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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Wednesday, 25th September, 2019** at **10.00 am** in Council Chamber, Scottish Borders Council Headquarters

AGENDA

Time	No		Lead	Paper
10:00	**1**	**ANNOUNCEMENTS & APOLOGIES**	**Chair**	Verbal
10:01	**2**	**DECLARATIONS OF INTEREST** Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.	**Chair**	Verbal
10:03	**3**	**MINUTES OF PREVIOUS MEETING**	**Chair**	(Pages 3 - 10)
10:05	**4**	**MATTERS ARISING** Action Tracker	**Chair**	(Pages 11 - 16)
10:10	**5**	**FOR DECISION**		
	5.1	Strategic Implementation Plan	**Chief officer**	(Pages 17 - 34)
	5.2	Transformation Fund Review	**Chief officer**	(Pages 35 - 52)
	5.3	Annual Review of IJB Terms of Reference	**Chief officer**	(Pages 53 - 70)
	5.4	Strata Evaluation	**Portfolio Manager**	(Pages 71 - 106)
	5.5	Bi-annual Review of Risk Register	**Chief officer**	(Pages 107 - 116)
11:30	**6**	**FOR NOTING**		

6.1	Monitoring of Integration Joint Budget 2019/20	**Interim Chief Financial Officer**	(Pages 117 - 124)
6.2	Inspections Update	**Interim Chief Officer Adult Services**	Verbal
6.3	Draft Winter Plan 2019/20	**Hospital Manager**	
6.4	Quarterly Performance Report	**Programme Manager**	(Pages 125 - 132)
6.5	Strategic Planning Group Report	**Chief officer**	(Pages 133 - 136)
7	**ANY OTHER BUSINESS**	**Chair**	
8	**DATE AND TIME OF NEXT MEETING** Wednesday 30 October 2019 at 10:00 in the Council Chamber, Scottish Borders Council.	**Chair**	

Minutes of a meeting of the Health & Social Care **Integration Joint Board** held on Wednesday 14 August 2019 at 10.00am in the Council Chamber, Scottish Borders Council.

Present:	(v) Dr S Mather (Chair)	(v) Cllr D Parker
	(v) Cllr J Greenwell	(v) Mr M Dickson
	(v) Cllr S Haslam	(v) Mr J McLaren
	(v) Cllr T Weatherston	(v) Mr T Taylor
	(v) Cllr E Thornton-Nicol	Mr R McCulloch-Graham
	Dr C Sharp	Mr M Porteous
	Mrs N Berry	Mrs S Aspin
	Mr S Easingwood	Mr D Bell
	Mrs J Smith	
In Attendance:	Mr R Roberts	Mrs T Logan
	Mrs C Gillie	Mr D Robertson
	Mr G McMurdo	Miss L Ramage
	Miss S Laurie	Mrs S Bell
	Ms S Holmes	Mr G Samson

1. Apologies and Announcements

Apologies had been received from Ms I Bishop, Ms L Gallacher, Dr A McVean, Mrs J Stacey and Mrs K Hamilton.

The Chair confirmed the meeting was quorate.

The Chair welcomed Graeme McMurdo to the meeting.

The Chair welcomed members of the public to the meeting.

2. Register of Interests

The Chair sought any verbal declarations of interest pertaining to items on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the Register of Interests.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 19 June 2019 were approved.

4. Matters Arising

4.1 Action 12: The Chair reiterated the action to be taken following the deputation to the IJB in June 2019; the Executive Management Team (EMT) would add to the September 2019 agenda for discussion and agree a mechanism to employ an IJB Service User representative.

Mr Tris Taylor enquired as to why a determination had not been made in time for the August IJB. Mr Rob McCulloch-Graham advised that, due to annual leave, a full discussion with EMT was not possible until September 2019 and provided assurance that the IJB would have a Service User representative by the end of November 2019.

Mr Rob McCulloch-Graham advised that a further summit was in the process of being planned for the Locality Working Groups by the end of September 2019.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. Integration Joint Board 2019/20 Financial Plan Addendum

Mr Mike Porteous provided a detailed account of the content of the addendum paper and presented the budget allocations from partner organisations. Evidence was given on the financial and resource implications for the IJB operating in a financially challenging environment.

Both NHS Borders and Scottish Borders Council are forecasting a breakeven position at the end of this financial year.

The process of Joint Financial Planning would be explored to try to establish a 3 to 5 year financial plan. Mr Mike Porteous informed members that a Joint Financial Plan timetable would be presented to EMT in September 2019 and the finalised version would be presented to the IJB later in the year.

Members were advised that actions were underway to address the budget gap across the whole partnership, with good progress made against some workstreams which would be referenced in the next monitoring report. However it was acknowledged the current delivery method of services was unsustainable.

The Chair sought comments from Director's of Finance from partner organisations. Mrs Carol Gillie and Mr David Robertson assured they had no further observations.

Mr Malcolm Dickson commented there would be no guarantee of future Scottish Government brokerage for NHS Borders, therefore a focus should be placed on projecting ahead and not only on the revised savings target of £3.3million in the current financial year. Mr Mike Porteous agreed that a focus on recurring savings across the whole partnership was required to maintain momentum in reaching financial balance. Mr Ralph Roberts confirmed the level of brokerage available for NHS Borders and assured the allocation was a fair share of the NHS Borders resource, reflective of the services.

Cllr Shona Haslam was assured the IJB were on target to deliver the quarter 1 committed savings and reminded there remained a gap in the overall year budget which was yet to be

closed. Mr Ralph Roberts commented that both partner organisations would make all endeavours to work within the set budget and, only after such actions would either partner fund the gap.

Mr Tris Taylor advised he was uneasy about the financial position and asked to be assured of strict governance around reporting on recurring savings reports to the IJB. Mr Tris Taylor also asked for clarity on the delay of reaching an agreed budget. Members were reminded the IJB were uncomfortable with accepting the budget earlier in the year due to the level of financial uncertainty. Joint Financial Planning would be a key mechanism going forward, linked to the NHS Borders 3 year recovery plan and Scottish Borders Council 5 year financial plan.

Cllr Shona Haslam commented the budget should be set on what savings would be realistically achievable whilst improving patient outcomes, then a remaining request for brokerage can be made. Mr Ralph Roberts agreed and advised NHS Borders would continue to provide Scottish Government with confidence on the level progress to reduce brokerage, therefore reducing the requirement of paying back.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the budget allocations from Scottish Borders Council (£49.078m) and NHS Borders (£134.016m) for the delegated functions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the revised savings targets which NHS Borders has calculated for their delegated functions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that any expenditure in excess of these delegated budgets in 2019/20 will require to be funded by additional contributions from the partners in line with the approved scheme of integration.

6. 2018/19 H&SC IJB Annual Performance Report

A legislative requirement stands for every Health & Social Care Partnership to publish an Annual Performance Report (APR) by 31 July each year, with a set reporting structure to look at past and future local performance. Mr Graeme McMurdo provided an overview of the local Annual Performance Report and gave assurance the report was published on time, but would require IJB retrospective approval. There is an opportunity to amend as necessary and re-publish.

The APR was received well by all members.

Cllr Shona Haslam was assured the table on page 34 of the report, setting out the proportion of spend, would be completed following the confirmation of the budget.

Mr Malcolm Dickson asked for the IJB Audit Committee to be represented in the governance structure on page 12 of the report.

Mr Malcolm Dickson commented that, despite good performance, there was little evidence to date of a shift of the balance of care or resource between organisations. Mr Rob McCulloch-Graham advised the balance of care would show more of a definitive shift over the coming year. The redesign of Dementia services would be the first opportunity to start the shift.

Mr Tris Taylor thanked Graeme McMurdo and the Communication & Graphics team for their contribution to producing the APR, which brought clarity to the information through well thought out design.

Mrs Jenny Smith commended the APR and thanked contributors, however asked if the potential of producing an easy read version could be considered next year for those with learning disabilities.

Mr John McLaren asked for clarification on the governance for the APR, prior to presentation to the IJB. Mr Rob McCulloch-Graham advised approval was gained through the Health & Social Care Partnership Leadership Team and EMT, and would be presented to the next Joint Staff Forum. Mr John McLaren and Mr Rob McCulloch-Graham agreed that input from locality groups would be sought and reflected in the future APR.

The Chair thanked members for their comments and agreed the amendments would be made to the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the 2018/19 Annual Performance Report, with the incorporation of the agreed amendments.

7. Redesign of Dementia Services

Mr Rob McCulloch-Graham provided an introduction to the report, providing assurance the senior management steering group had fully engaged with all partners. Members were advised of the current bed state; Cauldshiels assessment ward with 14 beds and Melburn Lodge long stay ward with 12 beds.

The reduction in the current overprovision of acute mental health inpatient beds would be in line with local and national reports to shift the balance of care. The resource from the disinvestment in acute inpatient beds would require a shift to appropriate community services, via programmes like the Care Home and Community Assessment Team to support care homes and nursing homes staff with challenging patient behaviours.

The Chair asked for Dr Cliff Sharp's professional view on the proposed changes in respect on what is best for patients. Dr Cliff Sharp gave an overview of the positive steps made in the transformation to develop better community mental health services, keeping people safe and supported at home. Dr Cliff Sharp commented the proposal was a much needed step and was very supportive of the approach, as long as community support is provided and trigger points of system pressure are made clear.

Tracey Logan commented she was very supportive of the proposed redesign and had gained an idea of the pressures community staff are facing in terms of dealing with the level of patient complexity; therefore a longer term investment of training support would be required.

Cllr Elaine Thornton-Nicol agreed with the requirement for additional staff training and the associated costs should be factored into the proposal.

Cllr John Greenwell was assured that the £338k funds would be ring fenced on an annual basis for the sole use of specialist care bed investment, until the evaluation has been carried out and a final decision has been made on appropriate reinvestment options. Mr Rob McCulloch-Graham commented that analysis of the community resource impact would be an essential step prior to confirming spend.

Mrs Shirley Aspin commented the mental health transformation programme had been ongoing for some time; however the Care Home and Community Assessment Team remained a small team and would require sufficient support.

Mr John McLaren raised concerns over the recent day centres closures and their potential impact on the patients with Dementia who would usually access such community resource. Mr Rob McCulloch-Graham advised that the clientele who are in Cauldshiels are high end specialist care, different to those who would utilise the day services. Cllr Elaine Thornton-Nicol advised the day centres closures are not part of this transformation. Mrs Jenny Smith was able to provide a user perspective from attending a recent meeting with carers, who still have concerns that effective alternatives are not in place to support the individuals who were previously cared for in the day centres. Mrs Tracey Logan advised the process of day centre closure was being revisited and assessments of all users will be completed before taking the next step of re-provisioning as part of an integrated approach. Members were reassured by this addition in the plan.

Mr John McLaren also asked that a further effort to engage actively with carers be made.

Cllr Tom Weatherston commented the proposal was a huge step in the right direction. Mr Malcolm Dickson echoed Cllr Tom Weatherston's view.

The Chair concluded that it was not a seismic change, instead part of the continuum of mental health re-provision which would be a positive step forward.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the reduction of the number of Dementia inpatient beds from 26 to 12.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved reinvestment in appropriate community resources.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to establish an IJB reserve of £338,000 of recurrent funding. This reserve will be earmarked for the purchase of additional Dementia care home beds, as required. Should the beds not be required the balance of the reserve would be used by the IJB to contribute to the delivery of efficiencies within the health arm of the IJB budget.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to review the impact of the new model by no later than March 2021, including the effectiveness of the Care Home and Community Assessment team, the need for NHS Inpatient beds and the ongoing requirement for the earmarked reserve.

8. Bi-Annual Review of Risk Register

Mr Rob McCulloch-Graham provided an overview of the risk register in Mrs Jill Stacey's absence.

Mr John McLaren asked if it would be appropriate for members to have more sight on the risks and the active steps taken to manage them. Cllr Tom Weatherston advised the management of the risks sat with the IJB Audit Committee who asked for additional information on outstanding risks at the last board meeting. Members were content with the oversight assurance from the IJB Audit Committee; risks will continue to be reviewed on a 6 monthly basis and reported back to the IJB.

Mr Tris Taylor commented that information should be included in the report to clarify a benchmarked position and what would be considered an acceptable risk level.

Mr Rob McCulloch-Graham advised the format of the appendix would be reviewed.

Mrs Tracey Logan asked for the item to be postponed to the September IJB and ensure Mrs Jill Stacey is available to attend.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to defer this item to the September 2019 IJB.

9. 2018/19 Integration Joint Board Annual Audit Report

Mr Mike Porteous gave an overview of the report and advised that Audit Scotland had given an unqualified report on the 2018/19 Annual Accounts.

Mr Rob McCulloch-Graham highlighted the reference to the Code of Corporate Governance which was discussed at the IJB Audit Committee earlier in the month to improve the methodology of performance scrutiny.

Cllr Shona Haslam commented the achievement section within the report should be strengthened. Mr Rob McCulloch-Graham advised this will be acknowledge with the auditors and built into the 2019/20 report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the independent auditor's 2018/19 Annual Report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the key messages and actions within the report.

10. Financial Outlook Update

NHS Borders

Mrs Carol Gillie gave a presentation on NHS Borders financial plan position, where a total of £6million of recurring savings had been identified from a robust mandate process. Mr Ralph Roberts commented NHS Borders was confident in delivering the identified savings for the in

year benefit and but would not reduce the underlying targets. Any deficit from current year would add further pressure on the targets for the next 2 years.

Mr Tris Taylor asked for clarification on the average amount of time taken to process an idea to a project plan. Mrs Carol Gillie advised she did not have the information to hand but would discuss with colleagues and confirm the timescales virtually.

Scottish Borders Council
Mr David Robertson advised Scottish Borders Council are on track to deliver £1.4million of the £1.6million savings target, with the variance due to the delays in the day centre redesign approach which the Executive Committee are aware of. The risks areas of interest to the IJB included the review and billing processes of care packages, which would be managed with appropriate social work engagement.

Mrs Nicky Berry commented on the beneficial financial overviews and advised that updates should be routinely presented to the IJB to monitor the interdependent risks, such as the packages of care.

IJB
Mr Mike Porteous agreed with finance colleagues from the partner organisations and advised the information would be incorporated into the next monitoring report for the IJB.

The Chair stated he had confidence that the IJB will start with an agreed budget in 2020 and asked for a joint presentation from the Director's of Finance at the start of the new financial year.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation and verbal updates.

11. Any Other Business

11.1 Equality Impact Assessment: Cllr John Greenwell enquired as to where the Equality Impact Assessments (EIA) were published for IJB projects which state the assessment was carried out. Jenny Smith agreed the EIA should be available in a central location for information. Graeme McMurdo agreed to follow up with Cllr John Greenwell query.

12. Date and Time of next meeting

The Chair confirmed that the next meeting of Health & Social Care Integration Joint Board would take place on Wednesday 18 September 2019 at 10am in Council Chamber, Scottish Borders Council.

The meeting concluded at 11.55am.

Signature: ……
Chair

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Scottish Borders
Health and Social Care
PARTNERSHIP

Health & Social Care Integration Joint Board Action Point Tracker

Meeting held 12 February 2018

Agenda Item: Inspection Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
24	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update and agreed to receive a presentation on the Public Protection Service at a Development session later in the year.	~~Murray Leys~~ Stuart Easingwood	~~December 2018~~ ~~May 2019~~ November 2019	**In Progress:** Item scheduled for 19 November 2018. **Update:** Session cancelled. Item scheduled to 27 May 2019 Development session. **Update:** Rescheduled to November Development session as a consequence of changing the IJB meeting dates.	G

Meeting held 23 April 2018

Agenda Item: Scottish Borders Health and Social Care Partnership 2017/18 Winter Period Evaluation Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
29	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** welcomed the opportunity to receive a report at a future meeting on Quality and Governance from Mrs Claire Pearce, Director of Nursing, Midwifery & Acute Services and Dr Angus McVean, GP Clinical Lead.	~~Claire Pearce,~~ Nicky Berry, Angus McVean	~~December 2018~~ ~~April 2019~~ December 2019	**In Progress:** Item scheduled for 17 December 2018. **Update:** Item rescheduled to April 2019 meeting. **Update:** Item rescheduled to June 2019 meeting due to reconfiguration of IJB meeting dates. **Update 08.05.19:** Agreed that Clinical Governance Annual Report will be submitted to the IJB annually to provide assurance on this item. Awaiting final report from Clinical Governance Committee.	G

Meeting held 28 May 2018

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
30	6	Mr Murray Leys to provide a presentation to a future Development session on Demographics	~~Murray Leys~~ Stuart Easingwood	~~2018~~ November 2019	**In Progress:** Item scheduled for 19 November 2018. **Update:** Session cancelled.	G

					Item rescheduled to 25 November 2019 Development session.	

Meeting held 8 May 2019

Agenda Item: Strata PathwaysTM – Proposed Extension of the Project

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
7	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the proposed extension and expansion of the Strata Prototyping Project (Phase 2) relating to the Discharge Management Process for 6 months – with a full evaluation in 6 months to be brought to the September IJB meeting.	Rob McCulloch-Graham, James Lamb	September 2019	**In Progress:** Item added to September meeting agenda.	G

Agenda Item: Primary Care Improvement Plan (April 2019-March 2020)

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	7	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a future Development session be led by service users and primary care leads in regard to long term conditions.	Rob McCulloch-Graham, Kenny Mitchell	November 2019	**In Progress**: Item added to November Development session schedule.	G

Meeting held 19 June 2019

Agenda Item: Chief Officer's Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
11	5	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to remove the Chief Officer's Report as a standing item on the agenda and instead to receive a newsletter format report on a monthly basis to also include what was happening around the partnerships across Scotland.	Louise Ramage	August 2019	Communications colleagues across NHS Borders and SBC to support the monthly newsletter.	A

Agenda Item: Deputation

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
12	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a wider approach to service user representation should be taken and Mr McGrath's submission should be considered as part of that wider approach and a report would be brought back to the next meeting.	Rob McCulloch-Graham	September 2019	Discussions with members of the Locality Working Groups have started and a further summit meeting id being planned for September.	A

Agenda Item: Integration Joint Board 2019/20 Financial Plan

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
13	8	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed the IJB Officers to continue to work with NHS Borders and SBC to develop a Joint Turnaround Programme and a Joint Financial Recovery Plan to address the financial gap and mitigate the risks relating to Health and Social Care services.	Mike Porteous	September 2019	Planning is underway and dates for joint planning will be discussed at the upcoming EMT. As a financial gap remains, further work and agreements are required.	

Agenda Item: Health & Social Care – Localities Approach

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
15	9	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to refer the matter of the Deputation to the Executive Management Team for further discussion.	Rob McCulloch-Graham	September 2019		

KEY:	
	Overdue / timescale TBA
	<2 weeks to timescale
	>2 weeks to timescale
Blue	**Complete** – Items removed from action tracker once noted as complete at each H&SC Integration Joint Board meeting

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Rob McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	01896 828290

STRATEGIC IMPLEMENTATION PLAN

Purpose of Report:	To seek approval from the Integration Board for the Strategic Implementation Plan for 2019 – 24.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) ***Approve*** the strategic implementation plan for 2019 to 2024 and the areas of work to be undertaken within that time period.

Personnel:	The plan itself does not have any direct impact on personnel however several of the suggested areas of work will. Further papers will be brought to the IJB for decision on these areas as and when required.

Carers:	The plan acknowledges the crucial work undertaken be carers across the Borders and it include work to support them within their role.

Equalities:	Impact assessments will be undertaken across a number of the suggested workstreams and will be undertaken as necessary when the programme is timed.

Financial:	No financial implications have been considered within this report other than preparing our services to meet the growing demographic of need for our services.

Legal:	N/A

Risk Implications:	N/A

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Strategic Implementation Plan for the Borders Integration Board 2019-2024

Contents

Integration Joint Board (IJB)
Strategic Implementation Plan (SIP)

1. Purpose

The purpose of the Strategic Implementation Plan (SIP) is to outline the priorities and workplan to implement the IJB Strategic Plan 2018 to 2021. The document details the proposed programmes, projects and governance for the SIP.

2. Background and Context

2.1 Demographics

The Scottish Borders is a rural area with a population of 115,270 in 2018, an increase of 0.2% from the previous year. Scottish Borders is a medium-sized local authority area in terms of its population but it has a large land area and a sparse population density. The largest town is Hawick with an estimated population of 13,889, followed by Galashiels with 12,603. The latest information indicates that 28% of the Scottish Borders population lives in settlements of fewer than 500 people or in isolated hamlets.

The population of Scottish Borders has risen by 8.7% in the past 10 years, a faster rate of increase than the Scottish average of 7.1%. The population of the Scottish Borders also has an older structure than the average, with a lower proportion of under 25s and a higher proportion of over 65s, particularly over 75s. In the past 10 years, the 25-44 age group in Scottish Borders saw the largest percentage decrease (a drop of 24.4%) and the 65-74 age group saw the largest increase (48.1%).

It is anticipated that the average age of the Scottish Borders population will continue to increase because:

- the current older working-age cohort will become pensioners.
- the reducing trend of younger people will continue.
- everyone is expected to live longer.

By 2026, the 16-24 age group is projected to see a decrease of 8.4% and the 75+ age group is projected to see an increase of 33.5%. In terms of actual numbers, the 45-64 age group will remain the largest cohort, but as stated above – they are ageing all the time!

Demographic factors have a unique and challenging impact on models for providing health and social care and will have a significant impact on the cost of care.

2.2 Health & Social Care Partnership Strategic Plan

Our Strategic Plan covers the period 2018 to 2021 and focuses on the delivery of three local strategic objectives:

(1) We will improve the health of the population and reduce the number of hospital admissions;
(2) We will improve the flow of patients into, through and out of hospital;
(3) We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

Our Annual Performance Report shows progress against the Strategic Plan.

2.3 South of Scotland Regional Skills Investment Plan

The SOSEP Regional Skills Investment Plan highlights a number of issues relating to rurality that impact the Borders labour-market, including:

- The region has higher levels of employment in lower level occupations. These occupations are typically lower-skilled and lower paid;
- The lack of high value jobs available can be a disincentive for couples and families moving into the region;
- Skills tend to be 'shallow and dispersed', resulting in insufficient demand to support traditional education and skills interventions;
- There are higher incidences of young people moving away from home to work or study due to (perceived) limited local opportunities;
- In the 'Human Health & Social Work' sector (across the SOSEP area) it is anticipated that there will be a demand for 3,300 additional jobs (by the year 2028).

Whilst demographics indicate a requirement to promote 'a Career in Care' and so retain workforce in the region and draw workforce into the region, there is limited evidence right now to demonstrate that a career in care can deliver the opportunities and wages that young people and families need. This is a major challenge which requires collective action from schools, colleges, private providers, SBC and Health to address (e.g.) via Skills Development Scotland career's advisors, college courses, modern apprenticeships, in-work training opportunities etc.

That said, there is a wider issue that, whilst young people may regard the Scottish Borders as a great place to grow up and bring up young families, there is a lack of 'things to do', places to go and a lack of transport. Most school pupils consulted aspire to leave the South of Scotland once they finish secondary education. Over half of college students plan to do the same.

2.4 Background Health & Social Care Reports

Both Health and SBC have commissioned reports which look at current practices, models and future requirements.

SBC commissioned work on an **'Integrated Plan for Older People's Housing, Care & Support'** [*Anna Evans*]. For the period 2018-2028, this set out an ambition plan to invest £130m to enable/deliver:

- 400 extra care houses (including 60 in a new care village).
- 300 new build houses suitable for older people for sale and in the rented sector.
- 300 existing houses in the social rented sector refurbished or remodeled.
- 300 households offered on-site Housing Support.
- >8,000 adaptations and small repairs made to enable people to stay in their own homes.
- A minimum of 20 specialist dementia spaces to be created
- Investment in Technology Enabled Care (TEC) for over 800 households.

In 2018, Health commissioned work on a **'Review of the Clinical Model for Community Hospitals in Scottish Borders'** [Prof. *Anne Hendry*]. There were a number of recommendations in the report, two of the high-level recommendations being that Scottish Borders should:

- Develop a Community Hospitals and Intermediate Care Framework within which a revised clinical model and technology enabled intermediate care and rehabilitation pathways can be progressed;
- Prioritise investment in community staff and not additional beds as the most effective way to rebalance system demand and capacity.

In 2017, SBC and Health commissioned a report from **Professor John Bolton** to "review joint care pathways and to provide recommendations to improve numbers of delayed discharges." The report was based on data where:

- The average number of admissions to the General Hospital is 35 new patients per day;
- Therefore requiring a minimum of 35 discharges per day;
- On average 10-12 of the people discharged each day are likely to need some level of care and support. The assumption is that the majority of these people 8-10 will be able to receive this care or support in their own homes.

This being the case, for the purposes of planning it should be assumed that approx. 1/3rd of discharges will require some level of care and support. Prof Bolton's view is that the aim of the hospital care system should be to assist people to get home with the maximum opportunity to recover from their condition(s) and therefore work should be focused on improving the hospital care system to reduce delayed discharges from BGH.

The main finding of the report was that Scottish Borders has not designed or developed a systematic set of services to support people who have care and health needs out of hospital and have instead used existing services to meet the needs. This has caused blockages in the system, at times resulting in insufficient capacity to support current discharges. People discharged from hospital have been offered very limited services to assist with their recovery. Prof Bolton's recommendations include:

- Domiciliary care should be reablement based and therapeutically supported;
- This should be included in the role of community therapists;
- There needs to be a clearer care pathway and better community support for those with a diagnosis of dementia.

2.5 IJB areas of responsibility

The responsibility for specific operational areas comes under the remit of different organisations, (e.g.) SBC delivers a range of services, Health delivers a range of services and the Health & Social Care Partnership collectively delivers a range of services. However, it is highly unlikely that service users or their families care whether the services they need come under the remit of Public Health or the IJB or whoever. Their primary concern is that services are available, joined up and effective.

The proposal therefore is that the IJB has a Strategic Implementation Plan in place that is clear on the IJB areas of responsibility & delivery, but that also has strategic awareness and recognition of related-work being undertaken outwith its remit – for example the wider activities being taken forward by SBC Fit for 2024 Programme and the Health Financial Turnaround Programme.

2.6 Fit for 24 and Financial Turnaround

The consultant reports referenced in Sections 2.3 and 2.4 are clear that there is a requirement for change, improved & joined up services and for investment in services. There are also a number of strategies and programmes of work planned or in place, which although under the specific remit of different organisations, will impact on one another. There is also a requirement for Health and for SBC to deliver significant cashable financial savings.

NHS Borders Financial Turnaround	SBC Fit For 2024
A programme of work has been initiated to deliver £12.8m of cashable financial savings in Health, within the 2019/20 financial year, with further significant annual recurring savings to be achieved every year thereafter.	SBC has a initiated a programme of work to deliver £850k of cashable savings in 2019/20, with £5m of recurring savings per annum thereafter, until 2024.

Some of the savings identified (or to be identified) within each organisation will be particular to that organisation. For example, savings covering areas such as Drugs and Prescribing is a major element of Health Turnaround savings, but a large part of prescribing budget is also part of the Health & Social Care Partnership budget.

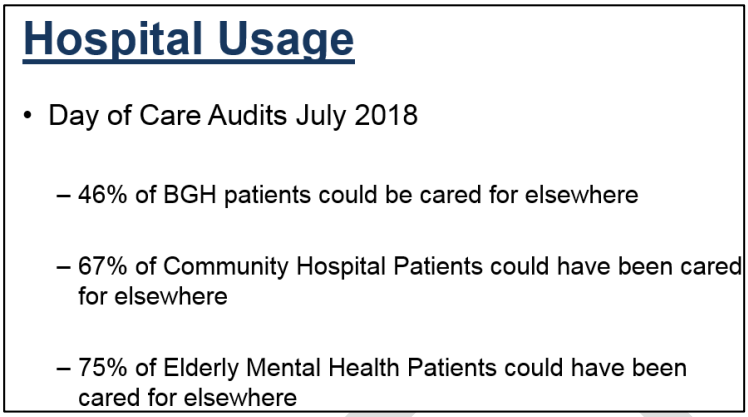
There is a lot of crossover between Health and SBC and there is a risk that unless both organisations work together to plan transformation & savings, and importantly ***agree*** the re-investment levels required to financially enable different and more effective ways of working, then change could be progressed albeit with the best intentions, but be in isolation and be counter-productive, for example;

- Closing a hospital ward will save money in Health. But patients will still need to be cared for somewhere within the Social Care system;
- Similarly making changes to transitional care models could save money in Social Care, but without such care patients who no longer require acute care, but are not fit enough to return home, may remain stuck in hospital.

It therefore makes sense to have a cross-organisational, joint approach to service change, service re-modelling, savings, reinvestment, delivery and timescale.

3. Current Position

The DOCA+ result from July 2018 evidences the requirement for change. In summary, a lot of the people currently in hospital do not need to be there.



We therefore need to shift the balance of care and invest in areas that drives this change.

Note: An evaluation of current initiatives including Discharge to Assess (Garden View), Transitional Care (Waverley), Matching Unit and Hospital to Home will be presented to IJB on 25th September 2019.

4. Accessing the Community Asset, Moving to a Local Operational Model

As this plan has already outlined there is a growing need for health and social care within the Scottish Borders and the current level of provision is already stretched, even at today's population. It is clear that the operational status quo is not fit for the future. There is a need for significant change in what we commission and how our services work with each other, work with our communities and work with our service users.

We need to maintain high quality acute health care as we move expenditure and capacity from these settings to the community. We need to do this in a way that increases the efficiency of health and social care services, reduces the number of exchanges between services and across budget accountabilities and allows our services and those that use them, to directly access the wide range of community assets.

Maintaining a healthy lifestyle in our population will reduce demand on the NHS. A healthy lifestyle requires both physical and mental exercise, mental stimulation, a good diet, and good accommodation, all within a safe environment. Accessing these elements reduces the need for individuals to access health or care provision. These are also essential elements for recuperation and re-ablement for people after they have received a health intervention.

We are fortunate that here in the Borders we have these facilities, activities, societies and organisations in abundance across the communities within our towns and hamlets. Whilst these opportunities exist however, many of our residents who would most benefit from them, don't currently make use of them. As a result their health suffers.

We need to commission and support the growth and maintenance of these 'communities of activities'.

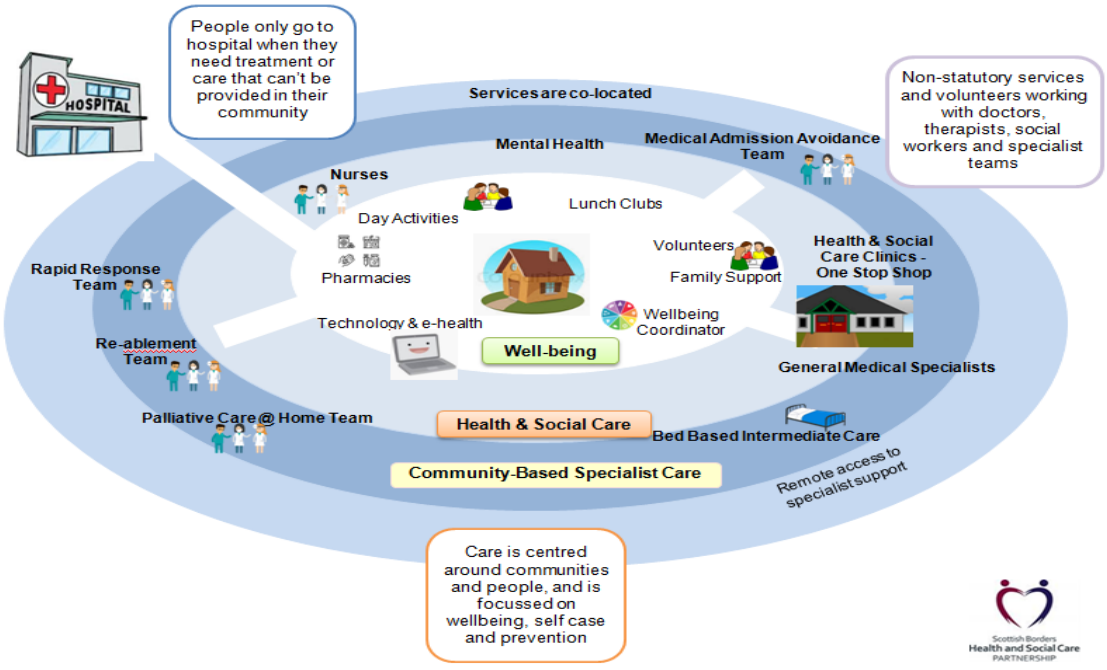
Our services in the main also operate within these same communities and can and do utilise them to the benefit of population, but we need more activity particularly for those citizens who would benefit most.

These services whilst operating locally are often hindered by a lack of joined up thinking and operational procedures which serve to isolate rather than promote collective response to local and individual needs. Separate budgets and accounting, different communication technology, separate management and governance structures, all of these serve to confuse both the staff and those trying to access services. They also introduce waste. This would evidenced in; excessive time to act, in duplication of effort, in competing for scarce resource and conflicting priorities from a variety of governing bodies both local and national. Response to individual need is therefore slow, reaction to demand is elongated and muddled as decisions are required at each layer of bureaucracy.

There is therefore a need for local coordination, management and direction.

This could be provided through Local Managers managing all Health and Social Care Services within the Borders five Local Communities of, Eildon, Cheviot, Teviot, Berwickshire and Tweeddale. Their collective aim to meet the three Strategic Plan Objectives of the Partnership (as shown in Section 2.2 above).

Health and Social Care working closely with Community Services and the Third Sector



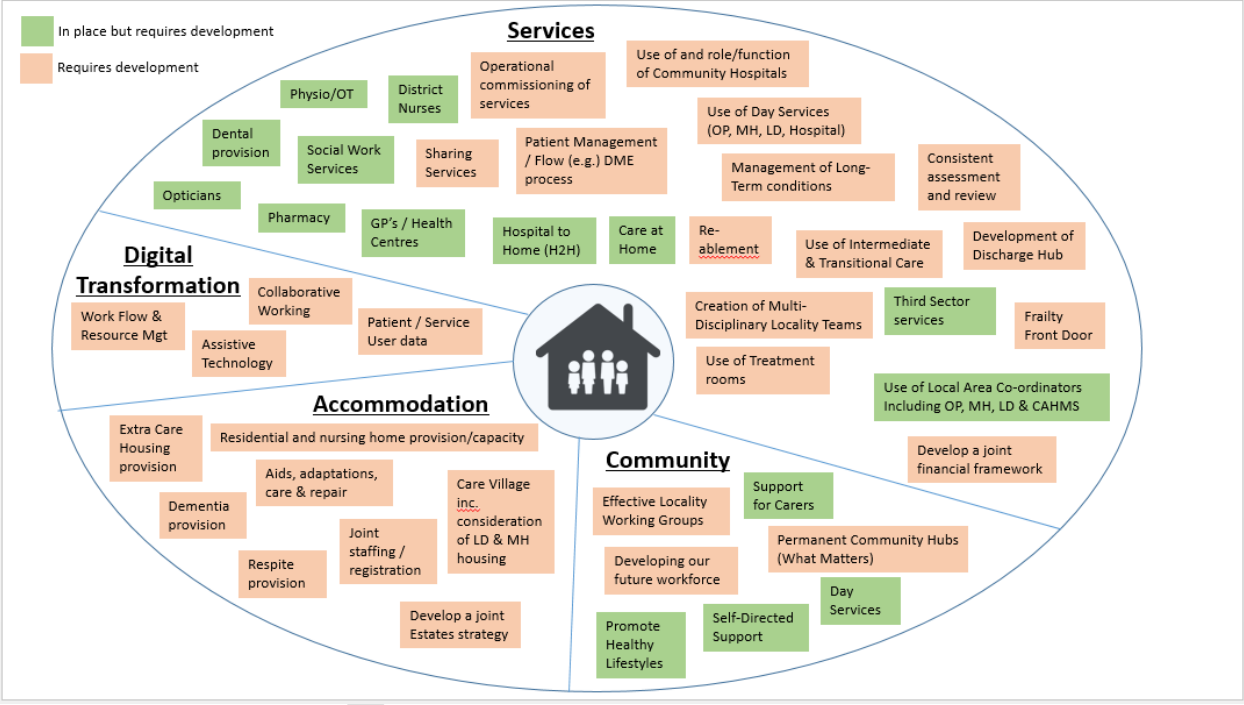
The IJB currently commissions almost 1,000 beds across health and care provision. All of these beds provide the care required however none of them are as good as the beds in the homes of our Border Citizens.

Our task is to shift the balance of care, to provide services for residents to enable them to live in their own homes, or enjoy homely environments within their community, and for them only to be in a hospital bed, when they need it.

Co-locating services, providing access to advice and guidance, and coordinating healthy activities all on a locality basis would reduce time required for decision making, assessments, reviews and give a much clearer and coordinated operation across the wide range of services and opportunities in each of our five localities. Having a single route for management and direction, through a "Locality Manager" should provide the ability to work jointly for the benefit of each resident within those local areas.

The diagram below sets out a visual representation of the work required to deliver this.

4.1 Locality Operation



The Strategic Implementation Plan is focused on the four broad areas of:

- Services;
- Community;
- Accommodation;
- Digital Transformation.

In summary:

- The diagram uses a 'best-fit' approach, but there is crossover and dependency between a number of the areas shown.
- Whilst a number of areas shown above can (and will) be grouped together, each is already a significant piece of work, requiring dedicated resource to define, plan and deliver.
- Each of the boxes shown above needs a business case/mandate detailing purpose, benefits, resources, savings, and timescales.

The "Work Plan" is shown below. The plan has grouped some activities together and includes suggested scope for each high level delivery area.

4.1 IJB Implementation Work Plan

High Level Delivery Area	Business Cases/Scope
Recommission services, including:	- Increase in Home Care - Increase in Residential care
Develop a reablement model of care, including:	- Hospital to Home - Domiciliary Home Care
Develop Multi-Disciplinary Teams, including:	- Locality model - Community assessment and review - AHP resource within localities - Wellness centres/Community/What Matters Hubs - Improved use of treatment rooms - Day Services
Improve patient flow, including:	- Create discharge hub - Implement trusted assessor - Implement single assessment and review - Develop Out of Hours provision
Develop Primary Care, including;	- Primary Care Improvement Plan, to introduce the new GP Contract and develop locality operation of health and social care teams.
Re-model bed use, including;	- Role/function of Community Hospitals - Step-up/step-down intermediate care facilities - Develop respite provision - Improve management of long-term conditions - Develop and introduce a front-door Frailty Unit
Progress Digital Transformation including;	- Collaborative working - Patient/Service-user data - Work-flow and resource management - Assistive Technology (TEC)
Develop our estate, including;	- Residential accommodation - ECH accommodation - Care Village(s) - Joint staffing/registration of services - Mental Health/dementia relocation - Joint Estates Strategy - Primary care estate
Develop Community and Workforce	- Develop future workforce - Support for carers - Promote healthy lifestyles

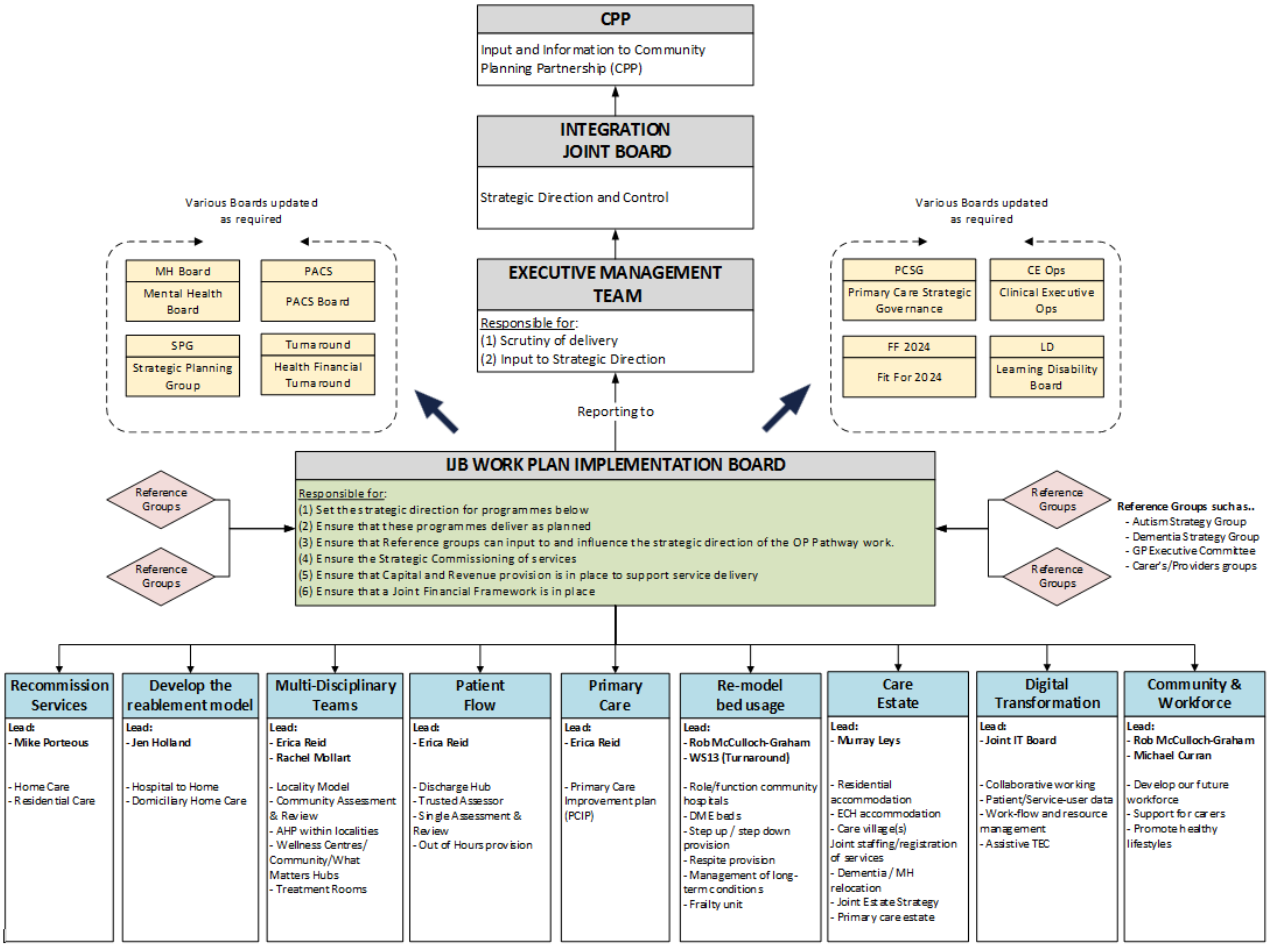
As said, the outline Work Plan provides the IJB and the Health and Social Care Partnership its direction for the next three years. Further reports will follow this plan which will offer the details on these delivery areas, providing costings, specific implementation plans and timescales for their delivery.

(The tables shown in ***Appendix 1*** provide some context/background to help progress this.)

5. IJB Strategic Implementation Plan Governance

While NHS Borders is working through its Financial Turnaround Programme, and Scottish Borders Council is developing its "Fit for 2024 Programme" the IJB will work this Strategic Implementation Plan within these programmes.

The draft governance set out below does not intend therefore to replace the governance that Health and SBC has in place, nor is it trying to add unnecessary layers of governance. The aim is to ensure that IJB has oversight and strategic control of all the improvement, change and transformational activity taking place that come within the remit of IJB service areas.



6. Appendices

6.1 Work Plan - background detail and context

Care Village(s)	Visits by senior management to sites in the Netherlands (e.g.) Hogeweyk have confirmed the strategic desire to create a care village containing high quality housing that can be used flexibly to meet the needs for dementia care, step-up/ step-down care, extra care housing etc… Discussions have also explored multi-generational options such as school, nursery provision and use of the site for key-worker housing and leisure/commercial opportunities. Tweedbank has been identified as the preferred location for a Care Village but the model should operate across the whole of the care estate.

Mental Health / Dementia	Dementia data suggests that by 2041 there could be >4,000 people in the Scottish Borders with a dementia diagnosis, where 13% of suffers are expected to have severe dementia, requiring full-time assistance. £4.8m has been approved in the SBC capital plan for creation of 20+ specialist residential dementia beds. IJB currently purchases a small number of specialist dementia beds (at a reduced rate) from Murray House in Kelso. This reduced rate will end 2023/24 14 clinical dementia beds within Health will close (Cauldshiels ward). This capacity will be 'replaced' through community capacity by funding Mental Health community outreach workers to work with care home staff and within care homes. Even with advances in the treatment of dementia, it seems likely that Borders demand for specialist residential dementia housing in a community setting will exceed supply for years to come.

Extra Care Housing provision	The Anna Evans report set out the aim to create 400 Extra Care houses. 209 units/locations have since been identified covering: - Todlaw, Duns - 30 units est comp 20/21 Under construction Est comp Aug 2020. - Langhaugh,Gala - 39 units est comp 20/21 Demolition and site clearance done, Est comp Jan 2021. - Ex HS Kelso - 34 units est comp 21/22 Planning Application lodged. - Ex HS Eyemouth- 36 units est comp 21/22 Master planning. Site agreed. Programming discussion. - Stirches Hawick - 40 units est comp 22/23 Design team to be appointed. - Peebles site to be identified - 30 units est comp TBC Ongoing revenue costs for ECH provision, based on the dependency/care levels of tenants needs to be agreed and the plans for ECH strategically reviewed.

Residential and nursing home provision	In regard to Council and private provision, Borders has a very low rate of registered care homes places (26 per 1,000 population >65). This is the lowest of our Local Government Benchmarking Framework (LGBF) cohort - and across all authorities only Orkney has a lower rate than Borders. The Borders rate also demonstrates a steady decline over time. Within the SBC Social Care estate, there are 5 Council-owned care homes: • St Ronan's (Innerleithen) – constructed in 1968 • Grove (Kelso) – constructed in 1976 • Waverley (Galashiels) – constructed in 1982 • Deanfield (Hawick) – constructed in 1987 • Saltgreens (Eyemouth) – constructed in 1989 In the years since construction there has been a marked shift in the average age of residents. Generally, people are living longer and more independently in their communities and are only entering residential care at a late age. In the Scottish Borders the average age (in 2016) of individuals entering residential care was mid-80s, with the vast majority of all new residents being 80+ years of age. The result is that residents' care needs are increasingly complex; requiring more equipment such as hoists for moving and handling and larger circulation spaces to support the increased use of mobility aids. Generally, care homes now require larger rooms, increased storage with design that supports people with a range of needs such as dementia, reduced mobility and multiple health conditions. Some of the care homes are probably better suited to be re-modelled (i.e.) to deliver modern care requirements, care models and to extend their usable life, whereas a programme of new build may be more appropriate for the others. A full condition and site survey will be carried out to understand the best fit for each care home aligned with the commissioning intentions of the Integrated Joint Board for Health and Social Work.

Aids adaptations, care & repair	In 2016/17 Borders Care & Repair Service delivered more than 750 adaptations and 4,200 handyperson jobs for older people. Evidence suggests that adaptations generate savings and value for health and social care budgets far in excess of the amount invested. Adaptations also bring increased independence, confidence, health and autonomy for individuals. A return on investment of £5.50 to £6.00 (in HSC savings) for every £1 invested in aids/adaptations is not unrealistic.

Hospital to Home	Hospital to Home (H2H) is a District Nurse led model of care focused predominantly on older people as they transition from hospital to home after a period of illness. The approach focuses on supporting individuals, who no longer require acute care, but are not yet capable of living independently at home. The service also supports people who are at high risk of being admitted to hospital if they do not receive support at home. It utilises a reablement approach and there is scope to further develop H2H within all 5 localities and to develop the reablement approach within domiciliary home care. Evidence to date suggests that H2H is saving 2 OBD per patient in relation to discharge and 9 OBD per patient in relation to readmissions. There are currently approx. 15 new patients per week are going through the H2H service.

Transitional Care	The Partnership is utilising up to 16 Transitional beds at Waverley Care Home (Galashiels) and up to 23 Transitional beds at Garden View (Tweedbank). This has helped to reduce occupied bed days due to delays (OBD), but the full bed capacity has only been rarely used.

Community Hospitals	There are 92 beds spread across our 4 Community hospitals (23 each in the Knoll, Haylodge, Kelso and Hawick). The June 2018 DOCA indicated that almost 50% of BGH patients no longer had a clinical requirement to be there and could be discharged. The DOCAs for Community Hospitals and Mental Health indicated that almost 70% of community hospital patients could be discharged and 75% of elderly mental health patients. In the context of looking at Locality models, bed-closure, transitional care options and DOCA data, it is important that the role and function of community hospitals is defined, including how we manage and care for people with long-term conditions.

Day Services	The use of 'traditional' day services (for Older People in particular) has declined significantly over the years, because of a number of factors including people having more choice and control in use of direct payments. This move to community-based/led day services is a fundamental strand of the partnerships work to improve the experiences of our elderly population and to keep them actively involved and engaged where possible with their own communities. Whilst doing so we also need to support those who care for the frail and elderly through access to respite care for their loved ones and for themselves.

Localities	We have 5x SW Locality offices, 4x Community Hospitals, 23 GP Practices, an increasing number of local area co-ordinators (covering MH, LD and Older People) and 10 NHS run treatment rooms. At Locality level, there is a need to look at how services and teams can work more effectively together and have the same focus (i.e.) improved outcomes for the client/patient. Local teams are to be introduced, that will deliver local solutions for people at risk, identifying people who may become a risk and therefore putting preventative solutions in place? Helping to ensure that people are re-abled and receive the appropriate level of care, support and respite. The aim is that the team get to the root cause of problems first time. Adopting an "assess and do" approach and moving away from a system that treats symptoms and encourages an "assess and refer" approach? The team will connect people with Community solutions and help to develop Community capacity. The Locality Model / MDT model implemented will impact on all areas within the IJB Implementation Plan.

Assessment & Review	Introducing a 'Trusted Assessor' model will help to reduce delays, where Health staff will have the authority to undertake an assessment that is traditionally undertaken by Social Work staff. Governance/control is needed around this to ensure assessments and decisions are effective and safe. It will deliver benefits in occupied bed day savings, Social Work time saving which could be used to focus on Review, giving better outcomes for the patient. This model will support other proposals including how a Discharge Hub operates and how Transitional Care operates.

Sharing Services	At one end of scale opportunities for and the scope of sharing services could cover areas such as Finance, Payroll, HR, Project Management. It could also cover joint-staffing of facilities and joint-registration, so that Health and Social Care provision can be provided in one setting. It can cover sharing of estates and joint investment into the care estate. At the other end of the scale it can cover joint fleet management and facilities management arrangements.

IT/TEC	IT has a focus on systems, primarily used by SBC and Health staff to improve collaborative working and improve and join up patient/service-user data. Technology Enabled Care (TEC) can be used to improve patient flow and resource management (e.g.) through using a system like STRATA, It can also deliver assistive technology for users such as: - Florence (Blood pressure monitoring) - Attend Anywhere (virtual consultation) - AskSara (equipment self-assessment) There are so many TEC products, TEC variables and TEC constraints (e.g.) poor Wi-Fi, broadband, 4G/5G coverage. It is critical that the Joint IT Board will oversee, control and prioritise the trial, evaluation and deployment of TEC across the Health and Social Care Partnership, including making decisions on the TEC for use in people's homes and in supported accommodation.

Community & Workforce	To cope with the changing demographic and demand, we need to develop community capacity. We will also continue to require a paid workforce so therefore need to encourage young people into a career in care and attract people and their families to the area. We need to work with skills agencies, schools, colleges and employers to plan how to do this. We want people to remain independent for as long as possible, ideally in their own homes - but they need good quality information and advice to do this, backed up by practical help and support. Similarly, we need to develop practical advice, information and support that helps people to move on when their home is no longer appropriate for them or their condition means they require more support. There is a risk that we can change models of care and have updated process/practice in place but cannot attract or retain staff of the level and quality required to support it all.

We recognise the huge importance of unpaid carers within our community. All of the services and policies detailed here will serve to support these carers in their vital role for their friends, families and neighbours.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Rob McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	07890564535

TRANSFORMATION FUND REVIEW

Purpose of Report:	The purpose of this report is to provide the Integration Joint Board (IJB) with an update on the position of the Transformation Fund and to seek approval for further investment in 2019/20.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the current position of Transformation Fund – Table 1; b) **Approve** the project extensions set out in section 4 and summarised in Table 3; c) **Note** the changes in funding commitments highlighted in Table 4.

Personnel:	The Transformation Fund enables the employment staff within each project. Agreement to continue funding to expand services will require appointment of new posts. Should the IJB not approve the proposal, normal HR processes will apply regarding redundancy and/or redeployment.

Carers:	The Health & Social Care Partnership will continue to liaise with Carers in the Borders around the ongoing development of the initiatives within this paper and the ongoing wider development of the Strategic Implementation Plan.

Equalities:	N/A.

Financial:	No resource implications beyond the financial resource identified within the report.

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.

Risk Implications:	Not supporting the continuation of step down facilities may adversely impact on patient flow and increase demand on acute provision.

1 Background

1.1 The Transformation Fund now supersedes the Integrated Care Fund (ICF) and is a ring fenced budget totalling £2.13m which is available to the IJB to invest in change and shifting the balance of care from acute to community services.

1.2 It has in the past been used to fund a range of small projects over the years, more recent investments however being in larger developments aimed at addressing delayed discharges within the acute and community hospitals.

1.3 The ring fenced nature of the Transformation funding and the approval of commitments against that funding for projects extending over financial years has meant any unspent balance has been carried forward from financial year to financial year.

1.4 The Day of Care Audit (DoCA) undertaken across our mental health wards for the elderly, medicine for the elderly in Borders General Hospital and across all community hospitals, identified a number of patients in excess of 50% who should have been cared for in their own home or within a more homely setting. There is therefore a clear need to introduce a range of services and initiatives within our Discharge Programme which will enable this. As well as providing a much improved provision for 80 plus patients, the DoCA evaluation has highlighted that there is a significant over resource being applied within our hospitals.

1.5 Individually each of the initiatives funded within the Discharge Programme have proven they reduce the length of stay, and therefore the number of occupied bed days caused by delays, (OBDs). This paper has outlined these figures. Collectively their impact will support a significant reduction in demand across our hospitals. The programme, over the next two financial years will support the reduction of the number of patients who are inappropriately placed within our hospitals, and therefore support a significant shift in the balance of care. It will provide the ability to increase resource within our care spend, whilst significantly inable efficiencies across our acute bed base.

2 Update

2.1 The IJB approved a number of commitments in the January 2019 Paper in relation to the funding of the services within the Discharge Programme (H2H, Transitional Care, Garden View, Matching Unit).

2.2 **Table 1** below summarises the funding brought forward from 2018/19 and the current commitments against that funding in 2019/20. Further detail is provided in **Appendix 1.**

Summary Funding and Committments 2019/20			**£'000**
Balance b/fwd from 2018/19			2,013
Annual Allocation			2,130
			4,143
Committed Funding	**Funded End Date**		
Discharge Programme	30/09/2019	1,347	
Community Capacity Building	31/07/2019	42	
Transport Hub	31/11/2019	44	
Community Led Support	31/03/2019	13	
Domestic Abuse Service	30/06/2019	43	
Strata	31/03/2020	115	
CHAT / Social Work	31/03/2020	68	
COPD / Long Term Conditions	30/09/2019	99	
Total Committed Funding			1,771
Uncommitted Funding Available			**2,371**

2.3 The uncommitted balance of £2,371k is available to the IJB for investment.

3 Projects Due to Finish

3.1 A number of projects have ended or are due to finish within this financial year. It is proposed to extend and enhance certain projects and the recommended actions are set out below for each project.

3.2 Transport Hub

3.2.1 The final tranche of funding has been confirmed and made to the Transport Hub. Any further funding bids will be considered as part of the Council's transport strategy work.

3.2.2 The IJB commitment will end on 31 November 2019.

3.3 Domestic Abuse Service

3.3.1 The planned funding has been fully utilised and expectation is that the service will be incorporated into the Public Protection Unit remit.

3.3.2 The IJB commitment has a planned end date of 30th June 2020.

3.4 Community Led Support

3.4.1 The spend against this project slipped into 2019/20 however the allocated funding has now been fully utilised and changes in work practices have been embedded in workplans.

3.4.2 The IJB Commitment ended on 31 March 2019.

3.5 Community Outreach Team / Social Work

3.5.1 The original funding request to the Transformation Fund was for 2 years of funding to invest in additional staffing within the CHAT team and Social Work, with the stated intention that the planned reduction in occupied bed days would

fund the recurring provision within that 2 year period. The CHAT team is working towards full staffing and the work to fully reduce the level of occupied bed days is planned to complete by the end of December 2019.

3.5.2 The assumption is that Transformation funds of £68k (3 months funding) will be required to support the staffing changes until theses costs can be mainstreamed.

3.6 COPD

3.6.1 The work to develop a pulmonary rehabilitation intervention model has been subsumed into a wider programme of work to review support for all main Long Term Conditions.

3.6.2 The utilisation of this funding has been held pending work to assess and prioritise the preferred model of delivery.

4 Projects Recommended for Extension

4.1 Community Capacity Building

4.1.1 The ongoing funding of the Community Capacity Building (CCB) service was due to be mainstreamed in 2019/20. However there has been significant slippage in related pieces of work which have resulted in a requirement to extend funding to 31 March 2020. The extension is key to delivering planned recurring savings of £350k through the Reimaging of Day Services. Funding required totals £214k.

4.2 Discharge Programme

4.2.1 The Discharge Programme comprised several interlinked services focused on preventing admissions, reducing the length of people's stay in hospital and ensuring they are cared for in the most appropriate setting.

4.2.2 Funding was approved for these services to continue to 30 September 2019 at the January IJB.

4.2.3 As part of an independent external review of Delayed Discharges within Scottish Borders an evaluation of the financial and non financial impact of these services on delivering their planned outcomes was obtained. The evaluation considered national and locally produced data and compared and contrasted service provision with other similar regions to evaluate the impact of these services. Reports were produced for each service reviewed and recommendations were made on the ongoing viability of each service. The overarching summary report is attached as **Appendix 2** to this paper.

4.2.4 The key message from the review is that the average length of stay per patient has decreased demonstrating the Discharge Programme is accelerating throughput and reducing occupied bed days (OBD) caused by delay per patient.

4.2.5 For the work moving forward within the discharge programme, we have utilised the number of OBDs as a proxy measure for the effectiveness of each work area. As a group, these programmes are aimed to reduce pressure within the BGH, Community Hospitals and across in patient Mental Health Wards.

4.2.6 We know that if we shorten length of stay and speed up discharge we will reduce the number of OBDs and hence reduce the required number of hospital beds.

4.2.7 By reducing OBDs by 10,950 within a ward area we will be able to close a whole ward, reducing costs by in excess of £1.4M.

4.2.8 You will see from the evaluation of Garden View, Waverley (Transition Service), the Matching Unit and Hospital to Home, that the evaluation identifies an OBD saving for each which equates to 17,115 OBDs, the equivalent of over 1.5 wards. From our day of care audit, we are targeting 76 in-patient beds (2.5 wards) which need to be provided for elsewhere. The collective efforts across these programmes and their expansion in the case of Hospital to Home are essential to meet this target.

4.2.9 The outcomes of the independent review are summarised in **Table 2** below. A comparison of costs and savings was difficult to make due to the compilation of costs within the different Discharge Programme services. Some service costs included indirect costs and overheads whereas others did not. The average direct cost of an OBD for a Medicine of the Elderly bed based on the current ward budgets is £136 per OBD. This represents the releasable saving from removing a full ward of these beds. These budgets are rebased each year so the final release would require to be confirmed. For comparison the full gross cost of a Medicine of the Elderly ward is £3.5m based on the 2017/18 National Cost Book which equates to £291 per OBD.

4.2.10 The table uses the current £136 OBD cost to estimate the savings that could be realised as a result of the work of each of the services to reduce OBD. Summary explanations of the outcomes and recommendations for further investment are set out in the paragraphs following the table.

Discharge Programme	Annual Cost £'000	Step Down Beds Commissioned	Average Beds Utilised	Annualised OBD Saved	Cost per OBD Saved	Saving Health £'000	Saving Social Work £'000
Garden View	811	15	11	4,015	202	546	
Transitional Care	649	16	9	3,344	194	455	
H2H	1,090			8,580	127	1,167	180
Matching Unit	151			1,176	128	160	28

4.3 Garden View

4.3.1
- Average occupancy 73%
- For every acute bed day saved this service cost £202

4.3.2 Further investigation is needed as to the input required from Garden View for the Winter Plan. It is therefore recommended to continue funding Garden View to the end of March 2020. A review will be undertaken in November to ascertain effectiveness following amendment to its admission criteria and operation.

4.4 Waverley Transitional Care

4.4.1
- Service has reduced the readmission rate to BGH by 10%

- 84% of users have returned to their own home or family home.
- Average length of stay has reduced from 6 to 4 weeks
- Average occupancy 56%
- Evidenced reduction in Care packages following discharge (11hrs to 9.4hrs) in small number of cases where information exists.
- For every acute bed day saved this service cost £194 – this reflects the estimated cost including the element commissioned through the block contract with SB Cares.

4.4.2 It is recommended that the service is extended at the current level to the end of the financial year to facilitate further progress in reducing demand for inpatient unscheduled care beds and the level of ongoing care clients require. The service will deliver a saving when capacity of 88% (14 beds) is reached. It is therefore recommended that NHSB and SB Cares work to ensure the appropriateness of referrals to ensure capacity is fully utilised. A final review of the ongoing use of this facility will be made prior to 1 April 2020.

4.5 Hospital to Home

4.5.1
- Saving of 9 bed days per year per service user through prevention of admission / readmission of service users
- Reduction of 61% in overall A&E attendance following discharge from H2H
- Further saving of 30 inpatient OBDs per week
- For every acute bed day saved this service cost £127
- Reduction in care requirements calculated at 9,800 hrs = £180k

4.5.2 This service is already delivering savings and it is recommended that it is expanded to incorporate the provision of additional AHP (Physiotherapy and Occupational Therapy), and additional Healthcare Assistant and Nursing support. This expansion would allow the Central model (which currently includes AHPs) to be rolled out and evaluated across the remaining 4 Localities and enable a fuller assessment of the service prior to 1 April 2020. We expect the expansion of the service to provide an increase in capacity of an additional 40 patients over the current 70 being catered for at any time. Funding for 5 months of the expanded element of the service will cost £254k.

4.6 **Matching Unit**

4.6.1
- Clear links to and potential synergies with the START team
- Potential overlap with H2H regarding Palliative and End of Life care
- Key role in restarting Packages of Care
- Poor data quality impacting on performance assessment
- Introduction of Matching Unit resulted in reduction of 150 outstanding client assessments.
- For every acute bed day saved this service cost £128

4.6.2 It is recommended that the data quality issues are addressed and that funding is continued to allow a more informed evaluation of the service by the 31 March 2020. The Matching Unit is key to the creation of the discharge hub which is expected to complete by November 2019. Synergies are expected to deliver savings which will allow the longer term configuration of the Matching Unit to be presented to the IJB by 1 April 2020.

5 Summary Discharge Programme Investments

5.1 The implications of all of these recommendations are summarised in **Table 3.**

Proposed Discharge Programme Investment 2019/20			
		Current Annual Costs £'000	Proposed Investment 2019/20 £'000
Garden View		811	406
Transitional Care	*	649	103
H2H		1,090	800
Matching Unit		151	76
		2,701	
Recommended Investment			**1,384**

*The proposed investment relates to the funding required from the Transformation fund. The balance is funded through a block contract agreement with SB Cares.

5.2 An investment of £1,384k is recommended to extend and expand the work to prevent and reduce delayed discharges and ensure patients are supported at home where possible to 31 March 2020. The expansion of the H2H programme and the recommended changes to the commissioned bed capacity will further reduce the demand for unscheduled care inpatient beds. An evaluation of the review of the data input and collection will be undertaken as a priority, addressing the issues raised in the external evaluation, to ensure effective monitoring and evaluation at the next review.

6 Summary

6.1 The review of existing Transformation projects and the external evaluation of the Discharge Programme have identified areas for extended and increased investment in 2019/20. **Table 4** below summarises the financial implications of these investments.

Summary of Funding and Planned Committments		
	2019/20 £'000	2019/20 £'000
Available Funding		2,371
Community Capacity Building	214	
CHAT	68	
Discharge Programme	1,384	
Recommended Investment		1,666
Uncommitted Balance post investment		**706**

6.2 A balance of £706k remains uncommitted in 2019/20.

7 Further Investment to support the Shift in the Balance of Care

7.1 We are aware from last year's review of patients (Day of Care Audit Plus) that over 50% of patients reviewed did not require hospitalisation and could have been cared for within Care Homes or at Home with Care.

7.2 From national comparisons of the level of commissioned care home beds, the Borders is the lowest with its statistical neighbours. The number of home care hours provided is also significantly below the Scottish Average when compared with 1000 people within the population. These numbers, both within the Borders and nationally, have been falling for a number of years.

7.3 The paucity of these resources has an obvious affect on our ability to move people out of hospital. We know therefore we have a need to increase the availability of care beds and home care hours. We can increase our efficiency further but even with this there will remain a gap, how big a gap is important to determine before entering into a new commissioning round for this care.

7.4 To this end Health Improvement Scotland consultants have been working with Council and NHS Borders staff to determine how much additional care provision is required to cater for the growing demographic and to enable a shift in the balance of care equating to approximately 76 hospital beds.

7.5 This work is nearing completion but needs significant verification. We do expect a final report within this month. It is prudent therefore to withhold a balance of the Transformation Fund to support an increase in the commissioning of these services. This fund would augment additional funding transfers following hospital bed closure and any additional resources through Scottish Borders Council following expected national budget announcements regarding the resource available for care.

Supported Discharge across Scottish Borders

A review Summary of 5 Projects Supported by ICF Funding Vers 2

Dr Kevin Williams

5th September 2019

Identified Project Savings:

STRATA:

NHS savings = £334,050 pa

Social Services = £22,350

Total: £356,400

Annual Savings against cost = £356,400 - £115,000= £241,400*
*excludes the £70,000 one off cost for integration and testing.

Garden View:

Annual potential savings, running at 11 bed capacity estimated at:

Total Savings (NHS) £525,965

Annual Savings against cost = £525,965 - £811,200 = -£285,235

However, Garden View could generate a net saving at higher occupancy levels:

Maximum Capacity	15	beds		
Annual Cost	£811,200			
BGH OBD Cost	£131			
Ave. No. Beds occupied	10	11	12	15
Occupancy %	67%	73%	80%	100%
OBD Saved	3,650	4,015	4,380	5,475
Effect bed cost/day	£222	£202	£185	£148
Cost Saving	£478,150	£525,965	£573,780	£717,225
Benefit	**-£333,050**	**-£285,235**	**-£237,420**	**-£93,975**

Waverley:

Total Savings (NHS) £210,729 (9 beds)

Annual Savings against cost = £438,064 - £648,793 = - £210,729

Maximum Capacity	16	beds			
Annual Cost	£648,793				
BGH OBD Cost	£131				
Ave. No. Beds occupied	9	10	12	14	16
Occupancy %	56%	63%	75%	88%	100%
OBD Saved	3,344	3,650	4,380	5,110	5,840
Effect bed cost/day	£194	£178	£148	£127	£111
Cost Saving	£438,064	£478,150	£573,780	£669,410	£765,040
Benefit	**-£210,729**	**-£170,643**	**-£75,013**	**£20,617**	**£116,247**

As can be seen from the table above, additional savings are possible form Waverley, but this would require very high occupancy levels.

Matching Unit:

NHS: £154,056

Social Care: £27,720

Total savings: £181,776

Annual Savings against cost = £181,776 - £151,000 = £30,776

Hospital to Home:

NHS: £1,124,280

Social Care: £180,000

Total Savings: £1,304,280

Annual Savings against cost = £1,304,280 - £1,092,000 = £213,280

Issues:

- Data received in general has been of poor quality, indicating a lack of compliance across all areas.
- Lack of aggressive targets is reducing the potential level of impact and thus savings realised.
- Inconsistency in approach across the reporting of projects and some double counting, certainly between Matching Unit and Strata.
- Future finances may be insufficient to maintain all of the reported projects, thus realisable savings need to be demonstrated.
- Demographic changes over the next 5-10 years will have a noticeable impact on hospital admissions and occupied bed days, possibly beyond the level of realisable savings that can be achieved.
- Implementation of STRATA has been under resourced, leading to many teething issues and non-compliance.
- Lack of true baseline measurements has made the reporting of benefits difficult (if you do not know where you were, you cannot know where you are going).
- Whilst the various projects have been successful in reducing the number of delayed discharges and occupied bed days in BGH, these are still big issues with the community hospitals.
- Going forward, the biggest impact on OBD could be achieved by greater focus on prevention of admission, particularly in the over 65 age group.

- The target focus of potential beneficiary for each project needs closer scrutiny and adjustments made if maximum savings are to be realised (e.g the overlap between H2H and MU with regards to Palliative and also End of Life Care).

STRATA:

Conclusions:

As experience with STRATA grows it is now possible to demonstrate real time savings in operational performance and better service for the end clients who receive the service request 2-3 days earlier on average.

Whilst there are still compliance issues with some users, new reports and dashboard charts are available to quickly identify non-compliance and take remedial action. The reporting dashboard in Strata IQ has been redesigned to better meet our needs and is now capable of being a valuable management information tool.

Recommendations:

- Better resourcing around implementation to manage compliance issues and ensure the right users have appropriate training.
- Expand the use of STRATA to other users as per proposal being developed elsewhere, in particular Waverley and Garden View to ensure all future referrals into and out of these transitional care homes go via STRATA.
- As found with all the other projects, data quality across all systems is particularly poor and needs to be improved to enable easy and more accurate reporting.

Garden View:

Conclusions:

Thus, whilst Garden View provides a valuable resource and means to remove people from BGH who still need a level of support, it may not be cost effective depending on the cost saving model employed.

Garden View does not impact on Social Care savings, nor has any data to support reduced readmission as a result of care provided which would be a significant cost saving. However, the fact that 12% of the users are admitted to hospital whilst still in Garden View, further analysis could be undertaken going forward as to whether service users discharged home have a reduced readmission rate in a similar way to Hospital to Home. Any effect of Hospital Acquired Infection data has not been considered because with relatively small numbers of users, the data would not be meaningful.

Recommendations:

- Occupancy at Garden View needs to be maintained at near maximum to realise any cost savings.
- Review patient admission data 3/6 months before admission to Garden View and again 3-6 months after Discharge from Garden View to see if there is any additional benefit that could be realised (may only be small due to the limited intervention capability at Garden View).
- Determine if the limited realisable cost benefits justify the ongoing running costs.

Waverley:

Conclusions:

As with Garden View, Waverley provides an invaluable step-down resource, however, the financial benefits that are realisable do not exceed the running costs at current capacity levels. Even at full capacity throughout the year a saving of only 16 beds at BGH would be realised.

The occupancy levels have dropped in the first half of 2019 (but starting to rise again) partly due to the inappropriate referrals and the more intensive needs of some of the more elderly service users.

Improvements need to be made to ensure delays to medications, paperwork or service user equipment that have been encountered from BGH to Waverley, often arriving many hours or sometimes days after the service user, impeding the effective care of the service user.

Recommendations:

- Better use of STRATA for referrals into and out of Waverley would overcome any delays in paperwork.
- The Unit Manager(s) should have more say in which patients are sent to Waverley to ensure appropriate resources are available to provide effective care.
- It could be useful to have representatives of Waverley (and Garden View) involved in any integrated discharge team to provide a 'pull' of patients rather than wait for patients to be 'pushed'. This may improve occupancy and reduce delayed discharges in BGH.
- Consider transferring some patients who have a delayed discharge in one of the Community Hospitals to Waverley as this would improve occupancy in Waverley, reduce delayed discharges in the Community Hospitals (which is a significant issue) and also, may well improve the outcomes and wellbeing for the patient/service users.

Matching Unit:

Conclusions:

The Matching Unit is not only demonstrating success by the criteria set out in the funding proposal, but based on the data provided and evaluated, the financial benefits give a modest ROI.

A big obstacle to the analysis was data quality arising from lack of compliance, mainly within Mosaic. It proved impossible to derive a realistic estimate of time from referral to approval of care plan and also from approved care plan to care package delivery due to poor data quality.

A new reporting and management information dashboard is needed and data quality issues need to be addressed to allow evidence-based decision making to take place.

Recommendations:

- Link with Hospital To Home re Palliative Care and End of Life Care.
- Record Location of patient (Home, BGH, Community Hospital, Care Home etc) at time of assessment/referral to enable better estimation of cost savings.
- Record Mosaic CHI number to enable better tracing of individual service user records.
- Improve data recording / data quality, numerous typos and errors with dates (people born in 2045 for example, misspelling of names and addresses). As most of the data originates in Mosaic, it would be beneficial to create a specific report in Mosaic to avoid retyping the data onto a spreadsheet. This will not only improve accuracy but save time when recording referrals.
- To save costs it would appear that merging the START team and the Matching Unit could realise additional benefits.
- There appears to be overlap between Hospital To Home and Matching Unit regarding Palliative and End of life Care, thus new process pathways need to be developed to eliminate duplication of effort.
- One consideration could be to split out the Hospital Discharge elements and hand over to an 'integrated discharge team' based in BGH and retain the other elements within a more Social care setting.

Hospital to Home:

Hospital to Home, at full capacity, based on current levels supports 15 new service users per week, resulting 71 service users per week in the service. Undeniably the service provided is of great benefit to the service users, however, the current focus of activity does not generate maximum cost savings in its current form.

Where the service is very successful is the prevention of admission / readmission of service users following Hospital To Home service, averaging 9 bed days per year saved per service user, which equates to the ability to close three, six-bed bays in BGH, saving > £1.0M.

The service has had limited effect in generating Social Care savings due to the limited numbers of Service Users where a saving can be demonstrated. It is believed there are potential savings due to cost avoidance for example a service user is able to return home without a care package, whereas without H2H, it is likely that a care package would have been required. However, there is no data available within the current systems that would allow a reliable estimate of what these savings could be.

Recommendations:

- For all H2H patients, review their admission / readmission history 3, or preferable 6, months prior to entry in to H2H care and again 3 /6 months following discharge from

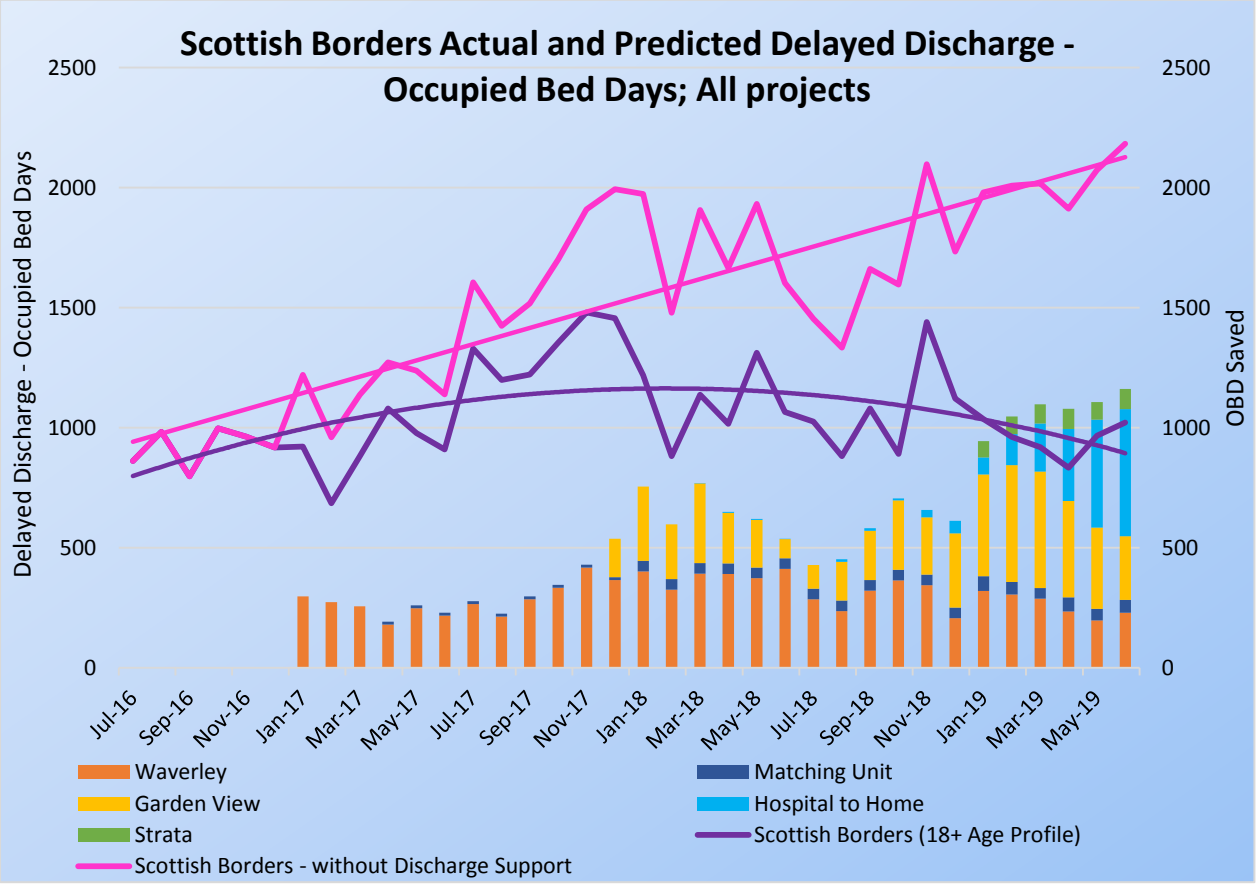
H2H. This will provide better data in which to truly assess a major benefit of the service.

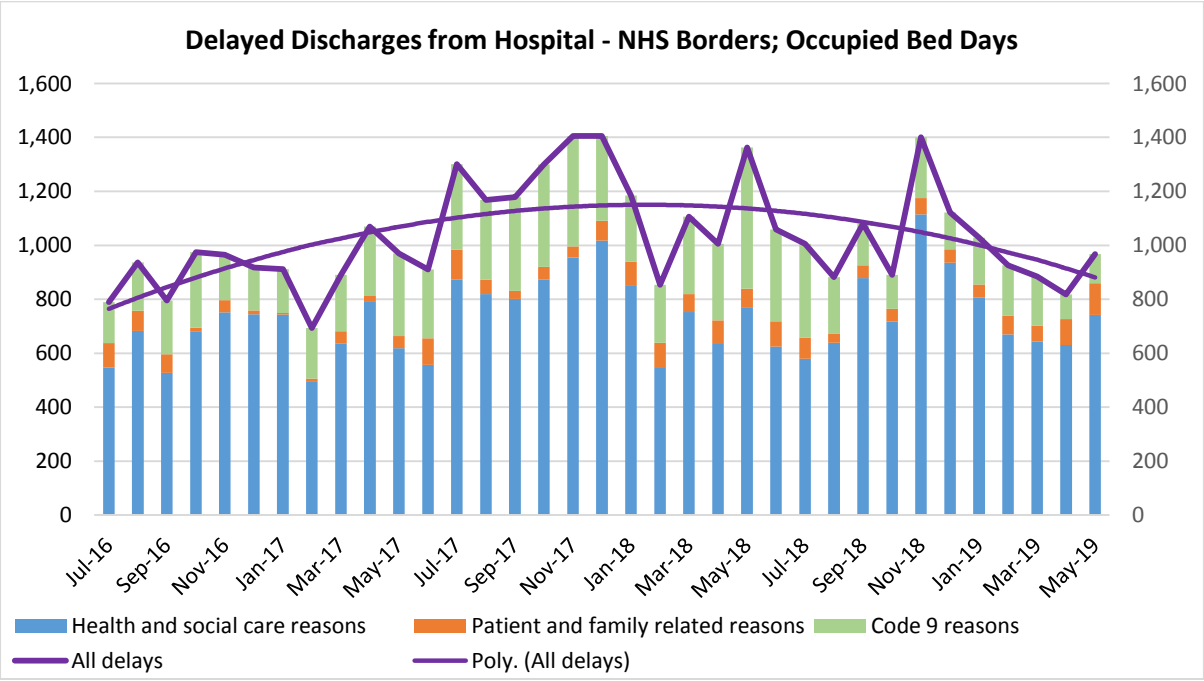
- Realign the focus of the H2H to more address admission prevention than hospital discharge, as this is most likely to have the most beneficial impact on both user health and well-being and also savings generated.
- Hospital delayed discharge, in terms of length of delay is far worse for Community Hospitals than BGH, thus H2H could have a noticeable beneficial effect if it were able to reduce delayed discharges in Community Hospitals, this in turn could ease pressure in BGH due to faster turnaround of patients in the community hospitals.
- Realign project metrics to focus on realisable cost savings such as bed days saved per new user:
    - Prevention / reduction of delayed discharge from hospital (OBD saved)
    - Reduced admission / readmission due to re-ablement
    - Cost savings from reduced Social Care packages for discharged service users
    - Social Care avoidance costs due to independent living capability
- Use STRATA to receive and send any referrals, patient care data etc for consistency with other projects and allow better management information reporting.

Detail:

Scottish Borders/NHS Borders Discharge Analysis

NHS Borders Delayed Discharge Trend

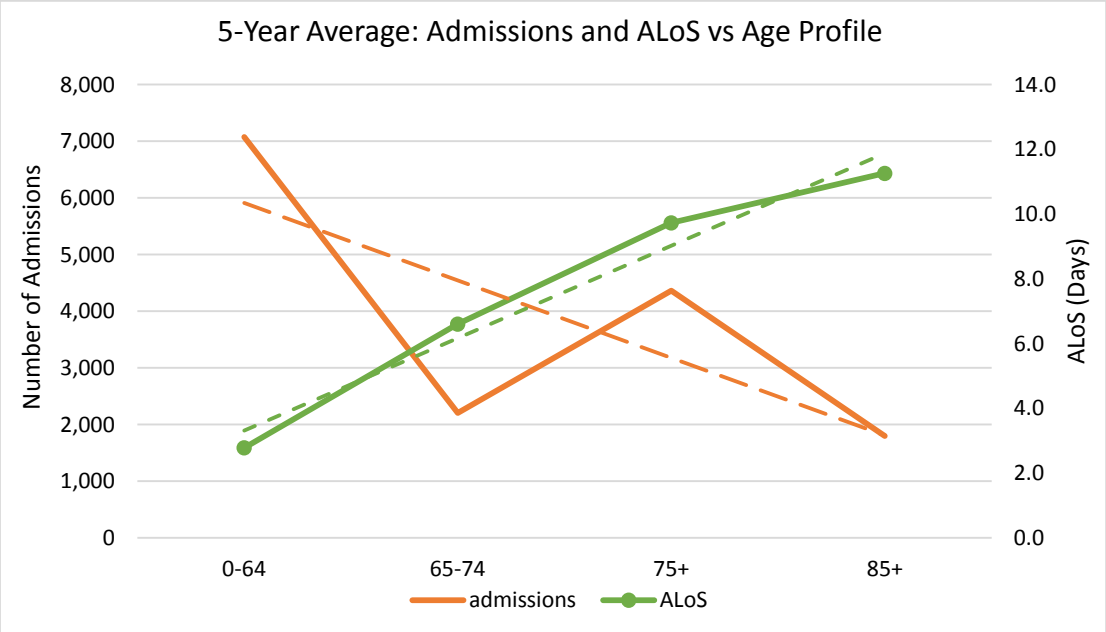




Admissions Data:

Admissions	All Patients	65+	75+	85+
1	6,577	31.7%	20.1%	8.4%
2	1,469	9.5%	6.6%	3.0%
3+	775	5.1%	3.4%	1.4%
Total	8,821	46.2%	30.2%	12.8%

- The 65+ age group account for almost half of all hospital admissions, and a significant number have multiple admissions in any one year.
- Approximately 8.8% of people admitted have 3 or more admissions.
- Approximately 8% of the Scottish Borders population will be admitted to hospital in any one year and as the Borders population demographics change to have a much higher proportion of over 65s, this could be expected to rise to 10-12% within the next 5-10 years. Thus there is unlikely to be sufficient capacity to meet demand in bed space by 2026.



Between 2016 and 2026 the 16-24 age is projected to see the largest percentage decrease (-8.4%) and the 75 and over age group see the largest percentage increase (+33.5%). In terms of size however, the 45-64 age group is projected to remain the largest group, but only just larger than the 65 and over age group.

The 65 and over age group increases by 19% by 2026, but becomes a bigger % of the total population as the under 65 age groups decline (27.8%).

This increase in the >65 age group means an additional 15,000 people, potentially meaning an increase of 55% in hospital admissions for this age group. This equates to an additional ~8,000 OBD based on emergency admission data from ISD, leading to a need for at least 22 additional beds a year. This data is also mirrored by similar data provided by NHS Borders own research into demographic changes and bed demand.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Robert McCulloch-Graham, Chief Officer Health & Social Care
Contact	Iris Bishop, Board Secretary Louise Ramage, Business Lead for Health & Social Care
Telephone:	01896 825525 01896 828290 / 01835 826685

REVIEW OF INTEGRATION JOINT BOARD TERMS OF REFERENCE

Purpose of Report:	To seek approval of the revised Terms of Reference for the IJB.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) ***Consider and agreed*** *the proposed additions to the non-voting membership of the IJB (2 Service User Representatives; GP Sub Committee Chair; Public Health Representative and 2 Housing Sector Representatives);* b) ***Approve*** *the revised IJB Terms of Reference.*

Personnel:	There are no resource implications directly arising from the report or it's accompanying IJB Terms of Reference.

Carers:	Any Carers implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Equalities:	There are no equality and diversity implications associated with the report.

Financial:	There are no resource implications directly arising from the report or it's accompanying IJB Terms of Reference.

Legal:	Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Risk Implications:	There are no risk implications associated with the report.

1 Background

1.1 The Terms of Reference for the IJB set out the principles for it to carry out the requirements of the Scheme of Integration. The Standing Orders of the IJB are the mechanism by which it operates.

1.2 The existing Terms of Reference were last reviewed and approved on 28 August 2017.

1.3 Following a review of the Terms of Reference by the Board Secretary, Chief Officer and Business Lead, the revised Terms of Reference are attached with tracked changes to enable Board members to see clearly the changes made.

1.4 The Executive Management Team have reviewed and endorsed the revised Terms of Reference for submission to the IJB.

2 Summary of Amendments

2.1 The Objectives section has been updated to reflect the three Strategic Objectives set out in the 'Changing Health & Social Care For You - 2018-2021' Strategic Plan.

The nine National Health and Wellbeing Outcomes have been included.

2.2 The Governance chart has been updated to reflect the current position.

2.3 The membership section has been updated to reflect the changes in membership by both Scottish Borders Council and NHS Borders.

3 Proposed Amendments

3.1 The Service User Representative role is currently vacant and is prescribed in legislation as a non-voting member of the IJB. Discussions have taken place at the IJB in regard to the role where the matter was demitted to the Executive Management Team (EMT) to consider. Following discussion at the EMT it is proposed that the role be undertaken by a representative of the Locality Working Group leads, plus an additional appointed representative. There would therefore be 2 Service User Representatives as non voting members of the IJB.

3.2 The GP Representative role on the IJB would be permanently undertaken by the GP Sub Committee Chair.

3.3 A Public Health Representative would be co-opted onto the IJB as a non-voting member to provide support and consistent advice on important public health and health inequality issues. The role would be permanently undertaken by the Director of Public Health.

3.4 Two Housing Representatives would be co-opted onto the IJB as non-voting members to provide insight and support from their lead roles within the Housing sector. The Housing Body would be approached to nominate two representatives.

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

TERMS OF REFERENCE

Version	2
Date	10.09.19
Author	Iris Bishop, Board Secretary

HEALTH & SOCIAL CARE PARTNERSHIP
INTEGRATION JOINT BOARD

Terms of Reference

Introduction

This document sets out the Membership and Terms of Reference of the Scottish Borders Health & Social Care Partnership Integration Joint Board (IJB) drawn from the Scheme of Integration approved by Scottish Ministers.

Role & Remit

The IJB is the formal Board meeting of the Scottish Borders Health & Social Care Partnership which was established on 6th February 2016 and consists of Local Authority Elected Members, Health Board Non-Executive Directors and representatives of the Third and Independent Sectors. Its establishment followed ministerial approval which makes the IJB a legal entity in its own right under the Joint Working Public Bodies (Scotland) Act 2014.

The Integration Joint Board members work together in order to plan, commission and oversee the delivery of integrated health and social care services meeting the needs of the population of the Scottish Borders whilst planning for the demands of the future.

The role of the IJB is to:-

- Strategically plan and commission health and social care services to ensure national and local outcomes are met. To enable this, the IJB convenes a Strategic Planning Group to assist in the preparation, approval and delivery of its Strategic Plan;
- Oversee the delivery of the integrated services for which it has responsibility by reviewing finance and performance against targets to ensure that delivery is in line with planned outcomes;
- Establish arrangements for locality planning in support of key outcomes for the 5 agreed localities in the context of the Strategic Plan;
- Ensure resources are sufficient and appropriately allocated to deliver the IJB's Strategic Plan within the revenue budget detailed in its Annual Financial Statement;
- Publish and share with partners an Annual Performance Report and Annual Accounts in line with statutory guidance, codes of practice and timescales;
- Seek assurance on the robustness of clinical and care governance frameworks from NHS Borders and Scottish Borders Council respectively and ensure that clear accountability is preserved;
- Establish a plan for communication, participation and engagement to ensure that the users of health and social care services, staff, carers and all other stakeholders are involved in or aware of the development and delivery of effective models of health and social care;
- Establish arrangements for handling complaints to and requests for information from the Health and Social Care Partnership;
- Appoint its Chief Officer and Chief Financial Officer;

Objectives

The three Strategic Objectives of the IJB are:-

1. We will improve the health of the population and reduce the number of hospital admissions;
2. We will improve the flow of patients into, through and out of hospital;
3. We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

In addition to the three Strategic Objectives, it is also paramount that the IJB manages and directs the resources delegated to it in a financially sustainable manner in order to ensure that current and future models of integrated health and social care remain affordable. The IJB will pursue Best Value in all of its commissioning decisions and seek to align and realign its resources appropriately to its priorities.

Outcomes

The Integration Joint Board, working together with NHS Borders and Scottish Borders Council, is responsible for the achievement of outcomes. The Integration Joint Board will receive regular and frequent reports overseeing the functions delegated to it and in particular, the performance and resources of the services related to those functions.

The Chief Officer is responsible for reporting to the Integration Joint Board on performance of the delegated functions in the context of a performance framework agreed by the Integration Joint Board.

By working with individuals and local communities, the Partnership aims to assist people to achieve the nine national health and wellbeing outcomes. These represent what the IJB is attempting to achieve through the integration of health and social care, in particular, improving the quality provided.

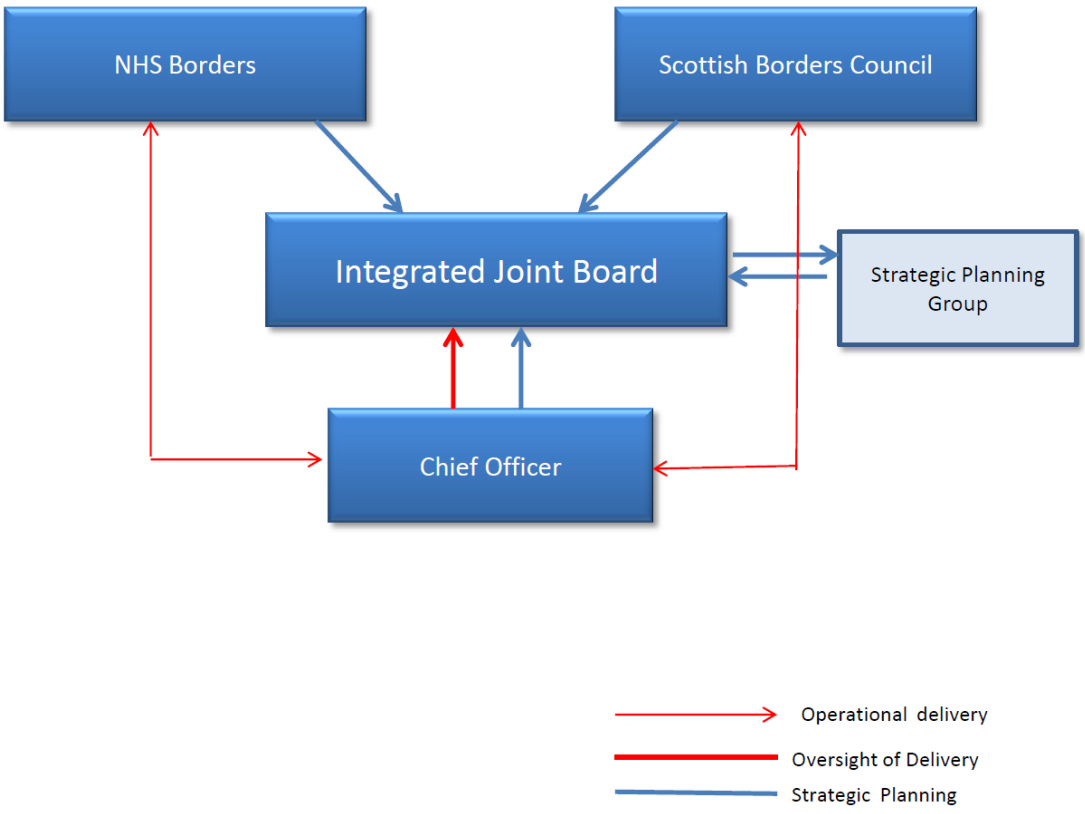
The nine National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under Section 5(1) of the Joint Working Public Bodies (Scotland) Act 2014 are detailed below:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

The affordable delivery of the nine defined national health and wellbeing outcomes and the 3 Scottish Borders local Strategic Objectives are the key priority for the IJB, therefore, to enable this, strong governance and robust transformational direction are required from the IJB.

Governance



The Integration Joint Board is required to and has established a standing Audit Committee to consider matters of financial audit, governance and risk, where necessary making recommendations to the IJB or its partners, in order to provide assurance over its operations.

Other sub-committees of the IJB may be established if the IJB deem it appropriate to its needs.

Frequency of Meetings

The Integration Joint Board is scheduled to formally meet 9 times annually. Other extra-ordinary meetings may be arranged out-with the planned cycle should the business of the IJB require it. Additionally, IJB development sessions may be scheduled around the formal Board meeting cycle, nominally twice a year.

Membership

Core Membership is as follows:-

The voting members of the IJB are appointed through nomination by NHS Borders and Scottish Borders Council. There are a total of 10 voting members, 5 from each partner organisation. A quorum for each meeting will only be established if a minimum of 3 voting members from each partner organisation are in attendance.

Nomination of the IJB Chair and Vice-Chair posts alternates between an Elected member and a Health Board Non Executive representative on a three yearly cycle.

The current Integration Joint Board voting members are:

Stephen Mather, NHS Borders Non-Executive Director (Chair)
Malcolm Dickson, NHS Borders Non-Executive Director
Karen Hamilton, NHS Borders Non-Executive Director
John McLaren, NHS Borders Non-Executive Director
Tris Taylor, NHS Borders Non-Executive Director

Cllr David Parker, Scottish Borders Council (Vice Chair)
Cllr Elaine Thornton-Nicol, Scottish Borders Council
Cllr Shona Haslam, Scottish Borders Council
Cllr Tom Weatherston, Scottish Borders Council
Cllr John Greenwell, Scottish Borders Council

Other non-voting Integration Joint Board members are:

Membership Requirements	**Local Non-Voting Membership**
Chief Social Work Officer of the constituent Local Authority	Stuart Easingwood Chief Social Work Officer, Scottish Borders Council
General Practitioner Representative, appointed by the Health Board	Dr Kevin Buchan GP Sub Committee Chair
Secondary Medical Care Practitioner Representative, employed by the Health Board	Dr Cliff Sharp Medical Director, NHS Borders
Nurse Representative, employed by the Health Board	Nicky Berry Director of Nursing, Midwifery and Acute Services, NHS Borders

Staff-Side Representative	David Bell, Scottish Borders Council Staff Representative Yvonne Smith, NHS Borders Staff Representative
Third Sector Representative	Jenny Smith Borders Care Voice
Carer Representative	Lynn Gallacher Borders Carers Centre
Chief Officer of the Integration Joint Board	Rob McCulloch-Graham Chief Officer, Health and Social Care Integration
Section 95 Officer of the Integration Joint Board	Mike Porteous Chief Finance Officer IJB (Interim)
Service User Representative	*Vacant*
Public Health Representative	Dr Tim Patterson Director of Public Health

A number of other officers are required to attend the IJB:

Board Secretary
Chief Internal Auditor, Integration Joint Board
Chief Executive, NHS Borders
Chief Executive, Scottish Borders Council
Director of Finance, NHS Borders
Chief Financial Officer, Scottish Borders Council
Director of Pharmacy
Communications Officer
Others as Required

Dispute Resolution

Within the Scheme of Integration for the Scottish Borders, a clear mechanism for the resolution of any dispute or failure to agree amongst all parties is defined which the IJB must follow in the event of a dispute (Appendix A).

14. Dispute resolution mechanism

14.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, then they will follow the process as set out below:

(a) The Chief Executives of Borders Health Board and Scottish Borders Council, will meet to resolve the issue;

(b) If unresolved, the Borders Health Board, and Scottish Borders Council will each prepare a written note of their position on the issue and exchange it with the others;

(c) In the event that the issue remains unresolved, the Chief Executives (or their representatives) of Borders Health Board, Scottish Borders Council will proceed to mediation with a view to resolving the issue.

(d) A professional independent mediator will be appointed. The mediation process will commence within 28 calendar days of the agreement to proceed.

(e) The Mediator shall have the same powers to require any Partner to produce any documents or information to him/her and the other Partner as an arbiter and each Partner shall in any event supply to him such information which it has and is material to the matter to be resolved and which it could be required to produce on discovery; and

(f) The fees of the Mediator shall be borne by the Parties in such proportion as shall be determined by the Mediator having regard (amongst other things) to the conduct of the parties.

(g) Where the issue remains unresolved after following the processes outlined above, the Parties agree the following process to notify Scottish Ministers that agreement cannot be reached.

14.2 The Chief Executive's shall write to Scottish Ministers detailing the unresolved issue, the process followed and findings of the mediator and seek resolution from Scottish Ministers.

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Appendix-2019-42

Scottish Borders
Health and Social Care
PARTNERSHIP

Scottish Borders Health & Social Care Integration Joint Board

TERMS OF REFERENCE

Version	2
Date	10.09.19
Author	Iris Bishop, Board Secretary

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HEALTH & SOCIAL CARE PARTNERSHIP
INTEGRATION JOINT BOARD

Terms of Reference

Introduction

This document sets out the Membership and Terms of Reference of the Scottish Borders Health & Social Care Partnership Integration Joint Board (~~the~~ IJB) drawn from the Scheme of Integration ~~Scheme~~ approved by ~~the~~ Scottish Ministers~~Government~~.

Role & Remit

The IJB is the formal B~~b~~oard meeting of the Scottish Borders Health & Social Care Partnership which was established on 6th February 2016 and consists of Local Authority Elected Members, Health Board Non-Executive Directors and representatives of the Third and Independent Sectors. Its establishment followed ministerial approval which makes the IJB a legal entity in its own right under the Joint Working Public Bodies (Scotland) Act 2014.

The Integration Joint Board members work together in order to plan, commission and oversee the delivery of integrated health and social care services meeting the needs of the population~~eople~~ of the Scottish Borders whilst planning for the demands of the future.

The role of the IJB is to:-

- Strategically plan and commission health and social care services to ensure national and local outcomes are met. To enable this, the IJB convenes a Strategic Planning Group to assist in the preparation, approval and delivery of its Strategic Plan;
- Oversee the delivery of the integrated services for which it has responsibility by reviewing finance and performance against targets to ensure that delivery is in line with planned outcomes;
- Establish arrangements for locality planning in support of key outcomes for the 5 agreed localities in the context of the Strategic Plan;
- Ensure resources are sufficient and appropriately allocated to deliver the IJB's Strategic Plan within the ~~medium-term~~ revenue budget detailed in its A~~a~~nnual Financial Statement;
- Publish and share with partners an A~~a~~nnual Performance ~~(delivery of the Strategic Plan)~~ Report and Annual ~~(Financial)~~ Accounts in line with statutory guidance, codes of practice and timescales;
- Seek assurance on the robustness of clinical and care governance frameworks from NHS Borders and Scottish Borders Council respectively and ensure that clear accountability is preserved;
- Establish a plan for communication, participation and engagement to ensure that the users of health and social care services, staff, carers and all other stakeholders are involved in or aware of the development and delivery of effective models of health and social care;
- Establish arrangements for handling complaints to and requests for information from the Health and Social Care Partnership;
- Appoint its Chief Officer and Chief Financial Officer;

Objectives

The three Strategic Objectives of the IJB are:-

1. We will improve the health of the population and reduce the number of hospital admissions;
2. We will improve the flow of patients into, through and out of hospital;
3. We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

In addition to the three Strategic Objectives, it is also paramount that the IJB manages and directs the resources delegated to it in a financially sustainable manner in order to ensure that current and future models of integrated health and social care remain affordable. The IJB willshould pursue Best Value in all of its commissioning decisions and seek to align and realign its resources appropriately to its priorities.

Outcomes

The Integration Joint Board, working together with NHS Borders and Scottish Borders Council, is responsible for the achievement of outcomes. The Integration Joint Board will receive regular and frequent reports overseeing the functions delegated to it and in particular, the performance and resources of the services related to those functions and its resources.

The Chief Officer is responsible for reporting to the Integration Joint Board on performance of the delegated functions those services in the context of a performance framework agreed by the Integration Joint Board via the Chief Officer.

By working with individuals and local communities, the Partnership aims to assist people to achieve the nine national health and wellbeing outcomes. These represent what the IJB is attempting to achieve through the integration of health and social care, in particular, improving the quality provided.

The nine National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under Section 5(1) of the Joint Working Public Bodies (Scotland) Act 2014 are detailed below:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.

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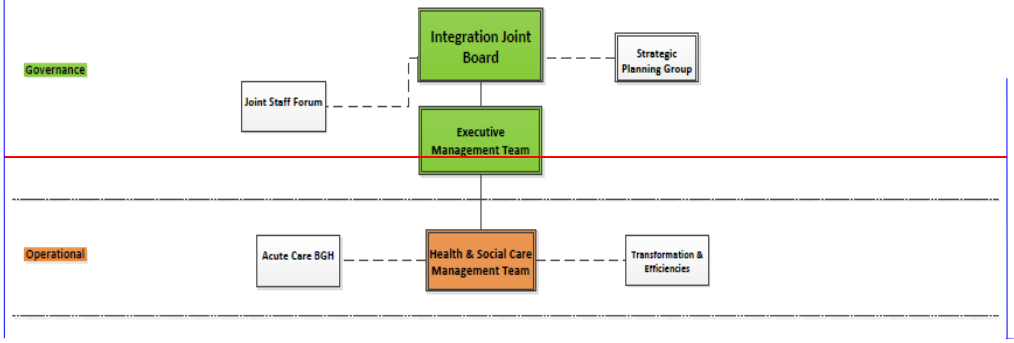
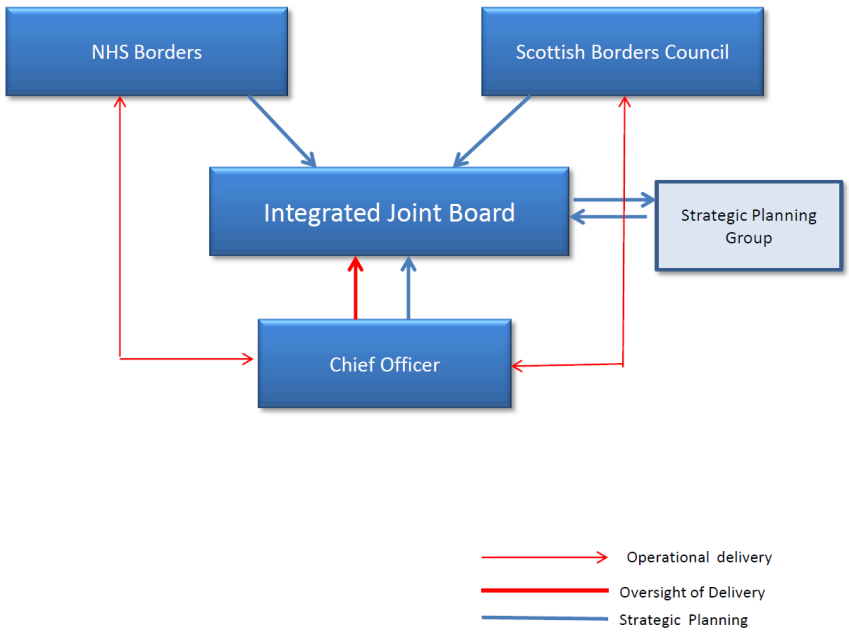
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

The affordable delivery of the nine defined national health and wellbeing outcomes and the 3 Scottish Borders local Strategic Objectives are the key priority for the IJB, therefore, t. To enable this, strong governance and robust transformational direction are required from the IJB.

Governance



Integration Joint Board Governance Arrangements



Comment [L1]: Remove old governance structure

The Integration Joint Board is required to and has established a standing Audit Committee to consider matters of financial audit, governance and risk, where necessary making recommendations to the IJB or its partners, in order to provide assurance over its operations.

Other sub-committees of the IJB may be established if the IJB deem it appropriate to its needs.

Frequency of Meetings

The Integration Joint Board is scheduled to formally meet 9 times annually. Other extra-ordinary meetings may be arranged out-with theis planned cycle should the business of the IJB require it. Additionally, IJB development sessions may be scheduled around theis formal Bboard meeting cycle, nominallyrmally twice a year.

Membership

Core Membership is as follows:-

The voting members of the IJB are appointed through nomination by NHS Borders and Scottish Borders Council. There are a total of 10 voting members, 5 from each partner organisation. A quorum for each meeting will only be established if a minimum of 3 voting members from each partner organisation areis in attendance.

Nomination of the IJB Chair and Vice-Chair posts alternates between an Eelected member and a Health Board Non Executive representative on a three yearly cycle.

The current Integration Joint Board voting members are:

Stephen Mather, NHS Borders Non-Executive Director (Chair)
Malcolm Dickson, NHS Borders Non-Executive Director
Karen Hamilton, NHS Borders Non-Executive Director
~~John Raine, NHS Borders Non-Executive Director~~
John McLaren, NHS Borders Non-Executive Director
Tris Taylor, NHS Borders Non-Executive Director

Cllr David Parker, Scottish Borders Council (Vice Chair)
~~Cllr Helen Laing, Scottish Borders Council~~
Cllr Elaine Thornton-Nicol, Scottish Borders Council
Cllr Shona Haslam, Scottish Borders Council
Cllr Tom Weatherston, Scottish Borders Council
Cllr John Greenwell, Scottish Borders Council

Other non-voting Integration Joint Board members are:

~~Chief Officer, Health and Social Care Integration~~
~~Medical Director, NHS Borders~~
~~Director of Nursing, Midwifery and Acute Services, NHS Borders~~
~~Chief Social Work Officer, Scottish Borders Council~~
~~Scottish Borders Council Staff Representative~~
~~NHS Borders Staff Representative~~
~~Third Sector Representative~~

~~Carers Representative~~
~~Service Users Representative~~
~~GP Representative~~

Membership Requirements	Local Non-Voting Membership
Chief Social Work Officer of the constituent Local Authority	Stuart Easingwood Chief Social Work Officer, Scottish Borders Council
General Practitioner Representative, appointed by the Health Board	Dr Kevin Buchan GP Sub Committee Chair
Secondary Medical Care Practitioner Representative, employed by the Health Board	Dr Cliff Sharp Medical Director, NHS Borders
Nurse Representative, employed by the Health Board	Nicky Berry Director of Nursing, Midwifery and Acute Services, NHS Borders
Staff-Side Representative	David Bell, Scottish Borders Council Staff Representative Yvonne Smith, NHS Borders Staff Representative
Third Sector Representative	Jenny Smith Borders Care Voice
Carer Representative	Lynn Gallacher Borders Carers Centre
Chief Officer of the Integration Joint Board	Rob McCulloch-Graham Chief Officer, Health and Social Care Integration
Section 95 Officer of the Integration Joint Board	Mike Porteous Chief Finance Officer IJB (Interim)
Service User Representative	*Vacant*
Public Health Representative	Dr Tim Patterson Director of Public Health

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A number of other officers are required to attend the IJB:

Board Secretary
~~Chief Financial Officer, Integration Joint Board~~
Chief Internal Auditor, Integration Joint Board
Chief Executive, NHS Borders
Chief Executive, Scottish Borders Council
~~Associate Medical Director~~
Director of Finance, NHS Borders
Chief Financial Officer, Scottish Borders Council
~~Associate Director, Primary and Community Services, NHS Borders~~
Director of Pharmacy
Communications Officer

Others as Required

Dispute Resolution

Within the Scheme of Integration for the Scottish Borders, a clear mechanism for the resolution of any dispute or failure to agree amongst all parties is defined which the IJB must follow in the event of a dispute (Appendix A).

14. Dispute resolution mechanism

14.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, then they will follow the process as set out below:

(a) The Chief Executives of Borders Health Board and Scottish Borders Council, will meet to resolve the issue;

(b) If unresolved, the Borders Health Board, and Scottish Borders Council will each prepare a written note of their position on the issue and exchange it with the others;

(c) In the event that the issue remains unresolved, the Chief Executives (or their representatives) of Borders Health Board, Scottish Borders Council will proceed to mediation with a view to resolving the issue.

(d) A professional independent mediator will be appointed. The mediation process will commence within 28 calendar days of the agreement to proceed.

(e) The Mediator shall have the same powers to require any Partner to produce any documents or information to him/her and the other Partner as an arbiter and each Partner shall in any event supply to him such information which it has and is material to the matter to be resolved and which it could be required to produce on discovery; and

(f) The fees of the Mediator shall be borne by the Parties in such proportion as shall be determined by the Mediator having regard (amongst other things) to the conduct of the parties.

(g) Where the issue remains unresolved after following the processes outlined above, the Parties agree the following process to notify Scottish Ministers that agreement cannot be reached.

14.2 The Chief Executive's shall write to Scottish Ministers detailing the unresolved issue, the process followed and findings of the mediator and seek resolution from Scottish Ministers.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	James Lamb, Portfolio Manager
Telephone:	01896 824000

STRATA PROJECT EVALUATION REPORT

Purpose of Report:	To seek approval for continuing the Strata project for a further 6 months.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) ***Note*** the attached Project Evaluation Report for the Strata project b) ***Approve*** the continuation of the Strata Project until the end of the financial year. c) ***Note*** that a further project evaluation will be produced for IJB in spring 2020, with the potential recommendation to seek funding to continue with the deployment of the Strata tool in a longer-term (multi-year) context

Personnel:	*There are no direct staffing implications relating to this report.*

Carers:	*There are no direct impacts on carers arising from this report.*

Equalities:	*No EQIA has been carried out. An EQIA was completed as part of the strategic planning process. EQIAs will be undertaken as appropriate for each project within the programme.*

Financial:	*Work has been ongoing since the last board meeting to quantify the savings associated with the introduction of Strata. The system will reduce administrative effort and inefficiencies in current processes and will make savings in two areas:* • *Social Work and Administrative savings – through reduced administrative time and reduced requirement for Social Worker input into the placement process. The attached report highlights a 60% (6 day) time saving in the process of completing a Residential Care placement using Strata. Figure 3, shows a corresponding 23% (3 day) time saving in the completion of a Care at Home Placement. At present, there are 68 staff members involved in these processes of which 46% are social workers and 17% employed on an agency*

	basis. The total cost of these staff is £314,366 and therefore it is reasonable to conclude that savings can be made through reduced agency, duplication, postage and telephony costs which will fund the costs of Strata. • *Occupied Bed Day (OBD) savings – it is estimated that the deployment of this system could enable some 3,060 NHS occupied bed days to be saved. During this evaluation it has been difficult to calculate and agree the actual cost and resource savings that would be obtained from the closure of beds due to the variable release costs related to closure or one bed, one bay or an entire ward. Estimates therefore range from £131-£500 per occupied bed day*. Having said that, this indicative cost-benefit analysis has assumed the lower and more conservative number which still indicates that a full and ongoing Strata deployment could enable potential recurring annual savings in excess of £400,000.* *To date, the potential of the system has only been assessed against two processes – referrals to Residential Care and referrals to Care at Home providers. The system provides the opportunities to reassess all Health and Social Care processes and deliver significant, as yet unquantified, savings and efficiency gains.* **These numbers are derived from discussions with NHS Borders and the published ISD blue book cost analysis.*

Legal:	*N/A*

Risk Implications:	*Continued buy-in from providers, service managers and staff will be critical to the project. Without a clear long-term commitment to the system – and the confidence this gives to consolidate on achievements and plan for the future – the corresponding commitment of providers is harder to secure.*

Page 2 of 2

Purpose

The attached report sets out an interim evaluation of the Strata e-referral project and seeks approval for the continuation of the project for a further 6 months until the end of the financial year when proposals will be brought forward for the next phases of the project.

Background

In May of this year, an initial evaluation report was presented to the IJB seeking ICF funding to extend and expand the project over the current financial year. The Board agreed to extend the project for 12 months but that a break clause be agreed after 6 months should it be required. A more detailed evaluation of the system and project was requested to be brought to the September IJB to consider whether the break clause should be required.

This report sets out an evaluation of the Strata project against 5 criteria:

1. **Does this system fit with our Strategic ICT Context and with the requirements and direction of our Joint IT Framework** *(see Section 3 of the full report)*

Strata forms a critical component of the Joint ICT framework agreed by EMT in December 2016. As part of that framework it addresses many of the key IT system related issues identified by staff and practitioners as obstacles to integrated working. It meets many identified system requirements in particular it:

- Is organisationally agnostic – i.e. it covers all partnership organisations and their staff, not just NHSB and SBC staff but also 3rd sector partners and private sector suppliers
- Manages referrals across organisational boundaries – including the transfer of patients from one care setting to another
- Matches people's needs to available resources
- Tracks people's progress through the system
- Shares information, records and data securely and ensures that information is captured once, follows the patient and is accessible to practitioners across multiple organisations
- Improves and enhances the quality and reliability of data
- Contributes to a single view of the patient
- Can be technically integrated with partner systems – particularly with TrakCare, EMIS-Web and Mosaic and contribute to a wider ICT Architecture
- Reduces duplication and the scope for error

None of the Partnership's pre-existing systems have this capability or have this functionality.

Strata was procured via G-Cat (an approved Government Procurement Catalogue) and was the only solution to meet our requirements.

2. Does the system drive operational process improvements, resource releasing savings, and other associated benefits *(See Section 4 of the full report)*

Focussing on referrals to Residential Care providers and Care at Home providers over the period January to July this year, the application of Strata has realised a 60% (6-day) time saving in referrals to Residential Care and a 23% (3-day) time saving in referrals to Care at Home providers. This enables savings in two key areas:

I. Social Work Administrative Savings – reducing administrative time and beginning to remove Social Worker input into the administrative placement process. There are currently 68 staff members involved in these two process of which 46% are social workers and 17% are employed on an agency basis. Over time and through service redesign, redeployment and turnover, it is reasonable to conclude that savings can be made through reduced agency, elimination of duplication, postage and telephony costs which will fund the costs of Strata.

II. Occupied Bed Day (OBD) Savings – it is estimated that, given the time savings identified above, that the deployment of the system could enable some 3,060 occupied hospital bed days to be saved each year. An indication of the value of this saving - based on the lowest of a range of savings (£131/OBD) - suggest potential annual savings in excess of £400,000. (This saving would be realised when hospital beds are closed due to a reduction in demand.)

Other benefits include, a reduction in the length of hospital stay reducing the risk of morbidity and mortality as a result of falls or contracting hospital acquired (HAI) or wound infections and associated risks and costs.

3. Assess the potential opportunities for future application and resultant additional system benefits *(See Section 5 of the full report)*

We have barely begun to scratch the surface in terms of what can be achieved with a fuller deployment of Strata. To date, the potential of the system has only been assessed against two processes – referrals to Residential Care and to Care at Home providers. The system provides opportunities to reassess all Health and Social Care processes and deliver significant, as yet unquantified, savings and efficiency gains.

Section 5 of the report identifies 4 service processes that are currently in development including:

- Encompass
- Borders Carer's Centre
- Borders Care and Repair
- Discharges from Hospital Ward to SW

A further range of services have been identified in section 5.3 of the attached report. Consideration will also be given to how Strata can support existing service redesign work including:

- Service Reviews and Outpatient Redesign Programme
- Older People's Pathway Redesign Programme
- Mental Health Transformation Programme
- Primary Care Improvement Programme

An impact analysis and baseline for each of these will be undertaken and a priority assigned. This will form the basis of a proposal that will be brought back to the IJB for the next phase of this project in March 2020.

There will be no additional Strata costs associated with applying the system to these additional processes. The cost of Strata (£115,000/year) is a fixed cost based upon £1/head of population. It will only increase (or decrease) with changes in population size – but remains fixed regardless of how many processes or pathways we apply it to. As a result, cost benefits will improve with each added efficiency we make across all our pathways.

4. **Does the system provide the necessary management information required to allow us to more effectively measure compliance in process, delivery and outcomes** (*see Section 6 of the full report*)

One of the major benefits of Strata lies in its ability to capture real time information across any referral process and provide strategic and operational information. Strata is providing us with data which is, over time, giving us a real time insight into:

- Capacity across the range of service providers
- Volumes of referrals
- The status of referrals – including completed cases, requests for further info and declinations
- Compliance and performance across stakeholders including contract management.

This information has not been available to us prior to Strata and is already enabling a better insight into the discharge management process.

5. **Does the system facilitate, support and enable the range of complementary IJB funded patient transition and discharge projects** *(see Section 7 of the full report)*

Strata is one of five IJB-funded projects relating to the improving the discharge management process (the others being the Matching Unit, Discharge to Assess, Garden View and Hospital to Home). A wider review of these projects is included elsewhere on this agenda.

The five projects need to be joined together and seen as complementary as they all interact and impact to a greater or lesser extent on each other. Strata is seen as being the key and foundational platform and the central enabler going forward to ensure maximum beneficial impact of all these projects.

Conclusions

This evaluation has shown that the Strata project:

- Is aligned with the Joint IT framework, addresses key IT issues raised by staff and practitioners, meets system requirements for an e-referrals process and addresses known data security risks.
- Delivers significant time savings in terms of referrals to residential care providers and care at home providers and enables the opportunity to make associated savings in terms of savings in administrative costs of the processes and occupied bed day savings.
- Has the potential to enable significant additional efficiency gains through extending Strata to other Health and Social Care processes – all without increasing the annual cost of Strata at £1/head of population of £115k/year.
- Provides unprecedented levels of real time management information which, in itself, provides the opportunity to help drive continuing improvements to service.
- Is the key and foundation platform and the central enabler going forward to ensure maximum benefits and efficiency gains from the other IJB-funded, discharge-related projects (Matching Unit, Transitional Care, Garden View and Hospital to Home) and other projects to deliver efficiencies, reduce occupied beds and prevention of admissions to hospital.

It is recommended that IJB approves the continuation of the Strata project until the end of the financial year. A further project evaluation will be produced for IJB in March 2020, with the potential recommendation to seek ICF funding to continue with the deployment of the Strata tool in a longer-term (multi-year) context.

STRATA PATHWAYS

Project Evaluation Report

IJB 25th September 2019

Contents:

The Challenge

Every year, the staff within our Borders health and social care system undertake over a million patient and client referral requests that involve a transfer of care between the different parts of our Health and Social Care services. The exact number of referrals is not known as currently there is no single system or integrated suite of systems that can be accessed by all partner organisations to record, manage and review outcome of these referrals.

Referrals can be relatively simple (e.g. from a GP to an OT) or complex (e.g. transferring a patient from one care setting to another). They can be made by telephone, in writing or by email; can be within an organisation between departments or services; or can be across multiple organisations. Referral records might be kept on paper, email trails and in individual computer systems. Sometimes a referral won't be recorded. Often the same referral will be recorded in duplicate in different systems and in slightly different ways, which wastes time, increases the likelihood of error and security failure and prevents a single trusted view of the person.

At present, staff making these referrals do not have visibility of capacity across the range of services and therefore time is often wasted trying to match referrals with unknown capacity and resources. Without a tool that provides staff with "real-time" transparency and visibility of both capacity and utilization across all parts of our integrated service, it is difficult to know whether a referral has been directed and completed effectively. It is also not possible to ensure that we are fully optimising our scarce resources. Sometimes referrals with personal information are distributed "blind" to a range potential of suppliers by post or to unsecured mailboxes which creates known security risks.

The Proposed Solution

Each referral forms part of a person's experience of their pathway across our complex health & social care system. Being able to make referrals electronically (an e-referral), attach the appropriate information, track progress and ensure that they are completed enables us to ensure that there is a better experience and outcome for the person and their family. Strata, the proposed e-referral tool achieves this in a standardised manner that is more efficient, cost effective, and reliable than our current systems and processes.

Additionally, by adopting this approach, there is significant scope for efficiency gains and savings through streamlining and automating processes with e-referrals. With an estimated million referrals each year, if we could reduce the time it takes to complete each of them (by even half-an-hour), this would represent a major opportunity for improved service quality, increased efficiency and significant cost-releasing opportunities.

1. Purpose of Report

In May of this year, an initial evaluation report was presented to the IJB seeking ICF funding to extend and expand the project over the current financial year. The Board agreed to extend the project for 12 months but that a break clause be agreed after 6 months should it be required. A more detailed evaluation of the system and project was requested to be brought to the September IJB to consider whether the break clause should be required.

This report sets out an evaluation of the Strata Health e referral and pathways system as:

- A system that enables the management of referrals, tracking people's journey, the sharing of records and data securely and which has the proven ability to integrate with other core IT systems **across multiple organisations**
- An effective tool to enable process improvements and achieve efficiency gains in terms of both productivity and hard savings
- A source of effective real-time management and performance information which provides insight and oversight of how processes are operating in terms of volumes flow, capacity and compliance
- Part of a wider suite of projects (Matching Unit, Transitional Care, Garden View and Hospital to Home) aimed at enabling efficiencies and savings in the Discharge Process.

It is intended that this report will provide the necessary information to enable the IJB to decide as to whether or not the project is continued.

2. Background

2.1 What is Strata?

Strata Pathways is an automated and web-based system that enables more efficient and secure processes which match individual patient's and client's needs to the available resources across multiple organisations, including third-party suppliers. It is an evidence-based system that can be applied across all health and social care pathways and therefore has the potential to be a critical tool for the Partnership in enabling the redesign, optimisation, performance improvement and the cost effectiveness of all integrated services.

As a web-based system, Strata stands alone from both our NHS and SBC systems and IT architecture but can be securely integrated with both to ensure and enable the automation of processes and improved information sharing.

Strata is not a "quick fix" to address the challenge outlined above. Instead, the deployment of the Strata tool needs to be seen in a longer-term (multi-year) context, as an enabler in managing change, supporting the integration and improvement of service processes and helping management to bring about compliance and the behavioural changes needed to deliver on our strategic objectives. This system has been successfully deployed across publicly funded health and social care systems, in Scotland, across the UK, in Canada, Australia and New Zealand.

2.2 Scope of the Evaluation

This evaluation is based around 5 main sections:

1) **Strategic ICT Context**
   How Strata addresses identified IT needs and provides a foundational platform to allow us to fulfil key elements of our joint IT approach and roadmap.

2) **Operational Process Improvements and Associated Benefits**
   Based on the first phase of the project and data from January 2019 and referrals to:
   - **Residential Care (including Garden View and Transitional Care)** from the hospital-based START team and from SW Community Teams
   - **Care at Home providers** from the Matching Unit

3) **In-development and Future Processes and Associated Anticipated Benefits**
   An outline of the processes where we are currently applying Strata and potential additional processes that we can use Strata in a further phase(s) of implementation.

4) **Management Information**
   The role that Strata plays in providing strategic and operational management information to enable compliance, improvement and progress against strategic objectives

5) **The Wider Discharge Programme**
   How Strata contributes to the wider Discharge Programme and supports the other related and complementary ICF-funded initiatives.

3. Strategic ICT Context

3.1 The Role of Technology in Transforming Services

Technology offers the single biggest opportunity to transform health and social care services and to deliver the kind of step change and efficiency gains that will be needed to contain the additional costs of meeting anticipated future demand for services. In particular, technology enables improved:

- access to services and information
- patient pathways – making them simpler, more joined-up, automated and reducing the scope for duplication and error
- reduction in variation of practice
- communication and collaboration across partner organisations
- data quality and data sharing – ensuring that the right information is available in the right place at the right time
- enabling people to assume greater responsibility in managing their own health

The adoption of proven and evidence-based technology is seen as the key enabler to the delivery of the required service redesign and improvement on the scale needed over the foreseeable future.

3.2 Staff and Practitioner Views

Staff and practitioners across the wider health and social care partnership have consistently identified the lack of joined-up IT systems as the single biggest obstacle to integrated working.

This view permeates the whole IT landscape from accessing networks to communication. Some of the key issues raised by social care staff and practitioners over a number of engagement sessions included:

- **Basic telephony, emails and calendars** – difficulty in accessing each other's directories/ address books and viewing calendars
- **Sharing files** – being able to share files in terms of both collaborating on documents as well as storing and accessing files (e.g. shared drives)
- **Accessing care records** – being able to access a person's medical and care records which may be held on a number of different systems (Mosaic for Social Care, TrakCare and EMIS for Health), on different networks, having all necessary information to be able to offer an effective and appropriate service. There are also difficulties in ensuring that the record on one system refers to the same person as the record on the other system. Ultimately, staff need a single trusted record or a single view of the patient and the ability to update records once rather than multiple times in different systems and networks
- **Accessing networks remotely** – particularly when operating from each other's buildings
- **Tracking people's journey** – being able to track people's progress through the system including anticipating – and preparing for – transition from one care setting to another
- **Matching people's needs to available resources** – seeing, in real time, where there is capacity in health and social care services that can meet the person's needs

3.3 Joint ICT Framework

Based on the above views, in December 2016 EMT broadly agreed a joint ICT framework to guide the development and delivery of ICF-funded IT projects. The framework also identified how the existing IT Roadmaps of both NHSB and SBC could address the issues identified by staff. The framework was based around 4 key principles to guide:

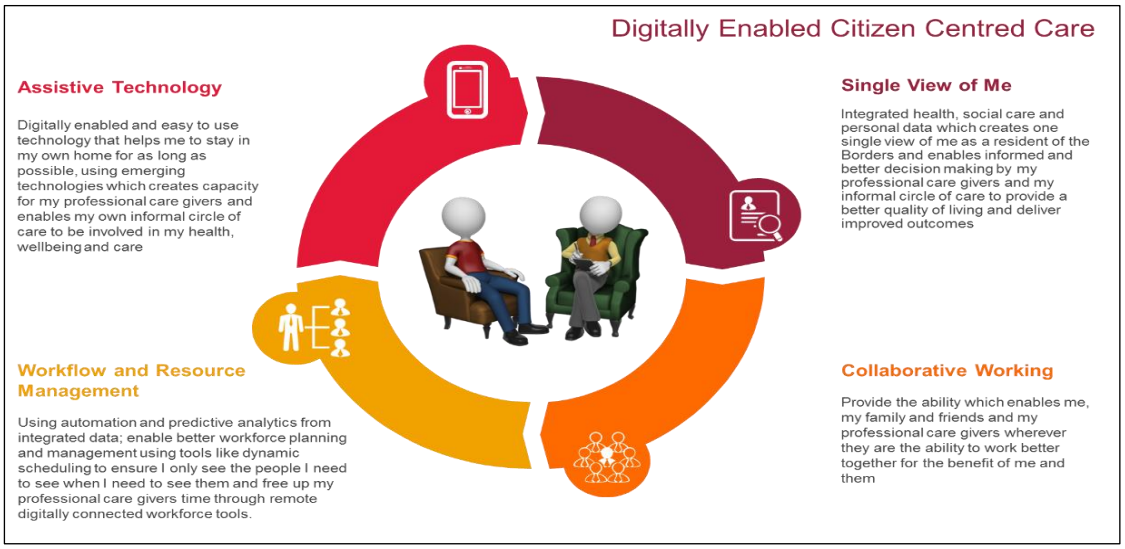
- **Collaborative Technologies**: shared outlook functionality (calendars, emails, collaboration tools), access to files, policies, etc.

- **Single view of the patient / person:** single view of information from TrakCare, EmisWeb and Mosaic and other key IT systems

- **Workflow**: referrals and information across multiple organisations and matching people's needs with available resources

- **Assistive Technologies:** how technology can enable people to live and manage their conditions at home in a safe and sustainable setting, and interact with services

Figure 1: Joint ICT Framework



This framework has guided specific ICF-funded projects and parallel streams of IT work to date through the coordination of the Joint IT Project Board.

3.4 System Requirements

To be able to address many of the issues raised by staff and fulfil the principles of the Joint IT framework, the Partnership need a system that:

- Is organisationally agnostic – i.e. it covers all partnership organisations and their staff, not just NHSB and SBC staff but also 3rd sector partners and private sector suppliers
- Manages referrals across organisational boundaries – including the transfer of patients from one care setting to another
- Matches people's needs to available resources
- Tracks people's progress through the system
- Shares information, records and data securely and ensures that information is captured once, follows the patient and is accessible to practitioners across multiple organisations
- Improves and enhances the quality and reliability of data
- Contributes to a single view of the patient
- Can be technically integrated with partner systems – particularly with TrakCare, EMIS-Web and Mosaic and contribute to a wider ICT Architecture
- Reduces duplication and the scope for error

None of the Partnership's pre-existing systems have this capability or have this functionality. Table 1 below outlines how Strata meets these requirements.

3.5 Best Value

Strata was procured via G-Cat (an approved Government Procurement Catalogue) and was the only solution that met our requirements. The G-Cat route avoids the need for us to go through a more detailed and lengthy procurement process involving specifying, selecting, building and testing a solution before implementing and proving its ability to meet our needs.

Strata offers a solution that meets our needs and is proven to work effectively in other Health & Social Care partnerships – such as Cumbria and Tayside – enabling us to learn from their experiences. Appendix 1 sets out a list of Strata clients and the processes where Strata has been deployed.

Table 1 – How Strata Meets Partnership ICT Requirements

System Requirements	How Strata Addresses These
Multi-Organisation System	As a cloud based system, Strata stands alone from both our NHS and SBC systems and IT architectures and can be accessed securely by ***any*** of our partner organisations (including 3rd sector and private sector) who can only see and update information appropriate to their needs/functions. The system is commissioned and governed by the Partnership and isn't owned by any single partner organisation.
Managing referrals within and across organisational boundaries	Strata enables electronic referrals between practitioners within organisations and from one organisation to another e.g. e-referrals from GP to Allied Health Professional; from Occupational Therapist to Borders Care & Repair; from Social Worker to Borders Carer Centre; from hospital ward to discharge hub; from discharge hub to residential / care at home providers; from residential care provider to OT etc.
Matching People's Needs to Resources	Service providers use Strata to identify individual patient and client needs and to match these needs with available capacity and resource in real time, along with any appropriate details (e.g. hospital or care beds, transport, appointment slots etc.) that referrers can view and make an immediate and appropriate referral.
Tracking People's Journey	Strata creates an audit trail and date stamps when referrals are made and accepted – e.g. GP could see that a patient e-referral to a specialist had been accepted and that the patient had attended or that a transfer from hospital to care home had been accepted and completed. This builds patient accountability and responsibility to attend/adhere to their care plan.
Sharing Information/Accessing Care Records	Strata enables appropriate records to be appended with an e-referral – e.g. an assessment, medication, personal details, next of kin contact details etc. – so that information is shared and follows or precedes the patient from one care setting to another to enable a successful outcome. With technical integration, the appropriate data from NHS and SBC systems can be added to the e-referral as required allowing information to be shared.
Integrates with core IT systems	Strata will be able to integrate with MOSAIC, TrakCare and EMIS-Web and other partners systems.
Data Quality and reducing duplication and error.	Technical integrations will enable e-referrals to be populated automatically from systems. This will reduce the scope for duplication and error that currently exists by having multiple paper, email and system records. By enforcing the completion of mandatory fields and actions such as attaching required documents the system ensures that all necessary information is collected so that downstream services have all the information needed to make the correct decision for the patient. Improving the data flow between systems will greatly improve data quality which can then be used for management and planning decisions.
Single view of the patient	Through technical integration and interoperability with other IT systems, Strata can contribute toward a single view of the person by automatically drawing the appropriate information to enable an effective e-referral.

4. Evaluation – Referrals to Residential and Care Home Providers

4.1 Background

Work on the original Strata project started in late 2018 and focussed on process improvements to referrals to residential care and care at home providers from the hospital-

based START team and the Matching Unit respectively. Through engagement with all stakeholders, existing processes were mapped and validated and redesigned, improved and automated processes were developed. These processes are summarised in Figures 2, 3 and 4 below.

Implementation

In May of this year, the project was extended to include referrals made from Locality Social Work Teams to Residential Care and Care at Home providers.

In this phase of the project, residential care and care at home providers use Strata to enable a live and dynamic directory of capacity, vacant rooms and services. The Matching Unit, START team and Locality Social Work Teams can view the directory in real time and place the patient or client, quickly, into an appropriate care setting. Once a place is identified, Strata securely sends the personal and medical details to the provider so that the necessary information precedes the patient's arrival.

Implementation involved each of the care homes and care at home providers setting up business broadband arrangements (a Static IP Address) which enables Strata to authenticate the provider and allow secure transfer of appropriate data. This has been one of the more challenging parts of the implementation.

Overall there are 16 providers covering 29 Residential Care Homes (including Garden View) and 9 Care at Home providers. Staff from all providers have been provided with the necessary training to operate the system, and the Strata implementation team has visited all establishments and providers to set up the system. Locality Social Work teams also received training in the use of Strata.

Challenges during implementation

There were two main challenges during implementation.

As mentioned above, providers are required to have a static IP address. In some instances, the provider did not have a static IP address, and was required to request this from their internet provider. This delayed the "on-boarding" of some providers.

Compliance is the other main challenge. It is essential that all stakeholders play their part and use Strata to send or receive referrals, and post capacity and bed vacancies.

Whilst there is still a compliance issue with some users, new reports and dashboard charts are available to quickly identify non-compliance and take remedial action. The reporting dashboard in STRATA IQ has been redesigned at no cost to SBC to better meet our needs and is now capable of being a valuable management information tool.

4.2 Process Improvements

a) Referrals to Residential Care

Figure 2 below shows the process relating to referrals to residential care from the hospital-based START team and locality (or community) social work teams. The process is shown in terms of its original form (before Strata) and the current form (using Strata).

Prior to Strata, the original manual process had no consistent method for making referrals to care homes. With no directory of care home bed vacancies, the only way to establish where

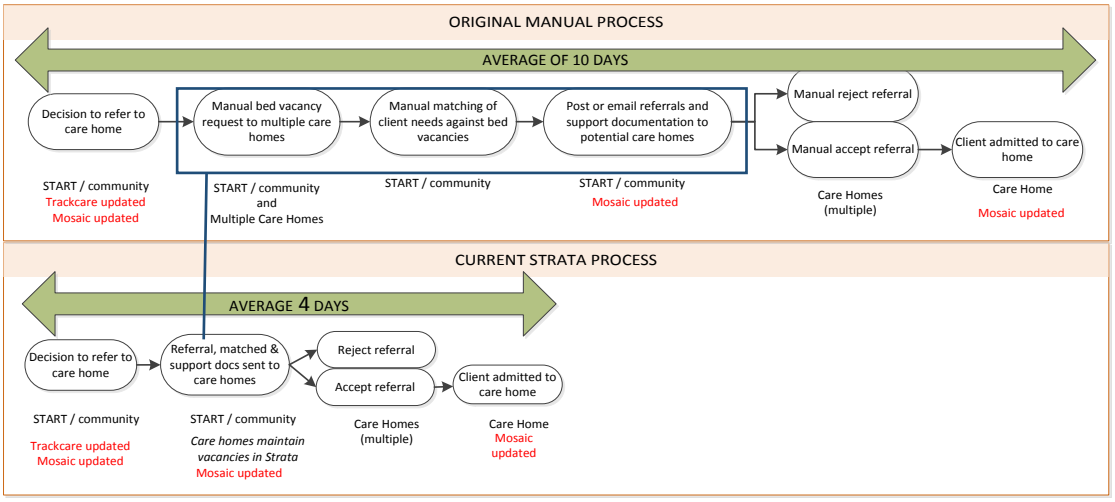
a patient/client could potentially be placed, was to make many phone calls or send email to multiple care homes. This often meant that patients remained unnecessarily in hospital, occupying scarce and expensive acute care bed capacity, often for long periods of time.

Once a suitable care home was identified, care plans and other associated support documents were posted or emailed to them. These processes – telephone, post and email – often created delays of up to 6 days in the provider's ability to act upon the referral, ultimately impacting on the person's needs. There were various reasons for the delays including:

- Missing key information or documentation
- Delivery of posted referrals can take up to 6 days longer
- Emails required referral forms to be password protected; emails are then blocked by NHS and SBC IT security and need to be 'released' by NHS/SBC IT provider
- Follow-up phone calls to receivers to let them know the password

Without a safe, secure and consistent process in place to send personal data, there was no way to ensure data was sent safely and securely to the provider, resulting in **known** data protection risks.

Figure 2: Referral to Residential Care – Original and Current Processes



*Original manual process: One client = **multiple phone calls/emails/postings** to many providers*
*Current Strata process: One client = **one e-referral form** to appropriate providers*

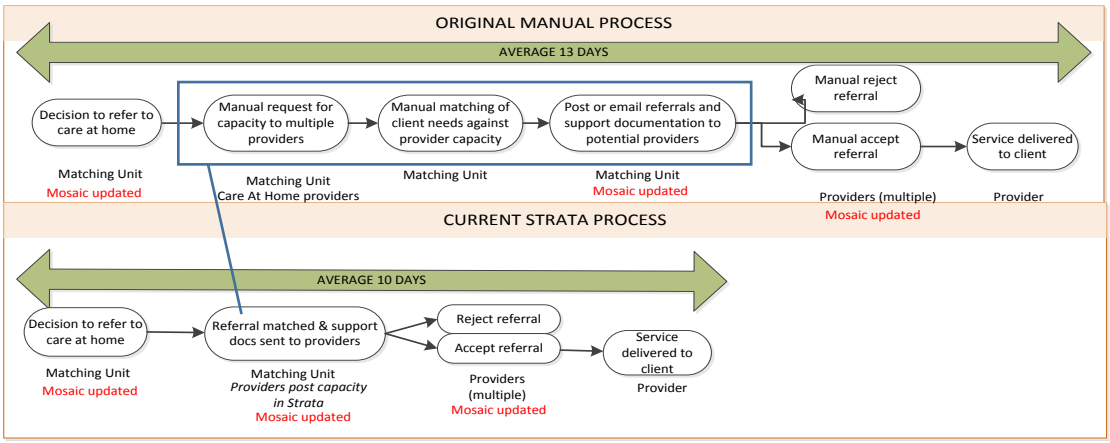
The current operational Strata process delivers a real-time directory of bed vacancies across all care homes. As patients transition in and out of care homes, the bed vacancy list is automatically maintained. This removes the need to phone/email multiple care homes. Once the e-referral is created, it is then sent to multiple providers based upon the client match and preference.

Strata imposes mandatory fields, allows uploading of files – for example assessments - and securely delivers real-time e-referrals to providers. Strata also provides an audit trail and visibility of the patient's e-referrals across multiple pathways. This not only addresses the delays mentioned above, it also addresses any concerns surrounding data security.

b) Referrals to Care at Home

The Care at Home referral process (see figure 3 below) is similar to the Residential Care process – with visibility of bed vacancies being replaced with care at home provider capacity. As with figure 2, multiple phone calls, emails and posted documents are replaced by one e-referral.

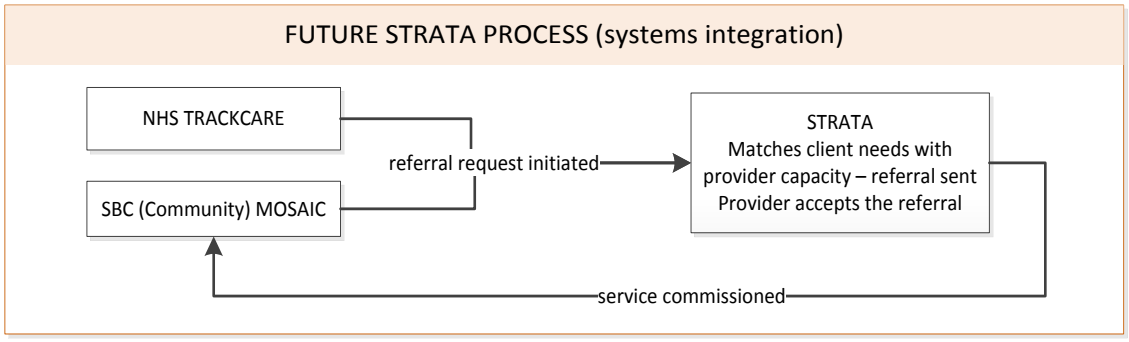
Figure 3: Referral to Care at Home – Original and Current Processes



c) Future Process – With Technical Integration

Technical integrations between Strata, Mosaic (SBC, Social Care), TrakCare and EMIS Web (NHSB, Health) will provide a further step-change in terms of process improvement. Essentially, this allows data to flow between core systems, allowing greater automation, reducing time and effort, and eliminating the need for double keying and the associated scope for error. It is expected that following the integration referred to above, the referral process for both residential care and care at home streams will be reduced to a period of 1-3 days.

Figure 4: Future Referral Process (with Integration) – Residential & Care at Home Providers



Appendix 2 provides a detailed summary of the benefits that have been achieved to date by adopting Strata, and to be achieved by integrating Strata tools and pathways with core IT systems across health and social care.

4.3 Cost Benefits (January 2019- July 2019)

The benefits described in this section relate to the data from Strata and comparative data from Mosaic relating to the application of the current state process in figures 2 and 3 above – i.e. the application of Strata to enable e-referrals to Residential Care and Care at Home providers from January 2019 – July 2019 inclusive.

Table 2: Volume of Placements and Average Number of Days

Referral Type	Year	Process	No of placements	Average no of days	**No. of days service delivery improved by (average no of days)**
Care Home	2018	Pre-Strata	83	10	
	2019	Strata	52	4	**6**
Care At Home	2018	Pre-Strata	860	13	
	2019	Strata	475	10	**3**

Work has been ongoing since the last board meeting to quantify the savings associated with the introduction of Strata. The system will reduce administrative effort and inefficiencies in current processes and will make savings in two areas:

I. Administrative and Social Worker savings – through reduced administrative time and reduced requirement for Social Worker input into the placement process. Figure 2 above highlights a 60% (6 day) time saving in the process of completing a Residential Care placement using Strata. Figure 3, shows a corresponding 23% (3 day) time saving in the completion of a Care at Home Placement. At present, there are 68 staff involved in these processes of which 46% are social workers and 17% employed on an agency basis. The total cost of these staff is £314,366 and therefore it is reasonable to conclude that savings can be made through reduced agency, duplication, postage and telephony costs which will fund the costs of Strata.

II. Occupied Bed Day (OBD) savings – it is estimated that the deployment of this system could enable some 3,060 NHS occupied bed days to be saved each year (see table 3 below). It has been difficult to calculate and agree the actual cost and resource savings that would be obtained from the closure of beds due to the variable release costs related to closure or one bed, one bay or an entire ward. Estimates therefore range from £131-£500 per occupied bed day*. Having said that, this indicative cost-benefit analysis has assumed the lower and more conservative number which indicates that a full and ongoing Strata deployment could enabler projected recurring annual savings in excess of £400,860.

Table 3: Indicative Occupied Hospital Bed Days savings

Referral Type	**No. of days service delivery improved by (average no of days)**	Estimated number of placements	Occupied Bed Days	Cost per OBD £	**Saving £**
Care Home	6	85	510	131	66,810
Care At Home	3	850	2,550	131	334,050
			3,060		**400,860**

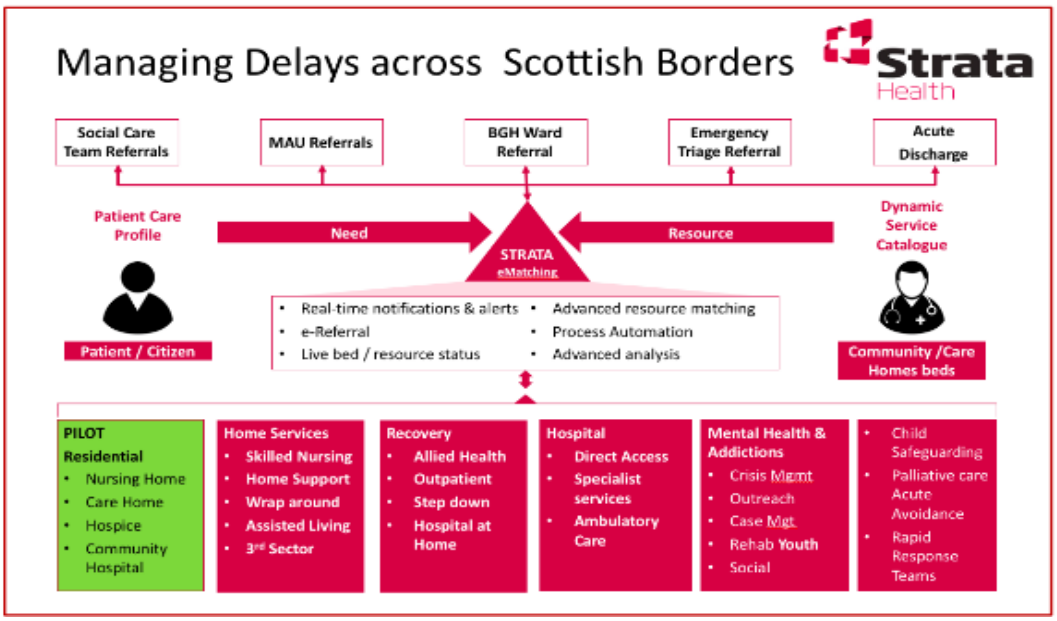
To date, the potential of the system has only been assessed against two processes – referrals to Residential Care and referrals to Care at Home providers. The system provides the opportunities to reassess all Health and Social Care processes and deliver significant, as yet unquantified, savings and efficiency gains.

*This figure has been calculated using publicly reported ISD "blue book" acute care cost data of circa £500 per bed day, and discounted to reflect the estimated net marginal cost savings at a rate of £131 per day.

4.4 Future Cost Benefit Opportunities

As figure 5 below shows, there are a large range of opportunities to be achieved by a fuller deployment of Strata. The cost of Strata (£115,000/year) is a fixed cost based upon £1/head of population. It will only increase (or decrease) with changes in population size – but remains fixed regardless of how many processes or pathways we apply it to. As a result, the cost benefit set out above will improve with each added efficiency we make across all our pathways.

Figure 5



Looking at the capabilities illustrated in the above diagram, Strata has the ability to offer significantly more savings in term of admin and Social Worker time as well as other potential hospital services resulting in additional potential bed day savings. Through comparison with other data internal data sources, we estimate that to date Strata is handling only about 50% of the care home placements and domiciliary care packages currently being placed by SBC, reinforcing the potential additional system benefits to be gained from a full and consistent adoption and deployment.

Section 5 below sets out the additional first wave of processes where we are currently working towards rolling-out Strata, and also identifies further potential areas for future deployment. Wherever possible, data from other Strata clients is shown to illustrate the quantum of benefit that can be achieved from applying Strata to these additional areas of service.

4.5 Other Benefits

Additional and non-financial benefits achieved from the first phase of the Strata project include:

- **Quicker Referrals** – Figure 2 and 3, also Table 1 above, apart from showing the financial benefits to be achieved, also illustrate a significant reduction (60%) in the number of days taken to process a referral from acute to residential care.

- **Quality and Patient Safety** – In future, as a result of a shorter length of stay in an acute hospital bed, patients will have a significantly reduced risk of morbidity and mortality as a result of falls or contracting a hospital acquired (HAI) or wound infection, with resultant significant personal risk and overall system costs.

- **Improved Management Information** – Strata provides management with real-time visibility of capacity within the system across both Residential Care and Care at Home Providers and enables a greater insight into the flow of referrals to providers and any actual or potential blockages or non-compliances. Data from the system will enabling improved business intelligence and contract management capability (see Section 6).

- **Data Quality** – Mandatory fields and workflow will help to ensure that the right information is included with all e-referrals. A drop in the number of RFIs (requests for further information) and declined referrals (see Appendix 4) over the 7-month period is evidence that this data quality is beginning to improve.

- **Improved Data Security** – Prior to Strata, many referrals were sent to multiple providers via post or through block-lists of patients on the waiting list via zipped files. These pre-existing processes carried known security risks that are being addressed through Strata. E-referrals are sent securely to appropriate providers with capacity matching the person's needs. The provider sees only details of patients that relate to potential and actual referrals for their service and their vacancies – rather than everyone on the waiting list.

- **Compliance** - Strata provides the opportunity to have mutually agreed and manageable process around which to build and enforce compliance. Mandatory fields within the system are already ensuring that referrals can only be made if the necessary information (e.g. assessment, medication, and next of kin contacts) are included with the referral. The audit trail and time-stamping of transactions enables the ability to identify and rectify areas of non-compliance.

- **A live and dynamic directory of services** – Strata provides our providers with a management tool that will allow them to broker their services directly to the council and hospital and ensure that the information they receive allows them to quickly accept a patient. It also provides them with a facility to allow them to catalogue the services and resources that they provide right down to the characteristics of the service, resource and staff skills. Furthermore, it will provide them with access to information around the quality of service that they provide and the referral activity and placement activity that happens over given time periods which will prove useful when interacting with the social care teams at council.

4.6 Data Analysis

An analysis of data from the Strata system over the 7 month period is set out in Appendix 4. The data not only shows the richness of the information that is available via the Strata reporting tool, Strata IQ, but also shows:

- The growing volume of e-referrals over the period, currently running at a monthly average of 97 Care at Home and 36 Residential Care referrals
- The source and destination of referrals
- The number of referrals by age range
- A drop in the number of requests for information (RFIs) and analysis of the RFI reasons
- A drop in declinations and associated reasons

5. New Pathways

5.1 Rolling-Out Strata to Other Health and Social Care Pathways

As described at figure 5 above, the work undertaken to date shows that we are barely scratching the surface of what can be achieved with a fuller deployment of the Strata system. This section sets out those processes that we are currently working on with a view to applying Strata, through a Phase 2 deployment as well as a number of other potential priority areas for applying Strata in a future phase(s).

5.2 Processes In-Development (Phase 2)

Phase 2 has focussed on three referral processes from Health and Social Care to specific third party organisations, and also discharge referrals from Hospital Ward to START team. These referrals are made on **a daily basis**. There is currently no consistent method used by NHS or SBC to make these referrals.

Table 4: E-referrals in development

Type	Purpose of referral	Stakeholders			Estimated Annual No. of referrals	Estimated Cost per referral	Potential cost saving
		NHS	SBC	3rd party			
Encompass	for support to individuals organise their own care staff to enable them to live independently	Y	Y	Y	192	£14	£ 2,688
Borders Carers Centre	for assessment of carer's needs	Y	Y	Y	540	£14	£ 7,560
Borders Care & Repair	Minor adaptations	Y	Y	Y	1250	£14	£ 17,500
Hospital Discharge	Assessment from hospital ward to discharge hub (START team)	Y	Y		unknown*	£14	£ unknown

Note: *no current method in place to capture volume of referrals

Working with the organisations, NHS and SBC colleagues and Strata, existing paper referral forms have been reviewed. The e-referral processes have been developed and tested in Strata. Stakeholder engagement is still to take place, to ensure that relevant staff are aware of the change in process and trained appropriately. A number of similar processes have been undertaken and successfully deployed in Cumbria. In the event of IJB board approval for further use and adoption of the Strata system, we have been invited to collaborate with the Cumbria partnership and leverage their work to date and so be able to definitively calculate the hard and soft costs to be saved as well as other system benefits.

Figure 6: Generic e-referral process will replace the current processes in phase 2

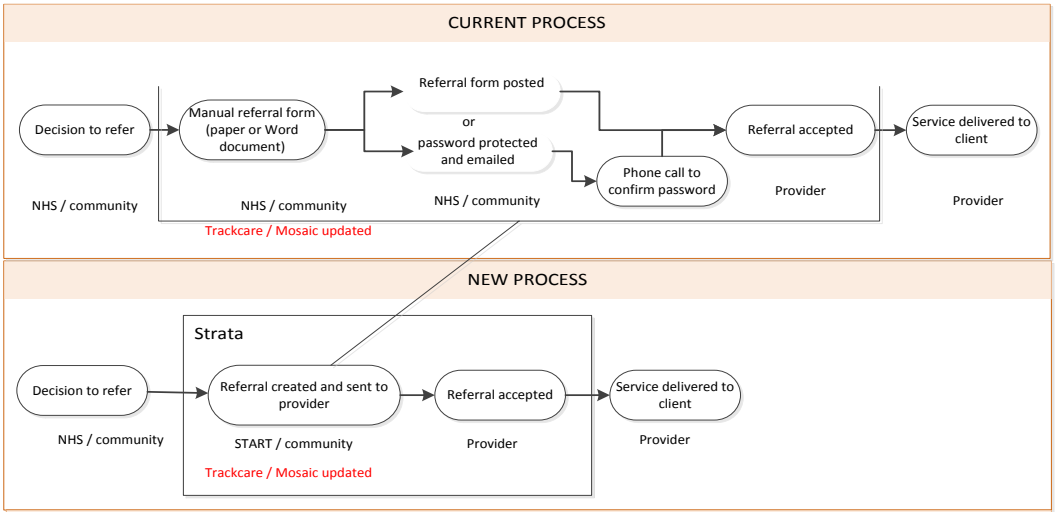
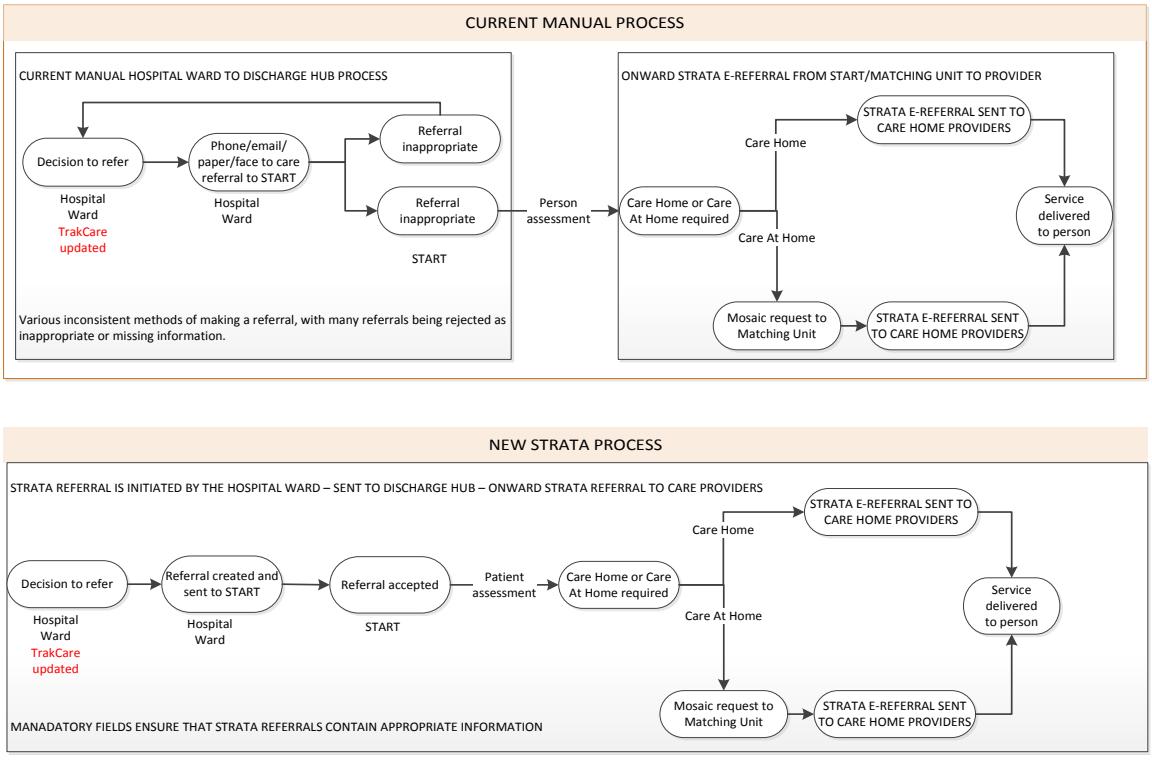


Figure 7: Hospital Ward to Discharge Hub (START team)



5.2 Further Potential Pathways

As stated earlier in this report, a number of additional pathways have been deployed by Strata Health in a number of other client settings (refer to Appendix 1). These pathways will be considered jointly by NHS and SBC.

Table 5: Further Potential Pathways to be assessed and prioritised

Placement	Assisted Living
	Mental Health (residential)
	Palliative / Hospice
	Personal Care Homes / Supported Living
eReferral	Central Intake and Triage (acute)
	Community Services (medical, professional)
	Community Services (general assistance, volunteer)
	Discharge Coordination
	Mental Health
	Rehab / Complex Continuing Care / Intermediate Care
	Safeguarding
	Social Services
	Specialty pathways (e.g., Frailty, Falls prevention)
Scheduled Care	Paediatrics
	Physiotherapy / Occupational Therapy
	Specialist / Diagnostics
Funding approvals	Services
	Equipment
Other products	Strata Connect
	Self / Public Referral
	Strata Kiosk(TM)

Consideration will also be given to how Strata can support existing and planned service redesign work including:

- Service Reviews and Outpatient Redesign Programme
- Older People's Pathway Redesign Programme
- Mental Health Transformation Programme
- Primary Care Improvement Programme

Impact analyses will be carried out on each pathway to determine the priority of pathways to be taken forward over the next six months and beyond.

6. Management Information

As stated at the beginning of this report, one of our major challenges is that currently we have no single system, or suite of systems that enable us to record, manage and review the outcomes of referrals across organisations. Referral records may be kept in many different ways including paper, email-trails and individual computer systems. Until now this has significantly limited the ability to capture and provide effective and accurate management information

One of the major benefits from the Strata system is its ability to capture real-time data across referral processes and provide strategic and operational management information. Data relating to all transactions over the system are illustrated in the figures below and in Appendix 4. Over time, this information is providing an insight into:

- Capacity across the range of providers (see fig 10 below)
  - The rooms available in each residential care establishment
  - The discharges out of residential care establishments and reasons
  - The capacity of care at home providers

- The volumes of referrals (see figs 8 and 9 below)
    - From each sender (Matching Unit, START team, Community Team)
    - To the care provider (organisations and individual facilities)
- The status of referrals:
    - The number of completed cases
    - The number of requests for further information (RFIs) and the reason
    - The number of declined referrals and reasons
- Audit trail – Compliance and Performance
    - The usage of the system by senders and providers including frequency of logging in and updating the system – e.g. making referrals or updating vacancies
    - Response times between the e-referral being generated to the placing of a person in the appropriate care setting
    - The audit history information could play a valuable role in the event of a potential data breach as the audit trail can show who has viewed a person's record, how often and when.

The above can be used to:

- Monitor actual trends
- Model future capacity requirements
- Monitor compliance in terms of use of the system
- Monitor contractual performance of providers
- Manage improvement – e.g. reducing the number of RFIs and declinations by using the information from the system to address the root cause of these.

The above information can be extracted from the strata and can be tailored to the needs of individual stakeholders including:

- Health & Social Care management/EMT/SPG
- Matching Unit
- Locality Teams
- Providers
- Contract Management

Again, this is not a "quick-fix"; the above information is, of course, dependent on compliance with the system and the quality and the completeness of management information is continuing to improve as compliance improves. It is important to see this as a capability that will take time to fully develop and exploit.

However, this information has not been available to us prior to Strata and, as is already enabling a better insight into the discharge management process. The cost of trying to gather comparable management information on a manual basis from multiple sources on a one-off, let alone on recurring, basis would be significant.

Thinking about how Strata will be applied to other pathways, the depth, breadth and quality of strategic and operational management information that will, over time, be available from the application of strata across multiple health and social care pathways will be potentially transformational.

Figure 8: Number of referrals to Residential Care Providers

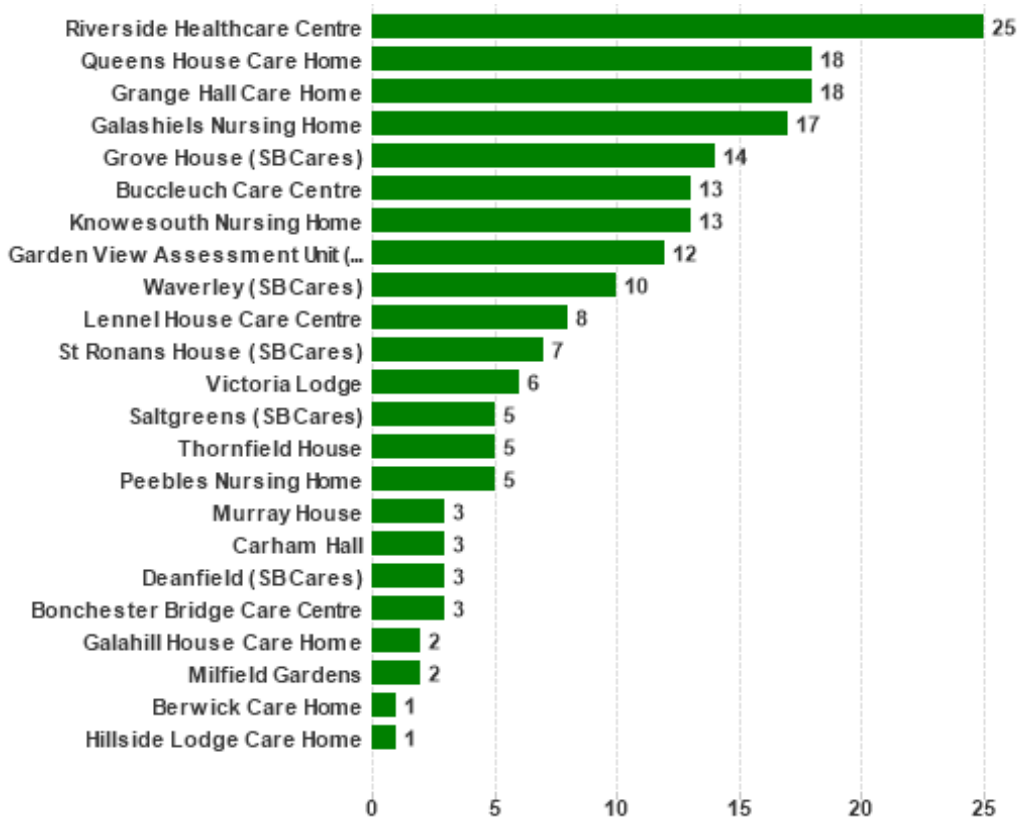
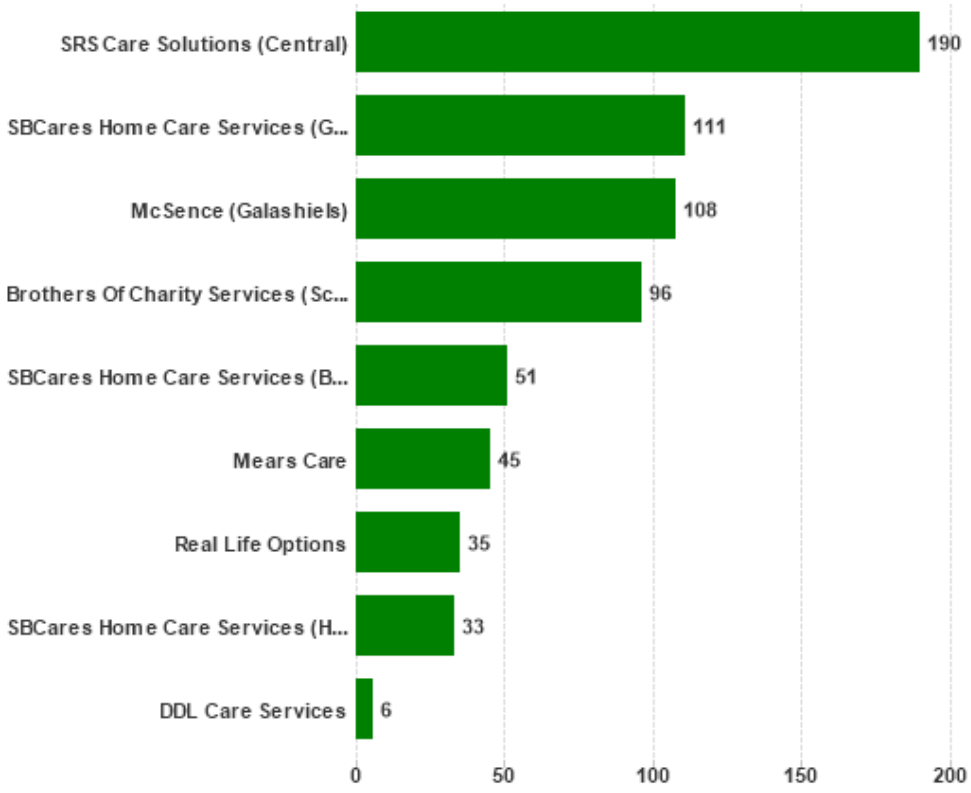
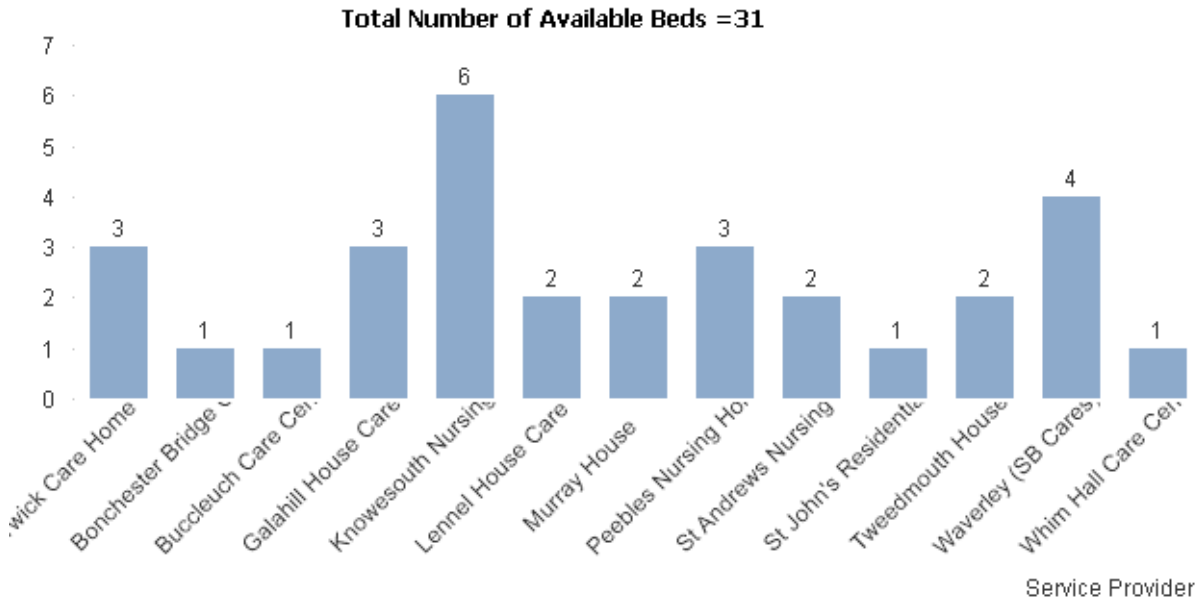


Figure 9: Number of referrals to Care at Home Providers



Strata is able to provide a live snapshot of care home vacancies based on responses from the suppliers as can be seen in the chart below.

Figure 10: Snapshot capacity of Residential Care Providers



7. Discharge Process Evaluation

Strata is one of five ICF-funded projects relating to the improving the discharge management process (the others being the Matching Unit, Discharge to Assess, Garden View and Hospital to Home). A wider review of these projects is included elsewhere on this agenda. The relationship between Strata and the other discharge-related projects is summarised below.

The five projects, to some extent, operate in isolation but need to be joined together and seen as complementary as they all interact and impact to a greater or lesser extent on each other. It should be noted that the Strata tool is seen as being the key and foundational platform and the central enabler going forward to ensure maximum beneficial impact.

- **Matching Unit**
  Currently 165 referrals per month, mainly going through Strata, however, if more services were able to send e-referrals to the Matching Unit (such as locality teams, Community Hospital / Acute Discharge Teams) this would support a wider range of patients/service users. Additional improvements could be realised by Matching Unit being able to send e-referrals to equipment suppliers, 3rd Sector Support Groups and GPs.

- **Discharge to Assess – Waverley**
  Waverley handles on average 18 admissions/month, but this could increase to 20+ if occupancy rates increased from better use of Strata. Currently, Waverley does not regularly post vacancies on Strata nor does it use it for onward referrals for discharged patients. If it did so it could save time and also reduce average length of stay by 1-2 days.

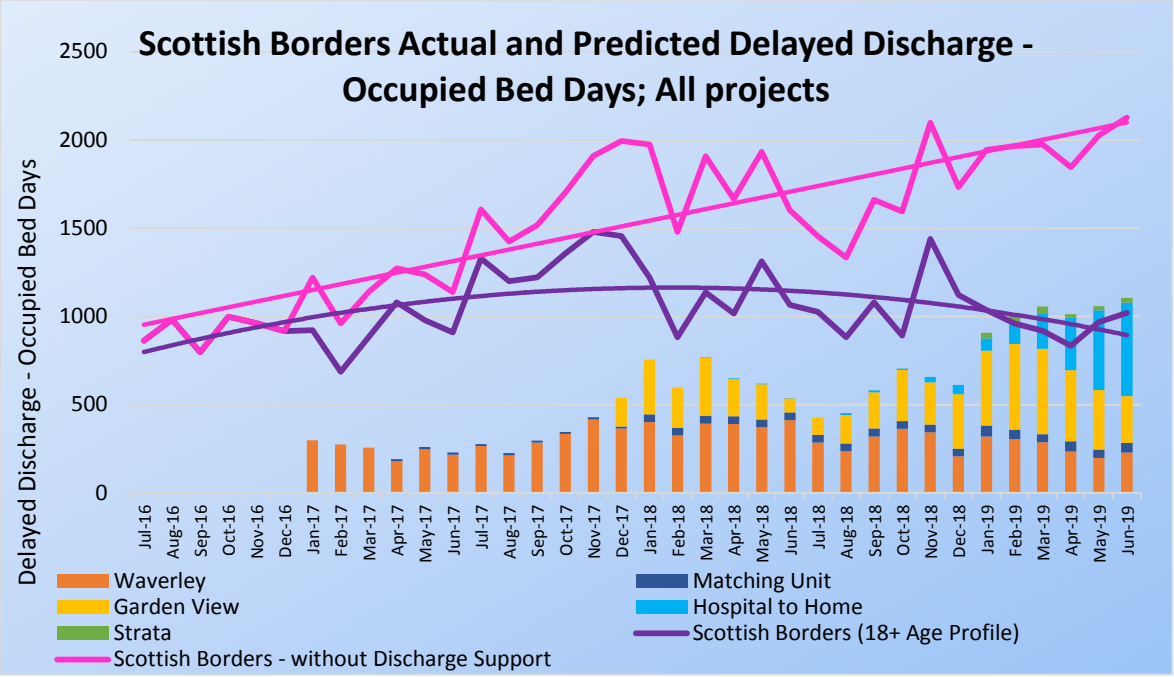
- **Garden View**
  Garden View does post vacancies regularly on Strata but does not always use Strata for onward referrals when discharging a patient, this has resulted in some discharge delays previously. There is scope for increasing occupancy and also reducing average length of stay

from better use of Strata and achieve better throughput of patients from the hospitals and enhance the overall view of the patient care pathway, providing a coherent single source of activity for all the agencies involved in support the service user.

- **Hospital to Home**
  H2H on average accommodates 15 new service users per week, Currently H2H does not really use Strata to manage referrals to care providers, if it did so it would result in an additional 21-25,000 referral per year being managed by Strata and could result in additional OBD savings and time savings for the nurses involved. It would also assist others involved in the service user's care in being able to identify the full packages of care in place for the service user.

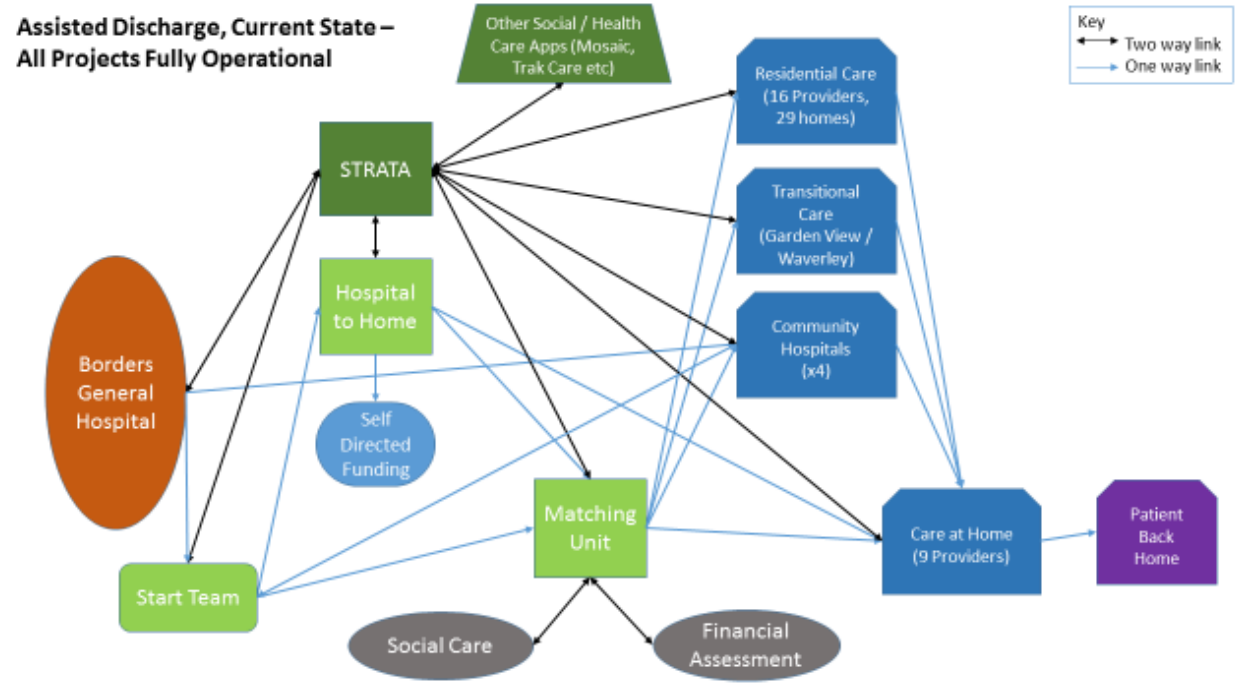
Whilst the effect of each of these projects can be evaluated in comparison, the true impact can only be seen when all projects are reviewed as a single entity, and a standardised e-referral process and capacity posting process with full compliance was used by all stakeholders.

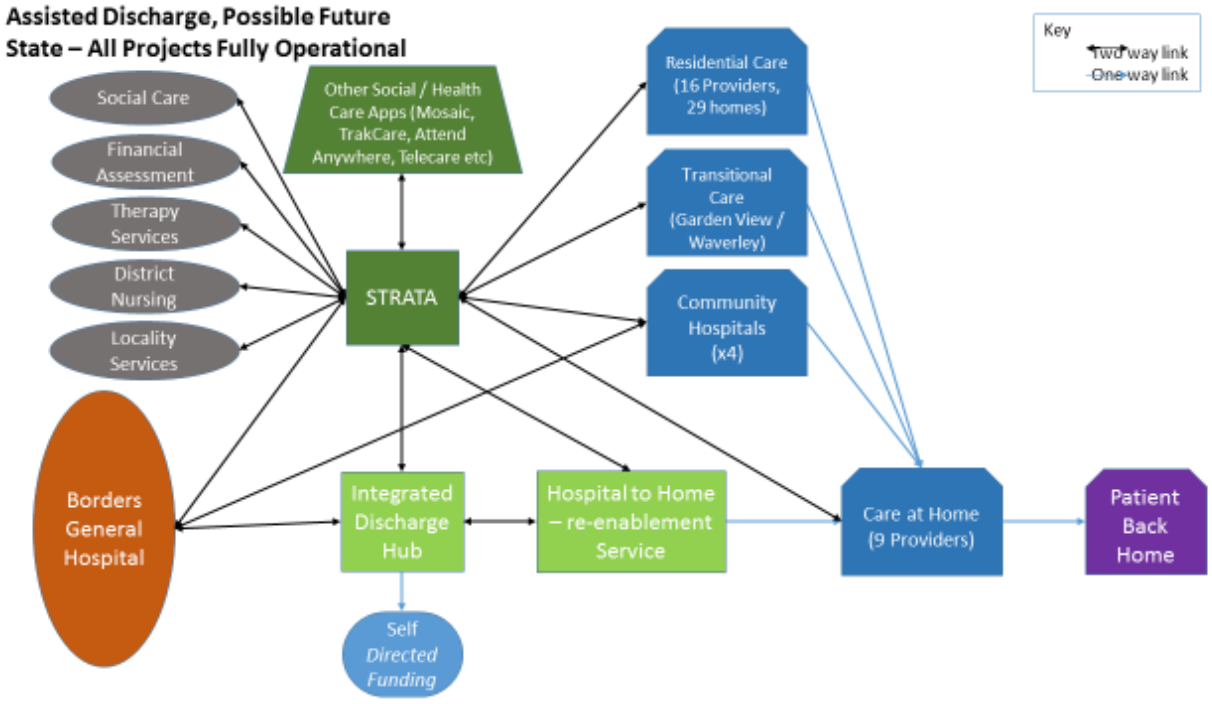
Figure 11



By looking at where the Delayed Discharge bed days that would have been incurred without intervention, compared to what has been achieved up until end June 2019, the chart above clearly shows the combined effects of these projects has almost halved the OBD due to delayed discharge. This is equivalent to being able to shut an entire ward and still retain some spare capacity in times of need.

To fully demonstrate the capability of Strata, a simple view of the "As Is" and potential "To Be" data flows can be illustrated as follows:





8. Conclusion and Recommendations

As experience with Strata grows, it is now possible to demonstrate real time savings in operational performance and better service for the end clients. The deployment of Strata now needs to be seen in a longer-term (multi-year) context, as an enabler in managing change, supporting the integration and improvement of service processes and helping management to bring about compliance and the behavioural changes needed to deliver on our strategic objectives.

This evaluation has shown that the Strata project:

- Is aligned with the Joint IT framework, addresses key IT issues raised by staff and practitioners, meets system requirements for an e-referrals process and addresses known data security risks.
- Delivers significant time savings in terms of referrals to residential care providers and care at home providers and enables the opportunity to make associated savings in terms of savings in administrative costs of the processes and occupied bed day savings.
- Has the potential to enable significant additional efficiency gains through extending Strata to other Health and Social Care processes – all without increasing the annual cost of Strata at £1/head of population of £115k/year.
- Provides unprecedented levels of real time management information which, in itself, provides the opportunity to help drive continuing improvements to service.
- Is the key and foundation platform and the central enabler going forward to ensure maximum benefits and efficiency gains from the other ICF-funded, discharge-related projects (Matching Unit, Transitional Care, Garden View and Hospital to Home) and other projects to deliver efficiencies, reduce occupied beds and prevention of admissions to hospital.

It is recommended that IJB approves the continuation of the Strata project until the end of the financial year. A further project evaluation will be produced for IJB in March 2020, with the potential recommendation to seek ICF funding to continue with the deployment of the Strata tool in a longer-term (multi-year) context.

Next Steps:

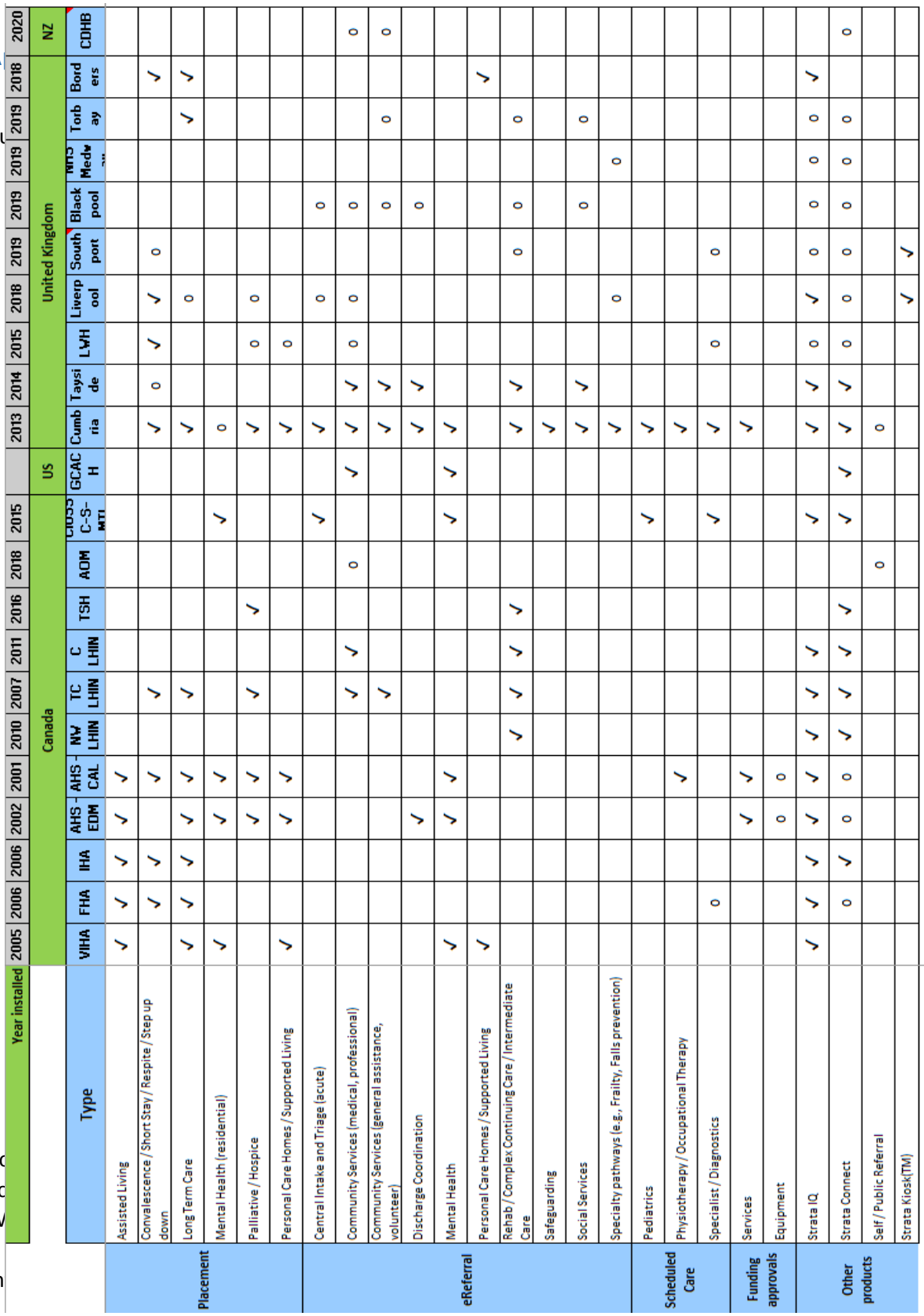
- Deployment of e-referrals to Encompass, Borders Carer Centre, Borders Care & Repair and Hospital Ward to Discharge Hub

- Impact analysis and Prioritisation of next pathways to be implemented following joint discussions with NHS and SBC professionals

- Expand the use of Strata based on the prioritised pathways

APPENDICES

Appendix 1 – List of Strata clients and the processes where Strata has been deployed



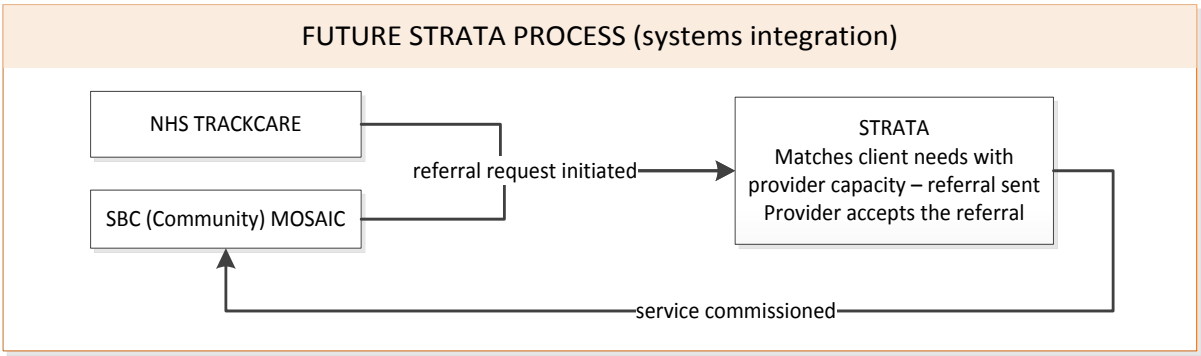
	Type	Year installed	Canada																United Kingdom										US		NZ
		2005	VIHA	FHA	2006	IHA	AHS-EDM	2002	AHS-CAL	2001	NW LHIN	2010	TC LHIN	2007	C LHIN	2011	TSH	2016	AOM	2018	Cross C-S-MTI	2015	GCAC H		Cumbria	2013	Taysside	2014	LWH	2015	Liverpool	2018	Southport	2019	Blackpool	2019	NHS Medway	2019	Torbay	2019	Borders	2018	CDHB	2020
Placement	Assisted Living		✓	✓		✓	✓		✓																															
	Convalescence / Short Stay / Respite / Step up down			✓		✓			✓				✓												✓		o		✓		✓	o							o
	Long Term Care		✓	✓		✓	✓		✓				✓												✓						o						✓		
	Mental Health (residential)		✓				✓		✓												✓				o														
	Palliative / Hospice						✓		✓				✓				✓								✓				o		o								
	Personal Care Homes / Supported Living		✓				✓		✓																✓				o										
eReferral	Central Intake and Triage (acute)																✓				✓				✓						o				o				
	Community Services (medical, professional)												✓		✓				o				✓		✓		✓		o									o	
	Community Services (general assistance, volunteer)												✓												✓		✓											o	
	Discharge Coordination						✓																		✓		✓								o				
	Mental Health		✓				✓		✓												✓			✓		✓													
	Personal Care Homes / Supported Living		✓																																		✓		
	Rehab / Complex Continuing Care / Intermediate Care										✓		✓		✓		✓				✓				✓		✓						o		o			
	Safeguarding																								✓														
	Social Services																								✓		✓								o				
	Specialty pathways (e.g., Frailty, Falls prevention)																								✓						o							
Scheduled Care	Pediatrics																					✓			✓													
	Physiotherapy / Occupational Therapy								✓																✓														
	Specialist / Diagnostics			o																		✓			✓				✓			o						
Funding approvals	Services						✓		✓																✓														
	Equipment						o		o																														
Other products	Strata IQ		✓	✓		✓	✓		✓		✓		✓		✓							✓			✓		✓		✓		✓		o		o		✓		
	Strata Connect			o		✓	o		o		✓		✓		✓		✓					✓		✓	✓		✓		o		o		o		o		o		o
	Self / Public Referral																		o						o													
	Strata Kiosk(TM)																														✓		✓						

Live = ✓ upcoming = o

Table 6: Current and Future Benefits of Strata

Current Strata Process	Future Strata (with systems integration)
Reduction in manual processes and effort • No need to make multiple phone calls to providers, as capacity can be viewed within Strata • Strata matches client needs against capacity, taking into account client preference	**Further reduction in manual processes** - Data flows between systems, no need to re-key information - Automated referrals – for hospital discharge, the process starts in the hospital ward
Improvements to data security and quality • Referrals and support documents transferred securely between referrer sender and receiver • Improved data quality as Strata imposes mandatory fields – reducing requests for further information	**Further improvements to data quality** - Removes the risk of errors when rekeying information - Two way integration would allow data to flow automatically between systems allowing for streamlining of other internal processes
Positive impact on client/patient • Speedier outcomes delivered by removing protracted manual processes	**Positive impact on client/patient** - Speedier referrals – process can start earlier in the client journey, for example the hospital ward
Improved management information • Volumes of referrals, outcomes • Trends • Client journey	**Improved management information** - Integration brings unique identifiers, creating opportunities to report across Health & Social Care

Figure 4: Future Referral Process (with systems Integration)



Appendix 3 – Data Analysis

Based on period 1st Jan – 31st July 2019

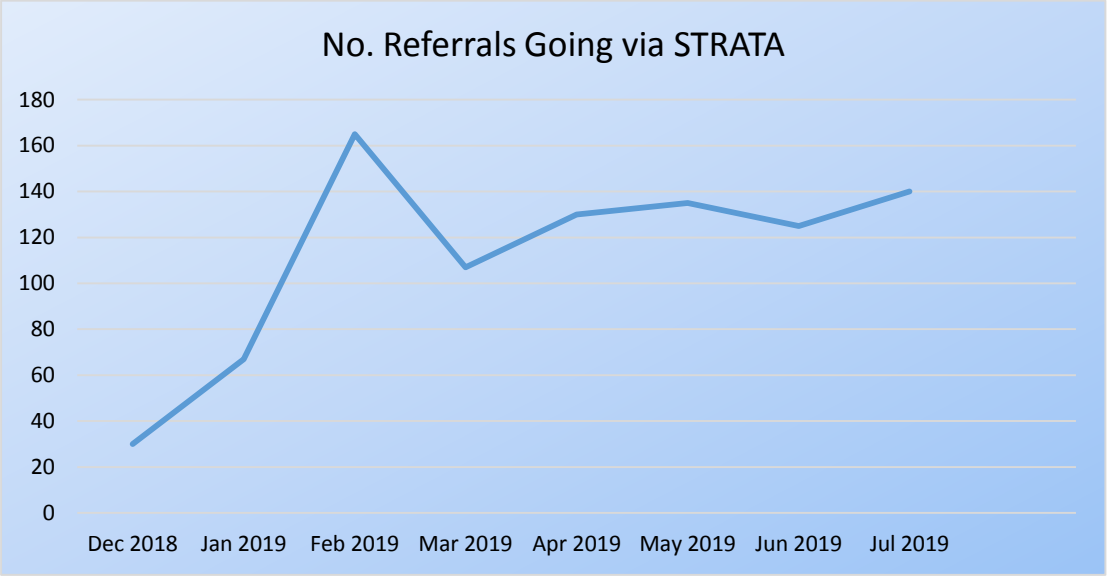
Information contained in the charts below come directly from either Strata system data or from ISD publicly reported data. In the case of Borders, the data shows that it took a couple of months for the Strata system to become adopted, and the use of the system is still growing. Given some local staff compliance issues, not all users are as efficient in recording their data as would be liked.

This data is comparable with similar data provided by NHS Tayside and NHS Cumbria where similar improvements have been observed. Tayside has seen a drop of about 50% in time taken for care at home referrals to be processed, most being actioned within 1-5 days. Thus it is possible Scottish Borders could see further efficiency savings as care providers become more familiar with Strata and other core services start to use Strata within Scottish Borders to send out referrals.

In one large health authority in Canada reported an 800% increase in referrals to care at home providers over a 6-year period of using Strata, whilst observing a 72% reduction in response time. This resulted in a significant reduction in delayed discharges from hospital saving many thousands of bed days.

In Cumbria, Strata is used across a wide variety of care settings and applications one of which is referrals to Palliative Care where the response time is now down to just 28hours.

Fig 8: Referrals being made via Strata (Jan – Jul 19)



In the 7 months, 1st Jan to 31st July 2019, a total of 869 referrals for 306 patients have been actioned.

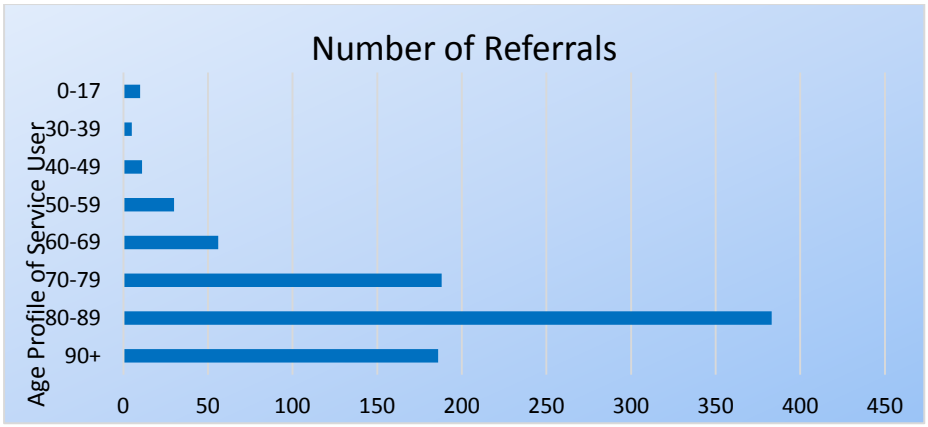
The referrals are from:

Source	No. Referrals	Monthly average
Care At Home: Matching Unit	675	97
Care Home:	194	36
Care Home Referrers:		
BGH Ward 14	*6*	
Locality Teams	*13*	
START Team	*175*	

This is reflects the destination of the referrals, Matching Unit looking at mainly domiciliary care and Start Team mainly concerned with 24hr residential care.

As would be expected, the bulk of the referral relate to patients in the 75+ age bracket, as can be seen from the attached age profile in figure 4 below

Fig 4: Referrals by age range



As users have become more familiar with the system, there has been a fall in both the requests for further information (RFI) and the number of referrals that have been declined (see figs 9-12). This suggests that the quality of information has improved – providers are receiving the information they need first time (Strata) has mandatory fields that require the necessary details to be included with the referral). However, as figure 10 shows, there is still scope to improve this with 43% of RFIs being due to info/forms not being provided with the e-referral.

Fig 9: Requests for further information (RFI)

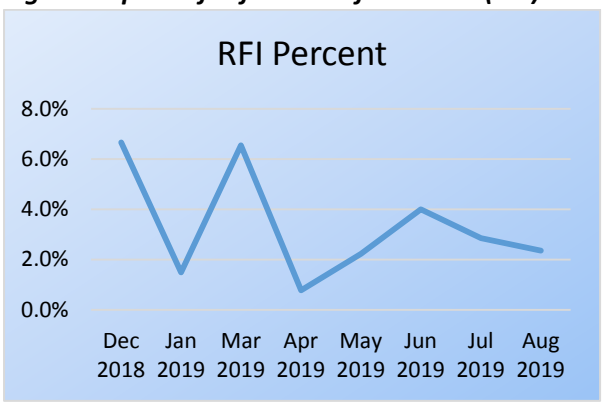
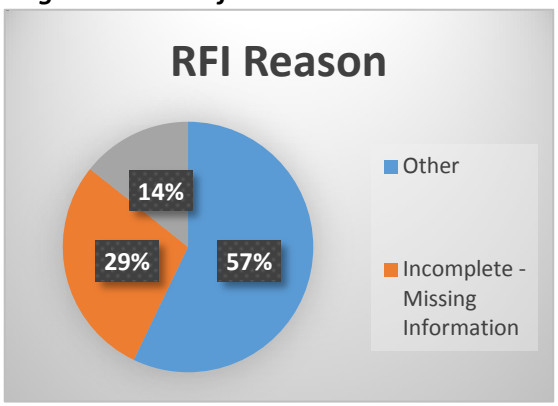


Fig 10: Reasons for RFI



The drop in the number of declined e-referrals is further evidence that Strata is improving performance. Referrers have visibility of provider capacity and while this likely to account for the 2% fall in declinations there is still scope to further improve this as can be seen in figure 8 which still shows that 80% of declinations are due to lack of capacity and e-referrals not meeting the acceptance criteria of the home.

Fig 11: Percentage Fall in Declined e-Referrals

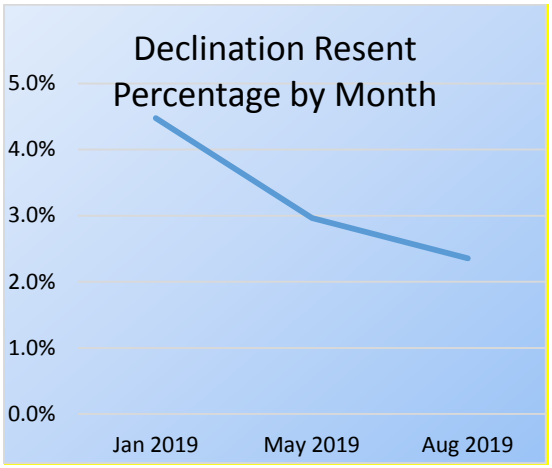
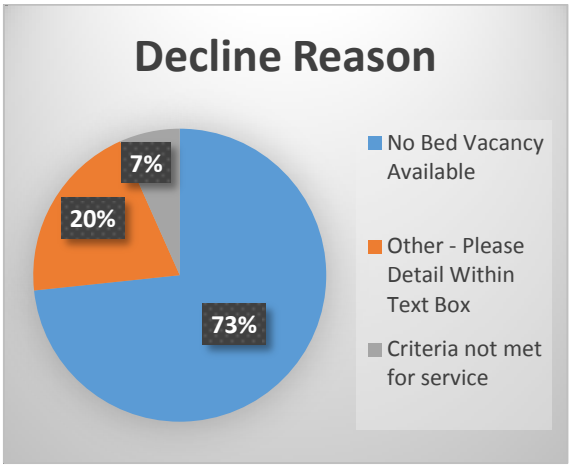


Fig 12: Reasons for Declined e-Referrals



Median respose times are also improving each month, but due to compliance issues with a few users the data is skewed and not fully representative of the more general picture. Most care homes respond to a referral within 48hrs, domicilliary care providers tend to take 2-5 days on average.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Jill Stacey, SBIJB Chief Internal Auditor (Scottish Borders Council's Chief Officer Audit & Risk)
Telephone	01835 825036

SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD STRATEGIC RISK REGISTER BI-ANNUAL UPDATE

Purpose of Report:	The purpose of this report is to provide Members of the Board with an update of the most recent review of the IJB Strategic Risk Register as it is important that the Board is kept informed of the IJB's key risks and the actions undertaken to manage these risks.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: (a) Consider the IJB Strategic Risk Register to ensure it covers the key risks of the IJB; (b) Note the progress in managing one of the risks to reduce its rating from Red to Amber; and (b) Note that a further risk update will be provided in December 2019.

Personnel:	In line with their roles and responsibilities the IJB's Chief Officer and Chief Finance Officer have carried out the current review of the IJB Strategic Risk Register during late July 2019, supported by SBC's risk management service.

Carers:	There are no direct carers' impacts arising from the report.

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

Financial:	There are no direct financial implications arising from the proposals in this report.

Legal:	Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.

Risk Implications:	Risk Management arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems in line with its agreed Risk Management Strategy within its governance arrangements.

Background

2.1 The IJB, as strategic commissioner of health and social care services, gives directions to NHS Borders and Scottish Borders Council for delivery of the services in line with the Strategic Plan. The Scheme of Integration sets out how the managerial arrangements across the integrated arrangements flow back to the IJB and the Chief Officer. These arrangements are further supported by the IJB's Local Code of Corporate Governance.

2.2 Compliance with the principles of good governance requires the IJB to adopt a coherent approach to the management of risks that it faces in the achievement of its strategic objectives. A Risk Management Strategy was approved by the IJB on 7 March 2016 which includes the: reporting structure; types of risks to be reported; risk management framework and process; roles and responsibilities; and monitoring risk management activity and performance.

2.3 The Internal Audit Annual Assurance Reports for the Scottish Borders Health and Social Care Integration Joint Board 2016/17 and 2017/18 highlighted that Risk Management is not yet fully embedded into the culture of the IJB, the strategic risk register was prepared in 2016 but never finalised, and documentary evidence of risk deliberations in decision making requires improvement. In order to significantly improve the risk management process and fulfil its Risk Management Strategy by identifying, evaluating, managing and monitoring key risks and mitigations, Internal Audit made the following recommendations "The IJB strategic risk register should be finalised. Ensure IJB strategic risks are considered and reviewed regularly at IJB meetings. Risk management deliberations associated with IJB decision making should be clearly documented".

2.4 On the recommendation by the IJB Audit Committee (17 December 2018), the IJB Strategic Risk Register was approved by the full Board on 28 January 2019 with agreement that it reviews the IJB Strategic Risk Register on a six monthly basis i.e. June and December each year.

2.5 The Internal Audit Annual Assurance Report for the Scottish Borders Health and Social Care Integration Joint Board 2018/19 highlighted that progress had been made in finalising the IJB Strategic Risk Register though further improvement was required to fully embed the process. The Internal Audit recommendation is "Ensure IJB strategic risks are considered and reviewed regularly at IJB meetings".

Summary

3.1 It is important that the IJB has its own robust risk management arrangements in place because if objectives are defined without taking the risks into consideration, the chances are that direction will be lost should any of these risks materialise. Furthermore the ability to manage risk will help the Board act more confidently on future business decisions. Knowledge of the risks they face will give them various options on how to deal with potential problems.

3.2 The current review of the IJB Strategic Risk Register has taken place during late July 2019, and was supported by SBC's risk management service. The review was undertaken by the IJB's Chief Officer and Chief Finance Officer in line with their roles and responsibilities.

3.3 A high level summary of the IJB's Strategic Risk Register, which sets out the key risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan, is shown in **Appendix 1**. There are currently 10 risks on the IJB Strategic Risk Register; two Red and eight Amber rated risks. Risk IJB006 current risk score was reduced from Red to Amber during the recent risk review after reassessing the likelihood of the risk materialising and the impact due to progress with the workforce development plan which was highlighted as having had a positive effect on controlling this risk.

3.4 This report and the IJB Strategic Risk Register are intended to provide the Board with assurance that risks are being effectively managed and monitored.

3.5 The Strategic Risk Register will continue to be reviewed alongside the implementation of the Strategic Plan by the IJB's Chief Officer and Chief Finance Officer with support from SBC's risk management service, and a further update will be presented to the Board in December 2019. This will assist to address the Internal Audit recommendation on managing risks

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Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 25 September 2019

Scottish Borders
Health and Social Care
PARTNERSHIP

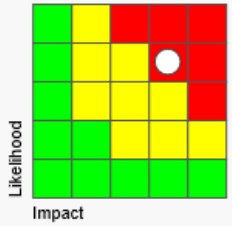
SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD STRATEGIC RISK REGISTER BI-ANNUAL UPDATE

APPENDIX 1

IJB IJB	2	8			
IJB001 Failure to achieve culture change may affect strategic objectives	12 Major - Possible		02 Aug 2019	12 –	
IJB002 Ineffective and innefficient use of resources may not achieve best value	12 Moderate - Likely		02 Aug 2019	12 –	
IJB003 Insufficient availability of residential and home care provision	16 Major - Likely		02 Aug 2019	16 –	
IJB004 Partnership approach to communicating and engagement with stakeholders	9 Moderate - Possible		02 Aug 2019	9 –	
IJB005 Insufficient funding, or failure to make savings, may affect provision	16 Major - Likely		02 Aug 2019	16 –	
IJB006 Inability to develop a workforce for the future	9 Moderate - Possible		02 Aug 2019	9 ↓	
IJB007 Significant supplier failure	12 Major - Possible		02 Aug 2019	12 –	
IJB008 If someone under the care of the IJB comes to harm	12 Major - Possible		02 Aug 2019	12 –	
IJB009 Failure to manage and appropriately resource major programmes/projects	9 Moderate - Possible		02 Aug 2019	9 –	
IJB010 If the Partners breach data protection legislation	8 Major - Unlikely		02 Aug 2019	8 –	

Risk IJB003: If availability of residential and home care is insufficient to meet demand then there may be gaps in service provision and poor outcomes/choices.

Current | Compare | Description



Impact 4 Major
Likelihood 4 Likely
Score 16

Assessment 16 Major - Likely
Date Assessed 02 Aug 2019
Internal Controls Score 2 Partially Effective

Next Assessment due 25 Oct 2019

Update

Home Tab | Risk Tree | History | Internal Controls | Related To | More...

Notes Notes from current assessment...

Rawlins, Neil , 02 Aug 2019
New internal control 3.4 added, additional nursing beds commissioned

Management

Approach Treat
Priority 0

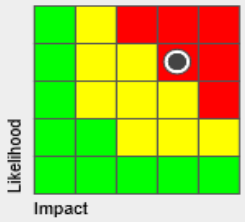
Profile

Year Identified 2018

Potential Effect
Gaps in service provision;
Delayed discharge;
Reduction in choice;
Poor outcomes;
Services may not be able to meet need;
Unable to deliver our statutory duty.

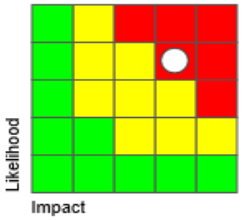
Risk Factors
Market may be unable to recruit and retain sufficient staff due to demographics - reduction in people of working age versus aging population;
Higher wages and alternative career options;
Less attractive T&C's;

Home Tab | Risk Tree | History | Internal Controls | Related To | More...



Date Assessed	Score	Assessment	Assessed by
02 Aug 2019	16	16 Major - Likely	Rawlins, Neil
17 Jul 2019	16	16 Major - Likely	Rawlins, Neil
09 Jul 2019	16	16 Major - Likely	Rawlins, Neil
30 May 2019	16	16 Major - Likely	Rawlins, Neil

02 August 2019



16 Major - Likely

Impact 4 Major
Likelihood 4 Likely
Score 16

Assessed By Rawlins, Neil

Notes Showing all Notes...

Rawlins, Neil , 02 Aug 2019
New internal control 3.4 added, additional nursing beds commissioned

Home Tab | Risk Tree | History | Internal Controls | Related To | More...

Summary

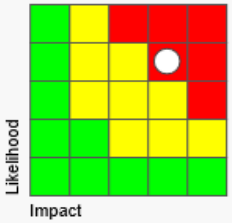
Internal Controls OK	✖
Internal Controls Score	2 Partially Effective

Internal Controls

Control	Score	Note
IJB003.1 Market Facilitation	2 Partially Effective	Regular meetings with independent providers of residential and homecare in place. Con...
IJB003.2 Work ongoing re commissioning of home care hours;	2 Partially Effective	
IJB003.3 Projection modelling on future demand v demographic pressures;	2 Partially Effective	Comparators in place with statistical neighbours. Modelling work underway across SBC...
IJB003.4 Further residential and nursing beds now comissioned	2 Partially Effective	

Risk IJB005: If the IJB receives insufficient funding from partners to fund the delegated functions, or if savings targets are not met, this may lead to an inability to meet demand.

Current | Compare | Description



Impact	4 Major	Assessment	16 Major - Likely
Likelihood	4 Likely	Date Assessed	02 Aug 2019
Score	16	Internal Controls Score	2 Partially Effective

Next Assessment due 25 Oct 2019

Update

Home Tab | Risk Tree | History | Internal Controls | Related To | More...

Notes Notes from current assessment...

Rawlins, Neil , 02 Aug 2019

Risk reviewed - no change. Linked action to be shared with NHS Borders Chief Exec

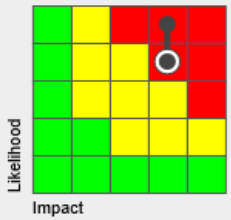
Management

Approach	Treat
Priority	0

Profile

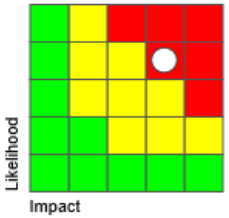
Year Identified	2018
Potential Effect	Overspend position, unless subsequent direction made to reduce spend across delegated functions or partners identify alternative temporary or permanent investment or savings proposals; Responsibility of the partner who originally delegated the budget to cover the shortfall; Inability to commission sufficient services to deliver the strategic objectives; Increased waiting times Delayed discharge Poor outcomes.
Risk Factors	Inability of the partners to resource the IJB to the levels required Lack of shared responsibility and accountability across the partnership for the prioritisation of resource to meet the strategic objectives of the IJB.

Home Tab | Risk Tree | History | Internal Controls | Related To | More...



Date Assessed	Score	Assessment	Assessed by
02 Aug 2019	16 –	16 Major - Likely	Rawlins, Neil
17 Jul 2019	16 ↓	16 Major - Likely	Rawlins, Neil
30 May 2019	20 –	20 Major - Almost Certain	Rawlins, Neil

02 August 2019



16 Major - Likely

Impact 4 Major
Likelihood 4 Likely
Score 16 –

Assessed By Rawlins, Neil

Notes Showing all Notes...

Rawlins, Neil , 02 Aug 2019
Risk reviewed - no change. Linked action to be shared with NHS Borders Chief Exec

Home Tab | Risk Tree | History | Internal Controls | Related To | More...

Summary

Internal Controls OK ✖

Internal Controls Score ⚠ 2 Partially Effective

Internal Controls

Control	Score	Note
⚠ IJB005.1 Transformation / Efficiency programme governance within NHSB...	2 Partially Effective	
⚠ IJB005.2 It will be the responsibility of the authority who originally delegate...	2 Partially Effective	
✔ IJB005.6 Performance and Finance group	3 Fully Effective	Reports to IJB

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Mike Porteous, Chief Finance Officer
Contact	Mike Porteous, Chief Finance Officer
Telephone:	07973981394

MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2019/20 AT 30th JUNE 2019

Purpose of Report:	The purpose of this report is to provide the IJB with a forecast year end position for the Health and Social Care Partnership (H&SCP) for 2019/20 based on available information to the 30th of June 2019.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Acknowledge** the forecast financial position for the Partnership of an overspend of (£1.464m) for the year to 31 March 2019/20 based on available information b) **Acknowledge** the underlying pressures, the actions being taken to manage these pressures, and the risks highlighted in relation to delivering a break even year end position. c) **Request** the H&SCP work to identify further actions which will inform the next Monitoring Report to bring the forecast spend back in line with budget by year end.

Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2019/20 will be reported to the Integration Joint Board.

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.

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 This report relates to the forecast 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 The forecast position is based on the Quarter 1 Financial Reviews carried out by the partner organisations and presented to Scottish Borders Council and the Board of NHS Borders. It highlights the key areas of financial pressure at 30 June 2019, the proposals in place or planned for their mitigation, and the any risks relating to the forecast position.

2.3 The NHS Borders forecast financial position changed materially in August when agreement was reached with the Scottish Government on the allocation of £9.3m of Brokerage. The anticipated impact of that agreement is included information presented.

Overview of Monitoring and Forecast Position at 30 June 2019

3.1 The IJB is reporting a forecast overspend of (£1.464m) for the year with (£1.3m) falling within services commissioned from Health. **Appendix 1** provides a breakdown of the forecast position by service within delegated Function.

Healthcare Functions

3.1 The delegated healthcare functions are forecasting an underspend of £0.054m based on Quarter 1 information. The impact of the allocation of non recurring savings and brokerage has reduced the outstanding savings forecast to (£0.980m) for 2019/20. An overspend of (£0.300m) within Prescribing reflects a high level of estimation due to the 2 month lag in getting actual information. The overspend within Learning Disabilities reflects the current forecast for care commissioned from external providers. These forecast overspends are offset by significant underspends forecast within Mental Health, relating to ongoing vacancies within the service and underspends within non pays, and within Generic services relating to vacancies in AHP and Dental services.

Social Care Functions

3.2 Social Care delegated functions are currently projecting an adverse variance of (£0.184m) to the end of the year. Increasing demand for client care packages – eg homecare and respite care - across Older People's and Mental Health services in particular are driving the forecast. These overspends are offset by a forecast underspend of £0.09m within Generic services in relation to a number of budget realignments.

3.3 Key assumptions underpinning the forecasts relating to income and prices across the main services are being reviewed to ensure they reflect the latest information. The reported position also assumes that all prior year and 2019/20 savings will be delivered in full and there is work ongoing to provide assurance in relation to savings expected within Homecare services.

Large Hospital Functions Set-Aside

3.4 The Set-Aside functions are forecasting an overspend of (£1.335m) to the 31st of March 2020. Staffing pressures within A&E (£0.205m) and further pressures within General Medicine (£0.750m) including the continued use of surge beds without a funding source are the main overspends. Recruitment is underway to mitigate the use of agency costs within A&E. The surge beds pressure is not expected to continue beyond October 2019 and further work to review the overall pressure within General Medicine since the Quarter 1 Review was completed has seen a reduction in the forecast balance.

3.5 The balance of the forecast overspend relates to the outstanding savings target of (£0.384m). The in year target of £2.145m has been reduced by the non recurring allocation of in year corporate savings and brokerage across the Business Units. Work is ongoing to identify schemes to deliver recurring savings against the remaining target.

Delivering Financial Balance

4.1 The H&SC Partnership is forecasting an overspend of (£1.463m) to the 31st March 2020. The size of the gap reflects the favourable impact of the allocation of non recurring savings and brokerage to the Business Units within Health. However pressures are emerging in relation to staffing, particularly within Set Aside services, and demand for services within Social Care. In addition further work is underway to confirm the delivery of planned savings across the partnership.

4.2 Delivering financial balance will require the H&SC Partnership to increase its focus on identifying and delivering savings in year and on a recurring basis. Monitoring of existing actions to mitigate emerging pressures will further support a reduction in spend required to address the pressures identified to date.

Risk

5.1 There is a risk that the overall forecast position worsens as a result of the work underway to review the assumptions underpinning the Social Care services forecast. Additional in year solutions will be required to mitigate any adverse movement in the forecast.

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5.2 There is also a risk that actions to mitigate existing pressures within Set Aside services relating to agency costs and surge bed usage do not result in the expected reduction in spend. Careful monitoring of the level and mix of staffing and the bed base alignment will highlight any changes in the forecast which require action.

5.3 There is an ongoing risk facing the Partnership in delivering in year and recurring savings schemes. Risks also exist in managing the Prescribing position due to the timing of available information, and in assessing the financial impact of winter as the plan has not been finalised. An update on the status of these risks and any implications for the IJB will be brought to the next meeting.

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2019/20	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	17,852	5,244	21,706	21,854	(148)	
Joint Mental Health Service	16,814	4,398	18,038	17,556	482	
Joint Alcohol and Drug Service	544	(3)	554	559	(5)	
Older People Service	24,818	7,097	20,682	20,887	(205)	
Unidentified savings	(4,714)	0	(2,503)	(1,523)	(980)	
Physical Disability Service	3,457	1,011	3,326	3,278	48	
Prescribing	22,795	5,781	24,155	24,455	(300)	
Generic Services	68,812	11,713	72,961	71,983	978	
Large Hospital Functions Set-Aside	22,514	6,459	24,566	25,901	(1,335)	
Total	172,892	41,700	183,486	184,950	(1,464)	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions	2019/20	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	14,301	4,132	17,463	17,483	(20)	The most significant overspends forecast relate to increased demand across Older People's and Mental Health services.
Joint Mental Health Service	2,040	579	1,977	2,068	(91)	
Joint Alcohol and Drug Service	175	7	175	180	(5)	
Older People Service	24,818	7,097	20,682	20,887	(205)	
Physical Disability Service	3,457	1,011	3,326	3,278	48	
Generic Services	4,287	568	5,257	5,168	89	
Total	49,078	13,394	48,880	49,064	(184)	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions	2019/20	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	**3,551**	**1,112**	**4,243**	**4,371**	**(128)**	**The forecast Learning Disabilities overspend relates to externally commissioned services. Vacancies are driving the underspend within Mental Health.**
Joint Mental Health Service	**14,774**	**3,819**	**16,061**	**15,488**	**573**	
Joint Alcohol and Drug Service	**369**	**(10)**	**379**	**379**		**The Prescribing forecast is based on 1 month of actual data.**
Prescribing	**22,795**	**5,781**	**24,155**	**24,455**	**(300)**	**The release of non recurring savings and brokerage has reduced the in year savings target by £6.665m.**
Unidentified savings	**(4,714)**		**(9,168)**	**(1,523)**	**(7,645)**	**Underspends relating to vacancies are forecast within AHPs and Dental services.**
Allocated Non Recurring Savings Projects			**2,570**	**0**	**2,570**	
Allocated Brokerage			**4,095**	**0**	**4,095**	
Generic Services	**64,525**	**11,145**				
Independent Contractors			**28,631**	**28,631**		
Community Hospitals			**5,347**	**5,347**		
Allied Health Professionals			**6,346**	**6,111**	**235**	
District Nursing			**3,497**	**3,497**		
Generic Other			**23,884**	**23,230**	**654**	
NEED A FORECAST						
Total	**101,300**	**21,847**	**110,039**	**109,985**	**54**	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2019/20	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	2,516	754	2,748	2,953	(205)	The use of agency staff to cover vacant posts is driving the overspend within A&E. The ongoing use of surge beds within Set Aside services has resulted in a forecast overspend which is not expected to continue beyond September. The savings target has been reduced in year as a result of the release of non recurring savings and brokerage.
Medicine & Long-Term Conditions	13,231	4,033	15,747	16,497	(750)	
Medicine of the Elderly	6,767	1,672	6,696	6,691	5	
Turnaround Savings Target			(2,145)	(240)	(1,905)	
Allocated Non Recurring Savings Projects			590	0	590	
Allocated Brokerage			931	0	931	
NEED A FORECAST						
Total	22,514	6,459	24,566	25,901	(1,335)	

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Gareth Clinkscale, Hospital Manager
Telephone:	01896 826052

SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP
DRAFT WINTER PLAN 2019/20

Purpose of Report:	To brief the Integration Joint Board on the draft Joint Winter Plan.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) ***Note*** the draft Joint Winter Plan 2019/20.

Personnel:	Resource and staffing implications of the Winter Plan will be addressed through the development of the plan.

Carers:	N/A

Equalities:	Final Winter Plan will be assessed using Equality and Diversity Scoping template Plan.

Financial:	Final Winter Plan will be assessed using Equality and Diversity Scoping template Plan.

Legal:	Request from the Scottish Government that a whole system Winter Plan is developed.

Risk Implications:	Will be undertaken as part of development of the final Winter Plan. The Winter Plan has been consulted on widely with stakeholders within NHS Borders and the Scottish Borders Council.

Background

This document forms the Scottish Borders Health and Social Care Partnership overarching Winter Plan. The overall aim of the planning process is to ensure that the partnership prepares effectively for winter pressures so as to continue to deliver high quality care, as well as national and local targets.

A winter debrief event was held on 30th April 2019. The learning from last winter has been invaluable in shaping the Winter Plan for 2019/20 as well as its early planning and execution.

The delivery of the Winter Plan in the Scottish Borders is overseen by an Integrated Winter Planning Board, chaired by the Chief Officer for Health and Social Care. The Board reports to both the health Board and the Council, with regular updates to the Integrated Joint Board.

Review of 2018/19

Analysis of data from previous years, along with the application of predictors, supported the development of a whole system bed model to meet the winter demand. Trajectories along with daily and weekly monitoring processes allowed the system to make early informed decisions. This had significant impact on our system and enabled us to protect the Medical Assessment and Surgical/Gynaecology Assessment areas on the whole. On the few occasions they were used, they were recovered quickly.

The review of last winter confirmed the effectiveness in last year's winter plan. NHS Borders achieved significantly better compliance with the 4 Hour Emergency Access Standard compared with the winter of 2017/18. There was a statistically significant reduction in the number of patients with a length of stay of over 28 days this winter compared with last winter.

Development of improved patient pathways increased whole system capacity and capability though winter which has continued all year round to meet the needs of the local population.

The 2018/19 winter plan incorporated the decision to cancel non urgent and non cancer related elective surgery for the month of January 2019, creating additional capacity for orthopaedic trauma patients. This will form part of this year's winter plan.

The BGH General Medicine winter ward model will be created again this year to ensure sufficient inpatient acute hospital capacity is in place. Process changes developed last year to protect GP assessment areas will also form part of this year's plan.

The BGH Escalation policy was reviewed and updated prior to last winter. This supported improved patient flow and safety across the site. This policy is currently under review ahead of this winter to incorporate learning from last winter.

Summary of Winter Plan for 2019/20

Clinical engagement and integrated working has been at the heart of this year's winter planning process. The 2019/20 Winter Plan aims to achieve the following objectives:

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- Weekend discharges will be increased to smooth flow across the seven days
- Capacity will be increased across Health & Social Care to meet increased demand
- Patient flow will be improved throughout the system
- Care will be enhanced in the community and fewer patients will be delayed
- Services will be safer
- Staff wellbeing will improve

The delivery of safe and effective care for people requiring the health and social care will be measured through delivery of:

- Emergency Access Standard
- Local and National Waiting Times Targets
    - Treatment Time Guarantee
    - 18 Weeks Referral to Treatment
    - Stage of Treatment
    - Cancer Waiting Times
    - Stroke Standards
- Number of delayed discharges
- Bed occupancy compared to target of 85%
- Maintained boarding levels

The plan seeks to ensure capacity is allocated appropriately to meet demand. Access to alternative care settings when acute care criteria is no longer met is a key focus for this year's plan. The planned extension of intermediate care in the community and development of community Health & Social Care Multi-Disciplinary Teams are critical components of the '19/20 Winter Plan. The new BGH Frailty model and seven day Margaret Kerr Hub both planned to open in January are innovative new developments within this year's plan that should help ensure more patients receive care in the right environment.

There is an ambition to protect the elective programme and this will be balanced against expected periods of high demand, only reducing elective admissions from the end of December 2019 until end January 2020. A full day case elective programme will run throughout the winter season.

Appendix 1 provides the high-level activities that will contribute to creating the capacity within the whole system to meet local need during winter.

Financial Plan

Committed to delivering safe effective patient flow during 2019/20 winter, the total winter allocation has been enhanced locally by £0.8m from NHS Borders with a further 0.1m from the Scottish Government. Below are the high level details of areas of additional capacity:

Borders Emergency Care Service – increased staffing at weekends
Increase ED staffing (medical and nursing)
Increase capacity of Hospital to Home Team

Staffing for surge capacity
Weekend medical cover
AHP staffing – extend
Weekend pharmacy cover
Weekend domestic and portering
Contingency plan – additional surge

Weekend and Earlier in the Day Discharge

In additional to enhanced resource being allocated to weekends, there is also focussed improvement support to achieve earlier in the day discharge and an increase in weekend discharge. Trajectories for weekend discharge rates, earlier discharge and average length of stay are in place and will be monitored weekly.

Admission Avoidance

Hospital to Home service now covers the whole of the Scottish Borders and will continue to provide a prevention of admission service and support discharge from the acute hospital.

A Pulmonary Rehabilitation Programme is in the final stages of implementation with the aim to have the programme fully implemented by January 2020.

Scottish Borders Council and NHS Borders are working to develop an anticipatory care planning pack which will include the ReSPECT document (the emergency care and treatment summary) for Care Homes.

We aim to provide all patients discharged from the Acute hospital to 24 hour care (Community Hospitals, Care Homes and some sheltered accommodation) with a completed ReSPECT form.

We also provide familiarisation training and support to undertake the ReSPECT process with current residents. Of the 24 Care Homes in the Scottish Borders, around 17 are using the forms. In some of the Care Homes, the process is GP led and in others, it is MDT led including the Care Home staff.

Measurement and Monitoring

A project management approach is being applied to ensure full implementation of the winter plan to ensure risks are highlighted allowing mitigation plans to be put in place. The Whole System activity datasets developed last year will be used to assess any fluctuations in how the system is managing so that timely action can be taken when patient flows slow.

Progress against the overall programme will be monitored through the Winter Planning Board, chaired by the Chief Officer on a bi-weekly basis.

Resilience

Business Continuity Plans are in place and a testing schedule developed.

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Norovirus & Seasonal Flu

NHS Borders now conducts on-site Norovirus testing which reduces the turnaround time for test results. This supports improved infection control decision making which reduces risk of cross transmission and reduces unnecessary bed closures. Test results are entered into the Laboratory Information System and ICNet Infection Control software.

NHS Borders Laboratories have capability to conduct on-site flu testing in small numbers to support decision making and patient flow at peak times when there is excessive demand for single rooms.

Appendix 1

High Level Winter Plan 2019/20	September					October				November				December			
	W/C 2nd	W/C 9th	W/C 16th	w/C 23rd	w/C 30th	W/C 7th	W/C 14th	W/C 21st	w/C 28th	W/C 4th	W/C 11th	w/C 18th	w/C 25th	W/C 2nd	W/C 9th	W/C 16th	W/C 23rd
Admission Avoidance																	
Creation of Frailty Model at Front Door																	
Hospital to Home Prevention of Admission Pilot in Central Borders																	
Emergency Department																	
Allocate capacity (medical and nurse staffing) to meet demand																	
Increase Rapid Assessment and Discharge to 7 day service																	
Expand Criteria and capacity to care home facility																	
Expand criteria to reduce delays																	
Enhance Hospital to Home																	
Implement Robust Discharge to Assess Service																	
Reduced Length of Stay - Acute																	
Increased medical cover at weekends and for surge capacity																	
Ensure Pharmacy and Physio access at the right time at weekends																	
Social Work access at weekends																	
Maintain "Hospital at Weekend"																	
Enhance DDD with the inclusion of criteria led discharge																	
Establish SCN Delayed Discharge meetings																	
Develop process for transfer of patients to Community Hospital at Weekends																	
Develop seven day Margaret Kerr Hub																	
Strengthen Health & Social Care locality working																	
Enhance multi-disciplinary decision-making and coordination																	
Patient Flow Management																	
Review Escalation Policy, implementing triggers																	
Develop Discharge Hub and implement STRATA																	
Review Boarding Policy																	
Better links between Site & Capacity Team with START Team at Weekend																	
Increase utilisation of Discharge Lounge																	
Safer Services																	
Protect Acute Assessment Unit																	
Protect Surgical Assessment Unit																	
Infection Control Plan																	
Severe Weather Plan																	
Staff Wellbeing																	
Wellness Wednesdays																	
Flu vaccination plan																	

Work Commenced	
Work Completed	

Appendix 2

Winter Plan 2019/20 – KPIs

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 ➢ Continue Hospital @ Weekend ➢ Increase discharge to community services	% weekend discharges
Increase capacity to meet demand	➢ Winter surge ward ➢ Elective cessation plan ➢ ED twilight shifts ➢ Enhanced BECS during public holidays ➢ Increase AHP capacity	Length of stay (LOS) ED first assessment breaches Cancelled Electives
Improve patient flow	➢ Daily Dynamic Discharge re-launch in DME and BSU ➢ Unscheduled care improvement forum ➢ Escalation policy review ➢ Establish rapid assessment and transfer/discharge	4 hour EAS breaches Pre 12pm discharges Delayed Discharges (DDs)
Reduce delays	➢ Enhancing Hospital to Home service ➢ Develop locality model ➢ Community hospital capacity ➢ Weekly Delayed Discharge (DD) meeting	Delayed Discharges (DDs) Community hospital DD Less than 28 days LOS
Safer Services	➢ Review BGH Boarding policy ➢ Protect Acute Assessment Unit (AAU) ➢ Protect Surgical Assessment Unit (SAU)	Boarders AAU bedded / functioning SAU bedded / functioning
Staff Wellbeing	➢ Winter Wellness	Reduced sickness absence

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25th September 2019

Report By	Robert McCulloch-Graham, Chief Officer for Integration
Contact	Graeme McMurdo, Programme Manager, Scottish Borders Council
Telephone:	01835 824000 ext. 5501

QUARTERLY PERFORMANCE REPORT, SEPTEMBER 2019
(LATEST AVAILABLE DATA AT END JUNE 2019)

Purpose of Report:	To provide a high level summary of quarterly performance for Integration Joint Board (IJB) members, using latest data available. The report focuses on demonstrating progress towards the Health and Social Care Partnership's Revised Strategic Plan 2018 -2021

Recommendations:	Health & Social Care Integration Joint Board is asked to: a) Note and approve any changes made to performance reporting. b) Note the key challenges highlighted. c) Direct actions to address challenges and to mitigate risk

Personnel:	*n/a*

Carers:	*n/a*

Equalities:	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process. Performance information supports the strategic plan.

Financial:	*n/a*

Legal:	*n/a*

Risk Implications:	*n/a*

Background

1.1 The Integration Performance Group (IPG) has established a set of high level Key performance indicators (KPI) to report on a quarterly basis to IJB. These indicators are aligned under the three strategic objectives in the Health and Social Care Strategic Plan 2018-2021:

- *Objective 1*: keeping people healthy and out of hospital
- *Objective 2*: getting people out of hospital as quickly as possible
- *Objective 3*: building capacity within Scottish Borders communities

1.2 The IPG will continue to review, refine and develop the indicators to better balance the mix of hospital-focussed and social care KPIs. Wherever possible, the indicators are selected from robust, reliable data sources that can be compared to the Scottish average. The IPG will ensure that any new indicators for reporting are similarly robust and that proposed changes are discussed at IJB.

1.3 The IPG will endeavour to present the latest available data. For some measures, there may be a significant lag whilst data is validated and released publicly, which increases robustness and allows for national comparison. Work will continue within the IPG to explore options to improve the timeliness of data and to explore the pros and cons of using unverified but timelier local data.

1.4 The IJB Strategic Risk Register focuses on risk and controls. The focus of the Quarterly Performance Report is to highlight performance trend but the indicators also show where performance is off target and where mitigating action to address this needs to be taken. Performance and risk are very closely linked.

1.5 Two appendices are provided with this report:

Appendix 1 provides a high level, “at a glance” summary for EMT, IJB and the public. This is aligned with the Strategic Plan 2018-2021.

Appendix 2 provides further details for each of the measures including more information on performance trends and analysis.

Summary of Performance

2.1 The rate of **emergency hospital admissions (all ages)**, shows a slight decrease over the last 4 quarters (from 28.3 to 27.7); however, performance is worse than target (27.5) and worse than the Scotland average of 26.4 (*note – National data is as of Q2 2018/19*). The admission rate specifically for **over 75 years** is showing declining performance over the last 4 quarters (86.8 to 89.8), but is close to Scotland average (88.5) and is slightly ahead of target (90.0). This suggests that action being taken to reduce emergency hospital admissions is having some impact, but more focus on the >75 age group may be required.

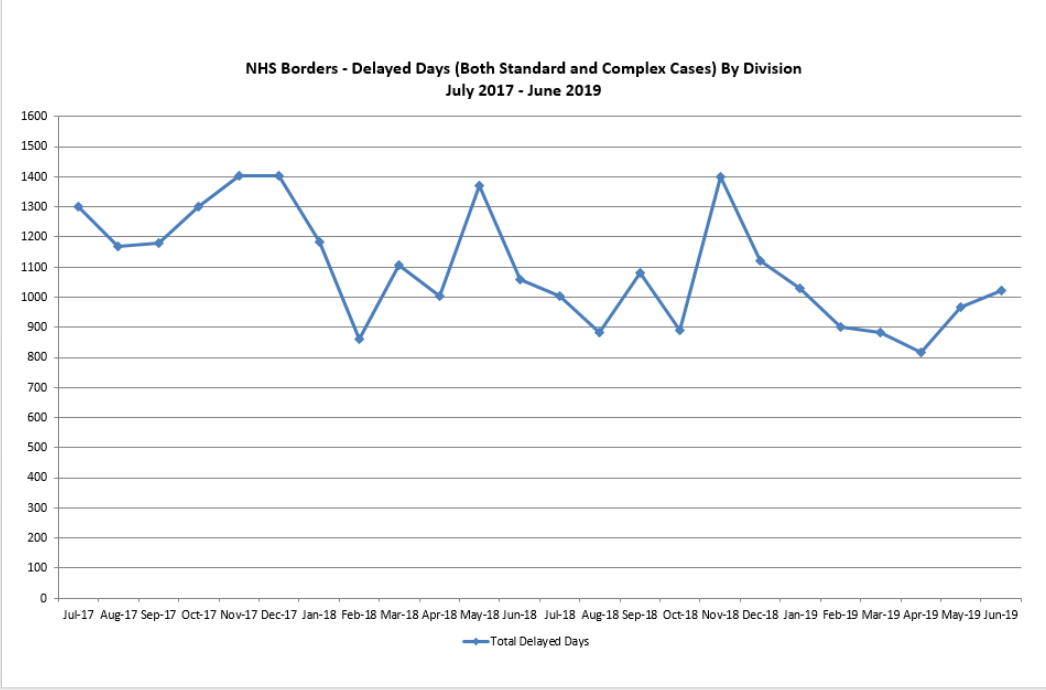
2.2 Borders is demonstrating excellent performance in regard to **A&E attendances** and **A&E waiting times**. Over 96% of patients are seen within 4 hours which exceeds our 95% target and compares favourably to the Scotland average (~90%). Our actual number of **A&E attendances** has generally fluctuated between 7,000-8,000

attendances per quarter (equivalent to 60-70 per quarter, per 1,000 population). Our latest figure is 59.6 per 1,000 population, which is the lowest it has been over the last 3-years of recorded data and compares very well against the Scotland average (69.9).

2.3 The **balance of spend on emergency hospital stays** performance remains positive - with 19.3% of health and care resource spent on hospital stays where the patient was admitted as an emergency (persons aged 18+). This is showing improvement over the last 4 quarters (23.1% to 19.3%), is better than the latest Scotland average (24.6%) and exceeds our local target (21.5%).

2.4 The **quarterly occupied bed day rates for emergency admissions** in Scottish Borders residents *age 75+* does fluctuate, but is generally demonstrating a positive performance trend over the last 4 quarters (876 to 883 – but this included a 'spike' of 1,032 in Q2 18/19) , is better than the Scotland average (1,072) and better than target (965).

2.5 With regard to delayed discharge, the **'snapshot' data** (taken on one day each month) performance is positive, with 17 delayed discharges recorded. The quarterly **rate of bed days associated with delayed discharges (75+)** is also showing a positive trend over the last 4 quarters (204 to 171), is better than the Scotland average (191 – 2017/18 Scotland average) and better than the local target of 180 Bed Days per 1,000 of the population Aged 75+. Over the long-term, there has been a consistent decrease in occupied bed days due to delays.



2.6 The **% of patients satisfied** with care, staff & information in BGH and Community hospitals remains positive. Although this has seen a slight decline over the last 4 quarters, the combined satisfaction rate remains very good (96.5%) and above our target of 95%. This data is taken from questions asked in the "*2 minutes of your time*" survey done at BGH and community hospitals.

2.7 The performance for **Quarterly rate of emergency readmissions within 28 days of discharge** for Scottish Borders residents has been declining. From a result of 10.2 per 100 discharges in Q2 2017/18, this peaked at 11.4 in Q3 2018/19. The Q4 result 2018/19 is now 10.8 showing positive change. However, performance is still worse than the Scotland average (10.5, Q3 2018/19) and worse than our local target (10.5). the action taken to address the declining performance trend appears to have begun to have an impact, but this work needs to continue.

2.8 The data in relation to **end of life care** demonstrates a positive trend over the last 4 quarters (86.1% to 86.4%), but the reality is that the measure has remained relatively static (always generally between 86% and 88%). We are currently below our local target (87.5%) and worse than Scotland (87.9% - 2017/18 average).

2.9 The % of **Carer Support Plans** completed performance of 33% continues to fall below our 40% target. However, the number of Unpaid Carers being offered a Carer Support Plan does demonstrate a steady month on month increase, indicating that unpaid Carers are being identified and offered support.

2.10 The **outcomes for carers** indicators remain positive. This suite of indicators looks at the positive outcome change between baseline assessment and subsequent review.

Changing Health & Social Care for You

Working with communities in the Scottish Borders for the best possible health and wellbeing

Summary of Performance for Integration Joint Board: September 2019

This report provides an overview of quarterly performance under the 3 Strategic Objectives within the Health & Social Care Partnership Strategic Plan, with **latest available data at the end of June 2019**. Annual performance is included in our latest Annual Performance Report 2018/19

KEY					
	• +ve trend over 4 reporting periods • compares well to Scotland average • compares well against local target		• trend over 4 reporting periods • comparison to Scotland average • comparison against local target		• -ve trend over 4 reporting periods • compares poorly to Scotland average • compares poorly to local target

How are we doing?

Objective 1: We will improve health of the population and reduce the number of hospital admissions

Emergency Hospital Admissions (Borders residents, all ages)	Emergency Hospital Admissions (Borders residents age 75+)	Attendances at A&E	£ on emergency hospital stays
27.7 admissions per 1,000 population (Jan – Mar 2019)	**89.8** admissions per 1,000 population Age 75+ (Jan - Mar 2019)	**59.6** attendances per 1,000 population (Jan – Mar 2019)	**19.3%** of total health and care resource, for those Age 18+ was spent on emergency hospital stays (Jan – Mar 2019)
+ve trend over 4 periods Worse than Scotland (26.4 – Q2 2018/19) Close to target (27.5)	-ve trend over 4 periods Worse than Scotland (88.5 – Q2 2018/19) Close to target (90.0)	+ve trend over 4 periods Better than Scotland (69.9 – Q4 2018/19) Better than target (70)	+ve trend over 4 periods Better than Scotland (24.6% - 2017/18) Better than target (21.5%)

Main challenges:

The rate of emergency admissions over the long-term (3 year period) shows an improving trend, but performance on a quarterly basis can fluctuate. For the overall admission rate and specifically for the 75+ admission rate, we are close to target but worse than the Scotland average. The number of A&E attendances generally fluctuates between 7,000-8,000 attendances per quarter (equivalent to approx. 60-70 per 1,000 population per quarter). This is better than the Scotland average and follows a similar seasonal trend to Scotland. In relation to the percentage of the budget spent on emergency hospital stays, Borders has consistently performed better than Scotland and can also demonstrate a positive trend over the last 4 quarters. As with all Health and Social Care Partnerships, we are expected to minimise the proportion of spend attributed to unscheduled stays in hospital.

Objective 1: Our plans for 2019/20

We will develop local "Wellness Centres", expanding the use of community hubs and drop-in centres to create 'one-stop shops' ideally covering both social care and a range of clinical needs. Through the development of single assessment and review, we will look to remove duplicate care assessments, develop more flexibility in regard to which professionals undertake assessments and increase Social Worker and Occupational Therapist involvement at daily ward rounds. We will introduce multi-disciplinary teams across the localities to triage individuals within the community to ensure that they can access services and receive appropriate Health & Social Care interventions ahead of any acute provision they may require

Objective 2: We will improve the flow of patients into, through and out of hospital

A&E waiting times (Target = **95%**)	Rate of Occupied Bed Days* for Emergency admissions (ages 75+)	Number of delayed discharges ("snapshot" taken 1 day each month)	Rate of bed days associated with delayed discharge	"Two minutes of your time" survey – conducted at BGH and Community Hospitals
96.1% of people seen within 4 hours (Mar 2019)	**883** bed days per 1,000 population Age 75+ (Jan – Mar 2019)	**17** over 72 hours (Mar 2019)	**171** bed days per 1,000 pop aged 75+ (Jan – Mar 2019)	**96.5%** Overall satisfaction rate (Jan – Mar 2019)
+ve trend over 4 periods Better than Scotland (89.8% - Dec 2018) Better than target (95%)	+ve trend over 4 periods Better than Scotland (1,072 Q2 2018/19) Better than target (min 10% better than Scottish average)	+ve trend over 4 periods Better than target (23)	+ve trend over 4 periods Better than Scotland (191 - 17/18 average) Better than target (180)	-ve trend over 4 periods Better than target (95%)

*Occupied Bed Days in general/acute hospital beds such as Borders General Hospital. This does not include bed days in the four Borders' community hospitals.

Main challenges:

Over the long-term (3 years) there has been an improving trend in regard to A&E waiting times and Borders is now performing above target and is consistently better than the Scottish Average. Occupied bed day rates for emergency admissions (age 75+) has seasonal fluctuations but performance trend is positive – both long-term (over 3-years) and short-term (over 4 quarters) – and we perform better than the Scottish average (*although see note above**). Delayed discharge rates vary and are erratic in regard to 'snapshot' data, but performance is positive and a target to reduce delayed discharges by 30% in 2019/20 has been set by the Health & Social Care Partnership. The percentage of patients satisfied with care, staff & information in BGH and Community Hospitals remains high, although has declined slightly over the last 4 quarters.

Objective 2: Our plans for 2019/20

We will continue to work across the HSC Partnership and Public Health to initiate a number of events, campaigns and communications promoting personal responsibility and encouraging Borderers to be healthy in areas such as diet, exercise and mental health. We will introduce a new Discharge Hub to deliver a more consistent approach to managing people's progress through Hospital, and we will improve out-of-hours provision across a number of services. We will look at ways to promote a career in care, make greater use of community pharmacies and engage with local communities regarding what services the HSC Partnership can and cannot provide. We will further develop community capacity and we will examine the bed-base mix across the care estate including the usage, role & function of Community Hospital beds.

Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

Emergency readmissions within 28 days (all ages)	End of Life Care	Carers support plans completed	Support for carers: change between baseline assessment and review. Improvements in self-assessment:
10.8 per 100 discharges from hospital were re-admitted within 28 days (Jan – Mar 2019)	**86.4%** of people's last 6 months was spent at home or in a community setting (Jan – Mar 2019)	**33%** of carer support plans offered that have been taken up and completed in the last quarter (Jan – Mar 2019)	Health and well-being Managing the caring role Feeling valued Planning for the future Finance & benefits (July - Sep 2018)
-ve trend over 4 Qtrs Worse than Scotland (10.5 – Q3 2018/19) Worse than target (10.5)	+ve trend over 4 Qtrs Worse than Scotland (87.9% - 17/18) Worse than target (87.5%)	Little change over 4 Qtrs Worse than target (40%)	+ve impact No Scotland comparison No local target

Main challenges:

The quarterly rate of emergency readmissions within 28 days of discharge (all ages) has increased from just under 10 per 100 during 2016/17. This is worse than the Scottish average and below target for this measure. Borders data in relation to end of life care shows relatively static performance but has been gradually improving over the longer term (3 years). However, end of life care figures for 2018/19 show Borders performed under target and worse than the Scotland average. The latest available data for Carers demonstrates positive outcomes as a result of completed Carer Support Plans.

Objective 3: Our plans for 2019/20

We will improve signposting and support for unpaid and paid carers and expand the reablement functions we offer. We will continue to utilise Technology Enabled Care (TEC) products across the partnership and promote the use of TEC with professionals and the public. We will follow up our June 2019 'TEC Fest' event with another event planned for December 2019. TEC can play an important role in supporting individuals with complex needs, so that they can better manage their conditions and lead healthy, active and independent lives for as long as possible and give everyone greater choice and control over their care.

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 25 September 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Louise Ramage, Business Lead for Health & Social Care
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STRATEGIC PLANNING GROUP REPORT

Purpose of Report:	To update the Integration Joint Board on the work of the Strategic Planning Group.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** this report

Personnel:	N/A

Carers:	N/A

Equalities:	N/A

Financial:	N/A

Legal:	N/A

Risk Implications:	N/A

Purpose

The purpose of this report is to update the Integration Joint Board (IJB) on any key actions and issues arising from the Strategic Planning Group (SPG) meeting held Wednesday 4 September 2019.

SPG Key Actions & Issues

Open Issues: Update on Day Services Transformation
Concerns were again raised over the continued redesign of day centres across the Scottish Borders, especially the impact of senior decision making had on Carer's and the third sector. The short notice of the reconstruction of Poynderview Centre and the potential closure of Teviot Day Centre were highlighted as specific areas of stress at the current time.

Members were advised that the intention for Poynderview was to revert to their assessment function instead on facilitating respite services.

Additionally, assurance was provided that each service user, in conjunction with their families and Carer's, would be thoroughly assessed for their ongoing needs to develop Local Area Coordination (LAC) alternatives to meet assessed need and social aspiration. Unless people can supported to meet their needs, services will continue to run in the Day Centres.

Discussions ensued regarding the recognised need to develop additional community assets and some personal service user accounts of the transition to LAC services.

Physical Disability Strategy
An outline of the strategy was given, advising how all partners aim to provide support for people with a physical disability or long-term condition to contribute, live and thrive in the Scottish Borders. It has been developed following a review of national and local strategies for people with a physical disability or long-term condition. A consultation on the draft strategy was carried out making full use of all standard Scottish Borders Council and NHS Borders communication channels to deliver key messages and encourage engagement.

Members were assured that individuals with lived experience of disability within the organisation had been consulted upon, as this was the essence of the approach when developing the strategy with the assistance of Ability Borders.

Quarterly Performance Report
The report was presented to members, which detailed several positive messages on trends against local and national targets.

The readmission rate indicator was again highlighted as a negative trend, however current data suggested it has declined. The sustainability of the change will be monitored.

Members agreed that better social care measures should be developed.

Concerns were raised over the inaccuracy of Carer's data, which was not a true reflection of current experience. Follow up meetings would be arranged to address this.

Older People's Pathway/Commissioning Strategy

A presentation was given on the proposed Strategic Implementation Plan which would be presented to the IJB in September, for comment and approval of the direction of travel.

Discussions ensued among members regarding the future workplan of the IJB in light of the proposal, of which everyone was supportive.

A clear communications plan was agreed to be developed, to engage with both public and staff members.

The importance of early intervention and prevention for patients was stressed, which will be picked up via the Primary Care Improvement Plan.

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