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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, 17th February, 2021** at **10.00 am** in MS Teams

AGENDA

Time	No		Lead	Paper
	1	**ANNOUNCEMENTS AND APOLOGIES**		
	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.*		
	3	**MINUTES OF PREVIOUS MEETING** 3. Minute of previous meeting 16.12 2020 (copy attached)		(Pages 3 - 10)
	4	**MATTERS ARISING** 4. IJB Action Tracker 16.12.20 (copy attached)		(Pages 11 - 14)
	5	**FOR DECISION**		
	5.1	Strategic Planning Group revised Terms of Reference Appendix 2021-1 SPG ToR cover (copy attached) Appendix 2021-1 SPG ToR final (copy attached)		(Pages 15 - 20)
	5.2	Health & Social Care Partnership Strategic Commissioning Plan Appendix 2021-2 Strategic Commissioning Plan update (copy attached)		(Pages 21 - 24)
	6	**FOR NOTING**		

6.1	Monitoring and Forecast of the Health & Social Care Partnership Budget 2020/21 at 31 December 2020 Appendix 2021-3 App 1 IJB Monitoring MO9 (copy attached) Appendix 2021-3 Budget Monitoring Report (copy attached)	(Pages 25 - 34)
6.2	Formative Evaluation of the Discharge Programme Appendix 2021-4 Discharge Prog Formative Evaluation Report (copy attached) Appendix 2021-4 Discharge Programme Evaluation Cover (copy attached) Discharge Programme Evaluation 2020 powerpoint (copy attached)	(Pages 35 - 102)
6.3	Independent Review of Adult Social Care in Scotland Report https://www.gov.scot/groups/independent-review-of-adult-social-care/	
6.4	Shared Lives Update Appendix 2021-5 attach sharedlivesborderfinal (copy attached) Appendix 2021-5 Shared Lives update cover (copy attached)	(Pages 103 - 110)
6.5	Strategic Planning Group Minutes Appendix 2021-6 SPG Minutes 4.11.2020 (copy attached) Appendix 2021-6 SPG Minutes cover (copy attached)	(Pages 111 - 120)
6.6	Category 1 Responder Appendix 2021-7 Category 1 Responder attach (copy attached) Appendix 2021-7 Category 1 Responder cover (copy attached)	(Pages 121 - 124)
7	**ANY OTHER BUSINESS**	
8	**DATE AND TIME OF NEXT MEETING** Wednesday 21 April 2021 10am to 12pm Microsoft Teams	

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 16 December 2020** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr J Greenwell
(v) Cllr S Haslam
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Ms S Lam, Non Executive
(v) Mr M Dickson, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mr T Taylor, Non Executive
Mr R McCulloch-Graham, Chief Officer
Mr D Bell, Staff Officer SBC
Dr K Buchan, GP
Mrs J Smith, Borders Care Voice
Mr K Allan, Associate Director of Public Health
Mrs N Berry, Director of Nursing, Midwifery & Operations

In Attendance:

Miss I Bishop, Board Secretary
Mr D Robertson, Chief Financial Officer SBC
Mr A Bone, Director of Finance NHS
Ms J Holland, Chief Operating Officer SBCares
Mr N Istephan, Chief Executive Eildon Housing
Mrs J Stacey, Internal Auditor
Ms S Bell, Communications Manager SBC
Mrs L Lang, Communications Officer NHS
Mr G McMurdo, Programme Manager SBC
Ms G Russell, Medical Labs Assistant, NHS
Mr C McClelland, Audit Scotland
Ms L Prebble, PA to Chief Officer
Mr P Lunts, General Manager NHS
Ms S Pratt, Strategic Lead PCIP
Ms F Doig, Strategic Lead ADP
Mr A McGillivray (Press)

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Dr Lynn McCallum, Medical Director, Mrs Morag Low, User Rep, Ms Lynn Gallacher, Borders Carers Centre, Ms Linda Jackson, Borders Carers Centre, Mr Ralph Roberts, Chief Executive NHS Borders, Dr Tim Patterson, Joint Director of Public Health and Mr S Easingwood, Chief Social Work and Public Protection Officer.

Mr Keith Allan deputised for Dr Tim Patterson.

The Chair confirmed the meeting was quorate.

The Chair welcomed guest speakers and members of the press to the meeting.

2. DECLARATIONS OF INTEREST

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the Extra Ordinary meeting of the Health & Social Care Integration Joint Board held on 21 October 2020 were approved.

4. MATTERS ARISING

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

5. IJB BUSINESS PLAN AND MEETING CYCLE 2021

Miss Iris Bishop provided an overview of the content of the paper.

Discussion focused on the business plan and the elements of budget planning and self-assessment.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the business plan and meeting cycle for 2021.

6. REPRESENTATION ON THE IJB

Mr Rob McCulloch-Graham provided a brief overview of the content of the paper.

Mr Tris Taylor sought clarification if the appointment was for the group or the individual. Mr McCulloch-Graham confirmed that it was to appoint a representative from the LGBT Plus (Lesbian, Gay, Bisexual, Transgender) sector for an initial period of 1 year.

Ms Sonya Lam sought clarification on the term “all” when referred to as “all groups” on page 13. Mr McCulloch-Graham advised that the intention was to hear the views from all groups via those appointed to the Board whilst maintaining a manageable membership size.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the appointment of Linda Jackson as a non-voting member of the Integration Joint Board of Scottish Borders.

7. SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP COMMISSIONING AND STRATEGY FUNCTION

Mr Rob McCulloch-Graham provided an overview of the content of the paper. He recognised that whilst it was a management decision, he was keen to share the paper with the Board to provide assurance that the shift in structure, by increasing capacity and leadership, would

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assist the Board to direct the £200m plus budget with sufficient information to enable it to make informed high level decisions and issue directions.

Mrs Karen Hamilton enquired if the appointment of Ms Jen Holland as the Integration Joint Board (IJB) Acting Chief Financial Officer (CFO) was a formal appointment. Mr McCulloch-Graham advised that it had been agreed by both SBC's Corporate Management Team and NHS Borders' Board Executive Team.

Cllr Shona Haslam commented that she was supportive of the direction of travel as the new structure should drive forward the IJB to achieve its purpose. She suggested the team should be co-located onto a single site to enable positive joint working, when office based working was available.

Further discussion focused on: appointment to vacant positions and expansion of functions; the changes would be contained within the existing budget and in future would be funded through the joint financial budget; split in roles for Chief Social Work Officer and Adult Social Care; Chief Operating Officer role and Chief Financial Officer role potential conflict of interest; and return on investment in the new structure seen through outcomes in terms of scale of change and redirection of the budget.

Mr Nile Istephan commented that he was supportive of the strengthening of the commissioning role and noted the interesting points made in regard to measuring success. He suggested there was a balance to the proposals given the costs of not doing anything compared to the costs of current arrangements and highlighted that often the relationship between commissioning, procurement and contracts could be challenging. He enquired how that commissioning, procurement and contracts process would be smoothed as much as possible moving forward.

Mr McCulloch-Graham commented that workstreams would be developed which would improve the partnership working of the existing joint groups and provide more capacity.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** supported the changes in reporting lines within the senior management team, outlined within the paper, to strengthen the "Strategic Commissioning" function of the Integration Joint Board.

8. PROPOSED EVALUATION PROCESS

Mr Philip Lunts provided an informative presentation on a proposed evaluation process.

Cllr Shona Haslam commented that she was content with the presentation and sought assurance the baseline data would be in place in terms of what was happening before the projects came into place. She also commented that patient impact should be at the centre of the strategy.

Mr Tris Taylor welcomed the theory of change and programme evaluation as a whole approach. He commented that non financial benefits should be included from the start.

Mr Taylor further enquired if the logic of the baseline argument was clear in evaluating the successive and not just the end project or programme. He was keen the evaluation should

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offer a real improved set of management information by extrapolation. Assurance information on delayed discharges could then lead to the beginnings of a model setting out the contributing factors to delays and modification of inter-dependencies. He was keen to build on the evaluation to get to that kind of model which could potentially help support decision making for managers.

Mr Lunts commented that there was an implicit and explicit theory of what the project had been set up for. It had been set up retrospectively and not as a programme and the question remained was it justified for the assumption in the first place and that was what it would be assessed against. For delayed discharges the evaluation would flush out the project areas, those that were not being addressed, the impact on the client of areas addressed and not addressed, and identification of service gaps and how to get a whole service approach.

Mr Lunts commented that as far as possible he was keen to have qualitative information on the impact on individuals as well as the financial and service implications, however the constraint to that aim was time.

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

9. SCENE SETTING - IJB FINANCIAL PLAN APPROACH AND TIMETABLE, PROGRESS FROM LAST YEAR.

Mr David Robertson advised that development of the revenue budget for 2021/22 had commenced. The Local Government settlement had been delayed and was expected towards the end of January 2021. He further advised that opportunities for savings were being jointly assessed as well as areas of pressure such as pay awards, price inflation, demographic growth and pressures through the COVID-19 pandemic. He assured the Board that a paper would be presented to them in due course on the joint financial assumptions of the budget, pressures, savings opportunities for 2021/22 and how to bring the partnership back into financial balance.

Mr Andrew Bone commented that NHS Borders was also awaiting its financial allocation and would normally prepare a 3 year budget however, it was required to prepare a 1 year budget and the COVID-19 pandemic costs and assumptions would be a substantial element of uncertainty within the budget. He assured the Board that he and Mr Robertson would continue to work closely together on the partnership budget.

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

10. MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2020/21 AT 30 SEPTEMBER 2020

Mr Andrew Bone presented the finance monitoring report to the end of September and highlighted the forecast positions for NHS Borders and SBC as well as COVID-19 costs. He also drew the attention of the Board to paragraph 3.12 and the actions to be progressed.

Cllr Shona Haslam enquired if the NHS budget position would have achieved its savings targets if COVID-19 had not happened. Mr Bone commented that the NHS financial plan had identified from the start a total health savings requirement across the system of £18m.

However it had only identified £11m of deliverable savings. A discussion had therefore taken place with the Scottish Government and a brokerage requirement of £8m had been agreed. Due to COVID-19 savings schemes had slipped in the current financial year, however he was confident progress on savings would be made in future years.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast adverse variance of (£5.525m) for the Partnership for the year to 31 March 2021 based on available information

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast position now includes Scottish Government funding allocations representing the IJB's share of a £50m tranche of funding to support immediate challenges in the Social Care sector and the first tranche of funding allocated to Health Boards from the national resource envelope of £1.1bn. Further funding allocations from the Scottish Government have been assumed in respect of the additional costs incurred responding to the Covid-19 situation for the remainder of the year, noting potential shortfalls of £1.720m in delegated functions and £0.29m in large hospital functions retained. No funding has been assumed currently however to mitigate the impact on the Partnership's ability to deliver agreed Financial Plan savings

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the position includes additional funding vired to the Health and Social Care Partnership during the first quarter by Scottish Borders Council of £3.164m to meet previously reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services. It also includes other miscellaneous budget adjustments across delegated and set-aside functions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that any expenditure in excess of the delegated budgets in 2020/21 will require to be funded by additional contributions from the partners in line with the approved Scheme of Integration

11. QUARTERLY PERFORMANCE REPORT, NOVEMBER 2020

Mr Graeme McMurdo provided an indepth overview of the content of the report and highlighted several elements including: emergency hospital admissions; percentage of budget spent on emergency hospital stays; older people receiving a package of homecare of less than 10 hours and those whose long term care needs had decreased; emergency admission occupied bed days; bed days associated with delayed discharges; patient satisfaction rates; discharges to permanent residential care beds without an opportunity for short term recovery; emergency readmissions within 28 days of discharge; end of life care; carer support plans; and people who required long term care after a period of short term reablement/rehabilitation.

Mr Malcolm Dickson welcomed the report and noted there would be caveats on performance due to COVID-19. He sought clarification that the occupied bed days for emergency admissions in the over 75s age group had been reducing prior to COVID-19, given there was a wealth of baseline data for that performance indicator. Mr McMurdo confirmed that had been the case and also commented that there was a wealth of baseline data available on a monthly, quarterly and yearly basis which would support Mr Lunts' evaluation process as described earlier in the meeting.

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Mrs Karen Hamilton enquired if there were any findings from the audit report into delayed discharges that should be incorporated into the performance report. Mr McMurdo commented that he would be reflecting on the audit report and would probably evolve the performance report further.

Mrs Nicky Berry updated the Board in regard to the emergency access standard performance and spoke of the challenges in the Emergency Department due to its size and how patients were to be handled given COVID-19 requirements such as testing and PPE. She further highlighted the progress made with delayed discharges, the introduction of the Borders minor injury unit, direct access to ambulatory care, that more patients would be assessed in their own homes, the expansion of the Home First service and ensuring AHPs were available to support patients to complete their reablement.

Mr Tris Taylor enquired about the purpose of the report and in the context of COVID-19 what the relevant and reliable indicators were that should be focused on. He was aware that some data was 6 months old and enquired how the Board might support the right range of indicators and data to be presented. Mr McMurdo commented that the report was based on where things could be measured and where data could be compared nationally, however national data had to undertake a validation process that was often lengthy. The purpose of the report was to provide information to the Board on where performance was good and where it required attention so that the Board could make informed collective decisions. He suggested he reflect on how much local data was used and if the addition of national data was helpful.

Mrs Jenny Smith commented that she was surprised at the positive trend in outcomes for carers given the conversations she was aware of with groups of carers and carers centre staff in terms of the extra pressures on unpaid carers. She was keen to ensure the carers indicators were as accurate as possible.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that Cllr David Parker, Rob McCulloch-Graham and Graeme McMurdo would discuss the format of the performance report outwith the meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and approved any changes made to performance reporting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the key challenges highlighted.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed actions to address the challenges and to mitigate risk.

12. BORDERS PRIMARY CARE IMPROVEMENT PLAN - UPDATE REPORT AND NEXT STEPS

Dr Kevin Buchan GP and Ms Sandra Pratt provided an update on the Primary Care Improvement Plan.

Mr Malcolm Dickson congratulated Dr Buchan and Ms Pratt on the progress that had been made. Dr Buchan commented that there had been improved communications and joint working which had achieved the progress made.

Mr Tris Taylor welcomed the progress made and commented that the Health Inequalities Impact Analysis (HIIA) appeared to fall short of its function. Ms Pratt commented that the HIIA was out of date, as it had been completed prior to the 70 wte posts being identified. She advised that she would revisit it and she was confident that the work of the new service would be accessible to all whatever their characteristics. She further commented that she would welcome the input of Mr Taylor to the revisit of the HIIA.

Dr Buchan commented that the culture and willingness of the IJB to allow the PCIP to develop and flourish had a direct impact on the progress made.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress of PCIP to date and supported the proposal to establish on-going governance once services are mainstreamed.

13. ALCOHOL & DRUGS PARTNERSHIP ANNUAL REPORT

Ms Fiona Doig provided an overview of the content of the ADP Annual Report and highlighted: substance use education; reducing barriers to treatment; and support to children impacted by parental substance use. Ms Doig also updated the Board on the drug death data that had been published the previous day.

Mr Tris Taylor commented that at the IJB held in October 2018 the Board had approved in principle investment into the service and had requested an update report on that. He further enquired in regard to lived/living experience, if the position was to employ from that group what was the positive approach taken, what was the proportion of applications received and what specific data showed progress on it.

Ms Doig commented that the service was small and staff may not have wished to disclose their lived/living experience. She did however provide assurance to the Board that it was normal practice. In terms of proportion of applications, as commissioners of the services ADP Support Team was not involved in recruitment processes.

Cllr John Greenwell commented that as the Convener of the Licensing Board he had been keen to reduce the number of occasions where licences were issued where children were involved, in order to protect them from harm. He was disappointed not to see a substantial reduction in children affected by drugs and alcohol. He enquired if there was an understanding of which was more prevalent, drugs or alcohol.

Ms Doig commented that based on low risk guidelines alcohol was more prevalent with a quarter of adults breaching low risk alcohol guidelines. In regards to drug use it was harder to receive data as drugs were an illicit substance. There was however a study on estimating usage of certain drugs (opiates and benzodiazepines) which looked at 'proxy data' including, for example, social work and crime data. It was estimated that alcohol was the larger problem. Those who used drugs and had associated problems tended to be more visible to services.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Annual Report and Update.

14. ANY OTHER BUSINESS

No further items of business were raised.

15. DATE AND TIME OF NEXT MEETING

The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 17 February 2021, from 10am to 12noon, via Microsoft Teams.

Signature: ……
Chair

SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Scottish Borders Health and Social Care PARTNERSHIP

Meeting held 8 May 2019

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

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	7	Future development session to be led by service users and primary care leads in regard to long term conditions.	Rob McCulloch-Graham	TBA	In light of Covid-19, it was suggested that this session is delayed until safe to do so. **23.09.20 Update:** Mr Rob McCulloch-Graham commented that with the use of MS Teams he was hopeful that plans to address the action would be secured in the next 8-10 weeks. **16.12.20: Update:** The current pressures on staff teams responding to C19 continue to prevent progress on this action.	R

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2	7	Evaluation report of new Primary Care Mental Health Service, funded through PCIP.	Rob McCulloch-Graham Kevin Buchan	August 2021	**In Progress**	G

Agenda Item: Strategic Implementation Plan & Priorities

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
3	11	Undertake a review of the Scheme of Integration.	Rob McCulloch-Graham Iris Bishop	March 2021	**23.09.20 Update:** Mrs Karen Hamilton enquired if the timescale for Action 3 was for the review to have been completed by the end of March 20201. Mr McCulloch-Graham confirmed that it was. **09.10.20: Update:** An initial review of the scheme is currently being taken forward and a timeline for completion is being worked up. **16.12.20: Update:** We intend to undertake a number of development sessions/workshops with board members and other stakeholders regarding the review of the Strategic Commissioning Plan. This work will inform any required amendments to the scheme of integration. The date for changes to the scheme will need to be determined after the review of the plan.	G

Meeting held 16 December 2020

Agenda Item: Quarterly Performance Report, November 2020

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
4	11	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that Cllr David Parker, Rob McCulloch-Graham and Graeme McMurdo would discuss the format of the performance report outwith the meeting.	Rob McCulloch-Graham Graeme McMurdo	April 2021	**In Progress:** The content, the purpose and the effectiveness of the current performance reporting in enabling IJB to direct corrective action requires discussion. Meetings to be arranged.	A

KEY:	
R	Overdue / timescale TBA
A	<2 weeks to timescale
G	>2 weeks to timescale

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: *17 February 2021*

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
STRATEGIC PLANNING GROUP TERMS OF REFERENCE	
Purpose of Report:	To seek approval of the revised Terms of Reference for the Strategic Planning Group. The revised Terms of Reference were agreed by the Strategic Planning Group at their meeting held on 4 November 2020.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the revised Terms of Reference for the Strategic Planning Group.
Personnel:	N/A
Carers:	N/A
Equalities:	N/A
Financial:	N/A
Legal:	The Strategic Planning Group (SPG) acts as an advisory committee to the Integration Joint Board (IJB). The role of the SPG is to identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan and against the agreed national outcomes. The group provides a forum for initial consultation and community engagement.
Risk Implications:	N/A

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Strategic Planning Group

Terms of Reference

Scottish Borders
Health and Social Care
PARTNERSHIP

BACKGROUND

The Integration of Health and Social Care is the Scottish Government's ambitious programme of reform to improve services for people who use health and social care services. Underpinned by the Public Bodies (Joint Working) (Scotland) Act 2014, it aims to ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.

Integration will see NHS Borders, Scottish Borders Council and the Third and Independent sectors work together to deliver services which focus around the needs of the person, their Carers and family members. The key aims of integration are:

- To improve the quality and consistency of services for patients, carers, service users and their families;
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so;
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

ROLE & REMIT

The Strategic Planning Group (SPG) acts as an advisory committee to the Integration Joint Board (IJB). The role of the SPG is to identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan and against the agreed national outcomes. The group provides a forum for initial consultation and community engagement. Members will be expected to contribute to the group agenda and:

- Act in an advisory capacity to the IJB;
- Represent their sector or professional area;
- Comment on and contribute to Partnership change programmes;
- Ensure the interests of the five localities are represented;
- Contribute to the ongoing development of the Strategic Plan.

MEMBERSHIP

The membership of the SPG is given in Appendix 1 and will be updated by the SPG administration lead when a change occurs. Should the group identify that other stakeholders or partners would add value then appropriate representatives will be invited to attend. Attendees are there to support the Strategic Planning Group.

Frequency of Meetings

Meetings will be aligned to Integration Joint Board meetings and are expected to take place on a quarterly basis, for 2 hours per meeting.

Quorum

No business shall be transacted at a Strategic Planning Group meeting unless there are present the Chair and at least 6 Members of the Strategic Planning Group.

Appendix 1 - Members and Contact Details of the Strategic Planning Group

Prescribed Group/Title	Role	Name & Deputy	Contact Information
Chair of SPG	Integration Joint Board (IJB) Member	Malcolm Dickson	Malcolm.Dickson@borders.scot.nhs.uk
Vice Chair SPG	Chief Officer for Health & Social Care	Robert McCulloch Graham	Robert.McCullochGraham@borders.scot.nhs.uk
Chief Financial Officer for IJB	Chief Financial Officer for IJB	Vacant	
GP	GP Sub-Committee Representative	Tim Young	Tim.Young@borders.scot.nhs.uk
User of Health Care	Representative from NHS Public Participation Network	Caroline Green	Caroline.Green@talk21.com
Chair of Scottish Care	Chair of Scottish Care	Jane Douglas	jane@queenshousehome.co.uk
Carers of Users of Health& Social Care	Manager, Borders Carers Centre	Lynn Gallacher Deputy: Linda Jackson	Lynn@borderscarers.co.uk Lindajack57@btinternet.com
Social Care Professional	Chief Social Work Officer	Stuart Easingwood Deputy: Gwyneth Lennox	SEasingwood@scotborders.gov.uk Gwyneth.Lennox@scotborders.gov.uk
Users of Social Care	Co-ordinator, Borders Voluntary Care Voice	Jenny Smith Deputy: Kathleen Travers	Jenny@borderscarevoice.org.uk Kathleen@borderscarevoice.org.uk
Statutory Housing Authority	Housing Strategy Manager	Gerry Begg Deputy: Donna Bogdanovic	GBegg@scotborders.gov.uk Donna.Bogdanovic@scotborders.gov.uk
Non-Commercial Social Housing Providers	Director of Housing and Care Services, Eildon Housing Association	Amanda Miller	AmandaM@eildon.org.uk
Third Sector Bodies whose activities relate to Health and Social Care	Executive Officer, The Bridge	Morag Walker	Morag.Walker@the-bridge.uk.net
Staff Representative, SBC	Staff Officer	David Bell	DABell@scotborders.gov.uk
Staff Representative, NHS Borders	Mental Health and Learning Disability Services Partnership Chair	Rotational representation	PartnershipCollective.Inbox@borders.scot.nhs.uk
Non-Commercial/Not for Profit Providers of Health Care	Marie Curie	Elizabeth Baines Deputy: Jessica English	Elizabeth.Baines@mariecurie.org.uk Jessica.English@mariecurie.org.uk
HSCP Leadership Team Representative	Chief Operating Officer for Adult Social Work & Social Care	Jen Holland	Jen.Holland@sbcares.co.uk
HSCP Leadership Team Representative	General Manager for Primary & Community Services	Chris Myers	Chris.Myers@borders.scot.nhs.uk
HSCP Leadership Team Representative	General Manager for Mental Health & Learning Disabilities	Simon Burt	Simon.Burt@borders.scot.nhs.uk
Business Change and Improvement, SBC	Programme Manager	Graeme McMurdo	GMcMurdo@scotborders.gov.uk
Community Council Network	Community Councillor	Colin McGrath	cflm@btinternet.com

In attendance

Dr Tim Patterson	Joint Director of Public Health	Tim.Patterson@borders.scot.nhs.uk
Stephanie Errington	Head of Performance and Planning, NHS Borders	Stephanie.Errington@borders.scot.nhs.uk

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Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 February 2021

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

HEALTH & SOCIAL CARE PARTNERSHIP
STRATEGIC COMMISSIONING PLAN

Purpose of Report:	The Health & Social Care Partnership Integration Strategic Commissioning Plan 2018-2021 is due for update and refresh by 1st April 2021. The purpose of this report to IJB is to seek approval for delaying the creation of the new Strategic Commissioning Plan by 12 months, for reasons including: 1) To enable the HSCP to undertake the appropriate level of consultation and engagement on the new plan, ideally once Covid-restrictions are relaxed. 2) To incorporate any findings from the Scottish Government's Independent Review of Adult Social Care. 3) To allow time for the recommendations of the Independent Review of Adult Care in Scotland to be implemented in addition to identifying capacity to develop an effective and accurate new strategic commissioning plan.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** a 12-month delay in the update and refresh of the Scottish Borders HSCP Integration Strategic Commissioning Plan. b) **Agree** that work to update and refresh the plan uses the Health Improvement Scotland strategic planning: good practice framework as its basis.
Personnel:	N/A
Carers:	Consultation on an updated and refreshed plan is required with representatives from all key stakeholder groups. It is intended that this engagement is governed by the Strategic Planning Group (SPG)
Equalities:	An Integrated Impact Assessment will be carried out as part of the update/refresh
Financial:	The Strategic Commissioning Plan details the HSCP priorities and therefore will have financial implications
Legal:	Production of a strategic commissioning plan is a legislative requirement under the Public Bodies (Joint Working) (Scotland) Act 2014
Risk Implications:	N/A

1. Background

1.1 Each Integration Authority must produce a strategic commissioning plan setting out how it plans and deliver services for its area over the medium term, using the integrated budgets under its control. Stakeholders must be fully engaged in the preparation, publication and review of the strategic commissioning plan, in order to establish a meaningful co-productive approach, to enable the HSCP to deliver the national outcomes for health and wellbeing, and to achieve the core aims of integration.

1.2 Our plan is built around the three strategic objectives of:

- We will improve the health of the population and reduce the number of hospital admissions.
- We will improve the flow of patients into, through and out of hospital.
- 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.

1.3 The Scottish Borders plan is underpinned by the Strategic Implementation Plan (SIP), agreed by IJB in August 2020. The SIP is the vehicle to deliver the three objectives and contains 10 priority areas of work, with a number of these reflecting lessons-learned from the Covid-19 pandemic

Priority workstream	Description
Carer Support Services	The partnership has always recognised the essential work of carers, and even more so through the Covid-19 pandemic. It is a precarious resource that requires support.
Locality Operations	Early intervention, prevention, shared client cohorts, agile responses, close coordination of effort, all reducing admissions and avoiding or slowing progression to higher levels of care and health needs. *(Prof. John Bolton Older People's Pathway 0)*
Older People's Pathway	Patient flow, including; Older Persons Assessment Area (admission avoidance), quicker discharge processes, Trusted Assessor models, new intermediate care and reablement services *(Prof. John Bolton Older People's Pathway 1,2 and 3)*
Technology	Technology support across health and care provision, workforce enablement, administration, processes and the sharing of information across the partnership.
Primary Care Improvement Plan	Supporting the introduction of the new GMS contract, and the development of community health services.
Mental Health Provision	For adults and children, including the Dementia Care Strategy and Autism Strategy
Learning & Physical Disability Provision	To support the recovery from the pandemic and "re-imagine" the service provision for both Learning Disability and Mental Health Cohorts
Joint Capital Planning	Including Primary Care capital strategy, new intermediate care and care provision and overarching joint Capital Plan for the Borders Public Sector.
Commissioning of Services	Reviewing, planning and contracting
Workforce support and provision	New skills, new operations, new equipment and processes

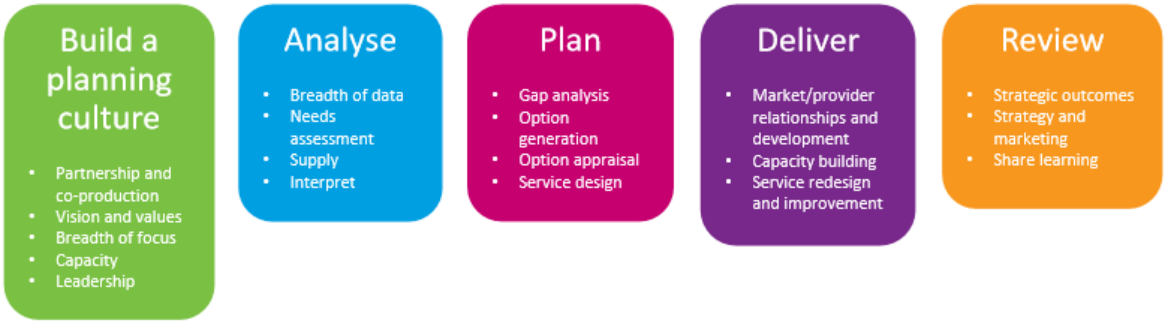
1.4 Our Strategic Commissioning Plan, agreed by IJB in May 2018, covers the period to 31st March 2021 and is therefore due for update, refresh, renewal and subsequent publication by 1st April 2021. A number of other Partnership's plans are also due to end on 31st March 2021 – including East, North & South Ayrshire, Glasgow, East Renfrewshire and Dumfries & Galloway.

1.5 Two meetings have been held with reps from the Partnerships above and Government representatives to discuss the refresh of Strategic Plans. Rather than do a full refresh, the 'Ayrshires' are planning to produce an interim plan to cover the period to March 2022. This will be followed by a more comprehensive review and update from 2022.

1.6 For the Scottish Borders HSCP it is recommended that the duration of the current plan, due to end 31st March 2020, be extended by a period of 12-months. Reasons for this including:

- Our recently agreed SIP identifies a number of the Covid-19 lessons-learned and incorporates these into the priority areas of work.
- Our three strategic priorities continue to cover the main areas of focus of the HSCP.
- Undertaking the appropriate and necessary consultation and engagement on an updated, refreshed and renewed plan is currently problematic due to Covid-restrictions. It is also likely that people would like to take stock of where they are post-Covid, prior to entering into a strategic planning consultation.
- The Scottish Government's Independent Review of Adult Social Care will impact on a number of health and social care areas and may result in changes being required to strategic commissioning.

1.7 It is further recommended that the plan from 2022 onwards uses the Health Improvement Scotland strategic planning: good practice framework as its basis. The framework is outcomes focussed, moving away from traditional service-related planning. It is designed to encourage practical and constructive local conversations on strategic planning and is built around the 5 areas shown below:



2. Conclusion and Recommendation

2.1 The Health and Social Care provision in the Borders needs to change significantly within the next two years to meet both growing demand and the current short-fall in significant areas of provision. This requires a shift in the "balance of care". The IJB will therefore need sufficient insight, detail and clarity of policy to be able to make

determinations on strategy and investment, which are well informed, accurate and appropriate to need.

2.2 To support this, the December 2020 IJB meeting agreed that the priority strategic focus for the IJB should be on the commissioning of Health and Social Care Services. It therefore follows that to enable the Board to commission effectively, the strategic and commissioning capacity of the management team needs to be strengthened. The same IJB meeting supported managerial appointments to better support the strategic commissioning role of the Board and the Partnership. These agreements are being enacted now but will not be complete in time to develop a new Strategic Commissioning plan by 1st April 2021.

2.3 It is recommended that additional time is given to implement the required managerial appointments, and to undertake proper consultation with the public, partner agencies and staff teams. We anticipate that significant change will be required to a number of services and it is appropriate to provide the time and support to undertake the development work required. It is recommended therefore that the current strategy which was updated in the summer of 2020 remain in place, and that it is replaced with a new Strategic Commissioning Plan from April 2022.

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2020/21	At end of Month:	December

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	20,139	15,664	20,558	20,558	0
Joint Mental Health Service	18,144	14,256	19,367	19,312	55
Joint Alcohol and Drugs Service	390	295	392	392	0
Older People Service	9,025	2,726	9,116	9,116	0
SB Cares	16,170	12,791	16,766	16,766	0
Efficiency savings	(4,740)	0	(4,740)	(1,185)	(3,555)
Physical Disability Service	2,458	2,216	2,648	2,648	0
Prescribing	23,130	17,153	23,132	22,802	330
Generic Services	74,558	59,015	85,118	83,960	1,158
Net Additional Covid-19 Costs / Funding	0	0	3,370	1,358	2,012
Large Hospital Functions Set-Aside	23,630	19,364	26,351	26,351	0
Total	182,904	143,480	202,078	202,078	0

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions **2020/21** **At end of Month: December**

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	**16,399**	**12,743**	**17,114**	**17,114**	**0**	At the end of M09, £1.819m surplus is projected, following virement between delegated service areas. This is entirely attriubutable to additional Covid-19 funding allocations to social care, the balance of which is held corporately for further drawdown during the remainder of the year. Within Learning Disability Service, additional Covid-19 pressures relating to carers' support, increased provider support, increased volume and cost of care packages (transitions) and residential care packages are forecast. There is a small forecast surplus within Mental Health attributable to income in relation to a seconded post and reduced care package which has been vired to meet pressures across other functions. Before funding allocations, SB Cares is forecasting a range of pressures relating to Covid-19, including overtime, additional staffing, PPE and Community Equipment, partially offset by other miscellaneous underspends (staffing). Within Generic Services, forecast pressures relating to legal fees, additional staffing, additional carers support, staffing and care costs are partially offset by a range of underspends across service areas. Before funding allocations, Older People is projecting pressure attributable to Covid-19 including increased external care and nursing beds, additional sustainability payments offset by operational savings. At M09, undeliverable savings across social care functions is projected to be £1.312m .The forecast position within social care functions assumes that these undelivered savings will be funded by Scottish Government allocations.
Joint Mental Health Service	**2,164**	**1,601**	**2,318**	**2,318**	**0**	
Older People Service	**9,025**	**2,726**	**9,116**	**9,116**	**0**	
SB Cares	**16,170**	**12,791**	**16,766**	**16,766**	**0**	
Physical Disability Service	**2,458**	**2,216**	**2,648**	**2,648**	**0**	
Generic Services	**5,278**	**3,948**	**6,486**	**6,486**	**0**	
Total	**51,494**	**36,025**	**54,448**	**54,448**	**0**	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions **2020/21** **At end of Month: December**

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,740	2,921	3,444	3,444	0	At the end of Month 6 across delegated functions £3.700m of Covid-19 costs remain unfunded in terms of budget drawn down. Further funding will be drawn down in light of the imminent additional Scottish Government funding allocation in late 20/21 reducing the overall forecast outturn to breakeven. To date, £1.185m of planned savings have been delivered against Financial Plan targets. The opportunity costs of non-delivery of savings (£3.555m) as a result of Covid-19 has been nearly all offset by savings across core operational budgets during the first 9 months of the year as a result of a reduction in activity. These operational underspends relate in the main to savings within Pay costs attributable to a significant number of vacancies across service areas including Community Nursing and Hospitals (0.250m), AHP Services (£0.300m), Dental Services (Generic Services (£0.541m), Clinical Psychology (0.173m), Adult Mental Health (£0.198m) and CAMHS (£0.046m) in addition to a number of other areas including Borders Addiction Service and Nursing. This is partially offset by ongoing agency useage to cover Mental Health medical vacancies(£0.206m).
Joint Mental Health Service	15,980	12,655	17,049	16,994	55	
Joint Alcohol and Drugs Service	390	295	392	392	0	
Prescribing	23,130	17,153	23,132	22,802	330	
Efficiency savings	(4,740)	0	(4,740)	(1,185)	(3,555)	
Allocated Non Recurring Savings Projects					0	
Allocated Brokerage					0	
Generic Services						
Independent Contractors	29,530	25,841	33,923	33,923	0	
Community Hospitals	5,780	4,085	5,596	5,447	149	
Allied Health Professionals	6,320	4,524	6,652	6,302	350	
District Nursing	3,580	2,866	3,743	3,643	100	
PCIP	0	771	1,159	1,159	0	
Generic Other	24,070	16,980	27,559	27,000	559	
Unallocated Additional Costs of Covid-19				1,358	(1,358)	
Covid-19 Funding not yet allocated			3,370		3,370	
Total	107,780	88,091	121,279	121,279	0	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2020/21	At end of Month:	December

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,830	2,571	3,116	3,361	(245)	The set aside budget is projecting an adverse variance attributable to the non-delivery of savings (£0.981m). This is offset by a reduction in DME during the first 9 months of the financial year as a result of the pandemic whilst A&E has seen higher than budgeted costs in respect of unscheduled activity.
Medicine & Long-Term Conditions	15,660	12,299	16,313	16,481	(168)	
Medicine of the Elderly	6,230	4,494	7,045	6,618	427	Work continues to review planned savings although it is not anticipated that there will be further savings planned and delivered this year although planning has commenced with regard to 2021/22.
Efficiency savings	(1,090)	0	(1,090)	(109)	(981)	
Covid-19 Funding not yet allocated			967		967	Forecasts assume that Covid-19 funding will be allocated to Set-Aside functions from the wider allocation to NHS Borders before the end of the finanical year.
Total	23,630	19,364	26,351	26,351	0	

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 February 2021

Report By:	David Robertson, Chief Finance Officer SBC & Andrew Bone, Director of Finance, NHS Borders
Contact:	David Robertson, Chief Finance Officer SBC & Andrew Bone, Director of Finance, NHS Borders
Telephone:	01835 825012 / 01896 825555

MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2020/21 AT 31 DECEMBER 2020

Purpose of Report:	The purpose of this report is to update the IJB on the forecast year end position of the Health and Social Care Partnership (H&SCP) for 2020/21 based on available information to the 31 December 2020.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the projected breakeven position for the Partnership for the year to 31 March 2021 based on available information b) **Note** the forecast position now includes additional Scottish Government funding allocations for 2020/21 c) **Note** that the position includes additional funding vired to the Health and Social Care Partnership during the first 9 months by Scottish Borders Council in order to meet previously reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services d) **Note** that any adverse movement in projected outturn position between now and the end of the financial year resulting in expenditure in excess of delegated budgets in 2020/21 will require to be funded by additional contributions from the partners in line with the approved Scheme of Integration.
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 2020/21 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 draws on information provided in finance reports presented to NHS Borders and Scottish Borders Council. 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 The 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 available information presented to Scottish Borders Council and the Board of NHS Borders. It highlights the key areas of financial pressure at 31 December 2020, together with how a combination of additional funding from the Scottish Government combined with forecast under-spends on core operational services as a result of activity reductions during the Covid-19 pandemic has mitigated these.

Overview of Monitoring and Forecast Position at 31 December 2021

3.1 The paper presents the consolidated financial performance for the period to end of December 2020 (9 months). Although this position includes a forecast of the year end outturn and a balanced and breakeven position at 31 March 2021, members should note that forecasts will continue to be reviewed on an ongoing basis between now and the end of the financial year.

3.2 At the end of month 9, functions delegated to the partnership are forecasting a breakeven position as is the large hospital budget retained and set-aside. This represents a favourable movement from the position previously reported, primarily as a result of confirmation of further funding allocations by the Scottish Government in respect of the additional costs associated with Covid-19.

3.3 There are other minor movements relating to savings within core operational budgets as a result in the reduction in activity caused by Covid-19 during the first 9 months of the financial year. Overall therefore, whilst significant additional costs have been incurred in respect of Covid-19 mobilisation and remobilisation, it is now confirmed that these costs will be met from additional Scottish Government Covid-

19 funding allocations received during the financial year. There are considerable additional financial pressures relating to the non-delivery of planned financial efficiency savings, but across both delegated and non-delegated functions, it is again forecast that these will be offset by a combination of virement from non-delegated functions and forecast under-spends across core operational services as a result of a reduction in service activity since this start of the financial year.

Covid 19

3.4 Costs incurred in the first 9 months are in line with the expenditure reported to Scottish Government through the Health & Social Care Local Mobilisation Plan financial model. In turn this has informed a second tranche of the Scottish Government's allocation of core revenue funding to meet Covid-19 costs to be made to Health Boards and Health and Social Care Partnerships including specific funding in respect of GP practices, social care sustainability and winter planning and nursing director support.

3.5 At the 31 December 2020 therefore, the Scottish Borders Health and Social Care Partnership actual and forecast expenditure pertaining to Covid-19 initial mobilisation subsequent remobilisation is:

	Actual to 31 Dec 20 £m	Projected to 31 Mar 20 £m
Healthcare Functions	4.862	6.351
Social Care Functions	4.223	6.586
	9.085	12.937

The figures above include the projected costs of current plans for remobilisation and winter planning programmes. The figures in the table above also include actual and forecast opportunity cost of planned savings that have been assessed as being undeliverable in 2020/21 as a result of Covid-19 and lost income opportunities. The forecast costs to 31 March 2021 above have increased by £2.300m since the position previously reported in December. These relate primarily to social care in respect of additional provider costs and an increase in the level of undeliverable planned savings as a result of Covid-19.

Efficiency Savings

3.6 Forecasts include the estimated impact of non-delivery of savings plans. This position remains under review and the reported position reflects assumptions across Scottish Borders Council's Fit for 2024 and NHS Borders' Financial Turnaround Programmes.

	Targeted Savings per Financial Plan £m	Projected Savings to be Delivered £m	Savings to be Delivered By Alternative Means £m
Healthcare Functions	(4.740)	(1.850)	3.555
Set-Aside Functions	(1.090)	(0.109)	981
Social Care Functions	(2.482)	(1.170)	1.312
	(8.312)	(3.129)	(5.848)

Year End Forecast

Healthcare functions

3.7 Beyond the additional costs of Covid-19, including the non-delivery of planned savings on which the financial plan is predicated, operational functions are reporting a reduction in core activity over the first 9 months of the financial year that net of the additional costs of Covid-19, result in a favourable position at the end of month 9 of £1.543m. This is primarily attributable to savings in pay and supplies costs in Community Nursing (£0.100m), vacancies within Community Hospitals (£0.200m) offset by additional non-pay costs (£0.050m), current vacancies within Allied Health Professionals (£0.350m), a number of Other Services' pay and non-pay under-spends attributable to reduced activity such as Dental Services and Prescribing (£0.330m).

3.8 These partially offset forecast Undelivered Efficiency Savings of £3.555m. NHS Borders has also projected that - based on allocations now confirmed - £3.370m of funding requires allocation to delegated functions in order to meet forecast costs over the remainder of the financial year.

It should be noted that NHS Borders identified a requirement for £7.9m brokerage within its financial plan for 2020/21. The additional Covid19 allocation includes further support to non-delivery of savings and as such NHS Borders has now revised its brokerage request. At this stage it is no longer anticipated that there will be a brokerage requirement for 2020/21. There remains a recurrent shortfall against savings plans and NHS Borders will consider any future brokerage requirements as part of its financial plan for 2021/22. This will include consideration of any gap emerging against the NHS delegated functions within the scope of the Health & Social Care partnership.

Social Care functions

3.9 At 31 December 2020, Scottish Borders actual spend to date on social care functions, as stated in Appendix 1, was £36.025m. The Council position includes Scottish Government allocation of £3.608m which has been released to meet specific Social Care pressures. Further anticipated Covid-19 pressures are built into the 2020-21 outturn projection of £54.448m. It is assumed that these pressures and any further pressures which materialise before the 31st March 2021 will be funded through further Scottish Government funding. Operational pressures have arisen in some service areas, however it is anticipated that the service will meet these from existing budgets during the remainder of the year, enabling a breakeven position to be reported.

3.10 The Scottish Borders Council forecast at month 9 is based on detailed monthly monitoring during the first 9 months of the financial year to assess the financial implications of the Covid 19 pandemic on the IJB including increased costs, loss of income and the impact of delays in delivery of financial plan savings. This impact has been reported through the Health & Social Care LMP and has, similar to healthcare functions, been mitigated by off-setting cost reductions due to non-delivery of services as a result of Covid-19.

General

3.11 Forecasts therefore include allocations for Covid-19 funding by the Scottish Government. Work is currently ongoing in partnership between the two organisations to determine the exact impact of the latest schedule of allocations and assess how best it should be allocated. This includes additional support provided against non-delivery of savings.

3.12 Further reports will be brought to the Integration Joint Board through financial year end confirming a more certain outturn position as it becomes available. In the interim work also continues on ongoing review of core financial performance across functions, any further anticipated costs of Covid-19 remobilisation programmes, delivery of planned efficiencies and forecast IJB reserves positions. Close liaison with the Scottish Government during this time therefore is assured. This will focus on ongoing analysis and reporting of the Health and Social Care Partnership's (and wider NHS Borders' and Scottish Borders Council's) local mobilisation plan financial models and the review of all costs, expenditure profiles, future commitments and refinement of assumptions for projected expenditure to the end of the financial year.

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Formative Evaluation

Scottish Borders Discharge Programme

February 2021

Prepared by: Phillip Lunts, Strategic Planning Lead, NHS Borders

Appraised by: Anne Hendry, Director, Scottish hub of the International Foundation for Integrated Care

Exec Summary

This is an evaluation of the Scottish Borders Health and Social Care Partnership Discharge Programme. The Discharge Programme consists of 5 projects initiated individually over 4 years from 2017 and brought together as a single programme in 2019.

The projects within the Discharge Programme effectively provide an intermediate care (IC) service for the Scottish Borders: bed-based intermediate care (Waverley and Garden View), home-based intermediate care (Home First) and infrastructure for enabling rapid and seamless access (Strata and Matching Unit).

This evaluation has found the following;

Waverley Transitional Care Unit delivers against its objectives of rehabilitating older people to regain independence following hospital discharge. Time to access service averages 1.8 days. Home discharge rates are 79%. However, the service runs at 70% occupancy and does not admit older people with higher levels of need due to restrictions on length of stay and lack of nurse cover. This is an issue for residents of Central Borders, most likely to benefit due to lack of a community hospital in the locality.

Garden View Discharge to Assess offers a facility for older people to leave hospital whilst completing assessment for care or waiting for home care or 24-hour care. Time to access the service averages 3.6 days. Average length of stay and home discharge rates are comparable to benchmarks. Occupancy is 66%. The service does not offer full reablement due to lack of AHP cover and is unable to admit people with higher levels of dependency.

Both services have positive user feedback. Costs are higher than benchmark but would be comparable if occupancy was higher. Neither service offers step-up access from home.

Home First offers a home-based reablement service. 25% of people who use the service are step-up referrals to remain at home and 75% are referrals at discharge from hospital. Time to access the service averages 1 day. The service meets its objective of 80% remaining at home at the end of their Home First episode, with a 57% reduction in their requirement for home care (against 40% target). 57% are fully independent at the end of their Home First episode while those who need ongoing home care have 11% reduction in the level of care required. The high rate of discharge with no ongoing care suggests that people with more chronic care and support needs may not have been referred to the service.

Infrastructure. The Matching Unit has been mainstreamed into SBCares and arranges 180 care packages a month, a 10% increase since 2019, with average time to start of package of 5 days. Strata digital referral system is managing 800 referrals per month to care homes, intermediate care, third sector and Trusted Assessor, with Strata referrals to homecare soon to be launched.

This evaluation concludes that these services make a critical contribution to system performance but their efficiency could be improved by some adjustment of criteria and skill mix.
The evaluation therefore recommends:

- Home First should be the default and should better align with What Matters locality hubs and services to increase the balance of step up IC and enable closer working with local Housing providers and Third sector support

- Bed based IC should be streamlined as a single pathway for older people with post-acute reablement / rehab / nursing care needs that cannot be met by Home First, particularly for residents in Central Borders

- The service budget for these projects should now be mainstreamed to enable strategic commissioning, substantive recruitment and workforce development as part of a comprehensive framework for integrated intermediate care in each locality

Critical to delivering these actions is the need to mainstream the operation and funding of these services in order to progress the strategic developments outlined in the recommendations.

1. Background

We know that too many older people remain in hospital when they could be cared for more appropriately and achieve better outcomes in a more enabling setting. The Discharge Programme brings together five distinct projects commissioned and funded through the Integrated Care Fund to help address this continuing challenge.

Three projects increased local capacity for specific components of Intermediate Care:

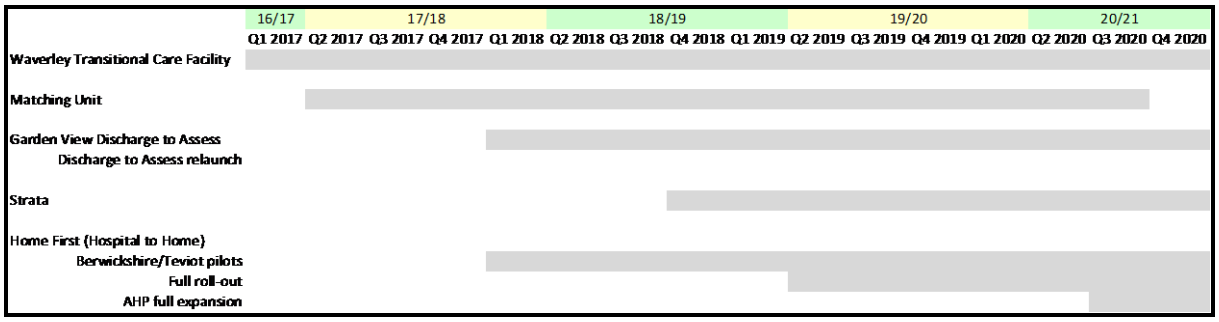
- Bed based Intermediate care in Waverley Transitional Care beds
- Step-down care in Garden View Discharge to Assess facility
- Reablement and crisis response at home in Hospital to Home, now known as Home First

Two projects provided enabling infrastructure to improve discharge processes and flow:

- The Matching Unit for effective allocation of home care support
- Strata electronic referral management system

These projects were established independently at different times since 2017 (figure 1). In recognition that there are significant interdependencies between the projects, they were brought together as a Discharge Programme in 2019, however potential synergies have yet to be fully realised. Further developments in the enabling infrastructure are expected to improve flow through a digitally enabled referral management system supported by an integrated discharge hub, a trusted assessment model and more efficient allocation by the Matching Unit and locality hubs.

Fig 1. Timeline for the 5 projects



This report reviews the progress of the projects to date and considers their individual and collective contribution to the strategic objectives set out in the Scottish Borders Health and Social Care Strategic Plan 2018-2021. It reflects on their limitations and identifies potential to enhance their effectiveness by adjusting the capacity, skill mix and alignment of services to further expand their reach and impact.

An important caveat is the lack of a common dataset for the projects which has limited the ability to compare data on case mix, experience and outcomes. Therefore, routinely collected health and social data have been used, where available, to review the progress of the projects. Although this is an internal evaluation conducted by NHS Borders, the analyses and conclusions have been critically appraised by Prof Anne Hendry, Director of the Scottish hub of the International Foundation for Integrated Care, to provide objectivity and insights from UK and international evidence and current practice in this field.

2. Why These Projects Matter

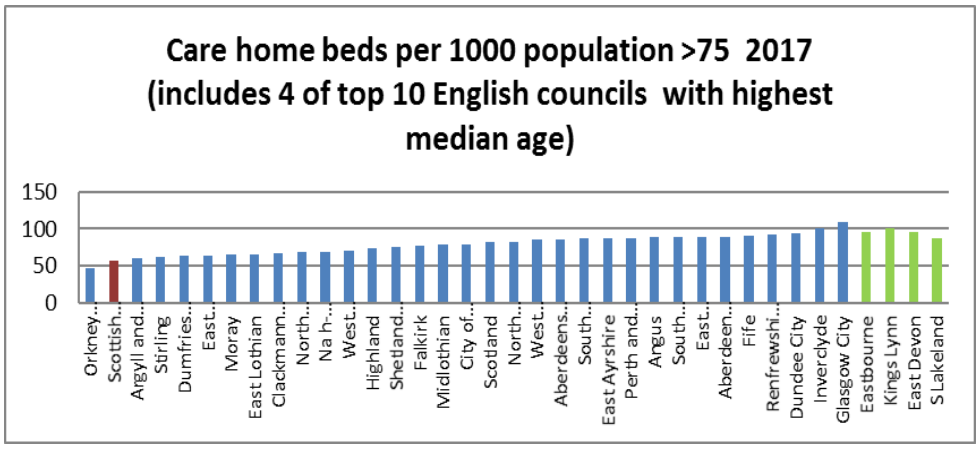
24% of the Scottish Borders population are age 65+, well above the Scottish average of 19% (2019 mid-year population estimates). Projections indicate the population aged 75+ will almost double by 2041 (Table 1). As they age, older people are more likely to live with frailty or long term conditions, associated with increased demand for acute and chronic care, rehabilitation and support.

Table 1 Population projections for Scottish Borders

Year	Age Grouping					Tot Pop
	<18	18-64	65-74	75-84	>85	
2016	21,507	65,780	15,451	8,633	3,159	114,530
2041	21,373	57,700	17,022	14,886	6,337	117,318
% change	-1%	-12%	10%	72%	101%	2%

Scottish Borders has a relatively high number of hospital beds (per 1,000 population) compared to other Scottish Health Boards. Figure 2 shows that the care home capacity is well below the national average, with only Orkney having a lower rate. This leads to delays in accessing long term care from the community and from hospital.

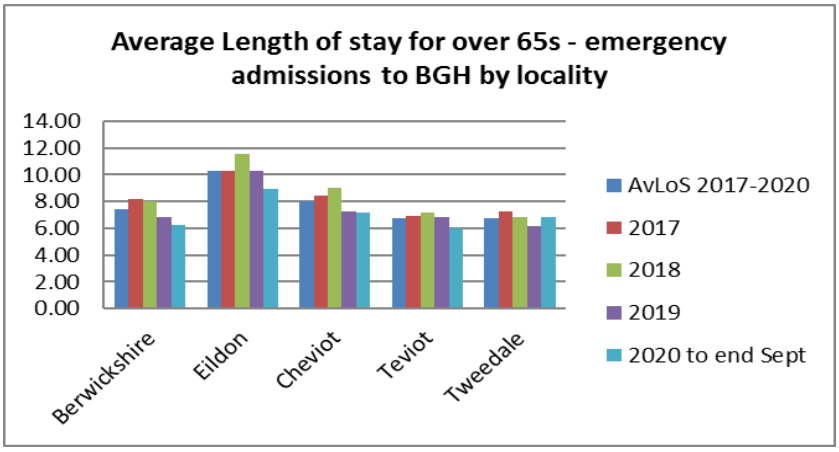
Fig 2. Care home provision by HSCP



Remaining in hospital longer than is necessary increases the risk of harms, particularly for older people who are already at greater risk from deconditioning, falls and hospital acquired infections. Achieving the best outcomes for older people and their carers requires timely discharge and support to recover in an enabling environment in order to regain independence. Delays in discharge following acute care serve to escalate dependency and further increase demand for long term support. This is the rationale for strategic investment in **intermediate care (1) :** a continuum of time limited integrated community services for assessment, treatment, rehabilitation and support for older people and adults with long term conditions at times of transition in their health and support needs.

Scottish Borders already has a bed based intermediate care capacity of 92 Community Hospital beds before commissioning of additional beds at Garden View and Waverley facilities. For a population of 115,510, the community hospital complement alone represents almost four times the average bed based intermediate care capacity reported in the 2018 National Audit of Intermediate Care in England **(2).** However, around a third of the Scottish Borders population live in Central Borders (Eildon locality) which lacks a community hospital. Central Borders residents have traditionally remained in the Borders General Hospital (BGH) for their post-acute care and rehabilitation. This results in a longer Length of Stay (LOS) at BGH for older people from the Eildon locality (Figure 3).

Fig. 3 Average LOS at BGH for over 65s by Locality



The continuing need for physical distancing and strict infection prevention processes in response to Coronavirus will impact on hospital capacity and configuration in the short to medium term. In their recent letter to Chief Executives **(3),** the Scottish Government restated the prime importance of actions to ensure people who are clinically ready for discharge experience minimum delay before being cared for in their own homes or other appropriate settings. The discharge projects were designed to augment intermediate care capacity, particularly but not exclusively for Central Borders, by introducing alternative pathways for supported discharge, reablement and crisis support at home or in community facilities.

But the context in which the five projects were implemented has radically changed. Coronavirus has heightened the need for rehabilitation and recovery for those affected by Covid-19 and by the response to the pandemic. Now more than ever we need dynamic and flexible community support and services that work with people and local communities. Therefore this review is a timely opportunity to reflect on what we have learned from the Discharge Programme and to consider the evidence and experience of reablement and intermediate care beyond our system in order to make the best use of our collective assets, skills and facilities.

The recently published report of the Independent Review of Adult Care in Scotland **(4),** recommends investment in models and approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. In the words of the independent review, this is a time to be bold and ambitious for the future.

3. What Works

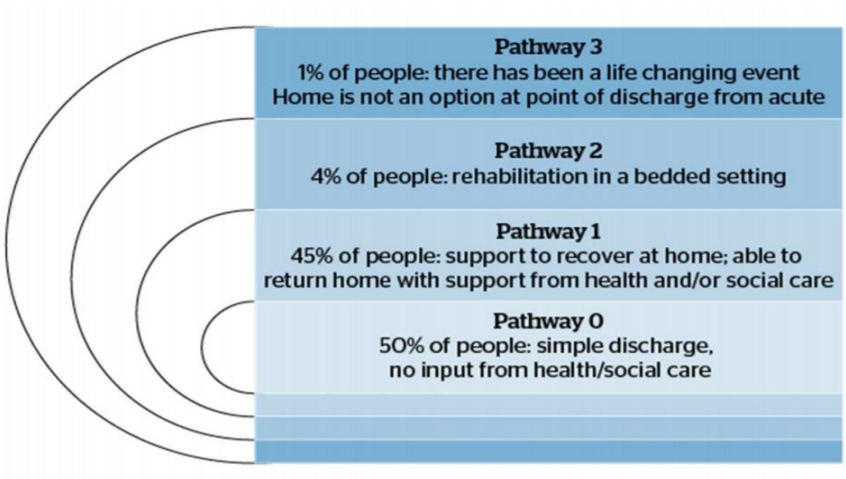
An international consensus study **(5)** agreed that Transitional care services are a subset of a broader continuum of **Intermediate Care**: a range of time-limited services that aim to ensure continuity and quality of care; promote recovery; restore independence and confidence; or prevent a decline in functional ability at the interface between hospital and home, care home, primary care and community services. The approach is based on holistic and person-centred care, the involvement of family and unpaid carers, support for self-management, and use of equipment and simple assistive living technologies to enable independence.

A scoping review of the evidence on Intermediate Care reports a range of positive outcomes **(6)**. Although several interventions reduced hospital utilisation and improved quality of life, impact on function, ED admissions, long-term care and costs critically depends on targeting the right cohort. NICE Guidance from 2017 **(7)** indicates these services particularly benefit people who have complex support needs or circumstances, are vulnerable to a decline in health status or functional ability or are at increased risk of (re)admissions to hospital or institutionalisation.

Services that offer reablement and rehabilitation at home demonstrate improvements in function and a reduction in the need for ongoing support **(8-10**). Therefore a Home First approach promotes Intermediate Care at home where safe and appropriate. However some people, particularly those who are most dependent, live alone or need alternative housing or major adaptations, may benefit from a period of bed based Intermediate Care to provide critical time and the right environment to restore their confidence and independence, and avoid premature long term care. Bed based Intermediate Care can be provided in dedicated capacity within a care home, housing with care, or community hospital setting. This may be as ***step up*** **(**admitted from home for assessment and rehabilitation) or ***step down*** (transfer from hospital).

These concepts are illustrated within the four **Discharge Pathways** developed by Prof John Bolton **(11)** and now widely adopted in the UK.

Fig 4. Discharge Pathways

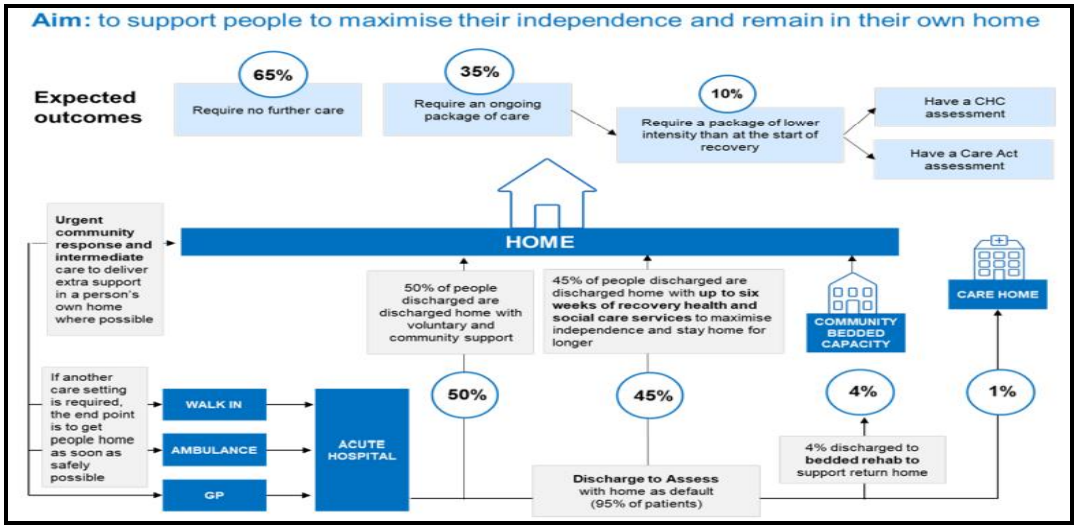


Pathways 1 and 2 are sometimes described as Discharge to Assess (D2A). The Local Government Association (LGA) and Association of Directors of Adult Social Care (ADASS) recommend that the

terms Discharge to Assess (D2A) should be rebranded as '**discharge to support recovery and then assess**' **(12).** They highlight that premature decision making may adversely impact on the balance of care if individuals are not given an opportunity to recover their independence in the right environment. Very few patients should be discharged from acute hospital to permanent residential care without an opportunity for short-term recovery through reablement at home or in bed – based intermediate care. Expert guidance and experience from the National Audit of Intermediate Care **(2)** suggests over **70%** of older people who received bed based intermediate care are able to return to their own homes within 6-8 weeks. As many as **65%** of those receiving reablement based domiciliary care may require no further on-going care and support within 6-8 weeks **(11)**.

Intermediate care is best delivered by an interdisciplinary team with a single point of contact to optimise service access, communication and coordination of care. Services should have sufficient capacity, expertise, clear governance arrangements, and support for team members to work collaboratively and to improve service quality and outcomes for people and care systems. However many intermediate care services have evolved from pilot projects established with time limited funding, often poorly integrated with other services. This makes the landscape increasingly complex to navigate resulting in duplication, inefficiencies and gaps. Effective intermediate care should be an integral part of the wider network of health and community care available in a locality. These principles are now embedded within NHS England's Hospital Discharge Service: Policy and Operating Model **(13)** as illustrated in figure 5.

Fig 5. Discharge Flow



Consolidation and further investment in intermediate care services is a key priority in NHS England's Long Term Plan through the Urgent Community Response element of the Ageing Well programme (14). This aims to achieve 2 hour standards for a crisis response at home and a 2 day standard for transitional care or supported discharge from hospital. Seven accelerator sites are creating the right capacity and infrastructure to optimise their reablement and intermediate care services. The Journal of Integrated Care will publish a special issue of case studies and research on this topic in 2021: https://www.emeraldgrouppublishing.com/journal/jica/intermediate-care-integrated-local-and-personal

4. Review of the Five Projects

4.1 Waverley Transitional Care Unit

16 designated beds within a 26 bed local authority residential care home in Galashiels were commissioned in 2017 to provide up to six weeks of transitional care for adults considered to have rehabilitation needs. The service is managed by SBC and includes support from:

- Care workers: 17 wte
- Occupational Therapy: 2 posts (1 x 18.75 hours per week and 1 x 18hrs)
- Physiotherapist: 30 Hours per week Mon – Thursday 8.30-4.30pm.

Aims

- Facilitate timely discharge from hospital for patients requiring further bed based rehabilitation to enable them to return home
- Remove the requirement to remain in an acute hospital when medically fit to transfer to a community facility, particularly but not exclusively for residents of Central Borders
- Provide rehabilitation support to enable clients to fully achieve their functional potential
- Reduce the demand for long term 24-hour care placements
- Improve staff satisfaction with the management of patients with rehabilitation needs

Referrals

Figure 6 shows source of referrals. All admissions were step down referrals from Borders General Hospital, principally from medical wards. Referrals from MAU are likely to reflect proactive input from the frailty at the front door team. There were few referrals from medicine for the elderly, orthopaedic or stroke wards. Referral to transfer time averaged 1.8 days.

Fig.6 Referral sources

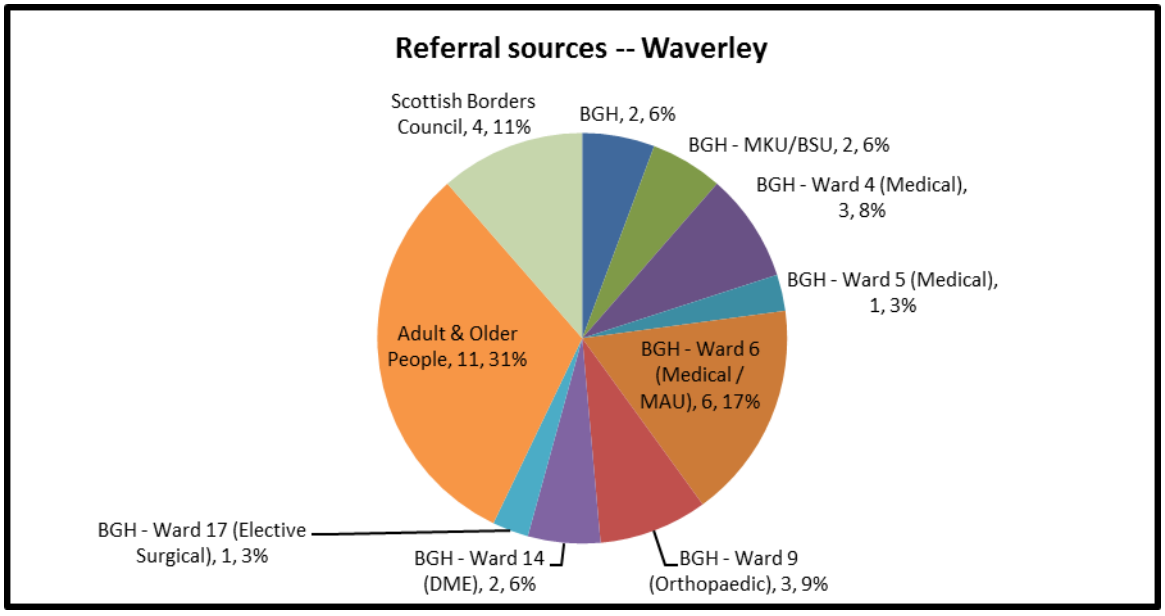
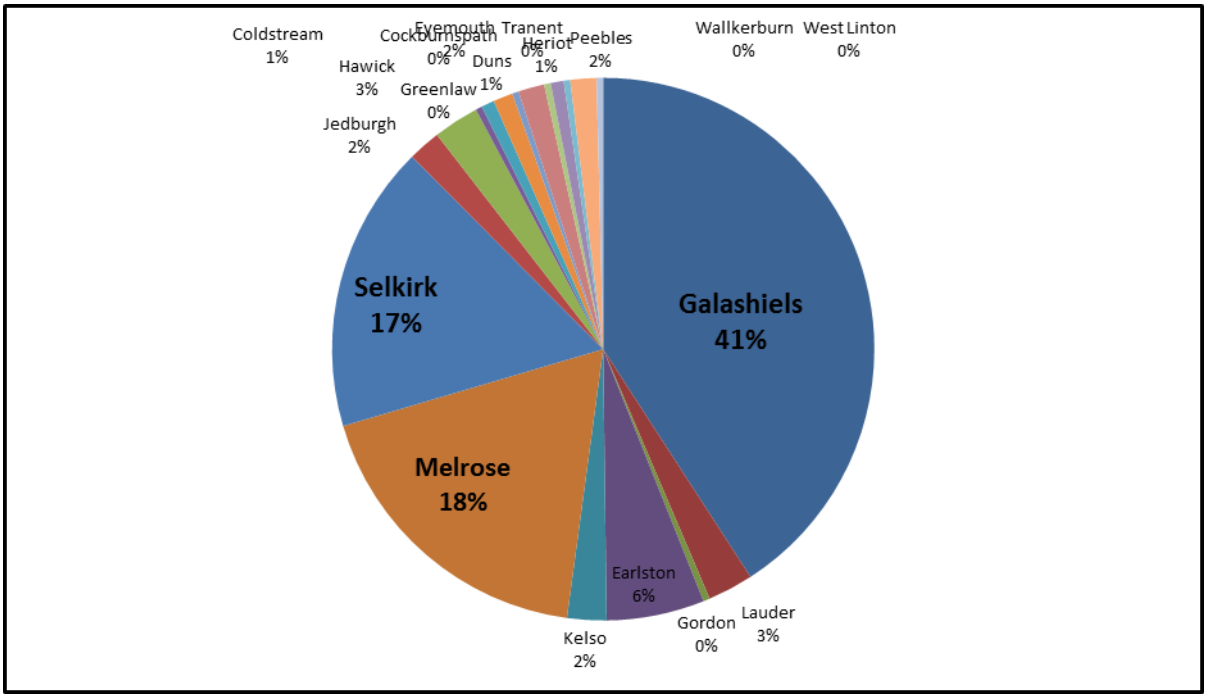


Figure 7 shows 85% of admissions to Waverley lived in Central Borders.

Fig 7. Place of residence of admissions



Casemix

71% of admissions were female. Average age was 84 years (range 51 – 105) with 3% < 65 years. The facility has no registered nursing staff and admission criteria state referrals should have ''no on-going nursing care needs except those ordinarily met by a District Nurse team. '' They should be ''able to mobilise with assistance from equipment and/or a maximum of two staff.'' Therefore the casemix is not comparable to community hospitals as admissions have only mild to moderate dependency:

- 94% had mobility issues or used a mobility aid
- 70% required help for washing and showering
- 35% were incontinent of urine or faeces
- 33% had visual impairment
- 20% had cognitive impairment
- 8% had another mental health illness

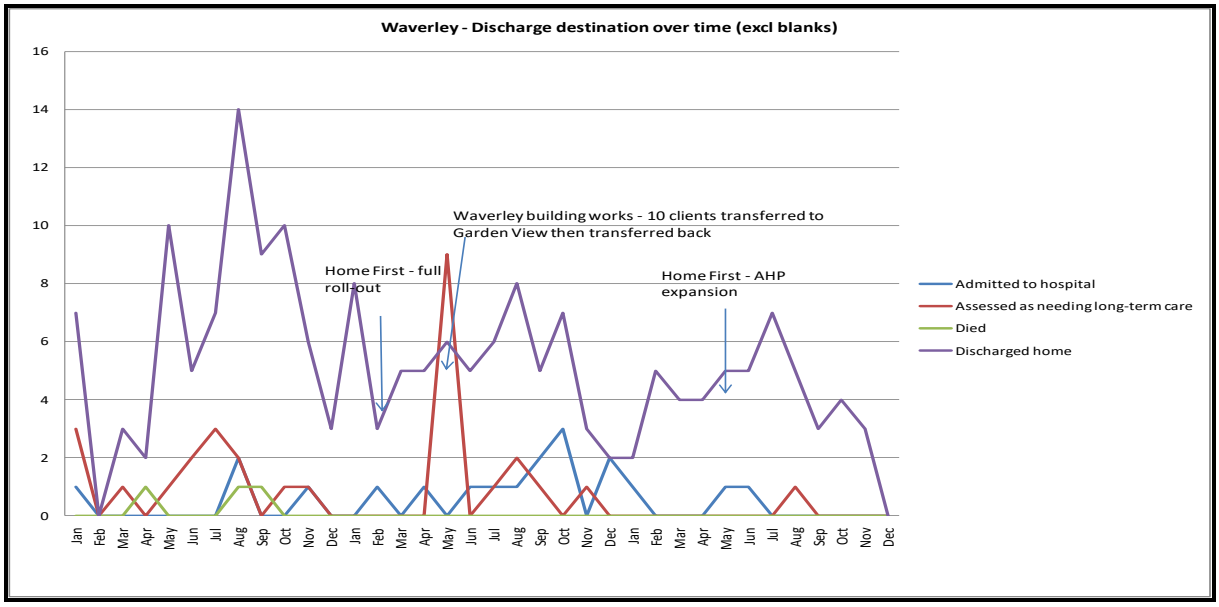
The low levels of cognitive impairment suggests a presumption that those with cognitive impairment have limited potential for rehabilitation, explicit in the admission criteria ''able to understand and be motivated to engage with their rehabilitation plan'' and ''Must be able to engage in a prescribed Programme of Rehabilitation.'' However, this is not an exact science and a significant proportion of people with dementia or recovering from an episode of delirium may be missing a vital opportunity for step down rehabilitation in a more enabling environment. Similarly, the admission criteria ''Able to achieve identified rehabilitation goals within 6 weeks'' may limit inclusion of such patients as well as some older people with neurological disability who may require a longer period of recovery and specialist supervision of therapists who may not

have neurorehabilitation expertise. This criteria may reflect financial rather than functional considerations as charges may apply beyond six weeks.

Outcomes

Overall, 79% of people admitted to the transitional care unit were discharged home. Figure 8 shows numbers being discharged home per month have reduced over time suggesting referrals with lower dependency requiring short term reablement are now more appropriately directed to Home First.

Fig. 8 Trends in discharge destination



Records show few adverse incidents (34 recorded Jan – Dec 2020) and only three deaths. The rate of readmissions to hospital was 6%, comparing favourably with 28 day readmission rates for discharges from BGH (10% for all wards and 19% from geriatric medical wards).

Experience of care

No routine survey of services users experience was available.

The unit has received 22 written compliments and no formal complaints in the past year.

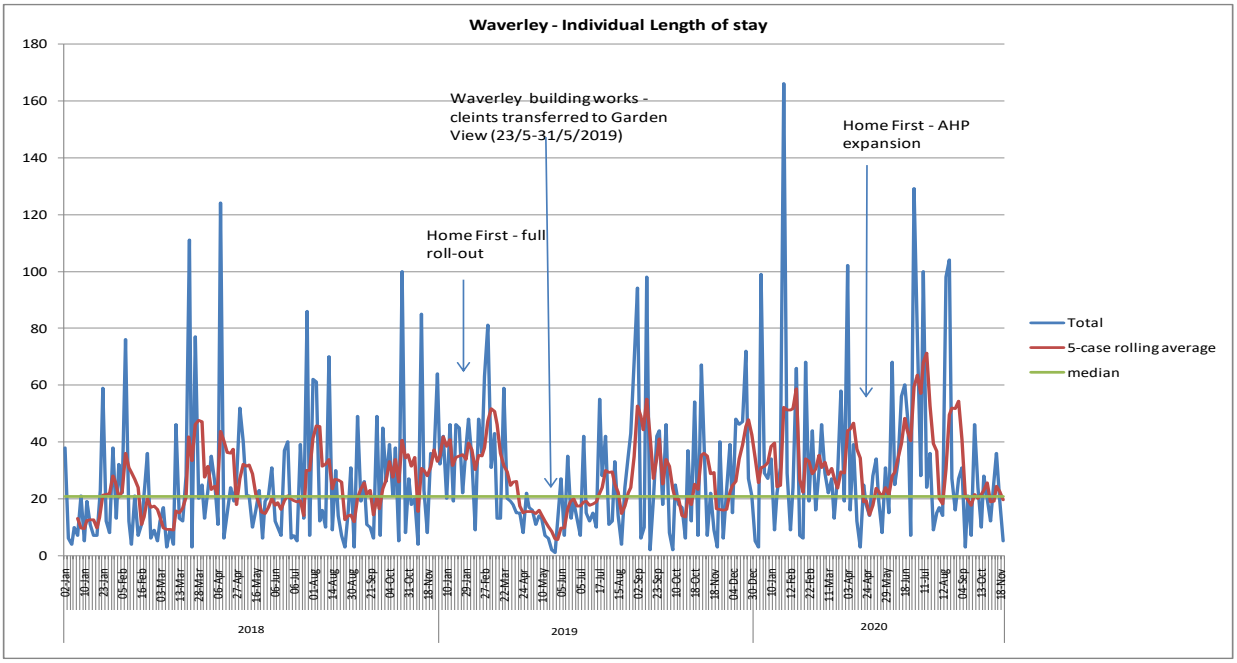
In the latest inspection report by the Care Inspectorate (October 2019), the four residents surveyed felt safe, accepted, treated kindly and satisfied with their care. The six relatives interviewed felt Waverley staff were fair, kind and treated their relatives with dignity. They suggested there could be more activities and more time to communicate any changes in condition or medications.

Throughput

Anticipated throughput per annum was 132 assuming an average LOS of 42 days and 95% occupancy for the 16 beds. The unit achieved an average annual throughput of 124 and a median 10 admissions per month.

Figure 9 shows the LOS for each admission over time. Overall, average LOS was 31 days (median 26 days, range 1-129 days). Average LOS for those discharged to home was 34 days, although a small number of people requiring rehousing or adaptations before discharge home stayed considerably longer. Average LOS was 36 days for those assessed as requiring long term care, reflecting current challenges in accessing care home placements. A small but discernible increase in the 5 case rolling average LOS over time reflects a shift in casemix following the roll out and extension of Home First offering an alternative pathway for short term reablement support at home.

Fig. 9 Individual LOS



Cost per case

Cost per case for 2020/21 budget and projected activity: £6,152. This compares to a benchmark average cost from National Audit of Integrated Care (2018 data) of £5,486 for bed-based intermediate care. If Waverley operated at 90% capacity at current average length of stay, cost per case would be £4,631

Summary of outcomes

Table 2 summarises performance for the project outcomes detailed in the Integrated Care Fund Project Brief (2016):

Table 2

Outcome	*Measure*	Performance Indicator	Benchmark
That individuals admitted to the facility can transition back to their own homes	*% of individuals returning to their own homes within 6 weeks of admission*	79%	NAIC 80%
That individuals who return home, stay at home	*% of transitional unit individuals readmitted to hospital*	At 7 days: 1% At 28 days:6%	Over 65s discharged from BGH 7 day / 28 day All BGH 4.7% / 10% Geriatric Medicine 7.7% / 18.8% General Medicine 7% / 16% (Discovery data)
That individuals remain as independent as they were prior to their admission to hospital	*% requiring more care than prior to their admission to hospital)*	Functional outcomes scoring (AUSTOMS) commenced Dec 2020. Data only available for 4 clients. All 4 clients improved functional scores on discharge	NAIC benchmark – 85% of clients with improved function

4.2 Garden View Discharge to Assess Facility

The Discharge to Assess Unit, based at Garden View in Tweedbank, opened in January 2017 to provide additional capacity of up to 24 residential care home beds to assess the support needs of people in an enabling environment prior to their return home or to long term care in supported accommodation. The facility is managed by SB Cares, closely aligned to the Waverley Transitional unit, but does not have aligned AHPs or HCSW resource. The initial focus was on patients with a goal to return home but from October 2018 admission criteria were extended to accept people who were being assessed for 24 hour care if they had no on-going nursing care needs.

Aims

- Individuals stay in the Facility no longer than 2 weeks (Oct 2018 revised to 6 weeks)
- Individuals are able to be discharged home (or to care home from Oct 2018)
- Individuals who return home, stay at home
- Feedback from people who use the service is positive
- Feedback from staff is positive

Referrals

Figure 10 shows residence of admissions. 48% lived outwith Central Borders, suggesting Garden View offered selected individuals an alternative pathway to their local community hospital.

Fig. 10

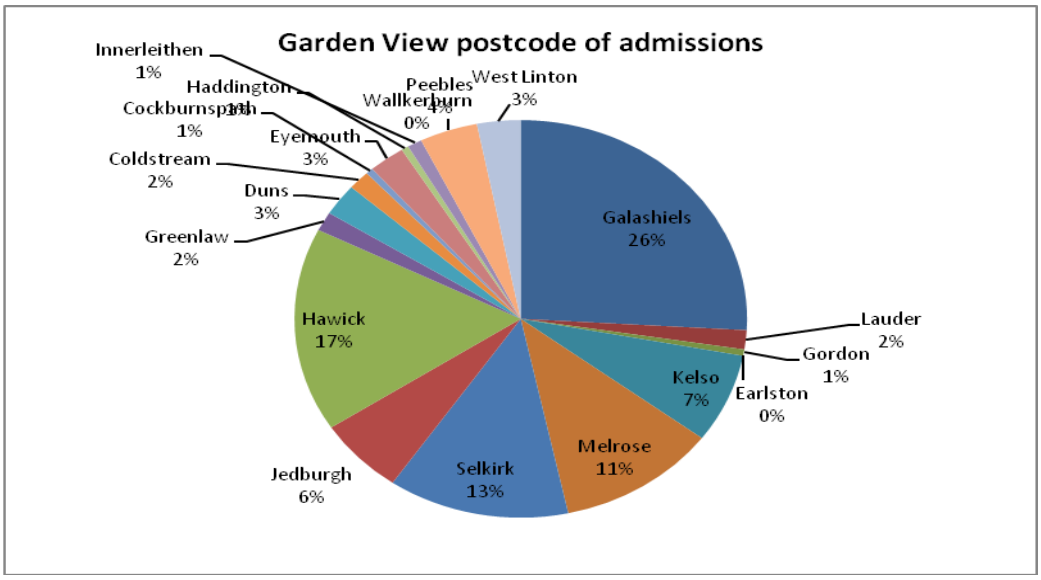
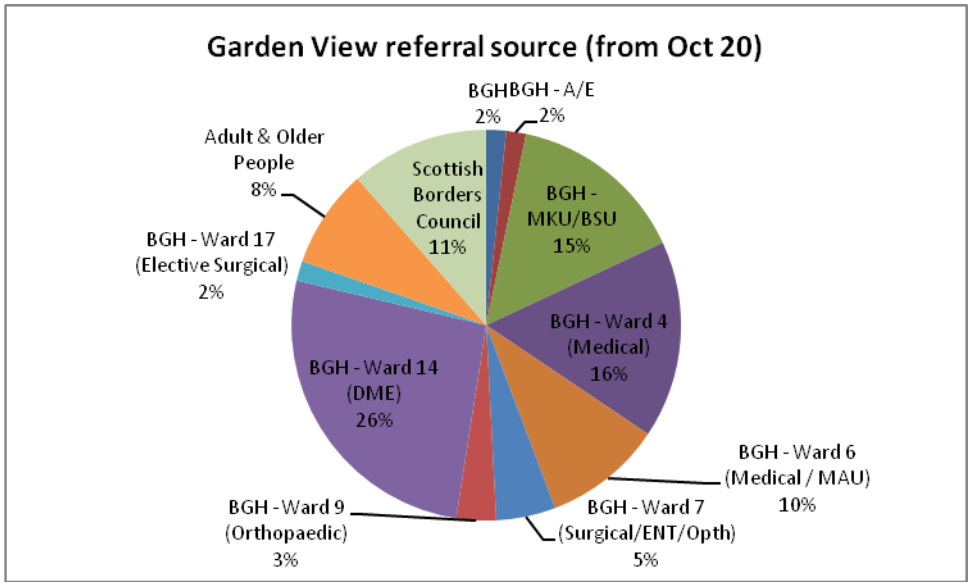


Figure 11 shows the source of referrals. All were step down following an episode of acute care at BGH and no referrals were from community hospitals. Using recent information from Strata, just over half of the admissions were transferred from BGH Medicine for the Elderly wards, Ward 4 or BSU/ MKU. Most were transferred to Garden View within 1 day of receipt of the referral.

Fig. 11 Source of referrals



Casemix

Average age was 83.4 years, range 50 to 99 years with only 4% under 65 years.

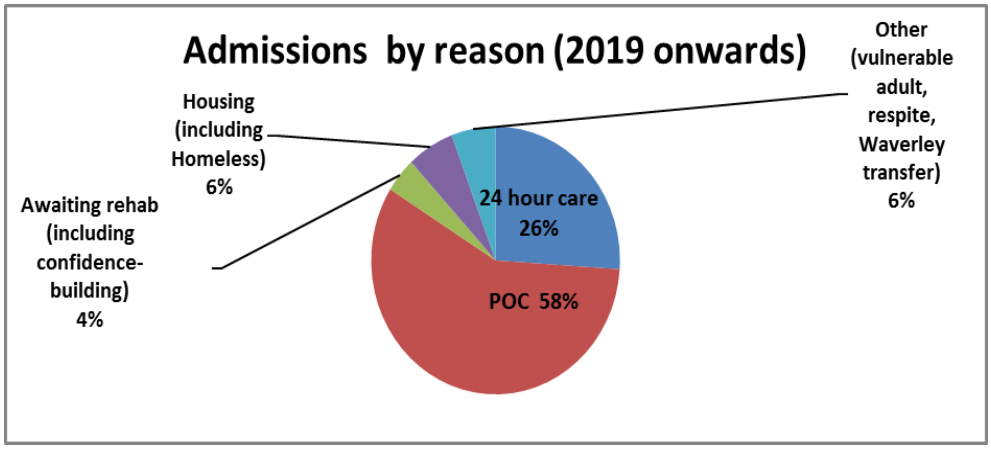
The casemix was broadly similar to Waverley but the Garden View cohort had a higher prevalence of people with cognitive impairment, including Adults with Incapacity, and a slightly lower proportion (75%) who had mobility issues.

Similar to admission criteria for Waverley, referrals should be able to mobilise with assistance from equipment and/ or a maximum of two staff and should have no on-going nursing care needs except those ordinarily met by a District Nurse team. However criteria for admission to Garden View required the identified goals to be achievable within six weeks without access to AHP support.

Figure 12 shows that goals at admission were largely about process rather than function and included:

- Undergoing Social Work assessment
- Waiting for commencement of a Package of Care (POC)
- Waiting for 24hr long term care placement
- Waiting for completion of Home Adaptations/Equipment/ Maintenance work
- Waiting for a new Tenancy
- Waiting for resolution of Delirium
- Waiting for surgery or recovery where there is a nonweight bearing status

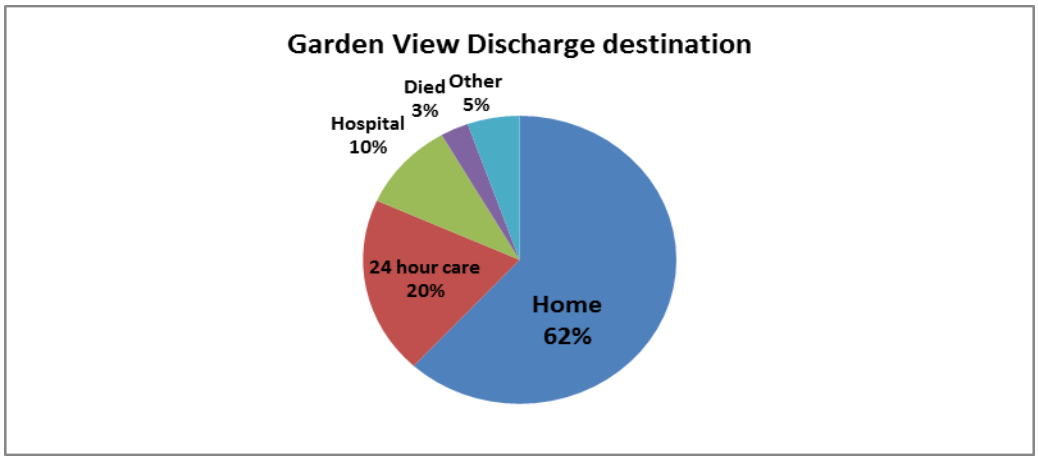
Fig. 12 Admission Goals



Outcomes

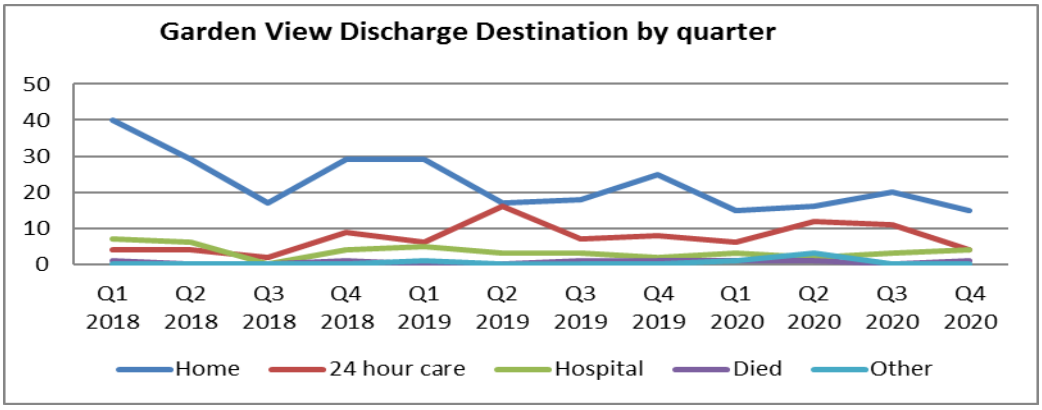
Figure 13 shows that almost two thirds of admissions to Garden View returned home with a Package of care (POC). With one-fifth transferring to residential care. This suggests that clients entering Garden View largely progress to their intended destination of referral.

Fig 13 Discharge Destination



Quarterly rates for discharges to home have decreased over time (Figure 14), in keeping with the increasing capacity for an alternative hospital discharge pathway to assess at home via Home First.

Fig.14 Discharge Destination over time



Records show a total of 96 adverse incidents in 2020, mainly falls. Three percent of admissions died in the Unit. The rate of readmissions to hospital from Garden View was 10%, equivalent to the average 28 day readmission rate for discharges from all BGH wards and significantly lower than the 19% readmission rate for discharges from BGH geriatric medical wards.

Experience of care

No routine survey of services users experience was available.

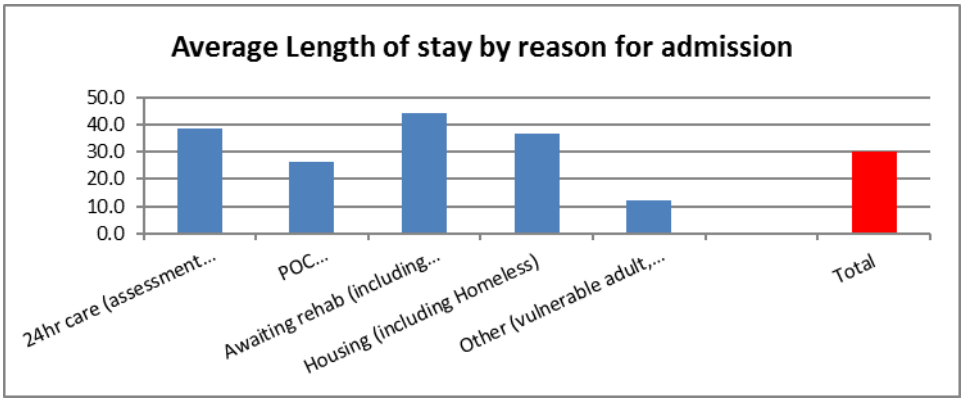
Ad hoc feedback from service users is consistently favourable and Care Inspectorate reports are mostly positive. Three residents surveyed reported feeling safe, accepted, treated kindly and satisfied with the quality of care and with the environment. The only criticism was of a lack of social activities.

Throughput

With a capacity of up to 24 beds, Garden View could be expected to achieve a throughput of at least 198 per annum, assuming an average of 42 days Length of stay (LOS) and 95% occupancy. This is a very conservative assumption for LOS for a cohort with largely process outcomes,

considering the average LOS achieved at Waverley for a cohort considered to have rehabilitation needs. Figure 15 shows how throughput at Garden View critically depends on the balance between the shorter LOS for those awaiting assessment and commencement of a POC to return home and the longer LOS for those being assessed for or awaiting placement in 24 hour care or awaiting housing solutions.

Fig 15 Average LOS by reason for admission



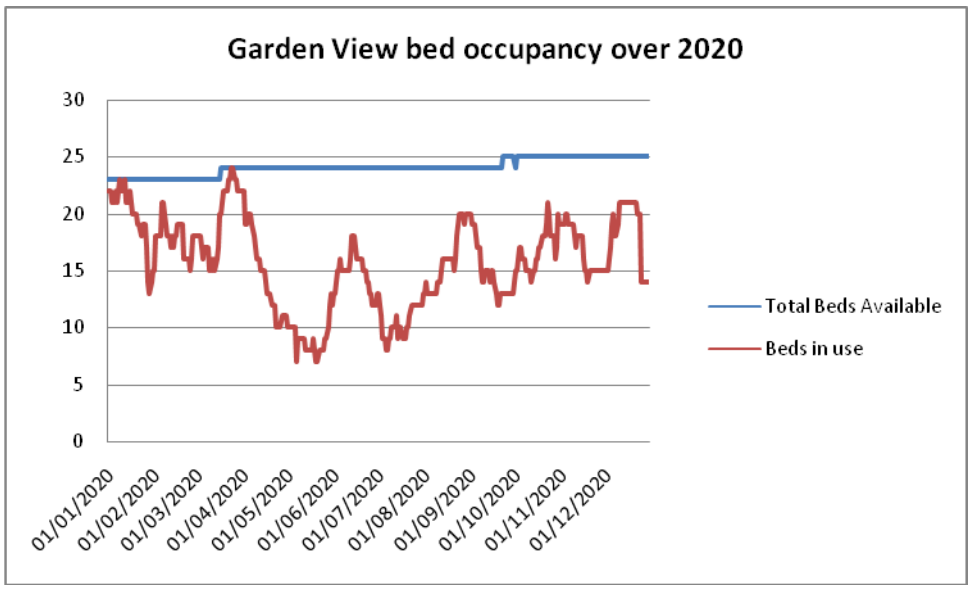
Throughput has been considerably less than anticipated from the outset and has further reduced over time. Table 3 shows the proportion of admissions discharged within 2 weeks halved between 2018 and 2020 and there has been a fourfold increase in the proportion staying longer than 6 weeks.

Table 3

	Admissions per year	Average no. of admissions / month	LOS 14 days or less	LOS > 42 days
2018	153	13	59%	8%
2019	149	12.4	36%	32%
2020	136	11.3	30%	32%

Figure 16 shows low average occupancy but recent increasing occupancy largely reflecting people undergoing assessment for long term 24 hour care as increased capacity for Discharge to assess at home via Home First has reduced the demand for admissions while awaiting a package of care.

Fig.16 Occupancy rates



Costs

Based on total service spend and current activity (145 cases), the cost per case for Garden View is £7,167. This compares to an average cost per case from the English NAIC benchmarking data (2018) of £5,486. If Garden View operated at 90% capacity at current length of stay (207 cases), the cost per case would be approximately £5,038.

Summary of outcomes

Table 3 summarises performance for the project outcomes detailed in the Integrated Care Fund Project Brief:

Table 3

Outcome	Performance Indicator	Benchmark
Individuals stay in Facility no longer than 2 weeks (changed to 6 weeks in Oct 2018)	Length of Stay (LoS): Up to 14 days 112 29% up to 42 days 202 70% >42 days 69 30%	NAIC (2018) average LOS 26 days for bed- based intermediate care
Individuals that stay in the Facility are able to be discharged home	Discharge destination : 62% discharged home 68% of transfer for assessment for package of care discharged home	NAIC (2017) – 69% discharged home from bed-based intermediate care
Individuals who return home, stay at home	Readmission rates: 7 day 28 day number 4 15 total 2% 6%	Readmission rates for over 65s discharged from BGH 7 day 28 day All BGH 4.7% 10%

		Geriatric Medicine	7.7%	18.8%
		General Medicine (Discovery data)	7%	16%
Service Users Feedback is positive	No routine data Care Inspectorate reports favourable			
Staff Feedback is positive	No data			

4.3 Home First

The service was initially established as *Hospital to Home* (H2H) to provide personalised reablement for individuals who no longer require acute hospital care, but are not yet able to live independently at home. Reablement is provided by HCSW with guidance from a district nurse or AHP. H2H evolved further to form Home First that also supports a crisis response for people who are at high risk of being admitted to hospital if they do not receive support at home. The service started on a small scale in Berwickshire in January 2018, extended to Teviot in March 2018, to Central Borders/Tweeddale in August 2018 and to Cheviot in late 2018. The care element was fully operational across Borders by March 2019. Full AHP/rehabilitation =roll-out was completed in May 2020. Clients were accepted if they were expected to benefit from reablement delivered by HCSW under supervision of a nurse or AHP.

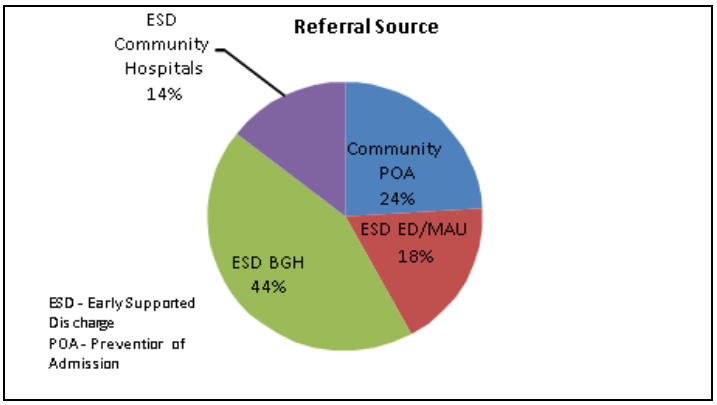
Aims

- Support earlier discharge from hospital
- Maximise rehabilitation potential during the early weeks post discharge
- Support individuals to continue to live at home.
- Increase capacity of homecare provision by reducing care needs by 40%
- Increased engagement with community based services in each locality
- Reduce avoidable attendances / admissions to hospital

Referrals and Casemix

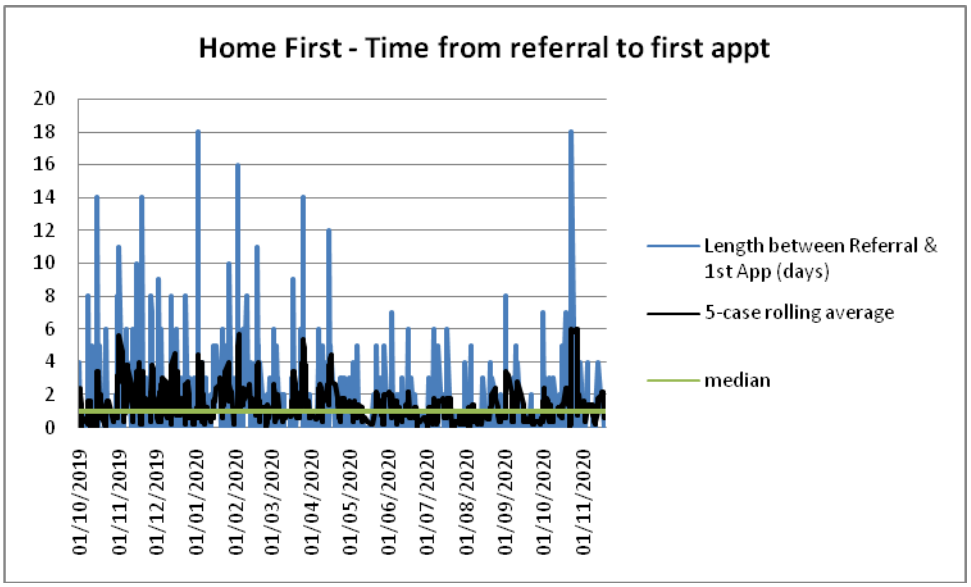
Activity increased by 23% between 2019 and 2020 and Home First managed 1280 people in the year to Nov 2020. 24% of referrals were from the community for an alternative to emergency admission to hospital. Figure 17 shows a further 18% were from the emergency department or medical admissions unit reflecting early intervention and return home.

Fig. 17 Referral Sources



Median time between referral and first visit by home carer was 1 day (Figure 18),

Fig.18 Time from Referral to First visit by Home carer



Overall, 88% of home care clients had visits 7 days per week. Figure 19 shows two thirds of the home care clients had at least two visits per day.

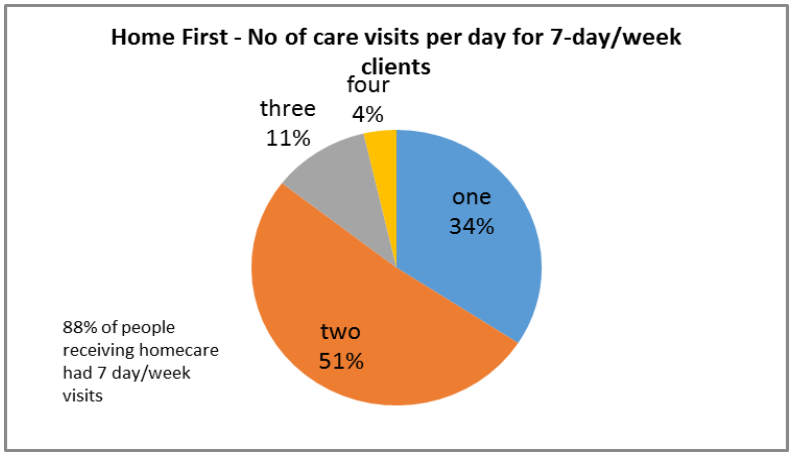


Fig.19

Some 96 clients who had sufficient unpaid carer or family support did not have HCSW visits but had early intervention by AHPs with average time to first visit 2.5 days (Figure 20). 94% of AHP only clients had one visit per day with over 50% of these daily visits occurring at least 5 days per week (figure 21). There may be scope for greater skill mix for follow through sessions under AHP supervision.

Fig. 20

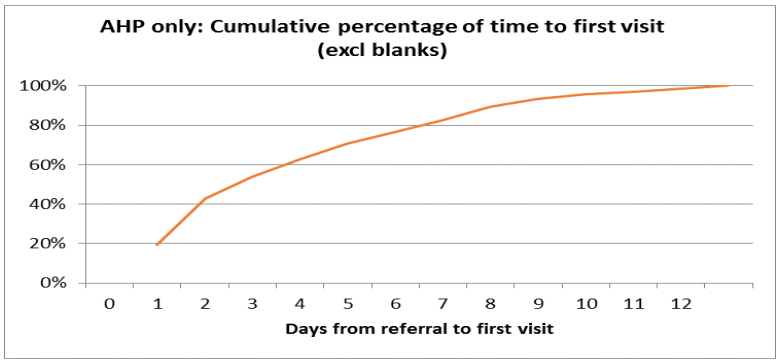
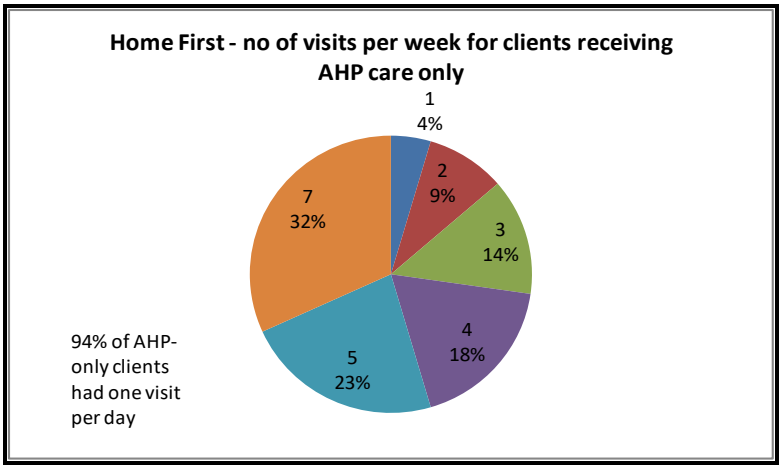


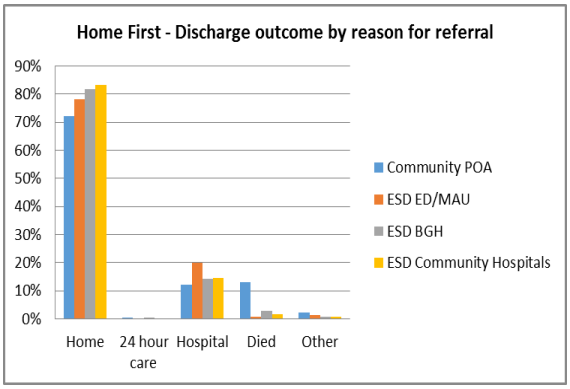
Fig 21



Outcomes

Overall, 80% remained at home. Figures 22 and 23 show the outcomes by source of referral. Around 11% were (re)admitted to hospital. This compares favourably with 19% rate for 28 day readmissions for BGH Geriatric medicine and 16% for General medicine. Mortality was low and includes expected deaths in people for whom Home First enabled their expressed wish to remain at home. Very few clients moved onto 24 hour care.

Fig. 22 Discharge outcome



Fig, 23 Home First LOS

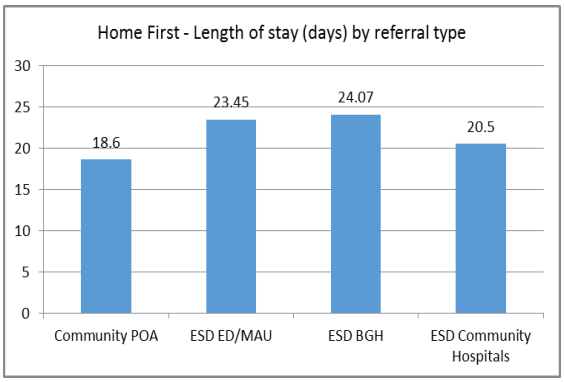


Table 4 shows the reduction in home care hours for those who received HCSW assistance for ADL. Overall, there was a 57% reduction in the intensity of the care packages required at the end of the Home First episodes. This level of reduction in demand for home care is central to the business case for the service and to the sustainability of home care provision for an ageing population with increasing levels of need

Table 4 Change in Home care package

	No. Service Users	**Total Care Minutes Per Week (Start)**	**Total Care Minutes Per Week (End)**	**Average Care minutes per week (start)**	**Average Care minutes per week (end)**	**% change**
Total clients with home care hours recorded	968	300,685	106,715	**310**	110	**57% reduction**
Subset who remained at home	722	208,955	89,600	289	124	**57% reduction**

Interestingly, some people considered to have longer term support needs were accepted onto the caseload to allow them to return home awaiting the availability of their assessed care package. Although there was little expectation of improvement, in fact the package of care required decreased in 23/86 'short term bridging package' cohort and there was an 11% reduction in the total care hours they required after only a short period (average 10 days) of Home First support. This underlines the acknowledged tendency for over prescription of care when assessments are undertaken in hospital settings and the potential benefits of reablement even for individuals considered to have more chronic care and support needs.
AHPs have recently introduced the AusTom tool to assess functional ability in the Home First caseload. The tool considers emotional and psychological wellbeing and levels of social participation as well as physical function. It also considers the level of carer distress.

Table 5 shows that three quarters of the patients assessed with the tool before and after their Home First episode showed improved scores. Carer distress reduced in around half.

Table 5 AusTOM scores

AusTom Scores	**Impairment N = 40**	**Activity Limitation N = 40**	**Participation Restriction N = 40**	**Distress (Patient) N = 40**	**Distress (Carer) N = 21**	**Overall Total scores n=40**
improved	22	27	23	22	10	30
same	15	13	15	17	10	9
deteriorated	3	0	2	1	1	1

The Care Opinion scenarios in Annex 1 give some insight into the improvements experienced and the benefits perceived by patients, carers and families. These are complemented by three scenarios shared by Home First staff to illustrate the added value of the service

Costs
Based on total service spend and activity, the cost per case for Home First is £1,093. This compares well with an average cost per case from the English NAIC benchmarking data (2018) of £839 for home based intermediate care and £1.987 for reablement.

Summary of outcomes

Table 6 summarises performance for the project outcomes detailed in the Integrated Care Fund Project Brief:

Table 6 Project Outcomes

<table>
<tr><th>Outcome</th><th>Performance Indicator</th><th>Benchmark</th></tr>
<tr><td>Personalised re-ablement approach to maximise early rehab potential in the early weeks post discharge</td><td>AUSTOM scores (n = 40): Functional change on discharge:
<table><tr><th></th><th>improved</th><th>same</th><th>deteriorated</th></tr><tr><td>Impairment</td><td>55%</td><td>38%</td><td>8%</td></tr><tr><td>Activity Limitation</td><td>68%</td><td>33%</td><td>0%</td></tr><tr><td>Participation Restriction</td><td>58%</td><td>38%</td><td>5%</td></tr><tr><td>Distress (Patient)</td><td>55%</td><td>43%</td><td>3%</td></tr><tr><td>Distress (Carer)</td><td>48%</td><td>48%</td><td>5%</td></tr><tr><td>Overall</td><td>75%</td><td>23%</td><td>3%</td></tr></table></td><td>NAIC 2018 (reablement): Improved 66%, no change: 27%, decreased: 7%</td></tr>
<tr><td>Increasing capacity of care provision by reducing care needs of this cohort by 40%</td><td>Overall care needs reduced by 57% at end of Home First
57% of clients discharged independent of care</td><td>IPC report (reference 11) suggests up to 65%</td></tr>
<tr><td>Increased engagement with community based services in each locality</td><td>No recorded data

7% of referrals are generated by District Nurses</td><td></td></tr>
<tr><td>It supports individuals to develop their confidence and skills to enable them to continue to live at home.</td><td>80% remained at home

See Austoms scores above

Also qualitative feedback from user stories – Annex 1</td><td>NAIC benchmark (2017) – 81% remained at home after home-based intermediate care</td></tr>
<tr><td>There will be reduction in hospital attendances / admissions</td><td>See section 5 for Programme impact assessment

11% (Re)admissions to hospital</td><td><table><tr><th></th><th>7 day</th><th>28 day</th></tr><tr><td>All BGH</td><td>4.7%</td><td>10%</td></tr><tr><td>Geriatric Medicine</td><td>7.7%</td><td>18.8%</td></tr><tr><td>General Medicine</td><td>7%</td><td>16%</td></tr></table></td></tr>
</table>

4.4 Enabling Infrastructure

Matching Unit

The Matching Unit was established as a small, central administrative team that ensures the service required by a client is matched with a provider who can meet their care requirements. The Matching Unit team collated and maintained a list of clients waiting for care at home and for end of life care. The unit reduced time previously spent by care managers in trying to secure packages of care and reduced waiting lists for people awaiting assessment and care in their community. The Matching Unit has been mainstreamed into SBCares and arranges 180 care packages a month, a 10% increase since 2019, with average time to start of package 5 days. The success of this initiative has led to the approach being mainstreamed within SB Cares with an opportunity to better align with the development of locality What Matters hubs.

Discharge referral Management

STRATA automates and improves the process of discharging patients from hospital to residential care or care at home providers. The system uses a real-time directory of available care home beds, capacity and specialist services allowing these to be matched to patients. The digital system is supported by creation of an integrated discharge 'hub' as a single point of contact multi-disciplinary team with responsibility for coordinating and arranging older people patient transfers and ongoing care.

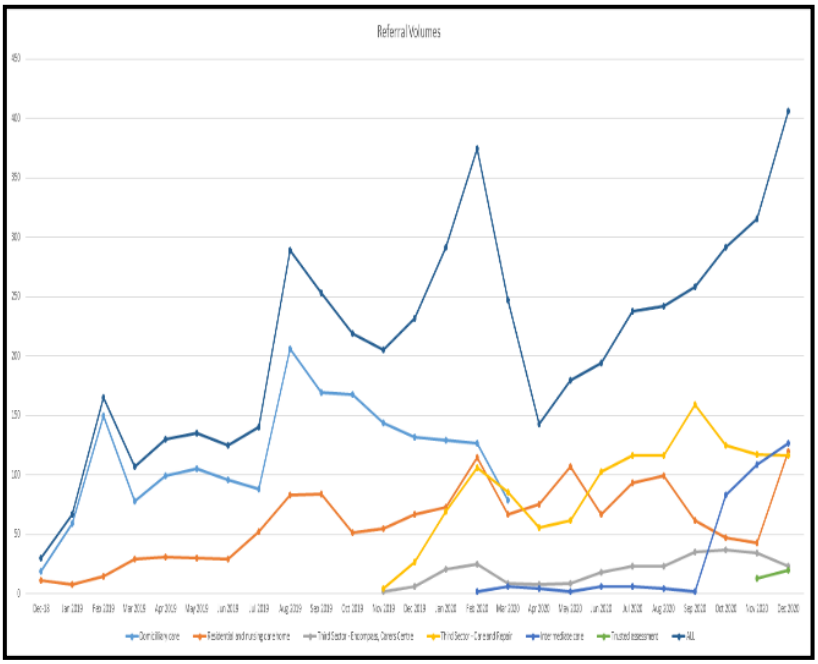


Fig 24 Strata Referrals

Strata is now managing around 800 referrals / month in eight pathways across hospital, social care and third sector (figure 24).

Figure 25 shows it takes a median time of 10 minutes for staff to submit a referral.

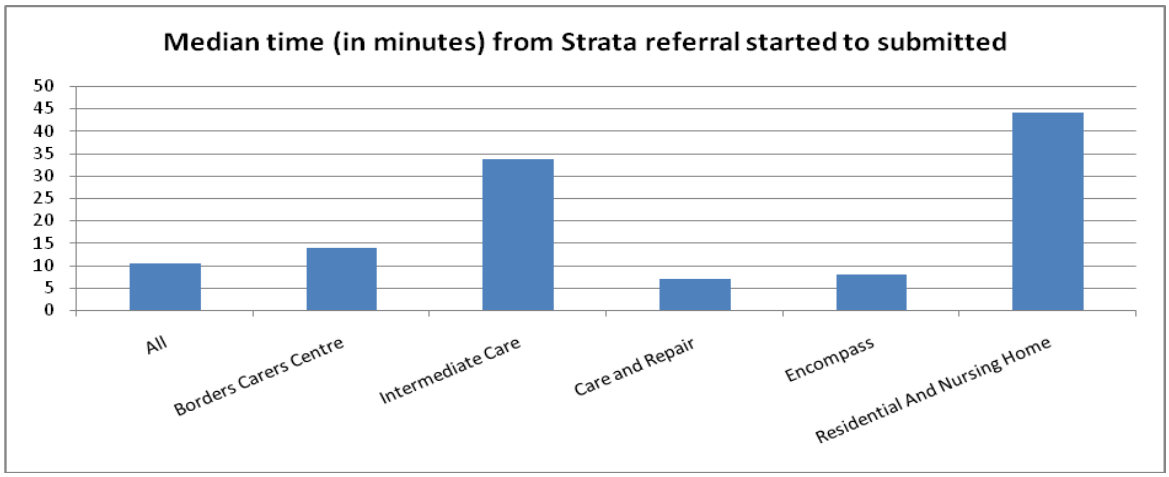


Fig 25 Median time to complete referral (minutes)

The relaunch of the domiciliary care referral pathway is imminent and will be followed by the pathway for referral to Community Hospitals in the next quarter. These are key in enabling BGH and community hospitals staff to directly refer for intermediate care and will be a step towards enabling community teams and GPs to access these through a simple single 'red button' referral process

5. Contribution to System Outcomes

The projects are collectively supporting the IJB to achieve two of their three key strategic aims and related actions (15).

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

- By supporting individuals to improve their health
- By improving the range and quality of community based services and reducing demand for hospital care

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

- By reducing the time that people are delayed in hospital
- By improving care/patient pathways to ensure a more co-ordinated, timely and person-centred experience/approach
- Providing short-term care and reablement to facilitate a safe and timely transition
- Caring for and assessing people in the most appropriate setting
- Providing an integrated approach to facilitating discharge
- Ensuring the reablement and hospital to home service development aligns with housing providers and care and repair services

While attribution of impact is not possible given the complex interdependencies of the projects alongside other actions being implemented within BGH and localities, the three services are

almost certainly contributing to the progress made by Scottish Borders from 2017/18 on key National Outcomes Indicators (16) as illustrated in figures 26- 28.

Fig 26 National Indicator 13 Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)

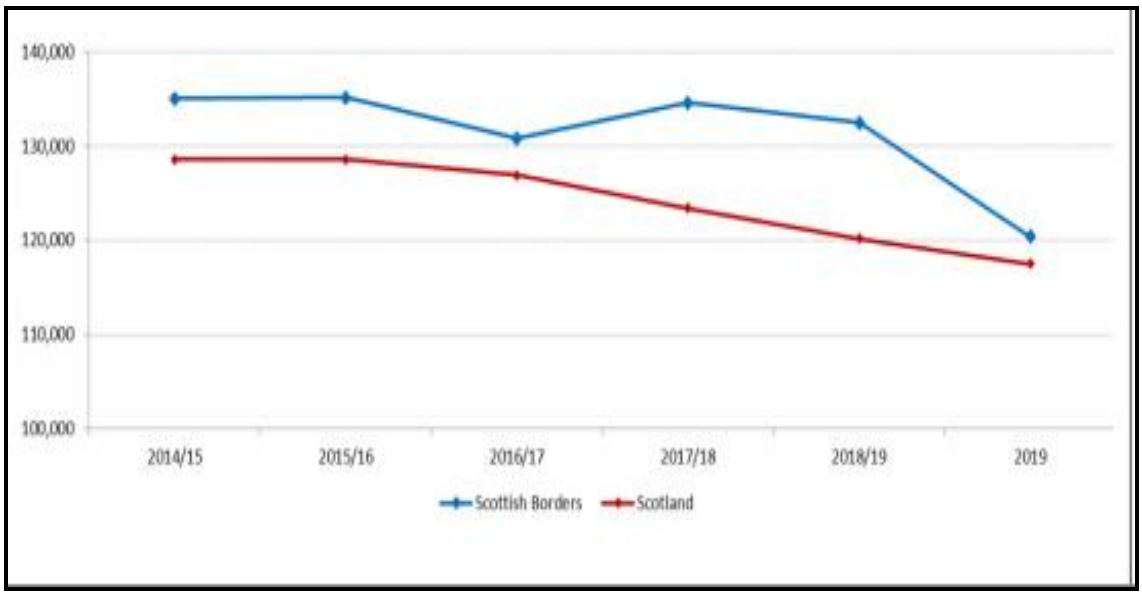


Fig. 27 National Indicator 19 – Number of days people aged 75+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 75+)

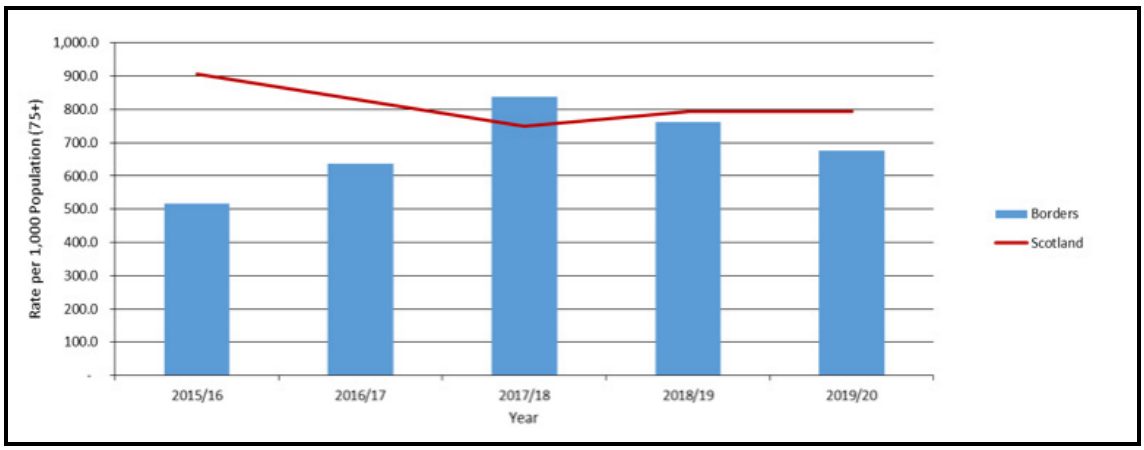


Fig. 28 Number of days people aged 18+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 18+)

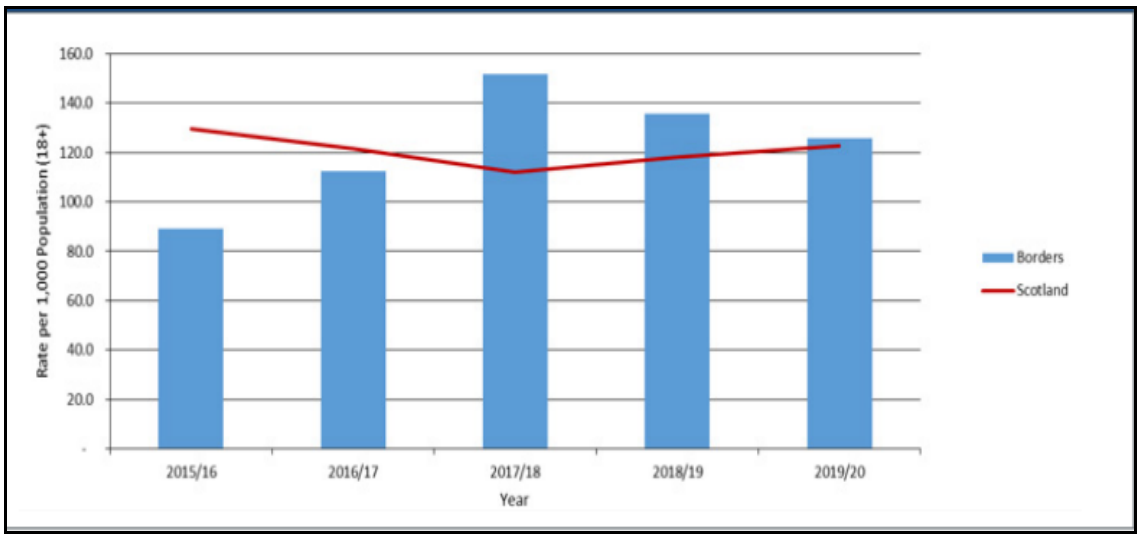


Figure 29 shows quarterly trends in BGH emergency admissions and occupied beddays for the over 65s. The chart has been annotated with the start dates of the new services.

Since 2017, BGH emergency beddays for >65s have decreased by 5% and LOS reduced by 11% despite admissions increasing by 7%.

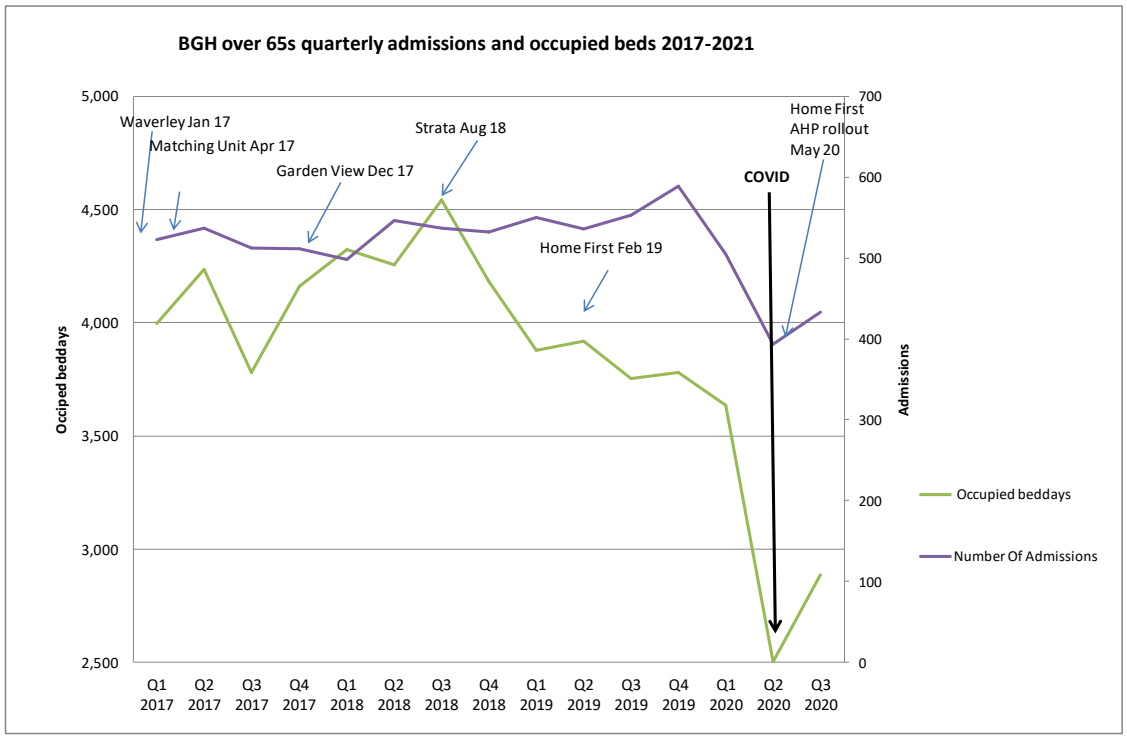


Fig. 29

Value

The lack of a core dataset for the intermediate care services limits the ability to link management information from these services with the wider health and social care information and resource utilisation data available through Source and Tableau.

The financial impact of the programme has therefore been assessed in two ways:

1. Cost per case. The services have been evaluated through a simple cost per case approach. Cost relates to staffing and other non-fixed costs only. This shows (against NAIC 2018 benchmark data)

	Project cost per case	Benchmark
Waverley Transitional Care	£6,152 At 90% occupancy, cost per case would be £4,631	£5,486
Garden View Discharge to Assess	£7,167 At 90% occupancy, cost per case would be £5,038	£5,486
Home First	£1,093	Home-based intermediate care: £ 834 Reablement: £1,987

2. Counterfactual. A counterfactual analysis has been undertaken to assess the potential demand for beds and other resources that would be incurred in the absence of the services provided within the Discharge Programme. This assessment is based on a range of assumptions, largely reflecting actual experience. Details are attached in Annex 2.

   This analysis indicates that, if the services within the Discharge Programme were not available, there would be;

   - an additional demand for hospital beds of between 40 and 57 beds
   - an additional increase in home care hours required of around 26,000 hours per year, representing approximately 5% of current provision

   The Care Opinion feedback is universally positive for Home First but the lack of systematic recording of functional and personal outcomes limits meaningful review of the experience of care in this report.

6. Recommendations

The IJB is invited to consider the following recommended actions that flow from the review:

- Continue to develop the enabling infrastructure: Strata digitally enabled referral management supported by an integrated discharge hub, Trusted assessment model and more efficient allocation of care by the Matching Unit team and locality hubs.

- Merge the two "Step Down" facilities of Waverley and Garden View as soon as possible to create a combined facility with a single set of admission criteria for the combined transitional care unit.

- Commission the required bed capacity for the combined Transitional Care Unit based on the projected impact of scaling up Home First discharge to assess at home

- Provide dedicated nursing expertise to enable the combined Transitional Care Unit to offer a local alternative to community hospital care for the cohort of older residents from Central Borders who have higher levels of dependency and more complex post-acute care needs

- Review the skill mix, leadership and governance of Home First and align the team more closely with locality *What Matters* hubs for greater continuity of care management, better coordination with local assets and housing solutions and to increase access to step up crisis response

- Test a locality integrated team model where the Home First team and community hospitals AHPs rotate / in reach / outreach, building on the lessons from the Neighbourhood Care pilot and work with SAS and out of hours services on urgent response to falls

- Explore opportunities to enhance the integrated locality teams with geriatric medical and palliative care expertise, using remote prof to prof decision support where appropriate

- Develop a core dataset for reablement and intermediate care to enable prospective tracking of service quality and outcomes across these services.

- Consider the use of IoRN within the core dataset to allow measures of dependency and functional ability to be prospectively linked to the Scottish Borders resource utilisation data through the Source returns and Tableau health and social care information dashboard

- Exploit the opportunities from the Older People's Pathway and Joint Digital Strategy

- Develop a route map for the above actions as a strategic framework for intermediate care with nested locality models that are better integrated with the range of locality assets and services including Community Hospitals

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Annex 1 Care Opinion: feedback of experience of Home First

'' I was concerned about how (my husband) would cope, he is a normally fit 87 and I am 75 but we knew he would be weak when he came home. Then we had a call from the local Home First offering morning and evening support. It was brilliant. Help with showering and dressing in the morning for 2 weeks which was as long as we needed it, evening help for a few days until we didn't need it any more. OT and Physio came and checked what we needed and saw him down the stairs the first time. A handyman came and fixed a grab handle over the bath so he could use that shower. The colo-rectal nurse, the continence pad service, the pharmacist from the health centre and the GP all made contact without us having to do anything and made sure we were alright. The overall service was excellent.''

'' My wife fell & fractured her hip in June. She's been battling with Alzheimers since 2015. Unbelievably she was back home 12 days later & then regularly visited & cared for by Home First care team for the next for two and half weeks. Both the hospital & care staff have been brilliant! Caring, kind, knowledgeable and making us both feel good. She had started to walk with a zimmer before she came home & 3 days ago we were getting back upstairs to our bed. Nothing was too much trouble and they all made us feel positive. Our family is all over the world & under lockdown they couldn't visit anyway. So actually we've had more contact than we would have normally! We're really sad to see them go, but couldn't have had better care.''

'' For myself I only had flu like symptoms and have made a fairly quick return to full health but my wife required hospital treatment. On her eventual release from hospital the local home care team swung into action by visiting morning and evenings, giving us all the support we required with aids, such as a wheeled walker, a commode and a handy wheeled shelved trolley. Physiotherapy and OT persons also visited to assess our everyday living and got a second bannister fitted on our stairs and support rails in the shower. Through this help with assisted showering, confidence boosting support and aids to help with everyday living, both my wife and myself are back to normal living and confident moving around the house and in the outside world again.''

'' The superb team from Home First came in with care for my husband who has a terminal brain tumour and is now receiving palliative care. Every single carer has been professional, skilled and spent time getting to know us and understand our needs. They have cared for both of us in very challenging circumstances. This is an excellent support for families in similar situations''

'' The Home First ladies did an amazing job of providing personal care to my mum, as well as

showing great compassion and assisting her to preserve some dignity when she was completely bed bound. They were so lovely to her and assisted in allowing my mum to stay at home during her last few weeks which is what she really wanted, rather than being confined to a covid ward in the hospital. They also provided immense support, both practical and emotional, to me as I looked after her during her last few weeks and I know I would not have been able to cope without their visits. I am so very grateful to all the lovely ladies in the team and I will never be able to fully express my gratitude to them for everything they did for me and my mum.''

Staff reflections on the impact of Home First

Patient A

An 89 year old lady who had experienced a fall and sustained a fracture to her right wrist and right Neck of Femur was admitted from BGH to Hawick Community Hospital where she underwent a period of rehab in HCH. She progressed to being mobile with a walking aid and transfers with equipment and supervision on the ward but consistently presented as lacking in confidence which impacted on her function. She was referred to Home First for further rehab with aim of regaining independence and returning to preadmission baseline for mobility, personal care and meal prep.

I visited the patient on ward to practice bed transfers which gave me a good picture of her level of function and opportunity to discuss re-ablement plan and purpose of Home First. This allowed seamless transition from hospital to home setting and good rapport established with myself and the Nurse Coordinator at the start of team involvement.

Re-ablement involved OT and PT input with daily visits from HCSW to support initially with personal care and meal prep. PT assessed mobility at home and progressed patient from Zimmer frame to stick for indoor mobility and use of a 4 wheeled walker for outdoor mobility with supervision of family. A home exercise programme was introduced to improve strength, mobility and to improve confidence. HCSW visited daily to supervise mobility and exercise programme. Initially the patient was apprehensive even about walking short distance to answer door, but within a week this was achieved independently with walking aid and eventually to one stick.

Under guidance of PT, HCSW progressed to supervising with outdoor mobility and outdoor step practice. Patient progressed in confidence and to achieve outdoor mobility again, albeit it with walking aid and supervision of family.

The OT provided equipment to assist with bed and toilet transfers and taking a shower. HCSW's initially provided assistance with setting everything up for a shower, elevating her leg and providing reassurance. This progressed to patient being able to perform transfer independently with equipment under supervision with the eventual outcome achieved of independent showering.

A Perching stool enabled a graded return to meal prep and a kitchen trolley enabled independence with transferring items and eliminating dependency on carers for support. Equipment needs were reviewed throughout and withdrawn as transfers and mobility improved.

Hand therapy was provided for fine motor skills, grasp and improving strength- this was reviewed weekly and the goal of returning to knitting was achieved.

HCSW adopted this reablement approach which started with minimal physical assistance to supervisory and this resulted in independence being regained with personal care tasks and meal preparation. The gradual improvement in confidence was significant throughout her time with the team.

At the outset this patient was dependent on care for all aspects of ADL and presented with extreme anxiety. Over a period of seven weeks she returned to independence within the home with no package of care. This was a more positive outcome that had been anticipated in the hospital.

Patient B

The lady, who was previously independent with all activities of daily living (ADL), had a fall on the high street in Peebles when out shopping. Unfortunately she sustained a left neck of femur fracture which was fixed with a dynamic hip screw 2/12/20. She was referred to home first for D2A and the first visit took place on the day of discharge on 14/12/20

She returned home using a large Pulpit frame to mobilise short distances only and required 3 visits per day for the first 3 weeks post d/c. She was initially slow to mobilise and there was marked loss of confidence and balance/fatigue issues evident. Gradually she has progressed from pulpit to 4 wheeled walker indoors. HCSW input has very gradually been reduced with lunch visit being initially reduced followed by the evening visit being discontinued this week. (25/01). She is now washing and dressing independently, making all her meals using the trolley provided and has progressed to practising with 2 sticks indoors, 5 weeks post discharge. The next step in her rehab plan is progression to stair practice (lives in a 1st floor flat).

She is also trying to mobilise to the toilet during the night but due to her urinary urgency she may need to continue to use the commode. She continues to progress with the reablement approach and we are hopeful we will be able to discharge her without a long term package of care. Her rehab has exceeded the 6 weeks but she is still benefiting from Home First input and there is still potential for improvement. There is currently no service in the community to pass this lady on to and we are keen for her to return to full independence if possible.

This example of Discharge 2 Assess shows how Home First can optimise the Fractured Neck of Femur pathway. This lady did NOT go to Haylodge as was originally anticipated, but was able to be discharged straight home with Home First.

Patient C

The patient was discharged from BGH with the request for OT & PT follow up only with no other needs identified. On the 1st visit (24hrs after discharge) she had deteriorated significantly in function and was unable to mobilise, completing transfers only. There was no apparent medical reason for this deterioration. It is possible that the patient was exhausted from travelling home to Berwickshire and the extent of her de-conditioning in hospital only became apparent once home.

Home First provided equipment and linked with the Nurse Coordinator to set up HCSW assistance for personal care and toileting. This managed to prevent a potential hospital re-admission. Her daughter was happy to attend to meals and assisting with toileting out-with our visits. She remained on our caseload while partial weight bearing but is now independently mobile with a zimmer frame, is confidently managing basic personal care and has started to participate in kitchen activities. HCSW calls were reduced to just x2 weekly to assist with full body wash, (daughter continues to assist with meal prep). When her daughter was able to return home we increased her HCSW calls to 1x daily to assist with meal prep/set up and basic domestic assistance. We anticipate, once her weight bearing status changes that she will quickly progress back to full independence and HCSW's will stop.

This example demonstrates Home First's responsiveness and flexibility of support as needs fluctuate, and the confidence and ability of the team to prevent an early re-admission to hospital.

Annex 2: Assumptions underpinning counterfactual analysis

Counterfactual analysis is based on a range of assumptions of alternative pathways for patients and clients. This is not an exact science.

Process

- Overarching assumption that no alternative arrangements for reablement and rehabilitation would be available
- Assumptions are based on data from a number of sources (detailed in list below)
- All Discharge Programme data based on analysis of actual activity 2019-20
- Variable time periods depending on availability of data (see evaluation for details)
- Numbers based on percentage split by discharge destination applied to average activity over time

Counterfactual Hospital bed demand assumptions

Average Length of stay assumptions by client group

	Lower estimate (days)	assumption	Higher estimate (days)	assumption
Home First				
Bridge PoC	10.4	average based on 84 cases - assumes 1:1 ratio - i.e. if PoC not available would be in hospital	10.4	average based on 84 cases - assumes 1:1 ratio - i.e. if PoC not available would be in hospital
PoA	5	based on analysis of average LoS for >65s in BGH as part of Older Peoples Assessment Area planning	5	based on analysis of average LoS for >65s in BGH as part of Older Peoples Assessment Area planning
reablement (discharge and step-up)	5	average time for care package for Hospital Discharge - 2020 (Matching Unit data)	10.4	assumed comparative length of stay to Bridge PoC
Garden View				
Care Home discharges	39	actual average LoS in Garden View - alternative would be hospital	39	actual average LoS in Garden View - alternative would be hospital
PoC discharges	5	average time for care package for Hospital Discharge - 2020 (Matching Unit data)	10.4	as above
House repairs	36.8	actual average LoS in Garden View	36.9	actual average LoS in Garden View
Waverley				
Admitted to hospital	14	average length of stay for DME patient	27	actual Waverley average length of stay
Assessed as needing long-term care	39	average Garden View wait for 24 hr care	56	actual Waverley average length of stay

Died	87	assumes would remain in hospital	87	assumes would remain in hospital
Discharged home	34	actual Waverley average length of stay	34	actual Waverley average length of stay

Counterfactual homecare demand assumptions

The following assumes that the impact of Home First service would not be available and 'saved' home care hours would therefore need to be provided.

- Only Home First activity included
- Waverley/Garden View activity – assumed no impact on home care demand (patients will remain in hospital)
- Average homecare package assumed to be 5.2 hours/week (based on Matching Unit data for Hospital Discharge 2020)

Home First

Bridge PoC	current data indicates 11% reduction in care needs on discharge from Home First
PoA -	
crisis	assume 11% reduction
reablement	care hours saved equivalent to average care package for Discharge patients (5.2 hours/week - 2020 data) for average length of stay in Home First (22 days or 6% of annual)
Reablement (discharge and step-up)	
Patients discharged as independent	care hours saved equivalent to average care package for Discharge patients (5.2 hours/week - 2020 data) for average length of stay in Home First (22 days)
Patients discharged with care package	current data indicates 11% reduction in care needs on discharge from Home First

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 February 2021

Report By:	Phillip Lunts, Strategic Planning Lead, NHS Borders Anne Hendry, Director, Scottish hub of the International Foundation for Integrated Care
Contact:	Phillip Lunts, Strategic Planning Lead, NHS Borders
Telephone:	07747 763963 phillip.lunts@borders.scot.nhs.uk
FORMATIVE EVALAUTION OF THE DISCHARGE PROGRAMME	
Purpose of Report:	To present the findings and recommendations of the Evaluation of the Discharge Programme.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the findings of the Discharge Programme Evaluation b) **Consider** the recommendations c) **Advise** on further actions
Personnel:	None (actions arising from recommendations may have staffing implications)
Carers:	None (actions arising from recommendations may have carer implications)
Equalities:	Equity of access and service provision is considered within evaluation
Financial:	None (actions arising from recommendations may have financial implications)
Legal:	None.
Risk Implications:	Not relevant.

Situation

This is an evaluation of the Scottish Borders Health and Social Care Partnership Discharge Programme.

Background

The Discharge Programme consists of 5 projects initiated individually over 4 years from 2017 and brought together as a single programme in 2019.

The projects within the Discharge Programme effectively provide an intermediate care (IC) service for the Scottish Borders: bed-based intermediate care (Waverley and Garden View), home-based intermediate care (Home First) and infrastructure for enabling rapid and seamless access (Strata and Matching Unit).

Assessment

This evaluation has found the following;

Waverley Transitional Care Unit delivers against its objectives of rehabilitating older people to regain independence following hospital discharge. Time to access service averages 1.8 days. Home discharge rates are 79%. However, the service runs at 70% occupancy and does not admit older people with higher levels of need due to restrictions on length of stay and lack of nurse cover. This is an issue for residents of Central Borders, most likely to benefit due to lack of a community hospital in the locality.

Garden View Discharge to Assess offers a facility for older people to leave hospital whilst completing assessment for care or waiting for home care or 24-hour care. Time to access the service averages 3.6 days. Average length of stay and home discharge rates are comparable to benchmarks. Occupancy is 66%. The service does not offer full reablement due to lack of AHP cover and is unable to admit people with higher levels of dependency.

Both services have positive user feedback. Costs are higher than benchmark but would be comparable if occupancy was higher. Neither service offers step-up access from home.

Home First offers a home-based reablement service. 25% of people who use the service are step-up referrals to remain at home and 75% are referrals at discharge from hospital. Time to access the service averages 1 day. The service meets its objective of 80% remaining at home at the end of their Home First episode, with a 57% reduction in their requirement for home care (against 40% target). 57% are fully independent at the end of their Home First episode while those who need ongoing home care have 11% reduction in the level of care required. The high rate of discharge with no ongoing care suggests that people with more chronic care and support needs may not have been referred to the service.

Infrastructure. The Matching Unit has been mainstreamed into SBCares and arranges 180 care packages a month, a 10% increase since 2019, with average time to start of package of 5 days. Strata digital referral system is managing 800 referrals per month to care homes, intermediate care, third sector and Trusted Assessor, with Strata referrals to homecare soon to be launched.

This evaluation concludes that these services make a critical contribution to system performance but their efficiency could be improved by some adjustment of criteria and skill mix.

Recommendations

The evaluation therefore recommends:

- Home First should be the default and should better align with What Matters locality hubs and services to increase the balance of step up IC and enable closer working with local Housing providers and Third sector support

- Bed based IC should be streamlined as a single pathway for older people with post-acute reablement / rehab / nursing care needs that cannot be met by Home First, particularly for residents in Central Borders

- The service budget for these projects should now be mainstreamed to enable strategic commissioning, substantive recruitment and workforce development as part of a comprehensive framework for integrated intermediate care in each locality.

- This will need to be maintained within the existing Transformation Fund limit of £2.2M, and will be included within the overall budget for IJB delegated services, to be agreed for 2021 to 2022. A further report will be provided for the IJB within the first quarter of the year, setting out recommendations for the way in which these budgets will be mainstreamed. Any resource implications arising from changes to staff contracts as a result of this proposal will be addressed through review of IJB budget as required.

Critical to delivering these actions is the need to mainstream the operation and finding of these services to allow the strategic developments outlined in the recommendations.

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Formative Evaluation of Discharge Programme

Phillip Lunts, Strategic Planning Lead, NHS Borders

Anne Hendry, Director, Scottish hub of the International Foundation for Integrated Care

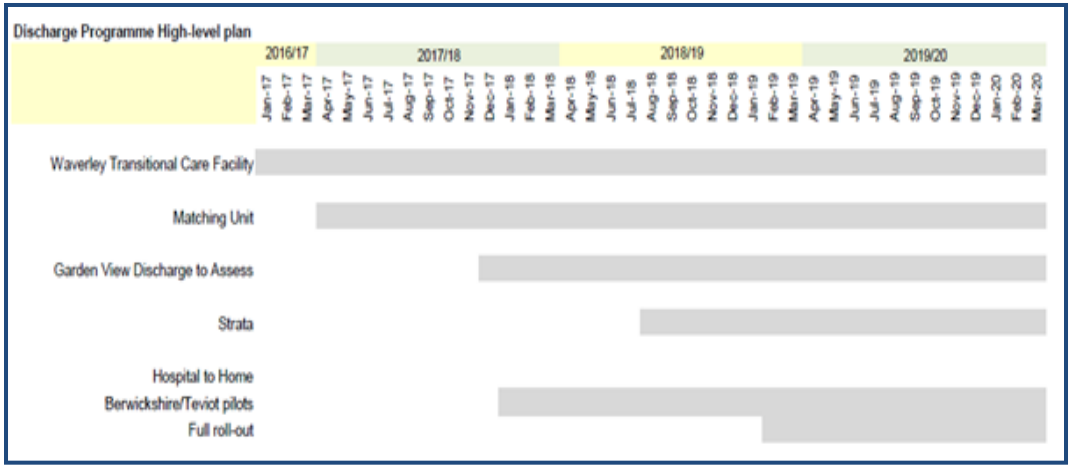
Discharge Programme

5 Projects commissioned and implemented at different times

- Waverley Transitional Care Facility
- Garden View Discharge to Assess Facility
- Hospital to Home – now Home First intermediate care at home
- Matching Unit
- Strata Referral Management

Problem Statement

Too many people are admitted to hospital and remain in hospital when they could receive more appropriate care and support in a more enabling environment



Local and National Strategic Fit

We will improve the health of the population and reduce hospital admissions

- By supporting individuals to improve their health
- By improving the range and quality of community based services and reducing demand for hospital care

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

- By reducing the time that people are delayed in hospital
- By improving pathways to ensure a more co-ordinated, timely and person-centred experience/approach
- Providing short-term care and reablement to facilitate a safe and timely transition
- Caring for and assessing people in the most appropriate setting
- Providing an integrated approach to facilitating discharge
- Ensuring the reablement and hospital to home service development aligns with housing providers and care and repair services

Strategic Fit with models elsewhere:

NHS England D2A Model

2018 National Audit of Intermediate Care

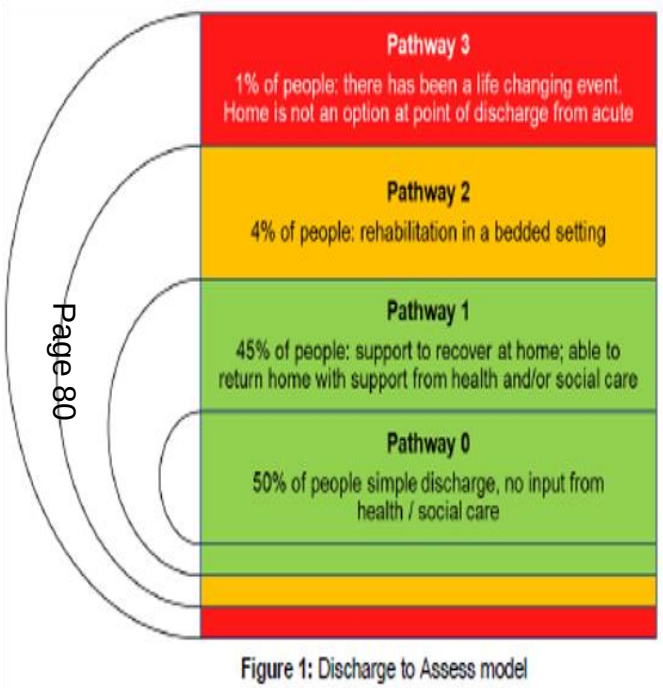
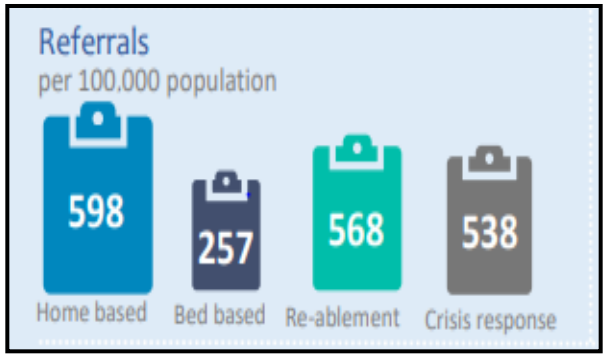
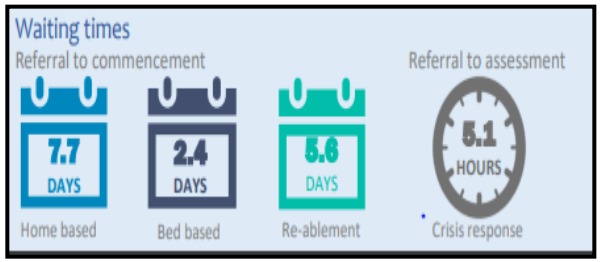
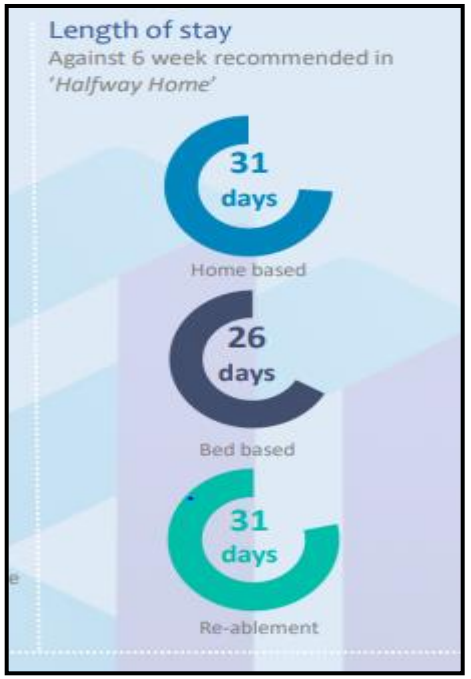
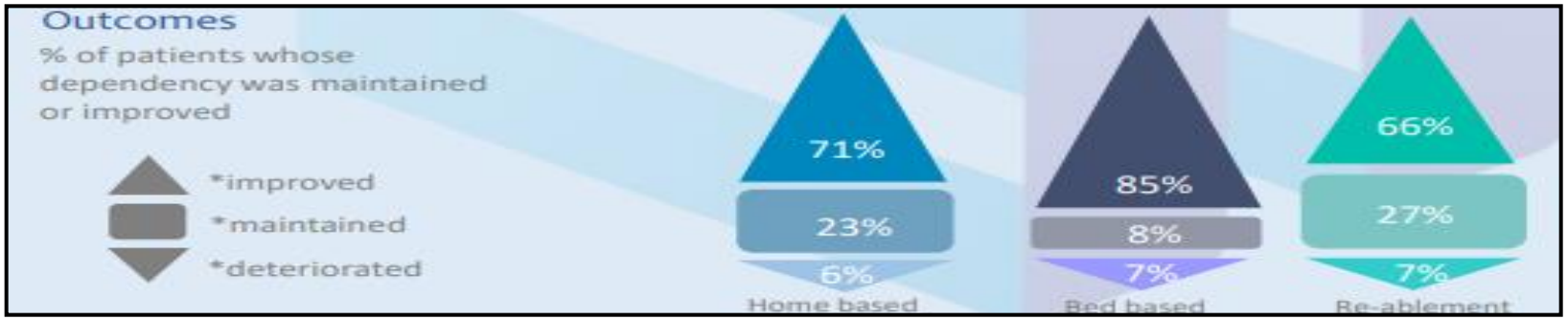


Figure 1: Discharge to Assess model





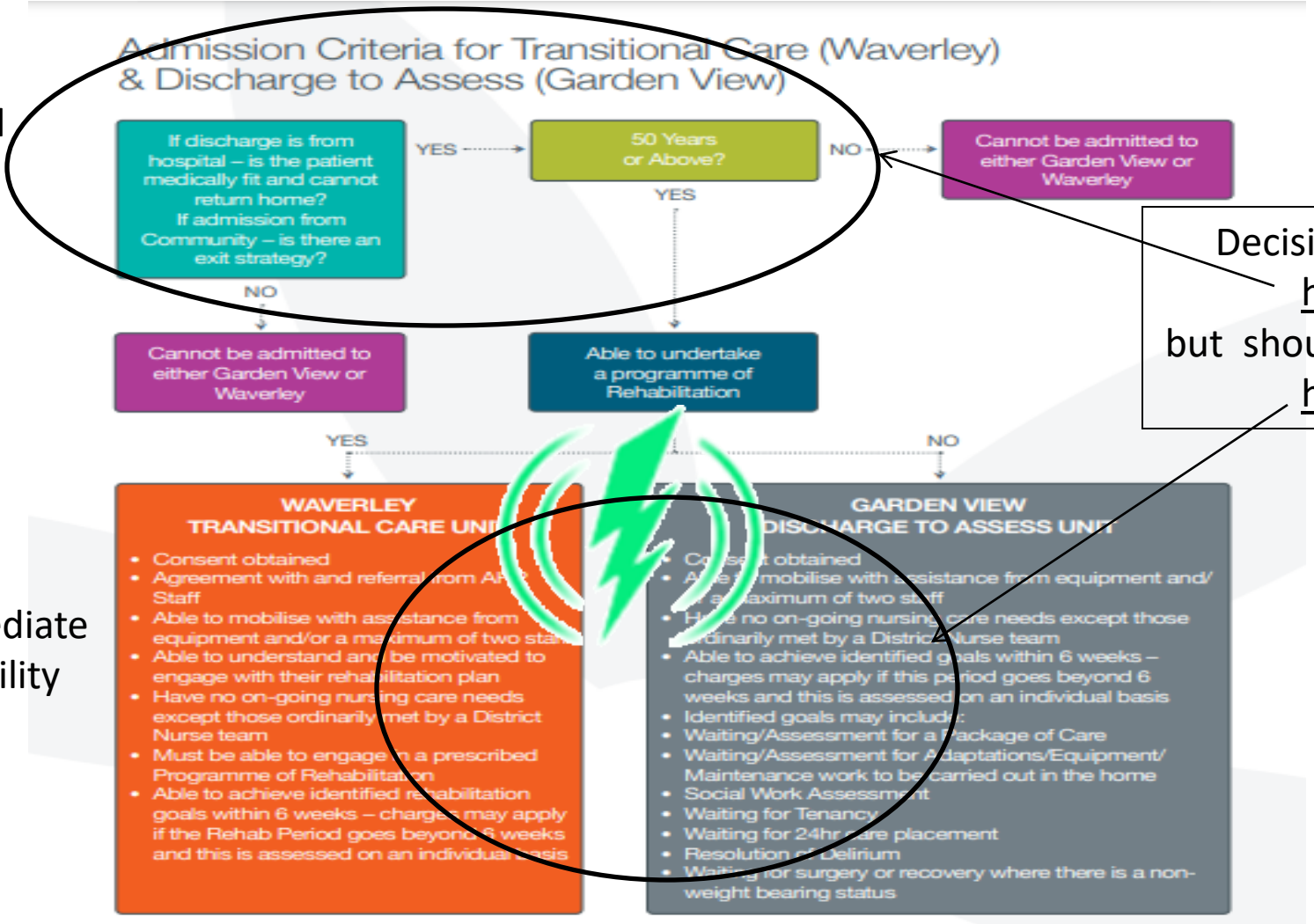




Bed-based D2A Pathway in Borders: Single pathway but 2 facilities

Hospital

Intermediate care facility



Decision taken here but should be taken here

Waverley Transitional Care

16 designated beds commissioned in 2017 in a 26 bed SBC residential care home in Galashiels. Dedicated AHP and HCSW resource but no nursing staff on site

Target cohort

Older people who are clinically stable and no longer need to be in hospital but require short term rehabilitation to regain their independence - and do not require care from a registered nurse.

Aims

- Facilitate timely discharge from BGH, particularly but not exclusively for residents of Central Borders which does not have a community hospital
- Provide rehabilitation support to enable people to fully achieve their functional potential and return home
- Reduce the demand for long term 24-hour care placements
- Improve client, carer and staff satisfaction

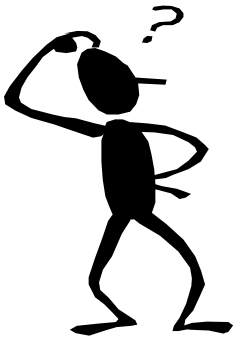
Waverley Referrals

- Average referral - transfer time = 1.8 days
- Redundant capacity - occupancy consistently less than 70%

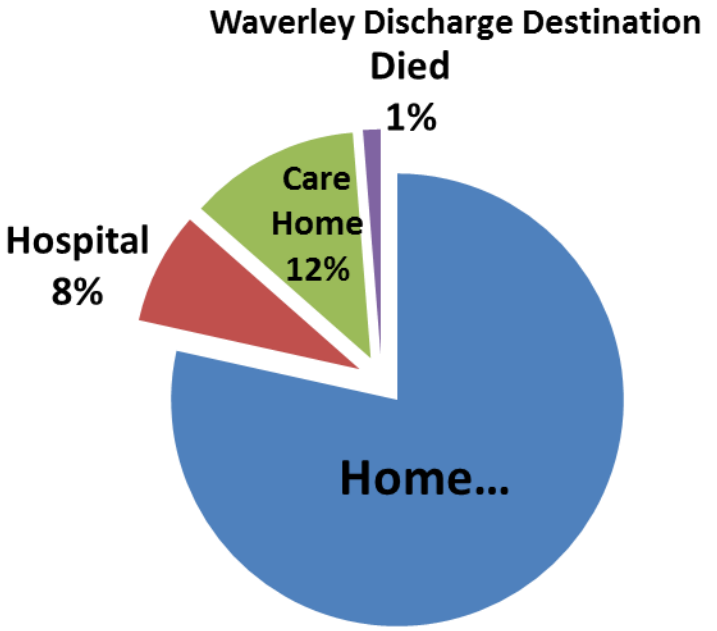
- Average 124 admissions /year; 85% Central Borders residents

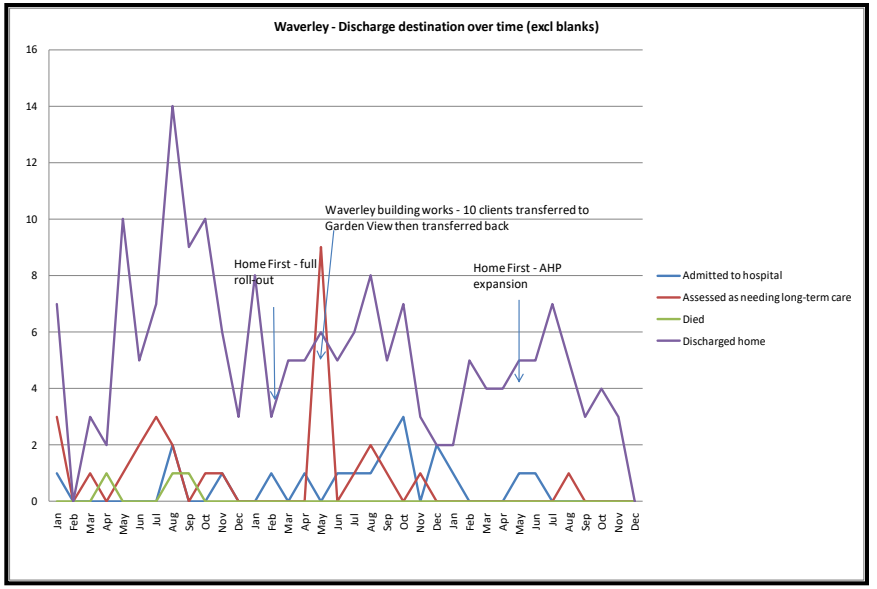
- Casemix – largely fits admission criteria
- Average age 84 years; 3% <65 years; 71% female
- 94% had mobility issues or used a mobility aid
- 35% needed help to manage continence
- 33% had visual impairment
- 8% had another mental health illness

- Only 20% had cognitive impairment
- Only 70% required help for washing and showering



Waverley Outcomes





Average Length of stay: 25 days – NAIC benchmark 26 days

Cost per case £6,152 – NAIC benchmark: £5,486

Waverley outcomes against objectives

1. That individuals admitted to the facility can transition back to their own homes → Discharge home rate – 79% (benchmark – 80%)

2. That individuals who return home, stay at home → Readmission to hospital:
   - 7 days: 1% (BGH benchmark, 6%):
   - 28 days:6% (BGH benchmark , 10%)

3. That individuals remain as independent as they were prior to their admission to hospital → V limited data – but suggests improvement in all cases (benchmark: 85% improve)

Reflections

Admission criteria target people with mild – moderate dependency. Home First is now offering an alternative pathway for this group

Excludes people with nursing needs – those with nursing needs from Central Borders are still staying longer in BGH

Largely excludes people with dementia/ delirium. Garden View now offers alternative pathway for this group but ‘’no rehab potential’’ should be a retrospective diagnosis

Operates as a step-down service only and Central Borders residents still lack a step up alternative to BGH

Garden View Discharge to Assess Unit

• 15 (up to 24) beds in SBC residential care home in Tweedbank , est. 2017

• to assess support needs of older people in an enabling environment prior to return home or moving to supported accommodation for long term care.

Target cohort

•Initial focus - assessment of post acute care patients with no on-going nursing care needs and a goal to return home.

•From Oct 2018, criteria extended to assessment for 24 hour care

Aims

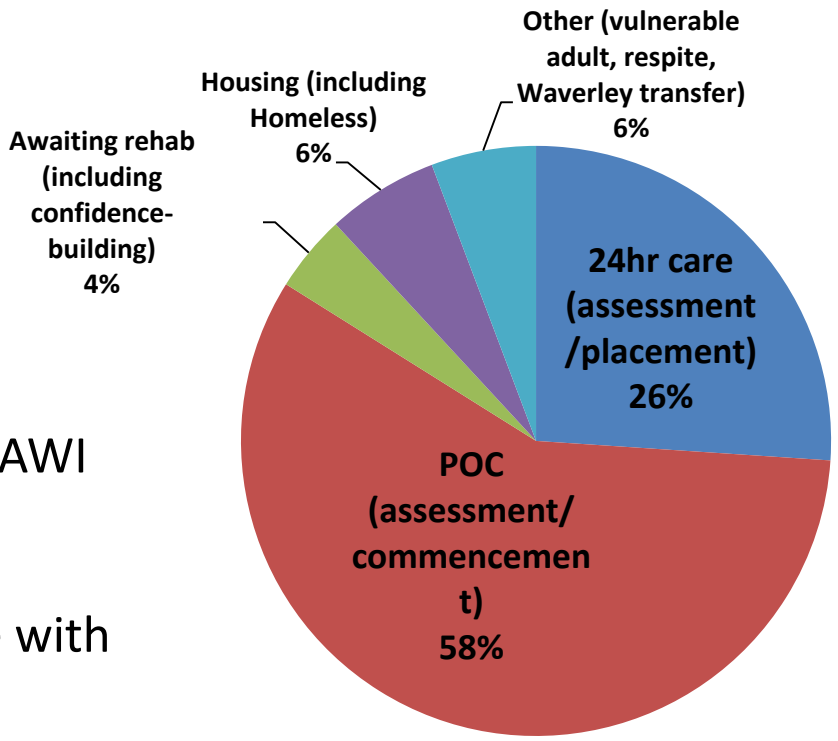
- Individuals stay no longer than 2 weeks (Oct 2018 revised to 6 weeks)
- Individuals are discharged home (or to care home from Oct 2018)
- Individuals who return home, stay at home
- Feedback from people who use the service is positive
- Feedback from staff is positive

Garden View Referrals

- Referral - transfer time = 3.6 days
- 145 admissions /year
- Occupancy 65%

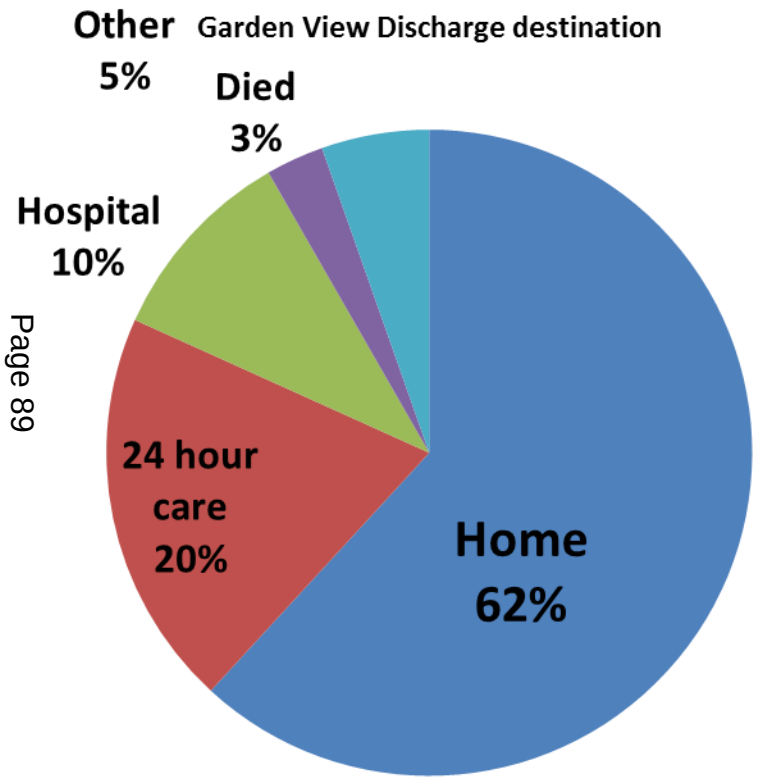
- Average age 84 years
- 4% < 65 years
- 52% Central Borders
- Casemix as Waverley but less mobility problems and more AWI and cognitive impairment

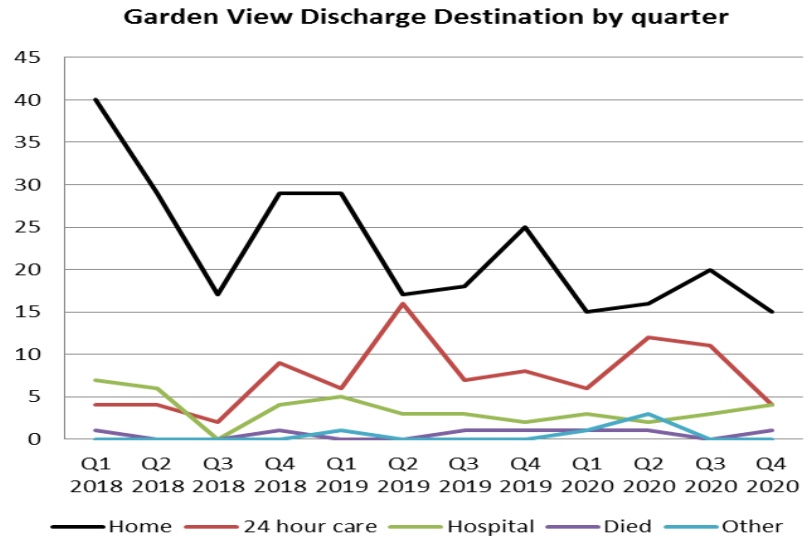
- 58% had initial goal for home with Package of Care (POC)
- 26% initial goal for 24 hour care



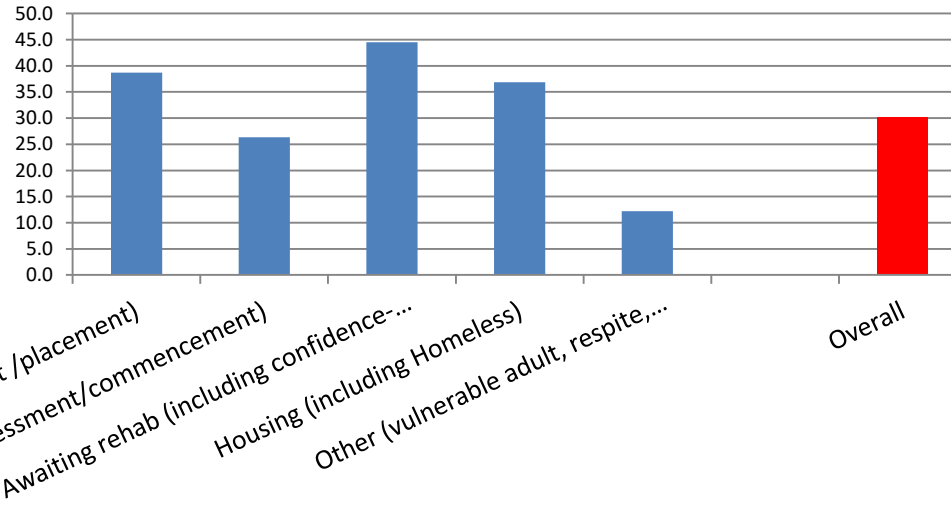
Admissions by reason (2019 onwards)

Garden View Outcomes





Average Length of stay by reason for admission



Costs per case: £7,167
(benchmark: £5,486)

Garden View outcomes

1. Individuals stay in Facility no longer than 2 weeks (6 weeks from Oct 2018) → 70% stay less than 6 weeks (30% less than 2 weeks) (2020 data)

2. Individuals that stay in the Facility are able to be discharged home → 68% referred for package of care discharged home (English benchmark: 69%)

3. Individuals who return home, stay at home → Readmission to hospital:
   7 days: 2% (all BGH, 6%):
   28 days:6% (all BGH 10%)

4. Service Users Feedback is positive → Care Inspectorate feedback +ve

5. Staff Feedback is positive → No staff feedback available

Reflections

Admission criteria target people with mild – moderate dependency
Home First is now offering an alternative pathway for D2A at home

Excludes people with nursing needs – those with nursing needs from Central Borders are still staying longer in BGH

Accepts people with dementia/ delirium but they have no access to AHP support

Operates as a step-down service only

Outcomes are primarily process (assessment and access to POC / placement) rather than functional outcomes

Large number of beddays for a small number awaiting housing solutions

Home First

- Time limited home-based reablement and support service
- Health Care Support Workers under guidance from District Nurse and/or AHP
- Incremental roll out over 2018. Fully across Borders by March 2019. Full AHP complement established May 2020

Target- older people who need assessment and support to remain at home or return home following an episode of illness or crisis

<u>Aims</u>

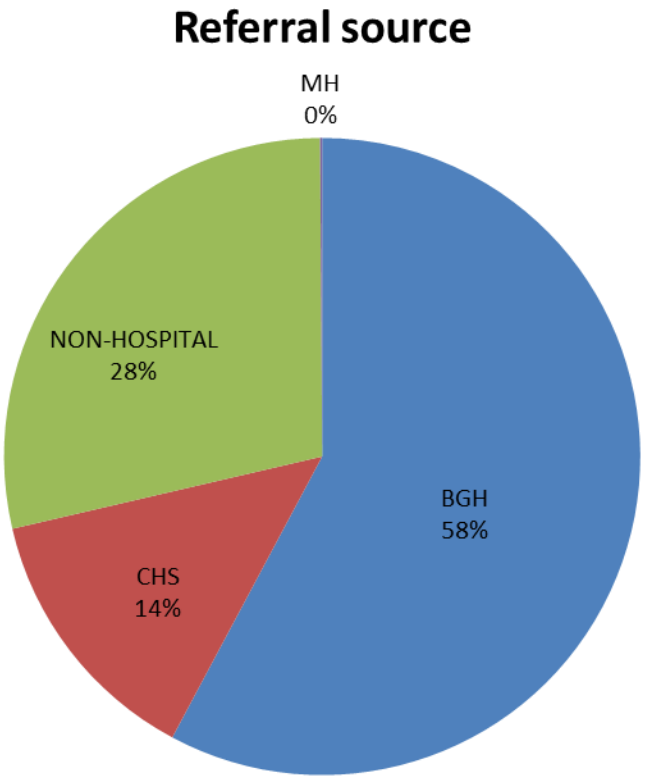
- Support earlier discharge from hospital
- Maximise rehabilitation potential during the early weeks post discharge
- Support individuals to continue to live at home.
- Increase capacity of homecare provision by reducing ongoing care needs by 40%
- Increased engagement with community based services in each locality
- Reduce avoidable attendances / admissions to hospital

Home First Referrals

- Caseload 1280 pts/year
- 24% step up from community
- 76% step down from BGH or community hospitals

- Average time from referral to first visit = 1 day;
- 84% seen at home within 48 hr

- 80% remained at or returned home



Home First Outcomes

- Personalised reablement
  - 57% did not require care at end of Home First episode
  - 17% improvement in average Therapy outcome measures
  - 57% overall reduction in ongoing care packages

- LOS in Home First Reablement: 22 days

- 11% (Re)Admission to hospital in 28 days – compares with 19% 28 day readmission rate for Geriatric medicine, 16% General medicine patients

Home First outcomes (2)

1. Personalised re-ablement approach to maximise rehab potential post discharge → Functional status on discharge:
   - improved -75%
   - Same – 23%
   - Deteriorated – 3%

   (NAIC benchmark: 66% improvement)

2. Reduce care needs of this cohort by 40% → Overall 57% reduction in care needs at discharge

3. Increase engagement with community based services → Limited data (DNs 3rd highest referrers)

4. Support individuals to develop confidence and skills to remain at home. → Discharge home rate – 80%

   Readmission rate – 11% (all BGH: 10%)

5. Reduction in hospital attendances / admissions → Reviewed later

Reflections

Efficient, effective and well received service but variable uptake across localities

Only 24% were Step-up referrals from the community (aim for 50%)

High rate with no care package required at end of Home First episode suggests chronic care and support needs were not high

Reduction in care needs post-reablement for those who had a PoC was only 11% (should be around 30%)

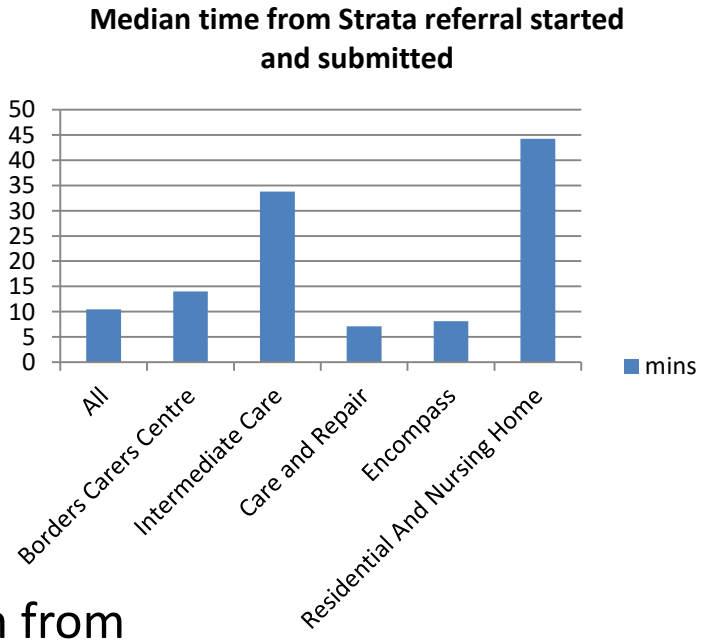
Enabling Infrastructure

Prompt matching of care and support needs to care providers is vital for an efficient and responsive service

Matching Unit now mainstreamed to Business As Usual within SB Cares. 10% increase in activity. The function now continues within core budget.

Strata

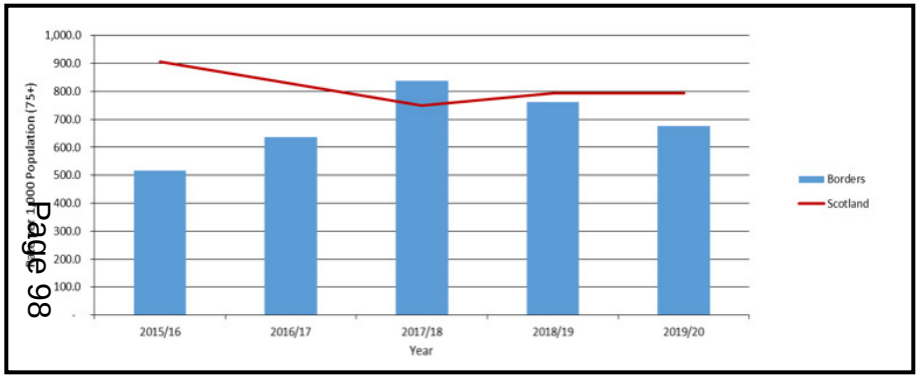
- Currently 600-800 referrals/mth (10,000/yr)
- Supports digital referral to Residential Care, Intermediate Care and third sector services: Encompass, Carers' Centre, Care & Repair
- Plan roll-out to homecare, community hosps
- Gap- not currently available to referrals from community



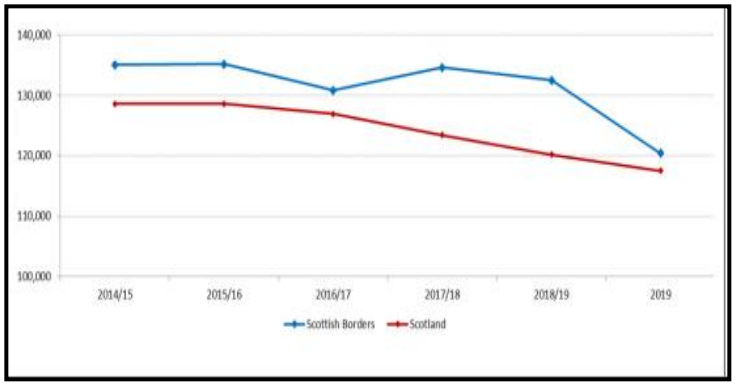
Opportunity to develop a single referral system from primary care/community services (big red button)

Contribution to National Health and Wellbeing Outcomes

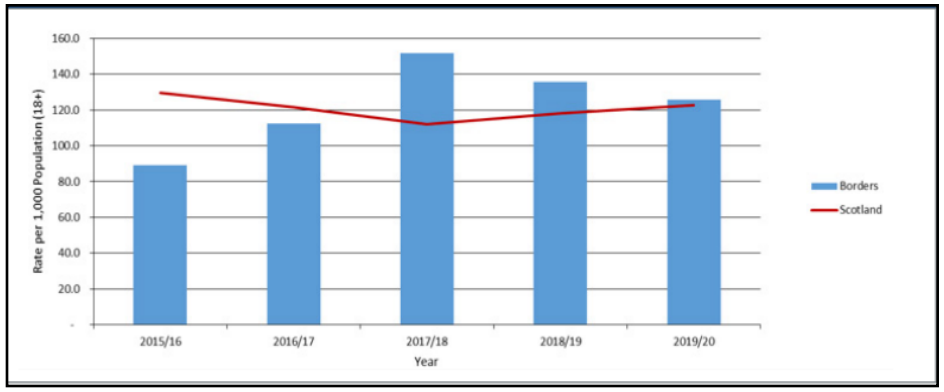
NI 19 – Number of days people aged 75+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 75+)



NI-13 Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)



Number of days people aged 18+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 18+)



Since 2017, BGH beddays for >65s have decreased by 5% and Length of Stay reduced by 11% despite admissions increasing by 7%

Cost

- Cost per case
  - Bed-based slightly higher than benchmark – result of low occupancy
  - Home First comparable to benchmark

- Counterfactual – cost of not providing service
  - Between 36-55 hospital beds
  - Approx. 5% additional care hours

Final Reflections

- IC services are effective for the current casemix but there are gaps in their reach for important care groups

- These services should be mainstreamed as business as usual to allow more strategic redesign and commissioning

- Home First should be the default and should be aligned with What Matters locality hubs and services to enable closer working with local housing providers and Third sector support and increase step-up IC

- Bed based IC should be streamlined as a single pathway for older people with post acute reablement / rehab / nursing care needs that cannot be met by Home First, particularly for residents in Central Borders

Strategic Developments

(Commissioning Framework)

- Further develop the D2A and IC services and fully align these with the Older People's Pathway developments
- Use Strata referral management data to build a core dataset and quality indicators for IC to assure quality and best value
- Link IC core dataset with Tableau and Source information to track impact on balance of care and resource utilisation to inform future commissioning
- Explore potential for using NearMe for Prof to Prof decision support and other opportunities for Technology Enabled Intermediate Care from the Joint Digital Strategy
- **Develop a Strategic Framework for Intermediate Care in Scottish Borders built up within each locality to integrate with the range of locality assets and services including the Community Hospitals**

Commissioning for Best Value

MEDIA RELEASE

11th December 2020

Share in the success of Shared Lives

Leading social care charity Cornerstone, have recently established their new Shared Lives service in the Scottish Borders and are looking for families, couples or individuals who feel they can make a real difference to someone's life by becoming shared lives carers.

Shared Lives is similar to fostering, helping people aged 16 and over with a wide range of disabilities, conditions and other support needs to live in their local community, by matching them with an approved carer. Carers share their home, family and community life with the person they are supporting, whilst providing them with the care they require in an inclusive and homely environment. Every placement is unique, with the support provided being tailored to meet the individual needs of each person. This includes people with learning disabilities or mental health issues, older adults and also young people being supported through transitional services. Placements can be offered on a full-time, short break or interim basis.

Andrew Will, Project Leader for Shared Lives Borders explains: "Shared Lives is set to make a huge difference to the lives of adults with disability and support needs in the Scottish Borders. We have recently approved our first six amazing families, all of whom will be a real asset to the Shared Lives service, and we are now looking to recruit more. Becoming a Shared Lives carer can be such an enriching experience and we are actively looking for a range of people from diverse backgrounds and with a wide variety of life experiences".

Andrew adds "For many people the last year has been challenging, disruptive and unsettling, with many re-evaluating their life priorities and considering a possible change of direction. I would encourage anyone looking for a truly rewarding life-change to seriously consider Shared Lives".

By choosing to become a Shared Lives carer, Cornerstone offers you the following;

- Full training to develop and build on existing life skills & knowledge and enhance professional development.
- A generous allowance and additional help with household costs
- Regular support from your assessor and 24hour on call service provided

- Continuous information updates regarding laws and legislation policies & procedures changes
- Opportunities to help evolve and shape Health & Social care provision for the future
- Information and guidance to access membership with Shared Lives plus and support groups within the local and wider community
- Ongoing support to ensure that you and the supported person have a successful transition and placement in your home
- Links to many different professionals including social workers, therapists, health care professionals, and community groups to ensure that all aspects of the supported person's life and needs are met, as well as those of the carers

One of the first couples to join the Shared Lives Borders service are Betty and Ian Falconer, from Newtown St Boswells. Betty explains: "The whole experience of joining the Shared Lives service has been very rewarding and we were delighted to be approved as carers, providing a young man with a supportive and loving family home. The support and training offered by Cornerstone has been great and has given us a really good insight into our caring role. We covered lots of different aspects including the legal process, health and safety and adult support and protection, and also explored some of the challenges we might come across. There has always been someone there to help us. I would encourage anyone who can consider offering a vulnerable adult the opportunity to become part of your extended family in a caring, supportive and stable home, to get in touch!".

Doreen Murray, another recent addition to the Shared Lives Borders team from Earlston adds: "As a family, it would be true to say we were apprehensive about becoming Shared Lives carers, having never considered this as an option before. However, the process was easier than we had anticipated and everyone involved has been kind, helpful and supportive. We are really looking forward to working together as a team, to provide a secure and happy setting for our young man".

Becoming a Shared Lives carer is guided by an initial process where the emphasis is on exploring if Shared Lives caring is right for a particular family. The process takes into consideration life experiences, motivations and mandatory checks and will help prospective families understand the rewards and challenges that becoming a Shared Lives carer could offer. The Shared Lives assessment and training process takes about four to six months and once complete is presented to an independent panel of professionals for approval. Once approved, a matching process begins where people are carefully matched with carers who are best suited to meet their needs. Planned visits take place supported by a nominated assessor and any areas where further support, training, or professional input may be required are identified.

Rob McCulloch-Graham, Chief Officer Health & Social Care, said: “The Scottish Borders Health and Social Care Partnership is excited to welcome our first carers to the newly commissioned Shared Lives Scheme to be run by Cornerstone.

“Shared Lives is an additional form of support that we can now provide adults with a learning disability to enable them to live within the community as equal and valued members of society, with these first carers being part of a group of 25 delivering such support over the next two to three years.

“We look forward to continued excellent partnership working with Cornerstone and seeing the undoubted opportunities our new and subsequent carers will provide adults with a learning disability in the Borders.”

Cornerstone has successfully run a similar Shared Lives service throughout the west of Scotland for the last 19 years. Christine Spiers is a Shared Lives carer in Ayrshire who explains: “Just over seven years ago we moved house, due to my husband Archie’s work. This led me to reassess what I wanted to do. I was sharing with a friend one day some of the ideas Archie and I had been looking into and she suggested we look at the Shared Lives service. Straight away we felt it was for us. All our children had flown the nest, so we had plenty of time and space to offer someone a loving, caring home. We contacted Cornerstone and have never looked back - being part of Shared Lives allows me to continue working with people and be at home to support Archie at the same time. Iram is a very much-loved member of our family and really enjoys living with us”.

Iram adds: “I have lived with my new mum and dad Archie and Christine and my niece and nephew Ellie and Riley for five and a half years. Shared Lives makes it possible to be part of a family again. It’s great living with the kids as I love children - we spend lots of time together having fun. I like being part of a family I have tried living on my own and really didn’t like it. Having a family is much better”.

Cornerstone’s Shared Lives service is registered with the Care Inspectorate as a Shared Lives Scheme and the service is an active member of Shared Lives Plus. You can find out more about becoming a Shared Lives carer by emailing: sharedlivesborders@cornerstone.org.uk or calling 01896 808750.

-Ends-

INTERVIEWS AND ADDITIONAL CASE STUDIES AVAILABLE ON REQUEST

Photographs: BettyandIanFalconer.jpg, ChristineandIramwithfamily.jpg, ChristineSpiers.jpg

For further press information contact: Katie Ronald, Cornerstone Marketing and Communications Lead on 07908 61 64 62 or email katie.ronald@cornerstone.org.uk

Editor's Notes

- Cornerstone is a leading social care charity that delivers vital services to people with a variety of physical and learning disabilities in Scotland. Since being first established in 1980, Cornerstone has grown to become one of the largest care providers across the country.

- During 2019 – 2020, Cornerstone delivered high quality care and support to adults, children and young people across Scotland with a variety of needs including learning disabilities, physical disabilities, autism, Asperger's and elderly care. The charity supported a total of 2,822 people, including 307 children and young adults. 327 people supported received 24 hour support, and 675 were based in the community. 386 people lived within sheltered housing and a further 73 people lived in our registered care homes. We were able to provide respite care to 72 people and 193 people were able to attend our day services.

- As a leading social care provider, Cornerstone is transforming social care through a culture of trust, empowerment and teamwork. With a focus on increasing social inclusion and reducing loneliness as well as improving health, independence and wellbeing, Cornerstone teams work closely with the people they support to set goals and ensure the high quality care and support they need to live a meaningful and valued life is available to them - where they need it, when they need it.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 February 2021

Report By:	Susan Henderson
Contact:	Susan Henderson
Telephone:	01896 840200 / 07772 912 373
SHARED LIVES UPDATE	
Purpose of Report:	To provide an update to the board on the progress of development of new Shared Lives Scheme.
Recommendations:	The Health & Social Care Integration Joint Board is asked to **note**: • the progress to date with regards to the set up of the new service and note that the first Shared Lives Carers were approved at panel. • That the Health and Social Care Leadership team will be asked to determine the demand for Shared Lives for other client groups in years 4-5 and indicate priorities to enable planning to begin in year 3.
Personnel:	This project is managed by the Learning Disability Service Planning and Development Officer. The service is commissioned by a 3rd sector provider – Cornerstone.
Carers:	Existing foster carers, who were considering becoming Shared Lives Carers, have been active participants involved with the set-up and implementation of the new Shared Lives Scheme from supporting the writing of quality questions within tender documentation through to interviewing organisations and reviewing the steps within the set up of processes and support arrangements. This has ensured that Carers will receive appropriate support and that situations arsing in the set up phase were addressed promptly to mitigate against any issues arising. The first 6 families have been approved at panel and the Shared Lives arrangements began on 30th November 2020. 5 of these are long term live in arrangements and 1 is a respite arrangement. Benefits of being a Shared Lives Carer are well documented and refer you to the IJB report of 25/2/2019 for these.
Equalities:	*n/a at this stage*

Financial:	The IJB authorised the funding of start up costs for this project split over 2 years with ongoing funding being met within the LD Commissioning budget. Our business case indicated that over the 3 year lifespan of the initial contract we may accumulate a cost avoidance of approximately £1.6m. Support arrangement costs are considerably reduced in comparison to the alternatives models of Supported Living and Care Home models of delivery and this will run as a cost avoidance model. Early indications demonstrate an in-year saving of circa £48k comparing previous foster care costs with Shared Lives costs. Moving forward, long term care cost avoidance would amount to circa £164.5k for these 6 people.
Legal:	This supports the move of young people from Foster Care registration to an adult placement scheme - Shared Lives where their existing foster carers can (when appropriate) become Shared Lives carers. Of the original 8 young people identified, 6 have now moved to the Shared Lives Scheme with their foster carers becoming Shared Lives Carers; 1 is moving into a different model of support by Jan 2021 and 1 other will be moving to a Shared Lives arrangement in the new year.
Risk Implications:	*Legal Risk as above in legal section now almost completely resolved.*

Situation

The Scottish Borders Shared Lives Scheme contract became live on 1st March 2020. The Service provider has worked closely as part of a project team with Scottish Borders Learning Disability services and Children's Services to progress and put in place all the relevant processes alongside carrying out the assessments of the first cohort of 6 families who were the existing foster carers of 6 adults with learning disabilities. All 6 families were successful at the Shared Lives Approval Panel and individuals started their new Shared Lives arrangements on the 30th November 2020. This is an incredible achievement during the global COVID-19 pandemic and a real tribute to the dedication of the project team and new provider working in partnership with the families.

Please see attached media release that Cornerstone will be issuing in week of 14 Dec 2020 for further information and quotes from various stakeholders.

Background

Work took place with Shared Lives Plus in 2018 to progress the development of the business case for Shared Lives as part of the Scottish Borders Learning Disability Strategic Commissioning Plan 2015-2019. In 2019 the Integrated Joint Board approved

funding to begin the set up of the new scheme and a collaborative approach to a robust tendering process and award of preferred tenderer took place.

Assessment

The first 6 families have now been approved as Shared Lives carers enabling 6 adults with learning disabilities to continue to be supported in the families they already live with.

A further cohort of young people have been identified who will benefit from this support arrangement and their prospective Shared Lives carers will go through the assessment process over the next few months.

The project manager will now be liaising with the Health and Social Care Leadership Team with regard to the future expansion of Shared Lives in Scottish Borders. Planning will need to commence during the next 12 months of the contract (year 2) in order to expand the service to other service user groups e.g. older adults, adults with mental ill health and adults with other disabilities from year 4 of the 5 year contract.

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Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 4 November 2020** at **10am** via Microsoft Teams

Present:
Malcolm Dickson, Non Executive NHS Borders (Chair)
Rob McCulloch-Graham, Chief Officer
Caroline Green, NHS Public Participation Network Representatives
David Bell, Joint Staff Forum
Colin McGrath, Community Councillor
Diana Findlay, Public Member
Lynn Gallacher, Borders Carers Centre
John McLaren, Joint Staff Forum
Gerry Begg, Housing Strategy Manager
Jane Douglas, Chair of Scottish Care
Kathleen Travers, Borders Voluntary Care Voice
Graeme McMurdo, Programme Manager

In Attendance:
Iris Bishop, Board Secretary
Susan Holmes, Communications Officer
Brian Paris, Project Manager

1. Apologies and Announcements

Apologies had been received from Dr Tim Young.

The Chair confirmed the meeting was quorate.

2. Minutes of the previous meeting

The minutes of the previous meeting held on 5 August 2020 were approved.

3. Matters Arising

Action18: Mr Graeme McMurdo advised that the EQIA had been updated, however he had not shared it with the Group. Mr McMurdo agreed to circulate the EQIA to the group for information.

The **STRATEGIC PLANNING GROUP** noted the Action Tracker.

4. Performance Report

Mr Graeme McMurdo provided an overview of the content of the report. He advised that the social care indicators were recorded at a point in time and he was actively seeking more

recent data. All of the data within the report was pre-COVID-19, however he had noted in certain areas of the report the impact of COVID-19. He emphasised that in some circumstances an improvement in performance could be seen and could be correlated directly back to the COVID-19 impact.

Mr McMurdo spoke to the key elements of the report including: improvements in performance for emergency hospital admissions for the over 75s, predominantly due to the impact of COVID-19; A&E attendances had dropped, due to the impact of COVID-19 as people refrained from attending A&E; A&E waiting times performance had reduced and had been significantly impacted by COVID-19; emergency hospital stays; Older people receiving packages of care; reduction in occupied bed days, largely due to the impact of COVID-19; snapshot of delayed discharges data; patient survey; acute patient discharges to residential care; emergency readmissions; end of life care; carer support plans and outcomes; and domiciliary care.

The Chair noted the positive point on page 6 of the report in regard to occupied bed days for emergency admissions and the sustained performance since 2018. Mr McMurdo agreed that it would be good to see performance continue to be sustained in the longer term.

Mr David Bell enquired about waiting times performance. Mr Rob McCulloch-Graham advised that scrutiny of waiting times data was being undertaken and he was awaiting feedback on the reasons for delays.

Mr Bell enquired about the percentage of older people receiving home care and whether their quality of life was improving. Mr McCulloch-Graham commented that surveys were undertaken and a report had been commissioned from the external auditors to look at packages of care, lessons learnt from COVID-19 and delayed discharges. He further commented that he was aware of the challenges for carers in looking after family members who would normally have access to respite and day services and additional resources were being put in place to support people further.

Mr McMurdo commented that any reduction in packages would be as a consequence of an assessment having been carried out. He anticipated a measured reduction in packages of care as the reablement service was introduced.

Mrs Jane Douglas enquired if any packages of care had been increased and in offering care at home if the frailty of people could be captured which would assist care homes when undertaking placements. Mr McCulloch-Graham commented that all services were driven to keep people at home or in a homely setting for as long as possible for quality of life purposes. Sometimes a person's quality of life would be better met, if they were admitted to a residential care facility and discussions would have been undertaken by social workers and clinicians before any such decision was made.

Mr Brian Paris commented that it was recorded both where packages of care were increased or decreased as part of the individuals review process.

Mrs Lynn Gallacher commented that there were delays in having the assessments completed which had an impact on the cared for person and the carers involved, as well as potentially

impacting on the frailty of people prior to admission to a care home. She was keen that the gap in the provision of day care services be highlighted.

Mr John McLaren highlighted the reported performance against Objective 1, Improving Health and Reducing Hospital Admissions, and commented that there was a need to focus on the whole objective and not just a part of it. He noted that whilst performance appeared to be good it was probably a consequence of the impact of COVID-19.

The Chair commented that waiting times and A&E performance were likely to be as a consequence of the response to the pandemic given the Ambulatory Assessment Unit (AAU) had ceased to operate alongside A&E. The AAU was the facility whereby doctors would prearrange admission to the hospital. Mr McCulloch-Graham commented that the AAU did serve to reduce the pressure on the Borders General Hospital (BGH) and it did have an impact on waiting times but it was difficult to quantify it.

The **STRATEGIC PLANNING GROUP** noted and approved any changes made to performance reporting.

The **STRATEGIC PLANNING GROUP** noted the key challenges highlighted.

5. Annual Performance Report

Mr Graeme McMurdo provided an overview of the content of the report and commented that it had been published. There had been a legislative requirement to produce the report by July however an extension to that deadline had been granted due to the pandemic. He further commented that the report had been received by the Integration Joint Board at its' August meeting and had been broadly accepted bar a few minor amendments.

The Chair commented that it had been a well written report and the links contained within it added to its meaningfulness.

The Chair and Mr Rob McCulloch-Graham thanked Mr McMurdo for producing the report.

The **STRATEGIC PLANNING GROUP** noted the published report.

6. Service User Engagement

Mr Rob McCulloch-Graham provided an overview of arrangements through a presentation on Locality Working Groups and highlighted that the intention was for service user engagement to be run in conjunction with the traditional Locality Working Groups membership. He was keen to test the concept in the first instance.

Mr Graeme McMurdo commented that consultation was currently problematic due to the pandemic with all communication being managed online. He was keen that all avenues were joined together so that an answer on any topic could be provided to the community.

Mr David Bell supported the direction of travel and was keen for the partnership to become more open and accessible to the public.

Mrs Diana Findlay commented that when the Locality Working Groups were in operation they had met during the day which excluded a proportion of the public and equally if meetings were to continue online they would exclude those who did not have access to the required technology. The Chair echoed the point and commented that to exclude those without access to the appropriate technology was an inequality that should not be tolerated.

Mr McCulloch-Graham commented that meetings could be both recorded and broadcast and questions on the subject matter could be gleaned in advance. He also suggested people would be given the ability to post questions and comments whilst the meeting was taking place. There would however be a resource requirement and a limit placed on the length of time for conversations. He suggested if some groups could be pin pointed then a buddy system could be put into operation.

Mrs Kathleen Travers commented that the third sector had played a huge part in getting people onto digital platforms, offering devices, and assisting people to get online. Good partnership working had taken place between the third sector and local authority and there were now several digital champions in place and funding, support and training were being made available.

Further discussion focused on: empowering people to have a stronger voice; potential title change – Hearing Peoples Voices/Having Your Say; inclusion of current groups; and the potential in the future for a blend of physical and digital meetings.

Mrs Lynn Gallacher offered to scope the format for the future through her existing third sector groups.

The **STRATEGIC PLANNING GROUP** noted the update.

7. Update to SPG Terms of Reference

The Chair highlighted the changes to the terms of reference.

The **STRATEGIC PLANNING GROUP** accepted the revised terms of reference and recommended their submission to the IJB for formal approval.

8. Meeting Cycle 2021

The Chair introduced the paper.

The **STRATEGIC PLANNING GROUP** approved the proposed meeting dates and business cycle for 2021.

9. Lessons Learned – Delayed Discharge

Mr Rob McCulloch-Graham provided an overview of the content of the report and highlighted: ultimate destination of delayed discharges; trusted assessment scheme in the right place; 7 day working; intermediate care; areas of work currently underway; and external support and advice. He further commented that at the commencement of the pandemic packages of care

had been reduced and some had been reinstated but not all. Some multi disciplinary teams had felt that some packages of care had been over prescribed and were preventing some people from leaving hospital and were in effect building in delays.

Mrs Lynn Gallacher enquired if it would lead to pressure being taken off of community social workers assessing. Mr Brian Paris explained the process to be followed and the role of the Trusted Assessor. He emphasised that the point at which the social worker engaged with the person would be in their home setting and not in the hospital setting. The benefit to the system would be to reduce any unnecessary delays or burdens on people awaiting a social work assessment as it would be done by the appropriate professional earlier in their care package journey.

Mrs Gallacher commented that she had received feedback from some carers in regard to care packages, where they had made the choice to stop their care package but were now wishing to have it reinstated, however that was being denied due to a lack of resource. Also the status of some paid carers had changed again due to a lack of resource.

Mr Paris commented that some of the programme of work within the paper was in regard to how to improve capacity across the care providing organisations. With regard to packages of care, some had been reinstated and some had changed due to an increased frailty of individuals. He accepted that there were service capacity issues and the intention was to maximise the scheduling to focus on reablement which should lead to less demand on long term care packages. Change was taking place at the moment and would impact on the next few weeks and months and he accepted it would unfortunately cause some distress in some households.

The Chair commented that delayed discharges affected each part of the partnership in terms of health and social care as it impacted on their main resources. He enquired if a common approach was being taken to address delayed discharges. Mr McCulloch-Graham commented that there was a high degree of frustration across the partnership in regard to delayed discharges. The direction of investment and prioritisation had been confirmed so that a focus on intermediate care, trusted assessor, identification of care levels, gaps and policies could be taken forward. In terms of moving forward he emphasised the need for managerial grip, learning from the outcomes of the internal audit, noting pressure and demand and putting in place more processes to ensure the policies were being followed and were enabling people.

Mrs Diana Findlay commented that she assumed when a patient was in hospital it was the NHS budget that covered the costs and when a patient was moved to the community it was the local authority budget the covered the costs. She suggested therefore that it was that point that was the test of being a partnership. She further commented that it appeared as if the local authority seemed to have the delays in regard to calculating what was required for the patient. Mr McCulloch-Graham commented that Ms Findlay's analogy was correct, however, the Integration Joint Board held the budget for delayed discharges across both the NHS and local authority and had responsibility for the strategy and policies to deal with delayed discharges by moving funding to the community.

The Chair commented that the whole raison d'etre of the partnership was to stop what Mrs Findlay has described happening.

The **STRATEGIC PLANNING GROUP** noted the report.

10. Any Other Business

Community Empowerment: Mr Colin McGrath requested to speak to the Group about community empowerment. He spoke of various legislation that had been put in place including the Public Bodies Joint Working (Scotland) Act 2014, and the Community Empowerment Act 2015. He then spoke of the Care Inspectorate report from 2017 and its recommendation in regard to the partnerships' strategic planning and management.

Mr McGrath sought a public voice on the Oversight Board or its supporting workstreams. He had been keen to be a public voice on the IJB and he noted that Mrs Morag Low had a seat on the IJB in the service user context.

Mr McGrath was keen that public members or citizens were members of each workstream that fed into the Oversight Board, so that they could put their views to the workstream and be empowered to make decisions on what should happen. He did not believe the Chief Officer, Chair or Executives should be making the decisions.

Mr McGrath reported that he was liaising with the Cabinet Secretaries for Health and Communities (Cabinet Secretary for Health and Wellbeing, Cabinet Secretary for Communities and Local Government) and that they were not happy with the proper consultation and empowerment of the people not just in the Scottish Borders.

He offered the view that it was important not to fall foul of the Care Inspectorate and suggested they were very upset at missing a meeting of the Strategic Planning Group in 2019/20 as the date had been changed at the last minute. He suggested inviting the Care Inspectorate to a future SPG meeting to give them a view on what was happening and that it should include involvement in empowering the people. He then suggested that Service User Engagement be changed to Service User Empowerment.

Mr McGrath proposed that the Community Council Network, of which he was the Chair and which he said represented 69 community councils, could fulfil the service user engagement role for the IJB.

Mrs Diana Findlay supported Mr McGrath's suggestion and said there were weaknesses in the way the IJBs had been set up by the Scottish Government and if they wanted it they needed to give all the power to the Chief Officer.

Mrs Lynn Gallacher commented that user carer involvement was very important as carers were part of the solution and she was keen that as far as possible they were at the centre of the process. She suggested working together to find cost effective solutions to meet peoples needs. There were areas that needed to be worked on and improved and there would be lessons to be learnt from the COVID-19 pandemic.

The Chair enquired if consultation via the Locality Working Group structure would improve things. Mrs Gallacher said she believed a name change was definitely required and the existing groups should be used for engagement purposes. She provided the example that

there were 6 Locality Peer Carer Groups with 12 carers on each group throughout the Borders who had a strong voice and would be willing to be involved.

Mrs Kathleen Travers reiterated Mrs Gallacher's suggestions and commented that in terms of service users, there were various groups of service users that were up and running, that would be keen to be involved and would provide meaningful feedback. She provided the example of service user and carer groups for mental health and dementia. She suggested there was an opportunity to provide meaningful engagement with service users and carers and the third sector had a very big role to play in that engagement process.

Mr Rob McCulloch-Graham reported that in terms of the Care Inspectorate report of 2017, referred to by Mr McGrath, a follow up inspection and review had taken place and the partnership had made progress in all of the areas identified. It had been unfortunate that the Care Inspectorate were unable to attend the SPG but they had at that time been invited to come back to the IJB and to the SPG and they had not taken up that offer.

In terms of representation on the SPG, Mr McCulloch-Graham referred to the earlier discussion about service user engagement and reiterated that the existing carer and user groups and locality working groups should be used for that wider engagement. He was keen that the experience of direct live debate through online and potentially physical arenas was undertaken in the first instance.

In concluding the conversation the Chair made several comments including that he had exchanged correspondence with Mr McGrath in regard to his take on community empowerment. He sympathised that things did not appear to be happening as fast as everyone would like and so he undertook to promote the influencing role of the SPG and to build on what could be done with engagement through locality working groups. He agreed there could be a name change to the locality working groups initiative. In regard to the workstream groups that sit below the Oversight Board, they had been agreed, recommended to the IJB and adopted. He reminded the SPG that the Oversight Board was a management group and it would not be appropriate for any IJB Board members, let alone SPG members, to sit on that management group.

The Chair commented that it had taken a while to get to the current situation and the COVID-19 pandemic had slowed down engagement further. He welcomed the suggestion of putting empowerment into some of the structure.

Mrs Gallacher further commented that it was a good opportunity to look at engagement, learn from previous mistakes, look at what had and had not worked in terms of commissioning decisions in the past especially where carers and service users had not been involved, particularly in terms of home care. She was keen that carers and service users had a strong voice in the commissioning of services going forward.

Mr McGrath said he felt the public should have a bigger say in the running of services and referred to Eyemouth deciding to take control of the primary school and Jedburgh moving to take over council activities and receiving a fee.

Mr McCulloch-Graham proposed that once the scoping and initial testing of the new service user engagement had been undertaken then a potential revisit of Mr McGraths' discussion on empowerment could be undertaken, if the SPG had an appetite for that.

The **STRATEGIC PLANNING GROUP** noted the discussion.

11. Date and time of next meeting

The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 3 February 2021, at 10am to 12pm via Microsoft Teams.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 February 2021

Report by:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
STRATEGIC PLANNING GROUP MINUTES	
Purpose of Report:	To provide the Integration Joint Board with the minutes of the recent Strategic Planning Group meetings, as an update on key actions and issues arising from meetings held on 4 November 2020.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** these minutes.
Personnel:	As detailed within the minutes.
Carers:	As detailed within the minutes.
Equalities:	As detailed within the minutes.
Financial:	As detailed within the minutes.
Legal:	As detailed within the minutes.
Risk Implications:	As detailed within the minutes.

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NHS Board Chief Executives
Local Authority Chief Executives
Integration Joint Board Chief Officers
Third Sector Collaborative
Consultation Respondents

By Email

January 2021

Dear Colleagues,

I am writing to outline the next steps in the inclusion of Integration Joint Boards as Category 1 Responders under the Civil Contingencies Act 2004. As you may recall, we wrote to you in October to announce the consultation on the equality and Fairer Scotland Duty impacts of the above. I would like to thank all who took the opportunity to respond to the consultation. The consultation concluded on the 22 November and today we have published an analysis of the responses, the official Government Response to the consolation, the Equalities Impact Assessment and the Fairer Scotland Duty. These are available at: https://consult.gov.scot/health-and-social-care-integration/consultation-to-amend-the-civil-contingencies-act/

As you will see from the consultation analysis, of the 42 valid responses received, 16 made no comment about potential equalities impacts. Of the 28 responses which did comment on equalities impacts, the vast majority felt that there were no potential equalities impacts and no responses mentioned any specific protected characteristics.

Although the consultation asked only about equalities impacts, 33 respondents took the opportunity to provide their views on the proposal itself. Ten responses were broadly supportive of the proposal, 14 responses stated that they did not support the proposal. Objections were generally associated with views that the proposal is potentially burdensome/unnecessary; detrimental to existing systems; likely to create complexity; and not compatible with IJBs' constitution. These concerns are addressed within the Government Response.

It is worth reiterating that the proposal to legislate emerged from evidence during the pandemic, referenced by the Health and Sport Committee on the 17 June 2020, that in some areas IJBs were not included in local response activity by the Health Board and/or Local Authority. By including Integration Joint Boards as Category 1 responders, it ensures that where there is a risk of an emergency which will impact functions delegated to the Integration Joint Board, there will be formal, coordinated and appropriate arrangements in place for emergency planning; information sharing and cooperation with other responders; and joined up information sharing and advice for the public.

I note concerns expressed by some partners that this proposal is potentially burdensome. However, given local partners are already working within an integrated health and social care model there should be limited additional resourcing implications associated with the requirement. Officers engaged via partnership arrangements in the Health Board and Local Authority would be expected to ensure the IJB is briefed and included in discussions and planning.

In considering the responses to the consultation, I have therefore concluded that there are neither clear equality, operational nor strategic planning barriers to progressing the proposal and legislating for the IJB inclusion within the Civil Contingencies Act 2004 as Category 1 responders. Therefore, the amendments to the Civil Contingencies Act 2004 will be laid before the Scottish Parliament on Monday 18 January for due consideration.

I would like to again thank all who took the time to respond to the consultation.

Kind regards,

JEANE FREEMAN

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 February 2021

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
CATEGORY 1 RESPONDER	
Purpose of Report:	To advise the Health & Social Care Integration Joint Board that it has been included as a Category 1 Responder within the Civil Contingencies Act 2004.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the letter from the Cabinet Secretary for Health & Sport, dated January 2021, in regard to inclusion as a category 1 responder.
Personnel:	As detailed within the letter.
Carers:	N/A
Equalities:	N/A
Financial:	N/A
Legal:	Amendments to the Civil Contingencies Act 2004 were laid before the Scottish Parliament on 18 January 2021.
Risk Implications:	N/A

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