Scottish Borders **Health & Social Care** Partnership

ANNUAL PERFORMANCE REPORT 2019-2020

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

Scottish Borders
Health and Social Care
PARTNERSHIP

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SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP ANNUAL PERFORMANCE REPORT 2019/2020

INTRODUCTION

This is the fourth Annual Performance Report for the Scottish Borders Health and Social Care Partnership (HSCP). It focuses on our performance between April 2019 and March 2020, outlines our priorities for 2020/21 and reflects back on our performance since April 2016. I joined the partnership in October 2017 and I am privileged to have entered a partnership of colleagues and a community which is determined to provide the best of care for the population of the Scottish Borders.

This has probably never been more evident than during the Covid-19 pandemic, where staff, carers, volunteers and Borders residents worked tirelessly to make sure that as many of our residents as possible were cared for during what has been an incredibly challenging and at times very sombre period for everyone. The Borders has a number of service delivery challenges in regard to geographical spread and transport provision - in getting from (a) to (b) and in ensuring that all of our residents have access to the services they need; when they need them. The Covid-19 pandemic increased these challenges exponentially and everyone in the Borders has played their part in making sure that our Health and Social Care services continued to be delivered, and I would like to take this opportunity to give my heartfelt thank you to every one of you.

As I mentioned above, this report covers the period April 2019 – March 2020. Covid-19 lockdown commenced late March 2020, so whilst the impact of Covid has been huge, this report will primarily focus on non-Covid facts and figures in relation to delivery of our Health & Social Care Partnership Strategic Commissioning Plan. Our Strategic Commissioning Plan is due for renewal in 2021 and given the current uncertainties in regard to the pandemic, it is my intention to produce an interim 1-year Strategic Commissioning Plan to cover the period 2021-22. This will reflect the impact of Covid, detailing the short-term priorities as we look to the future.

This Annual Performance Report presents how the Partnership has:

- Worked towards delivering against our three strategic objectives.
- Performed in relation to the National Health and Wellbeing Outcomes.
- Performed in relation to our key priorities.
- Performed financially.
- Progressed locality planning arrangements.
- Performed in inspections carried out by scrutiny bodies.

Among our key achievements this year was the redesign of dementia services. This work was in response to the increasing number of our residents with dementia. Reports commissioned by the Partnership highlighted the need for a step-change in the scale and scope of service provision for older people with dementia. A separate report by Alzheimer's Scotland highlighted that an estimated 60% of current patients with dementia do not have a clinical need for an acute inpatient bed and could be more appropriately cared for in the community. Based on this evidence, the IJB directed that the number of dementia inpatient beds be reduced from 26 to 12 (via the closure of Cauldshiels ward) and that investment be made into community services (BBC news coverage of the decision). This investment included the development of a Care Home and Community Assessment Team (CHAT) to support patients in the community, recruitment of a dedicated Social Worker to ensure flow through hospital into the community and allocation of £338,000 per annum to be set aside for the commissioning of up to five specialist dementia beds in the community should these be required.

Another of our projects focused on patients with Chronic Obstructive Pulmonary Disease (COPD). Our local data indicated that of the 2,500+ COPD patients in the Borders, 376 patients were admitted into either BGH or a Community Hospital in 2018/19. This is a high volume of admissions in comparison to some other Partnerships, such as Highland (20% higher). The (Pulmonary Rehabilitation) programme we put in place delivered a 6 week structured exercise and education programme for groups of people with respiratory conditions and encouraged increased physical activity, offered advice about drugs and how to use them, pacing activities, eating, weight management and psychological issues. The groups who completed the programme reported that their breathing had improved and that they found the service helpful and effective – and a number of the user groups have continued to meet after their PR programmes have ended. The Eyemouth group were featured on the BBC News in November 2019

The Covid-19 pandemic is a difficult and challenging time for us all. However, I am confident that the Borders has the will, the skill and the drive to come out of this stronger. As a result of Covid-19 the services we deliver may change, the method of delivery may change, but the Health and Wellbeing of every resident will continue to be the number one priority of the Health and Social Care Partnership.

Robert McCulloch-Graham
Chief Officer Health and Social Care
Scottish Borders Health and Social Care Partnership
September 2020

EXECUTIVE SUMMARY

The Scottish Borders Health and Social Care Partnership's Strategic Commissioning Plan, following a period of public consultation, was first published in April 2016. It set out the Partnership's objectives for improving health and social care services for the people of the Borders.

Our Strategic Commissioning Plan was reviewed to cover the period 2018 to 2021 – this refreshed version focusing on the delivery of three local strategic objectives and the associated challenges in delivering these. Our Annual Performance Report (APR) sets out the Partnership's performance between April 2019 and March 2020, outlining our priorities for 2020/21 and reflecting back on performance since inception in April 2016. Delivery on the progress is structured under our 3 Strategic Objectives, which are:

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

Included in the report are 'spotlight' sections, reflecting on some of the key work that has taken place during 2019/20. In this year's report the spotlights cover:

The spotlights cover:

- Pulmonary Rehabilitation
- Redesign of Dementia Services
- TEC Fest

The data periods included in the APR are a mixture of financial year and calendar year. This is not ideal, but the most up to date financial and performance data is shown wherever possible. Where it is not possible to show the latest data then previous years' data is shown. Where the latest data is provisional, this is denoted by [p].

In regard to performance, the following is included:

- Quarterly reporting to Integration Joint Board (IJB)
- Performance against the National 'Core Suite' of Integration identified by Scottish Government
- Performance against Ministerial Strategy Group (MSG) indicators
- Financial information, consistent with our Annual accounts

This report has been prepared in line with the Guidance for Health and Social Care Integration Partnership Performance Reports.

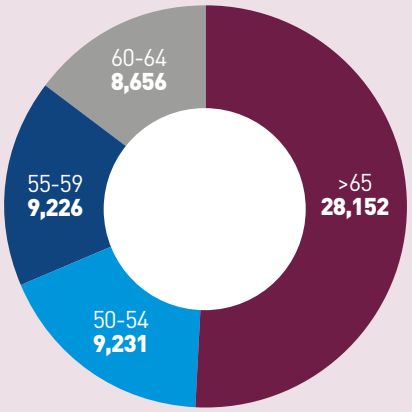
THE BORDERS AT A GLANCE

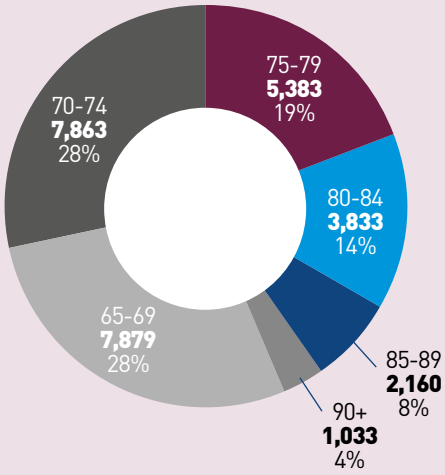
OLDER

2019 mid-year population estimates shows that the Border population is **115,510**. Of this, **24%** of the Borders population is **65+**, well above the Scottish average of **19%**.

- Male Life Expectancy in Scottish Borders is currently the 8th highest out of the 32 Scottish Local Authority areas (78.6 years)
- Female Life Expectancy in Scottish Borders, like male, is currently 8th best out of the 32 Local Authority areas (82.6 years)

LOCALITY	>16	16-64	>65	
Berwickshire	3,406	12,155	5,444	**21,005**
Cheviot	2,945	11,035	5,486	**19,467**
Eildon	6,005	21,832	7,863	**35,700**
Teviot	2,905	10,556	4,495	**17,956**
Tweeddale	3,858	12,661	4,863	**21,382**
	19,119	**68,239**	**28,152**	**115,510**





COLDER

As always, our 2019 Winter Plan is a joint plan across the Council, NHS and the IJB, with all services focusing on actions to reduce admissions, speed up hospital processes, reduce delayed discharge and support care in the community to prevent hospital readmission.

Specifics in the Winter Plan included:

- enhanced resource allocated to weekends to facilitate 7-day discharge including weekends.
- expansion of Home First to provide additional admission prevention and hospital discharge support

BOLDER

We continue to focus on improving the flow into and out of hospital and shifting the balance of care.

In 2019/20:

157 patients accommodated at **Garden View** discharge to **assess facility**

1,049 patients have gone through **Home First**

10,500 hours of Homecare delivered **per week**, for **1,350 people**

HOMECARE PACKAGES

47% ‹ **4hrs** per week

39% between **4 & 10hrs**

14% › **10hrs** per week

83% satisfaction with **social care** or **social work services**. Ranking Borders **9th** in **Scotland**

2,243 Community Alarms active in **individual's homes**

100% of **all patients requiring treatment** for **cancer** seen **within 31 days**

Use of **Strata** has **reduced average waiting time** to source **care home places** from **6** to **2 days**

2019/20 PARTNERSHIP PERFORMANCE AT A GLANCE

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

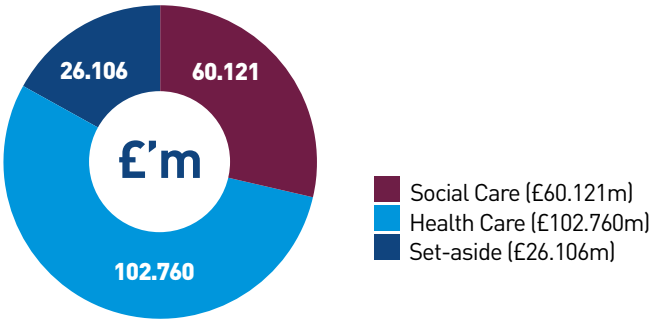
KEY

EMERGENCY HOSPITAL READMISSIONS (BORDERS RESIDENTS, ALL AGES) **110.6 admissions** per **1,000 population** (Calendar Yr - 2019)	**ATTENDANCES AT A&E (ALL AGES)** **274.3 attendances** per **1,000 population** (Financial Yr - 2019/20)	**RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)** **3,285 bed days** per **1,000 population Age 75+** (Financial Yr - 2019/20)
-ve trend over 4 periods **Worse than Scotland (110.1 – 2019/20)** **Worse than target (91.9)**	**-ve trend over 4 periods** **Better than Scotland (283.1 - 2019/20)** **Worse than target (216.1)**	**+ve trend over 3 years** **Better than Scotland (4,545.60 - 2019/20)** **Better than target (min 10% better than Scottish average)**
Work needs to continue to prevent emergency hospital admissions	*The number of attendances at A&E requires more improvement*	*Beds occupied by emergency admissions is within target but could be improved*
A&E WAITING TIMES (TARGET = 95%) **89.6%** of **people** seen **within 4 hours** (Financial Yr - 2019/20)	**NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)** **21 over 72 hours** (2019/20 Average)	**"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS** **93.1% overall satisfaction rate** (2019/20 Average)
-ve trend over 4 periods **Better than Scotland (87.7% - 2019/20)** **Worse than target (95%)**	**+ve trend over 4 periods** **Better than target (23)**	**-ve trend over 4 periods** **Worse than target (95%)**
A&E waiting time performance is below our local target	*Whilst positive we need to continue work to reduce delayed discharges further*	*We have a high satisfaction rate with hospital care but performance has declined*
EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES) **11.0** per **100 discharges** from **hospital** were **re-admitted within 28 days** (Calendar Yr - 2019)	**CARERS SUPPORT PLANS COMPLETED** **72%** of **carer support plans offered** that have been **taken up** and **completed** in the **last quarter** (Financial Yr - 2019/20)	**END OF LIFE CARE** **85.9%** of **people's last 6 months** was **spent at home** or in a **community setting** (Calendar Yr - 2019)
-ve trend over 4 periods **Worse than Scotland (10.3 - 2019)** **Worse than target (10.5)**	**+ve trend over 3 periods** **Better than target (40%)**	**+ve trend over 4 periods** **Worse than Scotland (88.6% - 2018/19)** **Worse than target (87.5%)**
More work is required to reduce readmission rates	*The percentage of carer support plans completed is good*	*This is improving, but more work is required to ensure that individuals can spend their last months of life in their chosen setting*

OUR PARTNERSHIP SPEND IN 2019/20

DURING 2019/20 THE INTEGRATION JOINT BOARD SPENT £188.987M

THIS WAS SPLIT:



£ ON EMERGENCY HOSPITAL STAYS

19.3% of **total health and care resource**, for those **age 18+** was **spent on emergency hospital stays** (Calendar Yr - 2019)

+ve trend over 4 periods
Better than Scotland (23.2% - 2019/20)
Better than target (21.5%)

STRATEGIC OVERVIEW

The Public Bodies (Joint Working)(Scotland) Act 2014 established the legislative framework for the integration of health and social care services in Scotland. The Act obliges Integration Authorities to publish an Annual Performance Report (APR) to cover the performance over the previous reporting year. The report should be published no later than four months after the end of the reporting year (i.e., the end of July) and should set out an assessment of the performance in planning and delivery of the integration functions for which the HSCP is responsible. However, as a result of the Covid-19 pandemic, the legislation was amended to allow for delayed publication of 2019/20 Annual Performance Reports.

In general terms, the legislation sets out the principles that services should:

- Be integrated from the point of view of service-users.
- Take account of the particular needs of different service-users.
- Take account of the particular needs of service-users in different parts of the area in which the service is being provided.
- Take account of the particular characteristics and circumstances of different service users.
- Respect the rights of service-users.
- Take account of the dignity of service-users.
- Take account of the participation by service-users in the community in which service users live.
- Protect and improve the safety of service-users.
- Improve the quality of the service.
- Be planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care).
- Anticipate needs, and prevents them arising, and
- Make the best use of the available facilities, people and other resources.

Underpinning the legislation is a set of nine National Health and Wellbeing Outcomes. These are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

To embed this and to contribute to the delivery of the National Health & Wellbeing Outcomes, the Scottish Borders Health and Social Care Partnership (HSCP) has identified three strategic objectives in our Strategic Commissioning Plan 2018-21

Our three strategic objectives are:

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

To deliver these outcomes, we have a Strategic Implementation Plan (SIP) in place, which sets out 10 Priority 'workstreams' as shown below:

SIP PRIORITY WORKSTREAM		DESCRIPTION
1	Carer Support Services	The partnership recognises the essential work of carers – even more so throughout the Covid-19 pandemic – looking to the future, it is a precarious resource that requires support.
2	Locality Operations	Early intervention, prevention, shared client cohorts, agile responses, close coordination of effort, all designed to reduce admissions and avoid/or slow progression to higher levels of care and health needs.
3	Older People's Pathway	Patient flow, including admission avoidance, quicker discharge, coordinated assessment, intermediate care and reablement.
4	Technology	Technology support across health and care provision, workforce enablement, improved administration processes and improved sharing of information across the partnership.
5	Primary Care Improvement Plan (PCIP)	Supporting the introduction of the new GP contract and the further development of community health services.
6	Mental Health provision	For adults (and children), including dementia care and autism.
7	Learning & Physical Disability provision	Reviewing and 're-imagining' the service – particularly important now in the context of Covid-19.
8	Joint Capital Planning	Whole system capital planning and investment including Primary Care and Intermediate Care.
9	Service Commissioning	Reviewing, planning, contracting and re-contracting
10	Workforce Support and provision	New skills, new operations, new equipment, new processes

Navigating this complicated 'landscape' of legislation, National Health & Wellbeing Outcomes, Strategic Objectives and Priority Workstreams can be challenging. The table below attempts to show how all of this fits together.

<table>
<tr><th colspan="3">INTEGRATION LEGISLATION</th></tr>
<tr><th>NATIONAL OUTCOMES</th><th>STRATEGIC OBJECTIVES</th><th>PRIORITY WORKSTREAM</th></tr>
<tr><td>Outcome 1: people are able to look after and improve their own health and wellbeing and live in good health for longer</td><td rowspan="3">We will improve the health of the population and reduce the number of hospital admissions

How
• By supporting individuals to improve their health
• By improving the range and quality of community based services and reducing demand for hospital care
• Ensuring appropriate supply of good quality and suitable housing

Links
National Outcomes: 1,2,3,5
SIP Workstream: 5,10</td><td>1. Carer Support Services</td></tr>
<tr><td>Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live as far as reasonably practicable, independently and at home or in a homely setting in their community</td><td>2. Locality Operations</td></tr>
<tr><td>Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected</td><td>3. Older People's Pathway</td></tr>
<tr><td>Outcome 4: Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services</td><td rowspan="3">We will improve the flow of patients into, through and out of hospital

How
• By reducing the time that people are delayed in hospital
• By improving care/patient pathways to ensure a more coordinated, timely and person centered experience/approach
• By ensuring people have a greater choice of different housing options which meet their long-term housing, care and support needs

Links
National Outcomes: 3,4,5,7
SIP Workstream: 3, 8,9</td><td>4. Technology</td></tr>
<tr><td>Outcome 5: health and social care services contribute to reducing health inequalities</td><td>5. Primary Care Improvement Plan</td></tr>
<tr><td>Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their role on their own health and wellbeing</td><td>6. Mental Health provision</td></tr>
<tr><td>Outcome 7: People using health and social care services are safe from harm</td><td rowspan="3">We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

How
• By supporting people to manage their own conditions
• By improving access to health and social care services in local communities
• By improving support to carers
• By building extra care homes, including amenity and mixed tenure provision

Links
National Outcomes: ALL
SIP Workstream: 1,2,4,6,7</td><td>7. Learning & Physical Disability provision</td></tr>
<tr><td>Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide</td><td>8. Joint Capital Planning</td></tr>
<tr><td>Outcome 9: Resources are used effectively and efficiently in the provision of health an and social care services</td><td>9. Service Commissioning
10. Workforce Support and provision</td></tr>
</table>

The Health and Social Care Partnership is responsible for planning and commissioning integrated services and overseeing their delivery. The services under the HSCP remit are adult social care, primary and community health care services and elements of hospital care. The Partnership has a pivotal role in regard to acute services in relation to unplanned hospital admissions and it works with key Community Planning Partners, including charities, voluntary and community groups to deliver flexible, locally based services. The table below details the Health & Social Care Partnership service areas of responsibility.

Health and Social Care Services which are integrated

ADULT SOCIAL CARE SERVICES*

- Social Work Services for adults and older people;
- Services and support for adults with physical disabilities and learning disabilities;
- Mental Health Services;
- Drug and Alcohol Services;
- Carers support services;
- Community Care Assessment Teams;
- Care Home Services;
- Adult Placement Services;
- Health Improvement Services;
- Reablement Services, equipment and telecare;
- Aspects of housing support including aids and adaptations;
- Day Services;
- Local Area Co-ordination;
- Respite Provision;
- Occupational therapy services.

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

- Accident and Emergency;
- Inpatient hospital services in these specialties:
  - General Medicine;
  - Geriatric Medicine;
  - Rehabilitation Medicine;
  - Respiratory Medicine;
  - Psychiatry of Learning Disability;
- Palliative Care Services provided in a hospital;
- Inpatient hospital services provided by GPs;
- Services provided in a hospital in relation to an addiction or dependence on any substance;
- Mental health services provided in a hospital, except secure forensic mental health services.

COMMUNITY HEALTH SERVICES*

- District Nursing;
- Primary Medical Services (GP practices)*;
- Out of Hours Primary Medical Services*;
- Public Dental Services*;
- General Dental Services*;
- Ophthalmic Services*;
- Community Pharmacy Services*;
- Community Geriatric Services;
- Community Learning Disability Services;
- Mental Health Services;
- Continence Services;
- Kidney Dialysis out with the hospital;
- Services provided by health professionals that aim to promote public health;
- Community Addiction Services;
- Community Palliative Care;
- Allied Health Professional Services

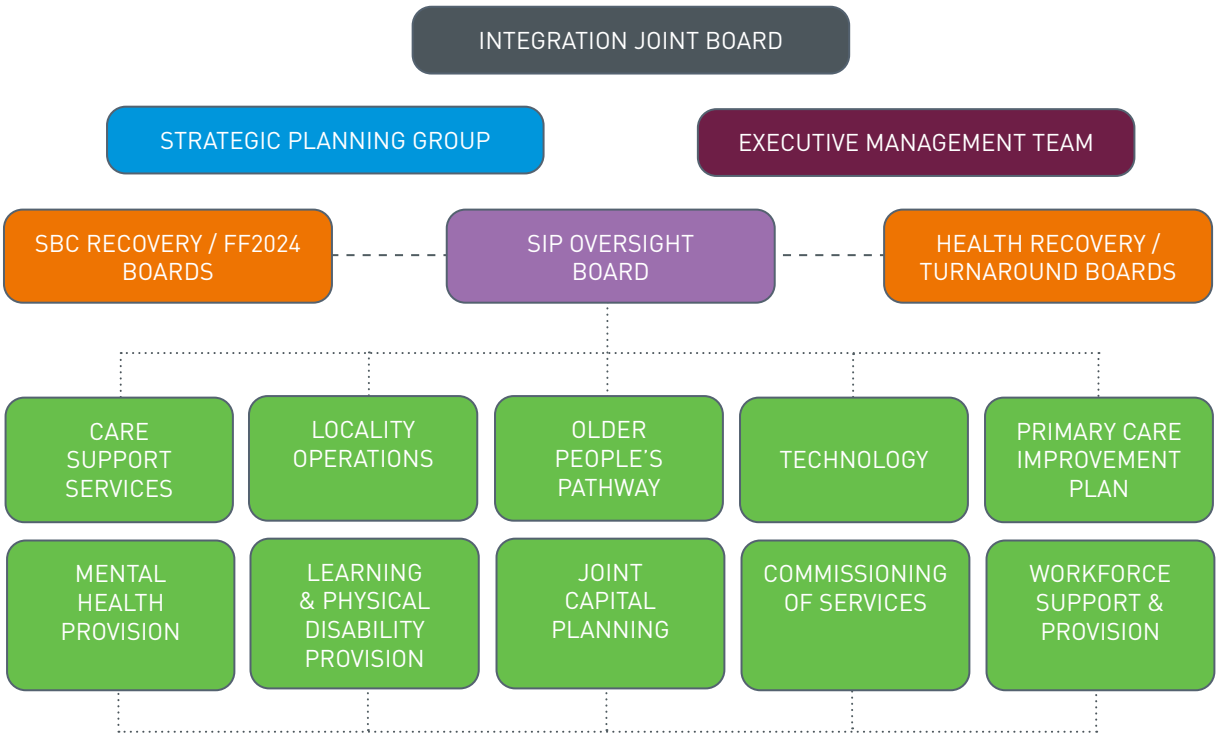
*Adult Social Care Services for adults aged 18 and over.
*Acute Health Services for all ages – adults and children.
*Community Health Services for adults aged 18 and over, excepting those marked with an asterisk (*), which also include services for children.

GOVERNANCE AND ACCOUNTABILITY

The governance structure for the Health & Social Care Partnership provides a robust and streamlined process for efficient and effective Partnership decision making. The Partnership works to fulfil its commitment to ongoing and continuous improvement and a range of activities continue to be developed in order that the Integration Joint Board (IJB) identifies and understands its key strengths and areas for improvement across all aspects of its governance, operations and performance.

Our governance structure has two decision making levels – the Integration Joint Board (IJB) and the Executive Management Team (EMT). Both are closely linked to health and social care operations, via the Integration Joint Board Leadership Team and both are closely linked to each organisations financial savings programmes.

H&SC Partnership Governance Structure



The governance structure and 10 Priority workstreams shown above were approved by IJB in August 2020. The priorities take into account the impact of the Covid-19 pandemic. The structure will ensure that work to deliver actions is taken forward efficiently, that there is clear direction and that delivery is regularly scrutinised.

Whilst the IJB has the ultimate decision making and commissioning authority for the Partnership, the EMT provides a useful assurance function, by ensuring that all reports and proposals being prepared are fit for purpose and clearly aligned to the Strategic Objectives.

The Strategic Implementation Plan Oversight Board is a multi-disciplinary team comprised of professional key leaders across Scottish Borders Council (SBC) and NHS Borders (NHSB) formed to support the delivery of the SIP of the Integration Joint Board. It also ensures the delivery of NHS Borders objectives in relation to service transformation and financial turnaround as well as relevant elements of Scottish Borders Council's Fit for 2024 programme.

The role of the SIP Oversight Board is to deliver the priority workstreams through working across the whole of the Health and Social Care Partnership. It is likely that the membership and content of the workstreams will change over time and this will be determined by the SIP Oversight Board, in line with partnership governance.

The function of the Strategic Planning Group (SPG) is to ensure effective links to each of the five Scottish Borders localities.

These localities are:

- Berwickshire
- Cheviot
- Eildon
- Teviot & Liddesdale
- Tweeddale

The relationship between the IJB and SPG is strengthened by the vice-Chair of the IJB chairing the SPG. The quarterly performance report for IJB contains a range of Health & Social Care performance measures aligned to the 3 Strategic Objectives. Quarterly performance reporting includes red, amber or green (RAG) status for each performance measure. The RAG status is based on a combination of performance against target, performance trend over time and performance in comparison to National results. Our Integration Performance Group (IPG) is responsible for the development of Partnership performance reporting locally and nationally. It is made up of performance leads from across the Council and NHS Borders and reports into SPG.

The Internal Audit work for 2019/20 covered:

- governance arrangements in place, including financial governance arrangements for the management of financial resources delegated to the partnership;
- transformation and change in service delivery to meet the Strategic Plan priorities, including the delivery of directions and workforce development;
- alignment of performance measures within the performance management framework to key outcomes and priorities; and
- follow-up work on previous Internal Audit recommendations.

Within the Internal Audit Annual Assurance Report 2019/20 presented to the IJB Audit Committee in June 2020 the IJB Chief Internal Auditor's statutory opinion was that Scottish Borders IJB's governance arrangements, risk management and systems of internal control are adequate, and improvements to these have been implemented during the year. Further improvements in governance and internal control have been agreed by Management.

The IJB Audit Committee approved the Scottish Borders IJB Internal Audit Annual Plan 2020/21 in March 2020 which has a specific focus on the contracts and commissioning of service delivery to inform strategies and plans to meet the Strategic Plan priorities.

KEY PARTNERSHIP DECISIONS 2019/20

For the period 2019/20, the Integration Joint Board has met regularly both as a formal meeting to transact business and also through Development sessions to raise its understanding of the more complex issues it will deal with as the Partnership continues to evolve.

During 2019/20, the Board:

May 2019 meeting:

- Approved the extension and expansion of the Strata project relating to Discharge Management.
- Agreed the revised Primary Care Improvement Plan (PCIP).

June 2019 meeting:

- Agreed that IJB Officers continue to work with NHS Borders and SBC to develop a Joint Turnaround Programme and a Joint Financial Recovery Plan to address the financial gap and mitigate the risks relating to Health and Social Care services.
- Agreed that Directors of Finance from NHS Borders and SBC provide a jointly agreed balanced budget for 2019/20.
- Agreed the revised approach to Locality working.
- Agreed the amended IJB Audit Committee Terms of Reference, incorporating the proposed changes set out in the IJB Audit Committee Annual Report 2018/19.
- Approved the performance management framework.

August 2019 meeting:

- Approved the HSCP budget allocations from Scottish Borders Council and NHS Borders for the delegated functions in 2019/20.
- Approved the 2018/19 Annual Performance Report
- Approved the redesign of Dementia services including:
- reduction of inpatient beds from 26 to 12 (closure of Cauldshiels Ward)
- re-investment in appropriate community resources.
- establishment of an IJB reserve of £338,000 of recurrent funding, earmarked for the purchase of additional Dementia care home beds, as required.
- Approved the independent auditor's 2018/19 Annual Report.

September 2019 meeting:

- Approved the Strategic Implementation Plan (SIP) for 2019 to 2024 and the areas of work to be undertaken within that time period.
- Approved extensions to projects set out under the Discharge Programme of work.
- Approved the revised IJB Terms of Reference.
- Approved the external audit report.

October 2019 meeting:

- Approved the Joint Winter Plan 2019/20.
- Approved the Physical Disability Strategy and Delivery Plan.
- Approved the proposed IJB meeting dates and business cycle for 2020.
- Supported the submission of the revised Primary Care Improvement plan (PCIP) document to Scottish Government.

December 2019 meeting:

- Agreed the utilisation of £0.404m to address the forecast overspend in the Social Care services within IJB delegated functions
- Agreed the release of £0.124m of the earmarked budget for the purchase of additional specialist dementia care home beds.

February 2020 meeting:

- Approved the appointment of Jim Wilson as External Member of the Scottish Borders Health and Social Care Integration Joint Board Audit Committee to 31 October 2021.
- Agreed the action to expand the quarterly performance report to include additional social care data.
- Agreed the action of asking the Executive Management Team to develop a whole system reporting framework to inform and provide context on the delayed patients across the health and social care estate.

March 2020 meeting:

- Approved the funding allocations from the Transformation Fund 2020-2021 for the Discharge programme of work
- Approved that the "Step Down" facilities of Waverley Care Home be merged with the operations of Garden View, as soon it is practical and safe to do so.
- Approved that the IJB receives a further paper outlining a detailed "Direction" on the reduction of hospital beds.
- Accepted the HSCP budget allocations of resources from NHS Borders and Scottish Borders Council for 2020/21.

PROGRESS AGAINST STRATEGIC OBJECTIVE 1

OBJECTIVE 1

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

Objective 1: Background and Challenges

We are committed to helping older people to manage their own health better, improving fitness and reducing social isolation. We know the number of older people in the Borders is increasing, and that the proportion of older people in the Borders is increasing at a faster rate than the Scotland average. It is crucial therefore that we continue our promotion of 'active ageing'. We know that many older people in Scottish Borders report poor health, therefore we must continue to promote healthier lifestyles, earlier detection of disease and support to individuals to recover and manage their conditions. We know that the population of the Scottish Borders is spread over a large geographical area with many people living in rural locations, therefore services must continue to be provided locally with accessible transport arrangements in place.

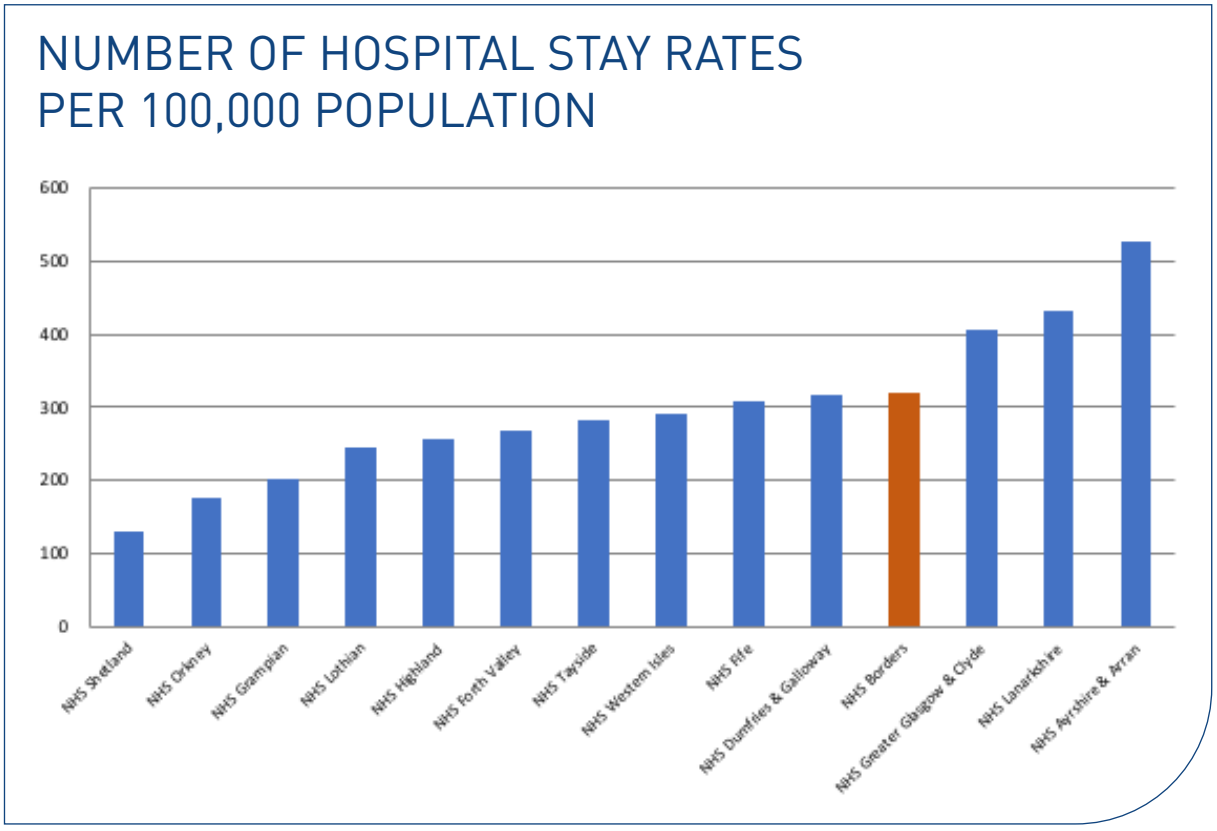
Key to achieving positive change is by:

- Supporting individuals in making positive changes in their health-behaviour and lifestyle, such as smoking, diet, alcohol consumption and physical activity; through patient education, encouraging the appropriate use of services and promoting personal responsibility through public information and signposting.
- Adopting preventative and early intervention approaches, promoting the uptake of screening opportunities and immunisation programmes, raising awareness of signs and symptoms of health conditions and ensuring staff and carers have the necessary knowledge, skills and equipment to provide care at home.

Objective 1: Spotlight – Pulmonary Rehabilitation

We initiated a Pulmonary Rehabilitation (PR) programme for patients with Chronic Obstructive Pulmonary Disease (COPD). This delivered a 6 week structured exercise and education programme designed for those with respiratory conditions. It encouraged increased physical activity (within the person's limitations), offered advice about drugs and how to use them, pacing activities, eating, weight management and psychological issues. The desired outcomes included helping patients to manage their own symptoms more effectively and to reduce hospital admissions.

It has been well evidenced in studies that PR programmes are beneficial to COPD patients and that there are benefits in starting a programme as soon as possible after a hospitalisation. Our local data indicates that over 2,500 patients in the Borders are known to have COPD and during 2018/19, 376 patients were admitted into either BGH or a Community Hospital, accounting for approx. 2,500 occupied bed days. This is a relatively high volume of admissions in comparison to a number of other Partnerships – for example, Borders has a 20% higher rate of hospital stays than Highland, although Borders length of stay is in line with the Scottish average.



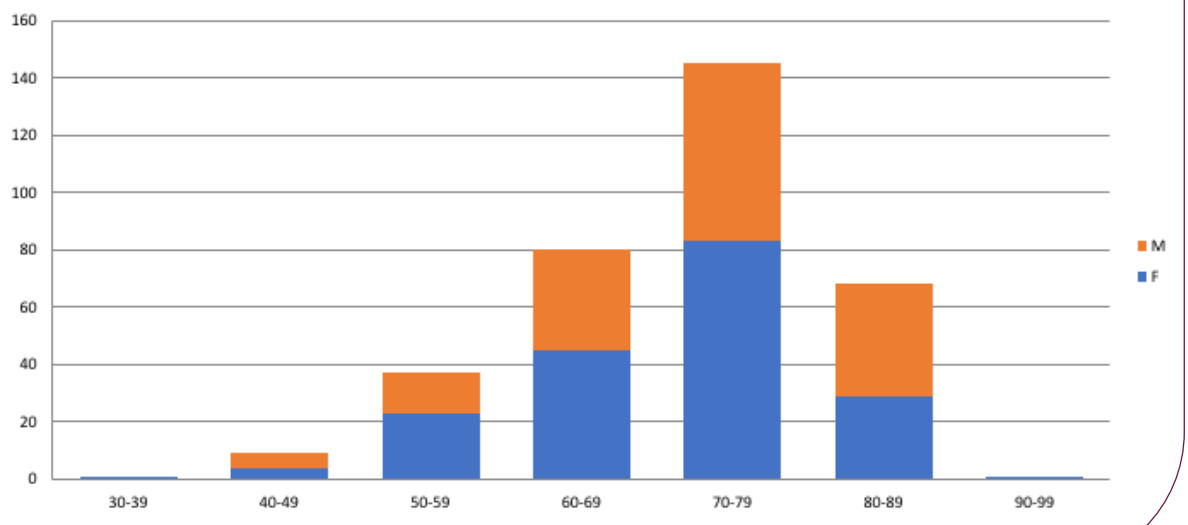
It is clear that reduced COPD admissions are beneficial both for managing hospital demand and for improving people's health.

The PR Programme was run across all 5 of our localities, with each programme consisting of an introductory week for assessments followed by 2 hour sessions twice weekly for six weeks, delivered by respiratory specialist nurses and physiotherapists. The programme was open to all COPD patients with an MRC score of 3 or higher:

MRC SCALE	
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying on the level or when walking up a slight hill
3	Walks slower than most people on the level, stops after a mile or so, or stops after 15 minutes walking at own pace
4	Stops for breath after walking 100 yards, or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing/undressing

COPD patients were able to access these sessions within their respective locality within 4 weeks of discharge from hospital or as a result of exacerbation of their condition. The age range of patients and gender split is shown in the graph below:

AGE RANGE/GENDER OF PATIENTS IN THE PR SERVICE



Between May 2019 and February 2020, 111 patients completed the PR programme. In addition to this, 20 patients dropped out/self-discharged. The 131 patients who started the programme is below the original volumes planned – one reason for this being issues in recruiting a Respiratory Nurse and Physiotherapists. At full capacity the programme has the potential to see 300 patients per year (i.e.) 6x classes of 10 patients per class, per annum, in each of our 5 localities. Clearly, reaching this capacity could have a significant impact on COPD admissions, which as mentioned above, was 376 admissions in 2018/19.

The results from the 111 patients who did complete the programme shows that 76% avoided hospital admission within the 6 months following their initial assessment. Patients also reported that their breathing had improved and that they found the service helpful and effective.

Individual's feedback received in the patient satisfaction questionnaire and follow up phone calls include:

- "It's been very good for me, before the rehab, I was still very breathless, the course has helped me tremendously"
- "I would suggest this course to anyone with breathing problems"

The table below shows the impact of the programme in regard to admissions, number of patients and total length of stay – all showing significant reductions:

TIME PERIOD	ADMISSIONS	PATIENTS	TOTAL LENGTH OF STAY
6 Months before Rehab	13	6	6
6 Months after Rehab	4	3	5
Difference	**-69%**	**-50%**	**-95%**

The COPD Assessment Test (CAT) and Lung Information Needs Questionnaire (LINQ) systems were used to evaluate patients before and after the PR programme. 65-70% of patients reported an improvement in their breathing.

Referrals to the programme were received from a number of sources which has resulted in a waiting list – which should be resolved once staffing capacity is increased.

REFERRAL SOURCE (MAY 19 TO JAN 20)	TOTAL
Primary Care	93
Secondary Care	77
Tertiary Care	1
Pharmacist	9
Community Hospital	17

The PR programme has been a good example of partners coming together to deliver services. The PR team use Live Borders premises – Live Borders operate a number of sport and culture facilities across the Borders including leisure, libraries, archive, halls, community centres and museums and Live Borders staff have been able to assist with the PR exercise sessions. Patients then feel confident to continue to use Live Borders for their ongoing exercise needs.

A number of user groups have continued to meet after their PR programmes have ended and the Respiratory Team can also refer patients onto these user groups at any point. The Eyemouth group are a particularly successful group and were featured on the BBC News in November 2019, where Eyemouth's Jock Sheills is quoted: "We provide classes in gym work, swimming and social interaction. I have over 100 people in total attending our classes throughout the week and they are all helped immensely both physically and mentally as a result. The combination of exercise and socialising is what makes this so beneficial."

For more information on COPD: click here

Objective 1: Priorities 2019/20 - What we said / What we did

Last year's Annual Performance Report contained a number of Partnership Priorities to be delivered in 2019/20. The table below details these and the key successes and achievements

Partnership Priorities for 2019/20 – What we said

1. **Develop Local "Wellness Centres"**
   We will look to expand the use of community hubs and drop-in centres to create 'one-stop shops'. Part of this work will also require ensuring that appropriate and adequate community space is available – covering both social care and clinical needs.

2. **Introduce Single Assessments and Reviews**
   We will look to remove duplicate care assessments, develop more flexibility in regard to which professionals undertake assessments and increase Social Worker and Occupational Therapist involvement at daily ward rounds.

3. **Introduce Local Multi-Disciplinary Teams across all 5 Localities(MDTs)**
   We will introduce multi-disciplinary teams across the localities to triage individuals within the community to ensure that they can access services and receive appropriate Health & Social Care interventions ahead of any acute provision they may require. We will expand the 'Cheviot' model that currently covers Kelso, Jedburgh, Coldstream and Greenlaw areas, where physiotherapists, occupational therapists, staff nurses and healthcare support workers work together to provide access to domiciliary occupational therapy, physiotherapy and nursing services - linked with medical practices. This supports prevention of hospital admission for identified patients who require therapy services at home, supports safe and timely discharge from BGH to community hospitals, supports anticipatory care and supports falls prevention.

4. **Shared Lives**
   We will commission a Learning Disability 'Shared Lives Scheme' to provide high quality and affordable services

Key Achievements/Successes : What we did

1. **Develop Local "Wellness Centres"**
   What Matters Hubs are available in Hawick, Peebles, Galashiels, Kelso, Walkerburn, West Linton, Duns, Eyemouth, Newcastleton and Newtown St Boswells. Hubs offer drop-in sessions and appointments where you can meet with people from community groups and voluntary organisations, meet with our staff such as social workers and occupational therapists

   These sessions and appointments can help you to get information and advice quickly to remain in your own home and get involved in your community, help you find the support you need to stay independent, such as equipment, transport or help at home, provide advice for carers about support available in your area, provide information about what is happening in your local area and where you could meet new people, provide information about volunteering opportunities

   Those offering advice can include British Red Cross, Borders Carers Centre, Alzheimer's Scotland, Borders Independent Advocacy Service, Chest, Heart & Stroke Scotland; Community Capacity Building and Domestic Abuse Service. They can also signpost you to other services. Appointments are available across the Scottish Borders, to find out more contact Customer Advice and Support on 0300 100 1800. ***(Note – these were the arrangements pre-Covid)***

2. **Introduce Single Assessments and Reviews**
   Work is underway with staff from across the Partnership to develop a 'Trusted Assessment' model, enabling staff from across health and social care to carry out assessments which have historically only been undertaken by Social Work staff. Staff within the Hospital, Waverley, Garden View and the Home First Team take part in this scheme.

   The aim to:

- Improve patient flow across the H&SC system
- Improve the customer experience because one professional is able to undertake a single assessment of their needs – traditionally this may have required multiple interactions / assessments
- Create efficiency by freeing up time and unnecessary travel
- Reduce length of stay and delays in transfer of care
- Improve the speed at which people can access the service and support they require

Winter pressure and then Covid-19 pandemic unfortunately interrupted this trial but the trial will continue during 2020/21. The Trusted Assessment process is currently being developed in STRATA pathways.

Key Achievements/Successes : What we did

3. **Introduce Local Multi-Disciplinary Teams across all 5 Localities(MDTs)**
A new model of 'Neighbourhood Care' was piloted in Coldstream. The aim was to reduce the amount of care people need at home by providing a co-ordinated approach for those who receive both health and social care services.

In essence:

- Putting the person at the centre of holistic care
- Building relationships with people to enable informed decisions
- Establishing person-centred care
- Using small self-organising teams
- Ensuring professional autonomy

The project focused on an outcomes based approach to care and teams from across Social Work and Health worked in partnership, holding regular multidisciplinary meetings that enabled discussion on a common caseload of patients and agreement on the best approach to their care.

Lessons learned from the trial include:

- Self-organising in large bureaucratic systems is difficult
- Effectiveness and efficiency can be improved by bringing teams together
- Relationships are crucial, but so is the technology/systems

This learning will be taken forward as we develop service provision and operations in each of our Localities.

4. **Shared Lives**
Shared Lives is a regulated form of social care which has historically been used primarily for people with learning disabilities. In Shared Lives, an adult who needs support or accommodation is matched with an approved Shared Lives carer, who supports and includes the individual in their family and community life. Shared Lives can provide long term live in, short breaks and day support options for the local population. Shared Lives has diversified across the UK to support other groups including: older people, people living with dementia, people with mental ill health, young people in transition, women fleeing domestic abuse, parents with learning disabilities and as a home from hospital alternative. Implementation of Shared Lives has been delayed by the Covid-pandemic, and our initial focus is on people identified with a learning disability identified as their primary support need and. The planned timeline for full implementation is:

Nov 2019 – April 2020	Set up the scheme, including infrastructure, advertising, recruitment of service manager, co-ordinator and admin person.
April 2020 – Sept 2020	Initial recruitment of and training for 1st cohort of Shared Lives Carers
Sept 2020-Dec 2020	First 8 Shared Lives arrangements go live
January 2021-March 2021	Recruitment of Shared Lives Carers and matching to LD clients
April 2021	Mainstreamed service provision and consider diversifying client group at this stage.

Objective 1: Partnership Priorities for 2020/2021

Development sessions of the IJB, coupled with events attended buy a range of senior professionals have considered the challenges facing the partnership. As a result, the following workstreams have been identified in our Strategic Implementation Plan (SIP):

SIP WORKSTREAM	DESCRIPTION	PLANNED DELIVERY DURING 2020/21
Primary Care Improvement Plan (PCIP)	Supporting the introduction of the new GP contract and the further development of community health services.	One of the PCIP development areas within the GP Contract is the creation of "Additional Professional Roles" which includes the introduction of 1st contact Physiotherapists and the development of Community Mental Health Workers. Within the work to develop the latter, a "test of change" took place at O'Connell Street Medical Practice in October 2019. This was to test a "see and treat" Mental Health model where patients with mild to moderate anxiety and depression were seen by a mental health practitioner (rather than the GP) and offered evidence based psychological therapy depending on their needs. The aim is to evaluate how this could assist GPs as well as offering a more effective and efficient intervention for patients. This work will continue throughout 2020/21
Workforce Support and provision	New skills, new operations, new equipment, new processes	The Covid-pandemic highlighted the importance of staff : • being able to work remotely. • having fewer paper-based processes. • being able to access the technology they need. • being trained to use the technology effectively. • being able to work collectively and seamlessly across Health and Social Care. • having the flexibility to deliver a range of services. Work to take forward the Covid-19 lessons-learned in regard to the Health and Social Care workforce will continue throughout 2020/21.

PROGRESS AGAINST STRATEGIC OBJECTIVE 2

OBJECTIVE 2

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

Objective 2: Background and Challenges

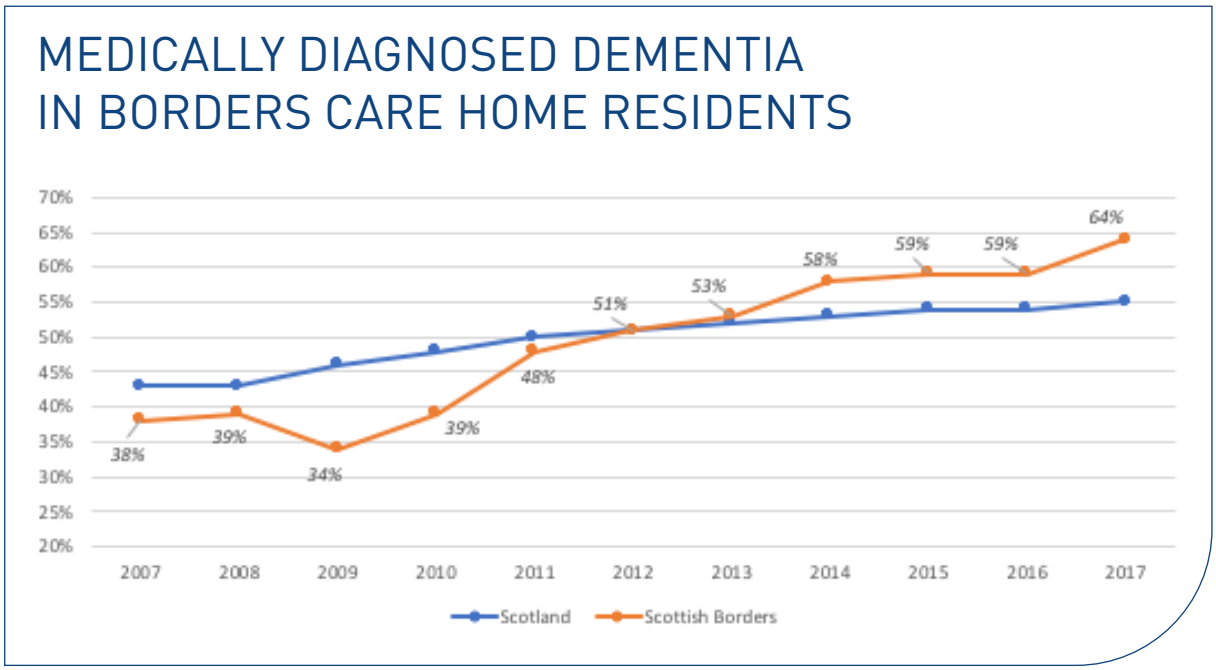
We are committed to reducing the time that people are delayed in hospital. People should also have a greater choice of different housing options available meeting their long-term housing, care and support needs. We know that we must continue to involve and listen to our communities in planning and delivering services across the five localities. We know that housing and supported accommodation options have an important role to play in regard to the flow of patients. We know that a number of people need flexible support arrangements to maintain and improve their quality of life.

K**ey to achieving positive change is by:**

- Ensuring that people are admitted to acute services only when required.
- Ensuring that those who do require hospital stays have a seamless and timely patient experience and journey; and that discharge from hospital uses an integrated/joined-up approach enabling patients to return home quickly and safely.
- Providing short-term care and reablement support options to facilitate a safe and timely transition from an acute setting to home.
- Ensuring the reablement and hospital to home services align with housing providers, equipment providers and care and repair services.
- Reviewing our approach to housing adaptations to ensure a holistic approach is taken to meeting longer term needs/conditions of older people.
- Ensuring that assessing and caring for people is done in the in the most appropriate setting.

Objective 2: Spotlight – Redesign of Dementia Services

The HSCP explored how to respond to the growing demographic pressure of people with dementia. The graph below shows how the percentage of individuals in Borders residential care homes with medically diagnosed dementia has increased over the last 10 years (from 2007 to 2017).



Reports commissioned by the HSCP from care experts including Anna Evans, Professor Anne Hendry and Professor John Bolton, identified a need for a step change in the scale and scope of service provision for older people with dementia in the Borders. As a result the HSCP invested in securing 7 specialist dementia care nursing beds within Murray House (Kelso).

A separate report by Alzheimer's Scotland - 'Transforming Specialist Dementia Hospital Care' identified that an estimated 60% of current patients with dementia do not have a clinical need for an acute inpatient bed and could be more appropriately cared for in the community. The average cost of providing a specialist dementia hospital bed is £2,520 per inpatient per week. Nationally this equates to £183 million per year, £110 million of which is spent on the 60% of patients who do not have a clinical need to be in hospital. The report recommended that acute hospital beds for dementia patients should be transferred to more appropriate residential provision within the community.

Cauldshiels ward (BGH) – 14 acute inpatient beds

Borders provision of inpatient dementia care was provided across a number of Borders General Hospital (BGH) wards/sites:

- Cauldshiels (a 14 bed assessment ward)
- Melburn Lodge (a 12 bed in-patient ward).
- Additionally, Lindean provides a specialist inpatient facility for older adults with acute mental health problems. (a 6 bed elderly functional mental health ward)

A review of 'need' (using our Day of Care Audit) was undertaken across all inpatient settings including Melburn, Cauldshiels and Lindean. This indicated that of the 28 patients in these wards, only 7 required a specialist inpatient bed. The other 21 could be cared for in a range of alternative settings such as nursing home, residential home or in their own homes if appropriate packages of care and support were in place. This reinforces the national estimation that there is a need for a significant reduction in the number of specialist inpatient beds for this patient group.

The Mental Welfare Commission's (MWC 2014) review of dementia care units identified serious concerns Nationally with quality of care, environments, access to multidisciplinary professionals and adherence to legal requirements for providing care. Cauldshiels ward had been highlighted in successive MWC reports as providing an unsuitable physical environment for dementia care (i.e.) specialist dementia wards are frequently located in environments that do not support person-centred care and can increase the distress of the person with dementia and their family. There can be a lack of access to the multi-disciplinary professionals required to support the complex care required in dementia. There can be difficulties with transition out of the acute setting, resulting in a large proportion of patients in these wards having no clinical need to be there. This can result in difficulties in providing appropriate care for such a wide range of individuals with differing needs, meaning that resources are not targeted effectively. In regard to Cauldshiels, rectifying the environmental issues on site would require a substantial rebuilding programme with significant capital investment. Melburn lodge already provides an appropriate environment and required little alteration.

Review also indicated that there was a lack of integration between specialist hospital dementia environments and the wider health and social care systems – resulting in hospital units sitting in isolation without the same focus on discharge to more appropriate care environments; and too often the window of opportunity being missed for safe transition to a more appropriate community setting to enhance quality of life.

Specialist hospital care will be required for people with dementia who have an acute psychological presentation as a result of dementia or co-morbid mental health illness. The clinical needs of this group will continue to be met in a hospital environment. (It is estimated that up to 1% of people with dementia will require management in a specialist dementia hospital environment at any one time)

Most people with dementia can be cared for in the community throughout their illness. But this requires a multi-disciplinary coordinated and planned approach to support those providing the day-to-day care.

Based on all of the evidence presented, the IJB directed that the number of dementia inpatient beds be reduced from 26 to 12 (via the closure of Cauldshiels ward) and that investment be made into community services – facilitating a shift in the balance of care. (BBC news coverage of the decision)

Financially, the IJB decision covered:

- Development of a Care Home and Community Assessment Team to support patients in the community.
- Investment in a dedicated Social Worker to ensure flow through hospital into the community.
- Allocation of £338,000 per annum to be set aside for the commissioning of five specialist dementia beds in the community should these be required.

Care Home and Community Assessment Team ('CHAT team')

The Care Home and Community Assessment Team (CHAT) specialise in meeting the needs of older adults with mental illness and dementia, working within care homes and community hospitals across the Scottish Borders.

The team works across the entirety of the Borders providing cover to 92 community hospital beds and 695 care home beds within Scottish Borders. The team has capacity to assess, plan treatment and intervene (where necessary) for 60-70 individuals per week. Additionally a rolling programme of training and implementation of stress and distress techniques is undertaken with each care home and community hospital throughout the year.

The team aims to provide proactive and responsive support to care homes and community hospitals to help them better meet the needs of their residents and patients with mental illness and dementia. Interventions offered by the team include carrying out mental health and memory assessments, advising on the best type of treatment for the individual and advising staff on managing the symptoms and behaviours of people with mental illness and memory problems. The team also provides training and education for care home and community hospital staff to provide them with the skills and knowledge to provide effective care for residents and patients.

The service can be accessed via referrals made by GPs, or senior care home/community hospital staff. All referrals are:

- Sent to a central CHAT referral inbox
- Screened on the same day and the referrer is informed of the outcome (if the referral is appropriate CHAT will contact the care home or community hospital by phone to arrange an appointment. If the referral is inappropriate contact will be made and advice given on how to proceed)

The team assess the individual looking at:

- Advice and treatment regarding specific mental health issues.
- A person-centred care plan that ideally involves the individual, family, carers and staff in maximising quality of life, physical health and comfort.
- The advice and training necessary to support staff in meeting an individual's care needs and maintaining them in their current care setting

Dementia Redesign follow-up

At the time of approval of the dementia redesign (August 2019), IJB also directed that the impact of this new model, including the effectiveness of the Care Home and Community Assessment team, the need for NHS Inpatient beds and the ongoing requirement for the earmarked financial reserve be reviewed and reported back to IJB no later than March 2021

For more information on the Mental Health for Older Adults Service: click here

Objective 2: Priorities 2019/20 - What we said / What we did

Last year's Annual Performance Report contained a number of Partnership Priorities to be delivered in 2019/20. The table below details these and the key achievements delivered.

Partnership Priorities for 2019/20 – What we said

1. **Introduce a renewed discharge hub**
   We will have a more consistent approach to managing people's progress through hospital. The "Moving-on" policy involves patients earlier in the process and enables joint health & social care decisions to be made when prioritising patient transfers and resources.

2. **Develop shared Out-of-Hours coordination**
   Through work with partners and our geographical neighbours, we will aim to streamline Out-of-Hours provision across a number of services.

3. **Promote Healthier lifestyles within the Borders**
   Working across the entire Health and Social Care Partnership and with direct links to our Public Health provision, we will direct a number of events and campaigns, coupled with our communications strategy, to encourage Borders residents to be healthy and make healthy choices. We will look at ways to promote a career in care, make greater use of community pharmacies and engage with local communities regarding what services the HSC Partnership can and cannot provide. We will promote personal responsibility and continue to provide public health education on diet, exercise and mental health.

4. **Commission the correct bed base mix**
   We will further develop community capacity, including residential care and home care. We will commence a series of commissioning exercises, including setting the strategic direction for future contracting arrangements. We will look at the bed-base mix at Borders General Hospital, Community Hospitals and Mental Health beds across the estate with a view to further develop community capacity. We will look at options for Community Hospitals to function as step-up from home facility as well as a step-down from BGH facility.

Key Achievements/Successes : What we did

1. **Introduce a renewed discharge hub**
   An integrated hospital based service was created to improve patient experience of hospital discharge. Traditionally the START team was responsible for the social work activity for patients requiring ongoing care and support beyond their hospital stay. The team acted as a link across hospital wards; hospital and community based discharge teams; intermediate care systems and the locality based resources that support patients to live in their own home or homely setting. Within the hospital there was also the Older People's Liaison Service (OPLS) and the Discharge Liaison Team (DLT). A review concluded that whilst all of these services add value, there was also inefficiency and duplication.

   An Integrated Discharge Hub was created. The 'hub' is a single point of contact multi-disciplinary team with responsibility for coordinating and arranging older people patient transfers and ongoing care.

   The Discharge Programme of work as detailed in last year's Annual Performance Report, was based on 5 projects covering:

- Home-based intermediate care: Home First
- Bed-based intermediate care: Garden View Discharge to Assess facility and Waverley Transitional Care Facility
- Referral and allocation management: Matching Unit and Strata electronic referral system.

The programme of work had only a limited impact on delayed discharge rates - one reason being that a number of delayed discharge patients tend to have higher dependency levels (level 3), whereas the projects within the Discharge Programme were focused on patients with moderate to low dependency needs. Data from the evaluation of the programme indicates that for clients going through Transitional care (Waverley), readmission rates to BGH reduced by 10%, 84% of users returned to their own homes and average care packages for those returning home were reduced from 11hrs to 9.4hrs per week. Home First saved 9 bed days per service user per annum and A&E attendances for Home First patients reduced by 61%. The Matching Unit played a key role in restarting packages or care (enabling discharge).

Key Achievements/Successes : What we did

2. **Develop shared Out-of-Hours coordination**
   Borders Emergency Care Service (BECS) employs a team of GPs, out-of-hours nurses and evening nurses who are supported by a team of receptionists and drivers and provides urgent care to patients who cannot wait until their own GP surgery reopens. The team also provide medical support to the Community Hospitals in the out-of-hours period. Work is required to develop shared out-of-hours coordination.

3. **Promote Healthier lifestyles within the Borders**

   The NHS Borders Wellbeing Service provides evidence based, early interventions supporting lifestyle change and emotional wellbeing through:

- Quit Your Way (QYW) – smoking cessation service
- LASS – lifestyle advice and support to increase physical activity, reduce weight and eat healthily
- Doing Well (DW) – support to improve low to moderate mental wellbeing

Existing advisers have been fully trained to undertake their new role and a new system to manage patient information and appointments has been introduced. We are also working closely with the Psychology Service to ensure we have straightforward patient pathways for different tiers of intervention.

Information about the service is available at:
www.nhsborders.scot.nhs.uk/wellbeing

Alternatively you can contact us via 01896 824502 or wellbeing@borders.scot.nhs.uk

Our new Mental Health Services (Adult) Information Resource has mapped out the supports and services available, and provides information on how to access them. This improves access and supports the delivery of integrated care across mental health services. The resource is available through Social Work 'What Matters' hubs, GPs (Refhelp website), Wellbeing College, NHS Borders Wellbeing Point. Benefits include making mental health services more accessible, helping people find the most appropriate service, allowing people to access help whilst waiting for other forms of support, promoting the active involvement of people in their own care, supporting recovery through reconnecting with local communities. The online tool was informed by consultation with service users and carers via the Borders Mental Health & Wellbeing Forum, service providers, planners and commissioners. The process included liaison with young people's Mental Health Services to support mutual awareness and inform transitions between mental health services for young people and adults.

Key Achievements/Successes : What we did

4. **Commission the correct bed base mix**
The partnership undertook 'demand modelling' work to establish the required bed-base for our increasingly ageing demographic.

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
2017	21,373	57,700	17,022	14,886	6,337	117,318
% change	**-1%**	**-12%**	**10%**	**72%**	**101%**	**2%**

This modelling work incorporated the requirement for acute beds (BGH and Community Hospital) and non-acute beds (residential care, intermediate care etc...)

A number of studies have shown that remaining in hospital longer than necessary is harmful to older people and results in increased risk of mortality, hospital-acquired infections, mental ill-health and reductions in mobility and placing greater burden on both health and social services. However, the Borders has a relatively low number of care home beds per head of population (25 beds per 1,000 population) and a relatively high number of hospital beds.

The modelling predicted that if nothing changes – and based on demographics alone - we would require more hospital beds and many more care home beds. When projects such as Home First, Intermediate Care and Reablement are built into the model, this then changes the result, but there is still a prediction for an increased amount of community-based care home beds.

Scottish Borders Council is therefore investing in the construction of two new 60-bed care units - one in Hawick and one in Central Borders.

Objective 2: Partnership Priorities for 2020/2021

Development sessions of the IJB, coupled with events attended buy a range of senior professionals have considered the challenges facing the partnership. As a result, the following workstreams have been identified in our Strategic Implementation Plan:

WORKSTREAM	DESCRIPTION	PLANNED DELIVERY DURING 2020/21
Older People's Pathway	Patient flow, including admission avoidance, quicker discharge, coordinated assessment, intermediate care and reablement.	Work will continue in regard to Older People's Pathway including developments to: • Intermediate Care • Trusted Assessor • Reablement • Matching Unit • Older Person's Assessment Unit • Discharge Huddles
Joint Capital Planning	Whole system capital planning and investment including Primary Care and Intermediate Care.	Capital investment is most often done to purchase, construct or develop a tangible asset (e.g.) property. This will continue, but on a partnership basis and will include: • 60 bed care developments • LD care developments • Staff accommodation and technology
Service Commissioning	Reviewing, planning, contracting and re-contracting	Commissioning and the recommissioning of services including: • home care, • our bed-base (acute, residential, intermediate care) • reablement .....will continue under the scrutiny of the SIP Oversight Board with the aim of re-contracting a number of services in 2022

PROGRESS AGAINST STRATEGIC OBJECTIVE 3

OBJECTIVE 3

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

Objective 3: Background and Challenges

We are committed to supporting people to manage their own conditions, by improving access to health and social care services in local communities, by improving support to carers and by delivering more supported accommodation, including extra care homes, dementia care and mixed tenure provision. We know that a range of support is required to support for people with dementia and their carers. We know that we need high quality support for the 12,500 people aged 16 and over who are providing unpaid care in the Scottish Borders.

Key to achieving positive change is by:

- Piloting and evaluating different approaches to the delivery of care and support in the community.
- Developing integrated, accessible transport options.
- Developing the use of technology to promote independence and enable prevention, through monitoring and 'early-warning' of an impending problem.
- Using technology to improving access and signposting to services and information
- Developing community-based mental health care
- Supporting carers and implementing the requirements of the Carers (Scotland) Act 2016
- Investing in physical and social infrastructure, looking to harness the strengths of our own communities in developing capacity in care and support for family members and friends

The Borders Carers Centre is responsible for Carers Support Plans and can assist in putting together a plan centred around carer needs, giving access to appropriate information, advice and support. Borders Carers Centre services are free and independent and all carers over the age of 18 years are supported.

Borders Care Voice is an independent Third Sector organisation working with people and providers to promote equality, support change in health & social care and give service users and carers a voice. Borders Care Voice promotes good practice in the planning and provision of health and social care services and provides free training for people who work or volunteer in the health and social care sector, and unpaid carers.

Objective 3: Spotlight - TEC Fest

Staff from across the Health and Social Care Partnership attended our 'TEC Fest' events in June 2019 and December 2019.

The events gave the opportunity to:

- talk to suppliers and see demonstrations of their Technology Enabled Care (TEC) products
- find out more about the Borders Technology Enabled Care Strategy
- talk to Partnership staff about current work around TEC.

The aim was for everyone to be better informed on available TEC, so that we can all work together to support and advise people in the Borders on using technology to remain independent for longer. More information on TEC can be found here

Some of the products on show included:

- **FALLS PREVENTION** - The falls prevention technology uses wearable devices to monitor an individual's 'normal' state and alert a nominated person if and when this changes. The aim is to use the technology and intervene before someone falls and injures themselves – which could result in a prolonged or permanent loss of mobility.
- **FLORENCE** (Home Mobile Health Monitoring) - allows patients to monitor a range of conditions (blood pressure, COPD, asthma) from home. This promotes self-management of their health condition and prevents GP/surgery time being taken up with routine tasks – such as BP monitoring appointments.
- **STRATA** - a web-based application that facilitates co-ordination across the entire partnership by automatically matching a patient/clients assessed need to available care resource.
- **NEAR ME** - instead of travelling to a face-to-face appointment, patients or service users enter the clinic's online waiting area from a web browser and their consultation is held via a video conference call.
- **ETHEL** - a large, stripped-down tablet which allows medication prompts, video calls and access to websites. It is simple to use with big, clearly labelled buttons and does not rely on the individual having broadband in their home.
- **ASKSARA** - a self-help website that allows individuals to answer a number of questions that will help them find equipment that can help them with everyday living. The website allows individuals to answer a number of questions, designed by Occupation Therapists, on a topic that they may be having difficulty with i.e. taking a bath, making food, climbing the stairs. It then produces an individualised report showing small items of equipment that can help and where they can be purchased. The website will recommend a full Occupational Therapy assessment via a What Matters hub if the report highlights any areas of concern.

TEC Goody Bag

The Scottish Borders H&SC Patnership launched a TEC Goody Bag to help support older people with everyday living. The bag contains small items of technology teams which members of the public are able to trial for up to 6 weeks to see if they help with everyday living and to remain independent. The bags are by the What Matters hubs and Home First teams.

The goody-bag kits contain a droplet hydration cup, a dementia clock, a large button phone, movement sensor night light and a simple remote control.

All of the items in the bags are readily available online and on the high street for people to purchase after the initial 6 week trial.

Florence Evaluation

Florence is a automated text messaging service which asks people to submit readings for long term conditions. The system generates automated responses and gives advice to the patient. The readings that are submitted sit in the florence system and can be reviewd by clinical staff at any time. Florence was trialled in a number of GP practices. To help give some context to how big an impact Florence could have - Teviot Medical Practice in Hawick alone has approx. 1,000 people requiring long term BP monitoring. Evaluation indicates that it could be possible to prevent 2-3 appointments per patient for diagnosis and titration. This is also true of hospital appointments – where a GP practice may routinely sent patients to the Borders General Hospital for monitoring. The use of Florence therefore removes the need for this, saving valuable GP and hospital time.

Falls Prevention

A 10 person trial of falls prevention technology took place in Deanfield Care Home from March to August. Unfortunately the technology used was not reliable in regard to connectivity and mobile phone signal and the trial did not prove successful. This stresses the importance of trailing and evaluating TEC in a systematic way prior to committing significant resource to it.

AskSARA

In Autumn 2018, the HSCP launched AskSARA. It is:

- an easy to use website that provides people with information and advice that can improve their quality of life by making everyday tasks such as cooking, bathing, taking medication and household chores easier.
- This can range from equipment to help them move around their home more safely to products that enable them to be more independent in the kitchen.

Anyone can use AskSARA, including family members, friends and carers. It's free and simple to use, and is available 24 hours a day, seven days a week.

All you do is choose from three broad categories – health, home or daily activities – and answer some questions. You will then receive a report written by an occupational therapist which will include recommendations for advice and support. If the assessment report highlights any areas of concern, AskSARA will recommend that a full occupational therapy assessment is undertaken - via one of the Partnership's What Matters Hubs.

The Borders AskSARA version is the first of its kind in Scotland and it has been developed by the Partnership with the help of the Disabled Living Foundation. To access AskSARA visit the Scottish Borders website www.scotborders.gov.uk/asksara

Objective 3: Priorities 2019/20 - What we said / What we did

Last year's Annual Performance Report contained a number of Partnership Priorities to be delivered in 2019/20. The table below details these and the key achievements delivered.

Partnership Priorities for 2018/19 – What we said

1. **Enable further support for Carers**
   We will improve signposting and support for unpaid and paid carers and also expand the reablement functions we offer.

2. **Improve Technology Enabled Care (TEC) and Data Sharing**
   Individuals expect more choice and more control over their care and TEC can play an important role in this to support individuals with complex needs, so that they can better manage their conditions and lead healthy, active and independent lives for as long as possible. We will continue to pilot and implement TEC products across the partnership and continue to promote the use of TEC with professionals and the public. We will follow up our June 2019 'TEC Fest' event with another event planned for December 2019.

Key Achievements/Successes : What we did

1. **Enable further support for Carers**
   We estimate that there are approximately 13,455 carers currently providing invaluable care and support across the Borders. Working with our colleagues in children and young people's services and the third sector, we are committed to providing services that support the health and wellbeing of carers as well as enabling them to participate in, and contribute to, the communities they live in.

   A short breaks statement for adult and young carers was published, providing a guide to the local and National resources available for carers and people who are supported. This was produced by the Health and Social Care Partnership and the Children and Young People's Leadership Team, along with adult and young carers from across the Borders. The aim is to help adult and young carers and the people they support with things such as:

- understanding what short breaks are
- who can access them
- what short breaks are available
- how short breaks can be accessed
- what other support is available

People with a learning disability from across the Borders held a range of events as part of Learning Disability Week (13-19 May 2019). The Local Citizens Panels' conference in Galashiels was just one of the opportunities taken to celebrate and share the contributions that people with a learning disability make to their local communities. Panel members gave presentations on their achievements over the previous year and outlined their plans for the next 12 months. There was also a special performance by the Keys to Life Choir, set up in August 2018 to give people with learning disabilities, family carers and support staff the opportunity to come together, learn songs, have fun and perform for others.

2. **Improve Technology Enabled Care (TEC) and Data Sharing**
   See TEC 'spotlight' above

Objective 3: Partnership Priorities for 2020/2021

Development sessions of the IJB, coupled with events attended buy a range of senior professionals have considered the challenges facing the partnership. As a result, the following workstreams have been identified in our Strategic Implementation Plan:

	DESCRIPTION	PLANNED DELIVERY DURING 2020/21
Carer Support Services	The partnership recognises the essential work of carers – even more so throughout the Covid-19 pandemic – looking to the future, it is a precarious resource that requires support.	We will improve accessibility to respite provision and further develop access to other sources of support both the community and across web/telephone services. We will continue working with Borders Carers Centre and Borders Care Voice to better understand the needs of carers and to work collectively to deliver the services they require.
Locality Operations	Early intervention, prevention, shared client cohorts, agile responses, close coordination of effort, all designed to reduce admissions and avoid/or slow progression to higher levels of care and health needs.	We will define the locality model, agree the aims, principles, scope, outcomes and the delivery model. Locality teams will use this for guidance, but will also then be able to develop the model in line with the needs of their locality. Our locality model will build on the work of the Community Assistance Hubs and What Matters hubs – and will work closely with communities to provide a joined up Health and Social Care service response that meets local needs.
Technology	Technology support across health and care provision, workforce enablement, improved administration processes and improved sharing of information across the partnership.	Technology is very closely linked to Workforce and we will continue to invest in technology for staff and invest in technology enabled care to help people live independently for as long as possible.
Mental Health provision	For adults (and children), including dementia care and autism.	Our Child and Adolescent Mental Health Service (CAMHS) is redesigning care pathways during 20/21. The adult mental health service will continue delivering the distress brief intervention service and, in collaboration with primary care will continue development of the community mental health model (where appropriate patients see a mental health professional rather than a GP) and are offered evidence based psychological therapy depending on their needs.
Learning & Physical Disability provision	Reviewing and 're-imagining' the service – particularly important now in the context of Covid-19.	We will update our Physical Disability Strategy and implementation plan, explore options for a complex care unit for adults with learning disabilities and continue to progress shared lives, with the first service users commence placements during the latter half of 2020. Respite Care and short breaks provision will be reviewed and supported living provision, in collaboration with local Registered Social Landlords explored. A key objective within the next 2-years is to develop increased supported housing for adults with complex care needs, reducing the number of out of area placements required.

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Performance Summary

The Integrated Joint Board (IJB) agrees a joint budget and commissions a range of health and social care partnership services within the functions delegated to it.

IJB financial governance includes:

- Approval of high level strategies and plans
- Quarterly financial monitoring reports
- Publication of the annual Statement of Accounts'

In 2019/20 the IJB controlled the direction of **£191.367m** of financial resource to support the delivery of its three strategic objectives.

The split of the resource is shown below:

IJB SERVICE AREA	BASE BUDGET £'000	REVISED BUDGET £'000	ACTUAL £'000	VARIANCE £'000
1. SOCIAL CARE SERVICES				
Joint Learning Disability Service	14,301	18,122	18,134	(12)
Joint Mental Health Service	2,039	2,083	2,076	7
Joint Alcohol and Drug Service	176	130	114	16
Older People Service	24,818	22,279	22,991	(712)
Physical Disability Service	3,457	3,129	3,191	(62)
Generic Services	11,684	13,495	13,615	(120)
SBC Contribution		883		883
Social Care sub-total:	**56,475**	**60,121**	**60,121**	**0**
2. HEALTH SERVICES				
Joint Learning Disability Service	3,551	4,080	4,435	(355)
Joint Mental Health Service	14,774	16,450	16,225	225
Joint Alcohol and Drug Service	369	735	777	(42)
Generic Services	75,209	78,347	81,323	(2,976)
NHS Contribution		6,255		6,255
Health sub-total:	**93,903**	**105,867**	**102,760**	**3,107**
3. SET-ASIDE HEALTHCARE SERVICES				
Accident & Emergency	2,516	2,957	3,206	(249)
Medicine & Long-Term Conditions	6,767	6,695	6,725	(30)
Medicine of the Elderly	13,231	16,033	16,175	(142)
Planned savings	0	(1,824)		(1,824)
NHS Contribution	0	1,518	0	1,518
Set-aside sub-total:	**22,514**	**25,379**	**26,106**	**(727)**
Overall:	**172,892**	**191,367**	**188,987**	**2,380**

Note: The 'set-aside' budget covers the in-scope integration functions of the NHS that are carried out in a large hospital setting. In our case, Borders General Hospital (BGH).

Proportion of spend by reporting year, broken down by service

The table below shows the actual delegated budget for 2016/17, 2017/18, 2018/19 and 2019/20 – and the proposed budget for 2020/21.

IJB SERVICE AREA	ACTUAL 2016/17 £'000	ACTUAL 2017/18 £'000	ACTUAL 2018/19 £'000	ACTUAL 2019/20 (£'000)	BUDGET 2020/21 (£'000)
1. SOCIAL CARE SERVICES					
Joint Learning Disability Service	15,261	16,730	17,516	18,134	16,399
Joint Mental Health Service	1,911	1,962	1,999	2,076	2,256
Joint Alcohol and Drug Service	103	173	136	114	-
Older People Service	20,979	18,685	20,762	22,991	25,194
Physical Disability Service	3,343	3,570	3,599	3,191	2,458
Generic Services	4,850	12,011	12,335	13,615	5,278
Social Care sub-total:	**46,447**	**53,131**	**56,347**	**60,121**	**51,585**
2. HEALTH SERVICES					
Joint Learning Disability Service	3,690	3,520	4,010	4,435	3,740
Joint Mental Health Service	14,173	13,725	14,974	16,225	15,980
Joint Alcohol and Drug Service	635	597	608	777	390
Generic Services	78,109	77,645	81,884	81,323	87,670
Health sub-total:	**96,607**	**95,487**	**101,476**	**102,760**	**107,780**
3. SET-ASIDE HEALTHCARE SERVICES					
Accident & Emergency	2,043	2,004	2,912	3,206	2,830
Medicine of the Elderly	13,029	12,905	15,571	16,175	15,660
Medicine & Long-Term Conditions	6142	6,434	6,642	6,725	6,230
Generic Services	-	3,075	-	-	-
Planned savings	(350)	-	-	-	(1,090)
Set-aside sub-total:	**20,864**	**24,418**	**25,125**	**26,106**	**23,630**
Overall:	**163,918**	**173,036**	**182,948**	**188,987**	**182,995**
	-	**+5.6%**	**+5.7%**	**+3.3%**	

(*) There is considerable budgetary pressure arising from the additional costs of Covid-19 mobilisation and the non-delivery of planned savings. One of the main reasons for non-delivery of savings has been because resource capacity (staff) has had to be allocated to meet the requirements of Covid-19 response. This is the case across the Health and Social Care Partnership and the Social Care, Health and Set-Aside budgets.

Overspend / Underspend

From the table above, it can be seen that whilst the HSCP budget has increased year on year, the Partnership continues to experience significant financial pressures across its delegated functions. During 2019/20 the Partnership required additional resources of **£6.255m** from NHS Borders and **£0.883m** from Scottish Borders Council to enable it to deliver a financial break-even position at year end.

Allocation of these additional resources enabled the Partnership to breakeven across its budget supporting the delegated functions. The positive position reported above relates entirely to **£3.107m** of ring-fenced funding allocations that were not spent during 2019/20 and which will be carried forward to 2020/21 – a significant proportion of which is committed. In addition, other balances are also being carried forward in relation to Transformation (**£0.396m**) and Older People's Change Funding (**£0.179m**), giving a total of **£3.682m**. In relation to Set-Aside budgets, there was an adverse variance in regard to large hospital functions set-aside of **£0.727m**.

Common drivers for the significant financial pressures include demographic growth, staff recruitment/ retention and the increased demand for services across the Partnership. In particular:

- Increased demand for social care in residential care and in care at home, particularly for those in the 75-84 and 85+ age cohorts.
- Increased costs within the Joint Learning Disability Service, particularly in relation to residential placements.
- Additional social care clients transitioning from Children and Families into Adult Health and Social Care services.
- Non-delivery or partial delivery of planned financial savings across the Partnership.
- Additional investment requirements to deliver transformation.
- The impact of vacancies and the subsequent use of agency staff.
- The impact of Covid-19 on acute hospital functions late in the financial year
- The impact of vacancies and the subsequent use of agency staff.
- The impact of Covid-19 on acute hospital functions late in the financial year

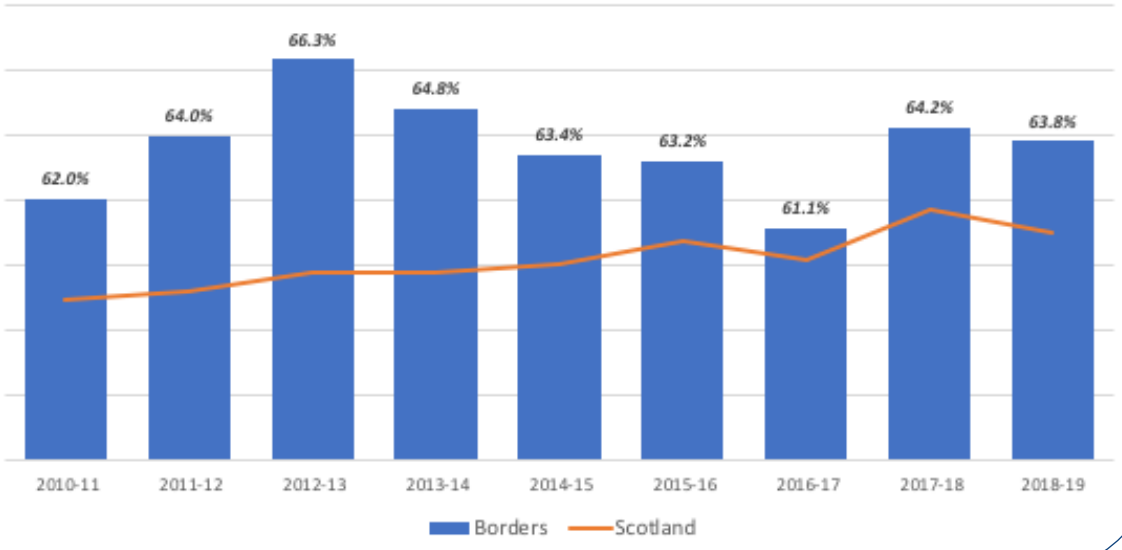
Balance of care

The HSCP Strategic Commissioning Plan is based on developing community capacity in a way that helps prevent unplanned hospital admissions and improves the flow of patients out of the acute hospital setting (i.e.) using resources more effectively on prevention, rather than treatment.

This will help us to invest in new integrated ways of working, particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting carers and supporting independent living. The development of Locality based services is critical to this.

The Borders has made some progress towards the aim of providing more care in the community, but this needs more improvement. In 2010/11 the percentage of people aged 65 and over with long-term care needs who receive personal care at home was **62.0%**. In 2018/19 this was **63.8%**, demonstrating a general upward trend.

% OF PEOPLE AGED 65 OR OVER WITH LONG TERM CARE NEEDS RECEIVING PERSONAL CARE AT HOME

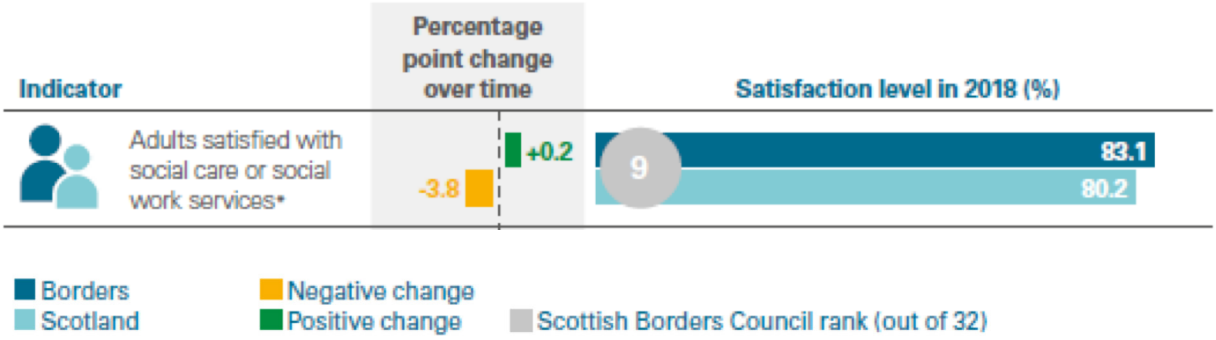


Source: Local Government Benchmarking Framework

Best Value and BV Audit

Best Value ensures that we have services in place that are efficient, economic, sustainable and that deliver improved outcomes for Borders residents.

The focus of the Audit Scotland October 2019 Best Value Assurance Report: Scottish Borders Council, was Scottish Borders Council, but the report touched on partnership working with the IJB. The report concluded that a number of Council services had performed well and demonstrated improvement, including aspects of social work. The report also showed that the satisfaction rate with social care or social work services was good (in comparison to other local authorities and with the Scotland average).



The October Best Value report, however also highlighted that Partnership working between SBC and NHS Borders needs to improve.

Accounts Commission finding 2010	Controller of Audit judgement 2019
Partnership The council works well with its partners and we welcome evidence of effective collaboration on services such as health improvement, jointly funded social care, community safety and child protection. The Commission welcomes particularly notable examples of partnership working such as the co-location of services in Peebles and the equalities and diversity officer jointly funded with NHS Borders.	Partnership working with NHS Borders, through the integration joint board, needs to improve. The council has made good progress with other aspects of joint working and recognises there are further opportunities for this. The council is a key partner in complex and ambitious economic initiatives.

Our governance framework is the rules, policies and procedures by which the IJB ensures decision making is accountable, transparent and carried out with integrity. The Board has legal responsibilities and obligations to its stakeholders, staff and residents of the Borders area. The Chief Officer Health & Social Care chairs the HSCP Leadership Team and the IJB ensures proper administration of its financial affairs by having a Chief Finance Officer in place.

At the start, middle and end of the financial year, the IJB and its partners undertake a full review and evaluation of its degree of compliance with legislation and recommended best practice in relation to the Partnership's financial governance, planning, management and reporting arrangements and clear forward planning is in place to ensure full assurance to the Partnership going forward.

The unaudited Annual Accounts have been approved through the IJB governance process. In accordance with legislation, the audited accounts will be signed off no later than 30th September and published no later than one month thereafter.

LOCALITY ARRANGEMENTS

Locality planning is a key tool in delivery of the change required to meet new and existing demands in the Borders. The IJB has developed locality arrangements where professionals, communities and individuals can inform locality planning and redesign of services to meet local need in the best way.

This is achieved through having 'Locality Working Groups' in each of the five localities of:

- Berwickshire
- Cheviot
- Eildon
- Teviot & Liddesdale
- Tweeddale.

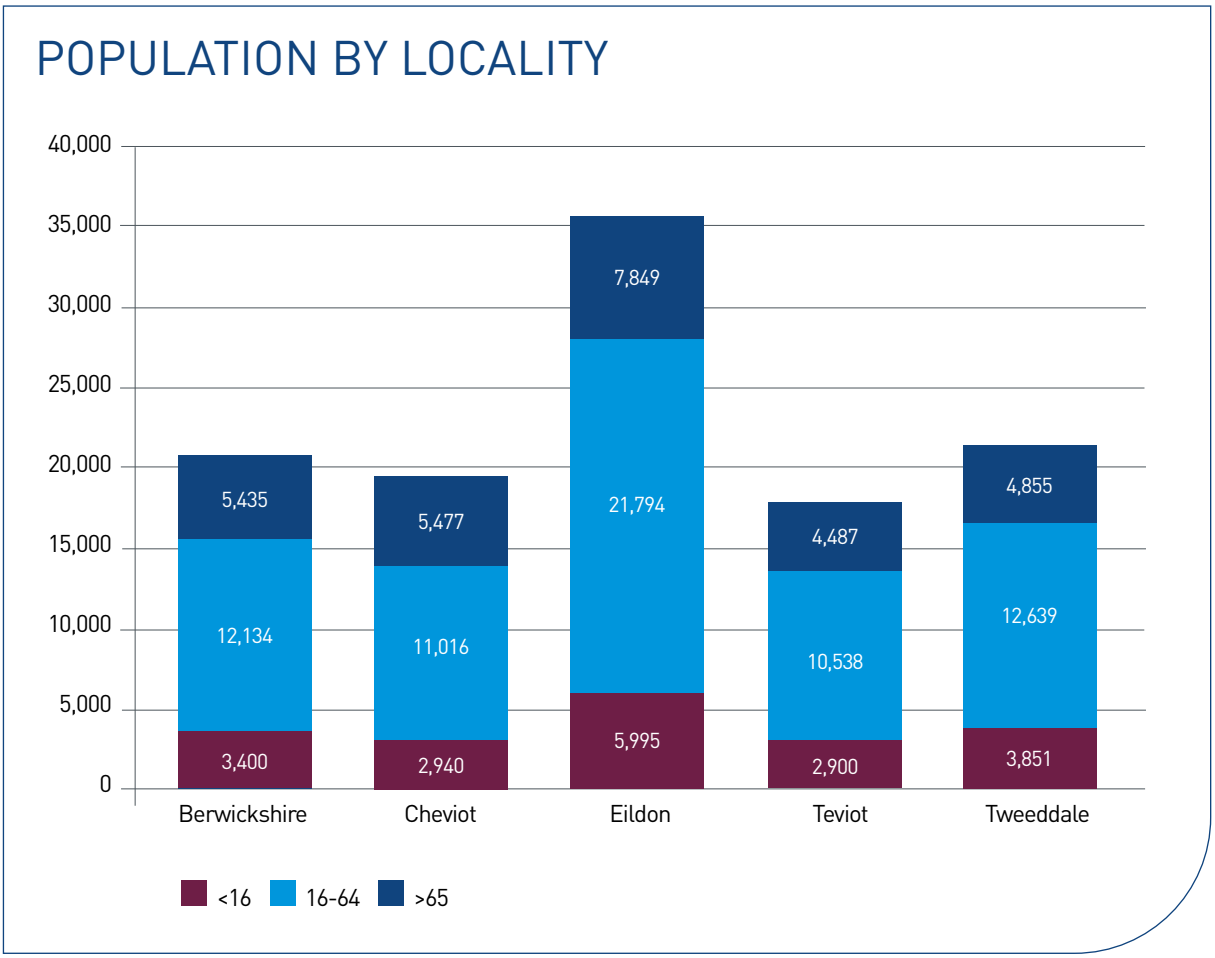
Each Locality has a Locality Plan and as highlighted in the Best Value report, there are opportunities to further integrate these Locality Plans within Community Planning Partnership (CPP) arrangements. Proposed changes to Locality Working arrangements were approved by IJB at their June 2019 meeting. These changes will strengthen and bolster Locality Working Group arrangements by ensuring that:

1. Each Locality Plan is aligned to CPP themes and outcomes – as well as being aligned under the three Health & Social Care Strategic Objectives.
2. Each Locality has an identified 'Locality Lead', responsible for the planning and delivery of the H&SC actions. It is anticipated that the bulk of these will align under the 'Our health, care and wellbeing' CPP theme.
3. Identified members of IJB Leadership Team are allocated to specific localities. Their role to work with each 'Locality Lead' to plan and deliver the H&SC actions.
4. Admin resource is in place to support the Locality Leads and IJB Leadership Team members in the delivery of H&SC actions and activity across all 5 localities and to ensure the coordination of relevant papers and updates for Strategic Planning Group, Area Partnership and CPP meetings.
5. All 5 of the Locality Leads are permanent members of Strategic Policy Group (SPG)
6. 1x Locality Lead is selected to represents the others to attend Integration Joint Board.

Note: locality working arrangements have been hampered by the Covid-19 pandemic

Locality Budget

The total population of each of our localities is shown in the graph below:



At a financial level, we do not allocate resource to specific localities, but based on population, services delivered and the location of services, the following table indicates how the HSCP budget could be attributed to each locality (based on 2018/19 actual spend):

Locality Split

LOCALITY	POPULATION	LOCALITY 'ALLOCATION (£M) - BASED ON 2018/19 ACTUAL											TOTAL (18/19 ACTUAL)
		Social Work	Learning Disability	Physical Disability	Mental Health	District Nursing	AHP	NHS Community Services	Family Health Services	Prescribing	Other	Set Aside	
Berwickshire	21,005	3.99	3.70	0.60	3.27	0.64	1.13	3.02	5.18	4.39	2.86	4.49	**33.27**
Eildon	35,700	6.78	6.27	1.02	5.55	1.08	1.93	5.13	8.80	7.47	4.86	7.63	**56.52**
Tweeddale	21,382	4.07	3.76	0.61	3.33	0.65	1.15	3.07	5.27	4.47	2.91	4.57	**33.87**
Cheviot	19,476	3.70	3.43	0.56	3.03	0.59	1.05	2.80	4.80	4.07	2.65	4.16	**30.84**
Teviot	17,956	3.41	3.47	0.51	2.80	0.55	0.97	2.58	4.42	3.76	2.45	3.84	**28.44**
	115,510	**£21.96**	**£20.32**	**£3.31**	**£17.07**	**£3.51**	**£6.24**	**£16.59**	**£28.46**	**£24.16**	**£15.74**	**£24.69**	**182.95**

LOCALITY	POPULATION	LOCALITY 'ALLOCATION' (£ SPEND PER HEAD OF POPULATION)											
		Social Work	Learning Disability	Physical Disability	Mental Health	District Nursing	AHP	NHS Community Services	Family Health Services	Prescribing	Other	Set Aside	
Berwickshire	21,005	£190	£176	£29	£156	£30	£54	£144	£246	£209	£136	£214	**£1,584**
Eildon	35,700												
Tweeddale	21,382												
Cheviot	19,476												
Teviot	17,956												

Based on a budget of £183m and a population of 115.5k, this equates to an average spend of approx. £1,584 per person per annum.

Locality Activity

One example of our Locality activity is our Older People's Local Area Co-ordination team (LAC) who supported this year's Silver Sunday event, held in Duns as part of the nationwide celebration of older people. Around 100 residents from across Berwickshire gathered for a day of food, interaction and entertainment. Organisers included A Heart for Duns, Berwickshire Housing Association and Duns Senior Citizens along with a range of community volunteers. Food was provided by the White Swan and flower arrangements donated by Farne Salmon & Trout Ltd. This was the third year that Silver Sunday has been celebrated in Berwickshire, following successful events held in previous years in Galashiels, Langlee and Hawick.

INSPECTION OF SERVICES

Joint Inspection Follow Up

The 2017 Care Inspectorate and Health Improvement Scotland inspection of services for Older People in Scottish Borders identified some strengths in the delivery of services, but also some significant weaknesses which resulted in 13 recommendations for improvement being made.

A follow up inspection held in late 2019 concluded that services for older people in the Scottish Borders are improving. The progress review confirmed that the HSCP had made good progress in addressing each of the recommendations and had demonstrated a commitment to ongoing improvement. In particular the inspectors found:

- Senior managers within the partnership demonstrated a commitment to a shared direction of travel and increased strengthening of joint working at a strategic level.
- The partnership had reviewed its governance framework and had a process in place for monitoring the progress of the strategic plan supported by a clear supporting structure.
- Continuity of senior staff in the partnership has provided much needed stability. Importantly, constructive working relationships had evolved.
- Work undertaken by the partnership to improve planning and commissioning is strategic and focused.
- There was a clear commitment by the partnership to continue building on the improvements and progress that had been made.

Ann Gow, Deputy Chief Executive of Healthcare Improvement Scotland, said:
"This was a positive review with progress made in key areas. In order to continue making progress, the partnership recognised the need to improve both self-evaluation and ongoing evaluation of initiatives and approaches. In addition, engagement and consultation with stakeholders needs to become more meaningful, and appropriate representation must be included and valued."

Peter Macleod, Chief Executive of the Care Inspectorate, said:
"Given the positive findings from our latest review, we do not intend to conduct any further scrutiny in relation to this inspection. Instead, we will continue to engage with the partnership about the possibility of offering further support on identified areas for improvement. People want to experience care that is consistently high quality, with health and social care staff working well together to support people in a way that promotes their rights and choices. There is still a lot of work for this partnership to do to continue to improve services for older people across the Scottish Borders health and social care partnership."

Health Inspections

NHS Borders has four community hospitals; Hawick, Hay Lodge, Kelso and Knoll. All four hospitals have 23 inpatient beds and provide medical care, palliative care and rehabilitation. The hospitals also have minor injuries services, GP treatment room services and a range of consultant-led clinics and day hospital services.

Health Improvement Scotland carried out announced inspections to Hawick, Hay Lodge, Kelso and Knoll community hospitals between Tuesday 21 May and Thursday 23 May 2019.

The inspectors focused on 3 areas:

- Education to support the prevention and control of infection
- Infection prevention and control policies, procedures and guidance, and
- Decontamination.

Across the four hospitals, 27 patient interviews were undertaken and 45 completed patient questionnaires were received.

The inspection findings were that all four community hospitals demonstrated:

- good compliance with mandatory infection control training, and
- good staff compliance with standard infection control precautions.
  but that ....
- the fabric of the built environment must be maintained to enable effective cleaning.

This inspection resulted in two requirements and no recommendations. The requirements are linked to compliance with the Healthcare Improvement Scotland HAI standards. An improvement action plan was developed by the NHS board.

Health improvement Scotland also carried out an announced inspection to Borders General Hospital on 4th & 5th November 2019 in regard to ionisiong radiation (medical exposure) regulations. Inspectors spoke with a number of staff including the Chief Executive, IR(ME)R lead, radiologists and radiographers. Borders General Hospital offers plain film, computerised tomography (CT) mamography and nuclear medicine. The focus of this inspection was the imaging department.

The inspection identified a number of areas of good practice but also a number of areas for improvement.

WHAT THE SERVICE DID WELL	WHAT THE SERVICE NEEDS TO IMPROVE
• There was a positive safety culture within the radiology team for radiation protection of persons undergoing medical exposure. • Prior to the inspectors visit, NHS Borders had carried out a self-evaluation of their medical exposure to ionising radiation safety arrangements and had developed an action plan to address areas of improvement. • All staff were fully aware of their roles and responsibilities in relation to radiation protection of persons undergoing medical exposure. • There was good evidence of audits being undertaken. Following the entitlement process, audit improvements were made to the process to ensure the appropriate documentation was in place.	• Inspectors found that the governance arrangement for developing and changing employer's procedures and associated documents was not clearly defined. • There was a lack of clarity of the role and responsibilities of the different staff groups and committees. • There were no procedures or guidance for staff to undertake continuous education or training in relation to IR(ME)R, following qualification. • The membership and function of the optimisation group needs to be formalised to ensure the involvement of key staff at all times.

This inspection resulted in five requirements and one recommendation. Requirements are linked to compliance with IR(ME)R. An improvement action plan was developed by the NHS Board to address the requirements and to make the necessary improvements as a matter of priority.

Ministerial Strategic Group Report on IJBs

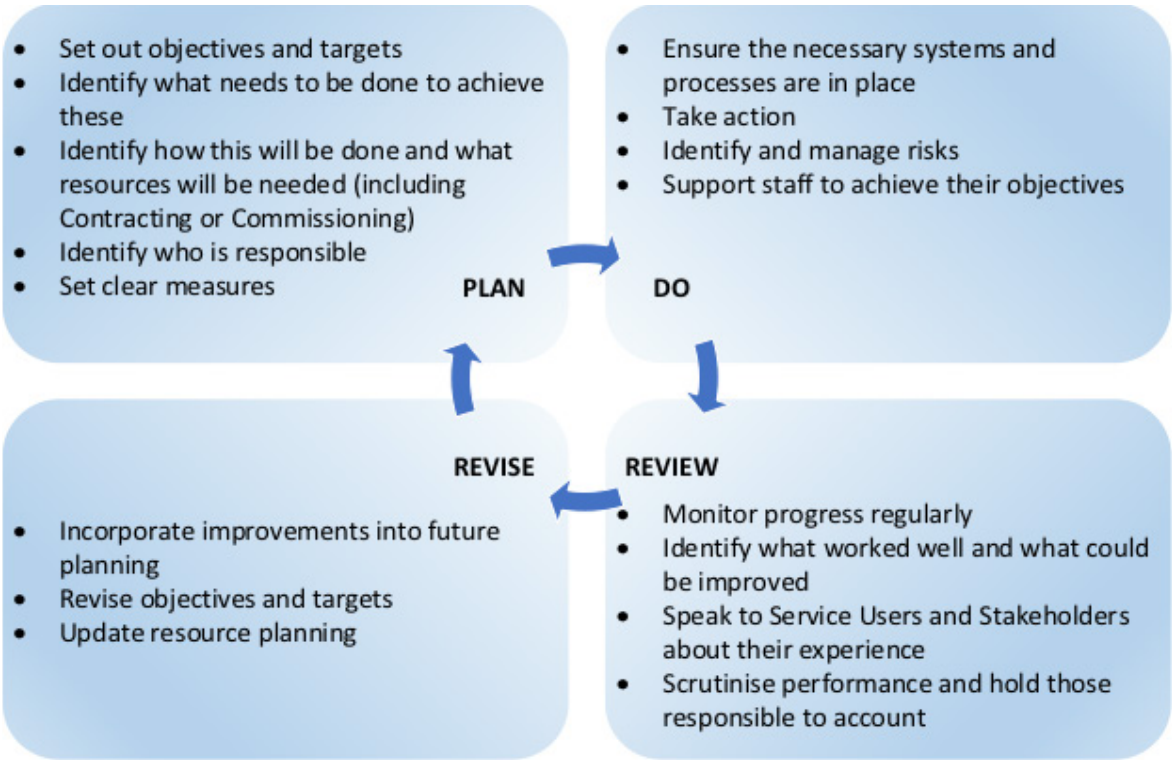
The Ministerial Strategic Group (MSG) for Health and Community Care February 2019 report on the 'Review of Progress with Integration of Health and Social Care' concluded that the pace and effectiveness of integration needs to increase. The report included 25 proposals to ensure the success of integration. Three of these proposals were being taken forward Nationally and all partnerships across Scotland, including Borders, completed a self-evaluation on the remaining 22 proposals. The Scottish Borders action plan to address the issues raised in the MSG report and to deliver against the 22 proposals is shown in Appendix 3.

PERFORMANCE MONITORING FRAMEWORK SUMMARY

Performance Management Framework

The Strategic Planning Group was instrumental in developing our Performance Management Framework (PMF). The PMF sets out the strategic context and performance reporting arrangements for the Health & Social Care Partnership.

The Partnership aspires to be "best in class" and seeks to promote a culture of continuous improvement, to deliver better outcomes for individuals and communities. The PMF provides the structure by which the partnership can make informed decisions on future priorities, using performance information to identify and drive improvement work. It can also be used to assess the effectiveness of transformation and change projects. The PMF gives a structure to help build continuous improvement by setting out a logical approach to driving performance improvement.



Source: Adapted from Audit Scotland

Our performance measures

We report on a quarterly basis on a number of performance measures. These measures are aligned under the 3 Strategic Objectives and are designed to show the progress being made in delivery of the strategic objectives and therefore the contribution being made by the Partnership to the National Health and Wellbeing indicators. Each performance has a 'RAG' status. This Red/Amber/Green, classification is based, wherever possible, on a combination of performance against target, performance trend and performance against National data. The RAG status helps to highlights areas of good performance and also areas where action is required.

Our quarterly measures are shown below:

Regular performance updates can be found here

HOW ARE WE DOING?

OBJECTIVE 1

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

EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES)	EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS AGE 75+)	ATTENDANCES AT A&E (ALL AGES)	£ ON EMERGENCY HOSPITAL STAYS
29.1 **admissions** per 1,000 population (Q3 - 2019/20)	**101.2** **admissions** per 1,000 population **Age 75+** (Q4 - 2019/20)	**59.6** **attendances** per 1,000 population (Q4 - 2019/20)	**19.1%** of **total health and care resource**, for those **Age 18+ was spent** on **emergency hospital stays** (Q2 - 2019/20)
-ve trend over 4 periods Worse than Scotland (27.6 – Q3 2019/20) Worse than target (27.5)	-ve trend over 4 periods Worse than Scotland (94.4 – Q3 2019/20) Worse than target (90.0)	+ve trend over 4 periods Better than Scotland (62.0 – Q4 2019/20) Better than target (70.0)	+ve trend over 4 periods Better than Scotland (23.5% - 2018/20) Better than target (21.5%)

Main Challenges

The rate of emergency admissions over the long-term (3 year period) remains relatively positive. Quarterly performance does fluctuate; and Covid-19 will have an impact – although not reflected in the figures to date. Historically, the number of A&E attendances has fluctuated between 7,000-8,000 attendances per quarter (which is equivalent to approx. 60-70 per 1,000 population per quarter), generally better than the Scotland average and better than our local target. Again, Covid-19 will impact A&E attendances and may well impact the peoples use of A&E for a long time to come. In relation to the percentage of the budget spent on emergency hospital stays, Borders has consistently performed better than Scotland and can demonstrate a positive trend over time. The most recent figure of 19.1% is the lowest % of spend in the last 3 years but the data is once again pre-Covid. *(note: as of December 2019, the denominator for this measure was updated to include Dental and Ophthalmic costs and, as a result, the % of Health Care spend has slightly reduced).* As with all Health and Social Care Partnerships, there is an expectation to minimise the proportion of spend attributed to unscheduled stays in hospital.

Objective 1: Our plans for 2020/21

Our Strategic Implementation Plan (SIP) includes the development of our Localities (e.g.) building on 'What Matters' and Community Assistance Hubs to improve and facilitate early intervention, shared client cohorts, agile responses, close coordination of effort, all reducing admissions and avoiding or slowing progression to higher levels of care and health needs Work continues to be progressed to improve patient flow, including; Frailty Front Door (admission avoidance), quicker discharge processes, trusted assessor models, new Intermediate Care and Reablement Services.

OBJECTIVE 2

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

A&E WAITING TIMES (TARGET = 95%)	RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)	NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)	RATE OF BED DAYS ASSOCIATED WITH DELAYED DISCHARGE	"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS
86.2% of **people seen within 4 hours** (Mar 2020)	**826** **bed days** per 1000 population **Age 75+** (Q4 - 2019/20)	**13** **over 72 hours** (Mar 2020)	**206** **bed days** per 1000 population **Age 75+** (Q4 - 2019/20)	**95.5%** **overall satisfaction rate** (Q4 - 2019/20)
-ve trend over 4 periods Worse than Scotland (88.6% – Mar 2020) Worse than target (95%)	-ve trend over 4 periods Better than Scotland (1,108 - Q3 2019/20) Better than target (min 10% better than Scottish average)	+ve trend over 4 periods Better than target (23)	-ve trend over 4 periods Worse than Scotland (198 – 19/20 average) Worse than target (180)	-ve trend over 4 periods Better than target (95%)

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

Main Challenges

The latest A&E Waiting Time (Mar 2020) figure is under our 95% target and also below the Scotland average. This data pre-dates the Covid pandemic and it is likely that our next reporting will show waiting time performance improvement as a result of fewer people attending A&E. Occupied bed day rates for emergency admissions (age 75+) has seasonal fluctuations and again in future reporting will be impacted by Covid. Delayed discharge rates vary in regard to 'snapshot' data, but performance is positive and a target to reduce delayed discharges by 30% in 2019/20 has been achieved by the Health & Social Care Partnership if comparing snapshot data for May 2019 (26) with May 2020 (13). The percentage of patients satisfied with care, staff & information in BGH and Community Hospitals remains positive. The rate of Bed Days Associated with Delayed Discharge has an overall positive trend over the long term (3 years) but Q4 2019/20 shows a significant increase to 206 days, which is above the average and above our 180 day local target. Covid will impact on a number of measures, including delayed discharge, A&E attendances/waiting times, and emergency admissions.

Objective 2: Our plans for 2019/20

As part of our Strategic Implementation Plan (SIP), we will continue to work across the HSC Partnership and Public Health to initiate a number of events, campaigns and communications promoting personal responsibility and encouraging Borderers to remain safe and to be healthy in areas including diet, exercise and mental health. We will further develop community capacity and we will examine the bed-base mix across the care estate including the usage, role & function of Community Hospital beds. We will review our contracted and commissioned services and support our workforce to ensure that we have flexible staff with the skills, training and equipment required to deal with the impacts of Covid and any future pandemics.

OBJECTIVE 3

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

EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES)	END OF LIFE CARE	CARERS SUPPORT PLANS COMPLETED	SUPPORT FOR CARERS: change between baseline assessment and review. Improvements in self- assessment
11.5 per **100 discharges from hospital** were re-admitted within 28 days	**87.6%** of **people's last 6 months** was spend at home or in a community setting	**82%** of **carer support plans offered** that have been **taken up and completed completed** in the **last quarter**	**Health and well-being** **Managing the caring role** **Feeling valued** **Planning for the future** **Finance & benefits**
(Q3 - 2019/20)	(Q3 - 2019/20)	(Q4 - 2019/20)	(Q4 - 2019/20)
-ve trend over 4 Qtrs **Worse than Scotland (10.4 - Q3 2019/20)** **Worse than target (10.5)**	**+ve trend over 4 Qtrs** **Worse than Scotland (88.1% - 2019/20)** **Worse than target (87.5%)**	**+ve trend over 4 Qtrs** **Better than target (40%)**	**+ve impact** **No Scotland comparison** **No local target**

Main Challenges

The quarterly rate of emergency readmissions within 28 days of discharge (all ages) peaked at 11.5% in Q3 2019/20 – the highest readmission rate in the last 3 years and increasing from a low of 10.0% in 2016/17. Borders data in relation to end of life care shows has improved but is still less than the Scotland average. The latest available data for Carers demonstrates positive outcomes as a result of completed Carer Support Plans.

Objective 3: Our plans for 2019/20

As part of our Strategic Implementation Plan (SIP), we will continue to support Carer services – the partnership has always recognised the essential work of carers, and even more so through the Pandemic. It is a precarious resource that requires support. We will continue trialling and implementing technology to improve health and care provision, workforce enablement, administration and processes. We will implement Joint Capital Development and Planning, including a Primary Care Capital Strategy, new Intermediate Care provision and an overarching Joint Capital Plan for the Border's Public Sector.

Performance Change

The table below gives a summary of the long-term trend for a range of performance measures used in the quarterly reporting – covering performance from inception of the HSCP in 2016 to date. Full detail can be found in the Integration section of the website (Appendix 2 of the Quarterly Reports).

KEY

▲ Improving Performance ▼ Declining Performance ◄ ► Little change

MEASURE	DATA RANGE	LONG-TERM TREND	NOTES
Emergency admissions in Scottish Borders residents - all ages	Q1 2016/17 – Q3 2019/20	▲	The rates fluctuate but over the long-term there has been a general decrease in volume of emergency admissions and the Partnership performs better than the Scotland average the majority of the time.
Rate of emergency admissions, Scottish Borders Residents age 75+	Q1 2016/17 – Q4 2019/20	▲	
Number of A&E Attendances per 1,000 population	Q1 2016/17 – Q4 2019/20	▼	As with emergency admissions, the rate for A&E attendances fluctuates. However, the long-term indicates an increasing volume of A&E attendance over time.
Percentage of total resource spent on hospital stays, where the patient was admitted as an emergency (age 18+)	Q1 2016/17 – Q2 2019/20	▲	The long-term trend indicates a decreasing percentage of total spend attributed to emergency hospital stays and the Partnership consistently performs better than the Scotland average.
Percentage of A&E patients seen within 4 hours	Mar 17 – Jun 20	▼	The performance in regard to the percentage of A&E patients seen within 4 hrs has been declining. The 2019/20 average of 89.9% is below our target of 95%.
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	Q1 2016/17 – Q4 2019/20	▲	The occupied bed day (OBD) rate does fluctuate but has reduced slightly over the long-term.
Numbers of Delayed Discharges over 72 hours ("snapshot")	Mar 18 – May 20	▲	Delayed discharge performance (pre-Covid) has improved slightly over the long term.
Bed days associated with delayed discharges in residents aged 75+, per 1,000 population	Q1 2016/17 – Q4 2019/20	◄ ►	There are spikes across the period; however, overall there is a neutral trend.
Patient satisfaction rates	Q1 2016/17 – Q4 2019/20	▼	Patient satisfaction (based on the '2 minutes of your time surveys' has declined but still remains high. However, the underlying reasons for the decline need to be explored.
Emergency readmissions within 28 days of discharge from Hospital (all ages)	Q1 2016/17 – Q3 2019/20	▼	The rate of emergency readmissions is increasing. This indicator in particular has been discussed a number of times by the IJB. One of the desired outcomes of increased Locality working is to see a reduction in emergency readmissions.
% of last 6 months of life spent at home or in a community setting	Q1 2016/17 – Q3 2019/20	◄ ►	The percentage of people able to spend their last 6 months of life at home or in a community setting has increased recently – but the long-term performance trend is generally neutral.
Support for Carers	Q1 2017/18 – Q4 2019/20	▲	The majority of unpaid carer Support Plans offered are subsequently completed.

Based on the range of measures above, we can demonstrate an overall positive performance trend since HSCP inception in 2016 (i.e.) a larger number of performance measures improving than declining. However, work will continue to ensure that further performance improvements are driven by Partnership priorities and actions.

Core suite

The table below summaries our performance against the 23 National core suite indicators. Full details are shown in Appendix 1.

The results for indicators 1-10 are based on the 2017/18 Scottish Government Health and Care Experience Survey (i.e.) recording peoples' perceptions. The results for indicators 11-23 are based on data. From the results below, it can be seen that Borders performance based on the data measures appears stronger than those measures based on people's perception.

National core suite indicators 1-10: outcome indicators based on survey feedback for year 2017/18

OUTCOME INDICATORS

INDICATOR		BORDERS			TREND	SCOTLAND **
		2013/14	2017/18	2019/20		
NI - 1	Percentage of adults able to look after their health very well or quite well	96%	94%	-	▼	93%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	79%	83%	-	▲	81%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%	74%	-	▼	76%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	78%	75%	-	▼	74%
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	83%	-	▲	80%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	89%	88%	-	▼	83%
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	80%	-	▼	80%
NI - 8	Total combined % carers who feel supported to continue in their caring role	41%	36%	-	▼	37%
NI - 9	Percentage of adults supported at home who agreed they felt safe	81%	86%	-	▲	83%
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	-	-	-	-	-

Source: (1-9) Scottish Government Health and Care Experience Survey 2017/18
http://www.isdscotland.org/Products-and-Services/Consultancy/Surveys/Health-and-Care-Experience-2017-18/
This national survey is run every two years

Source: (10) NHS Scotland Staff Survey 2015
http://www.gov.scot/Publications/2015/12/5980 . To date, equivalent information across the entire workforce of all Health and Social Care Partnerships is not available. Further work is required nationally and within Partnerships to collate and calculate this information.

DATA INDICATORS

INDICATOR		BORDERS PERFORMANCE						LONG-TERM TREND	SCOTLAND
		2014	2015	2016	2017	2018	2019		
NI - 11	Premature mortality rate per 100,000 persons; by calendar year	322	391	340	324	388	315	▲	426
NI - 12	Emergency admission rate	14,001	14,833	13,135	12,383	12,426	12,458	▲	12,602
NI - 13	Emergency bed day rate	135,029	135,124	130,816	134,563	132,492	120,372	▲	117,478
NI - 14	Readmissions to hospital within 28 days	105	107	102	105	109	109	▼	104
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	86%	86%	87%	86%	86%	◀ ▶	89%
NI - 16	Falls rate per 1,000 population aged 65+	20.8	20.9	21.0	22.3	18.7	22.1	▼	22.7
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	74%	75%	75%	81%	79%	86%	▲	82%
NI - 18	Percentage of adults with intensive care needs receiving care at home	65%	64%	64%	62%	62%	-	▼	62%
NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	628	522	647	855	761	676	▼	793
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	21%	20%	20%	21%	21%	19%	▲	23%

SCOTLAND figure is latest full year available (2019/20 or 2019 calendar year where Financial Year not available)

Source: ISD Core Suite Indicator Updates

MSG measures

A summary of the Ministerial Strategy Group (MSG) measures we use are shown below. Additional detail is shown in Appendix 2.

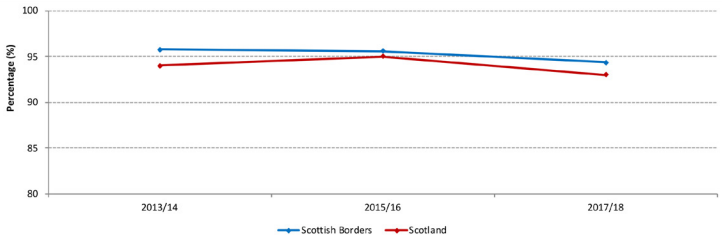
BORDERS MSG 2019/20 TARGETS

MSG MEASURE		19/20 TARGET	19/20 ACTUALS												
			Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2019	Feb 2019	Mar 2019	**Tot (Est.)**
1	Emergency Admissions (18+)	10,594	884	953	834	906	905	896	942	898	998	905	850	777	**10,748** 1% off target
2.1	Unplanned bed days (Acute 18+)	75,555	5,663	5,677	5,797	5,928	5,404	5,199	5,795	5,886	6,114	6,402	6,137	5,072	**69,074** 9% ahead of target
2.2	Unplanned bed days (Mental Health 18+)	16,534	-	-	3,943	-	-	3,767	-	-	2,945	-	-	2,690	**13,345** 19% ahead of target
2.3	Unplanned bed days (Geriatric 18+)	32,158	-	-	7,396	-	-	7,685	-	-	6,121	-	-	5,278	**26,480** 18% ahead of target
3	A&E	24,907	2,312	2,332	2,311	2,441	2,359	2,264	2,318	2,230	2,329	2,316	1,985	1,634	**26,831** 8% off target
4	Delayed Discharge (All reasons, 18+)	9,972	833	967	1,021	1,008	1,149	1,138	771	781	756	1,086	1,207	1,094	**11,811** 18% off target
5	% Last 6mths spent in Community	87.5%	-	-	-	-	-	-	-	-	-	-	-	-	**86.4%** 1% off target
6	% >65 living at home	96.9%	-	-	-	-	-	-	-	-	-	-	-	-	**97.0%** 0% ahead of target

APPENDIX 1
CORE SUITE OF INDICATORS

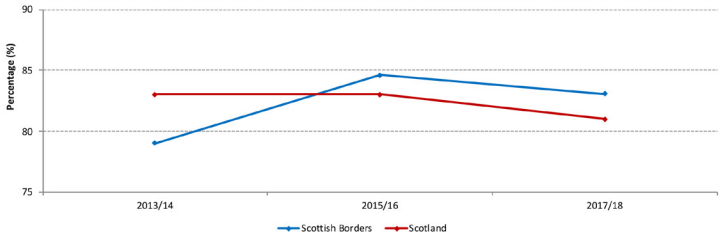
Note: The results for indicators 1-10 below remain the same as shown in last year's Annual Performance Report. The results will be updated once the Scottish Government Health and Care Experience Survey (indicators 1-9) and the NHS Scotland Staff Survey (indicator 10) become available.

NI-1 Percentage of adults able to look after their health very well or quite well

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	We will continue to improve information and advice available, and to promote Healthy Living.

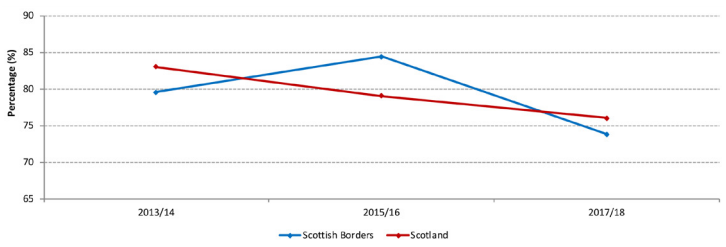
Source: Q52 - 2013/14 Health and Care Experience Survey, Q51 2015/16 Health and Care Experience Survey, Q40 2017/18 Health and Care Experience Survey

NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Technology is one of the priority areas in the Strategic Implmentation Plan and we will continue to develop technology enabled care and support as one method of enabling people to remain as independent as possible at home.

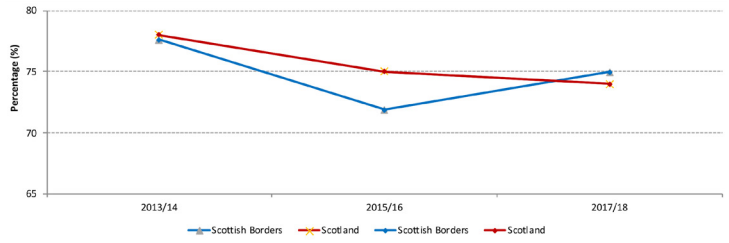
Source: Q36f - 2013/14 Health and Care Experience Survey, Q36g 2015/16 Health and Care Experience Survey, Q27f 2017/18 Health and Care Experience Survey

NI-3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Borders has a relatively high rate of Self-Directed Support We will continue to promote this and to ensure that there is choice in regard to the SDS options available locally.

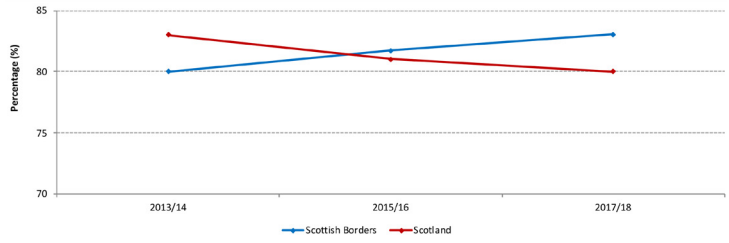
Source: Q36b - 2013/14 Health and Care Experience Survey, Q36b 2015/16 Health and Care Experience Survey, Q27b 2017/18 Health and Care Experience Survey

NI-4 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Work continues on the 'Older People's Pathway' to ensure that Health and Social Care services work seamlessly across acute care, rehabilitation, reablement, residential care and home care.

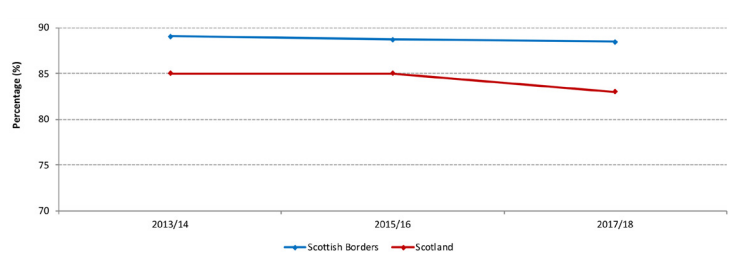
Source: Q36e - 2013/14 Health and Care Experience Survey, Q36f 2015/16 Health and Care Experience Survey, Q27g 2017/18 Health and Care Experience Survey

NI-5 Total % of adults receiving any care or support who rated it as excellent or good

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to seek the views of people receiving care (such as 2 minutes of your time survey) and will always seek to improve satisfaction rates with services.

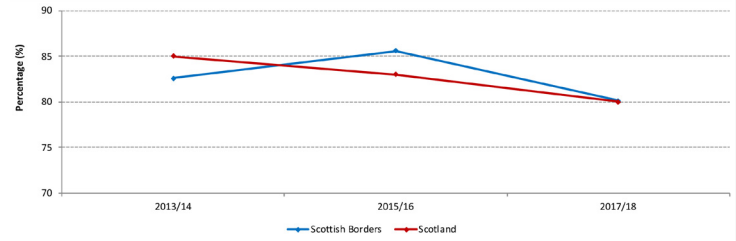
Source: Q37 - 2013/14 Health and Care Experience Survey, Q37 2015/16 Health and Care Experience Survey, Q28 2017/18 Health and Care Experience Survey

NI-6 Percentage of people with positive experience of the care provided by their GP practice

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	The Primary Care Improvement Plan (PCIP) and improvements to our Locality arrangements will help to improve this.

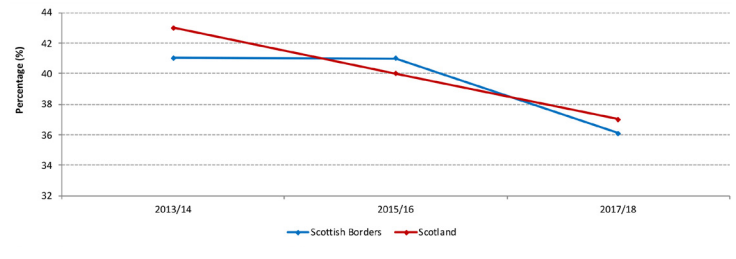
Source: Q27 - 2013/14 Health and Care Experience Survey, Q25 2015/16 Health and Care Experience Survey, Q8d 2017/18 Health and Care Experience Survey

NI-7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	We will continue to seek the views of adults supported at home and to develop our locality model.

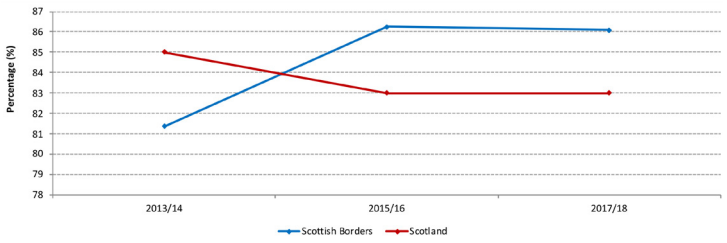
Source: Q36h - 2013/14 Health and Care Experience Survey, Q36i 2015/16 Health and Care Experience Survey, Q27h 2017/18 Health and Care Experience Survey

NI-8 Percentage of carers who feel supported to continue in their caring role

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Support for Carers is a key priority in the Strategic Implementation Plan.

Source: Q45f - 2013/14 Health and Care Experience Survey, Q45e 2015/16 Health and Care Experience Survey, Q32e 2017/18 Health and Care Experience Survey

NI-9 Percentage of adults supported at home who agree they felt safe

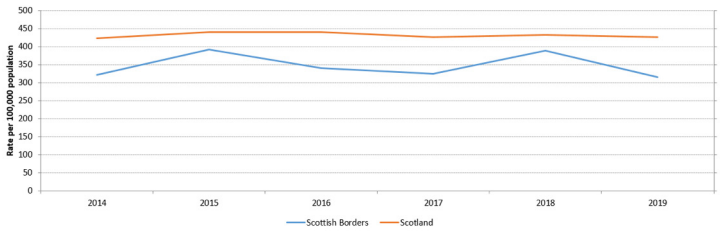
PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to seek the views of adults supported at home and to develop our locality model.

Source: Q36g - 2013/14 Health and Care Experience Survey, Q36h 2015/16 Health and Care Experience Survey, Q27e 2017/18 Health and Care Experience Survey

NI-10 Percentage of staff who say they would recommend their workplace as a good place to work

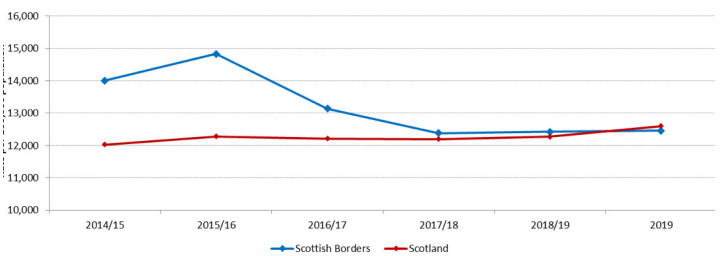
Indicator under development.

NI-11 Premature mortality rate per 100,000 persons (Age Standardised mortality rate for people aged under 75)

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to look at ways to improve care and support for Older People.

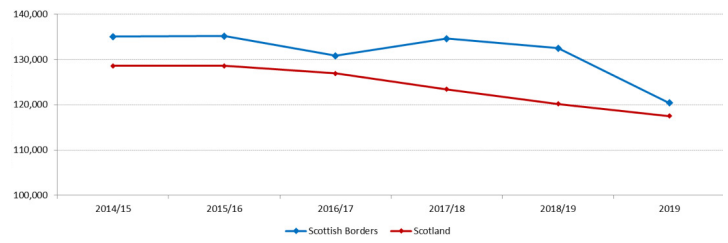
Source: National Records for Scotland (NRS)

NI-12 Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Work focused on preventing unplanned admissions, through creation of locality multi-disciplinary teams and community capacity.

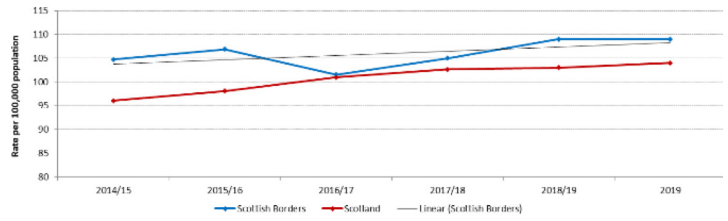
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Work at Locality level in communities will focus on admission prevention and therefore impact on emergency bed day rates.

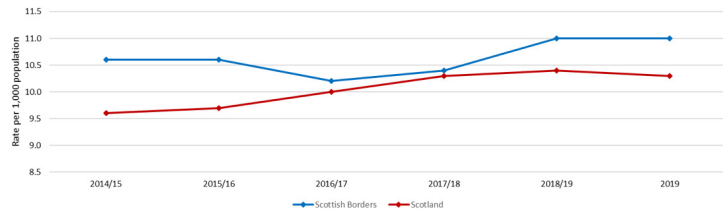
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

NI-14 (a) Readmissions to hospital within 28 days of discharge (per 100,000 population)

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Work progressing to reduce readmissions through increased community capacity and joined up care via multi-disciplinary teams.

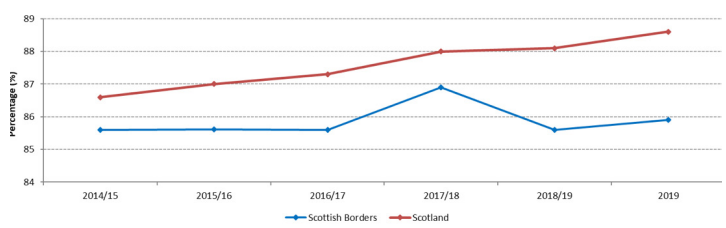
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges

NI-14 (b) Emergency readmissions within 28 days of discharge from hospital, Scottish Borders residents (all ages) (per 1,000 population) Bespoke Indicator to include Borders Community Hospital beds

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Work progressing to reduce readmissions through increased community capacity and joined up care via multi-disciplinary teams.

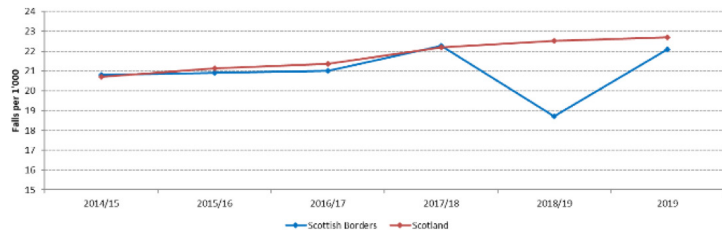
Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but also adding in Borders Community Hospital beds).

NI-15 Proportion of last 6 months of life spent at home or in a community setting (%)

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	◀ ▶	Improving data quality to allow hospice beds to be distinguished from acute beds and also commissioning additional care beds.

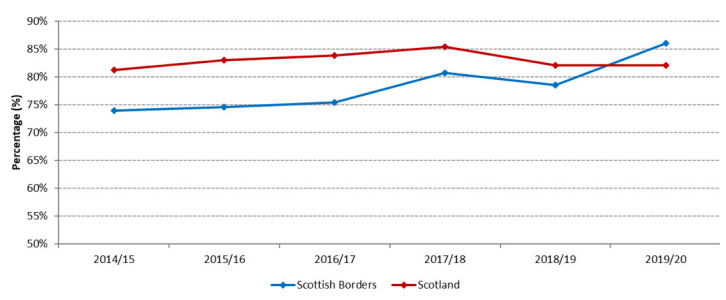
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) records
ISD Scotland: SMR04 (mental health inpatient records)
National Records for Scotland

NI-16 Emergency hospital admissions due to falls - rate per 1,000 population aged 65+

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Have trialed TEC solutions for falls prevention. More work required to improve.

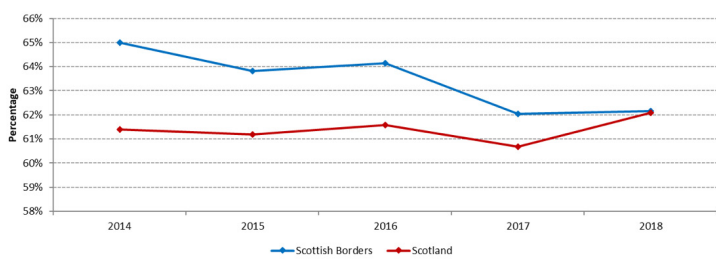
Source: ISD Scotland: SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges

NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Capital provision in place for the creation of extra care housing and additional care beds.

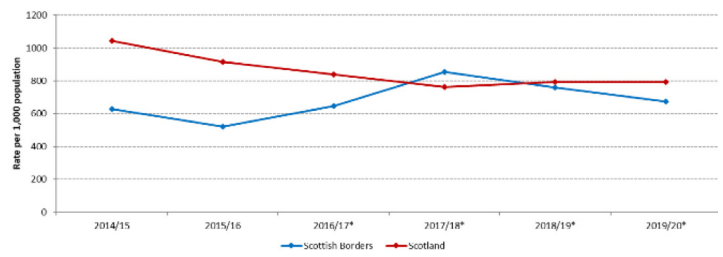
Source: Care Inspectorate

NI-18 Percentage of adults with intensive needs receiving care at home

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Changes to Locality arrangements and further development of Home First rehabilitation and reablement will support this.

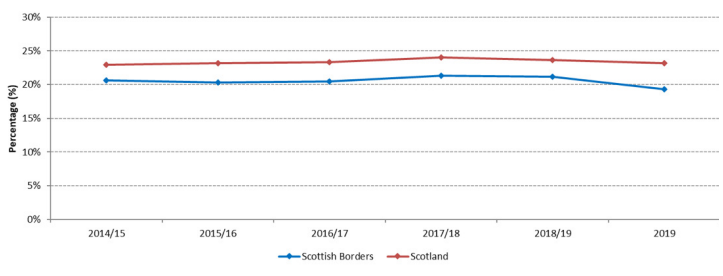
Source: Care Inspectorate

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

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▼	Implementation of new discharge hub and trusted assessor will improve this. Capital investment in additional care beds (including intermediate care) will also improve this.

Source: ISD Scotland Delayed Discharge Census

NI-20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (adults aged 18+)

PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	Work at Locality level in communities will focus on admission prevention and therefore impact on emergency admissions.

Source: SMR04 (mental health inpatient records from NHS hospitals in Scotland

NI-21 Percentage of people admitted from home to hospital during the year, who are discharged to a care home

Indicator under development.

NI-22 Percentage of people who are discharged from hospital within 72 hours of being ready

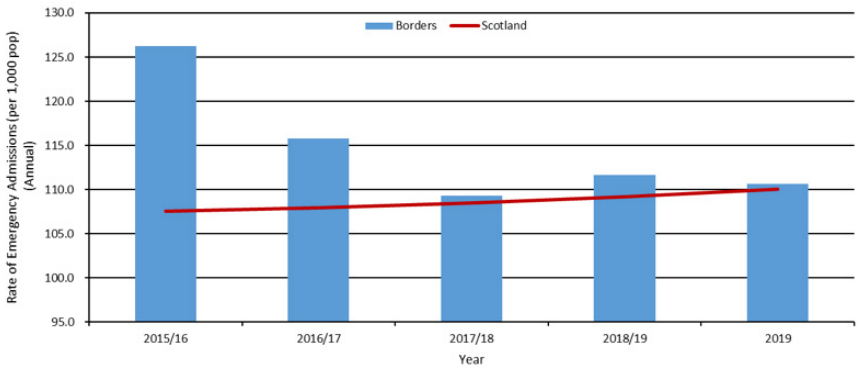
Indicator under development.

NI-23 Expenditure on end of life care

Indicator under development.

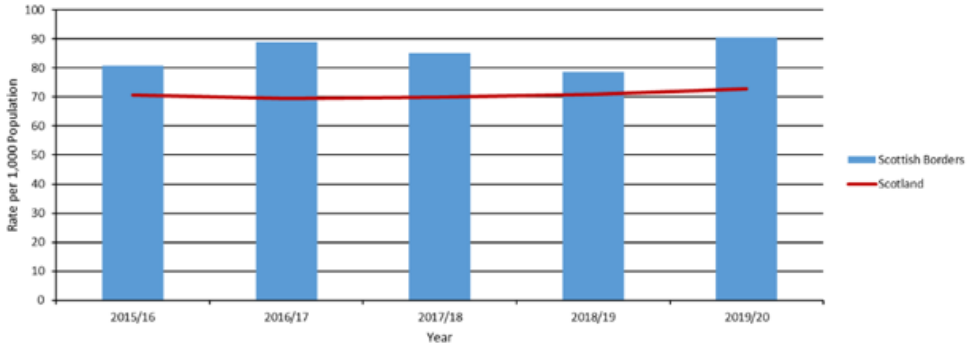
APPENDIX 2
MSG MEASURES

1a Number of emergency admissions (All Ages)

PERFORMANCE	BORDERS TREND
	▲

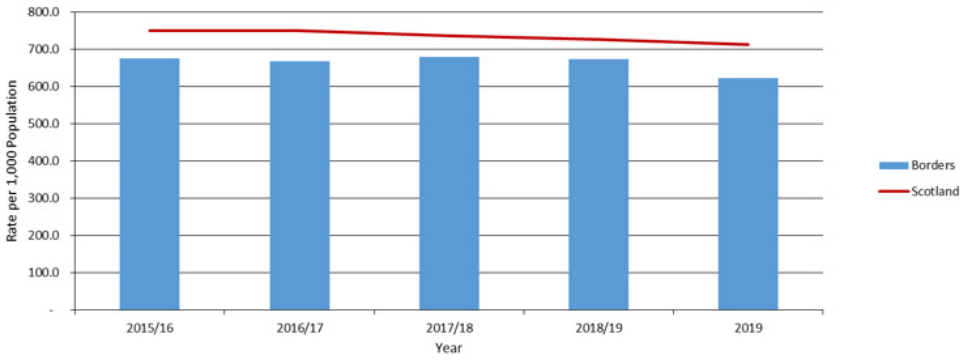
Source: SMR01, ISD

1b Admissions from A&E (All Ages)

PERFORMANCE	BORDERS TREND
	▼

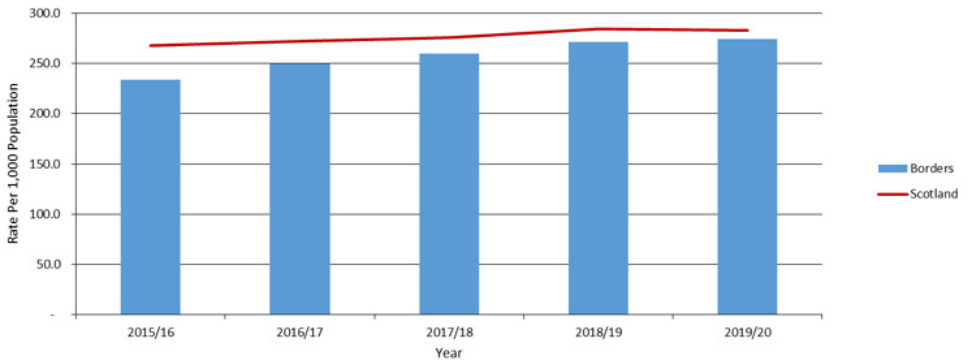
Source: A&E datamart, ISD

2 Number of unscheduled hospital bed days; acute specialties (All Ages)

PERFORMANCE	BORDERS TREND
	▲

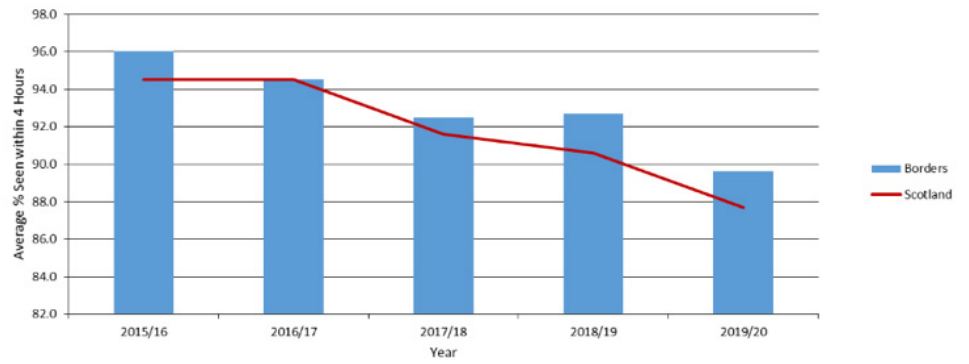
Source: SMR01, ISD

3a A&E attendances (All Ages)

PERFORMANCE	BORDERS TREND
	▼

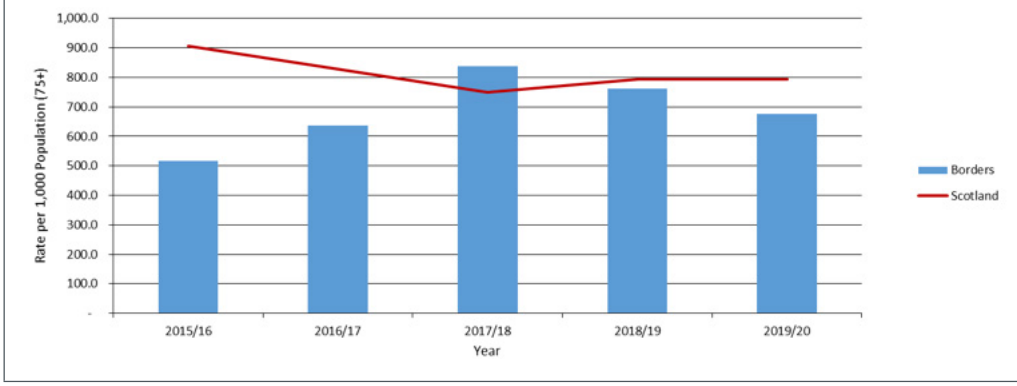
Source: A&E datamart, ISD

3b A&E % seen within 4 hours (All ages)

PERFORMANCE	BORDERS TREND
	▼

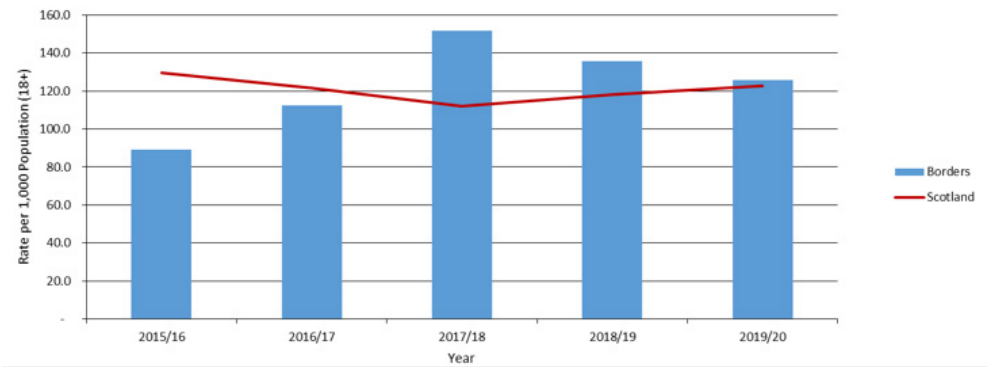
Source: A&E datamart, ISD

4a Delayed discharge bed days (i. 75+, ii. 18+)

PERFORMANCE	BORDERS TREND
	▼

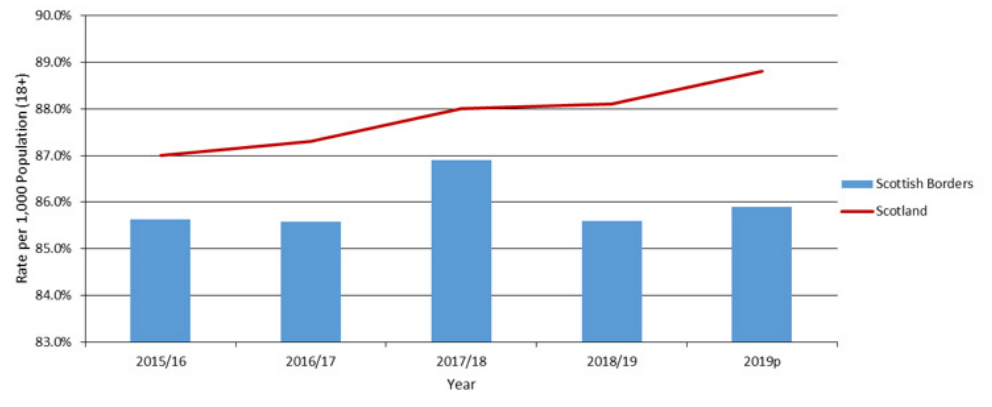
Source: Delayed Discharges, ISD

4b Delayed discharge bed days (i. 75+, ii. 18+)

PERFORMANCE	BORDERS TREND
	▼

Source: Delayed Discharges, ISD

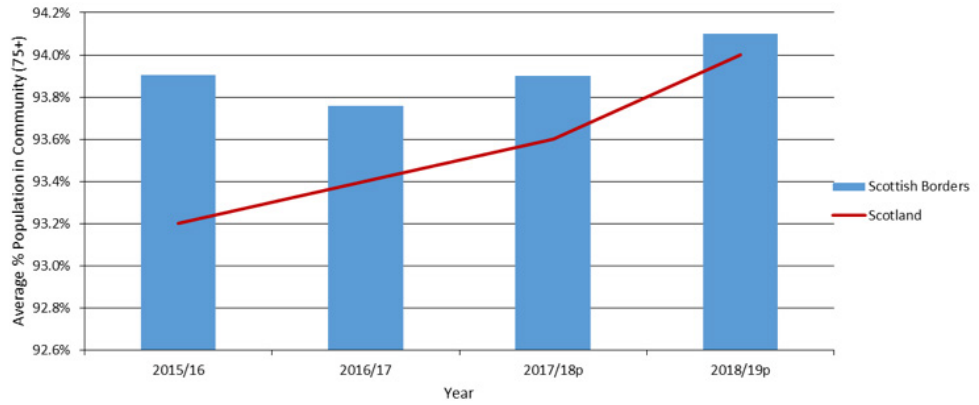
5 Percentage of last six months of life spent at Home or Community Setting

PERFORMANCE	BORDERS TREND
	◀ ▶

Source: Death records, NRS; SMR01, ISD; SMR04, ISD

Source: A&E datamart, ISD

6 Balance of care: Percentage of population in community or institutional settings (75+)

PERFORMANCE	BORDERS TREND
	▲

Source: SMR01, ISD; SMR04, ISD; Care Home Census, ISD; Social Care Census, SG; Population estimates, NRS

APPENDIX 3
SCOTTISH BORDERS MSG ACTION PLAN

Below shows the 22 Ministerial Strategic Group (MSG) for Health and Community Care February 2019 report on the 'Review of Progress with Integration of Health and Social Care' proposals to ensure the success of integration matched to the Borders HSCP actions and Best Value improvement areas.

MSG PROPOSAL		SCOTTISH BORDERS HSCP ACTION PLAN	RELATED BEST VALUE IMPROVEMENT AREA
1.	All leadership development will be focused on shared and collaborative practice. **Self-Assessment return: Partly Established**	1.1) Explore options for co-location of senior HSCP management	
		1.2) Explore options for co-location of HSCP operational staff and Locality staff	
		1.3) Explore options for Locality working	
		1.4) Implement a Leadership Team development programme (4 x quarterly development session commencing 2020)	
2.	Relationships and collaborative working between partners must improve. **Self-Assessment return: Partly Established**	2.1) Creation of regular meeting of Chairs – SPG, IJB and CE and CO to further promote partnership working	Raise visibility of key policies and decisions across respective governance groups including Executive Management Team and Corporate Management Team.
		2.2) Terms of Reference for EMT reviewed	
		2.3) Introduce new Governance structure on back of the SIP	
3.	Relationships and partnership working with the third and independent sectors must improve. **Self-Assessment return: Partly Established**	3.1) Re-establish Locality Working Groups. Define LWG governance - terms of reference, roles/remit, composition, reporting lines.	
		3.2) Resource locality working group delivery vis (a) Leadership Team representation in each Locality and (b) Admin resource across Localities	
		3.3) Develop regular input with Third Sector Interface (TSI)	
4.	Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration **Self-Assessment return: Partly Established**	4.1) Develop a 3-year IJB financial plan	Ensure a joint financial and service plan that is fully endorsed by respective partners is prepared for IJB on an annual basis.
		4.2) Develop the IJB strategic commissioning plan	

MSG PROPOSAL		SCOTTISH BORDERS HSCP ACTION PLAN	RELATED BEST VALUE IMPROVEMENT AREA
5.	Delegated budgets for IJBs must be agreed timeously **Self-Assessment return: Not Yet Established**	5.1) Integrate IJB, SBC and NHS budget development and planning to ensure joint financial planning for IJB	Ensure a joint financial and service plan that is fully endorsed by respective partners is prepared for IJB on an annual basis.
6.	Delegated hospital budgets and set aside requirements must be fully implemented **Self-Assessment return: Partly Established**		
7.	Each IJB must develop a transparent and prudent reserves policy **Self-Assessment return: Partly Established**	7.1) Develop a reserves policy	
		7.2) Have process in place to allocate balances to reserves	
8.	Statutory partners must ensure appropriate support is provided to IJB S95 Officers. **Self-Assessment return: Established**	8.1) Agree and implement clear protocols for the exchange of financial information between IJB partner organisations	
		8.2) Align finance officers in SBC and NHS Borders to support the Chief Officer & Chief Finance Officer of IJB	
9.	IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations **Self-Assessment return: Partly Established**	9.1) Develop the mechanism to mainstream fund IJB Transformation projects	
10.	Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB **Self-Assessment return: Partly Established**	10.1) Review the support requirements required by the Chief Officer integration	Raise visibility of key policies and decisions across respective governance groups including Executive Management Team and Corporate Management Team.
		10.2) Review the IJB reporting structure	
11.	Improved strategic planning and commissioning arrangements must be put in place **Self-Assessment return: Partly Established**	11.1) Recommission a range of services covering Homecare, Residential Care, Community Care, Mental Health, Learning Disability, Physical Disability	
12.	Improved capacity for strategic commissioning of delegated hospital services must be in place **Self-Assessment return: Partly Established**	12.1) Establish a commissioning board	

MSG PROPOSAL		SCOTTISH BORDERS HSCP ACTION PLAN	RELATED BEST VALUE IMPROVEMENT AREA
13.	The understanding of accountabilities and responsibilities between statutory partners must improve **Self-Assessment return: Partly Established**	13.1) Review the scheme of integration	Enhance governance arrangements and clarity of role of respective partnership groups including IJB Board, Executive Management Team and Strategic Planning Group.
14.	Accountability processes across statutory partners will be streamlined **Self-Assessment return: Partly Established**	14.1) Reduce and clarify the number reporting layers required as part of decision making process	
15.	IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis. **Self-Assessment return: Established**	15.1) Regular meetings between IJB chair and Chief Officer to be arranged	
		15.2) Ensure that Chair and Chief Officer have continued and ongoing involvement with National groups and Chairs.	
		15.3) Ensure support is in place to ensure that timely and accurate Board papers are produced	Improve the quality and availability of reports outlining proposals to enable these groups to plan and take decisions more effectively.
16.	Clear directions must be provided by IJBs to Health Boards and Local Authorities **Self-Assessment return: Partly Established**	16.1) Implement 5-year Strategic action plan to inform required directions	
17.	Effective, coherent and joined up clinical and care governance arrangements must be in place **Self-Assessment return: Established**	17.1) Establish information sharing protocols and invest in information sharing technology	
		17.2) Establish Locality working arrangements	Develop a model for localities that adopts a single structure for the management and provision of joint health and Social services.

MSG PROPOSAL		SCOTTISH BORDERS HSCP ACTION PLAN	RELATED BEST VALUE IMPROVEMENT AREA
18.	IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data. **Self-Assessment return: Effective**	18.1) Continue to develop the range of performance measures used by IJB to effectively demonstrate delivery of our Strategic Plan outcomes	Improve the quality and availability of reports outlining proposals to enable these groups to plan and take decisions more effectively.
		18.2) Improve our benchmarking reporting and monitoring across partnerships and Local Government Benchmarking Framework (LGBF)	
19.	Identifying and implementing good practice will be systematically undertaken by all partnerships **Self-Assessment return: Effective**	19.1) Continue to develop our Annual Performance Report (APR)	
		19.2) Develop a Joint Strategic Needs Assessment (JSNA)	
		19.3) Engage effectively with Health and Social Care Scotland (HSCS)	
20.	Effective approaches for community engagement and participation must be put in place for integration. **Self-Assessment return: Partly Established**	20.1) Re-establish Locality Working Groups (LWGs)	
		20.2) Establish a series of 'roadshows' in each of the 5 Localities. Led by Chief Officer, supported by respective Leadership Team Locality rep (5x roadshows per annum)	
21.	Improved understanding of effective working relationships with carers, people using services and local communities is required **Self-Assessment return: Effective**	21.1) Agree a concordat between IJB and Local Carers (including Carers Centre & Carers Voice)	
22.	We will support carers and representatives of people using services better to enable their full involvement in integration **Self-Assessment return: Partly Established**		

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