Scottish Borders **Health & Social Care** Partnership

ANNUAL PERFORMANCE REPORT 2020-2021

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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INTRODUCTION

This is the fifth Annual Performance Report for the Scottish Borders Health and Social Care Partnership (HSCP). It focuses on our performance between April 2020 and March 2021, outlines our priorities for 2021/22 and reflects back on our performance since April 2016.

To say that this year has been a huge challenge is an understatement. Many people have suffered as a result of the wider impacts of the COVID-19 pandemic, particularly those already most disadvantaged. People have lost their jobs or face future financial hardship; the pressure on health and social care services has been intense; key sectors of our economy have been severely impacted; and young people's education and opportunities have been disrupted.

However, I am privileged to lead a partnership of colleagues alongside a community which is determined to provide the best of care for the population of the Scottish Borders. Throughout the pandemic, we have seen the best of human spirit through the effort, sacrifice and resilience of individuals, communities and staff - a legacy which we must celebrate and preserve.

Some examples of where Health and Social Care services have delivered a joint response to the challenges posed by COVID-19 include:

- Our staff volunteering and being deployed into unfamiliar roles to ensure that essential services were maintained.
- Health and Care services adapting to the increased need for additional Personal Protective Equipment (PPE) in order to continue delivering services.
- Community Assistance Hubs (CAHs) created in each of our 5 localities to maximise community capacity and use multi-disciplinary teams to meet pandemic and lockdown challenges.
- A COVID-19 rapid response infection team mobilised to respond to infection outbreaks.
- Care Homes provided with iPads to enable residents to keep in touch with their loved ones.

The Borders already had a number of service delivery challenges in regard to geographical spread of the population, transport provision (i.e.) getting from (a) to (b) and ensuring that all of our residents have access to the services they need; when they need them.

Another example of how service continuity and workforce challenges of the pandemic were mitigated was through:

- Summer Childcare Hubs created - for children of key workers and vulnerable families. Supported by a number of staff, these hubs enabled key workers to continue to work and also enabled vulnerable families to continue to receive vital support.

This year's Annual Performance Report covers HSCP performance, but it also tries to highlight some of the huge efforts put in by everyone to continue delivering services across the Borders during the most challenging of times.

Annual Performance Report

This Annual Performance Report (APR) covers the period April 2020 – March 2021, which is essentially 12-months of pandemic restrictions and lockdown. As such, much of the content and the APR is Covid-related, including the 'spotlight' sections of the report, which highlight the impact of the pandemic on people and service delivery.

The APR is broadly split into 6-areas providing narrative and data on how we have:

- 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.

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

Robert McCulloch-Graham
Chief Officer Health and Social Care
Scottish Borders Health and Social Care Partnership
July 2021

EXECUTIVE SUMMARY

The Scottish Borders Health and Social Care Partnership's Strategic Commissioning Plan (SCP) 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 focused on the delivery of 3 strategic objectives and the associated challenges in delivering these.

The SCP was due for refresh and renewal from April 2021, however due to the pressures of the Covid-19 pandemic, the requirement for public engagement and a lack of staffing resource to take forward the SCP work, this has not been possible. Alternatively, and in line with Government guidance and legislation, the Strategic Planning Group (SPG) formally reviewed the SCP and recommended to IJB that the current plan be extended by 12-months, therefore deferring the production of our new SCP until April 2022. This was approved by IJB at its 17th February 2021 meeting.

Our Annual Performance Report (APR) sets out the Partnership's performance between April 2020 and March 2021, outlining our priorities for 2021/22 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 2020/21.

In this year's report the spotlights cover:

- Workforce
- Pandemic response in home care, residential care and Health
- Community Assistance Hubs (CAHs)

The most up to date financial and performance data has been included in the report. Where it is not possible to show the latest information then the previous years' data has been used. Where the latest data is provisional, this is denoted as (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 small area population estimates for the Borders [NRS] indicates a total Borders population **115,510**. Of this, **25%** of the Borders population is **65+**, well above the Scottish average of **19%**.

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

LOCALITY	>16	16-64	>65	
Berwickshire	3,365	12,077	5,478	**20,920**
Cheviot	2,921	10,816	5,576	**19,313**
Eildon	6,172	22,383	8,270	**36,825**
Teviot	2,925	10,469	4,546	**17,940**
Tweeddale	3,640	12,126	4,746	**20,512**
	19,023	**67,871**	**28,616**	**115,510**

YEAR	0-64	65+	% Split (65+)
2030	82,384	34,987	30%

By the year 2030, it is predicted that 30% of the Borders population will be 65+ (i.e.) The Borders has a proportionately ageing population.

To give some context, the population of the South-East Scotland area increased by 8.3% between 2008 and 2018. Percentage growth was highest in City of Edinburgh at 13.1% (59,980 pop. increase), followed by Midlothian at 12% (9,790) and East Lothian at 8.5% (8,310). The lowest percentage growth was Scottish Borders at 1.7% (1,910). Over the same period, for the 25-44 age group, the City of Edinburgh saw an increase of 20.1% while Scottish Borders saw a decrease of 18%. Between 2018 and 2043, the total number of Borders households is projected to increase by 7%, which is significantly lower than the 18% increase predicted for the South-East Scotland area.

COLDER

Our 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, support care in the community and prevent hospital readmission. The 2020/21 Winter Plan was heavily impacted by the COVID-19 pandemic and focused on areas including:

- Ensuring that a flexible hospital response was in place to open COVID-19 beds and meet increasing COVID-19 levels over the winter period.
- Supporting staff to work flexibly in dealing with the Covid-19 response.
- Building on the daily Integrated Huddle at the BGH to ensure timely discharge of patients.
- Using the Clinical Interface Group (CIG) for GPs and senior clinicians to have a shared understanding of pressures and worked in partnership to resolve issues throughout the winter period.
- Increasing flu and Covid-testing.
- Increasing capacity of the Community Care Review Team.
- Supporting Early Discharge (Bed Buster)
- Extending 7 day service cover.
- Delivering reablement in Care at Home Reablement
- Weekend provision of pharmacy acute and other services

BOLDER

We continue to focus on improving the flow into and out of hospital and shifting the balance of care.
In 2019/20:

409 social work cases allocated **per month**
(12mth average to Feb 2021)
(a 3% increase on the same period in the previous year)

1,280 patients have gone through **Home First**
(year to Nov 2020)
(> 20% increase on the previous year)

1,448 Homecare clients receiving **47,337 hours** of **homecare** per month
(4% increase in hours on the previous year)

HOMECARE PACKAGES
75% ‹ **10hrs** per week
25% › **10hrs** per week

79% of **people discharged** to **home** from **Waverley Transitional Care Unit**
(against a benchmark target of 80%)

8.4 working days to **complete** a **Social Work assessment**
(a 1% decline on the previous year)

100% of **Borders cancer patients** receive their **first treatment within 31 days** (from the date of the decision to treatment).

The Matching Unit arranges **180 packages** of **care per month**
(a 10% increase on the previous year)

2020/21 PARTNERSHIP PERFORMANCE AT A GLANCE
ANNUAL PERFORMANCE

• +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

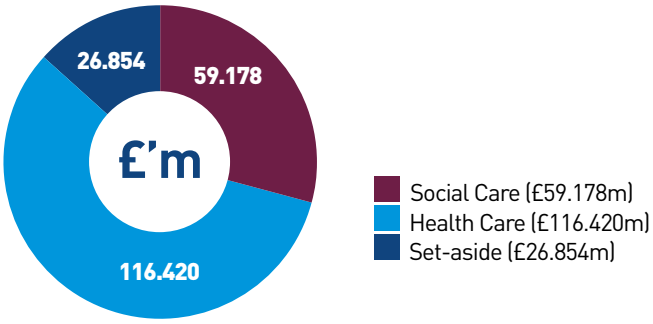
KEY

EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES) **85.5 admissions** per **1,000 population** (Financial Yr – 2020/21)	**ATTENDANCES AT A&E (ALL AGES)** **225.7 attendances** per **1,000 population** (Calendar Yr - 2020)	**RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)** **3,151 bed days** per **1,000 population Age 75+** (Calendar Yr - 2020)
-ve trend over 4 periods **Better than Scotland (112.1 – 2019/20)** **Better than target (91.9)**	**-ve trend over 4 periods** **Worse than Scotland (219.4 - 2020)** **Better than target (216)**	**+ve trend over 3 years** **Better than Scotland (3,997.6 - 2020)** **Better than target (min 10% better than Scottish average)**
Performance is positive but work will continue to prevent emergency hospital admissions	*The number of attendances at A&E requires more improvement*	*Performance is positive but Covid played a large part in this. Work will continue to reduce occupied bed days*
A&E WAITING TIMES (TARGET = 95%) **86%** of **people** seen **within 4 hours** (Financial Yr - 2020/21)	**NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)** **17 over 72 hours** (Financial Yr - 2020/21 Average)	**"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS** **93.1% overall satisfaction rate** (Financial Yr - 2019/20 Average)
-ve trend over 4 periods **Worse 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 target and needs to improve	*Reducing delayed discharges is a constant focus of the HSCP*	*We have a high satisfaction rate with hospital care but performance has declined*
EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES) **10.6** per **100 discharges** from **hospital** were **re-admitted within 28 days** (Financial Yr - 2019/20)	**CARERS SUPPORT PLANS COMPLETED** **72%** of **carer support plans offered** that have been **taken up** and **completed** in the **last quarter** (Financial Yr - 2020/21)	**END OF LIFE CARE** **89.7%** of **people's last 6 months** was **spent at home** or in a **community setting** (Financial Yr – 2020/21)
-ve trend over 4 periods **Worse than Scotland (10.5 - 2019/20)** **Worse than target (10.5)**	**+ve trend over 3 periods** **Better than target (40%)**	**+ve trend over 4 periods** **Worse than Scotland (90.5% - 2020/21)** **Better than target (87.5%)**
More work is required to reduce readmission rates	*The percentage of carer support plans completed continues to be 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 2020/21

DURING 2020/21 THE INTEGRATION JOINT BOARD SPENT £202.452M

THIS WAS SPLIT:



£ ON EMERGENCY HOSPITAL STAYS

19.9% of **total health and care resource**, for those **age 18+** was **spent on emergency hospital stays** (Financial Yr - 2019/20)

+ve trend over 4 periods
Better than Scotland (24.0% - 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 performance for 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, allowing the delayed publication of 2020/21 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)
- Best anticipate needs and prevents them arising, and
- Makes the best use of the available facilities, people and other resources.

Underpinning the legislation are a set of 9 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.

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), which sets out 10 Priority areas 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 'reimagining' 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 Priorities can be challenging. The table below shows how it all 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.

The December 2020 meeting of the IJB approved a paper recommending changes in reporting lines within the senior management team, to support the strengthening of the "Strategic Commissioning" function of the Integration Joint Board. The paper focused on resource and capacity to deliver and to provide a coherent governance and managerial/ project oversight of the four functions driving the partnership:

1. Resource management and control
2. Operational management and direction
3. Strategy and commissioning
4. Professional and clinical governance

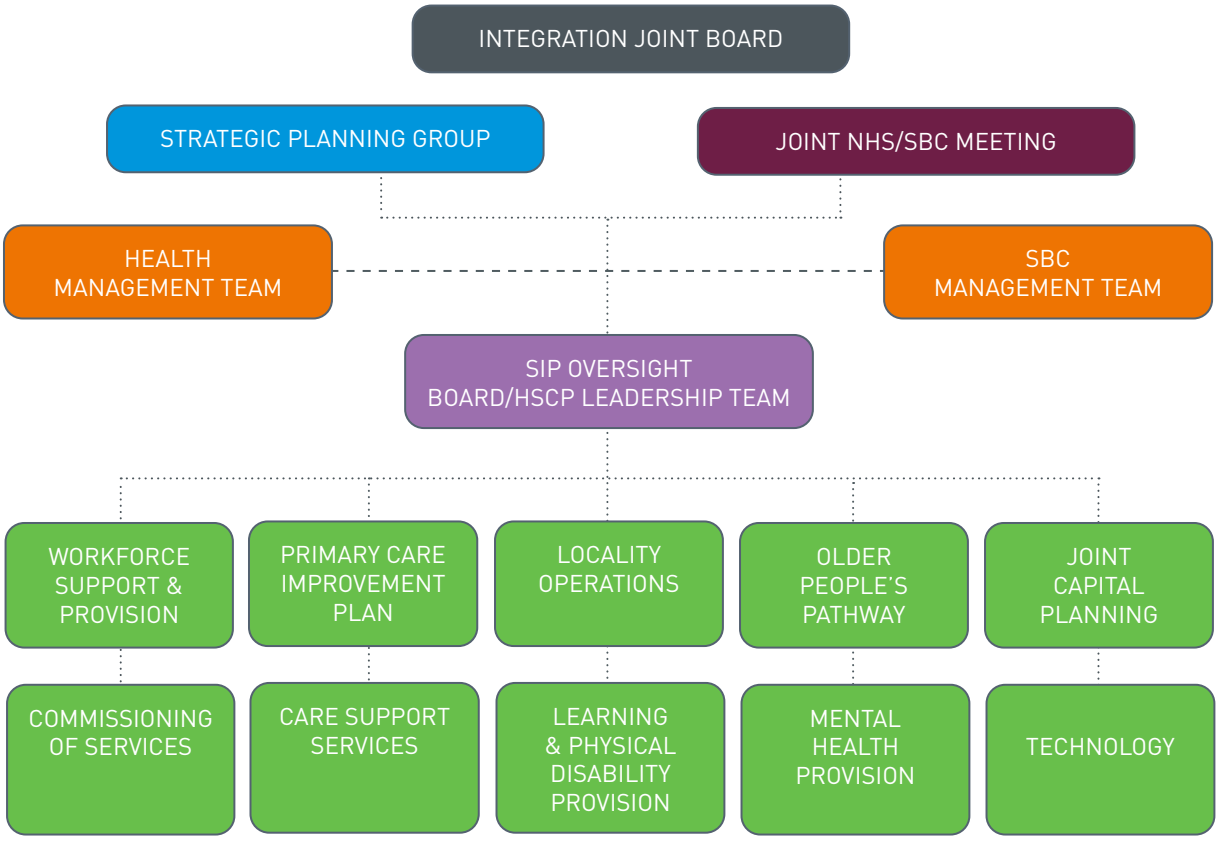
These changes will support the IJB in fulfilling its function as a strategic commissioning body and provide greater managerial capacity in both quality and compliance with policy.

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 was amended during the COVID-19 pandemic to reflect the fact that a decision-making 'Recovery Board' was initiated.

H&SC Partnership Governance Structure



Whilst the IJB has the ultimate decision making and commissioning authority for the Partnership, the Joint NHS/SBC meeting provides an operational function to deal with operational actions – including the pandemic challenges. The SIP Oversight Board and the HSCP Leadership Team are comprised of professional leaders from across Scottish Borders Council (SBC) and NHS Borders (NHSB) and have a remit of ensuring that the SIP priorities are being delivered and that all reports and proposals being prepared for IJB are fit for purpose and clearly aligned to the Strategic Objectives.

The Strategic Planning Group (SPG) acts as an advisory committee to the Integration Joint Board (IJB). The role of the SPG is to identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan and against the agreed national outcomes.

The group provides a forum for initial consultation and community engagement and to ensure effective links to each of the five Scottish Borders localities, which are:

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

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) and SPG is responsible for the development of Partnership performance

The Internal Audit work for 2020/21 covered:

- The operation of the governance and risk management arrangements, including strategic planning and Directions, and the workforce planning framework;
- The arrangements for the management of financial resources delegated to the partnership;
- The alignment of performance measures within the Performance Management Framework to key outcomes and priorities; and
- Follow-up of progress on areas of improvement recommended in previous Internal Audit assurance work.

Within the Internal Audit Annual Assurance Report 2020/21, presented to the IJB Audit Committee in June 2021, 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. Improvements made by Management during the year have been limited by the effect of the COVID-19 pandemic; however lessons learned from this have been noted. 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 2021/22 in March 2021, which has a specific focus on the contracts and commissioning of service delivery to inform strategies and plans to meet the priorities in the Strategic Commissioning Plan.

KEY PARTNERSHIP DECISIONS 2020/21

For the period 2020/21, and given the context of the Covid-pandemic the Integration Joint Board met as regularly possible as a formal meeting to transact business and also through development sessions to raise its understanding of more complex issues. During 2020/21 the Board covered the following issues:

During 2020/21, the Board:

April 2020:
- No meeting held because of the pandemic

May 2020:
- No meeting held because of the pandemic

June 2020:
- No meeting held because of the pandemic

July 2020:
- No meeting held because of the pandemic

19th August 2020 meeting:
- The Health & Social Care Integration Joint Board approved the new IJB Risk Management Policy
- The Health & Social Care Integration Joint Board approved the refreshed IJB Risk Management Strategy
- The Health & Social Care Integration Joint Board approved the Alcohol and Drugs Strategic Plan refresh.
- The Health & Social Care Integration Joint Board agreed the transfer of resource between Primary Care Improvement Plan (PCIP) workstreams but within the total resource allocation for the programme in order to develop a Borders wide Primary Care Mental Health Service called "Renew".
- The Health & Social Care Integration Joint Board directed actions to address the challenges and to mitigate risk identified in the regular Quarterly Performance Report.
- The Health & Social Care Integration Joint Board agreed the revised priorities for the IJB in set out in the Strategic Implementation plan (SIP) in light of lessons learned from experiences within services in their response to the pandemic.

23rd September 2020 meeting:

- The Health & Social Care Integration Joint Board approved the Annual Performance Report (APR) for publication, subject to the IJB directed changes being made.

21st October 2020 meeting:

- The Health & Social Care Integration Joint Board approved the 2019/20 Annual Accounts.

November 2020:

- No meeting held

16th December 2020

- The Health & Social Care Integration Joint Board approved the IJB Business Plan and Meeting Cycle for 2021.
- The Health & Social Care Integration Joint Board approved the appointment of Linda Jackson as a non-voting member of the Integration Joint Board of Scottish Borders.
- The Health & Social Care Integration Joint Board supported the changes in reporting lines within the senior management team, outlined within the paper, to strengthen the "Strategic Commissioning" function of the Integration Joint Board.
- The Health & Social Care Integration Joint Board directed actions to address the challenges and to mitigate risk identified in the regular Quarterly Performance Report.

January 2021:

- No meeting held

17th February 2021 meeting:

- The Health & Social Care Integration Joint Board approved the revised Terms of Reference for the Strategic Planning Group with the two additions to the membership of Wendy Henderson (Scottish Care) and Alastair McLean (Vice-Chair Independent Care Providers Group).
- The Health & Social Care Integration Joint Board approved a 12-month delay in the update and refresh of the Scottish Borders HSCP Integration Strategic Commissioning Plan.
- The Health & Social Care Integration Joint Board agreed that work to update and refresh the plan uses the Health Improvement Scotland strategic planning: good practice framework as its basis.
- The Health & Social Care Integration Joint Board considered and agreed the Discharge Programme Evaluation recommendations:-

- Home First should be the default and should better align with What Matters locality hubs and services to increase the balance of step up Intermediate Care (IC) and enable closer working with local Housing providers and Third sector support.
- Bed based IC should be streamlined as a single pathway for older people with post-acute reablement / rehab / nursing care needs that cannot be met by Home First, particularly for residents in Central Borders.
- The service budget for these projects should now be mainstreamed to enable strategic commissioning, substantive recruitment and workforce development as part of a comprehensive framework for integrated intermediate care in each locality. This will need to be maintained within the existing Transformation Fund limit of £2.2M, and will be included within the overall budget for IJB delegated services, to be agreed for 2021 to 2022.

24th March 2021 meeting:

- The Health & Social Care Integration Joint Board approved the budget allocations from NHS Borders (£140.2m) and Scottish Borders Council (£54.2m) for 2021/22.

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 that the number of older people in the Borders is increasing; 25% of the Borders population in 2020 is 65+; this is estimated to rise to 30% by 2030. This proportion of older people in the Borders is also increasing at a faster rate than the Scotland average. It is crucial that we continue to promote 'active ageing' as we know that many older people in Scottish Borders report poor health. We must continue to promote healthier lifestyles, earlier detection of disease and support to individuals to recover from and manage their conditions. 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 – Workforce

The COVID-19 pandemic placed huge pressures on our workforce and also demonstrated how flexible our workforce can be in delivering vital new tasks to support and safeguard communities during the pandemic. The commitment, flexibility & goodwill of our workforce has never been more evident than in the last year in responding to the pandemic and lockdown. A number of staff who were deployed into Health & Social Care from other areas of the Partnership or who volunteered to work in Adult Social Care have decided to stay working in care as a career pathway.

Some examples of how our staff came together during the pandemic to ensure the continued delivery of services include:

SB Cares Rapid Response Team

As part of the efforts to fight Covid-19, SB Cares homecare and residential care staff worked tirelessly to make sure that all operational practice adhered to rapidly changing guidance. The service informed stakeholders at every stage and ensured that all necessary materials and equipment were readily available. This included the development of a Rapid Response (RR) Team which included managers, senior staff and support staff. The RR Team provided a dynamic response to any outbreak within our care homes, with staff deployed in each locality to react to a call for assistance if and when an outbreak was declared. The staff all had experience of working in outbreak situations and were therefore able to quickly assess and put in place appropriate operational measures. The RR Team worked with flexibility and dedication throughout the pandemic and this model will be deployed again for any future outbreak situations.

Education Hubs

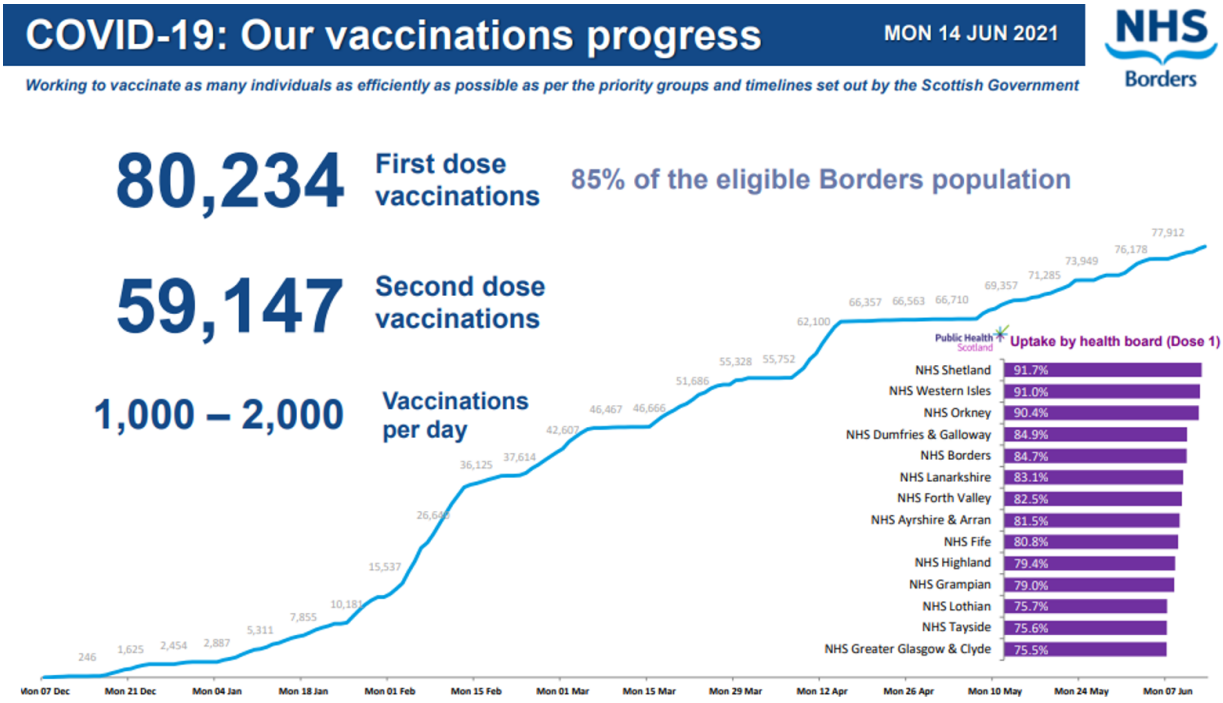
When the lockdown restrictions resulted in students being unable to attend school, Education Hubs were established to provide vital support, every day of the week, for the children of key workers and vulnerable families. The Hubs were supported by a range of HSCP staff working alongside summer students, probationer teachers and colleagues from Live Borders. Not only did this mean that we could continue to meet the needs of our most vulnerable young people, it also enabled key workers to continue to support the pandemic response. The Education Hubs continued to operate for the children of key workers in each of the Borders 9 high schools throughout the summer 2020 holiday period.

Vaccinator Workforce

139 existing staff were trained and appointed as vaccinators and over 150 new members of staff have been employed into the vaccinator role – providing a robust and stable vaccination workforce to carry out the mass vaccination programme without impacting on other services. Covid-19 has obviously been a priority, but the uptake of flu vaccination (as of January 2021) was also high:

AGE GROUP	UPTAKE (%)
>65	88.4%
<65 (at risk)	98.5%
Pregnant ladies	63.6%
Primary school age	82.2%
2-5 year olds	43.7%

The uptake of Covid-vaccination at June 2021 was:



Acute staff

NHS Borders Acute Services has met unprecedented levels of challenge and activity over the last 12 months. The initial Spring-wave and then second larger COVID-19 wave required innovation, flexibility and leadership. Services had to innovate and develop new workforce models to ensure continued delivery of safe and sustainable services. This pandemic experience has enabled swift changes that could normally take years; teams have developed an improved hospital-wide perspective and responding to the requirement for rapid change is now considered business-as-usual. Assets have been developed that will prove critical for

future service delivery (e.g.) during the pandemic, nurses were redeployed into high acuity areas such as Intensive Care Units (ICU) and High Dependency Units (HDU). Maintaining and updating these staffs' skills in HDU and ICU is continuing by the sharing of theatre and recovery staff to these areas. From April 2021 our community hospital patients have been able to have one visitor to the ward. This 'small' change has required, processes to be developed, a risk assessments completed, staff updated, consideration of flexibility with "essential visits", and visitor information updated. Every change to what has become the 'norm' requires a lot of work from a lot of people to communicate and implement successfully.

Staff Wellbeing

A Staff Wellbeing Group was established in NHS Borders. This group established the 'Here4U' service which supplied virtual ('Near Me') counselling and psychological support to staff who have felt anxious, stressed or depressed. The group organised food and drinks parcels for busy ward-based staff, arranged for free hot beverages in the staff dining room, lobbied for regular breaks and in response to concerns about hydration for staff working in full PPE, used Charities Together funds to purchase water bottles for staff. The group also supported a staff engagement program called Collecting Your Voices which sought staff opinions on the handling of the pandemic before the national Everyone Matter Pulse Survey was launched. The response was strong; high in numbers and rich in content.

Scottish Borders Council undertook a staff survey with 888 responses received. As was anticipated, this highlighted positives and negatives, for example:

- 54% of respondents said that their wellbeing is/has been very good during COVID, but 15% said their wellbeing was poor/very poor.
- 60% of respondents felt well supported by SBC during lockdown.

SBC has issued regular staff communications during the pandemic/lockdown signposting staff to areas of support including:

- The Advisory, Conciliation and Arbitration Service (ACAS) comprehensive guidance and resources on looking after your mental health during the current pandemic, covering looking after your mental health, supporting staff mental health and managing workplace mental health.
- The Department for Work and Pensions confidential Mental Health Support Service; which is a free service available to employees who may be experiencing with depression, anxiety, stress or other mental health issues affecting their work.
- SBCs occupational health provider, People Asset Management (PAM Assist) provides an employee assistance programme for all employees. The helpline is open 24 hours, 365 days a year and is a free confidential service (0800 882 4102).
- SBC also provides a Mental Health First Aiders service, available to anyone with concerns about the physical or mental wellbeing of themselves or a fellow employee (Telephone: 01835 825 038; Email: MHFirstAiders@scotborders.gov.uk)

Objective 1: What we said / What we did (Priorities 2020/21)

Last year's Annual Performance Report contained a number of Partnership Priorities to be delivered in 2020/21. The table below details these and some of the key achievements delivered.

Partnership Priorities for 2020/21 – What we said

1. **Primary Care Improvement Plan**
   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.

Key Achievements/Successes : What we did

Vaccination Transformation Programme
As a result of the Covid-19 pandemic, the planned delivery of the VTP was paused by Scottish Government. Building on the experience of delivering the flu vaccination programme during Covid for winter 2020/21, the VTP workstream is reviewing and revising the delivery model. Work is currently underway in collaboration with NHS Borders Primary Care & Community Services to develop an integrated approach to vaccinations which will incorporate and safeguard the PCIP specifications for VTP.

Pharmacotherapy
A significant increase in pharmacotherapy workforce was deployed to GP practices and outcomes delivered to better support GPs in their workload. This work continues.

Community Treatment & Care Services
There has been insufficient resource within PCIP to fully deliver this workstream, however work has continued in order to develop an appropriate model. The work is in partnership with secondary care, mental health and community services so that a whole system approach is being taken and as part of this broader service. The model is based on a central hub approach with Phlebotomy as the first priority. A Test of Change for the phlebotomy element of the service will begin early May 2021 in one Cluster area.

Key Achievements/Successes : What we did

Urgent Care
The main focus for urgent care has been the development and establishment of an Advanced Nurse Practitioner model. At May 2021, all posts have been filled.

First Contact Physiotherapists
Patients with musculoskeletal problems can be directed to First Contact Physiotherapists (FCP) rather than a GP within a practice. FCPs can assess, diagnose and address the immediate clinical needs of this patient cohort; initiating further investigations and making onward referrals where clinically appropriate.

Community Mental Health Workers
A model was tested where patients with mild to moderate anxiety and depression were seen by a mental health practitioner and offered evidence based psychological therapy depending on their needs. PCIP funding of £354k was allocated to scale up the model in one area as a first phase but work was delayed mainly because of the pandemic. The "see and treat" model that utilises a skill mix/ Multi-Disciplinary Team approach, where assessment and treatment take place in a variety of settings/formats and are as patient led as possible. There are strong links with secondary care and complementary/ commissioned services to ensure that patients are able to get the most appropriate help with as few barriers as possible. This new service, called 'Renew' has been very warmly welcomed by our GP colleagues and they see the service filling what was previously a significant gap in our provision.

Community Link Workers
The Community Link Workers (CLWs) work closely with the Local Area Coordinators (LACs) to enable the most appropriate support to be provided for individual clients. CLW support is provided for as long as necessary to enable the individual to achieve the outcomes they have identified, it is not time limited. Where the initial assessment determines that the service is not appropriate, signposting to other relevant services will be undertaken and information supplied to the referring agency.

Partnership Priorities for 2020/21 – What we said

2. **Workforce Support and provision**
   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.

Key Achievements/Successes : What we did

IRISS
Since June 2020, Adult Social Care & Health services have been leading on a recording practice project in partnership with the Institute for Research and Innovation in Social Services (IRISS), a national charity that works to improve the knowledge and skills of the workforce and ultimately, improve the quality of Social Services. IRISS ran a series of workshops which explored case recording and how the workforce could be supported to improve written analysis and confidence. The workshops were planned to be face-to-face, but due to the pandemic they took place virtually using MS Teams. Based on the workshops, IRISS designed an online course to provide a practical framework to support the writing and analysis of social care records. The course was launched in late March 2021 and is now available on the IRISS website. Additionally, podcasts of interviews with practitioners were launched on the site in April 2021 and the plan is that this newly developed training will be rolled out shortly. (Writing analysis in social care | Iriss)

Digital
The Partnership accelerated the roll out of MS Teams across the organisation, providing a digital platform for staff to collaborate virtually online as well as enabling the vast majority of office based staff to transition to home working with minimal disruption.

Collecting Your Voices
In the summer of 2020, following the first wave of COVID-19, Health commissioned a Collecting Your Voices staff engagement exercise, which provided valuable information to inform our remobilisation plans. Lessons learned from the initial response phase of the pandemic have been discussed in detail with the senior teams at NHS Borders and Scottish Borders Council and with colleagues on the NHS Borders Board, IJB and members of the Council. We aim to work collaboratively with staff and the users of services, to be more agile and devolve decision-making and ensure a greater sharing of accountability. This will both serve to support us as we address future service challenges as well as to establish a more robust, fair and effective organisation for the future.

Objective 1: Partnership Priorities for 2020/2022

Development sessions of the IJB, coupled with events attended by 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	PLANNED DELIVERY DURING 2021/22
Primary Care Improvement Plan Supporting and developing the GP contract.	Ongoing delivery of the 6 identified workstreams. Financial gap for delivery identified as £1.9m reported to Scottish Government, further support provided through an allocation of £1.1m. This is non-recurrent funding but can be carried forward to future years.
Workforce Support and provision New skills, new operations, new equipment, new processes	**IRISS** Continued use and development of IRISS
	Implementation of 'Total Mobile' The Partnership delivers more than 1.5 million home care visits per year, which help people to maximise their confidence, independence and to continue living in their own homes. Home care is provided by a mix of Council and external care providers. 360 care workers are directly employed by the Council and they undertake approx. 600,000 care visits per annum. Total Mobile deliver efficient and digitalised staff scheduling, re-scheduling and dispatching. It includes a mobile 'app' to optimise care workers' travel time, thus reducing associated fuel usage and vehicle repair.

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.

Key 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 – Pandemic response in home care, residential care and Health

Care Homes and Care at Home

The pandemic strengthened and developed collaborative working across the HSCP, for example where health professionals including District Nursing and GPs quickly implemented professional and resourcing support to care homes with COVID outbreaks. This also extended across Social Care where Social Work staff supported external Care Homes and Homecare providers with issues relating to COVID.

This strengthening of relationships between the HSCP and local providers, including private providers and the 3rd sector, was important and very effective. This was done through the creation of the Strategic Care Home Provider Group, the Strategic Care Oversight Group and the Operational Care Oversight Group. These groups met daily and included input from the Care Inspectorate. The groups were formed in every Health and Social Care Partnership to provide both assurance and support to both internal and contracted care providers in their response to the pandemic. Supportive assurance visits took place to all 23 residential care homes in the Borders to assess care, and specifically infection prevention control practice, understanding and the use of PPE. The groups established were multi-disciplinary and operated across all organisations within Health and Social Care. The strategic group was formed of Senior Directors from all disciplines, able to intervene, challenge and support as appropriate. The Operations group, led by senior practitioners and coupled to public health, infection control, social-care and nursing teams, were able to work across all sectors of health and care delivery.

These groups have been essential in both implementing new work practices and government guidance and have responded directly to outbreaks within our most crucial services. Their work has been both essential and outstanding, and well received across all front facing services.

An unintended outcome has been to bring together contractors and commissioners into a very strong and supportive partnership which will now continue long after the pandemic. It will support the co-production of the Partnership's new Commissioning Strategy from April 2022.

Existing groups such as the Homecare Forum, focused on delivery of care at home, with visits risk-assessed and consistency improved for remote visits, using resources as efficiently as possible. The group also set up and shared mechanisms with providers to enable access to funds to claim back excess COVID-related costs and to discuss and gain advice.

Community Care Review Team (CCRT)

The pandemic expanded the remit of the Community Care Reviewing Team (CCRT). The team played a pivotal role in ensuring quick and robust guidance was communicated to care providers; they had regular supportive communications with providers including a weekly call around. At the start of the pandemic the team gathered information quickly from all care providers which allowed issues to be resolved prior to the creation of the Scottish Government portal.

Infection Control

NHS Borders Public Health and Infection Control supported Care Homes and Care at Home, introducing a Community Infection Control Advisory Service (CICAS) at the beginning of the pandemic in order to enhance the level of infection control advice available. CICAS worked collaboratively with CCRT to provide Heath guidance around testing, infection and the set-up of local PPE hubs for all providers to support provision of PPE and updated support and guidance. The service consisted of staff from Public Health, Infection Control and others deployed from their substantive role into this service. This work proved critical to managing COVID-19 in the community and lessons-learned will feed into an enhanced infection control team.

Resilience Meetings

Primary Care services including our GP colleagues were involved in resilience meetings with support available to individual practices where additional needs were identified as a result of the COVID-19 pandemic. Colleagues from within the Scottish Ambulance Service (SAS) and NHS24 supported this response.

Waiting Times

At the end of March 2021 the waiting times position for outpatient services was:

- 3,500 outpatients patients who had waited over 12 weeks, of which 450 patients were reported as waiting longer than 52 weeks.
- 1,260 patients on Treatment Time Guarantee (TTG) waiting lists over 12 weeks, of which 590 who are reported as waiting longer than 52 weeks.
- 620 patients waiting for a key diagnostic test for more than 6 weeks, 165 endoscopies and 465 patients waiting for radiology.

A number of actions are being taken to address this. Patients on outpatient, TTG and diagnostic waiting lists are carefully prioritised according to clinical need and the national clinical prioritisation guidance. Available capacity is being targeted to those patients in the highest clinical priority groups and urgent waits are being monitored on a weekly basis. There is also provision for patients on routine waiting lists to contact clinical teams to discuss any deterioration in their condition which may require treatment being expedited.

Objective 2: What we said / What we did (Priorities 2020/21)

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 2020/21 – What we said

3. **Older People's Pathway**
   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

Key Achievements/Successes : What we did

The formal evaluation of the 'Discharge Programme' of work was considered by IJB at its February 2021 meeting. The evaluation covered 5 areas of OPP and found:

(1) Waverley Transitional Care Unit
Waverley TCU delivers against its objectives of rehabilitating older people to regain independence following hospital discharge. The time to access service averages 1.8 days and discharge to home rate is 79%. However, occupancy rates could be improved (70% occupancy) and patient criteria could be amended (did not admit older people with higher levels of need due to restrictions on length of stay and availability of nursing cover).

(2) Garden View Discharge to Assess
Garden View provides a facility for older people to leave the acute hospital environment and have an assessment for care undertaken in Garden View. The time to access the service averaged 3.6 days. As with Waverley TCF, occupancy could be improved (66%) and criteria/resource could be amended. Latest occupancy has been closer to 90% and AHPs have now been appointed therefore more able to now admit people with higher levels of dependency.

Both Waverley TCF and Garden View have positive user feedback, 'unit-cost' could be improved through increased occupancy rates and whilst delivering 'step-down' fro hospital, neither service offered step-up access from home.

Key Achievements/Successes : What we did

3) Home First

Home First offers a home-based reablement service. 25% of people who use the service are step-up referrals to remain at home and 75% are step-down referrals through hospital discharge. The time to access the service averages 1 day and 80% of the patients remain at home at the end of their Home First intervention. After service delivery, 57% of people are fully independent and for those who require ongoing homecare, there is an 11% reduction in the level of care required. Feedback for Home First includes:

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

(4) Matching Unit

The Matching Unit has been mainstreamed into SB Cares and it arranges 180 packages of care per month, a 10% increase on 2019 levels. The average time to start of package is 5 days.

(5) Strata

The Strata digital referral system is managing 800 referrals per month to care homes, intermediate care, the third sector and Trusted Assessment, with Strata referrals to schedule homecare to commence shortly.

The evaluation concluded that:

All 5 of these services make a critical contribution to 'whole-system' performance and that there are opportunities to improve this further through adjustment of criteria and skill mix (i.e.):

- Home First should be the default service for step-up and step-down. It should better align with locality services to better balance step up requirements and develop closer working arrangements with local Housing providers and Third sector support.
- Bed based care should be streamlined into a single pathway for older people with post-acute reablement / rehab / nursing care needs that cannot be met by Home First.
- The service budget for all 5 of these services should be mainstreamed to enable strategic commissioning, recruitment and workforce development as part of a comprehensive framework for integrated intermediate care in each locality

Partnership Priorities for 2020/21 – What we said

4. **Joint Capital Planning**
   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

Key Achievements/Successes : What we did

Extra Care Housing

Wilkie Gardens, Langhaugh, Galashiels (Eildon Housing):
Construction of 39 high quality flats within a safe and secure community setting; personalised care and support available on-site and services designed to meet the changing needs of older people. Target completion date of September 2021, with target go-live date of October 2021.

Todlaw, Duns (Trust Housing)
The tenancies are designed for later years living, with the freedom to live independently and access to care and staff support, home-made meals and social activities. All the properties are pet friendly, free Wi-Fi is available and all have space, and charging points, in the hall area for a mobility scooter. On site there are 19 modern, amenity bungalows (either 1 or 2 bedroom), each with patio doors opening to their own private, fenced garden, and ample parking. There are also 30 Extra Care Housing flats (again 1 or 2 bedroom) bedrooms, open plan kitchen and living room and wet floor bathroom. Tenants can use the level access garden area and shared living spaces such as the dining room, lounge and laundry.

Kelso (Eildon Housing)
Building work is underway at the former Kelso High School which is being turned into 36 new homes for Extra Care.

Care Homes
Planned investment into the Council-owned care homes in 2020/21 has been delayed because of Covid-restrictions, but £1.5m is planned to be invested during 2021/22 in internal and external works.

Care Village
An outline design proposal for 2x 60-bed care village developments continues to be progressed. The accommodation is based on self-contained 'units', with adjacent treatment space, retail/café and recreational facilities available on site for the use of residents and the wider community.

Partnership Priorities for 2020/21 – What we said

5. **Service Commissioning**
   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.

Key Achievements/Successes : What we did

During the pandemic, decisions had to be taken very quickly with regards to provision and capacity. The normal commissioning methods were curtailed as immediate responses were required. In the main these were undertaken at operational level, but where required the decisions were escalated to the Joint Executive meeting of the Council, Health Board and IJB.

At the beginning of the pandemic this joint group met daily. A direct outcome of this close liaison has been the evident improvement in partnership working and joint decision making. It is anticipated that this group will evolve into a permanent group, to determine the direction of joint working in Health and Social Care, and will report to both the Strategic Planning Group and the Integration Joint Board.

In preparation for the new Strategic Commissioning Plan (SCP), further detailed work was begun, with the intention of providing a more accurate and updated modeling for need within Health and Social Care. Further demographic modeling is underway and a repeat of the detailed "Day of Care Audit" which was first undertaken in 2018 has been completed. These two areas of work will inform how we will commission over the current and forthcoming years.

BOPPP

Borders Older Peoples Planning Partnership (BOPPP), one of the Health & Social Cares engagement and planning groups, engaged in a conversation with older people to explore how they coped during lockdown. The consultation was open from Nov-Dec 2020. 487 people responded to the consultation survey, with analysis suggesting a 95% statistical confidence level in regard to responses. The responses highlighted:

- Support with practical tasks such as medication collection, shopping, financial and other practical support was effective with >80% of responses reporting that the level of support received was "just right".
- Support to maintain physical health and staying mobile was >60% effective
- Similarly support around Mental Health and Emotional Well-being fairing were around 60% effective.
- Support to remain Socially Engaged was the lowest reported category with 45% of people reporting this support to be "Just Right"

The results here will be used to inform strategic planning, operational activity and the commissioning of key older peoples services.

Objective 2: Partnership Priorities for 2021/2022

Development sessions of the IJB, coupled with events attended by 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	PLANNED DELIVERY DURING 2021/22
Older People's Pathway We need to better coordinate and improve services for older people. Doing this will reduce ill health and hospitalization. Too many older people remain in hospital when they could be cared for more appropriately and achieve better outcomes elsewhere. We must work with older people to provide access to a range of sustainable, integrated and coordinated pathways based on the principles of prevention, early intervention and supported self-management. When people become unwell, we will have a model of care that minimises the time they spend in hospital.	Home First should be the default service for step-up and step-down care (i.e.) to help prevent admission to hospital and to enable discharge from hospital. It should better align with locality services to better balance step up requirements and develop closer working arrangements with local Housing providers and Third sector support.
Joint Capital Planning Whole system capital planning and investment including Primary Care and Intermediate Care.	**TEC** TEC requirements for future developments needs to be considered from the earliest stages. Most care tech relies on reliable and stable Wi-Fi, rather than hard wired systems. At the planning stage of developments we need to be considering: • Good quality, stable Wi-Fi in every room and throughout the building – ideally including outdoor space. • Resilience broadband back-up (e.g.) through 4G/5Gc to ensure service continuity. • Only where necessary, hard-wire cabling. • Use of smart-lighting and LEDs to create safer environments, reduce falls risk, reduce confusion and support better patterns of activity.
	Extra Care Housing Feasibility of ECH location options for Eyemouth and Peebles to be explored.
	Care Village Care village concept progressed to implementation
Service Commissioning Reviewing, planning, contracting and re-contracting	There has been a decrease in the number of Adult Protection concerns raised during 20-21 compared to the previous 2 years. Similarly, there were 453 referrals to Domestic Abuse services (Adults) in 2020/21, which is 240 fewer referrals than in 2019/20. As pandemic restrictions ease it is expected that referrals into the Domestic Abuse Advocacy Support service (DAAS) will increase and plans/resource will need to be in place to mitigate this.

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 improve 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 – including support to access funding; training & workshops; emotional support; hospital support; counselling or support groups.

Borders Carers Centre services are free and independent and all carers over the age of 18 years are supported. The Centre also supports carers to have a strong voice both on local and national levels through the Carers First Forum. The centre, based in Galashiels, is also on hand if carers just need to chat on the phone to somebody who knows what they're going through.

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 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 - Community Assistance Hubs (CAHs)

In March 2020, as a joined up response to the pandemic, Community Assistance Hubs (CAHs) were established across the Borders within each of our five localities. The hubs consisted of two main areas;

- Community response and...
- Health and Social Care

The Community response team acted as a single point of contact, receiving and coordinating local requests for support, maximising capacity to support elderly and vulnerable people, minimising potential hardship experienced through isolation and/or difficulties associated with accessing food, medical supplies or information.

An example of the response team representation for our Teviot locality hub is shown below. As can be seen, it is a collective mix of staff, volunteers and community resource coming together to deliver essential services during very challenging times.

Burnfoot Community Futures
Citizen's Advice Bureau
Food Train
Health in Mind
LAC – Older Adults, MH, LD
Red Cross
Salvation Army
Samaritans
SBC staff, Joint Health Improvement Team

The Health and Social Care team worked closely with Community Response teams to ensure that essential care requirements were met by nursing/homecare and also aligned with the community response. The single point of contact has been essential in providing support in communities for the elderly or otherwise vulnerable. The CAHs coordinated the distribution of PPE to care providers, supported the delivery of food and medication, signposted people to services and support groups and also coordinated the volunteer response.

Some examples of signposting from the CAH webpages included:

- NHS Inform provides the most update to date guidance on coronavirus, including mental health support. There is advice on how to stay informed, create a healthy home routine, stay connected with friends and family and where you can turn to for advice and guidance
- The Wellbeing Point on the NHS Borders website provides information about a range of support services available both locally and nationally that you may find helpful
- Clear Your Head provides advice on how to look after your mental wellbeing, including tips on how to stay positive and feel better
- SAMH has a developed specific information on COVID-19 and your mental wellbeing

- Age Scotland provides information and advice for anyone aged 50 and over, as well as a free, confidential helpline 0800 12 44 222 (Monday to Friday 9am-5pm)
- Alzheimer Scotland has a 24 hour Freephone Dementia Helpline 0808 808 3000
- The Royal Voluntary Service is providing a programme of themed online activities designed to help beat the boredom of isolation, as well as other hints and tips for staying active and connected
- Shared Care Scotland has developed a directory of short breaks for strange times. These include everything from online courses, virtual museums, exercise programmes, read-alongs, and websites for children and young people, as well as support services that are delivering online

The CAH approach helped to:

- resolve problems quickly and in a coordinated way
- develop good relationships with clients (some people received weekly welfare phone calls) and with partners
- connect people quickly to the support that they need, when they need it; whether that was by a community group, volunteer support or social care and health response.
- follow up the calls to find out if any other support was required

During the pandemic, across the Scottish Borders, there was an extraordinary willingness from communities to get involved in providing support to others, including supporting people who were required to shield and working collaboratively with the testing team to contact all residents to offer support to them and their families when requiring to isolate.

The CAHs have highlighted the clear benefits of 'true' joint-working and reinforced the huge importance of the Third Sector, Registered Social Landlords, local resilience groups, Community Learning & Development, Communities & Partnership staff and other volunteers. A key outcome of the CAH approach is the amount of community engagement and links to communities which have been established or strengthened.

An indication of the volume of local people supported by the community response of the CAHs is shown below.

LOCALITY	SHIELDERS	FOOD ONLY	FOOD & MEDICATION	OTHER
Berwickshire	773	208	39	29
Cheviot	834	181	66	59
Eildon	1,419	330	76	81
Teviot & Liddesdale	872	242	16	57
Tweeddale	643	115	27	51
Totals:	**4,541**	**1,076**	**224**	**277**

In regard to other calls into the CAHs, the table below shows how call volumes and call type varied during the pandemic with the easing/reinstatement of lockdown restrictions.

CALL TYPE	CALLS FOR WEEK COMMENCING....			
	22/06/20	07/09/20	11/01/21	31/05/21
Financial Support	37	2	163	6
Social Care & Health	41	15	32	10
General	156	38	182	29
Totals:	**234**	**55**	**377**	**45**

As restrictions eased after Lockdown#1 (Autumn 2020), so did calls to the CAHs. As restrictions came back into force (Lockdown #2), the volume of calls increased, a number of which concerned financial support.

Objective 3: What we said / What we did (Priorities 2020/21)

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 2020/21 – What we said

6. **Carer Support Services**
   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 to better understand the needs of carers and to work collectively to deliver the services they require

Key Achievements/Successes : What we did

Working in partnership with Borders Carers Centre, RVS and the Red Cross respite opportunities were created to support carers throughout the pandemic through the RVS sitting service and Red Cross Chit-Chat service. The Partnership provided additional funding to the Borders Carers Centre to top up the 'Time to Live' grant, providing creative breaks opportunities for carers – the use of the additional funding ranged from items of gym equipment to subscriptions and laptops to ensure that carers could stay connected and reduce isolation. The establishment of the Emergency Relief Fund, managed by Borders Carers Centre, was used to provide up to 40 hours of at-home respite for periods of up to 10 weeks to bridge the gap between lockdown restrictions and the reopening of local services.

A Carers 'workstream', in partnership with Borders Carers Centre and carers was created to ensure that carers have a strong voice in the direction and strategic planning of Partnership services, recognizing and valuing carers as equal partners in care.

Partnership Priorities for 2020/21 – What we said

7. **Locality Operations**
   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.

Key Achievements/Successes : What we did

Healthy Living

The 'Paths to Health Walk-It' project forms part of the national initiative to improve Scotland's Health. The project aims to:

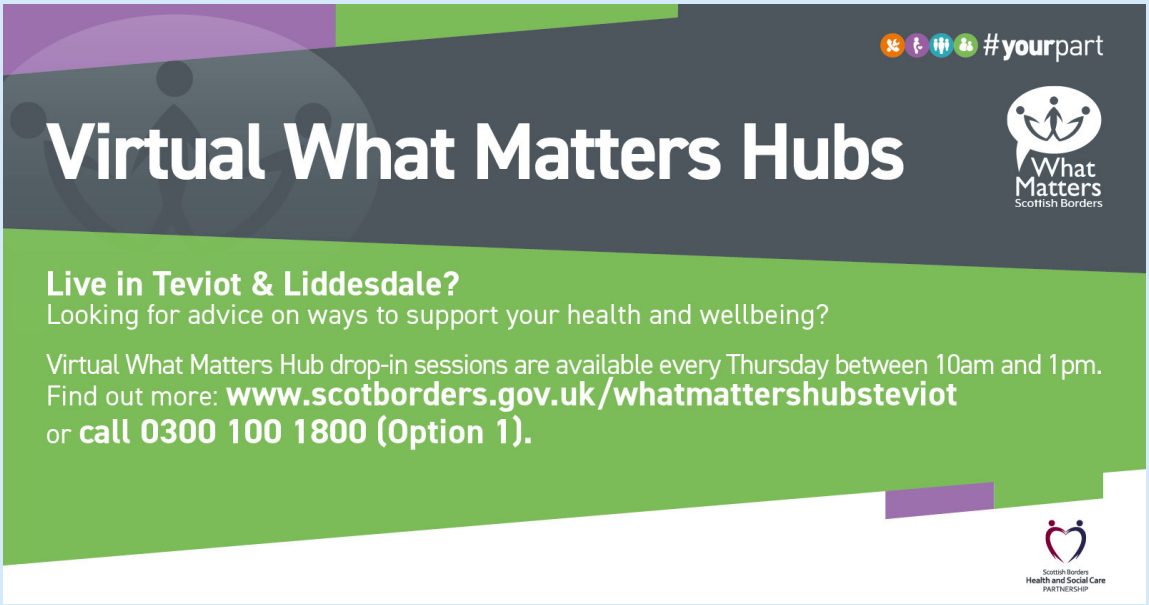
- Encourage exercise as part of a healthy lifestyle
- Promote walking as an ideal way of getting fit and relieving stress
- Create safe and social walks where all feel welcome
- Create links with partners and networks
- Recruit, train and support volunteers

The Walk It project boasts 30 mainstream walking groups across Borders towns and villages. There is also a 1-1 Buddy Walking Project for those with a long term health condition, a dementia diagnosis or other challenges which prevent them joining a mainstream group – since November 2020, 24 referrals have been taken into this project with plans for a larger project to be undertaken throughout 2021. Despite lockdown restrictions, the project delivered 107 mainstream Walk It Walks, with 994 walkers; and developed 62 brand new Walk It walk leaders.

Key Achievements/Successes : What we did

Locality Planning

Pre-Covid, What Matters Hubs provided a single point of contact in Borders towns for Social Work support. As a response to the pandemic, the Community Assistance Hubs (CAHs) were established in each locality which saw Health, Social Work and Social Care professionals coming together as multi-disciplinary teams. H&SC huddles and weekly community meetings are operational in all localities. A 12-week trial of a virtual What Matters hub was initiated in Teviot (starting from 22nd April 2021) and discussions held with ANP lead in regard to support for the hub and discussions with Pharmacy regarding support for H&SC huddles.



Dementia

During March 2021, a series of online engagement sessions were held to give those in the Borders who have direct experience of dementia a meaningful voice in how they want to receive support locally. The sessions were hosted by The Life Changes Trust, a charity which supports people living with dementia and unpaid carers of people with dementia. The sessions provide a creative and safe space for those living with dementia and those caring for someone with dementia to share their experiences and priorities.

The publication of the annual Dementia Benchmarking Toolkit by Public Health Scotland in November 2020 indicated that Borderers receive some of the most proactive and timely treatment for dementia, reflected through:

- proactive prescribing of dementia drugs
- acute & psychiatric admissions and readmissions

Additionally, the Partnership is committed to ensuring that people live as well as they can, for as long as they can by prescribing cognitive enhancers; using non-pharmaceutical 'talking therapies' and keeping people in their own homes or in homely settings whenever possible.

Key Achievements/Successes : What we did

Community Testing
Community Testing was put in place providing rapid Covid-19 testing for people without symptoms Tests could be booked by calling 01896 826370 or emailing ATS.Service@borders.scot.nhs.uk. Testing was only for people without symptoms; anyone with Covid-19 symptoms should book a test in the usual way via the NHS Inform website or by calling 0800 028 2816. The community testing programme used lateral flow devices (LFD), which are quick, easy and provide rapid results. This enables us to find people with Covid-19 who do not have symptoms and support them to self-isolate, therefore limiting Covid-19 from spreading to others." Further information about this testing initiative can be found on the NHS Borders Community Testing Programme webpage.

Partnership Priorities for 2020/21 – What we said

8. **Technology**
   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.

Key Achievements/Successes : What we did

Meetings tech

The pandemic has required the acceleration of new ways of working and deployment of technologies such as MS Teams for meetings and the distribution of iPads for residents in SBC care homes. These devices allowed the residents to keep in touch with their loved ones. The Community Assistance Hubs used technology to hold virtual meetings with representatives from a number of partners to identify local needs and target services to best effect. For over a year, a significant number of traditionally office-based staff have worked effectively and safely from home with a focus on maintaining service delivery. This required everyone adapting not only to home-working, but also to utilising the technology to make this work. A major barrier to home-working pre-Covid was the number of physical face-to-face meetings that people had on a weekly basis. Technology, such as MS Teams, has existed for years but the workplace 'norm' pre-Covid was that meetings took place in a physical room – often requiring travel and catering arrangements. The adoption of MS Teams for meetings (across SBC and also Health) has proved to be incredibly useful in reducing printing of meeting papers, travel expenses, travel time and meeting time. It has also removed barriers to people being able to attend therefore increasing participation in meetings. Mental Health services have embraced the use of video-link appointments using the Near Me platform and it has become a valuable tool in our in our clinical practice.

Sirenum

A system called Sirenum has been used in SB Cares to post offers of casual/supply work. This gives the ability to post offers of casual/supply work to all staff who meet the criteria at the push of a button removing the need to send text messages or make numerous individual phone calls, allowing staff to update their availability and accept/decline a 'shift' in minutes.

SHIFTS	SB CARES
Posted	2,657
Filled	1,976
%	**74%**

Key Achievements/Successes : What we did

Connecting Scotland

The Connecting Scotland programme, delivered by the Scottish Council for Voluntary Organisations (SCVO) on behalf of Scottish Government, was launched in response to the pandemic to help support vulnerable people get online. Individuals were provided with an appropriate internet enabled device (Chromebook or iPad), access connectivity (a mobile hotspot and 12-24 months of data) and paired with a 'digital champion'. Partner organisations identified those who faced barriers to digital inclusion, and devices were targeted initially to those who were shielding and clinically vulnerable. Subsequently devices were rolled out to other vulnerable groups, including households with pre-school and school age children, young care leavers on low incomes, and older people with a disability. Upon completion, the Connecting Scotland programme will have supported 834 people in the Borders. The digital champion 'buddying' is provided for a period of six months; it is delivered remotely and at a pace that suits the learner. The focus is on mastering digital foundations, building confidence online, and exploring hobbies and interests. Many of the people who were shielding in the initial phase have learned new skills such as how to make video calls with their friends and family, therefore helping to reduce social isolation.

Community Alarms

There is a complete range of Telecare services offering support to enable vulnerable people to live safely and independently in their own home using alarms and sensor activated devices. Telecare can monitor a vulnerable person and raise an alert if they trigger a personal alarm or if the sensor detects any problems such as a fall, heat or smoke in the property; and even offer mobile protection whilst out and about. When a Telecare sensor activates, an alert is automatically sent to the 24-hour monitoring centre who have relevant information about the individual using the service. The team contacts the person to check their safety and to provide the appropriate response – whether that be offering reassurance or advice, contacting a family member/friend or an emergency service.

Self-care/advice

A new digital resource hub was launched to provide self-care advice for people experiencing common musculoskeletal issues. The hub provides easily accessible advice which can be a useful starting point for anyone experiencing common aches and pains. Information includes useful exercises, videos and further information to help you to restore movement, relieve pain and improve strength in key areas of your body. If these self-management options do not help to improve your condition within 6-12 weeks, there is also a self-referral option available online so that you do not need to see your GP in order to access specialised care from our Physiotherapy Musculoskeletal Services.

Partnership Priorities for 2020/21 – What we said

9. **Mental Health provision**
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.

Key Achievements/Successes : What we did

Community Mental Health Teams (CMHT), Crisis, Liaison, Psychological Therapies and CAMHS.
During the pandemic, the CAMHS and Psychological Therapies teams received enhanced support from Scottish Government and used this to address the waiting lists to maintain a balance between demand and capacity.

1. Emerging evidence suggests a deterioration in population mental health and wellbeing as a result of the pandemic, and one of the early impacts of Covid-19 was a higher level of distress. Over time, there is expected to be a worsening incidence of mental health disorders, and rates of traumatic reactions, substance misuse, self-harm and suicide are expected to increase.

2. As part of the mental health contribution to the redesign of unscheduled care, we developed pathways to ensure that people with complex psychosocial needs benefit from a local multi-disciplinary compassionate response from across the health, justice and social care systems. This is a fully funded 2 year test of change.

3. The introduction of the "Renew" service through the Primary Care Improvement Plan, was started in the Autumn of 2020 and was fully operational by the Spring of 2021. For a long time our GP practices have been reporting an inability to cater for a significant proportion of our population with mental health needs who were just below the threshold for acute mental health provision. There was nowhere to refer these individuals to and little that could be offered in provision. "Renew" fills this gap, and evaluation to date has been very encouraging.

Partnership Priorities for 2020/21 – What we said

10. **Learning & Physical Disability provision**
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.

Key Achievements/Successes : What we did

The LD services is working very closely, flexibly and innovatively with LD Service providers in the community. The service has adapted to the changes brought about by COVID 19, focusing on reducing risks to clients whilst also taking into account the frequently changing pandemic position and advice from the Scottish Government.

Re-commissioning of Hawick Community Support Service
The change delivers an equivalent quality of support provision.

Commission Shared Lives
Shared lives delivers high quality services whilst delivering financial savings/best value. Contract awarded to Cornerstone in March 2020 and 6 placements commenced.

Objective 3: Partnership Priorities for 2021/2022

Development sessions of the IJB, coupled with events attended by 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	PLANNED DELIVERY DURING 2021/22
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.	**Carers Workstream** Continued development of the Carers workstream to ensure that carers have a strong voice in the direction and strategic planning of services.
	Hear From You As we look to recover and rebuild, we want to widen our network of public involvement support and reach in to all areas of the Borders community and to hear your views. We can then co-produce our approach to public involvement to ensure that it is inclusive, effective, fit for purpose and can be adapted to meet the changing needs of our communities as we emerge from the pandemic. Our aim is to establish a reference group of at least 200 people of varied age, background, location, interests in or experience of health conditions. You might have faced barriers in accessing healthcare, you might be part of a community you feel is under represented or seldom asked to express your views. Whoever you are and whatever you have to say we want to hear from you. You can do this in a number of ways: • email to public.involvement@borders.scot.nhs.uk • phone 0800 731 4052 (free of charge) • completing our online form • Sending us a note in the post to Public Involvement, Education Centre, Borders General Hospital, Melrose, TD6 9BS

WORKSTREAM	PLANNED DELIVERY DURING 2021/22
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.	**Locality Model** Pre-Covid, What Matters hubs operated in each locality. The hubs allowed people to make appointments or drop in to see a member of the Social Work team for advice or support. The hubs were supported by the Red Cross, Local Area Coordinators and other partner organisations such as Chest Heart Stroke Scotland, Alzheimer's Scotland, Fire Scotland and the Food Train. Following the pandemic, development of a new Locality Hub model is essential. It will retain the ethos of the Community Assistance Hubs and provide wide ranging support in local communities, using a combination of physical and virtual hubs (e.g.) enabling people to have a more personal conversation through a video call similar to Skype or Facetime, using 'Near Me' technology currently used by NHS and Social Work staff. Going forward. the Locality Hub model will provide a much broader range of support than was previously available and will be supported by a number of services including adult social work, homelessness, welfare advice & benefits, local area coordination (older adults, mental health and learning disabilities), Health, the wellbeing service and Third Sector organisations such as the Red Cross. - Continue the trial and monitor the Teviot virtual What Matters Hub. - Continue to support huddles and community meetings. - Continue to explore a virtual ward model. - Continue to develop the shared client list. - Update locality plans and locality data.
	Engagement/Place-making Development of a Place Making approach to community engagement and participation across Borders communities. The place making proposals aim to build on, and link with, a wide range of existing and planned national, partnership and community work. In particular, the proposals aimed to build on the learning and experience of joint working with Communities and Partners in responding to the Covid-19 pandemic and to reflect the national ambition for a Resilient Recovery.

WORKSTREAM	PLANNED DELIVERY DURING 2021/22
Technology Technology support across health and care provision, workforce enablement, improved administration processes and improved sharing of information across the partnership.	**Mobile working** Work with SBC to progress the new digital strategy ("Digital Borders"). The Strategy seeks to invest in change programmes, new ways of working and new IT infrastructure to harness the power of communities, empower individuals, reduce inequality, widen access to digital connectivity and expand the economic potential of the Region. Key elements of the Strategy include empowering frontline staff to use mobile technology; rationalise and integrate back office systems, reduce social isolation and digital exclusion in our communities, and enhance the skills and the digital capability of local people.
Mental Health provision For adults (and children), including dementia care and autism.	**We plan to:** **(1) Deliver CAMHS improvement** by taking forward improvement work, based on a gap analysis. This will include capacity building to meet expected increases in demand - to provide specialist neurodevelopmental assessments. **(2) Further reduce CAMHS and Psychological Therapies waiting lists** We will work to clear backlogs in CAMHS and Psychological Therapies waiting lists. **(3) Primary Care** Via a phased approach, we will work to introduce a multi-disciplinary MH Team in every GP cluster. **(4) Community Services** Scottish Borders MH services have been chosen as a test of change site along with NHS Lanarkshire to deliver a service for people in distress with complex psychosocial needs.
Learning & Physical Disability provision Reviewing and 're-imagining' the service – particularly important now in the context of Covid-19.	**Review of Day Services** The change will deliver a locality based service based upon inclusion. Review of services and new model planned to be complete by September 2022.

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 2020/21 the IJB controlled the direction of **£208,688m** 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	16,399	17,167	17,047	120
Joint Mental Health Service	2,022	2,155	2,132	23
Joint Alcohol and Drug Service	142	101	95	6
Older People Service	25,195	23,413	23,841	(428)
Physical Disability Service	2,458	2,644	2,646	(2)
Generic Services	12,897	13,605	13,417	188
SBC Contribution	0	93	0	93
Social Care sub-total:	**59,113**	**59,178**	**59,178**	**0**
2. HEALTH SERVICES				
Joint Learning Disability Service	3,740	3,445	3,830	(385)
Joint Mental Health Service	15,980	17,215	16,925	290
Joint Alcohol and Drug Service	390	757	757	0
Prescribing	23,130	23,132	22,660	472
Generic Services	64,540	74,182	72,248	1,934
NHSB Additional Contribution	0	3,925	0	3,925
Health sub-total:	**107,780**	**122,656**	**116,420**	**6,236**
3. SET-ASIDE HEALTHCARE SERVICES				
Accident & Emergency	2,830	3,132	3,634	(502)
Medicine & Long-Term Conditions	15,660	16,385	16,819	(434)
Medicine of Elderly	6,230	7,099	6,401	698
Planned savings	(1,090)	(1,090)	0	(1,090)
NHSB-Funded Costs above Budget	0	0	(1,328)	0
Set-aside sub-total:	**23,630**	**25,526**	**25,526**	**0**
Overall:	**190,523**	**208,688**	**202,452**	**6,236**

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). Note also that the overspend reported is that incurred by NHS Borders in the delivery of set-aside functions. From a partnership perspective, these functions broke even as the reported pressure was subsequently incorporated into the overall NHS Borders bottom-line outturn.

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, 2019/20, 2020/21 – and the planned budget for 2020/21.

IJB SERVICE AREA	ACTUAL 2016/17 £'000	ACTUAL 2017/18 £'000	ACTUAL 2018/19 £'000	ACTUAL 2019/20 (£'000)	ACTUAL 2020/21 (£'000)	PLANNED 2021/22 (£'000)
1. SOCIAL CARE SERVICES						
Joint Learning Disability Service	15,261	16,730	17,516	18,134	17,047	16,122
Joint Mental Health Service	1,911	1,962	1,999	2,076	2,132	2,052
Joint Alcohol and Drug Service	103	173	136	114	95	144
Older People Service	20,979	18,685	20,762	22,991	23,841	26,804
Physical Disability Service	3,343	3,570	3,599	3,191	2,646	2,734
Generic Services	4,850	12,011	12,335	13,615	13,417	6,339
Social Care sub-total:	**46,447**	**53,131**	**56,347**	**60,121**	**59,178**	**54,195**
2. HEALTH SERVICES						
Joint Learning Disability Service	3,690	3,520	4,010	4,435	3,830	3,975
Joint Mental Health Service	14,173	13,725	14,974	16,225	16,925	16,749
Joint Alcohol and Drug Service	635	597	608	777	757	395
Prescribing	Included within generic services			23,559	22,660	23,132
Generic Services	78,109	77,645	81,884	57,764	72,248	69,556
Health sub-total:	**96,607**	**95,487**	**101,476**	**102,759**	**116,420**	**113,807**
3. SET-ASIDE HEALTHCARE SERVICES						
Accident & Emergency	2,043	2,004	2,912	3,206	3,634	2,937
Medicine of the Elderly	6,142	6,434	6,642	6,725	6,401	6,400
Medicine & Long-Term Conditions	13,029	12,905	15,571	16,175	16,819	16,678
Generic Services	-	3,075	-	-	-	1,500
Planned savings	(350)	-	-	-	-	(1,090)
Set-aside sub-total:	**20,864**	**24,418**	**25,125**	**26,106**	**26,854**	**26,425**
Overall:	**163,918**	**173,036**	**182,948**	**188,986**	**202,452**	**194,427**
Year on year increase	-	**+5.6%**	**+5.7%**	**+3.3%**	**+7.1%**	**-4.0%**
Cumulative increase	-	**+5.6%**	**+11.6%**	**+15.3%**	**+23.5%**	**+18.6%**

During 2020/21 all additional direct costs arising as a result of Covid-19 mobilisation and subsequent remobilisation were met in full by additional funding allocations by the Scottish Government. These funding allocations also met the significant level of financial plan efficiency savings targets that were not delivered during 2020/21 on a non-recurring basis, as a result of a lack of capacity due to the deployment of staffing resource in direct response to the pandemic.

Overspend / Underspend

The HSCP reported an under-spend position of **£6.236m** against the delegated budget at 31st March 2021. This under-spend related to ring-fenced funding received by NHS Borders, slippage in service developments and cost pressures which have been carried forward. In order to achieve this additional allocations from each funding partner were required during the year, and at year end, to deliver a break even position overall. These amounted to **£0.093m** and **£3.925m** for social care and healthcare functions respectively.
In terms of the Health and Social Care Partnership set aside, the IJB directed **£25.526m** to NHS Borders in 2020/21. During the financial year, NHS Borders spent **£26.854m**, resulting in an over-spend of (**£1.328m**) within the Health Board functions. The over-spend position remains the responsibility of NHS Borders and as a result, has been absorbed within the overall health board financial position at outturn.

During 2020/21 the functions delegated to the HSCP experienced a range of budgetary variances. Reasons for this included:

- Increased demand for social care, both residential and at home, as a result of an increased number of older people requiring care and support, particularly in the 75-84 and 85+ age cohorts
- Additional direct costs of mobilisation to deal with the Covid-19 pandemic and subsequent remobilization.
- Additional social care clients transitioning from Children and Families (a service which is not delegated to the IJB) to Adult Health and Social Care services
- Non-delivery of planned Financial Planning savings across both Health and Social care functions delegated to the Partnership, only partly as a result of the Covid-19 pandemic
- A downturn in expenditure levels due to the reduction in or pausing of normal service activity during key periods of 2020/21
- Additional investment requirements as the Partnership strives to deliver its Health and Social Care transformation programme priorities.

At the start of 2020/21, the IJB carried reserves of £3.742m and at the end of the year, the draft unaudited reserve position is £10.240m.

AREA	YEAR COMMENCE £'000M	YEAR END £'000M
Ring-fenced funding carried forward in delegated functions	3,168	9,404
Transformation Fund	396	714
Older People's Change Fund	178	122
Totals:	**4,541**	**1,076**

Balance of care

The Partnership Strategic Commissioning Plan is based on developing community capacity in a way that prevents unplanned hospital admissions and improves the flow of patients out of the acute hospital setting.

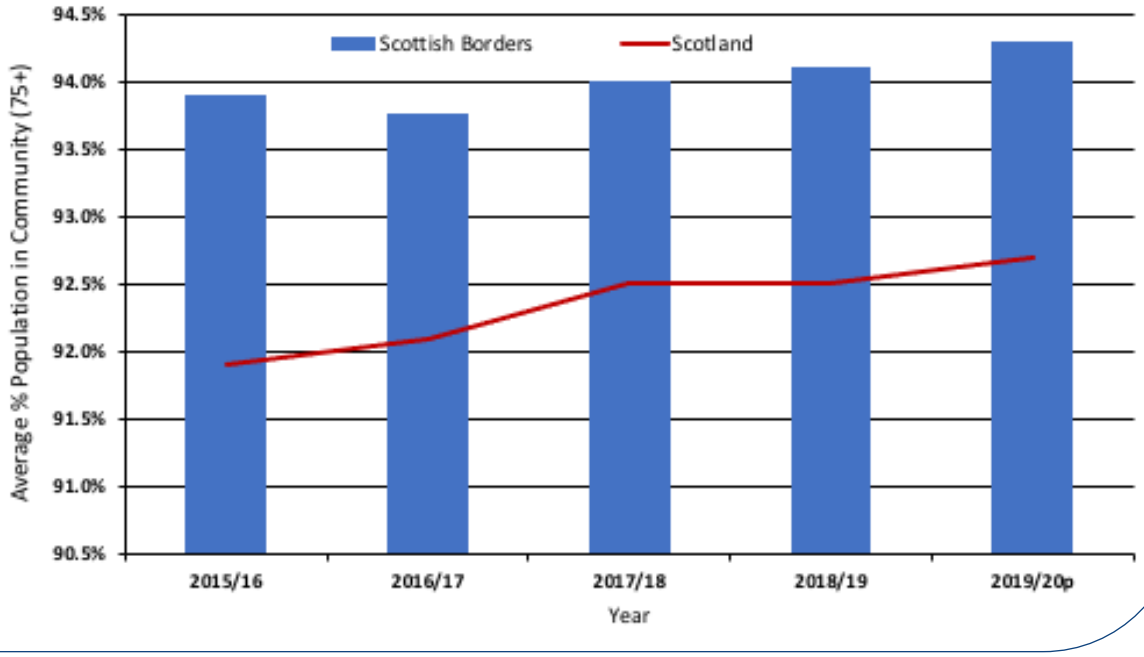
The development of Locality based services is a vital part in regard to investment in early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting carers and supporting independent living.

The Borders has made progress towards our aim of providing more care in the community and enabling older people to live independently at home.

The data below indicates that:

- **94.3 %** of our over 75 population lives at home – either with no requirement for any care at all or supported through social care to remain at home
- **5.7%** of our over 75 population are cared for in a care home, hospice or a hospital setting.

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



Best Value and BV Audit

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

Scottish Borders Council developed an Action Plan to progress improvements across all recommendations made in the 2019 Best Value Assurance Report by Audit Scotland.

The actions below are aimed towards improving partnership working and lie within the responsibility of the IJB:

ACTION	TIMESCALES	% COMPLETION	NOTES
Raise visibility of key policies and decisions across respective governance groups including Executive Management Team and Corporate Management Team.	31-Jul-21	80%	The joint SBC and Health Group who meet regularly has improved the quick, formal joint discussion and decision on key policies and actions – many relating to pandemic response. It is anticipated this group will continue to meet regularly post CV-19.
Enhance governance arrangements and clarity of role of respective partnership groups including Integrated Joint Board, Executive Management Team and Strategic Planning Group. Improving quality and availability of reports outlining proposals to enable these groups to plan and take decisions more effectively.	31-Jul-21	60%	At its December 2020 meeting, IJB approved changes in reporting lines within the senior management team to strengthen the "Strategic Commissioning" function of the Integration Joint Board. These changes enhance governance arrangements and joint working between SBC and Health.
Develop a model for localities that adopts a single structure for the management and provision of joint health and Social services.	31-Mar-22	50%	The joint SBC and Health Group who meet regularly has improved the quick, formal joint discussion and decision on key policies and actions – many relating to pandemic response. It is anticipated this group will continue to meet regularly post CV-19.
Ensure a joint financial and service plan that is fully endorsed by respective partners is prepared for IJB on an annual basis.	31-Jul-21	100%	March 2021 IJB agreed the joint budget. The changes to senior management team to strengthen the commissioning role of the IJB ensures that services and budgets are aligned to IJB delivery.

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 HSCP Senior Leadership Team (SLT) and the IJB ensures proper administration of its financial affairs. 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 will be 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 engagement, the identification of local issues and the delivery of the change. The IJB 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.

Like many things, work with the Locality Working Groups has been hampered by the pandemic and lockdown restrictions. The changes to Locality Working arrangements (approved by IJB in 2019/20) were intended to strengthen and bolster Locality Working Group arrangements by ensuring that:

1. Each Locality Plan is aligned to Community Planning Partnership (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.

At the time, these changes assumed 'traditional' face-to-face- meetings. This together with the pressure of Covid on staff and senior managers meant that Locality Working during 2020/21 did not progress as planned. The intention for 2021/22 is to better utilise the virtual technology and take forward engagement, discussion and debate with localities. This will better inform the partnership's Strategic Commissioning Plan and to co-design and co-produce the work that we do.

Locality Population

The total population of each of our localities is shown in the table below (based on 2019 mid-year population estimates):

LOCALITY	TOWN NAME	ALL AGES	AGED 0-15	AGED 16-64	AGED 65+	% 0-15	% 16-64	% 65+
Berwickshire	Ayton	579	86	314	179	15%	54%	31%
	Chirnside	1,447	324	808	315	22%	56%	22%
	Coldingham	479	61	279	139	13%	58%	29%
	Coldstream	1,856	233	968	655	13%	52%	35%
	Duns	2,787	472	1,612	703	17%	58%	25%
	Eyemouth	3,500	715	1,917	868	20%	55%	25%
	Greenlaw	623	73	399	151	12%	64%	24%
	Rural	9,649	1,401	5,780	2,468	15%	60%	26%
Berwickshire total:		**20,920**	**3,365**	**12,077**	**5,478**	**16%**	**58%**	**26%**
Cheviot	Jedburgh	3,826	649	2,205	972	17%	58%	25%
	Kelso	6,843	1,044	3,786	2,013	15%	55%	29%
	St Boswells	1,430	241	737	452	17%	52%	32%
	Yetholm	616	79	301	236	13%	49%	38%
	Rural	6,598	908	3,787	1,903	14%	57%	29%
Cheviot total:		**19,313**	**2,921**	**10,816**	**5,576**	**15%**	**56%**	**29%**
Eildon	Earlston	1,713	280	1,013	420	16%	59%	25%
	Galashiels	12,622	1,948	8,132	2,542	15%	64%	20%
	Lauder	1,813	437	1,012	364	24%	56%	20%
	Melrose	2,500	415	1,438	647	17%	58%	26%
	Newtown St Boswells	1,497	254	938	305	17%	63%	20%
	Selkirk	5,503	851	3,129	1,523	15%	57%	28%
	Stow	706	125	451	130	18%	64%	18%
	Tweedbank	1,994	341	1,269	384	17%	64%	19%
	Rural	8,477	1,521	5,001	1,955	18%	59%	23%
Eildon total:		**36,825**	**6,172**	**22,383**	**8,270**	**17%**	**61%**	**22%**
Teviot and Liddesdale	Denholm	706	89	392	225	13%	56%	32%
	Hawick	13,857	2,391	8,151	3,315	17%	59%	24%
	Newcastleton	796	119	430	247	15%	54%	31%
	Rural	2,581	326	1,496	759	13%	58%	29%
T&L total:		**17,940**	**2,925**	**10,469**	**4,546**	**16%**	**58%**	**25%**
Tweeddale	Cardrona	882	204	538	140	23%	61%	16%
	Innerleithen	3,171	528	1,850	793	17%	58%	25%
	Peebles	8,577	1,480	4,874	2,223	17%	57%	26%
	Walkerburn	700	100	442	158	14%	63%	23%
	West Linton	1,810	383	1,050	377	21%	58%	21%
	Rural	5,372	945	3,372	1,055	18%	63%	20%
T&L total:		**20,512**	**3,640**	**12,126**	**4,746**	**18%**	**59%**	**23%**
Scottish Borders:		**115,510**	**19,023**	**67,871**	**28,616**	**16%**	**59%**	**25%**
Scotland:		**5,463,300**	**921,397**	**3,497,758**	**1,044,145**	**17%**	**64%**	**19%**

At a financial level, we do not allocate resource to specific localities, but based on total population and the actual budget for 2020/21 (£202.45m), the following indicates how the HSCP budget could be attributed to each locality:

LOCALITY	POPULATION	LOCALITY 'ALLOCATION' (£M) - BASED ON 2020/21 ACTUAL								TOTAL
		Learning Disability	Physical Disability	Mental Health	Alcohol & Drugs	Older People	Prescribing	Generic Services	Set	
Berwickshire	20,920	3.78	0.48	3.45	0.15	4.32	4.10	15.51	4.86	**36.67**
Eildon	36,825	6.66	0.84	6.08	0.27	7.60	7.22	27.31	8.56	**64.54**
Tweedale	20,512	3.71	0.47	3.38	0.15	4.23	4.02	15.21	4.77	**35.95**
Cheviot	19,313	3.49	0.44	3.19	0.14	3.99	3.79	14.32	4.49	**33.85**
Teviot	17,940	3.24	0.41	2.96	0.13	3.70	3.52	13.30	4.17	**31.44**
	115,510	**£20.88**	**£2.65**	**£19.06**	**£0.85**	**£23.84**	**£22.66**	**£85.67**	**£26.85**	**202.45**

INSPECTION OF SERVICES

Independent Review of Adult Social Care

The Independent Review Adult Social Care will impact on the Health and Social Care Partnership. The core remit of the review was to "recommend improvements to adult social care in Scotland".

The report found that the 'story' of adult social care support in Scotland is

- one of unrealised potential
- where there is a gap between the intent of legislation and the lived experience of the people who need support.
- where there is unwarranted local variation, crisis intervention, a focus on inputs, a reliance on the market, and an undervalued workforce.

The report makes a number of recommendations specific to the care home sector whilst also recognising that most social care support is delivered in local communities and in people's homes. The report considers the key role of social workers, particularly in relation to assessment and considers future demographics - for example, the projected increase in the number of people living with dementia.

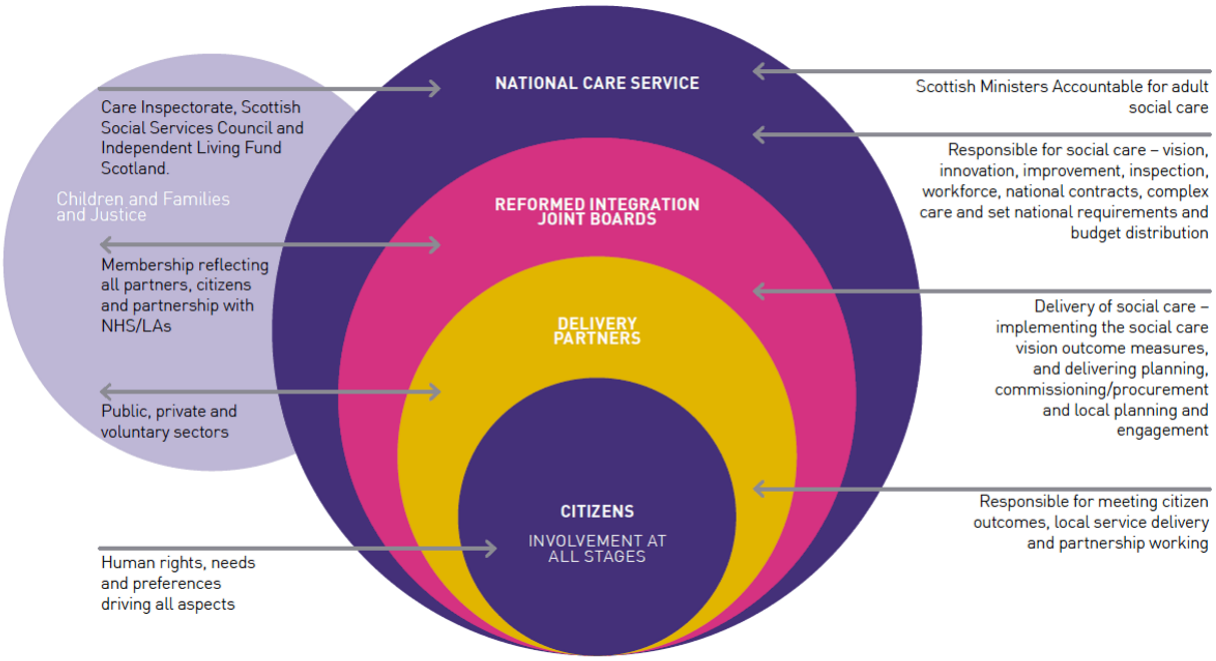
The vision is to have a system in place that replaces crisis with prevention and wellbeing; burden with investment; competition with collaboration and variation with fairness & equity. This 'culture-shift' places a high value on human rights, lived experience, co production, mutuality and the common good makes sense.

The proposal for taking this forward is through the creation of a National Care Service which brings together all adult social care support delivered in Scotland. The pandemic highlighted that the Scottish public expect national accountability for adult social care support. Statutory responsibility currently sits with Local Authorities and individual providers.

The intention is that the National Care Service will ensure that people have equity of access to social care supports, and experience a similarly high quality of care, wherever they live in Scotland. Where there is variation in the kinds of care provided in different parts of the country, then that should be in positive response to differences in geography, local assets and local priorities. There should be no inexplicable or un-evidenced variation in care that diminishes or harms people's life experiences. There should be a consistent, national focus on preventative, early intervention and anticipatory forms of support that shift the emphasis, and experience of care, away from crisis intervention and towards better quality of life. Lower level needs should not be left unattended until they become a bigger problem, they should be addressed to avoid the bigger problem occurring.

When someone has been assessed for care in one part of the country they should be able to move to another area and take their entitlement to social care support with them. The current situation, which requires people to be re-assessed for support in their new home, impinges directly on their rights to lead a socially engaged, full and active life, and is wasteful and bureaucratic. Provision should also be made at national level for support for people whose needs are very complex or highly specialist. This will provide people with greater levels of support and allow for the cost to be absorbed nationally.

All of this will mean that Local Authorities are no longer legally accountable for adult social care support. As partners in Integration Joint Boards, they will continue to influence and direct resources to meet identified local needs and will provide social care support and professional social work services. Local Authorities will continue to have a key statutory role to play in supporting public wellbeing that is wider than provision of social care support, extending to for instance housing, transport and, leisure and recreation.



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.

Haylodge Hospital (Peebles)
Haylodge Hospital in Peebles had an unannounced inspection by Healthcare Improvement Scotland (HIS) in December 2020. Performance was measured against a range of standards, best practice statements and other national documents, including the Care of Older People in Hospital Standards (2015) and Healthcare Associated Infection (HAI) standards (2015).

The inspectors:

- spoke with staff and used additional tools to gather more information. In the ward, we used a mealtime observation tool.
- observed infection control practice of staff at the point of care.
- observed interactions between staff and patients.
- inspected the ward environment and patient equipment, and
- reviewed patient health records to check the care we observed was as described in the care plans. We reviewed all patient health records for infection prevention management and control, food, fluid and nutrition, falls, and pressure ulcer care.

The inspection identified areas of good practice and also areas for improvement

GOOD PRACTICE	AREAS FOR IMPROVEMENT
• Evidence that learning from falls reviews have driven quality improvement work to reduce the number of falls. • Equipment and environmental cleanliness were good. • The nursing staff told us they were well supported and kept up to date during the pandemic.	• Person centred care plans should be in place for all identified care needs. • Mealtime management must be improved to ensure that a consistent approach to mealtimes is implemented.

NHS Borders - Health & Sport Committee (December 2020)
An evidence session with NHS Borders was held as part of the committee's on-going scrutiny of health boards. A written transcript of the meeting is available here

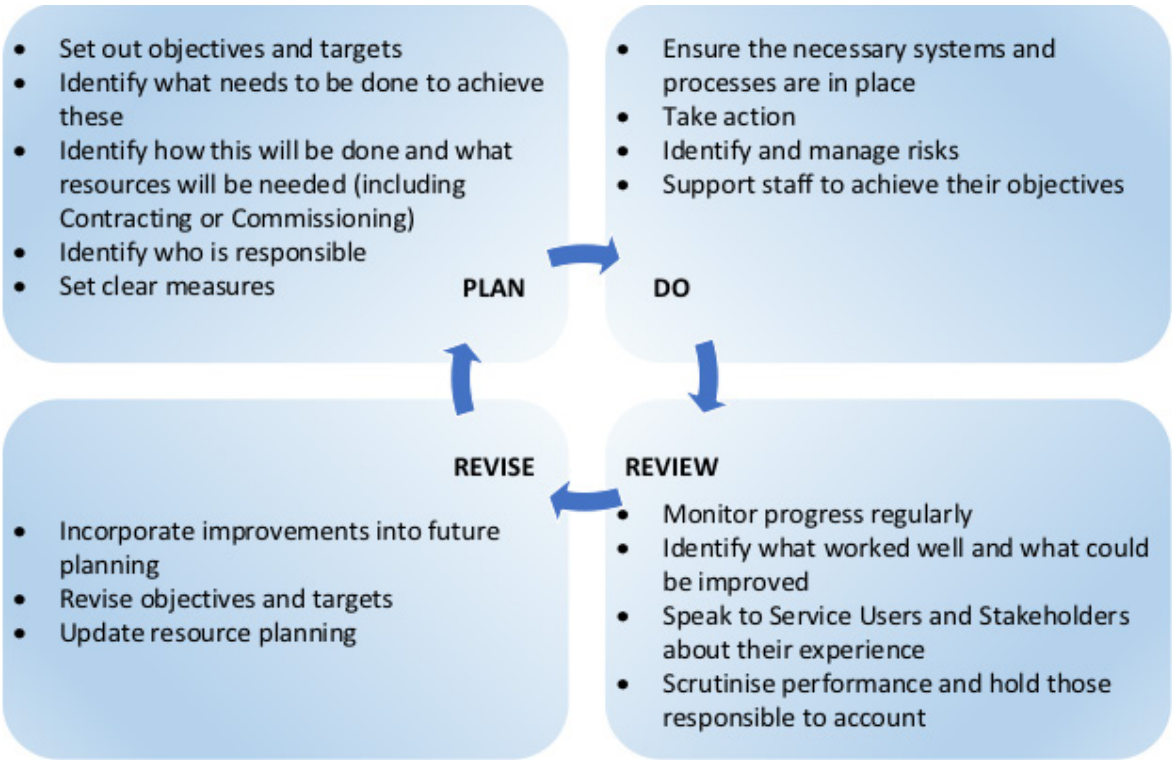
Care Home Inspections
Advice from directors of Public Health in Scotland was that inspection visits would present a real risk of introducing and spreading COVID-19 in Scotland's care homes. Therefore, to limit the spread of COVID-19, and with agreement from Scottish Government the Care Inspectorate restricted their presence unless necessary. This approach resulted in the majority of care homes not being graded as normal and instead retaining the grades they had last received. As an alternative, the Care Inspectorate intensified oversight using a range of remote and virtual approaches to ensure services were supported and operating well throughout the pandemic.

PERFORMANCE MONITORING FRAMEWORK SUMMARY

Performance Management Framework

The Partnership has a Performance Management Framework (PMF)in place. The PMF sets out the strategic context and performance reporting arrangements for the Health & Social Care Partnership.

The Partnership seeks to promote a culture of continuous improvement and 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, commissioning and change projects. The PMF gives the structure to build continuous improvement, setting out a logical approach to driving performance improvement.



Source: Adapted from Audit Scotland

Our performance measures

We report on a quarterly basis to IJB on a number of performance measures. These measures are aligned under our 3 Strategic Objectives and are designed to show the progress being made in delivery of the strategic objectives and the contribution 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) **22.1** **admissions** per 1,000 population (Q3 - 2020/21)	**EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS AGE 75+)** **75.3** **admissions** per 1,000 population **Age 75+** (Q3 - 2020/21)	**ATTENDANCES AT A&E (ALL AGES)** **54.7** **attendances** per 1,000 population (Q3 - 2020/21)
+ve trend over 4 periods **Better than Scotland (24.6 – Q2 2020/21)** **Better than target (27.5)**	**+ve trend over 4 periods** **Better than Scotland (83.3– Q3 2020/21)** **Better than target (90.0)**	**Flat trend over 4 periods** **Worse than Scotland (52.3 – Q3 2020/21)** **Better than target (70.0)**
£ ON EMERGENCY HOSPITAL STAYS **16.4%** of **total health and care resource**, for those **Age 18+ was spent** on **emergency hospital stays** (Q3 - 2020/21)	**THE % OF OLDER PEOPLE WHO RECEIVE A PACKAGE OF LESS THAN 10 HOURS OF DOMICILIARY CARE** **69%** (Dec 2020)	**THE % OF OLDER PEOPLE RECEIVING LONG-TERM CARE WHOSE CARE NEEDS HAVE DECREASED (FROM THEIR INITIAL ASSESSMENT/LATEST REVIEW)** **63%** (Dec 2020)
+ve trend over 4 periods **Better than Scotland (24% - 2019/20)** **Better than target (21.5%)**	**-ve trend over 4 periods** **Worse than target (15%)**	**+ve trend over 4 periods** **Better than target (15%)**

Summary:

The data for **emergency admissions** (all ages and specifically for 75+) covers the period to December 2020 and therefore a large part of the Covid-19 pandemic and lockdown restrictions. A considerable drop in emergency admissions (Q1) was followed by an increase (easing of Lockdown#1 restrictions, Q2) and then a plateau (possibly as a result of Lockdown#2 restrictions, Q3). This is similar to **A&E attendances**, where the data shows a drop in attendances in the early part of Covid, followed by an increase as restrictions eased, then another decrease as new, increased restrictions once again came into force. As would be expected, the **percentage of the budget spent on emergency hospital stays** mirrors this (i.e.) if we have fewer emergency admissions then the proportion of the budget spent on emergency stays should reduce. The latest data for the **percentage of Older people receiving a package of homecare of less than 10 hours** is 69% (as at Dec 20), which is very far from our locally set target of 15%. Our low target reflects Prof. John Bolton's view that homecare demand should be managed by (a) Focusing on help that supports recovery/ progression (b) Using community/family/ neighbourhood solutions rather than formal care and... (c) Not proscribing "dollops of formal care" as an easy solution. The indicator measuring the **percentage of older people whose long-term care needs have decreased** (again, data as of December 2020) indicates that 63% of those cases looked at can demonstrate a reduction in care needs and package of care, which is a very positive result.

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%) **86.5%** of **people seen within 4 hours** (Mar 2021)	**RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)** **1,179** **bed days** per 1000 population **Age 75+** (Q3 – 2020/21)	**NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)** **27** **over 72 hours** (Mar 2021)
-ve trend over 4 periods **Worse than Scotland (85.5% - Jan 21)** **Worse than target (95%)**	**-ve trend over 4 periods** **Worse than Scotland (1060– Q3 2020/21)** **Worse than target**	**-ve trend over 4 periods** **Worse than target (23)**
RATE OF BED DAYS ASSOCIATED WITH DELAYED DISCHARGE **165** **bed days** per 1000 population **Age 75+** (Q3 – 2020/21))	**"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS** **95.5%** **overall satisfaction rate** (Q4 - 2019/20)	**THE PROPORTION OF ACUTE PATIENTS DISCHARGED TO A PERMANENT RESIDENTIAL CARE BED WITHOUT ANY OPPORTUNITY FOR SHORT-TERM RECOVERY** **71%** (Dec 2020)
+ve trend over 4 periods **Better than Scotland (194 – 19/20 average)** **Better than target (180)**	**-ve trend over 4 periods** **Better than target (95%)** ***NB: Survey suspended due to CV-19 restrictions.**	**-ve trend over 4 periods** **Worse than target (0%)**

*Q3 20/21 onwards includes bed days in the four Borders' community hospitals and Borders General Hospital.

Summary:

Data for **A&E waiting times** (to January 2021) shows that less than 80% of people were seen within 4 hours. It remains the case that Covid presents challenges for A&E including testing, social distancing and PPE considerations all of which can add time to A&E processes and flow rates. The **occupied bed days** (for age 75+ emergency admissions) measure has been updated to include the 4x community hospitals as well as BGH. This means that the data is more consistent with the National data but it also means that performance has declined when comparing with previous quarterly performance reports. The **snapshot** data for delayed discharge (March 2021) shows a larger number of delays than previous monthly snapshots, however the **Rate of Bed Days Associated with Delayed Discharge** continues to be better than target and better than the National average. Due to Covid-restrictions, the **2 minutes of your time survey** is still on hold and the latest data remains that of March 2020. The **proportion of acute patients discharged to a permanent residential care bed without the opportunity for short-term recovery** shows that as of December 2020, 71% of those patients discharged to residential care were discharged directly from the acute setting. This measure reflects the Prof. John Bolton view that ideally no one (0%) should be admitted directly from a hospital bed to permanent residential/nursing care.

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)

11.1

per **100 discharges from hospital** were re-admitted within 28 days

(Q3 - 2020/21)

-ve trend over 4 Qtrs
Worse than Scotland (10.8 – Q3 2020/21)
Worse than target (10.5)

END OF LIFE CARE

89.7%

of **people's last 6 months** was spend at home or in a community setting

(Q4 – 2020/21)

+ve trend over 4 Qtrs
Worse than Scotland (90.5% - 2020/21)
Better than target (87.5%)

CARERS SUPPORT PLANS COMPLETED

68%

of **carer support plans offered** that have been **taken up and completed completed** in the **last quarter**

(Q4 - 2020/21)

+ve trend over 4 Qtrs
Better than target (40%)

SUPPORT FOR CARERS: change between baseline assessment and review. Improvements in self- assessment

- **Health and well-being**
- **Managing the caring role**
- **Feeling valued**
- **Planning for the future**
- **Finance & benefits**

(Q4 - 2020/21)

+ve impact
No Scotland comparison
No local target

THE PROPORTION OF PEOPLE WHO REQUIRE LONG-TERM CARE AFTER A PERIOD OF SHORT-TERM REABLEMENT/REHABILITATION

17%

(Dec 2020)

-ve trend over 4 periods
Worse than target (25%)

THE PROPORTION OF OLDER PEOPLE WHO RECEIVE A PERIOD OF DOMICILIARY CARE BEFORE ENTERING RESIDENTIAL CARE

71%

(Dec 2020)

-ve trend over 4 periods
Worse than target (>80%)

Summary:

The quarterly rate of **emergency readmissions within 28 days of discharge** peaked at Q1 at 13.4%, but has reduced to 11.1% as of Q3 – this is an improvement, however the latest result remains worse than target and worse than the Scotland average. The latest available data for **end of life care** remains encouraging with approx. 90% of people supported to spend their last 6 months of life at home or in a community setting. The latest available data for **Carers** continues to show that positive results in regard to completed Carer Support Plans and outcome measures. However it is clear that the pandemic has placed extra pressure on carers for an extended period of time and that these positive results could quickly change if sufficient support for carers, through the HSCP, is not in place. The **proportion of people who require long-term care after a period of short-term reablement/rehabilitation** (December 2020) is 17%, which, whilst off-target, is encouraging and hints towards the benefits of short-term rehabilitation/ reablement. The result for the **proportion of older people who receive a period of domiciliary care before entering residential care** (71%), is less than target but is still encouragingly high.

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. 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 – Q4 2020/21	▲	There has been a general decrease in volume of emergency admissions. Over the period, the Partnership has performed better than the Scotland average for the majority of the time.
Rate of emergency admissions, Scottish Borders Residents age 75+	Q1 2016/17 – Q3 2020/21	▲	
Number of A&E Attendances per 1,000 population	Q1 2016/17 – Q4 2020-21	▲	The long-term indicates a reduction in 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 – Q4 2020/21	▲	A reducing percentage of total budget is attributed to emergency hospital stays. The Partnership consistently performs better than the Scotland average.
Percentage of A&E patients seen within 4 hours	Apr 16 – Mar 21	▲	Over the entire period, the percentage of A&E patients seen within 4 hrs has improved. However, the 2020/21 performance of 85.6% needs to improve.
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	Q1 2016/17 – Q3 2020/21	▲	The occupied bed day (OBD) rate has reduced slightly over the long-term.
Numbers of Delayed Discharges over 72 hours ("snapshot")	Apr 16 – Mar 21	▼	Delayed discharge performance has decreased slightly over the long term.
Bed days associated with delayed discharges in residents aged 75+, per 1,000 population	Q1 2016/17 – Q4 2020/21	▲	Over the period the number of bed days associated with delayed discharge has reduced.
Emergency readmissions within 28 days of discharge from Hospital (all ages)	Q1 2016/17 – Q4 2020/21	▼	The rate of emergency readmissions has increased. One of the desired outcomes of increased Locality working is prevention, including a reduction in emergency readmissions.
% of last 6 months of life spent at home or in a community setting	Q1 2016/17 – Q4 2020/21	▲	The percentage of people able to spend their last 6 months of life at home or in a community setting has increased recently and also shows improved performance over the longer term.
Support for Carers	Q1 2017/18 – Q4 2020/21	▲	The majority of unpaid carer Support Plans offered are subsequently completed.

Based on the range of measures above, The Partnership can demonstrate overall improved performance since HSCP inception in 2016. However, work must continue to drive performance improvement.

Core suite of National indicators

The table below shows a summary of 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%	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%	▲	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%	70%	▼	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%	70%	▼	74%
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	83%	85%	▲	80%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	89%	88%	82%	▼	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%	▼	80%
NI - 8	Total combined % carers who feel supported to continue in their caring role	41%	36%	32%	▼	37%
NI - 9	Percentage of adults supported at home who agreed they felt safe	81%	86%	81%	▲	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 2019/20
This national survey is run every two years. The Health and Care Experience survey for 2019/20 was published by the Scottish Government on 15 October 2020.

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
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21		
NI - 11	Premature mortality rate per 100,000 persons	322	391	340	324	388	315	-	▼	426
NI - 12	Emergency admission rate (per 100,000 population)	14,001	14,833	13,135	12,383	12,426	12,458	10,071	▼	10,779
NI - 13	Emergency bed day rate (per 100,000 population)	135,029	135,124	130,816	134,563	132,492	120,372	98,649	▼	95,155
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	105	107	102	105	109	109	114	▲	116
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	85.6%	85.6%	85.6%	86.9%	85.6%	85.9%	89.7%	▲	90.5%
NI - 16	Falls rate per 1,000 population aged 65+	20.8	20.9	21.0	22.3	18.7	22.1	18.2	▼	21.5
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	74%	75%	75%	81%	79%	86%	90%	▲	83%
NI - 18	Percentage of adults with intensive care needs receiving care at home	65% (2014)	64%	64%	62%	62%	64%	-	▼	63% (2019)
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	628	522	647	855	761	676	601	▲	488
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%	17%	▼	20%
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	-	-	-	-	-	-	-	-	-
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	-	-	-	-	-	-	-	-	-
NI - 23	Expenditure on end of life care, cost in last 6 months per death	-	-	-	-	-	-	-	-	-

*SCOTLAND figure is latest full year available (2020/21 or 2019 calendar year where Financial Year not available)
Source: ISD Core Suite Indicator Updates

MSG measures

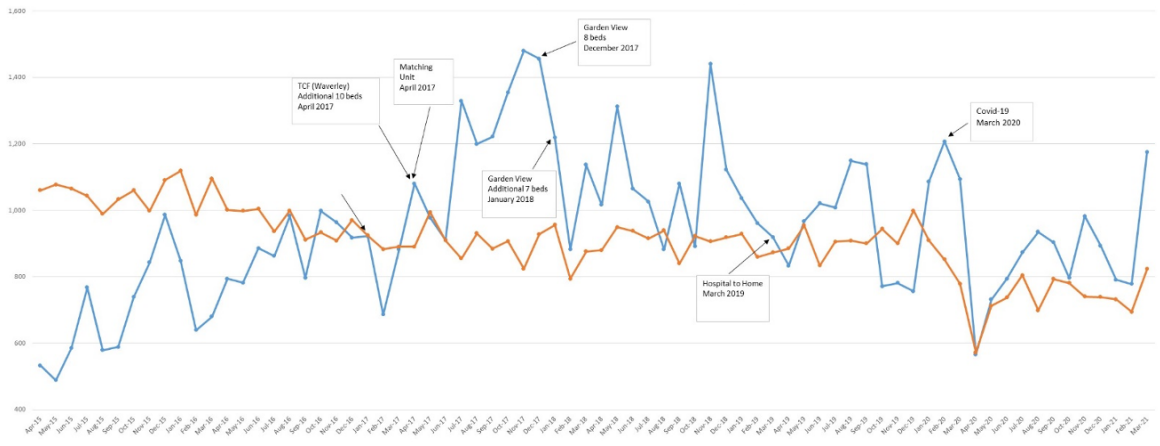
A summary of the Ministerial Strategy Group (MSG) measures we use are shown below. Additional detail is shown in Appendix 2.

BORDERS MSG 2020/21 TARGETS

MSG MEASURE		20/21 TARGET	19/20 ACTUALS												
			Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	**Tot (Est.)**
1	Emergency Admissions (18+)	10,064	572	712	737	804	699	793	781	740	739	732	694	823	**8,826** -12% ahead of target
2.1	Unplanned bed days (Acute 18+)	71,777	3,369	4,056	4,206	4,780	4,786	4,832	5,190	5,162	5,441	6,209	5,478	4,735	**58,244** -19% ahead of target
2.2	Unplanned bed days (Mental Health 18+)	15,707	-	-	2,825	-	-	3,252	-	-	3,117	-	-	2,600	**11,794** -25% ahead of target
2.3	Unplanned bed days (Geriatric 18+)	30,550	-	-	6,033	-	-	6,888	-	-	6,696	-	-	3,672	**23,289** -24% ahead of target
3	A&E Attendances (18+)	23,662	1,366	1,699	1,891	2,079	2,036	2,017	1,857	1,831	1,787	1,779	1,594	1,852	**21,788** -8% ahead of target
4	Delayed Discharge (All reasons, 18+)	9,972	566	731	794	873	935	903	796	982	893	791	778	1,175	**10,217** 2% off target
5	% Last 6mths spent in Community	90.0%	-	-	-	-	-	-	-	-	-	-	-	-	**90.0%** 0% ahead of target
6	% >65 living at home	97.5%	-	-	-	-	-	-	-	-	-	-	-	-	**97.1%** 0% off target

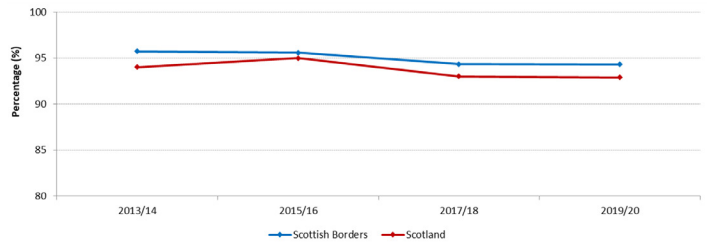
The graph below shows the delayed discharge (all reasons) in blue and emergency admissions (18+) in orange. Emergency admissions have been reducing. Delayed Discharge increased, levelled and has started to show a gradual decline.

DELAYED DISCHARGE - ALL REASONS (AGED 18+); EMERGENCY ADMISSIONS (AGED 18+) IN ORANGE



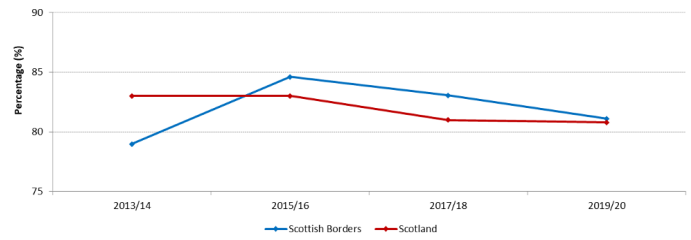
APPENDIX 1
CORE SUITE OF INDICATORS

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.

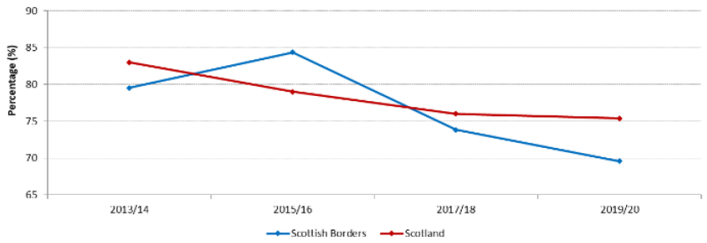
Source: Q52 - 2013/14 Health and Care Experience Survey, Q51 2015/16 Health and Care Experience Survey, Q40 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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 Implementation 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.

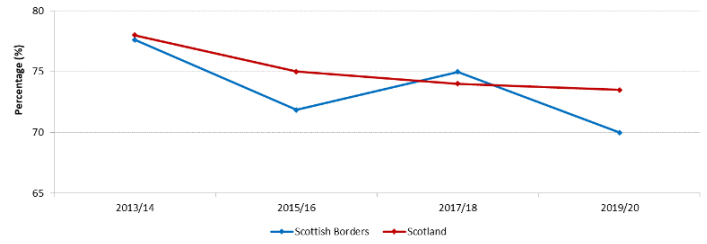
Source: Q36f - 2013/14 Health and Care Experience Survey, Q36g 2015/16 Health and Care Experience Survey, Q27f 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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.

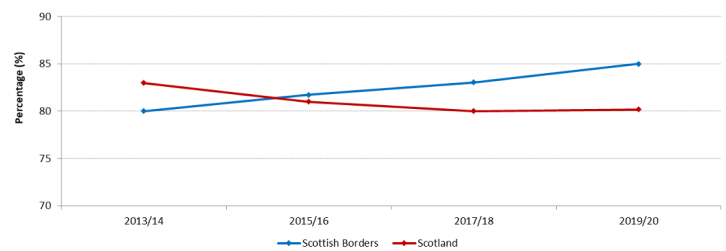
Source: Q36b - 2013/14 Health and Care Experience Survey, Q36b 2015/16 Health and Care Experience Survey, Q27b 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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.

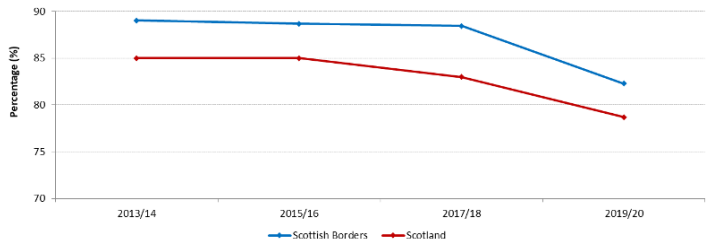
Source: Q36e - 2013/14 Health and Care Experience Survey, Q36f 2015/16 Health and Care Experience Survey, Q27g 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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.

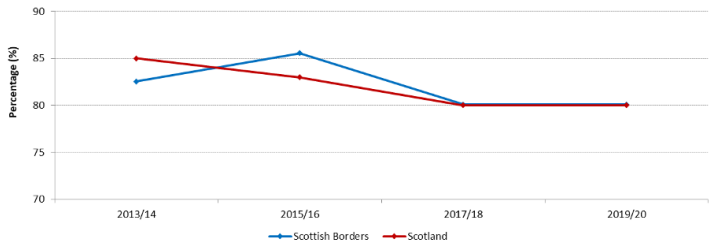
Source: Q37 - 2013/14 Health and Care Experience Survey, Q37 2015/16 Health and Care Experience Survey, Q28 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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.

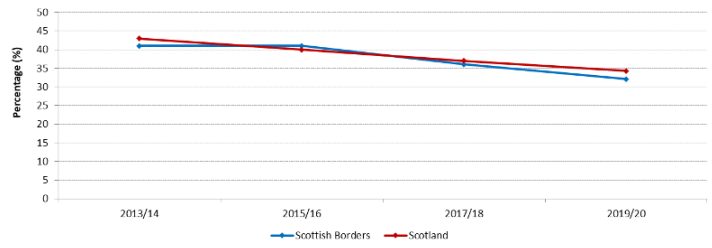
Source: Q27 - 2013/14 Health and Care Experience Survey, Q25 2015/16 Health and Care Experience Survey, Q8d 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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.

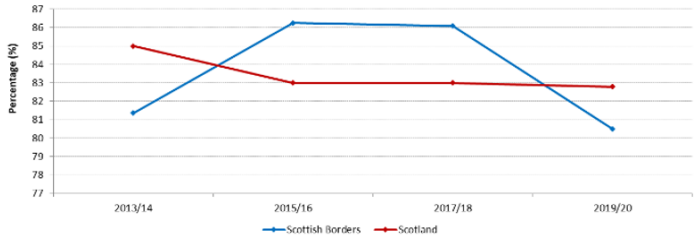
Source: Q36h - 2013/14 Health and Care Experience Survey, Q36i 2015/16 Health and Care Experience Survey, Q27h 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

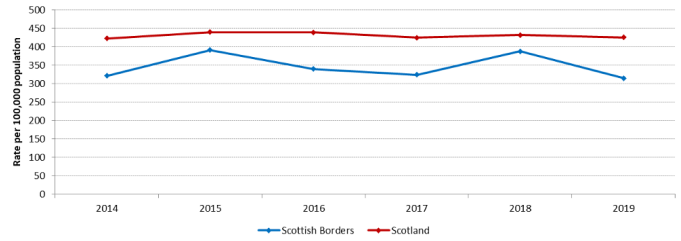
PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to seek the views of adults supported at home and to develop our locality model.

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. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

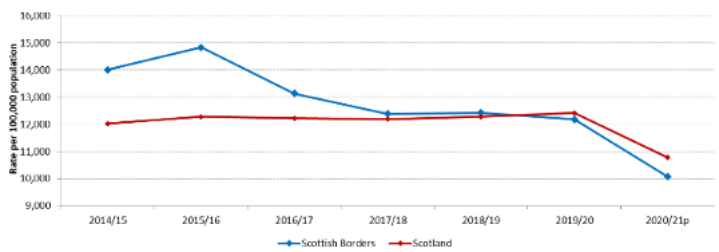
Indicator under development.

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.

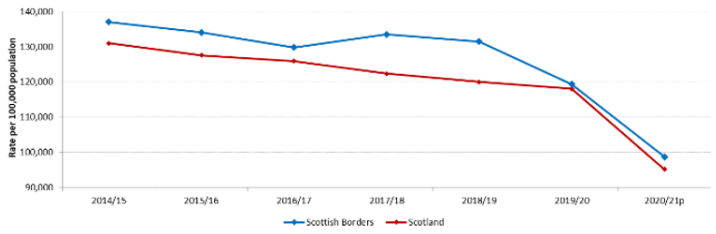
Source: National Records for Scotland (NRS)

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.

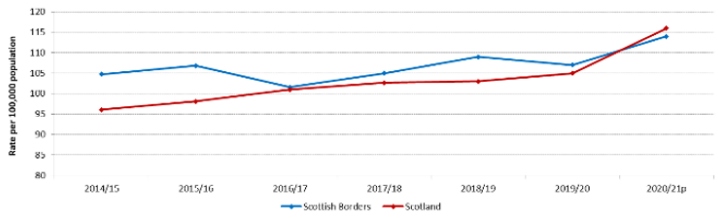
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland.

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.

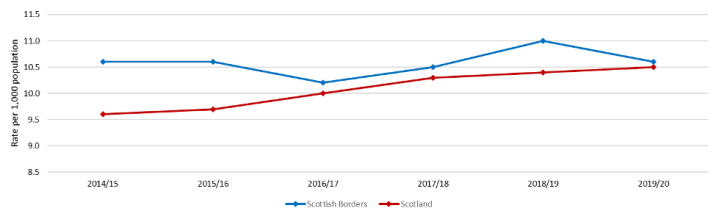
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland).

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.

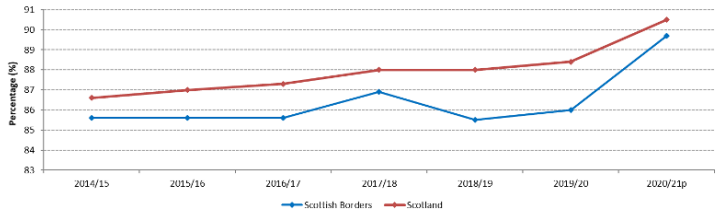
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges.

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.

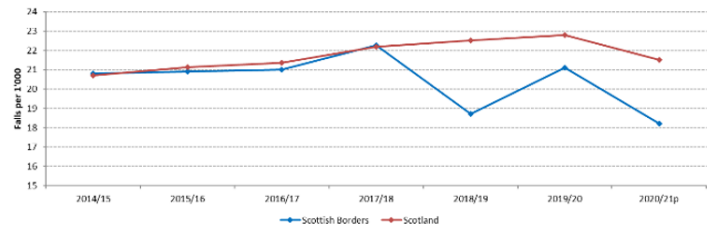
Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but also adding in Borders Community Hospital beds).

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.

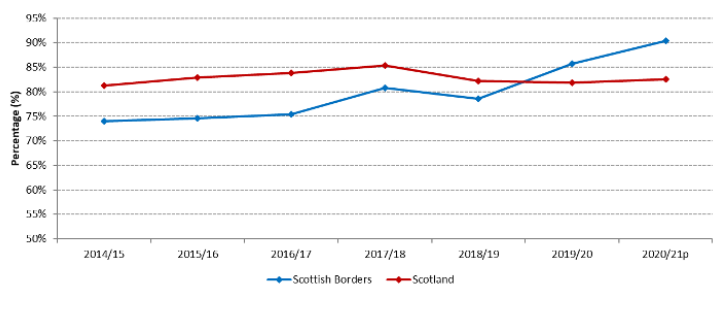
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland, National Records for Scotland.

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.

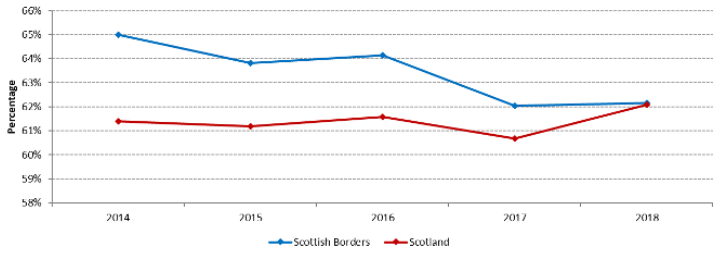
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges.

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.

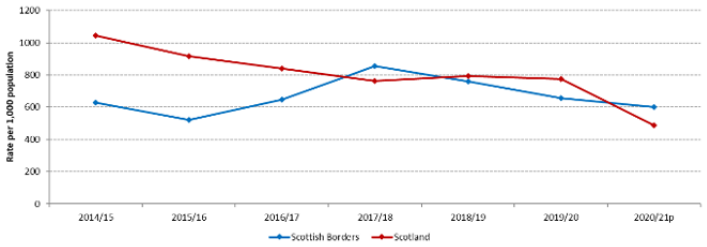
Source: Care Inspectorate

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.

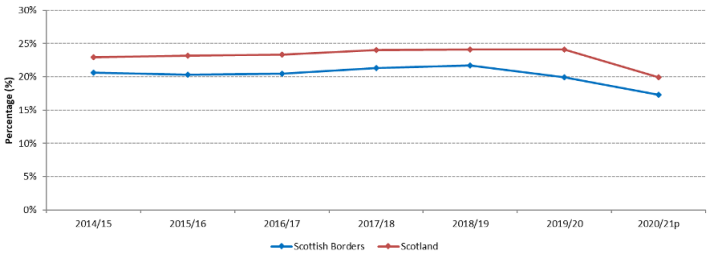
Source: Care Inspectorate

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: PHS Delayed Discharge data collection.

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

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

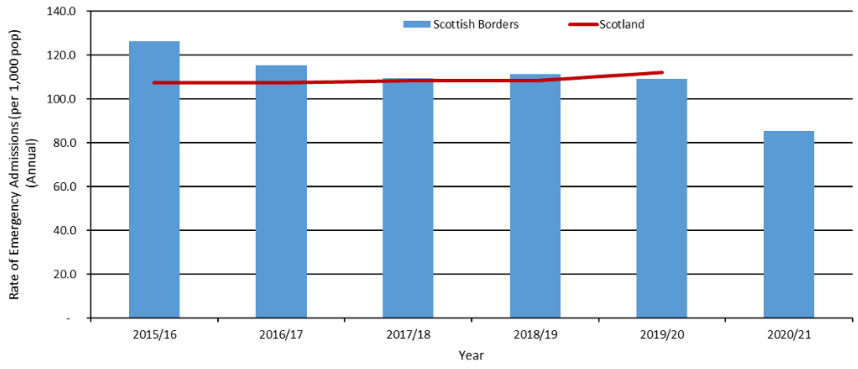
Indicator under development.

NI-23 Expenditure on end of life care

Indicator under development.

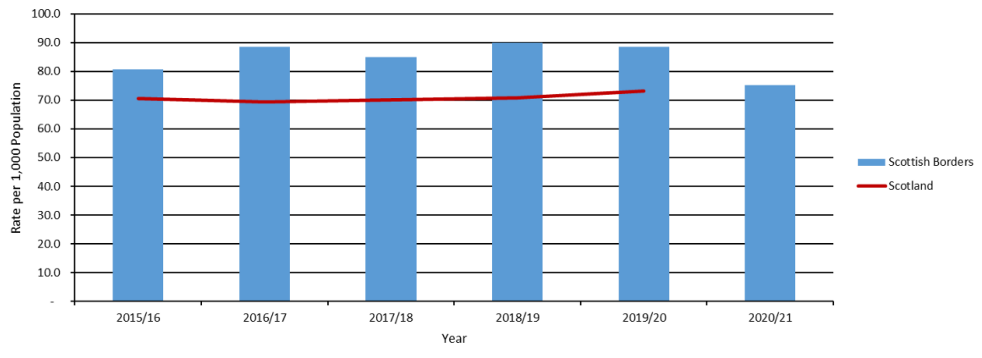
APPENDIX 2
MSG MEASURES

1a Number of emergency admissions (All Ages)

PERFORMANCE	BORDERS TREND
	▲

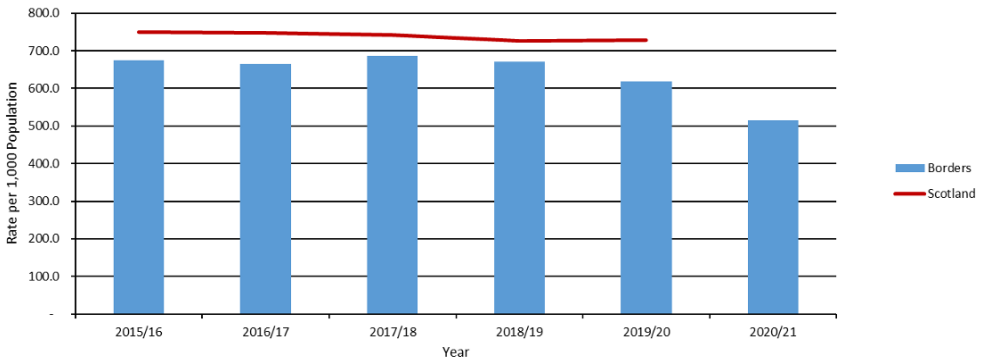
Source: SMR01, ISD

1b Admissions from A&E (All Ages)

PERFORMANCE	BORDERS TREND
	▼

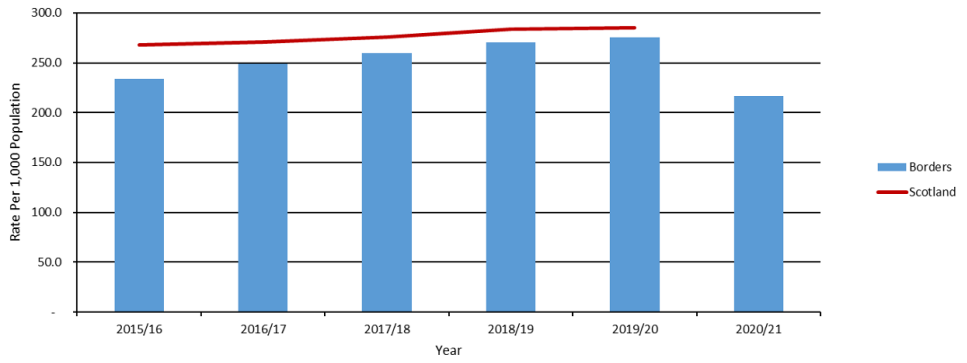
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▲

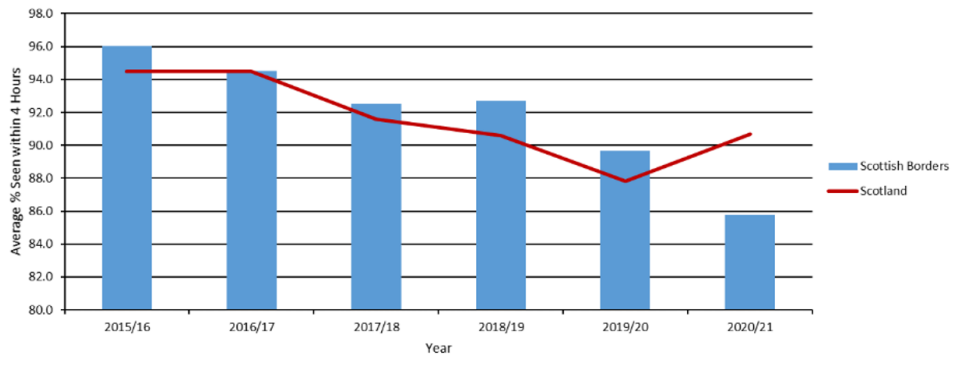
Source: SMR01, ISD

3a A&E attendances (All Ages)

PERFORMANCE	BORDERS TREND
	▼

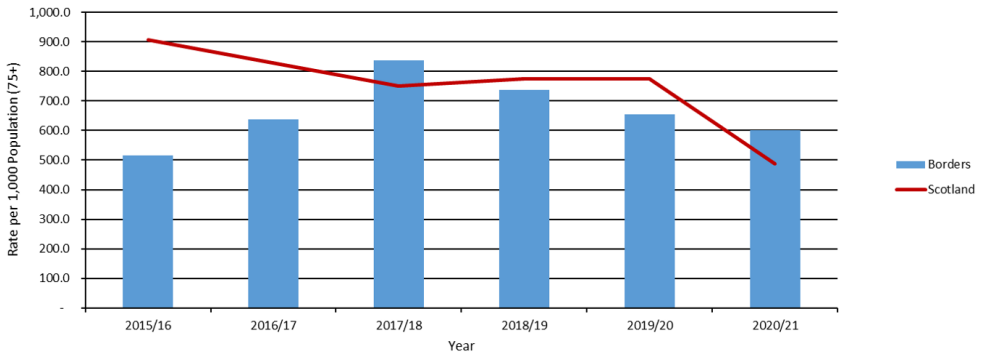
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▼

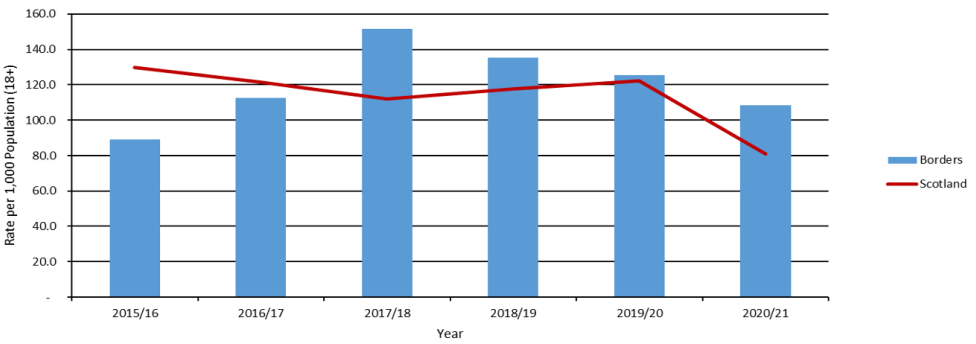
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▼

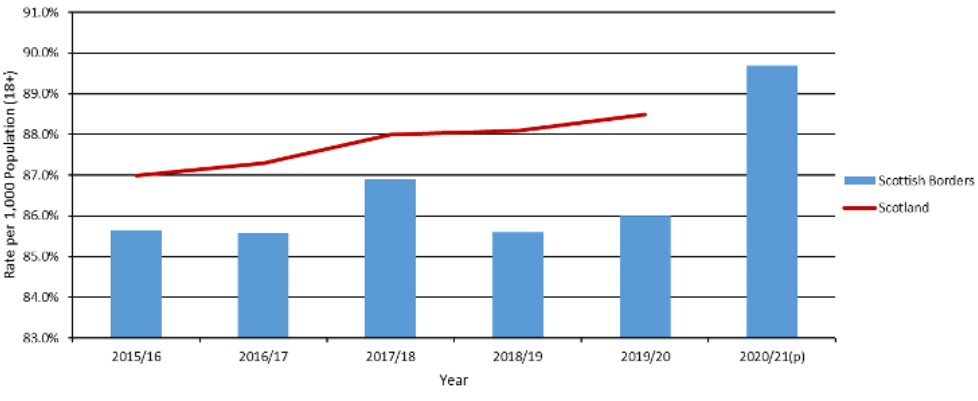
Source: Delayed Discharges, ISD

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

PERFORMANCE	BORDERS TREND
	▼

Source: Delayed Discharges, ISD

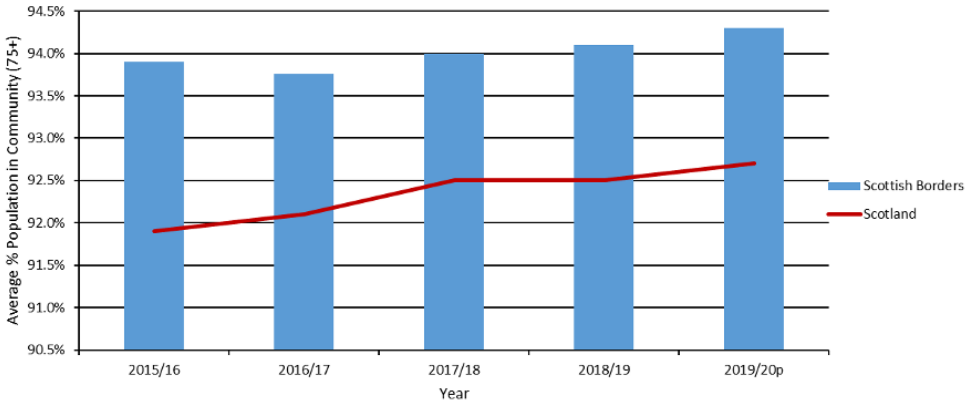
5 Percentage of last six months of life spent at Home or Community Setting

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

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