Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 19 June 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Rob McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 825528

DRYBURGH DEVELOPMENT SESSION OUTCOMES

Purpose of Report:	To inform the Board of the outcomes from the last development session of the IJB.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: *Note the intended areas of development for the partnership following the Dryburgh event.*
Personnel:	*None at this stage.*
Carers:	*Carer representatives were present and fed into the debate during the event. Their contribution has been recorded and included within the outcomes of the day.*
Equalities:	*N/A*
Financial:	*N/A.*
Legal:	*N/A*
Risk Implications:	*N/A*

The last development session of the IJB was held on 4 March 2019 at the Dryburgh Hotel. Over 50 participants attended and participated within the debate regarding the future direction for the Health and Social Care Partnership.

The participants were drawn from the full range of services delegated to the IJB, Council Members, Non Exec Directors of NHS Borders, IJB Members, Registered Social Landlords, Home Care and Residential Care leads, Carer representatives, locality leads, finance, policy and strategy leads.

The event was structured in two halves. Firstly the participants were provided with a clear outline of the operational model of the partnership, the governance of decision making, the financial delegation, demographics and the bed base within both acute and residential care.

Some time was spent on the both the current and future challenges facing the partnership. These included both financial and demographic issues. The current performance of the delegated services was also presented.

From all of the above information the participants were then tasked with identifying what actions, or areas of work are required to both meet the challenges ahead and to improve of service provision for the population of the Borders.

They were asked to focus their input within the three objectives of the Strategic Plan.

1. We will improve the health of the population and reduce the number of hospital admissions.
2. We will improve the flow of patients into, through and out of 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.

A very informed and engaged conversation ensued where all of the feedback and comments were recorded.

The senior management team has collated these comments, ideas and development areas. During this exercise it became clear that this output could be categorised into five areas.

1. Process
2. Principles
3. Physical/Estate
4. Campaign
5. Service

The output in each area is provided as appendix 1.

This will now inform our future planning for the Health and Social Care Partnership. Since the event, and in light of comments made, further work has been undertaken to review the range of boards, committees and groups all supporting the partnership and the IJB.

Further to the Dryburgh event a further session was undertaken with acute and primary care clinicians, supported by colleagues in Social Care on 28 May 2019. This session,

which was again very well attended, examined our current Older People's Pathway. The output from this session was very useful and in the main has verified the findings of the Dryburgh event.

This work is timely as it coincides with the Council's work on "Fit for 2024", its planning for the next 5 years, and with the current "Turnaround Programme" of the Borders NHS. There is a direct overlap of the partnership's work and the commissioning role of the IJB with both of these programmes.

The Executive Management Team (EMT) for the IJB will now consider the outputs of these events with the intention of bringing a range of recommendations to the September IJB for agreement on the future direction for the partnership.

The attached presentation outlines the outcomes of the events.

Appendix 1:

IMPROVE HEALTH & REDUCE ADMISSIONS	*IMPROVE PATIENT FLOW*	*INCREASE COMMUNITY CAPACITY AND CARE PROVISION*
	PRINCIPLES	
• Single point of contact • Realistic patient expectations • Right option is easiest option • Near patient testing • Better and wider use of TEC • Single shared assessment • Reduced duplication of care • Advanced care planning • Increase personal responsibility • Early intervention • Assessment and intervention by right person at right time	• People understanding patient flow • Only reassess when you need to reassess • Consider TEC to support discharge • Enforce choices policy • Linked programmes of work/Pathway approach to planning (OP, MH, LD) Whole Systems Approach • CH to become step up from home and less step down from BGH • Planning for discharge at point of admission or before • Ambulatory care – get out of bed • Risk tolerance aversion • Planning for discharge at point of admission or before • Conversation will be had between staff and individual patients regarding realistic expectations/degrees of risk • Communication and engagement • Remove barriers between health and social care provision	• Improve productivity and reduce time wastage

IMPROVE HEALTH & REDUCE ADMISSIONS	*IMPROVE PATIENT FLOW*	*INCREASE COMMUNITY CAPACITY AND CARE PROVISION*
	SERVICES	
• Revaluation of outpatients and ED (GPs) • Transport Links • Activity devices to reduce falls and dehydration • Provision of physical activities • Emergency health care team available for elderly available 24/7	• Hospice at Home • Signposting OOH provision • DME model operating as a continuum across acute and community • Walk in centre • Diagnostic and LTC monitoring centres locally	• Volunteer befriending the elderly at home • ALISS • Increase H2H services and reablement • Greater utilisation of pharmacies • Student accommodation offered in return for volunteered services • Recommision care home beds and care hours • Develop community MDT to manage complex needs with rapid access to H&SC • AHPs in the community • Short term PoC to prevent admission to hospitals • Reablement to reduce demand for care hours • Extension of cheviot model with integrated budget • Allow commissioned service to reassess need – don't wait for SW assessment • One stop shop • Interdisciplinary and multidisciplinary flexible home workforce

IMPROVE HEALTH & REDUCE ADMISSIONS	***IMPROVE PATIENT FLOW***	***INCREASE COMMUNITY CAPACITY AND CARE PROVISION***
	PROCESSES	
• ACP • Care rapid assessment • Near patient testing • Shared IT • Community Hubs • Transport links • Physical Activity opportunities • Emergency health care for the elderly	• Shared patient information • Shared assessment • ACP • Only reassess when you need to reassess • Signposting OOH provision • Enforce choices policy • Remove duplicate care assessments • OTs to undertake care assessments • CH to become step up from home and less step down from BGH • Increase OT/SW presence at daily ward rounds • IT matching system for volunteer support	• Analysis of small care packages • Locality • Signposting and support for unpaid and paid carers

IMPROVE HEALTH & REDUCE ADMISSIONS	***IMPROVE PATIENT FLOW***	***INCREASE COMMUNITY CAPACITY AND CARE PROVISION***
	CAMPAIGNS	
• Patient public health to reduce risky behaviour • Promote personal responsibility • Public health education on diet, exercise and mental health • Communicating how public should access health and social care	• People understand patient flow • Signposting OOH provision • Raise awareness of PoA and Guardianship	• Promote career in care showing service achievements • Locality focussed PH • Citizens and communities change health and social care expectations • Greater use of community pharmacies • Recruitment campaign • Engage proactively with local communities regarding what HSCP can/not provide • Signposting and support for unpaid and paid carers

IMPROVE HEALTH & REDUCE ADMISSIONS	***IMPROVE PATIENT FLOW***	***INCREASE COMMUNITY CAPACITY AND CARE PROVISION***
	PHYSICAL SPACE OR ESTATE	
• Expand community hubs • Walk in centres • Adequate community clinical space	• Co-location of services • Close beds – BGH, CH, MH with appropriate community support • One stop shop	• Expand community hubs • Walk in centres • Adequate community clinical space