NHS Borders

Care Village

Proposed Model of Care and Revenue Costing

The purpose of this document is to outline a proposed model of how care services will be structured and delivered within NHS Borders planned Care Village - a 60 bed development based on the Hogeweyk, Netherlands Dementia Village Mode. The document also describes potential staffing models, costs, model interdependencies and risks. This document should be considered alongside the Care Village Options appraisal, future whole system needs assessment and resultant commissioning plan/business case..

The vision of the Borders Care Village model is to create a paradigm shift in nursing home care, with an alternative model for traditional nursing and residential care which is based on deinstitutionalisation and transformation, where people live in small homely settings, with like-minded peers and are supported by family, staff and volunteers to live as normal a life as possible. They can visit the pub, restaurant, supermarket, cinema or one of many offered clubs and community facilities. The concept of the care village model supports unique needs, lifestyles and personal preferences for living, care and well being for people living mainly with severe dementia and frailty. The focus is on possibility rather than disability and is supported by 24 hour care delivered by trained professionals.

The model stresses the importance of supporting residents to live as normal a life as possible, maintaining their autonomy and managing risk accordingly. 24 hour care will be delivered within the village in partnership with local Primary and Community Services , General Practitioners, hospitals, social care, voluntary and community supports, individuals and their families, and wider public services. Services will be 'wrapped around' the individual and their family, who are connected to and supported by their local community. Compassionate, proactive, personalised care and support will be the norm.

1. Executive Summary

Scottish Borders Health & Social Care Partnership is working with partners in NHS Borders and Scottish Borders Council to develop a 6o bedded Care Village model that they will seek to implement over the next three years. The village concept focuses on a new model of housing and care, designed specifically to better support the changing needs of older people alongside high quality care and support through proactive early intervention and preventative action aimed at those with complex needs, frailty and dementia. In addition Digital technologies such as telehealth, telecare, video conferencing, digital apps, web based platforms and joint shared electronic records have the potential to transform the way in which the village model supports and empowers how people will engage and control their own health and well being, and how services will better integrate and co-ordinate care. The overall concept of the care village model is to support healthy ageing and for individuals to live longer in their community and reduce the need for reactive acute care and long term in-patient and residential care. It is described as a nursing home disguised to look like the outside world which helps people with mild to severe dementia and frailty suffer a little bit less in their remaining years.

It is recommended that the village operational model of care is based on components of care which focus around the needs of older people and people with complex needs rather than service structures. This will enable the design of a framework that can be further developed depending on a fuller gap analysis and review of current whole system model of older peoples care. The components of care are set out as follows:

(a) Supporting people to stay permanently within their village home and/or for a period of respite during a time of personal or carer crisis.
(b) Supporting older people with mental health issues particularly severe dementia
(c) Supporting people to regain and maintain independent living through rehabilitation
(d) Supporting people with chronic care, illness and deterioration, as an alternative to acute and community hospital care when appropriate
(e) Supporting people towards the end of their life

2. Overview

Housing Accommodation within the Hogeweyk village model is designed that each house reflects a style that is common to, and familiar for, the six or seven people who live in that house. Different settings are provided and residents choose from a setting which reflects their way of life and life style, for example, a setting for those used to living in an urban area, a setting for those who used to work as trades people, setting for those more brought up with theatre, cinema and culture, a setting for those with a central religious aspect to their life and so on! All housing design is tailored to be dementia friendly.

It is the intention of the village model design that these principles will be adopted however for the purposes of the future Business Case. The proposed distribution of the accommodation is as follows

- 16 specialist dementia residential care for people requiring long term care, respite care and/or intermediate care
- 10 residential care
- 24 transitional care for intermediate care, rehabilitation discharge to assess and step up/step down care
- 10 nursing care

The distribution of these beds has been agreed on a a) re-provision of existing beds and services within Waverly and Garden View, b) re-provision of social delays within Community Hospitals and c)current waiting list demand for nursing care within care homes in Borders.

Section 3 describes seven care elements and sub- elements which are defined as best practice and will improve the outcomes of people living within the care village. The model relies on implementing these care elements and sub-elements together with wider services in a co-ordinated sustainable way, at scale, to deliver person- centred care which will:-

- Place the older person and those with complex care needs at the heart of decision-making about their assessment, treatment, care and support, with a focus on maximising independence;
- Create a fully integrated, community-based physical health, mental health and social care team within each locality;
- Focus on preventative care and early intervention to support the effective management of long-term conditions;
- Establish home or homely setting as the norm for the delivery of specialist health and social care service delivery;
- Offer consistency and continuity of care for individuals at home, in a homely setting and in hospital; and
- Make use of technological advances to support the older person and those with complex care needs in managing their long-term condition(s) with rapid support when required from the integrated team.
- Support the individual receiving care and their family in planning, securing and delivering the highest quality of person-centred end of life care.
- Connect people to a local community based support network
- Enable effective use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care homes.

3. Care Elements

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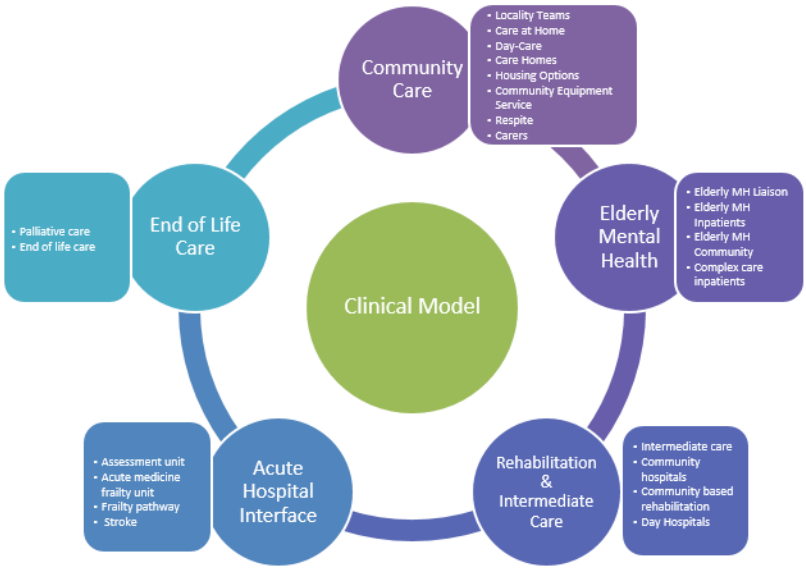
Table 1 sets out the care elements and sub-elements which comprise the proposed village care model.

Table 1	
Care Element	Sub- element
1. Daily Life	Personal Care Case Management Case Management Reviews Activities and Social interaction Money Matters/financial support
2. Enhanced Primary and Community Care Support	Each care home aligned to a General practice cluster or locality which leads a weekly multidisciplinary ' home round' Medicine Reviews Hydration and nutrition support Oral health care Access to out-of – hours /urgent care when needed
3. Multi-disciplinary team/locality support including co-ordinated health and social care	Expert advice and care for those with most complex needs Dedicated social work support Continence promotion and management COVID – 19 and flu prevention and management Tissue Viability/wound care/pressure area care, leg and foot ulcers Diabetes care Helping staff carers and individuals with needs navigate the health and care system
4. Fall prevention, re-ablement and rehabilitation including strength and balance	Rehabilitation and re-ablement services Falls strength and balance Developing and access to community assets to support resilience and independence
5. Respite Care	Adult Support Protection Carer crisis Step up support
6. Nursing Care	Preadmission Admission Ongoing assessment/care planning risk assessment Short stay/discharge Fundamental essential care

	Acute admission Other transfer End of life care
7. High quality palliative and end of life care, mental health and dementia care	Palliative and end of life care Mental Health Care Dementia Care
8. Workforce development	Joint workforce planning Training and development for staff
9. Data IT and technology	Linked health and social care data sets Access to care record and secure email Better use of technology

The diagram below depicts the components of the care that are required as enhanced support from other services and upon which the village model is crucially interdependent.



4. Staffing

It is envisaged that the Care Village will operate within the existing financial envelope of the current budget of Waverly and Garden View. However there will be an increased workforce requirement if moving towards the provision of nursing/clinical care and adoption of the principles of the Hogeweyk vision on living, care and wellbeing for people living with severe dementia and frailty. As the model develops, specific workforce modelling will be undertaken taking into consideration anticipated demands on the village and the skill mix required to support the proposed model. . This will describe the future skills staff will require in order to fully embrace the model, operate to the top of their license and ensure they operate within professional standards and clinical and care governance.

In order to deliver the model as described, this requires key elements examined in more detail below:

- transitioning the existing workforce from Waverly and Garden View to a new type of working model
- ability to recruit necessary workforce
- recognition of likely requirements within the proposed Health and Social Care Staff Bill
- Understanding dependency and the ratio of staffing to achieve personal outcomes

<u>Transitioning the existing workforce to a new type of working model:</u>

- The new model requires a full understanding and adoption of the principles of Hogeweyek through the use of reminiscences and inclusivity which aims to maximise independence and autonomy. This will require significant training and cultural change from the way people have previously been supported within traditional services.
- The majority of staff are on SBC contracts. Traditionally nursing staff will be on NHS contracts. One employee body will be required..
- Recognition that, regardless of process, workforce change may face resistance, and will require time, and significant staff engagement
- Important to highlight that the new model will not be possible to implement within existing resource –due to nature of dependency and the model itself which has been shown to be staff intensive.
- Attempts to provide element of 7 day OT cover may be challenging either due to lack of volunteers or workforce shortages.
- Allied Health professionals currently based on site within existing facilities will need to be based within the Care Village site to support service users with identified rehabilitation goals etc. New arrangements for AHP on site or in reach support will be required particularly when introducing a step up model to help prevent social admissions to BGH. Risk is associated with this and should be addressed.
- Staff often not keen to undertake work at weekends due to work/ life balance.

- Implementation of new model is dependent upon significant level of recruitment. In practical terms 7 day model will involve smaller teams operating on Saturday and Sunday. There is potential risk associated with the levels of autonomous, interdisciplinary decision making required, without the backup of the support of a full team and senior management. Induction to the required levels of professional confidence may take some time.
- Similarly, there will require to be adequate processes agreed to allow appropriate escalation to management support out of core hours, if required. It is recognized that this may place additional pressure on the current Borders LA and NHS management rotas.
- A review of GP Contract, BECS and out of hours support is essential as these have significant interdependency with the care village. Collaboration and alignment of both models will be required to ensure seamless 24 in/out of hours business continuity.
- Digital system (including TEC and Ehealth) will require review and alignment within this process particularly where sharing and access to information in out of hours services are required.

<u>Ability to recruit necessary workforce</u>

- There is reasonable confidence in ability to recruit the administrative and ancillary staff required,
- It is likely that there may be challenges in recruiting dedicated and appropriately experienced nursing staff. Nursing staff require expertise in dementia, rehabilitation, intermediate care and comprehensive geriatric assessment. Prior experience in Upper Deanfield presented huge challenges in nursing recruitment, therefore it is essential that nursing posts are presented as an attractive proposition with appropriate career development and professional governance
- It is recognised that the dedicated medical expertise and support to the home may be problematic and take time to achieve through contractual arrangements
- OT and nursing posts are likely to be filled, so long as they are permanent contracts. Temporary contracts will unlikely be successfully recruited to.
- Salary scale between NHS and LA OT contracts differ therefore it is possible that the post may be less attractive to NHS OT.
- There are particular issues around the availability of Occupational Therapy at present – locally and nationally. Again, permanent contracts are likely to make these posts more viable, however, the risk is of impact elsewhere in the system. For example – the new OT posts may be attractive to OTs within rotations creating vacancies elsewhere that may take time to, or be challenging to backfill.
- There is a significant risk that recruitment may impact on current independent sector workforce.
- Acceptance that even when funding is agreed, and where appropriate workforce available, additional recruitment will take time – average of 4 months from start of process to commencement of contract.
- There will also be continued need for appropriate governance models to support clinicians from professional perspective

Understanding dependency and the ratio of staffing to achieve personal outcomes

- There are three specific dependency tools used to assess staffing requirements. The three main tools in use are Indicator of Relative Need 2 (IORN 2), Isaac and Neville and a local Traffic Light System of Dependency. All tools use a range of measures such as long term conditions, risk of falls, continence, challenging behaviour, medication, personal care, palliative and end of life care etc to determine a score and the corresponding level of staffing required per person throughout a day and evening. In summary the higher the score or RAG classification the more staff are required.
- None of these dependency tools are comprehensive enough to take account of the principles of the model which requires each individual to be supported in their daily lifestyle and independence within the village.
- It is recognised however that the resident population will be targeted at specialist dementia, severe frailty with fast stream rehabilitation, intermediate care and comprehensive geriatric assessment, therefore staff to resident ratio is likely to be high. Key findings from the National Audit for Intermediate Care (2017) outline the workforce bed based requirement described in diagram 1 below

The following tables provide a breakdown of the current workforce within Garden View and Waverly whom would be subject to transition of 50 existing beds. Estimates of additional and total workforce requirements for 60 beds have been calculated based on an assumption of high levels of dependency. It is important to again re-iterate that further workforce modeling will be required and that this is interdependent on:-

- Layout of estate, ie 6 x 10 bedded units versus 10 x 6 bedded unit
- In reach and wrap around contractual support from other services
- One to one nature of the village specialist model
- Community assets, volunteering and family/un paid carer involvement

Existing staffing

Table 2

Staff Group	Waverly Hours	Waverly Cost £	Garden View Hours	Garden View Cost	Total Hours	Total Cost £
Residential Manager	35.00	£51,803	35.00	£39,179	70.00	103,606
Senior Support Worker	0	0	148.00	£130,987	148.00	£130,987
Clerical Assistant	17.50	£11,722	17.50	£10,262.28	35.00	£21,984.28
Cleaner	56.00	£30,962	56.00	£32,630	112.00	£63,592
Support Worker days	678.5+181.75	£464,588+£128	588.00	£304,882	1448.25	£769,588
Handy Person	0.0	£0	0.0	£0	0.0	£0
Support worker (nights)	210.12	£162,881	215.25	£142,033	425.37	£304,914
Night Support Supervisor	71.75	£53,208	71.75	£53,208.44	143.50	£106,416.44
Occupational Therapist	52.5	£75,000	0.0	£0	52.5	£75,000
Grand total	1494.62 hours	£903,164	1131.50	£713,181.72	2291.12	£1,616,345.72

Bed Distribution Requirements

The following determination of hours of need has been calculated based upon the Isaacs and Neville Dependency Tool. As stated previously this is one of three possible tools that could have been used that have been validated in relation to traditional residential and nursing home care. Other models currently in use are IORN2 (User Guide attached as appendix 1) and SBC Traffic Light system (TLS) Dependency tool (appendix 2)

16 severe dementia residents It is likely that these individuals will have exception need intervals which can also be calculated at 5 hours per person in 24 hours. The recent residential review project and paper to CMT has accounted for staffing resource for 15 however will require an increase to accommodate 16 residents and the estate layout change.

- Total support worker staffing required at 5 hours per person in 24 hours over one week equates to 560 hours in total. Assuming a split of 4 hours day and 1 hour evening support day worker equates to 448 hours and night support worker 112 hours .
- 52.5 OT hours have been agreed for 15 severe dementia beds. Further hours for 16 will not be required and could be absorbed within the existing calculations/additonality**.**

10 residential care service users, will have severe frailty and aspects of challenging cognitive behavior, likely that they will be people with long need intervals and therefore 2 hours per person in 24 hours. This can also be classified as a 1:8 ratio

- Total support worker staffing required at 2 hours per person in 24hours over 7 days equates to 140 hours in total. Assuming a 50:50 split support day worker equates to 70 hours and night support worker 70 hours

10 nursing care beds, will have significant long term condition, palliation, clinical and medical intervention and would be defined as critical need, ie 4 hours per person in 24 hours. This could also be classified as 1:4 ratio. Nursing clinical wte will also be required within transitional/ intermediate care, however generally only for a 2-3 week period.

- Total support worker staffing required at 4 hours per person in 24 hours over one week equates to 280 hours. Assuming a split of 3 hours day and 1 hour evening day support worker equates to 210 hours and evening support worker 70 hours.

24 transitional/intermediate care beds care will require critical need intervals for first 3 weeks (4 hours per person in 24 hours) and remaining 3 weeks should require short need interval 3.5 hours per 24hours). Intermediate and rehabilitation care should be no longer than 6 weeks

- For ease a 4 hour ratio has been used. Therefore total support worker staffing required at 4 hours per person in 24 hours over one week equates to 672 hours in total. Assuming a split of 3 hours day and 1 hour evening then day support worker equates to 504 hours and night support worker 168 hours.

Difference in Support Worker Staffing

Table 3 below describes the difference in the current support worker hours versus an anticipated requirement using dependency tool. Caution should be noted that this difference is based on a like for like service model. Ie staff allocation not based in discrete self contained units.

Table 3 Difference between current and assumed support workers hours per week			
	Day	**Evening**	**total**
Assumption requirement	1232	420	1652
Combined current senior and support worker	1596.25	568.87	2165.12
Deficit/Surplus hours	364.25	148.87	+513.12
Deficit /Surplus £			*+£266,056.21

**Surplus hours have been costed at Support works day and nights at 4D hourly rate , bottom of the scale £10.08 . Night Support Supervisor is a grade 5D hourly rate , bottom of the scale £11.10. Further breakdown would be required in Business Case*

Other Staffing/Workforce

Nursing

- Nursing is a crucial element in the overall model but particularly in relation to the specific nursing and intermediate care aspect of the service provision (further descriptor in appendix 1). We also know that 50% of severe dementia will have a medical/clinical need. Therefore Assuming a 1:4 ratio (0.250 of a person) for nursing of the overall 60 beds this equates to approx 3.0 full time equivalent

Clerical Assistant

- It is anticipated that additional clerical assistant support above the current 37.5 hours is required. There will be significant administration requirements in the form of Money Matters, tenure, performance management, co-ordination of volunteering, health and safety, COVID health protection requirements and vast amounts of other reporting. It is proposed that this resource is increased by 1 full time Wte to accomadate this requirement.

Deputy Residential Manager

- Both Garden View and Waverly currently have experienced residential manager. Given the leadership and management requirements incumbent of this new model, it is proposed that a deputy service manager is included within the additional staffing with specific responsibility for day to day operations. However only one residential manager will be required.

Due to the increase of an additional 11 beds over a different estate design there is a need for additional cleaning and housekeeping. It is proposed that these hours are increased proportionately 22.5 hours with uplift of approx 10 hours thereby increasing cleaning by 33.5 hours.
Overall housekeeping management is suggested as an additional role and function within the unit.

Therapies Co-ordinator

The Care Village model relies heavily on the adoption of reminiscent approaches, physical activity and interactive community based activity within the village. It is unlikely that this skill set exists within current workforce and therefore will require additional dedicated expertise. It is proposed that the proposed staffing model includes this full time role who will then assist to further develop competencies and skills across the workforce

Additional Workforce breakdown

Table 4 Additional Workforce breakdown		
Staff Group	Hours	Total
Deputy Residential Manager	35.00	£39,179
Rehab/Care of Elderly Nurse (Band 6)	112.5 (3 posts)	£137,742
House Keeper Manager	37.5	Approx £28,000
Clerical Assistant	37.5	£21,984.24
Cleaner	33.5	£25,962
Therapies Co-ordinator	37.5	Approx £28,000
Grand Total	11,296	£280,867.24

**Based on Community Hospital Band 6 with NI and employer costs at £45,914. Acute Band 6 pay scale £52,644 due to enhancements. Average nursing home salary in care Homes in Scotland £32,000*

Total Proposed Staffing

Table 5 Proposed Staffing		
Staff Group	Hours	Total
Residential Manager	35.00	£51,803
Deputy Residential Manager	35.00	£39,179
Rehab/Care of the Elderly Nurse (Band 6)	112.5	£137,742
Senior Support Worker Days	246.4	£218,075.65
Support worker days	924	£479,100.28
Night Support Supervisor	105	£77,866
Support worker nights	315	£207,853.17
Clerical Assistant	70	£41,049.12

Cleaner	56	£25,962
House Keeper Manager	35.0	Approx £28,000
Occupational Therapist	75.0	£75,000
Therapies Co-ordinator	37.5	Approx £28,000
Grand Total	2046.4	£1,409,629.73

Note

1.Senior Support day hours have been calculated based on the current 20% ratio of total support staffing hours

Senior Nigt Supervisor hours have been calculated based on the current 25% ratio of total night support staffing hours

Support works day and nights are grade 4D hourly rate , bottom of the scale £10.08:Night Support Supervisor is a grade 5D hourly rate , bottom of the scale £11.10

2. Further analysis of the above would be required to ensure appropriate inclusion of % reductions for for sickness, annual leave and training

Costing of Options in relation to Estate

The following attempts to give an indication of the staffing costs associated with 2 options of different estate environment. The layout itself will have a significant impact on the workforce requirement as the concept of the units and the associated workforce is that the staff within these units is self directed teams solely responsible for the residents within same unit. The options are

- Option 1: 10x 6-bed self-contained 'units'
- Option 2: 6x10-bed self contained units

Option 1: 10x6-bed self contained 'units'

Table 7 Option 1				
Flat Number	Bed Make Up	Level of Need	Dependency	Support staff per shift (including round up)
Flat 1	6 Specialist Dementia	Red/exception need	6 @ 1:4 ratio= 6x 0.250 (of a person) =1.5	2
Flat 2	6 Specialist Dementia	Red/exception need	6 @ 1:4 ratio= 6x 0.250 (of a person) =1..5	2
Flat 3	4 Specialist Dementia 2 Nursing	Red/Exception Red/Exception/critical	4 at 1:4 ratio= 4x 0.250 (of a person) =1 2x0.250 (of a person)= 0.5	2
Flat 4	6 Nursing	Red/Critical	6 @ 1:4 ratio= 6x 0.250 (of a person) =1.5 Hours required 30 hours over 24 hours	2
Flat 5	2 Nursing	Red/Critical	2@ 1:4 ratio = 0.250 (of a person)= 0.5	2

	4 IC	Amber	4@1:6= 4x0.175(of a person)=0.7 Total 1.2	
Flat 6	6 IC	Amber	6 @1:6 ratio= 6x 0.175 (of a person)=1.05	2
Flat 7	6 IC	Amber	6 @1:6 ratio= 6x 0.175 (of a person)=1.05	2
Flat 8	6 IC	Amber	6 @1:6 ratio= 6x 0.175 (of a person)=1.05	2
Flat 9	2 IC 4 Residential	Amber Green	2@1:6 ratio= 2x0.175(of a person=0.35 4@1:8 ratio = 4x0.125 (of a person)=0.5 Total =0.85	1
Flat 10	6 Residential	Green	6@1:8 ratio= 6x0.125(of a person)=0.75	1
Totals				18

Option 1 of 10x6- bed self contained units model would require a minimum of 18 support workers on duty and any given time. Assuming an additional 5 are required to provide support at key times the staffing roster would require a total of 23 staff on day and evening shifts. Reductions would be possible for night hours however this would require further analysis to be exact.

Option 2: 6x10-bed self contained 'units'

Table 8 Option 2				
Flat Number	Bed Make Up	Level of Need	Dependency	Support staff per shift (including round up)
Flat 1	10 Specialist Dementia	Red/exception need	10@ 1:4 ratio= 10x 0.250 (of a person) =2.5	3
Flat 2	10 Nursing	Red/Critical Need	10 @ 1:4 ratio= 10x 0.250 (of a person) =2.5	3
Flat 3	10 Residential	Green	10 at 1:8 ratio= 10x0.125 (of a person) =1.25	1
Flat 4	6 Dementia 4 Intermediate care	Red/Critical Amber	6 @ 1:4 ratio= 6x 0.250 (of a person) =1.5 4@1:6 ratio= 4x0.175= 0.7	3

			Total 2.2	
Flat 5	10 IC	Amber	10@1:6= 10 x0.175 (of a person) = 1.75	2
Flat 6	10 IC	Amber	10 @1:6 ratio= 10x 0.175 (of a person)=1.75	2
Total				14

Based on a total of 254 hours support worker time over 24 hours. This model would require a minimum of 14 support workers on duty and any given time. Assuming an additional 5 to provide support at key times the staffing roster would require a total of 19 staff on day and evening shift. Reductions would be possible for night hours.

Interpretation of Options

Option 2 : 6 x 10 bed units is the more attractive option for several reasons

- Easier and more effective distribution of support worker staff based on the lesser numbers to deliver same amount of care hours within a 24 hour period. Option 1 requires 4 additional staff day and evening.
- Both assumed and current support worker hours would be sufficient to provide care across option 2. Option 1 has required a rounding up of requirement across units therefore increasing staffing numbers.
- If applying health and social care criteria to the allocation of the flats as opposed to previous lifestyle -likes and dislikes then it is easier to group individuals who would require more specialist care and associated staffing. For example, nursing resource could be easier distributed across 3 flats as opposed to 6 flats which would be required in Option 1.
- Assuming agreement to a total of 56 hours cleaning per week with housekeeper management at 35 hours per week approx 8 hours in total per day and 1.3 hours per unit per day could be provided. If considering 10 units then cleaning hours would require to be increased by an additional 21 hours as it would not be feasible to clean each unit in less than 1 hour.
- Overall housekeeper management/supervision at 37.5 hours per week easier achieved

5. Wte Savings

There are no assumed Wte savings or staffing reductions although staffing redesign will be required. A full business case option will be required to identify and assess various options for recurring revenue. These can include tenure of tenancy, social enterprise and any reinvestment from de commissioning of alternative beds.

6. Clinical and Care Governance

Effective clinical and care governance provides assurance around the quality of services and safeguarding high standards of care across a range of services and sectors and to ensure continuous learning and improvement. The proposed outline operating model will support professional governance assured through professional leadership structures and their corresponding professional governance groups ensuring adherence to standards and guidelines,

It is imperative that there are arrangements for integrated governance and a joined up regulatory approach between the NHS and SBC. Learning from the opening of Upper Deanfield and indeed integration itself demonstrated joint governance as a key enabler of delivery of integrated services and working arrangement.

It is recommended that a joint governance framework is identified to oversee the core accountability elements of the delivery of the service.

- Professional accountability for the quality and standard of practice of nursing in line with requirements of the nursing professional regulatory bodies.
- Individual staff accountability to work according to the standards and requirements of the organisation by which they are employed.
- Chief Officer accountability for the service' performance; and its quality and safety.

7. Enablers

Given the magnitude of the change and the scale and pace required for the new model, effective development of enabling supports is critical. For the purpose of this paper, enabling areas are considered within the following areas:

- Organisational Development
- Future Workforce
- Estates
- Information Management and Information Communication Technology (ICT) (including Information Governance)

Organisational Development

There will be a need for significant investment in the development of the individual staff, existing teams and the new teams that will be created. With a focus on developing the culture and values that will be required to establish and sustain the new smodel, an Organisational and Professional Development Plan will be designed and delivered to:

- Provide individuals with the skills, competencies and experience required to operate at the top of their licence;
- Develop capacity and capability of those working within the settings, building confidence in alternatives to avoidable emergency admissions;

- Enhance the skill set of all staff to ensure every intervention is, as far as possible, a reablement , independence and reminiscence intervention;
- Ensure staff understand how to rapidly escalate issues to ensure timeous response;
- Secure the care management role within the village;
- Respect and promote the professions while removing professional barriers to ensure the staff member working with an individual in the village meets that individual's needs as far as their skills and competencies allow;
- Create new self directed teams capable working effectively and autonomously within the village while linking effectively with families, voluntary organisations General Practice, care homes, community hospitals, , emergency departments and acute wards as required;
- Increase and enhance the skills, competencies, knowledge and understanding of the staff in the principles of the village and in Comprehensive Geriatric Assessment
- Create, implement and refine an interdisciplinary, multi-sectoral training and education programme to support the assessment, care planning, treatment and care of the older person within the care village.

Future Workforce

The proposed village model of care will require a workforce that is adaptable, flexible and trained in the principles of independent living, self management and reminiscence. In addition staff will require to be skilled in specialist dementia care and Care Home Assisitant Practitioner qualifications which is aimed to equip staff the village to deliver **care** practice with clinical and management skills. CHAPS, adheres to many aspects of a registered nursing course. .multi-skilled and multi-professional working without boundaries in a fully integrated way.

Depending on agreements to in reach models, particularly those provided by AHPs, General Practice and Advanced Nursing Practice there may be a requirement to consider an additional workforce with respective qualifications as it will be necessary to ensure staff have the skill and expertise to assist in avoiding unnecessary admissions to hospitals.

Increased productivity will also be delivered through the implementation of new ways of working including eradicating multiple assessments, single care plans, engagement and planning with voluntary sector and families. Going forward work will include:

- Developing a specific Workforce Plan outlining - skills and knowledge requirements and engaging with local academic institutions, new role development; career pathways, staff consultation plan, workforce transition plans; HR and Recruitment Activity.

Information Management and Information Communication Technology

Information Management and Information Communication Technology is a key enabler for the new village model, particularly in order to deliver:

- Integrated systems and care records – access to a shared clinical and care management system, joint information governance and data sharing arrangements; in and out of hours
- Connected infrastructure - mobile working solutions; shared domains
- Self-management and signposting – technology enabled care; health monitoring systems;

- Business Analytics for evaluation
- Access to STRATA referral pathways
- Access to Datix for reporting of adverse events and incidents
- Attend Anywhere for Virtual Consultation with GP and other services
- WIFI access for patients and families
- information, advice and guidance

8. Risks and Interdependencies

It is worth re-iterating that many elements of the wider Strategic Plan key components and work streams are often critically intertwined and it is therefore difficult to create the village model and associated pathways which standalone. In addition, many components of this model and financial summary have key-dependencies with other Transformation Programmes. In the case of the Village Model there are critical interdependencies with Care at Home, Care Homes, Community Hospital, Acute Hospital transformation, GP Contracts and Digital . A full risk and issues log will be required.

9. Person Centred Care

The Village model will focus upon compassionate person centred care that supports the best outcomes for people. At all times people can expect to experience high quality care, positive outcomes and that their rights are respected at all times. Through our joint governance arrangements we will provide scrutiny, assurance and improvement that will continually inform the development of person centred care in accordance with the Care Inspectorate, NHS Borders and Scottish Borders Council Standards of Care.

10. Infection Control

Adopt all current protocols and oversight from Care and Clinical Governance scrutiny.

11. Quality Impact Assessment

A full quality impact assessment of the model is required. This should focus on the following domains;

1. **Duty of Quality**

Could the proposal impact positively or negatively on any of the following - compliance with the Constitution, partnerships, safeguarding children or adults and the duty to promote equality?

2. **Patient Safety**

Could the proposal impact positively or negatively on any of the following - positive survey results from patients and staff, patient choice, personalised & compassionate care?

3. **Patient/Staff Experience**

Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?

4. **Clinical Effectiveness**

Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and high quality standards?

5. **Prevention**

Could the proposal impact positively or negatively on promotion of self-care and improving health equality?

6. **Productivity and Innovation**

Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?

12. Quality Indicators

Table 10 Quality Indicators

Ref	Description	Owner	Frequency or measurement	Assurance Methodology	Current Performance	Expected Performance
1	Improved service user reported outcomes	Partners	Annual	Questionnaire	0	Improved outcomes
2	Improved service user access to services	Partners	Annual	Questionnaire	0	Improved access
3	Improved service user self-care and assessment	Partners	Annual	Questionnaire	0	Improved self-care

13. Dependencies and Risks

Table 11 Potential Dependencies	
Model	**Dependency**
Unscheduled Care	Access to Frail Elderly Pathways and COE Beds Front door combined assessment including geriatrician Integrated Discharge pathways and models Criteria led discharge and discharge before 12 noon 6 Essential Action Unscheduled Care
Primary Care	GP Contract and 20lignment to Village Development of wider services around General Practices in Localities Frailty Model Increase Capacity in community, maximising expertise provided by all contractors e.g. pharmacy/poly pharmacy Improved Primary Care Infrastructure e.g. Community Treatment Assessment Centres
Care Provision including Self Directed Support	Capacity in community maximising packages of care for older people
Mental Health	mental health infrastructure Review of CMHTs/PCMHTs and Integrated teams Joint Forensic Team effective crisis and response services Mental Health Waiting times and capacity
Community Hospitals	Transformation of Community Hospitals Plans

Table 12 Potential Risks			
Domain	**Title**	**Description**	**Mitigation**
Service / business interruption	Service / business interruption	Lack of cohesion with other Programmes or wider transformation result in disjointed pathways and do not release capabilities	Ensure care village business case developed and features within programme management of all strategic programme
Service / business interruption	Service / business interruption	The proposed investment required is not made available and therefore unable to implement the model as intended	Strategic agreement and commissioning
Service / business interruption	Service / business interruption	Failure of new model to prevent forecast level of performance within business case, eg acute admissions, community hospital delsys	Ongoing monitoring/PDSA cycles, benefit reviews at regular intervals to be conducted

			and reported strategically
Staffing and competence	Complaints / claims	Staff/resources required to make changes are not released to support implementation, impacting success of delivery.	Obtain strategic commitment from agreed commissioner and governing body release resources to support implementation.
Service / business interruption	Service / business interruption	Insufficient activity is referred by Primary And Community Services and acute hospitalsin order to avoid hospital admission.	Communication plan developed as part of implementation.
Staffing and competence	Service / business interruption	May not possible to increase capacity due to workforce shortages with the required level of skills, mean we cannot fully implement model	Ongoing review/management of plans and close working with workforce planners to develop solutions.
Service / business interruption	Service / business interruption	Community/Acute Hospital bed capacity is reduced or changed before the new model is able to demonstrate impact, negatively impacting quality/performance	Ongoing monitoring/PDSA cycles. SPOG/TLG to ensure stakeholders develop aligned plans.
Service / business interruption	Service / business interruption	Partners and services do not work together to ensure a seamless service for people within the Care Village	Develop shared operating procedures and pathways – agree reporting mechanism
Staffing and competence	Service / business interruption	Transitioning the existing workforce from Garden View/Waverly including transitioning AHPs	Review of existing contracts to understand scale of problem. Considerable staff engagement and consultation will take place to support staff with proposed model.
Staffing and competence	Service / business interruption	There may be difficulties in ensuring GP alignment and in reach model for Primary and Community Services	Review of enhanced contracts and commissioning with General Practice Ongoing review of community services capacity and plans for transformation
Staffing and competence	Service / business interruption	There may be difficulty recruiting to some posts and reducing current workforce capacity within overall system, eg Independent Care Homes. AHP, medical cover, Physio	The development of permanent contracts, several rounds of recruitment and recruiting to wider networks if necessary
Service / business interruption	Service / business interruption	Lack of investment in wider community infrastructure e.g. Care at Home, transport may mean bottlenecks in others parts of the system	On-going review agreed governance arrangements