Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Scottish Borders Health & Social Care Integration Joint Board** will be held on **15 December 2021** at **10am** via Microsoft Teams

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.02	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	Chair	*Verbal*
10.05	**3**	**MINUTES OF PREVIOUS MEETING**		
		20.10.2021 Extra Ordinary	Chair	*Attached*
10.10	**4**	**MATTERS ARISING**		
		Action Tracker	Chair	*Attached*
10.15	**5**	**FOR DECISION**		
	5.1	Formal Appointment of Chief Officer Health & Social Care	Board Secretary	*Appendix-2021-28*
	5.2	IJB Business Plan and Meeting Cycle 2022	Board Secretary	*Appendix-2021-29*
	5.3	Self Assessment	Board Secretary	*Appendix-2021-30*
	5.4	Directions Policy and Procedure	Chief Officer	*Appendix-2021-31*
	5.5	IJB Strategic Commissioning Approach	Chief Officer	*Appendix-2021-32*
	5.6	Day Services Petition and Future Provision	Chief Social Work Officer	*Appendix-2021-33*
11.00	**6**	**FOR NOTING**		
	6.1	Membership of the IJB	Board Secretary	*Appendix-2021-34*
	6.2	Monitoring and Forecast of the Health and Social Care Partnership Budget 2021/22 at 30 September 2021	Chief Financial Officer	*Appendix-2021-35*

	6.3	Strategic Risk Register Update	Chief Internal Auditor	*Appendix-2021-36*
	6.4	Quarterly Performance Report	Chief Officer	*Appendix-2021-37*
	6.5	Integrated Workforce Plan	Chief Officer	*Appendix-2021-38*
	6.6	Tweedbank Care Village	Chief Officer	*Appendix-2021-39*
	6.7	Review of Learning Disability (LD) Day Support Services – Market Testing	General Manager MH&LD	*Appendix-2021-40*
	6.8	The Alliance – Health & Social Care in the Scottish Borders	Chief Officer	*Appendix-2021-41*
	6.9	Alcohol and Drugs Partnership Annual Report 2020-21	Strategic Lead	*Appendix-2021-42*
	6.10	Strategic Planning Group Minutes: 04.08.21	Board Secretary	*Appendix-2021-43*
11.55	**8**	**ANY OTHER BUSINESS**	Chair	
12.00	**9**	**DATE AND TIME OF NEXT MEETING**	Chair	*Verbal*
		Wednesday 16 February 2022 10am to 12pm Microsoft Teams		

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of an Extra Ordinary meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 20 October 2021** at **10.30am** via Microsoft Teams

Present:
(v) Cllr D Parker (Chair)
(v) Cllr S Haslam
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
Mr D Bell, Staff Officer SBC
Mr R McCulloch-Graham, Chief Officer
Ms V MacPherson, Partnership Chair NHS
Mrs L Gallacher, Borders Carers
Mrs J Smith, Borders Care Voice
Mr S Easingwood, Chief Social Work and Public Protection Officer
Mrs S Horan, Director of Nursing, Midwifery & AHPs

In Attendance:
Miss I Bishop, Board Secretary
Mr R Roberts, Chief Executive NHS
Mr D Robertson, Chief Financial Officer SBC
Mrs J Stacey, Chief Internal Auditor SBC
Mr P McMenamin, Deputy Director of Finance/Business Partner IJB NHS
Mr G McMurdo, Programme Manager, SBC
Dr T Patterson, Director of Public Health
Ms J Amaral, BAVS
Mr G Samson, Audit Scotland
Mrs Gillian Woolman, Audit Scotland
Mr Asif Haseeb, Audit Scotland

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr Tom Weatherston, Cllr Jenny Linehan, Mr John McLaren, Non Executive NHS, Dr Lynn McCallum, Medical Director, Mr Andrew Bone, Director of Finance NHS, Mrs Netta Meadows, Chief Executive SBC, Ms Linda Jackson, LGBT+, Mr Nile Istephan, Chief Executive Eildon Housing, and Dr Kevin Buchan GP.

1.2 The Chair welcomed Mrs Gillian Woolman, Mr Asif Haseeb and Mr Graeme Samson from Audit Scotland to the meeting.

1.3 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

2.1 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 declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the meeting of the Health & Social Care Integration Joint Board held on 22 September 2021 were approved.

4. MATTERS ARISING

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

5. 2020/21 ANNUAL AUDIT REPORT

5.1 Mrs Gillian Woolman provided an overview of the content of the report and drew the attention of the Board to the specific elements set out in the covering letter.

5.2 The Chair recorded the thanks of the Board to Mrs Woolman and her team for providing the report during the on-going pandemic and all of the challenges that entailed.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** accepted the Audit Scotland Report and Management Letter.

6. SCOTTISH BORDERS INTEGRATION JOINT BOARD ANNUAL ACCOUNTS 2020/21 (AUDITED)

6.1 Mr David Robertson advised that he was acting as the Chief Financial Officer for the IJB on a temporary basis. He provided an in-depth analysis of the content of the Annual Accounts and drew the attention of the Board to each individual section and he specifically highlighted the carry forward and reserves positions, as well as the Audit Scotland recommendation that an appointment be made to the Chief Financial Officer post as soon as possible.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the 2020/21 Annual Accounts (audited).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the report and the 2020/21 Annual Accounts.

7. ANY OTHER BUSINESS

No further business had been notified.

8. DATE AND TIME OF NEXT MEETING

8.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 15 December 2021, from 10am to 12noon, via Microsoft Teams.

8.2 The Chair recorded his thanks to everyone for attending the Extra Ordinary meeting.

The meeting concluded at 11am.

SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2020 - 2	7	Evaluation report of new Primary Care Mental Health Service, funded through PCIP.	Rob McCulloch-Graham Kevin Buchan	~~August 2021~~ February 2022	**In Progress:** **Update 22.09.21:** Mr Rob McCulloch-Graham confirmed that the "Renew" service was being evaluated and regular reports were received by the PCIP Executive. He confirmed that a full evaluation would be shared with the IJB at a later date (2022).	G

Agenda Item: Strategic Implementation Plan & Priorities

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2020 - 3	11	Undertake a review of the Scheme of Integration.	Rob McCulloch-Graham Iris Bishop	~~March 2021~~ April 2022	**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.	G

					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. **Update 26.05.21:** Mr Tris Taylor sought a timeline for the review of the Scheme of Integration. Mr Rob McCulloch-Graham confirmed that the Strategic Commissioning Plan (SCP) would be reviewed by April 2022 and the Scheme of Integration (SoI) target date would be after that date. He explained that the review of the SCP may impact on the SoI and therefore it would make sense to complete the SoI after the SCP review had completed. He further commented that there may be changes to the SoI required as a consequence of the Derek Feeley recommendations being accepted by the Scottish Government. To date those recommendations remained with the Scottish Government for consideration.	

					Update 22.09.21: A timeline for the Scheme of Integration refresh was a substantive item on the agenda. **Complete:** Review in progress with an end date of 31.03.21.	

Meeting held 22 September 2021 *(26 May 2021 minute refers)*

Agenda Item: Quarterly Performance Report

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
4	7	Cllr Shona Haslam requested that the data and evaluation of discharge to assess as mentioned in the minutes of 26 May 2021 be formally recorded as an action on the action tracker and the data and evaluation be submitted to the IJB. *(26.05.21 Minute extract: Cllr Haslam agreed that the data was not inclusive of social care. She further commented that it appeared to be hospital admission focussed and not about improving the health of the population. She suggested including data on oncology, diabetes and obesity would give the Board a broad view of how population health could be improved. She further sought data on Discharge to Assess.)*	Rob McCulloch-Graham	December 2021		R

KEY:	
Grayscale = complete:	
	Overdue / timescale TBA
	Over 2 weeks to timescale
	Within 2 weeks to timescale

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
FORMAL APPOINTMENT OF CHIEF OFFICER HEALTH & SOCIAL CARE	
Purpose of Report:	To formally appoint the Chief Officer, Health & Social Care Integration.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) formally **appoint** Mr Chris Myers as Chief Officer Health & Social Care.
Personnel:	N/A
Carers:	N/A
Equalities:	N/A
Financial:	Both partner organisations equally fund the Chief Officer Health & Social Care post.
Legal:	Compliance with the Public Bodies (Joint Working) Act 2014
Risk Implications:	As detailed within the Scheme of Integration.

Aim

1.1 To seek formal approval from the IJB to the appointment of a new Chief Officer for Health & Social Care.

Background

2.1 Under Section 10 of the Public Bodies (Joint Working) (Scotland) Act 201 the Integration Board is required to appoint a Chief Officer following consultation with the Local Authority and the Health Board.

2.2 The Chief Officer, Health & Social Care Integration remains as a permanent employee of the substantive employing organisation in terms of employment terms and conditions.

2.3 The Chief Officer will be seconded by the employing party to the Integration Joint Board and will be the principal advisor to and officer of the Integration Joint Board.

The Chief Officer will hold membership of the Integration Joint Board as a non-voting member by virtue of the office held.

2.4 The Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the Integration Joint Board.

2.5 The arrangements in relation to the Chief Officer agreed by the parties within the Integration Scheme are that:-

- *The Integration Joint Board shall appoint a Chief Officer in accordance with section 10 of the Act.*
- *The Chief Officer will be accountable directly to the Integration Joint Board for the preparation, implementation and reporting on the Strategic Commissioning Plan, including overseeing the operational delivery of delegated services as set out in Appendices 2 and 3.*
- *Where the Chief Officer does not have operational management responsibility for services included in integrated functions, the parties will ensure that appropriate communication and liaison is in place between the Chief Officer and the person/s with that operational management responsibility.*
- *The Chief Officer will be a member of the Parties relevant senior management teams and be accountable to and managed by the Chief Executive's of both Parties.*
- *The Chief Officer is seconded to the Integration Joint Board from the employing body.*
- *Where there is to be a prolonged period where the Chief Officer is absent or otherwise unable to carry out their responsibilities, the Scottish Borders Council's Chief Executive and Borders Health Board's Chief Executive will jointly propose an appropriate interim arrangement for approval by the Integration Joint Board's Chair and Vice-Chair at the request of the Integration Joint Board.*

Summary

3.1 The appointment of Mr Chris Myers as Chief Officer was made following a recruitment process which included an assessment centre and Panel interview. The recruitment panel consisted of both, The Integration Joint Board Chair and Vice Chair, NHS Borders Chair, Scottish Borders Council Leader and the Chief Executives of both organisations.

3.2 In this role Mr Myers will remain an employee of NHS Borders and will be seconded to work for the Integration Joint Board to fulfil the role of the Chief Officer.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
IJB BUSINESS PLAN AND MEETING CYCLE 2022	
Purpose of Report:	To provide the Health & Social Care Integration Joint Board with a focused and structured approach to the business that will be required to be conducted over the coming year.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the business plan and meeting cycle for 2021.
Personnel:	Resource/staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Carers:	Any carers implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Equalities:	Not necessary.
Financial:	Resource/staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Legal:	Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.
Risk Implications:	Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Health & Social Care Integration Joint Board.

Background

1.1 To deliver against targets and objectives, the Health & Social Care Integration Joint Board must be kept aware of progress on a number of key issues on a regular basis. This is provided through scrutiny of the Quarterly Performance Report.

1.2 Health & Social Care Integration Joint Board meeting agendas are mainly focused on strategic, clinical and care governance and financial issues. These are the fundamental pillars of business items for the IJB to focus its attention on.

1.3 Standing items are submitted to the Health & Social Care Integration Joint Board in full format with verbal by exception reporting at the meeting. This enables time to be set aside at the meeting for robust scrutiny and debate of substantial business items.

1.4 Attached is the proposed Business Cycle for 2022 for the Health & Social Care Integration Joint Board. The business cycle will remain a live document and subject to amendment to accommodate any appropriate changes to timelines, legislative requirements, etc.

Summary

2.1 In order to ensure the IJB receives tangible business of a high quality standard the number of meetings for 2022 are proposed to be set at 6 per year which would afford officers time to ensure the delivery of quality reports worthy of robust scrutiny.

2.2 The IJB will continue to retain the ability to call Extra Ordinary meetings outwith the normal business cycle should that be necessary.

2.3 It is proposed that the Health & Social Care Integration Joint Board now meet formally on no less than 6 occasions throughout 2022.

2.4 It is proposed that the Health & Social Care Integration Joint Board undertake 2 Development sessions throughout 2022.

2.5 It is proposed the Audit Committee of the Integration Joint Board meet formally on no less than 4 occasions throughout 2022.

2.6 It is proposed that there are no meetings held in July or August.

2.7 Both the Scottish Borders Council and the Borders Health Board schedules of meetings have been taken into account in order to maximise attendance.

2.8 All Health & Social Care Integration Joint Board meetings, Development sessions and Audit Committee meetings will take place via MS Teams until such time as it is agreed to be safe to revert to face to face in person meetings.

2.9 In order to maximise the availability of Health & Social Care Integration Joint Board (H&SC IJB) members all IJB meetings and development sessions have been arranged for Wednesdays with IJB Audit Committee meetings scheduled to take place on Mondays. All are as per the schedule listed below:-

Date/Event	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
IJB Meeting 10am to 12noon		16		20		15			21		16	21
IJB Development Session 10am to 12noon			30							26		
IJB Audit Committee 2pm to 4pm			14			13			12			12

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD BUSINESS PLAN 2022/23

Item	Recurrence	Owner	IJB 16.02.2022	IJB Audit Committee 14.03.2022	IJB Development Session 30.03.2022	IJB 20.04.2022	IJB Audit Committee 13.06.2022	IJB 15.06.2022	IJB Audit Committee 12.09.2022	IJB 21.09.2022	IJB Development Session 26.10.2022	IJB Audit Committee 12.12.2022	IJB 16.11.2022	IJB 21.12.2022	IJB February 2023
Minutes	Each Meeting	Board Secretary	Approve	Approve		Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve
Action Tracker	Each Meeting	Board Secretary	Approve	Approve		Approve	Approve	Approve	Approve	Approve		Approve	Approve	Approve	Approve
Internal Audit Update Report	Each Meeting	Chief Internal Auditor		Annual Plan			Annual Assurance Rpt		Note			Note		Approve	
Monitoring of the Health & Social Care Partnership Budget	Each Meeting	Chief Financial Officer	Note			Note		Note		Note			Note	Note	Note
Performance Report	Quarterly	Programme Manager, Graeme McMurdo				Quarterly - Note		Quarterly - Note		Quarterly - Note				Quarterly - Note	
Inspections Update	As and when	Chief Social Work Officer													
SPG Minutes	When SPG mins approved	Chief Officer	Note			Note		Note		Note			Note	Note	Note
2022/23 IJB Joint Financial Plan	Annually - late feb	Chief Financial Officer	Draft Budget			Approve Budget									Draft Budget 2023/24
Issue Directions	Annually - March onwards	Chief Financial Officer				Approve Directions									
Discharge Programme Update	Annually	Chief Officer	Note												Note
Scheme of Integration	Annually	Board Secretary	Note revisions												
Register of Interests	Annually	Board Secretary				Note									
Winter Plan	Annually	Chief Officer / Director of Nursing								Note					
Code of Corporate Governance Refresh	Every 3 years	Board Secretary								Approval					
Clinical & Care Governance Annual Report	Annually	Chief Officer, Director of Nursing, Medical Director													
H&SC IJB Annual Performance Report	Annually	Chief Officer				Review Draft		Approve							
Chief Social Work Officer Annual Report	Annually	Chief Social Work Officer													
IJB Annual Accounts	Annually	Chief Financial Officer					Unaudited		Audited	Approve					
Board Committee Memberships	Annual	Board Secretary												only relevant if changes	
Board Meeting Dates & Business Cycle	Annually	Board Secretary								Approve					
Alcohol and Drug Partnership Annual Report	Annually	Director of Public Health												Note	
Strategic Commissioning & Implementation Plan Review (2018-2021)	Every 3 years	Chief Officer	Note any update												
External Audit Annual Plan	Annually	External Auditor		Approve											
IJB Audit Committee Annual Report	Annually	Chief Internal Auditor						Note							
External Audit Annual Audit Report	Annually	External Auditor								Approve					
IJB Self Evaluation	Annually	Chief Officer / Chief Internal Auditor		Undertake self assessment at session after the meeting			included in Annual Report item							IJB self assessment	
Strategic Risk Register Update	Bi-Annual IJB Annual Audit Committee	Chief Officer						**Next due 2023**							
Risk Management Policy & Strategy	Annually	Chief Internal Auditor				Risk Strategy				Approve					
Review of IJB Terms of Reference	Every 3 years	Board Secretary								Next due 2024					
Shifting the Balance of Care	Annually	Chief Officer													
Public Sector Equality Duty	Full report every 2 years	Simone Doyle and Jane Robertson								Next due 2023					
Shared Lives	Annually	General Manager MH & LD	Note												note
Charging Policy	Annually	Chief Officer								Approval					
Financial Outlook Update	Quarterly	SBC & NHSB Directors of Finance													Note
Locality Working Groups / Community Engagement	Annually	Chief Officer													
Look Forward/Look Back	Annually	Chief Officer													
Public Protection Service	Annually	Chief Social Work Officer													
PCIP - Primary Care Improvement Plan	Annually	Chief Officer / General Manager P&CS				Annual Update									
Auditor General Work Programme	Annually	Internal Auditor													

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
SELF ASSESSMENT	
Purpose of Report:	The purpose of this report is to seek the agreement of the Health & Social Care Integration Joint Board to the self assessment form template. It is good practice to undertake an annual review of the effectiveness of the Board and its Committees and Groups through annual self assessments. Such reviews should be conducted in the autumn, with the results being fed back to the Board/Committee/Group through an action plan to enable any learning, development or improvements to be made. When releasing the self assessment form it should be accompanied by the relevant Terms of Reference for the Board/Committee/Group to assist members in the completion of the self assessment form.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: **a) Approve** the format of the self assessment form template. **b) Approve** roll out to the Board and its Committees and Groups to undertake an annual self assessment in the autumn each year.
Personnel:	N/A
Carers:	N/A
Equalities:	N/A
Financial:	N/A
Legal:	N/A
Risk Implications:	N/A

BOARD/COMMITTEE/GROUP SELF ASSESSMENT - FEEDBACK FORM

NAME OF BOARD/COMMITTEE/GROUP:	
DATE OF RESPONSE	

Instructions

On the following pages you will find a number of statements in relation to the **INSERT NAME OF BOARD/COMMITTEE/GROUP**. Those statements relate to the following topics:

1. Board/Committee/Group membership and dynamics
2. Board/Committee/Group meetings, support and information
3. The Role and Work of the Board/Committee/Group

Please consider each statement and mark an **X** in the box that represents your view on the scale ranging from “Strongly Disagree” to “Strongly Agree”. A box is also provided for you to provide any further comments you may have in relation to each of the three topics. It would be particularly helpful to receive further comments where you have placed an X in either “Strongly Disagree”, “Disagree” or “Slightly Disagree”.

When complete, please email the feedback form to **INSERT EMAIL ADDRESS OF BOARD/COMMITTEE/GROUP ADMINISTRATOR** by **INSERT DATE**.

The results will be reviewed and aggregated, and used to inform the content of the Board/Committee/Group annual report. Any identified areas for development or improvement shall be translated into an action plan which will be reviewed and monitored by the Board/Committee/Group.

If you have any queries on the completion of the form, please contact Iris Bishop, Board Secretary email: iris.bishop@borders.scot.nhs.uk

BOARD/COMMITTEE/GROUP SELF ASSESSMENT - FEEDBACK FORM

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
A	Board/Committee/Group Membership and Dynamics						
A1	The membership of the Board/Committee/Group is appropriate with the correct blend of skills, knowledge and experience.						
A2	The Board/Committee/Group includes a sufficient number of members with directly relevant experience.						
A3	All members of the Board/Committee/Group contribute to its deliberations on an informed basis.						
A4	Board/Committee/Group members are offered appropriate development opportunities to support them in undertaking their role.						
A5	The leadership of the Board/Committee/Group by the Board/Committee/Group Chair is effective and supports input from all members.						

ADDITIONAL COMMENTS ON SECTION A

BOARD/COMMITTEE/GROUP SELF ASSESSMENT - FEEDBACK FORM

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
B	Board/Committee/Group Meetings, Support and Information						
B1	The number of Board/Committee/Group meetings in each year, and the scheduling of those meetings, is appropriate.						
B2	The length of Board/Committee/Group meetings is appropriate to allow the Board/Committee/Group to discharge its role.						
B3	Papers presented to the Board/Committee/Group are of a high standard and ensure that members have access to appropriate information.						
B4	The Board/Committee/Group receives adequate information in relation to national policy/ direction/ technical developments to enable it to fulfil its role and responsibilities.						
B5	The Board/Committee/Group agenda is well managed and ensures that all topics within the remit are considered.						
B6	The support provided to the Board/Committee/Group by executives and senior management is appropriate.						

ADDITIONAL COMMENTS ON SECTION B

BOARD/COMMITTEE/GROUP SELF ASSESSMENT - FEEDBACK FORM

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
C	The Role and Work of the Board/Committee/Group						
C1	The Board/Committee/Group has a clear understanding of its role and authority as set out in its terms of reference.						
C2	In discharging its role, the focus of the Board/Committee/Group is at the correct level.						
C3	The Board/Committee/Group has visibility of the mechanisms that are in place to monitor all aspects of its remit.						
C4	The work of the Board/Committee/Group enables it to assure the Board that the Board's policies and procedures (relevant to the Board/Committee/Group's remit) are robust.						
C5	The Board/Committee/Group undertakes appropriate oversight of the implementation of any relevant NHS Scotland strategies/ policy directions/ instructions.						
C6	The Board/Committee/Group links well with other Board Board/Committee/Groups and the Board itself, and opportunities are taken to share information, learning and good practice.						

ADDITIONAL COMMENTS ON SECTION C

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Chris Myers, Chief Officer Health & Social Care
Contact:	Chris Myers, Chief Officer Health & Social Care
Telephone:	Contact via MS Teams
DIRECTIONS POLICY AND PROCEDURE	
Purpose of Report:	To seek approval for the enclosed Directions Policy and Procedure which has been developed in line with the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014 and statutory guidance from the Scottish Government.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the content of this report, the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and the statutory guidance issued by the Scottish Government in January 2020 in relation to Directions. b) **Approve** the IJB Directions Policy and Procedure and IJB Directions template set out in Appendices 1 and 2 of this report. c) **Approve** the associated addition to the SBIJB Audit Committee Terms of Reference: The oversight and scrutiny of the implementation of the Strategic Commissioning Plan and the application of the Directions Policy. Monitor and review progress with the implementation of Directions made to partners to ensure that clarity and transparency can be demonstrated and aligned to performance and financial reporting, and escalate key delivery issues to the IJB. Maintain independent oversight of progress against the Strategic Commissioning Plan, and provide assurance to the IJB thereon.
Personnel:	No staffing implications
Carers:	The new policy and procedure will ensure consultation through the Strategic Planning Group on new Directions before they are considered by the Integration Joint Board.
Equalities:	When required, Equality and Diversity Impact Assessments will be carried out as part of the planning and implementation processes undertaken by the IJB, and the Health and Social Care Partnership
Financial:	There are no financial implications. However the use of Directions

	should improve the Integrated Joint Board's financial oversight
Legal:	The policy ensures compliance with the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014
Risk Implications:	Appropriate use of the Directions Policy and Procedure should reduce the level of risk to the Integrated Joint Board, NHS Borders and the Scottish Borders Council

Directions Policy and Procedure

Scottish Borders Integration Joint Board

1. Purpose

The Policy and Procedure seeks to enhance the governance, transparency and accountability between the Scottish Borders Integration Joint Board (SBIJB) and partner organisations NHS Borders and the Scottish Borders Council, by clarifying responsibilities. The Policy and Procedure has been developed to ensure compliance with Scottish Government statutory requirements and guidance on Directions. This policy sets out the process for formulating, approving, issuing and reviewing Directions.

This Policy and Procedure has been developed in line with the provisions set out in the Public Bodies (Joint Working) (Scotland) Act 2014[1] and Scottish Government best practice guidance[2].

2. Policy

2.1. Legislative and policy framework

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) states that an Integration Joint Board must give a Direction to a constituent authority to carry out each function delegated to the integration authority.

The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the IJB sits wholly with the IJB as a statutory public body.

The Act further places a duty on Integration Authorities to develop a strategic plan for integrated functions and budgets under their control. Integration Authorities require a mechanism to action these strategic commissioning plans and this mechanism takes the form of binding Directions from the Integration Authority to one or both of the Health Board and Local Authority.

In February 2016, the Scottish Government issued a 'Good Practice Note' on the use of Directions. The final report of the Ministerial Strategic Group (MSG) Health and Community Care Review of Progress with Integration, published February 2019, proposed enhanced governance and accountability arrangements.

2.2. Definition and purpose of Directions

Directions are a legal mechanism intended to clarify responsibilities requirements between partners. Directions are the means by which the SBIJB directs NHS Borders and the Scottish Borders Council how services are to be delivered using the integrated budget (i.e. the budget which is allocated to the SBIJB and for which the SBIJB is responsible).

The primary purpose of Directions are to set a clear framework for the operational delivery of the functions that have been delegated to the SBIJB and to convey the decision(s) made by the SBIJB about any given function(s)[3].

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[1] Public Bodies (Joint Working) (Scotland) Act 2014. Available from: https://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

[2] Scottish Government. Good Practice Note. Directions from integration authorities to health boards and local authorities: guidance. Available from: https://www.gov.scot/publications/good-practice-note-directions-integration-authorities-health-boards-local-authorities/

In line with national guidance on good practice, clear Directions must be given in respect of every function that has been delegated to the SBIJB. They must provide sufficient detail to enable NHS Borders and the Scottish Borders Council to discharge their statutory duties under the Act. Specific Directions can be given to NHS Borders, the Scottish Borders Council or both organisations depending on the services to be provided (Appendix B includes the Direction template to be used). However, Directions should not be issued unnecessarily and should be proportionate.

Directions must identify the integrated health and social care function it relates to and include information on the financial resources that are available for carrying out this function. The financial resource allocated to each function is a matter for the SBIJB to determine. The Act makes provision for the allocations of budgets for the sums 'set aside' in relation to commissioned services within large hospitals and finance statutory guidance published in 2015 provides detail[4].

Directions must also provide information on the delivery requirements. Directions may, if appropriate, specify a particular service or services to be provided.

In summary, the purpose of Directions is to set a clear framework for the operational delivery of the functions that have been delegated to the SBIJB and therefore all Directions must be in writing. Functions may be described in terms of delivery of services, achievement of outcomes and/or the strategic plan priorities.

The legislation does not set out fixed timescales for Directions. A Direction will stand until it is revoked, varied or superseded by later Direction in respect in the same function.

[3] Scottish Government. Directions from integration authorities to health boards and local authorities: statutory guidance. Available from: https://www.gov.scot/publications/statutory-guidance-directions-integration-authorities-health-boards-local-authorities/

[4] Scottish Government. Financial planning for large hospital services and hosted services: guidance. Available from: https://www.gov.scot/publications/guidance-financial-planning-large-hospital-services-hosted-services/

3. Procedure

3.1. Formulating Directions

As noted in the policy section, Directions provide the mechanism for delivering the strategic plan, for conveying and enacting the decisions of the SBIJB, clarifying responsibilities between partners, and improving accountability.

Moving forward, Directions will be clearly associated with an SBIJB decision, for example to approve a specific business case or to transform a service. Directions are formulated at the end of a process of decision-making which has included wider engagement with partners as part of commissioning and co-production. This will include consideration by the Strategic Planning Group prior to issuing to the SBIJB for review. A Direction should therefore not come as a surprise to either partner.

The development of new or revised Directions will be informed by a number of factors, including but not limited to:

- Content of the SBIJB's strategic plan which is reviewed annually and produced every 3-5 years
- Specific service redesign or transformation programmes linked to an approved business case
- Financial changes or developments (eg additional funding opportunities, matters relating to set-aside budgets or requirement to implement a recovery plan)
- A change in local circumstances
- A fundamental change to practice or service

The SBIJB's Strategic Planning Group (SPG) has responsibility for considering all draft business cases before submission to the SBIJB and overseeing the delivery of the strategic plan and therefore will play a key role in helping to shape Directions.

As Directions will continue to evolve in response to service change/redesign and investment priorities, new or revised Directions may be formulated at any point during the year and submitted to the SBIJB for approval. Please refer to the section below 'Approving and issuing Directions' for further detail.

3.2. Approving and issuing Directions

The SBIJB is responsible for approving all Directions. All reports to the SBIJB will identify the implications for Directions and will make a clear recommendation regarding the issuing of Directions, for example if a new Direction is required, or an existing Direction is to be varied or revoked. The detail of the new or revised Direction will be appended to the SBIJB report using the agreed tracker template and will be submitted to the SBIJB for approval.

Once approved, written Directions will be issued formally by the Chief Officer, on behalf of the SBIJB, to the Chief Executives of both partner organisations (NHS Borders and the Scottish Borders Council) as soon as practicably possible. Partners will be asked to acknowledge receipt of Directions and advised of performance reporting arrangements (as indicated in the section below).

Best practice denotes that Directions will be reviewed and issued at the start of the financial year. However, in order to provide flexibility and take account of strategic and financial developments and service changes, or a change in local circumstances, Directions may be issued at any time, subject to formal approval by the SBIJB.

3.3. Implementation of Directions

NHS Borders and the Scottish Borders Council are responsible for complying with and implementing SBIJB's Directions. Should either partner experience difficulty in implementing a Direction, or require further detail regarding expectations, this should be brought to the attention of the Chief Officer in the first instance.

Initially, the Chief Officer will seek to resolve issues, liaising with and involving the SBIJB Chair or Vice-Chair accordingly. If resolution proves difficult, for example if issues are particularly complex, the SBIJB will be informed prior to initiating the dispute resolution mechanism outlined in the SBIJB's Code of Corporate Governance[5].

3.4. Monitoring and review of Directions

A Directions tracker will be used as the template for monitoring progress on the delivery of each Direction on a six monthly basis. The SBIJB's Audit Committee will assume responsibility for maintaining an overview of progress with the implementation of Directions, requesting progress reports from NHS Borders and the Scottish Borders Council, and escalating key delivery issues to the SBIJB. Directions issued at the start of the year should be subsequently revised during the year in response to developments. The responsibility for maintaining an overview of Directions and ensuring that these reflect strategic needs and priorities sits with the Planning and Performance support team to the SBIJB.

The Chief Officer and Chief Financial Officer will ensure that all Directions are reviewed annually through the work of the Audit Committee. Recommendations for variation, closure and new Directions will be brought to the SBIJB at the start of each financial year.

This annual process does not preclude in-year development, formulation or revision of Directions. It is expected that new Directions will be brought forward throughout the year to reflect strategic developments and service transformation.

[5] Scottish Borders Health & Social Care Integration Joint Board Code of Corporate Governance. Available from: https://www.scotborders.gov.uk/downloads/file/1988/code_of_corporate_governance

4. Review of Directions Policy and Procedure

This Directions Policy and Procedure will be reviewed every two years or sooner in the event of new guidance or good practice becoming available.

Date of policy approval:	TBC
Date of implementation:	ON DAY OF APPROVAL
Date of review:	2 YEARS AFTER DATE OF APPROVAL

5. Appendices

Appendix 1: Summary of Directions Procedure

Appendix 2: Template to accompany SBIJB Directions

Appendix 1: Summary of Directions Procedure

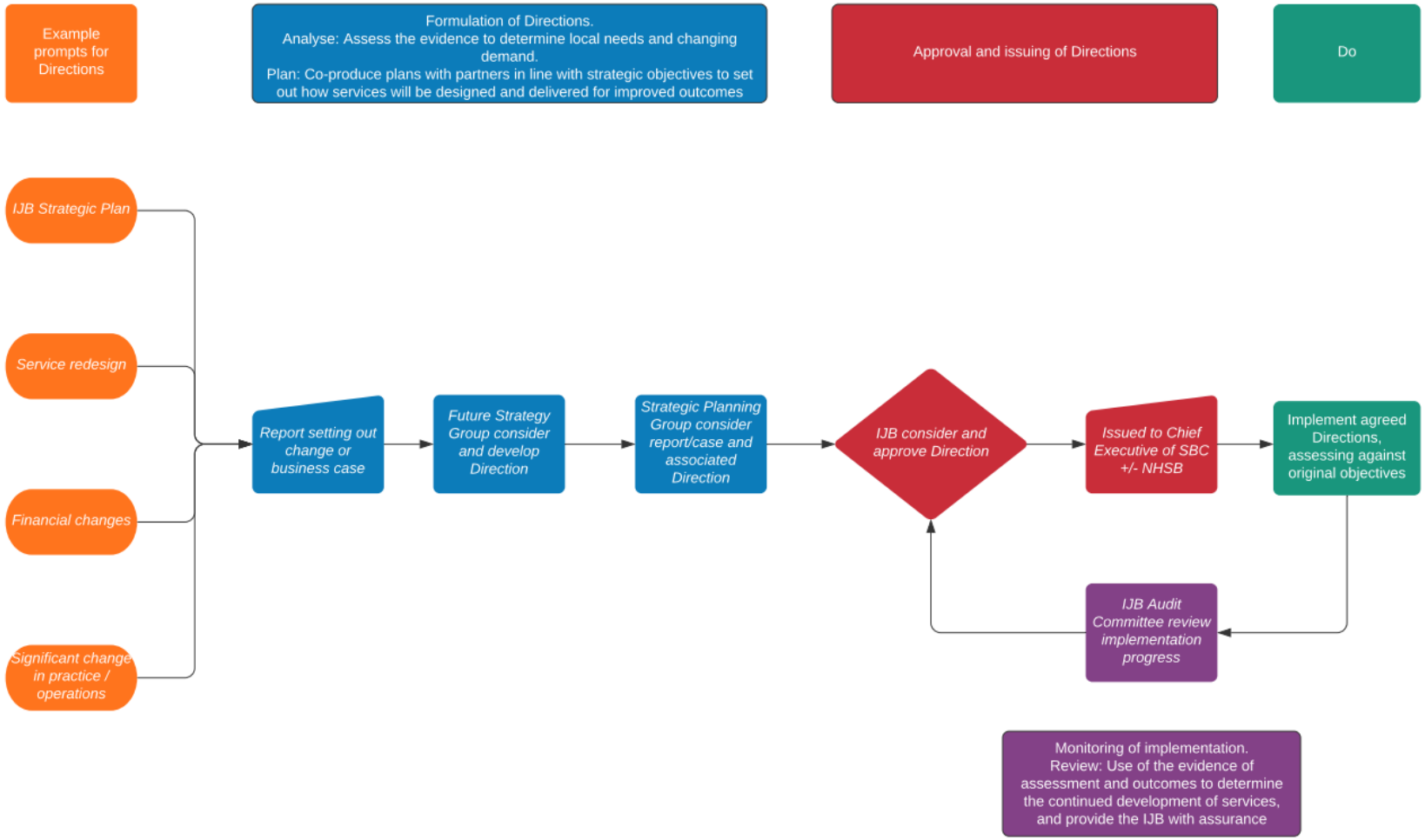

Figure 1 Directions Procedure, including reference to Strategic Commissioning cycle phases (Plan, Do, Review, Analyse)

Appendix 2: Template to accompany SBIJB Directions

Directions issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	Use format SBIJB-Date of IJB Meeting where Direction approved [DDMMYY] - Sequential number e.g. SBIJB-151221-1
Direction title	Insert brief Direction title
IJB Approval date	Insert date of IJB meeting when Direction was approved
Does this Direction supersede, revise or revoke a previous Direction – if yes, include the reference number(s)	No Yes (Reference number:_____) Supersedes / Revises / Revokes (delete as appropriate)
Services/functions covered by this Direction	List all services/functions covered by this Direction (e.g. palliative care, older adult social care etc)
Full text of the Direction	Outline clearly what the IJB is directing the Council, Health Board or both to do. The level of specificity is a matter of judgement to be determined by the IJB in relation to each Direction.
Timeframes	To start by: To conclude by: Consider and note the deadlines by when the Direction is expected to be commence and conclude carried out at the latest
Links to relevant SBIJB report(s)	Insert hyperlinks here
Budget / finances allocated to carry out the detail	State the financial resources allocated to enable NHS Borders or the Scottish Borders Council or both to implement the Direction. Provide sufficient detail especially if the Direction relates to multiple functions or services
Outcomes / Performance Measures	Detail of what the Direction is intended to achieve, or hyperlink to the appropriate document. Include reference to the link to the Strategic Plan, the National Health and Wellbeing Outcomes and IJB Performance Measures
Date Direction will be reviewed	Provide month / year to be reviewed by Audit Committee. No more than 6 months from date of approval

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 15 December 2021

Report By:	Chris Myers, Chief Officer Health & Social Care
Contact:	Chris Myers, Chief Officer Health & Social Care
Telephone:	Via MS Teams
IJB STRATEGIC COMMISSIONING APPROACH	
Purpose of Report:	The purpose of this paper is to seek approval for a refreshed Strategic Commissioning Approach to improve the IJB's efficacy, and to support compliance with the Public Bodies (Joint Working) (Scotland) Act (The Act).
Recommendations:	The Health & Social Care Integration Joint Board is asked to **consider and approve** the following recommendations: • That the work of the SIP Oversight Board is realigned to the Audit Committee rather than directly reporting to the IJB • That a 'Future Strategy Group' is developed that reports into the Strategic Planning Group to develop Directions and to manage the work associated with the delivery of the new Strategic Developments over the next 12-14 months • That the IJB endorse the approach of undertaking a comprehensive Joint Needs Assessment to inform the Strategic Commissioning Plan that will be concluded towards the end of 2022/23 to support the development of a 3 year Strategic Commissioning Plan for 2023-26 • That the Audit Committee oversee a rapid review of the Terms of Reference and a self-assessment of the IJB Committees to ensure that the IJB and these Committees are able to continue to effectively function in the context of the significant level of work required, in line with the IJB's duties outlined in the Act
Personnel:	It is expected that additional personnel will be required to support the Strategic Commissioning required over the next 14 months
Carers:	The recommendations contained within this report will improve the engagement and ongoing conversation that the IJB with Carers and other key partners in the IJB's Strategic Commissioning approach.
Equalities:	Equalities impacts will be considered by undertaking Healthcare Inequalities Impact Assessments where required as part of the strategic planning process
Financial:	Effective planning will ensure that a financially sustainable

	commissioning plan can be developed.
Legal:	This discussion paper aims to support the Integrated Joint Board to discharge its duties in line with the requirements of the Act.
Risk Implications:	There is a risk that should the current arrangements not be supported then there could be reduced compliance against the Act, and reduced efficacy as an Integrated Joint Board.

IJB Strategic Commissioning Approach

Scottish Borders Integration Joint Board

Scottish Borders
Health and Social Care
PARTNERSHIP

1. Introduction

This paper makes recommendations to the IJB to consider changing the reporting arrangements to strengthen the role, delivery and oversight of the IJB Board Committees, and the governance of the IJB in line with its statutory duties.

In the context of the major strategic developments required over the coming 14 months, the Strategic Planning Group have considered the required timescales to undertake this work comprehensively along with the IJB's approach to strategic commissioning, and the associated governance. The recommendations from the Strategic Planning Group are embedded within this report.

In addition, following the feedback of a number of IJB members and members of the Strategic Planning Group, the Chief Officer has worked to review the requirements associated to IJB Directions as established by the Public Bodies (Joint Working) (Scotland) Act 2014 "The Act" and subsequent guidance. This has led to the development of a Directions Policy and Procedure is contained within this report.

Discussions have occurred with the HSCP Joint Executive (relevant Directors working across Health and Social Care from the Scottish Borders Council and NHS Borders), and our IJB Auditors around these areas.

This paper will also be considered by the IJB's Audit Committee on 9 December 2021 as the Audit Committee to seek the views of the Audit Committee on this approach. It is worth noting that the Audit Committee had already noted that the use of Directions made to partner organisations would ensure that clarity and transparency can be demonstrated and aligned to performance and financial reporting.

2. Strategic Commissioning Approach

2.1. Drivers for change

Over the coming 14 months, there is significant scale and breadth of IJB strategic developments, which include:

- A need to review the progress of existing workstreams
- The review of the Scheme of Integration by NHS Borders, Scottish Borders Council and the IJB
- The development of an updated Joint Needs Assessment, incorporating population health and wellbeing needs assessment, consultation with staff and key partners including our communities, unpaid carers, the Third Sector, and Partner providers
- The development of an updated Strategic Commissioning Plan that meets the needs of our population identified by the Joint Needs Assessment with a sustainable approach from an operational and financial perspective
- Strategic Management of national policy and legislative changes in relation to the implementation of the National Care Service

Figure 1 Strategic Commissioning Cycle

The approach proposed within the paper aligns to the Strategic Commissioning Cycle[1] with the involvement, needs and

[1] Institute of Public Care. Strategic Commissioning Cycle

outcomes for people being at the heart of the Strategic Commissioning approach, in line with our updated HSCP procurement and contracting arrangements.

2.2. Review of existing workstreams

In line with the requirements of the IJB as set out in Section 37 of the Act there is a requirement to review of the effectiveness of the existing Strategic Commissioning Plan every 3 years. This process has recently commenced under the IJB's Strategic Implementation Plan Oversight Board, and will report by the end of the financial year. This will work to ensure that IJB commissioned workstreams remain focused on the delivery of:

- the outstanding areas of the Strategic Commissioning Plan
- the nine National Health and Wellbeing outcomes

In addition, due to the impacts of the Covid-19 pandemic, workstreams should take into consideration key areas such as the impacts of the pandemic to overall service sustainability across all delegated functions, and key partner interfaces, including but not exclusively, unpaid carers, third sector organisations, primary care providers, and partner social care providers.

The 'Do' and 'Review' commissioning segments will continue to be undertaken by the Strategic Implementation Plan Oversight Board. The procurement and contracting cycle are operational functions, and so would be undertaken by the HSCP team rather than IJB.

In order to ensure that we effectively comply with Section 37 of the Act, it is proposed that the work of the SIP Oversight Board is realigned to the Audit Committee rather than directly reporting to the IJB. This will ensure appropriate oversight of progress against the existing Strategic Commissioning Plan, which can in turn be summarised and reported to the IJB.

2.3. Future strategy

2.3.1. Strategic planning processes

Due to the scale of the future strategic work required, it is proposed that the IJB's forward planning processes also need to be enhanced. This is to ensure effective governance over progress to date and forward planning in the context of the scale of change required over the coming 12-14 months.

It is proposed that a 'Future Strategy Group' is developed that reports into the Strategic Planning Group to develop Directions and to manage the work associated with the delivery of the new Strategic Developments over the next 12-14 months.

The Future Strategy Group would support the Strategic Planning Group to undertake the 'analyse' and 'plan' commissioning segments of the Strategic Commissioning Cycle. The Strategic Planning Group could then use this information to develop Directions, as will be required, which can then be issued by the IJB. In line with national guidance on good practice, clear Directions must be given in respect of every function that has been delegated to the IJB. A Directions Policy and Procedure contains further information and is included within the IJB's papers.

By ensuring that the Future Strategy Group reports into the Strategic Planning Group, this will ensure that the IJB's key partners and communities have oversight and input into all strategic commissioning plans, and all IJB Directions before they are considered by the IJB.

2.3.2. Strategic Commissioning Plan timescales

The Act requires Local Authorities and Health Boards to have a Strategic Commissioning Plan. Updated Scottish Government guidance (as a result of Covid-19) noted that IJBs working with their Strategic Planning Group, could undertake a review of their Strategic Commissioning Plan (as opposed to necessarily creating a new plan). The result of the review could be a decision to continue with the same Strategic Commissioning Plan for a period of 12 months. This would be followed, in due course, by a subsequent review resulting in a comprehensive period of consultation and engagement and, ultimately, the creation of a new Strategic Commissioning Plan. At its meeting of 17th February 2021, the IJB approved the continuation of the Scottish Borders Strategic Commissioning Plan until April 2022.

The Act does not make prescribe the timescales for the preparation of revised Strategic Commissioning Plans. We have sought advice from the Scottish Government who have indicated that from a policy perspective, they would consider it reasonable to go beyond the planned April 2022 date for completion of the Strategic Commissioning Plan, to allow for comprehensive consultation to take place with stakeholders as part of the revision.

Considerations for the development of a Strategic Commissioning Plan include:

- That we underpin the Strategic Commissioning Plan with a robust Joint Strategic Needs Assessment – aligned to the Scottish Borders Council Council Plan, NHS Borders Strategic Plan, and underpinned by data
- That we take sufficient time to engage and consult as part of the Joint Needs Assessment and on the new Strategic Commissioning Plan
- That as part of this process, we strategically manage and take stock of the impact of the Feeley report and proposed National Care Service
- That we incorporate sustainability of services into the Strategic Commissioning Plan including HSCP and partner provided Health services, Social Care Services and services provided by unpaid carers who continue to experience increased demands associated to the impacts of Covid-19
- That time is built in to ensure an appropriate level of consideration for the Strategic Commissioning Plan sign off process

As a result, it is recommended that the IJB endorse the approach of undertaking a comprehensive Joint Needs Assessment to inform the Strategic Commissioning Plan that will be concluded towards the end of 2022/23 to support the development of a 3 year Strategic Commissioning Plan for 2023-26.

2.4. Terms of Reference and Committee member self-assessment

Acknowledging that changes are being made to the Strategic Commissioning Approach of the IJB, and that reporting lines for the Strategic Implementation Plan Oversight Board and a new Future Strategy Group have been proposed, if accepted, this is likely to have an impact on the terms of reference of the groups within the IJB Committee Structure.

It is also proposed that the Audit Committee oversee a rapid review of the Terms of Reference and a self-assessment of the IJB Committees to ensure that the IJB and these Committees are able to continue to effectively function in the context of the significant level of work required, and in line with its duties outlined in the Act.

3. Recommendations

In summary, it is recommended that the IJB consider and endorse the following recommendations:

- That the work of the SIP Oversight Board is realigned to the Audit Committee rather than directly reporting to the IJB.
- That a 'Future Strategy Group' is developed that reports into the Strategic Planning Group to develop Directions and to manage the work associated with the delivery of the new Strategic Developments over the next 12-14 months.
- That the IJB endorse the approach of undertaking a comprehensive Joint Needs Assessment to inform the Strategic Commissioning Plan that will be concluded towards the end of 2022/23 to support the development of a 3 year Strategic Commissioning Plan for 2023-26.
- That the Audit Committee oversee a rapid review of the Terms of Reference and a self-assessment of the IJB Committees to ensure that the IJB and these Committees are able to continue to effectively function in the context of the significant level of work required, in line with the IJB's duties outlined in the Act

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Stuart Easingwood, Chief Social Work Officer
Contact:	Brian Paris, Chief Officer Older Adult Social Work
Telephone:	By Microsoft Teams
DAY SERVICES PETITION AND FUTURE PROVISION	
Purpose of Report:	To consider the recommendation from the Scottish Borders Council Audit and Scrutiny Committee for the Health & Social Care Integration Joint Board to review the scope of buildings-based services that the Borders may require in the future, including the alternatives of day centres and social centres.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Consider and agree** to the request made by the Scottish Borders Council Audit and Scrutiny Committee b) **Note** the contents of the petition papers and Audit and Scrutiny meeting minute c) **Agree** to task the existing Carers Workstream with the task of undertaking this piece of work, as part of the workstream's new work to develop an Action Plan for Carers in the Scottish Borders. Progress of this work should be reviewed in the first instance by the Integration Joint Board's Audit Committee prior to reporting to the Integration Joint Board. d) **Note** that a future Integration Joint Board Direction for day services is likely to be required as a result
Personnel:	None. Staff are already allocated to the IJB Carers Workstream
Carers:	This piece of work will improve supports for carers Include any engagement/consultation/inclusion of carers.
Equalities:	An EQIA will be carried out as part of the work of the IJB Carers Workstream.
Financial:	This workstream is likely to have financial impacts. At this stage as the level of need has not been fully scoped, it is not possible to determine the level of financial impact. It must be noted that some or all of the financial impact may be offset through redesign
Legal:	Carers (Scotland) Act 2016
Risk Implications:	There is a risk that: • the impacts of Covid-19 temporarily close day based provision • there may not be sufficient workforce or facility (e.g.

	overnight respite) to deliver the recommendations.

Situation

A petition entitled "Re-Open Teviot Day Service" submitted to the Scottish Borders Council that received over 1,000 signatures has been considered by the Scottish Borders Council Audit and Scrutiny Committee. The petition makes the following recommendation to the Integration Joint Board:

1) To ask the Integration Joint Board to examine the scope of buildings-based services that the Borders may require in the future, including the alternatives of day centres and social centres.

Background

The Integration Joint Board's Strategic Implementation Plan 2018-22 noted that:

> "Transformational change and a short, medium and longer term view is needed to meet the increasing pressures on health and social care services due to unprecedented and escalating demand within the context of financial constraints and legislative change. In the Borders we are delivering a Partnership Transformation Programme which outlines the transformation required across health and social care services now and in the future."

The plan set out a number of transformation programmes including:

- out of hospital care programme focussing on community hospitals, enablement, allied health professionals and dementia
- strategic planning for older people housing, care and support
- mental health redesign
- reimagining day services
- carers strategy
- redesign of alcohol and drugs services
- ICT and telehealthcare
- localities and workforce planning

The aim of the Reimagining day services workstream noted by the Strategic Implementation Plan was to "redesign day services with a focus on early intervention and prevention." This strategic plan is in line with the strategic principles of Self Direct Support and the local authorities' statutory duties: "Self Directed Support is the way that all social care must be delivered in Scotland.[1]" The strategic plan also built on research undertaken by stakeholder representative organisations such as Scottish Care[2]. This type of research highlights the challenges and benefits of re-provisioning day services and gives examples that support SBC's strategic plan.

Audit Scotland's 2017 report states "Most people rate their social care services highly and there are many examples of people being supported in new and effective ways through SDS, but not everyone is getting the choice and control envisaged in the SDS strategy".

[1] Scottish Govt (2021) Social care - self-directed support: framework of standards (page 2)
[2] Scottish Care (2019) Meaningful Days: Self-Directed Support for older people during the day

Adult Day Services are under the Scheme of Integration, and the transformation workstream has been taken forward by the Scottish Borders Council. The Scottish Borders Council's strategy confirmed the need for Day Services to be transformed from a buildings base to a community based approach, with the focus on early intervention and prevention. The strategy is written in a context whereby local authorities were noted by Audit Scotland to be: "experiencing significant pressures from increasing demand and limited budgets for social care services. Within this context, changes to the types of services available have been slow and authorities' approaches to commissioning can have the effect of restricting how much choice and control people may have[3]."

The Council Executive Committee received and approved a paper on 4th June 2019 which outlined the progress made in delivering a Re-imagined Day Service for Older Adults and sought approval for the decommissioning of individual day services, although only when suitable alternatives that met assessed needs were identified and is based upon the introduction of the new model of Local Area Co-ordination for older adults.

The Local Area Co-ordination approach has a fundamental focus on community as sources of mutual support and creative solutions and is supported by government and community partners and has been for many years[4]. Local Area Co-ordination is a two-pronged approach working with individuals and communities. To deliver Local Area Co-ordination, each locality has a Local Area Co-ordinator and Community Link Workers.

The reimagining process was supported and facilitated by National Development Team for Inclusion (NDTI) and the transformation was delivered by a local core group. The project worked with partners from Leeds, Bradford and East Renfrewshire to explore what an alternative to day centres might look like. The new approach was based on the emerging consensus that communities already have lots going on, have the capacity and an interest in including the whole community and would best be facilitated by an older persons Local Area Coordination approach. This is the case across all of the Scottish Borders and not unique to the pilot area.

The evidence base for Local Area Coordination is broad and international. Since its introduction into the United Kingdom there have been 15 independent academic evaluations, the results of which can be found here.

The Scottish Government recognised that Local Area Coordination would facilitate many of its policy initiatives including: Changing Lives, a review of Social Work Services; Disability Equality duties, to engage people in discussing and planning services, as well as benefiting all clients groups. Local Area Coordination covers all client groups in the Scottish Borders with a total of 197 older people being supported (Sept 2021).

Locally the traditional day service model has been in decline with the volume of clients choosing day services reducing in number from 240 in 2014 to 43 in 2019. There has been a corresponding increase in people taking a direct payment to be supported to take part in activities of more interest to them and in their own communities.

The Social Care (Self-directed Support) (Scotland) Act 2013 places a duty on local authorities to offer people the 4 self-directed support options. The options allow the supported person to decide how much control they want to have over both their support and the budget and a duty on local authorities to promote a variety of support providers in

[3] Audit Scotland (2017) Self-Directed Support Progress report
[4] Scottish Government (2008) National Guidance on the implementation of Local Area Co-ordination

their area from which people can choose. The introduction of Local Area Coordinators facilitates a broader choice of options towards being socially engaged rather than a single service solution.

The strategic transformation also recognised that there is considerable overlap between Day Centres and Social Centres such as providing transport, meals and social opportunities. Day Centres are registered with the Care Inspectorate to provide personal care, whereas in Social Centres personal care would be provided by other means, e.g. a personal assistant. Social Centres are kept under review by the Scottish Borders Council to ensure that they meet the accessibility and volume requirements for a buildings based option.

Cheviot, Tweeddale, Berwickshire and Central areas' reimagining transformation is complete. Due to concerns raised in Teviot, the timescale was extended to allow for a further period of engagement and consultation. This was scheduled to conclude by early January 2020. Due to ongoing discussions and assessments the timescales were extended into February/March when the pandemic overtook discussion. In agreement with the Teviot support group a moratorium on activity was agreed to allow Health and social care focus on urgent Covid-19 related issues.

However, Covid-19 has resulted in Teviot Day Service being suspended, and the service has not been reopened. This was due to Covid infection prevention and control guidance, and as a number of people who would have been attending had either found alternatives or their circumstances had changed, meant only two people out of the original cohort were left. The view of Scottish Borders Council Officers was that the low number of services users then undermined the value of a day service which should facilitate social connection. With only one or two people attending this made re-opening impractical as it would not fulfil those needs and was not sustainable. As the day service is in the process of being decommissioned it was not open for new clients.

In the statement within the petition, it was explained that Teviot Day Service provided an essential resource for mainly older people, many with dementia related illnesses, enabling them to socialise with peers, engage in activities and generally improve their quality of life. It also provided essential respite for unpaid carers, enabling them to have time to themselves and confidence that their loved ones were being cared for by professionally trained Day Service staff.

Assessment

The Scottish Borders Council Audit and Scrutiny Committee agreed:

1) To refer the petition to the Director, Social Work & Practice (Chief Social Work Officer), and request that he:
   a) Undertook an immediate evaluation of the care packages for the two individuals impacted by the current closure of the Teviot Day Service, including addressing any respite care needs; and
   b) Ensured that those attending social centres were made aware that they could arrange to bring support with them to provide any personal care needs.
2) To refer the petition to the Health and Social Care Integrated Joint Board and ask the Board to examine the scope of buildings-based services that the Borders may require in the future, including the alternatives of day centres and social centres.

The focus on this paper and the discussion for the Integration Joint Board relates to the second recommendation.

Within the Integration Joint Board, there is a Carers Workstream which is working to develop an Action Plan for Carers, and so it is proposed that this work is delegated to the Carers Workstream. This workstream is attended by carer representatives, the Borders Carers Centre and representatives from the Health and Social Care Partnership. This workstream has started to co-produce an action plan which has the following vision:

> "Carers will be supported to easily access flexible support, advice and information to best meet their individual needs and choices"

The workstream aims to co-produce an action plan based on the voice of carers to ensure that they are able to influence the design and delivery of services. Crucially this will ensure that those using services and their carers are heard and understood so we can work collaboratively to meet critical need going forward. This is particularly important in terms of providing service users with safe environments, having meaningful experiences and access to peer support, as well as giving carers breaks / respite.

The workstream has agreed to the following approach:

- Appointment of new Carers Support Lead and SDS Lead - complete
- New Lead and Programme Manager to work with the Carers Workstream and the Borders Carers Centre to define the action plan / outcomes
- Co-production with carers, openness and transparency
- Mapping of individual needs as the starting point
- Matching of services to best meet the needs identified
- Assessment of unmet need
- Reviewing lived experience to identify current experience, raise awareness, and to support the evaluation
- Focusing on our drivers, aims and vision and outcomes, and including timescales and costs
- Testing the action plan with Carers before it goes to the IJB to see if it resonates
- Raising of the profile of unpaid carers within the Scottish Borders
- Identification of solutions to form recommendations for the Integrated Joint Board
- This work along with these recommendations can also feed into the IJB's Joint Needs Assessment and future Strategic Commissioning Plan

It has been agreed that the following approach will be adopted in order to evaluate and measure success:

- Several examples of real world experiences of carers as a starting point to identify model and action plan, and work to review these at the end of the process
- Temperature checking:
    - Follow up(s) to the Borders Carers Centre "A Change is as good as a rest"
- Delivery of actions within the action plan

Recommendations

The Health & Social Care Integration Joint Board is asked to:

a) Consider and agree to the request made by the Scottish Borders Council Audit and Scrutiny Committee

b) Note the contents of the petition papers and Audit and Scrutiny meeting minute
c) Agree to task the existing Carers Workstream with the task of undertaking this piece of work, as part of the workstream's new work to develop an Action Plan for Carers in the Scottish Borders. Progress of this work should be reviewed in the first instance by the Integration Joint Board's Audit Committee prior to reporting to the Integration Joint Board.
d) Note that a future Integration Joint Board Direction for day services is likely to be required as a result

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
MEMBERSHIP OF THE IJB	
Purpose of Report:	To advise the IJB of the change in voting membership.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the change in voting membership.
Personnel:	N/A
Carers:	N/A
Equalities:	N/A
Financial:	N/A
Legal:	Compliance with the Public Bodies (Joint Working) Act 2014
Risk Implications:	N/A

Aim

1.1 Under Public Bodies (Joint Working) (Scotland) Act 201 the Integration Board is required to agree the number of voting members to be appointed from each partner organisation (Scottish Borders Council and Borders Health Board).

Background

2.1 The arrangements in relation to the membership of the IJB were agreed by the parties and are detailed within the Integration Scheme:-

As agreed by Borders Health Board and Scottish Borders Council, the Integration Joint Board shall comprise five NHS Non-Executive Directors appointed by Borders Health Board, and five Elected Councillors appointed by Scottish Borders Council. The Integration Joint Board will include non-voting members as prescribed by Regulation 3 of the Public Bodies (Joint Working) (Proceedings, Membership and General Powers of Integration Joint Boards) (Scotland) Order 2014.

The term of office of voting Members of the Integration Joint Board shall last as follows:

(a) for Local Government Councillors, three years, thereafter Scottish Borders Council will identify its replacement Councillor(s) on the Integration Joint Board,

(b) for Borders Health Board nominees, three years, thereafter Borders Health Board will identify its replacement Non Executive(s) on the Integration Joint Board.

All appointments, including the appointment of the Chair and Vice Chair, will be reviewed every 3 years. Members can be reappointed.

Summary

3.1 A number of changes in the voting membership have taken place during the course of the year and these are set out below for noting by the Integration Joint Board.

3.2 At 1 January 2021 the voting membership of the IJB consisted of:-

Cllr David Parker (Chair)	Mr Malcolm Dickson (Vice Chair)
Cllr Shona Haslam	Mrs Karen Hamilton
Cllr Elaine Thornton-Nicol	Mr Tris Taylor
Cllr John Greenwell	Mrs Sonya Lam
Cllr Tom Weatherston	Mr John McLaren

3.3 The following changes have taken place during the year:-

- Mr Malcolm Dickson retired as a Non Executive and concluded his appointment on the IJB.

- Mrs Sonya Lam concluded her appointment on the IJB and the IJB Audit Committee.
- Mrs Lucy O'Leary joined the IJB and the IJB Audit Committee as the replacement for Mrs Sonya Lam.
- Mrs O'Leary was also nominated as the IJB Vice Chair on the conclusion of Mr Dickson's appointment.
- Cllr John Greenwell concluded his appointment on the IJB.
- Cllr Jenny Linehan joined the IJB as a replacement for Cllr Greenwell.
- Mrs Harriet Campbell now joins the IJB as the replacement for Mr Malcolm Dickson

3.4 The voting membership of the IJB as at 1 November 2021 is:-

Cllr David Parker (Chair)	Mrs Lucy O'Leary (Vice Chair)
Cllr Shona Haslam	Mrs Karen Hamilton
Cllr Elaine Thornton-Nicol	Mr Tris Taylor
Cllr Tom Weatherston	Mr John McLaren
Cllr Jenny Linehan	Mrs Harriet Campbell

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By	David Robertson, Chief Finance Officer SBC & Andrew Bone, Chief Financial Officer, NHS Borders
Contact	David Robertson, Chief Finance Officer SBC & Andrew Bone, Chief Financial Officer, NHS Borders
Telephone:	01835 825012 / 01896 825555
MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 30 SEPTEMBER 2021	
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 30 September 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the combined forecast adverse variance of (£6.186m) for the Partnership for the year to 31 March 2022 based on available information and arrangements in place to partially mitigate this position; b) **Note** that whilst the forecast position includes direct costs relating to mobilising and remobilising in respect of Covid-19, it also assumes that all such costs will again be funded by the Scottish Government in 2021/22; c) **Note** that the position includes additional funding vired to the Health and Social Care Partnership during the first half of the financial year by Scottish Borders Council to meet reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services and funding brought forward in respect of Covid-19 expenditure; **d)** **Note** that any residual expenditure in excess of the delegated budgets at the end of 2021/22 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 2021/22 will be reported to the Integration Joint Board.
Carers:	N/A
Equalities:	There are no equalities impacts arising from the report.
Financial:	There are no resourcing implications beyond the financial

	resources identified within the report. The report draws on information provided in finance reports presented to NHS Borders Board and Scottish Borders Council Executive Committee. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.
Legal:	Monitoring against the partnership's Financial Plan 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:	Risks are 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 mid-year 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 Executive Committee and the Board of NHS Borders. It highlights the key areas of financial pressure at 30 September 2021. Further reports will be brought to the IJB over the remainder of the financial year on a regular and frequent basis. As this happens, further analysis and refinement as a result of the impact of the Covid-19 pandemic on activity levels, mobilisation costs, remobilisation plans and associated costs, lost income and unachievable savings will take place.

Overview of Monitoring and Forecast Position at 30 September 2021

3.1 The paper sets out the consolidated financial performance for the period to end of September 2021 (month 6). Although this position includes a forecast of the year end outturn, IJB members should be aware that this remains subject to a number of risks and uncertainties which are likely to result in ongoing revision as greater clarity and assurance emerges over the second half of the financial year.

3.2 At the end of month 6, functions delegated to the partnership are forecasting an adverse projected pressure of £4.033m and the large hospital budget retained and set-aside is forecasting a similarly adverse pressure of £2.153m. Within delegated functions, following the delegation of additional budget to social are functions by Scottish Borders Council, an overall breakeven position is currently projected and the £4.033m adverse pressure therefore sits entirely across healthcare functions, mainly attributable to the forecast non-delivery of financial efficiency savings partially offset by savings on operational function budgets.

Efficiency Savings

3.3 Forecasts include the estimated impact of non-delivery of savings plans. This position remains under review and will be updated following the conclusion of the Scottish Government / NHS quarterly review process and the ongoing review and

challenge of 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	Shortfall £m
Healthcare Functions	(4.740)	(0.290)	(4.450)
Social Care Functions	(3.356)	(2.576)	(0.780)
Set-Aside Functions	(1.090)	0	(1.090)
	(9.186)	(2.866)	(6.320)

3.4 In order to partially offset the above, a contribution will be made from the IJB reserve brought forward at the start of the financial year. Within the overall reserves position, £1.103m has been earmarked specifically to support slippage in the delivery of the partnership's financial efficiency plan in 2021/22.

Year End Forecast

Healthcare functions

3.5 The Delegated Healthcare and Set-Aside forecasts at month 6 are based on detailed review currently being undertaken through the Q2 review process. As such, members should recognise that the forecast is presented as an indication of current expenditure trend and is unlikely to be a full representation of the likely outturn position. Additional costs relating to Covid-19 are included, with the expectation that these will be funded by the Scottish Government. Presently, NHS Borders' is presenting forecast savings undelivered in full, until funding allocations to meet this adverse impact are received from the Scottish Government. Beyond the additional costs of Covid-19, including the non-delivery of planned savings on which the overall affordability of the partnership's Financial Plan is predicated, operational functions are still reporting a reduction in core activity over the first half of the financial year that, excluding the additional costs of Covid-19 and undelivered savings, results in a favourable position at the end of month 6.

3.6 At the end of September, delegated healthcare functions are reporting a favourable net variance on core operational budgets of £0.417m. This is primarily attributable to ongoing delay / challenges in recruitment to vacant posts during the first half of the financial year due to the ongoing impact of Covid-19, slippage in the planned useage of recent additional funding allocations (district nursing, health visiting, etc) and a continued reduction in core activity in areas such as Dental Services. The position includes other net reductions in spend across Primary and Community Services and Mental Health / Learning Disability services. It also includes an adverse pressure of £0.300m relating to the Home First service. This service is currently under review and to mitigate the pressure in the interim until the review is completed, a further £0.300m has also been earmarked within the IJB reserves brought forward on a non-recurring basis this financial year.

Social Care functions

3.7 At 30 September, the mid-point of the financial year, Scottish Borders actual spend to date on social care functions, as stated in Appendix 1, is £19.926m which represents 36.2% of the current budget. Significantly less than the position

expected mid-year, this is again attributable to a number of factors specific to 2021/22. These relate to the upfront transfer of social care funding and health board resource transfer from NHS Borders during the first quarter for the whole of the financial year to enable local authority cash-flow, additional Scottish Government Covid-19 funding for social care sustainability and the offset of 2020/21 funding allocations brought forward into 2021/22.

3.8 The Scottish Borders Council forecast at month 6 is based on detailed monthly monitoring during the first 6 months of the financial year. It is noted that in order to deliver a breakeven position, social care functions assume all Covid-19 costs included within the Local Mobilisation Plan, including undelivered efficiency savings, will be funded by the Scottish Government in full.

Large Hospital functions retained and set-aside

3.9 Accident and Emergency continues to experience significant cost pressure as a result of additional nursing as a result of increased activity / triage and also in response to the Covid-19 pandemic. Within Medicine and Long-Term conditions, the adverse position is entirely attributable to increased drugs spend. To date, little progress has been made planning or delivering the set-aside share of recurring acute savings target as a result of reduced capacity due to Covid-19. These pressures are marginally offset by a reduced activity in Department of Medicine for the Elderly leading to a forecast underspend in this service area.

General

3.10 Additional costs of Covid-19 to date, together with the opportunity cost of lost income and non-delivery of financial plan savings, continues to outweigh any financial benefit and reduced cost within core operational services attributable to a reduction in activity during the first 6 months of 2021/22. This position may be mitigated considerably as a clearer picture of likely funding allocations from the Scottish Government emerges. A commitment however has been received from the Scottish Government during the 2nd quarter of the financial year that they will underwrite non-delivery of savings reported by partnerships within their Covid-19 local mobilisation plans, subject to further review of any available flexibility within IJB reserve positions brought forward into 2021/22 to support this non-delivery also.

3.10 Further reports will be brought to the Integration Joint Board on a quarterly basis as greater clarity develops. To enable this, work will be continue to be undertaken across a number of key areas in order to refine the forecast impact on the IJB in 2021/22 including:

- 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;
- Further review, challenge and remodelling of planned efficiency savings programmes as increased capacity is rebuilt;
- Ongoing engagement with other partnerships, health boards, local authorities and, in particular, the Scottish Government over likely funding scenarios;
- Review of all costs, expenditure profiles, future commitments and refinement of assumptions for projected expenditure to the end of the year.

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2021/22	At end of Month:	September

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	19,595	10,221	22,162	22,141	21
Joint Mental Health Service	19,211	10,311	21,774	21,992	(218)
Older People Service	9,880	(935)	8,874	8,874	0
SB Cares	16,924	8,625	15,955	15,955	0
Targeted Savings	(4,740)	0	(4,740)	(290)	(4,450)
Physical Disability Service	2,734	1,417	2,528	2,528	0
Prescribing	23,132	11,423	23,132	23,385	(253)
Generic Services	67,468	41,627	92,057	91,190	867
Large Hospital Functions Set-Aside	24,211	14,280	26,336	28,489	(2,153)
Total	178,415	96,969	208,078	214,264	(6,186)

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions **2021/22** **At end of Month: September**

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	**16,122**	**8,176**	**18,561**	**18,561**	**0**	Learning Disabilitie Service: Higher than anticipated staffing costs in relation to CFO / CMT approved Agency costs to provide client review support (£50k). Higher than budgeted 24hr Permanent care costs (£82k). Net increase in Community Based Care of £74k - (1 full time residential school client (18 year old) costing £108k plus emergency care required for 1 client costing £53k - off-set by other client reductions).
Joint Mental Health Service	**2,196**	**848**	**2,007**	**2,007**	**0**	
Older People Service	**9,880**	**(935)**	**8,874**	**8,874**	**0**	Older People: Net underspends in Extra Care Housing amounting to £174k, comprised of overspends at Longfield Cres., Duns and Dovecot, Peebles of £150k and £123k respectively. These overspends caused by requirement to pay void property rent costs and also TUPE costs associated with the transfer of care provision from SB Cares to Eildon at Dovecot. Underspends due to delays in construction at Wilkie Gardens in Galashiels amount to £447k. Direct Payment clawback amounts to £67k. Lower than anticipated 24 hour permanent care costs amount to £86k. Lower than anticipated Locality based care costs amount to £152k. Various minor overspends amount to £28k across the service. Virement relates to the transfer of budget from SB Cares to Older People's service reflecting the transfer of care provision at Dovecot Extra Care Housing development to Eildon Housing Association (£496k).
SB Cares	**16,924**	**8,625**	**15,955**	**15,955**	**0**	
Physical Disability Service	**2,734**	**1,417**	**2,528**	**2,528**	**0**	
Generic Services	**6,339**	**1,795**	**7,120**	**7,120**	**0**	
						SB Cares: Pressures relating to lower than anticipated client income (£40k). Virement relates to the transfer of budget from SB Cares to Older People's service reflecting the transfer of care provision at Dovecot Extra Care Housing development to Eildon Housing Association (£496k).
						PWPD: Higher than anticipated client care costs.
						Generic: Ongoing single client specific pressures in relation to delayed transfer to cheaper care provider (£52k). Higher than anticipated Locality Based Community Care costs (£197k). Off-setting savings from lower than anticipated staffing costs - £22k as well as other minor underspends - £17k.
Total	**54,195**	**19,926**	**55,045**	**55,045**	**0**	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions **2021/22** **At end of Month: September**

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,473	2,045	3,601	3,580	21	Mental Health: Medical staffing budgets are £279k overspent. The medical establishment is not staffed to capacity and ongoing recruitment gaps are backfilled by agency locums at increased hourly rates, generating this overspend. This forecast pressure is partially offset by vacancies.
Joint Mental Health Service	16,616	9,055	19,262	19,480	(218)	
Joint Alcohol and Drugs Service	399	408	505	505	0	Prescribing: A small forecast adverse pressure in Primary Care Prescribing is also projected (£253k) due to an increased number of items and forms issued over the last quarter, coupled to an increase also in the average unit cost per item. This position is likely to further change going forward however and we are now starting to see an ongoing trend of increased volumes again since the reported position at the end of the first quarter.
Prescribing	23,132	11,423	23,132	23,385	(253)	
Targeted savings	(4,740)	0	(4,740)	(290)	(4,450)	Targeted Efficiency Savings: Planned savings within NHS Borders (£4.450m) that are forecast not to be delivered due to CV-19. Scottish Borders Council savings offset by virement from non-delegated functions.
Allocated Non Recurring Savings Projects	0	0	0	0	0	
Allocated Brokerage	0	0	0	0	0	
Generic Services						Generic Services: is also forecasting an underspend position across Community Hospitals, AHP services and District Nursing due to ongoing vacancies, together with a general saving due to reduced service activity during the first half of the financial year as a result of the ongoing impact of Covid-19 (£836k). This is partially offset by an adverse pressure in Home First due to slippage in the review of the service against the planned reduction to its funding envelope (£300k). There is also a significant underspend within General Dental Services due to both a high number of vacancies and the ongoing yet-than-optimum level of normal activity (£331k). Generic Other is largely attributable to underspends in Public Dental Services, Sexual Health, Out of Hours and Health Promotion arising as a result of activity and staffing reductions, offset by pressures caused by fixed term recruitment in general staffing to support the management of remobilised services.
Independent Contractors	30,069	16,744	32,466	32,131	335	
Community Hospitals	5,770	2,950	5,893	5,860	33	
Allied Health Professionals	6,531	3,505	7,480	7,312	168	
District Nursing	3,701	1,963	4,191	3,860	331	
Generic Other	15,058	14,670	34,907	34,907	0	
Total	100,009	62,763	126,697	130,730	(4,033)	

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MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside | **2021/22** | **At end of Month: September**

Scottish Borders Health and Social Care PARTNERSHIP

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,762	2,080	3,309	4,100	(791)	A&E: Accident and Emergency is experiencing significant cost pressure as a result of additional nursing as a result of increased activity / triage and also in response to the Covid-19 pandemic. Work is ongoing to identify the full extent of the latter in order that it can be included within the local mobilisation plan and be funded by further Covid-19 allocations.
Medicine & Long-Term Conditions	16,187	9,106	17,629	18,201	(572)	
Medicine of the Elderly	6,352	3,094	6,488	6,188	300	General Medicine: Within Medicine and Long-Term conditions, the adverse position is entirely attributable to increased drugs spend. A small downturn in activity is the main driver of the favourable forecast position in DME.
Targeted Savings	(1,090)	0	(1,090)	0	(1,090)	Targeted Efficiency Savings: In terms of efficiency savings, this is the set-aside share of recurring acute savings related to NHS Borders overall allocated targets this year - Total £3.2m.
Allocated Non Recurring Savings Projects	0	0	0	0	0	
Allocated Brokerage	0	0	0	0	0	
Total	24,211	14,280	26,336	28,489	(2,153)	

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Chris Myers, Chief Officer Health & Social Care
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SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD STRATEGIC RISK REGISTER UPDATE

Purpose of Report:	The purpose of this report is to provide Members of the Board with an update of the most recent review of the IJB Strategic Risk Register as it is important that the Board is kept informed of the IJB's key risks and the actions undertaken to manage these risks.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Consider** the IJB Strategic Risk Register to ensure it covers the key risks of the IJB; b) **Note** the actions in progress to manage the risks; and c) **Note** that a further risk update will be provided in June 2022.
Personnel:	In line with the role and responsibilities, the IJB's Chief Officer has carried out the current review of the IJB Strategic Risk Register on 6th December 2021, supported by SBC's Corporate Risk Officer.
Carers:	There are no direct carers' impacts arising from the report.
Equalities:	There are no equalities impacts arising from the report.
Financial:	There are no direct financial implications arising from the proposals in this report.
Legal:	Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.
Risk Implications:	Risk Management arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems in line with its agreed Risk Management Strategy within its governance arrangements.

Background

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

2.2 Compliance with the principles of good governance requires the IJB to adopt a coherent approach to the management of risks that it faces in the achievement of its strategic objectives. A new Risk Management Policy and refreshed Risk Management Strategy were approved by the IJB on 19 August 2020.

2.3 In accordance with the Risk Management Policy and Strategy, the IJB Chief Officer carries out a review of the IJB Strategic Risk Register on a quarterly basis.

2.4 While the Risk Management Policy and Strategy states that six monthly risk reviews should be presented to the Board in June and December each year, the disruption caused by Covid-19 during 2020 and ongoing into 2021 has meant that the first formal report of 2021 was presented to the Board on 22nd September 2021, delayed from June 2021. In line with the agreed structure this most recent report is being presented on 15th December 2021, and will be followed by a report in June 2022.

Summary

3.1 It is important that the IJB has its own robust risk management arrangements in place because if objectives are defined without taking the risks into consideration, the chances are that direction will be lost should any of these risks materialise. The identification, evaluation, control and review of the IJB strategic risks is a Management responsibility. However, knowledge of the strategic risks faced by the IJB and associated mitigations will enable the Board members to be more informed when making business decisions.

3.2 The previous IJB Chief Officer carried out a management review of the risk register in February, May and August 2021. The most recent management review of the IJB Strategic Risk Register was undertaken by the new IJB Chief Officer on 6th December 2021. This review reflects first impressions while continuing to take into consideration the impacts of Covid-19 and gives reference to key policy revisions that will ultimately have a positive bearing on governance, commissioning and service delivery arrangements. The review was undertaken by the IJB's Chief Officer in line with his role and responsibilities and was supported by SBC's Corporate Risk Officer.

3.3 As part of the review undertaken in August 2021, a further risk for the IJB and delegated services, was considered, potentially arising from the Scottish Government consultation on the National Care Review. It was noted that proposals for change in structure and uncertainty over the future delivery of health and social care policy could result in a delay of implementing strategic commissioning decisions by the IJB. The intention is to continue this discussion at the next planned review in early 2022.

3.4 As part of the review undertaken on 6th December 2021 consideration was also given to the development of a new risk focusing specifically on the current pressures being experienced from increased demand for H&SC services (partly attributed to a build-up of need during Covid-19 lockdowns and restrictions), increasing levels of staff sickness/absence, and the significant numbers of people leaving the workforce/the decreasing workforce pool that can be utilised, some of which is related to the UK's exit from the EU. These factors place pressure on the opportunities that service users have to access the care they need, and the subsequent risks to their health and wellbeing. Recent media coverage from Dumfries and Galloway's (D&G) H&SC Partnership highlights the situation that their health and social care services are facing, described as 'one of the greatest pressures in living memory'. This situation has also been mirrored in Edinburgh. There is significant concern that SBIJB will face a similar situation and may need to put in place mitigations such as those implemented in D&G, which have included, for example, a call for help from the community. The potential need to develop a specific risk around this will be discussed at the next risk review with the IJB Chief Officer.

3.5 A high level summary of the IJB's Strategic Risk Register, which sets out the strategic risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan, is shown in Appendix 1. There are currently 10 risks on the IJB Strategic Risk Register: four Red, four Amber and two Green.

3.6 Changes on specific risks for the IJB to note since the previous report to the IJB Board on 22nd September 2021 include:

- IJB001 (Cultural Change) has reduced from a score of 8 (Amber) to 4 (Green) as result of closer partnership working (e.g. through the continuation of the joint NHS/SBC meetings). Specifically, the Likelihood of this risk materialising has been reassessed and changed from 2 (Unlikely) to 1 (Remote). Two key change papers have also been drafted and approval will be sought for them at the meeting on 15th December 2021, both serving to have a positive impact on this risk, and a new Internal Control "Use of IJB Directions (following co-production with partners – NHS/SBC)" has been added to reflect this. Furthermore, work is being undertaken to integrate operational structures and this too will have a positive bearing on culture. The Target Risk has also been revised down to reflect the intention to reduce the Impact of this risk as far as is possible.

- IJB002 (Efficient use of resources), remains Amber (Likelihood 4 – Likely and Impact 2 – Minor) at this review but it should be noted that consideration is being given to either retiring this risk or reframing it, perhaps with an enhanced focus on Covid-19. At the most recent review it was advised that this is potentially a legacy risk as several of the Risk Factors noted do not pose the threat that they once did.

- IJB003 (Future market for care), has increased from a score 12 (Amber) to a 16 (Red) after previously increasing from a score of 8 to a 12 (both Amber) in August 2021. Specifically, the Likelihood has increased from a 3 (Possible) to a 4 (Likely), and building on the last review where it was noted that the partnership were 'short' on packages of care, the situation continues to deteriorate in the sense that the number of people waiting for care in the community and in hospital indicates that current availability is insufficient. Significant recruitment/

retention, sickness/ absence rates and self-isolation requirements/ infection control measures are all putting negative pressure on this risk and affecting the ability of the partners to meet rising demand for services. At the most recent review the Target Risk Score was also revised in terms of Likelihood from 1 (Remote) to 2 (Unlikely) as based on the current situation it was felt that, in the first instance, this would be more achievable. Lastly, it should be noted that at the next review there is an intention to merge this risk with IJB006 (Workforce) as they are very similar and it was noted that threats facing the workforce directly feed into the future market for care.

- IJB004 (Stakeholder engagement), while remaining Amber has increased from a score of 9 to a 12. Specifically, the Likelihood has increased for a 3 (Possible) to a 4 (Likely) as the current processes for consultation requires to be improved. This has been reflected in the two change papers the will be presented to the IJB Board on 15th December 2021 and in short they detail that plans and directions should go through the Strategic Planning Group and that part of their role will be to assess whether or not consultation has been undertaken. In addition, the IJB Direction Policy and Procedure has been added as a new Internal Control for this risk. Lastly, it is worth noting that work is ongoing to develop the new Integrated Communications Strategy, which will also have a positive bearing on this risk.

- IJB005 (Delegated Budget) has increased from a score of 12 (Amber) to a 16 (Red). Specifically, the Likelihood has increased from a 3 (Possible) to a 4 (Likely) to reflect the fact that the partnership has overspent this year and that the achievement of an integrated budget is unlikely until 2023, given the large volume of work involved. The Target Risk Score has also been revised (Likelihood 4 – Likely and Impact 2 – Minor) and in the first instance the intention is to focus on reducing the impacts associated with this risk, including for example the appointment of a new IJB CFO. A Linked action was added to this effect at the last review and contained reference to the new IJB CO as well. This action has been marked as 75%, and will reach full completion upon the appointment of a new CFO.

- IJB007 (Supplier failure) has increased from a score of 12 (Amber) to 20 (Red). Specifically, the Likelihood has increased from 3 (Possible) to 4 (Likely) and Impact from 4 (Major) to 5 (Catastrophic). These increases reflect the recognised need to focus on the sustainability of services (internally and externally), issues of which have been identified in relation to e.g. some GP practices and the subsequent potential knock-on impacts this has to hospital admissions and appointments which is further compounded by the pressure already being felt by the NHS. A new Internal Control “GMS Contract and Primary Care Improvement Plan” has been added and should help to further mitigate this risk.

- IJB008 (Harm to service users) remains Amber with a Likelihood of 2 (Unlikely) and an Impact of 4 (Major) but it should be noted that there are plans to reframe this risk to more accurately reflect the specific context with regards to the IJB, as the IJB does not directly deliver services. It is expected that changes will be made to the risk description to focus on not just reputational damage but on commissioning appropriately to meet the needs of service users.

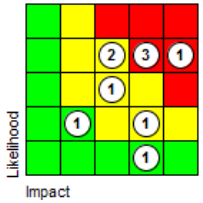
3.7 This report and the IJB Strategic Risk Register are intended to provide the Board with assurance that the strategic risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan are being effectively managed and monitored.

3.8 Reliance is placed on the risk management arrangements within the partner organisations in respect of the operational delivery of commissioned services. As stated in the IJB Risk Management Strategy, any of these risks that significantly impact on the delivery of the IJB Strategic Plan will be escalated to the Chief Officer for consideration.

3.9 The IJB Strategic Risk Register will continue to be reviewed alongside the implementation of the Strategic Plan by the IJB's Chief Officer on a quarterly basis with support from SBC's Corporate Risk Officer. A further update will be presented to the Board in June 2022 i.e. on a six monthly basis in line with the IJB's Risk Management Policy and Strategy.

Appendix 1: IJB Risk Register Summary

Last reviewed on: 06 December 2021



Scottish Borders
Health and Social Care
PARTNERSHIP

Risk Code	Risk Title	Risk Description	Risk Score	Status	Trend	Last Review Date	Risk Approach	Update
IJB001	**Cultural change**	If the required change in culture is not achieved then the delivery of the Partnership's strategic objectives may be delayed or may not be fully met	4 Major - Remote			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** It is still true that the advent of the Pandemic has demanded closer working of the senior Executive Teams of the Council and Health Services. Communications have improved and there is a greater understanding of agendas across organisations within the partnership. As at this review there continues to be close working between partners and the joint NHS/SBC meetings are going well. The vacant (permanent) CO post has now been filled and the recruitment process is underway to find a new permanent CFO, this is in the early stages of going to advert. As a result of the progress made the Linked Action "Permanent Appointment of IJB CO and CFO (recruitment underway)" has been moved to 75% complete. In addition, two change papers have been drafted and are being taken to the IJB meeting on 15.12.2021 for approval, these have endorsed by the Strategic Planning Group. One paper focuses on the IJB Directions Policy and the other on the Strategic Commissioning approach. New Internal Control "Use of IJB Directions (following co-production with partners - NHS/SBC) has been added and assessed as Not Effective as it is not yet in place. Following sign-off of the aforementioned paper it is expected that this will move to Partially Effective, in the first instance, in the new year. Furthermore work is being undertaken to integrate operational structures and this will have a positive bearing on culture. Current Risk Score reassessed and Likelihood reduced from 2 (Unlikely) to 1 (Remote). Impact remains the same at this review. Target Risk Score also reassessed and Impact reduced from 4 (Major) to 2 (Minor), reflecting the desire to reduce the impacts associated with this risk as much as possible. Target Risk Date also revised and set as 31.03.2022.

IJB002	**Resources**	If we do not ensure that an effective Commissioning Plan is agreed, and the required resource are directed by the IJB and allocated by NHSB and SBC then we may not secure the expected outcomes or achieve best value.	12 Moderate - Likely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** This risk is linked to the paper(s) going to the IJB on 15.12.2021 (Directions and Strategic Commissioning Approach). There is a question as to whether this risk should be kept and what triggered it, and it is perhaps the case that this is a legacy risk. EE to look through the history of this risk and advise CM, then a decision can be taken as to whether it should be kept. It could be that the Risk Description is amended to focus on Covid-19 in terms of the impact it may have on achieving timescales. No change to Current and Target Risk Scores at this review but if risk is recast to focus more on the threats posed by Covid-19 then initial thoughts are that the Risk Scoring is a Likelihood of 2 (Unlikely -upper end) with an Impact of 4 (Major).
IJB003	**Future market for care**	If the future market for care is insufficient to meet increasing demand then there may be gaps in service provision and poor outcomes/choices	16 Major - Likely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** As per a previous review, Covid-19 had developed more sufficiency within the community to care for those in lesser need, therefore we had been able to increase capacity. It was then noted that the impact of another cluster outbreak within one or more care homes, would significantly reduce ability to staff at the required level. Relationships with independent care providers has also improved significantly. It was also noted that we are currently modelling demand for both hospital beds and residential care capacity. This will inform a further review of the IJB Strategic Plan, which will aim to recommission to an appropriate level of residential care. It was felt that completion of this would have a positive bearing on the Likelihood of this risk. Lastly, it was noted that Scottish Care have been contracted with to employ an Independent Care Sector Representative. Funding for this post is currently short-term from slippage and it will need to be mainstreamed within the 2022/23 budget agreement *(consider adding this representative as an Internal Control at the next review).* At this review, the current situation with the number of people waiting for care in the community and in hospital (e.g. Delayed Discharges) indicates that current availability is insufficient. Concerns around the future market for care and current availability are distinct but result in the same consequences e.g. gaps in service provision and poor outcomes. There are also significant recruitment and retention difficulties being experienced across H&SC. Sickness/absence, self-isolation requirements and infection control measures are also putting negative pressure on this risk and affecting our ability to meet demand.

								As a result of the above the Current Risk Score has been revised and the Likelihood increased from 3 (Possible) to 4 (Likely). The Target Risk Score has also been revised and Likelihood increased from 1 (Remote) to 2 (Unlikely) in the first instance as based on the current situation this is felt to be a more achievable target. Lastly, due to the similarities with this Risk and Risk 006 "Workforce", the intention is to merge the two for ongoing management.
IJB004	**Stakeholder engagement**	If we do not ensure that we have a partnership approach when communicating and engaging with stakeholders then we may fail to get them to play their part in delivering the partnership's strategic objectives	12 Moderate - Likely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** There are papers going to the IJB on 15.12.2021 which refer to the fact that work (plans and directions) should go through the Strategic Planning Group who will assess, as part of their role, whether or not consultation has been undertaken. If it has not then the group will advise that this needs to be done before they will look at the paper, thus helping to build in de facto stakeholder engagement with e.g. the public and third sector. New Internal Control "IJB Directions Policy and Procedure" has been added and assessed as Not Effective as it is not yet in place and is to be approved by the IJB. With regards to Linked Action "New Integrated Communications Strategy", a meeting is to be held soon with MW (SBC) and CO (NHSB) to progress work around this. As improvements are needed to current processes the Current Risk Score has been reassessed and the Likelihood has increased from 3 (Possible) to 4 (Likely). As the new papers set out remediation to the current processes the Target Risk has also been revised and Likelihood reduced from 2 (Unlikely) to 1 (Remote) and Impact reduced from 3 (Moderate) to 1 (Negligible).
IJB005	**Delegated Budget**	If both Partners do not sufficiently and rigorously plan and manage their Efficiency and Savings Programmes then the delegated budget may continue to overspend leading to inability to commission sufficient services to deliver the strategic objectives	16 Major - Likely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** As the partnership has overspent this year and we are unlikely to have an integrated budget until 2023 (this is a large piece of work) the Current Risk Score has been revised and Likelihood has increased from 3 (Possible) to 4 (Likely). Impact remains the same at 4 (Major). The Target Risk has also been reassessed and Likelihood increased from 2 (Unlikely) to 4 (Likely), in the first instance, bringing it in line with the Current Likelihood. Target Impact reduced from 4 (Major) to 2 (Minor) as we will look to put in place measures to mitigate the impacts of this risk including the appointment of an IJB CFO.

								With regards to Linked Action "Permanent Appointment of the IJB CO and CFO", as with Risk 1, the vacant (permanent) CO post has now been filled and the recruitment process is underway to find a new permanent CFO, this is in the early stages of going to advert. As a result of the progress made this Linked Action has been moved to 75% complete.
IJB006	**Workforce**	If we do not have a workforce fit for purpose now and in the future then the Partnership may fail to deliver on the strategic objectives leading to poor outcomes	16 Major - Likely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** As per the note under Risk003 "Future Market for Care" the intention is to merge the two risks. Threats facing the workforce risk directly play into the future market for care. EE will look to draft something up for CM's approval before the next scheduled review. Both risks are noted as being Likelihood 4 (Likely) and Impact 4 (Major).
IJB007	**Supplier failure**	If a significant supplier was unexpectedly unable to fulfil their contract then there may be a serious gap in service provision leading to risk of harm and reputational damage	20 Catastrophic - Likely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** As per the last review it remains true that improved communications and relationships with external care home providers has reduced the likelihood of a supplier failing as there are early alert systems in place and we can react as a commissioner much quicker to prevent failure. However, the current pandemic continues to put pressure on this risk. As at this review there is a recognised need to focus on improving sustainability (internally as well as externally) and this will be discussed in more detail at the next review in order to present a more balanced view of this risk. It is also worth noting that consideration is being given to a Primary Social Care work stream. A number of GP surgeries have had sustainability issues which have been mitigated through significant work, but could have had a loss of primary care provision for large numbers of members of the public, with a subsequent knock-on impact to hospital admissions and appointments. This is further compounded by the significant pressures, demand and need that health and social care is already facing. Sustainability issues have been reflected in the Risk Factors as it ultimately puts pressure on this risk and can come in a variety of forms. New Internal Control "GMS Contract and Primary Care Improvement Plan" has been added and assessed as Partially Effective. As a result of the above the Current Risk Score has been revised and the Likelihood increased from 3 (Possible) to 4 (Likely), additionally, the Impact has been increased from 4 (Major) to 5 (Catastrophic). No change to the Target Risk Score at this review as it is felt to still be appropriate.

IJB008	**Harm to service users**	If someone under the care of the IJB comes to harm because of a failure attributed to the Partners then this may result is significant reputational damage	8 Major - Unlikely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** As per the last review - pre-pandemic we acknowledged that some improvements were needed across the fabric of our care estate and with our independent partners. Then, during the pandemic we have also registered some challenges with regards to infection control which were exacerbated by the age and format of the existing care estate. This has been mitigated to some extent by the level of staffing that has been required in each of the care homes. As at this review it was noted that the IJB is a Strategic Commissioning Body and as such does not deliver services - this is done by NHS/SBC. There is a need to look at recasting this risk to more accurately reflect the specific context in regard to the IJB and this will be carried out at the next review. It was further noted that the Risk Description is to be amended so that the sole focus is not on reputational damage but reflects e.g. the IJB not commissioning appropriately to meet need. No change to Current or Target Risk Scores at this review - these will be assessed when this risk has been rethought.
IJB009	**Programmes/ projects management**	If we fail to manage and appropriately resource major programmes/projects undertaken simultaneously then we may be unable to achieve objectives	9 Moderate - Possible			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** Previous review still felt to be accurate in that - the restructure intended has been impacted by further changes within the Exec Teams of NHSB, SBC and IJB. In addition, with the advent of the Feeley review of adult social care more time is required to determine the shape and function of the Exec Teams across the three organisations, to deliver health and social care. Linked Action "Implement changes to management structure..." was added to reflect this. Furthermore, building on the last update where it was noted that the current CO was retiring imminently and as such the opportunity has been taken to review the required skill mix for the leadership team of the IJB. Once in place the new CO and CFO will lead on the creation of a new leadership team for the IJB to support and prepare for the recommendations of the Feeley Report. As at this review the new CO is in post and the recruitment process is underway for the new CFO, which is in the early stages of going out to advert. Risk Factors updated to remove reference to the retiring CO. No change to Current or Target Risk Scores at this review.
IJB010	**Data Breach**	If the Partners lose sensitive data or use data inappropriately then we may be	4 Minor - Unlikely			06-Dec-2021	Treat	**Update from meeting with CM on 06.12.2021:** It was noted at the meeting that as per the Midlothian Plan, responsibility for data breaches does sit with the IJB as well as partner agencies. The risk is not significant as it is a strategic group but there is need to ensure that data

		in breach of data protection legislation resulting in fines and reputational damage						shared is done so appropriately. Risk Factors updated to reflect the Public Body Scotland Act (Section 5.1) which details IJB responsibility. All staff need to undertake training on data protection through respective agencies. Board members also need to complete an equivalent but it is not clear whether or not this has happened. *CM has advised that this will be raised at the next Information Governance Group meeting* and once the situation is clear this risk can be updated accordingly and with the aim that this risk can be returned to a Management Approach of Tolerate. Linked Action "Find out about update to Mandatory Training..." is still to be progressed, but initial contact was made with appropriate NHS/SBC colleagues. RMcC-G advised that this was something to raise with the Group and as such is tied into the point made above with regards to the Information Governance Group. Due date has been amended to 31.01.2021 in the first instance. Action remains at 40% complete. No change to Current or Target Risk Scores at this review and both remain aligned.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Chris Myers, Chief Officer Health & Social Care
Contact:	Meriel Carter, Analytical & BI Team Lead
Telephone:	MS Teams
QUARTERLY PERFORMANCE REPORT	
Purpose of Report:	To provide the regular high level quarterly performance report for IJB consideration.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the quarterly performance report.
Personnel:	N/A
Carers:	N/A
Equalities:	N/A
Financial:	N/A
Legal:	N/A
Risk Implications:	N/A

Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the
Scottish Borders Integration Joint Board December 2021

SUMMARY OF PERFORMANCE:
Latest available Data at end OCTOBER 2021

Structured Around the 3 Objectives in the Strategic Plan:

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

Objective 2: We will improve patient flow within and outwith hospital

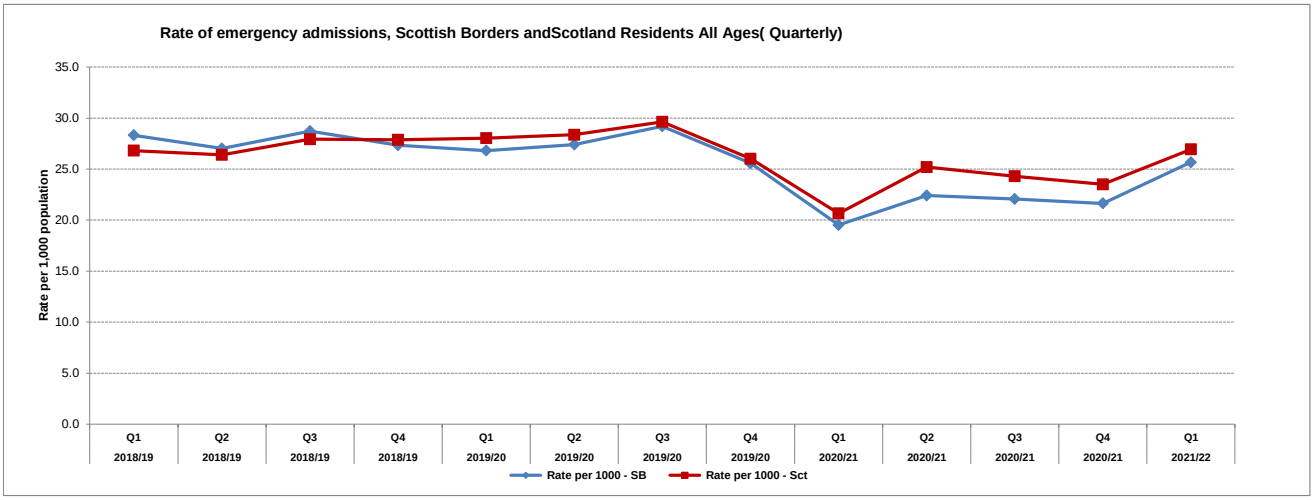
Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

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

Emergency Admissions, Scottish Borders residents All Ages

Source: MSG Integration Performance Indicators workbook (SMR01 data)

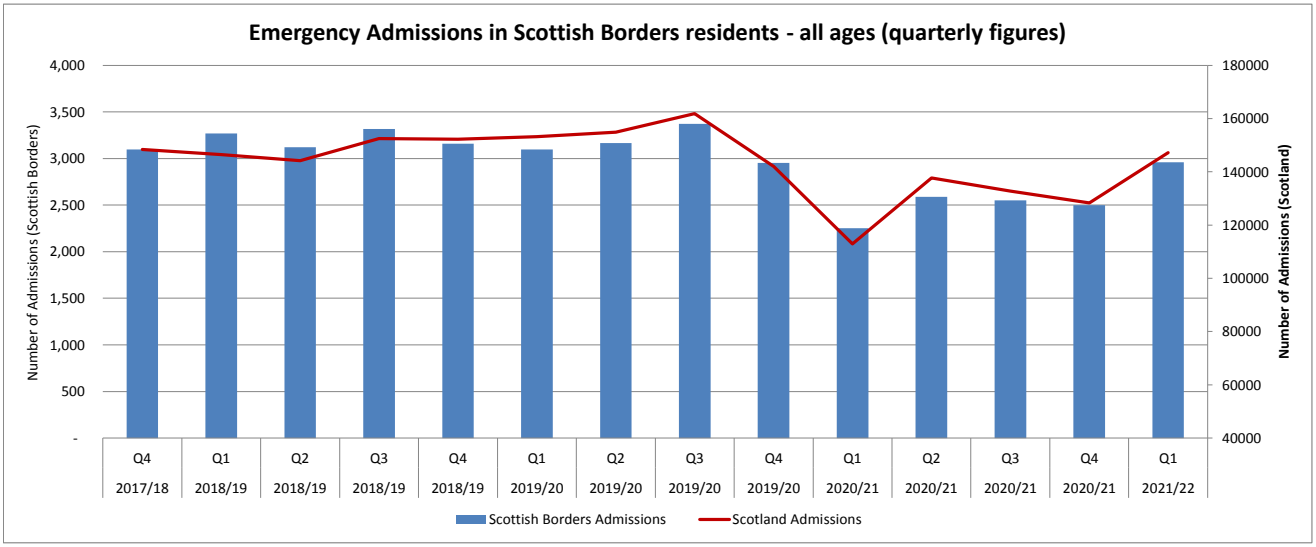
	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Scottish Borders - Rate of Emergency Admissions per 1,000 population All Ages	28.4	27.1	28.8	27.5	26.9	27.5	29.3	25.6	19.6	22.4	22.1	21.6	25.7
Scotland - Rate of Emergency Admissions per 1,000 population All Ages	27.0	26.6	28.1	28.1	28.2	28.5	29.8	26.1	20.6	24.6	24.3	23.5	26.9



Number of Emergency Admissions in Scottish Borders residents - all ages (quarterly figures)

Source: MSG Integration Performance Indicators workbook (SMR01 data)

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Number Scottish Borders Emergency Admissions - All Ages	3,271	3,120	3,317	3,158	3,097	3,166	3,372	2,953	2,254	2,586	2,547	2,500	2,959
Number Scotland Emergency Admissions - All Ages	146,500	144,177	152,552	152,223	153,176	154,966	161,865	142,079	112,034	133,783	132,773	128,364	147,240



Please Note: where two areas are concerned it is not possible to show values as a control chart.

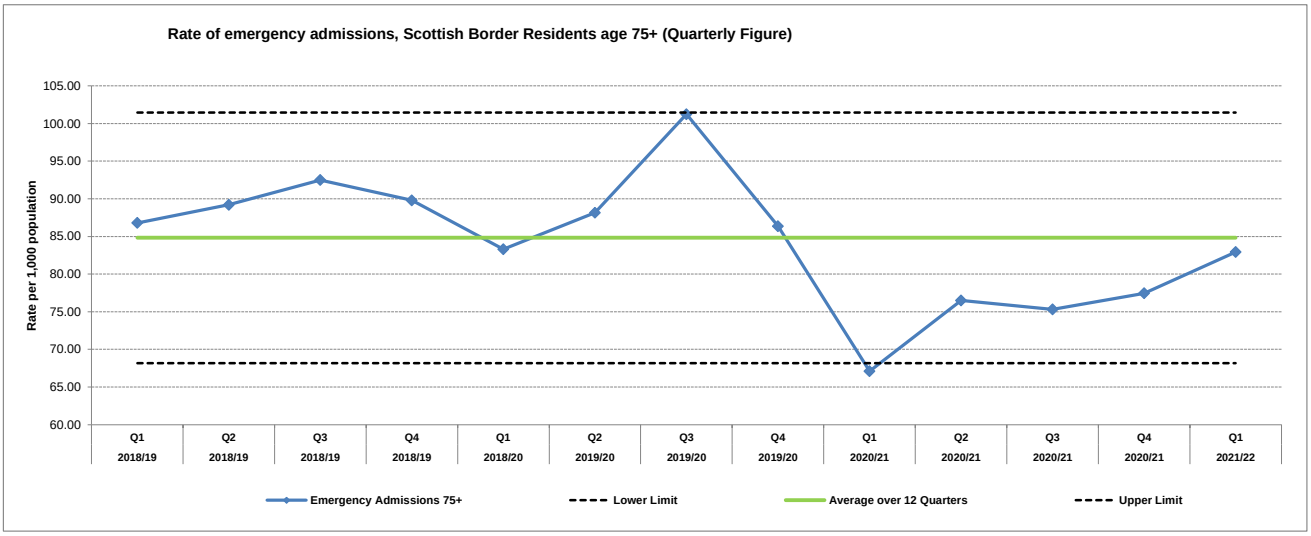
How are we performing?

The rate of emergency admissions continues to see minor fluctuations between quarters. Emergency Admission rates significantly reduced in both Q4 19/20 and Q1 20/21. This is reflective of the impact of the Covid-19 pandemic and the National measures introduced to reduce the spread of the virus. This rose again in Q2, following a similar trend to that of the rest of Scotland. There has been a dip subsequently in Q3 and Q4 2020/21 during the pandemic but emergency admissions have risen again in April - June 2021.

Emergency Admissions, Scottish Borders residents age 75+

Source: NSS Discovery

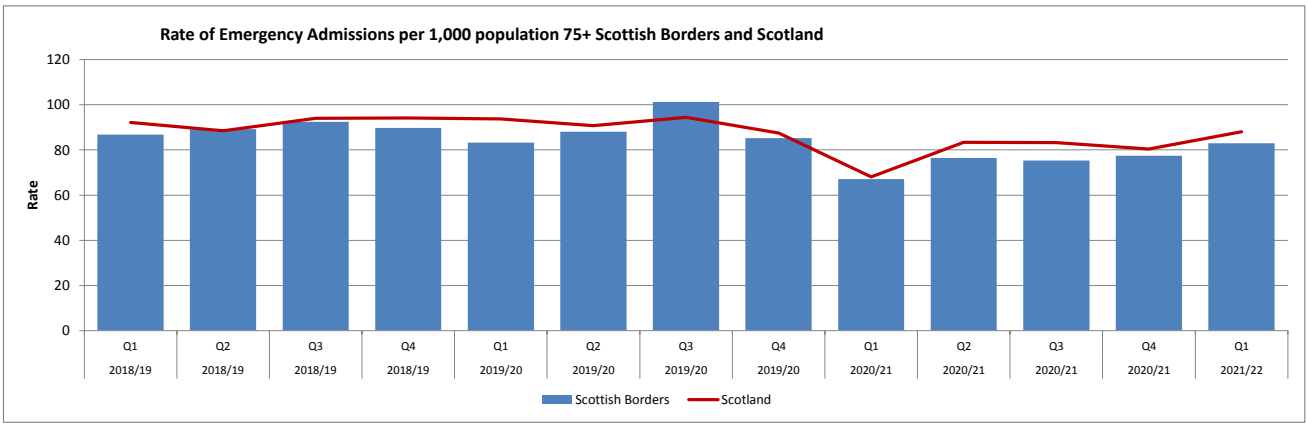
	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Number of Emergency Admissions, 75+	1,040	1,069	1,108	1,076	1,020	1,079	1,239	1,057	846	965	947	977	1,046
Rate of Emergency Admissions per 1,000 population 75+	86.8	89.2	92.5	89.8	83.3	88.2	101.2	86.4	67.1	76.5	75.3	77.5	82.9



Emergency Admissions comparison, Scottish Borders and Scotland residents age 75+

Source: NSS Discovery

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Rate of Emergency Admissions Scottish Borders	86.8	89.2	92.5	89.8	83.3	88.1	101.2	85.3	67.1	76.5	75.3	77.5	82.9
Rate of Emergency Admissions 75+ Scotland	92.2	88.5	94.0	94.2	93.7	90.8	94.4	87.5	68.0	83.4	83.3	80.5	88.0



Please Note: where two areas are concerned it is not possible to show values as a control chart.

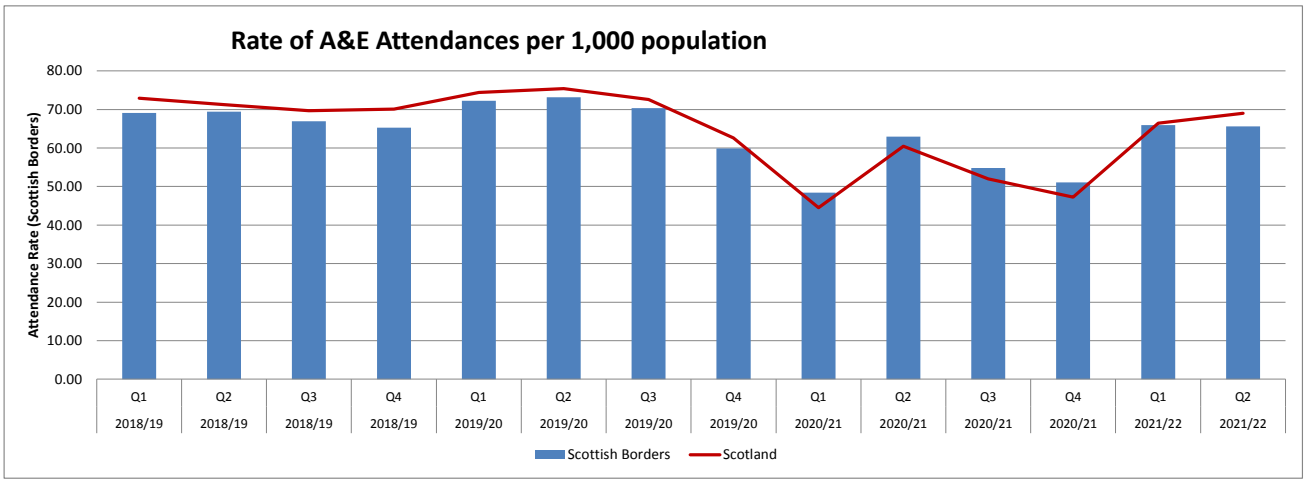
How are we performing?

The rate of 75+ emergency admissions was showing a negative trend over the last 3 years until Q4 2019/20. The graph shows Emergency Admission rates, for the 75+ age group, have dramatically decreased in Q4 2019/20 and Q1 2020/21. This change comes following the highest reported rate of admissions for this age group in the last 3 years - pushing the Borders rate ahead of the Scottish average. Again the onset of the Covid-19 pandemic during Q4 2019/20, and its ongoing effects, would explain the sudden decrease in Emergency Admissions over the Q4 19/20 and Q1 20/21. Q2 20/21 to Q1 21/22 saw this rate increase slightly; however, it remains below the average over 12 quarters.

Rate of A&E Attendances per 1,000 population

Source: MSG Integration Performance Indicators workbook (data from NHS Borders Trakcare system)

	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22
Rate of Attendances, Scottish Borders	69.7	67.2	65.6	72.4	73.3	70.5	60.0	48.5	63.0	54.7	51.0	65.9	65.6
Rate of Attendances, Scotland	71.8	70.1	70.6	74.8	75.7	72.9	62.9	44.6	60.5	52.3	47.3	66.4	69.0

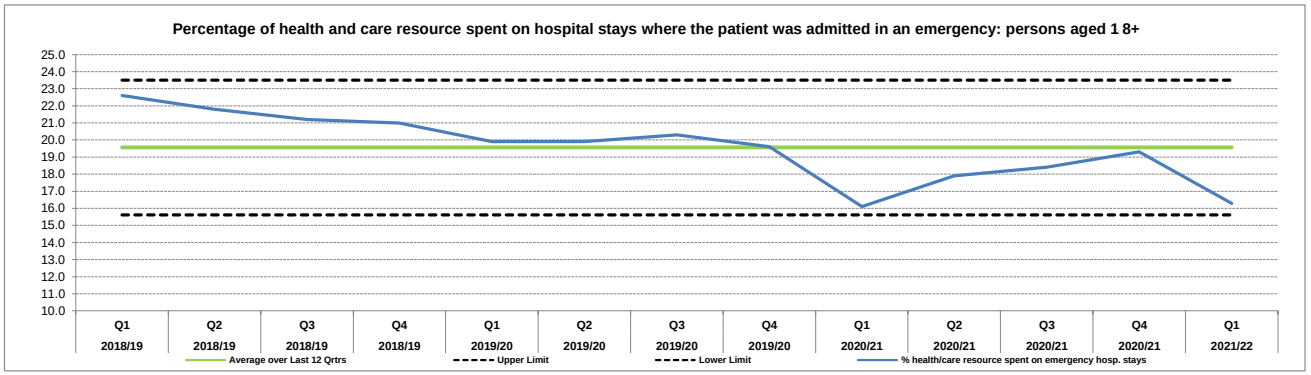


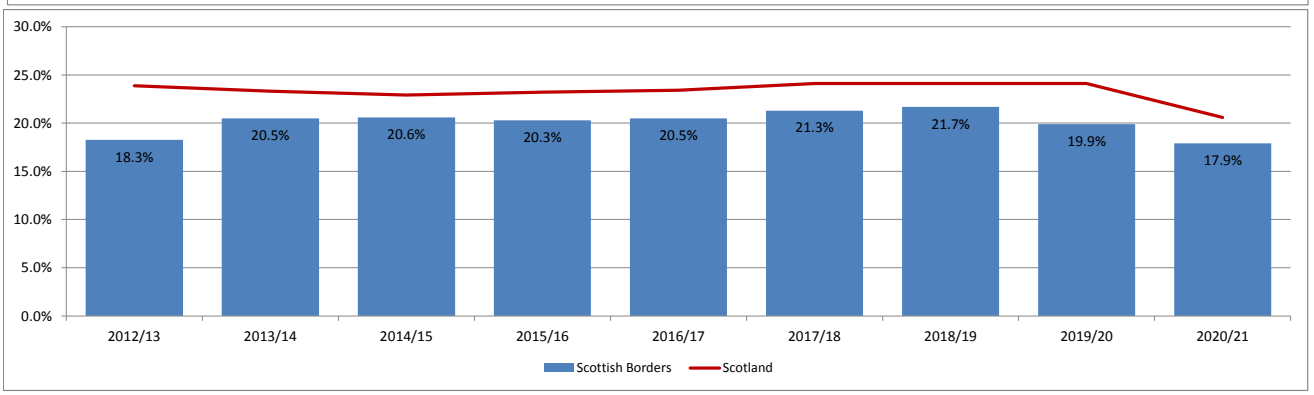
Please Note: where two areas are concerned it is not possible to show values as a control chart.

Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+

Source: Core Suite Indicator workbooks

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2018/19	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
% of health and care resource spent on emergency hospital stays (Scottish Borders)	22.6	21.8	21.2	21.0	19.9	19.9	20.3	19.5	15.9	17.7	16.4	19.3	16.3





Please Note: where two areas are concerned it is not possible to show values as a control chart.

How are we performing?

The onset of the Covid-19 pandemic (Q4 19/20 onwards) saw the rate of A&E attendances drastically reduce, with Q1 20/21 showing the lowest rate over the last 3 years. However, Q2 20/21 (Jul-Sept 20) has seen this rise to almost 'normal' levels at 62.4 admissions per 1,000 of the population. This behaviour mirrors that of the overall Scottish rate although it should be noted that in both Q1 to of 20/21 the Borders rate was greater than Scotland's.

The percentage of health and social care resource spent on unscheduled hospital stays has seen an overall slight decrease over the past 3 years. The significant reduction in spend reported in Q1 2020/21 echoes the reduced emergency admissions rate.

Both these indicators are impacted by the effects of the Covid-19 pandemic.

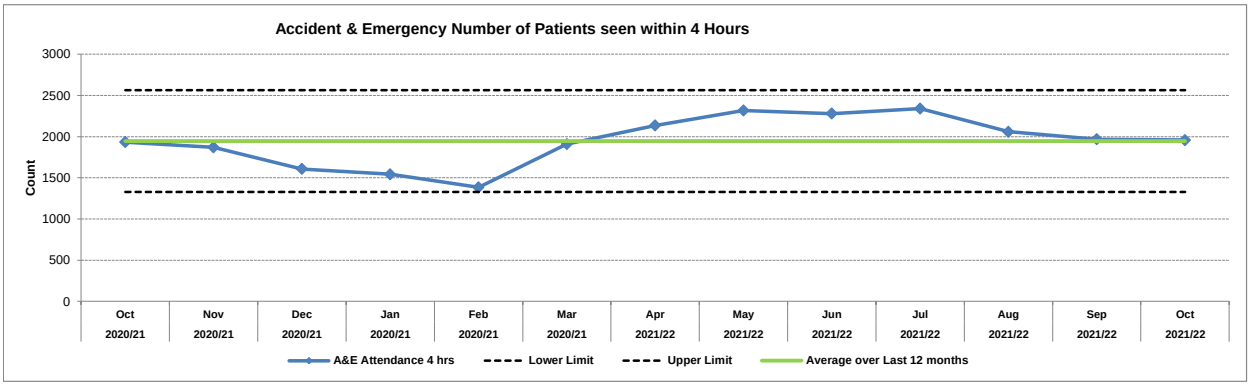
NB: December 2019, the denominator for this indicator now includes dental and ophthalmic costs. As a result, the % of spend has slightly decreased. The Table and Charts above have been updated to reflect the altered % as a result of this change.

Objective 2: We will improve patient flow within and out with hospital

Accident and Emergency attendances seen within 4 hours- Scottish Borders

Source: NHS Borders Trakcare system

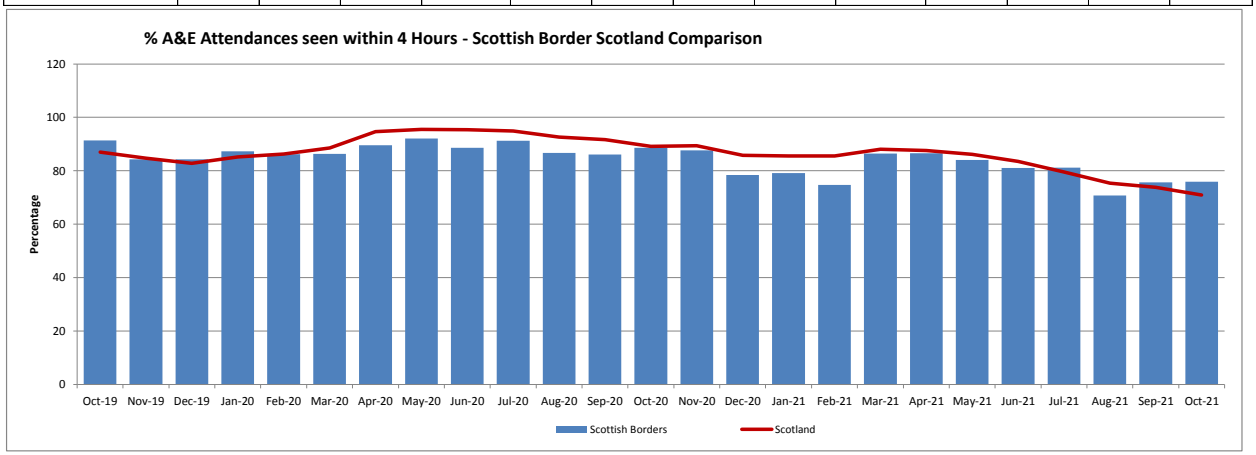
	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Number of A&E Attendances seen within 4 hours	1934	1871	1608	1543	1385	1910	2135	2318	2280	2341	2059	1969	1958



% A&E Attendances seen within 4 Hours - Scottish Borders and Scotland Comparison

Source: MSG Integration Performance Indicators workbook (A&E2 data) / ISD Scotland ED Activity and Waiting Times publication

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
% A&E Attendances seen within 4 hour Scottish Borders	88.6	87.6	78.4	79.1	74.7	86.5	86.6	84.0	81.1	81.2	70.8	75.6	75.9
% A&E Attendances seen within 4 hour Scotland	89.1	89.4	85.8	85.5	85.6	88.1	87.6	86.1	83.5	79.5	75.3	73.8	70.9



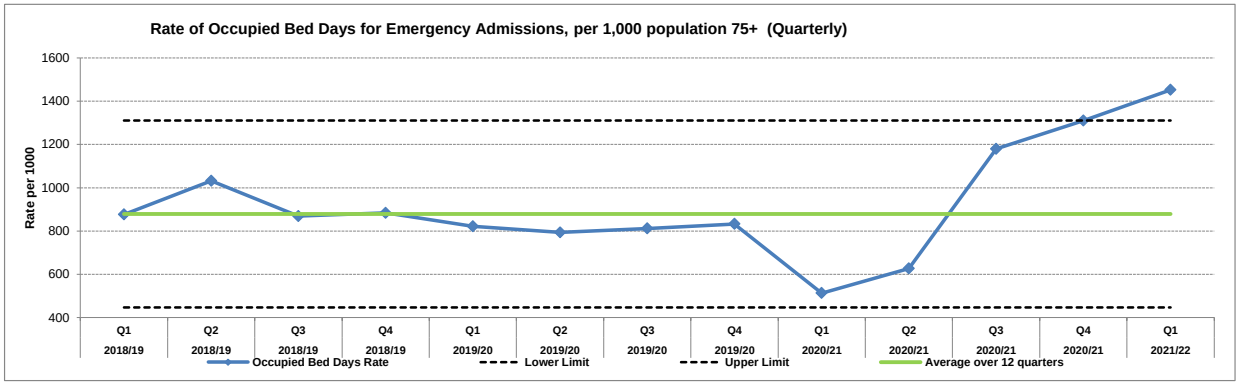
How are we performing?

Historically, NHS Borders consistently performed better than the Scottish comparator for A&E waiting times. Borders had fallen below the Scottish Average in 11 of the last 12 months reported, with the gap widening significantly since the onset of the Corona Virus pandemic in March 2020, however the last 2 months show improving performance and is now above the Scotland rate.

Occupied Bed Days for emergency admissions, Scottish Borders Residents age 75+

Source: NSS Discovery

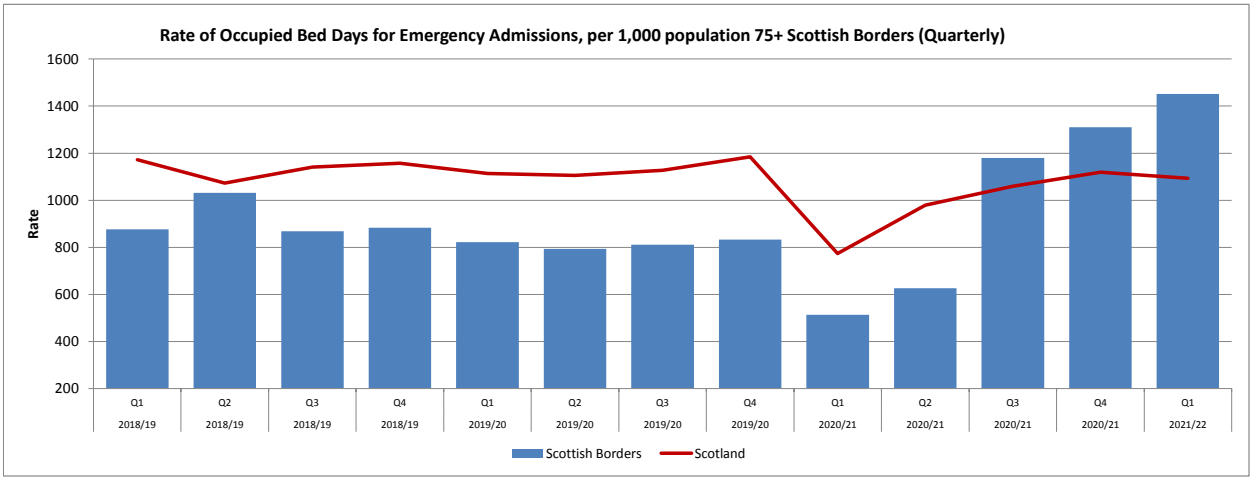
	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Number of Occupied Bed Days for emergency Admissions, 75+	876	1032	868	883	822	794	812	833	513	627	1179	1310	1452
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	10523	12356	10407	10587	10056	9719	9933	10505	6471	7903	14861	16521	18378



Occupied Bed Days for emergency admissions, Scottish Borders and Scotland Residents age 75+

Source: NSS Discovery

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	876	1032	868	883	822	794	812	833	513	627	1179	1310	1452
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1172	1072	1141	1157	1114	1105	1127	1185	774	979	1060	1119	1093



Please Note: where two areas are concerned it is not possible to show values as a control chart.

How are we performing?

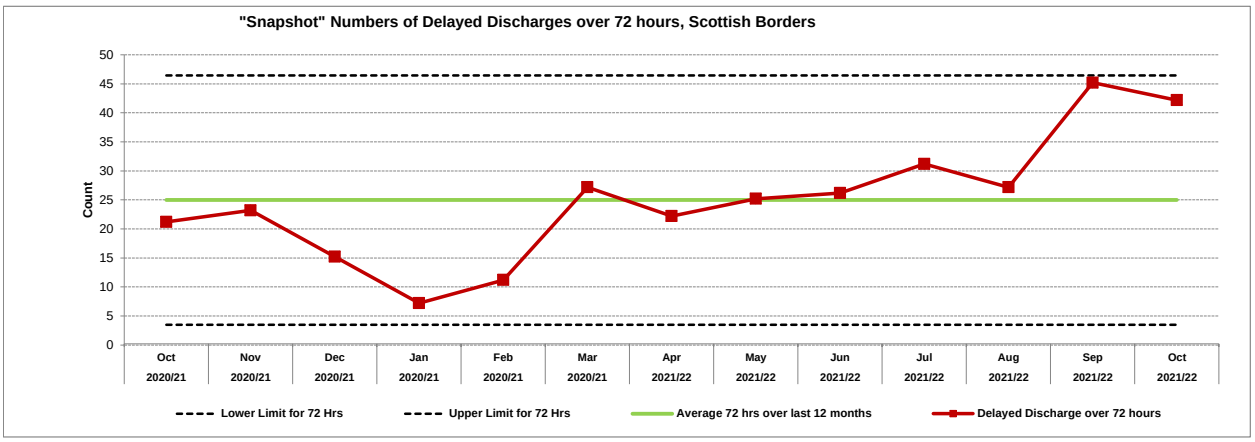
NB: Data for Community Hospitals is included in both Bed Days measures from Q3 2020/21 onwards.

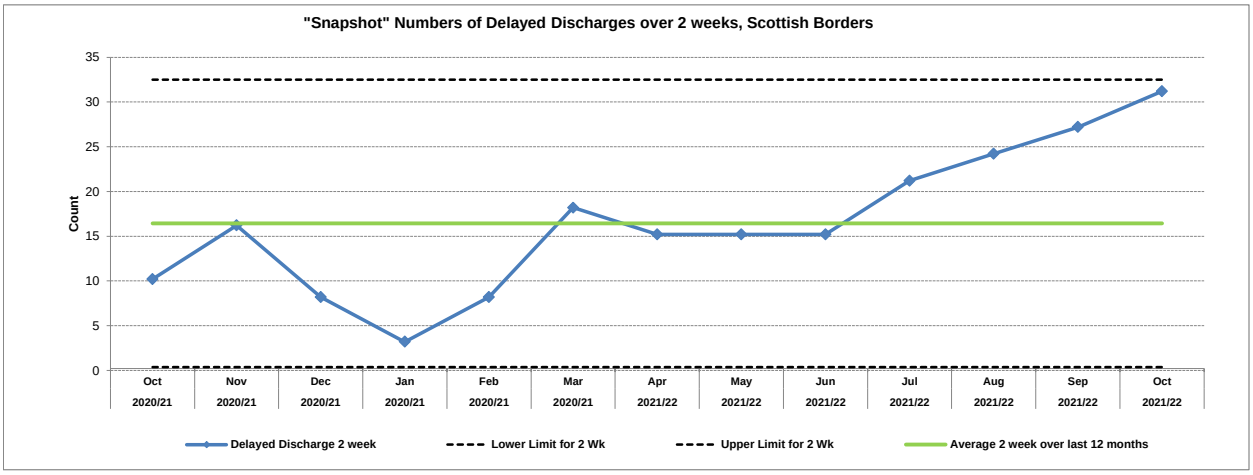
The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75+ has fluctuated over time and had remained lower than the Scottish Average; however, the Borders rate is greater than Scotland in Q3 20/21 - Q1 21/22 when Community Hospitals are included.

Delayed Discharges (DDs)

Source: EDISON/NHS Borders Trakcare system

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Number of DDs over 2 weeks	10	16	8	3	8	18	15	15	15	21	24	27	31
Number of DDs over 72 hours	21	23	15	7	11	27	22	25	26	31	27	45	42





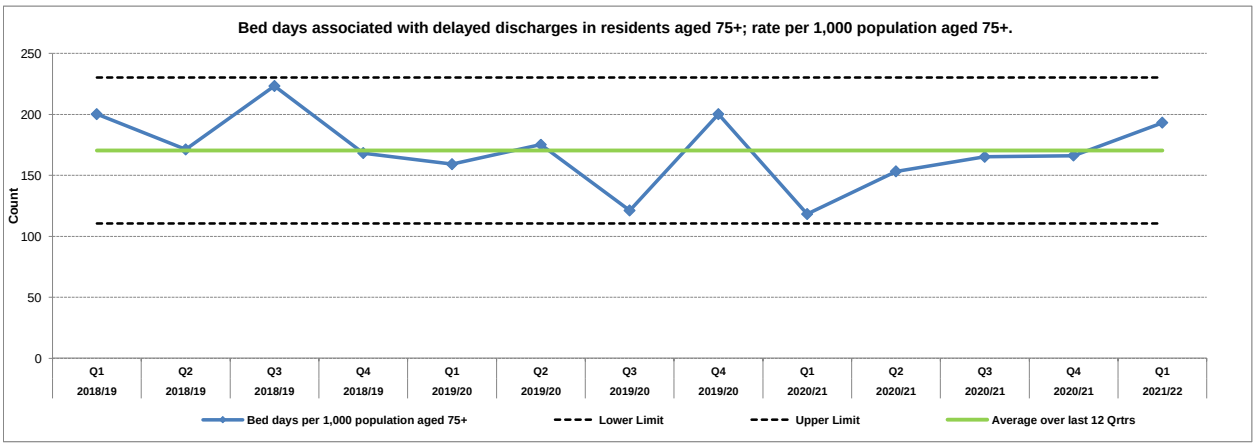
Please note the Delayed Discharge over 72 hours measurement has been implemented from April 2016.

The DD over 2 weeks measurement has several years of data and has been plotted on a statistical run chart (with upper, lower limits and an average) to provide additional statistical information to complement the more recent 72 hour measurement.

Bed days associated with delayed discharges in residents aged 75+; rate per 1,000 population aged 75+

Source: Core Suite Indicator workbooks

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Bed days per 1,000 population aged 75+	200	171	223	168	159	175	121	200	118	153	165	166	193



How are we performing?

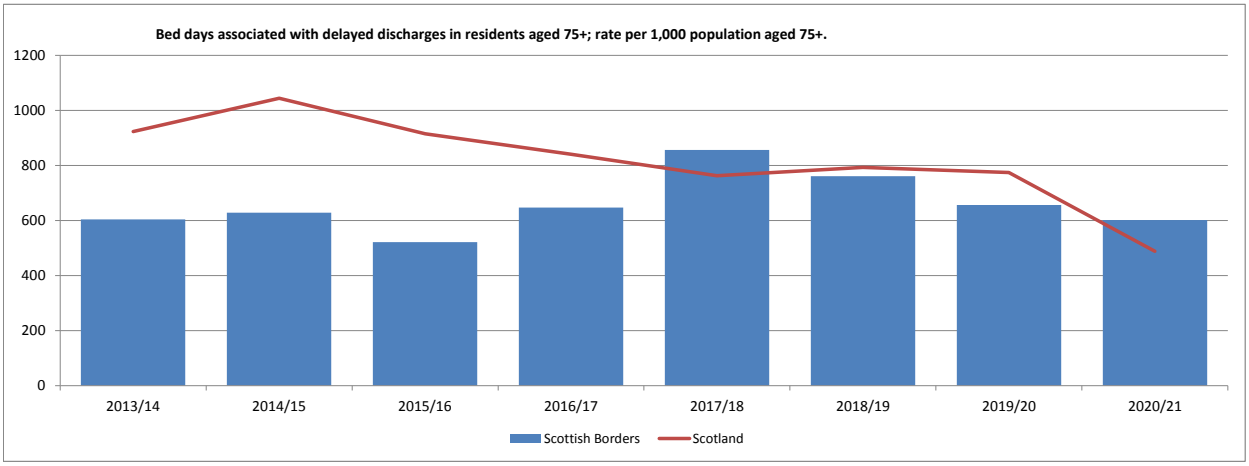
Although, at the onset of the Corona Virus pandemic there was a reduction in the number of delayed discharges, this was short-lived and these have again been on an increasing trend since May 20. December 2020 demonstrated a drop in delayed discharges; this is in-line with the previous year although the 2020 figure is higher than in 2019. In 2021 the rate of delayed discharges started to increase from February 2021 onwards.October 2021 was the first month to show a reduction in over 72 hour waits this year.

The rate of bed days associated with delayed discharges (75+) from Q1 18/19 to Q1 21/22 show fluctutations within control limits, there has been an icrease since Q1 20/21 in the bed day rate. The overall trend for this measure is positive. NHS Borders is facing significant challenges with Delayed Discharges, which continues to impact on patient flow within the Borders General Hospital and our four Community Hospitals. The measure has an overall positive trend over the last 3 years, although, Q4 2019/20 shows a significant increase to 200 days, which is above the average and well above the 180 day target. A trajectory and action plan for improvement has been put in place to March 2022.

Scotland / Scottish Borders comparison of bed days associated with delayed discharges in residents aged 75+

Source: Core Suite Indicator workbooks

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	628	522	647	855	761	656	601
Scotland	1044	915	841	762	793	774	488



Please Note: where two areas are concerned it is not possible to show values as a control chart.

How are we performing?

Up to 2016/17, rates for the Scottish Borders were lower (better) than the Scottish average. However, in 2017/18 the Borders' rate was higher than Scotland's. This reduced in 2018/19 - when the Scottish average increased - and further reduced in 2019/20 and 2020/21.

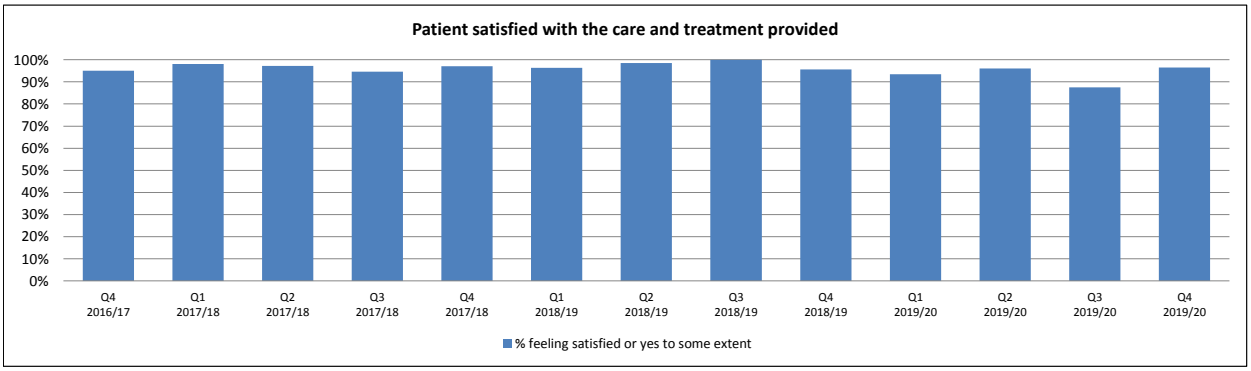
*Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.

BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

Source: NHS Borders Please Note: data is not available at the current time for these measures.

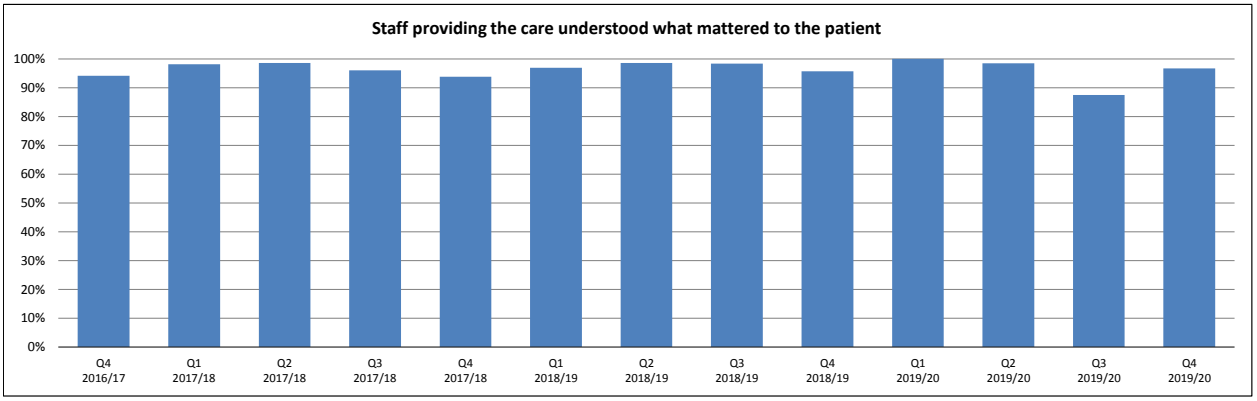
Q1 Was the patient satisfied with the care and treatment provided?

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Patients feeling satisfied or yes to some extent	116	105	206	141	135	156	135	117	108	99	121	63	56
% feeling satisfied or yes to some extent	95.1%	98.1%	97.2%	94.6%	97.1%	96.3%	98.5%	100.0%	95.7%	93.4%	96.0%	87.5%	96.6%



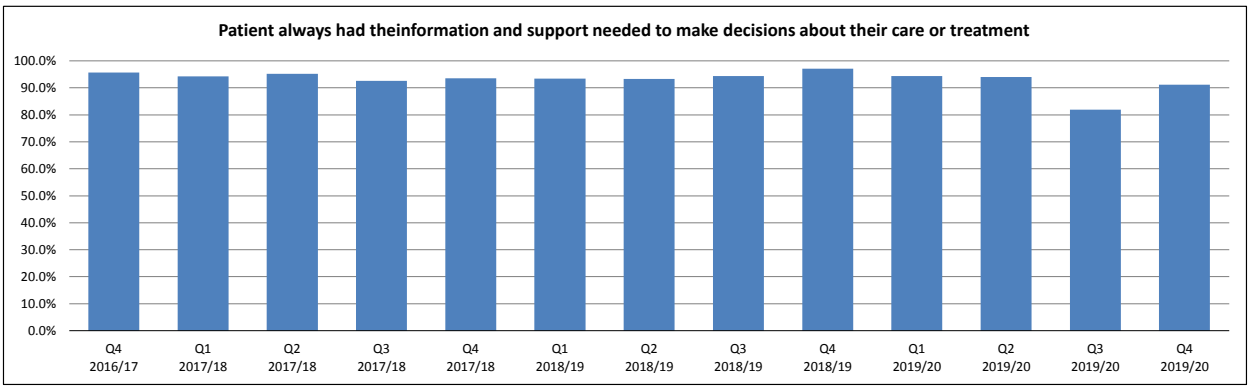
Q2 Did the staff providing the care understand what mattered to the patient?

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Staff providing the care understood what mattered to the patient, or yes to some extent	113	105	213	144	135	158	136	119	110	106	125	63	59
% understood what mattered or yes to some extent	94.2%	98.1%	98.6%	96.0%	93.8%	96.9%	98.6%	98.3%	95.7%	100.0%	98.4%	87.5%	96.7%



Q3 Did the patient always have the information and support needed to make decisions about their care or treatment?

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Patients always had the information and support needed to make decisions about their care or treatment, or yes to some extent	111	99	200	137	129	141	125	101	102	100	110	59	52
% always had information or support, or yes to some extent	95.7%	94.3%	95.2%	92.6%	93.5%	93.4%	93.3%	94.4%	97.1%	94.3%	94.0%	81.9%	91.2%



How are we performing?

The 2 Minutes of Your Time Survey is carried out across the Borders General Hospital and Community Hospitals and comprises of 3 quick questions asked of patients, relatives or carers by volunteers. There are also boxes posted in wards for responses. The results given here are the responses where the answer given was in the affirmative or 'yes to some extent'. Percentages given are of the total number of responses.

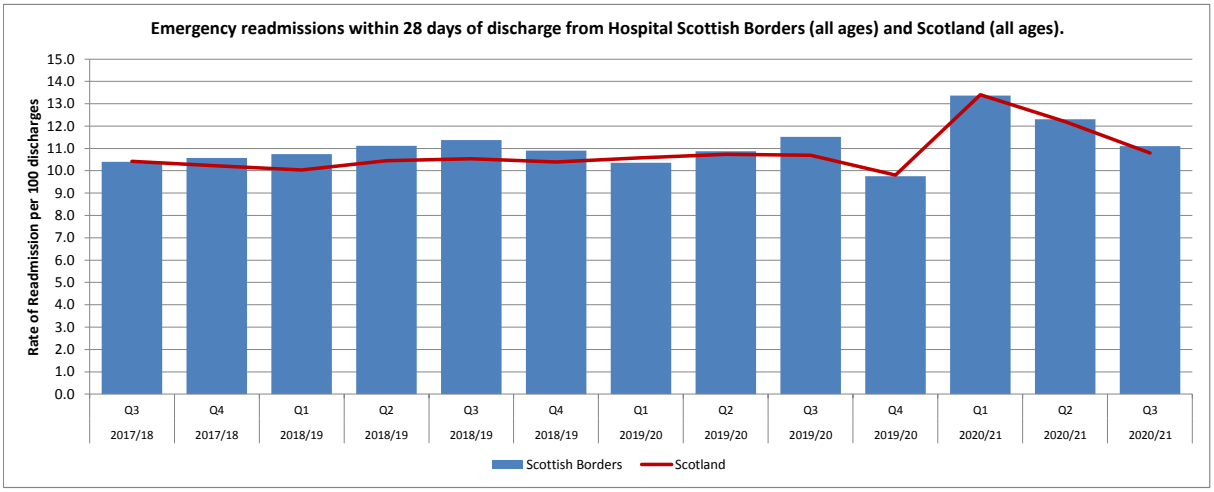
Overall, Borders scores well with an average 95.5% satisfaction rate. Patient satisfaction shows a positive trend over time and the latest overall average achieves the 95% target. *Please note the Patient Survey has been suspended from the start of the corona virus pandemic. This is due to the survey using volunteers for follow-up which is unable to happen as a result of restrictions.*

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

Emergency readmissions within 28 days of discharge from hospital, Scottish Borders residents (all ages)

Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but here also adding in Borders Community Hospital beds).

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Scottish Borders	10.4	10.6	10.7	11.1	11.4	10.9	10.4	10.9	11.5	9.8	13.4	12.3	11.1
Scotland	10.4	10.2	10.0	10.5	10.5	10.4	10.6	10.7	10.7	9.8	13.4	12.2	10.8



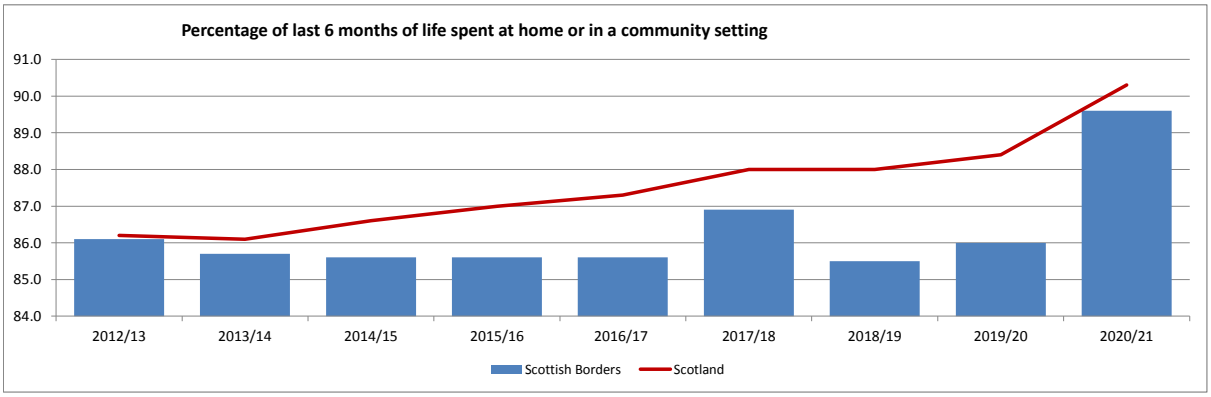
How are we performing?

The rate of emergency readmissions within 28 days of discharge shows a negative trend over the last 3 years. The Borders rate is generally higher than the Scottish average and this trend looks to be continuing. Readmissions in Q1 20/21 escalated to 13.4 readmissions for every 100 discharges. This is the highest rate of readmissions in the last twelve reported quarters. The rate has continued to decrease over the latest 2 quarters reported.

Percentage of last 6 months of life spent at home or in a community setting

Source: Core Suite Indicator workbooks

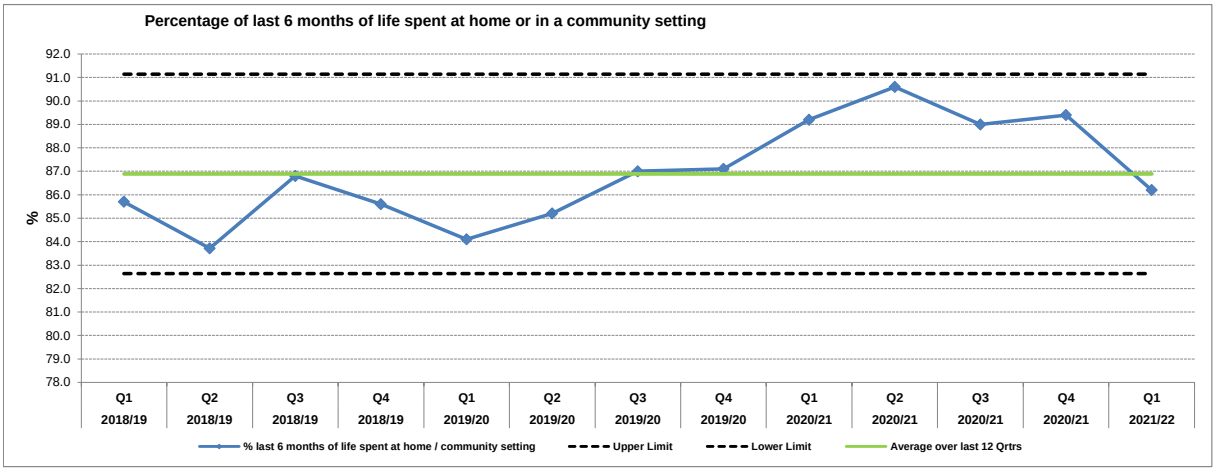
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Scottish Borders	86.1	85.7	85.6	85.6	85.6	86.9	85.5	86.0	89.6
Scotland	86.2	86.1	86.6	87.0	87.3	88.0	88.0	88.4	90.3



Percentage of last 6 months of life spent at home or in a community setting

Source: Core Suite Indicator workbooks

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
% last 6 months of life spent at home or in a community setting Scottish Borders	85.7	83.7	86.8	86.0	84.3	85.4	87.3	87.2	89.8	90.7	89.4	89.4	86.2



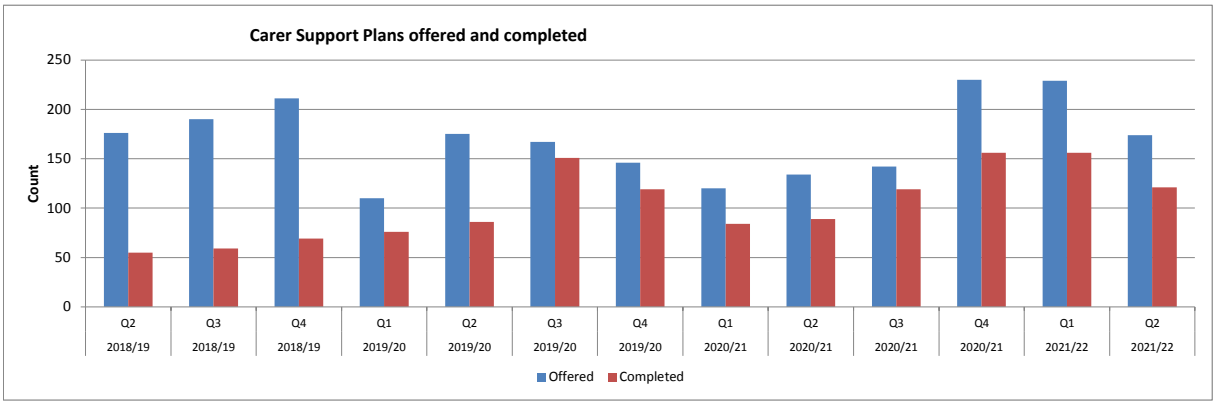
How are we performing?

The percentage of last 6 months of life spent at home or in a community setting remains below the Scottish average. Following a drop in 2018/19, 2019/20 saw performance improve for this measure. The first two quarters of 20/21 demonstrated continued improvement against this indica tor. Q2 20/21 demonstrates the highest % in the last 3 years for people spending the last 6 months at home or in a Community setting. After this point the re was a decrease in performance, reducing to 86% in Q1 21/22.

Carers offered and completed Carer Support Plans

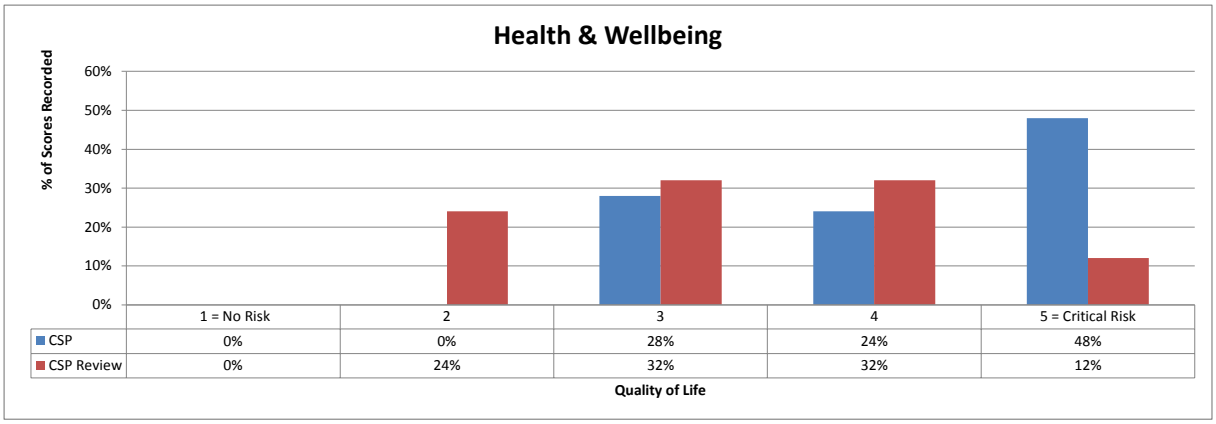
Source: Borders Carers Centre

	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22
Carer Support Plans Offered	176	190	211	110	175	167	146	120	134	142	230	229	174
Carer Support Plans Completed	55	59	69	76	86	151	119	84	89	119	156	156	121



Health and Wellbeing (Q2 2021/22)

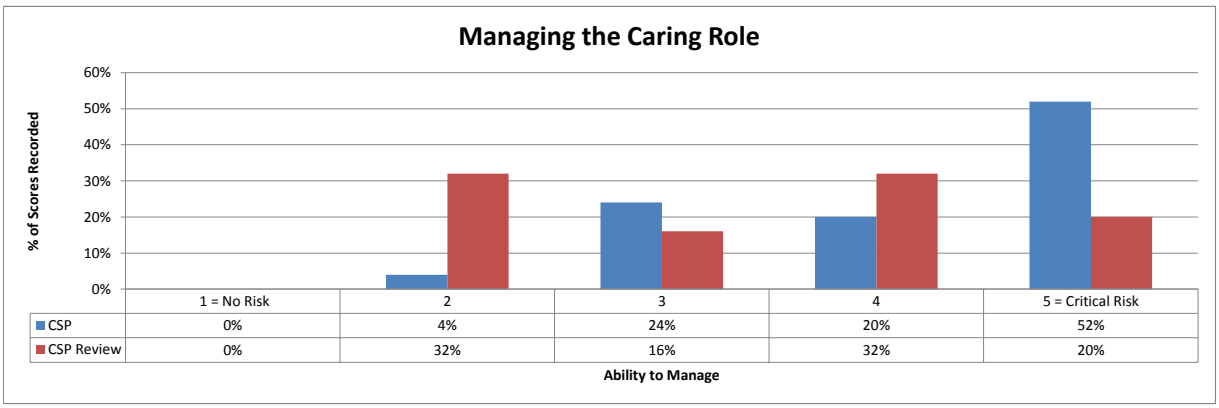
I think my quality of life just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0%	0%	28%	24%	48%
CSP Review	0%	24%	32%	32%	12%

Managing the Caring role (Q2 2021/22)

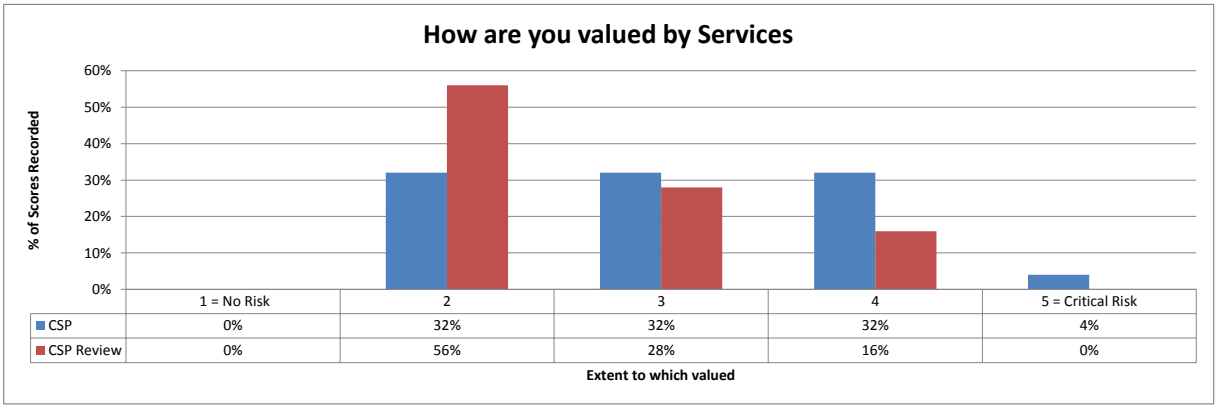
I think my ability to manage my caring role just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0%	4%	24%	20%	52%
CSP Review	0%	32%	16%	32%	20%

How are you valued by Services (Q2 2021/22)

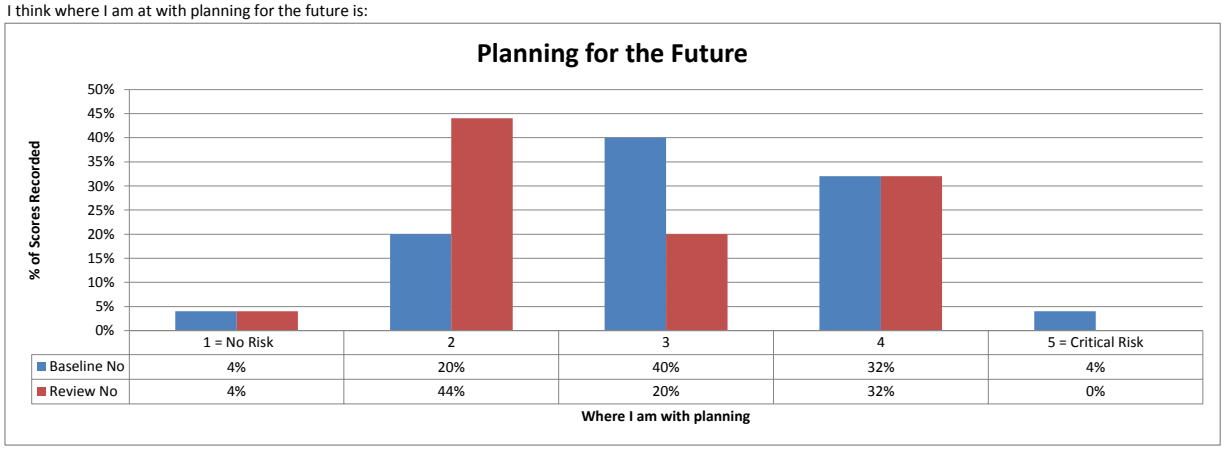
I think the extent to which I am valued by services just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0%	32%	32%	32%	4%
CSP Review	0%	56%	28%	16%	0%

Planning for the Future (Q2 2021/22)

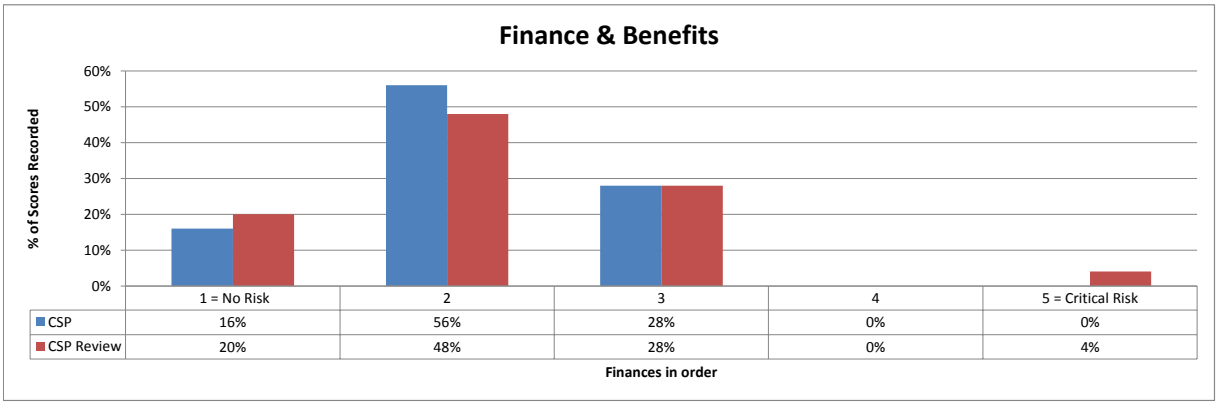
I think where I am at with planning for the future is:



	1 = No Risk	2	3	4	5 = Critical Risk
Baseline No	4%	20%	40%	32%	4%
Review No	4%	44%	20%	32%	0%

Finance & Benefits (Q2 2021/22)

I think where I am at with action on finances and benefits is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	16%	56%	28%	0%	0%
CSP Review	20%	48%	28%	0%	4%

How are we performing?

There has been a continued increase in the number of completed CSPs over the past 4 quarters.

Fluctuations in improvements in scores have been slight but still exist, which implies that we are managing to lift Carers out of the 'Critical Risk' category to 'Significant Risk' and from 'Significant Risk' to 'Moderate Risk' category.

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 15 December 2021

Report By:	Chris Myers, Chief Officer Health& Social Care
Contact:	Bob Salmond, Associate Director of Workforce
Telephone:	Via MS Teams or 01896 826157
INTEGRATED WORKFORCE PLAN	
Purpose of Report:	To appraise the Integrated Joint Board that an Integrated Workforce Plan is being developed in line with the requirements from the Scottish Government DL(2020)28.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** that Scottish Government DL(2020)28 outlines the requirement for: - Integration Authorities to ensure a 3 year workforce plan is developed no later than 31 March 2022. o This plan should cover the period 1 April 2022 to 31 March 2025. o Integration Authorities' Workforce Plans should be published on organisations' websites by 31st March 2022, and a link to each Plan should be forwarded to the Scottish Government's National Health and Social Care Workforce Planning Programme Office by that date b) **Note** that HR Directors have been advised that recognising the impact of COVID-19, this deadline may be postponed to a later date in 2022. c) **Note** that an Interim (integrated) Workforce Plan was submitted to the Scottish Government at the end of April 2021 d) **Note** that as a result, the Health and Social Care Partnership will continue to developing an Integrated Workforce Plan over the coming months
Personnel:	This will continue to require input from the HR and Partnership Teams, along with staff.
Carers:	The plan will be shared with the Strategic Planning Group, which includes representation from carers
Equalities:	Equality and Diversity Impact assessments will be undertaken at appropriate stages of the workforce planning process
Financial:	It is anticipated that there will be a financial impact associated to the future level of workforce, however at this stage, the level of impact and central reimbursement is unclear.
Legal:	Include confirmation that legal requirements are met where relevant.
Risk Implications:	That there are insufficient levels of workforce to meet future demand.

NHS Borders Interim Workforce Plan 2021/22

(Joint Submission with Scottish Borders Health & Social Care Partnership)

Section 1 – Background

Introduction

- Sound workforce planning is essential to support quality of patient care by ensuring NHS Borders and the Health & Social Care Partnership have a workforce with the right capacity, skills, and competences, deployed in the right locations to meet patient needs. Effective planning and management of the workforce supports recovery from the COVID-19 Pandemic as well addressing affordability; whilst retaining a focus on operational performance and patient care.

- In December 2019, the Scottish Government released new workforce planning guidance which set out a three-year workforce planning cycle, with NHS Boards and Integration Authorities (through Health and Social Care Partnerships) required to publish their first 3-year workforce plans by 31 March 2021. This is a departure from the previous Scottish Government guidance for NHS Boards to produce an annual workforce plan under CEL 32 (2011). The requirement to publish the 3-year workforce plan was delayed until 31 March 2022 by DL(2020)27 issued on 15 October 2020. Through its workforce practice sub-group, the National Workforce Planning Group (NWPG), it was recognised the considerable value moving to a longer-term workforce planning cycle which allows better alignment with other organisational strategic planning timescales and reduces or removes factors inhibiting effective workforce planning.

Workforce Planning During COVID-19 Pandemic

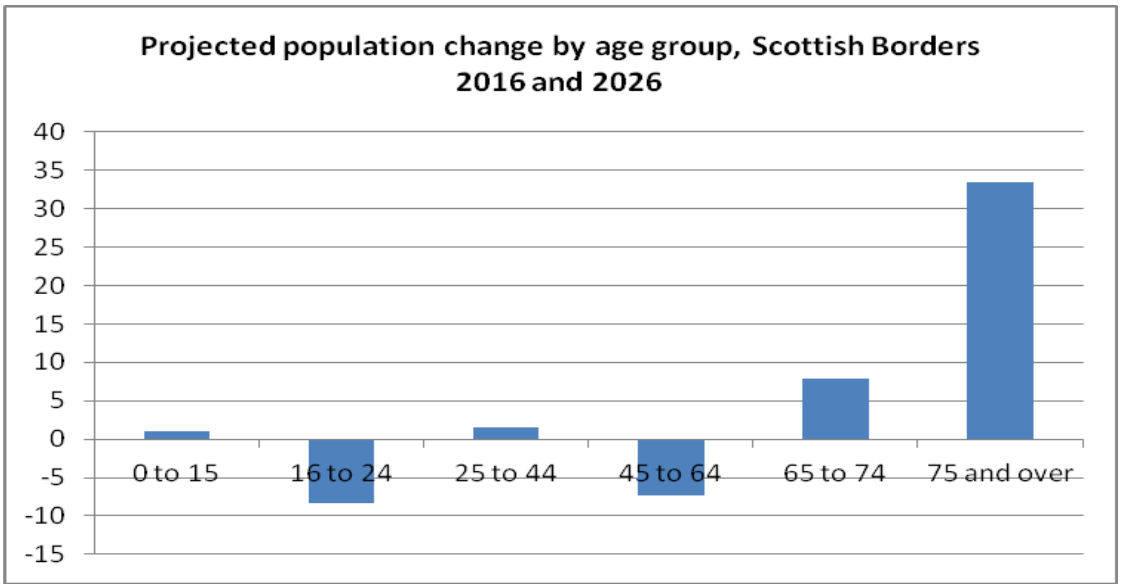
- We also recognise the significant impact of COVID-19 on the workforce planning processes during 2020/21 and the demand for a more agile approach to workforce planning involving rapid recruitment, deployment of current staff and redeployment to maintain essential core and new services. Our Interim Workforce Plan is intended to support our remobilisation and highlight how we can work differently because of the experience of the last year of the Pandemic. We benefit from a dedicated workforce which is committed to providing the highest quality services for our patients in the most challenging of times. However our workforce itself is becoming older and we need to plan now how we will address this looming demographic challenge.

Population Profile

- The profile of the Borders population presents demographic challenges for NHS Borders, and this plan highlights the importance of progressing Workforce Planning locally across health and social care, regionally and nationally over the coming years. Key fact - prior to the Pandemic it was forecast that 1 in 4 people born will now live to be over 100 years old.

- The chart below shows the percentage change in population in Scottish Borders and Scotland, 2016-2026 (2016-based projections). This shows that the population under 65 will continue to shrink and the over 65 age group will grow, with the over 75 age group expanding most.

Table 1 – Projected Population Change



- The population of the Scottish Borders in 2018 was 115,270, which is an increase of 8.7% in the 20 years from 1998 to 2018. This is the 12th highest percentage change out of the 32 council areas in Scotland and compares with a rise of 7.1% over the same period for the whole of Scotland.

- Demographics, the ageing population, will have a significant impact on our services as there will be a rise in the number of people with multiple and complex long term conditions increasing the demand on health and care services. There is also a consequent workforce and labour market implication as the population of working age reduces. Services over the longer term may need to be transformed to take account of this trend of reducing available workforce and some of our aspirations outlined in extant clinical strategy e.g. to develop 7-day services or new advanced roles (ANP roles for example) will require on-going review and potential modification. Workforce planning is essential to ensure a proactive approach to delivering care effectively in this changing demographic environment.

- In simple terms the ageing population will not only change the service demands, it will also be reflected in the availability of the NHS Borders workforce. To sustain services we need to be innovative in our employment practices and continue to strive to be an employer of choice, to ensure that we continue to attract the right people, in the right places, for the right job. This means we will also seek to attract the younger workforce within the Scottish Borders, succession plan and retain our staff to build our workforce for the future.

Cooperation between NHS and Local Authorities

- Throughout the pandemic NHS Borders has engaged with partners including the Integration Joint Board (IJB), the staff in our Health and Social Care Partnership (H&SCP) and Scottish Borders Council colleagues. Joint Executive groups between the Council, NHS Borders and the IJB met daily at the beginning of the pandemic and continue to meet, whilst a range of operational groups continue to deliver services to both mitigate the risk of COVID-19 outbreaks, and to deliver joint services to support vulnerable groups.

- To ensure oversight of care homes and care at home a Strategic Oversight group and an Operational Group were set up across the H&SCP which meets daily with input from the Care Inspectorate.

- In May 2020 recognising the importance of nursing professional leadership across health & social care in the context of management of the COVID-19 pandemic, the Cabinet Secretary for Health required Executive Directors of Nursing to be accountable for nursing leadership, support and guidance within the care home and care at home sector. To support this a lead nurse has been appointed responsible for care homes and work is underway to appoint to further roles in support of care homes, these include education and infection control. A small care home task force was established during the pandemic with Registered Nurses and Healthcare Support Workers seconded to SB Cares in the interests of mutual aid and to provide a rapid system response if there were workforce deficiencies due to COVID-19 absence. The District Nursing teams were and can be mobilised at any point to support care homes.

Mutual support across Territorial Board borders and Regional Working

- NHS Borders, NHS Fife and NHS Lothian have committed to a Regional Workforce Action Plan, with progress reported to the Regional Workforce Group, consisting of the HR Directors, other key staff and staff side partners.

- The Regional Workforce Group acts as the focus for regional workforce planning and also serves to influence national workforce planning to ensure the national commissioning of controlled occupations reflects the needs of both boards and the region as a whole.

- The regional workforce action plan, amended in the last year on account of the COVID-19 response, has been developed with current priorities. This includes the following areas:

  - Regional Recruitment
  - Regional Staff Bank
  - Health and Care (Staffing) (Scotland) Act 2019
  - Physician Associates Programme
  - Pharmacy Workforce

- Healthcare science
- Development of the Elective Treatment Centre
- Contribution to national planning groups
- Workforce analytics
- Primary Care
- Workforce Planning Network

We would focus on two projects of mutual support that will continue to progress in the next year:

- As part of the national Recruitment Shared Services Transformation; the Health Boards in the East Region (NHS Borders, NHS Fife, NHS Lothian, NHS Education for Scotland, Healthcare Improvement Scotland and the Scottish Ambulance Service) have worked to identify a preferred regional recruitment model and a service redesign based on detailed quality improvement work and stakeholder engagement. Following option appraisal a single employer/multi site model has been agreed with NHS Lothian acting as the single employer for the new service.

- A key project within the regional programme has been the establishment in this last year of a joint supplementary staffing service (covering nurse bank and general services supplementary workers) between NHS Lothian and NHS Borders. The NHS Borders Nurse Bank was transferred to the NHS Lothian supplementary staffing service on 1 November 2020 and the General Services Staff Bank transferred on 1 December 2020. NHS Borders transferred 450 bank staff to NHS Lothian payroll and this has the attraction of securing weekly pay as NHS Lothian runs a weekly payroll for bank staff therefore seeking to increase the availability of supplementary workers. NHS Lothian Supplementary Staffing service currently has in excess of 5,000 nursing staff and this may increase the number of bank shifts filled in NHS Borders due to this greater volume and availability. Also a key advantage is that NHS Lothian has strong representation on all national groups which will ensure that the bank system is kept up to date for all new legislation, sharing knowledge and experience in practice.

<u>East Region service planning priorities with Workforce Implications have been identified by the Regional Planning Director.</u>

<u>Cancer</u>

- There is well established regional collaboration in cancer services supported by SCAN, the Regional Cancer Network. Priority areas include supporting implementation of the Framework for Recovery of Cancer Surgery and the recently published National Action Plan for Cancer Services; and supporting development of the OBC for the reprovision of the regional cancer centre which includes planning the workforce requirements for future services.

Health Protection

- NHS Fife, Borders, Lothian and Forth Valley have agreed to work collaboratively on developing a regional model for Health Protection services which will support sustainability and resilience and have in place a function that is fit for the future, maximises the skills of the workforce and designed to respond effectively to 21st Century Health Protection challenges.

Ophthalmology

- NHS Lothian and Borders are prioritising the implementation of Clinical Viewer over the summer of 2021 which will enable Community Optometrists to manage more patients in the community by providing limited access to hospital records. This will not only benefit patients who will be able to access care more locally, and fully utilise the skills of the Community Optometrists, but reduce the pressure on acute hospital services.

Mechanical Thrombectomy for Stroke

- As part of a Scottish Government commitment, 3 regional Thrombectomy services will be established in Scotland. The East Region centre will be based at the Royal Infirmary of Edinburgh with NHS Fife, Forth Valley and Borders referring suitable patients to the centre for treatment. The costs for additional staffing requirements in all Boards to deliver the service will be met by Scottish Government, with regional collaboration on ensuring preparedness for the commencement of the service during 2021/22.

Diabetes

- The East Region continues to deliver on a programme to support prevention and reversal of Type 2 Diabetes across the 3 Health Boards, 6 IJBs and 6 Councils in the East Region. An evaluation of the impact of the programme will be undertaken during summer 2021 to review and learn from the regional approach.

Partnership and Workforce Planning

- Our Local Workforce Plan has been created in partnership over the years with staff and their representatives. This has included our annual joint Local Workforce Conference, discussion and agreement at the Area Partnership Forum, engagement with services using accepted methodologies for workforce planning, and workload measurement ensuring a consistent framework.

- A Partnership Subgroup (Area Partnership Forum led) will importantly be at the heart of the development of the 3-year Joint Workforce Plan in 2022, following which the final version will be considered for approval by the Staff Governance Committee.

- In the development of the 3-year Joint Workforce Plan (March 2022), engagement with Trade Unions, and colleagues from the Primary Care and Third and Independent Sector to ensure that, will be vital to present the cohesive health and care workforce requirements across the Scottish Borders region.

Section 2 – Stakeholder Engagement

- In developing this interim 12 month workforce plan the level of stakeholder engagement will be limited given the short timescale for development. However this plan has been submitted to newly formed Workforce Planning, Sustainability and Safety Group and Board Executive Team (BET) for feedback and approval prior to submission to the Scottish Government (SG).

- We will work with representatives from primary care and third and independent sector partners as key stakeholders in the development of workforce plans, it is an opportunity to reduce the uncertainty experienced by providers in determining their own future workforce needs.

- In the meantime a working group has been created to engage stakeholders in the preparation of this Interim Workforce Plan.

- The group includes membership from :

    - Professional / Occupational Leads
    - General Management
    - Local Service Planning Leads
    - Financial Planning Leads
    - Partnership and Trades Unions
    - HR Leads

- We recognise that in this next year that more consistent engagement is essential with all partners; with support from the NHS Borders and HSCP workforce planning leads (including engagement with Trade Unions and colleagues from the Primary Care and Third and Independent Sector). We will ensure that collectively, the 3-year joint workforce plan to be published by 31 March 2022 is relevant across the health and care workforce in the Scottish Borders geographic area. Along with our key partners from primary care, third and independent sector future workforce needs to meet shared objectives.

Section 3 - Supporting Staff Physical and Psychological Wellbeing

- The Partnership Staff Wellbeing Group set up primarily in response to COVID-19 is now formally our organisational process and decision making group. This group replaces our previous Work & Wellbeing group and is governed through our Occupational Health & Safety Forum. Our organisational wellbeing strategy is currently under review to incorporate the impact of the pandemic. Continued initiatives include hydration stations and staff online yoga classes.

- A dedicated microsite promotes national and local wellbeing advice and support available for all staff.

- A buddy system for medical staff was established - a number of senior doctor volunteers who are willing to help provide support for medical colleagues (especially across specialties).

- We have incorporated the additional psychological first aid support, established in response to the pandemic into our OH services using the existing professional expertise.

- There is continued collaboration between OH, Psychology, OD and Spiritual care developing a resilience roadmap for staff. This will facilitate staff to access timely and appropriate support.

- In addition 'bite size' development sessions on resilience and wellbeing are in development. These will enhance existing resources.

- Two of the five Acute Services 2021/22 DRAFT Priorities are in relation to staff and wellbeing. These are:

    - Develop workforce plans that build resilience and sustainability, and training to support staff to do their roles well
    - Support staff to rebuild their teams and promote wellbeing

<u>Staff Well Being and Working from Home</u>

- Since the onset of COVID-19, working from home has become the norm, for all or part of the contracted hours, for many staff, in line with Scottish Government 'stay at home' regulations. IM&T and risk assessment data confirms that 1089 members of staff are recorded as accessing NHS Borders systems from home during quarter 4 of 2020-2021 for at least part of their contracted hours. We are conscious of an impact on wellbeing specifically due to lone working and isolation, at a time when our staff are dealing with the COVID-19 pandemic and lockdown. Risk assessments have been used to determine if home working is the best solution and most appropriate working model for staff; with many staff indicating that this has allowed them to continue to work whilst shielding or providing essential childcare. Working from home is expected to continue to be the default position where possible for the foreseeable future and may feature in long term transformation of the workforce, estate and capital strategy. The reduction in travel for work purposes will also have had a positive impact on sustainability and the environment. A partnership 'working from home' group has established guidance and protocols, including advice on regular contact with team members and the APF and the Policy and Conditions of Employment (PACE) sub group will continue to be involved in developing the future approach on home working.

Staff Absence Data and COVID-19

- Throughout the Pandemic sickness absence rates have been lower than in previous years. For example in January 2021 NHS Borders overall sickness absence was recorded as 4.78%. This is 1.44% lower than the same period the previous year and better performance compared to the HEAT standard of 4% absence. However, with COVID related special leave absences included; the aggregate absence rate increases to 7.29%. In terms of absence reasons, we have found that anxiety / stress / depression / other psychiatric illnesses has consistently been the reason for the highest percentage of absences (up to a 1/3 of all sickness absence attributed to these causes. A remote 'teams based' sickness absence training for managers is currently being developed to try to help address sickness absence rate and support sickness absence management.

Table 2 – Sickness Absence Rates March 2020 – March 2021

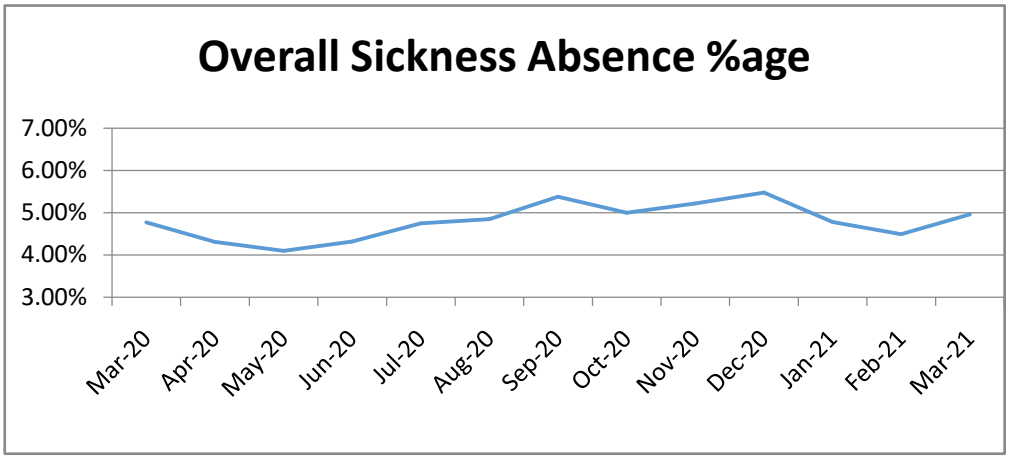
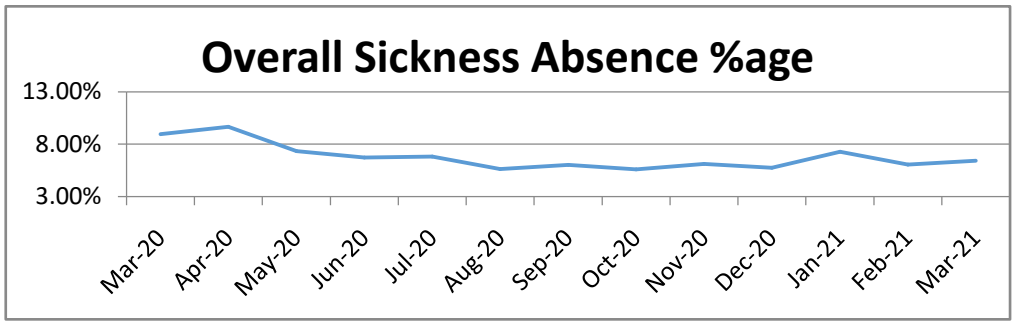


Table 3 – Aggregate Absence (Sickness and COVID Special Leave) Rates March 2020 – March 2021



Annual Leave Data and COVID-19

- In order to meet clinical need, a significant amount of 2020-21 annual leave was deferred. Reports have been generated to try to ensure that all staff have the opportunity to take the legal entitlement of 28 days (pro-rata) with restrictions on the carry forward allowance relaxed. The full extent of this is as yet unquantified but it will have an impact in the 2021-22 leave years and may result in an increase in the use of supplementary staffing to cover gaps.

Equality and Diversity

- NHS Borders has established an Equality, Diversity & Inclusion in Employment Group which has a number of important functions in the field of employment. The work of this group will help to mainstream the equalities agenda and support the wider agenda of the also recently established Addressing Health Inequalities group - with the aim of this group being to 'maximise the role of NHS Borders in reducing wider Health Inequalities'. The group has a Proposed Programme Brief and high level programme plan that maps out the required work streams and activities that will be undertaken up until March 2023.

Section 4 – Short Term Workforce Drivers (Living with COVID)

- This section addresses the immediate workforce implications of the forthcoming operational period (12 months) aligning with the content of the "NHS Borders Remobilisation Plan 3 – Responding to COVID-19".

- Additionality to the workforce as a consequence of COVID-19 response has been identified; recruitment to new services / enhanced services continues to be undertaken alongside routine recruitment for established vacancies.

- New / enhanced services include:

    - Care Home Task Force (mutual aid)
    - Test and protect
    - COVID-19 Vaccination
    - COVID-19 Assessment Hub
    - Rapid Response Home Treatment Team (mental health for older adults)
    - Enhanced Health Protection
    - Enhanced Infection Control Services

- In the acute services (Borders General Hospital) we have since January 2021 recruited to an additional 21.49 WTE healthcare support workers on temporary contracts to allow revised skill mix across the wards; this supports staffing to enable the escalation plan in the event of further Pandemic waves and COVID-19 specific wards to be established or re-established in line with our modelling.

- The occupations / services that we have prioritised for rapid recruitment in the immediate operational period:

    - Registered General Nurses – given the level of existing vacancies, RGNs remain a priority for rapid recruitment. As a guide we have reported 59.50 WTE vacancies in the most recent NES workforce return (December 2020) increase from 44.50 WTE in September 2020. We welcomed clarification on the extension of the NMC's temporary COVID-19 Register; after 30 September 2020. This has been supportive for the return of retired practitioners to the workforce particularly for the COVID-19 vaccination programme.

- RMNs - at present we are recruiting to 10.20 Whole Time Equivalent for existing vacancies and new services. With an increasing acuity of in-patients resulting from COVID-19, there has been a significant pressure on the mental health service. Similar to the acute services healthcare support workers on temporary contracts are being recruited to address persistent vacancies and a revised skill mix across services.

- Care Home Support (mutual aid) – on the conclusion of the NES national recruitment portal, potential applicants were asked if they would be interested in working in the Care Sector rather than Health. At present we have seconded NHS Staff (by agreement and consent) to SB Care / Scottish Borders Council to support Care Homes. The interest in such secondments agreements from NHS staff has been very low. As a response we are currently scoping potential of creating rotational posts between health and social care with final year student nurses on qualification.

<u>The Community Infection Control Advice Service (CICAS)</u>

- CICAS transitioned to our infection control team, and supports community services in infection control. Recruitment is progressing to permanently increase the Infection Prevention and Control Nurse capacity by 2.0 wte. Work will progress during 2021/22 to develop single infection prevention and control team covering acute, community, mental health and LD as well as care homes and care at home services which would provide resilience and synergy. Infection Control Nurses are specialist roles and there is a national shortage which has resulted in 'grow our own' initiatives which requires significant personal investment by the post holder and financial investment by NHS Borders to attain the post graduate infection control qualification. Currently two nurses are working towards an MSc in Infection Control. These nurses will continue to be supported with this qualification during 2021/22.

<u>Vaccination Workforce</u>

- We are continuing to train and appoint vaccinators in preparation for expanding the programme this year in line with the JVCI priority list and timescales. Originally we deployed 139 of our own staff to assist with our vaccination programme. Since January 2021 we have employed 156 new vaccinators. This is intended to provide a robust and stable vaccination workforce to carry out the mass vaccination programme without impacting on core services. At the moment professional registrants are undertaking vaccination. NHS Borders aims to pilot the Health Care Support Worker Vaccination role (Band 3) aligned to the national Protocol in line with developing a sustainable model.

Deployment of Substantive Staff

- At the outset of the COVID-19 pandemic rapid arrangements to help sustain essential services were implemented through an internal deployment hub. Where risks to the continuity of patient facing / essential core services were identified, managers in a partnership process sought volunteers from within our own workforce to assist and support core services. It was also recognised that whilst some services were essential, with prioritisation some services were stood down in the initial phase of the pandemic and this allowed staff to prepare for deployment to different roles or locations, on a temporary basis, to service areas of greatest need. We have taken steps to ensure that staff views are fully taken into account when considering deployment to other areas; or preferences to return to substantive post or remain within a deployed post.

- As an example, 21 members of administrative staff volunteered and undertook a rapid training and orientation training programme as ward based Health Care Support Workers in April 2020. On a daily basis staffing levels were reviewed through the daily management huddle meetings and staff reassigned for their shift to support and sustain essential services.

- NHS Borders staff have generally been highly flexible in challenging times and we are grateful for that support but staff have understandable concerns about being moved from their normal work area. It was vital that staff are given the opportunity to discuss any anxieties and guidance on supported conversations with managers and partnership leads was issued leading to the introduction of a 'Deployment Agreement' so that staff who may be asked to move to a deployed role have an opportunity to fully discuss the alternatives and have a confidential opportunity (with their staff side representative if they wish) to discuss concerns such as an underlying health condition, risk assessment/COVID-19 age, PPE and training requirements.

- The general principles in relation to deployment of non-clinical staff to Health Care Support Worker roles that have now been agreed:

    - Managers will discuss proposed re-assignment and any restrictions identified in risk assessment using the agreed Staff Deployment process
    - The staff voice will be heard and listened to at each stage in the process
    - Occupational health clearance was undertaken for all staff deployed to a different work area
    - The request to move to an alternate area must be within the scope of competence and capability of the staff member. Managers will provide reassurance in relation to use of risk assessment and Personal Protective Equipment and uniform
    - Timescales of the re-assignment will be discussed in advance however it is unlikely that managers were able to confirm the specific duration due to the evolving nature of the pandemic

- There will be no financial detriment to staff who undertake reassigned duties i.e. continue to receive, as a minimum, their standard rate of pay and allowances
- Training and where possible orientation shifts provided to equip staff for the role and local induction to the department to establish where facilities and equipment are located
- Observance of social distancing measures

- In the summer of 2020, NHS Borders ran a programme of staff feedback and engagement called 'Collecting Your Voices' - both clinical and non-clinical staff were interviewed to give us insight into their experiences of working during the COVID-19 pandemic. As a result of the feedback, attention was given to the internal deployment process particularly emphasising that moves to a new area of work or occupation were by consent. As mentioned above, in partnership with staff side representatives, a Staff Deployment protocol for internal deployment was introduced to support both managers and staff members throughout the deployment process and a Deployment Agreement form was developed, including a section which provided details where it was deemed not appropriate to deploy a staff member following a detailed discussion with their manager.

'Long' COVID and potential workforce implications

- The need for a Board-wide approach has been identified to address 'Long' COVID-19 and NHS Borders appointed a COVID-19 Clinical Lead in February 2021 in order to support and deliver a clinical network and pathways for those living with the affects of a COVID-19 diagnosis.

- A clinical network with a spectrum of relevant stakeholders will seek to establish clearly defined pathways and appropriate services for this patient group. Some of the initial conclusions regarding Long COVID-19 are outlined below.

- We are advised that one in 10 people who have had COVID-19 may experience long-term effects of COVID-19, at present it is impossible to know specific numbers across the Borders population.

- Current knowledge suggests that around 40% of people suffering ongoing symptoms may benefit from Respiratory Physiotherapy. A Pulmonary Rehabilitation programme has been established aimed at treating people with chronic lung conditions but this is has been temporarily funded initially from IJB resources and laterally through emergency COVID-19 funds. Workforce implications of the programme impact on a number of disciplines as well as AHPs e.g. Respiratory Specialist Nurses, Pharmacists and Physicians. An evaluation of the programme is essential to determine its long term future as a core service; staff working in the service possess relevant skills to treat the patient cohort, but they are already dedicated to delivering a core service and treating a patient cohort.

- A decision was taken to recruit a third respiratory/GIM consultant physician during 2021 (post is currently advertised); to address various service pressures but potentially support the pulmonary rehabilitation programme in their job plan.

- Occupational Therapy and Clinical Psychology are anticipated to see the largest number of post-COVID-19 referrals (up to 60% of those considered to have long COVID-19), with regards to anxiety, depression and fatigue management.

- Speech and Language Therapy are already seeing patients with swallowing and vocal disorders post-COVID-19, although currently numbers are low. Expectation is that this may rise, once people begin to reflect on their experiences of COVID-19/hospitalisation/survivor guilt.

- Previous staffing levels, especially on ward settings may need to be reviewed as a result of COVID-19 response, due to the ongoing need for PPE (e.g. time for donning/doffing, communication limitations etc).

<u>Health and Care (Staffing) (Scotland) Act 2019</u>

<u>Outputs from Existing Nursing and Midwifery Modelling Tools</u>

- During 2020 the Healthcare Staffing Programme was temporarily suspended due to most team members being deployed clinically. Work started to resume in August 2020 and has continued since then with regular meetings of Workforce Leads across all Boards looking at specific workforce needs in management of ongoing pandemic and the associated drivers.

- Nationally there has been work done by the Chief Nursing Officer's Directorate (CNOD) to develop a series of templates which can be used for the purpose of identifying staffing needs across a range of clinical areas related to COVID-19. These templates, whilst less complex than validated tools, enable leaders to identify staffing requirements using built in calculators which can be used to incorporate flexible calculations around absence etc.

- Safety Huddle and Professional Judgement Templates were also developed for use with District Nurses and AHPs and NHS Borders trialled both sets of templates with individual teams. Additionally, work has been undertaken to support the Vaccination Team Leader to use the template available for calculation of staffing requirements particularly looking towards the mass vaccination clinics that will be required.

- Ministerial guidance on the duties that will be placed on Boards from the legislation is still in draft but the local workforce lead has started to consider and identify existing reporting structures as well as work that will need to be completed in order to enable compliance with the legislation.

- A local Programme Board exists but was suspended during the Pandemic and was replaces with a specific COVID-19 Staffing Programme Board. This has now been stood down and work on the Programme Board in relation to the legislation will resume in March 2021.

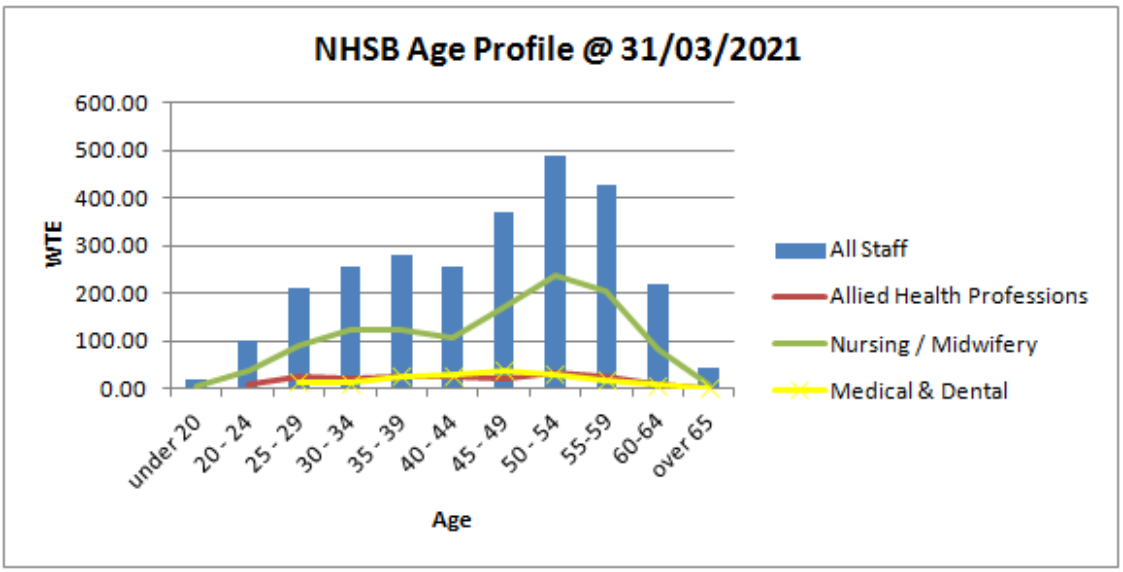
Section 5 – Medium Term Workforce Drivers

Demographics, Retirement Age and Turnover

- As evidenced in Table 1, the age profile of the population in general in Scottish Borders is higher than the Scottish average. The age profile of the workforce is also a challenge, as demonstrated in Table 4 below, the average of the local workforce increasing and retirements anticipated. In planning and responding to workforce turnover, based on projecting retirement age, there is less certainty than ever before.

- A Court of Appeal ruling earlier this year; to the effect that public sector pension reforms amounted to unlawful age discrimination, may lead to restoration of Special Class status and the ability of eligible staff to retire at 55 years. A high proportion of nursing staff and the workforce overall is aged over 50 years as demonstrated in table 4 below.

Table 4 – Age Profile of the NHS Borders Workforce

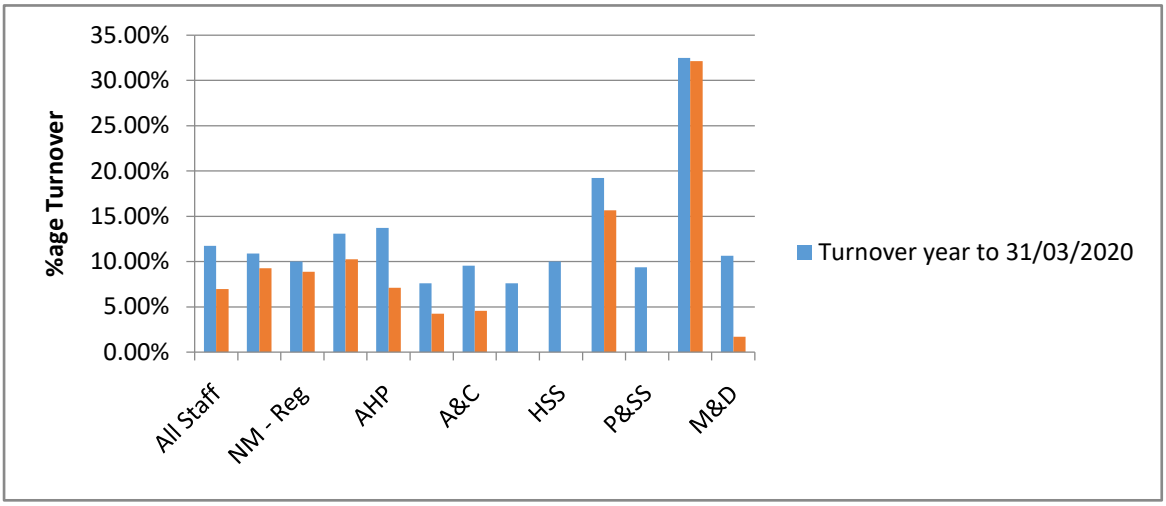


- The average age of our workforce has increased to 46.20 years. This is the most significant workforce driver in the medium term; addressing turnover, retention and recruitment.

- To date we have not seen a COVID-19 “bounce” in turnover rates. Our preliminary figures (between April – December 2020) in fact suggests a reduction in turnover across all occupational groups, possibly due to the impact on the local labour market with lesser opportunities to seek

opportunities outwith the NHS. However in the registered nursing occupational group the reduction in turnover is lower (less than 1%) whilst for all staff is has fallen by half from 12% to just over 7%.

Table 5 – Workforce Turnover (2019 - 20) and comparison (orange bar) with period April – December 2020



Medium Term Workforce Drivers Service Changes / Service Development over next 3 years

The key service redesign developments planned in the medium term with workforce implications across Health & Social Care in the medium term include:

- Our vision outlined in the Clinical Strategy to develop a workforce based on teams of staff rather than individual practitioners; to develop effective multi-disciplinary teams working with the appropriate knowledge and skills, integrating more closely the work of hospital based specialties alongside community based teams.

- Changes of the roles to support the transformation work for the Older Peoples Pathway.

- Greater need for development of ANP and Advanced AHP posts with independent prescribing supporting reduced medical cover, and given the likely recruitment pool addressing the potential impact on the availability of core clinical roles in NMAHP.

- There is the potential for reviewing skill mix to include further development of Band 4 Assistant Practitioner roles.

- In District Nursing new methods of delivering community care within multidisciplinary teams / Hospital to Home / changes to residential and nursing care homes and the potential impact on workforce requirements.

- New community models to include broader professional involvement for example of Physiotherapy, OT, Dietetics, SLT, psychology, Pharmacy and Social Workers as part of Multi Disciplinary Teams.

- The new GMS Contract impact on AHP resource to be community focussed in Community Health Centres and Pharmacy Resource.

- Drawing on resources within local communities with greater partnership working with social care and 3rd sector colleagues.

- Major Trauma Network Programme with the South East of Scotland Major Trauma Network will see the creation of a Major Trauma Centre for Adults at Infirmary of Edinburgh (RIE) and for Paediatrics at Royal Hospital for Children and Young People (RHCYP).

- Physician Associates (PA), defined as 'a healthcare professional who is trained to the medical model and who works as part of a medical team to provide holistic care'. As part of a South East Scotland initiative, NHS Borders has supported placement for trainee PAs with the first cohort due to complete training during 2021. Commitment has been given to appointment of PAs in primary care settings with consideration ongoing for acute settings (Orthopaedics and Trauma and General Surgery being the most likely).

- Workforce implications of remobilisation of acute elective activity will be under ongoing review recognising the provisions for social distancing, green pathway elective patients and infection control.

Section 6 – Supporting the workforce through transformational change

Introduction

- The opportunity to refresh existing workforce strategy will be taken during this next 12 months, learning from the experience of the COVID-19 pandemic response and importantly under new executive leadership. Key to our workforce strategy will be the sum of actions to be taken to acquire, retain, develop, motivate and deploy our workforce to support transformational change in our services.

Embedding Digital Health and Telecare / Working from Home

- Prior to the COVID-19 pandemic, NHS Borders recorded only 2 members of staff as contracted home-workers. Since March 2020 NHS Borders has made every reasonable effort to enable / facilitate staff working from home (where possible) in line with Scottish Government stay at home regulations. IM&T and risk assessment data confirms that in the region of 300 staff are currently working from home on a full time basis with a total of 1089 members of staff recorded as accessing NHS Borders systems from home during quarter 4 of 2020-2021 for at least part of their contracted hours. We envisage the Once for Scotland Homeworking policy (anticipated in Autumn 2021) will help with the transformation in our approach to home working over the longer term; this has implications for workforce planning as well as estates and capital strategy

- Whilst the focus has been on support and corporate roles, clinical roles have adopted partial working from home due to rapid advances in digital health and telecare. In October 2020 NHS Borders returned to 60% of our pre COVID-19 outpatient activity. This is split 40% virtual (telephone and Near Me) and 60% face to face consultations. Virtual consultations (Near Me and Telephone) can be undertaken by the clinician at home and will continue to be maximised where clinically appropriate.

Opportunities for Mutual Aid, Joint and Regional Working

- Implementation and continued development of the regional recruitment function, provided on a multi site basis by a single employer (NHS Lothian) for 6 Health Boards in the South East region. The service is underpinned by Jobtrain the Scottish NHS web based recruitment, national Key Performers Indicators and the objective of improving the experience of job applicants in an increasingly competitive labour market.

- Continued development of the joint supplementary staffing service provided by NHS Lothian on behalf of NHS Borders, the service covers nursing and general services and consideration if the service can be extended to further staff groups.

- The establishment of joint appointments to 'hard to fill' disciplines. Clinical Directors in acute services in NHS Lothian and NHS Borders have agreed to joint consultant appointments in two services with successful appointees who will commence later in 2021.

- The development and implementation of a regional approach to Health Protection services across four Health Boards. Agreed by the Chief Executives in November 2020, this regional collaboration has the objective of improved service resilience, sustainability, minimise duplication and ensure a service fit for the future. This decision was influenced by the inevitable impact of the COVID-19 Pandemic on Health Protection services but also separately occurring workforce challenges within some of the Boards. There has been immediate success in the adoption of a joint recruitment process for the appointment of a consultant in public health; a new consultant with a health protection remit will join the Borders Public Health team in August 2021.

Improving Workforce Data Quality

- A number of measures will be taken to improve the quality of Workforce reports and how they are presented in info graphic form (utilising TABLEAU analytics platform) to provide better understanding of workforce metrics. NHS Borders will participate in development of regional workforce dashboards, already TABLEAU is used for regional reports on absence, and very heavily at a local level for clinical data.

Workforce Supply - Hard to Fill Posts / Skills Gaps in key areas.

- The Pharmacy team is the largest department in the Therapeutic Services staff group, and has experienced significant implications from the new GMS contract and the need to establish a Pharmacotherapy Service. The Primary Care Improvement Plan requires an increase in numbers of both pharmacists and technicians working in primary care. Attracting Pharmacists and qualified pharmacy technicians has proved difficult in recent years with rotational posts, appointment of student technicians and pharmacists in an effort to 'grow our own' all considered as a potential way forward. The team have been reviewing the roles of the different staff groups with a view to creating more attractive posts to aid retention.

- We would highlight recruitment issues for the Medical workforce. On the positive side long term vacant consultant posts in Stroke Medicine and Radiology have been successfully recruited in recent months; with a joint appointment process agreed by the Clinical Directors in NHS Lothian and NHS Borders. New consultants have accepted offers of appointment and will commence later in 2021. However long term vacancies for consultant psychiatrists in Mental Health for Older Adults and General Adult Psychiatry have proved to be enduring with reliance on locum doctors to sustain the core services. Over the longer term, the outcomes of reviewing service and workforce models as part of Mental Health transformation is more likely to provide a solution than continued attempts to recruit consultant psychiatrists. The appointment of Clinical Development Fellows (CDFs) has continued to be successful in addressing vacancies for training grade doctors, lessening reliance on short term locums. To a lesser extent vacancies for specialty doctors have been resolved by CDFs, over the longer term we anticipate a new contract for sub consultant career grade doctors.

NMAHP Workforce and Workload Modelling Tools further developments:

- Whilst the Healthcare Staffing Programme/Scottish Government have not been directive in their instruction to Boards regarding use of the tools currently, NHS Borders has continued to run tools where appropriate in order to both identify staffing requirements and to prepare for full enactment of the legislation in due course.

- Locally the validated HSP workload tools have been used in a number of areas – all four community hospitals, all inpatient mental health wards, Emergency Department and currently with CCSNs and Community Nurses incorporating District Nurses, Community Nurses, Health Visitors and School Nurses. A robust reporting template has been developed locally to ensure that meaningful feedback is given to teams reflecting on all aspects of the Common Staffing Method which is integral to the legislation.

- The Workforce Lead meets with managers at the conclusion of workload tool run and discusses findings and the reports are then agreed and signed off so that any redesign of skill mix or service can be agreed or additional funding sought as appropriate where tool outputs indicate a requirement for higher staffing levels.

- Going forward, it is likely that existing workload tools will be reviewed and refined to enable them to be used in multi-professional teams where feasible; development of workforce planning templates building on the work undertaken by CNOD for use during the COVID19 pandemic is likely to progress with new tools and templates being developed for specific clinical settings, particularly where no tool has previously existed and NHS Borders Lead Nurse for Workforce Planning will continue to link with colleagues nationally as well as the Healthcare Staffing Programme leads to ensure that available resources are trialled and utilised to enhance our knowledge of workforce planning locally.

- AHP workforce templates derived during the last 12 months have enabled services to gain real-time understanding of skill mix and staffing levels per service. These templates will allow managers and service leads to proactively review staffing and workforce across all clinical boards.

<u>Fair Work and Employability</u>

- NHS Borders in this forthcoming year will apply to become accredited for the real Living Wage, which has implications for our workforce but also procurement processes and contractors. We seek to demonstrate that adoption of the real Living Wage is good for our service, our workers and our society.

- NHS Borders has a history of promoting health and care careers to young people and hosts Modern Apprenticeships (MAs). Other active initiatives that support youth employment and employability include:

    - Prince's Trust Programme
    - Train to Gain, and
    - Project Search which supports young people with a learning disability or autism into work

- Project Search employability scheme was paused during the first wave of the COVID-19 pandemic. Arrangements for trainees to return to the workplace have been agreed for May 2021, with remote learning replacing the previous classroom based teaching.

- NHS Borders will participate in the Kickstart employability programme scheme operated by the DWP, with 10 Kickstart opportunities currently advertised. The Kickstart Scheme aims to create new jobs for 16 to 24 year olds on Universal Credit. Posts created through Kickstart are new job opportunities bringing additionally to the workforce.

- Further development of Modern Apprenticeships will be considered in line with the future requirements of the Young Person's Guarantee.

Workforce Implications of E.U. Withdrawal (Brexit)

- We have not identified any significant workforce or labour market risk arising from Brexit – our experience is that retention and recruitment of health professionals has not faced significant impact. The focus has been on supporting EU nationals already in our workforce, maintaining regular contact and highlighting the settlement scheme and deadlines, which for EU nationals resident in the UK on 31 December 2020 is 30 June 2021.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Mrs Jen Holland
Contact:	Mrs Jen Holland
Telephone:	Via Microsoft Teams
TWEEDBANK CARE VILLAGE	
Purpose of Report:	To set out to the Integration Joint Board the proposal noted in the Outline Business Case (OBC) for the Tweedbank Care Village that were approved by the Scottish Borders Council on the 25th November 2021. The proposal is available in full, with supporting documentation from the link contained within the footnote[1]. This proposal aligns to the commitments within the Scottish Borders Integration Joint Board Strategic Commissioning Plan 2018-22 that: - We will plan and deliver health and social care services by locality area, using the Buurtzorg model of care - We will deliver on our partnership information our Integrated Transformation and Integrated Care Fund programmes (Waverley and Garden View)[2] The case for change/project will involve the transition of all bed based intermediate, discharge to assess and specialist long term and respite dementia care from Waverley and Garden View Units into the Tweedbank development. This will significantly improve the function and quality of these settings for their service users. Tweedbank Care Village will bring together 60 beds to support an integrated care model: which can flexibly meet the short and long stay health and social care needs of service users over coming years, including provision of rehabilitation, assessment for ongoing care needs, nursing care, palliative care and dementia care. The project will be further enhanced by its location on the Tweedbank site, which host 6 zones comprising housing, shops and facilities, social hub and the Aberlour Unit. The focus is based on a human rights based approach, and is on possibility rather than disability, and will be supported by 24-hour care delivered by trained professionals.
Recommendations:	The Health & Social Care Integration Joint Board is asked to:

[1] Scottish Borders Council. 25 November 2021. Tweedbank Care Village (Item 7). Available from: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=132&MId=5666&Ver=4

[2] Reviewed by the Discharge Programme Formative Evaluation, and approved in the 17 February 2021 Scottish Borders Integration Joint Board. Available from: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=5441&Ver=4

	a) Note the paper presented to Scottish Borders Council on 25th November 2021 and approval of its recommendations. b) Note the capital and revenue decision taken by Scottish Borders Council c) Note the expected growth in demand and current planned mitigations
Personnel:	The OBC describes the proposed staff requirement and based on the model descriptor and current workforce it is not anticipated that additional personnel will be required. Within the governance arrangements of the Project Board being developed to support the completion of the Full Business Case, a HR/Personnel group will be established.
Carers:	Impact to carers is described within the OBC in terms of consultation and engagement, collaboration and co-production in the village design and model of care. To date there has been some discussion and involvement with carers and carer representation however this will be further developed as part of the Full Business Case. The Integration Joint Board Strategic Planning Group will also be consulted as a key stakeholder group.
Equalities:	An Equality Impact Assessment has been undertaken (attached as appendix to OBC). Recommendations, risks and mitigation have been identified within the assessment and will be addressed in the development of the Full Business Case
Financial:	The Integration Joint Board is not empowered to own capital assets, and the capital assets owned (or leased) by the delegating partner are used to provide the integrated services together with the host partner's capital assets. As a result, the Scottish Borders Council isproviding the capital funding for this project. The Scottish Borders Council draft Revenue and Capital Investment Plan (Revenue 2021/2022 – 2025/26, Capital 2021/22- 2030/31) agreed at Council on 19 March 2021 includes a £22.679m capital allocation for “two residential care homes/care village development” one in Tweedbank and the other in Hawick. On 25th November 2021, the Scottish Borders Council has also approved the proposal that the revenue implications of the new development are met through the closure of Waverley Care Home and Garden View Intermediate Care Setting, and that revenue funding is transferred to the Care Village. The full detail of the revenue implications and proposals are detailed within the Outline Business Case for Change. The detailed modelling defines that all revenue costs can be met within existing budgets (including staffing and facilities). Additional budget to cover the cost of increasing demographics has been included in each year of the Scottish Borders Council 2021/22 five-year revenue plan.
Legal:	Full detail of legal implications and addressment are outlined both within the OBC and the Council Paper.
Risk Implications:	Full details of all risk implications are detailed within the OBC and

	Council Paper. However further consideration has been given to potential risk associated with the demographic increase in the population of older people and recent bed modelling studies, including the Care Home modelling considered at the Integration Joint Board meeting in September 2021[3]. These have suggested that there is a potential need for an additional 181 beds within Scottish Borders. This 2021 study of bed modelling and prediction is similar to that seen 10 years earlier in 2011. Despite this prediction in 2011 there has resultantly not been a requirement for 181 beds over the past 10 years and there is some evidence that the following projects have been instrumental in their impact: • The introduction of additional intermediate care beds in Waverley and Garden View in 2019, with the implementation of a discharge to assess model through these settings – bed-based reablement and care for up to six weeks which supports people to return home • The introduction of Home First – Reablement at Home – reablement at home supporting people to live independently and care for themselves Other proposals to mitigate this risk and are in progress include: • Further development of Extra Care Housing (including step up/step down) beds • Working with existing care home providers to commission additional beds • Extension and an increase in Discharge to Assess Model, moving assessment for social care away from the Acute Hospital setting, into individual's homes, or an intermediate care setting (Garden View/ the New Tweedbank Care Village, and the four Community Hospitals).

[3] Scottish Borders Care Home Modelling. Item 5c, Scottish Borders Integration Joint Board, 22 September 2021. Available from: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=5990&Ver=4

CARE VILLAGE DEVELOPMENT – TWEEDBANK

Report by Chief Officer Health & Social Care Integration

SCOTTISH BORDERS COUNCIL

25 November 2021

1 PURPOSE AND SUMMARY

1.1 **The purpose of this report is to present the Outline Business Case for change and seek approval to progress the innovative Care Village development at Tweedbank, Central Borders, as the first Borders Care Village.**

1.2 In 2020, Senior Managers and Elected Members visited and assessed new visions for care facilities, including the Hogeweyk development in the Netherlands. SBC then commenced design works for Care Villages in Tweedbank and Hawick.

1.3 The Draft Revenue & Capital Investment Plan (Revenue 2021/22 - 2025/26, Capital 2021/22-2030/31) agreed at 19 March 2020 Council includes a £22.679m allocation for "new residential care provision" for Tweedbank and Hawick.

1.4 Consultations and work undertaken by SBC and the Health and Social Care Partnership (HSCP) concluded that:

- We collectively recognise that the care needs of people in the Borders are changing and that we must respond appropriately to this demand across a range of services and across the region both now and into the future to ensure we provide a provision which focusses on possibility rather that disability and ensures we provide the right model of care to meet demand and the needs or our older people. The key outcome will be that the citizens of Scottish Borders can maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives.

- Both locally and nationally, a different model of care is required. One which provides a more person-centred approach which focusses on keeping our unique lifestyles alive in care. 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. In addition, a model that can also adapt and meet specific local demand for a range of residential care that includes; respite, intermediate, nursing and specialist care. This includes catering for dementia as well as "step up/down care" but at the heart non institutionalised.

- The Care Inspectorate strongly encourage innovation and diversity in future care provision and wish to encourage care providers and commissioners to provide care on a smaller unit scale. Following the lessons learned with regards infrastructure during the Covid 19 Pandemic we expect further more stringent demands on the fabric of residential care provision, to meet infection control measures. The Care Village concept will ensure we provide a building which ensures the highest standards of infection control in line with new guidance. Additionally there is a pressing need to address and improve the current estate to meet these expected demands.

- Work has been ongoing to identify suitable sites for the two new Care Villages. A site has recently been agreed within the Hawick area which is the focus of a separate paper and Outline Business Case. A possible site has also been identified and to progress an Outline business case for the inclusion of a Care Village within the Tweedbank site.

- This Tweedbank site is central within the Borders and offers the correct range of opportunities, partnerships resources and delivery of outcomes required for such a provision. The Care Village will form part of the overall expansion of Tweedbank in line with the approved Supplementary Planning Guidance including private, social and assisted living housing, neighbourhood centre and business zones. The Care Village itself will complement the wider developments and also contain an element of community based spaces and functions at the centre of the Village to ensure that the ethos of the village being at the heart of thriving residential area is delivered. The key factors include; location, strategic fit with the capital master plan, with very close proximity to the Borders General Hospital, (BGH).

- This Tweedbank proposal also provides further opportunities to support additional developments with two third sector partners. Aberlour are a well-respected provider for children's services and wish to expand their input to support vulnerable children through a new centre which could be accommodated within the Tweedbank initiative. Cornerstone have been working for a number of years with our Learning Disability service for adults to find a site for a residential provision for adults with extreme complex needs and again Tweedbank can provide an excellent location for this resource, this will enable people previously placed outside of the Borders, to return to their home setting. These two developments will enhance the Care Village model and we will work with both providers to enhance models and opportunities.

- The outcomes of this proposal align closely with the identified population/demographic demand and allows for the required revenue migration of current intermediate care provision and high level dementia provision, through the relocation of existing provision to the new development through the closure of two sites.

- The vision and outline of the model of care, operational delivery and staffing model are developed in the outline business case and the detail of this will be further jointly finalised between all key partners. New models since the visit to Hogeweyk have been completed with other

areas of UK and Netherlands – we will work with these designs and partners to deliver a fully innovative FBC. This will ensure effective outcomes are met which is person centred and meets the changing needs and desires of our older people in this new innovative development.

- The Care Village development will also be a key part of the new community offering providing a wide array of community and recreational facilities and activities for both local and wider communities in the Borders. The inclusion of these outlets will offer a catalyst for the development of a new vibrant local community.

- Scottish Borders Council and Scottish Borders Health & Social Care Partnership propose an innovative new model of housing and integrated 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.

2 RECOMMENDATIONS

2.1 Recognising the benefits outlined above, Scottish Borders Council is recommended to:

(a) Approve the timeline to proceed with the development of a full business case and design brief of a Care Village at the Tweedbank site, within the central locality of Eildon with a full business case submitted to Council by Summer 2022.

(b) Approve that both Waverley Care Home (24 beds)and Garden View Intermediate Care Home (25 beds) operated by SBC are decommissioned and closed to secure revenue funding to provide for the Tweedbank Care Village

(c) To note that an outline business case will be brought forward in Spring 2022 for a Care Village provision within Hawick.

3 BACKGROUND

3.1 During 2020, SBC commenced design works for a Care Village provision in the Borders.

3.2 The Draft Revenue & Capital Investment Plan (Revenue 2021/22 - 2025/26, Capital 2021/22-2030/31) agreed by 19 March 2020 Council, includes an allocation of £22.679m for a care village provision.

3.3 The outline design proposal for the Care Village development is based on self-contained 'units', with adjacent treatment space, retail/café and recreational facilities available on site for the use of residents, families and the wider community. The Care Village will be part of the wider community and not seen as a separate institution within an area. The vision incorporates community at the heart of the village.

3.4 Such a development would stimulate further local; economic and commercial facilities, as well as further encouraging the introduction of more private and social housing investment. The attraction of a Care Village development is through the benefit it would offer through a providing a new sustainable market place and a vibrant centre for local socialisation.

4 DEMAND AND POPULATION PROJECTIONS

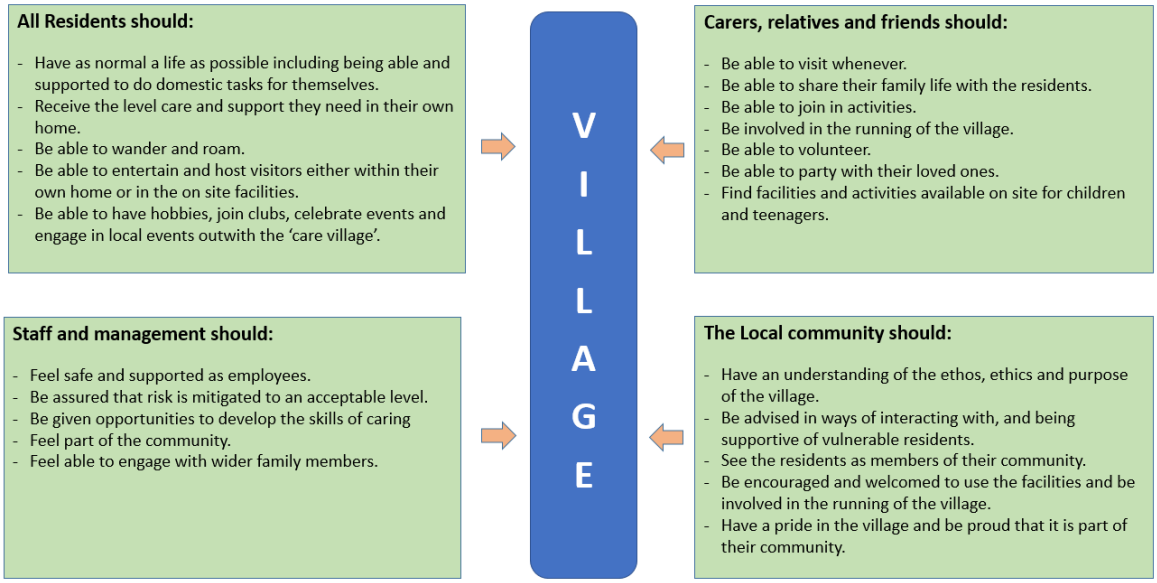
4.1 In May 2021, CMT requested further evidence in relation to care home demand and modelling of the Scottish Borders older population. A Stakeholder Care Home Modelling Group was established with a specific ask to: Provide a 10-year forward projection of 24-hour care demand for older people and describe the expected changes in 24-hour care demand broken down by residential care, nursing care and specialist care provision with worse case and best case scenarios. The outcomes of this study are detailed within the Outline Case for Change. Specific findings were:

- Demographic modelling indicates that there would be a need for 187 additional care home beds within the Scottish Borders by 2030 (28% residential care beds and 29% nursing care beds.) if no other programmes of work were implemented to provide for care of the elderly.
- This represents an annual increase of between 14 and 20 care home admissions per year. However, past experience is that care home demand will not increase proportionally to demographic change.
- Between 2009 and 2019, care home bed numbers in Scottish Borders increased by just 1%, despite a 20% increase in the population aged 75 and over. This disparity is shared across Scotland with a Scotland overall change of -1% during this period.
- Scottish Borders has the third lowest number of care home residents per head population in Scotland and has been amongst the lowest four Local Authorities for past 10 years (2009 to 2019)(per 1000 75+ population) .
- Scottish Borders: is a low outlier in terms of care home bed provision.
- It has one of the higher average ages for admission to care home.
- It benchmarks low for paid homecare provision.
- Has slightly higher than average rates of people providing unpaid care.

- Has higher than average provision of age-specific housing provision for older people.
- Studies show that fewer older people enter care homes in rural areas compared to urban area and this may be related to closer family support networks. This suggests older people in the Borders manage to remain at home longer than in other places.
- The % of residents who remain in their own locality is directly related to the number of care home beds in a locality (0.91 correlation).
- The number of SBC-funded residents out with Borders remained steady at 20% over the past 5 years. However, recent data suggests that it has actually fallen from 20% to around 15% during that time.
- Scottish Borders benchmarks mid-range of Local Authorities for home care packages and was the 6th lowest Local Authority in 2018.
- According to ISD collected data within Health & Social Care Publication reports in 2017/18, Scottish Borders was the second highest provider of Self Directed Support. This achievement is in line with Scottish Government Strategy to enable more people to live independently at home.
- Data from 2019 showed that Scottish Borders ranked as the 6th highest Local Authority in the number of Extra Care Housing units. Subsequently, this will have increased due to the recent opening in Duns of Todlaw ECH and Wilkie Gardens in Galashiels expected to open in January 2022.
- Based on looking solely at demographic change only and assuming no other changes in commissioning we can expect an increase of 188 beds by 2030. However, this demand is expected to be offset through the transformation programmes identified within the HSCP Strategic Plan which focuses on pathways and early intervention and prevention, eg Locality Model, What Matters Hubs, Virtual Ward, Older People's Pathways/Discharge Planning Programme and Social Prescribing.

5 MODEL OF CARE

5.1 A significant amount of research and debate has taken place over the last two years involving all stakeholders regarding what the future of residential care in the Borders should be. Two major seminars were held with local leaders, and professionals and further discussions and involvement has been undertaken, to influence the detail of the model. A local vision for the future of building based care has been formed. Whilst this will continue to develop and grow through further co-production, it gives a clear direction now, as to how we should proceed with this new model for a Care Village, and community development.



5.2 Several local Leaders and Senior Officers visited provision outwith the Borders and in particular the innovative Hogeweyk Care Village in the Netherlands. The Hogeweyk-type design, discussed extensively by colleagues from Health, the Council and IJB, has been the basis for the design work to date.

5.3 The vision of the Tweedbank Care Village model is to create a paradigm shift in care, with an alternative model for traditional nursing, residential and intermediate 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. 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.

5.4 The operational model provides a high quality person centred provision for 6 to 10 residents per unit, equating to total capacity for 60 residents, in a vibrant homely setting supporting unique needs, lifestyles and personal preferences for living, care and well-being for people living mainly with severe dementia and frailty. The units themselves have their own living room, kitchen and single en-suite bedrooms. This will be home for these residents, so the houses will be furnished as such, emulating in the main, the original homes of the residents. Lounge areas will have television, music, sofas, comfortable chairs and a large dining table both for day to day meals but also for entertaining. The atmosphere will be homely with no hint of being an institution. The kitchen will have normal every day appliances, familiar to the residents, who will be encouraged to use them to help prepare meals and do general house work. These everyday activities will be supported by the care staff, who will be allocated to one household. All as you would expect in someone's own home.

5.5 The Care Inspectorate strongly encourage innovation and diversity in future care provision and wish to encourage care providers and commissioners to provide residential care on a smaller unit scale.

The advantages of small-scale group living include:

- people living there are not overloaded with stimuli of noise, activity and too many other people.
- the design will support the unique need of all users, supporting lifestyles and personal preferences for living, care and well-being for people living mainly with severe dementia and frailty.
- it will be easier for people to participate in domestic activities as they would at home retaining independence and increasing possibility.
- it is easier for staff to get to know individual people and understand what matters to them.
- the small-group living model will enhance team development, knowledge and expertise that produces high-quality care, particularly for people with dementia.
- people experience less stress in smaller units .
- infection control is easier to maintain.
- staff develop a greater sense of ownership and pride in their unit.

Outside, the village will be designed with dementia needs in mind. It will have safe walkways, through parks, greenery and streets. The streets will have outlets such as activity centres for creative activities, such as cooking, hairdressing, chiropody, and physiotherapy etc, again all within a familiar street scene. There will be a local supermarket for day to day goods, foods and snacks which can also serve as a store for all of the care materials the households in the Village require.

An important feature will be the attractiveness of the Village for relatives and for other local external residents. It will have amenities all designed around the resident but also attractive for people to use and visit from outside of the "village". The experience of the village should be such that relatives, friends of the residents want to visit, and that the local population will want to interact as citizens, sharing a fantastic, vibrant local community asset.

We expect this vision and model to be further replicated in the future. It is therefore important that all parties across the Health and Care agenda are engaged with this first Care Village as it will form the prototype for those to follow. This is equally true for our partners within the independent care sector. Discussions have already commenced with these stakeholders and representative groups have been operating since the beginning of the year.

5.6 Operationally, the model stresses the importance of supporting residents to live as normal a life as possible, maintaining their autonomy and managing risk accordingly. There are a number of examples of this approach for residential care appearing across the UK, Europe and beyond. The major gain is the maintenance of personal autonomy, self-determination and cognitive ability. All of which leads to a longer maintenance of ability, and interaction with family and friends and society at large. It maintains people as a person within their community for longer.

5.7 Work to develop an outline business case for Hawick is now progressing and will come forward to Council in Spring 2022. Consultation with key partners has commenced.

6. CASE FOR CHANGE

6.1 Appendix 1 ' Scottish Borders Council – Case For Change - provides a detailed Outline Business Case covering :

6.2 The purpose of this Business Case for Change is to outline the case for the investment required to deliver a 60 bedded Care Village in Tweedbank, based on the Hogeweyk, Netherlands Dementia Village Model. The vision of the Tweedbank Care Village model is to create a paradigm shift in care, with an alternative model for traditional nursing, residential and intermediate 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. 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. It will offer integrated services which are closer to home, will prevent unnecessary admission to hospital and support timely discharge from hospital, the Care Village will provide greater opportunities for interdisciplinary services which realise individual personal outcomes.

6.3 24 hour intermediate and dementia care will be delivered within the village, aligned with 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. This case for change focuses on –

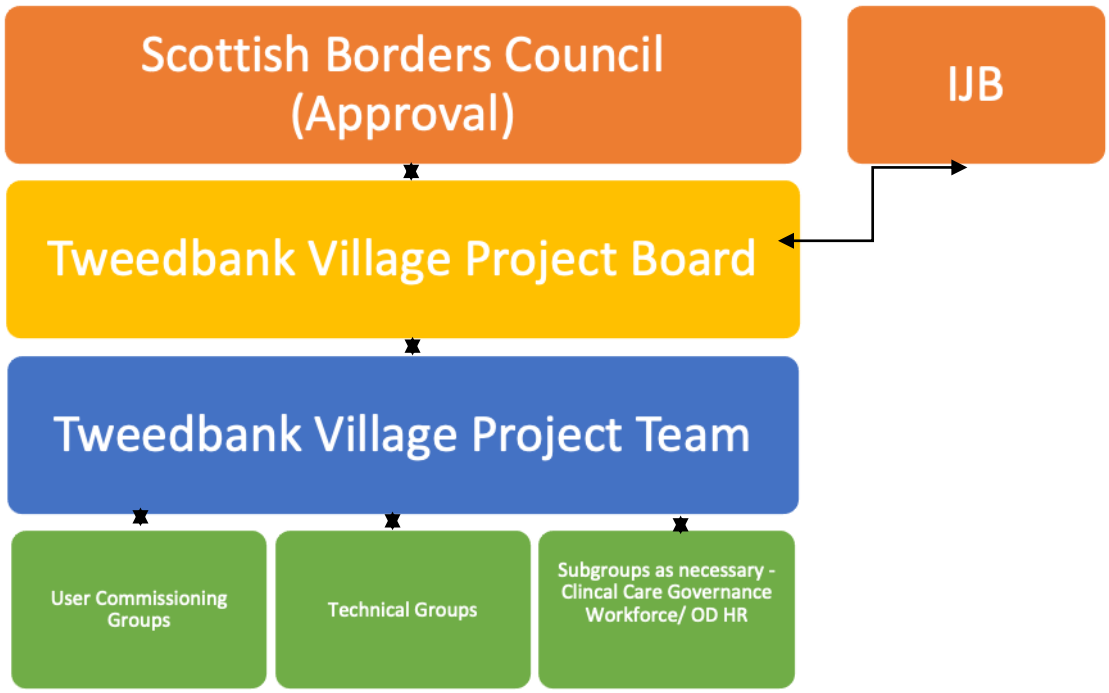
- Improving outcomes for older people both now and in the future,
- Harnessing the power of SBC Communities through their involvement, engagement, and active partnership within the model

- Further building SBC people capabilities and
- Operating within agreed financial boundaries through the reprovision of leased bed based intermediate care currently provided within Waverley Transitional Care Unit and Garden View Discharge to Assess Unit.

6.4 The Tweedbank Care Village is an innovative alternative social and health care support model for the future, which prioritises the principles of the Feely Review. Investment in this alternative health and social care model will enable people to stay in their own home, communities and where not possible in a person-centred homely environment. This will ensure that the citizens of Scottish Borders Council can maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives.

7 PROJECT GOVERNANCE AND DELIVERY

7.1 It is proposed that this work be managed as a project by "the Scottish Borders Care Village Project Board" which will be chaired by the Chief Officer for Scottish Borders Health & Social Care Partnership. The Project Board will report (via the Chief Officer) to Scottish Borders Council. The proposed governance structure is shown in the diagram below with further detail regarding the Governance arrangements including roles and responsibilities within the Outline Business Case, Appendix E.



7.2 The above will be applied to the full life of the project to ensure maximum control, quality and financial benefit.

7.3 An External Project Management and Design Team have already been appointed to assist with the early concept work and will continue through to the detailed stages. A project specific project plan and programme will be finalised to allow for the key design, procurement and construction stages to be progressed. Further updates on the delivery programme can be brought back to Council at key milestone stages.

7.4 It is noted within this report that the technical delivery of the project will be managed by Projects Section within Infrastructure & Environment. Procurement of the construction contractor will be undertaken at the appropriate point in the project timeline. This will be undertaken in conjunction with SBC Prourement policies including consideration of the use of delivery frameworks or Public Contracts Scotland arrangements.

8. PROJECT TIMELINE

8.1 Table 1 below details the high level timeline:

Stage 2: Consideration of Ouline Business Case (OBC)	November 2021
Stage 3: Submission of Full Business Case (FBC)	Autumn 2022 to accommodate procurement, contractor appointment, planning, and advanced works to accommodate Tweedbank Expansion Road)..
Stage 4: Start on site	Winter 2022
Stage 5: Planning and commence decommissioning Waverly and Garden View	Autumn 2022
Completion date	Summer 2024
Services Commencement	Summer 2024

8.2 During the same period works will commence to look at options for the current Waverly Care Home Estate based in Galashiels. In addition, the lease will be ceased with Eildon for the Garden View Property in Tweedbank.

9. RECOMMENDATION

9.1 The proposed operational model is a significant departure from existing models of care. It will dramatically move our practice forward in the service provided for our most vulnerable citizens. The vision, outline design and model have been shared with Scottish Government and the Care Inspectorate and it has been responded to very positively and enthusiastically. So much so, that the Borders is now regarded as a vanguard in the development of the future models for residential care.

9.2 The following paper puts forward a detailed case for change, and recommends that the Scottish Borders Council;

- Approve the timeline to proceed with the development of a full business case and design brief of a Care Village at the Tweedbank site, within the central locality of Eildon with a full business case submitted to council by Summer 2022.
- Approve that both Waverley Care Home (24)and Garden View Intermediate Care Home (25) operated by SBC are decommissioned and closed to secure revenue funding to provide for the Tweedbank Care Village.

- To note that an outline business case will be brought forward in Spring 2022 for a care village provision within Hawick.

10. IMPLICATIONS

10.1 Financial

The Draft Revenue & Capital Investment Plan (Revenue 2021/22 - 2025/26, Capital 2021/22-2030/31) agreed at 19 March 2021 Council includes a £22.679m allocation for "two new residential care homes" one for Tweedbank and another for Hawick.

It is proposed that the revenue implications of the new development are met through the closure of Waverley Care Home and Garden View Intermediate Care Setting and revenue funding transferred to the Care Village. The revenue modelling completed through the Outline Business Case is included in the 'Case for Change - Appendix D- Proposed Model of Care and Revenue Modelling'. The detailed modelling defines that all revenue costs can be met within existing budgets including staffing and facilities costs and incorporating the new models of care. Additional budget to cover the costs of demographic increases in the Borders has been included in each year of the 2021/22, 5 year revenue plan.

10.2 Risk and Mitigations

The Council-owned care estate would not meet all of the health and social standards introduced by the Care Inspectorate in 2018 for new buildings. Our existing facilities would therefore not be graded highly against these new standards.

We expect further revision of the guidelines in response to the Covid-pandemic. New facilities will need to be designed to meet this new guidance and be able to address any further changes to standards expected in future years.

To inform future development work additional demand modelling work will be undertaken and this will remain under review across both internal and external residential provision.

The Care Village will be an important step in the development and ultimately achieving the Tweedbank neighbourhood vision. A full engagement exercise will be required to ensure the aspirations of the whole community can be realised.

The Scottish Government is consulting on the recommendations from the recent Feeley Report following the review of adult social care. Should the Government decide to progress with the development of a National Care Service, there may be a risk regarding on-going funding arrangements to cover the impact of the capital funding for any development within the social care estate.

Any such risk could be mitigated through the current and future deliberations with the "Integration Unit" of Scottish Government. Agreement would be sought with the office for the Minister for Mental Wellbeing and Social Care ahead of the Council entering into a capital borrowing arrangement.

10.3 **Integrated Impact Assessment**
An initial EQIA has been completed and attached, this highlights the sift market testing to date and a full EQIA will be completed as part of the Full Business Case (Appendix A).

10.4 **Sustainable Development Goals**
The UN Sustainable Development Goals checklist will be completed.

10.5 **Climate Change**
The Climate Change checklist will be completed.

10.6 **Rural Proofing**
n/a

10.7 **Data Protection Impact Statement**
It is anticipated that the proposals in this report will have a minimal impact on data subjects and the Data Protection Officer has confirmed that a Data Protection Impact Assessment is not required.

10.8 **Changes to Scheme of Administration or Scheme of Delegation**
n/a

11 CONSULTATION

11.1 The Executive Director (Finance & Regulatory), the Monitoring Officer/Chief Legal Officer, the Chief Officer Audit and Risk, the Service Director HR & Communications, the Clerk to the Council and Corporate Communications have been consulted and any comments received have been incorporated into the final report.

Approved by

Name: Chris Myers **Signature .....**

Title: Chief Officer Scottish Borders HSCP / Director of Health and Social Care

Author(s)

Name	Designation and Contact Number
TBC	Programme Manager x5501

Background Papers:
Previous Minute Reference:

Note – You can get this document on tape, in Braille, large print and various computer formats by contacting the address below. Chris Myers can also give information on other language translations as well as providing additional copies.

Contact us at Chris Myers – chris.myers1@borders.scot.nhs.uk

Integrated Impact Assessment (IIA)

Part 1 Scoping

1 Details of the Proposal

Title of Proposal: Tweedbank Care Village development	
What is it? Construction of a new care village development at Tweedbank, Central Borders. This will in turn replace the provision currently in place at Waverley (Galashiels) and Garden View (Eildon)	A revised Policy/Strategy/Practice ☐
Description of the proposal: As above. The construction will enable the new residential care facility to: • Meet all care inspectorate legislation • Provide flexible accommodation that can potentially cover residential care, intermediate care and specialist care • Replace facilities that are currently part of the Council's care estate • Redeployment of staff from those facilities to the new facility	
Service Area: Health & Social Care **Department: Social Work**	
Lead Officer: Chris Myles Chief Officer, Health & Social Care Integration	

Other Officers/Partners involved: (List names, job titles and organisations)	Mrs Jen Holland, Director of Commissioning and Strategic Partnerships Mr John Currie, Director of Infrastructure and Chief Executive Scottish Borders Council Netta Meadows Chair of IJB Cllr David Parker IJB Councillors; John Greenwell, Elaine Thornton-Nicol, Shona Haslam, Tom Weatherstone Chair of the Care Home Providers Strategic Group Arthur McLean Independent Care Provider Coordinator Scottish Care, Wendy Henderson
Date(s) IIA completed: 20/10/2021	

2 Will there be any cumulative impacts as a result of the relationship between this proposal and other policies?

No
If yes, - please state here:

3 Legislative Requirements

3.1 Relevance to the Equality Duty:

Do you believe your proposal has any relevance under the Equality Act 2010? *(If you believe that your proposal may have some relevance – however small please indicate yes. If there is no effect, please enter "No" and go to Section 3.2.)* **Yes**	
Equality Duty	**Reasoning:**
Elimination of discrimination (both direct & indirect), victimisation and harassment. *(Will the proposal discriminate? Or help eliminate discrimination?)*	The proposal could help eliminate discrimination by providing an up to date residential facility, in a central Borders location, that can accommodate a range of client needs
Promotion of equality of opportunity? *(Will your proposal help or hinder the Council with this)*	This Tweedbank site is central within the Borders, and offers the correct range of opportunities, partnerships and resources required for such a provision. These factors include; location, strategic fit with the capital master plan, with very close proximity to the Borders General Hospital, (BGH). In addition, this central area of the Borders does not have access to a community hospital, and this new facility will significantly benefit patient flow from the General Hospital.
Foster good relations? *(Will your proposal help or hinder the council s relationships with those who have equality characteristics?)*	The proposal should help foster good relationships with clients, families and Health colleagues. Additionally, as the proposal incorporates replacement of existing facilities, this reduces the risk to private care providers and should therefore help to maintain good relations with them. This Tweedbank proposal also provides further opportunities to support additional developments with two third sector partners. Aberlour are a well-respected provider for children's services and wish to expand their input to support vulnerable children through a new centre which could be accommodated within the Tweedbank initiative. Cornerstone have been working for a number of years with our Learning Disability service for adults to find a site for a residential provision for adults with extreme complex needs, and again Tweedbank can provide an excellent location for

	this resource, this will enable people previously placed outside of the Borders, to return to their home setting.

3.2 Which groups of people do you think will be or potentially could be, impacted by the implementation of this proposal? (You should consider employees, clients, customers / service users, and any other relevant groups)				
Please tick below as appropriate, outlining any potential impacts on the undernoted equality groups this proposal may have and how you know this.				
	Impact			**Please explain the potential impacts and how you know this**
	No Impact	**Positive Impact**	**Negative Impact**	
Age Older or younger people or a specific age grouping		**X**		Residential care (short-term and long-term) is predominantly required for >65 age group.
Disability e.g. Effects on people with mental, physical, sensory impairment, learning disability, visible/invisible, progressive or recurring		**X**		Specialist provision (e.g.) for people with dementia, is a consideration of the proposal (i.e.) increasing capacity within the whole system to care for people with specialist needs. Relationship with Aberlour and Cornerstone
Gender Reassignment Trans/Transgender Identity anybody whose gender identity or gender expression is different to the sex assigned to them at birth	**X**			
Marriage or Civil Partnership people who are married or in a civil partnership		**x**		**The existing environment and accommodation facilities within Waverly and Garden View does not accommodate for married couples to share room and accommodation. This new facility design will allow married couples and families to share accommodation if required**
Pregnancy and Maternity (refers to the period after the birth, and is linked to **maternity** leave in the employment context. In the non-work context, **protection** against **maternity** discrimination is for 26 weeks after giving birth),	**X**			
Race Groups: including colour, nationality, ethnic origins, including minorities (e.g. gypsy	**X**			

travellers, refugees, migrants and asylum seekers)				
Religion or Belief: different beliefs, customs (including atheists and those with no aligned belief)	X			
Sex women and men (girls and boys)	X			
Sexual Orientation, e.g. Lesbian, Gay, Bisexual, Heterosexual	X			

3.3 Fairer Scotland Duty

This duty places a legal responsibility on Scottish Borders Council (SBC) to actively consider (give due regard) to how we can reduce inequalities of outcome caused by socioeconomic disadvantage when making strategic decisions.

The duty is set at a strategic level - these are the key, high level decisions that SBC will take. This would normally include strategy documents, decisions about setting priorities, allocating resources and commissioning services.

Is the proposal strategic?

Yes

If No go to Section 4

If yes, please indicate any potential impact on the undernoted groups this proposal may have and how you know this:

	Impact			**State here how you know this**
	No Impact	**Positive Impact**	**Negative Impact**	
Low and/or No Wealth – enough money to meet basic living costs and pay bills but have no		X		Residential care for the elderly can be costly. SBC will adhere to guidance set by Government on costs charged

savings to deal with any unexpected spends and no provision for the future.				
Material Deprivation – being unable to access basic goods and services i.e. financial products like life insurance, repair/replace broken electrical goods, warm home, leisure and hobbies	**X**			
Area Deprivation – where you live (e.g. rural areas), where you work (e.g. accessibility of transport)		**X**		The care village proposal is one where amenities as well as accommodation are created on/or close to site. Current demographic modelling has suggested that residents of the Tweedbank area experience longer stay within the Borders General Hospital due to lack of Community Hospital in the Tweedbank area and the need for nursing care. The model of care proposed within the Viallage will reduce area deprivation
Socio-economic Background – social class i.e. parents' education, employment and income	**X**			
Looked after and accommodated children and young people	**X**			
Carers paid and unpaid including family members		**X**		The philosophy of the village is based on family living and involvement therefore families and carers will have more involvement. The current design of Waverly and Garden View does not accommodate their involvement, for example no active kitchens, dining areas are also used as communal areas, no visitor/family rooms. The living arrangements proposed within the care village will allow for active family and carer participation. The village model of care will also receive locality referred short term respite.
Homelessness	**X**			
Addictions and substance use	**X**			

Those involved within the criminal justice system	**X**			

4 Full Integrated Impact Assessment Required

Select No if you have answered "No" to all of Sections 3.1 – 3.3.

Yes. This has been detailed within the Outline Business Case for Change

If a full impact assessment is not required briefly explain why there are no effects and provide justification for the decision.

Signed by Lead Officer:	**Chris Myers**
Designation:	**Chief Officer, Health and Social Care Integration**
Date:	**01/09/2021**
Counter Signature Service Director	**Jen Holland**
Date:	**01/09/2021**

Part 2 Full Integrated Impact Assessment

5 Data and Information

What evidence has been used to inform this proposal?
(Information can include, for example, surveys, databases, focus groups, in-depth interviews, pilot projects, reviews of complaints made, user feedback, academic publications and consultants' reports).

Care Home Demand and demographic analysis has informed this
Strataegic planning data has also informed
Visits by Elected Members and Senior Officers to other facilities (such as in the Netherlands)
Condition surveys undertaken in september 2021 for the existing Council-owned care estate. This survey benchmarked the existing estate against Care Inspectorate and Kings Fund Design recommendation for Care Homes
Care Homes – Case for Change outline business case
Workshops with carers and voluntary sector regarding residential and nursing home care provision within Scottish Borders Council
Discussions with Staff in Waverly and Garden View
Soft Market Testing/questionnaire with members of the Independent providers Strataegic Advisory Group

Describe any gaps in the available evidence, then record this within the improvement plan together with all of the actions you are taking in relation to this (e.g. new research, further analysis, and when this is planned)

Further evidence is required regarding the outputs and impact of current preventative models of care. Section 10 of the Outline Business Case for Change outlines the key benefits and the type of qualitative, quantitative and cash releasing measurements that will be used to evaluate. The benefits are in relation to the following objectives:
Increase integration & communication between health & social care services and delivery to service users
Improve user experience of local health & social care service provision
Improve access to care

Improve care pathways, capacity and flow management Maximise flexible, responsive and preventative care - at home, with support for carers Make best use of available resources Improve quality & effectiveness of accommodation used to support service delivery Improve safety of health & social care, advice, support & accommodation

6 Consultation and Involvement

Which groups are involved in this process and describe their involvement

Carers Voice- initial stakeholder engagement workshops

Carers Centre- initial stakeholder engagement workshops

Independent Providers Strategic Advisory Group- early discussion re proposals, comment on papers re vision and outline, discovery workshops. Soft Market testing was undertaken and all providers of the Strataegic Advisory Group were issued with an 6 point questionnaire. The purpose of this questionnaire was to understand their views on benefits, model of proposed care, concerns and ongoing involvement.

Scottish Care Local Representatives- early discussions re propsals, comment on papers re vision and outline, discovery workshops

Borders Health & Social Care Partnership IJB – comment on papers re proposal, vision and outline

SBC Residential Review Project Group- discussion re residential care model and business need against status quo

Staff groups within Waverly and Garden View- discussion re design of current environments

Corporate Manangement Team- discussion re proposals, vision and outline, feedback and comment on papers to date

Describe any planned involvement saying when this will take place and who is responsible for managing the process

The intention is to consult more fully as part of the SBC Place-Making approach. The Care Village Outline Case for Change has identified the intent within the project development for robust stakeholder engagement and co-production and communication. The stakeholder/communications strategy and plan will be developed using methodology of Managing Successful programmes and will demonstrate how co-production will be undertaken, the various stakeholders, milestones and key activities to be carried out and in what way.

An external providers full mpact assessment will also be undertaken which will consider extra Care Housing commission and planning and commissioning with Independent Care Home /Care at Home Providers

Responsibility for managing this process lies withn the Programme Governance arrangements. The Programme Director and Manager will have responsibility on behalf of the Executive.

Describe the results of any involvement and how you have taken this into account.

Feedback from Indepent Care Home Providers and Scottish Care have requested a full Impact Assessment of Housing and Private Care provision plus their ongoing involvement from this point forward– this has been built into the Outline Business Case for Change. The Soft Market Testing returns from 3 providers highlighted the following:

a) support for day centre and inreach provision/use.
b) potential of increasing inequalities – mainly due to people having to move outwith their locality and also creating differing standards of care
c) Suggestion that care village should be available and built across all localites in Scottish Borders
d) Potential to impact on recruitment and workforce currently within the Independent care home sector
e) Cost of funding this facility is significant and outcomes would be better allocated to alternative strategic funding proposals (Care Home Visions of Care)
f) Will require comprehensive understanding and staff resource requirements to deliver the concept of care
g) Some dissatisfaction regarding engagement and involvement to date

Elected Memebers have requested consultation and involvement of local communities- this has been built into the propsals for Co-production and Stakeholder Engagement within the Outlne Business Case

Corporate Manangement Team- requested further evidence regarding current condition, design and business need of SBC Residential Care estate. This has been undertaken and a report will be avialble in October 2021.

Both IJB and Corporate Management team requested economic case of options. Two options were considered, a) do nothing (remain with status quo) and b) build new care village. These options were measured against 8 critical success factors and impacts within the Outline Business Case for Change. In the management, strategic, commercial, economic case , option B – build of the new care village was the preferred/highest score option.

Staff groups on Waverly and Garden View were supportive of this new build proposal as it would enable them to provide safer, quality care for residents. Further details of their comments are outlined within a Design and Building Assessment of SBCare Homes report, conducted in Septemeber 2021.

What have you learned from the evidence you have and the involvement undertaken? Does the initial assessment remain valid? What new (if any) impacts have become evident?
(Describe the conclusion(s) you have reached from the evidence, and state where the information can be found.)

Access to and the availability of care, in particular specialist care and respite care, has come out strongly in conversations to date. The initial assessment remains valid. New impacts which have been identified and will be measured as critical success factors are:-

Deliver services within an Integrated Model

Give users greater choice and control of local health and social care provision

Improve access to services

Improve care pathways, capacity and flow management

Maximise flexible, responsive care at home, with support of carers

Optimise efficiencies and effectiveness

Improve quality of accommodation used to support service delivery

Improve safety of health & social care,advice support and accomodation

7 Mitigating Actions and Recommendations

Consider whether:

Could you modify the proposal to eliminate discrimination or reduce any identified negative impacts?
(If necessary, consider other ways in which you could meet the aims and objectives of the proposal.)

Could you modify the proposal to increase equality and, if relevant, reduce poverty and socioeconomic disadvantage?

Describe any modifications which you can make without further delay (e.g. easy, few resource implications)

Mitigation

Please summarise all mitigations for approval by the decision makers who will approve your proposal

Equality Characteristic/Socio economic factor	Mitigation	Resource Implications (financial, people, health, property etc)	Approved Yes/No
Foster Good relations	Additional engagement on the design/layout with 'people with lived experience', families and partners should be undertaken	There are potential financial implications if there are changes to scale/scope of the intended development	
	Additional engagement and ongoing consultation with independent care home and care at home providers	There are potential workforce and other unintended consequences from this new development with movement or reduction of staff from the private sector. It is essential to keep this sector on board and work in partnership	
	NHS and AHP involvement within the model of care within a new location. Cognising that some of this will resource and service will transfer from Waverly and Garden View , we need to consider how to resource the wrap around support for the additionality that will be required, particularly in the provision of bed based intermediate care with GPs, Geriatricians, AHPs, DNs / ANPs, CHAT, social care etc.	The new build will involve NHS employed staff moving to a different location. Engagement with senior manangers and HR will be required. May be a requirement to consider a tarrif type approach for input of GP and other health services input	

8 Recommendation and Reasoning *(select which applies)*

- Implement proposal taking account of mitigating actions (as outlined above)

Reason for recommendation:

The proposal addresses several factors which are required to improve the provision of care for the population of the Borders. It will significantly increase access to appropriate intermediate and long term residential care, which will meet the more exacting standards required of the Care Inspectorate, From the lessons learned fro the current pandemic this new facility will meet all infection control requirements and go beyond these standards.

This is a new model of care that is being proposed which will offer a access to new lifestyle with new activities and respite for our most vulnerable people, here in the Borders. It will make it easy for residents and service users to use these new dynamic facilities alongside and with their family and friends. It will forge very close relations with immediate the local community.

This new model of care and this new facility, aims to radically transforn current provision to one not just fit for now, but fit for the future,

The recent review into Adult Social Care, the Feeley Report, describes a new approach to care, one of entitlement as part of people's human rights. To provide facilities, not as "safety nets", but as "spring boards" allowing people to engage in both their local and wider communities. These proposals are recommended as a step change in the provision of care, and will drive the required ongoing change and development of all care provision within the Borders, and we expect beyond.

Signed by Lead Officer:	**Chris Myers**
Designation:	**Chief Officer, Health & Social Care Integration**
Date:	**01/09/2021**
Counter Signature (Service Director):	**Jen Holland**

Date:	**01/09/2021**

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This assessment should be presented to those making a decision about the progression of your proposal.

If it is agreed that your proposal will progress, you must send an electronic copy to corporate communications to publish on the webpage within 3 weeks of the decision.

Complete the below two sections. For your records, please keep a copy of this Integrated Impact Assessment form.

Action Plan (complete if required)

Actioner Name:	**Action Date:**
What is the issue?	
What action will be taken?	
Progress against the action:	
Action completed:	**Date completed:**

Monitoring and Review

State how the implementation and impact of the proposal will be monitored, including implementation of any amendments? For example what type of monitoring will there be? How frequent?

Please state your answer here

What are the practical arrangements for monitoring? For example who will put this in place? When will it start?

Please state your answer here

When is the proposal due for review?

Please state your answer here

Who is responsible for ensuring that this happens?

Please state your answer here

SCOTTISH BORDERS COUNCIL

Care Homes

Outline Case for Change

2nd September 2021

DOCUMENT CONTROL

Version Control

Version	Amendments	Issued by	Issued to	Date
v1	Initial Draft	BB	SR and KM	26 July 2021
V2	Test document	KMG	All	18th Aug 2021
V3	Test document	BB	All	18th Aug 2021
V4	Redraft of all items highlighted in yellow	BB	All	20th Aug 2021
V5	Remove tracking, format.	BB		26th Aug 2021
V5	Update from 26th Aug	BB		2nd Sept 2021
V6	Update from 12 Septemeber	KMG	All	13 sep 2021
V7	Update 24th October 2021	KMG	JH/JC	24 Oct 2021

Document Approval

Circulation

Document Storage

1. EXECUTIVE SUMMARY

1.1 Introduction

Scottish Borders Council and Scottish Borders Health & Social Care Partnership propose an innovative new model of housing and integrated 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. This model is described as the Tweedbank Care Village Model. The overall concept 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. 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 first phase of this case for change/project will involve the transition of all bed based intermediate, discharge to assess and specialist long term and respite dementia care from Waverley and Garden View Units into the Tweedbank development. The full scope of this case for change further develops opportunity for an integrated model using the Care Village concept as the preferred way forward

Tweedbank Care Village will bring together on one site, 60 beds to support an integrated care model: which can flexibly meet the short and long stay health and social care needs of service users over coming years, including provision of rehabilitation, assessment for ongoing care needs, nursing care, palliative care and dementia care; The project will be further enhanced by its location on the Tweedbank site, which host 6 zones comprising housing, shops and facilities, social hub and the Aberlour Unit.

This case for change describes the proposals for delivering the preferred option which demonstrably provides value for money; emphasises sustainability; sets out the contractual solution; demonstrates its affordability; details the supporting procurement strategy and the management arrangements for the successful delivery of the project.

1.2 Structure of the Case for Change

The Case for Change has been prepared using a Business Case Format and standard, as set out in the Scottish Capital Investment Manual (SCIM) – Business Case Guide. The document follows the recommended format of the Five-Case Model for business cases which explores the project from five perspectives:

The Strategic Case - explores the case for change – whether the proposed investment is necessary and whether it fits with the overall local and national strategy.

The Commercial Case - tests the likely attractiveness of the proposal to developers – whether it is likely that a commercially beneficial deal can be struck.

The Economic Case - asks whether the solution being offered represents best value for money – it requires alternative solution options to be considered and evaluated

The Financial Case - asks whether the financial implication of the proposed investment is affordable.

The Management Case - highlights implementation issues and demonstrates that the partner organisations can deliver the proposed solution

1.3 The Strategic Case

In 2020 following a request by senior managers and elected members, investigative assessment was undertaken to identify innovative housing and health thematic solutions for older people. This assessment involved researching eco systems, models and building solutions world wide and a visit to the award winning Hogeweyk development in the Netherlands. As a result Scottish Borders Council then commenced design works which would address SMART, Green Building solutions alongside an innovative social model which highlighted opportunities of a built environment—particularly with respect to residential and assisted living—to improve societal citizens' lives and health conditions.

Work has been on-going for some time to identify suitable sites for two new care villages. Further work is required to progress the business case and to identify a suitable site within Hawick. It has however been possible to identify a site and to progress the business case for the inclusion of a Care Village within the Tweedbank site.

This Tweedbank site is central within the Borders, and offers the correct range of opportunities, partnerships and resources required for such a provision. These factors include; location, strategic fit with the capital master plan, with very close proximity to the Borders General Hospital, (BGH). In addition, this central area of the Borders does not have access to a community hospital, and this new facility will significantly benefit patient flow from the General Hospital.

This Tweedbank proposal also provides further opportunities to support additional developments with two third sector partners. Aberlour are a well-respected provider for children's services and wish to expand their input to support vulnerable children through a new centre which could be accommodated within the Tweedbank initiative. Cornerstone have been working for a number of years with our Learning Disability service for adults to find a site for a residential provision for adults with extreme complex needs, and again Tweedbank can provide an excellent location for this resource, this will enable people previously placed outside of the Borders, to return to their home setting.

The outcomes of this proposal align closely with the identified population/demographic demand, and allows for the required revenue migration, through the transfer of existing provision to the new development.

The vision, and outline of the model of care, operational delivery and staffing model are agreed, and the detail of this will be further jointly finalised between care and health colleagues. This will ensure effective use of a flexible bed-base, accompanied with a full range of care and intermediate care provision.

The Care Village development will offer a wide array of community and recreational facilities and activities for both local and wider communities in the Borders. The inclusion of these outlets will offer a catalyst for the development of a new vibrant local community, with direct access to these commercial assets for local residents.

1.4 The Economic Case

1.4.1 Critical Success Factors

A review of the investment objectives and potential benefits, identifying the following list of Critical Success Factors:

Critical Success Factors	
1	Deliver Services within an Integrated Care Model
2	Give users greater choice and control of local health & social care service provision
3	Improve access to services
4	Improve care pathways, capacity, and flow management
5	Maximise flexible, responsive and preventative care - at home, with support for carers
6	Optimise efficiencies and effectiveness
7	Improve quality & effectiveness of accommodation used to support service delivery
8	Improve safety of health & social care, advice, support & accommodation

These outcomes were used to undertake the non-financial appraisal of options.

1.4.2 Short listed Options

Two deliverable options for consideration for appraisal – do minimum and replacement of Waverley and Garden View Care Homes. Consequently, a full economic and financial appraisal was carried out on these options. The scored short list of options for the project is summarised as follows:

Non-Financial Appraisal Summary

	Option 1 - Do Minimum	Option 2 – New Build Replacement
Appraisal Element		
Benefit Score a	36	94
Rank	2	1

The table below shows the analysis for the short-listed options.

1.4.3 Results of Economic and Financial Appraisals

The cost/ benefit and Value for Money analysis is summarised in the table below:

VFM Based on operational costs of the two existing facilities compared to a new build care village.

25 year Life Cycle		Option 1 - Do Minimum	Option 2 – New Build Replacement
Appraisal Element			
Benefit Score	a	36	94
Net Present Cost – excluding risk	b	£32,128,060	£47,921,386
Cost per benefit point	b/a	£892,446	£509,802
Rank		2	1

VFM Based on operational costs of bedspaces of the two existing facilities compared to a new build care village.

25 year Life Cycle		Option 1 - Do Minimum	Option 2 – New Build Replacement
Appraisal Element			
Benefit Score	a	36	94
Net Present Cost – per bed	b	£845,475	£840,726
Cost per benefit point	b/a	£23,485	£8,944
Rank		2	1

1.4.4 Preferred Option

The results of the Economic and Financial Analysis consolidate the position of **option 2 – new build at Tweedbank**.

1.5 Commercial Case

1.5.1 Procurement

The procurement route is still under consideration.

1.5.2 Risk Allocation

In parallel with consideration of the procurement options a risk workshop will be held to consider

Stakeholder Risks

Demand Risks

Financial Risks

Constructions Risks

Procurement and risk are considered together given than some risks identified may be mitigated through the method of procurement and the contractual appointment of the facility provider.

1.6 Financial Case

1.6.1 Capital costs

Initial capital cost estimates for the short-listed options are as follows:

Initial Capital Cost Estimates

Option	Initial Capital Cost Estimate
Option 1 – Do Minimum	£133,600
Option 2 – New Build Replacement	£14,290,930

1.7 Management Case

1.7.1 Operational Model

The proposed operational model is a significant departure from existing models of care. It will dramatically move practice forward in the service provided for the most vulnerable citizens. It is expected that the vision, outline design and model will be replicated in the future. It is therefore essential that all parties across health and social care are engaged and involved in the project and governance arrangements.

1.7.2 Project Plan

A summary of the estimated key project dates is provided in the table below:

Project Programme

Stage 2: Consideration of OBC	Oct 2021

Stage 3: Submission of FBC	Oct 2022 (to accommodate procurement, contractor appointment, planning, and advanced works to accommodate Tweedbank Expansion Road)..
Stage 4: Start on site	November 2022).
Completion date	April 2024 (Programme based on estimate for Stirches).)
Services Commencement	May 2024

1.7.3 Project Management Arrangements

In line with Managing Successful Programmes (MSP) and Prince 2 methodology A Project Board will be established to direct the project and will include the following three key roles, Executive Sponsor, Senior User and Senior Supplier . The Executive Sponsor will chair the project.

- Executive Sponsor : Chief Officer Scottish Borders Health & Social Care Partnership
- Senior User, Director of Strategic Commisioning and Partnership, SBC
- Senior Supplier, Director of Infrastructure.

The Project Board comprises representatives from the:

- Scottish Borders Council
- NHS Borders
- Key stakeholders from Health & Social Care Partnership
- SBC Capital Planning team.
- Finance Officer/representative
- Commissioner representation/function
- Independent Provider Representation
- Care Inspectorate
- External Consultant

Further description of the Project Governance and Management arrangements are described in Appendix E

1.7.4 Consultation with Stakeholders and the Public

An extensive programme of community engagement has been undertaken as part of the consultation process on the project since the development of the initial agreement and will

continue as the project progresses. Further details are set out in section 8 – Management Case.

1.7.5 Impact Assessment, Benefits Realisation, Risk and Contract Management and PPE

The management arrangements for these key areas are summarised as follows:

Robust arrangements will be put in place to undertake a full impact assessment, monitor the forthcoming benefits realisation plan throughout the development to maximise the opportunities for them to be realised.

The strategy, framework, and plan for dealing with the management of risk are as required by SFT in regard to all hub projects. A project risk register will be prepared with the PSDP which is actively managed by the Project Manager and reviewed monthly with the team.

Regarding contract management, form of contract is still to be considered.

Following satisfactory completion of the project, a Post Project Evaluation (PPE) will be undertaken.

2. Strategic Context

2.1 Introduction

This Business Case for Change describes a project developed in partnership with Scottish Borders Council, (SBC) NHS Borders and Scottish Borders Health and Social Care Partnership.

The purpose of this Business Case for Change is to outline the case for the investment required to deliver a 60 bedded Care Village in Tweedbank, based on the Hogeweyk, Netherlands Dementia Village Model. The vision of the Tweedbank Care Village model is to create a paradigm shift in care, with an alternative model for traditional nursing, residential and intermediate 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 amenties including restaurants, supermarket, 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. It will offer integrated services which are closer to home, will prevent unnecessary admission to hospital, and support timely discharge from hospital, the Care Village will provide greater opportunities for interdisciplinary services which realise individual personal outcomes.

24 hour intermediate and dementia care will be delivered within the village, aligned with 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.

This case for change focuses on

- Improving outcomes for older people both now and in the future,
- Harnessing the power of SBC Communities through their involvement, engagement, and active partnership within the model
- Further building SBC people capabilities and
- Operating within agreed financial boundaries through the reprovision of leased bed based intermediate care currently provided within Waverley Transitional Care Unit and Garden View Discharge to Assess Unit.

This Business Case for Change has reviewed and confirmed the value for money of the preferred option that was identified in the SBC Capital Plan, 2019. It has also selected a preferred procurement route and confirmed the affordability and achievability of the project.

2.2 National and Local Policy

Adult Social Care: Independent Review February 2021: The Feeley Report

The principal aim of this review was to recommend improvements to adult social care in Scotland, primarily in terms of the outcomes achieved by and with people who use services, their carers and families, and the experience of people who work in adult social care. The review takes a human-rights based approach.

Care Homes

The Tweedbank Care Village is an innovative alternative social and health care support model for the future which prioritises the principles of the Feely support the recommendations of the Feely Review and places. Investment in this alternative health and social care model support models prioritise will enable people to stay in their own home, communities and where not possible in a person-centred homely environment. This will ensure that the citizens of Scottish Borders Council can maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives

Scottish Borders Health & Social Care Partnership Strategic Plan: Changing Health & Social Care For You 2018- 2022

The Partnership Strategic Plan provides the local strategic context for taking forward the care village development. Following a review in April 2021 by the Scottish Borders Strategic Planning Group in April 2021 the decision was made to continue with the plan for a further 12months, continue with the three agreed existing objectives and to build in lessons learned from COVID-19 and update existing priorities. The strategy and its priorities aim to deliver a vision where NHS Health and Council Social Care Services are joined and work in new partnerships together, with communities, residents and third sector providers to :- improve the health of the population and reduce the number of hospital admissions; improve the flow of patients into, through and out of hospital; 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. The Tweedbank Care Village development will help to deliver these objectives and ensure services and care are

- Accessible
- Closer to home *(and offering greater support for care at home*)
- Delivered within an integrated model
- Give greater choice and control
- Optimise efficiency and effectiveness
- Reduce health inequality

Scottish Borders Council Strategic Plan 2018-2023 Our Plan for You and Your Part In It describes SBC commitment to reshaping and improving services that will allow a continuous positive “ripple effect” on quality of life, well-being, economy in communities. The Tweedbank Care Village will deliver those high-level actions and commitments in relation to:

a) Our Services for You: Continue to explore different models for delivering our services,

b) Independent Achieving People: Investment in property and infrastructure, in a planned sustainable way, and planning services for the projected increase in Older People: developing a dementia strategy that will support people to remain in their own home and community as long as they wish through a combination of specialist care and support and housing based and residential services

c) Empowered Vibrant Communities: Continue to invest in capital projects such as affordable and extra care housing, care services

3. Existing Arrangements

3.1 Existing Service Arrangements

Until March 2021 Waverley Transitional Care Unit and Garden View Discharge to Assess unit were separate intermediate care services based on two separate sites, respectively, Galashiels and Tweedbank. In essence they provided step-down care with referrals mainly from Acute.

In May 2021 as part of a review of Residential Care, and Borders Dementia Strategy all transitional care from Waverley was moved to Garden View changing the bed configuration of the unit and introducing beds focused on providing long stay and respite for specialist Dementia Care.

Waverley Transitional Care Unit has 25 beds, 10 of these are now designated for long stay specialist dementia care, 10 long stay residential and 5 respite for dementia, thus allowing community step up referrals. The service is fully managed by SBC and includes support from Care workers. Specialist Mental Health Services which are aligned and support is provided from the CHAT Team. All referrals are now screened by a panel comprising Social Work, Mental Health, Geriatricians.

Garden View Discharge to Assess Unit based 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 to home or to long term care in supported accommodation. In March 2021 as part of the review of residential care, the unit was developed to accept transitional care. Patients previously referred to Waverley are now referred to Garden View. In total there are 24 beds which provide a mixture of transitional care, (bed-based rehabilitation) and assessment. The service does not admit older people with higher levels of need due to restrictions on length of stay and lack of nurse cover. The admission criteria state referrals should have no ongoing nursing needs except those ordinarily met by a District Nurse. The facility is managed by SBC and includes support from aligned Allied Health Professional Services, contracted to NHS Borders and delivered by the Health & Social Care Partnership Community Services.

Almost all admissions to Garden View are currently step-down referrals from Borders General Hospital, principally from medical wards. Referrals from MAU are mainly from frailty at the front door team. A formative evaluation of the service in February 2021, prior to recent changes, highlighted very few referrals from medicine for the elderly, orthopaedic or stroke wards,. Throughput through both units prior to service change in May identified a total of 277 patients per annum which could be increased in order to ensure reduction in bed day costs and further efficiency.

In summary the current bed base within the existing facilities is as follows:

Care Homes

Name of Facility	Number of Beds	Purpose	Length of Stay
Waverly	10	Long Term Care	Approx. 2 – 5 years
Waverly	10	Long Term Dementia Specialist Care,	Approx 2-5 years
Waverly	5	Dementia Respite, step up and step down	To be determined
Garden View	24	Intermediate care and discharge to Assess. Beds will be allocated on first request and availability	2-6 weeks dependent upon requirement

3.2 Health and Social Care Services for Older People

The H&SCP is responsible for planning and commissioning integrated services and overseeing their delivery. These services are all adult social care, primary and community health care services and elements of hospital care which will offer the best opportunities for service redesign. The Partnership has a key relationship with acute services in relation to unplanned hospital admissions and works in partnership with community planning partners. This includes charities, voluntary and community groups so that, as well as delivering flexible, locally based services, they can also work in partnership with the local communities. of Scottish Borders.

3.3 Community Health Services – GP Practices.

Early experiences of the first Intermediate Care Unit in Borders in Galashiels identified an additional workload and complexity of care that local GPs were unable to deliver within their existing work patterns. As a result, an Intermediate Care Local Enhanced Service was agreed with the aim of ensuring that patient admitted to Intermediate Care would receive the necessary planned scheduled care from the local Waverley General Practice to assist their recovery and support their onward care back to their own home wherever possible. This Enhanced Service provides support for a maximum of 16 patients/beds between 8am and 6pm. Urgent care out with these hours is provided by the local Primary Care Out of Hours Service, Borders Emergency Care Service (BECS).

Exceptions to the Local Enhanced Service include patients in the unit who are already registered with a Galashiels practice other than Waverley Medical Practice who continue to be looked after by their own GP. Patients from out with the Borders area receive temporary care under this arrangement.

The arrangements for the enhanced service continue to apply to transitional care within Garden View and will remain on a yearly basis with the opportunity for review. Performance and workload information is collected by Primary & Community Services.

As part of the new Tweedbank Care Village 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 /7 in/out of hours business continuity.

Opportunity exists to consider further involvement and support from Consultant Geriatricians and Care of the Elderly within the Borders General Hospital partly due to their close proximity as an alternative and/or alongside General Practice . This would require a full options appraisal and financial review.

3.4 Existing Property Arrangements

There have been several reports highlighting challenges with current SBC owned residential property and ininability to make alterations/improvements to estate in a way that represents value for money. In addition, the requirements necessary as a result of the impacts associated with COVID-19 and of the need to respond to infection control techniques as cannot be easily met within existing estate and would require to feature in design/layout of new estate.

Currently Waverley is owned by SBC, Garden View is leased from Elidon Housing Association. It is understood that the SBC has the opportunity to terminate the lease over the next 3 years. Terms associated with this termination and any obligations on dilapidations associated with that termination are to be reviewed.

Details of the current condition of both properties is also to be reviewed in September 2021.

Care Homes

4. Corporate Management Strategy & Aims

During 2020 SBC commenced design works for 2 care facilities – one of these to be located in Hawick and one in Central Borders. £18.5m was allocated to the capital plan for the feasibility and construction of these facilities.

The Draft Revenue & Capital Investment Plan (Revenue 2021/22 - 2025/26, Capital 2021/22-2030/31) agreed at 19th March 2021 Council includes an updated capital plan with £22.679m allocated for “two new residential care homes”.

A project group was established, and work was taken forward to examine in more detail the key drivers for the 60-bed developments. This involved a full demographic review of demand and capacity, a review and scope of frailty and mental health, and a clinical and financial outline of a proposed care and staffing revenue model for Tweedbank Care Village. In summary conclusions were:

- Demographics suggest that there is ongoing demand for 24hr residential care in the Scottish Borders for our older residents requiring high end care (severe frailty, dementia). This is further explained in section 10.2
- The Council-owned care estate is ageing, currently does not meet all Care Inspectorate guidance and will not meet updated (post Covid-19) CI guidance. Directly linking new care home developments to the decommissioning/re-provision of existing care homes makes operational and financial sense.
- A different model of residential care which provides more personalised care, to meet both the needs of the individual and their human rights as citizens is required
- The physical accommodation and environment is important in supporting this new model of care and in also delivering against Care Inspectorate guidance and Covid-19 lessons-learned.
- The joint staffing and resource model will be a key element in realising the benefits of flexible bed-based care.

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5. Other Organisational Strategies

5.1 Older Peoples Pathway and Discharge Programme

NHS Borders and Scottish Borders Council are fully engaged in improving care and services for Older people as part of a Strategic Discharge Programme which was commissioned by the Integrated Joint Board (IJB). The original 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 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 Digital pathways and Matching Unit). These services remain in scope of the Older People's Pathways programme which aims to improves older people's hospital and intermediate care pathways, to improve outcomes, reduce need and dependence, and reduce costs.

The projects specific to this Business Case for Change are:

- Bed based intermediate care / Step down Intermediate care, discharge to Assess in Garden View
- Long term specialist and respite dementia care Waverly

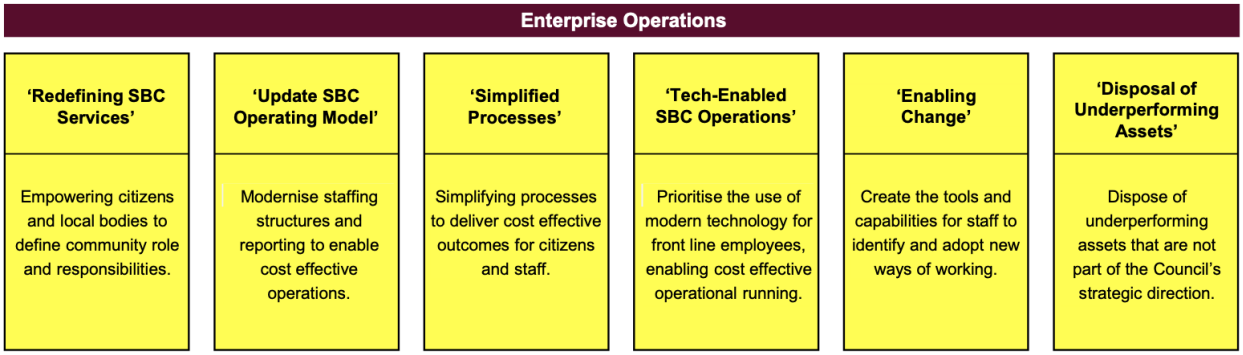
5.2 Digital Health & Care Transformation

Scottish Borders Council undertook a review of their Digital Strategy in February 2021 in order to build on their Vision to become a smart rural region delivering improved outcomes across the Borders. This strategy has two main objectives:

a) To use digital technology to improve SBC processes, improve the customer experience and improve operational efficiency, and
b) To set out the Council's digital vision for the Borders

To enable improved citizen and employee experience and unlock economic value, SBC's digital strategy sets out 12 key programmes of work, positioned across the 3 key areas of Demand Management, Response Management and Enterprise & Asset Optimisation. This strategy will assist with the delivery of existing savings plans and unlock future potential savings.

The diagram below describes the key priority imperatives, each of which will be inclusive within the Tweedbank Care Village development.



Care Homes

Information Management and Information Communication Technology is a key enabler for the new village model, particularly 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

Assessment and planning to deliver these component and operations are necessary and will be addressed further within the project planning and commissioning arrangements.

In addition, a Health and Social Care Digital Transformation Programme Outline Business Case (OBC) is currently being finalised. This programme aligns to the Scottish Borders and NHS Borders digital strategies and outlines that the Scottish Borders will be a Rural Integrated Health/Care Exemplar(rIHE) with the following vision:

“to deliver digital solutions that support everybody using and delivering health and social care within the Scottish Borders.”This means that the rIHE will leverage digital technology to enable an integrated health and social care service. It will connect people [our citizens and our workforce] and data to address inequalities and improve health outcomes in a financially sustainable way. It will enable citizens to keep themselves healthy and well, provide access to and support delivery of quality care at the ‘right time, every time’.

The rIHE would be extended to take into account the Scottish Ambulance Service, NHS 24 and our third sector partners.

6. Stakeholder Engagement

Sustainable change requires robust communication and co-production within and outside of the key organisations. In the Scottish Borders, the approach to communication is clearly described within both the H&SCP Communication Strategy and SBC Strategic Plan described as a “meaningful engagement and consultation with people living and working in the Scottish Borders “underpinning the approach to communication.

To date a range of stakeholders have been engaged in several sessions to formulate the Tweedbank Care Village Business Case for Change. Several briefings have taken place with local elected members as well as regular communication. There has been a series of ongoing papers and updates to Corporate Management Team.

A simple reprovision of current transitional care estate in Waverley and Garden View does not involve a major service change however agreement to proposed scope and business change outlined in section 10 would involve the need for a:

- Clear strategy/plan for co-production, engagement, and communications. The plan should define and demonstrate how co-production will be undertaken, the various stakeholders, milestones and key activities to be carried out and in what way.
- External Providers Impact Assessment : this should also consider Extra Care Housing provision
- Equality and Health Impact Assessment

7. Business Needs – Current and Future

This section identifies the 'business gap' in relation to existing arrangements. In other words, the difference between 'where we want to be' (as suggested by the Investment Objectives) and 'where we are now' (in terms of existing arrangements for the service). This highlights the problems, and difficulties with the status quo. The following table shows the existing arrangements in respect of each Investment Objective and describes the problems with these existing arrangements to identify 'business need'. It then further describes the change that is required to overcome these problems and improve existing services and outcomes based on the vision and principles of the Health & Social Care Partnership Strategic Plan

Note: the detailed information used to describe the existing arrangement will form the benchmark from which the future achievement of the Investment Objectives can be measured.

Investment Objective	Deliver Services within an Integrated Care Model
Existing Arrangement The status quo	Since May 2021 all discharge to assess and intermediate care services in the Eildon/Central locality are based within Garden View. This includes AHP provision Two referral/admission criteria remain in use Long stay/specialist dementia care and respite dementia care are now located in Waverley With the new bed configuration intermediate care /discharge to assess has reduced by 15 beds. It is not known if this reduction will meet demand. However it is expected that the unit will run at 95% occupancy, an improvement to the previous under-occupancy pre redesign. There is a great deal of overlap of provision within Community Hospitals which have also described as providing Intermediate Care, however a full review/evaluation is required to further justify Patients with more complex needs or requiring nursing are not included within the admission criteria.
Business Need Problems with the status quo	Although merging the two step down facilities to create one combined facility is an improvement there is a need to review admission criteria for the combined unit on one site separate admission criteria and current size/capacity of Home First Discharge to Assess restrict o Evaluation is required in order to ensure the required bed capacity and efficiency based on 95% occupancy and working alongside Home first Current Building estate has been assessed and deemed to require change/improvement in order to meet Care Inspectorate recommendations.
Potential Scope What is needed to overcome these problems	Provide dedicated nursing expertise in order to offer a local alternative to community hospital for the cohort of older residents from central borders who have higher levels of dependency and more complex post-acute care needs Commission the 60 bedded required capacity • 15 or 16 specialist dementia (10 long stay 5 respite, current Waverley proposal) (16 would better fit the units either 6x 10 or 10x 6) • 10 residential beds (from Waverley) • 24 discharge to assess with rehab/transitional care (previously garden view) including step up • 10 step up / nursing? (based on potential re-provision of community hospitals beds and nursing home waits) Provide locality, co-ordinated approach towards preventative care and alignment of care village with Locality What Matters Hubs Develop relationships with Third Sector organisations to offer preventative supports, which enable service users to live successfully in their own homes, reducing social isolation.

	Engender opportunities for joined-up working & improved communication between different service providers

Investment Objective	Give users greater choice and control of local health & social care service provision
Existing Arrangement The status quo	Consultation with the Borders community suggests that they want: The opportunity to stay in their own home, with friends and family around them for as long as possible. To have a service that can respond to changing need. Prevention from having to stay in hospital longer than needed. More choice around care home placement. There has been significant development of reablement / rehabilitative approaches over the last two years. Service users may need several transitions through the care journey to access the appropriate care (based on multiple locations for service delivery), which creates a fragmented approach to the delivery of health and social care services Service users access care via old, outdated accommodation that impacts on user perception of their overall experience
Business Need Problems with the status quo	Outcomes for individuals, particularly at the key decision points such as following illness, bereavement, or other traumatic life events, are at times adversely affected by the lack of appropriate levels of support at home or in a flexible intermediate care resource. The limitations of lack of nursing element in the current intermediate care model results in increased likelihood of admission to hospital and to long term care and delays in discharge. While Home First provides an excellent service and outcomes, further scaling up of this resource will support older people to help them maintain independence or intermediate care reduces quality of life for those in need and also contributes to an increase in emergency hospital days. Service fragmentation has the potential to confuse service users, require unnecessary transitions through the care journey, and restricts attainment of the best possible service. User perception of old, tired accommodation is that this will impact on the quality-of-service provision
Potential Scope What is needed to overcome these problems	Reduction in unnecessary hospitalisation through enhanced discharge pathways. Reduced delayed discharges. Increased number of people being supported to live at home supported by Home First, ensuring that all people requiring support at home go through an intermediate care discharge to assess pathway Shorter lengths of stay in care home Providing a greater proportion of care delivered at home, and reducing the number of direct admissions from hospital to care homes Co-locate services to reduce the number of disjointed transitions through the care journey. Improve the condition of facilities used to provide services

Care Homes

Investment Objective	Improve access to services
Existing Arrangement The status quo	There are multiple locations from which services are based and / or accessed; which includes separated accommodation for health care beds and social care residential beds, and 4 separate locations to access GP services. A review of existing premises suggests that they present difficulties regarding physical access to service delivery points.
Business Need Problems with the status quo	The variety of access points can lead to confusion over the most appropriate point of access and delays to care provision whilst transferring from one access point to another. Physical access to service providers can require several journeys which also increases the problems of accessibility to older properties. Access to the current model of care can lead to a more institutionalised placement when more user focussed intermediate care would be more suitable. There had been historical delays in accessing social care services for older people. Access to care through the current system is inflexible to user needs and, therefore, more flexible solutions are required.
Potential Scope What is needed to overcome these problems	Centralise services to reduce number of physical access points and create seamless link between health & social care beds. Improve accessibility of facilities used to provide services. Shift the focus from long term care in care homes to short stay intermediate care, maximising the potential for older people to be independent or cared for at home. Providing a greater proportion of care delivered at home, and thus ensuring that the 'Balance of Care Indicator is, at least, at Scotland average levels. Make effective use of resources to ensure that number of those waiting for social care assessment is reduced.

Care Homes

Investment Objective	Improve care pathways, capacity and flow management
	There are currently 25 transitional care beds, 15 long term care, 10 long term dementia care and 5 respite dementia care beds There are 92 community hospital beds which provide Intermediate Care, along with palliative care, and support step-up across the other 4 localities, For the population of 115,510 the community hospital compliment alone represents 4 times average bed based intermediate care. A third of the borders population lives in Central Borders which does not have a Community Hospital. These residents traditionally stay in acute hospital longer for their post acute care and rehabilitation thus increasing their length of stay and risk associated with acute hospitals. There are a high number of acute hospital beds (per 1000 population) compared to other Scottish health boards. Care home capacity is below the Scottish average and operates at approx. 92% capacity Population demographics predict a 30% increase over the next 20 years
Business Need Problems with the status quo	The current financial climate requires maximisation of all available capacity to minimise increased demand for beds. Current accommodation is unsuitable for modern service provision and patient expectations. It will therefore need to be replaced at some point in the near future. Flow of patients from Central Borders into available beds is compromised due to lack of availability of site and alternative use of capacity, this in turn means that people from the Eildon/Central locality requiring intermediate care are often transferred to community hospitals out with the locality Cumulative length of stay across the full hospital/ intermediate care stay requires to be reduced. Although average stays are between 6 and 10 weeks across the current models, lengths of stay at significantly higher levels are not uncommon for complex frail elderly individuals who often are discharged to long term care. Delays in discharge are generally low, however, meeting the two week target is extremely challenging and a lack of integration between models of care mean that more people than necessary are discharged to care homes rather than their own homes. Maintaining delayed discharge targets relies on minimising long term care demand through preventative models of care and adequate care home capacity and home care provision. Increased future demand for services, particularly for those over 65 years old will put increasing pressure on existing services to cope with that demand. The functional suitability difficulties associated with old, outdated accommodation restricts the effectiveness of care pathways and flow management. There is a critical need to further develop the collaboration of health care in localities model initiatives especially in remote and rural areas, to ensure that they receive the best possible service. This will mean working in conjunction with the locality multidisciplinary teams and the Virtual Ward initiative,
Potential Scope What is needed to overcome these problems	Reduce reliance on institutional care and demand for health & social care beds to ensure capacity continues to meet demand. Provide more suitable and flexible bed provision so that use for health and social care purposes can be interchangeable. Provide an integrated approach to service delivery to improve flow of patients from health beds to social care or own homes, whilst also maintaining current low levels of delayed discharge. To achieve this, resources need to be increased to enable more care at home, and bed capacity needs to be more flexible to cope with changing demands. Provide pathways that enable people to 'step up' to beds and avoid the need for admission to acute hospital.

Care Homes

Investment Objective	Maximise flexible, responsive and preventative care - at home, with support for carers
Existing Arrangement The status quo	Data from recent care home demand modelling • Females - 3.5% of 80-84, 9% of 85-90 and 25% of 90+ pop. live in care homes • Males – 3% of 80-84, 5% of 85-90 and 10.5% of 90+ pop. live in care homes • There is a clear correlation (.75) between very high and very low population density and number of care home beds – correlation is less clear for intermediate density • Most care home admissions are from hospital Scotland-level data: shows around 40% of admissions from hospital and round 35% from own home. Local Strata capacity data shows 33% of admissions from BGH, 25% from community hospitals (some community hospital admissions could be intermediate care), 15% from own home The number of home care hours is lower than the Scottish average. Scottish Borders ranked as 6th lowest: • Provision of intensive (10+ hours per week) care at home was significantly lower than the Scottish average, 14th in Scotland • Reablement and Rehabilitation are now core to community care services, but there continues to be limited effective delivery of step down/up care due to numerous sites and inconsistent pathways.
Business Need Problems with the status quo	The model for Older People's Care does not fully meet the Borders community's needs and aspirations for them to be able to stay at home for as long as possible, to have a service that is flexible to their changing needs, and which prevents them from staying in hospital longer than they need. Any lack of support to older people to help them maintain independence or intermediate care reduces 'quality of life' for those in need and also can contribute to an increase in emergency hospital days.
Potential Scope What is needed to overcome these problems	Increase the number of home care clients. Increase provision of intensive care at home through Home First and Virtual ward Model Develop effective step up and step-down Intermediate Care via Tweedbank Care Village o provide rehabilitation and reablement services to avoid hospital and care home admission and expedite hospital discharge where appropriate. Fully implement Pathway 0 and the What Matters Hubs and Third Sector interface which supports users and carers to maximise their potential, receiving effective sign-posting to community supports. Further scope to utilise Third Sector space to support people to continue to live well with long term conditions, through meeting and social spaces.

Care Homes

Investment Objective	Optimise efficiencies and effectiveness
Existing Arrangement The status quo	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. As they age , older people are more likely to live with frailty or long terms conditions, associated with increased demand for acute and chronic care, rehabilitation and support. Scottish Borders has a relatively high number of acute hospital beds (per 1000 population) compared to other Scottish Health Boards. Care Home capacity and provision is well below the national average with only Orkney having a lower rate. Over the past 10 years Scottish Borders has consistently been amongst the 4 lowest local authorities for care homes per head of older people's population consistently over the last 10 with care home resident places/numbers having only increased by 1%. In addition, 23% of SBC care home residents are funded outwith SBC. The above represents the strategic rationale for investment in flexible and responsive integrated communmity based intermediate care
Business Need Problems with the status quo	Recent evaluation of Scottish Borders Discharge Programme has highlighted areas of potential inefficiency. At that time both Waverley Transitional Care Unit and Garden View Discharge to Assess ran under capacity. Since the redesign in May 2021, it appears that both units have been operating at capacity, however further evaluation is required to determine e if this change reflects true demand and capacity Waverley Transitional Care Unit- does not admit older people with higher levels of need due to restrictions on length of stay and lack of nursing cover. This is an issue for residents of Central Borders most likely to benefit due to lack of Community Hospital in the locality Garden View Discharge to Assess –cannot offer full reablement due to lack of AHP cover and is unable to admit people with higher levels of dependency. There are 92 beds within Community Hospital which provide facilities for Intermediate Care, Palliative Care and step-up. Benchmarking data is unavailable however for a population of 115,510 the community hospital compliment alone represents almost 4 times the average bed based intermediate care capacity reported in the 2018 National Audit of Intermediate Care. More expensive interventions from both health & local authority provision are having to be utilised due to the lack of support for self-care and independent living at home.
Potential Scope What is needed to overcome these problems	Introduce a new model of older people's care that: Provides a greater proportion of care delivered at home. Provides the flexibility to deliver better services and deliver all the investment objectives described herein. Is able to cope with the projected increase in demand for services. And, is affordable for all partner organisations.

Care Homes

Investment Objective	Improve quality & effectiveness of accommodation used to support service delivery
Existing Arrangement The status quo	A formal AEDET assessment has not been carried out on Waverly and Garden View however there have been internal benchmark assessments against Care Inspectorate Guidance for Building Better Care Homes 2021 which has highlighted limited scope in improving standards of care for Older People. Previous Estate reviews and reporting to CMT has highlighted that much of SBC residential estate requires improvement and in current state would not meet quality standards in respect of Fit for 2024
Business Need Problems with the status quo	The main issues and problems highlighted within these assessments are summarised within the 'Existing Property Arrangements' section of this Full Business Case
Potential Scope What is needed to overcome these problems	The design of the new village delivered as part of this project will need to overcome the existing accommodation deficiencies, within Waverly and Garden View and will need to attain an agreed AEDET score each Design Area,

Investment Objective	Improve safety of health & social care, advice, support & accommodation
Existing Arrangement The status quo	The interior design and layout of bedrooms, bathrooms and communal spaces is limited and if benchmarked against new guidance for Care Homes and EDAT both Waverly and Garden View score poorly. The internal review of existing premises highlights the outdated accommodation which is challenged to be maintained to modern statutory compliance and health & safety standards.
Business Need Problems with the status quo	Design and layout features of existing premises present significant challenge in maintaining Infection Control /COVID – 19 requirements These age of the properties also increase the risk of harm from property related incidents due to: • HAI concerns • Trips and falls • Social Isolation
Potential Scope What is needed to overcome these problems	Small home dwelling of will reduce the risk of infection transmission, reduce falls, improve mental health & wellbeing and improve AEDET score for facilities used in providing services The concept/vision for the care village along with the size of the estate offers huge opportunity for co-location of other services, eg GP Practice / Health Centre , and for the full intergenerational involvement of the community

8. Investment Objectives

The investment objectives for this scheme have been developed to specifically fit with the key outcomes identified within the Health & Social Care Partnership Strategic Plan. Further review is proposed to map and correlate how exactly the investment objectives will align with and be measured with the local Strategic objectives.

8.1 Design Quality Objectives

As part of the Business Case for Change the Project Board will be required to identify and agree Design Quality Objectives and produce a design statement to ensure that implementation in terms of the design and construction of the physical premises, care village meets the needs and objectives of stakeholders.

The Design Statement will be used as the initial tool with which to communicate the vision of the Care Village to designers and those "non-negotiables" which form a variety of perspectives which the design must achieve. It will also be used to develop a more detailed design brief, again in consultation, which will form the basis of construction information used to develop all detailed proposals.

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.

To date there have been two design proposals relating to the number of units within the care village. These are

6 units of 10 houses and

10 units of 6 houses.

The final design shall follow Care Inspectorate guidance for Care Homes for Adults while also taking cognisance of New Models of Care and innovative, forward-thinking approaches to care facility design and governance. Guidance and good practice on infection prevention and control as per SFHN 30 Part A: HAI_SCRIBE Manual to be followed.

The final decision around the specification of design will be scored in relation to weighted outcomes which will include the Hogewek village model ethos, affordability, staffing, safety and independent living related to village concept.

A further assessment of Garden View and Waverley Facility current property arrangements will take place in September 2021.

9. Desired Scope and Service Requirements in the Case for Change

This section of the Business Case for Change provides detail of the business scope, the service outputs and the preferred way forward. The care village model has the opportunity to be at the core of a much broader community-based model for older people across Borders and in particular Tweedbank. It is a model that provides a unique opportunity to develop an innovative an integrated form of care provision and one which inherently facilitates and promotes significant integration of current health and social care services.

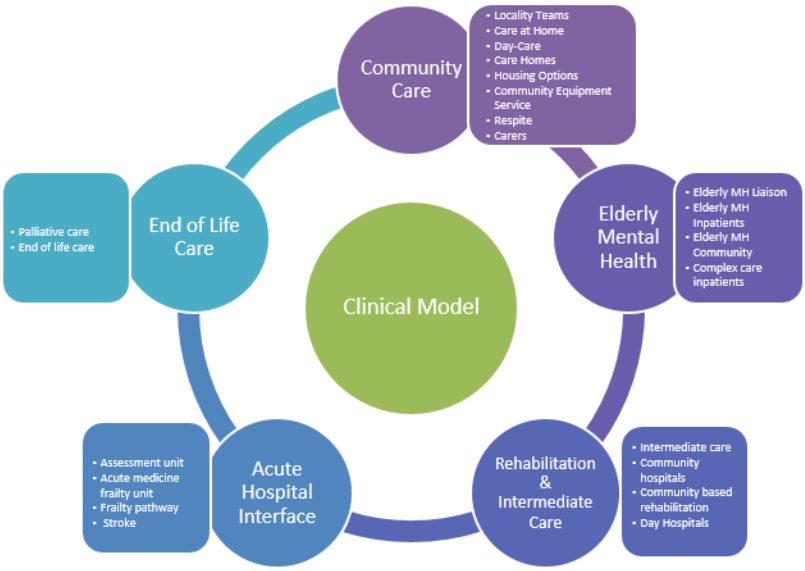
The Care Village will largely provide the intermediate and specialist dementia care capacity which will support acute hospital discharge whilst avoiding premature admissions to care homes. It also provides an opportunity for community services to 'step up' into the village at the point of crisis or as an alternative to acute hospital when care at home is no longer possible for reasons of health, carer crisis or for other reasons. The village is central to reducing time spent in institutional care and breaking the historic cycle of repeat emergency admission, delayed discharges, reducing the time spent unnecessarily in hospital and providing appropriate placement for long term assessment. The overlap in relation to intermediate care provided by Community Hospitals is evident, as is the requirement to reduce overall lengths of stay and generate a more effective flow of care with better outcomes.

The first phase of the scope will be a transfer of existing bed based Intermediate and Dementia Care services and existing model of care to Tweedbank.

This business case for change makes strong recommendation for further transformation and improvement as part of a wider commissioning of Older Peoples Services which would be wrapped around Tweedbank as an exemplar model of integrated care, housing and community support

- Fully integrate all referral criteria, processes etc. that exist within Garden View to ensure a combined facility with a single set of admission criteria
- Provide dedicated nursing expertise to enable the transitional care unit to offer a local alternative to community hospital care for the cohort of older residents from Central Borders who have higher level of dependency and more complex post-acute care needs, such as delirium
- Test a locality integrated team model within the Care Village which includes direct links for What Matters Hubs, Virtual Wards, geriatric, medical and palliative care expertise and an Enhanced Framework for Care Homes which will enable greater continuity of care management, better co-ordination with local assets and the village housing solution and to increase step up crisis response.
- Pilot work with SAS and out of hours services on urgent response to falls and higher levels of dependency

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.



Formative Evaluation of Intermediate Care and Discharge February 2021 (see appendix B)

From the model of transitional intermediate care services currently being delivered within Scottish Borders Council Care Homes, a formative evaluation of the partnership discharge programme in February 2021 found the following:

- Waverley Transitional Care Unit delivered 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%.The service runs at 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. 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

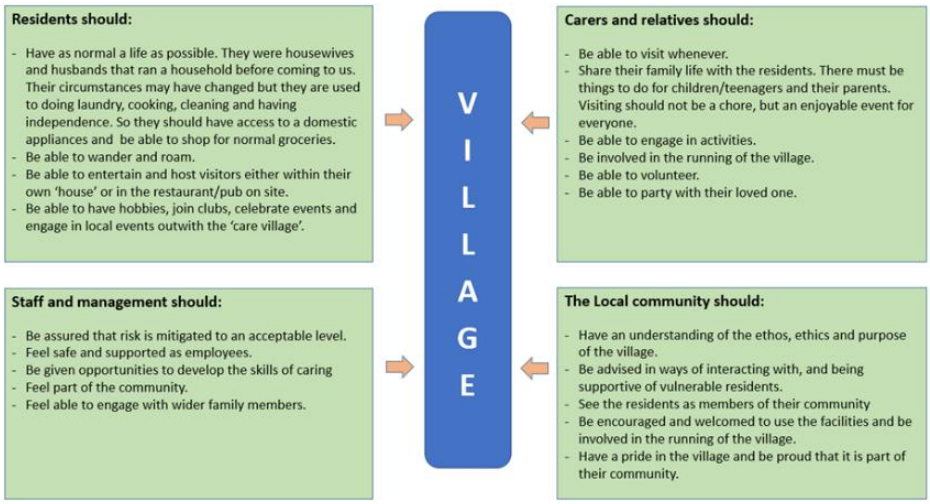
objective of 80% remaining at home at the end of their Home First episode, with a 57% reduction in their requirement for home care (against 40% target). 57% are fully independent at the end of their Home First episode while those who need ongoing home care have 11% reduction in the level of care required. 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.

The evaluation concluded 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 recommended that

- 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 to progress the strategic developments outlined in the recommendations.

The desired scope for this business case for change includes the above recommendations while adopting local vision and scope of a Care Village Model as described in diagram 2 (As agreed by the IJB)



9.1 Service Outputs

The services proposed within the scope of the Case for Change and project are intended to deliver a number of service outcomes. Outputs will be short and long term and should link directly to outcomes and commissioning. Further development of these is required once case for change and scope have been agreed.

9.2 Care Home Demand Modelling and Assumptions

In May 2021 CMT requested further evidence in relation to care home demand and modelling of the Scottish Borders older population. A Stakeholder Care Home modelling group was established with a specific ask to: Provide a 10-year forward projection of 24-hour care demand for older people and describe the expected changes in 24-hour care demand broken down by residential care, nursing care and specialist care provision with worse case and best case scenarios.. If possible, the group were also asked to include potential for mid-range scenario. Several assumptions were applied to predicted future demand, these were

- Expected changes in population frailty or dependency levels will increase demand
- Expected changes in dementia prevalence and need for 24-hour care will increase demand
- Impact of changes in older peoples integrated preventative models of care may decrease demand for future 24-hour care

The outcomes of this study (which are attached as a powerpoint presentation in appendix A) highlighted that the demographic projection and 30% increase in older people predicted the need for an additional 188 care home places by 2030, this represents between **8-11** additional care home places per year however :

- Scottish Borders benchmarks in lowest 4 Local Authorities for care home places
- There has been no change in Scottish Borders care home places 2009-2019 despite 20% increase in >75 Borders population
- The number of SBC-funded residents outwith Borders has been steady at 20% over the past 5 years
- Scottish Borders benchmarks in lowest 6 LAs for home care packages
- Suggestion that rurality and community/family support is maintaining more people at home
- The % of residents who remain in their own locality is directly related to the number of care home beds in a locality (0.91 correlation)

- Based on demographic change only, we can expect an increase of 188 beds by 2030. This has been broken down to a 28% increase in residential care beds and 29% nursing care beds

- The table below describes this in numbers and can be interpreted as an increase requirement of 14-17 beds per year by 2023-2026 and 19-23 beds per year in 2027-2029

Annual increase	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Care Home residents - residential	30	9	11	8	9	14	14	12	10
Care Home residents - nursing	16	6	6	6	5	9	8	7	6
Care Home residents - Total	46	15	17	14	14	23	22	19	16
Extra admissions/year	**26**	**8**	**9**	**8**	**8**	**13**	**12**	**11**	**9**

Consultation with the Carers centre regarding care home demand and reasons for lower level of placements: identified that there was various perceived reason that were related to quality of care homes, unmet need, higher dependency groups, reduction in respite care, closure of day centres, deterioration during Covid, isolation and dementia. There were also suggestions that budgets and financial resources contributed to the number of placements.

The following assumptions identified and measures that could reduce/offset some demand for care home bed increases are

- Intensive Rehabilitation and reablement support
- Staff Education on appropriate referrals to care homes
- Provision of early intervention and crisis support
- address lack of social contacts/loneliness and isolation
- reduce cognitive deterioration and functional decline

- Actions to support healthy living - ‘Live Well, Eat Well’, Dementia-friendly communities
- Different approach to managing pathway from hospital to care
- Support for Carer Stress and burnout (esp higher dependency clients)
- Location of care home beds influences number of residents who stay in own locality
- Telehealth/telecare
- Locality Models and Anticipatory Care Planning
- Virtual Ward /Hospital at Home

10. Benefits

On the basis that the proposed service model is put in place, the following identifies the key benefits likely to be attributable to achievement of each investment objective: As part of the project board deliverables a full benefits realization of existing /status quo and business scope is required.

Investment Objective: Increase integration & communication between health & social care services and delivery to service users			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Delivery of more effective care with improved user outcomes	High	Medium & longer term	Qualitative and quantitative
Greater collaboration between partner organisations to improve effectiveness of preventative and intermediate care	High	Medium & longer term	Qualitative
Improved staff engagement & communication between partner organisations	Medium	Medium & longer term	Qualitative
More service users able to return home following hospital care (based on draft intermediate care performance measures)	High	Medium	Quantitative
Shared use of partner resources	Low	Medium term	Cash & resource releasing
Improved working arrangements and facilities for staff resulting in greater job satisfaction and less turnover / sickness	Medium	Medium term	Qualitative & resource releasing

Investment Objective: Improve user experience of local health & social care service provision			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Positive experience of health and social care	High	Medium term	Qualitative
More people able to access care from their preferred location (i.e. at home)	High	Medium term	Quantitative
More people able to return home following hospital care (following rehabilitation and reablement)	High	Medium term	Quantitative & resource releasing
Better transition through each care journey	High	Medium term	Qualitative
Positive experience of the environment in which services are provided	Medium	Medium term	Qualitative

Investment Objective: Improve access to care			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Maximised range of health and social care services available locally	High	Medium term	Qualitative
Point of access to care is less confusing	Medium	Medium term	Qualitative
More likely to receive the most appropriate care	High	Medium term	Qualitative
Ability to access care at home	High	Medium term	Quantitative
Better physical access to care facilities	Medium	Medium term	Qualitative
Flexible bed usage enables more user focussed care	High	Medium term	Qualitative

Investment Objective: Improve care pathways, capacity and flow management			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
More people treated on a scheduled rather than unscheduled basis	High	Medium & longer term	Quantitative
Service capacity meets service demands	High	Medium & longer term	Quantitative
Flexible use of beds better meets service user needs	High	Medium term	Qualitative
Reduction in overall number of beds (from the baseline high of 161 in 2011)	High	Medium term	Quantitative & cash releasing
Services users don't have to stay in hospital longer than necessary	High	Medium term	Quantitative

Investment Objective: Maximise flexible, responsive and preventative care - at home, with support for carers			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
More people able to access care from their preferred location i.e. at home	High	Medium term	Quantitative
More people able to return home following hospital care	High	Medium term	Quantitative & resource releasing
Providing care at home is more cost effective than institutional care	High	Medium term	Cash & resource releasing to Council
Carers feel better supported in their role	High	Medium term	Qualitative
Increase in visits and involvement from relatives and wider damily, including childres to the residents and within the care village	High	Medium term	

Investment Objective: Make best use of available resources			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Affordable service delivery	High	Short, medium & longer term	Quantitative
Service capacity meets service demands	High	Medium & longer term	Quantitative
Service model is more flexible to future changes in demand	Medium	Medium term	Qualitative
Reduction in overall number of beds (from the baseline high of 161 in 2011)	High	Medium term	Cash & resource releasing to NHS & Council
Reduced demand for more expensive care pathways (through shift from health to social care models of care)	High	Medium to longer term	Cash releasing to NHS & Council

Investment Objective: Improve quality & effectiveness of accommodation used to support service delivery			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Improved user perception of quality of care	Medium	Medium term	Qualitative
Improved condition of available accommodation	Medium	Medium term	Qualitative
Accommodation meets modern service needs & enables flexibility of use	High	Medium term	Qualitative
Improved functionality of accommodation improves service effectiveness	High	Medium term	Qualitative

Investment Objective: Improve safety of health & social care, advice, support & accommodation			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Reduced risk of HAI incidents	High	Medium term	Qualitative
Reduced risk of harm from property related incidents	High	Medium term	Qualitative

11. Constraints & Dependencies

11.1 Service Model Constraints

The two main constraints to are the unsuitability of the existing facilities and the need to move towards a more integrated approach to service delivery in order to attain the identified benefits from this scheme.

It is possible, to a certain extent, to provide a co-ordinated approach to service delivery from the current arrangements but this is unlikely to achieve the full benefits that a fully integrated, centralised Care Village approach will achieve.

The main barrier is the existing accommodation. Reviews of the existing facilities identified the restrictions caused by this accommodation and the general poor condition and unsuitability for modern service provision. Also, the flexibility of bed usage inherent in the care model cannot be achieved from the outdated accommodation split over several sites.

11.2 Capital Funding Constraints

The project is proposed to be funded via the Council's Capital Plan. The current estimate for the facility of £14.3m including an allowance for road access to the Tweedbank site) is significantly above the capital plan estimate and will required further review.

Potential dilapidation costs for Garden View also required to be reviewed together with any potential capital receipt from Waverley.

11.3 Revenue Funding Constraints

It is currently assumed that the new facility will have lower property costs than the existing facilities due to building efficiency with regard to energy, reduced maintenance costs in early years and no rental payments.

It has been estimated (see appendix 2) that the staffing costs of the new facility will be equal to the current costs despite a change in delivery arrangements Equally there are pressures on revenue funding. Given the expected higher occupancy in the new facility cost per patient is substantially reduced.

11.4 Dependencies

Staffing- It is envisaged that the Care Village will operate within the existing financial envelope of the current budget of Waverley 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 required 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.

To deliver the model as described, requires key elements examined in more detail below:

- transitioning the existing workforce from Waverley 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

Long term continuing care and end of life care - intensity and therapeutic support will increase and decrease as crisis or events demand. This model requires to be responsive and focused on the individual's outcomes in relation to their ability and potential. As care needs increase the journey may flow into more regular care support. This could be at home with carer or respite support interspersed with short-term 24-hour care to maintain an individual within their home. The objective is to avoid admission to longer term care or at least delay this until living at home is no longer a possible option. This type of care is likely to support those with greater needs than is currently the case and for significantly shorter lengths of stay than currently.

The Care Village concept is also dependent upon the collaboration and inclusion of other partner organisations, such at the local GP practices, community nursing ,community hospital services, local care providers, local charities and the voluntary Sector will enhance the Care Village concept.

Allignment of Allied Health Professionals and Mental Health- Both Allied Health Professionals and Mental (CHAT) provide on site support within the current Waverley and Garden View estate. Arrangements for move an continued on site within the new Tweedbank Care Village will be required
:

Prevention - In the main, people wish to continue to make a positive contribution to society at the onset of their older years and although often relatively active, they need to be supported by a pro-active approach to health promotion and ill health prevention to avoid the need for care services.

Short term therapeutic intervention - As 'older' old age approaches and there begins a decline in health or ability, the focus shifts to services aimed at reducing incapacity and thus reducing the consequences of any decline. These 'short–term therapeutic interventions' require to be responsive to sudden changes in situation or health state, intervening to prevent or minimise e.g. hospitalisation or social crisis. Options including.

Without this collaboration, not only would each organisation need to progress with its own individual care intervention services but achieving optimal outcomes throughout the wider care model would not be possible.

The continued inclusion of the different partner organisations involved in this case for change and their interdependency on each other, is one of the key challenges to the success of the project.

12. Critical Success Factors for the project

In addition to the Investment Objectives set out in the previous section of this Full Business Case, the Care Village Partnership Group identified a number of factors which, while not direct objectives of the investment, will be critical for the success of the project, and are relevant in judging the relative desirability of options.

The agreed Critical Success Factors are shown in the table below.

Key CSF's	Broad Description
Strategic fit and business objectives	Fits with the strategic intention to shift the balance of care from acute to primary care and from institutional care to home care It is also in line with Scottish Borders Council's Single Outcome Agreement.
Potential VFM	It enhances service delivery, improves user experience, and achieves the project investment objectives from an efficient cost base, while at the same time reducing service delivery risks
Potential achievability	The key service providers are able to adapt to the proposed service changes and deliver an enhanced service from identified resources
Supply-side capacity and capability	Service providers have the resource capacity and capability to deliver the proposed service model and facilities; and the scheme will be able to attract the necessary investment.
Potential affordability	Available capital and/or revenue funds will be sufficient to provide the facilities and ongoing resources needed to deliver the proposed service model

13. Economic Case

13.1 Introduction

This section sets out the economic case where a number of options were identified and critically evaluated in both financial and non-financial terms including value for money analysis.

13.2 Critical Success Factors

The critical success factors were subject to workshop discussion at the early stages of the project and were revisited as part of the OBC option appraisal exercise and reconfirmed as valid. These are outlined below:

Critical Success Factors

Critical Success Factors	
1	Deliver Services within an Integrated Care Model
2	Give users greater choice and control of local health & social care service provision
3	Improve access to services
4	Improve care pathways, capacity and flow management
5	Maximise flexible, responsive and preventative care - at home, with support for carers
6	Optimise efficiencies and effectiveness
7	Improve quality & effectiveness of accommodation used to support service delivery
8	Improve safety of health & social care, advice, support & accommodation

13.3 Options Considered

This section identifies the processes for the short-listing of options contained within this OBC, which all need to be viable and deliverable.

The approach adopted for developing the options involved representatives from a range of stakeholders from the community including users, general practitioners, NHSB, patients and local residents in a series of workshops.

13.3.1 Options Shortlist

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The short-listed options included within the IA document are summarised in the following table.:

Options Short List

Option	Description
Option 1 (Do minimum - Retain **Waverley and Garden View Care Homes.**	This option would incur minor interior upgrade works to improve the building. This option would fail to meet the service and project objectives. However it has been included as an option to provide a baseline so that the extra benefits and costs of the other options can be measured against it.
Option 2 – New Build Tweedbank Care Village.	This option would allow the replacement of the current poor quality premises at Waverley and Garden View and the relocation of other services and staff to a new purpose-built health and care centre.

13.3.2 Evaluating the Short-listed Options

The SCIM Guidance includes the need to review the short listed options included in the IA. The Board have undertaken such a review during the early stages of the OBC.

13.3.3 Non-Financial Benefits Appraisal

Two major seminars were held with local leaders, and professionals and whilst further consultations will be undertaken to detail the model, a local vision for the future of residential care has been formed and to appraise the short list of options in non-financial terms.

The workshop commenced with an explanation of the background and context to explain how the option appraisal process fits within the OBC process. The workshop continued with a review of the investment objectives and the Critical Success Factors identified at IA stage, identifying the benefits associated with each and weighting those benefits all of which is described in more detail below.

A key component of any formal option appraisal is the assessment of non financial benefits that are likely to accrue from the options under consideration. The non financial benefits appraisal comparison was undertaken in an open and transparent environment.

The benefits appraisal had three main stages:

- Identification of the benefits criteria,
- Weighting of the benefits criteria,
- Scoring of the short listed options against the benefits criteria.

Although comparison of the relative non financial benefits of the options presented allows comparison to be made in this area, the outcome is critical in assessing the overall value for money presented by each of the options most commonly measured by the Net Present Cost (NPC) per unit of benefit delivered.

The role of the benefit criteria in the non financial appraisal is to provide a basis against which each of the options can be evaluated in terms of their potential for meeting the objectives of the proposed investment. The table below sets out the benefit criteria with an explanation of the factors considered against each.

The table details what the investment should achieve for residents, staff, careers and relatives/friends and the local community.

Weighted Criteria

Benefit Criteria	Weighting
Deliver Services within an Integrated Care Model	20%
Give users greater choice and control of local health & social care service provision	15%
Improve access to services	15%
Improve care pathways, capacity and flow management	10%
Maximise flexible, responsive and preventative care - at home, with support for carers	10%
Optimise efficiencies and effectiveness	10%
Improve quality & effectiveness of accommodation used to support service delivery	10%
Improve safety of health & social care, advice, support & accommodation	10%

Individual criteria have differing degrees of importance in determining the preferred solution to emerge from the benefits appraisal. As a result it is necessary to rank the criteria in order of importance and then to allocate a weighting, which reflects the degree to which each criterion will affect the outcome of the options scoring exercise.

13.3.4 **Scoring the Options**

The scoring of the options against the benefits criteria is designed to assess the extent to which the potential solutions meet the objectives of the proposed investment.

Scoring provides a means to assess how each of the options compares both in relation to the optimal position (i.e. meeting all the criteria in their totality) as well as in relation to the other options.

The benefits score, when contrasted with the whole life cost (derived from the Net Present Cost within the economic appraisal) provides a means by which the overall value for money delivered by the short-listed options can be assessed.

The benefit criteria in the context of the two options was considered and a score was generated using the option scoring scale shown in Table 19 below.

Options scoring scale

0	**Not at all**
1	**To some extent**
2	**Satisfactory**
3	**Good**
4	**Very good**
5	**Excellent**

The application of this scoring scale allows scope to differentiate the options against each of the criteria; as such the resultant output should provide a more robust overall assessment of the options.

The scores for the options were then collated and the options ranked according to the weighted scores. The results of the benefits scoring is summarised in the table below:

Benefit Appraisal Weighted Scores

Investment Objective	Weighting	Score Do Min	Weighted Score	Score New Build	Weighted Score
Deliver Services within an Integrated Care Model	20%	2	0.08	5	0.2
Give users greater choice and control of local health & social care service provision	15%	2	0.06	5	0.15
Improve access to services	15%	2	0.06	5	0.15
Improve care pathways, capacity and flow management	10%	2	0.04	4	0.08
Maximise flexible, responsive and preventative care - at home, with support for carers	10%	2	0.04	4	0.08
Optimise efficiencies and effectiveness	10%	2	0.04	4	0.08
Improve quality & effectiveness of accommodation used to support service delivery	10%	1	0.02	5	0.1
Improve safety of health & social care, advice, support & accommodation	10%	1	0.02	5	0.1
Total Score	100%		36.00%		94.00%

The table shows that **Option 2 –"Build new Waverley/Garden View** has the highest Non Financial Benefit Score with **Option 1 'Do Minimum'** achieving the lowest score.

13.4 Economic Appraisal

The initial capital cost estimates for the options short-listed are detailed as follows :

Initial Capital Cost Estimates

Option	Initial Capital Cost Estimate
Option 1 – Do Minimum	£133,600*
Option 2 – New Build	£14,290,930

*the initial costs for the Do Minimum option use the £133,600 of identified backlog maintenance. It is likely that substantial further investment would be required in these facilities over the next 25 years in addition to the Lifecyle maintenance identified.

**these costs are based on the cost estimates for Stirches plus the provision of an access road to the Tweedbank site.

13.4.1 **VfM Analysis**

The table below shows the value for money analysis for the short listed option. A summary of the economic analysis is included as appendix C.

VFM Based on operational costs of the two existing facilities compared to a new build care village.

25 year Life Cycle		Option 1 - Do Minimum	Option 2 – New Build Replacement
Appraisal Element			
Benefit Score	a	36	94
Net Present Cost– excluding risk[1]	b	£32,128,060	£47,921,386
Cost per benefit point	b/a	£892,446	£509,802
Rank		2	1

VFM Based on operational costs of bedspaces of the two existing facilities compared to a new build care village.

25 year Life Cycle		Option 1 - Do Minimum	Option 2 – New Build Replacement
Appraisal Element			
Benefit Score	a	36	94
Net Present Cost – per bed (based on occupancy)	b	£845,475	£840,726
Cost per benefit point	b/a	£23,485	£8,944
Rank		2	1

13.4.2 The Preferred Option

The results of the combined quantitative and qualitative appraisal of the shortlisted options shows that **Option 2 – new build replacement option** gives the lowest cost per benefit point and therefore is the preferred option.

[1] The net present cost (or life-cycle cost) is the present value of all the costs of installing and operating the facility over the project lifetime – assumed for comparison to be 25 years. To reflect the time value of money, future expenditure is discounted at 3.5% (compounded) in accordance with HM Treasury; Greenbook, Published: 21 April 2013

14. Commercial Case

14.1 Introduction

The purpose of this section is to highlight the current thinking with regard to appointing a contractor to provide the facility and likely contractual arrangements.

14.2 Procurement Route

Routes to be considered include for appointing a contractor to provide the facility include:

14.2.1 Open Market

Since SBC are a government funded body they will have to comply with stringent procurement rules. This will include advertising the contract with the European Union via OJEU. This sets the limit for a contract of £4,733,252 (net of VAT) so anything above this has to be marketed via the OJEU process. This process can be time consuming and can be very labour intensive in terms of reviewing the submitted returns. In some cases it can add between 3 – 6 months to the programme.

However, this process can begin early in the project to mitigate programme risks where possible. SBC has previously used Public Contracts Scotland to advertise projects above and below OJEU limits. It would be advisable to meet with the procurement team in the early stages of the project to establish the requirements.

There is also a requirement for the design information to be more developed at the point the tender is issued. Before tender design documentation is issued a pre-qualification process can be undertaken, and this can be undertaken earlier in the project as detailed design information is not required for this process. Once the pre-qualification process has been undertaken it will help to reduce the numbers of contractors that can take part in the main tender process. Although it is a lengthy process, if started early the programme impacts can be reduced. As SBC is a public funded body undergoing this tender process will be required for compliance with procurement rules.

One disadvantage of going along the open market route is location. There is a risk that contractors do not bid for the project or withdraw due to location and competition with smaller contractors who can offer a better price. Although this is advantageous for price the risk is that smaller contractors struggle with the size and scale of the project.

14.2.2 Existing Framework

There are a number of existing frameworks that could be accessed to procure the project. The use of frameworks provides rapid access to a list of pre-qualified contractors, who have been engaged on a competitive basis, complied with the necessary public procurement rules and proven to demonstrate value for money. By virtue of these contractors having pre-qualified, a level of assurance of service delivery can be taken; this fact can also save time within the tender process. With most frameworks, elements of terms and conditions can be pre-agreed at framework award, therefore time and effort is saved by not having to manage this as heavily.

Possible framework options include the following:

- SCAPE
- CCS Framework

- Hub (South East Scotland)
- SPA Framework

A final decision is to be made however utilising an existing framework is likely to result in the procurement of the suitable contractor to deliver best value in the shortest time frame.

14.3 Contractual Arrangements

Given the likelihood of utilising a framework to provide a contractor and that the contractor will take design responsibility for the final product, it is likely that a design and build contract[2] arrangement will be progressed – via a JCT[3], NEC3/4[4] or DBDA[5] arrangement.

[2] Design and build contracts can be advantageous in terms of time as it allows the overlap of design and construction reducing the overall project delivery time. The fact that there is also a single point of responsibility for the client to deal with once the contract is awarded can also enhance risk management.

[3] The Joint Contracts Tribunal (JCT) Design and Build Contract (DB) is intended for use on construction projects following the design and build procurement route. This involves appointing a main contractor to design (or complete the design) of the project and then to go on and construct it. It is a standard form contract which set out the responsibilities of all parties within the construction process and their obligations, so it is clear as to what work needs to be done, who is doing it, when are they doing it by, and for how much.

[4] New Engineering Contract (NEC) has similarities to JCT but can introduce target costs rather than fixed price, does not allow for provisional sums, pemits open book procedures and has the programme at the heart of the contract (JCT programme is not a contractual document).

[5] A Design and Build Development Agreement (DBDA) is a Hub contract model for delivering public sector projects. Although a DBDA does not involve finance, it position on risk is very similar to the Design, Build, Finance and Maintain projects such as the Jedburgh and Kelso schools projects.

16. The Financial Case

16.1 Introduction

This section sets out the financial case for the preferred option including the capital and revenue implications for the project.

16.2 HL&P, Rates & Domestic Costs

The current and future costs for the have been estimated but will require to be reviewed against actual costs.

16.3 Staffing Costs

Staffing costs have been taken from appendix D – Proposed Model of Care and Revenue Costing.

16.4 Capital Costs & Funding

The project is currently included within the capital plan although the current estimated cost of £14.3m will require to be reviewed against the allowance in the plan.

16.5 Land Purchase

All land required for the project is in Council ownership (to be confirmed re title check)

16.6 Disposal of Current Health Centre

The disposal of Waverley is requires to be considered, as does the potential for dilapidation costs for Garden House.

16.7 Overall Affordability

The current financial implications of the project in capital terms as presented above confirm the project's affordability.

17. Management Case

17.1 Overview

This section summarises the planned management approach setting out key personnel, the organisation structure and the tools and processes that will be adopted to deliver and monitor the scheme.

17.2 Project Programme

A programme for the project has been developed. A summary of the identified target dates is provided as follows.

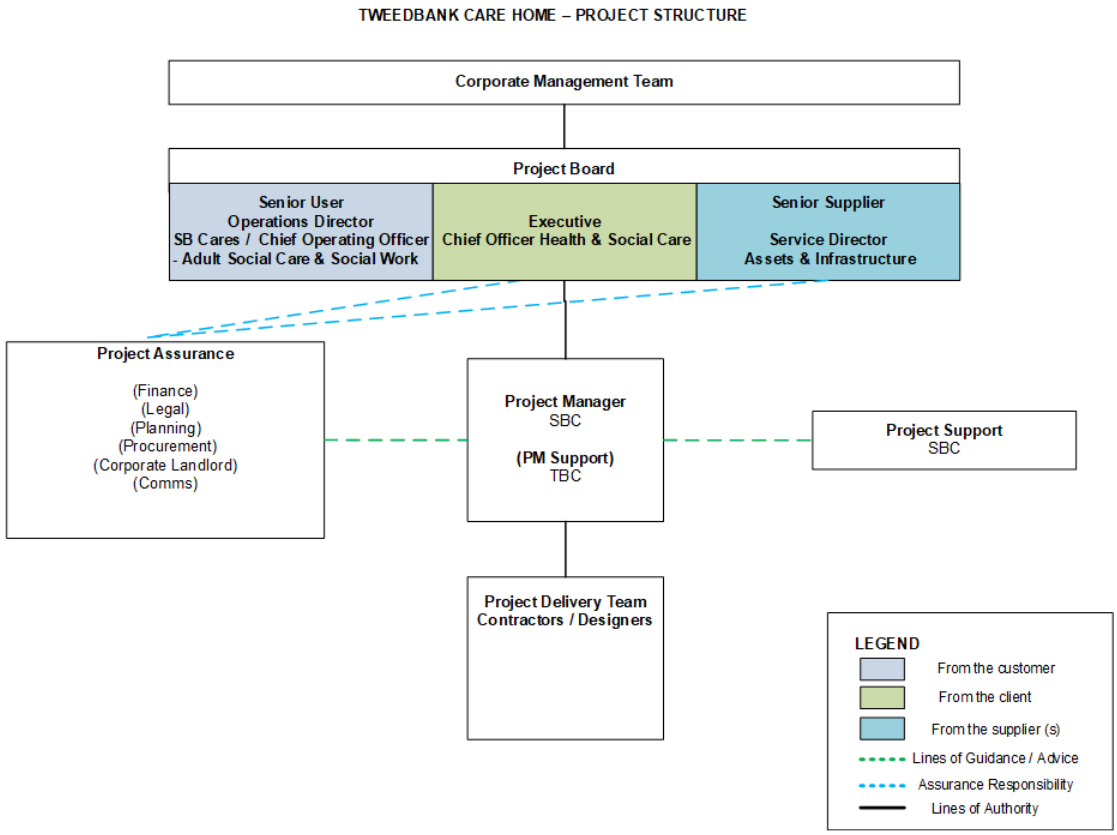
Project programme dates

Stage 2: Consideration of OBC	Oct 2021
Stage 3: Submission of FBC	Oct 2022 (to accommodate procurement, contractor appointment, planning, and advanced works to accommodate Tweedbank Expansion Road).
Stage 4: Start on site	November 2022).
Completion date	April 2024
Services Commencement	May 2024

17.3 Project Management Arrangements

A Project Board will be established and chaired by the Chief Officer Health and Social Care, the Chief Officer will also be the Project Sponsor.

Project Governance/Management Arrangements



(Project Structure - To be further developed)

The Project Board will be expected to represent the wider ownership interests of the project and maintain co-ordination of the development proposal.

The Project Board comprises representatives from the:

- Scottish Borders Council
- NHS Borders
- Key stakeholders from Health & Social Care Partnership
- SBC Capital Planning team.
- Finance Officer/representative
- Commissioner representation/function
- Independent Provider Representation
- Care Inspectorate
- External Consultant

A Project Steering Group has also been established to manage the day to day detailed information required to brief and deliver the project.

17.4 Communications and Engagement

In terms of the development of the project to date, the proposals have been developed through consultations with the following internal and external stakeholders.

- NHS staff and key leads of departments
- Public and resident representatives
- Local Councillors
- Local Authority Planning Department
- Local Community Planning Partnership partners.

More specifically the community engagement programme for the project will include the following activities:

- Immediate neighbours engagement meeting and formal planning permission communications
- Wider community engagement meeting – advertise widely – residents, service users, carers, invite key community groups and voluntary organisation, elected members,
- Display plans in public facilities and carry out engagement information sessions
- Update Public Partnership Forum regularly
- Presentations at local Community Groups
- Presentation at local Community Planning Partnership,
- Produce and distribute widely Newsletter which will detail of plans, timescale of proposal, stages, arts and environment strategy etc
- Information Stall at local community events
- Information Website

17.5 Reporting

The Project Manager will submit regular reports at the Project Board meetings. This will encompass.

- Executive summary highlighting key project issues
- A review of project status including:
    - Programme and Progress, including Procurement Schedules
    - Design Issues
    - Cost
    - Health and Safety
    - Comments on reports submitted by others

- Review of issues/problems requiring resolution.
- Forecast of Team actions required during the following period.
- Identification of information, approvals, procurement actions etc required from the Client
- Review and commentary of strategic issues to ensure ??? objectives are being met.

17.6 Change Management

To achieve successful change management outcomes key staff will continue to be involved in a process of developing detailed operational policies and service commissioning plans.

17.7 Benefits Realisation

The Benefits Criteria articulated earlier are all desirable outcomes for the project that are expected to be achieved by the preferred option. Criteria were identified and designed to be clear and capable of being consistently applied by the stakeholder group involved in the review of the short-listed options.

The plan outlines how the Benefits Criteria (including the financial benefits) will be measured and monitored through the project's lifetime. This is in order that a meaningful assessment can be made of the benefits yielded by the project and to benchmark the assessment criteria themselves so that lessons learned can be fed back into future projects. The monitoring and review of achievement in relation to each of these service aims will be built into the work plans of the management team as appropriate.

17.8 Project Completion Evaluation

Following satisfactory completion of the project, a Project Completion Evaluation will be undertaken. The focus will be the evaluation of the procurement process and the lessons to be learned made available to others. The report will review the success of the project against its original objectives, its performance in terms of time, cost and quality outcomes and whether it has delivered value for money. It will also provide information on key performance indicators.

The evaluation would be implemented (in accordance with the SCIM guidance documentation) in order to determine the project's success and learn from any issues encountered. It will also assess to what extent project objectives have been achieved, whether time and cost constraints have been met and an evaluation of value for money.

This review will be undertaken by senior member of the Project Board with assistance as necessary from the Project Manager.

The following strategy and timescales will be adopted with respect to project evaluation.

- A post project evaluation will be undertaken within 6 months after occupation.
- The benefit realisation register, developed during the Full Business Case stage, will be used to assess project achievements.

In parallel with the Post Project Evaluation the review will incorporate the views of user groups and stakeholders generally.

Whilst review will be undertaken throughout the life of a project to identify opportunities for continuous improvement, evaluation activities will be undertaken at four key stages:

Project Completion Evaluation stages

Stage 1	At the initial stage of the project, the scope and cost of the work will be planned out.
Stage 2	Progress will be monitored and evaluation of the project outputs will be carried out on completion of the facility.
Stage 3	Post-project evaluation of the service outcomes 6 months after the facility has been commissioned.
Stage 4	Follow-up post-project evaluation to assess longer-term service outcomes two years after the facility has been commissioned.

The evaluation review for this project will include the following elements:

17.8.1 Post Project Audit

The project audit will include:

- Brief description of the project objectives.
- Summary of any amendments to the original project requirements and reasons.
- Brief comment on the project form of contract and other contractual/agreement provisions. Were they appropriate?
- Organisation structure, its effectiveness and adequacy of expertise/skills available.
- Master schedule – project milestones and key activities highlighting planned v actual and where they met?
- Unusual developments and difficulties encountered and their solutions.

Brief summary of any strengths, weaknesses and lessons learned, with an overview of how effectively the project was executed with respect to the designated requirements of:

- Cost
- Planning and scheduling
- Technical competency
- Quality
- Safety, health and environmental aspects – e.g. energy performance
- Functional suitability
- Was the project brief fulfilled and does the facility meet the service needs? What needs tweaking and how could further improvements be made on a value for money basis?

- Added value area, including identification of those not previously accepted
- Compliance with requirements
- Indication of any improvements, which could be made in future projects

17.8.2 **Cost and Time Study**

The cost and time study will involve a review of the following:

- Effectiveness of:
    - Cost and budgetary controls, any reasons for deviation from the business case time and cost estimates.
    - Claims procedures.
- Authorised and final cost.
- Planned against actual cost and analysis of original and final budget.
- Impact of claims.
- Maintenance of necessary records to enable the financial close of the project.
- Identification of times extensions and cost differentials resulting from amendments to original requirements and/or other factors.
- Brief analysis of original and final schedules, including stipulated and actual completion date; reasons for any variations.

17.8.3 **Performance Study**

The performance study will review the following:

- Planning and scheduling activities.
- Were procedures correct and controls effective?
- Were there sufficient resources to carry out work in an effective manner?
- Activities performed in a satisfactory manner and those deemed to have been unsatisfactory.
- Performance rating (confidential) of the consultants and contractors, for future use.

17.8.4 **Project Feedback**

Project feedback reflects the lessons learnt at various stages of the project. Project feedback is, and will be, obtained from all participants in the project team at various stages or at the end of key decision making stages.

The feedback includes:

- Brief description of the project.

- Outline of the project team.
- Form of contract and value.
- Feedback on contract (suitability, administration, incentives etc).
- Technical design.
- Construction methodology.
- Comments of the technical solution chosen.
- Any technical lessons learnt.
- Comments on consultants appointments.
- Comment on project schedule.
- Comments on cost control.
- Change management system.
- Major source(s) of changes/variations.
- Overall risk management performance.
- Overall financial performance.
- Communication issues.
- Organisational issues.
- Comments on client's role/decision making process.
- Comments on overall project management.
- Any other comments.

Appendix A – Care Home Modelling

Appendix B – Formative Evaluation Discharge Programme

Appendix C - Tweedbank Appraisal

Appendix D – Proposed Model of Care and Revenue Costing

Scottish Borders Care Home Modelling

Overview of current findings

26th July 2021

The Ask

- Aim:
  - 10-year forward projection of 24-hour care demand for older people
- Output:
  - expected changes in 24-hour care demand broken down by
    - residential care,
    - nursing care
    - specialist care provision.
  - worse case and best case scenarios (potential for mid-range scenario)
- Methodology:
  - expected demographic changes in population at a locality level with adjustments for other predicted changes (migration etc).
- Assumptions to be applied to the model:
  - Expected changes in population frailty or dependency levels
  - Expected changes in dementia prevalence and need for 24-hour care
  - **Impact of changes in models of care on demand for 24-hour care**

Note on data

- 3 data sources
  - Care Home Census – end March snapshot survey of all care home residents in each area
  - SBC Care Home resident data – end March snapshot of SBC-funded care home residents (all locations)
  - NRS Population Projections

- Challenges
  - Reconciling two different datasets
  - Snapshot data – does not reflect in-year variation

Summary

- Demographic projection predicts need for additional 188 care home places by 2030 (30% increase)
  - This represents between **8-11** additional care home places per year

HOWEVER

- Borders benchmarks in lowest 4 LAs for care home places
- There has been no change in Borders care home places 2009-2019 despite 20% increase in >75 Borders population
- The number of SBC-funded residents outwith Borders has been steady at 20% (past 5 yrs)
- Borders benchmarks in lowest 6 LAs for home care packages

- Suggestion that rurality and community/family support is maintaining more people at home

- % of residents who remain in their own locality is directly related to the number of care home beds in a locality (0.91 correlation)

Implications

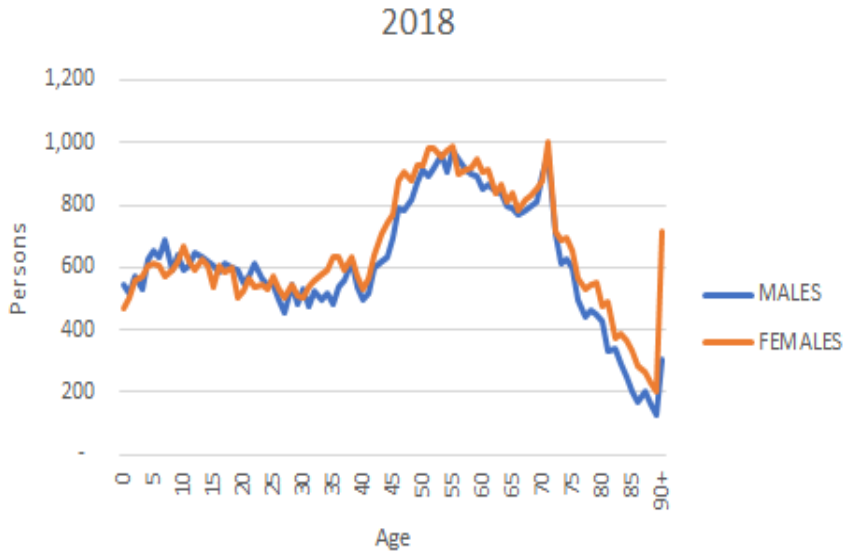
- Measures that could reduce demand for care home bed increases (from stakeholder meetings)
  - Intensive Rehabilitation support
  - Staff Education on appropriate referrals to care homes
  - Provision of early intervention and crisis support
  - Actions to
    - address lack of social contacts/loneliness and isolation
    - reduce cognitive deterioration and functional decline
  - Actions to support healthy living - 'Live Well, Eat Well', Dementia-friendly communities
  - Different approach to managing pathway from hospital to care
  - Support for Carer Stress and burnout (esp higher dependency clients)

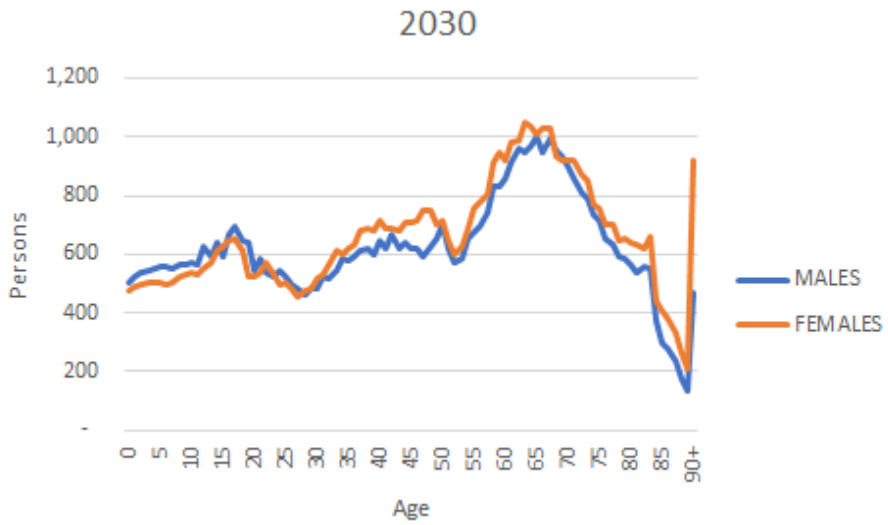
- Could reduce the 8-11 additional care home admissions/year

- Location of care home beds influences number of residents who stay in own locality

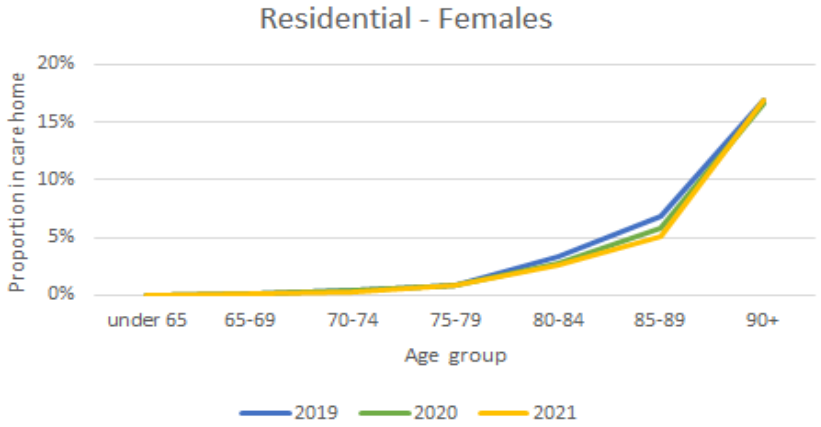
Phase 1: demographic modelling: Population analysis

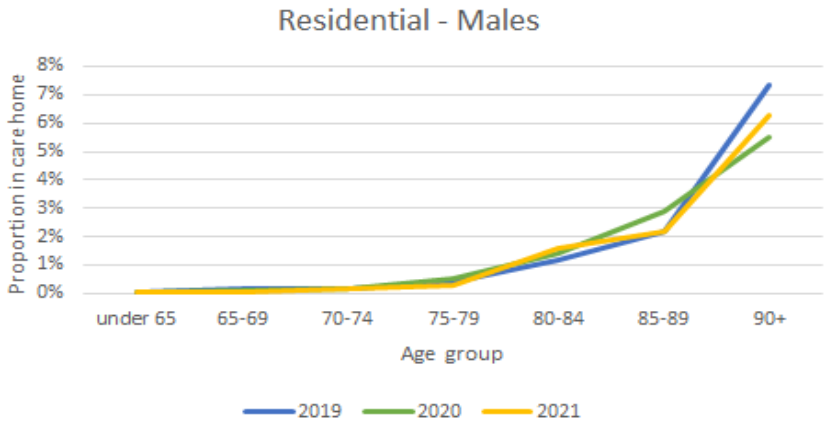
- Borders population currently dominated by people aged 50-70.
- By 2030,
  - 75+ population expected to grow by >20%,
  - overall population will increase by about 1%.

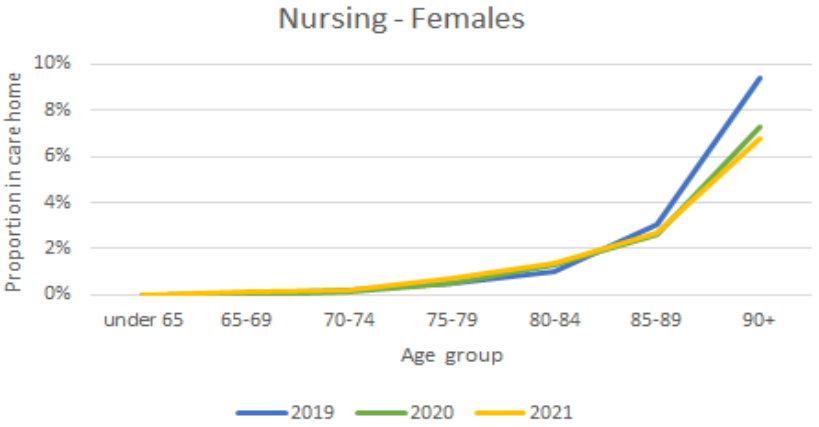


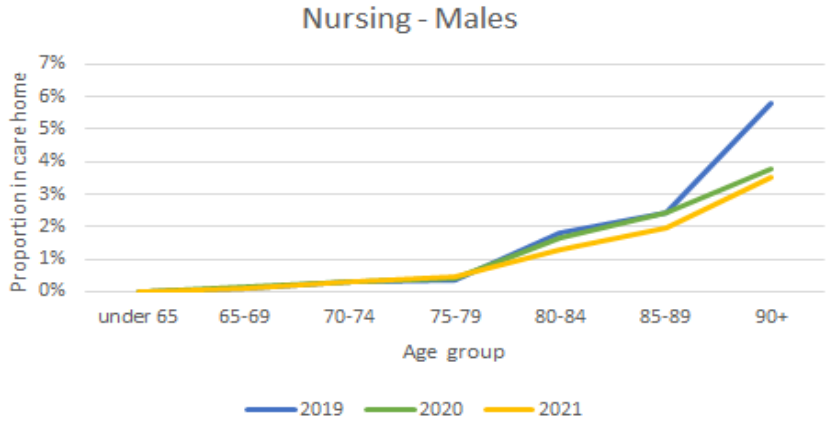


Percentage of population in long-term residential care (SBC-funded)



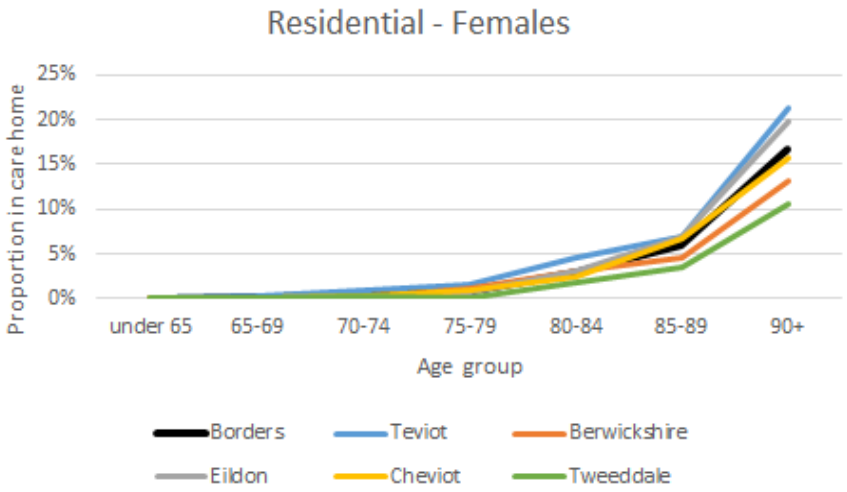


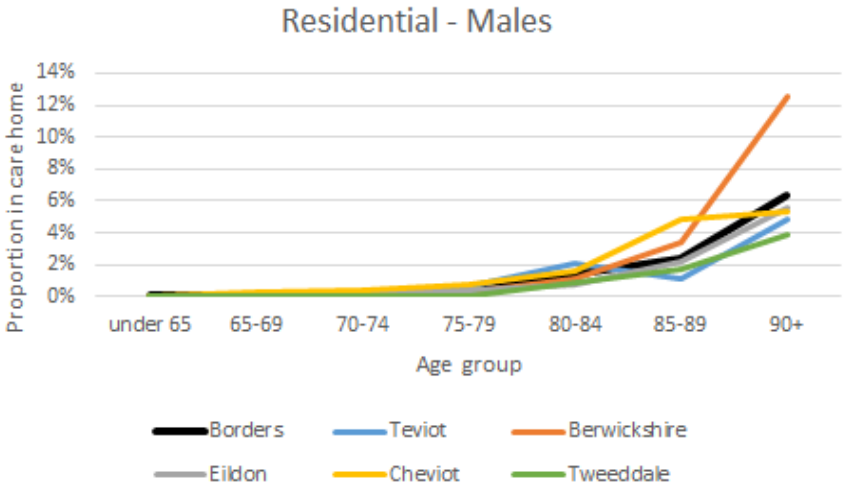


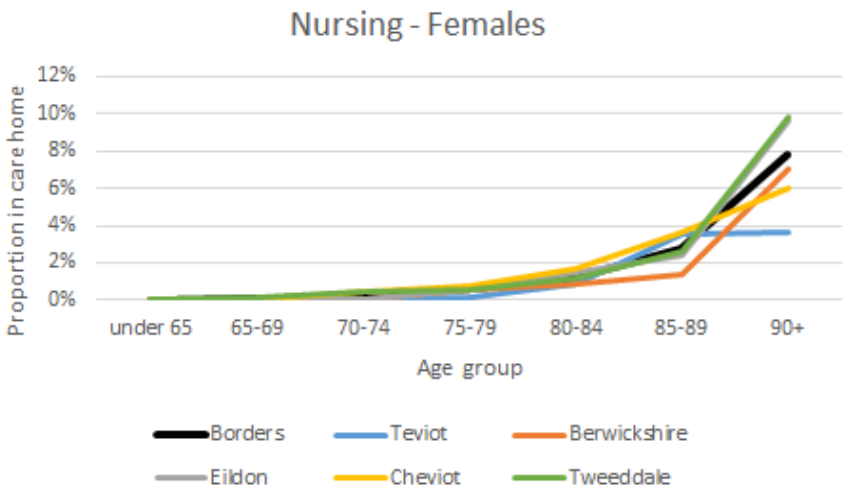


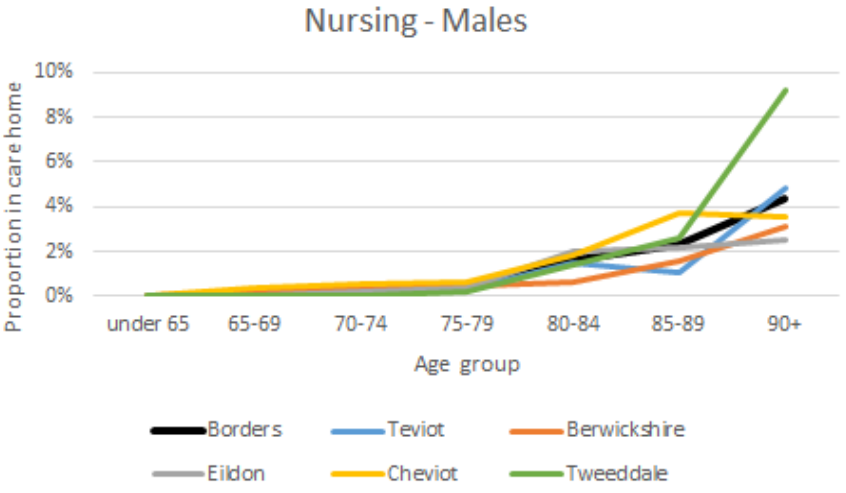
- Females - 3.5% of 80-84, 9% of 85-90 and 25% of 90+ pop. live in care homes
- Males – 3% of 80-84, 5% of 85-90 and 10.5% of 90+ pop. live in care homes

Percentage by locality









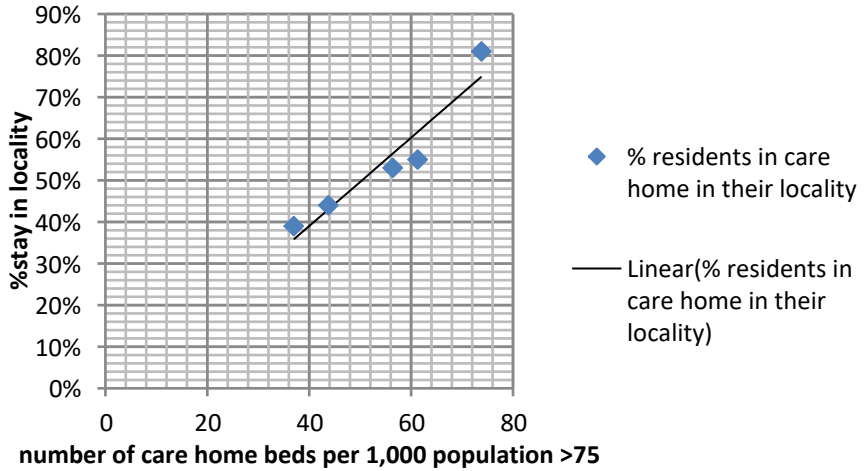
- Relatively little difference in care home occupancy by locality
- Tweeddale high for nursing home residents, Berwickshire high for male residential

Do people go into care homes in their locality?

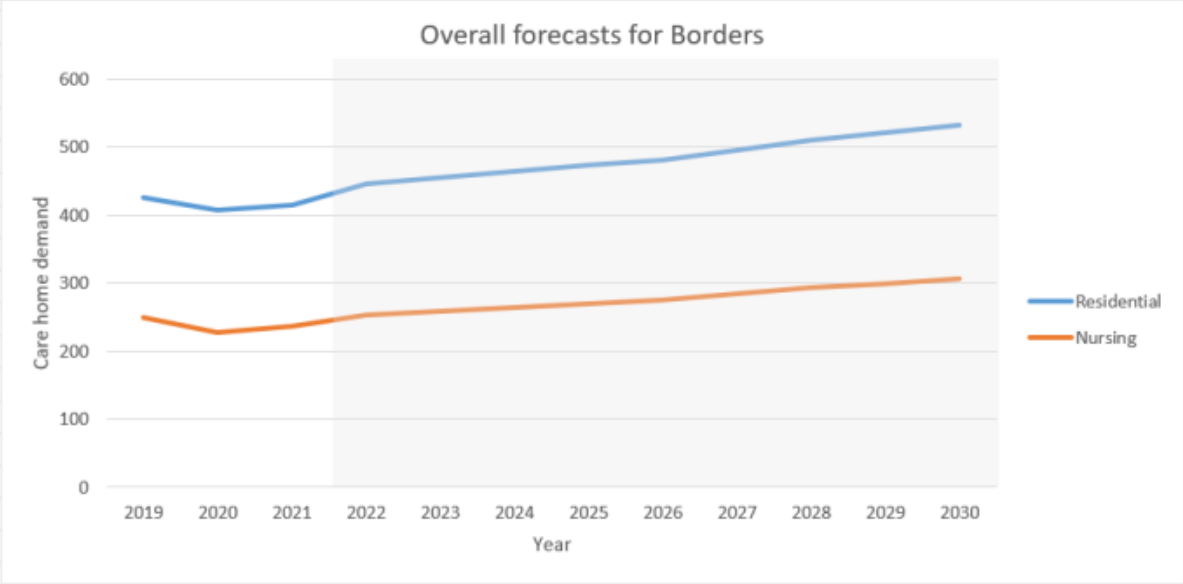
		Care home locality					
		Berwickshire	Cheviot	Eildon	Teviot and Liddesdale	Tweeddale	Outwith Borders
Client locality	Berwickshire	**39%**	5%	3%	2%	1%	50%
	Cheviot	18%	**53%**	11%	7%	1%	10%
	Eildon	2%	25%	**55%**	9%	4%	7%
	Teviot and Liddesdale	1%	12%	4%	**81%**	0%	2%
	Tweeddale	1%	13%	17%	1%	**44%**	26%

- 50% of Berwickshire care home residents live outwith Borders (mostly Berwick)
- Majority of residents go into care homes in their locality - Teviot (81%), Eildon (55%), Cheviot (53%)

There is a clear correlation (.91) between number of care home beds in a locality and % of residents who remain in their own locality



Care home demographic demand forecasting



Based on demographic change only, we can expect an increase of 188 beds by 2030
Residential:28% increase
Nursing: 29% increase

Year	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Care home residents - Residential	415	445	454	465	473	482	496	510	522	532
% increase from 2021	-	7%	9%	12%	14%	16%	20%	23%	26%	28%
Care home residents - Nursing	237	253	259	265	271	276	285	293	300	306
% increase from 2021	-	7%	9%	12%	14%	16%	20%	24%	27%	29%

NB: SBC-funded placements – in and out of area

Future demand by year

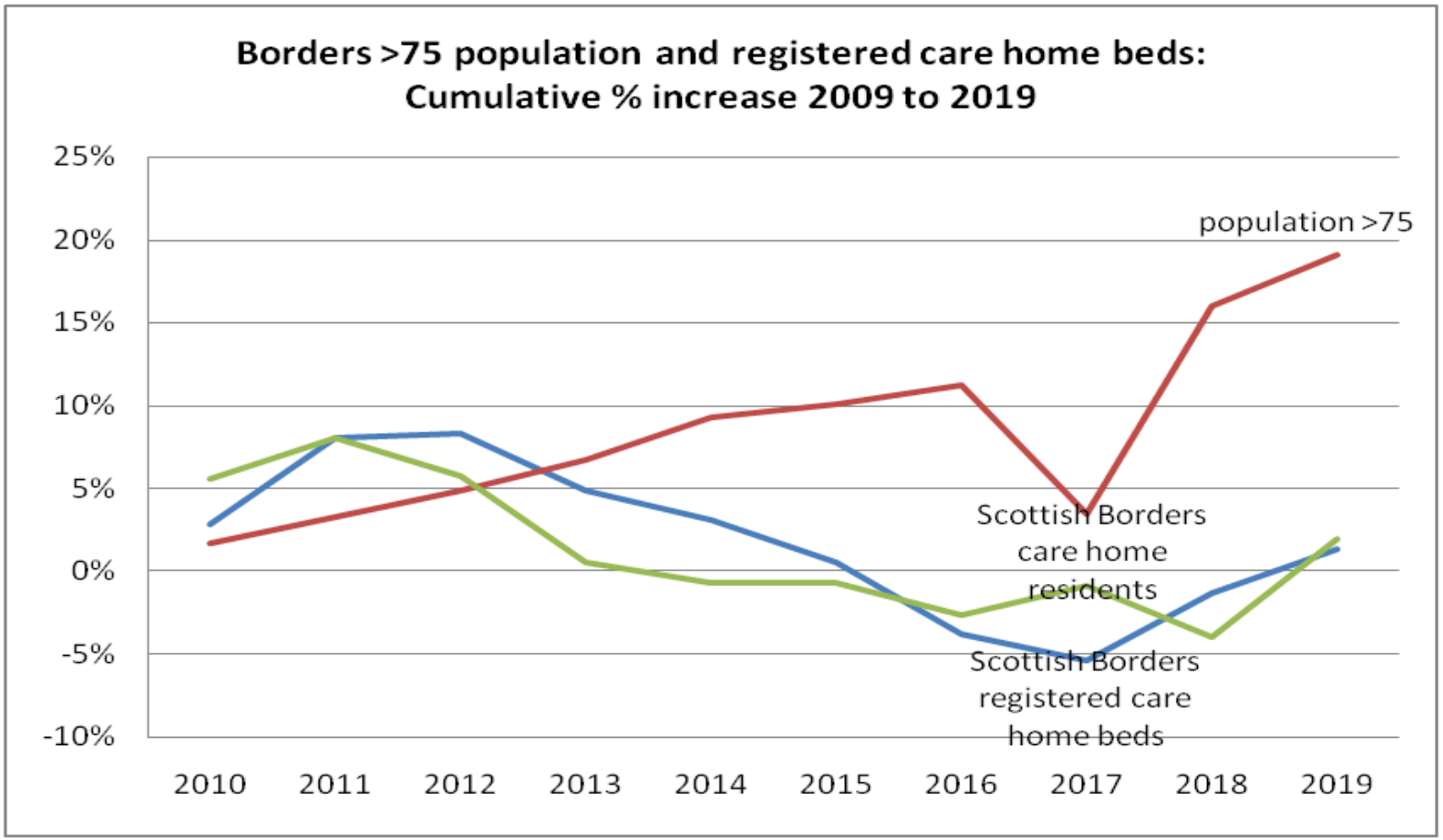
- Large jump in 2022 – probably data adjustment issue
- 2023-2026: increase of 14-17 beds/year.
- 2027-2029: increase of 19-23 beds/year.
- This equates to 8-11 **additional** admissions/year

(Ave length of stay for Borders residents is 1.4 (median) to 1.9 (mean) yrs)

Annual increase	2022	2023	2024	2025	2026	2027	2028	2029	2030
Care Home residents - residential	30	9	11	8	9	14	14	12	10
Care Home residents - nursing	16	6	6	6	5	9	8	7	6
Care Home residents - Total	46	15	17	14	14	23	22	19	16
Extra admissions/year	**26**	**8**	**9**	**8**	**8**	**13**	**12**	**11**	**9**

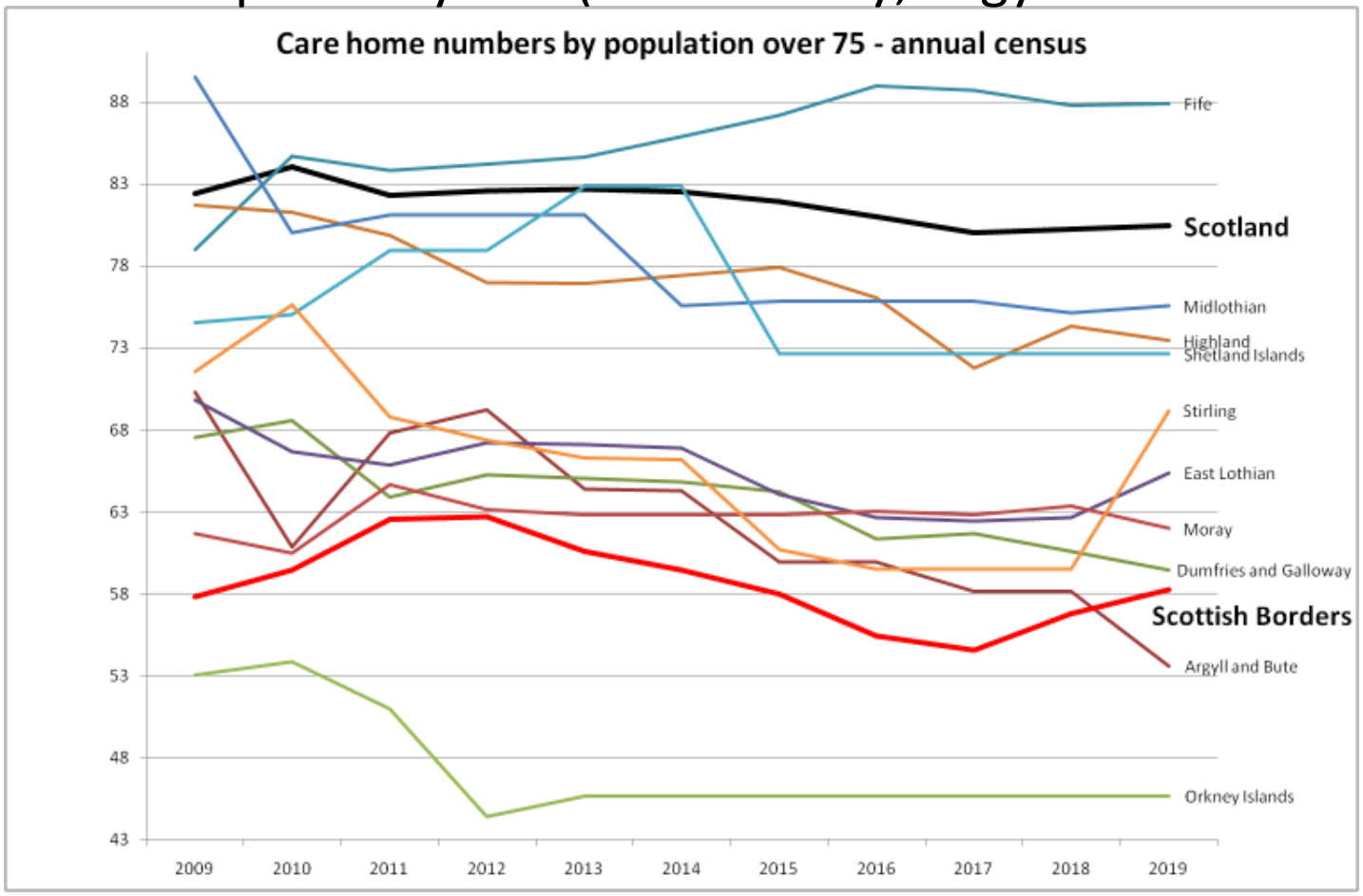
Care home places in Borders

- Between 2009 -2019:
  - >75 population in the Borders increased by 20%
  - Care home beds & care home residents increased by 1%



How do we compare?

Borders amongst 4 LAs with lowest rate of care home beds per head population for past 10 years (with Orkney, Argyll and Bute and D&G)

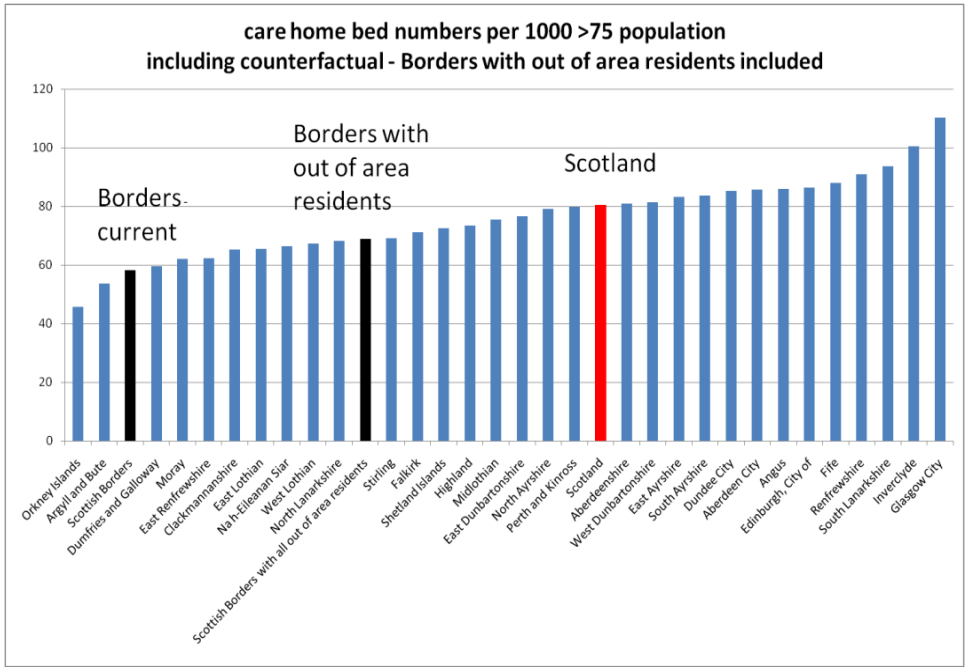


NB: Data from Scottish Care Home Census reports total care home beds in Borders – but closely correlates to SBC-funded care home numbers (.73-.98)

Are Borders care home residents accommodated out of area?

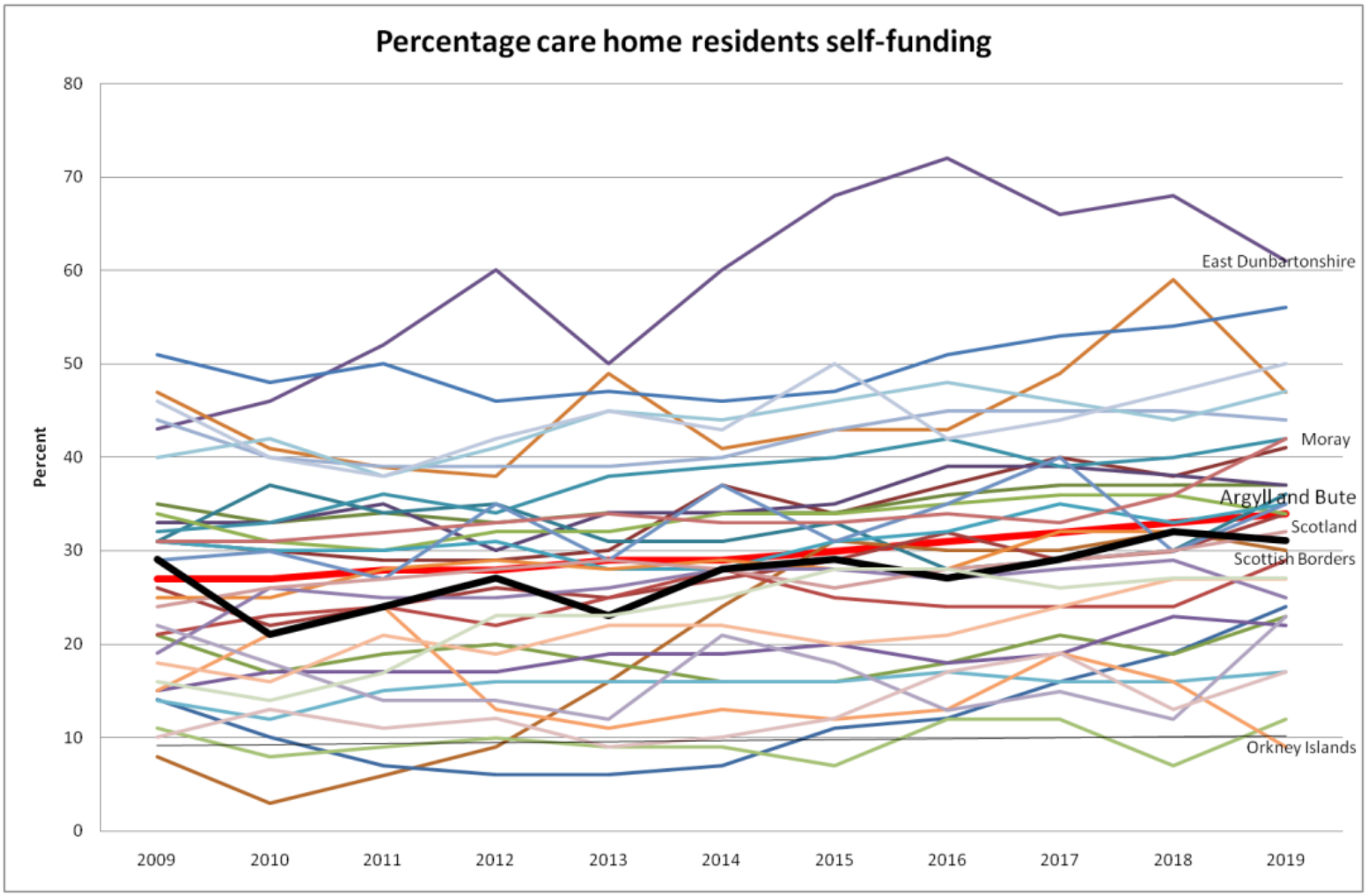
- SBC-funded out of area placements consistently around 20%
- Rate of out of area placements for other LAs unknown
- Out of area placements –
  - Berwick (53) – nearly all Berwickshire residents
  - Edinburgh (44) = up to 50% Tweeddale residents
  - Other areas (37)

Counter-factual check – if all out-of-area residents were in Borders care homes, Borders would still be well below Scottish average



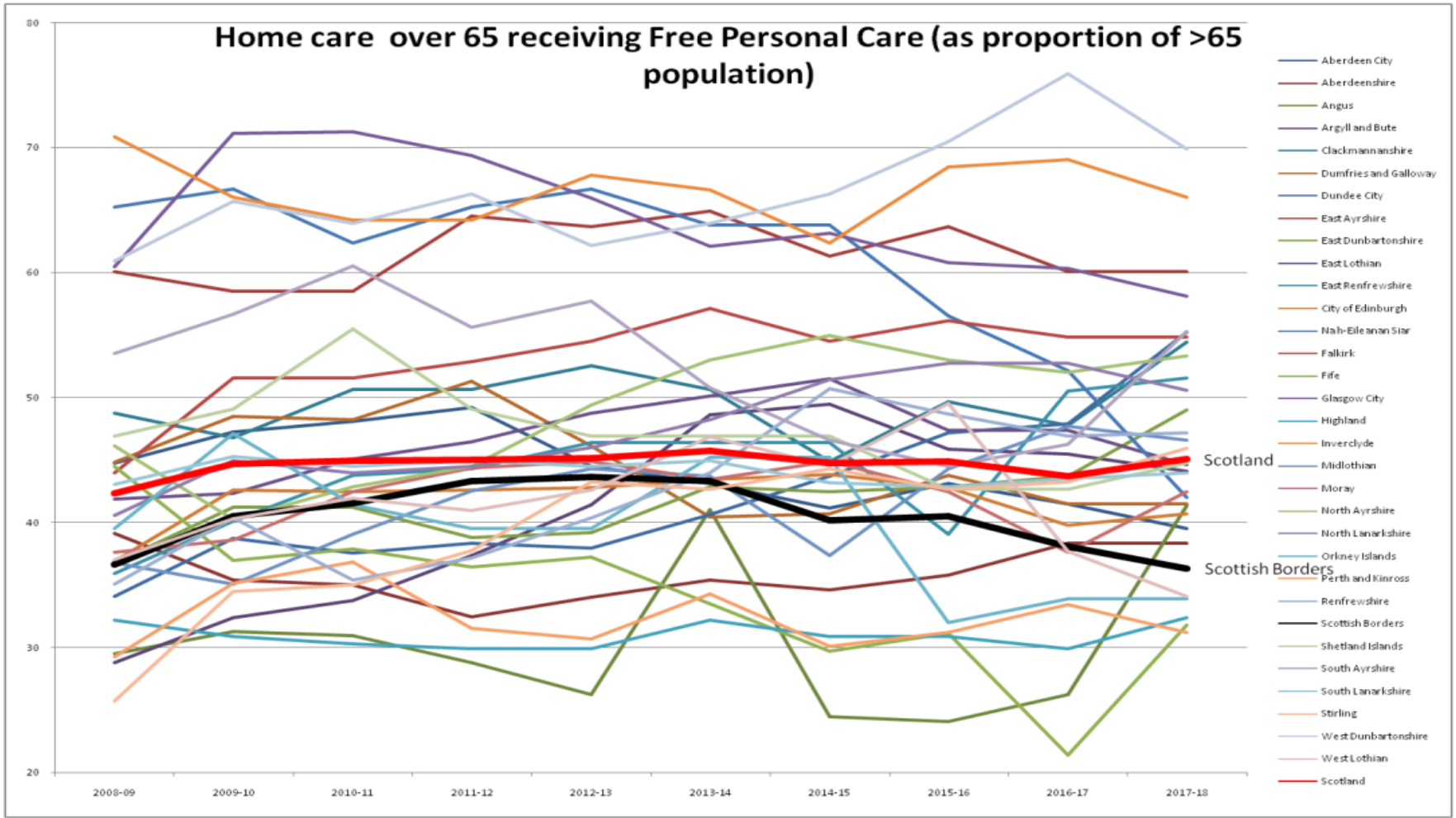
Is there a higher proportion of Borders residents self-funding?

- Scottish Borders slightly below Scottish average



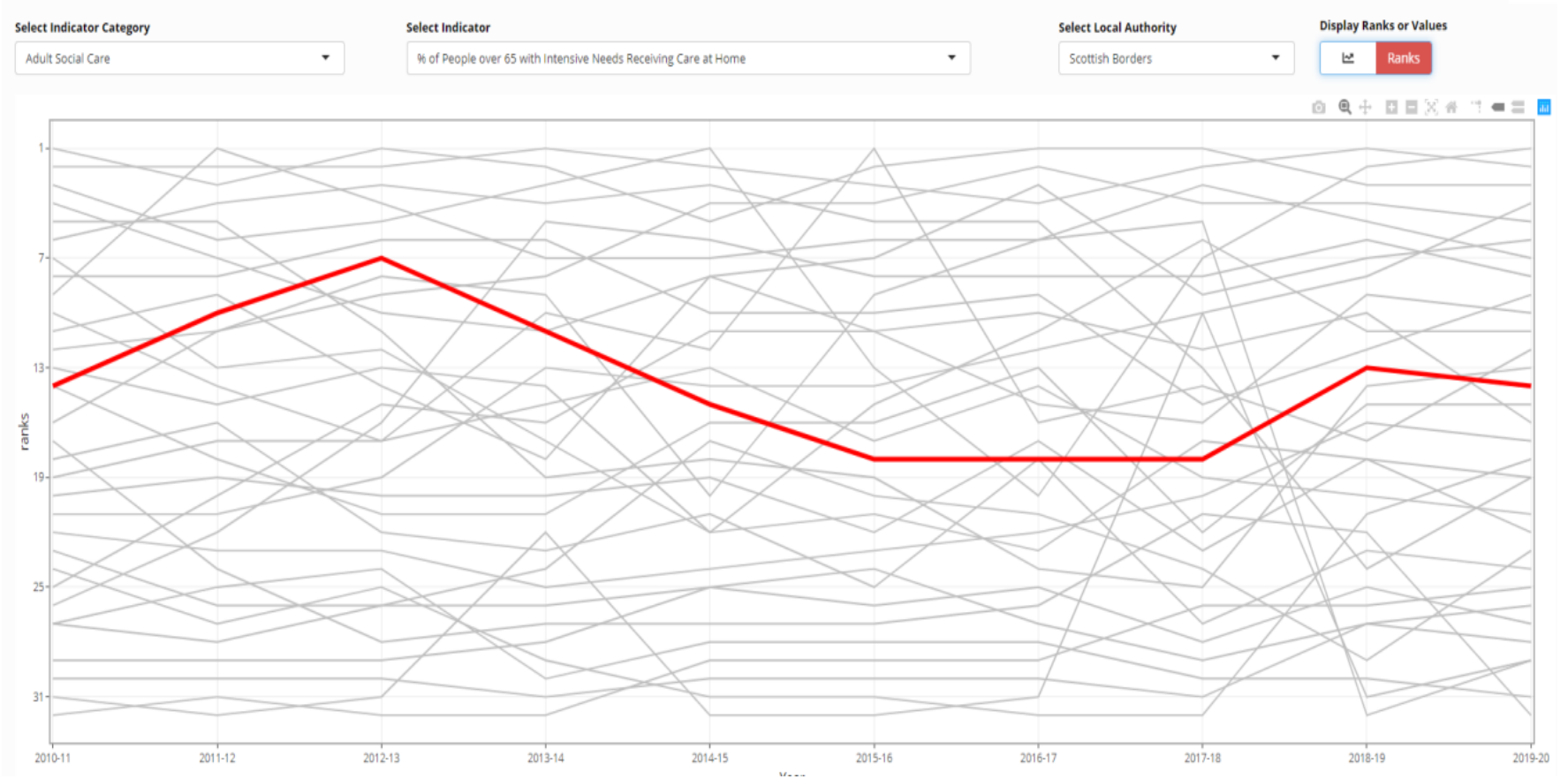
Is there a higher proportion of older people receiving care at home in Borders?

- Scottish Borders has 6th lowest level of care packages



Are older people home care packages larger (more intensive) in Borders?

- Scottish Borders ranks 14th out of 32 for level of care hours (below Argyll & Bute, Orkney, D&G and Stirling but above Moray)



Do more older people receive unpaid care in the Borders?

Unclear picture

- 2011 census
  - % of population providing unpaid care lower than Scottish average
  - % of population providing high intensity care lower than Scottish average

- Carers Centre: 'high level of unmet need'
  - Estimated 15,000 carers

Figure 43: Percentage of population providing care , Scotland 2011

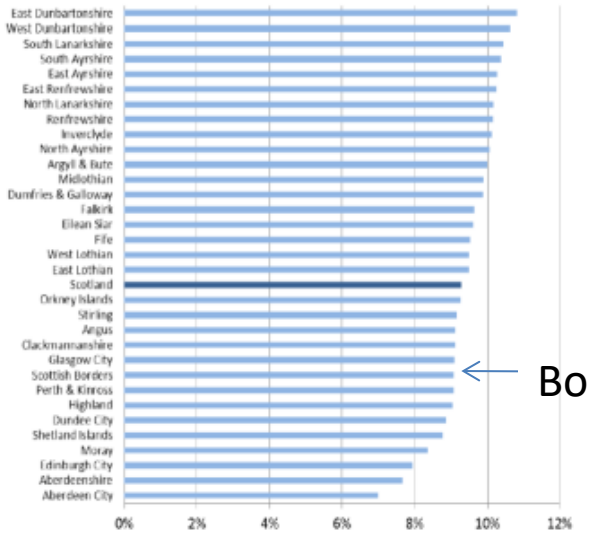
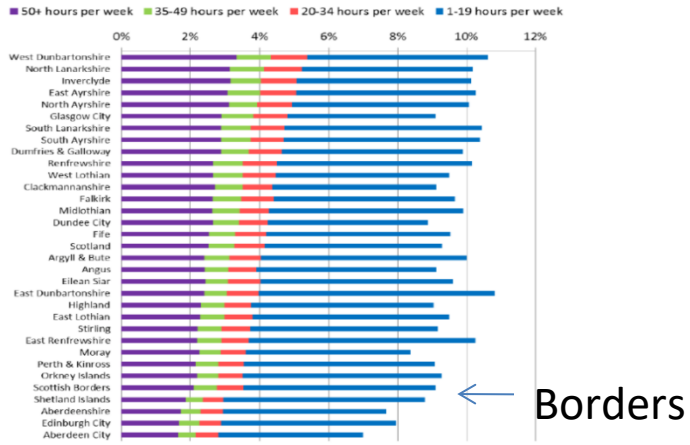


Figure 45: Percentage of population providing care, by intensity of caring, Scotland 2011
(Ranked according to percentage of population providing 35 hours of care each week)



Source: Scotland's 2011 Census

Carers Centre feedback

Reasons for lower level of placements:

- Level of care home placements – budget-driven
- Unmet needs
- Quality of care homes

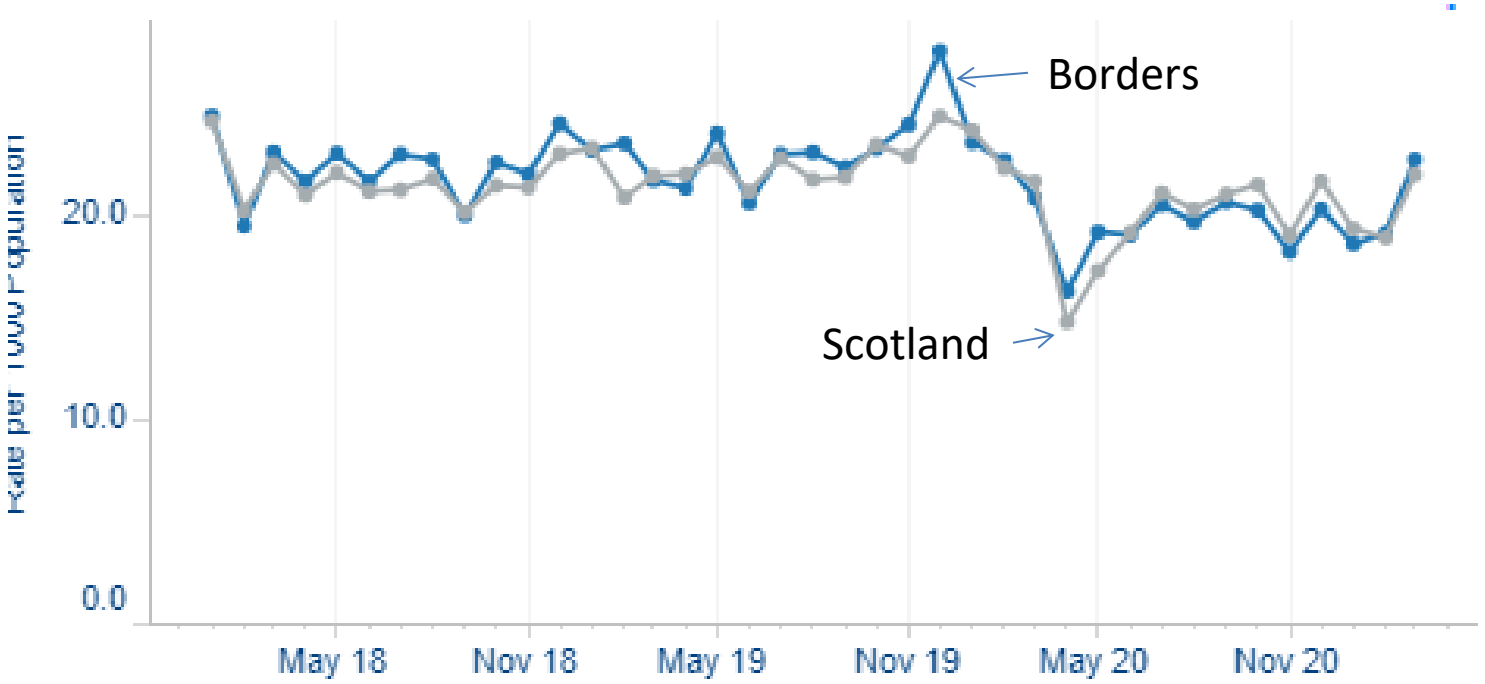
Main impact – higher dependency group

- Reduction in respite care
- Closure of day centres
- Deterioration during Covid
  - Isolation
  - Dementia

IS THERE HUGE UNMET NEED??

Unmet need - Do more older people get admitted to hospital ?

Borders rate of emergency admissions per 1000 70+ population is close to the national average



This suggests that Borders does not have a disproportionate number of older people admitted to hospital due to breakdown in care

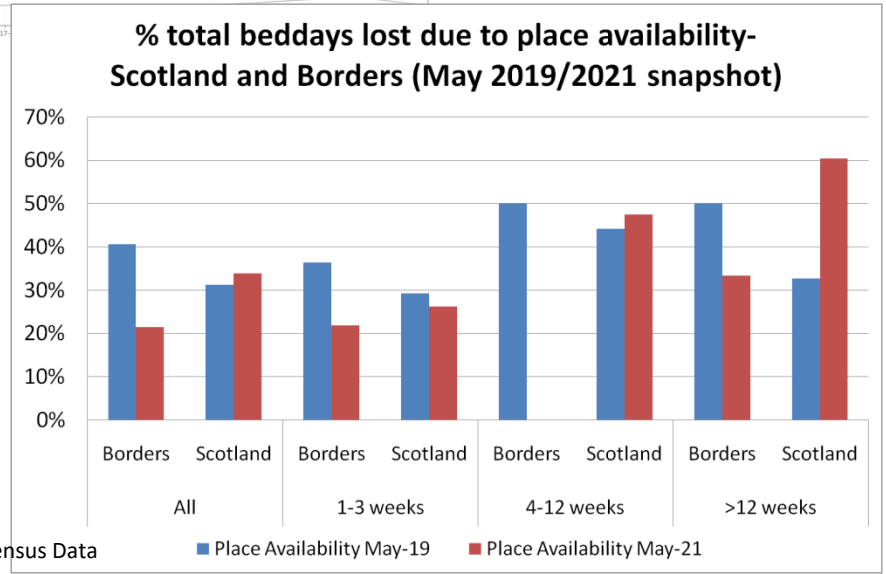
Unmet need – are more older people delayed waiting for care home?

Borders does not have disproportionate level of delays for care home beds

Source: Local Government Benchmarking Framework: https://scotland.shinyapps.io/is-local-government-benchmarking-framework-analysis/

Borders ranks 18th (out of 32) for number of days lost to delayed discharges

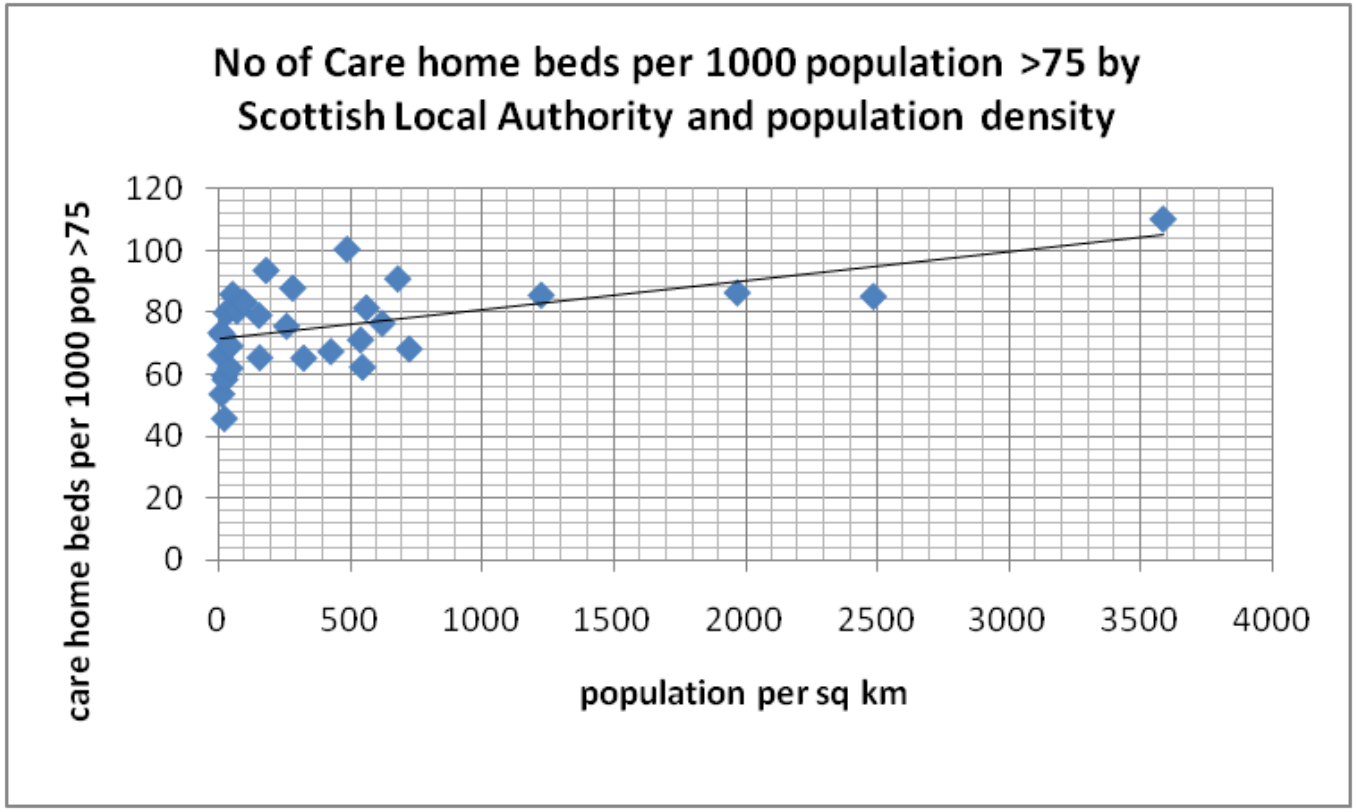
May snapshot indicates Borders is close to Scottish average for days lost due to waits for care home beds



Source: Delayed Discharge Census Data

Rural areas have lower numbers of care home beds

- There is a clear correlation (.75) between very high and very low population density and number of care home beds – correlation is less clear for intermediate density



What might be different in rural areas?

- Populations who have lived in an area for > 25 years have stronger informal (family) networks (but less use of community supports) Burholt et al, **The impact of residential immobility and population turnover on the support networks of older people living in rural areas: Evidence from CFAS Wales,** *Popul Space Place. 2018;**24:e2132.*** https://doi.org/10.1002/psp.2132
- Admissions to care homes in rural areas are 75% of urban and intermediate areas – due to better family support (N. Ireland study) McCann et al, Urban and rural differences in risk of admission to a care home: A census-based follow-up study , http://dx.doi.org/10.1016/j.healthplace.2014.09.009

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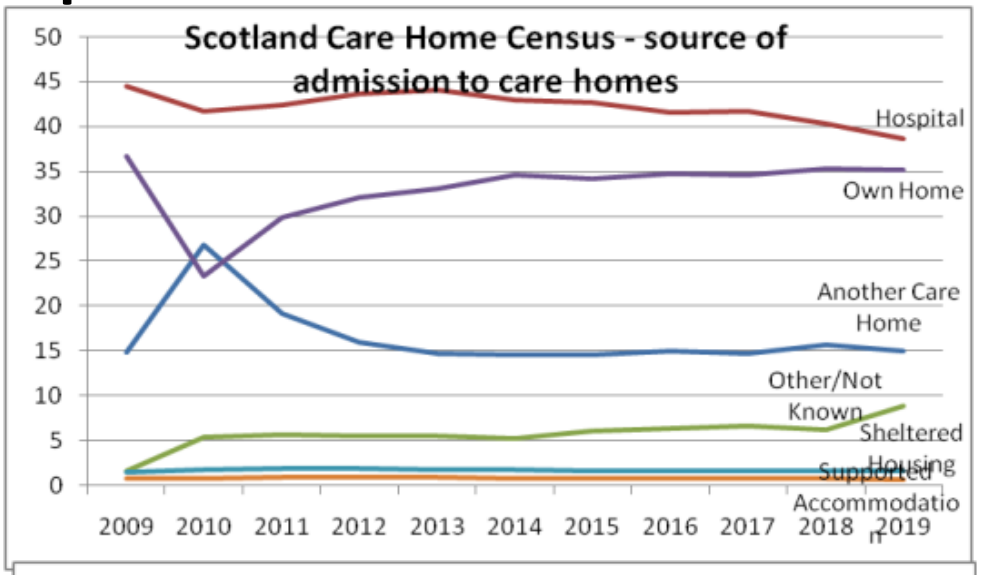
Most care home admissions are from hospital

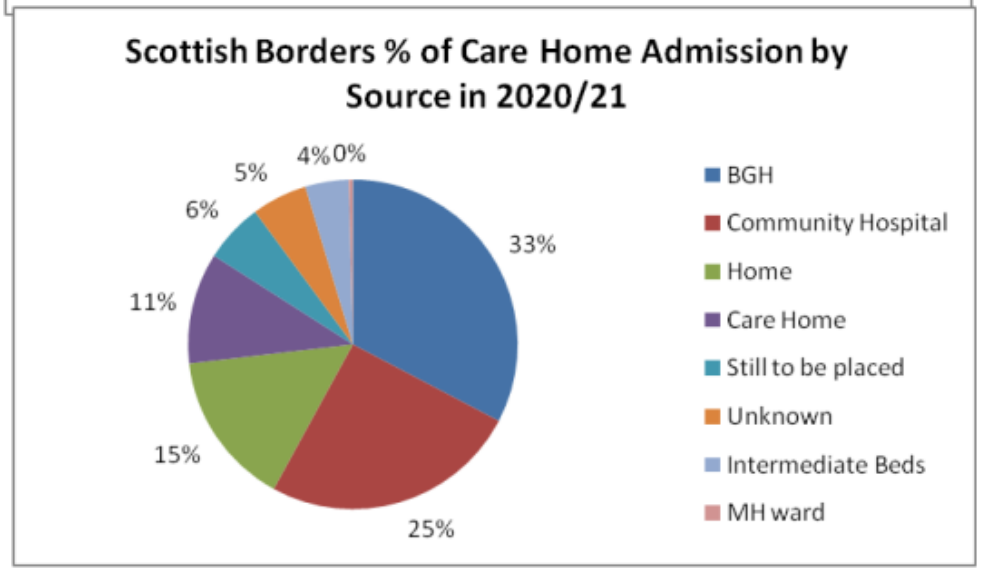
Scotland-level data:

- around 40% of admissions from hospital
- around 35% from own home.



In Borders (20-21 Strata data)

- 33% of admissions from BGH
- 25% from community hospitals (some community hospital admissions could be intermediate care)
- 15% from own home



How might we reduce care home admissions?

- Deterioration in cognition and behavioural and psychological symptoms, and caregiver burden were strongest predictors for dementia sufferer admission to care home : Toot et al, Causes of nursing home placement for older people with dementia: a systematic review and meta-analysis, https://www.cambridge.org/core/journals/international-psychogeriatrics/article/causes-of-nursing-home-placement-for-older-people-with-dementia-a-systematic-review-and-metaanalysis/62B350693121CB1E1B109714A58CD343

- Domiciliary multidimensional assessment and follow-up visits – 34% reduction
- Dementia carer training – delays admission to care homes by 20 months
- Short term rehabilitation – reduces care home admissions Lewis, 2007, https://www.kingsfund.org.uk/sites/default/files/Predicting%20book%20final.pdf)

- Care giver distress = 3rd strongest predictor for care home admissions (Bettini et al, 2017, https://link.springer.com/article/10.1186/s12913-017-2671-8)
- Loneliness as risk factor - ?20% of reasons for admission (Hanratty, 2018, https://academic.oup.com/ageing/article/47/6/896/5051695?login=true)

Stakeholder suggested areas/ideas

1. Rehabilitation support - Work underway - steering group
2. Staff Education to reduce inappropriate referrals (based on a number of reviews of care home referrals)
3. Provision of early intervention and crisis support
   - Community MDTs, Older Peoples Assessment Area, Intensive Home care (eg Tayside)
4. Actions to address lack of social contacts/loneliness and isolation and to reduce cognitive deterioration and functional decline
5. Supporting healthy living
   1. 'Live Well, Eat Well', Dementia-friendly communities (building on success of Innerleithen & Eyemouth)
   2. Digital support, Locality support
6. Different approach to managing pathway from hospital to care homes – Home First, other step down arrangements
7. Support for Carer Stress and burnout (esp higher dependency clients)
   - Directory of community support, Step-up care, Respite, Access to day centres

Impact on care home demand (Next Steps)

- Quantify potential impact
- Identify timelines for
  - implementation and when
  - impact on reduced care home admissions
- Assess impact on care home demand
- Comparison of resources required (cost-benefit analysis)

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:

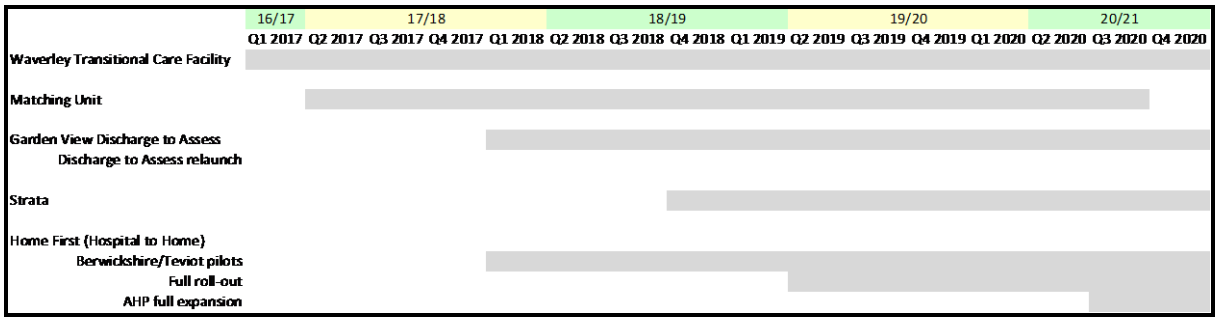
- Bed based Intermediate care in Waverley Transitional Care beds
- Step-down care in Garden View Discharge to Assess facility
- Reablement and crisis response at home in Hospital to Home, now known as Home First

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

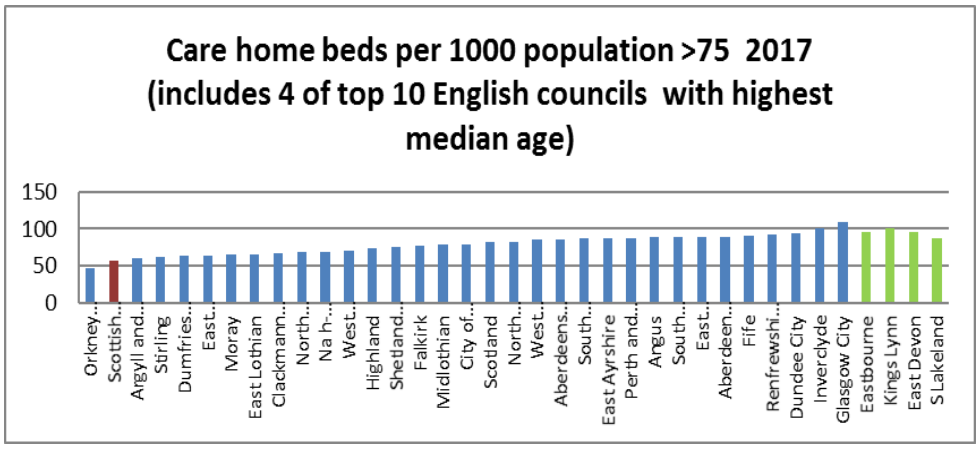
24% of the Scottish Borders population are age 65+, well above the Scottish average of 19% (2019 mid-year population estimates). Projections indicate the population aged 75+ will almost double by 2041 (Table 1). As they age, older people are more likely to live with frailty or long term conditions, associated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

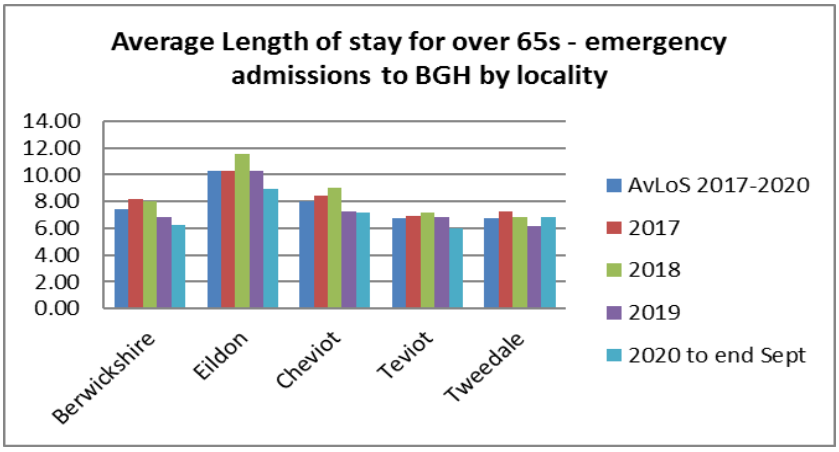
Fig 2. Care home provision by HSCP



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

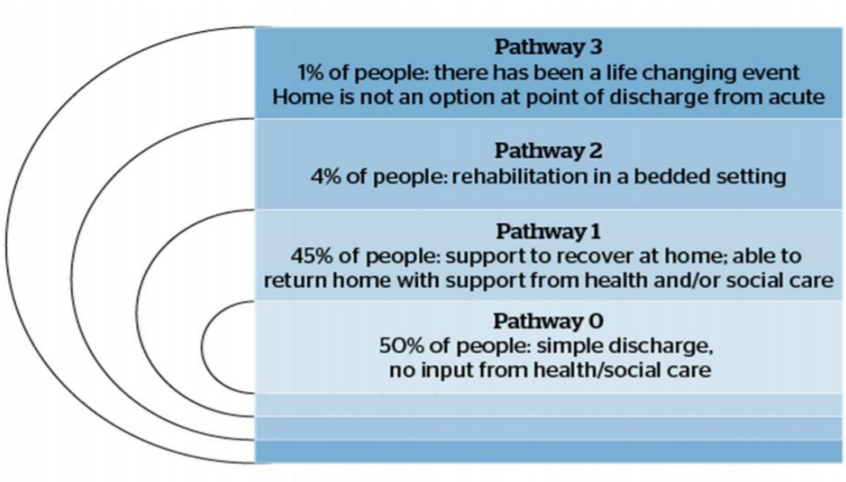
An international consensus study **(5)** agreed that Transitional care services are a subset of a broader continuum of **Intermediate Care**: a range of time-limited services that aim to ensure continuity and quality of care; promote recovery; restore independence and confidence; or prevent a decline 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

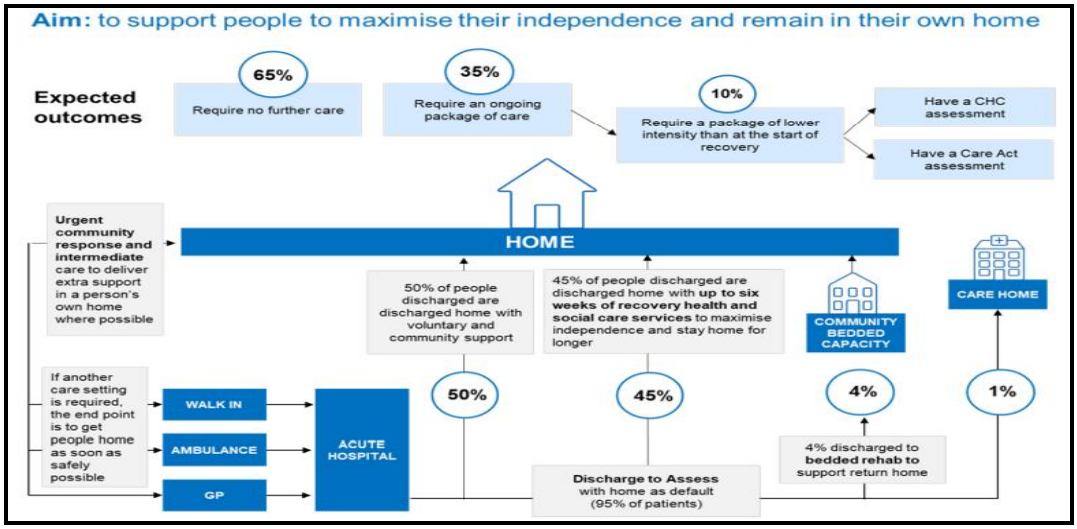


Pathways 1 and 2 are sometimes described as Discharge to Assess (D2A). The Local Government Association (LGA) and Association of Directors of Adult Social Care (ADASS) recommend that the

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

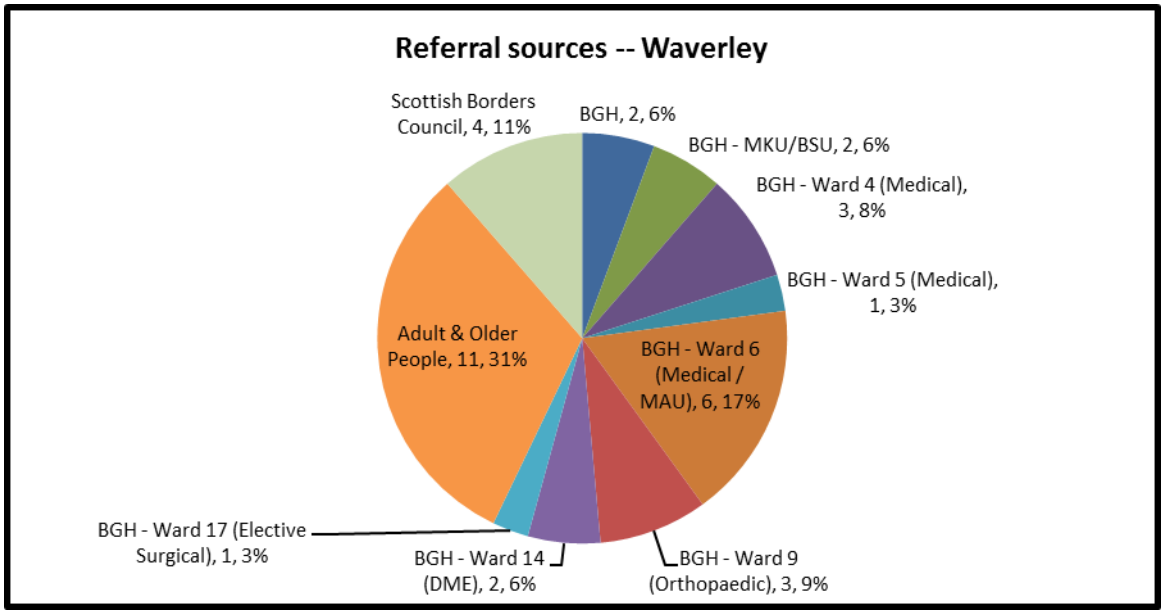
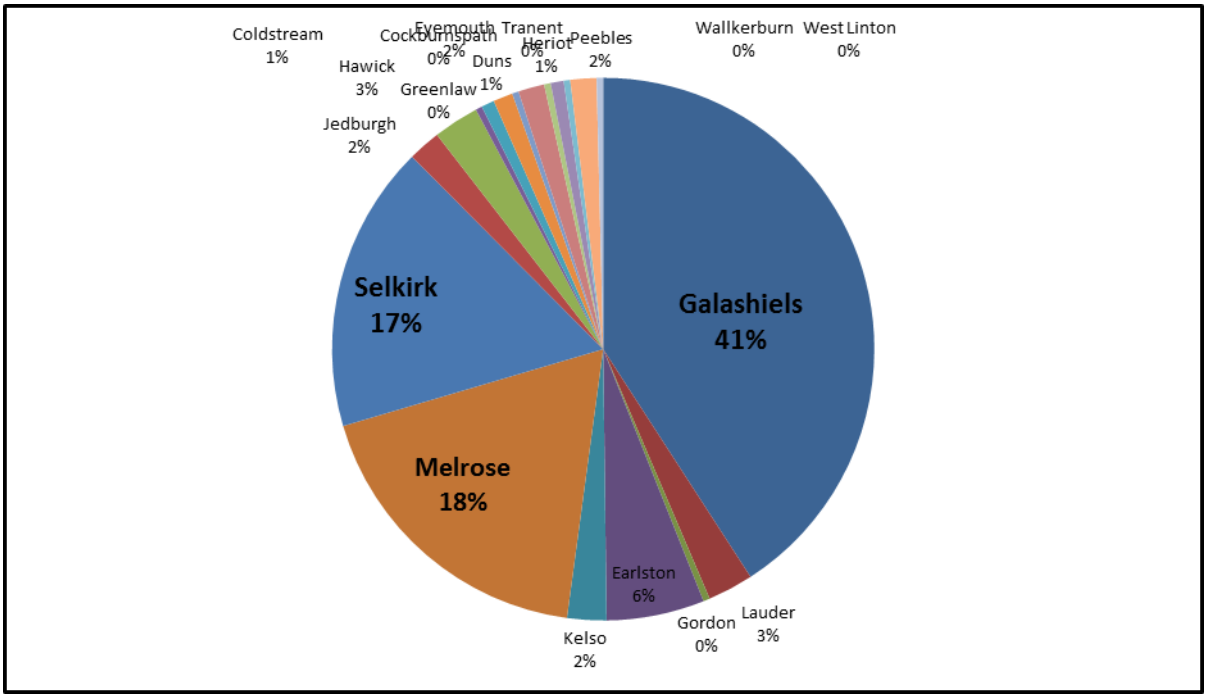


Figure 7 shows 85% of admissions to Waverley lived in Central Borders.

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

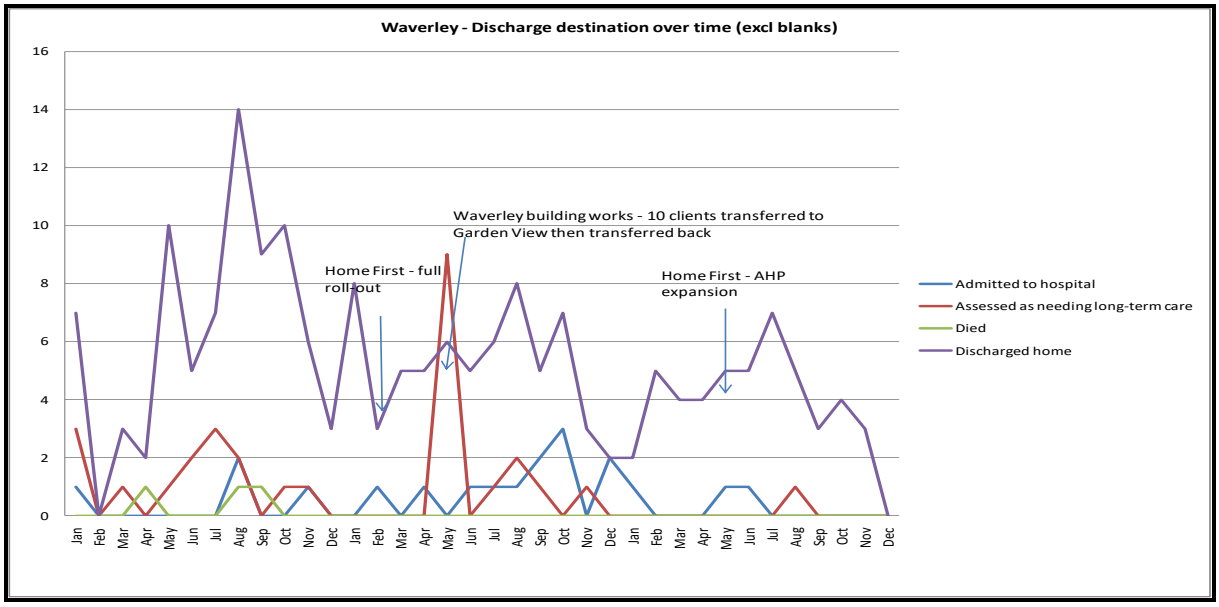
The low levels of cognitive impairment suggests a presumption that those with cognitive impairment have limited potential for rehabilitation, explicit in the admission criteria ''able to understand and be motivated to engage with their rehabilitation plan'' and ''Must be able to engage in a prescribed 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.

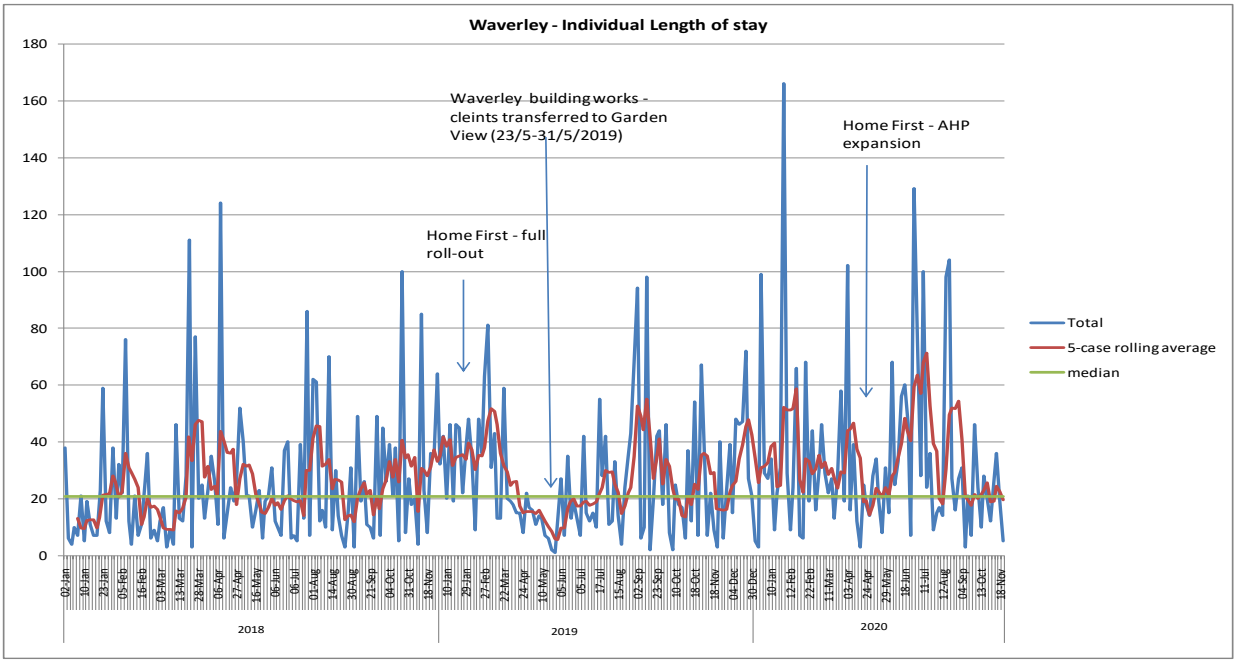
In the latest inspection report by the Care Inspectorate (October 2019), the four residents surveyed felt safe, accepted, treated kindly and satisfied with their care. The six relatives interviewed felt Waverley staff were fair, kind and treated their relatives with dignity. They suggested there could 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

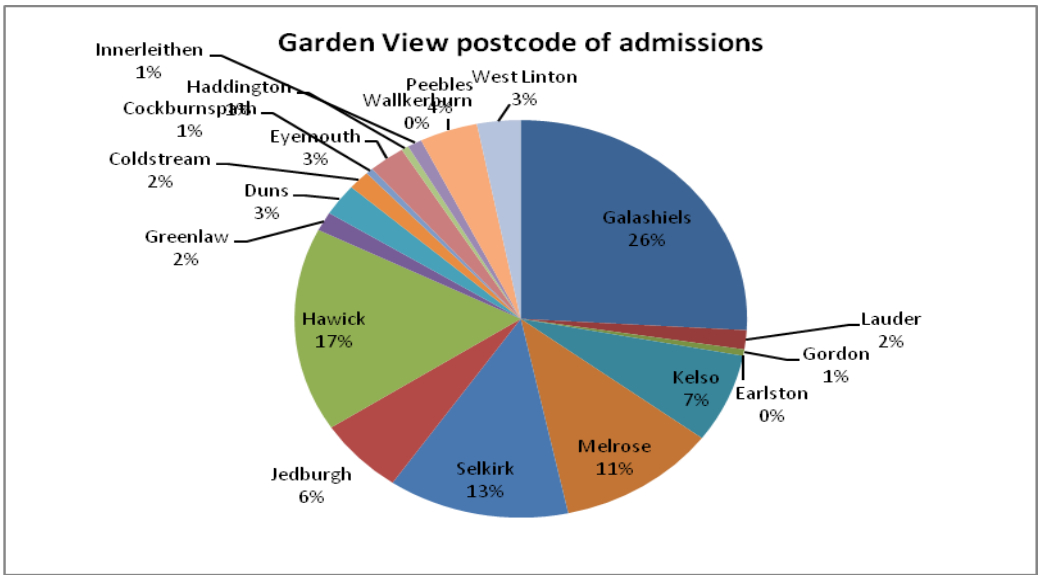
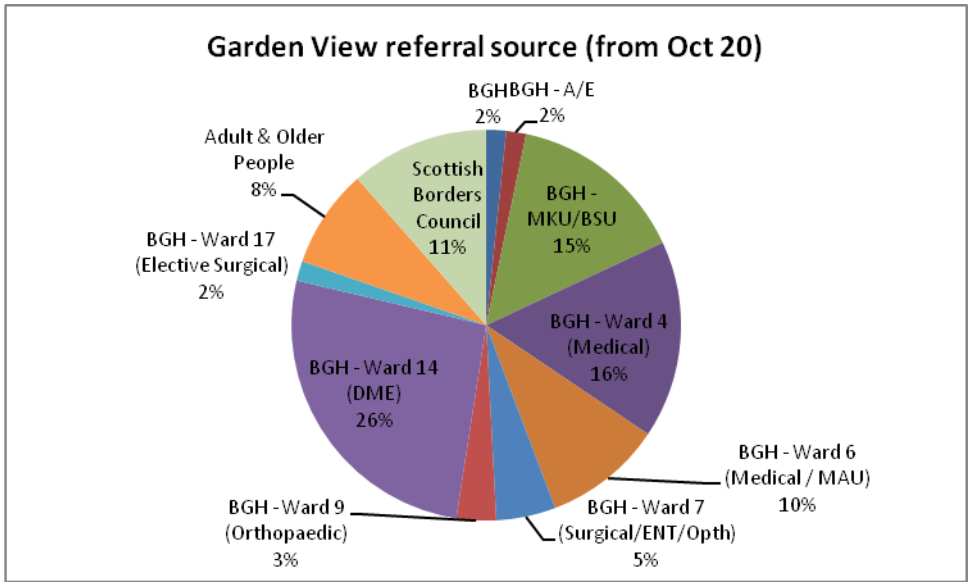


Figure 11 shows the source of referrals. All were step down following an episode of acute care at BGH and no referrals were from community hospitals. Using recent information from Strata, just over half of the admissions were transferred from BGH Medicine for the Elderly wards, Ward 4 or BSU/ MKU. Most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

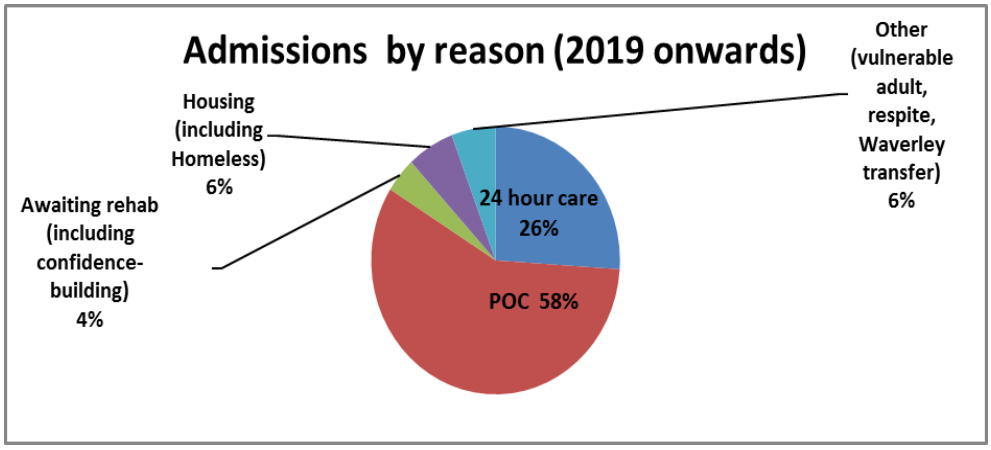
The casemix was broadly similar to Waverley but the Garden View cohort had a higher prevalence of people with cognitive impairment, including Adults with Incapacity, and a slightly lower proportion (75%) who had mobility issues.

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

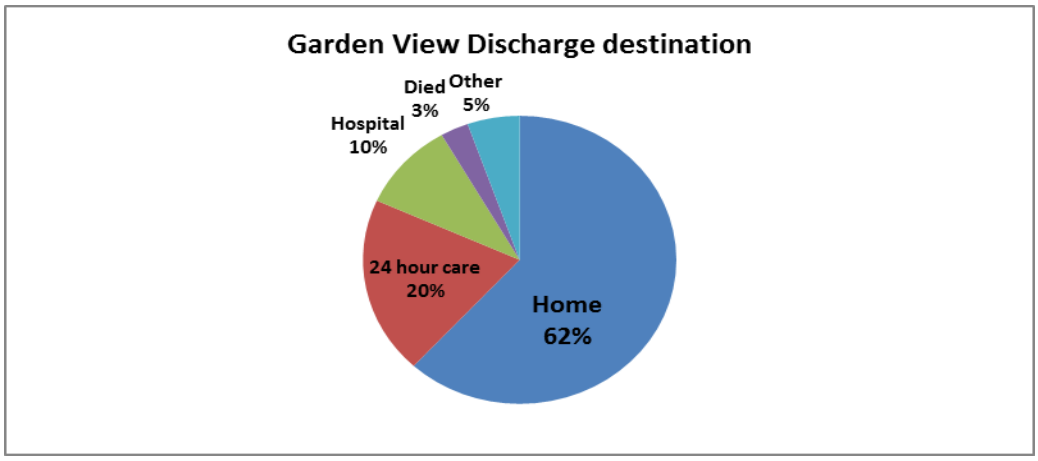
Fig. 12 Admission Goals



Outcomes

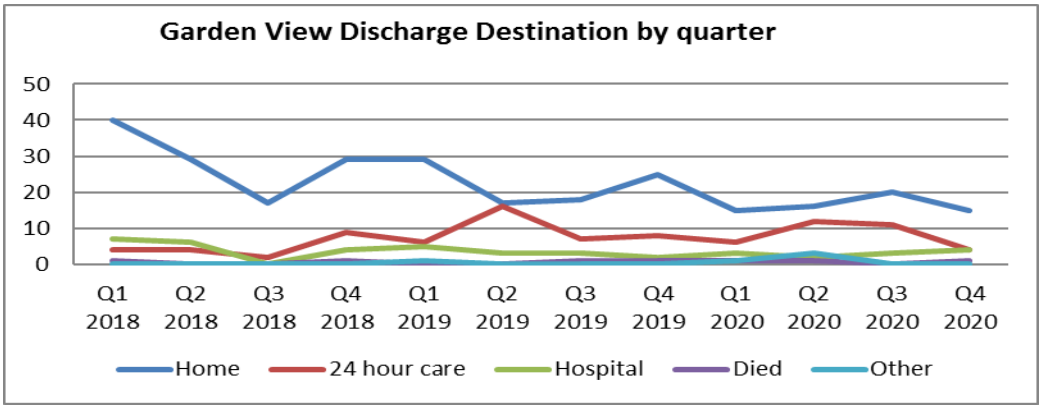
Figure 13 shows that almost two thirds of admissions to Garden View returned home with a Package of care (POC). With one-fifth transferring to residential care. This suggests that clients entering Garden View largely progress to their intended destination of referral.

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.

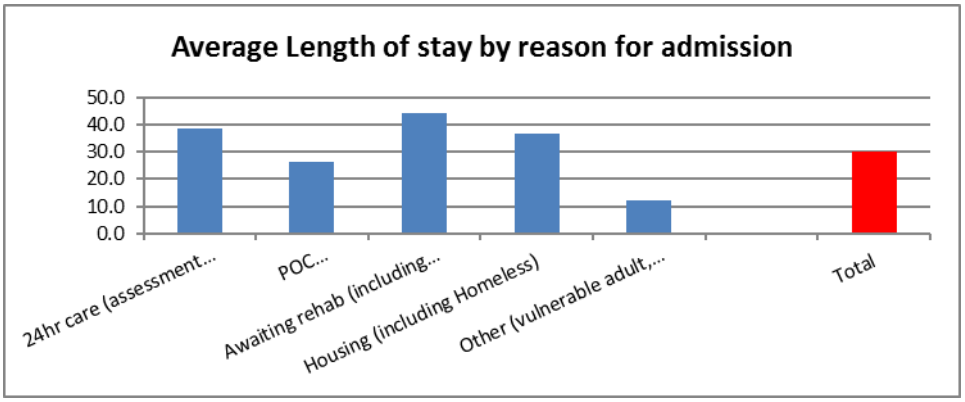
Ad hoc feedback from service users is consistently favourable and Care Inspectorate reports are mostly positive. Three residents surveyed reported feeling safe, accepted, treated kindly and satisfied with the quality of care and with the environment. The only criticism was of a lack of social activities.

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



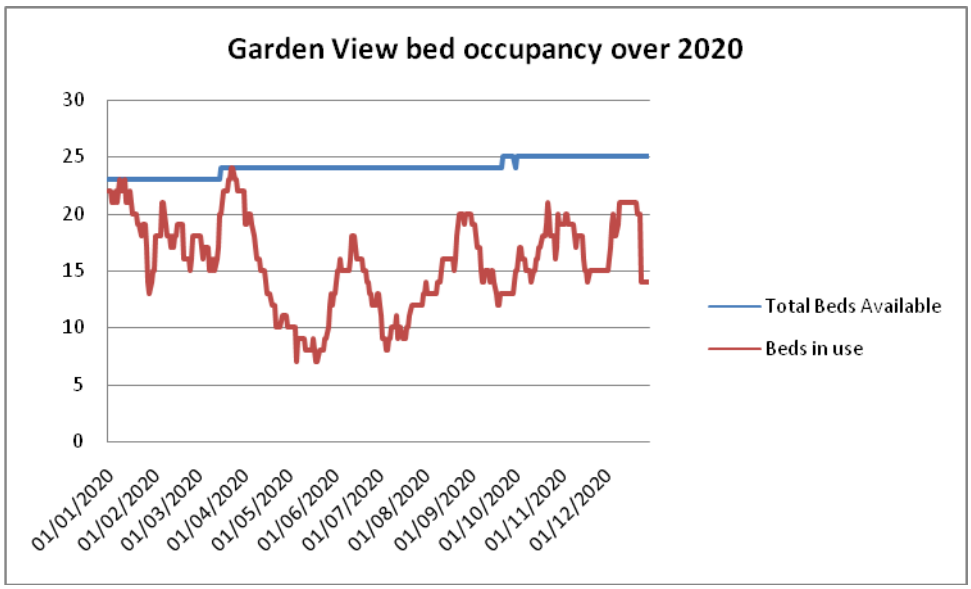
Throughput has been considerably less than anticipated from the outset and has further reduced over time. Table 3 shows the proportion of admissions discharged within 2 weeks halved between 2018 and 2020 and there has been a fourfold increase in the proportion staying longer than 6 weeks.

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 General Medicine (Discovery data)	7.7% 7%	18.8% 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.

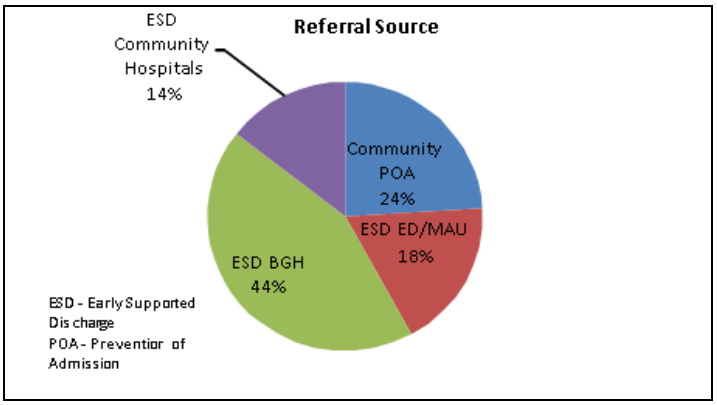
Aims

- 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

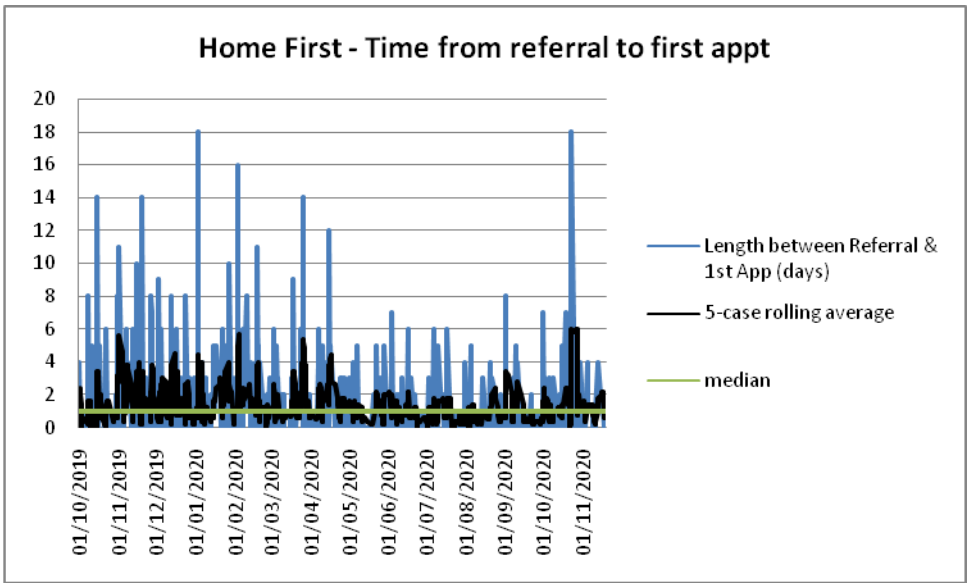
Activity increased by 23% between 2019 and 2020 and Home First managed 1280 people in the year to Nov 2020. 24% of referrals were from the community for an alternative to emergency admission to hospital. Figure 17 shows a further 18% were from the emergency department or medical admissions unit reflecting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

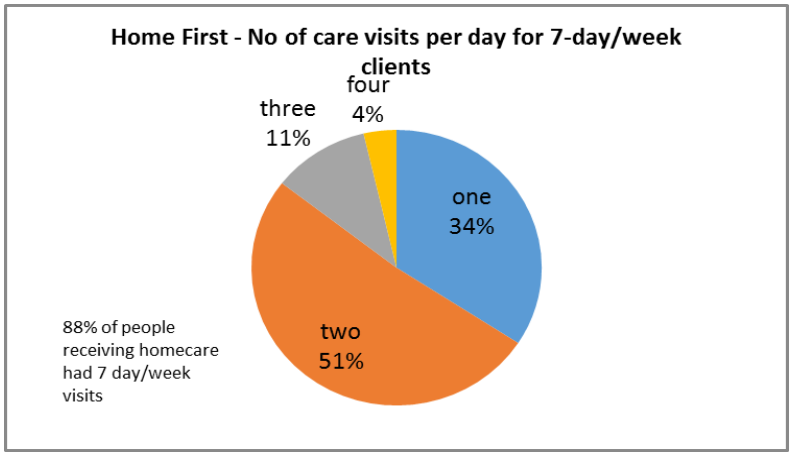


Fig.19

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

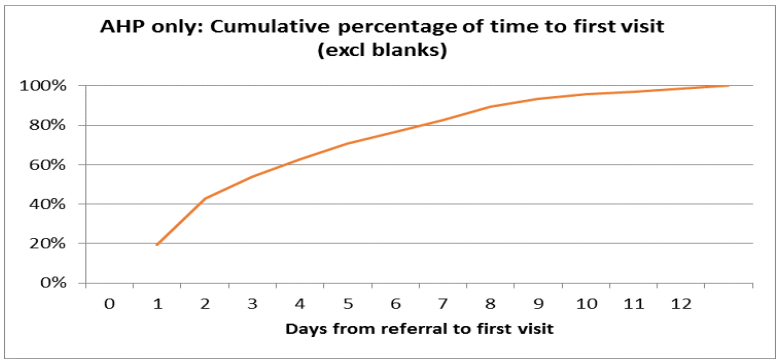
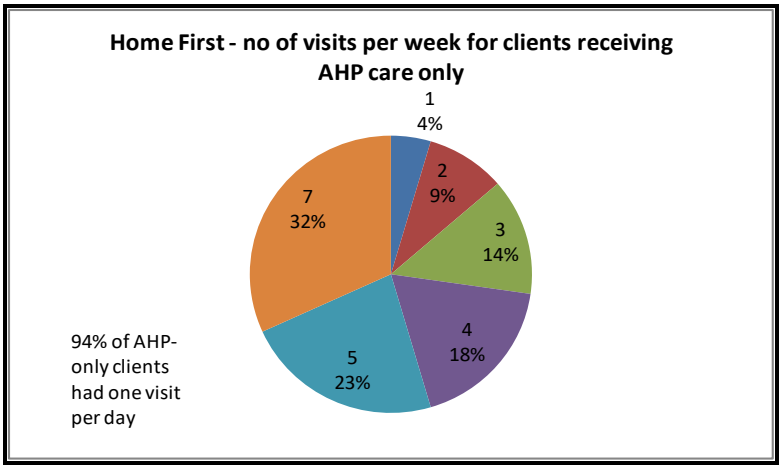


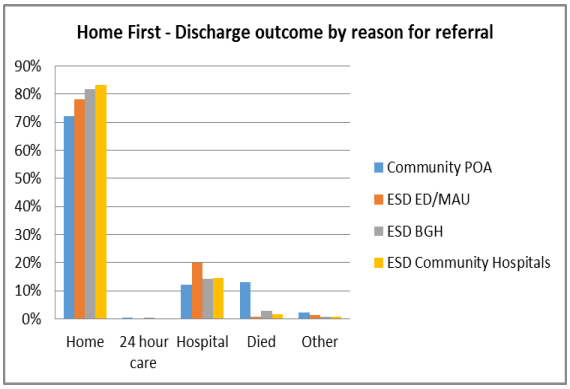
Fig 21



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

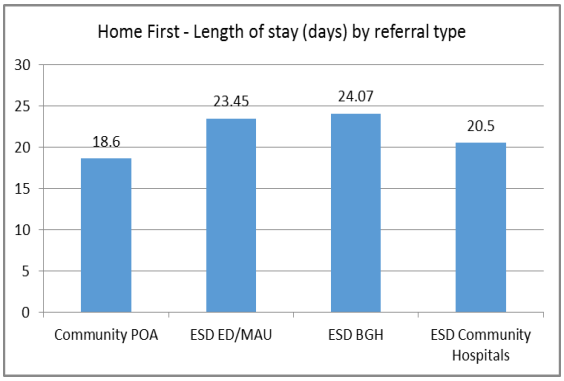


Table 4 shows the reduction in home care hours for those who received HCSW assistance for ADL. Overall, there was a 57% reduction in the intensity of the care packages required at the end of the Home First episodes. This level of reduction in demand for home care is central to the business case for the 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>

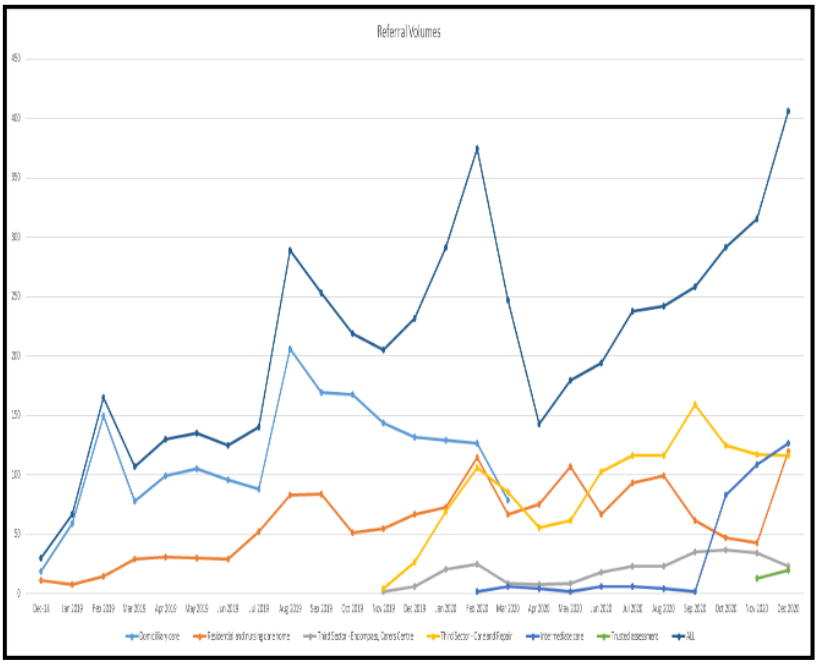
4.4 Enabling Infrastructure

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.



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

Fig 24 Strata Referrals

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

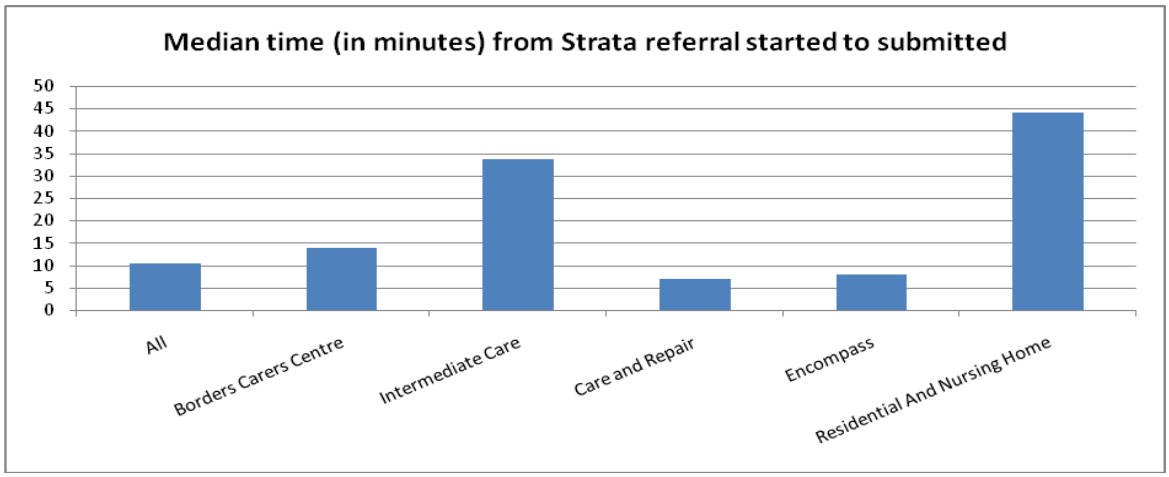


Fig 25 Median time to complete referral (minutes)

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)

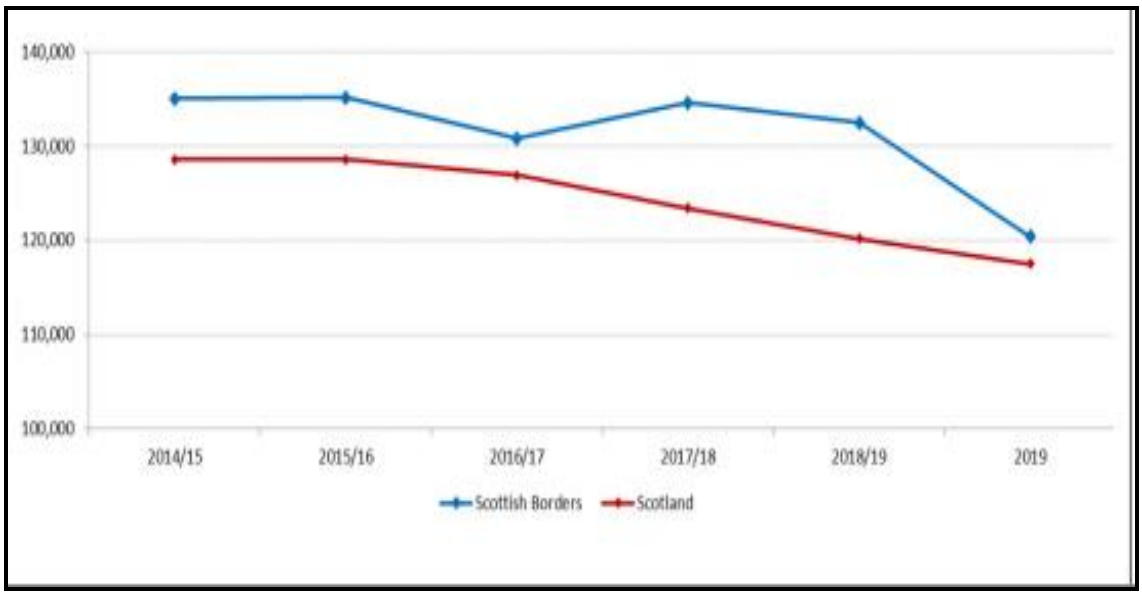


Fig. 27 National Indicator 19 – Number of days people aged 75+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 75+)

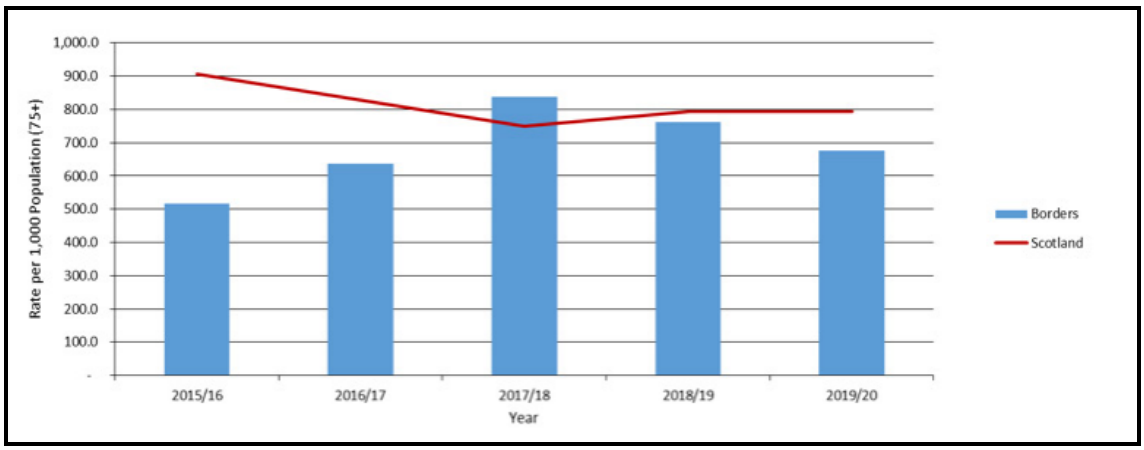


Fig. 28 Number of days people aged 18+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 18+)

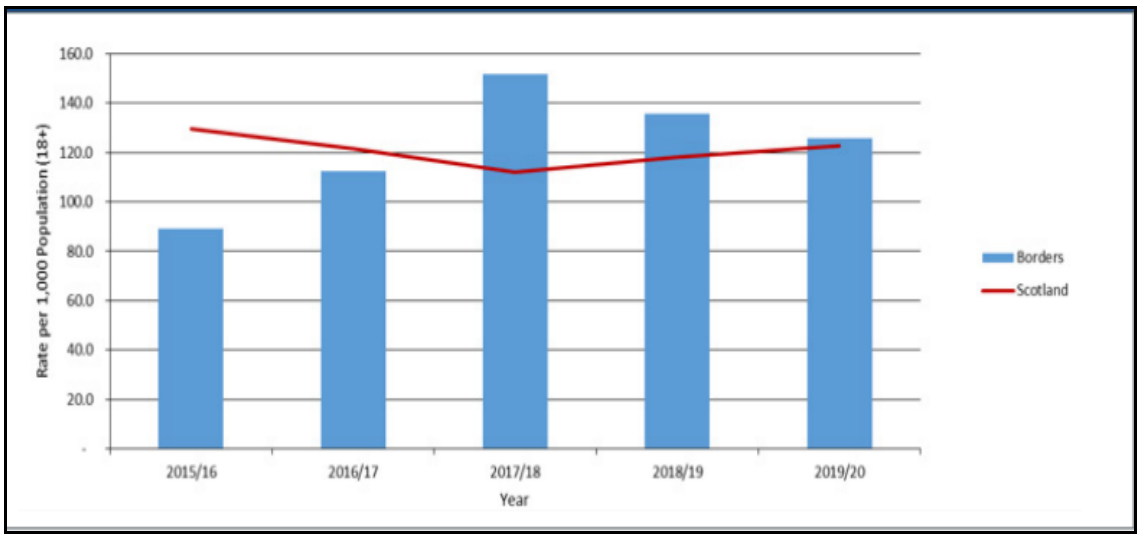


Figure 29 shows quarterly trends in BGH emergency admissions and occupied beddays for the over 65s. The chart has been annotated with the start dates of the new services.

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

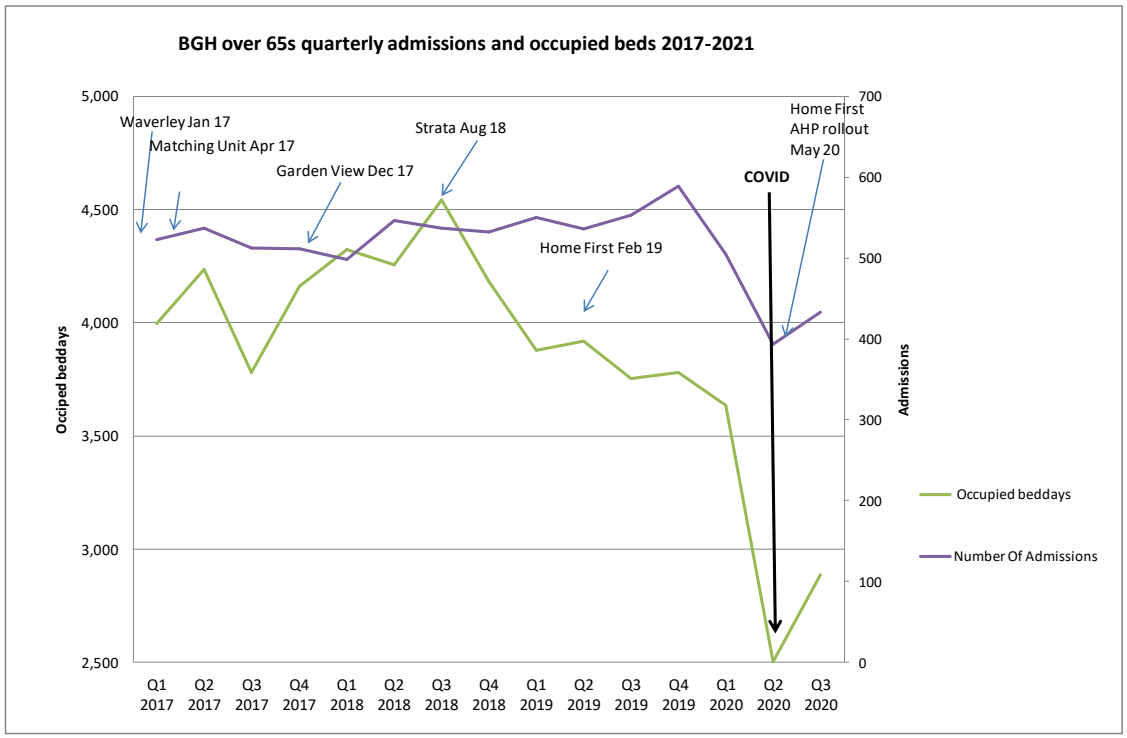


Fig. 29

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

Tweedbank

Preferred Option				Beds	Occupancy	Cost Per Bed		
Inputs	Area (Based on Stirches +	4290	sqm	60	0.95	£840,726.08	Discount r	3.50%
						To add staff cost		
Draft costs	Lifecycle Charge	£21	per sqm					
	Hard FM Charge	£18	per sqm					
	Heat Light and Power	£20	per sqm					
	Domestic Services	£20	per sqm					
	Rates, Including Water	£20	per sqm					
	Construction Costs	£8,733,200	(Stirches)					
	Support Accom	£2,810,400	(Stirches)					
	Site Works	£1,247,330	(Stirches)					
	Road Access	£1,500,000	(Tweedbank)					

Do Min	Beds	Occupancy	Cost Per Bed		
Waverley Care Home	26	0.7		2000	sqm
Garden View	24	0.66		2000	sqm
		To add staff cos	£1,028,141.50		sqm
					sqm
					sqm
					sqm
					sqm
					sqm
Total				4000	sqm

Lifecycle Charge	£28	per sqm
Hard FM Charge	£20	per sqm
Heat Light and Power	£24	per sqm
Domestic Services	£20	per sqm
Rates, Including Water	£20	per sqm
Rental Costs	£50,000	

Option 1 - Do Minimum

	Build	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Backlog Maintenance (Waverley)	£133,600																									
Lifecycle		£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000
Hard FM		£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000
Heat Light and Power		£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000	£96,000
Domestic Services		£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520	£81,520
Rates, Including Water		£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840	£79,840
Rental Costs (Garden View - Elidon Housing)		£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000
Staffing (Proposed Model of Care and Rev Cost 19/3/21)		£1,616,000	£1,616,000	£1,616,000	£1,616,000	£1,616,000	£1,616,000	########	########	########	########	########	########	########	£1,616,000	£1,616,000	########	########	########	£1,616,000	########	########	########	########	########	########
Total - Discounted	£133,600	£2,043,826	£1,974,711	£1,907,934	£1,843,414	£1,781,076	£1,720,847	########	########	########	########	########	########	########	£1,306,831	£1,262,639	########	########	########	£1,100,317	########	########	£992,422	£958,862	£926,437	£895,108
NPC	**£34,997,937**																									

Option 2 - Replacement Residential Care Home

	Build	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Const (Based on Stiches Residential Care Home)	£14,290,930																									
Lifecycle		£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090	£90,090
Hard FM		£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220	£77,220
Heat Light and Power		£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127	£84,127
Domestic Services		£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430	£87,430
Rates, Including Water		£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628	£85,628
Staffing (Proposed Model of Care and Rev Cost 19/3/21)		£1,616,000	£1,616,000	£1,616,000	£1,616,000	£1,616,000	£1,616,000	########	########	########	########	########	########	########	£1,616,000	£1,616,000	########	########	########	£1,616,000	########	########	########	########	########	########
Total - Discounted	£14,290,930	£1,971,493	£1,904,824	£1,840,410	£1,778,174	£1,718,042	£1,659,944	########	########	########	########	########	########	########	£1,260,581	£1,217,953	########	########	########	£1,061,375	########	£990,805	£957,300	£924,927	£893,650	£863,430
NPC	**£47,921,386**																									

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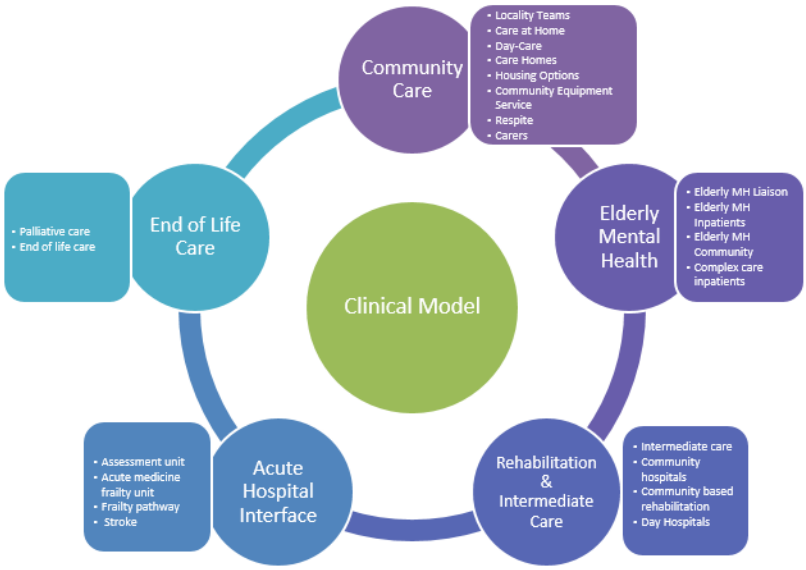
Table 1 sets out the care elements and sub-elements which comprise the proposed village care model.

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

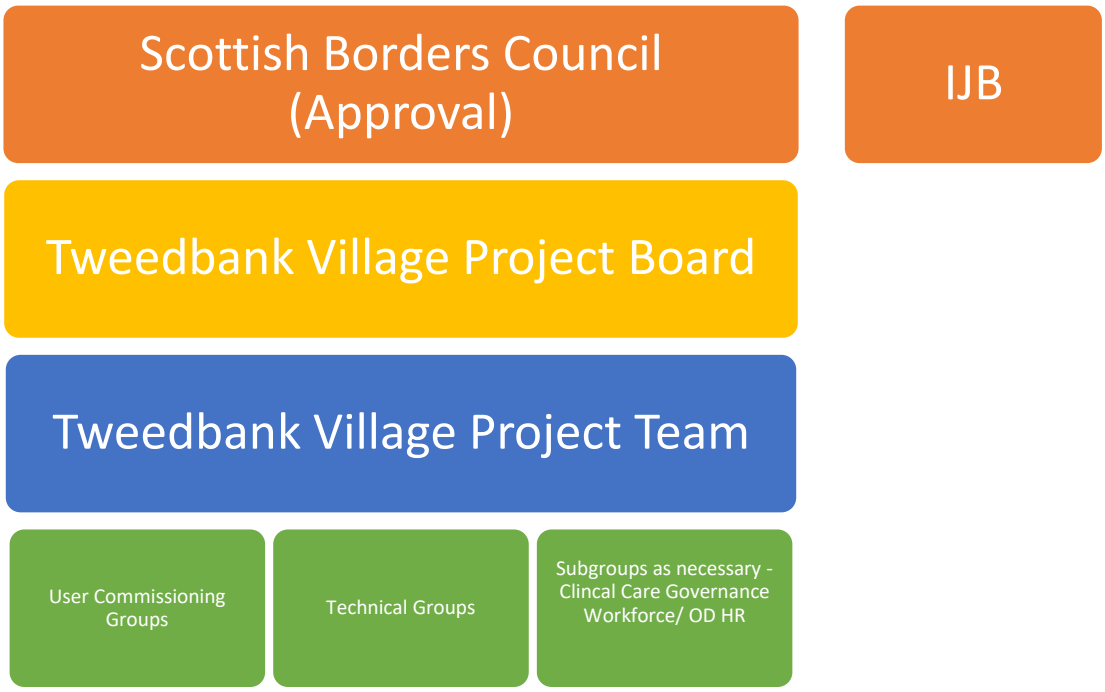
Care Homes Outline Case For Change

APPENDIX E

GOVERNANCE STRUCTURE

TWEEDBANK CARE VILLAGE

Insert Organisational Diagram



Care Village Project Board

Remit

In line with Managing Successful Programmes (MSP) and Prince 2 Methodology, a Project Board will be established to direct the project and will include the following three key roles: Executive Sponsor, Senior User(s) and Senior Supplier

Taking account of the scope and importance of the project, it is recommended that Project Board members are drawn from senior management levels and will 'manage by exception'. Members will be provided with regular progress reports prepared by the Project Director and will be asked for joint decision making at key points in the project. Exception reports will be submitted to the Board when it is forecast that agreed tolerance levels, for cost or key project milestones will be exceeded. The Project Board will be responsible for signing off the detailed governance arrangements as outlined in this document and for the delegation of authority to the Project Director/Manager and setting the latter's operational parameters.

It is envisaged that key milestones will be:

- Completion of preparation of design documents for tender
- Completion of process of appointment of construction contractors
- Full Business Case
- Contract close
- Construction Practical Completion and handover phase

It will be for the Project Board, via the Project Team, to ensure that communications within and external to the stakeholder organisations are conducted as appropriate.

Membership :

Executive (Chair) C Myles, Chief Officer Scottish Borders Health & Social Care Partnership

Senior User : J Holland, Director of Strategic Commissioning and Partnerships SBC

Senior Supplier :J Curry: Director Infrastructure and Environment

Project Director/Manager: S Renwick, Projects Manager

Other members to be confirmed, to include senior representative of Health, Social Care, Finance, Human Resources, Communications.

Project Team

The Project Team will require to contain the following disciplines:

- Project Management experience
- Service providers
- Clinical/Care
- Technical experience
- Facilities management

- Financial
- Legal
- HR

The requirement for the level of in-house expertise, particularly in relation to technical, legal and financial input will depend on the level of external advice commissioned to support the project

Remit

The Project Team will have the authority to and be responsible for driving the project and delivering outputs and will:-.

- Provide support and advice to the Project Director/Manager on a range of issues including the development of the detailed service brief, design, construction and commissioning of the new facility.
- Assist, where appropriate, in the evaluation of competitive bids from potential professional and technical advisors, building contractors/ developers and equipment suppliers/procurement managers. Advise the Project Director/Manager on recommendations to be made to the Project Board in relation to their appointments.
- Ensure the engagement of all internal and external stakeholders and that communications are undertaken appropriately as directed by the Project Board. Assist the Project Director/Manager to develop formal proposals for the Project Board, including in regard to the procurement/ownership issues arising from the multi- organisational nature of the project.
- Agree room data, equipment schedules, budgets, building and services specifications and service and building commissioning programmes.
- Agreement of all legal and contractual arrangements
- Appoint and manage the input of technical, financial and legal advisers and other external advice that may be required as necessary
- To consider any human resources issues and to take the appropriate HR and legal advice
- Support and assist the Project Director/Manager in relation to the development of the Business Cases for the project.

- Monitor the project in terms of cost and time and assist the Project Director/Manager in identifying potential variances and action to keep the project on time and to cost.
- Be satisfied that appropriate steps are being taken if problems are identified with the progress of the project.
- Oversee delivery of the benefits realisation plan defined in the Business Cases.
- Oversee the commissioning of services, including any changes to service models, and equipment.
- Oversee the development and implementation of detailed operational policies which embrace the principles set out in the Business Cases.
- Demonstrate a visible commitment to the project, ensuring that the project is actively promoted.
- A core element of the work of the Project Team, potentially requiring a sub group, will be the relationship with the hub company and their Supply Chain and have a key responsibility for the execution of procurement contracts and delivery of the construction project:
- Checking, implementing and monitoring of the contracts.
- Developing and monitoring the overall programme for the project.
- Developing the Business Cases in liaison with internal and external stakeholders. Eg Health Services

- Developing the design, ensuring compliance with technical standards and user requirements.
- Ensuring that statutory consents are secured.
- Provision of cost plans at agreed stages within the programme
- Monitoring expenditure against the cost plan and taking corrective action where variances are within tolerances and seeking direction/approval where they are not.
- Monitoring construction progress against the agreed programme and taking corrective action where variances are within tolerances and seeking direction/approval where they are not.
- Overseeing risk management and maintenance of the project Risk Register
- Delivery of the construction contract to programme, within budget and to the required standard
- Managing the process for Client Change Requests during the construction period

Membership: to be confirmed

It is envisaged that the make up and role of the Project Team or that the level of involvement of the individual members will change over the life of the project. The initial aim will be to set up a robust project team to progress through the stage up to and including contract close and construction commencement. The make-up of the project team should then be reviewed at this stage for the period through construction and revised again once the operational stage of the project is reached.

Users/Commissioning Group

Remit

In the early stages of the project, the Users Group will represent the interests of all those providing services/utilising accommodation within the Care Village in the planning and design stages of the project. This will include:

- Finalising the clinical/service brief
- Agreeing Schedules of Accommodation
- Agreeing the general layout
- Agreeing the detailed layout
- Contributing to the development of the Business Cases
- Contributing to the requirements of Room Data Sheets
- Contributing to the generation of the Services Specification

Sub Groups will be established as necessary to achieve the required outputs from the Group in these stages.

The Users Group and Sub Groups will be relatively short life groups, ie in operation until the completion and approval of the Full Business Case and members will thereafter be involved in the commissioning process, and making appropriate plans for the operation and use of the building, ensuring that users understand the nature of the services specification and payment/deductions mechanisms

At the appropriate time, therefore, the Group will plan and develop operational policies and procedures and any change to clinical or care models along with the preparation and implementation of the commissioning plan/programme.

Sub groups will be established as necessary to achieve the required outputs from the commissioning process eg in relation to administration, facilities management etc.

Membership: to be confirmed

Technical Group

Remit

The Technical Group will meet on a regular basis as required during the design development, construction and commissioning phases to ensure that all aspects of the development are fully compliant. This will include the development of the Technical Brief for the project and review of design proposals to ensure that they meet requirements.

The Technical Group will also provide support for the Project Manager and Director in finalising the legal and financial elements of the building contract as required.

The Group will include representation from Estates Maintenance, Risk Management (Fire Safety, Security, Infection Control, Manual Handling), ICT/E-Health, Telecoms, Support Services (Domestic Services, Catering, Waste). Each organisation will work together to ensure that the requirements of each are met without undue duplication of effort or detriment to others.

Membership: to be confirmed

3. Roles of Key Individuals

Executive

The Executive is the key decision maker and is ultimately responsible for ensuring that the project meets business needs/interests and gives value for money. The Executive will act as Chair of the Project Board

The Executive is responsible for the following;-

- Overseeing development of a viable business case
- Ensuring a coherent organisation structure and plans are in place
- Agreeing key milestones and ensuring that key stages are reported and approved prior to progressing to the next stage
- Monitoring and controlling progress of the business change at a strategic level and within pre-agreed parameters

- Referring serious problems upwards to top management
- Formally closing the project and ensuring lessons learnt are documented
- Ensuring that post project review takes place

The Executive will be supported by the Senior User and Senior Supplier

Senior User(s)

The Senior User(s) represent the interests of all those that will use the Final ‘product(s)’ .

The Senior User is responsible for the following;-

- Providing user resources
- Ensuring the project produces products that meet user requirements
- Ensuring that the products provide the expected user benefits

Senior Supplier

The Senior Supplier has to achieve the results required by the Senior User and is accountable for the quality of all products delivered by the supplier(s).

The Senior Supplier is responsible for the following;-

- Ensuring that proposals for designing and developing and using the products are realistic
- Achieve the results required by the Senior User within the cost and time parameters
- The role represents the interests of those designing, developing, facilitating, procuring and implementing. The role must have the authority to commit or acquire the required supplier resources.

Remit

- Overall direction and management of the project
- The success of the project
- Has responsibility and authority for the project set by corporate or programme management

- Approves all major plans
- Authorises any major deviations from agreed plans
- Signs off completion of stages/authorises the start of the next stage
- Ensures that resources are committed
- Arbitrates on conflicts/negotiates solutions to problems
- Approves the appointment and responsibilities of the Project Director/Manager
- Ensures the project remains on course to deliver the products of the required quality to meet the business case
- Project assurance – monitoring the projects performance and products independently of the Project Director/Manager

Project Director Remit

The role of the Project Director/Manager is key to the successful outcome of the project. The Project Director/Manager will:-

- Manage the stakeholders' interests in the project, including the co-ordination of user's interests and the production and agreement of operational policies and commissioning programmes.
- Monitor the project to minimise any planning, design, construction and commissioning time and cost overruns. Provide regular progress reports and exception reports when required.
- Ensure that a specification is prepared for the role of Project Manager and that an individual or practice is appointed to perform this role that is demonstrably capable of performing it.
- Ensure that services are delivered according to the service brief/output specification, project commissioning programme and service costs identified in the Business Cases.
- Ensure that competitive arrangements are put in place for procuring professional and technical advisors deemed necessary. Recommend the appointment of individuals/practices to the Project Board or approve their appointment where allowed by delegated financial limits.
- Ensure that competitive arrangements are put in place for procurement of contractors and that the stakeholders interests are represented in the selection process.
- Ensure that a process is put in place for engaging stakeholders in the development of the service brief, design and commissioning plan for the new facility and its services.
- Ensure that the new facility and its proposed services remain affordable in the context of the business case
- Ensure that arrangements are in place for controlling and accounting for the use of the facilities for services provided by third parties.
- Act as the point of contact in all dealings with advisors, contractors, and other external organisations involved in the project and provide all decisions and directions on behalf of the Project Board, including the preparation of all reports to the Project Board.
- Be aware of the business objectives and corporate management structure as it relates to the project.
- Ensure that adequate communications channels exist between the project and stakeholders (internal and external)
- Ensure that procedures are in place to involve service providers, and service users, where appropriate, at all phases of the commissioning and mobilisation of services to be provided from the facility.

- Ensure that the project is completed and handed over in a managed way.
- Ensure that the post project evaluation is planned and implemented and that appropriate processes are put in place for the on-going management of the services element of the contract.
- Demonstrate commitment to the project and promote the benefits which it will bring.
- Ensure that actions are taken to manage the risks to the project as identified in the risk register and any subsequent update.

Project Manager Remit

The Project Manager is responsible for:-

- Liaising with the Project Director to plan and design the project.
- The day to day management of the project, including execution of a wide range of the Project Director's responsibilities and co-ordination of the Project.

- Ensuring that the project is delivered in accordance with agreed timescales and resources.
- Effective co-ordination of the project and any interdependencies
- Managing and resolving risks and other issues.
- Managing the project's budget, monitoring expenditure and costs.
- Ensuring that the delivery of products/services meets project requirements within time, budget and quality parameters.
- Managing communications with stakeholders.
- Regularly reporting progress to the Project Director.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Simon Burt / Susan Henderson
Contact:	Simon Burt / Susan Henderson
Telephone:	01896 840200

REVIEW OF LEARNING DISABILITY (LD) DAY SUPPORT SERVICES – MARKET TESTING

Purpose of Report:	To inform the SIP oversight board of the progress of the review of adult learning disability day support services and advise them that a soft market testing event will take place on Friday 10th December 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the progress of the learning disability day support review b) **Note** that the LD service will, on completion of the market testing, seek a commissioning decision from the IJB in the spring of 2022.
Personnel:	Existing day support service provider staff may be affected. We have held early engagement sessions with staff teams.
Carers:	Day support services for adults with learning disabilities are important services to meet the critical needs of adults with LD across Scottish Borders and this in turn provides essential respite to family carers. Families were offered opportunities to engage early in this process of review and the outputs from these discussions are reflected in the presentation and will inform the future model.
Equalities:	An EQIA will be carried out on the proposed commissioning intention that will be worked up following soft market testing and presented to the IJB for a strategic decision.
Financial:	Included within the review is the need to realise a £350k savings target.
Legal:	Legal requirements are met where relevant.
Risk Implications:	At this stage the keys risks are 1. Day support will be provided that does not meet people's critical/substantial needs and outcomes 2. Respite needs of carers may not be met 3. The budget available is insufficient to meet demand

Please see PDF of slide set for more information

Introducing a Market Position Statement for Scottish Borders Learning Disability Day Services Review December 2021

Why a position statement?

This Market Position Statement aims to help service providers, stakeholders and community groups understand the future environment for their work and make plans for the future. It sets out our priorities for Learning Disability (LD) day services, opportunities for providers and how we will work with the market.

It will also be informative for providers already delivering services in Scottish Borders; businesses and community groups looking to develop new activities; organisations which do not currently work in Scottish Borders who wish to do so; people (and carers) who purchase services from their own resources or with a personal budget/Direct Payment.

Why now?

Commissioning LD day support has been a journey for over 10 years and support arrangements have undergone several re-configurations to ensure that they are fit for purpose.

The last significant review was in 2011 with a shift to more localised support, disinvestment in some buildings based support, and re-investment in Local Area Coordination support.

We need to continue on the journey of modernisation of locally based services, that maximise independence of individuals, ensuring there are some buildings based services for those with the most complex needs.

Our focus needs to continue to shift towards meeting people's outcomes in a variety of settings and models that can respond flexibly.

The National Context

The Public Bodies (Joint Working)(Scotland) Act

This Act changed how services were commissioned across health & social care in recent years. Setting the framework for the integration of Health & Social Care, this Act required integration partners to prepare a strategic plan for their area, setting out arrangements for the delivery of integration functions and how the national health and wellbeing outcomes will be met. Commissioning of social care services is now the responsibility of integration authorities via health and social care partnerships.

Scottish Government review of social care

The COVID-19 pandemic reset and refocused the agenda on social care. The Review engaged with people and organisations including those who have lived experience of using social care services and supports, carers and families. This resulted in options and recommendations that cut across: funding, delivery, governance and regulation, and how continuous improvement can be assured in social care services.

Self Directed Support (SDS)

SDS Provides four options for people, providing different degrees to which they are directly involved in organising their care. The aim of SDS is to help people live better lives by making sure that people get the kind of support they want - support that is personalised.

The Local Context

The Health & Social Care Partnership Strategic Plan

This Strategic plan 2018-2021 had three aims. That Learning Disability Day Services provide meaningful activity for assessed support needs towards meeting supported people's outcomes and maintaining the health and well being of their carers. In turn this supports the wider aims of the local strategic plan.

Fit for 2024

This programme aims to prepare for and meet the predicted demands for services; the challenges of meeting the needs of our growing older population, the need to grow the economic performance of the area; the far-reaching reforms in Health and Social Care; new requirements in Education; rapid digital transformation as a continuous and permanent feature of our environment; new duties under tackling Poverty and Inequality and budgetary, legislative and regulatory impacts as a re-driving improvement through collaboration.

Learning disability specific context

The Keys to Life (2013) and implementation plan

The **keys to life strategy** recognises that people who have a learning disability have the same aspirations and expectations as everyone else and is guided by a vision shaped by the Scottish Government's ambition for all citizens. The 2019-2021 implementation framework focuses on 4 key areas: Healthy life; choice and control; independence; active citizenship.

Principles of Good Transitions 3

The Principles of Good Transitions 3 provides a framework to inform, structure and encourage the continual improvement of support for young people with additional needs between the ages of 14 and 25 who are making the transition to young adult life. It is divided into 8 parts with seven key principles of good transitions. Scottish Borders Learning Disability Services have led improvements in this area locally.

The Charter For Involvement

The **Charter for Involvement** is written by the National **Involvement** Network. It sets out in their own words how supported people want to be **involved** in the support that they get in the organisations that provide their services.

The Local Context

Scottish Borders Learning Disability Strategic Commissioning Plan 2016-19

This strategy set out the commissioning priorities for the Learning Disability Service for the period from 2016 – 19. A key element of this strategy was to review the impacts of the previous review of Day Services. The new strategic commissioning plan was paused during COVID-19 and consultation will be restarted.

Outcomes focused Commissioning

Traditional commissioning of services is the process by which councils would decide how to spend their money to get the best possible services. Our future commissioning will aim to achieve the best possible outcomes for individuals and communities by understanding and accessing collective resources. We must also achieve best value, national quality standards, Equality, keeping people safe and involving them in why, how and what we commission.

Place making

This approach is in line with the Cosla Place Principle for "A more joined-up, collaborative and participative approach to services, land and buildings, across all sectors within a place, enables better outcomes for everyone and increased opportunities for people and communities to shape their own lives".

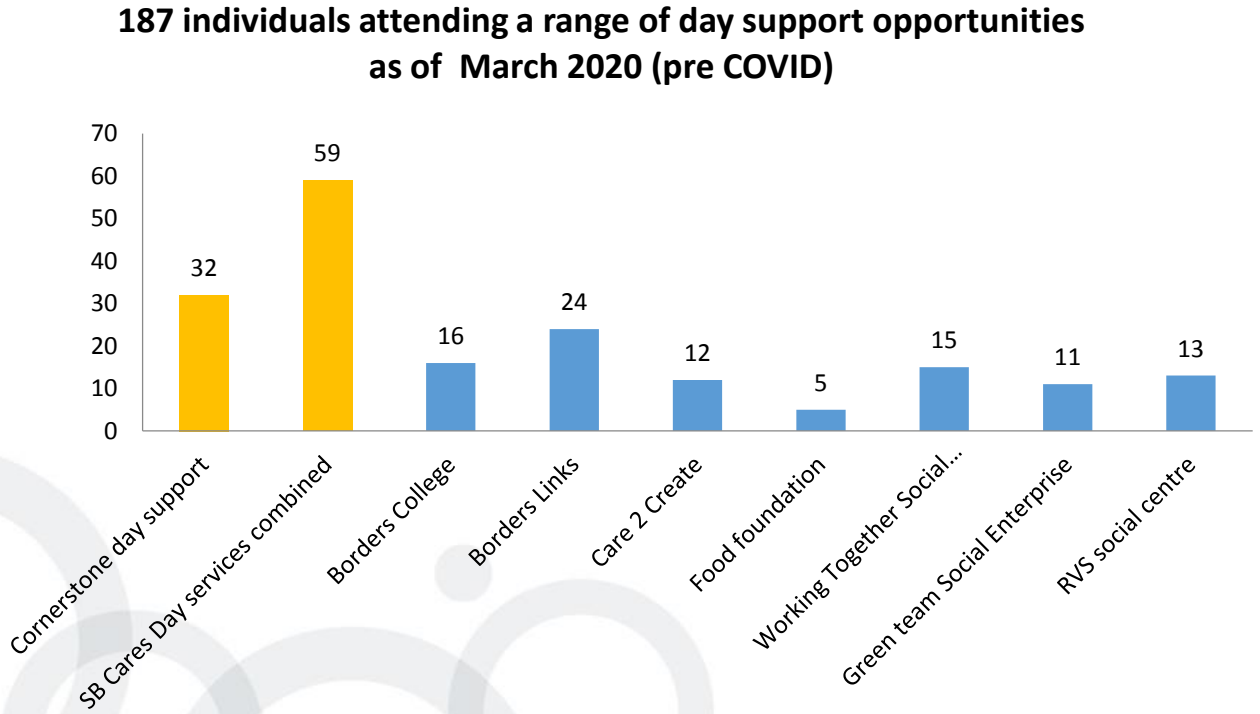
The case for change:
Living in post COVID-19 communities

The COVID-19 Pandemic has changed life for everybody over the past year and perhaps for the years to come. We will not return to exactly how things were before.

We need to:

- strengthen resilience and create efficiency through collaboration and innovation
- maximise the use of resources that are both commissioned and community led
- have services tailored to individuals and their communities that are outcomes focussed
- involve people, community groups, the third sector interfaces, organisations and service teams in the commissioning processes
- embrace and use technology by using technology as a partner.

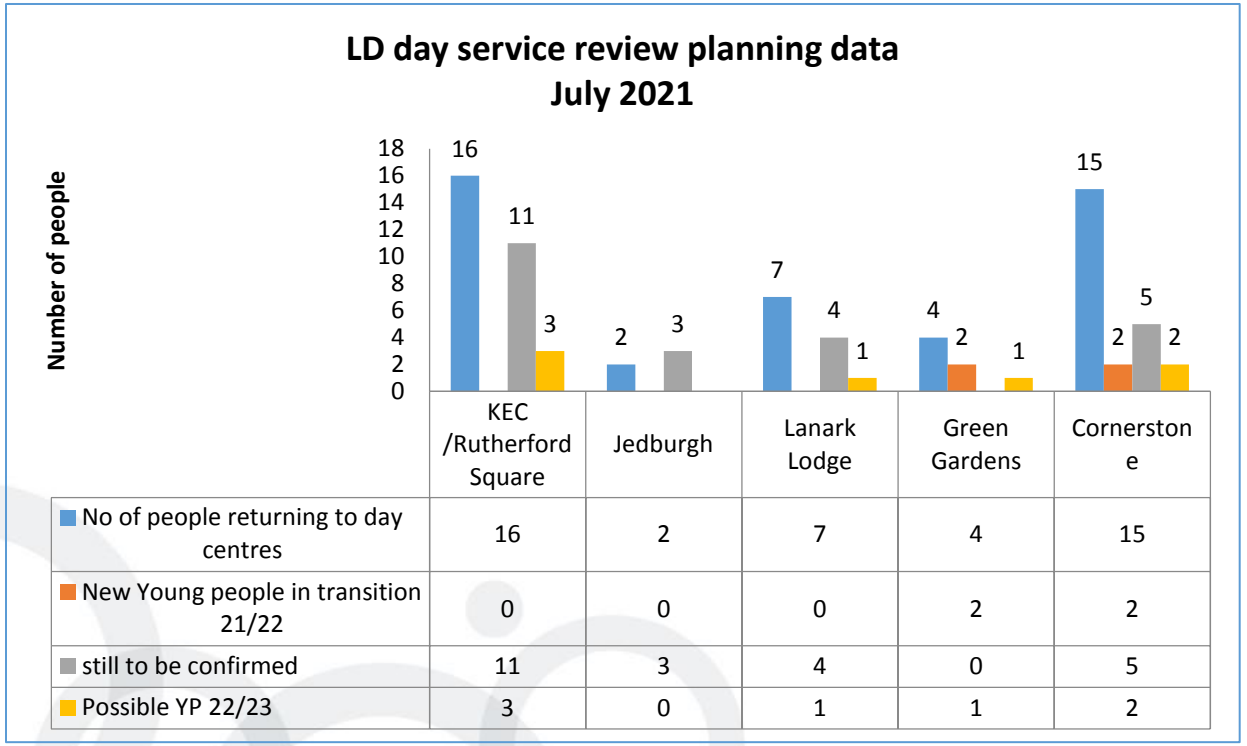
The case for change:
Learning disability service day support data



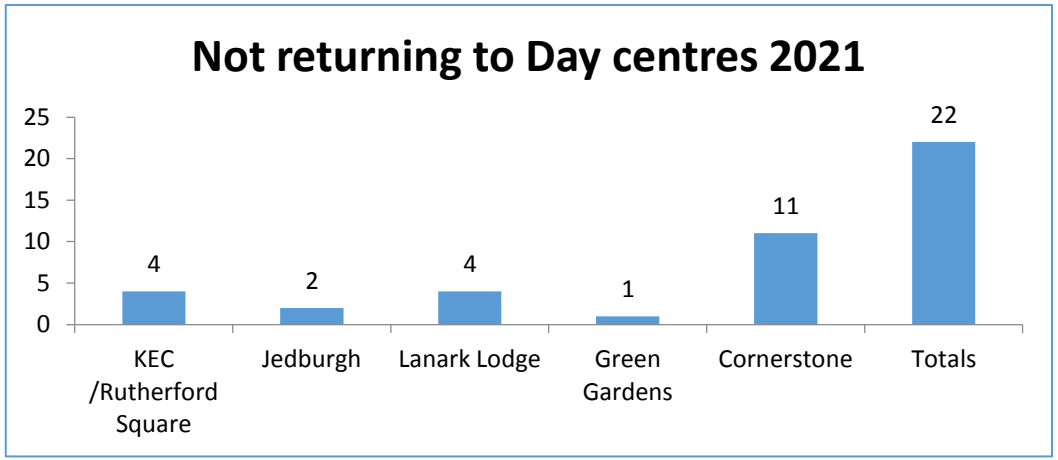
Prior to COVID-19 there were 187 adults with learning disabilities attending some form of day time opportunity.

The scope of this review is to modernise the formal traditional day services within SB Cares and Cornerstone – a total of 6 day centres with 91 attendees.

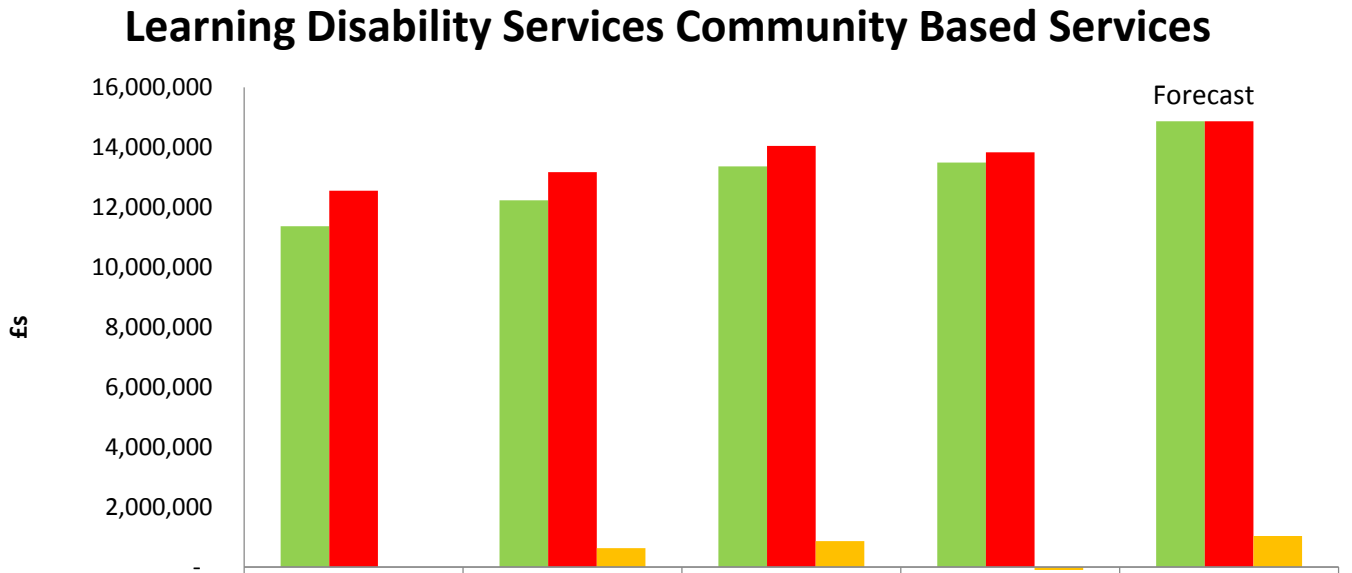
The case for change:
Learning disability service day support data



	KEC /Rutherford Square	Jedburgh	Lanark Lodge	Green Gardens	Cornerstone
No of people returning to day centres	16	2	7	4	15
New Young people in transition 21/22	0	0	0	2	2
still to be confirmed	11	3	4	0	5
Possible YP 22/23	3	0	1	1	2

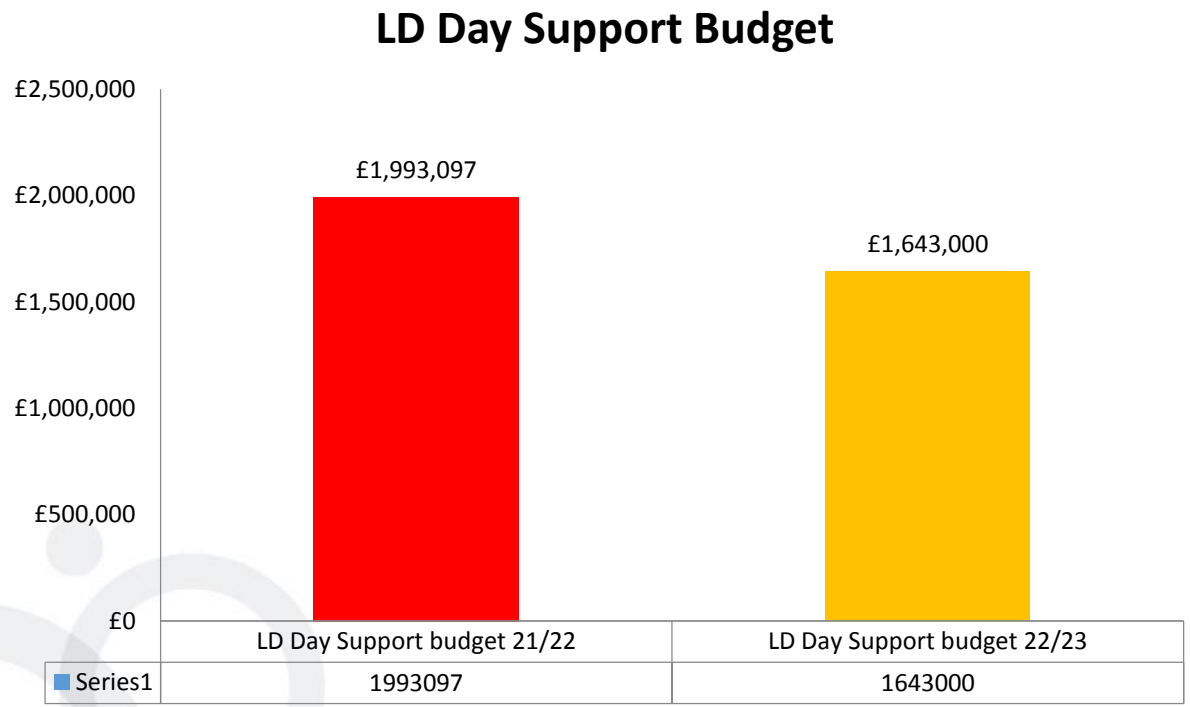


The case for change:
Learning Disability Services total spend since 2017



	2017/18	2018/19	2019/20	2020/21	2021/22
Outturn / F'cast	11,363,988	12,231,400	13,361,098	13,489,714	14,863,670
Inflation Adjusted	12,543,716	13,171,880	14,037,504	13,826,957	14,863,670
Variance		628,164	865,624	-210,547	1,036,713

The case for change:
Current & Future levels of council resources



Within the budget, £350k of efficiencies in LD Day Services are planned over the next 2 years

LD Day Services

Key learning messages from the Independent Review of Adult Social Care (2021)

"Service design and delivery can only improve if people with lived experience are involved in the process. It is impossible to address inequality if the people who experience it are not in the room"

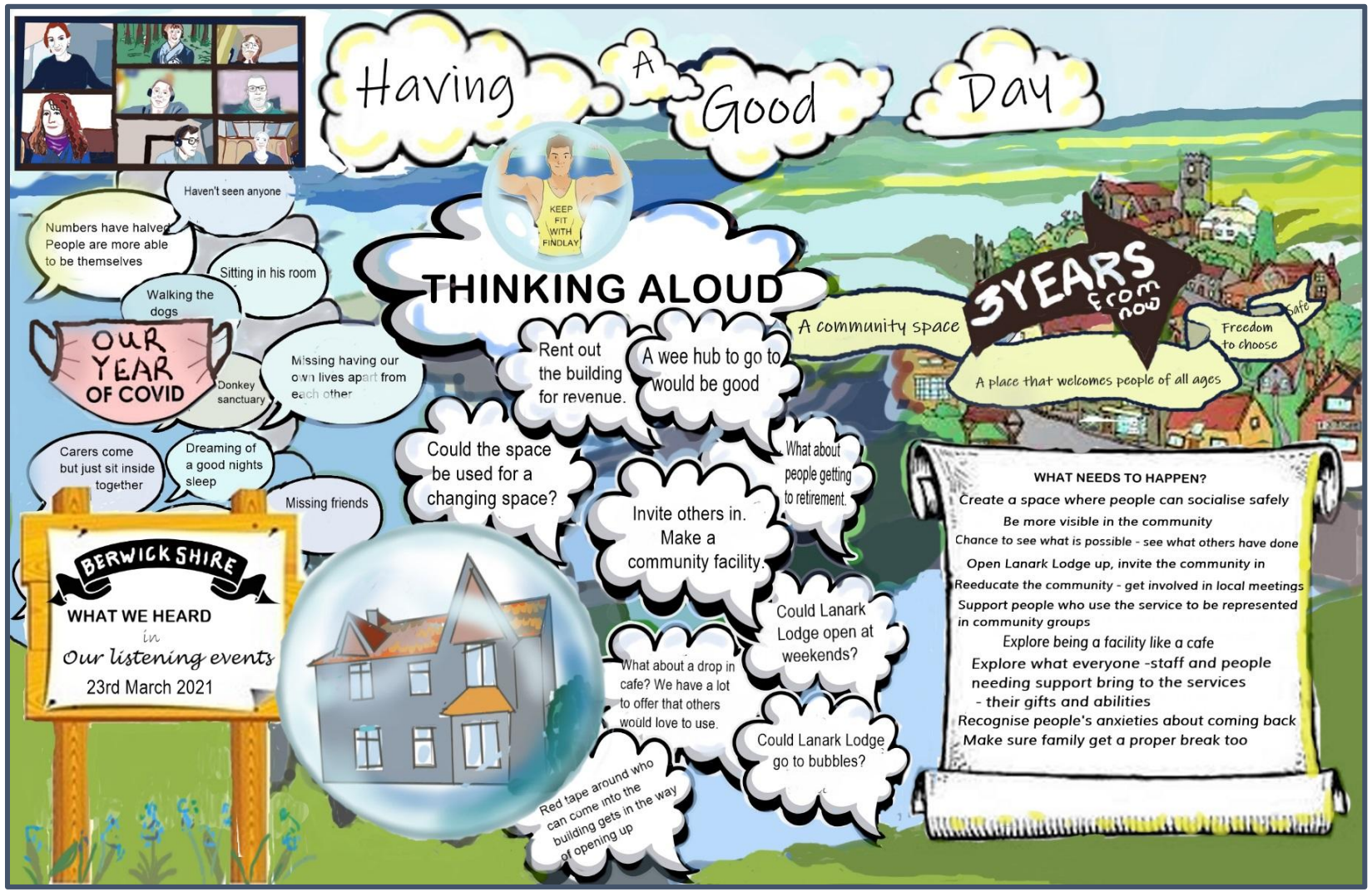
"We heard that our current system too often does not feel like a system at all: it feels like a guddle, and that causes people worry and anxiety"

"People also told us that the threshold for accessing support is too high, and too often meaningful support is only available when people are acutely unwell or in crisis"

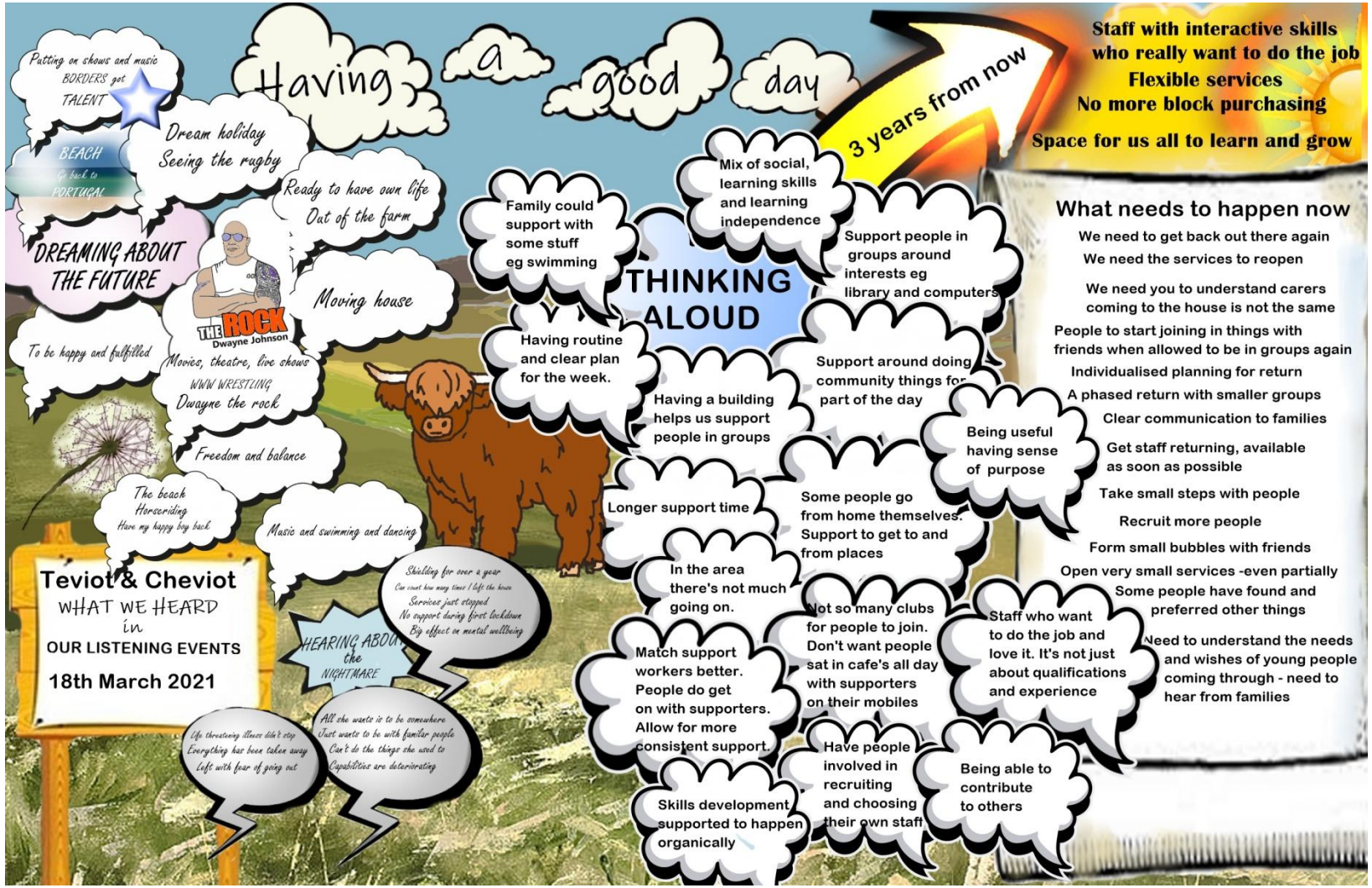
"People spoke to us about 'short-termism' resulting in providers spending significant time and resources applying and reapplying for contracts"

"We heard that the market approach to commissioning and procurement produces 'competition, not collaboration', which, in turn, leads to too much focus on costs rather than high quality, person-centred care and support"

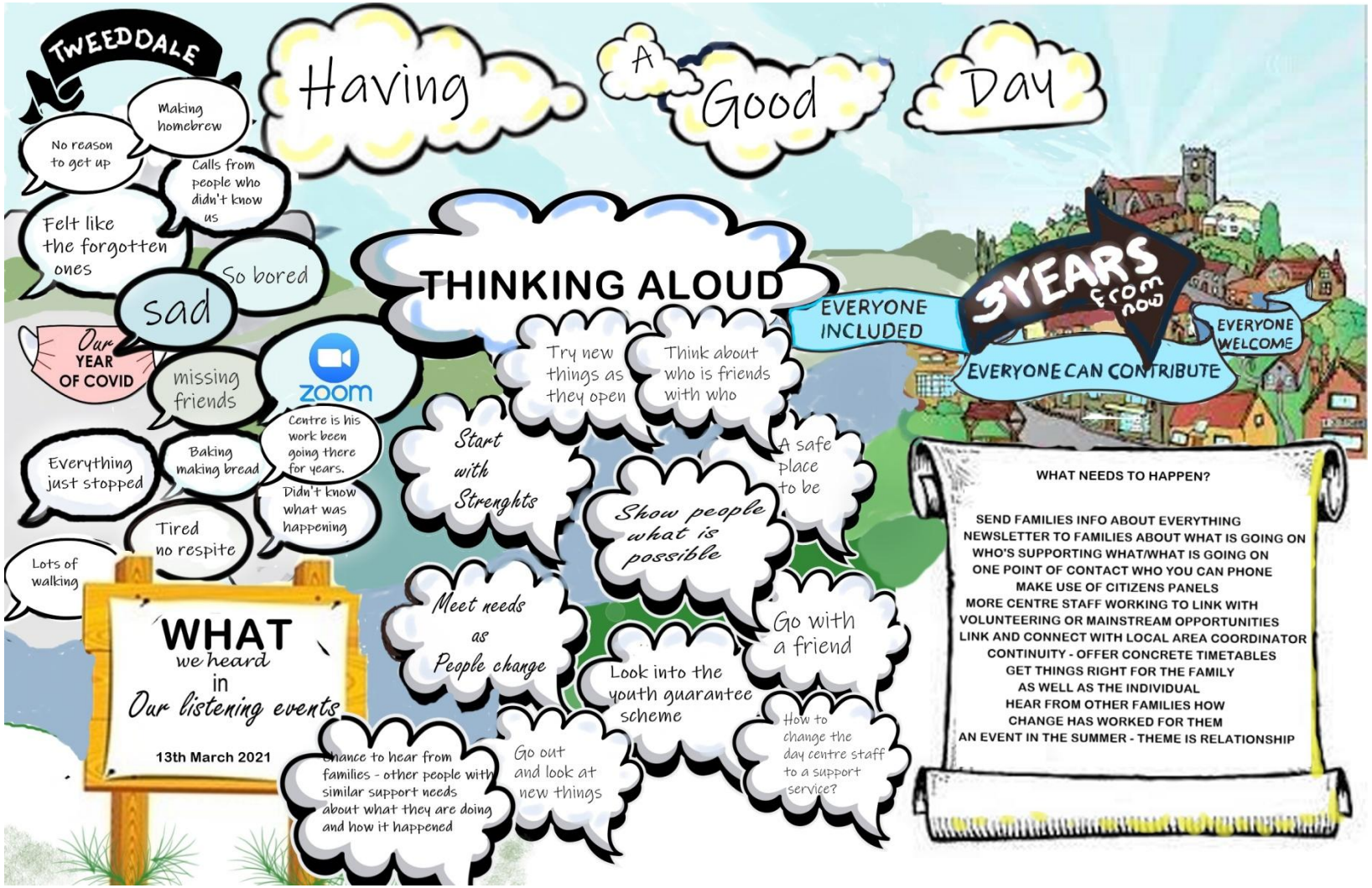
LD Day Services – 4 local consultation events



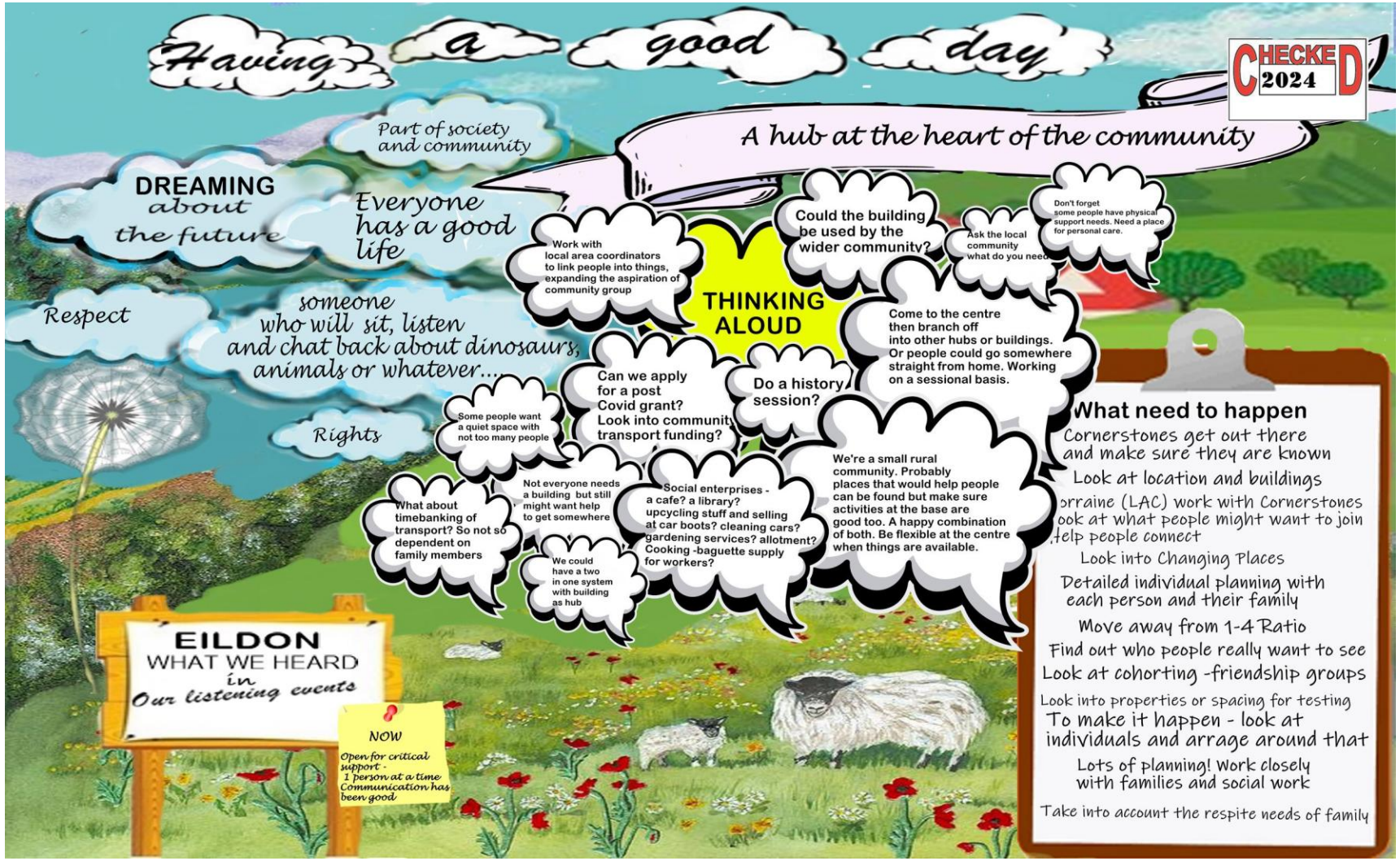
LD Day Services – 4 local consultation events



LD Day Services – 4 local consultation events



LD Day Services – 4 local consultation events



4 consultation events themes:

We start with people's strengths-.

- People develop **a sense of purpose** through what they love doing and how they contribute to others in their local community.
- People develop and maintain **friendships**

The kinds of things people want to do:

- **Outdoor and local opportunities** for people to be part of
- Opportunities **for fitness and wellbeing**
- Opportunities around enjoying and **contributing to others through food**- cooking, baking sharing and growing.
- Opportunities to take part in the **arts, music, local history** and leisure in a way that connects people with like-minded people.
- Opportunities to **try new things, explore** existing and new hobbies, and see what is going on

Enablers and Support to achieve these outcomes:

- People have a **way of getting around**
- Families want **personalised support**
- **Families and people with learning disabilities get a break from one another**
- **Personalised finance options** to increase flexibility of support
- **A place to be** and meet others- which is accessible and can be a place from which to branch out.
- The place we come together, and meet is **open to others in the local community**, rather than a segregated closed space.

Quality & Performance

Creating and achieving standards across the system
SBC and H&SC partnership

We will have a Quality & Performance Framework across five domains

Quality
National Health & Social Care Standards

Outcomes
National Health & Wellbeing outcomes

Best Value
The Duty of Best Value in Public Services

Safety
Adult & Child Support & Protection

Equality
Human Rights

LD Day Services – next steps

Commissioning approach:

- engage with a range of local providers and community groups to consider service specification options October and November 2021 (soft market testing)
- co-produce a new service specifications(s) that meets the outcomes expressed by stakeholders
- seek agreement from the Integrated Joint Board to commission the new model(s) of support
- continue to engage with key stakeholders
- commission new model(s) of support with a view to transition by September 2022.

Project timeline

Milestone	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22 Sept 22
Papers to CMT																							
Engage external																							
Aassessments based on needs and demands																							
Gather ideas of what the future could look like																							
Consult on findings and																							
Soft market testing																							
Options appraisal																							
Finalise EQIA on																							
Gain approval for commissioing process																							
Implement Commissioning process																							
Agree /award new																							
Implementation of new model(s)of day support																							

Engagement plan – next phase Sept 21-Jan22

Stakeholder	Messages and media	Media	Timeline
CMT	Approve direction of travel and key messages.	Presentation, paper, MS teams	Early September 21
APWG	Direction of travel and key messages. Fit with local and national policy. Stakeholder engagement.	Presentation, MS Teams	14 Sept 21
All Members	Update on direction of travel and key messages. Fit with local and national policy. Stakeholder engagement.	Briefing paper	Before 23 Sept 21
Trade Unions (SBC and Cornerstone)	Direction of travel and key messages. Fit with local and national policy. Stakeholder engagement. Potential impacts for staff.	Presentation, MS Teams	23 Sept 21
Staff teams	Direction of travel and key messages. Fit with local and national policy. Stakeholder engagement. Potential impacts for staff.	Presentation, MS Teams	End Sept 21
Service users, families	Update and direction of travel. Next steps re market testing, commissioning.	Easy read letter	End Sept 21
'The Market', local community groups	Direction of travel and key messages. Fit with local and national policy. Invitation for co productive specification drafting.	Presentation, MS Teams Group work	Dec 21 + Feb 22
IJB	Commissioning intention(s)	Presentation, MS Teams	Dec 21
ALL	Commissioning process timeline and opportunities	Various: MS teams, briefing, letters	Spring 22

Summary

- There is a need to continue to further develop daytime support in line with earlier reviews dating back to 2011.
- Services need to be locality based in line with national and local strategic direction.
- Services need to support individuals to achieve their desired outcomes and promote independence and individuality as highlighted through consultation.
- Services need to be provided from within the available budget.
- A new service model will be developed and presented to the IJB for agreement.
- A formal commissioning process will be implemented with new services in place September 2022.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By:	Chris Myers, Chief Officer Health & Social Care
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
ALLIANCE REPORT – HEALTH & SOCIAL CARE IN THE SCOTTISH BORDERS	
Purpose of Report:	To share with the Health & Social Care Integration Joint Board the report produced by the Alliance on Health & Social Care in the Scottish Borders. The report was discussed at the Strategic Planning Group meeting held on 4 November 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the Alliance Report
Personnel:	As detailed within the report.
Carers:	As detailed within the report.
Equalities:	N/A
Financial:	N/A
Legal:	N/A
Risk Implications:	N/A

Background

Throughout 2021, the Health and Social Care Alliance Scotland (the ALLIANCE) has continued its work engaging with the third sector in the Scottish Borders in partnership with Borders Care Voice and the Berwickshire Association for Voluntary Service (BAVS), who form part of the local Borders Third Sector Interface (TSI).

As of October 2021, the Alliance have organised two Third Sector Forums in partnership with Borders Care Voice and BAVS. The first of those in April gave participants the opportunity to discuss:

- Key messages they would like to communicate with the Health and Social Care Partnership (HSCP);
- Key issues their organisation, and the wider third sector in the Borders, are facing at the moment;

- As well as solutions to those key issues, which were prioritised following a vote.

Summary

The findings of the report are that people would like to see:

- Support in place which enables people to remain in their own community and, specifically, in their own homes;
- Their families well cared for, with adequate home care and childcare in place to ensure parents and grandparents are able to work, volunteer and support the community in the Borders;
- The support available to carers expanded to ensure that they are able to carry on their vital roles;
- Person centred approaches utilised to meet people's unique needs, with the voice of lived experience incorporated into strategic planning and commissioning;
- Greater financial resources allocated to the third sector and health and social care services;
- More to be done to promote the Borders as somewhere to live and work in the future;
- And fully integrated health and social care services which offer a choice of face to face, online and telephone support.

20 years into the future

Health and social care in the Scottish Borders

Learning from our series of Third Sector Forums in the Scottish Borders

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Borders
THIRD SECTOR INTERFACE

Borders Care Voice
Involving you to improve health and social care

Contents

Background

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As of October 2021, we have organised two Third Sector Forums in partnership with Borders Care Voice and BAVS. The first of these in April gave participants the opportunity to discuss:

- Key messages they would like to communicate with the Health and Social Care Partnership (HSCP);
- Key issues their organisation, and the wider third sector in the Borders, are facing at the moment;
- As well as solutions to these key issues, which were prioritised following a vote.

Amongst these key issues, commissioning was discussed extensively. People shared their concerns around short term funding, with contracts only being 'rolled over' in 2020 for 12 months as a result of the COVID-19 pandemic. There were also frustrations around the transparency involved in statutory commissioning and the length of time it takes to secure funding. Cumulatively, these issues have led to the development of an atmosphere of uncertainty for third sector organisations and job insecurity for third sector staff.

To address these concerns around commissioning, at our second Third Sector Forum in July, Robert McCulloch-Graham, Chief Officer of the Scottish Borders HSCP, provided an overview of the Partnership's new Strategic Commissioning Plan.

To inform this plan, Robert McCulloch-Graham asked those in attendance to imagine what they and their families will look like in 2042 and think of how they would like to look after themselves and their families 20 years from now.

What followed was a thought provoking workshop around what people believed they will expect from their health and social care services 20 years from now, with people discussing:

- Community support;
- Family support;
- Carer support;
- Promotion of the Scottish Borders;
- Person centred approaches;
- Financial concerns;
- And engagement with health and social care services.

This discussion is summarised in the following report and will be submitted to the Scottish Borders HSCP to inform their new Strategic Commissioning Plan.

The first workshop in April also uncovered learning around visibility, trust, uncertainty, digital working and place based approaches.

Visibility and trust of the third sector:

- It was shared that the statutory sector, as well as the public, is recognising the value and potential of the third sector more.
- This improved during the COVID-19 pandemic, with the third sector's flexibility and community base both being seen as huge assets. It was agreed that efforts should be made to build on this progress.

Uncertainty for the third sector:

- Many third sector organisations and providers have faced a great deal of uncertainty as a result of COVID-19. More clarity should be provided around future funding streams to remove some of this uncertainty.
- The third sector is also facing issues with the complexity of remobilisation and the reopening of face to face services. Many organisations depend on face to face support and the mitigations required to remobilise (risk assessments, test and protect and other COVID-19 restrictions) are daunting for some volunteer led services.
- There has been a rapid loss of volunteers within the third sector as people have returned to work, following a rapid increase at the beginning of the COVID-19 pandemic. As a result, it was argued that the expectations of what the third sector in the Borders can achieve at the moment should be managed.

Challenges of digital working:

- There were calls for a blended approach to be taken to digital working going forward, avoiding a 'one size fits all' approach.
- Digital exclusion for the people the third sector in the Borders support is still of concern. More should be done to address the barriers which prevent people from utilising online support, whether these relate to finance, knowledge or confidence.
- It was suggested that opportunities, support and resources which support digital access for the public should be mapped across the Borders.

Place based approaches:

- Concerns were also raised about the extent to which organisations who are Borders-wide, but with a low number of staff, are able to get involved in local planning processes.
- Those at this first workshop called for more to be done to ensure that 'the right organisations are involved at the right locality tables.'

To address the challenges facing the third sector in the Borders, we carried out a pinpointing exercise which supported the group in attendance to discuss and then vote on their top three recommended actions that should be taken.

Action one

Increase the third sector's influence with the local Health and Social Care Partnership (HSCP) by building relationships and raising awareness of what the third sector can offer.

- It was suggested that this could be achieved through organising information and development sessions for local third sector organisations and providers in partnership with the local HSCP.
- This would promote relationship building within the third and statutory sectors and create a greater mutual knowledge of what the third sector in the Borders currently provides.

Action two

Include a second Third Sector Representative at meetings of the local Integration Joint Board (IJB).

- This would create a more equal footing on the local IJB, with those at this first workshop also arguing in favour of all IJB members being given full voting rights.
- It was also suggested that one Third Sector Representative could be given a local wellbeing outcome focus, with the role of facilitating regular Third Sector Forums on this topic.

Action three

Encourage the local IJB to adopt a concerted focus on co-production and engagement.

- It was argued that this should involve greater public involvement in the IJB's own annual reviews and monitoring processes.
- To encourage a more long term focus on co-production and engagement, it was suggested that the third and statutory sectors in the Borders should aim to produce a 'Co-production Charter' in partnership which will aim to promote a closer working relationship going forward.

Community support

When asked about the future of health and social care in the Borders at our second Third Sector Forum in July, the most commonly raised theme was community support.

It was argued that the local community in the Borders could be more connected, supportive, fair and tolerant, with an emphasis on empowering people to support one another. Examples were shared of previous occasions in which the community in the Borders has come together effectively, with one person recalling 'the year we were all snowed in,' in 2018, and another adding that 'they had never seen the community come together to this extent before.'

People would like to see this community spirit replicated on a more regular basis and there was a feeling that more could be done to foster and nurture this spirit. It was suggested that more central community hubs could address this need, giving people a chance to meet in central locations such as GP surgeries and learn from one another. This would also help to address isolation in the Borders by creating connections and encouraging people to become more active members in their community.

It was argued that health and social care services should ideally be 'the last point of contact, because all my needs have been met before that point, through the community and through wellbeing programmes... And because prevention has been so effective.'

There was also widespread agreement at this forum in favour of support being put in place to enable people to receive services in their community and, specifically, in their own homes. One person in attendance with a long term neurological progressive condition shared that they would like to be reassured that their home would be adapted if needed and that they would not have to move.

Health and social care services should be more accessible and people should not be compelled to enter a communal care setting if this is not necessary to meet their needs: 'A communal care setting isn't an appealing one to me. It is important to have your family with you and your partner with you for support.'

Family support

It quickly became obvious during this workshop that family was a priority for most people in attendance. As outlined above, people see family as a crucial aspect of their support system.

People would like to see their parents and grandparents well cared for, ideally at home if this is possible. There should also be more options available to families in terms of childcare. Those in attendance shared that they loved spending time with and looking after their grandchildren, and other children within their family, however they did not agree with 'the current reliance on grandparents.'

Ideally, providing childcare should be optional, and not a duty that takes away from older people's ability to work, volunteer and support the community in the Borders. A number of people at this workshop noted that they have far fewer volunteers who are older or retired than they had in the past, with many volunteers who were unable to continue their role citing childcare responsibilities.

Carer support

Everyone in attendance was in agreement on the need to build upon the support available to carers in the Borders, to ensure that they are able to carry on their vital roles.

Respite, in particular, was highlighted as a matter of concern. Many of the people in attendance who work with carers in the Borders noted the extreme pressure carers were put under during the COVID-19 pandemic. As health and social care services were suspended, carers were expected to take on greater responsibilities and this has had a negative impact on carers' mental health. To alleviate this stress, it was argued that the issue of respite for carers should be considered urgently.

The Scottish Borders Council's decision to close all buildings based day services, which catered for people with higher levels of need, was also discussed. People shared that, as well as giving structure and purposeful activity for individuals away from the home (particularly people living with dementia), this was a crucial aspect of regular respite for carers. This pressure has been compounded by COVID-19 and is leading to carer burnout and increased hospital admissions.

The ALLIANCE has carried out previous engagement work in the Borders, gathering views on carers' experiences of integration. **The Integration Support team published a report following this engagement work which is available to read on the ALLIANCE website**

The views shared at our Third Sector Forum in July echoed these findings. However, there were concerns at our forum in July that the support available to carers has actually regressed over the last year and a half and that 'more needs to be done just to rebuild what has been lost during the lockdowns' that were put in place during the COVID-19 pandemic.

Person centred approaches

When discussing their expectations of future health and social care services, the importance of choice was repeatedly stressed.

People advocated the use of person centred approaches, adapting services to meet people's unique needs. Echoing the ALLIANCE's principle of putting people at the centre, it was repeatedly stated that more should be done to incorporate the voice of lived experience into strategic planning and commissioning.

More should be done to engage with people, involving them in the planning of their care to improve their quality of life: 'It shouldn't be done to people. It should be done with them.' This may require a culture change with one attendee claiming that 'a change of attitude is needed. Instead of refusing to make changes because this is the way we have always done it.'

As well as this, more should be done to involve the voice of lived experience in higher level decision making within the Scottish Borders HSCP. It was suggested that the connections required to involve the voice of lived experience at strategic groups already exist and it would simply be a case of utilising these current links on a more regular basis.

Financial concerns

Looking to the future, people shared concerns around the finances that will be available to the third sector as well as health and social care services 20 years from now.

Concerns were raised that 'services and care packages which were scaled back during the pandemic will not be restored.' These fears should be allayed, with people made aware that these changes are not permanent and were made in response to the crisis of the COVID-19 pandemic.

However, there is an impression that services have not expanded over the last 20 years, and have instead been reduced, with one attendee claiming that 'back in 2001, it felt as if we delivered a broader range of care. It felt like there was more money then.'

People also spoke about the importance of their own financial security, and that of their family, which is closely tied to their health and wellbeing.

Promotion of the Scottish Borders

Many people shared concerns around the appeal of the Borders as somewhere to live and work in the future. It was agreed that work needs to be done over the next 20 years to promote the Scottish Borders.

With the population of the Borders ageing, it was argued that more could be done to keep younger people in the Borders. At the moment many young people leave the area for career opportunities elsewhere. By developing career pathways for young people it is hoped that more will choose to stay in the Borders.

Certain career choices, such as working in social care, could also be far more valued to combat this. There is a feeling that social care is currently 'underfunded and undervalued,' discouraging people from pursuing this as a career. Many shared their hopes that the Feeley report, if 'brought to life,' may begin the transformation of social care in Scotland but more could already be done locally in the Borders to begin this journey.

It was suggested that infrastructure within the Borders could be improved to attract more residents, with a better road network and public transport links needed. Internet access and connectivity can also be an issue locally, particularly in rural areas. This will be increasingly important as more and more health and social care services are delivered online.

Lastly, it was highlighted that the Borders' housing stock 'is notoriously old and difficult to adapt,' creating issues for people with long term conditions who wish to be supported in their own homes.

Engagement with health and social care services

Those in attendance then discussed how they would like to engage with health and social care services in 2042.

People seemed unsure of how primary care will be structured 20 years from now and questioned what role GPs will play in the future. Currently, GPs act as a link to different specialists. There was a

suggestion that nurses have already begun to take on some of this role and that technology may be used in the future to perform some of these responsibilities to 'connect the dots' between services.

There was agreement that these connections need to improve, with better communication between health and social care professionals and services. A common complaint, that 'people don't want to tell ten people the same thing' and would instead prefer a single point of contact to facilitate their support, has still not been addressed. People appeared to be frustrated with the progress of health and social care integration and would like services to work together more closely in partnership.

There were welcome changes during the COVID-19 pandemic, including a shift towards online and telephone support. People would like to see these adaptations continue, with more technology incorporated into health and social care services over the next 20 years. However, these changes should not come at the expense of face to face services. People do not want to lose the 'human contact' of speaking to a GP or health and social care professional in person. And there was concern that symptoms, for example, may be missed over the phone or during an online appointment.

There were also calls to learn from international approaches. In the Netherlands, for example, the community is built around the needs of people with dementia to ensure that they have a safe environment in which to live, rather than vice versa. This raised the question of accessibility in the Borders. People in attendance said that they would like to see progress in this regard in the future, with services, and the buildings in which services are delivered, made to be as accessible as possible.

Summary

There was a real positivity during this workshop that almost everything people would expect from their health and social care services in 2042 is achievable right now.

People would like to see:

- Support in place which enables people to remain in their own community and, specifically, in their own homes;
- Their families well cared for, with adequate home care and childcare in place to ensure parents and grandparents are able to work, volunteer and support the community in the Borders;
- The support available to carers expanded to ensure that they are able to carry on their vital roles;
- Person centred approaches utilised to meet people's unique needs, with the voice of lived experience incorporated into strategic planning and commissioning;
- Greater financial resources allocated to the third sector and health and social care services;
- More to be done to promote the Borders as somewhere to live and work in the future;
- And fully integrated health and social care services which offer a choice of face to face, online and telephone support.

The ALLIANCE intend to continue our partnership work with Borders Care Voice and BAVS, with another Third Sector Forum due to take place in November 2021. This forum will continue to promote the voice of the third sector in the Borders and ensure that the local HSCP engage with the third sector meaningfully and on a regular basis. In partnership with Borders Care Voice, BAVS and the local HSCP, we intend to use this forum in November to support the production of a Co-production Charter which will promote a long term closer working relationship between the third and statutory sectors in the Scottish Borders.

About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. We have a growing membership of over 3,000 national and local third sector organisations, associates in the statutory and private sectors, disabled people, people living with long term conditions and unpaid carers. Many NHS Boards, Health and Social Care Partnerships, Medical Practices, Third Sector Interfaces, Libraries and Access Panels are also members.

The ALLIANCE is a strategic partner of the Scottish Government and has close working relationships, several of which are underpinned by Memorandum of Understanding, with many national NHS Boards, academic institutions and key organisations spanning health, social care, housing and digital technology.

Our vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

The ALLIANCE has three core aims; we seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.
- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.
- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

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The ALLIANCE is supported by a grant from the Scottish Government.

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 2021

Report By	Tim Patterson
Contact	Fiona Doig
Telephone:	07825523603
ALCOHOL AND DRUGS PARTNERSHIP ANNUAL REPORT 2020-21	
Purpose of Report:	The purpose of this report is to: • Update the IJB on the content of ADP Annual Review and highlight Annual Report 2020-21
Recommendations:	The Health & Social Care Integration Joint Board is asked to: • **Note** the Annual Review and highlight Annual Report
Personnel:	Staffing is provided within the agreed resource.
Carers:	A previous needs assessment for affected family members was carried out in 2019.
Equalities:	A Health Inequalities Impact Assessment was completed on the current ADP Strategy.
Financial:	ADP funding from Scottish Government is contingent on delivery of Ministerial Priorities.
Legal:	N/A
Risk Implications:	Engagement with this particular client group can be challenging and many social and economic influences outside the control of the ADP will impact on the success of the initiatives. If statutory agencies fail to prioritise this area of work outcomes may not be achieved.

1 Background

The ADP is required to submit an Annual Review to Scottish Government using a prescribed template (see embedded document (1)). Recognising the limitations of the template the ADP has also developed a narrative 'highlight' report which provides a more detailed update on some key developments and activities during 2020-21 (see embedded document (2)). The reports do not represent all work carried out across the partnership.

The Annual Review has been approved by the ADP Board and IJB Chief Officer.

The 'highlight' report includes an update on progress against Ministerial Priorities; drug and alcohol services responses during COVID-19 pandemic and progress in relation to areas for improvement identified in the ADP Strategic Plan 2021-2023.

Borders ADP is a partnership of agencies and services involved with drugs and alcohol. It provides strategic direction to reduce the impact of problematic alcohol and drug use. It is chaired by the Joint Director of Public Health and the Vice Chair is Scottish Borders Council's Director – Social Work and Practice. Membership includes officers from NHS Borders, Scottish Borders Council, Police Scotland and Third Sector

2 Assessment

The 'highlight' Annual Report shows positive progress in many of the reporting areas and extracts are presented below. There are some areas where the ADP will seek work to improve in future work. There is a two year Delivery Plan in place which is monitored by the ADP Board.

2.1 Highlighted areas in narrative Annual Report

- Drop-in clinics were postponed due to COVID-19 but all drug and alcohol services remained open throughout 2020-21 and adapted service provision to ensure all current and new clients were still able to access support (p4).

- During 2020-21, 512 individuals started treatment with 99% starting within three weeks of referral against target of 90% (p4).

- Online recovery/fellowship meetings continued throughout 2020-21 with WAWY Mutual Aid Partnerships meeting online and expanded (p5).

- In 2020-21 there were 49 first supplies of Take Home Naloxone provided across Borders. In Borders we have reached 86% of our estimated population of

opiates/benzodiazepines drug users with a first time kit compared with 57% nationally (p5).

- Good progress is being made in Borders in relation to Medication Assisted Treatment (MAT) standards[1] 1-5 and Borders Addiction Service (BAS) has been awarded national funding to participate in a MAT Sub-Group test of change. The numbers of people starting same day prescribing increased. Patient choice expanded to include additional formulations of an existing medication (buprenorphine) Espranor and Buvidal (p6). Espranor is a sub-lingual formulation and Buvidal is an extended release injection.

- Despite schools being closed due to restrictions, CHIMES (Children Affected by Parental Substance Use/Family Service) was able to support children impacted by a family member's alcohol and/or drug use, young carers and parents with concerns around their drug/alcohol use. During 2020-21 CHIMES staff members applied for and distributed over £65,000 to families to enable practical support e.g. fuel, energy, food and broadband costs as well as activities, technology and equipment (p6).

- During 2020-21 Borders ADP Support Team coordinated 12 online training courses with 130 participants attending (p8).

- A total of 1341 alcohol brief interventions were delivered across Primary Care, Antenatal and wider settings. This was against a target of 1312 (102%) (p8).

2.2 Areas for improvement

- Involvement of lived experience – The 2020-2023 ADP Strategy Refresh highlighted the need to improve the involvement of people with lived experience. Pre COVID-19 positive meetings were held with people with lived experience and family members. This panel has continued to meet online and consider how to develop lived experience involvement in ADP planning. This group is chaired by the Recovery Engagement Officer within We Are With You (WAWY) and supported by

[1] https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/

officers from Serendipity Recovery Café, Scottish Recovery Consortium and ADP Support Team (p8).

- Independent Advocacy
  The ADP contributes a small amount of funding (£5,000) towards the contract for independent advocacy in Borders. No further development has progressed in 2020-21 and the ADP is currently exploring additional capacity within the system (p9).

- Pathways for people experiencing both mental health and substance use concerns ('co-morbidity') - Development of formal pathways was not progressed during COVID-19, however, work is ongoing within Mental Health to progress this work (p9).

3 Preventing drug related deaths

Prevention of drug related deaths remains a priority for all ADP partners. The 2019 Annual Report was produced and presented at the Critical Services Oversight Group (CSOG).
In May 21, a pilot to test a Non Fatal Overdose Pathway was established to ensure people experiencing non fatal overdose are identified and offered appropriate outreach and aftercare including referral into drug treatment service (p6).

4 Financial Framework

4.1 The financial position for 2020-21 is presented in the Annual Review (p32). Members will be aware of the significant additional funding provided to ADPs as part of the £50 million investment by Scottish Government to support a National Mission to reduce drugs harm and deaths. This funding is in place for 5 years from 2021-2026.

Borders ADP received its funding notification in June and August 2021. At its meeting on 21.10.21 the ADP confirmed how it will allocate the funding. A total of £510,280 has been awarded to Borders. Due to the timing of the award letters and decision making processes, at time of writing contractual negotiations with providers are still being progressed.

Funding is awarded across seven different priority areas as presented in Table 1 below.

1. June letter - Additional allocations (2021-2026)

National Mission	*106,308*
Residential Rehabilitation	*106,308*
Whole family approach	*74,416*
Total announced June	£287,032
2. August letter – Additional allocations 2021-2026	
Buvidal	*85,047*
Outreach	*63,785*
Near-fatal overdose pathways	*63,785*
Lived and living experience panels/forums	*10,631*
Total announced August	*£223,248*

Table 1: Additional Borders allocation of National Mission £50 million.

A Scottish Government FAQ's document has been circulated to the ADP Board which confirms we should consider the Programme for Government funding as recurring pending confirmation following the Scottish Government spending review.

The ADP agreed allocation of these additional funds based on:

- existing evidence (MAT standard implementation assessment; residential rehabilitation survey, discussions to develop ADP Strategy 2020)
- feedback from services and people with lived and living experience
- funding requirements from Scottish Government.

4.2 Final agreements re funding dispersal were agreed at the ADP in October 2021 as follows:

4.21 National Mission Funding

National Mission Funding £106,287	**Award**
3% uplift on We Are With You (WAWY) contracts	£13,161
Additional WAWY capacity (1 WTE)	£35,000
Additional Borders Addiction Service (BAS) capacity	£57,126

4.22 Residential Rehabilitation Funding

Residential Rehab £106,287	
Additional places (70% of funding)	74,401
Peer navigator (WAWY 0.6 WTE)	18,625
Additional capacity BAS (equivalent Support Worker 0.5 WTE)	13,400
Total*	**£106,426**

*there is a minimal over commitment in this budget line

4.23 Whole Family Approach

Whole Family Approach £74,416	
3% uplift on CHIMES contract	£7646
Additional CHIMES capacity (1 WTE)	£35,000

Additional WAWY Capacity (0.8 WTE)	£31,500
Total	**£74,146**

4.24 Buvidal

Buvidal is a long acting formulation of buprenorphine which is administered by monthly injection. This funding will be allocated to support implementation of Buvidal supply.

4.25 Outreach and non-fatal overdoses

These funding streams have been bundled together to reflect current arrangements and existing successful working practices

Outreach and Non-fatal overdoses (£127,570)	
WAWY (1.0 WTE)	35,000
BAS	65,000
Pharmacy	12,500
Peer navigator (0.4WTE)	12,417
Logistics	2,000
Total	£126,917

4.26 Lived and living experience

We currently commission a role within WAWY to support this area of work. Scottish Drugs Forum has been awarded a national contract to co-ordinate and support panels. We await further information relating to the requirements for this funding prior to agreeing allocation.

4.3 Contracts and procurement

The ADP Support Team has been supported by SBC Contracts and Procurement to ensure appropriate routes to commissioning. The current plans are in place:

- WAWY – vary the existing contract with new funding requirements and extend to March 2023. A PIN notice has been issued in Winter 2021 to explore the market and inform a Commissioning Strategy.
- Action for Children CHIMES – this service is jointly funded by the Children and Young People's Leadership Group (CYPLG) funding. The CYPLG has extended all services until end March 2023 to enable a commissioning review. A variation will be issued to confirm new funding requirements.
- BAS – an SLA is in place until March 2024, however, due to new expectations and there is an agreement to review and updated this by March 2022.

4.4 Governance

Services participate in a quarterly contract monitoring meeting. Quarterly performance and finance reports are reviewed by the ADP. Scottish Government now requires quarterly reporting of finances and residential rehabilitation requirements.

5 Recommendation

- The IJB will wish to note the ADP Annual Review and highlight Annual Report.

Embedded documents:

(1) ADP Annual Review	(2) Narrative highlight Annual Report
 ADP Annual Review SG 2020-21.docx	 Narrative Annual Report 2020-21.docx

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 December 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 meeting, as an update on key actions and issues arising from the meeting held on 4 August 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the 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.

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 4 August 2021** at **10am** via Microsoft Teams

Present:
Lucy O'Leary, Non-Executive NHS Borders (Chair)
Rob McCulloch-Graham, Chief Officer
Keith Allan, Consultant in Public Health Medicine
Gerry Begg, Housing Strategy Manager
David Bell, Joint Staff Forum
Stuart Easingwood, Director of Social Work
Diana Findlay, Cheviot Locality
Lynn Gallacher, Borders Carers Centre
Caroline Green, Public Member
Wendy Henderson, Independent Sector Lead
Susan Holmes, Principal Internal Auditor
Graeme McMurdo, Programme Manager
Jenny Smith, Borders Care Voice

In Attendance:
Laura Prebble, Minute Taker
Philip Lunts, Strategic Planning Lead for NHS Borders

1. APOLOGIES AND ANNOUNCEMENTS

Apologies received from Clare Oliver, Colin McGrath, Amanda Miller and Stephanie Errington.

The Chair confirmed the meeting was quorate.

Introductions were made for the new Chair.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 5 May 2021 were approved with the following amendments:

- Pg. 2 amendment: 'Lynn Gallacher noted that it is difficult to capture co-production and asked if there was a way of measuring it. We need to be better at demonstrating outcomes. Wendy Henderson noted that her organisation uses the integrated impact assessment to track a process.' To be amended to 'Wendy Henderson advised that integrated impact assessments is one process that could be used to measure collaborative working and coproduction.'

3. MATTERS ARISING

Action Tracker: All items complete.

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

4. ANNUAL PERFORMANCE REVIEW

The draft review was circulated by Graeme McMurdo. This draft report was taken to last week's IJB meeting for approval but the meeting had not been quorate. Approval of the report was therefore deferred by the IJB to the SPG. Rob McCulloch-Graham confirmed the role of the SPG is to provide comment so the report can be approved formally at the next IJB meeting in September.

Background – The Annual Performance Review (APR) was due by the end of July 21 but due to Covid, this has been amended to November 21. Certain areas have to be in the report such a national wellbeing, inspections, governance and data. There has to be narrative around the 3 strategic objectives. The narrative focuses this year on Covid and its effect; how staff have adapted, community assistance hubs set up and changes in care at home. To evidence the partnership working that has been carried out. To show joint working and how partners have come together and worked better. To give evidence in the narrative and also look forward to 21/22. To show what we have done and how we have coped. The financial content is legislative.

IJB were concerned about the lack of benchmarking/targets. However, the IJB does not have targets as such so this is problematic. The report aims to reach a balance of narrative and data.

SPG to agree any changes to this report.

Comments: Jenny Miller was at the IJB meeting and agreed with the points made about the carers section. That the 'users of social care' had been light on measurement. Improved wellbeing is difficult to map. Jenny noted that the report is written for professionals and asked if there could be a brief, more user friendly version for the public/service users. Keith Allan commended Graeme McMurdo for bringing this report together. He shared Jenny's views. Public Health - Strategic objective 1 is to improve health. Keith asked if this could be expanded to include other wider indicators of health. To increase the public health content. Lynn Gallacher also agreed and added that the data needed updating for the strategic aim for carers and Graeme confirmed this data has now been updated. Lynn also noted that the right evidence needs to be against the right strategic aim. Work has been done with carers and to make sure this is reflected in the report.

Wendy Henderson asked about the split of spend as the care pathway changes. Is the increase in spend on social care balanced with a decrease in spend in health as people are not having to go in to hospital. The shift in the balance of care as the whole system improves. Rob McCulloch-Graham noted that there is currently an imbalance. However, the spend on the early stages of care will reduce the spend at the end of care stage. The shift has started but is in the early stages. Investment in the community sector and adult mental health has seen a success with the reduction in the number of delayed discharges.

Currently 3 or 4 where there used to be 16 plus. 0.5% of the budget has shifted and there is the intention to do more in the next few years. The National Care Service will bring this about going forward.

Jenny Miller suggested a 'snagging list' from the current strategic objectives so the planning can be right next year for the next report. Rob McCulloch-Graham confirmed he had noted some snags already.

Keith Allan acknowledged that the demand for health care is infinite. Moving the spend to preventative is a difficult and perpetual problem. It is an age old issue to reduce the demand for primary care.

Graeme McMurdo asked 2 questions - what to do now to shape this report and what to do in the future. Additional evidence is needed and then to create a shorter report.

Rob McCulloch-Graham thanked Graeme for producing the report and noted that he is very pleased with the report. It is balanced and is telling a story as well as reporting data.

To consider developing KPIs for the future so the report is easier next year. To include the shift in the balance of care in the report and include the support of Public Health to support the health of the population.

Lynn asked if Graeme could send her a template for data she can add data and case studies to be included in the report. Rob McCulloch-Graham noted that this would be useful. The report relies on stories from service users. He asked if members of this group could start to collect stories from service users for this report and those in the future. To include stories where things have not been done well too, for the improvement of services.

Wendy Henderson asked if the report could be translated into other languages, as part of the public duty.

Action: Following comments made today, Graeme McMurdo will make amendments suggested and recirculate to SPG members to approve the final report before September's IJB meeting. A shorter public facing report will also be produced.

The **STRATEGIC PLANNING GROUP** to approve the final report before it is sent to IJB in September.

5. NATIONAL CARE SERVICE

Rob McCulloch-Graham gave an update. Rob met the new Health Secretary and the new Minister for Care yesterday at the Chief Officer's meeting. The meeting looked at where we are at the moment and then looked at the National Care Service (NCS) and what needs to be done, following the Feeley Report. The NCS is under national consultation from 8th August to 18th October 21. The Scottish Government have asked Chief Officers to be champions for this consultation. To respond as individual agencies, collectively as organisations and also as a partnership.

It is hoped that one response can be submitted from the Chief Execs of the IJB, NHSB and the Council collectively as there is a commonality and it would be more powerful and show how joined up we are here.

Rob reminded the group of the recommendations made in the Feeley Report. The report recommends that the SPG merges with the IJB and every member of the new IJB will have a vote. The intention is to make sure every member has a greater degree of influence. To engage more with localities. There has been a first meeting of the social governance group. The new design of the NCS is to be led by the people who use the services. This group will meet monthly and Kevin Stewart will Chair. It was suggested that the Chief Officers Group meeting monthly too. Other recommendations are for the IJB to become an employing group with potentially 3,000 staff. IJB to hold capital and contracts and funding will be available directly through the IJB. How to do this is still under question. To potentially start with adult social care. The Scottish Government want to pass a new Act to be the foundation of the NCS within the next 2-3 years. The fundamental principle is to have equal access to services; a humanitarian right. To tap in to the resource of older people in society. To get the best out of every person. Applying the intention of children's services to adult services. Getting it right for every child and adult. To set up a common set of values and beliefs. Chief Offices to maintain the momentum created by the Feeley Report. A springboard. New legislation will bring all areas to the same point.

SPG to be a champion of the consultation. To ensure all comments from all cohorts are included. The next meeting on 3rd November 21 is after the close of the consultation. Timescale.

The Chair and Stuart Easingwood noted how inspirational and encouraged they are by the tone of this meeting. Stuart felt it was optimistic to have a collective response as this had been tried previously but was unsuccessful. He added that a broadening of voices was welcome. It will empower people in communities to have a voice. Jenny Miller agreed but asked how this would be carried out and offered to be involved in reaching adults and children in the community. Jenny asked how this would be resourced, given the economic effect of Covid. Rob noted that it would mean that adult care would be run by the Scottish Government rather than local authorities and so there will need to be a resource given to it.

The **STRATEGIC PLANNING GROUP** noted the update. Rob McCulloch-Graham thanked everyone for their comments and offers.

Action: Rob McCulloch-Graham to come up with a strategy on how to make a collective response to the consultation from the SPG.

6. JOINT EXECUTIVE TERMS OF REFERENCE – Senior planning group for the commissioning Strategy

Rob McCulloch-Graham gave the background to this group. In the APR, the decision making process during the pandemic was looked at. As a result of the pandemic, this process has changed. Previously, the EMT which was chaired by the 2 Chief Execs reported to the SPG who gave advice to IJB. It was a clearing house for papers.

This process meant it could take 9 months to approve a paper. The pandemic changed this process. Meetings took place daily, then weekly and now monthly. Decisions were made very quickly e.g. assistance hubs were set up in 2 weeks. Appling the lessons learnt, the process has become more streamline.
A new Joint Exec for Health & Social Care Partnership has been set up and the new ToR have been circulated to the SPG for approval today. The Chief Officer will be Chair. To focus primarily on Health & Social Care. To oversee an lead on the development of the commissioning strategy due by April 2022.

Comments: Jenny Miller asked about the representation from the 3rd sector. The connection to the 3rd sector needs to be formalised and noted on the ToR. Rob McCulloch-Graham suggested a concordat; an agreement between agencies. Wendy Henderson suggested something similar to the Independent Sector Providers Strategic Advisory Group, a sub group of the SPG that Rob chairs. An engagement framework with a formalised meeting structure. Caroline Green noted that the 3rd sector does not include smaller charities. All charities should be given the opportunity to be involved. Jenny Miller agreed. She noted that it is difficult to involve charities in the 3rd sector. The Red Cross has been involved and Macmillan used to have local representatives on the SPG. Charities offer important services to older people. Jenny agreed that charities need to be referenced to in the ToR. To reach out to charities as part of the engagement.

Action: Chair to add 3rd Sector Forum to AOB.

Rob McCulloch-Graham noted that co-production should include national and smaller local charities. National funding could be brought into the Borders. The Chair added that national charities may welcome being invited in to the Borders.

Caroline Green noted that £1K a week is being spent on food for the Galashiels food bank for people on universal credit. Food will have an impact on people's health.

The **STRATEGIC PLANNING GROUP** agreed the Terms of Reference with the amendments made on screen.

7. MODELLING BED DEMAND – Philip Lunts

The Chair welcomed Philip Lunts to the meeting. Philip gave a presentation on modelling future demand for care homes in the next 10 years. A forward projection to inform what beds will be required in the future. The report looks at demographics, frailty and dementia. The population in the Borders is aging. Currently, most residents are 50-70 which will shift to 60-80 over the next 10 years. There will also be a fall in the younger population to do the caring. 3% of the over 80s are in care homes. There is little difference between localities. It is anticipated that 188 more beds will be needed by 2030. To look at how to reduce the need for beds. There has been no increase in demand for beds despite a 20% increase in the older population currently. The report investigates why this might be. In the Borders we have 2nd/3rd lowest number of care beds in Scotland. There are a high number of out of area placements. That is because some Berwickshire residents go to Berwick and some Tweeddale residents go to Edinburgh. The Borders has a lower than average number of self-funded care beds. The Borders are middle ranking in the size of care packages. The Borders is slightly above average for non-statutory

care i.e. friends and neighbours doing the caring. The Borders has an aging estate of care homes. There is a high dependency on the community. The reduction of respite and the closure of day care have had an impact. The rates of emergency admissions are average. The Borders has 36 more hospital beds than the average. Delayed discharges are average.
No clear differences were identified to explain why the 20% increase in the population has not resulted in additional care beds being needed. Age designated housing is 6th highest in Scotland. A & E attendance is higher. Rural location may mean better family support networks. The next steps are for stakeholders and the Council to look at how to reduce care home admissions. Rapid action rehabilitation and early intervention - to look at the effect on care home beds.

The **STRATEGIC PLANNING GROUP** thanked Philip Lunts for his presentation and invited comments.

Comments: It was felt that more time was needed for members to look at the report in detail and to return to discuss again, out with the SPG meeting. Keith Allan agreed that a lot of need is obscured by the family taking up the care. Care is taken up at a very late stage as it is not understood to be available. There is a benefit to being kept out of hospital. To look after the mental and physical health of the carers. Wendy Henderson added that 75% of care home beds are provided by the independent sector. Providers are presenting their 10 year plans to Wendy. This is where the shortfall could be met. The Independent Sector Providers Strategic Advisory Group could feed into this. Lynn Gallacher confirmed that carers are burnt out and stressed as they are not getting access to respite care. Carers are looking for day care with care built in. Lynn is working with the Health & Social Care Partnership to deliver a respite event to look at what is available and where there are gaps so as to meet the needs of the service users and their carers. To involved the right people. Gerry Begg added that the housing strategy will contribute to this by providing specialist housing which included equipment and adaptations.

8. ANY OTHER BUSINES

Jenny Miller – 3rd Sector Forum Update. The second event took place 3 weeks ago and IJB were invited. The roles of the representatives was discussed and agreed. Good co-production and solid relationships built. Action plan – wider involvement needed. To consider who to invite.

Lynn Gallacher noted that there has been an underspend of the Carers Act Funding. This is sitting with the carers workstream to give direction of spend. Rob McCulloch-Graham noted that there needs to be a plan around it. To look at what is existing and what is new money. SPG/IJB to agree how it is to be spent.

The Chair noted that this is Rob McCulloch-Graham's last SPG meeting before he retires in October. On behalf of the group, she offered their sincere thanks for his contribution to this group which has been immensely helpful. The adverts have gone out for a Chief Officer and a Chief Financial Officer post. This will strengthen the commissioning function of the IJB.

9. DATE AND TIME OF NEXT MEETING

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