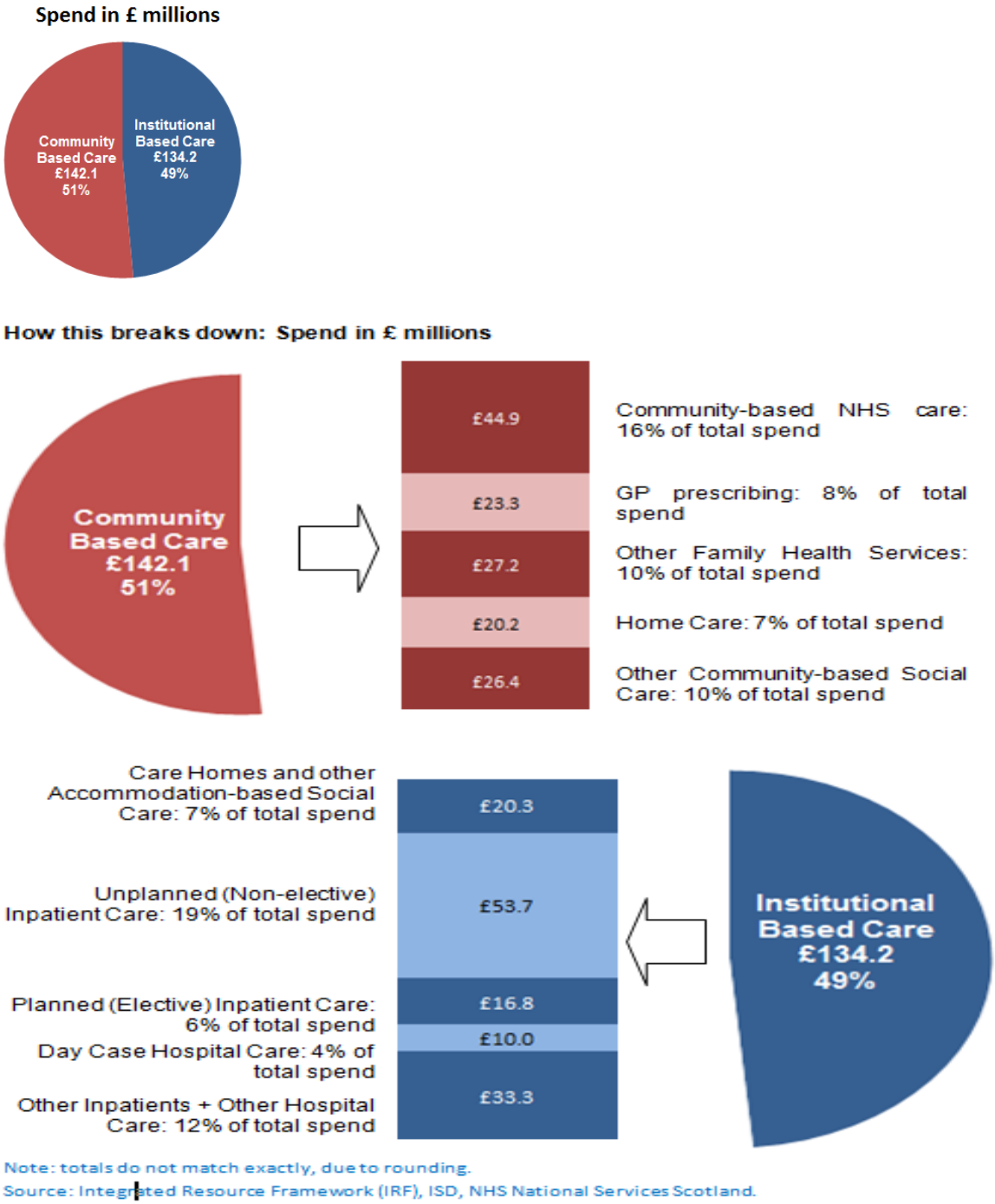
The role of the IPG is to:-

- Develop a performance framework to support effective decision making throughout the HSCP;
- Provide the Leadership Group with robust, accurate and timely performance information across all the strategic objectives within the current and revised H&SC Strategic Plan;
- Provide advice and support to managers cross the HSCP with the ongoing development of effective performance measures to aid continuous improvement;
- After discussion, input and agreement at Leadership Group, co-ordinate and prepare quarterly and annual performance reports for Executive Management Team (EMT) and Integrated Joint Board (IJB);
- Ensure that IJB performance information is made available publicly.

Health & Social Care Spending

The total NHS and social care spend in the Borders in 2015/16 was £276.3m. All NHS services are included in this total, including health services that are part of the Health and Social Care Partnership's responsibilities (such as planned outpatient care, and some inpatient services) as detailed in Figure 1 below:

Figure 1: How this total spend breaks down



Note: totals do not match exactly, due to rounding.
Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

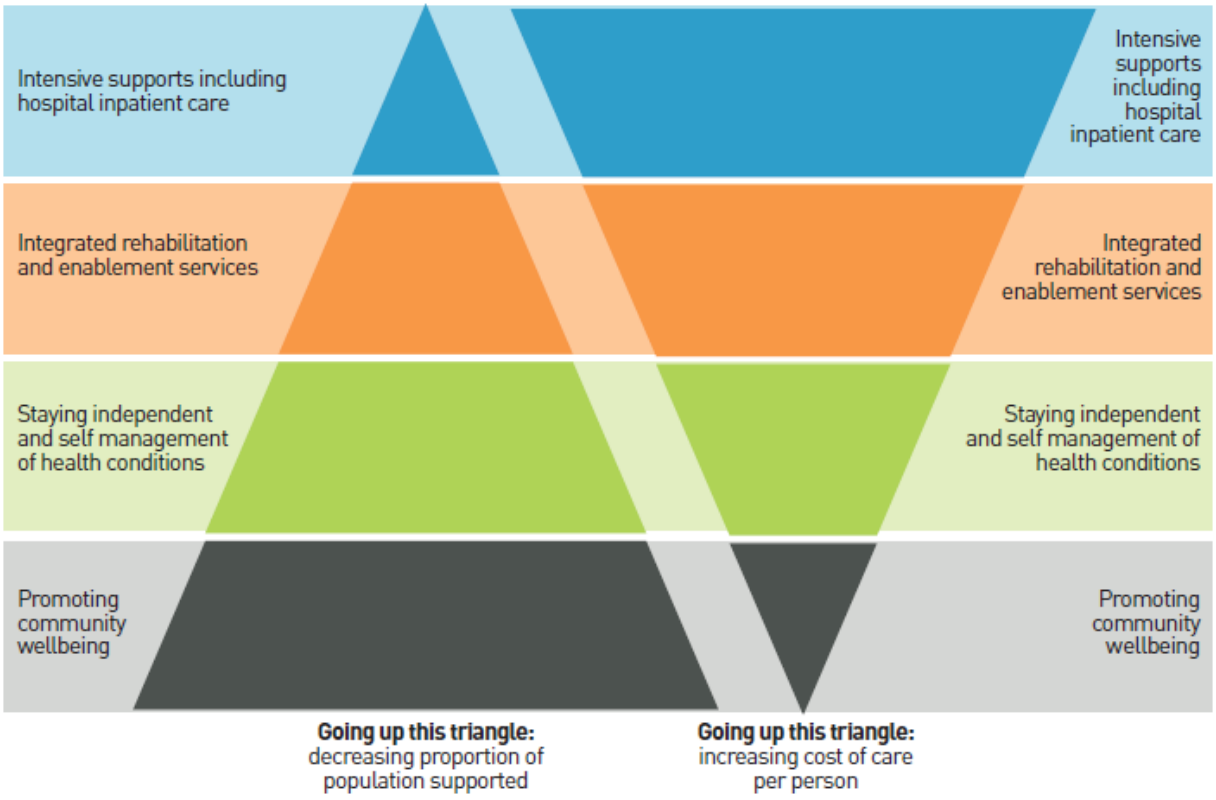
Shifting the Balance of Care Towards Prevention and Early Intervention

The aim of integrated health and social care services is to shift the balance of care towards prevention and early intervention (community-based services) to ensure that individuals have better health and well-being. Services need to be redesigned around the needs of the individual, to:

- Ensure that their journey through their care and treatment is as integrated and streamlined as possible;
- Enable them to remain independent for as long as possible; and
- Support them to recover after illness and at times of crisis.

In Figure 2 below, services that promote health and well-being are shown at the bottom of each triangle, whilst intensive support services (such as acute hospital inpatient care) are shown at the top. The triangle on the left shows that a small number of people need the intensive support and care provided within hospital. However the triangle on the right shows that this small group of people use a large amount of total resource available for health and social care.

Figure 2 CURRENT CARE MODEL



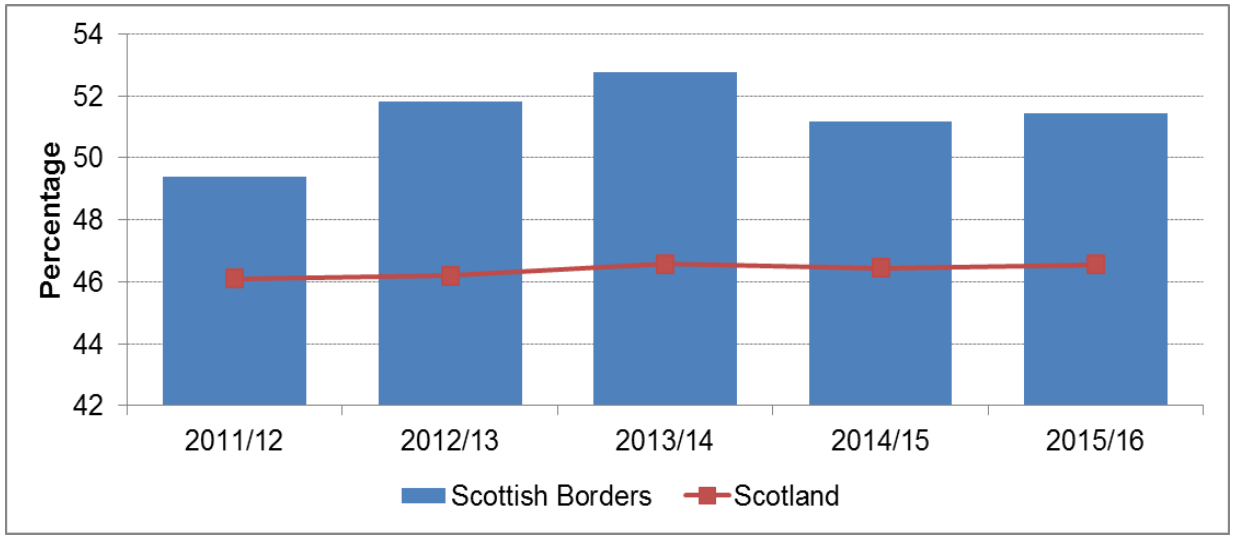
If we are able to improve health and wellbeing through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in Figure 3.

What shifts do we need to make?

By shifting resources FROM Unplanned Hospital Care and Institutional-Based Social Care TOWARDS Community-based NHS and Social Care and Planned Inpatient Care, resources are used more effectively and on prevention, rather than treatment. This will help us invest in new integrated ways of working, particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting Carers and independent living.

The Scottish Borders has already made some progress towards the aim of providing more care in the community compared with Scotland as a whole. In 2015/16, 51% of total NHS and Social Care Spend in the Borders was on Community-based services, higher than the 47% for Scotland as a whole.

Figure 3 Percentage of total NHS and social care expenditure spent on community based care



Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

Notes:

1. Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.
2. Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .....11 June 2018.....

Report By	Mr Robert McCulloch-Graham, Chief Officer
Contact	Mr David Robertson, Chief Financial Officer, SBC Mrs Carol Gillie, Director of Finance, NHS Borders
Telephone:	01835 824000 / 01896 825555

MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2017/18 AT 31 MARCH 2018

Purpose of Report:	The aim of this report is to provide an overview of the financial position of the Health and Social Care Partnership Budget at 31 March 2018.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note the report and the final outturn monitoring position on the partnership's 2017/18 revenue budget at 31 March 2018. b) Ask the Chief Officer to bring forward a plan to the next meeting of the IJB for delivery of permanent remedial savings to address the recurring resource gap experienced during both 2016/17 and 2017/18 which required additional contributions from partners at the financial year-end.

Personnel:	N/A

Carers:	N/A

Equalities:	There are no equalities impacts arising from the report.

Financial:	No resourcing implications beyond the financial resources identified within the report. The report has been reviewed by the Chief Officer and approved by NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer for factual accuracy. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.

Legal:	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance. A Recovery Plan will be presented to the next meeting of the IJB. The remedial actions it contains in order to address financial pressures across health and social care budgets may impact on the ability to deliver the partnership's strategic an commissioning plans

Risk Implications:	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.

Aim

1.1 The aim of this report is to provide an overview of the financial position of the Health and Social Care Partnership Budget at 31 March 2018.

Background

2.1 The report relates to the monitoring position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and the budget relating to large-hospital functions retained and set aside for the population of the Scottish Borders (the "set-aside budget").

2.2 On the 30th March 2017, the Integration Joint Board (IJB) agreed the delegation of **£140.157m** of resources supporting integrated health and social care functions for financial year 2017/18. At the same time, it noted the proposed budget of **£18.978m** relating to the large hospitals budget set-aside. Within the delegated budget, **£94.490m** related to healthcare functions delegated by NHS Borders **and £45.667m** related to social care functions delegated by Scottish Borders Council.

2.3 Since the Financial Statement was approved by the IJB in March 2017, a number of factors have resulted in the revisions to the base budgets supporting delegated and set-aside functions and subsequently their ongoing movement to a revised position. These factors include final grant allocation settlements having been made, intra-organisational budget realignments and additional funding provisions by the Scottish Government. The revised budget positions therefore relating to those functions delegated to the IJB and the large hospital set-aside are currently:

	2017/18 Revised Budget £m
Healthcare Functions – Delegated	105.164
Social Care Functions – Delegated	46.635
Total Delegated	**151.799**
Healthcare Functions - Set-Aside	**24.418**

2.4 Included in the above revised budgets, NHS Borders made an additional contribution at year-end of **£4.230m** to the delegated budget and **£3.792m** to the set-aside budget. Scottish Borders Council made an additional contribution of £0.294m to the delegated budget. Total IJB resources at year-end therefore amounted to **£176.217m**

2.5 This report sets out the final outturn monitoring position on both the delegated and set-aside budgets at 31 March 2018, identifying key areas of financial pressure.

Overview of Monitoring Position at 30 June 2017

Delegated Budget

Healthcare Functions

3.1 NHS Borders services have experience exceptional operational pressures during 2017/18. The largest area of financial pressure relates to prescribing and drug costs in delegated services (£**2.3m** adverse at outturn) due to unidentified savings targets, lower than anticipated delivery on Pregablin and Respiratory savings and the increase in cost of drugs in short supply. This continues to be an area of risk due to the volatility of drug prices, the time-lag in the availability of information on drug volumes and cost and the challenges associated with delivering efficiencies.

3.2 Additionally financial pressure is also reported at outturn within Community Hospitals (**£0.300m**) and Nursing (**£0.100m**).

3.3 Similar to 2016/17, NHS Borders made an additional contribution at year-end of **£4.230m** to the delegated budget. In order to do this, a range of measures were put in place. It is noted that these are largely non-recurring. These included:

- utilisation of contingency funding;
- the use of balance sheet flexibility;
- slippage on a number of local delivery plan developments;
- the use of capital funds to support revenue pressures;
- additional funding from the IJB linked to the impact of increase numbers of delayed discharges;
- central funding to support the loss of Northumberland income;
- A number of control measures linked to areas of discretionary spend including training, travel, equipment and stationery.

Social Care Functions

3.4 Health and Social Care services have experienced significant financial pressure in the year, in particular across those services delegated to the Health and Social Care Partnership. These pressures are primarily attributable to demand. The largest area of financial pressure is within the Older People's Service where **£1.425m** of expenditure was incurred in excess of the budget approved by the IJB on 30 March 2017. Despite additional resources having been invested in the Older People's Service during the year, pressures of **£0.613m** have been partially offset by

managed underspends of **£0.319m** within the Joint Learning Disability, Joint Mental Health, and People with Physical Disabilities services.

3.5 Across each service where financial pressure is being experienced, there is consistently additional levels of service being commissioned above available budget, either due to a greater number of clients or more intensive care and support being required. Where possible, Health and Social Care services have identified areas where savings can be delivered in order to mitigate these pressures going forward.

3.6 Scottish Borders Council made an additional contribution of **£0.294m** to the delegated budget from managed savings delivered across other Council functions not delegated to the IJB.

Large Hospital Budget Set-Aside

3.7 At the 31 March 2018, NHS Borders reported an overspend of **£3.792m** on the large hospital budget set-aside.

3.8 The key pressure was the continuing requirement throughout the financial year for surge beds to be open due to the level of delayed discharges occupied bed days. . This position was partially offset on a one-off basis by Social Care Funding directed by the IJB totalling **£1.0m** to support the use of surge bed capacity.

3.9 The use of agency and bank staff to cover gaps in both medical and nursing rotas and a shortfall in the delivery of required efficiencies also impacted adversely on the financial position.

3.10 NHS Borders made an additional contribution at year-end of **£3.792m** to the set-aside budget. This contribution was based on the same non-recurring actions as those that enabled the additional contribution to the delegated budget in 3.3 above.

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2017/18	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	19,204	20,025	20,250	20,025	225	Savings resulting from rigourous management of staff turnover and challenge on discretionary spend.
Joint Mental Health Service	15,847	15,597	15,687	15,597	90	Staff vacancies and reduction in discretionary spend.
Joint Alcohol and Drug Service	1,006	767	770	767	3	
Older People Service	20,265	19,298	18,685	19,298	(613)	Demand pressure in Residential Care / Housing with Care / Respite / Additional hours have resulted in a significant overspend
Physical Disability Service	3,432	3,535	3,570	3,535	35	Saving due to net reduction in a small number of care packages.
Generic Services	80,403	92,577	88,313	92,577	(4,264)	Prescribing, Community Hospitals and Nursing Pressures compounded by Non-Delivery of Financial Plan efficiency savings.
Contribution from NHSB / SBC - delegated	0	0	4,524	0	4,524	
Large Hospital Functions Set-Aside	18,978	24,418	20,626	24,418	(3,792)	Includes £3,792 of an additional contribution top-up by NHS Borders.
Contribution from NHSB - Set-Aside	0	0	3,792	0	3,792	
Total	159,135	176,217	176,217	176,217	0	

This page is intentionally left blank

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions	2017/18	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,643	3,432	3,520	3,432	88	
Joint Mental Health Service	13,881	13,760	13,725	13,760	(35)	
Joint Alcohol and Drug Service	833	597	597	597	0	
Generic Services	76,133	87,375	83,092	87,375	(4,283)	Prescribing budget is £2.3m overspent at the end of March due to unmet savings and increased drug costs. Non-Delivery of Planned efficiencies accounts for a further £1.2m of pressure. Other pressures at outturn include Community Hospitals £300k and Nursing £100k.
Contribution from NHS Borders Year end Plan	0	0	4,230	0	4,230	
Total	94,490	105,164	105,164	105,164	0	

This page is intentionally left blank

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2017/18	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	1,997	2,605	2,004	2,605	(601)	Continuing requirement for Surge Beds, partially offset by the non-recurring direction of Social Care Funding by the IJB.
Medicine & Long-Term Conditions	11,633	14,597	12,905	14,597	(1,692)	
Medicine of the Elderly	6,020	7,216	6,434	7,216	(782)	A combination of staffing gaps and patient acuity continues to have an adverse impact on Employee Costs.
Savings and Planned Actions	(672)	0	(717)	0	(717)	
Contribution from NHS Borders Year end Plan	0	0	3,792	0	3,792	Non-Delivery of Planned Efficiencies is also a key factor in the Set-Aside budget pressure.
Total	18,978	24,418	24,418	24,418	0	

This page is intentionally left blank

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions	2017/18	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	**15,561**	**16,593**	**16,730**	**16,593**	**137**	Staffing saving and increased efficiency in service delivery.
Joint Mental Health Service	**1,966**	**1,837**	**1,962**	**1,837**	**125**	Staffing saving in early part of year and increased efficiency in service delivery.
Joint Alcohol and Drug Service	**173**	**170**	**173**	**170**	**3**	
Older People Service	**20,265**	**19,298**	**18,685**	**19,298**	**(613)**	Demand pressure in Residential Care / Housing with Care / Respite / Additional hours have resulted in a significant overspend Outturn exceeds base budget by £1.425m.
Physical Disability Service	**3,432**	**3,535**	**3,570**	**3,535**	**35**	Saving due to reduced service demand.
Generic Services	**4,270**	**5,202**	**5,221**	**5,202**	**19**	Staff turnover saving.
Contribution from SBC	**0**	**0**	**294**	**0**	**294**	
Total	**45,667**	**46,635**	**46,635**	**46,635**	**0**	

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .11th June 2018

Report By	Rob McCulloch-Graham
Contact	David Robertson, Chief Financial Officer Carol Gillie, Director of Finance
Telephone:	01835 824000 01896 825501

DELIVERABILITY OF HEALTH & SOCIAL CARE PARTNERSHIP FINANCIAL PLAN SAVINGS FOR FINANCIAL YEAR 2018/19

Purpose of Report:	The aim of this report is to provide an overview on the delivery of 208/19 Financial Plan Savings to be delivered by the Health and Social Care Partnership during the Financial Year to 31 March 2019. The IJB requested at the meeting on the 22nd April 2018 a report be brought in June 2018 with details of how the unidentified savings requirement would be addressed. Due to the timing of NHS Borders Board meeting this information will not be available until the end of June. The report relates to the deliverability of savings required in order to ensure that the 2018/19 IJB Financial Plan is both affordable and deliverable. NHS Borders, Scottish Borders Council and the Health and Social Care Partnership are required to work together to prepare and deliver the required programme of transformation, efficiency and other savings to enable delivery of a balanced budget position. The Financial Plan taken to the Scottish Borders Health and Social Care Integration Joint Board on the 23rd April 2018 identified efficiency savings of £9.883m being required, of which £5.235m were unidentified at that date. Of the £9.883m savings required to deliver a balanced position in 2018/19, NHS Borders is committed to delivering £7.435m and Scottish Borders Council committed to delivering £2.448m. *Overview of Deliverability of Savings Position at 6th June 2018* Details of savings for Social Care and Health Care have been accessed as to their deliverability in the current Financial Year as follows:

	Category 1 have full plans agreed and no issues as to deliverability Category 2 have some plans agreed with potential issues as to deliverability Category 3 have no plans agreed and have potential issues with deliverability. <u>Social Care</u> Undelivered Health & Social Care savings of £650k have been carried forward from 2016/17 and new identified savings of £1.398m were agreed by Council on 20th February 2018 giving total savings to be delivered by the service of £2.048m. In addition the Council has allocated a number of corporate savings to each of the Council Services which include £400k to Health and Social Care. The total savings reported in the IJB Financial Plan on the 23rd April was therefore £2.448m. Full plans have been agreed within the Health and Social Care Service to deliver savings to the value of £216k (9%), plans are in development to deliver savings to the value of £1.627m (66%), plans remain outstanding to deliver the balance of savings £605k (25%). A detailed schedule showing the status of the £2.448m Health & Social Care savings is attached in appendix 1. <u>Health Care</u> Undelivered Healthcare savings of £3.917m (£3.414m NHS Base & £0.503m NHS Set-Aside) have been carried forward from 2017/18. Total NHS savings to be delivered in 2018/19 (including savings brought forward) are £7.435m. Full plans have been agreed within the Healthcare service to deliver savings to the value of £915k (12%). Some plans have been agreed to deliver savings to the value of £967k (13%) and no plans have yet been agreed to deliver savings to the value of £5.553m (75%). A detailed schedule of Healthcare savings of £7.435m is attached in appendix 2. <u>Overview</u> Of the total (£9.883m) savings required by the IJB to deliver a balanced budget, detailed plans are in place to deliver £1.131m (11%), plans are in development to deliver savings to the value of £2.594m (26%), and plans remain outstanding are for £6.158m (62%). The identification of planned savings to bridge the above funding gap remains the key risk associated with the delivery of a balanced budget in the 2018/19 financial year.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: **Note** the report on the deliverability of 2018/19 savings and efficiencies that are required in order to deliver a balanced budget for the year to 2019. **Ask** the Chief Officer to bring forward a plan to the next meeting of the IJB for delivery of savings to address the resource gap in year and recurrently.

Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2018/19 will be reported to the Integration Joint Board.

Carers:	N/A

Equalities:	There are no equalities impacts arising from the report.

Financial:	As detailed within the report.

Legal:	The report supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.

Risk Implications:	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.

This page is intentionally left blank

APPENDIX 3

FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH & SOCIAL CARE PARTNERSHIP

1- full plans agreed/ no issues with deliverability
2- some plans agreed/ potential issues with deliverability
3 - no plans yet agreed/ issues with deliverability

Social Care Brought Forward Savings	**£'000**	1	2	3	Notes
Review of Business Management & Specialist posts	53		53		
Review of Commissioning arrangements	597		597		May impact on SBCares ability to deliver forecast contribution level
2018/19 Savings:					
Purchase Criminal Justice Service (CJS) training (e.g. Health and Safety) from Scottish Borders Council instead of an	2	2			Budget reduced
Review of Day Services (Older People and Learning Disability)	290		145	145	Full delivery of this saving subject to realignment of SB Cares contract and full delivery of day centre rationalisation. No savings identified by LD or Mental Health for contribution towards this. Therefore assumed all has to come from Older People Day services. Significant saving on day services has already been delivered, the full extent will be clarified upon rebasing the SB Cares Contract.
Review of non-day service functions from SB Cares	100			100	Full delivery of this saving subject to realignment of SB Cares contract and completion of review of non-day services functions.
Review and recommission of Specialist Care and Support Services (Older People)	250			250	Non SB Cares - no plan in place yet.
Review the Shopping Service (Older People)	41	41			Service to be cancelled and contract amended as part of rebasing SB Cares contract exercise. Covers Older Peoples
Review Commissioned Services including SB Cares within Learning Disability Service	100		100		Service plans to recommisson with another provider at a reduced rate. Possible TUPE issue to be investigated - HR to guide service.
Decommission Learning Disability Services with new alternatives.	76	76			Commitment to delivering £66k. Balance to be identified

APPENDIX 3

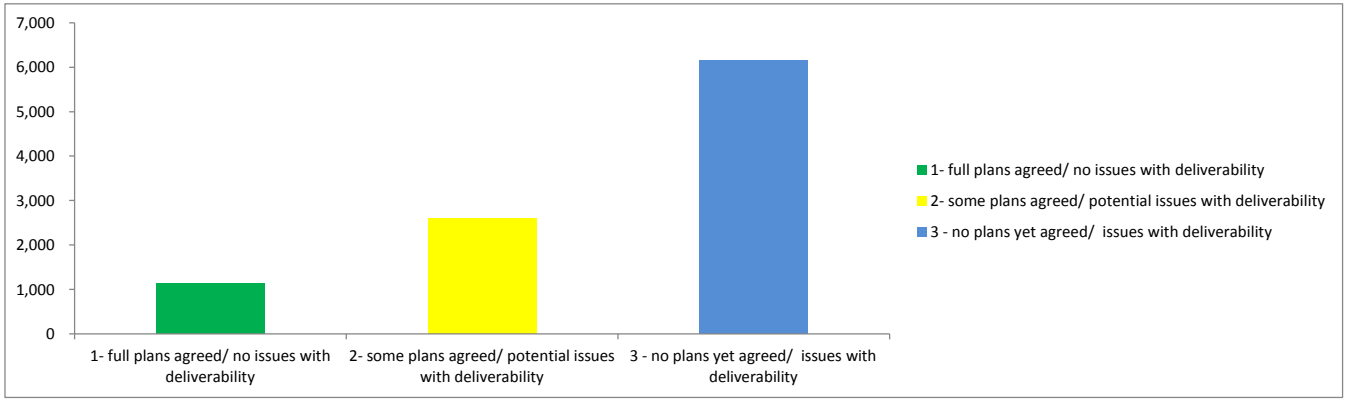
FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH & SOCIAL CARE PARTNERSHIP		1- full plans agreed/ no issues with deliverability 2- some plans agreed/ potential issues with deliverability 3 - no plans yet agreed/ issues with deliverability			
Reduction in Night-Time Support (note the wider context of a future strategic review of Night-Time Support) (Learning Disability)	74		74		Projects under way looking at 30+ sleep-in arrangements - project not likely to be delivering savings until 2019/20. Targeted reduction of 2.0FTE. Work already undertaken by a previous project. Any impact will be mitigated, with no impact on H&SC staff but potential impact on SB Cares staff.
Decommission Learning Disability Services delivered by	24	24			Borders College - saving from August 2018 (new term)
Decommission a specific Adults with Learning Disability contract	10			10	Artbeat (mental Health support group). Alternative proposal to re differential charging using SDS being investigated.
Decommission 2 Mental Health services with identified alternatives	53	13	40		National Help Line to replace Borderline to deliver £40k. Balance to come from Artbeat charging review.
Greater Use of Technology	100			100	No plan in place. Investment in technology may mitigate future care packages but unlikely to impact current care packages.
Undertake a productivity review programme across Adult Social Work services	88		88		Process to be worked on and timesclaes to be clarified.
Review management arrangements across all Adult social work services	60	60			Deletion of vacant post to deliver saving .
Review Community Based Services (considering posts / skill mix) covering Occupational Therapy and Social Work	110		110		Commitment to delete vacant OT posts following a review.
Review all small grants, contributions to communities and payments to 3rd sector organisations	20		20		Review undweway.
Share of Scottish Borders Council Corporate Savings	400		400		Plans being agreed at a corporate level.
Dental Services increased efficiency - non recurring	150			150	Dependant on SG Allocation - no update received from PacsGM
Increase in level of funding in primary care - non recurring	25			25	Schemes relating to weight management and Orthopaedic Workshop - no update received from PacsGM
AHP Management Review - recurring	100		100		Efficiency productivity work stream idenitifed £168k

APPENDIX 3

FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH & SOCIAL CARE PARTNERSHIP		1- full plans agreed/ no issues with deliverability	2- some plans agreed/ potential issues with deliverability	3 - no plans yet agreed/ issues with deliverability	
Medical Support to Community Hospitals- recurring	75			75	no update received from PAcs GM.
Clinical Board Managment Review - non recurring	55			55	update to plans received from MH GM with amended figure
MHOAT & Clinical Psychology Vacancy Managment - non recurring	265	265			detailed figures received from MH GM with a rag status of green confirmed.
MH Staff Turnover - non recurring	330		317	13	information received from MH GM confirming plans agreed with possible issues with deliverability.
Prescribing Benchmarking & Variation recurring	1,200	650	550		update to plans received from Director of Pharmacy. Verification of items highlighted as green required.
Unidentified savings NHSB	5,235			5,235	No plans yet agreed
	9,883	**1,131**	**2,594**	**6,158**	
		11%	**26%**	**62%**	



APPENDIX 3

FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH & SOCIAL CARE PARTNERSHIP	1- full plans agreed/ no issues with deliverability
	2- some plans agreed/ potential issues with deliverability
	3 - no plans yet agreed/ issues with deliverability

APPENDIX 2

FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH CARE

1- full plans agreed/ no issues with deliverability
2- some plans agreed/ potential issues with deliverability
3 - no plans yet agreed/ issues with deliverability

Brought Forward Savings	**£'000**	1	2	3	Notes
Dental Services increased efficiency - non recurring	150			150	Dependant on SG Allocation - no update received from PacsGM
Increase in level of funding in primary care - non recurring	25			25	Schemes relating to weight management and Orthopaedic Workshop - no update received from PacsGM
AHP Management Review - recurring	100		100		Efficiency productivity work stream idenitifed £168k
Medical Support to Community Hospitals- recurring	75			75	no update received from PAcs GM.
Clinical Board Managment Review - non recurring	55			55	update to plans received from MH GM with amended figure
MHOAT & Clinical Psychology Vacancy Managment - non recurring	265	265			detailed figures received from MH GM with a rag status of green confirmed.
MH Staff Turnover - non recurring	330		317	13	information received from MH GM confirming plans agreed with possible issues with deliverability.
Prescribing Benchmarking & Variation recurring	1,200	650	550		update to plans received from Director of Pharmacy. Verification of items highlighted as green required.
Unidentified savings NHSB	5,235			5,235	No plans yet agreed
	7,435	**915**	**967**	**5,553**	
		12%	**13%**	**75%**	

This page is intentionally left blank

APPENDIX 1

FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH & SOCIAL CARE

1- full plans agreed/ no issues with deliverability
2- some plans agreed/ potential issues with deliverability
3 - no plans yet agreed/ issues with deliverability

Brought Forward Savings	**£'000**	1	2	3	Notes
Review of Business Management & Specialist posts	53		53		
Review of Commissioning arrangements	597		597		May impact on SBCares ability to deliver forecast contribution level
2018/19 Savings:					
Purchase Criminal Justice Service (CJS) training (e.g. Health and Safety) from Scottish Borders Council instead of an	2	2			
Review of Day Services (Older People and Learning Disability)	290		145	145	Full delivery of this saving subject to realignment of SB Cares contract and full delivery of day centre rationalisation. No savings identified by LD or Mental Health for contribution towards this. Therefore assumed all has to come from Older People Day services. Significant saving on day services has already been delivered, the full extent will be clarified upon rebasing the SB Cares Contract.
Review of non-day service functions from SB Cares	100			100	Full delivery of this saving subject to realignment of SB Cares contract and completion of review of non-day services functions.
Review and recommission of Specialist Care and Support Services (Older People)	250			250	Non SB Cares - no plan in place yet.
Review the Shopping Service (Older People)	41	41			Service to be cancelled and contract amended as part of rebasing SB Cares contract exercise. Covers Older Peoples
Review Commissioned Services including SB Cares within Learning Disability Service	100		100		S Burt wishes to recommisson with another provider at a reduced rate. L Mirley has raised TUPE issues?? HR to guide service. No progress made to date.
Decommission Learning Disability Services with new alternatives.	76	76			S Burt has committed to delivering £66k. Balance to be identified.

APPENDIX 1

FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH & SOCIAL CARE

1- full plans agreed/ no issues with deliverability
2- some plans agreed/ potential issues with deliverability
3 - no plans yet agreed/ issues with deliverability

Brought Forward Savings	**£'000**	1	2	3	Notes
Reduction in Night-Time Support (note the wider context of a future strategic review of Night-Time Support) (Learning Disability)	74		74		Projects under way looking at 30+ sleep-in arrangements - project not likely to be delivering savings until 2019/20. Targeted reduction of 2.0FTE. Work already undertaken by a previous project. Any impact will be mitigated, with no impact on H&SC staff but potential impact on SB Cares staff.
Decommission Learning Disability Services delivered by	24	24			Borders College - saving from August 2018 (new term)
Decommission a specific Adults with Learning Disability contract	10			10	Artbeat (mental Health support group). EIA suggested negative impact and SB seeking CMT direction. Proposal rejected by EMT.
Decommission 2 Mental Health services with identified alternatives	53	13	40		National Help Line to replace Borderline to deliver £40k. Balance to come from Artbeat. EMT decision to reject Artbeat decommissioning.
Greater Use of Technology	100			100	No plan in place. Investment in technology may mitigate future care packages but unlikely to impact current care packages.
Undertake a productivity review programme across Adult Social Work services	88		88		In locality offices - processes being worked on - no cashable savings yet identified - possibly redepoy staff to work on roll out of carers act. Underway with initial focus on Duns Social work office. Initially will focus on a small number of identified key processes to identify improvement options.
Review management arrangements across all Adult social work services	60	60			Possibly deleting vacant post to deliver saving .
Review Community Based Services (considering posts / skill mix) covering Occupational Therapy and Social Work	110		110		Commitment to delete vacant OT posts following a review.
Review all small grants, contributions to communities and payments to 3rd sector organisations	20		20		Will be reviewed
Alocation of SBC Corporate Savings programme	400		400		Relates to overtime / people planning / digital transformation. Programme of work currently under way to deliver savings.
	2,448	**216**	**1,627**	**605**	
		9%	**66%**	**25%**	

APPENDIX 1

FINANCIAL PLAN SAVINGS DELIVERY - 2018/19

HEALTH & SOCIAL CARE

1- full plans agreed/ no issues with deliverability
2- some plans agreed/ potential issues with deliverability
3 - no plans yet agreed/ issues with deliverability

Brought Forward Savings	**£'000**	1	2	3	Notes

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .....11 June 2018.....

Report By	Robert McCulloch-Graham, Chief Officer
Contact	Jane Robertson, Strategic Planning and Development Manager
Telephone:	01835 825080

INTEGRATED CARE FUND UPDATE

Purpose of Report:	The purpose of this report is to update the Integration Joint Board (IJB) on the Integrated Care Fund (ICF) following decisions taken in April 2018 to disinvest in three ICF funded projects.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note the timescale for ending the Autism Strategy, ARBD Pathway and Stress and Distress Training projects. b) Note the total Integrated Care fudning being returned for redirection.

Personnel:	Projects under review employ staff.

Carers:	A number of projects have positive outcomes for carers.

Equalities:	Related to EIA for Strategic Plan.

Financial:	Potential for redirection of ICF if projects disinvested.

Legal:	N/A

Risk Implications:	N/A

INTEGRATED CARE FUND - UPDATE

June 2018

Purpose

1.1 The purpose of this report is to update the Integration Joint Board (IJB) on the Integrated Care Fund (ICF) following decisions taken in April 2018 to disinvest in three ICF funded projects.

Background

2.1 In April 2018 the IJB reviewed eleven projects and agreed to carry over unspent ICF funding previously allocated to allow eight projects to continue. Due to insufficient evidence regarding impact and benefits realised, the IJB decided that three projects should not be supported to continue via ICF funding. The three projects are detailed below:

- Delivery of the ARBD Pathway;
- Delivery of the Autism Strategy;
- Stress and Distress Training.

2.2 It was agreed that these projects be wound down within an agreed timescale and any remaining IC funding beyond this point should be returned for redirection by the IJB.

Update on Progress

3.1 Since the decision taken by the IJB to disinvest in the three above named IC funded projects, discussions have taken place with each project lead regarding the time required to wind down each project. All three projects used IC funding to recruit staff and therefore staff notice requirements have been taken into account when determining the time required to wind down each project. A summary of project end dates and the amount of funding to be returned to the ICF are detailed in the table below:

Project	End Date	ICF Returned
Delivery of the Autism Strategy	30 September 2018	£25,500
Delivery of the ARBD pathway	30 September 2018	£25,500
Stress & Distress Training	30 September 2018	£96,000

3.2 All three projects will end by 30 September 2018 resulting in a return of funding to the ICF of circa **£147k** increasing the total uncommitted ICF funding from 31 March 2018 to **£298k**.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 11th June 2018

Report By	Michael Curran & Tim Paterson
Contact	Michael Curran
Telephone:	01835 824000 ext. 5939

INTERIM REPORT ON COMMUNITY CAPACITY BUILDING

Purpose of Report:	To update the IJB on progress made by the Community Capacity Building Project to support transformation. To set out the qualitative impact of the work carried out by Community Capacity Building Project. To set out the high level plan to engage with acute and primary care colleagues to facilitate the evaluation of the clinical impact of Community Capacity Building project.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: Note the work of the Community Capacity Building Team to date.
Personnel:	There are no personnel implications outlined in the content of this Interim report
Carers:	There is an inherit benefit to carers in delivering effective community capacity building.
Equalities:	There are no equalities impacts arising from this report
Financial:	Financial impacts where covered in previous reports
Legal:	Supports the delivery of the strategic plan and is in compliance with the Public Bodies (joint working) (Scotland) Act 2104.
Risk Implications:	To be reviewed in line with agreed risk management strategy inability to deliver enhanced capacity within the community will undermine the delivery of key strategic objectives.

1. Background

1.1. Community Capacity Building is a mechanism for early intervention, reducing health inequalities, supporting carers and supporting independent living. The team has and will continue to improve health and wellbeing through preventive and supportive community based care, this will enable the delivery of the strategic intention to move the balance of care into the community.

1.2. The IJB approved a further 12 months ICF funding for the Community Capacity Building Team in December 2017 for financial year 18/19. It was agreed at this time that an evaluation set up which would include acute and primary care colleagues, should be carried out within 12 months as well as an update on progress to the IJB at six months.

2. Summary of impact

2.1. The Community Capacity Building Team (CCBT) has won the silver award in the 'Creating Community Capacity' at the Public Sector Transformation Awards in London. The award recognises the substantial impact on transformation and was presented to Cllr Weatherston and members of the team by Chairman of IESE, Councillor Paul Bettison.

2.2. The CCBT continue to maintain the existing level of activity and have added 4 new activities to the programme since December 17. There has been an increase in participants in the programme from 500 per week to 650 per week. The team have enlisted 14 new volunteers to support the new groups. Whilst the Hawick Gentle exercise class has ceased due to issues around viability, the overall participation numbers have increased.

2.3. The CCBT have engaged with transformation projects and explored how their input could be best realised. A broad theme has emerged for several transformation projects; having a mechanism to pull people through to longer term activities post clinical input. The mechanism for this would be via the Community Led Support "What Matters Hubs" where community capacity workers would be in attendance.

2.4. The CCBT have successfully created new community based alternatives for the remaining clients attending the Ability Centre as part of the reimagining day centre project. This has allowed the Centre to be decommissioned as a building based model. The community based model is provided via a community link worker model.

2.5. The CCBT is engaged in further re-imagining work in the Berwickshire area where new joint models of care are being developed to deliver a joint approach to day time opportunities.

2.6. The CCBT are engaged in the type two diabetes agenda with current and future activity delivering the community capacity building element of the actions required to address this growing issue.

Page 2 of 4

2.7. An additional benefit generated by the support offered by the CCBT to local projects in the community has been the allocation of additional funding to local groups and organisations. The CCB team have supported the raising of £117,600 (appendix 1) which has strengthened these organisations and has made many other activities possible across the Scottish Borders.

3. Impact Evaluation approach

3.1. The CCB team have brought together a range of case studies to support the evaluation and to offer insight for colleagues in acute and primary care to develop an impact assessment approach (see Appendix 2). The case studies cover a range of clinical conditions such as clinical depression, osteoporosis, parkinson's, early onset dementia, joint replacement, falls and prostate cancer.

3.2. It is agreed that colleagues from Acute Care (Cliff Sharp) and Primary care (Kenny Mitchell) as well as Public Health (Tim Paterson) explore and agree the most appropriate evaluation approach considering both the broad and specific nature of benefits outlined in the case studies. It is also proposed that Partnership Programme support should be utilised to ensure that evaluation mechanisms are aligned to those for all ICF funded projects.

3.3. It is proposed that the evaluation should be completed by November 2018 and the presented to the IJB in December or very early in 2019.

Page 205

Appendix 1

An additional unexpected benefit generated by the support offered by the CCB team to local projects in the community has been the allocation of additional funding to local groups and organisations which has strengthened these organisations and has made many other activities possible across the Scottish Borders.

Group	Funding Source 17/18	Amount
Food Train	Scottish Government	£38,000
Gala walking football	Aviva	£1,000
	Hayward Sanderson Trust	£400
Just Cycle	Transport Scotland	£25,000
	Scottish landfill communities Fund	£25,000
	The Foyle Foundation	£ 2,000
	Foundation Scotland	£ 2,000
Food Foundation	Local Trust Fund	£5,000
Silver Sunday	Berwickshire Housing Association	£1,000
New Age Kurling	Barchester's Charitable Foundation	£500
	Coldingham community Council	£300
	Coldingham Book Shop	£200
Walking Netball	Foundation Scotland – Drone Hill Windfarm	£500
Duns veterans club	RAF Edinburgh, Lothians and Borders Branch	£200
Writing for wellbeing	Blackhill Windfarm	£750
	Christie's Trust	£450
Wellbeing Week	Health In mind	£800
	Community Grant	£500
Mens shed	Hudson Hirsel	£3500
	Blackhill Community Fund	£3500
	Localities Bid fund	£7000
Total		**£117,600**

Appendix 2

Case Study 1:

A PENSIONER - AND FINISHED?

I started work at 17 and retired nearly 50 years later without a day's unemployment. For much of that time I was also active, healthy and effectively illness-free – there's was one period of 27 years without a single day's absence. Unfortunately I then fell into an extended period of clinical depression where I had a breakdown and was diagnosed by my psychiatrist as "passively suicidal". The recommended treatment was cognitive therapy rather than medication – essentially being active mentally and physically. With support, this worked very well for a long period – I had a challenging job and I played football in some form until nearly 60.

This support programme disappeared almost overnight on retirement – opportunities for mental and physical agility disappeared simultaneously and I felt myself slip into dark moods, bad ways and poor health. Depression, although a mental illness, brings with it a host of physical problems as the ability – even the interest - to fight any illness disappears as well. It's a downwards spiral.

Walking football pulled me out of that spiral.

I spotted the opportunity advertised in local publications and shops. Checking Walking Football generally on-line was not encouraging – it has an air of "care in the community for old folk". However when I spoke to the local contact, Amanda Renwick, she was very positive, emphasising the fun side - with the benefits flowing as natural outcome. I was persuaded. When I first attended I found her enthusiasm and commitment infectious, something that has been constant ever since. I may not match her for effort and energy but she sets a standard to aim for.

Since I began attending I have missed only one night – due to the snow. I have also identified additional outlets in Gala. Much of my week is now taken up with football. Foremost fun – with benefits to follow as promised. My social skills are coming back and extending beyond football: my self-esteem has been restored. I'm using my brain again. My health is better than can be expected for someone approaching 70, my fitness compares with many 50+. I have regular bruises and strains from playing but these are badges of honour, carried with pride!

Depression never goes away but I am once again handling it as an irritation in the background and not as a life-threatening issue. Who would have thought all this from walking football - and Amanda?

I am grateful to them both.

Pensioner LAUDER

Case Study 2:

X started attending the gentle exercise class, however, suffered from osteoporosis, and as a result if this has a very weak neck, her head carriage was very low and a lot of the time x was unable to look up and straight ahead of her.

This had impacted her greatly as she had stopped going out of the house as often as she had to rely on a mobility scooter but often became quite distressed as she was banging into things. This resulted in a loss of confidence, lack of self-esteem and an unwillingness to socialise.

X started attending the weekly gentle exercise class and after a short number weeks of attending the class, the lady asked me over to her seat as she said she had something to show me, she slowly lifted her head from her chest and was able to hold it up – she explained that this was a result of the exercise class and thanked myself and the instructor for making a difference to her.

Not only had this helped with her muscle strength, she had slowly built up the confidence to go out and about in her mobility scooter again.

Case study 3:

X started coming to the walking football as he saw it advertised around the town. After a brief conversation, x told me he had arthritis in both knees and was unable to play football now. He explained this had impacted him both physically as he felt he was not getting the exercise he needed, and socially, as he struggled in company with his friends who still played and he sometimes felt slightly isolated from the conversation.

He has now been coming to the walking football for a number of months and says he physically he feels much fitter and managed to persuade one of his friends to come along and play too.

Case study 4:

One of our players was asked to write for the Walking Football Scotland website back in the autumn. Gordon has been playing with the Gala team almost since they started nearly three and a half years ago

He is age 71 and as a sixteen year old was asked to sign an “S” form for Hearts-such was his talent. His mother said that he would be better off with a “proper job” and so he turned down the chance and took a job with DHSS –where he stayed until his retirement.

Even with Parkinsons disease you can see the skilful touches he has when playing.

Cant help but wonder , what if…

Moral of the story is, you should not always listen to your mother!

Article

Having retired four years ago I was determined that the time had now come to agree a course of action with my GP regarding a knee that had been damaged for a long time and which resulted in a knee replacement. Prior to this my limping caused some to sympathise and others mild amusement!

As time went by and I continued with exercises to strengthen my new knee. This was mainly by walking and within the Galashiels area and developing quite a knowledge of the town and also meeting many other walkers. Whether they had also had a replacement knee or not I don't know! I also started attending a weekly badminton group at our church and gradually began to strengthen my knee but also increase my confidence as to what was possible or not.

The next discovery was walking football. I had loved football since the start of living memory and hadn't anticipated becoming involved again but this seemed to be a possibility and I determined to investigate. I spoke with Lynn who coordinates the walking football, particularly in the Galashiels area. She suggested that I come along to the two weekly sessions – one at the Langlee Community centre and the other at Netherdale – to see how I felt.

This has resulted in developing friendships with other like-minded guys but also in rediscovery of football involvement to my great delight. I'm still wary about strong tackles and over enthusiastic play and I think others back off a bit which I appreciate and I still don't want to get too competitive but usually I love the sessions and the banter.

Furthermore since starting walking football I have been diagnosed with Parkinsons. This has not affected my attending the football and I consider the exercise beneficial and necessary as I intend to keep playing football, badminton, walking and going to the gym for as long as possible.

To sum up I am SO PLEASED to have the opportunity to play football again

Case study 5:

X is a 70 year old who has not long moved to the Borders. Other than her children and grandchildren she only knew 1 other person her own age when she moved here.

Upon turning 70 X realised she needed to become proactive in term of looking after her health, realising the importance of strength and balance to prevent falls and injuries. X weekly goes online to the NHS Choices website and carries out the exercises online to improve balance.

Having joined a local yoga class she saw advertised Walking Netball (a community capacity building (CCB) organised session) and thought why not, especially after her teenage granddaughters encouraged her to go along and try it out. X had not played netball since a child herself.

Walking netball is now the highlight of her week! "Our netball sessions are excellent, not only are the games enjoyable but the drills are great for remembering things and coordination/ movement – having to follow general instructions is brilliant for the brain"

X told me that having the opportunity to still be competitive in game play inspires confidence and is inclusive of all abilities to ensure everyone can take part and enjoy the sport.

Personally the great thing for me (CCB worker) is that as a result of X attending Walking Netball she has made a whole other network of people who she never knew before, X now volunteers with a different CCB activity – soup lunch, and has gone on to join another CCB class (arts and crafts) as well as various other things in the local community that she has since discovered through meeting new friends at netball!

Walking netball has therefore been beneficial to this individual both physically and socially.

Case study 6:

X attends one of our gentle exercise classes and has done since it began in 2014. She is now 85 years old and lives with Parkinson's Disease as well as early onset Dementia.

X takes part weekly in the classes completing the whole 45 minutes of exercise. The exercise really helps to reduce her shakes and tremors out with the class, she feels the coordination of the moves is very beneficial mentally as well as helping with general fitness levels. Although she walks regularly around the town she may not be taking part in such exercise if it hadn't been for this class.

Having a regular, consistent class to attend also is helpful to her now living with dementia as well. As she has been coming for a few years now she is familiar with getting there and back and all of the people and surroundings which is empowering.

The physical activity yes is a huge bonus but so is the general socialising with friends. X stays on for refreshments after the session with the other participants and her peers will always ensure she gets a cup of tea and is ok.

Case study 7:

Duns Tea Dance was created not only as an alternative to traditional fitness activities, although has similar benefits the initial aim was to bring people in the community together through a shared interest.

Participants are mainly local people but other regular attendants come as far as Selkirk, Jedburgh and Hawick. Recently however, a new participant has been attending the sessions. This person has been diagnosed with MS and as the condition progressed, the individual felt unable to attend regular groups such as crafts and knitting which requires a higher level of motor coordination. This has had an impact in the person's social life, self-esteem and confidence. It has also put a strain on her husband, her main carer. This person has reported feeling renewed and with a greater sense of purpose since she started attending the sessions in Duns and, despite her limited mobility, she really enjoys being there and part of the group. She reported feeling more connected to others and the music has a great impact on her wellbeing.

"I look forward to attending the sessions and so does my husband, it is the only activity that I attend which is really meaningful to me and not only time away from the house or respite time for my husband. I come back home on a high note and the feeling stays for

days after. My husband also welcomes the opportunity to have time for himself and do things he also enjoys and this is priceless."

Case study 8:

Men's shed have been well supported by the CCB team across the whole of the Borders. The involved with Men's sheds often talk about how important it is to have a meaningful space for social connections and skills sharing but equally as a space for mutual support and information sharing.

In one of the sheds for example, one of the members who had been diagnosed with prostate cancer shared his story with the other shedders during one of their meetings. His personal story prompted other men in the shed to book for the test, and all other men there stated that they had never had it done neither had considered having the test done despite seeing so much on tv and being constantly reminded by health professionals on the importance of having the test done. As one of the men put it: "you never think it is going to happen to you until it hits close to home".

Case study 9:

The programme was successful in attracting people from disparate backgrounds and skills which helped reduce intellectual and even, social inequalities. In addition, it provided intergenerational experience where participants of different ages could benefit through skills sharing; it fostered a sense of shared endeavour in the creative work and promoted social interaction and a sense of belonging. One participant for example, is 89 years old and a full time carer with no family or friends around. She signed up to the programme aiming to meet new people who shared an interest in writing. During the course, the participant talked openly about her feeling of isolation and how having a purpose has had an impact on her well-being and even on her relationship with her husband who she cares for at home. Once a keen writer, she disclosed to the group that she even "managed to revive an old typewriter which had been neglected and forgotten for many years". After the programme, the organisers had the chance to speak with the participant's husband who spoke openly about how beneficial the activity had been to his wife:

"She has gained a new purpose in life and we both look forward to our own times apart. She looks forward to attend the session and when she comes back home, she is full of a very contagious enthusiasm. I look forward to hear her written pieces which she is always keen to share with me".

This page is intentionally left blank

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 11 June 2018

Report By	Robert McCulloch Graham, Chief Officer
Contact	Jane Robertson, Strategic Planning & Development Manager
Telephone:	01835 825080

STRATEGIC PLANNING GROUP REPORT

Purpose of Report:	To update the Integration Joint Board on the work of the Strategic Planning Group

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note this report

Personnel:	*N/A*

Carers:	*N/A*

Equalities:	*N/A*

Financial:	*N/A*

Legal:	*N/A*

Risk Implications:	*N/A*

Purpose

The purpose of this report is to update the Integration Joint Board (IJB) on any key actions and issues arising from the Strategic Planning Group (SPG) meeting held 16th May 2018.

SPG Key Actions & Issues

BGH Campus Development

A presentation was given on the *BGH Campus Development Programme* to advise SPG members of this project and get their thoughts on how to engage going forward. This generated discussions around the costs, locations and timescales of the development, Scottish Government involvement and links with neighbouring health boards.

The SPG agreed an update would be brought back to a future meeting.

Annual Performance Report

An overview was given of the draft *Annual Performance Report* which is due to be published online on 30th July. Summary and easy read copies of the final report will also be produced. It was advised this report is requested annually by the Scottish Government, with a set format to work from, for every IJB across the country.

The report was accepted by SPG members, with the condition of further changes to be made as discussed in the meeting.

Strategic Plan

A further overview was given on progress made on the refresh of the Partnership's Health & Social Care Strategic Plan.

The SPG agreed with the direction of the Strategic Plan, subject to amendments suggested in the meeting. A revised draft is to be circulated to the SPG members via email for comment and sign off prior to the IJB meeting on 11th June 2018. It was also agreed that the final SP would be brought back to a future SPG meeting.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 11th June 2018

Report By	Robert McCulloch-Graham, Chief Officer Health and Social Care
Contact	Susan Henderson, Planning Manager
Telephone:	01835 825080

INSPECTION ACTION PLAN UPDATE

Purpose of Report:	To report on progress on the inspection action plan

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Note this report.

Personnel:	There are no staffing implications

Carers:	Recommendation five in the inspection report focuses specifically on carers. It recommends that the Partnership identify carers and ensure that their needs are assessed and met. The actions to meet this recommendation are complete but will be ongoing. They include: • Updating the Carers Strategy to include carer identification • Putting in place a pathway of support for carers; this includes developing a new carer support plan and publishing a carer eligibility criteria plan • A health needs assessment being produced, based on survey of carers. Carers and carer representatives participate in decision making about actions through the Carers Advisory Group and Carers Act Board.

Equalities:	A specific ED impact assessment has not been done for the action plan as actions within the action plan are subject to their own ED impact assessment requirements.

Financial:	The action plan is consistent with current strategy. It has not identified any additional staffing or resource requirements.

Legal:	Legal requirements are met where relevant.

Risk Implications:	A key risk is that feedback from the Care Inspectorate/Healthcare Improvement Scotland could require changes or additions to the plan. This could impact on the Partnerships ability to continue to meet the timescales set within the plan. However there is a robust monitoring system in place for the action plan. There are also meetings between the Chief Officer and the inspection team lead to discuss the plan..

The Care Inspectorate and Healthcare Improvement Scotland undertook an inspection of the Partnership's older people's services between October 2016 and February 2017. The inspection report[1] was published on 28th September 2017. Across the nine key indicators of performance, inspectors found one i.e. 'impact on the community' to be 'good', five to be 'adequate' and three to be 'weak,' including 'delivery of key processes'; 'strategic planning and plans to improve services'; and, 'leadership and direction.'

There are thirteen recommendations for improvement in the report. An action plan has been prepared to meet the thirteen recommendations. This is monitored through the Joint Older People's Services (JOPS) inspection group and reports to the Joint Leadership Group and the Integrated Performance Group. The Inspection Action Plan is attached to this report.

The table below summarises performance on the inspection action plan. There are 59 actions to meet the thirteen recommendations. All the actions to meet recommendations one, two, five, ten and eleven are now complete. Work is ongoing to ensure that the recommendations are sustained.

Some actions have had their timescale extended due to either staff absence, amendment to the action that is required or complexity of the action requiring additional time. All other actions are progressing within timescale (10.5.18).

The action plan has been submitted to the Care Inspectorate and Healthcare Improvement Scotland. The recent feedback from the Care Inspectorate/Healthcare Improvement Scotland is for more clarity on the indicators of success and on the measures that will be used to ensure that outcomes are met. The JOPS group is now ensuring this is incorporated into the action plan.

1 http://www.careinspectorate.com/images/documents/4030/Scottish%20Borders%20services%20for%20older%20people%20joint%20inspection%20report%20September%202017.pdf

Recommendation	Action No.	Responsible Person	Status	Expected Completion Date	Comment
1. Deliver more effective consultation and engagement with stakeholders on the vision, service redesign and key stages of transformational change. **Update:** A co-productive approach is being progressed. Locality working groups are in place with representation on SPG; the groups have produced locality plans that reflect local need and actions. Consultation sessions have been held on mental health transformation, dementia strategy and currently on physical disability and carers strategies.	1.1.1	Jane Robertson	Complete	31/08/2017	Communication plan reviewed/updated
	1.1.2	Jane Robertson	Complete	31/08/2017	Stakeholder lists reviewed/updated
	1.2.1	Jane Robertson	Complete	Ongoing	Partnership communication activity recorded
	1.2.2	Jane Robertson	Complete	31/10/2017	Arrangements in place to support engagement with locality working groups
	1.3.1	Jane Robertson	Complete	31/07/2017	Locality plans published and circulated
	1.3.2	James Lamb/Robert McCulloch-Graham	Complete	30/09/2017	Staff consulted on transformation projects through workshop and newsletters
	1.3.3	Peter Lerpiniere	Complete	31/01/2018	Consultation sessions held on mental health transformation, dementia strategy
2. Ensure the revised governance framework provides more effective performance reporting and an increased pace of change. **Update**: The governance structure is in place with a performance reporting process to monitor effectiveness.	2.1.1	Robert McCulloch-Graham	Complete	28/02/2017	Governance structure in place
	2.2.1	Robert McCulloch-Graham	Complete	31/10/2017	Governance reviewed through quarterly performance reports
	2.3.1	Robert McCulloch-Graham	Complete		Quarterly performance reports in place
	2.3.2	Robert McCulloch-Graham	Complete	30/04/2018	I-matters staff survey completed; now includes social care and health staff.
	2.3.3	Robert McCulloch-Graham	Complete	31/07/2018	2016/17 annual performance in place; 2017-18 report in draft format
3. Further develop and implement the joint approach to early intervention and prevention services so there is a range of services working together that support older people to remain at home and help avoid hospital admission. **Update:** The strategic review is at an early stage of scoping services and gaps. Recommendations with priorities will follow. There has been development of specific services such as roll out of What Matters Hubs and the hospital to home services.	3.1.1	Tim Patterson	In Progress	31/05/2018	Strategic review session delayed due to staff absence **Timescale revised (was 28/02/18)**
	3.2.1	Tim Patterson	In Progress	31/05/2018	Strategic plan delayed. **Timescale revised (was 31/03/2018)**
	3.2.2	Gwyneth Lennox	Complete	30/11/2017	What matters hubs signpost to a range of community activities and services.
	3.3.1	Murray Leys	In Progress	30/05/2018	Anticipatory care plans to be within MOSAIC
	3.3.2	Murray Leys	In Progress	31/12/2019	Software to be introduced to disseminate information on activities: contact with providers made
	3.4.1	Murray Leys	In Progress	30/06/2018	Anticipatory care planning in care homes to

					link to early warning scores
4. Review delivery of care at home, care home, intermediate care and palliative care services to better support a shift in the balance of care towards more community based support **Update:** Review of delivery of support services progressing. Option appraisal report completed on shifting the balance; social care demographic report prepared and benchmarking report to follow. Integrated Strategic Plan for Older People Housing, Care and Support Needs has been drafted with launch on 1 June. These all inform older person's commissioning plan which will have formal consultation in October.	4.1.1	Robert McCulloch-Graham	In Progress	30/06/2018	Older people's commissioning strategy in progress.
	4.2.1	Robert McCulloch-Graham	In Progress	30/06/2018	As above
	4.3.1	Eric Livingston	In Progress	30/06/2018	As above
	4.4.1	Robert McCulloch-Graham	Complete	30/06/2018	Care at home contract enables flexible care at home delivery
	4.5.1	Murray Leys	Complete	31/01/2018	ISD is undertaking a national consultation about performance measures – includes how units such as Mgt Kerr are viewed
5. Update the carers' strategy to have a clear focus on how carers are identified and have their needs assessed and met. Monitor and review performance in this area. **Update**: The interim carers strategy 2018-19 is being consulted on. It has a focus on raising awareness of the caring role and a clear pathway for carer support is in place. Planning has started for the 3 year Carers Strategy from April 2019. **Target:** Annual increase in carer take up of support plans.	5.1.1	Susan Henderson	Complete	30/04/2018	Carers support plan, eligibility and pathway in place
	5.1.2	Susan Henderson	Complete	30/04/2018	Communication and training plan in place and ongoing
	5.2.1	Susan Henderson	Complete	30/04/2018	Currently consulting on carers strategy 2018-19.
	5.2.2	Susan Henderson	Complete	30/04/2018	Carers support plan now includes monitoring information.
	5.2.3	Tim Patterson	Complete	31/05/2018	Health Needs Assessment of carers in Scottish Borders completed, with action plan
6. Ensure that people with dementia receive access to a timely diagnosis **Update**: Following a mapping exercise to identify areas of improvement arrangements have progressed to promote consistent and accurate information on GP registers when	6.1.1	Peter Lerpiniere	In Progress	31/05/2018	Arrangements being put in place to ensure that GPs are alerted when a diagnosis is made in hospital; audit then to be undertaken to ensure process working
	6.2.1	Peter Lerpiniere	Complete	30/11/2017	Awareness session taken place
	6.2.2	Peter Lerpiniere	In Progress	31/10/2018	Consultation events held; review capacity to rebalance resources to support more memory clinics**. Revised timescale (was 30/04/18)**
	6.2.3	Peter Lerpiniere	Complete	31/07/2017	Patient pathway mapped
	6.3.1	Peter Lerpiniere	Complete	31/08/2017	Gap analysis completed

people have a diagnosis of dementia. This is to be audited	6.4.1	Peter Lerpiniere	Complete	30/09/2017	Request made to GPs to add missing diagnosis info to register
	6.4.2	West Team Secretary	Complete	31/07/2017	Assessment letter to GPs for diagnosis completed
	6.4.3	Peter Lerpiniere	In Progress	30/06/2018	Patient leaflet on post diagnostic support drafted
7. Take action to provide equitable access to community alarm response services for older people. **Update:** Bordercare service is now being provided through East Lothian. Performance information will be provided by SBCares Options paper on response services to be prepared for IJB.	7.1.1	Murray Leys	In Progress	31/09/2018	Protocol to be put in place for responder service. **Revised timescale (was 31/03/18)**
	7.2.1	Murray Leys	In Progress	30/09/2018	**Revised timescale (was 30.4.18) t**o review method of response
	7.3.1	Murray Leys	Complete	31/12/2018	
8. Provide stronger accountability and governance of transformational change programme. Ensure that: progress of the strategic plan priorities are measured and evaluated; service performance and financial monitoring are linked; locality planning is implemented and leads to changes at a local level; independent needs assessment activity is included in the joint strategic needs assessment; There is appropriate oversight of procurement and commissioning work; A market facilitation strategy is developed and implemented **Update:** An updated Strategic Plan has been drafted and is monitored through quarterly performance reports; the 2017-8 Annual Performance Report to be approved on 31 July. Locality working groups and locality plans which reflect local need and priorities are in place; reps sit on the SPG which monitors progress. A commissioning plan is being progressed which will then inform a market facilitation plan.	8.1.1	Jane Robertson	Complete	31/10/2017	
	8.2.1	Robert McCulloch-Graham	Complete	31/12/2017	
	8.3.1	Robert McCulloch-Graham	In Progress	31/07/2018	Work has been commissioned to review model of community capacity in relation to hospital capacity. **Revised timescale (was 30/04/18)**
	8.4.1	Robert McCulloch-Graham	In Progress	30/06/2018	Financial plan and provision of health and social care in progress. **Revised timescale (was 30/04/18)**
	8.5.1	Robert McCulloch-Graham	In Progress	30/06/2018	Progressing work with locality working groups**. Revised timescale (was 31/03/18)**
	8.5.2	Robert McCulloch-Graham	Complete	30/09/2017	Locality groups representatives sit on the SPG
	8.6.1	Robert McCulloch-Graham	Complete	31/12/2017	Commissioning and implementation plan agreed
	8.7.1	Robert McCulloch-Graham	Complete	31/07/2018	Above combined with Strategic Plan
	8.8.1	Robert McCulloch-Graham	In Progress	31/08/2018	Commissioning plan to be in place in order to progress the market facilitation plan. **Timescale revised (was 31/03/18)**
9. Develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are	9.1.1	Carol Gillie / David Robertson	Complete	30/06/2018	Financial plan agreed 23.4.18.
	9.2.1	Carol Gillie / David Robertson	In Progress	30/06/2018	Financial statement for 2017/18 agreed. The 2018/19 financial plan is in discussion.

achieved **Update:** A financial plan was agreed in Feb with work ongoing for a longer term sustainable plan. A transformation and efficiency programme is being progressed and monitored with the contribution from this to be confirmed.					
10. Ensure that there are clear pathways for accessing services and that eligibility criteria are developed and consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists and that waiting times for services and support are minimised. **Update:** What Matters hubs offer speedy community access, and have had a positive impact on waiting lists which are reviewed through performance clinics. The discharge to assess policy paper to clarify and develop a more robust hospital to home process is within approval process.	10.1.1	Murray Leys	Complete	31/01/2018	Community led hubs rolled out; assessments shortened; performance clinics review waiting lists
	10.1.2	Jane Prior	Complete	31/05/2018	Assess to discharge policy drafted.
11. Work together with the critical services oversight group and adult protection committee to ensure that: risk assessments and risk management plans are completed where required; quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve; and improvement activity resulting from quality assurance processes is well governed **Update:** Adult protection audit system in place and utilising Care Inspectorate system; a series of risk management sessions have been held in May with operational team managers and a risk assessment protocol has been developed from this to ensure improved response.	11.1.1	Stuart Easingwood	Complete	31/08/2017	AP audits are undertaken and reported on to CSOG
12. Develop and implement a tool to seek health	12.1.1	Robert McCulloch-Graham	Complete	31/05/2018	I matters survey undertaken

and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services. **Update:** I Matters survey has been extended to social care and health staff; results are being sent to team managers to develop action plan based on response, with report to joint leadership group.	12.1.2	Robert McCulloch-Graham	In Progress	31/07/2018	Survey to be sent to team managers and report made to joint leadership group
13. Develop and implement a joint comprehensive workforce strategy, involving the third and independent sectors. This should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and skills mix that delivers high quality services **Update:** A draft workforce plan has been has been drafted for approval. Once agreed the next stage will be to develop a workforce plan with third and independent sector	13.1.1	Robert McCulloch-Graham	In Progress	30/06/2018	Draft workforce plan prepared. **Timescale revised (was 30/04/18)**
	13.1.2	Robert McCulloch-Graham	In Progress	30/11/2018	Progress with third and independent sector once above approved**. Timescale revised (was 30/04/18)**
	13.1.3	Robert McCulloch-Graham	In Progress	30/11/2018	As above**. Timescale revised (was 30/04/18)**

Status	**No.**	**%**
Complete	36	61%
In progress	23	39%
Overdue	0	0%
Total	**59**	**100%**

This page is intentionally left blank

Scottish Borders Health and Social Care PARTNERSHIP

Inspection of Older People's Services 2017- DRAFT ACTION PLAN

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
1. Deliver more effective consultation and engagement with stakeholders on the vision, service redesign and key stages of transformational change.	1.1 Clear communication plan which outlines the Partnership's vision and how the Partnership will engage and consult with all key stakeholders on key developments in terms of service redesign, joint plans and policies	1.1.1 Review and update existing Partnership communication plan	Jane Robertson, Strategic Planning and Development Manager	**August 2017**	HSC Comms Engagement Plan 16 · H&SC Partnership - Proposed Comms Stra	**Complete**	G
		1.1.2 Review and update Partnership stakeholder lists and distribution lists Use staff survey to evidence that staff aware of vision and consulted	Jane Robertson, Strategic Planning and Development Manager	**August 2017**	SC&H Locality office contacts.docx ICS Staff List.doc List of all Borders GPs as at 23.06.2017 Additional Contact List APR June 2017.x	**Complete**	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
					APR Communications Plan v4.doc		
	1.2 Evidence of increased engagement and consultation activity specifically related to the Partnership Transformational Programme i.e. meetings with staff, communication via newsletter	1.2.1 Record all partnership communication activity on overarching action tracker and individual project communication plans	Jane Robertson, Strategic Planning and Development Manager	**Ongoing**	H&SC Comms action tracker 2018 v.2.xls Transformation & Efficiencies Event Age	**Complete**	G
		1.2.2 Agree arrangements going forward to support the ongoing engagement with members of the locality working groups	Jane Robertson, Strategic Planning and Development Manager	**October 2017**	Locality Consultation Communications Plan	**Complete**	G
	1.3 Ongoing commitment to support the Locality Working Groups which offers regular forum for engagement and consultation with representatives of all relevant stakeholder groups.	1.3.1 Distribute Health and Social Care Locality Plans for public consultation	Jane Robertson, Strategic Planning and Development Manager	**July 2017**	https://www.scotborders.gov.uk/hscplocalityplans	**Complete** Local measures of success of implementation of locality plans are being considered as part of a wider performance reporting framework for the Partnership	G
		1.3.2 Consult staff – a) workshop to	James Lamb, Portfolio	**September 2017**	a) Feedback	**Complete**	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
		provide information on transformation projects b) Regular newsletters	Manager, Chief Exec Robert McCulloch-Graham, Chief Officer H&SC Integration		H&SC Transformation Work H&SC Transformation Work b) Newsletter Health and Social Care News Update W healthsocialcarenews SEP2017.pdf		
		1.3.3 Mental Health and Dementia Strategy Workshops	Peter Lerpiniere Associate Director, Mental Health	**January 2018**	Strategy. Comments collated & action plan in place. Dementia Strategy Consultation Feedbac	Consultation dates on mental health transformation and development of dementia strategy. Sessions held separately Sep – Jan 2018.	G
2. Ensure the revised governance framework provides more effective	2.1 Revised Partnership governance structure in place and evidence of more effective and timeous approval and	2.1.1 Implement revised governance structure.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**February 2017**	Revised Governance.pdf	**Complete** Governance structure remains the same. Integration	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
performance reporting and an increased pace of change.	decision making processes which in turn is supporting an increased pace of change.				Integration-performance-indicators-17021	performance measures.	
	2.2 Quarterly Partnership performance reports presented to Executive Management Team and Integration Joint Board and aligned to Ministerial Strategic Group performance reporting. Operational managers across the Partnership engaged in dialogue about data, performance and impact of service redesign.	2.2.1 Review effectiveness of revised governance structure.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**October 2017**	IJB Quarterly Performance Report (*Refer to evidence provided at point 8*	**Complete**	G
	2.3 A better understanding of staff views across the Partnership	2.3.1 Provide quarterly Partnership performance reports to the IJB.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**Complete**	IJB Quarterly Performance Report - June 2017 *Refer to evidence provided at point 8 (8.1)*	Ongoing	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
		2.3.2 Staff survey due to be sent out to all staff across the Partnership in Feb 2018	Robert McCulloch-Graham, Chief Officer H&SC Integration	**April 2018**	Report to be embedded as evidence	iMatter survey completed. Managers will use the report to make improvements	G
		2.3.3 Report Partnership Performance via published Annual Performance Report and to the Ministerial Strategy Group.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**July 2017**	Annual Performance Report *Refer to evidence provided at point 8 (8.1)*	**Complete**	G
3. Further develop and implement the joint approach to early intervention and prevention services so there is a range of services working together that support older people to remain at home and help avoid hospital admission.	3.1 A range of services work together that support older people to remain at home and help avoid hospital admission.	3.1.1 Hold a ½ day strategic review session to fully understand the current landscape and Identify the key components of a good EI & P approach for older people and identify gaps	Tim Patterson, Joint Director of Public Health	**May 2018**	Health Improvement & Self-Management ir Fall Conference Update (22.11.17).dc		A
	3.2 There is a clear strategic overview of the early intervention and prevention landscape in the Borders supported by a clear understanding of the broad range of early intervention and prevention	3.2.1 Develop a strategic delivery plan to address gaps in EI & P identified at the strategic review session	Tim Patterson, Joint Director of Public Health	**May 2018**	Community Capacity leaflet (Nov 17) V3.pc Borders Community Capacity Project Rep Evidence: Delivery plan to be	Develop map of ACPs focus to be placed on Care Homes in the first instance.	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
	approaches required to achieve positive outcomes for older people.				written Current prevention/early intervention services Patient pathway work Telecare Falls work		
		3.2.2 The community hubs and customer services are signposting to healthy living activities and preventing social isolation	Gwyneth Lennox, Social Work Group Manager	**November 2017**	Paper - Community Led Support, Hub Sig	As Community Led Support is rolled out in each area, weekly planners detailing community activities and services are being drawn up and used by Customer Services and staff in the What Matters hubs to signpost and connect people on to a range of appropriate services. Data is then collated on the number and range of these signposted services	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
	3.3 Early intervention and prevention providers understand their role and function in the broader landscape and develop complementary approaches with partners that enhance the positive outcomes experiences by older people.	3.3.1 Embed anticipatory care planning and plans into care assessment and planning	Murray Leys, Chief Social Work Officer	**May 2018**	Anticipatory care plans are within MOSAIC		A
		3.3.2 Introduce specific software to collate and disseminate information on a range of positive activities on a locality basis.	Murray Leys, Chief Social Work Officer	**December 2019**	Software in place and being utilised	Contact with providers has been made	A
	3.4 Anticipatory Care Plans in Care Homes are up to date.	3.4.1 Ensure ACP in Care Homes are up-to-date.	Murray Leys, Chief Social Work Officer	**June 2018**	Early Warning Scores		A
4. Review delivery of care at home, care home, intermediate care and palliative care services to better support a shift in the balance of care towards more community based support	4.1 The older people's commissioning strategy is reviewed and strategic plans put in place based on demographic evidence across the Scottish Borders.	4.1.1 Update the older peoples commissioning strategy to reflect the outcome of the Older Peoples Housing Strategy currently under development.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**June 2018**	Draft strategies to be completed. Option appraisal report final (21.02.18 Demographic paper v3.7 Final.docx Equality impact assessments	Consultation process being taken forward in relation to the Physical Disability Strategy Michael Curran formulating a benchmarking report as follow up on the	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
					undertaken. Consultation process with local communities	demographic paper	
	4.2 Equality of access and choice for those who meet eligibility criteria in all areas of the Borders, in a timely way, that ensures individuals remain at home.	4.2.1 Development of Care Home and Care at Home Commissioning Strategy Develop commissioning plan for all areas in the Borders in terms of access to Care at Home and Care Homes.	Murray Leys, Chief Social Work Officer	**June 2019**	Development of commissioning strategy and plan Development of revised contractual specifications that ensure service outcomes and individual outcomes are met.	KPI's are measured in terms of both qualitative and quantitative information. Measurement of individual outcomes Consultation with local communities regarding current and future provision	A
	4.3 A cohesive commissioning plan that is informed by the market strategy is developed which clearly states expectation of contracted services both in the statutory sector and in the voluntary sector.	4.3.1 Plan cohesively to ensure that specifications for services are understood and align to ensure service users experience joined up health and social care services. Commission all services in a way that ensures service users are given	Eric Livingston, Social care & Health Business Partner	**June 2018**	Evidence to be provided		A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
		maximum control via revised contractual requirements with providers.					
	4.4 All services are able to deliver choice and flexibility in line with SDS approach while integrated pathways for individuals ensure that people are able to achieve their outcomes.	4.4.1 Establish a contractual position with care at home providers which allows for flexible care at home delivery.?	Robert McCulloch-Graham, Chief Officer H&SC Integration	**June 2018**	Schedule C - Contract (2016).pdf		G
	4.5 Margaret Kerr Unit is viewed as a homely setting in Scottish Government performance figures	4.5.1 Discuss with Scottish Government the use of Margaret Kerr Unit as a homely setting in Scottish Government performance figures	Murray Leys, Chief Officer Adult Social Work	**January 2018**	Margaret Kerr letter to ISD.docx	Julie Kidd informed; ISD colleagues are considering the letter from Murray in the broader context of national data, service configurations in other NHS Board areas etc. ISD are going to be undertaking wider consultation nationally about these sorts of	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
						measures. timescales not yet known	
5. Update the carers' strategy to have a clear focus on how carers are identified and have their needs assessed and met. Monitor and review performance in this area.	5.1 There is a clear pathway for identifying carers and ensuring their needs are assessed and met.	5.1.1 Develop a Carers support plan, eligibility criteria and pathway for assessing and supporting carers	Susan Henderson, Planning Manager	**April 2018**	Pathway in place with supporting documentation Scottish Borders Carers Eligibility Fram Adult Carers Support Plan.docx		G
		5.1.2 Put communication and training plans in place to ensure stakeholders are aware of the legislation	Susan Henderson, Planning Manager	**April 2018**	DRAFT Communications Plan DRAFT Stakeholder Analysis 91217 - Care	Remove the word draft from both documents	G
	5.2 A carers strategy is in place that indicates how carers needs are identified and have their needs assessed and met.	5.2.1 Carers strategy 2017-19 agreed and published that states how carers needs are identified and met.	Susan Henderson, Planning Manager	**April 2018**	Carers Act policy and procedure 20318.doc	Consulting on a 2018-19 Strategy and preparing for a 2019 strategy	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
	The partnership monitor and review this performance				Caring Together - Supporting Carers Str Project Proposal Health Needs Assessı		
		5.2.2 A performance process in place to monitor and review progress in identifying and supporting carers	Susan Henderson, Planning Manager	**April 2018**	Reporting regularly to IJB. Carer feedback. *See quarterly report at point 2.2*	Measure the increase in uptake of carers support plans. The carers support plan includes the monitoring information required by the Scottish Gov. The Borders Carers Centre (BCC) will maintain information and report to the IJB and Scottish Gov. BCC will update their IT to facilitate this.	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
		5.2.3 An assessment of the health needs of carers in Scottish Borders is produced	Tim Patterson, Joint Director of Public Health	**May 2018**	Health Needs Carers Stakeholder event ag Health Needs of Carers Report - DRAF	Draft Health needs Assessment has been completed Recommendations and action plan are being prepared following the stakeholder event on 01.05.18	G
6. Ensure that people with dementia receive access to a timely diagnosis	6.1 Clinicians will be supported to recognise the importance of a dementia diagnosis, make appropriate referrals, and support people through their diagnosis.	6.1.1 Develop and circulate a checklist of "things to consider" in relation to dementia diagnosis for GPs, Junior Doctors and Care Homes.	Peter Lerpiniere, Associate Director, Mental Health	**May 2018**	V1.3 Leaflet for GP's, Junior Doctor's	"Checklist" will be developed by Dementia Strategic Partnership Group (DSPG). Possibly pass to OPAH to take forward– Peter/Rob to confirm	A
	6.2 Resources will be utilised as effectively as possible to widen opportunities for access to diagnostic services.	6.2.1 Carry out awareness session on TiME agenda November facilitated by MHOAS	Peter Lerpiniere, Associate Director, Mental Health	**November 2017**	The Importance of Diagnosis in Dementia		G
		6.2.2 Consider increasing capacity to carry out more memory clinics	Peter Lerpiniere, Associate Director, Mental Health	**October 2018**	Sessions held Sept 17 – Dec 17 with further sessions planned for Jan 2018	MH strategy & dementia strategy consultation events are underway and will include	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
						evaluating capacity to rebalance resources to support more clinics. The dementia strategy is being written and Transformation Programme is taking this forward.	
		6.2.3 Map the patient pathway from referral to diagnosis to entry on to Dementia Register to look for any challenges and areas for improvement	Peter Lerpiniere, Associate Director, Mental Health	**July 2017**	Diagnosis of Dementia - Pathway.(	Mapped and areas identified for improvement include communication with GPs to request diagnoses be added to the register (see action 7).	G
	6.3 All patients who receive a diagnosis of dementia will be recorded on the primary care register.	6.3.1 Discuss with GP practices in order to carry out a gap analysis of the diagnoses on MHOAS records against GP records	Peter Lerpiniere, Associate Director, Mental Health	**August 2017**	No evidence available – telephone calls		G
	6.4 All people given a diagnosis have an understanding of what to expect from the service.	6.4.1 Write letters to GP practice to follow up on discussions in point 5 above and ask GP to add missing diagnoses	Peter Lerpiniere, Associate Director, Mental Health	**September 2017**	DoD Letter - GP Practices - Sept 17.d(		G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
		on to register					
		6.4.2 Adjust first assessment letter used by MHOAS to include clear diagnoses & request to GP to add to dementia register	West Team secretary/ Consultant Psychiatrist	**July 2017**	MHOAS Assessment template.docx	Discussed at Mental Health Operational Group and agreed for implementation.	G
		6.4.3 Develop patient awareness leaflet to set expectations of what will be offered / delivered	Peter Lerpiniere, Associate Director, Mental Health	**June 2018**	PDS Borders Leaflet for Patients (Draft).p	Draft leaflet prepared – MHOA Team & Borders Dementia Working Group to take forward	A
7. Take action to provide equitable access to community alarm response services for older people.	7.1 Protocol in place for a comprehensive responder service that is equitable to all.	7.1.1 Produce protocol	Murray Leys, Head of Adult Social Care	**September 2018**	Protocol in place for responder service	SB Cares shall produce information that relates to the success of the alarm service.	**A**
	7.2 Older people have access to a 24 hour response service	7.2.1 Audit current systems through use of SWOT analysis.	Murray Leys, Head of Adult Social Care	**September 2018**	Consultation undertaken with local communities and other stakeholders		**A**
	7.3 Resilience aspects of current (Tunstall) technology (SB Cares risk owner)	7.3.1 In conjunction with a Falls Strategy increase focus on telecare and establish feasibity of introducing a universal alarm service	Murray Leys, Head of Adult Social Care	**April – December 2018**	Actions from strategy realised via implementation plans. BOPPP highlight reports to show scrutiny of work – to be embedded		**G**

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
8. Provide stronger accountability and governance of transformational change programme. Ensure that: progress of the strategic plan priorities are measured and evaluated; service performance and financial monitoring are linked; locality planning is implemented and leads to changes at a local level; independent needs assessment activity is included in the joint strategic needs assessment; There is appropriate oversight of procurement and	8.1 There is clear evidence of the impact of improvements and service redesign on the delivery of local strategic objective as laid out in the Strategic Plan through: • Annual performance report • Quarterly performance reports to IJB A number Ministerial Strategy Reports	8.1.1 Improve the content, structure and format of the IJB quarterly performance reports	Jane Robertson Strategic Planning and Development Manager	**October 2017**	IJB Annual Performance Report 2 DRAFT IJB Annual Report 2017 -18 (May IJB Quarterly performance reports can be found at: https://www.scotborders.gov.uk/downloads/download/872/joint_board_quarterly_performance_reports H&SC Partnership Annual Performance R H&SC Partnership Annual Performance R	**Completed** Note: The 2017-18 report is in DRAFT format – pending updates have been highlighted in yellow - due to be approved 31.07.18.	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
commissioning work; A market facilitation strategy is developed and implemented					H&SC Partnership Annual Performance F Next MSG submissions -FILE, Leadership Group, IJB, EMT Locality Plans:– https://www.scotborders.gov.uk/directory_record/49234/health_and_social_care_locality_plans/category/306/current_consultations		
	8.2 - Commissioning & Implementation Plan in place	8.2.1 Ratification of Commissioning and Implementation Plan by IJB	Robert McCulloch-Graham, Chief Officer H&SC Integration	**December 2017**	IJB Agenda 23.10.17.pdf IJB Minutes 23.10.17.doc	THE IJB was presented with a finalised Commissioning & Implementation Plan at its meeting on 23rd October 2017	G
	8.3 Fully costed Commissioning and Implementation Plan and Locality Plans in place. Clear identification of financial costs/benefits and expected outcomes	8.3.1 Both IJB and strategic planning group bodies have timetabled development sessions throughout the year which will cover strategic planning and commissioning	Robert McCulloch-Graham, Chief Officer H&SC Integration	**July 2018**	Strategic needs analysis	Review/Develop the "bath tub model" i.e. Community Capacity & relation to hospital capacity. Work has been commissioned.	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
	including all project briefs / PIDs.	functions with a clear inclusion of outcomes and value for money. Further development of financial elements of Locality Plans and demonstration of "fair share"					
	8.4 Comprehensive assessment of performance impacts of Financial Planning efficiency targets and in-year recovery plans.	8.4.1 *Refer to Action Point 9*	Robert McCulloch-Graham, Chief Officer H&SC Integration	**June 2018**	NHS Recovery Plan NHS financial plan SBC financial plan IJB financial statement Descriptor of how strategy not impacted by above IJB financial planning budgetary control reports	*Refer to Action Point 9* The IJB Financial Plan is not directly linked to performance outcomes. The 18/19 budget has gone to IJB, further work required from NHS and Scottish Government to close the 5 million funding gap.	G
	8.5 Clear mechanisms in place for progressing and monitoring locality implementation plans. Clear evidence of changes made at a local level	8.5.1 Continued support for locality working groups to take on monitoring role of progress of implementation of Locality Plans	Robert McCulloch-Graham, Chief Officer H&SC Integration	**April 2018**	Locality Action Plans have been set up Representatives from locality offices sit on the Strategic Partnership Group (SPG) and report on progress.	SPG to monitor progress	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
		8.5.2 Implementation of robust reporting mechanisms to evidence changes made at a local level	Robert McCulloch-Graham, Chief Officer H&SC Integration	**September 2017**	Extension of locality co-ordinator role until 31 March 2018 Progress reports Locality Plans	**Complete**	G
	8.6 Commissioning and Implementation Plan approved by IJB	8.6.1 Commissioning and Implementation plan ratified by IJB October 2017	Robert McCulloch-Graham, Chief Officer H&SC Integration	**December 2017**	IJB agenda and minute; *Refer to documents provided at point 8 (8.2)* *Refer to Joint Strategic Commissioning plan below*	The Commissioning and Implementation Plan was presented to the IJB 23.10.17	G
	8.7 Regular monitoring and reporting of the Commissioning and Implementation Plan	8.7.1 Monitor the Commissioning and Implementation Plan	Robert McCulloch-Graham, Chief Officer H&SC Integration	**July 2018**	Joint Strategic Commissioning and In SPG Minutes (10.01.18).doc	The Commissioning & Implementation Plan has now been combined with the Strategic Plan to create one document, with a draft going to the SPG on 16.05.18 for approval before EMT and the IJB.	G
	8.8 A medium-term Market Facilitation Plan and regular and frequent reports to the IJB over its	8.8.1 Development, approval and implementation of a Market Facilitation Plan for the IJB	Robert McCulloch-Graham, Chief Officer H&SC Integration	**August 2018**	Market Facilitation Plan IJB agenda and minute	**Ongoing**	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
	delivery		(Eric Livingston)		*Refer to documents provided at point 8 (8.2)*		
9. Develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved	9.1 A joined-up approach to ensure that the partnership medium-term financial plan not only underpins its Strategic and Commissioning Plans, but assures its affordability, robustness and sustainability. Its component provisions and assumptions are transparent and consistent.	9.1.1 Develop and implement a detailed financial recovery plan to ensure that a sustainable financial position is achieved and agreed by the Integration Joint Board.	Carol Gillie Director of Finance (NHS) David Robertson Chief Financial Officer Chief Financial Officer IJB – Recruitment pending	**June 2018** There is a joint EMT on 14th March to consider what the 3 partner organizations can do to address the financial challenge and to develop integrated and medium/ longer term financial planning.	Balanced 2017/18 Outturn Actions from EMT Financial Planning Me IJB Financial Plan 2018-19.pdf IJB Presentation to be embedded	A Recovery Plan was approved by the IJB in January 2017 – total value of savings delivered in excess of £4m, enabling a breakeven outturn position The partnership's new Medium-term Joint Financial Planning and Reserves Strategy was approved by the IJB on 27 February 2017 IJB presented with a financial plan paper on the 23.04.18. Work is ongoing on a longer term sustainable financial plan.	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
	9.2 The delivery of a balanced, affordable and sustainable medium-term financial plan for the Health and Social Care Partnership which will be presented to members of the IJB as its Financial Statement.	9.2.1 To achieve this: • Identification of the impact of the current planned transformation and redesign programme in terms of resource realignment, efficiency opportunities and ongoing sustainability requirements beyond transitional funding arrangements • Identification of further joint opportunities for service redesign and agree a joint plan for any associated capital or revenue investment requirements • Implementation of a medium-term solution for addressing the recurring efficiency gap across the partnership's devolved and large hospital budget set-aside resulting from non-recurring savings delivered in current and historic years • Identification of any additional investment	Carol Gillie Director of Finance (NHS) David Robertson Chief Financial Officer Chief Financial Officer IJB – Recruitment pending	**June 2018**	Balanced 2018/19 Financial Statement All recurring pressures to be addressed by recurring mitigating actions Delivery of financial planning and reserves strategy over medium-term	Partnership approved its 2017/18 Financial Statement on 27 March 2018 Noting that majority of healthcare savings within 2016/17 recovery plan were non-recurring. Due diligence carried out at the inception of IJB confirmed the IJB had received a fair provision of resources as part of the delegated functions from the overall Health & Social Care resources available, however this was not confirmed to be adequate and had required recurring efficiency targets to achieve financial balance. 2017/18 Financial Recovery plan has again been underpinned by non-recurring measures and has	A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
		requirements associated with the delivery of the partnership's approved Strategic Plan and how these investment requirements can be met				required additional non-recurring monies to be approved to Health and Social care delegated functions. The IJB Financial Plan and provision of health and social care for 2018/19 is currently in discussion. This will confirm the level of efficiency required to achieve a breakeven financial position. The IJB is progressing a Transformation and Efficiency Programme which will contribute a level of efficiency savings from the delegated functions. The quantum of the contribution from the T&EP has yet to be confirmed.	

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
10. Ensure that there are clear pathways for accessing services and that eligibility criteria are developed and consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.	10.1 Accessible pathways are in place to enable people to access appropriate and timely support	10.1.1 Deliver community led services via hubs in localities Provide shortened 'what matters' assessments	Murray Leys, Chief Officer Adult Social Work	**January 2018**	Eligibility criteria on website Waiting List Monthly Report Performance (Waiting List Weekly Report Team Leaders Waiting Time Report WC 30-04-18.pdf Paper - What Matters Hubs.docx Introduction to Social Care Leaflet.pdf Community Led Support Hub Screenir Matching unit evidence91017.docx	Waiting list figures are discussed at the monthly Performance Clinic. Figures are issued to Locality Team Leaders on a Monday morning showing people on waiting lists and how long they have been on it. A new waiting list report giving weekly/monthly figures for people waiting on assessment and also care at home / care home placement goes to IJB Leadership Team Meeting with consideration being given to inclusion in the IJB Quarterly Report. Measures will be monitored at the	**G**

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
					Matching Unit evidence (2).docx	Finance and Performance Group	
		10.1.2 Through matching unit provide more speedy access to services Develop a more robust hospital to home process	Jane Prior, General Manager, Patient Pathways	**May 2018**	Discharge to Assess Policy.docx Pathways from hospital final version. Pathways from hospital Professionals	The Discharge to Assess Policy paper is due to be scrutinized by the IJB Leadership Team in the next couple of weeks before going to IJB Board to be formally adopted as Policy. Documents for service users/ family/carers and professionals will be available following IJB approval process. Asked Jane for more up-to-date matching Unit evidence	**G**
11. Work together with the critical services oversight group and adult protection committee to ensure that: risk assessments and risk	11.1 Risk assessment and management plans are completed and recorded in MOSAIC Quality assurance process reflects appropriate responses	11.1.1 Quarterly Adult Protection file audits to be carried out. The Adult Protection Committee Coordinator conducts a 100% Audit of Adult Protection. All Audits are reported to the AP Audit sub group	Stuart Easingwood, Chief Officer Public Protection	**August 2017**	AP Audit - Referrals & Interventions Q1 2 AP Quality Assurance & Audit Te	There is now an AP Audit Tool on Mosaic which allows Teams to self-audit or audit neighbouring teams The Adult	G

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
management plans are completed where required; quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve; and improvement activity resulting from quality assurance processes is well governed	to Adults at risk	and any team remediation is captured through an individualised team improvement plan. Produce performance reporting reports for the AP Audit sub group, AP Committee & CSOG. These reports will be subject to peer scrutiny particularly in relation to Risk assessment, Protection plans, Chronologies and Case Conferences. Refresher AP training to be set up.			AP Quarterly Report Q3 2017-18.pdf 11.1.1 - AP Monthly Report March 2018.p 2017-18 Q3 ASP KPI Scorecard (Updated 2 Adult Protection KPI Score Card – Update AP Learning & Development Scoreca Inspection File Reading Improvemen AP Highlight Report DP Dec 2017.docx SB Adult Support & Protection Training Ma	Protection procedure has been refreshed AP Level 3 Refresher Training has been set for Nov 2017 and this will further support the AP Process, Outcomes and use of Risk assessment, Protection Plans and Chronologies. New Monthly reports for AP data are being produced and replace the currently quarterly reports. Performance reports to be discussed at the Finance & Performance Group.	

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
					Level 3 ASP LD Figures 2017.docx		
12. Develop and implement a tool to seek health and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services.	12.1 Health and Social Care staff feedback is sought and used to inform staff experience and support services	12.1.1 Implement i-matters staff survey across the Partnership	Robert McCulloch-Graham, Chief Officer H&SC Integration	**May 2018**	Provision of joint combined list to iMatter National Team iMatter (NHS) Result of iMatters to be embedded	Survey completed, action plan being prepared and will be sent to managers to take forward recommendations. Update report to be provided by Jennifer Boyle	G
		12.1.2 Examination of iMatter output Include feedback through Self-evaluation strategy Annual Appraisal process/PRD Report to Integration Joint Board Team	Robert McCulloch-Graham, Chief Officer H&SC Integration	**July 2018**	Self-evaluation strategy NHS Borders HSCP iMatter Timetable.doc		A

Risk or Issue	What good looks like	Action	Lead Person	Date to be completed	Evidence of completion (insert)	Measure/ Progress	RAG
13. Develop and implement a joint comprehensive workforce strategy, involving the third and independent sectors. This should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and skills mix that delivers high quality services	13.1 Draft Integrated Workforce Development Plan developed will reflect the workforce requirements of the Third and Independent Sectors within the Integrated Workforce Plan for the Partnership Including sustainable recruitment plans	13.1.1 Draft Joint Workforce Plan to include third and independent sectors to incorporate plans for developing a sustainable workforce. Present Draft Workforce Plan for sign off by IJB.	Robert McCulloch-Graham, Chief Officer H&SC Integration	**June 2018**	Draft Workforce Plan 2017-2019 v1.docx	Draft Plan complete process for agreement to take place next stage will include third and independent sector.	G
		13.1.2 Work with the 3rd and independent sector to collate information on recruitment & retention in the workforce	Robert McCulloch-Graham, Chief Officer H&SC Integration	**November 2018**	Private and 3rd sector staff survey Minutes of providers meeting to be added		A
		13.1.3 Support the 3rd and independent sector with a strategy to meet the demands of the workforce – plan for this?		**November 2018**			A