Scottish Borders **Health & Social Care** Partnership

CHANGING HEALTH & SOCIAL CARE FOR YOU 2018-2021

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

Strategic Plan 2018 -2021

Scottish Borders
Health and Social Care
PARTNERSHIP

#yourpart

CONTENTS

SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP STRATEGIC PLAN 2018-2021

FOREWORD

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

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

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

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

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

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

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

I look forward to joining with you in our challenge to create the healthiest region in Scotland.

Rob McCulloch-Graham
Chief Officer, Health and Social Care Integration
August 2018

EXECUTIVE SUMMARY

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

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

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

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

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

This refreshed Strategic Plan outlines three refocused local strategic objectives and the key challenges on delivering these. The strategy also presents a high level summary of the continued case for transforming the way in which health and social care services are delivered in the Scottish Borders before outlining a plan for the resource and delivery of the strategic objectives (Appendix 3).

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

LOCAL STRATEGIC OBJECTIVES

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

We have identified three strategic objectives:

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

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

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

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

Details of the Partnership's duties under the Equality Act 2010 can be seen in Appendix 5.

This high-level Plan will be supported by the implementation of strategies related to specific themes such as dementia, mental health, carers and locality plans that reflect differing patterns of need across the Scottish Borders. The full Implementation Plan ("Plan and "Do" components of the Commissioning Cycle) is shown as Appendix 3.

OBJECTIVE 1

We will improve the health of the population and reduce the number of hospital admissions.

How?

- By supporting individuals to improve their health
- By improving the range and quality of community based services and reducing demand for hospital care
- Ensuring appropriate supply of good quality and suitable housing

WE ARE COMMITTED TO	YOUR PART
• Helping older people manage their own health better, improving fitness and reducing social isolation • Supporting positive changes in health behaviour and lifestyle, such as smoking, diet, alcohol consumption and physical activity • Adopting preventative and early intervention approaches where possible • Ensuring staff and carers have the necessary knowledge, skills and equipment to provide care at home • Through patient education, encouraging the appropriate use of services and promoting personal responsibility through public information and signposting • Continuing to promote uptake of screening opportunities and immunisation programmes and raising awareness of signs and symptoms of health conditions • Implementing the Integrated Strategic Plan for Older People's Housing, Care and Support 2018-28	✓ Use our What Matters Hubs as the first point of contact for health and social care services ✓ Find out about the range of activities available through our Community Capacity Building team [Sue to sort link for this] ✓ Find out about health improvement programmes and initiatives in your area ✓ Use our Lifestyle Advisory Support Service ✓ Consider whether or not simple equipment could help a family member remain at home. Find out how to purchase or hire equipment.

What will success look like?

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

OBJECTIVE 2

We will improve the flow of patients into, through and out of hospital.

How?

- By reducing the time that people are delayed in hospital
- By improving care/patient pathways to ensure a more co-ordinated, timely and person-centred experience/approach
- By ensuring people have a greater choice of different housing options which meet their long-term housing, care and support needs

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

What will success look like?

More people are seen within four hours at A&E	There are less unplanned admissions to hospital	More patients are satisfied with care and treatment, felt that staff understood what mattered and felt they had the information they needed to make decisions

DELAYED DISCHARGES		
Less people wait • over 72 hours • over two weeks	We analysed the reasons for delay to make improvements	The rate of occupied bed days (associated with delayed discharge) will reduce

OBJECTIVE 3

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

How?

- By supporting people to manage their own conditions
- By improving access to health and social care services in local communities
- By improving support to carers
- By building extra care homes, including amenity and mixed tenure provision

WE ARE COMMITTED TO	YOUR PART
• Piloting and evaluating the Buurtzorg Neighbourhood Care Model in Coldstream and extending it to other areas • Providing locally based What Matters Hubs which can be easily accessed by the community as the first point of contact for health and social care services • Develop integrated accessible transport • Using technology where appropriate to provide better home based health care services • Developing community based mental health care • Ensuring people have choice of control over the support they need and are supported to live independently in their own homes • Supporting carers and implementing the requirements of the Carers (Scotland) Act 2016 • Investing in social infrastructure, looking to harness the strengths of our own communities in developing capacity in care and support for family members and friends • Supporting an outcome-focussed approach across all areas • Improving access and signposting to services and information	✓ Use our What Matters Hubs as the first point of contact for health and social care services ✓ Use the Community Transport Hub and SBC Community Transport services to help you get to appointments or attend social activities ✓ Get in touch with the Borders Carers Centre to see what support is available for carers ✓ Get involved in your Local Citizens Panel supported by the Learning Disability Service ✓ Help us to pilot new technology and equipment in your own home ✓ Find out about the support available through the Community Mental Health Service ✓ Use the Care and Repair Service provided in partnership with Eildon Housing Association to create a safer living environment

What will success look like?

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

KEY PRIORITIES

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

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

See Appendix 2 for the list of health and social care services that are integrated.

CASE FOR CHANGE: WHY WE NEED TO CHANGE

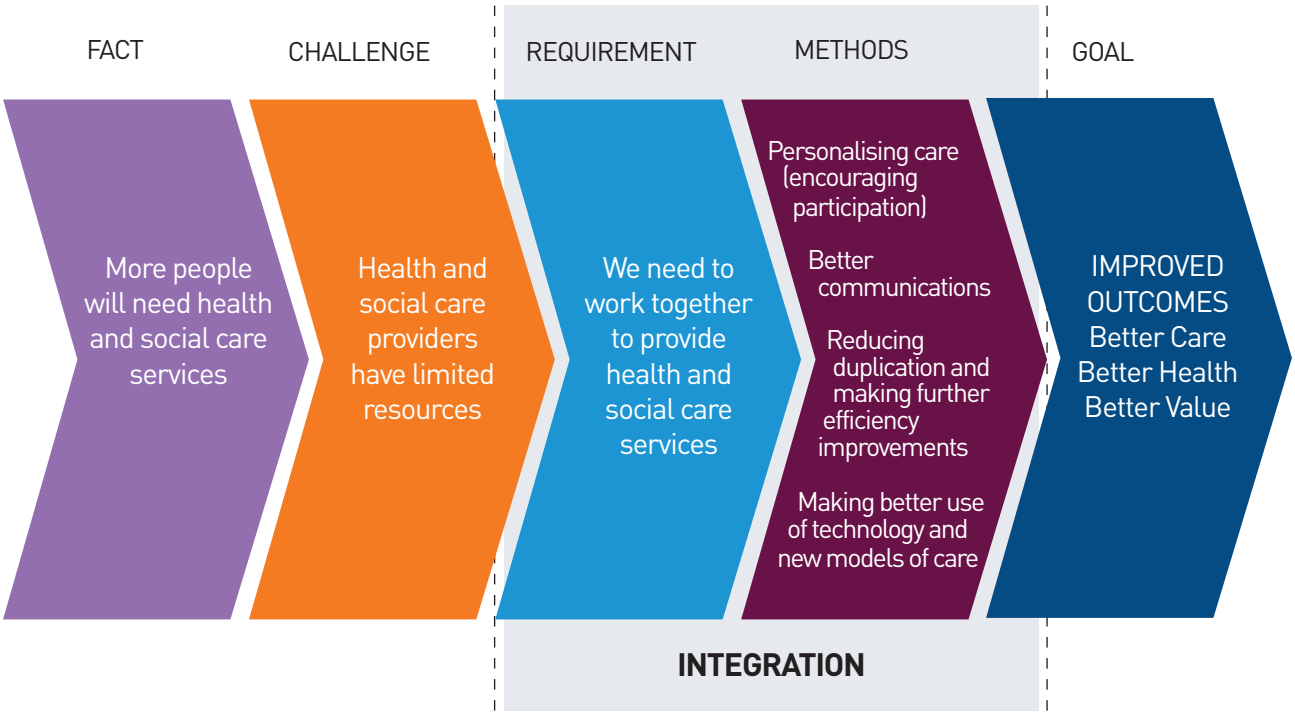
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in Figure 1 below and include:

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

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

FIGURE 1
THE CASE FOR CHANGE



KEY CHALLENGES

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

TABLE 1

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

These challenges are supported by evidence related to the Scottish Borders area profile and key challenges presented in **Appendix 6**.

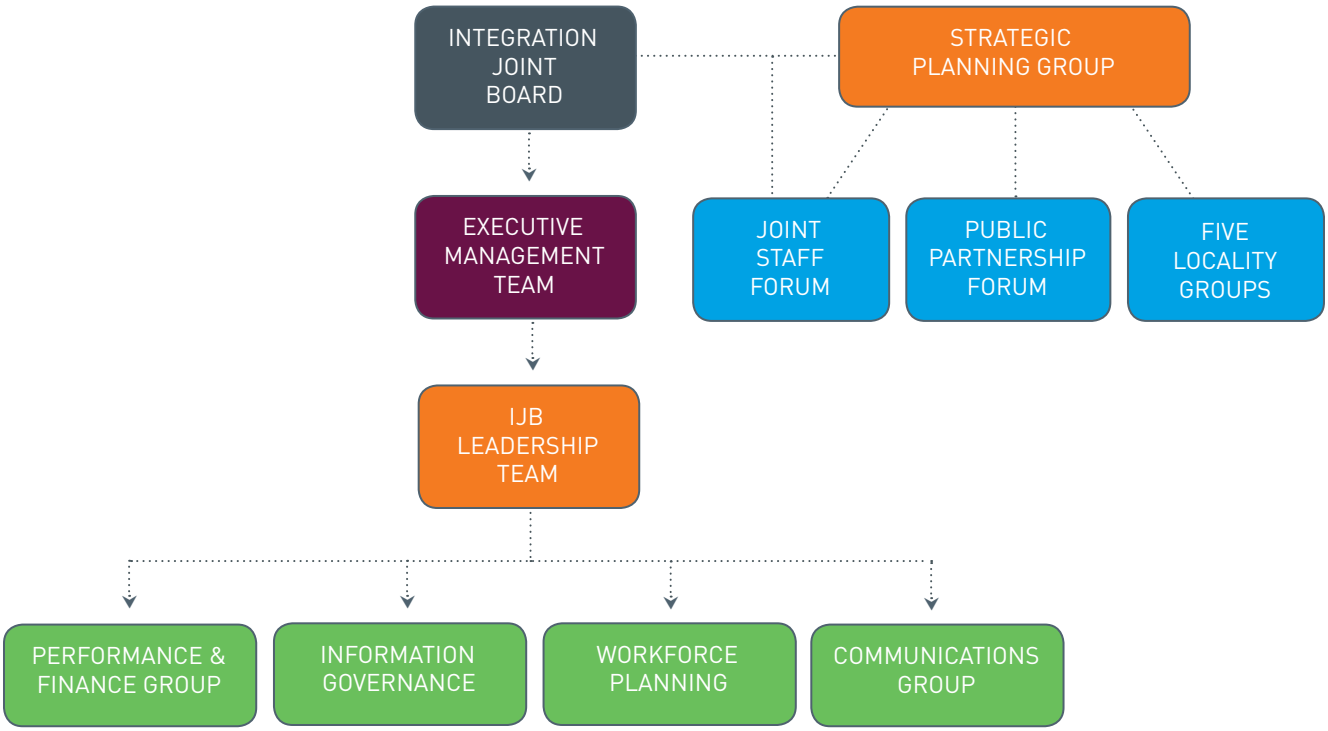
COMMISSIONING

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

Leadership and governance

Leadership and effective governance with the (IJB) and across the partner organisations are essential factors in the successful integration of health and social care services. In the Scottish Borders the work of the IJB is informed by, and in turn informs, the strategic priorities of the two partnership bodies – Scottish Borders Council (SBC) and NHS Borders (NHSB).

H&SC Partnership Governance Structure



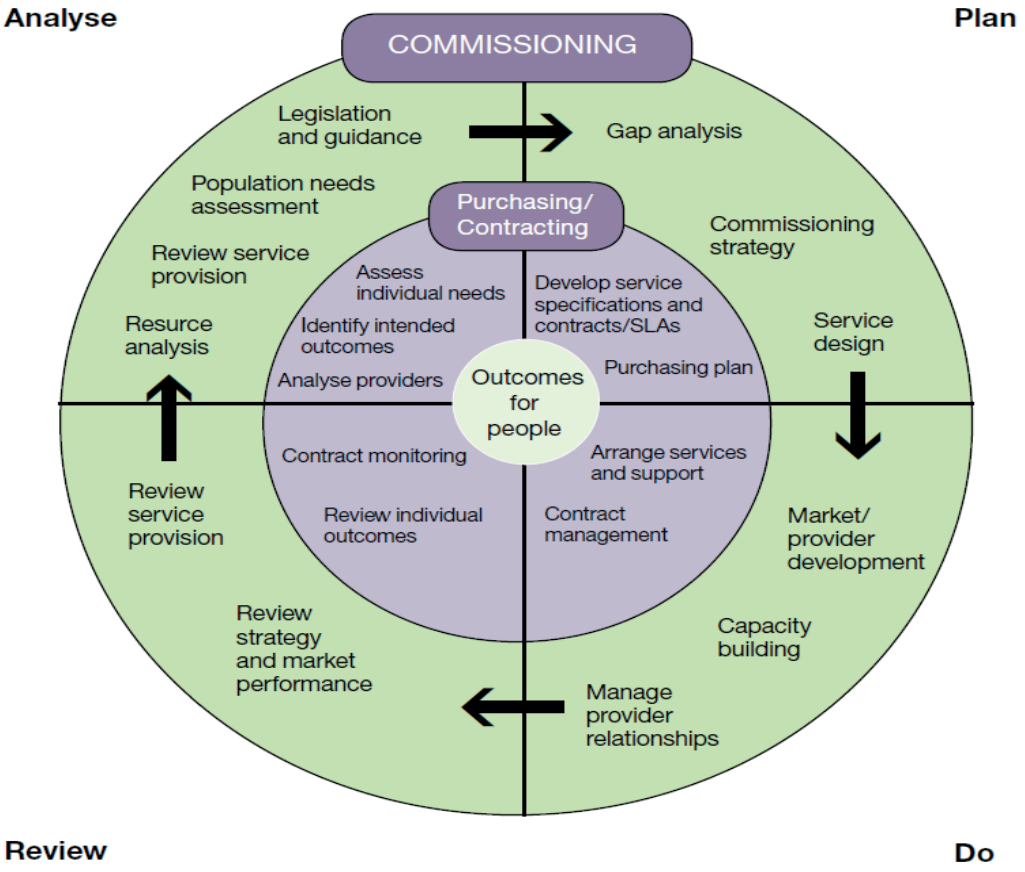
A summary of the role and function of each group can be seen in Appendix 7.

Strategic Procurement of Commissioned Services

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

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

Strategic Commissioning Cycle



Locality Planning

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

Transformational Planning

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

The key identified areas for transformation currently include:

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

Also included in the transformation programme are:

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

The programme is currently under review to ensure that it is aligned not only to the revised Strategic Plan 2018–2021 and the delivery of the associated Financial Plan, but also with emerging Integrated Care Fund (ICF) projects and the transformation programmes of both NHSB and SBC.

Workforce Planning and Development

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

Evidencing Improvement

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

Communication and Engagement

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

Strategic Priorities

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

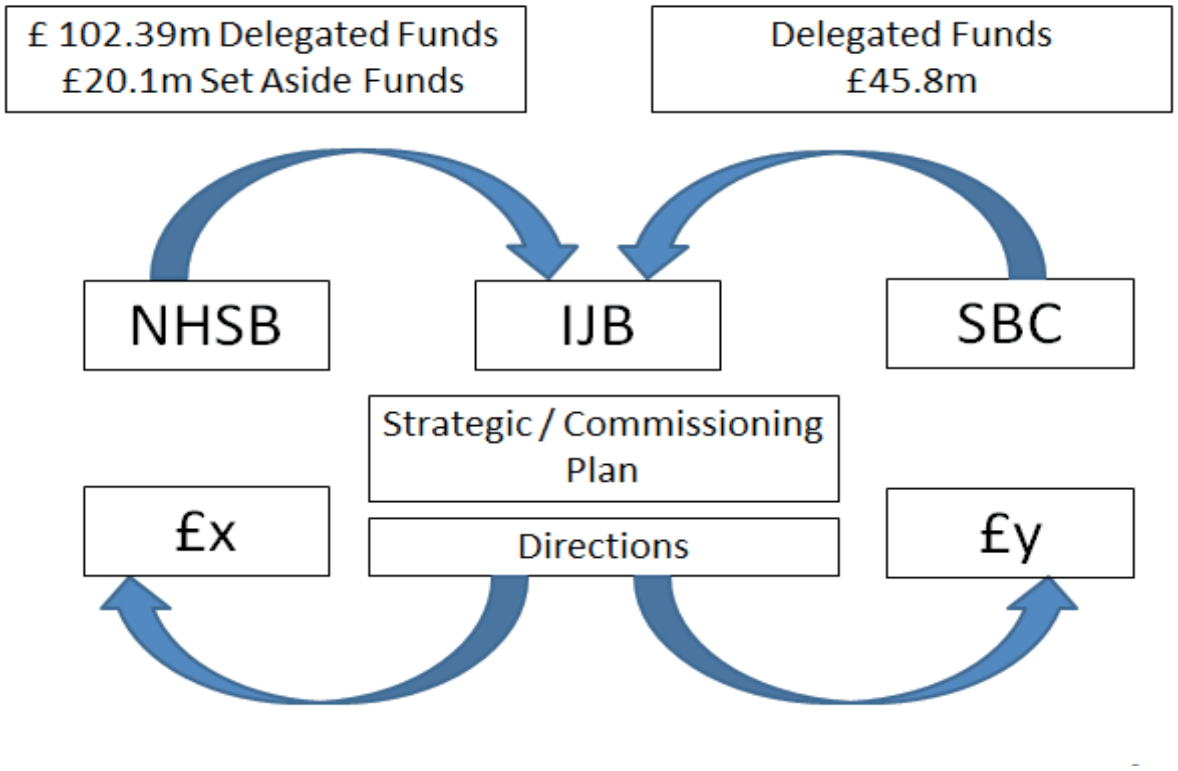
PARTNERSHIP SPENDING

In April 2018 the H&SCP agreed its Financial Plan for 2018/19 comprising of:

- the Delegated Budget i.e. the sum of payments to the IJB from partners (SBC £45.8m, NHSB £102.39m)
- the Notional Budget i.e. the amount set aside by NHSB for large hospital services used by the IJB population (£20.1m Set Aside Funds)

The IJB agrees its Strategic Commissioning Plan and decides how it should allocate funds to NHSB and SBC. Where there is significant change the IJB will issue a new Direction alongside a budgetary allocation to either or both NHSB and SBC.

The diagram below illustrates this:



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

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

LOCAL STRATEGIC OBJECTIVES	PLANNED SPEND 2018/19
1. We will improve the health of the population and reduce the number of hospital admissions.	 £58 MILLION
2. We will improve the flow of patients into, through & out of hospital.	 £67 MILLION
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.	 £43 MILLION
INTEGRATED CARE FUND	 £2.13 MILLION

The (ICF) has been used to enable the shift in health and social care services from hospital to community and outreach. This has resulted in a decrease in hospital admissions and increase in alternatives to hospital care. A detailed on plan on how the H&SCP will deliver on its strategic objectives within agreed resource can be seen in Appendix 8.

APPENDIX 1
THE NATIONAL HEALTH AND WELLBEING OUTCOMES

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

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

Source: Scottish Government

APPENDIX 2
SERVICES THAT ARE INTEGRATED

Which health and social care services have we integrated?

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

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

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

APPENDIX 3
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 two part-time LAC co-ordinators 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	
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 demand.
	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	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/ Benefits
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. 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. 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. 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 (Integrated Care Fund)	April 2017 – March 2019	

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 2020	
	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	
	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	
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	

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. 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. • 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. 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	
	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 2
We will improve the flow of patients into, through and out of 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 2020	
	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	
	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. 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. • 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. 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	
	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.	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 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 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 demand.
	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	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/ Benefits
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. 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. 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)	April 2017 – March 2019	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/ Benefits
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. • Reduce re-admissions to hospital. • Reduced revenue costs from reduced demand.
	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	
	We will develop 'step-up' facilities to prevent hospital admissions and increase opportunities for short-term placements. (Integrated Care Fund)	April 2017 – March 2019	
	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	
	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 2019	

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/ Benefits
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. • 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	
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.

Desired Outcome	What Will We Do?	Timescales Start and End Date	Target Impact/ Benefits
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. • Improved consistency and equity in the application of the resource allocation system. • Responsibility for spend of allocated personal budget is transferred to individuals.
	The pilot phase of the Transforming Care after Treatment Programme is complete. It will continue in Tweeddale and a rollout to the rest of the Borders is commencing with Eildon. (Other External Funding)	March 2018 – December 2018	
Resources are used effectively and efficiently in the provision of health and social care services.	We will deliver on our partnership information our Integrated Transformation and Integrated Care Fund programmes. (Transformation Programme) (Integrated Care Fund)	April 2017 – March 2019	• Reduced costs through management of demand, reduced unit costs and elimination of duplication and waste. • Scarce resources will be directed to those most in need and secure best value. • Health and social care will continue to be affordable within a context of constrained funding, increased cost and greater demand. • Improved outcomes for patients, clients and carers.
	We will deliver our three year Workforce Plan. (Core Funding Investment)	October 2016 – March 2019	
	We will shift resources from acute health and social care to community settings. (Transformation Programme) (Integrated Care Fund)	April 2017 – March 2019	
	We will demonstrate best value in the commissioning and delivery of health and social care. (Transformation Programme) (Integrated Care Fund) (Core Funding Investment)	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 deliver Post Diagnostic Support to a higher proportion of people with dementia. In the last year the NHS Mental Health Older Adult service has moved from paper to electronic records (EMIS) affording the opportunity for revision of our Post Diagnostic Support pathway which is under way. At beginning of May 2018 a revised recording template will be implemented to provide a live and interactive template for each person with a diagnosis of dementia and will allow direct national reporting and local audits to be conducted which will result in improved PDS going forward. (Core Funding Investment)	October 2017 – October 2018	• All people newly diagnosed with dementia are offered at least one year post-diagostic support. • Local health and social care services which are designed to meet local need. • Improved standard of health centre premises. • Increased community support work form improved health centres. • Improved GP services. • Greater focus on prevention will result in reduced revenue costs from reduced demand and increased efficiency.
	We will continue to increase appropriate GP referrals for people with dementia. Over the last year primary care colleagues have been alerted to the importance of referrals of people with a suspected diagnosis of dementia through a variety of means. Including at the November Medical Education session and a data cleansing process matching diagnoses known in mental health with the primary care dementia register. (Core Funding Investment)	October 2017 – October 2018	
	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)		
	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)		
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. • Better understanding of the numbers of people providing informal care.
	We will meet all identified carer needs which are assessed as critical. (Core Funding Investment)	April 2017 – March 2019	

APPENDIX 4
HOUSING CONTRIBUTION STATEMENT 2018-2021

INTRODUCTION

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

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

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

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

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

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

LOCAL HOUSING STRATEGY

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

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

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

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

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

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

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

Local Housing Strategy Partnership

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

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

FIGURE 1
LHS PARTNERSHIP

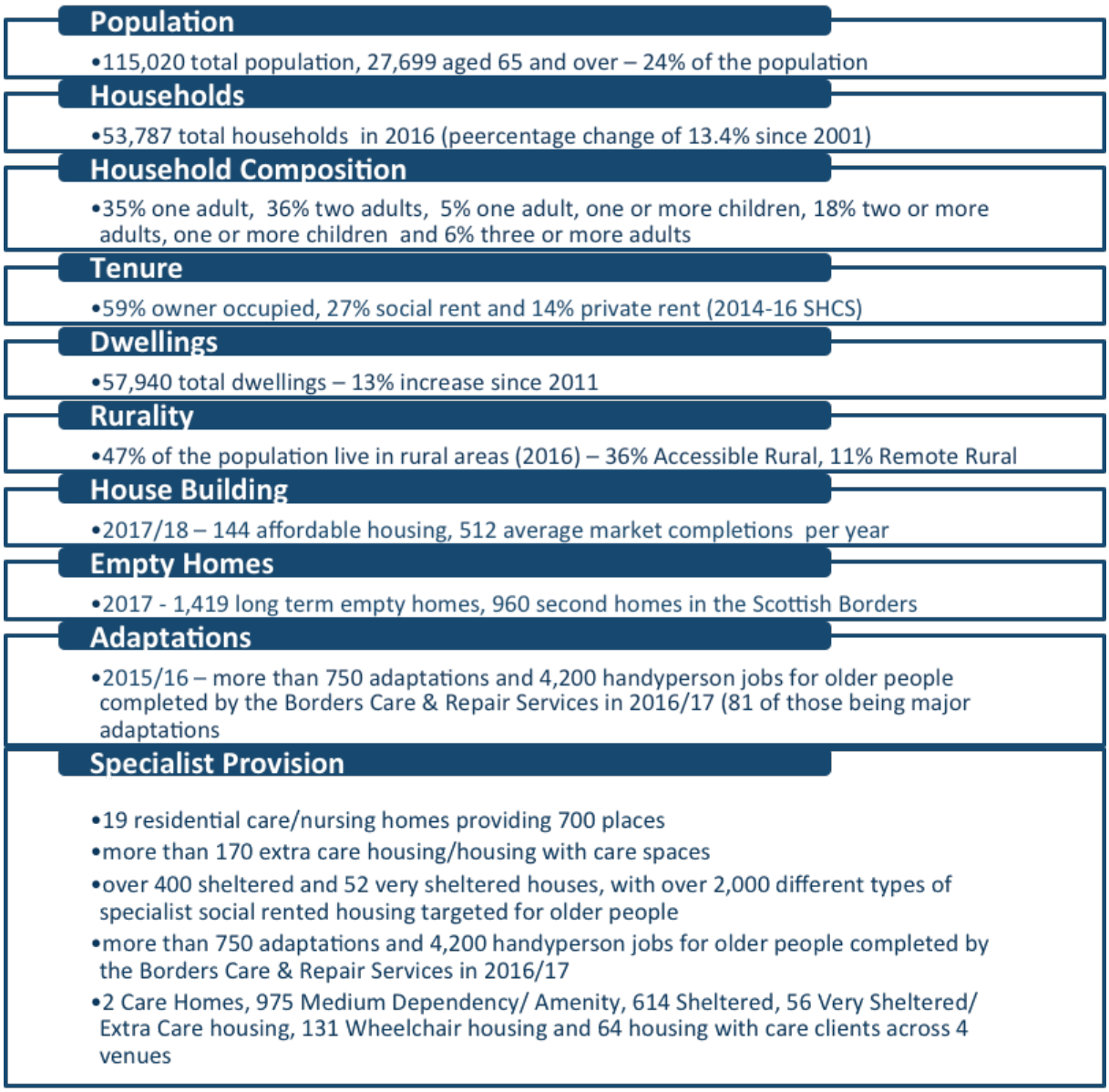
The LHS strategic outcomes and delivery plans are reviewed annually by the LHS Partnership Groups. Key LHS indicators will also be reviewed in a number of areas: in particular, annually through the Community Plan and within Partners' returns to the Annual Return on the Scottish Social Housing Charter.

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

HOUSING PROFILE

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

FIGURE 2
HOUSING PROFILE



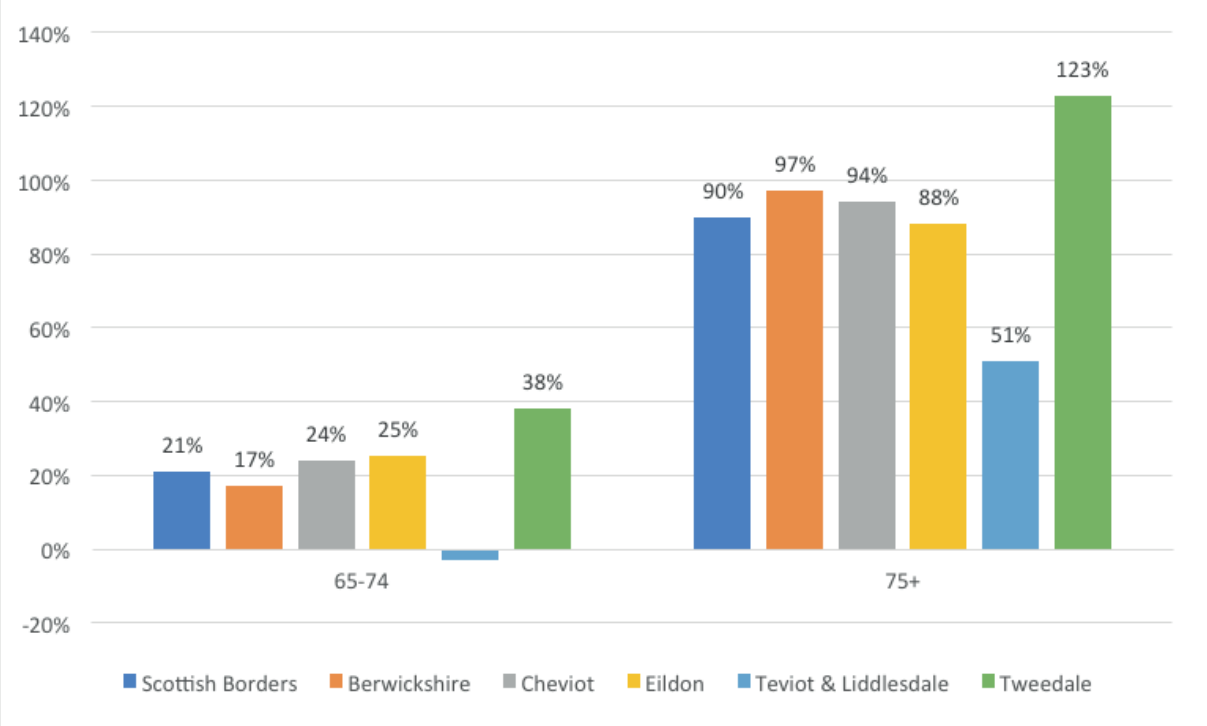
Older people in the Scottish Borders

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

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

FIGURE 3

INCREASE IN OLDER HOUSEHOLDS IN THE SCOTTISH BORDERS 2012-2037



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

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

Housing Need and Demand Assessment

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

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

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

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

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

HEALTH AND SOCIAL CARE PARTNERSHIP

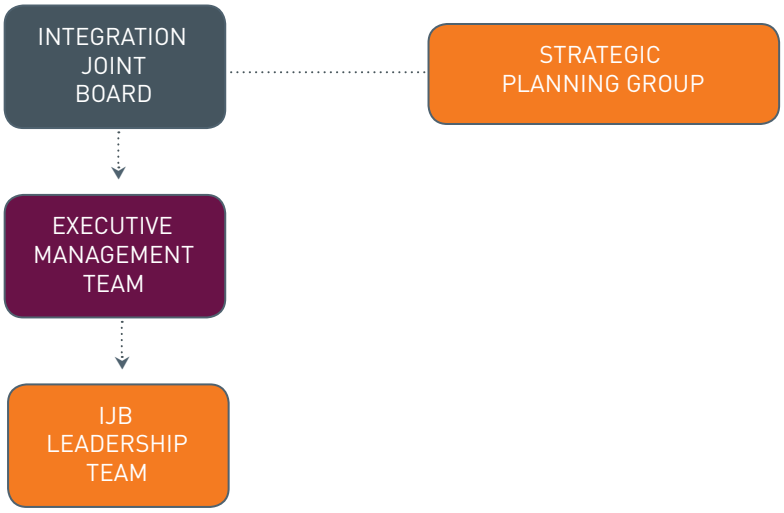
The Scottish Borders Health and Social Care Partnership launched in April 2015. The partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital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

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

Governance

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

FIGURE 4
INTEGRATION JOINT BOARD GOVERNANCE ARRANGEMENTS



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

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

TABLE 1: STRATEGIC PLANNING GROUP

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

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

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

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

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

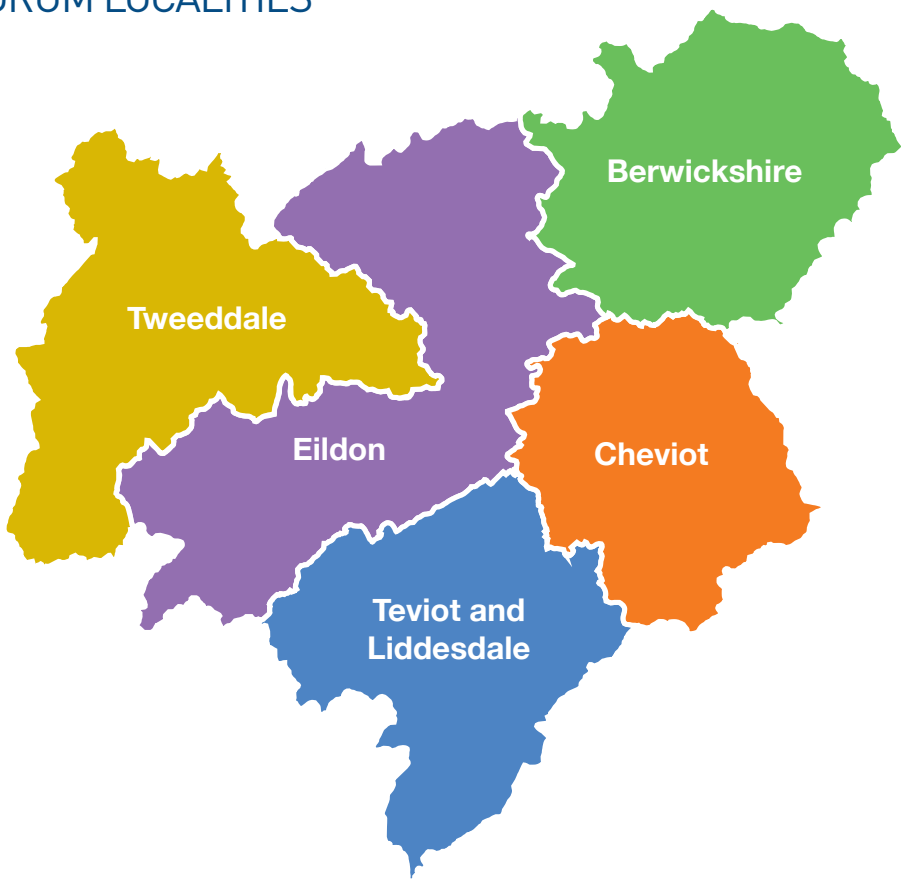
1. Prevention & early intervention
2. Accessible services
3. Care close to home
4. Delivery of services with an integrated care model
5. Greater choice & control
6. Optimise efficiency & effectiveness
7. Reduce health inequalities

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

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

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

FIGURE 5
AREA FORUM LOCALITIES



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

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

DELEGATED AND NON-DELEGATED FUNCTIONS

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

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

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

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

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

THE ROLE OF HOUSING IN THE INTEGRATION OF HEALTH AND SOCIAL CARE (Shared Outcomes and Priorities)

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

FIGURE 6

NATIONAL HEALTH AND WELLBEING OUTCOMES

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

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

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

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

TABLE 2: LINKS BETWEEN STRATEGIC OBJECTIVES AND LHS OUTCOMES

	LHS Priorities			
Strategic Objectives	1. The supply if housing meets the needs of our communities	2. More people live in good quality, energy efficient homes	3. Less people are affected by homelessness	4. More people are supported to live independently in their own homes
We will improve the health of the population and reduce the number of hospital admissions;	✓	✓	✓	✓
We will improve patient flow within and out with hospital;	✓	✓	✓	✓

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

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

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

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

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

TABLE 3: HOUSINGS CONTRIBUTION TOWARDS STRATEGIC PLAN OBJECTIVES AND PRINCIPLES

Objectives and Principles of Strategic Plan 2018-21	Housing Contribution
Objective: We will improve the health of the population and reduce the number of hospital admissions	• The vision of the LHS is to ensure "Every person in the Scottish Borders lives in a home that meets their needs". Providing safe, secure, warmer and more comfortable homes of an appropriate size, in an appropriate location and that are affordable to live in will reduce existing health problems – heart attacks, strokes, hypothermia, raised blood pressure, asthma, mental health problems, respiratory disease and also help prevent health issues occurring. • Delivery of adaptations and handyman's service (including fall prevention measures such as grab rails) • Providing housing support, directly and with partners to help people remain in their own home and prevent homelessness. Reduces stress, anxiety – keeping people in their homes
Objective: We will improve patient flow within and out with hospital	• Implementing the Older People's Housing, Care and Support Strategic Plan • Ensuring the reablement and hospital to home service development aligns with housing providers and care and repair services.
Objective: We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.	• Part of the ambitions of the Integrated Older People's Housing Care and Support Strategic Plan is to Invest in social infrastructure, looking to harness the strengths of our own communities in developing capacity in care and support for family member and friends. • Housing Representation on key partnership groups, including the SPG and the Community Led Support Steering Group • The availability of Housing related information and advice at the "What Matters Hubs"
Principle 1: Prevention & early intervention	• Preventing homelessness through the Housing Options approach • Investment in Adaptations • Expand on and develop new initiative housing with support models for particular needs groups such as transitional housing for those leaving care or institutions • Provision of welfare benefits advice and financial inclusion services • Unified, partnership working framework for assessing health and housing needs (Unified Health Assessment) • Housing Officers visiting vulnerable households on a regular basis – identifying the needs of that person • Development of Housing Information and Advice Strategy/ Communications Plan for private sector households • Strategic review of Scheme of Assistance to shift activity towards preventative investment • Development of Affordable Warmth Plan and fuel poverty awareness raising activity • Expanding the Care and Repair model • Review the falls prevention strategy, working widely across all partners in the Borders to ensure consistent approach and sharing of intelligence across key health, social care and also housing staff. • The 2015 Scottish Public Health Network paper "Restoring the public health response to homelessness" identified preventing through much earlier intervention and prevention activity https://www.scotphn.net/wp-content/uploads/2015/10/Restoring-the-Public-Health-response-to-Homelessness-in-Scotland-May-2015.pdf

Principle 2: Accessible services	• Access to affordable housing – delivering affordable housing across the area • Delivering warm housing in good condition • Working with local housing associations and private sector landlords to provide housing which is fit for purpose • Deliver more accessible, barrier free housing • Tenancy sustainment and Support Services through Housing Providers
Principle 3: Care close to home	• Housing Support Services • Borders Care & Repair provide a handyman service which will carry out handyperson jobs or advise on home upgrading & grant funding
Principle 4: Delivery of services with an integrated care model	• Using the planned investment in extra care housing to drive wider service change, including using the new extra care developments as hubs in a wider 'hub and spoke' approach to delivering home care services to people in their own homes across Scottish Borders • The housing sector in the Borders has a range of partnership mechanisms to enhance the level of staff engagement: - LHS Partnership - Borders Housing Hub - Older Persons Housing, Care and Support Steering Group - Strategic Housing Investment Plan Working Group - New Borders Alliance - Private Landlord Forum - Community Planning Partnership - New Integrated Homelessness and Wellbeing Strategic Partnership • Commitment to review and formalise commitments to Care & Repair to enable long term development of the service, enhancing the service to include a dementia service and increase capacity in prevention information and advice and falls prevention, including moving home service. • Commitment to review the spend on adaptations to consider scope for consolidation between funding streams, and continue dialogue with Scottish Government over the adequacy of funding for the RSL sector tenants / future demand.
Principle 5: Greater choice & control	• LHS Priority 4 "More people are supported to live independently in their own homes" • Implementation of the integrated Older Persons Housing Care and Support Strategic Plan • Flexible Housing Support options • Modernisation, remodelling and reprovisioning of existing sheltered housing schemes • Training and employment skills development and opportunities for employment • Aids and Adaptations • Borders Care & Repair services help disabled homeowners or private sector tenants with adaptations that will enable them to stay in their own home. • Safe Housing Options and co-ordinated services for Domestic Abuse Victims and their families • Undertaking a Housing needs and Aspirations study for Young people in the Borders – through extensive engagement and qualitative/quantitative research to help identify appropriate responses to meet those needs

Principle 6: Optimise efficiency & effectiveness	• Collaborative approaches to delivery plans and commissioning services through a range of partnership mechanisms such as: • SPG • LHS Partnership Group • Borders Housing Alliance • Integrated Older Persons Housing Care and Support Steering Group • Integrated Homelessness and Wellbeing Strategic Partnership
Principle 7: Reduce health inequalities	• The four outcomes of the LHS aim to tackle the inequalities in our society – this includes health inequalities • Building safer and thriving communities is a key priority to focus local community planning activities to assist Borders's most disadvantaged communities and improve employment and health inequalities. • Specific examples include: - Significant levels of investment in improving the Energy Efficiency of homes across the Borders, as well as the provision of Home Energy - Advice, helping to make homes warm and more comfortable. - Activities of Housing providers in terms of the provision of information and advice to tenants on a range of issues from financial advice, eating well and keeping warm. - Improving access to health and social care services for homeless people, particularly for those with complex needs by working with integration partners.

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

The Local Housing Strategy 2017-22 identified the development of an integrated older persons housing strategy as a strategic priority. Partners in the Scottish Borders have since produced an integrated Strategic Plan setting out a vision for enabling older people to have greater choice of housing, support and care that meets their long-term needs. It is focused on enabling independent living but proposes an investment and service framework which tackles the logistical and market challenges experienced in the Scottish Borders. It proposes investment in housing for older people, technology-based services, and additional people capacity as a means of ensuring future needs can be met.

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

- Enable investment in existing homes, and to invest significantly in technology (including telecare) to enable older people to continue living at home as their needs change

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

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

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

WHAT THIS MEANS...

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

PRIORITIES AND CHALLENGES

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

Priorities

Housing Support and Homelessness

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

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

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

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

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

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

Access to housing

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

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

Affordable warm and fuel poverty

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

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

Key areas for action include:

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

Adaptations

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

A 2012 study about adaptations found that:

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

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

Priorities include:

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

Housing supply

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

Priority:

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

Private sector

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

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

Sustainable places

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

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

Ongoing Challenges

Since the development of the previous Strategic Plan (2016-19) and the new Local Housing Strategy in 2017 there has been significant progress and achievements realised across many priority areas, as reflected in the Annual Performance Reports and LHS Annual Reports. The development of the new Integrated Strategic Plan for Older People's Housing, Care

and Support 2018-2028 in particular demonstrates the commitment to a collaborative and preventative approach in the Borders and an understanding of the inter-relationship and strong, linkages between Housing and Health and Social Care.

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

- Improving the joint analysis of housing, health and social care needs – ensuring that we all work jointly to identify the needs of the local community – building on work in the JSNA, Local Housing Strategy and Housing Need and Demand Assessment. There is a requirement for joint analysis and s shared evidence base and for the JSNA and HNDA to be more closely aligned in the future.
- Improving strategic and operational planning structures - effective working between different agencies, in particular housing, health and social service authorities with respect to strategic planning, service commissioning and service provision
- Identifying and implementing initiatives to get a better understanding of the housing sectors role and improve outcomes - Housing, health and adult social care services will develop closer working relationships in the commissioning arrangements of supported housing and housing support services in order that we maximise their impact for both individuals and the wider health and social care system
- Providing support to all staff across the housing sector – ensuring staff are kept up to date and supported through transformational changes.
- Providing housing options advice – continuing to provide housing options advice and widening this service to assist people as they get older - helping people stay at home for longer. Closer working relationships with housing, health and social care will provide opportunities to prevent and intervene earlier for 'at risk' communities, including homeless people. This should consider the role of communities, the voluntary sector, and any workforce that comes into contact with 'at risk' groups, including, primary and secondary health care, allied health professionals, social care, housing and homelessness.
- The establishment of the Homelessness and Wellbeing Partnership in 2018 and the development of the Integrated Homelessness and Wellbeing Strategy will support this activity. Strategic Housing Services will also consider what further resources may be required to ensure frontline health and social care professionals can identify appropriate services in their area to refer people at risk of homelessness.
- Responding to the needs of the older population - Scottish Borders HSCP and the Integrated Joint Board are aware of the challenges in health and social care for older people and has instigated a Transformational Programme. This will redesign services for older people including discharge to assess hospital at home, telehealth/telecare and What Matters Hubs. The period of new Strategic Plan will also see the early stages of the implementation of the new Integrated Strategic Plan for Older People's Housing, Care and Support 2018-2028.

RESOURCES

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

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

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

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

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

The extent of the resources that could be influenced by the health and social care agenda is less clear. Some examples of housing activities that can be influenced by health and social care (and vice versa) include new build housing, housing improvement across all tenures, actions to address poverty and disadvantage.

New-build housing

Strategic oversight of delivery of the new supply of affordable housing is led by the Council working in partnership with locally active Registered Social Landlords (RSLs) to develop the Strategic Housing Investment Plan (SHIP) submission to Scottish Ministers. This is now submitted every two years and provides a rolling five year planning horizon to set out proposed and prioritised affordable housing projects. This is framed within Resource

Planning Assumptions. RSL project proposals are considered in context of deliverability, housing need, strategic fit, and impact, which enables projects which contribute to the health and social care agenda to score highly in the prioritisation process. Examples of this include new supported housing solutions to assist the Joint Learning Disability Service and Extra Care Housing.

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

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

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

Housing improvement across all tenures

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

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

- Berwickshire Housing Association £41k
- Eildon Housing Association £68k
- Scottish Borders Housing Association £109k
- Waverley Housing £41k

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

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

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

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

Housing Support Services

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

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

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

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

TABLE 4: FINANCIAL PLAN

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

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

Monitoring and Review

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

- worked towards delivering against our strategic priorities;
- performed in relation to the National Health and Wellbeing Outcomes;
- performed in relation to our local objectives;
- performed financially within the current reporting year;
- progressed locality planning arrangements;
- performed in inspections carried out by scrutiny bodies.

TABLE 5: THE STRATEGIC PLAN 2018-21 HAS IDENTIFIED WHAT SUCCESS WILL LOOK LIKE

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

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

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

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

APPENDIX 5
EQUALITIES

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

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

The characteristics that are protected under the Act are:

AGE Younger people, older people, or any specific age group	**DISABILITY** Including physical, sensory, learning, mental health and health conditions	**GENDER** Male, Female and Transgender
GENDER REASSIGNMENT Someone who proposes to go through, is going through or has gone through a process, or part of a process, to change his or her gender from man to woman or woman to man.	**PREGNANCY AND MATERNITY** Including breastfeeding	**RACE** People from ethnic minorities including Gypsy Travellers and Eastern European immigrants
RELIGION OR BELIEF Including people who have no belief	**SEXUAL ORIENTATION** Bisexual, Gay, Heterosexual and Lesbian	**CARERS*** Both formal and informal carers

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

In taking forward the work of the H&SCP, we will embrace these duties and ensure that all requirements are met, through the implementation of the business and commissioning plans for the service and strategic areas that are integrated.

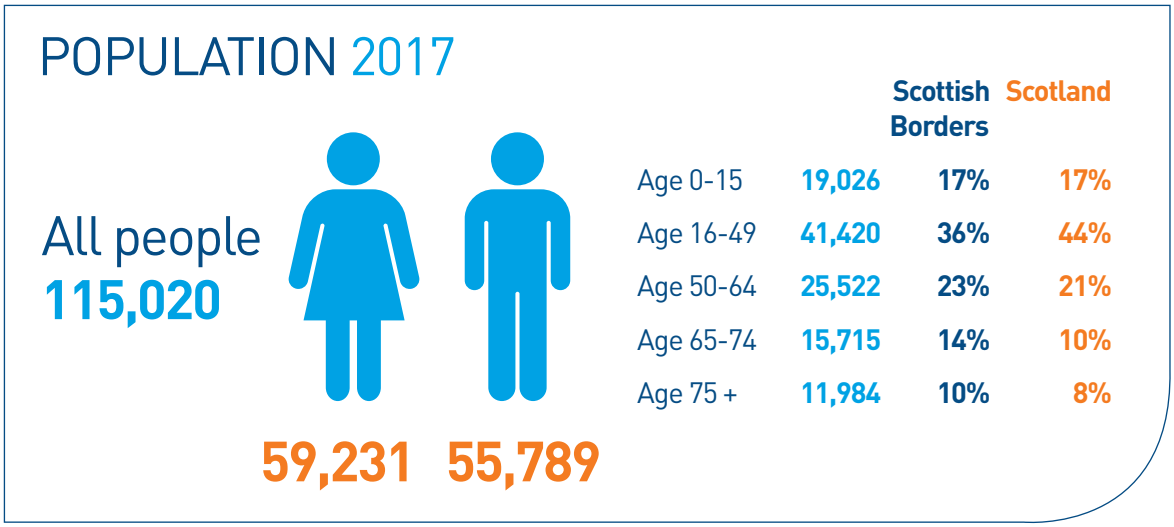
APPENDIX 6
THE SCOTTISH BORDERS: PROFILE AND KEY CHALLENGES

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

Who lives in the Borders?

Understanding the needs and issues of people and communities across the Borders is critical in the planning and provision of better health and social care services. In this section, we look at how the population structure and characteristics impact on health and social care services. This highlights some of the challenges we need to address.
As the figure below shows, we have a higher percentage of older people than the rest of Scotland.

FIGURE 2



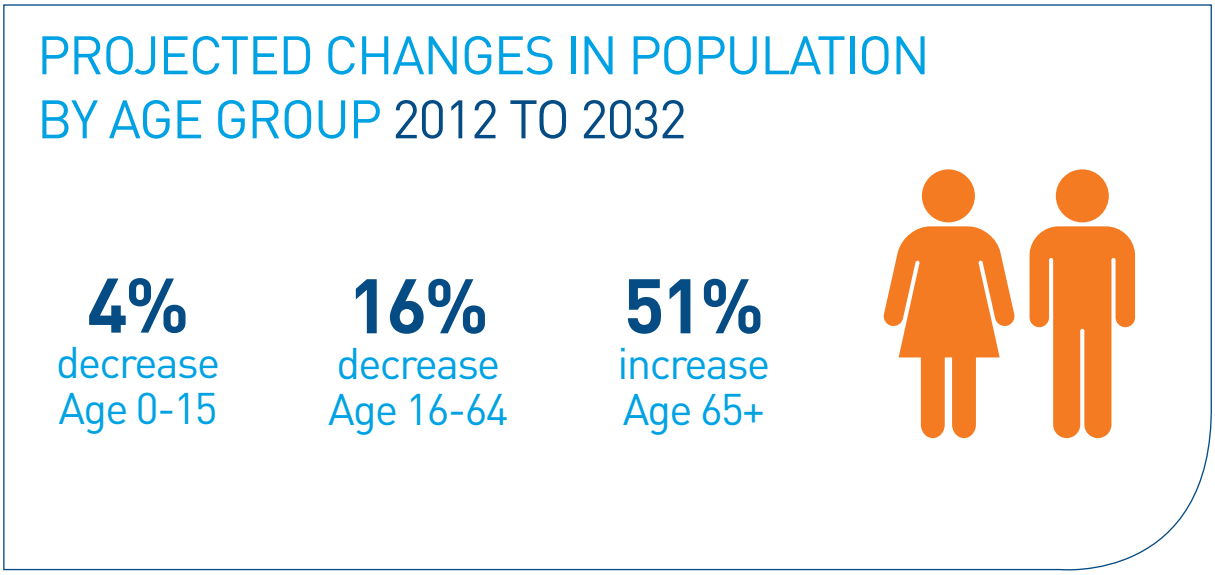
Source: National Records of Scotland, mid-year population estimates.

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

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

FIGURE 3

PROJECTED CHANGES IN POPULATION BY AGE GROUP 2012 TO 2032



Source: National Records of Scotland 2012-based population projections

WHAT THIS MEANS...

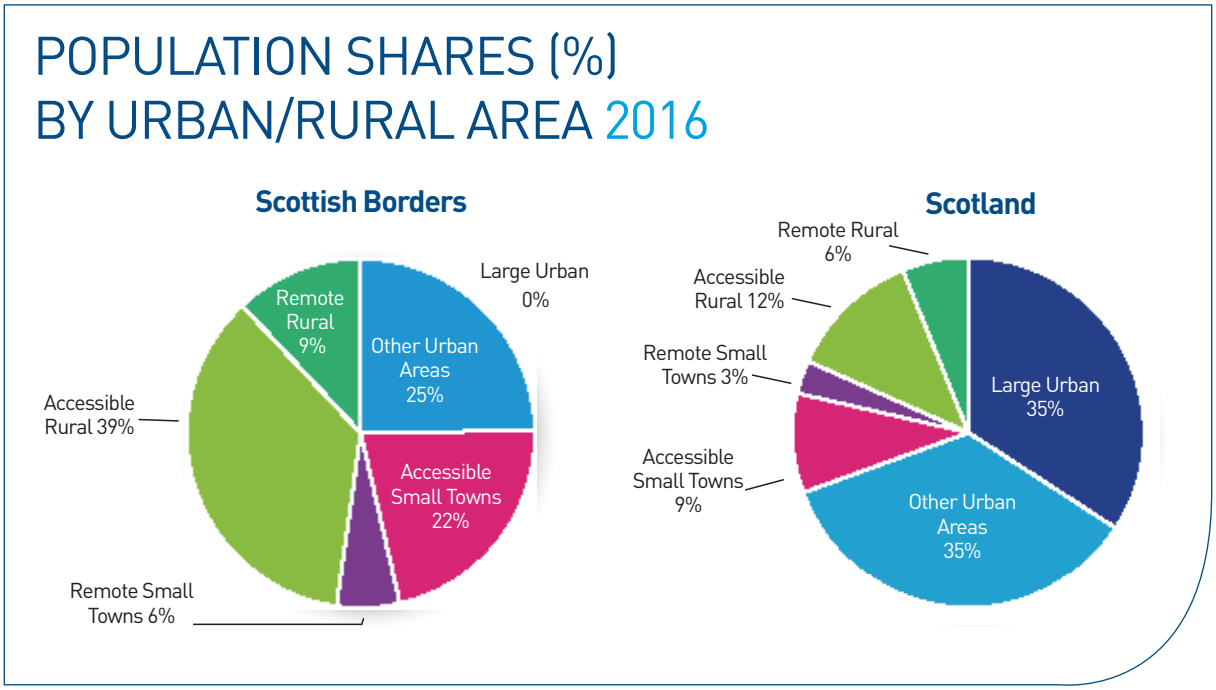
We need to promote active ageing and address the range of needs of older people.

Where do people live?

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

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

FIGURE 4



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

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

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

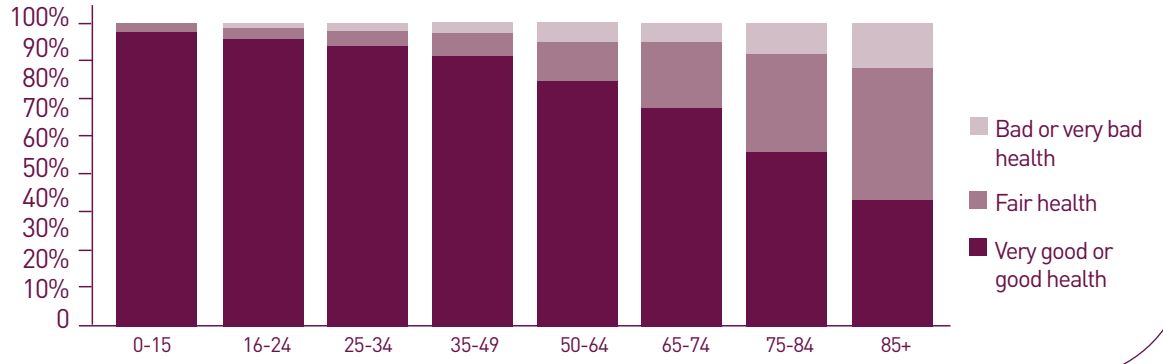
How Do People in the Borders View Their Health?

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

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

FIGURE 5

SELF REPORTED GENERAL HEALTH AMONGST SCOTTISH BORDERS RESIDENTS



Source: Scotland Census 2011

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

HOW IS HEALTH AFFECTED IN THE SCOTTISH BORDERS?

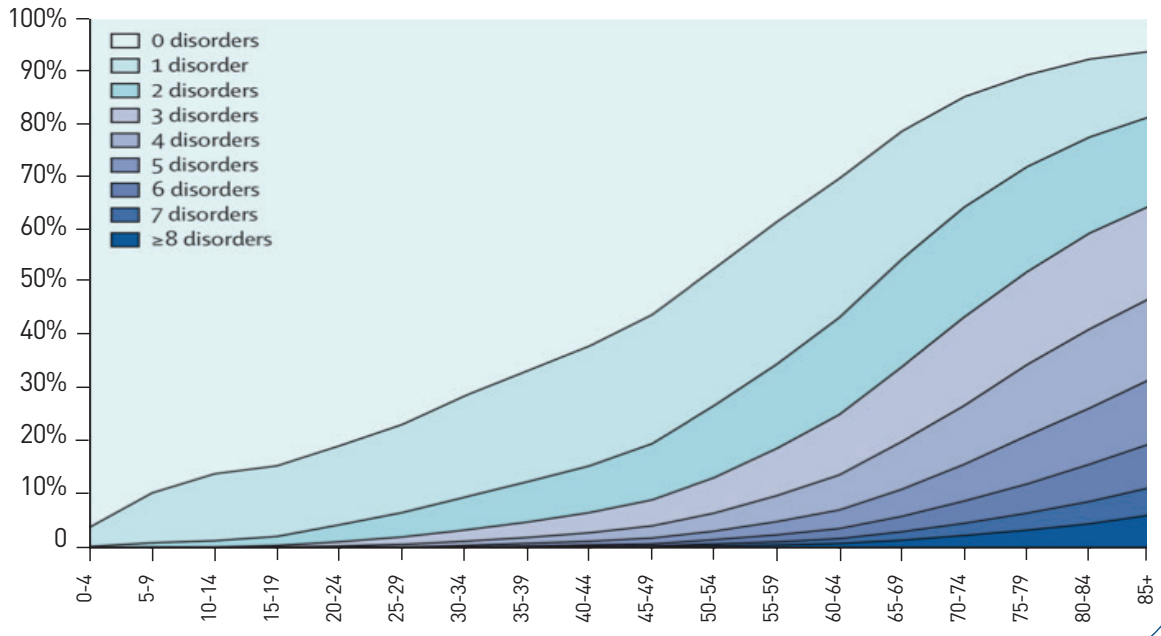
Long term conditions

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

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

FIGURE 6

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



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

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

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

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

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

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

Disability and sensory impairment

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

A physical disability is unique for each individual in the way it affects their life. It is not unusual for people to be affected by more than one health condition or physical disability, or for someone with a physical disability to experience mental health problems. Services therefore need to be person-centred, with a clear understanding of an individual's rights to independence, self-determination, dignity and respect.

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

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

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

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

WHAT THIS MEANS...

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

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

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

Learning disability resources within NHSB and SBC social work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than

that provided by mainstream H&SC services. As part of the learning disability governance structure, people with learning disabilities and family carers have places at the Partnership Board to help inform decision making and strategic direction. Locality Citizens' Panels throughout the Borders provide opportunities for conversations between the Learning Disability Service and people directly affected by learning disabilities. A local area coordination service supports people to be more involved in their local communities.

Mental Health

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

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

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

Dementia

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

FIGURE 7

ESTIMATED NUMBERS OF PEOPLE WITH DEMENTIA / ANNUAL NEW DIAGNOSES IN THE SCOTTISH BORDERS, 2017-2020

DEMENTIA PREVALENCE

Estimated **2,468** Scottish Borders residents living with dementia in 2017

DEMENTIA INCIDENCE

Projected to be around **500** new diagnoses of dementia each year in the Borders 2018-2020

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

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

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

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

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

WHAT THIS MEANS...

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

Providing a caring role

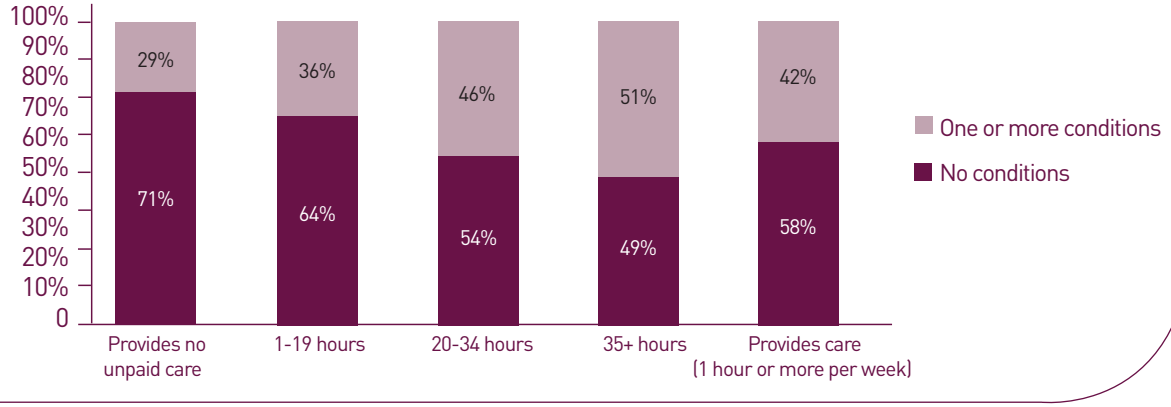
Health and social care services are dependent on the contribution of carers*. In the Borders, approximately 12,500 people aged 16 and over provide unpaid care, around 13% of people in this age group.

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

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

FIGURE 8

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



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

WHAT THIS MEANS...

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

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

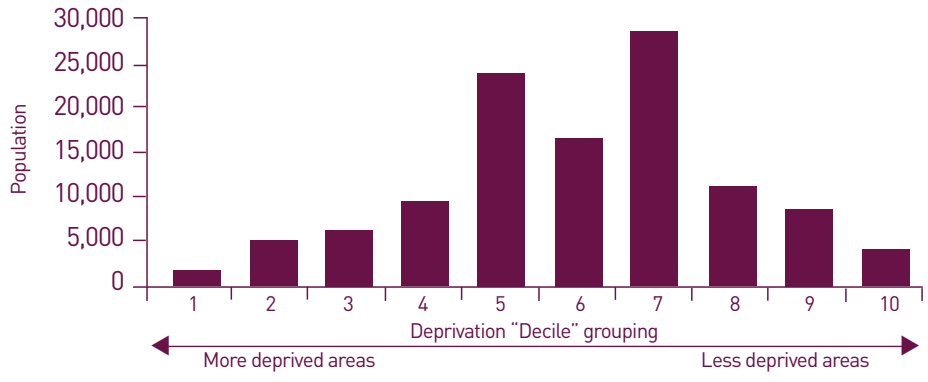
*Carers are individuals who care for a friend, relative or neighbour without receiving paid income in addition to income received through the benefits system. (Definition source: Care 21 Report: The future of unpaid care in Scotland. www.gov.scot/Publications/2006/02/28094157/0).

Deprivation in the Scottish Borders

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

FIGURE 9

SPREAD OF THE SCOTTISH BORDERS POPULATION BETWEEN 10 LEVELS OF DEPRIVATION



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

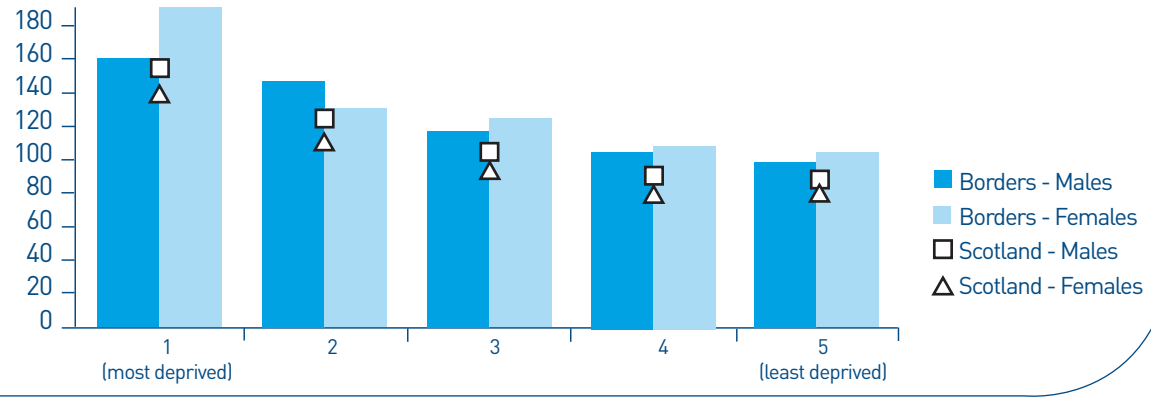
We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

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

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

FIGURE 10

EMERGENCY HOSPITAL ADMISSION RATES PER 1,000 POPULATION, BY DEPRIVATION QUINTILE 2016/17



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

WHAT THIS MEANS...

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

APPENDIX 7
PARTNERSHIP GOVERNANCE STRUCTURE SUMMARY OF ROLE AND FUNCTION OF EACH GROUP

Integration Joint Board (IJB)

The IJB is the formal board meeting of the H&SCP which was established on 6 February 2016 and consists of local authority elected members, Health Board non-executive directors and representatives of the Third and Independent Sectors. Its establishment followed ministerial approval which makes the IJB a legal entity in its own right under the Joint Working Public Bodies (Scotland) Act 2014.

The IJB members work together in order to plan, commission and oversee the delivery of integrated health and social care services meeting the needs of the people of the Scottish Borders whilst planning for the demands of the future.

The role of the IJB is to:

- Strategically plan and commission health and social care services to ensure national and local outcomes are met. To enable this, the IJB convenes a Strategic Planning Group (SPG) to assist in the preparation, approval and delivery of its Strategic Plan
- Oversee the delivery of the integrated services for which it has responsibility by reviewing finance and performance against targets to ensure that delivery is in line with planned outcomes
- Establish arrangements for locality planning in support of key outcomes for the five agreed localities in the context of the Strategic Plan
- Ensure resources are sufficient and appropriately allocated to deliver the IJB's Strategic Plan within the medium-term revenue budget detailed in its annual Financial Statement
- Publish and share with partners an annual Performance (delivery of the Strategic Plan) Report and Annual (Financial) Accounts in line with statutory guidance, codes of practice and timescales
- Seek assurance on the robustness of clinical and care governance frameworks from NHSB and SBC respectively and ensure that clear accountability is preserved
- Establish a plan for communication, participation and engagement to ensure that the users of health and social care services, staff, carers and all other stakeholders are involved in or aware of the development and delivery of effective models of health and social care
- Establish arrangements for handling complaints to and requests for information from the H&SCP
- Appoint its Chief Officer and Chief Financial Officer.

IJB Leadership Team

The IJB Leadership Team is a weekly meeting of key senior operational, strategic and financial leaders who represent the H&SCP. The meeting is chaired by the Chief Officer for Integration and the group has a critical role in overseeing and ensuring the delivery of integration of health and social care in the Scottish Borders in line with the strategic intentions and priorities outlined in the Strategic Plan and on behalf of the IJB.

The role of the IJB Leadership Team is to:

- take an overview and support the delivery of outcomes as outlined in the Strategic Plan
- support the integrated delivery arrangements for health and social care
- contribute to the agenda for the IJB
- support the implementation of a change programme designed to improve outcomes and manage within available resources
- focus on achieving financial balance.

Executive Management Team (EMT)

The EMT is a meeting of key leaders and decision makers across SBC and NHSB with the intent to improve outcomes through the integration of health and social care and support the delivery of the Strategic Plan.

The role of the EMT is to:

- take an overview and support the delivery of outcomes as outlined in the strategic plan
- support the integrated delivery arrangements for health and social care
- co-ordinate the agenda for the IJB
- support the implementation of a change programme designed to improve outcomes and manage within available resources
- focus on achieving financial balance
- act as the programme board for transformational redesign.

Strategic Planning Group (SPG)

The SPG acts as an advisory committee to the IJB. The role of the SPG is to identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan and against the agreed national outcomes. The group provides a forum for initial consultation and community engagement.

Members are expected to:

- Act in an advisory capacity to the IJB
- Represent their sector or professional area
- Comment on and contribute to Partnership change programmes
- Ensure the interests of the five localities are represented
- Contribute to any formal updates of the Strategic Plan.

Joint Staff Forum (JSF)

The JSF will:

- Take a proactive approach in embedding integrated working at all levels of the organisation to assist the process of devolved decision making
- Monitor the application of all workplace policies related to agreed integration programme and subsequent ongoing development
- Consider and comment on other policies
- Support the work of the Workforce Development Project Group as required
- Ensure the best workforce practice is shared across the H&SCP
- Contribute to the development of strategies and action plans to inform the integration programme of care and subsequent ongoing development
- Assist in assessing the impact of strategic decisions upon staff by monitoring and evaluating outcomes through staff surveys and other staff engagement exercises
- Contribute to responses on consultation from the Scottish Government, its sub groups and supporting infrastructure
- Ensure that any workforce strategies are underpinned by appropriate staff governance, financial planning, implementation planning and evidence
- Ensure adequate and necessary facilities arrangements are in place
- Ensure that the views of all recognised trades unions with an interest in improving the health and social wellbeing and health and social care services, local communities and wider staff are appropriately heard and considered
- Ensure that there is an effective risk management arrangement in operation focusing on staff issues that identifies clinical, legislative, financial and other risks, and is focused on the safety of patients, clients and users and staff
- Ensure that members of the JSF have knowledge and understanding of national health policies and local health and social care issues, and the ability to contribute to strategic leadership and to develop effective working relationships
- Secure assurance that all staff are effectively trained, properly supported and performance is formally reviewed on an annual basis.

Public Partnership Forum (PPF)

The PPF will build upon existing methods of public involvement to establish and maintain an effective partnership with the IJB and to ensure that the community is represented in the decision-making process of the IJB.

The PPF will:

- help promote positive change in the health of the local community and in the service provided by the H&SCP, commissioned and governed by the IJB
- where possible, represent the views of the communities in Scottish Borders paying particular attention to those who could be socially excluded or face discrimination when accessing services

- provide a way for the IJB to inform local people about the range and location of services it provides throughout Borders
- support the involvement of local people, service users and carers in discussions about how to improve services provided by the IJB
- assist the IJB to promote equal access to services by respecting equality, diversity and transparency in all aspects of its work
- assist the IJB to engage with local communities either directly or through existing groups/ organisations
- offer insights from local communities regarding the planning and delivery of services. raise issues, concerns and other comments from local communities in relation to services provided by the IJB
- support the IJB to meet the national standards for community engagement as adopted by SBC, NHSB and other partners
- act responsibly, in an appropriate manner without bias or discrimination.

Locality Groups (LG)

The five LGs comprise of key representatives with responsibility for:

- working together with, and reporting directly to the SPG
- providing a locally based focus for the development of locality plans (bottom up approach, as referred to in the legislation/guidance from Scottish Government) to support improved health and social care outcomes for local people
- monitor the progress of the locality plans
- communicate progress and delivery to all community stakeholders within each respective locality

Communications Group

The aim of the Communications Group is to support the delivery of the revised H&SCP's Strategic Plan objectives through effective and consistent communication.

Information Governance

Still to be developed.

Workforce Planning

The overall aims of the strategic approach to engaging with and developing our workforce and our partnership are:

- To develop workforce plans which describe the current workforce profile, the roles, skills and competencies needed to deliver the strategic objectives and outcomes for the partnership in line with the 2016/2019 Strategic Plan and the Local Government Delivery Plan

- To focus role development on the needs of service users
- To develop a multi-skilled flexible workforce, who are engaged and involved, and have the professional skills, the aptitude and drive to take a team approach to service delivery and improvement
- To develop initiatives (internships, apprenticeships, sector based work academy) which will enable the recruitment and maintenance of the required workforce
- To develop leadership capability and capacity at every level of the H&SCP
- To develop organisational structures and processes which enable the right balance of accountability and assurance, and encourage our workforce to deliver services which can change, evolve and innovate to meet the challenges ahead.

Integration Performance and Finance Group (IP&FG)

The IP&FG is a meeting of key partnership, performance and information officers across the H&SCP with the intent of providing performance information and analysis that can aid decision making within the Partnership and improve outcomes for people in the Scottish Borders.

The role of the IPG is to:

- Develop a performance framework to support effective decision making throughout the H&SCP
- Provide the IJB Leadership Team with robust, accurate and timely performance information across all the strategic objectives within the current and revised H&SCP Strategic Plan
- Provide advice and support to managers cross the HSCP with the ongoing development of effective performance measures to aid continuous improvement
- After discussion, input and agreement at Leadership Team, co-ordinate and prepare quarterly and annual performance reports for EMT and IJB
- Ensure that IJB performance information is made available publicly.

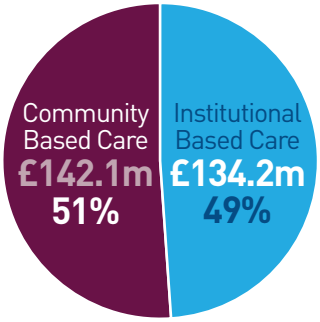
APPENDIX 8
HEALTH & SOCIAL CARE SPENDING

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

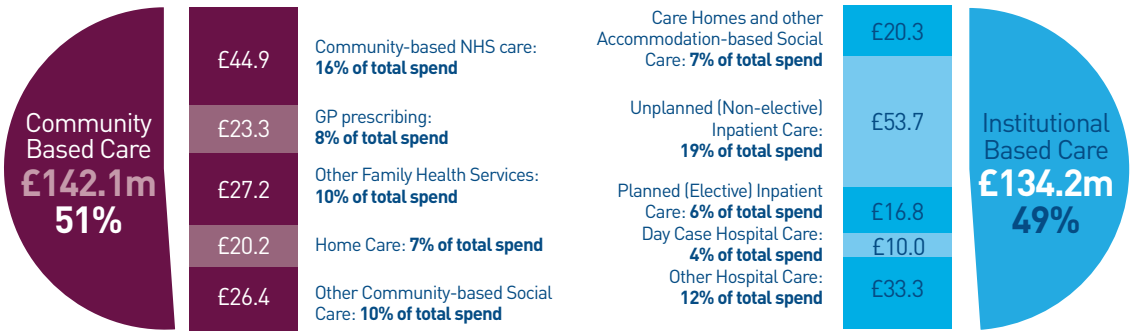
FIGURE 1

HOW THIS TOTAL SPEND BREAKS DOWN

SPEND IN £ MILLIONS



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



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

Shifting the Balance of Care Towards Prevention and Early Intervention

The aim of integrated health and social care services is to shift the balance of care towards prevention and early intervention (community-based services) to ensure that individuals have better health and well-being.

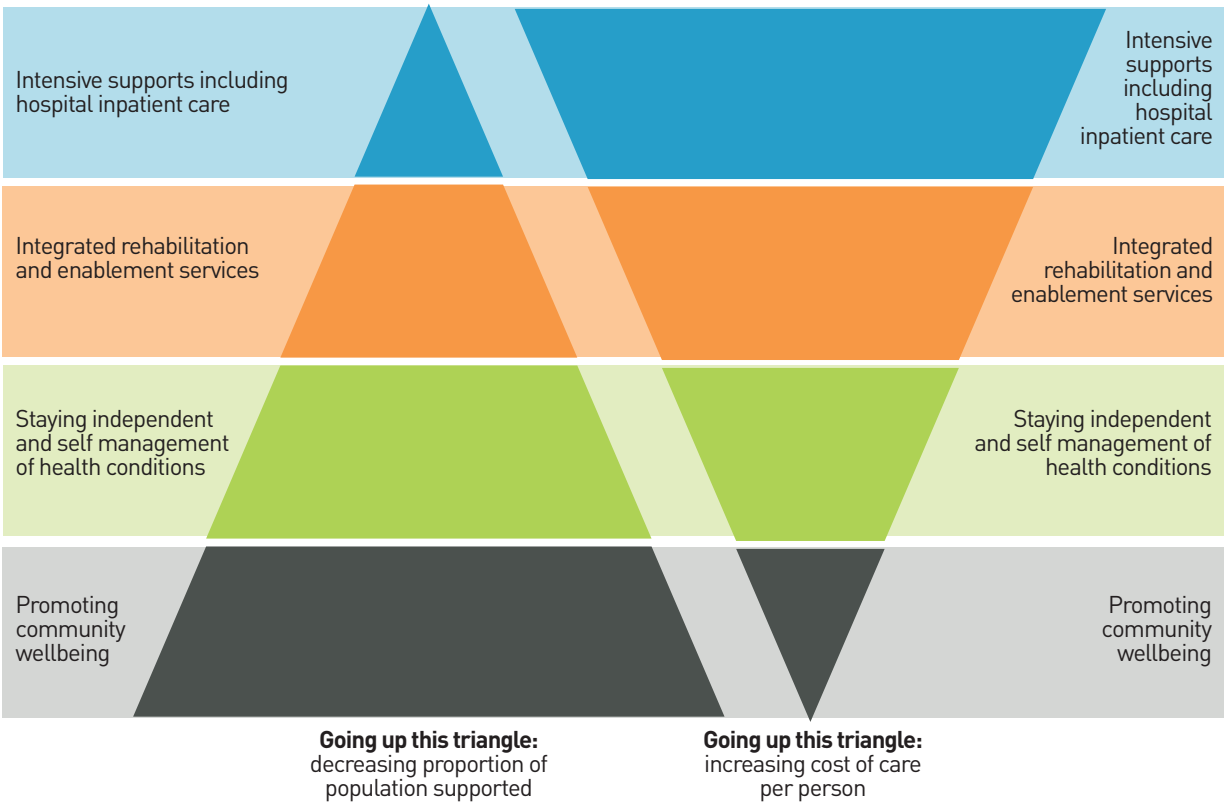
Services need to be redesigned around the needs of the individual, to:

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

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

FIGURE 2

CURRENT CARE MODEL



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

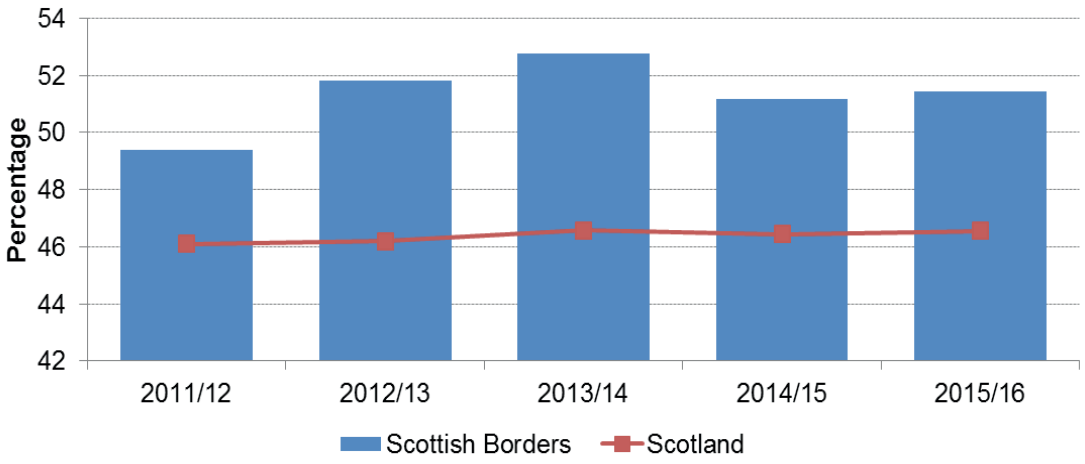
What shifts do we need to make?

By shifting resources FROM unplanned hospital care and institutional-based social care TOWARDS community-based NHS and social care and planned inpatient care, resources are used more effectively and on prevention, rather than treatment. This will help us invest in new integrated ways of working, particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting carers and independent living.

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

FIGURE 3

PERCENTAGE OF TOTAL NHSB AND SOCIAL CARE EXPENDITURE SPENT ON COMMUNITY BASED CARE



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

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

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