**Borders HSCP February 2022 progress against IJB Strategic Commissioning Plan outcomes**

| | Objective 1 | | Objective 2 | | Objective 3 | | Overall | |
|---|---|---|---|---|---|---|---|---|
| Score | No | % | No | % | No | % | No | % |
| Red | 2 | 10 | 0 | 0 | 4 | 13 | 6 | 10 |
| Amber | 9 | 45 | 5 | 50 | 13 | 41 | 27 | 44 |
| Green | 7 | 35 | 3 | 30 | 13 | 41 | 23 | 37 |
| Blanks | 2 | 10 | 2 | 20 | 2 | 6 | 6 | 10 |
| Total | 20 | 100 | 10 | 100 | 32 | 100 | 62 | 100 |

A point in time assessment has been undertaken against the scores given for each scored deliverable and original delivery date where available in order to give a RAG satus. An overview is demonstrated on this tab and details for each objective can be found in their associated tab within this document.

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

| Desired Outcome | Feb 22 RAG status | Summary of activities etc | Timescales start & end date | Target Impact / Benefits | Progress against desired outcome end Feb 22 | Lead delivery body | Key Risks | Controls/Actions | Outcome(s) - as listed on the 'Outcomes summary' tab | Major strategies/ programmes that the outcome(s) relates to |
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| People will be informed and have access to the right support at the right time. | | We will develop local area co-ordinators (LAC) for adults and older people. | July 2017 – October 2018 | Reduced demand on statutory services through increased local alternatives.<br><br>Reduced waiting lists.<br><br>Increased access to information and community support.<br><br>Reduced revenue costs from reduced demand. | Local Area Co-ordination (LAC) service for older adults and adults with a physical disability operational from 2019 an intergrated with existing LAC Service in Borders (which provides a service to adults with a learning disability and adults who experience mental ill-health) under one management structure. Focus of team is locality working and developing inclusive communities. Delivery of LAC service in adult learning disability, adult mental health, older adults and adults with a physical disability - enablement/re-ablement, asset based approach to reduce demands on statutory services/packages of care. | Claire Veitch / Simon Burt | | | 1,2,3,4,5,6,7,8,9 | Range of 'Fit for 2024' work-streams. Older adults pathway-specifcally Pathway Zero. H&SC locality plans. 'A Connected Scotland' National Strategy for tackling isolation and loneliness. |
| | | After an analysis of demand, the additional funding was utilised to recruit two part-time LAC coordinators and two part time community link workers. This has enabled an improved geographical spread for the LAC service in mental health across the Borders. (Core Funding Investment) | April 2017 – March 2020 | | Expansion outlined in summary of activities etc funded by PCIP for delivery of Community Link Worker (CLW) programme, funds expansion of MH LAC. Delivery of CLW service operational from March 2020. Service has only operated during the pandemic navigating the associated restrictions on service delivery & communities. Established collaborative working with Wellbeing Service & 'Renew' as partners also operating in Primary Care. | Claire Veitch / Simon Burt | Low level of referrals via GP's (Between 2020 & 2021, 43% increase in referrals into MH LAC overall). Perceived need for service and concerns re: best use of PCIP funding from GPs given low uptake. | Working with 'Renew' to pilot single referral route for GPs as means of offering more accessilble referral route for GPs. Further work to continue to promote the service with GPs across the Borders. Exploring options for physical presence in GP practices as further test of change in terms of increasing use of the service. | 1,2,3,4,5,6,7,8,9 | GMS Contract. Forms part of the Primary Care Improvement Plan (PCIP). Contributing/linked into discussions on mental health & wellbeing in primary care funding. |
| 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.<br><br>Improved health and wellbeing.<br><br>Reduction in demand for statutory services.<br><br>Reduced demands on GPs.<br><br>Improved access to advice on minor health complaints.<br><br>Reduced revenue costs from reduced demand. | Following a decision at the Audit & Scrutiny Committee the IJB are leading an exploration into Day Centres/ Building based activities. This is being progressed through the Carers Workstream. | John Barrow / Stacy Patterson / Brian Paris | Nation strategy calls for a shift away from structured day services in favour of more choice and control through flexible use of SDS - Risk - Local resistence to the national policy | Involvement of broad range of stakeholders including people who use various SDS options. | The Output of this process will be a decision will be made by IJB following the exploration. | IJB Strategic Commissioning; SBC Corporate Plan; Shifting the Balance of Care and Self-Directed Support strategy; Carers Strategy. Population Needs Assessment |
| | | We are building on the work and expanding the Community Capacity Building Team (CCB) 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 | | As per box F5 - CCB Team members were job matched over to form the older adults & adults with a physical disability. | Claire Veitch / Simon Burt | | | | |
| Health and Social Care services reduce admission to hospital, improve health and wellbeing and reduce demand for statutory services. | | 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.<br><br>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 two years ago (sick day rules). This has been shown in another NHS Board to reduce admissions. We will continue to promote this service. | April 2017 – March 2019 | Reduced admissions to hospital.<br><br>Improved health and wellbeing.<br><br>Reduction in demand for statutory services.<br><br>Reduced demands on GPs.<br><br>Improved access to advice on minor health complaints. | 1. PCIP Pharmacy staff work is under review. A decision whether to follow Level 1 Pharmacy technician work only or offer Level 1 - 3 GMS contract. The MoU2 relesed in Aug 2021 suggested moving away from the Level system and this is what we are aiming for in the next 2 months. The HB funded Pharmcy staff will be focusing on managing long term conditions and doing polypharmacy reviews as well as assisting secondary care with medication initiaion and monitoring in disease management (starting imminently). 2. A B5 technician has been working to support medicines management on discharge, a project was completed and written up. The technicians funding is now under review (moving from PCIP to IJB) as well as a case being submitteed to the IJB to fund the recommendations from the outcome of the project. The 'Sick day rules' being promoted is ongoing, however I am unaware of any actual review clinics taking place, a dicussion is normally had with patients when initiated on these medications and a 'wallet/purse' card was available for patients to refer to if needed. I cannot comment on any changes in wards | Mhairi Struthers / Rachel Mollart / Cathy Wilson | 1.Continuing with Level 1 work only and not folloing MoU2 recommendations. 2. No long term funding for Technician to continue to support discharges and social work with package of care | 1. Negotiating wth PCIP Exec regarding service and gaining views of all stakeholders involved in service. Working alongside secondary care to provide a seemless transition of medication initiation and review after diagnosis locally.<br>2. Bid submitted to IJB to fund outcomes from project completed to fund staff that support discharge as well as social work with medicines in teh community and care home staff. | 1, 2, 3,6,7 | National Disease strategies (Pain, Respiratory, Diabetes, Polypharmacy, mental Health), Memorandum of Understanding 2, GP Contract 2018, Care Home Responsibility with Board, Sick Day Rules |

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| | | 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 which are timely to prepare and provide a safer system to support medicines management by carers.<br><br>4 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. | | Reduced revenue costs from reduced demand. | cannot comment on any changes in wards practice. 3. The PCIP Pharmacy is currently under 70% funded compare to the original budget with some of the budget being removed to fund other work streams causing a vast reduction in support and capacity in GP practices to fulfil the GP contract. Currently, the demand for medicine compliance aid is at an all time high, with many Pharmacies unable to accept any more. There are other alternatives (tick reminder charts) avaialable but some of these cannot be used for patients on Packages of Care. 4. The Community Pharmcists are using Pharmacy First/ Pharmacy First Plus to assist with out of hours care, however, this is very location specific. The service is dependant | Mhairi Struthers / Rachel Mollart / Cathy Wilson | 3. Additional funding not being allocated to the PCIP Pharmacy Service (as a priority service) from SG 4. Staff feeling under valued and leaving the profession | 3. Submission of quarterly returns to SG highlighting the service demands and situation. Providing PCIP with data on demand/capacity data. Assisiting community pharmacies to educate patients on other ways to manage medicines other than medicines complaince aids. 4. providing education to the GP practices about these services to educate patients on alternate treatments routes. | 4,8,9 | GP Contract 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) | | Reduced costs through management of demand, reduced unit costs and elimination of duplication and waste.<br><br>Scarce resources will be directed to those most in need and secure best value.<br><br>Health and social care will continue to be affordable within a context of constrained<br><br>Improved outcomes for patients, clients and carers. funding, increased cost and greater demand. | Reviewed at Feb 2021 IJB as part of the Discharge Programme evaluation | | | | | |
| | | We will deliver our three year Workforce Plan. (Core Funding Investment) | October 2016 – March 2019 | | | Ailsa Paterson / Bob Salmond | | | | |
| | | We will shift resources from acute health and social care to community settings. (Transformation Programme) (Integrated Care Fund) | April 2017 – March 2020 | | Some progress has been made with regard to Implementation and subsequent mainstreaming of tests of change - transitional care provision/ Home First/STRATA/Matching Unit/etc. Beyond this however, there has been little evidence collected or demonstrated supporting reduced impact on acute services which would in turn create the ability to target efficiencies and redirect benefits realised to community based services. | Paul McMenamin | • Despite provision of new or developed community-based reablement or transitional care, demand for acute provision does not decrease due to unmet need, prohibiting acute rationalisation or cessation and the redirection of resources to elsewhere on care pathway.<br>• Evidence / Business Cases supporting service transformation and the redirection of resources is not wholly trusted and owned.<br>• Acute healthcare functions are not delegated to the H&SCP and as a result, the IJB has limited opportunity to strategically | • Review of functions delegated under Scheme of Integration<br>• Re-establishment of FF24 and Financial Turnaround Programmes<br>• Relaunch of H&SCP Transformation Programme<br>• Outcome evaluation of OPP<br>• Specifically targeted objectives within H&SCP Strategic / Commissioning Plans<br>• Agreed Business Plan of H&SC Leadership Team<br>• Costed strategic objectives<br>• Review of Scheme of Integration and functions within which are delegated to the H&SCP Integration Joint Board | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation Programme / Fund |
| | | We will demonstrate best value in the commissioning and delivery of health and social care. (Transformation Programme) (Integrated Care Fund) (Core Funding Investment) | April 2017 – March 2019 | | LDS Projects:<br>Re-provision of HCSS service - re-commissioned from the market with savings of £198k to LD budget - complete<br>LD Day support review: progressing as per project plan. Consultation has taken place. New model being designed. Plan to re-commission early summer 22.<br>Shared Lives (LD)- end of year 2 of set up of this new service model. 13 matches achieved for 8 people. On target for placement target of 25 within 3 years. Cost avoidance model - low cash releasing savings.<br>Complex care support (LD) - land has been agreed within Tweedbank Care village. Working with Provider to gather data rto build business case. This is not a commissioned service but we have demand to purchase the service. planning for design and model of staffing with Provider.<br>LD reviews project - increase number of LD reviews that take place. Financial savings attached. At review costs of packages may increase or decrease. Currently not on track for savings attached to project as a result of increased need identified. | Jen Holland / Holly Hamilton-Glover / Susan Henderson / Simon Burt / Cathy Wilson | HCSS - complete<br>LD Day support- new model not affordable; delays in timeline ; lack of providers to deliver; carer respite needs not met<br>Shared Lives - lack of carers coming forward; not cash releasing model;<br>Complex care - timeline; model doesn't meet need; demand / outstrips capacity;<br>LD reviews - costs of packages increase as well as decrease and savings target not met; capacity within the LD sw team to review. | HCSS - complete<br>LD Day support - clear project plan; good engagement throughout project; co-productive model building and specification setting; market testing events held; provider of last resort currently SBC<br>Shared Lives: clear project plan; active recruitment of carers; building working relationships across adult and children services; Complex care- partnership working; clear understanding of demand; part of Tweedbank Care Village programme board; project officer attached to project; business case being updated<br>LD reviews - plan in place; reviews taken into resource panel for sign off; | 1,2,3,4,5,6,7,8,9 | Fit for 2024 |

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| | | 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 | | • Previous achievements include the closure of Cauldshiels and investment into other mainstream services, some new, some existing.<br>• Agreement to pilot of Millar House initiative is another example of realignment of resources to improve outcomes, increase capacity and achieve greater cost effectiveness.<br>• Former ICF / Transformation Funded initiatives supporting OPP now mainstreamed. | Paul McMenamin | • Ongoing pressure across budgets result in inability to achieve cashable savings<br>• Increased stakeholder expectation / SG direction limits ability to disinvest from services in line with strategic intention / requirement<br>• Insufficient transformation funding restricts ability to pilot tests of change / fund transition period | • Clarity of directions from IJB to partners<br>• Establishment of a self-sustaining transformation programme / fund<br>• Work to better integrate strategic and operational financial planning process across H&SCP and its partner organisations<br>• Greater evaluation / benefits realisation / return on investment<br>• Wider delegation of functions and resources to Health and Social Care Partnership under the Scheme of Delegation. | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation Programme / Fund<br>Targeted reviews of delegated services across social care, Mental Health (e.g. transformation programme, GRC, etc) and Primary & Community Services |
| | | 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 | | The Social Care and Social Work Delivery Board and FF2024 governance agenda have led a large portfolio of work to implement significant reviews of alternative models to ensure cost effectiveness Within 21-22 we have implemented significant projects within SBC with regards Social Care - We have outsourced Dovecot extra care housing to implement a more cost effective housing and care model. Implemented Upper Waverley to introduce a more cost effective models for high end dementia care further rolled out trusted assessment to eradicate unnecessary resource in carrying out assessments, opened up two Extra Care Housing Developments to allow more older people to remain at home as independently as possible reducing demand on 24 hour care and finally implemented Total Mobile in the East Area which maximises scheduling and reduces travel and admin time so more time can be focussed on care. | Jen Holland / Paul McMenamin | • Insufficient transformation funding restricts ability to pilot tests of change / fund transition period<br>• Insufficient evaluation and evidence enabling redirection of resource targeting new and more cost-effective models of care<br>• Insufficient H&SCP influence over strategic direction of non-delegated models of care | • New, wholly owned Strategic Plan<br>• Development of a new robust framework of programme evaluation<br>• Representation / Membership of wider stakeholder group within Integration Joint Board e.g. Acute Services Executives<br>• Review of IJB Reserves b/f and creation of a financially sustainable 2022 Transformation Fund<br>• Additional Scottish Government allocations supporting the development of new models of care | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation Programme / Fund<br>Strategic / Commissioning Plans |
| 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.<br><br>More people at home or in a homely setting including when at the end of their life.<br><br>Reduced demand for care at home and other health and social care services.<br><br>Reduced revenue costs from reduced demand and greater efficiency. | The service is fully operational. | Julie Glen | | Fully operational | 1,2,3,4,5,7,9 | |
| | | 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 | | Work re-launched in January 2022. Due to staffing constraints from health board - moving away for 5 localities model to 2 Communities based model. Focus on identifying and discussing the most complex patients to discuss:<br>• Answer the immediate care needs of people in a community setting;<br>• Reduce the risk of hospital admissions; and<br>• Focus on promoting independent living for older people through reablement, rehabilitation, and rapid response.<br><br>Health Board has identified key staff for each community huddle. Further work needed with social work to agree on how it will be coordinated. | Suzie Flower / Cathy Wilson / Brian Paris | HSCP Joint Leadership, Buy-in and Commitment<br>Shared understanding of outcomes and deliverables from both health and social work side<br>Difficulty in planing and arranging joint meetings during challenging/high pressure time. | HSCP Leadership Group membership and high level principles agreed in January.<br><br>Next meeting to take place in March 2022 to agree underlying operational principles. | 1,2,3,4,5,7,8,9 | Older People Pathway<br>Home First<br>HSCP Locality Working |
| | | We will increase the use of telecare and telehealthcare. (Transformation Programme) | October 2017 – June 2018 | | The COVID pandemic has prevented progress in this area due to meeting demand of everyday demands. | Paul Cathrow / Julie Glen | Risk aversion/lack of knowledge re available telecare and tec. | workstreams have now been created to review this project and establish target audience/provide input/training to SW staff and managers of social care services. | 1,2,3,4,5,7 | |
| | | We will increase the provision of Housing with Care and Extra Care Housing. (Core Fund Investment) | April 2017 – March 2020 | | We have opened up two ECH housing provisions in 21-22 one in Duns in March 21 and one in Wilkie Gardens in Galashiels in Jan 22. Development in underway in Kelso and Hawick plans are underway. | Jen Holland | | | | |
| | | 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. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a three year plan from 2018/19 to 2020/21. (Core Fund Investment) | April 2018 – March 2021 | | Full survey of all Health Centre Premises (Buchan Associate Report) is now complete. Identified overall capacity within Primary Care and shrtfalls in accommodation needs.<br><br>Established investment priorities via gap analysis and prioritisation exercise. (Short, | Cathy Wilson / Steph Errington | Current NHSB Estate & Project Support Resources/Team constraints which may cause delays in requests for works. | Premise Group Oversight of works and regular engagement with key stakeholders including GPs (GP Sub).<br><br>Offering transparency and accountability in terms of process for premises works | 1,2,3,4,5,6,7,8,9 | |

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| Health and social care services will reduce health inequalities. | | 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. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a three year plan from 2018/19 to 2020/21. (Integrated Care Fund) | April 2018 – March 2021 | All people newly diagnosed with dementia are offered at least one year post-diagnostic support.<br><br>Local health and social care services which are designed to meet local need.<br><br>Improved standard of health centre premises.<br><br>Increased community support work form improved health centres.<br><br>Improved GP services.<br><br>Greater focus on prevention will result in reduced revenue costs from reduced demand and increased efficiency. | Full survey of all Health Centre Premises (Buchan Associate Report) is now complete. Identified overall capacity within Primary Care and shrtfalls in accommodation needs. (see above update) | Cathy Wilson / Tim Young | Current NHSB Estate & Project Support Resources/Team constraints which may cause delays in requests for works. | To be discussed at the next Premises Group and ensure that | 1,2,3,4,5,6,7,8,9 | |
| | | 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 | | | Brian Paris | | | | |
| | | 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 | | | Brian Paris / Tim Young | | | | |

## Objective 2: We will improve the flow of patients into, through and out of hospital

| Desired Outcome | Feb 22 RAG status | Summary of activities etc | Timescales start & end date | Target Impact / Benefits | Progress against desired outcome end Feb 22 | Lead delivery body | Key Risks | Controls/Actions | Outcome(s) - as listed on the 'Outcomes summary' tab | Major strategies/ programmes that the outcome(s) relates to |
|---|---|---|---|---|---|---|---|---|---|---|
| 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.<br><br>Scarce resources will be directed to those most in need and secure best value.<br><br>Health and social care will continue to be affordable within a context of constrained funding, increased cost and greater demand.<br><br>Improved outcomes for patients, clients and carers. | Evaluated at IJB in Feb 2021 (Discharge Programme evaluation) | | | | | |
| | | We will deliver our three year Workforce Plan. (Core Funding Investment) | October 2016 – March 2019 | | | Ailsa Paterson / Bob Salmond | | | | |
| | | We will shift resources from acute health and social care to community settings. (Transformation Programme) (Integrated Care Fund) | April 2017 – March 2020 | | Some progress has been made with regard to Implementation and subsequent mainstreaming of tests of change - transitional care provision/ Home First/STRATA/Matching Unit/etc. Beyond this however, there has been little evidence collected or demonstrated supporting reduced impact on acute services which would in turn create the ability to target efficiencies and redirect benefits realised to community based services. | Paul McMenamin | • Despite provision of new or developed community-based reablement or transitional care, demand for acute provision does not decrease due to unmet need, prohibiting acute rationalisation or cessation and the redirection of resources to elsewhere on care pathway.<br>• Evidence / Business Cases supporting service transformation and the redirection of resources is not wholly trusted and owned.<br>• Acute healthcare functions are not delegated to the H&SCP and as a result, the IJB has limited opportunity to strategically | • Review of functions delegated under Scheme of Integration<br>• Re-establishment of FF24 and Financial Turnaround Programmes<br>• Relaunch of H&SCP Transformation Programme<br>• Outcome evaluation of OPP<br>• Specifically targeted objectives within H&SCP Strategic / Commissioning Plans<br>• Agreed Business Plan of H&SC Leadership Team<br>• Costed strategic objectives<br>• Review of Scheme of Integration and functions within which are delegated to the H&SCP Integration Joint Board | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation Programme / Fund |
| | | We will demonstrate best value in the commissioning and delivery of health and social care. (Transformation Programme) (Integrated Care Fund) (Core Funding Investment) | April 2017 – March 2019 | | LDS Projects:<br>Re-provision of HCSS service - re-commissioned from the market with savings of £198k to LD budget - complete<br>LD Day support review: progressing as per project plan. Consultation has taken place. New model being designed. Plan to re-commission early summer 22.<br>Shared Lives (LD)- end of year 2 of set up of this new service model. 13 matches achieved for 8 people. On target for placement target of 25 within 3 years. Cost avoidance model - low cash releasing savings.<br>Complex care support (LD) - land has been agreed within Tweedbank Care village. Working with Provider to gather data rto build business case. This is not a commissioned service but we have demand to purchase the service. planning for design and model of staffing with Provider.<br>LD reviews project - increase number of LD reviews that take place. Financial savings attached. At review costs of packages may increase or decrease. Currently not on track for savings attached to project as a result of increased need identified. | Jen Holland / Holly Hamilton-Glover / Susan Henderson / Simon Burt / Cathy Wilson | HCSS - complete<br>LD Day support- new model not affordable; delays in timeline ; lack of providers to deliver; carer respite needs not met<br>Shared Lives - lack of carers coming forward; not cash releasing model;<br>Complex care - timeline; model doesn't meet need; demand / outstrips capacity;<br>LD reviews - costs of packages increase as well as decrease and savings target not met; capacity within the LD sw team to review. | HCSS - complete<br>LD Day support - clear project plan; good engagement throughout project; co-productive model building and specification setting; market testing events held; provider of last resort currently SBC<br>Shared Lives: clear project plan; active recruitment of carers; building working relationships across adult and children services; Complex care- partnership working; clear understanding of demand; part of Tweedbank Care Village programme board; project officer attached to project; business case being updated<br>LD reviews - plan in place; reviews taken into resource panel for sign off; | 1,2,3,4,5,6,7,8,9 | Fit for 2024 |

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| | | 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 | | • Previous achievements include the closure of Cauldshiels and investment into other mainstream services, some new, some existing.<br>• Agreement to pilot of Millar House initiative is another example of realignment of resources to improve outcomes, increase capacity and achieve greater cost effectiveness.<br>• Former ICF / Transformation Funded initiatives supporting OPP now mainstreamed. | Paul McMenamin | • Ongoing pressure across budgets result in inability to achieve cashable savings<br>• Increased stakeholder expectation / SG direction limits ability to disinvest from services in line with strategic intention / requirement<br>• Insufficient transformation funding restricts ability to pilot tests of change / fund transition period | • Clarity of directions from IJB to partners<br>• Establishment of a self-sustaining transformation programme / fund<br>• Work to better integrate strategic and operational financial planning process across H&SCP and its partner organisations<br>• Greater evaluation / benefits realisation / return on investment<br>• Wider delegation of functions and resources to Health and Social Care Partnership under the Scheme of Delegation. | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation Programme / Fund<br>Targeted reviews of delegated services across social care, Mental Health (e.g. transformation programme, GRC, etc) and Primary & Community Services |
| | | 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 | | The Social Care and Social Work Delivery Board and FF2024 governance agenda have led a large portfolio of work to implement significant reviews of alternative models to ensure cost effectiveness Within 21-22 we have implemented significant projects within SBC with regards Social Care - We have outsourced Dovecot extra care housing to implement a more cost effective housing and care model. Implemented Upper Waverley to introduce a more cost effective models for high end dementia care further rolled out trusted assessment to eradicate unnecessary resource in carrying out assessments, opened up two Extra Care Housing Developments to allow more older people to remain at home as independently as possible reducing demand on 24 hour care and finally implemented Total Mobile in the East Area which maximises scheduling and reduces travel and admin time so more time can be focussed on care. | Jen Holland / Paul McMenamin | • Insufficient transformation funding restricts ability to pilot tests of change / fund transition period<br>• Insufficient evaluation and evidence enabling redirection of resource targeting new and more cost-effective models of care<br>• Insufficient H&SCP influence over strategic direction of non-delegated models of care | • New, wholly owned Strategic Plan<br>• Development of a new robust framework of programme evaluation<br>• Representation / Membership of wider stakeholder group within Integration Joint Board e.g. Acute Services Executives<br>• Review of IJB Reserves b/f and creation of a financially sustainable 2022 Transformation Fund<br>• Additional Scottish Government allocations supporting the development of new models of care | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation Programme / Fund<br>Strategic / Commissioning Plans |
| 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. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a three-year plan from 2018/19 to 2020/21. (Core Fund Investment) | April 2018 – March 2021 | All people newly diagnosed with dementia are offered at least one year post-diagnostic support.<br><br>Local health and social care services which are designed to meet local need.<br><br>Improved standard of health centre premises.<br><br>Increased community support work form improved health centres.<br><br>Improved GP services.<br><br>Greater focus on prevention will result in reduced revenue costs from reduced demand and increased | Full survey of all Health Centre Premises (Buchan Associate Report) is now complete. Identified overall capacity within Primary Care and shrtfalls in accommodation needs.<br><br>Established investment priorities via gap analysis and prioritisation exercise. (Short, Medium and Long Term priorities) | Cathy Wilson / Steph Errington | Current NHSB Estate & Project Support Resources/Team constraints which may cause delays in requests for works. | Premise Group Oversight of works and regular engagement with key stakeholders including GPs (GP Sub).<br><br>Offering transparency and accountability in terms of process for premises works<br><br>Premises Group and Programme Management | 1,2,3,4,5,6,7,8,9 | |
| | | 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. It forms part of the Primary Care Improvement Plan (PCIP)and is currently being drafted. This is a three year plan from 2018/19 to 2020/21. (Integrated Care Fund) | April 2018 – March 2021 | | Full survey of all Health Centre Premises (Buchan Associate Report) is now complete. Identified overall capacity within Primary Care and shrtfalls in accommodation needs. (see above update) | Cathy Wilson / Tim Young | Current NHSB Estate & Project Support Resources/Team constraints which may cause delays in requests for works. | To be discussed at the next Premises Group and ensure that | 1,2,3,4,5,6,7,8,9 | |
| | | 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 underway. 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 | | Being actively monitored | Brian Paris | | | | |

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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 | efficiency. | | Brian Paris / Tim Young | | | | |

## 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 | Feb 22 RAG status | Summary of activities etc | Timescales start & end date | Target Impact / Benefits | Progress against desired outcome end Feb 22 | Lead delivery body | Key Risks | Controls/Actions | Outcome(s) - as listed on the 'Outcomes summary' tab | Major strategies/ programmes that the outcome(s) relates to |
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| People will be able to access a range of community-based health and social care services. | | 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.<br><br>Reduced waiting lists.<br><br>Increased access to information and community support.<br><br>Reduced revenue costs from reduced demand. | Pre Covid 14 Hubs were in operation across the Borders. These were stopped during COVID. The main hubs (Hawick, Kelso, Duns, Eyemouth, Galashiels and Peebles) have been back in operation since Sept 21. Work is now underway to restart the smaller/rural hubs. These should be fully operational by June 22. | Shona MacCorquodale | Staffing Pressures, low attendance making staffing the hubs unviable. | Increased communications - Regular social media updates, local posters advertising, promoting service wih GPs. | 1,2,3,4,5,6,7,8,9 | |
| People will be informed and have access to the right support at the right time. | | We will develop Local Area Coordination (LAC) for adults and older people. | July 2017 – October 2018 | | Local Area Co-ordination (LAC) service for older adults and adults with a physical disability operational from 2019 an intergrated with existing LAC Service in Borders (which provides a service to adults with a learning disability and adults who experience mental ill-health) under one management structure. Focus of team is locality working and developing inclusive communities. Delivery of LAC service in adult learning disability, adult mental health, older adults and adults with a physical disability - enablement/re-ablement, asset based approach to reduce demands on statutory services/packages of care. | Claire Veitch / Simon Burt | | | 1,2,3,4,5,6,7,8,9 | Range of 'Fit for 2024' work-streams. Older adults pathway-specifcally Pathway Zero. H&SC locality plans. 'A Connected Scotland' National Strategy for tackling isolation and loneliness. |
| | | After an analysis of demand the additional funding was utilised to recruit two part-time Local Area Co-ordinators and two part-time Community Link Workers. This has enabled an improved geographical spread for the Local Area Coordination Service in mental health across the Borders.(Core Funding Investment) | April 2017 – March 2020 | | Expansion outlined in summary of activities etc funded by PCIP for delivery of Community Link Worker (CLW) programme, funds expansion of MH LAC. Delivery of CLW service operational from March 2020. Service has only operated during the pandemic navigating the associated restrictions on service delivery & communities. Established collaborative working with Wellbeing Service & 'Renew' as partners also operating in Primary Care. | Claire Veitch / Simon Burt | Low level of referrals via GP's (Between 2020 & 2021, 43% increase in referrals into MH LAC overall). Perceived need for service and concerns re: best use of PCIP funding from GPs given low uptake. | Working with 'Renew' to pilot single referral route for GPs as means of offering more accessilble referral route for GPs. Further work to continue to promote the service with GPs across the Borders. Exploring options for physical presence in GP practices as further test of change in terms of increasing use of the service. | 1,2,3,4,5,6,7,8,9 | GMS Contract. Forms part of the Primary Care Improvement Plan (PCIP). Contributing/linked into discussions on mental health & wellbeing in primary care funding. |
| 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.<br><br>Improved health and wellbeing.<br><br>Reduction in demand for statutory services.<br><br>Reduced demands on GPs.<br><br>Improved access to advice on minor health complaints.<br><br>Reduced revenue costs from reduced demand. | Following a decision at the Audit & Scrutiny Committee the IJB are leading an exploration into Day Centres/ Building based activities. This is being progressed through the Carers Workstream. | John Barrow / Stacy Patterson / Brian Paris | Nation strategy calls for a shift away from structured day services in favour of more choice and control through flexible use of SDS - Risk - Local resistence to the national policy | Involvement ofbroad range of stakeholders including people who use various SDS options. | The Output of this process will be a decision will be made by IJB following the exploration. | IJB Strategic Commissioning; SBC Corporate Plan; Shifting the Balance of Care and Self-Directed Support strategy; Carers Strategy. Population Needs Assessment |
| | | We are building on the work and expanding the Community Capacity Building Team (CCB) 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 | | As per box F5 - CCB Team members were job matched over to form the older adults & adults with a physical disability. | Claire Veitch / Simon Burt | | | | |
| | | 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. | | | 1. PCIP Pharmacy staff work is under review. A decision whether to follow Level 1 Pharmacy technician work only or offer Level 1 - 3 GMS contract. The MoU2 relesed in Aug 2021 suggested moving away from the Level system and this is what we are aiming for in the next 2 months. The HB funded Pharmcy staff will be focusing on managing long term conditions and doing polypharmacy reviews as well as assisting secondary care with medication | | 1.Continuing with Level 1 work only and not folloing MoU2 recommendations. | 1. Negotiating wth PCIP Exec regarding service and gaining views of all stakeholders involved in service. Working alongside secondary care to provide a seemless transition of medication initiation and review after diagnosis locally. | 1, 2, 3,6,7 | National Disease strategies (Pain, Respiratory, Diabetes, Polypharmacy, mental Health), Memorandum of Understanding 2, GP Contract 2018, Care Home Responsibility with Board, Sick Day Rules |

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| Health and social care services reduce admission to hospital, improve health and wellbeing and reduce demand for statutory services. | | 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 known to cause acute kidney injury was set up two years ago (Sick Day Rules). This has been shown in another Board to reduce admissions. We will continue to promote this service. | April 2017 – March 2019 | | initiaion and monitoring in disease management (starting imminently). 2. A B5 technician has been working to support medicines management on discharge, a project was completed and written up. The technicians funding is now under review (moving from PCIP to IJB) as well as a case being submitteed to the IJB to fund the recommendations from the outcome of the project. The 'Sick day rules' being promoted is ongoing, however I am unaware of any actual review clinics taking place, a dicussion is normally had with patients when initiated on these medications and a 'wallet/purse' card was available for patients to refer to if needed. I cannot comment on any changes in wards practice. 3. The PCIP Pharmacy is currently under 70% funded compare to the original budget with some of the budget being removed to fund other work streams causing a vast reduction in support and capacity in GP practices to fulfil the GP contract. Currently, the demand for medicine compliance aid is at an all time high, with many Pharmacies unable to accept any more. There are other alternatives (tick reminder charts) avaialable but some of these cannot be used for patients on Packages of Care. 4. The Community Pharmcists are using Pharmacy First/ Pharmacy First Plus to assist with out of hours care, however, this is very location specific. The service is dependant on Prescribing Pharmacists and a consistent staffing level | Mhairi Struthers / Rachel Mollart / Cathy Wilson | 2. No long term funding for Technician to continue to support discharges and social work with package of care | 2. Bid submitted to IJB to fund outcomes from project completed to fund staff that support discharge as well as social work with medicines in teh community and care home staff. | 1, 2, 3,6,7 | National Disease strategies (Pain, Respiratory, Diabetes, Polypharmacy, mental Health), Memorandum of Understanding 2, GP Contract 2018, Care Home Responsibility with Board, Sick Day Rules |
| | | 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, e.g. BECS through Pharmacy First, medicines review, carer support and using quality improvement techniques. (Integrated Care Fund) | | | | | 3. Additional funding not being allocated to the PCIP Pharmacy Service (as a priority service) from SG 4. Staff feeling under valued and leaving the profession | 3. Submission of quarterly returns to SG highlighting the service demands and situation. Providing PCIP with data on demand/capacity data. Assisiting community pharmacies to educate patients on other ways to manage medicines other than medicines complaince aids. | 4,8,9 | National Disease strategies (Pain, Respiratory, Diabetes, Polypharmacy, mental Health), Memorandum of Understanding 2, GP Contract 2018, Care Home Responsibility with Board, Sick Day Rules |
| Provide people with alternatives to hospital care. | | 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 six 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 | Reduced emergency admissions and associated bed days.<br><br>Reduce readmissions to hospital.<br><br>Reduced revenue costs from reduced demand. | Garden View was opened in 2018 which houses 25 Discharge to Assess transitional Care Beds which house up to 6 weeks fro rehab care. | Julie Glen / Jen Holland | | | | |
| | | 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:<br>(a) Craw Wood Discharge to Assess residential facility for up to 15 adults.<br>(b) Berwickshire Hospital to Home Pilot Project.<br>(c) Hawick Hospital to Home Pilot Project.<br>(d) Central Discharge to Asses at Home Project. (Integrated Care Fund) | December 2017 – October 2018 | | Garden View was opened in 2018 which houses 25 Discharge to Assess transitional Care Beds which house up to 6 weeks fro rehab care. | Julie Glen / Jen Holland / Suzie Flower / Paul Williams / Cathy Wilson | | | | |
| | | We will develop 'step-up' facilities to prevent hospital admissions and increase opportunities for short-term placements. (Integrated Care Fund) | April 2017 – March 2019 | | 4 step up / step down beds are now open at DUNS ECH. | Julie Glen / Jen Holland / Suzie Flower / Paul Williams / Cathy | | | | |
| | | A review has been completed by Professor 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. This forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a three year plan from 2018/19 to 2020/21. (Transformation Programme) | April 2018 – March 2021 | | Older People Patway PID approved in end of 2021.<br><br>In Feb/Mar 2022 - Each Workstream Lead has reviewed their action plan and identified any challenges or blockages preventing progress and re-align aims and objectives.<br><br>New Community Geriatrician joining in April and will help progress of | Cathy Wilson / Paul Williams / Suzie Flower | There is a risk that if we do not fully engage with clinicians, staff, public and patients in this transformation/project work stream leading to a lack of understanding of the overarching programme, people | Regular key stakeholder events/meeting including Delivery Group<br><br>Regular meeting with workstream leads and identifying opportunuity for joing or collaboartive working. | 1,2,3,4,5,6,7,8,9 | Older People Pathway |

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| | | We will redesign the way care at home services are delivered to ensure a re-ablement approach. (Transformation Programme) | March 2018 – October 2018 | | Work had been underway to deliver a HSCP reablement team with Home First to deliver for older people. This wortk ahs been stalled sue to the pandemic. SBC are now creating an inhouse reablement service to meet the needs of all homecare clients to ensure all clients go through a reablement programme to deliver improved independent living and care outcomes | Jen Holland / Julie Glen (would suggets Paul as its currently in NHS re Home First) | | | | |
| | | The Distress Brief Intervention Service has now been commissioned and commenced a role out in October 2017. (Integrated Care Fund) | April 2017 – March 2019 | | In place | Simon Burt | | | | |
| 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.<br><br>More people at home or in a homely setting including when at the end of their life.<br><br>Reduced demand for care at home and other health and social care services.<br><br>Reduced Revenue Costs from reduced demand and greater efficiency | The service is fully operational. | Julie Glen | | Fully operational | 1,2,3,4,5,7,9 | |
| | | 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 | | Work re-launched in January 2022. Due to staffing constraints from health board - moving away for 5 localities model to 2 Communities based model. Focus on identifying and discussing the most complex patients to discuss:<br>• Answer the immediate care needs of people in a community setting;<br>• Reduce the risk of hospital admissions; and<br>• Focus on promoting independent living for older people through reablement, rehabilitation, and rapid response.<br><br>Health Board has identified key staff for each community huddle. Further work needed with social work to agree on how it will be coordinated. | Suzie Flower / Cathy Wilson / Brian Paris | HSCP Joint Leadership, Buy-in and Commitment<br>Shared understanding of outcomes and deliverables from both health and social work side<br>Difficulty in planing and arranging joint meetings during challenging/high pressure time. | HSCP Leadership Group membership and high level principles agreed in January.<br><br>Next meeting to take place in March 2022 to agree underlying operational principles. | 1,2,3,4,5,7,8,9 | Older People Pathway<br>Home First<br>HSCP Locality Working |
| | | We will increase the use of telecare and telehealthcare. (Transformation Programme) | October 2017 – June 2018 | | The COVID pandemic has prevented progress in this area due to meeting demand of everyday demands. | Paul Cathrow / Julie Glen | Risk aversion/lack of knowledge re available telecare and tec. | workstreams have now been created to review this project and establish target audience/provide input/training to SW staff | 1,2,3,4,5,7 | |
| | | We will increase the provision of Housing with Care and Extra Care Housing. (Core Fund Investment) | April 2017 – March 2020 | | We have opened up two ECH housing provisions in 21-22 one in Duns in March 21 and one in Wilkie Gardens in Galashiels in Jan 22. Development in underway in Kelso and Hawick plans are underway. | Jen Holland | | | | |
| 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.<br><br>Reduced demand on statutory services through increased local alternatives.<br><br>Increased access to Information and Community Support.<br><br>Reduced Revenue Costs from reduced demand and greater efficiency. | The implementation of STRATA is progressing. This referral software allows NHS, SBC, Third and Independent sector to make referrals securely and with the right information. This also builds commissioning and process improvement. Currently more duplication as STRATA needs connected to SBC/NHS systems and this is scheduled into digital programme. Commission programme approach has been established (Community Led Support, Co-production,Outcomes focused). The way in which outcomes will be met will come through IJB Commissioning directions. HSCP Senior Leadership to establish agreed what joint governance and structure over Community services would look like. This perhaps through the SBC Corporate Plan, NHS Plan, IJB | Brian Paris | Integrated Locality Management requires joint governance and agreement on the professional and operational business. This is at risk of experiencing creepage/ delay in a context of high whole system pressures and National Care Service discussions | STRATA integrates organisations, processes and data from cross sector. This is progressing through clear plan and will continue. Roll-out of STRATA is happening within Hospital and Community, it is adversely impacted as it is not yet integrated into SBC or NHS systems. When this is in place much more integration and management control will be achieved. Locality Huddles are the start of integrated decision making. This needs strengthened and tasked with the question "what might an integrated management look like" in that locality. | Outcomes: peoples experience of services is more seamless | SBC Corporate plan, IJB Strategic Commissioning, Population Needs Profile, Carers Strategy, Commissioning strategy in relation to supporting people to live more independently in their own homes - shifting the balance of care. |
| 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.<br><br>Increased opportunities to have greater choice and control over planned care and support.<br><br>Improved consistency and equity in the application of the resource allocation system. | All people are now assessed and have choice of all four SDS Options. It is a statutory duty. SDS Working Group is actively involved in co-producing areas of improvement to promote creativity in usage of SDS. | John Barrow / Stacy Paterson / Brian Paris | Risk is that currently difficulties in workforce and recruitment mean a more limited choice than we'd like. Commissioning and recruitment need careful evaluation as establishing one type of service may have detrimental impact on an existing service. | Actions: Continue to coproduce and promote Self-Directed Support so that it better understood. Also, growing awareness of SDS in communities prior to crisis or immediate need. Reviewing contract with Encompass to support Direct Payment employers. Introductino of Direct Payment Prepaid cards to improve funding for people and to increase level of audit and due diligence of funds. | People will have more choice and control over their care. | Self-Directed Support: My Care My Choice, |

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| | | 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 | Responsibility for spend of allocated personal budget is transferred to individuals. | | ? Tim Young | | | | |
| 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 CareFund 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.<br><br>Scarce resources will be directed to those most in need and secure best value.<br><br>Health and social care will continue to be affordable within a context of constrained funding, increased cost and greater demand.<br><br>Improved outcomes for patients, clients and carers. | Evaluated at IJB in Feb 2021 (Discharge Programme evaluation) | | | | | |
| | | We will deliver our three year Workforce Plan. (Core Funding Investment) | October 2016 – March 2019 | | | Ailsa Paterson / Bob Salmond | | | | |
| | | We will shift resources from acute health and social care to community settings. (Transformation Programme) (Integrated Care Fund) | April 2017 – March 2019 | | Some progress has been made with regard to Implementation and subsequent mainstreaming of tests of change - transitional care provision/ Home First/STRATA/Matching | Paul McMenamin | • Despite provision of new or developed community-based reablement or | • Review of functions delegated under Scheme of Integration<br>• Re-establishment of FF24 and Financial Turnaround Programmes | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway |
| | | We will demonstrate best value in the commissioning and delivery of health and social care. (Transformation Programme) (Integrated Care Fund) (Core Funding Investment) | April 2017 – March 2019 | | Older People social care - full contract management control within procurement service and processes procedures in line with legislation regards procurement and Best Value. Care homes beds purchased in line with National Care Home rate and | Jen Holland / Holly Hamilton-Glover / Susan Henderson / Simon Burt / Cathy Wilson | | | | |
| | | 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 | | Previous achievements include the closure of Cauldshiels and investment into other mainstream services, some new, some existing.<br>Agreement to pilot of Millar House initiative is another example of realignment of resources to improve outcomes, increase capacity and achieve greater cost effectiveness.<br>Former ICF / Transformation Funded initiatives supporting OPP now mainstreamed. | Paul McMenamin | • Ongoing pressure across budgets result in inability to achieve cashable savings<br>• Increased stakeholder expectation / SG direction limits ability to disinvest from services in line with strategic intention / requirement<br>• Insufficient transformation funding restricts ability to pilot tests of change / fund transition period | • Clarity of directions from IJB to partners<br>• Establishment of a self-sustaining transformation programme / fund<br>• Work to better integrate strategic and operational financial planning process across H&SCP and its partner organisations<br>• Greater evaluation / benefits realisation / return on investment<br>• Wider delegation of functions and resources to Health and Social Care Partnership under the Scheme of Delegation. | 9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation Programme / Fund<br>Targeted reviews of delegated services across social care, Mental Health (e.g. transformation programme, GRC, etc) and Primary & Community Services |
| | | 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 | | The Social Care and Social Work Delivery Board and FF2024 governance agenda have led a large portfolio of work to implement significant reviews of alternative models to ensure cost effectiveness Within 21-22 we | Jen Holland / Paul McMenamin | • Insufficient transformation funding restricts ability to pilot tests of change / fund transition | • New, wholly owned Strategic Plan<br>• Development of a new robust framework of programme evaluation<br>• Representation / Membership of wider stakeholder group within Integration Joint | 1,2,3,4,5,6,7,8,9 | Fit for 2024<br>Financial Turnaround / Sustainability<br>Older People's Pathway<br>H&SCP Transformation |
| | | 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 | | Being actively monitored | Simon Burt / Peter Lerpiniere / Philip Grieve / Brian Paris | | | | |
| | | 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 | All people newly diagnosed with dementia are offered at least one year post-diagnostic support.<br><br>Local health and social care services which are designed to meet local need.<br><br>Improved standard of health centre | | Brian Paris / Tim Young | | | | |

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| 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. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a three year plan from 2018/19 to 2020/21. (Core Funding Investment) | | premises.<br><br>Increased community support work form improved health centres.<br><br>Improved GP services.<br><br>Greater focus on prevention will result in reduced revenue costs from reduced demand and increased efficiency. | Full survey of all Health Centre Premises (Buchan Associate Report) is now complete. Identified overall capacity within Primary Care and shrtfalls in accommodation needs.<br><br>Established investment priorities via gap analysis and prioritisation exercise. (Short, Medium and Long Term priorities)<br><br>Findings being revised into an action plan. | Cathy Wilson / Steph Errington | Current NHSB Estate & Project Support Resources/Team constraints which may cause delays in requests for works. | Premise Group Oversight of works and regular engagement with key stakeholders including GPs (GP Sub).<br><br>Offering transparency and accountability in terms of process for premises works<br><br>Premises Group and Programme Management office to agree the most appropriate way to take forward on selecting priority works with Premises Group fully taking forward short term works. | 1,2,3,4,5,6,7,8,9 | |
| | | 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. It forms part of the Primary Care Improvement Plan (PCIP) and is currently being drafted. This is a three year plan from 2018/19 to 2020/21. (Core Funding Investment) | | | Full survey of all Health Centre Premises (Buchan Associate Report) is now complete. Identified overall capacity within Primary Care and shrtfalls in accommodation needs. (see above update) | Cathy Wilson / Tim Young | Current NHSB Estate & Project Support Resources/Team constraints which may cause delays in requests for works.<br><br>Further work need to link in work with Buchan Associate report and the development of dementia friendly premises. | To be discussed at the next Premises Group and ensure that | 1,2,3,4,5,6,7,8,9 | |
| People who provide unpaid care are supported to look after their own health and wellbeing in order to fulfil their caring role. | | We will continue to commission the Borders Carers Centre to undertake all carers' assessments. (Core Funding Investment) | April 2017 – March 2019 | Improved and more consistent support for carers.<br><br>Better understanding of the numbers of people providing informal care. | Recruitment of SDS/Carers Lead to interface with unpaid carers and those organisations representing or providing support, information and guidance to unpaid carers | John Barrow / Stacy Paterson / Michael Curran / Brian Paris | Risk that Borders Carer centre is understood as the only organisation supporting carers whereas other services and teams are involved. These connections need to be more integrated. Majority of unpaid carers are unknown to HSCP and live independently often until crisis. National statistic implies 16k unpaid carers whereas Borders Cares Centre have had contact with 2,000 people over last three years and active 600 at moment. | Carers Workstream and involvement of carers and borders carers centres; care panel of replacement care where all decisions are jointly made. Commissioning of services will support third and independent sectors are also in contact and providing support to carers and families eg British Red Cross, Alzheimer Scotland, Post Diagnostic Support services..... | Carers have improved health and wellbeing and have choice and control in their life outside of their carers responsibilities. | |

# 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. |