Scottish Borders
Health and Social Care
PARTNERSHIP

SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP

JOINT STRATEGIC COMMISSIONING & IMPLEMENTATION PLAN

2017-2019

SERVICE DELIVERY ACTIONS TO ACHIEVE LOCAL OBJECTIVES

Contents

1. Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislative framework for the integration of health and social care in Scotland. The main principles underpinning the Act are:

- there should be a single system for health and social care;
- informal community resources and supports are crucial and should be invested in;
- resource allocation needs to factor in prevention and early intervention as a priority;
- the quality and consistency of services should be continuously improved;
- people's pathway through services should be seamless;
- resources should be used effectively and efficiently.

The Act requires Health Boards and Local Authorities to establish formal partnership arrangements to oversee the integration of services. Scottish Borders Health and Social Care Partnership have established a Partnership body - the Integration Joint Board (IJB). The IJB is required to formally issue 'directions' to the two partner bodies within the Partnership.

The Scottish Borders Health and Social Care Strategic Plan describes a shared vision for improved health and well-being for all adults living in the Scottish Borders as well as sets out nine Local Strategic Objectives which are aligned to the nine National Health and Wellbeing Outcomes.

This 'Commissioning and Implementation Plan' describes the priorities and related actions for the Scottish Borders to ensure that the strategic intentions outlined in the Strategic Plan are delivered. The Commissioning and Implementation Plan therefore gives practical detail on the change required to meet local objectives, how change will be achieved and measured as well as highlighting associated resource implications.

The plan incorporates both local priorities that have been determined through robust consultation with the public and also high level national priorities, which are articulated within the legislation as well as across a myriad of related policy such as the Health and Social Care Delivery Plan.

2. Demographics

In developing the Commissioning and Implementation Plan it is crucial to consider the population structure and characteristics that impact upon health and social care services to ensure that we are prepared for the delivery of services now and in the future.

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. 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 the population is spread across the Borders planning services is more challenging.

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%.

By the year 2032, the number of people aged 65 and over in the Scottish Borders is projected to increase by 51% compared to 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 and there is a need to promote active ageing as well as address the range of needs of older people.

With the changes predicted in the population it is expected there will be 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% compared to 21% for Scotland as a whole.

In a recent Scottish Borders survey, the number of people who considered their health to be 'very good or good' decreased with age. For example more than 1 in 10 people aged over 75 years reported that their health is 'bad or very bad' compared to only 1 in 100 people aged 16-24 years. Nearly two thirds of people aged 65-84 years and more than 8 in 10 aged over 85 years had multi-morbidity. This presents the need for a significant challenge to the planning and delivery of health and social care services.

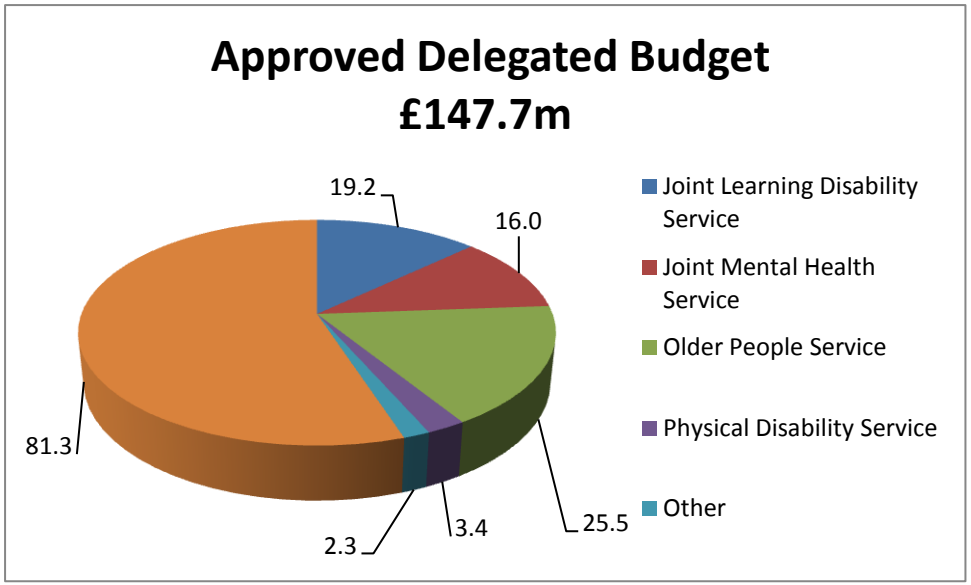
The Borders follows the national pattern of having higher emergency hospital admission rates for people living in areas of higher deprivation. The figure also shows that emergency admission rates in the Borders are higher than the Scottish average within any given deprivation grouping.

Dementia is a growing issue across Scotland and the rate of increase in the Borders may be faster than the Scottish average as the population is older. The condition represents a challenge for individuals, families and for planning and providing appropriate integrated care.

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

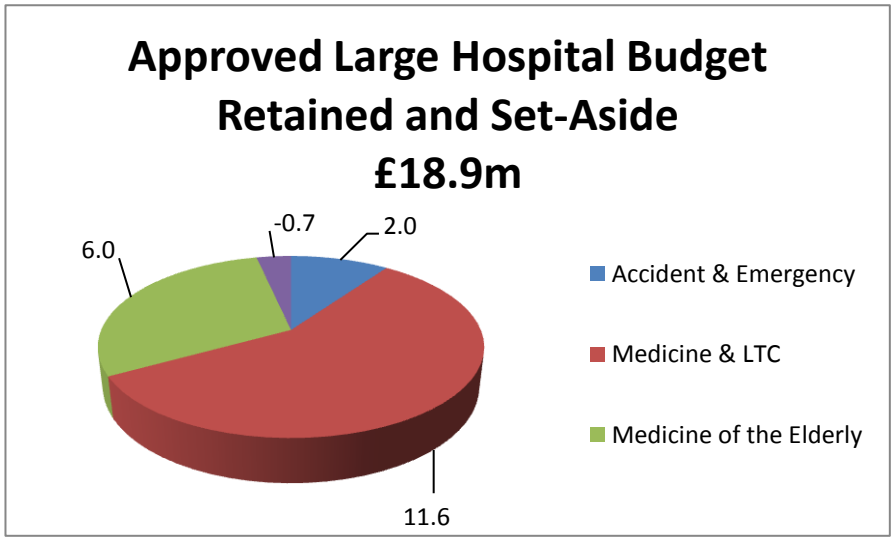
The level of caring is greater in more deprived areas. 46% of carers living in the most deprived areas of the Borders provide 35 or more hours of care per week compared with 22% of carers living in the least deprived areas. Research also indicates that providing care for someone else often affects the carer's own health. 42% of carers have one or more long-term conditions or health problems compared to 29% of non-carers.

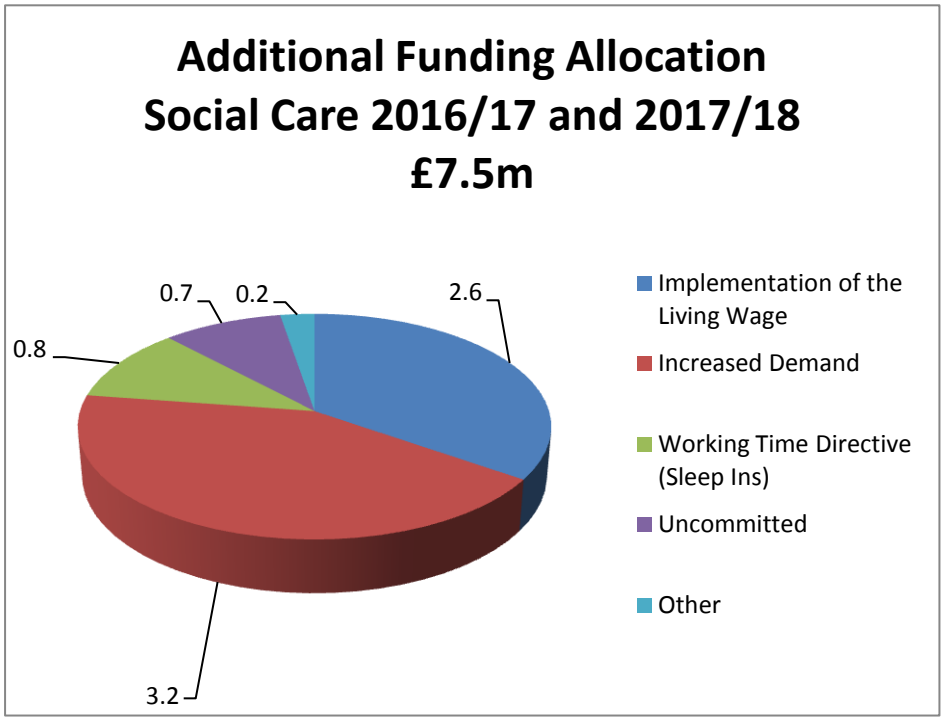
3. Financing our Priorities within the Scottish Borders



Prior to the start of 2017/18, the Scottish Borders Health and Social Care Partnership approved its 3-Year Financial Statement. As part of this, it agreed to the delegation of £147.7m of core budget in respect of the functions delegated to it. £94.5m of resource has been delegated by NHS Borders to support the commissioning of healthcare services whilst £52.9m has been delegated by Scottish Borders Council to support social care.

In addition to the budget delegated to the partnership, £18.9m has been retained by NHS Borders and set-aside for the population of the Scottish Borders in relation to large hospitals. This supports the provision of a range of hospital services, mainly unscheduled, such as Accident and Emergency. Whilst not directly controllable by the IJB, this budget taken in conjunction with the budget for functions delegated, forms the overall level of resources available to support the delivery of the partnership's Strategic Plan (£157.2m).

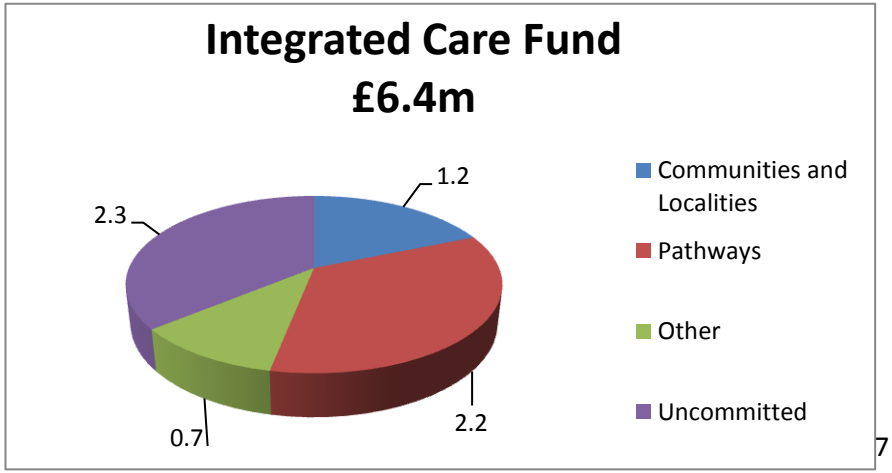




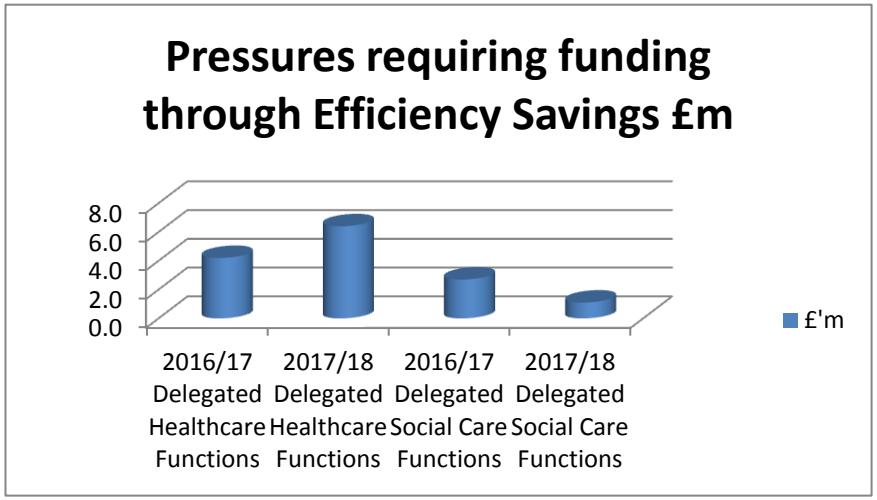
£5.3m of additional resources was also delegated to the partnership in 2016/17 to support a range of priorities, primarily within social care. This additional allocation by the Scottish Government was directed in full by the partnership's Board during the year in order to meet a number of national and local priorities. These included the implementation of a Living Wage of £8.25 per hour for all social care staff from the 1st October 2016 as well as enabling the partnership to mitigate the impact of increased demand for health and social care services and increased market costs for services such as homecare and goods such as drugs and pharmaceuticals.

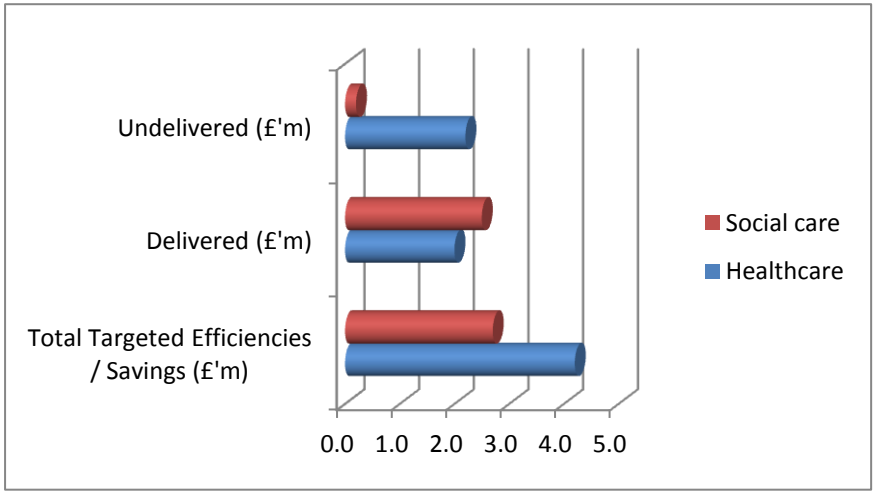
In 2017/18, a further £2.2m of additional funding has been allocated to the partnership by the Scottish Government (total £7.5m). This again however is including an increase in the hourly Living Wage to £8.45 and with the exception of £0.7m to date, has been fully directed by the IJB.

The partnership is also directing £6.4m of Integrated Care Funding towards the transformation and redesign of its models of health and social care over a 3-year period to the end of 2017/18. To date, over £4.0m has been approved across a range of projects summarised within the key themes of Communities and Localities and Pathways. The remaining uncommitted funding allocation will be directed in full during 2017/18 when the partnership's integrated transformation programme is finalised and approved.



Austere funding allocations linked to increasing costs and greater demand continues to put significant financial pressure across health and social care services. In order to ensure its financial plans are affordable, the partnership has to plan and deliver a considerable programme of efficiency and other savings plans. In 2016/17, this amounted to a total of £6.9m. Going forward a further £7.5m of savings require delivery in 2017/18 in order to ensure that the provision of services remains affordable.





During its first year of operation since its establishment, the partnership delivered £4.5m of its savings plans, with £2.4m remaining undelivered, the impact of which was met by a range of non-recurring remedial measures. The Executive Management Team of the partnership is working closely with the board in order to develop and implement a range of efficiency, savings and transformation initiatives within an overall plan during 2017/18 that will deliver the level of savings required and improve the partnership's performance and outcomes.

4. Creating the Correct Conditions for Change

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

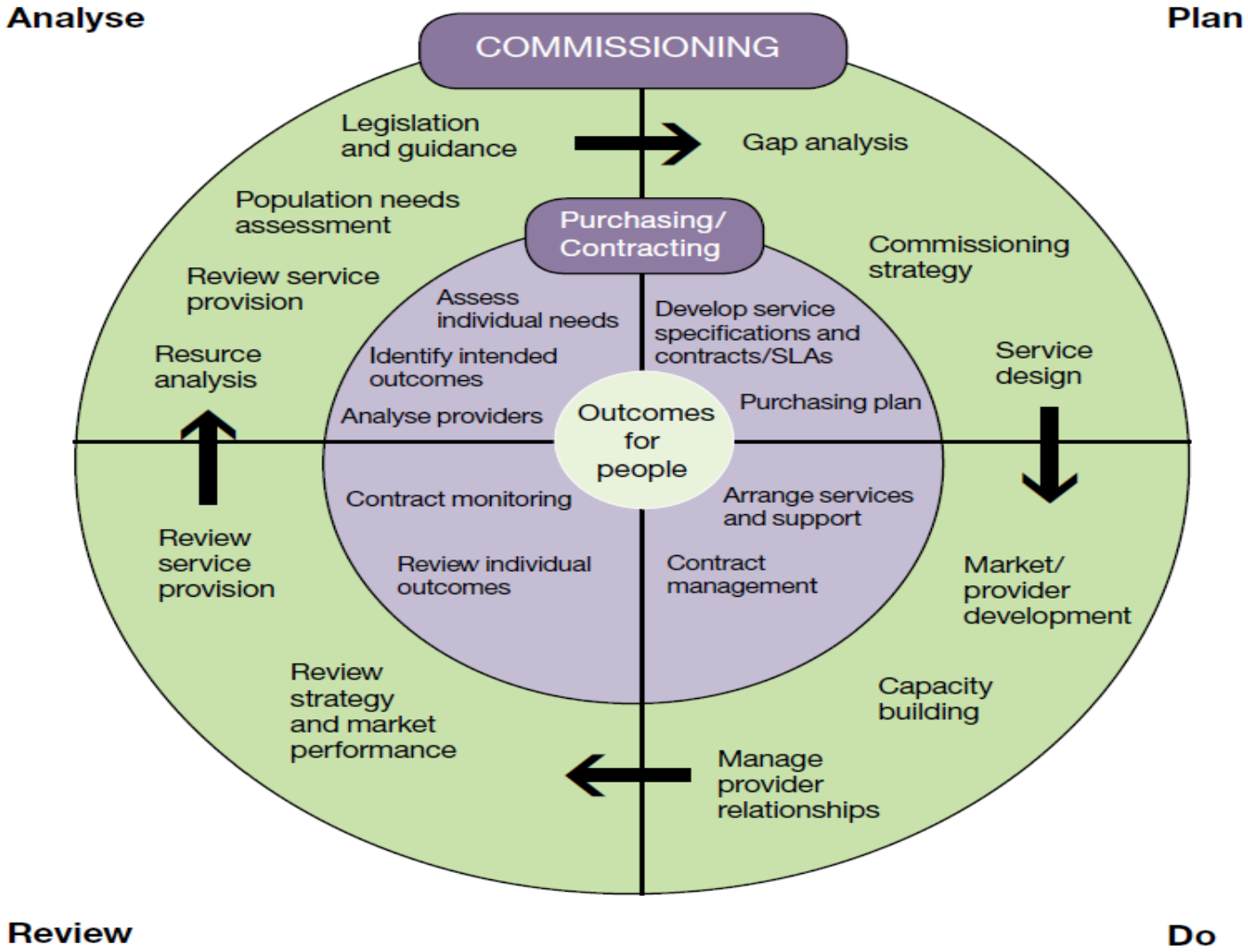
Leadership and Governance

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

- out of hospital care programme focussing on
- community and day hospitals,
- enablement,
- allied health professionals and
- dementia.

Also included in the transformation programme are:

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

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.

5. 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 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. 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 the following strategic priorities for the Scottish Borders Health and Social Care Partnership have been identified:

Local Strategic Priority	Aligned to National Outcomes:									Planned Investment	
	1	2	3	4	5	6	7	8	9	Invested Annually	Additional Investment
1. Services are accessible and community focussed.	✓	✓	✓	✓		✓		✓		£25m	£0.4m
2. Improve prevention and early intervention.	✓	✓		✓	✓			✓		£23m	£0.3m
3. Reduce avoidable admissions to hospital.	✓	✓							✓	£13m	£0.3m

Local Strategic Priority	Aligned to National Outcomes:									Planned Investment	
	1	2	3	4	5	6	7	8	9	Invested Annually	Additional Investment
4. Provide care close to home.	✓	✓	✓	✓	✓	✓			✓	£23m	£1.0m
5. Deliver services within an integrated care model.				✓				✓	✓	£3m	£0.7m
6. People will have more choice and control over their services and support.	✓	✓	✓	✓	✓	✓	✓			£5m	£0.3m
7. Efficiency and effectiveness will be increased.								✓	✓	£29m	£0.5m
8. Reduce health inequalities.	✓	✓	✓		✓	✓	✓			£22m	£0.3m
9. Support for carers.	✓	✓	✓	✓	✓	✓	✓			£15m	£0.3m
£2.3m Integrated Care Fund Remains Unallocated											

6. Implementation Plan ("Plan" and "Do" components of the Commissioning Cycle)

Priority	Desired Outcome	What Will We Do?	Timescales Start and End Date	Lead Person	Target Impact/Benefits
1. Services are accessible and community focussed.	People will be able to access a range of community-based health and social care services.	We will develop local hubs. ***(Integrated Care Fund)***	October 2016-April 2018	Murray Leys	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	Murray Leys	
		We will extend Local Area Co-ordination capacity in Mental Health by 2 new posts. ***(Core Funding Investment)***	April 2017 – March 2020	Simon Burt	
2. Improve Prevention and Early Intervention.	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	Murray Leys	Reduced admissions to hospital. Improved health and wellbeing. Reduction in demand for statutory services. Reduced demands on GPs. Improved access to advice on minor health complaints. Reduced Revenue Costs from reduced demand.
		We will build on the work of the Community Capacity Team. ***(Integrated Care Fund)***	July 2017 – October 2018	Murray Leys	
		We will review the role of the clinical Pharmacist. ***(Integrated Care Fund)***	April 2017 – March 2018	Alison Wilson	
3. Reduce avoidable admissions to hospital.	Provide people with alternatives to hospital care.	We will further develop assessment services at the hospital front door including Rapid Assessment for Discharge Team. ***(Integrated Care Fund)***	April 2017 – March 2018	Philip Lunts	Reduced emergency admissions and associated bed days. Reduce re-admissions to hospital.

Priority	Desired Outcome	What Will We Do?	Timescales Start and End Date	Lead Person	Target Impact/Benefits
					Reduced Revenue Costs from reduced demand.
		We will develop transitional care to include a "step-up" facility and increase opportunities for short-term placements. ***(Integrated Care Fund)***	April 2017 – March 2018	Murray Leys	
		We will develop a co-produced transition-friendly pathway articulated in a new Frailty Improvement Plan. ***(Core Funding Investment)***	April 2017 – March 2018	Philip Lunts	
		We will review community and day hospitals, defining their role within an improved patient pathway and model of care. ***(Transformation Programme)***	April 2017 – March 2018	Sandra Pratt	
		We will redesign the way care at home services are delivered to ensure a re-ablement approach. ***(Transformation Programme)***	September 2017 – March 2018	Murray Leys	
		We will implement a Distress Brief Intervention model of care within Mental Health. ***(Integrated Care Fund)***	April 2017 – March 2020	Simon Burt	
4. Provide care close	People are able to access the care and support they require	We will establish a centralised specialist Matching Unit to source	June 2017 – December 2018	Murray Leys	Quicker and more efficient planning of care and support.

Priority	Desired Outcome	What Will We Do?	Timescales Start and End Date	Lead Person	Target Impact/Benefits
to home.	within their own community.	care at home to meet assessed need. ***(Integrated Care Fund)***			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? Palliative			
		We will plan and deliver health and social care services by locality area. ***(Integrated Care Fund)*** ***(Transformation Programme)***	April 2017 – March 2019	Elaine Torrance	
		We will increase the use of telecare and telehealthcare. ***(Transformation Programme)***	October 2017 – June 2018	Murray Leys	
		We will increase the provision of Housing with Care and Extra Care Housing. ***(Core Fund Investment)***	April 2017 – March 2020	Murray Leys	
5. Deliver services within an Integrated Care Model.	The delivery of health and social care services is improved through more integration at a local level.	We will develop locally based integrated health and social care teams. ***(Transformation Programme)*** ***(Core Funding Investment)*** ***(Integrated Care Funding)***	June 2017 – October 2018	Murray Leys	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.
		We will develop integrated locality management. ***(Core Funding Investment)***	June 2017 – October 2018	Murray Leys	
		We will embed the Buurtzorg model of care.	July 2017 – June 2018	Sandra Pratt	

Priority	Desired Outcome	What Will We Do?	Timescales Start and End Date	Lead Person	Target Impact/Benefits
		(Integrated Care Fund)			
		We will develop local hubs. ***(Integrated Care Fund)***	October 2016 – April 2018	Murray Leys	
6. People will have more choice and control over their services and support.	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 assessing all Self Directed Support options. **(Core Funding Investment)**	April 2016 – March 2019	Murray Leys	Improved care pathways for all care groups. Increased opportunities to have greater choice and control over planned care and support. Improved consistency and equity in the application of the Resource Allocation System. Responsibility for spend of allocated personal budget is transferred to individuals.
		We will review the SDS Resource Allocation System (RAS).	October 2017 – March 2018	Murray Leys	
		We will deliver Phase 2 of the Transforming Care after Treatment Programme. **(Other External Funding)**	October 2016 – March 2018	Murray Leys	
		We will continue to support the Borders Dementia Working Group to act as a voice of people with dementia living in the Borders. **(Core Funding Investment)**	September 2017 – March 2019	Murray Leys	
7. Efficiency and effectiveness will be increased.	Resources are used effectively and efficiently in the provision of health and social care services.	We will develop and deliver our Integrated Transformation and Integrated Care Fund programmes. **(Transformation Programme)** **(Integrated Care Fund)**	April 2017 – March 2019	Elaine Torrance	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.
		We will deliver our three year Workforce Plan. **(Core Funding Investment)**	October 2016 – March 2019	Elaine Torrance	
		We will shift resources from acute health and social care to	April 2017 – March 2019	Elaine Torrance	

Priority	Desired Outcome	What Will We Do?	Timescales Start and End Date	Lead Person	Target Impact/Benefits
		community settings. **(Transformation Programme)** **(Integrated Care Fund)**			Improved outcomes for patients, clients and carers.
		We will demonstrate best value in the commissioning and delivery of health and social care.	April 2017 – March 2019	Elaine Torrance	
		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	Elaine Torrance	
		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	Elaine Torrance	
8. Reduce health inequalities	Health and social care services will reduce health inequalities.	We will deliver Post Diagnostic Support to a higher proportion of people with dementia. **(Core Funding Investment)**	October 2017 – October 2018	Murray Leys	All people newly diagnosed with dementia are offered at least one year post-diagostic support. *Needs clarification as to whether the action is intended to mean referrals TO or FROM a GP.* Local health and social care services which are designed to meet local need.
		We will increase appropriate GP referrals for people with dementia. **(Core Funding Investment)**	October 2017 – October 2018	Murray Leys	
		We will plan and deliver health and social care services by locality area.	April 2017 – March 2019	Elaine Torrance	

Priority	Desired Outcome	What Will We Do?	Timescales Start and End Date	Lead Person	Target Impact/Benefits
		(Integrated Care Fund) **(Transformation Programme)**			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 improve the standard of health centres through Primary Care Premises Modernisation Programme. **(Core Funding Investment)**	April 2017 – March 2018	Sandra Pratt	
		We will appoint 4 Cluster Quality Leads to deliver GP quality initiatives. **(Integrated Care Fund)**	April 2017 – March 2018	Sandra Pratt	
9. Support for Carers.	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	Elaine Torrance	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	Elaine Torrance	
		We will meet all identified carer needs which are assessed as critical through commissioning support services. **(Core Funding Investment)**	April 2017 – March 2019	Elaine Torrance	

7. Performance Monitoring ("Review" and "Analyse" components of the Commissioning Cycle)

Priority	Target Impact/Benefits	How will we know this is changing? Performance measures *Blue italics reflect appropriate performance measures drawn from existing Performance Reports/Scorecards.* NB gaps will remain in what is available currently to monitor some impacts/benefits.
1. Services are accessible and community focussed.	Reduced demand on statutory services through increased local alternatives.	• Number of attendances at A&E /Acute Assessment Unit (overall and/or with focus on flow type 1) *[Reported on an existing Scorecard?]*
	Reduced Waiting Lists.	• Social Work waiting list – N and % within/over standard wait time *[SBC: SC&H Monthly report].* • Community Care Assessment waiting list – N and % within/over standard wait time *[SBC: SC&H Monthly report].* • OT waiting list - N and % within/over standard wait time *[SBC: SC&H Monthly report].* • AHP waiting times standard *[NHSB: Performance Scorecard].* • Treatment Time Guarantee (TTG) and Referral To Treatment (RTT) Standards – multiple indicators *[NHSB: Performance Scorecard].*
	Increased access to Information and Community Support.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Reduced Revenue Costs from reduced demand.	• Finance data on revenue costs.
2. Improve Prevention and Early Intervention.	Reduced admissions to hospital.	*NHS Borders Primary, Acute and Community Services (PACs) scorecard currently tracks numbers of admissions to BGH; H&SC Management Team to consider whether this or an alternative measure would be appropriate.*
	Improved health and wellbeing.	• Evaluations from ICF projects such as Building Community Capacity *[H&SCP: ICF Project Evaluation reports; H&SCP: Quarterly Performance Reports for IJB].* • Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life *[H&SCP Annual Performance Report].*
	Reduction in demand for statutory services.	See Priority 1.

Priority	Target Impact/Benefits	How will we know this is changing? Performance measures *Blue italics reflect appropriate performance measures drawn from existing Performance Reports/Scorecards.* NB gaps will remain in what is available currently to monitor some impacts/benefits.
	Reduced demands on GPs.	• 48 hour access or advance booking to an appropriate member of the GP practice team *[NHSB: Managing Our Performance Annual Reports; H&SCP Annual Performance Report].* • *Potential for other measures to be agreed/developed in cross-working with GP Clusters.*
	Improved access to advice on minor health complaints.	This is a broad impact and will need more cross-working and discussion to define this and identify appropriate measures. E.g. may be in relation to any or all of access to GP practice staff, community pharmacy Minor Ailments Scheme, and/or CLS Hubs.
	Reduced Revenue Costs from reduced demand.	• Finance data on revenue costs.
3. Reduce avoidable admissions to hospital.	Reduced emergency admissions and associated bed days.	• Number and rate of emergency admissions, people aged 75+ *[H&SCP: Quarterly Performance Reports for IJB].* • Number and rate of emergency occupied bed days, people aged 75+ *[H&SCP: Quarterly Performance Reports for IJB].* • Rate of emergency admissions for Falls, people age 65+ *[H&SCP: Quarterly Performance Reports for IJB].* • Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+ *[H&SCP: Quarterly Performance Reports for IJB].*
	Reduce re-admissions to hospital.	• Readmissions to BGH (NB. Not specified whether 7 or 28 day) *[NHSB: Primary, Acute & Community Services Scorecard].*
	Reduced Revenue Costs from reduced demand.	• Finance data on revenue costs.
4. Provide care close to home.	Quicker and more efficient planning of care and support.	• Performance/Impact evaluations of the Matching Unit. *[H&SCP: ICF Project Evaluation Reports.]*
	More people at home or in a homely setting including when at the end of their life.	• Community based services as a percentage of total Health & Care Expenditure *[H&SCP: Quarterly Performance Reports for IJB].* • Adults aged 65+ within the Scottish Borders with intensive care needs receiving

Priority	Target Impact/Benefits	How will we know this is changing? Performance measures *Blue italics reflect appropriate performance measures drawn from existing Performance Reports/Scorecards.* NB gaps will remain in what is available currently to monitor some impacts/benefits.
		support in a community setting rather than a care home. *[H&SCP: Quarterly Performance Reports for IJB].* • Proportion of last 6 months of life spent at home or in a homely setting *[H&SCP: Quarterly Performance Reports for IJB].*
	Reduced demand for care at home and other health and social care services.	Requires further discussion with Social Care & Health re appropriate measures, be this numbers of requests for social care assessment/referral and/or other measures.
	Reduced Revenue Costs from reduced demand and greater efficiency.	• Finance data on revenue costs.
5. Deliver services within an Integrated Care Model.	Decreased duplication and more streamlined and efficient delivery of health and social care services at a local level.	• Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated. *[H&SCP: Annual Performance Report].*
	Reduced demand on statutory services through increased local alternatives.	See Priority 1.
	Increased access to Information and Community Support.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Reduced Revenue Costs from reduced demand and greater efficiency.	• Finance data on revenue costs.
6. People will have more choice and control over their services and support.	Improved care pathways for all care groups.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Increased opportunities to have greater choice and control over planned care and support.	• Percentage of Social Care & Health clients on SDS. *[SBC: SDS report].* • Adults with SDS arrangements per 1,000 population *[SBC: PDMT report].*
	Improved consistency and equity in the application of the Resource Allocation System.	

Priority	Target Impact/Benefits	How will we know this is changing? Performance measures *Blue italics reflect appropriate performance measures drawn from existing Performance Reports/Scorecards.* NB gaps will remain in what is available currently to monitor some impacts/benefits.
	Responsibility for spend of allocated personal budget is transferred to individuals.	• Percentage of SDS clients on options 1, 2 or 4. *[SBC: SDS report].*
7. Efficiency and effectiveness will be increased.	Reduced costs through management of demand, reduced unit costs and elimination of duplication and waste.	• Finance data.
	Scarce resources will be directed to those most in need and secure best value.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Health and social care will continue to be affordable within a context of constrained funding, increased cost and greater demand.	• Finance data.
	Improved outcomes for patients, clients and carers.	• Delayed Discharges – 72 hours / 2 weeks *[H&SCP: Quarterly Performance Reports for IJB; NHSB: Performance Scorecard].* • Percentage of Social Care clients reporting they felt safe *[H&SCP: Quarterly Performance Reports for IJB; NHSB: Performance Scorecard; SBC: PDMT Report].* • Percentage of adults supported at home who agree that they are supported to live as independently as possible. *[H&SCP: Annual Performance Report].* • Carers Centre assessments – improved responses to multiple questions on Carer Choice and Carer Stress *[H&SCP: Quarterly Performance Reports for IJB].*
8. Reduce health inequalities	All people newly diagnosed with dementia are offered at least one year post-diagostic support.	• Percentage of people with newly diagnosed dementia offered a minimum of 12 months post-diagnostic support. *[HEAT Dementia PDS standard] [NHSB: Performance Scorecard and Mental Health Performance Scorecard].*
	Needs clarification as to whether the action is intended to mean referrals TO or FROM a GP.	

Priority	Target Impact/Benefits	How will we know this is changing? Performance measures *Blue italics reflect appropriate performance measures drawn from existing Performance Reports/Scorecards.* NB gaps will remain in what is available currently to monitor some impacts/benefits.
	Local health and social care services which are designed to meet local need.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Improved standard of health centre premises.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Increased community support work form improved health centres.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Improved GP services.	This is a broad impact and will need more cross-working and discussion to define this and identify the most meaningful measures.
	Greater focus on prevention will result in reduced Revenue costs from reduced demand and increased efficiency.	• Finance data on revenue costs.
9. Support for Carers.	Improved and more consistent support for Carers.	• Carers Centre assessments – improved responses to multiple questions on Support for Carers *[H&SCP: Quarterly Performance Reports for IJB].* • Percentage of Carers who feel supported to continue in their caring role. *[H&SCP: Annual Performance Report].*
	Better understanding of the numbers of people providing informal care.	Scottish Health Survey results provide estimates of % of adults providing unpaid care and this is the basis of Carer numbers used in Carer Strategy work. Cross working/discussion needed to define what would be agreed as meaning "Better Understanding" and how this would be measured.

Appendix 1: Overview of Services Health and Social Care Partnership

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;

-Carers support services;

-Community Care Assessment Teams;

-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 specialities-

-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 hospital, except secure forensic mental health services.

*Adult Social Care Services-over 18yrs. * Acute Services –all ages.
* Community Health Services-over 18yrs except those marked with * which also includes services for children.

COMMUNITY HEALTH SERVICES *

-District Nursing;

-Out of Hours Primary Medical Services*

-Primary Medical Services (GP practices*);

-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.

Appendix 2: The National Health and Wellbeing 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.