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	
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	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	

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	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	
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	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	