Older People's Joint Commissioning Strategy

A Plan for the Future 2013 – 2023

ScottishCare
The voice of the Independent Care Sector in Scotland

NHS Borders

Scottish Borders Council

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1. INTRODUCTION

1.1 This Strategy is a key development which sets out the vision for older people's services in the Borders over the next ten years. Delivering these services will be challenging, particularly at a time when there are reduced resources to deliver services and where demographic trends indicate a significant increase in the population of older people and carers.

1.2 The Strategy has been developed using a strategic commissioning approach.

> *Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.*

Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.

1.3 The Strategy has been developed by the Reshaping Care for Older People Partnership, after reviewing:

- The views of the public, service users and carers
- Information about the future make up and needs of the Scottish Borders population (Joint Strategic Needs Assessment)
- The services currently provided

1.4 This Strategy sets out the future commissioning intentions of Scottish Borders Council, NHS Borders and partners in the Independent Sector and Voluntary Sector. It is primarily focused upon the health care, social care and wellbeing of the 65 plus age group and complements other plans and strategies that affect older people.

2. EXECUTIVE SUMMARY

This Strategy sets out the principles and identifies key actions by which we will design, fund and deliver services for older people for the next ten years. The Strategy aims to ensure we develop the right services to meet the needs of the population of the Scottish Borders over this time.

The Strategy has been developed by the Reshaping Care for Older People Partnership comprising of representatives from NHS Borders, Scottish Borders Council and the Voluntary and Independent Sectors.

What do people want from services?

During 2012 we undertook a series of locality consultation exercises with service users and other stakeholders across the Scottish Borders. In summary, the consistent themes from these sessions were:

- A desire for joined-up services
- Flexible and personalised services
- Better information
- A single point of contact
- Better support for carers
- Improved transport systems
- Appropriately trained staff, especially carers and other staff trained in how to manage people with particular needs or conditions (e.g. dementia)
- Improved support and opportunities for social interaction
- Better and more flexible housing options
- A greater use of co-production – the involvement of service users in the design and planning of the services they use

Commissioning principles

We have used the Institute of Public Care (IPC) model for strategic commissioning.

People who need help and use services do not recognise the formal divisions between health, social care and other services and we cannot allow organisational boundaries to get in the way of delivering quality services. The principles underpinning the commissioning of services are:

- Person-centred delivery of older peoples services
- Services run efficiently and effectively
- Flexibility of service provision
- Positive risk management
- Designing services together

Commissioning outcomes

We have focused the outcomes that this Strategy seeks to deliver around the needs of the individual. These are:

- Having choice, dignity and control
- Keeping healthy and feeling well
- Enjoy, achieve and contribute
- Keeping independent with support and care when and where it is needed
- Keeping safe
- Supporting carers

Joint Strategic Needs Assessment

The Scottish Borders faces significant challenges over the period of this Strategy which includes:

- There will be a 100% increase in the over 75 age group and a 50% increase in the 65-74 age group in the next 25 years.
- Whilst the older people's population rapidly expands, the working age population is forecast to reduce.
- The number of older people with a long-term condition is set to increase and a major challenge will be caring for people with multiple illnesses and long-term conditions.
- There is a high and above average number of emergency and multiple admissions to the Borders General Hospital (BGH) and community hospitals.
- The most common reasons for admission to the BGH and community hospitals during 2011/12 were urinary infections, stroke, lung and heart disease for the 65+ age group regardless of gender.
- The number of people aged 65+ with dementia rises steadily with the increase in the aging population.
- Almost 30% of the older people's population are termed as being 'access deprived'.
- Single pensioners account for more than 1 in 5 of all Borders households and 85% of people over 65 live in ordinary housing.

Commissioning intentions 2013-23

From this information, the following themes will determine the investment of resources to deliver services to older people for the future:

- Coordination and navigation for individuals through the health and social care system
- Integrated provision capable of providing responsive and individualised services
- Building capacity in communities to support older people at home
- Specific areas of focus – falls, dementia and long term conditions
- Improved transport arrangements
- Housing solutions to keep people independent
- Involving and supporting Carers
- Locally delivered care

3. WHAT OLDER PEOPLE TELL US?

During 2012 we undertook a series of locality consultation exercises with service users and other stakeholders across the Scottish Borders. In summary, the consistent themes from these sessions were:

- A desire for joined-up services
- Flexible and personalised services
- Better information
- A single point of contact
- Better support for carers
- Improved transport systems
- Appropriately trained staff, especially support workers and other staff trained in how to manage people with particular needs or conditions (e.g. dementia)
- Improved support and opportunities for social interaction
- Better and more flexible housing options
- A greater use of co-production – the involvement of service users in the design and planning of the services they use

In more detail, feedback comments included:

- People welcomed the moves to more individual services, acknowledging the success of the publication of the 'Ageing Well' handbook and commented that joint services should be better publicised.

- People wanted all those providing services to older people to be committed to re-balancing care, better co-ordination in hospital discharge and outpatient services.

- When asked what services might be developed many attached importance to services designed for individuals, improved information services with a single point of access/ contact for all social care and health services, improved support and identification of support to carers, better co-ordination of and responsive transport provision and more contact/social interaction with other people.

- People emphasised the need for staff within care homes and homecare to receive adequate dementia training along with greater positive staff development and career opportunities to maintain people in the profession.

- The personalisation of services was regarded as a positive development with service users placed at the centre. Information should be widely available to explain this approach and the range of services available.

- The availability of responsive and flexible transport provision from a range of providers with suggestions that it might be better planned with local populations – to meet specific needs and demands.

- Housing suggestions included the requirement for modernised quality housing accommodation in all forms, inclusive of care and support services, with good information being available on different housing/accommodation types and how to access and pay for them.

- When asked what would assist carers, key themes were to have flexible respite arrangements, improved support to carers and greater identification of carers and carer's needs.

- Increased availability of both general and targeted information covering all services, including information on new ways of providing care and health services (e.g. Telecare), how to access them, along with other types of support and any charges.

As well as general consultation, the Strategy has been developed based on user stories. In particular, in developing the themes of the Strategy, a composite case study, Mrs Scott, was developed. Mrs Scott became the touchstone against which the proposals within the Strategy have been assessed.

Mrs Scott Case Study:

Mrs Scott encounters daily frustration in navigating the health and social care system.

Mrs Scott is 81 years old, has diabetes and has had a stroke for which she was hospitalised and required rehabilitation in order to return home.

She has slight memory loss and her diabetes can be unstable. She has poor mobility due to her stroke and is at high risk of falling. Due to her diabetes she has a leg ulcer which is being dressed by the District Nurse. She is prone to Urinary Tract Infections (UTIs) which exacerbate her cognitive impairment. Due to the falls and the UTIs she has recurrent admissions to hospital.

She has equipment in the home such as a stair lift and other aids to assist with her mobility. She receives a package of care three times a day and care managed by the local Social Work office. She has family living near by and they visit regularly and she still attends church. She is in receipt of the frozen meal service and has a Bordercare Alarm. There are allegations of financial abuse which have been reported to Social Work.

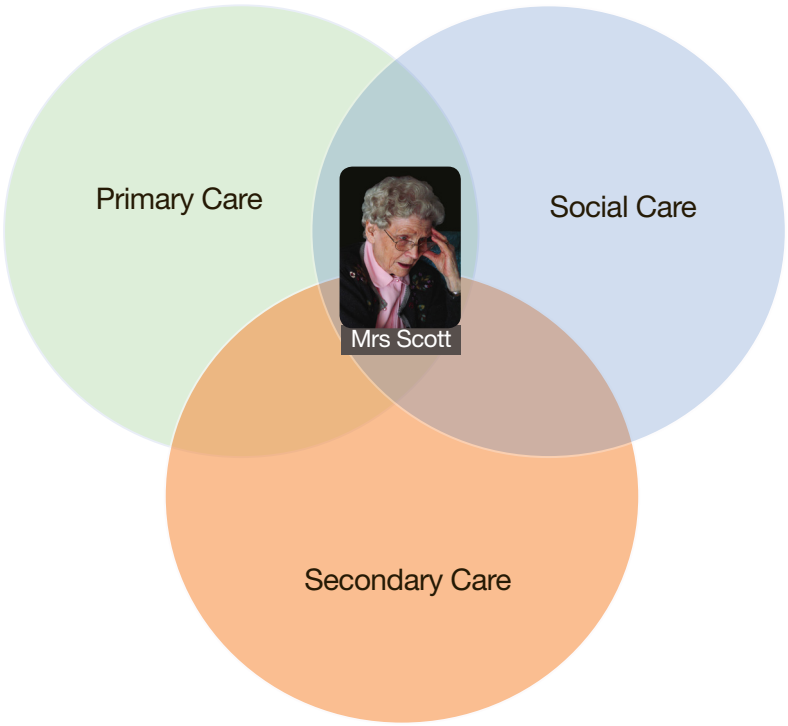


Figure 1

We propose Mrs Scott as a way of keeping our planning and delivery of services focused on delivering what is right for the people of the Scottish Borders.

4. MODEL OF COMMISSIONING AND WORKING TOWARDS OUTCOMES

4.1 Model of 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.

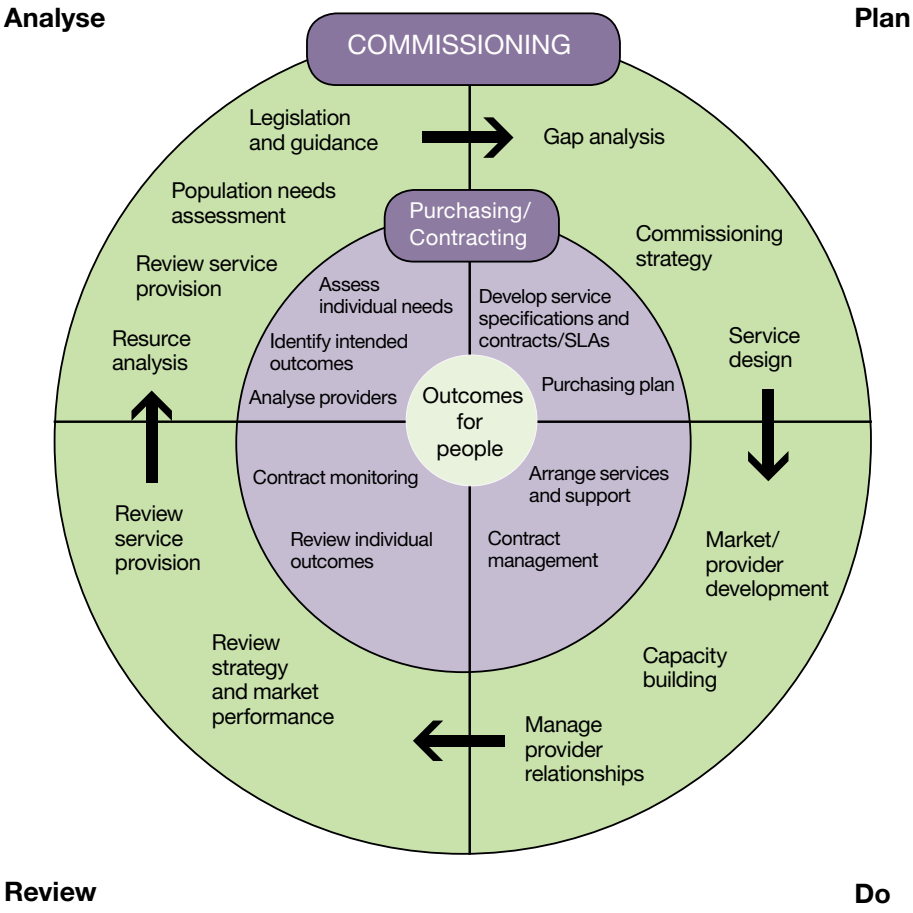


Figure 2

4.2 Commissioning services for older people

This Strategy provides an approach for the joint commissioning of health, social care and other support services for older people.

- It describes the commissioning intentions of NHS Borders and Scottish Borders Council in conjunction with the Third Sector for the next ten years to 2023.
- It has been developed by gathering information from what older people tell us, the changing needs of the population, and national and local priorities and comparing these to the current patterns of service delivery and spending. This information enables us to continue developing services that more accurately meet the needs of older people in the Scottish Borders.
- This Strategy takes the themes from a large number of other plans and/or strategies that relate to services for older people and their carers. The purpose of this is to enable commissioners to take a co-ordinated approach to service development and delivery across a very large and complex range of services from many different providers.
- The Strategy encompasses other work locally to achieve the vision set out in the national Reshaping Care for Older People – A Programme for Change, the emergent Borders Community Planning themes and our own perception of the future as outlined by the Borders Community and Health Care Partnership through supporting healthy communities capable of:
  - Promoting health and wellbeing and delivering equalities
  - Building solutions with local communities
  - Providing care as close as possible to home
  - Making the best use of resources
- The specific focus of the Strategy is on health, social care and early intervention/ preventative services, the commissioning arrangements for which are under the governance of the partners and the relationship of this approach to other forms of care is defined in the tiered approach outlined in figure 3 below.

Tiered - Approach to Care

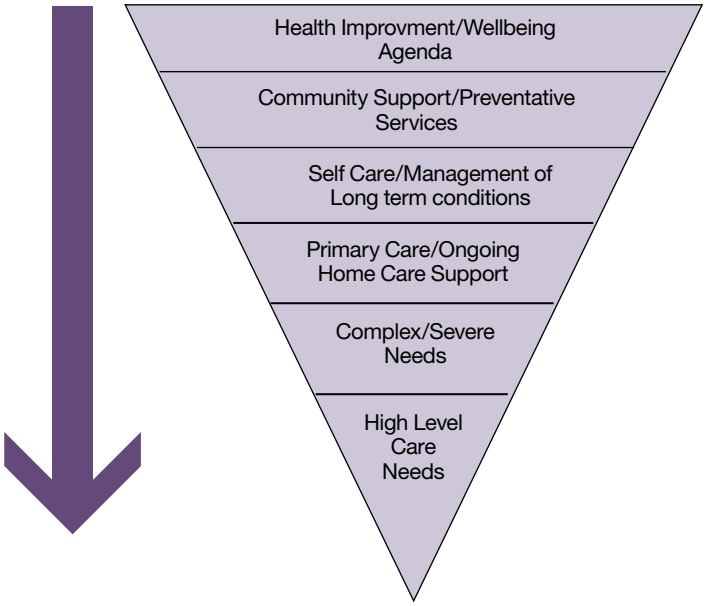


Figure 3

4.3 Working together: Commissioning Principles

- People who require assistance, use services and their carers do not recognise the formal divisions between health, social care and other services means we cannot allow organisational boundaries to get in the way of delivering quality services. Local public sector organisations need to work with the third sector and private providers to help shape the market to deliver the personalised options for support and care that older people and their carers need.

- To achieve this, the following principles will guide the process when NHS Borders and Scottish Borders Council, in conjunction with other parties, commission services for older people:

Person-centred delivery of older peoples services. Services should be designed to support a person by providing the assistance the person and their family and/or carer requires. All care and support providing personalised care should be based on outcomes/goals that the older person agrees with us. Services will, as far as possible, be provided when the person requires them, where they would like to receive them and delivered by the people most appropriate to the older person.

Services need to be run efficiently and effectively. A focus on developing services that use limited public resources as effectively as possible will underpin service models. It is anticipated that this will mean an emphasis on community provision and the use of bed-based services only where absolutely necessary.

Flexibility of service provision. Underpinning person-centred service delivery is recognition that different people will want different services, and there needs to be flexibility and a suitable menu of service options available to individuals and their families and carers.

Positive risk management. Developing personalised services requires weighing up the potential benefits and possible negative outcomes of one choice of action over another, identifying the potential risks involved, and developing plans and actions that reflect the positive potential and stated priorities of the service user.

Designing services together. All services should be developed by providers, service users and their carers together ('co-production'). We aim to make this a routine part of the development of services to support the measures outlined in this Commissioning Strategy. This will mean different ways of working for all partners and will require investment in training and support to ensure that service users and service providers have the required skills and tools to permanently adopt this approach.

4.4 Developing the market

- The market will need to diversify the products and services it offers older people and their carers in the Borders to meet needs in the future. As people increasingly use individual budgets or their own funds to buy the services they need, the demand for a range of high quality, value for money services will grow.

- The integration of adult health and social care as envisioned by the recent Scottish Government Consultation Paper on Integration of Adult Health and Social Care in Scotland will see changes in how services are commissioned and delivered in future.

- Service provision will need to focus much more on delivering person-centred, high quality, preventative services. It is important that older people benefit to the full from the opportunities offered by personalisation. Commissioners and providers will need to work together.

- Challenges also apply to public sector providers, where organisational change is required to deliver better services during a challenging economic climate. More formal joint working structures will need to be considered and established between health, social care and other services in the future.

4.5 The economic context

- Health and social care services are facing an unprecedented financial challenge to reduce costs and meet growing demand. Commissioners must ensure that services are cost-effective, provide value for money and achieve good outcomes for people. This will result from working with service providers to redesign or decommission services, to deliver services in ways that maximise use of the fixed resource available and transform the way services are delivered.

- Across health and social care - resources can be spread further by assisting people to stay well and independent for as long as possible, for example through re-ablement and potentially reducing the need for care; by ensuring that people receive care and support in the most preferred, individualised and cost effective way to meet their personal outcomes.

4.6 Making the Strategy a success

The outcomes listed above and the commissioning themes will inform the basis of a joint Implementation Plan. Success criteria are identified under each commissioning theme, to highlight the way in which we will be able to see if we have made changes to older people's experience.

4.7 Our six commissioning priorities

We regard it as fundamental to build services around the needs of the individual. The following priority areas reflect the main personal outcomes as developed through research and analysis, in particular the national "Talking Points" personalised outcomes project.

It is fundamentally important that services for older people meet the needs of the individual. Assessments should also include an offer of a carers assessment to allow carers to be fully included as partners in care.

National policy in both health and social care increasingly encourages the Council and NHS Borders to ensure that we develop systems, processes and direct involvement with people to provide more individualised services.

This approach increasingly informs all aspects of public services. Services that are specific to older people and those that might be used by all of the Borders population are designed and delivered with the needs of older people and their carers in mind, especially those used by people when they are at their most vulnerable, for example when in hospital or at the end of their life. At such times the promotion of appropriate services relevant to the person's specific circumstances and needs is at its most important.

In the Borders we are proud of our increasingly diverse population. We want older people and their carers to enjoy the rights and entitlements that other people take for granted. By taking advantage of these rights and entitlements as a fully active citizen in the Borders, there is also the expectation that they will exercise their choice and control in a fair and contributory way.

Having choice, dignity and control

- Have greater choice and control over how older people live their lives through personal budgets
- Have accurate and easily accessible information about services
- Full involvement in the commissioning process

There are many effective services already provided to support older people and their carers in the Borders. Older people, in common with the whole population, live within formal and informal communities and rely on their immediate families, acquaintances and communities for the vast majority of support and assistance they require. The most common feedback about existing health and social care services is that people are not aware of them, do not know how to access them and do not understand who provides which services.

We will jointly build systems that allow service users and their carers to identify and access the services they require in a seamless and effective manner. This means:

- Providing information at your fingertips – in formats that suit the needs of all and are accessible in a variety of different ways.
- Getting the same advice – we will ensure that staff and service providers provide consistent and detailed information to the level required by service users and their carers and at the time they require it.
- We will ensure that everyone who needs additional support to navigate and identify the services they require will be able to and feel comfortable to access that support.
- We will build on new models that give service users the ability to design their own support packages, through self-directed support, to ensure that people receive the care that they have determined is right for them.
- We will support models such as self-management that allow older people to effectively manage their own health conditions and take responsibility for their own care.
- We will ensure that older people and their carers are aware of their statutory rights to services.

Keeping healthy and feeling well

- Individuals and communities are able and motivated to look after and improve their health and well-being, resulting in more people living in good health for longer with reduced health inequalities
- More older people and their carers will achieve real improvements in their health and well-being as a result of improved access to health services and other services making a greater contribution to enabling older people and their carers to stay healthy

Being unhealthy and feeling unwell, both physically and mentally, has a major impact on our quality of life. As a result older people and their carers will make a greater call on both health and social care services.

Through a combination of factors, such as deprivation, economic circumstances and housing, people of all ages experience higher levels of poor health. As people get older there is a greater likelihood of a depressive illness or a condition such as dementia or carer stress.

People often do not understand the distinction between health and social care services but if services are provided with people in mind that should not be a stumbling block. Services need to be joined up so that older people can be confident that their doctor or community nurse, social worker, home carer or housing with care worker are working together for their benefit.

Through the development of early action, placing greater emphasis on preventing illness and in promoting well-being, the health of the wider community and of individuals will be improved. As the population ages, this will include an emphasis on supporting people with long-term conditions and their carers to live with their illness, maintain their independence and control over their lifestyle.

Enjoy, achieve and contribute

- Older people have positive experiences of health, social care and support services which help to maintain or improve their quality of life
- More older people and their carers will be included in activities that they say assist them to feel they are making a positive contribution to their communities, and more people will say they felt listened to and valued by their communities

Being active and involved helps people to feel better about themselves and to be more valued by others. Older people and their carers have a lot to offer their communities through a variety of informal and formal social activities with their families, friends, neighbours and colleagues.

Keeping busy and active, physically and mentally, does a lot to maintain good health and a positive mental attitude. People who have regular social contact and who access local amenities such as shops and leisure centres, maintain their independence, quality of life and their mental health.

Grandparents are making an increasing contribution to the local economy of providing free childcare to enable their children to work, or looking after their grandchildren to keep them safe.

Future delivery of health and social care services will be collaborative and older people will not only feel involved in the delivery of their care, but will be an essential element of delivering services to others within the community, through volunteering, befriending and general community support.

People need to feel able to influence and direct the work of the statutory and voluntary agencies, who provide services for older people and their carers. These agencies need to provide easier and more responsive ways of enabling people to contribute to the way they operate.

Keeping independent with support and care when and where it is needed

- People with disabilities, long-term conditions or who have become frail, and their carers are able to live as safely and independently as possible in the community and have control over their care and support
- More older people will be supported to reach optimum independence as a result of improvements in the way we assist people to avoid and recover from illness and injury e.g. re-ablement

More people are living to an age where they are more likely to be physically frail or have a dementia related condition. The predicted growth of our area and the knock-on health implications provides sound evidence for the future needs to be identified. We will develop commissioning processes to widen choice that will deliver reliable, effective, and high quality joint services. We will need to provide new services and some existing services in a different way and move towards more integrated health and social care services which remove barriers, and allow the development and provision of seamless, cost effective services for older people.

Older people have worked hard to create a home that holds memories and emotional attachments. As a consequence many older people want to stay in their own homes. However, this can become difficult if their home is not designed to meet their changing needs if they develop frailties or disabilities.

When people experience illness, short or long term, or have spent time in hospital, they need support that aids quick recovery and the ability to manage their health problems while maintaining independence and control over their own lives. To address these challenges we will work with our partner organisations to expand the range of community-focused health services including specialist nursing care and crisis support that will allow older people to remain independent at home.

We aim to provide the right kinds of services and support which will avoid the need for residential care, or delay this for as long as possible. Wherever possible these services will be close to people's homes and at a time when their need is identified. We recognise that with our partners we need to respond to our residents, as consumers, by allowing them to exercise choice that enables them to receive high quality care that meets their needs more effectively.

Keeping Safe

- Older people using health, social care and support services are safe guarded from harm and have their dignity and human rights protected
- More older people and their carers will feel safe – physically and psychologically both at home and in their local community

People need to feel safe in their own home and their community if they are to have the confidence and a desire to retain their independence.

People should feel safe not just in their homes, but in the care and support they receive from health and social care organisations, wherever they receive it. They should be assured that services do not cause harm, and that they have the support they require at home to maintain themselves and manage their health conditions independently but with responsive appropriate support.

Fear of crime is a major concern that stops people leaving their homes after dark increasing the risk of social isolation and anxiety which limits their opportunities.

Everyone has a right to a life free from violence and abuse. Some of us are more at risk of harm than others due to age, disability, physical or mental ill health or substance misuse.

Adults at risk needing support should be given the greatest protection possible from harm. In addition to raising standards of care by regulating the providers in a more thorough and consistent way, we will ensure that all partner agencies understand and implement vulnerable adults protection policies and procedures and recognise the outcomes this will achieve for all the population of the Borders.

Organisations continue to work together so that procedures are in place to protect and ensure the well being of people who may be at risk. We will continue to raise awareness of the potential for abuse and neglect and how people can address it.

Supporting carers

- Carers will receive the support and recognition they entitled to
- People who provide unpaid care to others are supported and able to maintain their own health and well-being
- More carers will be recognised and supported across all older peoples' services and in support of the Scottish Borders Carer's Strategy

Carers are a huge resource in our care and support system. For this system to be sustainable in the future, we need to increase every areas capacity to encourage and enable families to make positive informed choices about how they contribute to care. Carers are however also individuals with their own aspirations. Alongside their role as carer they may need support so that they can live healthy and independent lives and have the same opportunities as the rest of the Borders population. Carers providing or planning to provide a substantial amount of care have an entitlement to an assessment of their needs. We will ensure that carers in the Scottish Borders are offered this at every available opportunity.

5. SUMMARY OF JOINT STRATEGIC NEEDS ASSESSMENT

A comprehensive Joint Strategic Needs Assessment has been undertaken to support this Strategy. The Needs Assessment has reviewed the information we have about older people, the evidence about changes in service pressures and the anticipated trend in population, illness and social care needs. The key messages from the Needs Assessment have been covered in the development of this Strategy and are summarised within this section.

The forecast of local demand is a product of several factors and the full version of the Joint Strategic Needs Assessment.

5.1 Population growth

> There will be a 100% increase in the over 75 age group and by 50% in the 65-74 age group in the next 25 years.

Around 23,000 older people live in the Borders and this will increase to 39,000 by 2033. Projections also indicate that there will be a 20% increase in the number of men aged 75 and over by 2035. There will be a corresponding increase in the number of carers.

5.2 Population contraction

> Whilst the older people's population rapidly expands, the working age population is forecast to reduce by 8.4% with, in particular, a larger than average loss to the 30-49 age group.

5.3 Current service and financial pressures

A large proportion of the overall budget for older people's services is spent on hospital and care home services. Over £31.05 million was spent on hospital health care for the elderly in 2011/12 and over £15.97 million on caring for older people in care homes, making a total of £47.02 million. While there are a range of resources for people at all levels of need in the Borders, the majority of spending takes place looking after the smallest group of older people with the most critical needs.

Only 28.85% of people over 65 with intensive social care needs are cared for at home. This percentage has remained relatively stable in the Borders over the last six years.

5.4 Long-term conditions

> The number of older people with a long-term condition is set to increase by 41.7% at 2025 increasing to 70.2% at 2035.

This means that 48% or almost half of the older people population of the Borders will have a limiting long-term condition (10,902 now, 15,628 in 2025 and 18,690 in 2035). A further 19% of the 65+ population also have a non-limiting long-term condition.

The increasing number of older people living with multiple long-term conditions creates greater challenges in delivering health and social care services.

5.5 Emergency and multiple hospital admissions

> There is a high and above average number of emergency and multiple admissions made to the BGH and community hospitals.

Although the length of stay in hospital has been reduced there has been a 5% increase in emergency admissions per year and an 11.3% increase in two or more emergency admissions per year.

5.6 Hospital diagnosis

> The most common reasons for admission to the BGH and community hospitals during 2011/12 were diagnosis of urinary infections, stroke, lung and heart disease for the 65+ age group regardless of gender.

The main and overwhelming diagnosis for women aged 85+ was fracture of the femur. Additionally there is a higher proportion than the Scottish average of persons aged 65+ receiving fatal injuries as a result of a fall.

5.7 Dementia

> The prevalence rate for people aged 65+ with dementia rises steadily with the increase in the aging population. There will be a corresponding increase in the number of carers. This will see an increase of 12.6% by 2025 and 58.57% by 2035.

Significantly it is estimated that 60% of the Borders older people's care home population will have some form of dementia – diagnosed or undiagnosed.

5.8 Access to services

> Almost 30% of the older people's population are termed as being 'access deprived'. In other words there are challenges for a significant group of older people in the Borders to either drive or be driven or use public transport to access their local GP's, shops and Post Office.

5.9 Carers

There are an estimated 12,502 adult carers living in the Scottish Borders. It is further estimated that 19% or 2,375 are aged 60 – 69 years, and 18% or 2,250 are aged 70 and over. The number of adult carers, which have been in a caring role for at least 5 years is 8,751 or 70%.

- People over 65 account for a third of all carers providing more than 50 hours of care a week.
- 65% of older carers (aged 60–94) have long-term health problems or a disability themselves.
- 68.8% of older carers say that being a carer has an adverse effect on their mental health.
- One third of older carers say they have cancelled treatment or an operation for themselves because of their caring responsibilities.

5.10 Welfare benefits

Only 12.4% of the Borders population aged 60 and over claim the main means-tested benefit – Pension Credit. In other words 87.6% of pensioners do not claim Pension Credit.

Attendance Allowance (for 65+) is claimed by 3,150 people with 54% claiming the high rate and 46% - lower rate. The percentage of claimants aged 90 or over is 17% and 65% of all claimants are female.

5.11 Fuel poverty

The number of Borders Pensioner housholds which are fuel poor is 63% – defined as those paying more than 10% of their disposable income on energy costs. This is 13.6% above the national average.

5.12 Household type

Older householders are more common in the Borders than nationally, they account for 40% of all Borders households, compared to 31% nationally. Single pensioner households are more common in the Borders than across Scotland as a whole and account for one in five of all Border households.

6. A SUMMARY OF THE CURRENT SUPPLY OF SERVICES AND COSTS

This section begins to describe the current services and supply of care provision and support, and also the demand placed upon this.

N.B. a full market analysis will require knowledge of the full range of support utilised by older people and their carers. The challenge for commissioners is to broaden our understanding beyond that of traditional services and start to map the complex network of provisions which support people and communities.

6.1 Demand

As well as understanding assessment of individual need, demand is influenced by the needs of the population. The Joint Strategic Needs Assessment provides the detail to predict impact on demand. Alongside population prediction, the changing expectations and choices of older people influence the type of services for which there will be demand in the future.

The restrictions on resources will require that demand be directed towards services that deliver outcomes as effectively as possible. This can help to identify those who may not be accessing services and in answering questions of whether resources are being targeted to those whose need is greatest.

This Commissioning Strategy is influenced by the current patterns of demand for services. Services under pressure, and services with excess or fluctuating capacity, are indicators of a need for change.

There are requirements for more profiling information about the 'known populations' and to develop the capacity jointly with stakeholders to know more about key decision points along the care pathway to support a whole older peoples perspective on demand.

For the purposes of this resource analysis services are grouped under the following headings:

- Care homes
- Homecare
- Rehabilitation/ re-ablement
- Housing including Housing with Care and Extra Care Housing services
- Day services
- Telecare/ assistive technology/ Telehealthcare
- Support for carers
- Other services including shopping, meals and payments to voluntary organisations
- Community healthcare services, including community nursing, day hospitals
- GP services
- Outpatient services
- Hospital services, including day patients, emergency care and planned care

6.2 Care home

- The current supply of care home places is greater than the number of placements made by Scottish Borders Council
- The demand for care home places is currently being met with continuing numbers of placements countered by decreased lengths of stay. Supply is generally sufficient to meet demand, although people may have to wait to move to the home of their choice
- There are a small number of out of area placements predominantly linked to choice
- The demand for specialist short term provision such as intermediate care and rehabilitation beds is increasing, as is the demand for interim care beds and assessment beds. This is partly the result of a greater focus on promoting independence and facilitating prompt discharge from acute hospital settings
- There are a total of 750 registered care/nursing home places for older people in the Borders. The Council currently commissions approximately 680 care home places, equating to 377 residential care home places and 304 nursing home places. This includes out of area placements
- The utilisation rate for respite beds has remained constant. Whilst demand is relatively constant throughout the year, the need to ensure that carers have access to respite when they need it makes capacity planning difficult

6.3 Homecare

- There are currently 1,346 older people supported from a mixture of Council and external providers from a budget of £10.2 million
- Demand for homecare is growing in line with an ambitious improvement and rehabilitation programme to increase the numbers of people supported at home
- Additional funds are not presently available to meet the increasing demand for home care commissioned by the Council
- Demand for homecare within specific localities, at specific times during the day and during evenings and weekends is often greater than supply, which can result in delays and lack of choice which limits the ability of people to remain supported at home
- The development of this market is essential if people are to be supported in their own homes in a way that reflects increased individual choice and control. A range of services are required which address specialist needs such as those of people with dementia, are flexible and responsive and available 24/7, and offer the full benefit of assistive technology

The growth in the use of direct payments, individual budgets and older people who are funding their own care will change the focus from services wholly commissioned by the Council and NHS Borders towards individualised services with people specifying how they expect their care to be delivered, whether that is by direct payment or exercising choice about their care provider. Providers will need to demonstrate they can respond to these changes in the nature of demand, which will include attention to training workforce planning and the general maintenance of consistently high standards.

6.4 Re-ablement services

Re-ablement services are generally designed to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or increased support. The total number of people who have regained independence and better functioning as a result of receiving an intermediate care placement in a council care home is 250, and many more have been supported back to independence through community and home-based services.

6.5 Housing

The Council is reviewing its strategy for older citizens housing, agreed in 2010 which has so far achieved a reconfiguration of the Borders' sheltered housing stock and developed the first Housing with Care facilities. It is expected that the draft strategy will reflect needs and aspirations of older residents in all tenures and includes the following key aims:

- Continued development of Housing with Care (7am to 10pm, 7 days per week) currently providing for 39 tenants within the Borders
- Extra Care Housing (24/7) throughout the Borders
- Examination of all housing stock for older people including sheltered housing, amenity housing and general housing.

6.6 Telecare/ assistive technology/ telehealthcare

Provision of packages of care that include assistive technology has slowly grown, stimulated by the provision of funding from the Older People's Change Fund. There is some evidence of the benefits to older people. However, more work is needed to embed the use of assistive technology in early intervention to avoid crises. During 2011/12 the Council spent 1% of its total social care budget on telecare/ assistive technologies/ telehealthcare.

6.7 Day services

The provision of day services amounts to an expenditure of £1.46 million for 233 service users attending 8 day centres and 100 attendees in 10 social centres. Two SBC day centres are now co-located with NHS day hospitals in Kelso and Peebles.

6.8 Community Health Services

District Nurses make 3,000 visits a year to older people at home providing multiple functions.

There were 8,480 attendances at day hopsitals in the four community hospitals in 2011-12. Close to 100% of these would be people over the age of 65 years.

Rehabilitation services for older people are predominantly provided in day hospitals. Older people form 48% of people seen by physiotherapists and 61% of people seen by occupational therapists.

There were a further 8,825 attendances at dementia day hospitals during 2011/12.

6.9 GP Services

There are 23 GP practices across the Scottish Borders served by 107 GPs. People over 65 form 22% of GP practice lists.

6.10 Outpatients

There were 51,817 outpatient attendances from people aged 65 and over. Of these, 44,458 were in the BGH and 7,359 were in peripheral clinics. The main attendances were for:

BGH	Ophthalmology
	Podiatry
	Diabetes
	Dietetics
	Orthopaedic Surgery
	Gynaecology
	General Surgery
	Gastroenterology
	General Medicine
	Parkinson's Disease

Peripheral Clinics (at community hospitals and health centres)	Ophthalmology
	Podiatry
	Diabetes
	Dietetics
	Orthopaedic Surgery
	Gynaecology
	General Surgery
	Gastroenterology
	General Medicine
	Parkinson's Disease

6.11 Hospital care

Services for in-patients at BGH and community hopsitals fall into planned and unplanned (emergency care):

Planned care: NHS Borders performed 12,019 operations on people aged 65 or over. Much more surgery is now performed without an overnight stay with 31% of theatre operations carried out as day cases in 2011/12.

Unplanned Admissions: In 2011/12 there were 6,580 emergency admissions of people over 65 which accounts for 40% of all unscheduled admissions. In February 2012, people over the age of 75 occupied 182 beds across NHS Borders.

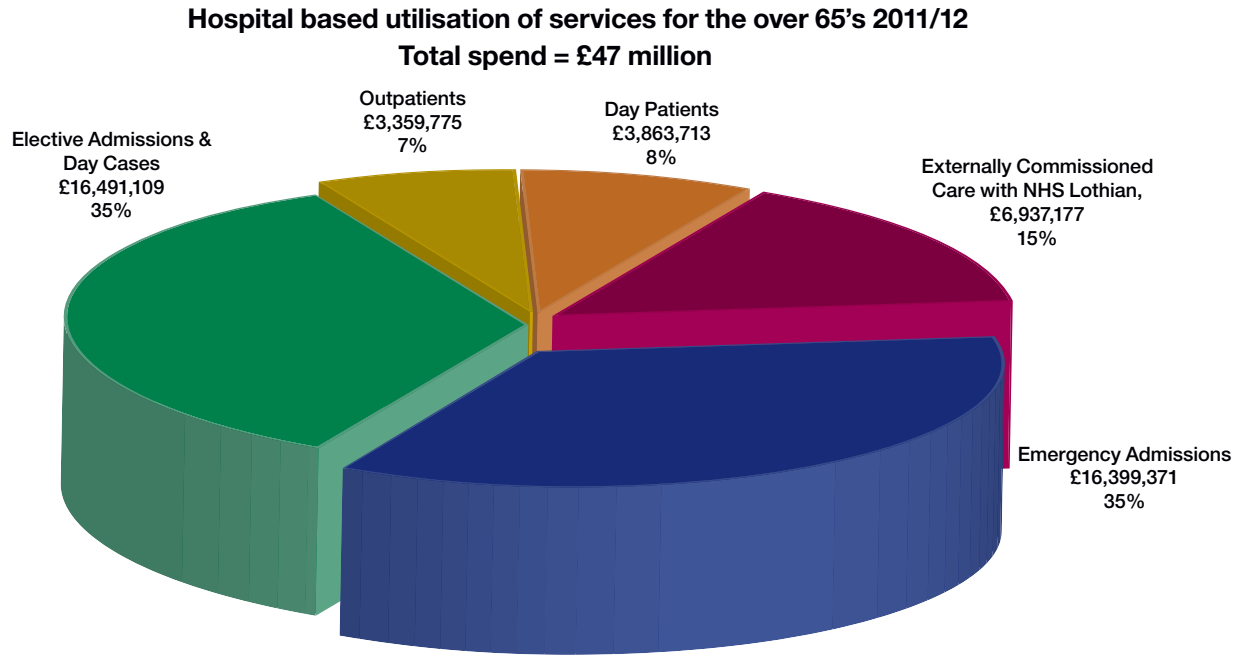
Many Borders patients receive treatment in tertiary centres mostly within NHS Lothian, and a significant proportion of these will be over 65. There is an active programme of work to develop local services that can replace part or all of the need for Borders patients to receive care in Edinburgh.

6.12 Health and Social Care Services – current utilisation of resources for the over 65's population

The total resource spent on providing health and social care for over 65's identified to date is £78.26m. This amounts to £47m hospital based services and £31.2m for Scottish Borders social care expenditure. Currently NHS community services cannot be broken down by age group, so the total spend on services is presented below.

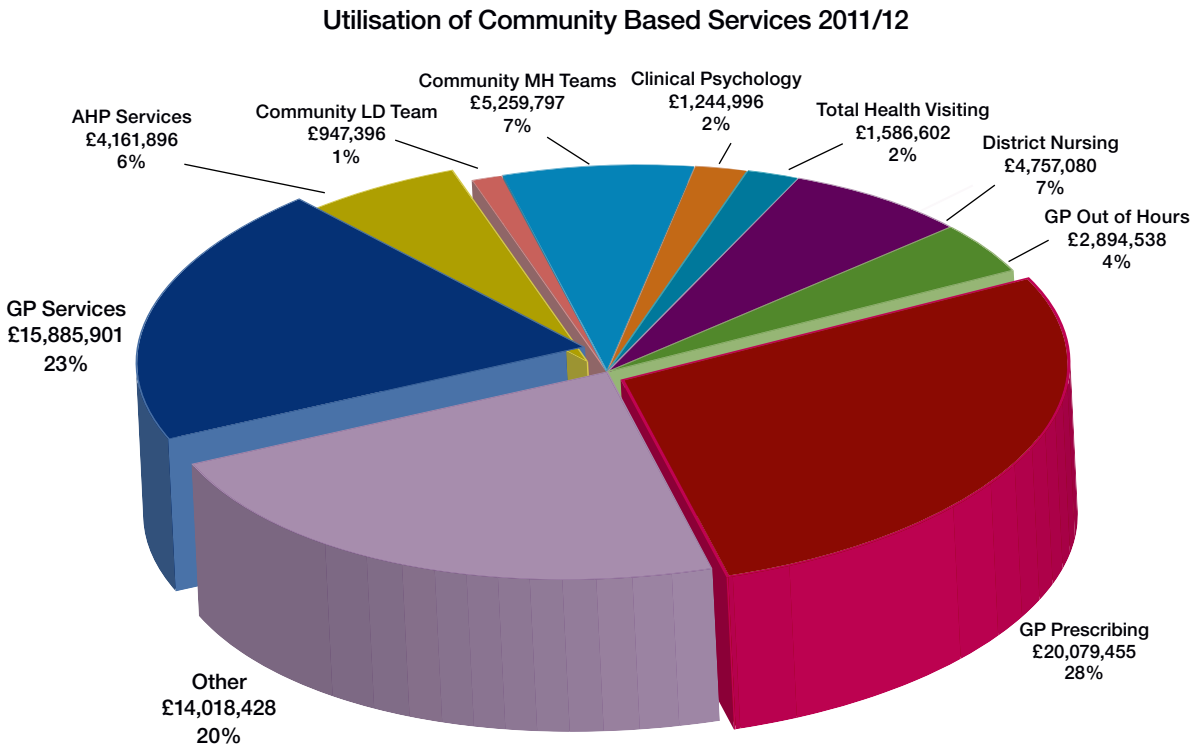
6.12.1. NHS hospital resources

The chart below shows the current hospital utilisation for over 65's in the Scottish Borders:



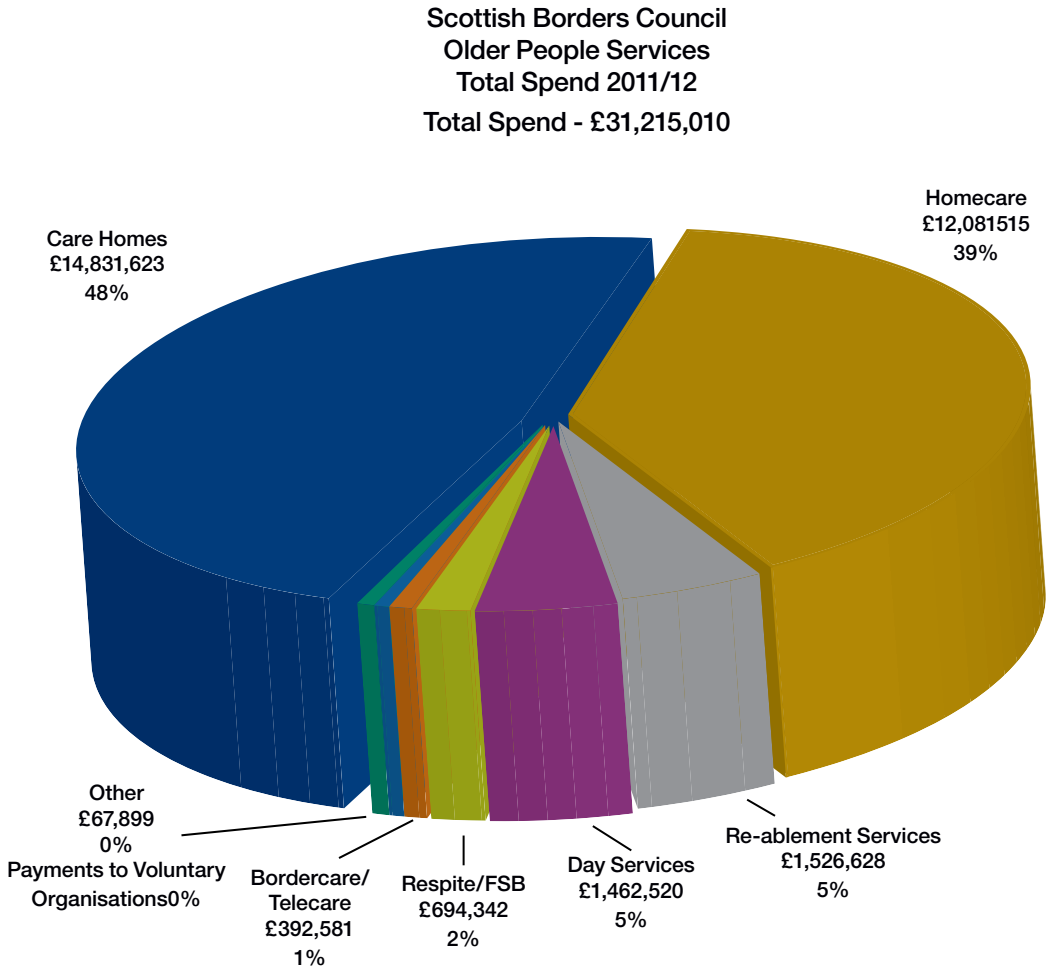
6.12.2 NHS community based services total 2011/12

Utilisation of community based services 2011/12	£
GP Services	15,885,901
GP Prescribing	20,079,455
District Nursing	4,757,080
Total Health Visiting	1,586,602
Midwifery	1,252,768
Child Health	1,269,554
Specialist Nursing	211,895
Clinical Psychology	1,244,996
Community MH Teams	5,259,797
Community LD Team	947,396
Addiction Services	839,704
Family Planning	637,920
AHP Services	4,161,896
Laboratory - Direct Access/FHS Practitioners	2,245,817
GP Out of Hours	2,894,538
Community Dentistry	1,037,405
Incontinence Services	359,566
Health Promotion	562,666
Other	5,601,133

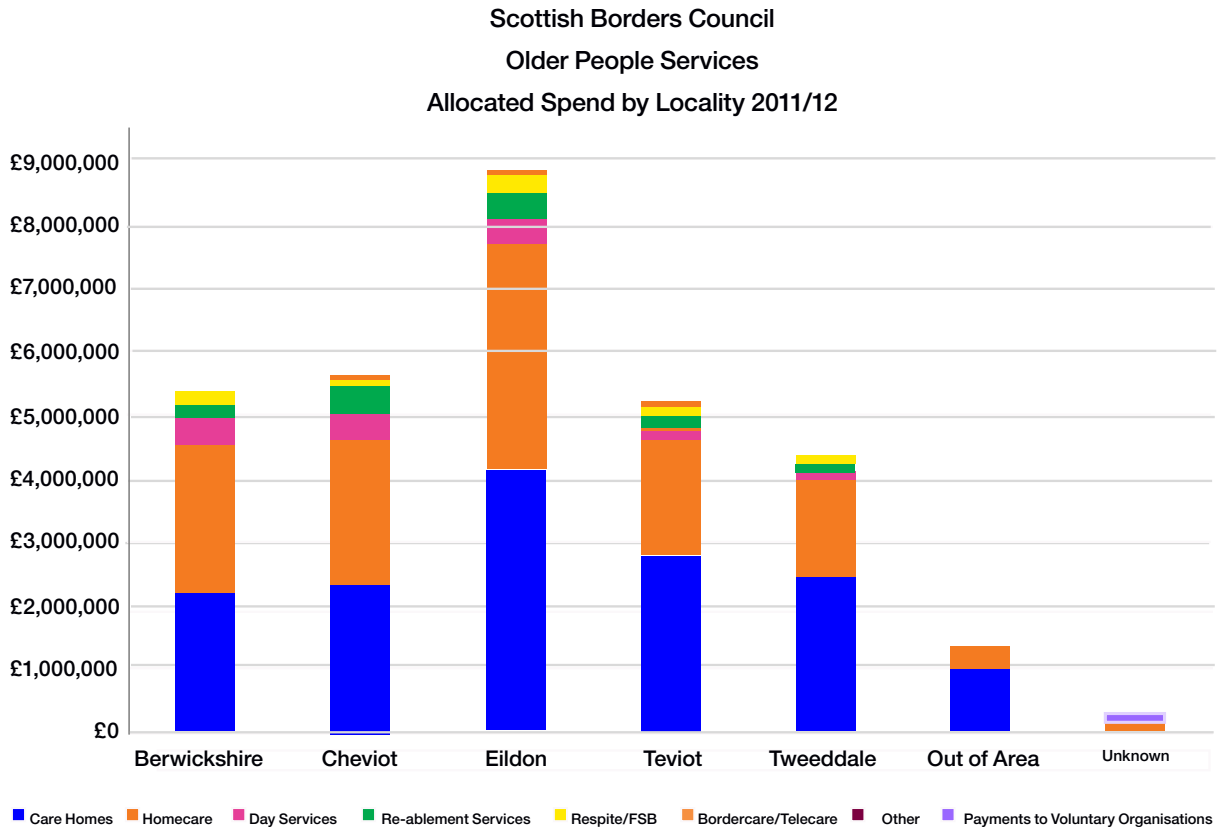


6.11.3 Social care expenditure by service area

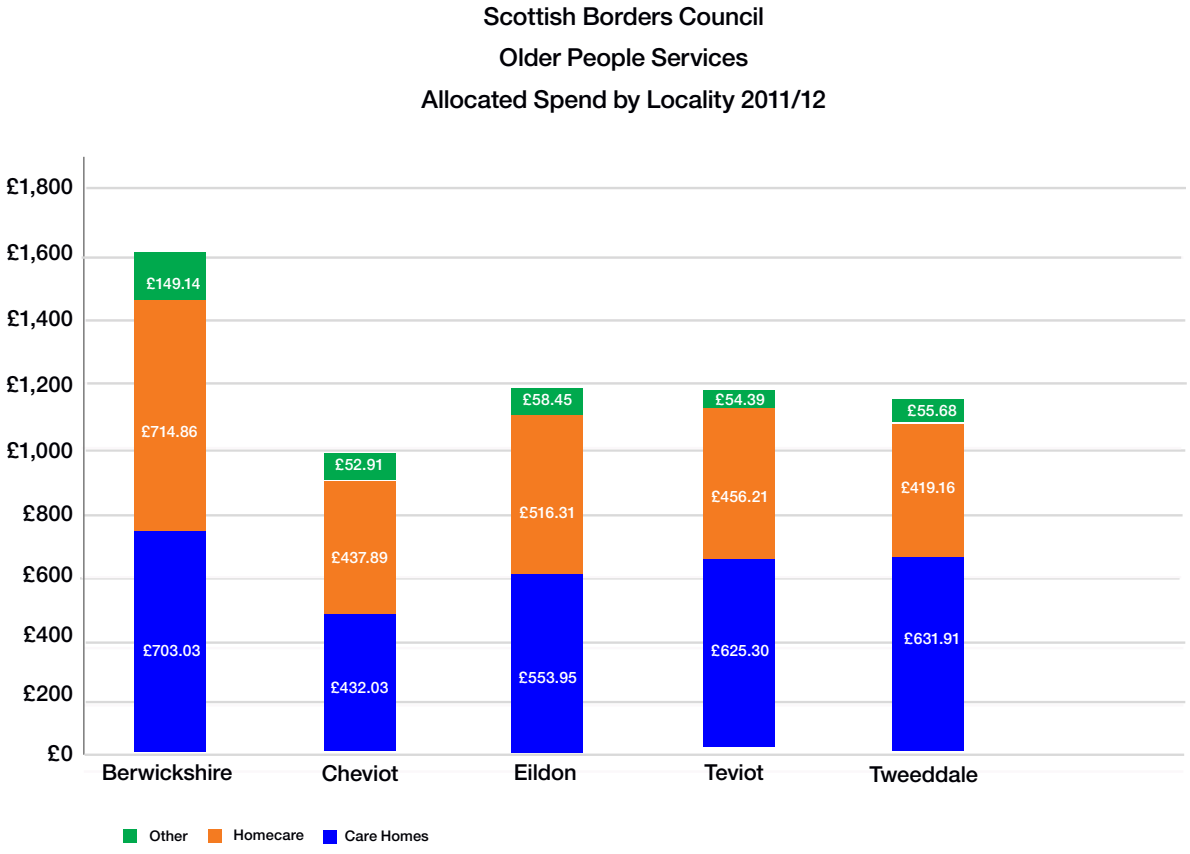
The chart below displays 65 plus social care expenditure (2011/12), 48% of these resources is currently spent on care homes provision:



6.11.4 Social care expenditure by locality



6.11.5 Social care services per capita (65+) by locality



7. OUR ANALYSIS OF THE CHALLENGES AHEAD

By applying the four linked elements of the Joint Commissioning Model (analyse, plan, do and review) as outlined in section four above we are able to assess our progress in taking forward a Joint Strategic Commissioning arrangement for older people services. Critically we are able to identify and focus our future attempts on those areas we are jointly striving to accomplish or are in the process of doing so.

The four distinct commissioning elements and the associated priority areas for taking forward are itemised below and will be incorporated into the forthcoming Implementation Plan to be drawn up.

Analyse	Plan	Do	Review
Common understanding of the joint outcomes we wish to achieve going forward	Enhance strategic partnership working to drive the strategic commissioning of services	Ensure sufficiently robust joint leadership and management arrangement to oversee implementing of joint commissioning	Monitoring of implementation of Commissioning Strategy and related procurement activity
Further examine joint needs, preferences and intended outcomes	Development of policy/guidance to support strategic commissioning of services	Translation of Commissioning Strategy into effective Implementation Plan	Systematically jointly monitor and review services
Jointly map and review existing service provision to inform future commissioning	Taking account of outcome of consultation to consolidate existing work into Joint Commissioning Strategy with proposed Implementation Plan	Ensure joint and effective/procurement of services	Regular joint reviewing of commissioning plan and make adjustments as necessary - including frequently updated risk analysis
Fully analyse the range of joint options	Plan for cultural change across stakeholder groups		
Jointly develop a sound basis for analysis of resources to support the future commissioning of services			

8. COMMISSSIONING PRIORITIES

Having choice, dignity and control

- Have greater choice and control over how older people live their lives through personal budgets
- Have accurate and easily accessible information about services
- Full involvement in the commissioning process

There are many good services already provided to support older people and their carers. Older people and their carers, in common with the whole population, live within formal and informal communities and rely on their immediate families, acquaintances and communities for the vast majority of support and assistance they require. The most common feedback about existing health and social care services is that people are not aware of them, do not know how to access them and do not understand who provides which services.

We will jointly build systems that allow service users to identify and access the services they require in a seamless and effective manner. This means:

- Providing information at your fingertips – in formats that suit the needs of all and are accessible in a variety of different ways
- Getting the same advice – we will ensure that staff and service providers provide consistent and detailed information to the level required by service users and the time they require it
- We will ensure that everyone who needs additional support to navigate and identify the services they require will be able to and feel comfortable to access that support

We will build on new models that give service users the ability to design their own support packages, through self-directed support, to ensure that people receive the care that they have determined is right for them.

We will support models such as self-management that allow older people to effectively manage their own health conditions and take responsibility for their own care:

- Consistent and accessible portfolio of information sources
- Introducing people to the possibilities of new technology including its innovative use (such as iPads for health information)
- Use of navigators to assist with the identification of potential services for individuals
- Development of individual budgets for social care and related services supporting the role of staff in the voluntary and private sectors, to implement personalisation
- New models of brokerage of services to support people navigating the system
- Supporting people with long-term conditions to manage their conditions and prevent unnecessary admissions to hospital, including support and guidance from community pharmacists
- Developing opportunities for self-assessment of services
- Improving dialogue with all providers to develop new models of support and care

- Ensuring new service developments take account of transport and access arrangements
- Joining up statutory and voluntary sector services which provide information, advice and signposting
- Making sure that information is available through lots of different sources, and in different formats
- Improving multi-agency working to increase access to services in hard to reach communities
- The role of universal services such as libraries and contact centres

Measures of Improvement

- Increase the number of patients aged 75 plus living at home with an Anticipatory Care Plan
- Increase the number of adults with self-directed care arrangements per 1,000 population
- Increase time in the last six months of life spent at home or in the community
- Measure the impact of new entrants admitted from home, hospital etc
- Increased percentage of users and carers satisfied with their involvement in the design of their care package.

Keeping healthy and feeling well

- Individuals and communities are able and motivated to look after and improve their health and well-being, resulting in more people living in good health for longer with reduced health inequalities
- More older people and their carers will achieve real improvements in their health and well-being as a result of improved access to health services and other services making a greater contribution to enabling older people and their carers to stay healthy

From the consultation we have conducted as part of developing this Strategy and detailed user feedback, a consistent theme is that people want to and are mostly able to manage their own social and health care conditions. People build their own networks of support in ways that suit them. However, there are periods when additional support is needed to help people maintain their independence or to allow people to manage through short periods of crisis.

Delivering this support in a person-centred manner means ensuring that this support fits into the individual's personal circumstances.

We will therefore approach the delivery of support from a community-focused basis.

We will enable communities to develop services and opportunities that help individuals to maintain independence and social interaction at three levels:

- We will support communities to build capacity for older people to access the activities and social interactions that suit them, through clubs, events and other informal arrangements that are inclusive and combat social isolation
- Community resilience, so that communities understand the needs of and support older people in a preventative and early intervention way
- Community service delivery. We will support and invest in communities' own abilities to provide support for individuals who require care in areas where statutory services either do not provide support or are not best placed to provide support (e.g. social support and first-level social care provision)

We will build and redesign our services wherever possible to bring these services to where the user is, rather than bringing users to where the services are delivered. The early identification of health needs along with regular health checks can make a contribution to this.

We will develop systems that allow people with long-term conditions easy access to the specialist support and advice they require for the periods when they require it, ideally in the home or as close to the person's home as possible.

Measures of Improvement

- Indicator: emergency hospital admissions for older people; measure: rate of admissions to hospital for people aged 75 plus
- Indicator: premature mortality; measure: under 75 mortality rate (age standardised)
- Reduce emergency in-patient bed days for people aged 75 plus (rate per rolling year)
- Reduce the number of people aged 65+ admitted as an emergency twice or more to acute specialities per 100,000 population

- Reduce accumulated bed days for delayed discharge
- Increase the number of registered volunteers
- Increase the percentage of users satisfied with opportunities for social interaction.
- Increase the number of organisations (public sector, business, voluntary sectors) engaging volunteers

Enjoy, achieve and contribute

- Older people have positive experiences of health, social care and support services which help to maintain or improve their quality of life
- More older people and their carers will be included in activities that they say assist them to feel they are making a positive contribution to their communities, and more people will say they felt listened to and valued by their communities

The changes to the population that we will see over the next ten years tell us that, not only will there be a large increase in people over 75 who may require additional care and support, but there will also be a large increase in people retiring and in their early old age. Not only will it be very important that this group in society are active and fully integrated members within the community, but also offers opportunities to develop community-based volunteer work.

We will invest in supporting the communities, many of which will be these population groups, in building local voluntary groups, clubs and other initiatives. We will build systems that not only listen to the views of communities and voluntary groups, but make them an active, if not leading, part of service design and delivery.

We will ensure that communities can access readily and simply the support they need to do this.

In return, there is an obligation on individuals to access this support and to develop services and engagement processes that do provide what the community and older people require in the most effective ways.

We also recognise that there are many different types of communities, not necessarily geographically based, and indeed family networks are as much communities as localities. Our systems need to be able to recognise what represents a community for the individual and support individuals to participate in their own assessment of what the community is for them.

All people are individuals and older people may choose not to participate in their community or may not consider themselves part of a community. We will respect the individuality of older people and our services will be flexible enough to provide support in personally-tailored ways.

Measures of Improvement

- Increase the number of registered volunteers
- Increase the percentage of users satisfied with opportunities for social interaction
- Increase the number of organisations (public sector, business, voluntary sectors) engaging volunteers
- Indicator: emergency hospital admissions for older people; measure: decrease the rate of emergency admissions to hospital for people aged 75 plus
- Indicator: delayed discharge; measure: decrease the number of people delayed more than 28 days in hospital

Keeping independent with support and care when and where it is needed:

- People with disabilities, long-term conditions or who have become frail, and their carers are able to live as safely and independently as possible in the community and have control over their care and support
- More older people will be supported to reach optimum independence as a result of improvements in the way we assist people to avoid and recover from illness and injury e.g. re-ablement

Over the past ten years, services for older people have been transformed and we have invested heavily in developing models of care that enable older people, who have been unwell to recover independence and the ability to lead their lives within the limits of their conditions.

These initiatives have slowly become embedded within our services. However we recognise that they continue to be institutionally focused and built around organisations.

Our future models of service delivery need to be built around the needs of the individual.

We will develop services that are flexible enough to address individual need. We will ensure that at every step in a person's access to services, they receive consistent and accurate information and advice about their progress and the opportunities they have to return to independence. This includes ensuring that people are supported to make their own decisions about the care they wish to receive at the points when they are best-placed to make those decisions.

Where possible, we will bring services to where the individual is and wishes to receive them. We will deliver services that recognise that independence is a central focus of care and that it is defined by the user.

We will develop services that work towards outcomes that are user-determined.

Measures of Improvement

- Reduce the number of delayed discharges over 4 weeks
- Indicator: balance of care home use between short and long stay; measure: percentage of people in care homes that are short stay residents
- Reduce hours of support required after reablement service provided
- Indicator: proportion of partnership resource invested in acute sector provision; measure: still to be determined
- Reduce the number of delayed discharges for complex cases
- Reduce the number of delayed discharges under 4 weeks
- Reduce the percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment
- Indicator: emergency hospital admissions for older people; measure: rate of admissions to hospital for people aged 75 plus
- Indicator: support for people with care needs; measure: percentage of people with personal care needs receiving care at home (rather than in a care home or hospital).
- Indicator: older people living at home; measure: percentage of older people 75 plus who live in housing rather than a care home or hospital
- Indicator: end of life care; measure: proportion of last 6 months of life spent at home or in community setting

Keeping safe

- Older people using health, social care and support services are safe guarded from harm and have their dignity and human rights protected
- More older people and their carers will feel safe – physically and psychologically both at home and in their local community

Older people, along with the rest of society, feel more safe when they are in familiar environments where they feel in control.

This Strategy seeks to invest in ways ensuring that older people's homes and communities are safe places.

We will invest in practical means ensuring that older people can remain in their homes independently. This includes simple and rapid access to support for maintenance and repair of their homes.

We will support the development of community arrangements for supporting people within the local area to feel safe and to access help when needed.

The ability to get out of the home and travel to the places that people feel important is a critical factor that has featured in all our discussions and consultations. Transport is therefore an essential element in this Commissioning Strategy. We will develop a range of models for making access to transport readily available and ensuring that transport models are appropriate. Most importantly, we will ensure that systems allow the user to be fully in control of their access to transport.

Where people are not able to remain independent in their own home, we will ensure the provision of the most appropriate alternative housing models within the individual's own community, as far as possible. We will build models of housing that enable older people to remain independent and to access the support they require when they require it, but to return to independence, as far as is possible.

When in health and social care settings, we will ensure that care is delivered in ways that minimise risk and that safety is our paramount concern. Safe delivery of services is maintained by systems that ensure we do things right first time. We will continue to pursue the eradication of delays and errors in our systems.

We will ensure that older people have readily available information on how to access support, advice and reassurance when they feel unwell, especially for occasions when they have exacerbations of long-term conditions.

Measures of Improvement

- Reduce number of patients aged 65+ with a fall diagnosis conveyed to/ attending Accident and Emergency (A&E)
- Reduce waiting time between housing adaptation request and delivery

- Increase proportion of people aged 75+ with a Telecare package
- Increase the percentage of people aged 65+ receiving long-term care who receive an intensive homecare service (10+ hours a week)
- Increase the percentage of service users feeling safe
- Increase frail elderly admissions accessing specialty unit within 24 hours
- Number of people waiting longer than target for assessment per thousand population
- Number of people waiting longer than target time for service per thousand population
- Measure the over 6 weeks to service (substantial and critical)

Supporting carers

- Carers will receive the support and recognition they entitled to
- People who provide unpaid care to others are supported and able to maintain their own health and well-being
- More carers will be recognised and supported across all older peoples' services and in support of the Scottish Borders Carer's Strategy

This Strategy recognises that unpaid carers are the foundation of the majority of care for older people. We also recognise the different models, types and arrangements for care. A theme that has come across very clearly in our consultation work is that carers and those they care for build their own networks of support, but need services to recognise and support these, rather than replacing them.

We will create more formal approaches to recognising the role of unpaid carer. We aim to bring carers into a central position within the teams supporting individuals, formally recognising their role and giving them access to a carers assessment and equal voice in the design and delivery of services to support older people and their carers.

We will ensure that the support we give to carers themselves is readily available, that carers are aware of this, and that it is appropriate to the needs of carers. We will recognise that carers are individuals and ensure that support is provided on that basis.

We will continue to be aware of the informal nature of carer networks and ensure our services are sensitive to building on them, rather than replacing or undermining them.

Measures of Improvement

- Indicator: amount of time older people need to spend in hospital in emergencies; measure: rate of emergency bed days in acute specialities for people aged 75 plus
- Increase the percentage of carers who feel able to continue their role
- Increase the percentage of carers satisfied with their involvement in the design of their care package
- Increase the rate of diagnosis for dementia
- Increase the percentage of carers assessments offered and measure acceptance rates
- Increase in short breaks/respite care for older people
- Care plan expected outcomes
- Indicator: older people living at home; measure: percentage of people 75+ who live in housing rather than a care home or hospital

9. RESOURCE ALLOCATION

Within this Strategy, we have set out to develop new, more person-centred services for older people. We have outlined the expected challenges of increasing numbers and different demographic and health changes of the older people's population within the Scottish Borders over the next ten years.

Given the current economic realities we have also recognised that we require to deliver services in different ways to manage the identified availability of resource. This Commissioning Strategy will guide the use of the identified resource committed to older people's care within both NHS Borders and Scottish Borders Council. There is a fixed level of resource available within partner organisations. This totals for 2012/13 £78.26m as identified in the 2011/12 updated IRF work. However we recognise this is not the entire resource and further work is required specifically with regard to NHS community services. We do recognise the complexities of identifying specific resource for older people when a number of services are provided across the entire population.

There will be several challenges to redevelop and re-provide services:
Developing new services requires financial and human resource investment. The Older People's Change Fund currently provides short-term funding to allow new services to be developed, tested and agreed. However, the Older People's Change Fund ends in 2015. If new services are developed, we will have to stop providing some existing services, so that the resource can be used elsewhere. It is not just the financial resource that is limited; there will be significantly less working age people available to deliver these services.

Whilst many people will welcome new and improved services, disinvesting in other services will be challenging, both practically for human resources delivering these services, but also politically and personally for users – most services will be supporting people who may not wish to see their service change.

There are additional challenges as the resource we currently utilise is spread across NHS, Local Authority, Voluntary and Independent Sectors. To ensure that the most appropriate agency is providing the service, money and staff may need to move between different organisations.

Many of our existing services have been established for many years and we have developed measures for testing their effectiveness. We need to ensure that the resources we allocate to new services are used as effectively as possible. This plan has described an approach focused around person-centred outcomes as the ultimate measure of success. Measuring the benefits that people want from their lives can be challenging and we will need to work more closely with partners to develop robust measures that show that services are effective in supporting older people.

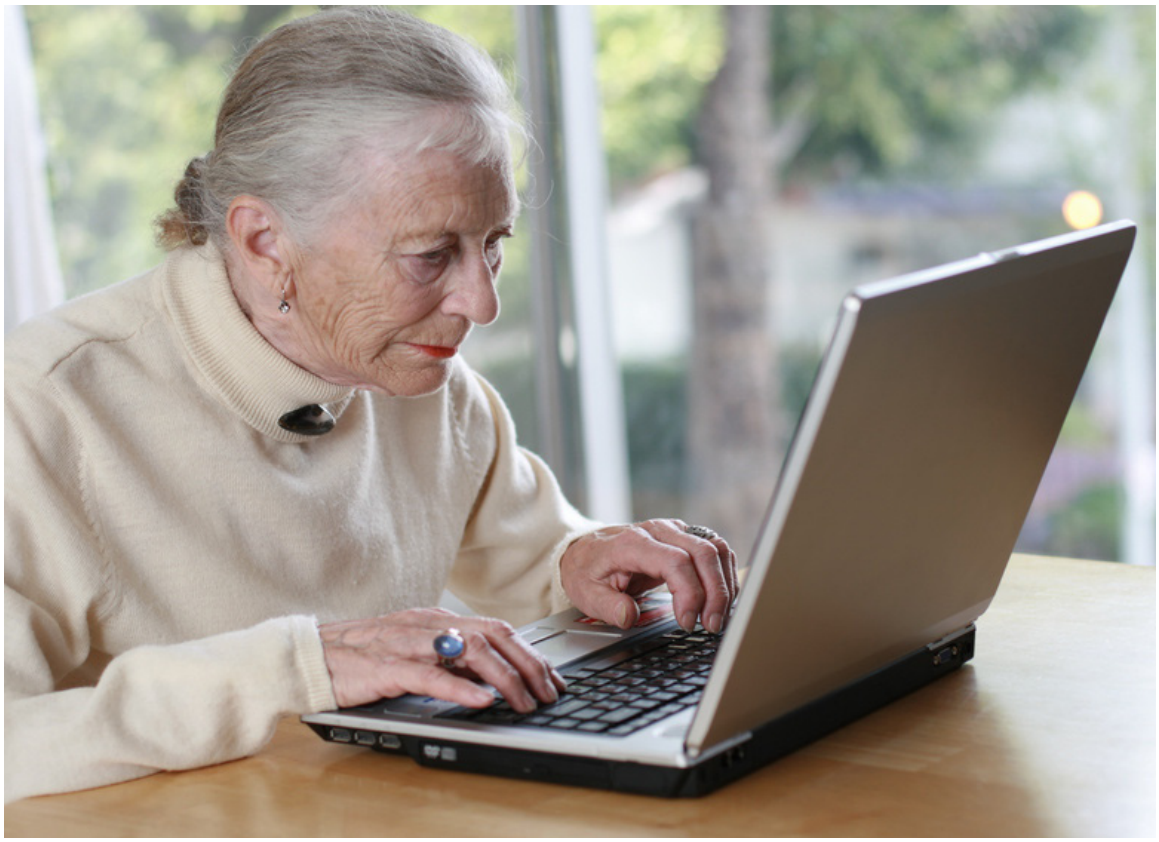
Work to develop ways of addressing the challenges outlined above has already started. In order to move ahead with delivering the changes that we have outlined in this plan, we are taking a pragmatic approach, dealing with issues as they arise and searching for the simplest practical solution.

Summary of potential areas to be considered for investment/ disinvestment

From the work completed to date this Strategy recommends focusing upon those priority areas including:

- Improved access to information
- Care at home
- Housing with Care and support
- Self management of long term conditions
- Rehabilitation/ re-ablement/ intermediate care services
- Dementia services
- Supporting carers
- Activities/ services to minimise falls and avoid hospital admissions
- Preventative services and activities including health improvement
- Access to transport
- Adult protection
- Telecare

The implementation of this Strategy should allow us to consider reducing the reliance on institutional care solutions including beds and buildings, and enable efficiencies in management arrangements and resource allocation.



10. APPENDIX ONE

The Bigger Picture: Summary themes from National and Local Policy

This appendix provides an overview of policy developments affecting NHS Borders, Scottish Borders Council Social Work Services and housing related services, and the local response in implementing these changes.

Key themes from national policy:

- Tackling age discrimination and ensure older people are included in social, community and economic life.
- The importance of keeping the whole population of older people well and active and able to access universal services such as transport, leisure, housing, shops.
- The importance of information to help people to make informed choice about services and other means of support.
- Prevention and early intervention for people at risk of or experiencing problems affecting health and well-being.
- Health and social care services offering high quality, flexible and joined up services, responding to individual needs.
- Rehabilitation and re-ablement following ill-health e.g. falls, stroke.
- Joined up services, especially to manage long-term conditions e.g. breathing problems, heart failure, arthritis.
- The right services, skills and understanding for people with mental health conditions, especially dementia and depression, so that such conditions are seen as part of mainstream services, everybody's business.
- Providing services at home, or closer to home, reducing avoidable admissions to hospitals and care homes.
- Choice and control – deciding how to spend the funding allocated for your care and support needs.
- Support to families and carers.
- A focus on outcomes – finding out if people are satisfied, and experiencing good results from using services.
- The importance of commissioning, to understand the needs of local population and to achieve the best use of resources.

Key themes from local strategy and policies

- Addressing health inequalities with a focus on health improvement and prevention.
- Develop integrated care models to meet individual needs.
- Care closer to home.
- Development of housing models of care such as Housing with Care and Extra Care Housing.
- Involving older people, for example through volunteering and in the design of services.
- Support for people to remain healthy and receive a high quality care experience.
- The high value of the contribution of carers to the maintenance of quality of life people at home and in the community.
- Focus on rehabilitation and independence across all community services.
- Improving multidisciplinary and inter-agency working within core services, including between NHS organisations.
- Improving well-being in older people and recognising broader mental health needs.
- New signposting and brokerage services supporting people through the system.
- Development of new models of care spanning community and acute services.
- Improving access and information to ensure housing related support is widely known as an option for enabling people to live independently.
- Implementation of the Borders Dementia Strategy with a focus on early diagnosis services.
- An integrated approach to supporting patients to stay out of hospital eg long-term condition management.
- Reducing avoidable admissions to hospital, for example through falls prevention.
- Supporting successful discharges from hospital and a return to independent living.
- Multi-agency approach to improving discharge arrangements.
- Reduction in the numbers of people going straight from acute hospital care into long-term care.
- Transformation of community services starting with joint reviews of major service areas where necessary.
- End of life care to be flexible and help all concerned to plan and make informed choices about where to live, what to do in a crisis, and what care and support is needed.

Sources:

National

"Reshaping Care for Older People: A Programme for Change 2011-2021", Scottish Government, 2012
"Commission on the Future Delivery of Public Services", Scottish Government, 2011
"Joint Working (Public Bodies) (Scotland) Bill", Scottish Government, 2013
"Social Care (Self-directed Support) (Scotland) Act", Scottish Government, 2013
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