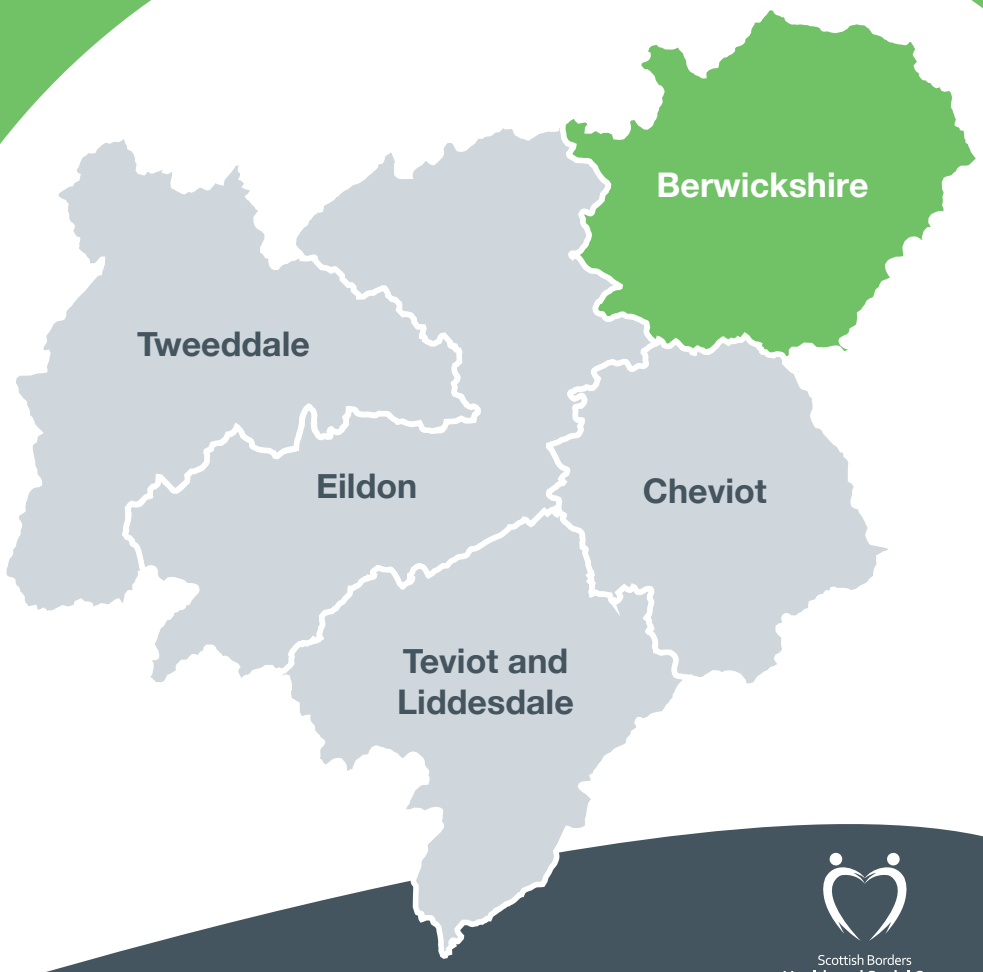
Scottish Borders **Health & Social Care** Partnership

HEALTH & SOCIAL CARE LOCALITY PLAN BERWICKSHIRE

2017-2019



Scottish Borders
Health and Social Care
PARTNERSHIP

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BERWICKSHIRE
HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

1. FOREWORD

In April 2016, we published the Scottish Borders Health and Social Care Partnership's Strategic Plan. The Strategic Plan sets out the Partnerships objectives for improving health and social care services for the people in the Scottish Borders and lays the foundations for the key priorities for improvement going forward.

In parallel to this, Community Planning Partnerships (CPP) are also required to produce Locality Plans under the requirements of the Community Empowerment (Scotland) Act 2015. In the future our aspiration is to bring these plans together within one plan.

Guidance from the Scottish Government is clear that local representatives – including health and social care professionals, third and independent sectors, housing, service users and carers – are given the opportunity to influence and inform service planning as we move towards achieving the objectives set out in the Strategic Plan.

As a result local working groups across the five localities in the Scottish Borders have been established. These working groups are made up of local representatives and they have made a significant contribution to the development of this Locality Plan which focuses on local needs and key priorities for improvement from the perspective of local people who use and deliver health and social care services.

Our aim is that we plan, commission and deliver services in a way that puts people at the heart of decision making as well as meets the needs of local communities. As such we want to continue to work in partnership with everyone who has an interest in improving health and social care services at a local level.

We all want to live in healthy, vibrant communities. We therefore need to work closely together, to bring a focus to all our efforts. The Health and Social Care Partnership spans NHS Borders, Scottish Borders Council, independent and third sectors and the people within the community. As a united team, we will ensure that the futures of our wider communities are bright and healthy.

Robert McCulloch-Graham
Chief Officer, Health and Social Care

2. CONTEXT FOR THIS PLAN

The Scottish Government, through the Public Bodies (Joint Working) (Scotland) Act 2014 has two very clear aims. **www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf**

Better **outcomes and experiences** for individuals and communities

Better **use of resources** across health, care and support systems at national and local levels.

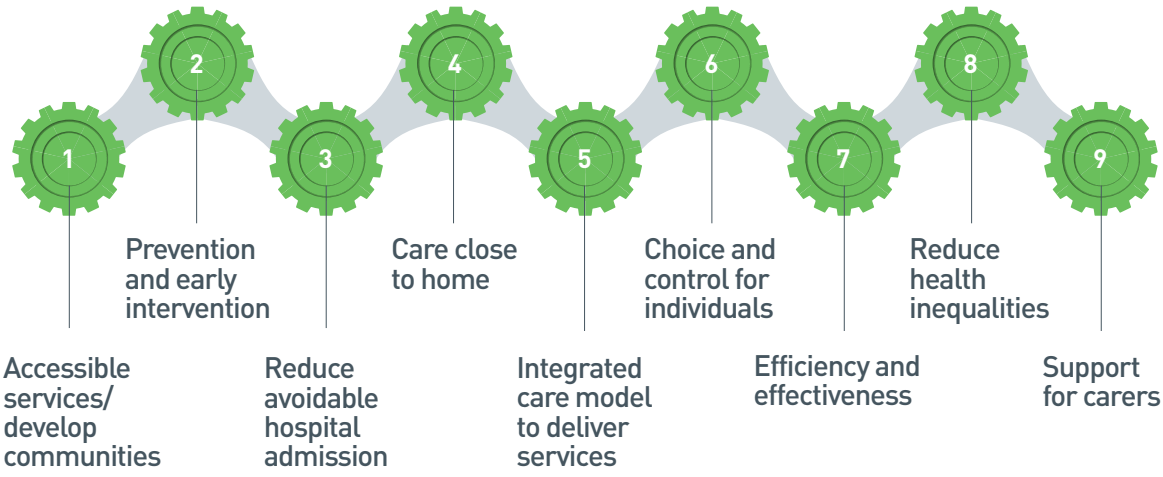
In order to address these aims and after extensive consultation during 2015-2016, the Scottish Borders Health & Social Care Partnership published its Strategic Plan where the following vision and objectives are outlined.

Scottish Borders Strategic Plan 2016 -19

"work together for the best possible health and well-being in our communities"

9 Scottish Borders Local Objectives

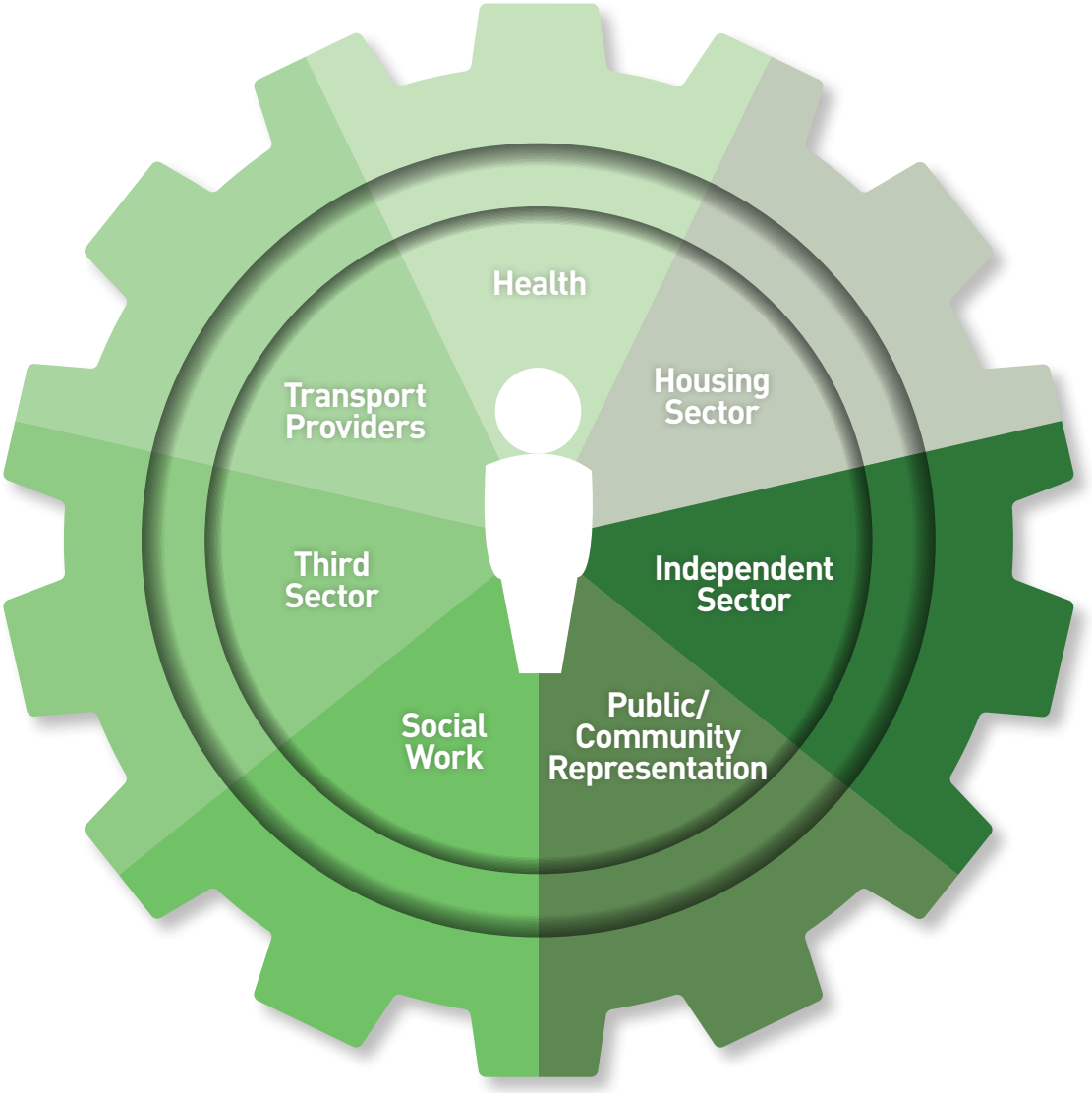
(defined during consultation on our Strategic Plan in 2015)



The Borders Health & Social Care Strategic Plan can be accessed **www.scotborders.gov.uk/HSCStrategicPlan**

How the Partnership seeks to meet the Objectives laid out in the Strategic Plan at a local level requires to be demonstrated in a local plan. The Scottish Borders already has five localities – Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale. **This plan is for Berwickshire**.

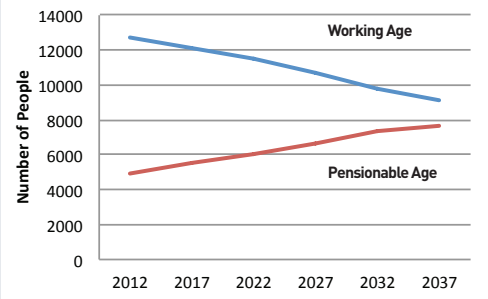
Five Locality Working Groups have been established and have contributed to the development of the five local plans. All key stakeholders are represented on the locality working groups as indicated below:



Details of the Berwickshire Locality Working Group can be found
www.scotborders.gov.uk/BerwickshireLocality

3. THE BERWICKSHIRE AREA - AREA PROFILE

PROJECTED POPULATION 2012-2037 FOR BERWICKSHIRE



57.2% increase in **pensionable age**

28.1% decrease in **working age**

POPULATION

20,657 population*
(19% of the Scottish Borders)

15.1% aged **0-15**
(Scottish Borders = 16.7%)

60.4% aged **16-64**
(Scottish Borders = 60.2%)

24.5% aged **65+**
(Scottish Borders = 23.1%)

17.3% of registered** **unpaid carers** are based in Berwickshire
** Borders Carers Centre

***(est 2014)**

AREA

45.3% live in an area of **less than 500 people**
(Scottish Borders = 27.4%)

85% live in **rural areas**
30% Remote rural
55% Accessible rural

Settlements with **more than 500 people:**

TOWN	POPULATION
Eyemouth	3,540
Duns	2,722
Coldstream	1,867
Chirnside	1,426
Greenlaw	629
Ayton	573
Coldingham	549

HEALTH OF THE LOCALITY

LIFE EXPECTANCY RANGE

78.3 to **83 yrs men**
(Scottish Borders = 78.1)

81.5 to **87.5 yrs women**
(Scottish Borders = 82)

Higher rate of **of new cancer diagnosis**
(compared to Scottish Borders)

Lower rate of **early cancer deaths**
(compared to Scottish Borders and Scotland)

A&E ATTENDANCE

47.5% non-emergencies could be cared for within Locality of which **75+ age group represent the highest proportion**
(last year 43.5%)

52.5% emergencies require hospital care
(last year 56.5%)

7.67 rate of **Over 75 Falls** per 1,000
(Scottish Borders = 5.62)

LONG TERM CONDITIONS

1,107 on **Diabetes Register**
6.23% of **GP Register over 15 yrs**

183 on **Dementia Register**
3.55% of **GP Register over 65 yrs**

NEIGHBOURHOOD AND COMMUNITY INFLUENCES ON HEALTH

20.5% report **public transport** as an accessibility issue

People in Berwickshire place a **higher priority** on:

providing **sustainable transport links** including **demand responsive transport**

HOUSEHOLD PROFILE

aged 65+

26.8% Berwickshire
(Scottish Borders = 25.4%)
(Scotland = 20.7%)

7.9% feel lonely or **isolated**
(Scottish Borders = 6.1%)

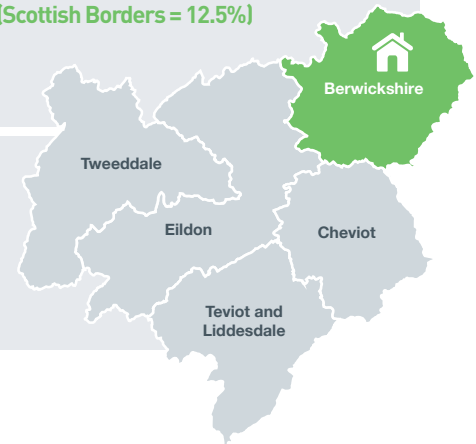
12 culture and sport facilities operated by the public sector
(Scottish Borders = 69)

SAFETY

9.92 rate of **road** and **home safety incidents** per 1,000
(Scottish Borders = 7.65)

0.81 rate of **fires** in **homes** per 1,000
(Scottish Borders = 0.74)

8.1% say there are **areas** where **they feel unsafe**
(Scottish Borders = 12.5%)



PROPOSED HOUSING DEVELOPMENTS

	2018-2019	2019-2020	2020-2021	2021-2022	>2022-2023
Extra Care	NPD*	NPD*	30	36	NPD*
General Affordable	28	48	43	169	
Particular	2	49		36	

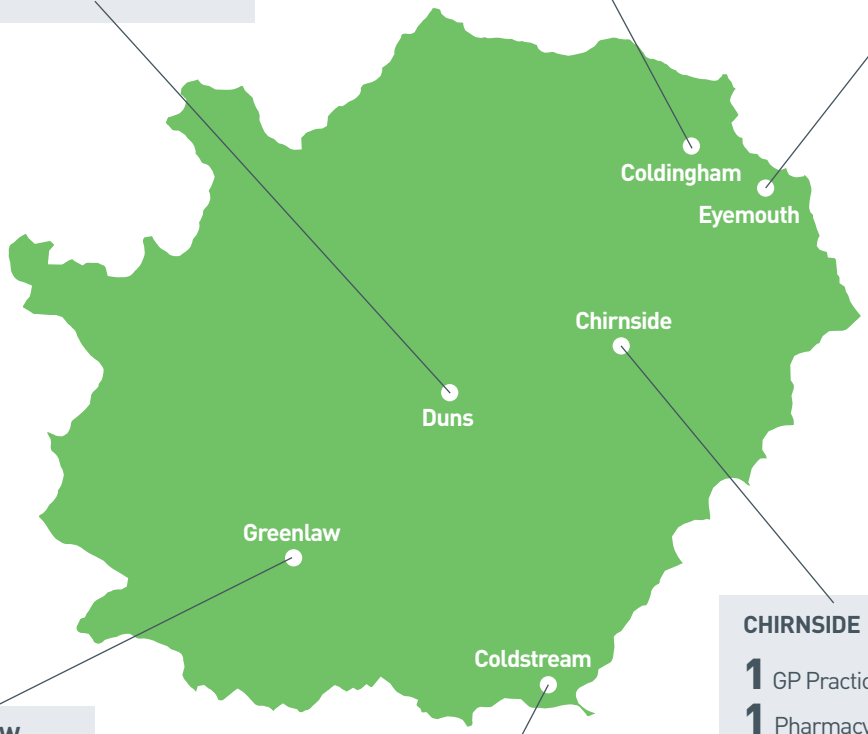
* NPD - No planned Extra Care development

3. THE BERWICKSHIRE AREA
SERVICES & SUPPORT 2017-2019

DUNS
- **2** GP Practices
- **1** Pharmacy
- **1** Optician
- **1** Dental Practice
- **1** Community Hospital
- **1** Day Hospital
- **1** Social Care & Health Team

COLDINGHAM
- **1** Pharmacy

EYEMOUTH
- **1** GP Dispensing Practice
- **1** Pharmacy
- **1** Dental Practice
- **1** Community Nursing Team
- **36** Residental Care Beds
- **1** Day Hospital



CHIRNSIDE
- **1** GP Practice
- **1** Pharmacy

GREENLAW
- **1** GP Practice
- **1** Pharmacy

COLDSTREAM
- **1** GP Practice
- **1** Dental Practice
- **74** Residental Care Beds

4. PRIORITIES FOR BERWICKSHIRE 2017-2019

Our understanding of Berwickshire is taken from:

- our analysis of both national and local data and statistics (e.g. Area Profile)
- the knowledge and experience of our service users and carers
- the views of the Locality Working Group
- the knowledge and experience of staff working within the community

The following priorities for Berwickshire have been identified and will contribute to the 9 local objectives for Integration:

PRIORITIES FOR BERWICKSHIRE		WHAT MAKES THIS A PRIORITY FOR BERWICKSHIRE
•	Improve the availability and accessibility of services for people living in rural areas and towns across Berwickshire	• majority of the population live in remote and rural areas • limited access to public transport networks • lack of volunteer drivers • increasing 65+ age group who are reliant on private accessible transport
•	Increase the availability of locally based rehabilitation services	• limited allied health professional services in the community • limited rehabilitation support workers in the community • no domiciliary physiotherapy services in the community • limited access to day hospital services
•	Increase the range of housing options available across the locality	• significant projected increase in people of pensionable age • limited options for suitable housing in rural/outlying areas
•	Improve support for unpaid carers	• high proportion of unpaid carers across the locality • without unpaid carers there would be more pressure on NHS, Social Work and Third Sector organisations • Carers (Scotland) Act 2016 legislates for support for unpaid carers
•	Increase the range of care and support options across the locality to enable people to remain in their own homes and communities	• lack of paid carers across locality • lack of domiciliary care provision • no transitional care beds in Berwickshire • increased reliance on residential and nursing home placements • tendency to pilot different models and approaches within one locality with no roll out to other localities • difficulty recruiting and sustaining capacity in provider organisations

Work is currently underway to support the delivery of the 9 Local Objectives and an action plan has been developed which identifies work required to ensure the ongoing delivery of the priorities for Berwickshire. This is summarised in **Appendix 1**. Some areas of work/actions are repeated, where they are relevant to more than one priority.

There are some actions which are common across the whole of the Scottish Borders and will be progressed at a Scottish Borders Partnership level, for example the provision of IT access within integrated sites. These actions can be viewed in the Borders wide summary plan in **Appendix 2**.

These actions will be continually evaluated and the plan updated annually.

APPENDIX 1
ACTION PLAN FOR BERWICKSHIRE

PRIORITY: Improve the availability and accessibility of services for people living in rural areas and towns across Berwickshire

Key to actions = In Progress * / Action Required **

WORK UNDERWAY	ACTION IN PROGRESS*/ ACTION REQUIRED**	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Re-design Locality Based Integrated Health & Social Care Teams	• Design and Implementation of Integrated Health & Social Care Teams within the Berwickshire Locality**	• Improves access to health and social care services at a local level • Sharing of information to support people at home • Improves sharing of information at a local level • Improves staff understanding of roles and responsibilities • Increases efficiency and reduce duplication • Improves access to care at home • Reduces avoidable admission to hospital • Provides alternatives to attendance at hospital • Reduces inequalities for people within rural areas	Chief Officer for the Scottish Borders Health and Social Care Partnership	2017-2019
• Working with the Transport Providers to improve rural transport solutions	• Develop a link with the Transport providers to establish rural needs and potential solutions within Berwickshire*	• Supports people from rural areas to access services • Reduces inequalities for rural populations • Reduces lonelieness and isolation	Strategic Transport Group	2017-2019
• "What Matters" Hub operational by December 2017/January 2018 in Berwickshire	• Eyemouth Community Centre* • Venue to be accessible to all users* • Social Work and Allied Health Professional, Third sector staff and volunteers to operate the hub* • Operational Plan: - to reduce the social work waiting list within Berwickshire* - Thereafter the hub will support 'First point of contact' through Customer Services on Tel: 0300 100 1800 and 'Walk in' enquiries** - Communicate the information and services which are available to the public e.g. Signposting to other services such as a health professional/third sector**	• Reduces social work waiting lists • People are able to access information and services earlier • People are supported to be as independent as possible • Community resources are key to support people at home • People are supported to self-manage • People requiring a proactive response to complex care needs can be seen by the right professional at the right time	Berwickshire Social Work Team Leader	2017-2018

PRIORITY: Increase the availability of locally based rehabilitation services

Key to actions = In Progress * / Action Required **

WORK UNDERWAY	ACTION IN PROGRESS*/ACTION REQUIRED**	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Allied Health Professionals (AHP) transformation workstream- the aim of the project is to reshape AHP services to support community care	• AHP Clinical Productivity Programme • External consultancy phase of Allied Health Professional services across the Partnership concluded in Aug 2017 • AHPs embedding new ways of working* • Improve access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community**	• Supports peoples' rehabilitation at home • Reduces hospital admissions • Improve peoples' outcomes • Supports safe discharge from hospital • Reduces the reliance on home care provision • Reduces delayed discharges • Reduces the admissions to bed based care facilities • Supports positive risk taking	Associate Director of Community and Primary Services NHS Borders	March 2019
• Third sector partners supporting people they work with, encouraging as much independence as possible	• Support the further development of enablement services provided by our Third sector partners	• People are supported to stay at home • People are supported to self-manage/gain independence • Less reliance on home care provision	Chief Social Work Officer	October 2018
• Transform Day Services	• Community Connections approach piloted in Berwickshire* • Proposed next step - Introduce community connection link workers across all localities**	• Supports people to access an appropriate alternative service within the locality • Supports reduction in loneliness and isolation • Supports a community capacity building approach • Engages those with support needs in more natural community based opportunities	Chief Social Work Officer	March 2018
• Live Borders "Health and Fitness" Programme in Berwickshire	• Live Borders programmes including Active Aging*	• Supports people to stay active, healthy and age well • Improves wellbeing and reduces social isolation • Reduced risk of falling • Lowers risk of illness and hospital admissions	Live Borders	September 2017
• Community Capacity Building Project	• Design development of physical and social activities aimed at adults and older people	• Supports people to stay active, healthy and age well • Improve balance and reduce risk of falls • Improves wellbeing and reduces social isolation • Reduces reliance on formal services	Community Capacity Building Team	April 2019

PRIORITY: Increase the range of housing options available across the locality

Key to actions = In Progress * / Action Required **

WORK UNDERWAY	ACTION IN PROGRESS*/ ACTION REQUIRED**	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Strategic Housing Investment Plan (SHIP) 2018-2023	• Increase availability of affordable housing throughout the locality* • Trust Housing Association development of Extra Care Housing planned in Duns**	• Reduces inequalities: - More people live in good quality, energy efficient homes - Less people affected by homelessness - More people are supported to live independently	Scottish Borders Council	2018-2023 2020-2021
• Local Housing Strategy 2017-2022	• Integrated Strategic Plan to address housing, care and support needs of older people* • Proposed timeframe for the delivery of Extra Care Housing Development within Duns is 2020 - 2021	• Housing requirements for older people is an identified key priority for the new Local Housing Strategy	Scottish Borders Council	2020-2021

PRIORITY: Improving support for Unpaid Carers in line with the requirements of the Carers (Scotland) Act 2016

Key to actions = In Progress * / Action Required **

WORK UNDERWAY	ACTION IN PROGRESS*/ ACTION REQUIRED**	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Work co-productively, through the Health and Social Care Partnership, with Carers representative organisations and with carers, to implement the Carers(Scotland) Act 2016 legislation effectively	• The Borders Health and Social Care Partnership has a duty to provide support to unpaid carers', based on the carer's identified needs which meet the local eligibility criteria • In conjunction with the Borders Carers Centre a new draft Carers support Plan has been tested* • Options appraisal on the pathways to provide support completed and prefered option agreed • Consult on and respond to the Scottish Government consultation on draft regulations**	• Supports carers' health and wellbeing in order to fulfil their caring role • Recognises the support required by individual unpaid carers through an eligibility criteria agreed by the Carers Act Board • More consistent support for unpaid carers	Chief Officer, Scottish Borders Health and Social Care Partnership	March 2018

PRIORITY: Increase the range of available care and support options across the locality to enable people to remain in their own homes and communities

Key to actions = In Progress * / Action Required **

WORK UNDERWAY	ACTION IN PROGRESS*/ ACTION REQUIRED**	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• "What Matters" Hub operational by December 2017/January 2018 in Berwickshire	• Eyemouth community centre* • Social Work and Allied Health Professional, Third sector staff and volunteers operate the hub* • Operational Plan: - to reduce the social work waiting list within Berwickshire* - thereafter the hub will support 'First point of contact' through SBC Customer Services on Tel: 0300 100 1800 and 'Walk in' enquiries** • Communicate the information and services which will be available to the public e.g. Signposting to other services such as a health professional/third sector**	• Reduces social work waiting lists • People are able to access information and services earlier • People are supported to be as independent as possible • Community resources are key to support people at home • People are supported to self-manage • People requiring a proactive response to complex care needs can be seen by the right professional at the right time	Berwickshire Social Work Team Leader	December 2017 – January 2018
• Increasing awareness and use of 'Self-Directed Support' (SDS)	• Continue to increase the number of people accessing all Self Directed Support options • Review the SDS Resource Allocation System (RAS)	• Increases opportunities to have greater choice and control over planned care and support • Improves consistency and equity for applicants/reduction in inequalities	Chief Social Work Officer	October 2017-March 2018
• To employ Health Care Support Workers to support gaps in home care provision in the Berwickshire Locality initially in Coldstream from Mid-December 2017	• NHS Borders and SB Cares are working together to support current gaps in the 'at home care provision' to facilitate a reduction in delayed discharges from hospital due to lack of care provision in Coldstream initially* Or • Prevent crisis of care increasing risk of hospitalisation due to lack of care available within Coldstream*	• Reduces delayed discharges from hospital • Reduces waiting lists for care provision • People are supported to remain at home • People are engaged with at an earlier stage to prevent crisis occurring • Reduction in unnecessary hospital admission	Lead Nurse for Primary and Community Services, NHS Borders	December 2017 for 6 months initially
• Implementation of the Scottish Borders Mental Health Strategy	• Promoting mental health awareness and literacy through community based activities and capacity building* - Healthy Living Networks - Community Leaning & Development • Awareness raising and education on suicide prevention* • Workplace initiatives on mental health and wellbeing in SBC and NHS* • Outreach work to share experience of recovery* • Providing support through Local Area Co-ordination and building capacity in communities* • Delivering locality based, integrated health and social care community mental health teams*	• People are able to find and access information and advice on mental health and wellbeing • Communities are more confident about what they can do to promote mental health • Improved support pathways for people who are at risk of or experience mental ill health • Frontline staff have the appropriate levels of knowledge and skill to enable them to provide the best support for people • Individuals will have an increased understanding of their own mental wellbeing • Improved access to services and reduce barriers particularly for those with dual diagnosis	General Manager for Mental Health Services NHS Borders	March 2020

cont .....

PRIORITY: Increase the range of available care and support options across the locality to enable people to remain in their own homes and communities

Key to actions = In Progress * / Action Required **

WORK UNDERWAY	ACTION IN PROGRESS*/ ACTION REQUIRED**	HOW THIS CONTRIBUTES TO THE PRIORITY	OWNER	TIMEFRAME
• Third sector partners supporting people they work with, encouraging as much independence as possible	• Support the further development of enablement services provided by our Third sector partners	• People are supported to stay at home • People are supported to self-manage/ gain independence • Less reliance on home care provision	Chief Social Work Officer	March 2018
• New Community Equipment Service opened October 2017	• New Community Equipment Service in Tweedbank Galashiels* • New automated equipment decontamination process in place which facilitates faster turnaround of essential equipment* • 17 Satellite stores across the Borders Localities – stock small commonly used items which are easily accessible to staff* • Community Equipment Service can advise members of the public who wish to purchase items from the service to maintain personal independence**	• Improves access to equipment at point of need • People are supported to maintain independence and stay at home or within the community	Community Equipment Service	October 2017
• Transform Day Services	• Community Connections approach piloted in Berwickshire* • Proposed next step - Introduce community connection link workers across all localities**	• Supports people to access an appropriate alternative service within the locality • Supports reduction in loneliness and isolation • Supports a community capacity building approach • Engages those with support needs in more natural community based opportunities	Chief Social Work Officer	March 2018
• Knoll Community and Day Hospitals Review	• External review of services currently in progress* • Implement Best Practice service models** with an aim to provide: - Improved 'patient pathways' of care - Maximise resources available to address care and support closer to home	• Increases capacity to provide health and social care within the locality • Improves patient pathways • Make best use of resources across the Health and Social Care Partnership • Decreases avoidable hospital appointments and admissions to the Borders General Hospital	Associate Director for Community and Primary Services	March 2019
• Matching Unit operational in Berwickshire	• A new centralised service matching requests for care at home provision with home care providers	• Releases social work staff capacity • Increases available options to source home care provision and match with assessed need • Highlights areas where there is difficulty sourcing home care e.g. Rural areas	Chief Social Work Officer	2017
• Facilitate transformation through development of community based opportunities	• To work in co-production with community partners to meet un-met needs and develop positives sustainable outcomes for adults and older people* • To engage with all transformation projects*	• Support people to stay active, health and age well • improves wellbeing and reduces social isolation • Lowers risks of people being dependant on other services • Empowers individuals • Develops communities	Community Capacity Building Team	April 2019

APPENDIX 2
BORDERS WIDE SUMMARY ACTION PLAN

Devised in line with the strategic plan together with the national outcomes, local objectives and the joint commissioning and implementation plan for the Scottish Borders Partnership 2017-2019.

PRIORITIES	ACTION PLAN
Increase the range of available care and support options across the Scottish Borders to enable people to remain in their own homes and communities	• Establish a centralised Matching Unit to source care at home to meet assessed need by December 2018 • Redesign day services with a focus on early intervention and prevention by October 2018 • Improve provision of IT access within integrated health and social care premises • Increase the use of telecare and telehealth care by June 2018 • Support discharge from hospital at an appropriate stage with the right service interventions to prevent avoidable delays • Improve the assessment, treatment, care and support for people who are frail.
Improve the availability and accessibility of services across the Scottish Borders	• Plan and deliver health and social care services by locality area by March 2019 • Extend Local Area Co-ordination capacity in Mental Health by two new posts by March 2020 • Develop Local Area Co-ordination for adults and older people by October 2018 • Review community and day hospitals, defining their role within an improved patient pathway and model of care by June 2018
Increase the availability of locally based rehabilitation services across the Scottish Borders	• Develop transitional care facilities to support avoidable admissions to hospital • Redesign the way care at home services are delivered to ensure a re-ablement approach • Increase access to Allied Health Professionals and support staff to manage peoples' rehabilitation needs within the community
Increase the range of housing options available across the Scottish Borders	• Increase the provision of Housing with Care and Extra Care Housing by March 2020 • The Strategic Housing Investment Plan (SHIP) 2018 -2023 seeks to maximise funding to deliver new affordable housing to meet needs of local people at all stages of their lives
Improving support for unpaid carers in line with the Carers (Scotland) Act 2016	• An adult carers support plan/young carers statements and a carers eligibility criteria will be in place by April 1st 2018 • We will have published a short breaks statement with information about national and local short breaks by the end of 2018 • Have a Carers Strategy in place by April 2019

Updated based on the Scottish Borders Health and Social Care Partnership Joint Strategic Commissioning and Implementation Plan 2017-2019.

BERWICKSHIRE HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019

WORK HAS BEEN INFORMED BY

This plan has been informed in consultation and dialogue with the stakeholders involved in developing the plans, strategies and programmes listed below:

- Community Learning and Development Strategic Plan 2015-2018
- Community Led Support – National Development Team for Inclusion (NDTi)
- Frailty Redesign Programme – 'Think Frailty' Health Improvement Scotland
- Living well with disability – Future services for people with physical disability 2013
- Reducing Inequalities in the Scottish Borders 2016 Strategic Plan
- Scottish Borders Alcohol & Drugs Partnership Strategy 2015-2020
- Scottish Borders Autism Strategy 2015-2025
- Scottish Borders Council Local Housing Strategy 2017-2022
- Scottish Borders Learning Disability Service Strategic Commissioning Plan 2016-19
- Strategic Housing Investment Plan (SHIP) 2018-2023
- 'The Keys to Life Strategy' 2013
- Scottish Borders Health and Social Care Partnership Joint Strategic Commissioning and Implementation Plan 2017-2019
- Scottish Government Health and Social Care Delivery Plan December 2016
- Strategic Framework for Action on Palliative and End of Life Care 2016-2021
- IJB Transformation Workstreams 2017-2019
- Borders Carers Centre Database of Unpaid Carers 2017
- Scottish Borders Mental Health Strategy 2018

HEALTH & SOCIAL CARE LOCALITY PLAN 2017-2019
GLOSSARY OF TERMS

Below is a list of terms, phrases and abbreviations commonly used in the Scottish Borders Health and Social Care Locality Plan along with a description of how they apply to the Locality plans.

TERM	DESCRIPTION
Allied Health Professionals (AHP)	Allied Health Professionals (AHPs) e.g. physiotherapists / occupational therapists support people of all ages in their recovery, helping them to regain movement or mobility, overcome visual problems, improve nutritional status, develop communication abilities and restore confidence in everyday living skills, consequently helping them to enjoy quality of life, even when faced with life limiting conditions. They work as key members of multi-disciplinary, multi-agency teams, bringing their rehabilitation focus and specialist expertise to the wider skills pool
Accessible Services	The ability to get care and support when needed
Borders Community Transport Hub	A one-stop approach to affordable transport for those in the Scottish Borders who are unable to use public transport or do not have access to a car. Phone: 0300 456 1985 borderscommunitytransporthub@gmail.com
Buurtzorg	Buurtzorg is a nurse-led, nurse-run organisation where support workers provide home care and support to people in their own surroundings. Buurtzorg nursing teams work with primary care providers, community supports, and family resources to bring patients to optimal functioning as quickly as possible.
Carers (Scotland) Act 2016	The Act is designed to support carers' health and wellbeing and help make caring more sustainable.
Clinical Productivity Programme	Provide personalised, evidence based care as close to home as possible. Working with people to define treatment goals and optimise outcomes. Supporting people to stay well; treat illness and manage crises.
Community Care	Care for people who are ill, elderly, or disabled, which is provided within the community rather than in hospitals or institutions. The preference is to support people in the community, especially in their own homes, where possible.
Community Connector	Connecting people to local services, facilities and activities, and providing them with tailored and informed support
Coproduction	People who run services working together with people who use services and Carers and frontline staff as equals to help make services better for people
Demand Responsive Transport (DRT)	An advanced, user-oriented form of public transport characterised by flexible routing and scheduling of small/medium vehicles operating in shared-ride mode between pick-up and drop-off locations according to passenger's needs.
Distress Brief Intervention in Mental Health (DBI)	The DBI is a short intervention for people in distress who do not need emergency medical treatment, in settings like A&E departments or GP surgeries. Specially trained staff will help them to manage difficult emotions and problem situations early on, and come up with a 'distress plan' to prevent future crisis. **The DBI approach is initially being piloted over 53-months (November 2016 to March 2021) by NHS Borders Joint Mental Health Service.**
Dual Diagnosis	'Dual Diagnosis' is used in health services to describe people with mental health problems, who also misuse drugs or alcohol
Extra Care Housing (ECH) & Housing with Care (HwC)	Housing designed with the needs of frailer older people in mind and with varying levels of care and support available on site for 24 hours a day (ECH) or from 7am till 10pm (HwC). People who live in this type of housing have their own self-contained homes, their own front doors and a legal right to occupy the property.
Frailty	Is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.
Healthy Living Networks	Network covering 5 localities involved in food and health work, physical activity, mental health and volunteering. Includes community lunch provision and cooking skills courses.
Integrated Care Model	People benefit from care that is person-centered and coordinated within healthcare settings, across mental and physical health and across health and social care. For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs.
Integration	In this case, it means health and social care services working closer together to help achieve better outcomes for individuals and communities in the Scottish Borders

Integrated Joint Board (IJB)	A new legal entity that binds the Health Board and the Local Authority together in a joint arrangement. The membership of an Integration Joint Board reflects equal participation by the Health Board and Local Authority to ensure that there is joint decision making and accountability.
Intergenerational Support	Learning opportunities or activities and support that involve people of more than one generation who are not necessarily related
JSA	Job Seekers Allowance
Key Stakeholders	An individual, group or organisation that can affect, be affected by, or perceive itself to be affected by, an initiative (program, project, activity, risk)
Locality Working Groups (LWG)	LWG comprises of key representatives whose primary function is to operate as a working group with responsibility for the planning, design and delivery of the Health and Social care model within each Locality in line with the Scottish Borders Partnership Strategic Plan and Scottish Governments Locality Guidance.
Long Term Condition (LTC)	A long term condition (also called chronic condition or chronic diseases) can be defined as health problems that require ongoing care and management over a period of years.
Matching Unit	A small central administrative team or 'Matching Unit', to match a Care at Home provider to the assessed needs of clients
My Home Life	My Home Life is a UK-wide initiative to promote quality of life for those living, dying, visiting and working in care homes for older people through relationship-centered and evidence based practice.
Options appraisal	Systematic evaluation of the relative pros and cons of alternative options in meeting specific health and Social Care objectives.
Outcome measures	Mortality, readmission, patient experience, etc. are the quality and cost outcomes that Health and Social Care organisations are trying to improve.
Patient Pathways	The route a patient follows from first contact with an NHS member of staff through referral to completion of treatment.
Person Centered Care	Person Centered Care is a mutual partnership between clients, their families and those delivering healthcare services as well as social care support which respect the individual needs and values of each person and demonstrates compassion, continuity, and clear communication along with shared decision-making.
Risk Taking	Risk management is the activity of exercising a duty of care where positive and negative risks are identified. ... The activities may involve preventative, responsive and supportive measures to reduce the potential negative consequences of risk and to promote the potential benefits of taking appropriate risks
Prevention and Early Intervention	Prevention is intervening before something becomes a problem; whereas 'early intervention' is about responding where there is already a problem, but trying to tackle it in its early stages. Pre-empting their occurrence, rather than treating their consequences.
Reablement	Time-limited support services that aim to help people learn or re-learn the skills necessary for daily living.
Rehabilitation	Rehabilitation is to restore some or all of a person's physical, sensory, and mental capabilities that were possibly lost following a hospital admission.
Respite	Respite care involves short term or temporary care of a few hours or weeks. Respite care is designed to enable both the cared-for person and the regular care-giver to experience a break.
Self-Directed Support (SDS)	Self-directed support (SDS) is a term that describes the ways in which individuals and families can have informed choice about how their support is provided to them. It is most commonly used in the delivery of social care and support but it can cover a much wider range of services.
Sustainable Transport	Allows the basic access needs of individuals and societies to be met safely in a manner consistent with human and ecosystem health, and with equity within and between generations
Strategic Housing Investment Plan (SHIP)2018-23	Sets out how investment in affordable housing will be directed over a five year period to achieve the outcomes in the Local Housing Strategy.
Telehealth care	Is a term used to describe a range of equipment used to support people in their own homes such as community alarm schemes
Third Sector	Community Groups, voluntary organisation's, co-operatives and individual volunteers.
Transitional Care Beds	Transitional Care beds aim to reduce the number of older people experiencing inappropriate, extended lengths of stay in hospital or being prematurely admitted to residential care. Transitional Care Beds also enable older people to have more time in a non-hospital environment to complete their restorative process.
"What Matters Hub"	The What Matters hubs offer residents the chance to attend drop-in sessions in their own communities and meet with a range of professional staff and trained volunteers to get advice about social care needs, general wellbeing and independence.

You can get this document on audio CD, in large print, easy read, and various other formats by contacting us at the address below. In addition, contact the address below for information on language translations, additional copies, or to arrange for an officer to meet with you to explain any areas of the publication that you would like clarified.

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