Borders NHS Board

NHS BORDERS CLINICAL STRATEGY

Aim

The purpose of this paper is to update members of the Board on NHS Borders Clinical Strategy. This paper also seeks approval for next steps including a Public Consultation exercise.

Background

NHS Borders is facing a number of significant challenges which will have a definite and significant impact over the next 3 to 5 years. If the organisation is to address these issues and remain sustainable, the way in which services are configured should be examined. In redesigning our delivery mechanisms we have an opportunity to improve accessibility to our services focusing on outreach with people only being admitted to hospital when they absolutely need to be. Redesigning our services to ensure they are future proofed and will meet the challenges outlined above will take effective leadership, teamwork and creativity. There is an opportunity for the organisation to trial innovative models.

As in recent years, NHS Borders will also need to deliver significant efficiency savings, meaning that just to stand still NHS Borders will need to make savings on the overall budget and deliver more activity with this reduced resource. Over the last 4 years, the organisation has been successful in achieving notable efficiency savings, however based on current targets between 2015 and 2020 it is estimated that a further £25 million of efficiency savings will need to be achieved.

To accommodate the increasing demand across all of our services will require a radical and innovative approach to the provision of our services and this presents an opportunity to explore new models of care, with a focus on integration of services where possible.

We can capitalise on the opportunity to ensure care is patient-centred, integrated and responsive whilst ensuring NHS Borders is an efficient and effective organisation and our performance is amongst the best in Scotland. A positive factor which will enable NHS Borders to achieve this aim is the relatively small size of the organisation meaning we can adapt more readily.

Clinical Strategy

Over a number of months work has been underway to produce a Clinical Strategy for NHS Borders to outline a number of Key Principles. These Key Principles outline how our services could be delivered in the future to ensure high quality healthcare.

These principles now require full engagement from our patients, carers, staff and partners through a full Public Consultation. A Communications and Engagement plan has been developed to support this exercise and can be found at ***appendix 1***.

The consultation document provides our patients, carers, staff and partners the opportunity to consider the Key Principles and give us their thoughts and views on these. The consultation period will last for 12 weeks commencing on the 10th March 2014. The consultation will be Borders wide and take the form of open sessions, formal presentations, road shows, drop in sessions and engagement with various committees.

The Clinical Strategy Consultation document can be found at ***appendix 2***. The document provides examples to demonstrate how these principles could be applied to work in practice. The first example demonstrates how our Children and Young Peoples services could look if the Principles were applied. Early feasibility work is already underway to test the current market for fundraising opportunities in relation to this area. It is proposed this work is continued and a full feasibility study commences during the course of this consultation. The second example looks at our Out of Hours and Emergency Care services, again demonstrating the potential with the Principles applied. Lastly the final example covers the Poynder View service to outline how these Principles have already successfully been applied within an area.

Efficiency Programme

Work is well underway to build the Efficiency Programme for the next 3 years to support the work described above in relation to the Clinical Strategy. A number of ideas are being progressed and it is anticipated that year 1 savings (2014/15) will be achieved if all projects deliver as expected. Plans are now being developed for years 2 and 3 through discussions with clinical leaders across the organisation. Continued work and involvement across the South East and Tayside regional planning group is also continuing with a focus on capacity planning and rebalancing care.

Summary

Redesigning our services to ensure they are future proofed and will meet the challenges outlined above will take effective leadership, teamwork and creativity. There is an opportunity for the organisation to trial innovative models.

The consultation document provides our patients, carers, staff and partners the opportunity to consider the Key Principles and give us their thoughts and views on these. The consultation period will last for 12 weeks commencing on the 10th March 2014. The consultation will be Borders wide and take the form of open sessions, formal presentations, road shows, drop in sessions and engagement with various committees.

Recommendation

The Board is asked to **approve** the Public Consultation on NHS Borders Clinical Strategy Key Principles.

The Board is asked to **approve** a full feasibility study during the course of the Consultation, including fundraising opportunities, to support the Children and Young Peoples services project.

Policy/Strategy Implications	The Clinical Strategy will further develop and implement the key principles as this work is progressed taking into account the

	comments and views captured throughout the Public Consultation exercise.
Consultation	Full discussions with key clinical leaders and managers have been undertaken to date. Please see Communications and Engagement plan for further detail. A full Public Consultation will take place.
Consultation with Professional Committees	See above
Risk Assessment	Consideration of issues and risks will be a continuous process.
Compliance with Board Policy requirements on Equality and Diversity	The consultation aims to take into account the views of local individuals, groups and communities including those with protected characteristics. The strategy is, in itself, an inclusive method of ensuring that all views are heard, all impacts are considered and it takes account of our ageing population and changing demographic profile, among other important Equlaity and Diversity considerations.
Resource/Staffing Implications	These will be assessed as the work continues.

Approved by

Name	**Designation**	**Name**	**Designation**
Calum Campbell	Chief Executive	June Smyth	Director of Workforce and Planning

Author(s)

Name	**Designation**	**Name**	**Designation**
Stephanie Errington	Head of Planning and Performance	Joanne Weir	Planning & Performance Officer

Clinical Strategy

ENGAGEMENT AND COMMUNICATIONS PLAN

February 2014

(This is a live document and will be continually updated throughout the process)

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NHS BORDER CLINICAL STRATEGY ENGAGEMENT AND COMMUNICATIONS PLAN

This plan sets out the key actions to be undertaken to inform, engage, consult and communicate with all stakeholders regarding NHS Borders Clinical Strategy.

AIM

NHS Borders recognises it is essential to inform, engage, consult and communicate with a range of stakeholders around the work of NHS Borders Clinical Strategy as it progresses.

This document outlines the communications and engagement activities planned to ensure open dialogue and offer opportunities for stakeholders to have their say in changes that may have an impact on their lives.

BACKGROUND

NHS Borders is facing a number of significant challenges which will have a definite and significant impact over the next 3 to 5 years. If the organisation is to address these issues and remain sustainable, the way in which services are configured should be examined. In redesigning our delivery mechanisms we have an opportunity to improve accessibility to our services focusing on outreach, with people only being admitted to hospital when they absolutely need to be.

A Changing Population

Compared with most other areas in Scotland, population growth is a unique challenge for the Borders. The population has risen by almost 10% in the last 20 years to just over 113,000[1] in 2011 and is predicted to rise by a further 5% to just over 116,000 in 2020. For healthcare services, an increasing local population will mean more demand for our services and this is exacerbated with a rise in the proportion of the population aged over 65 years of age which is expected to increase from 20% at present to 23% by 2020.

Borders residents can also expect to live longer compared with other parts of Scotland. Life expectancy (2008-10) for women was predicted to be 83[2] (Scotland 80.4) and for men was 78 (Scotland 75.8). As the local population becomes increasingly elderly, there will be a rise in people with multiple and complex long term conditions, which will increase the burden on our organisation. People will from time to time flare ups and ill health as a direct result of a long term condition. A lack of advance planning will mean that care is haphazard and with an increasing population, our acute services are likely to become stretched beyond their limits. The system in its current form will not be able to continue to deliver high quality healthcare to meet the needs of our population.

Health & Well-being

To deliver effective health care services resource needs to be appropriately targeted at the health needs of the population. Services must reflect the widely recognised demographic trends with a small increase in children and a large increase in the elderly. These two groups have very different health needs; the elderly have chronic multiple conditions but there is much that can be done to prevent or lessen this. Given the shrinking resources with which to deliver health care, services must provide value and financial sustainability; they must not only be evidenced as effective but have significant cost benefit and also be cost effective. Demands on health care services can be reduced by improving population health and well-being. As a large proportion of the population are NHS employees, initiatives and interventions to improve the health of the workforce are significant in delivering improved health and well-being in the local community.

Interventions with evidence of the greatest benefits include initiatives in the early years, reducing health inequalities where interventions will include integrated multiagency work with communities to improve local health and well-being, improving access to

[1] General Register Office, Scotland, Demographic Factsheet (2012)
[2] General Register Office, Scotland, Life Expectancy in Scotland for Areas in Scotland (2011)

preventative programs such as immunisation and screening services. This latter will be one element to increase the early detection of cancer. The approach of the 'Deep-end' GP practices needs rolled out more widely where appropriate to relevant areas. Preventative measures are a priority, at both national and local level, to prevent downstream demand on health care services. These include measures relating to alcohol, and tobacco, dental health, physical activity, health promoting health service and health improving end of life care.

Workforce

NHS Borders benefits from a dedicated workforce which is committed to providing the highest quality services for our patients. However our workforce itself is becoming older and we need to plan now how we will address gaps in the coming years. By 2020, approx 8%[3] of the current workforce will be eligible to receive the state pension. Of this 8% just over 40% currently have direct clinical roles and if they choose to retire at this point, this may result in challenges in recruitment for some of our services. Plans need to be put in place now to ensure that there are no gaps or loss of expertise across our services.

In addition there are a number of changes introduced centrally such as Reshaping the Medical Workforce in Scotland which is already impacting on the way we deliver services. In Obstetrics this means a reduction in one trainee post and so through learning from local initiatives such as Paediatric Hospital at Night we are beginning to introduce new roles and skill mix to ensure we can continue to deliver our services effectively and safely with this being based on workforce profiling and modelling. Although new models of service delivery can be developed which will ensure sustainability reflecting the reduction in medical staffing, there may be increased costs associated with Nursing, Midwifery and Allied Health Professional staff providing more enhanced roles.

Now is the time to implement a new model of service delivery which must meet our changing demographics, be able to meet a higher level of demand with fewer resources, and this requires a move away from the historic configuration of services requiring us to build capacity and capability amongst our workforce.

[3] Figure based on current guidelines/legislation on qualifying for state pension

Financial Constraints & Sustainability

In addition to increasing demand, as in recent years, NHS Borders will need to deliver significant efficiency savings, meaning that just to stand still we will need to make savings on the overall budget and deliver more activity with this reduced resource. Over the last 4 years, we have been successful in achieving notable efficiency savings, however based on current targets between 2015 and 2020 it is estimated that a further £25 million of efficiency savings will need to be achieved.

To accommodate the increasing demand across all of our services will require a radical and innovative approach to the provision of our services and this presents an opportunity to explore new models of care, moving away from traditional, demarcated bed based service delivery and to ensure our future provision is sustainable with a focus on integration of services where possible.

We can capitalise on the opportunity to ensure care is patient-centred, integrated and responsive whilst ensuring NHS Borders is an efficient and effective organisation and our performance is amongst the best in Scotland. A positive factor which will enable NHS Borders to achieve this aim is the relatively small size of the organisation meaning we can adapt more readily.

OBJECTIVES

Accurate identification of stakeholders and the appropriate use of communication and engagement tools and processes are essential to ensuring high quality engagement and communication.

Stakeholders need to know what changes are planned, why they are happening and how they can contribute to the decision making process.

Our objectives are:

- To maintain a high level of awareness and commitment to the Clinical Strategy Key Principles
- To help ensure consistent messages within NHS and amongst wider stakeholder groups

- To ensure that staff and the public feel listened to and that their views can influence decisions
- Where difficult decisions are needed, a clear and robust case will be communicated
- To help promote a sense of public ownership within the organisation and amongst external stakeholders
- To ensure NHS borders complies with governmental policy, guidance and best practice in terms of public involvement
- To ensure stakeholders have opportunities to be engaged and involved in the work of Clinical Strategy

Achieving these objectives will be measured by:

- Increase in positive messages about NHS Borders, its staff and services, and the Clinical Strategy to all stakeholders
- Increased positive coverage in a wide range of media
- Increased positive or neutral comment on NHS Borders, its staff and services and the Clinical Strategy by all stakeholders
- Two-way conversation process is consistent and reflective of feedback at all stages
- Continuing to improve work with core stakeholders
- Expanding our contacts to new stakeholders
- Revamp of the communication and engagement tools to promote the Clinical Strategy
- Stakeholders display improved understanding of the Clinical Strategy and issues/outcomes
- Media coverage is more accurate and unsurprising – less corrections or clarifications required. If corrections and clarifications are required, these are issued promptly
- Planned and managed strategies for Clinical Strategy updates, reports, events and issues (involving pre-emptive thinking and planning; pre-agreed prioritisation and lead-in as far as possible)
- Increased buy-in by services and use of senior clinicians/managers to disseminate information as appropriate

KEY PRINCIPLES

With the support and agreement of both the Scottish Health Council and Public Involvement Team, NHS Borders will promote the National Standards for Community Engagement as the core principles of all activities of the Clinical Strategy, these are:

KEY MESSAGES

A number of key messages have been developed around the Clinical Strategy. However this process is ongoing and these messages will evolve throughout the process.

The key message themes are:

- Clinical drivers
- Demographic change and Health and Wellbeing
- Workforce planning
- Financial constraints and sustainability

Key messages need to develop at each stage to ensure risk stakeholders do not disengage with the process.

The messages should be agreed by the Project Board (Clinical Strategy Core Group) and Public Involement at each stage with advice and support of the local Scottish Health Council and should reflect the feedback received from stakeholders.

AUDIENCES

To help ensure public engagement and communications is meaningful and appropriate, a stakeholder analysis helps ensure we identify all relevant stakeholders and use the most appropriate methods of communications and engagement.

Particular efforts will be made to make sure we communicate and engage with stakeholders in a method that is suitable to them, and to communicate and engage with 'hard to reach' groups.

The following stakeholders have been identified:

- Patients
- Public
- Staff
- NHS Borders Board, Advisory Committees and Non-Executives Directors
- Independent Contractors
- Participation Network including Public Partnership Forum & Public Reference Group
- Scottish Borders Council – elected members and officers
- Community Planning Partners
- Local Community Groups, Area Committees / Area Forums
- Other Health Boards and Special Boards
- Scottish Government
- Scottish Health Council
- MSPs / MPs
- Media
- Borders community groups
- Third Sector (voluntary groups/organisations)
- Commissioned service providers
- Joint service providers
- Public Governance Committee
- Cross Borders patient flows/neighbour Boards
- Equality Forum
- Children & young people - schools

ENGAGEMENT AND COMMUNICATION METHODS

The selection of the appropriate delivery method is directly related to the content of the message and also on the aim of the communication. For example a PowerPoint presentation is appropriate in some cases to "inform" but not designed to "engage" or facilitate "participation". The selection of delivery method and timescale required for delivery is to a great extent dependant on message agreement and formulation.

- Reactive media service offering direct contact with the media
- Proactive media service offering direct contact with the media - Identification of positive stories to be fed proactively to all media or specifically targeted to one media outlet. Interview, feature or comment articles placed proactively where appropriate.
- Briefing/interview sessions (in person or by telephone)
- Photocalls/press releases/conferences as appropriate
- Advertising/advertorials
- Internal NHS publications – staff
- Staff briefings – globals/line manager briefs
- Training/information sessions for key staff who will help deliver the conversations
- Use of Stakeholder/partner publications
- Use of partner agencies communication tools
- Use of internet
- Use of intranet
- Use of new media – blogs, social media
- Development of communications materials – leaflets, postcards, pop-ups
- NHS Borders information sessions/events/presentations (structured or drop-in) for stakeholders
- Use of stakeholder sessions/events to provide update/presentations
- Display/information stands
- Public events
- Public meetings
- Roadshows
- Outreach work
- Online surveys
- Target harder to reach groups
- Focus groups
- Questionnaires
- Surveys

CRITERIA TO CONSIDER

NHS Boards have a statutory responsibility to involve patients and members of the public in how health services are designed and delivered. To help NHS Borders staff plan Public Involvement in a consistent way there is the **NHS Borders Process for Co-ordinating Public / Patient Engagement**, which is being adhered to throughout our consultation.

Other Criteria to Consider

- Scottish Government Guidance on Informing, Engaging and Consulting the Public in Developing Health and Community Care Policies and Services: 2010 http://www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf

- Equality Impact Assessment guidance: *The consultation aims to take into account the views of local individuals, groups and communities including those with protected characteristics. The strategy is, in itself, an inclusive method of ensuring that all views are heard, all impacts are considered and it takes account of our ageing population and changing demographic profile, among other important Equality & Diversity considerations.*

IMPLEMENTATION PLANS

CONVERSATION ONE

Description: This involves NHS Borders outlining the work to date and progress of the Clinical Strategy, through examination of the full range of services against a set of principles.

Key Messages: Why does NHS Borders Need to Change?
What could happen if we don't change?
Are the principles correct?
What do we know about our services ie activity data
How can NHS Borders respond to these changes?
The Challenges?
Next Steps?
What are your initial thoughts/feedback?
How can you get involved?

Timescale: **November 2013 – February 2014**

Activities: **Clinical Board/Committee discussions/validation**
Clinical Strategy
Testing services against key principles
Ideas generation
Exploring new models of care

- **NHS Borders Board Executive Team (BET)**
- **NHS Borders Associate Medical Directors (AMDs)**
- **NHS Borders Planning & Performance (P&P)**

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
28th Nov 13	Key Clinicians & Managers, Scottish Health Council, Chair of PPF	Presentations & group discussions to seek views on the Clinical Strategy Key Principles – Clinical Strategy Event	BET, AMDs, P&P	Complete
Feb 14	Scottish Government Performance Team	Email & telephone communication	P&P	Ongoing
Nov – Feb 14	Scottish Health Council	Various, including Joint SHC/PI monthly meeting (Oct), Clinical Strategy Event (Nov), draft consultation document	BET & P&P	Ongoing
October 13	BGH Clinical Board	Presentation on Clinical Strategy Strawman	Chief Executive	Complete
October 13	Primary & Community Services Clinical Board	Presentation on Clinical Strategy Strawman	Chief Executive	Complete
October 13	Mental Health Clinical Board	Presentation on Clinical Strategy Strawman	Chief Executive	Complete
Aug 13 – Feb 14	NHS Borders Strategy Group	Presentation on Clinical Strategy Strawman / Key Principles	BET & P&P	Ongoing
July 13 – Feb 14	Clinical Strategy Core Group	Clinical Strategy Strawman / Key Principles	BET & P&P	Ongoing
February 14	BGH Participation Group	Presentation on Clinical Strategy Key Principles	Chief Executive	Pending

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
Nov – Feb 14	Public Reference Group	Presentation on Clinical Strategy Key Principles / Update on Consultation Document	BET, P&P	Ongoing
December 13	Public Partnership Forum	Presentation on Clinical Strategy Key Principles	Chief Executive	Complete
Dec 13	Senior Medical Staff Committee	Presentation on Clinical Strategy Strawman / Key Principles	BET & P&P	Ongoing
August 13	Area Staff Side	Presentation on Clinical Strategy & Corporate Objectives	Director of Workforce & Planning	Complete
December 13	Public Governance Committee (PGC)	Verbal update on Clinical Strategy Key Principles	Lead Director for PGC	Complete
17th Feb 14	Area Clinical Forum / Area Partnership Forum	Presentation on Clinical Strategy Key Principles	Chief Executive	Pending

CONVERSATION TWO

Description: This involves NHS Borders outlining the case for change, including the drivers behind this and the challenges we face. This process provides an opportunity for stakeholders to comment on the Clinical Strategy Key Principles and the direction of travel for NHS Borders. (This is the three month consultation period).

Key Messages: Why does NHS Borders Need to Change?
What could happen if we don't change?
Are the principles correct?
What do we know about our services ie activity data
How can NHS Borders respond to these changes?
The Challenges?
Next Steps?
What are your initial thoughts/feedback?
How can you get involved?

Timescale: **10th March – 6th June 2014**

Activities: Public and staff Consultation

- **NHS Borders Board Executive Team (BET)**
- **NHS Borders Associate Medical Directors (AMDs)**
- **NHS Borders Planning & Performance (P&P)**

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
March – June 14	Public, staff & media – all	Regular proactive (& reactive) press releases, media briefings and interviews	BET / P&P	Pending
March – June 14	Staff	Regular updates in monthly Staff Update	P&P	Pending
March – June 14	Public, staff & media – all	Various on **Internet,** including Presentation with voice over, Consultation Document, regular updates	BET / P&P	Pending
March – June 14	Staff	Various on **Intranet**, including Presentation with voice over, Consultation Document, regular updates	P&P	Pending
March – June 14	Staff	Regular updates in Corporate & Team Brief	P&P	Pending
Date tbc	All	SBC Connect newsletter	P&P	Pending
March – June 14	All	Consultation Document available in BGH waiting areas, GP Practices, Libraries etc	P&P	Pending
March – June 14	Staff	PC desktop post-it: Key Principles	P&P	Pending

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
March – June 14	Scottish Government Performance Team	Email & telephone communication	BET / P&P	Ongoing
March – June 14	Scottish Health Council (SHC)	Various, including Joint SHC/Public Involvement monthly meetings	BET & P&P	Ongoing
March – June 14	Public Involvement (PI) Team, NHS Borders	Various, including Joint SHC/PI monthly meetings	BET & P&P	Ongoing
March or April 14	BGH Clinical Board	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
March or April 14	Primary & Community Services Clinical Board	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
March or April 14	Mental Health Clinical Board	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
March or April 14	Learning Disabilities Clinical Board	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
March	Staff	Drop-in session at BGH	BET / Strategy Group / P&P	Pending
April	Public	Drop-in session at BGH	BET / Strategy Group / P&P	Pending
April	Staff	Drop-in session Hawick Community Hospital	BET / Strategy Group / P&P	Pending
April	Public	Drop-in session (Hawick), i.e. each locality	BET / Strategy Group / P&P	Pending
April	Staff	Drop-in session Haylodge Community Hospital	BET / Strategy Group / P&P	Pending

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
April	Public	Drop-in session (Peebles), i.e. each locality	BET / Strategy Group / P&P	Pending
May	Staff	Drop-in session Knoll Community Hospital	BET / Strategy Group / P&P	Pending
May	Public	Drop-in session (Duns), i.e. each locality	BET / Strategy Group / P&P	Pending
May	Staff	Drop-in session Kelso Community Hospital	BET / Strategy Group / P&P	Pending
May	Public	Drop-in session (Kelso), i.e. each locality	BET / Strategy Group / P&P	Pending
March – June 14	Clinical Strategy Core Group	Fortnightly meetings	BET	Ongoing
March – June 14	NHS Borders Strategy Group	Clinical Strategy Consultation Document & Presentation	BET	Ongoing
April 14	Charge Nurses meeting	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April 14	BGH Participation Group	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
March – June 14	Public Reference Group	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April 14	Public Partnership Forum	Clinical Strategy Consultation Document & Presentation	Chief Executive	Pending
April 14	Senior Medical Staff Committee	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
April 14	Area Partnership Forum	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
May 14	Public Governance Committee	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April/May 14	Children & Young People's Planning Partnership	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
May	Children & Young People's Health Network Steering Group	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April, May or June 14 - tbc	Joint Health Improvement Team	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April, May or June 14 - tbc	Area Clinical Forum	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
March – June 14	Staff Update	Regular updates	P&P	Pending
March – June 14	Corporate & Team Brief	Regular updates	P&P	Pending
March, April, May or June – tbc	Board Advisory Committees	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
March, April, May or June – tbc	Non Executive Directors of Borders NHS Board	Regular updates and/or Non Exec Director meetings	BET	Pending
March, April, May or June – tbc	Scottish Borders Council	NHS Borders Chair / Chief Executive meeting with SBC Chair / Chief Executive	Chairman / BET	Pending

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
March, April, May or June – tbc	MPs / MSPs	NHS Borders Chair / Chief Executive meeting with MPs / MSPs	Chairman / BET	Pending
March, April, May or June – tbc	Community Council Partners	Scottish Borders Area Forum meetings, Community Councils Network, Community Planning Partnership	Chairman / BET	Pending
April/May 14	Equality Forum (Corporate Equalities Group)	Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April/May 14	Third sector partners	Borders Voluntary Care Voice meeting - Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April/May 14	Carers	Borders Carers Centre - Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending
April/May 14	Elder Voice	Elder Voice meeting - Clinical Strategy Consultation Document & Presentation	BET / Strategy Group	Pending

*** Timescales may change depending on availability of groups.**

CONVERSATION THREE

Description: This involves NHS Borders producing the Business Case as a result of Coversations one and two for Board consideration.

Key Messages: How will NHS Borders Change

Timescale: **June 2014 - August 2014**

Activities: Business case production and approval

TIMESCALE	AUDIENCE	METHOD/ACTIVITIES	LEAD	STATUS
Timeline for production and Board sign off				

NHS Borders Clinical Strategy
"An evolving conversation"

Key Principles for redesigning our services to ensure high quality healthcare
What do you think?

This Consultation will run from 10th March – 6th June 2014

Extra copies and additional formats

This document is available electronically on the NHS Borders website at: www.nhsborders.org.uk. Extra copies and alternative formats are available on request, for example, large print, audio, Braille, or in a different language. Please contact Freephone 0800 7314052 or email public.involvement@borders.scot.nhs.uk and we will do our best to help.

Contents

1. Foreword

NHS Borders provides healthcare services to our local population of 113,000. We take great pride in the delivery of healthcare to our local community and all 4000 staff who work within NHS Borders carry out their role with the aim of improving the lives of our patients and the health of our local communities.

Our vision is for NHS Borders to be a leader in the quality and safety of care we provide, doing this by the continual improvement and development of local services to meet the needs of our population. This will require innovation in the design of our services ensuring they are sustainable, equitable and fit for purpose to meet the demands of the future.

To achieve our vision we intend to continue to work with you, and to build on the strong relationships we have with Scottish Borders Council and the voluntary sector to provide services which are person-centred, seamless and integrated. In the immediate future this will require a focus on developing the right services for those in their early years of life, older people and the most vulnerable in our community.

In addition we will continue to focus on our staff, our most valuable asset, who are central to the delivery of person-centred, safe and sustainable healthcare. We will work to a common set of values which guide the work we do, the decisions we take and the way we treat each other. By promoting excellence in organisational behaviour we believe we can improve patient experience and the quality of care we provide.

NHS Borders is committed to involving volunteers and the voluntary sector to improve the outcomes for patients and carers. We will increase the range of high quality volunteering opportunities, as we recognise volunteering enhances the services we provide, has benefits for our patients and helps build stronger communities.

We acknowledge that there are challenges ahead of us. Challenges which will require us to think differently, with you and our partners, about the way we deliver our services to maintain the quality and coverage we are currently able to provide. However we intend to grasp this challenge and consider it an opportunity to innovate for the future.

We firmly believe that by ensuring the services we provide are thriving, as well as transforming the traditional models of delivery, that we can continue to deliver health services which lead the way in the Borders. By the relentless pursuit of quality within our organisation we can drive down costs and improve the effectiveness and safety of our services.

We aim to achieve our vision through our Clinical Strategy which has six Key Principles. We would like to engage with you to seek your thoughts and views on the Key Principles of the Strategy. The appendices of this consultation document include a number of examples of models of care to show how services could operate with these principles applied.

We look forward to working with you to continually develop and evolve our local services across the Scottish Borders.

Calum Campbell
Chief Executive, NHS Borders

John Raine
Chairman, NHS Borders

2. Executive Summary

To accommodate the increasing demand across all of NHS Borders services will require a radical and innovative approach to how we provide them. This presents an opportunity to explore new models of care to ensure our future provision is sustainable with a focus on integration of services where possible.

We can seize this opportunity to ensure care is person-centred, integrated and responsive. We want to ensure NHS Borders is an efficient and effective organisation and our performance and quality is amongst the best in Scotland. A positive factor which will enable NHS Borders to achieve this aim is the relatively small size of the organisation meaning we can adapt more readily.

The aim of this consultation document is to help you understand, and for us to get your thoughts on, our proposed Key Principles of the NHS Borders Clinical Strategy. We would like to engage and involve you so that you are able to feedback your thoughts and views on the Key Principles.

We are inviting responses to this consultation paper between 10th March and 6th June 2014. More information on how to respond can be found at the end of this document (page 20).

3. Introduction

NHS Borders along with all other health boards are aware of the challenges in delivering reliable and responsive high quality healthcare, and in improving people's health. These include increased public expectations, changes in lifestyles, demographic change, an ageing population, new opportunities from developments in technology and information, and the current economic climate which brings with it significant financial constraints. The Clinical Strategy provides the basis for us all to focus our combined efforts on what is required to address these current and future challenges, and to ensure high quality healthcare for ourselves and for generations to come. These challenges are described below.

3.1 A Changing Population

Compared with most other areas in Scotland, population growth is a unique challenge for the Borders. The population has risen by almost 10% in the last 20 years to just over 113,000 in 2011 and is predicted to rise further. For healthcare services, an increasing local population will mean more demand for our services. There is also an expected rise in the proportion of the population aged over 65 years of age, which will also impact on our services.

Borders residents can also expect to live longer compared with other parts of Scotland. As the local population becomes increasingly elderly, there will be a rise in people with multiple and complex long term conditions, which will increase the burden on our organisation. People will from time to time have flare ups and ill health as a direct result of a long term condition. A lack of planning could mean that care is delivered in a haphazard and reactive way, and with an increasing population, our acute services are likely to become stretched beyond their limits. The system in its current form will not be able to continue to deliver high quality healthcare to meet the needs of our population.

3.2 A Changing Workforce

NHS Borders benefits from a dedicated workforce which is committed to providing the highest quality services for our patients. However our workforce itself is becoming older and we need to plan now how we will address gaps in the coming years. By 2020, approx 8% of the current workforce will be eligible to receive the state pension. Of this 8% just over 40% currently have direct clinical roles and if they choose to retire at this point, this may result in challenges in recruitment for some of our services. Plans need to be put in place now to ensure that there are no gaps or loss of expertise across our services.

In addition there are a number of changes which have been introduced across Scotland such as "Reshaping the Medical Workforce in Scotland", which is already impacting on the way we deliver services. An example of where we are now working differently because of these changes is in the Paediatric Hospital at Night service. For this service we have introduced new roles and skill mixing between the different professions, to ensure we can continue to deliver our services effectively and safely based on our workforce.

There are a number of factors which drive an urgent need to change our models of care and workforce configuration. This includes changes in patient populations, especially an increasingly elderly population, and more patients living with long term, chronic conditions. Other challenges within the workforce include a new contract for doctors, the European working time directive, and an aging workforce.

The traditional model of delivering care in hospitals and in the community is very focused on care being delivered by doctors and other medics in a clinical setting. As we move towards 2020 there will be a requirement to deliver care in radically different ways, maximising self care and community support where possible and avoid hospital admissions wherever possible.

3.3 A Changing Economic Climate

In addition to increasing demand, as in recent years, NHS Borders will need to deliver significant efficiency savings. For NHS Borders just to stand still, we will need to make savings on the overall budget and deliver more activity with this reduced resource. Over the last 4 years we have been successful in achieving notable efficiency savings. However based on current targets between 2015 and 2020 it is estimated that a further £25 million of efficiency savings will need to be achieved.

NHS Borders has a good track record in managing its finances and is committed to continuing to do so in the future. Over the last few years NHS Borders has achieved its financial targets annually. It has also worked hard to ensure the amount of income it receives matches what it spends and therefore it has a balanced budget on a recurring basis.

Annually the Scottish Government uplifts the health budget by an inflationary percentage, however inflation in areas such as drugs is considerably greater than the general uplift. In order to fund inflationary increases greater than the general uplift and achieve a balanced budget NHS Boards must implement cash releasing efficiency savings.

The financial challenge that the public sector is embracing is clear and well understood. It is essential that our services are provided and developed appropriately within the funding available to us and for which the Board is responsible. In order to continue to deliver quality patient care the organisation must keep a firm grip on its finances as well as drive improved quality and efficiency which is critical to service delivery and public credibility. That means having a clear focus that is firmly and openly set on providing patient care that is safe, effective, sustainable and affordable.

3.4 Focus on Health & Well-being

To deliver effective health care services we must ensure our resources are appropriately targeted at the health needs of the population. Services must reflect the widely recognised demographic trends with a small increase in children and a large increase in the elderly. These two groups have very different health needs; the elderly have chronic multiple conditions but there is much that can be done to prevent or lessen the impact of this on the individual and service. Given the shrinking resources with which to deliver health care, services must provide value and financial sustainability; they must not only be evidenced as effective but must also be cost effective.

Demands on health care services can be reduced by improving population health and well-being. The NHS has an important focus in this along with our key partners within Scottish Borders Council and the third sector.

3.5 Technological Capability – based on evidence

Technology is becoming part of the majority of peoples daily lives from smartphones and digital TVs to telephones and tablet devices. They are used to using technology to undertake many aspects of their daily lives, from banking and ticket booking to on-line shopping. They want the option to undertake contact with the NHS in a similar way: to book appointments, order their medicines, access the people looking after them for advice and support and accessing their own information on-line.

Similarly, staff rightly demand technology that supports them to do their jobs and to deliver the best care as effectively as possible. Advances in technology presents us with an opportunity to really support staff in delivering new models of care, for example, remote monitoring of patients at home or in hospital, or remote access to clinical experts.

We already have good foundations and strong partnerships to ensure we are well placed to make the most of all that technology can offer to new models of patient-centred, safe care.

The next section of this document sets out the six Key Principles of the Clinical Strategy which we would like to hear your views on.

4. NHS Borders Clinical Strategy "Key Principles"

The six Key Principles are detailed below with examples of what we mean by each of these principles.

Redesigning our services to ensure they are future-proofed and will meet the challenges outlined above will take effective leadership, teamwork and creativity. There is an opportunity for the organisation to trial innovative models, moving away from our current traditional, bed-based systems. All NHS Borders services should be patient-centred, safe, high quality, and efficient (i.e. delivered within our means). They will need to evolve rapidly to ensure that the following principles are embedded within standard practice:

1. **Services will be Safe, Effective and High Quality:**

    a. Patient Safety will remain NHS Borders' number one priority and at the centre of all of our services.
    b. We will continue to develop standardised care pathways to ensure effective, high quality services, supporting staff to develop the skills to deliver them.
    c. We will continue to identify and address avoidable harm, for example, post operative infections and hospital acquired infections will become an exception within our hospitals.
    d. There will be continued work to further reduce our Hospital Standardised Mortality Ratio (HSMR).
    e. The Patient Safety programmes in both Primary and Secondary care will continue to be implemented and driven forward.

2. **Services will be Person-Centred and Seamless:**

    a. The individual (along with family and carers) will be at the heart of new service delivery models to ensure better outcomes, as genuine partners in their treatment and care.
    b. Integration between health, local authority and the third sector will provide better working arrangements and co-location of services, to ensure seamless care for the patient.
    c. Care will be delivered in an integrated way, with patients, carers, primary and secondary care clinicians, Social Care and the third sector working together as a team to manage conditions.
    d. Discharge from hospital will be smooth and timely, engaging with the patient, carers and multidisciplinary team, to reduce the risk of readmission and support safe, effective care in the community.

3. **Health Improvement and Prevention will be as important as treatment of illness**:

    a. Every healthcare contact will be a health improvement opportunity – NHS staff will encourage, sign-post and refer as appropriate to help patients with lifestyle changes and any wider issues that may affect their health.
    b. We will continue to strive to reduce Health inequalities, by working in partnership with the local authority and the population of the Borders.
    c. For our patients with long term conditions, we will anticipate their needs, and strive to address any problems before they become emergencies, to avoid hospital admission where possible, (the "anticipatory care" approach).
    d. We will work with our local authority and other partners to support people to become more resilient, take more responsibility for their own health, and to

build on assets in their communities to maintain and improve their health and wellbeing. We will focus particularly on early intervention and prevention in our most deprived communities.

4. **Services will be delivered as close to home as possible**:

    a. We will develop community services to help people receive their treatment and care within their own communities so that they will only be admitted to hospital when clinically necessary.
    b. Treatment and care will be provided in the most appropriate setting, which may include the GP practices, community hospitals, day centres etc.
    c. We will continue the journey whereby specialist or secondary care services are increasingly provided in health centres, community hospitals or in a day care setting, (e.g. day case treatment becoming the norm for planned surgery).
    d. We will continue to develop better alternatives to hospital admission.

5. **As a consequence of the above principle, admission to hospital will only happen when necessary, and will be brief and smooth:**

    a. The focus for the general hospital will be the planned treatment of patients requiring surgical intervention, or the stabilisation of acutely unwell medical patients.
    b. Admission processes will continue to be simplified and standardised with minimal delays for those requiring hospital treatment.
    c. The goals of admission will be reached as soon as possible, with minimal time wasted waiting or queuing for expert opinions, investigations or diagnostic procedures.
    d. Discharge from hospital will be smooth and timely, working with patients and carers to reduce the risk of readmission, by engaging local health and care services as soon as their needs allow.

6. **Services will be delivered efficiently, within available means**:

    a. The use of new technology in all aspects of healthcare will be maximised.
    b. More streamlined pathways of care to reduce delays and wastage and improve the patient experience.
    c. Treatments and service provision will take account of evidence, cost effectiveness and opportunity costs.
    d. NHS Borders subscribes to the development of a Fair and Just culture to ensure that all staff in the workforce feel valued and supported in delivering both the current service and pursing the necessary changes.

These principles are in line and fully support the 2020 vision for Healthcare in Scotland. The vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on early intervention and prevention and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with no risk of re-admission.

We want your views on the Key Principles. You can do this by giving us your answers to the following questions:

1. **Do you agree and support the Key Principles of NHS Borders Clinical Strategy?**

2. **Do you agree that the delivery of these Key Principles will enable NHS Borders to best meet the healthcare needs of the Borders population?**

3. **Are there any Key Principles missing? If so, please give a practical example of how this would work in practice?**

4. **Did the examples of models of care, shown at the Appendices of this document (page 13), help you to understand the application of the Key Principles?**

Please give us your answers on the Public Engagement Response Sheet at the end of this document (page 20).

5. How to give us your views

The public consultation process for Clinical Strategy is very important to NHS Borders. We want everyone in the Borders to be aware of our "Key Principles" and we want your comments.

Please complete the Public Engagement Response Sheet which you will find at the end of this document (page 20).

This consultation document is one of the main ways we are consulting with people, we will also be:

- Holding a series of public "road-shows" held across the Borders - please look on the website or contact (tel no to be confirmed) for details of where and when these will be held.
- Meeting with staff.
- Meeting with voluntary sector groups/organisations.
- Meeting with local community groups.
- Providing updates via the local media, e.g. Radio Borders.
- This document will also be available in local GP Practices and Libraries.

Length of consultation
The consultation runs from 10th March to 6th June 2014.

How to comment
You can give us your views using the attached Public Engagement Response Sheet and returning it to the Freepost address provided below. Alternatively, you can give us your views by completing the Electronic Feedback Form which you will find on the NHS Borders website.

Post: **Include address for FREEPOST**

Electronic Feedback Form: **www.nhsborders.org.uk**

Please make sure that your comments reach us by no later than 6th June 2014.

How to contact us
If you have questions about this consultation please telephone Freephone 0800 7314052 or email public.involvement@borders.scot.nhs.uk.

The next steps
The public engagement period ends on 6th June 2014. We will gather and consider all the views that we receive and produce a Summary and Feedback document. Please give your name and address or email address on the Response Sheet if you would like to automatically receive a copy.

6. Appendices: Examples of models of care with the "Key Principles" applied

Being successful in overcoming the challenges to be faced over the next 3 – 5 years will require a redesign of services across the spectrum i.e. from Children & Young People (Paediatrics) to the Department of Medicine for the Elderly. This is required to make these services more efficient, effective, person-centred and accessible, available 24 hours a day and 7 days a week, where care is delivered close to people's homes in the community, with people only being admitted to hospital when it is absolutely necessary.

These are a few examples to show what a service could look like if the Key Principles were applied and how it would be different. We have described the current service and how it could be different under each principle

Appendix A: Children and Young Peoples Services

The Current Service

NHS Borders currently provides in-patient and out-patient care in a variety of clinical settings. Children's Services is made up of staff trained in the care of children and young people. They deliver this care in the hospital and in the community. The current in-patient Paediatric Service is a Consultant led service in a ward in the Borders General Hospital (BGH), which has 2 short stay beds, 2 high dependency beds and 6 inpatient beds.

In order to maximise the effectiveness of the team, the Paediatric Service has changed the skill mix of the team, extending the roles of nursing staff, and developing a service model. This model is delivered by Consultant Paediatricians and Advanced Paediatric and Neonatal Nurse Practitioners. Where our team cannot provide a service, patients are attended to in NHS Lothian. Children and young people are attended to on an out-patient basis in the BGH and ambulatory care is delivered from the in-patient ward instead of admitting children where appropriate. (Ambulatory care is a healthcare consultation, treatment or intervention using advanced technology and procedures, delivered on an out-patient basis to allow patients to depart after treatment on the same day).

In the community children and young people are supported by paediatric clinicians such as Health Visitors, Allied Health Professionals (AHPs), School and Community Nurses who work within locality teams.

Children and Adolescent Mental Health Services (CAMHS) are delivered from the Andrew Lang Unit in Selkirk with staff working throughout the Community.

A key team within the Service is the Child Protection Team (a multi agency team) based at the Langlee Centre in Galashiels.

How this service could look if the Key Principles were applied

In common with the key principles detailed in NHS Borders Clinical Strategy, the provision of Children's Services could be provided from the same site, from a Children and Young People's Centre (CYPC) at the Borders General Hospital. This Paediatric Centre would include an in-patient ward, a range of out-patient clinics and ambulatory care. Physiotherapy, occupational therapy, speech and language therapy and CAMHS would also run clinics here.

Principle 1: Services will be Safe, Effective and High Quality
Patient safety is the number 1 priority for Children's Services. A new centre could meet the needs of the developments in the service and allow for safe delivery of Children's Services. An effective Children's Service would see clinicians extending and expanding their scope of practice so they could deliver exemplary care as part of a multidisciplinary team. A CYPC could have a small in-patient unit for children and young people, however the majority of patients would be seen as near to their home as possible.

Principle 2: Services will be Person-Centred and Seamless
The child would continue be at the heart of care and the service would be developed with children and young people's input. The co-location of services, (all services provided from the same site), would reinforce seamless and integrated care. NHS Borders is committed to working in partnership with children and their families. Parents and carers of in-patients would be involved in their care whilst during their hospital stay; relative beds would be provided in every room.

The out-patient space could be an age appropriate space for patients and could have the flexibility to accommodate patients' families and provide the opportunity for more integrated working. NHS Borders would continue to work with other agencies to deliver Scottish Government programmes' - GIRFEC (Getting it right for every child) and the Early Years Collaborative.

Principle 3: Health Improvement and Prevention will be as important as treatment of illness
Child Practitioners would consider the wider needs of children and their families. They would work in partnership with families to look at the bigger picture of each child's health, addressing issues at the earliest opportunity possible. This could also tackle lifelong health improvement, have effect on public health and therefore service requirements in the future. In a CYPC there would be a focus on management of long term conditions. We would provide a service for patients that is close to home and less disruptive for patients and families than using services in Lothian.

Principle 4: Services will be delivered as close to home as possible
NHS Lothian is currently rebuilding the Royal Hospital for Sick Children (RHSC); the new facility will be based at the Royal Infirmary of Edinburgh site and is due to open in 2017. Complex cases will be attended to at the RHSC as required. However a proportion of out-patient activity which is delivered by NHS Lothian needs to come back to the Borders. This would allow NHS Borders to deliver care closer to home. In order to accommodate increased out-patient activity, out-patient spaces must be updated and expanded. NHS Borders would continue to provide services in a range of community facilities and locations as well as in a CYPC. Children's Services would ensure patients were seen as close to home as possible in line with GIRFEC.

Principle 5: As a consequence of the above principle, admission to hospital will only happen when necessary, and will be brief and smooth.
In-patient hospital care would continue to be a part of NHS Borders Children's Services. The service would provide a smooth move back into the community so that paediatric patients could be at home with their families and resume normal life, as far as possible.

Occupancy within the children's ward can be fairly low and this ranged between 30.9% and 64.1% in 2012/13. A CYPC would have less in-patient beds but would have an enhanced out-patient space; there would be an emphasis on community care. This recognises that Paediatric Practice has changed significantly since the BGH was built. Children have a better

recovery at home, and community care is easier for families to manage.

Principle 6: Services will be delivered efficiently, within available means
Developing the roles of the varying members of the clinical team would ensure that Children's Services are delivered efficiently and cost effectively, whilst maintaining a high standard of care and providing a range of clinical skills.

What would be different?
For the first time in the Scottish Borders services would be delivered in a purpose built environment, designed with children and young people in mind. The building would be easily accessible for patients and their families, with ground floor access. Inpatients would be treated in rooms specifically designed for paediatric care with therapeutic areas and overnight stay beds for parents and carers built-in. A glass atrium would provide natural light for in-patients and out-patients. Out-patients would start their treatment journey in an age appropriate waiting area and would then go through to specially designed treatment rooms. There would be age appropriate facilities which would allow integrated working. There would be rooms with two way mirrors for clinical observation, and a play space designed for the same purpose.

The Centre would improve the patient experience for children and their families and, in the long run, improve outcomes for the children of the Borders.

Appendix B: Unscheduled Care

The Current Service
Historically, the service has been delivered entirely by doctors and in NHS Borders by employed doctors as opposed to sessional GPs from local GP practices. Over a period of years the overnight period of the service has increasingly been delivered by two nurses and a single doctor, with the nurse doing the vast majority of home visits during the night and liaising with the doctor to agree appropriate action.

The service was initially based from four sites, these being Borders General Hospital (BGH) in Melrose and three peripheral sites at Kelso, Duns and Hawick. However, in response to reduced call volume and activity levels, two of these sites were combined some years ago, Duns and Kelso, and covered by a single GP shift.

Over the last year it has become increasingly difficult to recruit to vacant posts within the GP part of the service and there has been an increasing number of unfilled shifts occurring regularly. The vacant shifts has driven action to remove doctors from the peripheral sites on weekday evenings from August 2013, to allow the service to consolidate its limited resource and to continue to provide a service across NHS Borders. However, increasing difficulties continued over the next 5 months despite an uplift in salary and sessional rates for GPs and extensive advertising and close working with agency services.

From January 2014 all GP's shifts were centralised and are now based at the BGH throughout the out-of-hours period. This is to ensure adequate and safe cover of the service across the Borders. It has resulted in the removal of a GP for a fixed period during the day on a Saturday and Sunday at the peripheral sites. In the evenings and overnight period the out-of-hours nurse and evening nurse service continues to deliver a major element of care in the patients own home. All patients who attend the central hub (at the BGH) by arrangement through NHS 24 or the professional to professional contact line, are currently seen by a GP and the GP's continue to carry out appropriate home visits. Walk-in patients are triaged by

the joint Emergency Department and the walk-in nurse triage service and are referred to either the Borders Emergency Care Service (BECS), the GP or the Emergency Department (ED) for further assessment and treatment.

How the service could look if the Key Principles were applied
If the principles were applied we could develop a more resilient service by developing a combined community, Borders Emergency Care Service (BECS) and Accident and Emergency (A&E) response.

Principle 1: Services will be Safe, Effective and High Quality
This service would be provided across a range of areas, but in the first instance in an integrated Emergency Department and Borders Emergency Care Service (BECS). It would be provided by a multidisciplinary workforce (professionals with different fields of expertise) with generic skills. This would increase resilience of the service and increase the pool of staff to deal with all situations including home visits. All staff would be trained to a common and established standard. Patients would access unscheduled care through a single hub - whether this be walk-ins, referred by NHS 24 or through professional to professional contact.

Principle 2: Services will be Person-Centred and Seamless
We would provide a single point of contact and a team with generic skills. Patients would be seen in a smooth fashion, without multiple hand overs and clinicians involved in their care.

Principle 3: Health Improvement and Prevention will be as important as treatment of illness
As part of the wider work in unscheduled care, anticipatory care plans would be developed for all patients that might benefit from such an approach. By this we mean for our patients with long term conditions we will anticipate their needs and strive to address any problems before they become emergencies. Self management would be encouraged and patients would know who to turn to for help, for example their community pharmacy.

Principle 4: Services will be delivered as close to home as possible
The services would continue to use technology, for example smartphones or “face-time” to assess patients in their own homes or community hospitals. Home visits and assessments would be carried out by the most appropriate clinician, for example the paramedic nurse or doctor. If a visit to hospital is necessary this assessment would take place in the central hub with access to diagnostics and specialist opinion.

Principle 5: As a consequence of the above principle, admission to hospital will only happen when necessary, and will be brief and smooth.
By assessing all patients brought in by ambulance in a central hub, access to specialist advice and investigations would help minimise the need for admissions. The wider unscheduled care redesign would focus on ambulatory care and rapid seven day access to hospital assessment. This would prevent the need for admission unless medically necessary. The integration of services would ensure that services in the community wrap around the patients, allowing them to stay at home for as long as possible.

Principle 6: Services will be delivered efficiently, within available means
A changed service would move away from doctor dependency. A new redesigned service would be delivered within the existing resource package yet deliver a resilient and safe service.

What would be different:
The service would be integrated across the area delivering a high quality and seamless service. Changes in the workforce would make the service less dependent on the doctor and more resilient.

Appendix C: Poynder View Dementia Day Service

This example demonstrates how we have already applied the Key Principles to a service and the changes have proved successful. The way in which Dementia Services is delivered in Eastern Borders was changed back in January 2009.

The Previous Service:

Until January 2009, Poynder View in Kelso was an in-patient continuing care ward for people with moderate to advanced dementia, with considerable difficult behaviours and or resistance to intervention at home or other care environments. The unit was run in line with social psychiatry, but was hampered from some choices by being on the first floor, upstairs, of Kelso Community Hospital. Patients could not choose to go outside or for a walk or be involved in the garden without fairly major intervention. Despite these challenges staff within the unit were extremely dedicated to ensuring a good quality of life was enjoyed by those in their care.

Prior to the changes made to the service, as detailed below, Eastern Borders had no NHS day care and resource centre. There was a limited outreach service from Poynder View to enable the community team to support people in their own homes or in the community. There was a strong desire to shift the balance of care in terms of where the resources were currently used. A large amount of money was tied up in an in-patient resource with little intervention available for those who had an early onset of their dementia or were of a younger age.

How the new service applied the Key Principles:

A window of opportunity arose due to lower levels of in-patient activity within Poynder View Ward, to pilot an innovative model in Eastern Borders and test out a community based service from January 2009.

This new, community based “resource centre / outreach” model provided the opportunity to support the existing resource of primary care, community hospitals, nursing and residential home provision, homecare and linking with Social Work dementia services in Duns. It was envisaged that the service would be responsive and support patients both in and out with office hours.

Throughout the pilot, there was engagement and involvement with key stakeholders, including patients, carers, relatives, the public and staff.

Following the success of the piloted service, and the engagement as described above, the service was approved as a permanent service change for Eastern Borders.

Principle 1: Services will be Safe, Effective and High Quality
The service now delivers a comprehensive range of services that are reliable, safe, flexible and efficient.

Principle 2: Services will be Person-Centred and Seamless
There is improved quality of care across providers, particularly between community hospitals and care homes. The service delivers a more person-centred approach to meet integrated care needs.

Principle 3: Health Improvement and Prevention will be as important as treatment of illnesses
There is improved access to support for patients and carers. Carers are supported to enable them to manage behaviours that are challenging, and engage in a meaningful way with those they care for.

Principle 4: Services will be delivered as close to home as possible.
Individuals with dementia are able to remain within their community for as long as possible, promoting and maintaining independence. Individuals are supported at home or as close to their community as able. Support is provided to primary care to enable early diagnosis of dementia.

Principle 5: As a consequence of the above principle, admission to hospital will only happen when necessary, and will be brief and smooth.
The service supports early diagnosis and intervention, and assessment and treatment of dementia, to help reduce unnecessary hospital admissions and enable individuals to stay at home for longer.

Principle 6: Services will be delivered efficiently, within available means
There is increased, shared responsibility for the range of services between NHS Borders and all key partners.

What is different now:

This service is made up of two parts:

- An outreach service which provides for the service to support individuals in their own homes or in the community setting.
- A resource centre which provides a meaningful, interactive daytime service for patients with dementia.

The outreach team visit people with dementia at home, or in a care home or community hospital, within their area. The team offers support and practical help in managing people with dementia. For the people they visit, they develop a comprehensive care plan and do a risk assessment to ensure they are safe.

The resource centre provides a seven day service as required. When people are referred to the centre they are assessed and a comprehensive care plan and risk assessment is completed to ensure they receive appropriate care. Attendance at the centre is worked through with all involved in the care of each individual person. The centre provides different therapies, groups and activities, depending on each individuals needs, and/or gives some respite to carers.

In summary this is what would be different if the "Key Principles" of the Clinical Strategy were applied throughout our services:

- Service users will know who to contact and know how to access the service.
- The contact will know how to organise care.
- Care will be proactive and anticipatory, (we will anticipate peoples needs, including those for carers, and strive to address any problems before they become emergencies).
- One-stop care will be provided if at all possible.
- The community will be empowered to deliver healthy living.
- Trained and supported volunteers will be actively involved in the community.
- Hospitals and communities will collaborate to deliver integrated and seamless care.
- Care will be delivered by the most appropriate and trained member of the multidisciplinary team.
- Delays, repetition, waste and queues will be eliminated from the process of care.
- Information will be shared and available at the point of need.
- Technology will be used to enhance information sharing and transfer, and Team working.
- Healthcare provision will be delivered in the most appropriate setting.
- Staff will be supported and allowed to fully use their skills.
- Broader measures of patient safety will have been developed through the Scottish Patient Safety Programme.

7. Summary of questions – Response Sheet

We want to hear as many views as possible, so please tell us what you think of the "Key Principles" of the NHS Borders Clinical Strategy.

Please return this response sheet by 6th June 2014 at the latest. If you are able to return your response earlier than this, please do so.

Question 1:

Do you agree and support the Key Principles of NHS Borders Clinical Strategy?

Question 2:

Do you agree that the delivery of these Key Principles will enable NHS Borders to best meet the healthcare needs of the Borders population?

Question 3:

Are there any Key Principles missing? If so, please give a practical example of how this would work in practice?

Question 4:

Did the examples of models of care, shown at the Appendices of this document, help you to understand the application of the Key Principles?

Do you have any other comments you wish to make:

Please continue on separate sheet if necessary.

How did you find out about this Consultation:

……

Thank you for taking the time to give us your views. Please return **by 6th June 2014 at the latest** to:

(Add Freepost address) or email public.involvement@borders.scot.nhs.uk

If you wish to let us know who you are (this is optional), or if you would like to automatically receive a copy of the Summary and Feedback document, please provide your name and address or email address:

Name *(Title, first name, surname):*

……

Name of Organisation or Group *(if applicable):*

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Postal Address, including post code:

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…… Post Code: ……...

Email: ……