



Strategic Change Programme:

The Case for Change

August 2009

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GLOSSARY OF ABBREVIATIONS AND TERMS

ABBREVIATIONS

A&E	Accident and Emergency
AHP	Allied Health Professional (i.e. Physiotherapists, Dieticians etc)
BECC	Borders Emergency Care Centre
BECS	Borders Emergency Care Service
BGH	Borders General Hospital
CHCP	Community Health & Care Partnership
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
DC	Day Case
DME	Department of Medicine for the Elderly
EQIA	Equality Impact Assessment
EWTD	European Working Time Directive
FTSTA	Fixed Term Specialist Training Appointments (for Doctors)
GAD	Government Actuary's Department
GFFTF	Getting Fit For The Future (NHS Borders Report from 2005)
GMS	General Medical Services
GP	General Practitioner
GRO	General Registers Office
HEAT	Health, Efficiency, Access & Treatment targets
IHS	Integrated Health Strategy
IP	Inpatient
JHIP	Joint Health Improvement Programme
KCND	Keeping Childbirth Natural & Dynamic
LOS	Length of Stay
LTC	Long Term Condition
MMC	Modernising Medical Careers
NES	NHS Education for Scotland
NHS	National Health Service
NHS 24	24 x 7 access to healthcare advice via telephone and the web
NMAHPs	Nurses, Midwives & Allied Health Professionals
NRAC	NHS Scotland Resource Allocation Committee
OP	Outpatient
RIC	Rapid Impact Assessment Checklist (Equality & Diversity)
SAS	Staff Grade & Associate Specialist (doctors)
SCP	Strategic Change Programme
SGHD	Scottish Government Health Department
SOA	Single Outcome Agreement
SPACE	Strategic Policy Analysis Collaborative
SPARRA	Scottish Patients At Risk of Readmission & Admission
TAGRA	Technical Advisory Group on Resource Allocation
TOPS	Transforming Older People's Services
UK	United Kingdom

TERMS

Bed Modelling / Scenario Planning	A tool which allows healthcare planners to test changes in demographic, admission rates and bed/specialities prior to making changes in clinical settings.
Benchmarking	Benchmarking is the process of comparing variables including activity levels and costs of departments/organisations with other comparable areas. In the NHS this is usually across Health Board areas.
Better Health, Better Care	The Better Health, Better Care: Action Plan for NHSScotland was launched in December 2007 following wide consultation with the people of Scotland. This strategic document sets out the key actions which will lead to better health and better care for all the people of Scotland.
Blue Book	Scottish Health Service Costs (known as the Costs Book or "Blue Book") provides a detailed analysis of where resources are spent in the NHS in Scotland. This information is mainly derived from financial and statistical data compiled by Scottish Health Boards. It is published by ISD with the support of the Scottish Government Health Department and is used mainly for comparison across health care providers to ensure efficiency and to benchmark costs.
Capital Investment	The original or additional expenditure on an asset (building or piece of equipment) with a cost of £5,000 or more which provides benefits beyond a period of one year.
Changing Clinical Practices Action Plan	NHS Borders document setting out a series of changes (2008/9-2011/12) across the healthcare system in NHS Borders to improve patient care.
Community Planning Partners	Community Planning is a process which helps public agencies to work together with the community to plan and deliver better services which make a real difference to people's lives.
Continuous Improvement	<p>One strand of the Strategic Change Programme which will find opportunities to change the way we work.</p> <p>The continuation of ongoing service redesign work alongside new initiatives and collaboratives, adopting improvement methodology throughout wider service improvement / redesign work.</p>
Episode of Care	The services provided by a hospital in the continuous course of care of a patient with a health condition. It may cover a sequence from emergency through inpatient to outpatient services.
Getting Fit For The Future	NHS Borders report from 2006 setting out how future challenges will be addressed to provide and develop a modern, effective and high quality service that caters for the needs of patients and staff in the Scottish Borders.
HEAT Targets	<p>HEAT (Health Efficiency Access Treatment) targets are a core set of Ministerial objectives, targets and measures for the NHS.</p> <p>For 2008/09 there are 30 HEAT Targets:</p> <ul style="list-style-type: none">• 7 targets on Health improvement• 7 targets on Efficiency and Governance• 7 targets on Access to Services• 9 targets on Treatment
Improving Efficiency & Reducing Waste	<p>A project with the Strategic Change Programme.</p> <p>Joint working with staff to identify opportunities to make improvements across the service. Aiming to reduce waste and inefficient use of resources across the organisation, identifying opportunities to work more efficiently on a day to day</p>

basis (e.g. use of technology, reducing waste, printing less etc).

Integrated Health Strategy	<p>The work stream within the Strategic Change Programme tasked with looking at options to re-shape how services are delivered.</p> <p>Reviewing the strategic direction for NHS Borders in relation to services, ensuring the most efficient use of our inpatient facilities and shifting the balance of care, ensuring the joint agenda is taken into consideration. Subsequently, developing a coherent strategic plan for the next decade with recommendations for a major programme of change with particular focus on utilisation of our estate and maximising efficiency.</p>
Intermediate Care	<p>A term used to describe a number of services that provide short-term rehabilitation and recuperation. It aims to increase independence and help people avoid unnecessary admission to hospital or long-term care, or to aid discharge from hospital. Intermediate Care can be provided in a range of settings including a person's own home, day service, residential care home or within a hospital environment.</p>
Involving People Network (IPN)	<p>A network of local individuals and organisations who have an interest in how health and social care services are designed and provided.</p>
Local Delivery Plan	<p>The Local Delivery Plan is a key strategic document which sets out the agreement reached with the Scottish Government on delivering the HEAT targets over the course of the next 3 years.</p>
Operational Budget Savings	<p>This workstream of the Strategic Change Programme will operate on an annual basis for the life of the programme.</p> <p>It will seek out all opportunities to reduce costs and achieve efficiency savings – building on work to date through the Clinical Executive savings programme.</p>
Patient Focus Public Involvement (PFPI)	<p>A framework for delivering a culture change in the NHS where patient-focus is at the heart of service design and delivery.</p>
Preventative Services	<p>Preventative Services are mainly for older people with low support needs. They aim to help people to maintain health, promote independence, prevent crises, and thereby avoid the need for statutory services.</p>
Productivity & Benchmarking	<p>The strand of the Strategic Change Programme tasked with comparing NHS Borders with other health boards and identifying variances in local service delivery.</p> <p>A high level challenging and enabling group which will use evidence to drive out inefficiencies in the system. The group will provide information and comparable data to managers and clinicians and support them to review systems/ways of working. This work stream will operate on an annual basis for the life of the programme.</p>
Public Partnership Forum (PPF)	<p>The PPF is a way of supporting wider public involvement in planning and decision making about public services and informing local people about the range of health and social care services that are provided locally.</p>
Scottish Patients At Risk of Readmission & Admission	<p>SPARRA is a risk prediction algorithm, developed by Information Services Division (ISD) to identify patients aged 65 years and over at greatest risk of emergency inpatient admission.</p> <p>The algorithm uses selected information from patient histories of hospital admission to predict their risk of future emergency inpatient admission. It will identify patients at highest risk of emergency admission i.e. where the predicted probability of emergency inpatient admission in the next year is 60% and above.</p>

Shifting the Balance of Care	Shifting the Balance of Care describes changes at different levels across health and social care – all of which are intended to bring about better outcomes for people, providing services which reduce inequalities, promote independence and are quicker, more personal and closer to home. This means we need to develop clinical and care pathways that may involve shifting location, shifting responsibility, shifting care and preventing or delaying more intensive and expensive interventions.
Single Outcome Agreement (SOA)	Agreements between the Scottish Government and Community Planning Partners which set out how each will work in the future towards improving outcomes for the local people in a way that reflects local circumstances and priorities, within the context of the Government's National Outcomes and Purpose.
Strategic Change Programme	A coordinated change programme to respond to the challenges (demographic profile of the population and workforce; shifting the balance of care; separating elective and emergency care; delivering more care closer to home; working in partnership and the need to deliver significant savings) while outlining a new way of thinking about how NHS Borders operates, delivers services and conducts business.
Sustainable Workforce	A theme within the Strategic Change Programme The current workforce is not sustainable in terms of age profile, staffing models etc. Current staffing models/grading structures will be reviewed and succession planning and redesign processes explored in light of affordability of such models and ability to recruit and retain staff.
Telecare / Telehealth	Telecare refers to equipment that can send messages and generate a response when people need help. Telehealth involves measuring information about health conditions in the patients' home and sending these electronically to a central monitoring and response point.
Whole Systems Scorecard	NHS Scotland's National Benchmarking Project has developed a Whole System Balance Scorecard. This contains data comprising of over 100 indicators, ranging from length of stay to mortality, across 5 domains: <ul style="list-style-type: none"> • Cost • Efficiency • Patient Experience • Health Improvement • Supply and Demand <p>The system has been designed to allow Health Boards to measure how well they are performing compared to other NHS Scotland Health areas and the combined Scottish and English average.</p>

1 INTRODUCTION

- 1 NHS Borders is committed to delivering a more modern, accessible service – a service that is better, quicker, closer and safer. *Getting Fit for the Future*¹ (*GFFTF*) outlined NHS Borders intention to move to a more sustainable and appropriate range of services for patients across the Scottish Borders. The strategic goals outlined within that redesign programme were widely consulted on with the public and approved by the Board in March 2006 and remain just as applicable today. Through our subsequent Strategic Change Programme (SCP), our goal is that the people of NHS Borders will have access to a networked range of services, operating from hospitals, health centres and within the community that are modern, convenient and well-equipped.
- 2 This document describes the drivers for change in NHS Borders and NHS Scotland over the next 5-10 years. It draws on UK and international information about trends in health and health care and the workforce, as well as wider societal changes.
- 3 In setting the scene, it explains how health care is changing. It acknowledges the progress that has been made since *Getting Fit for the Future*, but it also points to the substantial challenges that remain, not least of which will be a much tighter public sector financial outlook for the next few years.
- 4 A central policy driver for us is *Better Health, Better Care*². With a presumption against centralisation, *Better Health, Better Care* makes a pledge to bring services closer to patients' homes – taking services to them rather than them requiring to go to health services – ensuring that the people in society most at risk of ill-health are recognised and engaged. Fundamental to this is:
 - a transformation in the way the NHS works, from an acute, hospital-driven service to one that is community-based;
 - a focus on meeting the challenges of an ageing population and the rising incidence of long-term conditions;
 - a concentration on preventing ill-health by equipping the health service to encourage and secure improvements in health, rather than just treating illness;
 - a drive to treat people faster and closer to home;
 - a determination to develop services that are proactive, modern, safe and embedded in communities, or as close to home as possible.
- 5 A changing population in a rapidly shifting society requires a different response than that which has gone before. The wider strategic challenges described in *Better Health, Better Care* highlight the need for us to review the configuration of our services over the next decade and to plan and deliver care in quite different ways. In doing so, there is also a clear expectation, through a mutual NHS, of earlier and closer involvement of communities and other stakeholders in designing services that are fit for the future.
- 6 Building on *Getting Fit for the Future*, there is a need to maintain the momentum in designing more sustainable services and delivering better outcomes. *“The next 20 years will see an ageing population, a continuing*

¹ Getting Fit for the Future Report to NHS Borders (March 2006)

² Scottish Government Better Health, Better Care: Action Plan (December 2007)

shift in the pattern of disease towards long-term conditions, and growing numbers of older people with multiple conditions and complex needs. These changes in themselves make the current model of healthcare delivery unsustainable".³ Simply doing "more of the same" is therefore not an option and so requires us to examine all the resources at our disposal.

- 7 It is clear that we need to think perhaps more radically than we have to date about what the shape of our services might look like in the next 5-10 years and steps we should be taking now.
- 8 In this document, we explain in more detail the Case for Change. We set out five broad reasons for change:

Reason One: The need to improve Borderers health

Reason Two: The need to meet the expectations of Borderers

Reason Three: More care can now be delivered outside hospital

Reason Four: Using our workforce and buildings more effectively

Reason Five: Making the best use of taxpayers money

³ Scottish Executive, *Drivers for Change in Health Care in Scotland*, National Framework for Service Change in the NHS in Scotland (2005) p80

2 ONGOING CHANGE

- 9 When the NHS began in 1948 it was designed to treat 'acute' illness. Sixty years later, people are living much longer than they used to and medical advances mean that long-term illnesses – like diabetes – can now be treated very effectively without the need to go to a hospital. Developments in medical care mean that more and more illnesses and conditions which have traditionally been treated in hospitals can now be managed in the community, and patients can often be offered care in their own home. However, the challenge is not simply about redesigning services; it is also about making a transformation in our approach to improving health. We can make substantial steps forward in reducing the prevalence of long-term conditions, such as diabetes, and reduce premature death, by investing in measures to improve health and tackle inequalities.
- 10 Increasingly, the delivery of more integrated care requires us to work beyond our current organisational and geographical boundaries. The delivery of more integrated care requires a fundamental shift in thinking with the creation of single unified services between health and social care (such as the Learning Disability Service). The provision of sustainable services requires us to develop mature strategic partnerships with other NHS areas, most notably our neighbouring Health Board, NHS Lothian, and the fostering of managed clinical networks. We also recognise our part in delivering responsive and accessible services to a sizeable population in North Northumberland.
- 11 Another key partner for us is Scottish Borders Council; we have been working particularly closely with them around their Community Care review, known as Transforming Older People's Services (TOPS). Through this, a joint vision for both NHS Borders and SBC for older people's services has been agreed and is outlined below in summary:
- Health, wellbeing and independence are actively promoted;
 - Access to support services is easy, quick and integrated;
 - Support is more individualised, promoting choice and control for the service user;
 - Community options are developed wherever possible in preference to institutional settings;
 - Specialist services are available for dementia, mental illness and learning disability;
 - Family carers are given flexible and responsive support;
 - Networks of independent support are maintained and developed in local communities;
 - New technology is exploited;
 - Good information and advice is available.
- 12 Work is progressing in parallel with the review to develop and improve the core adult Assessment & Care Management process (the process through which needs are identified, outcomes are defined, and outcomes are delivered through the most appropriate service responses and reviewed), and to ensure this can be undertaken by either Social Work or Health staff.

- 13 There are a number of other examples of more integrated work with our community planning partners, including:
- Joint Learning Disability Service;
 - Integrated Mental Health Service;
 - Community Health & Care Partnership;
 - Joint Director of Public Health;
 - Joint Equality and Diversity Service;
 - Integrated Community Safety Unit.

Further opportunities should be explored to build on this good practice.

- 14 Continuing the necessary level of transformation in our health services (e.g. an 18 week waiting time from GP referral to treatment, to be achieved by 2011) means substantial change in the design of services. Incremental “fixes” will be insufficient to meet patient expectations and sustain service delivery.

- 15 Alongside better health is the drive to deliver more sustainable services. A key principle for the service is the provision of safe services delivered as locally as possible. Building on *Getting Fit for the Future* we need to ensure that we are continuing to adapt our services to changing circumstances. These issues include achieving:

- **a more sustainable mix** of services in response to increasing clinical standards, higher public expectations, sub-specialisation, more rigorous safety & quality standards, staff recruitment, retention and retirements, and issues raised by European Working Time Directive compliance, *Modernising Medical Careers*, new GMS and Consultant contracts, *Agenda for Change* and changing expectations of work;
- **a more flexible configuration** of services, with a shift in emphasis away from buildings, thereby streamlining the patients journey between services;
- **balanced funding and prioritisation** of services based on projected needs whilst retaining future flexibility and financial balance.

- 16 In addressing these fundamental issues we are beginning to rebalance care away from out-of-date facilities and traditional, demarcated, models of care and those services that are, or will shortly become, unsustainable or fail to offer value-for-money. Key to this is the drive to alter current practices which are deemed to be inappropriate for the provision of patient-centred, integrated and responsive care.

- 17 The next twenty years will see an ageing population, a continuing shift in the pattern of disease towards long-term conditions and growing numbers of older people with multiple conditions and complex needs. These changes in themselves will make the current model of health care delivery unsustainable.

- 18 In future, there will be greater focus on primary prevention and health improvement. We will achieve this by providing continuous, preventative, supportive and enabling care for people with long term conditions, balancing this with our need to react quickly and safely to medical emergencies. Alongside these changes will be the increasing demands to deliver a demonstrably safe service which is better tuned to meeting the needs of patients and their families.

- 19 We are not starting from a “blank sheet of paper”. Over the last twelve months work to agree a series of clinical changes has been completed. The aims of decreasing patients’ length of stay across NHS Borders hospitals, services and specialties and faster throughput of patients in the future are captured in NHS Borders’ “Changing Clinical Practices Action Plan”. Using a bespoke bed modelling tool, work has included the testing of performance indicators using current activity levels to test these improvements over time. The list of ideas for changes captured in the Action Plan have been baselined with 2007/08 activity and have been linked to Corporate Objectives and HEAT standards and targets as detailed in NHS Borders’ Local Delivery Plan⁴.
- 20 Figure 2.1 demonstrates the bed requirements on the BGH for three demographic scenarios.

Figure 2.1: Bed Model baseline with 2007/08 data - BGH bed capacity requirements under different demographic assumptions

	2007/08 Bed Base	2007/08 Beds Required	2012/13 Beds Required	2018/19 Beds Required
Scenario A. No Change in Admissions	319	312	312	312
Scenario B. Admissions Change in Direct Proportion to Projected Demographic Change	319	312	334	363
Scenario C. Growth in Emergency Admission above Demographic Trend, Elective Admissions in Proportion to Projected Demographic Change	319	312	363	435

- 21 The baseline Scenario A assumes no change. This is unlikely based upon the population forecasts for the area. If admissions remain in direct proportion to the projected change in population, and no changes in clinical practice are introduced into the local healthcare system, then as outlined under Scenario B, an additional 8 beds within the next four years rising to 44 beds in a ten year period would be required. Scenario C looks at a growth in emergency admissions more than that which would be expected given the projected change in population. It is hoped that through delivery of the current national HEAT targets around reduction in emergency admissions that this scenario would not be realised. If it did, however, an additional 44 beds would be required within the next four years rising to 116 beds by 2018/19.
- 22 Scenario B is generally accepted as the most likely model for NHS Borders. If the changes contained within the Changing Clinical Practices Action Plan are not achieved the model suggests that there will be a requirement for increased beds in specialties across Primary and Secondary Care, as outlined in Figure 2.2.

⁴ NHS Borders Local Delivery Plan 2008/09 (April 2008)

Figure 2.2: Specialty Beds required assuming Admissions Changing in Direct Proportion to Projected Demographic Change

	01/04/2008	2012/13	2015/16	2018/19
Adult Medical/GP Acute	154	170	178	185
Adult Surgery/Orthopaedics	79	87	91	94
DME	30	34	35	36
Gynaecology/Obstetrics/Paediatrics	41	43	45	48
Medical Acute Receiving Unit (Ward 4 changed mid-year 2008)	15	0	0	0
Total Beds	319	334	349	363

Community Beds	140	153	156	159
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- 23 In order to provide illustrative costs of what this increase in bed numbers might mean, outline calculations have been made based on 2008/09 budgets for current ward staffing and direct supplies, as outlined in Figure 2.3. These illustrative costs take no account of any configuration of beds, and the Community costs are based on the average cost of all four Community Hospitals. These costs are not the actual cost of opening new beds as they do not include any medical staffing costs, capital, utilities, facilities or overhead costs - they are purely illustrative at this stage.

Figure 2.3: Increase on Existing Spend for Additional Specialty Beds assuming Admissions Changing in Direct Proportion to Projected Demographic Change

	2012/13		2018/19	
	Increase over 2008/09		Increase over 2008/09	
	Beds	£	Beds	£
Adult Medical/GP Acute	16	735,936	31	1,425,776
Adult Surgery/Orthopaedics	8	284,856	15	534,105
DME	4	122,328	6	183,492
Gynaecology/Obstetrics/Paediatrics	2	126,378	7	442,323
Medical Acute Receiving Unit (Ward 4 changed mid-year 2008)	0	0	0	0
Total Beds	30	1,269,498	59	2,585,696

Community Beds	13	440,440	19	643,720
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- 24 There is currently no available space on the BGH campus to accommodate the increase in beds detailed above, therefore it is likely that a significant element of new build would be required to accommodate this increase in capacity, or alternatively a review of services to be located locally may have to be considered. This would have a potential knock-on impact on the already stretched capital programme.
- 25 Information to measure performance across the healthcare system is now available from the National Benchmarking Whole Systems Scorecard which complements the Changing Clinical Practices Action Plan described above. The scorecard contains a combination of Scottish and English data highlighting potential starting points for the NHS Borders Productivity and

Benchmarking project within the SCP. By reviewing clinical comparisons NHS Borders is able to measure how well we are performing compared to the Scottish and English averages. The Benchmarking data comprises over 100 indicators, ranging from length of stay to mortality, across 5 domains (Cost, Efficiency, Patient Experience, Health Improvement and Supply and Demand).

- 26 Benchmarking data tells us that NHS Borders has one of the highest number of beds per 100,000 population across Scotland (Figure 2.4) and specifically that the older population is very well provided for in terms of beds. Analysis of data over a six-year period shows a general reduction in beds overall across Scotland. Whilst our numbers have reduced over these 6 years, we still have consistently more beds per 100,000 population than Dumfries and Galloway, which is a similar Health Board to Borders in terms of its population size and rurality.

Figure 2.4: Beds Numbers (average available staffed beds per 100,000 Population)

Year	Scotland	Borders	Dumfries & Galloway
2002/03	608	584	518
2003/04	590	608	547
2004/05	572	570	559
2005/06	525	555	527
2006/07	510	556	523
2007/08	497	534	487

- 27 Inpatient, Day Case and Outpatient activity levels are also available via the Benchmarking data. In terms of inpatient activity, if NHS Borders were to achieve the NHS Scotland average length of stay across all specialities, it would be able to release 12,857 beds days, or 35 beds, across secondary care specialties in the BGH. In a similar fashion, a move towards the average for Outpatient activities would see a saving of approximately £200,000 per year, and £175,000 by treating more patients as Day Cases rather than inpatients.
- 28 Detailed analysis of our activity also suggests that there is a high level of variation within and across specialties within Borders in terms of length of stay, referrals and other activities.
- 29 NHS Borders Clinical Boards have started to review specific areas and locations to start to understand the reasons for variability. Through the SCP Productivity and Benchmarking project, areas such as GP referrals, Clinical Delivery and use of the BGH and Community Hospital beds will inform the reviews. This information will be used alongside national and local data to set and agree local improvement targets.
- 30 Information contained within the Whole Systems Scorecard (2007/08) allows NHS Borders to compare itself to the expected cost per episode using benchmarking data. In order to ensure there are no issues with how overhead costs have been apportioned, an exercise to consider General Medicine and Surgery inpatients, day cases and outpatients has been carried out (Figure 2.5). If the costs per episode are realised there is potential to release significant resources, over £1million pounds year on year, which could be used elsewhere in the healthcare system.

Figure 2.5: Potential Savings in General Medicine and General Surgery using Cost per Episode v Expected Cost from Whole System Scorecard 2007/08.

Speciality	Patient Type	Episodes	Cost per Episode	Expected Cost	Potential Savings
General Medicine	Inpatient	7,382	1,470.20	1,358.90	821,616
	Day Case	699	537.60	462.30	52,635
	Outpatient	9,604	141.00	148.00	(67,228)
Total					807,023
General Surgery	Inpatient	2,858	1,860.20	1,786.70	210,063
	Day Case	319	1011.50	716.00	94,264
	Outpatient	3,649	102.70	128.60	(94,509)
Total					209,818

31 The Whole System Scorecard data suggests that NHS Borders carries out less day cases than expected (Figure 2.6). The Day Surgery in Scotland Report estimates the saving associated with a day case compared to an elective admission is £237 per patient; the impact of achieving the expected rate for General Medicine and Surgery in NHS Borders is over £190,000. This will be reviewed as part of the Continuous Improvement work strand of the SCP.

Figure 2.6: Potential Savings by Increasing Day Case Surgery in General Medicine and General Surgery from Whole System Scorecard 2007/08

Speciality	Elective Admissions	Observed Day Cases	Expected Day Cases	Difference	Potential Savings
General Medicine	1,904	1,318	1,822	504	119,448
General Surgery	1,189	343	654	311	73,707
Total					193,155

32 Using information contained within the Whole Systems Scorecard it appears that acute specialties in NHS Borders require more outpatient follow ups than the national average, as demonstrated in Figure 2.7. A move towards the national average would release around 2,500 appointments as well as clinical and support time. Aiming for the national average may not be good enough in the current climate, and as a result of this we will be looking for all services and specialties to aim for higher performance levels when compared to their peer group, in order to release time and potentially money currently held within the system.

Figure 2.7: Potential Saved Outpatient Appointments from Whole System Scorecard 2007/08

Speciality	Total Attendances	New	New / Review	Mean New / Review	Potential Appointments Saved
Endocrinology	1,370	143	1 / 9.6	1 / 5.7	554
Cardiology	2,922	812	1 / 3.6	1 / 2.7	730
Gynaecology	3,144	1,196	1 / 2.6	1 / 2.3	393

Obstetrics	3,250	699	1 / 4.7	1 / 3.4	873
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33 A move towards reviewing bed locations and numbers and reducing the average length of stay will also help address future requirements. However, as highlighted in paragraph 28, it has been noted that there is a significant variance across a number of clinical areas. For example, the bed numbers and lengths of stay vary across our Community Hospital sites, with the length of stay in Kelso Community Hospital being much closer to the Scottish average than other sites.

34 If all sites were to achieve the Kelso average length of stay this would release 8,673 bed days, or 24 beds. As demonstrated in Figures 2.8 and 2.9, NHS Borders is well resourced in terms of GP Acute and Continuing Care beds, and has, on average, longer lengths of stay in GP Acute beds than the national Scottish average and that of Dumfries & Galloway. We have a shorter length of stay than the Scottish average for Continuing Care beds, but longer than that of Dumfries & Galloway. There may be a number of reasons as to why these differences occur, and we need to understand this further.

Figure 2.8: Beds Numbers (average available staffed beds per 100,000 Population)

	Year	Scotland	Borders	Dumfries & Galloway
GP Acute & Continuing Care	2005/06	79	168	129
	2006/07	73	151	125
	2007/08	68	142	105

Figure 2.9: Length of Stay in Community Hospital beds

	Year	Scotland	Borders	Dumfries & Galloway
GP Acute	2005/06	16.5	24.8	1.7
	2006/07	16.5	21.9	10.7
	2007/08	15.5	24.2	10.9
Continuing Care	2005/06	113.9	83.6	39.0
	2006/07	106.9	66.3	37.7
	2007/08	100.7	68.0	48.6

35 Within Mental Health there is a significant variance between NHS Borders cost per activity and the Scottish Average for similar facilities and services. This is directly attributed to NHS Borders caring for more of these individuals (than some of their peers throughout Scotland) in the community setting; alongside this the running costs of the buildings remain. In order to release these monies a review of NHS Borders strategic commitments and its properties will be carried out through the Integrated Health Strategy strand of the SCP.

Figure 2.10: Mental Health Activity and Cost Variance to Scottish Average from Whole System Scorecard 2007/08

Designation	Patient Type	Activity 06/07	Cost per Activity per Week 06/07	Activity 07/08	Cost per Activity per Week 07/08	Variance to 07/08 Scottish Average
Poynder View	Inpatient	5,152	£1,730	4,153	£2,128	£590
Cauldshiels	Inpatient	6,289	£1,606	5,937	£1,800	£262
Wilton View	Inpatient	4,400	£1,700	4,229	£1,843	£304
Melburn	Inpatient	5,353	£1,628	5,285	£1,658	£119
Galavale	Inpatient	9,103	£2,073	8,316	£2,365	£479
Priorsford	Day Patient	1,178	£127 (per day)	459	£369 (per day)	£262

- 36 Patients often have needs which require input from a number of services from across primary, secondary and mental health, and across organisation boundaries such as the one between health and social care. The traditional model of delivery often means waits between needs being met, as referrals between services and organisations work their way through the system. A more integrated approach to the delivery of services, such as that seen in the Borders Learning Disability service, and Intermediate Care such as Rapid Response and the Waverley Intermediate Care Service, reduces the delays inherent in more traditional services. It is now the time to deliver care outwith the historical demarcation lines within NHS Borders (e.g. primary and secondary care), between organisations (e.g. NHS Borders and Scottish Borders Council) and between sectors (e.g. public and voluntary sectors).
- 37 It is clear that there are significant variations in performance both across services within NHS Borders but also against other Health Boards in Scotland. Within the current climate aiming to achieve the “average” will be insufficient, and a move towards addressing future challenges and requirements will mean that performance will need to meet the upper quartile for all services.

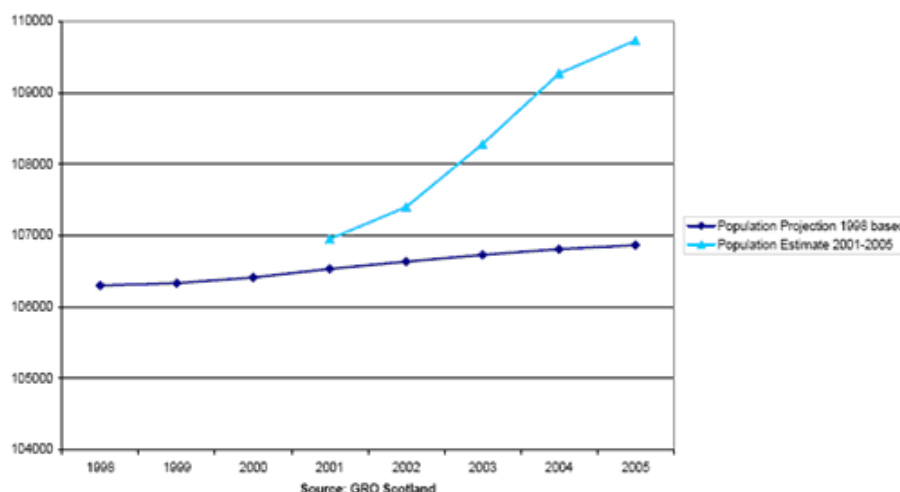
KEY MESSAGES

- There is significant variation in performance
- A changing and ageing population requires us to shift the model of care
- There is a continued path of change building on Getting Fit For The Future
- Aiming to achieve the average will be insufficient, performance will need to meet the upper quartile for all services

3 REASON ONE: THE NEED TO IMPROVE THE HEALTH OF BORDERERS

38 The Scottish Borders is predicted to have the highest percentage of population increase in Scotland, as demonstrated in Figure 3.1. Whilst the increased population will undoubtedly mean higher levels of patient activity and more complex health care needs, it also potentially provides opportunities to recruit from a wider market.

Figure 3.1: Scottish Borders Population Projection 1998-based & 2001-2005 Population Estimates

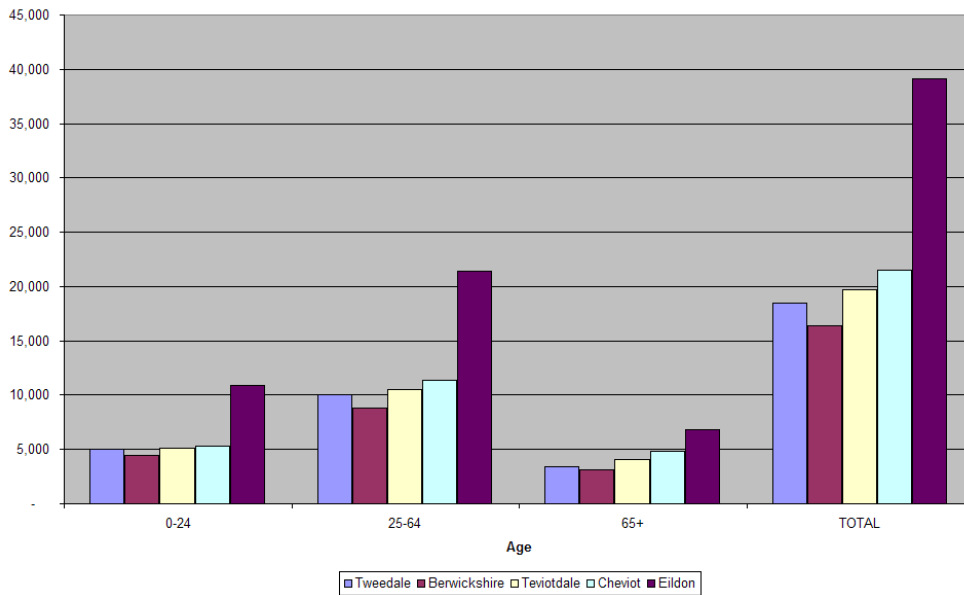


39 In the Scottish Borders, we already have a significant proportion of our population aged over 65 years compared with other parts of Scotland. By 2018 it is expected that people aged 65 years and over will have increased from 19% at present to 25% of the local population. By 2018 there will be 37% more people in the 65-74 year old age range than there are today, and 25% more people aged 75 years and over. As life expectancy increases, the most marked rise will be seen in the numbers aged 90 years and over. By 2018 it is expected that these numbers will increase by 77%.

40 From the TOPS programme we know that local consultation consistently shows that older people in the Borders want to remain independent and stay at home for as long as possible. People have rising expectations and are looking for a choice of service provision and seeking high standards of care and accommodation for their later years.

41 Our region is sparsely populated with a population density of only 23 people per square kilometre. The population of the Borders has risen by almost 10% in the last 20 years to just over 110,000, at a time when the population of Scotland overall has remained virtually static. Between 2004 and 2024 the local population is projected to increase by around 15%. Figure 3.2 highlights the age profile of Scottish Borders residents by locality, from information contained in GP practice lists.

Figure 3.2: NHS Borders Population by locality area and age group



42 The Government Actuary's Department (GAD) is responsible for official national population projections for the UK.⁵ Figure 3.4 illustrates the 2004-based principal projection from GAD and the 2004-based population projections from GRO (General Registers Office) Scotland, which show a higher increase of the population in the Scottish Borders than in Scotland and the UK as a whole.

Figure 3.3: GAD 2004 based Principal Population Projections & GROs 2004 based Population

	2004	2011	2018	2024	% Growth 2004 - 2024
Scottish Borders	109,000	115,000	121,000	126,000	15.6%
Scotland	5,078,000	5,120,000	5,128,000	5,114,000	0.7%
UK	59,835,000	61,892,000	63,880,000	65,766,000	9.9%

43 Most of the population growth, however, has been in older age groups over the statutory retirement age. The number of those over working age increased by more than twice the rate for working age people. The health care needs of the ageing population, and therefore more dependence on local health and social care services, will require the workforce of the future to adapt accordingly.

44 The morbidity information for the Scottish Borders shows ageing but healthier communities. In the period 2003-05, Scottish Borders had the 3rd longest life expectancy at birth for males in Scotland and for females the Scottish Borders is ranked 8th out of the 19 Scottish areas analysed. At the heart of our strategy is ensuring that these extra years of life are healthy ones.

⁵ Government Actuary's Department Population Projections. www.gad.gov.uk (10 May 2006)

- 45 In terms of the overall position of Scottish Borders in the Scottish Index of Multiple Deprivation for 2006 (when measuring across a range of measures including health, income, housing, crime and employment etc), the Scottish Borders accounts for only 0.3% of the most deprived data zones in Scotland⁶. This compares with local authority areas with the largest *national* shares of the 15% most deprived in Scotland being Glasgow City (34 per cent), North Lanarkshire (nine per cent), City of Edinburgh (seven per cent) and South Lanarkshire (six per cent).

Equalities

- 46 There has been good partnership working on poverty for some time in Borders, initially through an Anti-Poverty Group and more recently a Strategic Partnership Against Poverty. This work has focussed mainly on the co-ordination of money advice and income maximisation, tackling fuel poverty and raising awareness of the problems caused by poverty. Recent changes in the wider economy and the impact they will have locally mean that this is an even more important topic, with the number affected by poverty and social exclusion and their impacts likely to increase over the next few years.
- 47 NHS Borders equalities policies, schemes and action plans help set out our aspirations and how we will achieve them. Translating these commitments into everyday practice will benefit and involve everyone who works for and uses NHS Borders services.
- 48 'Equality' is about a fairer society where everyone can participate and has the opportunity to fulfil their potential. 'Diversity' is about the recognition and valuing of difference in its broadest sense. It is about creating a culture and practices that recognise, respect, value and harness difference for the benefit of all.
- 49 We are clear that our population, living for longer, will require greater support from our health and social care services, and carers, in the years to come. There will need to be less reliance on hospital or institutional based models of care, and greater attention to the provision of anticipatory, flexible and rehabilitative care closer to home. We will be required to work in concert with a range of partners to tackle inequalities in health and to ensure that services are tailored to the needs of individuals and communities. The Report of the Scottish Government Taskforce on Tackling Health Inequalities (*Equally Well*)⁷ places an obligation on Community Planning Partnerships to work together to improve outcomes. Moreover, unless we invest in health improvement measures to alleviate the future burden of ill-health, the demands on our health services will become unsustainable.
- 50 Adults can be harmed in many different settings and situations. It is usually a very complex area of work; therefore staff need to be aware of situations which may put adults at risk. This has confirmed the need for guidelines and procedures for Social Work Services, Police, Health Services, and Independent Providers. NHS Borders, Scottish Borders Council and Lothian and Borders Police, as the key agencies involved in the protection of adults at risk are committed to an integrated approach, and to the prevention and

⁶ Scottish Index of Multiple Deprivation 2006, Based on the 15% most deprived data zones

⁷ Equally Well: Report of the Scottish Government Taskforce on Tackling Health Inequalities, 2008

detection of harm and exploitation of some of the most at risk members of our community.

Health Improvement

- 51 Improving Scotland's health is a national priority for the Scottish Government; targets have been set around this, in areas such as reducing smoking and the misuse of alcohol and drugs, and for improving diet and exercise. Figure 3.4 explains key challenges.

Figure 3.4: Health Profile of the Scottish Borders

Scottish Borders Community Health & Care Partnership (CHCP) is a partnership between Scottish Borders Council and NHS Borders; it serves an estimated total population of 110,240. The percentage of the population who are of working age is below average. Both male and female life expectancies are better than the Scottish average. The area has a 0.6% ethnic minority population (2001 Census), which is significantly lower than the Scottish average (2.0%).

All-cause mortality (all ages) and mortality rates from heart disease, cancer and stroke (under-75s) are all significantly better than (below) the Scotland average.

An estimated 23.9% of adults smoke, compared to 27.3% in Scotland as a whole. There have been 74 alcohol related deaths in the last five years, a death rate significantly better than (below) the Scotland average. The proportion of the population hospitalised for alcohol related and attributable causes is significantly better than average. The proportion of the population hospitalised for drug related conditions is also better than average, with 120 patients discharged from hospital over the last three years.

For emergency admission patients, multiple admission patients aged 65 and over, and road traffic accident casualty patients, the proportions of the population hospitalised are significantly worse (higher) than the Scotland average. In contrast, expected years of life in good health are 70.4 for males and 74.3 for females, both significantly better than the Scottish averages of 66.3 and 70.2 respectively.

In Scottish Borders CHCP, 27.7% of older people with intensive care needs are cared for at home, rather than in care homes or geriatric long-stay hospital beds (Scotland 29.2%). The percentage of older people receiving free personal care at home is the same as Scotland (4.8%). At the 2001 Census, lone pensioner households accounted for 16.9% of total households (Scotland 15.0%).

Scottish Borders CHCP has a significantly better (lower) than average percentage of people living in the 15% 'most deprived' areas of Scotland. This is reflected in the education, employment & prosperity indicators, with the area rating significantly better than Scotland on all indicators, except for working age adults without educational qualifications (not significantly different to the Scotland average).

The crime rate is significantly better (lower) than average, as is the assault hospital patient rate. The percentage of the population living within 500 metres of a derelict site (48.4%) is significantly worse than the Scotland average (27.3%). This is a partly rural area, with 31.9% of people living in the 15% 'most access deprived' areas in Scotland (Scotland 15.0%).

The percentage of women smoking during pregnancy is significantly worse than average (26.1%, compared to 24.3% Scotland-wide). The percentage of babies exclusively breastfed at 6-8 weeks (35.6%) is significantly better than average. Child dental health in primary 1 ranks second best of the 40 CHPs in Scotland.

- 52 Smoking is the most avoidable cause of premature death in Scotland. Every year, it is estimated that 13,000 people die from smoking-related diseases such as lung cancer, coronary heart disease and stroke. More than 35,000 people are admitted to hospital each year with smoking-related diseases, costing the NHS in Scotland around £200m.
- 53 The amount of alcohol consumed in Scotland has increased over the past decade, and every year it is estimated – based on figures produced in May 2008 - that dealing with the effects of alcohol on our health costs the NHS in Scotland £405m per year. The wider societal costs are many times greater. The level of liver cirrhosis deaths in Scotland outstrip the rest of Europe, where rates are falling. Every year there are around 40,000 alcohol related hospital admissions in Scotland, 50% more than a decade ago.
- 54 Scotland has the second highest level of obesity in the developed world. The number of obese children in Scotland is running at double the UK average, with around one boy in six and one girl in seven being obese. Among adults, that number rises to one man in four and one woman in five. Being overweight or obese during childhood can lead to physical and mental health problems in later life, such as heart disease, diabetes, osteoarthritis, back pain, low self-esteem and depression.
- 55 These challenges reinforce the need to accelerate our local effort. In our *Joint Health Improvement Programme (JHIP)* we have set out key targets and milestones for delivering improved health and reducing the inequalities in health. Through the Borders Single Outcome Agreement (SOA) we have the opportunity to work closely with our partner agencies to ensure concerted action to improve the life chances of our children and to address the inequities in health.

KEY MESSAGES

- Our population is ageing, with an increase in long-term conditions
- While health is improving, unacceptable variations in health status and outcomes remain
- Critical health challenges remain in tackling obesity and alcohol misuse

4 REASON TWO: THE NEED TO MEET THE EXPECTATIONS OF BORDERERS

Expectations

- 56 For over 60 years NHS Scotland has informed, diagnosed, treated and cared for the population of Scotland. The achievements of the NHS are substantial and delivered through the efforts, dedication and commitment of all who work in, and with, the NHS.
- 57 Our successes as an organisation are a direct result of our ability to evolve and provide the highest quality care that meets the changing needs and expectations of the people of Scotland.
- 58 The people of Scotland have told us what they need and want from their NHS and have described what a high quality patient-centred service means to them in the following ways:
- **Caring** and **Compassionate** Staff;
 - Clear **Communication** and Explanations;
 - Effective **Collaboration**;
 - **Clean** Care Environment;
 - **Continuity** of Care;
 - **Clinical** Excellence.
- 59 In NHS Borders our current levels of activity, alongside the configuration of our staff, services and sites from which we operate, need to be reviewed if we are to ensure the sustainability of services within Borders, offer value for money, improve patient care and adopt evidence based change. Implementation of the Strategic Change Programme (SCP) will therefore enable NHS Borders to review current activities, reaffirm the overall strategic direction for the Board and release efficiencies required to redesign and improve services.
- 60 The real opportunities lie in better arranging and co-ordinating services across secondary, primary and community services, across health and social care, and across sectors. The core principles introduced in *Getting Fit for the Future* introduced a model of care which still applies today:
- Improved management of patient groups by changing the balance between hospital beds and community services – so that care is local, modern and better fitted to the individual's needs;
 - Separation of emergency and planned care – so that patients needing emergency care can be diagnosed and treated promptly, without affecting the care for patients who are waiting for planned treatment;
 - Managing the services to people who are more likely to need hospitalisation and whose health may place them more at risk – so that people with long-term conditions are actively supported to remain at home for as long as possible;

- A greater focus on partnership – working more effectively with other organisations to deliver a service that is better connected across health and social care.

61 There are also a number of aspects of healthcare that are important to adult inpatients. Research has recently been carried out through the Better Together programme. This research has highlighted a number of aspects that are important to Borders patients; these are outlined in order of priority in Figure 4.1⁸.

Figure 4.1: Better Together: Patient Experience Programme – Publication of Research into Patients’ Priorities for Inpatient Care

NHS Borders: items in order of priority

1. A clean ward	32. Being told who to contact if I am worried after I leave hospital
2. Staff cleaning their hands before touching patients	33. Being involved in decisions about my care and treatment
3. Getting the best treatment for my condition	34. My family or someone close to me being given enough information to help me recover
4. Being treated quickly in an emergency	35. Being given consistent advice by all members of staff
5. Doctors knowing enough about my condition and treatment	36. Nurses answering the call bell quickly
6. Clear explanations about what will happen during an operation or procedure	37. A short time on the waiting list
7. Nurses knowing enough about my condition and treatment	38. Being told which doctor is in overall charge of my care
8. Being treated with dignity and respect	39. Not having to share a room or bay with patients of the opposite sex
9. Being told the risks and benefits of any treatment in a way I can understand	40. The ward being quiet at night
10. Being told about danger signals to watch for after I leave hospital	41. Staff being polite to me
11. Clear explanations of my condition or treatment	42. Somewhere secure to keep my belongings
12. Privacy when being examined or treated	43. Being given understandable written or printed information about my condition and treatment
13. Getting pain relief quickly	44. Not having to repeat my medical history to different members of staff
14. Privacy when discussing my condition or treatment	45. Being told when I can resume normal activities (such as going to work or driving a car)
15. Staff being open with me about my condition and treatment	46. Being offered healthy meals
16. Being told how and when I should take my medicines	47. Short journey time to get to hospital
17. Being told how my operation or procedure has gone in a way I can understand	48. Getting copies of letters between the hospital doctors and my GP
18. Before going into hospital, being given accurate information about my treatment	49. Being given help to eat my meals when I need it
19. Being told about possible side effects of medicines	50. Being given a choice of food
20. Enough nurses on duty to take care of me	51. Not having to wait around in the hospital once I have been told I can go home
21. Being told what my medicines are for	52. Not having my admission date changed by the hospital
22. Having enough time to talk to a doctor	53. Being given accurate information about ward routines
23. Staff listening to me	54. Being given help to arrange transport home
24. Being able to talk to a member of staff about any concerns I might have	55. Having a choice about which hospital I go to
25. Staff working well together to organise my care	56. Not having to pay too much to make phone calls
26. Not being bothered or threatened by other patients or visitors	57. My religious beliefs being respected
27. Not having to wait too long in the emergency department	58. Being able to watch television without having to pay for it
28. A fair system for which patients are seen first in the emergency department	59. Being able to get an interpreter
29. Being able to park easily	60. Having access to food when I am hungry (not just at mealtimes)
30. Being told accurately how I can expect to feel after an operation or procedure	
31. My family or someone close to me having a chance to talk to staff about my care	

⁸ Better Together: Publication of Research into Patient Priorities for Inpatient Care

Engagement and Involvement

- 62 NHS Borders is committed to involving all stakeholders in the way we plan and develop services. For example:
- Through the Patient Focus Public Involvement work we engage with the Public Partnership Forum (PPF) and the Involving People Network (IPN);
 - In line with our Communications Strategy we engage with staff around and work in partnership to deliver service changes;
 - We ensure engagement and involvement with our external partners, including the voluntary sector, who have a key role in representing the views and interest of patients and families.
- 63 To support the work of the Strategic Change Programme we have developed a Stakeholder Communication, Engagement and Involvement Plan to ensure our stakeholders have the opportunity to influence and contribute to the service changes.

5 REASON THREE: MORE CARE CAN NOW BE DELIVERED OUTSIDE HOSPITAL

- 64 There are around 2 billion health care incidents in the UK each year; around 1 in 8 of those come into contact with the health service. In relation to the Scottish Borders there may be around 4.4m health incidents each year for our 110,000 population – around 550,000 of these incidents come into contact with health services, with around 90% of these beginning and ending in primary care. Pharmacy makes an important and increasing contribution to self-care in the community and the delivery of out-of-hours services through such schemes as the Minor Ailments Service and the National Patient Group Direction enabling emergency supplies. These developments are in partnership with NHS 24.
- 65 Our goal is to make care more consistent, faster and more responsive to patients' needs. We are already delivering quicker care, with good progress being made towards the 18 week Referral to Treatment target. For those with long-term conditions, their care will be more integrated and preventative; backed by modern information technology systems, individuals will be monitored regularly and supported by a range of skilled professionals to keep them at home for as long as possible. Support will, wherever possible, be focussed on enabling individuals to better manage their own condition and treatment. Those requiring urgent medical attention will be assessed and diagnosed. Investigations and treatment will be initiated quickly with admission to hospital only if it is absolutely necessary. Discharge will be co-ordinated and planned around patients' needs.
- 66 The changing pattern of disease and a shift in our approach to the delivery of care is making us question the current model of health care. Figure 5.1 shows the historical model of care and Figure 5.2 shows how the future pattern of care is evolving.

Figure 5.1: Historical Pattern of Care

Primary Care	Secondary Care
GP led supported by primary care team	Consultant-led with some nurse specialists / AHP specialists
All undifferentiated illness Little cross referral Chronic disease management	Most access to diagnostics Acute management major conditions Long-term follow up of many conditions

Figure 5.2: Future Pattern of Care

Pre-primary		Primary & Intermediate		Secondary & Tertiary	
<i>Nurse/Pharmacist/Social Work</i>		<i>GP led</i>		<i>Consultant led</i>	
NHS24 Email/Intranet Pharmacist-led Prescriptions Self-Help	Assessing risk factors Minor illness Major illness Specialist nurses Social care	Diagnostic uncertainty 1 ⁰ diagnostic support Complex problems Follow ups Sub-specialisation	Surgical/High tech Interventions True consultancy function Management of rare conditions		

- 67 The future configuration of the service should reflect a service that is designed around the needs of patients and delivers modern and flexible care, as close to home as possible. With around 90% of care already delivered in the community, the share of health care provided close to home is expected to rise. However, investment in modern primary care premises and diagnostics should be balanced with ensuring capacity in secondary care is able to meet challenging access targets.
- 68 Fewer older people now reside in institutional care than in previous decades. Around 95% of the over 65s live at home, many of whom make no greater demands on health and social care services than do younger members of the community. However, the likelihood of care being required increases significantly with age, particularly in the over 80s age group. As the absolute number within this age group is growing and will continue to grow in coming decades there will be increased pressure placed on health and social care services.⁹
- 69 As people develop more than one long-term condition, their care becomes disproportionately more complex and challenging for the individual or health and social care system to manage. Over the last thirty years, growing numbers of older people have experienced emergency admission to hospital, a major source of strain on the system. The numbers admitted several times in a year have grown most rapidly. In the main, increases have not happened because the population is getting older, or sicker. Evidence would suggest that the increase is because many of our most at-risk population have not been receiving the kind of preventative, integrated care that they need. Instead, the system often waits for a crisis to occur, resulting in a hospital admission.
- 70 We are working to streamline emergency and planned care, so that patients who need emergency care can be diagnosed and treated promptly without affecting the care for patients who are waiting for planned treatment. NHS Borders is assessing a number of options on how patients who need emergency care at the Borders General Hospital might be assessed, diagnosed and treated more quickly and effectively.
- 71 All of the increase in bed days for emergency inpatients over the last 20-25 years has been accounted for by patients aged 65 and over, with the vast majority being accounted for by patients aged 80 and over¹⁰. The evidence

⁹ <http://www.scotland.gov.uk/library5/rural/opr-09.asp>

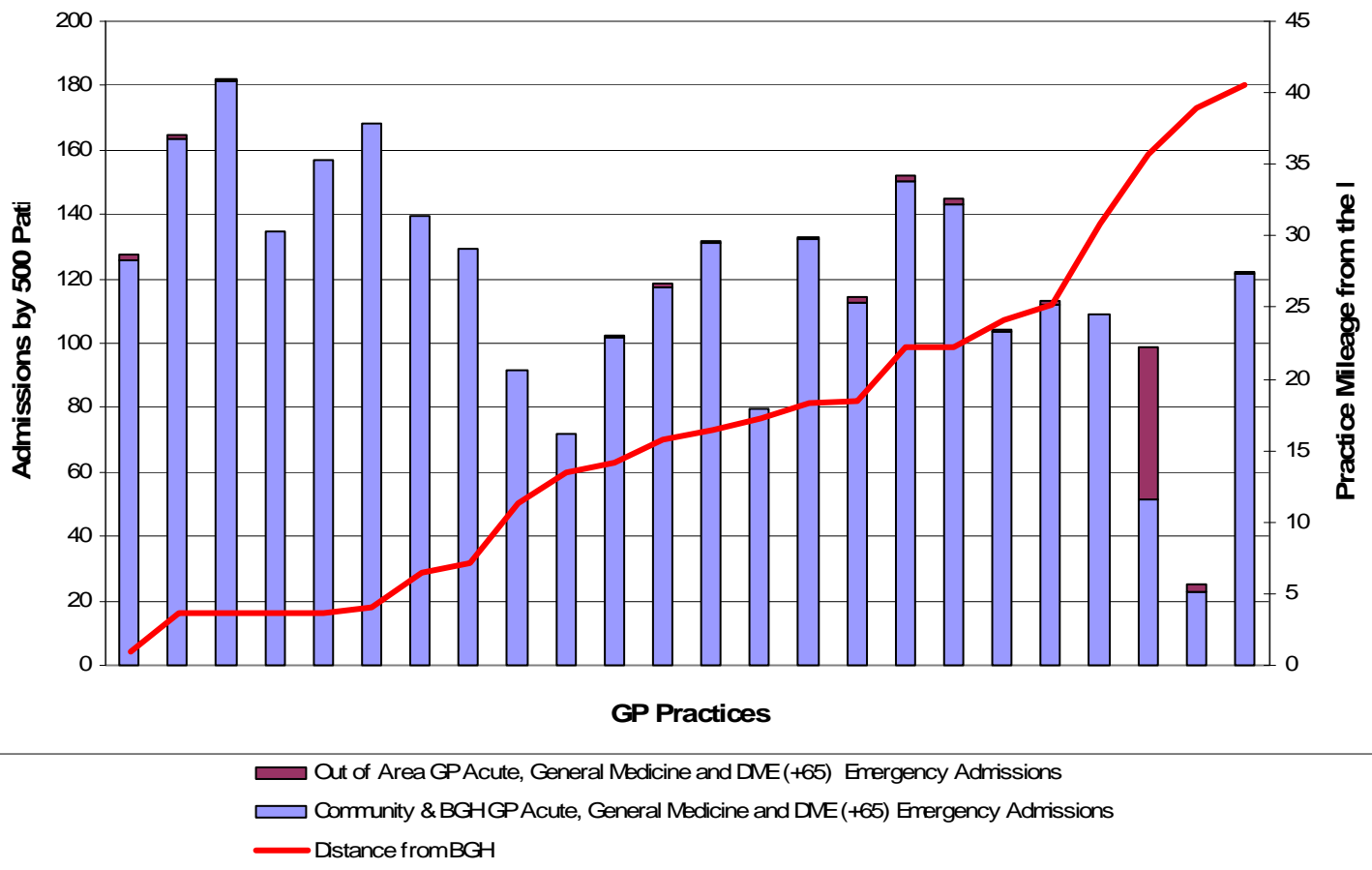
¹⁰ http://www.isdscotland.org/isd/files/SPARRA_Report.pdf

cited in the Scottish Patients At Risk of Readmission and Admission (SPARRA) Report points to age alone as not being the sole factor accounting for the rise in emergency admissions: *“a lack of integration and co-ordination in the system and a lack of proactive, holistic care, focused on long-term conditions has meant that the system tends to wait until medical crises occur”*¹¹.

- 72 Figure 5.3 shows the number of emergency admissions to the Department of Medicine for the Elderly and General Medicine for the 65+ age group, reviewed at a rate of admission by 500 patients. There appears to be a link between closeness to the Borders General Hospital and the level of admissions to the hospital. There is a pressing requirement to review these trends further as there is a level of variability when the data is considered over a 3 year period at a GP Practice level. This suggests that individual General Practitioners manage their patients in different ways to their peers. Standardising care through the use of integrated care pathways for this patient cohort may address this imbalance in the future.
- 73 A continued increase in admissions would place NHS Borders well above the national average for the over 65 age group and in terms of the requirement for additional beds and the costs associated to this, as discussed in the *Ongoing Change* section of this document and demonstrated in Figure 2.3, would be untenable as the funding allocation formula is unlikely to deliver any significant increase in the resources received by NHS Borders.

Figure 5.3: Number of emergency admissions to the Department of Medicine for the Elderly and General Medicine for the 65+ age group

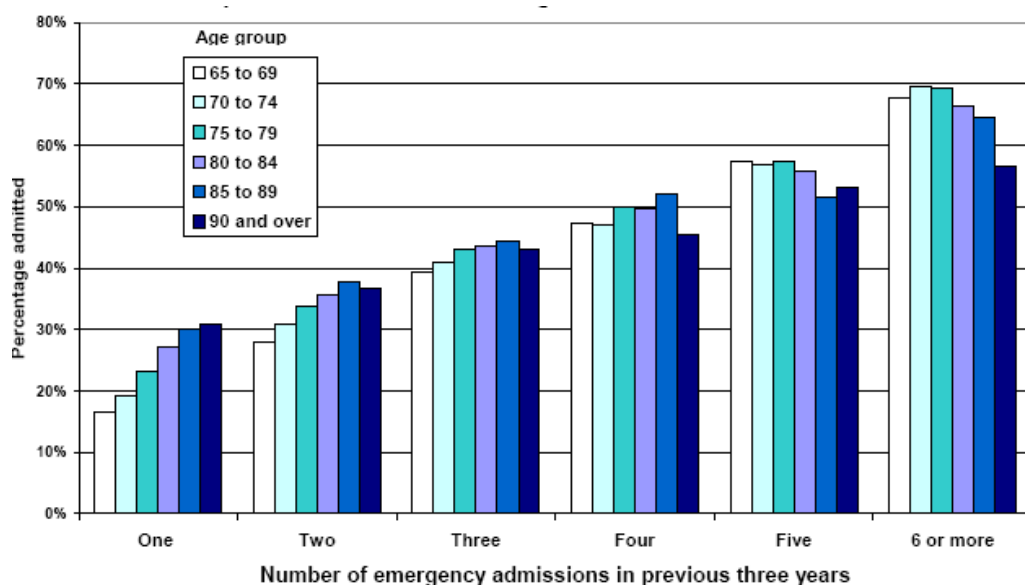
¹¹ SPARRA report Page 7



74 The following chart from the SPARRA Report (Figure 5.4) shows the predicted number of admissions in the forthcoming twelve months within each category, defined by age and number of previous admissions.¹²

Figure 5.4: Predicted Percentage Admitted as an Emergency in Next Year By Number of Previous Admissions and Age

¹² http://www.isdscotland.org/isd/files/SPARRA_Report.pdf



- 75 An estimated 2 million people in Scotland live with one or more long term condition and it is widely acknowledged that the appropriate management of long term conditions is one of the biggest challenges facing health and social care systems. Largely preventable chronic diseases (now referred to as Long Term Conditions) cause 86% of deaths in Europe and are estimated to comprise 8 of the top 11 causes of hospital admission¹³.
- 76 Research indicates that in Borders approximately 21.1 - 23.5 % of adults within the area have a limiting long-term condition (i.e. long-term health condition which limits activities) and that 28 – 33% of households within the local authority area contain someone with a long term condition. While there are other areas with higher proportions, these statistics are significant locally in terms of health and social care resources and the planning of future service delivery needs to take account of the predicted increases over the next few decades.
- 77 It is recognised that staff use different practices to manage patients with long-term conditions such as Coronary Heart Disease. The publication of Better Health, Better Care and the development of Single Outcome Agreements for community planning partners mean that there needs to be more significant, visible and better-coordinated improvements in relation to Shifting the Balance of Care. NHS Scotland has adopted the independent **Strategic Policy Analysis Collaborative (SPACE)** process in order identify high impact changes which, if implemented across Scotland, will have the biggest effect on what, how, where and by whom care is delivered to shift the balance of care.
- 78 Each year the Scottish Government sets targets for Health Board areas. The introduction of target T6 sets the challenge to “*achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, asthma, diabetes or CHD from 2006/07 to 2010/11*”.The information shown in Figure 5.5 reviews patients with Coronary Heart Disease who have had an in-patient stay in the Borders General Hospital. The table highlights the difference in discharges and lengths of stay for patients over 65 compared to those aged 25-64 years of age.

¹³ World Health Organisation, European Strategy(Sept 2006)

79 In 2007/08 over 5,000 BGH bed days were used for this cohort of patients, with over 87% of the patients aged 65 or over. The increase in emergency admissions among older people has been primarily the result of how the care system has worked to deal with older patients, rather than any increase in ill health or morbidity. Social factors, such as those living alone, may have increased the demand for “formal” care to the extent where health and social care are unable to cope with a sustained increase in demand. With the population getting older and prevalence towards longer term conditions there is a pressing requirement to look at alternative ways to look after these patients.

Figure 5.5: CHD Cases and Occupied Beds Days by Age Band

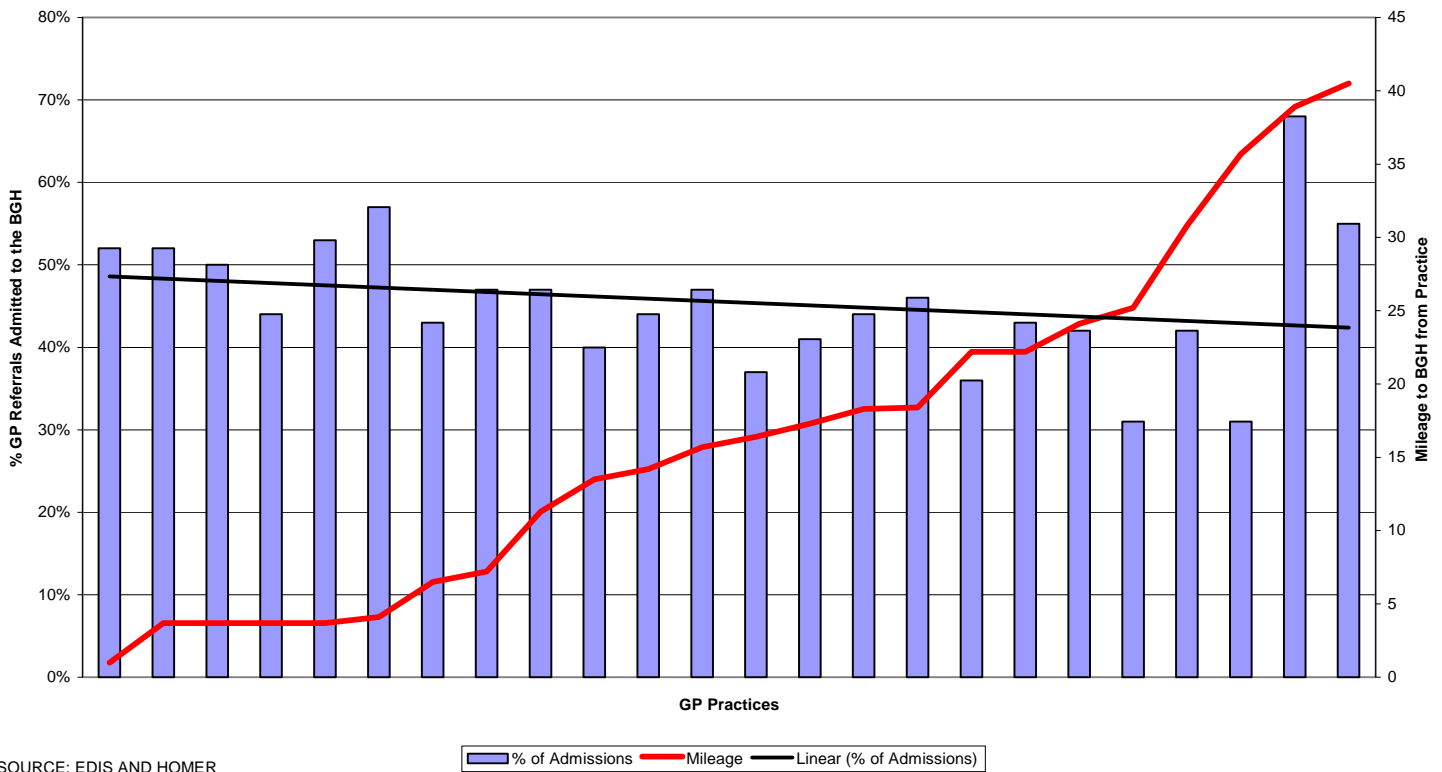
Year	Age Bands	Discharges	OBDs	Average LoS
2005-06	25-64	182	832	5
	65+	728	5807	8
2005-06 Total		910	6639	7
2006-07	25-64	155	599	4
	65+	593	4875	8
2006-07 Total		748	5474	7
2007-08	25-64	166	635	4
	65+	579	4384	8
2007-08 Total		745	5019	7
Grand Total		2403	17132	7

80 Fundamental to the whole approach in tackling long-term conditions is the need to optimise the provision of pre-hospital care, so that hospital is at one end of a continuum of care, rather than being the ‘default’ option. In other words, patients should only go to hospital if it adds value to their care. Many patients continue to access A&E services as an out-of-hours alternative to more appropriate daytime provision.

81 Figure 5.6 illustrates the relationship between proximity of a GP practice to A&E services at BGH. The ascending line indicates the miles from BGH and the bars in the chart show the percentage of GP referrals to A&E which result in an admission to hospital. There is a requirement to understand how and why there is the degree of variation which is illustrated in Figure 5.6; GP referrals to all specialities will be reviewed as a key service area by the Productivity and Benchmarking work strand of the SCP.

Figure 5.6: Total Admissions from GP referral to A&E for 2006/7 to 2007/08

Chart 5: Total Admissions from GP Referral to A&E for 2005/6 to 2007/8



SOURCE: EDIS AND HOMER

- 82 In order to face the challenges ahead it is vital that a “whole systems” approach is applied within NHS Borders to ensure services continue to be fit for purpose and sustainable.
- 83 Working with SBC and other partners we will ensure that for those most at-risk in our society there is a more consistent, holistic and integrated response to their needs by health, social work and other agencies. For those who can be supported in the community, we will design cost-effective but more homely services that respect their right to dignity and privacy. By pooling resources between health and social work, such as for people with learning disability, within a clear accountability structure, we will remove the artificial barriers to delivering care that is tailored to the needs of the individual rather than the provider.
- 84 Almost three quarters of people needing very high levels of care and support are currently in residential care, nursing homes or hospital long stay beds. In line with people’s wishes to stay at home for as long as possible NHS Borders and SBC require to jointly redesign existing services and develop new services to provide appropriate accommodation and the right sorts of care in the Community.
- 85 There are already a range of approaches in order to deliver the right type of care at the right time within the right place, including: Intermediate Care; Telecare/Telehealth; Day Services & Day Hospitals; Preventative Services.

- 86 *Better Health, Better Care*¹⁴ and *Changing Lives*¹⁵ together emphasise the need for a fundamental shift in the way we plan and deliver services so that we tackle the causes of ill-health and social inclusion – to provide effective, quicker and more personalised care and support that is closer to people’s own homes and communities. Over recent years, there has been a strong drive towards more integrated service delivery between NHS Borders and Scottish Borders Council. The establishment of a single, unified learning disability service is an example of the delivery of more integrated and responsive services. The *Changing Children’s Services Fund* is an example of the substantial challenges in seeking a shared approach to decision-making and prioritisation across our organisations.
- 87 In co-operation with Scottish Borders Council, there is a significant review of dementia services underway. The review will examine the challenges posed by an ageing population and the accompanying rise in dementia. With the forecast growth in elderly population we are predicting significant increases in demand for Dementia services. To meet this demand will require looking at delivering services in a different way. Again, the review presents opportunities to consider how best to meet the needs of service users and their families by rationalising service provision and facilities between NHS, social work and the independent sector.
- 88 We need to continue to work with our partners to further enhance and develop these services and joint initiatives. The design of future service provision also needs to consider the rural nature of the Scottish Borders, striving to make sure that older people in all areas have access to a variety of local, flexible and responsive services.
- 89 During June 2008 a window of opportunity arose due to lower levels of inpatient activity within Poynder View to look at piloting for 12 months an innovative model in Eastern Borders and test out a community based service. Following a review of dementia care in the Borders one of the emerging recommendations was a move away from institutional care to services provided closer to individuals’ homes. An older people’s resource centre/ outreach team based in Kelso hospital has been developed and is currently being piloted using the resource from within the previous provision at Poynder View.

KEY MESSAGES

- The nature of healthcare is increasingly less about beds and more about high quality local care delivered through multi-disciplinary teams
- We have a higher than average bed provision
- There is sizable variation in referral patterns and admissions that need to be analysed and understood

¹⁴ Better Health Better Care, Scottish Government, December 2007

¹⁵ Changing Lives Implementation Plan, Scottish Executive, June 2006

6 REASON FOUR: DEPLOYING OUR WORKFORCE AND USING OUR BUILDINGS MORE EFFECTIVELY

Workforce

- 90 We are witnessing substantial changes in the pattern of work. By 2025, for the first time, the number of older people over 60 in Britain will outnumber those under 25¹⁶. The principal projection estimate is that the ratio of people aged over 65 to those aged 20 to 64 will increase from 27% today to 47% in 2050, with the great majority of the increase occurring by 2035¹⁷. Around 60% of undergraduates at medical school are now female¹⁸ and by 2012 it is predicted that female doctors will outnumber male doctors¹⁹. It is likely that this will impact the service due to a possible increase in requests for maternity leave and changes to patterns of work utilising more flexible and part time working. These are just a few of the changes underway now and in the future.
- 91 Our local Workforce Plan highlights the substantial challenges facing us in maintaining a well-trained and motivated workforce. Greater emphasis is given to the integration of workforce development, service planning, education, training and professional development as a result of the changing demographics of society and workforce dynamics. The combination of an ageing workforce, the need for better work-life balance, skills shortages and the implementation of new legislation has driven us towards a more fundamental rethink of how services should and can be provided in future.
- 92 In NHS Borders, we have benefited from a stable workforce with, generally, low labour turnover. There are risks associated with this, with the loss of even one experienced member of a team leading to service difficulties, whether it is the experience they take with them or trying to recruit someone else with the same skills.
- 93 Using information held in the Whole Systems Scorecard it is possible to compare staffing levels across all Scottish Health Boards. NHS Borders is above the national average and would appear to be well resourced. Teaching Hospitals have higher levels of staffing and if these are taken out of the equation, then NHS Borders would be very close to being the best resourced Board in terms of its workforce numbers.
- 94 The workforce drivers outlined above require a range of responses including:
- breaking down barriers between primary and secondary care;
 - changing skill mix between and within professions;
 - role enhancement for nurses, AHPs and other clinical staff;
 - a more robust training strategy including the modernisation of medical training, and a modernising of nursing careers;
 - creation of clinical networks;
 - greater differentiation of scheduled and unscheduled care;
 - selective concentration of services.
- 95 A critical challenge placed upon us is to align the workforce to the demands and expectations of a 24-7 society. The goal is ultimately to deliver a service

¹⁶ NHS Confederation, *Maximising care at home* (November 2005)

¹⁷ The Pensions Commission Final Report (November 2005)

¹⁸ Gray S. Our work is not yet done. *Hospital Doctor* 2004 Oct 1

¹⁹ Roberts J. The feminisation of medicine. *BMJ Careers* 2005;330:13-5.

that is no longer designed around a 5 day 'in-hours' service, but is consistent, integrated and delivered to a high standard 24 hours a day, 7 days a week, all-year round. It is therefore, for example, becoming increasingly difficult to justify substantial capital investment in high cost equipment and facilities and to fail to staff and use such assets in an efficient and effective manner 7 days a week.

- 96 Pay Modernisation – including the new Consultant Contract and *Agenda for Change* – is intended to provide new levers to not only reward the workforce more appropriately but also to achieve a more flexible service, that is better fitted to meeting the needs and expectations of patients and their families. It is important that we build on the *Pay Modernisation Benefits Delivery Plan*²⁰ and demonstrate that we are translating changes in how we deploy staff, such as in shift working, into perceptible improvements in the patient experience.
- 97 The substantial changes arising from changes in the medical workforce have been well-documented. The forthcoming reduction in working hours as a result of the European Working Time Directive (EWTD) and the imminent implementation of changes to training through *Modernising Medical Careers* means a continued reliance on trainees to provide 24/7 receiving rotas is not realistic. Alternative workforce models are therefore needed to sustain the existing 24/7 receiving pattern. It is important to recognise that a model which increases the number of doctors in training to match EWTD requirements is likely to result in actual clinical experience being diluted therefore not satisfying training requirements as a steady flow of clinical activity would be required to maintain skills and certification.
- 98 Yet unless we take action, we know that the introduction of *Modernising Medical Careers* will impact on our acute services. The potential risks regarding the allocation of places for specialty training and the availability of FTSTA (Fixed Term Specialist Training Appointments) posts will require us to review the sustainability and retention of services on a specialty-by-specialty basis. Between 2010 and 2012, it is expected that there will be a 40% shortfall in the availability of specialty trainees to meet the current configuration of services; if we were to continue to rely on trainees to continue to provide 24/7 receiving rotas this will mean either a regional approach to the design of services or a regional approach to the allocation of specialty trainees.
- 99 The NHS is a 24 hour, 7 day a week service making substantial demands on our staff. The greatest challenge to sustaining our acute services is presented by emergency services, which have to be available 24 hours a day. Keeping them local is important. It is also important that they are of the highest possible quality, with easy access to specialist care when needed.
- 100 In common with other small boards, the trend towards increasing sub-specialisation, linked with workforce issues (e.g. *Modernising Medical Careers*) and rigorous clinical standards, presents a challenge to the sustainability of some local services. The changing workforce, allied to increasing expectations and new technologies, is challenging our current thinking. The Borders General Hospital is 20 years old – securing its future over the next 20 years and beyond requires us to think and act differently. Its future is as an acute hospital, firmly embedded within the local health system – as a specialist centre supported by first class, and rapid access, diagnostics and assessment services.

²⁰ Pay Modernisation Benefits Delivery Plan

- 101 In the future, managed clinical networks will be crucial in securing sustainable services across the region. Mobile clinical teams become central to the drive to deliver safe, but local services, working to shared objectives. For some conditions, patients will have to travel further. More complex paediatric surgery and vascular surgery are current examples of where Borders patients currently do have to travel further for care and treatment. In future, the number of conditions or specialties requiring greater distances to be travelled may increase – such as with the rise in sub-specialisation – but off-setting that will be the trend towards more day case surgery and care within health centres and by non-invasive means such as drug treatment. It may also be possible for certain key services to be expanded locally – achieving a critical mass of services for a larger catchment population.
- 102 The European Working Time Regulations make the provision of care through traditional 'on call' arrangements difficult because of the number of hours clinical staff are allowed to work. These regulations will become more stringent in 2009 with the extension of the regulations to training grade doctors, meaning that new ways of organising staff will be needed.
- 103 The introduction of the EWTD and *New Deal* for junior doctors has placed an obligation on us to reduce the number of hours staff are allowed to work and to introduce safe working patterns. By August 2009, our staff will work no longer than 48 hours a week. The new Consultant contract has introduced a time-based working pattern (to replace a professional contract) for NHS Consultants. Our response cannot simply increase the Consultant establishment. Without increasing the volume of clinical activity, individuals would not be able to remain appropriately skilled and therefore accredited to practice. The further changes introduced by sub-specialisation (such as in general surgery) further impact on the availability of clinical staff to participate in on-call and out-of-hours cover. Sub-specialisation also requires Consultants to have access to larger patient cohorts to maintain skill levels.
- 104 These changes have a substantial impact on the delivery of acute services across the NHS. Our local experience has been that we have been able to maintain and develop a wide range of services with reports highlighting strong performance in terms of service quality and the opportunities offered for training. We do not pretend that the current configuration of services can be easily sustained.
- 105 However, there is a need to review the contribution of SAS (Staff Grade and Associate Specialist) doctors and how those doctors, combined with other posts, will support service delivery in future. This group of doctors will also transfer to a time-based contract during 2009. A more flexible response to meeting the staffing needs will require imagination and radical service redesign rather than a simple reliance on filling gaps in service provision with consultants.
- 106 A range of measures are being adopted to meet changes in the employment of staff, such as *Hospital at Night within the Borders General Hospital*. The implementation of Hospital at Night initially in August 2007 relies on a team approach with a generic tier of junior doctors supported by Advanced Practitioners overnight, and this has assisted with the safety and compliance of some rotas. As this service model has developed successfully over the past two years there is now a need to concentrate on appropriate staffing 24/7 and the development of new ways of working, not only at night, but also in the evenings, at weekends and for emergency care during the day.

Experience across the UK indicates that at night, activity varies by specialty: medicine in general continues to have activity throughout the night and at weekends, but surgery in general falls to a much lower level. Few patients have life threatening conditions and around a quarter of junior doctors' time is spent on tasks that do not require medical skills (e.g. requesting investigations, finding notes or information, some minor procedures).

- 107 It is essential that there is a wider response to meeting the challenges facing us, involving a range of health professionals. It is envisaged that teams of professionals will deliver healthcare outwith the traditional professional or organisational barriers – our future workforce strategy must harness new and advanced roles of healthcare professionals. NHS Education for Scotland (NES) will continue to consolidate specific educational initiatives to support the development, integration and evaluation of new roles and skill development.
- 108 This review by NES emphasises that a *“modernised workforce is essential to sustainability. At a local and national level, many new roles are being developed based on a more modern and flexible workforce that possesses the appropriate skills to deliver modern, safe and effective healthcare. Role development is an innovation that is crucial to the long term sustainability of BGH. The overarching NHS Career Framework is the theoretical underpinning of role development.”*
- 109 Many more services are now delivered by non-medically trained professionals. The expanded role for NMAHPs (nurses, midwives and allied health professionals) demonstrates the opportunities for health professionals to take on new duties.
- 110 The National Review of Mental Health Nursing in Scotland, Rights, Relationships and Recovery has emphasised the widening role and development of mental health nurses, such as in the provision of psychological therapies.
- 111 Modernising Nursing Careers: Setting the Direction²¹ focuses on the careers of registered nurses, but recognises that nurses do not work in isolation and nursing teams include more than registered nurses. It acknowledged that nursing careers need to take account of changes in the careers of other professional groups and must respond to the profound changes taking place in the structure of health care delivery.
- 112 The Scottish Government expects an expanded role for pharmacists through the new pharmacy contract, delivering new core services such as the Minor Ailments Service, Public Health and Chronic Medication Services and pharmacists in general through independent prescribing.
- 113 It is also vital that the workforce plan emphasises the development of technical and support staff, including review of configurations in light of improved changes in the delivery of services. This also allows for opportunities to develop staff through vocational training.
- 114 The wider role for the workforce in supporting the embedding of health improvement requires to be considered and what measures are required to achieve this needs to be carefully thought through.

²¹ Modernising Nursing Careers, Setting the Direction, Scottish Executive 2006

- 115 The workforce changes that are now upon us can only accelerate. Changing expectations about work-life balance, set against growing expectations of a 24/7 service, and rising standards will mean that the workforce of tomorrow needs to change and adapt. In acknowledging this, we need to ensure that workforce strategy is fully integrated with our strategic planning for the future.

Buildings

- 116 We need to make the most efficient and effective use of our facilities whilst delivering care in modern premises that are fit for the 21st Century.
- 117 Over the past several years, we have undertaken a major capital programme to transform our community health facilities that will amount to an extra £16m of one-off capital expenditure. With new health centres for Stow and Newcastleton, and the substantial upgrading of Kelso and Galashiels Health Centres, we have demonstrated a commitment to modernising local health care. We have also made substantial improvements in Duns, Kelso and Peebles Community Hospitals as well as a new community hospital in Hawick. We are now advancing plans to improve health care facilities in Jedburgh, Lauder and Galashiels.
- 118 It is important to emphasise that the principal consideration in the redesign of our services is not the availability of capital funding. Capital funding is clearly an important means to introducing improved health care, but the starting point in deciding how to make the most effective use of our resources will be the underpinning clinical strategy and the subsequent design of services that are sustainable, efficient, and as local as possible. Capital investment should therefore reflect strategic priorities and objectives rather than drive them.
- 119 Simply injecting additional capital investment, without considering how best to make efficient and effective use of the current estate would not be sensible. It is therefore important that we are designing an integrated and efficient estates strategy that maximises the use of our existing assets and delivers care in patient environments that are safe and modern.
- 120 Figure 6.1 demonstrates that we still retain a diverse range of small facilities, alongside the wide range of other health facilities including day care and health centres. Maintaining such a diverse range of facilities has an opportunity cost in terms of service delivery and improving patient care. In total, we have an estate covering 80,000 square metres.

Figure 6.1: Health Facilities in Borders

Hospital	Description	No. of Beds
Borders General Hospital inc Central Borders Community Hospital, Melrose	District general hospital opened in 1988 offering range of in-patient, day case and diagnostic services and Community hospital facility based within the Borders General Hospital	320
Knoll Community Hospital, Duns	Opened in 1976. Recently upgraded to include new provision for frail elderly patients	27
Kelso Community Hospital, Kelso	A wide variety of services are provided, with three wards, Day Hospital, Physiotherapy, Occupational Therapy Services. BECS (Borders Care Emergency Service) and Minor Injuries Services are also provided. This facility has recently been upgraded and modernised	40
Poynderview, Kelso	A 16-bedded unit based in Kelso Hospital providing long stay care for people who have dementia.	16
Haylodge Community Hospital, Peebles	The Haylodge Community Hospital opened in 1983, and has recently been part of a community hospital refurbishment project. It offers a similar range of facilities as Kelso Community Hospital.	46
Hawick Community Hospital, Hawick	The new Hawick community hospital recently opened in 2005. The hospital brings together the services formerly provided in Hawick cottage hospital, the Adult Day Unit, the Dementia Day Unit at Westport, Mental Health Services, Outpatients and Dental Services.	24
Teviotbank, Crumhaugh House, Hawick	NHS continuing care unit, opened in 1994, replacing the previous Drumlanrig Hospital in Hawick	17
Wilton View Crumhaugh House, Hawick	A 16-bedded unit based in Crumhaugh House providing long stay residential care for people who have dementia.	16
Huntlyburn House, Melrose	Huntlyburn House opened in January 2000 and is a 30-bedded acute admission mental health unit situated on the hill above and behind the Borders General Hospital. Patients are admitted for assessment and treatment of mental health problems.	30
Cauldshiels, BGH, Melrose	A 24-bedded Dementia Assessment Unit situated within the Borders General Hospital, which opened in August 1999.	20
Melburn Lodge, BGH, Melrose	This purpose built unit opened in January 2000 and is a 20-bedded unit situated on the Borders General Hospital Campus, providing NHS care for people with dementia.	16
Galavale, Galashiels	An 11-bedded (one respite bed) unit providing a rehabilitation service and home for residents of both sexes with long standing mental health problems who can no longer cope in their own	11

	homes or other supported accommodation.	
East & West Brig, Galavale, Galashiels	A mental rehabilitation and a slow stream rehabilitation facility which focuses on assessment and treatment.	12 & 5
Total Beds		604

121 The Whole Systems Scorecard allows areas to compare estates costs by reviewing fixed assets per head of population. Figure 6.3 demonstrates that NHS Borders has a significantly higher asset value per head of population than the national average, a result of diverse range of properties owned by the organisation. The Integrated Health Strategy (IHS) strand of SCP will review the use of all properties, owned and rented, to understand how the existing estate is utilised.

Figure 6.2: Comparison by Health Board area of Fixed Assets per Head of Population

Health Board	Fixed Assets Per Head of Population
Highland	£1,023.30
Borders	£988.30
Ayrshire & Arran	£900.30
Tayside	£893.90
Scotland (Mean)	£834.40
Dumfries & Galloway	£681.10
Grampian	£677.00

122 Our investment programme has been heavily geared towards the provision of a modern network of primary care facilities and community hospitals. With an ageing population and the extended opportunities to provide care and diagnostics closer to home, we have tailored the investment accordingly.

123 The investment in new buildings needs to be accompanied by the modernisation of care processes within these facilities. Simply replicating out-of-date practices, or providing limited therapeutic input, in more modern surroundings defeats our goal of achieving more responsive care and better outcomes. There is a need to have a more explicit strategy for other health care facilities across the Scottish Borders that ensures that we are not sustaining facilities that are no longer tailored to meeting the modern, responsive services that we seek to achieve. That strategy should emphasise the connected and networked nature of care and the need, for example, for the community hospital beds to be seen as an integrated part of the bed complement of the whole system.

124 We need to ensure that across the area that we have a range of facilities that are truly “fit for purpose” and we operate services that are modern, flexible and responsive. The changes we have made in recent years in Jedburgh and Coldstream have signalled a willingness to rethink the pattern of service delivery. We need to ensure similar level of review and scrutiny is applied to our other health care facilities. Arguably, we are still seeking to sustain an inefficient multiplicity of facilities based on an historical pattern of care, rather than as a result of an over-arching and well-defined strategy reflecting local need. There needs to be further thought given to how we can achieve a more efficient concentration of high quality services in more modern facilities and a more co-ordinated networking with acute services, whilst minimising the impact on access.

- 125 It makes little sense to operate services from multiple sites – sometimes distances between them can be measured in a few miles or less – when co-location of services offers substantial advantages in terms of integrated care and the opportunities to achieve efficiencies and economies of scale. We should also consider opportunities to collocate with our partner agencies, wherever possible. At present NHS Borders operates from over 30 sites across 17 communities.

KEY MESSAGES

- An ageing and changing workforce requires us to think radically about how we deliver care
- Our model of service delivery is balanced towards “care through buildings and beds”
- There is an opportunity cost in delivering care through buildings and multiple sites

7 REASON FIVE: MAKING THE BEST USE OF TAXPAYERS MONEY

- 126 On integration in 2003, NHS Borders inherited a recurring deficit of £3million. As a result of the hard work of staff across the organisation this was addressed and the Board returned to financial balance in 2006/07; this has been maintained through 2007/08 and 2008/09. **This is a substantial achievement recognising where we came from in 2003 and the range of issues dealt with since then.**
- 127 The conclusion of the last UK Comprehensive Spending Review settlement in 2007/08 has signalled the end of a period of above-average growth for the NHS in general. NHS Borders currently expects that future investment will need to be much more closely tied to self-generated efficiency savings, in order to secure the improvements in health and health care that we want to deliver and secure value for money. This latter point is emphasised by a requirement of all public sector bodies in Scotland to secure 2% recurring efficiency savings each year between 2008/09 and 2010/11. This means we need to make around £10m of recurring savings between now and 2011 which will be monitored by the Operational Budget Savings strand of the Strategic Change Programme.
- 128 As we look forward the new NHS Scotland Resource Allocation Committee (NRAC) funding formula will have an impact on our plans as, whilst we will still receive an annual uplift each year this uplift will be set at the minimum level, and NHS Borders share of the national allocation will become smaller over a number of years. This is due to a change in the formula that estimated the level of excess costs arising from remoteness and rurality. This recent change has had an impact on our longer term financial assumptions, as whilst we will not receive less funding our funding will not now grow as quickly as previously planned. Given that Borders also faces a projected increase in population over the next two decades this will mean us meeting the demands of a rising population alongside the minimum annual uplifts in our allocation. NHS Borders has welcomed the establishment of TAGRA (Technical Advisory Group on Resource Allocation) which in its first year will look specifically at the impact of NRAC on health care in remote and rural areas and also the costs of providing out of hours services. NHS Borders is working closely with colleagues in NHS Highland and NHS Dumfries and Galloway with this work.
- 129 The general reduction in the level of growth in NHS funding, the longer term impact of NRAC and other wider changes e.g. in the workforce and technology will mean that services will need to adjust. Doing “more of the same” will not be tenable – nor will our traditional arguments for extra resources – such as having a rural area and an ageing population be able to be supported by more recent evidence.
- 130 It is vital that through the Strategic Change Programme a detailed analysis around NHS Borders performance, both in clinical and non-clinical areas, is carried out as a single organisation. Any gaps where NHS Borders performs differently to the “average” should be reviewed and agreed actions taken to address any issues uncovered. Given the challenges we face an average performance for NHS Borders will no longer be acceptable and we need to aim for the upper-quartile of performance outturns over the next five years.
- 131 For example the use of GP acute beds in Community Hospitals may require review. The average length of stay (LOS) is 26 days with a cost per case of

£5,647. NHS Borders Community Hospitals are fairly typical to standard however there is significant variance across the sites. In Hawick Community Hospital the average length of stay is 26.2 days with each case costing £5,281, Kelso has an average LOS of 14.9 costing £3,810, Haylodge's average LOS is 23.4 costing £4,378 and Duns has an average LOS of 27.7 and costs £4955. We recognise that hospitals by their nature are not generic, and the hospitals in Borders are of different sizes and ages which will be a contributing factor however the disparity in cost per case and length of stay in our Community Hospitals does need further consideration.

KEY MESSAGES

- Growth in NHS resources will be at a slower rate than in previous years
- The changing funding formula has had a material impact on our financial outlook
- We need to make hard choices about the future mix and configuration of services
- We need to constructively challenge the current model of care and performance
- Average performance for NHS Borders will no longer be acceptable and we need to aim for the upper-quartile of performance outturns over the next five years

8 LEADING CHANGE AND IMPROVEMENT

- 132 Achieving our vision will also require substantial investment to be matched with major change. The preceding sections of this report have demonstrated why we cannot stand still. New technologies, changes in the workforce, an ageing population and the rising tide of expectations mean that we must look to new ways to deliver care. The changes in the funding formula simply accelerate the need for change. Creating a more healthy population means more proactive approaches to tackling inequalities in health and targeting the most at risk. All of these actions, we must do in concert with our partners and the wider public.
- 133 Achieving the scale and magnitude of change required will not be possible within the current configuration of health care services in the Borders. Standing still risks an erosion of services or a failure to improve health care. The status quo is therefore not an option, and we must now look to implement further those strategic goals set out in *Getting Fit for the Future* by reviewing what, how, where and when NHS Borders deliver services to the people of the Scottish Borders.
- 134 Our current levels of activity alongside the configuration of our staff, services and sites from which we operate must be reviewed if we are to ensure the sustainability of services within Borders, offer value for money, improve patient care and adopt evidence based change. Implementation of the Strategic Change Programme enables NHS Borders to review current activities, reaffirm the overall strategic direction for the Board and release efficiencies required to redesign and improve services, within an overall context of achieving £10 million recurring savings to sustain its financial balance over the next 3 years.
- 135 NHS Borders is committed to delivering a more modern, accessible service – a service that is better, quicker, closer and safer. Through our subsequent Strategic Change Programme, our goal is that the people of NHS Borders will have access to a networked range of services, operating from hospitals, health centres and in the community that are modern, convenient and well-equipped.