APPENDIX

HEALTH & SOCIAL CARE INTEGRATION - COMMISSIONING & IMPLEMENTATION PLAN

SERVICE DELIVERY ACTIONS FOR YEAR ONE TO ACHIEVE LOCAL OBJECTIVES

Local 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.

How delivery of our services will help us to meet this Objective.

- **Review Primary Care Premises Modernisation programme to review and increase capacity for services available to local communities and assess opportunities for co location**
- **Development of Community Capacity Building delivered through the Eildon work and Locality planning and implementation.**
- Development of Locality Plans by Locality Co-ordinator posts
- Home Care Tender to ensure we meet requirements at a locality level.
- Further develop Local Citizen's Panels
- **Improve access to social care and health from local communities and GP practices (test first point of contact model)**
- Development of Veterans Mental Health Services
- **Review Day Hospitals providing day services delivered within a locality model and providing a local resource to the wider communities for health and social care**
- Development of Child and Adolescent Mental Health intensive support
- Improvement work to increase capacity to deliver Psychological Therapies
- Redesign services and develop processes under the Transitional Quality arrangements of the GP Contract for 2016/17, to suit a locality approach.
- Further development of Local Area Co-ordination to increase independence, resilience and local resources.
- Provision of Emergency Dental Services 7 days per week
- Work with partners to remove barriers to access dental services within the community
- Review Day Services and preventative services to ensure they meet needs within each Locality
- Provide Health Literacy Training for staff to improve accessibility of information

Local Objective 2

We will improve prevention and early intervention

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

How delivery of our services will help us to meet this Objective.

- Ongoing creation and review of existing Anticipatory Care Plans.
- **Ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract.**
- **Personalised care planning and self management as part of the Long Term Condition management improvement work (supported by ICF)**
- Develop preventative services that involve the third and independent sector
- Promote good physical and mental health through well-being advisors.
- Develop an Integrated health and social care transitions pathway for young people moving from children's to adult services.
- Reduce the amount of drug and alcohol use through early intervention and prevention approaches
- **Promote healthier lifestyles for patients, staff and visitors through our health improvement campaign 'small changes, big difference'.**
- Increase referrals to Lifestyle Advisory Services, Quit4Good, as well as signposting to community resources such as 'Walk It' groups.
- Deliver the Long Term Conditions project to support people to self manage their conditions better, promoting social contact and reducing isolation.
- Promote the uptake of health screening opportunities and immunisation programmes
- Raise awareness of the signs and symptoms of health conditions and encourage people to get checked e.g. Detecting Cancer Early, Suicide Prevention Training.

Local 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.

How delivery of our services will help us to meet this Objective.

Opportunities to reduce emergency admissions will include development and review of Anticipatory Care Planning, District Nursing Services, Social Care Services, GP clusters and new GP contract, Out of Hours Services, models of Intermediate Care, and the use of Technology Enabled Care, all of which will support people through all stages of the care pathway.

- **Development of the Eildon Community Ward and links with the Health & Social Care coordination project to provide a proactive case management approach for people with multiple complex co-morbidities most at risk of hospital admission and readmission. (supported by ICF)**
- **GP Enhanced Services to support the management of patients in the community or at home, such as near patient testing, warfarin and services to people in care homes.**
- Health and Social Care coordination projects Services will support the 'Reducing Inappropriate Emergency Admissions Working Group' to achieve its objectives.
- Hawick Paramedic Practitioner Pilot. Two GP Practices are working directly with SAS to test a different model of in-hours response to emergency calls to GPs. (Unscheduled Care Project)
- **GPs working with BGH consultants via direct access by phone to discuss any cases for early ward or clinic review by a Specialist team**.
- The 2015/16 Unscheduled Care Project work streams will be mainstreamed within local services and will include a range of initiatives to support this objective;
- Ambulatory Care and Acute Assessment - A new Ambulatory Assessment Unit has been established and the model is being evaluated in line with agreed improvement methodologies.
- **Review Mental Health Crisis Team input to the Emergency Department – discussions are underway to identify the most appropriate location for the team to ensure timely access and support for patients attending in crisis**.
- Ongoing collaboration with local GPs and District Nurses to ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract.
- Effective Psychiatric Liaison Services operating within hospital settings
- Effective Community Mental Health Rehabilitation Services
- Increasing uptake of Self-Directed Support to increase effective individualised community support arrangements.

Local 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.

How delivery of our services will help us to meet this Objective.

- District Nursing and Treatment Room services will continue to provide care delivered in a locality model that; ensures people achieve the best possible health outcomes – promotes self-management and independence – uses skilled assessment working with a person and their family to develop their care plan – focuses on prevention and anticipatory care – avoids unnecessary hospital admission/supports early discharge – offers a care management function and improves coordination of services – ensures collaboration and interface with third and independent sector – uses knowledge of local community resources and networks
- **We will work with care providers to develop different models of care that will support people to stay at home for as long as possible.**
- Specialist Outreach clinics and screening services will be delivered in localities
- **Development of Technology Enabled Care models to maintain independence and care closer to home**.
- Long Term Care will be reviewed to ensure care homes are providing high quality care across the localities
- **We will commission 24 Specialist Dementia care beds to support people with high level dementia care needs and provide specialist in-reach nursing services to support providers**.
- We will commission effective community support and supported accessible housing options with our communities
- NHS Dental Services will be available across the region with domiciliary care to those cared for at home or in long term care facilities.

Local 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.

How delivery of our services will help us to meet this Objective.

- **Quality agenda within the Transitional Year GP Contract to develop processes with the full involvement of Practices**.
- Creation of Quality Clusters in Localities.
- Review assessment and care management to ensure teams across the partnership are able to work efficiently and enable further integrated working.
- Ongoing HB engagement with GP representative bodies regarding development work and best use of Primary Care funding.
- Ongoing use of the Primary Care Feedback facility to identify interface issues affecting everyday working, e.g. with Secondary Care.
- START staff based in Community Hospitals and working the hospital and community MDTs
- Deliver projects supported by the Integrated Care Fund to maximise integrated working for Health and Social Care.
- Discharge Hub Developments (supported by Connected Care)
- Complete integration of Community Mental Health teams and continue to deliver services within an integrated governance structure incorporating service providers, users, professionals and other stakeholders.
- Joined up Adult Protection services and response.
- **Linking to GP practices to ensure communication and speedier access**
- **Linking to the third and independent sector locally to improve access to services and coordinate between the services**
- Facilitating the development of locality plans based on local needs and co produced in the context of local partnership arrangement.
- Working with services across the NHS and Council to redesign services locally to meet the needs of the local population, local communities and in line with improved outcomes, using localities group
- In consultation with partners, make recommendations to the Localities group on future arrangements to support locality planning and integrated organisational arrangements on an ongoing basis.

Local 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.

How delivery of our services will help us to meet this Objective.

- Further the development of personalisation and outcomes approaches to assessment
- **Embed co-production within the care management and assessment approach and deliver at a locality level**
- **Complete the review of the Physical Disability Strategy**
- **Increase overall uptake of Self Directed Support**
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- Public involvement and representation in teams working on the redesign and development of services.
- Multidisciplinary presence in projects developing new services.
- Increase the use of patient/service user feedback processes.
- Lifestyle advisory services will work with communities offering support with a specific emphasis to vulnerable groups.

Local 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.*

How delivery of our services will help us to meet this Objective.

- **Continue to employ service improvement methodology across a range of services to enable staff to spend increasing time with service users and patients improving the quality of service provision**.
- Creation of Quality Clusters with clear set of outcomes and their improvement through repeating cycles of work and evidence bases approach to their improvement.
- Review of current management arrangements towards a more integrated model that delivers efficiency and effective use of resources
- Joint approach to Efficiency Planning by partners
- Commission a review of assessment and care management teams to ensure they are able to meet future demand and deliver services efficiently and effectively.
- Commission care at home through a tender process.
- Ensure intelligence is available from locality planning processes to inform any commissioning cycles.

Local 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.

How delivery of our services will help us to meet this Objective.

- **Through the development of locality plans we will identify how to include those who are hard to reach within our communities**
- We will ensure that we carry out Equality Impact Assessments across all strategic developments
- Representation at the Health Equalities steering group.
- We will ensure Rural Proofing is carried out
- GP Keep Well Enhanced Service, targeting populations in the most deprived areas.
- Ensure intelligence is pulled from locality planning activity and considered in any future service reviews.
- **Revision of the Mental Health Commissioning Strategy**

Local Objective 9

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

How delivery of our services will help us to meet this Objective.

- Acknowledge the significant role carers have in meeting health and social care needs of our population.
- Review of Carers Strategy to identify the key areas of development over the next 3 years
- **Ongoing identification of carers within GP Practices and signposting to carer support such as the local Carer Centre**.
- Carer's assessments carried out by the main stream services.
- Engagement with carers on Strategic Planning Group and emerging Locality Planning groups.
- **Ongoing information and education for carers across the range of health and social care services**
- **School Nursing Services will continue to support young carers and their physical and mental wellbeing**.

The Nine 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

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	★	★	★	★	★	★	★		

Priority Indicators for focus in 2016/17

Core Suite Indicator Number	Indicator description
10	Percentage of staff who say they would recommend their workplace as a good place to work.*
12	Rate of emergency admission for adults.
14	Readmissions to hospital within 28 days of discharge.*
16	Falls rate per 1,000 population in over 65s.*
18	Percentage of adults with intensive needs receiving care at home.
19	Number of days people spend in hospital when they are ready to be discharged.
22	Percentage of people who are discharged from hospital within 72 hours of being ready.