Scottish Borders **Health & Social Care** Partnership

Scottish Borders
Health and Social Care
PARTNERSHIP

changing health & social care for you

Working together for the best possible health and wellbeing in our communities

strategic plan 2016 -19

CONTENTS

SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP STRATEGIC PLAN

*This document is referred to in our legal "Scheme of Integration" document as the Strategic Commissioning Plan.

FOREWORD

People are living longer than ever and this trend is set to continue. This is something that we should all celebrate. It means that we need to plan ahead, both as communities and as individuals, to ensure that we, in the Borders, make the most of the benefits and positive experiences of a long healthy life. This Plan sets out why we want to integrate health and social care services, how this will be done and what we can expect to see as a result. We want to create health and social care services that are more personalised and improve outcomes for all our service users, their Carers and their families.

This is our first Strategic Plan as a new Health and Social Care Partnership (HSCP). This Plan builds on the progress that has already been made by NHS Borders, Scottish Borders Council and our partners to improve services for all people in the Scottish Borders.

This Plan is based on what we have learned from listening to local people; service users, Carers, members of the public, staff, clinicians, professionals and partner organisations. From April to December 2015 we engaged on the first and second consultation drafts of the Plan through workshops and local events across the Borders.

We believe that through strong leadership, innovative thinking, robust planning and by putting the views of patients, service users and Carers at the heart of all that we do, we can achieve our ambition of "Best Health, Best Care, Best Value" for our communities. We will make sure that strong and effective relationships continue to develop between Scottish Borders Council and NHS Borders, colleagues in the Third and Independent sectors and with other key partner organisations. The aim is that we plan, commission and deliver services in a way that puts people at the heart of decision-making.

Together, with you, we know we can make a real difference.

Susan Manion
Chief Officer Health and Social Care Integration
March 2016

EXECUTIVE SUMMARY

This Plan sets out what we want to achieve to improve health and well-being in the Borders through integrating health and social care services.

The case for changing the way we deliver health and social care services in the Borders is compelling. We have a growing number of people needing our services, but limited resources with which to deliver them. These services could be provided more effectively and efficiently if they are integrated. We want to achieve better outcomes for all our communities. The Borders is largely a remote and rural area. There are five Area Forum localities in the Borders, which have individual characteristics and therefore different needs. This makes delivery of services complex. About a quarter of the households in the Borders are composed entirely of people aged 65 and over. This age group has a greater need for our services. The growing number of people with dementia is a big challenge.

Deprivation is an issue in the Borders. Although it may only seem to affect a small number of communities, it is often hidden in rural areas. Research indicates that people from deprived areas are more likely to make greater use of hospital and other health and social care services. Health inequalities exist beyond deprivation and we need to take into account that some people have different health outcomes. As an example, people with mental health issues or a learning disability tend to have poorer health outcomes. This plan contains actions to address such issues. It also sets out our local objectives, which will enable us to achieve the nine national health and well-being outcomes.

This Plan sets out a high level summary of some of what we will do when working together to deliver more personalised care, making best use of advancing technology to achieve "Best Health, Best Care, Best Value". This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

CASE FOR CHANGE: WHY WE NEED TO CHANGE

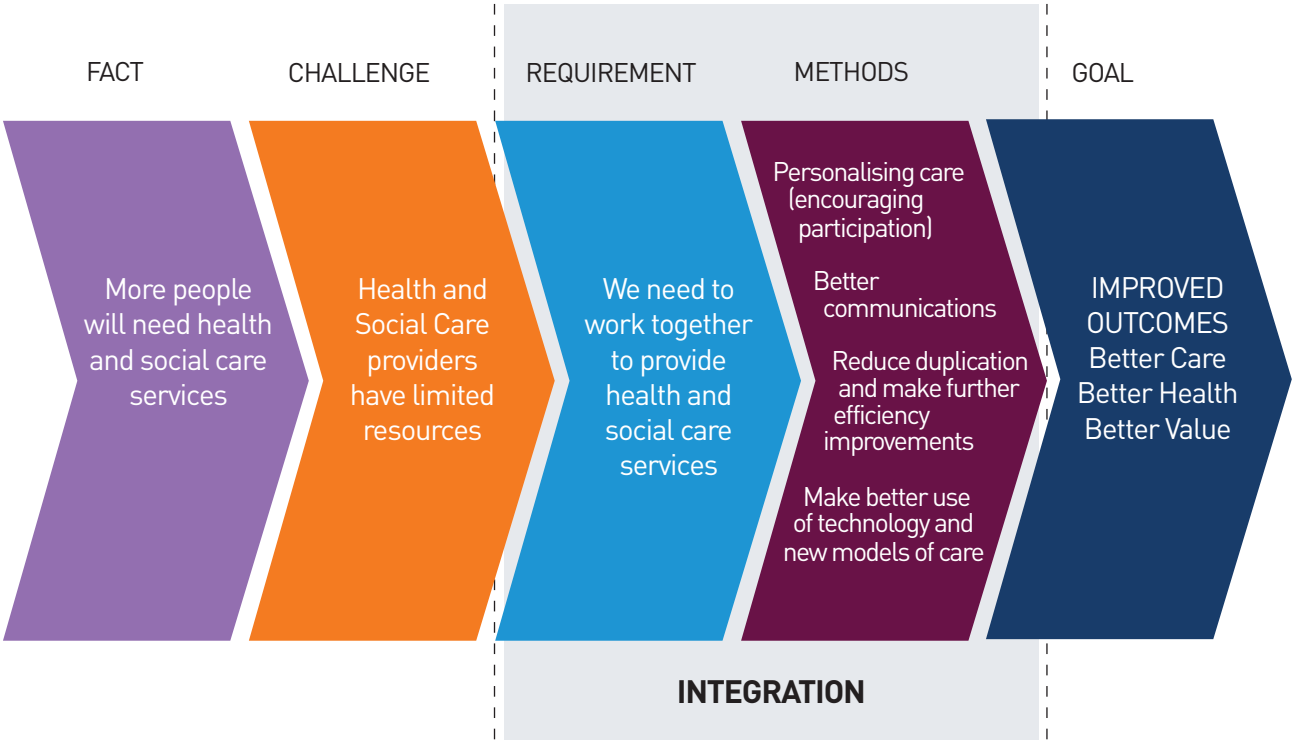
There are a number of reasons why we need to change the way health and social care services are delivered.

These are illustrated in the figure below and include:

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

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

FIGURE 1 – THE CASE FOR CHANGE



THE SCOTTISH BORDERS: A SUMMARY PROFILE AND SOME OF OUR KEY CHALLENGES

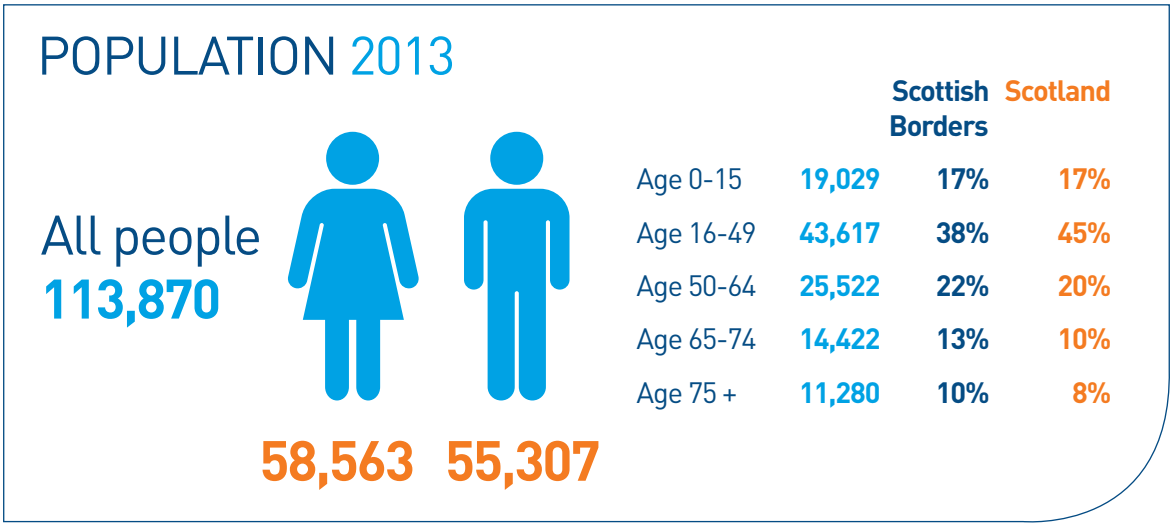
This section of the Plan gives a high level summary profile of the Scottish Borders and some of our key challenges. More detailed information is also available in two further documents published alongside this Plan – Facts and Statistics, and the Joint Strategic Needs Assessment.

Who Lives in the Borders?

Understanding the needs and issues of people and communities across the Borders is critical in the planning and provision of better health and social care services. In this section, we look at how the population structure and characteristics impact on health and social care services. This highlights some of the challenges we need to address.

As the figure below shows, we have a higher percentage of older people than the rest of Scotland.

FIGURE 2

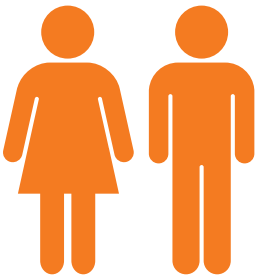


Source: National Records of Scotland, mid-year population estimates.

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

FIGURE 3

PROJECTED CHANGES IN POPULATION BY AGE GROUP 2012 TO 2032



4% decrease Age 0-15

16% decrease Age 16-64

51% increase Age 65+

Source: National Records of Scotland 2012-based population projections

WHAT THIS MEANS...

This is a priority. We need to promote active ageing and address the range of needs of older people.

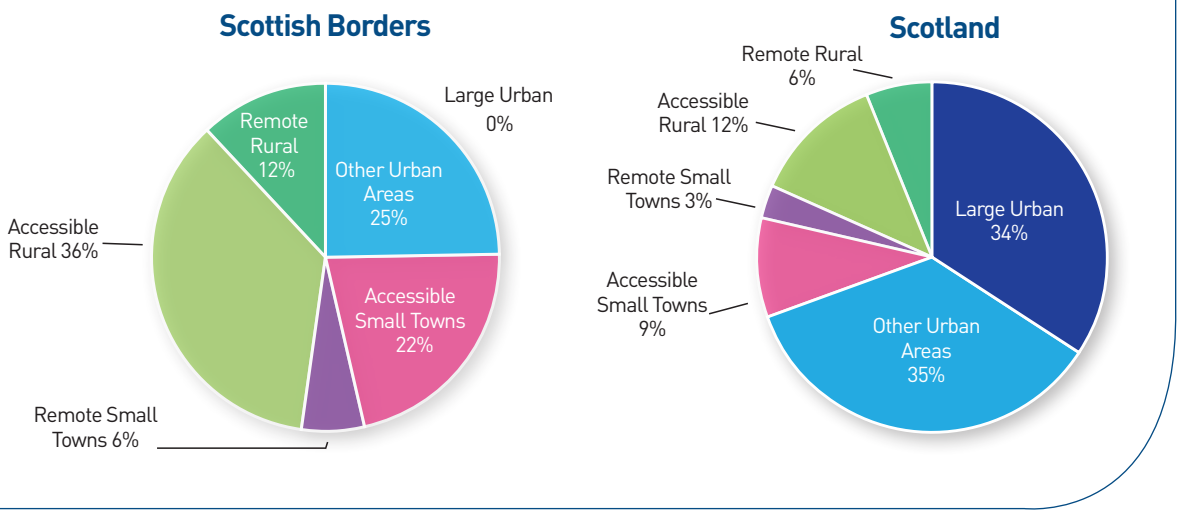
Where do people live?

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

In the Borders nearly half (48%) of the population live in rural areas, as shown in Figure 4. Just under one-third of people live in settlements of fewer than 500 or in remote hamlets, in contrast to 34% of the Scottish population who live in "Large Urban" areas (part of towns/ cities with populations of more than 125,000). Our main towns are Hawick (with a population of 13,696 in 2013) and Galashiels (population 12,394), which come under the Scottish Government classification of "Other Urban Areas". Peebles, Kelso and Selkirk are the only other towns with a population of more than 5,000. As people in the Borders do not live close together in cities, planning services is more challenging.

FIGURE 4

POPULATION SHARES (%) BY URBAN/RURAL AREA 2012



Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland

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

WHAT THIS MEANS...

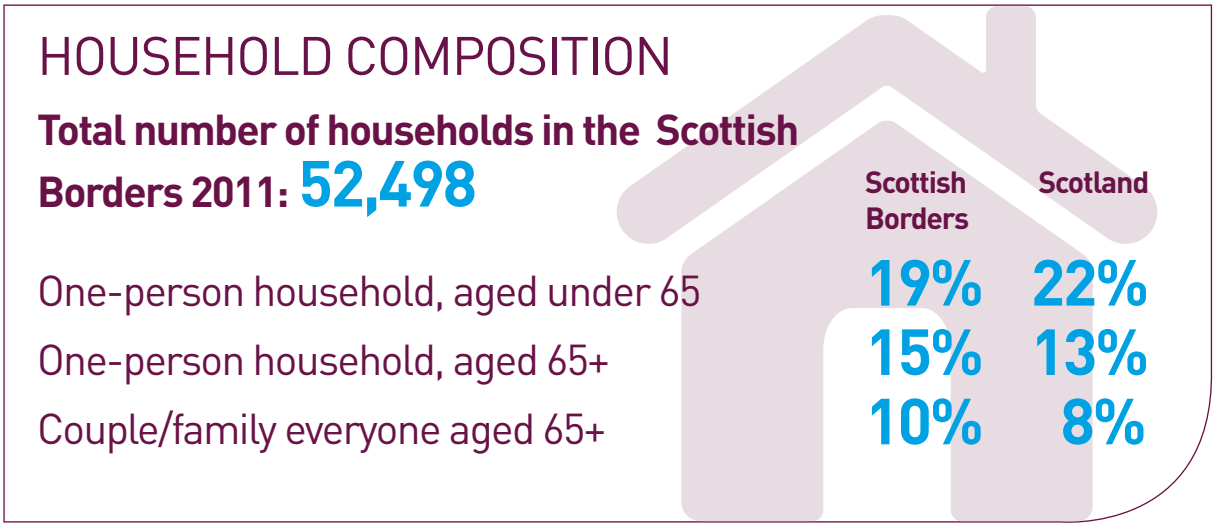
Services therefore need to be provided locally whenever possible and accessible transport arrangements put in place.

Borders Households

With the changes predicted in the population (see Figure 3 on page 7), we expect an increase in the numbers of older people living alone with complex needs. This will have major implications for housing, health and social care.

More than one third of households in the Borders are made up of one adult. The number of households in the Borders in which one or all occupants are aged over 65 is 25%, higher than the 21% for Scotland as a whole.

FIGURE 5



Source: Scotland Census 2011

The number of single adult households is projected to increase by 24% between 2012 and 2037, whilst the number of larger households is projected to decline. Households headed by people aged 60-74 are projected to increase by 9% and those headed by a person aged over 75 are projected to increase by 90%.

WHAT THIS MEANS...

Housing options need to be a key feature of our integrated health and social care services. Our existing Local Housing Strategy (2012-2017) and Housing Contribution Statement (2016) set out our work in relation to housing in more detail. An updated strategy will be in place in 2017.

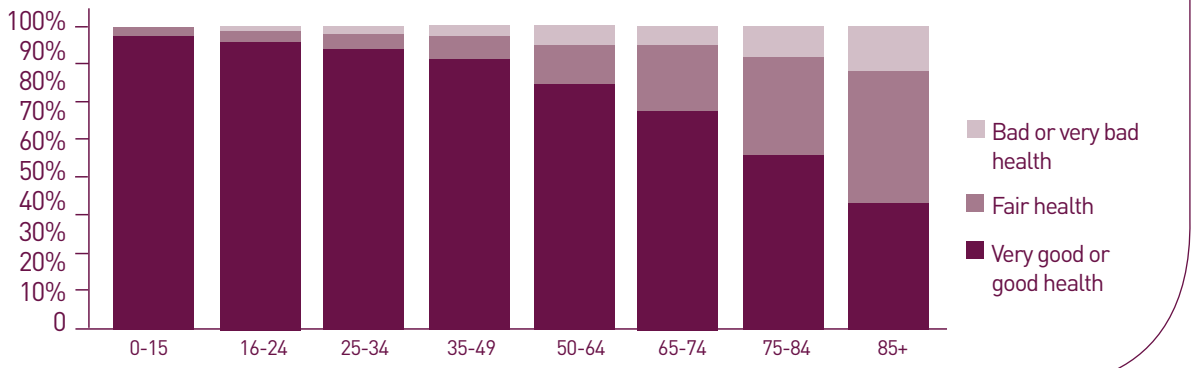
How Do People in the Borders View Their Health?

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

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

FIGURE 6

SELF REPORTED GENERAL HEALTH AMONGST SCOTTISH BORDERS RESIDENTS



Source: Scotland Census 2011

WHAT THIS MEANS...

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

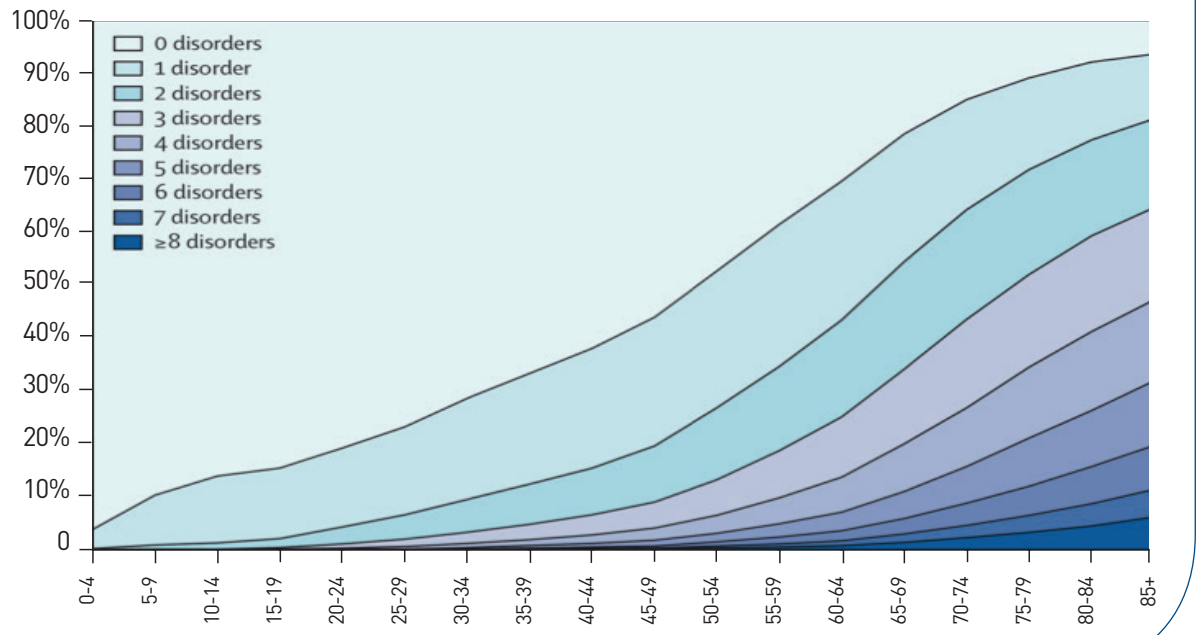
People Living with Multiple Long Term Conditions

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

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

FIGURE 7

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



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

Disability

The needs of people living with disabilities and sensory impairments are distinct from those who live with one or more health conditions. According to the 2011 Scotland Census, 6,995 people in Borders live with a physical disability. We have at least 555 people aged over 16 in our population who have a learning disability. About 2,300 people are estimated to have severe sensory impairment.

WHAT THIS MEANS...

People with a disability need flexible support arrangements to maintain and improve their quality of life.

It is estimated that around 500 people in our population are blind or have severe sight loss, while 1,800 people have severe or profound hearing loss. The National Health and Wellbeing Outcomes focus on people having a positive experience and their dignity respected when in contact with health and social care services, and that services are to be centred on helping maintain and improve the quality of life of people who use those services. This means that we must ensure services are accessible and easy to use by people with sensory impairment.

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

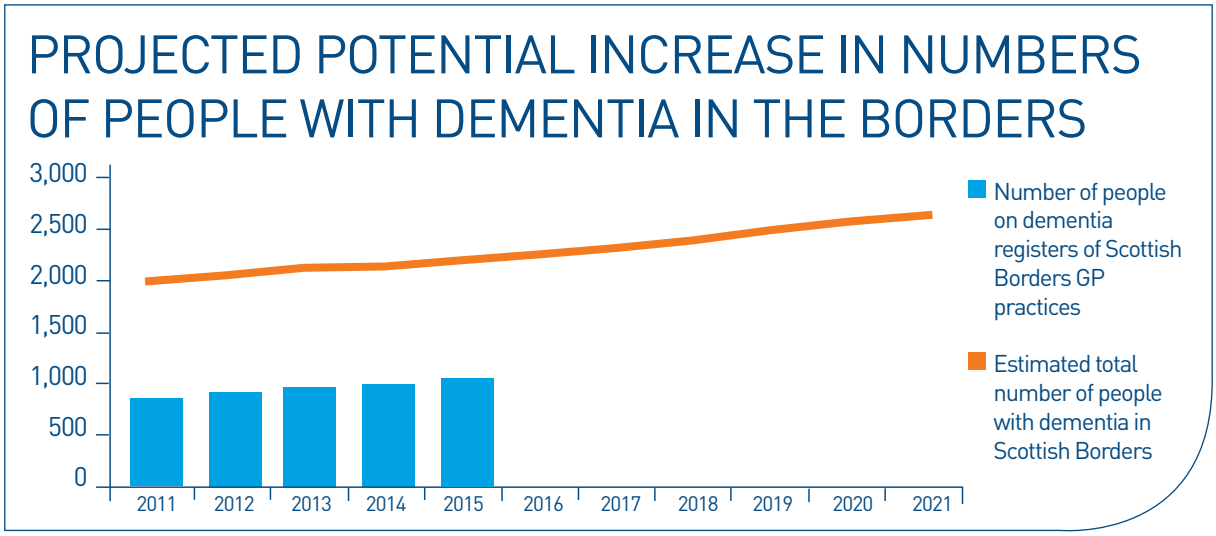
Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than that provided by mainstream Health and Social Care services. As part of the Learning Disability governance structure, people with learning disabilities and family Carers have places at the Partnership Board table to help inform decision making and strategic direction. Locality citizens' panels throughout the Borders provide opportunities for conversations between the Learning Disability Service and people directly affected by learning disabilities. A local area coordination service supports people to be more involved in their local communities.

Around one in four Scottish adults will experience at least one diagnosable mental health problem every year, and we are all likely to experience poor mental wellbeing at some point in our life. Due to the stigma related to mental illness, many will not access treatment and tend to have poorer health outcomes. Mental Health Services are in the process of developing integrated teams to provide easy access and multi-agency support to people with mental health needs. A full mental health needs assessment has been completed and this will help shape how we plan services in the future.

Dementia

Dementia is a growing issue and represents a challenge for planning and providing appropriate integrated care. The number of people living with dementia is projected to increase across Scotland, however the rate of increase in the Borders may be faster than the Scottish average as our population is older. Figure 8 below shows the number of people diagnosed with dementia in the Borders (shown in blue bars). For a number of reasons, including difficulties in diagnosis, the actual figures of people living with dementia are likely to be higher. The red line shows the likely number of people and how this number is predicted to increase over time as the population ages.

FIGURE 8



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

WHAT THIS MEANS...

A range of support needs to be provided for people with dementia and their Carers, with appropriate training for all involved, to provide care across all settings.

People Living with Complex and Intense Needs

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

Work to support people living with complex and intense needs will include:

- Identification of the main factors that increase the risk of emergency admission or re-admission to hospital;
- Use of this information to help strengthen our responses to patients and service users earlier on, and
- Exploration of alternative models of care.

USE OF HEALTH AND SOCIAL CARE RESOURCES: AN EXAMPLE

Analysis of expenditure in 2012/13 showed that:

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

*Health Services included in the analysis were: A&E attendances, inpatient and day case hospital admissions (all specialties), new attendances at consultant-led outpatient clinics, and community prescribing.

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

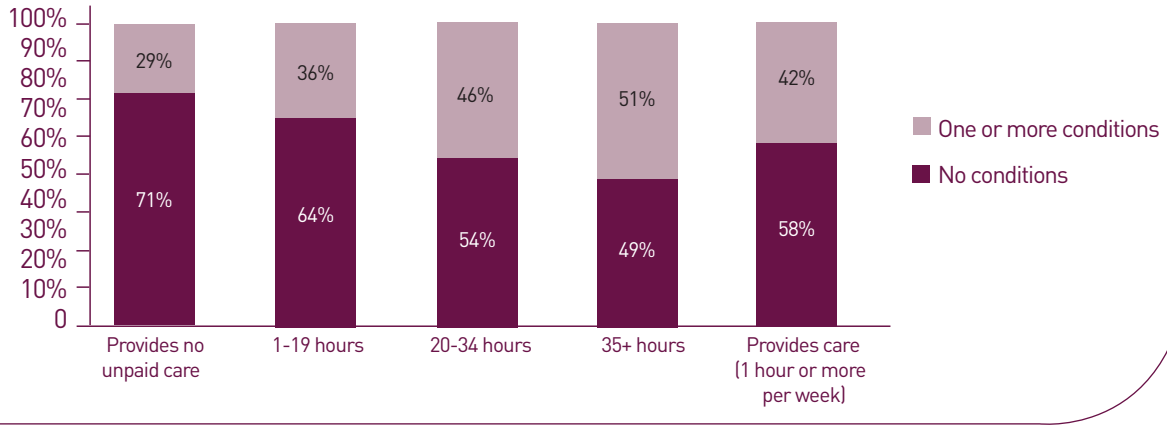
Carers in the Borders

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

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

FIGURE 9

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



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

WHAT THIS MEANS...

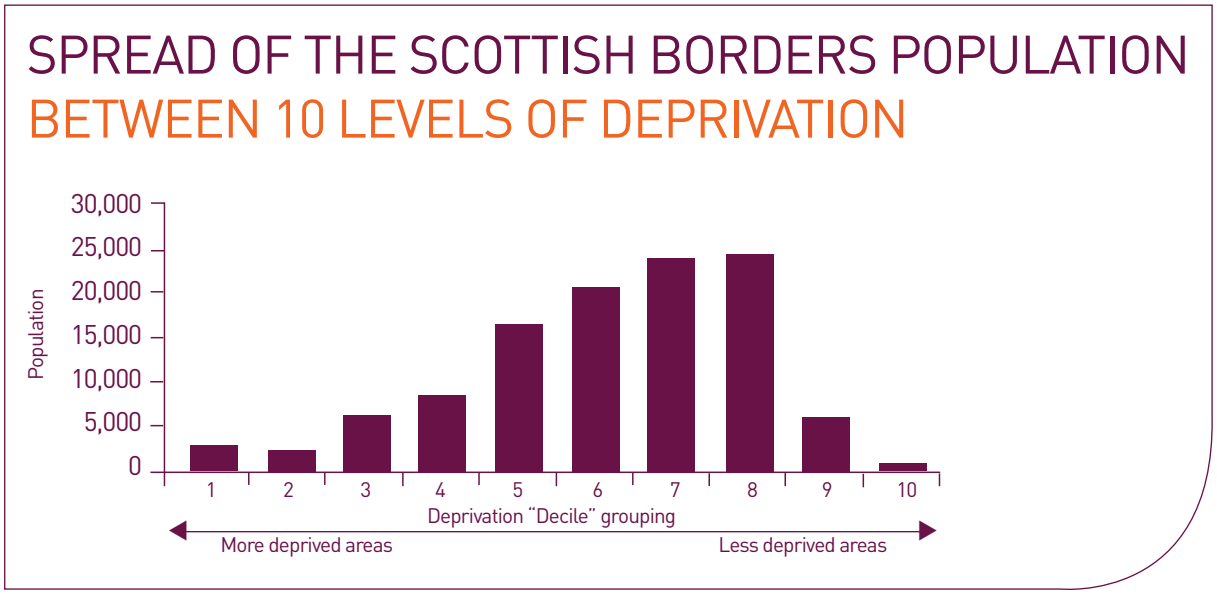
A range of easily accessible information and available support needs to be a key priority to ensure the wellbeing of Carers.

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

Deprivation in the Scottish Borders

Deprivation has a big effect on the need for, and use of, health and social care services. Taken as a whole, levels of deprivation in the Borders' population are relatively lower in comparison to Scotland. Figure 10 below shows the spread of our population between 10 different categories of deprivation (with 1 being the most deprived and 10 being the least deprived). If our deprivation profile were the same as Scotland's, we would see about 10% of our population in each category. What we see instead is an uneven distribution, with clearly less than 10% of our population living in the most deprived areas. However, some of our more urban areas - in Burnfoot (Hawick) and Langlee (Galashiels) - continue to show as amongst the most deprived in Scotland.

FIGURE 10



Source: Scottish Borders Strategic Assessment 2014

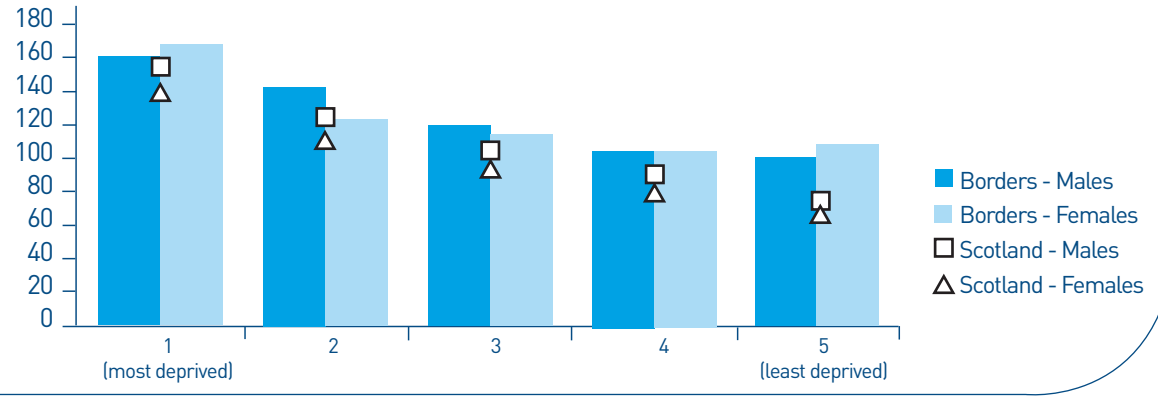
We know, however, that deprivation is not confined to geographical areas. It also applies to more vulnerable groups who may live in deprived circumstances, such as homeless people, offenders, people with disabilities and/or mental health problems.

An example of how the use of health and care services varies by deprivation is shown in Figure 11 below. The Borders follows the national pattern of having higher emergency hospital admission rates for people living in areas of higher deprivation. The figure also shows that emergency admission rates in the Borders are higher than the Scottish average within any given deprivation grouping.

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

FIGURE 11

EMERGENCY HOSPITAL AGE-STANDARDISED ADMISSION RATES PER 1,000 POPULATION, BY 5 DEPRIVATION LEVELS 2011/12



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

WHAT THIS MEANS...

The Strategic Plan and Locality Plans that we will be developing in 2016 must reflect the local needs of communities, recognising patterns of deprivation and inequality. These plans will cross-reference with work already being developed under our Reducing Inequalities Strategy.

HEALTH AND SOCIAL CARE SPENDING

The total NHS and social care spending in the Borders in 2013/14 was £248.7m. All NHS services are included in this total – including health services that are not covered by integration (such as planned outpatient and inpatient care). The overall spending was split 51% Community-Based Care versus 49% Institutional Care.

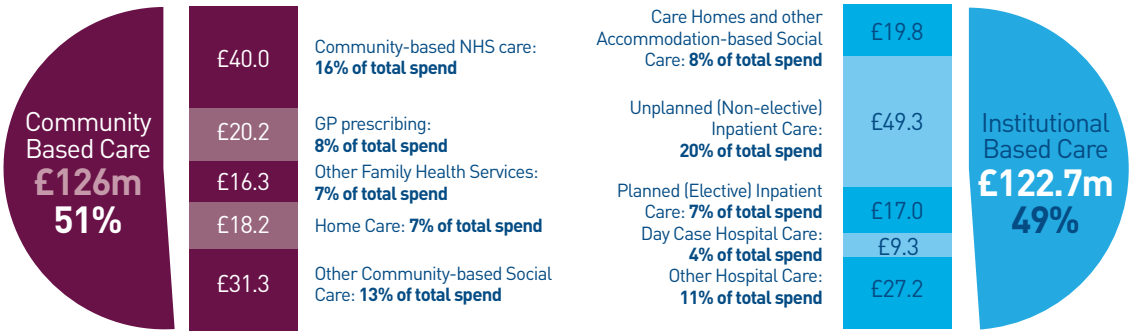
- Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.
- Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus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

The Borders has already made significant progress towards the aim of providing more care in the community compared with Scotland as a whole, where the split was 44% on Community-Based Care versus 56% on Institutional care.

FIGURE 12

SPEND IN £ MILLIONS

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



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

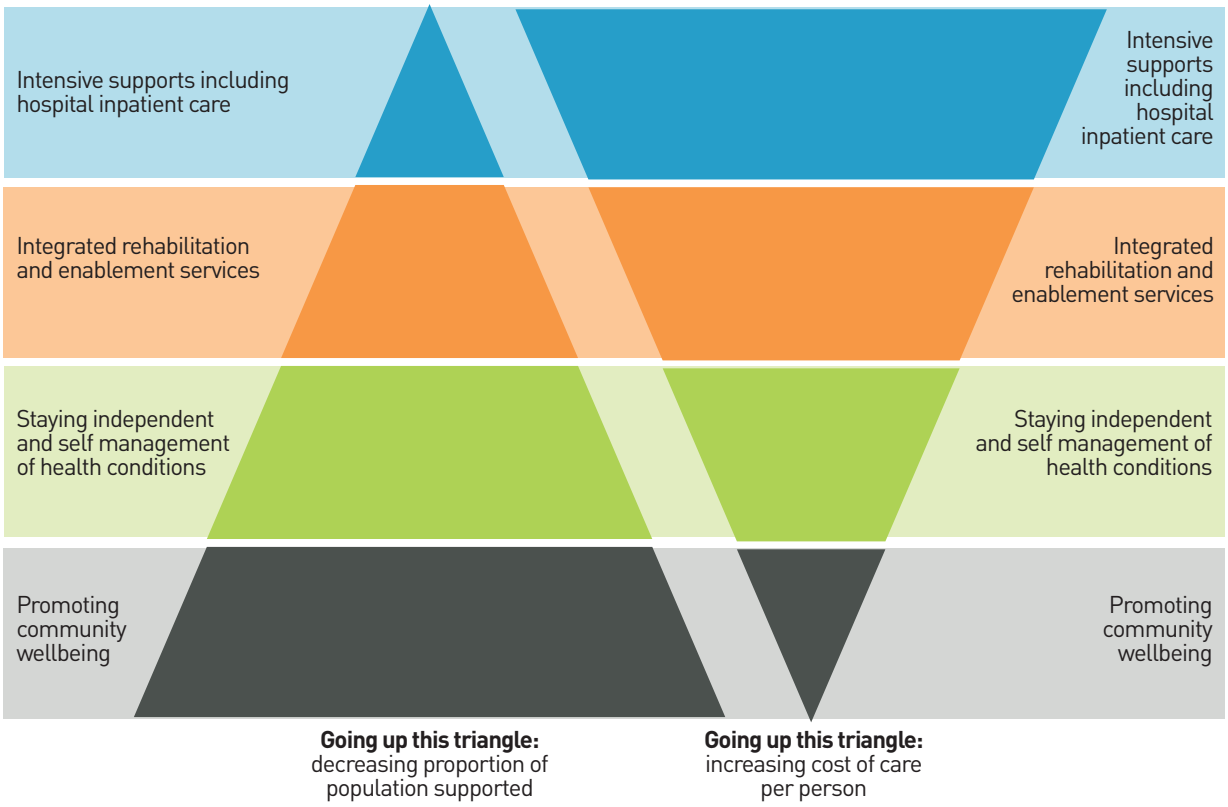
Shifting the Balance of Care Towards Prevention and Early Intervention

The aim of integrated health and social care services is to shift the balance of care towards prevention and early intervention to ensure that individuals have better health and well-being. Services need to be redesigned around the needs of the individual, to:

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

In Figure 13 below, services that promote health and well-being are shown at the bottom of each triangle, whilst intensive support services (such as acute hospital inpatient care) are shown at the top. The triangle on the left shows that a small number of people need the intensive support and care provided within hospital. However the triangle on the right shows that this small group of people use a large amount of total resource available for health and social care.

FIGURE 13
CURRENT CARE MODEL

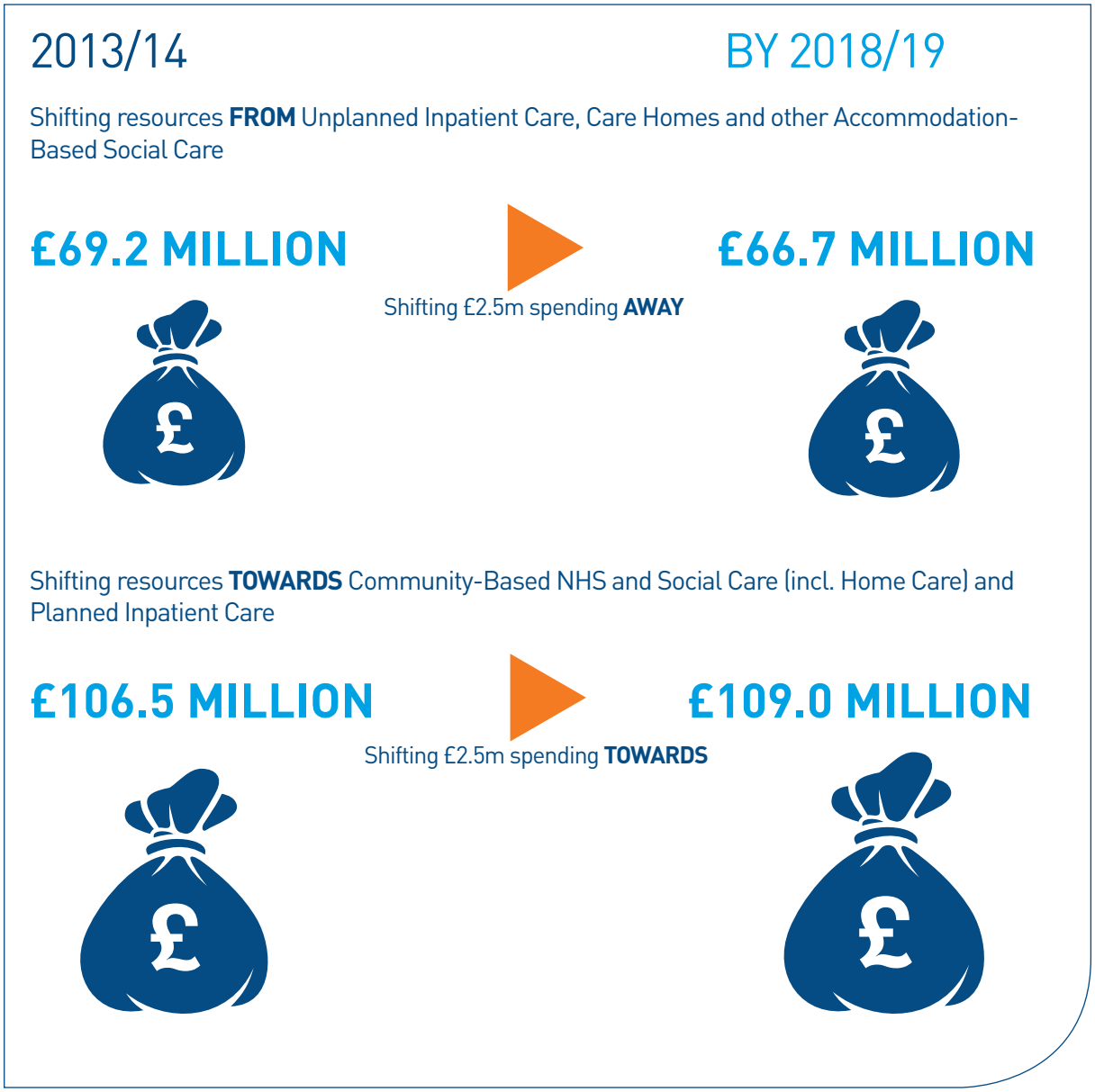


If we are able to improve health and wellbeing through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in Figure 14.

What shifts do we need to make?

By shifting just 1% of our total spend of approximately £250m FROM Unplanned Inpatient Care and Institutional-Based Social Care TOWARDS Community-based NHS and Social Care and Planned Inpatient Care, we will use our resources more effectively. This will help us invest in new integrated ways of working particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting Carers and independent living.

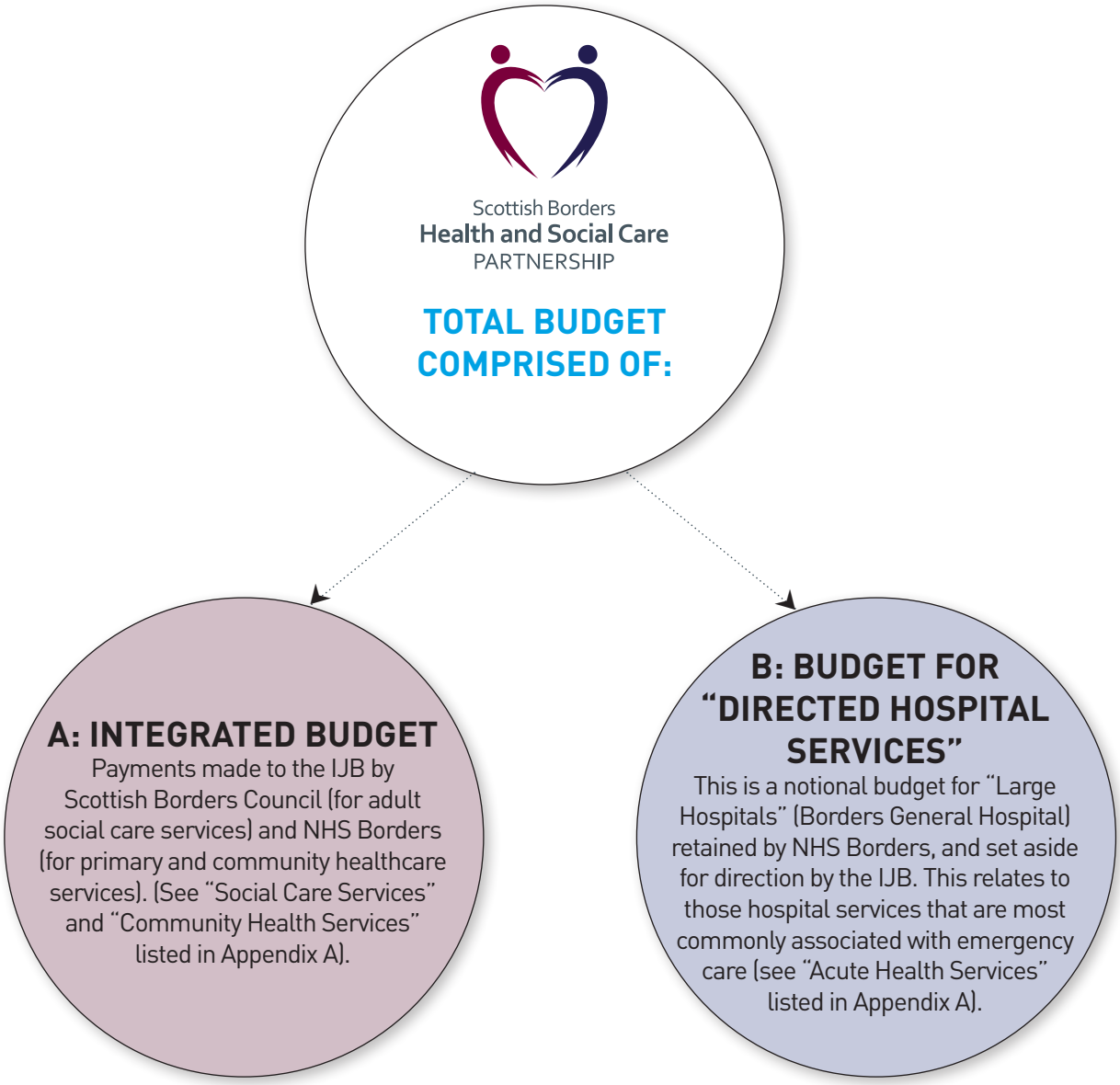
FIGURE 14



The Health and Social Care Partnership's budget

We have shown above that total NHS and social care expenditure in the Borders in 2013/14 was £248.7m. The budget the new Health and Social Care Partnership will be responsible for will represent a high proportion (about two thirds) of total spend on Health and Social Care. The use of this budget will be directed by the Partnership's Integration Joint Board (IJB), which is a separate legal entity from either the Council or the NHS Board, and is responsible for directing and overseeing the delivery of integrated health and social care services in the Borders. Details of our final budget for 2016/17, once formally approved in March 2016, will be published in our first annual Financial Statement at www.scotborders.gov.uk/integration. The Financial Statement will support the delivery of this Strategic Plan.

FIGURE 15



WHAT YOU SAID AND WHAT WE PLAN TO DO

This section of this document describes some of the actions we will take to start to make the shift towards more community-based health and social care services, the outcomes we will seek to achieve and the steps we will take to deliver our local objectives. We describe some of the performance measures we will use to assess the progress we are making. This has been influenced by what you have told us was important to you.

Each of our 9 Strategic Objectives is set out on the following pages with:

- A reflection of some of your feedback relating to each objective.
- An outline of how we intend to deliver what is needed to achieve the objective.
- Examples of activities identified in our current service strategies which relate to the objective. Although many examples give the name of a particular service or strategy in brackets, all of the objectives apply to all of our client/patient groups and we intend that they all benefit from these approaches.
- Related projects which are already underway.
- What people can expect to see in terms of targets and outcomes against each objective over the next 3 years.

Objective 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role - was added as a Strategic Objective following the round of consultation in May and June 2015. This reflects the way in which engagement with the people who use and provide our services is central to the development of our Strategic Plan and the activities that underpin it.

The information given on the following pages is not exhaustive. This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

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

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

The characteristics that are protected under the Act are:

AGE Younger people, older people, or any specific age group	**DISABILITY** Including physical, sensory, learning, mental health and health conditions	**GENDER** Male, Female and Transgender
MARRIAGE AND CIVIL PARTNERSHIP Including single, divorced, civil partnership, married, separated	**PREGNANCY AND MATERNITY** Including breastfeeding	**RACE** People from ethnic minorities including Gypsy Travellers and Eastern European immigrants
RELIGION OR BELIEF Including people who have no belief	**SEXUAL ORIENTATION** Bisexual, Gay, Heterosexual and Lesbian	**CARERS** Both formal and informal carers

In taking forward the work of the Health and Social Care Partnership, we will embrace these duties and ensure that all requirements are met, through the implementation of the Business and Commissioning Plans for the Service and Strategic areas that are Integrating.

OBJECTIVE 1

We will make services more accessible and develop our communities

Strong communities are a real asset of the Borders. Community capacity building makes a big improvement to the health and independence of people.

What we heard you say is important to you:

- Ensure information is up-to-date, accessible both off- and on-line and improve how people are directed to and can access services.
- Build on existing work to increase to community capacity throughout the Borders.
- Use community-based education from an early age to encourage better lifestyles.

We want to:

- Improve access and signposting to our services and information, and assist people to help themselves.
- Develop local responses to local needs.
- Communicate in a clear and open way.

Some examples of how we intend to do this through our current services and strategies:

- Improve co-ordination for individuals and build capacity in communities to support older people at home. (Older People).
- Put people with dementia at the centre of planning and providing services and ensure they are able to live independently within their own homes and community. (Dementia).
- Improve information and advice to Carers. (Carers).
- Strengthen partnership and governance structures. (Drugs and Alcohol).
- Achieve best outcomes for service users, foster recovery, social inclusion and equity. (Mental Health and Wellbeing).
- Ensure that people with sensory loss receive seamless provision of assessment, care and support. This will be provided by local partnerships, which will identify local priorities and approaches. This will include a review of the local sensory loss strategy in the light of the publication of the national "See Hear" Strategy. (Sensory Services).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- Health literacy training (delivered by Health Improvement Team) for staff to improve the accessibility of information about keeping well and services.
- Delivering affordable housing across the Scottish Borders; working with local housing associations to provide housing which is warm, in good condition and fit for purpose.

These are some of the changes that we have started to make:

- **Burnfoot Community Hub** – supporting the creation of a Community Hub facility to allow delivery of a range of community services and activities.
- **Borders Community Capacity Building** – supporting older people in Cheviot, Tweeddale and Berwickshire to establish or create new activities and support in their local communities – initiated through co-production and involving local residents.
- **Learning Disabilities** – Involve service users in the design and delivery of services. Local area co-ordinators are available to support people in accessing support and services in their local communities.
- **Locality Citizens Panels** – providing forums for people with learning disabilities and their Carers to meet and discuss local issues affecting them, and to contribute as part of the Learning Disabilities governance structure.
- **Locality Planning/Locality Management** – Taking into account the varying needs of the Borders population, we will have local plans and will devolve some services accordingly.

We will measure performance against this objective over the next three years by measures including:

- We would like to maintain 90% of adults in the Borders rating the overall care provided by their GP as "Excellent" or "Good" (higher than 87% overall for Scotland) in 2013/14. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We want to increase the proportion of adults who received support and care services in the Borders and rated the services as "Excellent" or "Good" in 2013/14 from 83% to 85%.
- We want to see the number of adults who agree that the support or care services they had received improved or maintained their quality of life from 83% (lower than the Scottish average of 85%) to 86%.

OBJECTIVE 2

We will improve prevention and early intervention

Ensuring that people struggling to manage independently are quickly supported through a range of services that meet their individual needs.

What we heard you say is important to you:

- Be proactive about providing early intervention and prevention: support people better/ earlier, and promote existing services e.g. health checks at GP surgeries.
- More Anticipatory Care Planning for people, their families or Carers.
- Work with other organisations, staff and people to develop integrated approaches to prevention and promote personal responsibility.
- More acute care and community services in local communities.
- Local wheelchair-friendly housing options.
- A good transition into adult services that ensures young adults with disabilities can live as independently as possible and can prevent/reduce reliance on services.

We want to:

- Prioritise preventative, anticipatory and early intervention approaches.
- Focus services towards the prevention of ill health, to identify problems earlier on, to anticipate the need for support, to offer care and support at an early stage, and to respond where possible to prevent crisis.
- Improve supports for people to manage their health conditions, improve access to healthcare when required, and make best use of recovery models.
- Ensure that young people with disabilities transition from children's to adult services in a seamless way.

Some examples of how we intend to do this through our current services and strategies:

- Help the growing pool of 'young old' people to stay well through prevention measures. (Older People).
- Reduce the amount of drug and alcohol use through early intervention and prevention. (Drugs and Alcohol).
- Promote healthier lifestyles for patients, staff and visitors through our health improvement campaign 'Small changes, big difference'.
- Increase referrals to services that support lifestyle change, such as Lifestyle Advice & Support Services (LASS) and Quit4Good (smoking cessation services) in primary care; and signpost to community resources such as 'Walk It' groups to promote physical activity.
- Strengthen falls prevention work.
- Deliver the Long Term Conditions project to support people to manage their conditions better.
- Promote uptake of health screening opportunities and immunisation programmes.
- Raise awareness of signs and symptoms of health conditions (physical and mental health) and encourage people to get checked early (e.g. Detecting Cancer Early campaign; Suicide prevention training).

OBJECTIVE 2 - continued

Examples of how we intend to do this through our current services and strategies (continued):

- Provide Housing Options and Housing Support, directly and with partners, to help people remain in their own home and prevent homelessness. This includes Housing Officers visiting vulnerable households on a regular basis – identifying the needs of those people.
- Promote social contact with local resources to reduce isolation and loneliness.
- Develop a mechanism to ensure that anticipatory care plans are used effectively.
- Implement the recommendations in the Mental Health Needs Assessment.
- We will work with all partners to raise awareness about dementia and improve diagnosis rates.
- Review the support mechanisms for transition into adult services (Physical Disability).

These are some of the changes that we have started to make:

- **Telehealth Care** – look at how technology can be used to provide better home-based health care services.
- **Lifestyle Advice and Support Services (LASS)** – strengthen pathways from acute care to these services.
- **Bowel Screening** - Improve uptake in deprived areas.
- **Long Term Conditions** - Test out new ways of working to support the shared-management **of long term conditions.**
- **Targeted health improvement projects for people with learning disabilities**. For example 'A healthier me'.

We will measure performance against this objective over the next three years by measures including:

- We want to maintain and improve on the 96% of Scottish Borders GP practice patients who felt that they were able to look after their own health 'very well' or 'quite well' (a little higher than the Scottish average of 94%) (Source: Health and Care Experience Survey 2013/14, Scottish Government).

OBJECTIVE 3

We will reduce avoidable admissions to hospital

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

What we've heard you say is important to you:

- Ensure essential equipment is easily accessible at all times for people, staff, families and Carers.
- Improve discharge planning to ensure it is clearly communicated and coordinated.
- Ensure there is an integrated response to prevent admissions.
- Increase self-referral and reduce waiting list times so that people can be supported as quickly as possible before their needs change.

We want to:

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

Some examples of how we intend to do this through our current services and strategies:

- Help older people to stay well through prevention measures; improve coordination and help them in making their way through the health and social care system.
- Build capacity in communities to support older people at home.
- Holistic assessments and personalised care planning that addresses broader health and social care issues important to individuals, such as welfare benefits/financial issues, housing issues, and social connectedness.
- Stronger links with community based support services/resources.
- Housing - Provide well insulated, comfortable homes to help prevent existing health problems from becoming worse. Ensure adaptations to homes, such as grab rails, are in place to help prevent falls or other injuries, and to help keep people independent.

These are some of the changes that we have started to make:

- Connected Care – aims to create improved community support to prevent hospital admission and ensure timely discharge. We are working with other organisations to develop new and improved approaches to make this happen.

OBJECTIVE 3 - continued

We will measure performance against this objective over the next three years by measures including:

- We would like to reduce overall rates of emergency hospital admissions by 10%, by improving health and care services for people in other settings.
- We would like to reduce the rate of multiple emergency hospital admissions in people aged 75 and over, by 10%, by improving health and care services for people in other settings.
- We will reduce instances of patients being readmitted to hospital within 28 days of discharge by 10%.
- We will reduce falls amongst people aged 65 and over by 10%.

OBJECTIVE 4

We will provide care close to home

Accessible services which meet the needs of local communities, allows people to receive their care close to home and build stronger relationships with providers.

What we've heard you say is important to you:

- Ensure there are appropriate and accessible services in the community to support prevention.
- Ensure that the right staff are in place to support people who need to access services.
- Work more closely with our communities and organisations and make better use of local knowledge.
- Make the care profession a more attractive career.

We want to:

- Support people to live independently and healthily in local communities.
- Improve care pathways to ensure more co-ordinated, timely and person-centred care.
- Ensure the right services are in place to meet people's needs.
- Ensure staff (and Carers) have the necessary knowledge, skills and equipment to provide care at/close to home.
- Move to outcome-focussed delivery of care and support.

Some examples of how we intend to do this through our current services and strategies:

- Work with other organisations so people with a physical disability can live as independently as possible; develop opportunities for people with a physical disability to fully engage in their local community; and improve access to public transport. (Physical Disability).
- Build capacity in communities to support older people at home.
- Have appropriate housing in place to keep people independent. (Older People).
- Ensure people with dementia have access to services which enable them to remain independent within their own homes and community as long as practical. (Dementia).
- Develop a joint approach to commissioning; achieve the best outcomes for service users; foster recovery, social inclusion and equity; and achieve a balanced range of services. (Mental Health and Wellbeing, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.
- Use Locality Planning to inform service development based on the needs of people in each of our localities.

OBJECTIVE 4 - continued

These are some of the changes that we have started to make:

- **Health Improvement** – To support people to live well with long term conditions – we will promote self-management to empower people and their Carers to actively engage in creating individualised care.
- **Borders Ability Equipment Store** – Ensure provision meets the future demands of a growing elderly population which will require additional equipment, technology options **and support.**
- **Introduction of local area co-ordination services for Learning Disabilities**.
- **Change models of support** – reduce the number of people with Learning Disabilities living in a care home setting to living in a Supported Living Model of support.

We will measure performance against this objective over the next three years by measures including:

- We would like to see more people supported and cared for in their own homes or another homely setting, currently 65% in the Borders and 62% in Scotland overall.
- We would like to maintain the average proportion of the last six months of a person's life that they spent at home at 91.6%, a little higher than the Scottish average of 91.2%. (Source: Health and Care Experience Survey 2013/14, Scottish Government).

OBJECTIVE 5

We will deliver services within an integrated care model

Through working together, we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.

What we've heard you say is important to you:

- More integrated and proactive local teams, sharing responsibility and enabling faster decision making.
- Recognise and clarify the roles of all organisations involved in providing health and care services and make better use of each other's skills and experience.
- Integrate IT systems between organisations to improve communications and information sharing.
- Ensure communities are considered individually when planning health and care services.

We want to:

- Ensure robust and comprehensive partnership arrangements are in place.
- Pro-actively integrate health and social care services and resources for adults.
- Integrate systems and procedures.
- Ensure that our workforce are equipped to provide good quality, effective, integrated services with the person at the centre.

Some examples of how we intend to do this through our current services and strategies:

- Improve the coordination and help for individuals making their way through the health and social care system. (Older People).
- Develop an integrated approach to commissioning, and achieve a balance of services. (Mental Health and Wellbeing, Older People).
- Improve access and develop effective and integrated quality services. (Sensory Impairment).
- The housing sector in the Borders has a range of partnership mechanisms to enhance the level of staff engagement, including the Local Housing Strategy Partnership, Borders Housing Hub, New Borders Alliance and the Strategic Housing Investment Plan Working Group.

OBJECTIVE 5 - continued

These are some of the changes that we have started to make:

- **Mental Health Integration** – build on existing arrangements in Mental Health Service to integrate community teams.
- **Improve integration of health and social care provision**. (Learning Disability, Older People).
- **Co-production approach** – professionals and patients/clients working together to review, redesign and deliver integrated services.

We will measure performance against this objective over the next three years by measures including:

- We would like to see the proportion of adults who agreed that their health and care services seemed to be well co-ordinated rise from 79% (the average for Scotland) to 85% (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We would like to reduce the number of bed-days occupied by adults due to delayed discharge across all ages, but particularly for those aged 75 and over, from 84% to the Scottish average of 73%.
- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. We will aim to improve our rating to a minimum of 61%, preferably higher at 70%. The same question will be included in future council staff surveys.

OBJECTIVE 6

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

Ensuring people have more choice and control means that they have the health and social care support that works best for them.

What we heard you say is important to you:

- Ensure services are flexible to address short- and long-term needs and as close to 24/7 as possible, to enable people to access the services they need when they need them.
- Provide more housing options, giving people more freedom and choice.
- Increase availability of self-referral to access services and ensure consistency across services.
- Encourage more people to self-manage their conditions.

We want to:

- Ensure the principles of choice and control, as exemplified in Self Directed Support legislation, are extended across all health and social care services. This includes the participation and involvement of people in their care and support.

Some examples of how we intend to do this through our current services and strategies:

- Enable people with a physical disability to have choice and control over how they are supported to live independently. (Physical Disability).
- Borders Care & Repair services help disabled homeowners or private sector tenants with adaptations that will enable them to stay in their own home. Borders Care & Repair offer help and assistance and can project manage the entire adaptation process. (Housing).
- Ensure the needs of people with dementia are at the centre of all planning and provision of services specific to them. (Dementia).
- Improve the provision of information and advice to Carers, improve quality of Carer assessments/ support plans and involvement of Carers in care planning. (Carers).
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment, Older People).

OBJECTIVE 6 - continued

These are some of the changes that we have started to make:

- **Self-Directed Support (SDS)** – is now being implemented across health and social care services. SDS is an approach across health and social care services that ensures people have choice over their support and over how it is arranged and paid for.
- **Dementia** – The Scottish Borders Dementia Strategy is being updated to align it with national strategies. One area of focus is Post Diagnostic Support for people who are recently diagnosed. New models of care are being explored. Another area of development is a local Dementia Working Group which, with support from Alzheimer Scotland, will ensure people with dementia have their voices heard and are involved in service development. The group will link to the Scottish Dementia Working Group and will have opportunities to be involved with strategic developments at a national level.

We will measure performance against this objective over the next three years by measures including:

- Amongst adults who received support and care services in the Borders in 2013/14, 83% agreed that they were supported to live as independently as possible (a little lower than the Scottish average of 84%). We want to increase this to 85% (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We want to increase the number of people who agreed that they had a say in how their support or care was provided, from 80% to 85% (the Scottish average was 83%) (Source: Health and Care Experience Survey 2013/14, Scottish Government).
- We will ensure that everyone eligible for social care support will have choice and control through the Self-Directed Support approach.

OBJECTIVE 7

We will further optimise efficiency and effectiveness

Strategic Commissioning requires us to constantly analyse, plan, deliver and review our services which give us flexibility to change what we do and how we do it.

What we've heard you say is important to you:

- Improve clarity of decision making process and enable decisions to be made more quickly.
- Ensure that we make the most of our staff through training and flexibility and create more opportunities to offer additional support.
- Acknowledge and address changes required for a more flexible and responsive workforce.
- Value and support our volunteers.
- Make better use of our existing resources and assets, including buildings, people, and finance to ensure that they are sufficient and used as effectively and efficiently as possible.

We want to:

- Transform the way we provide and deliver services.
- Efficiently and effectively manage resources to deliver "Best Health, Best Care, Best Value".
- Support and develop our staff to be confident and reach their full potential.
- Deliver effective support and care through a mixed economy of care, utilising all key partners in the voluntary and private sector.

Some examples of how we intend to do this through our current services and strategies:

- Work to improve the energy efficiency of homes; providing adaptations to enable people to stay at home rather than move someone at higher cost.
- Make efficient use of the funding and other resources available. (Dementia, Older People).
- Deliver a programme of workforce development to ensure that staff have the right skills to support people with more complex care needs.

These are some of the changes that we have started to make:

- **Transitions** – focusing on improving the transition pathway for young people with learning disabilities as they move from children's to adults' specialist services.
- **My Home Life** – offer training to managers to help improve quality of life in care homes.
- **Focus on Outcomes Training** – deliver a new outcome-focused assessment for social care and associated training.

OBJECTIVE 7 - continued

We will measure performance against this objective over the next three years by measures including:

- We will do more to support and empower our staff and achieve a higher proportion of employees who would recommend their workplace as a good place to work. (Currently 56% of NHS Borders staff would recommend their workplace as a good place to work compared to 61% for NHS Scotland as a whole. The same question will be included in future council staff surveys.)
- We would like a higher proportion of our budget to be spent on community-based health and social care and planned hospital care. In the Borders, 20% of all NHS and Social Care expenditure in 2013/14 was in relation to hospital stays, where the patient was admitted as an emergency. This is lower than the Scottish average of 22%. (Source: Integrated Resource Framework, www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/index.asp)

OBJECTIVE 8

We will seek to reduce health inequalities

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

What we've heard you say is important to you:

- Ensure openness and consistency around access to services.
- Work with communities to address loneliness, deprivation and inequality and empower them to develop their own solutions.
- Work with local transport providers across all sectors to provide appropriate and accessible transport services.
- People with learning disabilities are more likely to have more undiagnosed health conditions, die younger than the general population and need more support to access health care.

We want to:

- Reduce inequality, in particular health inequality and support and protect those who are vulnerable in our communities.

Some examples of how we intend to do this through our current services and strategies:

- Develop a Carers Rights Charter, ensure Carer representation on Health and Social Care Partnership. (Carers).
- Reduce the amount of drug and alcohol use through early intervention and prevention, reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reduce related deaths. (Drugs and Alcohol).
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (Sensory Impairment).
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (Adult Support & Protection).
- The four outcomes of the Local Housing Strategy (2012-2017) aim to tackle the inequalities in our society – this includes health inequalities.

OBJECTIVE 8 - continued

These are some of the changes that we have started to make:

- **Transport Hub** – Scottish Borders Council, NHS Borders, The Bridge, Red Cross, Berwickshire Association of Voluntary Services and Royal Voluntary Service are working as partners to put in place a coordinated, sustainable approach to providing community transport.
- **Community Learning Portal** – provide free access to the Community eLearning Portal for staff in partner organisations.
- **Stress & Distress Training** – provide training in a personalised way to understanding and intervening in stress and distressed behaviours in people with dementia. This training aims to improve the experience, care, treatment and outcomes for people with dementia, their families and carers.
- **Deaf Awareness E-learning** – create an e-learning training resource focusing on the needs of older people with hearing loss. Initially the training will be available to Scottish Borders Council and NHS staff, but the intention is to ensure that partner organisations have access to it in the future.
- **Community nurses and social care staff** support people with Learning Disabilities to access mainstream healthcare.
- **Liaison nurses** are based in Borders General Hospital (Learning Disabilities, Mental Health).

We will measure performance against this objective over the next three years by measures including:

- We want to improve and increase the percentage of adults who received support and care services in the Borders who agreed that they felt safe from 81% (lower than the Scottish average of 85%) to 86%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We would like to maintain the downward trend in the Borders in death rates in people aged under 75.
- We will address the recommendations within "The Keys to Life" (2013) National Strategy for people with learning disabilities, through local action plans for people with learning disabilities, to improve their health.

OBJECTIVE 9

We want to improve support for Carers to keep them healthy and able to continue in their caring role

What we've heard you say is important to you:

- Improve support for Carers to avoid deterioration in their own health and wellbeing and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.

We want to:

- Improve support for Carers so they can avoid deterioration in their own health and wellbeing and prevent crisis.
- Encourage people to recognise their roles as Carers and ensure Carers are involved in decision making and planning.
- Improve access to respite care.

Some examples of how we intend to do this through our current services and strategies:

- Ensure the needs of Carers are considered alongside those of the person living with dementia. (Dementia).
- Develop a Carers Rights Charter, improve communication and advice to Carers, improve quality of Carer assessments and support plans, ensure Carer representation on health and social care partnership and produce a resource on issues relating to stress and caring. (Carers).
- Improve identification of Carers at an earlier stage and signpost/refer them for their own assessment.
- All staff will be provided with training around Carers and their needs.
- Carers will be consulted and included in all aspects of their relative's care needs, on planning and delivering the care need, during any hospital stays, on discharge, and in the community.
- Implement requirements set out within the new Carers legislation in 2017.

OBJECTIVE 9 - continued

These are some of the changes that we have started to make:

- **Carers** - We have commissioned the Carers Centre to be the first point of contact for Carers' Assessments. This model has been extremely successful and reduced the length of time for Carers waiting for assessment. However not all Carers are accessing the Centre. Work is underway to consider how we can promote the service and additionally how the Carers Centre can be supported to meet increased demand.

We will measure performance against this objective over the next three years by measures including:

- We want to increase the percentage of Carers reporting that they feel supported to continue caring from 41% (lower than the Scottish average of 44%) to 50%. We will review this target with a view to improving it further if possible.
- We want to support Carers in the Borders so that fewer Carers feel caring has had a negative impact on their health and well-being and reduce this figure from 30% to 20% (Source: Health and Care Experience Survey 2013/14, Scottish Government).

Planning for Change – Key Priorities

Below are the Partnership priorities identified so far for 2016/17. A fund of £2.13m per year has been provided to assist, support and develop the integration of Health and Social Care Services until March 2018.

- To develop integrated accessible transport.
- To integrate services at a local level.
- To roll out care coordination to provide a single point of access to local services.
- To improve communication and accessible information across groups with differing needs.
- Work with communities to develop local solutions.
- Provide additional training and support for staff and for people living with dementia.
- Further develop our understanding of housing needs for people across the Borders.
- To promote healthy living and active ageing.
- To improve the transition process for young people with disabilities moving into adult disability services.
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the Third Sector.
- To improve support for Carers within our communities.
- Promote support for independence and reablement so that all adults can live as independent lives as possible.

LOCALITY PLANNING

There are five commonly recognised localities in the Borders as the maps in this section show. These are based on the five existing Area Forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale. Summary profiles for each of the five localities show some of the differences between them. As part of the planning process, we will build more detailed locality profiles, including a wider range of measures relevant to health and social care. This will allow us to target need most appropriately.

Map showing our five Area Forum Localities (with all towns and villages with a population of 500 or more).

We have set up a group to oversee the development of planning in each of the five localities. We expect to appoint locality co-ordinators to act as a focus for planning in each locality.

They will:

- Build relationships with established community groups, partners across the localities, such as other leads working at locality level, for example in Community Learning and Development.
- Map out what is already happening, use and build upon the mapping work already in existence across relevant partnerships - established community groups, many of which are linking up through the Community Learning Partnership approach.
- Identify where existing funding is coming from, where there are gaps and where there are ideas or plans.
- Clearly define what is happening in the short, medium and longer term, how these priorities have been identified and what the consultation process has been/is going to be.
- Co-ordinate action plans, planned expenditure and how these fit with local priorities.

Planning at this level will need to take account of existing local plans such as Community Action Plans or Neighbourhood Plans as well as cross-Borders strategies, such as the reducing inequalities strategy and health inequalities action plan. It will also need to address cross-border issues (between Borders localities, and between Borders and neighbouring areas of Scotland and England). Some priorities are the same across localities but others are different. Locality plans will also need to take account of projects starting at the moment. For example, we are beginning to develop care coordination, which will be undertaken by care coordinators which will be rolled out across the localities in a phased way. This will help us provide more person centred care. Another current project is to provide a means for Borders Community Transport providers to work together to make best use of available transport and reduce duplication of journeys. Some other projects are specific to a locality such as "the Eildon Community Ward".

Service users, Carers, families, communities and professionals – particularly GPs – must be actively involved in locality planning, so that they can influence how resources are spent in their area – genuine co-production. Co-production is where people using services, their families and their neighbours work as equals with professionals to plan and deliver services. We are rolling out a "Borders Community Capacity Building Project" which will provide communities with support and ability to do this. We want communities to use the collective resources (assets) which they have at their disposal, to protect against poor health and improve health.

Assets are the strengths that people and communities have such as relationships, networks, enthusiasm, social cohesion and resilience as well as plans, land, buildings and funding. The people of the Scottish Borders are perhaps our single biggest asset. The networks and relationships that exist within and across communities are invaluable in themselves and they are health-improving. They provide a solid foundation for any work to improve health and wellbeing alongside the strong volunteer ethic and a natural commitment to supporting others. There is growing evidence of the combination of local people, community

groups, partners and physical assets in action across localities, such as the Borders Healthy Living Network, Langlee Residents Association, Burnfoot Community Futures, Eyemouth Community Development Trust and the relationships and activities these community based groups/organisations have been developing with agencies and local people.

In addition to people, other assets within the Scottish Borders include land and buildings. The Scottish Borders is a stunning place to live and this applies to all localities, with some of the most breath-taking views, areas of green space and outdoor walks available right on our doorstep. The Scottish Borders is steeped in history and this could be brought to life through social projects that involve communities and people who have experience of the changes influencing health and wellbeing in the Borders. We know that older people are living longer, healthier lives and they have a wealth of knowledge, skills and experience to share with others. We should make every effort to capitalise on this and positively influence the next generation of children and young people by connecting up these assets.

The Scottish Borders is made up of 'can do' communities and this is very much seen through their actions to support others on a day to day basis, as well as in times of crisis. If these assets are nurtured and harnessed in everyday life, this culture of support could be further enhanced. This has been referred to as an assets approach, which at its simplest turns what we know on its head and questions what we think in a positive way, for example, instead of asking about what is not going well, we ask about what is going right and do more of this. This is very much the current thinking influencing some local groups and networks. This can also be applied in practice through training and development to ensure that people are viewed in this way and seen for their strengths and the contribution they have to make. An assets approach therefore presents a significant shift in the way we engage with people and communities, from a deficit model that emphasises need and problems to an asset model that values active participation and sees people and communities as co-producers of long term sustainable solutions. Focusing particularly on health, the fundamental shift from what makes us ill to what makes us well and doing more of this is at the heart of an asset approach.

Where appropriate, we will devolve resources towards the delivery of particular local outcomes. For example, we will strengthen the work of the healthy living network in areas of disadvantage to improve the health and well-being of those communities. We will prioritise engagement with vulnerable groups, isolated residents and people who are not already accessing existing groups and local services. We will make the best use we can of community capacity and capability to do this.

Some illustrative Facts and Statistics about our Area Forum Localities

Tweeddale

- Estimated population in 2013: 19,192.
- 41% of live in its largest settlement, Peebles (population 7,908), whilst 59% live in smaller settlements or rural areas.
- The locality with the highest proportion of its population aged under 16 (18.7%). 60.1% of the population are aged 16-64 and a further 21.2% are aged 65+.
- In 2014/15 there were 16.6 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 80 per 1,000 population.

Eildon

- Estimated population in 2013: 38,798. Our largest locality in population terms (over one third of Scottish Borders residents live here).
- Nearly one third of residents live in Galashiels (estimated population 12,394) and another 14% in Selkirk (estimated population 5,608).
- The locality with the highest proportion of its population aged 16-64 (62.3%) and the lowest proportion aged 65+ (20.5%). A further 17.2% of the population are aged under 16.
- In 2014/15 there were 27.3 attendances at Borders General Hospital A&E for every 100 population – this is the highest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 93 per 1,000 population; this is the highest rate across our localities.

Berwickshire

- Estimated population in 2013: 20,862.
- No large towns; most people live in small settlements or rural areas. Eyemouth (population 3,152) and Duns (population 2,444) are the largest settlements here.
- 15.8% of the population are aged under 16, 60.0% are aged 16-64, 24.2% are aged 65+.
- In 2014/15 there were 15.8 attendances at Borders General Hospital A&E for every 100 population – this is the lowest rate across our localities.
- In 2011-2013 the emergency hospital admission rate was 79 per 1,000 population.

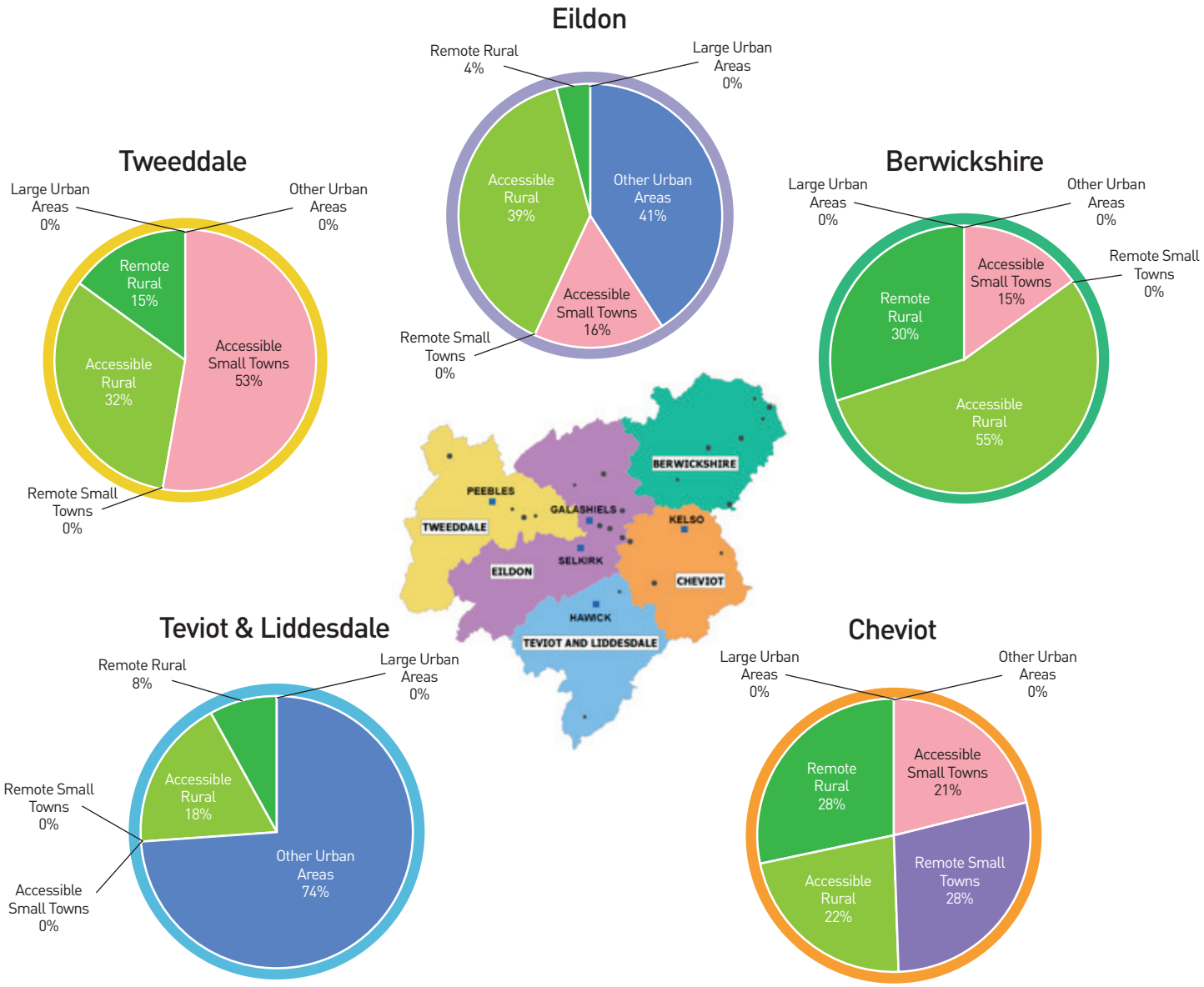
Cheviot

- Estimated population in 2013: 16,407. Our smallest locality in population terms.
- More than 60% of residents live in Kelso and Jedburgh, which have estimated populations of 6,139 and 3,959, respectively.
- The locality with the highest proportion of its population aged 65+ (25.6%). It also has the lowest proportions of children aged under 16 (15.6%) and people aged 16-64 (58.8%).
- In 2014/15 there were 19.7 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 75 per 1,000 population; this is the lowest rate across our localities.

Teviot & Liddesdale

- Estimated population in 2013: 18,611.
- Nearly three-quarters of the population live in the town of Hawick (estimated population 13,696).
- 15.7% of the population are aged under 16, 60.6% are aged 16-64, 23.7% are aged 65+.
- In 2014/15 there were 23.4 attendances at Borders General Hospital A&E for every 100 population.
- In 2011-2013 the emergency hospital admission rate was 87 per 1,000 population.

OUR AREA FORUM LOCALITIES AND THEIR URBAN/ RURAL POPULATION PROFILES



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

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

WHAT WILL SUCCESS LOOK LIKE

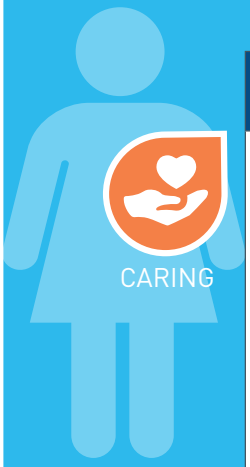
- Services are integrated and there is less duplication
- There is easier access to services through a single point of contact
- People with multiple long term conditions are supported
- Carers will feel better supported and have improved health and well-being
- Make best use of staff
- People participate in planning their own care and support
- The benefits of new technology improve people's health and well-being
- There is a shift to early intervention and prevention for children and young people, families and carers
- There will be a reduction in health inequalities
- Spend money wisely

PLANNING FOR INTEGRATED SERVICES

The two case studies here illustrate how ordinary people should experience a better integrated health and social care service.

PAMELA AGE 57

I'm Pamela and I've lived in Innerleithen most of my life. I live with my husband Owen and our daughter Jane. My 83 year old Father lives in sheltered housing nearby and our eldest daughter Jillian lives 7 miles away in Peebles. I have a lot of friends who live in the area.



MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
I look after my 3 year old grandson, Jack, 3 times a week. I visit my elderly father every day and I am the first responder to his Bordercare alarm. I recently had a Carer Assessment carried out.	I recently realised how much I've been looking after my Father. I love my Father and I want to care for him, but sometimes, I resent being his first responder and I feel I sacrifice things that are important to me to look after him. I feel guilty for thinking these things. Sometimes I don't understand what's happening with his care. I worry a lot about him.	• Clear information on available support and services. • Health and care co-ordinated services. • A single number to access services. • More support for me as a Carer.
I live in a modern, rented house. My husband Owen and I don't drive so we rely on public transport.	I love where I live and I like that I can walk to shops and the bus stop. But I find organising transport to get my Father to appointments can be really difficult.	• A single number to book transport. • Easier access to more coordinated services.
Owen recently retired for health reasons. My Father has dementia and is prone to falling. Jane is taking her higher exams. I love looking after Jack and seeing Jillian. Her partner Bill is nice too.	Owen is eight years older than me. He struggles with depression and I feel I need to be with him, which can result in me not being able to spend enough time with my Father or Jane. My Father falls occasionally. He has been recommended to attend gentle exercise classes but he says no.	• More opportunities to meet other people in the local community. • Supporting local communities to connect people and interests.

HOME

FAMILY

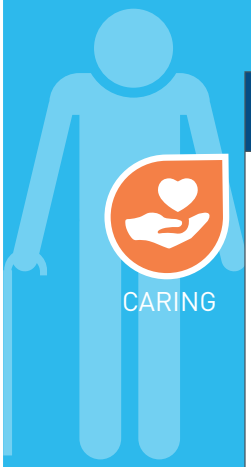
PAMELA
AGE 57

Continued ...

MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
I work part-time in a shop in nearby Galashiels.	I've considered reducing my hours to spend more time with my Father and my family, but I can't for financial reasons. I often have calls to make or receive about my Father when I'm at work which is challenging as I've limited flexibility. I sometimes have to take leave to take him to appointments.	• More options to enable me to take my father to appointments. • Longer opening hours for services.
I've high blood pressure, arthritis and anxiety. I'm a cancer survivor. I take many prescription drugs. I've been a heavy smoker for years.	I don't take the best care of myself because by the time I've looked after my Father, grandson, Owen, daughter, been to work and volunteered at Church I'm often too tired. I tend not to tell Owen about my worries because of his depression. Smoking helps me feel more relaxed, but I've noticed I smoke more now. I'm quite anxious so I was grateful that the Carer's Assessment lady listened to me.	• Locally available acute health and care services. • Forward (Anticipatory) care planning for my Father, Owen and me. • A named person that I can speak to.
Owen and I have many friends here. I enjoy volunteering at my local church.	We have a good community with neighbours and friends helping out. I've school friends and friends at Church, so every once in a while, if things are ok, I meet them for lunch. My Father is isolated and he would really like visits from people as he has trouble going out.	• Supporting local communities to connect people and interests.

CHARLIE AGE 78

I'm Charlie. I've lived in Kelso since I retired here 15 years ago with my wife, Sandra, who died 5 years ago. I've been alone since. My two children live far away. They come for visits, but they have busy lives and their own families. I love Kelso, I feel safe and happy here, apart from being so far from my family.



	MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
CARING	I am a widower. I don't need health and care services at the moment.	I feel capable, but having recently had a fall, I had a bit of a fright and I was admitted to hospital for a short while. It was sad as I had no visitors which made me start to think about what would happen to me when I do need more help. I don't want to be a burden to my children. I always thought I would grow old with Sandra. There are home carers who can help me, but I would prefer to have someone I could rely on, not a lot of different people.	• I can choose the staff I want to support me at home. I will get support if I want to employ my own staff. • A single number to access services.
HOME	I live in a 3 bedroom house with a large garden, on the outskirts of the town. I drive, but I'm less confident now so I don't like driving.	I know my house is too big and I cannot manage the garden alone, but I don't want to move and start over with a new house and neighbours. I'm a 10 minute walk to the bus stop and buses are regular but if I need to go to the Hospital, I have to change buses. I feel I need to drive more and more.	• Better co-ordinated local transport • Bigger range of locally based housing options
FAMILY	My son Paul lives in England. My daughter Steph and her family moved to Florida 3 years ago.	Paul visits every couple of months. I can see he's worrying about me and I know Steph feels guilty for being so far away. I want to be able to reassure them I have a plan for any future needs and that I can support myself. Paul wants me to move near him but I don't deal with change very well.	• Forward (Anticipatory) Care Planning. • I am in control of planning for the future.

CHARLIE
AGE 78

Continued ...

MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
WORK I'm retired. I had to step back from my voluntary work at my bowls club which I enjoyed.	I liked being Treasurer of my local bowls club. My friend introduced me to bowls and she takes me when she can, but she can't make it every week. I had to give up being Treasurer as it became too much. I don't feel as fulfilled as I did. I would love to do more voluntary work.	• Appropriate volunteering opportunities for older people
HEALTH I'm slowing down and finding things harder. I've many medications, I'm not sure what they are and why I take them.	I like to keep active and I do drive when I need to, usually to appointments and shops. It was scary when I fell, but I don't think I needed to go to the emergency department, but I couldn't be checked locally. I felt very overwhelmed by the number of people asking me the same questions – surely the staff can look it up on my medical notes?	• Locally based services • Better information sharing across organisations
COMMUNITY When Sandra was alive we did lots of things together, but it's not the same without her.	I feel lonely without my wife and not as confident to socialise with people. My neighbours are lovely, but I don't see them as often as I used to. I wish there were more activities and groups for older people like me.	• Community based groups and activities

PLANNING INTO THE FUTURE

The Strategic Plan will only be the beginning. It will be a living working document which will change and grow throughout its life. It will build on feedback from people living in the Borders. It will be reviewed at least every three years, based on on-going assessment of need. In the future, we will focus particularly on how to meet the needs of people who use services in local communities.

Throughout the last 12 months we held a number of engagement events for both the public and staff. The information we received from these events has been used to inform this document. For example, the 9th local objective on support for unpaid carers was added as a direct result of your feedback. Thank you to all who gave us feedback in person or in writing throughout the process of developing this Plan. We have been able to act on some of your comments at this stage whilst others will be retained to help us in our ongoing planning and engagement work.

APPENDIX A
SERVICES THAT ARE INTEGRATING

Which health and social care services are we integrating?

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

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

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

APPENDIX B
THE NATIONAL HEALTH AND WELLBEING OUTCOMES

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

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

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

Source: Scottish Government

APPENDIX C
OUR LOCAL OBJECTIVES AND THE NATIONAL OUTCOMES CROSS-REFERENCED

Our Local Objectives are:

1. We will make services more accessible and develop our communities.
2. We will improve prevention and early intervention.
3. We will reduce avoidable admissions to hospital.
4. We will provide care close to home.
5. We will deliver services within an integrated care model.
6. We will seek to enable people to have more choice and control.
7. We will further optimise efficiency and effectiveness.
8. We will seek to reduce health inequalities.
9. We want to improve support for Carers to keep them healthy and able to continue in their caring role.

The National Outcomes cross-referenced with Our Local Objectives

National Outcomes	1	2	3	4	5	6	7	8	9
Local objective 1	★	★	★	★		★		★	
Local objective 2	★	★		★	★			★	
Local objective 3	★	★							★
Local objective 4	★	★	★	★	★	★			★
Local objective 5				★				★	★
Local objective 6	★	★	★	★	★	★	★		
Local objective 7								★	★
Local objective 8	★	★	★		★	★	★		
Local objective 9	★	★	★	★	★	★	★		

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