NHS BORDERS
CLINICAL STRATEGY

'A plan for person-centred, innovative healthcare to help the Borders flourish'

NHS Borders

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FOREWORD

NHS Borders has a proud history of delivering high quality care to patients and families, and we have much to celebrate about our primary care, community and hospital based services.

It is over three years since NHS Borders consulted and published 'NHS Borders Clinical Strategy 2014' which set out key principles for redesigning services to meet the future health needs of the Borders population. In that time, we have seen an important change in the way in which health and social care is planned and delivered with the establishment of the Borders Health and Social Care Integration Joint Board. The ways in which Scottish clinical services are to be provided in the future as set out in the Scottish Health & Social Care Delivery Plan have also moved on.

This revised and refreshed NHS Borders Clinical Strategy, based on the healthcare needs of the population, outlines plans for improving services to meet this new environment in order to ensure services continue to be safe, effective, person-centred and sustainable.

We acknowledge that this will require us to think differently with our patients, carers, and local partners in order that we transform the traditional models of healthcare delivery. We are however committed to ensuring Borders people have a high quality of life within their communities, accessing the care that is most appropriate for them, and if there comes a time when they need us more we want to make sure that the additional support is there.

Within this Clinical Strategy, we feel that we have set out the first steps in how we might go about making the real transformational changes to the way we work and the services that we deliver. Despite the challenging financial backdrop, we feel we have a real opportunity to change things for the better. By developing our current system to be innovative and forward-thinking, making the most of new technology and supporting Borders people to live well for longer, we can ensure that everyone has a better experience of health and care and the opportunity to be independent for as long as possible for them.

Some of the work described in this Strategy has already started. Some is in the planning stage. Some of it puts forward ideas about how the healthcare system could change to meet the challenges we face.

We look forward to working with you to continually develop and evolve our local services to ensure they meet the changing needs of local people now and in the future.

John Raine
Chair of NHS Borders Board

NHS BORDERS CLINICAL STRATEGY

EXECUTIVE SUMMARY

The Clinical Strategy underpins the strategic direction for NHS Borders and provides the service framework for our supporting strategies to deliver clinical services in the future. It forms the basis on which the Board will deliver outcomes and focus resources.

The vision for the Clinical Strategy is to:

"Provide personalised, evidence based care as close to home as possible. Working with people to define treatment goals and optimise outcomes. Supporting people to stay well; treat illness and manage crises."

The Board is keen to develop its services at pace over the coming months and years through a programme of work required to deliver the strategy. The strategy and work plan will align with the Borders Health and Social Care Integration Board Strategic Plan and the national vision for health and social care in Scotland, as set out in the Scottish Health & Social Care Delivery Plan.

The heart of our Clinical Strategy for providing care to our service users, both young and old, is that we will shift more health care from hospitals to settings closer to people's homes, and from reactive care to prevention and proactive models based on early intervention.

As a result our future services will provide:

- A greater focus on the prevention of ill health and reduction of health inequalities so that people are enabled to look after and improve their own health and wellbeing and live in good health for longer.
- A more coordinated approach to ensure 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.
- More effective care of people living with long term conditions, including increased support for self-management and greater use of anticipatory care plans.
- Integrated community teams (based locally in community led–hubs) to provide support to people across the spectrum from primary prevention through to intensive care at home.
- A greater provision of safe alternatives to admitting people to a hospital with care packages delivered by joint health and social care teams, and on-going recovery and rehabilitation in the community.
- A proactive approach to Realistic Medicine in primary and secondary care to reduce harm, waste and unwarranted variation and promote patient choice and control, all while managing risks and innovating to improve.
- The development of our workforce to meet future workforce challenges to include a greater reliance on community based roles of extended scope such as Advanced Practitioners.

NHS BORDERS CLINICAL STRATEGY

THE CASE FOR CHANGE

The Changing Health and Social Care Needs of the People of the Borders

In Scotland, just as in the rest of the developed world, health and social care services are facing a rising tide of demand which is driven by demographic changes, advancing medical science and new technologies, at a time of constrained resources. As people live longer, healthy life expectancy is not advancing at the same pace. This means that we will have more people, many of whom are older, living with multiple long-term conditions and often complex needs, who will be reliant on support and intervention from health and social care services. We therefore need to change our approach by shifting the balance of care away from acute hospital-focused care to one where there is a greater emphasis on prevention, self-management and community-based intervention. A detailed analysis of the changing health and social care needs of the people of the Borders is given in Appendix 1.

This shows for the Borders our population will change significantly over the next few years:

- The elderly population will grow at the fastest rate – while greatly welcomed, this population will proportionately need most healthcare resources. The numbers aged 65-74 will increase by 32% between 2012 and 2032 whereas the over 75s population is expected to grow by 75%.
- Average life expectancy is increasing in Borders people as is the case for Scotland, however there are stark differences in the life expectancy of those living in our most deprived areas compared with the least deprived. There are areas within the Borders where the male and female life expectancy is lower than for Scotland as a whole.
- Due to the increase in average life expectancy, the burden of disease in later life will increase the proportion of people with long-term health conditions. By the age of 65, nearly two-thirds of people will have developed a Long Term Condition: 75% of people aged 75-84 have two or more such conditions.

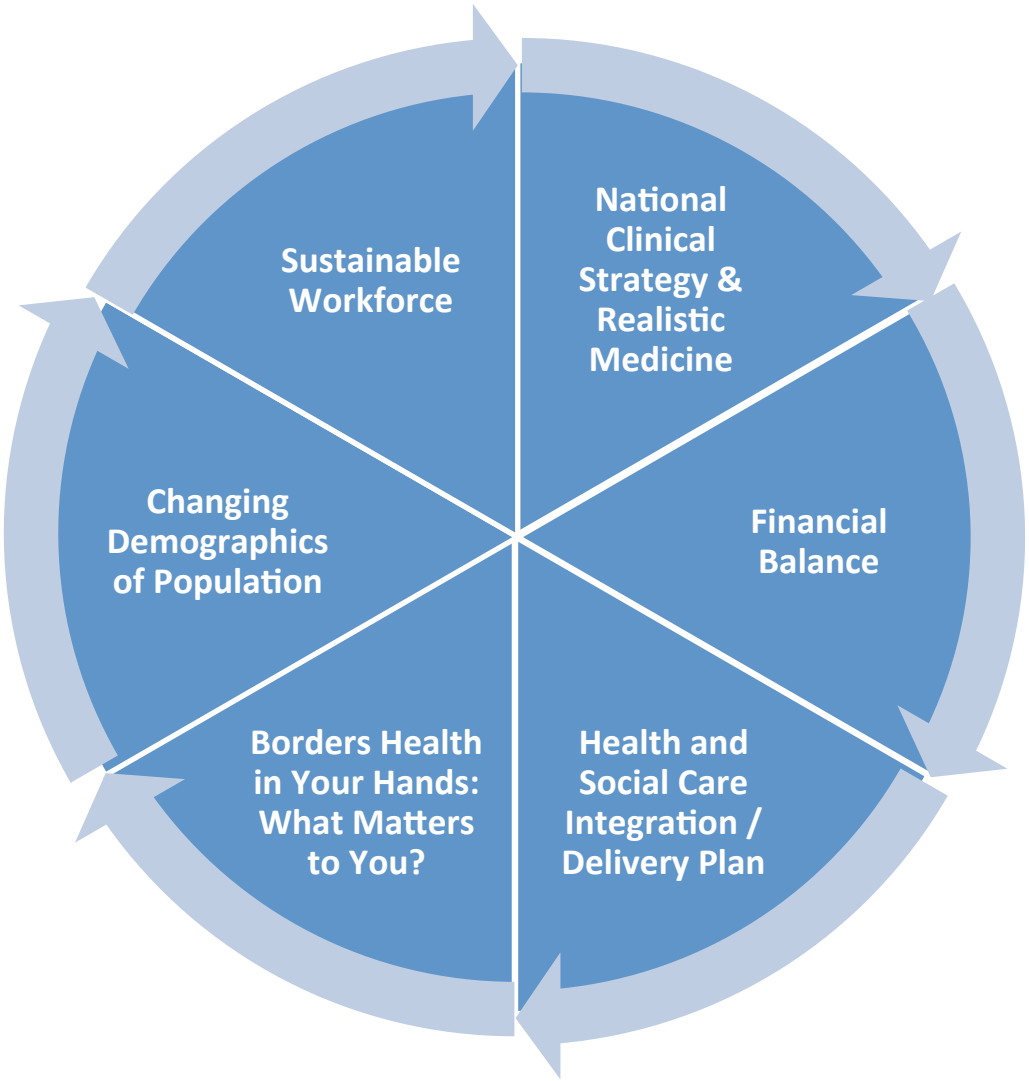
The Changing Context and Environment

The organisational landscape for health and social care in Scotland has also changed. A major step in public sector reform began in April 2016, when Health Boards and Local Authorities delegated a significant number of functions and resources to Integration Joint Boards (IJB), working as a Health and Social Care Partnership in the Scottish Borders, the IJB has responsibility to plan and deliver services for adults, including primary care, community services, mental health services and a number of acute services.

In addition to this, there have been a number of national and regional initiatives such as:

- 2020 Vision for Healthcare in Scotland (2011).
- The Chief Medical Officer's annual report on Realistic Medicine (2014/15) and Realising Realistic Medicine (2015/16).
- The National Clinical Strategy for Scotland (February 2016).
- Regional Planning (East of Scotland Health & Social Care Delivery Plan).

Alongside this, we have an increasingly challenging financial environment across the NHS and the wider public sector as well as workforce challenges. The diagram below summarises the main drivers for shifting the balance away from acute hospital-focused care to one where there is greater emphasis on prevention, self-management and community based intervention.



Clinical Strategy Development Stages

In response to these changing contexts, NHS Borders commissioned a number of pieces of work to inform future strategic developments. These are outlined below.

1. Development of key strategic principles

In 2014, following consultation with staff and the public, the Board approved Key Strategic Principles. These principles form the basis for the future design and development of clinical services across NHS Borders and are in line with and fully support the 2020 vision for Healthcare in Scotland. The Board made a commitment to ensure that each service within NHS Borders would be tested against the key principles with a view to improve the quality and effectiveness of services. The key principles are summarised below.

NHS BORDERS KEY STRATEGIC 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
4. Services will be delivered as close to home as possible
5. Admission to hospital will only happen when necessary and will be brief and smooth
6. 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

http://www.nhsborders.scot.nhs.uk/patients-and-visitors/latest-news/2014/september/11/nhs-borders-clinical-strategy/

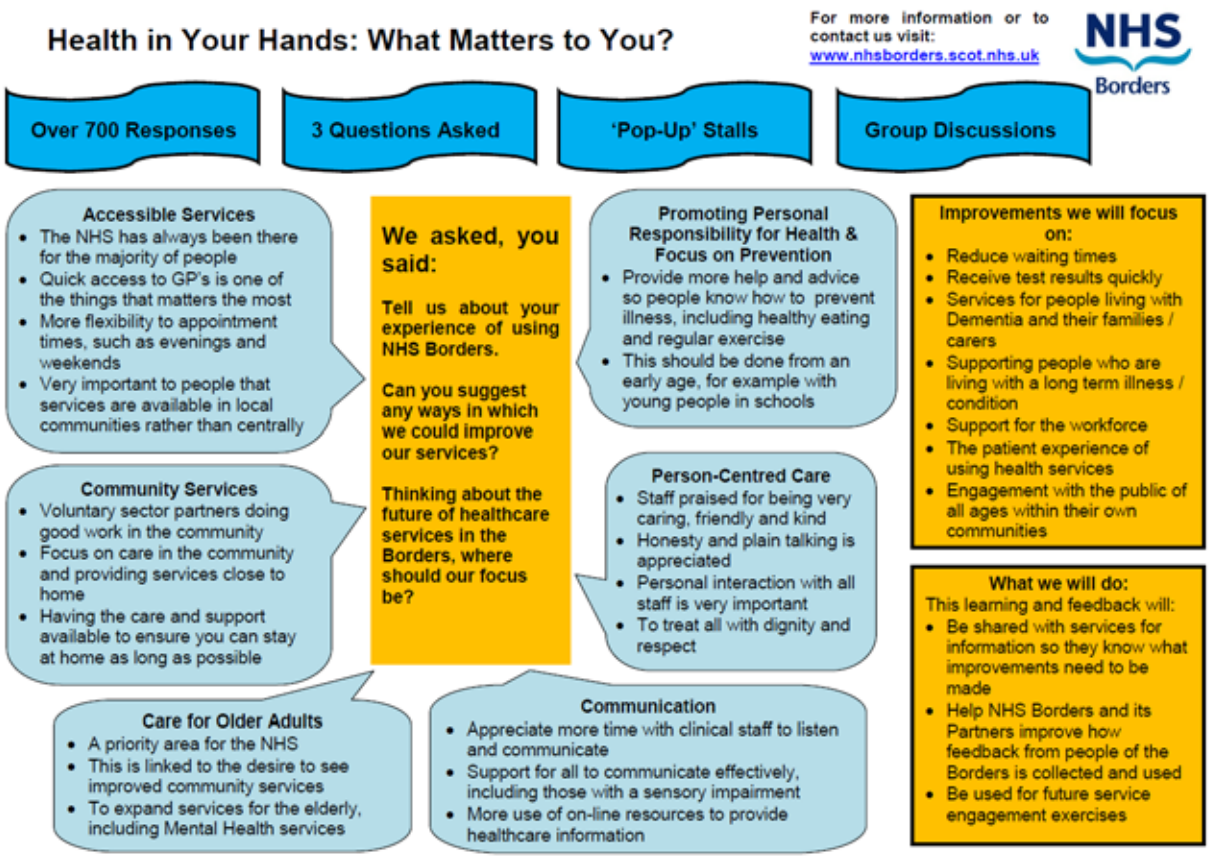
2. Inpatient service review 2015 – 2016

Recognising that a number of service reviews and developments were already underway a Business as Usual approach was adopted. Existing workstreams were therefore referenced under the umbrella of the Inpatient Services Review, all working to their own, independent timescales, reporting to the Clinical Executive Strategy Group. Progress updates on the specific projects were provided to the Board on a regular basis.

3. What Matters to You?

In addition to the specific workstreams held under the umbrella of the inpatient services review, a key commitment made by the Board was to undertake a dialogue and a series of conversations with our communities, our staff and the people of the Borders, in the most meaningful way following on from our consultation work around the key strategic principles.

A large scale public engagement exercise Health in Your Hands: What Matters to You?; was undertaken to give the Borders public an opportunity to tell us what was important to them to help NHS Borders shape future services and give consideration to future priorities. A full report on the engagement exercise was presented to the Board at its meeting in June 2016[1]. A summary of the findings is shown below.



All of this culminated in the board recognising that we needed to refresh our strategic direction of travel and produce a more detailed clinical strategy.

[1] *Health in Your Hands: What Matters to You? http://www.nhsborders.scot.nhs.uk/media/391764/Appendix-2016-56-HIYH.pdf*

Strategic Aims of the Clinical Strategy

Based on the above, NHS Borders Board has developed a set of aims for this Clinical Strategy.

The strategic aims are:

- To deliver the national vision for health and social care in Scotland, as set out in the Scottish Health & Social Care Delivery Plan (December 2016).
- To provide clarity for staff, the public and partners on the direction and key priorities for staff in NHS Borders, focusing on the delivery of safe and sustainable services and ensuring the best possible patient experience and health outcomes.
- To have a clear response to how we will maximise opportunities and adequately manage current and future predicted challenges facing the NHS (and other partner organisations), such as increasing population needs, advances in technology, workforce and financial challenges.
- To support future decision making and guide how we best use our limited resources.
- To set out how collaborative working with partners will be supported to meet the needs of the East of Scotland populations and ensure sustainability of health and social care services.

The Clinical Strategy is therefore a culmination of a number of developments over recent years that supports an integrated health and social care system which has a focus on prevention, anticipation and supported self-management. It takes full account of national drivers such as the Scottish Health & Social Care Delivery Plan that set out principles to underpin clinical service changes across Scotland. It also takes into account current and projected activity data and future challenges (financial, workforce, increasing population needs and advancing technology); findings from "What Matters to You: Health in Your Hands"; and views from key stakeholder workshops and engagement sessions held with clinicians and senior managers.

What Will Change

The common overarching principles emerging from this Strategy overall are that we need to shift more health care from hospitals to settings closer to people's homes, and from reactive care to prevention and proactive models based on early intervention.

As a result NHS Borders services in the future will provide:

- A greater focus on the prevention of ill health and reduction of health inequalities so that people are enabled to look after and improve their own health and wellbeing and live in good health for longer.
- A more coordinated approach to ensure 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.
- More effective care of people living with long term conditions, including increased support for self-management and greater use of anticipatory care plans.
- Integrated community teams (based locally in community led–hubs) to provide support to people across the spectrum from primary prevention through to intensive care at home.
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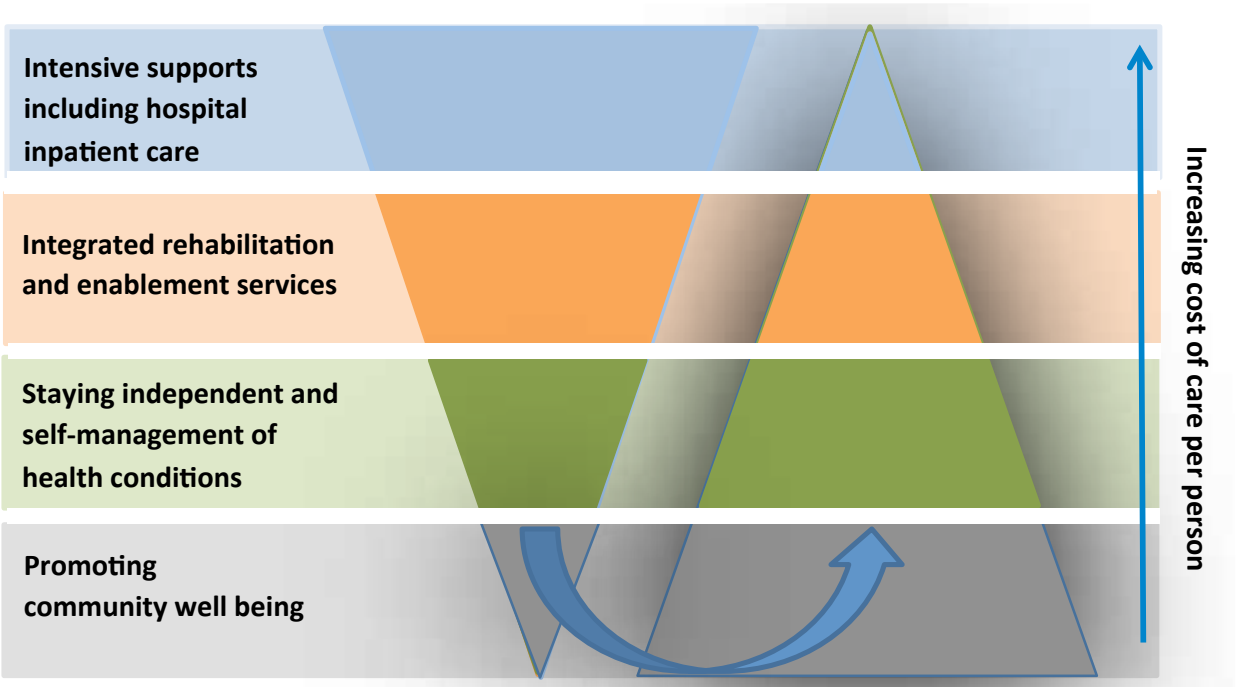
- A proactive approach to Realistic Medicine in primary and secondary care to reduce harm, waste and unwarranted variation and promote patient choice and control, all while managing risks and innovating to improve.

- The development of our workforce to meet future workforce challenges to include a greater reliance on community based roles of extended scope such as Advanced Practitioners.

The diagram below demonstrates the desired shift of balance from acute to community focussed care.



Improving health and wellbeing through preventative and supportive community based care, would allow resources to be moved and the balance of care shifted into the community

Role of the Borders Health and Social Care Integration Board

Integration of health and social care is the Scottish Government's programme of reform to improve services for people who use adult health and social care services. The Scottish Government Vision for Health and Social Care Integration is:

'Ensuring better care and support for people where users of health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. This will result in better outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities.'

Health Boards and Local Authorities have therefore delegated a significant number of functions and resources to Integration Joint Boards (IJB). Working as a Health and Social Care Partnership in the Scottish Borders, the Borders Health and Social Care IJB has responsibility to plan and deliver services for adults, including primary care, community services, mental health services and a number of acute services. The Borders IJB is responsible for planning and has oversight of integrated care in the Borders. The Borders IJB Strategic Plan 2016-2019 gives an overview of why we have to integrate and what we expect to see as a result and gives the strategic directions for local health and social services for the next three years.

NHS Borders will work closely with the Borders IJB in moving towards locality-based planning, providing localities with the autonomy to identify priorities and shift resources within a coherent strategic context with due regard to clinical and professional governance. Five localities has been formed - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale. Locality profiles for each area based on a Strategic Needs Assessment have been produced, which provide details of activity, demand and resource within each of the 5 localities.

These profiles will support the identification of key actions to enable the delivery of better outcomes for the people in each locality. This needs assessment can be found at **https://www.scotborders.gov.uk/downloads/download/211/strategic_assessment**

Draft joint health and social care locality plans have been co-produced with local communities detailing priorities for each local area to ensure delivery of the Borders IJB Strategic Plan and the NHS Borders Clinical Strategy.

The NHS Borders Clinical strategy and work plan will align with the Borders IJB Strategic Plan and the national vision for health and social care in Scotland, as set out in the Scottish Health & Social Care Delivery Plan.

The next sections of the Clinical Strategy explores 12 core workstreams by which NHS Borders will shift more health care from hospitals to settings closer to people's homes, and from reactive care to prevention and proactive models based on early intervention. Each section will set out a vision, the need for change, what will change and what success will look like. These workstreams are:

- Primary Care
- Long Term Conditions
- Frail Older People
- Palliative and End of Life Care
- Mental Health
- Learning Disabilities
- Maternity and Neonatal Services
- Children and Young People
- Urgent Acute Care and Planned Care
- Cancer Services
- Pharmacy Services
- Support Services (cross referenced against all of the other workstreams)

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PRIMARY CARE

Vision

The vision puts general practice and primary care genuinely at the centre of a community health service, improving outcomes for local communities. All clinicians will be working in practices that are proud of delivering care to patients in wider truly integrated teams who work in partnership with patients, families and carers as well as colleagues across care sectors, including voluntary organisations and wider public services.

Current Services

Primary Care provides the first point of contact in any health care system and consists of a wide range of clinical services including:

- GPs, General Dental Practitioners, Community Pharmacists and Optometrists
- NHS directly employed community services:
- District Nurses, Health Visitors, Treatment Room nurses, Evening Nurses;
- Day Hospitals;
- Public Dental Service including Dentists, Dental Nurses, Hygienists, Oral Health Services;
- Sexual Health services including Consultant and Nursing;
- Lifestyle Advisor Support Service (LASS);
- Allied Health Professionals: Physiotherapy, Occupational Therapy, Dietetics, Podiatry, Speech and Language Therapy.

Services are provided across Borders in and from a network of 23 health centres, four community hospitals, five day hospitals, two NHS dental centres and in a range of independent, community and domiciliary settings.

The Need for Change

As detailed in the 'Case for Change' section of the Strategy, NHS Borders needs to respond to demographic changes, increased demand on health and social care services, recruitment difficulties and an increasingly difficult financial context. Alongside this, there has been a focus on quality improvement in healthcare, supported by the publication of Realistic Medicine in Scotland[2] and in 2016 changes were announced to the General Medical Services contract whereby the GP Cluster Model was introduced. The aim of this is to support peer-led quality improvement activity within and across practices and to enable GPs to contribute to the oversight and development of care within the wider health and social care system[3].

[2] *Realistic Medicine: The Chief Medical Officer's Annual Report 2014/15*
[3] *Improving Together: A National Framework for Quality and GP Clusters in Scotland (January 2017)*

What Will Change?

- There will be 4 GP Clusters in the Borders. The 'GP Cluster Model[4]' will support peer-led quality improvement within and across practices, enabling GPs to contribute to the oversight and development of care within the wider health and social care system.
- Community staff will work as an integrated team to provide support to people across the spectrum from primary prevention through to intensive care at home. This will lead to different care models, improved patient pathways, improved care co-ordination based on the needs of the local community.
- To manage recruitment and other workforce difficulties, a key development area will be to blur the traditional healthcare professional boundaries. New roles will be developed to work alongside GPs e.g. Advanced Practitioners and Care Support Workers in order to enhance capacity across the system.
- A proactive approach will be taken to Realistic Medicine (Care) across primary care and in partnership with colleagues in secondary care to reduce harm, waste and unwarranted variation, all the while managing risks and innovating to improve.
- Joined up communication between different healthcare providers and the wider social care system is of critical importance to an integrated healthcare model. Significant work is being undertaken to develop a truly integrated clinical IT system which eradicates waste, reduces duplication and maximises the time spent by GPs and other health professionals in the community with their patients.
- Operating under the banner of 'first class buildings for a world class service' the strategy seeks to develop and deliver a physical environment that matches the service model and aspirations of the future.
- As part of the new GP contract arrangements the Scottish Government has agreed that GPs will no longer have responsibility for immunisation services. As a result NHS Borders will work together with primary and community care staff in developing and delivering this new programme.

What Will Success Look Like?

- Primary Care in all its forms will be accessible and provide for our patients in the right place at the right time and by the right person.
- Recruitment and retention across all services will have improved with sustainable career structures and supports in place.
- New roles and skills will be established e.g. Advanced Practitioners, which will enhance capacity across the system and support patients to remain at or return home.
- The interfaces across care sectors will be effective and enable smooth transitions and effective treatment and discharge planning.
- GP Quality Clusters and the overarching Quality Improvement approach will be fully supported, established and flourishing.
- Improving communication including use of IT systems across all health and social care will be a priority moving forward.

[4] *Improving Together: A National Framework for Quality and GP Clusters in Scotland (January 2017)*

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LONG TERM CONDITIONS

Vision

Active and early interventions will prevent the onset of Long Term Conditions, and coupled with more effective management of the conditions, will improve health and wellbeing outcomes for the Borders population and reduce unnecessary admissions to hospital.

Current Services

Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require on-going care and support.

EXAMPLE 1: DIABETES

At the end of 2013, 6,031 people in Scottish Borders (5.3% of the population) were registered as having diabetes and the numbers of cases have been rising by around 5% each year.[5] The crude prevalence rate for diabetes in the Borders population was higher than the overall Scotland rate of 5.05%, but this reflects the relatively older age profile of the Borders population in comparison with Scotland's overall. Of the total 6,031 registered as having diabetes at the end of 2013: 3,528 (58%) were aged 65 and over; 2,503 (41.5%) were aged under 65 (this figures includes children).

EXAMPLE 2: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease (COPD) is a major cause of chronic morbidity and mortality; many people suffer for years and die prematurely from it or its complications. COPD is both preventable and treatable and the COPD burden is projected to increase because of continuing exposure to COPD risk factors and aging of the population. It is the only major cause of death in Scotland on the increase. Over 2,700 people have COPD in NHS Borders, an increased of 13% since 2010. The prevalence is 2.35% (c/f 2.39% nationally) and it is one of the top 5 potentially preventable admissions to the Borders General Hospital.

The Need for Change

- By the age of 65, nearly two-thirds of people will have developed a Long Term Condition (LTC).[6]
- Older people are also more likely to have more than one Long Term Condition (27% of people aged 75-84 have two or more).
- There is a predicted rise of 38% in the number of people who will be over 85 in the population by 2016, and a 144% rise in the over 85s by 2031.
- 60% of all deaths are attributable to Long Term Conditions and they account for 80% of all GP consultations.
- People with Long Term Conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer, and account for over 60% of hospital bed days used.
- People living with Long Term Conditions are also more likely to experience psychological problems therefore it is important that they have an Anticipatory Care Plan to minimise stress when the need for a hospital admission occurs.

Given the population projection for the Borders and the links between Long Term Conditions and age, future challenges to service provision can be clearly seen.

[5] *Borders Director of Public Health Report 2015 http://www.nhsborders.scot.nhs.uk/media/358805/DPHNov15Report.pdf*
[6] *Scottish Government http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions*

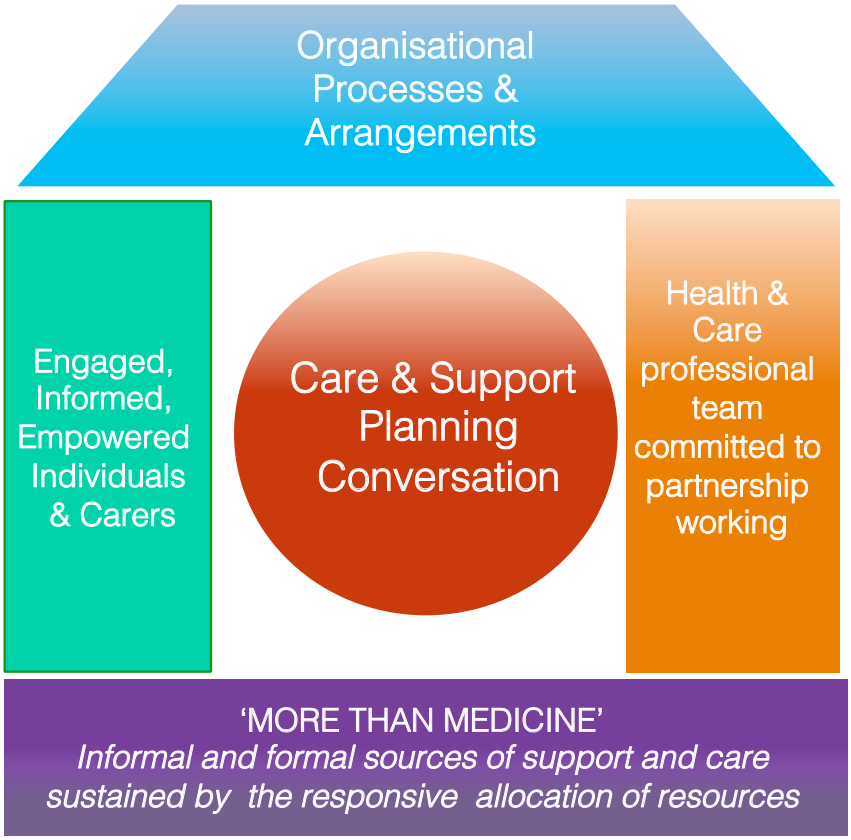
What Will Change?

We will provide a solid foundation of:

- Population-wide prevention
- Health promotion and targeted health improvement activity
- Action to prevent disease
- Raise awareness of risks to health
- Support for healthy lifestyle choices

This is essential given the high prevalence of Long Term Conditions which are preventable, and the health inequalities associated with living with Long Term Conditions.

The House of Care model (HoC), shown below will be used as a framework to enhance the quality of life for people with Long Term Conditions, no matter what their condition. At its core is listening to experiences and feedback from people coping with Long Term Conditions, to inform how care should be designed and implemented.



The framework describes the building blocks that need to be in place to enable effective care delivery for individuals with one or more Long Term Condition.

The future model will demonstrate that we have listened to patients who universally say that they wish to be treated as a whole person and for the NHS and social care to act as one team.

As we move to implement change we will modernise our workforce to develop the skills required to meet future requirements.

What Will Success Look Like?

Success for NHS Borders will mean:

- People with Long Term Conditions will not require hospital admission unless in the most acute health circumstances.
- We will actively listen to patients which will result in a more integrated community health service where people will live longer in an independent environment.
- Worsening of a Long Term Condition will be identified early, through self-monitoring or enhanced community monitoring and treated appropriately.
- Community based staff will be further equipped to support more complex illness in caring for people with Long Term Conditions promoting self-care and better management of health conditions, not undertaking care using a single disease approach.
- Transitions of care across the system will be seamless, supported by robust information systems around episodes of care, creating care continuums using the house of care model.
- Tailored care pathways and anticipatory care plans will be developed with carers, families and patients with Long Term Conditions to support changes in care needs and the ability to return to a home or to a community setting as quickly as possible.

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FRAIL OLDER PEOPLE

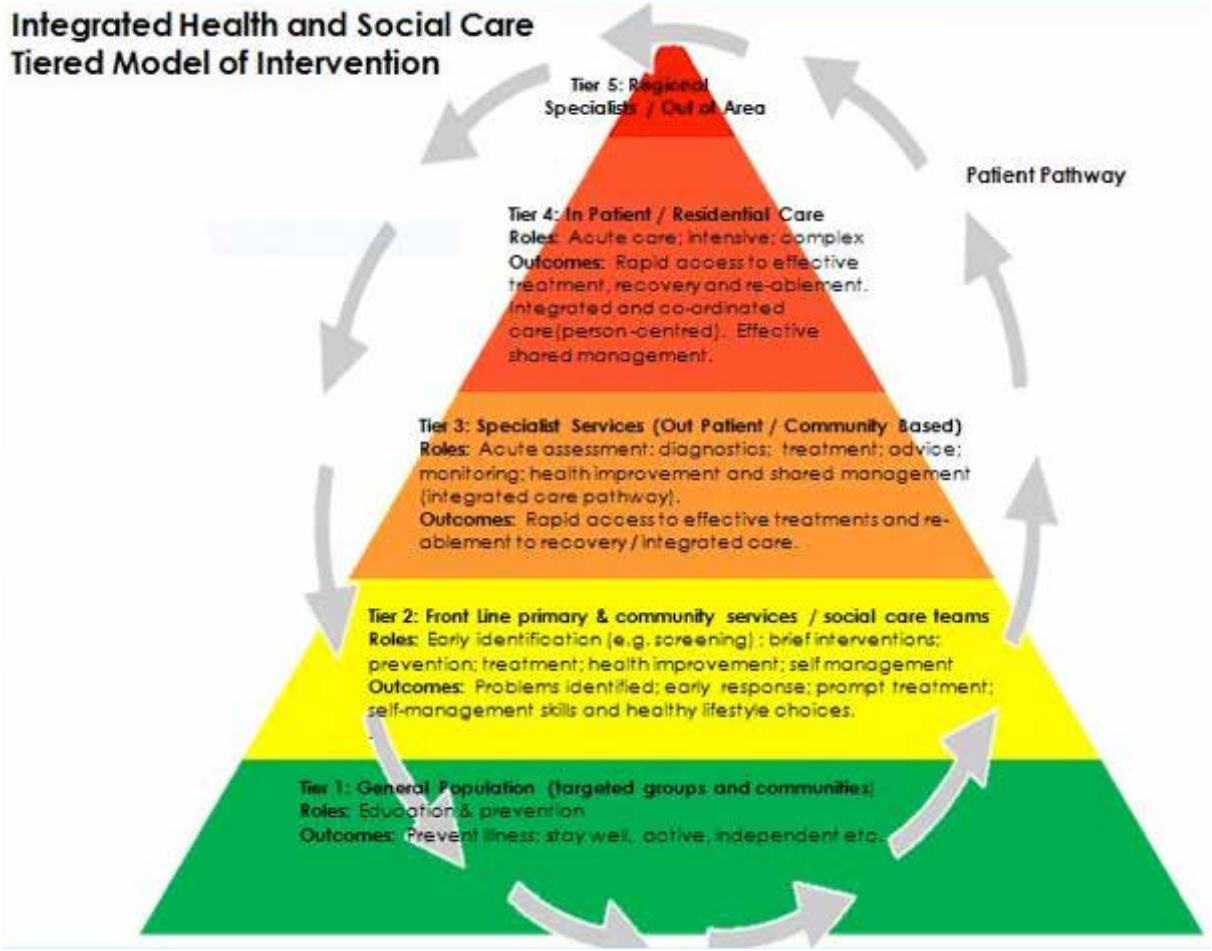
Vision

We will promote independent, active and engaged citizenship; ensure clear recognition of crises through shared information between agencies; support active early specialist management of acute illness; facilitate rapid recovery and independence at home or close to home and provide patient-centred, dignified, supportive care to those who require support at the end of life. This information will be documented in a comprehensive Anticipatory Care Plan (ACP) held and completed by the patient, carer and/or family.

Current Services

The care of older people is currently provided by both acute and community services through a 'whole systems' approach. This 'whole systems approach' is presented in Figure 1 below using a Tiered model of intervention, describing at each level the outcomes to be achieved, and the role of services and resources helping to achieve these outcomes.

FIGURE 1
TIERED MODEL OF HEALTH AND SOCIAL CARE INTERVENTION



Within the Borders, front line primary and community services and social care teams provide early interventions, support self-management and provide treatment. Specialist community services provide rapid access to acute assessment, treatment and reablement to promote recovery and provide integrated care.

The Borders General Hospital provides acute services for older people and is supported by four community hospitals. Within the Borders General Hospital, the Department of Medicine for the Elderly (DME) provides a comprehensive Older Peoples Liaison Service for older people which delivers a rapid comprehensive assessment on admission, multi-disciplinary inpatient services for both acutely unwell patients and those with rehabilitation needs as well as specialist outpatient services (e.g. Falls clinic, Stroke and Parkinson's disease). DME consultants also provide specialist input to the four community hospitals.

The Need for Change

Reducing unnecessary emergency admissions amongst older people to hospital has been singled out as a particular challenge in the Director of Public Health's Annual Report in 2015.

A recently commissioned review of services offered advice and recommendations on how the out of hospital care system might be improved with a specific focus on reducing delayed discharges from the Borders General Hospital.

The report also suggested that Borders has to develop more services to support people who have care and health needs out of hospital. This has created challenges for the system, which has meant that at times there is less capacity to support current discharges.

The report additionally noted that there is pressure on the capacity of domiciliary care in some parts of the Borders, which compounds problems in those areas. People who are discharged from hospital need to access the right services at the right time to assist with their recovery.

What will change?

Locally based multi-disciplinary community-led hubs will improve access to health and social care services for older people.

The majority of advice, support and care (including some urgent and non-urgent acute care) will be provided in the person's home or place of ordinary residence such as residential or nursing home.

In order to reduce inappropriate admissions and improve the discharge process from both the BGH and Community Hospitals we will work collaboratively with health, social care, third sector partners, patients, families and carers.

To reduce the length of stay in hospital, we will identify patients' acute, rehabilitation and homecare needs earlier in their illness. The further development of Anticipatory Care Plans (including plans to be held by individuals in their own homes) will also help reduce time spent in hospital, and the repetition of key information.

We will change the way in which hospital beds are used (at BGH and Community Hospitals) and review the function of day hospitals to improve care for older people, with more focus on rehabilitation and therapist-led enablement followed by support at home. By building capacity and capability in the community we will lessen dependence on residential care homes and hospital-based care.

Vulnerable adults will be able to live safely at home through improved Adult Protection practices and the creation of a matching unit, where staff link services to the needs of patients, improving access to locally based care at home.

Carers' health will be improved through a refreshed 'Carers Strategy' and by increasing the number of Carer Support Plans. All this will be done through a partnership programme of improvement and self-evaluation between Carers, Scottish Borders Council, NHS Borders, third sector partners and local service providers.

What will success look like?

- Older People will be supported to look after and improve their own health and wellbeing to live in good health for longer.
- Integrated health and social care teams will operate from locality hubs, providing a comprehensive package of care to help older people live, as far as reasonably practicable, independently and at home or in a homely setting.
- Carers will be supported to look after their own health and wellbeing, including a reduction on any negative impact of their caring role. Older people who need intermediate or acute hospital care will receive it promptly. Support from within an integrated community team will be available to patients and families in order to complete their Anticipatory Care Plans.
- Providing safe alternatives to admitting older people to a hospital will lead to care packages delivered by a joint health and social care teams, with on-going recovery and rehabilitation in the community. Joint working also results in better discharge planning and earlier return to home or community care.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Given the population projection for the Borders and the links between Long Term Conditions and age, future challenges to service provision can be clearly seen.

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PALLIATIVE AND END OF LIFE CARE

Vision

The vision for palliative and end of life care (PEOLC) in the Scottish Borders is for all services to work together to provide high quality and seamless care, enabling choice and promoting a dignified, fulfilled life and death, and a positive experience for all involved.

Current Services

Palliative Care is a term used for people who are living with a life limiting illness, where cure is no longer possible but quality of life is a central focus. To enable that quality of care early referral and diagnosis of a palliative nature is required.

End of Life Care is an important later aspect of Palliative Care. The timeframe of an individual's end of life is hard to predict but the Scottish Government recently quantified it as the last year of life[7].

The NHS Borders Palliative Care Team provides specialist outreach support to acute and community services. There is also an 8 bedded Specialist Palliative Care Unit – The Margaret Kerr Unit (MKU) where individuals can receive an inpatient assessment of their complex needs by a multidisciplinary team as well as a location for out-patient reviews at short notice in working hours.

Most admissions to hospital services for specialist input are entirely appropriate and allow the individual to receive good symptom control to enable them to return to their preferred place of care.

Numerous admissions occur which are related to:

- Changes in symptoms requiring urgent hospital based input
- Rapid alterations required to care packages
- Emotional distress of family members (sometimes requiring professionals to take command of the situation and no single service in charge)
- Lack of overnight care.

The Need for Change

The Scottish Borders Palliative Care Needs Assessment (2014) identified that 200-300 individuals received input from the palliative care services in NHS Borders. There was an estimation that at least 920 individuals may have benefited from referral and access to the services resulting in more timely intervention, better symptom control, better anticipatory care planning and a better experience towards the end of life. This number will increase year on year due to demographic changes and earlier identification and recognition of need.

What Will Change?

We will identify people earlier in their illness so they and their family, can achieve the right support, at the right time, rather than just at end of life.

Development and improvement of the palliative care services within the community will add value to individuals and their families' experience; this will be taken forward in line with the NHS Borders Palliative Care Strategy. This will lead to care being delivered in a more appropriate location, which will also lead to a better experience and reduced length of stay. In addition to this, anticipatory care planning will occur with all individuals.

[7] *The Strategic Framework for Action on Palliative and End of Life Care. Edinburgh: Scottish Government, 2015*

All care pathways will be reviewed to remove waste and reduce duplication to improve the quality of care for Palliative patients.

Enhancing skills and knowledge of palliative care through the NHS Borders Healthcare workforce is also a key aim.

We will also support all health and social care professionals to develop communication skills to enable difficult conversations and true informed discussion around treatment options including that of best supportive care. These conversations will also enable professionals to have a Realistic Medicine approach to healthcare ensuring all options, including what would happen if the individual doesn't have an investigation or treatment, discussed openly and honestly[8].

What Will Success Look Like?

Success for NHS Borders will mean:

- Anyone who requires access to palliative care is identified at the earliest opportunity and receives this care at right time, in the right way and in the right place.
- Information will, with the patients' permission, be shared with all those involved in their care in real time and be updated regularly.
- Good anticipatory care planning allows patients to express what matters to them.
- People approaching the palliative and end of life phases of their illness undergo only those interventions that are effective at optimizing their quality of life.
- People die (receive end of life care) in their preferred place of care with the support they and their carers require.
- The service puts in place measures that allow staff to monitor the support and input provided to patients enabling further improvement in a cost effective manner.
- All staff are comfortable talking about death, dying and bereavement.
- All individuals in our community are encouraged to have anticipatory discussions even with no palliative diagnosis so loved ones know how best to support them.
- Health, social care and third sector partners will have an increased level of knowledge and skills appropriate to their needs in order to deliver person-centred, safe, effective care.

[8] *Realistic Medicine: CMO Annual Report 2015-16. www.gov.scot/Resource/0049/00492520.pdf [accessed 29.6.16] and Realising Realistic Medicine CMO Annual Report 2016-2017 http://www.gov.scot/Publications/2017/02/3336*

NHS BORDERS
CLINICAL STRATEGY

MENTAL HEALTH

Vision

Borders will be a community which; promotes good mental health and wellbeing for all, respects protects and supports people with mental health issues and mental illness to live well, recognises, supports and values families and carers, and finally promotes partnership between services and the population they serve.

Current Services

Evidence shows that mental illness affects 1 in 4 adults and 1 in 10 children under 15. This would suggest that around 19,800 adults and 1,898 children and young people, living in the Scottish Borders will experience mental ill health at some point in their lives. Depression and anxiety are the most common illnesses; others include eating disorders, personality disorders and schizophrenia. However it should be noted that these figures estimates, the exact prevalence of mental health issues is problematic to approximate as many do not seek assistance.

The Mental Health service currently provides inpatient care for acute admission, rehabilitation, older adult assessment and treatment and complex care for older adults. The Mental Health service delivers this service across five wards with a total of 63 beds. One ward is based in Galashiels and the remainder are based within the Borders General Hospital campus. In addition, urgent assessment and liaison services are available 24/7 at the Borders General Hospital providing advice, assessment and support for people experiencing mental health crises and to general hospital inpatients.

Specialist inpatient provision is provided by NHS Lothian for example NHS Borders has service level agreements covering Children and Adolescent Mental Health Services (CAMHS), Intensive Psychiatric Care Unit (IPCU), Eating Disorders and Mother and Baby services. Hospital care is increasingly being used for the shortest time required to ensure a person's safety and the clinical effectiveness of any treatment required.

The community mental health services are delivered by co-located integrated multi-disciplinary community mental health teams for adults, older adults, addictions services and Children and Adolescents. These multi-disciplinary teams bring together staff from health and social care to provide a wide range of interventions from low level inputs through to high intensity support for people with complex needs, and this is delivered in local communities. In addition, there are services, commissioned by Scottish Borders Council, delivered by third sector organisations supporting this work.

The Need for Change

In order to inform future planning and service development, in 2014, the Mental Health Service commissioned an independent organisation to undertake 'The Scottish Borders Mental Health Needs Assessment'. In addition to the Needs Assessment, there are a number of action plans and work plans which arise from the Mental Health Board sub-groups including; Mental Health Commissioning Strategy Delivery Plan, Mental Health Improvement and Suicide Prevention Action Plan.

What Will Change?

There will be a framework for improving mental health and well-being for all age groups, which brings together a range of work including:

- Prevention of mental health problems
- Promotion of population mental health
- Delivery of care and treatment of mental illness
- Support for recovery

This framework will ensure delivery of commitments from the national strategies on mental health and suicide prevention, as well as enabling implementation of the local Mental Health Needs Assessment recommendations and Scottish Borders Health & Social Care Partnership Strategic Plan objectives as they relate to Mental Health.

A review of the Adult Mental Health service provision will be undertaken to ensure the most efficient use is made of resources across community and inpatient services and that services are delivered in the most effective way to meet the needs of the Scottish Borders. As part of this review, we will examine the balance between inpatient provision and community services across the statutory and voluntary sector.

For adult and older adult community mental health teams the continuation of the integration of health and social care will also impact on the services provided, this will mean:

- Easier access to the right worker at the right time
- Consistency in the service people can expect
- Evidence of continuous improvement across health social care partnerships creating a seamless experience for service users.

The Borders Dementia Working Group whose membership is solely people with a dementia diagnosis will further develop its role in; campaigning, influencing policies, reducing prejudice and stigma, service development, as well as being the voice of people with dementia.

The Children and Young People's Planning group is committed to; increasing understanding of mental health, raising awareness of the information resources and supports available for children and young people and families, and improving access to support when required. Engagement with young people and with parents will be essential.

What Will Success Look Like?

Success for NHS Borders Mental Health Services will mean:

- People are able to find and access information and advice on mental health and wellbeing when they need it
- Communities are more confident about what they can do to promote mental health
- Improved support pathways for people who are at risk of or experience mental ill health
- Frontline staff have the appropriate levels of knowledge and skill to enable them to provide the best support and signposting
- Individuals will have an increased understanding of their own mental wellbeing
- Improved access to services and reduced barriers particularly for those with dual diagnosis.
- Admission to hospital will be avoided and people will be effectively supported in their communities where possible

- Services will be delivered in settings that are appropriate in design to meet the need of service users
- Financial resources will be aligned to ensure services are delivered in the most appropriate way

NHS BORDERS
CLINICAL STRATEGY

LEARNING DISABILITIES

Vision

Our vision is that adults with learning disability within the Borders will have opportunities to live as healthily and independently as possible, as valued members of their local communities.

Current Services

The service consists of an integrated Health and Social Care staffing group of professionals including:

- Social work
- Learning disability nursing
- Occupational therapy
- Physiotherapy
- Dietetics
- Speech and language therapy
- Psychology
- Psychiatry
- Music Therapy
- Local Area Co-ordination

The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require more specialist interventions than those provided by mainstream Health and Social Care services. The service is responsible for commissioning packages of support for people with learning disabilities living within Scottish Borders and some specialist out of area placements. The service provides; assessment, care management, treatment, specialist advice and consultation, training and support.

There are 21 providers that are contracted with in Scottish Borders and 19 providers out with the Borders. The services range from Residential Care Homes, Supported Living (Care at Home and Housing Support), Day Opportunities and Grant-Agreements for Day, Opportunities/Social Enterprises and Independent Advocacy.

The Need for Change

There is a range of evidence to suggest the number of people with learning disabilities may be increasing at a national level, because of a range of factors including changes in the size and composition of the population; changes in the incidence of learning disabilities; and changes in life expectancy among those with learning disabilities.

Inpatient Services

NHS Borders closed the learning disability in-patient unit in 2006. Following closure of the unit if a patient with a learning disability requires an admission to hospital for assessment and treatment because of their learning disability the following options are considered in order of preference:

1. Huntlyburn – only suitable for people with a mild learning disability
2. Learning Disability Managed Care Network (MCN) (Lothian, Forth Valley or Fife)
3. NHS Scotland
4. Private hospital in Scotland or England

An option appraisal took place in 2014 to consider the options for the future for in-patient beds when needed and the preferred option was to consider purchasing beds from NHS Lothian in their redesigned service. Currently a business case is being drafted to reflect this and will be presented to NHS Borders Board and the Borders Health and Social Care Integrated Joint Board in 2017.

Step up step down services provide health and social care input and are designed to allow transition from hospital to community living or to prevent hospital admission for people requiring skilled and typically high levels of support. There are no such facilities within the Borders therefore clients who require this level of service are currently placed out of area. Scottish Borders are currently exploring what a local facility might look like. There have been some preliminary discussions with NHS Lothian and local authorities. We need to consider all potential options including the feasibility of local options.

What Will Change?

The Learning Disability Service will:

- Improve Contractual Arrangements
- Improve Housing and Models of Support
- Further develop care pathways
- Improve the quality of transitions as young people move into Adult Services
- Provide better local area co-ordination
- Increase employment and volunteering opportunities
- Provide opportunities for short breaks for clients and families
- Improve advocacy services

What Will Success Look Like?

The focus will be to enable more people to have more choice and control over their care, support and health needs.

Success for adults with Learning Disabilities is that they will:

- Stay healthy
- Live well
- Have a place to live
- Have a job
- Stay safe
- Have the right support from carers

NHS BORDERS

CLINICAL STRATEGY

MATERNITY AND NEONATAL SERVICES

Vision

All mothers and babies will be offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences, supported by fathers, partners or other family members.

Current Services

Maternity and Neonatal Services within NHS Borders are delivered from a wide range of community settings including the woman's own home and the Borders General Hospital. Community Midwives provide care for women close to home. A Consultant-led service is available for women with more complex pregnancies. A multi-agency Early Years Assessment Team is based in Selkirk and delivers care to vulnerable families. In addition, the Family Nurse Partnership delivers an intensive, preventive, home visiting programme for first-time, teenage parents to give their children the best possible start in life.

NHS Borders has approximately 1000 deliveries per annum, with 23% of these being delivered by caesarean section. Newborn babies are kept with their mothers wherever possible. Transitional care is provided by neonatal nurses, midwives and maternity care assistants at the mother's bedside in the postnatal ward. The BGH Special Care Baby Unit (SCBU) is capable of caring and monitoring newborn babies delivered within Borders General Hospital although the smallest and sickest are transferred to the Neo natal unit in the Royal Infirmary of Edinburgh.

The Need for Change

Service improvements are driven by learning from audits, reports and evidence from work by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and the Scottish Maternity Care Experience Survey: 2015. In addition two significant recent investigations into maternity care (the Report of The Morecambe Bay Investigation: 2015 and the Montgomery Judgement: 2015) have driven improvements in NHS Borders.

The Review of Maternity and Neonatal Services in Scotland sets out a vision for the future planning, design and safe delivery of high quality maternity and neonatal services in Scotland. It puts the family at the centre of decisions so that all women, babies and their families get the highest quality of care according to their needs. The key objective of the review recommendations is to secure improved health and wellbeing for mothers and babies in the short, medium and long term.

While most women remain healthy, trends within the general Scottish population show a significant proportion dealing with one or more co-morbidities. This is evident among childbearing women, with a steady rise in older mothers and women with a range of other health issues and long-term conditions. These factors are associated with an increased need for intervention.

Maternal obesity levels are expected to rise from the current level of 20% to a conservatively estimated 30% by 2030. This may lead to an increase in caesarean section rates and length of hospital stay. Therefore, hospital maternity services will need to adapt.

What Will Change?

Universal and Additional Service Provision: NHS Borders Maternity Services are in the process of adopting the recommendations from THE BEST START, (A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland), Scottish Government 2017. In line with the recommendations women

and families will benefit from enhanced support from universal midwifery and health visiting and Advanced Health Practitioner services enabling earlier identification of need and subsequent appropriate intervention. Women and babies with additional needs will benefit from multi-professional working.

A single Maternity Network for Scotland will be developed, along with a single Neonatal Managed Clinical Network. ‘In addition to this, a national training plan for maternity services is being developed and once completed, this will be implemented within NHS Borders.

Services will be redesigned using the best available evidence, to ensure optimal outcomes and sustainability, as well as maximise benefits from resources. The views of current service users are critical to informing the future design of services to ensure that the changing expectations of women and their families are being addressed.

Current access to perinatal mental health services will be reviewed to ensure early and equitable access is available to high quality services, with clear referral pathways.

In every case where a family is bereaved, they will be offered access to appropriate bereavement support before they leave the unit, with access to staff members trained in bereavement care.

What Will Success Look Like?

We will focus on the key recommendations of the Maternity and Neonatal Review laid out in Scottish Government’s Best Start document.

- All mothers and babies will be offered a truly family-centred, safe and compassionate approach to their care.
- Fathers, partners and other family members will be actively encouraged and supported to become an integral part of all aspects of care.
- Women will experience real continuity of care and carer across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require.
- Services will be redesigned using the best available evidence, to ensure optimal outcomes and sustainability, maximising the opportunity to support normal birth processes and avoid unnecessary interventions.
- Staff are empathetic, skilled and well supported to deliver high quality, safe services, every time.
- Multi-professional team working is the norm within an open and honest team culture, with everyone’s contribution being equally valued.

NHS BORDERS
CLINICAL STRATEGY

CHILDREN AND YOUNG PEOPLE

Vision

All children and young people will have the best possible start in life and reach their full potential, regardless of their starting point and will be able to access high quality universal and targeted services.

Current Services

Much of the health care related to children is carried out in the community. Many outpatient consultant clinics are held in local health centres. Community Children's Nurses support families who have a child with complex health needs. Allied Health Professionals provide care at home and in local health centres as part of the multidisciplinary team around the child. Outpatient clinics are provided for both general and community paediatrics and also a range of specialist clinics including cardiology, epilepsy, diabetes, allergy and respiratory. Other clinics include tertiary specialists who visit NHS Borders to bring appropriate care closer to the child.

Hospital and Ambulatory Care for children and young people is concentrated on a single site at Borders General Hospital. Ambulatory Care provides children and young people with a one stop service for further investigation, assessment and treatment. Approximately 1400 children per year are seen on an ambulatory care basis.

There are approximately 4500 attendances per annum at the Emergency Department (ED) within the Borders General Hospital for patients aged under 18, 14% of which are admitted.

Children and young people who need highly specialised care are transferred by the SCOTSTAR team to tertiary centres. The Borders General Hospital provides step up and step down care for children who use these tertiary services.

Scottish Borders Child Protection services are delivered from a co-located multiagency unit in Galashiels with the Looked After Children's service as part of this team.

The Need for Change

We can expect the population of children and young people to fall over the next 20 years as the age profile of the Scottish Borders population shifts and we will need to adapt our models of child health accordingly. This will mean keeping under review what can be provided locally, within Borders and regionally. Patterns of childhood illness are also changing, with implications for service demand. Nutrition and healthy weight are of particular concern, around one in five 3 year olds are overweight or obese.

Increasingly, the mental and emotional health of children and young people is a concern.
The Children and Young People (Scotland) Act 2014 requires us to strengthen the focus on the rights and wellbeing of individual children to enable them to achieve their full potential. It is therefore essential that the services we provide to children, young people and their families are timely, of high quality, evidence based, efficient and continually improving.
Alongside this we need to demonstrate through the services we provide that we understand the health needs of Borders' children and young people and that we are responsive to them. This will require us to further develop pathways of care and improve how we use the skills and experience of the multidisciplinary health care team.

NHS Borders, together with our partners in Community Planning Partnership, are implementing the Universal Pathway for children and young people set out in Getting It Right For Every Child

(GIRFEC) national guidance which spans the early antenatal period until the child's 18th birthday. The National Delivery Plan for Specialist Children's Services has set the framework for enhanced local provision in Borders, with access to highly specialist services regionally and nationally.

What Will Change?

Through the Community Planning Partnership, NHS Borders will engage with others to address the key public health challenges and wider influences that affect health and wellbeing outcomes for children and young people, in order to reduce inequalities.

This will mean that:

- Children will be admitted to hospital only when the care they require cannot be equally well provided in the community.
- We will develop and deliver health care for children and young people in close alignment with other key local services, particularly social work and education.
- We will work with regional planning partners to improve quality, effectiveness and efficiency of models of care for children and young people in the Borders.
- In line with the Children and Young People (Scotland) Act 2014 children and families will benefit from enhanced support from universal services (midwifery and health visiting) and specialist services (Advanced Health Practitioner, School Nursing and Community Children's Nursing) services enabling earlier identification of need and subsequent appropriate intervention.
- We will need to undertake workforce planning and development to meet the needs of new models of care.

What Will Success Look Like?

- Overall, we will focus on the delivery of the key outcomes set out in the Integrated Children and Young People's Plan to ensure the health and wellbeing of children, young people and families is improved and health inequalities are reduced.
- As is their right, children and young people will be involved in decisions and planning that affect their health and, when it is appropriate, families will also be included
- The transitions from child health services to adult services will be seamless.
- There will be greater capacity to deliver health care services in the community for children who are unwell.
- We will have a sustainable workforce with appropriate skill mix, adaptive to changing needs and new models of care.
- Services will be delivered in environments which are suitable for children, young people and families.

NHS BORDERS

CLINICAL STRATEGY

URGENT ACUTE CARE AND PLANNED CARE

Vision

The urgent and planned acute care needs of the Borders population will be delivered through seamless and integrated working between acute, primary and social care teams delivering care in the most appropriate setting.

Current Services

The Borders General Hospital (BGH) has the following core services:

- An emergency department (ED)
- Acute medical and surgical services
- Diagnostics, imaging and laboratory services
- Operating theatres and critical care
- Outpatient services

In addition to this, the BGH delivers care for the whole of the Borders population for a range of medical, surgical and gynaecological specialty level services with consistently high levels of clinical quality and patient satisfaction. These services are underpinned by clear patient pathways supported by the Scottish Ambulance Service, NHS24, Scottish Borders Council, voluntary sector partners and regional partnerships with tertiary service providers and managed clinical networks.

Great success has been achieved in the last 10 years in moving traditionally urgent care work streams to be undertaken as planned activity.

Significant shifts have been made towards models of care delivered through:

- Ambulatory care
- Rapid access clinics
- Open access diagnostics
- One stop clinics for diagnosis and treatment
- Treatments delivered through outpatients and day case pathways

Many specialities have moved to models of care predominately delivered in an outpatient setting and have well developed enhanced and specialist nursing and allied health professional roles to support this care model.

Other specialities have moved largely to the provision of treatment through day case pathways including gynaecology, ophthalmology, ENT, general surgery, orthopaedics and urology with only a small proportion of patients being treated as inpatients. These models are supported by a day procedure unit and planned surgical assessment unit minimising the impact of planned surgical activity on inpatient beds.

NHS Borders commission specialist assessment and treatment for specific patient pathways from strong links are already established with tertiary centres including Edinburgh and Greater Glasgow and Clyde.

NHS Borders is one of four national test sites working to improve patient flow across planned and urgent care. The project is sponsored by the Scottish Government and is being delivered by the Institute for Healthcare Optimization (IHO). The aims in phase one of this project is to build a sustainable and resilient surgical service, reducing the numbers of patients sent out of area for treatment due to the competition between urgent and planned resources (i.e. reliance on

shared resources like theatres, beds and staffing), which will in turn reduce cancellation of planned procedures and improving patient experience.

In addition to this work major revisions were made in 2016 to the medical model of care within the BGH. Strengthening the ability to assess and treat patients through an ambulatory care model, whilst also enhancing senior medical decision making and services for care of frail elderly patients.

The Need for Change

The challenges facing urgent and planned care in NHS Borders are real and pressing. The main issues for the service at present are around workforce, the increasing demand on the service, mainly due to an ageing population with increasing multi-morbidities, and the pressure that this is putting on the physical environment means that facilities require improvement.

These issues translate into the following drivers for change:

- Our demographics indicate we have an ageing population and proportionately higher older population than the Scottish average.
- Increasing multi-morbidity.
- Indications that Borders has higher urgent hospitalisation rate per 100,000 head of population than Scottish average.
- We continue to have regional clinical pathways for specialised tertiary care.
- The physical environment is ageing and difficult to modify to fit modern clinical models of care.
- We have an aging workforce and an increasingly challenging vacancy rate in medical and nursing staffing.
- Finite resources to meet the needs of the population across health and social care.

Alongside this there is a need to focus on quality improvement in healthcare, supported by the publication of Realistic Medicine in Scotland .

The level of community and intermediate care available has resulted in delays to discharge for those who require an acute or community hospital stay. Such delays have necessitated additional surge capacity within the acute hospital and staffing to maintain safe patient care.

What Will Change?

- The Borders General Hospital will continue to have staffing and infrastructure to deliver urgent and planned care that includes resilient services for:
  - Emergency department (ED)
  - Acute medical and surgical services
  - Diagnostics, imaging and laboratory services
  - Operating theatres and critical care
  - Outpatient clinics
- Reduction in the proportion of care which is unscheduled in nature, only using emergency inpatient hospital services as a last resort. This will, in turn, allow us use a greater proportion of resources to deliver more planned care in the hospital and in the community reducing the need for inpatient stays.
- Roles will shift between secondary and primary care – new models of care will need to be developed to provide support and outreach within the community.
- Realistic medicine will form a strong focus for all local service eliminating procedures with low clinical effectiveness and reducing variation in clinical practice.

[9] *Realistic Medicine – Annual Report by the Chief Medical Officer; Scottish Government, 2016*

- Participate in regional and national discussions to develop resilient specialist services through collaboration with tertiary centres, trauma centres and diagnostic and elective treatment centres as part of the East Region Health & Social Care Delivery Plan.
- Where assessment, diagnosis and treatment are required it will increasingly be provided through models of ambulatory care, rapid access, outpatient and day case treatment.
- Work to separate out elective flow and minimise impact of unscheduled flow will ensure patients receive and timely planned service and will enable NHS Borders to bring back all of the patients sent for elective treatment out of area for routine procedures in general surgery, orthopaedics, gynaecology, ENT and urology.
- Explore potential for surgical ambulatory care model, further standardisation of high volume pathways to make hospital stay as brief as possible for patients and a continued move to treatments and procedures offered through outpatient, day case and 23 hour stay models.

Specifically NHS Borders will:

1. Work jointly with primary care, social care and other agencies to deliver a sustainable modern clinical model of care
2. Work towards an effective seven day model for urgent care and a smoothed scheduled of planned services across the week
3. Consider traditional ways of work against new models of delivery to help overcome the workforce challenges facing urgent and planned care
4. Continue to develop enhanced and specialist roles in nursing and allied health professions to provide the appropriate level of support to both medical and surgical assessment and treatment
5. Will convert urgent care activity to planned care activity through further developments to ambulatory care models, planned clinics and treatments for both medical and surgical pathways
6. Develop resilient diagnostic services which can be flexible and responsive in support of clinical decision making enabling early diagnosis, preventing admission and reducing length of stay in hospital
7. Review ambulatory care to assess if expanding this service could bring relief to other areas of the hospital and improve ways of working between departments
8. Review the space and design of urgent care facilities and explore potential for co-location of services to assess the possibility of an urgent care hub
9. Work with partners in social care to ensure seamless transitions of care for those who need on-going care at home
10. Ensure new service models are underpinned by agreed patient pathways and workforce plans to optimise clinical expertise

What Will Success Look Like?

Success for Urgent and Planned Care services in NHS Borders will mean:

- Urgent and planned care services that are integrated in order to provide seamless care
- Closer ties with other specialties and less traditional ways of working to resolve staffing pressures
- Emergency services accessed as a last resort ensuring only people who require specialist hospital care are admitted into a general hospital
- More patients treated within planned care services through improved access to diagnostics, ambulatory and rapid access services, outpatients and day surgery procedures
- Timely access to urgent care services across primary and secondary care
- Outcomes of care and treatment continue to improve through continuing to adapt as new treatments develop

- Timely specialist care from a multi-disciplinary team to support self-management of Long Term Conditions
- Partnership working results in no delays in transitions of care from hospital to home
- Regional partnerships identify clear pathways for those who require tertiary care with timely repatriation
- Ways of working adapt to address the challenges of providing timely and appropriate care in the community for our frail older population
- Working with partners on pathways for people with dementia to keep them well in their home environment
- Developing and supporting our staff to ensure a highly skilled and motivated workforce

NHS BORDERS
CLINICAL STRATEGY

CANCER SERVICES

Vision

To provide high quality, safe, seamless and sustainable cancer services for NHS Borders population which recognises prevention and early detection being as important as treatment and cure and that cancer, for many, is now a Long Term Condition. Underpinning this will be integrated multi-disciplinary working and communication across health and social care boundaries to ensure people affected by cancer are supported to have the best quality of life, including at end of life.

Current Services

Cancer care for patients in the Scottish Borders is delivered over primary, secondary, tertiary and social care settings to ensure that care is delivered by the most appropriate team in the most appropriate setting.

NHS Borders participates fully in the Regional Managed Clinical Network for South East Scotland (SCAN) to support up to date, equitable and accessible care for Borders patients. Through the SCAN network NHS Borders feeds into the national cancer agenda.

A large number of cancer services are delivered locally, namely

- Diagnostics
- Surgical Treatments
- Level 2 Haematology
- Systemic Anti-Cancer Therapy (SACT) and Supportive Treatments
- Unscheduled Cancer Care
- Palliative Care
- Non-surgical Visiting Oncology service for breast and lung cancer
- Information and Support Services

The Borders Macmillan Centre provides a focus for specialist services and hosts the Cancer Information and Support Service, Macmillan Welfare Benefits Team, Cancer Clinical Nurse Specialists and the SACT treatment area.

Tele-presence facilities in the Borders Macmillan Centre allow tele-links with colleagues regionally and nationally and have been key to facilitating access to specialist cancer teams across the region supporting timely clinical decisions.

We aim to treat people as close to home as is safely possible however to ensure best outcomes some specialist cancer services are delivered out with the locality e.g. Radiotherapy, specialist surgery, stem cell transplants and some SACT treatments.

The Need for Change?

Every year around 730 people in the Borders are told they have cancer and trends predict that the number is likely to rise to 850 by 2027. The total number of people diagnosed with cancer is increasing year on year, due to the increasing number of older people in the population as well as improvements in diagnosis. The number of people living with cancer at any one time (prevalence) is also increasing not only as a result of advances in cancer treatments but also due to effective screening programmes, early detection and improved diagnostics.

The increase in number of people diagnosed and living with cancer, as well as the increasing age profile of people using these services will place further demand on current service. The advent of new diagnostic methods, therapies and technology will also bring challenges, as well as opportunities, for local cancer services.

What will change?

To improve early detection of cancer and reduce health inequalities partnership working, across health and social care boundaries, will be built upon, to develop and implement evidence based health improvement programmes.

NHS Borders is committed to supporting our diagnostic services to proactively manage demand and ensure timely and efficient access for patients, particularly those with a suspicion of cancer.

We will ensure people with cancer in the Borders are not disadvantaged by geography and have access to the most up to date surgical techniques e.g. minimally invasive surgery.

We will commit to reviewing the trial portfolio available for local delivery, as well as working with the regional tumour groups to increase recruitment to trials for less well represented tumour groups.

Further work is required to build on the success of the Transforming Care After Treatment (TCAT) programme work and embed this concept as business as usual. On-going work will look to maximise opportunities for integration and ensure equity of access for all.

We will promote further culture change, both within and between professional groups and agencies, to create an environment which enables innovative thinking and working which acknowledges expertise across the professional groups and agencies.
We will work with our e-health team to ensure that we maximise the use of technology to deliver timely communications across teams as well as considering innovative eHealth approaches to service delivery and data sharing.

We are committed to developing person centred services and our recently formed Cancer Experience Group ensures the feedback given by users of cancer services (staff, patients, public and stakeholders) is used to inform current and future services. This group provides a forum for us to learn and change from positive and negative feedback and will continue to underpin all future service delivery.

What Will Success Look Like?

- Services co-designed with patients, carers, staff and the public to ensure care is delivered in the right place by the right team at the right time.
- Sustainable safe, high quality services across the pathway informed by evidence and supported with modern, adaptive and sustainable e-Health and digital technologies.
- A workforce that has the capacity, capability and adaptability to meet future demands
- A reduction in health inequalities with improved planning and coordination of activities that contribute to cancer prevention.
- Every person diagnosed with cancer having access to specialist information and support from diagnosis.
- Every person diagnosed with cancer having access to support after treatment

NHS BORDERS

CLINICAL STRATEGY

PHARMACY SERVICES

Vision

All patients, regardless of their age and setting of care, will receive pharmaceutical care tailored to their needs to ensure they get the best possible outcomes from their medicines and avoiding waste and harm.

Current Services

Medication is by far the most common healthcare intervention in the NHS, within NHS Borders prescriptions are dispensed each year at a cost of over £30 million. This indicates that the vast majority of people who seek healthcare advice and treatment will access pharmacy services at some point during their care journey.

NHS Borders has 29 community pharmacies dispensing medicines to patients and providing advice and help to prescribers, patients and carers about how to use their medicines safely and to the best effect. In addition to dispensing medicines, community pharmacists also provide complete packages of care without the need for referral to others; this includes smoking cessation, emergency contraception and the supply of medicines to treat self-limiting minor conditions, including urinary tract infections in women, and undertake medicine reviews for some clinical conditions.

Within the hospital pharmacy service a team of pharmacists, technicians and support staff provide a range of services including medicine procurement and supply, and specialist dispensing services such as aseptic and cancer chemotherapy dispensing. This is supported by long-established clinical pharmacy services in which clinical pharmacists are fully integrated into the ward medical and nursing teams to provide care for patients that are focused on achieving the best outcomes from medicines.

The Prescribing Support Team works within primary care to provide analysis, advice and support to general practitioners and other healthcare professionals and clinical teams in order to promote high quality and cost effective prescribing. The team is undergoing a transformation in roles and the services they provide, which will see the introduction of general practice clinical pharmacist independent prescribers into a substantial number of GP practices across NHS Borders.

The Need for Change

The care of patients with multiple medical conditions is one of the greatest challenges now faced by healthcare providers. Across the NHS the use and cost of medicines has continually increased over the years.

While medicines have a significant impact on improving patient outcomes there are risks and the potential over use of medicines and polypharmacy (use of multiple medicines) is a cause for concern. A key healthcare aim for individual patients is to ensure the on-going safe and effective use of their multiple medicines.

Each year in Scotland it is estimated that 61,000 non-elective admissions are due to a medicine-related issue. To support the continued safe, effective and efficient use of medicines requires that there are robust medicine governance systems in place so that all prescribers in Borders have access to information and support they need.

National drivers from Scottish Government, such as 'Prescription for Excellence'[10], 'Realistic Medicine'[11], and the Primary Care Fund, will direct changes in practice and it is essential that we take this opportunity to improve the use of medicines for the benefit of our patients.

There is scope for pharmacists and other healthcare professionals to work together to better utilise their considerable training and expertise and contribute more to how our healthcare system and patients use medicines to best effect.

What will Change?

Within NHS Borders we will embrace the opportunities provided through the national drivers and locally through the Integrated Care Fund and the local Transformational Change Programme.

For example:

- The pharmacy workforce will be supported and developed to ensure that its unique skill-set is able to be utilised to deliver safe and effective patient care and service efficiently across all health and social care settings.
- We will continue to develop and build upon our foundation of locally negotiated contracts with community pharmacists, particularly in the areas of minimising harm from medicines through the medicines review service and providing support for vulnerable patients.
- We will develop services to help patients and their carers understand the benefits and risks of medication to empower patients to make fully informed decisions about their medication treatments.
- NHS Borders pharmacy services will review costs associated with the money invested in medicines.

What Will Success Look Like?

- Every person is able to get the best health outcome that they can from their medicines
- Patients are able to make informed decisions about their medicines and discuss them with anyone involved in their care
- Patients are able to ask for help if they have a question or a difficulty with their medicines
- Harm from medicines is reduced
- Ensuring that treatments of little value or no longer required are reviewed
- NHS Borders achieves greater value the for money invested in medicines

[10] *Prescription for Excellence; Scottish Government, 2013*
[11] *Realistic Medicine - Annual Report by the Chief Medical Officer; Scottish Government, 2016*

NHS BORDERS
CLINICAL STRATEGY

SUPPORT SERVICES

ESTATES

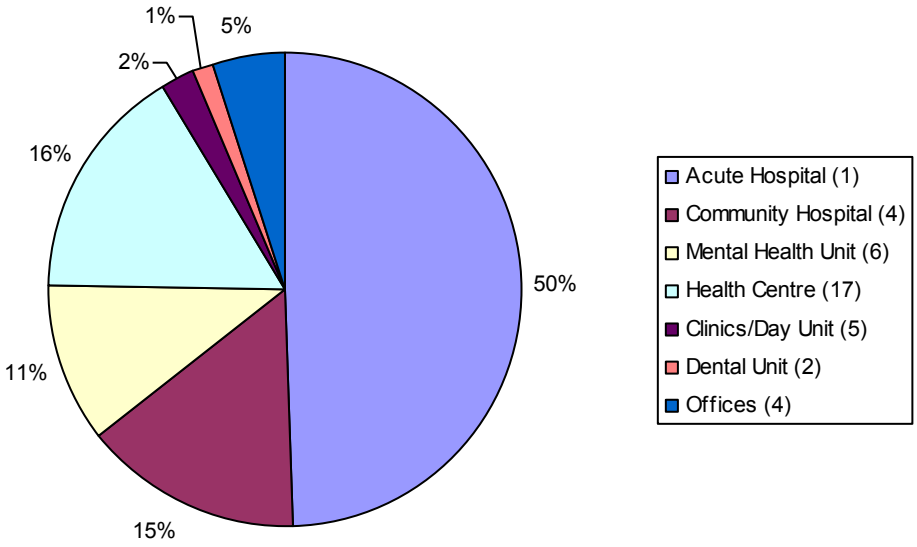
Vision

All of the facilities in NHS Borders will be fit for purpose; they will meet the needs of the patients and staff of, as well as being flexible enough to adapt to change and development within services. We will seek to optimise the utilisation of assets in terms of service benefit and financial return.

NHS Borders's Property

Healthcare premises within the portfolio of NHS Borders include the District General Hospital (the BGH); Community Hospitals; Health Centres and Outpatient Clinics, which are sometimes located within Community Hospitals (Kelso and Hawick); Health Centres/Premises which are owned and operated by GPs and other family health services, independent contractors, Mental Health Services sites, dental centres and office sites.

Overall, services are provided from 39 buildings, below is an analysis of the buildings owned by NHS Borders, by property type,



Backlog maintenance is defined as investment to maintain or to restore properties to a fully acceptable condition in relation to building fabric, building engineering services and infrastructure.

In the financial year 2017/18 the backlog maintenance requirement for NHS Borders is estimated at £8.34m, an increase of around £2.14m from that reported within NHS Borders PAMS 2014/15.

Need for Change

The strategic direction and vision of NHS Borders Estates is underpinned by key national drivers and local priorities:

- The Scottish Borders Health and Social Care Integrated Joint Board (IJB) has published a Strategic Plan for 2016 – 19 which encapsulates the way in which an integrated approach to health and social care services will be taken forward.
- The Community Planning Partnership (CPP) in line with the Community Empowerment (Scotland) Act 2015[12], will be supporting localities to consider how they can use their land and buildings more efficiently and ensure resources are used more effectively.
- All NHS Boards have a legal duty to prepare for climate change with specific duties set out in Part 4 of the Climate Change (Scotland) Act 2009[13]. In November 2014 the Scottish Government made Climate Change Reporting a mandatory requirement for all public bodies and stated that an annual Public Sector Sustainability Report be submitted in November of each year commencing in 2015.

What Will Change?

The future of our buildings will be determined by the NHS Borders Clinical Strategy and Transformational Change Programmes. Additionally the synthesis of the Health and Social Care Integration, implications of National Treatment Centres, developments with regional working, changes to GMS contracts and population projections, will all have significant impact.

All of these factors will combine to define what we need from our buildings and what must change within our estate to allow NHS Borders to provide the best possible service for our patients within acute, primary care and mental health settings.

Although the detail of what needs to change is not yet clear, what can be said is that significant capital spend will be required and a business case will need to be developed to bid for resource, in order to bring the buildings and infrastructure within NHS Borders up to the standard of the fit for purpose facilities that we expect to use for the next 30 years.

What Will Success Look Like?

Success for the future of NHS Borders will mean:

- The Borders General Hospital will be a modern, fit for purpose facility which will be the key to NHS Borders delivering 21st century health and social care.
- Primary and community care will be provided from adaptable buildings able to meet the future changing needs of the population.
- All of our properties will be efficiently used with little underutilisation or overcrowding.
- We meet or exceed our carbon-reduction targets in terms of heating, light and power.
- We will optimise opportunities for shared accommodation with other public and third sector partners.

[12] *http://www.legislation.gov.uk/all?title=Community%20Empowerment%20%28Scotland%29%20Act*
[13] *http://www.legislation.gov.uk/asp/2009?sort=title*

NHS BORDERS
CLINICAL STRATEGY

TRANSPORT

Vision

NHS Borders will continue to work with stakeholders and partners to address the varied transport needs of the community of the Borders, to ensure that clinical services are as accessible as possible.

Current Services

The geographical spread and sparse population in the Borders means that the ways in which the NHS Borders population access healthcare services are both challenging and essential, transport is a key element of planning for redesign.

Scottish Ambulance Service (SAS) is our main provider of transport services for NHS Borders and provides non-emergency patient transport services for patients who whom travelling by any other means could be harmful to their health.
The SAS service operates predominantly between 8am and 4pm. There is a limited service funded by NHS Borders after this time and at weekends.

Staff also use their own vehicles to travel to and from their sites of work, staff who regularly use their vehicle for work purposes can apply for a lease car through NHS Borders and this process is managed by the finance department.

In terms of public transport First Bus has recently withdrawn services from the Borders and Borders Buses have now taken over. This is a fluid situation which leaves uncertainty regarding public transport arrangements. To address this NHS Borders is liaising with Scottish Borders Council as part of the Strategy Transport Board for the Community Planning Partnership.

NHS Borders has a fleet of vehicles for a range of purposes, the fleet consists of different makes, models and specifications, to ensure that appropriate support can be provided across all service requirements.

Some of the main areas of service where vehicles are utilised are; Catering, Laundry, Courier service, General Estates vehicles to support maintenance of properties, Specialist vehicles e.g. the BECS "On-Call" cars which are fitted out with specific equipment, 4x4 vehicles which are particularly important during severe weather.

The Need for Change

There a number of challenges with patient transport within NHS Borders, the major areas of focus are as follows:

- There is a need to increase integrated working between NHS Borders emergency departments and SAS.
- Exploring a wider mix of service providers, such as third sector providers could help to support some transport needs.
- There is a need for rapid access to appropriate transport, including in out-of-hours periods, to support developing service models.

There are parking pressures on almost all of our sites but most acutely at the Borders General Hospital. Despite the introduction of Car Park Management in 2013 and construction of 43 additional spaces and an informal parking area with space for approximately 40 more cars the

availability of spaces at BGH for patients and staff is very restricted most particularly in the afternoons.

NHS Borders undertakes an assessment of all vehicles owned by the organisation annually, although some investment has been made in this area NHS Borders continues to purchase second hand vehicles by way of refreshing the fleet, but continues to own an ageing vehicle estate.

What Will Change?

- In connection with our partners an NHS Borders Transport strategy will be produced to ensure that our sites are supported by appropriate public transport links, which are recognised as proportionate and accessible.
- We will explore new or enhanced ways of working with the Scottish Ambulance Service and Third Sector partners.
- We will continue to work with the national shared services programme, across the east region as well as continuing to share best practice with regional partners.
- NHS Borders will consider a range of initiatives including revised car park management and extension initiatives such as our existing car-sharing scheme. However no additional movement of people or services to BGH Campus will be undertaken without assessment of the Car Parking implications.
- NHS Borders will explore opportunities around shared transport issues within the region. This work is only just beginning but the intention is to share examples of good practice linked to fleet and transport management.

What Will Success Look Like?

For NHS Borders success will mean:

- No patient is unable to access NHS Borders services due to inability to travel to them.
- Patients requiring access to NHS Borders services are able to do access them simply and in a variety of ways that are suitable to their needs.
- Improved transport links to our facilities, as well as more access to accurate and up-to-date travel information.
- Patients are able to and supported to easily access services out with the Borders as part of their pathway of care.
- Improved joint-planning with all of our transport partners.

NHS BORDERS
CLINICAL STRATEGY

eHEALTH

Vision

Meeting the 2020 Vision for Scotland and the ambitions set out in the National Clinical Strategy for Scotland requires a well-trained and highly motivated workforce that is supported with modern, adaptive and sustainable eHealth and digital technologies.

We need to strengthen our ambition to use technology to enable safer, more efficient delivery of services and provide the ability to collect and analyse data to guide service planning and treatment decisions. eHealth and digital technologies will support the transformation of patient care enabling further self-care /management supporting patients and their carers.

Current Services

NHS Borders has successfully implemented a range of eHealth and digital technologies to support the provision of care. eHealth systems are operational across primary and secondary care. Where possible the adoption of national systems has been taken place.

While NHS Borders has successfully implemented eHealth solutions across many settings there is still much to do. Electronic data capture remains relatively modest and much clinical information is still stored on paper. The majority of systems are local and hosted in a data centre at the Borders General Hospital but where more appropriate and cost effective, national systems have been adopted.

The Need for Change

Clinicians are increasingly reliant on technology and information systems to deliver care meaning there is a high dependency on a reliable and robust IT infrastructure. The increased complexity of systems that comes with this reliance can make it challenging for a small health board to deliver a sustainable support model.

Looking forward:

- Many of our current applications are reaching end of life and will need to be upgraded or replaced.
- Community based teams are poorly served, making very little use of technology and require access to high quality patient information wherever they are, whether on NHS premises or visiting a patient at home.
- Borders General Hospital still relies on paper systems for prescribing and medicines administration, which has been identified nationally as a high risk area. A Hospital Electronic Prescribing and Medicines Administration system (HEPMA) would provide a solution to mitigate this risk.
- The increasing need for workforce mobility and working in multi-disciplinary teams across health, but also social care, will need new modern technology solutions.
- We need to find new ways for technology to support clinicians to interact with patients and make services more accessible to patients in hard to reach groups.

What Will Change?

The opportunity to include digitised "live" health records will start to build the key components needed to deliver a single view of the patient's record, accessible real-time 24/7 and will eradicate many of the problems experienced with the traditional paper record.

We will start to capture more clinical information electronically at the point of care.
This will reduce the need for handwritten patient records. Significant benefits will be delivered including; legible records, increased availability, easier to share, easier to secure, manage and monitor.

A new Community Information System will provide greater access to information so that community based teams are able to plan and care for their patients more effectively, preventing unnecessary hospital admission and facilitating faster discharge from hospital.

The introduction of a HEPMA will provide clinical decision making support improving patient safety; the system will reduce drug errors, speed up the medication reconciliation and improve the notification of allergies, drug interactions and duplicate treatments.

Improved electronic information sharing is required between health and social care and their third sector partners, to ensure that the patient receives the right level of care based on all the information being available. This will be enabled through the new Community Information System and by taking advantage of collaboration tools now in the market place like Office 365.

The ability for patients to electronically access their personal health record is still only possible in very limited circumstances, for example for some diabetes patients. The need to extend this access for all patients is a key national strategic objective.

We aim to deliver an Electronic Patient Record that is accessible by all appropriate clinical staff, operating in multiple clinical settings, to support the delivery of timely, consistent and high quality patient care.

What will Success Look Like?

Success for eHealth in NHS Borders will mean:

- Person centred information available across sectors and boundaries of care
- Digital patient information available, with minimal use of paper
- Ultimately, a single view of disparate digital health and social care records with increased use of structured digital data to support clinical decision making
- New ways of patients accessing services using video technologies
- Improved access and collaboration between all partner agencies

NHS BORDERS
CLINICAL STRATEGY

WORKFORCE

Vision

The NHS Borders's workforce will be based on teams of staff rather than individual practitioners to develop effective multi-disciplinary teams working with the appropriate knowledge and skills. It will integrate more closely the work of hospital based specialties alongside community based teams, with a clear understanding and value of each other's roles and a culture which supports people with long term conditions and their carers to be the lead partners in decisions about their health and wellbeing.

Current

NHS Borders currently employs 3,150 staff. As with the general demographics in the Borders region, our workforce is aging. Currently 70.20% of our staff are aged over 40, with 41.80% of the total workforce aged over 50 years old.

There are specific areas of clinical expertise where there are difficulties in local recruitment due to national shortages of trained staff. In these cases opportunities have been taken to look at extended roles across the multidisciplinary team.

The Need for Change

The route map to the 2020 Vision for Health and Social Care outlines the Scottish Government's vision for improving quality and making measurable progress towards high quality, sustainable health and social care services in Scotland[14]. We will also continue to demonstrate our organisational values of Dignity and Respect, Care and Compassion, Openness, Honest and Responsibility and Quality and Teamwork.

In developing the Clinical Strategy we will continue our actions to support the five priorities outlined within Everyone Matters (2020 Workforce Vision).

[14] *Scottish Government. Everyone Matters: 2020 Workforce Vision. Edinburgh: Scottish Government, 2013*

As noted above the NHS Borders has an aging workforce, this along with challenges in the recruitment of General and Mental Health Staff Nurses, Health Visitors, Community Nurses, Clinical Physiologist, Sonographers and Radiographers presents us with opportunities and challenges in relation to workforce planning.

The ageing population will not only change the service demands, it will also be reflected in the availability of the NHS Borders workforce. In effect, we will have an older workforce in 2025 and a higher volume of retirement's year on year. With this we need to be innovative in our employment practices and continue to strive to be an employer of choice, to ensure that we continue to attract the right people, in the right places, for the right job. This means we will also attract the younger workforce within the Borders and retain them to build our workforce for the future.

We have faced such challenges previously with good results. One example of imaginative Workforce Planning is our out of hour's service Paediatric Hospital at Night, which introduced resident Advanced Neo-Natal Practitioners and Advanced Paediatric Nurse Practitioners and Consultant, delivered service. This model has worked well for a number of years, has secured the on-going stability of the unit without service disruption and has been recognised by the Scottish Government Health Department as a model of good practice. Succession planning is now being factored in to future proof this service. We currently have a further 15 Advanced Nurse Practitioners working in Mental Health, Hospital at Night, Out of Hours, Critical Care, Cardiology, Gastro-Intestinal and Cancer services all of whom are contributing to the sustainability of safe, effective and patient centred care. This is a model we will continue to expand in the future.

What Will Change

The future model for the workforce will be realistic and consider the workforce availability, adaptability and affordability to deliver the revised clinical model in the specified timeframe.

In effect, the workforce model requires:

- Early projection and preparation of staff to meet the future demand if different skills sets are required, succession planning is key
- Adequate opportunity for staff to be developed to meet these requirements
- All this to be framed within a financially viable workforce model

To provide safe, effective and person-centred care, the workforce of 2025 should match the workload demands in the care context, location and hours of service. This will see a shift in staffing into the community workforce and will require a change from the existing patterns of work towards 24 x 7 day working. The workforce needs to be adaptable, skilled and prepared to accommodate any changes in service delivery.

NHS Borders will undertake detailed multi-professional workload and workforce planning. Effective use of existing resources will be essential as will gaining an understanding of current utilisation of the workforce and their skills, together with the likely implications for retention of the existing workforce, many of whom will remain part of the workforce for the next 5-10 years. This will provide essential baseline data for future remodelling work.

What will Success Look Like?

The workforce to support the Borders Healthcare Strategy will not be "more of the same". The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will work to the "top of their licence" with work aligned to their skills. The workforce may require to be redistributed to match the increased workload demand in the community.

It is difficult at this stage to indicate the exact numbers and development requirements for each role until more detailed workload and planning has been undertaken. The work streams within this strategy have identified key areas of role requirements that have already been developed in other areas within NHS Borders and the approach can be used to support the development and extend the roles of our existing staff. In addition, leadership and team development approaches are well embedded within NHS Borders and can be utilised to further develop the knowledge and skills required to achieve the required outcomes.

NHS BORDERS
CLINICAL STRATEGY

FINANCIAL RESOURCES

NHS Borders Position

The financial outlook the public sector is facing and the challenges this brings are clearly understood. In order to continue to deliver the required quality of patient care the organisation must keep a firm grip on its finances, as well as drive improved quality and efficiency which are critical to ongoing service delivery and public credibility. That means having a clear focus that is firmly and openly set on providing patient care that is safe, effective and affordable and includes efficiency plans and goals.

The Scottish Parliament has agreed a one year budget for 2017/18 and for this reason the financial plan for 2018/19 onwards, as presented to the Board in April 2017, should be considered with a degree of reservation as these are only planning assumptions at this stage.
However it remains clear that the financial outlook remains extremely challenging and there is a need to increase the efficiency of our services and a requirement to deliver services with at least the same level or reduced resources. There is also a clear direction to shift the balance of care from acute to community setting as part of the commitment to deliver more than 50% of NHS frontline spending on community health services by 2021/22.

NHS Borders is committed to maintaining financial balance. Currently this is proving challenging; given the economic environment, finite resource allocations and the high level of efficiencies to be achieved whilst sustaining the range of services currently provided, ensuring accessible healthcare across remote and rural areas, managing increased demand generated through population growth and public expectations, and delivering HEAT trajectories. NHS Borders strategy must be built on the triple aim of ''better health, better care and better value''.

NHS Borders will need to save £15.7m in 2017/18 in order to stay within budget. Apart from those areas that received specific additional funding (e.g. primary care and mental health) any clinical service change would need to be achieved within the existing budgets.
An integral part of the financial plan is the efficiency programme which consists of a series of projects with potential cost savings that will be progressed during 2017/18.
Currently the financial plan for 2017/18 is unable to demonstrate a break even position due to the challenging level of efficiency (£15.7m) required in 2017/18. There is a level of identified saving within the efficiency plan that releases an estimated £11.9m, giving an outstanding balance on our efficiency programme of £3.8m. The Board continues to work with services to bridge this gap while continuing to ensure that the quality of care currently provided is not compromised.
This does not detract from the Board's statutory obligation to operate within the financial resources available.

Capital Investment

In terms of capital, NHS Borders continues to work within the reduced level of capital funding available within NHS Scotland. Capital investment is a key part of delivering safe and effective patient care and to releasing significant efficiency gains from the rationalisation of the estate and the associated supporting service redesign. The Board continues to improve links to the Scottish Asset & Facilities Report (SAFR) and using information available from the developing Property and Asset Management Strategy (PAMS), has committed resource over the duration of its plan to addressing priority areas.

NHS BORDERS

CLINICAL STRATEGY

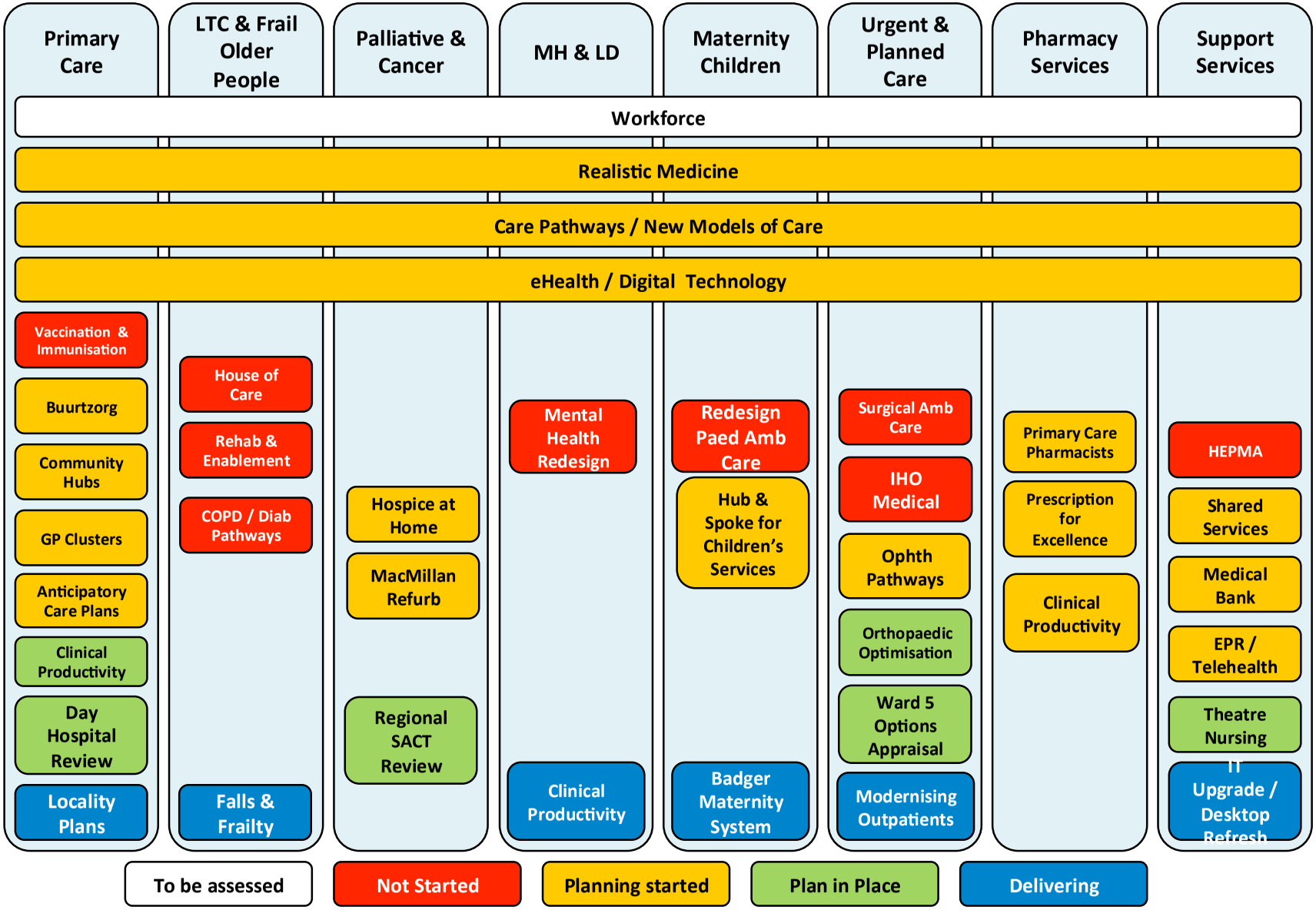
PLANS FOR SERVICE CHANGE

The Clinical Strategy outlines the challenges ahead and provides a vision for the future. It recognises that the status quo is no longer an option in terms of rising demand and finite budgets, therefore models of care must change if the challenges of preventing ill health and improved access to healthcare are to be met. The Strategy discusses initiatives designed to improve provision in a number of key areas and has been designed with the overarching principle of delivering person-centred, safe and effective services which patients value and trust.

The initiatives described will be delivered as part of the Betters Borders Transformational Change Programme, NHS Borders IM&T Delivery Plan and NHS Borders Efficiency Programme. Some of these changes will be implemented soon, but others will take time to plan and develop before implementation is possible. NHS Borders will in conjunction with the Health and Social Care Partnership, develop a phased plan for delivery over a number of years, beginning in 2017.

The diagram below outlines the changes to services described earlier in the document. Many of these changes go across work streams for example Workforce, Realistic Medicine, New Models of Care, eHealth and Digital Technology. In addition to this some of the changes are at an early stage of development and further engagement and discussion will be necessary, to ensure these can realise expected benefits as well as to provide clarity of the resourcing and financial impact of some of these developments

Service Change Plan



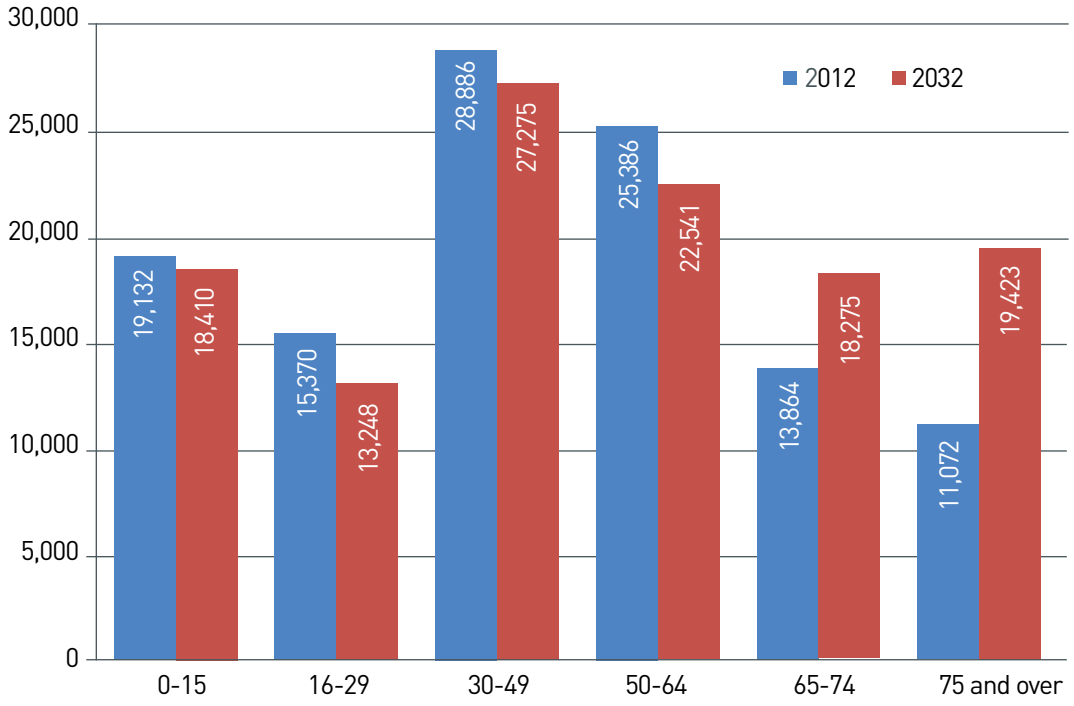
APPENDIX 1
THE CHANGING HEALTH AND SOCIAL CARE NEEDS OF THE PEOPLE OF THE BORDERS

Population Profile

The Scottish Borders is a rural local authority with 5 towns with a population of between 5,000 and 15,000 (Hawick, Galashiels, Peebles, Kelso and Selkirk) and a further 5 towns with a population of 2,000 to 5,000 (Jedburgh, Eyemouth, Innerleithen, Duns and Melrose). 47% of the population of the Scottish Borders live in rural areas compared to 18% for all of Scotland. The rural nature of the Scottish Borders can lead to additional challenges for those experiencing inequalities[15].

Figure 1 below shows there may be very little change in the overall number of people resident in Scottish Borders between 2012 (113,710) and 2032 (114,881), however, the numbers of people aged 65-74 may increase by almost one third (32%), whilst the numbers aged 75 and over may increase by 75%.[16] By 2039 the population of Scottish Borders is projected to be 117,120, an increase of 2.7 per cent compared to the population in 2014. The population of Scotland is projected to increase by 7.5 per cent between 2014 and 2039. Over the 25 year period, the age group that is projected to increase the most in size in Scottish Borders is the 75+ age group. This is the same as for Scotland as a whole[17].

FIGURE 1
PREDICTED POPULATION CHANGE IN BORDERS FROM 2012 TO 2032 BY AGE GROUP



Source: National Records for Scotland 2012-based population projections

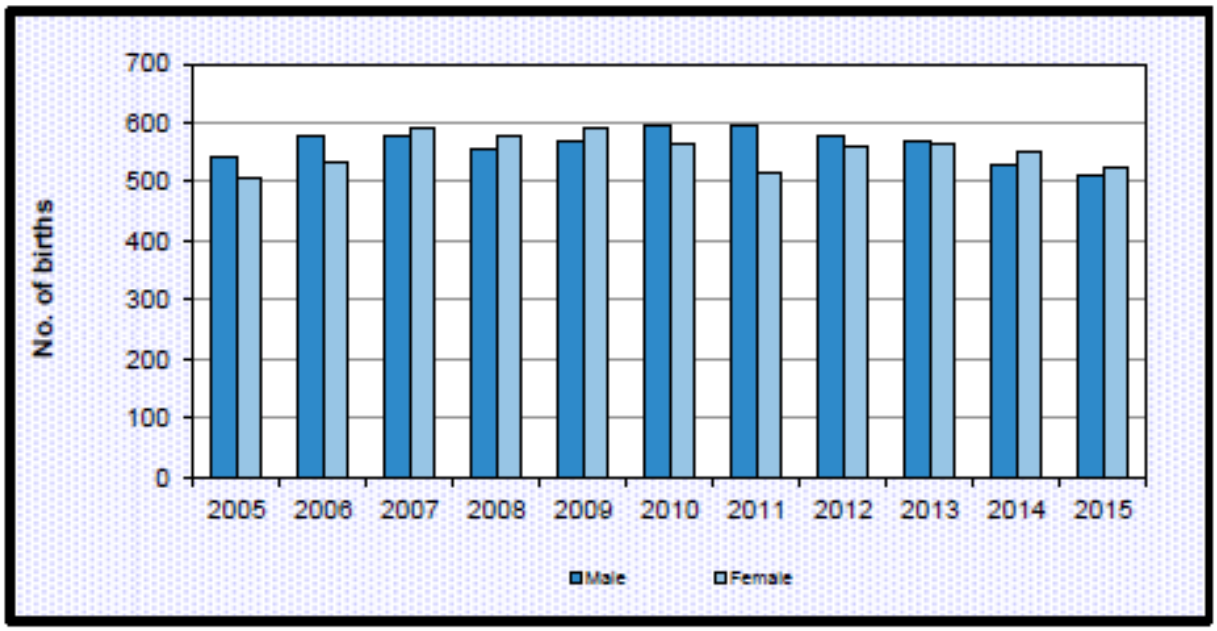
[15] *2015 Borders Director of Public Health Report.*
[16] *National Records of Scotland (NRS) Statistics and Data*
[17] *Scottish Borders Council Area Demographic Factsheet March 2017, National Records of Scotland*

Birth and Death Rates and Life Expectancy in Borders

Births

Figure 1 below shows that between 2014 and 2015 Scottish Borders experienced a 4.1 per cent decrease in the number of births, dropping from 1,081 in 2014, to 1,037 in 2015. The number of births in Scotland fell by 2.9 per cent. Fertility in Scottish Borders decreased from 60.3 births per 1,000 women aged 15 to 44 in 2014, to 58.5 in 2015. For Scotland as a whole, the general fertility rate decreased from 54.7 births per 1,000 women aged 15 to 44 in 2014, to 53.2 in

FIGURE 2
LIVE BIRTHS BY SEX IN SCOTTISH BORDERS 2005-2015[18]



Deaths

Deaths rates from the so-called 'big killer' diseases of cancer, coronary heart disease (CHD) and stroke continue to fall but still caused almost half of all deaths in 2015.

Life expectancy

Within the Scottish Borders there has been a significant improvement in premature mortality between 2006 and 2013 and currently the region has the lowest rate of any mainland Board when deaths rates are adjusted for age[19]. Female life expectancy at birth (82.5 years) is greater than male life expectancy (78.8 years), and both were greater than the equivalent Scottish average. Male life expectancy at birth in Scottish Borders is improving more rapidly than female life expectancy. In Scottish Borders female life expectancy at age 65 (20.5 years) is greater than male life expectancy at age 65 (18.1 years).

[18] *Scottish Borders Council Area Demographic Factsheet March 2017, National Records of Scotland*
[19] *2015 Borders Director of Public Health Report.*

In the Scottish Borders both men and women are expected to have higher life and healthy life expectancy compared to Scotland. The "gaps" between healthy life expectancy and overall life expectancy are also narrower in Scottish Borders, at around 5-6 years, compared with Scottish averages of 7-8 years. Healthy life expectancy for Borders population is also higher than national levels; both males and females in Borders live on average 4 years more healthy life than others in Scotland. There are areas within the Scottish Borders where the male and female life expectancy is lower than for Scotland. Differences in average life expectancy between people living in the least and most deprived areas are mainly due to deaths from coronary heart disease, stroke, cancer and respiratory disease.

Inequalities and Social Issues

The link between inequalities and poverty to poor health has been firmly established. Inequalities lead to poorer health and increased demands upon clinical services.

The Scottish Index of Multiple Deprivation alone does not provide a complete picture of deprivation. Although 5 datazones in the Borders were identified as being in the top 15% most deprived in Scotland, it could be argued that this does not take into account small pockets of deprivation in more rural areas, which may be overlooked by being located in areas including great wealth.

Particular indicators of concern where deprived Borders areas do not fare well compared to more affluent areas include:

- Higher smoking rates particularly the percentage of pregnant women smoking at the time of booking for antenatal care.
- Mental illness (hospital admissions and suicide) that may be due to unequal distribution of factors that promote and protect positive mental health and factors that are detrimental to mental health e.g. low income.
- Hospital admissions related to alcohol.
- Scottish Borders also has a significantly higher hospital emergency admissions rate compared to Scotland as a whole although the reason for this is unclear. Admissions to hospital for coronary heart disease in the Borders are around a third higher in the most deprived areas compared to the most affluent areas and admissions due to respiratory disease almost twice as much. The reasons for this are also unclear but are likely to be related to higher rates of coronary heart and respiratory disease and associated lifestyle factors (smoking, diet, exercise) and possibly differing admission practices and community support.
- Lower uptake of cancer screening (cervical, breast, colorectal)
- It is of interest that the most affluent areas in the Borders have a higher admission rate for cancer. This may be related to more affluent persons seeking early help for symptoms and to the lower uptake of cancer screening (cervical, breast, colorectal) seen in the most deprived communities.

Scottish Borders also has distinct inequalities issues. For example, results from surveys include the following[21]:

- Around 43% of all households in the Scottish Borders are fuel poor, higher than the Scottish average of 36%.
- Around 12% of households in the Scottish Borders are in extreme fuel poverty, compared with a Scottish average of 10%.
- Pensioners are most at risk of fuel poverty. Around 60% of pensioner households in Scottish Borders are fuel poor, higher than for other household types in Scottish Borders and for pensioner households across Scotland as a whole (54%).

[21] *Scottish House Conditions Survey 2011-2013*

Tackling these specific health inequalities will require concerted efforts across many partners at national and local levels.

Long Term Conditions

As described, we will see more people surviving into old age, often continuing to contribute to our communities as carers. It will be the role of our health and social care services to support people as they grow older to help people to maintain an active and enjoyable old age. However, this will mean we will have to adapt these services. Diseases such as dementia, hip fractures, Parkinson's, stroke and frailty generally have a strong age correlation. In addition, multi- morbidities (the possession of more than one chronic disease) are increasingly common amongst older adults leading to increased vulnerability to acute illness as well as a risk of dependence or disability.

For the care sector, impaired health resulting in disability can lead to increased demands on care at home or admissions to long term care. Sustaining services to promote healthy ageing, active social involvement, the management of acute illness, rehabilitation and ultimately palliation must be done with the patient and carer at the centre and with the aim of maximising a healthy, engaged and independent old age.

By the age of 65, nearly two-thirds of people will have developed a Long Term Condition: 75% of people aged 75-84 have two or more such conditions. Studies have also found that socioeconomic deprivation is also associated with an increased prevalence of multi-morbidity (including a mental health disorder)[22].

Significant Risk Factors and Issues

The risk to individuals of developing the major life-threatening illnesses (cancer, coronary heart disease and respiratory illness) that can be such a burden to themselves, their families and to their local health and care services; can be reduced by:

- Not smoking;
- Being a healthy weight and being physically active;
- Drinking within recommended levels of alcohol and maintaining a healthy diet;
- And good mental health.

Tobacco

Smoking is still the most important cause of preventable ill health and early death in the UK. Smoking is a major risk factor for many diseases, such as lung cancer and many other cancers, chronic obstructive pulmonary disease and heart disease. About half of long-term smokers will die earlier as a result of smoking[23].

Results from the annual Scottish Household Survey indicate a gradual decline over recent years in the prevalence of smoking in Scotland. The overall percentage of the Scottish Borders adult population who smoke appears to have been consistently lower than the average for Scotland. For example, in the two years 2012-2013, an estimated 19.3% of Scottish Borders residents aged 16 and over smoked, compared with 23.0% for Scotland as a whole.

[22] *2015 Borders Director of Public Health Report. (Barnett et al 2012)*
[23] *2015 Borders Director of Public Health Report*

In contrast, the rate of smoking amongst pregnant women in Borders appears to be higher than for Scotland (source: ScotPHO Tobacco Control Profiles 2015). In the three years 2010-2012 combined, just under one in four (24.9%) of pregnant women in Borders were recorded as being smokers at the time of their first ante-natal appointment, compared with an average of around one in five (20.1%) across Scotland[24].

Obesity

Excess weight, diet and physical activity all have a significant impact on health. Obesity is a major determinant of premature mortality and avoidable ill health, increasing the risk of diabetes, heart disease, cancer, muscle and joint problems and depression. Whilst estimates are based on relatively small numbers of survey respondents across Scotland), the estimated prevalence of obesity as generated from surveys has been very consistent across each successive year since 2008. The estimated prevalence of obesity tends to rise with increasing age from around 1 in 9 people aged 16-24 to more than 1 in 3 people aged 55-74[25].

Physical Activity

The majority of the population in the Scottish Borders do not meet the recommended level of physical activity. 29% of the population has low levels of physical activity. Local partnerships are looking to make significant changes. Live Borders and NHS Borders work in partnership with the aim of improving lives, health and wellbeing through physical activity programmes[26].

Examples include:

- Steadi-Falls Prevention Class Working together with NHS Borders, Live Borders delivers classes over a 12-week period. Physiotherapists refer individuals who have either suffered from a fall or are potentially at high risk of falling. The class consists of 8 individuals working with resistance bands and chairs for balance.
- Health Conditions Classes: The aim of these classes is to improve the lives of people living with specific health conditions by encouraging uptake of physical activity. The classes are tiered to suit each individual's ability with the hope that progression through the levels is achieved, resulting in the self-management of their own exercise programme.
- Lifestyle Advisory Support Service (LASS) The Lifestyle Advisor Support Service (LASS) engages with people over the age of 16 who wish to make a lifestyle change to improve their health. Working in partnership with the LASS team, Live Borders aims to help improve and change lives through getting the inactive active.

[24] *Scottish Borders Health and Social Care Partnership - Facts and Statistics document September 2015*
[25] *2015 Borders Director of Public Health Report*
[26] *Live Borders Exercise Referral Programme: http://www.liveborders.org.uk/healthylivesreferral*

Alcohol use in Borders

The consumption of alcohol contributes to a range of health conditions and admissions to hospital. Alcohol-related conditions include liver disease, hypertension, oesophageal and other cancers and mental and behavioural disorders. Drinking alcohol is also linked to hospital admissions due to accidents and injuries and toxic effects of consumption, and causes considerable costs to the NHS.

In the Scottish Borders 43% of adults are estimated to drink outside of government guidelines i.e. men regularly exceeding 3-4 units of alcohol a day (equivalent to a pint and a half of 4% beer) and women regularly exceeding 2-3 units of alcohol a day (equivalent to a 175 ml glass of wine) during 2008-2011[27]. There is no significant difference between the rate of drinking outside guidelines or problem drinking between Borders and the Scottish average.

46% of Borders males are estimated to exceed recommended limits compared to 40% of females. A recent national UK study also suggested there has been an increase in drinking amongst women and an increase in drinking among middle and older age groups. A further study found that people may significantly under-report their drinking and true estimates of persons exceeding recommended limits may be 19% more men and 26% more women. Applying this to the Borders may mean that 65% of men and 66% of women may be exceeding recommended limits[28].

Substance Misuse

The illicit use of drugs and particularly opiates, benzodiazepines and psychostimulants, causes significant problems within Scotland as it does in other parts of the UK and Europe. Some of these problems are primarily social in nature, involving, for example, increases in acquisitive crime, prostitution, unemployment, family breakdown and homelessness. Others are more clearly associated with health problems, for example, the transmission of communicable diseases (HIV, hepatitis), injecting related injuries and increased demands upon health care services[29].

An estimated 1% of the adult population in Scottish Borders have a problem with drug use, a little lower than the 1.7% across Scotland as a whole. In the year ending March 2015, there were 72 alcohol-related hospital stays in Scottish Borders. This translates as an age standardised rate of 82 stays per 100,000 population, which is lower than the Scottish average of 143 stays per 100,000 population. In 2015, there were 13 drug-related deaths in Scottish Borders, translating as an age-standardised rate of 12 deaths per 100,000 population, slightly lower than the Scottish average of 13.5 deaths per 100,000[30]. It is estimated that there are around 700 persons with problem drug use in the Borders: 550 males; 150 females[31].

Mental Health and Learning Disabilities

Within the Scottish Borders, there were 518 mental health admissions during 2012/13. This was a reduction from 2010/11 and 2011/12 figures. The Scottish Borders has a similar level of psychiatric hospitalisations to Scotland. Within the Scottish Borders, areas with more hospitalisations than Scotland are all of Galashiels, all of Hawick, Eyemouth, Jedburgh, Selkirk and parts of Kelso.

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[27] *Scottish Alcohol Profile 2013/14*
[28] *Boniface S. Shelton N. How is alcohol consumption affected if we account for under-reporting? A hypothetical*
[29] *Source of the above paragraph: Scottish Public Health Observatory (ScotPHO) website (accessed April 2017) http://www.scotpho.org.uk/behaviour/drugs/introduction*
[30] *ScotPHO Drug Profile 2014 (accessed April 2017) www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool*
[31] *Estimating the National and Local Prevalence of Problem Drug Use in Scotland 2012/13. ISD Scotland. Publication date - 28th October 2014*

There were 16 probable suicides within the Scottish Borders in 2016 which is a similar rate to Scotland as a whole[32]. A breakdown of these figures indicates that men of working age are a key risk group in the Scottish Borders. One key principle is that there is no health without mental health: every part of the health and social care system is required to play a more active part in improving the mental health and well-being of the people of Borders.

It is estimated that there are over 1000 people with dementia living in Borders. Dementia presents a significant challenge for health and care services, now and going forward into the future. At March 2014, the 23 GP practices in Scottish Borders recorded a total of 1,027 patients known to them as having dementia. This equates to 0.9% of all patients registered to a GP practice in Scottish Borders at the time, or 4% of all patients aged 65 and over (the majority of dementia sufferers are aged 65+).

As at March 2014, 599 people aged 16+ with Learning Disabilities were known to Scottish Borders services, of which 555 had confirmed addresses in the area.

The number of people with learning disabilities is likely to grow by 14% by 2021: advances in medical science and care mean that many more people with learning disabilities are living longer, more fulfilled lives than has ever been the case before.

[32] *SCOTPHO Health and Wellbeing profiles (Borders) Accessed April 2017*

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