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Scottish Borders
Health and Social Care
PARTNERSHIP

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

AGENDA

Time	No		Lead	Paper
09:30	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
09:31	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their business.*	Chair	*Verbal*
09:33	**3**	**MINUTES OF PREVIOUS MEETING** 23.04.18	Chair	(Pages 3 - 12)
09:35	**4**	**MATTERS ARISING** Action Tracker	Chair	(Pages 13 - 18)
09:40	**5**	**CHIEF OFFICER'S REPORT**	Chief Officer	(Pages 19 - 22)
	6	**FOR DECISION**		
09:45	6.1	Refresh of Health & Social Care Strategic Plan 2018 - 2021 Update on progress.	Chief Officer	(Pages 23 - 172)
	7	**FOR DECISION**		
11:00	7.1	Authorisation to Sign Off Annual Accounts 2017/18	Chief Officer	(Pages 267 - 268)
11:15	**8**	**ANY OTHER BUSINESS**	Chair	*Verbal*

11:20	**9**	**DATE AND TIME OF NEXT MEETING** Monday, 11 June 2018 at 2.00pm in Committee Room 2, Scottish Borders Council	Chair	*Verbal*

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Monday 23 April 2018 at 2.00pm in the Committee Room 2, Scottish Borders Council.

Present:	(v) Cllr D Parker	(v) Dr S Mather (Chair)
	(v) Cllr H Laing	(v) Mr M Dickson
	(v) Cllr S Haslam	(v) Mrs K Hamilton
	(v) Cllr T Weatherston	(v) Mr T Taylor
	Mrs J Smith	Mr R McCulloch-Graham
	Mr D Bell	Mrs C Pearce
	Mrs Y Chapple	Mr S Easingwood
	Ms L Gallacher	Dr A McVean
	Mr C McGrath	
In Attendance:	Miss I Bishop	Mrs J Davidson
	Mrs T Logan	Mrs J Stacey
	Mrs C Gillie	Mr D Robertson
	Mrs S Bell	Mrs S Holmes
	Mrs J Robertson	Mr L Gill
	Ms V MacPherson	Ms K Lawrie

1. Apologies and Announcements

Apologies had been received from Mr John Raine, Cllr John Greenwell, Dr Cliff Sharp, Mr Murray Leys and Mr John McLaren.

The Chair confirmed the meeting would not be quorate until Mr Tris Taylor or Mrs Karen Hamilton arrived.

The Chair welcomed Mr Malcolm Dickson (Non Executive, NHS Borders) as a voting member of the Integration Joint Board (IJB). Mr Dickson had been approved by Borders NHS Board on 5 April as a voting member of the IJB to replace Mr David Davidson who had now concluded his term of office as a Non Executive of NHS Borders.

The Chair welcomed Mr Stuart Easingwood, Interim Chief Officer Public Protection to the meeting who was deputising for Mr Murray Leys.

The Chair welcomed Ms Yvonne Chapple to the meeting who was deputising for Mr John McLaren.

The Chair welcomed Ms Vicky MacPherson and Ms Karen Lawrie from the NHS Borders Partnership Office who were shadowing Mrs Yvonne Chapple.

The Chair welcomed members of the public to the meeting.

2. Chief Officer's Report

Mr Robert McCulloch-Graham gave an overview of the content of the report and highlighted increased activity in the secondary care sector, delayed discharges, financial pressures, the protection of individuals and regional activities.

Mr Tris Taylor arrived.

Mr Tris Taylor enquired about the Chief Financial Officer position. Mr McCulloch-Graham recorded his thanks to those who had covered the Chief Financial Officer post on an interim basis to date. He advised that there had not been enough interest received in the post and he was now intending to re-advertise the position. He confirmed that he was also in contact with the Scottish Government in regard to interim arrangements. He assured the Board that measures were in place to ensure financial governance through the support of Mr David Robertson, Mrs Carol Gillie, Mr Leslie Gill and Mrs Susan Swan. He assured the Board the appointment remained a priority.

Mr David Robertson suggested the Board may wish to consider and agree who would sign off the partnership annual accounts for 2017/18 given the current position in regard to a vacancy for the Chief Financial Officer position.

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

The Chair confirmed the meeting was quorate.

3. Declarations of Interest

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Register of Interests.

Mrs Karen Hamilton arrived.

4. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 19 March 2018 were amended at page 3, minute 6.1, line 3, to read "..funding. However it was agreed that it be included ..." and with that amendment the minutes were approved.

5. Matters Arising

5.1 Action 22: Joint Older People's Services Report: Mr Robert McCulloch-Graham advised that he still awaited formal feedback from the Care Inspectorate on the revised Action Plan that had been submitted. He assured the Board that regular contact was maintained with the link inspector. The Chair voiced his frustrations at the lack of engagement from the Care Inspectorate and Mrs Tracey Logan suggested she could raise the matter with Scottish Government colleagues.

Page 2 of 10

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

6. Scottish Borders Health & Social Care Partnership Financial Plan 2018/19

Mr Robert McCulloch-Graham introduced the Financial Plan presentation.

Mr David Robertson provided an informative presentation that was intended to reflect the paper. During the presentation Mr Robertson covered the full range of financial elements, including: strategic context; flow of funds; achievements the partnership had made; operational context; budget movement; Integrated Care Fund; Social Care Fund; efficiency savings and pressures for 2018/19.

Cllr David Parker sought confirmation that conditions around the implementation of the living wage and Carers Act were calls that would be directed to be fulfilled through social care funding.

Mr Tris Taylor enquired about the split of funding when resourcing joint services, such as a 1.5% increase in funding for the Mental Health Service given the 2018/19 budget was smaller than the 2017/18 budget. Mr Robertson advised that there was an expectation that NHS resources would stay the same. Mrs Carol Gillie confirmed that in moving forward there was a commitment in the NHS allocation letter baseline for 2017/18 compared to 2018/19. Some efficiencies had been delivered in the Mental Health Service which had enabled the 1.5% uplift from the NHS, which Mrs Gillie advised was in effect an allocation rather than an actual.

Mr Colin McGrath enquired of the overall proportion of the NHS budget in the partnership. Mrs Gillie advised that 52% of the NHS budget was transferred to the partnership. Mr Robertson also advised that 100% of the social services budget for all adult services was allocated to the partnership.

Mr Taylor enquired about the ring fenced funding received from the Scottish Government. Mr Robertson advised that ring fenced funding had been received based on future projections which had been estimated in good faith, however the funding did not fully cover the costings and there were therefore pressures to be addressed.

Ms Lynn Gallacher commented that she was aware that the Carers Action Plan implementation monies had been allocated around the various areas and she enquired where the Carers Information Strategy funding currently sat given it was not new money. Mr Robertson advised that there was a proposal to be put before the Strategic Board and a recommendation would be submitted to the Integration Joint Board meeting in June for decision.

Cllr David Parker commented that he understood some funding for the Carers Act payable to the Borders Carers Centre and was already mainstreamed, and he was aware that there were some things requiring payment as they involved salaries for people. Mr Robertson suggested if the Board were not minded to set the budget that day then it would be appropriate for the Board to take the decision to continue to fund certain areas at the discretion of the Chief Officer in conjunction with the Chair and Vice Chair of the Integration Joint Board.

In regard to efficiency savings, Mr McGrath enquired if services were given direction on where to make savings. Mrs Tracey Logan commented that services were made aware of the challenges and pressures within the Council and were asked to formulate proposals for savings. Proposals were assessed corporately and all dependencies were looked at through a fully rounded process before any recommendations were made. She stated that far more proposals were rejected than taken forward.

Mrs Claire Pearce noted that there had been a 30% occupancy rate at Craw Wood given the acuity of people had made them unsuitable to transfer to the facility from the acute sector and she enquired if 15 beds was an appropriate number. Mr McCulloch-Graham commented that funding had been agreed for 15 beds in total and the most used at any one point in time had been 14 over the winter period. He anticipated that demand would reduce during the summer and was mindful that a reduction in beds over that period might be appropriate, however he was keen to ensure the full compliment were maintained for the winter period. Mrs Pearce noted the high cost of maintaining 15 beds when only 5 were occupied. Mr McCulloch-Graham suggested retaining the resource allocated and keeping the number of beds under review with an ability to flex them as and when necessary.

Mrs Jane Davidson suggested the crucial point was to maintain flexibility throughout the year.

Cllr Helen Laing enquired if the right criteria were in place for Craw Wood. Mrs Logan reminded the Board that Craw Wood was a temporary unit and was restricted in terms of its use and she would support a reduction in beds when appropriate.

Mr Taylor sought clarification on the status of the financial plan. Mr McCulloch-Graham commented that the report was requesting that the Board note the financial gap and request a paper be brought back in June on how that gap would be addressed.

The Chair sought confirmation that the resource allocations were actual. Mrs Gillie confirmed that they were.

Cllr Parker sought clarification that certain business as usual activity would still progress such as the carers issue, staffing costs and looked for reassurance from Mr Robertson that those things would not be suspended until a decision was made by the Board in June. Mrs Logan confirmed that business as usual activity would continue.

Cllr Parker challenged if the Integration Joint Board was allowed to agree a budget that was not fully funded. Mr Robertson clarified that the Board could accept the report and on the recommendation of the Chief Officer ask for a future report to be brought before the Board in terms of the budget. He recommended that the Board accept the report, note the deficit in the budget and ask for a report from NHS Borders in June to detail how the funding gap would be bridged before final approval of the budget.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** accepted the report on the 2018/19 Health and Social Care Financial Plan and asked that a report be brought to the June 2018 meeting with details of how the unidentified savings requirement would be addressed, recognising that plans to deliver £5.2m of savings remain unidentified.

7. Integrated Care Fund Review of Projects 2015-18

Mr Robert McCulloch-Graham gave an overview of the content of the report and reminded the Board of the decisions agreed at the last meeting. He then drew the attention of the Board to table 4 page 6 and the recommendation suggested for each project.

Mr Tris Taylor declared an interest in the autism item as he had a step son with autism.

7.1 Delivery of the Autism Strategy: Mr Tris Taylor sought assurance that the action plan would not be compromised by disinvestment in the project. Mrs Tracey Logan assured the Board that mainstreaming of the project and outcomes to be achieved would be appropriate, it was more of a matter of thinking differently about how that was achieved.

Mrs Jenny Smith was mindful of autism in terms of public perception, press, education and working with partners. She accepted that the project was not delivering and wished to be assured on how the agenda around autism would be supported.

Cllr Shona Haslam accepted the inefficient use of resources, however she could not agree to disinvest in the project based on an outcome of too few individuals benefitting from the project, given there was no original objective in regard to numbers of people to benefit from the project.

Mrs Jane Davidson recollected that the Autism Strategy was about the reshaping of services, how the strategy could be mainstreamed and she commented that some of the strategy itself had been aspirational.

The Chair advised of the proposed recommendation within the paper.

Cllr Haslam proposed: funding the project for a further 6 months with a view to mainstreaming into other services; ensuring the autism strategy and action plan were delivered in the mainstream services; and identification of succession planning.

Cllr David Parker seconded the proposal.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the proposal to fund the project for a further 6 months with a view to mainstreaming into other services; ensure the autism strategy and action plan were delivered in the mainstream services; and for succession planning to be identified.

7.2 Delivery of the Alcohol Related Brain Damage (ARBD) Pathway: Both Cllr Shona Haslam and Cllr David Parker raised concerns in regard to the limited evidence and progress with the project. Cllr Tom Weatherston commented that it was a difficult group of people to assist, however he recognised the limited evidence available.

The Chair advised of the proposed recommendation within the paper.

Cllr David Parker proposed to cease the project as soon as practicable.

Cllr Shona Haslam seconded the proposal.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the proposal to cease with the project as soon as practicable.

7.3 Stress & Distress Training: Mr Tris Taylor enquired if the project was integrated with the general scheme of activities around executing the statutory duty required of Health Boards to look after the wellbeing of their staff. Mr Robert McCulloch-Graham advised that the project was focused on pump priming an effective training programme to enable people to deal with difficult behaviours.

The Chair advised of the proposed recommendation within the paper.

Cllr David Parker proposed to cease the project as soon as practicable and suggested mainstreaming be considered within the training programme.

Mrs Karen Hamilton seconded the proposal.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the proposal to cease with the project as soon as practicable.

7.4 Transitions: The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding.

7.5 Transitional Care Facility – Waverley Care Home: The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding with a view to mainstreaming the service at the project end.

7.6 Pharmacy Input: Cllr David Parker was fully supportive of the project and recognised the potential for savings to be achieved.

The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding with a view to mainstreaming the service at the project end.

7.7 GP Clusters Project: Cllr Shona Haslam commented that it was vital to progress with the project along with regular reporting and evaluation of the project as she was keen to see the demonstrative impact on health outcomes. Mr Robert McCulloch-Graham advised that it would form part of the primary care improvement plan.

Dr Angus McVean welcomed Cllr Haslam's comments and advised that the Primary Care Improvement Plan would contain the detail of what the Cluster Leads would be doing. He also suggested there might be a move from 4 to 5 clusters or into 1 single cluster. He advised that the plan would be brought to a future meeting of the Board.

The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding.

7.8 Domestic Violence Pathway: The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding with a view to mainstreaming as part of the Public Protection Review.

7.9 Buurtzorg Project Management: Cllr David Parker recalled that the Board had been fully supportive of the project in the past as it believed it could deliver the fundamentals of integration, however progress had been slow. He supported the project but wished to see some momentum behind it.

Mr Tris Taylor enquired of the options on merging with Hospital to Home. Mrs Jane Davidson recognised that progress had been slow as the project was being led by community nurses and workers in the community. She suggested there were challenges around getting 3 organisations to work together namely, SB Cares, NHS Borders and Scottish Borders Council, and staff had been working through what they could and could not do together. She accepted that the project required some pace around it and commented that it did link to Hospital to Home.

The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding with a further update on progress.

7.10 Craw Wood: The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding with a review of the staffing rota.

7.11 Hospital to Home: The Chair advised of the proposed recommendation within the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the carry forward of funding.

Cllr David Parker requested that an indication be provided to the next meeting on the impact of the decisions made, updated timescales and projects to be mainstreamed.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive an update on the impact of the decisions made, updated timescales and projects to be mainstreamed.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the review of ICF projects due to carry over funding in the financial period 2018-19.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** decided as above, which projects should have continued investment or disinvestment.

8. Integration Joint Board Meeting Cycle

The Chair gave an overview of the content of the paper and the rationale for amending the meeting cycle.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the increase from 6 formal meetings to 8 per year and a reduction from 5 Development sessions to 3 per year.

9. Scottish Borders Health and Social Care Partnership 2017/18 Winter Period Evaluation Report

Mrs Claire Pearce, outlined to the Board the effects on hospital capacity and staffing levels of a difficult winter period in terms of weather, acuity of patients and staff sickness. She emphasised that the effects manifested on people and gave the example of people having to wait in the Emergency Department in excess of 8 hours. Mrs Pearce enquired if the Board would find it helpful if she brought a quality and governance report on the effects of winter.

Dr Angus McVean suggested the report also involve primary care and welcomed the opportunity to work on a joint report with Mrs Pearce.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the learning and improvement opportunities for next year which would be taken forward by the Winter Planning Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** welcomed the opportunity to receive a report at a future meeting on Quality and Governance from Mrs Claire Pearce, Director of Nursing, Midwifery & Acute Services and Dr Angus McVean, GP Clinical Lead.

Cllr Helen Laing left the meeting.

10. Strategic Planning Group Report

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

Mrs Jenny Smith commented that the Strategic Planning Group (SPG) had been focused on the review of the Strategic Plan and she suggested it should also have more of an eye on performance and be able to provide the Board with an overview of performance. Mr McCulloch-Graham commented that he was also keen for the SPG to monitor performance against the Strategic Plan and then advise the Board accordingly.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the key issues and actions arising via the Strategic Planning Group, in particular progress being made in relation to the refresh of the Partnership's Strategic Plan.

Page 3 of 10

11. Inspections Update

Mr Stuart Easingwood advised that in regards to the Joint Older People's inspection the interface between the services and the Care Inspectorate was not ideally where he would like it to be. However, there was progress being made in line with the action plan and within those timescales. He assured the Board that there were no matters outwith the timescales planned, and a further meeting with the Care Inspectorate was awaited.

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

12. Quarterly Performance Report

Mr Tris Taylor commented that it did not feel like an adequate set of indicators to monitor against. He suggested that the measures evolved out of policy and in terms of performance against what he would perceive the public would wish to see they would fall short.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the additional/amended measures for reporting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the key challenges highlighted.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** did not advise of any further measures to be considered for inclusion in future quarterly performance reports.

13. Equality Mainstreaming Progress Report

Mr Malcolm Dickson enquired if the Integration Joint Board participated in Equality and Diversity week.

Mrs Jane Davidson suggested the Board may wish to direct the Chief Officer to participate in it. She commented that the week had been a success and had been lead by the Joint Public Health Team across NHS Borders and Scottish Borders Council and welcomed the involvement of the Integration Joint Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Equality Mainstream Report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the draft Progress Report for publication.

14. Any Other Business

14.1 Social Isolation & Loneliness: Mr Colin McGrath commented that at a recent Locality meeting the Scottish Government document on Social Isolation and Loneliness had been mentioned and he suggested the Board may wish to respond to the document. Mr Robert McCulloch-Graham advised that he would discuss the matter with Mr McGrath outwith the meeting.

15. 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 28 May at 9.30am in Committee Room 2, Scottish Borders Council.

The meeting concluded at 4.20pm.

Signature: ……
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 17 October 2016

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

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

Meeting held 27 February 2017

Agenda Item: Health & Social Care Delivery Plan

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

Meeting held 23 October 2017

Agenda Item: Update on Buurtzorg in the Borders

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
19	13	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress to date and welcomed hearing more at a later date.	Robert McCulloch-Graham	April 2018	**In Progress:** Item scheduled for April 2018 meeting agenda. **Update:** Item rescheduled to 11 June meeting due to agenda business pressures.	G

Meeting held 18 December 2017

Agenda Item: Community Capacity Building – Transformation Proposal

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

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

Meeting held 12 February 2018

Agenda Item: Inspection Update

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

Meeting held 23 April 2018

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

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

Agenda Item: Buurtzorg Project Management

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

Agenda Item: Hospital to Home

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

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

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

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

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 28 May 2018

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

CHIEF OFFICER'S REPORT

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

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

Personnel:	Not Applicable

Carers:	Not Applicable

Equalities:	Not Applicable

Financial:	Not Applicable

Legal:	Not Applicable

Risk Implications:	Not Applicable

Chief Officer Report

Winter pressures continue into Spring

Whilst we have seen fluctuations within the delayed discharge rate over the last few months it remains a challenge. We now have however, more beds available within our Community Hospitals and the demand on Craw Wood step down facility has dropped significantly in the last four weeks. In addition the Hospital to Home Service is dealing with more people leaving hospital and providing alternative provision to hospital admissions. There remains however, a pressure of delays within the system impacting on a number of parameters within our hospitals.

Further planning is underway to determine our preparations for next winter. These include continuing our discharge to assess policy, and expanding and further developing on our hospital to home services, maintaining the Craw Wood and Waverley Care step down provision, centralising our Matching Hub at Borders General Hospital with our START team, and commissioning additional care hours and residential care beds to better meet the demand.

We have also expanded on our offer of community hubs and more third sector partners are joining this work as we roll out a full drop in service across the five localities.

We have spot-lighted, the work of Craw Wood, Hospital to Home, the Matching Unit and the Transitional Care Facility at Waverley Care Home within our Annual Performance Plan, a draft of which is on this IJB agenda.

External Auditors and Inspection.

I have recently met with the Care Inspectorate and Health Improvement Scotland regarding our progress against the recommendations made within their report of 2017. I am pleased to report they were impressed with progress especially around the governance of the partnership, the vision and the controls put in place around planning and direction.

They commented on the comprehensive action plan we have in place, but they stated it was perhaps *over* comprehensive with regards to the evidence provided showing our progress. They have requested a summary rather than providing the whole evidence base we have currently been collating.

I also met with our external auditors who also passed similar comments, and were pleased to see that the IJB had introduced the Direction on Discharge to Assess and the work we have undertaken to bring the ICF resource back on focus. However arduous this was for us, they appreciated the greater control exercised by the Board on this spend.

They remained critical however at our struggle to appoint a Section 95 Officer stating that this is essential for the future. We are in process of appointing a recruitment agency to support a more thorough search for the position.

We did discuss the signing off of the accounts for 17/18 and they would support the proposal that the accountable officer from the Council to sign off the accounts on behalf of the IJB for this year as an exception.

Page 204

Parliament Health and Sport Committee.

Continuing on the theme of scrutiny, five IJB Chief Officers have been requested to attend a meeting of this committee tomorrow to examine our work in preparing our budgets.
The questioning will mainly focus on the shifting balance of care from Acute to Partnership, and in particular how the Set Aside arrangements are supporting this or otherwise.

Other questions I anticipate will relate to our overall budget preparations within partnership and on our current position for 18/19 and our expected savings. As you know the Borders IJB does not as yet have a final overall budget agreed at this time, this is however, also true of a number of IJBs.

I will provide an additional verbal report after the event tomorrow.

Adult Social Care

Michael Murphy has been appointed to the Adult Social Care role on an interim basis and we are shortly to advertise for the permanent position. Michael has extensive experience of Adult Social Care both in Scotland and in Wales. He supported East Lothian IJB through their development as a Health and Social Care partnership.

He has already made a start at going through our savings actions and the preparation for determining further commissions to meet the demand of Care.

Regional/National Work

At the last IJB I reported on the regional work on Diabetes 2, this continues and we expect to see some progress soon on the introduction of a support/leadership team to take the work forward under the governance of the steering group chaired by Tracey Logan.

I've been involved in some further national work regarding children's health and mental health in particular, with COSLA's statistical team. This work is attempting to identify trends and contributory demographic factors which lead to poor outcomes for some people, particularly in the area Mental Health.

This is particularly pertinent to local concerns here within the Borders. The COSLA team felt it important that the national direction is suitably informed by a clear understanding of the reality of local need and demand.

Primary Care

The GP Sub Committee considered an early draft of the Primary Care Improvement Plan. A working group has now been brought together with individual GPs to develop this plan to utilise the national direction to meet the needs here in the Border. We are excited by the emphasis on locality and cluster working which supports the locality planning already begun by the partnership.

The new contract for GP's provides some encouraging opportunities for a greater join up of our services both within the community but also within our hospitals.

Further iterations of the plan will be brought to the Strategic Planning Group and the IJB.

Future work

This IJB meeting will consider the drafts of our reviewed strategic plan and of our annual performance report. Together these documents show the necessity of our partnership working and the direction required to meet the on-going pressures of providing effective health and social care within the Borders. Whilst we have seen some success, the quantum of demand needs more capacity to be released through the greater management of demand.

We have only made a start; there remains a great deal to do,

Rob

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: .....28 May 2018.....

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

REFRESH OF HEALTH AND SOCIAL CARE STRATEGIC PLAN 2018 - 2021
UPDATE ON PROGRESS

Purpose of Report:	The aim of this report is to update the Integration Joint Board (IJB) on work underway to refresh the Health and Social Care Strategic Plan.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) note progress made on refreshing the Strategic Plan; b) comment on the content and format of the refreshed Strategic Plan.

Personnel:	None.

Carers:	Consultation with representatives from all key stakeholder groups via the Strategic Planning Group, Locality Working Group and other relevant Partnership fora.

Equalities:	Equality and Diversity Impact Assessment to be updated.

Financial:	None.

Legal:	This document proposes changes to the existing Health and Social Strategic Plan in line with proposals made by the Strategic Planning Group.

Risk Implications:	Risks are identified with the IJB Risk Register.

Background

In January 2018 the Strategic Planning Group reviewed the existing Health and Social Care Strategic Plan (**Attachment 1**) and proposed a number of changes to the Plan. Proposed changes included:

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

Update on Progress

Since then, work has been underway to refresh the Strategic Plan in line with proposals outlined by the Strategic Planning Group. A draft of the refreshed Strategic Plan can be seen in **Attachment 2**. The document has considerably reduced in size from 60 to 17 pages. This has been achieved by removing detailed information such as the area profile and financial information into a number of appendices to the Strategic Plan (see **Attachment 3**).

The vision statement has been worded to reflect a strong link with communities in the Scottish Borders and the number of local strategic objectives has reduced from nine to three. The refreshed three objectives are high level and focus on keeping people health and well, improving service flow and managing health conditions. Underpinning the objectives are a number of key principles.

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

Page 34

Scottish Borders **Health & Social Care** Partnership

Scottish Borders
Health and Social Care
PARTNERSHIP

changing health & social care for you

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

strategic plan 2016 -19

CONTENTS

SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP STRATEGIC PLAN

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

FOREWORD

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

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

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

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

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

Susan Manion
Chief Officer Health and Social Care Integration
March 2016

EXECUTIVE SUMMARY

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

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

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

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

CASE FOR CHANGE: WHY WE NEED TO CHANGE

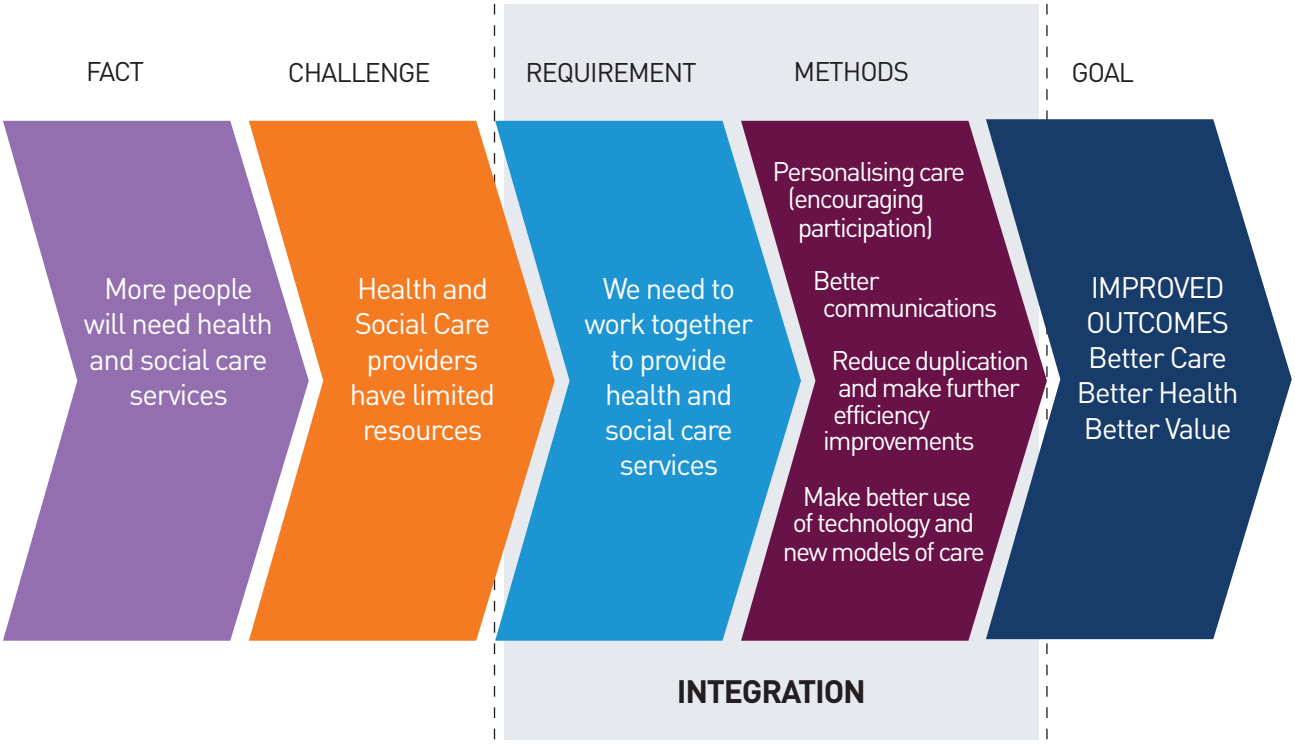
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in the figure below and include:

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

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

FIGURE 1 – THE CASE FOR CHANGE



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

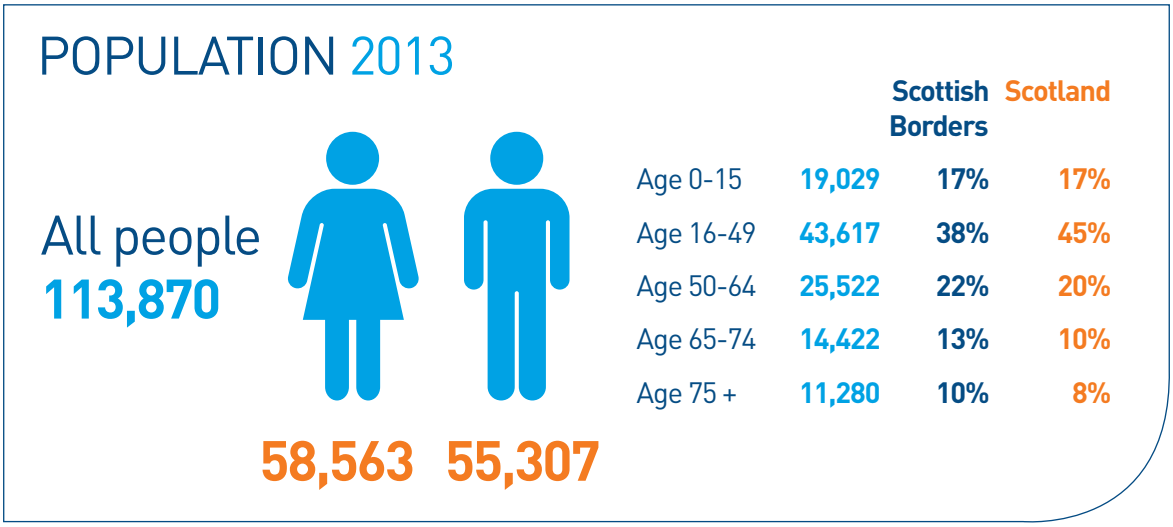
This section of the Plan gives a high level summary profile of the Scottish Borders and some of our key challenges. More detailed information is also available in two further documents published alongside this Plan – Facts and Statistics, and the Joint Strategic Needs Assessment.

Who Lives in the Borders?

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

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

FIGURE 2



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

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

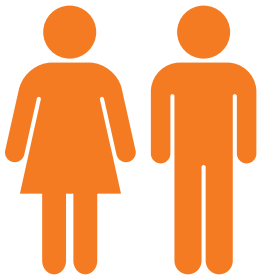
FIGURE 3

PROJECTED CHANGES IN POPULATION BY AGE GROUP 2012 TO 2032

4% decrease Age 0-15

16% decrease Age 16-64

51% increase Age 65+



Source: National Records of Scotland 2012-based population projections

WHAT THIS MEANS...

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

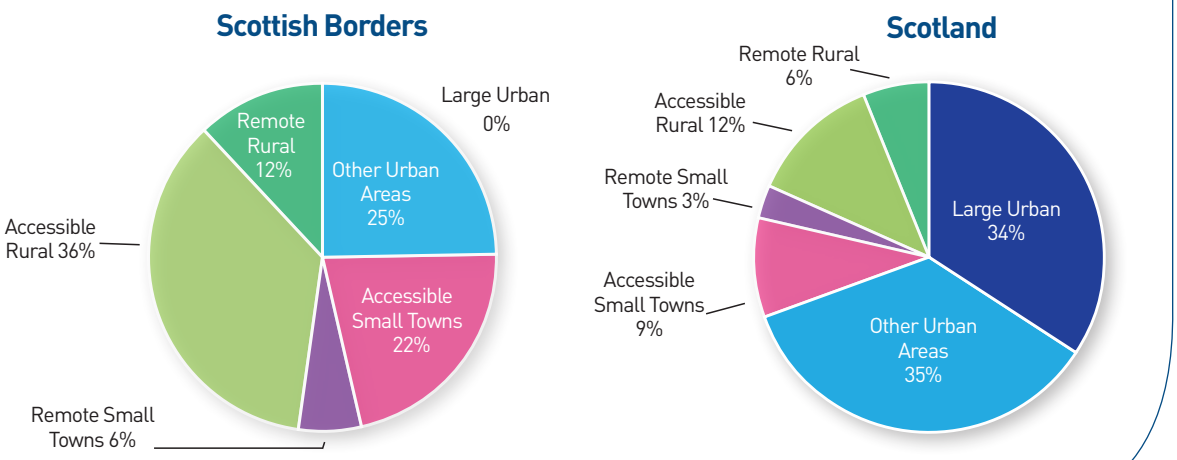
Where do people live?

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

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

FIGURE 4

POPULATION SHARES (%) BY URBAN/RURAL AREA 2012



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

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

WHAT THIS MEANS...

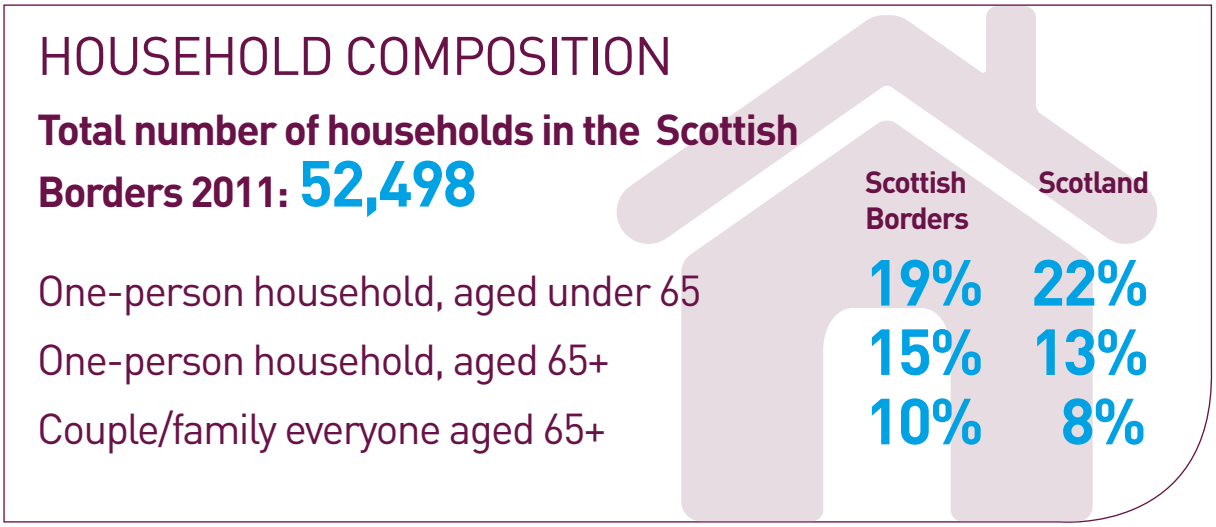
Services therefore need to be provided locally whenever possible and accessible transport arrangements put in place.

Borders Households

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

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

FIGURE 5



Source: Scotland Census 2011

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

WHAT THIS MEANS...

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

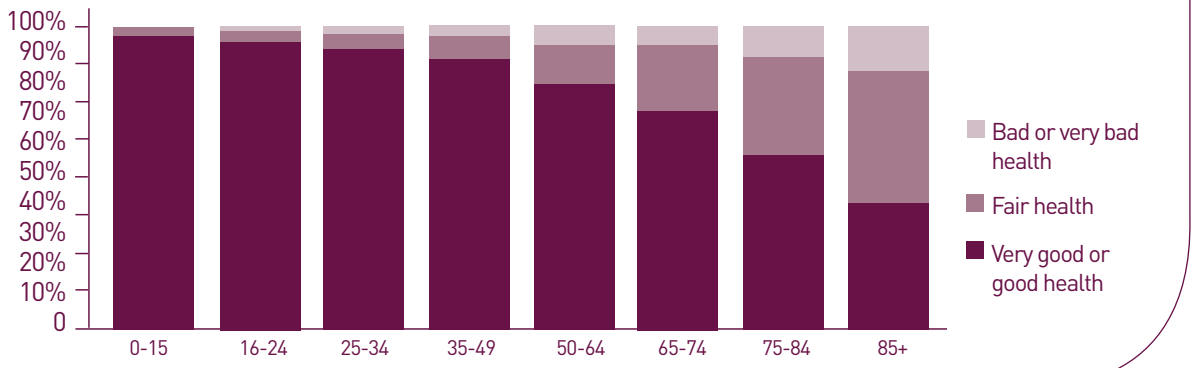
How Do People in the Borders View Their Health?

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

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

FIGURE 6

SELF REPORTED GENERAL HEALTH
AMONGST SCOTTISH BORDERS RESIDENTS



Source: Scotland Census 2011

WHAT THIS MEANS...

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

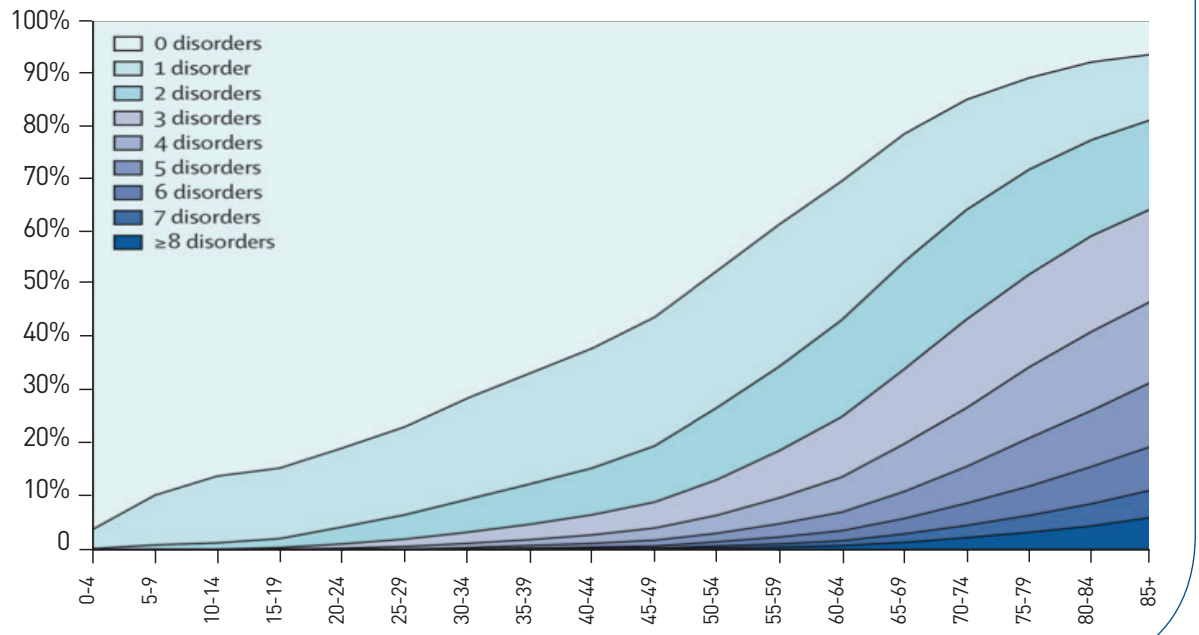
People Living with Multiple Long Term Conditions

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

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

FIGURE 7

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



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

Disability

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

WHAT THIS MEANS...

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

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

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

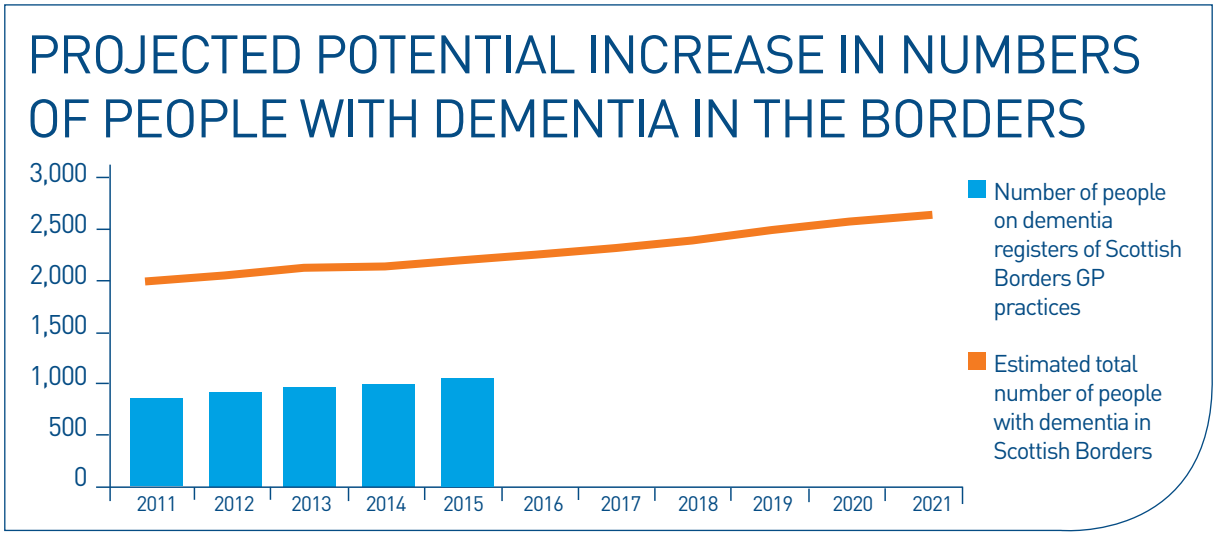
Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people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

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

Dementia

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

FIGURE 8



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

WHAT THIS MEANS...

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

People Living with Complex and Intense Needs

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

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

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

USE OF HEALTH AND SOCIAL CARE RESOURCES: AN EXAMPLE

Analysis of expenditure in 2012/13 showed that:

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

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

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

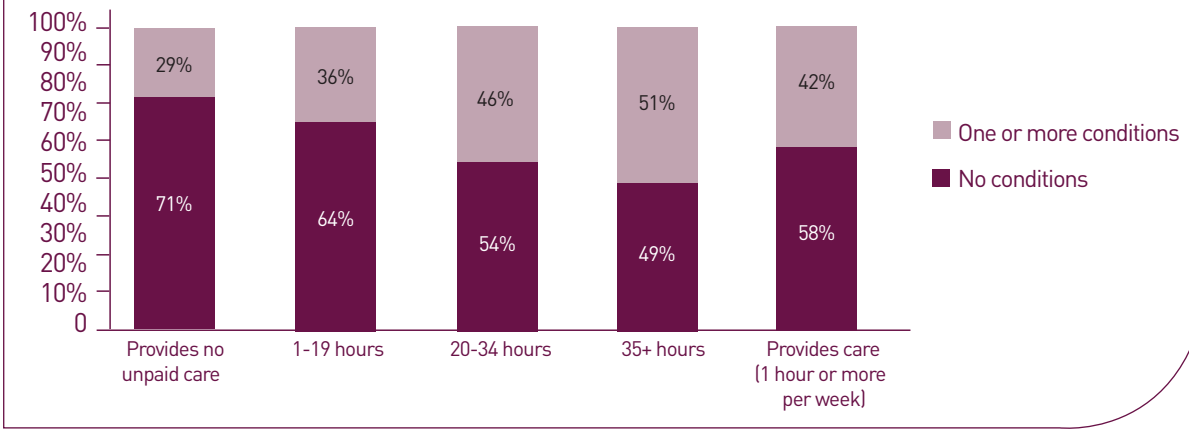
Carers in the Borders

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

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

FIGURE 9

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



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

WHAT THIS MEANS...

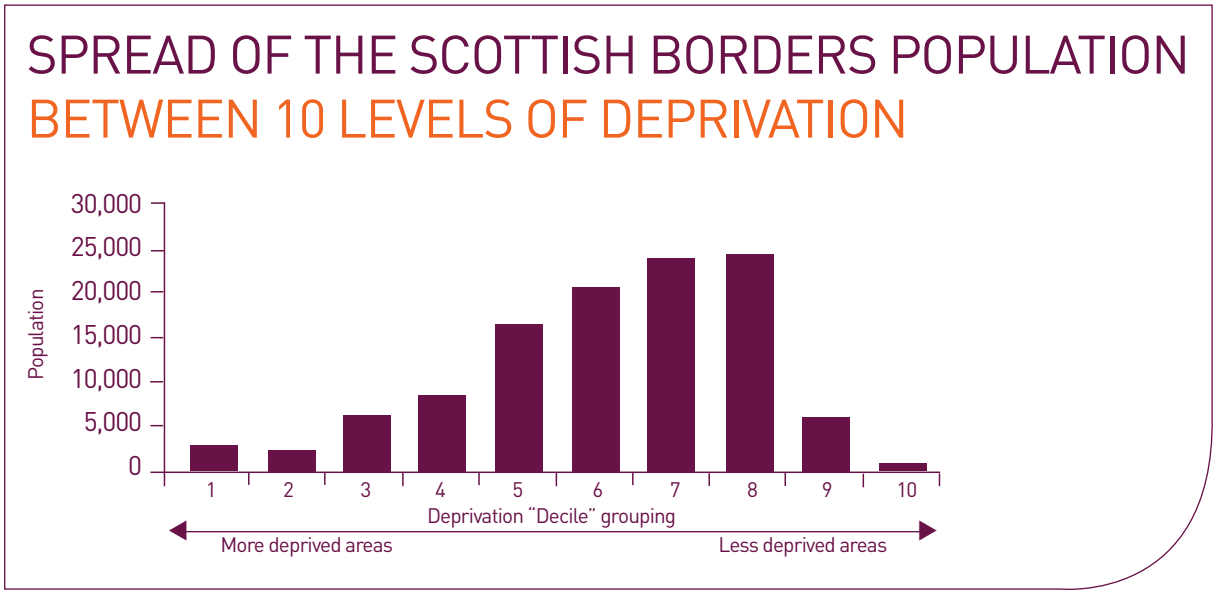
A range of easily accessible information and available support needs to be a key priority to ensure the wellbeing of Carers.

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

Deprivation in the Scottish Borders

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

FIGURE 10



Source: Scottish Borders Strategic Assessment 2014

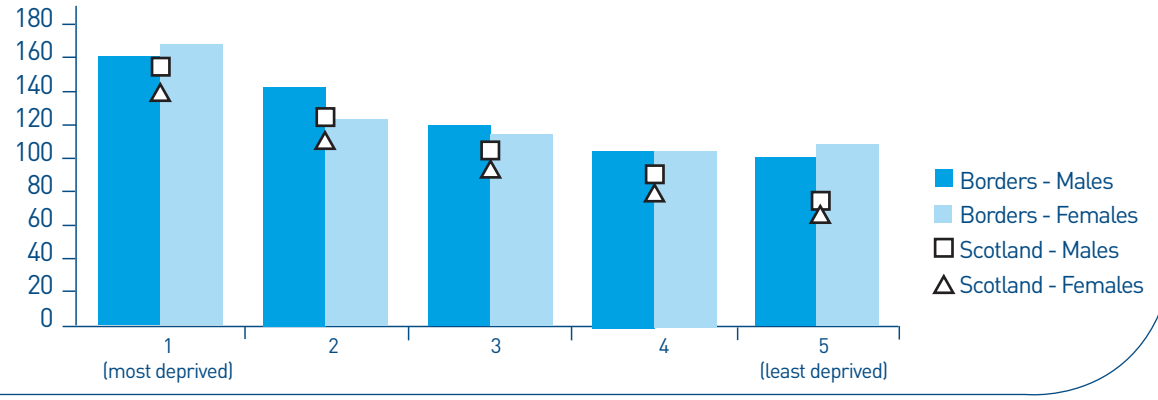
We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

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

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

FIGURE 11

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



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

WHAT THIS MEANS...

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

HEALTH AND SOCIAL CARE SPENDING

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

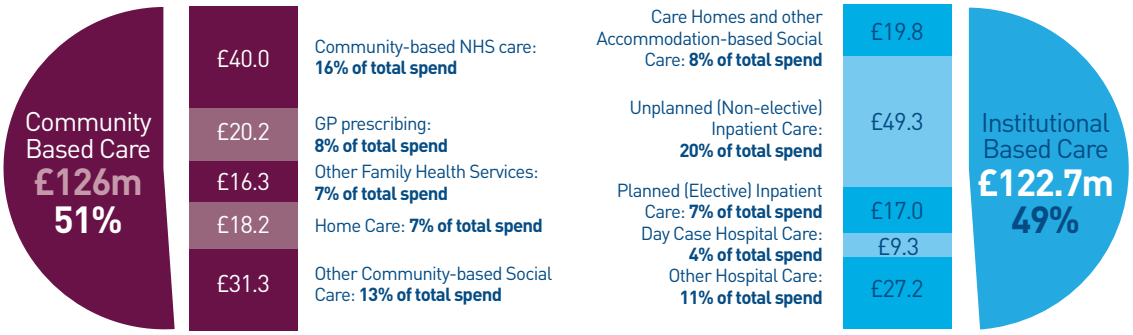
- Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.
- Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus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

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

FIGURE 12

SPEND IN £ MILLIONS

HOW THIS BREAKS DOWN: SPEND IN £ MILLIONS IN THE BORDERS 2013/14



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

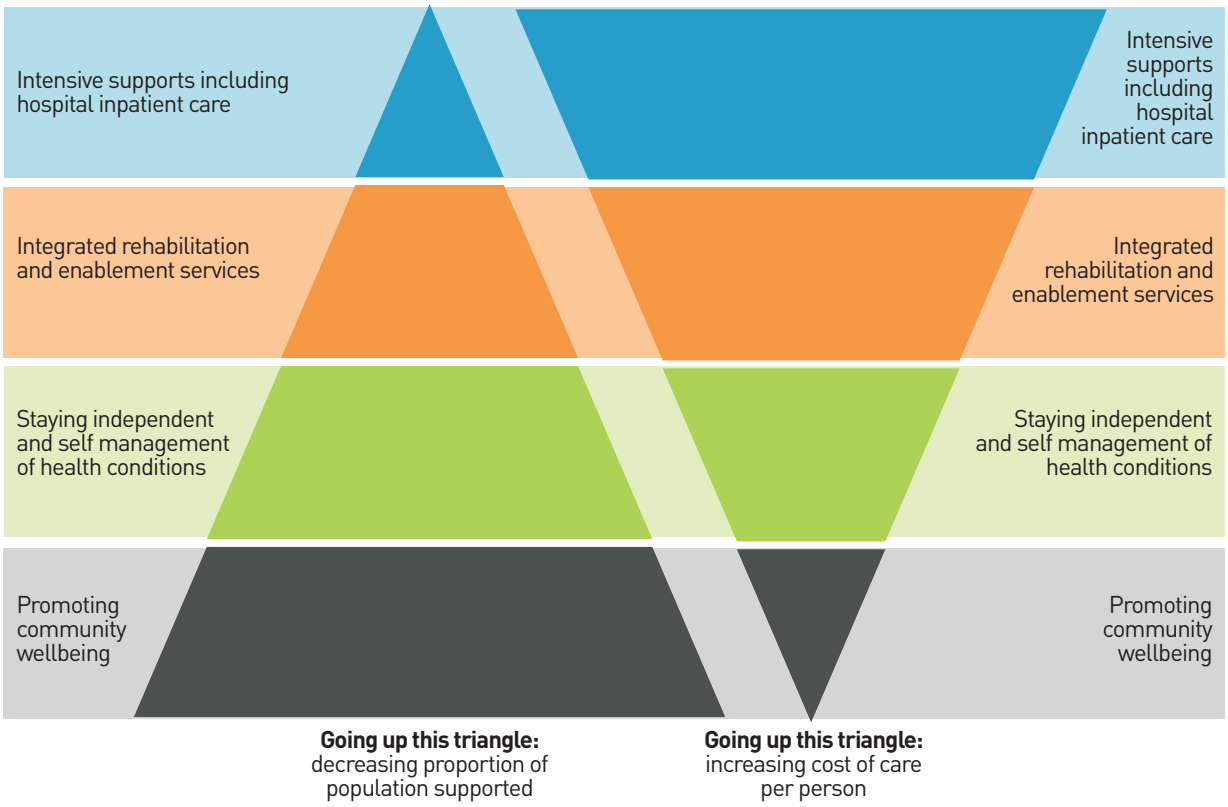
Shifting the Balance of Care Towards Prevention and Early Intervention

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

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

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

FIGURE 13
CURRENT CARE MODEL

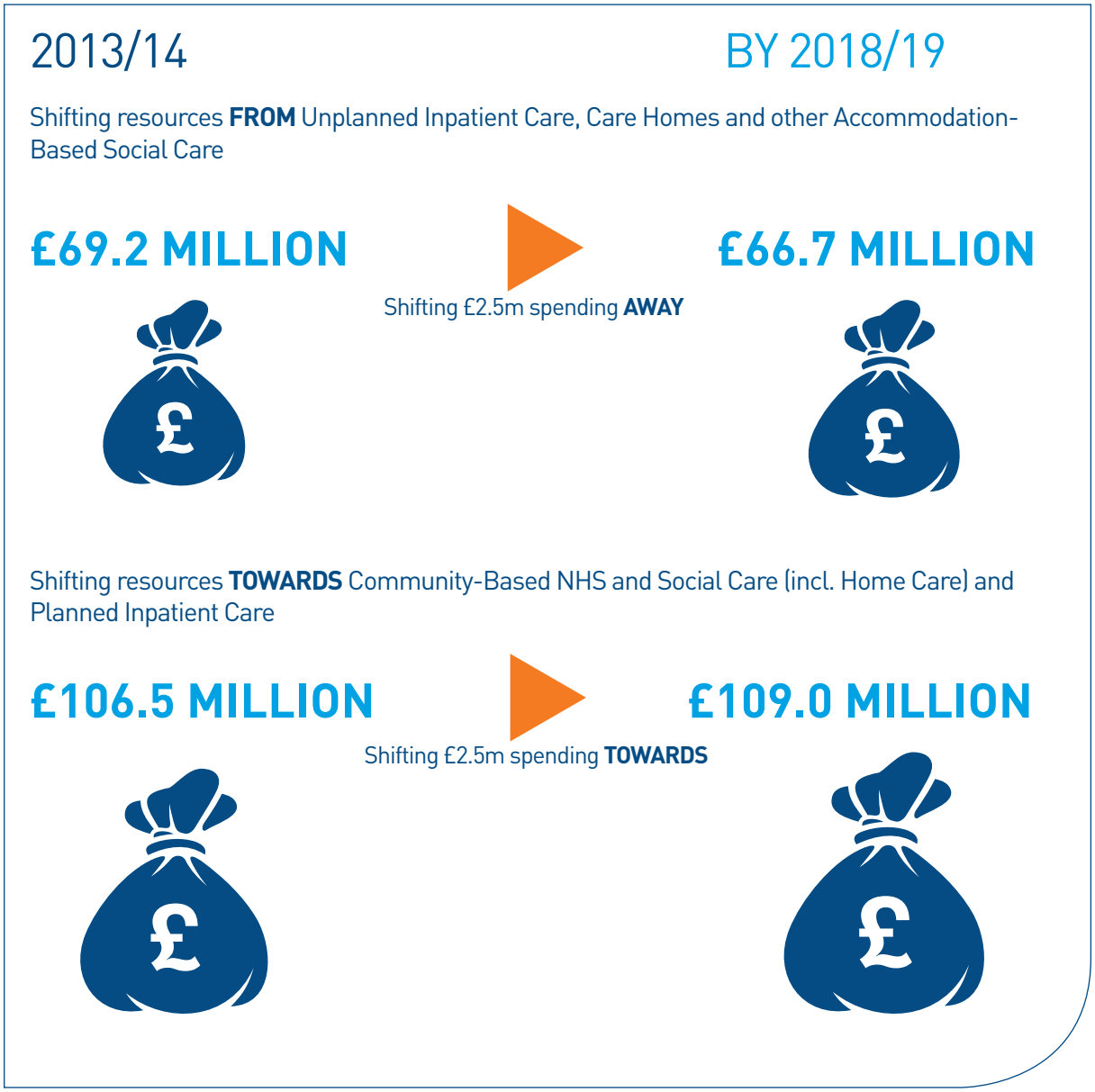


If we are able to improve health and wellbeing through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in Figure 14.

What shifts do we need to make?

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

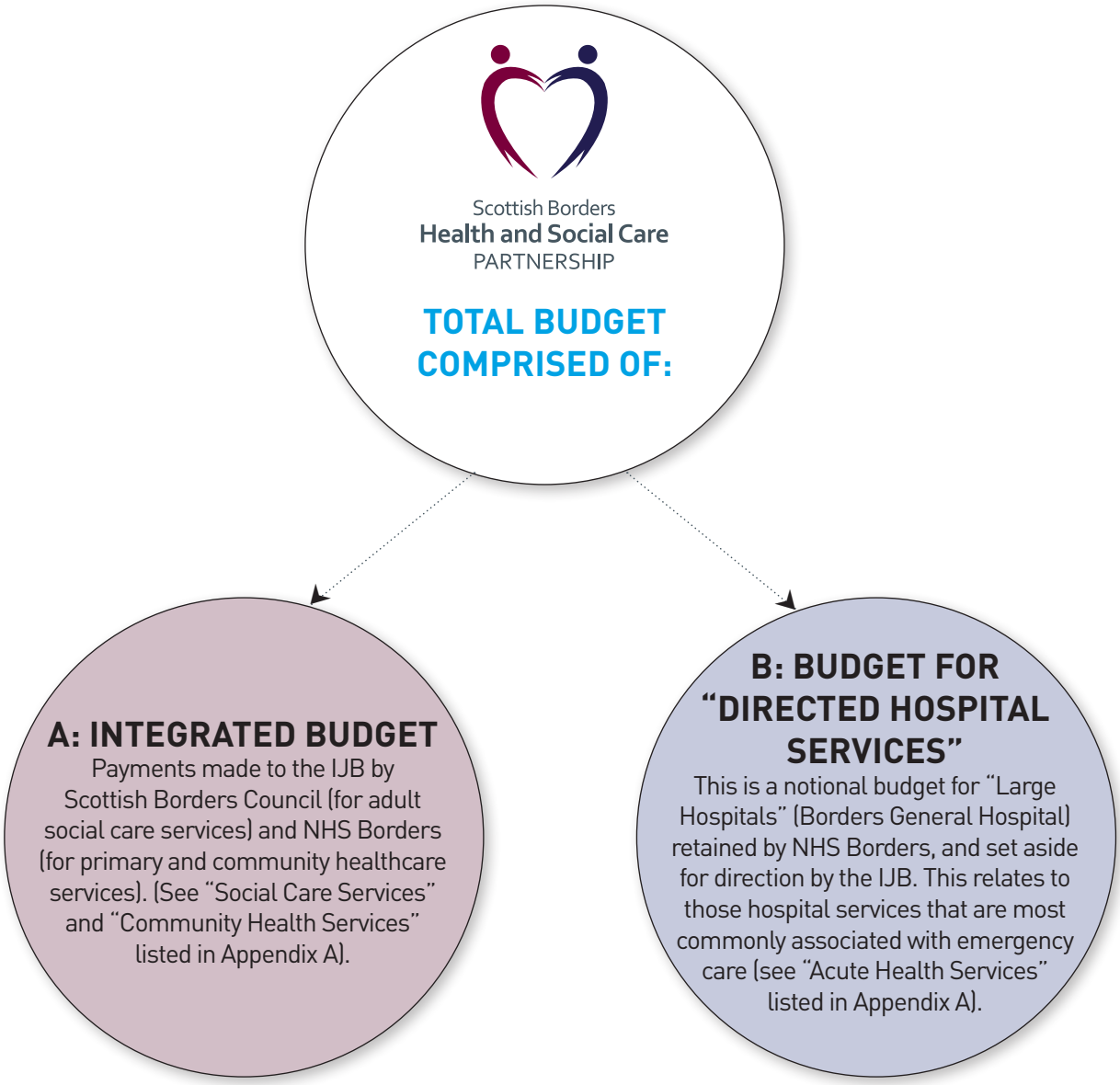
FIGURE 14



The Health and Social Care Partnership's budget

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

FIGURE 15



WHAT YOU SAID AND WHAT WE PLAN TO DO

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

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

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

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

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

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

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

The characteristics that are protected under the Act are:

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

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

OBJECTIVE 1

We will make services more accessible and develop our communities

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

What we heard you say is important to you:

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

We want to:

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

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

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

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

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

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

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

OBJECTIVE 2

We will improve prevention and early intervention

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

What we heard you say is important to you:

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

We want to:

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

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

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

OBJECTIVE 2 - continued

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

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

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

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

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

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

OBJECTIVE 3

We will reduce avoidable admissions to hospital

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

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

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

We want to:

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

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

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

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

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

OBJECTIVE 3 - continued

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

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

OBJECTIVE 4

We will provide care close to home

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

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

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

We want to:

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

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

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

OBJECTIVE 4 - continued

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

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

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

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

OBJECTIVE 5

We will deliver services within an integrated care model

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

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

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

We want to:

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

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

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

OBJECTIVE 5 - continued

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

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

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

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

OBJECTIVE 6

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

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

What we heard you say is important to you:

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

We want to:

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

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

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

OBJECTIVE 6 - continued

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

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

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

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

OBJECTIVE 7

We will further optimise efficiency and effectiveness

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

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

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

We want to:

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

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

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

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

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

OBJECTIVE 7 - continued

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

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

OBJECTIVE 8

We will seek to reduce health inequalities

Ensuring that people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.

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

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

We want to:

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

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

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

OBJECTIVE 8 - continued

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

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

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

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

OBJECTIVE 9

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

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

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

We want to:

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

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

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

OBJECTIVE 9 - continued

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

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

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

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

Planning for Change – Key Priorities

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

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

LOCALITY PLANNING

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

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

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

They will:

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

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

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

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

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

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

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

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

Some illustrative Facts and Statistics about our Area Forum Localities

Tweeddale

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

Eildon

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

Berwickshire

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

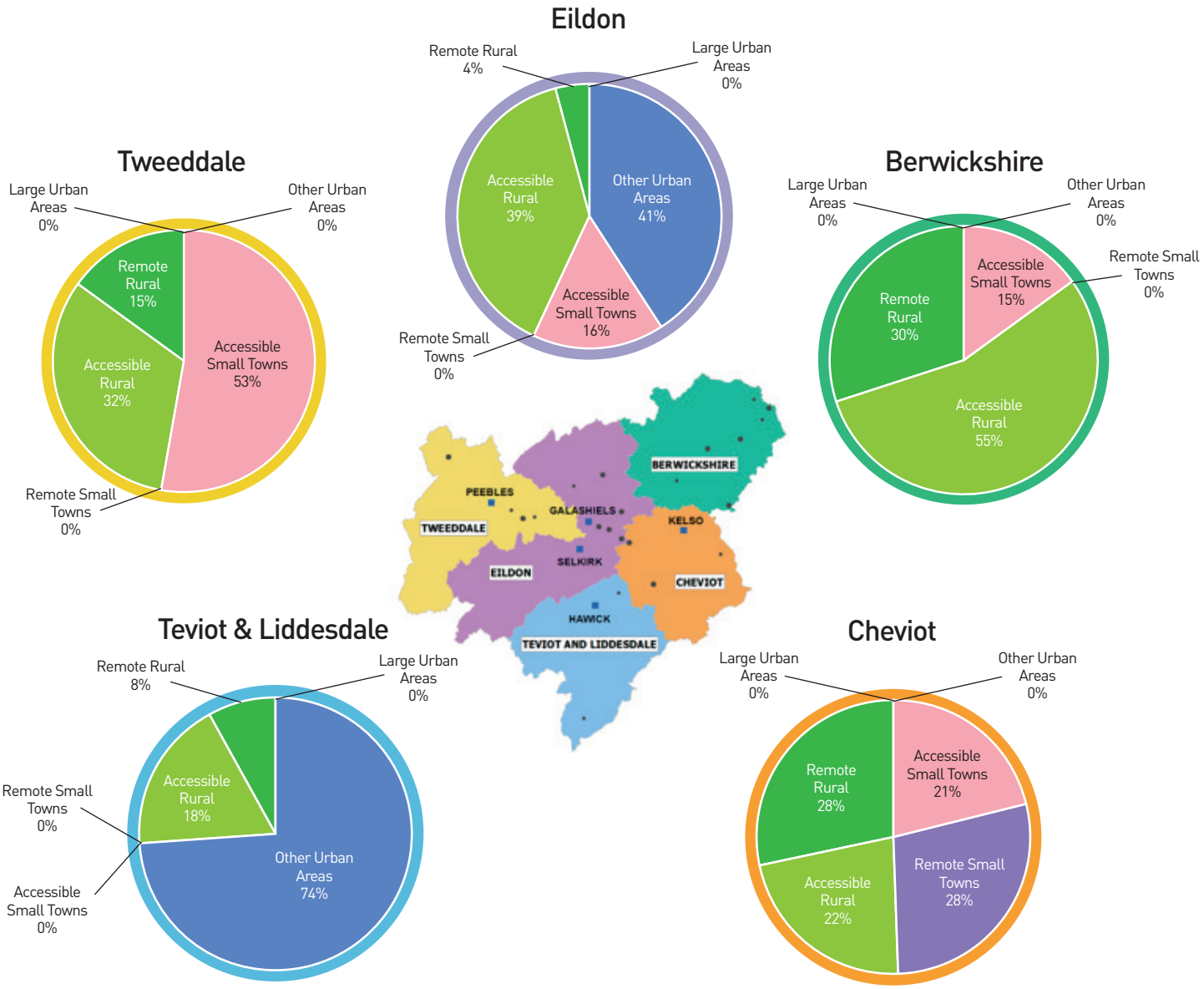
Cheviot

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

Teviot & Liddesdale

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

OUR AREA FORUM LOCALITIES AND THEIR URBAN/ RURAL POPULATION PROFILES



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

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

WHAT WILL SUCCESS LOOK LIKE

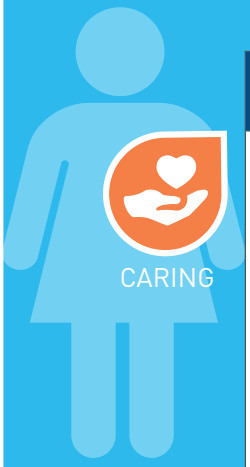
- Services are integrated and there is less duplication
- There is easier access to services through a single point of contact
- People with multiple long term conditions are supported
- Carers will feel better supported and have improved health and well-being
- Make best use of staff
- People participate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

PLANNING FOR INTEGRATED SERVICES

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

PAMELA AGE 57

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



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

HOME

FAMILY

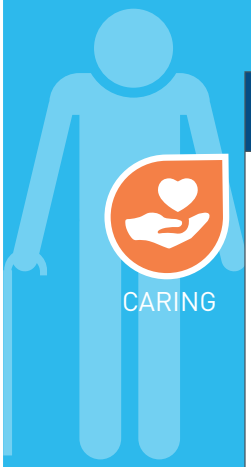
PAMELA
AGE 57

Continued ...

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

CHARLIE AGE 78

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



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

CHARLIE
AGE 78

Continued ...

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

PLANNING INTO THE FUTURE

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

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

APPENDIX A
SERVICES THAT ARE INTEGRATING

Which health and social care services are we integrating?

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

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

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

APPENDIX B
THE NATIONAL HEALTH AND WELLBEING OUTCOMES

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

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

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

Source: Scottish Government

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

Our Local Objectives are:

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

The National Outcomes cross-referenced with Our Local Objectives

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

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Changing Health & Social Care for You

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

Draft Revised Strategic Plan 2018 – 2021

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

Contents

Foreword

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

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

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

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

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

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

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

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

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

Executive Summary

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

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

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

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

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

This refreshed Strategic Plan sets out a high level summary of the continued case for transforming the way in which health and social care services are delivered in the Scottish Borders as well as identifying the key challenges in delivering on three refreshed and refocused local strategic objectives. The Plan also highlights the key priorities for the Partnership from 2018-21 and outlines a plan for the resource and delivery of these (Appendix 3).

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

Case for Change: Why we need to change

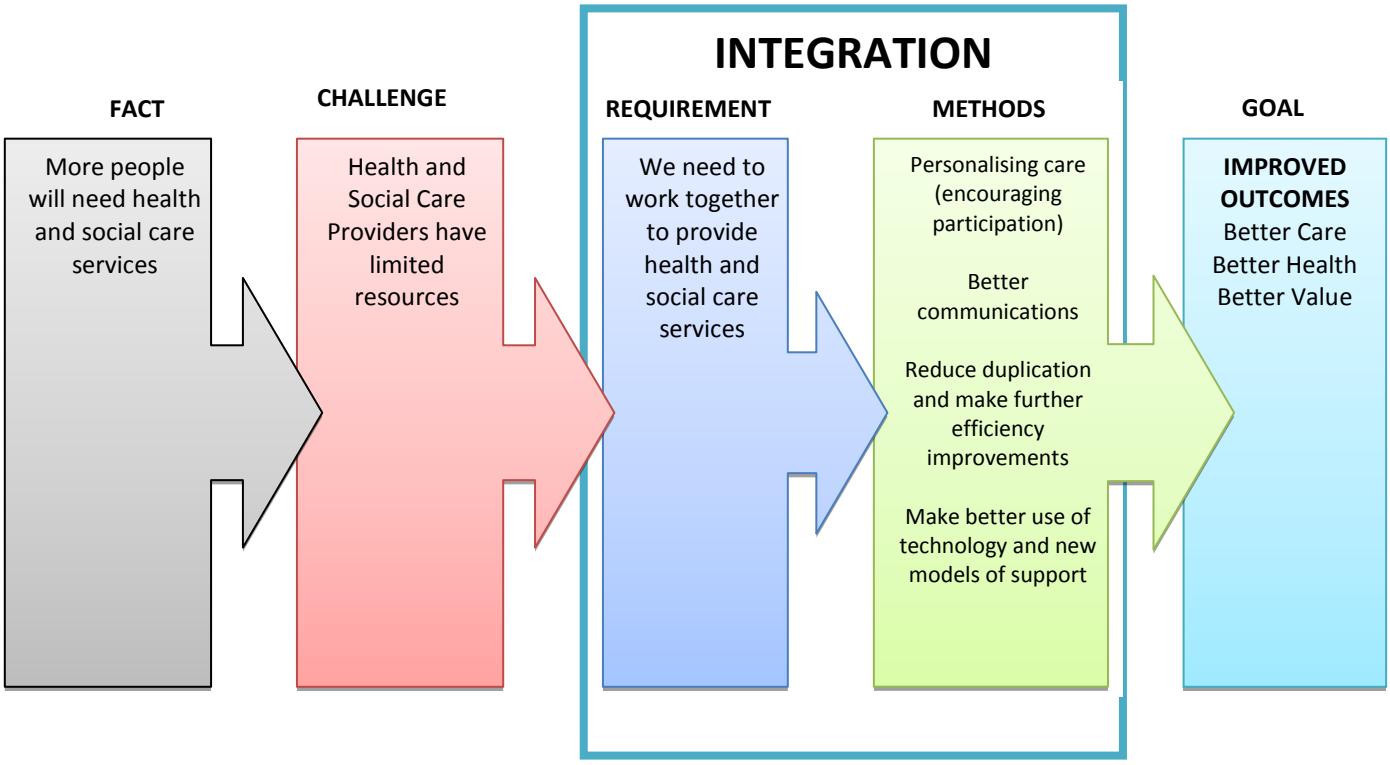
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in Figure 1 below and include:

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

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

Figure 1 – The Case for Change



Key Challenges

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

Table 1

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

These challenges are supported by evidence related to the Scottish Borders area profile and key challenges presented in **Appendix 5.**

Local Strategic Objectives

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

We have identified 3 Strategic Objectives:

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

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

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

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

Details of the Partnership's duties under the Equality Act 2010 can be seen in Appendix 6.

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

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

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

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

What will success look like?

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

OBJECTIVE 2: We will improve patient flow within and out with hospital

How?
• By reducing the time that people are delayed in hospital • By improving care/patient pathways to ensure a more co-ordinated, timely and person-centred experience/approach

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

What will success look like?

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

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

How?
• By supporting people to manage their own conditions • By improving access to health & social care services in local communities • By improving support to carers

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

What will success look like?

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

Key Priorities

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

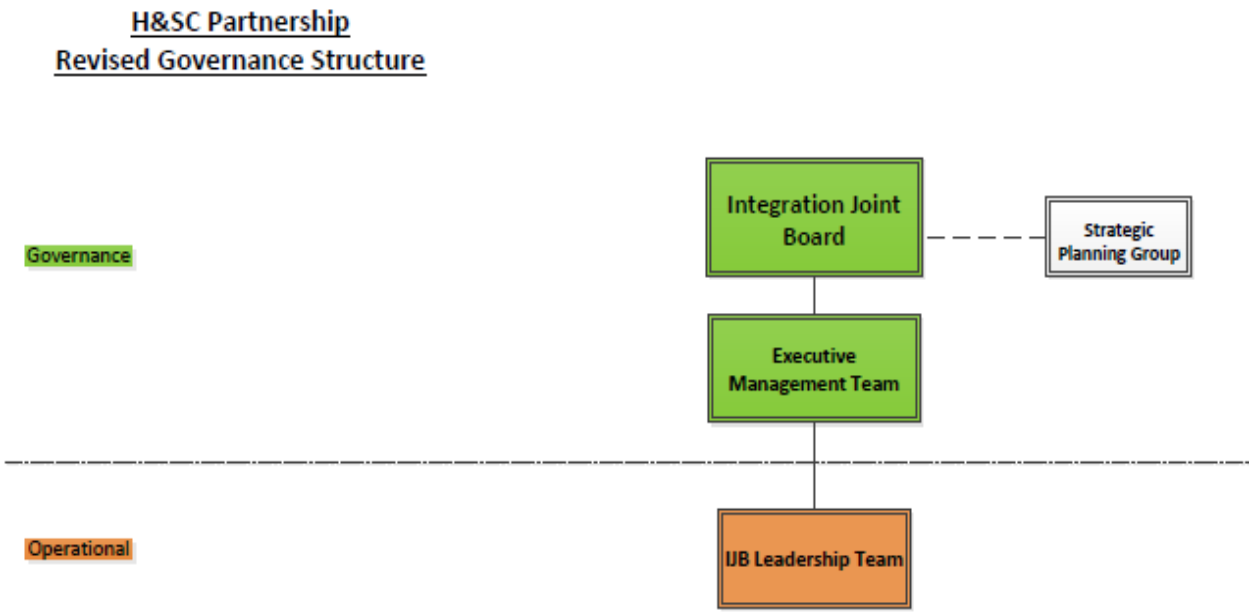
- Promote healthy living and active ageing
- Improve communication and access to information
- Work with communities to develop local solutions
- Improve support for Carers within our communities
- Integrate services at a local level
- Promote support for independence and reablement so that all adults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

Commissioning

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

Leadership and Governance

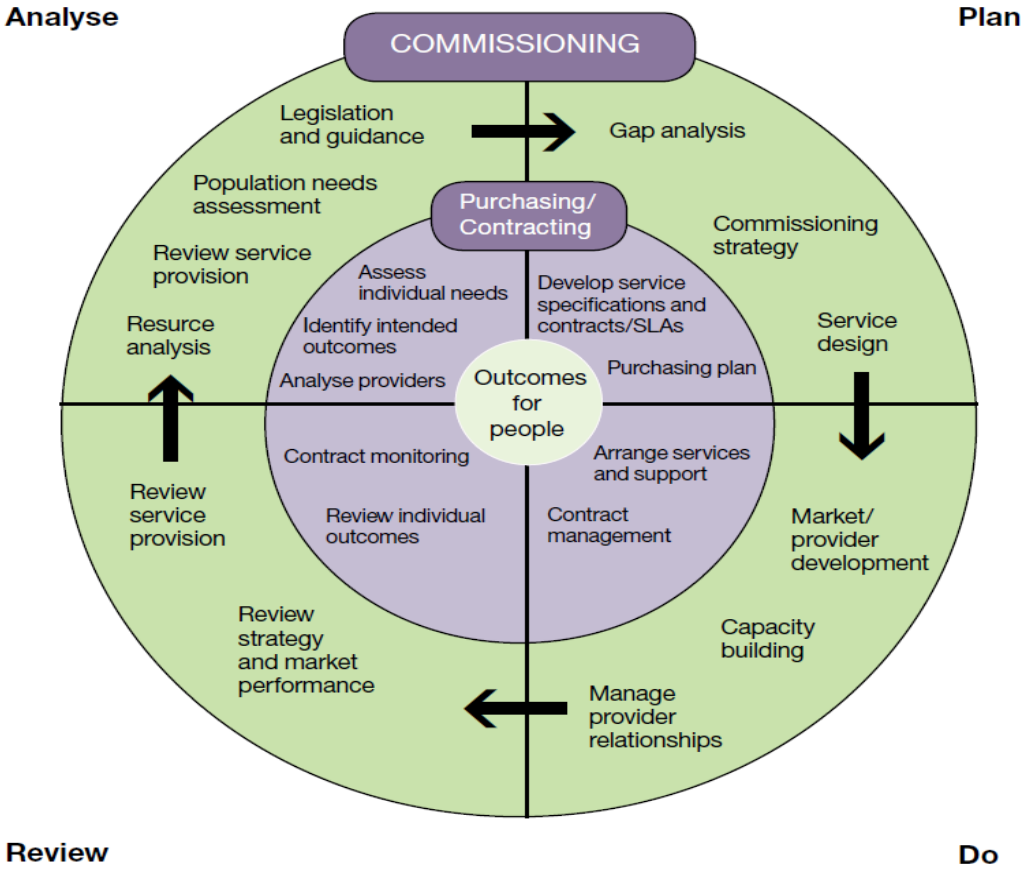
Leadership and effective governance with the Integration Joint Board (IJB) and across the partner organisations is an essential factor in the successful integration of health and social care services. In the Scottish Borders the work of the IJB is informed by, and in turn informs, the strategic priorities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



Strategic Procurement of Commissioned Services

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

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



Strategic Commissioning Cycle

Locality Planning

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

Transformational Planning

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

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

Also included in the transformation programme are:

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

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

Workforce Planning and Development

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

Evidencing Improvement

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

Communication and Engagement

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

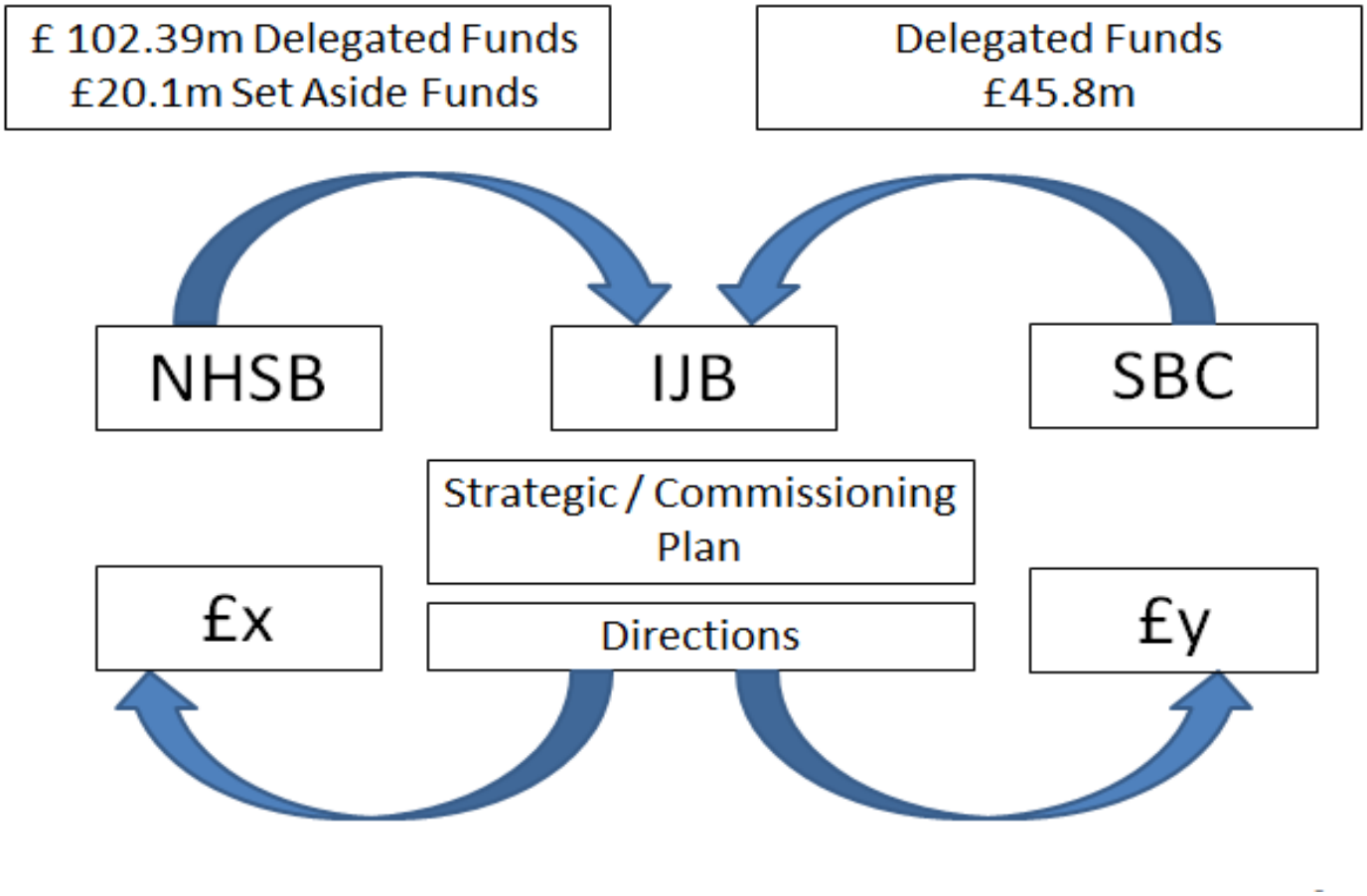
Strategic Priorities

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

Partnership Spending

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

- The Delegated Budget i.e. the sum of payments to the Integration Joint Board from (IJB) partners.
- The Notional Budget i.e. the amount set aside by NHS Borders for large hospital services used by the IJB population.



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

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

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

The integrated Care Fund (ICF) has been used to enable the shift in health and social care services from hospital to community and outreach. This has resulted in a decrease in hospital admissions and increase in alternatives to hospital care. A detailed on plan on how the partnership will deliver on its strategic objectives within agreed resource can be seen in Appendix 7.

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Appendix 1

The National Health and Wellbeing Outcomes

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

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

Source: Scottish Government

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Appendix 2

Services that are Integrated

Which health and social care services have we integrated?

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

ADULT SOCIAL CARE SERVICES*	ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*	COMMUNITY HEALTH SERVICES*

• Social Work Services for adults and older people;
• Services and support for adults with physical disabilities and learning disabilities;
• Mental Health Services;
• Drug and Alcohol Services;
• Adult protection and domestic abuse;
• Carers support services;
• Community Care Assessment Teams;
• Care Home Services;
• Adult Placement Services;
• Health Improvement Services;
• Re-ablement Services, equipment and telecare;
• Aspects of housing support including aids and adaptations;
• Day Services;
• Local Area Co-ordination;
• Respite Provision;
• Occupational therapy services.
	• Accident and Emergency;
	• Inpatient hospital services in these specialties:
	  ○ General Medicine;
	  ○ Geriatric Medicine;
	  ○ Rehabilitation Medicine;
	  ○ Respiratory Medicine;
	  ○ Psychiatry of Learning Disability;
	• Palliative Care Services provided in a hospital;
	• Inpatient hospital services provided by GPs;
	• Services provided in a hospital in relation to an addiction or dependence on any substance;
	• Mental health services provided in a hospital, except secure forensic mental health services.
		• District Nursing;
		• Primary Medical Services (GP practices)*;
		• Out of Hours Primary Medical Services*;
		• Public Dental Services*;
		• General Dental Services*;
		• Ophthalmic Services*;
		• Community Pharmacy Services*;
		• Community Geriatric Services;
		• Community Learning Disability Services;
		• Mental Health Services;
		• Continence Services;
		• Kidney Dialysis outwith the hospital;
		• Services provided by health professionals that aim to promote public health;
		• Community Addiction Services;
		• Community Palliative Care;
		• Allied Health Professional Services

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

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

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

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

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	1 Pharmacy teams are taking on new responsibilities within GP surgeries in line with the new GMS contract pharmacotherapy service. This includes case management, supporting long term conditions (particularly respiratory disease and diabetes), care homes and polypharmacy reviews. The work should help prevent medication-related admissions and improve the quality of disease management. 2 A clinical technician is in place to support medicines management at discharge and an ICF project (using a project manager and pharmacy technician) is testing pharmacy input to patients receiving care packages. A change in the way pharmacy services are provided to the wards is speeding up the discharge process by helping to ensure medicines are ready in advance and increasing patient contact to discuss medicine issues. Medicine reviews of patients on certain medicines know to cause acute kidney injury was set up 2 years ago (Sick Day Rules). This has been shown in another Board to reduce admissions. We will continue to promote this service. 3 Increased funding for pharmacy services through the Primary Care Transformation Fund is support and increase in capacity within GP surgeries. The ICF project will free up capacity within community pharmacies by reducing carer's reliance on medicines compliance aids (MCAs), which are timely to prepare and provide a safer system to support medicines management by carers. We continue to develop the role of the community pharmacist to improve health and wellbeing, reduce admissions and demand for other services, eg. BECS	April 2017 – March 2018	demand.

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

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
People are able to access the information they require within their own community.	We will extend the scope of the Matching Unit to source care and respite care at home to meet assessed need. ***(Integrated Care Fund)***	June 2017 – December 2018	Quicker and more efficient planning of care and support. More people at home or in a homely setting including when at the end of their life. Reduced demand for care at home and other health and social care services. Reduced Revenue Costs from reduced demand and greater efficiency
	We will plan and deliver health and social care services by locality area, using the Buurtzorg model of care. ***(Integrated Care Fund)*** ***(Transformation Programme)***	April 2017 – March 2019	
	We will increase the use of telecare and telehealthcare. ***(Transformation Programme)***	October 2017 – June 2018	
	We will increase the provision of Housing with Care and Extra Care Housing. ***(Core Fund Investment)***	April 2017 – March 2020	
Health and social care services will reduce health inequalities.	We will continue to review the standard of our health centres as part of the Primary Care Modernisation Programme. This is directly linked to the new GMS Contract. ***(Core Fund Investment)***	April 2017 – March 2018	All people newly diagnosed with dementia are offered at least one year post-diagnostic support. Local health and social care services which are designed to meet local need. Improved standard of health centre premises. Increased community support work form improved health centres. Improved GP services. Greater focus on prevention will result in
	The Cluster Leads is concluded, as we have to have cluster leads as part of the new contract. This is directly linked to the new GMS Contract. ***(Integrated Care Fund)***	April 2017 – March 2018	
	We will continue to deliver Post Diagnostic Support to a higher proportion of people with dementia. In the last year the NHS Mental Health Older Adult service has moved from paper to electronic records	October 2017 – October 2018	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	(EMIS) affording the opportunity for revision of our Post Diagnostic Support pathway which is under way. At beginning of May 2018 a revised recording template will be implemented to provide a live and interactive template for each person with a diagnosis of dementia and will allow direct national reporting and local audits to be conducted which will result in improved PDS going forward. **(Core Funding Investment)**		reduced Revenue costs from reduced demand and increased efficiency.
	We will continue to increase appropriate GP referrals for people with dementia. Over the last year primary care colleagues have been alerted to the importance of referrals of people with a suspected diagnosis of dementia through a variety of means. Including at the November Medical Education session and a data cleansing process matching diagnoses known in mental health with the primary care dementia register. **(Core Funding Investment)**	October 2017 – October 2018	

Objective 2: We will improve patient flow within and out with hospital

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

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

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

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

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

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

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

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

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

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

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/Benefits
	We will continue to review the standard of our health centres as part of the Primary Care Modernisation Programme. This is directly linked to the new GMS Contract. **(Core Funding Investment)**	April 2017 – March 2018	
	The Cluster Leads is concluded, as we have to have cluster leads as part of the new contract. This is directly linked to the new GMS Contract. **(Integrated Care Fund)**	April 2017 – March 2018	
People who provide unpaid care are supported to look after their own health and wellbeing in order to fulfil their caring role.	We will deliver the requirements of the Carers (Scotland) Act 2016 by 1st April 2018. **(Other External Funding)**	April 2017 – March 2018	Improved and more consistent support for carers. Better understanding of the numbers of people providing informal care.
	We will continue to commission the Borders Carers Centre to undertake all carers' assessments. **(Core Funding Investment)**	April 2017 – March 2019	
	We will meet all identified carer needs which are assessed as critical. **(Core Funding Investment)**	April 2017 – March 2019	

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

Housing Contribution Statement

Scottish Borders COUNCIL

CONTENTS

1. INTRODUCTION

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

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

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

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

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

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

2. LOCAL HOUSING STRATEGY

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

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

LHS VISION

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

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

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

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

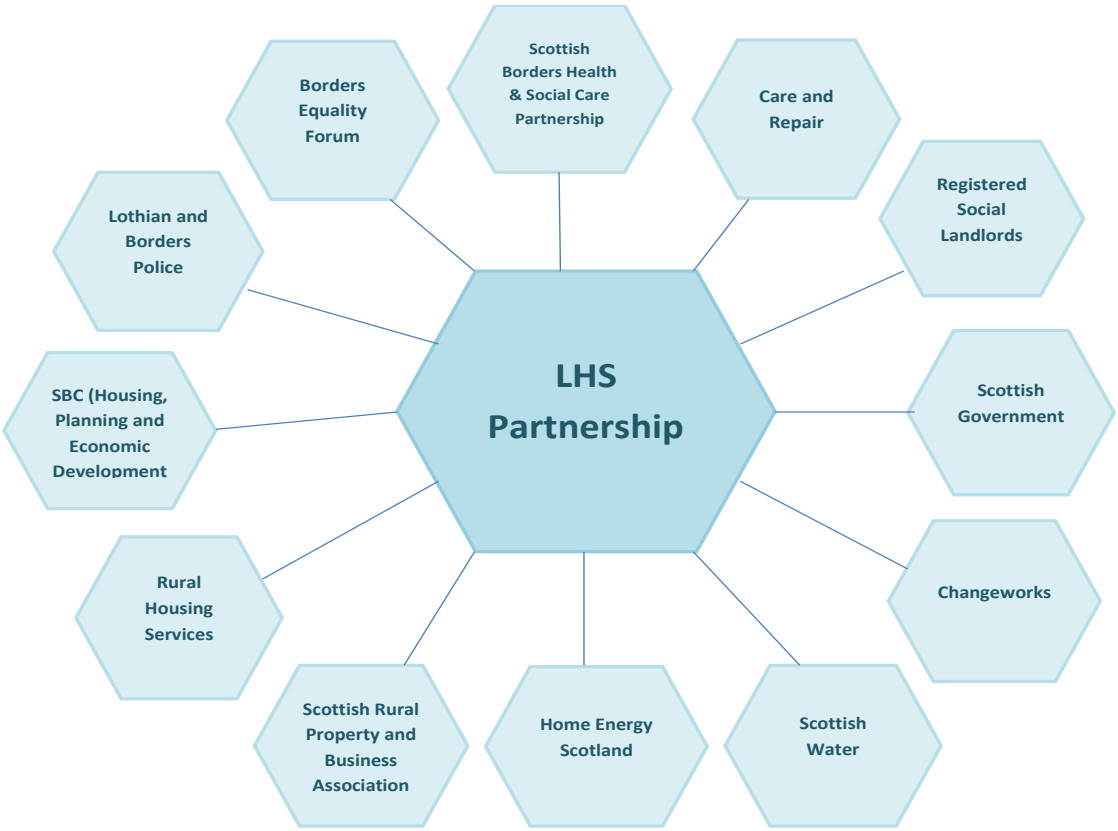
The refreshed strategic plan, the LHS, and this Housing Contribution Statement sets out clearly the contribution that housing can make in support of this agenda, through the design and delivery of housing and housing related services, that are capable of responding to the needs of individuals as and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

Local Housing Strategy Partnership

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

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

Figure 1: LHS Partnership



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

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

3. HOUSING PROFILE

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

Figure 2: Housing Profile

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

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

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

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

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

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

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

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

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

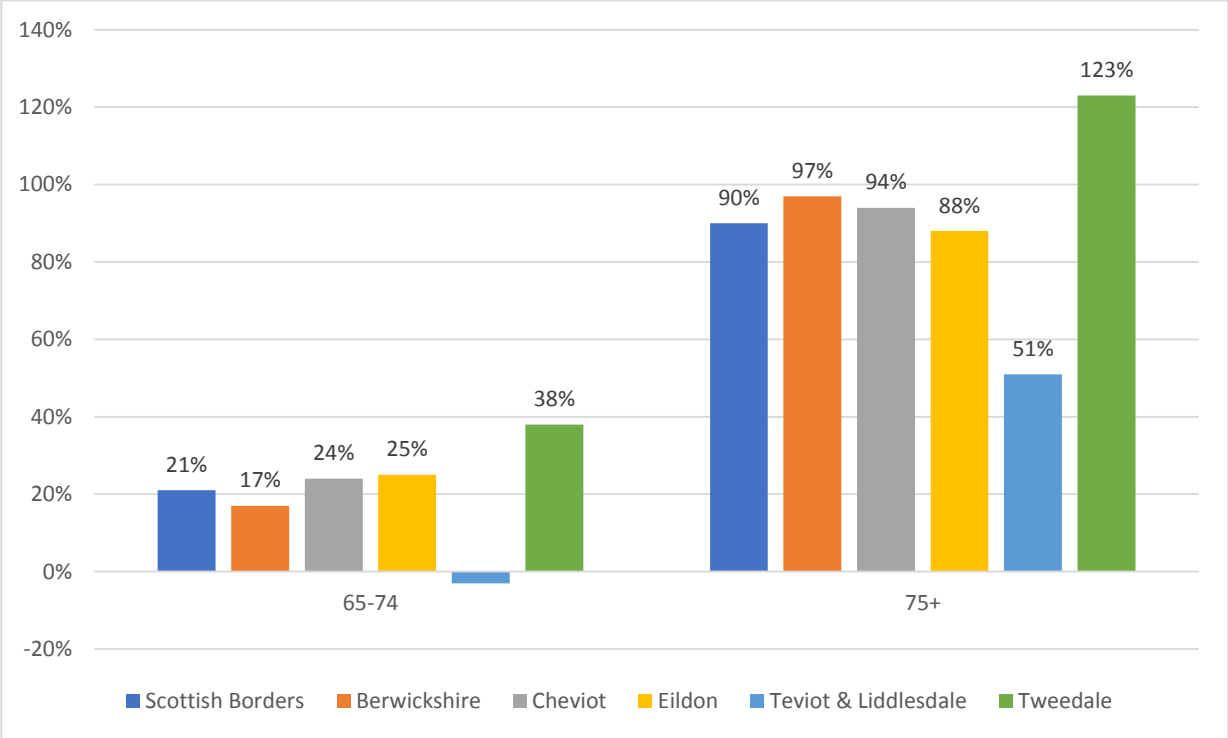
Specialist Provision
- 19 residential care/nursing homes providing 700 places
- more than 170 extra care housing/housing with care spaces
- over 400 sheltered and 52 very sheltered houses, with over 2,000 different types of specialist social rented housing targeted for older people
- more than 750 adaptations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

Older people in the Scottish Borders

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

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

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



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

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

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

Housing Need and Demand Assessment

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

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

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

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

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

4. HEALTH AND SOCIAL CARE PARTNERSHIP

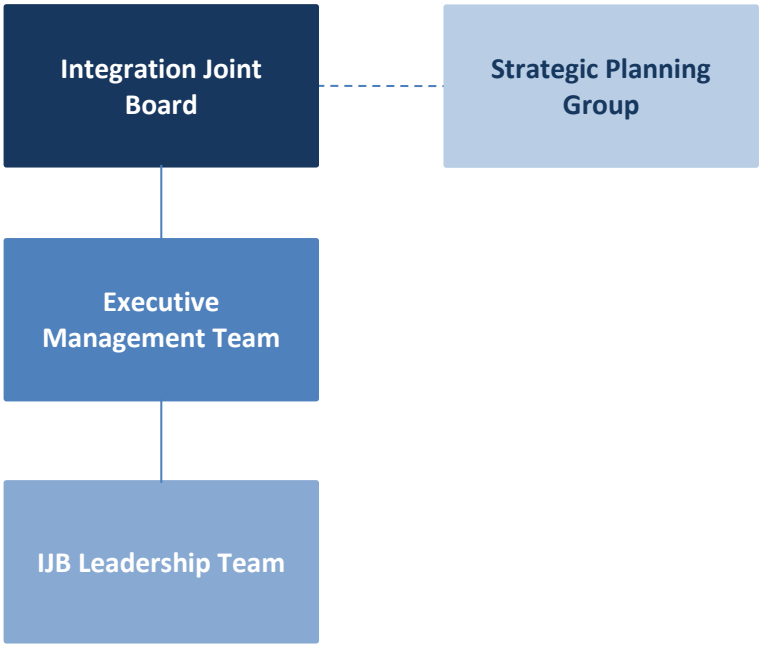
The Scottish Borders Health and Social Care Partnership launched in April 2015. The partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The total NHS and social care spending in the Borders in 2015/16 was £276.3m. The partnership has a key relationship with acute services in relation to unplanned hospital admissions and will continue to work in partnership with Community Planning Partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, and we can also work in partnership with our communities.

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

Governance

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

Figure 4: Integration Joint Board Governance Arrangements



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

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

Table 1: Strategic Planning Group

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

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

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

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

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

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

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

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

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

Figure 5: Area Forum Localities

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

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

5. DELEGATED AND NON-DELEGATED FUNCTIONS

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

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

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

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

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

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

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

Figure 6: National Health and Wellbeing Outcomes

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

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

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

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

Table 2: Links between Strategic Objectives and LHS Outcomes

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

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

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

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

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

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

Table 3: Housings Contribution towards Strategic Plan Objectives and Principles

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

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

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

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

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

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

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

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

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

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

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

WHAT THIS MEANS…

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

7. PRIORITIES AND CHALLANGES

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

Priorities

Housing Support and Homelessness

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

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

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

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

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

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

Access to housing

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

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

Affordable warm and fuel poverty

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

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

Key areas for action include:

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

Adaptations

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

A 2012 study about adaptations found that:

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

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

Priorities include:

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

Housing supply

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

Priority:

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

Private sector

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

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

Sustainable places

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

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

Ongoing Challenges

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

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

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

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

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

8. RESOURCES

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

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

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

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

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

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

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

New-build housing

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

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

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

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

Housing improvement across all tenures

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

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

- Berwickshire Housing Association £41k

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

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

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

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

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

Housing Support Services

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

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

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

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

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

Table 4: Financial Plan

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

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

Monitoring and Review

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

- worked towards delivering against our strategic priorities;
- performed in relation to the National Health and Wellbeing Outcomes;

- performed in relation to our local objectives;
- performed financially within the current reporting year;
- progressed locality planning arrangements;
- performed in inspections carried out by scrutiny bodies.

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

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

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

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

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

This Housing Contribution Statement has been approved by:

Scottish Borders Council Chief Housing Officer
Cathie Fancy
Signature

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

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The Scottish Borders: Profile and Key Challenges

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

Who Lives in the Borders?

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

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

Figure 1 Population 2017

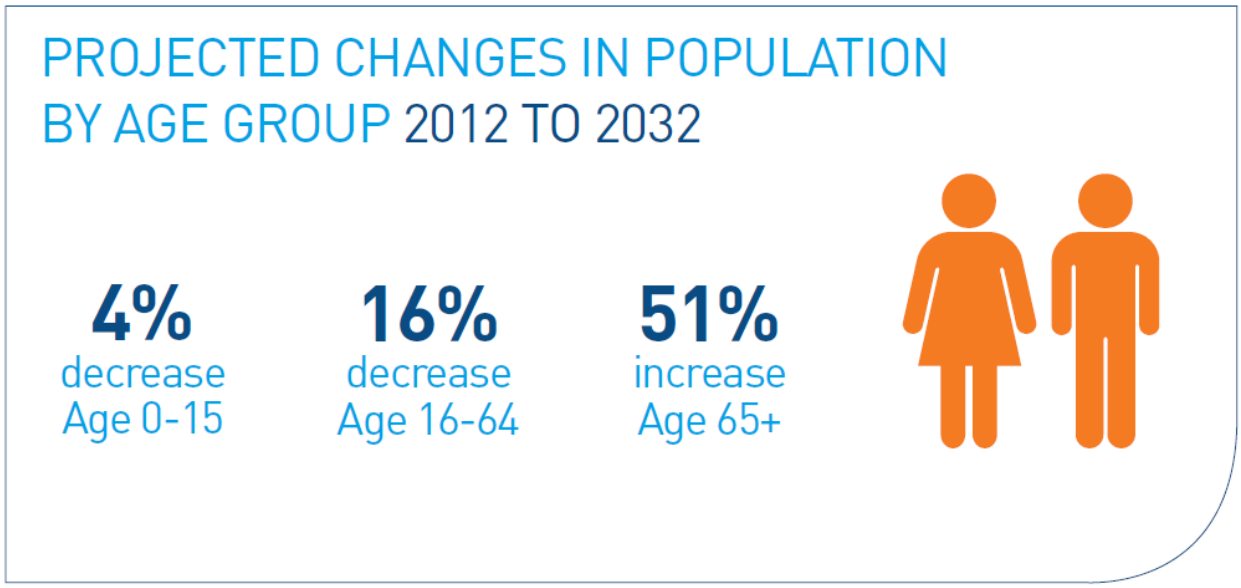
				Scottish Borders	Scotland
		Age 0-15	19,026	17%	17%
All People		Age 16-49	41,420	36%	44%
115,020		Age 50-64	26,875	23%	21%
		Age 65-74	15,715	14%	10%
	59,231 55,789	Age 75+	11,984	10%	8%

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

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

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

Figure 2



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

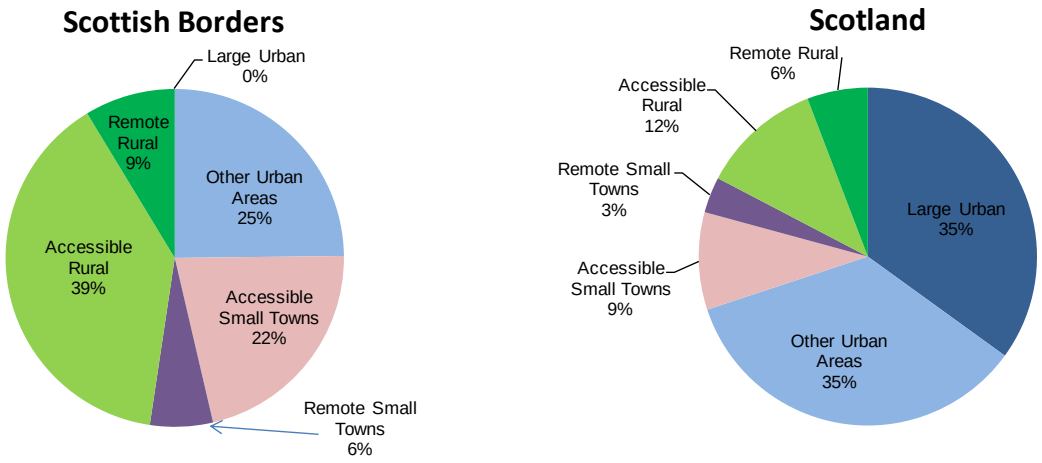
WHAT THIS MEANS…
We need to promote active ageing and address the range of needs of older people.

Where do people live?

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

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

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



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

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

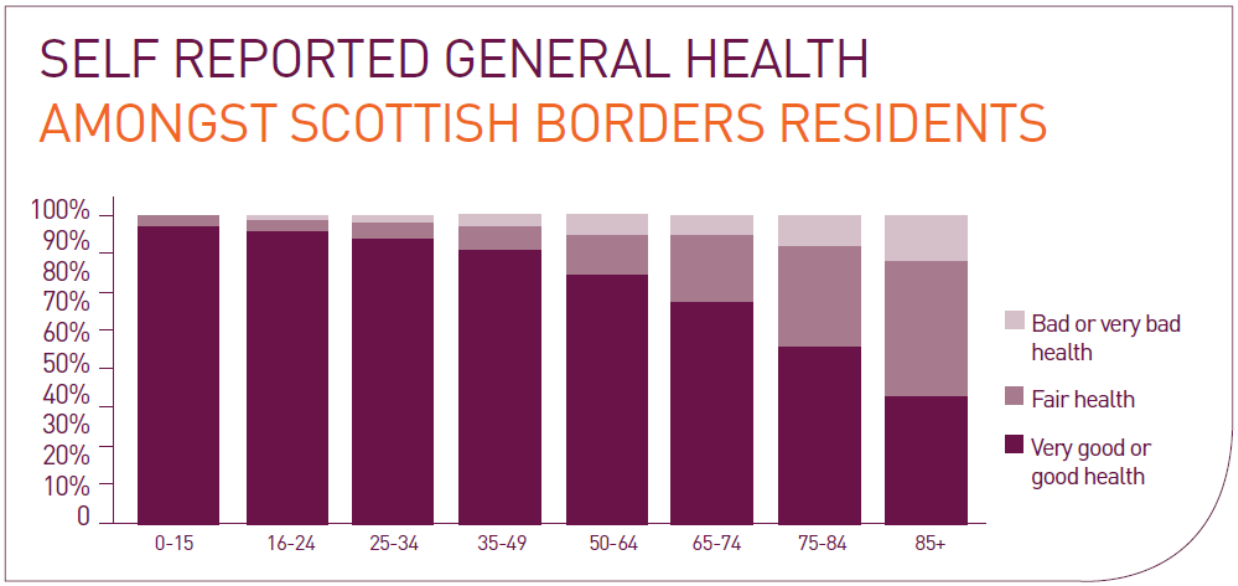
WHAT THIS MEANS…
Services need to be provided locally whenever possible and accessible transport arrangements put in place.

How Do People in the Borders View Their Health?

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

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

Figure 4



Source: Scotland Census 2011

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

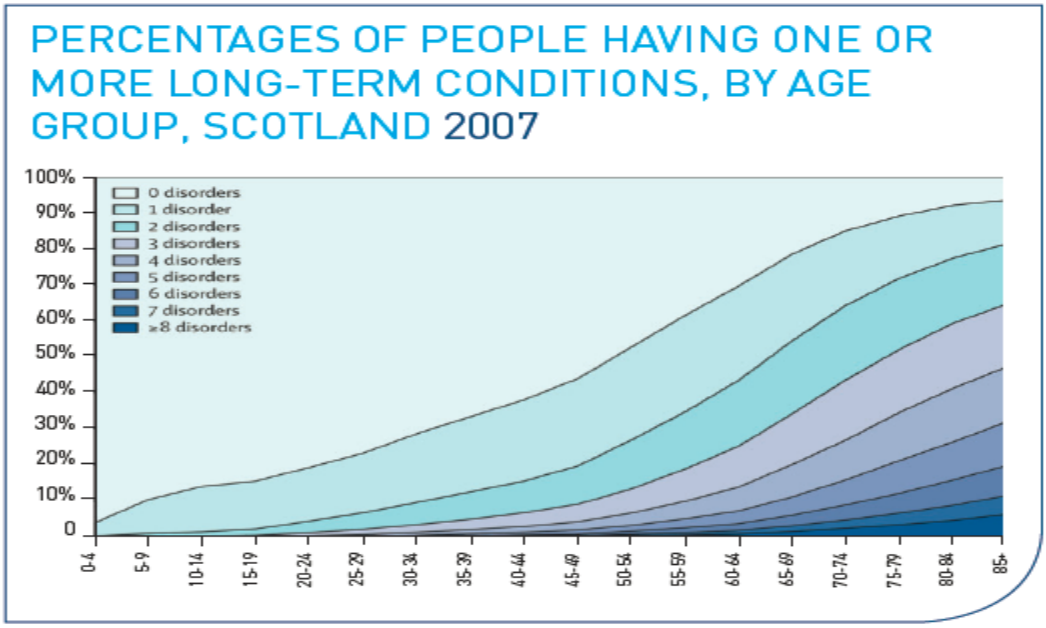
How is health affected in the Scottish Borders?

Long Term Conditions

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

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

Figure 5



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

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

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

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

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

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

Disability & Sensory Impairment

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

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

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

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

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

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

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

WHAT THIS MEANS…

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

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

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

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

Mental Health

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

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

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

Dementia

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

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

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

Sources:

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

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

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

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

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

WHAT THIS MEANS…

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

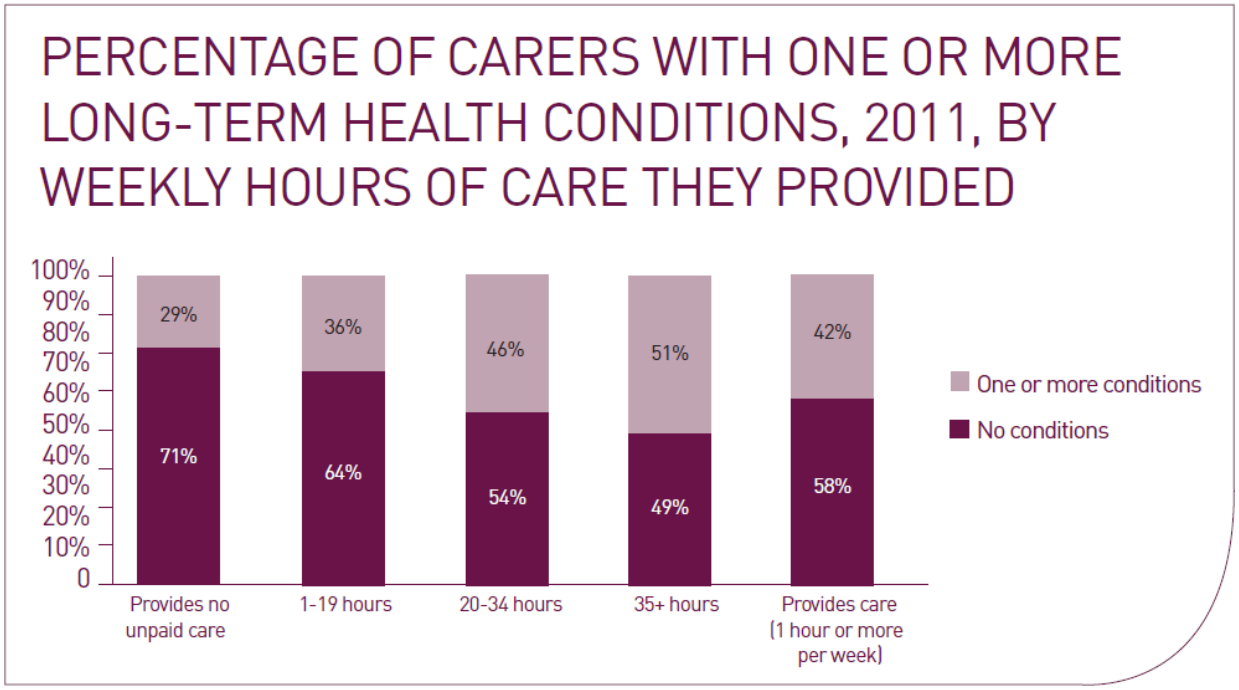
Providing a Caring Role

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

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

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

Figure 9



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

WHAT THIS MEANS…

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

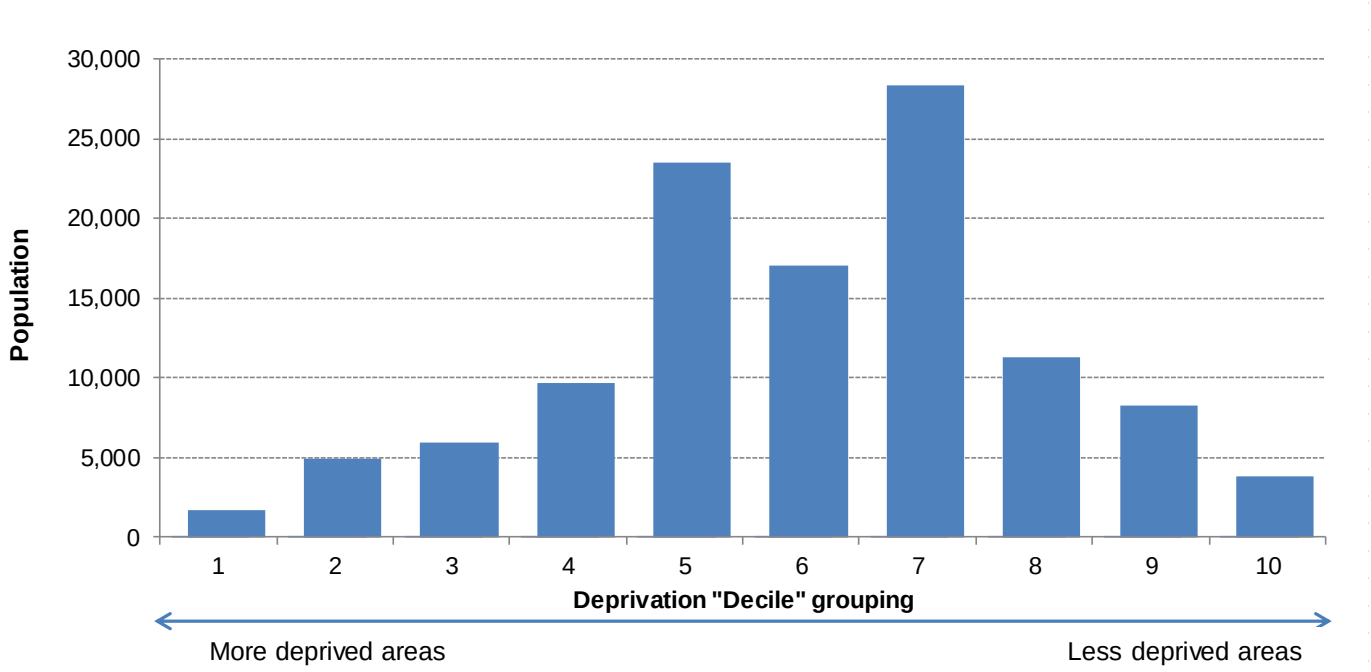
- Carers are identified early and that a range of easily accessible information is available;
- There is a clear pathway for carers to access support and a carers eligibility criteria is in place;
- Carers are informed and involved in hospital discharge planning;
- Carers have a strong voice in planning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

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

Deprivation in the Scottish Borders

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

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



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

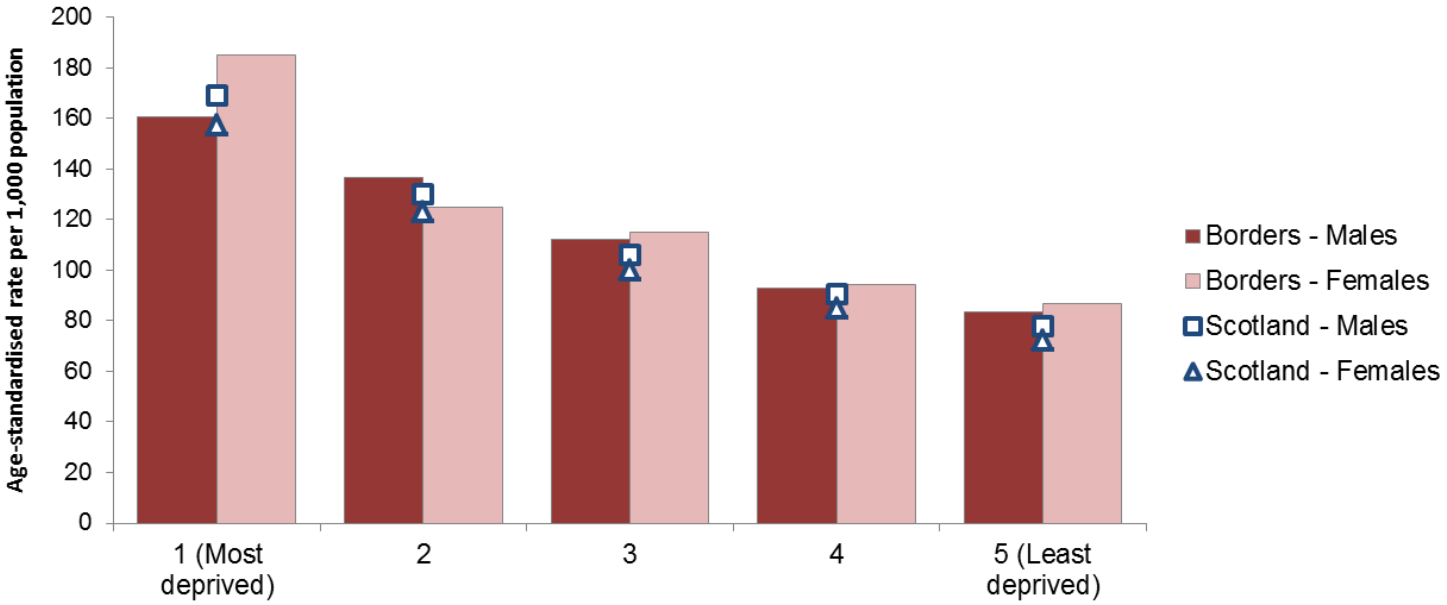
We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

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

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

Figure 11

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



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

WHAT THIS MEANS…

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

Equalities

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

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

The characteristics that are protected under the Act are:

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

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

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

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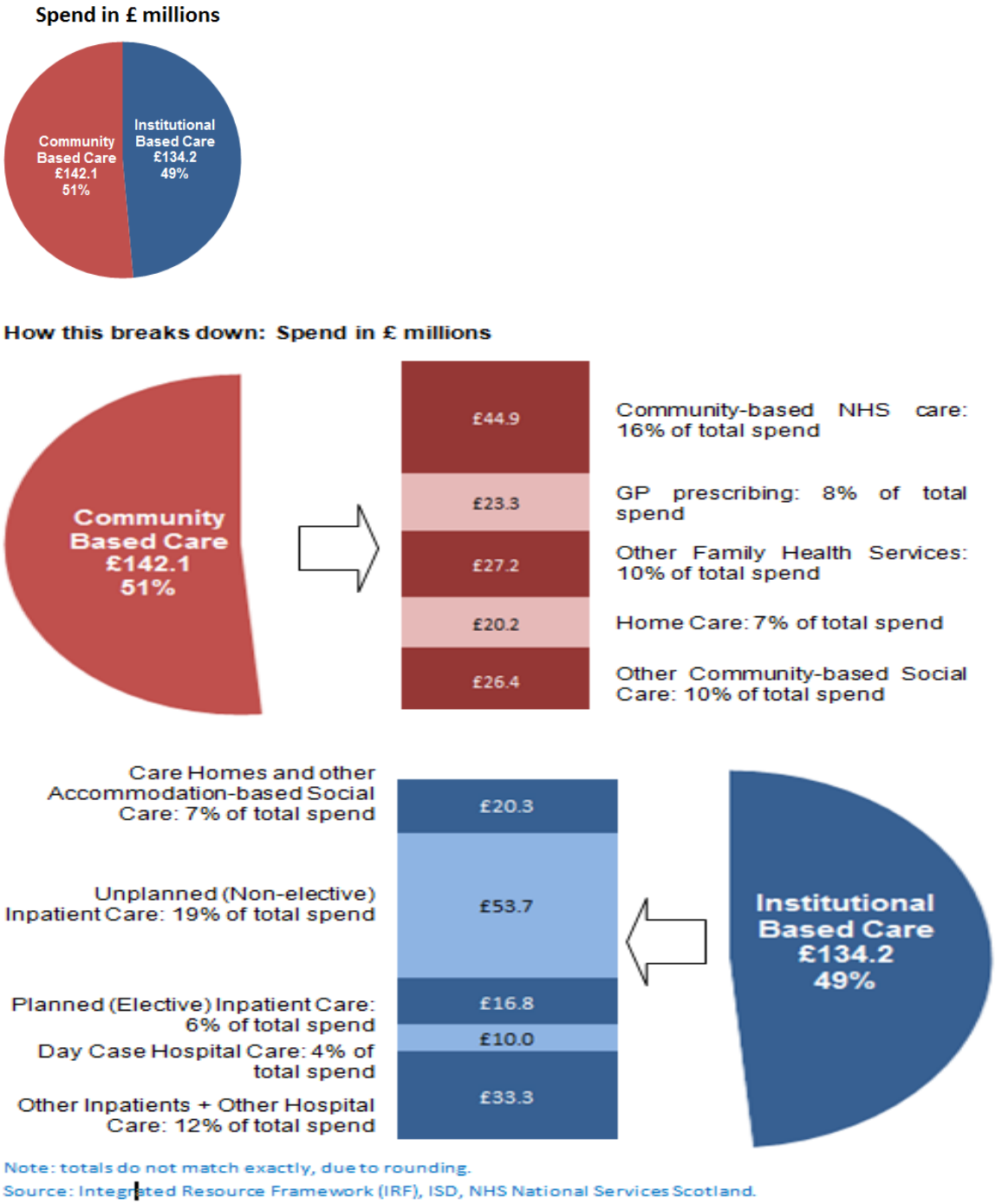
Health & Social Care Spending

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

Figure 1: How this total spend breaks down



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

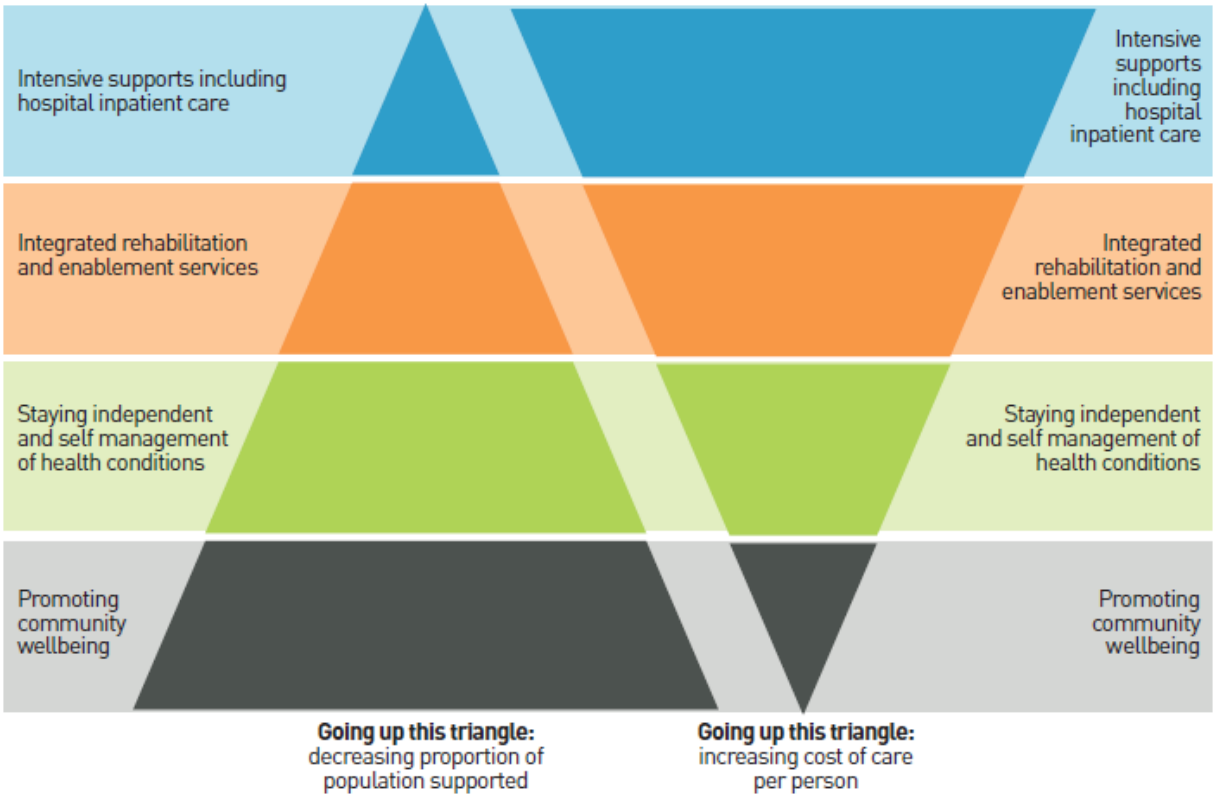
Shifting the Balance of Care Towards Prevention and Early Intervention

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

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

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

Figure 2 CURRENT CARE MODEL



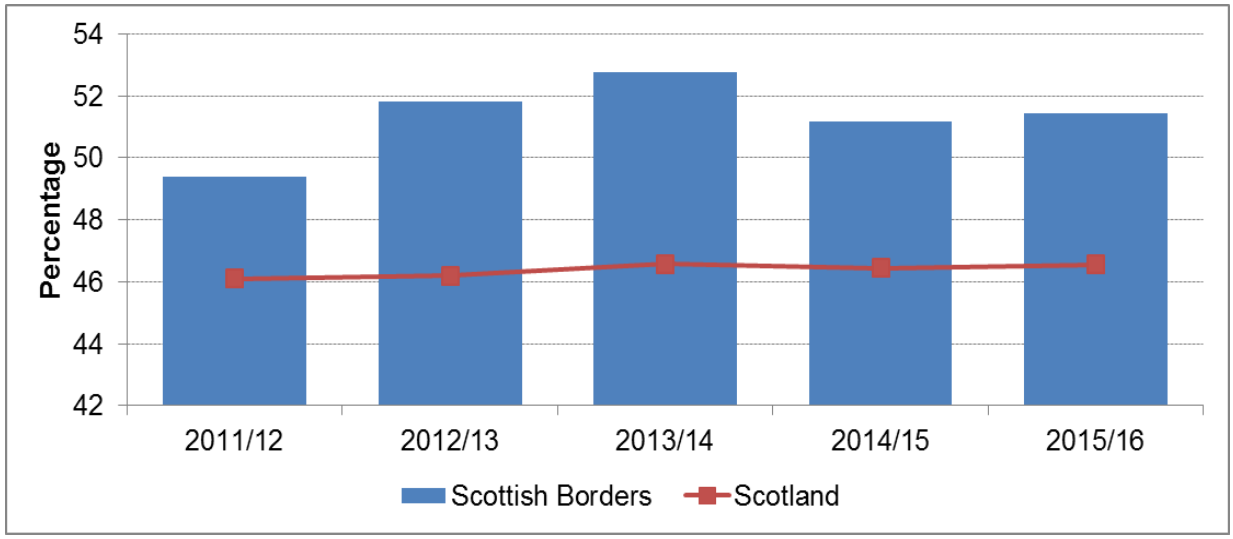
If we are able to improve health and wellbeing through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in Figure 3.

What shifts do we need to make?

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

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

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



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

Notes:

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

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: ...28 May 2018.....

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

ANNUAL PERFORMANCE REPORT 2017/18 – UPDATE

Purpose of Report:	To update the Integration Joint Board (IJB) on progress of the development of the Partnership's Annual Performance Report for 2017/18.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) note progress made on the development of a draft Annual Performance Report and Summary Report; b) endorse proposals for publication of the reports.

Personnel:	The document has been developed with key stakeholders from across the partnership.

Carers:	The document has been developed with key stakeholders from across the partnership.

Equalities:	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.

Financial:	This will be covered in the final report.

Legal:	This report gives an update on progress of the delivery of the Partnerships strategic objectives as laid out in the Strategic Plan.

Risk Implications:	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.

Background

It is a requirement for every Health and Social Care Partnership to publish an Annual Performance Report. The required contents are set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 and must include the following:

Page 172

- 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

Following extensive engagement with all key stakeholders across the Partnership a draft Annual Performance Report has been produced for the period 2017/18 (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 updates on performance received from key stakeholders. Areas highlighted in yellow within the draft report indicate further information is required before the report can be finalised.

Work is also underway to develop a Summary Report (see **Appendix 2**) which provides key highlights from the Annual Performance Report condensed into two pages.

The report requires to be published by 31 July 2018 and will be presented to the IJB in its final form on 11 June for approval prior to publication. Following IJB approval the Annual Performance Report and the Summary Report will be published electronically on Partnership websites.

Page 21 of 42

Scottish Borders **Health & Social Care** Partnership

Annual Performance Report 2017-18

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 2017/18

INTRODUCTION

This is the Second Annual Performance Report for the Scottish Borders Health and Social Care Partnership and it reports on our performance between April 2017 and March 2018. I joined the partnership in October of 2017 and I am privileged to have entered a partnership of colleagues and a community which is determined to provide the best of care for the population of the Scottish Borders.

The Borders is a wonderful and beautiful place to both live and work within. It does however present several challenges that are particular to the region in terms of getting from A to B and ensuring all our citizens have access to the services they need, when they need them. This report outlines our progress in meeting the aspirations outlined within our strategic plan for the Health and Social Care Partnership of the Borders.

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.

Among our key achievements to date is Discharge to Assess; a group of projects including Craw Wood and Hospital to Home which are helping to reduce delayed discharges and support individuals in returning home sooner. This complements the work of the Transitional Care Facility which supports individuals to remain as independent as they can after a stay in hospital and the Matching Unit where home care is matched to individual needs.

This financial year just gone has seen the Integration Joint Board introduce a new Direction to both the Council and NHS Borders to introduce a new policy of Discharging Patients from Hospital and to assess their needs within the community. In this way we will get people back to their homes quicker and can assess their needs in their home, making the assessment more relevant to their needs and more accurately identifying their requirements. This new direction has spurned a great deal of new work and a new direction from both Council and Health Services. The future priorities for 2018/19 are also 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.

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

Robert McCulloch-Graham
Chief Officer for Integration
Scottish Borders Health and Social Care Partnership May 2018

EXECUTIVE SUMMARY

The Scottish Borders Health and Social Care Partnership's Strategic Plan was published in April 2016 following a period of public consultation. The Strategic Plan sets out the Partnership's objectives for improving health and social care services for the people in the Scottish Borders for 2016 – 2019.

The Strategic Plan will be refreshed for 2018/19, however this Annual Performance Report outlines the Partnership's performance between April 2017 and March 2018 in relation to the progress made against the delivery of the 9 Local Objectives identified in the current Strategic Plan.

Included in the report are four spotlight sections, reflecting some of the key work that has taken place in the last year. These spotlights focus on the Matching Unit, Transitional Care Facility and two elements of the Discharge to Assess programme – Craw Wood and Hospital to Home. Each of these services demonstrate the new approaches taken by the Partnership in addressing key challenges and managing resources.

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.

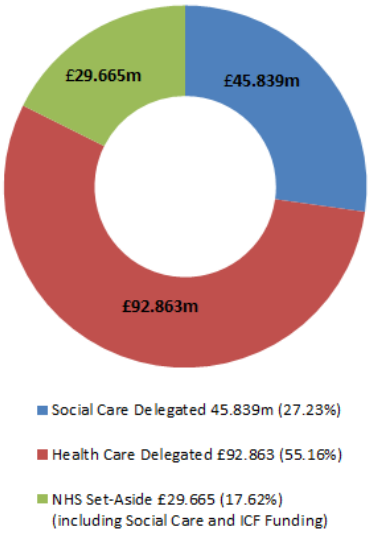
A statement is also provided of the financial performance of the Partnership and its performance against the National "Core Suite" of Integration Indicators identified by the Scottish Government.

Wherever possible 2017/18 data has been provided. Where this is not possible 2016/17 figures have been included. Where the 2017/18 data is provisional, this is denoted as 2017/18 p.

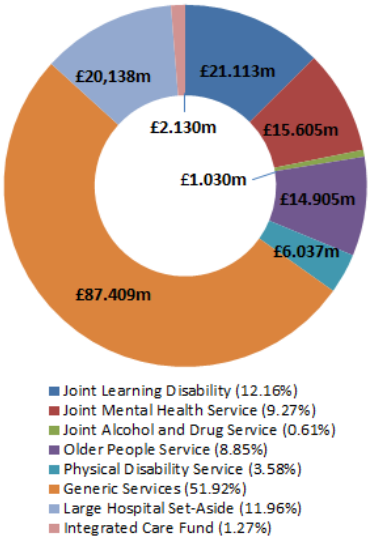
The report has been prepared in line with the Guidance for Health and Social Care Integration Partnership Performance Reports.

THE YEAR AT A GLANCE 2017/18

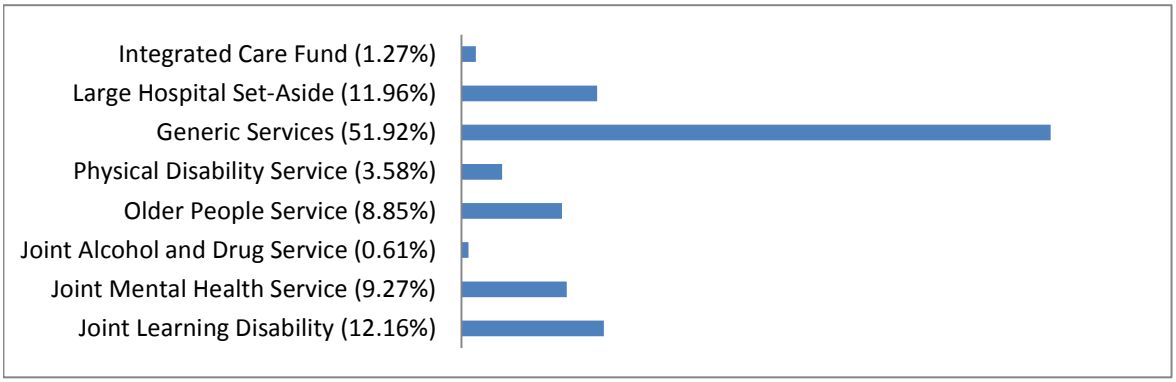
SPLIT OF BUDGET



SPEND BY EACH SERVICE AREA OVERSEEN BY THE INTEGRATED JOINT BOARD



PARTNERSHIP HEALTH AND SOCIAL CARE FUNCTIONS TOTAL



COMMUNITY SERVICES

51.4%

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

DISCHARGE TO ASSESS

74%

of admissions to Craw Wood are discharged home

328

home visits by the Berwickshire Hospital to Home team

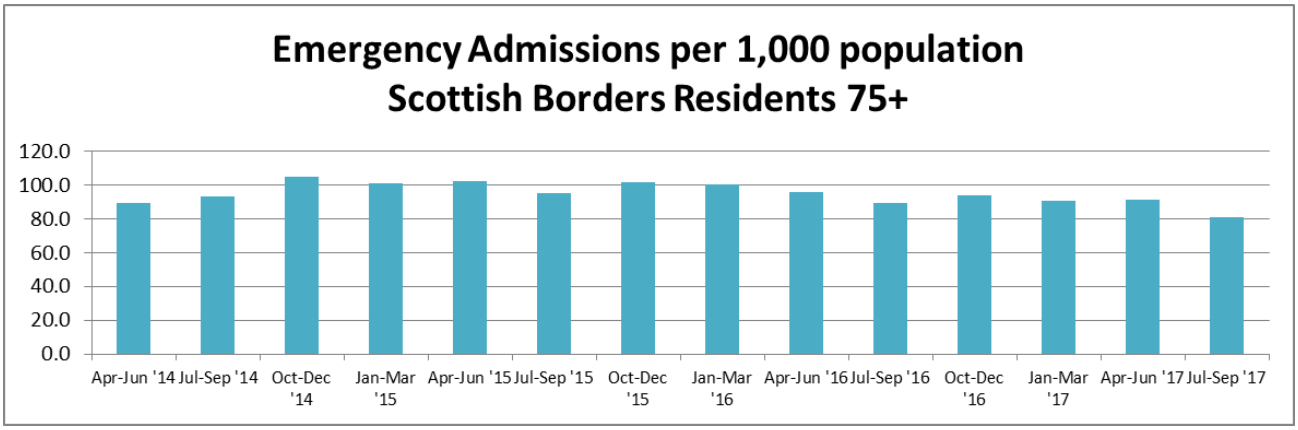
BORDERS COMMUNITY CAPACITY BUILDING

40+
activity sessions now running in local communities per week

£41,000
volunteering contributions to the community – cost of equivalent paid staff

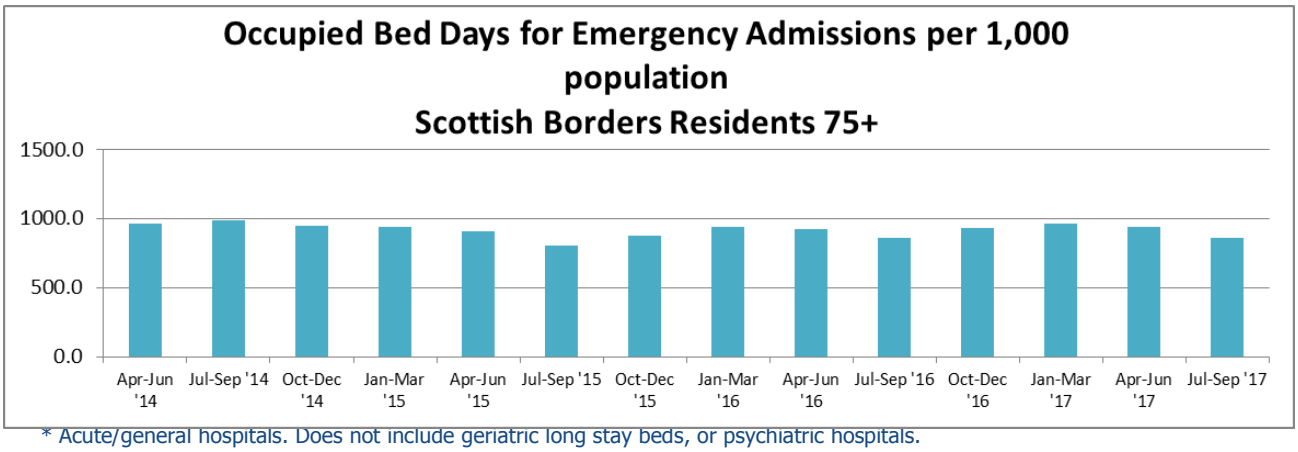
75%
of older people reported being more socially active as a result of taking part in Community Capacity Building activities

NUMBER OF EMERGENCY ADMISSIONS TO HOSPITAL*



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

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



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

899 PEOPLE WERE DELAYED FROM BEING DISCHARGED FROM HOSPITAL

10.5% OF ASSOCIATED OCCUPIED BED DAYS

PERFORMANCE AGAINST KEY PRIORITIES FOR 2017/18

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

There has been a continued focus on reducing unplanned admissions to hospital as well as reducing delayed discharges. This has resulted in the development of a number of discharge to assess initiatives, pathway redesigns and enablement approaches in 2017/18.

The key priorities identified by the Partnership for 2016/17 continued to be the focus in 2017/18. The Integrated Care Fund (ICF) has remained central in supporting and developing many of these priorities. Below is a summary of progress in 2017/18.

1	**To Develop integrated and accessible transport** The Community Transport Hub (CTH) run in partnership by Scottish Borders Council, NHS Borders, The Bridge, The Red Cross, Berwickshire Association of Voluntary Services and the Royal Voluntary Service (RVS) is coming to the end of its third year of operation. In 2017/18 alone the hub facilitated 22506 journeys and 92% of services users said the booking system was easy to use
2	**To integrate services at a local level** Locality working groups have been established and Locality Plans developed in each of the 5 localities in the Scottish Borders. This will support the redesign of health and social care services at a local level
3	**To roll out care co-ordination to provide a single point of access to services** Community Led Support 'What Matters' Hubs are now operational in all 5 localities, providing local communities with more accessible health and social care services. Additional outreach hubs are also run in rural communities when required. There have been over 300 attendances at the hubs since June 2017 and 95% of attendees said that the hubs were easy to access

4	**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. In 2017/18 Local Area Coordinators were identified as a contact point for young people with learning disabilities during transition between children and adult services
5	**Work with communities to develop local solutions** The Community Capacity Building team continues to work with communities to develop local solutions. This year the team was expanded to cover more local communities and to support the redesign of day services. 10% of participants in Community Capacity Building activities go on to volunteer within their community, further strengthening the local solutions available
6	**Provide additional training and support for staff and for people living with dementia** The Stress and Distress training project provides training to those working with people with dementia. It uses an evidence based approach to improve the experience, care and outcomes for people with dementia. To date, 433 bite size training sessions and 217 2 day training sessions have been delivered
7	**Further develop our understanding of housing needs for people across the Borders** The Integrated Strategic Plan for Older People's Housing, Care and Support Needs has been finalised and will be launched in June 2018 at the "Time to Re-think Housing for Older People Event". Analysis undertaken in the development of the strategic plan pointed to both improvements and efficiencies arising from service reform proposals. These include: • Better outcomes through the discharge to assess model, as well as a reduction in delayed discharge and reduced likelihood of returns to hospital in the short term • Increased ability to remain in an independent living environment for longer as a result of the Care & Repair services and associated adaptations • Improved outcomes and reduced costs associated with the introduction of assistive technologies (such as telecare) • Reduced costs and an increase in resilience associated with a change in the service commissioning balance • Enhanced logistics and better resource scheduling through the adoption of a locality-based hub and spoke mode • Potential to layer these benefits through a coherent approach to service reform implementation. Work has been commissioned to carry out an assessment on the housing needs and aspirations of young people through 2018. This includes

	robust local assessment on housing support and housing for young people with particular health needs.
8	**To promote healthy and active living** • The Borders Community Capacity Building Team has developed a range of over 40 activities across the Scottish Borders including gentle exercise, walking football, lunch clubs and Men's sheds. 86% of older people reported improvements to core strength and balance as a result of attending exercise activities, reducing their risk of falls and admission to hospital. • The Healthier Me network of learning disability service providers continues to work with service users on healthy eating and active living.
9	**To improve the transition process for young people with disabilities moving into adult services** A transitions pathway has been developed as well as an information pack for young people with a learning disability, to allow a smooth transition process into adult services. A key contact person has also been established
10	**To improve the quality of life of people with long term conditions by supporting self-management and promoting healthy living** • The learning from the Long Term Conditions Self-Management project has been used to inform further work to support those with long term conditions and improve pathways to access prevention and lifestyle assistance through the more effective integration of service delivery. • A Diabetes Prevention Partnership has been developed to look at prevention, raising awareness, community support and more intensive intervention.
11	**To improve support for Carers within our communities** • The Partnership continues to support the Carers' Centre, which offers practical support and advice to Carers as well as undertaking Carer's assessments. In 2017/18, 453 new Carers have been referred to the Carers Centre service and 488 Carer Support Plans developed. • The Transitions and Autism pathways have also focused on Carers/parents as a key partner in this work

12	**Promote support for independence and reablement so that all adults can live as independently as possible**
	• The Transitional Care Facility based within Waverley Care Home is a 16 bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. 81% of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is 6% which is low given that the average age of service users is 83 years old.
	• A number of 'discharge to assess' projects have been piloted to allow adults to return home sooner and remain as independent as possible. These include:
	  ○ Craw Wood Discharge to Assess – a 15 bed unit where adults can have their rehabilitation needs assessed.
	  ○ Hospital to Home – Teams of Healthcare Support Workers facilitation discharge home from hospital and prevention of admission to hospital with a re-ablement focus. A pilot is currently running in Berwickshire, with further pilots due to commence in Teviot & Liddesdale and Eildon.
	• The Borders Ability Equipment Store provides community loan equipment to people across the Borders. The facility moved to a new building in summer 2017 which allows increased capacity for stock to support hospital discharges and prevent admissions. Additionally, the new facility supports improved infection control procedures and is able to better respond to increased demands in service

KEY PARTNERSHIP DECISIONS 2017/18

For the period 2017/18 the Integration Joint Board has met regularly both as a formal meeting to transact business and also through Development sessions to raise its understanding of the more complex issues it will deal with as the partnership continues to evolve.

During this period the Integration Joint Board has focused on governance and operating arrangements as well as performance and resource planning.

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

- Welcoming new voting members to the Board;
- Appointment of its Chief Officer, Mr Robert McCulloch-Graham;
- Review and approval of its Terms of Reference;
- Approval of the Mental Health Service Strategy;
- Approval of the Learning Disability Strategic Commissioning Plan;
- Issuing Directions for a Discharge to Assess Policy;
- Agreement to pilot a Hospital to Home initiative;
- Approval of its Climate Change Report;
- Approval of its Integrated Complaints Handling Procedures;
- Approval of its Model Publication Scheme;
- Instigating a refresh of its Strategic Plan through the Strategic Planning Group.

Examples of key performance and resources decisions it has made during the financial year include:-

- Approval of its Commissioning and Implementation Plan for 2017/19;
- Review of the Integrated Care Fund Schemes and Direction of funding.
- Directed the use of Social Care Funding;
- Approved and delivered its 2017/18 financial plan;
- Directed resources to assist with Joint Winter Planning performance;
- Review of progress with the development of the Transformation and Efficiencies programme.

SPOTLIGHT:
Craw Wood – Discharge to Assess Facility

In December 2017 Craw Wood opened initially as a 15 assessment bed facility at Tweedbank, in the heart of the Scottish Borders.

Craw Wood is a short term facility to which a person can be admitted in order to better understand their strengths and on-going critical needs for rehabilitation and support.

Length of stay is typically between 48 hours and two weeks. During this time a rehabilitation team assess how best to improve rehabilitation opportunities and promote independence and wellbeing of a person when it is not clear how best to achieve this. The facility is designed to ensure that a person retains as much independence as possible and does not become institutionalised.

Key Achievements

(December to end March 18)

72	69%
Patients have used the facility	Average Occupancy

Outcomes for Discharged Service Users

43	9	6
Left Craw Wood Discharged to Home	Left Craw Wood Discharged to BGH	Left Craw Wood to other destinations *i.e. private care*

Craw Wood primarily opened in December 2017 as 15 bed facility with an aim to improve hospital flow over the winter of 2017/18.

However, its success has been proven in the initial months and it the facility was expanded to a capacity of 23 beds. This will continue to support the model of "Discharge to Assess" for patients in the Scottish Borders throughout 2018.

<PICTURE>

Service User Feedback

'Felt comfortable and safe'

'Friendly staff, willing to spend time which makes me relaxed and comfortable'

'Everyone has been very helpful. I can't praise Craw Wood enough and would recommend it to anyone'

'Can't fault the facility'

"In December 2017 we opened an assess-to-discharge unit within Craw Wood in Tweedbank. This service works with all Scottish Borders hospitals, but mostly with BGH to help improve outcomes for individual patients who need some extra support to regain skills on discharge from an acute hospital bed. We aim to always discharge people home from hospital as quickly as possible and to promote on-going independence at home. It has 15 assessment beds, where we are successfully providing rehabilitation support and building on each person's strengths. Most people are staying in the unit between two and two weeks. So far, 72 people have used the facility, saving over 1000 occupied bed days in the BGH"

Robert McCulloch-Graham – Chief Officer Health & Social

For more information on this project please contact Sonia Borthwick (Project Change Manager, Better Borders) Sonia.Borthwick@borders.scot.nhs.uk

SPOTLIGHT: MATCHING UNIT

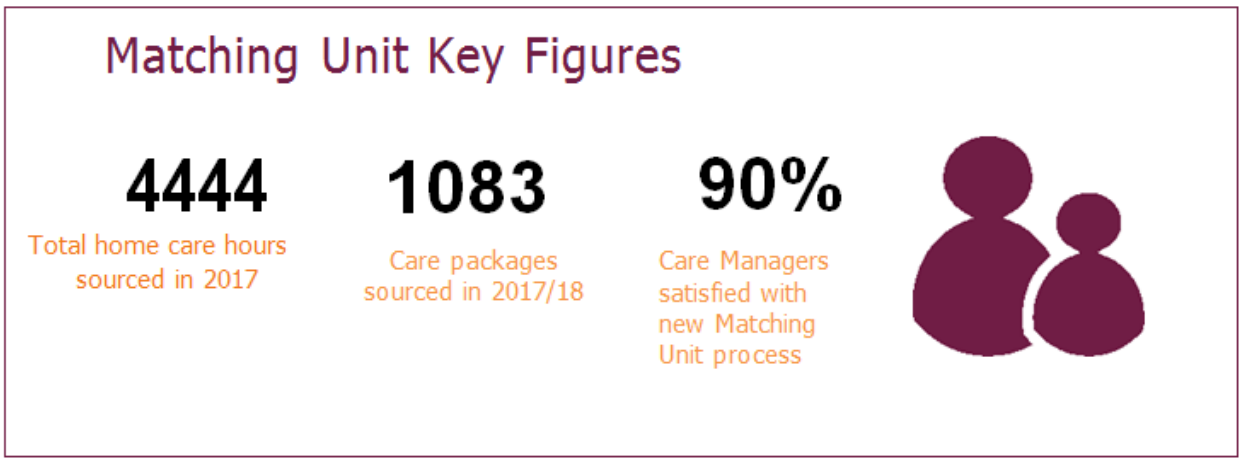
The 'Matching Unit' is a small central administrative team created to match a service to the assessed needs of the client.

The focus for the Matching Unit at this point is sourcing Care at Home. Prior to the introduction of the Matching Unit, Care Managers would call round all the providers in their area to secure a home care service for their client. This meant that on any one day a provider could receive several calls from different care managers from various teams requesting a service.

The diagram below shows how the process has been streamlined and the availability of the provider is determined within a phone call. This simplifies the process and provides opportunities to more efficiently deliver the service.

The Matching Unit ensure the new provider is made fully aware of the needs of the client, and complete the process by undertaking a number of administrative tasks. By undertaking these tasks the Matching Unit staff free up the care managers time to focus on assessment and care management.

The Matching Unit was rolled out to all Social Care and Health Teams during 2017 and the number of care packages sourced in each month is shown in the diagram below.



The total number of care packages sourced by the Matching Unit per month

MONTH	CARE PACKAGES SOURCED
APRIL	4
MAY	45
JUNE	38
JULY	80
AUGUST	83
SEPTEMBER	91
OCTOBER	86
NOVEMBER	101
DECEMBER	113
JANUARY	138
FEBRUARY	133
MARCH	171

Within a short space of time the MU has promoted a significant number of positive matches of support packages for service users both at home and to support hospital discharge. Matching Unit staff are building expertise and efficiency around matching care needs and freeing up care managers to focus on other aspects of assessment and support planning. This along with other initiatives is helping reduce waiting list and with achieving quicker turnover of work. To date the Matching Unit has been very successful in promoting positive outcomes and with an enhanced role will work to increase efficiency across other practice areas.

Gwyneth Lennox, Social Work Group Manager

'Again the Matching Unit has come up trumps. I had an urgent duty request for an assessment this morning, and following my duty visit it was clear that she not only needed a small piece of equipment, more importantly, she needed a package of care today. She had fallen at the weekend and fractured her right dominant hand and humerus. The Matching Unit have just confirmed they can start the package of care tonight, how cool is that? Not only have I not had to waste my day going round and round endless care providers but a service that is needed critically today has been provided…..result.'

Occupational Therapy Care Manager

The focus for the Matching Unit at this point is Care at Home which is social work managed. Their remit can be further developed to include other services:

- Direct payment
- Individual service fund
- Respite
- Care home placements

The Matching Unit also has the potential to extend the service to include additional client groups:

- District Nurse access to the Matching Unit to source care at home for patients receiving end of life care, for care managed, direct payment and individual service fund options.

- All clients of the Learning Disability Team, for social work managed, direct payment and individual service funds. Respite and care home placements can also be considered in consultation with the LD Team.
- All clients of the Mental Health Team, social work managed, direct payment, individual service fund. Respite and care home placements can also be considered in consultation with the MH Team.

<PICTURE>

For more information about the Matching Unit please contact Elena Hendry, Project Manager, Health and Social Care Partnership Team.
Elena.Hendry@scotborders.gcsx.gov.uk

SPOTLIGHT: TRANSITIONAL CARE FACILITY

The Transitional Care Facility is a 16 bed unit based within the Waverley Care Home in Galashiels. It provides short term care for patients leaving hospital to enable them to return to their own homes within 6 weeks. The facility is run by a multi-disciplinary team of Support Workers, Allied Health Professionals and Social Workers.

The purpose of the service is to:

- Support individuals who have received hospital treatment but no longer need to be in hospital, who have rehabilitation requirements which prevent them from immediately returning to their own homes.
- Provide a period of short-term rehabilitation to individuals (over a maximum 6 week period)
- Support service users to return to their own homes as independently as possible.
- Maximise independence of service users
- Undertake an assessment of need prior to discharge home
- Ensure service users have any care and equipment required for a safe discharge home.

TRANSITIONAL CARE FACILITY

In 2017:

99	BGH Discharges supported
6%	Readmission Rate within 28 days – this is significantly lower than the BGH over 65s readmission rate
81%	Service Users were discharged to their own home
87%	Service Users were satisfied with the service provided

Quotes from Service Users

'It gave me time to consolidate my exercise programme and get back my independence following my reactions to infections and medications'

'The unit is very well laid out, enabling me to be as independent as I can. The staff were very friendly and efficient when supporting me'

The Transitional Facility at Waverley has made a real impact for some of the most vulnerable people who live in the Borders. By having some time in the Unit people have regained skills and developed strategies which help them to move back to their own homes and communities.

Murray Leys, Chief Social Work Officer

<PICTURE>

For more information about this project please contact Elena Hendry, Project Manager, Health and Social Care Partnership Team Elena.Hendry@Scotborders.gcsx.gov.uk

SPOTLIGHT:
Hospital to Home - Berwickshire

The Integration Joint Board of NHS Borders and Scottish Borders Council approved a proposal to introduce a new direction of "Discharge to Assess" late in 2017.

To meet this new direction and to support the easing of pressures within the secondary care the Hospital to Home pilot was initiated.

This project is a test of change and is the first step to developing a Hospital to Home service to support the provision of care in people's homes. It started in the Berwickshire locality on 15th January 2018.

This has a re-ablement approach with the aim to maximise the early rehabilitation potential of the person during the early weeks of care. Its aim is to develop their confidence and skills so that they can carry out activities themselves to enable them to continue to live at home.

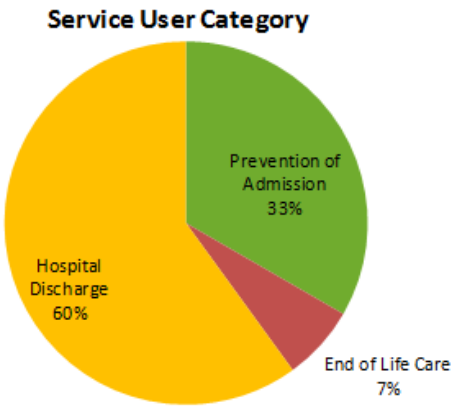
This service is for adults, aged 65 and over who require support at home following:

- Discharge from hospital
- A period of ill health such as a fall or other illness

This service will also be available to anyone requiring end of life care.
This service is carried out by Health Care Support Workers, under the guidance of District Nurses.

Progress – 10 pilot weeks
The pilot has been able to accommodate 15 service users to date.
From 15th January – 28th March 2018, a total of 328 visits have been carried out.

- 186 Morning Visits
- 28 Lunch Time Visits
- 16 Tea Time Visits
- 98 Evening Visits



Since 15th January:

- 60% have been a Hospital Discharge
- 33% of patients have been a Prevention of Admission
- 7% of patients have received End of Life Care

The Average Duration individuals have received care for is 18 days.

18% of service users became independent
36% have a reduced care requirements
6% of service users care requirements remained the same

Feedback from a Service User

"The caring team who visited me during the "Hospital to Home" period were very patient focused and attentive."

"I can find no fault with the care I have received,"

<PICTURE>

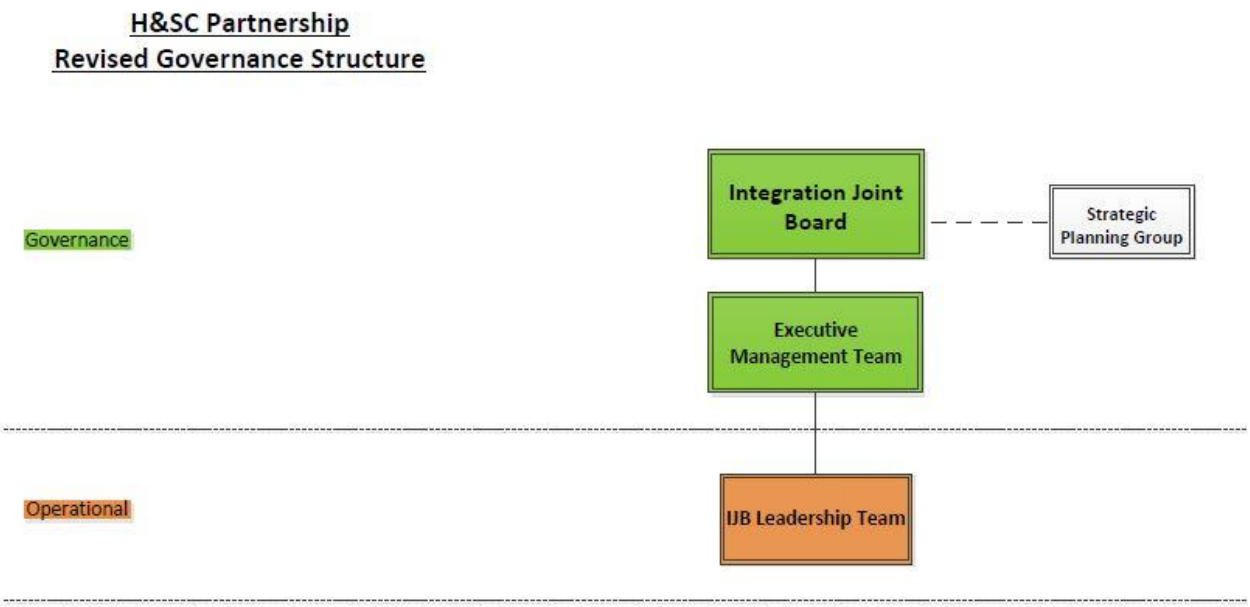
For more information about this project please contact Erica Reid, Lead Nurse for Community, NHS Borders Erica.Reid@Borders.scot.nhs.uk

GOVERNANCE AND ACCOUNTABILITY

During 2017/18 the governance structure for the Partnership has remained the same and provides a robust and streamlined process for efficient and effective Partnership decision making. The Partnership has continued to work 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.

The governance structure has two decision making levels – the Integration Joint Board and the Executive Management Team – which are closely linked to Health and Social Care operations via the IJB Leadership Team. The governance structure for the Health and Social Care Partnership is illustrated in the diagram below:

H&SC Partnership Revised Governance Structure



Whilst the IJB has ultimate decision making and commissioning authority for the Partnership the Executive Management Team provides a useful assurance function to the IJB ensuring that all reports and proposals being prepared for the IJB are fit for purpose and are clearly aligned to Partnership's priorities identified within the Strategic Plan.

The focus of the Strategic Planning Group has been refreshed in 2017/18 resulting in amended Terms of Reference and Membership to ensure an improved understanding of function and role and more effective links to each of the five Localities in the Scottish Borders. The relationship between the IJB and the SPG has been strengthened in 2017/18 with the Vice Chair of the IJB now chairing the SPG and the work plan for the Strategic Planning Group being directly aligned to the work plan of the IJB.

The Integration Joint Board Chief Internal Auditor will present to the IJB Audit Committee in June 2018 the findings, conclusions and audit opinion for each of the areas of Corporate Governance, Financial Management, Performance Management, Risk Management and Follow-Up on Previous Recommendations delivered as part of its 2017/18 Internal Audit Annual Plan to provide the required assurance. The Internal Audit Annual Assurance Report 2017/18 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 IJB Audit Committee also agreed the 2018/19 Internal Audit Annual Plan for the Integration Joint Board at its meeting in March 2018.

A quarterly performance report for the Integration Joint Board continues to be produced in line with the themes defined by the Ministerial Strategic Group for Health and Social Care. In addition to these themes, the report allows for performance information relating to more localised measures which have a primary, community or social care focus.

A newly formed Integration Finance and Performance Group has been established which has responsibility for the development of Partnership Performance reporting locally and nationally and is made up of performance leads from across Scottish Borders Council and NHS Borders.

The report on the joint inspection of the Health and Social Care Partnership's older people's services undertaken by the Care Inspectorate and Healthcare Improvement Scotland was published in September 2017. An action plan based on the recommendations in the report provides assurance and a clear strategy for further improvement across the Partnership.

The Internal Audit planned work in 2017/18 included 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 was incorporated into the Annual Governance Statement within the draft Statement of Accounts which was 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 2017/2018:

- GP Cluster Quality Leads have been established and are involved in the development of the new General Medical Services contract. The Cluster Quality Leads are integral to a number of projects modernising the delivery of primary care locally, for example home based rehab services, continued development of practice based paramedic model and healthcare hub. This role will be key to the Primary Care Improvement Plan.
- The Local Area Coordinators and Community Capacity teams work across the Scottish Borders and services. These teams work within communities to build relationships, increase resilience and develop the capacity of local communities.
- Key Health and Social Care information is available across the Partnership in a wide range of formats, including easy read, to improve access to information and services.
- A range of training is provided to staff and Partnership organisations to improve accessibility to Health and Social Care services and develop community capacity.
- Community Led Support provides locally based 'What Matters' Hub which can be easily accessed by people as the first point of contact for Health and Social Care Services. This involves working together in local communities with Third Sector and voluntary organisations to connect people to locally based solutions that work for them.
- The Learning Disabilities team held workshops with service users and Carers asking people what makes good support. This was used to develop a new Supported Living Framework and the basis of a revised contract for commissioning services for people with learning disabilities.
- Use of video conferencing to enable patients to have on-line, virtual appointments with clinicians and service providers is being piloted via the "Attend Anywhere" project. The main focus is on providing the capability within care homes and support Out of Hours Emergency Care, Diabetes Services and Orthopaedics avoiding the need for expensive travel and hospital visits and helping to reduce missed appointments.
- 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 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, with a commitment to develop and support volunteering as part of the 3 year Community Learning and Development Strategy.
- 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.
- Improving care pathways across services remains a key priority. For example the continued development of the Transitions Pathway for young people who will require assistance from the Adult Learning Disability service.
- An Autism Coordinator was appointed to take forward the requirements of the Autism Strategy, ensuring that people with autism have access to all of the services they require including healthcare, education and housing.

- Project Search is now in its second year and supports interns to gain skills which will allow them to improve their opportunities for employment.
- There is a range of support available in community settings including dementia clinics and home based memory rehabilitation service.
- The Borders Dementia Working Group continues to promote 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.
- "Lifestyle Matters" groups assist people with dementia in anxiety management, improving self-esteem and regaining skills.
- 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 through partnership working with Changeworks, Home Energy Scotland and Housing Associations. A Home Energy Forum has been established and will be producing a strategy to deliver on national objectives for energy efficiency and affordable warmth.
- There are monthly Carers support groups held in all five localities.
- Interest Link Borders continues to use 100s of 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 allows better access to equipment for communities.
- There are a number of activities within Burnfoot Community Futures including:
  - Regular input from NHS Borders Quit You Way, screening services and from Hawick-wide partnership initiatives on health and wellbeing.
  - Development of volunteering, participatory budgeting and local action plan.
  - Support a reminiscence group and a recent life stories pilot
  - Delivery of meals to older people who regularly attend drop in lunch facilities during adverse weather conditions to ensure they continue to receive a hot meal.

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

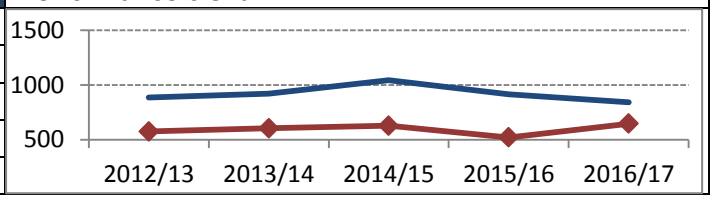
- Ongoing fuel poverty.
- Challenging budgets and changes to living wage implications.
- Access to volunteers for community led activities.

Performance - National "Core Suite" Indicators

NI-1 94% of adults able to look after their health very well or quite well (Scotland 93%).

Source: Scottish Government Health and Care experience survey 2017/18.

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

YEAR	SCOTTISH BORDERS	SCOTLAND	Historical Performance trend
2012/13	575	886	
2013/14	604	922	
2014/15	628	1044	
2015/16	522	915	
2016/17	647	842	

Source: ISD Scotland Delayed Discharge Census.

In terms of overall rates of occupied bed-days associated with delayed discharge, which have fluctuated from year to year, Borders has performed consistently better than the Scottish averages. However, delays in discharging patients from hospital remains a significant challenge for us. More detail on delayed discharges is given in the June 2018 quarterly performance report for the Integration Joint Board.

Performance – Specific programmes

BORDERS COMMUNITY CAPACITY BUILDING

75%

Of older people reported being more social active as a result of taking part in activities

95

Volunteers have invested their time into projects. They report increased self-esteem and pride in giving back to the community

The team won silver in the Creating Community Capacity category at the Improvement and Efficiency Social Enterprise Public Sector Transformation Awards 2018. The award recognises initiatives that create greater resilience in local communities

5 of the 8 Participants in Project Search in in 2017/18 gained employment.

PROJECT SEARCH
CASE STUDY

My name is Euan Aikman and I was an Intern with Project SEARCH 2017/18 which I really enjoyed. I did 2 rotations, one in ward 15 as a Domestic Assistant and the other in the RVS shop, I enjoyed both rotations and learning new skills.

Catering is something I have always wanted to do, Project SEARCH helped to build my confidence and apply for a Cook Modern Apprenticeship, I was successful with the application and have now left Project SEARCH to start my MA, I am only a few weeks in and really enjoying it.

I enjoyed Project Search and the people I met there; I would like to thank them all for helping me achieve my dream.

Partnership Priorities for 2018/19

- Establish the Attend Anywhere programme using technology to improve access to care.
- 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 2017/2018:

- The Lifestyle Advice Support Services assist people to make healthy behaviour changes in relation to smoking, diet, alcohol consumption and physical activity. LASS increasingly working closely with other services such as Quit 4 Good to encourage lifestyle change in areas where needs are greater.
- Work has commenced in improving pharmacy input into social care services. The aim of this is to reduce medication errors and help people to maintain their independence with self-administration of medicines for as long as possible.
- The learning from the Long Term Conditions Self-Management project has been used to inform further work to support those with long term conditions and improve pathways to access prevention and lifestyle assistance through the more effective integration of service delivery.
- An Alcohol Related Brain Damage (ARBD) coordinator was appointed to develop an integrated care pathway for people with ARBD. One of the key aims of this work is to ensure that individuals receive the right treatment at the right time, and increase opportunities for early intervention.
- The initial development of a Diabetes Prevention Partnership has been undertaken, to include awareness raising and prevention, community support and more intensive intervention.
- 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 national dental programme which offers older people and their Carers information help in looking after their teeth and oral health. Within the Scottish Borders Caring for Smiles continues to be led by the Public Dental Service in hospital and care home settings. Training for carers and staff is delivered by the Public Dental Service. This is key to the success of the programme and to supporting dependent older people improve their oral health.
- "Meet Ed" pocket are available in 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 a public website where resources and advice are available to assist people to manage their foot care.
- The Health Living Network has developed and delivered initiatives to reduce health inequalities by promoting good mental health, inclusion and preventing avoidable illness (diabetes). Regular activities happen in partnership in a ranger of settings that increase community based peer support and volunteering opportunities/development.
- Health screening opportunities have been actively promoted, particularly cervical screening, to increase uptake.
- Anticipatory care planning is a key element of support for patients across the Borders.

- Following a successful pilot in Tweeddale of Transforming Care After Treatment (TCAT) – a multi-agency initiative between Scottish Borders Council, NHS Borders, Red Cross and MacMillan- the programme is to be rolled out across the Borders with the Central Borders area as the next stage. This service offers a reablement approach to enable people to live as independent a life as possible following their treatment and recovery of cancer.
- The Borders Falls Steering Group is developing a strategy in line with self-assessment using the 'Prevention and Management of Falls in the Community' Tool and Older People in Acute Hospital standards.
- A Falls Prevention Working Group has been formed with stakeholders from acute services, community hospitals and inpatient mental health wards to review current guidance and drive forward improvement work.
- The Borders Community Capacity Building team promote and run a range of exercises classes for older adults with a variety of ability levels, for example Walking Football, New Age Kurling and Gentle Exercise classes. By increasing basic health and fitness levels, as well as general wellbeing, these activities reduce the need for formal social care services.
- Community Led Support offers access to help and advice, and allows individuals to remain in their own home, get involved in their community and find the support they need to stay independent. The 'What Matters' Hubs promote early intervention and prevention and assist individuals in sourcing equipment, transport and help at home.
- 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, providing evidence to support the Licensing Board in policy development and supporting multiagency partners in 'Don't Buy/Don't Supply' campaign to reduce the number of over 18's buying or supplying alcohol to young people.
- The Mental Health Strategy identifies areas of work to ensure a focus on mental health improvement within local communities, early intervention and prevention through commissioning, partnership working and service delivery.
- The Learning Disability Transitions Steering Group has developed a high level pathway and information pack to support young people in transitioning from children's to adults services.
- 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 pathway is available to all those diagnosed with dementia for one year post diagnosis, and focuses on early intervention and prevention by increasing understanding of good health and considering lifestyle changes.
- 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 completed work to redesign the Carers Support Plan in partnership with carers and the statutory and third sectors. This includes 5 key areas – Health and Wellbeing, Managing the Caring Role, How you are valued by Service, Planning for the Future , Finances and Benefits.

- A programme of training is in place for professionals to improve Carer awareness, and to encourage early identification and preventative assistance for Carers. A programme of Carers Act training is also available for professionals and 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.
- The Transitional Care Facility use a rehabilitation focused approach to ensure that individuals discharged from hospital are able to return to their own homes and remain there as independently as possible.
- The Scottish Ambulance Service, as part of the wider Frailty Multi-disciplinary team, has ensured that ambulance crews in the Borders complete a Frailty Screening Tool for all older adults. This provides key information to the receiving nurse at Borders General Hospital and helps to prevent falls while driving improvements for frail elderly patients.
- SB Cares 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:

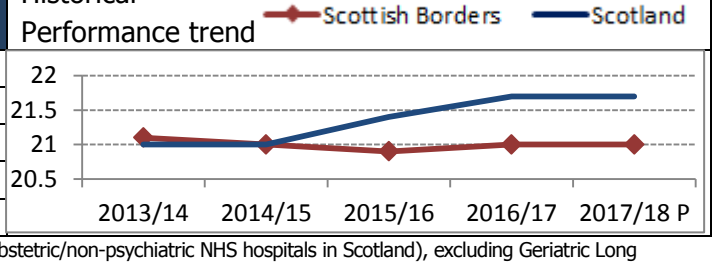
- A key challenge faced by a number of areas in the delivery of this objective is the capacity of staff to invest in prevention.
- Short term funding of initiatives
- Measurement of impact of preventative outcomes

Performance - National "Core Suite" Indicators

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2013/14	21.1	21.0
2014/15	21.0	21.0
2015/16	20.9	21.4
2016/17	21.0	21.7
2017/18 P	21.0	21.7

Historical Performance trend



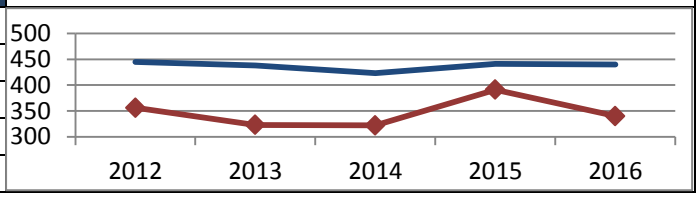
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

Since 2013/14 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 2018 quarterly performance report for the Integration Joint Board.

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

YEAR	SCOTTISH BORDERS	SCOTLAND
2012	356	445
2013	323	438
2014	322	423
2015	391	441
2016	340	440

Historical Performance trend



Source: National Records for Scotland (NRS).

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

Performance – Specific programmes

Inpatient Falls Prevention

28% Decrease in inpatient falls in 2017/18 compared with 2012/13

32% Decrease in falls resulting in harm in 2017/18 compared with 2012/13

TRANSITIONAL CARE FACILITY

CASE STUDY

Mrs B was admitted to the Borders General Hospital after a fall at home where she fractured her ankle. She had no formal support at home prior to her fall.

Mrs B's recovery was complex and she was admitted to the Transitional Care Facility for a period of rehabilitation. She required the support of one staff member with all transfers, and whilst using a zimmer. She also required assistance with personal care and for her medication to be administered. Her goal once the cast was off was to be independent with a 4 wheeled walker.

The Physiotherapist provided an exercise programme which support staff followed with Mrs B until she was able to undertake stair practice with the Physiotherapist. Mrs B was keen to manage her medication independently and staff supported her to self-administer. She had kitchen practice with the Occupational Therapist and then support staff followed the rehab plan to support Mrs B until she was able to prepare her own breakfast independently.

After 3 weeks in the facility Mrs B was independent with personal care and medication, and a home visit was arranged. Mrs B was very anxious about going home however once there she became more relaxed. It was identified that additional equipment would be required to support Mrs B to remain independent at home and the Occupational Therapist arranged this.

Mrs B continued to do well and was discharged home after 6 weeks with no care package. While Mrs B was still in the hospital, the opinion was that this lady she would require a full care package of 4 times per day.

COMMUNITY LED SUPPORT

CASE STUDY

Mrs T attended a "What Matters" hub appointment following an appointment made through Customer Services. She was struggling to manage personal care due to arthritis and low blood pressure but wanted to remain as independent as possible. It was identified that a small package of care to assist with washing 3 times per week would be sufficient (1.5 hours), and that she would benefit from a hand rail to assist her safe transfer in and out of the bath. The paperwork was completed at the hub and sent to the Matching Unit. Mrs T telephoned the hub back about an hour after her appointment to say that care had been matched and would be starting the following Monday. The Occupational Therapy Assistant carried out an environmental visit and identified a rail and raised toilet seat which were arranged.

Partnership Priorities for 2018/19

- Continue to develop Community Led Support 'What Matters hubs', extending the service to more communities to improve access to Health and Social Care services for all Scottish Borders residents.
- Improved pathways for prevention and early intervention

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 2017/2018:

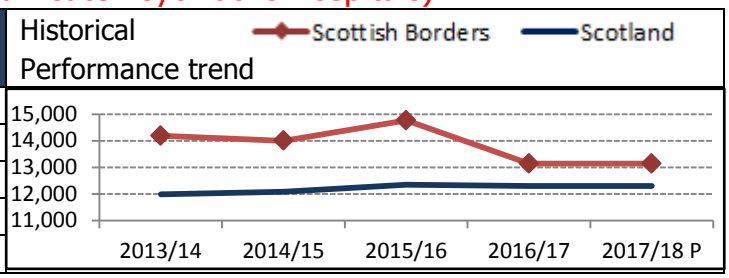
- A review of community and day hospitals is ongoing following an initial data gathering in 2017/18. This work will help to define the future role of community and day hospitals within the overall patient pathway and will help to identify the appropriate model of care for redesign.
- A trial with the Scottish Ambulance Service and local GP practices in Hawick, testing a model of in-hours response to emergency calls to GPs, has been extended due to its continued success. The model 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. This is supported through Primary Care Transformation resources.
- The Lifestyle Advisor Support Service continues to improve wellbeing and aid prevention of ill health, which includes:
  - Support and agreement from GPs, offering opportunistic health checks in all GP surgeries.
  - Adult weight programme "Weigh 2 Go Borders" which combines a number of evidenced based approaches offering wider options to the clients.
- The pilot site for the Buurtzorg neighbourhood care project and a clear plan for extending the model across the Borders has been identified. This is a nurse led approach to integrated and holistic care which allows people to be supported in their own homes.
- A patient flow project continues 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.
- Reablement principles are embedded in the social work department's adult/older people business plans and are at the heart of the commissioning process.
- 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 being discharged from hospital, 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 commissioning of services ensures that a broad range of options aimed at enabling independence in the community are provided.
- 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.
- The Mental Health Older Adult Team work to reduce the likelihood of admission to hospital by keeping people engaged with primary health care services and with activities which will enable them to stay well.
- 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, private sector, Carers and relatives is being provided to improve interventions with people with Dementia.
- 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.
- Scottish Borders Council works in partnership with Home Energy Scotland to provide 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 through the Scheme of Assistance.
- 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 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
2013/14	14,184	11,989
2014/15	14,001	12,083
2015/16	14,763	12,342
2016/17	13,135	12,294
2017/18 P	13,135	12,294

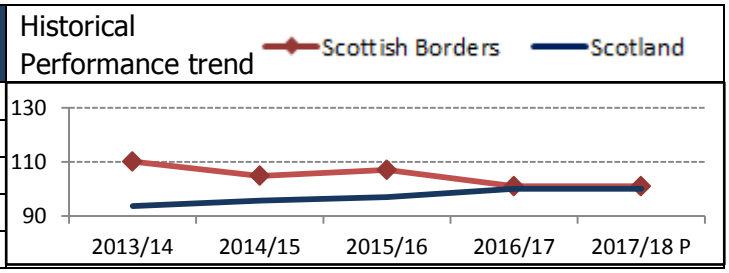


Source: ISD Scotland. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

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 2017/18 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
2013/14	110	94
2014/15	105	96
2015/16	107	97
2016/17	101	100
2017/18 P	101	100



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 2017/18 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 2017/18 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.

Partnership Priorities for 2018/19:

- Enhance the role of Allied Health Professionals to support the Modernising Community Hospital/Healthcare programme and develop AHP role with the long term conditions pathway
- Reduce delayed discharge rates and percentages of associated occupied beds.
- 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 2017/2018:

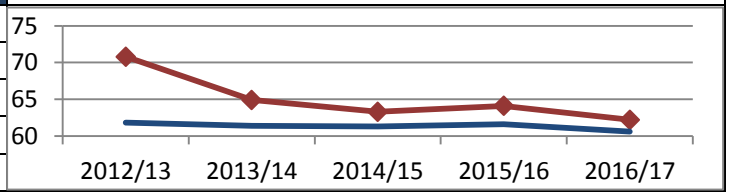
- A pilot of the Buurtzorg nursing approach via integrated nursing and social work teams, and a plan for extending the model across the Borders is in development.
- The Public Dental Service offers and enables an annual programme of dental assessments and treatment within care establishments.
- The Sexual Health Service continues to build on an enhanced presence in secondary schools and Borders College to improve young peoples' access to sexual health services and improve access to services for people living in postcodes associated with multiple deprivation through increasing the availability of walk in services.
- Diabetic retinal screening continues to be delivered by local opticians.
- Locality Plans for all localities have been produced after consultation with local communities. These identify local variations in need of health and social care services and will be implemented to ensure that the right services are provided.
- Technology is offering new opportunities for transforming the health outcomes and experiences of people and helping them to continue living independently at home. A Technology Enabled Care Strategy is being developed to co-ordinate and maximise these opportunities and to build on local, national and international good practice.
- Ability Borders works with individuals and the wider partnership to identify and meet people's information needs and identify gaps and issues.
- The Integrated Strategic Plan for Older People's Housing, Care and Support Needs has been finalised and will be formally launched on the 1st June 2018. Over the next 10 years the Scottish Borders Health and Social Care partners will invest close to £130m to enable increased specialist dementia care, increased housing adaptations and investment in telecare and telehealth.
- Community Led Support 'What Matters hubs' provide access to Health and Social Care services in a local community setting.
- The Hospital to Home service supports individuals to return home from hospital as soon as they are able to and provides a re-ablement approach using Healthcare Support Workers under the direction of the District Nurse.
- Smartcare, a web based self-management system which enables people to access advice, information and self-help assessment to identify equipment solutions, has recently been launched
- The Mental Health service use 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.
- The Low Vision Services assess and provide equipment for people within their home.
- The Local Area Coordination Service covers all areas of the Scottish Borders. The key function of this service is:
  - Support self-assessment, establish personal life plans and support people to implement those plans
  - To support adults with a disability find volunteering or employment opportunities
  - Help people to access low cost and no cost services, and reduce the need for formal services

Performance - National "Core Suite" Indicators

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

YEAR	SCOTTISH BORDERS	SCOTLAND	Historical Performance trend
2012/13	70.8	61.8	
2013/14	64.9	61.4	
2014/15	63.3	61.3	
2015/16	64.1	61.6	
2016/17	62.2	60.6	



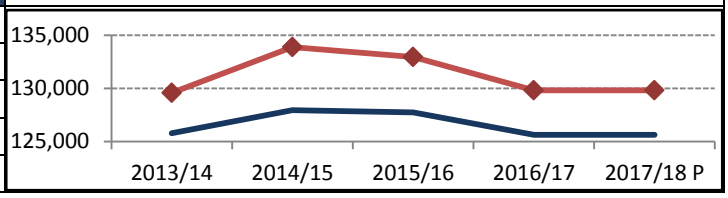
Source: Scottish Government Health and Social Care Statistics.

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 2017/18 have yet to be published. However, we have included local reporting for a similar indicator 2017/18 in the June 2018 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
2013/14	129,586	125,789
2014/15	133,888	127,959
2015/16	132,957	127,725
2016/17	129,828	125,634
2017/18 P	129,828	125,634

Historical Performance trend



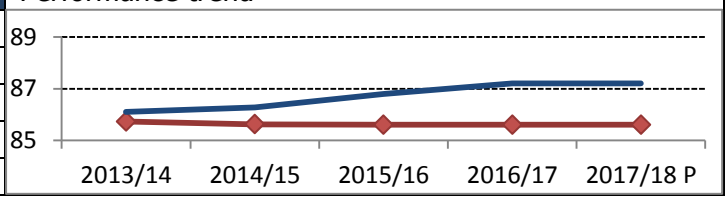
Source: ISD Scotland. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

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 2017/18 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
2013/14	85.7	86.1
2014/15	85.6	86.3
2015/16	85.6	86.8
2016/17	85.6	87.2
2017/18 P	85.6	87.2

Historical Performance trend



Source: ISD Scotland.
Note: Figures for 2017/18 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 2018 quarterly performance report for the Integration Joint Board.

Performance – Qualitative data

THE MATCHING UNIT

CASE STUDY

Mr J lives with his wife Mrs J and has a diagnosis of Multiple Sclerosis. He mobilises with a zimmer frame but has poor mobility and he is at high risk for falls. He has had several falls in recent months in which he has been unable to get up from the floor. Mr J also has a recent dementia diagnosis and feels safest when Mrs J is at home.

Mrs J suffers from back pain and acknowledges that her caring role has increased since Mr J was diagnosed with dementia. She admits that she is suffering from considerable carers stress but is reluctant to accept any help at home.

Mr J was admitted to hospital after a fall at home. The Care Manager had identified a support plan for him previously but had not sent this to the Matching Unit because Mr and Mrs J had not been agreeable to accepting help. Nursing staff at the hospital were concerned about Mrs J's ability to care for her husband and contacted the Care Manager.

The Care Manager discussed a care package with Mrs J, and with her agreement made a call to the Matching Unit to advise of the situation and the urgency of sourcing care as soon as possible. The Care Manager received a call from the Matching Unit 2 hours later to advise that the package of care would start that evening. The Care Manager felt that if the care provision had not been provided as quickly Mrs J may have changed her mind.

Without the Matching Unit to provide this service, it is unlikely that the care could have been sourced as quickly.

Key Partnership Priorities for 2018/19

- Following reviews by Professor A Hendry and John Bolton, the Community Hospital/Healthcare Modernisation Programme will progress the recommendations made. This will include:
  - Development of an Intermediate Care Framework
  - Development of revised structure for community nursing
  - Development of ANP led community hospital model
  - Development of an alternative Clinical model for Community Hospitals
  - Develop hospital to home models
  - Develop hospice at home models

- 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.
- Expand the Matching Unit to improve access to locally based care at home for more service user groups.
- 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 2017/2018:

- The Integrated Joint Board Leadership Team meets weekly and is made up of key senior operational, strategic and financial leaders who represent the Health and Social Care Partnership. The role of the Leadership Team is to support the delivery of outcomes as outlined in the Strategic Plan, support the integrated delivery arrangements for Health and Social Care, implementation of a change programme to improve outcomes and manage within available resources.
- 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.
- 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.
- A range of 'Discharge to Assess' pilots are currently underway including Craw Wood and Hospital to Home. The aim of these services is to work together across Health and Social Care services to ensure individuals are supported in the most efficient and effective way.
- An integrated Joint Workforce Planning Framework is in place to look at the current workforce and what is required going forward, as well as to ensure staff are equipped with the right skills and experience.
- An Independent Sector Rep communicates across all Health and Social Care groups to ensure representation of the independent sector in local decision making and awareness of key local activities in the Health and Social Care sector.
- A joint IT Road Map is being developed and progressed with an aim to enable and exploit convergence between the NHSB's and SBC's ICT strategies. The joint road map is built around 4 themes:
  - Collaboration - addresses electronic communications (email, diaries, telephony, connectivity and sharing of information),
  - Person-centric data - developing a joined-up view of the patient and avoiding duplication of data entry
  - Workflow – looking at how technology can be used to improve and simplify patient pathways
  - Technology Enabled Care – how technologies in the home can be used to improve health outcomes for people and enable them to live independently and safely at home
- 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.
- Joint services continue to develop integrated working plans based on the Mental Health and Learning Disabilities model.
- Adult Protection service user questionnaires enable Scottish Borders to understand and improve support services.
- The Learning Disabilities Commissioning Strategy and Mental Health Strategy provide an integrated approach to commissioning and deployment of resources.

- Community-Led Support brings together health and social care, third sector and the independent sector to deliver services to local communities.
- The Transitional Care Facility is a multidisciplinary unit bringing health and social care staff together
- Work has commenced on the development of an integrated care pathway, commissioning strategy and action plan across Health and Social Care for individuals with a suspected or diagnosed Alcohol Related Brain Damage (ARBD). A multi-agency conference was held to identify local challenges and requirements.
- 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 in ongoing to ensure we deliver the right support at the right time.
- Colocation of Mental health service Health & Social Care staff in three locality based community teams and a rehabilitation team which covers the whole of Scottish Borders.
- The Learning Disability service undertook a people planning process in 2017 which identified the need to reorganise resources to support parts of the service under the greatest pressure.
- SB Cares has established the first single care registration for a co-located older people and learning disabilities day service in Peebles which has resulted in improved outcomes and experiences for clients in both services.
- A review of the model currently utilised in the delivery of community hospitals and community health care has been completed. The review considered best practice locally and nationally and identified options and recommendations for improvement. Plans for implementing these recommendations are being developed.
- Buurtzorg Model of neighbourhood care allows a multi-agency and person-centred approach to providing integrated care in people's homes.

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

- Partnership IT systems
- Delivering quality services with reducing resources.

Performance - National "Core Suite" Indicators

NI-4 75% of adults supported at home strongly agreed or agreed that their health and social care services seemed to be well co-ordinated (Scotland 74%).

Source: Scottish Government Health and Care experience survey 2017/18.

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 2018/19

- 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; using learning across the services.
- Implement 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 2017/18:

- 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. Providers, support organisations and partnership representatives have joined the Self Directed Support Working Group.
- 75% of people receiving social care support have had an assessment using a self-directed support approach and 326 people are managing their support through direct payment.
- An interim Carers Strategy and planning for the implementation of the Carers Act in 2018 has been developed with the Carers Advisory Board. Work is underway on the new 2017-1019 strategy.
- Work continues on the Reimagining day services project, developing an inclusive model for reimagining 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 with three new staff having commenced training this year.
- 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.
- 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 Carers Centre provides training for Carers including assertiveness training and how to build resilience.
- SB Cares 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.
- Locally based Community Led Support 'What Matters Hubs' provide an additional flexible option for those seeking to access information and advice on Health and Social Care services, allowing them to make informed choices and live their life the way they want.
- Locality Working Groups have been established in all 5 localities with representation from Health and Social care, third sector, independent sector and members of the local community. These groups allow participation in locality planning and more choice and control in local communities.

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 83% of adults supported at home strongly agreed or agreed that they are supported to live as independently as possible (Scotland 81%).

NI-3 74% of adults supported at home strongly agreed or agreed that they had a say in how their help, care, or support was provided (Scotland 76%)

Source: Scottish Government Health and Care experience survey 2017/18.

Key Priorities for the Partnership for 2018/19

- Increase the number of people accessing all self-directed support options by streamlining financial and other processes, removing barriers to change.
- 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.

Performance – Specific programme

SELF DIRECTED SUPPORT

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

▲ **1667** people using self directed support at the end of March 2018

& 77.6% of service users have been offered self directed support options (up from 59% in 2016/17)

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 2017/18:

- To date, the Partnership has delivered over £6.5m of permanent recurring 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 Health and Social Care Strategic Plan is currently being refreshed and sets the strategic direction and framework for the Partnership for 2018/19. The Strategy is informed by a local needs assessment and projections of need.
- The Joint Commissioning and Implementation Plan has been refreshed as part of the refresh of the Strategic Plan.
- An Information Analyst from the Local Intelligence Support Team has been working in collaboration with the Partnership over the past year and continues to look at ways that data can be used to improve efficiency.
- There is an established programme of leadership including 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 Partnership continues to build on experience of co-located teams through existing 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.
- A second cohort of 'My Home Life' training has taken place enabling Care Home Managers to develop transformational leadership skills and relationship-centred care. Participants of both cohorts felt that the training had enabled them to make an improvement in the quality of practice in the care home.
- A Matching Unit is in operation to maximise efficiencies across care at home and release paid Carer capacity. The unit plans to expand the services provided by developing a matching service for direct payments and District Nursing teams.
- 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.
- The Pharmacy Input project is working to improve the way in which medications are administered in peoples' homes to reduce the unnecessary use of compliance aids and ensure the most efficient use of home care services.
- Service users and Carers are involved in service developments and recruitment.

- The Learning Disability Transitions Steering Group has made progress towards a Transitions Pathway by developing a high level pathway and information pack for young people in transition from children's into adult services. This is part of a 3 year project which continues to 2019.

- SB Cares has delivered £2.6m of reduced costs of service since inception in 2015 through improved deployment of staff, efficient procurement, and reduced staff travel and improved financial management processes. £1m of this has been delivered as permanent annual cost reductions in our services.
- SB Cares continued to improve the quality care with 85% of their registered care services receiving Care Inspectorate grades of Good or above.
- The Community Led Support 'What Matters Hubs' use a simplified version of the social work assessment which reduces bureaucracy and streamlines the assessment process.
- The IJB Transformation Programme comprises of a number of projects aimed at improving service delivery and the realization of efficiencies. Current projects include Mental Health, Day Services, Carers Strategy and IT Integration.

Performance - National "Core Suite" Indicators

NI-5 83% of adults receiving any care or support rated it as excellent or good (Scotland 80%).

NI-6 88% of people rated the experience of the care provided by their GP practice as excellent or good (Scotland 83%).

NI-7 80% of adults supported at home strongly agree or agree that their services and support had an impact on improving or maintaining their quality of life (Scotland 80%).

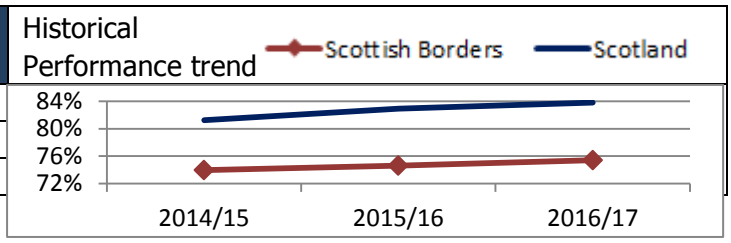
NI-9 86% of adults supported at home strongly agree or agree they felt safe (Scotland 83%).

Source: Scottish Government Health and Care experience survey 2017/18.

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%
2016/17	75.4%	83.8%

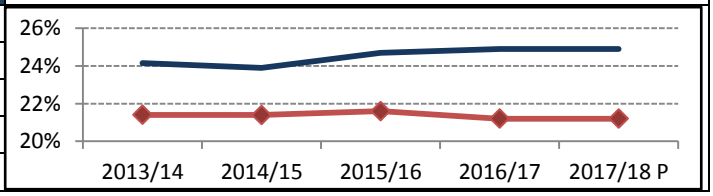
Source: Care Inspectorate (indicator in development).



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
2013/14	21.4%	24.2%
2014/15	21.4%	23.9%
2015/16	21.6%	24.7%
2016/17	21.2%	24.9%
2017/18 P	21.2%	24.9%

Historical Performance trend



Source: ISD Scotland. Note: Underlying costs data for 2016/17 have been used as a proxy for 2017/18 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

MATCHING UNIT

30% Drop in Social Work waiting list numbers between April and December 2017

1083 Care Packages sourced by the Matching Unit in its first year of operation

Data April 2017 – March 2018

"TWO MINUTES OF YOUR TIME" SURVEY

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

97% 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 2017 – March 2018

Key Priorities for the Partnership for 2018/19

- Shared aims and language across the partnership through developing and aligning performance activities across the Partnership, identifying opportunities for integrated approaches.
- 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.
- Primary Care Improvement Plan which will address a number of key priorities.

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 2017/18:

- Community Learning Disability Nurses work on an individual basis with people with learning disabilities to access mainstream healthcare, and provide additional support and guidance for those who struggle with this. The also work with Public Health to promote access to the main health screening programmes.
- The Public Dental Service continue to deliver the Childsmile programme and provide enhanced services to special needs/ additional needs children with core tooth brushing in all schools with special needs units. The service also continues to encourage early dental registration of children by working closely with key partners in health and social care.
- Public Dental Services work in partnership with independent dental practitioners to improve access to NHS Dental Care across the Scottish Borders, with an emphasis on patients identified as having mental health challenges, drug and alcohol dependencies, the homeless and ex-offenders.
- The Borders Community Planning Partnership 'Reducing Inequalities Strategy' sets the priorities and high level outcomes for health, care and wellbeing to address inequalities.
- The Learning Disability Liaison Nurse service supports people with learning disabilities access hospital services by working with them and their Carers prior to admission, during admission and discharge. The service works closely with the Borders General Hospital to develop training and raise awareness of learning disabilities. A Hospital Passport is now used by people with learning disabilities access the hospital. It carries important information for staff to know about the person.
- The Pathway 2 project continues to deliver high quality, responsive services to victims of domestic abuse and their children across the Scottish Borders.
- Service leaflets are available in a variety of formats to allow all people to access the information they require in a way that is most appropriate for them.
- Interagency and cross sectoral work to tackle health inequalities, focusing on prevention, mental health and inclusion.
- Implementation of the Six Steps to Being Well guide through a programme of capacity building, following the launch of the guide in Mental Health Awareness Week in May 2017.
- Further development of healthy lifestyle supports for vulnerable groups.
- Effective piloting of intervention with Live Borders, Health Improvement and the Diabetes Service 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 Living Network staff chair locality support groups and act as a conduit to the Diabetes Prevention Steering Group.
- Continuing to build on the priorities and actions arising from the Health Inequalities Impact Assessment of local health screening programmes to improve reach and uptake among harder to reach and vulnerable groups.

- Following the launch of the Six Ways to Be Well guide, tailored resources have been developed for children and young people, jobseekers, parents and other groups.
- An Autism Coordinator has been appointed to take forward the recommendations of the Autism Strategy including ensuring that people with autism are able to access mainstream services.
- The Carers team are targeting the issue of Carer ill-health in the new Health Inequalities plan.
- 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.
- Health literacy is being promoted with a range of staff groups and through focused work in one Learning Community Partnership, generating the 'Healthy Hawick' initiative.
- 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 and health staff including eLearning tools on dementia and adult and child protection.
- The Community Transport hub provides a coordinated and accessible transport service across the Scottish Borders, bringing together the resources of a number of third sector organisations.
- 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 such as the Serendipity Recovery Café and Mutual Aid Partnership Groups in Addaction.
- The Alcohol and Drug Partnership held a multiagency workshop to identify ideas for preventing drug related deaths and an action plan is being implemented.
- The Alcohol and Drugs Partnership has carried out a review of alcohol related deaths to improve understanding of the patient journey, identify services provide to individuals and learning points to inform potential interventions.
- 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 provide 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 was finalised in 2017 and the first year of the strategy has been implemented.
- In 2017/18 an additional £1.73m has been allocated by the Scottish Government to improving energy efficiency in homes across the Borders with around 1000 measures expected to be installed by June 2018.

- 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.

Performance – Specific programmmes

LOCALITY PLANS

In 2017/18 consultation with local communities across the Scottish Borders took place. As a result of this Locality Plans were produced for each of the 5 localities. These plans were coproduced through Locality Working Groups each representing the needs and priorities of the local community.

Each Locality Plan was produced in an easy read format as well as full and summary versions.

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.

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.

- New Carer Support Plan developed with Carer involvement.
- Planning underway for the implementation of the Carers Action with the development and implementation of new eligibility criteria designed in partnership with Carers.
- The Partnership is committed to increasing referrals for Carers Support Plans 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.
- A Carers Health Needs Assessment has been carried out led by Public Health and informs the Carer Strategy for the next 2 years.
- 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 information and assistance for people with Dementia and their Carers whilst they are in hospital.
- A Carers support group runs in Gala Day Unit and work is ongoing 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.
- 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.
- Carers can access advice on support available in their area at their local Community Led Support 'What Matters Hub'.

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

- Identifying Carers to ensure they get timely and appropriate support
- Support Carers to maintain their health and wellbeing
- Making sure information is easily accessible by Carers
- Ensure Carers are aware of and can access their Carers Rights

Performance - National "Core Suite" Indicators

NI-8 36% of Carers strongly agree or agree they feel supported to continue in their caring role (Scotland 37%).

Source: Scottish Government Health and Care experience survey 2017/18.

Performance – Specific programmes

- 1032 professionals have received Carers Awareness and Carers Act Training through Flying Start, induction training and talks and visits. This training is delivered in partnership with Carers.

CARERS

453 new Carers have been referred to the Carers Centre service

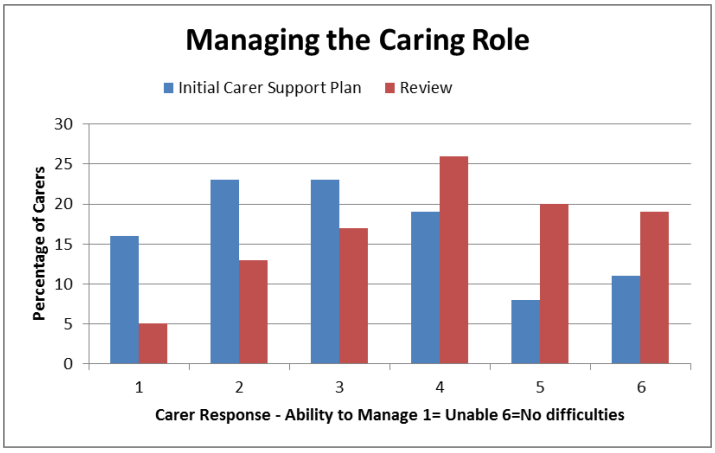
278 Carers have been referred to the hospital liaison worker

488 Carers Support Plans have been offered

442 Carers attending Carer support groups

1811 Carers have received on-going support and guidance

Data from April 2017 - March 2018



Successful Support of Carers

Carers report less difficulty in managing their caring role on review of the Carer Support Plan at 3-6 months.

Key Priorities for the Partnership for 2017/18

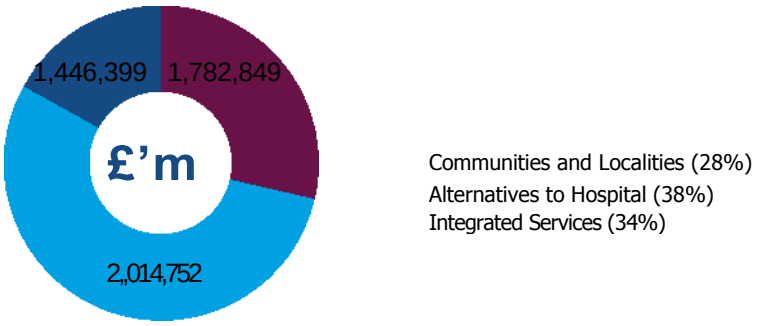
- Increase the identification of Carers
- Prepare and consult on a Carers strategy to be published in 2019.
- Improve Carer health, using the recommendations from the Carers Health Needs assessment.
- Prepare a Carers Health Needs Assessment based on the Carers survey and implement an action plan based on the recommendations.
- 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 pivotal in 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, £5,244,000 has been directed by the Integration Joint Board to meet the costs of a range of transformational initiatives.

INTEGRATED CARE FUND DIRECTED BY KEY THEMES



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

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

Alternatives to Hospital – Includes projects such as: Transitional Care Facility, Craw Wood, Hospital to Home and Buurtzorg. All of these projects work prevent admissions to hospital and to reduce time spent in hospital.

Integrated Services – Includes: Programme Team, Autism Strategy, Alcohol Related Brain Damage, Transitions and Independent Sector Representation. These projects bring together services across Health and Social Care, and include pathway projects and integrated teams.

INSPECTION OF SERVICES

Joint Inspection of Services for Older People in the Scottish Borders

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

An action plan is in place to meet the thirteen recommendations, with 60 actions to meet the thirteen recommendations. The inspection started when the Health and Social Care Partnership was at an early stage of development and the Partnership was already committed to an ambitious plan that is transforming the approach to meeting the needs of older people. The inspection action plan consolidates a range of these plans.

The partnership is working very hard to address the challenges outlined within the report and are not complacent about the changes required to improve the aspects of our work highlighted by the inspectorate. We do also welcome their acknowledgement of the progress already made in bringing the partnership together and in meeting our local challenges.

All services within the Health and Social Care arena within the Borders are now part of an improvement programme reporting to the Performance and Finance Group ultimately to the full Integration Joint Board. We have embarked on an ambitious plan to reduce demand, make our services more efficient and to improve quality of provision throughout. The commitment of our staff teams towards this goal is evident within all our services.

More information on how we are meeting the recommendations is within Appendix B

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

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Arrangements

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

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

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

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

These arrangements ensured all partners received sufficient assurance over:

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

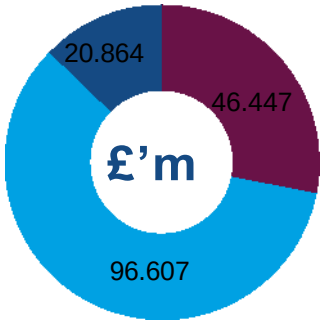
At the end of its first year the Partnership is well established in terms of financial governance, planning, management and statutory reporting evidenced by:

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

Financial Management

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

THE PARTNERSHIP'S BUDGET 2016/17



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

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

FINANCIAL PRESSURE EXPERIENCED DURING 2016/17

£4.481m
large hospital budget set-aside

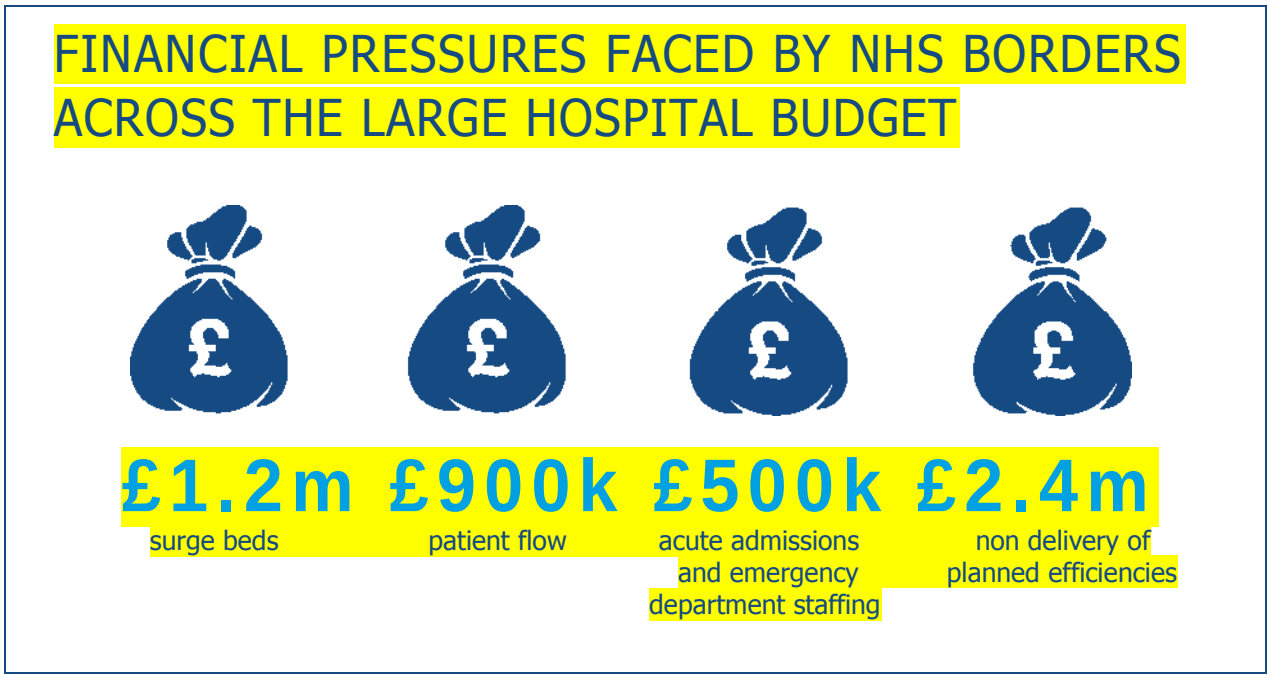
£3.879m
Delegated budget

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

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

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

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



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

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

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

PERFORMANCE MONITORING FRAMEWORK: SUMMARY

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

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

- Within the Partnership we are also reporting on a series of measures identified locally as priorities to be monitored to help manage and improve services. This series of measures will develop further over time. More information on performance against locally set measures is available at www.scotborders.gov.uk/integration

Performance areas that have been challenging for the Partnership have helped to determine the strategic priorities for 2018 – 2019.

DELIVERY OF KEY PRIORITIES FOR 2018/19

The Scottish Borders Health and Social Care Strategic Plan has been refreshed for 2018/19.

3 Strategic Objectives have been identified as follows:

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

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

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

The key priorities identified for 2018/21 are:

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

Conclusion

So the second year of the partnership closes and we embark on our third. The challenges have not abated and if anything they have increased. Our elderly population continues to grow and our available resources diminish.

We do however have a great deal of opportunity within our communities to improve everyone's health and well-being and to reduce demand across the whole range of Health and Social Care Services.

I look forward to reporting back to you next year on the progress through 2018/19.

I wish you every success.

Robert McCulloch-Graham

APPENDIX A
FINANCIAL PERFORMANCE AND BEST VALUE

I) FINANCIAL PERFORMANCE

Legislative and Governance Framework

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

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

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

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

These provisions specifically include:

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

Statutory Reporting Requirements

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

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

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

2016/17 - Resources Delegated to the Integration Joint Board

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

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

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

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

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

- Partners' absolute level of funding by the

Scottish Government

- Past performance and known areas of financial pressure arising due to cost, demand, legislative and other factors
- Efficiencies and other required savings delivery to ensure overall affordability
- New priorities as expressed within partners' plans and the Integration Joint Board's Strategic Plan
- Other emerging areas of financial impact

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

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

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

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

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

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

These included or related to:

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

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

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

Recovery Planning and Delivery during the Financial Year

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

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

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

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

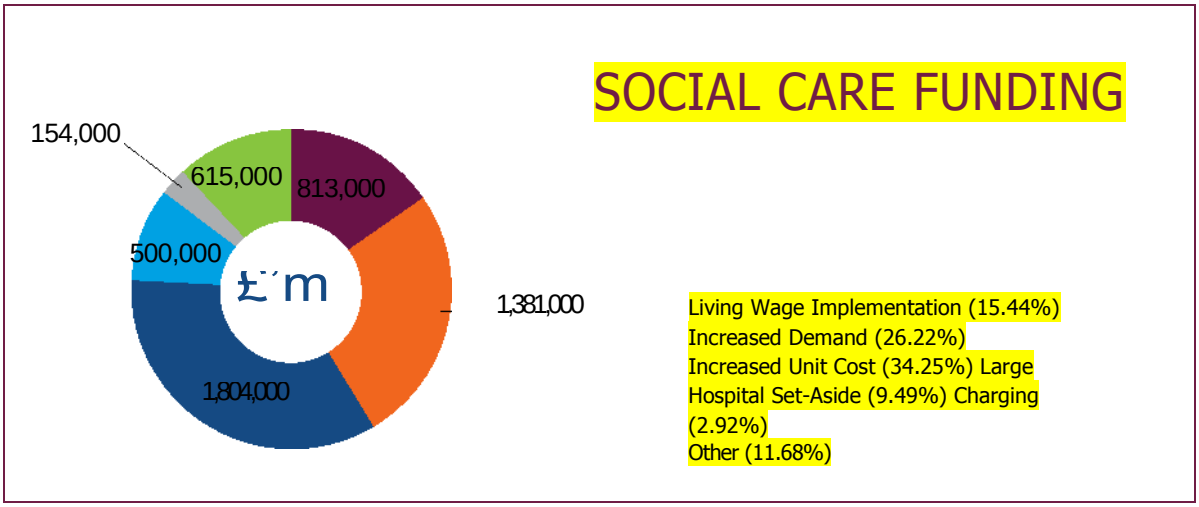
Establishing this impact and reviewing the Strategic Plan in light of prevalent financial pressures is now a key work package for the Partnership. Underpinning this will be the implementation of an integrated medium-term transformation programme for all health and social care aimed at improving performance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

Funding Priorities

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

Social Care Funding

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



Integrated Care Fund

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

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

INTEGRATED CARE FUND PROJECTS

Pathways

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

Communities and Localities

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

Other

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

ICF remaining resource

£2.374m

II) BEST VALUE

Introduction

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

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

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

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

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

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

Leadership, Partnership Working and Inclusion

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

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

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

Transformation and Redesign

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

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

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

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

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

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

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

Use of Resources

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

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

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

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

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

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

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

Performance Management

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

Forward Planning

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

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

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

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

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

APPENDIX B

Inspection of Services

The recommendations for improvement in the report are as follow

	Recommendations Made	Action Taken to Implement Recommendations
1.	The partnership should deliver more effective consultation and engagement with stakeholders on its vision, service redesign and key stages of its transformational change.	We have a clear communication plan which outlines the Partnership's vision and how the Partnership will engage and consult with key stakeholders in service design, joint plans and policies. The locality working groups are a positive and recent example of a regular forum for engagement and consultation.
2.	The partnership should ensure its revised governance framework provides more effective performance reporting and an increased pace of change.	Quarterly performance reports are presented to the IJB and managers across the Partnership managers engage in dialogue about these.
3.	The partnership should further develop and implement its joint approach to early intervention and prevention services so that it continues to improve the range of services working together that support older people to remain at home and help avoid hospital admission.	'What matters' hubs are now in place across the Borders and work jointly with the third sector, signposting people to healthy living activities. A strategic delivery plan is in progress. to identify the current landscape of early intervention and prevention services, and the gaps, in order to make recommendations to address this.
4.	The partnership should further develop and implement its joint approach to early intervention and prevention services so that it continues to improve the range of services working together that support older people to remain at home and help avoid hospital admission.	'What matters' hubs are now in place across the Borders and work jointly with the third sector, signposting people to healthy living activities. A strategic delivery plan is in progress. to identify the current landscape of early intervention and prevention services, and the gaps, in order to make recommendations to address this.
5.	The partnership should review its delivery of care at home, care home and intermediate care services to better support a shift in the balance of care towards more community based support.	This complex piece of work in a challenging market environment is progressing. An older person's housing strategy has been drafted, a commissioning plan will be in place by summer 2018 as will a plan for development of telecare
6.	The partnership should update its carers strategy to have a clear focus on how carers are identified and have their	The Carers Advisory Group- a group of carers- has led on a Carers Strategy for 2017-19. There has been an extensive

	needs assessed and met. The partnership should monitor and review performance in this area.	programme to raise awareness about carers through staff training and through SBConnect, sent to every Borders household.
7.	The partnership should ensure that people with dementia receive access to a timely diagnosis.	Awareness raising sessions have been held on the importance of diagnosis and discussions with GP practices to ensure that people with a diagnosis of dementia are recorded.
8.	The partnership should take action to provide equitable access to community alarm response services for older people.	A telecare strategy is in development for summer 2018 to ensure best use is made of telecare and telehealth care options to assist people to remain at home.
9.	The partnership should provide stronger accountability and governance of its transformational change programme. It should ensure that: • progress of the strategic plan priorities are measured and evaluated; • service performance and financial monitoring are linked • locality planning is implemented and leads to changes at a local level • independent needs assessment activity is included in the joint strategic needs assessment• there is appropriate oversight of procurement and commissioning work• a market facilitation strategy is developed and implemented.	There is quarterly performance reporting to the IJB; a long term sustainable financial plan will be agreed by summer 2018. A commissioning plan and market facilitation plan will be in place by autumn 2018. Locality working groups have recently published their plans and there is regular reporting to the IJB.
10.	The Integration Joint Board should develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved.	The 2017/18 financial recovery plan was agreed. This required additional non-recurring monies to be approved to health and social care delegated functions. The IJB is progressing a transformation and efficiency programme which will contribute a level of efficiency savings.
11.	The partnership should ensure that there are clear pathways for accessing services and that eligibility criteria are consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.	A What Matters hub has now been established in each area of the Borders- with more hubs in some rural areas like Ettrick/Yarrow. The impact has been to significantly reduce waiting lists for social care support. The matching unit, to link people with available providers, has speeded up access to services.

12.	The partnership should work together with the critical services oversight group and adult protection committee to ensure that: • risk assessments and risk management plans are completed where required • quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve • improvement activity resulting from quality assurance processes is well governed.	Quarterly file audits are undertaken to ensure that appropriate action and recording are in place. Performance is reported on quarterly to the Adult Protection Committee and Critical Services Oversight Group. These reports are subject to peer scrutiny.
13.	The partnership should develop and implement a tool to seek health and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services.	Health and Social Care are using the IMatter tool to seek staff feedback. A survey has just been completed within social care and feedback is being analysed and reported to the IJB.
14.	The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and providing a skills mix that delivers high quality services.	A workforce plan has been drafted. In stage one this includes NHS Borders and SBC. Stage two will include the third and independent sectors and will be completed in 2018.

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

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	94%	93%
NI - 2	Percentage of adults supported at home who strongly agreed or agreed that they are supported to live as independently as possible	83%	81%
NI - 3	Percentage of adults supported at home who strongly agreed or agreed that they had a say in how their help, care, or support was provided	74%	76%
NI - 4	Percentage of adults supported at home who strongly agreed or agreed that their health and social care services seemed to be well co-ordinated	75%	74%
NI - 5	Percentage of adults receiving any care or support who rated it as excellent or good	83%	80%
NI - 6	Percentage of people who rated the experience of the care provided by their GP practice as excellent or good	88%	83%
NI - 7	Percentage of adults supported at home who strongly agreed or agreed that their services and support had an impact on improving or maintaining their quality of life	80%	80%
NI - 8	Percentage of Carers who strongly agreed or agreed they feel supported to continue in their caring role	36%	37%
NI - 9	Percentage of adults supported at home who strongly agreed or agreed they feel safe	86%	83%

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

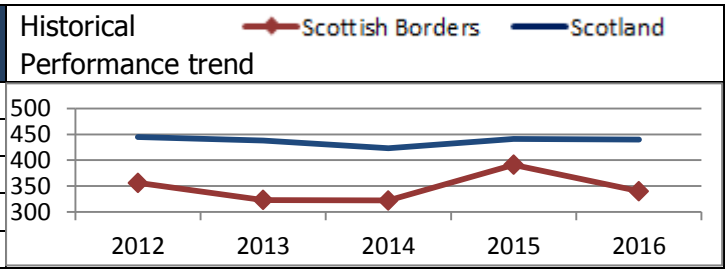
NATIONAL INDICATOR NUMBER	INDICATOR DESCRIPTION	SCOTTISH BORDERS	SCOTLAND
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	57% (NHS Borders only)	59%

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)

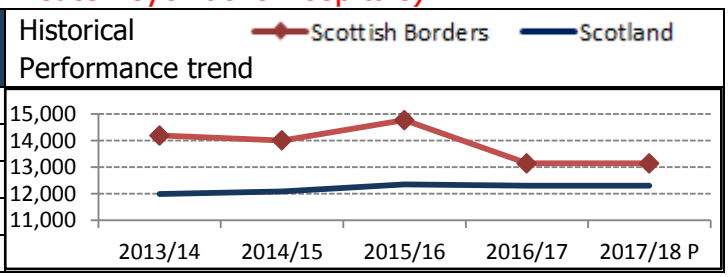
YEAR	SCOTTISH BORDERS	SCOTLAND
2012	356	445
2013	323	438
2014	322	423
2015	391	441
2016	340	440



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)

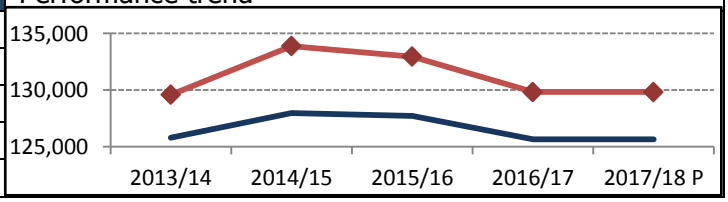
YEAR	SCOTTISH BORDERS	SCOTLAND
2013/14	14,184	11,989
2014/15	14,001	12,083
2015/16	14,763	12,342
2016/17	13,135	12,294
2017/18 P	13,135	12,294



Source: ISD Scotland. Note, figures for 2017/18 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)

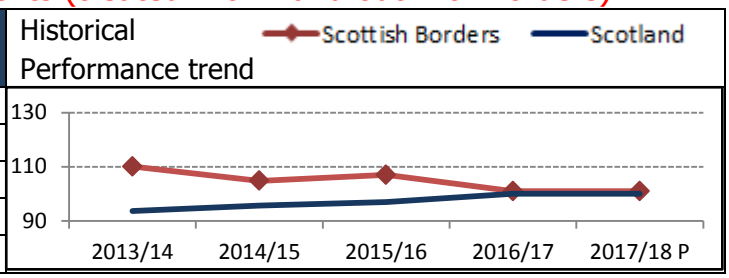
YEAR	SCOTTISH BORDERS	SCOTLAND
2013/14	129,586	125,789
2014/15	133,888	127,959
2015/16	132,957	127,725
2016/17	129,828	125,634
2017/18 P	129,828	125,634



Source: ISD Scotland. Note, figures for 2017/18 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).

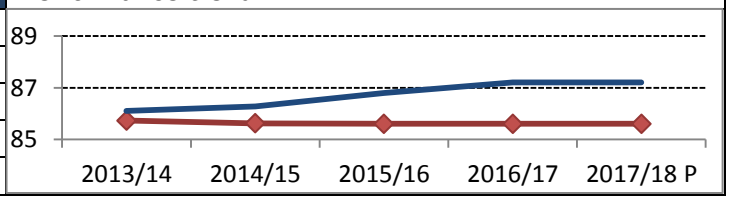
YEAR	SCOTTISH BORDERS	SCOTLAND
2013/14	110	94
2014/15	105	96
2015/16	107	97
2016/17	101	100
2017/18 P	101	100



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 2017/18 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 (%)

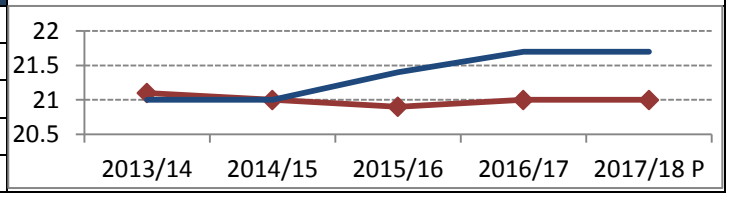
YEAR	SCOTTISH BORDERS	SCOTLAND
2013/14	85.7	86.1
2014/15	85.6	86.3
2015/16	85.6	86.8
2016/17	85.6	87.2
2017/18 P	85.6	87.2



Source: ISD Scotland. Note: Figures for 2017/18 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+

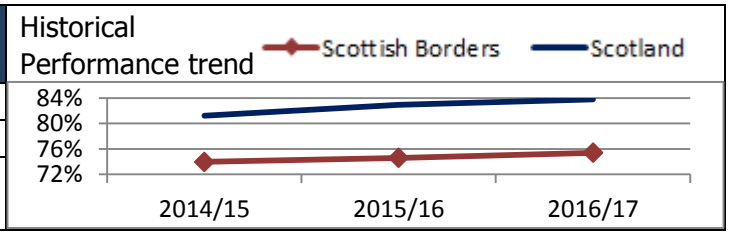
YEAR	SCOTTISH BORDERS	SCOTLAND
2013/14	21.1	21.0
2014/15	21.0	21.0
2015/16	20.9	21.4
2016/17	21.0	21.7
2017/18 P	21.0	21.7



Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges. Note, figures for 2017/18 are provisional, as some hospital data are incomplete for the later part of the year.

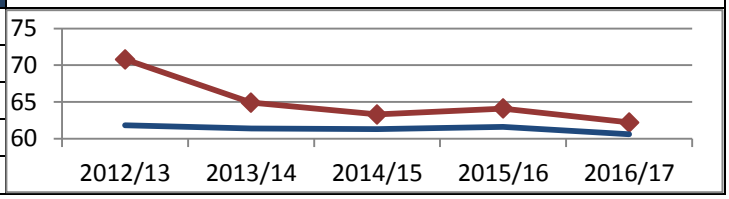
NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

YEAR	SCOTTISH BORDERS	SCOTLAND
2014/15	73.9%	81.2%
2015/16	74.6%	82.9%
2016/17	75.4%	83.8%



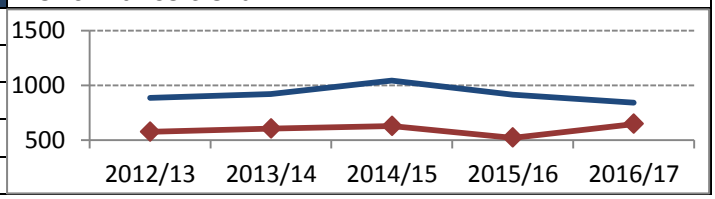
Source: Care Inspectorate (Indicator in development)

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

YEAR	SCOTTISH BORDERS	SCOTLAND	Historical Performance trend
2012/13	70.8	61.8	
2013/14	64.9	61.4	
2014/15	63.3	61.3	
2015/16	64.1	61.6	
2016/17	62.2	60.6	

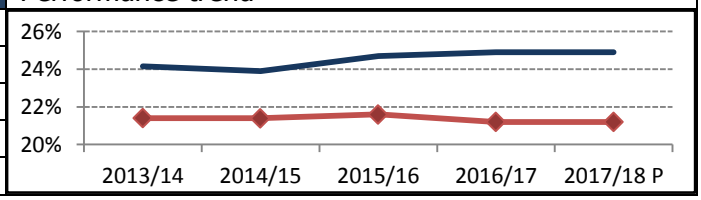
Source: Scottish Government Health and Social Care Statistics.

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

YEAR	SCOTTISH BORDERS	SCOTLAND	Historical Performance trend
2012/13	575	886	
2013/14	604	922	
2014/15	628	1044	
2015/16	522	915	
2016/17	647	842	

Source: ISD Scotland Delayed Discharge Census.

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

YEAR	SCOTTISH BORDERS	SCOTLAND	Historical Performance trend
2013/14	21.4%	24.2%	
2014/15	21.4%	23.9%	
2015/16	21.6%	24.7%	
2016/17	21.2%	24.9%	
2017/18 P	21.2%	24.9%	

Source: ISD Scotland. Note: Underlying costs data for 2016/17 have been used as a proxy for 2017/18 costs in the calculation of this indicator. These figures are therefore provisional and will be refreshed once updated costs data become available.

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

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

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

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

NI-23 Expenditure on end of life care.

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

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

Health and Social Care Services which are integrating

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

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

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Scottish Borders Health & Social Care *Partnership*

Annual Performance Report

2017-18

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

summary report

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:

- 94% of adults able to look after their health very well or quite well
- 83% of adults supported at home strongly agreed or 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 strongly agreed or agreed that their health and social care services seemed to be well co-ordinated
- 83% of adults receiving any care or support rated it as excellent or good
- 88% of people rated the experience of the care provided by their GP practice as excellent or good
- 88% of adults supported at home strongly agree or agree that their services and support had an impact on improving or maintaining their quality of life
- 36% of Carers feel supported to continue in their caring role
- 86% of adults supported at home agreed they felt safe

OUR DECISION –MAKING

The Partnership is overseen by the Integration Joint Board. During 2017/18 the board have made the following key decisions:

The appointment of Chief Officer, Robert McCulloch-Graham;
Approval of the Mental Health Service Strategy;
Approval of the Learning Disability Strategic Commissioning Plan;
Directions for a Discharge to Assess Policy;
A refresh of the Strategic Plan through the Strategic Planning Group.

A YEAR AT A GLANCE

OUR SUCCESSES

74%
Of admissions to Craw Wood are discharged home

328
Home visits by the Berwickshire Hospital to Home team

51.4%
of total health and social care expenditure in Scottish Borders was on community based services

1083
Care Packages Sourced by the newly established Matching Unit in 2017/18

81%
Of Transitional Care Service Users who are discharged to their own home

75%
of older people reported being more socially active as a result of taking part in Community Capacity Building activities

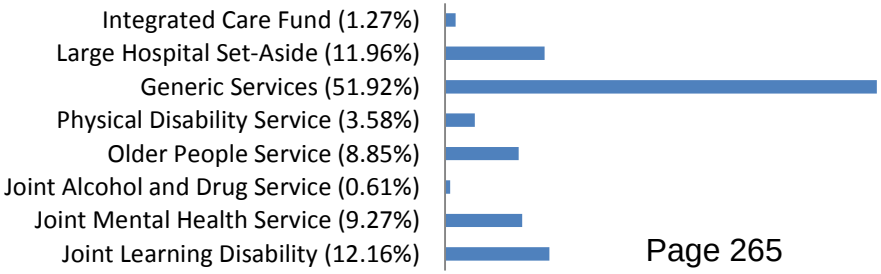
OUR CHALLENGES

36%
Of Carers feel supported to continue in their caring role

899
Delayed discharges

10.5%
occupied bed days associated with delayed discharges

SPEND BY DELEGATEDFUNCTION



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 of 2017. The recommendations and subsequent actions can be seen in the full performance report.

FINANCIAL PERFORMANCE

During 2017/18, the partnership spent over £168m commissioning health and social care services and implementing new models of care in order to deliver its Strategic Plan priorities. This includes over £20m of hospital budget set-aside, over £7m of social care funding and around £2m Integrated Care funding. Increasing demand and costs remains a major challenge for the partnership.

DISCHARGE TO ASSESS

In 2017/18 directions were issued for a Discharge to Assess policy, supporting people to get out of, or remain out of, hospital and within their own communities. The Craw Wood Discharge to Assess facility and Hospital to Home Berwickshire are examples of how this has been put into practice so far. In 2018/19 Hospital to Home will expand to more localities in the Scottish Borders.

FURTHER INFORMATION

The full Annual Performance report is available at **www.scotborders.gov.uk/integration**

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: ...28 May 2018.....

Report By	*Robert McCulloch-Graham, Chief Officer*
Contact	*Iris Bishop, Board Secretary*
Telephone:	*01896 825525*

AUTHORISATION TO SIGN OFF ANNUAL ACCOUNTS 2017/18

Purpose of Report:	To seek agreement that Mr David Robertson as the Chief Financial Officer for Scottish Borders Council should sign off the Integration Joint Board Annual Accounts for 2017/18.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Consider and agree that Mr David Robertson as Chief Financial Officer of Scottish Borders Council should sign off the Integration Joint Board (IJB) Annual Accounts 2017/18 in the current absence of a Section 95 Officer for the IJB.

Personnel:	The Chief Financial Officer post remains vacant. Mitigating actions have been put in place whereby the position is being covered by both the Section 95 Officer for Scottish Borders Council (Mr David Robertson) and the Director of Finance, NHS Borders (Mrs Carol Gillie). It has been suggested that Mr David Robertson be identified to undertake the Section 95 Officer role for the IJB for the purposes of signing off the Integration Joint Board Annual Accounts 2017/18.

Carers:	N/A

Equalities:	N/A

Financial:	The Chief Financial Officer is the accountable officer for financial management, governance and administration of the IJB. This includes accountability to the IJB for the planning, development and delivery of the IJB's financial strategy and responsibility for the provision of strategic financial advice and support to the IJB

	and the Chief Officer. The Chief Financial Officer is to promote sound financial management by the IJB to ensure public funds are safeguarded and used appropriately, effectively, economically and efficiently at all times.

Legal:	Section 13 of the Public Bodies (Joint Working) (Scotland) Act 2014 amends the Local Government (Scotland) Act 1973, by extending the application of Part 7 of the 1973 Act (with the exception of sections 101A and 105A) to Integration Joint Boards. Under that provision, the Integration Joint Board requires to appoint a “proper officer” (Chief Financial Officer) who has responsibility for the administration of the financial affairs of the Integration Joint Board (IJB) in terms of section 95 of the 1973.

Risk Implications:	None compliance with Section 95 of the Local Government (Scotland) Act 1973. Inability of the Integration Joint Board to approve its Annual Accounts for 2017/18.