Scottish Borders Health & Social Care Partnership

Draft Strategic Commissioning Plan

2015 – 2018

Work in Progress

Borders Partnership – Strategic Commissioning Plan – 2015-2018

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Section 1 Introduction & Background

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

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

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

Making the case for change is at the centre of this Plan. It is not a critique of current provision but rather a fundamental recognition that the existing model of care needs to change in order to meet both current and future challenges. There are no neutral decisions – if we do nothing the health and care system will not be able, in its current form, to continue to deliver the high quality service we expect to meet the needs of the Borders population.

We recognise that our health and care system is challenged and we need to be a strong and effective planner and commissioner in order to drive improvements in performance and deliver the efficiencies required for the future. Nowhere is this more apparent than in our acute hospitals where we have not yet secured the urgent care system that any of us want to see for the future. This has to change and our plans aim to address this issue through immediate action plans, medium term plans and through a longer term sustainability plan, all delivered through our locally driven programmes.

In further developing this Strategic Plan we will undertake an extensive public engagement programme. Our plan will be developed with, and through, our localities, our clinicians and professionals, our wider workforce and the population of The Borders; this is key to our future success.

1.1 What is the H&SC partnership?

From 2015, Health and Social Care Partnerships (HSCPs) will replace Community Health Partnerships (CHPs). In the Borders, the HSCP has been established in shadow form since late 2013. Health and Social Care Partnerships will be accountable for delivering a range of nationally agreed outcomes which will apply across adult health and social care.

The establishment of HSCPs will also see a requirement on Health Boards and Local Authorities to integrate adult health and social care budgets and to strengthen the role of clinicians and care professionals, along with those in the third and independent sectors, in the planning and delivery of services. The policy aim in developing HSCPs is to ensure that adult health and social care budgets are used efficiently and effectively to achieve quality and consistency, and to realise a shift in the balance of care from institutional to community based settings.

1.2 What is the Strategic Plan?

The Strategic Plan will describe the changes and improvements in health and social care services that Scottish Borders HSCP wants to make over the next ten years. It will explain what our priorities are, why and how we have decided them, and how we intend to make a difference working closely with partners in and beyond the Borders.

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

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

1.3 Locality planning

Geographically the Strategic Plan covers the area within Borders Council and NHS boundaries and it sets out the service delivery intentions of our partnership for the medium-term. It identifies priorities for joint working during the next ten years, improving quality and strengthening joint arrangements.

Strategic planning as described in the Public Bodies (Joint Working) (Scotland) Act 2014 requires that our services should be provided in a way in which, as far as possible, takes account of the particular needs of recipients from different parts of

the county and is planned in a way which is engaged with the community and with local professionals.

1.4 What services will a SCP cover?

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care in Scotland and requires the Health Board and Local Authority to delegate some of its functions to the new Integration Authorities – the Health and Social Care Partnerships. By delegating responsibility for health and social care functions the objective is to create a single system for local joint planning and delivery of health and social care services which is built around the needs of patients and service users and which supports service redesign in favour of preventative and anticipatory care in communities.

The regulations which underpin the Act clearly set out which health and social care functions and services must be delegated to the HSCP. The Act limits the functions that can be included in the"must be delegated" list to services provided to people over the age of 18. The effect of this is that the primary legislation ensures that no children's health and social care services will be required to be integrated and it is up to local systems to decide whether to integrate children's services as well as adult services.

A key feature of legislation is that integration must include adult social care, adult primary and community health care services, and elements of adult hospital care which offer the best opportunities for service redesign. Other services can also be included in integrated arrangements if there is local agreement to do so.

The social care services relating to adults which must be delegated to the HSCP are:

- 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
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare

Each Health Board must also delegate all adult primary and community health services, along with a proportion of hospital sector provision. Health services which must be delegated to the HSCP are:

- District nursing services
- Substance misuse services
- Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital
- The public dental service
- Primary medical services
- General dental services
- Ophthalmic services
- Community geriatric medicine services
- Community palliative care services
- Community learning disability services
- Community mental health services
- Community continence services
- Kidney dialysis services provided outwith a hospital
- Services provided by health professionals that promote public health.
- Hospital services

In regulations Scottish Government has also identified which aspects of acute hospital care offer the best opportunity for improvement under health and social care integration. These are:

- Accident and Emergency services provided in a hospital
- Inpatient hospital services relating to:
  - 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 substance dependence
- Mental health services provided in a hospital, except secure forensic mental health services

New Integration Authorities will therefore be responsible for strategic planning of these services which are the ones most commonly associated with the emergency care pathway - that is, hospital specialties which demonstrate a predominance of unplanned hospital bed day use for adults. Within the context of integration, “unplanned” refers to those stays that are potentially avoidable with the provision of some sort of preventative care.

The interface with housing will be crucial to the success of the integration agenda. Whilst only certain limited aspects relating to housing are included within the current scope of services delegated to the HSCP we believe that it is vital that this Strategic Plan links effectively to the strategic housing needs assessments carried out by Scottish Borders Council. The housing sector makes a significant contribution to the national outcomes for health and wellbeing by:

- Providing information and advice on housing options
- Facilitating or directly providing "fit for purpose" housing that gives people choice and a suitable home environment
- Providing low level, preventative services
- Building capacity in local communities
- Undertaking effective strategic housing planning

The integration of adult health and social care now brings opportunities to strengthen the connections between housing and health and social care, to improve the alignment of joint planning, to support the shift to prevention and to incorporate arrangements for housing support and homelessness services. We will, therefore, actively consult with and work with housing colleagues in the development of the final version of this Strategic Plan.

1.5 How will the HCSP develop and agree this plan?

The Integrated Joint Board, the HSCPs governing body, will replace the former Community Health Partnership committee and has been meeting in shadow form since 2013. This draft Strategic Plan is a joint statement, the initial development of which has been overseen by the Shadow Board and the Strategic Planning Group which has representation from NHS, local authority, clinicians, service users, carers, voluntary sector and the independent sector. In writing the draft plan we have reviewed information about health needs, issues and concerns raised by local people and current service delivery and discussed and refined our plans and priorities. From this work we have developed this document which is a consultation draft of the Strategic Plan. We want to listen to as many stakeholders as possible so that when we prepare the final version of the Strategic Plan we are confident that we have actively encouraged contributions. We intend to consult widely on the significant strategic themes following which we will review and finalise the plan.

Section 2 Summary of National & Local Context & Policy Priorities

- Community Planning statement
- Local and national plans/strategies re-care groups health conditions, inequalities, approaches etc.
- Key messages
- *Let me be clear about the objectives of this programme of reform. We want to ensure that adult health and social care services are firmly integrated around the needs of individuals, their carers and other family members; that the providers of those services are held to account jointly and effectively for improved delivery; that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the needs of the organisations through which they are delivered; and that those arrangements are characterised by strong and consistent clinical and professional leadership…*
- *There is now a consensus around the contention that separate and—all too often—disjointed systems of health and social care can no longer adequately meet the needs and expectations of the increasing number of people who are living longer into old age, often with multiple, complex, long-term conditions and who, as a result, need joined-up, integrated services.'*

- **Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, December 2011**
- The Scottish Government is integrating health and social care services to ensure that people get the right care, in the right place, at the right time. Historically, there has been a divide between "health" and "social care" services. Increasing numbers of people do not experience neatly segregated "health" and "social care" needs, so our systems to support them need to evolve to reflect complexity of needs and multimorbidity in the population
- 'Public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve. We must prioritise expenditure on public services which prevent negative outcomes
- From arising. And our whole system of public services – public, third and private sectors – must become more efficient by reducing duplication and sharing services wherever possible. Experience tells us that all institutions and structures resist change, especially radical change. However, the scale of the challenges ahead is such that a comprehensive public service reform process must now be initiated, involving all stakeholders."
-
- **The Christie Commission Report**
- **Commission on the future delivery of public services, June 2011**

Section 3 Objectives, Ambition & Outcomes

3.1 The Nine National Outcomes

Our work will be to deliver a set of National Outcomes agreed by the Scottish Government. These are:-

- **Healthier Living** – people are able to look after and improve their own health and wellbeing, and live in good health for longer

- **Independent Living** – people, including those with disabilities, long-term conditions, or who are frail, are able to live as far as reasonably practicable, independently at home, or in a homely setting, in their community. This outcome aims to ensure delivery of community based services, with a focus on prevention and anticipatory care, to mitigate against avoidable emergency admissions to hospital. It recognises that independent living is key to improving health and well-being

- **Positive Experiences and Outcomes** – people who use health and social care services have positive experiences of those services, and have their dignity respected. It is important that health and social care services take full account of the needs and aspirations of the people who use services. Person centred planning and delivery of services will ensure that people receive the right service at the right time, in the right place, and services are planned for and delivered for the benefit of people who use the service

- **Quality of Life** – health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live. This outcome provides for any on-going focus on continuous improvement in relation to health and care services.

- **Reduce Health Inequality** – health and social care services contribute to reducing health inequalities. This outcome is focussing upon the role of services in seeking to reduce the gap in health inequalities.

- **Carers are Supported** – people who provide unpaid care are supported to reduce the potential impact of their caring role or their own health and well-being. This outcome acknowledges the support carers require including the maintenance of their own health and well-being.

- **People are Safe** – people who use health and social care services are safe from harm. In carrying out our responsibilities, we must ensure that the planning and provision of health and social services and supports protects individuals from harm.

- **Engaged Workforce** – people who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide, and feel engaged with the work they do

- **Resources are used effectively and efficiently -** to deliver Best Value Services and Supports

The Partnership has determined that the following seven areas of focus will drive work in the first phase of strategic planning and therefore *shape* the way the Council, NHS and partners *respond locally to the challenges of rising demand, rising expectations and financial constraint.*

Partnership Strategic Policy Drivers

- Improved outcomes for service users and carers
- Easily accessible services with clear available information
- Quality services delivered in a person's own home or community in a timely way
- Open, transparent and understandable governance arrangements
- Effective use of resources and delivery of agreed efficiencies across the partnership
- Flexible skilled workforce
- Meets agreed performance targets

These will be achieved and strengthened through the following strategic objectives which are designed to deliver the National Outcomes.

3.2 Local Strategic Objectives

Our local strategic objectives

1. ***We will make services more accessible and develop our communities***

   - We want to improve access to our services, but also to assist people and communities to help and support themselves too.
   - We will develop local responses to local needs.
   - We will communicate in a clear, open and transparent manner.

2. ***We will improve prevention and early intervention***

   - We will prioritise preventative, anticipatory and early intervention approaches.
   - We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crisis.

3. ***We will reduce avoidable admissions to hospital***

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.

4. ***We will provide care close to home***

   - We will support people to live independently and healthily in local communities.

5. ***We will deliver services within an integrated care model***

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

6. ***We will seek to enable people to have more choice and control***

   - We will ensure the principles of choice and control, as specified in Self Directed Support, are extended across all health and social care services.

7. ***We will further optimise efficiency and effectiveness***

   - We will institute a transformational change programme across the functions delegated to the Partnership.
   - We will efficiently and effectively manage resources to deliver Best Value.
   - We will support and develop our staff.

8. ***We will seek to reduce health inequalities***

   - We want to reduced inequality in particular health inequality, and support and protect those vulnerable in our communities.

NHS Clinical Strategy Principles

Section 4 Summary of Joint Strategic Needs Assessment

Introduction

In order for the Borders Health and Social Care Partnership to commission and deliver services that best meet the needs of its local communities (and to intervene at an early stage to address health problems) we require a clear understanding of the health and care needs of the population, from both the perspective of the NHS and Local Authority.

The purpose of this Joint Strategic Needs Assessment (JSNA) is to provide this clear understanding. It brings together data on the health and care needs of the people of the Scottish Borders together in one place; to create a picture of the health and care service needs and enhance and strengthen the information intelligence available to the Partnership. This information is used to support strategic decision making and will enable us to develop responses to meet the challenges of the future.

The key features of the JSNA are that it involves partnership working with input from stakeholders ('joint'), it provides direction for decision making ('strategic') and it identifies current and future health and wellbeing needs ('needs assessment').

The JSNA is work in progress, but for the purposes of this consultation draft it provides a summary of the key findings to date from a wide range of data on demographics, population projections, health and social care provision, long term conditions, etc. The JSNA is supported by a 'Statistics and Facts' appendix which contains detailed charts, tables and technical notes

The next draft of the JSNA will include more detailed localities profiles, comparing and contrasting the 5 planning localities within the Scottish Borders. At the time of writing this draft we are awaiting updated locality profile information, such as the ScotPho Profile data, which will be made available to us in March 2014, and the JSNA will be update to include the locality profile analysis

(Note: Add in what the JSNA will demonstrate – change the way we deliver service and also the key gaps)

Existing Local Strategies and Plans

The JSNA is an evidence based document, and there are a number of strategies and plans that underpin and inform it. Some of these strategies are based on existing partnership working, and it is important to note that the JSNA does not aim to replace or revise any of the current live plans. Where appropriate however this document references more up to date data and information that has become available since the strategies and plans were published, in particular the recent publication of 2011 Census data.

The joint strategies and plans referenced are (Note: check for completeness)

- Older People Joint Commissioning Strategy
- Alcohol and Drugs Partnership Strategy
- Living Well with a Disability
- Review of learning Disability Service Provision
- Mental Health Commission Strategy and Needs Assessment
- Caring Together in the Scottish Borders
- Strategy for Sensory Services in Scottish Borders
- Draft Needs Assessment for Palliative Care Services
- Borders Dementia Strategy
- Single Outcome Agreement and Strategic Assessment

Each of these strategies were reviewed prior to the drafting of this JSNA and a number of key themes were identified, which relate to the National Outcome Indicators for Health and Wellbeing. These are:-

- People are allowed to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- People who provide unpaid care supported to reduce the impact of their caring role on their own health and wellbeing
- People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do

National Strategic Context

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

- Maximising scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities
- Concentrating the efforts of all services on delivering integrated services that deliver results

- Prioritising preventative measures to reduce demand and lessen

Local Strategic Context (others?)

The Single Outcome Agreement (SOA) for the Scottish Borders (September 2013) sets out the Scottish Borders Community Planning Partnership vision that

'By 2023, quality of life will have improved for those who are currently living within our most deprived communities, through a stronger economy and through targeted partnership action.'

This vision will be achieved by delivering on 3 key priorities; growing our economy, reduce inequalities, and maximise the impact from the low carbon agenda. The SOA was based on a Strategic Assessment which analysed the issues affecting the Scottish Borders and referenced the 16 national outcomes in the Scottish Government's National Performance Framework. For the purposes of the JSNA, it is the information relating to the key priority of reducing inequalities which is referenced.

POPULATION

The Scottish Borders and its People (will this be covered elsewhere in detail in the SPlan?)

The Scottish Borders geographic area is 473,614 hectares (1,827 square miles); located in the South East of Scotland. It has Edinburgh and the Lothian's to the North, Northumberland to the South and Dumfries and Galloway to the West.

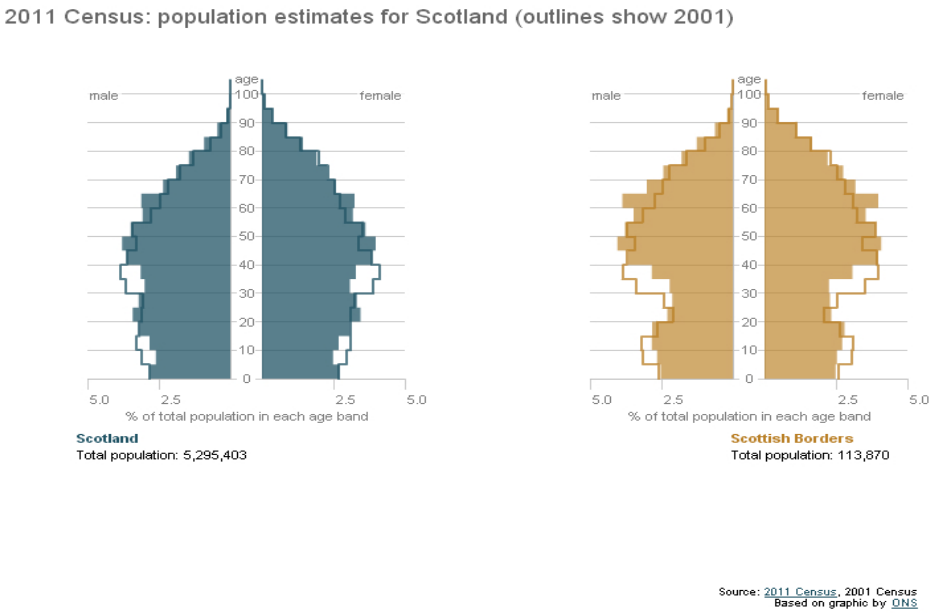
Scottish Borders is a rural local authority where 30% of the population lives in settlements of fewer than 500 people or in isolated hamlets. The largest town is Hawick with a 2011 Census population of 14,029, followed by Galashiels with 12,604 – although, if neighbouring Tweedbank were included, Galashiels would be the largest town in Scottish Borders with a population of 14,705. The only other towns with a population of over 5,000 people are Peebles, Kelso and Selkirk.

The 2011 Census showed that there were 113,870 people in the Scottish Borders. The proportion of children aged under 16 is around the Scottish average at 17%. Working-age people aged 16-64 make up 62% of the Scottish Borders population, below the Scottish average of 66% and the proportion of pensioners aged 65 and over is well above average, at 20.9% in Scottish Borders compared with 16.8% in Scotland.

The diagram below show the population pyramids for Scotland and the Scottish Borders with a reference to the 2001 population structure. The pyramids show that the Scottish Borders greater proportion of people aged 40 and older compared to

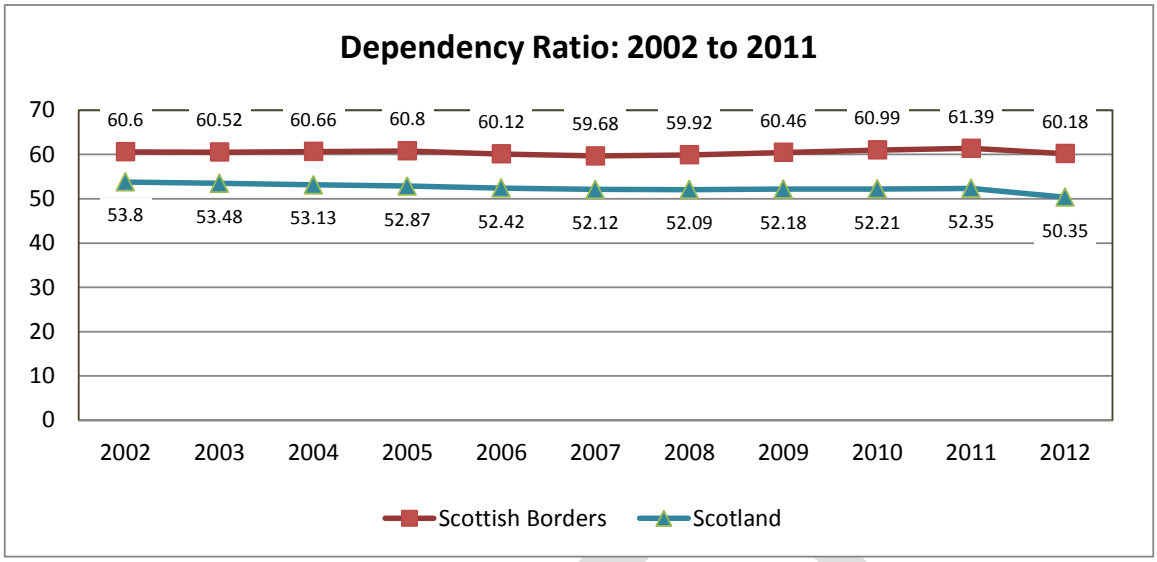
Scotland. The Scottish Borders pyramid also clearly shows the 'baby boomer' progression from 2001.

Figure 1



The Scottish Borders has a smaller proportion of people of working age compared to Scotland and this is likely to continue. This is illustrated by the dependency ratio (one of the Local Outcome Indicators used by Local Authorities). The dependency ratio is calculated by dividing the sum of the population of 0-15 and 65 plus year-olds by the population of 16-64 year-olds. The ratio is then converted to a percentage by multiplying by 100. In 2012 the Scottish Borders had a dependency ratio of 60.18 (see Figure 2 below) compared to 50.35 for Scotland, meaning that there are more people aged under 15 or aged 65 and older in the Scottish Borders compared to Scotland.

Figure 2



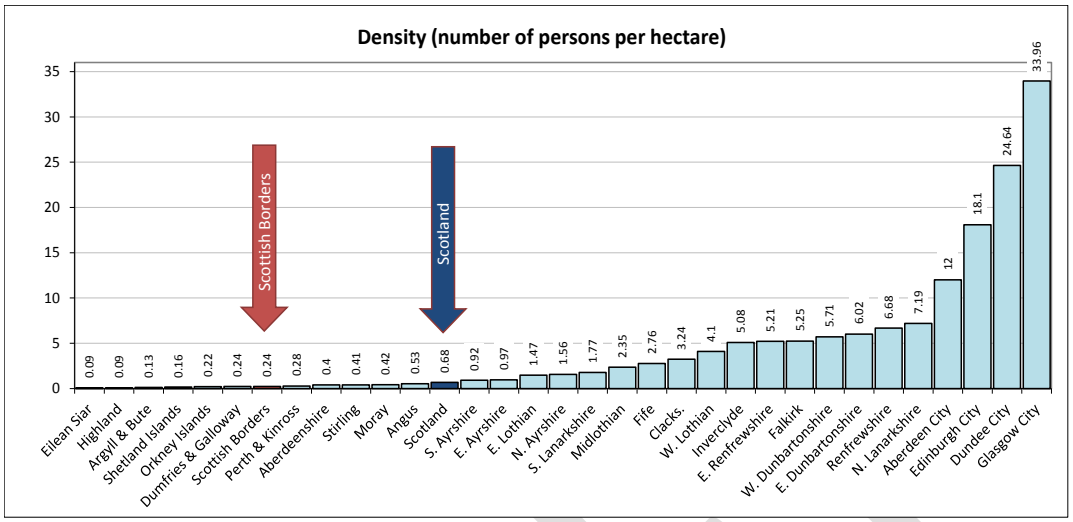
This demographic profile has significant implications on the delivery of services into the future, especially in relation to the provision of care, on our future workforce and on economic development.

In terms of household structure, the 2011 Census shows that, in combination with the ageing profile, family and household structures tend to be more traditional than in Scotland as a whole although this trend is diminishing as households become older and smaller. The most usual household type in Scottish Borders is couples with or without children, which is more common in Scottish Borders than in Scotland as a whole, whereas in Scotland the most usual household type is the single person household aged under 65. In a break with tradition, cohabiting couples with children are now slightly more usual in Scottish Borders than in Scotland as a whole, although lone parent families are still well below average. **Single person households are growing rapidly in Scottish Borders, particularly the single person household aged over 65, which affects 15.2% of households compared with 13.1% in Scotland**.

Scottish Borders has a healthy and industrious population with a higher than average rate of economic activity and a lower than average unemployment rate, despite the fact that 18.6% of adults aged under 74 are officially retired, which is again higher than the Scottish average. However, low wages, lack of employment opportunities and underemployment are ongoing issues in rural areas and the 2011 Census shows that Scottish Borders has a higher rate of part-time employees and a lower rate of full-time employees than average. Despite the popularity of traditional family household structures in the region, a lower-than-average percentage of adults consider themselves full-time home-makers and most adult family members aged under 75 are economically active in some capacity, either through preference or through necessity.

Scotland is a relatively sparsely-populated country with most of the population concentrated in the industrial Central Lowlands. **Scottish Borders is one of the most sparsely-populated regions of Scotland,** as shown below.

Figure 3



According to the 2011 Census, the population density for Scottish Borders is 0.24 persons per hectare, which is lower than the Scottish average of 0.68 persons per hectare and makes Scottish Borders the 6th-equal least-populated region in Scotland, alongside neighbouring South of Scotland region Dumfries & Galloway. The only mainland Local Authority areas with sparser populations than the South of Scotland regions are Highland and Argyll & Bute; the remainder are island regions. **This has an implication on the costs of providing services in more rural environments,** especially compared to the city environments like Glasgow, Edinburgh and Dundee. **The uneven distribution of the population in Scottish Borders also makes it harder to plan services,** with residents scattered in isolated hamlets in many parts of the region, yet with towns such as Hawick having a higher average population density than Glasgow. (Query delete the following? Despite these difficulties, Scottish Borders Council's total service net expenditure is similar to the Scottish average and satisfaction rates for council services are higher than the Scottish average?

Projections of future population

The National Records of Scotland population projections suggest that there may be little or no change in the overall number of people resident in Scottish Borders between 2012 (113,710) and 2037 (113,725). These latest estimates differ from 2010-based projections, which suggested that the Scottish Borders population might grow by about

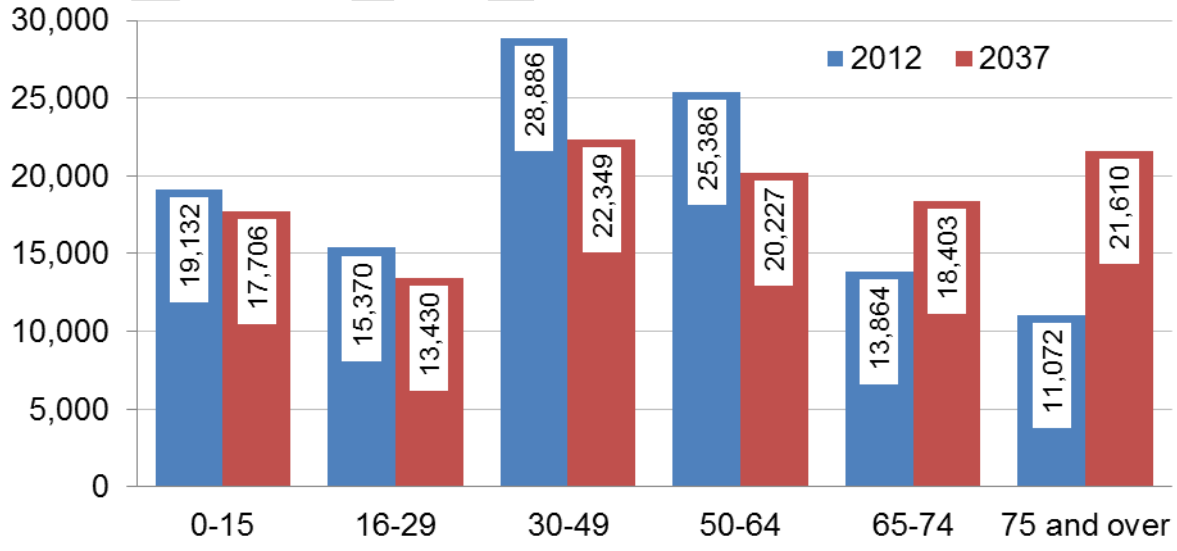
11% overall. However, what is consistent between the two sets of projections is that the relative numbers of older people in Scottish Borders are expected to increase substantially. The numbers of people aged 65-74 may increase by almost one third (32.7%), whilst the numbers aged 75 and over may almost double (95.2%). Meanwhile, the numbers of children and people of working age are predicted to decrease. This has substantial implications for potential levels of need for health and care support within Scottish Borders.

Table 1: Projected population of Scottish Borders (2012-based) for 2012 and 2037, by broad age group (amend table to include 10 and 25 years)

Age group	2012	2037	Projected change in number of people 2012 to 2037	Projected % change from 2012 to 2037
0-15	19,132	17,706	- 1,426	-7.5%
16-29	15,370	13,430	- 1,940	-12.6%
30-49	28,886	22,349	- 6,537	-22.6%
50-64	25,386	20,227	- 5,159	-20.3%
65-74	**13,864**	**18,403**	**+ 4,539**	**32.7%**
75 and over	**11,072**	**21,610**	**+ 10,538**	**95.2%**
Scottish Borders Total	113,710	113,725	+ 15	0.0%

Source: National Records for Scotland 2012-based population projection

Figure 4: Projected population of Scottish Borders (2012-based) for 2012 and 2037, by broad age group



Source: National Records for Scotland 2012-based population projections

Inequalities

Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep seated and have proved difficult to change. Such inequalities are due to a complex mix of social, economic, cultural and political reasons, with unequal provision of healthcare responsible for only a proportion.

Scottish Index of Multiple Deprivation (SIMD) is a nationally used model that measures multiple domains of deprivation including income, employment, health, education, housing, crime and geographic access. The limitations of the SIMD are acknowledged in a rural area where deprivation can be hidden more easily. Because data is averaged for an area, SIMD can hide what is happening in a rural community.

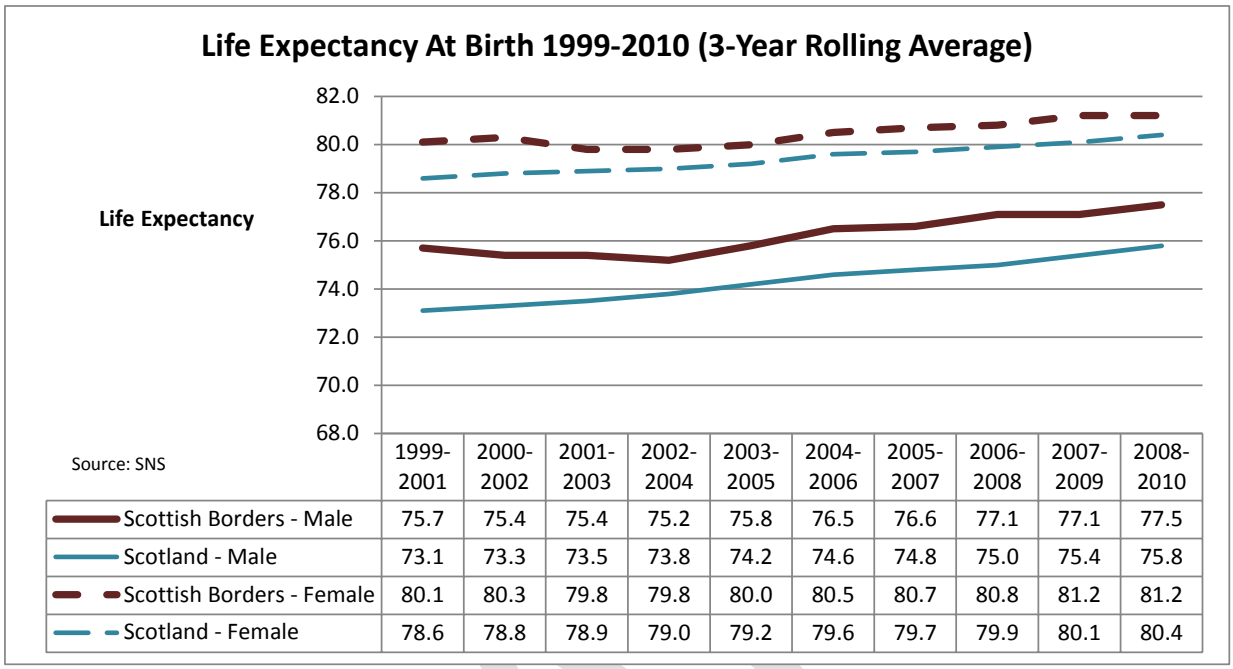
The latest SIMD analysis (2012); shows that the more deprived areas in Scottish Borders are still as deprived as they were in 2009, relative to the rest of Scotland. Furthermore, as other regions in Scotland succeed in decreasing inequality in their more deprived localities (this effect is particularly marked in Glasgow City), this has a displacement effect that can make localities in Scottish Borders appear relatively more deprived than before. . In 2012, Scottish Borders had 5 (or 0.5%) of Scotland's "most-deprived 15%" data zones, compared with 5 (0.5%) in 2009, 3 (0.3%) in 2006 and 2 (0.2%) in 2004. This concept of relative deprivation adds impetus for Scottish Borders to tackle deprivation and reduce inequalities with at least the same level of commitment as is being deployed in other regions.

The most deprived data zone in Scottish Borders is still the Central Burnfoot area in, Hawick. The other 4 "15% most deprived in Scotland" data zones in Scottish Borders are also in Burnfoot (South and West), Hawick and in Langlee (Langlee Drive and Kenilworth Avenue), Galashiels.

Life Expectancy and Healthy Life Expectancy

Life expectancy has increased greatly over the last 100 years. In general the life expectancy at birth for women is greater that for men. In the Scottish Borders both men and women have a higher life expectancy at birth compared to Scotland. Over time the life expectancy for men has increased at a greater rate than that for women. The graph below shows the 3-year rolling average of life expectancy at birth between 1999 and 2010; comparing Scottish Borders to Scotland.

Figure 5



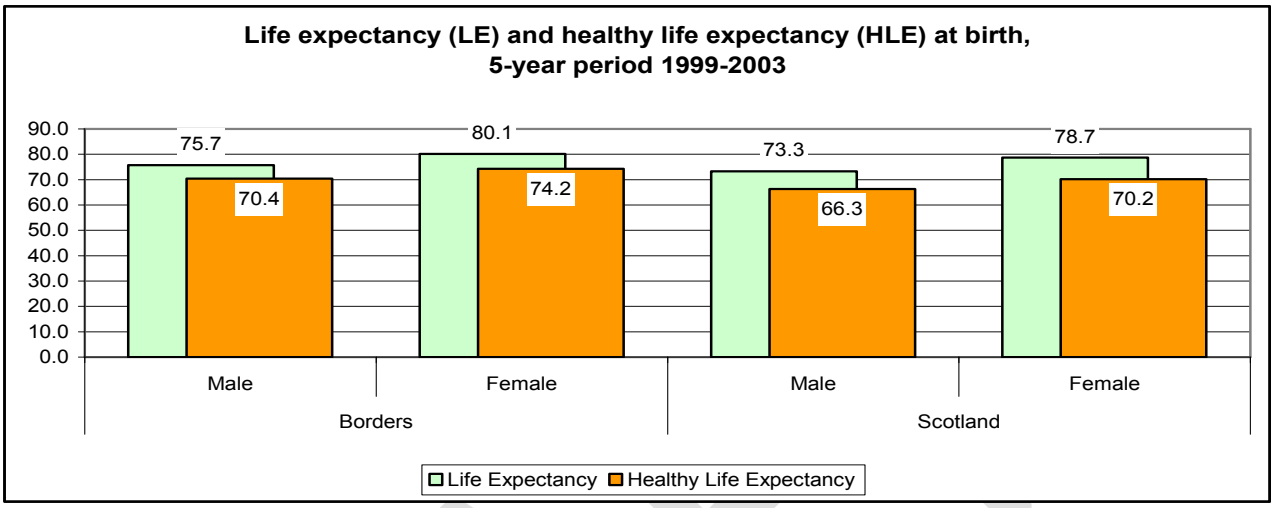
Source: SNS

	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Scottish Borders - Male	75.7	75.4	75.4	75.2	75.8	76.5	76.6	77.1	77.1	77.5
Scotland - Male	73.1	73.3	73.5	73.8	74.2	74.6	74.8	75.0	75.4	75.8
Scottish Borders - Female	80.1	80.3	79.8	79.8	80.0	80.5	80.7	80.8	81.2	81.2
Scotland - Female	78.6	78.8	78.9	79.0	79.2	79.6	79.7	79.9	80.1	80.4

Life expectancy within the Scottish Borders area differs, with people living in the most deprived neighbourhoods, can on average, expect to die x years earlier than people living in the wealthier neighbourhoods and spend more of their lives with ill health. The partnership alone cannot fully address the inequalities issues, but it can look at how effectively it can contribute to better outcomes for all its citizens.

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. The graph (Figure 6) below compared life expectancy to healthy life expectancy for the Scottish Borders and Scotland based on data from 1999 to 2003. In the Scottish Borders both men and women are expect to have higher life and healthy life expectancy compared to Scotland.

Figure 6



Life expectancy and healthy life expectancy is important for planning health and social care services. As life expectancy has increased, Government have responded to the challenge of the ageing population by increasing the age at which people qualify for the state pension to 68 in future years. This has been done to maintain the ratio of working-age adults to pensioners. But people can only work if they remain in good health, hence the importance of healthy life expectancy. As life expectancy rises it is important that the gap between it and healthy life expectancy does not widen.

Premature Mortality

Premature mortality is another important indicator of the overall health of the population, and is influenced by lifestyle factors. Scotland has the highest rates of premature mortality in the UK, as well as significant inequalities in premature mortality.

Include a chart on major causes of premature death (before age 75) for Scottish Borders over x years?

Plus longer trend graph by – locality?

Cancer graph?

Locally, (Analysis to be added.)

Is this how we want our key findings to be presented?

Key Findings:

- Proportion of pensioners aged 65 and over is well above average (20.9% in Scottish Borders compared with 16.8% in Scotland)
- Dependency ratio (people aged under 15 or aged 65 and older) higher in the Scottish Borders compared to Scotland
- More people aged over 65 in single person households compared to Scotland
- Sparsely populated region with an uneven distribution of the population
- Pockets of deprivation
- Overall population will remain unchanged over the next 25 year, however the relative number of older people are expected to increase significantly, 65-74 increase by one third whilst numbers aged 75 and over may double
- Life expectancy and healthy life expectancy higher compared to Scotland

Implications for Partnership

What are we going to do about it

CURRENT USE OF HEALTH AND CARE SERVICES

This section of the JSNA describes the current pattern of health and social care provision (have we identified all the measures of current provision?)

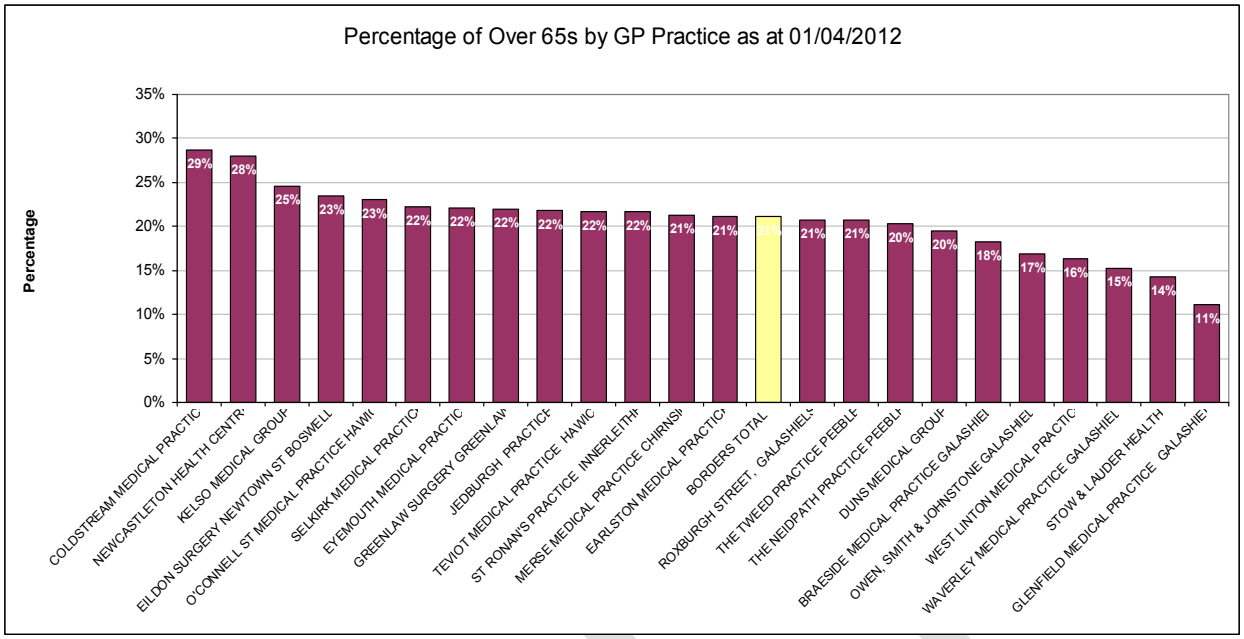
GP Services

Primary care, and in particular care delivered by general practice has been a cornerstone of the NHS since its inception. GPs and their practices will play an important part in influencing and shaping the priorities for the Partnership. Over the next few years, GPs will be faced with new challenges in terms of demand, capacity and access from an aging population.

The recent 'Assessment of the Needs of Older People in the Scottish Borders 2012', commented that with the exception of babies and pre-school children, the older the person, the more like they are to visit their GP on a regular basis. The over 75s consult their GP an average of 5 times and a practice nurse 3 times during the year (compared to 3 times and once respectively for all ages).

The percentage of over 65s registered with individual GP practices varies significantly across the region, ranging from 11% in one of the Galashiels practices to 29% in Coldstream. The Older People Needs Assessment, goes on to say that it is likely that the projected increase in the number of older people will have a similarly varied impact on primary and community services and their capacity to respond accordingly, particularly where these services are delivered by the only practice present in smaller town.

Figure 7: percentage of over 65s by GP practices in the Scottish Borders, April 2012 (to be updated)

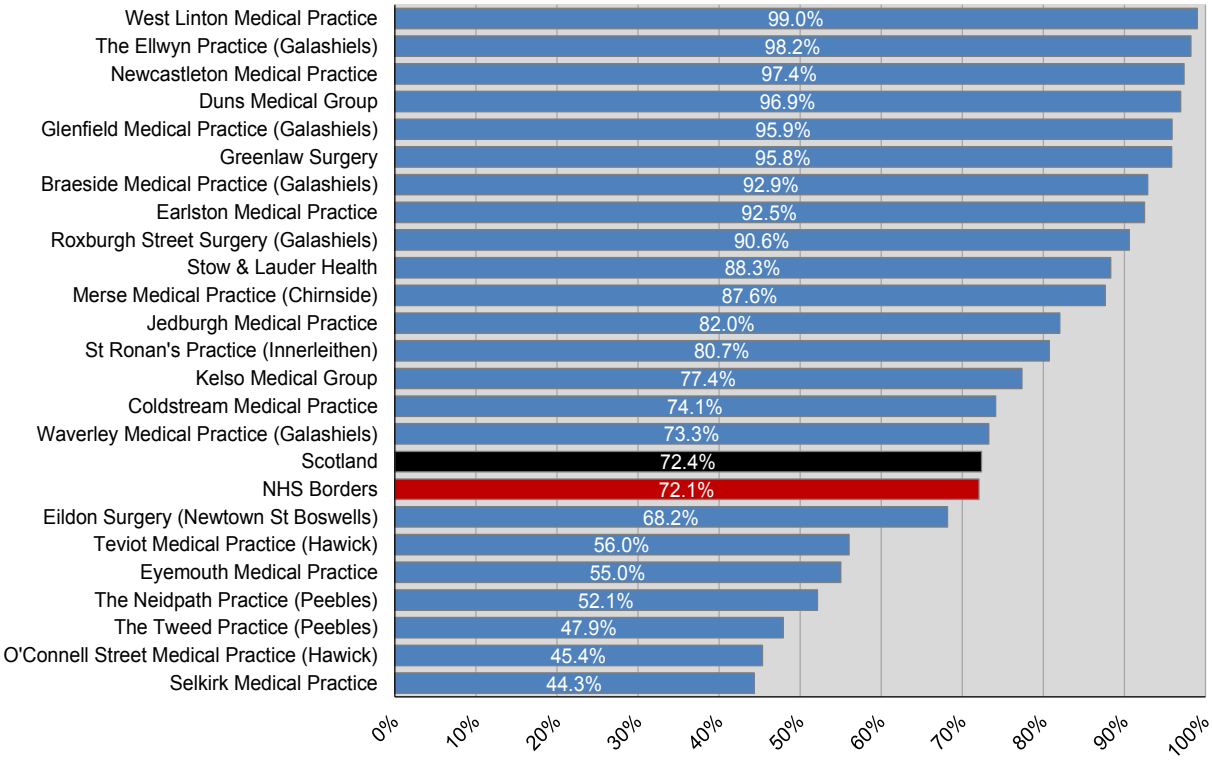


Do we want to add in how our out of hours service is delivered?

The recent national Patient Experience Survey demonstrates variation across the Scottish Borders GP practices in terms of satisfaction with arrangements to see a GP. We need to understand this variation and support General Practices in dealing with significant demand, capacity and access challenges. As mentioned above, the rural nature of the Scottish Borders presents a particular challenge.

Figure 8 % Satisfaction with arrangements to see a GP

(Source: Patient Experience Survey 13/14)



Primary care is not simply about general practice, and includes community pharmacy, dentistry and optometry independent practitioners. (Note: to be developed further)

Unscheduled Care

Unscheduled care is a term used to describe any unplanned treatment, help or advice to people in an emergency or urgent situation. It can occur at any time and crosses the traditional boundaries between general practice, community and social care services and hospital services.

The Scottish Government has set partnerships targets for unscheduled care, including A&E attendances and unplanned hospital admissions. With an aging population in the Scottish Borders, pressure will continue to increase on acute hospital services and residential care placements unless we look to changing the way we deliver services.

Emergency Hospital Care

Accident & Emergency (A&E) and other Emergency Departments are located at five hospitals within NHS Borders. Over 90% of A&E/Emergency Department attendances within NHS Borders are at Borders General Hospital, which has a full

A&E Department open 24 hours a day, 7 days a week. Patients may also attend Minor Injuries Services in four community hospitals:

- Knoll Community Hospital, Duns (24 hours a day)
- Hawick Community Hospital (24 hours a day)
- Hay Lodge Hospital, Peebles (24 hours a day)
- Kelso Community Hospital (Minor Injuries Service available Out of Hours)

The number of attendances across all A&E and Minor Injuries services fluctuates from month to month, tending to dip in winter and peak between March and October each year. In addition to seasonal variations in pressures on A&E, an overall upward trend is apparent in the average monthly admissions from year to year:-

In **2008**, the average **monthly number of attendances** at A&E / other Emergency Departments in NHS Borders was **1,887**. By 2014, the monthly average had risen to **2,230**.

Over the past ten years, overall rates of emergency hospital inpatient admissions across Scotland have increased gradually. Meanwhile, instances of individual patients having two or more emergency hospital stays within the same year are also increasing.

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

Rates of emergency admission and multiple emergency admission vary by age, as does the situation for Scottish Borders relative to Scotland as a whole. For example:-

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

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

- Similarly, by far the highest rates of multiple emergency admissions occur in people aged over 75, and it is in this age group that increases over time are the most pronounced. In 2004/05, 634 Scottish Borders residents aged 75

and over had two or more emergency hospital stays within one year (a rate of 65 per 1,000 population). By 2013/14 this had increased to 937 people (a rate of 83 per 1,000 population).

- Emergency and multiple emergency admission rates amongst Scottish Borders residents aged 50-64 and 65-74 have tended to be a little lower than average rates for these age groups for Scotland.

- In contrast, rates for younger adults (15 to 49) and the oldest members of the Scottish Borders population (75+) have tended to be higher than average rates for the same age groups across Scotland.

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

Figure 9: Scottish Borders residents admitted to hospital as an emergency; trends in rates per 1,000 population by age group

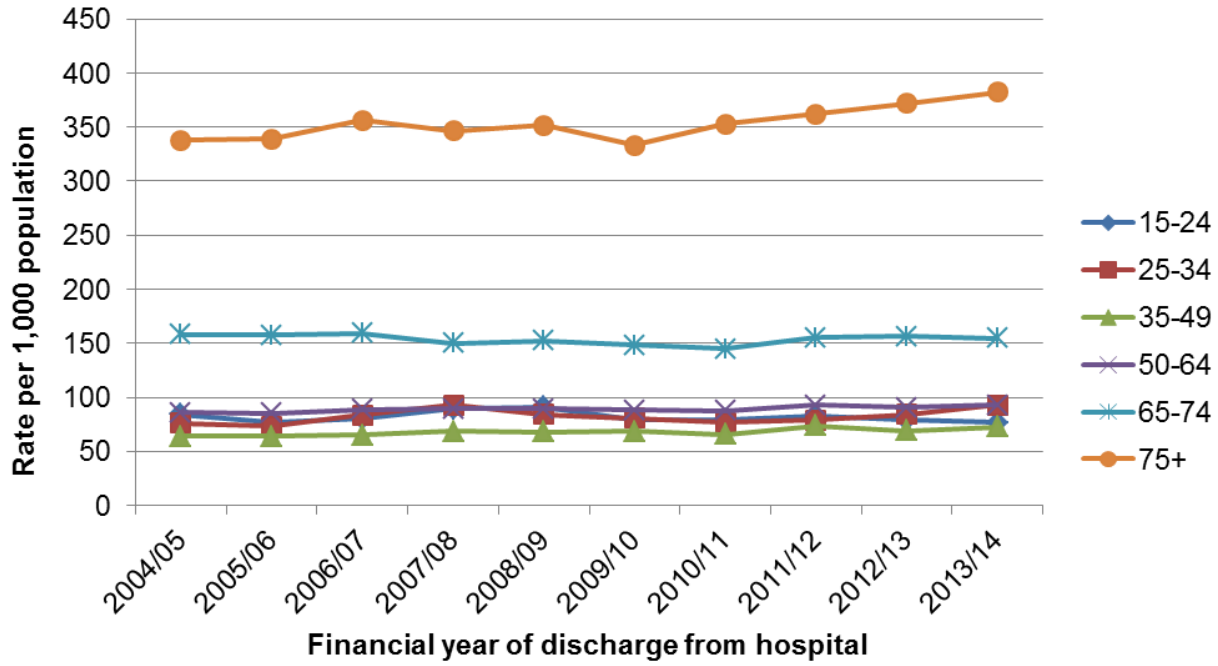
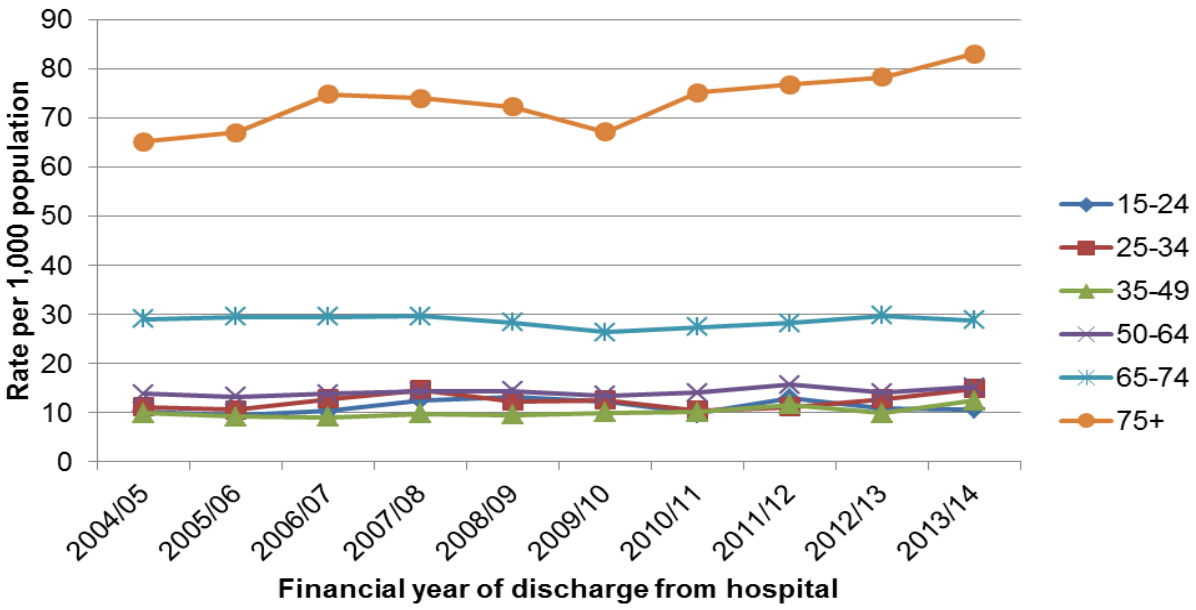


Figure 10: Scottish Borders residents with two or more emergency admissions to hospital within the same year; trends in rates per 1,000 population by age group



Reducing the level of emergency in-patient hospital care is a key target for the Partnership……

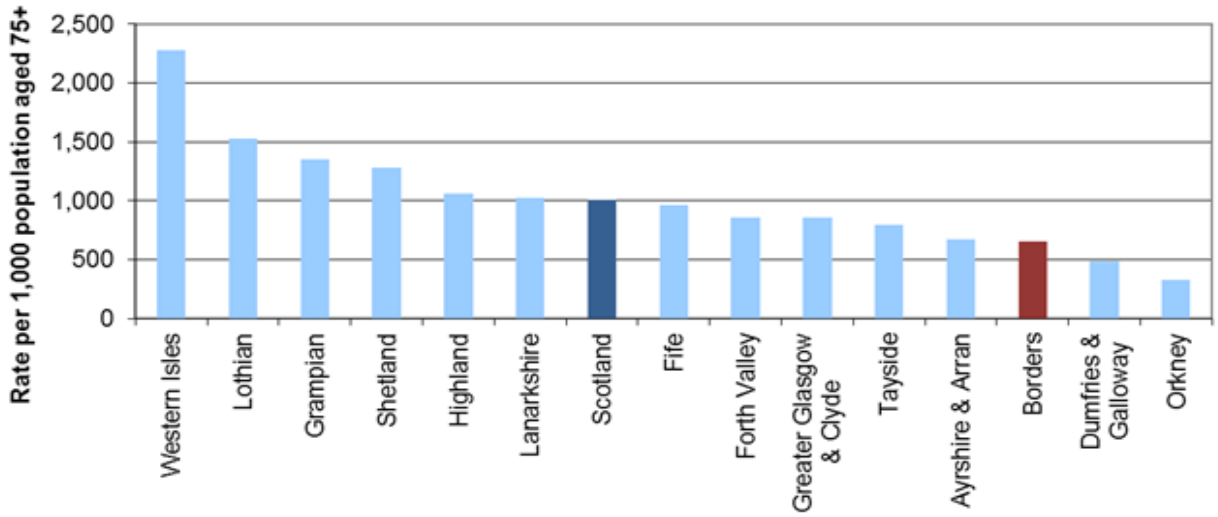
Reducing unnecessary admissions: Anticipatory Care

As stated in the 'Assessment of the Needs of Older People', not all hospital admissions will be avoidable, some may be prevented through anticipatory care, and the provision of alternatives to admission. (what more can we say here?).Anticipatory care planning helps people to make positive choices around the management of their condition, and promotes effective person-centred arrangements for the communication, planning and co-ordination of care, which is a cornerstone of the new national outcomes for health and wellbeing

Delayed Discharges from hospital

A delayed discharge is experienced by a hospital inpatient that is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons. Over the period October 2013-September 2014, 85% of bed-days occupied by adults in NHS Borders hospitals due to delayed discharge were for patients aged 75 and over, higher than the 73% average for Scotland. However, we already know that Borders has a higher proportion of older people than the Scottish average. Furthermore, for patients whose discharge from an NHS Borders hospital is delayed, the rate per 1,000 population of bed-days occupied patients aged 75+ is one of the lowest amongst the NHS Boards in Scotland, as shown in the graph below

Figure 11: Delayed discharges from inpatient care, patients aged 75+: Bed days occupied per 1,000 population, October 2013-September 2014, by NHS Board



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

Note: More can be added here later if desired, for example to give a breakdown of reasons for delay in discharging patients. It can be compiled for a selection of delayed discharge patients by combining monthly census figures into annual totals.

Note: what other indicators 'supply' of health care do we want to include: reference with Colin F's paper

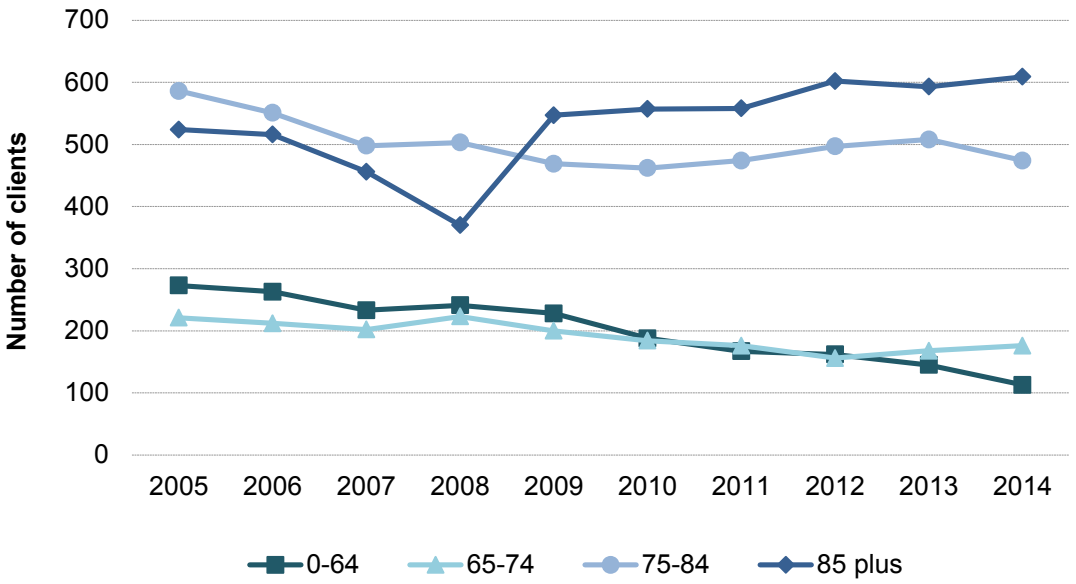
Following section needs an introduction – review with BH re what other indicators to include

Home care

Home care is care provided in an individual's own home to enable them to maintain independence. It involves regular visits from home care workers to assist with daily living and can include support with washing, dressing, eating and taking medications,

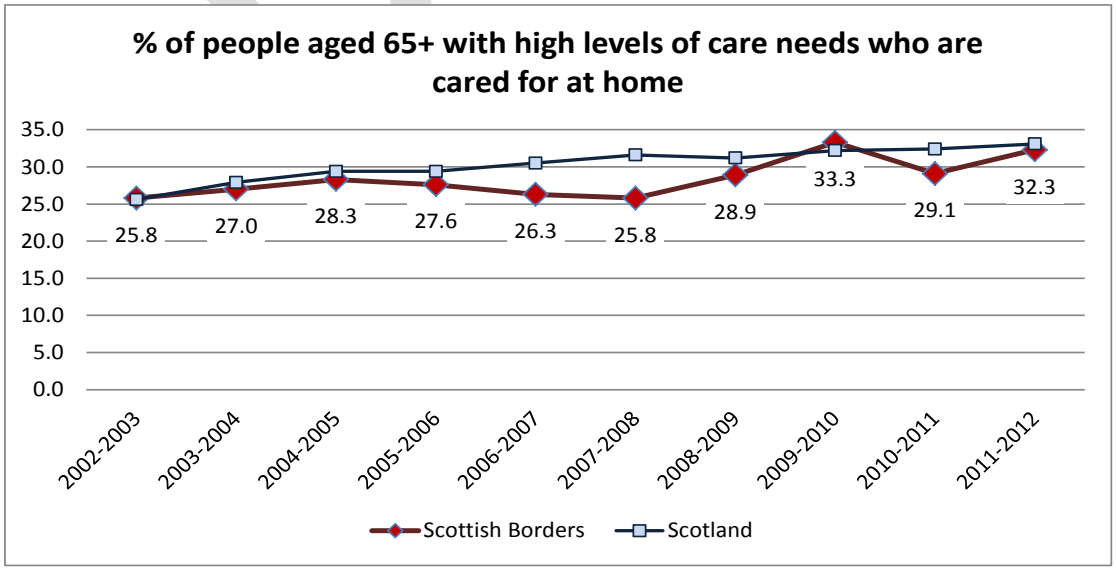
Figure 12 below shows the number of home care clients, by age group.

Source: SG H&SC Data November 2014



Balance of care represents the number of people aged 65+ receiving 10 hours or more care at home (defined as intensive) as a percentage of this number plus all those in residential or nursing placements. The number has increased and risen fairly steadily, showing that people receiving care at home have increasing levels of need.

Figure 13



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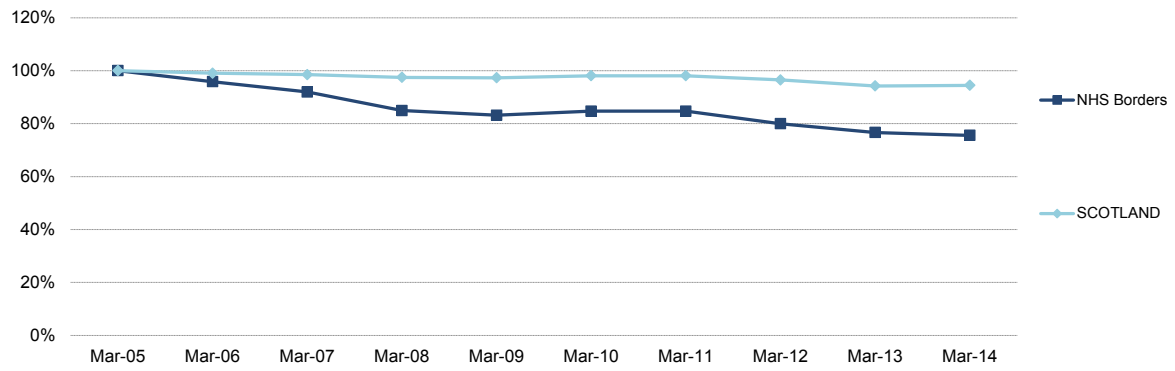
What additional analyses do we want to put in this section about utilisation of care services?

Although the overall trend in numbers of residents in long stay care home is falling, (see Figure 14 blow), the residents have increasingly complex and high level of care and support needs. Given the age, frailty and multiple morbidities of care home residents they can be views as one of the most complex and vulnerable group of people in our communities which have significant implications for the workforce providing their care and support.

Figure 14

Trend in long-stay care home residents (percentage change on 2005), March 2005 to 2014



Living and Dying Well-

The **percentage of last 6 months of life spent at home or in a community setting.**, is a national Quality Outcome Measure focuses on measuring the impact of "Living and Dying Well" and in particular on its objective to "produce achievable and measurable changes which will ensure quality improvement and enhance patient and carer experience".

Ideally, this measure would relate directly to the preferred place of care at the end of life. However, this can change over time and is, therefore, difficult to track. National data is not currently available at this level of detail so it is not possible to focus the measure directly on preferred place of death.

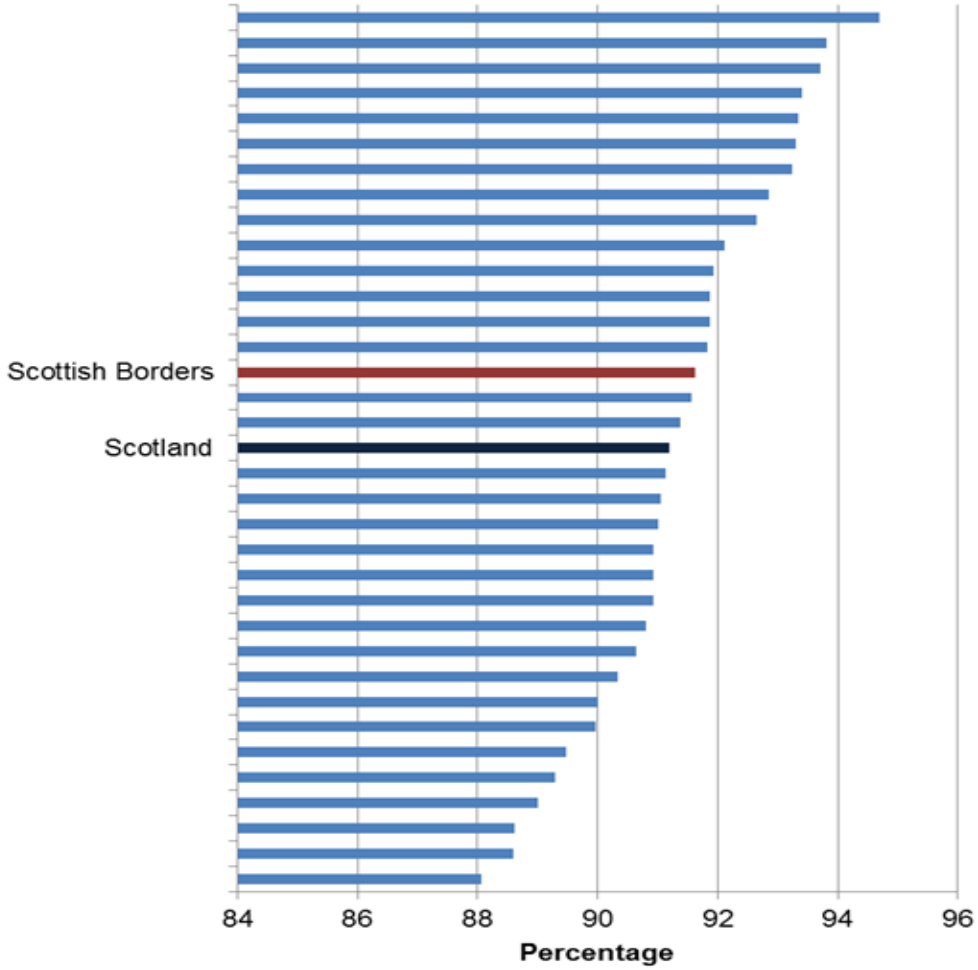
In the meantime, the proportion of time spent at home or in a community setting towards the end of life provides a high level indication of progress in implementation of the national action plan. These data can be inferred by measuring the amount of time spent in an acute setting during the last months of life (using hospital

admissions data) and from this estimating the time spent at home or in a community setting.

It is envisaged that an increase in this measure will reflect both quality and value through more effective, person centred and efficient end of life care with people being better able to be cared for at home or closer to home with a planned approach to end of life care resulting in less time in an acute setting.

The figure below shows that we perform well in supporting appropriate end of life care outside hospitals compared to other areas. (Reference the draft Palliative Care Needs Assessment)

Figure 15 The percentage of last 6 months of life spent at home or in a community setting, by Community Health Partnership, financial year 2012/13



Respite Care

Respite care is a service intended to benefit a carer and the person he or she cares for by providing a short break from caring tasks. (query this data and interpretation?)

Table 2 Provision of respite weeks for people aged 65+, 2007/08 to 2013/14

Type of Provision	2007/08[0]	2008/09[0]	2008/09[1]	2009/10[1]	2009/10[2]	2010/11[2]	2010/11[3]	2011/12[3]	2012/13[3]	2012/13[4]	2013/14[4]
Overnight Respite	814	990	823	796	796	907	907	1,097	1,154	1,154	1,131
Daytime Respite	21	25	25	18	18	50	50	68	15	15	15
Total	**835**	**1,015**	**848**	**814**	**814**	**957**	**957**	**1,165**	**1,169**	**1,169**	**1,145**

Carers

Many older people are making a valuable contribution to the economy by working longer, or as carers or volunteers. The contribution that carers make to the economy is estimated to be worth twice that of public spending on care (check reference)

Review against carer strategy

Costs of Health and Social Care in Scottish Borders

For the financial year 2012/13, the total expenditure on Health and Social Care (for children and adults) within Scottish Border s was just over £260 million. The majority of that expenditure (£239.4 million) has been analysed to show how the total breaks down by age as well as type of service.

- 72% (£171.3 million) was spent on NHS services and 28% (£68.1 million) was spent on Social Care. The equivalent proportions for Scotland were 74% and 26%, respectively.

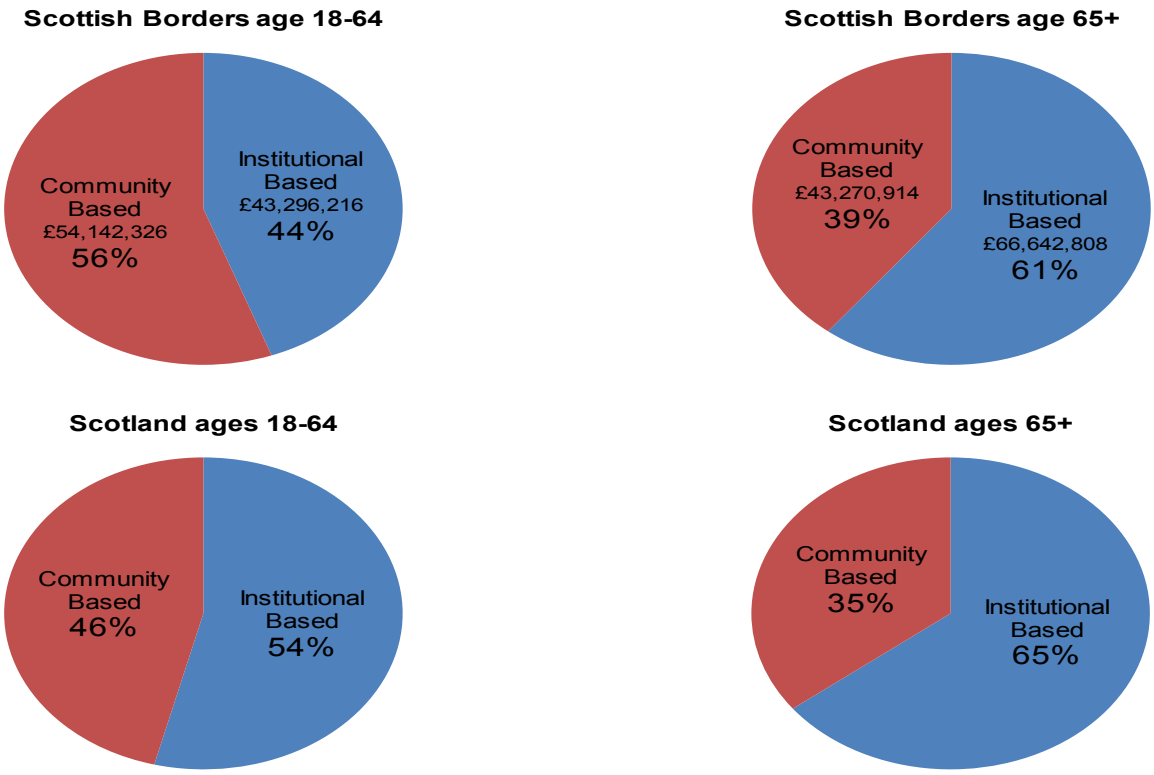
- 46% (£109.9 million) of the total expenditure was in relation to people aged 65 and over, higher than the 40% for Scotland overall. We know, however, that Scottish Borders has an older population profile than the national average.

- Across all age groups combined (including children) the spend in Scottish Borders split almost exactly 50:50 into Community-based care versus Institutional care. The overall split for Scotland was 56:44.

- The shares of overall spend that are accounted for by Institutional care increase with increasing age. For example, in Scottish Borders 44% of the

costs for 18-64 year olds were in relation to Institutional care whereas this rose to 62% for people aged 75 and over.

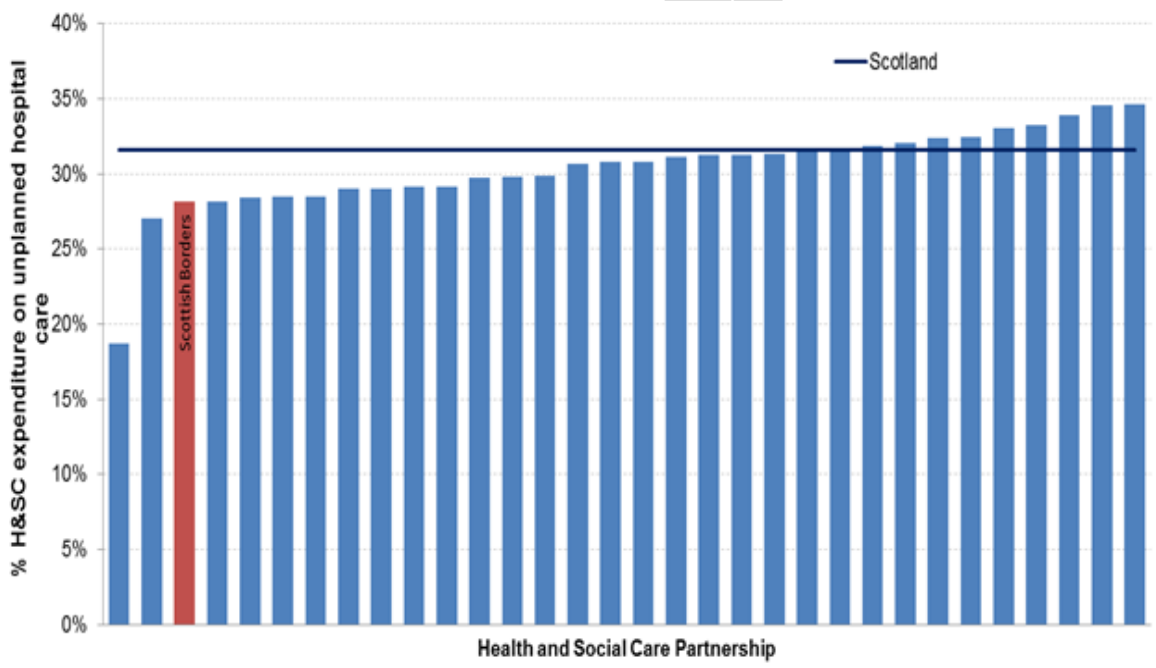
- The pie charts below illustrate the variations by age, and between Scottish Borders and Scotland, in how expenditure was split between Community-based care and Institutional care.



In Scottish Borders, the percentage of health and social care expenditure on people aged 65 and over that related to unplanned hospital inpatient care is one of the lowest in Scotland, as shown in the figure below. This might appear surprising as Scottish Borders has higher rates of emergency admissions to hospital than the national averages. However, it also has one of the highest proportions of overall spend on

community-based care (as opposed to institutional based care) so this Partnership's ranking on the graph below will be influenced by overall balance of care within Scottish Borders

Figure xx: **Percentage of all health and social care expenditure for people aged 65+ that was due to unplanned inpatient hospital care, financial year 2012/13**



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

Suggestion: we could look at the overall proportion of NHS spending that goes on unplanned hospital care (rather than overall proportion of total H&SC spend). This doesn't appear to be available from the standard outputs currently but I expect it could be asked for (or as a minimum I could derive the figures for Borders compared with Scotland, without the full ranking).

LONG TERM CONDITIONS AND MULTI-MORBIDITY

This section of JSNA provides information on long term conditions. These are defined as health problems that require ongoing management over a period of years or decades. These include dementia, cancer, diabetes, mental health disorders, and ongoing impairment such as blindness.

Long term conditions are conditions that cannot be cured, but can be managed and controlled through self-care, medication and other therapies. We know that the number of older people living with long term conditions, such as diabetes, CHD, stroke, cancer is projected to increase and there are clear links between long term conditions, deprivation and lifestyle factors. It is widely acknowledged that the appropriate management of long term conditions is one of the biggest challenges facing health and social care systems

The joint strategy on 'Living Well with Long Term Conditions' (2008) states that ' our challenge is to make sure that people with a long term condition are supported to meet their needs by fostering good management of the condition and providing high quality specialist services where they are needs. As important is a preventative approach to tackle the factors that lead to LTC'

Long term conditions are therefore a significant area of focus in this document. Currently we know that 60% of all deaths are attributable to long term conditions and they account for 80% of all GP consultations in Scotland.(source:) Furthermore people with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionally longer and account for over 60% of hospital bed days used. (source:)) While within the social care sector most peoples who need long term residential care have complex needs usually arising from their multiple long term conditions. Patients with multi-morbidity, (people who suffer two or more long term conditions at the same time), are a significant challenge to health and social care services. We examine some Scotland wide data at the end of this section.

Some or the main long term conditions and their supporting strategies are discussed below

Cancer

Over the period 2008-2012, an annual average of 737 Scottish Borders residents were newly diagnosed with a malignant cancer (excluding non-melanoma skin cancer). This is an 18% increase from the average of 624 newly diagnosed cases per year over the period 1998-2002. Whilst the crude cancer incidence rate in Scottish Borders is higher than the crude rate for Scotland (649 per 100,000 in 2008-2012 compared with 577 per 100,000, respectively), this apparently higher rate overall is due to Borders having an older overall population profile compared to Scotland. Cancer incidence rates increase markedly with increasing age. Once the age profile of the Borders population is taken into account, overall age-standardised rates of cancer incidence in Scottish Borders are generally lower than that for Scotland.

Over the ten years from 2003 to 2012, age-standardised incidence rates of cancer in Scotland have fallen by 5% in males but increased by 8% in females. New cancer cases are expected to increase by approximately 8% every five years up to 2020, reflecting projected increases in the number of older people. Two in five people in Scotland will be diagnosed with some form of cancer during their lifetime, although this includes cancers that will have no detrimental impact on life expectancy.

Although expectations are that overall cancer incidence will continue to increase, overall mortality rates from cancer have fallen across Scotland. Although mortality rates have been falling, the numbers of deaths from cancer have not similarly fallen, largely reflecting an increase in the size of older age groups within the population. An average of approximately 350 deaths due to cancer is recorded amongst Scottish Borders residents annually. Although the crude cancer mortality rate for Borders is higher than for Scotland overall (311 per 100,000 compared with 293 per 100,000 over the period 2009-2013), once the relatively older age profile for Borders is taken into account, this difference reverses. The overall age-standardised (to the European Standard Population, 2013) cancer mortality rate for Borders residents was 295 per 100,000 in 2009-2013, compared with 339 per 100,000 for Scotland.

Increasing incidence of cancer and relatively stable numbers of cancer deaths/falling mortality rates combine to indicate increases in the numbers of people completely cured of their cancer and increases in the number of people living with cancer (that is, cancer prevalence). As part of the Quality and Outcomes Framework (QOF), GP practices across the UK keep cumulative registers of all of their patients that they know to have been diagnosed with cancer after 1st April 2003. At March 2014, the number of patients on the cancer registers of Scottish Borders GP practices was 3,282 (compared with a cumulative total of 3,057 at March 2013).

Significant patterns exist when examining incidence and mortality rates by deprivation in Scotland. For all cancers combined, the most deprived areas (those in the bottom quintile for multiple deprivation) have incidence rates that are 34% higher than the least deprived areas. Mortality rates are 71% higher in the most deprived areas compared with the least deprived.

Sources of cancer information:-
www.isdscotland.org/Health-Topics/Cancer/Cancer-Statistics/
www.isdscotland.org/qof

Dementia

The key aim of the Borders Dementia Strategy (2009 -2014) is to ensure that services providing care and support to people with dementia are appropriate to need and demand. It is recognised that services need to be varied, flexible, local and delivered by appropriately skilled and supported staff to ensure quality of life for people with dementia and their Carer.

	2006	2011	2016	2021
Borders predicted number of individuals with dementia	1538	1764	2044	2419
Borders predicted % growth from 2006		15%	33%	57%
Scotland % growth		9%	21%	38%

The Scottish Borders is experiencing a 3% increase each year in the number of people presenting with dementia. The prevalence rates for 2009 were 1,738 with approximately 57 people considered to have younger onset dementia. Delete? This is estimated to increase to 5% yearly by 2015. This growth has the potential to overwhelm social care and health services. For the Scottish Borders, the problem is particularly acute as there is estimated to be a significantly higher growth rate than the Scottish average

(Speak to Julie about Dementia data)

Diabetes

At the end of 2013, 6,031 people in Scottish Borders (5.3% of the population) were registered as having diabetes. 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).

The breakdown of diabetes type was as follows:-

- 5,349 (88.7%) had type 2 diabetes
- 633 (10.5%) had type 1 diabetes
- 49 (0.8%) had another type of diabetes

The prevalence of diabetes across Scotland is increasing year on year for several reasons, including:

- Diabetes is more prevalent in older people so the increasing number of older people each year increases the prevalence;
- The increasing levels of type 2 diabetes are associated with rising levels of overweight and obesity;
- Improved detection and management of diabetes has resulted in increased survival.

The chart below shows the rise in overall prevalence (all types, all ages) in Scottish Borders and Scotland.

Insert chart

Source: Scottish Diabetes Survey: www.diabetesinscotland.org.uk/Publications.aspx

Learning Disability

Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. A 'Review of Learning Disability Service Provision' was published in September 2013, which recommended xxx……. 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 mainstream Health and Social Care services provided by the NHS and Scottish Borders Council, respectively.

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. Figures from the 2013 eSAY ("electronic Same As You) report, published by the Scottish Consortium for Learning Disabilities, indicate that 601 adults with Learning Disabilities were known to Scottish Borders in that year. The age and gender profile of this group is shown in the table below.

Table XXX: Numbers of adults with Learning Disabilities known to Scottish Borders services 2013, by age and gender*

Age group	Number of Males	Number of Females	Both genders combined	% within age group
16-17 and not in full-time education	7	0	7	1%
18-20	27	22	49	8%
21-34	106	70	176	29%
35-44	57	45	102	17%
45-54	66	39	105	18%
55-64	48	39	87	15%
65 and over	32	42	74	12%
Total	343	257	600	100%

*Age/gender not shown for one individual

Source: Learning Disability Statistics Scotland 2013 (the "eSAY" report) http://www.scld.org.uk/scld-projects/esay/publications-and-resources/statistics-releases

Mental Health

NOTE regarding Mental Health stats and facts:

Mental Health Needs Assessment being conducted within Scottish Borders as at late 2014/early 2015. We anticipate stats collated for that Needs Assessment to become available to us for reference here at end of February 2015. Therefore, this section currently has only limited information within it, as to collate more would duplicate effort and/or increase the likelihood of apparently contradictory figures being presented.

Prescriptions for anxiety, depression and/or psychoses

In the year ending March 2013, an estimated 18,795 people in Scottish Borders (16.5% of the population) were prescribed drugs for anxiety, depression and/or psychoses. These figures will include patients with short-term and long-term problems. (Source: ScotPHO Health and Wellbeing Profiles 2014, accessed 5th January 2015, http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool).

Self-reported Long-Term Mental Health problems

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

GP practice Mental Health registers

At March 2014, the 23 GP practices in Scottish Borders recorded a total of 881 patients with schizophrenia, bipolar affective disorder or other psychoses. This equates to 0.76% of all patients registered to a GP practice in Scottish Borders at the time. (Source: Quality & Outcomes Framework statistics 2013/14; www.isdscotland.org/qof).

Physical Disability

The Living Well with a Disability' Joint Commissioning Strategy was written in March 2013, with the key aim of '*to work in partnership to provide quality services that support the health and wellbeing of people with a physical disability and which enables them to live will with their disability'*.

At the time of the 2011 Scotland Census, 6,995 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Physical Disability (see Table xx below) . This equates to 6.1% of all Scottish Borders residents at that time.

The age and gender profile of these 6,995 residents is shown in the table below. Overall, of this group:-

- 1,286 (55%) were aged 65 and over.
- 1,868 (27%) were aged 50-64.
- 1,127 (16%) were aged 16-49.
- 143 (2%) were aged under 16.

The prevalence of physical disabilities in the Scottish Borders population rises with increasing age. Just over 1% of young adults aged 16-24 are affected, compared with 10.8% of people aged 65-74 and 31.7% of people aged 85 and over.

Table XXX: Numbers of Scottish Borders residents identified through the 2011 Scotland Census as having a physical disability, by gender and age group.

Age group	Number of Males	Number of Females	Both genders combined	Number in this age group as a % of all ages	% of this age group who have a physical disability
0 to 15	87	56	143	2%	0.7%
16 to 24	62	47	109	2%	1.1%
25 to 34	102	69	171	2%	1.7%
35 to 49	404	443	847	12%	3.4%
50 to 64	948	920	1,868	27%	7.3%
65 to 74	673	729	1,402	20%	10.8%
75 to 84	629	886	1,515	22%	19.2%
85 and over	277	663	940	13%	31.7%
Scottish Borders Total	3,182	3,813	6,995	100%	6.1%

Source: Scotland Census 2011

These figures from the 2011 Scotland Census give us a more complete picture of potential need for services for people with physical disabilities than information on service use alone. The "Living Well with a Disability strategy " noted that) noted that in 2012 (before 2011 Scotland Census figures were available):-

- 5,700 people in Scottish Borders received Disability Living Allowance.
- 1,385 people aged under 65 and with a physical disability received a Social Work service (whereas the Scotland Census 2011 identified 3,138 Scottish Borders residents in this age group with a physical disability)
-

Sensory Impairment

The term 'sensory impairment' encompasses visual impairment (including people who are blind and partially sighted), hearing impairment (including those who are profoundly Deaf, deafened and hard of hearing) and dual sensory impairment (Deaf blindness). Sensory impairments may be congenital (present from birth) or acquired at any age. Most sensory impairments develop gradually and are often secondary to other disabilities.

Hearing and/or sight loss can significantly impact on health and/or social care needs. For example, amongst older people, sensory impairment is a major contributory factor in falls and subsequent admission to hospital, and from there to a care home. Meanwhile, people with a learning disability are more likely than the general population to have a hearing loss, and ten times more likely to have some sight loss. This in turn can impact on how they are able to interact with other people. Hidden and/or untreated sensory loss leads to a withdrawal from social interaction and can result in consequent failure to respond appropriately to a person's needs

Hearing Loss

Approximately one in six adults is affected by some degree of hearing loss. "See Hear", the Scottish Government's strategic framework for meeting the needs of people with a sensory impairment in Scotland (April 2014) acknowledged that this translates as around 850,000 people across the country.

The prevalence of hearing loss increases with increasing age, and the numbers of people with hearing loss is expected to rise as the projected numbers of older people in the population rises. By applying age-specific estimates of the prevalence of hearing loss in the UK to the current population profile of Scottish Borders and projected changes to the profile in future, we have calculated the following estimates:

- Around 21,500 people aged 16 and over living in Scottish Borders in 2012 may have some extent of hearing loss, of whom:-
    - Between 350-400 individuals may be Deaf/with profound hearing loss.
    - A further 1,400 people may have a severe hearing loss
    - Around 8,500 people may have moderate hearing loss

- Amongst people with moderate, severe or profound hearing loss, the estimated age breakdown is as follows:-
    - Around 1,200 people aged 16-60 (about 2%, or one in fifty of the population in this age group)
    - Around 4,900 people aged 61-80 (about 19%, or one in five people in this age group)
    - Around 4,200 people aged 81 and over (about 74%, or three quarters of people in this age group)

- The total numbers of Scottish Borders residents affected by hearing loss could rise to approximately 25,000 by 2022 and 29,500 by 2032.

Sources: Prevalence rates from Shield (2006) applied to NRS 2012-based population projections for Scottish Borders

Many people may not notice that they are experiencing hearing loss until it becomes more pronounced, and/or they may consider it an inevitable part of growing older. This can partly explain why, for example, only around 8,500 Scottish Borders residents were identified through the 2011 Scotland census as having hearing loss, compared with the much higher estimates of likely prevalence, above.

Sight Loss

Significant sight loss is estimated to affect over 180,000 people in Scotland, equivalent to approximately one in 30 of the population. The majority are older people; it is estimated that one in five people over the age of 75 are living with sight loss, rising to one in two people aged over 90 (Success in Sight?, 2012). The "See Hear" strategic framework (Scottish Government 2014) notes that more than half of sight loss may be due to preventable or treatable causes, and over three quarters of people living with sight loss may have one or more other conditions for which they receive medical care.

As with hearing loss, the numbers of people with sight loss is expected to rise as the projected numbers of older people in the population rises. By applying age-specific estimates of the prevalence of sight loss in the UK to the current population profile of Scottish Borders and projected changes to the profile in future, we estimate that:

- Over 4,000 people aged 15 and over living in Scottish Borders in 2012 may have some degree of sight loss, of whom:-
    - Approximately 500 are blind or have severe sight loss.
    - A further 1,000 people may be living with moderate sight loss.
- Amongst people who are blind or have severe or moderate sight loss, the estimated age breakdown is as follows:-
    - Around 250 people aged 15-64
    - Around 300 people aged 65-74
    - Over 900 people aged 75 and over
- The total numbers of Scottish Borders residents aged 15 and over and affected by some extent of sight loss could rise to over 5,000 by 2022 and to around 6,500 by 2032.

Sources: Prevalence rates from Access Economics (2009) applied to NRS 2012-based population projections for Scottish Borders

The Strategy for Sensory Services in Scottish Borders 2012-2017 notes that at the end of August 2012, there were 298 people in the Scottish Borders registered as blind and 366 as partially sighted. Of these 664 people, 149 were known to also have a hearing loss. However, registering is voluntary and people do not have to be registered to seek/receive help. The estimated figures given in the box above illustrate the likely tendency of the "registered" figures to undercount the total numbers of people in the population who may be affected by sight loss.

Deaf Blindness/dual sensory loss

The term Deaf blind does not necessarily mean a person is totally deaf and totally blind; indeed many Deaf blind people have some residual sight and/or hearing. A person is regarded as Deaf blind if their combined sight and hearing loss causes difficulties with communication, access to information and mobility.

Deaf blind Scotland estimate that there are approximately 5,000 people in Scotland with significant hearing and sight loss, most of who are aged over 60 and having become dual sensory impaired as part of the ageing process. A significant cause of dual sensory loss in younger adults is Usher Syndrome, a genetic/inherited condition that affects hearing, vision and balance. http://www.deafblindscotland.org.uk/deafblindness/facts/

The Strategy for Sensory Services in Scottish Borders 2012-2017 notes that in 2012, Deaf blind Scotland (the association for deaf blind and dual sensory impaired adults) was aware of 26 dual sensory impaired adults living in Scottish Borders.

Diabetes

At the end of 2013, 6,031 people in Scottish Borders (5.3% of the population) were registered as having diabetes. 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).

The breakdown of diabetes type was as follows:-

- 5,349 (88.7%) had type 2 diabetes
- 633 (10.5%) had type 1 diabetes
- 49 (0.8%) had another type of diabetes

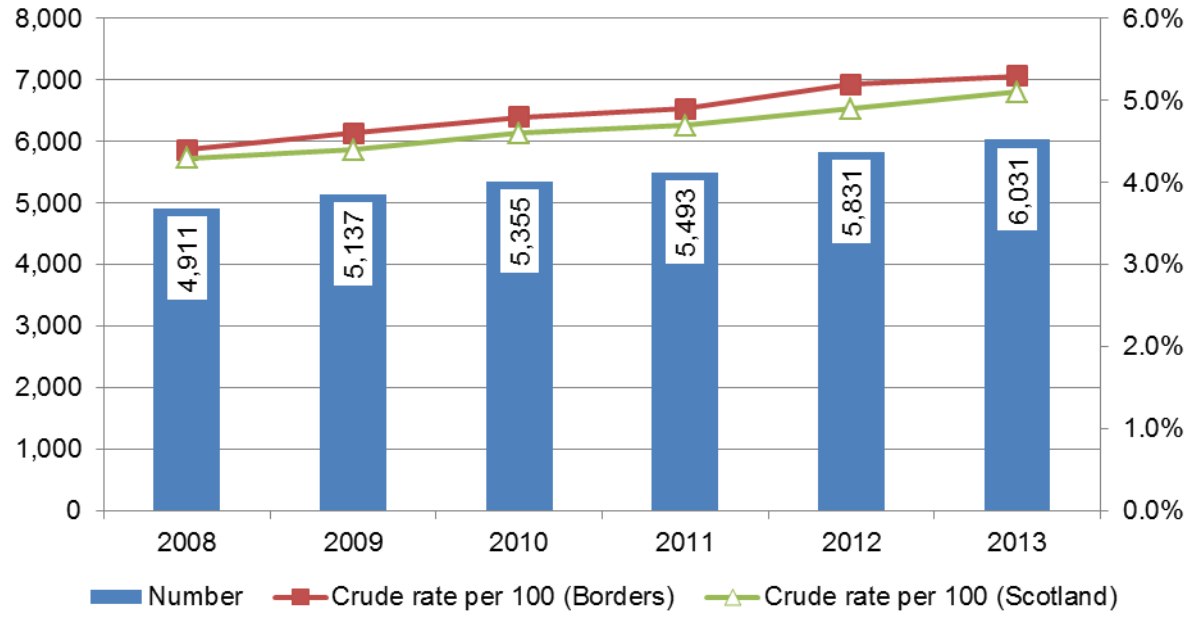
The prevalence of diabetes across Scotland is increasing year on year for several reasons, including:

- Diabetes is more prevalent in older people so the increasing number of older people each year increases the prevalence;
- The increasing levels of type 2 diabetes are associated with rising levels of overweight and obesity;

- Improved detection and management of diabetes has resulted in increased survival.

The chart below shows the rise in overall prevalence (all types, all ages) in Scottish Borders and Scotland.

Figure XXX: Crude prevalence of diabetes (all types) in the Scottish Borders and Scotland 2008-2013 per 100 population (all ages)



Source: Scottish Diabetes Survey.: www.diabetesinscotland.org.uk/Publications.aspx

Other Long Term Conditions

As part of the Quality and Outcomes Framework (QOF), GP practices across the UK are funded to keep registers of all of their patients that they know to have certain health conditions. The table below shows, across all 23 GP practices in Scottish Borders, the numbers of patients included on 12 of these QOF registers.

Table XXX: Numbers of patients on selected QOF registers of Scottish Borders GP practices

QOF register	Number at March 2014	Percentage of all practice patients at March 2014	Number at March 2013	Number at March 2012
Asthma	7,733	6.6	7,715	7,619
Atrial Fibrillation	2,324	2.0	2,202	2,177
CHD (Coronary Heart Disease)	5,774	5.0	5,798	5,811
CKD (Chronic Kidney Disease) (excluding people aged under 18)	4,206	3.6	4,235	4,310
COPD (Chronic Obstructive Pulmonary Disease)	2,621	2.2	2,579	2,551
Epilepsy (excluding people aged under 18)	798	0.7	799	798
Heart Failure	1,154	1.0	1,166	1,140
Hypertension	17,121	14.7	16,851	16,654
Hypothyroidism (under-active thyroid)	4,272	3.7	4,184	4,046
Peripheral Arterial Disease	1,013	0.9	N/A	N/A
Rheumatoid arthritis (excluding people aged under 16)	713	0.6	N/A	N/A
Stroke & Transient Ischaemic Attack (TIA)	3,000	2.6	2,917	2,911

Source: www.isdscotland.org/qof

Notes:-

- The total number of registered patients (all ages) across all 23 practices at 1st January 2014 was 116,597.
- Atrial fibrillation is a heart rhythm disorder. The QOF register definition applies to people with an initial event; paroxysmal (intermittent); persistent and permanent atrial fibrillation.
- CKD is from any cause. Inclusion in the register is based on estimated Glomerular Filtration Rate (eGFR), a measure of kidney function. Those whose kidney function is assessed at stage 3-5 based on this test are eligible for inclusion on the register.
- Peripheral Arterial Disease is a common condition where a build-up of fatty deposits in arteries restricts blood supply to leg muscles – a process called atherosclerosis. If someone has this condition, they have a much higher risk of developing other cardiovascular diseases including coronary heart disease and stroke.
- Rheumatoid arthritis is a long term condition which causes pain, swelling and stiffness in the joints. It is an autoimmune disease which means that the body's own immune system attacks the joints.

For most (nine) of the conditions listed above, a slightly higher percentage of patients in Borders practices are affected than for Scotland as a whole. However, the prevalence of many conditions is strongly related to age, and it is likely that the slightly higher apparent rates of prevalence in Scottish Borders reflects the older age profile in this area compared with Scotland as a whole. The numbers of people on each of these registers in Scottish Borders have remained relatively similar in each

of the past three years, the most noticeable change being for hypertension (high blood pressure). In March 2012, there were 16,654 people on hypertension registers, but this had risen to 17,121 by March 2014. The risk of hypertension rises sharply with age and this increase over time will at least partly reflect the rising proportion of the population who are in older age groups. Unfortunately, information on the age profile of patients on QOF registers is not readily available so we cannot examine these differences in detail.

For epilepsy, hypothyroidism and peripheral arterial disease, slightly lower percentages of patients in Borders practices are affected than for Scotland as a whole. In the case of epilepsy and hypothyroidism, this is likely to reflect the age and gender profile of the Borders population. For example, hypothyroidism is more common in females than males, and rates of epilepsy, unlike those for many conditions, do not rise continuously with increasing age, but tend to decline in the oldest age groups. The small difference for peripheral arterial disease (which will be more common in older people) may be due at least in part to this being a new QOF register for 2013/14.

Multi-Morbidity

As reference earlier in this JSNA, emergency admission to hospital and attendance at A&E departments (and prescribing costs – find these out) are rising in areas with a high level of multimorbidity – the term used for the presence of two or more long term health conditions. Across Scotland, annual adult health and social care spend is over £10.9 billion and is projected to rise with this increasing demand.

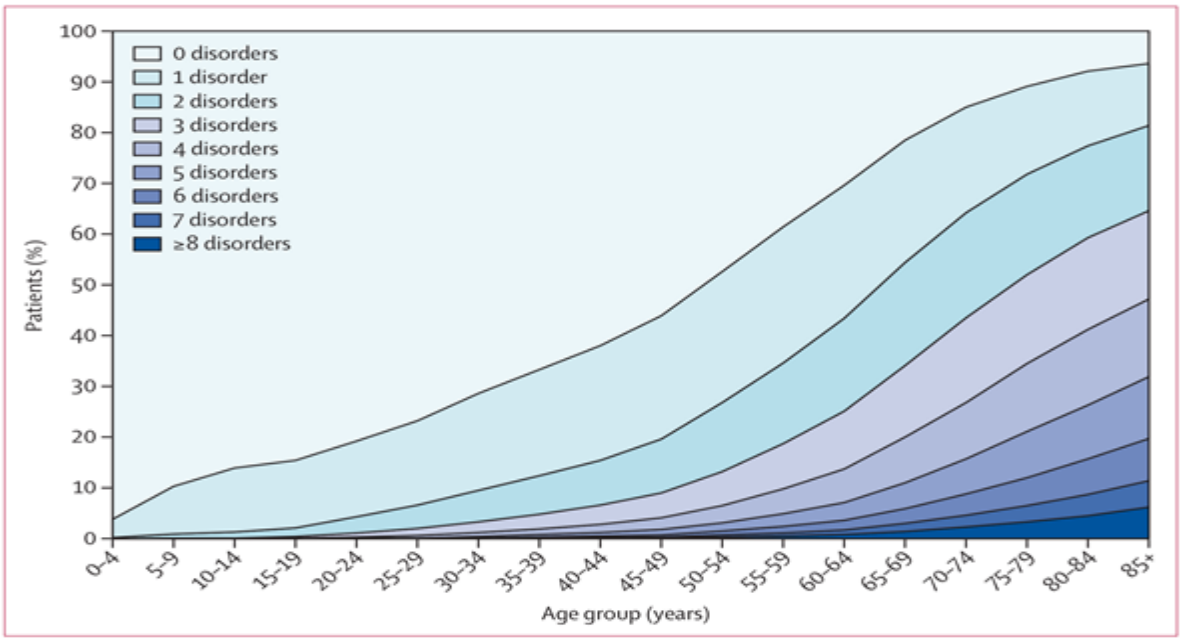
Most people with multi-morbidity in Scotland are under 65 years; we know it occurs 10 to 15 years earlier in deprived areas compared to more affluent areas. We also know that the most common co-morbidity in deprived areas is a mental health problem (reference this statement)

An examination of anonymised records for over 1,750,000 GP practice patients across Scotland (Barnett et al, 2012) found that:-

- 42.2% of the patients had one or more out of a set of 40 morbidities (long term conditions rather than short-term /minor issues).

- 23.2% of the patients overall had two or more morbidities (that is, they had “multi-morbidity”).
- Prevalence rates of multi-morbidity rose with age; nearly two thirds of patients aged 65-84 and more than 8 in 10 patients aged 85+ had multi-morbidity.
- Multi-morbidity can occur at any age, however, and the absolute number of people with multi-morbidity who were aged under 65 was higher than the absolute number aged 65 and over. This reflects that the total population aged under 65 is larger than the total population aged 65 and over.
- Onset of multi-morbidity tended to occur at a younger age (10-15 years earlier) in people living in the most deprived areas compared with the most affluent.
- Socioeconomic deprivation was associated with an increased prevalence of multi-morbidity that included a mental health disorder. 11.0% of people in the most deprived areas had both a physical and mental disorder, compared with 5.9% of people in the least deprived areas (the authors of this study used deprivation deciles derived from Carstairs scores).

Figure xx Percentages of patients having one or more chronic disorders, by age group, Scotland 2007



What do want to conclude from this for Scottish Borders

Lifestyle and behaviours

Evidence shows that those from more disadvantaged backgrounds are more likely to adopt unhealthy behaviours such as smoking, poor nutrition, low levels of physical

exercise and problematic drug or alcohol use, all of which give rise to poor health- particulary heart disease, stroke and cancer (amend this…)

Smoking

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. The relationship is not consistent by age, however. Whilst smoking prevalence amongst Borders residents aged 40-64 appears somewhat lower than the Scottish average (19.4% versus 25.3%, respectively), amongst people aged 16-39 the percentages are very similar (26.1% versus 25.7%, respectively).

Overall rates of key smoking-related morbidity and mortality are significantly lower in Scottish Borders than across Scotland overall. Taking account of the age profile of Scottish Borders, the area has, in comparison with Scotland:-

- A lower incidence (new cases) of lung cancer and COPD (Coronary Obstructive Pulmonary Disease);
- A lower rate of hospital admissions for illnesses that are attributable to smoking;
- A lower rate of deaths from lung cancer, COPD and smoking-attributable causes overall.

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. Note: check is this anything to suggest that this could relate to coding for SMR02?

Figure XXX: Trends in percentage of adults aged 16+ who smoked; Scottish Household Survey results from 1999 to 2013

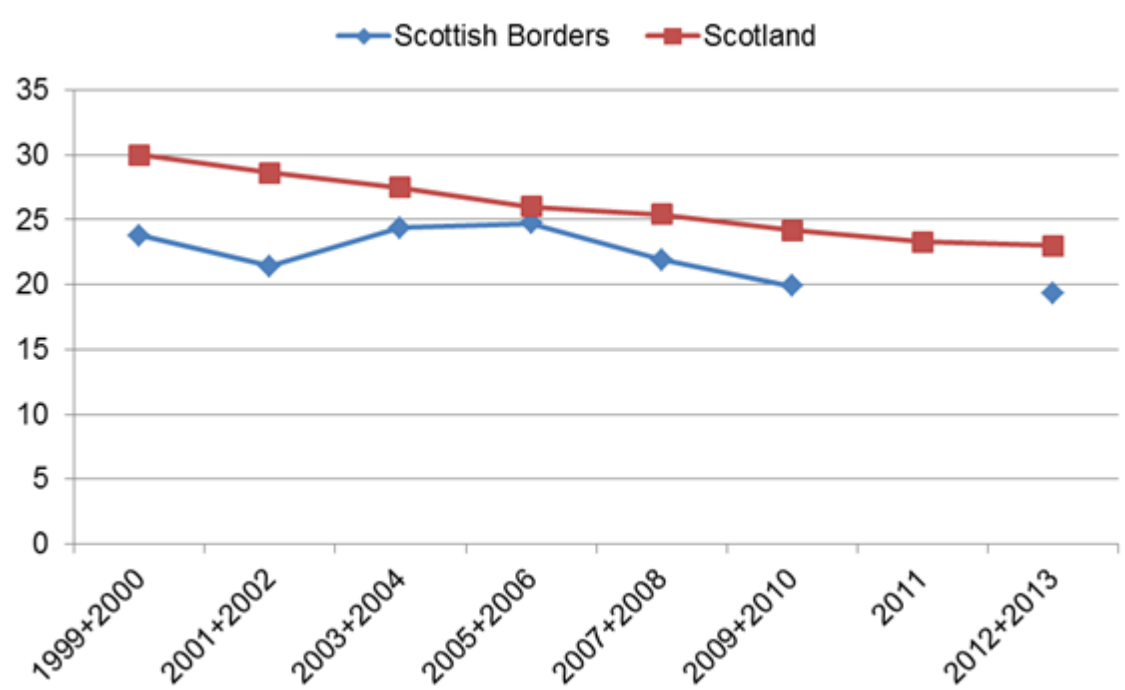


Figure XXX: Proportion of Scottish Household Survey respondents who smoked, by age band, 2012+2013

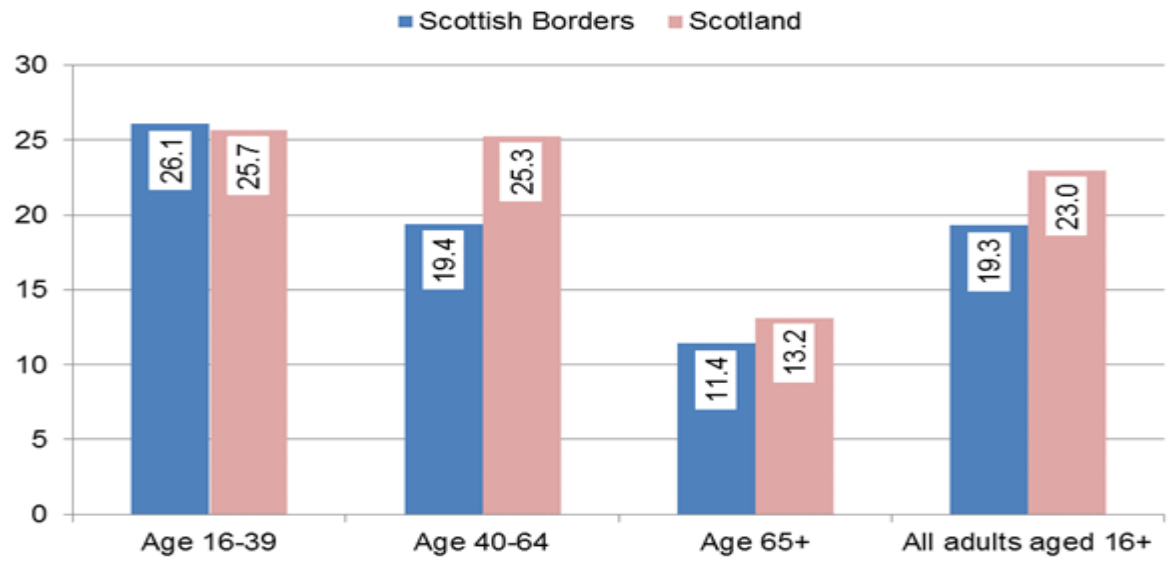


Table XXX: Age-standardised rates per 100,000 population of smoking-related illness and mortality, Scottish Borders versus Scotland

Measure	Calendar years	Scottish Borders	Scotland
Smoking attributable deaths (people aged 35+)	2012-2013	276.6	325.4
Lung cancer deaths (people aged 16+)	2011-2013	84.8	107.1
COPD deaths (aged 16+)	2011-2013	58.1	77.9
Smoking attributable admissions (people aged 16+)	2011-2013	2,531.4	3,149.4
Lung cancer registrations (people aged 16+)	2010-2012	106	133.3
COPD "incidence" (first hospital admission for COPD within 5 years) (people aged 16+)	2011-2013	303.6	391.1

Obesity

Obesity occurs when a person puts on weight to the extent that it seriously endangers health. Obesity is associated with an increased risk of a number of common causes of disease and death, such as diabetes, cardiovascular disease, osteoarthritis and some types of cancer. For example, type 2 diabetes is estimated as being 13 times more likely to occur in obese women than in women of normal weight (Source: Scottish Public Health Observatory www.scotpho.org.uk/clinical-risk-factors/obesity/key-points). Being obese can impact on quality of life and/or health at any age in a person's life.

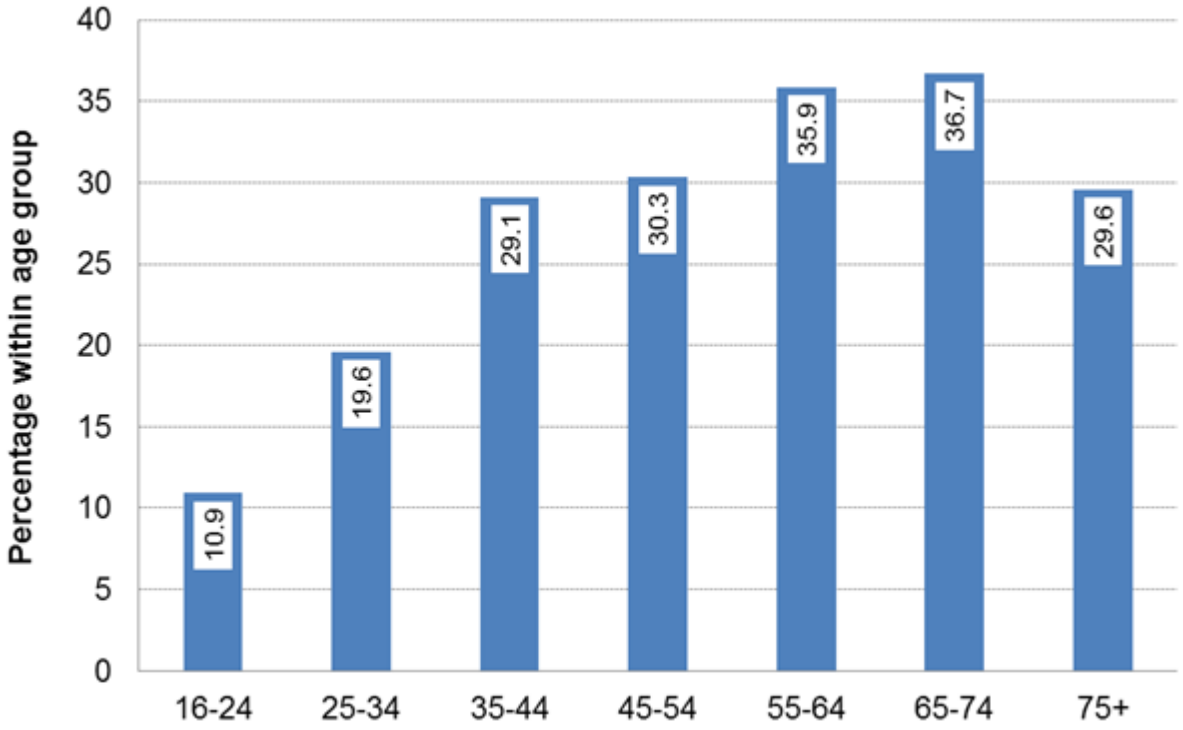
A principal source of information on the prevalence of obesity in Scotland is the Scottish Health Survey. In 2013, it was estimated that, across Scotland

- 27% of the population aged 16 and over were obese (had a Body Mass Index of 30 or more)
- 25% of males in this age group were obese
- 29% of females in this age group were obese

Whilst these estimates are based on relatively small numbers of survey respondents across Scotland (just over 4,100 for the 2013 survey), the estimated prevalence of obesity as generated from the survey have been very consistent across each successive year since 2008.

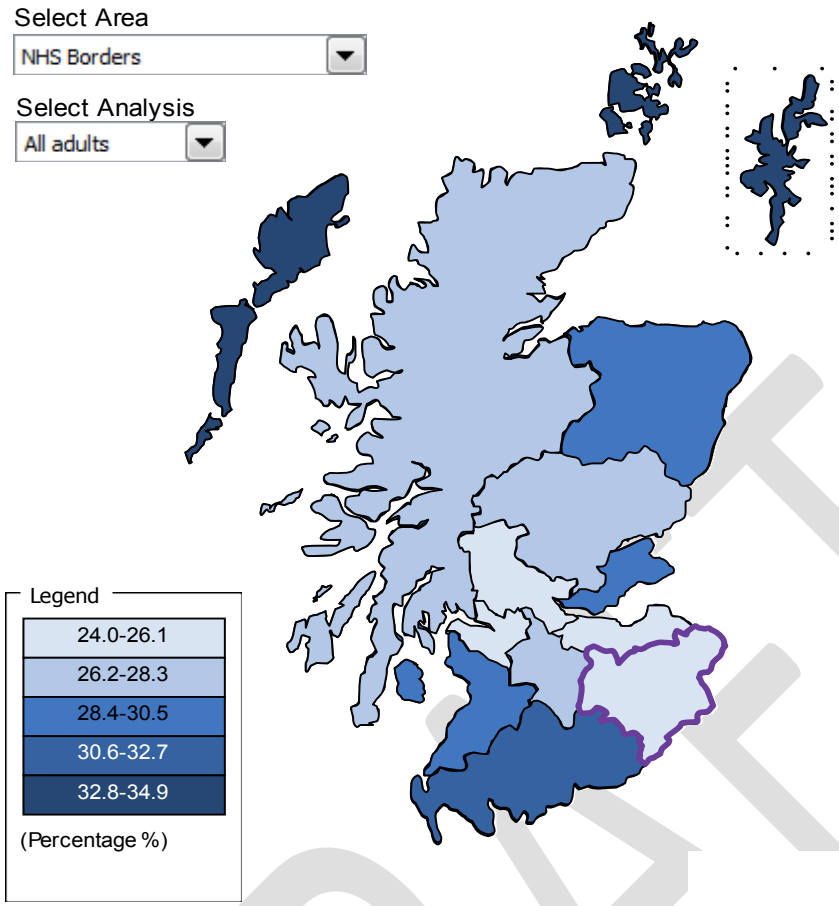
The estimated prevalence of obesity tends to rise with increasing age, from around 1 in 9 people aged 16-24 to more than 1 in 3 people aged 55-74, as shown in the graph below

Figure XXX. Survey-based estimates of the proportions of the Scottish population who are obese (Body Mass Index of 30 or more), by age band, 2013



Due to the relatively small sample size of the survey, most of the results are published as national totals only. However, periodically the Scottish Government publishes figures at NHS Board level, based on aggregated results from a combined set of years. The map, graph and table below illustrate some of the results for Scottish Borders compared with other parts of Scotland. For 2008-2011, the estimated prevalence of obesity amongst adult females in Scottish Borders was higher than for Scotland. Conversely the estimates for males, and for both genders combined, were lower than for Scotland. However, none of these differences are statistically significant.

Figure XXX: Survey-based estimates of the proportions of the population aged 16 and over who are obese (Body Mass Index of 30 or more), 2008-2011



Housing

Housing and the condition of someone's home is a key influence on a person's health and wellbeing. Living conditions affect health in a variety of ways which could see inequality spiral.

A cold and damp home can exacerbate respiratory conditions, a property that is in poor condition may be detrimental to mental wellbeing , whilst a home in poor repair has the potential to increase falls and accidents.

The quality of housing within the Scottish Borders …..

Section 5 The Case for Change

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

Ultimately our case for change is built on a number of key drivers which are articulated throughout this draft plan. These are:-

- Rising Demand – demand for services is growing with an ageing population, and an increase in the number of people living with long-term conditions, which means more people require care and support for longer
- Pressurised Budgets
- High Costs
- Poor Outcomes

Against this backdrop we have identified 6 key elements supporting the need for change and the priorities for this Strategic Commissioning Plan. How we respond to these will be key to shaping the decisions for the future configuration of adult health and social care services in the Borders.

1. THE NEED TO IMPROVE THE PREVENTION OF ILL HEALTH

The population of the Borders can become a healthier community through prevention of ill health and the promotion of health and wellbeing.

[INSERT POSTIVE TREND DATE/INFO]

It is encouraging to see these trends, but they will remain important measures to maintain greater progress in as we re-new our focus on prevention of poor health and the active promotion of wellbeing.

2. THE SIGNIFICANCE OF RECEIVING CARE CLOSE TO HOME

There is good evidence that people are best cared for as close to home as possible and, this have told us you agree emerge throughout previous consultations. Inpatient hospital care will always be an important part of how care is provided, but it is only best for someone with acute medical needs. There are many benefits associated with delivering care within people's homes and providing choice about where they are cared for.

[INSERT EVIDENCE DATA/INFO]

The care closer to home approach is not about challenging hospital provision but about clearly defining and agreeing the role of hospitals alongside community health and social care provision in meeting the needs of the population.

3. INCREASING DEMAND

[INSERT DEMOGRAPHIC DATA/INFO]

Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. The health and social care system has a key role in enabling people to live as full and healthy a life as possible and caring for the most vulnerable when needs change.

All our demographic trends indicate that in future we will be characterised by older people living for longer. However it is also anticipated that a smaller working age population will be available to supply he care sector workforce we will need to look after people: this in itself is a challenge. The higher level of dependence on institutional and hospital care for older people in particular, - whether care at home, in a care home or in a hospital – not only accounts for a high level of health and social care expenditure, it also requires a skilled and quality workforce to deliver the increased care.

Outlining and agreeing a new model of care which fully meets the needs of all people is therefore a priority and our services need to reform and modernise in order to respond to this growing demand, with an increased emphasis on personal, community based services.

We also know that there are increasing numbers of people of all ages with long term (sometimes call chronic) conditions such as heart disease, lung disease and diabetes.

[INSERT SUMMARY QOF REGISTER DATA]

All our data describes an increase in these long term conditions in the Borders. People with a long term condition very often have multiple conditions – around 25% of people with a long term condition have at least three or more – and our care delivery system does not always deal with such multiple conditions in a person centred, integrated way. This can mean people engaging with services clinicians and various supporting services which are not always effectively "joined up".

Finally, best practice in health and social care is developing constantly. There are new technologies, new care pathways, new drugs and new regulations and our population will expect ready access to these improvements. It has been estimated that the demand for services will be growing by around 4% per year by 2015. The need to better understand demand patterns and to ensure safe and effective management of demand will equally be a vital issue for the future.

The Strategic Commissioning Plan, therefore, needs to recognise all of these demands and effectively lead and put in place to achieve the process necessary service transformations to address them.

HEALTH INEQUALITIES IN OUR POPULATION

Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and have proved difficult to change.

[INSERT SUPPORTING DATA/INFO]

Across the Borders people living in the most deprived neighbourhoods, can, on average, …[*Insert latest life expectancy figures*]…….earlier than people living in the more advantaged neighbourhoods and spend more of their lives with ill health. Such inequalities are due to a complex mix of social, economic, cultural and political reasons with unequal provision of healthcare responsible for only a proportion of ill health. As a health and social care partnership, however, we now need to actively work with colleagues in the housing sector, leisure and education and a range of other interests in order to address such inequalities as a priority.

Health and social care alone cannot fully address the issue of inequalities. If we are to deliver effectively on improving the health of our population we need collegiate partnerships and a shared agenda to be developed with leisure and education colleagues and within Community Planning Partnership. It is, however, binding on us as a Health and Social Care Partnership to look at how we effectively contribute to better outcomes for all our citizens.

4. SUSTAINABILITY AND QUALITY OF HOSPITAL SERVICES

Given the increasing and changing nature of our population, changing practices in medicine and increased expectations of the public, the gap between demand for services and current provision is widening. We know we cannot continue to provide services as they currently are. The choice is stark; it is not principally about money but about sustainability and about evidence.

[INSERT UNSCHEDULED ADMISSIONS DATA]

The Borders does have an overall higher unplanned admission rate than the Scottish average which is of concern but the average length of stay in hospital for someone from the Borders is shorter, accounting for a lower proportion of occupied bed days in hospital. We also know that the Borders performs better at reducing our delayed discharge figures – when people are delayed in a hospital bed whilst waiting for care or support closer to home.

The real measure of success for both our service users and for the health and social care partnership should be safe and supported "bed days at home" – a measure inversely related to hospital bed days. In simple terms we know it is possible and it's better to provide services closer to home, yet we continue to use hospitals. This is an unsustainable and undesirable model and this draft Strategic Plan will set our priority measures to address this.

5. MAKING BEST USE OF RESOURCES AVAILABLE

This Strategic Commissioning Plan is not intended to exclusively focus upon money and recognises that any discussion on resources has the potential to produce a divergence of views and opinions. The Strategic Commissioning Plan does, however, start to consider our joint resources, how we use them and consequent efficiency and productivity – in other words how we best spend our resource to achieve maximum efficiency and effectiveness.

In that regard it is difficult not to conclude that, with the overall level of joint resources now available we should have the ability, in time, to provide a better service. With pressure from the demand and a changing population as outlined above, then change becomes an imperative. The challenge presented is best summed up as how best to spend the joint resource to achieve maximum benefits and outcomes.

- **Best Use of Estate**

  We currently have access to a District General Hospital and community hospital facilities in Duns, Peebles, Hawick and Kelso. In addition to this there are residential and nursing homes for older people and a range of day centres and health centres.

  Any future models of care should, therefore, take into consideration the best use of the total health and social care estate that is currently available to us in the Borders. It should not, necessarily concentrate on the preservation of the existing building stock but rather consider and present new service models which could deliver more care throughout our communities.

[INSERT SUPPORTING DATA/INFO]

- **Best Use of Staff**

  Better joined up and integrated services to meet the needs of people and communities is a key ambition for the Borders HSCP and we recognise that true integration will not work without the support and commitment our workforce. However it's also crucial to recognise the broad reach of health and social care integration which includes relationships beyond traditional NHS and Scottish Borders Council as providers. The majority of social care services, for example, are delivered by the independent and not for profit sectors and as such the integration of services is as relevant and important for those sectors as it is for wider public services such as education and leisure.

The independent and not for profit sector is the largest social services employer in Scotland as a whole and ? of the care delivery workforce in the Borders is currently employed in this way. Given their pivotal role in both supporting care at home and in care homes this Strategic Plan must recognise the contribution of the independent and not for profit sector and ensure their active participation in present and future service planning.

In considering workforce support, workforce development and service modernisation, this Strategic Plan also recognises the roles of independent contractors – such as GPs, community pharmacists, dentists and optometrists – and the voluntary sector. Each provides a highly significant workforce which supports and delivers health and social care for our population and we need to ensure active and meaningful involvement of all in our future planning and development of services and supports.

- **Best Use of Money**

The Borders HSCP has a higher percentage spend on institutional care than the Scottish average as highlighted below.

[INSERT SUPPORTING PIE CHART DATA]

There will always be a need for hospitals and care homes, particularly as people get older, but the policy focus is on ensuring that these specialist services are used appropriately to meet people's needs. This data therefore highlights the need to focus on significantly realigning resources to provide more community based planning and activity.

Equally within our own HSCP there is significant variation in activity and costs associated with hospital activity.

Addressing the reasons for this variation may require changes to be made which ensure resources are actively focused in the areas with greatest need. Such changes in how we deliver care in the future will be necessary in order to deliver best value for the public purse.

THE CASE FOR CHANGE: A SUMMARY

Across all of the above elements we are not at a huge variation with other areas. Whilst there are unique factors affecting the Borders impacting on the demand for services, a number of these issues are common across the country.

Consequently the Borders cannot insulate itself from the need for change and this Strategic Commissioning Plan presents an opportunity to consider and commission a range of new services, a more integrated model for the health and social care system that allows us to deliver an excellent and equitable service to the population of the Borders.

We believe that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we continue to deliver services as we currently do they will not meet the needs of our population and will not be sustainable for the years to come. Changes are needed to meet future health and social care needs. In looking to recommend new models, the Health and Social Care Partnership is reviewing data and research evidence to inform the changes that are required. We will also engage and continue to engage widely with the public, clinicians, providers and interest groups to further inform our thinking. The aim throughout will be to consider what changes will make the greatest difference to outcomes for patients, users and carers.

Section 6 Change Programme

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

This section provides a description of how we think health and social care in the Borders could look in three years' time as a result of each of our strategic objectives, and will describe the change programmes that will bring this about. Fuller detail on the change programmes, if and when agreed, will be set out each year in dedicated delivery plans and our business action plan.

The Strategic Change Programme for the Borders will retain a focus on national and local outcomes and local strategic objectives and will address them through work programmes overseen by senior officers who will be accountable for delivery. The draft programmes are based on:

[*INSERT DIAGRAM*]

Strategic Objective:
MAKING UNIVERSAL SERVICES MORE ACCESSIBLE and DEVELOPING OUR COMMUNITIES

We need to ensure that people with health and social care needs benefit from the full range of mainstream services and resources such as primary healthcare, housing, information, support and advice.

Primary care, and in particular care delivered by general practice has been a cornerstone of the NHS since its inception and its delivery model has evolved through the years. With the demands all services are facing at a time of changing populations with increasing health and wellbeing needs, primary care needs to equally address the challenges of variation in access to services and a changing workforce profile. GPs and their practices will, therefore, plan an important role in influencing and shaping this Strategic Commissioning Plan and its outcomes.

Over the next few years, primary medical service providers are faced with new challenges in terms of demand, capacity and access. This will make it essential that the Health and Social Care Partnership works in a supportive and collaborative way with primary care. The timing of this Strategic Commissioning Plan is therefore important in supporting GPs and primary care improvement and to provide assurance that the HSCP is striving for excellence in primary care.

Primary care is concerned with a wide of service and also includes community pharmacy, dentistry and optometry - independent practitioners who provide essential services for our population. The Health and Social Care Partnership therefore must explore opportunities to work with all professions to ensure they are an integral part of our planning and care delivery.

Most crucially, however, this strategic objective focuses not simply on how access to health and social care services will be supported but equally on the way all services connect between themselves and connect people into their local communities.

Achieving our priorities will be dependent on maximising the use of all available resources. Therefore this Plan will be supported by a model which seeks to develop communities and build resilience within the provision of community services and to intervene early where individuals, families and carers require additional support. By having clear and consistent themes of community capacity and resilience running through all our programmes, we aim to make it easier for everyone to work together. By getting organisations to work together more closely, sharing resources and information so as to provide a better network of local support, we aim to create such resilient communities across our country. This is to make sure that everyone can be a part of a community and experience the friendships, sense of belonging, support and care that can come from families, friends, neighbours and communities. Through this, our aspiration is that people and communities will be better equipped to do more for themselves. As well as reducing inequalities and promoting quality of life, these wider supports will play an important role in reducing the need for health and social care support services as well as developing more creative and effective ways of delivering support.

What does our Joint Strategic Needs Assessment tell us?

We have also already highlighted the rural nature of much of the Borders and the challenges this presents in accessing care. The Strategic Plan now needs to address these challenges and support innovative solutions for enhancing access.

The HSCP in the Borders is committed to working in partnership with the Third and Independent Sectors to focus on prevention and the promotion of health and well-being; Community Groups organised around their own local issues, working and learning together, building relationships and networks in neighbourhoods and communities are a vital resource we must recognise. As part of our evolving Joint Strategic Needs Assessment we have now started to map this often untapped resource.

Our Draft Priorities for the Future?

[List]

Strategic Objective
IMPROVING PREVENTION and EARLY INTERVENTION

Prevention is integral to the delivery of sustainable health and social care. It enables individuals to make better health and wellbeing decisions and it is an important determinant in optimising better outcomes for our population. Preventative services are a means of ensuring good health, well-being and independence in later life. This means providing information, advice and guidance at the right time and in the right format, ensuring that there are a range of activities and services that help people to stay physically and mentally alert and active and to commission services that enable people to gain or regain their independence in the community.

Preventative services for individuals and their families should ensure that our aim to increase the life expectancy of people is not about just adding years to life but life to years.

The real starting point, however, is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It certainly begins with the individual and the choices they make, but improving health and reducing health inequalities also requires joint action and partnership working. Factors or interventions can only be addressed effectively through real partnerships across the NHS, Council, the community and voluntary sector, local communities and private sector organisations. A sustainable model of adult health and social care services needs to place greater emphasis on maintaining people's independence and resilience, preventing deterioration into substantial or critical categories of need.

What does our Joint Strategic Needs Assessment tell us?

Multimorbidity/Long Term conditions

Emergency admissions to hospital, attendance at Accident and Emergency departments and prescribing costs are rising, particularly in areas with a high prevalence of multimorbidity – the term used for the presence of two or more long term health conditions. Across Scotland annual adult health and social care spend is over £10.9billion and is projected to rise with this increasing demand.

Most people with multimorbidity in Scotland are under 65 years and we know it occurs 10 to 15 years earlier in deprived areas compared to more affluent areas.

As part of our needs assessment we have concentrated on understanding multimorbidity and where the greatest support need is across the Borders. This is outlined in the chart and map below.

[INSERT MULTIMORBIDITY RATES DATA]

We know that what matters most to people with multiple long term condition is:

- Coordination and continuity of care
- Trusted relationships
- Accessible information and advice
- Good communication with, and between staff

Our current systems are not well geared to deliver these outcomes. Fragmented care from multiple professionals and teams disrupts lives, increases the burden of treatment for individuals, their families and carers and increases costs, waste and risk of harm. Transitions of care are a particular pressure point and we don't always support people to use individual and community assets to build resilience, prevent or delay dependency and reduce demand for more intensive support.

As multimorbidity increases, our need to coordinate and integrate the care of the most vulnerable and at risk people in our communities grows in importance. A risk assessment methodology which recognises multimorbidity as well as other associated risk factors and allows us to identify those in our population at highest risk will be a key tool in the targeted identification of people who will benefit from the better coordination of their care.

For all these reasons this draft Strategic Commissioning Plan has risk assessment/prediction, multimorbidity/long-term conditions, prevention and care coordination as priority themes.

Carers

We also recognise the vital role played by **carers** and the need to prioritise planning to make sure that carers remain in good health so that their health-related quality of life does not deteriorate as a result of their caring responsibilities. In order to do this we need to maximise the early identification of carers – both early self-identification and by care professionals. We also need to provide personalised support for carers as well as those receiving care and, crucially, support carers to remain healthy.

What does our Joint Strategic Needs Assessment tell us?

[INSERT CARERS INFO]

Dementia

Dementia is a national priority and we need to make it a priority for the Borders Health and Social Care Partnership. Given the challenging times we all face in the next few years in terms of public spending, it is important that we tackle this agenda strategically now if we are to begin to fundamentally reshape the model of dementia care –especially as we expect the number of people with dementia to double over the next 25 years.

What does our Joint Strategic Needs Assessment tell us?

We recognise that if we are going to support people and address this increase we need to work closely with all our partners in the statutory, voluntary and private sectors in order to identify the best levers for changing and improving the entire system of dementia care locally.

At each stage of the journey of someone's dementia there are things we need to do better – for example in providing consistency in the quality of post-diagnosis support and improving the experience of those with dementia and their carers in all settings including our communities. Evidence also clearly highlights the value of early intervention and diagnosis as up to two thirds of people and their families are living with dementia unaware of its existence. Early intervention can help to slow the progress of dementia and its symptoms. It can also help to better prepare individuals and their families for the future of living with the condition.

The key role played by carers of those with dementia is also recognised and prevention and early intervention to support this crucial role.

Falls are a major cause of disability and mortality in the UK. Recurrent falls are associated with increased mortality, increased rates of hospitalisation, curtailment of daily activities and higher rates of institutionalisation.

What does our Joint Strategic Needs Assessment tell us?

We also know from our needs assessment that whilst the Borders has a [Update info] hospital admission rate for falls.

Because falls are one of the largest causes of harm in health care and are a safety and quality priority for our population, falls.prevention should be addressed through the priority actions of this Strategic Commissioning Plan.

Telecare/Telehealth

Finally, with an ageing population and the increasing prevalence of long-term conditions the need for new care models and technologies – such as **telehealth** and **telecare** – to support long-term care has increased. Innovations such as telehealthcare solutions challenge our systems to focus on preventing ill health, supporting self-care, and delivering care closer to people's homes.

What does our Joint Strategic Needs Assessment tell us?

Telehealth and telecare innovations have the potential to improve quality of life for users and to reduce unnecessary hospital and care home admissions. The integration of health and social care and the closer working between health, housing and social care organisations now provides an opportunity to consider and adopt innovative and personalised technology-based solutions as part of our formal, integrated care pathways.

Our Draft Priorities for the Future

We will increase use of risk assessment and case finding at primary care and community level. In future our multi-disciplinary teams will focus on providing care to individuals who are at greatest risk of unscheduled admission to hospital. we will categorise our population by their risk of admission to hospital and by use of social care. We will know which of our population are in the greatest need of our help, and can target our resources – doctors, nurses, social workers, care support and community support – appropriately towards those in greatest need.

We will improve planned care and anticipatory care. A central facet of our plans to transform our local health and care system centres on the development of an expanded and effective primary and community care sector. We want to organise our GP practices into "hubs"; each cluster will have a multi-disciplinary team of integrated, health and community professionals and new care coordinators who will signpost care across third sector support providers. Establishing this will require us to:

- Reorganise our services so that we have the right number of people, with the right skills, in the right place, targeting patients with the highest risk of hospital admission
- Develop the concept of multi disciplinary neighbourhood teams to support people in the community and reduce reliance on hospital care

We will develop more primary and community care services in our localities following on from the successful implementation of the 'Torbay' model of health and social care.

We will develop and refresh an integrated falls pathway which identifies fallers at an early stage and which provides a multi-disciplinary, multi-agency response to prevention.

We will appoint a dedicated post diagnostic support worker for Dementia.

We will continue to develop an integrated telehealthcare strategy for the Borders which ensures a suitable spread of technology enabled care.

We will carry out a review of Day Centres in the Borders in order to address capacity, capability and equity of provision and implement the recommendations of this.

Strategic Objectives: **REDUCING UNSCHEDULE CARE**
CARE CLOSER to HOME
DELIVERING SERVICES within an INTEGRATED CARE MODEL
ENABLING PEOPLE to have MORE CHOICE AND CONTROL

Unscheduled care is a term used to describe any unplanned treatment, help or advice to people in an emergency or urgent situation. It ranges from emergency hospital treatment to help for individuals to care for themselves at home. Unscheduled care can occur at any time and crosses the traditional boundaries between general practice, community and social care services and hospital services.

The Scottish Government has specifically challenged partnerships with targets around unscheduled care, including A & E attendances and unplanned hospital admissions. Currently, our health system appears to be overly dependent on hospital services and people can end up in hospital when they don't need to be there. More generally in both health and social care there is now a greater emphasis and focus upon providing care at home rather than in institutional settings, with more choice being given to individuals to say how, when and by whom services are provided i.e. personalised services.

Managing admissions to acute hospital beds, residential and nursing homes is, therefore, a key part of this Strategic Commissioning Plan and we believe there is a clear case for the transformation of our out of hospital care. The population of the Borders is changing, people are living longer and this

will continue to increase the pressure on acute hospital services and residential care placements unless we transform service delivery.

Some of the key challenges are apparent – the need to develop a more comprehensive, integrated approach to how we deliver our care services, and the need to help people better understand the complex array of unscheduled care services so that they access the most appropriate treatment for their needs. This delivery programme of the Strategic Commissioning Plan gives us the opportunity to develop a coherent, joint modernisation strategy which addresses the challenges of increased unscheduled care attendances and admissions and safely and equitably meet the needs of the public.

What does our Joint Strategic Needs Assessment tell us?

Our Joint Strategic Needs Assessment tells a powerful story of unscheduled care patterns in the Borders. We have carried out an analysis of unscheduled care activity [*Update latest figs*]

In response to the continued growth of unscheduled care attendance and admissions, and in recognition of the opportunity for modernisation integration brings, this draft Strategic Commissioning Plan has a major focus on the need to redesign services to address this pressure and better meet the needs of our population.

The aims of this strategic commissioning programme will be to:-

- Ensure that pre-designed pathways are in place so that the right treatment is provided in the most appropriate place, from the right person, as quickly as possible 24/7

In doing this we will always recognise that carers are the largest group of care providers in Scotland, providing more care than the NHS and local authorities combined. Any redesign of services, therefore, has an impact on people and on the carers who support them. As services shift from hospital and residential settings to greater support within the home and wider community settings more pressure could be placed on carers if their needs are not considered. The Strategic Commissioning Plan must take account of this at all points and ensure positive outcomes for both carers and the people they care for.

Care at home and care homes in the Borders, and surrounding area, are pivotal services in ensuring the vision to support people to maintain independence for as long as possible and to enjoy full and positive lives in their home or a homely setting: such they are key elements of the Strategic Commissioning Plan.

What does our Joint Strategic Needs Assessment tell us?

The objective of maintaining independence appears to be taking hold although we recognise that more needs to be done. The number of people receiving personal care services in their own homes in the Borders has increased and risen steadily, showing that people receiving care at home have increasing levels of need.

[*INSERT BALANCE OF CORE DATA/INFO]*

Residents in care homes have increasingly complex and high levels of care and support needs and as a partnership we need to ensure we commission the right services in the right place.
From April 1st 2016 there will no longer be a national agreement and this presents the opportunity for the strategic direction of Care Homes for Older People to be arranged on a more localised basis. This work will be encompassed in the Strategic Commissioning Plan.

Given the age, frailty and multiple morbidities of care home residents they can be viewed as one of the most complex and vulnerable group of people in our communities which has significant implications for the workforce providing their care and support. As a partnership we need to recognise this and promote and support quality services for all.

Care for people nearing the **end of life** is one of the most important challenges that we face and there are challenges for planning and delivering good, person centred end of life care. This is a complex and multifaceted subject, covering a broad range of conditions and issues. The default position is often overuse of hospitals, but we know that hospital is not a good place to be for many people. However, at its best, end of life care can be really excellent – in the community, in hospices, hospitals and elsewhere. Improving community care and reducing inappropriate hospitalisation is doubly beneficial in end of life care, meeting the wishes of patients and carers.

What does our Joint Strategic Needs Assessment tell us?

In the Borders we perform relatively well in supporting appropriate end of life care outside hospitals compared to other areas.

Overall in this strategic commissioning programme our joint ambition is to ensure that the service we plan and deliver are organised as much as possible around our citizens' needs, and not institutional boundaries. If we are to realise this ambition, the principles of choice and control as specified in **Self Directed Support** need to extend across all health and social care services, and the Health and Social Care Partnership and the Strategic Plan should act as enabling forces in this respect.

Our Draft Priorities for the future

In the Borders we have begun redesigning our services to meet the challenges of unscheduled or unplanned care and crisis support for some time.

However, future progress and service improvement will require a further significant whole system enhancement of services such as this in order to capitalise on the inter-dependencies (and potential efficiencies) between health, social care and the third and independent sectors and our draft priorities for this delivery programme include:

Strategic Objective
FURTHER OPTMISING EFFICENCY AND EFFECTIVENESS

In order to deliver quality care some health and social care services should be viewed as a single, interdependent system. Services designed from this perspective should take into account the whole spectrum of an individual's needs, and care delivered in response to these needs should be comprehensive and person centred.

However, both the NHS and local authority are under pressure to find financial efficiencies whilst offering patients and service users the improved choice, control and quality of this kind of care which we aspire to. Pressures on services are exacerbated by an ageing population with chronic conditions and increased public expectations. The need to innovate around service provision is therefore now greater than ever as costs continue to increase.

We have outlined how a whole systems approach to integration can offer the opportunity of efficiencies and service improvements through reduced residential care reduced emergency admissions and reduced delayed discharges from hospital. Integration can also offer operational efficiency through reduced duplication and can facilitate potential increased productivity – ensuring sustainable services in the face of the known demographic and financial pressures.

For both local authorities and the NHS the financial climate has made delivering significant efficiencies a priority so in many ways there has never been a better time to integrate health and social care services.

The Borders has a duty to provide quality services that are good value for money. Since the onset of the economic downturn, a wide range of studies and reports have been published to shape care planning and there is a consensus that while conventional approaches to good operational and financial management are essential, these approaches of themselves will be insufficient to deliver the depth and duration of efficiency savings required in the medium term. In other words, strategies for cost avoidance and reduction need to be combined with a drive to release resources associated with traditional ways of organising and delivering services. We also need to reduce unwarranted variation in service provision and remove potential waste.

Whilst each of the delivery programmes prioritised throughout this Plan are designed and intended to deliver the best outcomes for our population, as an accountable body the Health and Social Care Partnership equally needs to ensure best value for the public purse. To this end we will establish a dedicated transformation programme which focuses on efficiency and effectiveness.

Quality

People and the quality of the care they receive is the focus of everything we do. We will ensure that we plan and commission services based on the quality of care they deliver and ensure that individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services which are planned and commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.

Quality and professionalism need to be clearly at the core of everything that we do. It is an essential element to assure safe practice and positive outcomes for our population. To ensure this quality, people who are providing care and support must be appropriately skilled, qualified and have the personal attributes to be in a role that has dignity and respect as an essential requirement.

Locally, this will mean all our staff and care providers operating within our own quality and professional frameworks and with other agencies such as the Care Inspectorate and Health Care Improvement Scotland as a regulatory and inspection bodies. We will actively promote the development of effective care, working closely together through audit, support and a focus on quality outcomes.

We want to ensure that care and support provision not only complies with the essential standards of care but that we work collaboratively to ensure that best practice an continuous improvement are assured and vulnerable people remain safe.

What does our Joint Strategic Needs Assessment tell us?

We have a range and variety of bed based models across the Borders provided and supported by NHS, local authority and independent and third sector; these bed based services also support a range of need and complexities. Any future models of care should take into consideration the best use of the total health and social care estate that is currently available to us in the Borders and which best meets both current and future projections of need.

As an accountable body we must ensure that we plan and commission services based on the quality of care they deliver. As well as promoting ongoing quality improvement, as service commissioners we equally need to assure ourselves that existing services meet standards in terms of safety, quality, sustainability, cost effectiveness and financial viability. As an accountable body we also need to understand variation in our activity and our service delivery.

[INSERT DATA ON UNSCHEDULED CARE COSTS

Our Draft Priorities

- We will therefore commission and complete a bed modelling exercise across the total health and social care landscape to identify current and future need for provision
- We will refresh and complete a financial exercise to better understand variation in spend and costs within the HSCP
- We will commission and complete an exercise to map high resource use of health and social care services
- We will develop a comprehensive performance monitoring framework

Section 7 Governance

- clear future governance structure
- System of performance management to support delivery of SCP
- Accountable and transparent

Section 8 Planning for Future/Next Steps

- SCP can only be fully implemented with a substantial shift in the current investment pattern for services
- Transformation therefore requires
    - a good understanding of how resources are being used at a local level
    - Clarity about what works
    - A mechanism to move resources
    - A clear plan about what resources will move when this will happen and evidence of impact

Section 9 Workforce Development

Workforce Development

- Future workforce are knowledgeable and skilled and able to respond to requirements of SCP
- Enhancement of workforce capacity and capability
- Development of community skills and capacity
- Equipping people with the appropriate level of skills, competence and capabilities

Section 10 Locality Planning

The role of localities should be to feed into the strategic planning and commissioning processes a distinct view on what needs to be made available in respect of their locality, and on an on-going basis consider proposals from local professionals, users and communities on ways to improve the delivery of services for the locality.

Through our Joint Needs Assessment we can clearly see differences in a wide range of outcomes and measures across the five localities established in the Borders.

We now need to focus on these differences and introduce more localised conversations and more localised service provision to meet the needs of these populations.

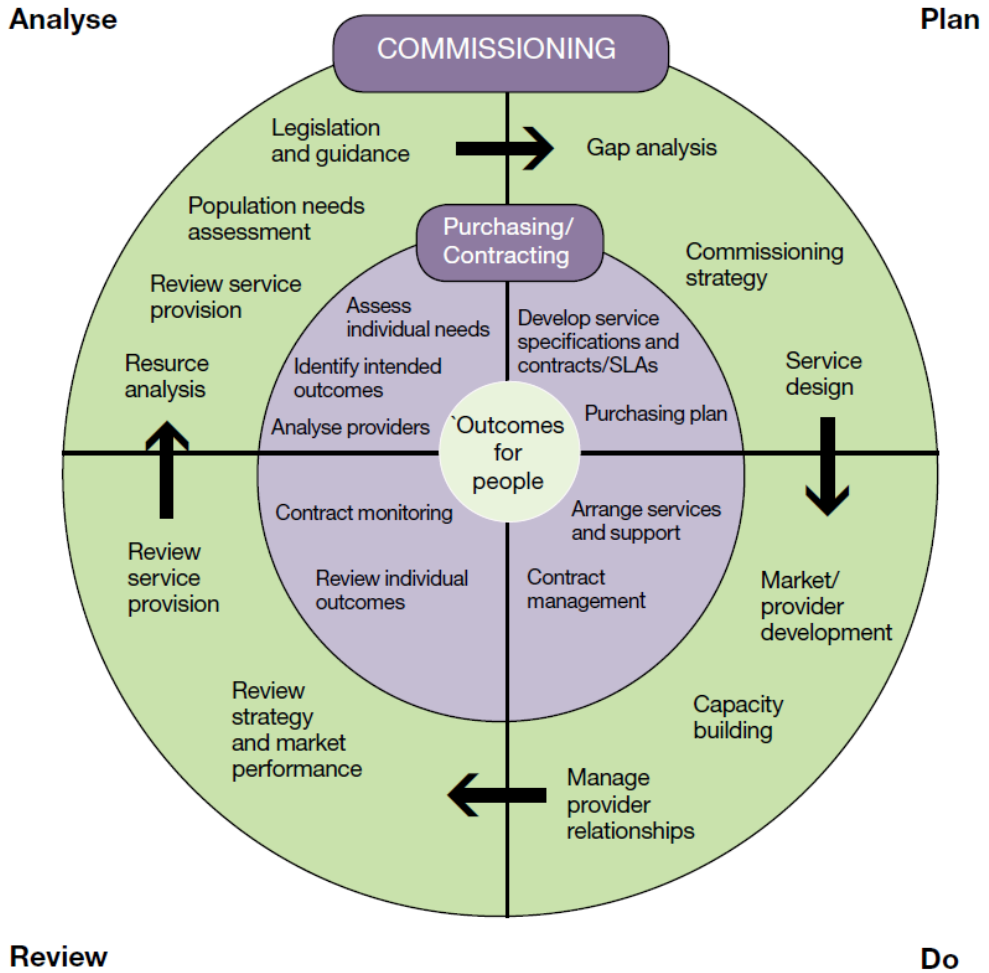
We will further analyse our information at a local level and continue with others to develop more local solutions in the next iteration of the draft Strategic Commissioning Plan. We will continue to consult on proposals through the Area Forums and other arrangements in the Borders in order to allow this level of discussion to take place and consider local information and activities within local communities.

Section 11 Commissioning

Commissioning

The Model of Commissioning we are using for this Strategy, and as recommended by Scottish Government, is taken from the Institute of Public Care (IPC) and is based upon four key performance components:

- Analysis – drawing meaningful conclusions from available data, projections and from people about their needs.
- Planning – working with partners to make short, medium and long term decisions about how services need to change and how this will happen.
- Doing – implementing strategic plans which involve maintaining a strategic overview of what we are trying to achieve as well as effectively commissioning and decommissioning services and implementing sound procurement arrangements.
- Reviewing – taking an evidence based approach to monitoring and reviewing progress and making adjustments as circumstances and market forces change.



Section 12 Strategic Plan Review

- Period of SCP, 2015-18
- Will be reviewed and rolled-on each year
- Date of first review
- Format of review
- Accountabilities and SCP review s

Section 13 Measurable Tasks to Deliver Plan Objectives

- Performance framework
- Matrix for outcomes and the strategic objectives