Scottish Borders *Health & Social Care Partnership*

Changing Health & Social Care for You

A further conversation

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

Draft Strategic Plan (Version 3)

2016 – 2019

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Foreword

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

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

This second draft is based on what we have learned from listening to local people; service users, carers, members of the public, staff, clinicians, professionals and partner organisations. Earlier this year we engaged on the initial draft of the plan through workshops and locality events across the Borders.

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

This is an exciting time. Together, with you, we know we can make a real difference.

Susan Manion
Chief Officer Health and Social Care Integration

Executive Summary

This plan sets out how we are planning to improve health and well-being in the Borders through integrating health and social care services.

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

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

There are five localities in the Borders which have individual characteristics and therefore different needs. This plan sets out how we will work better together to deliver more personalised care, making best use of advancing technology to achieve “Best Health, Best Care, Best Value”.

Case for Change: Why we need to change

There are a number of reasons why we need to change the way health and social care services are delivered. These are illustrated in the diagram below and include:

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

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

Diagram 1 – The Case for Change

FACT
More people will need health and social care services

CHALLENGE
Health and Social Care Providers have limited resources

REQUIREMENT
We need to work together to provide health and social care services

METHODS
Personalising care *(Better communications, improved efficiency, reduce duplication)*
Make better use of technology and new models of care

GOAL
IMPROVED OUTCOMES
Better care
Better Health
Better Value

INTEGRATION

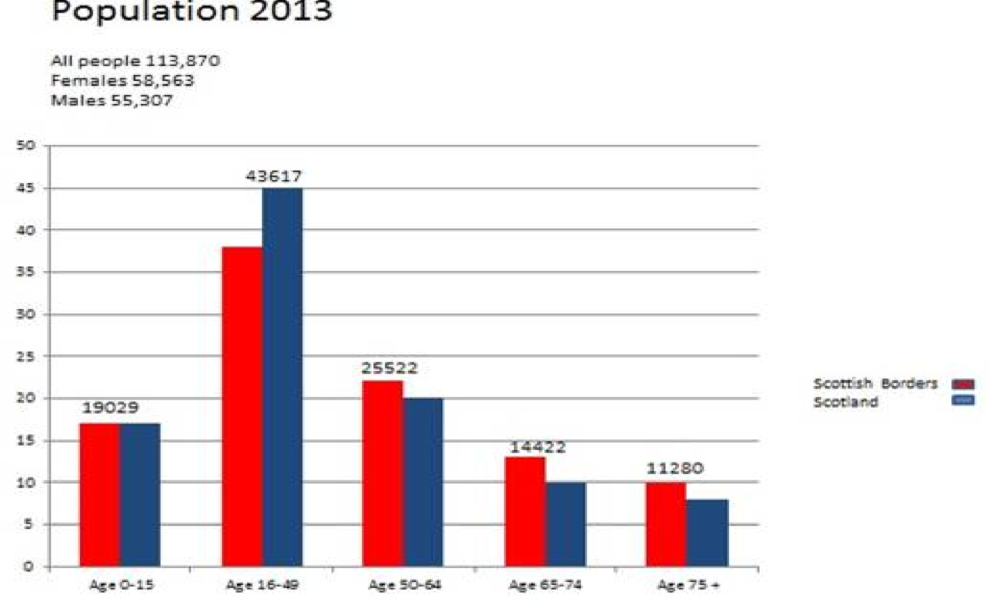
The Scottish Borders

Who Lives in the Borders?

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

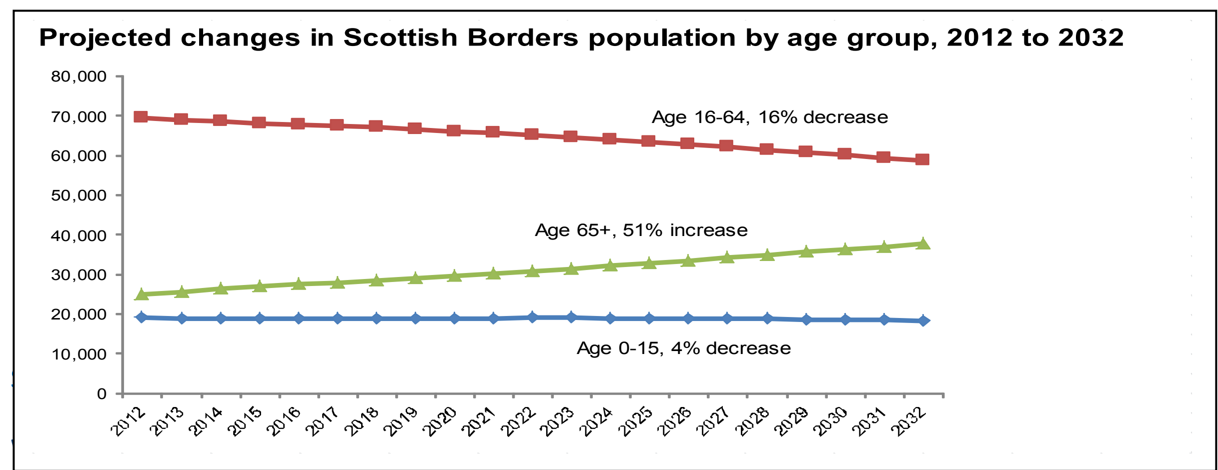
As the graph below shows, we have a higher percentage of older people than the rest of Scotland.

Figure 1 - Population



By the year 2032, the number of people aged over 65 is projected to increase by 51%, a faster rate than the 49% for Scotland overall. The number of people under 64 is also projected to decrease in the Scottish Borders. Age is strongly related to patterns of need for health and social care. These changes will influence how we deliver services in the future. Integration will enable us to work more effectively and efficiently to achieve “Best Health, Best Care, Best Value”.

Figure 2 – Projected population changes



Source: National Records of Scotland 2012-based population projections.

What this means…

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

Where do people live?

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

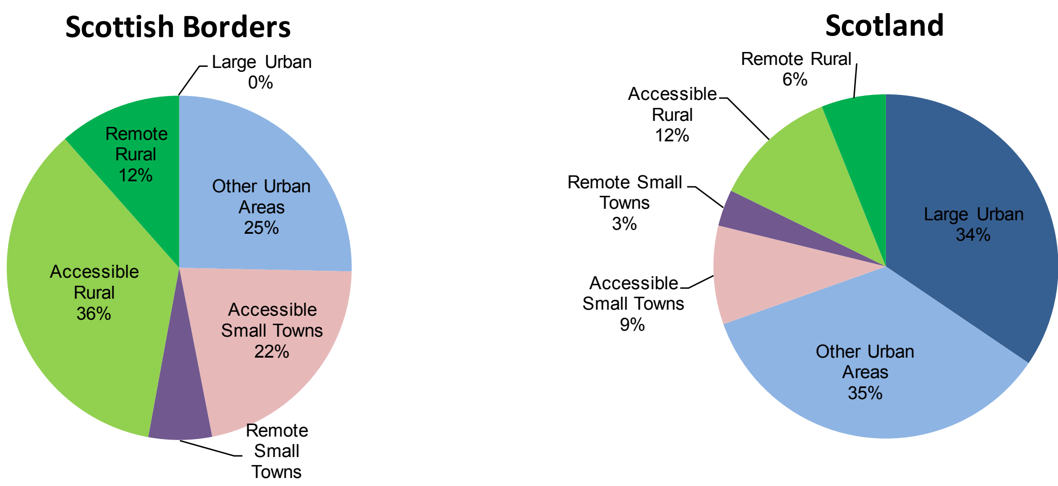
In the Borders nearly half (48%) of the population live in rural areas, as shown in Figure 3. Under one-third of people live in settlements of fewer than 500 or in remote hamlets. In comparison, 34% of the Scottish population live in “Large Urban” areas (part of towns/cities with populations of more than 125,000). There are no “Large Urban” areas in the Borders.

The largest town in the Borders is Hawick, with a population of 14,029. Galashiels is the second largest with 12,604 (although, if neighbouring Tweedbank was included, Galashiels would be the largest town with a population of 14,705). Peebles, Kelso and Selkirk are the only other towns with a population of more than 5,000.

As people in the Borders do not live close together in cities, planning services is more challenging. People live in remote hamlets in many parts of the region, but towns like Hawick have a higher average population density, in parts, than Glasgow.

Figure 3 – Population shares

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



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

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

What this means…

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

Borders Households

With the changes predicted in the population (see Figure 2 on page 7), we expect an increase of the numbers of older people living alone with complex needs. This will have major implications for housing, health and social care.

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

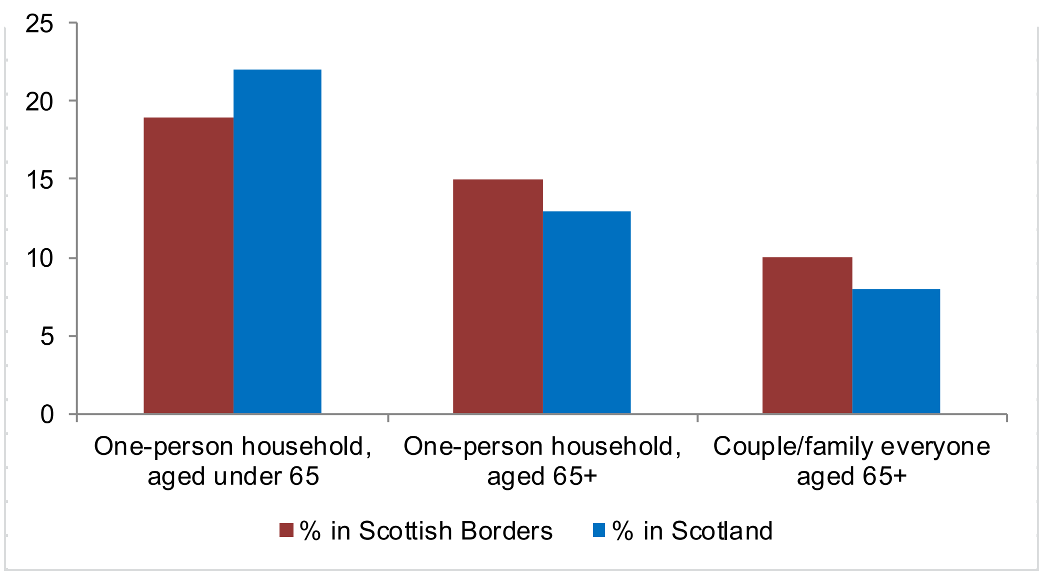
Figure 4

Household composition

Total number of households in Scottish Borders 2011: **52,498**

	% in Scottish Borders	% in Scotland
One-person household, aged under 65	19	22
One-person household, aged 65+	15	13
Couple/family everyone aged 65+	10	8

Source: Scotland Census 2011



Source: Scotland Census 2011

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

What this means…

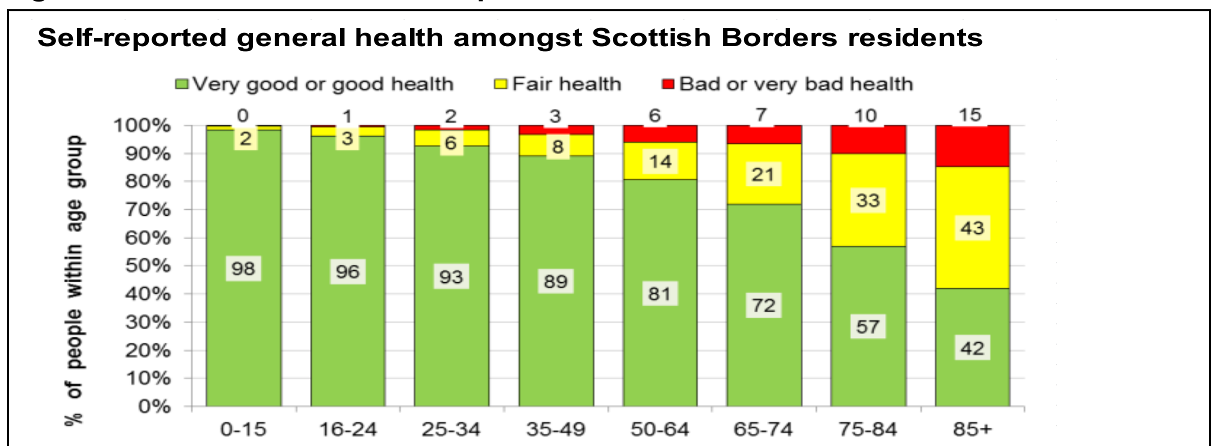
Housing options need to be a key feature of the Strategic Plan.

How Do People in the Borders View Their Health?

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

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

Figure 5 – General Health – self reported results



Source: Scotland Census 2011

What this means…

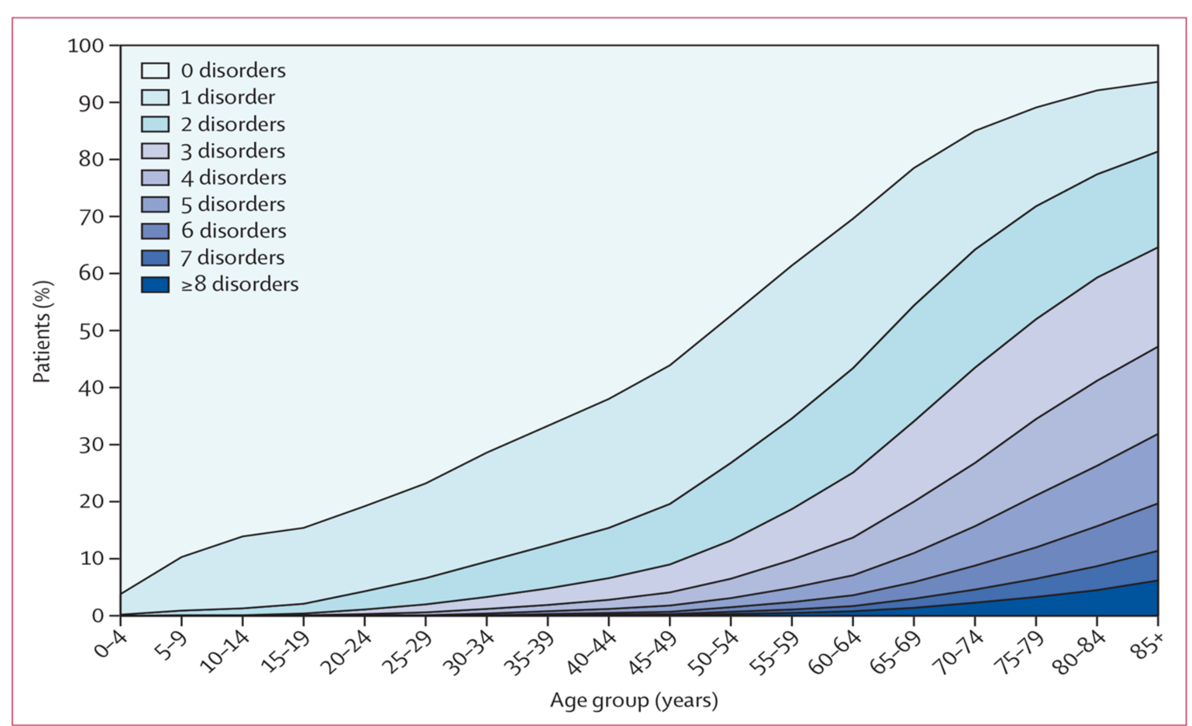
Healthy living and support to promote health improvement need to be key priorities in the Borders to continue to support good health.

People Living with Multiple Long Term Conditions

We know that many people in the Borders live with one or more long-term conditions. This may affect how they access and use services. We need to make sure that services are integrated around individuals with complex needs.

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

Figure 6 - Percentages of people having one or more long-term conditions, by age group, Scotland 2007



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

Disability

The needs of people living with disabilities and sensory impairments are distinct from those who live with one or more health conditions. According to the 2011 Scotland Census, 6,995 people in Borders live with a physical disability and 601 people with a learning disability. About 2,300 people are estimated to have sensory impairment.

What this means…

People with a disability need flexible support arrangements to maintain and improve their quality of life with services designed to meet their specific needs.

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

Learning Disability resources within NHS Borders and Scottish Borders Council Social Work were formally integrated in 2006. The Scottish Borders Learning Disability Service provides a range of specialist health and social care services for people with learning disabilities. The service is open to people with learning disabilities who need additional support to access other health and social care services, or whose needs are complex and require a more specialist intervention than that provided mainstream Health and Social Care services provided by the NHS and Scottish Borders Council, respectively.

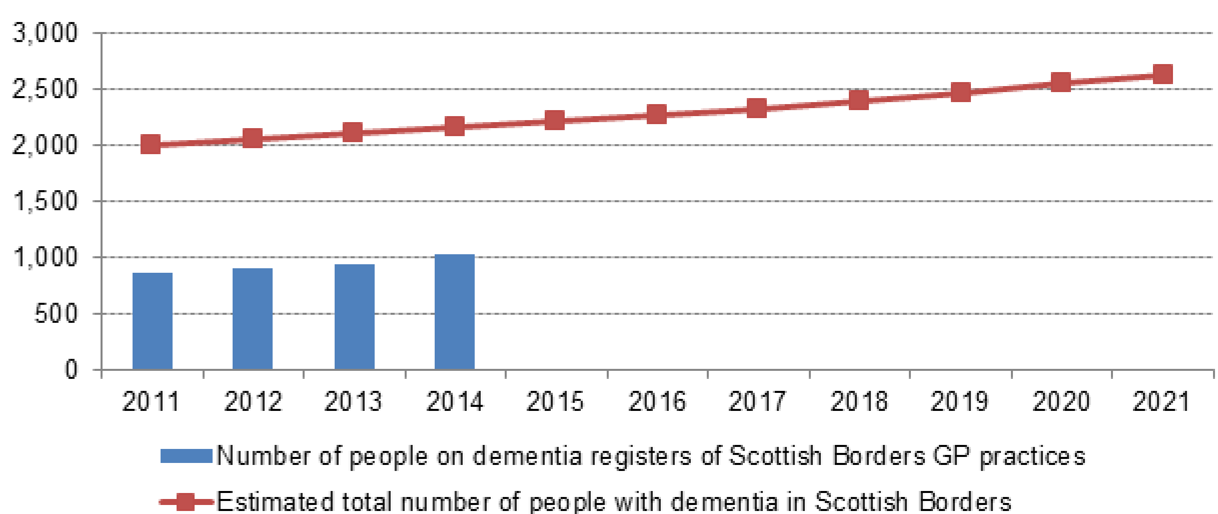
At the time of the 2011 Scotland Census, 612 people resident in Scottish Borders identified themselves (or were identified by a member of their household) as having a Learning Disability. 485 people in this group (81%) were aged 16 or over in 2011. Meanwhile, the total number of adults with Learning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

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

Dementia

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

Figure 8 - Projected potential raise in numbers of dementia cases in the Borders



What this means…

A range of support needs to be provided for people with dementia and their carers with appropriate staff training given.

People Living with Complex and Intense Needs

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

Analysis of expenditure in 2012/13 showed that:

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

Unpaid Carers in the Borders

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

There appears to be a link between deprivation and providing care as 46% of unpaid carers living in the most deprived areas of the Borders provide 35 or more hours of care per week, compared with 22% of carers living in the least deprived areas. Research also indicates that providing care for someone else affects the carer's own health. More carers (42%) than non-carers (29%) have one or more long-term conditions or health problems. Of people proving more than 50 hours of unpaid care per week 13% rated their own health as 'bad or very bad' compared with 4% of people who were not carers. Support for carers is an issue that needs to be addressed.

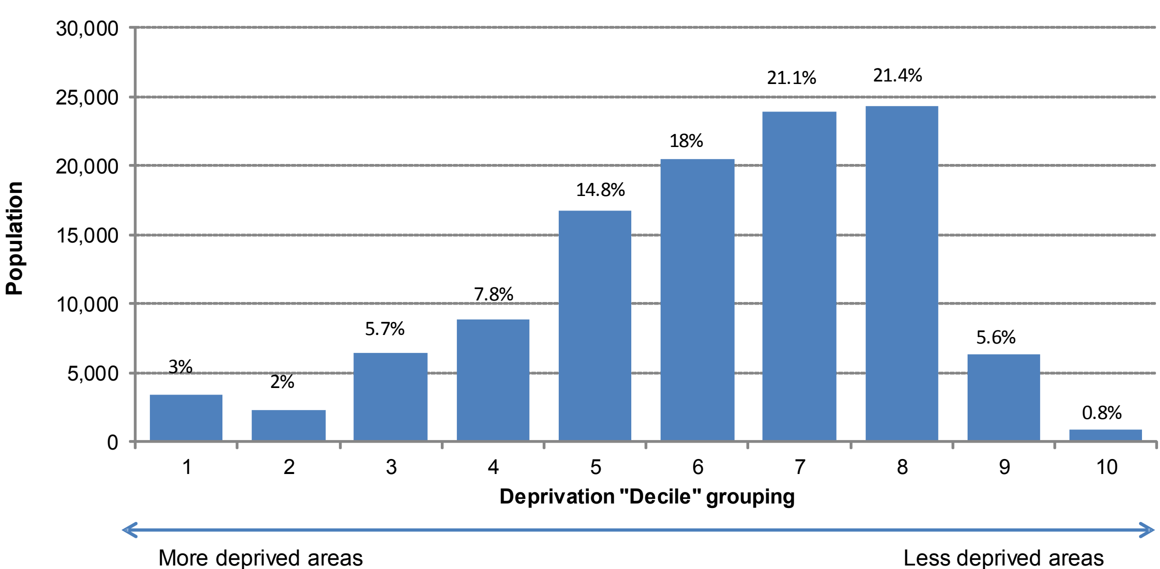
What this means…

A range of easily accessible information and carer support needs to be a key priority to ensure the wellbeing of carers and to support them in their carer role.

Deprivation in the Scottish Borders

Deprivation has a big effect on the need for, and use of, health and social care services. Taken as a whole, levels of deprivation in the Borders population are relatively lower in comparison to Scotland. Figure 11 below shows the spread of our population between 10 different categories of deprivation (with 1 being the most deprived and 10 being the least deprived). If our deprivation profile were the same as Scotland's, we would see about 10% of our population in each category. What we see instead is an uneven distribution, with clearly less than 10% of our population living in the most deprived areas. However, some of our local areas - in Burnfoot (Hawick) and Langlee (Galashiels) - continue to show as amongst the most deprived in Scotland.

Figure 11 - Spread of the Scottish Borders population between 10 levels of deprivation.



Source: Scottish Borders Strategic Assessment 2014.

What this means…

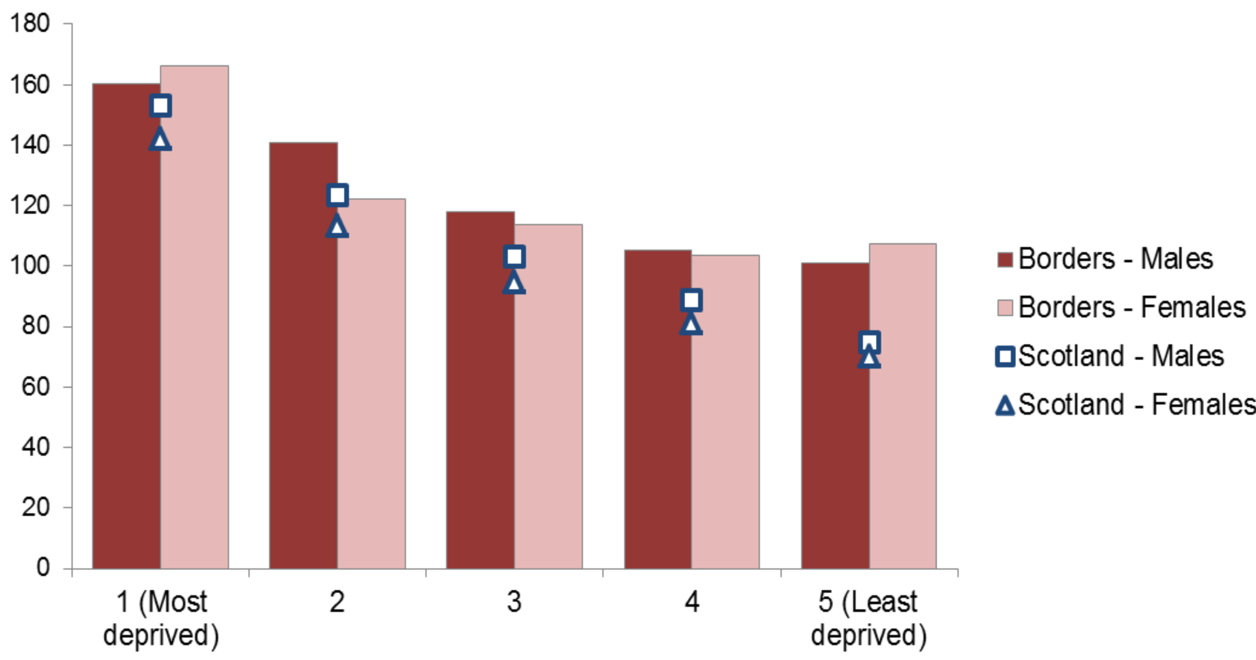
The Strategic Plan, therefore, needs to reflect the local needs of communities, recognising elements of deprivation.

Emergency Hospital Admissions by Deprivation

The Borders follows the national pattern of having higher emergency hospital admission rates for people living in areas of higher deprivation as shown in Figure 12 below. The figure also shows that emergency admission rates in the Borders are higher than the Scottish average within any given deprivation grouping.

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

Figure 12 - Emergency Hospital age-standardised admission rates per 1,000 population, by 5 deprivation levels 2011/12



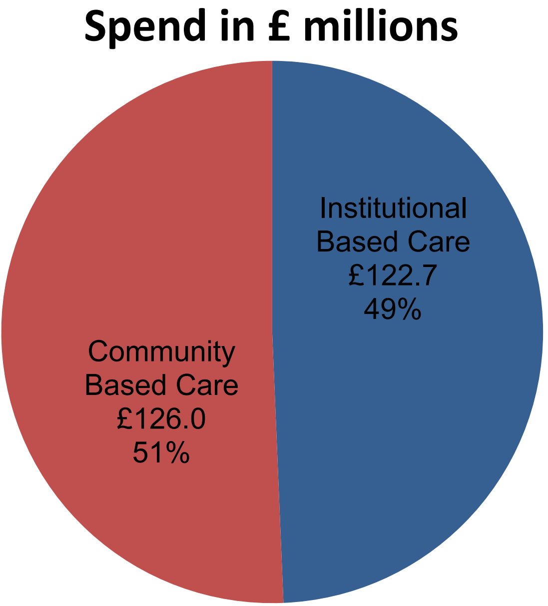
Source: NHS Health Scotland (March 2015) Hospital discharges and bed days in Scotland by deprivation 2011-12.

Health and Social Care Spending 2013/14

The total NHS and social care spending in the Borders in 2013/14 was £248.7m. The overall spending was split 51% Community-Based Care versus 49% Institutional Care.

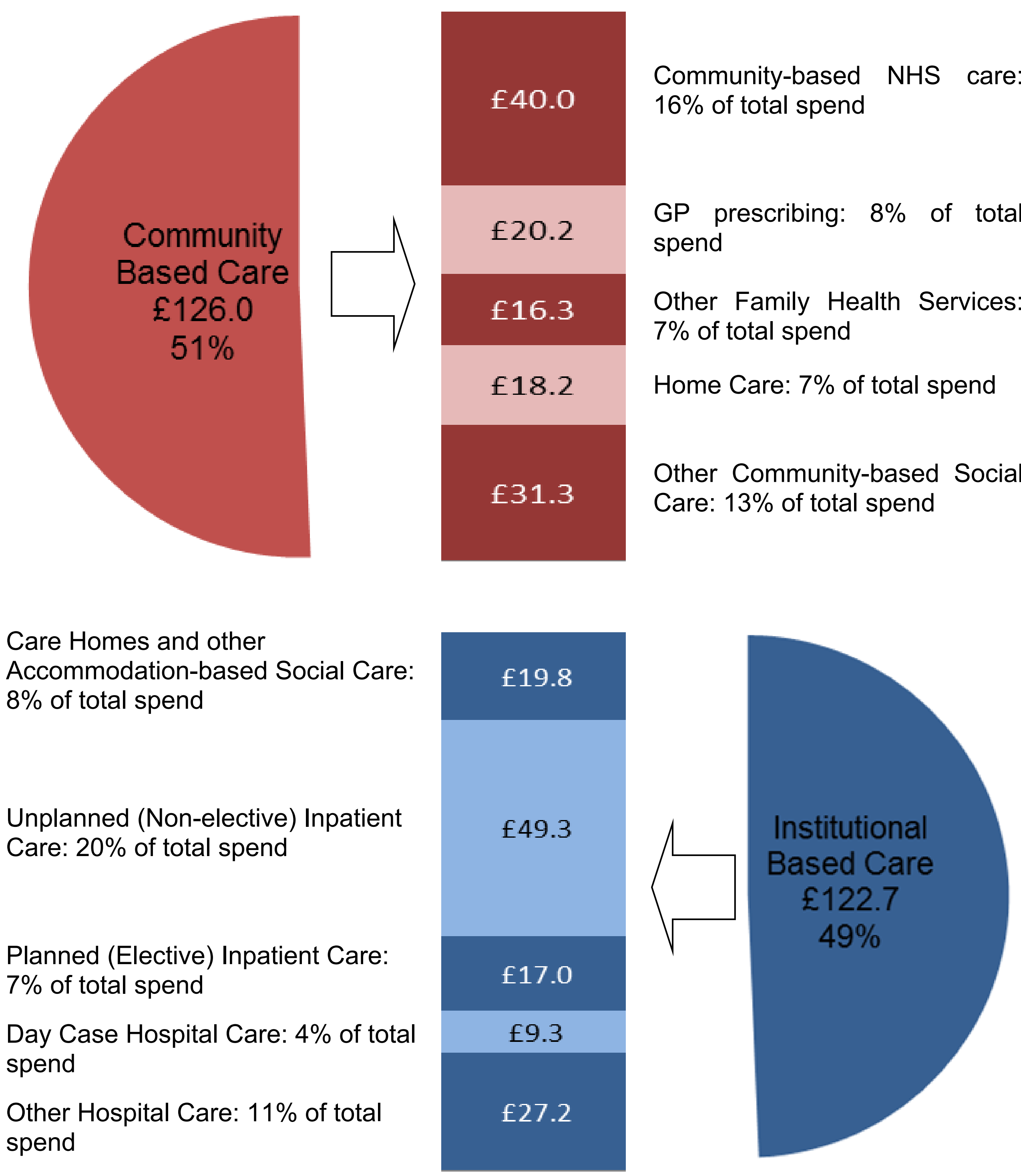
- *Community-Based Care* comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation-based social care services.
- *Institutional Care* comprises all hospital-based care including outpatients, day case and day patients,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

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



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

How this Breaks Down: Spend in £ millions in the Borders 2013/14



Note: totals do not match exactly, due to rounding.

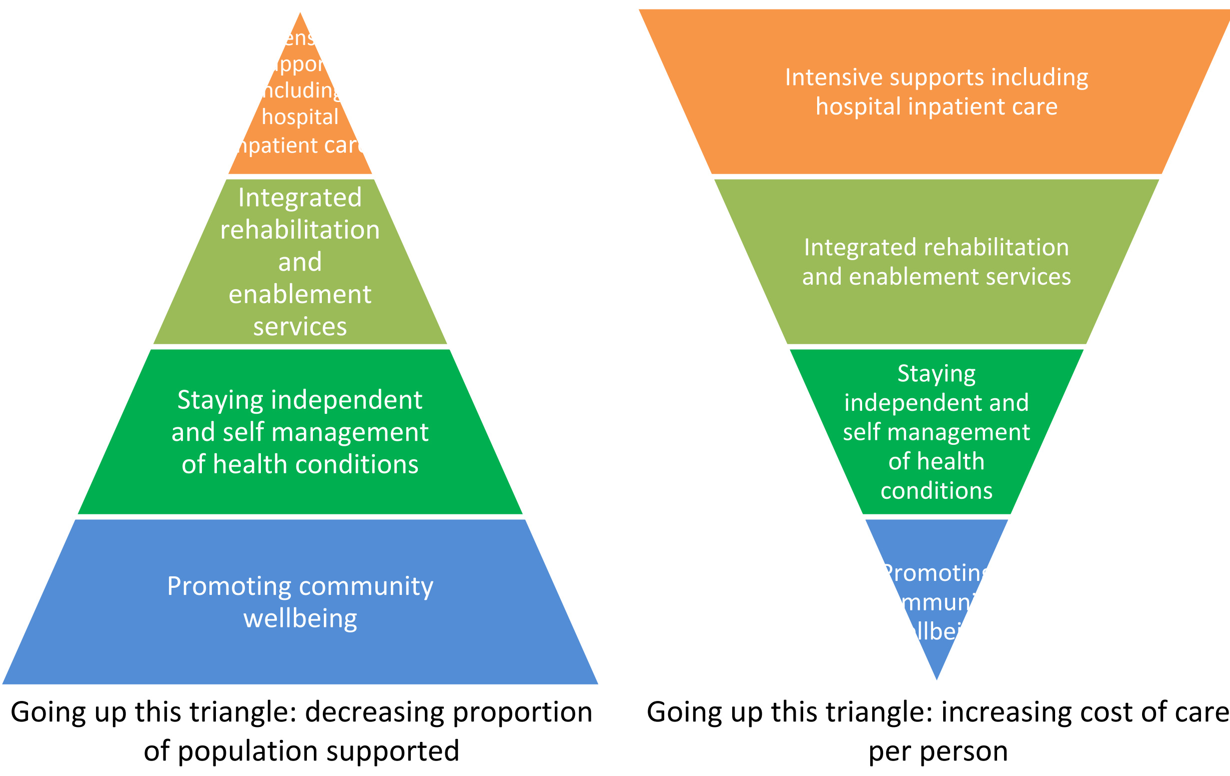
Source: Integrated Resource Framework (IRF), ISD, NHS National Services Scotland.

Shifting the Balance of Care Towards Prevention and Early Intervention

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

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

Figure 13 – Current Care Model



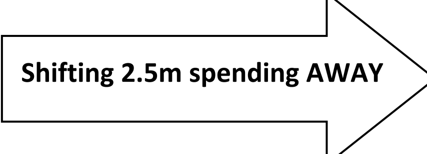
If we are able to improve health and well-being through preventive and supportive community-based care, resources can be moved and the balance of care shifted into the community as illustrated in the diagram below.

What shifts do we need to make?

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

2013/14 — By 2018/2019

Shifting resources FROM Unplanned Inpatient Care, Care Homes and other Accommodation-Based Social Care



£66.7 million

Shifting resources TOWARDS Community-Based NHS and Social Care (incl. Home Care) and Planned Inpatient Care

£106.5 million

£109.0 million

The next section of this document describes the actions we will take to make this shift, the outcomes we will seek and the steps we will take to deliver our local objectives. We will describe the performance measures we will use to assess the progress we are making. In what follows we have taken into account what you have told us was important to you.

What You Said and Our Plans

This section builds on the feedback we have received from our engagement with you over the past year. Each of our 9 Strategic Objectives is set out on the following pages with:

- a summary of your feedback relating to each objective
- an outline of how we intend to deliver what is needed to achieve the objective
- The activity identified in our current service strategies which relate to the objective
- related projects which are already underway
- what people can expect to see in terms of targets and outcomes against each objective over the next 3 years

Objective 9, *We want to improve support for unpaid carers to keep them healthy and able to continue in their caring role,* has been added as a new Strategic Objective following the last round of consultation in May and June of this year. This reflects the way in which engagement with the people who use and provide our services is central to the development of our Strategic Plan.

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

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

What we heard you say is important to you:

- Be clear in the way communication is delivered and consider the audience.
- Build on existing work to increase to community capacity.
- Use community-based education from early age to encourage better lifestyles.
- Ensure information is up-to-date, accessible both off- and on-line and improve how people are directed to services.

We want to:

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

This is how we intend to do this through our current services and strategies:

- Introduce area co-ordinators and involve service users in the design and delivery of services. (*Learning Disability*)
- Improve co-ordination for individuals and build capacity in communities to support older people at home. (*Older People*)
- Put people with dementia at the centre of planning and providing services and ensure they are able to live independently within their own homes and community. (*Dementia*)
- Improve information and advice to carers. (*Carers*)
- Strengthen partnership and governance structures. (*Drugs and Alcohol*).
- Achieve best outcomes for service users, foster recovery, social inclusion and equity. (*Mental Health and Wellbeing*)
- Improve access, develop integrated services, ensure quality services. (*Sensory Impairment*)
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (*Adult Support & Protection*)

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

- **Burnfoot Community Hub** – supporting the creation of a Community Hub facility to allow delivery of a range of community services and activities.
- **Borders Community Capacity Building** – supporting older people in Cheviot, Tweeddale and Berwickshire to establish or create new activities in their local communities – initiated through co-production and self-sustainable.
- **Locality Planning/Locality Management** – Taking into account the varying needs of the Borders population, we will have local plans and aim to devolve some services accordingly.

What you can expect to see over the next three years:

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

Objective 2: We will improve prevention and early intervention

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

What we heard you say is important to you:

- Be more proactive about providing early intervention and prevention: support people better/earlier, and promoting existing services e.g. health checks at GP surgeries.
- More Anticipatory Care Planning for people and their main carer.
- Work with other organisations, staff and people to develop integrated approaches to prevention and promote personal responsibility.
- More acute care and services in local communities.

We want to:

- Prioritise preventative, anticipatory and early intervention approaches.
- Focus services towards the prevention of ill health, to anticipate early-on the need for support and to react where possible to prevent crisis.

This is how we intend to do this through our current services and strategies:

- Help the growing pool of ‘young old’ people to stay well through prevention measures. (*Older People*)
- Reduce the amount of drug and alcohol use through early intervention and prevention. (*Drugs and Alcohol*)

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

- **Telehealthcare** – looking at how technology can be used to provide better home-based health care.

What you can expect to see over the next three years:

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

Objective 3: We will reduce avoidable admissions to hospital

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

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

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

We want to:

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

This is how we intend to do this through our current services and strategies:

- Helping older people to stay well through prevention measures; improving the coordination and help them in making their way through the health and social care system; building capacity in communities to support older people at home; and having appropriate housing in place to keep people independent.(*Older People*)

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

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

What you can expect to see over the next three years:

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

Objective 4: We will provide care close to home

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

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

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

We want to:

- Support people to live independently and healthily in local communities.

This is how we intend to do this through our current services and strategies:

- Introduce area co-ordinators and involve service users in the design and delivery of services. (*Learning Disability*)
- Work with other organisations so people with a physical disability can live as independently as possible; develop opportunities for people with a physical disability to fully engage in their local community; and improve access to public transport. (*Physical Disability*)
- Build capacity in communities to support older people at home and have appropriate housing in place to keep people independent. (*Older People*)
- Ensure people with dementia have access to services which enable them to remain independent within their own homes and community as long as practical. (*Dementia*)
- Develop a joint approach to commissioning; achieve the best outcomes for service users; foster recovery, social inclusion and equity; and achieve a balanced range of services. (*Mental Health and Wellbeing*)

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

- **Health Improvement –** To support people to live well with long term conditions – we will promote self-management to empower people and their carers to actively engage in creating individualised care.
- **Borders Ability Equipment Store** – Ensure provision meets the future demands of a growing elderly population which will require additional equipment, technology options and support.

What you can expect to see over the next three years:

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

Objective 5: We will deliver services within an integrated care model

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

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

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

We want to:

- Ensure robust and comprehensive partnership arrangements are in place.
- Pro-actively integrate health and social care services and resources for adults.
- Integrate services, staff, systems and procedures.

This is how we intend to do this through our current services and strategies:

- Improve integration of health and social care provision. (*Learning Disability*)
- Improve the coordination and help for individuals making their way through the health and social care system. (*Older People*)
- Developing an integrated approach to commissioning, and achieve a balance of services. (*Mental Health and Wellbeing*)
- Improve access and develop effective and integrated quality services. (*Sensory Impairment*)
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (*Adult Support & Protection*)

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

- **Mental Health Integration** – build on existing arrangements in Mental Health Service to integrate community teams.
- **Co-production approach** – working together between professionals and patients to review redesign and deliver integrated services.

What you can expect to see over the next three years:

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

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

Allowing people to have more choice and control of their health and social care services means they can receive the right services at the times they want to receive them

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

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

We want to:

- Ensure the principles of choice and control, as exemplified in Self Directed Support, are extended across all health and social care services.

This is how we intend to do this through our current services and strategies:

- Enable people with a physical disability to have choice and control over how they are supported to live independently. (*Physical Disability*)
- Ensure the needs of people with dementia are at the centre of all planning and provision of services specific to them. (*Dementia*)
- Improve the provision of information and advice to carers, improve quality of carer assessments/support plans. (*Carers*)
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (*Sensory Impairment*)
- Develop a multi-agency training strategy and programme, specialist development sessions and forums, disseminate knowledge, share good practice and enhance practitioner skills. (*Adult Support & Protection*)

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

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

What you can expect to see over the next three years:

- We want to increase the proportion of adults who received help and care services in the Borders and agreed that they were supported to live as independently from 83% (a little lower than the Scottish average of 84%) to 85%.
- We want to improve upon the 80% of those recipients of help and care services who agreed that they had a say in how their help, care or support was provided (lower than the 83% average for Scotland) to 85%.
  (Source: Health and Care Experience Survey 2013/14, Scottish Government.)

Objective 7: We will further optimise efficiency and effectiveness

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

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

- Improve clarity of decision making progress and enable decisions to be made quicker.
- Ensure that we make the most of our staff through training and flexibility and create more opportunities to offer additional support.
- Acknowledge and address changes from traditional roles like District Nurses and Carers.
- Value and support our volunteers.
- Make better use of our existing resources – buildings, people, and finance to ensure that they are sufficient and used as effectively and efficiently as possible.

We want to:

- Transform the way we provide services.
- Efficiently and effectively manage resources to deliver "Best Health, Best Care, Best Value".
- Support and develop our staff.

This is how we intend to do this through our current services and strategies:

- Make efficient use of the funding and other resources available. (*Dementia*)

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

- **Transitions** – focusing on young people who have a diagnosed learning disability and who are moving from children's to adult's services across Health, Social Care, Children's Services and Education to improve the transition.
- **My Home Life** – offer training to managers to help improve quality of life in care homes.
- **Focus on Outcomes Training** – deliver a new outcome-focused assessment for social care and associated training.

What you can expect to see over the next three years:

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

Objective 8: We will seek to reduce health inequalities

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

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

- Ensure openness and consistency around access to services.
- Work with communities to address loneliness, deprivation and inequality and empower them to develop their own solutions.
- Work with local transport providers across all sectors to provide appropriate and accessible transport services.

We want to:

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

This is how we intend to do this through our current services and strategies:

- Develop a Carers Rights Charter, ensure carer representation on Health and Social Care Partnership. (*Carers*)
- Reduce the amount of drug and alcohol use through early intervention and prevention, reduce drug and alcohol related harm to children and young people, improve recovery outcomes for service users and reducing related deaths. (*Drugs and Alcohol*)
- Improve access, develop effective and integrated services, ensure high quality of delivery of services. (*Sensory Impairment*)

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

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

What you can expect to see over the next three years:

- We want to improve and increase the number of adults who received help and care services in the Borders who agreed that they felt safe from 81% (lower than the Scottish average of 85%) to 86%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)
- We would like to maintain the downward trend in the Borders in death rates in people aged under 75.

Objective 9: We want to improve support for unpaid Carers to keep them healthy and able to continue in their caring role

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

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

We want to:

- Improve support for carers so they can avoid deterioration in their own health and well-being and prevent crisis.
- Encourage people to recognise their roles as carers and ensure carers are involved in decision making and planning.

This is how we intend to do this through our current services and strategies:

- Ensure the needs of carers are considered alongside those of the person living with dementia. (*Dementia*)
- Develop a Carers Rights Charter, improve communication and advice to carers, improve quality of carer assessments and support plans, ensure carer representation on health and social care partnership and produce a resource on issues relating to stress and caring. (*Carers*)

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

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

What you can expect to see over the next three years:

- We want to increase the number of unpaid carers reporting that they feel supported to continue caring from 41% (lower than the Scottish average of 44%) to 50%.
- We want to support unpaid carers in the Borders so that fewer carers feel caring has had a negative impact on their health and well-being and reduce this figure from 30% to 20%. (Source: Health and Care Experience Survey 2013/14, Scottish Government.)

Planning for Change – Key Priorities

A fund of £2.13m has been provided to integrate services. Detailed below are the priorities for 2016/17.

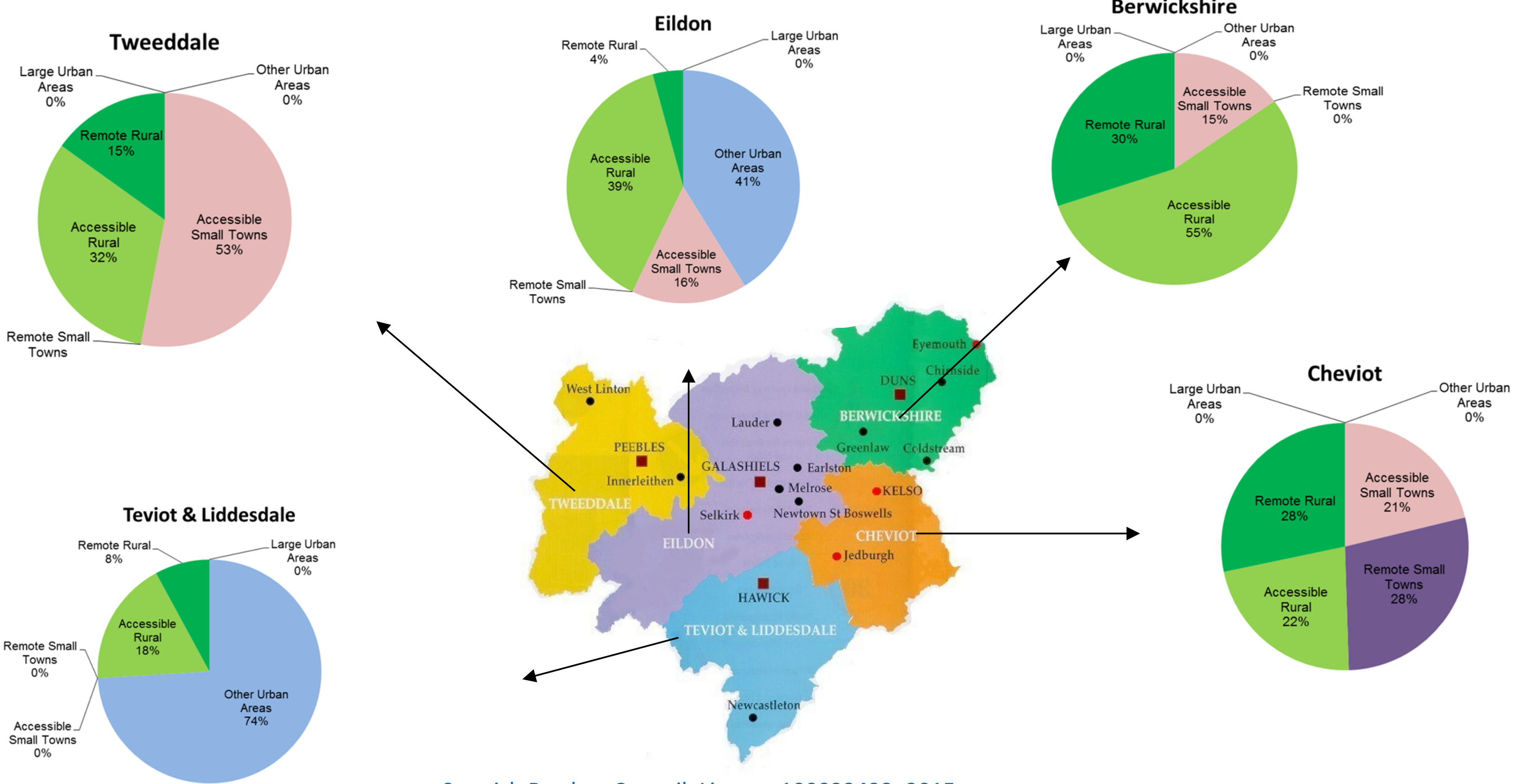
- To develop integrated accessible transport.
- To integrate services at a local level.
- To roll out care coordination to provide a single point of access to local services.
- Work with communities to develop local solutions.
- Provide additional training and support for staff and for people living with dementia.
- Further develop case for extra care housing for older people in Berwickshire.
- To promote healthy living and active ageing.
- To improve planning for young people moving from young people services to adult services.
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the Third Sector.
- Promote support for independence and reablement so that all adults can live as independent lives as possible.

Locality Planning

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

We have set up a group to oversee the development of planning in each of the five localities. Service users, carers, communities and health and social care professionals – including GPs – must be actively involved in locality planning so that they can influence how resources are spent in their area.

Working together in this way is central to our approach. Where appropriate, we will devolve resources towards the delivery of particular local outcomes. We will develop services in localities through discussion with individuals, families and carers. Planning groups will be established in each locality. The role of the locality planning groups will be to identify local priorities and help shape plans to address them.



Scottish Borders Council, Licence 100023423, 2015.

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

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

Our Area Forum Localities and their Urban Rural Population Profiles

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

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

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

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

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

What will Success Look Like

Services are integrated and there is less duplication

People are involved in planning their own care

There is easier access to services through a single point of contact

The benefits of new technology are realised

People with multiple long term conditions are supported

Make best use of staff.

There is a shift to early intervention and prevention for children and young people, families and carers

Spend money wisely

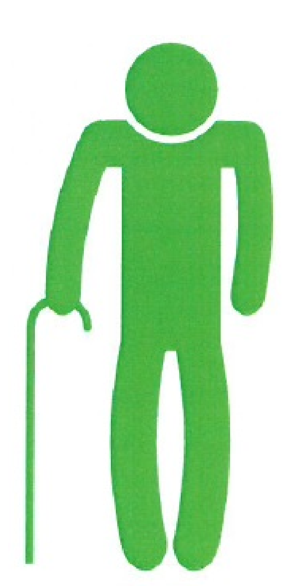
Planning for Integrated Services

The case on the next page is here to illustrate how ordinary people should experience a better integrated health and social care service.

PAMELA, 57	I'm Pamela and I've lived in Innerleithen most of my life. I live with my husband Owen and our daughter Jane. My 83 year old Father lives in sheltered housing nearby and our eldest daughter Jillian lives 7 miles away in Peebles. I have a lot of friends who live in the area.			
		MY SITUATION	**MY THOUGHTS**	**INTEGRATION FOR ME**
	CARING	I look after my 3 year old grandson, Jack, 3 times a week. I visit my elderly father every day and I am the first responder to his Bordercare alarm. I recently had a Carer Assessment carried out.	I recently realised how much I've been looking after my Father. I love my Father and I want to care for him, but sometimes, I resent being his first responder and I feel I sacrifice things that are important to me to look after him. I feel guilty for thinking these things. Sometimes I don't understand what's happening with his care. I worry a lot about him.	• Coordinated health and care teams • Single point of access • More support for unpaid carers • Clear information on available services
	HOME	I live in a modern, rented house. My husband Owen and I don't drive so we rely on public transport.	I love where I live and I like that I can walk to shops and the bus stop. But I find organising transport to get my Father to appointments can be really difficult.	• A single number to book transport • Easier access to more coordinated services
	FAMILY	Owen recently retired for health reasons. My Father has dementia and is prone to falling. Jane is taking her higher exams. I love looking after Jack and seeing Jillian. Her partner Bill is nice too.	Owen is eight years older than me. He struggles with depression and I feel I need to be with him, which can result in me not being able to spend enough time with my Father or Jane. My Father falls occasionally. He has been recommended to attend gentle exercise classes but he says no.	• More ways to address social isolation in a community • Building community capacity to support people in communities
	WORK	I work part-time in a shop in nearby Galashiels.	I've considered reducing my hours to spend more time with my Father and my family, but I can't for financial reasons. I often have calls to make or receive about my Father when I'm at work which is challenging as I've limited flexibility. I sometimes have to take leave to take him to appointments.	• More options to support people to attend appointments • Increased health and social care service hours.
	HEALTH	I've high blood pressure, arthritis and anxiety. I'm a cancer survivor. I take many prescription drugs. I've been a heavy smoker for years.	I don't take the best care of myself because by the time I've looked after my Father, grandson, Owen, daughter, been to work and volunteered at Church I'm often too tired. I tend not to tell Owen about my worries because of his depression. Smoking helps me feel more relaxed, but I've noticed I smoke more now. I'm quite anxious so I was grateful that the Carer's Assessment lady listened to me.	• Locally available acute health and care services • Anticipatory care planning for my Father, Owen and me • Coordinated teams with a lead worker
	COMMUNITY	Owen and I have many friends here. I enjoy volunteering at my local church.	We have a good community with neighbours and friends helping out. I've school friends and friends at Church, so every once in a while, if things are ok, I meet them for lunch. My Father is isolated and he would really like visits from people as he has trouble going out.	• Building community capacity to support people within communities

CHARLIE, 78

I'm Charlie. I've lived in Kelso since I retired here 15 years ago with my wife, Sandra, who died 5 years ago. I've been alone since. My 2 children live far away. They come for visits, but they have busy lives and their own families. I love Kelso, I feel safe and happy here, apart from being so far from my family.



	MY SITUATION	MY THOUGHTS	INTEGRATION FOR ME
CARING	I am a widower. I don't need health and care services at the moment.	I feel capable, but having recently had a fall, I had a bit of a fright and I was admitted to hospital for a short while. It was sad as I had no visitors which made me start to think about what would happen to me when I do need more help. I don't want to be a burden to my children. I always thought I would grow old with Sandra. There are home carers who can help me, but I would prefer to have someone I could rely on, not a lot of different people.	• Ensure appropriate staff and services in place when people need them • Review Home Care to adapt to changes in carer roles • Local coordinated and integrated teams
HOME	I live in a 3 bedroom house with a large garden, on the outskirts of the town. I drive, but I'm less confident now so I don't like driving.	I know my house is too big and I cannot manage the garden alone, but I don't want to move and start over with a new house and neighbours. I'm a 10 minute walk to the bus stop and buses are regular but if I need to go to the Hospital, I have to change buses. I feel I need to drive more and more.	• Coordinated local transport • Bigger range of locally based housing options
FAMILY	My son Paul lives in England. My daughter Steph and her family moved to Florida 3 years ago.	Paul visits every couple of months. I can see he's worrying about me and I know Steph feels guilty for being so far away. I want to be able to reassure them I have a plan for any future needs and that I can support myself. Paul wants me move near him but I don't deal with change very well.	• Anticipatory Care Planning
WORK	I'm retired. I had to step back from my voluntary work at my bowls club which I enjoyed.	I liked being Treasurer of my local bowls club. My friend introduced me to bowls and she takes me when she can, but she can't make it every week. I had to give up being Treasurer as it became too much. I don't feel as fulfilled as I did. I would love to do more voluntary work.	• Appropriate volunteering opportunities for older people
HEALTH	I'm slowing down and finding things harder. I've many medications, I'm not sure what they are and why I take them.	I like to keep active and I do drive when I need to, usually to appointments and shops. It was a scary when I fell, but I don't think I needed to go to the emergency department, but I couldn't be checked locally. I felt very overwhelmed by the number of people asking me the same questions – surely the staff can look it up on my medical notes?	• Locally based services • Better information sharing across organisations
COMMUNITY	When Sandra was alive we did lots of things together, but it's not the same without her.	I feel lonely without my wife and not as confident to socialise with people. My neighbours are lovely, but I don't see them as often as I used to. I wish there were more activities and groups for older people like me.	• Community based groups and activities

Planning into the Future

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

Throughout the last 12 months we held a number of engagement events for both the public and staff. The information we received from these events has been used to inform this document. For example, the 9th local objective on support for unpaid carers was added as a direct result of your feedback. Thank you to all who came along and contributed.

In the coming months, we will be arranging another round of events to discuss this draft and how we can improve on it in developing the formal Strategic Plan by the end of March 2016. We want to know what you think about this second draft and look forward to receiving your feedback.

We Want to Hear From You

Some suggested questions:

1. Have we got the right priorities, if not what changes would you like to see?

2. Do you think the targets set out in the plan (on pages 24 to 32 at the bottom of each page) are ambitious enough or too ambitious?

3. Do you think the plan will address the concerns of your community, if not what changes would you make?

4. Is there enough detail or information in this plan for you and, if not, what more would you like to see?

5. Is there anything else that you think we should be doing apart from the projects outlined within this document?

APPENDIX A: Services that are Integrating

Which health and social care services are we integrating?

Our partnership will be responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The total resource within the partnership is £135.2 million. The partnership has a key relationship with acute services in relation to unplanned hospital admissions and will continue to work in partnership with Community Planning Partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, we can also work in partnership with our communities.

Social Care Services

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

Acute Health Services

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

Community Health Services

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

APPENDIX B: The National Health and Wellbeing Outcomes

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

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

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

APPENDIX C: The Local Objectives and the National Outcomes cross-referenced with the Local Objectives

The Local Objectives are:

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

The National Outcomes cross-referenced with the Local Objectives

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