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Scottish Borders Health and Social Care PARTNERSHIP

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD MONDAY, 20TH AUGUST, 2018

Please find attached the reports which were to follow in respect of Items 6.4, 6.5 and 7.3 on the agenda for the above meeting

6.	**6.4**	**Integrated Care Fund**	(Pages 3 - 58)	Chief Officer
6.	6.5	**Monitoring of the Integration Joint Budget 2017/18**	(Pages 59 - 66)	Interim Chief Financial Officer
7.	**7.3**	**Winter Plan 2018/19**	(Pages 67 - 82)	General Manager Unscheduled Care

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 20 August 2018

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Jane Robertson, Strategic Planning and Development Manager
Telephone:	01835 825080

INTEGRATED CARE FUND PROPOSALS
August 2018

Purpose of Report:	The purpose of this report is to outline the four Integrated Care Fund (ICF) proposals and to seek approval from the Integrated Joint Board (IJB) for three of these proposals. The fourth IC funding proposal has already been agreed and is here for noting.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the ICF proposal which has already gained approval for the Strata Programme b) **Approve** the proposals for IC funding to the end of March 2019 for: Craw Wood, Hospital to Home and COPD.

Personnel:	A number of projects employ staff

Carers:	A number of projects have positive outcomes for carers

Equalities:	Related to EIA for Strategic Plan

Financial:	n/a

Legal:	n/a

Risk Implications:	Risk of not delivering on strategic priorities if those projects which are clearly supporting delivery are not supported to continue

Purpose

1.1 The purpose of this report is to outline the four Integrated Care Fund (ICF) proposals and to seek approval from the Integrated Joint Board (IJB) for three of the proposals. The fourth IC funding proposal has already been agreed through emergency decision making by the IJB Chair, the IJB Vice Chair and the Chief Officer and is here for noting.

Proposals

2.1 Further funding for two projects already ratified by the IJB is sought to ensure the continuation and expansion of the services until the end of March 2019. These are:

Craw Wood	£
Further resources required:	£411,100
Proposal to continue to use the facility up to March 2019 to facilitate early discharge from hospital and meet on going critical needs for rehabilitation and support. Continuance of this facility over the winter months of 2018/19 will alleviate winter pressures and support the functioning of the hospital at that time. Full project proposal to fund the facility from October 2018 to end of March 2019 can be seen in Appendix 1.	

Hospital to Home	£
Expansion of resources required:	£984,745
Proposal to continue the Hospital to Home service in Berwickshire and Teviot, expand the service in Kelso and Peebles linking in with Community Hospitals and develop the model with AHP input in the Central area to facilitate discharge prior to social work assessment. The work will then be resourced to cover the whole of the Borders Funding required for October 2018 to October 2019. Full project proposal can be seen in Appendix 2	

2.2 The proposal for Strata detailed below has already been approved by the IJB Chair and Vice Chair through urgent decision making as the contract needed to be in place to begin work in July ahead of winter. The report is presented for noting:

Strata	£
Further resources required	£75,000
Proposal to use a test of change project which seeks to deliver efficiencies to the current process for moving patients out of hospital and matching them to appropriate services. Expected benefits are to streamline the current service, provide significant reduction in time wasted, improve communication across stakeholders and reduce the number of delayed discharges in NHS Borders. The reduction in delays and the streamlining of processes will culminate in savings in administration and bed days. The urgent need for this decision related to the requirement to begin the work in July so it could be completed ahead of the expected pressures due to winter. Full project proposal can be seen in Appendix 3.	

2.3 The following proposal has been developed to fill a gap in service provision regarding COPD and is detailed below:

COPD	£
Further resources required	£99,000k
Proposal to develop a robust rehabilitation model for individuals with long term conditions that includes pulmonary rehabilitation (PR) as a core element. PR is a cost effective intervention which has been proven to have a significant impact on quality of life and supports the avoidance of unnecessary hospital admissions. Full project proposal can be seen in Appendix 4	

2.4 Each project proposal included as an appendix addresses how it will meet the five proposed conditions for the ICF.

2.5 Following the urgent decision to contract with Strata and should the IJB approve the three proposals for IC funding this will reduce the unallocated fund for 18/19 to £1.265m as detailed in Table 3 and 4 below.

Table 3

Funding Proposals 2018/19		
Unallocated Funding at 30/6/2018		£2,351,000
Extension of Crawwood Oct 18 to Mar 19	(411,100)	
COPD (Full year costs)	(99,000)	
Hospital to Home full year costs	(984,745)	
Unallocated Funding after above proposals		**856,155**

Table 4

Approved Funding 2018/19		
Unallocated Funding after above proposals		£856,155
Strata (6 months trial)	(75,000)	
Total Unallocated Funding remaining		**£781,155**

2.6 The following information contained within the following table outlines the costs and potential savings within the first year.

Proposal	**Projected Costs**	**Projected Financial Savings in first year of operation** *(less projected costs)*	**Projected Non-Financial Savings** *(Occupied Bed Days)*
Craw Wood (until April 2019)	£411,100	£ 85,650	3,880
Hospital to Home	£984,745	£382,009	5,670
Strata	£75,000	-	
COPD	£99,000	£166,000	
Total savings after programme costs		£633,659	

Strata, COPD and Hospital to Home are all expected to continue beyond their first year of operation funded from within base budget. Significant recurring savings are expected beyond the 19/20 financial year from these programmes.

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Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Project Name	Discharge to Assess – Craw Wood		
Project Owner	Rob McCulloch-Graham	**Application Main Contact**	Sonia Borthwick
Main contact email	Sonia.Borthwick@borders.scot.nhs.uk	**Main Contact Telephone**	01896 827616

Guidance on Project Brief

The purpose of this form is to give an outline on the key aspects of the proposal to the Integrated Care Fund for the continuation of the Craw Wood facility from October 2018 to 2019.

1 Outline project description

Please summarise the project in no more than 250 words

The paper presents the case for continued investment in this Discharge to Assess facility to enable it to remain open up until 31st March 2019.

In 2017, the Integration Joint Board approved the issuing of a Direction to NHS Borders and Scottish Borders Council to introduce a policy of "Discharge to Assess". In December 2017, Craw Wood opened as a 15 bed Discharge to Assess facility after a period of refurbishment work.

Craw Wood is an assessment facility where people stay for a short period of time. These people must be over the age of 50 and be clinically ready for discharge from hospital. During their stay at the facility, an assessment of care and re-ablement needs is completed.

This enables the multi-disciplinary team to:

- gain an accurate understanding of the person and their strengths and critical needs
- consider the most appropriate place for a person to receive the care and whenever possible to support a person to return to their own home
- minimise delays in discharge for all people who, due to their health status or due to lack of available resources cannot return home at present

The facility is run by SB Cares, supported by input from local GP's, AHP's and the District Nurse Team when required. The facility is registered through the Care Inspectorate and valid until October 2018.

The facility opened on 4th December 2017 and quickly after this, opened a second wing and runs with a capacity of 15 beds.

There have been a total of 101 patients that have been discharged from the BGH and have used the facility. This has saved a total of 1980 bed days during this period assuming an average length of stay is 19.6 days for DME wards within the BGH. This would equate to a £259,380 saving if we take the average bed day cost to be £131. (Or the closure of five beds, if the performance was maintained.)

A number of patients who have used the Discharge to Assess facility have needed to be re-admitted to an acute Hospital.

Of the 101 patients who were in Craw Wood:	Number of Patients	Percent
Re-admissions less than 7 days	6	6%
Re-admissions less than 28 days	22	22%
Readmitted During stay at Craw wood	14	14%

Over a longer period of time the outcomes of these patients will be able to be compared to the longer term outcomes of other patient groups to better understand long term benefits. What is indicative of this data is that the length of stay upon re-admission is shorter than those who have not been discharged via the facility.

The facility has sufficient funding to operate until the end of September 2018. We propose to continue to use the facility up to the end March 2019 to facilitate early discharge from hospital and on-going assessment of critical needs for both rehabilitation and support. Using the data and experience from 2017, it is proposed to flex the number of beds available within the facility to match the demand. The staffing compliment will be adjusted to match this need.

The table below illustrates how the facility will flex over the period, and demonstrates what the potential savings in occupied bed days would be is operating at full capacity.

Month	Oct 18	Nov 18	Dec18	Jan19	Feb 19	Mar 19	Totals
Beds	8	8	15	15	15	15	
Bed days available	248	248	465	465	420	465	2311
Max number of patients. (CW length of stay 12 days)	21	21	39	39	39	39	198
Length of hospital days avoided (DME ward ave 19.6 days)	412	412	764	764	764	764	3880
Operating full capacity, with a hospital bed costed at £131, the potential saving available is;							£508,280

The continuance of Craw Wood over the winter months of 2018/19 will significantly contribute to the alleviation of the winter pressures. It is forecast that this model could potentially offer a saving of no less than bed days from October 2018 to March 2019. Average cost of a hospital bed is £131 therefore a potential saving of £508,280.

2 Project's strategic fit (see guidance notes section 2)

Which Strategic objectives will it meet?

IJB Strategic Plan Objectives

Improve the health of the population and reduce the number of hospital admission
The facility provides further recuperation for patients after their stay in an acute setting. The environment is more homely so more accurate assessment of needs can be undertaken. All of which reduces the likelihood of an acute readmission.

Improve the flow of patients into, through and out of hospital
The facility allows discharge from hospital when alternative support is not available. The evidence for the last winter months is that the facility was well utilised and the average throughput of patients was less than two weeks, which is exceptional in comparison with other similar facilities.

Improve the capacity for people to better manage their own conditions and support those who care for them
Through a more timely discharge from an acute setting, access to better assessment of need and a supported transition to a care home or their own home, these patients are more able to support themselves, and their carers are more able to care for their needs.

3	**ICF Conditions** *Please give a description of how the project meets each condition for ICF?*
1.	Investment of the resource must be in line with the strategic commissioning plan and weight given within that to the key priority areas of reducing delayed discharges and unscheduled admissions

The START Team within the BGH are focused on identifying patients who meet the criteria for being transferred to Craw Wood. This has a direct impact on the number of delayed discharges. Since December 2017, 101 patients have been discharged to Craw Wood, saving at least 1980 occupied bed days.

It is estimated that the continuance of this facility from 1st October to 31st March 2019 operating at full capacity could provide a further saving of 3,880 occupied bed days if operated at full capacity throughout this period.

2.	Projects must have a positive measurable impact on delayed discharge numbers and occupied bed days

Please see data in Point 1 above.

3.	Projects must deliver change which result in reduced costs

The use of Craw Wood as a Discharge to Assess facility has a reduction 3,880 occupied bed days, average bed cost being £131; this would amount to £508,280.

4.	Projects must be evidenced based

Borders is an outlier in the provision of this type of service. All other areas have a similar model that supports early discharge.

5.	Funding for each project will be non-recurring and each project must have a clear exit strategy

Over last winter, Craw Wood provided essential step down facilities for patients who would have been delayed within BGH. Until other initiatives planned within the community are fully operational there will be a need for the Craw Wood facility. Plans to introduce these new community facilities are underway and it is anticipated that Craw Wood will not be required beyond March 2019.

4	**Project Aims/ Achievements** *Please give a high level description of what will success look like?*

The investment will enable the continuance of the discharge to assess facility which will:

1. provide timely discharge and assessment out with the acute hospital
2. remove the unnecessary need to stay in an acute hospital when medically fit and provide a realistic and practical assessment of need in a 'homely' setting
3. improve patient flow out of hospital, by having a clear pathway and criteria of patients able to use the service

5	**Project outcomes and benefits** (see guidance notes section 3) *Please be specific about project benefits and outcomes – outcomes should be measurable*

The benefits of this model include:

- A personalised assessment of need which looks at critical needs and also a re-ablement approach with the aim to maximise the early rehabilitation potential of the person during the early weeks of care
- Supporting individuals to develop their confidence and skills so that they can carry out activities themselves to enable them to continue to live at home.
- Support early discharge from hospital

Patient opinion who have been transferred to the discharge to assess facility:

'Felt comfortable and safe'

'Friendly staff, willing to spend time which makes me relaxed and comfortable'

'Everyone has been very helpful. I can't praise Craw Wood enough and would recommend it to anyone'

'Can't fault the facility'

6	**What areas of the Borders will the project cover** *Will the project affect the whole of the Borders or a specific locality, if so please state?*

The project covers discharging patients from the BGH and from all areas of the Borders who meet the criteria.

7	**Which care groups will the project affect?** (see guidance notes section 4)

There are three pathways to admission to Craw Wood. In all instances the following six criteria must be satisfied:

1. The person must either retain capacity for making welfare decisions or the legal proxy for welfare decisions must have signed a letter of undertaking regarding the timely discharge of the person from the facility. The anticipated date of discharge will be advised to the person, their family and/or proxy by the support team at Craw Wood in conjunction with social work within 3 days of admission. Section 13ZA of the mental health act may apply for those patients meeting this criterion; final decisions on these cases will be the responsibility of the Chief Social Work Officer.
2. The person must be medically fit for discharge and not require on-going medical or nursing input on discharge from an acute medical bed and from a community hospital. This is because Craw Wood does not have nursing staff on site.
3. The person to be admitted must be an adult over the age of 50.
4. The person to be admitted must be able to transfer with a maximum of two carers.
5. The person must be transferred following the agreed discharge protocol.

8	**Estimated duration of project** *Please provide high level milestones and including planning and evaluation time*

The project is currently operational. This request is for continuation of funds to March 2019, to cover the forthcoming winter pressures. SBCares are ready to increase the provision as requested within the timescale required.

9	**How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs*

In order to continue to run the Discharge to Assess Facility from October 2018 – March 2019 this will require funding of £411,102

10	**What would happen if ICF didn't invest in the project?**

- Detrimental impact on Occupied Bed Days
- Increase in Delayed Discharges
- Loss of flexibility and capacity for flow of patients
- Increase use of surge beds within acute care
- Loss of ability to assess need in a realistic environment
- Loss of accumulative benefits with other transformation change projects

11	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*

Predicted saving based on:	
OBD Saved	3,880 days
Sub-total saving	£508,280
Less cost running facility from 1st October 2018 – 31st March 2019 (6months)	£411,102
Predicted saving (6months)	**£97,178**

12	**How would you identify/ recruit staff to support the project?**

Facility is operated by SB Cares, existing MDT to continue support the facility.

13	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)

Project support would continue to be provided by the Better Borders NHS and the Council's transformational change teams.

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Appendix 1 – Annualised costs April 2018 – March 2019

	Detailed elements	WTE	HRS	Grade	1.0 wte Salary	Full Year cost Apr 2018-Mar 2019 (15 beds)	Full Year cost Apr 2018-Mar 2019 (8 beds)
Care Staff							
	Senior Support Worker	3.4	119	7A	£32,912	135,197	135,197
	Support Worker (days) - 8 beds	6.8	210	4D	£22,974		157,518
	Support Worker (days) -15 beds	8.28	306.4	4D	£22,974	229,826	
	Senior Sleep Over payments (Nights)	10 hours per night at minimum wage				21,024	21,024
	Support Worker (nights) - 8 beds	4.3	133	4D	£22,974		99,774
	Support Worker (nights) - 15 beds	4	148	4D	£22,974	111,027	
	Cleaner - 8 beds	0.38	14	1D	£17,657		6,161
	Cleaner - 15 beds	0.5	14	1D	£17,657	8,106	
	Unit Admin	0.57	20	6A	£26,795	15,273	15,273
	Allocation of management time	0.2	7	10A	£50,657	10,131	10,131
	Team Leader	1	37	9A	£43,489	43,489	43,489
	Agency Cost estimate provision					0	
	Total Staffing Costs					**574,073**	**488,567**
Non-Staff Running Costs	HLP - Additional utilities/heating/lighting					38,000	38,000
	Unit Consumables and admin expenses					10,000	10,000
	Equipment, fixtures and fittings					3,000	3,000
	Catering Costs					29,901	15,947
	Waste disposal					1,500	1,000
	Grounds maintenance					800	800
	Total Non- Staff Running Costs					**83,201**	**68,747**
Rent	Lease - Eildon					60,000	60,000
TOTAL SBC/SB	CARES COSTS					**143,201**	**128,747**
NHS COSTS							
NHS Staff Costs	**Staffing**						
	GP Cover					25,000	25,000
	OT					45,300	45,300
	Physio					45,300	45,300
	District Nurse					22,650	22,650
TOTAL NHS COSTS						**£138,250**	**£138,250**
TOTAL COSTS						**£855,524**	**£755,564**

Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Project Name	Discharge to Assess – Hospital to Home		
Project Owner	Rob McCulloch-Graham - Chief Officer Health & Social Care	**Application Main Contact**	Erica Reid – Lead Nurse for the Community
Main contact email	Erica.Reid@borders.scot.nhs.uk	**Main Contact Telephone**	01896 826906

Guidance on Project Brief

The purpose of this form is to give a brief outline on the key aspects of the proposal to the Integrated Care Fund.

1 Outline project description

Please summarise the project in no more than 250 words

This paper provides an update on the progress and impact of the Hospital to Home pilots in Teviot and Berwickshire. This also presents the case for expanding the Hospital to Home service across all five localities.

The care provision in some areas in the Borders has resulted in people delayed to discharge due to waiting for care to be in put in place. A prolonged hospital stay leads to reduction in function in older people which can in consequence lead to an increase in dependency on care provision post discharge.

The two pilot areas have made a significant impact:

- 44 patients in the cohort, saving a minimum of 1,434 occupied bed days (over 10 months), (Average length of stay in a community hospital being 32.6 days.)
- 14 admissions prevented by providing timely intervention in patients' homes saving a minimum of 456 occupied bed days, (Together saving 1,890 obds)
- 40% reduction of care packages for those who have been in the pilot on discharge

This proposal is to expand Hospital to Home across all 5 localities and put an enhanced model in place in the Eildon Locality, therefore targeting all four Community Hospitals and the Medicine for the Elderly wards within BGH.

This is an integrated model led by District Nurses which is transforming care for our older people as they transition home after a period of illness. Without this service in place Borders will remain an outlier by not having an early supported discharge model and demand on in-patient beds will continue to grow, due to the lack of alternatives.

If the parameters of this model are extrapolated across all localities, we anticipate having a significant system level impact. If this proposal is successful, the staff teams be recruited and processes implemented in the same way as the pilot. It would be fair therefore, to base the proposed first year's impact of the expansion on the data collected from the first pilot.

Proposed Costs

The proposal provides expected costs and savings for the first year of expansion and in appendix 2 it provides full costs and expected saving when operating at full capacity for a complete year.

First year of H2H model expansion

- Hospital to Home for four localities linking with the four Community Hospitals = £708,272,
- Central Discharge to Assess, linking with BGH = £276,473

£984,745

Using the data and experience from the pilot, and extrapolating across 12 months rather than 10, and five localities rather than 2, and building to a full staff compliment within three months, we would expect;

- To save a minimum of 5,670 occupied beds days annually, (equivalent to closing 16 beds.)
- At an average cost of £131 for a bed for a patient over the age of 65 this could release £742,770 in the first year of operation

This not only leads to improved outcomes for older people, but will also reduce occupied bed days in the over 65 age group, leading to increased capacity in our in-patient facilities.

In addition to bed saving, we have experienced a 40% reduction in the level of care packages from the pilot. If we assume an hourly rate of care as £22/hr and extrapolate these figures over five localities for a full initial year, costs avoided would be for 132 patients per year, with collectively 48,180 care hours per year, costing in total £1,059,960.

The 40% reduction would then equate to £423,984.

Savings Summary

Occupied bed day saving	= £ 742,770
Care costs avoided	= £ 423,984
Total	= £1,366,754
Programme Cost	= £ 984,745
Final Saving	= £ 382,009 within the first year

Operating at full capacity for a full year, the programme expects to make a potential saving of £2,640,960 in reducing OBDs by 20,160, equivalent to closing 56 beds. The impact on reducing demand on care packages by 40% for 720 patients in a full year, would equate to £2,312,640.

£984,745 is the full programme cost so the potential overall saving/costs avoided would be £3,968,855

(Appendix 2. gives the rationale for these potential savings from the model operating at full capacity for a full year.)

2	**Project's strategic fit** (see guidance notes section 2) *Which Strategic objectives will it meet?*

IJB Strategic Plan Objectives

Improve the health of the population and reduce the number of hospital admission
The trial in Berwickshire and Hawick has already proven the ability of this work to cater for patients who normally would have been admitted to hospital. This is also been evidenced within East and Mid Lothian.

Improve the flow of patients into, through and out of hospital
The work targets patients who are already delayed within the Community Hospitals, the addition of AHP support within the Eildon Locality will target patients delayed within the DME wards within the Borders General Hospital.

Improve the capacity for people to better manage their own conditions and support those who care for them
The rehabilitation nature of the work reduces the need for continued care by approximately 40%, enabling people to better look after themselves, and consequently better enables family and carers to cope better with individuals needing support, keeping them healthier and less likely to need re-admission.

3	**ICF Conditions** *Please give a description of how the project meets each condition for ICF?*
1.	Investment of the resource must be in line with the strategic commissioning plan and weight given within that to the key priority areas of reducing delayed discharges and unscheduled admissions

The pilot teams have primarily focused on the discharge of patients waiting for care packages in Hawick Community Hospital and the Knoll. There are no delayed discharges now in either of these hospitals for people waiting for care packages. This is reviewed regularly by the MDTs to ensure people who meet the criteria of the pilot teams are discharged when clinically ready.

In the 10 months (6 months in Berwickshire, 4 months in Teviot) of the pilot teams 44 people have been discharged who would have continued to wait in hospital for packages of care, saving 1434 bed days. The teams have also prevented unscheduled admission of 14 people, saving at least 456 bed days. Of these people, none of them were re-admitted to hospital within 28 days.

It is anticipated, if H2H is rolled out across all localities it will save a minimum of 5,670 occupied bed days, in its first year of operation. This will rise significantly over a further year, operating at full capacity the expected reduction of OBDs is 20,160.

Data shows that the average re-admission rate from Community Hospitals is 11.2%. The re-admission rate of people who have been in the service is at a lower rate of 7%.

Over a longer period of time the outcomes of these patients will be able to be compared to the longer term outcomes of other patient groups to better understand long term benefits.

2.	Projects must have a positive measurable impact on delayed discharge numbers and occupied bed days

This work will target patients who, currently we would expect to be delayed, waiting for further support to allow them to go home from hospital. There will therefore be a direct impact on the rate of delays. At full capacity we expect the programme to take 60 people out of hospital every month.

3.	Projects must deliver change which result in reduced costs

See response to question 1 for the first year savings based on the start-up costs and savings of the pilot and appendix 2 for the full year costs and saving when operating at full capacity.

4.	Projects must be evidenced based

The Borders is an outlier in the provision of this type of service. All other Health and Social Care Partnership areas have similar models that support early discharge. There is a shared evidence base that using this re-ablement approach on discharge, improves outcomes for this patient cohort. In addition, we now have an evidence base from the pilot work from which we have drawn our predictions for this proposal.

5.	Funding for each project will be non-recurring and each project must have a clear exit strategy

The improved outcomes for individuals have already been proven both in the Borders and elsewhere. The financial savings are also evident here and across a range of Health and Social Care Partnerships, for both the NHS and to Council Services. The ICF will offer pump priming however this invest to save programme can accrue sufficient savings to mainstream the programme and continue reduce overall costs.

4 Project Aims/ Achievements

Please give a high level description of what will success look like?

The investment will enable Scottish Borders:

1. To deliver a Borders-wide Hospital to Home service with enhanced AHP support in the Eildon locality.
2. To promote a reduction in dependence on care provision by optimising function of older people post discharge
3. To deliver a redesigned pathway of care that promotes timely discharge of older people in our hospital settings
4. Improve patient flow into and out of hospital, by having robust community support in place.

5 Project outcomes and benefits (see guidance notes section 3)

Please be specific about project benefits and outcomes – outcomes should be measurable

The benefits of this model include:

- Personalised re-ablement approach with the aim to maximise the early rehabilitation potential of the person during the early weeks post discharge
- Increasing the capacity of care provision by reducing the care needs of this cohort by 40%
- Increased engagement with community based services in each locality
- It supports individuals to develop their confidence and skills to enable them to continue to live at home.
- There will be a reduction in attendances / admissions to hospital
- Support early discharge from hospital

Qualitative Impact – During the pilot phase, feedback has been sought and offered from service users, staff and other professionals.

"Over the past few weeks the input from your team has been invaluable in preventing admission, and improving his mobility, confidence and self care, including recognising problems with medication compliance and helping him to get into a better routine." – GP, Newcastleton

"Since the new health care support workers started to go in, it's like seeing a different man " – HCSW, Newcastleton

"I have found each HCSW in Hawick to be very enthusiastic and keen to be hands on/help. On the evening service we are lone workers and have found to have the HCSW working with us very beneficial". – Evening Nurse, Hawick

"The caring team who visited during the 'Hospital to Home' period were very patient focused and attentive. Thank you very much for the excellent service." – Service User Berwickshire

6	**What areas of the Borders will the project cover** *Will the project affect the whole of the Borders or a specific locality, if so please state?*

H2H will be delivered across all five Borders localities within the costs identified

7	**Which care groups will the project affect?** (see guidance notes section 4)

This will focus on early supported discharge of older people to promote independence and optimise function on discharge home.
It will also provide support to prevent admissions of older people.

8	**Estimated duration of project** *Please provide high level milestones and including planning and evaluation time*

The project will be delivered over a 12 month period to further develop and embed robust pathways of care from hospital to home for older people. It is anticipated that this work will be mainstreamed in 19/20.

9	**How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs*

In order to further develop and embed a Hospital to Home model across the five localities funding of £984,745 (see appendix 2).

10	**What would happen if ICF didn't invest in the project?**

- Continued rise in delayed discharges due to waits for packages of care
- Increase of inappropriate use of inpatient capacity for people who are clinically ready for discharge
- Growing pressure on in-patient flow to be able to accommodate the demand for admission
- Complex systems of care would remain for older people with few options other than continued in-patient care
- Financial and workforce pressures would remain
- The level of admissions & re-admissions would increase
- The cost of creating surge capacity for in-patient care will continue to grow

11	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*

Two areas of savings are provided for within this work.

1. Reducing the need for hospital beds.

   Operating at full capacity, over all localities, the work will release 20,160 occupied bed days. If we assume that we do not need a bed for 365 days we therefore will no longer need that bed. This work has the potential of releasing 56 beds. Ward 12 and 14 together have 59 beds, our Community Hospitals each have 23 beds.

   The calculations on the cost of bed days used in this application are based on minimum costs of nursing and care, £131 per bed day. The NHS costings for bed days, including all costs, is £744. This cost could only be realised if all the beds in a single ward were closed. This proposal will give the ability for NHS Borders to rationalise its bed base.

   This saving would complement the costs of this programme several times over.

2. Reducing demand on home care services

   There is a rising demographic of the over 65yrs in our population, we know the demand for care services will be increasing, we expect to pay more every year to keep up with this pressure unless we can slow the demand.

   We need to help people stay well enough to live their lives for longer without the need for care. Through the re-ablement aspect of this work we have already seen an impressive 40% reduction from the intended packages of care to those required at the end of the four week programme.

   On this area alone the work returns more than 100% of its costs as a saving.

12	**How would you identify/ recruit staff to support the project?**

Local / external advertisement and a discussion and internal secondments. Close work with Borders College, offering an access route to a career within the Health or Social Care Professions.

13	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)

Project support would continue to be provided by the Better Borders (NHSB) and Scottish Borders transformational change teams.

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Appendix 1:

Costs

To operate the Hospital to Home Service via the four Locality Hospitals

Four Localities Hospitals to Home Annual Resource Cost		
Role	**Staffing Level**	**Total**
Band 2 HCSW	20	£456,000.00
Travel	20	£120,000.00
Band 5 Co-ordinator	4	£132,272.00
TOTAL		**£708,272.00**

To operate the Hospital to Home Service via the General Hospital – Central Model

Central Locality Hospital to Home Annual Resource Cost		
Role	**Staffing Level**	**Total**
Band 2 HCSW	5	£114,000.00
Travel	5	£30,000.00
Band 7 Co-ordinator	1	£46,473.00
Band 6 OT	1.2	£40,000.00
OT Travel	1	£3,000.00
Band 6 Physio	1.2	£40,000.00
Physio Travel	1	£3,000.00
TOTAL		**£276,473.00**

Appendix 2

Savings for a full year operating at full capacity

Occupied Bed Days Savings for a full year assuming full capacity

5 staff working with 12 patients for 4 weeks in each locality

5 localities therefore 60 patients every 4 weeks = 720 in a year

Targeting both Community Hospitals and DME wards within the BGH
Community Hospitals average length of stay = 32.6 days, DME average length of stay = 19.6days.
Assuming therefore, a fair average between the two as 28 days, average length of stay.
Total bed days saved in the year therefore;

720*28 = 20,160 OBDs

Cost of a Community Hospital Bed is £137/day a DME Bed £125/day, taking the mid point as £131/day, and operating at full capacity for the year the potential saving is;

£131 * 20,160 OBDs = £2,640,960

Savings due to the reduction in packages of care for a full year at full capacity

Number of Patients in a year = 720

Assuming 3 visits a day of 20minute duration, so each patient receives 7hours per week. Cost of an hour of care through SBCares is £22/hour.

Full anticipated costs for home care without H2H re-ablement = 720*£22*365 = £5,781,600

H2H operating at full capacity expect to reduce packages by 40% as experienced through the pilot. Maximum saving would therefore be;

40% of £5,781,600 = £2,312,640

Hospital to Home Programme for full year Costs

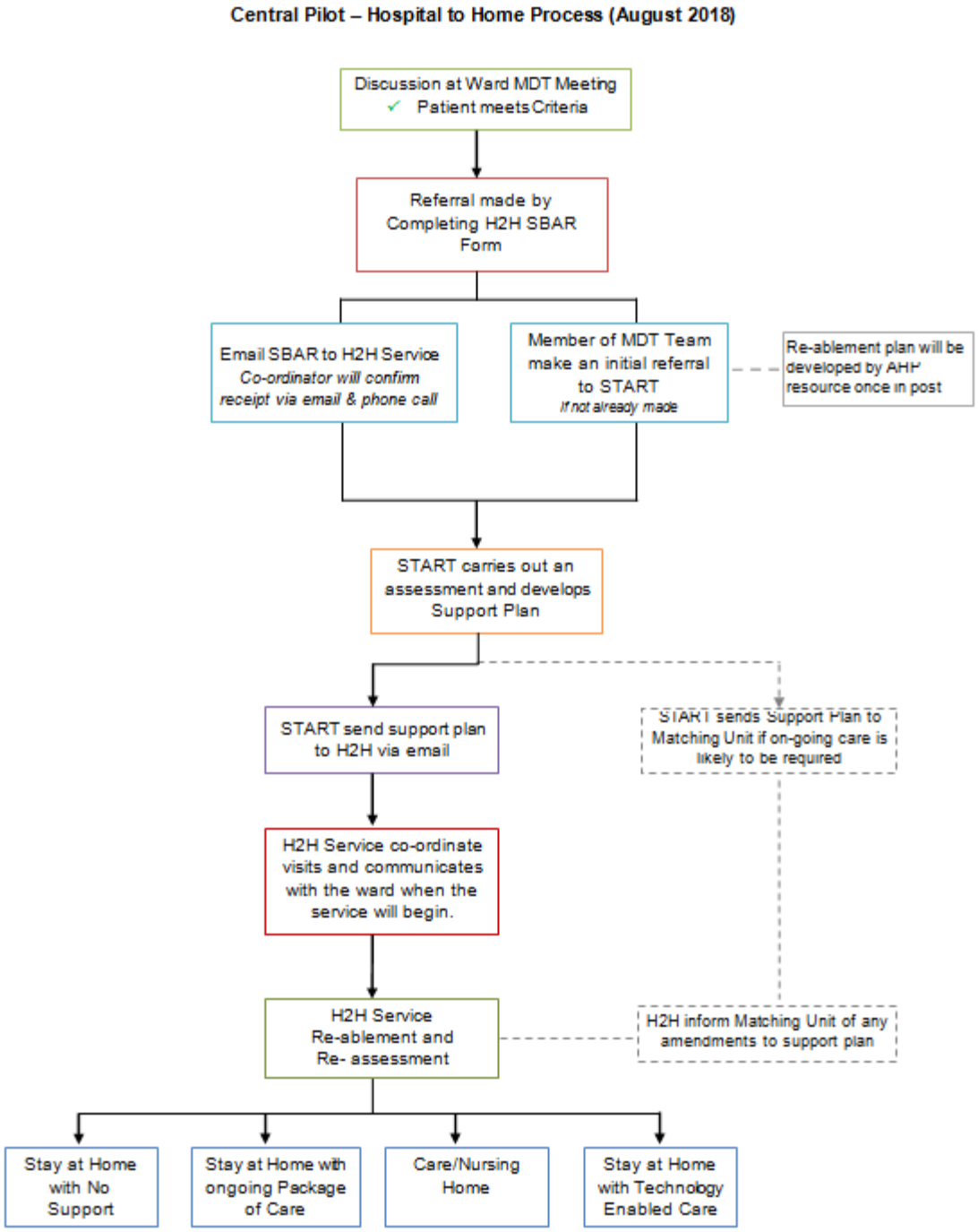
5 Localities = £708,272
Additional support in Eildon Locality for BGH DME discharges = £276,473

Total = £984,745

Final savings

OBDs	= £2,640,960
Home Care Hours	= £2,312,640
Combined saving	= £4,953,600
Programme Cost	= £ - 984,745
Saving	= £3,968,855

Appendix 3: Central Process



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Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Project Name	Strata		
Project Owner	James Lamb	**Application Main Contact**	James Lamb
Main contact email	JLamb@scotborders.gov.uk	**Main Contact Telephone**	

Guidance on Project Brief

The purpose of this form is to give an outline on the key aspects of the proposal to the Integrated Care Fund 2015-18

Please refer to the accompanying guidance notes for more information on the Integrated Care Fund (ICF) when completing this document.

1 Outline project description

Please summarise the project in no more than 250 words

This paper and its appendix outline the proposal to introduce a proof of concept trial with the software company Strata Health.

The scope of the trial will examine how to automate and improve the process currently used to discharge patients to social care and then onwards to downstream care providers and domiciliary care services.

The trial will integrate the workflow and e-referral system across Health and Social Care stakeholders and assess the clinical, operational and financial benefits of digitising the existing processes.

2 Project's strategic fit (see guidance notes section 2)

Which local strategic objectives and Scottish Government ICF principles will it meet?

Borders IJB Strategic Plan objectives

1. **Improve the health of the population and reduce the number of hospital admission**
   This work will support the matching unit in reducing the work load on Social Workers freeing them up to undertake assessments and reviews. In this way care and support will get to individuals keeping them healthy and well for longer, thus reducing hospital admissions.
2. **Improve the flow of patients into, through and out of hospital**
   Strata is a software solution designed specifically to better manage pathways and flow. This first work stream will be followed by others reaching across the whole of the health and social care partnership from GPs, to acute assessment units, to discharge units, to social care and to mental health and a host of other services within the partnership.
3. **Improve the capacity for people to better manage their own conditions and support those who care for them.**
   The system also supports direct access for the patient into services and local activities, there is a huge potential for STRATA to unlock the many community assets we have for those who may not normally have accessed them

ICF Conditions Proposed by the NHSB Board

1. Investment of the resource must be in line with the strategic commissioning plan and weight given within that to the key priority areas of reducing delayed discharges and unscheduled admissions.
2. Projects must have a positive measurable impact on delayed discharge numbers and occupied bed days
3. Projects must deliver change which result in reduced costs
4. Projects must be evidenced based
5. Funding for each project will be non-recurring and each project must have a clear exit strategy

The intention of this work is to ensure access to live data regarding the availability of services and care beds for those people we are seeking to support their discharge from the BGH and our four community hospitals.

The software and improved processes are expected to significantly reduce the time required by staff to search for such availability, thus speeding up the overall matching process.

This work will also support the further identification of bottlenecks within existing patient pathways and support our intention to re-commission care services in 19/10.

The system is now working with a number of partnerships both in the UK and abroad, and there are further opportunities beyond the scope of this proposed trial.

Details of the proposal and how it fits the principles and objectives of the ICF are contained within the appendix to this paper.

3	**Project Aims/ Achievements** *Please give a high level description of what will success look like?*

The investment will enable Scottish Borders:

1. To deliver a Borders-wide matching service to support patients leaving hospital but also those requiring services within the community.
2. Improve patient flow into and out of hospital.
3. To identify other alternatives to hospital admission
4. It will reduce patient delays due to process.

This will be achieved by:

1. Developing a live directory of all relevant health and care services.
2. Digitisation of paper/manual processes.
3. Building electronic pathways to automate decisions and actions.
4. Implementing a single pathways platform to manage transitions.

4	**What areas of the Borders will the project cover** *Will the project affect the whole of the Borders or a specific locality, if so please state?*

All five Borders localities.

6	**Which care groups will the project affect?** (see guidance notes section 4)

In the first six months the work will focus on older people requiring care. The model would however also support mental health and the allocation of support for people with learning difficulties.

7	**Estimated duration of project** *Please provide high level milestones and including planning and evaluation time*

6 Months with a potential to then mainstream the proposed scope or widen it further into other areas of the Health and Social Care Partnership.

8	**How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs*

In order to develop and embed a model, funding of £75,000 is required

9	**What would happen if ICF didn't invest in the project?**

Work would continue to improve the current systems, however this will be slow and the benefit of a strategic partner with experience elsewhere will not be available.

10	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*

There will be a reduction in the number of matching and assessment tasks, as these will become more automated. The matching unit has already released Social Worker time from these administrative tasks which has currently reduced waiting times for packages of care by 50%. This has allowed Social Workers to focus more on their professional tasks which does support people to remain cared for in their communities longer before requiring health interventions.

This will result in freeing a great deal of resource but it is difficult to determine this in a monetary sense ahead of running the programme.

11	**How would you identify/ recruit staff to support the project?**

Internal project management support has been identified to compliment the implementation staff from STRATA

12	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)
Project support would be provided by the Better Borders NHSB and SBC transformational change teams.	

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Business Case for

BORDERS HEALTH & SOCIAL CARE PARTNERSHIP

Strata PathWays™ - Discharge to Social Care

Version:	V.2.7
Status:	Final
Date of issue:	12th June 2018
Valid for:	30 days from date of issue.

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1. Executive Summary

Strata PathWays™ is a proven technology that has been deployed across Canada, Australia and the UK over the past 2 decades. It is a web-based application that uniquely facilitates patient centred coordinated care across an entire health and social care economy.

This document presents a proposal to Borders Health and Social Care Partnership (hereafter Borders IJB or the HSCP) for the use of the Strata Pathways™ to manage an automated workflow for managing the discharge of frail and elderly patients from hospital into appropriate out of hospital settings in a partnership between NHS Borders, Scottish Borders Council and their care partners across the geography.

The details as set out in this proposal are based on information shared with Strata Health Ltd during several meetings with the Joint board over the past twelve months. The project is scoped to ensure that we can jointly demonstrate the benefits of integrated the service across partners and stakeholders and is measurable against the targets and metrics that the IJB would wish to use as success criteria.

2. Background

The Borders HSC Partnership would like to examine how to automate and improve the processes currently used to discharge patients to Social Care and then onwards to downstream care home providers and domiciliary care services across the geography. In order to do this, they wish to assess the ability to integrate with a workflow and eReferral solution which will manage these referrals across health and social care stakeholders and assess the clinical, operational and financial benefits of digitising this currently ineffective process.

The referral process can consist of several discreet components or form an MDT pathway as part of a more complex case and care package. The components include:

- Integration - services to link appropriate information
- Services - a live dynamic directory of all relevant health and care services
- Process - Digitisation of paper/manual processes
- Flow - Building electronic pathways to automate decisions and actions
- Referral - Implementing a single pathways platform to manage transitions.

The referral process would require integration with the existing PAS system in NHS Borders and the Mosaic Social Care system in Borders Council. We will do this using the Strata PathWays™ platform and will create a directory of services to allow live dynamic brokerage of all out of hospital beds and care at home services throughout the public and private sector across the Borders geography.

3. Scope

The high-level scope for service to be deployed across the NHS Borders region is the end-to-end automation of a delayed discharge referral pathway for elderly patients requiring a placement in a care home or a domiciliary care package. The service will deploy the Strata PathWays™ platform to manage referrals across a number of organisations for the pilot period of six months. For the purposes of this pilot, the service will be focused on the NHS Borders region only and the organisations involved will include:

PAS Users

1. Borders General Hospital,
2. Kelso Community Hospital
3. Knoll Community Hospital, Duns
4. Hawick Community Hospital
5. Hay Lodge Hospital

Mosaic Users

6. Scottish Borders Council

Pathways Users

7. Domiciliary Care Provider – Care at Home services
8. Care homes across Borders Area

Project Remit

The test of change project will digitise the process of referring hospital patients (acute and community) to the hospital based social care team from Scottish Borders Council, and then onwards to care home beds and care at home services across the region. The referral source will come from various entry points:

- A&E Registration where the patient is flagged as already having a care plan.
- Medical Assessment Unit within Borders General Hospital
- Ward referrals (acute)
- Ward referrals (community)

Once a referral needs to happen within the NHS setting, the referrer will simply click a button, and this will then do three things:

- Send a digital referral request to the council Mosaic system
- Send a message/alert to the hospital social care team
- Timestamp, audit and track the referral between the two services.

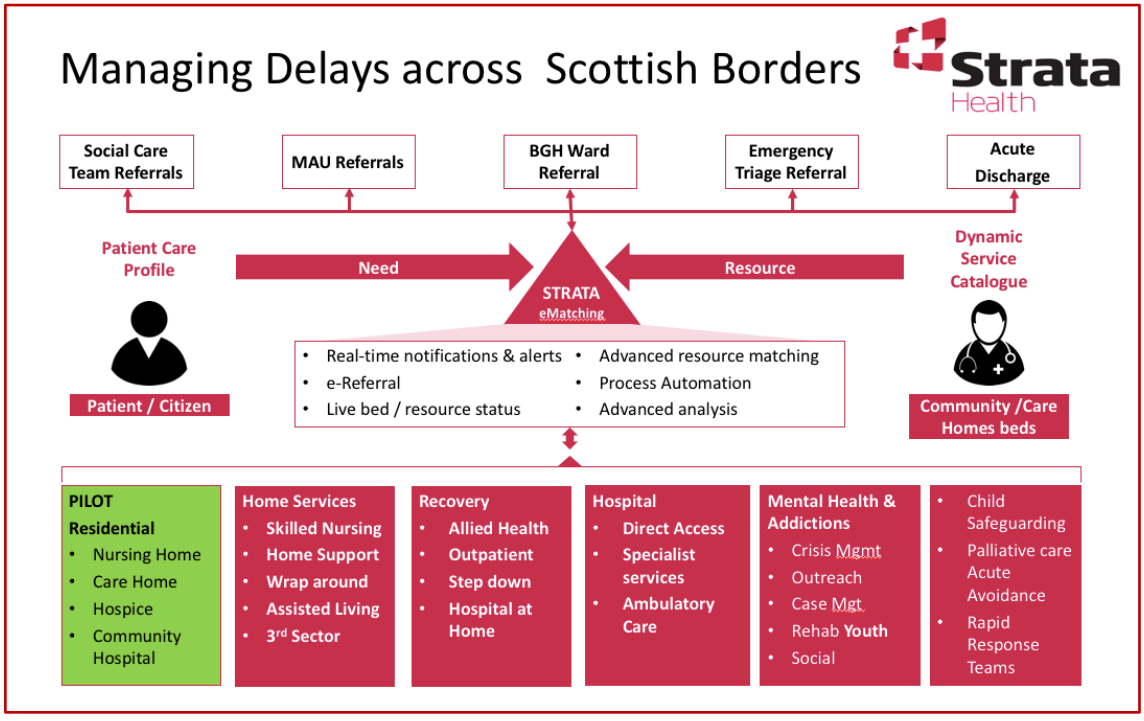
The referral will include all necessary patient information including their demographics and where they are located in the hospital so that the Social Care team can locate them. This is all processed instantaneously without the need for manual processes such as mails, letters or phone calls. It will track all the actions and, if required, will allow the social care team to complete digital assessments that will populate directly to mosaic. This can include the social care assessment and the financial assessment (FA1). This information as well as any relevant hospital and discharge information is held together so that patients only needs to tell their story once.

On the non-NHS/LA provider side, the providers will directly access the Strata system to broker their services and beds. As well as showing availability, they should also include the features and characteristics of their resources. These characteristics may include:

Care Homes	**Care at Home Services**
• Conditions the care home can accommodate – dementia, post-surgery, • Staff skills – care/residential and/or nursing/specialist • Bed characteristics – hoist, oxygen, wound management • Secure facilities • Availability of resources/beds • Location • Fees (if required)	• Services offered – day care, care in the home, Independent living etc. • Staff skills – care and/or nursing/specialist services • Service characteristics – social isolation, independence, equipment etc. • Residential services – supported living • Availability of resources • Location served • Fees (if required)

By continuously collecting this information from the providers, Strata Pathways then holds a live, dynamic directory of services which we use to match available services, in real time, to patient needs as part of the process of finding an appropriate care setting. As part of this Test of Change project we will include community beds and domiciliary care services from council approved providers.

As determined by the council, once it is decided that a service is to be allocated (funded or part-funded) the patient and their families will be presented with a list of the most suitable, soonest available, homes or packages that can accommodate the patient. If required the number of options can be set at three as is the current process; however, as the system matures it will allow patients to be presented with a longer-term view, for example if they only need a care home bed for post-op convalescence, this will be shown as well as any required care at home package that should be put in place when they are fit to return home. The options are fully configurable to the process that the council social care team wishes to deliver. The diagram below shows an example of the potential scope across the entire health and care system. Please note that the pilot area is shown in green



4. Business Case Preparation

The test of change project will seek to deliver many efficiencies to the current process for moving patients out of hospital and matching them to appropriate services. It will seek to streamline the current process, provide significant reduction in time wasted, reduce admin overheads (such as phone calls, letters etc), greatly improve communications across stakeholders (primary, secondary & social care) and reduce the number of delayed discharge days within NHS Borders. In addition, the solution will provide much greater visibility on gaps in services across the region using the data captured to identify opportunities for service improvement based on real evidence. This will help and support all stakeholders to make service decisions that meet demand across the region.

During the pilot project we will produce a business case to examine whether or not Borders HSCP should proceed with the project over a longer time period. The business case document will be based on:

- Outputs of the Discharge to social care test of change project
- Likely improvements to enhance discharge to social care by adding other out-of-hospital services.
- Benefits of adding other clinical/operational pathways.
- Indicative whole-system service improvements against current baseline.
- Indicative whole-system financial improvements against current baseline.
- Likely impact on patient/citizen care

Supporting Information

Over a defined six-month pilot which only focusses on hospital to care-homes and care at home service providers. It will be unrealistic to expect to show the full potential of the solution however we do expect to be able to demonstrate:

- How processes can be improved
- How data collection can be digitised leading to reduction in paper processes.
- How communications will be improved
- How activity will be audited
- How integration will drive efficiency
- How referral refusals/declination will decrease significantly
- Reductions in delayed discharges due to process changes
- Live information on capacity – winter pressures planning, Anticipatory care planning, how to address guardianship delay issues.

In addition, the solution will provide a full suite of dashboards and reports to provide referrals metrics. These will include metrics by ward, department, specialty. Referrals to care home metrics, readmissions etc.

As part of a business case for proceeding we will endeavour to analyse and baseline other services that may assist with reducing delays such as step-down services, domiciliary care, hospital at home services etc. By doing this, we will be able to support the business case by including other services that the solution can use to assist with moving patients into appropriate care settings. We will expect the stakeholders to provide appropriate baseline data to support this exercise.

Additional care pathways.

As well as considering the outputs from the Test of change study into discharging to social care services, in preparing a business case, we will also consider and identify other opportunities for other Strata pathways to provide short, medium and long-term

benefits to the delivery of health and care across the Borders Health and Social Care Partnership. This could include, but is not limited to:

• Admittance avoidance
• Referral to GP
• Social Prescribing
• AHP – any-2-any referrals
• Community Referral
  • District Nursing
  • Continence
  • Respiratory
  • Dressings Clinic
• Child Safeguarding
• Palliative Care
• Step-down
• ICC Hub Services
  • Care Navigators
  • Case Manager
  • Integrated Rapid Response
  • MDT
  • Community Physiotherapy
• Cancer 2ww
• Emergency Eye Care
• Unity Drug and Alcohol
• Financial Assessments
	• LTC Long Term Conditions
	• Community Physiotherapy
	• Respiratory
	• Community Heart Failure
	• Tissue Viability
	• Paediatric Liaison notifications
	• Adult Safeguarding
	• Child Early Help
	• Diabetes
	• 3rd Sector (referral to 3rd sector services and support)
	• Care Coordination referral
	• Non Elective
	  • Surgical Incl. ENT and Orthopedics
	  • Medical
	  • Paediatrics
	  • Frailty
	• Discharge Screening Tool
	• Children's Assessment Tool
	• Children's Complex Needs Panel Submission

Strata Health Solutions will work with the Borders HSC partnership to determine the benefits and timelines for rolling out additional pathways based on the benefits delivered to patient groups whilst also determining which projects will bring the quickest operational and financial efficiencies.

In order to create baseline data, so that we can determine service improvements, we will work with the appropriate NHS Borders and Scottish Borders Council teams to determine the key metrics they wish to benchmark against.

We anticipate that the business case will be delivered to Borders HSC partnership with 2 weeks of the test of change end date.

5. Integration.

In order to deliver this solution, Strata will integrate Pathways to send and receive actions and messages from the existing PAS across the NHS Borders sites and Mosaic Social Care system used by Borders Council. These systems will be linked to the Strata PathWays™ platform which will allow the flow in referral and assessment information to be exchanged when a patient requires a care home package. The ALB/private providers will directly use the Strata Pathways solution to broker their services and to manage the receipt of referrals. The interoperability will support Single Sign On (SSO) and patient context pull through so that staff will continue to use their existing systems

Exchanging Information between Systems

Clinical Document Architecture (CDA®) Release 2 is a document mark-up standard which defines the structure and semantics for clinical documents exchanged between health and care providers and/ or patients.

A CDA document can contain a multitude of clinical content, with early adoption in areas such as the generation of Discharge Summaries; Admissions; Pathology; History; Medical Imaging and Reporting. Another area of wide application is within Health Information Exchanges (HIE), where CDA becomes the standard for all document structures. A CDA R2 document consists of the following 6 characteristics:

1) Persistence,
2) Stewardship,
3) Potential for authentication,
4) Context,
5) Wholeness
6) Human readability.

The CDA document is comprises of 2 components.

1. An unstructured mandatory textual component which allows for the inclusion of composite documents encoded in pdf, docx, or rtf, as well as image formats like jpg and png. This section is designed to ensure human readability and interpretation of the document content

2. A structured optional element for clinical system & software processing. This section is designed to allow for the inclusion of clinical codification using coding systems such SNOMED.

Benefits:

- Supports the exchange of clinical documents between health and care providers.
- Standardises the exchange of data between health and care providers.
- Supports the re-use of clinical data for public health reporting, quality monitoring, patient safety and clinical trials
- Is supplier & system agnostic

6. Deployment.

Typically, Strata PathWays™ deployments consist of the following activities:

Item ref.	Activity	Description	Costs
1	Service Scoping	A series of client scoping sessions to confirm the workflow process needed around pathways and agree the data set and assessment form design.	**Consultancy.** Charged at standard day rate £850 pd – Included for TOC
2	Integration	Scoping of interoperability requirements, data sets, transport mechanisms and 3rd party systems. All dialogues are led by the client.	**Consultancy.** Charged at the SHL standard day rate £850 pd – Included for TOC
3	Deployment & Configuration	Initial deployment, configuration & build of the workflow within Strata Pathways. It will provide an interpretation of the discussed process requirements and validation rules as discussed with client. Functionality will be limited to a pre-agreed scope.	**Consultancy.** Included in the MSP base fee
4	Workshops	Structured workshops with IJB operational/clinical leads to evaluate the initial configuration and provide clinical expertise, input and guidance through an iterative cycle of development to reach the final accepted configuration. Each workshop will be booked as a half day slot (4hrs).	**Consultancy.** Included in the MSP base fee
5	Training & user setup	SHL will adopt a train the trainer approach so that the IJB can cascade the workflow process and change/manage the approach internally.	**Consultancy.** Included in the MSP base fee
6	S & M	SHL will provide Mon to Friday business hours support. Final SLA's and operating hours will be agreed prior to the start of the iterative development process and workshops.	**Consultancy.** Included in the MSP base fee
7	Go Live	Launch of the service.	**Consultancy.** Included in the MSP fee

7. Managed Service

The Strata Health PathWays™ Managed service consists of the following components:

No.	Component	Description
1	Pathways™ Non-perpetual licenses*	Test of Change Access to software 6 month, Inclusive of Hosting and data storage. TOC is for 6 Months paid in advance.
2	Pathways™ Support	Technical Support for PathWays users. Tier 2 and above delivered for pre-agreed hours of business.
3	Pathways™ Integration Hosting	Use of the Strata Connect ESB to manage and Host all bespoke interfaces. The storage of transient message data.
4	Equipment / 3rd party SW	Oracle license fees Windows Server License fees Server hardware
5	Pathways™ BI Reporting	The inclusions of standard performance reporting, SW licenses and MI reports.
6	Pathways™ Configuration Staff	Access to Strata Health Implementation consultants for: a) Scoping, analysis and running of workshops b) Delivery of initial workflow configuration for required workflow. c) Delivery of System Training. d) Set up of Users, roles and permissions ~~e)~~ Set up of Organisations
7	Pathways™ Configuration Maintenance	Access to Strata Health Implementation consultants for the on-going review and maintenance of the delivered workflow to ensure it continues to meet the needs of the client.

8. User Support

The deployment of the Strata PathWays™ platform will adhere to the standard support and maintenance framework. Specifically:

- Hours of service
- Out of Hours support
- Rates

Whilst full support costs are included in the MSP/TOC fee, additional elements requested will incur support and maintenance fees as based on the Strata UK NHS Rate card as published on G-cloud.

9. GDPR

Strata Health Solutions products were built with privacy in mind, and as such Strata has always respected private data – allowing immediate GDPR privacy law compliance.

As part of our GDPR compliance program, here is a summary of what Strata has done to protect your data:

- All the Strata databases are fully pseudo-anonymized
- Data Residency is a key concept for our hosting services. Strata never transfers data across geographic boundaries unless there is a data sharing agreement in place with our clients that explicitly requires it to be done.
- The Strata platform has been built with consent management features that allows individual records to be locked down easily and includes background auditing and alerting once enabled.
- Consent requirements are highlighted to all users when accessing this system to ensure that consent has been given before using the system.
- We use industry recognized standards for interoperability to ensure it can communicate with any other system in the health care spectrum.

- Strata has developed processes to ensure any individual can opt-in or opt-out at any time and can request a full disclosure of the information we hold.

Strata Health UK Ltd, is committed to continuous improvement, and all our policies and processes are regularly reviewed and updated to meet the needs of our clients and the individuals whose data is stored in our systems.

10. Training / Change Management

Super user training will be delivered to each main site to include NHS staff, Council staff, Care Homes and Care at home over a series of 6 half-day sessions to be planned in conjunction with the IJB project team. Any additional training for additional users will be chargeable using our stated daily rates. System training is a required professional service and is normally chargeable. It is imperative that that all users within all stakeholders are trained on the system in order to deliver project success. In order to control cost Strata would hope to run these sessions in parallel with other project activities such as two sessions per day or one session on the same day as a project delivery team meeting.

Change Management

Any requirements that arise outside of the project scope will be discussed and document within the forum of the project delivery board. Strata will work with Borders to access the relevance and provide a cost for carrying out any additional work based on our stated daily rate card. No additional work will be carried out, or additional invoices raised for such work unless fully signed off by the Borders Senior Responsible Officer for this project.

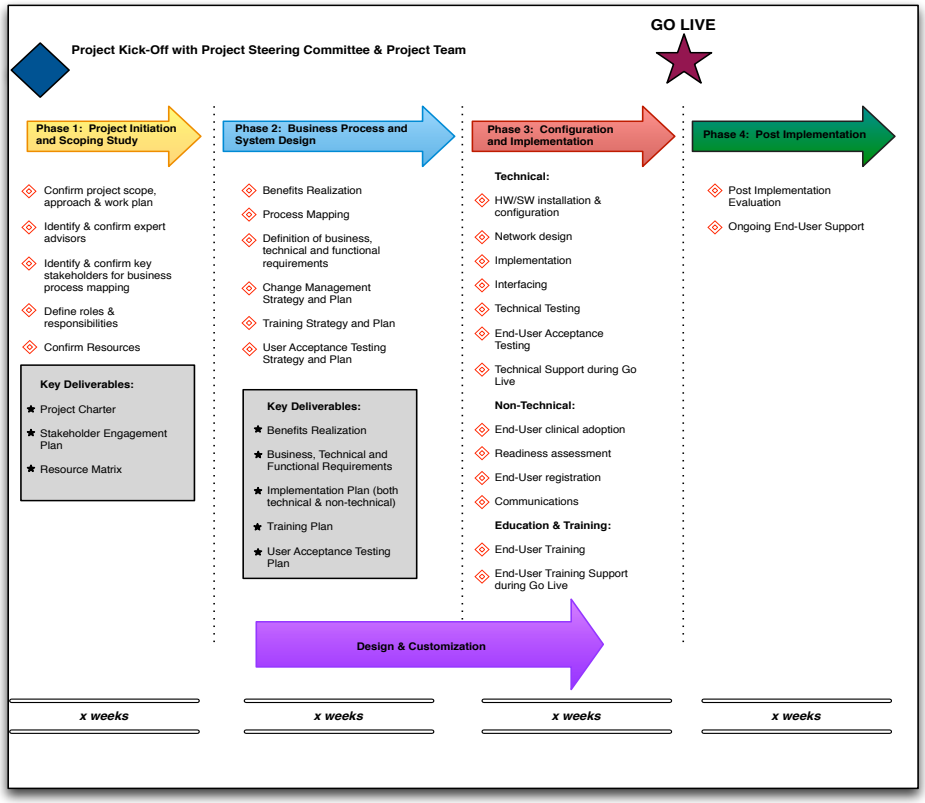
11. Resource Requirements

Client will be required to provide the following resources for the project:

- Senior management leadership and support of the project.
- Single point of contact for communications support to keep the organisation updated and informed.

- Project Management coordination of meetings (face-to-face and con-call) with required personnel to guide/test the application access.
- IM&T project management including localised support of the running of the deployment including training and go live; and necessary support in integration.
- Initial access to application teams to assist with linking Pathways to health and care systems.
- It will be the responsibility of the client to ensure that their system supplier are made available to the Strata integration team.

None of the above requirements will require a full-time engagement with the project. It is likely that in the initial stage of the implementation, we will require regular contact with the above resources. Once the system is live, contact will reduce to an NHS/Council project lead. A typical implementation will follow the processes as mapped in the diagram below.



As an indicative plan of engagement during all stage of the project delivery we have included below, a RASCI plan which details requirements from the client side using the following coding:

Responsible	Those who do the work
Accountable	Answerable for correct completion of work
Consulted	SMEs
Informed	Non-contributors, kept abreast of activities/decisions
Support	Assistance in completing the work

Please note that where the letter R does not appear against the Client for each action, this indicates that Strata health will be responsible for carrying out these duties.

Indicative Project Timetable –

To be developed and agreed at Initial Planning Meeting. We expect to be able to deliver the project quicker than detailed below provided access to all project resources happen as planned

1. Scoping and Planning Meetings	Early July
2. Build Pathways Instance Build Integration APIs Build Services Directory Populate user database Role based access planning	Over July and August
3. Stage 1 go-live – Council and NHS User Acceptance Testing User Training	Early September
4. Stage 2 go live – Care Home Users User Acceptance Testing User Training	Mid-September
5. Stage 3 go live – Care at Home Users User Acceptance Testing User Training	September 30th
6. Full Go Live	Early October
7. Wrap-up Training	
8. Post Go-live Benefits Realisation Study	Two weeks from project end

RASCI Plan

Phase	Task	Description	Client and Stakeholders														
			Project Lead / Manager	Software Steward	IM/IT Manager	Change Management Lead	Communication Lead	Senior Business Analyst	Benefits Realization Exoert	IM/IT Application Resource	IM/IT Networking Resource	Communication Lead	Privacy Resource	Steering Committee	Working Group	Project Executive Soonsor	Site Management	Super Users
Inception	Initiation	Initiation Meeting	A	I		I										I		
	Confirm Project Scope	Confirmation and Discussion on: • Hardware and infrastructure • eReferrals for identified care pathways • Integration Pilots • Future Expansion • Agree upon measurable goals and strategic priorities • Agree upon timelines	C	I	C	I				I	I	I	I	I		I	I	
	Confirm Project Approach	Confirmation and Discussion on: • Assign activities and tasks to project team • Change Management Strategy • Communication Plan • Stakeholder Engagement Plan • Chronological assessment of critical path and risk mitigation strategies	S	C		R	S					S				I		
	Integration Standard & Initiation	Agreement on integration method & initiate with sites			S			S										
	Data Sharing Agreements	Establish and sign Data Sharing Agreements with all stakeholders	R											I				
	Detailed Statement of Work	Develop detailed Statement of Work	A															
	Steering Committee	Kick off and Confirmation of Scope	A			C								R				
	Sign Off	Sign Off on Project Plan (Strata Health Solutions / Client and Stakeholders)	R													R		
Initiation	Stakeholder Engagement and Communication	Implement Stakeholder Engagement and Communication Plans	A	S		R	S					S						
		Initiate Change Management activities with impacted managers	A	C		R											S	
	Privacy Impact Assessment(s)	Complete PIA(s)	A										R					
	Business Process Design	Validate Current State Workflows	S			S		R							S			
		Develop process improvements, Future State Workflows and GAP analysis	S			S		R							S			
		Conduct Readiness Assessment for each organization, including technical and change evaluation	S			R		S							C			
	Requirements Elicitation	Define business, technical and functional requirements	S	C				R							C			
	Implementation Plan	Develop Implementation Plan	S	C		C		S										
	Training Strategy and Plan	Develop a training strategy and plan to engage all key stakeholders, super-users and end-users, covering: • Process • Technology	S	S		R		S									I	I
	Benefits Evaluation	Detail expected outcomes of implementation	S						R					C				
		Establish quantitative and qualitative measures and associated benchmarks	S						R					C				
		Gather baseline data (stakeholders, pre-GO LIVE)	S	R					S					C				
	Sign Off	Sign Off												I		S		
Implementation	Business Process Change	Implement required changes in process (workflow and responsibilities) • put changes independent of software in place in advance of GO LIVE when appropriate	S	R		S		A							S			S
	Ongoing Change Management	Continue with Change Management activities • Communication effort • Resistance Management • Ongoing coaching		R		A									S		S	
	Configuration	Configure PathWays to meet the needs of the care stream(s)	S					S							C			
	Development & Integration Development	Develop PathWays to meet the needs of the care stream(s) • Requirements met • Environments deployed	S					S							C			
		Develop Integration functionality with IT solutions • Integration requirements met • Integration deployed		S	I					S								
	Networking Configuration & Set up	Network activities to connect user locations to PathWays		S	I						R							
	Quality Assurance Testing (Application and Interface)	Changes and interfaces tested by technical team and project team • Functionality certified • Interface certified	I	C	C					S	S							
	User Acceptance Testing	Changes and interfaces tested by end-users		R				A							C		S	
	Client Sign Off	Collaboration during UAT to determine readiness for GO LIVE	C	C				R							C			
	Super User Training / Train the Trainer	Train Super Users and Trainers	C	C				R									C	C
	End User Training	Implement Training plan, including: • Training for end users • Training of administrative users • Training of technical support team	A	S		C		C								I	R	S
	Go Live	GO LIVE		R														S
	Sign Off	Sign Off												R		S		
Post- implementation	Benefits Realization	Gather post implemenation data for benefits realization and key metrics reporting	S	S					R									
		Benefits Reporting	S	S					R									
	Sustainability Plan & Project Closeout	Review of lessons learned	S	S		R									I			
		Additional requirements elicited	S	S				S							I			
		Transition to SHS Support planned	S	S		R											S	I
		Continued engagement and coaching	S	S		R		S							I		S	S
		Diagnose GAPs, resistance	S	S		R									I			
		Compliance Audit	S	S		R									I			
		Recommend full province roll out strategy and implemenation plan	S	S											I			
		Ongoing maintenance/sustainability group	S	R										I	I	A	S	C
	Sign Off	Sign Off												R		S		

12. Investment, Payment Terms and Agreement

- The Strata PathWays™ platform is being purchased as a short-term ToC:
  - The client becomes an active user for a 6-month period with access to their own PathWays™ server instance hosted within HSCN.
  - A bespoke workflow for delayed discharge referrals will be scoped out and delivered.
  - The solution can be purchased via the G-cloud framework.

13. ToC Investment for Borders HSC Partnership

No.	Pathways™ MSP Test of Change	Rate	Qty	Total MSP
1	• ToC - as stated in OGC G-Cloud pricing for Public sector	NA	1	£75,000
	Total MSP:			***£75,000***
To Include the following elements for defined projects				
	Professional Services	**Rate**	**Qty**	**Total**
2	• Scoping Configuration & Design • Training & User Set up (6 half day sessions) • Integration to existing systems. (10 Days) • Project management	NA		£INC
	Total PS for deployment:			***£INC***
	Total (Prices stated subject to VAT)			*£75,000*

User Access

For the purpose of and within the remit of the stated project scope, Strata Health will provide, within the cost envelop stated above, user access to all relevant staff within the stakeholder groups to include:

1. Borders Health and Social Care Partnership (the IJB)
2. NHS Borders Staff
3. Scottish Borders Council staff and third-party service providers:
   a. All care homes contracted to the Council
   b. All care at home providers contracted to the council

Additional considerations:

- Standard professional service day rate is £850 per day.
- Expenses incurred in the event that client requires added Strata consulting and support are not included in the price and will be invoiced monthly in arrears; Strata will endeavour to keep these expenses at a minimum. An indicative value for expenses is £ 250 / night consisting of return travel to the client location (approx. £130), hotel accommodation (approx. £80per night) and subsistence (approx. £40 per night).
- Where pre-paid professional service days are to be provided but are not scheduled you must schedule with Strata dates and times for use of those Days within fifteen (15) months from the Commencement Date. Strata will endeavour to contact you after a period of twelve (12) months from the Commencement Date to notify you of any outstanding pre-paid days with a view to scheduling dates. Any Prepaid Days not scheduled to be performed within this time period will expire and be deemed cancelled without refund. Strata shall have no responsibility for any lost pre-paid days if we are unable to contact you or if you are unable to accommodate the dates within the fifteen-month period.

14. Test of Change Agreement

Signed by a duly authorised representative for Borders IJB:	Signed by a duly authorised representative for and on behalf of Strata Health:
Name Printed:	Name Printed: Mark McElholm
Title:	Capacity: Director of Sales.
Date:	Date:

15. Commercially Sensitive Information

All Strata Health Limited pricing levels and software terms are considered a trade secret and, if available to the market, could damage Strata Health Limited's business activities. For that reason, no pricing information can be released under a Freedom of Information request or to anyone outside of this direct engagement without prior written approval from Strata Health Limited.

----END----

Terms & Conditions

i. Pre-Conditions

The detail of the work assumes certain Pre-Conditions:

- Relevant personnel will be made available at key times in order to assist with the correct collection of information during scoping
- Sufficient resources will be available on the network and devices to allow for data to be collected
- Work to be completed during normal office hours Monday – Friday (9am – 5pm)
- Any required risk assessments to be carried out by the client, before consultant arrives on site
- Any necessary site passes will be provided upon arrival
- Adequate and available network bandwidth is available across the links
- Provision of full connectivity rights across N3 / web-based access
- Timely and appropriate access to supporting technology administrators for investigations and changes.
-

ii. Description of Services

SaaS Managed Services Program.

The Managed Services Program comprises all necessary 3rd party software licenses, hardware, hardware support and application hosting as described below:

- **a. Hardware /Software Licenses**

Strata will provide all necessary hardware & 3rd party operating licenses (Oracle) to support a secure, fail safe web-based architecture as mutually agreed with 'The Client'. This environment will be updated and scalable to fulfil 'Clients" variable resource utilization (i.e. system is scalable) with formal hardware renewal cycles not exceeding thirty-six (36) months.

- **b. Network /Security**

Strata will contract all necessary network bandwidth and redundant internet access within a mutually agreed subcontracted Tier 1 hosting environment and supporting secure access to levels.

- **c. Hardware/Software and Network Warranty**

Strata warrants that all hardware / software and network functionality will be maintained and serviced as required to deliver the Service Level Requirements for the term of this Agreement.

iii. Cancelation Charges

On the receipt of an official purchase order, the following cancellation charges will apply:-

- Advance notice in writing / email of 10 or more working days no charge
- Advance notice in writing / email of 9 to 3 working days 50% of rate
- Advance notice in writing / email 3 to 0 workings days 100% of rate

Any reschedule of professional service days instigated by the client are subject to the cancellation charges identified above. Strata reserve the right to invoke these charges for any resource that cannot be re-utilised.

iv. Warranties

Strata warrants that:

- The Services shall be performed by trained staff with task appropriate qualifications in accordance with all standards, codes, laws, regulations, orders or by-laws relevant thereto.
- All of Strata's equipment or facilities used in relation to the performance of the Services will be in good condition and suitable and adequate for the use being made.
- Any equipment of the Client utilized or handled by Strata in the performance of the Services will be treated by Strata with reasonable care and utilized or handled only for its intended purposes.
- Strata will monitor and maintain all equipment supplied by Strata under the Agreement so to ensure that the foregoing standards are met on a continuous basis, such maintenance to include routine monitoring of systems, provision of expendables and an on-going program of research and technical upgrading.

Client warrants to Strata, relative to the services received, that it will:

- Make training facilities available including computer enabled training venues.
- Use the Software for the agreed purpose.

- Use hardware or Software in accordance with specification or manuals for use, including keeping equipment in the environment prescribed by Strata.
- Adhere to the technical specifications approved by Strata.

v. Application of Conditions

You acknowledge and agree that You have had the opportunity to read the Conditions before entering into this Statement of Work Agreement.

vi. Supplementary Terms

For the purposes of the Conditions, the following provisions apply:
Commencement Date

- **a, Term**

  This Statement of Works will come into force on the Commencement Date and, unless terminated earlier by either party in accordance with its terms, will remain in force project-based services until the Parties have fulfilled their obligations under this Agreement generally.

- **b. Insurance**

  The insurance policies which we will take out and maintain under Clause 15 of the Conditions are as follows:
  - Public & Product liability insurance with a limit of not less than £2,000,000 per claim or series of related claims;
  - Employer's liability insurance with a limit of not less than £10,000,000 per claim or series of related claims;
  - Professional indemnity insurance with a limit of not less than £2,000,000 per claim or series of related claims.

Scottish Borders

Integrated Care Fund Project Brief

Project Name	Transformational proposal to develop and embed a rehabilitation model for individuals with long term conditions that includes Pulmonary Rehabilitation (PR).		
Project Owner	Alison Wilson, Director of Pharmacy	**Application Main Contact**	Kenny Mitchell, GM, PACs Gareth Clinkscale, GM Unscheduled Care
Main contact email	Alison.Wilson@borders.scot.nhs.uk	**Main Contact Telephone**	01896 825585

Guidance on Project Brief

The purpose of this form is to give a brief outline on the key aspects of the proposal to the Integrated Care Fund.

1 Outline project description

The paper presents the case for investment of £98,734 to develop and embed a robust rehabilitation model for individuals with long term conditions that includes PR as a core element. The model would be delivered across all five localities, in order to improve clinical outcomes, reduce admissions/re-admissions, support early discharge and enhance a self management approach. Current figures state that in 2016, patients coded with a respiratory condition was 10,962, approximately 10% of Borders population; however phase 1 (this funding) will focus on individuals with a diagnosis of a respiratory condition, estimated at 3,000 in Borders. Priority in the first year would be to individuals identified to be most 'at-risk' of admission / re-admission, from GP practice lists.
(see appendix 1 for funding outline)

PR, a well proven cost effective intervention, that can be offered to individuals with other long term conditions, has been proven to have a significant impact on quality of life, and the avoidance of unnecessary hospital admissions.
The PR programme is made up of two, 2 hour sessions per week for a period of 7 weeks. Offering a 42 week service, it would run 6 times per year and run 4 programmes concurrently. Twenty-four programmes a year would be run in the first 2 years, reaching approximately 1,000 patients. This is based on a class of 15 'attend-in-person' participants and up to 5 additional participants attending via video link-up remotely.
To reduce clinician travel time, sessions would run concurrently - morning and afternoon in the same venue. One full-time respiratory physiotherapist would lead on the delivery of the PR programme and additional support will be provided by a respiratory specialist nurse, a clinical support worker or a physiotherapy assistant. Support from other agencies/specialists would be co-opted when appropriate for example – Pharmacist, LASS adviser, Community Capacity facilitator, GP, Occupational Therapist or Psychologist.

By 2019/20 it is envisaged that PR will be offered as part of rehabilitation model for suitable individuals with multiple long term conditions for example – Heart Failure, Stroke, at risk of falling, and/or who may be frail. The Scottish Health Survey 2016 reported that 31% of people, in Borders, over 16 years, had a limiting long term condition.(see appendix 2)
Currently we know that 60% of all deaths are attributable to long term conditions and they account for 80% of all GP consultations in Scotland. Furthermore people with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionally longer and account for over 60% of hospital bed days used. While within the social care sector most peoples who need long term residential care have complex needs usually arising from their multiple long term conditions.

It is important to note that Scottish Borders is the only region in Scotland **not providing** Pulmonary Rehabilitation for its citizens'.

2	Project's alignment to H&SC Strategic Plan Objectivs

Improve the health of the population and reduce the number of hospital admission
The redesigned respiratory care pathway (then other LTC) will ensure that services are integrated to support individuals with complex needs, to enable them to manage their condition to live healthy, active and independent lives as long as possible. The number of people living with a respiratory condition in Borders is 3,000 presenting a significant and currently unmanageable challenge to improve the quality of life for those individuals.

Improve the flow of patients into, through and out of hospital
We expect fewer patients to be admitted to the acute hospital, thus reducing pressure and increasing its capacity. Through a better ability to manage their conditions we also expect the length of stay of patients with copd to be shortened.

Improve the capacity for people to better manage their own conditions and support those who care for them
This programme directly relates to enabling patients to manage their condition. The programme has already been tested with very good results, there is a high degree of confidence that this work will reduce admissions and re-admissions of patients.

Set out below are the 5 key commitments of this project:

1. Prevents admission to hospital
2. Supports early discharge
3. Deliver a sustainable rehabilitation model for long term conditions, using technology as a key component
4. Robust engagement and support plan for Carers
5. An exit strategy to transfer to BAU will be included within the implementation plan

Admission Avoidance (COPD)	Outcomes within the 12 month timeframe of the project: 10% Reduction in rates of admission for patients who have a main diagnosis of COPD (342 / 34) Reduction in the instances of patients being readmitted to hospital with 28 days of discharge by 10% (83 / 8) Reduce unscheduled bed-days in hospital by 10% (OBD 2,306 / 230) Reduce Length of stay by 2 days (6.6 / 4) (Data source ISD April 2017 – March 18)
Supporting early discharge	Delivering PR as part of an integrated care pathway for individuals diagnosed with a respiratory condition, in combination with new and existing initiatives for example: • Technology: has the potential to speed up the discharge process by providing key information across the whole system; we will explore Attend Anywhere to link GPs, Health & Social care staff, Patients & Carers to have informed discussions / virtual clinics. Test the use of mobile apps for example, 'Florence' to increase support in the community • Hospital 2 Home: provides an avenue for early discharge and working with HCSW to support and motivate respiratory patients discharged from hospital to comply with their self-management plan • ACP: Part of a PR programme, and supported by - SAS paramedics undertaking home visits / clinics in practices, and practice nurses completing a respiratory patients 'MOT' has the potential to review or initiate conversations regarding an ACP By combining these and other work-streams provides assurance to Patients, Families, and Professionals to support early discharge and reduce length of stay.
Sustainability	The PR programme will become embedded within a long term conditions pathway, as business as usual, delivered in any locality by a range of individuals. A PR training pack will be developed to ensure that the quality, safety and reliability of the programme are sustained. The pack will create the ability to deliver PR as a hub-spoke programme:

	• Utilising capacity within the H2H project • Utilising technology, for example Attend Anywhere and Phone Apps ('Florence') - for individuals who are harder to reach • Develop capacity from within the PR groups to lead and support continuation of the group • Locality facilitator(s) as part of the Community Capacity building programme, personnel from CHSS and Red Cross will work with the PR groups (post-programme completion) in order to sustain and enhance skills to prevent admission to hospital. Overall by introducing this model it will build both capacity and capability of key individuals in the community.
Engagement & support plan for Carers	The Carers (Scotland) Act 2016 states, 1 in 6 adults have caring responsibilities for someone with a longstanding illness or disability and within Borders unpaid carers 9-9.5% in 2011 census. It is also well recognised that nearly half of carers have long-term conditions themselves and many carers are aging. It is within this context that this project will undertake to deliver 4 support 'clinics' for individuals who care for an individual with a long term condition.
Exit Strategy	By transforming the pathway for managing patients with a respiratory condition it is envisaged that: • A robust and efficient rehabilitation model will be produced and embedded as business as usual • 'Savings' from the project will be re-invested to enhance capability from within the community, to spread the model to other long term conditions, for example Stroke and Heart Failure patients. • By linking with Community Capacity Programme Facilitators, Carers Centre, H2H and Red Cross assurance, has been given that ongoing support post-programme, will be provided.

3 Project Aims

The investment will enable Scottish Borders:

1. To deliver a Borders-wide rehabilitation model that can be replicated for many long term conditions.
2. To empower individuals to be in control of their health condition by providing the necessary skills to maintain independence.
3. To introduce a whole system pathway model of care, including PR that aims to move away from a largely reactive episodic hospital model to a pro-active community based and patient – centred pathway of care.
4. To provide evidenced based interventions at key touch points for individuals as they experience the various stages of their long term condition.
5. Improve patient flow into and out of hospital, by having robust community support in place, self-management plans offering alternatives to hospital admission.
6. The House of Care model will be used as a framework to enhance the quality of life for people with Long Term Conditions, no matter what their condition (see appendix 3)

4 Project outcomes and benefits

The benefits of this rehabilitation model include:

- Personalised exercise regime - re-ablement approach with the aim to maximise the early rehabilitation potential of the person during the early weeks of care
- Educational component supporting self-management by assisting lifestyle and behaviour change
- Increased number of individuals with an active Anticipatory Care Plan
- Increased engagement with community based activities in each locality
- Delivered in a community setting – schools, care centres and day hospitals
- Supports delivery of other key local initiatives such as Hospital to Home, Supported Early Discharge

and reduce avoidable admissions by providing support in the community (current evidence demonstrates that participants within a PR programme evolves into a self-support group, after the programme ends)

- It supports individuals to develop their confidence and skills so that they can carry out activities themselves to enable them to continue to live at home.
- It is envisaged that through Attend Anywhere technology support will be available to a group or individual
- There will be a reduction in attendances / admissions to hospital
- Support early discharge from hospital
- Strengthening links with Red Cross, Community Capacity Builders, Carers Centre and H&S Care partnership initiatives.
- Reduction in the number of SAS conveyances to hospital with patients experiencing exacerbation of their condition
- Enable discussions and possible pilot to develop Community Rehabilitation Team as single point of contact

Patient opinion from individuals with COPD who have attended a PR programme:
"Really feel the rehab class has benefitted my health mentally & physically"
"My OT found out about the rehab group and the water-based exercises, to be honest it has been a lifeline as it has helped to stop isolation & helps your depression"
" I think the exercises & losing weight has done the power of good and kept me out of hospital"
"Before I would have said I was dying from COPD. Now I feel like I'm living with it."

5 What areas of the Borders will the project cover

Pulmonary Rehabilitation programme when resourced will be delivered across all five Borders localities.

6 Which care groups will the project affect?

In the first 12 months PR will focus on those individuals diagnosed with a respiratory condition, those that are in the top 5% of most 'at-risk' of a hospital admission, and meet the eligibility criteria for PR. Thereafter when the model is established it will be spread to include individuals who have had a stroke, diagnosed with diabetes or have a heart condition.
In Scottish Borders approx 3,000 individuals have a confirmed primary diagnosis of COPD with a further 30% having an additional chronic health condition with a secondary diagnosis of COPD or Asthma. Metrics from the Public Health service predicts that a further 25% are currently living with a respiratory condition, which as yet, has not been formally diagnosed.

7 Estimated duration of project

When funding is secured for PR, the project will be delivered over a 12 month period to develop and embed a robust Border wide PR programme.

8 How much funding would the project need and how would it be spent?

In order to develop and embed a robust rehabilitation model funding of £98,734 (see appendix 1)
Over this period the project board will collate and review the necessary data to develop a self-reliant funding model that can be delivered within existing services.

9 What would happen if ICF didn't invest in the project?

- Inequity of care for individuals with long term conditions
- Fragmented, complex systems of care would remain
- Financial and workforce pressures would remain
- The level of admissions & re-admissions would increase
- The cost to health care and pressure on community services would increase as the number of individuals with LTC's is diagnosed.
- This project assists in the delivery of recommendations from CHSS, Dr A Murray's report and the Carers Act,

Integrated Care Fund Project Brief

10	**How would the project release resources in order to sustain the project?** *What services would no longer be provided or would be provided in different ways*

Predicted saving based on:	
Length of stay Reduction 2 Days (30%)	106,000
Admission rates reduced by 30%	137,000
Sub-total saving	243,000
Less cost of new PR service	(77,000)
Predicted annual saving overall	166,000

11	**How would you identify/recruit staff to support the project?**

Local / external advertisement and a discussion with General Managers for Primary & Community Services, Unscheduled Care and Clinical Directors to explore re-organising capacity from within acute care.

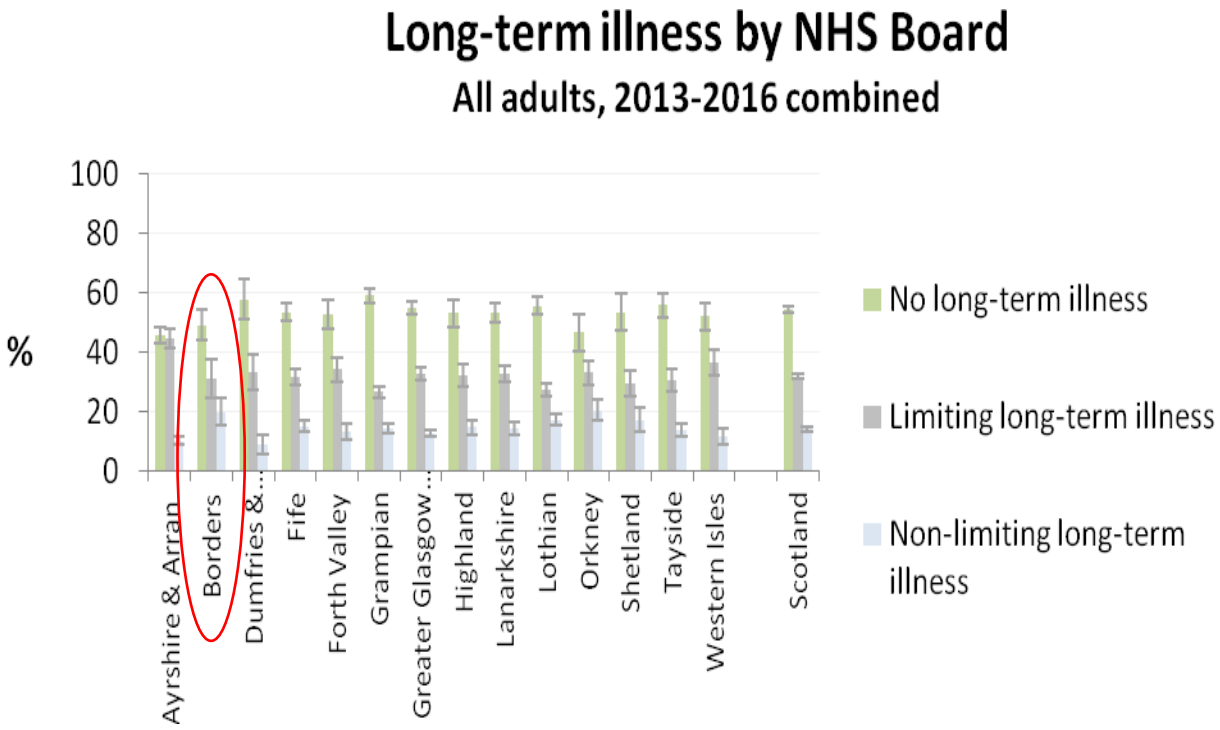
12	**Would the project require dedicated project support from the programme team**

Project support would be provided by the BB transformational change team.

Appendix 1

Staffing costs						
Team member	Grade	Number of sessions per PR programme	Cost per hour	Cost per session (session = 3.75 hours)	Cost per 7 week block (4 programmes running concurrently)	Cost per year (cost per 7 week block x 6)
Respiratory Physiotherapists x2	7	Full-time	£28.41 (£56.82)	£106.54 (£113.64)	100 sessions	£44,746.8 (£68,184)
Support Worker	3	10	£14.80	£55.50	70 sessions	£23,310
Respiratory Specialist Nurse	6	4	£15.68	£58.80	40 sessions	£2,352
Practice Nurse		1 half-day /month				£1,000
Administrator	3	4	£14.80	£55.50	16 sessions	£888
Red Cross support						£2,000
Equipment & Sundries						£1,000
	Total					£98,734

Appendix 2



Appendix 3

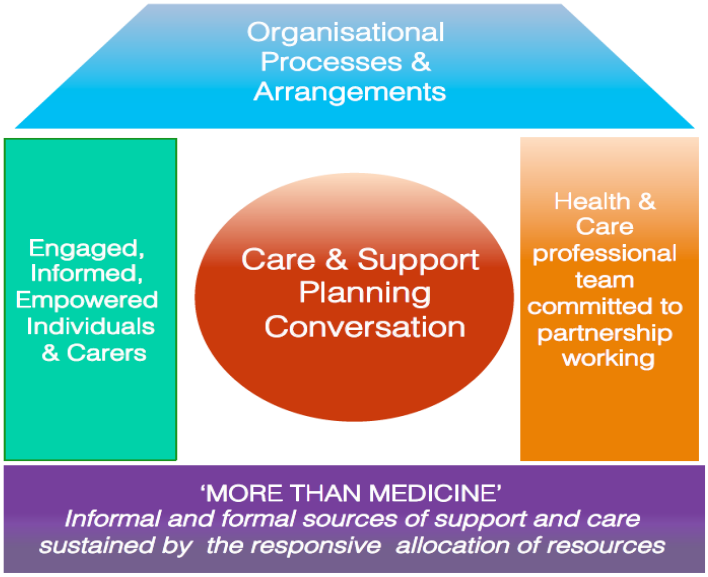
The House of Care model (HoC), shown below will be used as a framework to enhance the quality of life for people with Long Term Conditions, no matter what their condition. At its core is listening to experiences and feedback from people coping with Long Term Conditions, to inform how care should be designed and implemented.

The framework describes the building blocks that need to be in place to enable effective care delivery for individuals with one or more Long Term Condition.

The future model will demonstrate that we have listened to patients who universally say that they wish to be treated as a whole person and for the NHS and social care to act as one team.

As we move to implement change we will modernise our workforce to develop the skills required to meet future requirements.

Integrated Care Fund Project Brief



Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 20 August 2018

Report By	Robert McCulloch-Graham, Chief Officer for Integration
Contact	David Robertson, Chief Financial Officer
Telephone:	01835 825080

MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2018/19 AT 30 JUNE 2018

Purpose of Report:	The aim of this report is to provide an overview of the monitoring position of the Health and Social Care Partnership Budget at 30 June 2018.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the report and the monitoring position on the partnership's 2018/19 revenue budget at 30th June 2018. b) **ask** the Chief Officer to bring forward a plan to the next meeting of the IJB for delivery of remedial savings to address the forecast Outturn variance.

Personnel:	N/A

Carers:	N/A

Equalities:	There are no equalities impacts arising from the report.

Financial:	No resourcing implications beyond the financial resources identified within the report. The report has been reviewed by the Chief Officer and approved by NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer for factual accuracy. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.

Legal:	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.

	A Recovery Plan will be presented to the next meeting of the IJB. The remedial actions it contains in order to address financial pressures across health and social care budgets may impact on the ability to deliver the partnership's strategic an commissioning plans

Risk Implications:	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.

Background

2.1 The report relates to the monitoring position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and the budget relating to large-hospital functions retained and set aside for the population of the Scottish Borders (the "set-aside budget").

2.2 On the 23rd April 2018, the Integration Joint Board (IJB) considered the proposal to delegate **£148.229m** of resources supporting integrated health and social care functions for the financial year 2018/19, and a proposed budget of **£20.138m** relating to the large hospitals budget set-aside. Within the proposed delegated budget, **£102.390m** related to NHS Borders healthcare functions, **and £45.839m** related to Scottish Borders Council social care functions. The budget was not accepted by the IJB Board due to the inclusion of £5.2m of unidentified savings within the NHS Borders budget proposals. Since the last Board meeting there has been ongoing work to bridge the resources gap, the NHS Board have to agree with the Scottish Government Health and Social Care Department how financial targets will be met in 2018/19. NHS Borders have requested a level of brokerage and award of this funding will be dependent on the NHS Board having in place a plan on how it will return to a recurring balance.

	2018/98 Budget £m
Healthcare Functions - Delegated	102.390
Social Care Functions - Delegated	45.839
Total Delegated	**148.229**
Healthcare Functions - Set-Aside	**20.138**
Total	**168.367**

2.3 This report sets out the current monitoring position on both the delegated and set-aside budgets at 30June 2018, assuming levels of delegation are accepted by the Board, identifying key areas of financial pressure and proposals for their mitigation. The scheme of integration requires NHS Borders and Scottish Borders Council to each fund their share of any overspend arising from the delegated budget at year end. An overspend of £7.059m is forecast for the year with unidentified savings within NHS Borders delegated functions accounting for £4.814m of this forecast overspend.

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Overview of Monitoring Position at 30June 2018

Healthcare Functions

3.1 As in 2017/18, delegated healthcare functions are experiencing considerable financial pressure this financial year. Currently an adverse outturn projection of £6.3m is forecast, representing 6.2% of the overall budget.

£4.8 m of this pressure relates to non-delivery of unidentified savings. In addition almost £1m of this pressure is being experienced in Generic Services within which a range of miscellaneous functions such as community hospitals, dental, pharmacy and nursing, prescribing and general medical services and primary staffing and management are managed.

Social Care Functions

3.2 Social Care delegated functions are currently projecting an adverse variance of £20k which will be addressed from other Council funds. Demographic pressures across all services are being experienced with an increased number of care packages being delivered, many of a more permanent and complex nature. A comprehensive management action plan to contain costs within delegated budget levels has been agreed and is being led by the IJB Chief Officer.

Of Scottish Borders Council Financial Plan savings of £2.048m, savings to the value of £1.6m are forecast to be delivered permanently, with the remainder forecast to be delivered on a non-recurring basis, with reviews underway to identify permanent solutions for the balance. The 2018/19 direct council allocation from the Social Care Fund of £1.537m has been fully deployed in providing for the Cosla Care Home contract uplift of 3.39% (£402k), the impact of the Carers Act (£322k) with the balance required for paying the Scottish Living Wage of £8.75 per hour to providers of commissioned services. The delegated health and social care budget also assumes the £7.3m provided by Scottish Government via NHS Borders will be fully deployed to support living wage policy delivery and additional care packages as previously approved.

Large Hospital Functions Set-Aside

3.3 Due to the funding of agreed cost pressures the budget of £20.1m has been increased to £21.4m. The current projected forecast outturn is £22.1m with the main area of pressure being one to one care, sickness cover and the requirement to open additional beds to deal with the impact of delayed discharges. An action plan to address the current nursing pressure and year end trajectory has been requested.

Risk

4.1 A number of risks associated with the reporting of the IJB's monitoring position were reported to the IJB during 2017/18. These risks include the extent of recovery required, the challenge over ensuring its delivery and the assumption of price/demand stability between now and the end of the financial year. Similar risks exist for 2018/19. The main risks in both the Health Care and the Social Care budget continue to be the non-identification and non-delivery of Financial Plan savings, and managing the impact of demand pressures.

4.2 Any adverse variance at the end of the financial year will, as per the Partnership's Integration Scheme, be met from managed underspends elsewhere across partner organisations.

Appendix 1

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2018/19	At end of Month:	JUNE

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	20,216	3,607	21,005	20,927	78	An overspend of £7.1m is currently being forecast for 2018/19 based on actual expenditure to the 30th June 2018 and projected expenditure to the end of the year.
Joint Mental Health Service	15,422	3,758	15,649	15,774	(125)	
Joint Alcohol and Drug Service	357	184	370	370	0	Savings yet to be identified within Healthcare account for £4.8m of this variance with overspends in Generic Services (£1.4m) with Large Hospital Set-aside accounting for most of the remaining overspend
Older People Service	19,281	5,328	20,207	20,174	33	
Physical Disability Service	3,322	568	3,409	3,553	(144)	
Unidentified Savings	(1,239)	0	(4,814)	0	(4,814)	
Generic Services	91,267	19,174	91,592	92,959	(1,367)	
Large Hospital Functions Set-Aside	20,138	5,913	21,368	22,088	(720)	
Total	168,764	38,532	168,786	175,845	(7,059)	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions	2018/19	At end of Month:	JUNE

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	16,644	2,638	17,466	17,296	170	Demographic pressures in excess of £1m were identified during budget onitoring to 30 June 2018. These have been addressed by a Management action plan. It is anticipated that the residual projected overspend of £20k will be addressed through operational efficiencies during the remainder of the year.
Joint Mental Health Service	2,108	448	2,170	2,237	(67)	
Older People Service	19,281	5,328	20,207	20,174	33	
Physical Disability Service	3,322	568	3,409	3,553	(144)	
Generic Services	4,881	954	4,649	4,661	(12)	
Total	46,236	9,936	47,901	47,921	(20)	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions	2018/19	At end of Month:	JUNE

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,572	969	3,539	3,631	(92)	The current month reported position includes the full allocation of efficiency savings required in 2018/19 as advised by NHS Borders as the Provision of Resources to the IJB Funding has not yet been allocated to operational budgets linked to pay award uplift as this will be processed for payment in July & August 2018. The Healthcare delegated budgets are forecasting an overspend of £6.3m being a combination of £4.8m of as yet unidentified savings and an overspend of £0.955m in Generic Services and £0.4m in GP prescribing.
Joint Mental Health Service	13,314	3,310	13,479	13,537	(58)	
Joint Alcohol and Drug Service	357	184	370	370	0	
GP Prescribing	21,700	5,716	22,955	23,355	(400)	
Unidentified savings	(1,239)	0	(4,814)	0	(4,814)	
Generic Services	64,686	12,504	63,988	64,943	(955)	
Total	102,390	22,683	99,517	105,836	(6,319)	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2018/19	At end of Month:	JUNE

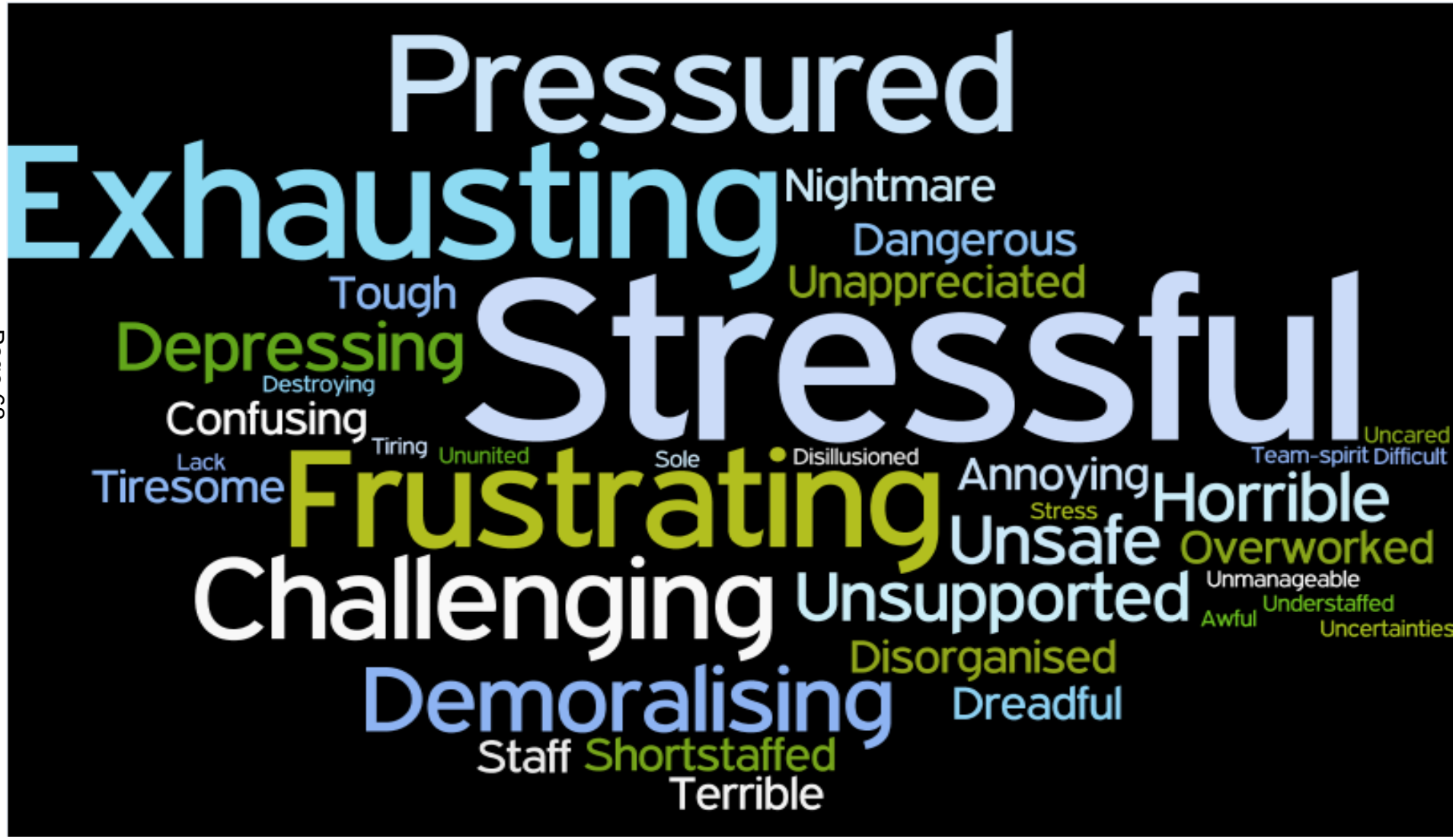
	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,003	656	2,458	2,564	(106)	
Medicine & Long-Term Conditions	11,847	3,481	12,502	12,638	(136)	
Medicine of the Elderly	6,288	1,776	6,408	6,886	(478)	
Total	20,138	5,913	21,368	22,088	(720)	

Scottish Borders
Health and Social Care
PARTNERSHIP

Joint Winter Plan 2018/2019

IJB August 2018

Gareth Clinkscale, General Manager Unscheduled Care


Pressured
Exhausting
Nightmare
Dangerous
Unappreciated
Tough
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Depressing
Destroying
Confusing
Tiring
Ununited
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Uncared
Team-spirit
Difficult
Lack
Tiresome
Frustrating
Annoying
Stress
Horrible
Unsafe
Overworked
Challenging
Unsupported
Unmanageable
Understaffed
Awful
Uncertainties
Disorganised
Demoralising
Dreadful
Staff
Shortstaffed
Terrible

Scottish Borders
Health and Social Care
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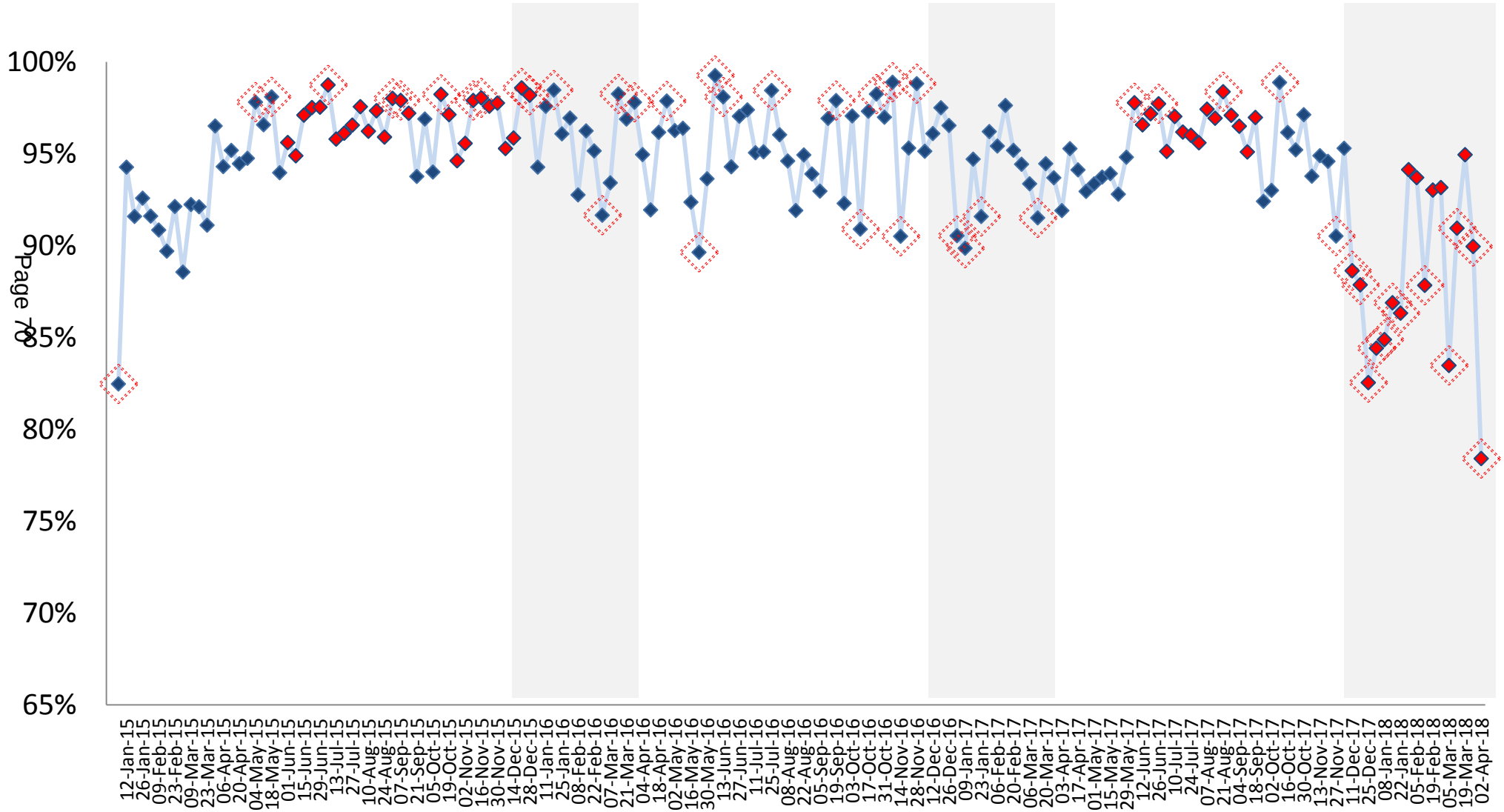
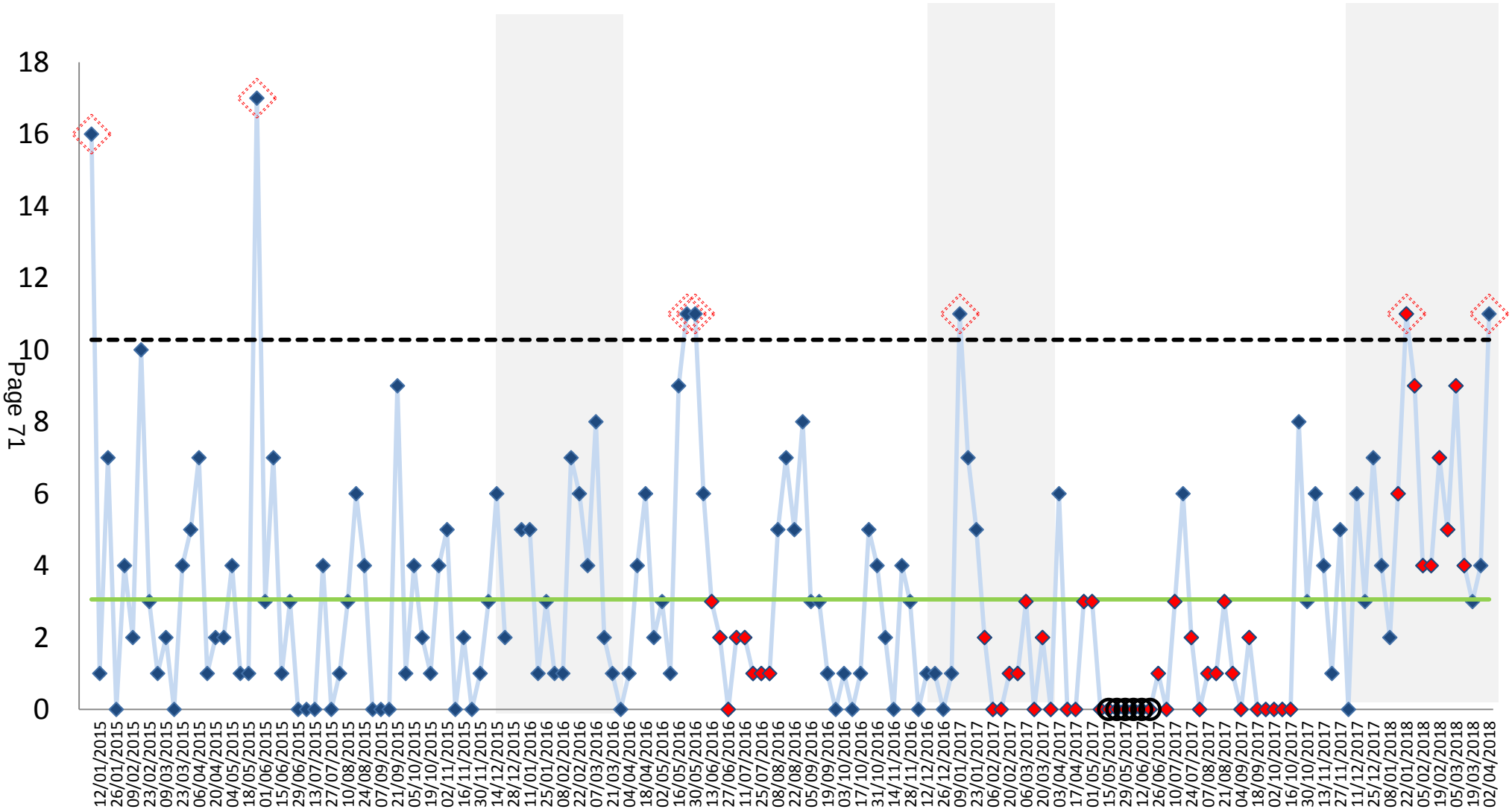
4-hour performance

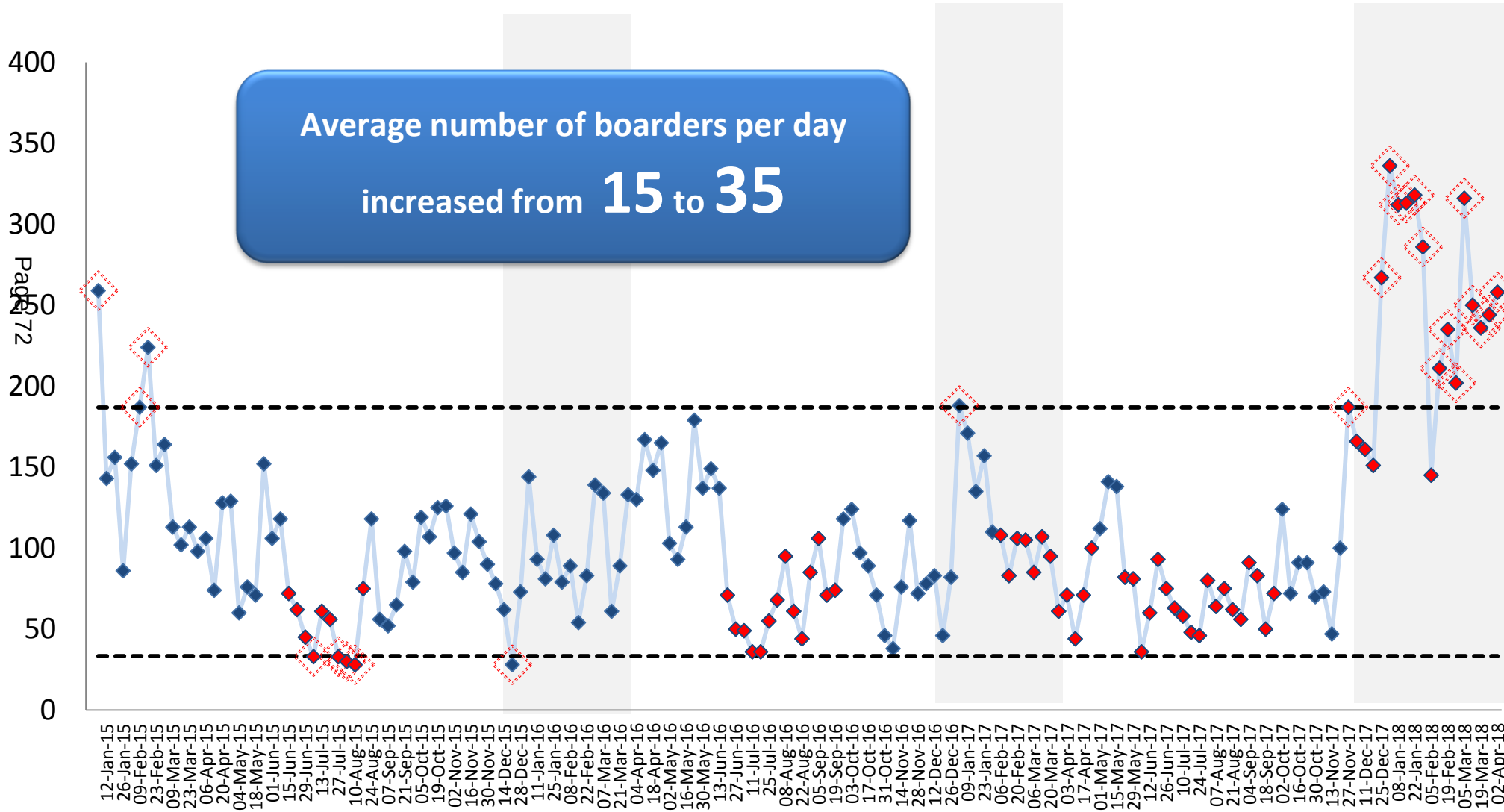


Inpatient Cancellations

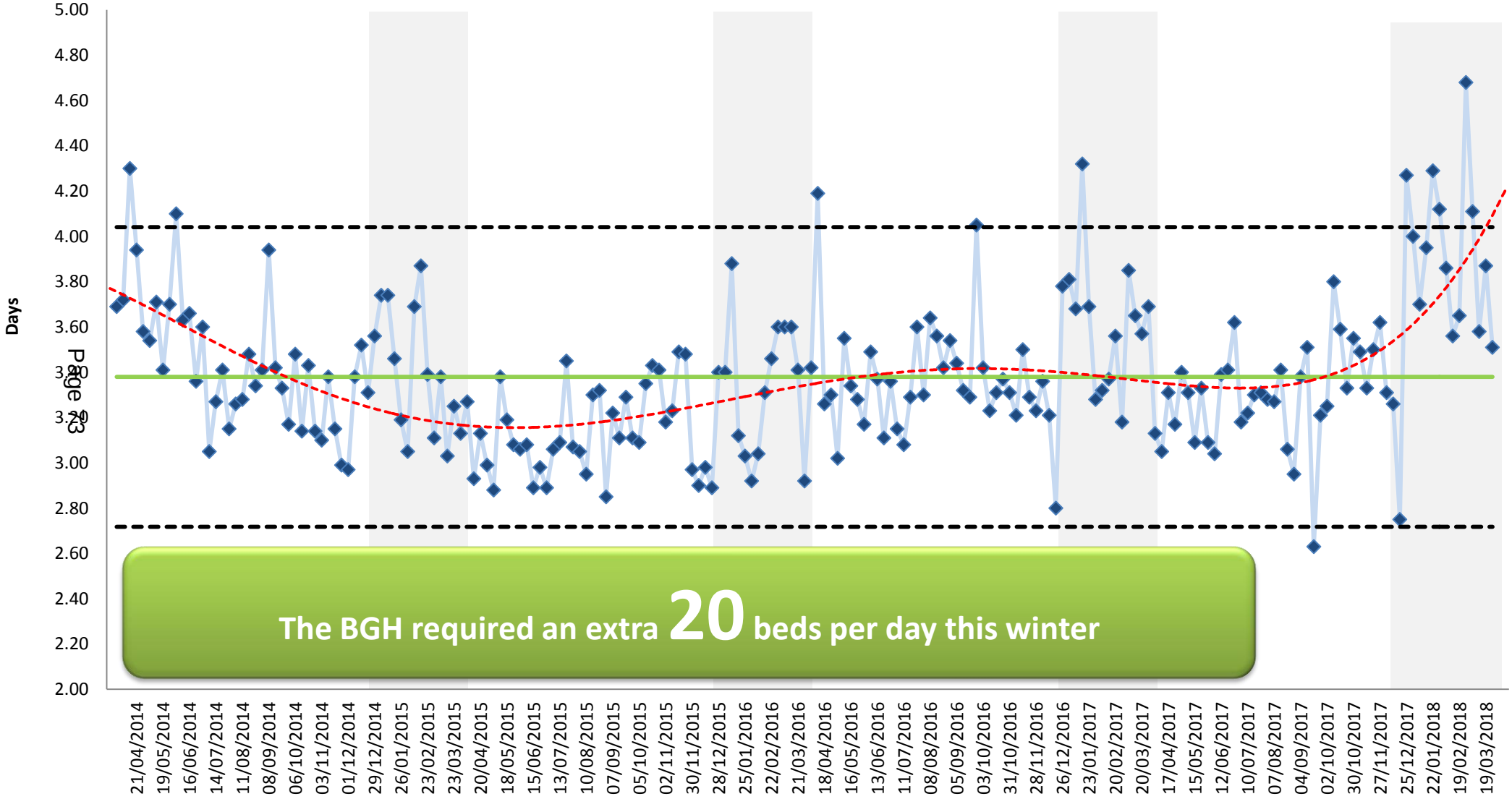


Boarding bed days

Scottish Borders Health and Social Care PARTNERSHIP



BGH Average Length of Stay

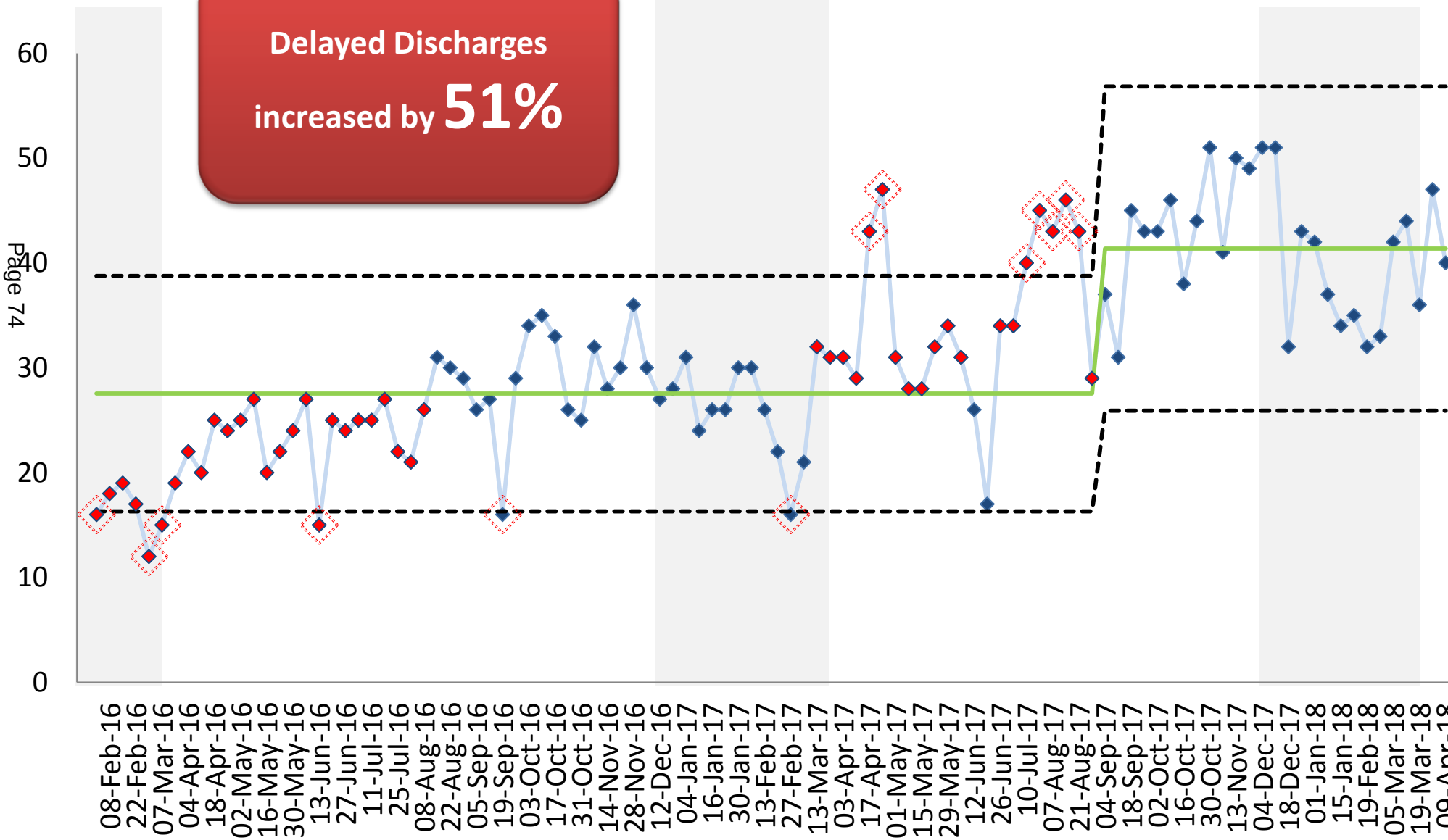


The BGH required an extra 20 beds per day this winter

Delayed Discharges over 72 hours

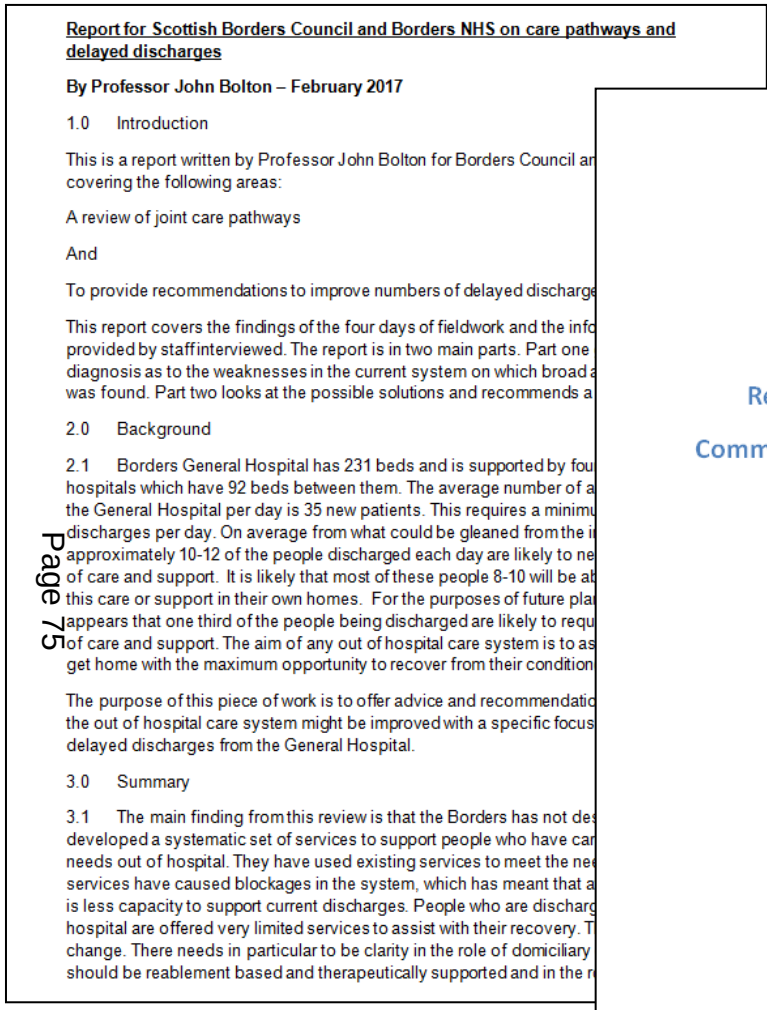
Scottish Borders Health and Social Care PARTNERSHIP

Delayed Discharges increased by 51%



A way forward

Scottish Borders Health and Social Care PARTNERSHIP



Report for Scottish Borders Council and Borders NHS on care pathways and delayed discharges

By Professor John Bolton – February 2017

1.0 Introduction

This is a report written by Professor John Bolton for Borders Council ar
covering the following areas:

A review of joint care pathways

And

To provide recommendations to improve numbers of delayed discharge

This report covers the findings of the four days of fieldwork and the info
provided by staff interviewed. The report is in two main parts. Part one
diagnosis as to the weaknesses in the current system on which broad a
was found. Part two looks at the possible solutions and recommends a

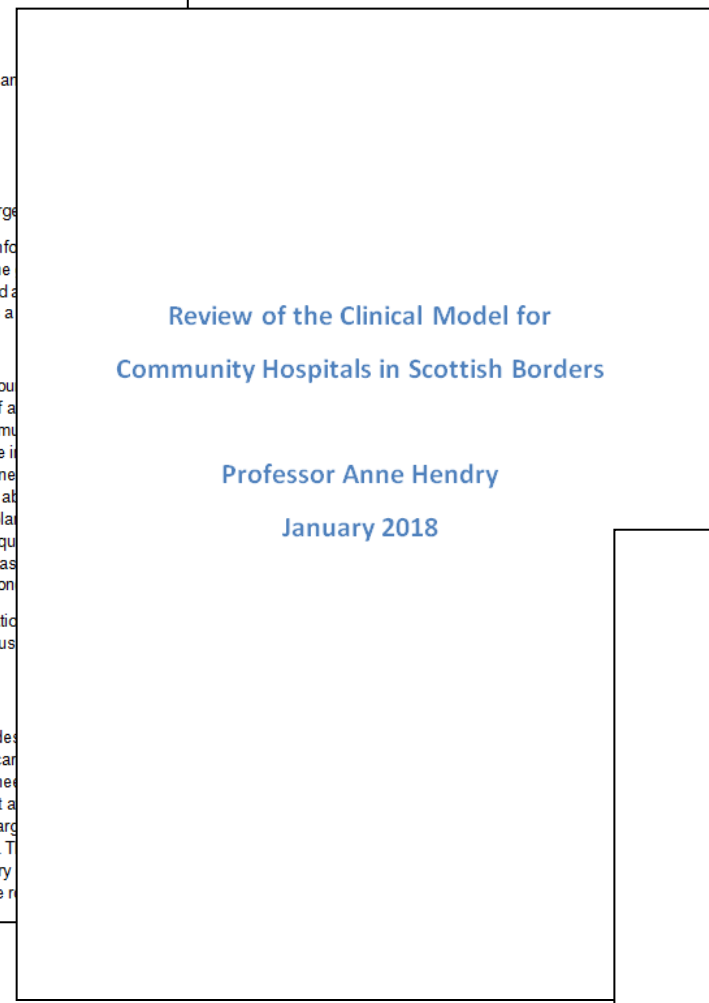
2.0 Background

2.1 Borders General Hospital has 231 beds and is supported by fou
hospitals which have 92 beds between them. The average number of a
the General Hospital per day is 35 new patients. This requires a minimu
discharges per day. On average from what could be gleaned from the i
approximately 10-12 of the people discharged each day are likely to ne
of care and support. It is likely that most of these people 8-10 will be ab
this care or support in their own homes. For the purposes of future pla
appears that one third of the people being discharged are likely to requ
of care and support. The aim of any out of hospital care system is to as
get home with the maximum opportunity to recover from their condition

The purpose of this piece of work is to offer advice and recommendatio
the out of hospital care system might be improved with a specific focus
delayed discharges from the General Hospital.

3.0 Summary

3.1 The main finding from this review is that the Borders has not de
developed a systematic set of services to support people who have car
needs out of hospital. They have used existing services to meet the ne
services have caused blockages in the system, which has meant that a
is less capacity to support current discharges. People who are discharg
hospital are offered very limited services to assist with their recovery. T
change. There needs in particular to be clarity in the role of domiciliary
should be reablement based and therapeutically supported and in the r



Review of the Clinical Model for

Community Hospitals in Scottish Borders

Professor Anne Hendry

January 2018

BGH Unscheduled Care Improvement Forum

BGH Winter Review

Gareth Clinkscale, General Manager

Lynn McCallum, Unscheduled Care Clinical Lead

2018/19 Winter Plan

Scottish Borders Health and Social Care PARTNERSHIP

Objectives	Activities	Key Performance Indicators
Increase Weekend Discharge	7 Day RAD Service Increased Weekend Medical Cover Enhanced Weekend Pharmacy Service Increased Weekend Social Work Access Establish Hospital @ Weekend Increase discharge to Care Homes and POC	% Weekend Discharges
Increase Capacity To Meet Demand	Winter Surge Ward Elective Cessation Plan ED Twilight Shifts Enhanced BECS during Public Holidays Increase AHP capacity Enhance Ambulatory Care	Length of Stay ED First Assessment Breaches Cancelled Electives Ambulatory Care Numbers
Improve Patient Flow	New Site & Capacity Team Daily Dynamic Discharge Re-launch Unscheduled Care Improvement Forum Escalation Policy Review Establish Rapid Assessment and Transfer	4 Hour Emergency Access Standard Pre 12pm Discharges Delayed Discharges
Reduce Delays	Establish central Borders Hospital to Home Community Hospital capacity Weekly Delayed Discharge Meeting Day of Care Audit Plus	Delayed Discharges Community Hospital DD > 28 Days Length of Stay
Safer Services	Review BGH Boarding Policy Protect Acute Assessment Unit Protect Surgical Assessment Unit Winter Communications strategy	Boarding bed days AAU Bedded/Functioning SAU Bedded/Functioning
Staff Wellbeing	New monthly BGH Staff Awards Staff Wellbeing Champion Targeted Wellbeing Activities	Sickness Absence

2018/19 Winter Plan

Scottish Borders Health and Social Care PARTNERSHIP

Objective	Projects	KPIs
Increase Weekend Discharge	7 Day RAD Service	% Weekend Discharges
	Increased Weekend Medical Cover	
	Enhanced Weekend Pharmacy Service	
	Increased Weekend Social Work Access	
	Establish Hospital @ Weekend	
	Increase discharge to Care Homes and Packages of Care	

2018/19 Winter Plan

Scottish Borders Health and Social Care PARTNERSHIP

Objective	Projects	KPIs
Increase Capacity To Meet Peak Demand	Winter Surge Ward	Length of Stay ED First Assessment Cancelled Electives Ambulatory Care activity
	Elective Cessation Plan	
	ED Twilight Shifts	
	Enhanced BECS during Public Holidays	
	Increase AHP capacity	
	Enhance Ambulatory Care	

2018/19 Winter Plan

Scottish Borders Health and Social Care PARTNERSHIP

Objective	Projects	KPIs
Improve Patient Flow	New Site & Capacity Team	4 Hour Emergency Access Standard Pre 12pm Discharges Delayed Discharges
	Daily Dynamic Discharge Re-launch	
	Unscheduled Care Improvement Forum	
	Escalation Policy Review	
	Establish Rapid Assessment and Transfer	

2018/19 Winter Plan

Scottish Borders Health and Social Care PARTNERSHIP

Objective	Projects	KPIs
Reduce Delays	Establish central Borders Hospital to Home	Delayed Discharges Community Hospital DD > 28 Days Length of Stay
	Community Hospital capacity plan	
	Weekly Delayed Discharge Meeting	
	Day of Care Audit Plus	

2018/19 Winter Plan

Scottish Borders Health and Social Care PARTNERSHIP

Objective	Projects	KPIs
Deliver Safer Services	Review BGH Boarding Policy	Boarding bed days
	Protect Acute Assessment Unit	
	Protect Surgical Assessment Unit	AAU open
	Winter Communications strategy	SAU open

Objective	Projects	KPIs
Maintain Staff Wellbeing	New monthly BGH Staff Awards	Sickness Absence
	Staff Wellbeing Champion	
	Targeted Wellbeing Activities	

Anticipated benefit