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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health And Social Care Integration Joint Board** will be held on **Monday, 26th June, 2017** at **2.00 pm** in Committee Room 2, Scottish Borders Council

AGENDA

Time	No		Lead	Paper
14:00	**1**	**ANNOUNCEMENTS AND APOLOGIES**		
14:01	**2**	**DECLARATIONS OF INTEREST**		
14:02	**3**	**MINUTES OF PREVIOUS MEETING** 27 March 2017		(Pages 1 - 8)
14:05	**4**	**MATTERS ARISING** Action Tracker		(Pages 9 - 12)
14:10	**5**	**CHIEF OFFICER'S REPORT**		
14:15	**6**	**STRATEGIC**		
	6.1	Transformation & Efficiencies Report by Chief Officer.		(Pages 13 - 24)
	6.2	Learning Disabilities Strategic Commissioning Plan Report by Chief Officer.		(Pages 25 - 112)
	6.3	Integrated Care Fund Update Report by Chief Officer.		(Pages 113 - 130)
	6.4	Primary Care Funding - Pharmacists in GP Practices Report by Director of Pharmacy.		(Pages 131 - 132)
	6.5	Quarterly Performance Report Report by Chief Officer.		(Pages 133 - 168)
	6.6	Health & Social Care Locality Plans		(Pages 169 - 264)

		Report by Chief Officer.	
15:00	**7**	**CLINICAL & CARE GOVERNANCE**	
	7.1	Inspections Update	
15:10	**8**	**GOVERNANCE**	
	8.1	Annual Report 2016/17 Report by Chief Officer.	(Pages 265 - 280)
	8.2	Annual Performance Report of IJB 2016/17 Report by Chief Officer.	(Pages 281 - 374)
15:30	**9**	**FINANCE**	
	9.1	Report on the refresh of partners financial regulations across the partnership resources	
	9.2	Financial Plan Update Report by Interim Chief Financial Officer.	(Pages 375 - 380)
15:50	**10**	**FOR INFORMATION**	
	10.1	Committee Minutes	(Pages 381 - 390)
15:55	**11**	**ANY OTHER BUSINESS**	
	11.1	Health & Social Care Integration Joint Board Development Session: 25 September 2017 • Commissioning and Implementation Plan • Pharmacy Development and Prescribing Pressures	
16:00	**12**	**DATE AND TIME OF NEXT MEETING** Monday 28 August 2017 at 2.00pm in Committee Room 2, Scottish Borders Council.	

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Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 27 March 2017 at 2.00pm in the Committee Room 2, Scottish Borders Council.

Present:	(v) Cllr J Mitchell	(v) Mrs P Alexander (Chair)
	(v) Cllr G Garvie	(v) Mr J Raine
	(v) Cllr S Aitchison	(v) Mr D Davidson
	Mrs E Torrance	(v) Dr S Mather
	Mr M Leys	(v) Mrs K Hamilton
	Mr D Bell	Ms T Ball
	Mrs J Smith	Dr A McVean
	Mrs E Rodger	Mrs A Trueman
	Ms L Gallagher	
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mr P McMenamin	Mrs T Logan
	Mrs J Stacey	Ms M Smith

1. Apologies and Announcements

Apologies had been received from Cllr Catriona Bhatia, Cllr Frances Renton, Dr Cliff Sharp, Mr John McLaren and Mrs Carol Gillie.

The Chair welcomed Ms Tracey Ball who was deputising for Mr John McLaren.

The Chair advised that this would be the last Board meeting for both Cllr Catriona Bhatia and herself, as they were both stepping down from their positions at Scottish Borders Council and NHS Borders. The Chair reminded the Board that the Integration Scheme provided for the Chair and Vice Chair positions to alternate on an annual basis with the new chair being provided from NHS Borders. She further advised that the new chair had been identified as Dr Stephen Mather, subject to final approval from NHS Borders on 6 April 2017.

The Chair confirmed the meeting was quorate.

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. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 27 February 2017 were approved.

4. Matters Arising

4.1 Minute 15.1: Development Session: Mrs Elaine Torrance confirmed that the Prof John Bolton session had been confirmed for 4 April 2017.

4.2 Minute 8: Health & Social Care Delivery Plan: The Chair suggested adding the Live Borders update to the Action Tracker.

The Chair commented that some items had been on the action tracker for some time and she requested assurance that there would be no further slippages on timescales. Mrs Elaine Torrance provided assurance on timescales.

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

5. Transformational Programme

Mrs Elaine Torrance updated the Board with progress on the transformational programme through a presentation which also set the context for the financial items later on the agenda.

Mr Paul McMenamin set the context for the financial challenges for the partnership for 2017/18 and beyond. He spoke of: initial funding gap; mitigation; £2.6m affordability gap for the partnership for 2017/18 and the need to put in place a medium term transformational plan; seeking efficiencies and savings to contribute to closure of the affordability gap; areas of initial focus included the Prof John Bolton work, care pathways, delayed discharges, sharing buildings, assets, people, IT, data, localities and prescribing.

Mrs Torrance spoke of the shape the transformational programme would take following direction and support from the Executive Management Team. She emphasised that transformation was about pathways, reducing blockages, redesigning flow, improving outcomes, and making services fit for the future to manage increased demand and affordability.

Mrs Torrance advised that the next steps were to develop detailed proposals for the transformational programme, identify resources to manage the programme, identify indicative efficiencies and then bring a report back to the next Board meeting.

Cllr Sandy Aitchison enquired about “realistic medicine”. Dr Angus McVean explained that it was about providing what was needed and no more. He commented that there was a tendency for people to receive more and more interventions and at some point a pause needed to be instigated to review if they really required everything that was being provided.

Cllr Sandy Aitchison enquired if the drug and alcohol partnership should be provided through the public sector. Mrs Torrance commented that services were already commissioned through the third sector and there was an intention to work together differently, more closely and more efficiently.

Discussion focused on several key areas including: prioritisation; pooling resources and funding; culture change; transfer of funds; affordability; indicative costs; timescales; resources in primary care; delivery against the Strategic Plan; and a redesign of services.

Ms Lynn Gallacher enquired about progress in regard to the Carers Legislation as she was aware that there could potentially be increased demand on the third sector if there was less demand on statutory services. Mrs Torrance advised that further guidance was awaited however a small sum had been set aside to support the formulation of a plan.

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

6. Integrated Care Fund (ICF) Update

Mrs Elaine Torrance gave an overview of the content of the paper and explained each project in turn.

In regard to the GP Clusters proposal, discussion focused on: what could be achieved in 2 hours a week; if the funding level was adequate; good will; intense pressure in GP community services; a move to make the GP a specialist generalist; locum rates; and difficulty in recruiting to GP positions.

Mr John Raine said it was concerning to hear from Dr McVean that there was a general lack of goodwill on the part of GPs. Primary Care was essential to the effective delivery of integrated services and the pressures faced by GPs were well understood. However, the Board needed to take serious note of Dr McVean's statement and ensure action was taken to mitigate the impact. A focus should be put on building and supporting relationships with GP practices.

Mrs Tracey Logan commented that the Executive management Team were supportive of the proposal and of building bridges and relationships with the GP community and were engaging with them.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the utilisation of ICF funding to establish the Cluster Quality Lead posts at 2 hours per week per post and to assess capacity levels against their remit and the outcomes delivered over the initial 12 month period at a cost of circa £50k over one year.

In regard to the Domestic Abuse Service Pathway proposal, discussion focused on: big lottery and match funding; redesign of the pathway; well established and well recognised service in the Scottish Borders; and sharing services more effectively with the third sector.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the request for £120k total funding over 3 years, and a further update on the redesign of the service at the next meeting.

In regard to the Alcohol & Drug Partnership (ADP) Transitional Funding proposal, discussion focused on: redesigned service proposals; reduced expenditure profile; Executive Management Team support for the proposal; future funding requests; and effects on childrens education in closing the attainment gap.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the request for £46k of transitional funding from the Integrated Care Fund to allow further work to be taken forward by the ADP.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current expenditure position of the Integrated Care Fund.

7. Annual Performance Report 2016/17

Mrs Elaine Torrance presented the draft performance report and sought feedback on the content. She drew attention to pages 51, 52 and 53 which set out the priorities for the next year and commented on the performance data.

Comments received included: good layout; comparison to the scottish average for population; intended audience; acronyms and language; simplified easy read version; photographs of the Board members; and local objectives to the local geographical area or borders wide.

Mrs Torrance confirmed that the timeline for publication was by the end of July and that a final version would be brought to the next meeting of the Board and would include tracked changes and version control.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** commented on the content, structure and format of the draft Annual Performance Report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the timeline for the development and publication of the report.

8. NHS Borders Local Delivery Plan 2017/18

Mrs Elaine Torrance introduced the NHS Borders draft Local Delivery Plan (LDP) and welcomed Ms Meriel Smith who was present to answer any technical questions.

Comments received included: additional information required for the suicide prevention section; public involvement and the community engagement strategy; feedback from the results of the information gathered from patients and carers – published - information on ward boards; difficulties in engaging with the public through the Public Patient Forum (PPF); challenges of engagement with the wider public; attendance at Area Forums; attendance at the PPF; and production of an easy read version.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the draft LDP and provided feedback and comments on the draft.

9. Inspections Update

Mr Murray Leys gave feedback to the Board following the recent joint inspection. He confirmed that the inspectors had provided initial feedback which had focused on anticipated areas of improvement, key processes, and work with communities and localities. Evaluation scores were expected on the 28th April and formal feedback was expected around the 11th

May. The final report was expected to be available in late June, early July. He further advised that the final report would be brought to the Board post publication for consideration.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and that the final report would be brought to the Board for consideration.

10. Review of Strategic Planning Group

Mrs Elaine Torrance spoke of the reasons for refocusing the role and function of the Strategic Planning Group (SPG).

Mrs Angela Trueman commented that she was concerned there was only one representative on the SPG as a user of health care and one community council network representative for the whole of the Scottish Borders. She enquired if the membership was prescribed or could be expanded? Mrs Torrance advised that the membership was prescribed in Scottish Government guidance and conversations had taken place in regard to the substantial size of the group.

Cllr Sandy Aitchison left the room.
The meeting was not quorate.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made in reviewing the role, function and membership of the SPG.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** endorsed the revised Terms of Reference.

11. Monitoring of the Health & Social Care Partnership Budget 2016/17

Mr Paul McMenamin presented the report and highlighted the work that had been undertaken in regard to the NHS Borders recovery plan and the continued work that was underway to deliver financial balance at the year end.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report and the monitoring position on the partnership's 2016/17 revenue budget at 31st January 2017.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** supported the management teams within both organisations as they continue to make every effort to ensure the IJB returns a balanced position for 2016/17.

Cllr Sandy Aitchison returned to the meeting.
The meeting was quorate.

12. Scottish Borders Health & Social Care Partnership Financial Plan 2017/18

Mr Paul McMenamin introduced the paper and highlighted the future work required in terms of due diligence, refining how the budget is allocated, savings targets and also presented the provisional budget. He emphasised that both partners had committed to deliver a flat cash budget to the Integration Joint Board and that the transformational programme would be

utilised to bring forward other efficiency and savings measures to help address the unmitigated pressures.

Mr David Davidson advised that if both Chief Executives were satisfied with the content of the paper, then he had confidence in them and would be supportive of the paper.

Cllr Graham Garvie suggested a budget should never be approved unless it was balanced and on the advice of the Finance Officer that the budget was 95% balanced and the other 5% would be worked on he was supportive of the paper.

Mrs Jane Davidson commented that for the Health Board it would provide the resource that it had been asked to provide and could not provide any additional funding. She suggested the challenge would be for the partnership to deliver on the transformational agenda and she assured the Board that partners were working better behind the scenes to reduce the gap.

Mrs Tracey Logan commented that for the Local Authority it would be looking to deliver efficiencies in the same way as the NHS and she expected delivery of transformational change programme to be fundamental to deliver on budgets.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the report and the provisional 2017/18 Health and Social Care Financial Plan.

13. Social Care: Additional Funding Allocation to Partnerships 2017/18

Mr Paul McMenamin gave a brief presentation which encapsulated an overview of the content of the paper. He highlighted the additional funding from the Scottish Government that had been routed through the NHS to the partnership to support social care and the direction of that funding by the Board during the previous year.

Cllr Sandy Aitchison sought clarification of the additional support to integration authorities. Mr McMenamin explained that the Scottish Government had advised Health Boards that they must provide the same amount of funding to the partnership as they had provided in 2016/17 and that Local Authorities had the ability to reduce their funding to the partnership by up to 80%. Mr McMenamin confirmed that the Local Authority had agreed not to reduce its funding to the partnership.

Mr McMenamin explained the social care new commitments and sustainability and advised that COSLA and the Scottish Government had reached agreement with residential care home providers to agree an uplift of 2.6%. As agreement had been reached he was now able to build that into the direction of funding of the living wage. Mr McMenamin further spoke of the pressures on the system of catering for those with complex needs, those transitioning into adulthood and older peoples care requirements.

Karen Hamilton left the meeting.

Mrs Tracey Logan suggested the Board may wish to consider deferring the allocation of funding until further clarity of detail was provided, apart from the uplift to the living wage element which was payable from 1 April 2017.

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The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the uplift in the living wage allocation and deferred any further allocations until the next meeting in June.

Mr John Raine wished to record thanks to the Council for choosing not reduce their financial allocation to the partnership in line with the discretion given to Local Authorities to make reductions.

14. Chief Officer's Report

Mrs Elaine Torrance advised that the Integration Joint Board's Audit Committee had been held earlier that morning and that the Prof John Bolton event had been confirmed for 4 April.

Cllr John Mitchell advised that the Audit Committee had agreed to recommend to the Health & Social Care Integration Joint Board that it issue a direction to both partner organisations to direct them to undertake a refresh of financial regulations across partnership resources.

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** issued the direction to partner organisations to undertake a refresh of their financial regulations across the partnership resources.

15. Any Other Business

15.1 Mrs Evelyn Rodger: The Chair advised that this was the last meeting of the Board for Mrs Evelyn Rodger, Director of Nursing, Midwifery and Acute Services, in her capacity as a professional advisor to the partnership. Mrs Rodger was retiring to pursue other interests beyond nursing and the Board wished her well for the future.

15.2 Mrs Pat Alexander: Mr David Davidson thanked Mrs Pat Alexander for chairing her last meeting of the Board and recorded the thanks of the Board to her for being the vice chair for the past two years and wished her well for the future.

15.3 Cllr Catriona Bhatia: Mr David Davidson also recorded the thanks of the Board to Cllr Catriona Bhatia for chairing the Board for the past two years and wished her well for the future.

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

15.4 Health & Social Care Integration Joint Board Development Session: 29 May 2017

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that an alternative date was being sought.

16. 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 26 June at 2.00pm in the Committee Room 2, Scottish Borders Council.

The meeting concluded at 4.06pm.

Signature: …….
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 27 April 2015

Agenda Item: Draft Strategic Plan – A conversation with you

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
1	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to have a Development session later in the year dedicated to the Commissioning and Implementation Plan.	Elaine Torrance	2017	**Update:** Item rescheduled for 25 September 2017 Development session.	A

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.	Elaine Torrance Evelyn Rodger Cliff Sharp	2017	**In Progress:** Item scheduled for 27 November 2017 Development session.	A

Meeting held 19 December 2016

Agenda Item: Further Direction of Social Care Funding – Borders Ability & Equipment Services

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
11	12	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a further report on the operation of the BAES at a future meeting.	Elaine Torrance	March 2017	**In Progress:** Item scheduled for 27 March 2017 meeting agenda. **Update:** Item rescheduled to 28 August meeting as the report is with NHS National Services Scotland for review.	A

Meeting held 27 February 2017

Agenda Item: Transformational Programme

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
12	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation and agreed to receive an update at the next meeting.	Elaine Torrance	March 2017	**Complete:** Item discussed at 27 March 2017 meeting agenda.	G

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 to 28 August meeting.	A

Meeting held 27 March 2017

Agenda Item: Integrated Care Fund (ICF) Update (Domestic Abuse Service Pathway)

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
14	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the request for £120k total funding over 3 years, and a further update on the redesign of the service at the next meeting.	Elaine Torrance	June 2017	**In Progress:** Verbal update to be provided.	A

Agenda Item: Inspections Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
15	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and that the final report would be brought to the Board for consideration.	Murray Leys	August 2017	**In Progress:** Item scheduled to 28 August meeting.	A

Agenda Item: Social Care: Additional Funding Allocation to Partnerships 2017/18

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
16	13	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the uplift in the living wage allocation and deferred any further allocations until the next meeting in June.	Paul McMenamin	June 2017	**Complete.**	G

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
17	14	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** issued the direction to partner organisations to undertake a refresh of their financial regulations across the partnership resources.	Paul McMenamin	June 2017	**Complete:** Item appears on 26 June meeting agenda.	

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

Scottish Borders
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TRANSFORMATION & EFFICIENCIES PROGRAMME

Aim

1.1 To update the Integration Joint Board (IJB) on progress of the development of the Health and Social Care Partnership Transformation and Efficiency Programme.

Background

2.1 The IJB have a challenging financial position in 2017/18. The total budget available to the IJB is £166,694,000. This is a "flat-cash" settlement and therefore there are unfunded pressures that require to be addressed. The total shortfall is £6.37m and actions to achieve efficiencies of £3.781m have already been identified by both partners. This still leaves an affordability gap of £2.6m for the Partnership to address.

2.2 The IJB's Transformation Programme is being developed to ensure that services continue to deliver the agreed Strategic Plan, continue to provide effective, quality services and help bridge the £2.6m affordability gap in the IJB financial plan for 2017/18.

2.3 An outline of the proposed Programme was presented to the IJB at its meeting on 27 of February and a further update was provided on the 27 March. The Programme will seek to establish efficiency gains through the redesign of care pathways, reducing blockages and making better use of IT/ technology to improve outcomes and ensure that services are fit for the future to manage increased demand.

2.4 While the development of the Programme is still work-in-progress, 10 initial project areas have been identified. These are:

1. Improving Community & Day Hospital Services
2. Enablement
3. Allied Health Professionals (AHP's)
4. Dementia
5. Mental Health Redesign
6. Re-imagining Day Services
7. Carer's Strategy
8. Redesign of Alcohol and Drug Services
9. Telecare and Telehealth Care
10. Localities and Workforce Planning

2.5 Projects 1-6 and 8 are focused on the redesign of services and the associated care pathways. Projects 9 and 10 are cross-cutting projects. The Telecare and Telehealth Care project will look at how technology can support and enhance the

processes around each pathway and help achieve both service improvements and efficiency gains. The Localities and Workforce Planning project will look at streamlining Health and Social Care management and staffing structures at a local level to deliver redesigned services in the most efficient and effective way. An Integrated Workforce Plan is currently being developed to reflect the impact of redesign on the workforce across the Partnership.

2.6 A summary overview of the ten projects is set out in Appendix 1 and an associated summarised Programme Plan, setting out high level timescales, is included at Appendix 2.

2.7 The Executive Management Team (EMT) will be the Programme Board having strategic oversight of the Programme and monitor progress on a monthly basis.

Affordability Gap

3.1 The initial focus on developing the Programme has been on the need to address the 2017/18 funding gap. Given the scale of the savings, and the need to achieve them within the current financial year, it would not be reasonable to expect these 10 projects, alone, to achieve the full £2.6m savings. In the short-term, there will be a need to identify additional projects and to look across all areas of the budget for one-off savings within the current financial year. The nature of the Transformation Programme – and the challenges that it seeks to address – will require a longer-term (3-5 year) view

3.2 Further work is needed to finalised the contribution that the current projects can make to the £2.6m affordability gap. Most projects have existing savings targets attached to them which are already factored into SBC and NHSB financial plans. Contributions to the affordability gap will be in addition to these existing savings targets.

3.3 Appendix 2 outlines the timeframe for the delivery of efficiencies and demonstrates that this will take time to realise given the need for significant engagement and service redesign.

3.4 Proposed steps to clarifying the one-off and recurring savings include:

- Clarifying the amount and timing of expected savings from the 10 projects
- Identifying further projects and associated savings
- Senior operational managers across the Partnership have also been tasked to identify further one-off and recurring savings within the current financial year.

Resources

4.1 While the Executive and Programme leads have been identified for each project, the resource required to support the delivery of projects still needs to be fully identified.

4.2 The resource will need to include a range of skills including people with the appropriate operational/professional experience as well as knowledge of and credibility in the Health and Social Care landscape in order to successfully lead and deliver change.

Technology

5.1 An initial technology brief has been developed around a telecare project. The brief will be expanded to include the technology requirements identified from each of the service redesign projects. This reflects the role that technology will play in improving care pathways – and in the review and redesign of the processes associated with each care pathway.

Dependencies & Cross-Cutting Themes

6.1 There is a high level of interdependency between the 10 Partnership projects and across both the NHS and SBC Transformation Programmes. These dependencies are partly illustrated in Appendix 3. In particular, there will be a need to manage the relationship betweeen the cross-cutting technology and workforce projects (Projects 9 and 10) with the service/pathway redesign projects.

Summary

7.1 This paper updates the IJB on progress in establishing the Transformation Programme, the timescales, progress to date and next steps.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the progress made in developing the Transformation and Efficiencies Programme.

The Health and Social Care Integration Joint Board is asked to **endorse** identified workstreams.

Policy/Strategy Implications	This Programme will support the delivery of the Partnership's Strategic Plan.
Consultation	Programme Proposals are being developed through the Joint H&SC Management Team and with service leads.
Risk Assessment	The risks relating to each project are being developed as part of the project briefs. Overall, there is a risk that without a robust Programme, the Partnership will be unable to address the current – and future – affordability gap.
Compliance with requirements on Equality and Diversity	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.
Resource/Staffing Implications	Resource and staffing implications are being developed as part of both the development of the project briefs and the service redesigns that will be addressed through the projects.

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Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer, Health and Social Care		

Author(s)

Name	Designation	Name	Designation
James Lamb	Portfolio Manager		

Appendix 1

1. Community & Day Services *(Sandra Pratt)*

Summary - Implement best practice service models in Community Hospitals to improve patient pathway and make best use of resources.

Aims:

- Reduce length of stay in Community Hospitals
- Reduce delayed discharges across system
- Improve admission and transfer processes across all care sectors
- Delivery of care in the right place at the right time
- Deliver savings and efficiency gains

Activities:

- Identify model options based on best practice
- Appraise options against agreed criteria
- Develop preferred option in detail along with associated implementation plan.
- Implement the approved model

2. Care at Home – Including Re-ablement *(Murray Leys)*

Summary - Targeted and appropriate Enablement within a homecare setting to deliver improved outcomes for individuals and contribute to reductions in the average hours of long-term care required. Links with Technology Enabled Care (TEC) to enhance or replace direct contact time by carers

Aims:

- Delivery of a shortened assessment process in hospital
- Commissioning an improved hospital to home service
- Improved assessment support and outcome based planning
- Deliver savings and efficiency gains

Activities:

- Develop and agree proposals
- Agree ICF Funding
- Plan and implement a phased roll-out

3. AHPs *(Sandra Pratt)*

To promote the use of AHP services to support more people in their own homes or community. Brief is being developed

4. Dementia *(Murray Leys)*

Summary - Redesign the care and support service to deliver improved outcomes for people with dementia.

Aims & Activity:

- Establish dementia centre of excellence
- Improve post-diagnosis support
- Improve home based care to reduce hospital admissions
- improve training and support to carers

5. Mental Health Services Redesign *(Simon Burt)*

Summary - Service redesign in line with Mental Health Needs Assessment Recommendations, MH Strategy and to achieve identified Financial Savings

Activities:

- Preparation - Gathering data and mapping current service pathways
- Development - Stakeholder engagement, Benchmarking and Best Practice
- Planning - Developing new Care pathways and consultation
- Refine, Agree and implement new pathways.

6. Redesigning Day Services *(Murray Leys)*

Summary - Review of Day Services to identify and deliver a more effective and efficient service

Aims:

- Eliminate duplication
- Better use of technology and new models of support
- Improved accessibility and choice
- Provide care closer to home
- Prevention & Early Intervention
- Reduce avoidable hospital admissions

Activities:

- Data gathering and identify options
- Identify and develop preferred option
- Plan and Implement

7. Carers Strategy *(Elaine Torrance)*

Summary - Work co-productively, through the Health and Social Care Partnership and children and young people's services, with carer representative organisations and with carers, to implement the legislation effectively

Aims:

- Compliance with The Carers (Scotland) Act 2016
- Support Carer's Health & Wellbeing

Activities:

- Carer Assessments replaced by Care Support plans and Young Carer Statements
- Local Eligibility Criteria for carers
- Charging Policy Updated
- Information and advice is in place
- Local Carer's Strategy
- Clarification of the H&SC Partnerships role under the Act
- Short Breaks statement

8. Redesigning Alcohol & Drug Services *(Tim Patterson)*

Summary - To undertake work with Borders Addiction Service (BAS) and Addaction to confirm potential development of a single management structures and/or co-location to improve joint working

Aims:

- Improved joint working
- More efficient use of resources
- Deliver identified savings

Activities:

- Identification of Co-location Solution
- Scoping new management structure
- Implement agreed site and structure.

9. Telecare & Telehealthcare *(Murray Leys)*

Summary - Delivery of a video conferencing capability to support Out of Hours Emergency Care, Diabetes Services and Orthopaedics which for care homes will avoid the need for expensive travel (time) and hospital visits - including avoidance of missed appointments. Improving the use of telecare to support people in their own homes.

Aims:

- Avoiding need for hospital visits and associated travel costs and time
- Improved access to services
- Reduction in missed appointments
- Deliver savings and efficiency gains

Activities:

- Roll-out of video conferencing capability (pilot)
- Training
- Evaluation

10. Re-Imagining Integrated H&SC Teams at Locality level (Murray Leys)

Summary - Design and Implementation of Integrated Health & Social Care Teams across the 5 localities

Aims:

- Improved local accessibility
- Improved Prevention and Early Intervention
- Deliver services within an integrated care model
- Optimise efficiency and effectiveness - including contributing to the affordability gap
- Reduce avoidable hospital admissions

Activities:

- Agree over-arching vision and design principles
- Locality Redesign - localising the vision and applying the design principles to each locality
- Plan and implement a phased roll-out

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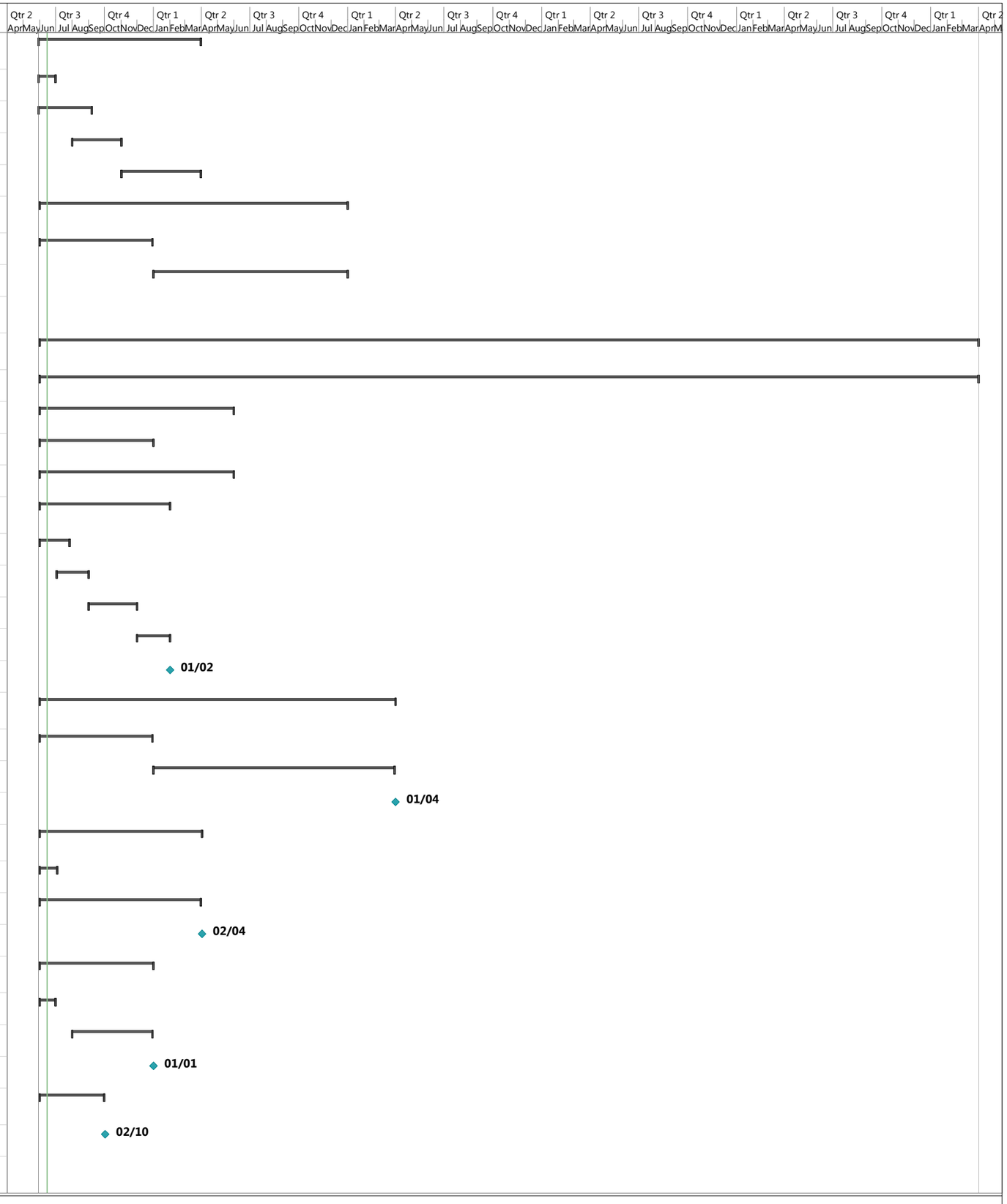
ID	Task Mode	Task Name	Start	Finish
1		**Improving Community & Day Hospital Services**	**Tue 30/05/17**	**Fri 30/03/18**
2		**Mobilisation**	**Tue 30/05/17**	**Fri 30/06/17**
5		**Establish and Cost Service Models**	**Tue 30/05/17**	**Wed 06/09/17**
8		**Agree & Develop Preferred Option and Implementation Plan**	**Tue 01/08/17**	**Wed 01/11/17**
13		**Implementation**	**Thu 02/11/17**	**Fri 30/03/18**
16		**Care at Home - Including Enablement**	**Thu 01/06/17**	**Tue 01/01/19**
17		**Mobilisation**	**Thu 01/06/17**	**Fri 29/12/17**
22		**Implementation**	**Mon 01/01/18**	**Tue 01/01/19**
27		**AHPs (Brief to be developed)**		
28		**Dementia**	**Thu 01/06/17**	**Thu 31/03/22**
29		**Create a specialist dementia centre of excellence**	**Thu 01/06/17**	**Thu 31/03/22**
31		**Support improvements in dementia post-diagnosis support**	**Thu 01/06/17**	**Thu 31/05/18**
33		**Deliver improvements in care home liaison**	**Thu 01/06/17**	**Sun 31/12/17**
35		**Deliver improvements in dementia specific training and the support**	**Thu 01/06/17**	**Thu 31/05/18**
37		**Mental Health**	**Thu 01/06/17**	**Thu 01/02/18**
38		**Preparation**	**Thu 01/06/17**	**Wed 26/07/17**
42		**Development**	**Mon 03/07/17**	**Thu 31/08/17**
46		**Transformation planning**	**Fri 01/09/17**	**Thu 30/11/17**
49		**Refinement, agreement & implementation**	**Fri 01/12/17**	**Wed 31/01/18**
52		Implementation from	Thu 01/02/18	Thu 01/02/18
53		**Day Services**	**Thu 01/06/17**	**Mon 01/04/19**
54		**Phase 1 - Analysis, Options Appraisal and Planning**	**Thu 01/06/17**	**Fri 29/12/17**
58		**Phase 2 - Implementation**	**Mon 01/01/18**	**Fri 29/03/19**
62		Implementation Complete	Mon 01/04/19	Mon 01/04/19
63		**Carers Strategy**	**Thu 01/06/17**	**Mon 02/04/18**
64		**Evaluate & Plan**	**Thu 01/06/17**	**Mon 03/07/17**
68		**Deliver Action Plan**	**Thu 01/06/17**	**Fri 30/03/18**
71		Acts Requirements Met	Mon 02/04/18	Mon 02/04/18
72		**Alcohol & Drug Services Redesign**	**Thu 01/06/17**	**Mon 01/01/18**
73		**Scoping & Identifying Relocation Site**	**Thu 01/06/17**	**Fri 30/06/17**
75		**Implementation**	**Tue 01/08/17**	**Fri 29/12/17**
79		New Structure Goes Live	Mon 01/01/18	Mon 01/01/18
80		**Telecare & Telehealth Care**	**Thu 01/06/17**	**Fri 29/09/17**
84		Completion	Mon 02/10/17	Mon 02/10/17
85		**Re-Imagining Integrated H&SC Teams (Being Developed)**		



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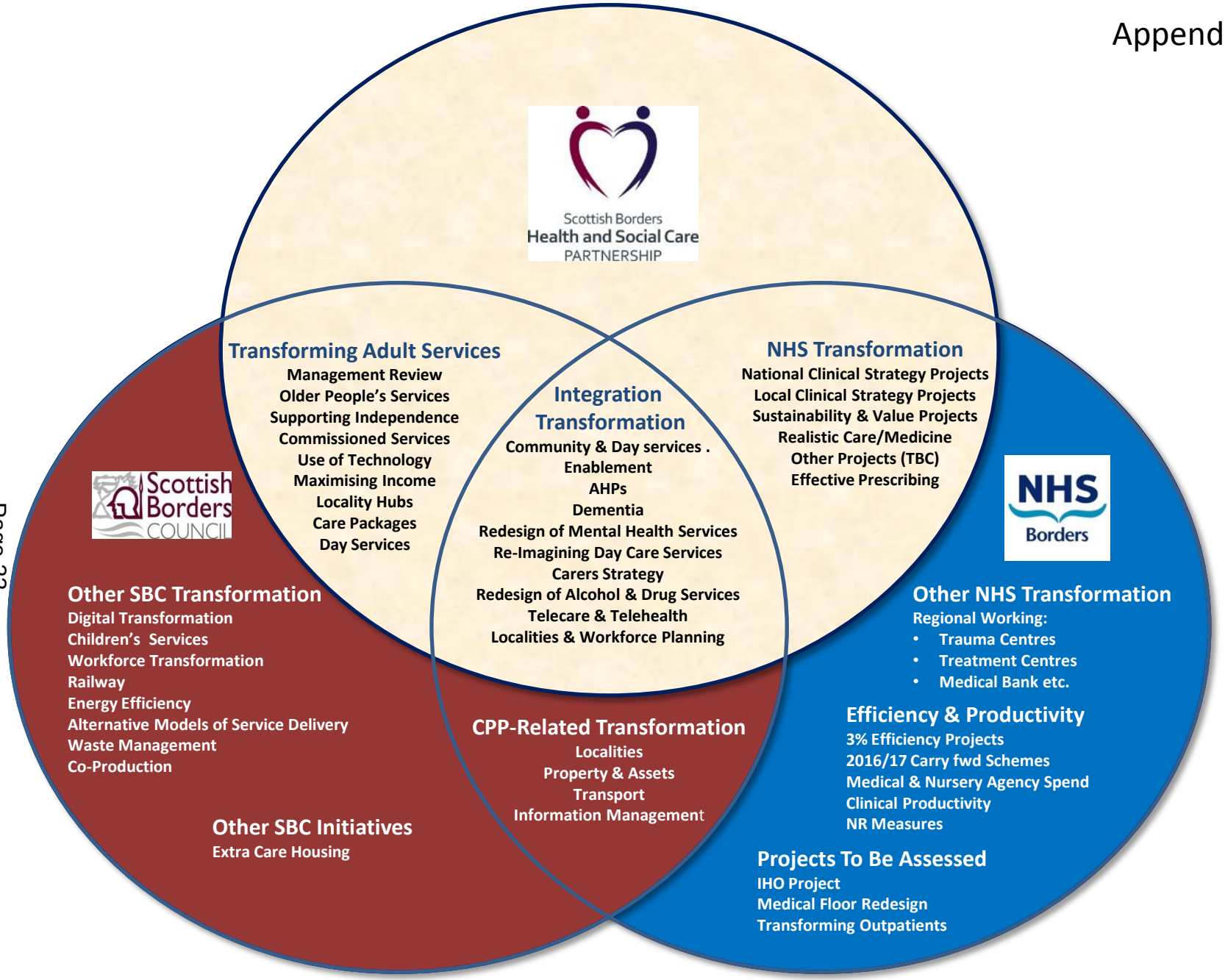
Scottish Borders
Health and Social Care
PARTNERSHIP
Transforming Adult Services
Management Review
Older People's Services
Supporting Independence
Commissioned Services
Use of Technology
Maximising Income
Locality Hubs
Care Packages
Day Services
Integration Transformation
Community & Day services .
Enablement
AHPs
Dementia
Redesign of Mental Health Services
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Redesign of Alcohol & Drug Services
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NHS Transformation
National Clinical Strategy Projects
Local Clinical Strategy Projects
Sustainability & Value Projects
Realistic Care/Medicine
Other Projects (TBC)
Effective Prescribing
Scottish Borders COUNCIL
NHS Borders
Other SBC Transformation
Digital Transformation
Children's Services
Workforce Transformation
Railway
Energy Efficiency
Alternative Models of Service Delivery
Waste Management
Co-Production
Other SBC Initiatives
Extra Care Housing
CPP-Related Transformation
Localities
Property & Assets
Transport
Information Management
Other NHS Transformation
Regional Working:
• Trauma Centres
• Treatment Centres
• Medical Bank etc.
Efficiency & Productivity
3% Efficiency Projects
2016/17 Carry fwd Schemes
Medical & Nursery Agency Spend
Clinical Productivity
NR Measures
Projects To Be Assessed
IHO Project
Medical Floor Redesign
Transforming Outpatients

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Scottish Borders
Health and Social Care
PARTNERSHIP

SCOTTISH BORDERS LEARNING DISABILITY STRATEGIC COMMISSIONING PLAN

Aim

1.1 This Strategic Commissioning Plan has been written to provide information for stakeholders regarding commissioning arrangements and future plans of the Scottish Borders Learning Disability Service (2016-2019).

Background

2.1 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 the 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 the Scottish Borders services, of whom 555 had confirmed addresses in this area.

2.2 Learning Disability resources (apart from the budget) 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.

2.3 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 more specialist interventions than that provided by mainstream Health and Social Care services.

2.4 The Service is responsible for commissioning packages of support for people with learning disabilities living within Scottish Borders and some specialist out of area placements. The bulk of commissioning takes place through Scottish Borders Council.

2.5 The commissioning of services for people with Learning Disabilities is an essential function of the Learning Disability Service (LDS). The LDS holds 6-weekly Clinical Governance and Quality meetings and reports performance currently though NHS Borders Performance and Planning routes with quarterly performance reviews. The Partnership Board meets bi-monthly and has a diverse membership including NHS, SBC, carers, people with learning disabilities, Borders Carer Centre, Borders Independent Advocacy Service.

2.6 This Strategic Commissioning Plan highlights areas for development across several themes identified through a co-productive approach with users, carers and staff groups and provides a high level plan for 2016-19.

2.7 The plans are in line with 'The keys to life – Improving quality of life for people with learning disabilities', The Scottish Government, 2013 and have been mapped against the National Health and Well Being Outcomes and the local Strategic Plan. Specific measures for evidencing the effectiveness of these high level plans are being worked up within the Learning Disability Service and will be reported on through existing governance structures.

Summary

3.1 The Strategic Commissioning Plan looks at the journey the Learning Disability Service has travelled within the Scottish Borders over the past 10 years within commissioning, lays out some of the key themes and provides an outline plan for development during 2016-19.

3.2 This document has been co-produced by the Learning Disability Policy and Strategy Group with stakeholders, including the Local Citizens Panels and the Providers Group and has been through the Governance structure within the Learning Disability Service to the Learning Disability Partnership Board, with the draft being approved by them in October 2016.

3.3 This Strategic Commissioning Plan demonstrates how these plans fit within the National Health and Wellbeing Outcomes and the local Scottish Borders Strategic Plan 2016-19.

3.4 More detailed measures will be developed to evidence the impact of this plan.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the report.

Policy/Strategy Implications	This has been mapped across the National Health and Wellbeing Outcomes and the local Strategic Plan and responds directly to 2 of the 'The keys to life', (national strategy) recommendations.
Consultation	Service users, carers, provider organisations, NHS Borders and SBC commissioning, LD service governance structure groups.
Risk Assessment	The commissioning of services for people with Learning Disabilities is an essential function.
Compliance with requirements on Equality and Diversity	Draft Equality Impact Assessment attached  Equality Impact Assessment LD Strat An easy read version of the strategy has been created in partnership with people with Learning Disabilities.
Resource/Staffing Implications	This Strategy is to be delivered within existing staffing resources and with an

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	agreed commissioning budget set annually, primarily with SBC but also health packages through the NHS Borders ECR panel approach.

Approved by

Name	Designation	Name	Designation
Simon Burt	General Manager Learning Disabilities & Mental Health	Elaine Torrance	Chief Officer Health & Social Care

Author(s)

Name	Designation	Name	Designation
Susan Henderson	Planning & Development Officer Learning Disabilities Service		

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learning disability service

PEOPLE

STRATEGIC COMMISSIONING PLAN 2016-19

Scottish Borders
Health and Social Care
PARTNERSHIP

CONTENTS

LEARNING DISABILITY SERVICE

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

1. OUR SHARED VISION

Our vision is that adults with learning disabilities will have opportunities to live as independently as possible as valued members in their local communities.

We recognise that people with Learning Disability and their carers have rights of equality and are diverse in all aspects of life, however they may experience difficulties in achieving these rights, and many require additional support to attain their outcomes and live their lives.

To successfully support people to achieve their outcomes, we must work in partnership with health, social care and third sector provider organisations and most importantly with people with learning disability and their carers.

I am thankful for the input of the Policy and Strategy Group in collating and writing this strategic commissioning plan on behalf of the Learning Disability Service, acknowledging the considerable input from the Local Citizens Panels and the Providers Group.

Simon Burt
Joint Manager
Scottish Borders Learning Disability Service

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

2. INTRODUCTION

'The keys to life – improving quality of life for people with learning disabilities 2013'[i] lays out a 10 year strategy for people with learning disability, with 9 key themes and 52 recommendations.

In the Scottish Borders, we have consulted with many people to look at our local responses to these recommendations and have identified work streams across communities, health and social care services, third sector providers to support people with learning disabilities to live their lives and achieve their outcomes. Through the Policy and Strategy Group this activity is collated under four strategic outcome headings mirroring Scottish Governments approach:

- A healthy Life
- Choice and Control
- Independence
- Active Citizenship

We have also identified any gaps.

This strategic commissioning plan responds to the following 2 recommendations directly, incorporates many of the other key themes and supports us to target our existing resources to the areas of greatest need.

RECOMMENDATION 3 STATES:

"That by April 2015 community planning partners should ensure that local arrangements for joint commissioning are developed across relevant partner agencies and service areas to support the delivery of agreed outcomes, and that these take account of the needs of people with learning disabilities." [ii]

AND RECOMMENDATION 7 STATES:

"That by April 2015 local authorities and NHS Boards should ensure that joint commissioning plans take account of the needs of people with learning disabilities of all ages. Plans should have regard to relevant guidance, scope current and future need, identify the total resources available to meet those needs, and set out how they will be invested to secure sustainable, high quality services and supports that can deliver outcomes for individuals, including those agreed as part of person-centred care planning and self directed support (SDS). Plans should make reference to early interventions, maximising independence and control." [iii]

We are also mindful of the **National Health and Well Being Outcomes**[iv] and the **local Scottish Borders Strategic Outcomes**[v] and demonstrate how the objectives within this Strategic Commissioning Plan fit.

WHAT THIS STRATEGIC COMMISSIONING PLAN TELLS US:

This commissioning strategy shows how, we, the Learning Disability service:

- make commissioning decisions within the changing national context
- currently spends the money allocated to us amidst ever increasing tightening of budgets, introduction of the Scottish Living Wage, Scottish Borders Council eligibility criteria
- have identified our priorities that fall within commissioning for development over the next 3 years

There are themes that underpin this strategy and while not always explicitly described include:

- supporting people to maximise their community participation within a co-productive, assets based approach
- creative and innovative ways of working are encouraged
- friendships and relationships are paramount to supporting people to feel valued and have identity
- a focus on health and well being runs central to all of our commissioning plans not excluding where healthcare placements may be required.
- geographical challenges can create restrictions on all of the above and we need to work hard to overcome these and highlight areas for improvement.

These were summarised through consultation with the Local Citizens Panels into 6 headings:

This strategy looks at the journey within the Scottish Borders, lays out some of the key themes for inclusion and under several headings provides an outline plan for the next 3 years.

We have mapped these plans against the Scottish Borders Strategic Commissioning Plans and the National Health and Wellbeing Outcomes and this is shown in tables in Appendix 5.

As part of our continual journey towards greater involvement and co-production the Learning Disability Partnership Board endorses the National Involvement Network's Charter for Involvement and at the June 2016 meeting signed up to this **Charter**.[vi]

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

3. BACKGROUND

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 the 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 the Scottish Borders services, of whom 555 had confirmed addresses in this area.

Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006, with the exception of the budgets which were retained separately. 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 more specialist interventions than that provided by mainstream Health and Social Care services. The service is responsible for commissioning packages of support for people with learning disabilities living within Scottish Borders and some specialist out of area placements.[vii]

WHAT HAS CHANGED OVER THE PAST 10 YEARS?

Over the past 10 years the service has led many changes through the implementation of the "**Same as you**" 2000[viii] principles and developments in service provision for people, **Social care (Self-directed Support) (Scotland) Act 2013**,[ix] **Carers (Scotland) Act 2016**,[x] **'The keys to life' 2013**[xi] among others. A list of many of the policy drivers and legislative frameworks is included as **Appendix 1**.

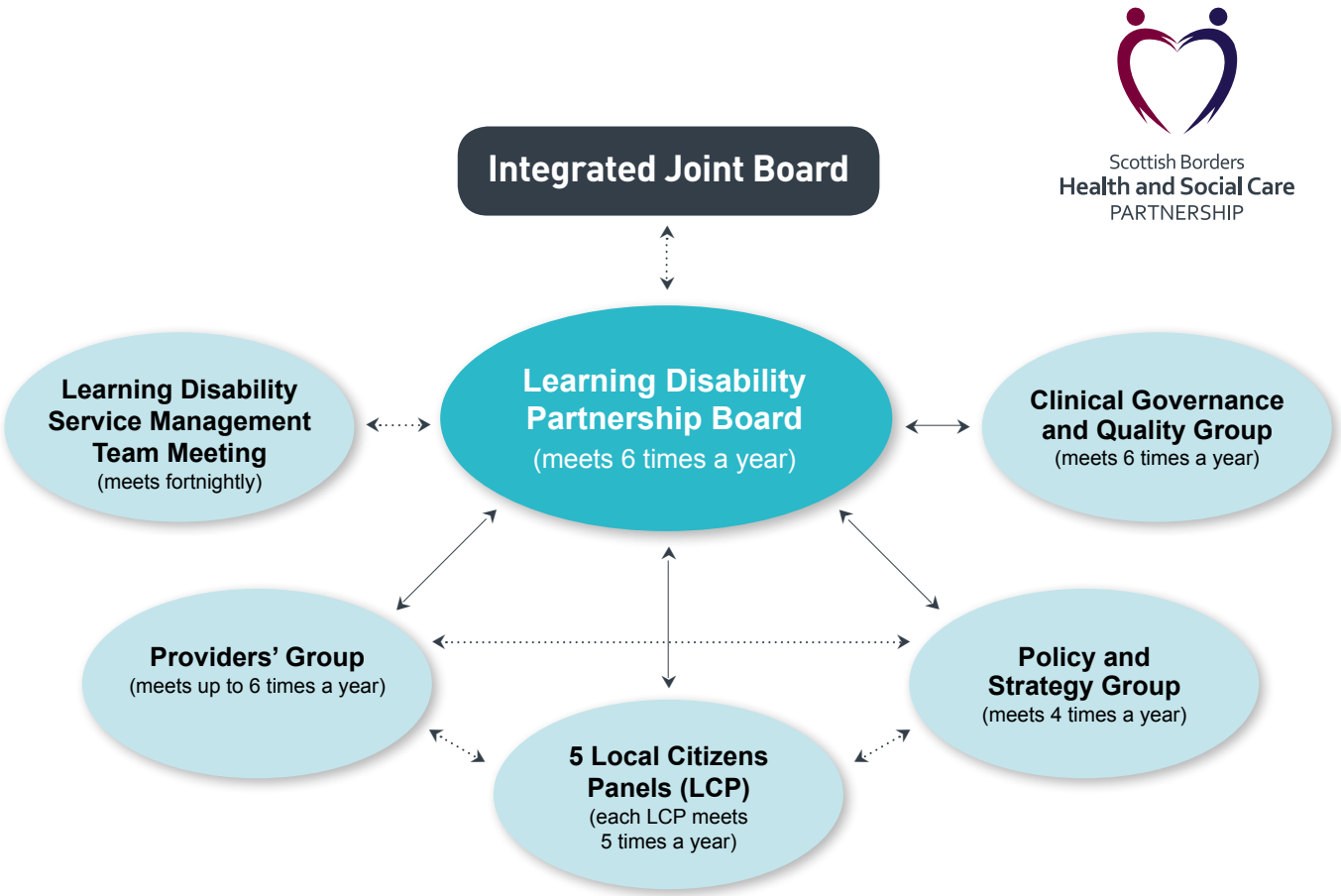
- There have been changes in the way in which services to people with learning disabilities have been provided, through for example: the Day Opportunities Review, closure of local in-patient Learning Disability beds, re-provisioning of the majority of care home service provision.

- The re-organisation of the Learning Disability Service governance structure, in 2013, enables providers and people with Learning Disability and their carers to have a greater influence in decision making, as members of the Learning Disability Policy and Strategy Group and the Learning Disability Partnership Board.

- There has been an intentional shift towards providers and most importantly people with Learning Disability and their carers having greater inclusion and influence. The development of the Local Citizen Panels, from a central panel to a locality model has enabled people to be more active participants in their local communities with total membership currently at 66.

- Local Citizens Panels throughout the Borders provide opportunities for conversations between the Learning Disability Service, people with learning disabilities and family carers.

THE SCOTTISH BORDERS LEARNING DISABILITY SERVICE GOVERNANCE STRUCTURE



- Where appropriate, changes in the model of support from learning disability specialist care homes into supported living models of support and development of the growing supported living workforce through third sector partners have been proactively pursued.

- We recognise that there needs to continue to be a variety of accommodation and support arrangements available to meet needs of people within the Scottish Borders including care home support where appropriate. We are supportive of the National Care Home for Adults with Learning Disabilities national framework contract but also retain the right to look at local options.

- A Review of Learning Disability Short Breaks Provision took place in 2012 where some reorganisation of the model of delivery of respite services for people moved to a more flexible approach.

- A needs assessment was commissioned in 2012 to examine the current and projected needs of people with Learning Disabilities locally.

- The Learning Disability Service has invested in a Local Area Co-ordination service, locality citizen's panels, befriending and independent advocacy services and will continue to support this in the future. Support has been given to setting up social enterprises, Borders College training and skills development courses, Health Champions course and other supported learning. In 2016, Project Search will be launched.

- We can also signpost individuals and families to a range of other local opportunities and services. These include Interest Link Borders, a befriending service part-funded by the Learning Disability service which works with around 150 adults with learning disabilities each year.

- The promotion of health and wellbeing must be a consistent thread through the commissioning process, to emphasize the role of services providers and Carers in getting the best health outcomes for people with learning disability. A Healthier Me pathway is promoted throughout all Provider Services.

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

4. COMMISSIONING SERVICES

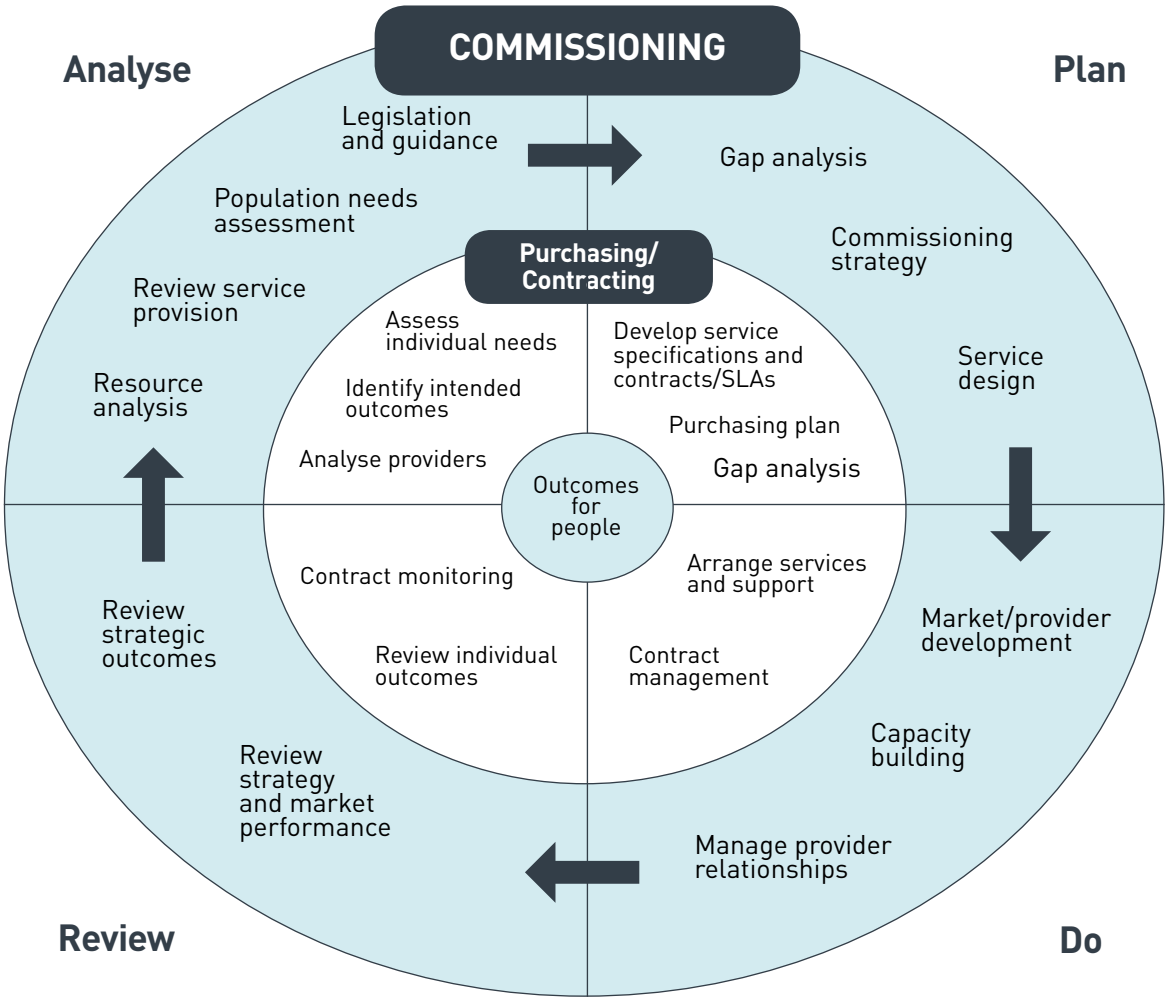
Scottish Borders Learning Disability Service commissions a range of services to support people with learning disabilities and their carers in the Scottish Borders and is responsible for writing this Strategic Commissioning Plan.

When commissioning the range of services required, support provided by Scottish Borders Council Procurement Service will ensure that robust procurement processes are implemented where Scottish Borders Council fund all or part of a package.

All services commissioned by the Scottish Borders Learning Disability Service are undertaken in line with the principles of **The Public Contracts (Scotland) Regulations 2015 and the new Procurement Reform 9Scotland) Act 2014**.[xii] The objective is to ensure that related procurement activity is transparent, fair and open in order to increase the sustainability and efficiency of public spending and to enable the Third Sector and small and medium-sized enterprises to participate in procurement opportunities.

Where a health funded service out with Scottish Borders is required, requests for funding must be reviewed in line with the NHS Borders' Extra Contractual Referral (ECR) process.

JOINT COMMISSIONING MODEL FOR PUBLIC CARE[xiii]



"Commissioning is commonly described as a cycle of strategic activities similar to that shown above.

In this model, based on that developed by the Institute of Public Care (IPC), the Commissioning cycle (the outer circle) drives purchasing and contracting activities (the inner circle), and these in turn inform the ongoing development of Strategic Commissioning.

"Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.

'Access to the options provided under the 2013 (Social Care) Act is of very little value if there

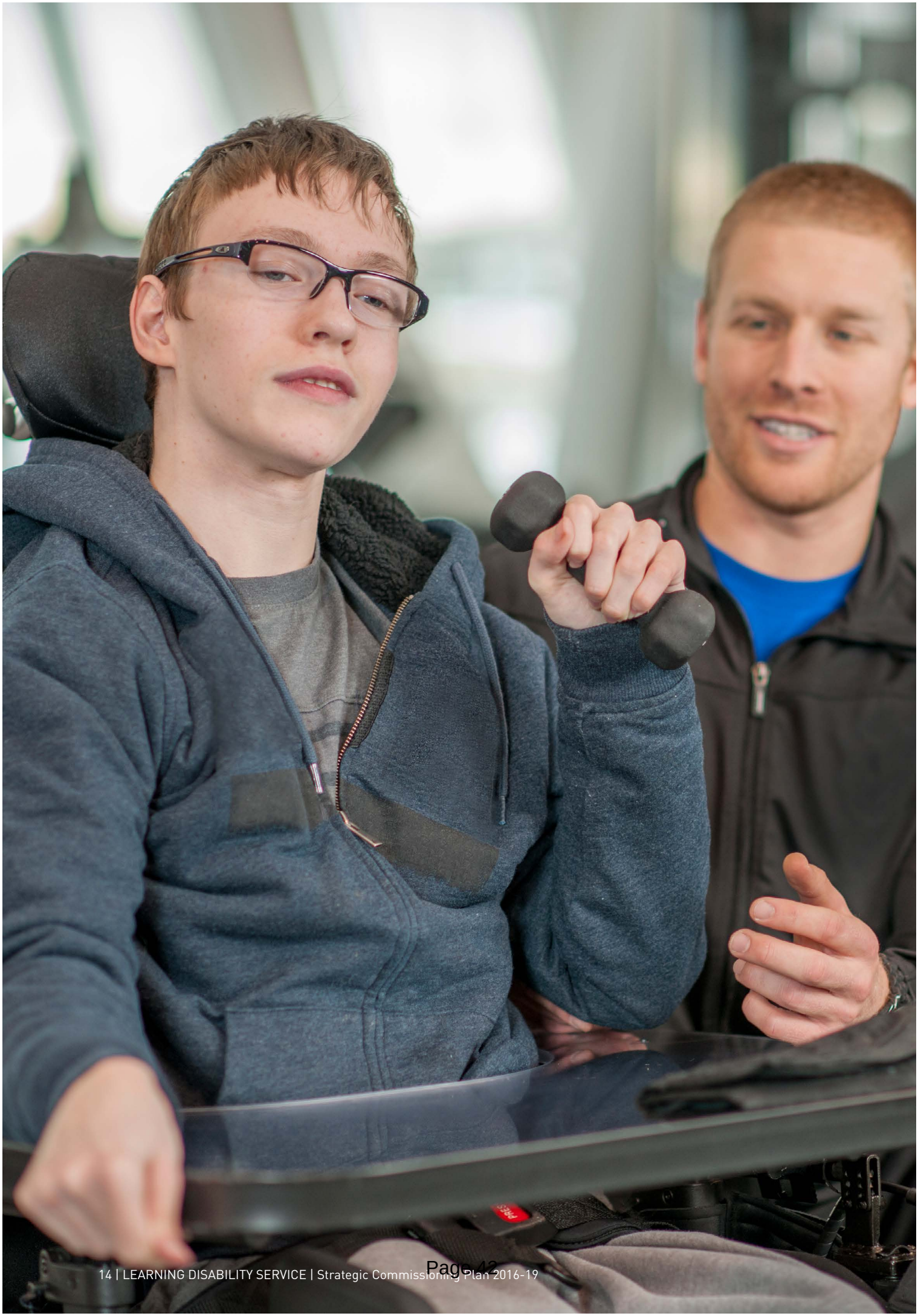
is a lack of variety of providers available or a lack of variety in the type of support on offer.' Statutory Guidance, 2014.

Commissioning involves facilitating choice and is set in a wide context that recognises the importance of community capacity building, prevention and universal services."[xiv]

The Procurement of Care and Support Services guidance issued by The Scottish Government and COSLA will underpin any approach taken and will be used as a guide for commissioners. The Learning Disability Service will ensure that the correct stakeholders are identified and involved in the procurement process.

Where National Frameworks are available the Learning Disability Service may access these frameworks where the services meet the needs of people with learning disabilities and their carers.

Traditionally, the majority of services commissioned by the Scottish Borders Learning Disability Service were mainly block funded and at times this approach had the potential to be restrictive due to the inflexibility of funding arrangements. While there is still a place for some services to continue to be funded in this way, the Learning Disability Service has always worked to ensure that supports have been commissioned in person centered ways as far as possible. The landscape has also changed with the introduction of a self directed support approach. Eligibility criteria for support is applied during assessment processes.



LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

5. SELF DIRECTED SUPPORT (SDS)

Self-directed Support is a major culture shift in the way health and social care services are delivered. The shift sees a move towards a more person centred and outcomes focused assessment of needs and delivery of services.

Social Care (Self-directed Support) (Scotland) Act 2013[xv]

The Act promotes an approach, and sets duties, in order to provide individuals with greater choice and control over their social care and health support.

The new duties include ensuring that the principles of dignity, involvement, informed choice, and collaboration are taken into account as part of assessment and support planning, and that people are offered a choice from the four options to manage their support and funding.

Innovation, Responsibility and Risk Enablement have been added to a **statement**[xvi] released in 2014 to reflect the opportunity for creative and flexible approaches to care and support.

The 4 SDS options are:

OPTION 1
To have a direct payment i.e. the person or their guardian, chooses to receive a budget and manage their own support.

OPTION 2
To oversee the support but not hold the money e.g. choose a provider to provide support and hold the money. This is called an individual service fund.

OPTION 3
To let the local authority select and make arrangements for support.

OPTION 4
A mix of the above options.

SDS is aimed at providing individuals greater choice and control over their social care and health support. It is not aimed at individuals requiring emergency hospital admission and therefore individuals are not able to use SDS within the healthcare system.

Easy read versions of the options are available from the Learning Disability Service.

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

6. WHO WE CONSULTED IN DEVELOPING THIS COMMISSIONING PLAN

We consulted with a range of people including people with learning disabilities, carers, provider organisations, staff from the integrated learning disability service, and others in a variety of ways including: one to one conversations, meetings, documents drafts, focus groups to inform and then shape this document. A summary of this is outlined below.

SUMMARY

WHO WE CONSULTED	DATE	METHODS OF CONSULTATION
Scottish Borders Learning Disability Service Policy and Strategy Group	2015-2016	Meetings Strategy document drafts
Scottish Borders Learning Disability Service Partnership Board	2015-2016	Meetings Strategy Documents
Borders Carer Centre	Sept 2015 Feb 2016 May 2016	Involvement through Policy and Strategy group
Scottish Borders Providers Group	Nov 2015 Feb 2016	Meetings Strategy document drafts
Local Citizens Panels	2014 Nov 2015 Feb 2016	Meetings, focus groups
Borders Voluntary Care Voice	Jan 2016	Strategy document drafts
Scottish Borders Learning Disability Service	Feb 2016	Meeting Strategy document drafts
Borders Independent Advocacy Service	June 2016	via drafts to LD Partnership Board and Policy and Strategy Group
3rd sector partnership	June 2016	Document Drafts
Scottish Borders Learning Disability Service Partnership Board	Oct 2016	Document Drafts
NHS Borders Commissioning Team	Oct 2016	Document Drafts
Commissioning and Implementation Delivery Group (Scottish Borders Health and Social Care Partnership Governance)	Nov 2016	Final draft to Commissioning, Development and Implementation Group
NHS Borders Clinical Strategy Group	Jan 2017	Final draft
Scottish Borders Council People Department Management Team	Jan 2017	Final draft

Local Citizens Panels

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

7. WHAT PEOPLE TOLD US

LOCAL CITIZENS PANELS

The **Local Citizens Panels** were established in 2013, as part of the learning disability governance structure and have an active local community presence. They are based in 5 localities in the Scottish Borders and meet 5 times a year. They are for people who have a learning disability and/or care for a family member who has a learning disability.

Being a panel member means that you can:

- help to make sure that learning disability services meet your needs
- raise concerns about services so that improvements can be made
- take part in consultations about services and give feedback
- put forward ideas for things that will help improve quality of life for people with a learning disability
- work together with other groups to get things done
- get and share information about what is happening in learning disability services and in your local community.

Initially consultation took place at panel meetings in 2014 and 2015 around local priorities in relation to 'The keys to life' recommendations. Panel members told us their priorities for us to work on and an action plan was drawn up based on the 4 key strategic themes in line with the National themes:

- A healthy life
- Choice and control
- Independence
- Active Citizenship

Later in 2015 we consulted with the panel members regarding what was important to them in the commissioning plan asking 2 key questions:

- "What is important?"
- "What needs to change?"

This conversation continued at a 'Celebrating Citizens Panels' event in February 2016.

The key themes from these consultations fell into 6 broad areas which are picked up throughout the 2016-19 plans in the various sections that follow in this strategy:

LOCAL LEARNING DISABILITY SERVICE PROVIDERS

In the Scottish Borders, the local provider organisations have formed a Providers Group that meets 6 times a year. The Borders Learning Disabilities Services Providers Group aims to provide a forum to enable organisations providing services for people with learning disabilities in the Scottish Borders to work together in order to contribute to the strategic development and quality of those services.

A member of the Providers Group sits on the Learning Disability Service Policy and Strategy Group and has contributed to the first draft of the Strategic Commissioning Plan.
A workshop took place with Providers in January 2016 and changes were made to the first draft of the plan to reflect their input.

LEARNING DISABILITY SERVICE STAFF

The Learning Disability Service is staffed by a group of professionals and includes:

- Social work
- Learning disability nursing
- Occupational therapy
- Physiotherapy
- Dietetics
- Speech and language therapy
- Psychology
- Psychiatry
- Music Therapy
- Local Area Co-ordination

As a service we provide:

- assessment
- care management
- treatment
- specialist advice and consultation
- training and support

We are responsible for commissioning and monitoring support services for adults with learning disabilities who meet eligibility criteria, from other organisations.

A service development day took place in February 2016 with the whole Learning Disability Service. At this workshop the staff team made changes to the service's 3 year work plan which sits alongside this Plan.

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

8. EQUALITY IMPACT ASSESSMENT PROCESS

The learning Disability Policy and Strategy group carried out an initial **Stage 1** of an equality impact assessment in Oct 2015.

Stage 2 of the equality impact assessment was drafted and reviewed following engagement with relevant stakeholders at the end of June 2016.

The final draft of the Equality Impact Assessment was sent to the Commissioning and Implementation Delivery Group in November 2016, amended and taken to the Integrated Joint Board during final sign-off of this plan in June 2017 before being published.


Berwickshire
Tweeddale
Eildon
Cheviot
Teviot and
Liddesdale

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

9. LOCAL DEMOGRAPHICS

STATISTICAL INFORMATION[xvii]

In the Scottish Borders in 2013 there were 601 adults known to the Learning Disability Service including people with Autism. This equates to 6.3 adults per 1,000 population, calculated using 2013 mid-year population estimates (General Register Office for Scotland), with the average for Scotland being 5.9 per 1,000 population. At the outset of writing this document, we used data collated for the Scottish Commission for Learning Disabilities obtained by the Learning Disabilities Statistics Scotland and published in 2014. This information has not changed in any considerable way for Scottish Borders.

TABLE 1: NUMBERS AND RATES OF PEOPLE WITH LEARNING DISABILITY IN SCOTLAND, 2013 IN SOUTH EAST AND TAYSIDE (SEAT) REGION[xvii]

LOCALITY	NO. OF ADULTS KNOWN TO LAS	ADULTS KNOWN PER 1000 [xvii]POPULATION
Scottish Borders	601	6.3
Fife	1,321	4.4
Clackmannanshire	269	6.4
Falkirk	918	7.1
Stirling	441	5.8
East Lothian	710	8.6
Midlothian	596	8.7
West Lothian	774	5.5
Scotland	26,236	5.9

Table 2 below identifies the age brackets of adults with Learning Disability known to Borders and the percentage of the total number of people within the defined age brackets.

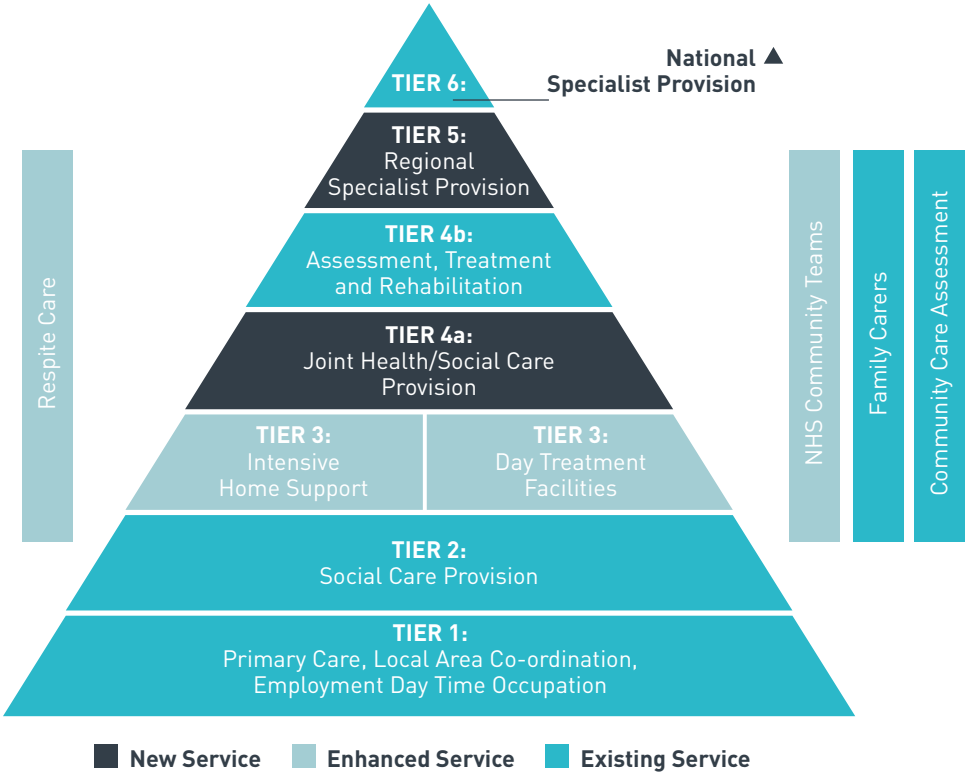
TABLE 2: MEN AND WOMEN WITH LEARNING DISABILITIES KNOWN TO LOCAL AUTHORITIES, BY LOCAL AUTHORITY AREA 2013[xvii]

BORDERS	16-17	18-20	21-34	35-44	45-54	55-64	65 +	NOT KNOWN	TOTAL
Male	7	27	106	57	66	48	32	0	343
Female	0	22	70	45	39	39	42	0	258
%	1.2%	8.2%	29.3%	17%	17.5%	14.5%	12.3%	0	
Scotland									
Male	344	1,457	5,286	2,287	2,696	1,936	1,339	37	15,382
Female	127	685	3,255	1,748	2,090	1,532	1,389	28	10,826

In 2012, as part of a review of Learning Disability services in the Borders a needs assessment[xviii] was commissioned and a mapping exercise took place, identifying the type of support arrangements people needed against the South East and Tayside (SEAT) Models of Care. This review also found that English studies have suggested that the numbers of people with a learning disability is most likely to be higher than those known only to the Learning Disability Service. This has implications for housing and support into the future with the Borders' prevalence rate likely to be an underestimate of the true population prevalence. Some people with a Learning Disability will not be known to the Learning Disability service because they have not been identified or diagnosed as having a Learning Disability. Undiagnosed people are more likely to be people with a mild Learning Disability because the majority of people with more severe Learning Disability's would require health and social care input and be known to services.

LEARNING DISABILITY MCN CONCEPTUAL MODEL OF CARE

TABLE 7: CONCEPTUAL MODEL OF CARE[xix]



In the Scottish Borders, we adapted this model of support to fit our local situation.

TIER 1 is viewed as people living within their own homes completely independently or with family support. There may be support from the Learning Disability service in the form of local area co-ordination, day time opportunities or supported employment.

TIER 2 locally is split into 2a and 2b. 2a refers to people who live in supported accommodation. Tier 2b is for those living in supported accommodation but within significantly enhanced models of support – locally labelled as Intensive Support Services.

TIER 3 There are no buildings-based day treatment facilities provided in Scottish Borders and so our local model does not include this

TIER 4A We currently fund some people, in this enhanced model of support but in out-of-area only placements. We do not currently have appropriate support and accommodation arrangements available to mange this level of support locally.

TIER 4B refers to Learning Disability specific inpatient hospital accommodation and support. These are all accessed out of the Scottish Borders if required.

TIER 5 is the SEAT regional specialist provision.

TIER 6 is National Specialist Service Provision.

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10. HOW WE MANAGE CONTRACTUAL ARRANGEMENTS

CONTRACTS

There are 21 Providers that Scottish Borders Council contract with in Scottish Borders and 19 Providers out with the Borders. The services range from Residential Care Homes, Supported Living (Care at Home & Housing Support), Day Opportunities and Grant Agreements for Day Opportunities/Social Enterprises and Independent Advocacy.

The outturn report on actual contract spend for Scottish Borders Council for people with learning disabilities in 2015-16 was £13,523,664 broken into three main areas of spend (this excludes the Learning Disability Social Work staff spend):

AREA SPEND	SPEND
Residential Care	£1,591,817
Supported Living	£8,969,107
Day Opportunities	£2,962,740

The Provider under the terms of the Contract will supply the Commissioner with monitoring information on an annual basis.

The information required will vary depending on the type of service but there are standard themes required as follows:

The majority of spending is based on spot purchasing arrangements.
Block contracts remain in place for a number of services.
We anticipate that there will be an increase in the future of the number of service providers offering Individual Service Fund arrangements.

Where health funding is required for all out of area placements these requests must be reviewed in line with NHS Borders Extra Contractual Referral (ECR) Process.

The ECR panel decision to fund a placement is made on an individual basis. Each case is anonymised and the information received by the ECR panel is in the main submitted by the referrer. The membership of the ECR panel consists of Senior Clinicians and Managers along with representation from finance.

Regular monitoring and updates are required for placements approved through the ECR panel. The frequency of monitoring and updates on these placements will be discussed on each individual basis as part of the decision making process.

ANNUAL CONTRACT MONITORING MEETING

The Provider and the Council aims to meet annually to review the commissioned service. The Annual Report for the previous year is submitted to the Council prior to the review meeting. The Annual Report for the service will detail the following information:

QUALITY

- Details of service delivery over the past year, detailing excesses, non-delivered services
- Service capacity
- Outcomes for service users and evaluation of the outcomes
- Staff training, development/understanding of national developments
- Service management, management changes or re-design
- Service developments, any new developments within the last year or any new developments for the future
- Comments & complaints

KNOWLEDGE & EXPERIENCE

- Details of Person Centred Planning
- Details of risk management strategies
- Evidence of promoting independence, community presence for service users
- Evidence of promoting health & wellbeing
- Details of the joint working approach with Learning Disability team and other agencies
- Strategies for staff training and development

CAPACITY

- Capacity to provide commissioned service and meet individual support plans
- Strategies for staff recruitment
- Staff retention
- Staff turnover in the past year

FINANCIAL

- Audited Accounts

In addition the Care Inspectorate reports and grades are monitored.

Meetings are held with Providers every 6 months, a Link Meeting with Managers and the relevant Care Manager/Link Person for the service followed 6 months later by a Contracts Meeting with the Team Leader/Budget holder and Contracts Officer to monitor the service against the Contract including information from the previous Link Meeting.

With the introduction of Self Directed Support (SDS) we have incorporated Individual Service Funds into the Service Contracts where applicable. Over the next two years we will assess the impact of SDS on Providers and services to inform commissioning of services beyond 2017.

Current priorities have been to work with Providers to ensure they are complying with the recent changes to the Employment Legislation regarding payment of sleepovers, holiday pay calculation, National Minimum Wage increases and National Living Wage increases.

2016-19 PLAN

Future areas for improvement are:

- assess impact of SDS on providers and services to inform commissioning beyond 2017
- improve the process for incorporating individual client outcomes from reviews into the overall monitoring information
- review all the Service Specifications to include Health and Wellbeing Outcomes and any other update required
- engage with local providers in the conversation around work force issues such as lone working, staff development and turnover
- review night time support arrangements with providers
- look at ways to improve upon collaborative working with providers to gain best outcomes for individuals.

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11. HOUSING AND MODELS OF SUPPORT

According to the Exploration of Housing Support Needs in the Scottish Borders (2010) [xx], while there is a range of support available for people with learning disabilities, there is a need for more flexible housing options which meets people's long term housing and health requirements (in terms of location, access and adaptations).
It is too simplistic to assume that those with "high" housing and/or support needs equates to the need for specialist accommodation. There will be a significant variation in the level and profile of learning disability-related needs across the Borders, including in terms of particular housing needs.

Those with medium/low needs are likely to live in mainstream housing with varying levels of support. Statistics in Table 3 show that 40.6% of people with Learning Disability in 2013 in the Borders lived in mainstream accommodation.

TABLE 3: ACCOMMODATION AND LIVING ARRANGEMENTS FOR PEOPLE WITH LEARNING DISABILITY IN BORDERS 2013

ACCOMMODATION AND LIVING ARRANGEMENTS	NO.	%
Person lives with family carer	208	34.6%
Person does not live with family carer	334	55.6%
Not Known	59	
Accommodation type	No.	%
Mainstream accommodation with support	25	4.2%
Mainstream accommodation with no support	36	6.0%
Mainstream accommodation: support status not recorded	183	30.4%
Supported accommodations	236	39.3%
Registered adult care home	59	9.8%
Other	5	0.8%
Not Known	58	9.7%

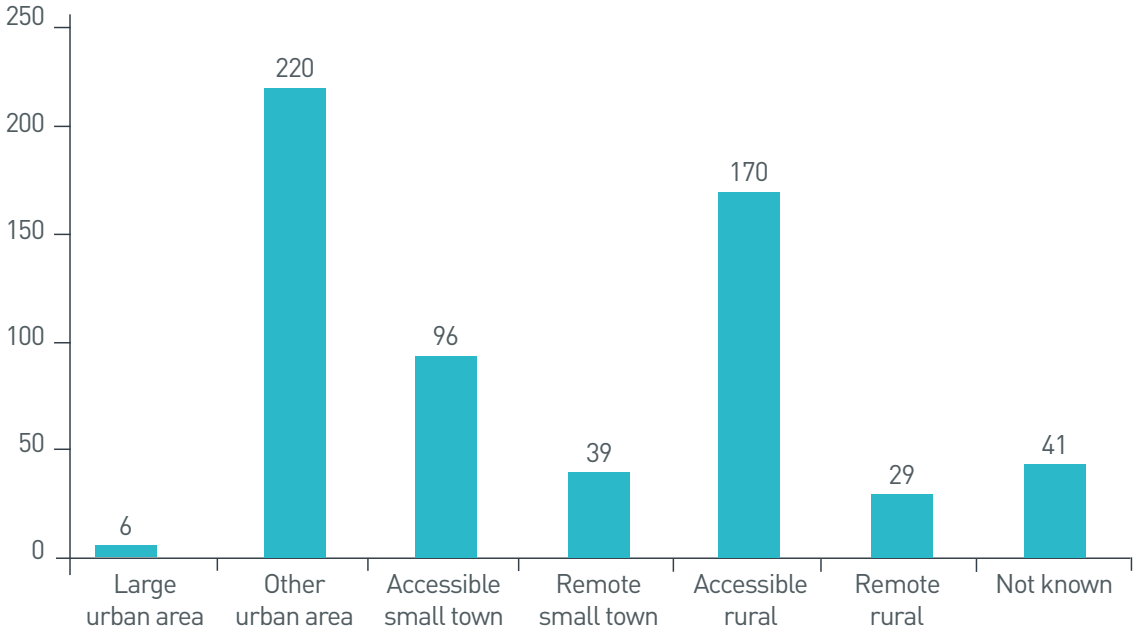
Those with high needs will include some requirement for specialist accommodation, but a proportion of people are likely to prefer independent living in mainstream accommodation. There is also an increasing expectation that more people with learning disabilities can live independently. This trend is supported by changes in family attitudes and services focusing on enablement work and continues from "The Same as You" 2000 implementation plans and 'The keys to life' 2013.

There is a range of evidence to suggest the number of people with learning disabilities may be increasing at a national level, because of a range of factors (including changes in the size and composition of the population, changes in the incidence of learning disabilities and changes in life expectancy among those with learning disabilities). There is likely to be changes in the profile, for example, a Lancaster University study makes specific reference to increasing numbers of older people with learning disabilities due to people with learning disabilities living longer. The study also mentions decreasing mortality for young people with learning disabilities (and complex needs) although people with learning disabilities still die on average 20 years before those in the general population (NHS Scotland, Health Needs Assessment 2004). As a way of addressing some of the above, the new 10 year strategy for people with Learning Disability in Scotland "The keys to life – improving quality of life for people with learning disabilities" 2013 was written. Within the 9 key themes are 52 recommendations which seek to address some of the issues faced by people with Learning Disability and their carers both at local and national levels. The Scottish Borders has devised an action plan to address these, which was collated by the Learning Disability service Policy and Strategy Group.

Many of the causes of learning disabilities may lead to physical and mental ill health. An individuals' profile of needs can vary significantly, and people with complex needs may have a combination of learning disability, physical disability and mental health needs. Some people may require specific specialised accommodation, or have very high support needs.

The Scottish Commission for Learning Disabilities publishes the Learning Disability Statistics Scotland dataset, previously known as eSAY. The Statistics Release 2013 provides information on the lives adults with learning disabilities lead and how these are changing over time. The release includes information on employment, further education, how people spend their days, housing, and who people live with. For the first time, the 2013 data was analysed against the Scottish Index of Multiple Deprivation (SIMD), which ranks small geographical areas of Scotland based on a number of measures of deprivation. The graph below shows the percentage of adults with Learning Disability known to Scottish Borders Council according to deprivation quintile.

URBAN/RURAL AREA CLASSIFICATION OF ADULTS WITH LD KNOWN TO SBC IN 2013



Data from the collection of postcodes for analysis of the urban/rural classification of areas in which adults with Learning Disability in Scotland live – Borders statistics.

The MCN model of care demonstrates that people's support needs are varied and their housing requirements are different.

Within the Scottish Borders, there is a need to provide a range of housing and support options for people with learning disabilities. These include specialist learning disability care home placements, supported living support options and enhanced supported living arrangements all within a variety of styles of accommodation.

TIER 4B SERVICES

NHS Borders closed the learning disability in-patient unit in 2006. Following closure of the unit if a patient with a learning disability requires an admission to hospital for assessment and treatment because of their learning disability the following options are considered in order of preference:

1. Huntlyburn – only suitable for people with a mild learning disability
2. Learning Disability Managed Care Network(MCN) (Lothian, Forth Valley or Fife)
3. NHS Scotland
4. Private hospital in Scotland or England

Since 2006, the service has rarely been able to secure a bed in the MCN or NHS Scotland and in the majority of cases has had no option but to admit people to private hospitals.

An option appraisal took place in 2014 to consider the options for the future for in-patient beds when needed. The preferred option was to consider purchasing beds from NHS Lothian in their redesigned service. Currently a business case is being drafted to reflect this and will be presented to NHS Borders Board and the Integrated Joint Board in 2016.

TIER 4A SERVICES

These services are usually funded jointly. There are no Tier 4a facilities within the Borders therefore clients who require this level of service are placed out of area. We are currently exploring what a local facility might look like. There have been some preliminary discussions with NHS Lothian and other local authorities. We need to consider all potential options including the feasibility of local options.

Health professionals on a regular basis review individuals in Tier 4a upwards. Individuals in Tier 2a and Tier 2b are picked up as part of the social work review process and capacity within the social work team means they may not have been reviewed on a regular basis however, systems are being implemented to attempt to address this.

Returning people to the Borders where appropriate is a high priority for the service however, for people out of area in Tiers 2a and 2b where Borders is no longer considered to be their home it may not be in their interests to return. For some of the individuals in Tier 4a there are no services in the Borders to meet their needs.

Individuals requiring health funded services are currently reviewed through NHS Borders Extra Contractual Referral process which is referred to in section 10.

IN AREA JOINT FUNDED

These placements are often joint funded 50:50 between NHS Borders and Scottish Borders Council and funding requirements are reviewed on an individual basis.

The individuals all live in their own home with support from a variety of social care providers. Cost of placements range from £50,000/year up to £170,000/year.

NHS FUNDED LEARNING DISABILITY PLACEMENTS – JUNE 2015

At June 2015, NHS Borders funded 35 places for people with a learning disability. This is detailed in Table 4.

TABLE 4: NHS BORDERS FUNDED PLACES FOR PEOPLE WITH A LEARNING DISABILITY

	IN AREA		OUT OF AREA	
	NHS Funded	Joint Funded	NHS Funded	Joint Funded
Tier 2a		9	9	
Tier 2b		6		3
Tier 4a				5
Tier 4b			2	
Tier 5			1	

TABLE 5: SCOTTISH BORDERS COUNCIL LEARNING DISABILITY FUNDED PLACES (OUT OF AREA)

	SCOTTISH BORDERS COUNCIL FULLY FUNDED PLACES OUT OF AREA	SCOTTISH BORDERS COUNCIL PART FUNDED PLACES OUT OF AREA (EXCLUDES THOSE JOINTLY FUNDED WITH NHS BORDERS)
Tier 2a	0	2
Tier 2b	6	0
Care Home place	3	0

MOVING ON FROM CARE HOME TO SUPPORTED TENANCIES WHERE APPROPRIATE

In 2014/15, the Learning Disability Service in partnership with housing and support providers successfully supported 23 people living within 3 local learning disability specific care homes to move on into supported living models of support within registered social landlord properties in their local areas. The care homes closed following these re-provision processes. This has been a shift in the balance of support provision, as part of the strategic direction for supporting people, in line with the '**Same as you**' and '**The keys to life**'

Two of the new properties had high levels of physical adaptations fitted to meet physical care needs. This strategic shift from care home support to supported living enables people with learning disabilities to obtain tenancies and maximise their incomes whilst having a greater community presence within bespoke packages of support. Non-competitive actions were undertaken to provide continuity of support for these people during these times of significant transition.

The rural nature of the Borders can place considerable pressure on visiting housing support services due to travelling time, and there is a requirement to supply core and cluster housing that provides a good housing option for some clients, combined with a more efficient model of supported housing. The Council and NHS Borders continues to house a small number of people out of area where highly specialised housing and support services do not exist locally to meet the needs of some individuals.

We currently commission services for a small number of people with more intensive support needs who cannot be supported in mainstream supported living models of support.

PEOPLE WHO MAY OR HAVE OFFENDED

There will continue to be a need to provide specialist housing and support for people with learning disabilities who have offended, or may offend. There are constantly changing demands linked to the criminal justice system. There is a need for access to appropriate, affordable housing to allow maintenance of a safe and secure home life, balancing risk management and protection of the individual and the wider community. There needs to be flexibility to manage changing needs and risks within the philosophy of least restrictive approaches.

LIVING WITH FAMILY CARERS

Over a third (34.8%) of adults with learning disabilities in Scotland known to local authorities were reported as living with a family carer in 2013. The local statistics show this to be the case for 34.6% of the known Learning Disability population of adults living in the Scottish Borders.

55.3% of adults with learning disabilities in Scotland known to local authorities were the only person with learning disabilities in their accommodation compared to 70.7% in the Scottish Borders. 21.8% of adults with learning disabilities in Scotland known to local authorities live with at least one other person with learning disabilities. In the Borders this equates to 27.3% of people.

TABLE 4: ADULTS WITH LEARNING DISABILITY LIVING IN THE SAME ACCOMMODATION

	ADULTS WITH LEARNING DISABILITY LIVING IN THE SAME ACCOMMODATION				
BORDERS	Only person	1-3	4+	Not known	All Adults
	425	87	77	12	601
	70.7%	14.5%	12.8%	2.0%	

SUMMARY

The needs of people with learning disabilities in the Borders are varied and complex. There is a requirement to be flexible in approach to accommodation types and to recognise the importance of independence in living and the implications for adaptations and assistive technology to support this. Changes to welfare benefits may have some implications for people with learning disabilities and their families living in properties where either a person received sleepover support in the past and no longer requires this or additional space is required due to essential equipment required. It is important to include people with Learning Disability and their families in decision around housing as noted in Recommendation 29 of 'The keys to life'.

2016-19 PLAN

- consider models of care for development at Tier 4a
- build on the business case to consider the purchase of beds at Tier 4b from NHS Lothian
- progress plans to repatriate any people identified as appropriate to return to Borders
- improve upon current performance of numbers of reviews for all placements
- increase the uptake of Carers Assessments
- ensure carers are signposted for support and are aware of their rights
- in line with the Carers Act ensure carers are supported to make emergency plans
- recognise carers as "Partners in Care"
- evaluate the Intensive Support Service
- develop the local Behaviours that Challenge pathway to ensure that learning disability staff and support provider staff are equipped to support people appropriately in place.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12. PATHWAYS

There are a number of established local pathways to support people with learning disabilities in the Scottish Borders. Some of the pathways have overt commissioning responsibilities within them. Further information about how we will look at two of these pathways is noted below and in **section 13**.

PEOPLE WITH DEMENTIA

Within the Scottish Borders, there is an overarching Dementia Pathway with two sections specifically written to meet the needs of people with a learning disability.

The diagnostic pathway (**Appendix 2**) has two routes of access and is scrutinised through performance reporting by the Learning Disability Service into NHS Borders.

The 2nd pathway (**Appendix 3**) is a post diagnostic support pathway and is based on **Alzheimer Scotland's pillars of support model.**[xxvii]

A mapping exercise was undertaken within the Learning Disability service to identify people with a learning disability on the Learning Disability Dementia Pathway which includes people diagnosed with a dementia, or on the proactive pathway for screening and projected the potential future changes needed in their housing and/or support arrangements as part of the future demand on services.

Within the Learning Disability service there is a multi agency Dementia Group who monitors compliance with the pathways.

2016-19 PLAN

- ensure compliance with the dementia diagnostic pathway and monitor through Performance Scorecard
- finalise the Learning Disability Post Diagnostic Pathway and ensure that all people with Learning Disability newly diagnosed in Scottish Borders receive one year's post diagnostic support in line with the HEAT target (health improvement, efficiency, access and treatment)
- look at housing and support options for people with dementia and those who are frail.

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13. YOUNG PEOPLE MOVING INTO ADULT SERVICES – TRANSITIONS

In the Scottish Borders currently there are 93 young people with a learning disability actively tracked through the Transitions Tracking Group, a multi agency group looking at the needs of young people with learning disabilities who may require adult services support. Their ages range from 13-19 years.

The needs of these young people are very varied, from minimal or very low level to extremely complex needs arising from a mix of behaviours that challenge and /or profound learning disability and associated health and social care needs.

Currently we anticipate that we will find it very challenging to provide appropriate support within the Scottish Borders for a number of these young people.

We recognise that the pathway of transition into adulthood is often unclear with families finding the transition to adult services scary and difficult to navigate.

An interagency transitions steering group meets monthly to look at making improvements in the Transitions pathway and a successful bid to the Integrated Care Fund in 2015 enabled us to recruit to a Transitions Development Worker post in 2016 for 1 year to look at specific areas for development. Association for Real Change (ARC) Scotland have become partners in this work with us and will support the developments over a 3 year period.

We aim to promote and improve upon delivery of work within transitions for young people and their families in line with the 7 Principles of Good Transition 2[xxi] as outlined by the Scottish Transitions Forum 2014 below:

1. All plans and assessments should be made in a person-centred way
2. Support should be co-ordinated across all services
3. Planning should start early and continue up to age 25
4. Young people should get the support they need
5. Young people, parents and carers must have access to the information they need
6. Families and carers need support
7. Legislation and policy should be co-ordinated and simplified

2016-19 PLAN

- recruit to 1 year Transitions Development Worker Post in 2016
- progress transitions pathway development 2016-17
- continue to monitor progress of young people in transition through Transitions Tracking Group and Complex Care Group
- make recommendations for improvements, implement these and then review in 2018
- look at housing and support options for young people in transition
- involve carers as "Partners in Care" and ensure that the needs of carers are taken into account during planning
- contribute to the development of **Principles of Good Transitions 3**[xxviii] in 2016/17

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14. LOCAL AREA CO-ORDINATION

Local Area Co-ordination (LAC) is an asset-based approach that aims to build inclusion by working with individuals and families to connect to their local communities, and working with communities to develop their capacity for inclusion.

The LAC team work on the fundamental principle that everyone has the right to have a full, valued and meaningful life as members of their local community and to have equal access to opportunities offered in the local community.

The team covers the whole of the Scottish Borders area and each LAC is rooted in the local community in which they operate.

In 2014, 287 people used the LAC service = 47.4% of people known to the Learning Disability Service.

Our focus is on personal outcomes and aspects that contribute to a good quality of life such as:

- having friendships/relationships
- developing skills and abilities
- building confidence and develop strengths
- having a sense of belonging
- having meaningful opportunities & roles
- increased independence
- challenging social exclusion and discrimination
- promoting good health & well-being
- supporting people to develop their individual capacity
- Social capital
- reduce social isolation.

Taking a community development approach, the LAC model has a fundamental focus on community as sources of mutual support, creative solutions and inclusive spaces, as well as offering opportunities for individuals to make a contribution and so bring about positive change.

The focus is on supporting individuals to access mainstream, universal opportunities and resources with the aim of reducing inequalities and building stronger local communities that are able to include everyone.

The LAC team also have a key role in developing the availability of opportunities in local communities and work in partnership with a wide range of organisations, agencies and community groups to develop these.

Most recently, with support from clients, we have established local **Boccia**[xxii] groups across the Borders. Boccia is a Paralympic sport closely related to bowls but played by competitors with a physical or learning disability from a sitting position.

A co-productive approach is fundamental to the work of the LAC team; the commitment and enthusiasm of people with a learning disability in terms of sharing their experiences, delivering training, running Boccia courses etc. are all crucial in enabling the LAC team to continue to broaden its work and expand the opportunities available to people in local communities.

We can also signpost individuals and families to a range of local opportunities and services.

There is a focus on prevention and early intervention. Input from the LAC team can delay or prevent the need for more intensive levels of support.

LAC contributes to a wide range of LD service work streams.

2016-19 PLAN

- increase Independent travel training
- work with colleagues across the learning disability service to look to develop a weight management 'clinic'
- increasing role in supporting Local Citizen Panel (LCP) members to take ownership of their own panel
- continue to embed **'A Healthier Me'**[xxiii] pathway across the work of the LAC service
- continue to support the development of Boccia groups across the Borders
- support Health Champions to engage with peer support agenda
- consider the health and well-being of carers
- increase awareness of carer information pack and Carers Assessment.

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15. EMPLOYMENT AND VOLUNTEERING

People with learning disabilities in the Scottish Borders continue to struggle to find employment and volunteering opportunities. A consultation in February 2015 sought to understand what some of the barriers to work and volunteering faced by people with learning disabilities living locally are. Some of the issues faced are addressed through, for example, access to appropriate skills based courses with Borders College, engagement with local area coordinators throughout 5 localities in the Borders, better links with Volunteer Borders, development of Social Enterprises, use of Employment Support Service.

The recommendations from the consultation are outlined below:

1. Local Area Co-ordination Service should continue to offer support to people with learning disabilities to find volunteering opportunities within their local area.
2. Support for people in paid employment needs to be tailored to each individual and not time limited. Having someone on the end of a phone is very reassuring. This should be in place for as long as the person needs it.
3. There should be more employment opportunities for people who only want to work a few hours every week (less than 8) to build skills and confidence as current eligibility for Employment Support Criteria is too high for some people.
4. Transport issues must always be addressed at the earliest opportunity and improvements made to public transport services.
5. Training for work schemes should continue to be available but linked to opportunities for real jobs at the end.
6. Accessible information about welfare benefits needs to be available to people with learning disabilities to support them to make informed choices about work and volunteering and the impacts on their benefits.
7. NHS Borders, SBC, Borders College should continue to explore the possibility of making Project Search available as an opportunity for people with LD to gain work skills through this internship program.

2016-19 PLAN

- establish a working group to take forward the recommendations in the local Work and Volunteering Report (2015)
- review the progress of social enterprises locally
- establish better links with Volunteering opportunities for people to develop skills which may make them more 'work ready'
- pilot Project Search, starting September 2016
- involve carers in the planning and design of services.

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16. SHORT BREAKS

Following the review of short breaks and respite for people with learning disabilities in 2012 a report was taken to the Social Work and Housing Committee at Scottish Borders Council in March 2013. The Committee recommended some further consultation to try to elicit more information.

As a result of this an easy read version of the report was developed and some additional questions in accessible formats created. This consultation confirmed areas for development and noted what people said was important, including the need to have a range of short breaks available to them locally.

There is a small range of short breaks options available to people with learning disabilities and their family carers.

These include:

- ARK short breaks
- Garden Villa Care Home
- Day time opportunities
- Out of area placements in specialist centres
- People using direct payments to choose own accommodation and take own support

It is important that the needs of carers are recognised and that that they have access to short breaks and respite. Respite needs to be regular and planned for many carers. There are a range of funding sources available if carers do not meet Scottish Borders Council eligibility criteria and these can be sourced via a Carers Assessment. It is important when supporting emergency planning that plans for crisis respite is included.

2016-19 PLAN

Future areas for improvement are:

- review recommendations of 2012/13 review of short Breaks
- explore other options for short breaks locally
- provide signposting of short breaks in neighbouring authorities and boards
- explore availability of respite for carers
- review Flexible short breaks service in 2017-18 and complete by Autumn 2018.

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17. DAYTIME OPPORTUNITIES

When we refer to daytime opportunities we mean weekdays, weekends and evenings.

We understand that people with a learning disability, and family carers on their behalf, want to be able to access a range of meaningful opportunities.

We commission a range of daytime opportunities:

- Social enterprises
- Borders College
- Support with employment and volunteering.
- Our LAC service supports people to engage in a range of activities and opportunities within local communities and to work with partners to develop opportunities in local communities across the Borders.
- We also have day services provided by SB Cares in Hawick, Duns, Kelso, Jedburgh and Peebles. Cornerstone provides day services in Galashiels.
- We use the Royal Voluntary Service Social Centre in Galashiels for some older adults with a learning disability.
- We can also signpost individuals and families to a range of local opportunities and services. These include Interest Link Borders, a befriending service part-funded by the Learning Disability Service which works with around 150 adults with learning disabilities each year.

All of these opportunities provide scope for people to keep contact with their friends and build relationships.

The Day Opportunities Review, undertaken between 2011-2014, drove forward a focus on supporting individuals to access opportunities within their own local communities. The review also re-focussed day service provision for individuals with high-level needs as well as providing carer support and respite.

We will review how day service providers continue to support individuals to develop their skills and confidence and enable people to access a range of community based opportunities. Where appropriate we will support people to move on from day services.

We want to continue to ensure a balance between buildings-based day services and a range of community-based alternatives.

2016-19 PLAN

- we will undertake an evaluation of social enterprises
- we will continue to monitor and review, through link and contract meetings, all commissioned day services
- we will look at the impact of SDS in relation to choices made around day time opportunities
- we will continue to liaise closely with Borders College
- evaluate the impacts of the day opportunities review
- understand and measure the impact of day service provision.

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

18. ADVOCACY SERVICES

The Learning Disability Service is committed to ensuring that advocacy services are made available to people with learning disability at point of need. Advocacy can take many forms as demonstrated in the table below.

Locally the Learning Disability Services commissions service from Borders Independent Advocacy Service to provide Independent Advocacy to adults.

"Independent advocacy is about speaking up for an individual or group. Independent advocacy is a way to help people have a stronger voice and to have as much control as possible over their own lives. Independent Advocacy organisations are separate from organisations that provide other types of services."[xxvi]

PEOPLE RECORDED AS USING AN ADVOCACY SERVICE IN 2014

TYPE OF ADVOCACY	NUMBER OF PEOPLE
Professional advocate	96
Self advocacy	5
Group/collective advocacy	29
Total	21% of adult LD population


› GOOD SUPPORT
› BE INDEPENDENT

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

19. PLANS MAPPED AGAINST NATIONAL AND LOCAL STRATEGIC OUTCOMES

The National Health and Wellbeing outcomes are high-level statements of what health and social care partners are seeking to achieve through integration and the improvements in the health and social care sector.

The Scottish Borders Local Strategic objectives are a summary of what the Scottish Borders Integrated Partnership is seeking to achieve through Strategic Planning processes, working in partnership with local communities.

We have mapped this Learning Disability Strategic Commissioning Plan against these to show where the plans fit with these national and local outcomes and the expected impact of achieving these.

This is found in **Appendix 4.**

LEARNING DISABILITY SERVICE
STRATEGIC COMMISSIONING PLAN 2016-19

20. SUMMARY

Our shared vision is that adults with learning disabilities will have opportunities to live as independently as possible as valued members in their local communities.

We recognise that in order for this to be realised, we have responsibilities to commission packages of support for some people. This Strategic Commissioning Plan has outlined the journey the Scottish Borders Learning Disability Service has travelled over the past 10 years in the context of a changing health and social care landscape.

The themes highlighted in this document were identified as important by people with learning disabilities and their carers as well as Provider organisations and other key stakeholders. Areas for development are reflected in the 2016-19 plans.
These high-level plans have been mapped against the National Health and Wellbeing Outcomes and the Local Strategic Plan to ensure that they fit the overall direction that our local Health and Social Care Partnership is travelling.

It will be the responsibility of the Learning Disability Service Policy and Strategy Group to capture progress on these plans and report to the Learning Disability Partnership Board 6-monthly. This group will also look at ways of demonstrating the impact of these plans and will seek feedback from people with learning disabilities and their carers.

Susan E. Henderson
Planning and Development Officer
Scottish Borders Learning Disability Service

APPENDICES

Appendix 1: Policy Drivers
Appendix 2: Dementia Diagnostic Pathway (Learning Disability)
Appendix 3: Post Diagnostic Pathway Dementia (Learning Disability)
Appendix 4: Plans mapped against National and Local Outcomes

APPENDIX 1
POLICY DRIVERS

Legislation and Policy relevant to the delivery of services for people with learning disabilities in Scotland over the last decade. This list is based on an original list compiled by Mary O'Toole, Scotland Excel and is not exhaustive.

THE HUMAN RIGHTS ACT 1998

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to including the right to life, freedom from torture or degrading treatment, liberty and security, slavery and forced labour, respect for private and family life, home and correspondence; freedom of thought, belief, religion and expression; the right to marry and start a family, to be protected from discrimination and peaceful enjoyment of property; right to education and to participate in free elections.

SCOTTISH EXECUTIVE (2000) THE SAME AS YOU? A REVIEW OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

The review provided the framework for the development of supports and services for people with learning disabilities in Scotland. The review had 29 recommendations and acted as a blueprint for services over the subsequent 10 years.

SCOTTISH EXECUTIVE (2002) PROMOTING HEALTH, SUPPORTING INCLUSION - THE NATIONAL REVIEW OF THE CONTRIBUTION OF ALL NURSES AND MIDWIVES TO THE CARE AND SUPPORT OF PEOPLE WITH LEARNING DISABILITIES

A national nursing review of the contributions required from all nurses and midwives to meet the health needs of children and adults with learning disabilities, to improve health and support inclusion.

SCOTTISH EXECUTIVE (2003) WORKING FOR A CHANGE? THE SAME AS YOU? NATIONAL IMPLEMENTATION GROUP REPORT OF THE SHORT-LIFE WORKING GROUP ON EMPLOYMENT

In June 2001 the Scottish Executive set up the National Implementation Group to oversee the implementation of the 29 recommendations in 'The same as you?' The group decided on three priority areas which it considered would have a significant impact on quality of life for people with learning disabilities. This is the final report of the short-life working group on employment for people with learning disabilities.

NHS HEALTH SCOTLAND (2004) HEALTH NEEDS ASSESSMENT REPORT. PEOPLE WITH LEARNING DISABILITIES IN SCOTLAND

The Health Needs Assessment was undertaken in response to the first recommendation of Promoting Health, Supporting Inclusion: The National Review of the Contribution of All Nurses and Midwives to the Care and Support of People with Learning Disabilities. The recommendations within the Health Needs Assessment Report are aimed at reducing health inequalities, to promote social inclusion and are

SCOTTISH EXECUTIVE (2006) CHANGING LIVES: REPORT OF THE 21ST CENTURY SOCIAL WORK REVIEW

Report of the recommendations made by the 21st Century Social Work Review Group for the future of social services in Scotland. Services need to be open to 'developing the aspirations of people with learning disabilities, and must protect those who may be vulnerable from bullying and challenging behaviour'.

NHS QUALITY IMPROVEMENT SCOTLAND (2006) LEARNING DISABILITY SERVICES - A NATIONAL OVERVIEW

The report looks at the progress towards the implementation of the Quality Indicators, which were published in February 2004. These reports have information on NHS services and on the progress that has been made towards the closure of learning disability long-stay hospitals.

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES 2007

UK government sign the agreement ensuring that the rights of disabled people are respected and upheld and they will not be treated differently or unfairly because of their disability.

SCOTTISH EXECUTIVE (2007) BETTER HEALTH, BETTER CARE

This Action Plan places emphasis on prevention and health inequalities, particularly health inequalities experienced by people with learning disabilities.

ADULT SUPPORT AND PROTECTION (SCOTLAND) ACT 2007

Legislation to better protect adults at risk of harm.

OPSI (2007) PROTECTION OF VULNERABLE GROUPS (SCOTLAND) ACT 2007 ASP 14

The act bars certain individuals from working with children or certain adults; requires the keeping of a list of those individuals and to establish a scheme under which information about individuals working or seeking to work with children or certain adults is collated and disclosed.
Equality Act 2010 – (add hyperlink)

The act sets out the different ways in which it is unlawful to treat someone, including direct or indirect discrimination, harassment, and victimisation and failing to make a reasonable adjustment for a disabled person. It prohibits unfair treatment in the workplace when providing goods, facilities or services when exercising public function.

EQUALITY ACT 2010

Equality Act 2010 legally protects people from discrimination in the workplace and wider society, replacing previous legislation.

CARING TOGETHER – THE CARERS STRATEGY FOR SCOTLAND 2010-2015

Sets out 10 key actions to improve support for carers.

PATIENTS RIGHTS (SCOTLAND) ACT 2011

The Act gives all patients the following rights:
that the health care people receive should consider their needs, consider what would be of optimum benefit to them, encourage them to take part in decisions about their health and wellbeing, and provide information and support for them to do so.
to give feedback (both positive and negative) or comments, or raise concerns or complaints about the health care they have received.
access for patients and members of the public to an independent Patient Advice and Support Service (PASS) which will provide information and help raise awareness and understanding their rights and responsibilities when using health services.

PUBLIC SERVICES (CHRISTIE) COMMISSION (2011)

The Christie report states that "public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve" with specific recommendations including

a new set of statutory powers and duties, common to all public service bodies, focussed on improving outcomes. These new duties should include a presumption in favour of preventative action and tackling inequalities.

Making provision in the new Community Empowerment and Renewal Bill to embed community participation in the design and delivery of services.

Forging a new agreement between the Scottish Government and local government to develop joined-up services, backed by funding arrangements requiring integrated provision.

Applying commissioning and procurement standards consistently and transparently to achieve competitive neutrality between suppliers of public services

HOUSING (SCOTLAND) ACT 2006, ADVISORY GUIDANCE FOR LOCAL AUTHORITIES, PRIVATE RENTED HOUSING (SCOTLAND) ACT 2011

The Act sets out the role for the Housing section including the provision of information and advice on housing options, facilitating or directly providing fit for purpose housing that gives people choice and a suitable home environment, providing low level preventative services, building capacity in local communities and through strategic housing planning contributing to shaping the market.

THE KEYS TO LIFE: IMPROVING QUALITY OF LIFE FOR PEOPLE WITH LEARNING DISABILITIES 2013

A strategy for the next 10 years to drive an attitudinal and cultural shift in supporting people to live healthier and happier lives with an emphasis on health practice and outcomes and partnership working between statutory organisations, the private and third sector and people with learning disabilities and their carers. There are specific sections on commissioning, health, independent living, shifting the culture and keeping safe, breaking stereotypes, people with profound and multiple learning disabilities, criminal justice, and complex care.

COMMUNITY PLANNING AND SINGLE OUTCOME AGREEMENTS (SOA) (2012)

A requirement for each Community Planning Partnership (CPP) to enter into a Single Outcome Agreement (SOA) with setting out the local outcomes that the CPP aims to deliver. There is flexibility to choose local outcomes according to local needs and priorities, but these need to be aligned to the National Outcomes set out in the National Performance Framework. While Local Government has the facilitation role in Community Planning, all partners have an important part to play and, as a minimum, statutory partners and other public bodies in the CPP must sign the SOA.

SOCIAL CARE (SELF-DIRECTED SUPPORT) (SCOTLAND) ACT 2013

The Act promotes an approach, and sets duties, in order to provide individuals with greater choice and control over their social care and health support.. The new duties include ensuring that the principles of involvement, informed choice, and collaboration are taken into account as part of assessment and support planning, and that people are offered the four options to manage their support and funding

These options are:

- To have a direct payment i.e. the person chooses to receive a budget and manage their own support, or
- To oversee the support but not hold the money e.g. choose a provider to provide support and hold the money. This is called an individual service fund, or.
- To let the local authority select and make arrangements for support, or
- A mix of the above options.

THE PUBLIC BODIES (JOINT WORKING)(SCOTLAND)ACT (2014)

The new legislation focuses on making services better for patients especially those with long term conditions and disabilities by providing joined up seamless health and care social provision closer to home.

Nationally agreed outcomes, which will apply across health and social care, and for which NHS Boards and Local Authorities will be held jointly accountable

A requirement on NHS Boards and Local Authorities to integrate health and social care budgets

A requirement on Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services

Partnerships will be jointly accountable to Ministers, Local Authorities, NHS Board Chairs and the public for delivering the nationally agreed outcomes.

NATIONAL HEALTH AND WELLBEING OUTCOMES 2014

Health and social care services should focus on the needs of the individual to promote their health and wellbeing, and in particular, to enable people to live healthier lives in their community.

Key to this is that people's experience of health and social care services and their impact is positive; that they are able to shape the care and support that they receive; and that people using services, whether health or social care, can expect a quality service regardless of where they live.

SCOTTISH BORDERS CARERS STRATEGY 2011-2015

The Borders Carers Strategy is currently under review and a new interim Strategy will be produced prior to the implementation of the Carers Act in 2018. The key aim of the Strategy is to recognise carers as Equal Partners in care and to ensure that carers are aware of their rights and have access to support information and advice.

COMMUNITY EMPOWERMENT (SCOTLAND) ACT 2015

To empower community bodies through the ownership of land and buildings and by strengthening their voices in decisions that matter to them.

CARERS (SCOTLAND) ACT 2016

The package of provisions in the Act is designed to support carers' health and wellbeing. These include, amongst other things:

a duty on local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria. National matters which local authorities must have regard to when setting their local eligibility criteria will be set out in regulations;

a specific Adult Carer Support Plan and Young Carer Statement to identify carers' needs and personal outcomes; and

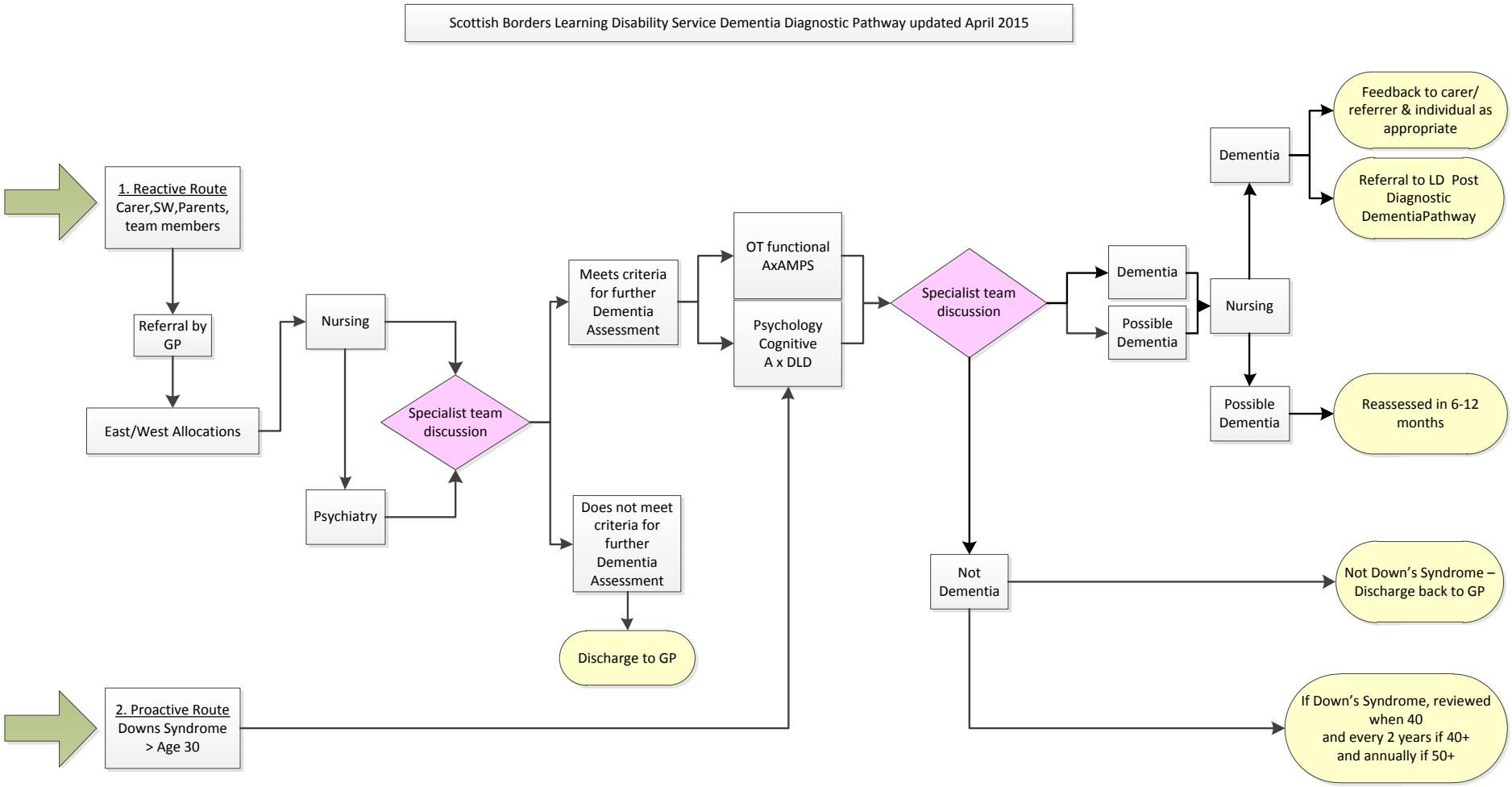
a requirement for each local authority to have its own information and advice service for carers which must provide information and advice on, amongst other things, emergency and future care planning, advocacy, income maximisation and carers' rights.

The Act contributes to the Scottish Government's vision of a healthier and fairer Scotland, and sits within the wider policy landscape including: integration of Health and Social Care; GP contract; National Clinical Strategy; new social security powers; and Fair Work agenda.

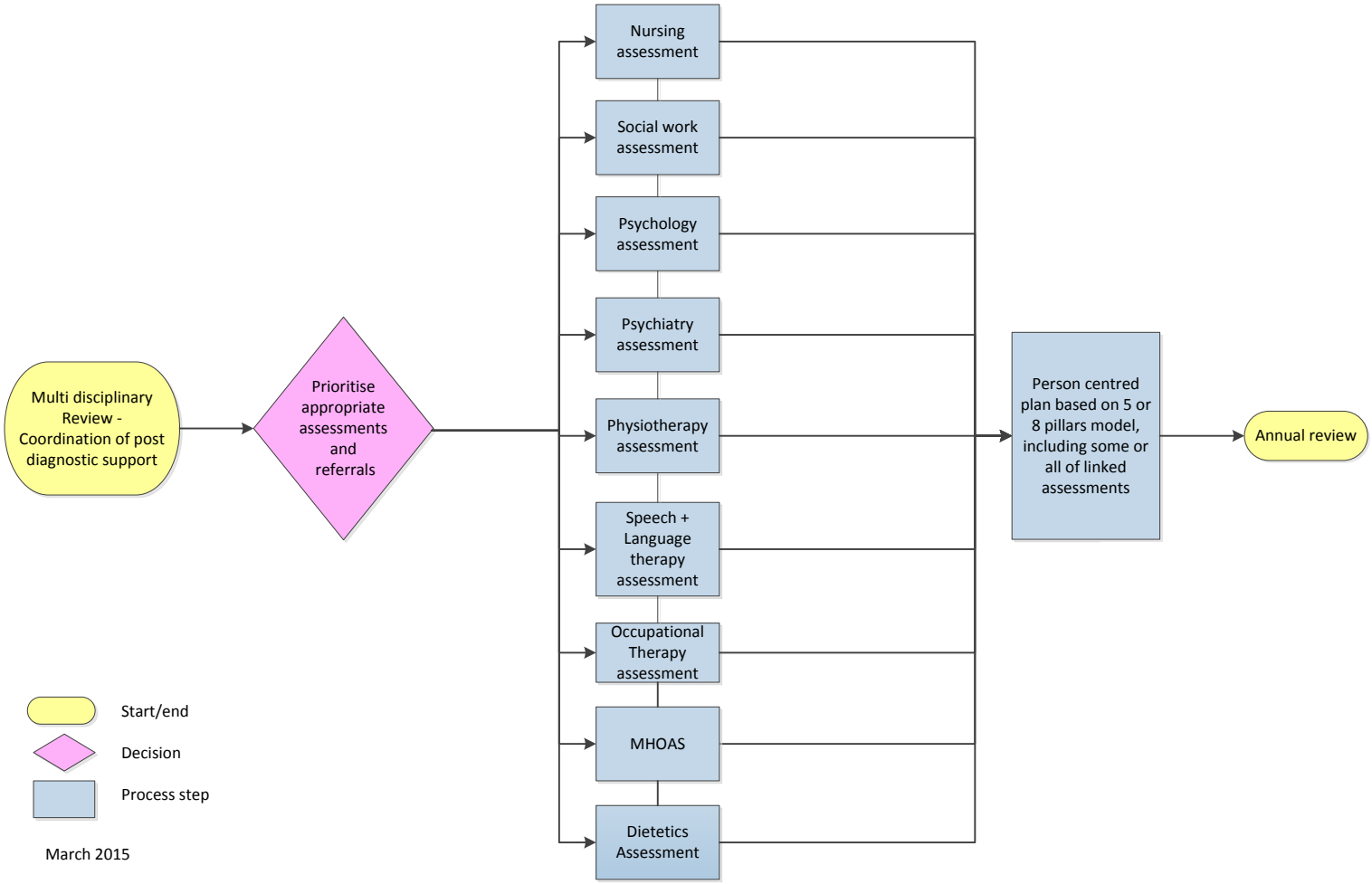
SCOTTISH BORDERS STRATEGIC PLAN 2016-19

Changing health and social care for you – working together for the best possible health and wellbeing in our communities. This gives the strategic direction for the local partnership over the next few years.

APPENDIX 2
SCOTTISH BORDERS LEARNING DISABILITY SERVICE DEMENTIA PATHWAY



APPENDIX 3
SCOTTISH BORDERS LEARNING DISABILITY POST DIAGNOSTIC DEMENTIA PATHWAY



APPENDIX 4
MAPPING OF COMMISSIONING PLAN WORK STREAMS

MAPPING OF COMMISSIONING PLAN WORK STREAMS AGAINST NATIONAL HEALTH AND WELLBEING OUTCOMES[xxv]

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
COMMISSIONING	Assess impact of SDS			x	x					x
	incorporate client outcomes in monitoring	x	x		x	x				
	Review Service Specifications in contracts				x	x				x
	Discuss work force with Providers				x				x	x
	Improve collaborative working	x		x	x			x		x

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
HOUSING AND MODELS OF SUPPORT HOUSING AND MODELS OF SUPPORT	Consider models of care for Tier 4a	x	x	x	x	x		x		x
	Build on the business case to purchase beds at Tier 4b from NHS Lothian				x	x		x		x
	Progress plans to repatriate people appropriately		x							
	Increase number of reviews	x	x	x	x		x	x		x
	Encourage carers to have Carers Assessments						x			
	Signposted carers for support and make them aware of their rights						x			

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
	Support people and carers to make emergency plans		x				x			
	Recognise carers as "Partners in Care"	x					x			
DEMENTIA PATHWAY	Monitor dementia pathway compliance	x	x			x		x		x
	All people with Learning Disability newly diagnosed in Scottish Borders receive one year's post diagnostic support	x	x		x					
	Look at housing and support options for people with dementia and those who are frail		x							

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
YOUNG PEOPLE IN TRANSITION	Recruit Transitions Development Worker for 1 year	x	x	x	x		x			x
	Progress transitions pathway development		x	x	x	x	x			x
	Monitor progress of young people in transition through Transitions Tracking Group and Complex Care Group.				x					x
	Make recommendations for improvements, implement these and then review in 2018.		x	x		x		x		x
	Look at housing and support options for young people in transition		x							

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
	Involve carers as "Partners in Care"						x			
	Ensure that the needs of carers are taken into account during planning						x			
LOCAL AREA CO-ORDINATION	Increase Independent travel training		x							
	Look to develop a weight management 'clinic' with LD colleagues	x				x				
	Support Local Citizen Panel (LCP) members to take ownership of their own panel.	x	x	x						x
	Embed 'A Healthier Me' pathway across the work of the LAC service					x				

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
	Continue to support the development of Boccia groups across the Borders		x							
	Support Health Champions to engage with peer support	x			x	x				
	Consider the health and well-being of carers						x			
	Increase referrals for Carers Assessments						x			
EMPLOYMENT AND VOLUNTEERING	Establish a working group to take forward recommendations in the local Work and Volunteering Report (2015).		x			x				x
	Review the progress of local social enterprises		x							x

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
	Establish better links with Volunteering opportunities to develop skills which may make people more 'work ready'		x							x
	Pilot Project Search, starting September 2016		x							x
	Involve carers in planning and design of services									x
SHORT BREAKS AND RESPITE	Review recommendations of 2012/13 review of short Breaks						x			x
	Explore options for short breaks locally		x							x

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
	Provide signposting of short breaks in neighbouring authorities and boards						x			x
	Explore availability of respite for carers						x			x
	Review Flexible short breaks service in 2017-18 and complete by Autumn 2018						x			x
DAY TIME OPPORTUNITIES	Evaluate social enterprises.		x							x
	Monitor and review, through link and contract meetings, all commissioned day services			x	x	x				x

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		People are able to look after and improve their own health and wellbeing and live longer	People, including those with disabilities or LTC's 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	People who use health and social care services have positive experiences of those services, and have their dignity respected	Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Health and social care services contribute to reducing health inequalities	People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	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	Resources are used effectively and efficiently in the provision of health and social care services
	Look at the impact of SDS in relation to choices made around day time opportunities		x							
	Liaise closely with Borders College			x						
	Evaluate impacts of day opportunities review		x	x	x	x				
	Understand and measure the impact of day service provision		x	x	x					x
	Look at how we capture and measure outcomes	x	x	x	x	x				

Key: x = applicable work stream to national/strategic outcome area Highlighted blue = most relevant area

MAPPING OF COMMISSIONING PLAN WORK STREAMS AGAINST SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION PLAN STRATEGIC OBJECTIVES[xxvi]

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide Care close to home	Deliver services with an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
COMMISSIONING	Assess impact of SDS						x			
	incorporate client outcomes in monitoring							x	x	
	Review Service Specifications in contracts								x	
	Discuss work force with Providers							x		
	Improve collaborative working	x				x				
HOUSING AND MODELS OF SUPPORT	Consider models of care for Tier 4a			x	x					
	Build on the business case to purchase beds at Tier 4b from NHS Lothian				x					
	Progress plans to repatriate people appropriately				x					

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide Care close to home	Deliver services with an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
	Increase number of reviews		x				x	x		
	Encourage carers to have Carers Assessments									x
	Signposted carers for support and make them aware of their rights									x
	Support people and carers to make emergency plans									x
	Recognise carers as "Partners in Care"	x					x			x
DEMENTIA PATHWAY	Monitor dementia pathway compliance		x							
	All people with Learning Disability newly diagnosed in Scottish Borders receive one year's post diagnostic support	x	x							x

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide Care close to home	Deliver services with an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
	Look at housing and support options for people with dementia and those who are frail		x	x	x		x			
YOUNG PEOPLE IN TRANSITION	Recruit Transitions Development Worker for 1 year					x			x	
	Progress transitions pathway development	x						x		
	Monitor progress of young people in transition through Transitions Tracking Group and Complex Care Group.		x					x		
	Make recommendations for improvements, implement these and then review in 2018.	x						x	x	x
	Look at housing and support options for young people in transition	x	x	x	x					

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide Care close to home	Deliver services with an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
	Involve carers as "Partners in Care"									x
	Ensure that the needs of carers are taken into account during planning						x			x
LOCAL AREA CO-ORDINATION	Increase Independent travel training						x			
	Look to develop a weight management 'clinic' with LD colleagues								x	
	Support Local Citizen Panel (LCP) members to take ownership of their own panel.	x					x			
	Embed 'A Healthier Me' pathway across the work of the LAC service								x	
	Continue to support the development of Boccia groups across the Borders								x	

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide Care close to home	Deliver services with an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
	Support Health Champions to engage with peer support								x	
	Consider the health and well-being of carers									x
	Increase referrals for Carers Assessments									x
EMPLOYMENT AND VOLUNTEERING	Establish a working group to take forward recommendations in the local Work and Volunteering Report (2015).					x		x		
	Review the progress of local social enterprises	x					x	x		
	Establish better links with Volunteering opportunities to develop skills which may make people more 'work ready'	x								
	Pilot Project Search, starting September 2016	x				x				

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide Care close to home	Deliver services with an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
	Involve carers in planning and design of services									x
	Review recommendations of 2012/13 review of short Breaks						x	x		x
	Explore options for short breaks locally	x			x					x
	Provide signposting of short breaks in neighbouring authorities and boards						x			x
	Explore availability of respite for carers									x
	Review Flexible short breaks service in 2017-18 , complete by Autumn 2018	x				x	x	x		x
DAY TIME OPPORTUNITIES	Evaluate social enterprises.	x					x	x		
	Monitor and review, through link and contract meetings, all commissioned day services	x					x	x		

		OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3	OBJECTIVE 4	OBJECTIVE 5	OBJECTIVE 6	OBJECTIVE 7	OBJECTIVE 8	OBJECTIVE 9
		Make services more accessible and develop our communities	Improve prevention and early intervention	Reduce avoidable admissions to hospital	Provide Care close to home	Deliver services with an integrated care model	Enable people to have more choice and control	Further optimise efficiency and effectiveness	Reduce health inequalities	Improve support for Carers to keep them healthy and able to continue their caring role
	Look at the impact of SDS in relation to choices made around day time opportunities						x			
	Liaise closely with Borders College	x					x			
	Evaluate impacts of day opportunities review	x					x	x		
	Understand and measure the impact of day service provision	x					x	x		
	Look at how we capture and measure outcomes						x	x		

Key: x = applicable work stream to national/strategic outcome area Highlighted blue = most relevant area

REFERENCES

[i]The keys to life – Improving quality of life for people with learning disabilities, The Scottish Government, Edinburgh 2013
[ii]The keys to life – Improving quality of life for people with learning disabilities, The Scottish Government, Edinburgh 2013 pg 16
[iii]The keys to life – Improving quality of life for people with learning disabilities, The Scottish Government, Edinburgh 2013 pg 21
[iv]National Health and Wellbeing Outcomes, The Scottish Government
[v]Health and social care integration – Scottish Borders Strategic Plan, 2016-2019
[vi]Charter for Involvement, ARC Scotland, January 2015
[vii]Changing health and social care for you – strategic plan 2016-19 pg 14
[viii]The Same as You, A review of services for people with learning disabilities, Scottish Government 2000
[ix]Social care (Self-directed Support)(Scotland) Act 2013, A summary guide, Self directed Support, January 2013
[x]Carers (Scotland) Act 2016, Scottish Government
[xi]The keys to life – Improving quality of life for people with learning disabilities, The Scottish Government, Edinburgh 2013
[xii]The Public Contracts (Scotland) Regulations 2015 and the new Procurement Reform 9Scotland) Act 2014
[xiii]IPC Joint commissioning model for public care
[xiv]IPC Joint commissioning model for public care in The keys to life – Improving quality of life for people with learning disabilities, The Scottish Government, Edinburgh 2013 pgs 14-16
[xv]Social Care (Self-directed Support) (Scotland) Act A Summary Guide, January 2013
[xvi]Care and support in Scotland Statement of values and principles, Scottish Government, 2014
[xvii]Scottish Commission for Learning Disability website
[xviii]Review of Learning Disability Service Provision 2013, Scottish Borders Public health and Learning Disability Service
[xix]Learning Disability MCN Conceptual Model of Care,
[xx]Exploration of Housing Support Needs in the Scottish Borders (2010)
[xxi]7 Principles of Good Transition 2
[xxii]https://www.scotborders.gov.uk/news/article/1317/first_ever_borders_boccia_open_competition_a_huge_success
[xxiii]'A Healthier Me' https://www.scotborders.gov.uk/downloads/file/299/a_healthier_me
[xxiv]http://www.siaa.org.uk/
[xxv]National Health and Wellbeing Outcomes, The Scottish Government
[xxvi]Health and social care integration – Scottish Borders Strategic Plan, 2016-2019
[xxvii]Alzheimer Scotland's pillars of support
[xxviii]Principles of Good Transitions 3

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Scottish Borders
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PARTNERSHIP

INTEGRATED CARE FUND UPDATE – June 2017

Aim

1.1 The aim of this report is to provide Integration Joint Board (IJB) members with an update on the Partnership's Integrated Care Fund (ICF) Programme and further detail on those projects approved to date in terms of their cost commitments.

Background

2.1 Integrated Care Funding was first allocated to the shadow partnership in 2015/16. The ICF commenced on the 1st April 2015 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of **£6.39m** over the 3 years of the programme. During this year, a number of projects were approved by the partnership. Of the £2.13m allocated for 2015/16, **£224k** was spent by the partnership in 2015/16 and a further **£897k** in 2016/17, a combined total of **£1.122m** over the life of the programme to date. Analysis of the spend to date on those projects approved by the IJB is detailed in **Table 1**.

Current Position

3.1 A decision was ratified by the IJB in December 2016 to close the Integrated Care Fund to new bids for resources in order to enable the EMT, with IJB ratification, to direct funding to deliver the transformational and strategic plan priorities. Proposals for these areas will come to the IJB for ratification in the coming months. The remaining ICF balance is **£2.37m.**

3.2 Overall, 22 projects, projected to cost **£4.15m** have been commissioned as part of the ICF programme to date, with two further requests for funding recommended by the Executive Management Team.

In summary, these are:

Table 1 – Summary of 3-Year Resource Requirements of ICF Projects Approved by EMT to date

	Approved Projects	Approved
1	Community Capacity Building	£ 400,000
2	Independent Sector representation	£ 93,960
3	Transport Hub	£ 139,000
4	Mental Health Integration	£ 38,000
5	My Home Life	£ 71,340
6	Delivery of the Autism Strategy	£ 99,386
7	BAES Relocation	£ 241,000
8	Delivery of the ARBD pathway	£ 102,052

9	Health Improvement (*phase 1*) and extension	£ 38,000
10	Stress & Distress Training	£ 166,000
11	Transitions	£ 65,200
12	Delivery of the Localities Plan 18 mths)	£ 259,500
13	Locality Managers x 1 locality for 1 year	£ 65,818
14	H&SC Coordination x 1 locality for one year	£ 49,238
15	Community Led Support	£ 90,000
16	The Matching Unit	£ 115,000
17	RAD	£ 140,000
18	Transitional Care Facility	£ 941,600
19	Pharmacy Input	£ 97,000
20	GP Clusters Project	£ 50,000
21	Pathways	
	Domestic Violence pathway project	£ 120,000
	Care pathways and delayed discharge consultancy	£ 7,000
22	ADP Transitional Funding	£ 46,000
	Programme delivery	£ 580,458
		£ 4,015,522
	For Approval	
23	Partnership Programme Team extension	£126,000
24	Buurtzorg – Project Management	£52,000

3.3 The projects that are already approved are constantly under review and scrutiny to ensure that they continue to deliver outcomes in line with the strategic plan. The progress of these projects can be seen in **Appendix 1.**

3.4 Work continues with the approved projects to ensure that their outcome monitoring is robust and consistent with the other Integrated Care Funded projects.

Update

4.1 Two projects have been recommended by the Executive Management Team since the last IJB report. These are:

4.2 **Partnership Programme Team:** The Programme Team consists of three Project Managers and 3 Project Support Officers who support the existing integration partnership programme. This team currently provides support for the Chief Officer for Integration and provides the infrastructure required to support the IJB. The team is currently supporting the production of the Partnerships Annual performance Report, quarterly performance reports for the IJB, workforce planning, localities planning and the management and support of the Integrated Care Fund. The team also provides dedicated Project Management support to the following ICF funded projects – Matching Unit, Transitional Care Facility and Community Led Support. It has been recognised that the support provided by the team has been critical to the successful progression of these projects. EMT have recognised the importance of extending this team's remit to cover the support of a number of the partnerships transformation and efficiencies programme projects. In order to provide this support it is recommended that team contracts are extended up until the end of December

2018. This will allow the team to support transformation projects such as the review of community and day hospitals, AHP's and Reablement when the projects that they are currently supporting are concluded. The cost of this extension would be £126k.

4.3 **Buurtzorg:** The nursing led Buurtzorg model for the provision of health and care has been consulted on in the Borders and it has been strongly supported. Approval has been given to test the model in the Coldstream area. A study trip to the Netherlands has been organised for June 2017, with further training to be provided by the Buurtzorg nurses following this. In order to take this test forward EMT have approved the funding for project support a period of 12 months at a cost of £52k.

Recently Approved Projects - Progress

5.1 Three projects that have recently been approved by the IJB have been making significant progress. The Matching Unit, Community Led Support and Transitional Care facility were approved by the IJB in September and December 2016.

5.2 **The Matching Unit:** The Matching Unit was ratified by the IJB in September 2016. The aim of the project was to create a small central administrative team "Matching/Brokerage Unit", to match clients to home care providers, assessed by care managers as needing care at home services. The matching unit commenced in April 2017 with 4 matching staff in post.

5.3 The project aims to improve outcomes including:

- % reduction in Care Manager time taken to identify and secure provision for clients
- % increase in caseloads held per Care Manager
- Improved Care Manager satisfaction with the matching process
- Improved Care provider satisfaction with the matching process
- Improved speed of service provision

5.4 A full midyear evaluation will be available in October 2017 however initial feedback from the Tweeddale area shows that on the first day of operation the Matching Unit reduced the number of people on the local care at home waiting list from 12 down to 3.

5.5 **Community Led Support:** The Community Led Support Project was ratified by the IJB in September 2016. The project aims to develop a community hub model, promoting early intervention, self-directed support and community solutions on a local level. Engagement sessions across the Borders were carried out throughout November and December with 233 people attending planning and evaluation workshops . Staff and third sector partners have been trained and the first hub opened in Burnfoot Community Hub on 22nd May. This was followed by the opening of the first hubs in Ettrick Bridge and Yarrow Valley on the 7th June.

5.6 This approach has been successful in other areas by:

- Increasing customer satisfaction around access to services
- Increasing staff morale and motivation within social work teams
- Reducing in the need for formal care services
- Improving access to services
- Improving wellbeing of service users
- Reducing bureaucracy

- Reducing waiting lists/waiting times
- Increasing collaboration with voluntary sector and partners
- Reducing in health and social care expenditure

5.7 Initial feedback has been very positive with 6 people attending the Burnfoot Hub which has had a positive impact on waiting lists for social work services.

5.8 Initial surveys from the first two "What Matters – Hawick" hubs show that 100% of attendees at the hub felt that the venue was suitable; that the staff were welcoming; that the service was easy to access; that they received the guidance and support that they required; and that they would recommend the service. 80% of attendees were satisfied on the outcome of their visit.

5.9 The first full evaluation will be available in September 2017.

5.10 **The Transitional Care Facility:** The Transitional Care Facility Project was ratified by the IJB in December 2016. The unit has been operation since December with the aim to provide multi-disciplinary care for people leaving hospital for a period of 6 weeks to enable people to safely return to their homes. Two multi-disciplinary workshops have been held to promote collaborative working and identify and resolve process issues. A third and final workshop is planned to complete a review of the process from the community to the Transitional Care Facility. Verbal feedback from these workshops indicates that the workshops have had a positive impact on multi-disciplinary team working by increasing awareness of the importance of differing roles.

5.11 To date, the project has seen:

- 81 referrals and 42 admissions
- 72 % of patents returned to their original home (returned home or to a new home 78%)
- 75% of patients stayed for 6 weeks or less

Summary

6.1 To date **£4.193** of the ICF has been approved although only **£1.122m** has been spent to date.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the position of the Integrated Care Fund.

The Health & Social Care Integration Joint Board is asked to **ratify** the 2 new funding requests (**Table 1 Projects 23-24**).

The Health & Social Care Integration Joint Board is asked to **note** progress on key projects.

Policy/Strategy Implications	The programme is being developed in order to enable transformation to new models of care and achieve the partnership's objectives expressed within its Strategic

	Plan and national health and wellbeing outcomes
Consultation	The recommendations to the IJB have been made following consultation with a wide range of stakeholder representatives through the ICF Executive Management Team.
Risk Assessment	There are no risk implications associated with the proposals
Compliance with requirements on Equality and Diversity	There are no equality implications associated with the proposals
Resource/Staffing Implications	The proposals approved within the programme to date will be funded from the ICF grant allocation over its life

Approved by

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Chief Officer Health & Social Care		
Carol Gillie	NHS Borders Director of Finance	David Robertson	Scottish Borders Council Chief Financial Officer

Author(s)

Name	**Designation**	**Name**	**Designation**
Jane Robertson	Strategic Planning and Development Manager	Clare Richards	Project Manager

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Approved projects

Integrated Care Fund Project RAG Status - May 2017

Outcomes, milestones, financial status and overall project status.

	Programme Delivery	Community Capacity Building	Ind Sector Representation	Transport Hub	My Home Life	Delivery of the Autism Strategy	BAES Relocation	Delivery of the ARBD pathway	Stress and Distress	Transitions	Delivery of the Localities plan	CLS	Transitional Care Facility	Matching Unit	Pharmacy Input	RAD
Outcome Status									Awaiting report							Awaiting report
Milestone Status																
Financial Status																
Overall project Status																

Notes: Awaiting information from RAD project

Key:

Red – Off Track

Amber – At Risk

Green – On Track

Approved projects

Project	Objectives	Benefits Realised (ROI)		Progress	Sustainability	Funding
		Contribution to National Health and Wellbeing Outcomes	Contribution to Local Strategic Objectives			
ICF Project Delivery April 2015 - March 2016	To allocate the Integrated Care Fund in line with the ICF Plan 2015-18	• Providing support to all ICF projects in order to assist them in the delivery of their outcomes. • The team therefore contributes to all National Health and wellbeing outcomes and Local Strategic Objectives.		19 Projects are in progress and 10 are being supported to produce project briefs for appraisal. The governance structure has been reviewed and the new structure will commence in September 16. The projects are under scrutiny for their performance and alignment the Strategic Plan. Two workshops have been completed with project leads to assist with their outcome monitoring and evaluations.	One off cost for the term of the ICF Funding. No ongoing costs.	£469,626
Independent Sector Representation April 2015 – March 2018	The provision of Independent Sector advice to the programme.	Outcome 4 • Training/educating care providers • Providing tools to assist delivery • Working with the service users	Objective 2 • Training/educating care providers • Providing tools to assist them in prevention and early interventions • Assisting providers in delivery of new models of care • Working with partners in gaining trust	Progress has been made in 3 key areas – the review of care assistants training needs, the setup of a second rapid reaction team from a care home and the development of the My Home Life Project.	One off cost for the term of the ICF Funding. No ongoing costs.	£93,960

Approved projects

Transport Hub April 2015-March 2017	Putting in place a co-ordinated, sustainable approach to community transport provision.	Outcome 1 • Simplification of accessing transport to health services • Greater levels of support for users	Objective 9 • Providing a more efficient service with better utilisation of vehicles • Reduced duplication of journeys • Better coordination with planned facilities discharge.	Improvements have been reported around ease of use, appropriate transport provision, better vehicle utilisation, greater partnership working, improvement of the skill of the volunteer base and respite provision for carers. In the first year the transport hub has facilitated 482 journeys by using 56 volunteers. In June the Transport Hub received an award for the Accessibility project of the year.	The project will be part of a bigger review of transport provision in the Borders with a primary aim of being sustainable.	£139,000
Health Improvement, Self-Management Phase 1 September 2015 – June 2016	To improve shared management of LTCs amongst older people (Phase One). The new proposal (Phase Two) extends the basic concept to include all adults with Long Term Conditions (LTC's), including those with multiple conditions, so	Outcome 1 & 2 • Promoting shared management of existing conditions • Helping to bridge the gap between community and acute care • Development of knowledge, skills, pathways and	Objective 2 by • Equipping practitioners to build health improving measures into their assessments • Integrated anticipatory, treatment and recovery/re-	Phase 1 of this project is underway and showing improvement in service with 49% of people questioned rating the service as good and 50% rating the service as Excellent. This project has also evidenced a 10% improvement in wellbeing scores across the project. This project is now complete	The project will end with no ongoing costs as all the changes will have become business as usual.	£19,000 (For the extension to phase 1.)

Approved projects

	learning from experience and maximising the use of short-term funding.	processes • Supporting and enabling carers to look after their health	ablement care plans • Supporting people to live well with their conditions	but the findings will guide future service delivery.		
Transitions August 2015 – May 2018	This project will focus upon young people who have a diagnosed learning disability between the ages of 14 and 21 who are moving towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education.	Outcome 3 • Ensuring people receive the correct information at the right time • Giving timely collaborative assessment and support plans	Objective 7 • Creating a clear transitions pathway, accessible to all partners including young people and their carers.	Recruitment is now complete and the post filled. The new Transitions Development Officer is now in post and gathering information on the current pathways.	The project would specify that recommendations must be achieved within the existing resources across services. This may mean disinvestment in one area and re investment in another. More efficient and effective pathways for the customer would also have a positive impact upon staffing resources	£65,200
Borders Community Capacity Building September 2015 – May 2018	Sept.	• Outcome 1 Encouraging people to engage and participate in activities • Improving their mental and physical wellbeing • Reducing isolation	Objective 1 • Encouraging and supporting communities to create and run their own services.	BCCB have reported an increase in the number of people, from different communities, becoming engaged in physical activities and being more active in their communities. They are also reporting an improvement in their participants' physical and mental wellbeing.	Projects initiated by this Team during the term of the ICF funding should be self-sustaining by 2018.	£400,000
Mental Health	The transition from a	Outcome 9	Objective 5	This project is now complete	One off cost to	£37,500

Approved projects

Integration – April 2015 – October 2015 **Project now complete**	dedicated social work team to having social work functions such as care management and assessment and use of IT software such as Frameworki embedded within the integrated teams.	• Integrating social work into the community • Reduce duplication • Ensuring referrals are managed effectively	• Providing support to admin staff and team managers • Ensuring effective and efficient delivery of social work services within an integrated model.	and has reported improvement in the service provided to patients, working relationships and communications. It has also reported a reduction in duplication of work.	implement a new integrated model of service delivery.	
My Home Life January 2016 – February 2017	A fourteen month programme of leadership support and training to help improve quality of life in care homes.	Outcome 4 • Educating and providing tools to assist care homes in delivery of service improvements • Ensuring that staff are trained to the same level of competency. Developing care homes to provide different models of care	Objective 3 • Providing different models of care supporting the discharge agenda and prevention of admission to hospitals	The training for the 1st cohort of manager is complete and the second round of training has commenced. The first round saw outcomes such as: increased staff morale, increased quality of leadership and management, improved communication skills.	One off project – no ongoing costs.	£71,340
Delivery of the Autism Strategy April 2016 – August 2018	Delivery of all of the work streams within the Borders Autism Strategy.	Outcome 3 • Improving awareness and understanding of the needs of those with autism	Objective 2 • Improving awareness and understanding of the needs of those with autism • Ensuring that those with autism receive the right	A project initiation document has been produced and the project delivery planned. The Autism Coordinator is now in post.	One off cost to deliver the Autism Strategy.	£99,386

Approved projects

			support at the earliest opportunity			
Delivery of Stress and Distress Training July 2015 – April 2018	Stress & Distress Training provides training in an individualised, formulation driven approach to understanding and intervening in stress and distressed behaviours in people with dementia.	Outcome 8 • Providing training to over 700 staff • Improve the experience, care, treatment and outcomes for people with dementia, their families and carers	Objective 3 • Reducing the likelihood of situations becoming exacerbated and resulting in residential or hospital care	Work has been undertaken to train stress and distress trainers and plan the training sessions. 117 staff have attended the 2 day training and 148 have completed the bite size training.	The potential for release of resources is a key task for the project group seeking sustainable support from internal/external funders. The evidence is that within prescribing alone it is expected that a £47k saving will be realised year on year.	£166,000
Implementation of the ARBD pathway April 2016 – August 2018	Delivery of the actions identified in the 2013 ADP needs assessment.	Outcome 2 • Assessing and improving pathways of care for those with ARBD • Reducing the need for out of area placements in residential care	Objective 4 • Assessing and improving pathways of care for those with ARBD • Reducing the need for out of area placements in residential care	A project initiation document has been produced and the project delivery planned. The ARBD development officer is now in post.	The resource currently being used to fund residential places could be released and used differently in order to support improved coordination in the community.	£102,052
Borders Ability Equipment Store (BAES) Relocation February 2016	Relocation of the Borders Ability Equipment store to a purpose built location.	Outcome 2 • Efficiently providing individuals with the correct equipment to enable them to	Objective 4 - as outcome 2.	This project requested an additional £141,000 when tenders were received which were over budget. This was approved in July 2016. The tender has been	One off cost.	£100,000 £141,000 Total £241,000

Approved projects

– December 2016		have care in the home setting.		accepted and construction work commenced on 26th September. The relocation is now underway.		
Community Ward Pilot Programme Management and Support	Programme Management and Support to develop, plan and deliver alternative proposal to replace Community Ward pilot	• The outcomes and objectives of this work package will be determined when the development of the alternative options is complete		Project Support Officer in post. As the community ward project has been withdrawn this post will be used to support the approved projects and contribute to the central project support team.	One off project – no ongoing costs.	
Health and Care Coordination Programme Management and Support	Programme Management and Support to develop, plan and deliver Health and Care Coordination project	• This work package is an enabler to delivery of the outcome and objective detailed below in relation to the wider Health & Social Care Coordination project		Project Support Officer in post and contributing to the centre project support team.	One off project – no ongoing costs.	
Delivery of the Localities Plan April 2016 – October 2017	Development of locality plans. The redesign services to meet needs. Make recommendations to the localities group. Link to GP services, the third and Independent sector.	Outcome 4 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model	Objective 5 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model.	Draft localities plans have been produced and are awaiting approval.	One off cost.	£259,500 for 18 months
Health & Social Care Coordination	Introduction of a Health and Social Care Coordination approach through integrating	Outcome 7 • Providing one point of access for health and social	Objective 5 • Improving access to health and social care	This project is on hold.	One off cost, for a 1 year test.	£49,238

Approved projects

September 2016- August 2017	teams within one locality to test the change and consider scaling up across the remaining localities.	care services • More streamlined service • More efficient response times	services • Improving referral and waiting times • Reducing unnecessary admissions to hospital • Improving discharge from hospital Improving co-ordination of multiple services			
Locality Management September 2016- August 2017	Overall management and strategic development of Adult Health and Social Care services within one locality to test the change and consider scaling up across the remaining localities.	Outcome 4 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model	Objective 5 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model.	This project is on hold.	One off cost, for a 1 year test.	£65,818
Community Led Support September 2016 – March 2018	To develop a community hub model, promoting self-directed support and setting up social work drop ins.	Outcome 1 • Providing self-directed support and drop in social work sessions within the community.	Objective 1 • Providing self-directed support and drop in social work sessions within the community.	Two hubs are due to open in the next couple of months.	One off cost, for 18 months.	£90,000
The Matching Unit September	The creation of a small central administrative team "Matching/Brokerage	Outcome 9 • A Borders-wide overview of resource and	Objective 7 • Care managers time is significantly	The matching unit is now up and running.	The running cost of the matching unit will come from the efficiencies created	£115,000

Approved projects

2016 – September 2017	Unit", to match clients, assessed by care managers as needing care at home services.	capacity will be in place resulting in a consistent and more effective approach to securing provision.	reduced in trying to identify & secure provision for clients.		from the more effective use of practitioner time (e.g.) increased productivity resulting in reduced requirement to either hire additional care managers or to reduce the existing number of care managers	
Rapid Assessment and Discharge Team	The funding of a rapid discharge and assessment team at the front door of the BGH.	Outcome 9 • Patients will not be admitted to BGH when admission is not required.	Objective3 • All frail, elder patients will be assessed at the hospital front door and discharged home where possible.	Project approved in December 2016 and fully underway as it was already established.	A business case to divert resource to sustain the team function is in development.	£140,000
Transitional Care Facility	The provision of a multidisciplinary team with a transitional care facility.	Outcome 1 • By providing a multi-disciplinary model of care.	Objective 4 • By providing a facility in the Eildon Locality.	Project approved in December 2016. The project is underway and basic evaluation data is available.	This project will have an impact on the budget required for commissioning flex-beds during the winter 'surge', and on the budget required to fund long-term, complex packages of care. These savings could be used to fund the facility.	£941,600
Pharmacy Input	The provision of pharmacy support in the community,	Outcome 9 • By undertaking medicines	Objective 5 • Providing access to care plans that	Project approved in December 2016. The recruitment for the	From the end of funding the cost of the provision would come	£97,000

Approved projects

	undertaking medicines reviews and supporting the transitional care facility, enablement and matching unit projects.	reviews, reducing the need for medicines and carer visits.	are reviewed regularly by specialist staff.	pharmacist was unsuccessful so they are now recruiting a pharmacist technician and a project manager.	from the efficiencies created by the efficient use of resources.	
Domestic Abuse Service (DAS)	Match funding of the DAAS Service and DACS Service and the planning and the implementation of service redesign.	Outcome 7		Project approved in March 2017. Project documentation is currently being finalised and the project is due to start in July 2017.	A full scale review of domestic abuse services will commence in 2017/18 with the aim of ensuring sustainable funding solutions for the range of services at local level.	£40,000 each year for 3 years
GP Cluster Leads		Outcome 9		Project approved in March 2017.	It is proposed that during the initial 12 months, the post holders, general practice and the Partnership would work together to agree the longer-term requirements of the post in terms of capacity and workload and agree the funding stream.	£50,000
Alcohol and Drug Partnership	ADP to work with commissioned service providers in developing a new model of delivery following service			Project approved in March 2017.	If service redesign work is unsuccessful a more radical programme of savings through service	£46,000

	redesign.				rationalisation will be implemented.	

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Scottish Borders
Health and Social Care
PARTNERSHIP

PRIMARY CARE FUNDING – PHARMACISTS IN GP PRACTICES

Aim

1.1 The Scottish Government circular (PCA (P)(2017) 4) advises of funding of up to £12m from the Primary Care Fund to NHS Boards for 2017-18, to both continue with the commitment to fund 140 WTE Pharmacists to work with GP's, in GP practices and to work towards the Programme for Government objective that every GP practice in Scotland should have access to Pharmacist with advanced clinical skills.

Background

2.1 The Cabinet Secretary for Health and Sport announced on 25 June 2015 details of how the Primary Care Fund will be used to support the primary care workforce, including GP's, and improve patient access to these services.

2.2 Circular PCA (P) (2015) 16 advised Boards that over three years £16.2m would be allocated to recruit up to 140 whole time equivalent additional Pharmacists with advanced clinical skills training, or those undertaking the training. The year three element of this funding, now £12m, will be baselined in 2017-18.

2.3 NHS Borders could receive up to an extra £85,800 from this fund by continuing to build on the plans already in place to recruit, or enter into arrangements with, Pharmacists to work directly with GP's to deliver patient facing care. These Pharmacists will be trained to work as Pharmacist Independent Prescribers, managing caseloads of patients with complex medicines needs, carrying out medicines reviews for a range of patients, and supporting the care of patients with long term conditions.

Priorities and targeting

2.4 Funding is to be prioritised on Pharmacist recruitment or sessional arrangements with local pharmacy contractors. There may however be instances, in consultation with the GP's, where a skill mix of both Pharmacist and Technician time is more appropriate.

2.5 GP practice capacity pressure is the highest priority in terms of targeting resource and meeting patient need. Boards are expected to target resources towards those practices and localities facing the greatest pressures. Priority populations continue to include areas with a greater proportion of elderly patients, deprived areas, and patients with multiple morbidities who receive a significant number of prescriptions and who have been identified as being statistically more at risk of hospital admission or readmission. In previous years, the focus has been on priority

populations. Using SPARRA & NRAC weighting, NHS Borders Prescribing Support Team (PST) has targeted key practice populations; this change in targeting will allow us to also target practices under pressure. All practices receive some element of PST cover. The PST is working with a number of practices on more specific projects and will review the impact of this and reassess over the coming months.

Summary

3.1 NHS Borders PST will continue to develop and roll out their program of Polypharmacy reviews and clinics, specifically targeting priority groups of Respiratory, Care Homes and Community Hospital patients. We will also recruit and train extra Pharmacists and Technicians to the team to increase the current service provision to more practices.

3.2 The Prescribing Support Team is required to submit regular updates to Scottish Government on request, on:

- Progress towards recruitment;
- How the additional funding is supporting the Programme for Government commitment; and
- Details of training plans (National Education Scotland have produced templates).

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report.

Policy/Strategy Implications	Continuation/expansion of existing policy
Consultation	Consultation with LNC and individual GP's, Primary Care Prescribing Group.
Risk Assessment	May have difficulty recruiting as other Boards also receiving funding and this is now the third round.
Compliance with requirements on Equality and Diversity	Full
Resource/Staffing Implications	None – all funded externally

Approved by

Name	Designation	Name	Designation
Alison Wilson	Director of Pharmacy		

Author(s)

Name	Designation	Name	Designation
Keith Maclure	Lead Pharmacist – Medicines Utilisation & Planning		

Scottish Borders
Health and Social Care
PARTNERSHIP

QUARTERLY PERFORMANCE REPORT UPDATE JUNE 2017

Aim

1.1 The aim of this report is to provide a quarterly performance update to the Integration Joint Board (IJB). The report highlights how the quarterly performance scorecard has evolved since the last report in February 2017.

Background

2.1 The performance reporting scorecard for the IJB was originally developed to include the six themes defined by the Ministerial Strategy Group (MSG) for Health and Community Care. These themes are:

1. unplanned admissions;
2. occupied bed days for unscheduled care;
3. A&E performance;
4. delayed discharges;
5. end of life care;
6. balance of spend between institutional and community care.

2.2 The themes identified by the MSG are heavily weighted to hospital care and in recognition of this the performance report presented to the IJB in February 2017 included an additional section headed Social Care which included reports on local data collated via the Social Care Survey and the number of carers assessments completed by the Carers Centre.

2.3 Since the last quarterly performance report the scorecard has been developed to include additional locally defined themes which relate to other measures with a primary, community or social care focus as well as an additional measure on unplanned admissions (see **Appendix 1**).

2.4 A summary of the additional measures included in the June 2017 report is given below:

Theme	**Measure(s)**
1. Unplanned Admissions	Emergency admissions to hospital as a result of falls, patients aged 65+
4. Delayed Discharges	Bed-days associated with delayed discharges of patients aged 75+
8. Carers	Carers Centre Survey of Carer Outcomes: • Support for Caring • Caring Choices • Carer stress

9. Other Relevant Measures	"Two minutes of your time" survey for NHS Borders' hospital patients. All available measures relating to evaluation of Integrated Care Fund (ICF) projects.

Summary

3.1 In a number of areas Borders is demonstrating improvement locally and/or good performance compared to Scotland. These include unscheduled occupied bed day rates, balance of spend measures, increases in the percentage of older adults looked after in the community rather than in care homes, and in the positive impacts of the five ICF projects included in this report. These are all examples of improvements/successes that could be built upon.

3.2 Areas of challenge as illustrated in this performance report include:-

- Rates of emergency admissions have reduced in recent months however remain above the Scottish average. The development and implementation of the Falls Strategy could be an important contributor to further reductions in emergency admissions.
- A&E performance and Delayed Discharges remain ongoing challenges.
- There is a need to improve the consistency and robustness of social care client outcomes reporting.
- There is clear scope to improve outcomes for Carers; the work to implement the requirements of the new legislation will assist with this.
- Palliative care is one of the key themes in the National Health and Social Care Delivery Plan and an area for reporting to the Ministerial Strategy Group. The recording of data relating to the Margaret Kerr Unit requires review and amendment.

3.3 Given the many elements of integrated care and the wide range of services delegated to Health and Social Care Partnership it is anticipated that performance reporting to the IJB will further develop over time to include reporting at locality level and more specific reports on particular groups of service users and staff.

Recommendation

The Health & Social Care Integration Joint Board is asked to:-

- **note** the additional themes and measures for reporting;
- **note** the key performance issues highlighted;
- **advise** of any further measures to be included in future quarterly performance reports.

Policy/Strategy Implications	This report gives an update on Partnership performance reporting which is directly related to the delivery of local objectives as detailed in the Strategic Plan.
Consultation	The performance report has been prepared in partnership with NHS Borders and SBC performance teams.

Risk Assessment	A number of risks in relation to partnership performance have been highlighted in the report.
Compliance with requirements on Equality and Diversity	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.
Resource/Staffing Implications	Financial implications outlined in finance reports.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer for Integration		

Author(s)

Name	Designation	Name	Designation
Jane Robertson	Strategic Planning and Development Manager	Julie Kidd	Principal Information Analyst, NHS National Services Scotland

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Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the Scottish Borders Integrated Joint Board

June 2017

1. Unplanned Admissions

Part 1 - Emergency admissions for people aged 75+

What is this information and why is important to measure it?

Excellent emergency services are necessary when people are at a point of crisis or suffer serious injury. But many people who come to hospitals in emergencies could potentially have been offered better support or services earlier on, which would have prevented the need for them to go to hospital, or may have involved a planned visit to hospital instead.

Rates of emergency admissions in people aged 75 and over are of particular concern and are higher in Scottish Borders than across Scotland as a whole. Existing work within the Borders to reduce emergency admission rates needs to continue and be built on.

A reduction in this indicator should demonstrate improved partnership working. It should represent a shift from a reliance on hospital care towards proactive and coordinated care and support in the community. It should demonstrate the effectiveness of anticipatory care, identifying people who are at risk of emergency hospital admission, supporting people to be more confident in managing their long term conditions and providing coordinated care and support at home where safe and appropriate. Safe and suitable housing for people will also be important.

Data Source(s)

1. Hospital admissions are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.
2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

Part 2 - Emergency admissions for falls, people aged 65+

What is this information and why is important to measure it?

With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major concern.

Falls can have a significant impact on an older person's independence and quality of life, impeding a person’s mobility and confidence. However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence based practices can prevent many falls and fractures in older people in the community setting. Rehabilitation services are also key to preventing repeat falls. In addition, the safety of a person’s immediate environment as well as their prescribed medicines will be important.

An economic evaluation published in 2013 estimated the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million (http://www.ncbi.nlm.nih.gov/pubmed/24215036) and without intervention is set to rise over the next decade as our population ages and the proportion with multi-morbidity and polypharmacy grows.

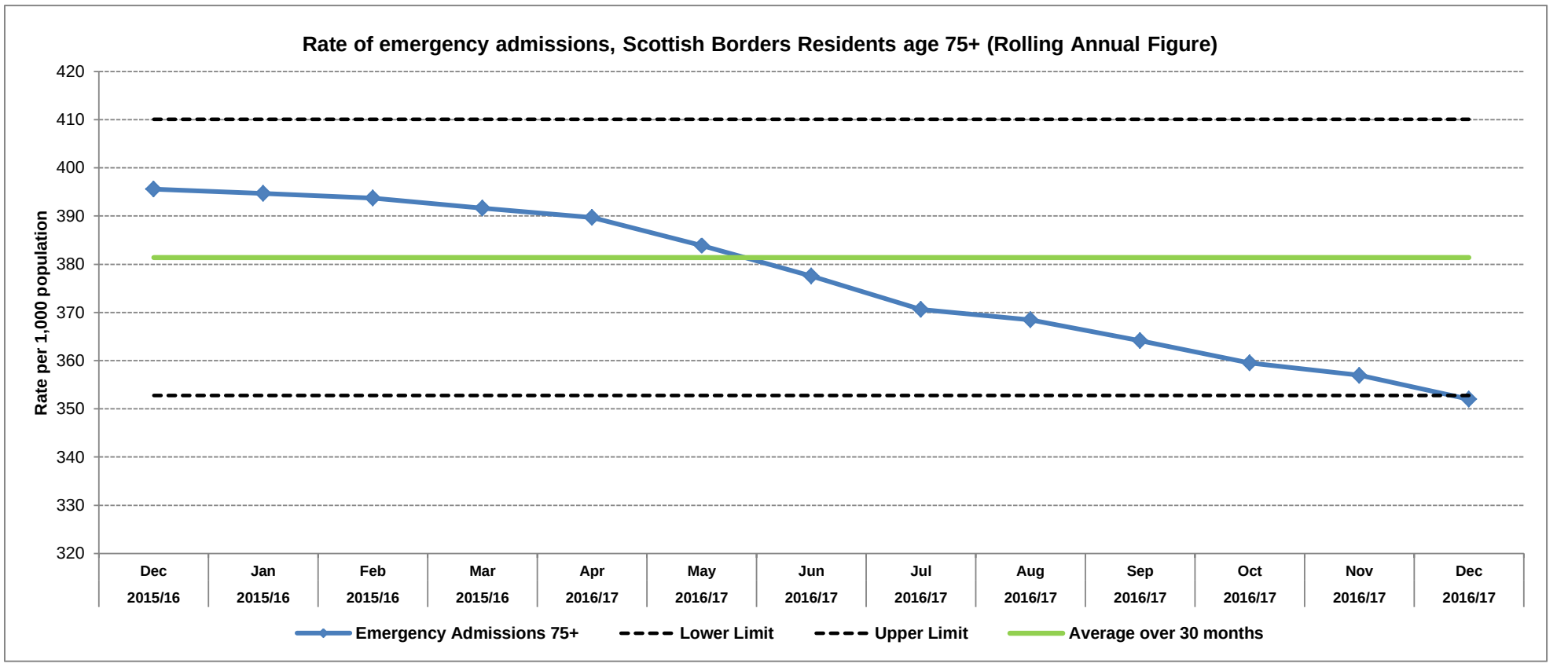
Data Source(s) and notes

1. Emergency Hospital admissions due to falls are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.
2. Diagnostic codes used to identify falls are ICD-10 codes W00-W19.
3. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

1. Unplanned Admissions

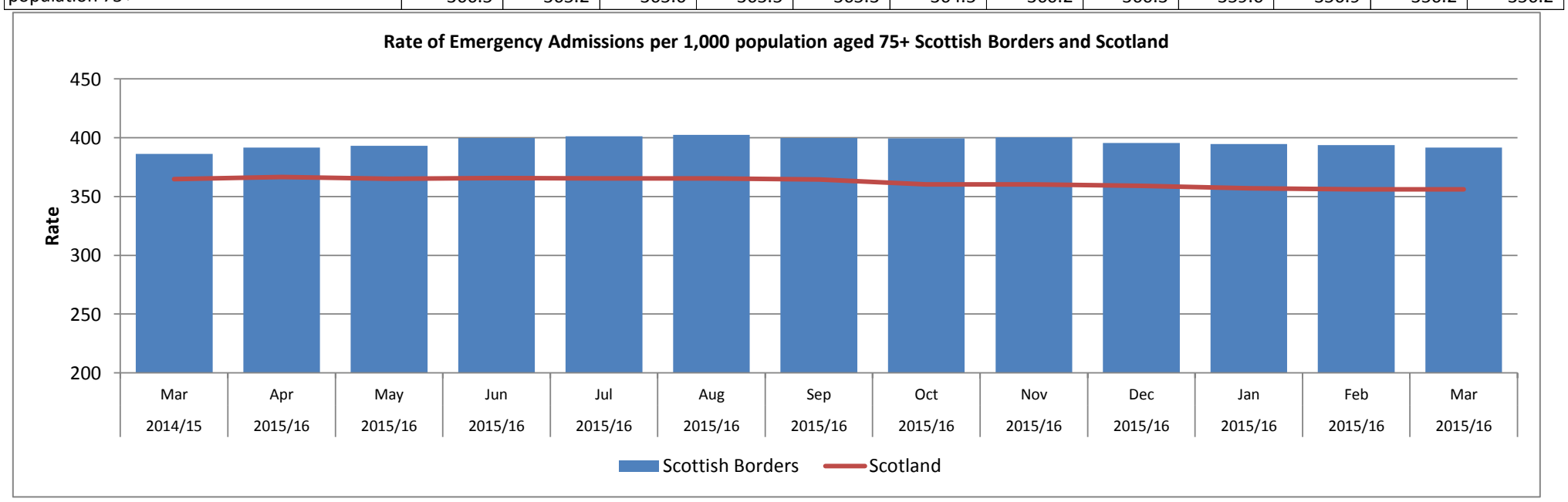
Emergency Admissions, Scottish Borders residents age 75+

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Emergency Admissions, 75+	4,543	4,475	4,401	4,320	4,295	4,245	4,191	4,161	4,103			
Rate of Emergency Admissions per 1,000 population 75+	389.7	383.9	377.5	370.6	368.4	364.2	359.5	357.0	352.0			



Emergency Admissions, Scotland residents age 75+

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Number of Emergency Admissions, 75+	158,770	158,228	158,380	158,330	158,263	157,923	157,684	157,707	157,150	156,222	155,922	155,916
Rate of Emergency Admissions per 1,000 population 75+	366.5	365.2	365.6	365.5	365.3	364.5	360.2	360.3	359.0	356.9	356.2	356.2



How are we performing?

The rate of emergency admissions for the over 75 age group in Scottish Borders is decreasing: the rate was increasing gradually to August 2015 but from that point has seen a gradual decrease, in line with the Scottish trend. The Borders rate at March 2016 (latest published data point for Scotland) is higher than the national average. There is a lag time in data points as rates are produced from a nationally available source from ISD, based on data submitted by all the Health Boards that has been validated. There may be slight under-reporting for December 2016.

What are we doing to improve or maintain performance?

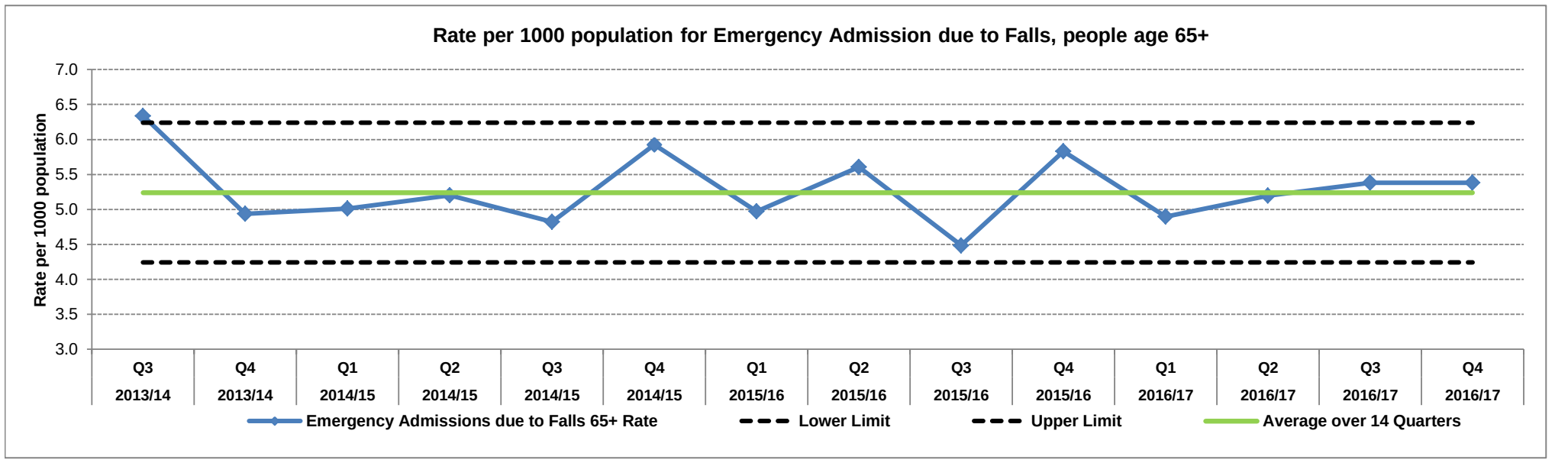
We are undertaking work to reduce emergency admissions for common conditions, focusing on developing pathways for patients with common respiratory and cardiac conditions to be reviewed and managed within their own homes and on reducing readmission rates.

Use of the Acute Assessment Unit has improved our emergency admission rate allowing patients to receive tests and monitoring then discharge rather than being admitted into the hospital (Medical Assessment Unit) for this.

1. Unplanned Admissions

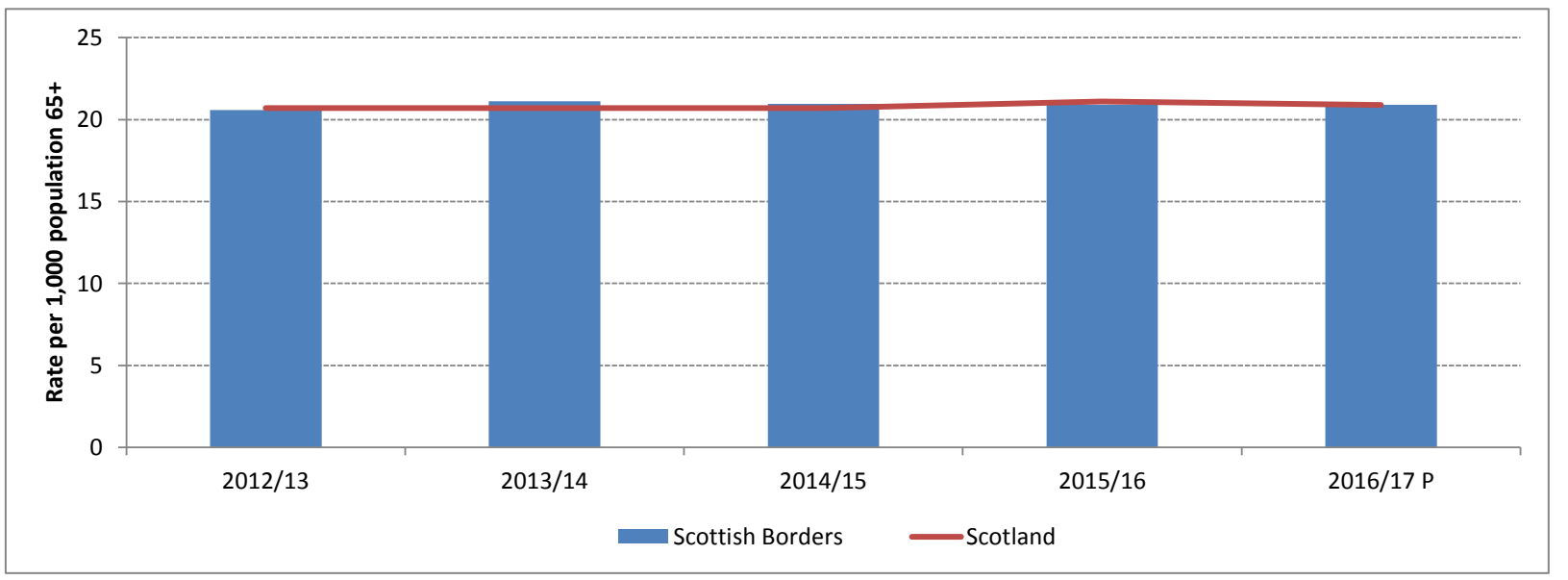
Emergency Admissions for falls, people aged 65+, rates per 1,000 population (aged 65+) in Scottish Borders residents

	Apr-Jun '14	Jul-Sep '14	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17
Rate of Emergency Admissions for falls per 1,000 population 65+	5.0	5.2	4.8	5.9	5.0	5.6	4.5	5.8	4.8	5.1	5.7	5.3



Emergency Admissions for falls, people aged 65+, rates per 1,000 population (aged 65+) in Scottish Borders and Scotland Residents

	2012/13	2013/14	2014/15	2015/16	2016/17 (provisional)
Scottish Borders	20.6	21.1	21.0	20.9	20.9
Scotland	20.7	20.7	20.7	21.1	20.9



How are we performing?

Since 2012/13 the rate of admissions due to falls in Borders residents aged 65+ has been very close to the Scottish average.

What are we doing to improve or maintain performance?

Work of the Borders Falls Steering Group is ongoing, including to finalise the draft Falls Strategy (with Action Plan) for 2017-19. This will be informed by a shared self-assessment exercise using the 'Prevention and Management of Falls in the Community' tool.

2. Occupied Bed Days

What is this information and why is important to measure it?

It is possible for the number of emergency admissions to increase whilst emergency bed days reduce, and vice versa, so this measure is included to ensure a balanced view. Once a hospital admission has been necessary in an emergency, it is important for people to get back home as soon as they are fit to be discharged to avoid the risk of them losing their confidence and ability to live independently.

Health and Social Care Partnerships have a central role in this by providing community-based treatment and support options, “step down” care and home care packages to enable people to leave hospital quickly once they are well enough. Additionally, care homes should where appropriate be able to support people with a wider range of physical and mental frailty and needs.

Hospitals also have a role to play, by streamlining their processes and sharing best practice to ensure more people can leave hospital quickly once they are well enough. This will include improving rehabilitation and also reducing the possibility of infections, harm and injury all of which can result in longer stays.

Data Source(s)

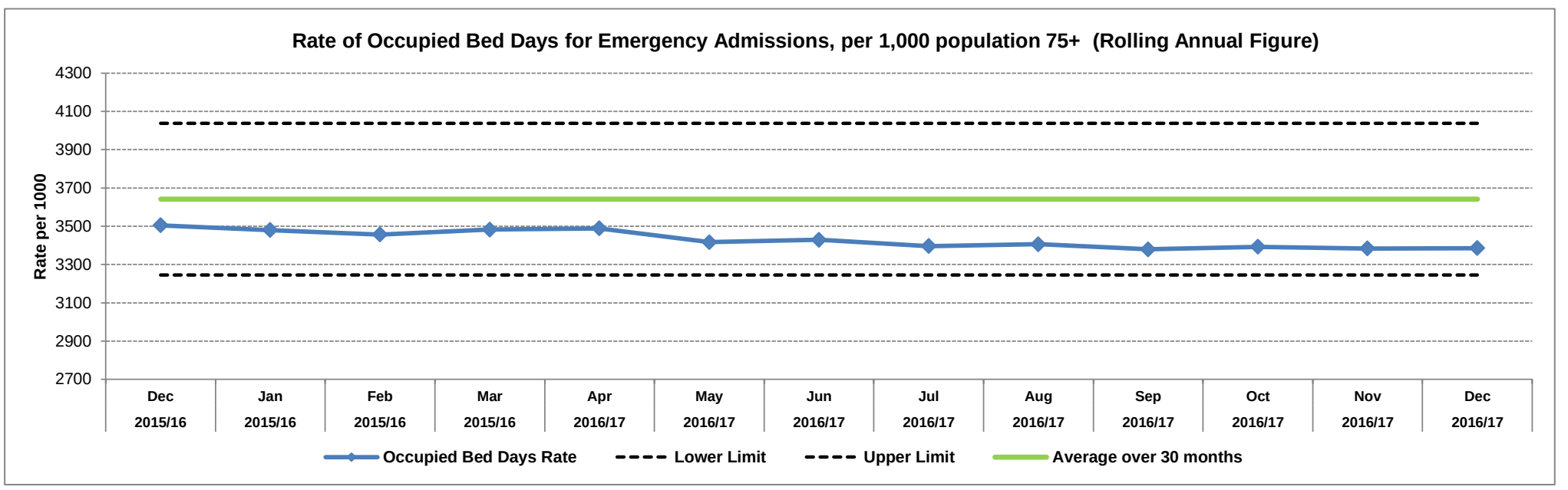
1. Hospital bed-days are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.

2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

2. Occupied Bed Days

Occupied Bed Days for emergency admissions, Scottish Borders Residents age 75+

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Occupied Bed Days for emergency Admissions, 75+	40,671	39,832	39,972	39,592	39,702	39,396	39,555	39,445	39,470			
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	3489	3417	3429	3396	3406	3380	3393	3384	3386			



How are we performing?

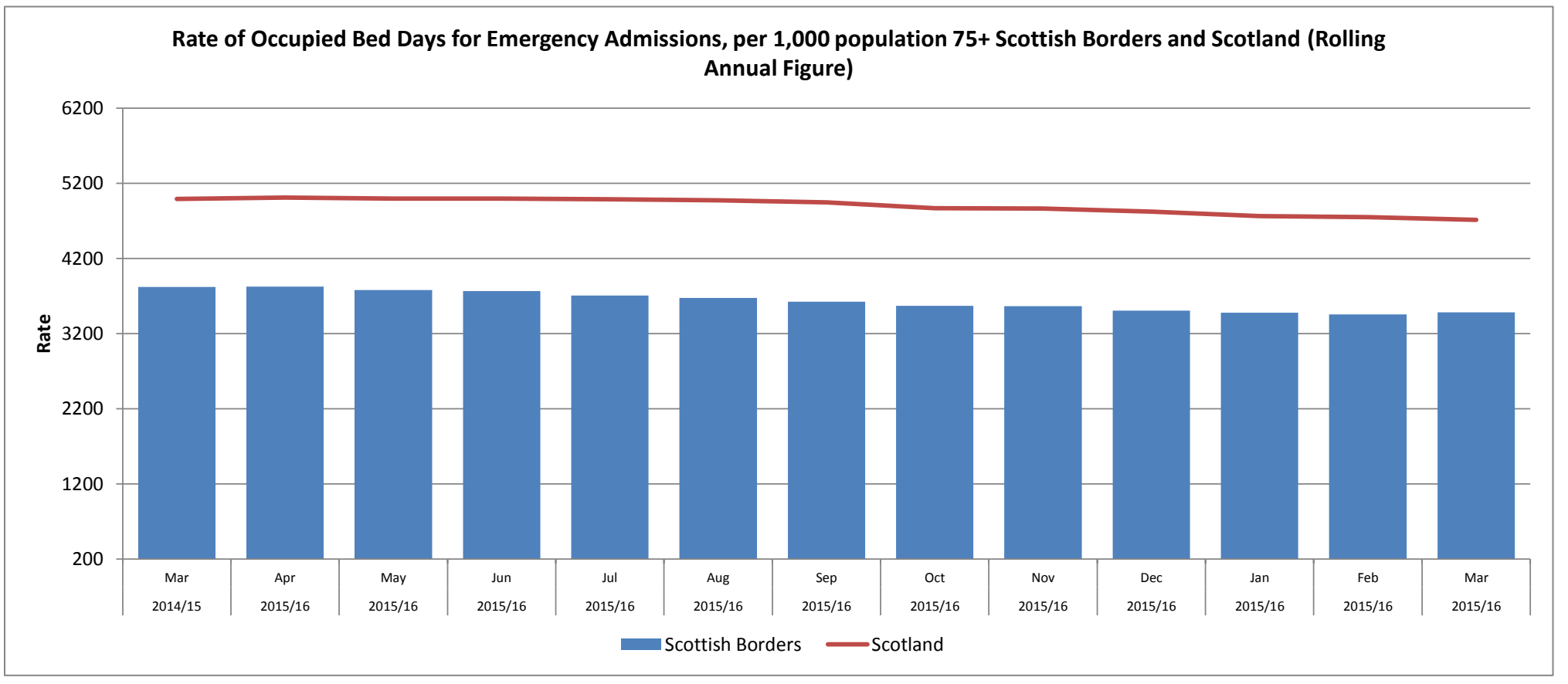
Emergency Occupied bed days for over 75s have been on the whole reducing since September 2014, following redesign work to reduce waits for patients requiring rehabilitation and elderly care beds.

What are we doing to improve or maintain performance?

The medical inpatient floor was remodelled in October 2016 to create one acute medical ward and two acute elderly care wards. This change is intended to stream frail elderly patients who are acutely unwell directly to an elderly care ward and avoid delays in medical wards. The redesign is intended to reduce overall length of stay by 0.6 days within the medical unit. There is also an increase in partnership working across health and social care to reduce delays for people requiring support on discharge home. There continue to be delays in transitions of care and we are working closely with partners to address these.

Occupied Bed Days for emergency admissions, Scottish Borders and Scotland Residents age 75+

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	3,824	3,782	3,765	3,707	3,675	3,627	3,570	3,567	3,505	3,480	3,454	3,483
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	5,013	4,998	4,996	4,989	4,976	4,948	4871.62	4866.16	4824.01	4764.4	4750.2	4713.73



3. Accident and Emergency Performance

What is this information and why is important to measure it?

The national standard for Accident & Emergency waiting times is that 95% of people arriving at an A&E Department in Scotland (including Minor Injury Units) should be seen and then admitted, transferred or discharged within 4 hours. NHS Boards are to work towards achieving 98% performance.

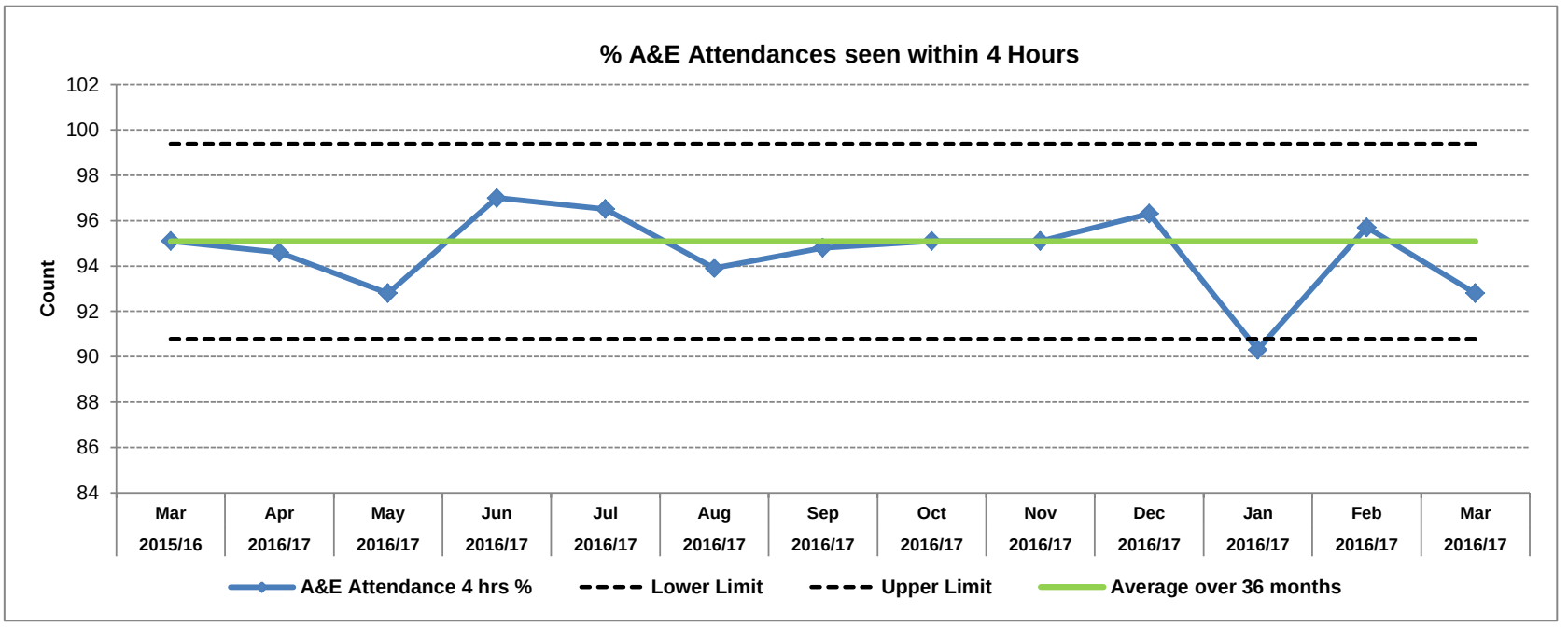
Although the standard is measured in the A&E Department, NHS Boards and Health and Social Care Partnerships are required to ensure that best practice is installed throughout the whole system, including health and social care, supporting joined up work to address wider issues of patient flow through each hospital that will safeguard timely access to services across the patient's journey and ensure the whole system works together effectively.

Data Source(s)
NHS Borders TrakCare system.

3. Accident and Emergency Performance

Accident and Emergency attendances seen within 4 hours

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of A&E Attendances seen within 4 hours	2,389	2,735	2,436	2,406	2,555	2,506	2,465	2,244	2,319	2,323	2,079	2,401
% A&E Attendances seen within 4 hour	94.6%	92.8%	97.0%	96.5%	93.9%	94.8%	95.1%	95.1%	96.3%	90.3%	95.7%	92.8%



How are we performing?

Patients attending A&E and the Acute Assessment Unit (AAU) are routinely discharged within 4 hours. NHS Borders is working towards consistently achieving the 98% local stretched standard.

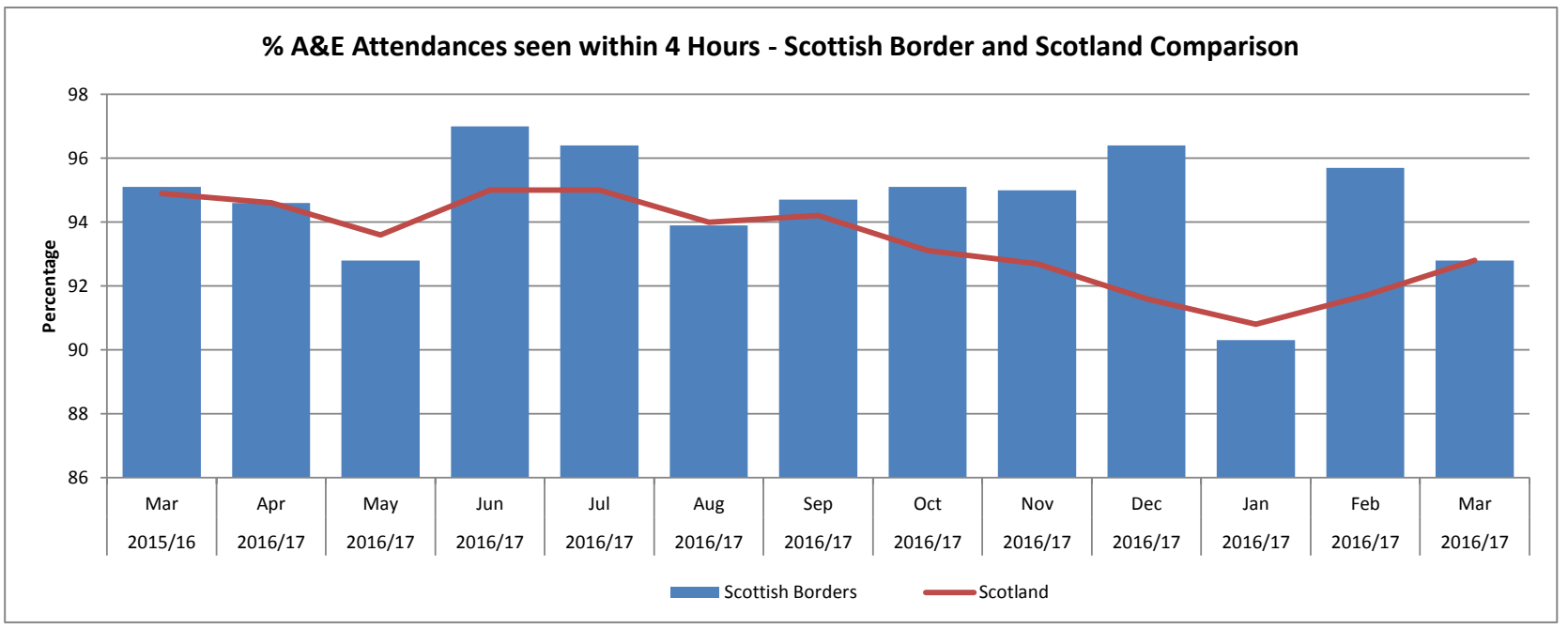
Following an improvement in performance in February, there was a marked deterioration in performance against the Emergency Access Standard in March with 173 breaches of the standard and a performance of 92.8%. There were 5 days when there were more than 10 breaches - 3 of these days were Monday, reflecting challenges in inpatient flow over the weekends. This was predominantly related to challenges in inpatient flow, with 50% of breaches due to patients waiting for beds to become available. Breaches related to wait for assessment within ED were just 7.5% in January and show a consistent fall since December.

What are we doing to improve or maintain performance?

especially on Mondays, when bed pressures tend to be most challenging.
A new action plan for addressing delayed discharges is being developed following the John Bolton review (more detail of which is given under Theme 4, Delayed Discharges).

% A&E Attendances seen within 4 Hours - Scottish Border and Scotland Comparison

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
% A&E Attendances seen within 4 hour Scottish Borders	94.6%	92.8%	97.0%	96.4%	93.9%	94.7%	95.1%	95.0%	96.4%	90.3%	95.7%	92.8%
% A&E Attendances seen within 4 hour Scotland	94.6%	93.6%	95.0%	95.0%	94.0%	94.2%	93.1%	92.7%	91.6%	90.8%	91.7%	92.8%



4. Delayed Discharge

What is this information and why is important to measure it?

A delayed discharge (often referred to in the media as "Bed Blocking") occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible. For example, a person's house may first need to be altered to help them get around, or there may not be a place available in a local care home.

A long delay increases the risk of the patient falling ill again, or losing vital life skills, independence or mobility. It could ultimately result in the patient having to be admitted to a care home due to the deterioration in their health and mobility.

Data Source(s)
Monthly Delayed Discharge Census, ISD Scotland.

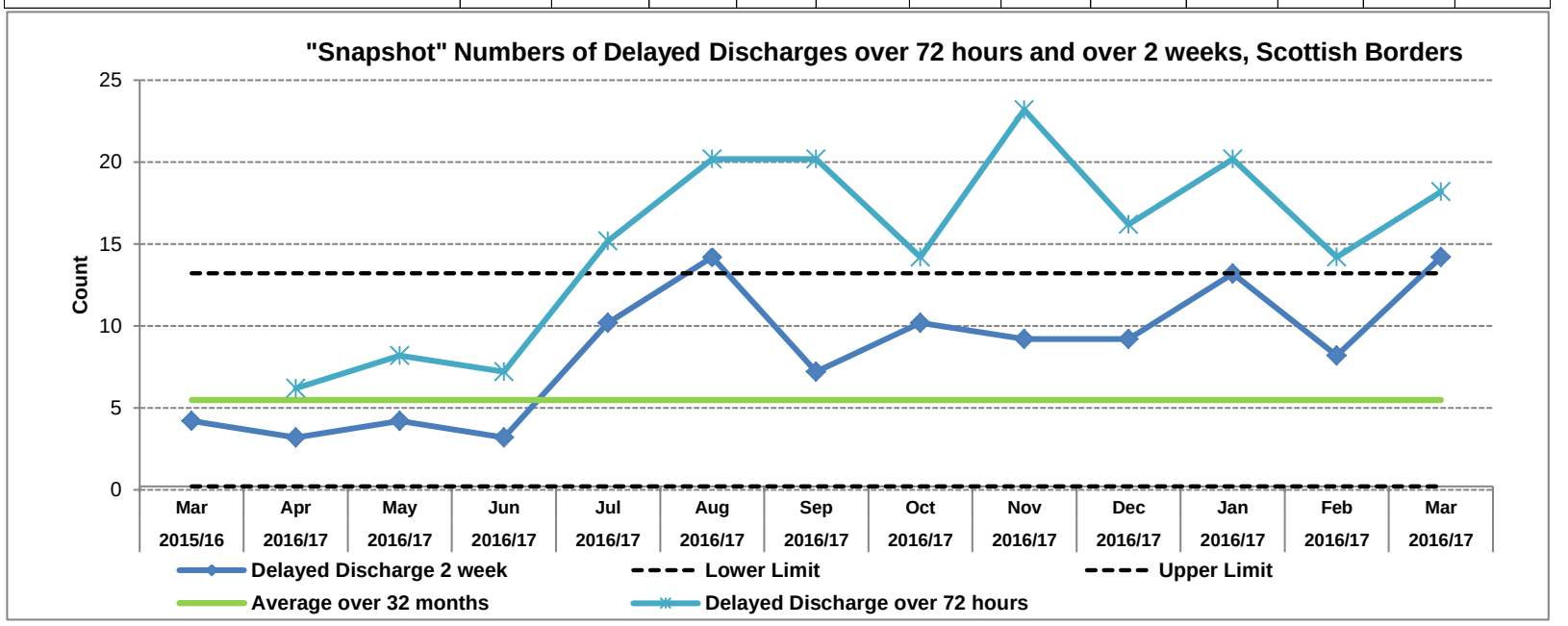
1) The measures on numbers of discharges delayed by more than 72 hours/more than 2 weeks, are snapshots of the number of patients waiting to be discharged, on a single day in each month.

2) The measure of bed days associated with delayed discharges is based on all delayed discharges within the specified time period.

4. Delayed Discharge

Delayed Discharges (DDs)

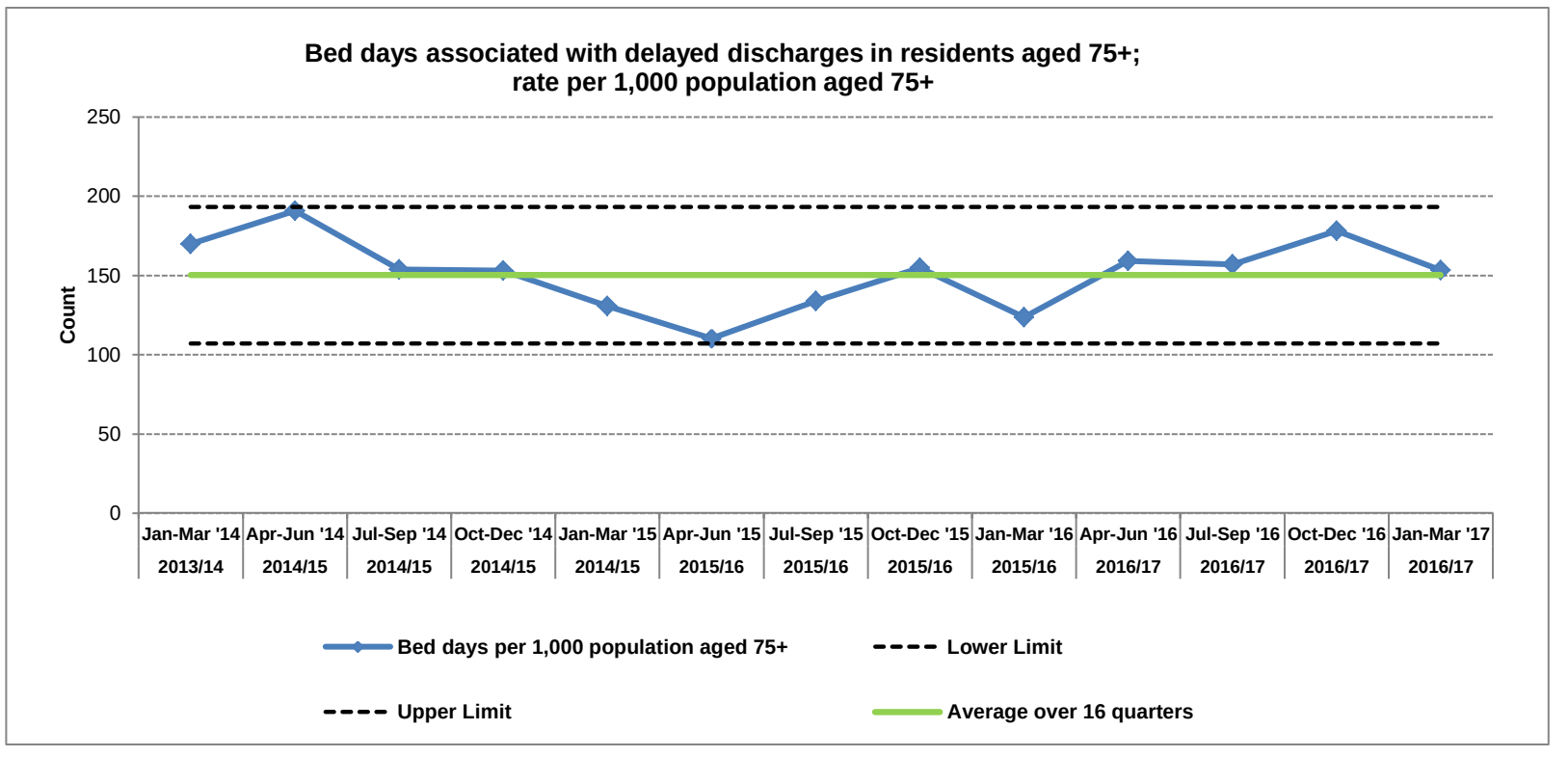
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of DDs over 2 weeks	3	4	3	10	14	7	10	9	9	13	8	14
Number of DDs over72 hours	6	8	7	15	20	20	14	23	16	20	14	18



Please note the Delayed Discharge over 72 hours measurement has only recently been implemented from April 2016. It has been overlayed on this graph as an indicator of the new measurement (light blue line) however as data is limited to less than one year we cannot provide a statistical run chart for this.
The DD over 2 weeks measurement has several years of data and has been plotted on a statistical run chart (with upper, lower limits and an average) to provide additional statistical information to complement the more recent 72 hour measurement.

Bed days associated with delayed discharges in residents aged 75+; rate per 1,000 population aged 75+

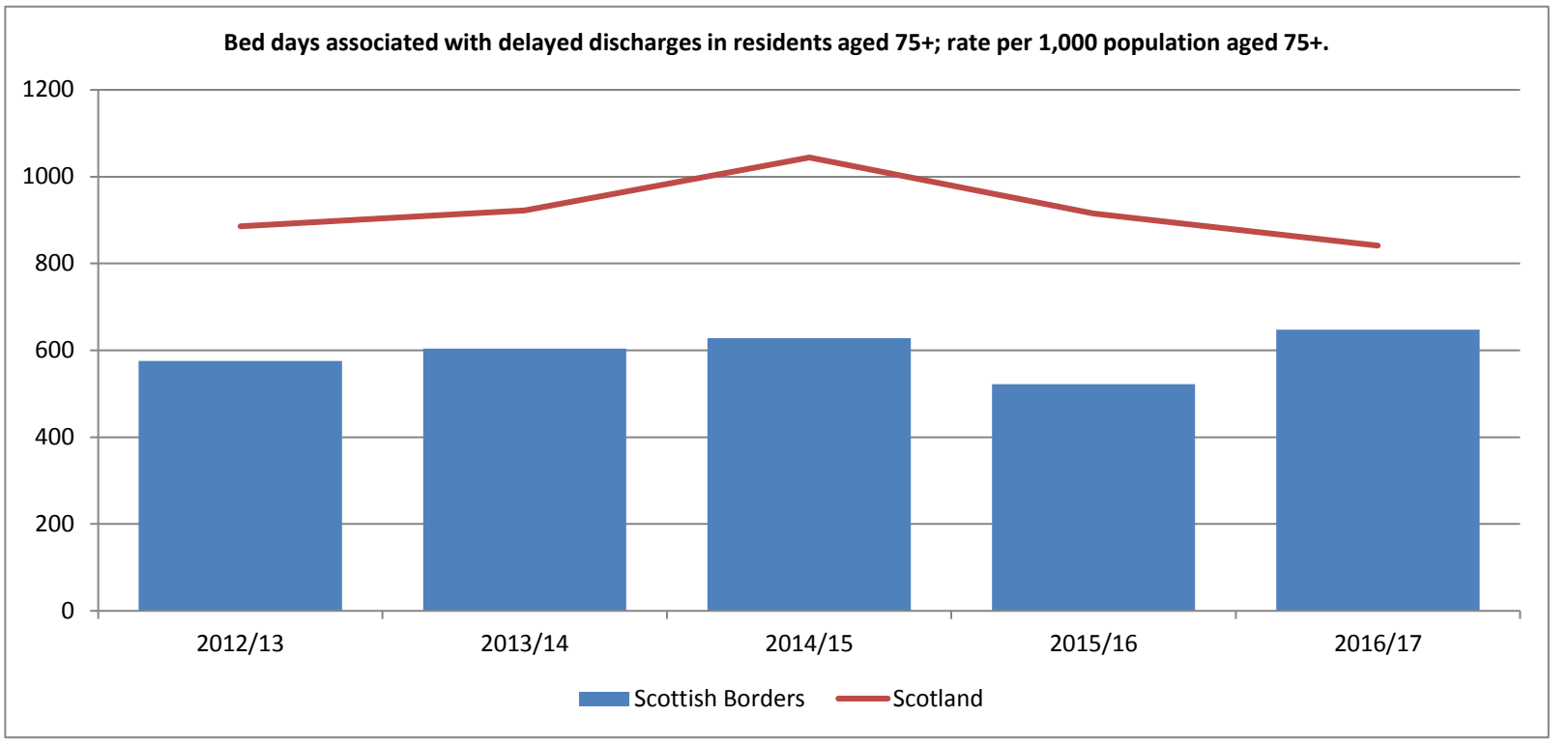
	Apr-Jun '14	Jul-Sep '14	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17
Bed days per 1,000 population aged 75+	191	154	153	131	110	134	154	124	159	157	178	153



4. Delayed Discharge

Scotland / Scottish Borders comparison of bed days associated with delayed discharges in residents aged 75+

	2012/13	2013/14	2014/15	2015/16	2016/17	
Scottish Borders	575	604	628	522	647	
Scotland	886	922	1044	915	842	



How are we performing?

In terms of overall rates of occupied bed-days associated with delayed discharge, Borders has performed consistently better than the Scottish average. However, the local rate for 2016/17 as a whole was higher than for the preceding year.

A new national target of zero delays over 72 hours came into force on 1st April 2016. New definitions for recording delayed discharges were introduced on the 1st July 2016. NHS Borders is facing significant challenges with delayed discharges, which continues to impact on patient flow within the Borders General Hospital and our four Community Hospitals.

The key reasons for delay experienced by patients are currently being influenced by challenges relating to the following issues:
- Care at home – we continue to be challenged in sourcing care at home across the Borders.
- Choices of care home placements and availability thereof and total capacity in Care Homes in Borders, particularly for more complex cases.
- A number of complex cases with a significant length of stay.

Ongoing focus is being placed upon supporting the discharge of delayed patients awaiting their next stage of care across the system. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 Hour ED Standard, quality of care and ensuring people are in the right care setting, and the avoidance of disruption to planned surgical admissions.

There are weekly delayed discharge meetings with senior managers and senior colleagues from Scottish Borders Council and SB Cares, Chief Officer for Health and Social Care, and General Managers for Primary & Community Services and Unscheduled Care. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring and to implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

What are we doing to improve or maintain performance?

Further work underway and planned:
- Professor John Bolton was commissioned to work with us to help to improve Delayed Discharges and Patient Flow across the system. This will inform subsequent work to improve community hospital LOS, effective use of community capacity across home care and care homes, pathway development, thresholds and risk management and improve patient safety. He reported back in early April 2017 and an action plan to redress his recommendations is being progressed.

- Dr Anne Hendry, HIS National Clinical Lead for Integrated Care and Consultant Geriatrician has agreed to work with us to review and develop our community & day hospital model. This fits well with and will build upon the outcomes from Professor Bolton's work.

4. Delayed Discharge

What are we doing to improve or maintain performance?

- In early 2017/18 a Matching Unit was introduced, the role of which is to source the provision of home care to meet assessed need, to free up care managers' time to undertake assessment. Recruitment is now complete with a Team Leader and 3 Matching unit co-ordinators now in post based in Hawick Town Hall. The Unit went live in the Hawick area on 17th April and was rolled out to Tweeddale on 22nd May and the home care waiting list in Peebles has been significantly reduced in a short period with care being sourced quickly and efficiently. The Matching Unit will continue to be rolled out throughout the Borders.

- Within BGH, work is underway to support the early identification of patients who have the potential to become delayed discharges in order to plan "upstream", identifying and removing potential blocks to discharge, putting in place appropriate processes etc. MDTs and Board Rounds will be revised to accommodate this approach. If this proves to be effective, the aim would be to roll out to community hospitals.

- Social Work are working to develop the care at home market and part of this is the review of recruitment & retention of care at home staff.

- Plans to review and remodel Rapid Response services are being developed by Social Work which will allow an out of hours home care response. The focus of this service will be prevention of admission. This redesign will be developed in full liaison with BECS.

- Work is to be progressed with Mental health to consolidate the MDT processes and manager advocate role in order to gain a better understanding of their patient profile.

5. End of Life Care

What is this information and why is important to measure it?

This indicator measures the percentage of time spent by people in their last 6 months of life at home or in a community setting. It is derived by linking recorded deaths data with hospital bed day data to calculate the percentage of time spent outside hospitals in the last 6 months of people's lives. Accidental deaths are excluded.

It is now possible to predict the progress of many diseases, enabling a planned approach to palliative and end of life care in ways which reflect best practice and which, as far as is practicable, in accordance with the needs and wishes of patients, carers and their families. Health and Social Care Partnerships are expected to be able to influence this by commissioning
high quality end of life services, and working with communities, families and staff to enable discussion about planning for end of life. As more people have anticipatory care plans and as electronic palliative care summaries are rolled out throughout the country, then we should see a gradual increase in this measure in the medium to long term.

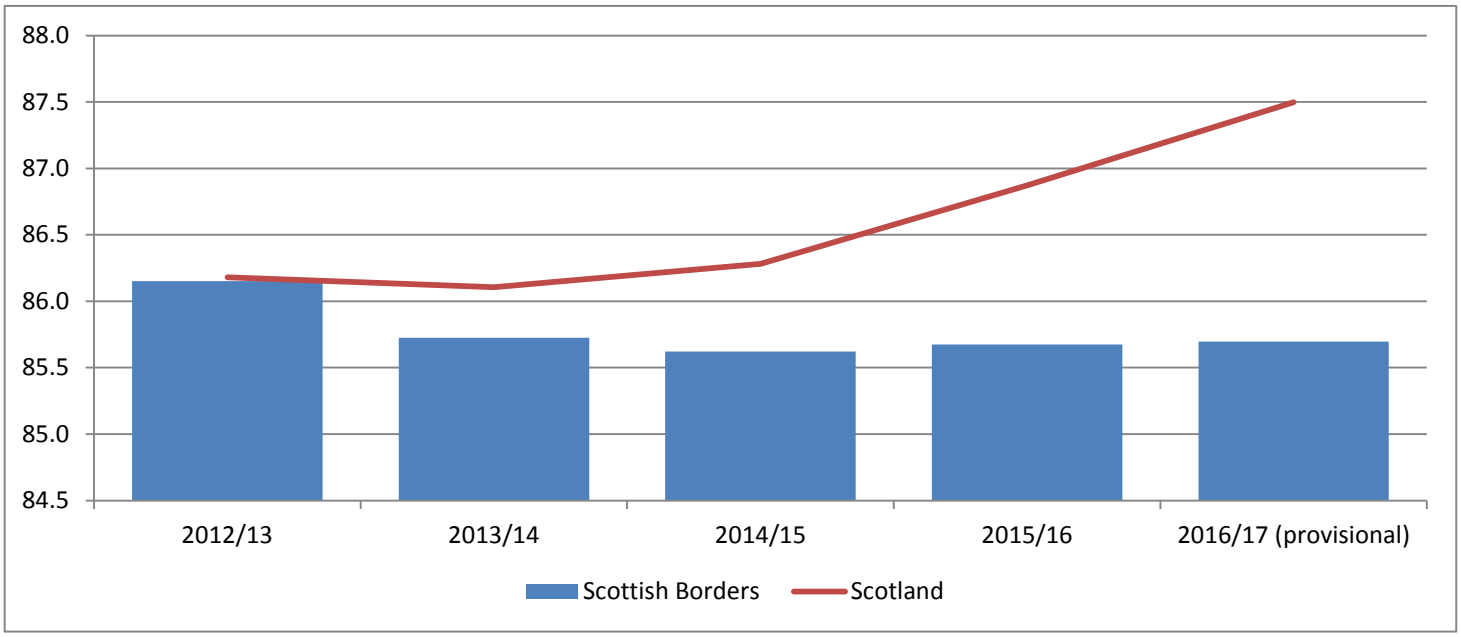
The indicator should ideally represent the wishes and choices for patients and their carers and also demonstrate the effectiveness of having a planned approach to end of life care. For an individual, the preferred place of care can change as their condition and/or family circumstances change over time, making this very difficult to measure and track. Therefore this indicator has been chosen by the Scottish Government as an alternative. The last six months of life was chosen as this is the period when most hospital admissions occur, and the period when clinicians would tend to plan end life care if the patient was not expected to live longer than 6 months.

Data Source(s)
This is the "Core Suite Integration Indicator" number 15, taken from Core Suite Indicator Workbooks for Health and Social Care Partnerships, ISD Scotland. Data taken from National Records for Scotland (deaths) and SMR records for acute/general hospitals, geriatric long stay beds, and acute psychiatric hospitals.

5. End of Life Care

Proportion of last 6 months of life spent at home or in a community setting.

	2012/13	2013/14	2014/15	2015/16	2016/17 (provisional)	
Scottish Borders %	86.2%	85.7%	85.6%	85.7%	85.7%	
Scotland %	86.2%	86.1%	86.3%	86.9%	87.5%	



How are we performing?

The percentage of last 6 months of life spent at home or in a community setting has appeared fairly consistent in the Borders from year to year since 2013/14 but in each case remains a little below the Scottish average, which is gradually increasing.

What are we doing to improve or maintain performance?

Part of the reason for the Borders' figures appearing lower than average will be related to the way in which stays at the Margaret Kerr Unit (MKU) are recorded. This specialist palliative care unit, which opened at Borders General Hospital in January 2013, provides a range of care that in other parts of Scotland are often provided in hospices (run by voluntary/independent sector organisations). This means that what in many other areas might be identified as time in a community setting has been, for the Borders, instead recorded as time in a hospital setting. From April 2017 onwards, changes have been implemented to the recording of stays within the MKU so it will be possible to more readily distinguish in national databases between it and the wards in the main BGH.

Areas of development by the specialist team include MKU outreach providing ward based teaching and support - practical and clinical, MKU hospice at home to deliver the same level of care in the patient's home that is within the MKU, and sourcing care home beds for palliative patients - MKU care Home. Part of the role throughout is education of a wide range of staff throughout the patient journey in palliative care skills- through communications skills courses directed at difficult conversations, deteriorating patients and dealing with complaints, and a joint project with PATCH (a charity to support palliative patients in acute care) and St Columbas Education department, encouraging cross group and joint learning. We are also contributing to Borders carers education and are developing care home education.

The local specialist palliative care team are in the process of developing a suite of outcome measures (including those validated through the Cicely Saunders institute) which were included in the recommendations sent in by the Scottish Partnership for Palliative Care, to the national work. These and other data the team are starting to collect will inform in greater detail the quality and extent of palliative care provision.

Overarching all of this, there is national work planned to progressively develop data recording, collection and reporting in order to gain better insight into provision of palliative care across a range of settings. We anticipate that Scottish Borders H&SCP, in common with other H&SCPs across Scotland, will be involved in discussions and work around this.

6. Balance of Spend

Part 1 - % spent on community based care.

What is this information and why is important to measure it?

Health and Social Care Integration should allow Health and Social Care Partnerships to commission changes in the health and social care pathway that will optimise (where appropriate) community based care. For example, through intermediate care, anticipatory and preventative care. This ensures that emergency/non elective resources (staff, beds, equipment) are
used for those who need acute medical and trauma care.

Under integration it is expected that an increasing proportion of total health and social care spend should be on community-based services.

Data Source(s)

"Source" reporting system for Health and Social Care Partnerships, ISD Scotland. Please note:-
1. All NHS services are included in total spend, including health services that are not covered by integration (such as planned outpatient and inpatient care).
2. 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.
3. Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.
4. Figures shown here for 2013/14 differ from those shown in the Scottish Borders HSCP Strategic Plan as they have since been updated to incorporate Community Dental Services and Community Ophthalmic Services.

Part 2 - % of total spend on hospital stays where the patient (age 18+) was admitted as an emergency.

What is this information and why is important to measure it?

Health and Social Care Integration should allow Health and Social Care Partnerships to commission changes in the health and social care pathway that will optimise (where appropriate) community based care. For example, through intermediate care, anticipatory and preventative care. This ensures that emergency/non elective resources (staff, beds, equipment) are
used for those who need acute medical and trauma care.

Under integration it is expected that a decreasing proportion of total health and social care spend should be on unscheduled hospital care.

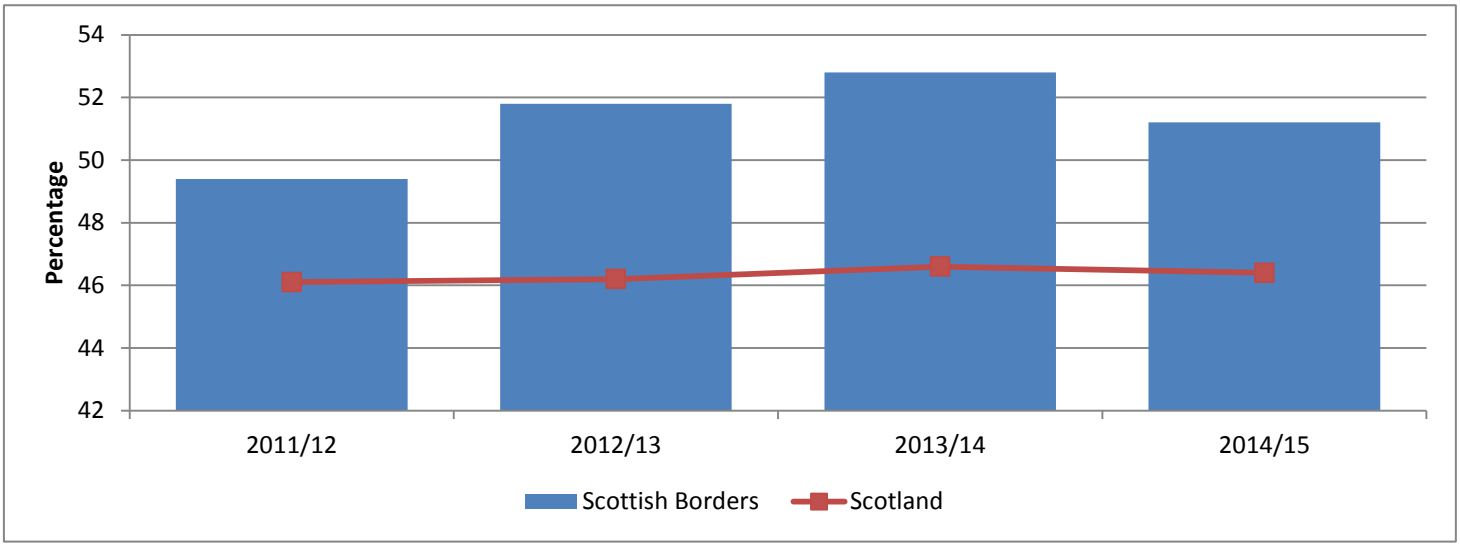
Data Source(s)

This is the "Core Suite Integration Indicator" number 20, taken from Core Suite Indicator Workbooks for Health and Social Care Partnerships, ISD Scotland.

6. Balance of Spend

Total Health and Social Care Expenditure

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders Total Spend (£ millions)	248.7	247.7	257.8	267.2		
Scottish Borders % spent on Community-Based care	49.40%	51.80%	52.80%	51.20%		
Scottish Total Spend (£ millions)	11,675	11,782	12,109	12,620		
Scottish % spent on Community-Based care	46.10%	46.20%	46.60%	46.40%		



How are we performing?

In the four years 2011/12 to 2014/15 the percentage of total health and care spend in the Borders that was accounted for by community-based services has been consistently higher than the Scottish average. Whilst this is a good baseline position for the Health and Social Care Partnership relative to Scotland, it will be important to ensure that the community service share is maintained/improved. The share for 2014/15 dropped relative to that for 2013/14. We anticipate figures for 2015/16 will be available to us at the end of June 2017, when they are published as Official Statistics.

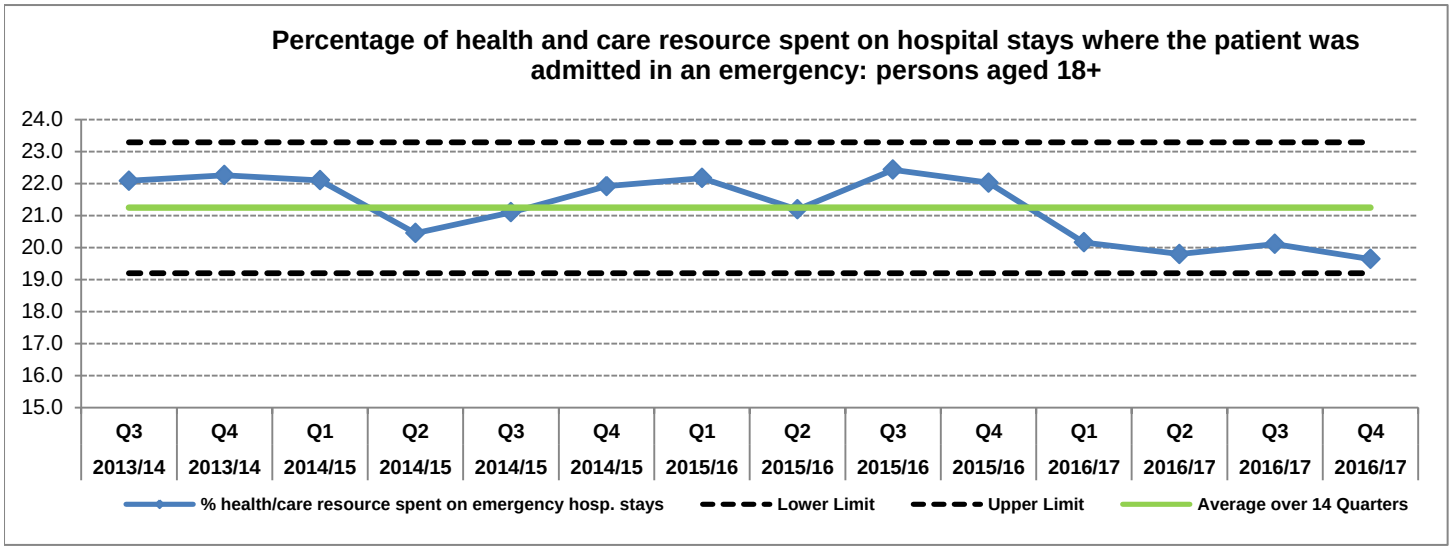
What are we doing to improve or maintain performance?

There are a wide range of factors that impact on the balance of spend between acute and community based services. Following the work that John Bolton has carried out on discharge flows there is a requirement for re-ablement services in the community. An action plan is being developed to follow this through. The Buurtzorg pilot is also underway looking at a new model for community based services to support patients at home. This will deliver improvements in a person-centred holistic model for both health and social care in the community.

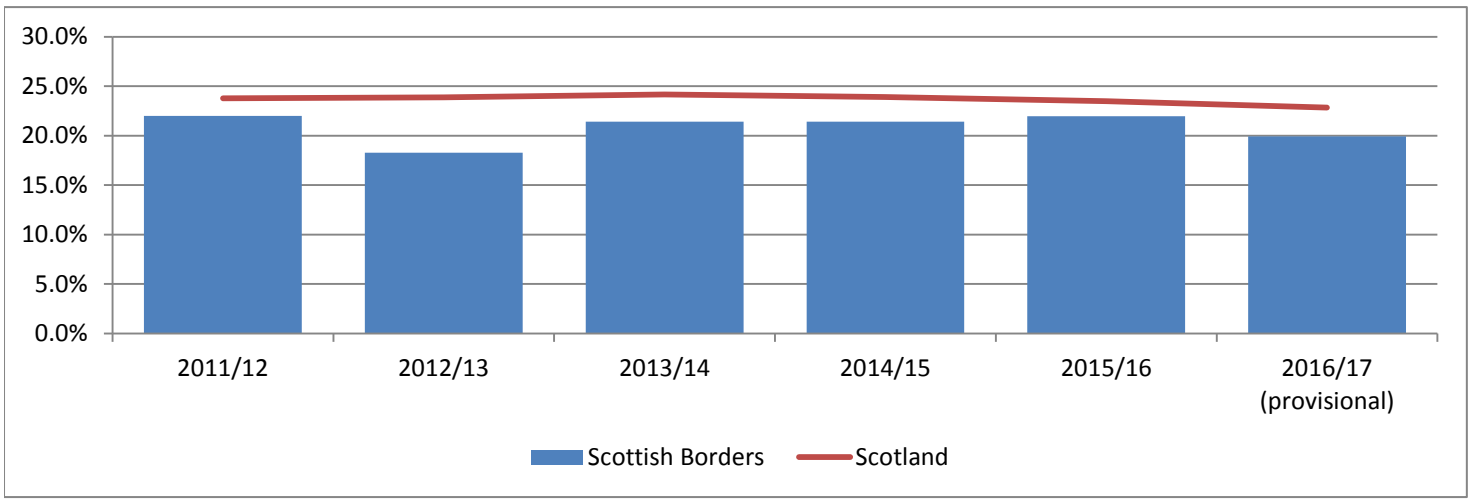
6. Balance of Spend

Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+

Quarter ending	Apr-Jun '14	Jul-Sep '14	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17
% of health and care resource spent on emergency hospital stays	22.1	20.5	21.1	21.9	22.2	21.2	22.4	22.0	20.2	19.8	20.1	19.6



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (P)
Scottish Borders	22.0%	18.3%	21.4%	21.4%	22.0%	19.9%
Scotland	23.8%	23.9%	24.2%	23.9%	23.5%	22.8%



How are we performing?

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

What are we doing to improve or maintain performance?

Work continues to reduce emergency admissions to the BGH. The Long Term Conditions self-management project helps patients with chronic conditions to support themselves in the community. Also Anticipatory Care Plans are routinely created and shared between health and social care to make sure patients receive the support that they require in their own homes.

7. Social Care

Part 1 - Percentage of social care clients reporting that they feel safe.

What is this information and why is important to measure it?

All adults who require support receive a care assessment by an occupational therapist, social worker or a nurse. A care assessment looks at the emotional and social side of an individuals life as well as any physical difficulties they may be experiencing.

At the end of a care assessment the individuals views are recorded to give an indication of how they feel the support discussed during the assessment will make them feel.

Ensuring our assessments and social care provision allow an individual to remain at home and feel safe in their environment is a fundemental requirement for care within a community setting. If this care is correctly administered it will allow individuals to remain within the community and in their own homes for longer. By increasing our ability to successfully support individuals in the community, we reduce the impact on other services over time.

Data Source(s)

1. Do you feel safe? is a Social Care Survey measurement taken during a social care adult assessment . It is recorded on the SBC Framework System and collated on a monthly basis. The questions applies to any adult who has received (and completed) an adult social care assessment during the month.

Part 2 - People within SB with intensive care needs receiving support in a community setting rather than a care home.

What is this information and why is important to measure it?

This measurement considers how we are managing to support elderly clients to remain within the community rather than move into residential care. It reviews our ability to support clients to sustain an independent quality primarily through home care, however it considers other areas:

- Homecare service (irrespective of hours)
- Direct payment or SDS payment
- Living within an extra care housing facility (Dovecot)
- The number of clients age 65 or older supported within a community setting is then compared to those age 65 or older in a residential setting (Care Home).

Home care is one of the most important services available to local authorities to support people with community care needs to remain at home. Increasing the flexibility of the service is a key policy objective for both central and local government, to ensure that people receive the type of assistance which they need, when they need it.

The measurement only captures 'home care services' which are provided on an hourly basis. Other services which support people at home, such as laundry services, home shopping, community alarms and meals-on-wheels, are not included. The measurement will be affected by the pattern of need and demand within the area, influenced by the age-structure of the elderly population, the distribution of poverty and ill health, household composition and other factors.

It will become increasingly important that we maximise our ability to support the elderly within the community as budget and financial considerations impact our service.

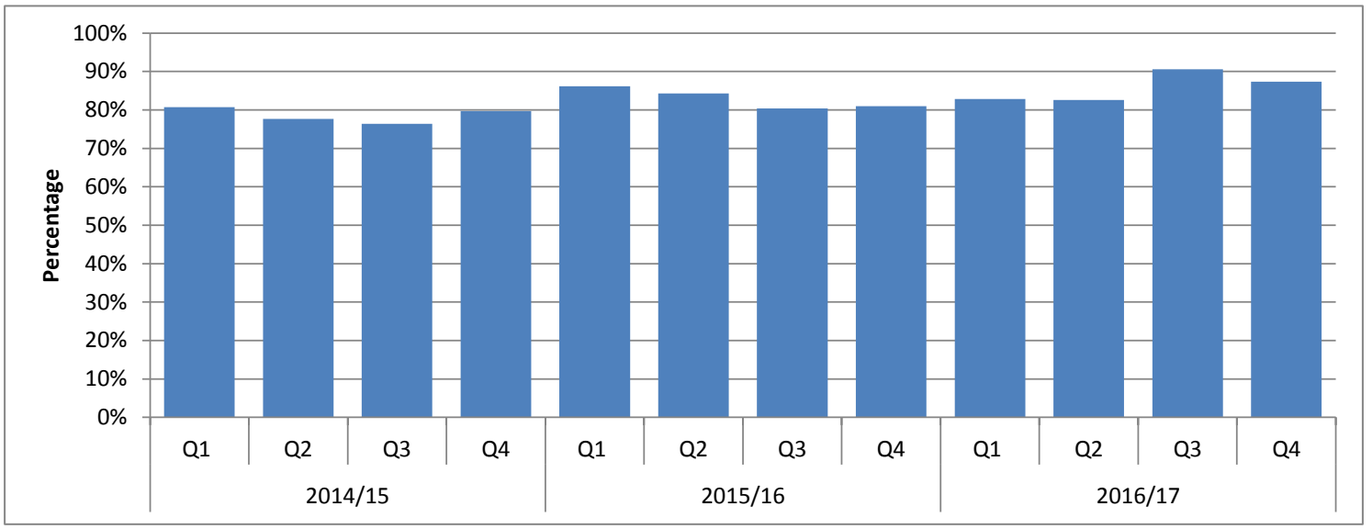
Data Source(s)

1. Report from SBC Framework System provided monthly for internal monitoring via the current reporting structure.

7. Social Care

Social Care Survey - Do you feel safe?

	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Number of People Feeling Safe	559	562	504	659	690	638	624	629	585	445	502	504
Ave. % of People Feeling Safe	81%	78%	76%	80%	86%	84%	80%	81%	83%	83%	91%	87%



How are we performing?

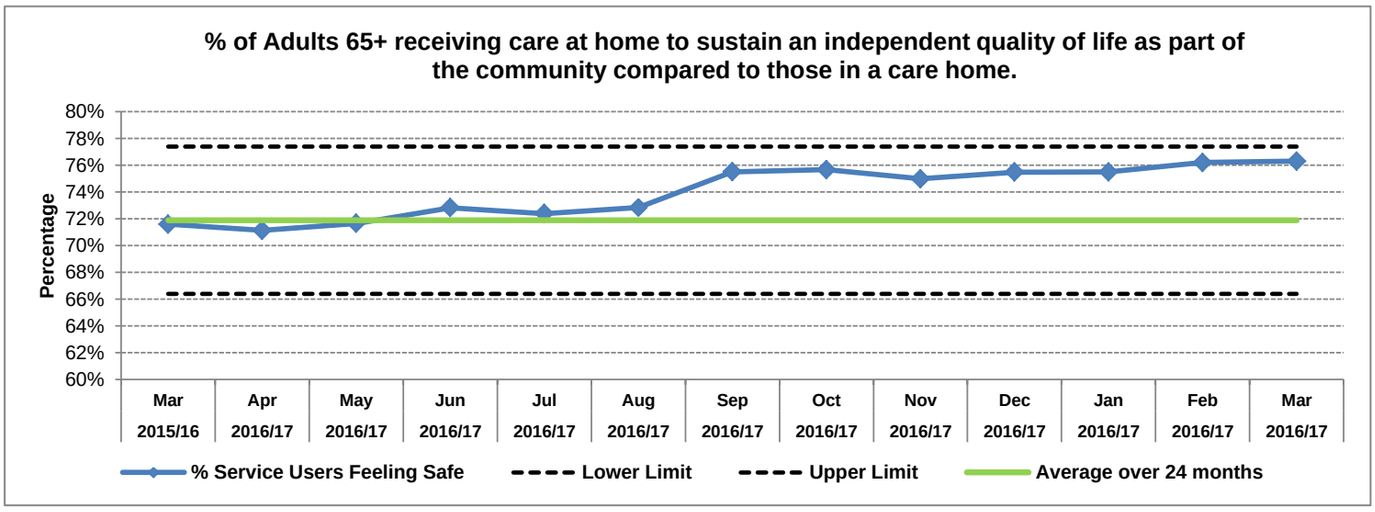
Fluctuating over the past 3 years, this indicator shows on average over 80% of those asked if they feel safe following a Social Care Adult Assessment answered yes.

What are we doing to improve or maintain performance?

This question has been consistently used to measure the outcome of a Social Care Assessment in which the clients needs are assessed and desired outcomes discussed. The methodology of collecting and measuring this outcome has changed over time and these inconsistencies may impact the measure. Further work is underway to find new and more specific outcome measures which will have more stringent collection methodology and provide a wider ranging outcome evaluation.

People within the Scottish Borders with intensive care needs receiving support in a community setting rather than a care home.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Adults 65+ within community.	1563	1619	1716	1710	1766	2032	2019	1988	2018	2074	2126	2153
% of Adults 65+ receiving care at home compared to those in a care home.	71%	72%	73%	72%	73%	76%	76%	75%	75%	76%	76%	76%



7. Social Care

How are we performing?
Since June 2016 this measure has been consistently better than the average over the past two years. This indicator shows we are actively supporting a large percentage of adults over 65 within a homely, community setting rather than a residential environment.
What are we doing to improve or maintain performance?
Locality based teams monitoring and assessing the needs of our clients ensure a more community based outcome for clients. Further emphasis on locality management of client will further maintain and improve this measure.

8. Carers

Part 1 - Carers Centre Assessments - Support for Caring

A Carers Assessment includes a baseline review of several key areas including Support for Caring, Caring Choice, and Caring Stress based on the Quality of Life assessment tool. These areas are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for Carers.

Data Source(s)

1. Carer Center Assessment responses to - Support for Caring questions
2. Carer Center Assesment responses to - Caring Choice
3. Carer Center Assesment responses to - Caring Stress

Part 2 - Carers Assessments offered and completed.

What is this information and why is important to measure it?

It is estimated that around 788,000 people are caring for a relative, friend or neighbour in Scotland. This includes around 44,000 people under the age of 18. A large percentage of these are currently not recognised as carers and are unpaid. Their contribution to caring within the community is substantial and could not be replaced.

The Carers (Scotland) Act will commence on April 1, 2018. There is a package of provisions within the Act designed to support carers' health and wellbeing. Local Authorities have a requirement to identify and support carers needs and personal outcomes.

Any carer who appears to have a need for support should be offered an assessment. The assessment is provided regardless of the amount or type of care provided, financial means or level of need for support.

Improving our methods of identifying and offering support to carers will ensure their contribution is recognised and complements the social care system currently in place.

Data Source(s)

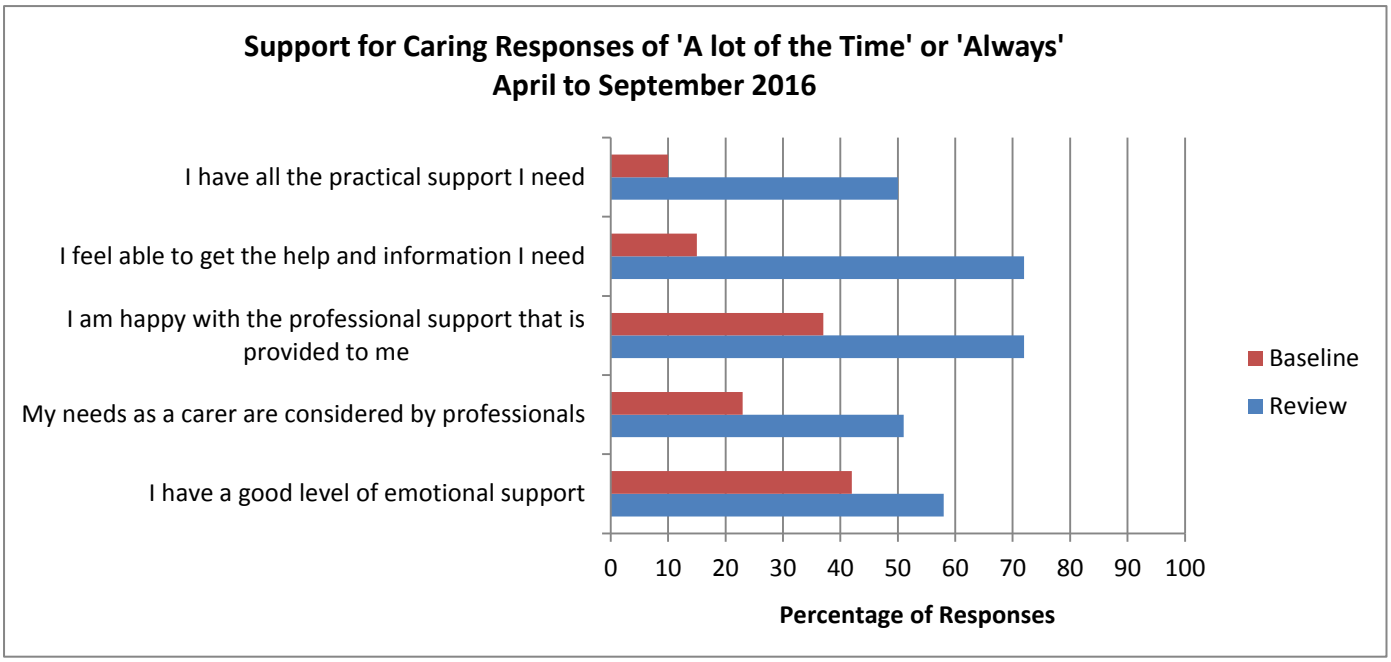
1. Offered assessment data is extracted from the SBC Framework System and is a question asked during a Adult Assessment.

2. The Carer Centre provides a monthly count of all completed assessments for the Scottish Borders.

8. Carers

Carers Centre Assessments - Support for Caring

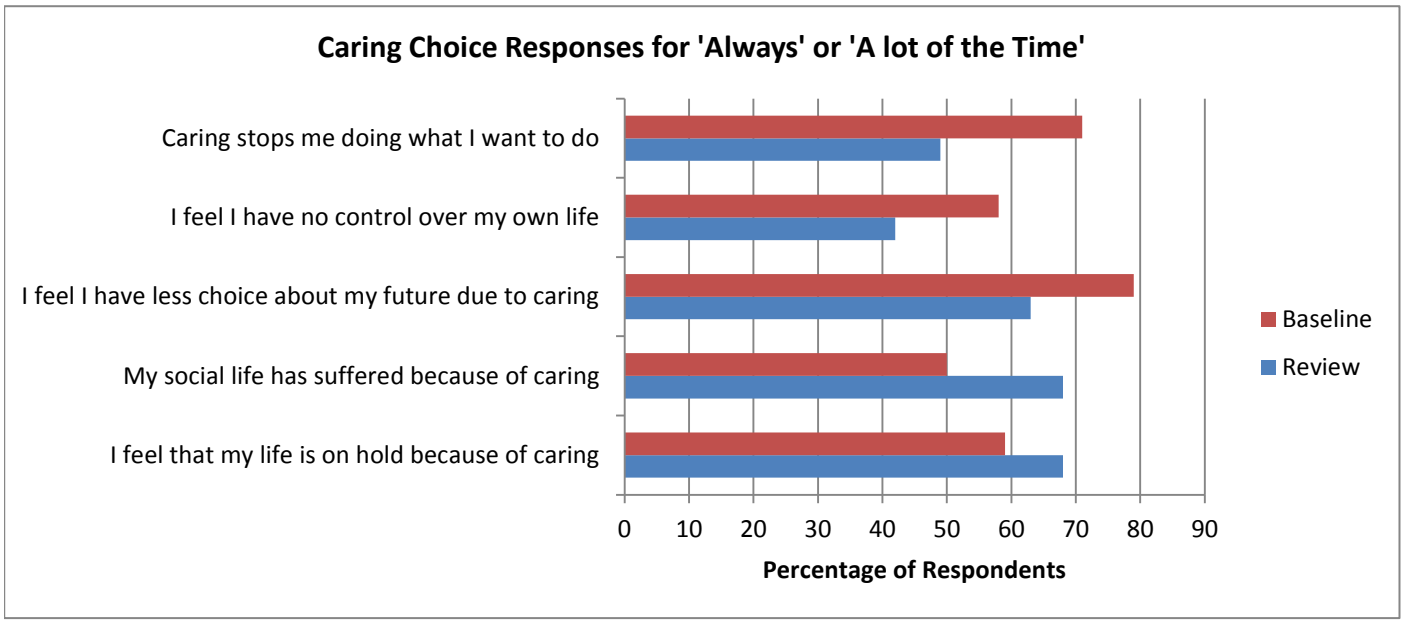
	Apr-Sep 2016									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always / A lot
I have a good level of emotional support	21	21	28	30	**42**	21	37	35	7	**58**
My needs as a carer are considered by professionals	2	21	35	42	**23**	22	29	21	28	**51**
I am happy with the professional support that is provided to me	23	14	35	28	**37**	37	35	14	14	**72**
I feel able to get the help and information I need	8	7	64	21	**15**	28	44	21	7	**72**
I have all the practical support I need	7	3	40	50	**10**	22	28	36	14	**50**



Carers Centre Assessments - Caring Choice

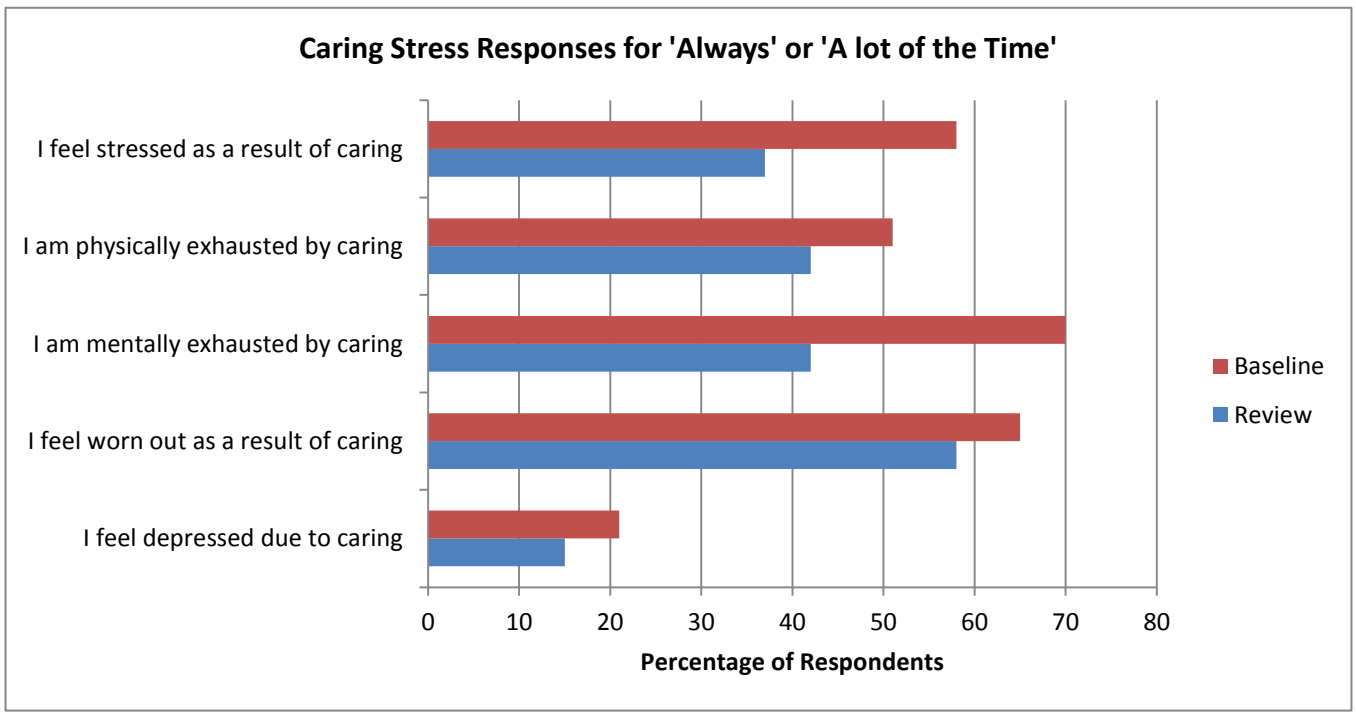
	Apr-Sep 2016									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always / A lot
I feel that my life is on hold because of caring	45	14	28	13	**59**	44	24	22	12	**68**
My social life has suffered because of caring	50	0	35	15	**50**	45	23	35	7	**68**
I feel I have less choice about my future due to caring	65	14	0	21	**79**	28	35	23	14	**63**
I feel I have no control over my own life	30	28	14	28	**58**	21	21	22	36	**42**
Caring stops me doing what I want to do	57	14	15	14	**71**	28	21	36	15	**49**

8. Carers



Carers Centre Assessments - Caring Stress

	Apr-Sep 2016									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always / A lot
I feel depressed due to caring	7	14	51	28	**21**	8	7	57	28	**15**
I feel worn out as a result of caring	50	15	35	0	**65**	21	37	28	14	**58**
I am mentally exhausted by caring	35	35	22	10	**70**	14	28	35	23	**42**
I am physically exhausted by caring	23	28	14	35	**51**	21	21	36	22	**42**
I feel stressed as a result of caring	30	28	35	7	**58**	14	23	42	21	**37**



8. Carers

How are we performing?

A Carers Assessment includes a baseline review of several key areas including Support for Caring, Caring Choice, and Caring Stress based on the Quality of Life assessment tool. These areas are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for carers.

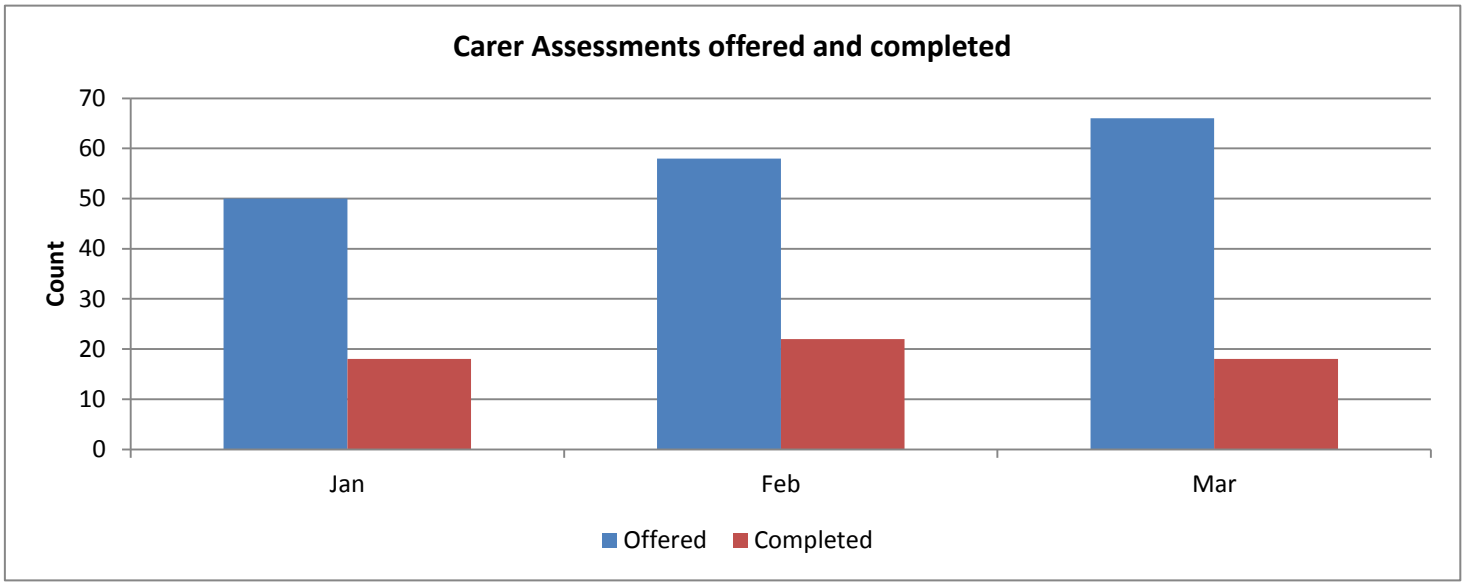
Data for April-September 2016 shows improvement between the baseline and review surveys in nearly all respects. There are just two exceptions to this – the questions under caring choices around Carers' social lives and feelings as to whether their lives have been put on hold.

What are we doing to improve or maintain performance?

The Carers (Scotland) Act 2016, which will be implemented from 1st April 2018, includes a range of duties on the Partnership and Scottish Borders Council to support Carers' health and wellbeing. These include a duty to provide support to adult and young Carers, based on the Carer's identified needs which meet the local eligibility criteria. The H&SCP is working to implement the requirements of the Act; in collaboration with the Carers Centre we have set up a Project Board and we are developing a structure to ensure Carers and Carer representatives participate in the planning process. It is anticipated that this will lead to an increase in the number of Carers who will seek support and in the range of support made available to Carers. The work of the Borders Carers Centre (commissioned by the Partnership) is a crucial component of the support offered to Carers.

Carers offered and completed assessments.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	###
Assessments offered during Adult Assessment										**50**	**58**	**66**
Carers Centre	New measure. Recording started in 2017									18	22	18



How are we performing?

This information shows that during the last quarter of 2016/17 we offered of average 58 assessment to individuals who were identified as carers during a Social Work Adult Assessment. Within the same month the Carers Centre completed on average 20 assessments per month. Although these measurement are taken within the same month they may not relate to the same individuals, for example a person offered an assessment in January may not actually undergo an assessment until some time later. We expect over a year the total offered will be similar to the total completed.

8. Carers

What are we doing to improve or maintain performance?
Although the offering of an assessment to a carer identified during an adult assessment is not a new action, we have not regular recording or monitored the take up of the offer. With regular monitoring and review of this measure we can identify improvement we can make in the service to ensure uptake of the carers assessment is maintain or improved.

9. Other Relevant Measures

Part 1 - BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

What is this information and why is important to measure it?

NHS Borders has introduced a proactive patient feedback system '2 minutes of your time', which comprises a brief survey of 3 quick questions. Feedback boxes are located within our acute hospital (the BGH), community hospital and mental health units. In addition patient feedback volunteers have been recruited and gather feedback from patients, carers and their relatives within clinical and public areas throughout the hospital. This enables us to look at changing the way in which we do things and ensuring our work has a more person centred approach.

Data Source(s)

NHS Borders

Part 2 - Integrated Care Fund Project Evaluations

What is this information and why is important to measure it?

It was recognised nationally, and evidenced locally, that the Reshaping Care for Older People Fund had worked well in encouraging the NHS , Local Authority, the third and independent sectors to work together to begin to redesign services for the future with a focus on older people.

It has now set more ambitions challenges; to be innovative, taking preventative approaches with the express intent to reduce inequalities across all adult services. This fund (Integrated Care Fund) is allocated to parnerships to help facilitate and drive forward the changes requied, tackling collectively the challenge associated with multiple and chronic conditions for all adults.

Several project have been established to focus on specific preventitive areas and this section summerises the project evaluations. More detail of each project and their evaluation findings are available via the 2 page summaries.

Data Source(s)

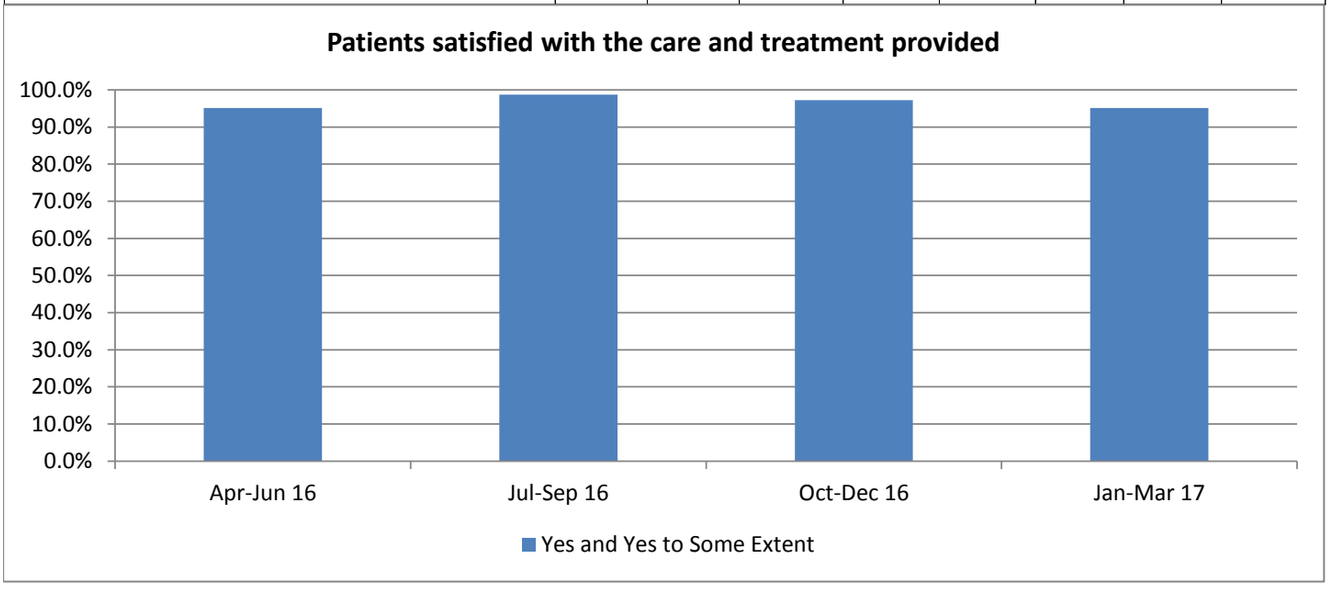
1. Borders Community Capacity Building (Apr-16 to Mar-17)
2. My Home Life (Feb-16 to Jan-17)
3. Community Transport Hub
4. Long Term Conditions (Jan-14 to Dec-16)
5. 'Stress and Distress Training'

9. Other Relevant Measures

BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

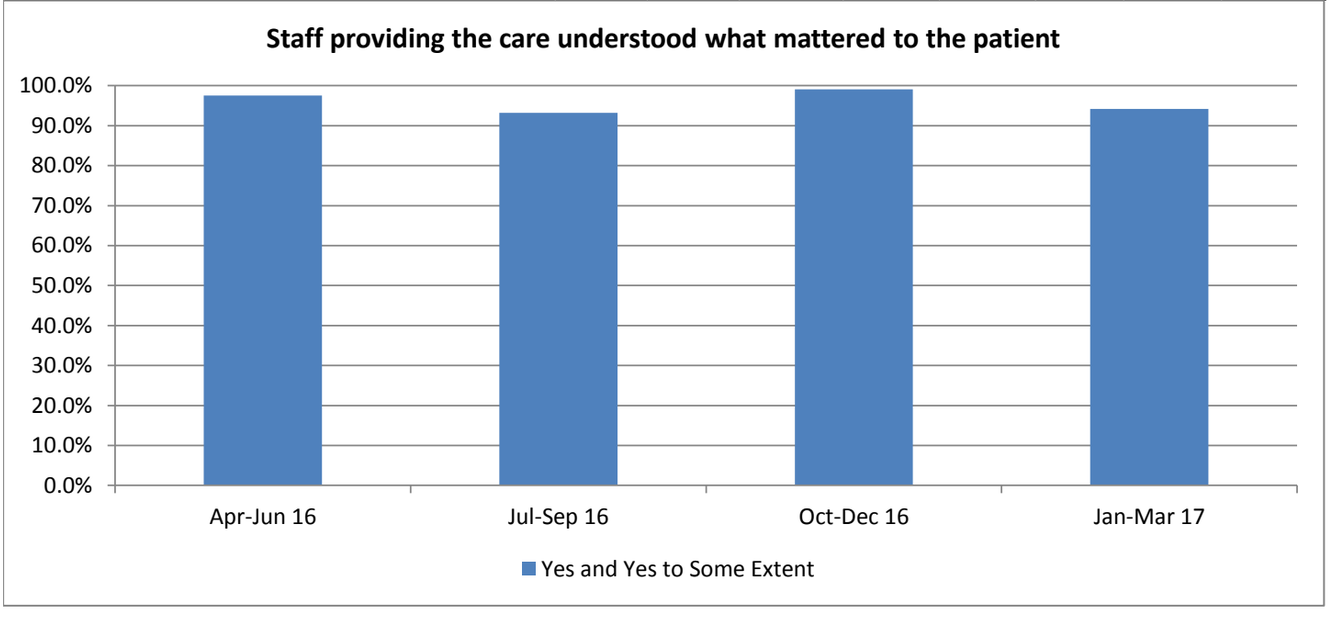
Q1 Was the patient satisfied with the care and treatment provided?

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Patients feeling satisfied or yes to some extent	232	160	105	116				
% feeling satisfied or yes to some extent	95.1%	98.8%	97.2%	95.1%				



Q2 Did the staff providing the care understand what mattered to the patient?

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Staff providing the care understood what mattered to the patient, or yes to some extent	238	151	106	113				
% understood what mattered or yes to some extent	97.5%	93.2%	99.1%	94.2%				

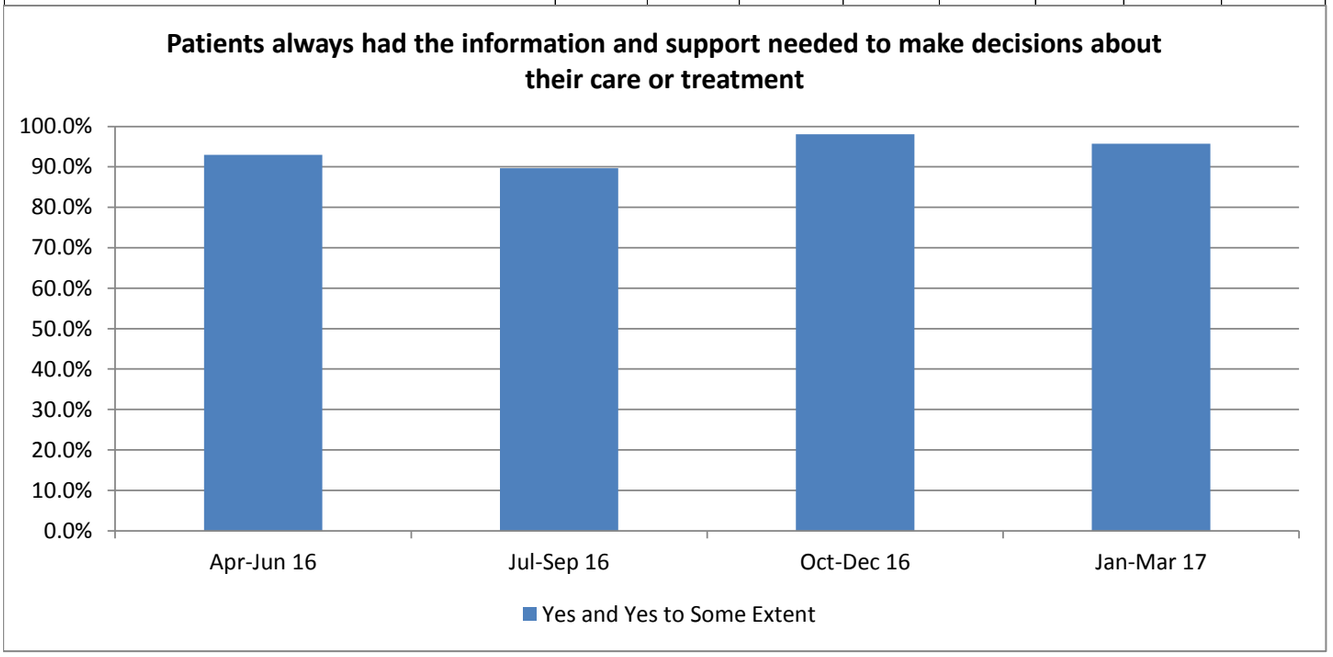


9. Other Relevant Measures

BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

Q3 Did the patient always have the information and support needed to make decisions about their care or treatment?

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Patients always had the information and support needed to make decisions about their care or treatment, or yes to some extent	226	147	101	111				
% always had information or support, or yes to some extent	93.0%	89.6%	98.1%	95.7%				



How are we performing?

The 2 Minutes of Your Time Survey is carried out across the Borders General Hospital and Community Hospitals and comprises of 3 quick questions asked of patients, relatives or carers by volunteers. There are also boxes posted in wards for responses. The results given here are the responses where the answer given was in the affirmative or 'yes to some extent'. Percentages given are of the total number of responses.
The positive response averages for the year are 96% for questions 1 and 2 and 94% for question 3.

What are we doing to improve or maintain performance?

The feedback collected is reported to our clinical and public areas in a timely manner. Within our clinical areas this is displayed on their quality and safety information boards and in public areas this is visible in a 'You said, We did' report. This enables the public and staff to see what changes have been made as a result of feedback. This feedback is reported across the organisation and to the Board.

9. Other Relevant Measures

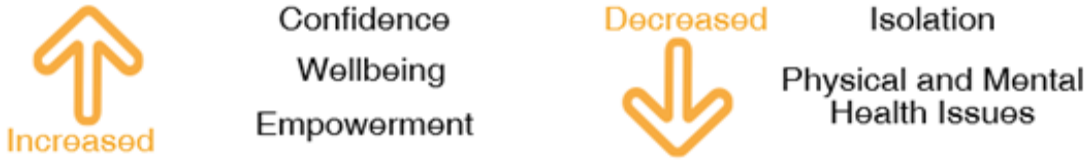
Integrated Care Fund Projects

Borders Community Capacity Building (Apr-16 to Mar-17)

What is this project and why is important?

The purpose of the community Capacity Building project is to encourage the development of social capital within communities to allow them to become stronger and more self-reliant through the use of evidence based investment.

Key Findings



My Home Life (Feb-16 to Jan-17)

What is this project and why is important?

Care home managers were provided funding to complete the My Home Life leadership support programme. The aim was to promote quality of life for those living, dying, visiting and working in care homes through relationship-centred and evidence-based practice.

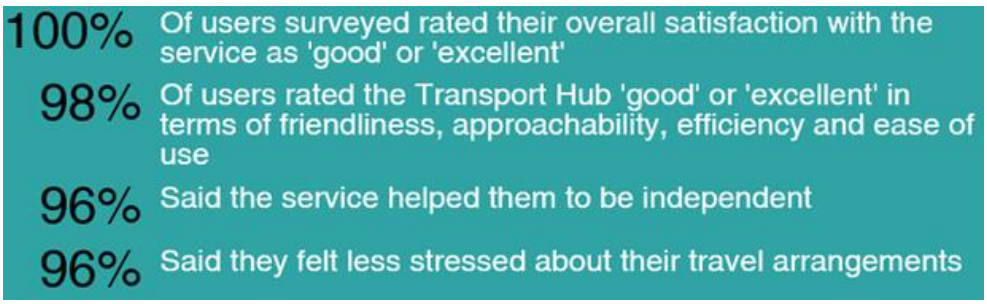
Key Findings

Community Transport Hub

What is this project and why is important?

The purpose of the Community Transport Hub is to create a coordinated approach to community transport provision across the Scottish Borders.

Key Findings



9. Other Relevant Measures

Long Term Conditions (Jan-14 to Dec-16)

What is this project and why is important?

This project was designed to support improvements in the shared-management of Long Term conditions amongst older people in the Borders.

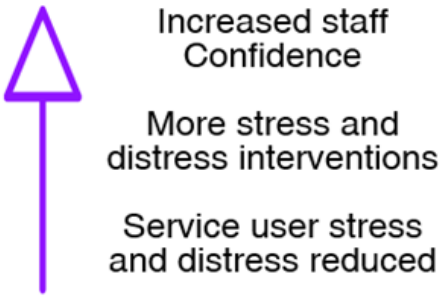
Key Findings

Stress and Distress Training'

What is this project and why is important?

The Stress and Distress Training Project is a 2 year project funded by the ICF, which delivers training in a psychologically informed model to staff within Health, Social Care, Third and Independent Sector in the Scottish Borders. The training teaches staff a proven approach to understanding and intervening in stress and distressed behaviours in people with dementia. The aim of this approach is to improve the care and outcomes for people with dementia and thier families.

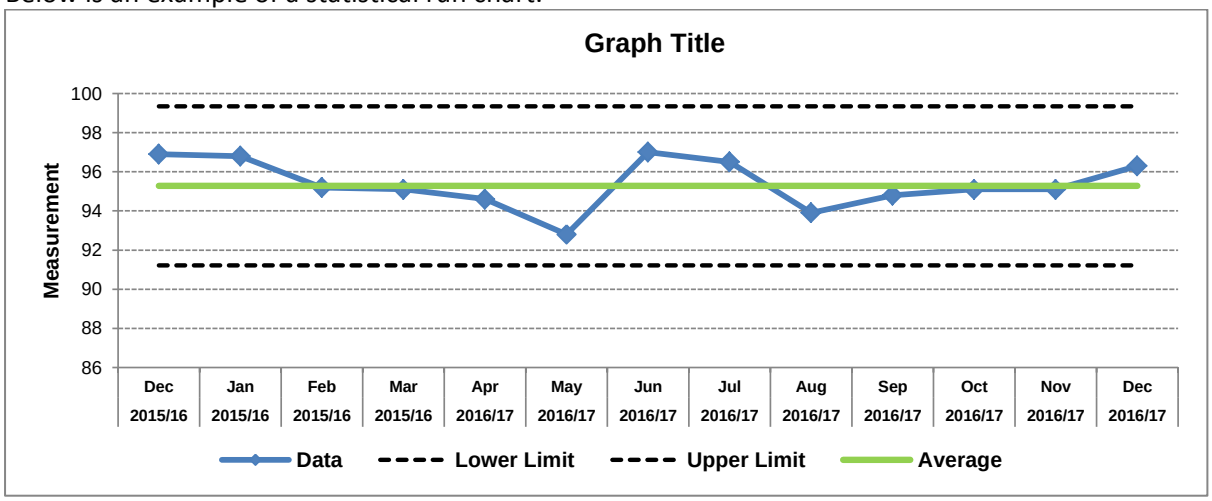
Key Findings



Background: Explanation of the line charts in this report.

A run chart or Statistical Process Control (SPC) chart is a graphical display of data over time. They are used to visually analyse processes according to time or sequential order. They are useful in assessing process stability, discovering patterns in data, and facilitating process diagnosis and appropriate improvement actions.

Below is an example of a statistical run chart.



- The blue line in this graph is showing the data for a performance measure, plotted over a succession of months.
- The green line shows the average value of the measure over a longer time period
- The statistical run chart then adds an upper and lower limit sometime referred to as the Upper Control Limit (UCL) and Lower Control Limit (UCL). These are shown as bold black dashed lines.

To find the upper and lower limit we use a statistical measurement known as standard deviation which in essence takes the data over a long period of time (for example over 24 points or in this case months) and works out what variation would be expected. From the expected variation it is then possible to put an upper and lower limit on the run chart.

How to read a statistical run chart

If the blue line (Data) goes above or below the dotted line this should be noted. It is saying the measurement has moved out with what would normally be 'expected' on the basis of random variation. If the data returns back in between the dotted lines when next measured it could be considered extraordinary but not an 'issue'. Where the measurement moves out with the dotted lines for a period more than 3 consecutive times then is would be considered a change which is not likely to be due to chance, not an anomaly but likely to indicate a change in the process/data measurement. These are the points which we need to review and pay attention to.

Another area to consider is the movement of the line above or below the average (green line). We will be taking the average over a long period of time (24 months or more normally) and any consistent movement of the data above the line (or below) would indicate an increase/decrease in the process. E.g. if the blue line is consistently above the green line, this would indicate a consistent increase (which may be an improvement or worsening, depending on the measure).

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Scottish Borders
Health and Social Care
PARTNERSHIP

HEALTH AND SOCIAL CARE LOCALITY PLANS: UPDATE JUNE 2017

Aim

1.1 The aim of this report is to update the Integration Joint Board (IJB) on work progressed by the Locality Co-ordinators to develop Health and Social Care (H&SC) Locality Plans for each of the five localities in the Scottish Borders.

1.2 The report also proposes an outline for consultation on the Locality Plans.

Background

2.1 Following the endorsement of the two page summary plans by the IJB in March 2017 (see **Appendix 2**) and in line with the requirements of the Public Bodies Joint Working Scotland Act work has been underway to develop a H&SC Locality Plan for each of the five localities in the Scottish Borders.

2.2 Five H&SC Locality Plans (see **Appendix 1**) have been developed in consultation with members of the Locality Working Groups (LWG's) which include members of the public, service users, Carers and health and social care professionals, Senior Managers across the Partnership, the Community Planning Partnership and Public Health.

Summary

3.1 The area profiles presented in the summary plans are presented within the H&SC Locality Plans and inform the identification of key priorities for each locality. Included in each plan is a detailed action plan which outlines the action required in order to deliver on the key priorities. The key priorities and actions outlined in the H&SC Locality Plans are aligned to the national outcomes and local objectives and will assist with the delivery of the Partnership's key priorities.

3.2 It is proposed that a two month period of consultation on the plans begins in July 2017. Feedback on the plans will be sought from all stakeholders. Methods and timescales for consultation are detailed in the table below:

H&SC Locality Plans – Consultation

Consultation Method	Timescale	By Whom
Electronic circulation of the plans to all key stakeholders including members of the Locality Working Groups.	July 2017	Locality Co-ordinators
Place electronic copies of plans on Partnership websites/ facebook pages and twitter.	July 2017	Locality Co-ordinators/Partnership Communication Teams

Dissemination of hard copies of two page summary plans within local communities including locality planning groups	July 2017	Locality Co-ordinators/Locality Working Group Members
Press release requesting feedback on plans	July 2017	Locality Co-ordinators/Partnership Communication Teams

3.3 It is then proposed that the Locality Co-ordinators collate and analyse feedback received during consultation and amend the plans accordingly before presenting the revised H&SC Locality Plans to the IJB in September 2017 for final sign off.

3.4 The responsibility for delivery of actions identified within the action plans lies with Managers across the Partnership in collaboration with partners in the Third, Independent and Housing Sectors as well as people living in local communities. The Locality Working Groups have a critical role in contributing to and monitoring progress at a local level.

3.5 Many of the actions identified are already in the process of either planning or implementation however there are number of actions which remain outstanding. The Locality Co-ordinators will continue to contribute to the delivery of those actions which remain outstanding including the development of an overall vision for integrated health and social care teams.

Recommendation

The Health & Social Care Integration Joint Board is asked to:-

- **note** the progress made by Locality Co-ordinators in relation to the development of the H&SC Locality Plans;
- **endorse** the plans and proposals for consultation;

Policy/Strategy Implications	This report gives an update on progress of the delivery of Health and Social Care Locality Plans.
Consultation	The plans have been developed co-productively with colleagues from across the partnership, members of the public, service users and carers and the third and independent sectors.
Risk Assessment	There is a risk of not delivering identified actions if sufficient resources are not available.
Compliance with requirements on Equality and Diversity	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.
Resource/Staffing Implications	Work underway to determine locality resource.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer for Integration		

Author(s)

Name	Designation	Name	Designation
Jane Robertson	Strategic Planning and Development Manager		

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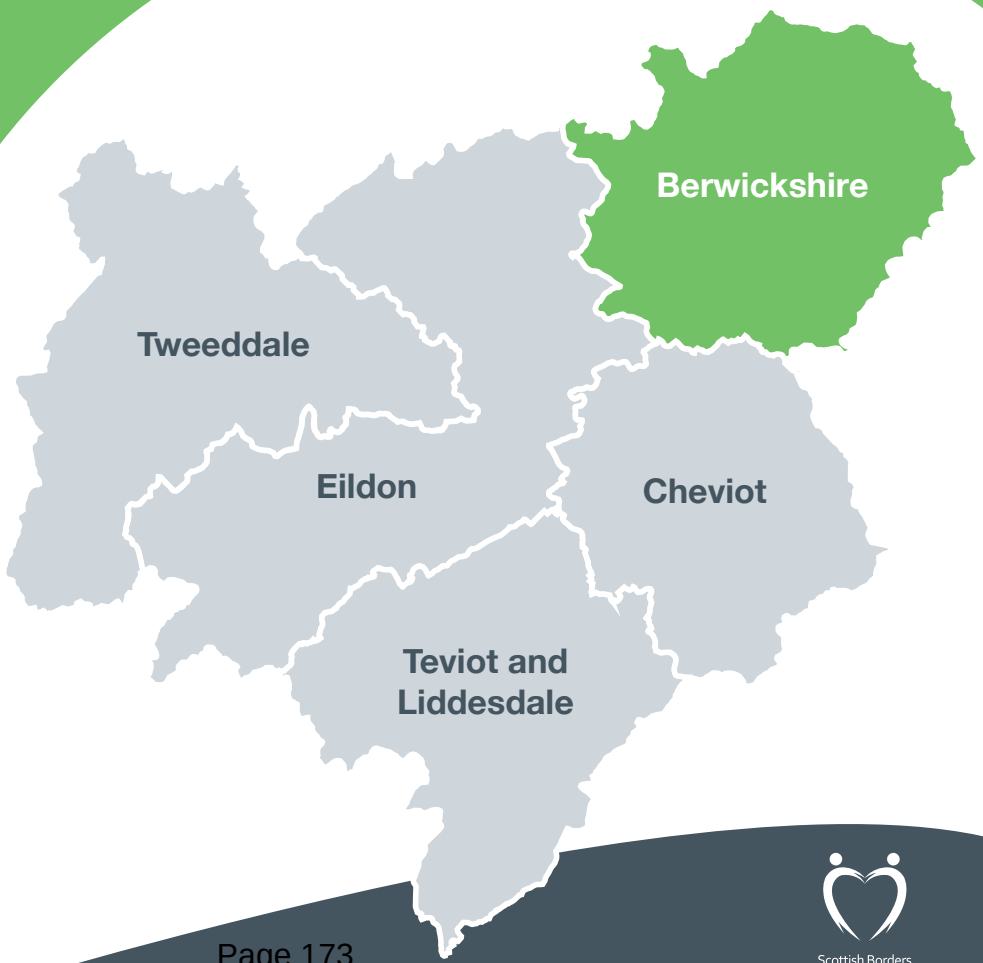
Scottish Borders **Health & Social Care** Partnership

HEALTH & SOCIAL CARE LOCALITY PLAN BERWICKSHIRE

for consultation

2017-2019



Scottish Borders Health and Social Care PARTNERSHIP

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HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

APPENDICES

BERWICKSHIRE
HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

1. FOREWORD

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

In parallel to this, Community Planning Partnerships (CPP) are also required to produce Locality Plans under the requirements of the Community Empowerment (Scotland) Act 2015. In the future our aspiration is to bring these plans together within one plan.

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

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

Our aim is that we plan, commission and deliver services in a way that puts people at the heart of decision making as well as meets the needs of local communities. As such we want to continue to work in partnership with everyone who has an interest in improving health and social care services at a local level and seek your view on this Locality Plan.

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

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

2. CONTEXT FOR THIS PLAN

The Scottish Government, through the Public Bodies (Joint Working) (Scotland) Act 2014 has two very clear aims.

Better **outcomes and experiences** for individuals and communities

Better **use of resources** across health, care and support systems at national and local levels.

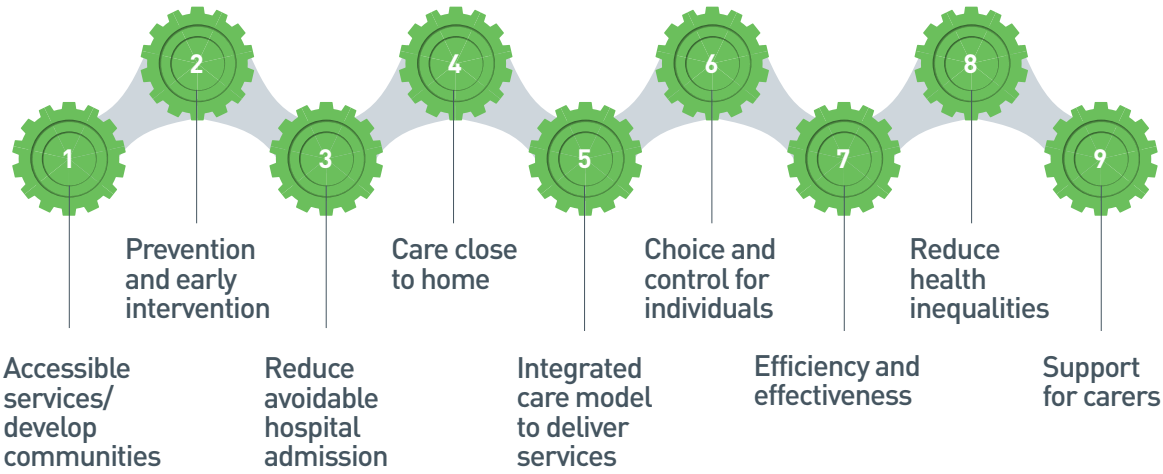
In order to address these aims and after extensive consultation during 2015-2016, the Scottish Borders Health & Social Care Partnership published its Strategic Plan where the following vision and objectives are outlined.

Scottish Borders Strategic Plan 2016 -19

"work together for the best possible health and well-being in our communities"

9 Scottish Borders Local Objectives

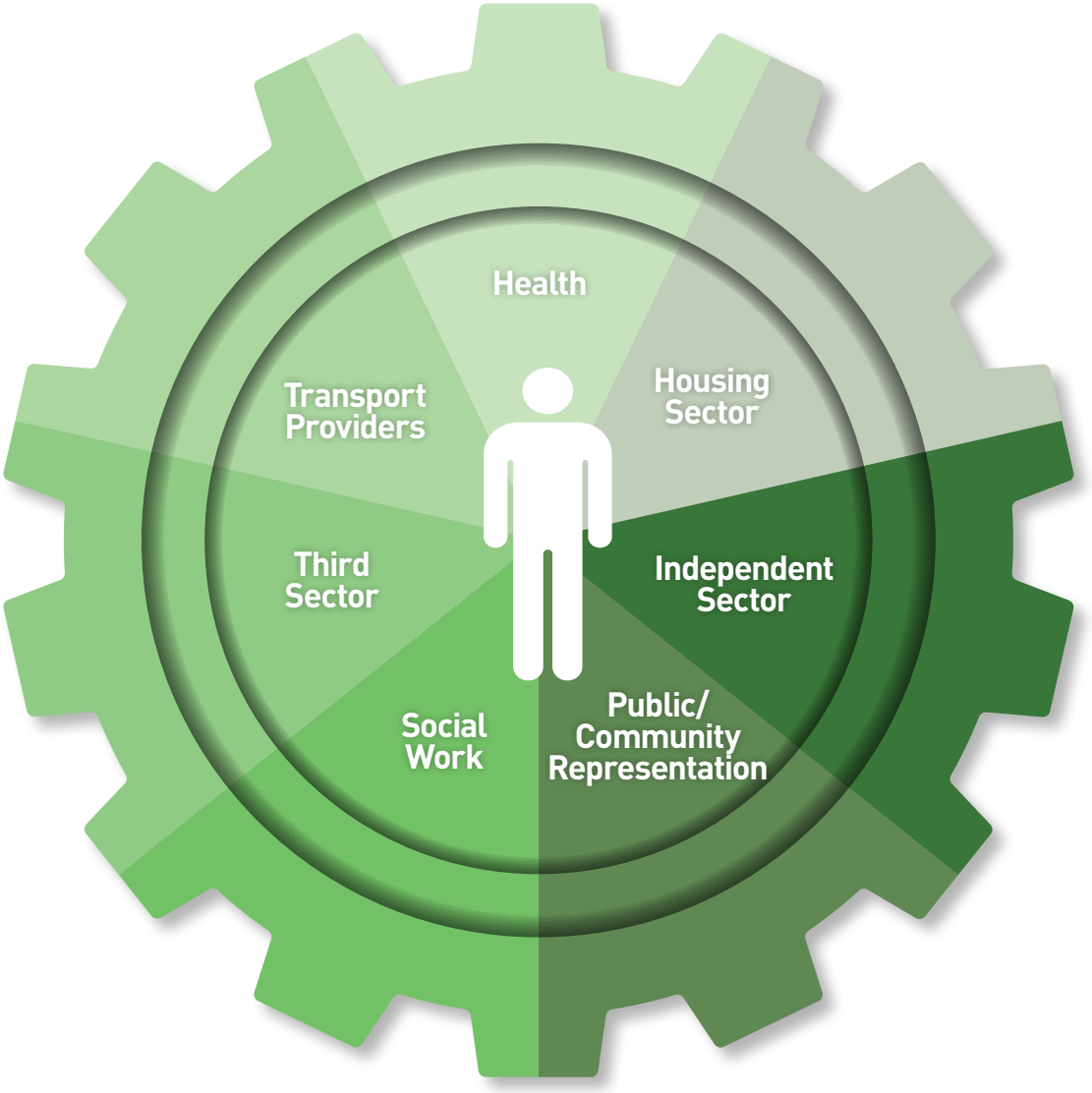
(defined during consultation on our Strategic Plan in 2015)



The Borders Health & Social Care Strategic Plan can be accessed **here**

How the Partnership seeks to meet the Objectives laid out in the Strategic Plan at a local level requires to be demonstrated in a local plan. The Scottish Borders already has five localities – Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale. **This plan is for Berwickshire**.

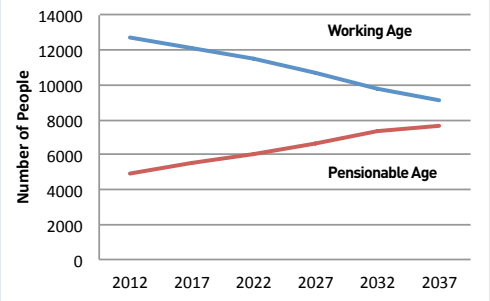
Five Locality Working Groups have been established and have contributed to the development of the five local plans. All key stakeholders are represented on the locality working groups as indicated below:



Details of the Berwickshire Locality Working Group can be found **here**

3. THE BERWICKSHIRE AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR BERWICKSHIRE



57.2% increase in **pensionable age**

28.1% decrease in **working age**

POPULATION

20,657 population*
(19% of the Scottish Borders)

15.1% aged **0-15**
(Scottish Borders = 16.7%)

60.4% aged **16-64**
(Scottish Borders = 60.2%)

24.5% aged **65+**
(Scottish Borders = 23.1%)

9.9% provide **unpaid care**

*(est 2014)

AREA

45.3% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

85% live in **rural areas**
30% Remote rural
55% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Eyemouth	3,540
Duns	2,722
Coldstream	1,867
Chirnside	1,426
Greenlaw	629
Ayton	573
Coldingham	549

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

78.3 to **83 yrs men**
(Scottish Borders = 78.1)

81.5 to **87.5 yrs women**
(Scottish Borders = 82)

Higher rate of **of new cancer diagnosis**
(compared to Scottish Borders)

Lower rate of **early cancer deaths**
(compared to Scottish Borders and Scotland)

A&E ATTENDANCE

47.5% non-emergencies could be cared for within Locality of which **75+ age group represent the highest proportion**
(last year 43.5%)

52.5% emergencies require hospital care
(last year 56.5%)

7.67 rate of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

1,107 on **Diabetes Register**
6.23% of **GP Register over 15 yrs**

183 on **Dementia Register**
3.55% of **GP Register over 65 yrs**

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

20.5% report **public transport** as an accessibility issue

People in Berwickshire place a **higher priority** on:

providing **sustainable transport links** including **demand responsive transport**

HOUSEHOLD PROFILE

aged 65+

26.8% Berwickshire
(Scottish Borders = 25.4%)
(Scotland = 20.7%)

7.9% feel lonely or **isolated**
(Scottish Borders = 6.1%)

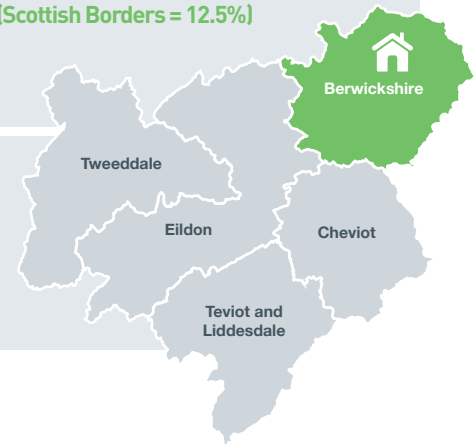
12 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

SAFETY

9.92 rate of **road** and **home safety incidents** per 1,000
(Scottish Borders = 7.65)

0.81 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

8.1% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

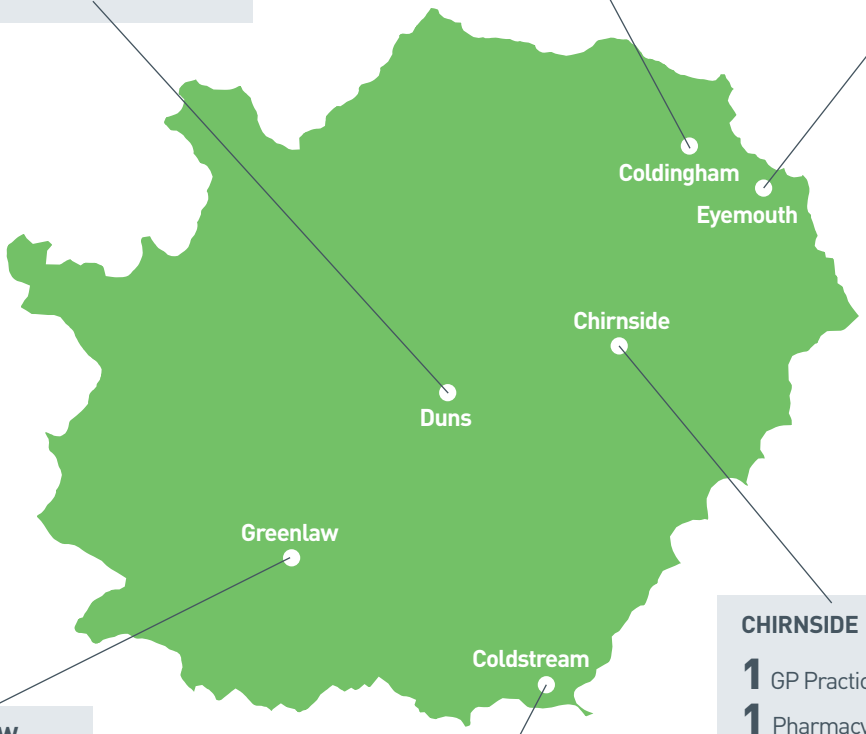
AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	26 units	-
2018-2019	73 units	-
2019-2020	59 units	30 units

3. THE BERWICKSHIRE AREA
SERVICES & SUPPORT 2017-2019

DUNS
- **2** GP Practices
- **1** Pharmacy
- **1** Optician
- **1** Dental Practice
- **1** Community Hospital
- **1** Day Hospital
- **1** Social Care & Health Team

COLDINGHAM
- **1** Pharmacy

EYEMOUTH
- **1** GP Dispensing Practice
- **1** Pharmacy
- **1** Dental Practice
- **1** Community Nursing Team
- **36** Residental Care Beds
- **1** Day Hospital



CHIRNSIDE
- **1** GP Practice
- **1** Pharmacy

GREENLAW
- **1** GP Practice
- **1** Pharmacy

COLDSTREAM
- **1** GP Practice
- **1** Dental Practice
- **74** Residental Care Beds

4. PRIORITIES FOR BERWICKSHIRE 2017-2019

Our understanding of Berwickshire is taken from:

- our analysis of both national and local data and statistics (e.g. Area Profile),
- the knowledge and experience of our service users and carers
- the views of the Locality Working Group
- the knowledge and experience of staff working within the community

The following priorities for Berwickshire have been identified and will contribute to the 9 local objectives for Integration:

PRIORITIES FOR BERWICKSHIRE		WHAT MAKES THIS A PRIORITY FOR BERWICKSHIRE
•	Improve the availability and accessibility of services for people living in rural areas and towns across Berwickshire	• majority of the population live in remote and rural areas • limited access to public transport networks • lack of volunteer drivers • increasing 65+ age group who are reliant on private transport
•	Increase the availability of locally based rehabilitation services	• limited allied health professional services in the community • limited rehabilitation support workers in the community • no domiciliary physiotherapy services in the community • limited access to day hospital services
•	Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• lack of paid carers across locality • lack of domiciliary care provision • lack of transitional care beds in Berwickshire • increased reliance on residential and nursing home placements • tendency to pilot different models and approaches within one locality with no roll out to other localities • difficulty recruiting and sustaining capacity in provider organisations
•	Increase the range of housing options across the locality	• significant projected increase in people of pensionable age • limited options for housing in rural/outlying areas

Work is currently underway to support the delivery of the 9 Local Objectives and an action plan has been developed which identifies work required to ensure the ongoing delivery of the priorities for Berwickshire. This is summarised in **Appendix 1**.

There are some actions which are common across the whole of the Scottish Borders and will be progressed at a Scottish Borders Partnership level, for example the provision of IT access within integrated sites. These actions can be viewed in the Borders wide summary plan in **Appendix 2**.

These actions will be continually evaluated and the plan updated annually.

APPENDIX 1
ACTION PLAN FOR BERWICKSHIRE

PRIORITY: Improve the availability and accessibility of services for people living in rural areas and towns across Berwickshire

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated team working between Health, Social care and Third sector	• Develop two integrated teams covering all areas across the locality • Implement joint staff meetings and training for Health, Social care and Third sector staff	• Improve access to health and social care services at a local level • Sharing of information to support people at home • Improve sharing of information at a local level • Improve staff understanding of roles and responsibilities • Increase efficiency and reduce duplication • Improve access to care at home • Support the prevention of unnecessary admission to hospital • Provide alternatives to attendance at hospital • Reduced inequalities for people within rural areas	• Health and Social care partnership leads • Allied Health Professional leads • Third sector leads	September 2017
• Working with the Transport Hub to improve rural transport	• Develop a link with the Transport Hub to establish rural needs and potential solutions	• Supports people from rural areas to access services	• Transport Hub	September 2017
• Community led support steering group considering suitable locations for "What Matters" hubs throughout Berwickshire	• Work with community led support steering group to establish appropriate 'What Matters' hubs across the Berwickshire locality	• Supports people from rural areas to access information, support and services	• Community led support	2017-18

PRIORITY: Increase the availability of locally based rehabilitation services				
WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated working across Health, Social care and Third sector	• Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community	• Support peoples' rehabilitation at home • Reduce hospital admissions • Improve peoples' outcomes • Support safe discharge from hospital • Reduce the reliance on home care provision • Reduce delayed discharges • Reduce the admissions to bed based care facilities • Supports positive risk taking	• Locality working group • Allied Health Professional leads	September 2017
• Rehabilitation approach ongoing with care providers across SB cares and Third/ Independent sector	• Link with Third sector around development of the model and roll out	• Support the reablement work within SB cares and independent home care providers	• Red Cross • SB cares • Independent providers	March 2018
• Day services review	• Link with the programme and input into service redesign as required from the locality • Engagement events on 27 June 2017 to agree next steps	• Supports the redesign of day services • Increased options to support people to remain at home	• Day services review project manager • Locality working group	September 2017
• Live Borders "Active ageing" programme	• Raise awareness of programme in the local community	• Supports self-management • Prevents hospital admissions • Maintains peoples' current abilities	• Locality working group • Live Borders	March 2017

PRIORITY: Increase the range of available care and support options across the locality to enable people to remain in their own homes and communities

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Community led support steering group considering suitable locations for "What Matters" hubs throughout Berwickshire • Ongoing communication in relation to Carers Act • Increased awareness and usage of self-directed support	• Work with Community led support steering group to establish "What Matters" hubs across the Berwickshire locality • Ensure "What Matters" hubs have relevant information available eg. Carers Act and self-directed support	• People are able to access information and services earlier • People are supported to be as independent as possible • Community resources are key to support people at home • People are supported to self-manage • Reduced waiting lists	• Community led Support Steering group	March 2018
• Increased recruitment by providers • Work with care providers to identify opportunities for development of care services • Frailty redesign programme to ensure people are supported to stay at home • Long term conditions pathway work across the partnership • My Home Life initiative	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathways • Support the independent sector to implement My Home Life	• Reduced care home admissions • Reduced waiting lists • People are supported to remain at home • People are engaged with at an earlier stage to prevent crisis occurring • Helps to fully engage the skills and expertise of voluntary and third sector partners	• Locality working group •	March 2018
• Reablement provision through Red Cross	• Support the further development of reablement services within the Third sector	• People are supported to stay at home • People are supported to self-manage • Less reliance on home care provision	• Locality working group • Red Cross	March 2018
• Equipment provision being reviewed • Satellite equipment stores being reviewed	• Support the redesign of Borders Ability Equipment Service to support people in the community	• Improved access to equipment at point of need • People are supported to stay at home	• Borders Ability Equipment service	October 2017
• Healthy living network" local activities programme in Eyemouth	• Link to develop locality specific services • Development of further healthy living network activity plans	• Supports local people to continue to be managed at home • Supports the health inequalities agenda	• Joint Health Improvement Team • Locality working group	September 2017
• Refurbished of Eyemouth health centre	• Work to support future developments within this practice	• Increased capacity to provide health and social care	• Eyemouth practice • Locality working group	September 2017
• Development of new community resources	• Support development of community capacity building initiatives	• People are supported to self-manage • Training and development to empower Individuals, therefore building capacity to form stronger communities • Intergenerational support and learning	• Borders community capacity building team	2017/18

PRIORITY: Increase the range of housing options available across the locality				
WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Local housing providers represented on Locality working group	• Work with registered social landlords to develop alternative accommodation across all areas of the locality	• Increase availability of affordable housing	• Registered social landlords • Housing Strategy team	2017-2019
• Strategic Housing Investment Plan (SHIP) 2017-22	• Work with Berwickshire Housing Association to support the development of appropriate extra care housing	• People are able to access appropriate supported housing within their own communities	• Berwickshire Housing Association • Housing Strategy team	2019-2020

APPENDIX 2
BORDERS WIDE SUMMARY ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES	ACTION PLAN
Increase the range of care & support options across the Scottish Borders to enable people to remain in their own homes and communities	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathway • Support the independent sector to implement "My Home Life" initiative • Support the redesign of Borders Ability Equipment Service to support people in the community • Support development of community capacity building initiatives to develop locality specific services • Development of further healthy living network activity plans • Provide joint training and development for staff • Develop "What Matters" hubs • Adopt the National Anticipatory care plan • Develop integrated teams within each Locality to improve outcomes for the people of that locality • Increase interventions to support people to remain at home and reduce the need for ED /GP attendance • Support discharge from hospital at an appropriate stage with the right service interventions • Early identification of people who require support through early interventions and screening • Establish SBC IT access within identified Health centres to enable NHS staff to access SBC systems and allow Social care & health staff to work from health office
Improve the availability and accessibility of services across the Scottish Borders	• Bring together staff from NHS, SBC and Third sector to work together within integrated teams • Develop a link with the transport hub to establish rural need and potential solutions • Develop "What Matters" hubs
Increase the availability of locally based rehabilitation services across the Scottish Borders	• Support the further development of reablement services within the Third sector • Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community • Link with Third sector around development of the reablement model and roll out to all areas • Link with the Day services review programme and input into service redesign as required from each locality • Support and inform future developments within the locality
Increase the range of housing options available across the Scottish Borders	• Work with registered social landlords to develop alternative accommodation across all localities • Support delivery of extra care housing

WORK HAS BEEN INFORMED BY

This plan has been informed in consultation and dialogue with the stakeholders involved in developing the plans, strategies and programmes listed below:

- Community Learning and Development Strategic Plan 2015-2020
- Community Led Support
- Frailty Redesign Programme
- Living well with a disability - Future services for people with a physical disability 2013
- Reducing inequalities in the Scottish Borders 2015-2020 Strategic Plan
- Scottish Borders Alcohol & Drugs Partnership Strategy 2015-2020
- Scottish Borders Autism Strategy 2015
- Scottish Borders Council Local Housing Strategy 2012-17
- Scottish Borders Learning Disability Service Strategic Commissioning Plan 2016-19
- Strategic Housing Investment Plan (SHIP) 2017-22
- The Keys to life strategy 2013

This consultative approach will continue throughout the delivery of this plan.

HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019
WHAT DO YOU THINK?

We want to know what you think about this plan.

Please answer these questions and send it back by **31 August** to:

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tel: 0300 100 1800 | email: integration@scotborders.gov.uk
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Are you answering these questions....

☐ On behalf of yourself ☐ On behalf of a group or organisations - if so which one?

.....

Q1. Do you think we have missed anything in your Locality plan that you feel is important?

☐ No ☐ Yes. If so – what is missing?

1. Where do you live?

.....

2. What is your age?

.....

3. Do you have a disability?

☐ Yes ☐ No ☐ I do not want to say

4. Are you a carer?

☐ Yes ☐ No ☐ I do not want to say

THANK YOU

Thank you for completing this questionnaire.

FOR MORE INFORMATION

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NHS Borders

Scottish Borders Health and Social Care PARTNERSHIP

Printed in the Scottish Borders. Designed by Scottish Borders Council Graphic Design Section. KG/02/17.
07 June 2017

Scottish Borders **Health & Social Care** Partnership

HEALTH & SOCIAL CARE LOCALITY PLAN

CHEVIOT

for consultation

2017-2019

Scottish Borders
Health and Social Care
PARTNERSHIP

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CHEVIOT
HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

1. FOREWORD

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

In parallel to this, Community Planning Partnerships (CPP) are also required to produce Locality Plans under the requirements of the Community Empowerment (Scotland) Act 2015. In the future our aspiration is to bring these plans together within one plan.

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

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

Our aim is that we plan, commission and deliver services in a way that puts people at the heart of decision making as well as meets the needs of local communities. As such we want to continue to work in partnership with everyone who has an interest in improving health and social care services at a local level and seek your view on this Locality Plan.

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

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

CHEVIOT HEALTH & SOCIAL CARE
LOCALITY PLAN 2017-2019

2. CONTEXT FOR THIS PLAN

The Scottish Government, through the Public Bodies (Joint Working) (Scotland) Act 2014 has two very clear aims.

Better **outcomes and experiences** for individuals and communities

Better **use of resources** across health, care and support systems at national and local levels.

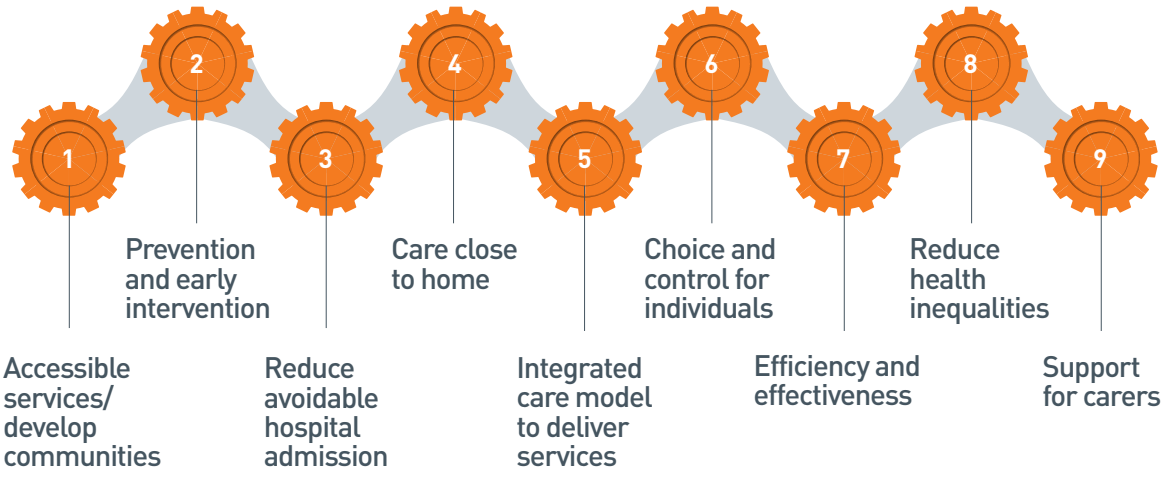
In order to address these aims and after extensive consultation during 2015-2016, the Scottish Borders Health & Social Care Partnership published its Strategic Plan where the following vision and objectives are outlined.

Scottish Borders Strategic Plan 2016 -19

"work together for the best possible health and well-being in our communities"

9 Scottish Borders Local Objectives

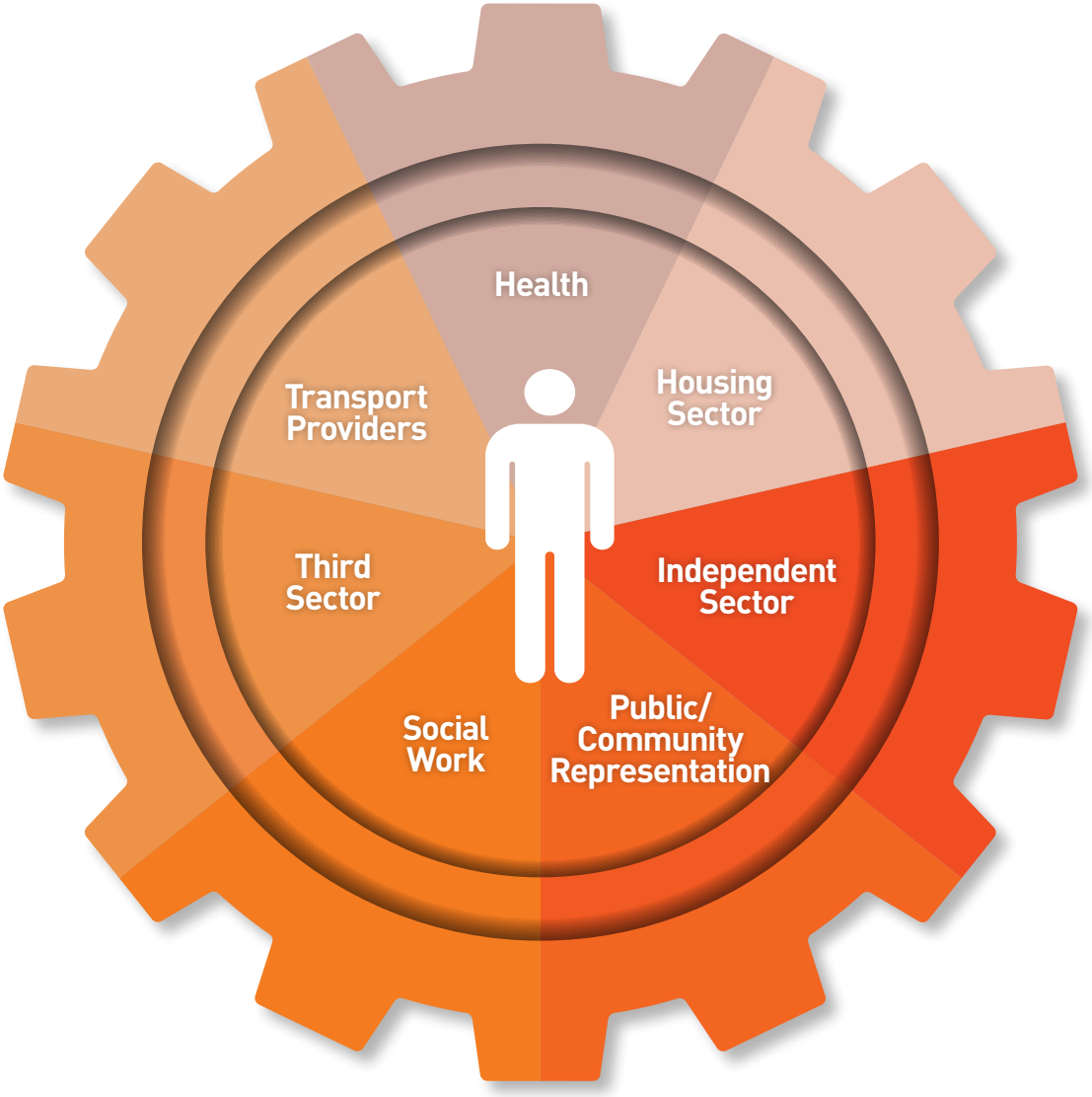
(defined during consultation on our Strategic Plan in 2015)



The Borders Health & Social Care Strategic Plan can be accessed **here**

How the Partnership seeks to meet the Objectives laid out in the Strategic Plan at a local level requires to be demonstrated in a local plan. The Scottish Borders already has five localities – Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale. **This plan is for Cheviot**.

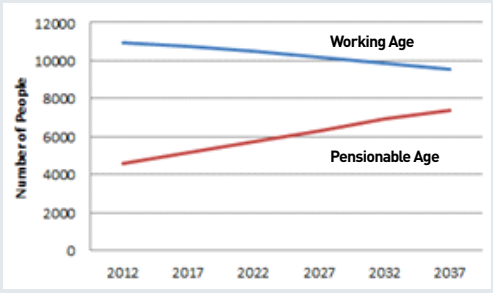
Five Locality Working Groups have been established and have contributed to the development of the five local plans. All key stakeholders are represented on the locality working groups as indicated below:



Details of the Cheviot Locality Working Group can be found **here**

3. THE CHEVIOT AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR CHEVIOT



61.4% increase in **pensionable age**

12.70% decrease in **working age**

POPULATION

19.503 population *
(17% of the Scottish Borders)

14.9% aged **0-15**
(Scottish Borders = 16.7%)

58.2% aged **16-64**
(Scottish Borders = 60.2%)

26.9% aged **65+**
(Scottish Borders = 23.1%)
of this 11.8% are aged 75+
the highest percentage of the Scottish Borders

*(est 2014)

AREA

34.0% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

50% live in **rural areas**
28% Remote rural
22% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Kelso	6,821
Jedburgh	3,961
St Boswells	1,466
Yetholm	618

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

77 to **82 yrs men**
(Scottish Borders = 78.1)

81.4 to **85.8 yrs women**
(Scottish Borders = 82)

Lower rate of **coronary heart disease hospitalisations** and **early deaths** (compared to the Scottish borders and Scotland)

Cheviot has a **higher** rate of **suicide** (compared to Scottish Borders and Scotland)

A&E ATTENDANCE

59.8% the locality has the **highest percentage who attend A&E out of hours in the Scottish Borders**

55.5% non-emergencies could be cared for within the Locality, between **2014/16** the **over 65 age group represented** the **largest proportion** of **attendees**

Cheviot had the **lowest rate** of **emergency hospitalisations** (compared to other Borders Localities and Scotland)

5.36 rate of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

1,073 on **Diabetes Register**
6.76 % of **GP Register over 15 yrs**

193 on **Dementia Register**
4.0% of **GP Register over 65 yrs**

3972 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Cheviot has the lowest rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

16.4% report **public transport** as an accessibility issue
(Scottish Borders = 16.6%)

People in Cheviot place a **higher priority** on:

providing **high quality care for older people** and making **more affordable housing available**

HOUSEHOLD PROFILE

One person household: aged 65+

16.6% **Cheviot**
(Scottish Borders = 15.2%)
(Scotland = 13.1%)

5.1% **feel lonely** or **isolated**
(Scottish Borders = 6.1%)

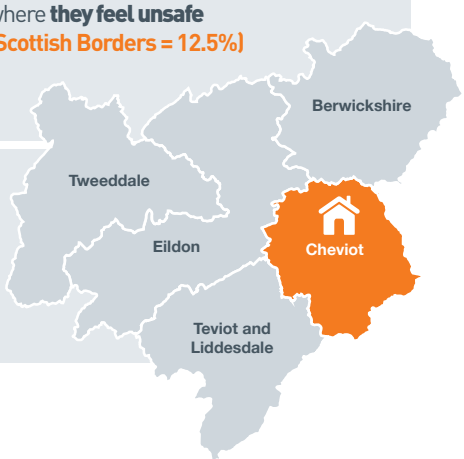
9 **culture and sport facilities** operated by the public sector
(Scottish Borders = 69)

SAFETY

7.13 rate of **road** and **home safety incidents** per 1,000
(Scottish Borders = 7.65)

0.49 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

11% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



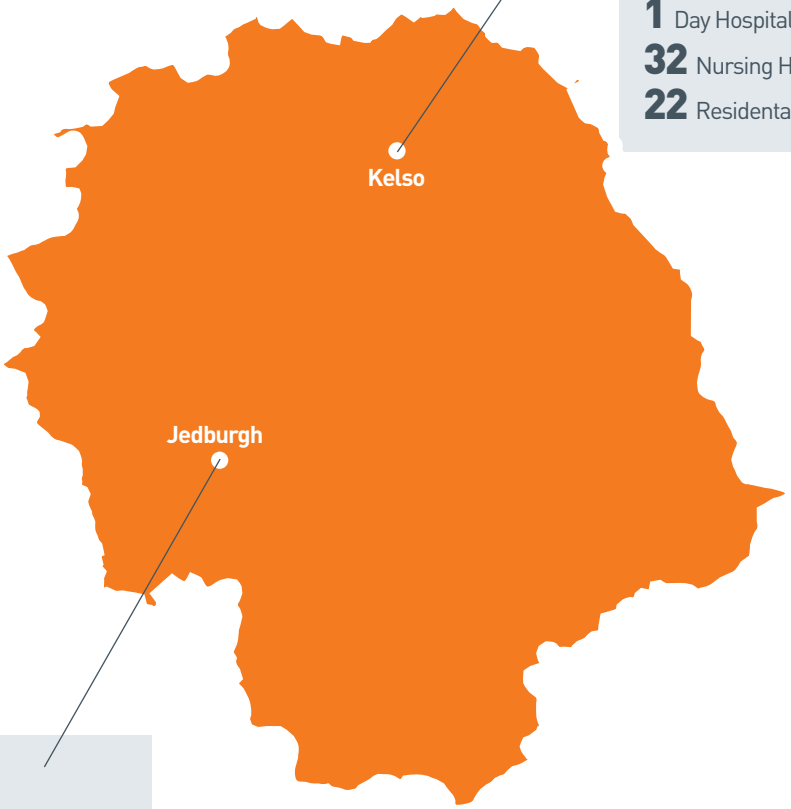
PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	18 units	-
2018-2019	26 units	-
2019-2020	20 units	-

3. THE CHEVIOT AREA
SERVICES & SUPPORT 2017-2019

KELSO

1 GP Practice
2 Pharmacies
1 Dental Practice
1 Optician
1 Community Nursing Team
1 Social Care & Health Team
1 Community Hospital
1 Cheviot Community Healthcare Team
1 Day Hospital
32 Nursing Home Beds/Residential
22 Residental Care Beds



JEDBURGH

1 GP Practice
1 Pharmacy
1 Dental Practice
47 Nursing Home Beds
23 Residental Beds

4. PRIORITIES FOR CHEVIOT 2017-2019

Our understanding of Cheviot is taken from:

- our analysis of both national and local data and statistics (e.g. Area Profile),
- the knowledge and experience of our service users and carers
- the views of the Locality Working Group
- the knowledge and experience of staff working within the community

The following priorities for Cheviot have been identified and will contribute to the 9 local objectives for Integration:

PRIORITIES FOR CHEVIOT		WHAT MAKES THIS A PRIORITY FOR CHEVIOT
•	Increase the availability of locally based rehabilitation services	• limited allied health professional services in the community • limited rehabilitation support workers in the community • no domiciliary physiotherapy services in the community • limited access to day hospital services
•	Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• difficulty recruiting and sustaining capacity in provider organisations • lack of paid carers across locality • lack of domiciliary care provision • lack of transitional care beds in Cheviot • increased reliance on residential and nursing home placements • tendency to pilot different models and approaches within one locality with no roll out to other localities
•	Increase the range of housing options available across the locality	• significant projected increase in people of pensionable age • limited options for housing in rural/outlying areas
•	Improve efficiency and effectiveness of existing co-located and integrated teams	• number of existing co-located and integrated teams who work independently • scope to further integrate these teams in order to:- - remove barriers to service provision - empower staff to be more effective - increase efficiency and effectiveness
•	Improve transport links across Cheviot	• limited access to transport networks in rural areas • increasing over 75+ age group who are reliant on private transport

Work is currently underway to support the delivery of the 9 Local Objectives and an action plan has been developed which identifies work required to ensure the ongoing delivery of the priorities for Cheviot. This is summarised in **Appendix 1**.

There are some actions which are common across the whole of the Scottish Borders and will be progressed at a Scottish Borders Partnership level, for example the provision of IT access within integrated sites. These actions can be viewed in the Borders wide summary plan in **Appendix 2**.

These actions will be continually evaluated and the plan updated annually.

APPENDIX 1
ACTION PLAN FOR CHEVIOT

PRIORITY: Increase the availability of locally based rehabilitation services

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated working across Health, Social care and Third sector • Cheviot Community Healthcare Team	• Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community	• Support peoples' rehabilitation at home • Reduce hospital admissions • Improve peoples' outcomes • Support safe discharge from hospital • Reduce the reliance on home care provision • Reduce delayed discharges • Reduce the admissions to bed based care facilities • Supports positive risk taking	• Locality working group • Allied Health Professional leads	September 2017
• Rehabilitation approach ongoing with care providers across SB cares and Third / Independent sector	• Link with Third sector around development of the model and roll out	• Support the reablement work within SB cares and independent home care providers	• Red Cross • SB cares • Independent providers	March 2018
• Day services review	• Link with the programme and input into service redesign as required from the locality	• Supports the redesign of day services • Increased options to support people to remain at home	• Day services review project manager • Locality working group	September 2017
• Live Borders "Active ageing" programme	• Support and inform future developments within the locality	• Supports self-management • Prevents hospital admissions • Maintains peoples' current abilities	• Locality working group • Live Borders	June 2017
• "Living Safely in the Home" – promotion of safer communities across Cheviot	• Raise awareness of programme in the local community	• Provides support to older people at risk of falls • Direct link to refer to the Cheviot Community Healthcare Team	• Scottish Fire and Rescue Service	June 2017

PRIORITY: Increase the range of available care and support options across the locality to enable people to remain in their own homes and communities

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Community led support steering group considering suitable locations for "What Matters" hubs throughout Cheviot • Ongoing communication in relation to Carers Act • Increased awareness and usage of self-directed support	• Work with Community led support steering group to establish "What Matters" hubs across the Cheviot locality • Ensure "What Matters" hubs have relevant information available eg. Carers Act and self-directed support	• People are able to access information and services earlier • People are supported to be as independent as possible • Community resources are key to support people at home • People are supported to self-manage • Reduced waiting lists	• Community led support steering group	March 2018
• Increased recruitment by providers • Work with care providers to identify opportunities for development of care services • Frailty redesign programme to ensure people are supported to stay at home • Long term conditions pathway work across the partnership • My Home Life initiative	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathways • Support the independent sector to implement My Home Life	• Reduced care home admissions • Reduced waiting lists • People are supported to remain at home • People are engaged with at an earlier stage to prevent crisis occurring • Helps to fully engage the skills and expertise of voluntary and third sector partners	• Locality working group • Commissioners • Frailty Group • Independent sector • Scottish Care	March 2018
• Reablement provision through Red Cross	• Support the further development of reablement services within the Third sector	• People are supported to stay at home • People are supported to self-manage • Less reliance on home care provision	• Locality working group • Red Cross	March 2018
• Equipment provision being reviewed • Satellite equipment stores being reviewed	• Support the redesign of Borders Ability Equipment Service to support people in the community	• Improved access to equipment at point of need • People are supported to stay at home	• Borders Ability Equipment Service	October 2017
• Development of new community resources	• Support development of community capacity building initiatives	• People are supported to self-manage • Training and development to empower Individuals, therefore building capacity to form stronger communities • Intergenerational support and learning	• Borders community capacity building team	2017/18

PRIORITY: Increase the range of housing options available across the locality

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Local housing providers represented on locality working group	• Work with registered social landlords to develop alternative accommodation across all areas of the locality	• Increase availability of affordable housing	• Registered social landlords • Housing Strategy team	2017-2019
• Strategic Housing Investment Plan (SHIP) 2017-22	• Support the development of appropriate extra care housing	• People are able to access appropriate supported housing within their own communities	• Housing Strategy Team	2020-2021

PRIORITY: Improve efficiency and effectiveness of existing collocated and integrated teams

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• GP on Locality Working Group Co- • Located health and Social Care team Multidisciplinary team meetings • Cheviot Community Healthcare Team	• Establish current demand and plan future service to meet need • Arrange workshop with all key stakeholders • Share workshop outcomes with health and social care partnership operational leads and agree future service structure • Agree review date to evaluate service and future proof	• Provide equitable service provision • Support people to stay in their own home • Support improved outcomes for people • Support peoples rehabilitation at home • Reduce the admission to bed based care facilities • Support safe discharge from hospital • Enable older people to adapt and learn new skills to support health and wellbeing • Support reablement within Locality	• Health and social care partnership operational leads	November 2017
• Investigating Buurtzorg Nursing Pilot for Coldstream	• Link with Buurtzorg development planned for Coldstream	• Support safe discharge from hospital • Support people to stay in their own home • Support improved outcomes for people • Support peoples rehabilitation at home • Reduce the admission to bed based care facilities • Enable older people to adapt and learn new skills to support health and wellbeing	• Health and Social Care Partnership	September 2017

PRIORITY: Improve transport links across Cheviot				
WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Working with transport hub to improve rural transport • Transport representative on Locality Working Group • Demand Responsive Transport (DRT) Smailholm, Stichill and surrounding area	• Work with the Strategic Transport Group and Transport Hub to develop sustainable and demand responsive transport	• Increase transport options available • Support people from rural areas to access services • Reduce inequalities for rural population • Reduce loneliness and isolation	• Transport hub and Strategic Transport Group	September 2017

APPENDIX 2
BORDERS WIDE SUMMARY ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES	ACTION PLAN
Increase the range of care & support options across the Scottish Borders to enable people to remain in their own homes and communities	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathway • Support the independent sector to implement "My Home Life" initiative • Support the redesign of Borders Ability Equipment Service to support people in the community • Support development of community capacity building initiatives to develop locality specific services • Development of further healthy living network activity plans • Provide joint training and development for staff • Develop "What Matters" hubs • Adopt the National Anticipatory care plan • Develop integrated teams within each Locality to improve outcomes for the people of that locality • Increase interventions to support people to remain at home and reduce the need for ED /GP attendance • Support discharge from hospital at an appropriate stage with the right service interventions • Early identification of people who require support through early interventions and screening • Establish SBC IT access within identified Health centres to enable NHS staff to access SBC systems and allow Social care & health staff to work from health office
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Increase the range of housing options available across the Scottish Borders	• Work with registered social landlords to develop alternative accommodation across all localities • Support delivery of extra care housing

CHEVIOT HEALTH & SOCIAL CARE
LOCALITY PLAN 2017-2019

WORK HAS BEEN INFORMED BY

This plan has been informed in consultation and dialogue with the stakeholders involved in developing the plans, strategies and programmes listed below:

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- Community Led Support
- Frailty Redesign Programme
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- Scottish Borders Autism Strategy 2015
- Scottish Borders Council Local Housing Strategy 2012-17
- Scottish Borders Learning Disability Service Strategic Commissioning Plan 2016-19
- Strategic Housing Investment Plan (SHIP) 2017-22
- The Keys to life strategy 2013

This consultative approach will continue throughout the delivery of this plan.

HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019
WHAT DO YOU THINK?

We want to know what you think about this plan.

Please answer these questions and send it back by **31 August** to:

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Are you answering these questions....

☐ On behalf of yourself ☐ On behalf of a group or organisations - if so which one?

.....

Q1. Do you think we have missed anything in your Locality plan that you feel is important?

☐ No ☐ Yes. If so – what is missing?

1. Where do you live?

.....

2. What is your age?

.....

3. Do you have a disability?

☐ Yes ☐ No ☐ I do not want to say

4. Are you a carer?

☐ Yes ☐ No ☐ I do not want to say

THANK YOU

Thank you for completing this questionnaire.

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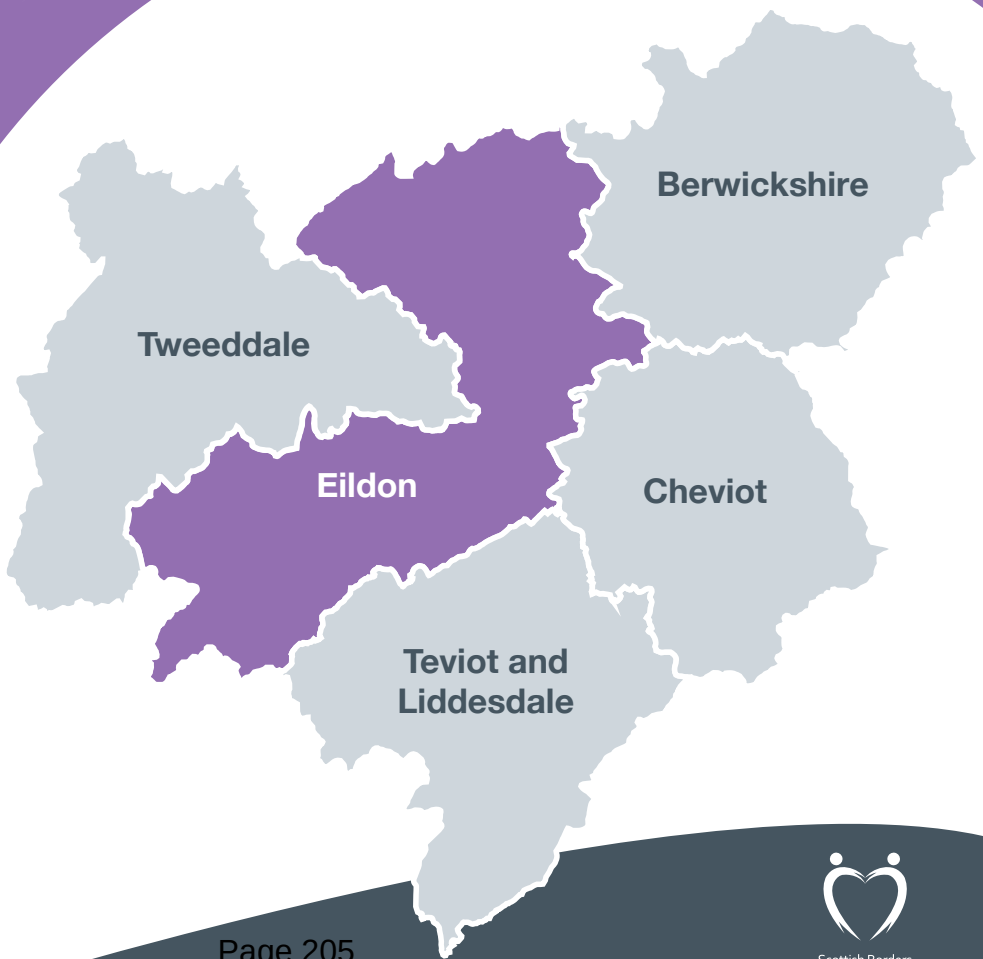
Scottish Borders **Health & Social Care** Partnership

HEALTH & SOCIAL CARE LOCALITY PLAN

EILDON

for consultation

2017-2019



Scottish Borders
Health and Social Care
PARTNERSHIP

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EILDON

HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

1. FOREWORD

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

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Chief Officer for Health and Social Care Integration
Scottish Borders

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Better **use of resources** across health, care and support systems at national and local levels.

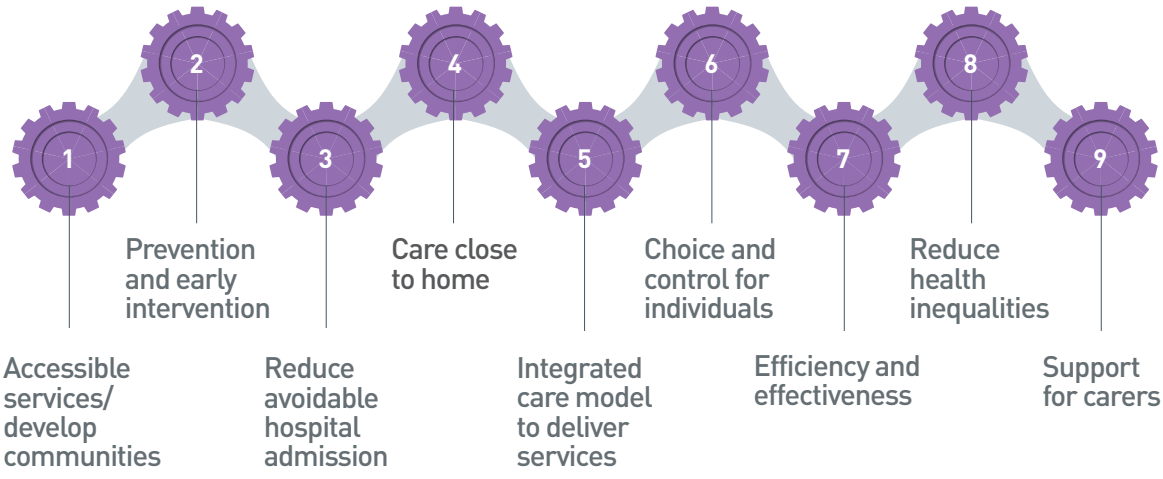
In order to address these aims and after extensive consultation during 2015-2016, the Scottish Borders Health & Social Care Partnership published its Strategic Plan where the following vision and objectives are outlined.

Scottish Borders Strategic Plan 2016 -19

"work together for the best possible health and well-being in our communities"

9 Scottish Borders Local Objectives

(defined during consultation on our Strategic Plan in 2015)



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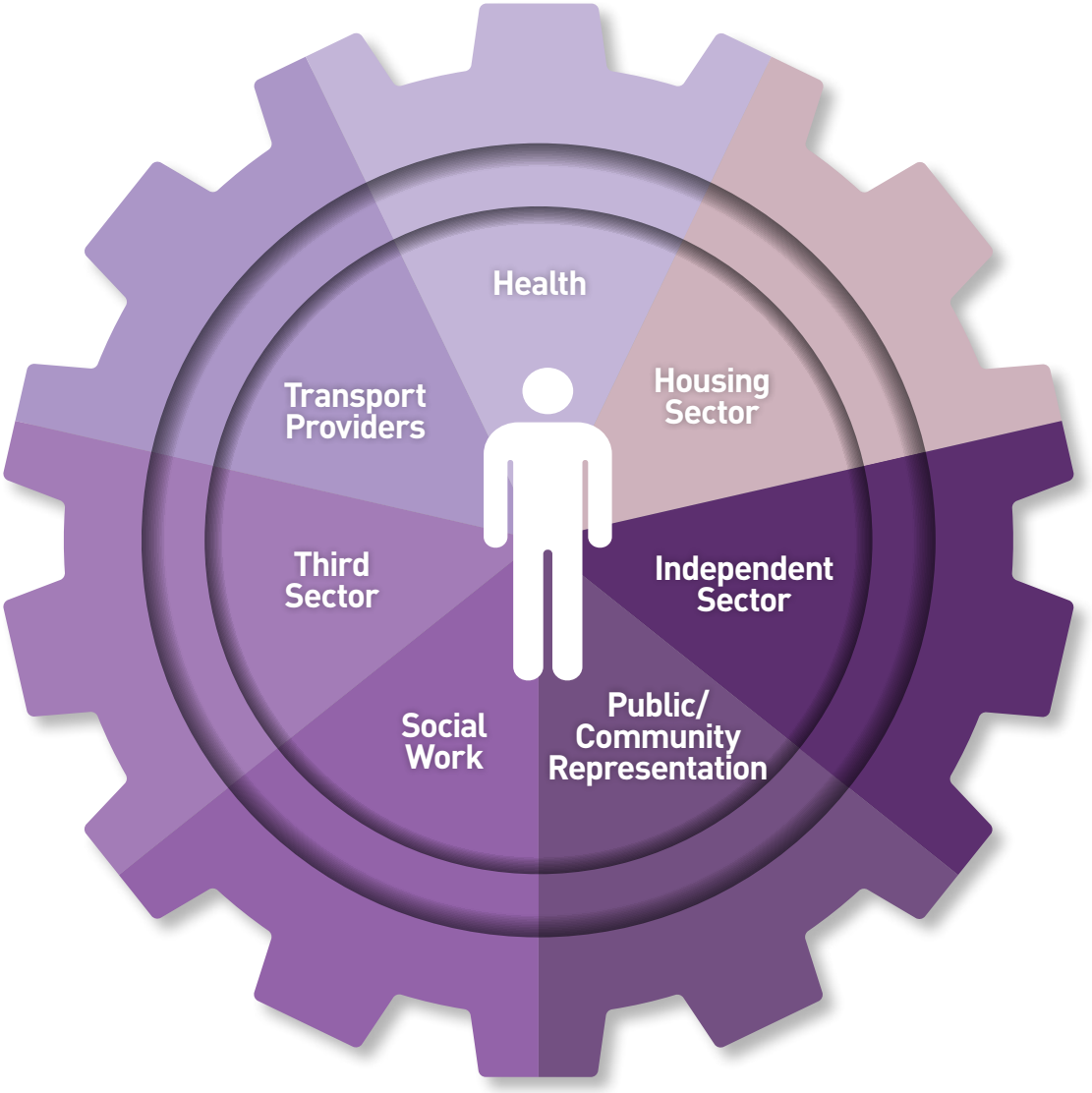

Details of the Eildon Locality Working Group can be found **here**

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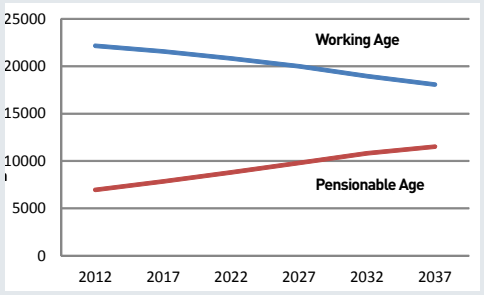
PROJECTED POPULATION 2012-2037 FOR EILDON



65% increase in **pensionable age**

18.4% decrease in **working age**

POPULATION

35,000 population*
(31% of the Scottish Borders)

17.8% aged **0-15**
(Scottish Borders = 16.7%)

60.9% aged **16-64**
(Scottish Borders = 60.2%)

21.3% aged **65+**
(Scottish Borders = 23.1%)

*(est 2014)

AREA

19.3% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

43% live in **rural areas**
15% Remote rural
32% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Galashiels	12,670
Selkirk	5,586
Melrose	2,457
Tweedbank	2,073
Lauder	1,773
Earlston	1,766
Newtown St Boswells	1,347

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

74.7 to **82.5 yrs men**
(Scottish Borders = 78.1)

79.1 to **89 yrs women**
(Scottish Borders = 82)

Higher rate of **coronary heart disease hospitalisations**
(Compared to Borders and Scotland)

700.5 per 100,000 **Higher rate** of **alcohol related hospitalisations** and **deaths**
(compared to Borders = 566)

108.9 per 100,000 **Higher rate of drug related hospitalisations and deaths**
(compared to Scottish Borders= 88.1)

A&E ATTENDANCE

59.4% non-emergencies could be cared for within **Locality**
(last year 56.8%)

40.6% emergencies
(last year 43.2%)

Higher rate of **emergency hospitalisations**
(compared to Scottish Borders)

3.74 rate of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

2,050 on **Diabetes Register**
6.14 % of **GP Register****

315 on **Dementia Register**
3.82% of **GP Register*****

5684.8 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Eildon has the highest rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

** over 15 yrs
*** over 65 yrs

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

16.6% report **accessibility** to **public transport as an issue**
(lower than any other Locality)

5.5% feel lonely or **isolated**
(Scottish Borders = 6.1%)

28 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

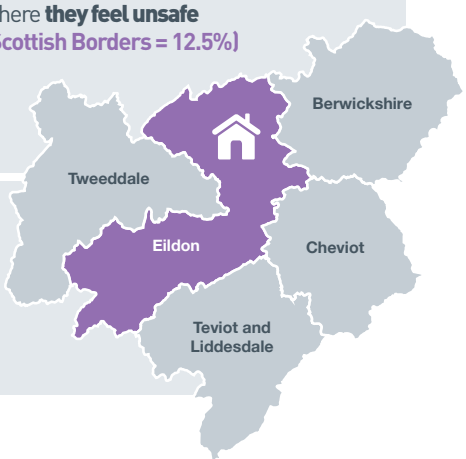
Eildon has a **proportion** of its **population living** in each of the **ten deprivation deciles, demonstrating the large degree of variance** in **deprivation profile** within the **locality**

Eildon has the **highest rate** of **suicide 21.7 per 100,000**
(Scottish Borders=15.7. Scotland =14.7)

SAFETY

0.80 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

15.3% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	54 units	-
2018-2019	181 units	-
2019-2020	84 units	24 units

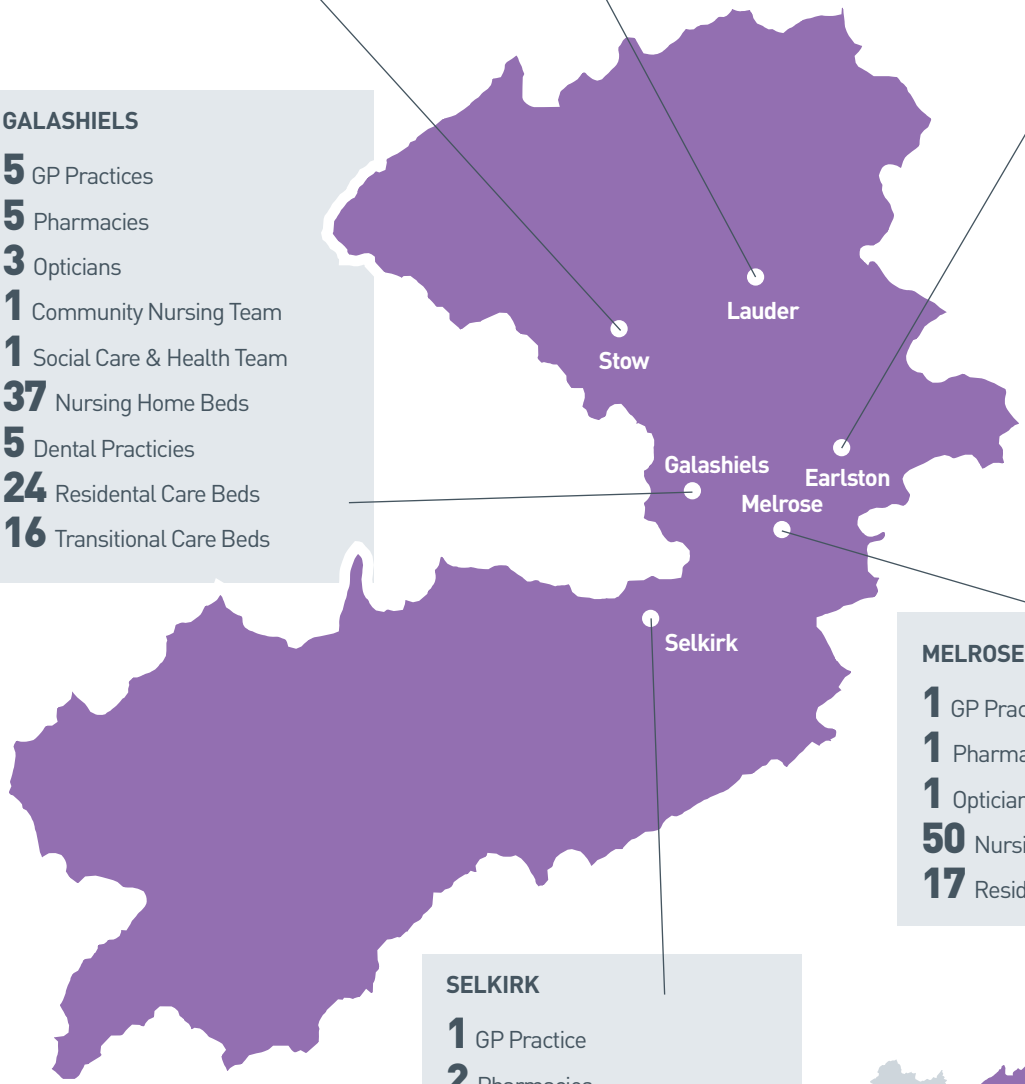
3. THE EILDON AREA
SERVICES & SUPPORT 2017-2019

STOW
1 GP Dispensing Practice

LAUDER
1 GP Practice
1 Pharmacy
1 Dental Practice

EARLSTON
1 GP Practice
1 Pharmacy
1 Dental Practice

GALASHIELS
5 GP Practices
5 Pharmacies
3 Opticians
1 Community Nursing Team
1 Social Care & Health Team
37 Nursing Home Beds
5 Dental Practicies
24 Residental Care Beds
16 Transitional Care Beds



MELROSE & ST BOSWELLS
1 GP Practice
1 Pharmacy
1 Optician
50 Nursing Home Beds
17 Residental Care Beds

SELKIRK
1 GP Practice
2 Pharmacies
1 Optician
1 Dental Practice
45 Nursing Home Beds
25 Residental Care Beds

4. PRIORITIES FOR EILDON 2017-2019

Our understanding of Eildon is taken from:

- our analysis of both national and local data and statistics (e.g. Area Profile),
- the knowledge and experience of our service users and carers
- the views of the Locality Working Group
- the knowledge and experience of staff working within the community

The following priorities for Eildon have been identified and will contribute to the 9 local objectives for Integration:

PRIORITIES FOR EILDON		WHAT MAKES THIS A PRIORITY FOR EILDON
•	Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• difficulty recruiting and sustaining capacity in provider organisations • lack of paid carers across locality • lack of domiciliary care provision • lack of transitional care beds in Eildon • increased reliance on residential and nursing home placements • tendency to pilot different models and approaches within one locality with no roll out to other localities
•	Increase the availability of Locally based rehabilitation services	• limited allied health professional services in the community • limited rehabilitation support workers in the community • no domiciliary physiotherapy services in the community • limited access to day hospital services
•	Improve the availability and accessibility of services for people living in rural areas	• limited access to transport networks in rural areas • tendency for services to be located in large settlement areas • lack of care at home providers in rural areas
•	Increase the range of housing options available across the locality	• significant projected increase in people of pensionable age • limited options for housing in rural/outlying areas
•	Reduce the number of people admitted to hospital with drug and alcohol related problems	• increased number of people using drugs and alcohol in the larger Eildon settlements
•	Reduce the number of people attending the Borders General Hospital on multiple occasions	• no community hospital in the locality • limited options for GP's to maintain people at home • evidence of increased attendance at BGH possibly due to proximity • limited access to day hospital services

Work is currently underway to support the delivery of the 9 Local Objectives and an action plan has been developed which identifies work required to ensure the ongoing delivery of the priorities for Eildon. This is summarised in **Appendix 1**.

There are some actions which are common across the whole of the Scottish Borders and will be progressed at a Scottish Borders Partnership level, for example the provision of IT access within integrated sites. These actions can be viewed in the Borders wide summary plan in **Appendix 2**.

These actions will be continually evaluated and the plan updated annually.

APPENDIX 1
ACTION PLAN FOR EILDON

PRIORITY: Increase the range of available care and support options across the locality to enable people to remain in their own homes and communities

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Ettrick "What matters hub launch 7th June • Ongoing communication in relation to Carers act • Increased awareness and usage of self directed supported	• Work with community led support steering group to establish "what matters" hubs across Eildon locality • Ensure "What matters" hubs have relevant information on carers act and self-directed support	• People are able to access information and services earlier • People are supported to be as independent as possible • Community resources are key to support people at home • People are supported to self-manage • Reduced waiting times	• Community led Support Steering group	March 2018
• Increased recruitment by providers • Frailty redesign programme to ensure people are supported to stay at home • Work with care providers to identify opportunities for development of care services • Long term conditions pathway work across the partnership • My Home Life initiative	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathways • Support the independent sector to implement "My Home life"	• Reduce care home admissions • reduce waiting lists • support people to remain at home • People are supported to remain at home • People are engaged with at an earlier stage to prevent crisis occurring • Helps to fully engage the skills and expertise of the voluntary and third sector partners	• Locality working group Commissioners • Frailty group • Independent sector • Scottish Care	March 2018
• Reablement provision through red cross	• Support the further development of reablement services within the third sector	• People are supported to stay at home • People are supported to self-manage • Less reliance on home care provision	• Locality working group Red Cross	March 2018
• Equipment provision being reviewed • Satellite equipment stores being reviewed	• Support the redesign of the Borders Ability Equipment service to support people in the community	• Improved access to equipment at point of need • People are supported to stay at home	• Borders Ability Equipment service	October 2017
• Development of new Community resources	• Support development of community capacity building initiatives	• People are supported to self manage • Training and development to empower individuals • Building capacity to form stronger communities	• Borders Community capacity building team	2017/18

PRIORITY: Increase the availability of locally based rehabilitation services				
WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated working across Health, Social care and Third sector.	• Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health professionals and support staff to manage peoples rehabilitation needs within the community • Work with the Rapid assessment and discharge team (RAD) re potential to support people post discharge	• Support peoples rehabilitation at home • Reduce hospital admissions • Improve people's outcomes • Support safe discharge from hospital • Reduce the reliance on home care provision • Reduce delayed discharges • Reduce the admissions to bed based care facilities • Supports positive risk taking • Links to Frailty Pathway • Provides limited Follow-up Post Discharge • Supported Discharge Model	• Locality working group with • Allied Health Professional leads • Rapid Access And Discharge team	September 2017
• Rehabilitation approach ongoing with care providers across SB cares and Third/ Independent sector	• Link with third sector re development of the model and roll out	• Support the reablement work within SB Cares and independent home care providers	• Red Cross • Independent Providers • SB cares	March 2018
• Day services review	• Link with the programme and input into service redesign as required from the Locality	• Supports the redesign of day services • Increased options to support people to remain at home	• Day services review project manager • Locality working group	September 2017
• Transitional care beds in Waverely care home within the Independent sector	• Support the further development of transitional care beds within Waverley	• Supports local needs to remain managing at home • Supports the health inequalities agenda	• Health and Social partnership operational leads	September 2017
• Live Borders "Active Ageing Programme	• Support and inform future developments within the locality	• Supports self-management • Prevents hospital admissions • Maintains people's current abilities	• Locality working group • Live Borders	March 2018

PRIORITY: Improve the availability and accessibility of services for people living in rural areas across Eildon

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated team working between Health, Social care and Third sector	• Develop three Integrated teams covering all areas across the Eildon Locality • Implement joint staff meetings and training for Health, Social care and Third sector staff	• Supports people from rural areas to access services equitably • Reduced inequalities for people within the rural areas • Supports staff joint working	• Health and Social care Partnership leads	March 2018
• Working with the Transport Hub to improve rural transport	• Develop a link with the transport hub to establish rural needs and potential solutions	• Support people from rural areas to access services	• Transport Hub	September 2017
• Establishing "What Matters" Hub in Ettrickbridge	• Work with Community led support steering group to establish appropriate "What Matters" Hubs across the Eildon locality	• Support people from rural areas to access information, support and services	• Community led support	2017/18

PRIORITY: Increase the range of housing options available across the locality

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Local housing providers represented on locality working group	• Work with registered social landlords to develop alternative accommodation across all areas of the locality	• Increase availability of affordable housing	• Registered social landlords • Housing Strategy team	2017-2019
• Strategic Housing Investment Plan (SHIP) 2017-22	• Work with Eildon and Trust housing associations to support the development of appropriate extra care housing	• People are able to access appropriate supported housing within their own communities	• Housing Strategy Team	2019-2020

PRIORITY: Reduce the number of people admitted to hospital with drug and alcohol related problems

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Health Living network localities activity plan for Langlee, Galashiels	• Support individuals with drug and alcohol problems	• Support people to access appropriate services within the community	• Borders Alcohol and drug partnership	2019-20
• Health inequalities provision and establishing new ways to reach all groups	• Work with health inequalities to support people at home	• Provides alternatives for people other than attending the acute hospital	• Borders Alcohol and drug partnership	2019-20

PRIORITY: Reduce the number of people attending the Borders General Hospital on multiple occasions

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Regular meetings between H&SC staff to coordinate services	• Implement three integrated health and social care teams across Eildon • Ensure joint staff meetings and training are in place between all relevant Health and Social care teams to support joint working • Provide access to SBC IT system within NHS sites to support joint working • Further develop the frailty pathways work across the partnership	• Provides services within the person's community to support them to remain at home • Can support the prevention of admission and support discharge home • Can provide a seamless approach to care provision • Can provide alternatives to hospital attendance • Sharing of information to support • Improved staff understanding of roles and responsibilities • Increased confidence between different professions • Increase efficiency from staff • Improved outcomes for people	• Health and Social care team leaders • Allied health professional leads Voluntary sector • SBC Corporate Transformation • Frailty group	March 2018
• Pilot of Anticipatory Care Plans within the Galashiels Health Centre practice population	• Work with GP practices to roll out anticipatory care plans	• Identifies people with long term conditions and frailty who require ongoing support • provides alternative options when medical conditions change • supports people to remain at home	• GP Quality cluster lead	April 2018
• Locality working group established	• Further development of Locality working group to progress plans	• cross organisations, professional approach to locality provision • supports future service change agenda	• Locality working group	September 2017
• Community capacity building across Eildon	• Work with communities to engage support for people to remain at home	• provides alternatives within the community to support people at home	• Community Capacity Building Team	March 2018

APPENDIX 2
BORDERS WIDE SUMMARY ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES	ACTION PLAN
Increase the range of care & support options across the Scottish Borders to enable people to remain in their own homes and communities	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathway • Support the independent sector to implement "My Home Life" initiative • Support the redesign of Borders Ability Equipment Service to support people in the community • Support development of community capacity building initiatives to develop locality specific services • Development of further healthy living network activity plans • Provide joint training and development for staff • Develop "What Matters" hubs • Adopt the National Anticipatory care plan • Develop integrated teams within each Locality to improve outcomes for the people of that locality • Increase interventions to support people to remain at home and reduce the need for ED /GP attendance • Support discharge from hospital at an appropriate stage with the right service interventions • Early identification of people who require support through early interventions and screening • Establish SBC IT access within identified Health centres to enable NHS staff to access SBC systems and allow Social care & health staff to work from health office
Improve the availability and accessibility of services across the Scottish Borders	• Bring together staff from NHS, SBC and Third sector to work together within integrated teams • Develop a link with the transport hub to establish rural need and potential solutions • Develop "What Matters" hubs
Increase the availability of locally based rehabilitation services across the Scottish Borders	• Support the further development of reablement services within the Third sector • Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community • Link with Third sector around development of the reablement model and roll out to all areas • Link with the Day services review programme and input into service redesign as required from each locality • Support and inform future developments within the locality
Increase the range of housing options available across the Scottish Borders	• Work with registered social landlords to develop alternative accommodation across all localities • Support delivery of extra care housing

EILDON HEALTH & SOCIAL CARE
LOCALITY PLAN 2017-2019

WORK HAS BEEN INFORMED BY

This plan has been informed in consultation and dialogue with the stakeholders involved in developing the plans, strategies and programmes listed below:

- Community Learning and Development Strategic Plan 2015-2020
- Community Led Support
- Frailty Redesign Programme
- Living well with a disability - Future services for people with a physical disability 2013
- Reducing inequalities in the Scottish Borders 2015-2020 Strategic Plan
- Scottish Borders Alcohol & Drugs Partnership Strategy 2015-2020
- Scottish Borders Autism Strategy 2015
- Scottish Borders Council Local Housing Strategy 2012-17
- Scottish Borders Learning Disability Service Strategic Commissioning Plan 2016-19
- Strategic Housing Investment Plan (SHIP) 2017-22
- The Keys to life strategy 2013

This consultative approach will continue throughout the delivery of this plan.

HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019
WHAT DO YOU THINK?

We want to know what you think about this plan.

Please answer these questions and send it back by **31 August** to:

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

Are you answering these questions....

☐ On behalf of yourself ☐ On behalf of a group or organisations - if so which one?

.....

Q1. Do you think we have missed anything in your Locality plan that you feel is important?

☐ No ☐ Yes. If so – what is missing?

1. Where do you live?

.....

2. What is your age?

.....

3. Do you have a disability?

☐ Yes ☐ No ☐ I do not want to say

4. Are you a carer?

☐ Yes ☐ No ☐ I do not want to say

THANK YOU

Thank you for completing this questionnaire.

FOR MORE INFORMATION

Please contact the address below.

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.

SCOTTISH BORDERS COUNCIL
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tel: 0300 100 1800
email: integration@scotborders.gov.uk
www.scotborders.gov.uk/integration

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07 June 2017

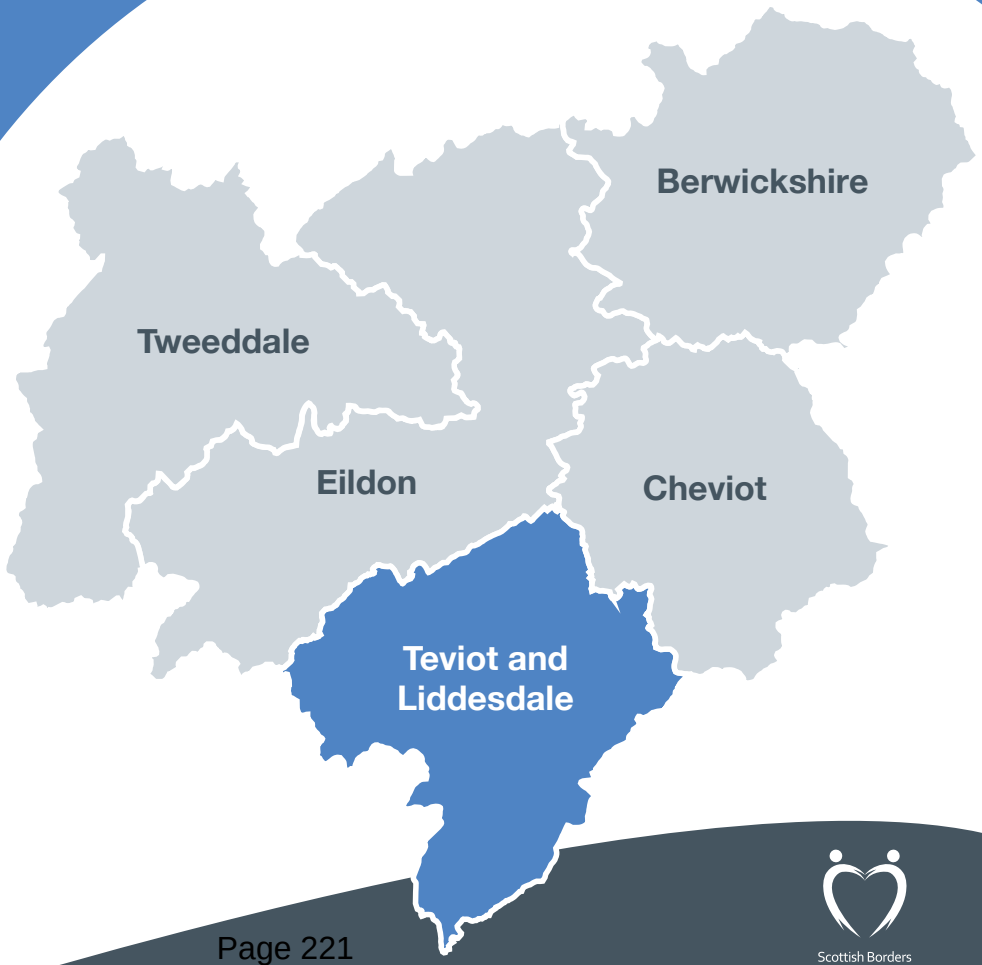
Scottish Borders **Health & Social Care** Partnership

HEALTH & SOCIAL CARE LOCALITY PLAN

TEVIOT & LIDDESDALE

for consultation

2017-2019



Scottish Borders Health and Social Care PARTNERSHIP

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Our aim is that we plan, commission and deliver services in a way that puts people at the heart of decision making as well as meets the needs of local communities. As such we want to continue to work in partnership with everyone who has an interest in improving health and social care services at a local level and seek your view on this Locality Plan.

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

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Scottish Borders

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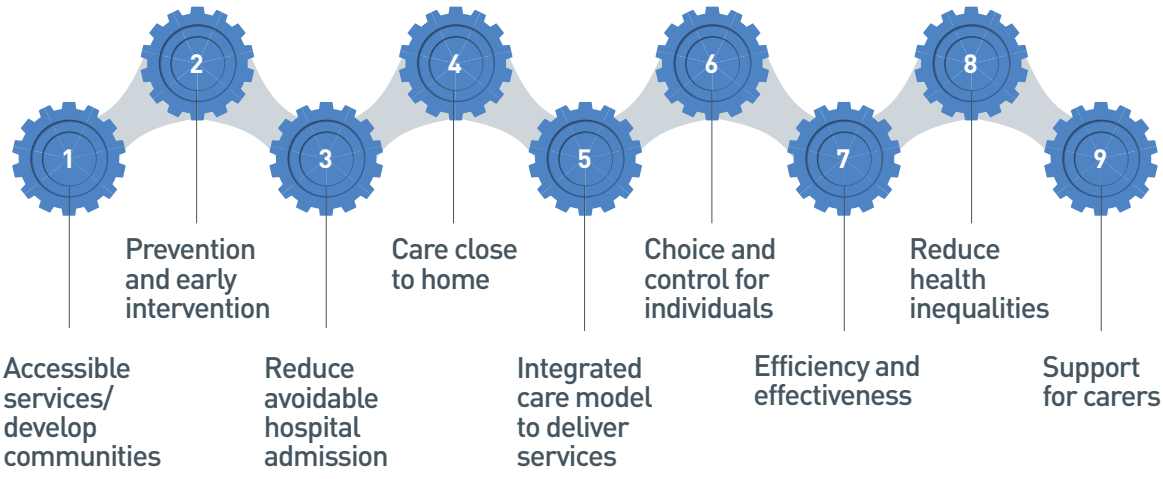

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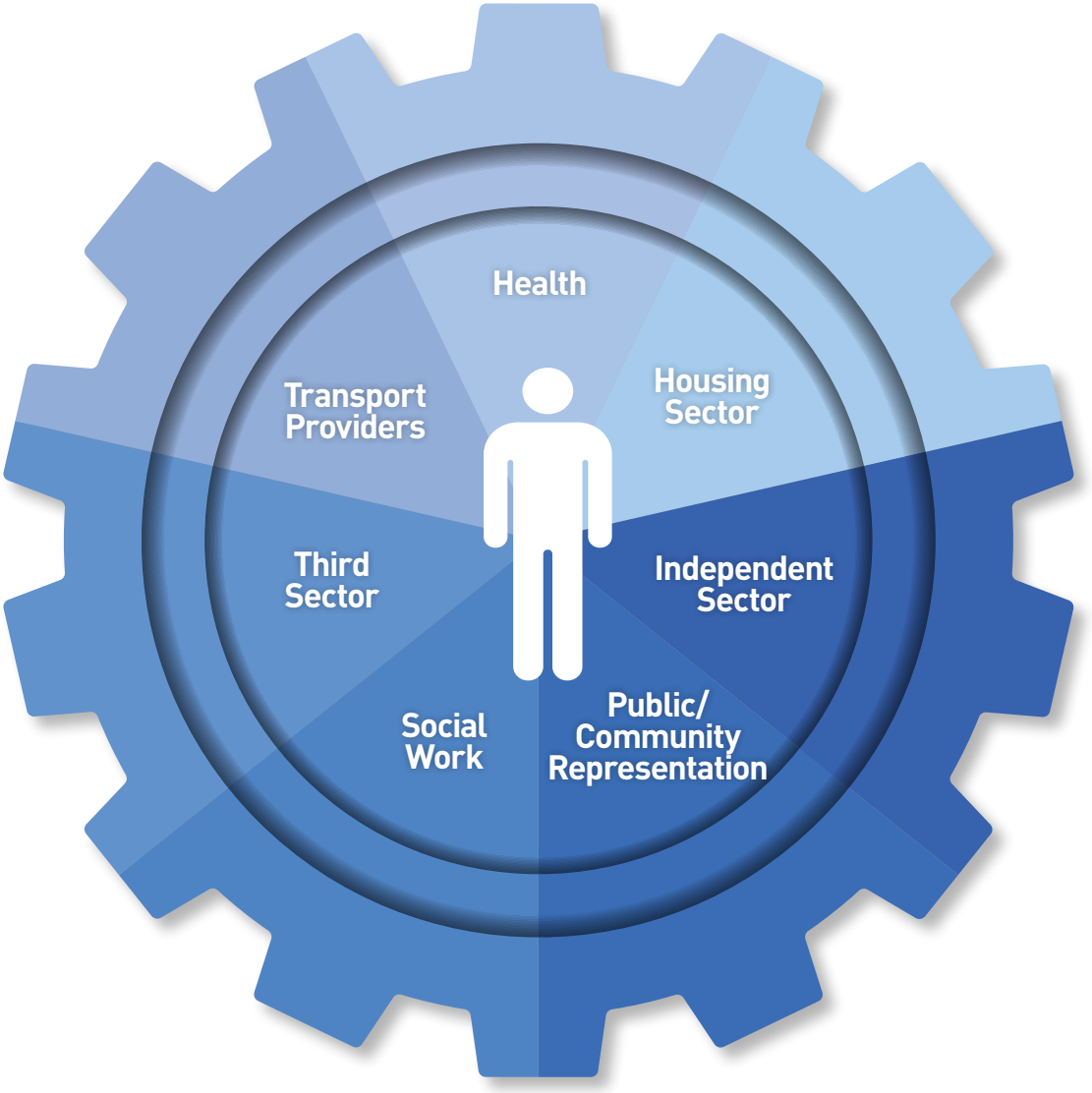
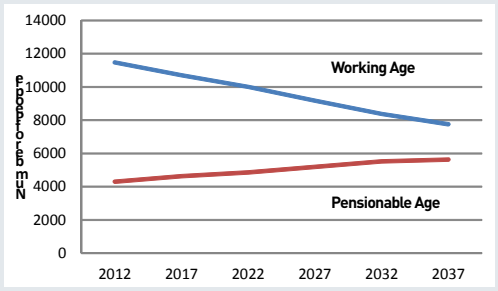


Details of the Teviot Locality Working Group can be found **here**

3. THE TEVIOT AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR TEVIOT & LIDDESDALE



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*(est 2014)

AREA

14.2% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

26% live in **rural areas**
8% Remote rural
18% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Hawick	14,003
Newcastleton	757
Denholm	625

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

77.3 to **78.5 yrs men**
(Scottish Borders = 78.1)

79.9 to **84.1 yrs women**
(Scottish Borders = 82)

Highest rate of **coronary heart disease hospitalisations** and **early deaths**
(compared to the Scottish Borders and Scotland)

646.3 per 100,00
Higher rate of **alcohol related hospitalisations** and **deaths** and **increasing in recent years**
(Compared to Borders = 566)

580.9 per 100,000 Highest rate of **COPD hospitalisations**
(compared to Scottish Borders=497.6)

A&E ATTENDANCE

50.2% non-emergencies could be cared for within **Locality**
(last year 45.9%)

49.8% emergencies
(last year 54.1%)

Higher rate of **emergency hospitalisations**
(compared to Scottish Borders)

LONG TERM CONDITIONS

1,233 on **Diabetes Register**
7.65 % of **GP Register over 15 yrs**

201 on **Dementia Register**
4.34% of **GP Register over 65 yrs**

5463 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Teviot has a higher rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

15.0% report **accessibility** to **public transport as an issue**
(Scottish Borders=16.6%)

8.4% feel lonely or **isolated**
(Scottish Borders = 6.1%)

8 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

Teviot is the **most deprived population** in the **Scottish Borders** with **over 40%** of its **population living in the 4 most deprived deciles**

Teviot has **highest number** of individuals **claiming JSA and pension credits**

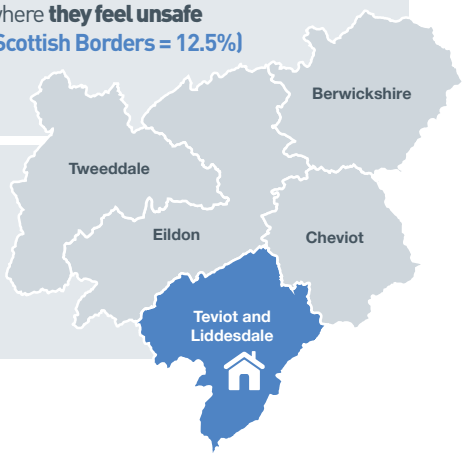
Among lowest suicide rates in the **Scottish Borders** at **12.3 per 100,000**

SAFETY

9.19 Highest rate of **over 75 falls** per 1000
(compared to 5.62 for Scottish Borders)

1.07 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

17% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	6 units	-
2018-2019	12 units	-
2019-2020	-	-

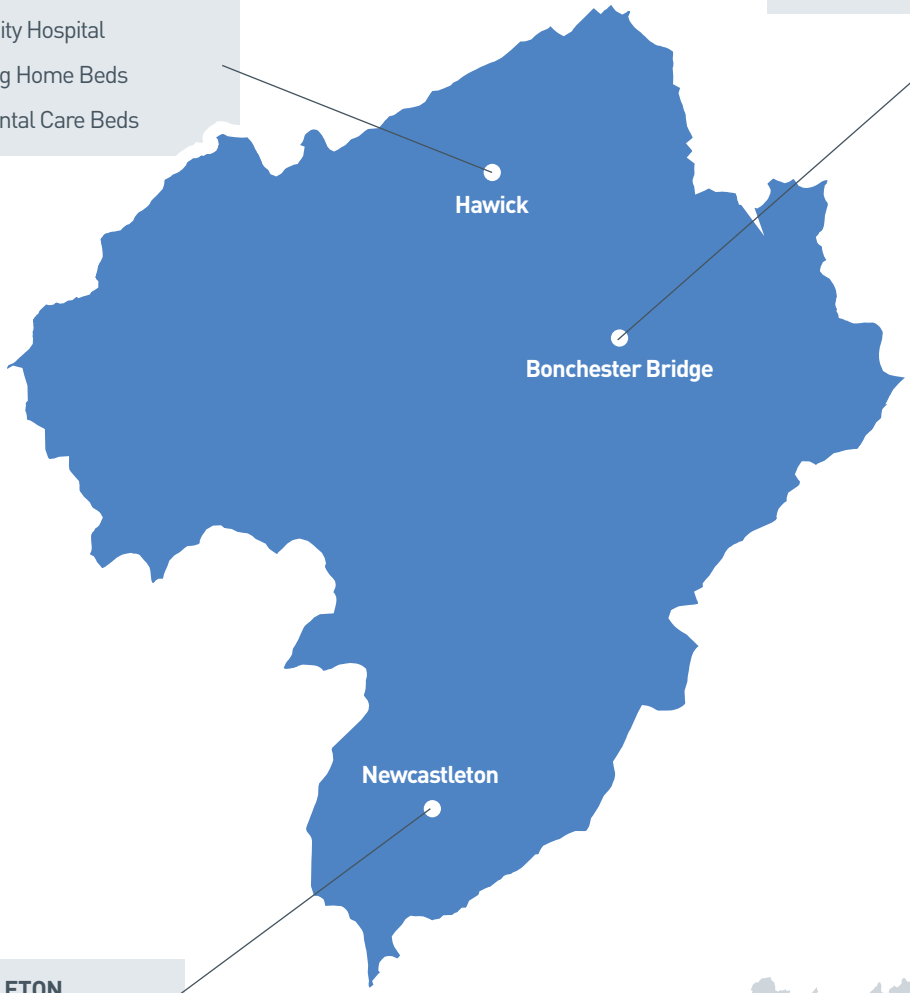
3. THE TEVIOT & LIDDESDALE AREA
SERVICES & SUPPORT 2017-2019

HAWICK

2 GP Practices
5 Pharmacies
3 Dental Practices
3 Opticians
1 Community Nursing Team
1 Social Care & Health Team
1 Community Hospital
72 Nursing Home Beds
56 Residental Care Beds

BONCHESTER BRIDGE

24 Residental Care Beds



NEWCASTLETON

1 GP Dispensing Practice

4. PRIORITIES FOR TEVIOT & LIDDESDALE 2017-2019

Our understanding of Teviot & Liddesdale is taken from:

- our analysis of both national and local data and statistics (e.g. Area Profile),
- the knowledge and experience of our service users and carers
- the views of the Locality Working Group
- the knowledge and experience of staff working within the community

The following priorities for Teviot & Liddesdale have been identified and will contribute to the 9 local objectives for Integration:

PRIORITIES FOR TEVIOT & LIDDESDALE		WHAT MAKES THIS A PRIORITY FOR TEVIOT & LIDDESDALE
•	Improve the availability and accessibility of services for people living in rural areas and towns across Teviot	• limited access to transport networks in rural areas • tendency for services to be located in large settlement areas- • lack of care at home providers in rural areas
•	Increase the availability of locally based rehabilitation services	• limited allied health professional services in the community • limited rehabilitation support workers in the community • no domiciliary physiotherapy services in the community • limited access to day hospital services
•	Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• difficulty recruiting and sustaining capacity in provider organisations • lack of paid carers across locality • lack of domiciliary care provision • lack of transitional care beds in Teviot • increased reliance on residential and nursing home placements • tendency to pilot different models and approaches within one locality with no roll out to other localities
•	Increase the range of housing options available across the locality	• significant projected increase in people of pensionable age • limited options for housing in rural/outlying areas
•	Develop robust preventative services and early intervention for long term conditions	• higher than average incidence of long term conditions in Teviot • increased non-emergency attendances at BGH due to lack of local alternatives • limited access to preventative services

Work is currently underway to support the delivery of the 9 Local Objectives and an action plan has been developed which identifies work required to ensure the ongoing delivery of the priorities for Teviot. This is summarised in **Appendix 1**.

There are some actions which are common across the whole of the Scottish Borders and will be progressed at a Scottish Borders Partnership level, for example the provision of IT access within integrated sites. These actions can be viewed in the Borders wide summary plan in **Appendix 2**.

These actions will be continually evaluated and the plan updated annually.

APPENDIX 1
ACTION PLAN FOR TEVIOT & LIDDESDALE

PRIORITY: Improve the availability and accessibility of services for people living in rural areas and towns across Teviot

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated team working between Health, Social care and Third sector	• Develop one integrated team covering all areas across the locality • Implement joint staff meetings and training for Health, Social care and Third sector staff	• Improve access to health and social care services at a local level • Sharing of information to support people at home • Improve sharing of information at a local level • Improve staff understanding of roles and responsibilities • Increase efficiency and reduce duplication • Improve access to care at home • Support the prevention of unnecessary admission to hospital • Provide alternatives to attendance at hospital • Reduced inequalities for people within rural areas	• Health and Social care partnership leads, Allied Health Professional leads Third sector leads	March 2018
• Working with the Transport Hub to improve rural transport	• Develop a link with the Transport Hub to establish rural needs and potential solutions	• Supports people from rural areas to access services	• Transport Hub	September 2017
• Establishing "What Matters" hub in Burnfoot, Hawick	• Work with Community led support steering group to establish appropriate "What Matters" hubs across the Teviot locality	• Supports people from rural areas to access information, support and services	• Community led support	2017-18

PRIORITY: Increase the availability of locally based rehabilitation services				
WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated working across Health, Social care and Third sector	• Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community	• Support peoples' rehabilitation at home • Reduce hospital admissions • Improve peoples' outcomes • Support safe discharge from hospital • Reduce the reliance on home care provision • Reduce delayed discharges • Reduce the admissions to bed based care facilities • Supports positive risk taking	• Locality working group • Allied Health Professional leads	September 2017
• Rehabilitation approach ongoing with care providers across SB cares and Third/ Independent sector	• Link with Third sector around development of the model and roll out	• Support the reablement work within SB cares and independent home care providers	• Red Cross • SB cares • Independent providers	March 2018
• Day services review	• Link with the programme and input into service redesign as required from the locality	• Supports the redesign of day services • Increased options to support people to remain at home	• Day services review project manager • Locality working group	September 2017
• Live Borders "Active ageing" programme	• Support and inform future developments within the locality	• Supports self-management • Prevents hospital admissions • Maintains peoples' current abilities	• Locality working group • Live Borders	
• Investigating previous examples of good practice	• Review benefits of Teviot Project and scope out opportunities for future development	• Reduced length of stay in hospital • Increased options to support people to remain at home • More people treated at home instead of hospital	• Locality working group • Allied Health Professional leads	October 2017

PRIORITY: Increase the range of available care and support options across the locality to enable people to remain in their own homes and communities

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Burnfoot, Hawick "What Matters" hub launch 22nd May • Ongoing communication in relation to Carers Act • Increased awareness and usage of self-directed support	• Work with Community led support steering group to establish "What Matters" hubs across the Teviot locality • Ensure "What Matters" hubs have relevant information available eg. Carers Act and self-directed support	• People are able to access information and services earlier • People are supported to be as independent as possible • Community resources are key to support people at home • People are supported to self-manage • Reduced waiting lists	• Community led Support Steering group	March 2018
• Increased recruitment by providers • Work with care providers to identify opportunities for development of care services • Frailty redesign programme to ensure people are supported to stay at home • Long term conditions pathway work across the partnership • My Home Life initiative	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathways • Support the independent sector to implement My Home Life	• Reduced care home admissions • Reduced waiting lists • People are supported to remain at home • People are engaged with at an earlier stage to prevent crisis occurring • Helps to fully engage the skills and expertise of voluntary and third sector partners	• Locality working group • Commissioners • Frailty group • Independent sector • Scottish Care	March 2018
• Reablement provision through Red Cross	• Support the further development of reablement services within the Third sector	• People are supported to stay at home • People are supported to self-manage • Less reliance on home care provision	• Locality working group • Red Cross	March 2018
• Equipment provision being reviewed • Satellite equipment stores being reviewed	• Support the redesign of Borders Ability Equipment Service to support people in the community	• Improved access to equipment at point of need • People are supported to stay at home	• Borders Ability Equipment service	October 2017
• Development of new Community resources	• Support development of community capacity building initiatives	• People are supported to self manage • Training and development to empower individuals • Building capacity to form stronger communities	• Borders Community capacity building team	2017/18
• "Healthy living network" local activities programme in Burnfoot, Hawick	• Link to develop locality specific services • Development of further healthy living network activity plans	• Supports local people to continue to be managed at home • Supports the health inequalities agenda	• Joint Health Improvement Team • Locality working group	September 2017

PRIORITY: Increase the range of available care and support options across the locality cont...

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Paramedic practitioner project, Teviot Medical Practice	• Support rollout at other practices	• Supports people to remain at home • Releases GP capacity	• Teviot Medical Practice • Scottish Ambulance Service	
• Matching Unit launched in Hawick 17th April to source home care provision and match with assessed need	• Increase range of available options from Social Work managed care packages offered at launch to include direct payments and individual service fund	• Releases staff capacity • Highlight areas where there is difficulty sourcing home care eg. Rural areas	• Matching Unit Project Manager	2017/18
• Participatory budgeting (PB) at Burnfoot Community Centre	• Engage with Burnfoot Community Futures following their successful bid for a new social group for senior ages	• Reduces loneliness and isolation • Provides services within local community	• Burnfoot Community Futures	October 2017

PRIORITY: Increase the range of housing options available across the locality

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Local housing providers represented on Locality working group	• Work with registered social landlords to develop alternative accommodation across all areas of the locality	• Increase availability of affordable housing	• Registered social landlords • Housing Strategy team	2017-2019
• Strategic Housing Investment Plan (SHIP) 2017-22	• Support the development of appropriate extra care housing	• People are able to access appropriate supported housing within their own communities	• Housing Strategy team	2020-2021

PRIORITY: Develop robust preventative services and early intervention for long term conditions

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Ongoing long term conditions pathway work • Gathering information on diabetes pathway with Information Service Division (ISD)	• Improve preventative and early intervention elements of the care pathway	• Supports people to self-manage at home • Supports people to remain well for longer	• Primary Care Team • Consultant for diabetes	March 2018
• GP Cluster leads appointed	• Work with GP cluster quality leads to improve preventative approaches in primary care	• Identifies people with long term conditions to be supported earlier	• GP cluster quality leads	March 2018
• Establishing "What Matters" hub in Burnfoot, Hawick • NHS Informs relaunched	• Improve access to information on self -management	• Earlier access to condition specific information	• Locality working group	September 2017
• National Anticipatory Plan	• Support the rollout of anticipatory care planning	• Early identification of support mechanisms	• GP cluster quality leads	March 2018

APPENDIX 2
BORDERS WIDE SUMMARY ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES	ACTION PLAN
Increase the range of care & support options across the Scottish Borders to enable people to remain in their own homes and communities	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathway • Support the independent sector to implement "My Home Life" initiative • Support the redesign of Borders Ability Equipment Service to support people in the community • Support development of community capacity building initiatives to develop locality specific services • Development of further healthy living network activity plans • Provide joint training and development for staff • Develop "What Matters" hubs • Adopt the National Anticipatory care plan • Develop integrated teams within each Locality to improve outcomes for the people of that locality • Increase interventions to support people to remain at home and reduce the need for ED /GP attendance • Support discharge from hospital at an appropriate stage with the right service interventions • Early identification of people who require support through early interventions and screening • Establish SBC IT access within identified Health centres to enable NHS staff to access SBC systems and allow Social care & health staff to work from health office
Improve the availability and accessibility of services across the Scottish Borders	• Bring together staff from NHS, SBC and Third sector to work together within integrated teams • Develop a link with the transport hub to establish rural need and potential solutions • Develop "What Matters" hubs
Increase the availability of locally based rehabilitation services across the Scottish Borders	• Support the further development of reablement services within the Third sector • Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community • Link with Third sector around development of the reablement model and roll out to all areas • Link with the Day services review programme and input into service redesign as required from each locality • Support and inform future developments within the locality
Increase the range of housing options available across the Scottish Borders	• Work with registered social landlords to develop alternative accommodation across all localities • Support delivery of extra care housing

WORK HAS BEEN INFORMED BY

This plan has been informed in consultation and dialogue with the stakeholders involved in developing the plans, strategies and programmes listed below:

- Community Learning and Development Strategic Plan 2015-2020
- Community Led Support
- Frailty Redesign Programme
- Living well with a disability - Future services for people with a physical disability 2013
- Reducing inequalities in the Scottish Borders 2015-2020 Strategic Plan
- Scottish Borders Alcohol & Drugs Partnership Strategy 2015-2020
- Scottish Borders Autism Strategy 2015
- Scottish Borders Council Local Housing Strategy 2012-17
- Scottish Borders Learning Disability Service Strategic Commissioning Plan 2016-19
- Strategic Housing Investment Plan (SHIP) 2017-22
- The Keys to life strategy 2013

This consultative approach will continue throughout the delivery of this plan.

HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019
WHAT DO YOU THINK?

We want to know what you think about this plan.

Please answer these questions and send it back by **31 August** to:

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

Are you answering these questions....

☐ On behalf of yourself ☐ On behalf of a group or organisations - if so which one?

.....

Q1. Do you think we have missed anything in your Locality plan that you feel is important?

☐ No ☐ Yes. If so – what is missing?

1. Where do you live?

.....

2. What is your age?

.....

3. Do you have a disability?

☐ Yes ☐ No ☐ I do not want to say

4. Are you a carer?

☐ Yes ☐ No ☐ I do not want to say

THANK YOU

Thank you for completing this questionnaire.

FOR MORE INFORMATION

Please contact the address below.

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.

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

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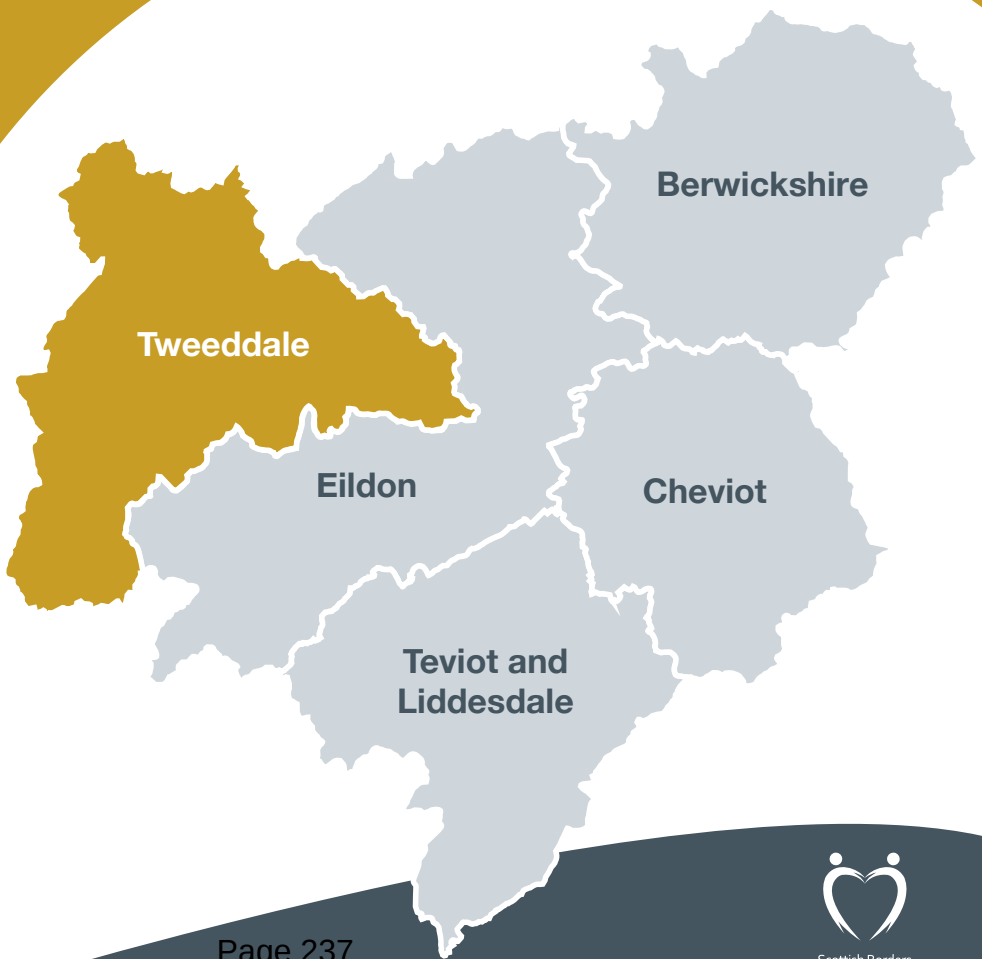
07 June 2017

Scottish Borders Health & Social Care Partnership

HEALTH & SOCIAL CARE LOCALITY PLAN TWEEDDALE

for consultation

2017-2019



Scottish Borders Health and Social Care PARTNERSHIP

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HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

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TWEEDDALE
HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

1. FOREWORD

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

In parallel to this, Community Planning Partnerships (CPP) are also required to produce Locality Plans under the requirements of the Community Empowerment (Scotland) Act 2015. In the future our aspiration is to bring these plans together within one plan.

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

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

Our aim is that we plan, commission and deliver services in a way that puts people at the heart of decision making as well as meets the needs of local communities. As such we want to continue to work in partnership with everyone who has an interest in improving health and social care services at a local level and seek your view on this Locality Plan.

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

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

2. CONTEXT FOR THIS PLAN

The Scottish Government, through the Public Bodies (Joint Working) (Scotland) Act 2014 has two very clear aims.

Better **outcomes and experiences** for individuals and communities

Better **use of resources** across health, care and support systems at national and local levels.

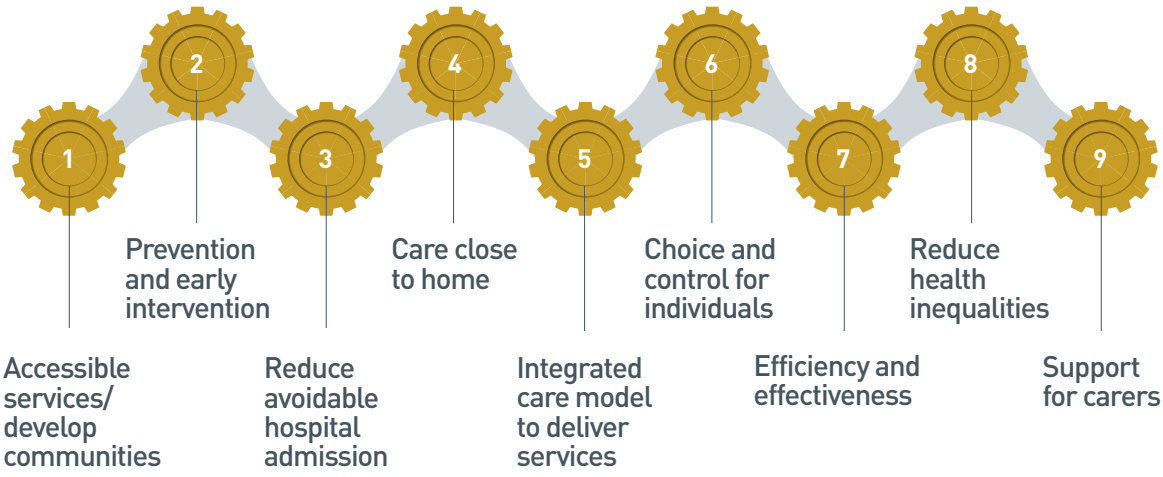
In order to address these aims and after extensive consultation during 2015-2016, the Scottish Borders Health & Social Care Partnership published its Strategic Plan where the following vision and objectives are outlined.

Scottish Borders Strategic Plan 2016 -19

"work together for the best possible health and well-being in our communities"

9 Scottish Borders Local Objectives

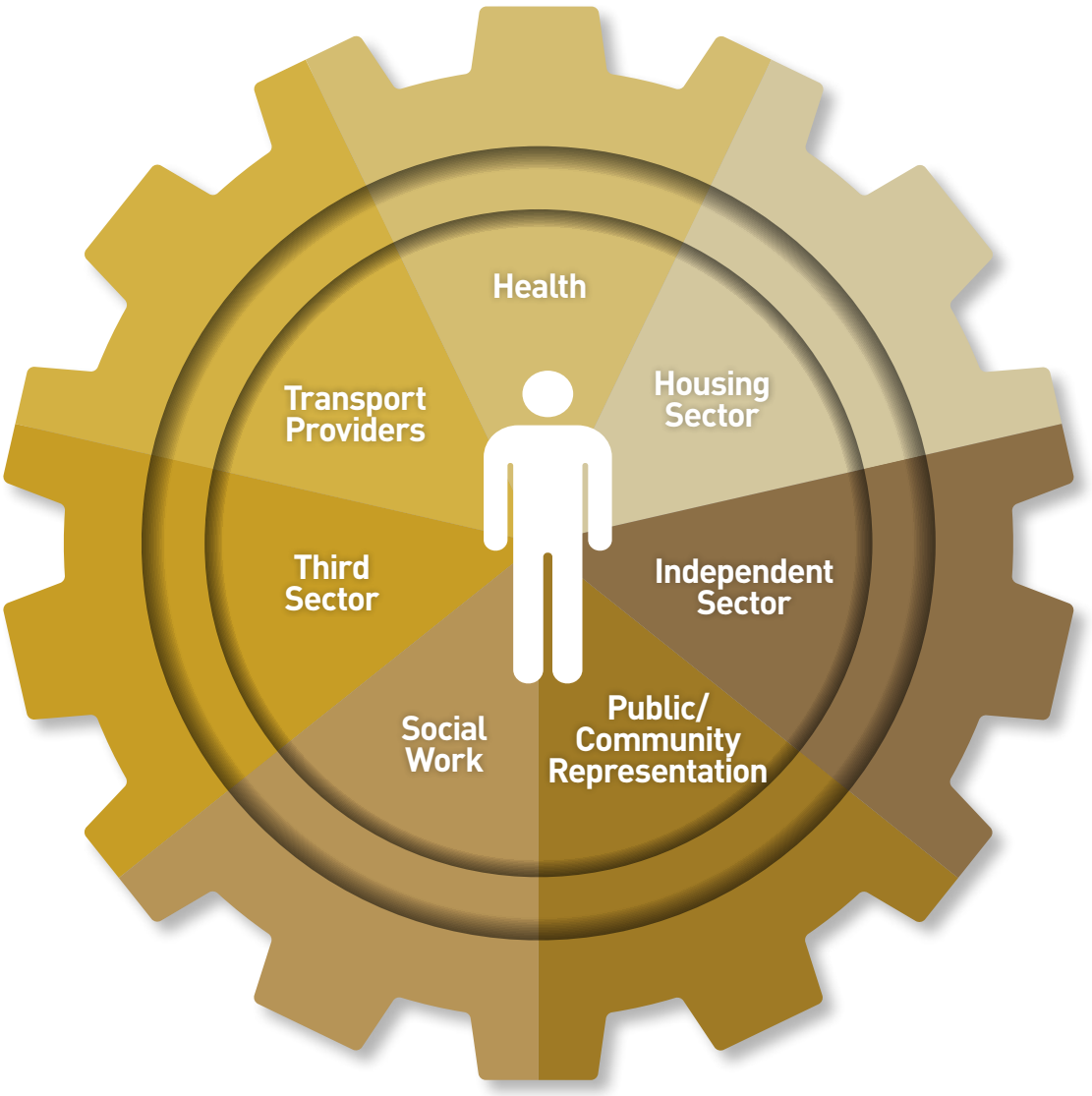
(defined during consultation on our Strategic Plan in 2015)



The Borders Health & Social Care Strategic Plan can be accessed **here**

How the Partnership seeks to meet the Objectives laid out in the Strategic Plan at a local level requires to be demonstrated in a local plan. The Scottish Borders already has five localities – Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale. **This plan is for Tweeddale**.

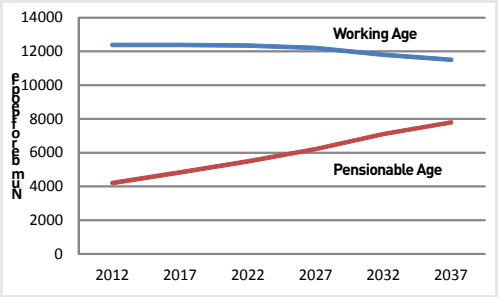
Five Locality Working Groups have been established and have contributed to the development of the five local plans. All key stakeholders are represented on the locality working groups as indicated below:



Details of the Tweeddale Locality Working Group can be found **here**

3. THE TWEEDDALE AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR TWEEDDALE



85.1% increase in **pensionable age**

28.1% decrease in **working age**

POPULATION

20,175 population*
(31% of the Scottish Borders)

18.8% aged **0-15**
(Scottish Borders = 16.7%)

61.6% aged **16-64**
(Scottish Borders = 60.2%)

19.6% aged **65+**
(Scottish Borders = 23.1%)

*(est 2014)

AREA

28.4% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

47% live in **rural areas**
15% Remote rural
32% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Peebles	8,583
Innerleithen	3,064
West Linton	1,561
Cardrona	919
Walkerburn	711

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

77.6 to **81.2 yrs men**
(Scottish Borders = 78.1)

80.9 to **84.5 yrs women**
(Scottish Borders = 82)

Higher rate of **of coronary heart disease**
(Compared to Scottish Borders and Scotland)

Lower rate of **early deaths** of **coronary heart disease or cancer**

Rate of **alcohol related hospitalisations (518.4 per 100,000)** has **risen in last 12 years, increasing from lowest to 3rd highest in the Scottish Borders (566.0)**

A&E ATTENDANCE

54.0% non-emergencies could be cared for within **Locality**
(last year 51.1%)

46.0% emergencies require hospital care
(last year 48.9%)

Lower rate of **emergency hospitalisations**
(compared to Scottish Borders)

Lowest rate **3.96** of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

898 on **Diabetes Register**
5.5 % of **GP Register over 15 yrs**

148 on **Dementia Register**
3.54% of **GP Register over 65 yrs**

5410 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Tweeddale has a higher rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

13.8% report **Accessibility** to **public transport** as an issue
(Scottish Borders =16.6%)

3.5% feel lonely or **isolated**
(Scottish Borders = 6.1%)

12 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

Tweeddale is the **least deprived locality** with none of its **population living** in the **most deprived deciles and over 75% living in least deprived.**

Lower percentage of **pension credit claimants (4.9%)** than **Scottish Borders (5.8%)** and **Scotland (7.7%)**

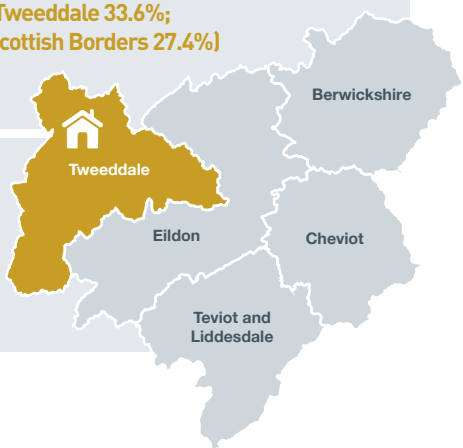
Among lowest suicide rates **12.9 per 100,000**
(Scottish Borders=15.7; Scotland =14.7)

SAFETY

Lowest rate 0.42 of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

11.5% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)

Highest number of **residents involved** in **voluntary work**
(Tweeddale 33.6%;
Scottish Borders 27.4%)



PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	4 units	-
2018-2019	42 units	-
2019-2020	40 units	-

3. THE TWEEDDALE AREA
SERVICES & SUPPORT 2017-2019

WEST LINTON

1 GP Practice
1 Pharmacy
1 Dental Practice
1 Optician

LAMANCHA

38 Residental Care Beds

PEEBLES

2 GP Practices
2 Pharmacies
4 Dental Practices
3 Opticians
1 Community Nursing Team
1 Social Care & Health Team
28 Nursing Home Beds

INNERLEITHEN

1 GP Practice
1 Pharmacy
24 Residental Care Beds

4. PRIORITIES FOR TWEEDDALE 2017-2019

Our understanding of Tweeddale is taken from:

- our analysis of both national and local data and statistics (e.g. Area Profile),
- the knowledge and experience of our service users and carers
- the views of the Locality Working Group
- the knowledge and experience of staff working within the community

The following priorities for Tweeddale have been identified and will contribute to the 9 local objectives for Integration:

PRIORITIES FOR TWEEDDALE		WHAT MAKES THIS A PRIORITY FOR TWEEDDALE
•	Improve the availability and accessibility of services for people living in rural areas and towns across Tweeddale	• limited access to transport networks in rural areas • tendency for services to be located in large settlement areas • lack of care at home providers in the rural areas
•	Increase the availability of locally based rehabilitation services	• limited allied health professional services in the community • limited rehabilitation support workers in the community • no domiciliary physiotherapy services in the community • limited access to day hospital services
•	Increase the range of care and support options available across the locality to enable people to remain in their own homes and communities	• difficulty recruiting and sustaining capacity in provider organisations • lack of paid carers across locality • lack of domiciliary care provision • lack of transitional care beds in Berwickshire • increased reliance on residential and nursing home placements • tendency to pilot different models and approaches within one locality with no roll out to other localities
•	Increase the range of housing options across the locality	• significant projected increase in people of pensionable age • limited options for housing in rural/outlying areas

Work is currently underway to support the delivery of the 9 Local Objectives and an action plan has been developed which identifies work required to ensure the ongoing delivery of the priorities for Tweeddale. This is summarised in **Appendix 1**.

There are some actions which are common across the whole of the Scottish Borders and will be progressed at a Scottish Borders Partnership level, for example the provision of IT access within integrated sites. These actions can be viewed in the Borders wide summary plan in **Appendix 2**.

These actions will be continually evaluated and the plan updated annually.

APPENDIX 1
ACTION PLAN FOR TWEEDDALE

PRIORITY: Improve the availability and accessibility of services for people living in rural areas and towns across Tweeddale

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated team working between Health, Social care and Third sector	• Develop one integrated team covering all areas across the locality • Implement joint staff meetings and training for Health, Social care and Third sector staff	• Improve access to health and social care services at a local level • Sharing of information to support people at home • Improve sharing of information at a local level • Improve staff understanding of roles and responsibilities • Increase efficiency and reduce duplication • Improve access to care at home • Support the prevention of unnecessary admission to hospital • Provide alternatives to attendance at hospital • Reduced inequalities for people within rural areas	• Health and Social care partnership leads • Allied Health Professional leads • Third sector leads	September 2017
• Working with the Transport Hub to improve rural transport	• Develop a link with the Transport Hub to establish rural needs and potential solutions	• Supports people from rural areas to access services	• Transport Hub	September 2017
• Community led support steering group considering suitable locations for 'What Matters' hubs throughout Tweeddale	• Work with community led support steering group to establish appropriate "What Matters" hubs across the Tweeddale locality	• Supports people from rural areas to access information, support and services	• Community led support	2017-18

PRIORITY: Increase the availability of locally based rehabilitation services				
WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Investigating integrated working across Health, Social care and Third sector	• Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community • Improve the availability and accessibility of information provided around what services and types of care are available to patients	• Support peoples' rehabilitation at home • Reduce hospital admissions • Improve peoples' outcomes • Support safe discharge from hospital • Reduce the reliance on home care provision • Reduce delayed discharges • Reduce the admissions to bed based care facilities • Supports positive risk taking	• Locality working group • Allied Health Professional leads	September 2017
• Rehabilitation approach ongoing with care providers across SB cares and Third/ Independent sector	• Link with Third sector around development of the model and roll out	• Support the reablement work within SB cares and independent home care providers	• Red Cross • SB cares • Independent providers	March 2018
• Day services review	• Link with the programme and input into service redesign as required from the locality	• Supports the redesign of day services • Increased options to support people to remain at home	• Day services review project manager • Locality working group	September 2017
• Live Borders "Active ageing" programme	• Support and inform future developments within the locality	• Supports self-management • Prevents hospital admissions • Maintains peoples' current abilities	• Locality working group • Live Borders	March 2018
	• Further develop Day hospital and Day services options to meet rehabilitation needs	• Increased rehabilitation options	• Health and Social care partnership leads • Allied Health Professional leads	March 2018
	• Investigate options to provide domiciliary multidisciplinary outreach services	• Increased options to support people to remain at home	• Allied health professional leads	March 2018

PRIORITY: Increase the range of available care and support options across the locality to enable people to remain in their own homes and communities

WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Community led support steering group considering suitable locations for "What Matters" hubs throughout Tweeddale • Ongoing communication in relation to Carers Act • Increased awareness and usage of self-directed support	• Work with Community led support steering group to establish "What Matters" hubs across the Tweeddale locality • Ensure "What Matters" hubs have relevant information available eg. Carers Act and self-directed support	• People are able to access information and services earlier • People are supported to be as independent as possible • Community resources are key to support people at home • People are supported to self-manage • Reduced waiting lists	• Community led Support Steering group	March 2018
• Increased recruitment by providers • Work with care providers to identify opportunities for development of care services • Frailty redesign programme to ensure people are supported to stay at home • Long term conditions pathway work across the partnership • My Home Life initiative	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathways • Support the independent sector to implement My Home Life	• Reduced care home admissions • Reduced waiting lists • People are supported to remain at home • People are engaged with at an earlier stage to prevent crisis occurring • Helps to fully engage the skills and expertise of voluntary and third sector partners	• Locality working group • Commissioners • Frailty group • Independent sector • Scottish Care	March 2018
• Reablement provision through Red Cross	• Support the further development of reablement services within the third sector	• People are supported to stay at home • People are supported to self-manage • Less reliance on home care provision	• Locality working group • Red Cross	March 2018
• Equipment provision being reviewed • Satellite equipment stores being reviewed	• Support the redesign of the Borders Ability Equipment Service to support people in the community	• Improved access to equipment at point of need • People are supported to stay at home	• Borders Ability Equipment Service	October 2017
• Development of new Community resources	• Support development of community capacity building initiatives	• People are supported to self-manage • Training and development to empower Individuals, therefore building capacity to form stronger communities • Intergenerational support and learning	• Borders Community capacity building team	2017/18
• Transforming Care after Treatment joint project (TCAT)	• Link with TCAT joint project team	• People are able to live as independently as possible in their community following treatment from cancer	• Macmillan • Red Cross • FitBorders • Scottish Borders Council • NHS Borders	October 2017
• Matching Unit launched in Peebles 22nd May to source home care provision and match with assessed need	• Increase available options from Social Work managed care packages offered at launch to include direct payments and individual service fund	• Releases staff capacity • Highlight areas where there is difficulty sourcing home care eg. Rural areas	• Matching Unit Project Manager	2017/18

PRIORITY: Increase the range of housing options available across the locality				
WORK UNDERWAY	ACTION REQUIRED	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Local housing providers represented on Locality Working Group	• Work with registered social landlords to develop alternative accommodation across all areas of the locality	• Increase availability of affordable housing	• Registered social Landlords Housing strategy team	2017-2019
• Extra care housing, Dovecot Court, Peebles	• Ongoing support and development of Dovecot Court, Peebles	• People are able to access appropriate supported housing within their own communities	• Eildon Housing Association	2017-2019

APPENDIX 2
BORDERS WIDE SUMMARY ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES	ACTION PLAN
Increase the range of care & support options across the Scottish Borders to enable people to remain in their own homes and communities	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathway • Support the independent sector to implement "My Home Life" initiative • Support the redesign of Borders Ability Equipment Service to support people in the community • Support development of community capacity building initiatives to develop locality specific services • Development of further healthy living network activity plans • Provide joint training and development for staff • Develop "What Matters" hubs • Adopt the National Anticipatory care plan • Develop integrated teams within each Locality to improve outcomes for the people of that locality • Increase interventions to support people to remain at home and reduce the need for ED /GP attendance • Support discharge from hospital at an appropriate stage with the right service interventions • Early identification of people who require support through early interventions and screening • Establish SBC IT access within identified Health centres to enable NHS staff to access SBC systems and allow Social care & health staff to work from health office
Improve the availability and accessibility of services across the Scottish Borders	• Bring together staff from NHS, SBC and Third sector to work together within integrated teams • Develop a link with the transport hub to establish rural need and potential solutions • Develop "What Matters" hubs
Increase the availability of locally based rehabilitation services across the Scottish Borders	• Support the further development of reablement services within the Third sector • Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community • Link with Third sector around development of the reablement model and roll out to all areas • Link with the Day services review programme and input into service redesign as required from each locality • Support and inform future developments within the locality
Increase the range of housing options available across the Scottish Borders	• Work with registered social landlords to develop alternative accommodation across all localities • Support delivery of extra care housing

TWEEDDALE HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

WORK HAS BEEN INFORMED BY

This plan has been informed in consultation and dialogue with the stakeholders involved in developing the plans, strategies and programmes listed below:

- Community Learning and Development Strategic Plan 2015-2020
- Community Led Support
- Frailty Redesign Programme
- Living well with a disability - Future services for people with a physical disability 2013
- Reducing inequalities in the Scottish Borders 2015-2020 Strategic Plan
- Scottish Borders Alcohol & Drugs Partnership Strategy 2015-2020
- Scottish Borders Autism Strategy 2015
- Scottish Borders Council Local Housing Strategy 2012-17
- Scottish Borders Learning Disability Service Strategic Commissioning Plan 2016-19
- Strategic Housing Investment Plan (SHIP) 2017-22
- The Keys to life strategy 2013

This consultative approach will continue throughout the delivery of this plan.

HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019
WHAT DO YOU THINK?

We want to know what you think about this plan.

Please answer these questions and send it back by **31 August** to:

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

Are you answering these questions....

☐ On behalf of yourself ☐ On behalf of a group or organisations - if so which one?

.....

Q1. Do you think we have missed anything in your Locality plan that you feel is important?

☐ No ☐ Yes. If so – what is missing?

1. Where do you live?

.....

2. What is your age?

.....

3. Do you have a disability?

☐ Yes ☐ No ☐ I do not want to say

4. Are you a carer?

☐ Yes ☐ No ☐ I do not want to say

THANK YOU

Thank you for completing this questionnaire.

FOR MORE INFORMATION

Please contact the address below.

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.

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

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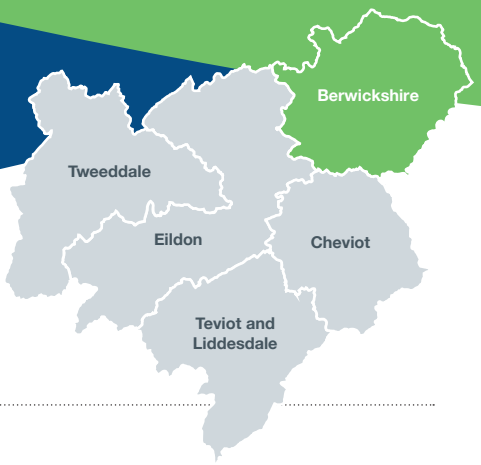
07 June 2017

Scottish Borders **Health & Social Care** Partnership

SUMMARY ACTION PLAN for consultation
BERWICKSHIRE



ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

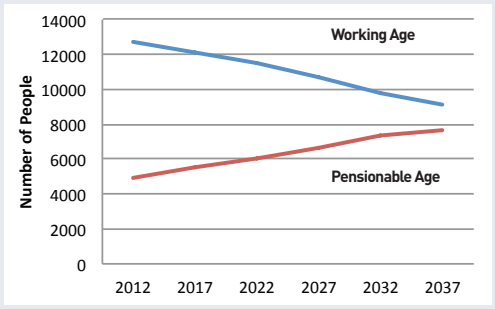
PRIORITIES FOR BERWICKSHIRE	ACTION PLAN
Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• Establish "What Matters" hubs across Berwickshire • Redesign equipment service and satellite stores • Support care providers to develop services designed for the Berwickshire locality • Support further development of "healthy living networks" across the locality • Support the ongoing development of community capacity building initiatives • Support future developments within Eyemouth Medical Practice
Improve the availability and accessibility of services for people living in rural areas and towns across Berwickshire	• Develop two Integrated teams between Health, Social Care and Third sector • Work with the transport hub to improve access to transport across Berwickshire • Establish "What Matters " hubs across the Berwickshire locality
Increase the availability of locally based rehabilitation services	• Scope out current gaps in service provision across Berwickshire and look to address these • Increase access to Allied Health Professionals from the community • Link with the Third sector around their model of rehabilitation • Link with Day services review • Support Live Borders to design programmes with rehabilitation incorporated within them across Berwickshire • Support development of Transitional care beds within Berwickshire
Increase the range of housing options available across the locality	• Work with Registered social landlords to develop alternative accommodation across all areas of the locality • Support the development of extra care housing in Berwickshire

This is a summary plan for Berwickshire.
To view the full Health and Social Care plan for Berwickshire please visit **here**

Scottish Borders
Health and Social Care
PARTNERSHIP

THE BERWICKSHIRE AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR BERWICKSHIRE



57.2% increase in **pensionable age**

28.1% decrease in **working age**

POPULATION

20,657 population*
(19% of the Scottish Borders)

15.1% aged **0-15**
(Scottish Borders = 16.7%)

60.4% aged **16-64**
(Scottish Borders = 60.2%)

24.5% aged **65+**
(Scottish Borders = 23.1%)

9.9% provide **unpaid care**

*(est 2014)

AREA

45.3% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

85% live in **rural areas**
30% Remote rural
55% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Eyemouth	3,540
Duns	2,722
Coldstream	1,867
Chirnside	1,426
Greenlaw	629
Ayton	573
Coldingham	549

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

78.3 to **83 yrs men**
(Scottish Borders = 78.1)

81.5 to **87.5 yrs women**
(Scottish Borders = 82)

Higher rate of **of new cancer diagnosis**
(compared to Scottish Borders)

Lower rate of **early cancer deaths**
(compared to Scottish Borders and Scotland)

A&E ATTENDANCE

47.5% non-emergencies could be cared for within Locality of which **75+ age group represent the highest proportion**
(last year 43.5%)

52.5% emergencies require hospital care
(last year 56.5%)

7.67 rate of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

1,107 on **Diabetes Register**
6.23% of **GP Register over 15 yrs**

183 on **Dementia Register**
3.55% of **GP Register over 65 yrs**

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

20.5% report **public transport** as an accessibility issue

People in Berwickshire place a **higher priority** on:

providing **sustainable transport links** including **demand responsive transport**

HOUSEHOLD PROFILE

aged 65+

26.8% Berwickshire
(Scottish Borders = 25.4%)
(Scotland = 20.7%)

7.9% feel lonely or **isolated**
(Scottish Borders = 6.1%)

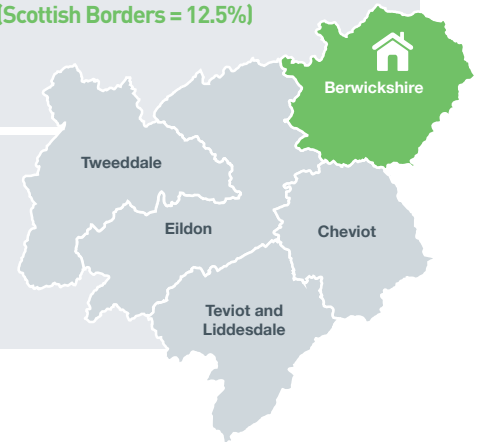
12 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

SAFETY

9.92 rate of **road** and **home safety incidents** per 1,000
(Scottish Borders = 7.65)

0.81 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

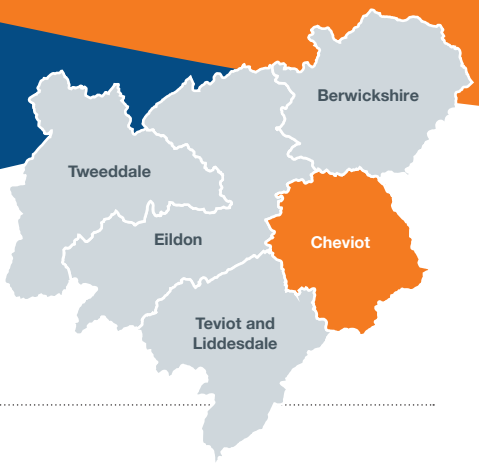
8.1% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	26 units	-
2018-2019	73 units	-
2019-2020	59 units	30 units

SUMMARY ACTION PLAN for consultation
CHEVIOT



ACTION PLAN

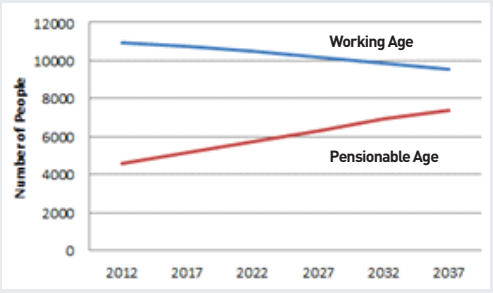
Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES FOR CHEVIOT	ACTION PLAN
Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• Establish "What Matters" hubs across Cheviot • Redesign equipment service and satellite stores • Support care providers to develop services designed for the Cheviot locality • Support development of "healthy living networks" across the locality • Support the ongoing development of community capacity building initiatives
Increase the availability of locally based rehabilitation services	• Scope out current gaps in service provision across Cheviot and look to address these • Increase access to Allied Health Professionals from the community • Link with the Third sector around their model of rehabilitation • Link with Day services review • Support Live Borders to design programmes with rehabilitation incorporated within them across Cheviot • Support development of Transitional care beds in Cheviot
Increase the range of housing options available across the Locality	• Work with Registered social landlords to develop alternative accommodation across all areas of the locality • Support development of extra care housing within Cheviot
Improve efficiency and effectiveness of the existing co-located and integrated teams	• Agree future service structure across the locality
Improve transport links across Cheviot	• Work with the Strategic transport group and transport hub to develop sustainable and demand responsive transport across the locality

This is a summary plan for Cheviot.
To view the full Health and Social Care plan for Cheviot please visit **here**

THE CHEVIOT AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR CHEVIOT



61.4% increase in **pensionable age**

12.70% decrease in **working age**

POPULATION

19.503 population *
(17% of the Scottish Borders)

14.9% aged **0-15**
(Scottish Borders = 16.7%)

58.2% aged **16-64**
(Scottish Borders = 60.2%)

26.9% aged **65+**
(Scottish Borders = 23.1%)
of this 11.8% are aged 75+ the highest percentage of the Scottish Borders

*(est 2014)

AREA

34.0% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

50% live in **rural areas**
28% Remote rural
22% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Kelso	6,821
Jedburgh	3,961
St Boswells	1,466
Yetholm	618

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

77 to **82 yrs men**
(Scottish Borders = 78.1)

81.4 to **85.8 yrs women**
(Scottish Borders = 82)

Lower rate of **coronary heart disease hospitalisations** and **early deaths** (compared to the Scottish borders and Scotland)

Cheviot has a **higher** rate of **suicide** (compared to Scottish Borders and Scotland)

A&E ATTENDANCE

59.8% the locality has the **highest percentage who attend A&E out of hours in the Scottish Borders**

55.5% non-emergencies could be cared for within the Locality, between **2014/16** the **over 65 age group represented** the **largest proportion** of **attendees**

Cheviot had the **lowest rate** of **emergency hospitalisations** (compared to other Borders Localities and Scotland)

5.36 rate of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

1,073 on **Diabetes Register**
6.76 % of **GP Register over 15 yrs**

193 on **Dementia Register**
4.0% of **GP Register over 65 yrs**

3972 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Cheviot has the lowest rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

16.4% report **public transport** as an accessibility issue
(Scottish Borders = 16.6%)

People in Cheviot place a **higher priority** on:

providing **high quality care for older people** and making **more affordable housing available**

HOUSEHOLD PROFILE

One person household: aged 65+

16.6% Cheviot
(Scottish Borders = 15.2%)
(Scotland = 13.1%)

5.1% **feel lonely** or **isolated**
(Scottish Borders = 6.1%)

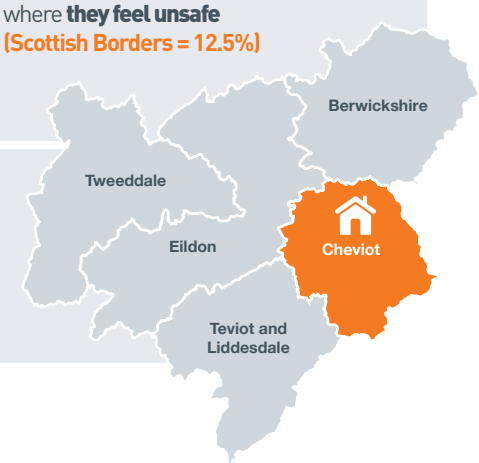
9 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

SAFETY

7.13 rate of **road** and **home safety incidents** per 1,000
(Scottish Borders = 7.65)

0.49 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

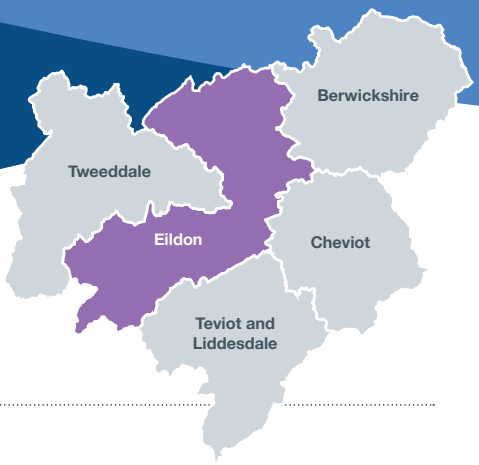
11% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	18 units	-
2018-2019	26 units	-
2019-2020	20 units	-

SUMMARY ACTION PLAN for consultation
EILDON



ACTION PLAN

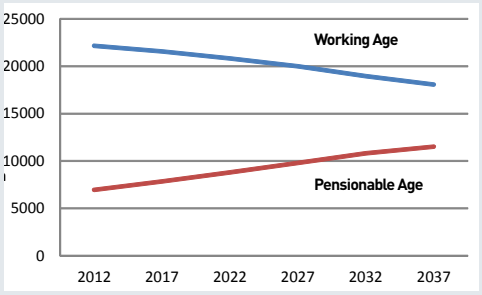
Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES FOR EILDON	ACTION PLAN
Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• Establish "What Matters " hubs across Eildon • Redesign equipment service and satellite stores • Support care providers to develop services designed for the Eildon locality • Support further development of "healthy living networks" across the locality • Support the ongoing development of community capacity building initiatives
Improve the availability and accessibility of services for people living in rural areas across Eildon	• Develop three Integrated teams between Health, Social Care and Third sector • Work with the transport hub to improve access to rural transport across Eildon • Establish "What Matters" hub within Ettrickbridge / Yarrow valley • Establish further "What Matters" hubs across the Eildon locality
Increase the availability of locally based rehabilitation services	• Scope out current gaps in service provision across Eildon and look to address these • Increase access to Allied Health Professionals from the community • Link with the third sector around their model of rehabilitation • Link with Day services review • Support Live Borders to design programmes with rehabilitation incorporated within them across Eildon • Work with Rapid assessment and discharge team to support people in the community post discharge • Support further development of Transitional care beds within Waverley Care home
Increase the range of housing options available across the locality	• Work with Registered social landlords to develop alternative accommodation across all areas of the locality • Support the development of extra care housing in Eildon
Reduce the number of people admitted to hospital with drug and alcohol related problems	• Support individuals within drug and alcohol problems • Work with inequalities to support people to remain at home
Reduce the number of people attending the Borders General hospital on multiple occasions	• Implement three integrated Health, Social Care and third sector teams across Eildon • Ensure joint staff meetings and training in place • Provide SBC IT and training within NHS facilities • Further develop the frailty pathways work across the Partnership • Work with GPs to rollout anticipatory care plans • Further develop locality working group to progress locality plans • Work with communities to engage support for people to remain at home

This is a summary plan for Eildon.
To view the full Health and Social Care plan for Eildon please visit **here**

THE EILDON AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR EILDON



65% increase in **pensionable age**

18.4% decrease in **working age**

POPULATION

35,000 population*
(31% of the Scottish Borders)

17.8% aged **0-15**
(Scottish Borders = 16.7%)

60.9% aged **16-64**
(Scottish Borders = 60.2%)

21.3% aged **65+**
(Scottish Borders = 23.1%)

*(est 2014)

AREA

19.3% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

43% live in **rural areas**
15% Remote rural
32% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Galashiels	12,670
Selkirk	5,586
Melrose	2,457
Tweedbank	2,073
Lauder	1,773
Earlston	1,766
Newtown St Boswells	1,347

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

74.7 to **82.5 yrs men**
(Scottish Borders = 78.1)

79.1 to **89 yrs women**
(Scottish Borders = 82)

Higher rate of **coronary heart disease hospitalisations**
(Compared to Borders and Scotland)

700.5 per 100,000 **Higher rate** of **alcohol related hospitalisations** and **deaths**
(compared to Borders = 566)

108.9 per 100,000 **Higher rate of drug related hospitalisations and deaths**
(compared to Scottish Borders= 88.1)

A&E ATTENDANCE

59.4% non-emergencies could be cared for within **Locality**
(last year 56.8%)

40.6% emergencies
(last year 43.2%)

Higher rate of **emergency hospitalisations**
(compared to Scottish Borders)

3.74 rate of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

2,050 on **Diabetes Register**
6.14 % of **GP Register****

315 on **Dementia Register**
3.82% of **GP Register*****

5684.8 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Eildon has the highest rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

** over 15 yrs
*** over 65 yrs

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

16.6% report **accessibility** to **public transport as an issue**
(lower than any other Locality)

5.5% feel lonely or **isolated**
(Scottish Borders = 6.1%)

28 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

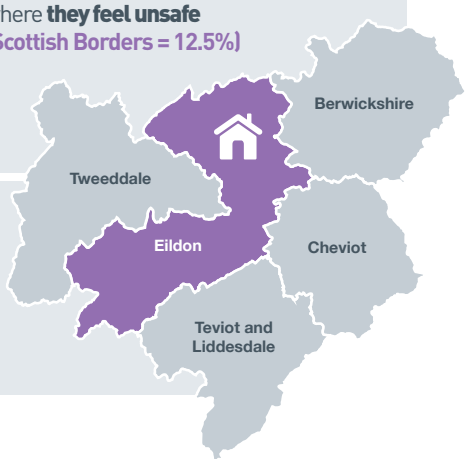
Eildon has a **proportion** of its **population living** in each of the **ten deprivation deciles, demonstrating the large degree of variance** in **deprivation profile** within the **locality**

Eildon has the **highest rate** of **suicide 21.7 per 100,000**
(Scottish Borders=15.7. Scotland =14.7)

SAFETY

0.80 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

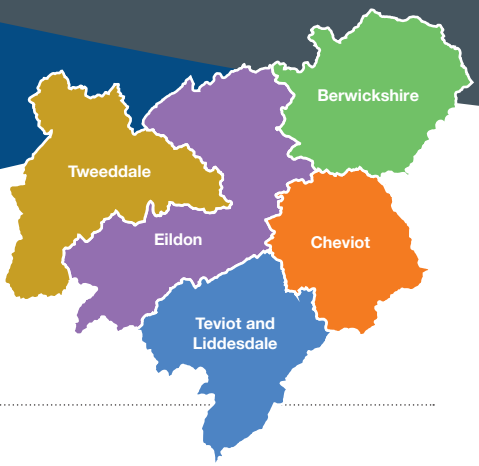
15.3% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	54 units	-
2018-2019	181 units	-
2019-2020	84 units	24 units

SUMMARY ACTION PLAN for consultation
SCOTTISH BORDERS



ACTION PLAN

Devised in line with strategic plan together with national outcomes and local objectives.

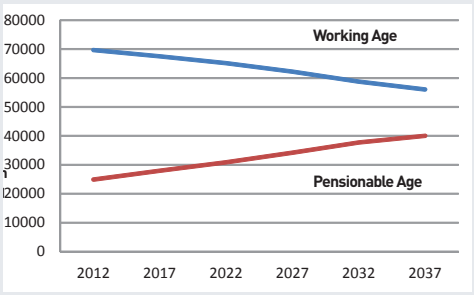
PRIORITIES FOR SCOTTISH BORDERS	ACTION PLAN
Increase the range of care & support options across the Scottish Borders to enable people to remain in their own homes and communities	• Work with providers in the development of available support services • Support the implementation of new ways of working through the frailty redesign pathway • Support the independent sector to implement "My Home Life" initiative • Support the redesign of Borders Ability Equipment Service to support people in the community • Support development of community capacity building initiatives to develop locality specific services • Development of further healthy living network activity plans • Provide joint training and development for staff • Develop "What Matters" hubs • Adopt the National Anticipatory care plan • Develop integrated teams within each Locality to improve outcomes for the people of that locality • Increase interventions to support people to remain at home and reduce the need for ED /GP attendance • Support discharge from hospital at an appropriate stage with the right service interventions • Early identification of people who require support through early interventions and screening • Establish SBC IT access within identified Health centres to enable NHS staff to access SBC systems and allow Social care & health staff to work from health office
Improve the availability and accessibility of services across the Scottish Borders	• Bring together staff from NHS, SBC and Third sector to work together within integrated teams • Develop a link with the transport hub to establish rural need and potential solutions • Develop "What Matters" hubs
Increase the availability of locally based rehabilitation services across the Scottish Borders	• Support the further development of reablement services within the Third sector • Scope out the gaps in community rehabilitation services across the partnership and devise and implement a structure to address these • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community • Link with Third sector around development of the reablement model and roll out to all areas • Link with the Day services review programme and input into service redesign as required from each locality • Support and inform future developments within the locality
Increase the range of housing options available across the Scottish Borders	• Work with registered social landlords to develop alternative accommodation across all localities • Support delivery of extra care housing

This is a summary plan for Scottish Borders.
To view the full Health and Social Care plan for Scottish Borders please visit **here**

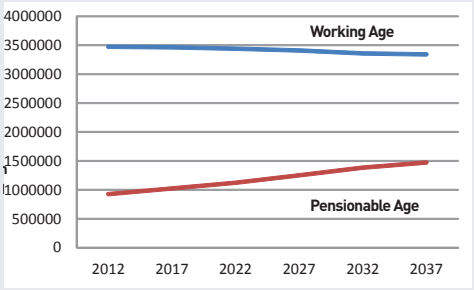
Scottish Borders Health and Social Care PARTNERSHIP

THE SCOTTISH BORDERS AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR SCOTTISH BORDERS



FOR SCOTLAND



60.5% increase in **pensionable age** **(Scotland 59.1%)**

19.6% decrease in **working age** **(Scotland 3.77%)**

POPULATION

114,030 **population***

- **13.5%** aged **16 to 29 years** **(Scotland = 18.3%)**
- **30.2%** aged **60 and over** **(Scotland = 24%)**

*(est 2014)

AREA

4732 **sq km (1827 sq miles)**

4th most sparsely-populated **mainland area in Scotland**

- **47.1%** of the **population live in a rural area**
- **30%** live in settlements with **less than 500 people**

HEALTH OF THE SCOTTISH BORDERS

LONG TERM CONDITIONS

6,361 on **Diabetes Register** **6.40%** of **GP Register**** **(Scotland = 5.88%)**

1,040 on **Dementia Register** **3.85%** of **GP Register***** **(Scotland = 4.58%)**

** over 15 yrs
*** over 65 yrs

11% **increase** in **emergency hospitalisations 2002-2013** **(Scotland = 1%)**

5122 per **100,000 Multiple emergency hospitalisations Patients 65+ (Scotland = 5159.5)**

KEY HEALTH AND SOCIAL CARE ISSUES FOR SCOTTISH BORDERS RESIDENTS*

- High quality care for older people
- Tackling poverty and inequality
- Sustainable transport links
- More affordable housing

*(Scottish Borders Household Survey 2015)

OUR NEIGHBOURHOODS 2015

91.2% rate their **neighbourhood as very/fairly good**

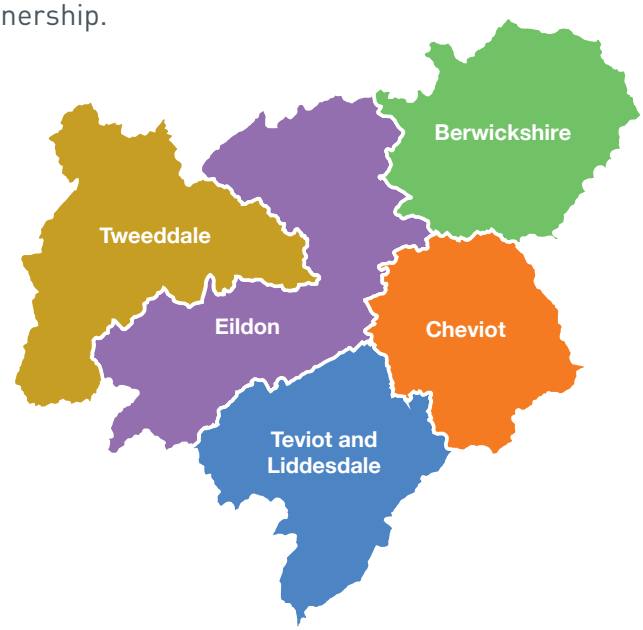
VOLUNTEERING 2015

27.4% **adults** involved in **voluntary work**

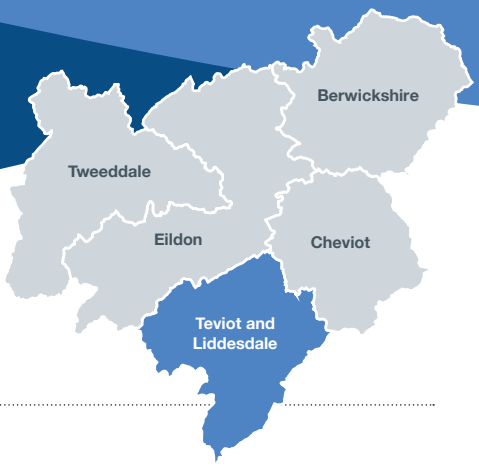
INFLUENCE / INVOLVEMENT IN PUBLIC SECTOR 2014

17% **agree** that they **"can influence decisions affecting my local area"** **(Scotland = 23%)**

This information is taken from the Scottish Borders Strategic Assessment 2016 "KnowBorders", produced for the Scottish Borders Community Planning Partnership.



SUMMARY ACTION PLAN for consultation
TEVIOT & LIDDESDALE



ACTION PLAN

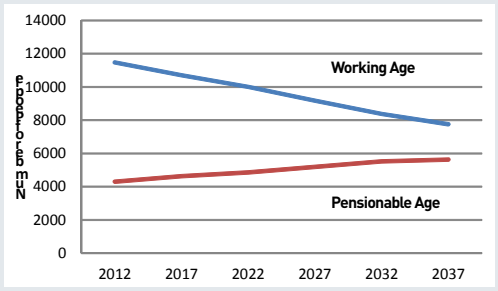
Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES FOR TEVIOT	ACTION PLAN
Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• Establish "What Matters" hubs across Teviot • Redesign equipment service and satellite stores • Support care providers to develop services designed for the Teviot locality • Support further development of "healthy living networks" across the locality • Support the ongoing development of community capacity building initiatives • Support rollout of paramedic practitioner project at other practices in locality
Improve the availability and accessibility of services for people living in rural areas and towns across Teviot	• Develop one integrated team between Health, Social Care and Third sector • Work with the transport hub to improve access to rural transport across Teviot • Establish "What Matters" hub within Burnfoot, Hawick • Establish further "What Matters" hubs across the Teviot locality
Increase the availability of locally based rehabilitation services	• Scope out current gaps in service provision across Teviot and look to address these • Increase access to Allied Health Professionals from the community • Link with the Third sector around their model of rehabilitation • Link with Day services review • Support Live Borders to design programmes with rehabilitation incorporated within them across Teviot
Increase the range of housing options available across the locality	• Work with Registered social landlords to develop alternative accommodation across all areas of the locality • Support the development of extra care housing in Teviot
Develop robust preventative services and early intervention for long term conditions	• Improve preventative and early intervention elements of the care pathway • Work with GP cluster quality leads to improve preventative approaches in primary care • Improve access to information on self-management • Support the rollout of anticipatory care planning

This is a summary plan for Teviot and Liddesdale.
To view the full Health and Social Care plan for Teviot and Liddesdale please visit **here**

THE TEVIOT AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037
FOR TEVIOT & LIDDESDALE



65% increase in **pensionable age**

18.4% decrease in **working age**

POPULATION

17,965 population*
(31% of the Scottish Borders)

13.5% aged **0-15**
(Scottish Borders = 16.7%)

58.6% aged **16-64**
(Scottish Borders = 60.2%)

27.9% aged **65+**
(Scottish Borders = 23.1%)

*(est 2014)

AREA

14.2% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

26% live in **rural areas**
8% Remote rural
18% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Hawick	14,003
Newcastleton	757
Denholm	625

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

77.3 to **78.5 yrs men**
(Scottish Borders = 78.1)

79.9 to **84.1 yrs women**
(Scottish Borders = 82)

Highest rate of **coronary heart disease hospitalisations** and **early deaths**
(compared to the Scottish Borders and Scotland)

646.3 per 100,00
Higher rate of **alcohol related hospitalisations** and **deaths** and **increasing in recent years**
(Compared to Borders = 566)

580.9 per 100,000 Highest rate of **COPD hospitalisations**
(compared to Scottish Borders=497.6)

A&E ATTENDANCE

50.2% non-emergencies could be cared for within **Locality**
(last year 45.9%)

49.8% emergencies
(last year 54.1%)

Higher rate of **emergency hospitalisations**
(compared to Scottish Borders)

LONG TERM CONDITIONS

1,233 on **Diabetes Register**
7.65 % of **GP Register over 15 yrs**

201 on **Dementia Register**
4.34% of **GP Register over 65 yrs**

5463 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Teviot has a higher rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

15.0% report **accessibility** to **public transport as an issue**
(Scottish Borders=16.6%)

8.4% feel lonely or **isolated**
(Scottish Borders = 6.1%)

8 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

Teviot is the **most deprived population** in the **Scottish Borders** with **over 40%** of its **population living in the 4 most deprived deciles**

Teviot has **highest number** of individuals **claiming JSA and pension credits**

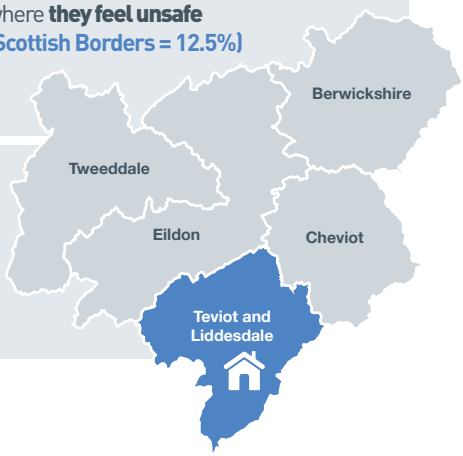
Among lowest suicide rates in the **Scottish Borders** at **12.3 per 100,000**

SAFETY

9.19 Highest rate of **over 75 falls** per 1000
(compared to 5.62 for Scottish Borders)

1.07 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

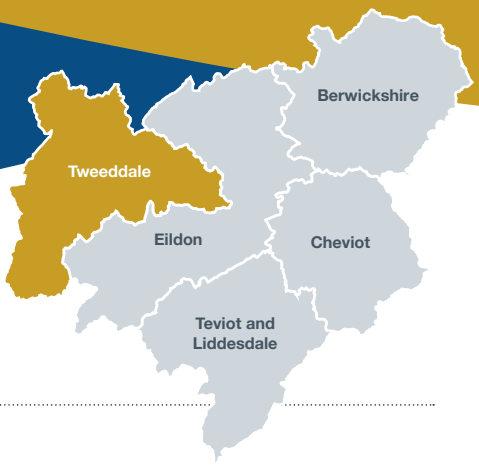
17% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	6 units	-
2018-2019	12 units	-
2019-2020	-	-

SUMMARY ACTION PLAN for consultation
TWEEDDALE



ACTION PLAN

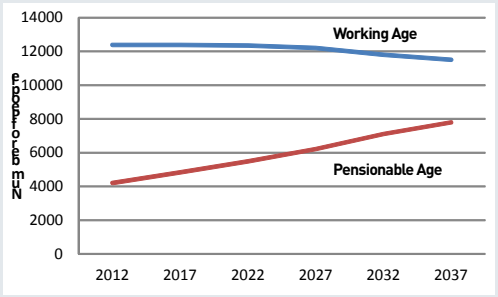
Devised in line with strategic plan together with national outcomes and local objectives.

PRIORITIES FOR TWEEDDALE	ACTION PLAN
Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• Establish "What Matters " hubs across Tweeddale • Redesign equipment service and satellite stores • Support care providers to develop services designed for the Tweeddale locality • Support the ongoing development of community capacity building initiatives • Link with Transforming Care after Treatment (TCAT) joint project team
Improve the availability and accessibility of services for people living in rural areas and towns across Tweeddale	• Develop one integrated team between Health, Social Care and Third sector • Work with the transport hub to improve access to transport across Tweeddale • Establish "What Matters" hubs across Tweeddale
Increase the availability of locally based rehabilitation services	• Scope out current gaps in service provision across Tweeddale and look to address these • Increase access to Allied Health Professionals from the community • Link with the Third sector around their model of rehabilitation • Link with Day services review • Support Live Borders to design programmes with rehabilitation incorporated within them across Tweeddale • Develop Day hospital and Day services options to meet rehabilitation needs • Investigate options to provide domiciliary multidisciplinary outreach services
Increase the range of housing options available across the locality	• Work with Registered social landlords to develop alternative accommodation across all areas of the locality • Ongoing development and support of extra care housing at Dovecot Court, Peebles

This is a summary plan for Tweeddale.
To view the full Health and Social Care plan for Tweeddale please visit **here**

THE TWEEDDALE AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR TWEEDDALE



85.1% increase in **pensionable age**

28.1% decrease in **working age**

POPULATION

20,175 population*
(31% of the Scottish Borders)

18.8% aged **0-15**
(Scottish Borders = 16.7%)

61.6% aged **16-64**
(Scottish Borders = 60.2%)

19.6% aged **65+**
(Scottish Borders = 23.1%)

*(est 2014)

AREA

28.4% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

47% live in **rural areas**
15% Remote rural
32% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Peebles	8,583
Innerleithen	3,064
West Linton	1,561
Cardrona	919
Walkerburn	711

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

77.6 to **81.2 yrs men**
(Scottish Borders = 78.1)

80.9 to **84.5 yrs women**
(Scottish Borders = 82)

Higher rate of **of coronary heart disease**
(Compared to Scottish Borders and Scotland)

Lower rate of **early deaths** of **coronary heart disease or cancer**

Rate of **alcohol related hospitalisations (518.4 per 100,000)** has **risen in last 12 years, increasing from lowest to 3rd highest in the Scottish Borders (566.0)**

A&E ATTENDANCE

54.0% non-emergencies could be cared for within **Locality**
(last year 51.1%)

46.0% emergencies require hospital care
(last year 48.9%)

Lower rate of **emergency hospitalisations**
(compared to Scottish Borders)

Lowest rate **3.96** of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

898 on **Diabetes Register**
5.5 % of **GP Register over 15 yrs**

148 on **Dementia Register**
3.54% of **GP Register over 65 yrs**

5410 per **100,000 Multiple emergency hospitalisations Patients 65+**
(Tweeddale has a higher rate)
(Scottish Borders = 5122.5
Scotland = 5159.5)

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

13.8% report **Accessibility** to **public transport** as an issue
(Scottish Borders =16.6%)

3.5% feel lonely or **isolated**
(Scottish Borders = 6.1%)

12 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

Tweeddale is the **least deprived locality** with none of its **population living** in the **most deprived deciles and over 75% living in least deprived.**

Lower percentage of **pension credit claimants (4.9%)** than **Scottish Borders (5.8%)** and **Scotland (7.7%)**

Among lowest suicide rates **12.9 per 100,000**
(Scottish Borders=15.7; Scotland =14.7)

SAFETY

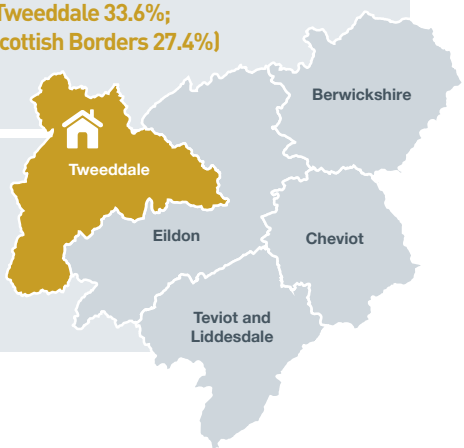
Lowest rate 0.42 of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

11.5% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)

Highest number of **residents involved** in **voluntary work**
(Tweeddale 33.6%;
Scottish Borders 27.4%)

PROPOSED HOUSING DEVELOPMENTS

AFFORDABLE HOUSING		EXTRA CARE HOUSING
2017-2018	4 units	-
2018-2019	42 units	-
2019-2020	40 units	-



Scottish Borders
Health and Social Care
PARTNERSHIP

SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD ANNUAL REPORT 2016/17

Aim

1.1 To provide the Health & Social Care Integration Joint Board with a report on the business it has undertaken during the period 1 April 2016 to 31 March 2017.

Background

2.1 An annual report of the business of the Health & Social Care Integration Joint Board should be produced as part of good practice processes.

Summary

3.1 This Annual Report forms part of the assurance required for the Governance Statement as produced for the NHS Borders Audit Committee as part of the Borders NHS Board Annual Accounts process.

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the Health & Social Care Integration Joint Board Annual Report 2016/17 report.

Policy/Strategy Implications	Required as part of the governance statement process for NHS Borders.
Consultation	Not required.
Risk Assessment	Required as part of the governance statement process for the NHS Borders Annual Accounts process.
Compliance with requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	Not applicable.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer Health & Social Care		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

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Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

ANNUAL REPORT 2016/17

CONTENTS

1. Introduction to Scottish Borders Health & Social Care Integration Joint Board

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 required Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. They could also choose to integrate planning and delivery of other services – additional adult health and social care services beyond the minimum prescribed, and children's health and social care services.

1.2 In line with the legislation, the Scottish Borders Health & Social Care Integration Joint Board was remitted to plan and oversee the delivery of the integrated services for which it had responsibility. In line with its Strategic Commissioning Plan, the Health & Social Care Integration Joint Board required that the Local Authority and Health Board provide services to match what was required and it would oversee performance and targets to ensure that delivery was in line with the outcomes.

2. Vision, Aims and Outcomes

2.1 By maximising the opportunities presented through legislation the Health & Social Care Integration Joint Board aimed to achieve the highest outcomes for the people of the Scottish Borders. By creating new integrated arrangements across health and social care it would enhance, strengthen and develop the formerly separate services for the provision of adult health and social care. By integrating service delivery and fulfilling the expectations of the Strategic Commissioning Plan it sought to enhance and promote the health and wellbeing of the people of the Scottish Borders.

2.2 Working with the Third and Independent Sector, it would provide a unified approach across the public sector with a common sense of purpose. It would engage with service users, carers, staff and members of the public to empower individuals and communities to be a driving force for how the services would be shaped and developed. In turn, it would deliver the best possible services that would be safe, of the highest quality, person centred, efficient and fair.

2.3 The main purpose of integration was to improve the wellbeing of people who used health and social care services, particularly those whose needs were complex and involved support from health and social care at the same time. The Health & Social Care Integration Joint Board set out within its Strategic Commissioning Plan how it was to deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under Section 5(1) of the Act namely:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- 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.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

- Health and social care services contribute to reducing health inequalities.
- 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 wellbeing.
- People using health and social care services are safe from harm.
- 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.
- Resources are used effectively and efficiently in the provision of health and social care services.

2.4 During the period 2016/17 the Health & Social Care Integration Joint Board had the following functions:-

- delegated local authority functions as agreed by Council;
- delegated NHS functions as agreed by the Health Board;
- exercise NHS and Council functions relating to the development and delivery of the partnership Integration Plan;
- exercise NHS and Council functions relating to the development and delivery of the Integration Board's Strategic Plan;
- development of locality planning;
- development of joint performance management arrangements;
- development of partnership mainstreaming report and equality outcomes 2016/17;
- finances

3. Management

3.1 The Health & Social Care Integration Joint Board was supported in its work through the Chief Officer for Health & Social Care Integration. The original post holder secured a position at another organisation from December 2016 and an Interim Chief Officer replacement was sought and secured through a secondment agreement.

3.2 During 2016/17 the Health & Social Care Integration Joint Board appointed its Audit Committee, membership and remit. Audit Scotland were appointed as the External Auditors for the Scottish Borders Health & Social Care Integration Joint Board.

4. Professional Advice

4.1 The Health & Social Care Integration Joint Board had the authority to access appropriate professional advice and guidance to fulfil its remit.

5. Membership

5.1 The Health & Social Care Integration Joint Board for 2016/17 was chaired by Cllr Catriona Bhatia, the membership was as follows:-

Voting Membership	
Elected Members of Scottish Borders Council	Cllr Catriona Bhatia (Chair) Cllr Frances Renton Cllr John Mitchell Cllr Jim Torrance *member until 15.08.16* Cllr Graham Garvie *member from 31.08.16* Cllr Iain Gillespie *member until 15.08.16* Cllr Sandy Aitchison *member from 31.08.16*
NHS Borders Non Executive Members	Mrs Pat Alexander (Vice Chair) Mr John Raine Dr Stephen Mather Mr David Davidson Mrs Karen Hamilton
Non Voting Membership	
Chief Officer	Mrs Susan Manion *until 01.12.16* Mrs Elaine Torrance *from 19.12.16*
NHS Borders Medical Director	Dr Andrew Murray *until 13.02.17* Dr Cliff Sharp *from 14.02.17*
NHS Borders Director of Nursing, Midwifery & Acute Services	Mrs Evelyn Rodger *until 31.03.17* Mrs Claire Pearce *from 01.05.17*
SBC Chief Social Work Officer	Mrs Elaine Torrance *until 19.12.16* Mr Murray Leys *from 19.12.16*
Joint Staff Forum Chair	Mr David Bell
NHS Borders Staff Side	Mr John McLaren
Borders Voluntary Care Voice Coordinator	Mrs Jenny Smith (nee Miller)
Borders Carers Centre	Mrs Lynn Gallacher
Public Partnership Forum Chair	Mrs Angela Trueman
GP	Dr Angus McVean
Attendees	
Board Secretary	Miss Iris Bishop
Interim Chief Financial Officer	Mr Paul McMenamin
IJB Chief Internal Auditor	Mrs Jill Stacey
NHS Borders Chief Executive	Mrs Jane Davidson
SBC Chief Executive	Mrs Tracey Logan

6. Meetings

6.1 The Health & Social Care Integration Joint Board met on ten occasions during the year from 1 April 2016 to 31 March 2017, on the following dates:-

- 18 April 2016
- 20 June 2016
- 15 August 2016
- 31 August 2016 – Extra ordinary meeting

- 17 October 2016
- 21 November 2016 – Extra ordinary meeting
- 19 December 2016
- 30 January 2017 – Extra ordinary meeting
- 27 February 2017
- 27 March 2017

6.2 The Health & Social Care Integration Joint Board also undertook a series of development sessions throughout 2016/17 on the following dates:-

- 25 May 2016
- 26 September 2016
- 21 November 2016
- 30 January 2017

6.3 Appendix 1 details the schedule of business for 2016/17, Appendix 2 the attendance record for 2016/17 and Appendix 3 the full Annual Performance Report for 2016/17.

7. Conclusion

7.1 The Health & Social Care Integration Joint Board has worked to further develop the joint agenda and strengthen the partnership between NHS Borders, Scottish Borders Council, the voluntary sector and the public.

8. Statement of Approval

8.1 The report has been produced as a record of work undertaken during the year ending 31 March 2017.

Approved by: Dr Stephen Mather (Chair)

Signed: .....

Date: .....

Health & Social Care Integration Joint Board
Schedule of Business considered: 1 April 2016 to 31 March 2017

Date of Meeting	Title of Business Discussed
18 April 2016	Minutes of Previous Meetings of 7 March 2016, 30 March 2016 Matters Arising & Action Tracker
	STRATEGY
	Housing Contribution Statement Integrated Care Fund NHS Borders Local Delivery Plan 2016/17
	GOVERNANCE
	Issue of Directions from Integration Joint Board 2016/17 Health & Social Care Integration - Commissioning & Implementation Plan Draft Performance Management Framework
	FINANCE
	Monitoring of the Shadow Integrated Budget 2015/16 Financial Statement 2016/17 – Overview of Due Diligence Process Update: Financial Governance & Management Arrangements
	FOR INFORMATION
	Chief Officer's Report Committee Minutes
Date of Meeting	Title of Business Discussed
20 June 2016	Minutes of Previous Meeting of 18 April 2016 Matters Arising & Action Tracker
	STRATEGY
	Integrated Care Fund Revised Governance Arrangements for Integrated Care Fund The Localities Framework for Integrated Health & Social Care Draft: Health & Social Care Integration Partnership Mainstreaming Report and Equality Outcomes 2016/17 Delayed Discharges
	GOVERNANCE
	Draft Corporate Services Support Plan Update Clinical & Care Governance Framework Appointments to Sub Committees/Groups Health & Social Care Shadow Integration Board Annual Report 2015/16
	FINANCE
	Monitoring of the Joint Integrated Budget 2015/16 Delegated Functions 2016/17 Financial Plan Level of Investment & Savings 2016/17 Financial Plan – Social Care Funding Alcohol & Drugs Partnership Funding 2016/17
	FOR INFORMATION
	Communications Quarterly Report

	Chief Officer's Report Committee Minutes NHS Borders Pharmaceutical Care Services Plan 2016/17
Date of Meeting	Title of Business Discussed
15 August 2016 Not Quorate	Minutes of Previous Meeting of 20 June 2016 Matters Arising & Action Tracker
	STRATEGY
	GP Contract Update and Cluster Approach Integrated Care Fund Update Prescribing Efficiencies Performance Management Framework
	GOVERNANCE
	Health & Social Care Public Governance Arrangements
	FINANCE
	Monitoring of the Integration Joint Budget 2016/17 Chief Financial Officer Update
	FOR INFORMATION
	Chief Officer's Report Delayed Discharges
Date of Meeting	Title of Business Discussed
31 August 2016 Extra Ordinary Meeting	Minutes of Previous Meeting of 20 June 2016, 15 August 2016
	STRATEGY
	Integrated Care Fund Update
	FINANCE
	Monitoring of the Integration Joint Budget 2016/17
Date of Meeting	Title of Business Discussed
17 October 2016	Minutes of Previous Meeting of 31 August 2016 Matters Arising & Action Tracker
	CLINICAL & CARE GOVERNANCE
	Clinical & Care Governance – Integrated Joint Board Reporting Scottish Borders Professional Assurance Framework: Health & Social Work Professionals Inspections Update Chief Social Work Officer Annual Report 2015/16
	GOVERNANCE
	Staff Governance Arrangements Health & Social Care Integration Joint Board Business Cycle 2017
	FINANCE
	Monitoring of the Integration Joint Budget 2016/17 Delivery of Efficiencies and Savings Plans Direction of Social Care Funding Prescribing Efficiencies – Past, Present & Future Health & Social Care Integration Joint Board 2015/16 Final Audited Statement of Accounts
	FOR INFORMATION
	Chief Officer's Report

	Committee Minutes Integrated Winter Plan 2016/17
Date of Meeting	Title of Business Discussed
21 November 2016 Extra Ordinary Meeting	Minutes of Previous Meeting of 17 October 2016 Matters Arising & Action Tracker
	FINANCE
	Efficiency Savings and Recovery Action Plans
Date of Meeting	Title of Business Discussed
19 December 2016	Minutes of Previous Meeting of 21 November 2016 Matters Arising & Action Tracker
	STRATEGY
	Integrated Care Fund Update Annual Performance Reporting Requirements
	CLINICAL & CARE GOVERNANCE
	Inspections Update
	GOVERNANCE
	Code of Conduct Staff Governance Arrangements
	FINANCE
	Recovery Plan Monitoring of the Integration Joint Budget 2016/17 Further Direction of Social Care Funding – Borders Ability Equipment Service
	FOR INFORMATION
	Chief Officer's Update Joint Winter Plan 2016/17
Date of Meeting	Title of Business Discussed
30 January 2017 Extra Ordinary Meeting	2016/17 Integrated Budget Monitoring Position – Recovery Plan
Date of Meeting	Title of Business Discussed
27 February 2017	Minutes of Previous Meetings of 19 December 2016, 30 January 2017 Matters Arising & Action Tracker
	STRATEGY
	Partnership Performance Reporting Transformational Programme Updated arrangements for managing the Integrated Care Fund Health & Social Care Delivery Plan Locality Planning Progress Report NHS Borders 2016/17 Festive Period Report
	CLINICAL & CARE GOVERNANCE
	Inspections Update
	FINANCE
	Monitoring of the Integration Joint Budget 2016/17 as at 31 December 2016 Health & Social Care – Medium Term Joint Financial Planning Strategy & Reserves Policy

	FOR INFORMATION
	Chief Officer's Report
Date of Meeting	Title of Business Discussed
27 March 2017	Minutes of Previous Meeting of 27 February 2017 Matters Arising & Action Tracker
	STRATEGY
	Transformational Programme Integrated Care Fund Update Annual Performance Report 2016/17 NHS Borders Local Delivery Plan 2017/18
	CLINICAL & CARE GOVERNANCE
	Inspections Update
	GOVERNANCE
	Review of Strategic Planning Group
	FINANCE
	Monitoring of the Integration Joint Budget 2016/17 Scottish Borders Health & Social Care Partnership Financial Plan 2017/18
	FOR INFORMATION
	Chief Officer's Report

Appendix 2

Health & Social Care Integration Joint Board
Attendance Record: 1 April 2016 to 31 March 2017

VOTING MEMBER	18.04.16	20.06.16	15.08.16	31.08.16 EO	17.10.16	21.11.16 EO	19.12.16	30.01.17 EO	27.02.17	27.03.17
Cllr C Bhatia	P	P	A	P	P	P	P	P	P	A
Cllr J Mitchell	P	P	P	P	P	P	A	P	A	P
Cllr F Renton	P	P	P	P	P	P	P	P	P	A
Cllr J Torrance To 15.08.16	A	P	A	-	-	-	-	-	-	-
Cllr G Garvie From 31.08.16	-	-	-	A	P	A	P	P	P	P
Cllr I Gillespie 07.03.16 to 15.08.16	P	P	A	-	-	-	-	-	-	-
Cllr S Aitchison From 31.08.16	-	-	-	P	P	P	P	P	P	P
Mr J Raine	P	P	P	P	D – D Steele	A	P	A	P	P
Mrs P Alexander	P	P	P	A	P	A	A	P	P	P
Mr D Davidson	P	P	P	P	P	P	P	P	P	P
Dr S Mather	P	P	P	A	A	P	P	P	P	P
Mrs K Hamilton	P	P	P	P	P	P	P	P	P	P
NON VOTING MEMBER	**18.04.16**	**20.06.16**	**15.08.16**	**31.08.16 EO**	**17.10.16**	**21.11.16 EO**	**19.12.16**	**30.01.17 EO**	**27.02.17**	**27.03.17**
Mrs S Manion To 01.12.16	P	P	P	P	P	A	-	-	-	-
Mrs E Torrance	P	A	P	P	P	P	P	P	P	P
Dr A Murray To 13.02.17	A	A	P	P	P	D – C Sharp	P	A	-	-
Dr C Sharp From 14.02.17	-	-	-	-	-	-	-	-	A	A
Mrs E Rodger To 31.03.17	P	P	P	P	P	P	P	A	A	P
Mr M Leys From 19.12.16	-	-	-	-	-	-	P	P	P	P
Mr D Bell	P	P	P	P	P	P	P	P	P	P
Mr J McLaren	P	D – I Clark	A	P	P	A	P	P	P	D – T Ball
Ms L Gallacher	P	D –	P	A	P	P	P	D	A	P

		L Jackson						L Jackson		
Mrs J Smith (nee Miller)	P	P	P	A	A	P	P	A	P	P
Mrs A Trueman	D – A Leitch	P	P	P	P	P	P	P	P	P
Dr A McVean	P	P	P	A	P	A	P	P	P	P
ATTENDEES	**18.04.16**	**20.06.16**	**15.08.16**	**31.08.16 EO**	**17.10.16**	**21.11.16 EO**	**19.12.16**	**30.01.17 EO**	**27.02.17**	**27.03.17**
Miss I Bishop	P	P	P	P	P	P	P	P	P	P
Mr P McMenamin	P	P	P	P	P	P	A	P	P	P
Mrs J Stacey	P	P	P	A	P	P	P	P	P	P
Mrs J Davidson	P	A	P	A	A	P	P	P	P	P
Mrs T Logan	P	A	A	A	A	P	P	P	P	P

P = Present, A = Absent, D = Deputy attended

Appendix 3 – Annual Performance Report 2016/17

To be approved at the Scottish Borders Health & Social Care Integration Joint Board meeting on 26 June 2017 and then appended to this report.

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Scottish Borders
Health and Social Care
PARTNERSHIP

ANNUAL PERFORMANCE REPORT 2016/17 UPDATE JUNE 2017

Aim

1.1 To update the Integration Joint Board (IJB) on progress of the development of the Partnership's Annual Performance Report.

Background

2.1 It is a requirement for every Health and Social Care Partnership to publish an Annual Performance Report for 2016/17. The required contents are set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 and must include reports on the following:

- Assessment of performance in relation to the 9 National Health and Wellbeing Outcomes;
- Financial performance and best value;
- Performance monitoring;
- Reporting on localities;
- Inspection of services;
- Review of strategic commissioning plan (if applicable).

Summary

3.1 Following extensive engagement with Senior Managers across the Partnership a final draft Annual Performance Report has been produced (see **Appendix 1**). The report includes all of the legally required elements as laid out in the guidance and has been amended to reflect all comments received from key stakeholders.

3.2 The report requires to be published by 31 July 2017 and requires IJB approval prior to publication. Following IJB approval the Annual Performance Report will be published electronically on Partnership websites and hard copies of the summary report (see **Appendix 2**) will be disseminated widely within local communities.

3.3 Work is currently underway to develop a two page summary of the report and it is expected that following publication of the full report on Partnership websites hard copies of the two page summary of the report will be distributed widely within local communities. The draft summary report can be seen in Appendix 2.

Recommendation

The Health & Social Care Integration Joint Board is asked to:-

- **approve** the Annual Performance Report;

- **endorse** proposals for publication of the report.

Policy/Strategy Implications	This report gives an update on progress of the delivery of the Partnerships strategic objectives as laid out in the Strategic Plan.
Consultation	The document has been developed with colleagues from across the partnership and third sector.
Risk Assessment	There is a risk of delay and not meeting the statutory publication date if the approval dates for the final versions of the document are not met.
Compliance with requirements on Equality and Diversity	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.
Resource/Staffing Implications	This will be covered in the final report.

Approved by

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Chief Officer for Integration		

Author(s)

Name	**Designation**	**Name**	**Designation**
Jane Robertson	Strategic Planning and Development Manager	Clare Richards	Project Manager

Scottish Borders **Health & Social Care** Partnership

Annual Performance Report 2016-17

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

Scottish Borders
Health and Social Care
PARTNERSHIP

CONTENTS

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

INTRODUCTION

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

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

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

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

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

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

EXECUTIVE SUMMARY

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

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

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

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

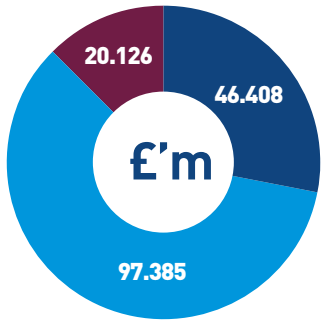
A statement is also provided of the financial performance of the Partnership and its performance against the National "Core Suite" of Integration Indicators identified by the Scottish Government.

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

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

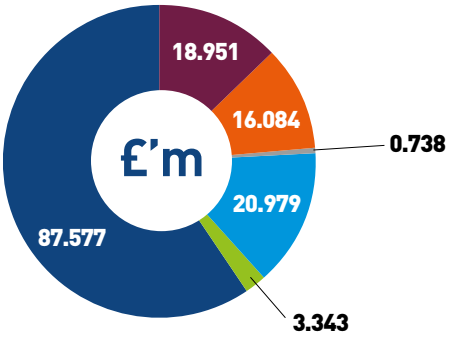
THE YEAR AT A GLANCE 2016/17

SPLIT OF BUDGET



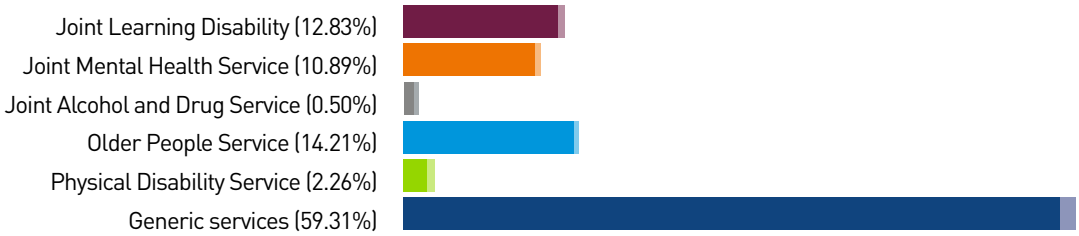
- Social Care Delegated Functions (28.31%)
- Healthcare Delegated Functions (59.41%)
- Healthcare Functions Set-Aside (12.28%)

SPEND BY EACH SERVICE AREA OVERSEEN BY THE INTEGRATED JOINT BOARD



- Joint Learning Disability (12.83%)
- Joint Mental Health Service (10.89%)
- Joint Alcohol and Drug Service (0.50%)
- Older People Service (14.21%)
- Physical Disability Service (2.26%)
- Generic services (59.31%)

DELEGATED FUNCTIONS TOTAL

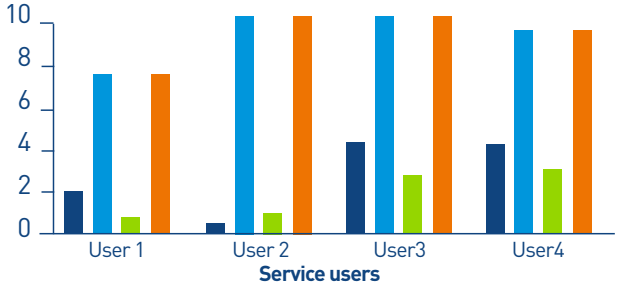


LOCALITY PLANNING

5
Summary Locality Plans created

5
Locality Working Groups in operation

TRANSFORMING CARE AFTER TREATMENT (TCAT)



- Before Performance
- After Performance
- Before Satisfaction
- After Satisfaction

Evaluation covers self care, productivity and leisure

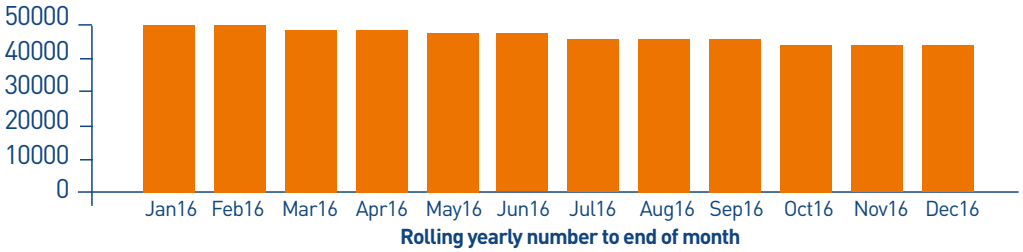
BORDERS COMMUNITY CAPACITY BUILDING

40+
activity sessions now running in local communities

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

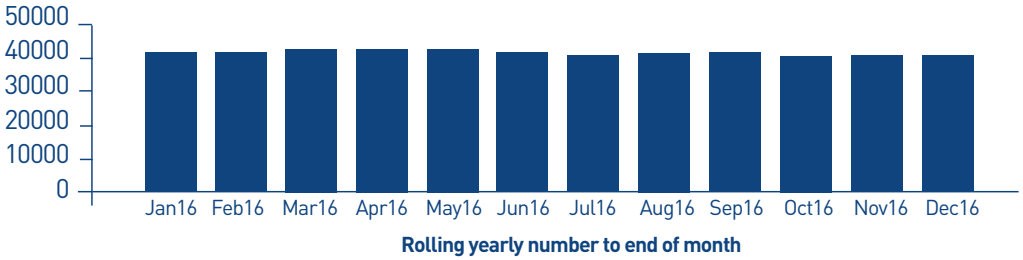
85%
of participants felt that the gentle exercise class had improved their fitness

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



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

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



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

823 PEOPLE WERE DELAYED FROM BEING DISCHARGED FROM HOSPITAL

7.8% OF ASSOCIATED OCCUPIED BED DAYS

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

WHERE WE PERFORMED WELL

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

90%
of adults supported at home feel safe

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

ONE OF OUR KEY CHALLENGES

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

PERFORMANCE AGAINST KEY PRIORITIES FOR 2016/17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• **To improve support for Carers within our communities** –

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

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

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

KEY PARTNERSHIP DECISIONS 2016/17

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

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

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

In relation to performance and resources, the IJB has:

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

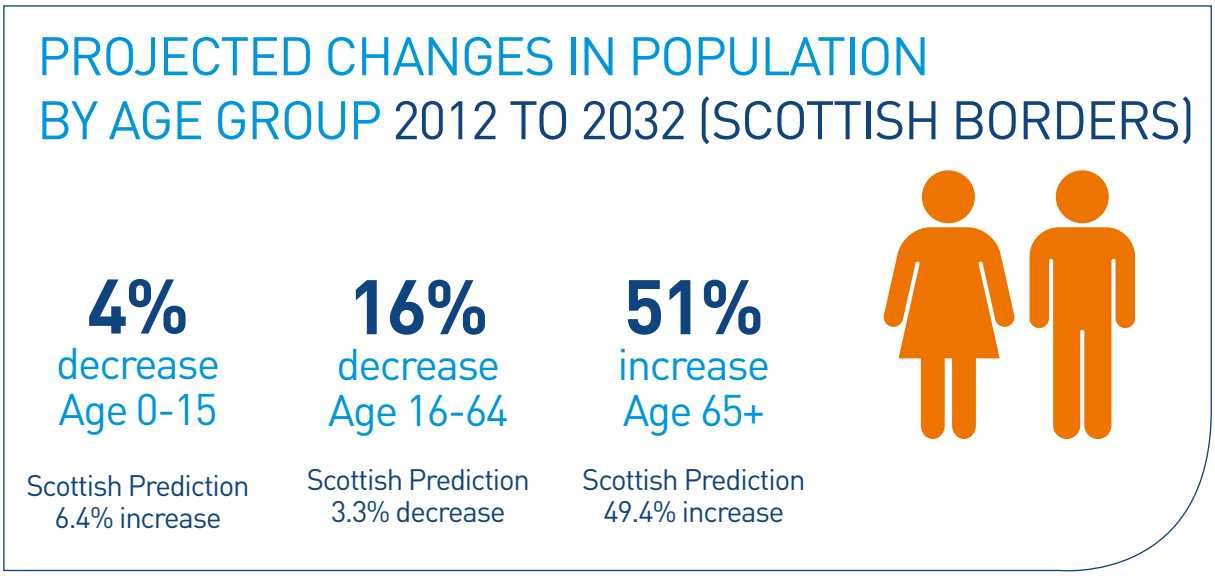
SPOTLIGHT: LOCALITIES PLANNING

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

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

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

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



Source: National Records of Scotland 2012-based population projections

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

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

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

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

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

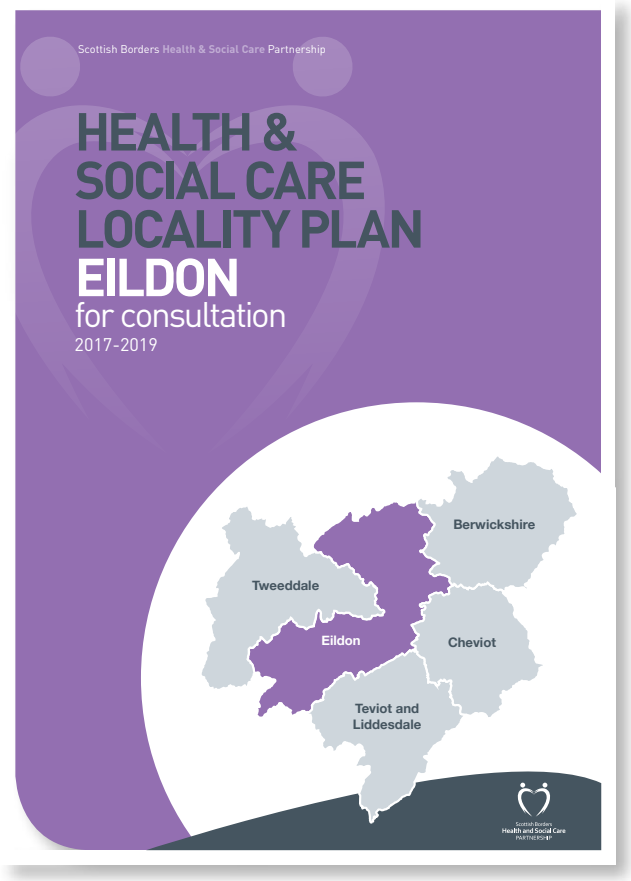
Priorities across the localities are broadly similar and can be grouped into the following categories:

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

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

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

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



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

SPOTLIGHT: COMMUNITY-LED SUPPORT

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

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

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

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

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

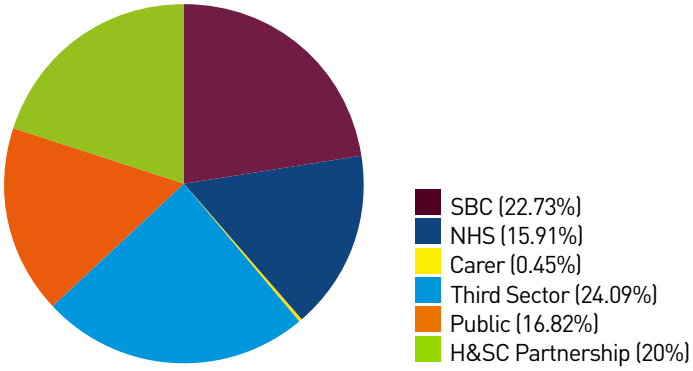
Progress

COMMUNITY LED SUPPORT

12
Community Led Support engagement sessions held across the Borders

233
People attended the engagement sessions

BREAKDOWN OF ATTENDEES AT ENGAGEMENT SESSIONS



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

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

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

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

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

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

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

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

SPOTLIGHT: BUURTZORG – NEIGHBOURHOOD CARE

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

Progress

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

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

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

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

Next Steps

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

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

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

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

GOVERNANCE AND ACCOUNTABILITY

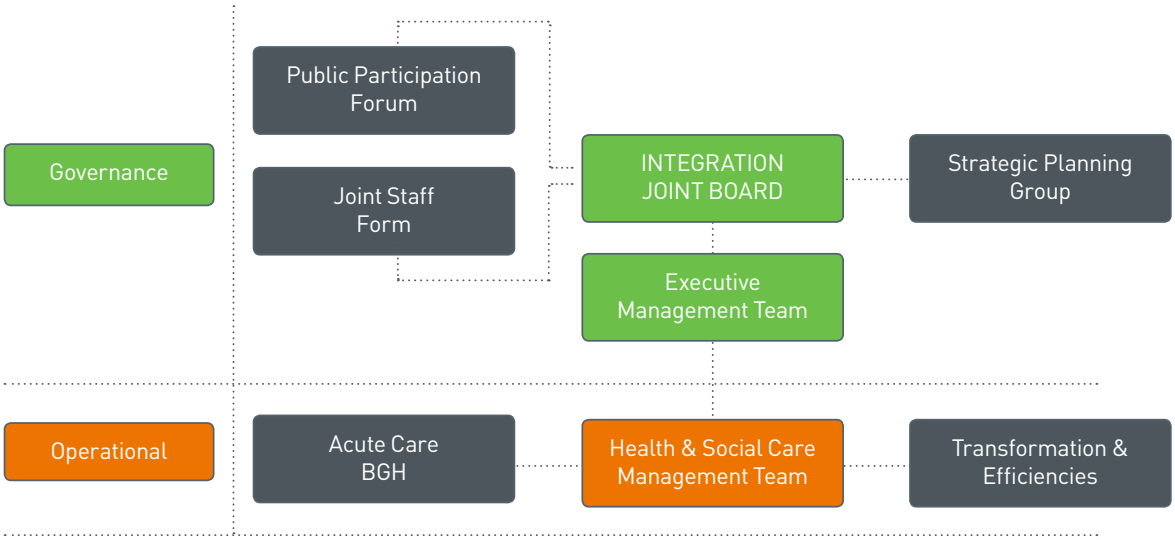
During 2016/17 the governance structure for the Partnership has been revised in order to streamline the process and clarify the decision making roles within the structure. The revised governance structure consists of two layers:

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

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

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

H&SC Partnership Revised Governance Structure



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

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

At the start, mid-point and end of the financial year, the Integration Joint Board and its partners undertook a full review and evaluation of its degree of compliance with legislation and recommended best practice (Integrated resources advisory group) in relation to the Partnership's financial governance, planning, management and reporting arrangements. A number of positive outcomes have been reported following these processes and clear forward planning is in place to provide full assurance to the Partnership going forward.

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

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

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

PROGRESS AGAINST OUR LOCAL STRATEGIC OBJECTIVES

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

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

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

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

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

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

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

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

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

OBJECTIVE 1

We will make services more accessible and develop our communities

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

Key achievements during 2016/2017:

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

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

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

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

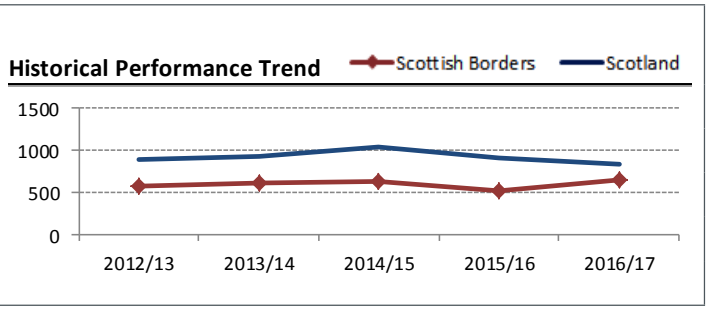
Performance - National "Core Suite" Indicators

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

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

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

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



Source: ISD Scotland Delayed Discharge Census.

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

Performance – Specific programmes

BURNFOOT COMMUNITY FUTURES

22 volunteers engaged

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

134 local residents have become members of Burnfoot Community Futures

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

PROJECT SEARCH

CASE STUDY

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

Partnership Priorities for 2017/18

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

OBJECTIVE 2

We will improve prevention and early intervention

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

Key achievements during 2016/2017:

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

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

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

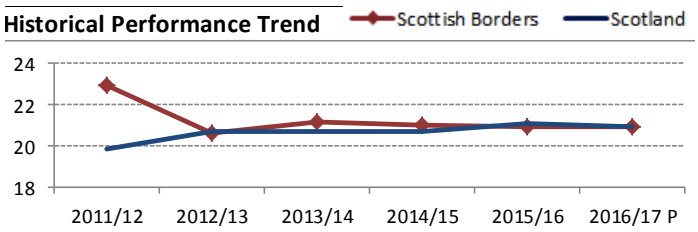
Key Challenges faced by the Partnership when delivering this objective are:

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

Performance - National "Core Suite" Indicators

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

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

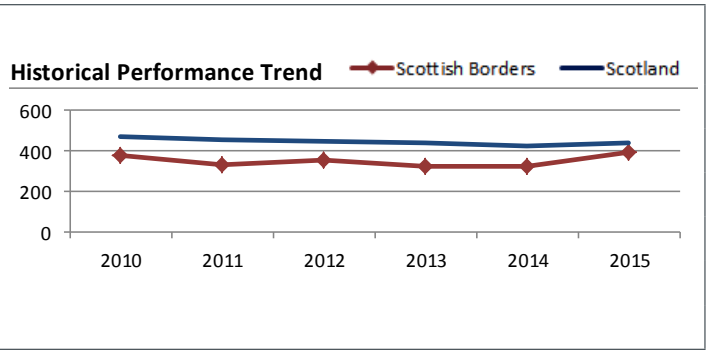


Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

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

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

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



Source: National Records for Scotland (NRS).

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

Performance – Specific programmes

DEMENTIA

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

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

INPATIENT FALLS PREVENTION

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

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

HEALTH IMPROVEMENT LONG TERM CONDITIONS PROJECT

21%▲ Improvement in wellbeing recorded for service users.

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

TRANSFORMING CARE AFTER TREATMENT (TCAT)

CASE STUDY

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

LONG TERM CONDITIONS PROJECT

CASE STUDY

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

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

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

Partnership Priorities for 2017/18

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

OBJECTIVE 3

We will reduce avoidable admissions to hospital

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

Key achievements during 2016/2017:

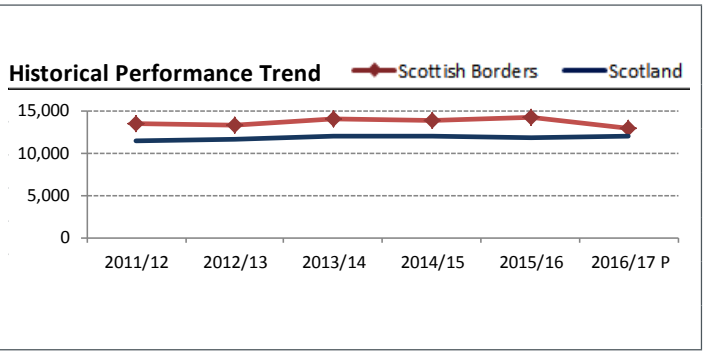
- A review of community and day hospitals is planned following an initial data gathering and analysis exercise commissioned from Professor John Bolton. This work will help to define the future role of community and day hospitals within the overall patient pathway and will identify the appropriate model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

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

Performance - National "Core Suite" Indicators

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

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

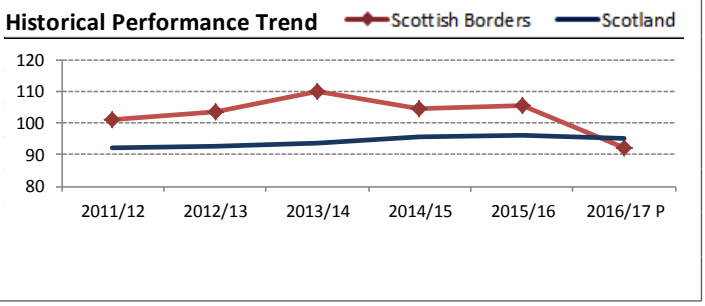


Source: ISD Scotland. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

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

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

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



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

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

Performance – Specific programmes

TEVIOT MEDICAL PRACTICE SCOTTISH AMBULANCE SERVICE PARAMEDIC PRACTIONER COLLABORATIVE TRIAL

187 domiciliary visits were undertaken

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

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

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

STRESS AND DISTRESS TRAINING

148 people completed bite size Stress and Distress Training

117 people completed the 2 day Stress and Distress training

DELAYED DISCHARGES

People were delayed from being discharged from hospital

635 delayed discharges in 2015/16

823 delayed discharges in 2016/17

&

The % of associated occupied bed days

5.5% in 2015/16

7.8% in 2016/17

Partnership Priorities for 2017/18:

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

OBJECTIVE 4

We will provide care close to home

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

Key achievements during 2016/2017:

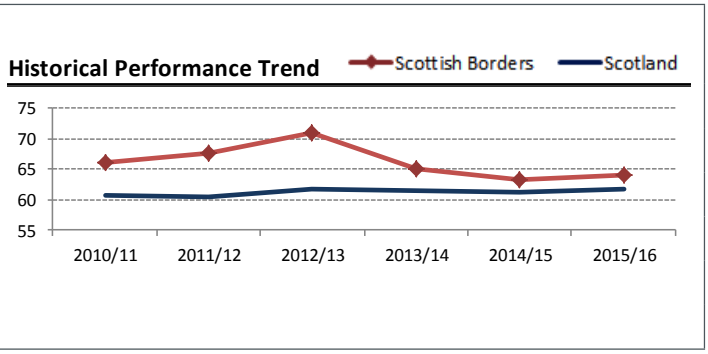
- Improvements planned and underway at local health centre sites across the Borders will improve access to a range of services provided from these.
- A pilot of the Buurtzorg nursing approach via integrated nursing and social work teams is in development. (See Spotlight section for more details)
- The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

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

Performance - National "Core Suite" Indicators

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

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

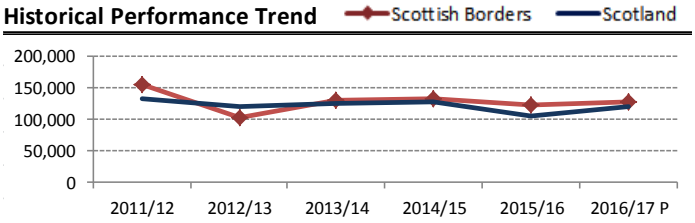


Source: Scottish Government Health and Social Care Statistics.

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

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

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

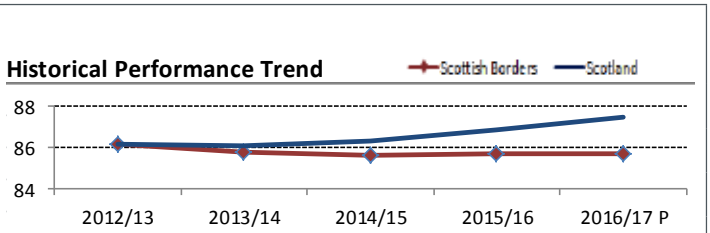


Source: ISD Scotland. Note, figures for 2016/17 are provisional, as some hospital data are incomplete for the later part of the year.

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

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

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



Source: ISD Scotland.

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

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

Source: ISD Scotland.

Performance – Qualitative data

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

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

LOW VISION AID CLINIC

CASE STUDY

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

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

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

Key Partnership Priorities for 2017/18

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

OBJECTIVE 5

We will deliver services within an integrated care model

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

Key achievements during 2016/2017:

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

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

- Delivering quality services with reducing resources.

Performance - National "Core Suite" Indicators

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

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

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

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

Key Priorities for the Partnership for 2017/18

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

OBJECTIVE 6

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

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

Key Achievements for 2016/17:

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

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

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

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

Performance - National "Core Suite" Indicators

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

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

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

Performance – Specific programmes

DEMENTIA

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

SELF DIRECTED SUPPORT

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

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

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

Key Priorities for the Partnership for 2017/18

- Improve shared management of Long Term Conditions in older people through extended application of the "House of Care" model, measured through the new outcome focused, Self-Evaluation Calendar.
- Increase the number of people accessing all self-directed support options by streamlining financial and other processes, removing barriers to change.
- More choice and control for the public through the development of a 'People Involvement Strategy'.
- Increased role for service users and stakeholders in service planning through the application of the Partnership Board approach, learning from Learning Disabilities and Mental Health developments.

OBJECTIVE 7

We will further optimise efficiency and effectiveness

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

Key Achievements for 2016/17:

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

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

Performance - National "Core Suite" Indicators

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

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

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

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

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

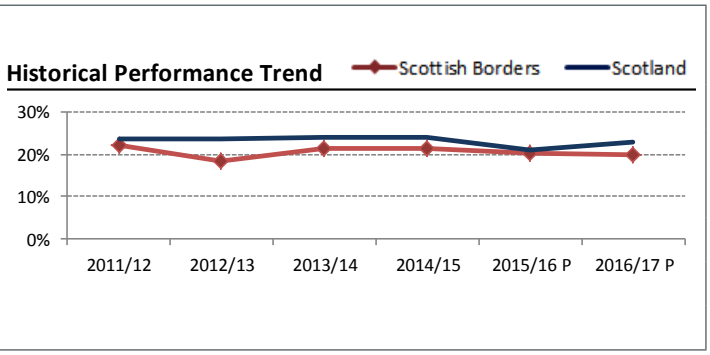
NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

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

Source: Care Inspectorate (indicator in development).

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

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



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

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

Performance – Specific programmes

MY HOME LIFE PROJECT

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

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

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

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

Data Jan 2016 - Dec 2017

"TWO MINUTES OF YOUR TIME" SURVEY

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

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

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

Data April 2016 - Feb 2017

Key Priorities for the Partnership for 2017/18

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

OBJECTIVE 8

We will seek to reduce health inequalities

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

Key Achievements for 2016/17:

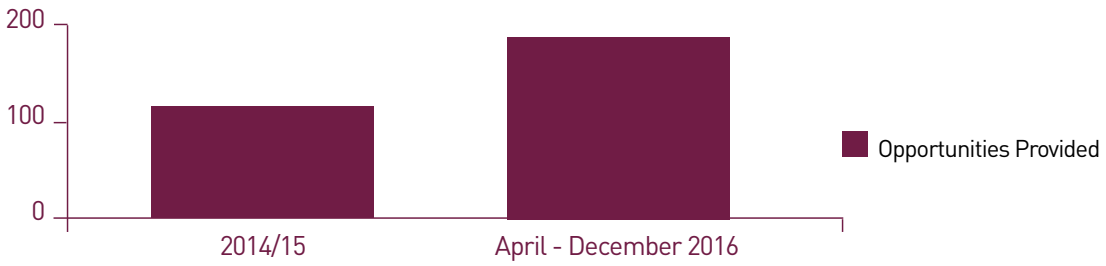
- The Public Dental Service will:
  - Continue to provide enhanced services to Special needs/ additional needs with core tooth brushing in all schools with special needs units;
  - Through more effective communication and interagency work increase the emphasis on ensuring improved access for patients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

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

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

Performance – Specific programmmes

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



SEE HEAR TRAINING

8 courses provided

88 people attended

98% rated the training as very good or good

Key Priorities for the Partnership for 2017/18

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

OBJECTIVE 9

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

Key Achievements for 2016/17:

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

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

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

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

Performance - National "Core Suite" Indicators

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

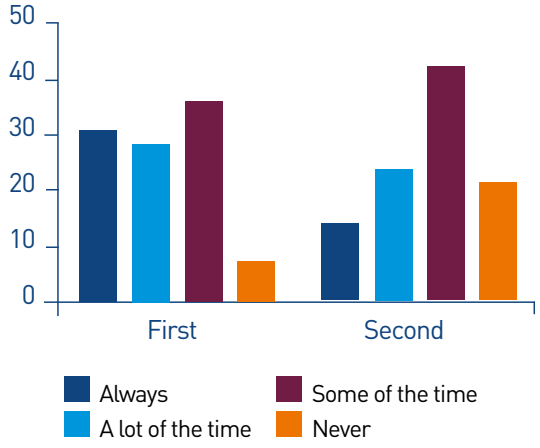
Source: Scottish Government Health and Care experience survey 2015/16.

Performance – Specific programmes

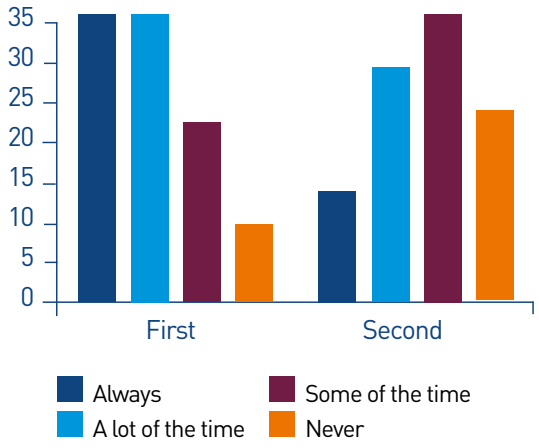
- 417 professionals have received Carers Awareness Training through Flying Start, induction training and talks and visits. This training is delivered in partnership with Carers.

CARERS

I feel stressed as a result of caring



I feel mentally exhausted as a result of caring



Data from 1 April - 30 September 2016

401 new Carers have been referred to the Carers Centre service

285 Carers have been referred to the hospital liaison worker

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

430 Carers attending Carer support groups

675 Carers have received on-going support and guidance

Data from April 2016 - March 2017

Key Priorities for the Partnership for 2017/18

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

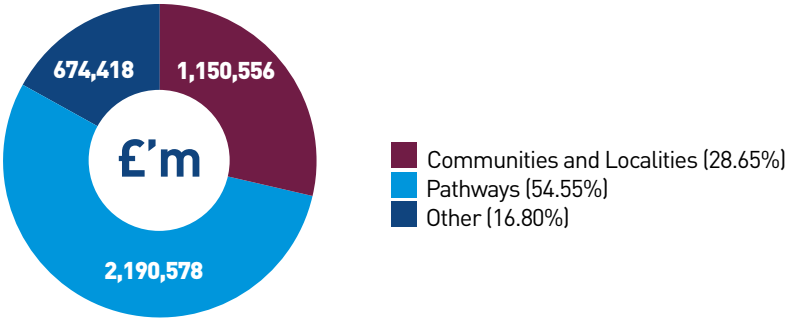
INTEGRATED CARE FUND

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

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

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

INTEGRATED CARE FUND EXPENDITURE BY KEY THEMES



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

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

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

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

INSPECTION OF SERVICES

Joint Inspection of Services for Older People in the Scottish Borders

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

A staff survey was also undertaken covering:

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

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

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

Older People in Acute Hospitals Inspection – April 2016

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

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

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

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

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

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Arrangements

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

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

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

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

These arrangements ensured all partners received sufficient assurance over:

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

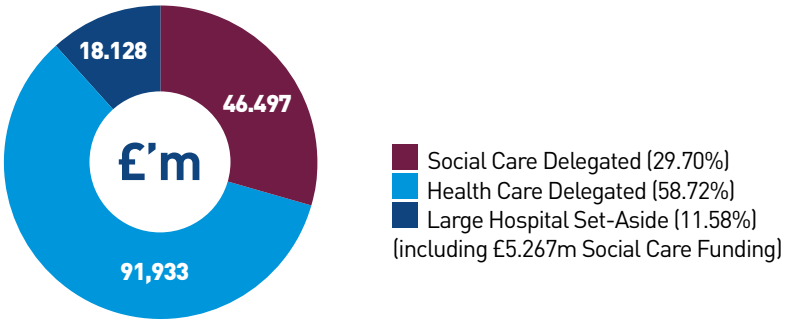
At the end of its first year the Partnership is well established in terms of financial governance, planning, management and statutory reporting evidenced by:

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

Financial Management

In 2016/17 £156.558m was available to the Partnership for direction to support the delivery of its strategic objectives. Of this, £138.430m (including £5.267m of Social Care Funding) was delegated directly to the Integration Joint Board, whilst £18.128m was retained by NHS Borders in respect of large hospitals and set-aside.

THE PARTNERSHIPS BUDGET 2016/17



The Partnership has experienced considerable financial pressure beyond the level of budget delegated to it during 2016/17. At the 31st March 2017 an adverse outturn variance on delegated functions of £3.879m is reported. This is in addition to an adverse variance of £4.481m on set-aside functions although for 2016/17 this will be accounted for within NHS Borders as per the Scottish Government advice. In respect of both delegated and set-aside variances both partners made an additional payment to the Integration Joint Board in order to supplement available resources to the required level. These resources are primarily as a result of the in year recovery actions delivered.

REPORTED VARIANCE AT 31 MARCH 2017

£4.481m
large hospital budget set-aside

£3.879m
Delegated budget

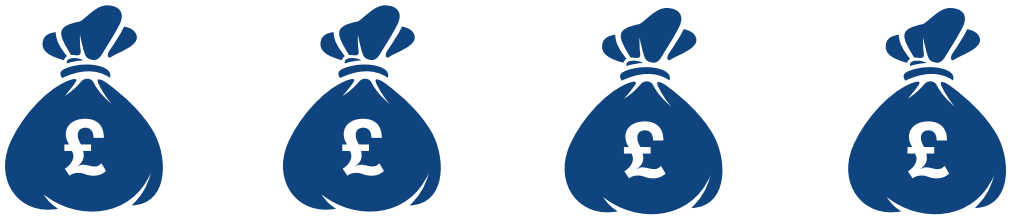
These pressures were primarily experienced across healthcare functions. Social care functions also experienced pressure during the year arising from factors such as increased demand from services, increased cost as a result of market pressures and the introduction of a living wage of £8.25 for all social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

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

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

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

FINANCIAL PRESSURES FACED BY NHS BORDERS ACROSS THE LARGE HOSPITAL BUDGET



£1.2m
surge beds

£900k
patient flow

£500k
acute admissions and emergency department staffing

£2.4m
non delivery of planned efficiencies

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

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

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

PERFORMANCE MONITORING FRAMEWORK: SUMMARY

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

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

- Within the Partnership we are also reporting on a series of measures identified locally as priorities to be monitored to help manage and improve services. This series of measures will develop further over time. More information on performance against locally set measures is available at INSERT LINK TO JUNE 2017 INTEGRATION JOINT BOARD QUARTERLY PERFORMANCE REPORT ONCE IT HAS BEEN PRODUCED, AND ENSURE THAT IT IS PUBLISHED ALONGSIDE THIS ANNUAL PERFORMANCE REPORT FOR COMPLETENESS.

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

DELIVERY OF KEY PRIORITIES FOR 2017/18

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

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

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

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

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

APPENDIX A
FINANCIAL PERFORMANCE AND BEST VALUE

I) FINANCIAL PERFORMANCE

Legislative and Governance Framework

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

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

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

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

These provisions specifically include:

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

Statutory Reporting Requirements

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

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

For 2016/17, the first full year of operation of the Integration Joint Board following its establishment, draft unaudited accounts will be prepared by 30th June 2017 and submitted to the Integration Joint Board for approval on 28th August 2017. Final audited accounts will be submitted to the Integration Joint Board on 25th September 2017. Despite a challenging year the Integrated joint Board is likely to break even for 2016/17.

2016/17 - Resources Delegated to the Integration Joint Board

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

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

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

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

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

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

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

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

DELEGATED HEALTHCARE FUNCTIONS	BASE BUDGET £'000	REVISED BUDGET £'000	PROVISIONAL OUTTURN £'000	OUTTURN VARIANCE £'000
Joint Learning Disability Service	3,599	3,634	3,690	(56)
Joint Mental Health Service	14,015	14,190	14,173	17
Joint Alcohol and Drug Service	749	634	635	(1)
Older People Service	0	0	0	0
Physical Disability Service	0	0	0	0
Generic Services	73,570	78,927	82,727	(3,800)
	91,933	**97,385**	**101,225**	**(3,840)**

DELEGATED SOCIAL CARE FUNCTIONS	BASE BUDGET £'000	REVISED BUDGET £'000	PROVISIONAL OUTTURN £'000	OUTTURN VARIANCE £'000
Joint Learning Disability Service	14,671	15,448	15,261	187
Joint Mental Health Service	1,962	1,963	1,911	52
Joint Alcohol and Drug Service	199	169	103	66
Older People Service	22,843	20,635	20,979	(344)
Physical Disability Service	3,180	3,448	3,343	105
Generic Services	3,642	4,745	4,850	(105)
	46,497	**46,408**	**46,447**	**(39)**

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

SET ASIDE HEALTHCARE FUNCTIONS	BASE BUDGET £'000	REVISED BUDGET £'000	PROVISIONAL OUTTURN £'000	OUTTURN VARIANCE £'000
Accident & Emergency	1,806	2,043	2,043	0
Medicine & Long-Term Conditions	11,330	13,029	13,029	0
Medicine of the Elderly	6,080	6,142	6,142	0
Planned Savings	(1,088)	(1,088)	(1,088)	0
	18,128	**20,126**	**20,126**	**0**

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

These included or related to:

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

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

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

Recovery Planning and Delivery during the Financial Year

SIGNIFICANT PRESSURES

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

RECOVERY ACTION AREAS

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

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

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

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

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

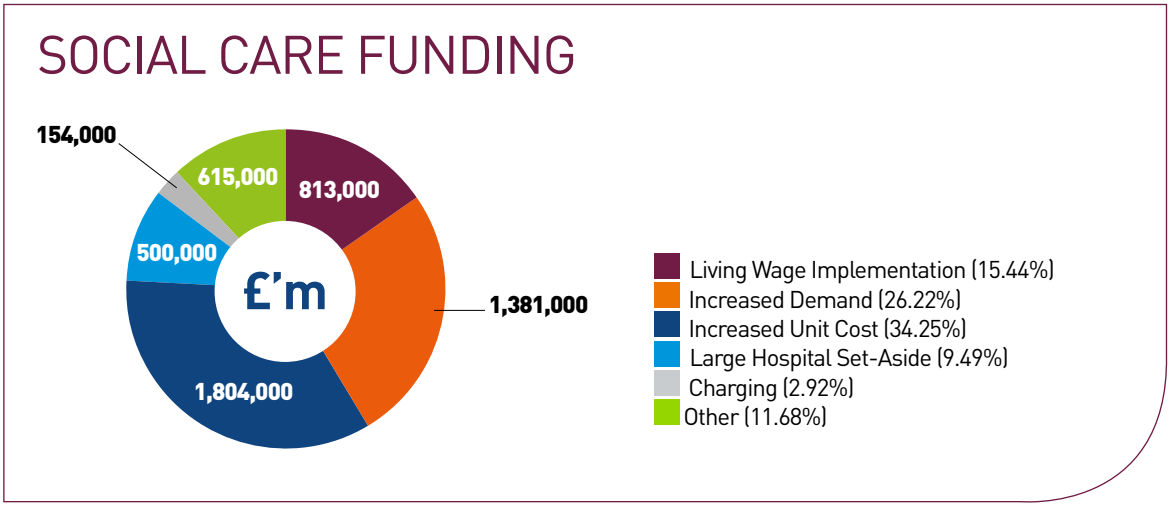
Establishing this impact and reviewing the Strategic Plan in light of prevalent financial pressures is now a key work package for the Partnership. Underpinning this will be the implementation of an integrated medium-term transformation programme for all health and social care aimed at improving performance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

Funding Priorities

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

Social Care Funding

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



Integrated Care Fund

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

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

INTEGRATED CARE FUND PROJECTS

Pathways

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

Communities and Localities

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

Other

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

ICF remaining resourse

£2.374m

II) BEST VALUE

Introduction

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

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

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

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

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

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

Leadership, Partnership Working and Inclusion

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

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

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

Transformation and Redesign

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

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

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

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

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

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

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

Use of Resources

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

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

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

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

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

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

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

Performance Management

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

Forward Planning

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

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

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

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

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

APPENDIX B
INSPECTION OF SERVICES

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

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

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

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

APPENDIX C
PERFORMANCE MANAGEMENT

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

NATIONAL INDICATOR NUMBER	INDICATOR DESCRIPTION	SCOTTISH BORDERS	SCOTLAND
NI - 1	Percentage of adults able to look after their health very well or quite well	95%	94%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	84%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	85%	79%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	75%	75%
NI - 5	Percentage of adults receiving any care or support who rated it as excellent or good	84%	81%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	90%	87%
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	87%	84%
NI - 8	Percentage of Carers who feel supported to continue in their caring role	41%	41%
NI - 9	Percentage of adults supported at home who agreed they felt safe	90%	84%

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

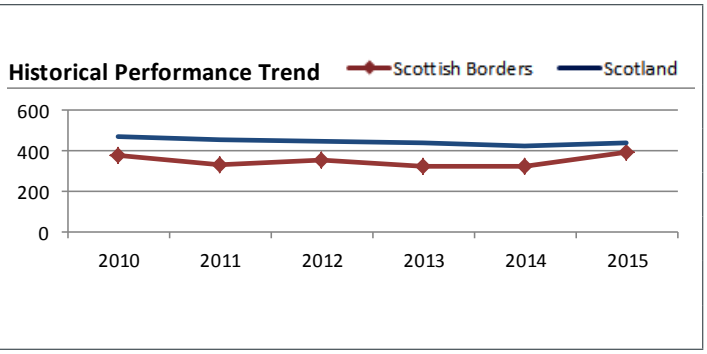
NATIONAL INDICATOR NUMBER	INDICATOR DESCRIPTION	SCOTTISH BORDERS	SCOTLAND
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	57% (NHS Borders only)	59%

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

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

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

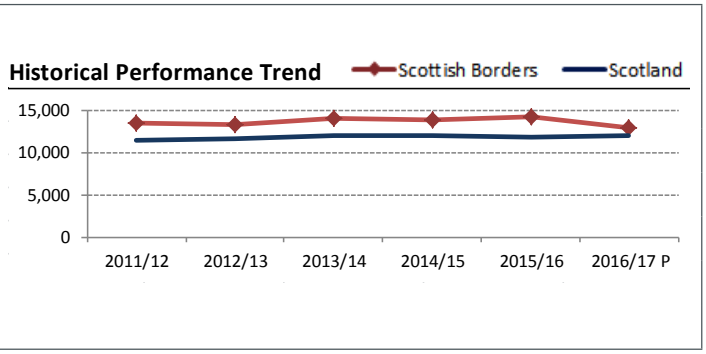
YEAR	SCOTTISH BORDERS	SCOTLAND
2010	374	467
2011	334	456
2012	356	445
2013	323	438
2014	322	423
2015	391	441



Source: National Records for Scotland (NRS).

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

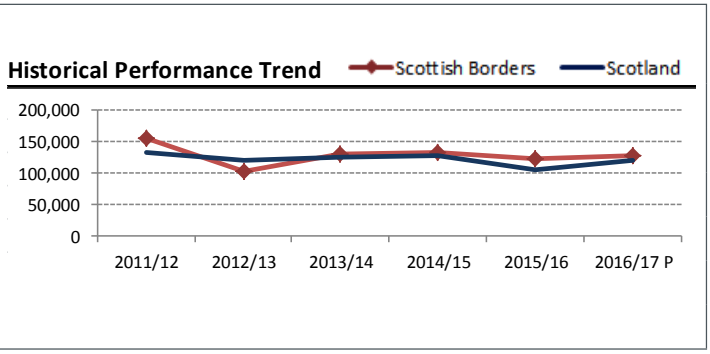
YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	13,560	11,570
2012/13	13,376	11,668
2013/14	14,184	11,989
2014/15	14,001	12,083
2015/16	14,719	12,138
2016/17 P	12,995	12,037



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

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

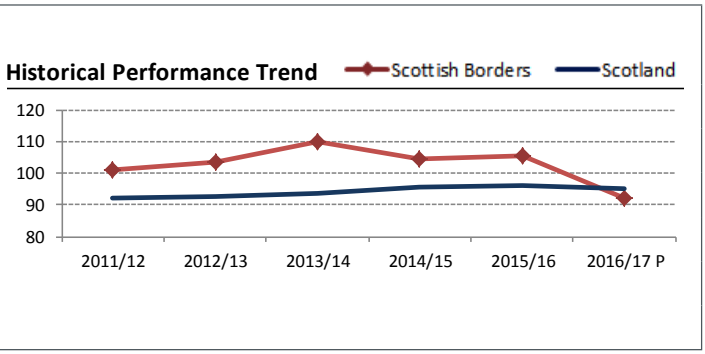
YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	156,604	132,560
2012/13	103,393	120,078
2013/14	129,586	125,789
2014/15	133,888	127,959
2015/16	135,078	122,713
2016/17 P	127,259	119,649



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

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

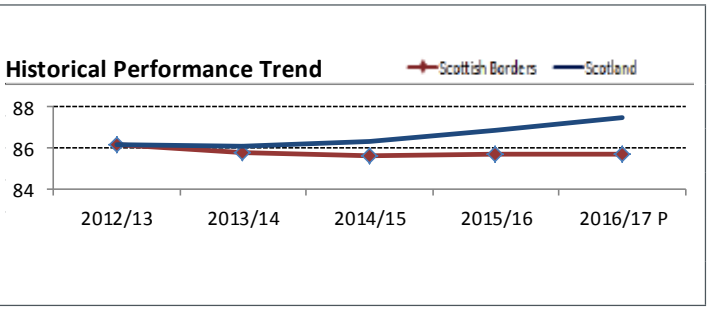
YEAR	SCOTTISH BORDERS	SCOTLAND
2011/12	101	92
2012/13	104	93
2013/14	110	94
2014/15	105	96
2015/16	106	96
2016/17 P	92	95



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

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

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

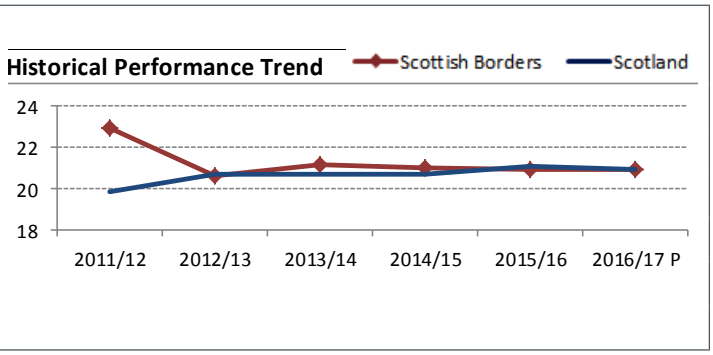


Source: ISD Scotland.

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

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

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



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

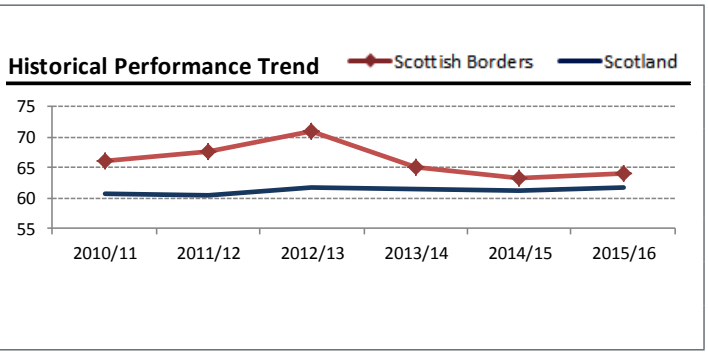
NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

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

Source: Care Inspectorate (indicator in development).

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

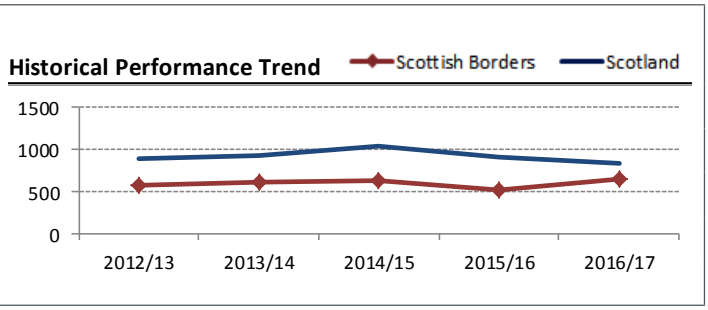
YEAR	SCOTTISH BORDERS	SCOTLAND
2010/11	66.0	60.6
2011/12	67.6	60.5
2012/13	70.8	61.8
2013/14	64.9	61.4
2014/15	63.3	61.3
2015/16	64.1	61.6



Source: Scottish Government Health and Social Care Statistics.

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

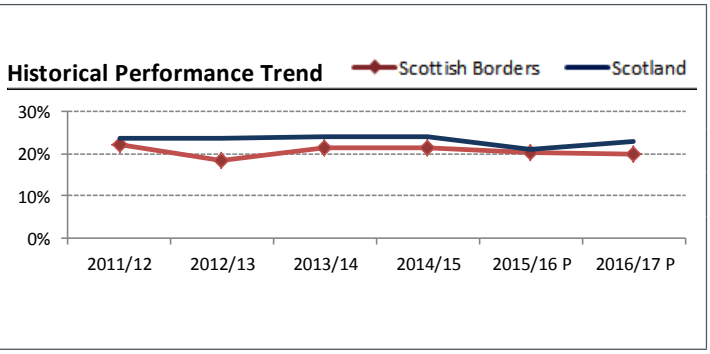
YEAR	SCOTTISH BORDERS	SCOTLAND
2012/13	575	886
2013/14	604	922
2014/15	628	1,044
2015/16	522	915
2016/17 P	647	842



Source: ISD Scotland Delayed Discharge Census.

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

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



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

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

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

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

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

NI-23 Expenditure on end of life care.

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

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

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

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

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Scottish Borders **Health & Social Care** Partnership

Annual Performance Report 2016-17

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

Scottish Borders
Health and Social Care
PARTNERSHIP

WHO WE ARE

Scottish Borders Health and Social care Partnership formed in April 2015, bringing together the full range of community health and care services in the Scottish Borders.

OUR VISION

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

OUR PERFORMANCE

The full Annual Performance Report details our achievements against our local strategic objectives.

The report shows that the Partnership has made positive progress in a number of key areas:

- 95% of adults able to look after their health very well or quite well
- 85% of adults supported at home agreed that they are supported to live as independently as possible agreed that they had a say in how their help, care, or support was provided
- 75% of adults supported at home agreed that their health and social care services seemed to be well co-ordinated
- 84% of adults receiving any care or support rated it as excellent or good
- 90% of people reported a positive experience of the care provided by their GP practice
- 87% of adults supported at home agree that their services and support had an impact on improving or maintaining their quality of life
- 41% of feel supported to continue in their caring role
- 90% of adults supported at home agreed they felt safe

OUR DECISION –MAKING

The Partnership is overseen by the Integration Joint Board. During 2016/17 the board have made the following key decisions:

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

A YEAR AT A GLANCE

OUR SUCCESSES

95%
of adults are able to look after their health and wellbeing

90%
of adults supported at home feel safe

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

OUR CHALLENGES

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

823
delayed discharges

&

7.8%
of associated occupied bed days

SPEND BY DELEGATED FUNCTION

LOCALITY PLANNING

5
summary locality plans created

5
locality working groups in operation

BEST VALUE AND INSPECTION

The Partnership has worked to embed the key themes of best value in how it plans and delivers models of health and social care across the Scottish Borders with specific focus on its leadership, strategic and financial governance, joint working, inclusion and co-production/consultation and the sound management of resources.
A joint inspection of the Health and Social Care Partnership's older people's services was undertaken by the Care Inspectorate and Healthcare Improvement Scotland between during 2016/17. The findings of the inspection will be published in the Summer 2017. An Older People in Acute Hospital Inspection took place in April 2016. The recommendations and subsequent actions can be seen in the full performance report.

FINANCIAL PERFORMANCE

During 2016/17, the partnership spent over £178m commissioning health and social care services and implementing new models of care in order to deliver its Strategic Plan priorities. This includes £148m of resources for delegated functions, over £20m of hospital budget set-aside, over £5m of social care funding and around £1m Integrated Care funding. Increasing demand and costs remains a major challenge for the partnership.

LOCALITY ARRANGEMENTS

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

FURTHER INFORMATION

The full Annual Performance report is available at **www.scotborders.gov.uk**

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NHS Borders

Scottish Borders Health and Social Care PARTNERSHIP

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Scottish Borders
Health and Social Care
PARTNERSHIP

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP FINANCIAL STATEMENT 2017/18 to 2019/20

Aim

1.1 This report aims to set out the 3 Year Financial Statement of the Scottish Borders Health and Social Care Partnership 2017/18 to 2019/20. This further develops the Financial Plan 2017/18 report approved by the Integration Joint Board (IJB) on 27 March 2017.

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the framework for the integration of health and social care in Scotland. This legislation requires that the Integration Joint Board produces a Strategic Plan which sets out the services for the population over the medium-term. It also stipulates that the Strategic Plan incorporates a medium-term Financial Plan (3-years) for the resources within its scope comprising of:

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

2.2 The report to the IJB in March set out:

- The amount of budget to the Integration Joint Board that partners proposed to delegate for financial year 2017/18 and the flat-cash large hospital budget set-aside
- The affordability gap within these budgets, primarily across healthcare functions, and the remaining efficiency and savings target that requires delivery
- Key financial risks inherent across health and social care functions/budgets
- The remaining work required to produce a 3-year Financial Statement for the IJB

2.3 The report also outlined the basis and amount of additional funding for social care allocated to the partnership by the Scottish Government in 2017/18 (£2.280m)

2017/18 Summary of Position

3.1 The previous report to the IJB in March only presented a budget for 2017/18 as future years' assumptions, indicative pressures and required savings were not yet defined or known at that time.

3.2 For 2017/18, the provisional budget of the partnership is:

	2017/18 Provision £m
Healthcare Functions - Delegated	94,490
Social Care Functions - Delegated	45,667
Social Care Funding 16/17 Allocation	5,267
Social Care Funding 17/18 Allocation	2,280
Healthcare Functions - Set-Aside	18,978
	166,682

This includes both the recurring allocation for social care from 2016/17 of £5.267m and an additional amount of £2.280m for 2017/18.

3-Year Financial Statement 2017/18 to 2019/20

4.1 A copy of the partnership's 3-year financial statement is detailed in **Appendix 1**.

4.2 Whilst it is a 3-year plan, years 2 and 3 remain indicative. Additionally, budgets may change in line with revised funding settlements and in particular, further guidance is expected imminently with regard to how partnerships should calculate the set-aside budget.

4.3 What is also clear is that there is a substantial shortfall in resources against projected pressures across the 3-year life of this financial plan, given the ongoing expected restrictions on funding settlements to partners and in particular what this means in terms of the level of resources delegated to the IJB. Funding by the Scottish Government is increasingly accompanied by conditions over its use in full or part which when coupled to the significant number and level of pressures projected to emerge over this same timeframe, poses a significant challenge for the IJB and its partner organisations.

4.4 **£6.105m** of savings require delivery in 2017/18 in order that an operational Delegated and Set-Aside Budgets remain equivalent in cash terms to 2016/17:

	2017/18 £'000	2018/19 £'000	2019/20 £'000
Scottish Borders Council Funding Delegated	(1,133)	(556)	(656)
NHS Borders Funding Delegated	(3,781)	(2,397)	(2,470)
NHS Borders Large Hospital Budget Set-Aside	(1,191)	(2,048)	(3,519)
	(6,105)	**(5,001)**	**(6,645)**

A further **£5.001m** and **£6.645m** require delivery in 2018/19 and 2019/20 respectively.

4.5 Beyond the pressures already factored into the provision of resources above, a further **£2.592m** of pressures is projected across healthcare functions within the delegated budget in 2017/18, for which no mitigating savings have yet been

identified. Similarly, there is **£1.858m** of as-yet unmet projected pressures within the large hospital set-aside budget.

4.6 In order to be affordable overall, the IJB is required to direct the planning and delivery of further savings across delegated functions. It is intended that primarily this will be through the implementation of an Integrated Transformation Programme which is currently in development. To be successful and ensure the delegated budget achieves overall affordability, this programme will require cashable efficiencies and savings of **£2.592m** to be delivered during 2017/18 and similar to the extent of the savings plans already identified by NHS Borders, is not an insubstantial challenge.

Risks

5.1 A range of financial risks were identified and reported to the IJB in March associated with the approval of the 2017/18 delegated budget. Together with wider risk relating to the term of the proposed 3-year Financial Statement, these risks can be summarised as:-

Affordability	Delivery
Historic Pressures not permanently resolved	Level of Identified Savings requiring Delivery
Affordability Gap - Level of Unidentified Savings	Ownership over Planned Savings e.g. Gen. Efficiency
Likelihood of further Emerging Pressures	Embryonic Integrated Transformation Programme
High-Risk Budget Areas e.g. Prescribing	Limited Seedcorn Funding to enable Transformation
NHS Winter Plan activity levels remain	

Uncertainty	Impact
Revised Current / Unknown Future Funding Levels	Impact on Strategic Plan unidentified as-yet
Working Time Directive re: Night Support	Value for Money assessment requires development
Impact of Future Legislative Changes e.g. Carers Act	Shift of Resources along Care Pathways challenging
New IJB following Local Government Election 2017	
Provider Market remains volatile and uncertain	

Recommendation

The Health & Social Care Integration Joint Board is asked to **approve** the report and the Health and Social Care Financial Statement 2017/18 to 2019/20.

Policy/Strategy Implications	The financial statement 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.
Consultation	The report has been reviewed by senior officers within the Health and Social Care Partnership, Health Board and Local Authority/.
Risk Assessment	Risks are extensively detailed within the report. Risk facing the partnership are both substantial and numerous at the current

	time and the Executive Management Team is working to mitigate these through robust governance, planning, management and reporting of the required actions to delivering an affordable medium-term financial plan.
Compliance with requirements on Equality and Diversity	There are no equalities impacts arising from the report.
Resource/Staffing Implications	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 the period of the Financial Statement will be reported to the Integration Joint Board and a full revision of the financial planning cycle will occur later in 2017.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer Health & Social Care		

Author(s)

Name	Designation	Name	Designation
Paul McMenamin	Chief Financial Officer		

Appendix 1

ANNUAL FINANCIAL STATEMENT
2017/18
(2017/18 - 2019/20 Indicative)

	2017/18 £'000	2018/19 indicative £'000	2019/20 indicative £'000
Budgets Delegated:			
Scottish Borders Council Funding Delegated	45,667	45,783	45,685
NHS Borders Funding Delegated :			
- Primary & Community Services	94,490	94,490	94,490
- Large Hospital Budget	18,978	18,978	18,978
- Social Care Fund 16/17 Allocation	5,267	5,267	5,267
- Social Care Fund 17/18 Additional Allocation	2,280	2,280	2,280
Total Delegated Funding	**166,682**	**166,798**	**166,700**
Expenditure Plans per 2016/17 Financial Plans:			
Social Care			
Expenditure Plans:			
Adults with Learning Disabilities	15,561	15,833	16,076
Older People	25,532	25,163	24,654
Generic Services	4,270	4,365	4,437
People with Mental Health Needs	2,139	2,168	2,187
People with Physical Disabilities	3,432	3,521	3,598
	50,934	**51,050**	**50,952**
Heathcare			
Expenditure Plans:			
Learning Disability	3,643	3,698	3,753
Mental Health	13,881	14,145	14,413
GP Prescribing	21,753	23,276	24,905
General Medical Services	17,252	17,252	17,252
Non-Cash Limitied Service	10,236	10,236	10,236
Other Generic Primary & Community Services	29,647	28,280	26,401
Unmet Financial Pressures - Savings Requirement	(1,922)		
New Savings as yet unidentified		(2,397)	(2,470)
Social Care Fund 16/17 Allocation for Direction	2,280	2,280	2,280
	96,770	**96,770**	**96,770**
Large Hospital Budget Set Aside			
Large Hospital Budget Set Aside	19,650	21,026	22,497
Unmet Financial Pressures - Savings Requirement	(672)		
New Savings as yet unidentified		(2,048)	(3,519)
	18,978	**18,978**	**18,978**
Total Planned Expenditure	**166,682**	**166,798**	**166,700**

Scottish Borders
Health and Social Care
PARTNERSHIP

COMMITTEE MINUTES

Aim

To raise awareness of the Health & Social Care Integration Joint Board on the range of matters being discussed by the Strategic Planning Group.

Background

The Health & Social Care Integration Joint Board will receive various approved minutes as appropriate.

Summary

Committee minutes attached are:-

- Strategic Planning Group: 23.01.17, 11.07.16

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the minutes.

Policy/Strategy Implications	As detailed within the individual minutes.
Consultation	Not applicable
Risk Assessment	As detailed within the individual minutes.
Compliance with requirements on Equality and Diversity	As detailed within the individual minutes.
Resource/Staffing Implications	As detailed within the individual minutes.

Approved by

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer, Health & Social Care		

Author(s)

Name	Designation	Name	Designation
Iris Bishop	Board Secretary		

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Scottish Borders Health and Social Care PARTNERSHIP

Meeting of the Strategic Planning Group
2.00pm to 3.30pm on 11 July 2016
Committee Room 2, Scottish Borders Council Headquarters

Minute

Present: Margaret McGowan, David Bell, Peter Symms, Jenny Miller, Linda Jackson, Morag Walker, Amanda Miller

In Attendance: Susan Manion (Chair), Eric Baijal, Tim Patterson, Carin Pettersson, Clare Malster, Paul McMenamin, Trish Wintrup, Shona Donaldson, Julie Watson, Claire Penny, Suzanne Hislop (Minutes)

1.	**Welcome** • Introductions were made and the Chair welcomed those present to the meeting.	
2.	**Apologies**: Gwyneth Johnston, Gerry Begg, Shirley Burrell, Karen McNicoll, Tim Young	
3.	**Minutes of the previous meeting** • The minutes of the previous meeting of 18 May 2016 were accepted as a true record. SPG Minutes.doc • The group went through the actions arising from the last minute and updated the action tracker. SPG Action Tracker.doc	
4.	**Matters Arising** • The Chair provided an update on the performance monitoring item discussed at the previous meeting. The overall framework is in place and it is now about making it specific to the Partnership. Currently looking at other partnerships (including Fife and Ayrshire) and the performance monitoring indicators they have adopted. The Integration Joint Board (IJB) will receive a draft to consider at the August meeting.	
5.	**Feedback from Integration Joint Board Meeting** • The revised governance arrangements for the Integration Care Fund (ICF) were discussed. The complexity of some of the arrangements has meant that there has been difficulty progressing work. Now live	

	as Partnership and need to be on the front foot in terms of governance and decision making. • The focus has been on the ICF which is a relatively small amount of money against the totality of the budget. The ICF is important but is only part of Health & Social Care enablement and has to be viewed in the context of the overall governance model for Health & Social Care. Important to look at the whole funding mechanism in terms of the delivery of models of Health & Social Care and the other funds that will allow us to do things in a better way. • It was decided that there was a need to slim down the governance arrangements and make this clearer for the IJB, this group and the wider organisation. • The paper approved at the IJB meeting held 20 June titled *Revised Governance Arrangements for Integrated Care Fund* was discussed. The paper positions the respective key stakeholders groups with the aim of devolving as much responsibility for governance as possible. • The paper generated a lot of discussion and some changes were made as a result. Decision making to be retained at Executive Management Team (EMT) level with the ultimate decision being made by the IJB. • Delivery will be commissioned by the SPB, the Terms of Reference and membership of which will now require review. The ICF steering group will become the Strategic Commissioning and Implementation Group. This will mean things can start before they go to the IJB but with the IJB retaining the final say. EMT will be able to expedite decisions with SM making recommendations to the IJB with the support of the Chief Executives. • This does not take away the responsibility of this group to influence the strategic direction. Reports from, for example the Strategic Commissioning and Implementation Group will, in future, come to the Strategic Planning Group (SPG). • An update will be available at the next meeting when there is a clearer indication of where things are. • The issue of where the Locality Planning Group sits in the new structure was raised. There is work to do around Localities and this will therefore fit in though the SPB at the moment. The Localities paper that went to the IJB meeting of 20 June touched on this and is to be revised in light of the comments received at that meeting. • Following discussions with Councillor Catriona Bhatia (Chair of the IJB), Pat Alexander (Vice Chair of the IJB) has been invited to join the SPG.	**ACTION CR**
6.	**Integrated Care Fund Update** • Claire Penny (Project Support Officer) tabled and gave a brief overview of the ICF report discussed at the Executive Management Team meeting on Friday 8 July.  SPG paper July 16 - Amended.docx • The additional funds comprising of a one off cost of £141,000 for the Borders Ability Equipment Store (BAES) Relocation project were approved. This is jointly funded by Scottish Borders Council and NHS Borders. It was agreed some time ago that the equipment store needed to be upgraded and relocated and the funding would	

	come from the Change Fund. To ensure the best use of the equipment in the system a number of improvement works around tracking and recycling for example were agreed. In line with this it was felt appropriate to fund this improvement through the ICF. • The way in which the Access to Information project will link into the council infrastructure is to be given further consideration. • The Locality Management project was approved for one year at a cost of £65,818. • The Health & Social Care Co-ordination project was also funded for one year at a cost of £49,238. • The Chair highlighted some of the other projects that are already up and running and contributing to change.	
7.	**Linkages Between Work Streams** • The diagram produced by PM was discussed. • This is not just about the governance but about all groups and the overall process. It was agreed that this was helpful as it puts into context the mapping of the various groups. • The Chair gave a brief overview of the work that has been approved, including investment in The Transport Hub project which has been awarded winner of the *Accessibility Project of the Year* at the recent Scottish Transport Awards, the Borders Community Capacity Building project which was initiated to address the gap identified in local services, and the Transitions project which is working with young people with a learning disability and their families as they make the move from children's' to adult services. • Other projects were discussed that also demonstrate progress made to date. • There was some discussion around the mechanisms for gathering feedback from people using services. It was agreed that it was important to ensure that this is built into the programmes at the very beginning so that a baseline can be established to facilitate the final analysis. It was agreed that this was not just about the ICF Projects but about capturing feedback across all of the redesign being undertaken.	
8.	**AOB** • PS raised the issue of waiting times in accessing physiotherapy services and circulated a brief note. This was discussed among the group and PS is to receive a full response to the issues raised.	**ACTION SM**
9.	**Date and time of next meeting:** **The date of the next meeting was given as 13 September 2016 from 10.00am to 11.30am in Committee Room 2.**	

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Scottish Borders Health and Social Care PARTNERSHIP

Meeting of the Strategic Planning Group
9.00am to 10.30am on 23 January 2017
Committee Room 2, Scottish Borders Council Headquarters

Minute

Present: Linda Jackson, Caroline Green, Gerry Begg, Lynn Gallacher

In Attendance: Elaine Torrance (Chair), Jane Robertson, Suzanne Hislop (Minutes)

1.	**Welcome** • The Chair welcomed those present and explained that while the meeting was not quorate, it would be useful for members to discuss the agenda issues, including the review of the role of the group.	
2.	**Apologies**: Gwyneth Johnston, Tim Young, Margaret McGowan, David Bell, Amanda Miller, Anne Livingstone, Morag Walker, Jenny Smith, Lynne Crombie, Shirley Burrell	
3.	**Review of Role of SPG – Including Review of Terms of Reference & Membership** • The Chair informed the group that Eric Baijal had recently left his post as Director of Strategy for Integration. • The team managed by Jane Robertson are now looking at how best to support the delivery of the integration agenda and join the different strands of work together. • The Chair explained that an aim of this meeting was to bring members up-to-date and to look to the future of the Strategic Planning Group (SPG). • The SPG is an important group as the Partnership's key partners sit here and the group is a statutory requirement of the Joint Public Bodies Scotland Act, with a key role to act as an advisory committee to the Integration Joint Board (IJB). • The guidance available in the legislation is very much focused on the the first year and the development of the Partnership's Strategic Plan, with very little set out after this period. The existing Terms of Reference (ToR) reflects this and is focused on this initial period. • A revised ToR was tabled for discussion. SPG Terms of Reference JR.docx • The following comments/suggestions were made: ▪ There should be a closer link between the IJB and the SPG. ▪ This group provides an opportunity to speak with those outwith the organisation and it has sometimes felt that this contribution was not taken full advantage of. ▪ The processes in place are lengthy and cumbersome. (It was	

	acknowledged that there had been too much emphasis on governance and processes in the past but that a streamlining of the structures was currently being undertaken to address this)	
	▪ Quarterly meetings aligned to the IJB meetings were proposed.	
	▪ An IJB representative should be included on the SPG. (This has been addressed in the revised ToR).	
	▪ SPG members should be able to raise issues with the IJB. It was agreed that the wording of the revised ToR be changed to 'Identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan…'	**ACTION JR**
	▪ Performance reporting data should be coming to this group. The IJB are not currently receiving a regular update on performance reporting or the strategic plan. This is currently being looked at and will be addressed.	
	▪ SPG members should feel able to have a frank exchange of views and trust and confidentiality are key to this.	
	▪ The opportunity for fuller discussion is required before documents etc. go to the IJB for sign off.	
	▪ Everything that goes to the IJB should come through the SPG. Papers for the IJB are currently made available 7 days in advance of meetings. To be established if IJB papers can be made available two weeks in advance in order to give SPG members opportunity to review and comment. This issue is to be raised when the revised ToR for the SPG goes to the IJB. Timings of future meeting to be looked at with this in mind, with frequency of meetings also to be kept under review.	**ACTION ET**
	▪ Revised ToR to be updated to capture that the SPG has a responsibility to contribute to any formal updates of the Strategic Plan.	**ACTION JR**
	▪ Proposed Quorum to consist of Chair and a minimum of six Members.	**ACTION JR**
	▪ Jane Robertson to be added to membership as the representative of localities.	**ACTION JR**
	▪ Chair to be moved from the attendance list to the membership list in light of the revised quorum.	**ACTION JR**
	▪ To be made clear that the prescribed group titled 'Non-Commercial Providers of Health Care' includes not for profit organisations.	**ACTION JR**
	▪ Nominations to be sought for representatives of 'Non-Commercial/Not for Profit Providers of Health Care'. Organisations including Marie Curie are to be approached. CG to pass on contact details for possible representative from Marie Curie.	**ACTION JR** **ACTION CG**
	▪ The Membership of other partnerships' SPG's to be identified to inform the finalisation of this group's membership.	**ACTION JR**
	▪ There was some discussion around Third Sector representation. It was acknowledged that while the SPG membership cannot include everyone, it was important that we are linking in with groups that are not part of the formal governance. A co-ordinated approach by the Third Sector would enable/facilitate this, with a workshop to bring organisations together to discuss this issue suggested.	

	▪ The outcome of the ongoing review of the governance and structures to be brought to this group when available. ▪ An updated version of the ToR is to be circulated and come to the next meeting of the SPG for ratification.	**ACTION JR** **ACTION JR/SH**
4.	**Health & Social Care Delivery Plan** • The H&SC Delivery Plan was published in December. • The Chair gave a brief overview of this document, highlighting key sections of interest including the H&SC actions contained on pages 8 & 9. • This document provides a useful prompt for a dialogue around what the Partnership's priorities should be and will help to identify 10 or 15 priorities linked to the national objectives that will help to progress work such as the Commissioning & Implementation Plan.	
5.	**Annual Performance Report** • The Partnership is required to publish an Annual Performance Report (APR) by the end of July. Currently in the process of gathering information to populate the proposed template that will go to the IJB at the end of February. • The APR will take the form of an impact report and the tight timescale for completion was highlighted. • The Carers Centre would be willing to offer data to help produce the report. • APR to come to this group in due course. The intention is to capture some qualitative data and the Carers Centre may again be able to help with.	
6.	**Performance Monitoring Framework** • Very little has been going to the IJB around performance. • The PMF included in the papers for today's meeting is work that has been undertaken up to this point. • A performance report will go to the IJB at the end of February and this will be refined and developed following this.	
7.	**Locality Planning Update** • Draft Summary Locality Action Plans have been produced through the five Locality Working Groups (LWGs). The LWGs were tasked with developing the Locality Plans for the Partnership. JR gave a brief overview of the format of the plans. These have gone to the Executive Management Team (EMT) and are due to go to the next IJB meeting scheduled for 27 February. The plans will also be presented at the various Area Forums. • Thoughts and comment on how to enhance the draft Summary Locality Action Plans are welcomed with feedback to be forwarded to JR as soon as possible. • It was suggested that the partnership with the Third and Voluntary Sectors needs to be further reflected in the plans. • It was also suggested that the reference to Extra Care Housing in relation to Berwickshire should to be expanded. • The demographic information present in the summary plans was felt to be useful.	**ACTION ALL**
8.	**Workforce Development** • JR has met with June Smyth (Director of Workforce & Planning) and Clare Hepburn (Chief Officer HR). In the process of outlining a plan, with the joint workforce plan and joint recruitment process identified as key priorities.	

9.	**AOB** • None noted.	
10.	**Date and time of next meeting: Monday 13 February 2017 between 2.00pm and 3.30pm in Committee Room 1 SBC HQ**	