Borders NHS Board

DRAFT STRATEGIC PLAN

Aim

The purpose of this paper is to present NHS Borders Board members a draft of the Health & Social Care Strategic Plan for discussion and comment prior to formal consultation from July 2015 for 3 months.

As required by the Public Bodies (Joint Working) (Scotland) Act 2014 – The Strategic Commissioning Plan lays out the health and social care priorities for the Borders within an integrated framework in which NHS Borders and Scottish Borders Council will jointly use their resources.

Background

The Strategic Plan is not only a statutory requirement but is also driven by local and national policy and aims to meet the needs of adults now and in the future, by working within available financial and workforce resources and by tackling inequalities, along with offering new ways of working and early preventative measures.

The final plan is to be of three years duration and will be reviewed and rolled-on each year.

This is the second version of the Plan and builds on the progress that has already been made by NHS Borders, Scottish Borders Council and their partners to improve and re-design local services.

A wide range of information has been drawn on to start to form a case for change and this draft Plan profiles the all important Strategic Objectives derived from National Outcomes by which local future ambitions are directed.

The Strategic Commissioning plan requires to be co-produced with all key stakeholders and therefore over the last 2 months there has been engagement across all localities and staff groups. Key stakeholders have had the opportunity to express views, opinions and thoughts and these have informed this version of the plan. This version of the plan (subject to comments and changes during June as various stakeholders contribute) will then be subjected to a full formal 3 month consultation exercise from July 2015.

The final version of the plan will be based on what is learned from the consultation exercise by listening to people in the Borders – patients, service users, carers, members of the public, clinicians, staff and professionals and other partner organisations.

Other key stakeholders that will be part of this exercise are listed below and a fully detailed Communications and Engagement plan will underpin this work.

- SBC Elected Members
- Community planning partners
- Community councils
- Area Forums
- Other Health Boards and special boards
- NHS Borders Board, Advisory Committees and Non-Executives Directors
- Independent contractors
- Participation Network - including public partnership forum and public reference group
- Scottish Government
- Scottish Health Council
- MPs MSPs
- Media
- 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

Summary

This draft of the plan has taken on views and comments from the staff and public engagement exercise during May and June.

It is proposed to use the appended Draft of the Strategic Plan (subject to final changes) in a formal 3 month consultation and engagement process from July – September 2015.

Recommendation

The Board is asked to **approve** the Draft Strategic Plan to go forward for a 3 month public consultation.

Policy/Strategy Implications	The documentation and exercise outlined above is designed to inform the development of the Strategic Commissioning Plan
Consultation	The purpose of this report is to recommend an initial consultation on the Strategic Commissioning Plan. There will be further and more detailed consultations to follow.
Consultation with Professional Committees	
Risk Assessment	If Scottish Borders Council and NHS Borders do not conduct an initial consultation exercise there is a potential risk that the requirements of the integration legislation and associated guidance will not be fulfilled i.e. the people who use and provide services and others will not have an opportunity to be involved in the development of the Plan from its earliest stages.

Compliance with Board Policy requirements on Equality and Diversity	An Equalities Impact Assessment is being conducted alongside the development of the Plan. At this stage there are no adverse equality implications attached to recommendation contained in this report
Resource/Staffing Implications	There are no resource/staffing implications as a result of the recommendation contained within this report

Approved by

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Scottish Borders Health & Social Care Partnership

Draft Strategic Commissioning Plan

2015 – 2018

Work in Progress

Borders Partnership – Strategic Commissioning Plan – 2015-2018

Contents

Links to Full needs assessment and stats and facts document to follow

Foreword

People are living longer than ever and the trend is set to continue into the future. Increased life expectancy is something that we should all celebrate, but longevity means that we need to plan ahead, both collectively and individually, to ensure that we in the Scottish Borders can maximise the benefits and positive experiences of a long life. Our population in Borders is as diverse in their circumstances, interests, activities and abilities as the rest of the population. In Borders we want to create a health and social care system which is more personalised, and one which places paramount importance on improving outcomes for our service users and carers.

This is our second draft of a Strategic Plan as an emergent Health and Social Care partnership (HSCP) and it builds on the progress that has already been made by NHS Borders, Scottish Borders Council and partners to improve local services for all adults in the Scottish Borders. The Health and Social Care partnership in the Scottish Borders has drawn on a wide range of information to form a case for change, and this draft plan describes why we selected each of the strategic aims and includes a review of the financial context in which our plans and ambitions are set.

This second draft of the plan also, importantly, is based on what we have learned from listening to local people – patients, carers, members of the public, staff, clinicians, professionals and other partner organisations – over the last few months as we have engaged on drafts of the plan through various workshops and locality events.

We believe that through strong leadership, innovative thinking, robust planning and by putting the views of patients, service users and carers at the heart of all that we do, we can achieve our ambition of Best Health, Best Care, Best Value for our communities across the Scottish Borders. We will make sure that strong and effective partnerships are established between Scottish Borders Council and NHS Borders, colleagues in the third and independent sectors and with other key partner agencies, so that we plan and commission services in a way that puts people at the heart of decision-making.

This is an exciting time. Through honest and open dialogue with our key stakeholders, together we know we can make a difference.

Section 1 Introduction & Background

This Strategic Plan describes how Scottish Borders Health and Social Care partnership, an integrated partnership between Scottish Borders Council and NHS Borders, will develop health and social care services for adults over the coming ten years. Health, social care and wellbeing are key factors which impact on communities and individuals.

The Council and the NHS locally have a long and successful history of working in partnership and the Plan builds on that history through emphasising the importance of integrating our care services further. This is because ill, vulnerable or disabled people often need support from more than one service and for their care to be effective it needs to be personalised and well coordinated. Integrated care is also essential because gaps or weaknesses in one part of the network of services often affect services elsewhere: for example, weaknesses in community services can cause unnecessary admissions to hospital, while over reliance on hospital or residential care diverts money away from community services, reducing their ability to support people at home.

In a time of rising demand for services, growing public expectations and increasing financial constraint it is essential to make sure that social care, primary care, community health and acute hospital services work well together with all our partners, including the voluntary and independent sectors, in a truly integrated way.

Making the case for change is at the centre of this Plan. It is not a critique of current provision but rather a fundamental recognition that the existing model of care needs to change in order to meet both current and future challenges. If we do nothing the health and care system will not be able, in its current form, to continue to deliver the high quality service we expect to meet the needs of the Borders population.

We recognise that our health and care system is challenged and we need to be a strong and effective planner and commissioner in order to drive improvements in performance and deliver the efficiencies required for the future. This has to change and our plans aim to address this issue through immediate action plans, medium term plans and through a longer term sustainability plan, all delivered through our locally driven programmes.

1.1 What is the Health and Social Care Partnership?

The Public Bodies (Joint Working) (Scotland) Act, came in to effect on 2nd April 2014. The purpose of the Act is to provide a framework that supports improvements in the quality, efficiency and consistency of health and social care services, through the integration of NHS and Local Authority community based services in Scotland.

This is in line with the Scottish Government's overarching purpose, "to focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth".

The main purpose of Integration is stated as being to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and require support from both health and social care.

Additionally, the integration of health and social care services, aims to:

- Improve the quality and consistency of services for patients, carers, service users and their families;

- Provide seamless, joined up, high quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and

- Ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with longer term and often complex needs.

In the Borders, NHS Borders and Scottish Borders Council have agreed an Integration Scheme (Partnership Agreement) that enabled the establishment of the Integration Joint Board. This new Board is a body corporate (a separate legal entity) and acts independently of the Health Board and the Council. It is tasked with delivering the purpose behind the legislation in Borders.

As specified in the Regulations made under the terms of the legislation, the Health Board and Council has delegated community health and social care functions for adults and older people to the Integration Joint Board. A full list of the functions and services delegated to the Integration Joint Board is included at Appendix 1.

The key functions of the Integration Joint Board are to:

- Prepare a Strategic Plan for Integrated Functions that is in accordance with National and Local Outcomes and Integration Principles;
- Allocate the Integrated Budget in accordance with the Strategic Plan; and
- Oversee the delivery of services within the scope of the Partnership.

1.2 What is the Strategic Plan?

The Strategic Plan aims to provide a 10 year vision for integrated health and social work services and contains a three-year strategic planning framework which sets out priorities for the new Partnership and how it will use its resources to integrate services in pursuit of National and Local Outcomes.

Some hospital based services will be within the scope of the Strategic Planning process, particularly those around unplanned emergency admissions which are central to one of the primary objectives of Integration, which is to shift the balance of care from a hospital and institutional setting to the community. These are:

- Unplanned inpatients - (Medical care for the treatment of urgent or emergency conditions that require an unplanned admission to hospital); and

- Accident and emergency services - (services provided within a hospital for the treatment of urgent or emergency conditions)

Future versions of this Strategic Plan will set out how the Partnership intends to commission services to meet local needs in a way that is compliant with the Principles of Integration and ensures progress in terms of National and Local Outcomes.

At the heart of this approach to strategic planning will be the provision of services and support across the sectors in a way that meets the needs of particular individuals, communities and localities and to facilitate this, a locality planning framework has been developed by the Partnership which is described in Section 4 of this Plan. Locality Profiles are provided at Appendix 2.

The Plan is underpinned by a number of national and local policies, strategies and action plans. It will provide the strategic direction for how health and social care services will be shaped in this area in the coming years and describes the key transformational changes that will be required to achieve this vision.

The Plan is about innovation and professionally led service redesign with sustained financial stability; it is equally about services which meet the needs of our population and are not just fit for purpose, but the best for purpose and fit for the future. The Plan will integrate all the major changes and work to be undertaken over the next few years by the HSCP to improve the quality and safety of services, to improve the health of local people, and to innovate in how services are delivered to meet the tough financial challenges we all face; it will equally demonstrate that optimum use is being made of existing resources across Borders.

1.3 How will the HSCP develop and agree this plan?

The Integrated Joint Board, the HSCP's governing body, will replace the former Community Health Partnership committee and has been meeting in shadow form since 2013. This draft Strategic Plan is a joint statement, the initial development of which has been overseen by the Shadow Board and the Strategic Planning Group which has representation from NHS, local authority, clinicians, service users, carers, voluntary sector and the independent sector. In writing the draft plan we have reviewed information about health needs, issues and concerns raised by local people and current service delivery and discussed and refined our plans and priorities. From this work we have developed this document, which is a consultation draft of the Strategic Plan.

Section 2 Summary of National & Local Context & Policy Priorities

This section summarises the background that will inform the strategic planning for the Health and Social Care Partnership.

The current public service environment is considered to be under increasing strain and facing a great transition. The increasing demand for public services, particularly due to an ageing population and the sharp decline in the availability of public funds, is creating intense pressure for governments and third sector organisations to meet local needs, a 'new concept of public governance' is required in order to address this challenge and provide services in a targeted and efficient manner.

National Context

The Scottish Government has clearly set out its goals and policy framework for improving health and wellbeing through a number of key strategic statements. These are ambitious in scope and will accelerate radical reform in the way public services are delivered. Priorities include:

- Maximising scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities
- Concentrating the efforts of all services on delivering integrated services that deliver results
- Prioritising preventative measures to reduce demand and lessen inequalities

Local Context

NHS Borders Clinical Strategy recognises the challenges of demographic change, quality aspirations and resource constraints and describes what NHS Borders proposes to do over the coming decade to address these challenges whilst providing a high quality and sustainable healthcare system for its citizens. NHS Borders, in consultation with its staff and public, have agreed on a set of principles which each service will implement. Like the local Strategic Plan, NHS Borders articulates a vision of services designed around people with multiple conditions, located in communities, coordinated and integrated, and preventative in focus. It is therefore essential that we must take cognisance of NHS Borders key principles in order to ensure maximum synergies, effectiveness and best use of resources.

NHS Borders Clinical Strategy Key Principles:

1. Services will be Safe, Effective and High Quality
2. Services will be Person-Centred and Seamless
3. Health Improvement and Prevention will be as important as treatment of illness
   Services will be delivered as close to home as possible
4. As a consequence of the above principle, admission to hospital will only happen when necessary, and will be brief and smooth
5. We are committed to working in Partnership with staff, communities and other organisations to deliver the best outcomes for the people we serve
7. Services will be delivered efficiently, within available means

The Scottish Borders Single Outcome Agreement (SOA) 2013 – 2023 sets out the Scottish Borders strategic plan to improve the lives and opportunities for the Borders population and to reduce inequalities within our communities. The SOA, which has been developed with 12 partner organisations, lays out 3 strategic objectives – Grow our Economy, Reduce Inequalities and Maximise the impact from the low carbon agenda – with a range of contributory outcomes.

As the Health and Social Care partnership further develop this Strategic Plan we will ensure close alignment with all these relevant policies and strategies. In the Scottish Borders, organisations and communities do already work in partnership to address key health and care needs for adults, focusing on priority groups. There are a wide range of joint strategies and plans already in place and this Strategic Plan neither replaces nor revises any of the current, live plans; it will, however, focus on the priority actions and encompass these in our delivery programmes. A summary of these joint strategies and their key aims and priorities are included below. The key outcomes have also been mapped against the local strategic objectives.

Summary of Current Joint Strategies:

Learning Disability
The *Review of the Joint Learning Disability Service* (Sept 2013) was undertaken to: quantify the number of people with a Learning Disability (LD) currently and in the future, to assess the appropriateness of the level of care being received and to provide recommendations for future joint commission and service design.
Summary figures from this and/or later work
As at March 2014, 599 people aged 16+ with Learning Disabilities were known to Scottish Borders services.
Key Outcomes and Themes Identified
Since the LD strategy was written and prioritised the need to improve joint health/social care provision, the LD service has shifted the balance of care by disinvesting in social work resources and moving it to local area co-coordinators. Through regular meetings, service users and carers continue to have a voice in the service. ***Local Strategic Objectives: We will make services more accessible and develop our communities. We will deliver services within an integrated care model. We will provide care close to home.***

Physical Disability
The *Living Well with a Disability* was written in March 2013, and is currently being reviewed. The strategy outlined the way in which services will be delivered for people with a physical disability living in the Scottish Borders now and in the future.
Summary figures from this and/or later work
At the time of the 2011 Scotland Census, 6,995 people identified themselves (or were identified by a member of their household) as having a Physical Disability, this equates to 6.1% of all Scottish Borders residents at that time. The prevalence of physical disabilities in the population rises with increasing age, with 10% of people aged 65-74 affected and 31.7% of people aged 85 and over.
Key Outcomes and Themes Identified
Some of the key themes are; to work in partnership to enable people with a physical disability to live as independently as possible, to develop opportunities for people with a physical disability to fully engage in local community, improve access to public transport and enable people with a physical disability to have choice and control over how they are supported to live independently. ***Local Strategic Objectives: We will provide care close to home. We will seek to enable people to have more choice and control.***

Older People
An Assessment of the Needs of Older People was published in August 2013. The needs assessment was undertaken to understand if local services were meeting the needs of the older population of the Scottish Borders.
Summary figures from this and/or later work
At the time of the 2011 Scotland Census, the proportion of people aged 65 and over was well above average, at 20.9% compared to the Scotland figure of 16.8%. Between 2012 and 2032 there is an expected increase of 32% amongst 65-74 year olds, and 75% increase amongst 75+ years.
Key Outcomes and Themes Identified
Some of the key themes are: to help the growing pool of 'young old' people to stay well through robust prevention measures, improve the co-ordination and navigation for individuals through health and social care system; building capacity in communities to support older people at home and having housing solutions in place to keep people independent Long Term Conditions (LTCs) can occur in all ages, but are more common in older people: there is a greater proportion of over 65s with two or more LTCs than not. LTCs used to be referred to as 'chronic diseases' including, for example, common conditions such as diabetes, arthritis, asthma, hypertension, cancers, and long-term mental health problems such as depression, schizophrenia and dementia. ***Local Strategic Objectives: We will improve prevention and early intervention. We will make services more accessible and develop our communities. We will deliver services within an integrated care model. We will reduce avoidable admissions to hospital. We will provide care close to home***

Dementia
The *Borders Dementia Strategy* was published in 2009, and considered how the specific needs of people with dementia and their carers could be met. Increasing identification (diagnosis) and post-diagnosis support. Scotland's Dementia Strategy 2013 – 2016 sets out the work that the Scottish Government and its partners in NHS Scotland, local government and the voluntary and private sectors are doing to improve support, care and treatment for people with dementia, their families and carers. It focuses on promoting excellence and improving support.
Summary figures from this and/or later work
At March 2014, the 23 GP practices in Scottish Borders recorded a total of 1,027 patients known to them as having dementia. However the number already diagnosed with dementia is only part of the picture, as many people will be living with signs and symptoms but have not formally been identified as having it. Estimates suggest that the prevalence of dementia will continue to rise across Scotland, and that in the Scottish Borders the rate of increase will be faster than the national average, given the relatively higher proportion of older people in our population.
Key Outcomes and Themes Identified
Some of the key themes: The needs of people with dementia are at the centre of all planning and provision of services specific to them, people with dementia have access to services which enable them to remain independent within their own homes and community as long as is practical, the needs of carers for people with dementia will be considered alongside those of the person with dementia and to make efficient use of the funding and other resources available. Increasing early diagnosis and identifying post-diagnosis support is also key. ***Local Strategic Objectives: We will seek to enable people have more choice and control. We will provide care close to home. We will makes services more accessible and develop our communities.***

Carers Strategy

Caring Together in the Scottish Borders (2011-2015) recognises the need to have carers at the heart of any shift in the balance of care which will take place as a result of the integration of health and social care services.

Summary figures from this and/or later work

- The number of people aged 16+ in Scottish Borders who provide unpaid care for someone else may be around 12,500. This estimate translates as around 13% of all residents aged 16+ having some sort of caring responsibilities.
- The number of children aged 4-15 in Scottish Borders who act as a carer for someone may (if the situation in Borders is similar to that for Scotland) be roughly 760, translating as around 4% of all children in this age group.

Key Outcome and Themes Identified.

Caring together sets out key actions to improve support to carers and young carers over a 5 year period. Key actions include: developing a Carers Rights Charter, improving the provision of information and advice to carers, put in place measures to help professions in health & social care to identify carers, improve the quality of carer assessments/support plans, ensure carer representation on the health and social care partnership and produce a bespoke resource on issues relating to stress and caring.

Local Strategic Objectives: We will seek to enable people to have more choice and control. We will make services more accessible and develop our communities. We will seek to reduce health inequalities.

Drugs & Alcohol

The *Drugs and Alcohol Partnership Strategy (2015-2020)* is currently out for consultation. The vision is that individuals, families and communities live in an area where fewer people are using alcohol and drugs and, for those that do, recovery is a realistic option.

Summary figures from this work

1% of the adult population in Borders are estimated to have a problem with drug use, a little lower than the percentage overall for Scotland. 43% of the adult population drink out with recommended guidelines. 9% (983) of attendance to A&E in 2013/14 had alcohol as a contributing factor. Compared to Scotland the Scottish Borders has lower rates of drugs or alcohol related hospital stays, and lower rates of drug or alcohol related deaths.

Key Outcomes and Themes Identified

The draft strategy was informed by themed focus group, and four strategic aims have been developed**: (1)** To reduce the prevalence of alcohol and drug use by 5% by 2020 through prevention and early intervention. **(2)** Reducing alcohol and drugs related harm to children and young people. **(3)** Improving recovery outcomes for service users and reducing related deaths to 4 or less per year by 2020. **(4)** Strengthening partnership and governance structures.

Local Strategic Objectives: We will improve prevention and early intervention. We will make services more accessible and develop our communities. We will seek to reduce health inequalities.

Mental Health & Wellbeing

The Joint Mental Health Commissioning Strategy (2012-2015) is supported by a full mental health needs assessment. The strategy promotes closer integration and partnership working in the way different services and agencies meet the needs of people with mental health problems.

Summary figures from this and/or later work

- Mental wellbeing in the Scottish Borders appears to be improving, and is better than that for Scotland.
- At the time of the 2011 Scotland Census, 4,037 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Mental Health condition that had lasted, or would last, for at least 12 months. This equates to 3.5% of all Scottish Borders residents at that time.

Key Themes and Outcomes Identified

The Strategy has 10 strategic commissioning aims which cover developing a joint approach to commissioning, achieving the best outcomes for service users and carers, fostering recovery, social inclusion and equity and achieving a balance of investment across a range of supports. The main outcomes include; improving the health outcomes for people with severe and enduring mental health, reducing admissions to hospital, developing an integrated care pathway and developing a balance of services that are preventative and those that provide intensive support. Improving the health outcomes for people with severe and enduring mental health problems

Local Strategic Objectives: We will make services more accessible and develop our communities. We will deliver services within an integrated care model. We will provide care close to home.

Sensory Impairment

The Strategy for Sensory Services in Scottish Borders (2012-2017) is founded on the belief that people who have a sensory loss have an equal right to access appropriate opportunities and services. Sensory impairment encompasses visual impairment, hearing impairment and dual sensory impairment. The Strategy is outcome focused and centres on improving the lives of individuals with sensory loss and their carers. Hearing and/or sight loss can significantly impact on health and/or social care needs.

Summary figures from this and/or later work

- Approximately 500 of our resident population are estimated to be blind or have severe sight loss.
- Approximately 1,800 of our resident population are estimated to have severe or profound hearing loss.

Key Themes and Outcomes Identified

The Strategy has 3 key objectives: Improve Access, Develop effective and integrated services, Ensure high quality of delivery of services. Outcomes identified include: people have equality of assess, individuals are fully involved in the design and planning of services, services are effective and person centred, more effective processes are in place, and support plans are based on outcome and individuals feel they are appropriate to their needs.

Local Strategic Objectives: We will seek to enable people to have more choice and control, we will seek to reduce health inequalities; we will make services more accessible and develop our communities, we will deliver services within an integrated care model.

Adult Support & Protection
The Adult Support and Protection (Scotland) Act 2007 was enacted in 2007 and imposes legal duties and powers to support and protect those adults identified as "Adults at Risk" of harm in Scotland. The Adult Support and Protection (Scotland) Act 2007 forms part of a protective suite of legislation for "at risk" adults in our communities which also includes the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003.
Key Themes and Outcomes Identified
Within Scottish Borders there is a clear multi-agency Training Programme and Training Strategy. Specialist development sessions and forums are in place to disseminate knowledge, share good practice, and enhance practitioner's skills. ***Local Strategic Objectives: We will seek to enable people to have more choice and control, we will seek to reduce health inequalities; we will make services more accessible and develop our communities, we will deliver services within an integrated care model.***

Conclusion of Joint Strategies – Making the connections

From all of the above it is apparent that the planning and policy landscape is complex. In order to affect maximum impact and positive improvements we therefore need to ensure a thread runs through all of our planning and all of our work and ensure that it's well connected.

Section 3 The Case for Change

Making the case for change is at the centre of this Plan. If we do nothing the health and care system will not be able, in its current form, to continue to deliver the high quality service we expect to meet the needs of the Borders population. Ultimately our case for change is built on a number of key drivers which are articulated throughout this draft plan. These are summarised in the diagram below.

We have described our case for change through an analysis of our current health and social care outcomes, the strategic aims based on this analysis, the financial context in which we work and a gap analysis which has allowed us to focus on local priorities. Now, in the section below we set out our local strategic objectives to bring about the transformation of local health and social care services in the coming years.

The Move towards Personalisation and Self Directed Support (SDS)

There has been a gradual shift in the way care has been delivered from one where the professional identifies the need and delivers a service with a passive role for the service user and carer, to one that enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being

a recipient of services, citizens can become actively involved in selecting and shaping the services they receive. Personalisation seeks to enable people to plan and choose health and social care support that is more flexible and can better suit their individual needs. As part of personalisation, individuals are supported to make informed choices about meeting their assessed needs, and where they wish to, are supported to manage the support they receive.

Self-Directed Support aims to empower people to direct their own care and support and to make informed choice about how their support is provided. Regardless of the care setting, services can be individualised to become tailored to individuals' choices and preferences. For some service users, this may mean choosing to use a direct payment to manage their own support. For others, it may mean being a recipient of a service provided by the NHS, Council, Independent or Third Sector, or a combination of these.

The Move towards Co-production

Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way both services and neighbourhoods become far more effective agents of change.

The purpose of co-production is to encourage people and communities to use the human skills and experience they have to help deliver public or voluntary services.

Potentially the move towards co-production will radically alter the way that the Partnership will plan for the provision and delivery of services during the first three year strategic planning period. In the next planning period, the first steps towards the scaling up of co-production approaches will be supported throughout the component parts of the Implementation Plan and through the broader developmental work that needs to be in place to support such a fundamental change.

The Move towards Technology Enabled Care

The move towards greater utilisation and mainstreaming of Technology Enabled Care (TEC) is an integrated part of care planning.

The "20:20 vision for Health & Social Care" provides the strategic context for TEC and is seen as vital to the successful delivery of this vision.

The National vision is to mainstream and spread technologies across Scotland. The drivers for this are the National TEC Programme (2014-2016), the National Telehealth and Telecare Delivery Plan (2015) and the Integrated Care Fund for Scotland which aims to:

"*enable greater choice and control in health and wellbeing services for an additional 300,000 people by March 2016, enabling more of our citizens to remain at home in their communities*"

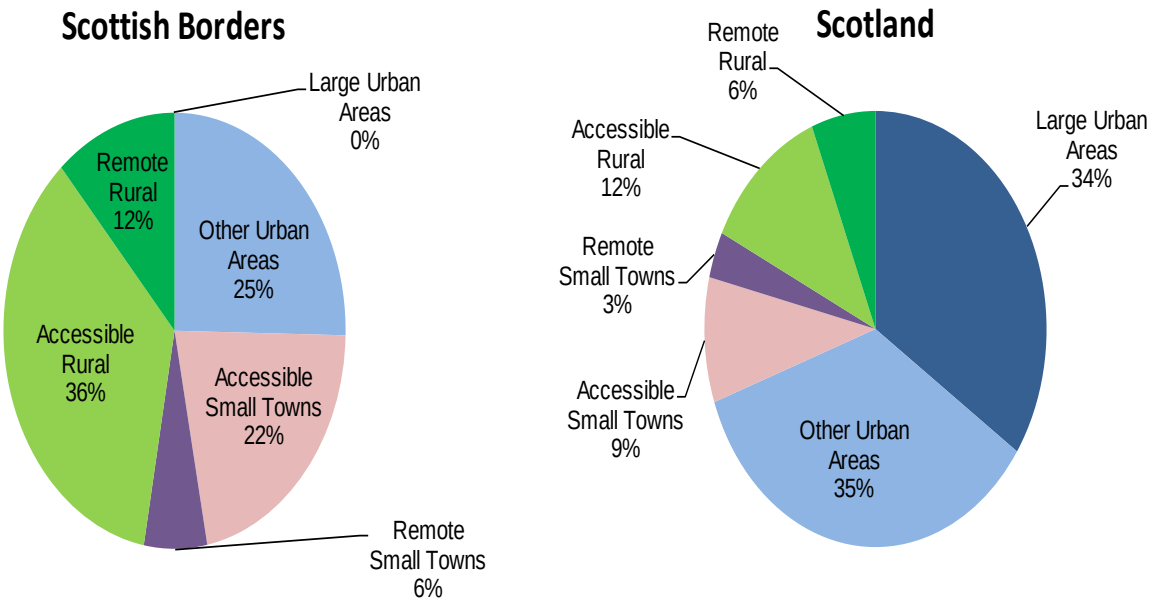
Our Local Strategic Objectives - What we Know, What you have told us and what we will do

This section provides a summary description of what we know about our health and social care in Borders, what our staff partners and our communities have told us through our recent engagement exercise throughout May & June 2015 and then what this could look like over the next three years as a result of each of our strategic objectives being implemented. Fuller detail on the change programmes, when agreed, will be set out each year in dedicated delivery plans and our business action plan.

Local Strategic Objective 1
We will make services more accessible and develop our communities

What we already know – what does our Joint Needs Assessment tell us?
Scottish Borders is a rural area, with nearly half (48%) of the population in 2012 living in rural areas. Three out of every ten residents live in settlements of under 500 people or in isolated hamlets. Conversely, whilst 34% of the Scottish population live in "Large Urban" areas (part of towns/cities with populations of more than 125,000), there are no "Large Urban" areas in Scottish Borders. The largest town is Hawick, with a 2011 Census population of 14,029, followed by Galashiels with 12,604 – although, if neighbouring Tweedbank were included, Galashiels would be the largest town in Scottish Borders with a population of 14,705. The only other towns with a population of over 5,000 people are Peebles, Kelso and Selkirk.

Population shares (%) by Urban/Rural area, 2012



Category	Description
1 – Large Urban Areas	Settlements of 125,000 or more people.
2 – Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 – Accessible Small	Settlements of 3,000 to 9,999 people and within 30

Towns	minutes drive of a settlement of 10,000 or more.
4 – Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 – Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 – Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland. www.gov.scot/Publications/2014/11/2763/downloads

The relatively low population density, and the urban/rural profile of Scottish Borders, has implications on the costs of providing services in Scottish Borders, especially compared to densely populated city environments such as Glasgow, Edinburgh and Dundee. The uneven distribution of the population in Scottish Borders also makes it harder to plan services, with residents scattered in isolated hamlets in many parts of the region, yet with towns such as Hawick having a higher average population density than Glasgow.

Combinations of circumstances such as low income, disability, poor quality accommodation and no private transport can exacerbate access deprivation for vulnerable people, making it more difficult for them to access services.

What our staff and communities have told us?

- Improved access to services that are flexible and preferably 24/7
- Better access to reliable and accessible information both on and offline
- Education and training in communities to build up knowledge and skills of key issues
- Single points of information to enable better signposting for patients and clients
- Increased use of the third sector
- Equity of access across all localities

What are the key areas of development over the next 3 years?

- We will improve access to our services, but also to assist people and communities to help and support themselves too
- We will develop local services to local needs and ensure information is available at all times in the right place and in the right format
- We will communicate in a clear, open transparent manner

Strong communities are a real asset to the Scottish Borders. Community capacity building has the potential to significantly improve the health and independence of people with heath and social care needs.

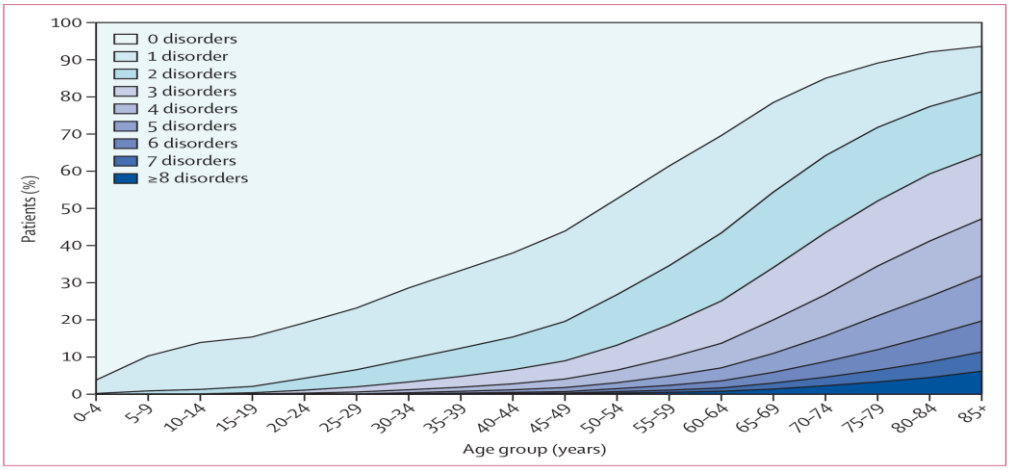
Local Strategic Objective 2
We will improve prevention and early intervention

What we already know – what does our Joint Needs Assessment tell us?

Whilst long-term health conditions are a significant challenge to the planning and delivery of health and social care services, even more so is "multi-morbidity", referring to people who suffer two or more long term conditions at the same time. An examination of anonymised records for over 1,750,000 GP practice patients across Scotland (Barnett et al, 2012) found that:-

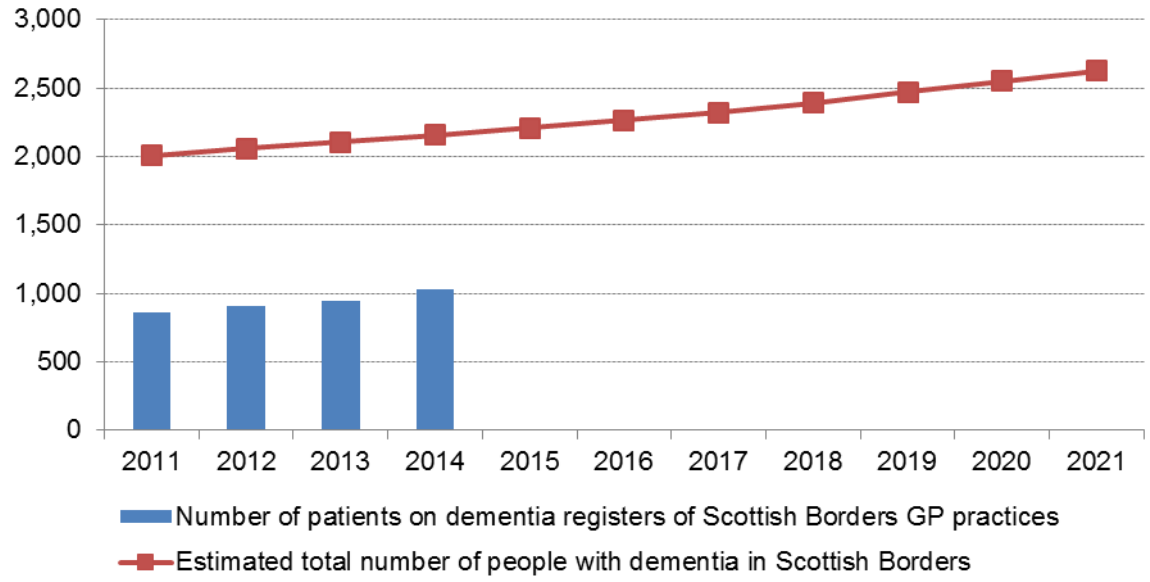
- 42.2% of the patients had one or more out of a set of 40 morbidities (long term conditions rather than short-term /minor issues).
- 23.2% of the patients overall had two or more morbidities (that is, they had "multi-morbidity").
- Prevalence rates of multi-morbidity rose with age; nearly two thirds of patients aged 65-84 and more than 8 in 10 patients aged 85+ had multi-morbidity.
- Multi-morbidity can occur at any age, however, and the absolute number of people with multi-morbidity who were aged under 65 was higher than the absolute number aged 65 and over. This reflects that the total population aged under 65 is larger than the total population aged 65 and over.
- Onset of multi-morbidity tended to occur at a younger age (10-15 years earlier) in people living in the most deprived areas compared with the most affluent.
- Socioeconomic deprivation was associated with an increased prevalence of multi-morbidity that included a mental health disorder. 11.0% of people in the most deprived areas had both a physical and mental disorder, compared with 5.9% of people in the least deprived areas.

Percentages of patients having one or more out of 40 chronic disorders, by age group, Scotland 2007



Dementia also presents a significant challenge for health and care services, now and going forward into the future. Estimates suggest that the prevalence of dementia will continue to rise across Scotland and that in Scottish Borders the rate of increase will be faster than the national average, given the relatively higher proportion of older people in our population. Overall, the number of people with dementia may double within the next ten years.

Diagnosed dementia cases in Scottish Borders versus Scottish Government projections of possible overall prevalence



Sources:
1. Diagnosed cases: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof
2. Estimated overall prevalence: Scottish Government projection, based on Eurocode prevalence model used by Alzheimer's Scotland, and 2010-based population projections.

What our staff and communities have told us?

- Education and training for staff and communities

- A focus on prevention and early intervention opportunities
- More support for unpaid carers
- Improved discharge planning
- Honest conversations at the right time
- All relevant health and social care staff having the correct information

What are the key areas of development over the next 3 years?

- We will promote shared-management of LTCs by developing personalised care and support planning that empowers patients and carers to be actively involved in their care
- We will support professionals to have the necessary competencies, including carer awareness, through workforce development
- We will strengthen a partnership approach and connections to local resources
- We will prioritise preventative, anticipatory and early intervention approaches
- We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crisis

Ensuring people who are struggling to manage independently can be rapidly supported through a range of services that meet their individual needs.

Local Strategic Objective 3
We will reduce avoidable admissions to hospital

What we already know – what does our Joint Needs Assessment tell us?

Over the past ten years, overall rates of emergency hospital stays and multiple emergency admissions for Scottish Borders residents have been consistently higher than the Scottish averages, and since the 2009/10 financial year have been increasing more rapidly than those for Scotland.

- By far the highest rates of emergency admissions to hospital are amongst people aged 75 and over. In 2004/05, 3,285 hospital inpatient stays for Scottish Borders residents began with an emergency admission (a rate of 338 per 1,000 population in this age group). By 2013/14 the (provisional) total had risen to 4,310 hospital stays (a rate of 382 per 1,000 population).

- The increase over the past ten years in emergency admissions amongst the over 75s accounts for approximately half of the overall increase in numbers of emergency admissions across all adult (age 15+) residents in Scottish Borders.

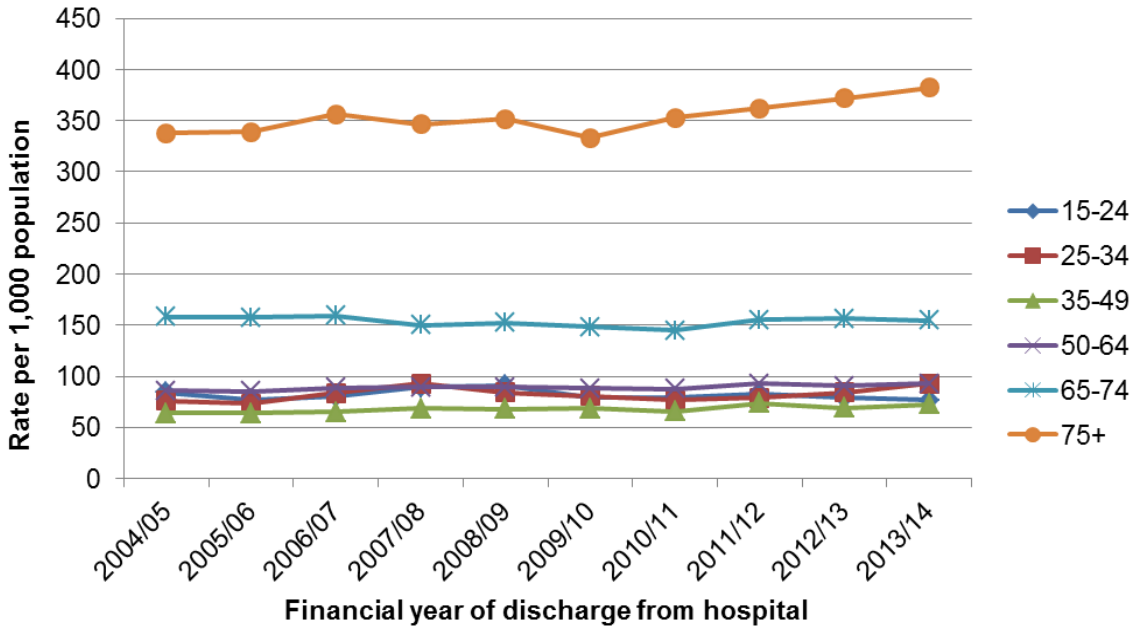
- Similarly, by far the highest rates of multiple emergency admissions occur in people aged over 75, and it is in this age group that increases over time are

the most pronounced. In 2004/05, 634 Scottish Borders residents aged 75 and over had two or more emergency hospital stays within one year (a rate of 65 per 1,000 population). By 2013/14 this had increased to 937 people (a rate of 83 per 1,000 population).

- Emergency admission rates vary by locality of residence as well as age. For example, in 2013/14 the highest emergency admission rate amongst people aged 75+ was amongst those living in Eildon Area Forum Locality. The lowest emergency admission rate in this age group was amongst people living in the Cheviot Area Forum Locality.

Note that the figures given above exclude patients admitted to Geriatric Long Stay beds and/or hospital stays that exceeded one year in duration.

Scottish Borders residents admitted to hospital as an emergency; trends in rates per 1,000 population, by age group



Source: Hospital Care National Statistics, ISD, NHS National Services Scotland, published Dec 2014
www.isdscotland.org/Health-Topics/Hospital-Care/

Emergency admissions to hospital in Scottish Borders residents aged 75+, for the year ending 31 March 2014. Rates per 1,000 population, by Area Forum locality

Source: ISD, NHS National Services Scotland (bespoke analysis conducted for Scottish Borders)

What our staff and communities have told us?

- Empower people through self-management and self-referral
- Improved signposting to services – statutory and voluntary
- Resources available to provide home care packages, equipment etc. as soon as they are needed
- Ensure there are other services to avoid last resort admission to hospital
- Improved discharge planning to avoid delays
- Only admit to one hospital rather than the BGH and then the Community Hospitals

What are the key areas of development over the next 3 years?

- We want to reduce unnecessary demand for services including hospital care. If a hospital stay is required we will minimise the time that people are delayed in hospital

By having the appropriate support in the right place at the right time, we can ensure people are supported to remain in their own homes.

Local Strategic Objective 4
We will provide care close to home

What we already know – what does our Joint Needs Assessment tell us?

We are increasing the range of options available to look after people in or close to their home. The options include provision of care packages to people in their own homes, increasing the numbers of people in receipt of Self-Directed Support, and provision of supported and sheltered housing.

- In 2014 the percentage of people aged 18+ receiving personal care at home, rather than in a care home or hospital, was 65% in Scottish Borders compared to an average of 62% for Scotland.

What our staff and communities have told us?

- Improved career/ professional and recruitment opportunities for home carers
- Resources to provide home care packages as soon as they are needed
- More recognition and support for home carers
- More information on Self-Directed Support
- Clear definitions for cross-Border working

What are the key areas of development over the next 3 years?

- We will work with our staff to create a dynamic workforce to ensure we can deliver on the aims and objectives outlined within this plan, allowing varied recruitment across health and social care
- We will support people to live independently and healthily in local communities by providing the right support at the right time by the right person.
- We will provide accessible information on the support available to patients and their carers.
- We will design accessible care which meets the needs of the local communities which allows people to receive their care close to home and build stronger relationships with care providers.

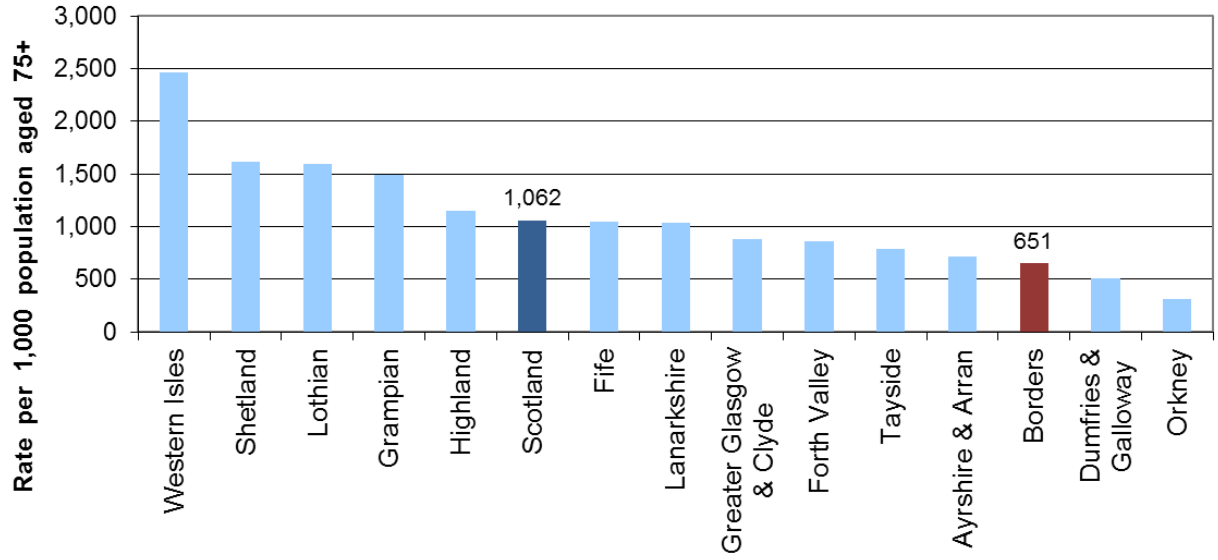
Local Strategic Objective 5
We will deliver services within an integrated care model

What we already know – what does our Joint Needs Assessment tell us?

A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons. Over the period January to December 2014, 84% of bed-days occupied by adults in NHS Borders hospitals due to delayed discharge were for

patients aged 75 and over, higher than the 73% average for Scotland. However, we already know that Borders has a higher proportion of older people than the Scottish average. Furthermore, for patients whose discharge from an NHS Borders hospital is delayed, the rate per 1,000 population of bed-days occupied patients aged 75+ is one of the lowest amongst the NHS Boards in Scotland, as shown in the graph below.

Delayed discharges from inpatient care, patients aged 75+: Bed days occupied per 1,000 population, January-December 2014, by NHS Board



Source: Delayed Discharge Census, ISD Scotland, www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/

What our staff and communities have told us?

- Co-located services e.g. in hospital
- More generic roles
- Have different types of beds, acute not needed all of the time (step up, step down)
- Integrated multi-disciplinary teams
- Improved IT opportunities between organisations

What are the key areas of development over the next 3 years?

- We will ensure robust and comprehensive partnership arrangements are in place
- We will pro-actively integrate health and social care services and resources for adults
- We will integrate services and staff supported by the development of integrated strategy, systems and procedures

Through working together, services will become more efficient and effective providing a better service to people who use their services and more satisfaction to those who provide the service.

Local Strategic Objective 6
We will seek to enable people to have more choice and control

What we already know – what does our Joint Needs Assessment tell us?

The national Health and Care Experience Survey 2013/14 is a useful source of information on the experiences of people aged 16+ who have received help and care services for everyday living. Although the numbers of people included in the survey are relatively small (it was sent to a random sample of people aged 16+ registered at each GP practice in Scotland), the survey design means that the results provide a good overview of the experiences of people who have received care within each Local Authority area. In Scottish Borders, 197 survey respondents (out of 2,576 respondents overall) indicated that they had received help and support with everyday living from their Council, the NHS, voluntary organisations or private care agencies. The results of the Health and Care Experience Survey 2013/14 suggest that the experiences of these randomly sampled care recipients tend to be fairly positive overall, but also that there is scope for improvement. Findings included:-

- Whilst 80% of the care recipients agreed or strongly agreed that they had a say in how their help, care or support was provided, 6% disagreed or strongly disagreed. A further 13% neither agreed nor disagreed. The 80% responding positively to this question in Scottish Borders was lower than the 83% overall for Scotland.

- Whilst 79% agreed or strongly agreed that their health and care services seemed to be well coordinated, 8% disagreed or strongly disagreed.

- Whilst 83% agreed or strongly agreed that they were supported to live as independently as possible, 4% disagreed or strongly disagreed with the statement. A further 14% neither agreed nor disagreed.

- 81% agreed or strongly agreed that they felt safe, lower than the 85% overall for Scotland.

Experiences of a sample of care recipients in Scottish Borders, 2013/14

Question	Number of responses	Response				Borders % Positive 2014	Scotland % positive 2014
		Very positive	Positive	Neutral	Negative		
Q36a. People took account of the things that matter to me	190	42%	48%	8%		90	88
Q36b. I had a say in how my help, care or support was provided	191	33%	47%	13%		80	83
Q36c. I was treated with respect	189	43%	50%			93	92
Q36d. I was treated with compassion and understanding	186	39%	49%	10%		88	89
Q36e. My health and care services seemed to be well coordinated	187	34%	45%	13%	8%	79	79
Q36f. I was supported to live as independently as possible	182	38%	44%	14%		83	84
Q36g. I felt safe	185	39%	42%	16%		81	85
Q36h. The help, care or support improved or maintained my quality of life	178	39%	44%	15%		83	85
Q37. Overall, how would you rate your help, care or support services?	201	38%	45%	14%		83	84

Explanation of graph:-

Number of responses - the number of survey respondents in Scottish Borders who provided a valid response to this question. People who indicated that a question was not relevant to them, or who did not know the answer, are not included in the results.

Response - The percentage of positive, neutral and negative responses received for this question within Scottish Borders. For example, when asked if they were supported to live as independently as possible, the percentage positive refers to care recipients who strongly agreed or agreed. Where care recipients said they disagreed or strongly disagreed these responses have been counted as negative. Where they neither agreed nor disagreed their responses have been counted as neutral.

Borders % Positive 2014 - the percent positive result; the total percentage of patients who responded positively (very positive + positive) to this question within Scottish Borders.

Source: Health and Care Experience Survey 2013/14, www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

The results of the Health and Care Experience Survey 2013/14 also indicate clearly that there is scope for improving the situation for carers in Scottish Borders. Findings included:-

- 30% of the Carers felt that caring had a negative impact on their own health and wellbeing; only 42% disagreed that there was any impact on them (the remaining 27% neither agreed nor disagreed).

- Only 41% agreed that they felt supported to continue in their caring role, lower again that the Scottish average of 44%.

- Whilst 54% felt they had a say in the services provided for the person(s) they looked after (better than the Scottish average of 49%), 20% disagreed (the remaining 27% neither agreed nor disagreed).

- Only 44% felt that the services for the person(s) they looked after were well co-ordinated, compared with 48% nationally.

Experiences of a sample of carers in Scottish Borders, 2013/14

Question	Number of responses	Response: Very positive	Positive	Neutral	Negative	Borders % Positive 2014	Scotland % positive 2014
Q45a. I have a good balance between caring and other things in my life.	337	24%	44%	20%	12%	68	70
Q45b. I am still able to spend enough time with people I want to spend time with.	332	22%	49%	16%	13%	71	72
Q45c. Caring has had a negative impact on my health and wellbeing.	324	14%	29%	27%	30%	42	42
Q45d. I have a say in services provided for the person I look after.	307	13%	41%	27%	20%	54	49
Q45e. Services are well coordinated for the person(s) I look after.	304	14%	30%	39%	17%	44	48
Q54f. I feel supported to continue caring.	306	11%	31%	41%	18%	41	44

Source: Health and Care Experience Survey 2013/14, www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

What our staff and communities have told us?

- Further information and funding for Self-Directed Support providing choice and flexibility
- Increasing use of community hospitals, day centres and community hubs and providing more health and care services locally
- Having the right information available for families to make decisions

What are the key areas of development over the next 3 years?

- We will ensure choice and control is extended across all health and social care services as far as practicably possible.

Allowing people to have more choice and control of their health and social care

services means they can receive the right services at the times they want to receive them.

Local Strategic Objective 7
We will further optimise efficiency and effectiveness

What we already know – what does our Joint Needs Assessment tell us?

Health and Social Care resources are not utilised evenly across the population. As a Partnership, we need to develop a better understanding about the people who use very high levels of resource and use this knowledge to help plan our services. For example, where someone has had multiple hospital admissions and/or visits to A&E, it might have been more appropriate to deliver more of their care at home or in another community setting and reduce the risk of them having an avoidable admission to hospital. Changes in how care is provided to these people could produce better outcomes for them and their carers and allow us to treat more people more effectively.

To date, it has been possible to analyse money spent per patient across the following major health services:-

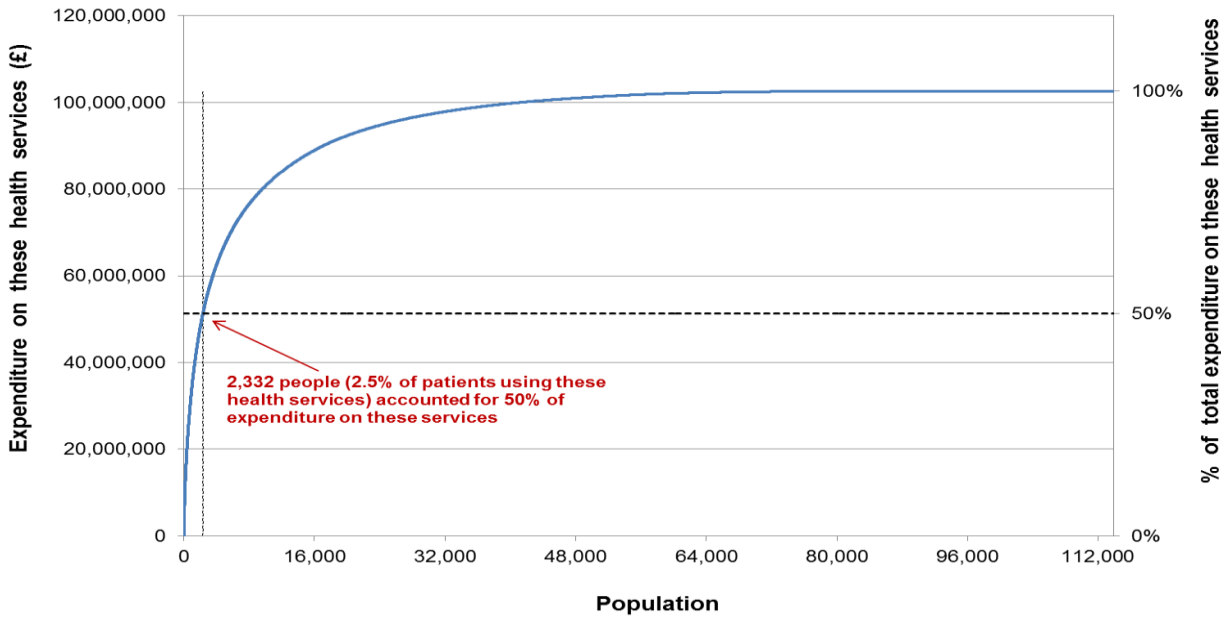
- Inpatient and day case hospital admissions (including all acute specialties, maternity, geriatric long stay inpatient care, and psychiatric inpatient care)
- A&E attendances
- New attendances at consultant-led outpatient clinics
- Community prescribing

"High Resource Individuals" (HRIs) are defined as the group of people who between them account for 50% of total expenditure. From analysis of expenditure in 2012/13, it has been identified that:-

- 2,332 people (2.5% of all Scottish Borders residents using any of these health services) accounted for half of all expenditure on this group of major health services.
- 1,451 people aged 65 and over (7% of Scottish Borders residents in this age group, who used any of these health services) accounted for half all expenditure on the over 65s across those services.

Future work is planned to include additional services in this analysis, as health and social care information is integrated and more becomes available at individual patient/service user/carer level. This will allow us to look in more detail at the combinations of services that HRIs use and to examine where we could improve pathways of care.

Cumulative expenditure for selected major health services*; for Scottish Borders residents; financial year 2012/13



*Health Services included are: inpatient and day case hospital care, A&E attendances, new attendances at consultant-led outpatient clinics, and community prescribing.

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

What our staff and communities have told us?

- Clear understanding of local population demographics and services needed
- Resource flexibility to better support people when they need services
- Streamlining of process
- Improved access to IT systems across organisations

What are the key areas of development over the next 3 years?

- We will institute a transformational change programme across the functions delegated to the partnership
- We will efficiently and effectively manage resources to deliver Best Value
- We will support the development of staff

Strategic commissioning requires us to constantly analyse, plan, do and review our services allowing us flexibility to change what we do and how we do it.

Local Strategic Objective 8
We will seek to reduce health inequalities

What we already know – what does our Joint Needs Assessment tell us?

We know that many people in our population endure ill health from one or more Long Term Conditions and that these may impact upon the way in which they need to access and use services. Some of the numbers of people affected are:-

- 601 people with Learning Disabilities were known to Scottish Borders services in 2013
- 6,995 residents of Scottish Borders reported a physical disability in 2011 (Scotland Census)
- Approximately 500 of our resident population are estimated to be blind or have severe sight loss*
- Approximately 1,800 of our resident population are estimated to have severe or profound hearing loss*

*Based on estimated hearing/sight loss prevalence rates for the UK population, applied to official population estimates for Scottish Borders.

We also know that if people do not have access to a car or other means of private transport, that public transport journey times can be very long in some parts of the Borders.

- The longest estimated drive times to a GP are 15-20 minutes for people living in the following four "datazones" (small areas):- Teviothead and the area around (but not including) Newcastleton; Ettrick, Ettrickbridge & around; Broughton & Upper Tweed; Cockburnspath/Cranshaws/Abbey St Bathans.

- Meanwhile, in six rural datazone areas, estimated average public transport journey times to a GP were an hour or more. These areas were:- Teviothead and the area around (but not including) Newcastleton; Broughton & Upper Tweed; Bonchester Bridge/ Chesters; Midlem/ Lilliesleaf/Ashkirk; Yarrowford/ Yarrow Feus & around; Longformacus/ Westruther/ Polwarth.

What our staff and communities have told us?

- Address rurality and isolation issues which can lead to health implications
- Improved co-ordinated community transport
- Increase opportunities for social interaction through accessibility to services

What are the key areas of development over the next 3 years?

- We want to reduce inequality in particular health inequality, and support and protect vulnerable people in our communities

Ensuring that people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.

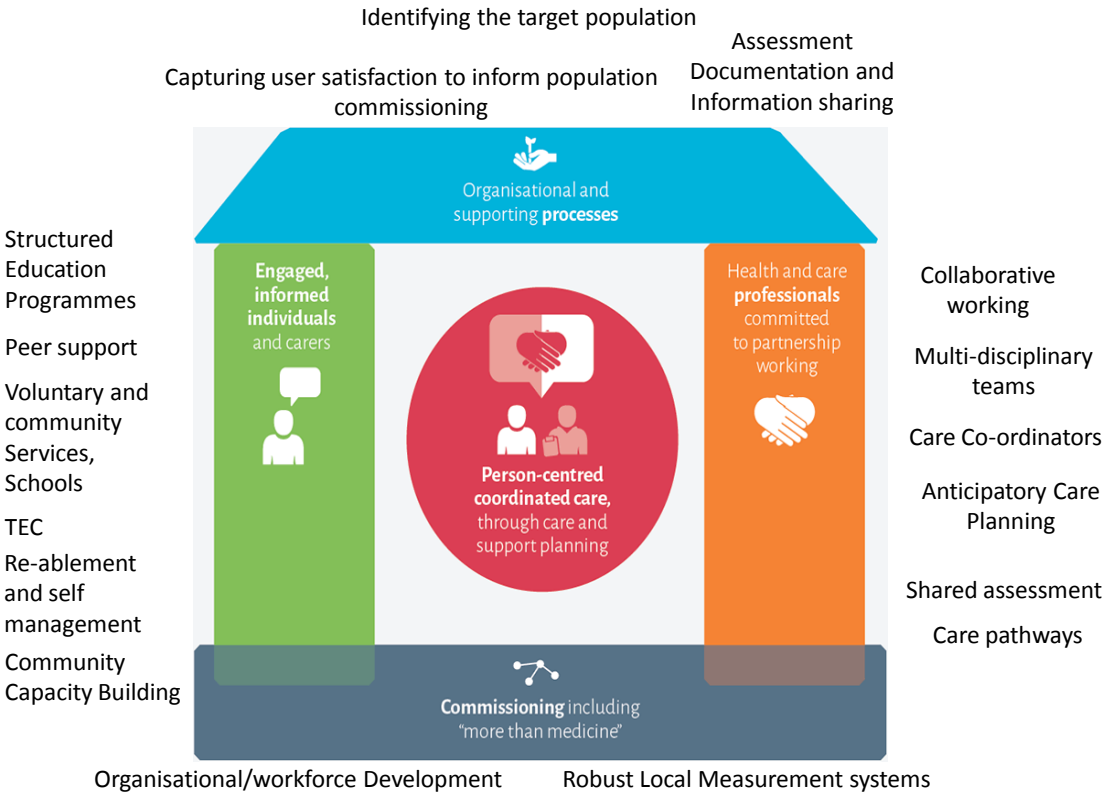
The proposed approach

The barriers to great care for people with long term conditions have been identified by a wide range of reports and reviews, and can best be summed up as failure to provide integrated care.

- **Single condition services:** services dealing with single conditions only and adopting single condition guidelines (with attendant dangers of polypharmacy, and excluding an holistic approach to service users).
- **Lack of care coordination:** people being unaware of whom to approach when they have a problem, and nobody having a generalist's 'bird's eye' view of the total care and support needs of an individual.
- **Emotional and psychological support:** in particular, a lack of attention to the mental health and wellbeing of people with 'physical' health problems (as well as failure to deal with the physical health of people with mental disorder as their primary long term condition).
- **Fragmented care:** the healthcare system remaining within its own economy, and not being considered in a whole system approach with social care or other services important to people with long term conditions (e.g. transport, employment, benefits, housing). Failure to support people with 'more than medicine' offers as provided by, for example, third and voluntary sectors.
- **Lack of informational continuity:** care records which can't be accessed between settings, or to which patients themselves don't have access.
- **Reactive services, not predictive services:** ***failure*** to identify vulnerable people who might then be given extra help to avoid hospital admission or deterioration/complications of their condition(s).
- **Lack of care planning consultation:** services which treat people as passive recipients of care rather than encouraging self-care and recognising the person as the expert on how his/her condition affects their life.

One of the key successes for this partnership will be to change the way we deal with long term conditions to overcome these barriers, shifting to a more integrated and person-centred model of care and support planning. Personalised care involves patients, carers and professionals working together to prepare for consultations, discuss options, agree goals and how these will be achieved, and review progress. Such an approach takes into account the expertise and resources of those affected by long term conditions and their carers and supports a holistic approach that improves health and social care outcomes.

House of Care approach, illustrated in the diagram below, provides a framework for making that shift. House of Care supports the development of person-centred, coordinated care that will enable individuals to make informed decisions which are right for them, and empower them to manage their long term conditions in partnership with health and care professionals.



The House of care model relies on four key interdependent components, all of which must be present for the goal, person-centred coordinated care, to be realised:

1. *Commissioning* – which is not simply procurement but a system improvement process, the outcomes of each cycle informing the next one.
2. *Engaged, informed individuals and carers* – enabling individuals to self-manage and know how to access the services they need when and where they need them.
3. *Organisational and clinical processes* – structured around the needs of patients and carers using the best evidence available, co-designed with service users where possible.
4. *Health and care professionals working in partnership* – listening, supporting, and collaborating for continuity of care.

The House of care model is useful for drawing together the building blocks of integrated care to incorporate the essential elements of continuity:

- Informational continuity: by which people and their families/carers have access to information about their conditions and how to access services;

health and social care professionals will have the right information and records needed to provide the right care at the right time.

- Management continuity: a coherent approach to the management of person's condition(s) and care which spans different services, achieved through people and providers collaborating in drawing up collaborative care plans.

- Relational continuity: having a consistent relationship between a person, family, and carers and one or more providers over time (and providers having consistent relationships with each other), so that people are able to turn to known individuals to coordinate their care.

This framework is suitable for all people with LTCs, not just those with single diseases or in high risk groups. To implement this requires a large number of complex changes. It is not just a question of changing patient attitudes, or workforce cultures, or organisational or commissioning systems, each of which by itself is a huge challenge; radical change in all these areas is required.

Moreover, this change needs to occur system-wide, vertically as well as horizontally. This entails the House framework being used in 'front-line' clinical practice, and being supported by local and national policy and strategy.

By implementing and delivering against our strategic objectives and changing our services to support a house of care model, we can achieve the best possible outcomes for the people of the Scottish Borders.

Rather than addressing these objectives independently, this Strategic Plan will look innovatively to an integrated approach which seeks to maximise health gain and the improvement of social care outcomes. The Plan should therefore deliver on the ambition of the Health and Social Care Partnership to promote integrated planning and to encourage integrated working.

The Strategic Plan aims to enhance the capacity of the whole system to improve health and social care outcomes, providing the tools for communities and a wide range of organisations to promote and improve health and wellbeing. The delivery of the plan should therefore result in the development of sustainable skills, structures and resources which maximise opportunities for health improvement and reduce inequality at every opportunity.

Section 4 Locality Planning

Locality planning is a key element of Health and Social Care Integration which, with the enactment of the Public Bodies (Joint Working) (Scotland) Act, becomes a legal requirement in relation to the planning and delivery of health and social care services. This Strategic Plan requires to provide details of the way in which the statutory partners plan to commission services in identified localities.

Locality planning is:

- Joint strategic planning that is effectively and demonstrably informed by, and responsive to, local priorities, as articulated by professional leaders and other stakeholders. These include users, carers, third and independent sector representatives, elected members and community representatives who understand local needs; and

- Professionals being empowered to agree and initiate changes to services at the locality level which are of benefit to the local population.

In working towards the delivery of the National Health and Wellbeing Outcomes, the Public Bodies (Joint Working) (Scotland) Act states that services and support should be planned and provided in a way that is consistent with the Integration Principles as set out in Section 25 of the Act, which are:-

(a) that the main purpose of services which must or may be provided in pursuance of the integration functions for the council area is to improve the wellbeing of recipients;

(b) that those services should be provided in a way which:

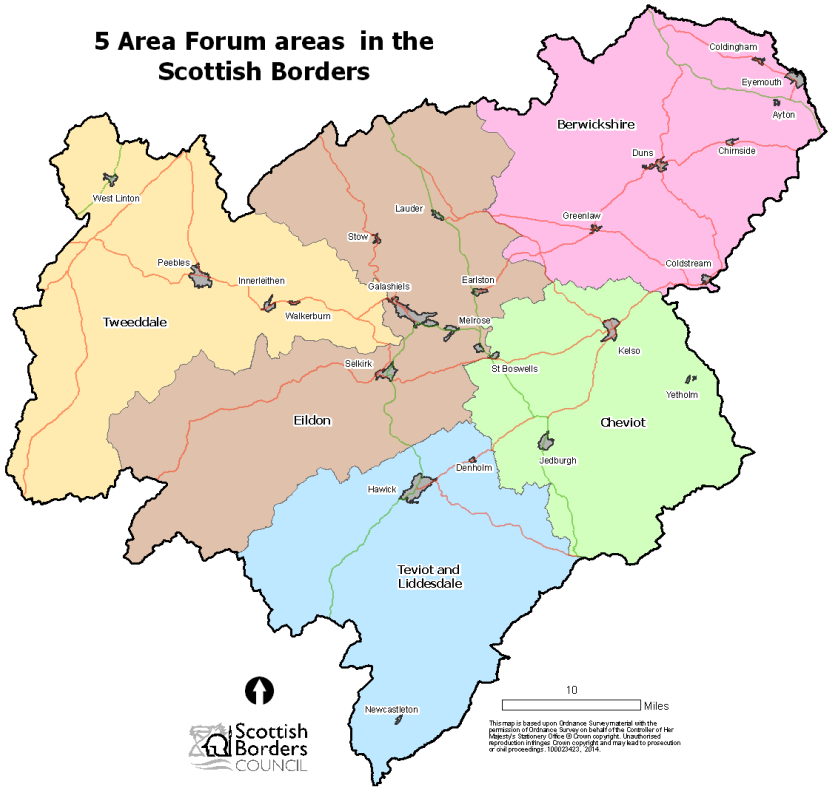
- is integrated from the point of view of recipients;
- takes account of the particular needs of different recipients;
- takes account of the particular needs of recipients in different parts of the area in which the service is being provided;
- is planned and led locally in a way which is engaged with the community and local professionals;
- best anticipates needs and prevents them arising; and
- makes the best use of the available facilities, people and other resources.

Locality Planning in the Scottish Borders will have two main purposes:

- to jointly assess need, prioritise and plan how all resources, irrespective of their origin, can best be deployed in pursuit of the delivery of the National Outcomes for Health and Social Care; and

- to be the local focus for service delivery and support to the population or communities within the area concerned. These services and support may be provided through the statutory, independent, or voluntary sectors, or from within or between local communities.

For this Strategic Plan to take account of local needs and resources and the different needs of different people in each area, it will require to be constructed from the bottom up and there will, therefore, require to be effective engagement with all key stakeholders at a range of different levels, each with its own unique purpose within the strategic planning process.



Building and supporting strategic partnerships

This Health and Social Care Partnership will be built on strong relationships and partnerships with a number of stakeholders. Its ability to realise the National and Local Outcomes set out in this Strategic Plan will be dependent in large part on how well founded these partnership relationships are and how well they are integrated into the Partnership's Strategic Planning process.

Significantly, the development of Locality Planning will afford a very significant opportunity for much more extensive partnership engagement at a more local level.

The new Partnership will establish robust and comprehensive partnership arrangements with the following key groups:

Public Partnership

An enhanced relationship will be established with the general public thus ensuring that they are much more active participants in shaping their own health and social care in the future. The work of the new Partnership will greatly depend on active communities and families taking steps to improve their own health and to provide neighbourly care and support.

Partnership with service users and carers

The accepted way of working is one based on 'Co-production' which will include supporting service users and carers to be equal partners in, and contributors to, their own health care and support. The Partnership will put in place 'structural' arrangements for ensuring good joint work, for example, building on the strong foundation of the Public Partnership Forum and by changing overall working practice.

Partnership with workers within the Health and Social Care Partnership

The workforce, both Health and Council, is the main resource for the delivery of quality outcomes for people in Borders and the Partnership will support staff to be motivated, committed, skilled and valued. Extensive involvement of staff both formally (through staff partnership groups and staff involvement in strategic planning) and within operational teams is a key priority.

Partnership with Primary Care Independent Contractors

General Practice - As the primary universal healthcare service for the majority of people, General Practice is a vital component in the work of the Partnership. General Practitioners (GPs) are already engaged in a range of work programmes that support the strategic objectives of this Plan. The Partnership recognises the centrality and importance of this work and will consequently seek to strengthen its relationship with General Practitioners (through formal structures, at locality level, and in the way it shapes and manages its services). It will seek to listen to the challenges of this sector and to respond sensitively and practically to allow the GPs to be integrated fully into the Partnership's strategic planning and policy development.

Community Pharmacy - Community Pharmacists play an increasingly clinical role. This provides major opportunities for the Partnership to work more collaboratively with Community Pharmacists to support local people. Community Pharmacies are located throughout Borders and are an important point of contact for the general public and service users. The Partnership will ensure that Community Pharmacists form an important part of our strategic planning and policy development and will jointly with them explore opportunities from the development of services provided from their premises.

Dentistry - Dentists and Dental Practices are located extensively throughout Borders and are a vital point of contact for a range of service users and the general public. The role traditionally played by Dentists is changing for example, in relation to public health issues and the contribution made by Dentists will be important to the delivery of agreed National and Local outcomes.

Optometry - Optometrists and Optician Practices are a vital point of contact for a range of service users and the general public. Increasingly Optometrists are playing a developing role, for example, in relation to public health issues such as smoking cessation. Again, their contribution forms an important contribution to the delivery of outcomes.

Partnership with Third Sector - The Third and Community sector play an important role in supporting the delivery of the Partnership's vision and mission. In Borders there has been significant strengthening of the valuable role of this Sector and there is a positive relationship in place which provides a solid foundation for future work.

Partnership with Independent sector - Arrangements are in place to ensure Independent Care Providers are included and engaged within significant planning processes, particularly in relation to adult and older people.

Partnership with other Local Authority Departments - In creating the Partnership it is vital that strong internal connections with council services are not lost or weakened. In particular, continuity and partnership planning will include:

- Education and Early Years;
- Housing and Housing Support Services;
- Leisure Services;
- Libraries; and
- Other support services.

Partnership with Non-Delegated Health Services "Non-delegated" refers to health services that are not under the direct responsibility of the Health and Social Care Partnership (for example planned hospital inpatient care). The Partnership will have a responsibility to support clinical and care pathways that lead to and from Acute Hospital sites, including services provided by other NHS Boards. Acute sector representation in the Strategic Planning Group and the development of patient pathways creates an opportunity for engagement across the sectors in a way that ensures a joint approach to the attainment of outcomes.

Partnership with and within the Community Planning Partnership - The Health & Social Care Partnership will have an important role within the Community Planning Partnership arrangements for Borders and support the delivery of specific key Single Outcome Agreement outcomes.

Housing

Having a suitable and affordable place to stay is at the very core of addressing an individual's health and social care needs and in meeting one of the National Outcomes for Health & Social Care regarding "Independent Living" – namely that "people, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community".

Housing providers and those who provide housing services will be key partners in the provision of health and social care services and in meeting the needs of individuals and families within our communities and will, therefore, be key to this Strategic Planning process and will be part of the membership of the Strategic Planning Group.

Section 5 Resource Overview

Financial Resources

This draft Strategic Plan for the emergent Scottish Borders Health and Social Care partnership is intended to be viewed as a continuum of work, with much still to be done to make the vision of the plan a reality. The plan provides the strategic framework for the development of health and care services over the next few years and lays the foundation for the integration of the plan into the core work of NHS, council and partners, with priorities and proposals reflected in the business plans of each organisation.

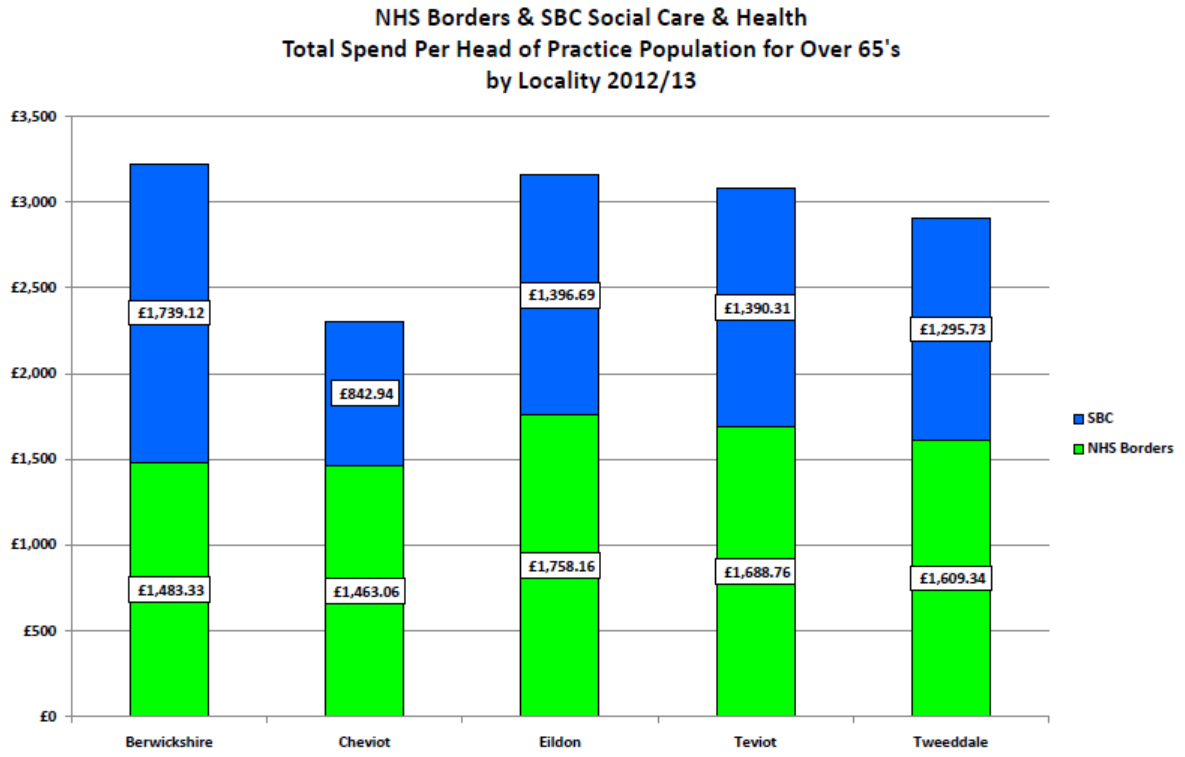
There is, therefore, a requirement to identify and develop a resource strategy, including a clear financial framework which will support delivery of the plan. Equally, there is clear recognition by NHS and council partners that whilst our aims and aspirations are extensive, the Strategic Plan and its associated programmes will have to be delivered within the finite resources available to the partner organisations.

Both NHS Borders and Scottish Borders Council have complex financial arrangements with three to five year financial plans which focus primarily on annual budget plans.

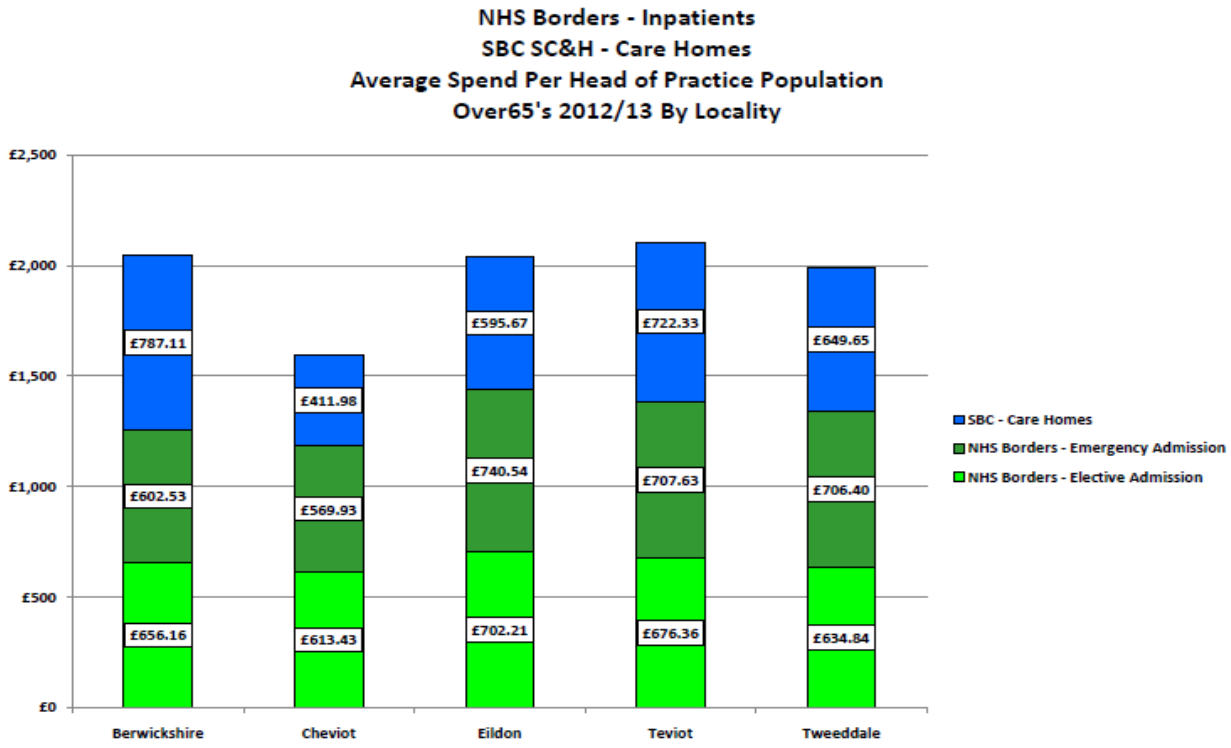
As set out as mandatory in the health and social legislation, resources for a number of functions will be delegated by the partner bodies to the Integrated Joint Board. The relevant functions and associated resources are detailed in appendix 3.

The Integrated Joint Board (IJB) will consider how it will utilise these resources to deliver the required outcomes of health and social care integration. The financials required to match the delivery programmes outlined in this document is challenging and not without risk linked to the financial environment and the financial challenges of the public sector.

The graph below outlines the total spend per head of practice population for over 65s by locality. The IJB will need to analyse and review how resources are directed and spent to understand any inequities and the reasons behind this.

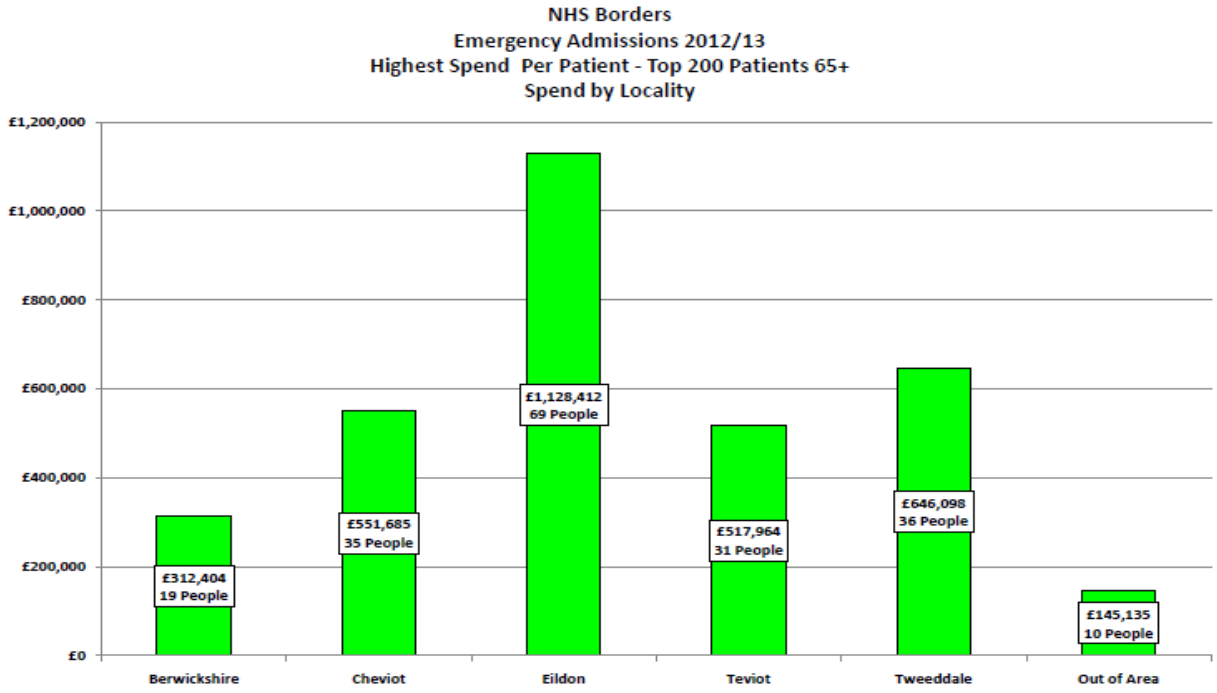


The clear imperative already derived from initial financial analysis, however, is that as a Health and Social Care partnership we must embed new ways of working which divert significant financial resources from expensive bed based models where clinically safe and appropriate, into community based services. We equally need to critically and robustly appraise and challenge our current local models of service delivery across the Borders to ensure we are focusing our combined resources on areas of most need and greatest impact. The amounts spent by locality in bed based care are detailed below.



There is divergence on the amount spent per locality within Borders. The IJB will analyse the reasons for this and where appropriate look to address any inequities.

There is a need to focus on high cost individuals who make significant use of our services in order to avoid unplanned high cost care and deliver care in the future in a way which meets the strategic aims highlighted in this report.



As the above issues are addressed systems and processes need to be put in place which ensures resources are redirected in line with the new models of care.

Transformational Change and Organisational Development

The Integration Joint Board will oversee a programme of transformational change which will see all activity areas, strategies, policies and operational procedures reviewed and appraised. Through this process, decisions will be made on how resources will be deployed in future years.

Section 6 Workforce Development

The changing nature of adult health and social care within the integration agenda is complex and challenging. In collaboration with all our partners and stakeholders Scottish Borders Health and Social Care partnership must ensure that the workforce of tomorrow, both paid and voluntary, are knowledgeable and skilled and able to respond to the changes outlined in this Strategic Plan. This will require flexible and responsive sectors and a workforce that is fit for the future.

To meet these challenges and deliver the vision for adult health and social care we expect the workforce to continue to diversify. They will be employed by individual employers, small to medium enterprises and large organisations across the NHS, local authority, private, voluntary and independent sectors and also in local communities.

The continued transformation of our care delivery will also result in a workforce that is deployed in a wider range of ways, including through integration with health, social care and, potentially, other public sector team arrangements. These teams will need to deliver care which provides more:

- Choice and control
- Self Directed Support
- Support to people with increasingly complex needs

Critical to delivering this and making it real is the need to develop leadership and vision that is shared and understood and linked to effective organisational development and sustainability. This will ensure quality and a commitment to continuous improvement.

Priorities will include the enhancement of workforce capacity and capability in some sectors, the development of community skills and capacity, and equipping people with the appropriate level of skills, competence and capability.

We recognise that an engaged and supported workforce underpins the delivery of our vision and is a key priority for the Strategic Plan. Therefore, the development of a supporting workforce development plan is underway.

Section 7 Commissioning

Strategic commissioning will help us realise our vision for the Scottish Borders through the way in which we design, develop and deliver improved and effective services that meet the needs of our changing population.

In developing this draft Plan we have already adopted a Strategic Commissioning approach in order to:

- Analyse and understand the evolving needs of our communities, so that we can shape the key strategic priorities that we are committed to deliver against; and

- Plan, design, and deliver appropriate services to meet the needs of our communities and secure value for money.

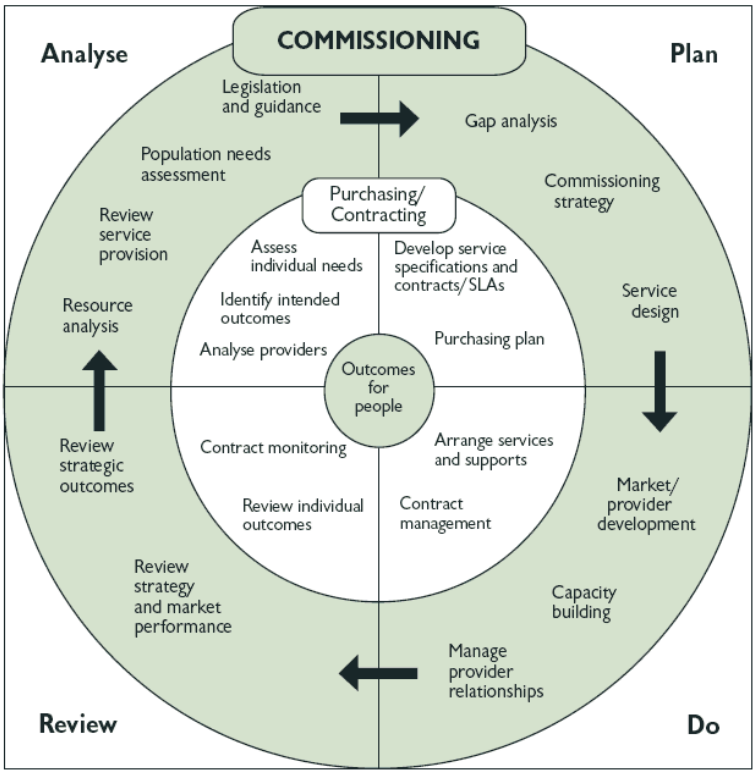
We now need to complete the cycle for services in scope for the new Health and Social Care Partnership, particularly those new, delegated hospital services by:

- Analysing– drawing meaningful conclusions from available data, projections and from people about their needs;

- Planning – working with partners to make short, medium and long term decisions about how services need to change and how this will happen;

- Doing – implementing strategic plans which involve maintaining a strategic overview of what we are trying to achieve as well as effectively commissioning and decommissioning services and implementing sound procurement arrangements;

- Reviewing – taking an evidence based approach to monitoring and reviewing progress and making adjustments as circumstances and market forces change.



Market Analysis and Provider Landscape

Based on a good understanding of need and demand, market analysis or facilitation is "the process by which strategic planners and commissioners ensure there is sufficient, appropriate service provision available to meet needs and deliver effective outcomes both now and in the future". In essence it should provide a picture of the current state of supply and the areas where partnerships would wish to see future services develop.

No service can be commissioned without a proper overview of what is currently being provided, how well this is meeting local needs, and where the gaps lie. Mapping the market's present capabilities helps us meet local needs and deliver value for money. It supports the decision whether to maintain existing provision or adapt, develop, or transform service delivery altogether.

As the Strategic Plan develops we will expand this section to support the successful development of services to meet the needs of the local population effectively.

Section 8 Performance Management

The draft Strategic Plan for Health and Social Care in the Scottish Borders has been designed with an aim of meeting the outcomes and performance measures for integration within Scottish Government's National Performance Framework. We must ensure a clear link between our vision, aims and objectives to ensure we can monitor our progress but more importantly improved outcomes for the population of the Scottish Borders.

Throughout this Strategy we have emphasised our commissioning aim of delivering good outcomes for the people of the Scottish Borders, by working together to provide services that maximise independence and improve wellbeing, while enabling people to take increased responsibility for their own health. To realise this objective we intend to develop a performance management framework that will monitor progress towards the objectives set for each priority.

The following diagram outlines how our vision and aims contribute to the national health and wellbeing outcomes and our local strategic objectives but more importantly what indicators we will measure along the way.

Appendix 4 aims to outline each national outcome and highlight the performance measures that will need to be delivered on in order to achieve these. As this plan is further developed and through further consultation with key stakeholder's local measures will be further agreed.

Our Vision: Working together for the best possible health and wellbeing of our communities

Our Aims:

- Improve outcomes for service users and carers
- Make services easily accessible with clear available information
- Deliver quality services in a person's own home or community in a timely way
- Have open, transparent and understandable governance arrangements
- Make effective use of resources and delivery of agreed efficiencies across the partnership
- Develop a flexible skilled workforce
- Meet agreed performance targets

National Health & Wellbeing Outcomes

People are able to look after and improve their own health and well-being and live in good health for longer

People, including those with disabilities, long term conditions, or who are frail are able to live, as far as reasonably practicable independently at home or in a homely setting in their community

People who use Health and Social Care Services have positive experiences and have their dignity respected

Health and Social Care Services are centred on helping to maintain or improve the quality of life of service users

Health and Social Care Services contribute to reducing health inequalities

People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing

People who use Health and Social Care Services are safe from harm

People who work in Health and Social Care Services are supported to continuously improve the information, support, care and treatment they provide, and feel engaged with the work they do

To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of Health and Social Care Services

Scottish Borders Local Strategic Objectives

We will make services more accessible and develop our communities

We will improve prevention and early intervention

We will reduce avoidable admission to hospital

We will provide care close to home

We will deliver services within an integrated care model

We will seek to enable people to have more choice and control

We will further optimise efficiency and effectiveness

We will seek to reduce inequalities

Strategic Plan Review

This Strategic Plan has been written for the period 2015 – 18 and will be reviewed and rolled-on each year. The first review will be undertaken in the period January to March, 2016 and the updated document for 2016 – 19 will be submitted to the Integration Joint Board for approval in April, 2016. The process followed in this regard will be in accordance with that laid out by Scottish Ministers in Regulation.

Section 9 We want to hear from you

We are seeking help to develop our plans for integrated services. This is the second part of that process. We have already sought your views on the first draft Strategic Plan between April – June 2015 through various engagement sessions.

This is now the more detailed draft Strategic Plan, which has been developed with the help of the feedback we received during the first part of our consultation process.

We are seeking your views on this Plan, by 22nd September, to help develop the final plan in October. We will organise a series of public meetings across the Borders during July/August/September. Please look out for details in your local press and/or on our website: www.scotborders.gov.uk/integration.

Once the Plan is finalised it will be reviewed and renewed on a three-year basis and, once again, this process will be supported by a programme of public engagement on an ongoing basis.

Your views and contribution

We want to hear your thoughts and views and help us shape our Strategic Plan moving forward. What matters to you is important to us and this is your opportunity to influence the way our services are delivered through Health and Social Care.

Please return this response sheet by 22nd September 2015 at the latest to FREEPOST RRBU-KBCB-JBJG Integration, Strategic Policy Unit, Scottish Borders Council, Newtown St Boswells, Melrose, TD6 0SA. Alternatively, you can complete the Electronic Feedback Form which you will find by clicking on the following link:
(link to be added)

QUESTION 1:

QUESTION 2:

QUESTION 3:

QUESTION 4:

QUESTION 5:

QUESTION 6:

QUESTION 7: Do you have any other comments you wish to make?

ABOUT YOU – optional

You **do not** need to complete any of the questions below. This information will be used for data analysis purposes only.

GLOSSARY OF TERMS

The following terms have the following meanings:

Acute services / care	Specialist care provided in hospital setting under consultants.
Adult placement services	Adult placement services provide or arrange accommodation for vulnerable adults in the homes of families or individuals, together with personal care and support.
Anticipatory Care	Reduces avoidable unscheduled acute admissions, for people with a pre-existing condition particularly older people and those with mental health conditions.
Borders Ability Equipment Store (BAES)	The Borders Ability Equipment Service provides equipment to allow patients to continue to live at home, with dignity and comfort.
Care Pathways	Anticipated care placed in an appropriate time frame.
Commissioning	The act of granting authority to undertake certain functions.
Community Capacity Building	The process of supporting individuals and communities to help them better identify and meet the needs of their areas. It involves building on the existing skills, providing opportunities for people to learn through experience and increasing people's awareness and confidence to enable them to participate more fully in society
Community Care Assessment Teams	A member of a Community Care Assessment Team will do an assessment of an individual to see if they require support from social services. Support may be from aids and adaptations in the person's own home to care workers or residential care.
Day Services	Day services provide opportunities for individuals to do things during the day and help people stay independent and living at home.
Demographics	Studies of a population based on factors such as age, race, sex, economic status, level of education, income level and employment, among others.
General Dental Services	Patients register with an NHS General Dentist (a "High Street dentist") to receive the full range of NHS treatment provided by independent contractor dentists working on behalf of local NHS boards.
General Medical Services	General Medical Services (GMS) is the term used to describe the range of healthcare that is provided by General Practitioners (GPs or family doctors) as part of the National Health Service.
Health Inequalities	Health inequalities are preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups – they exist between different genders and different ethnic groups.

Health and Social Care Partnership	Health and Social Care working together as one agency to provide a range of services. Services contained within the partnership include: all community health services, adult social care services, health visiting, community dental services, sexual health services, unscheduled care.
House of Care approach	The House of Care takes a whole system approach to Long Term Conditions management. It makes the person central to care. It is about aligning levers, drivers, evidence and assets to enhance the quality of life for people with long term conditions no matter what or how many conditions they have.
Independent Contractors	An independent contractor is a person(s) or business providing goods or services to another organisation under specific terms specified in a contract. In health terms this can be GPs, dentists, pharmacists, opticians contracted by NHS Borders to carry out specific services.
Independent Sector	Made up of organisations that are neither governmental nor for-profit businesses.
Integration of Services / Integrated Services	Joined up services / services working together as one team.
Integration Joint Board	A board of people who will be responsible for providing joined up health and social care and community health services.
Integrated Resource Framework (IRF)	The IRF enables partners to make investment choices informed by a comprehensive understanding of current resource and activity patterns, across the whole health and adult social care system. It provides Boards & their Local Authority partners with the information required to plan strategically and review services more effectively, partners will be able to realign their resources accordingly to support shifts in clinical/care activity within and across health and social care systems.
Local Area Co-ordination	Local Area Co-ordinators work with individuals and their families to help them to become more confident, supporting them to build independent lives.
Multi-disciplinary teams	A multidisciplinary team (MDT) is different healthcare / social care professions with specialised skills and expertise who collaborate together to make treatment & care recommendations that facilitate quality patient care. Multidisciplinary teams form one aspect of the provision of a streamlined patient journey by developing individual treatment plans that are based on 'best practice'.
Ophthalmic Services (Optometrists)	Services provided by opticians – they carry out eye examinations, provide eye glasses, repairs or replacements.
Polypharmacy	Polypharmacy is the use of four or more medications by a patient, generally adults aged over 65 years.
Palliative Care Services	Services provided to patients who have a life threatening illness.
Person-Centred	Person Centred means putting the person at the centre of all you do. For example, providing them with information in a format and language they can relate too and understand fully, enabling them to make informed decisions and judgements, encouraging them to have as

	much control over their treatment, care and lives as possible.
Prevalence rates	Prevalence is the proportion of a population found to have a condition (typically a disease, illness or a risk factor such as smoking). It is the proportion of a population that has the condition at a specific point in time.
Primary Care	Primary care is the day-to-day health care given by a heatlh care provider, who acts as the first contact of continuing care for patients & co-ordinates other specialist care that the patient may need. Patients commonly receive primary care from professionals such GPs, nurse practitioners etc.
Procurement	Procurement is the acquirement of goods, services or works from an external source. It is favourable that the goods, services or works are appropriate and that they are procured at the best possible cost to meet the needs of the acquirer in terms of quality and quantity, time, and location.
Public Dental Services	Dental services provided by the Community Dental Service and the Salaried General Dental Service.
Re-ablement health services	A re-ablement service provides planned, short term, intensive help. The service is designed to help a person: restore their independence, do as much as they can for themselves, rather than someone doing things for them. Re-ablement workers spend time with individuals to help them re-learn lost skills following a period of illness or disability.
Rehabilitation Medicine	Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.
Respite provision	Respite care or provision is short-term accommodation in a facility outside the home in which a loved one may be placed. This provides temporary relief to those who are caring for family members.
Seamless service	Moving from one area of treatment / care to another easily and without any interruptions or problems – a smooth service.
Social Care	Social care services enable people to remain independent as possible. These services include many forms and you can get help from them while you live at home, out and about in the community, or even in a new place of residence such as a care home.
Socioeconomic deprivation	Socioeconomic deprivation is the reduction or prevention of normal interaction between an individual and the rest of society - individuals are deprived due to factors such as low income, education and occupation.
Stakeholders	A stakeholder is anyone who is affected and should be involved in a particular piece of work.
Strategic Plan	"Strategic Plan" means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with section 29 of the Public Bodies (Joint Working) (Scotland) Act.
Strategic Planning	Strategic planning is an organisations process of defining

	its strategy or direction, and making decisions allocating its resources to pursue the strategy.
Technology Enabled Care (TEC)	Technology enabled care services help to support people with long-term conditions by managing risks, both personal and environmental, and can help people to remain independent and in their own homes for longer. An example of TEC is provided below – Telecare.
Telecare	"Telecare" provides different alarm systems which are available for your home, some of which can let a family member, friend, neighbour, nurse or warden (if you're in sheltered housing) know by phone when there's something wrong.
Voluntary Services (also referred to Third Sector services)	Voluntary Services are services provided by charity organisations, and individuals, who provide a service that enhances the care and wellbeing of individuals.

Appendix 1 - List of services delegated to the Integration Board

Our partnership will be responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, adult primary and community health care services and elements of adult hospital care which will offer the best opportunities for service redesign. The total resource within the partnership is £135.2 million.

The partnership has a key relationship with acute services in relation to unplanned hospital admissions and will continue to work in partnership with Community Planning Partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, we can also work in partnership with our communities.

NHS

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

Scottish Borders Council

- Social Work Services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental Health Services
- Drug and Alcohol Services
- Community Care Assessment Teams
- Care Home Services
- Adult Placement Services
- Health Improvement Services
- Re-ablement Services
- Aspects of housing support including aids and adaptations
- Day Services
- Local Area Co-ordination
- Respite Provision
- Continence Services

There are other, hospital-based, services where in integrated planning is essential and, as a result, they are included within the scope of our integration arrangements. The combined budget for these services is £20.2 million and is in addition to the £135.2 million identified above.

These services are:

- Accident and Emergency
- General Medicine
- Geriatric Medicine
- Rehabilitation Medicine
- Respiratory Medicine
- Psychiatry of Learning Disability
- Palliative Care Services

Appendix 2 – Locality Profiles

This Appendix provides a summary profile of a few key statistics for each of the five Area Forum Localities within Scottish Borders. As outlined in the main body of this draft Strategic Plan, locality planning of Health and Social Care Services in Scottish Borders will be based on each of the five existing Area Forum localities. These locality areas – Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale - are shown on the map below. The information shown here is just a start. As part of the Strategic Planning process, we will be building fuller locality profiles, inclusive of a wider range of measures as relevant to Health and Social Care Planning.

Figure 1: Map showing the five area forum localities in the Scottish Borders

Our Five Area Forum Localities: Area and population overview

Berwickshire is our northernmost Area Forum locality, sitting between East Lothian, Northumberland and the Scottish Borders Eildon and Cheviot localities. The estimated population of of Berwickshire in 2013 was 20,862, most of whom live in small settlements or rural areas. There are no large towns in Berwickshire; the largest settlements in this locality are Eyemouth and Duns, with estimated populations of 3,152 and 2,444, respectively.

Figure 2: Map of Berwickshire Area Forum Locality

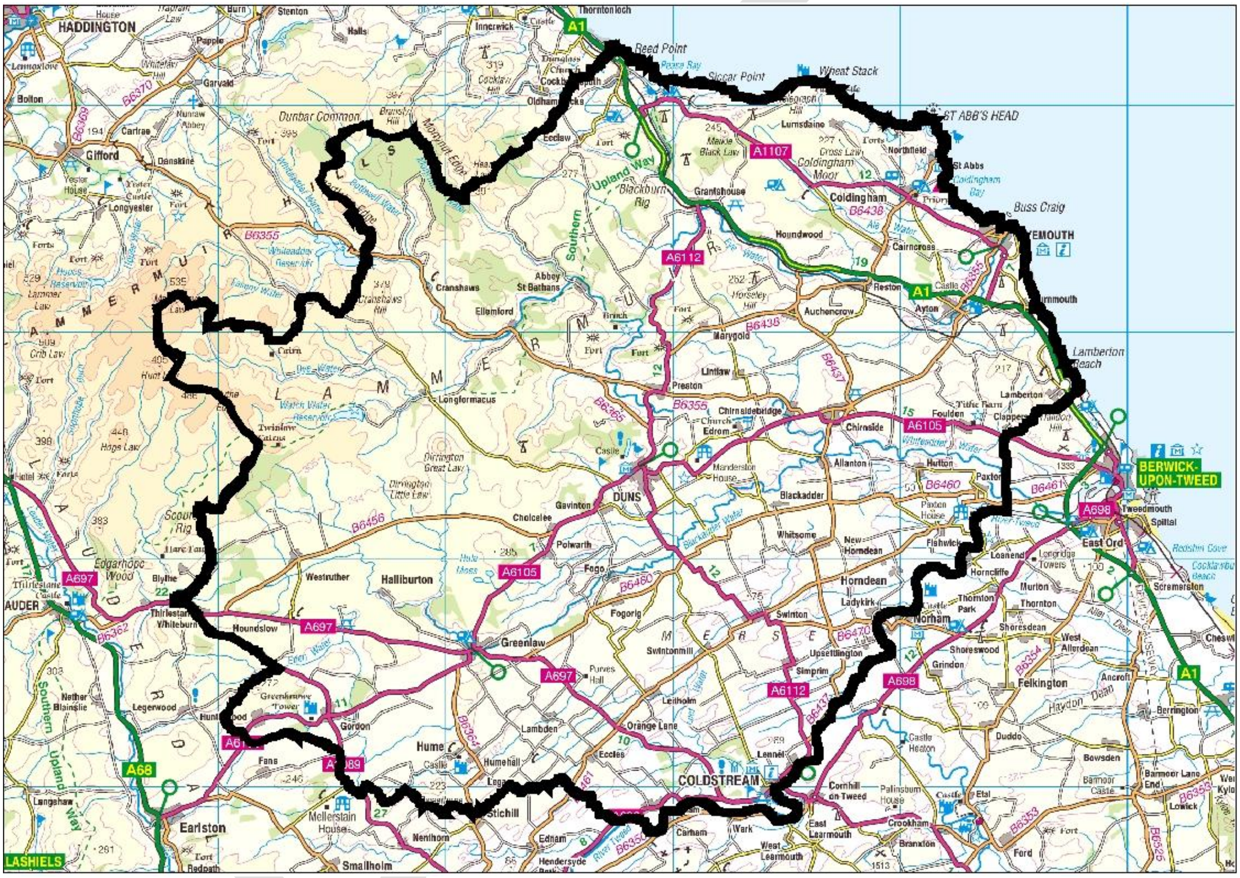


Table 1: Estimated populations of settlements and rural areas in Berwickshire Area Forum Locality, 2013

Settlement/ Datazone*Name	Total population	Percentage of population
Eyemouth	3,152	15%
Duns	2,444	12%
Coldstream	1,864	9%
Chirnside	1,252	6%
Foulden & around	1,169	6%
Rural area around (but not including) Eyemouth and Ayton	1,065	5%
Eccles/Leitholm/Fogo/Birgham	1,057	5%
Rural area around (but not including) Duns and Gavinton	999	5%
Cockburnspath, Cranshaws, Abbey St Bathans	962	5%
Longformacus, Westruther, Polwarth	940	5%
St Abbs & area covering Coldingham Moor	917	4%
Hutton & Ladykirk	905	4%
Gordon/Hume & around	882	4%
Swinton and rural area around (not including) Coldstream	808	4%
Grantshouse & Edrom	683	3%
Greenlaw	641	3%
Ayton	562	3%
Coldingham	560	3%
Berwickshire total	**20,862**	**100%**

*Datazones are small areas used for statistical reporting in Scotland.

Source: National Records of Scotland.

Cheviot Area Forum locality sits between Northumberland and three other Scottish Borders localities – Berwickshire, Eildon, and Teviot & Liddesdale. It is our smallest locality in population terms, with an estimated 16,407 residents in 2013. More than 60% of residents of this locality live in its two main towns, Kelso and Jedburgh, which have estimated populations of 6,139 and 3,959, respectively.

Figure 3: Map of Cheviot Area Forum Locality

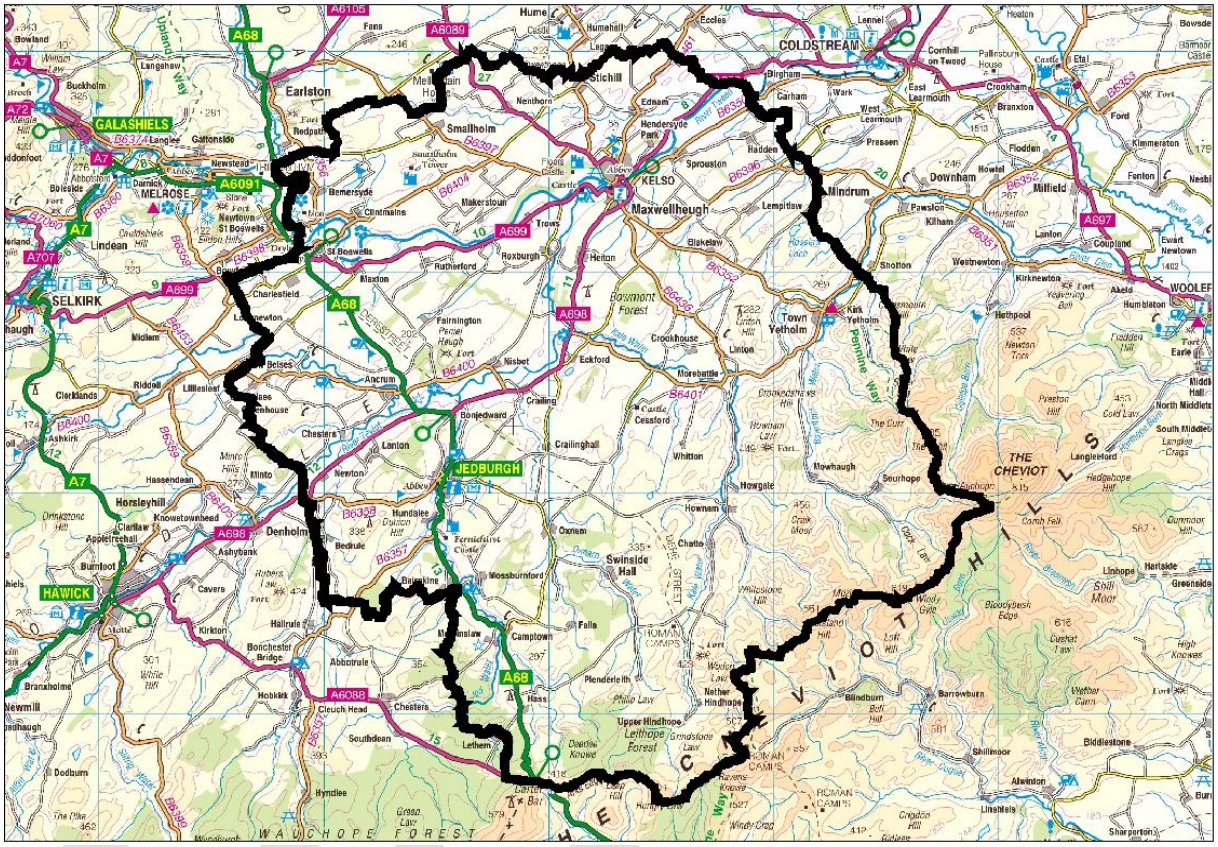


Table 2: Estimated populations of settlements and rural areas in Cheviot Area Forum Locality, 2013

Settlement/ Datazone* Name	Total population	Percentage of population
Kelso	6,139	37%
Jedburgh	3,959	24%
Heiton & Sprouston area	1,475	9%
Nenthorn, Stichil, Ednam	1,422	9%
Ancrum & Lanton	1,001	6%
Nisbet & Oxnam	957	6%
Morebattle, Hownam and rural area around (not including) Yetholm	885	5%
Kirk & Town Yetholm	569	3%
Cheviot total	**16,407**	**100%**

*Datazones are small areas used for statistical reporting in Scotland.

Source: National Records of Scotland.

Eildon is the largest of the five Area Forum localities. In 2013, an estimated 38,798 people lived in this area, accounting for 34% of the total population of Scottish Borders. This locality sits between all of the other four Area Forum areas in Scottish Borders, and also shares borders with Midlothian in the north and Dumfries & Galloway in the south. Nearly one third of this locality's residents live in Galashiels (estimated population 12,394) and another 14% in Selkirk (estimated population 5,608).

Figure 4: Map of Eildon Area Forum Locality

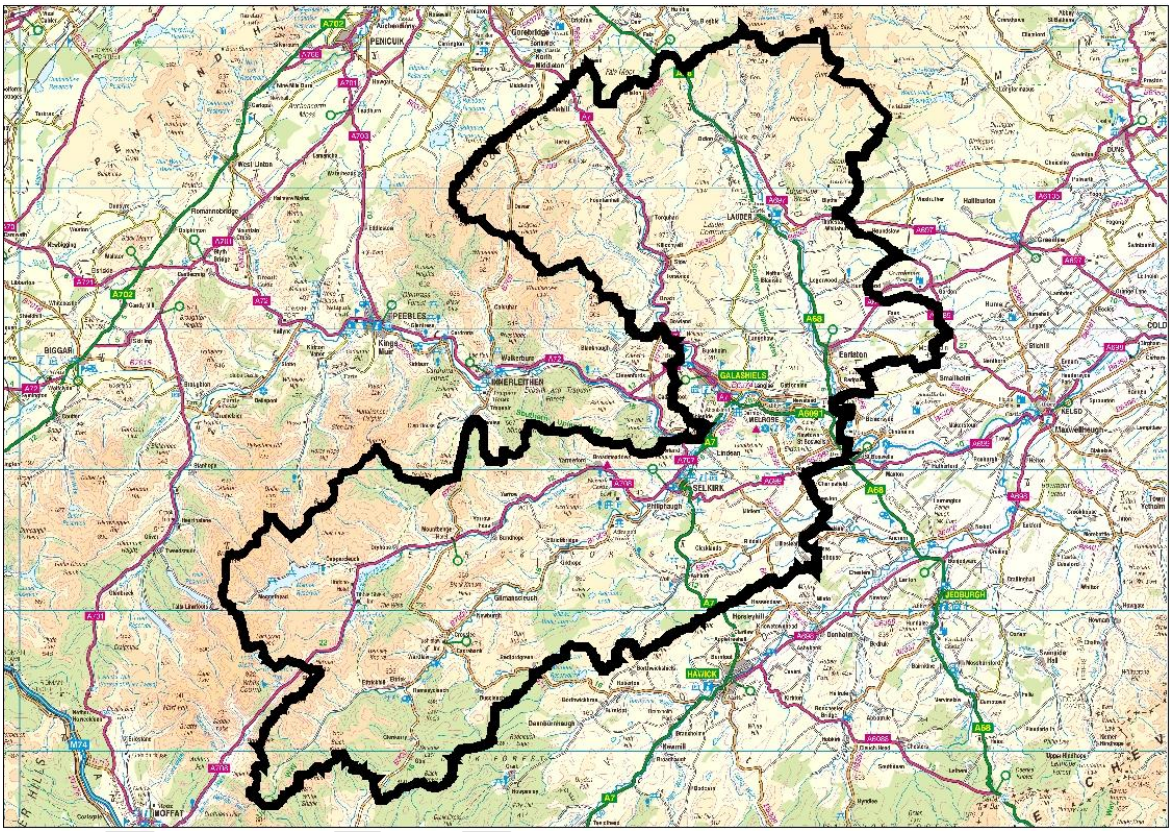


Table 3: Estimated populations of settlements and rural areas in Eildon Area Forum Locality, 2013

Settlement/ Datazone* Name	Total population	Percentage of population
Galashiels	12,394	32%
Selkirk	5,608	14%
Melrose, Darnick & Gattonside	3,226	8%
Tweedbank	2,076	5%
Earlston	1,774	5%
Oxton & Lauder Landward	1,490	4%
Clovenfords & Area	1,425	4%
Newtown St Boswells	1,303	3%
Heriot, Fountainhall, rural area around (not including) Stow	1,172	3%
Lauder	1,130	3%
Smailholm Maxton & Area	1,100	3%
Rural area around (not including) Earlston	1,069	3%
Midlem, Lilliesleaf, Ashkirk	1,049	3%
St Boswells	1,038	3%
Bowden/ Charlesfield & Area	966	2%
Yarrowford/ Yarrow Feus & Area	727	2%
Ettrick Ettrickbridge & Area	647	2%
Stow	604	2%
Eildon total	**38,798**	**100%**

*Datazones are small areas used for statistical reporting in Scotland.

Source: National Records of Scotland.

Teviot & Liddesdale is our southernmost Area Forum locality and shares borders with Dumfries & Galloway, Cumbria and Northumberland as well as Eildon and Cheviot localities. The estimated population of of Teviot & Liddesdale in 2013 was 18,611; nearly three-quarters of the population live in the town of Hawick (estimated population 13,696).

Figure 5: Map of Teviot & Liddesdale Area Forum Locality

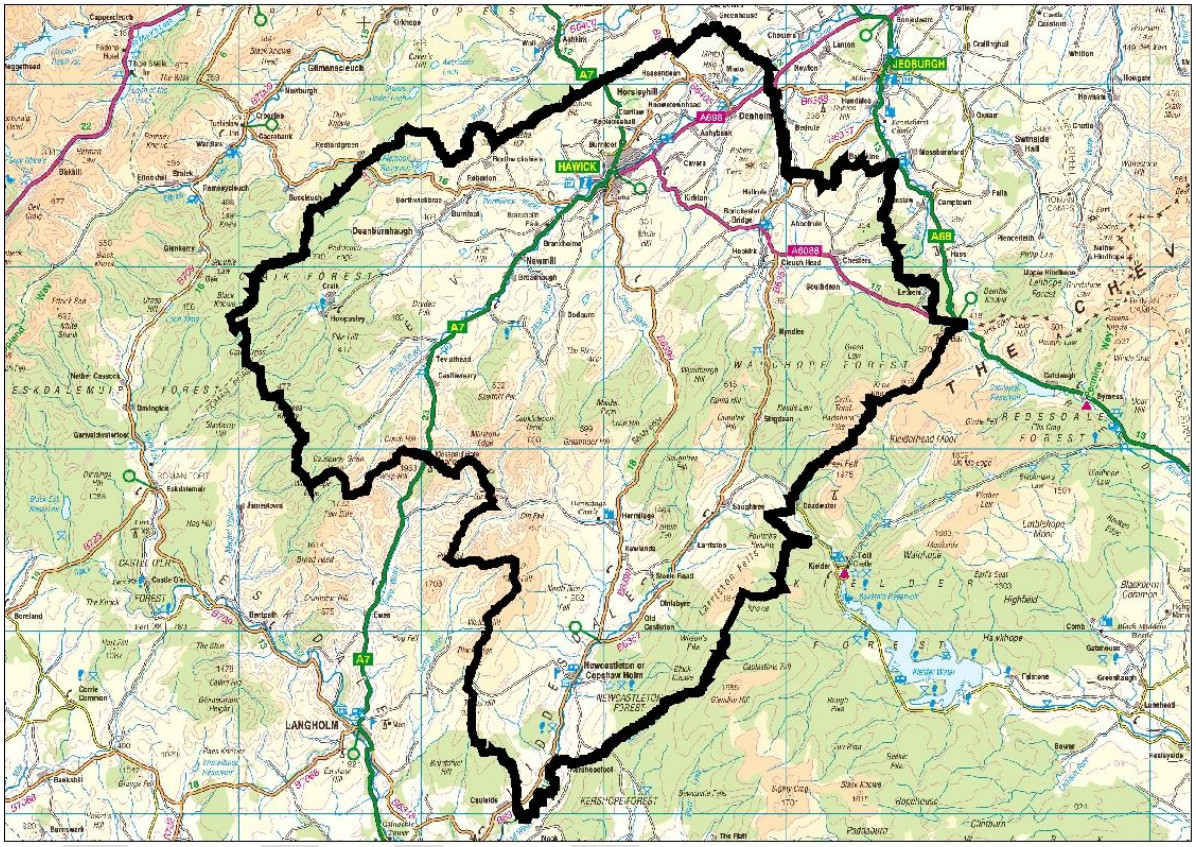


Table 4: Estimated populations of settlements and rural areas in Teviot & Liddesdale Area Forum Locality, 2013

Settlement/ Datazone* Name	Total population	Percentage of population
Hawick	13,696	74%
Minto, rural area around (not including) Denholm	976	5%
Bonchester Bridge/ Chesters	950	5%
Craik/ Roberton/ Newmill	880	5%
Newcastleton	770	4%
Teviothead & rural area around (not including) Newcastleton)	714	4%
Denholm	625	3%
Teviot & Liddesdale total	**18,611**	**100%**

*Datazones are small areas used for statistical reporting in Scotland.

Source: National Records of Scotland.

Tweeddale is our westernmost Area Forum Locality. It shares borders with a number of other local authority areas – Lanarkshire, Dumfries & Galloway, West Lothian, City of Edinburgh and Midlothian, as well as with the Eildon locality. In 2013, an estimated 19,192 people lived in the Tweeddale locality, 41% of whom lived in its largest settlement, Peebles (population 7,908). 59% of the Tweeddale population live in smaller settlements or rural areas.

Figure 6: Map of Tweeddale Area Forum Locality

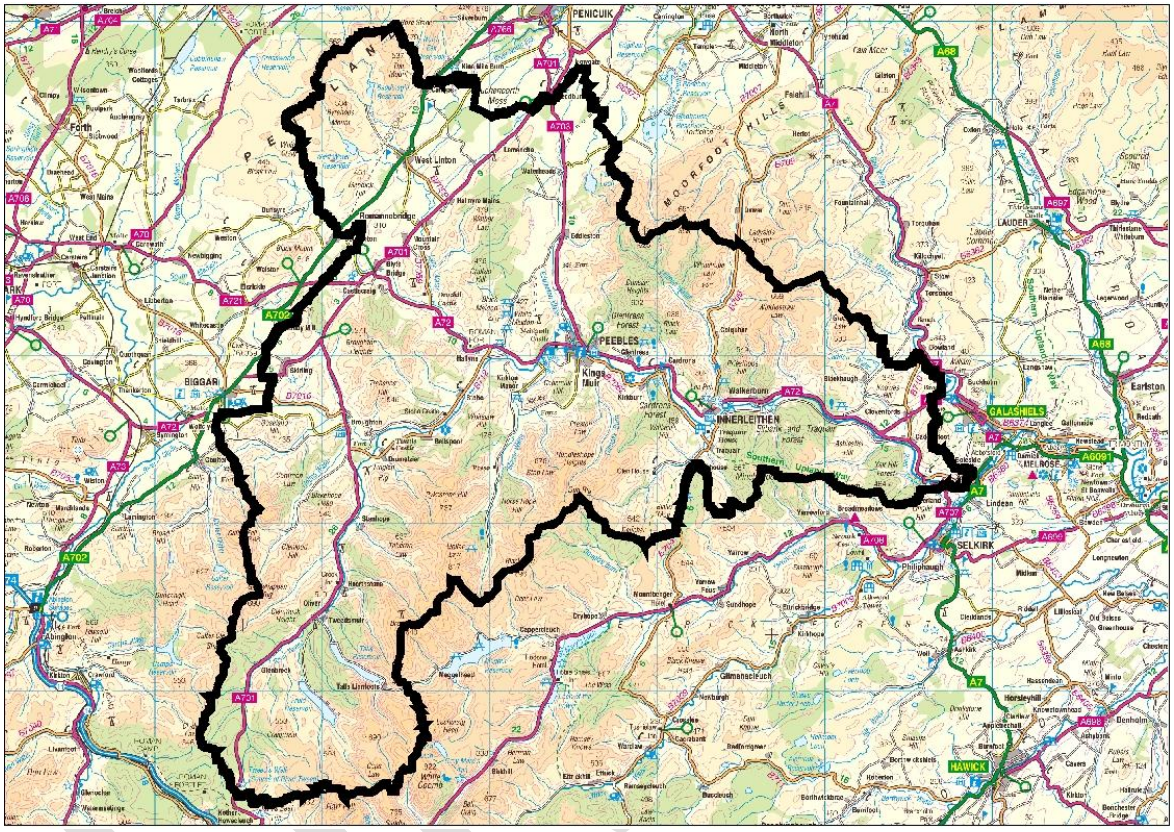


Table 5: Estimated populations of settlements and rural areas in Tweeddale Area Forum Locality, 2013

Settlement/ Datazone* Name	Total population	Percentage of population
Peebles	7,908	41%
Innerleithen	2,980	16%
Glentress & Manor Valley	2,285	12%
West Linton	1,460	8%
Carlops/ Romannobridge	1,108	6%
Eddleston	976	5%
Broughton & Upper Tweed	882	5%
Stobo/Blyth Bridge/ Skirling	879	5%
Walkerburn	714	4%
Tweeddale total	**19,192**	**100%**

*Datazones are small areas used for statistical reporting in Scotland.
Source: National Records of Scotland.

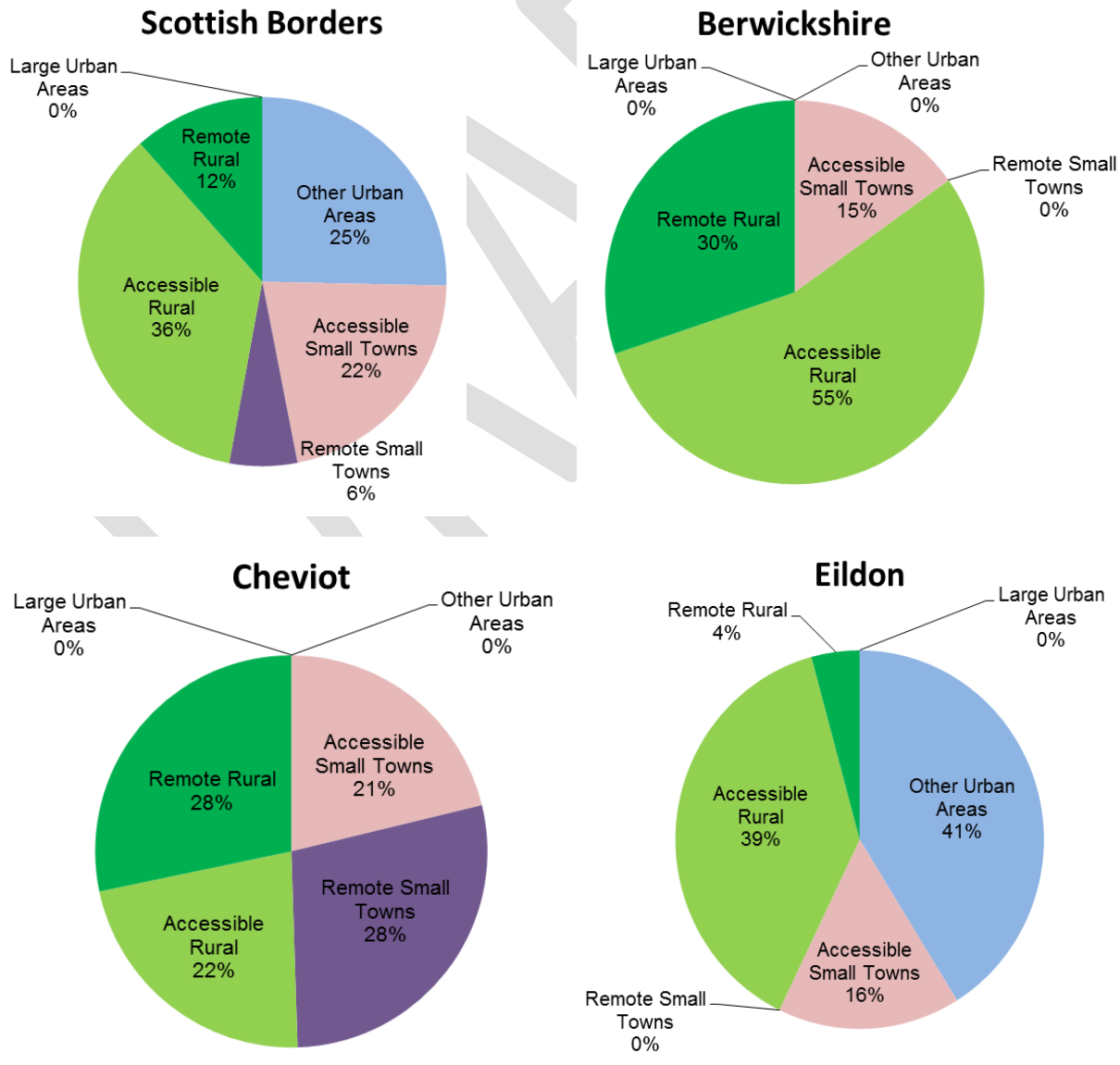
Population Shares by Urban/Rural area

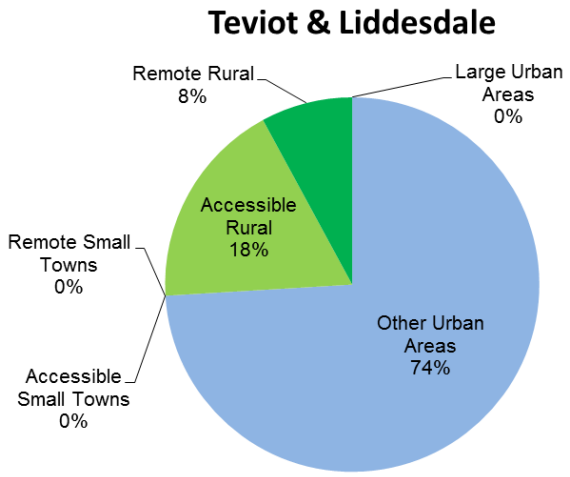
We know that our localities vary in terms of their Urban/Rural profile, as shown in the charts below. For example:-

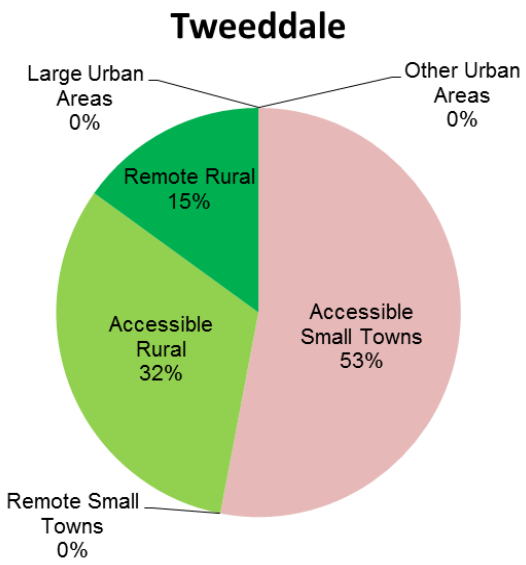
- Berwickshire is our most rural locality, with 85% of the population living in areas classified by the Scottish Government as “Remote Rural” or “Accessible Rural”.
- Teviot & Liddesdale has the highest proportion of the population living in “Urban” areas.

The differences illustrated below will be important in influencing how services are planned and delivered in each area.

Figure 7: Population shares (%) by Urban/Rural area in Scottish Borders and each Area Forum Locality, 2012







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

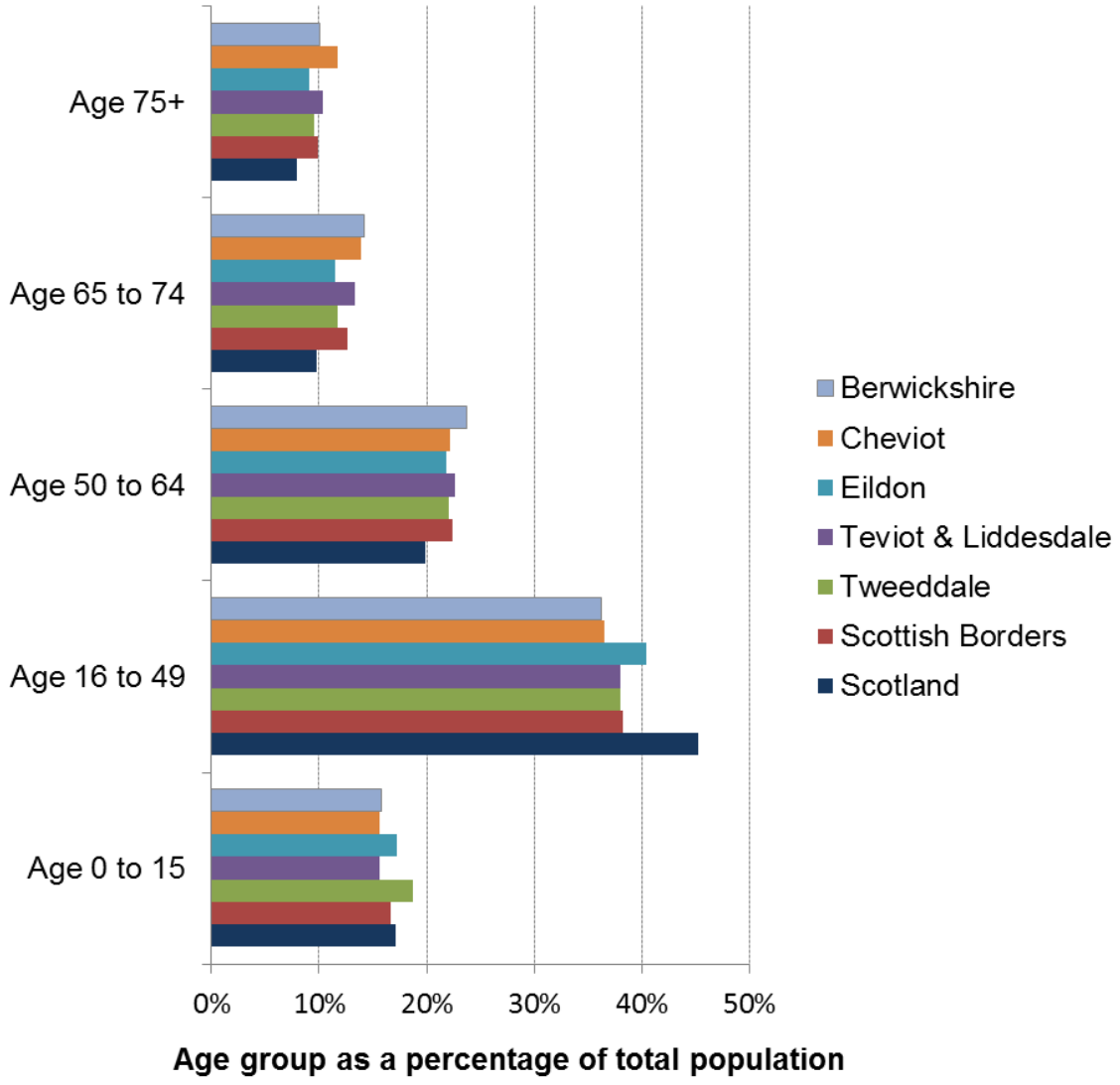
Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland. www.gov.scot/Publications/2014/11/2763/downloads

Population age profiles

We know that the age profile of the Scottish Borders population is a little different from that for Scotland overall. We have a higher proportion of people aged 50+ and a lower proportion of people aged under 50. There are also variations between our localities in terms of their population age profiles, as shown in the graph below. Two examples of differences between the localities are:-

- Within Scottish Borders, the Cheviot locality has the highest proportion of people aged 75+ (12%).
- Eildon has the "youngest" adult population profile of the five localities, for example having the highest proportion of people aged 16 to 49 (40%). However, although this is higher than the Scottish Borders average of 38%, it is still lower than the Scottish total of 45%.

Figure 8: Population age profile for each Area Forum Locality, compared with Scottish Borders and Scotland, 2013



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

Emergency Admissions to hospital

Scottish Borders has a higher rate of emergency admissions to hospital than the national average, and when we examine the data at locality level we can see that there are clear variations between them. The graph below shows, as an example, emergency admission rates amongst people aged 75+ in the year ending March 2014. From this, we can see that Eildon residents in this age group had the highest rate (420 emergency admissions for every 1,000 residents aged 75+). Rates for Tweeddale and Teviot & Liddesdale residents were also higher than the Scottish Borders average. Meanwhile, Cheviot alone had a rate that was lower than both the Scottish Borders and Scotland averages. There is more work to be done to reduce the occurrence of emergency hospital admissions that could be avoidable.

Table 6: Emergency admissions to hospital in people aged 75+ for the year ending 31 March 2014; Rates per 1,000 population

Note: This is emergency admission to acute/general inpatient specialties and excludes Geriatric Long Stay beds and psychiatric hospital admissions.

Source: ISD, NHS National Services Scotland, bespoke analysis for Scottish Borders.

Appendix 3 - The relevant functions and associated resources

Range of services and indicative base budgets to be delegated by NHS Borders to the Integration Joint Board*

Service	Base Budget 2015-16 (£'000s)	Base WTE
Learning Disability Service	3,642	21
Mental Health Service	13,077	302
Alcohol and Drug Service	871	3
Community Nurse ex HV/SN	4,061	104
GP Prescribing	21,552	-
AHP Services	5,364	146
General Medical Services	15,887	-
Community Hospitals	4,690	122
BAES	246	-
Other	2,130	-
Sexual Health	566	6
Public Dental Services	4,184	85
Community Pharmacy Services	3,690	-
Continence Services	430	3
Smoking Cessation	250	4
Accommodation Costs	985	-
Resource Transfer	2,563	-
Primary and Community Management	1,466	22
Health Promotion	421	8
Ophthalmic Services	1,577	-
Total**	**87,652**	**826**

*Alcohol and Drugs funding excludes funding recurrently allocated to BAS which is Included in Mental Health

** The above figures are based on 2015/16 opening recurring direct budgets.

Range of services and indicative base budgets to be delegated by Scottish Borders Council to the Integration Joint Board*

Service	**Base Budget 2015-16 (£'000s)**	**Base WTE**
Learning Disability Service	14,488	101
Mental Health Service	1,988	23
Alcohol and Drug Service	197	4
Older People Services	23,669	484
Physical Disability Service	2,897	5
Assessment and Care Management	238	8
Management and Planning	669	11
Localities	2,636	61
BAES	471	11
Duty Hub	51	5
Extra Care Housing	353	-
Joint Health Improvement	116	-
Respite	42	-
Other	(248)	6
Total	**47,567**	**719**

* The above figures are based on 2015/16 opening budgets

NHS BORDERS - Indicative base budgets which relate to set aside services for NHS Borders*

Service	**Base Budget 2014-15 (£'000s)**	**Base WTE**
Accident and Emergency including OOH	4,051	73
Medicine for the Elderly	5,662	131
General Medicine inc Palliative Care, Respiratory, Renal	10,521	178
Total	**20,234**	**382**

* The above figures are based on 2015/16 opening recurring direct budgets

Appendix 4 Draft Performance Management measures against National Outcomes

The goal or vision	Primary Drivers	Assessing Performance
National Outcome 1		
People are able to look after and improve their own health and well being and live in good health for longer	Accessible and appropriate information and support on lifestyle factors	Percentage of adults able to look after their own health very well or quite well
	Build capacity in communities	Premature mortality rates
	Improve prevention and early intervention	Emergency admission rate
		Local indicators to be determined
The goal or vision	Primary Drivers	Assessing Performance
National Outcome 2		
People, including those with disabilities, long term conditions, or who are frail are able to live, as far as reasonably practicable independently at home or in a homely setting in their community	Accessible and appropriate information on self care and services available	% of adults supported at home who agree that they are supported to live as independently as possible
	Increase the use of technology enabled care	Rate of emergency admissions for adults.
	Provision of appropriate housing/adaptations/equipment	% of adults with intensive needs receiving care at home
	Planning and delivery of service to ensure they are accessible e.g. transport links	Proportion of last 6 months of life spent at home or in community setting
		No of days people spend in hospital when they are ready to be discharged.
	Build Community Capacity	% of people admitted from home to hospital during the year, who are discharged to a care home
		% of people who are discharged from hospital within 72 hours of being ready

The goal or vision **National Outcome 3**	Primary Drivers	Assessing Performance
People who use Health and Social Care Services have positive experiences and have their dignity respected	Appropriate opportunities to gather information from service user before, during and after health and care services has been delivered	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated. % of adults receiving any care or support who rate it as excellent or good % of people with positive experience of care at their GP practice
	Appropriate, accessible and consistent information	Proportion of last 6 months of life spent at home or in community setting Proportion of care services graded 'good' or better in Care Inspectorate inspections
	Coordinated Care across health and social services	% of people who are discharged from hospital within 72 hours of being ready Local indicators to be determined

The goal or vision	Primary Drivers	Assessing Performance
National Outcome 4		
Health and Social Care Services are centred on helping to maintain or improve the quality of life of service users	Build Community Capacity	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
	Prevention and early intervention/anticipatory care	Rate of emergency admissions for adults
		No of days people spend in hospital when they are ready to be discharged
	Accessible information	Local indicators to be determined

The goal or vision	Primary Drivers	Assessing Performance
National Outcome 5		
Health and Social Care Services contribute to reducing health inequalities	Build Community Capacity	Premature mortality rate
	Prevention and early intervention/anticipatory care	
	Accessible information	Rate of emergency admissions for adults
	Targeted support for vulnerable groups	
	Targeted interventions	Local indicators to be determined

The goal or vision	Primary Drivers	Assessing Performance
National Outcome 6		
People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing	Accessible information for carers on where and who they can go to for support	% of Carers who feel supported to continue in their caring role
	Ensuring the partnership organisations identify and provide appropriate practical support to carers	% of adults with intensive care needs receiving care at home
	Ensuring the partnership has a clear mechanism for carers to relay feedback on their experiences	No of people receiving respite care
		Local indicators to be determined
The goal or vision	Primary Drivers	Assessing Performance
National Outcome 7		
People who use Health and Social Care Services are safe from harm	Build Community Capacity	% of adults supported at home who agree they felt safe
	Appropriate care packages including equipment/adaptations on discharge	Readmissions to hospital within 28 days of discharge
	Appropriate Staff and Clinical Governance	Falls rate per 1,000 population in over 65s
		Local indicators to be determined

The goal or vision	Primary Drivers	Assessing Performance
National Outcome 8		
People who work in Health and Social Care Services are supported to continuously improve the information, support, care and treatment they provide, and feel engaged with the work they do	Engaged workforce	% of staff who say they would recommend their workplace as a good place to work
	Appropriate training, support and development	
	Appropriate workload and prioritisation	Local indicators to be determined

The goal or vision	Primary Drivers	Assessing Performance
National Outcome 9		
To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of Health and Social Care Services without waste	Robust discharge planning	Readmissions to hospital within 28 days of discharge
		No of days people spend in hospital when they are ready to be discharged
	Prevention and early Intervention	% of total health and care spend on hospital stays where the patient was admitted in an emergency
		Proportion of last 6 months of life spent at home or in community setting
	Shared Services/processes	Local indicators to be determined