Strategic Implementation Plan for the Borders Integration Board 2019-2024

Contents

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

1. Purpose

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

2. Background and Context

2.1 Demographics

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

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

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

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

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

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

2.2 Health & Social Care Partnership Strategic Plan

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

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

Our Annual Performance Report shows progress against the Strategic Plan.

2.3 South of Scotland Regional Skills Investment Plan

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

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

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

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

2.4 Background Health & Social Care Reports

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

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

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

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

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

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

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

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

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

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

2.5 IJB areas of responsibility

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

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

2.6 Fit for 24 and Financial Turnaround

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

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

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

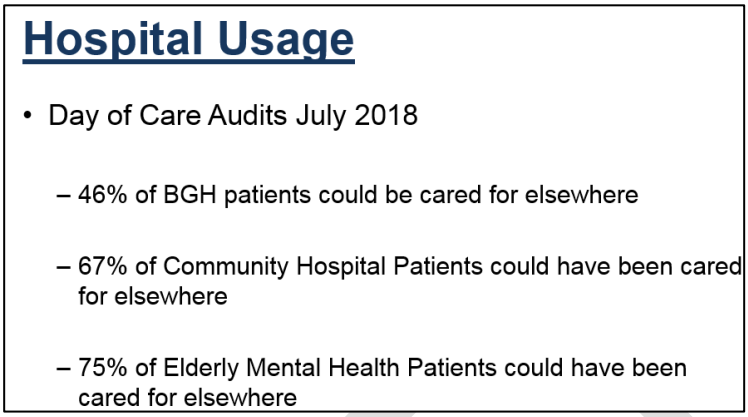
There is a lot of crossover between Health and SBC and there is a risk that unless both organisations work together to plan transformation & savings, and importantly ***agree*** the re-investment levels required to financially enable different and more effective ways of working, then change could be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

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

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

3. Current Position

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



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

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

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

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

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

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

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

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

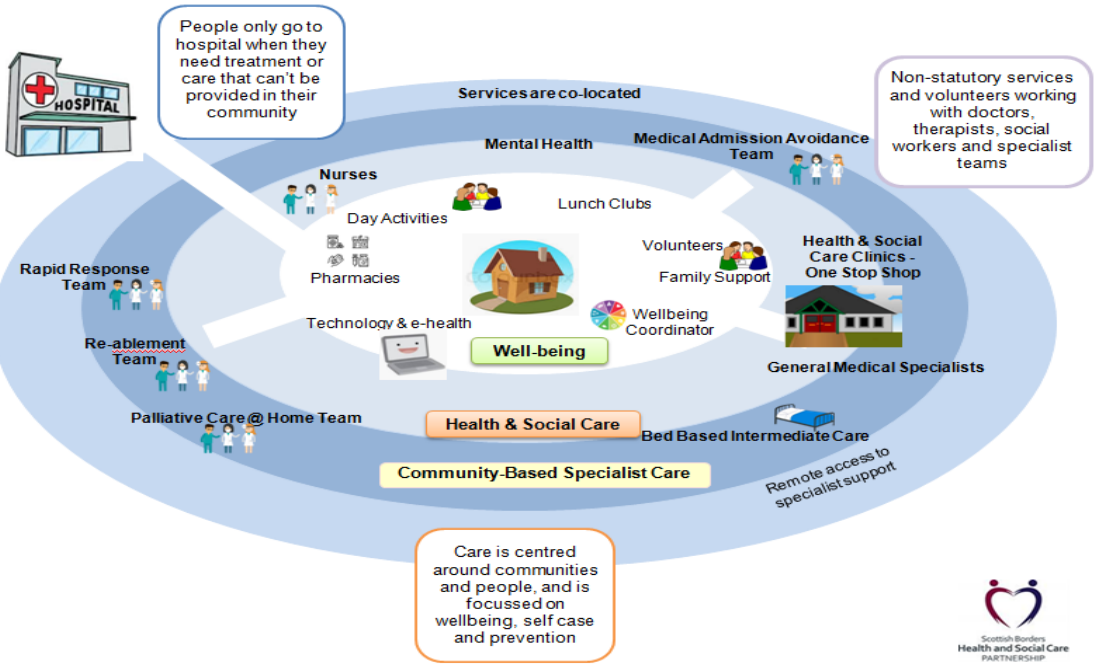
Our services in the main also operate within these same communities and can and do utilise them to the benefit of population, but we need more activity particularly for those citizens who would benefit most.

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

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

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

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



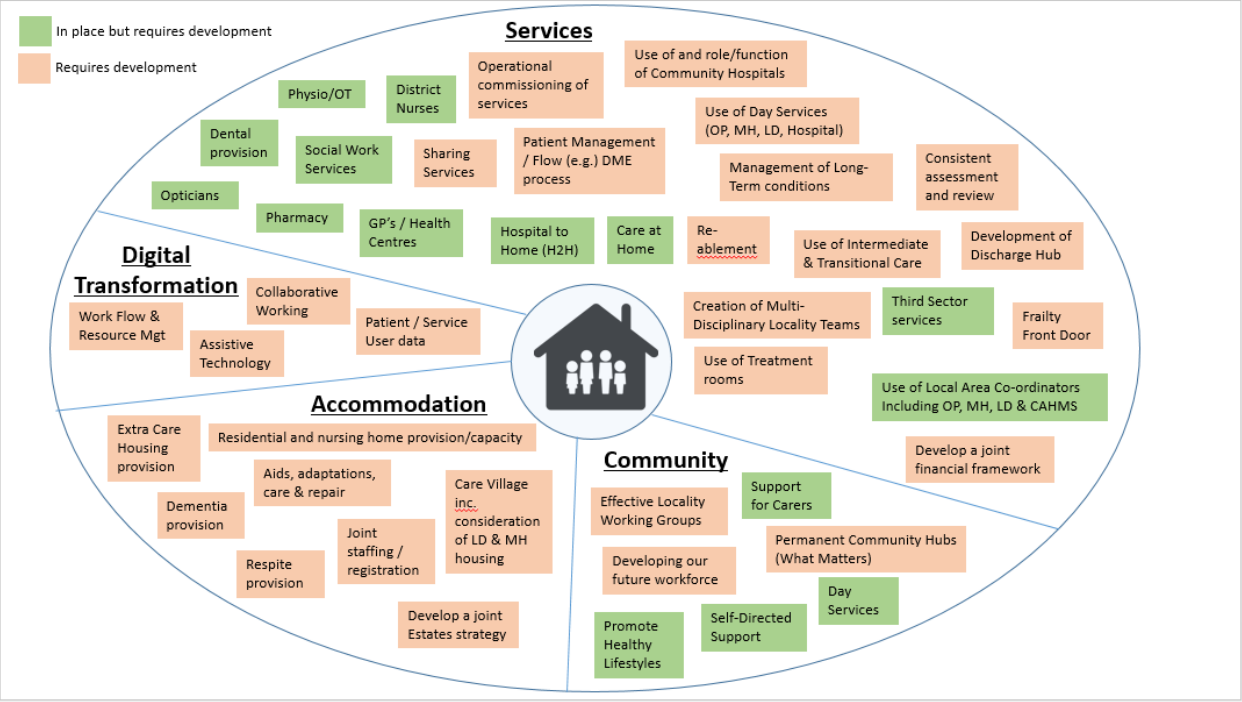
The IJB currently commissions almost 1,000 beds across health and care provision. All of these beds provide the care required however none of them are as good as the beds in the homes of our Border Citizens.

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

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

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

4.1 Locality Operation



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

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

In summary:

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

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

4.1 IJB Implementation Work Plan

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

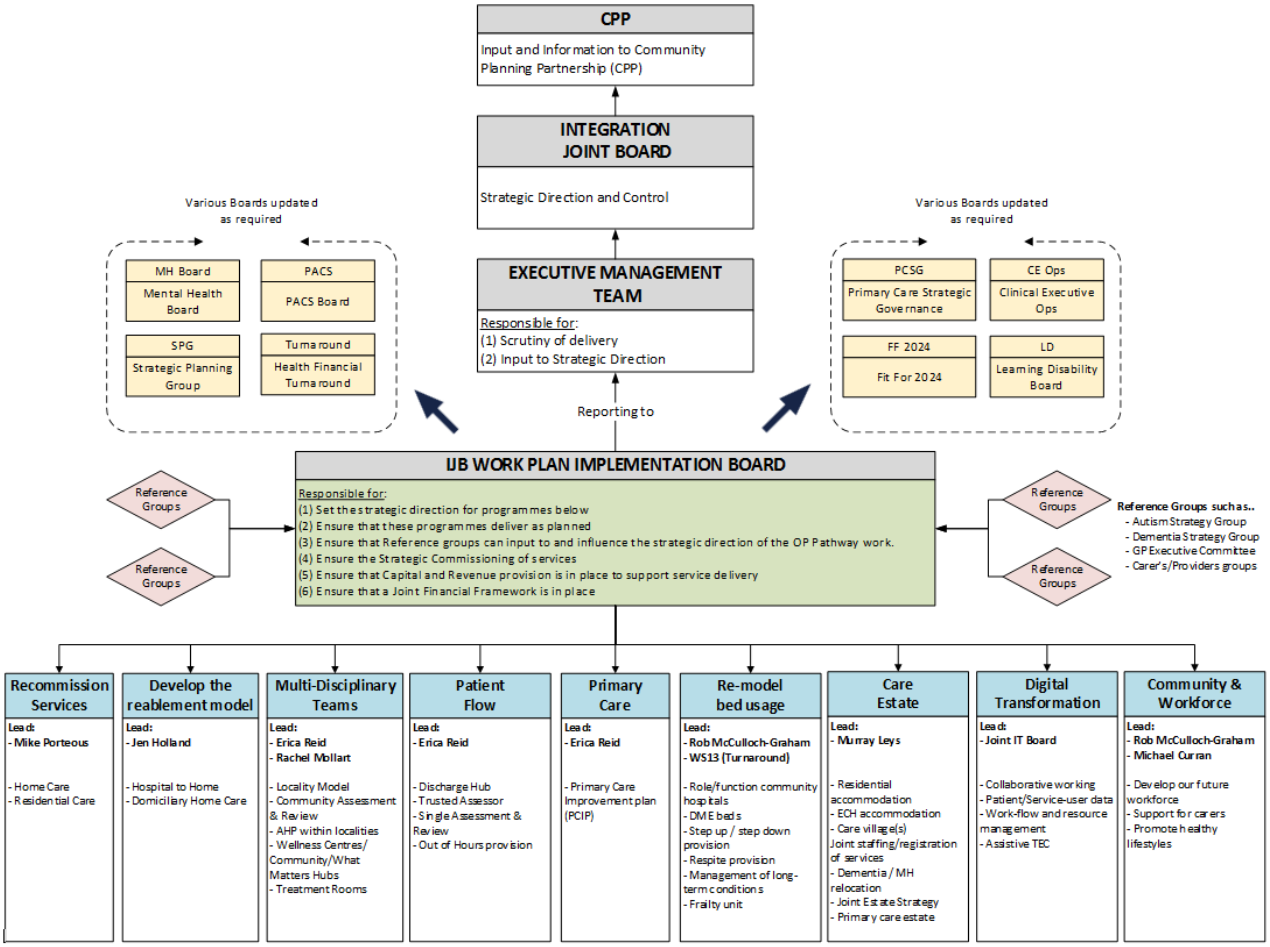
As said, the outline Work Plan provides the IJB and the Health and Social Care Partnership its direction for the next three years. Further reports will follow this plan which will offer the details on these delivery areas, providing costings, specific implementation plans and timescales for their delivery.

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

5. IJB Strategic Implementation Plan Governance

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

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



6. Appendices

6.1 Work Plan - background detail and context

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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