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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Wednesday, 26th May, 2021** at **10.00 am** in Via Teams

AGENDA

Time	No	Lead	Paper
10:00	**ANNOUNCEMENTS & APOLOGIES**		(Pages 3 - 60)
10:02	**DECLARATIONS OF INTEREST**		
10:05	**MINUTES OF PREVIOUS MEETING**		
10:10	**ACTION TRACKER**		
10:15	**FOR NOTING**		
	PCIP Funding		
	Older People's Pathway		
	Quarterly Performance Report		
	Monitoring of the Health & Social Care Partnership Budget		
11:55	**AOB**		
12:00	**DATE AND TIME OF NEXT MEETING - WEDNESDAY 28 JULY 2021 - 10 AM - 12 NOON**		

VIA TEAMS

Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Scottish Borders Health & Social Care Integration Joint Board** will be held on **26 May 2021** at **10am** via Microsoft Teams

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.02	**2**	**DECLARATIONS OF INTEREST** *Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.*	Chair	*Verbal*
10.05	**3**	**MINUTES OF PREVIOUS MEETING**		
		17.02.21 24.03.2021 Extra Ordinary	Chair	*Attached*
10.10	**4**	**MATTERS ARISING**		
	4.1	Action Tracker	Chair	*Attached*
10.15	**5**	**FOR NOTING**		
	5.1	PCIP Funding	Chief Officer	*Appendix-2021-9*
	5.2	Older People's Pathway	General Manager P&CS	*Appendix-2021-10*
	5.3	Quarterly Performance Report	Programme Manager	*Appendix-2021-11*
	5.4	Monitoring of the Health & Social Care Partnership Budget	Chief Financial Officer	*Appendix-2021-12 To Follow*
11.55	**6**	**ANY OTHER BUSINESS**	Chair	
12.00	**7**	**DATE AND TIME OF NEXT MEETING**	Chair	*Verbal*
		Wednesday 28 July 2021 10am to 12pm Microsoft Teams		

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 17 February 2021** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr J Greenwell
(v) Cllr S Haslam
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Ms S Lam, Non Executive
(v) Mr M Dickson, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mr T Taylor, Non Executive
Mr R McCulloch-Graham, Chief Officer
Dr K Buchan, GP
Dr L McCallum, Medical Director NHS
Mrs N Berry, Director of Nursing, Midwifery & Operations NHS
Mrs J Smith, Borders Care Voice
Mrs Morag Low, User Rep
Ms Lynn Gallacher, Borders Carers Centre
Ms Linda Jackson, Borders Carers Centre
Ms V MacPherson, Partnership Representative NHS
Mr N Istephan, Chief Executive Eildon Housing

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Stacey, Internal Auditor
Mr Ralph Roberts, Chief Executive NHS
Mr D Robertson, Chief Financial Officer SBC
Mr G McMurdo, Programme Manager SBC
Mr P Lunts, General Manager NHS
Dr Anne Hendry, Consultant
Mr Chris Myers, General Manager P&CS NHS
Mr Simon Burt, General Manager, MH&LD
Mr P McMenamin, Finance Business Partner NHS
Mrs Lucy O'Leary, Non Executive NHS
Mrs June Smyth, Director of Planning & Performance NHS
Ms J Holland, Chief Operating Officer SBCares
Mr Paul Williams, Associate Director of AHPs NHS
Ms S Bell, Communications Manager SBC
Mrs L Lang, Communications Officer NHS
Mr A McGilvray (Press)

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Mr Stuart Easingwood, Chief Social Work and Public Protection Officer, Mr Andrew Bone, Director of Finance, NHS Borders, and Mr David Bell, Staff Officer, Scottish Borders Council.

The Chair welcomed Ms Linda Jackson from the LGBTPlus Group to her first meeting of the Board as a non-voting member.

The Chair confirmed the meeting was quorate.

The Chair welcomed guest speakers and members of the press to the meeting.

2. DECLARATIONS OF INTEREST

The Chair sought any verbal declarations of interest pertaining to items on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 16 December 2020 were approved.

4. MATTERS ARISING

4.1 Minute 12: Borders Primary Care Improvement Plan: Dr Kevin Buchan confirmed that work on the Health Inequalities Impact Analysis (HIIA) had commenced and he would bring back an update to a future meeting.

4.2 Minutes 11: Quarterly Performance Report: Ms Linda Gallacher clarified that in regard to the issue raised by Jenny Smith at the last meeting, the reason that the Borders Carers Centre still made a difference was because it had been able to operate seamlessly throughout the pandemic. In January there had been a 40% increase in carers plans for that month so the Carers Centre were still acting to their full extent as well as carers.

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

5. STRATEGIC PLANNING GROUP REVISED TERMS OF REFERENCE

Mr Rob McCulloch-Graham commented that there had just been 2 additional people added to the Group membership, who were Ms Wendy Henderson of Scottish Care and Mr Alastair McLean, Vice Chair of a new group to represent Independent Care Providers.

Mrs Karen Hamilton enquired if there were any outliers not signing up to the Independent Care Providers group. Mr McCulloch-Graham advised that at the onset of the pandemic weekly meetings had been arranged with Independent Sector Care Homes and Care at Home Private Providers. Those meetings now took place on a monthly basis and would be maintained as they covered a variety of issues and were a valuable strategic level resource.

Ms Linda Jackson enquired if there were any guidelines on how groups could receive feedback from consultations. Mr McCulloch-Graham advised that the consultation process that had been previously used had been revised and a different approach was being adopted in regard to engagement, via MS Teams, local media and locality meetings. The first

engagement session would be a live debate with the Integration Joint Board (IJB) leadership team via MS Teams to answer any questions raised by the public. The first session would focus on the strategic plan and public expectations of the Derek Feeley report.

Mr Tris Taylor suggested it was an opportunity to revise engagement with the local population and third sector. He suggested if the IJB was being an effective Board it ought to note that it didn't appear to have a coherent approach to engagement that would operate to the satisfaction of the community and suggested some actions be formulated and taken forward.

Mr McCulloch-Graham accepted Mr Taylor's suggestion and commented that lessons had been learnt from previous engagement attempts and the new approach via MS Teams would be exercised and reviewed and feed into a more meaningful formal strategy on engagement.

Mr Taylor suggested there should be quantitative targets set on what was expected in regard to engagement activity as it was important to show the population and third sector that the IJB was delivering change to its plans as a consequence of being guided by and listening to its communities. He suggested the engagement strategy come back to the IJB for review and that it should contain quantitative targets and measures.

Mrs Lynn Gallacher echoed Mr Taylor's comments and suggested it looked likely that the majority of the Feeley report recommendations would be accepted. She suggested it would underpin what the IJB should be working towards and whatever way the new social care agenda was driven the third sector, carers and service users should all be at the heart of it.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the revised Terms of Reference for the Strategic Planning Group with the 2 additions to the membership of Wendy Henderson and Alastair McLean.

6. HEALTH & SOCIAL CARE PARTNERSHIP STRATEGIC COMMISSIONING PLAN

Mr Rob McCulloch-Graham introduced the report and Mr Graeme McMurdo provided an indepth analysis of the content of the report picking up on the previous discussion on timing and effects of the pandemic. He specifically highlighted sections 1.1, 1.2, 1.4, 1.6, 1.7 and referred to the need to review the content of the Feeley report.

Mr Nile Istephan commented that he saw the logic in what was suggested and enquired if there were any thoughts about the impact and implications of a delay and whether it would be a one year hiatus or other commissioning decisions needed to happen in the interim. Mr McCulloch-Graham commented that the Strategic Plan although it would be out of date, still provided direction and vision, it would be missing the detailed commissioning plan. He assured the Board that there were aspects of commissioning that would continue in the next financial year and the work on levels of care and acute bed numbers would continue. As the Scottish Government considered the Feeley Report recommendations, potentially structures and lines of accountability could change. It would be preferable to take cognisance of what might change to ensure there was a clear picture on what to engage on.

Mr Tris Taylor enquired if there was any risk in terms of legislative requirements by not doing the refresh. He further suggested the Board should be clear on the reason for a deferral not just because of policy change nationally, but about the adequacy of engagement and

consultation due to capacity during a pandemic and whether the Board was content with the risks posed by that suggestion. Whilst he was open to deferral he commented that it was important that the Board be absolutely clear on what basis the deferral was being sought. Mr McCulloch-Graham reminded the Board of the restructure of the management function paper shared with the Board in December 2020. He commented that the restructure had not yet been completed and it was that capacity in the restructure that was missing to enable good engagement and consultation to take place

Ms Sonya Lam agreed with the deferral and was keen that the Board had early sight of the plan from now into the next year along with a projection of activity. Mr McCulloch-Graham agreed to provide that documentation.

Cllr John Greenwell commented that in section 1.8 it highlighted the risk of a delay and he suggested a full account of the risks in delaying would have been helpful in the discussion.

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.

7. MONITORING AND FORECAST OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET 2020/21 AT 31 DECEMBER 2020

Mr David Robertson provided an overview of the Finance report and highlighted the projected breakeven position at month 9 after accounting for additional resources provided by central government associated with the pandemic and the large hospital budget. He commented that the pandemic had impacted significantly on the proposed change programme and associated savings for both the NHS and Local Authority. Additional costs were being reported to the Scottish Government on a regular basis through remobilisation plans. He further highlighted sections 6.6 and 3.7 of the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the projected breakeven position for the Partnership for the year to 31 March 2021 based on available information

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast position now includes additional Scottish Government funding allocations for 2020/21

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the position includes additional funding vired to the Health and Social Care Partnership during the first 9 months by Scottish Borders Council in order to meet previously reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that any adverse movement in projected outturn position between now and the end of the financial year

resulting in expenditure in excess of delegated budgets in 2020/21 will require to be funded by additional contributions from the partners in line with the approved Scheme of Integration.

8. FORMATIVE EVALUATION OF THE DISCHARGE PROGRAMME

Mr Philip Lunts provided a presentation on the formative evaluation of the discharge programme. During the presentation he highlighted several key elements including: local and national strategic fit; bed base; discharge to assess pathway; Waverley; Garden View; Home First; cost; and commissioning for best value.

Dr Anne Hendry spoke of the services that had been established as non-recurring funded projects and the need to bring them together.

Mr Malcolm Dickson welcomed the report and reminded the Board that although good progress had been made, the starting position had been a high point. He enquired if sometimes in the intermediate care areas there may be some risk averse behaviour leading to the over prescribing of care. Mr Lunts commented that the main issue had been in regard to occupancy around Waverly and Garden View and an analysis was yet to be completed. Services were designed on what was thought to be required and then a review would be undertaken of usage and a refinement of services would be pursued. It was suggested that both facilities would fit into Garden View at its fullest extent, however more work was required to be done to see if that was correct.

Cllr Shona Haslam welcomed the evaluation report and commented that it provided all of the information required to be able to make a decision. As the data was available and it was clear that progress had been made, it was now time for the knitting together of services as described by Dr Hendry.

Ms Sonya Lam sought clarification in terms of mainstreaming as there was more work to do on strategic design and commissioning. Mr Lunts advised that in terms of mainstreaming there were 3 key elements, a full needs assessment, determination of need, and current service provision.

Mr Nile Istephan declared an interest in the item, in that Eildon Housing owned an interest in Garden View and also managed the Borders Care and Repair Service.

Mr Istephan commented that he was intrigued by the move away from a bed based model and suggested that in order to do that Home First, packages of care and physical home environment adaptions would be a key driver. He suggested there would be additional work to be done on physical adaptations, packages of care and pathways to get people home quickly and safely.

Mr Lunts agreed it was a valid point and the commissioning of pathways and the services within those would need to be clarified.

Mrs Karen Hamilton welcomed the report and suggested there could be a tension created between the provision of services provided by the Community Hospitals, Waverley and Garden View. She further commented that she was concerned about the possibility of

localisation and the referral process being conditional on looking at where a patient would wish to go as opposed to referring them to the right place for the services they required.

Mr Lunts commented that Community Hospitals had not been included in the evaluation and recognised the validity of the point that had been made. The pathway for people outwith central Borders to Community Hospitals did not intimate that people would receive the same care. He suggested if the role of bed based community care was defined through Waverley and Garden View then that model would need to be tested in different locations and the community hospitals would be a part of that testing.

Dr Hendry commented that testing that model would highlight what was lacking in central Borders by it not having a Community Hospital. She further commented that the strategic plan to engage with localities about available assets and population health needs would provide a platform for redesign.

Cllr Tom Weatherston supported the paper and agreed that the direction of travel as set out should be progressed.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the findings of the Discharge Programme Evaluation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and agreed the 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 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. A further report will be provided for the IJB within the first quarter of the year, setting out recommendations for the way in which these budgets will be mainstreamed. Any resource implications arising from changes to staff contracts as a result of this proposal will be addressed through review of IJB budget as required.

Critical to delivering these actions is the need to mainstream the operation and funding of these services to allow the strategic developments outlined in the recommendations.

9. INDEPENDENT REVIEW OF ADULT SOCIAL CARE IN SCOTLAND REPORT

Mr Rob McCulloch-Graham provided a presentation on the Independent Review of Adult Social Care in Scotland Report

Cllr Shona Haslam commented that COSLA had discussed the report and were unanimous in welcoming the focus on carers, unpaid carers, additional monies and the human rights approach. They also had concerns in regard to the removal of accountability and the creation of a structure to divert funds away from frontline services to create a national care service. The report had been debated in the Scottish Parliament the previous day and it remained unclear which elements of the report might be accepted.

Mr Ralph Roberts thanked Cllr Haslam for providing the COSLA position on the report and he commented that NHS Scotland Health Board Chief Executives had also discussed the report and sent in comments to the Scottish Government. Health Board Chief Executives had been keen to tease out some of the understanding better and the reasons for the recommendations did appear to be clear. Like COSLA the Health Board Chief Executives also welcomed the focus on carers and the human rights approach and were concerned about the structural elements.

Mr Malcolm Dickson welcomed the feedback from Cllr Haslam and Mr Roberts and commented that he had reservations about the centralisation of something that needed to be as local as possible for people. Whilst there were huge advantages in centralisation, local people still needed some kind of democratic control over budgets and policies.

Mrs Karen Hamilton commented that it was a large and far reaching report that was aspirational. The NHS Scotland Health Board Chairs had also read the report and made representations to the Scottish Government. Reading through the report one of her observations had been the criticism of eligibility criteria and how people were admitted and discharged from services and that had seemed to have been glossed over. She suggested there would be a need to bring together all agencies and the IJB to discuss views and share ideas to work out what would work best for the people of the Borders.

The Chair commented that there were a number of unknowns in regard to the content of the report and the suggestion of a focused session or workshop on the report would be worthwhile. He suggested it was likely to be the summer before more clarity was known on how much of the report was likely to be accepted a workshop at that point would be helpful.

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

8. SHARED LIVES UPDATE

Mr Rob McCulloch-Graham provided an overview of the content of the report. He commented that there were 6 families approved for shared lives arrangements. The care arrangements were expensive however they focused on continuing existing relationships as individuals transitioned from foster care into adulthood.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress to date with regards to the set up of the new service and noted that the first Shared Lives Carers were approved at panel.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Health and Social Care Leadership team would be asked to determine the demand for Shared Lives for other client groups in years 4-5 and indicate priorities to enable planning to begin in year 3.

8. STRATEGIC PLANNING GROUP MINUTES

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

9. CATEGORY 1 RESPONDER

Mr Rob McCulloch-Graham provided background to the item by explaining that some partnerships had felt excluded from COVID-19 Pandemic Committees (Gold Command structures) and he emphasised that he had always been included in the Borders gold command structures.

Mrs Karen Hamilton enquired what the status actually meant for the IJB given it did not directly deliver any services.

Mr Ralph Roberts commented that it was important for the IJB to be mindful that it was responsible for strategy and the operational delivery of services was through the Local Authority and NHS Board under the partnership umbrella. The point in the IJB becoming a category 1 responder was as part of its' responsibility for commissioning and planning services that needed to be delivered and able to respond to incidents, in essence ensuring any commissioning decisions in the future considered the fact that those services may need to respond to an emergency incident and that was the point for the IJB to focus on.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the letter from the Cabinet Secretary for Health & Sport, dated January 2021, in regard to inclusion as a category 1 responder

10. ANY OTHER BUSINESS

Remobilisation Plan Update: Mr Ralph Roberts provided an update to the Board on the status of the draft Remobilisation Plan. He commented that the draft would be shared with the IJB and feedback on the content would be welcomed. In terms of development he advised that the draft remobilisation plan was being produced through the remobilisation planning group which involved members of the health and social care partnership and elements of it would require contributions from the Chief Officer.

Mr Roberts advised that it would be effectively a standstill report to describe where we were at a point in time and how we would remobilise for the following year as well as being an operational plan to decide what was required. The timeline for the plan was to have it finalised by the beginning of April 2021.

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

11. DATE AND TIME OF NEXT MEETING

The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 21 April 2021, from 10am to 12noon, via Microsoft Teams.

The meeting concluded at 12.11.

Signature: ……
Chair

Minutes of an Extra Ordinary meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 24 March 2021** at **10am** via Microsoft Teams

Present:
(v) Cllr D Parker (Chair)
(v) Cllr J Greenwell
(v) Cllr S Haslam
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Mrs K Hamilton, Non Executive
(v) Mr M Dickson, Non Executive
(v) Mr T Taylor, Non Executive
(v) Mr J McLaren, Non Executive
Mr R McCulloch-Graham, Chief Officer
Dr K Buchan, GP
Mrs N Berry, Director of Nursing, Midwifery & Operations NHS
Ms Lynn Gallacher, Borders Carers Centre
Ms Linda Jackson, Borders Carers Centre
Ms V MacPherson, Partnership Representative NHS
Mr N Istephan, Chief Executive Eildon Housing

In Attendance: Miss I Bishop, Board Secretary
Mr D Robertson, Chief Financial Officer SBC
Mr A Bone, Director of Finance, NHS
Mrs N Meadows, Chief Executive, SBC
Mrs Lucy O'Leary, Non Executive NHS
Ms J Holland, Chief Operating Officer SBCares
Ms S Bell, Communications Manager SBC
Mrs C Oliver, Head of Communications NHS

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Ms Sonya Lam, Non Executive, Mrs Morag Low, Service User Rep, Mrs Jenny Smith, Borders Care Voice, Dr Lynn McCallum, Medical Director and Mr Ralph Roberts, Chief Executive.

The Chair welcomed Mrs Netta Meadows, Chief Executive, Scottish Borders Council to the meeting.

The Chair confirmed the meeting was quorate.

2. DECLARATIONS OF INTEREST

The Chair sought any verbal declarations of interest pertaining to items on the agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. INTEGRATION JOINT BOARD 2021/22 FINANCIAL PLAN

Mr David Robertson provided an overview of the content of the report and highlighted that Scottish Borders Council had approved their budget resource to the Integration Joint Board (IJB) on 19 March 2021 and NHS Borders had approved an indicative level of resource to the IJB on 4 March 2021. He further explained the key aspects of the Scottish Government budget announcements and their implications for NHS Borders and Scottish Borders Council in regard to financial allocations to the IJB.

Mr Robertson commented that the impact of known and expected costs and pressures had been modelled across the partner's services to identify the level of funding the IJB required for 2021/22 to fully fund commissioned services. He then drew the attention of the Board to paragraph 4.2 which explained the financial implications of additional costs and pressures included in the plan and their comparison to the resources NHS Borders and Scottish Borders Council had provided for 2021/22.

Mr Robertson further drew the attention of the Board to section 5 Assumptions Underpinning Delivery of Financial Balance, and section 6 Risk, of the report.

Mrs Karen Hamilton thanked Mr Robertson for the comprehensive report and the description of the process followed. Mrs Hamilton enquired if the total funding transferred from the health portfolio to support health and social care integration of £883.6m in 2021/22 was a national figure. Mr Robertson confirmed that it was.

Mr John McLaren enquired in regard to the living wage if the IJB encountered local groups who were unable to be financially supported in terms of providing the living wage could the monies be diverted to those groups or if it was ring-fenced for Scottish Borders Council contracts.

Mr Robertson commented that Scottish Borders Council as a wage employer paid the living wage to all staff and the NHS were working towards that also. The Council encouraged all suppliers and contractors to also pay the living wage. The contribution of £34m to the continued delivery of the real living wage was primarily focused on the national care home contract.

Cllr John Greenwell enquired in regard to ring fenced reserves if the allocation of those reserves was done in collaboration by both sides. Mr Robertson confirmed that it was done in collaboration between himself, Andrew Bone and Rob McCulloch-Graham to ensure any usage was in line with the reason for the reserve. There was an expectation that a draw down of reserves would take place in support of both organisations.

Cllr Shona Haslam enquired how the judgement was made in terms of additional funding being required. Mr Robertson clarified that the process was set out in the Scheme of Integration and a recommendation would be brought to the Board to confirm that all reasonable steps had been taken to minimise any impact on the budget and seek approval should further monies be required.

Cllr Haslam enquired about the level of confidence in meeting savings targets. Mr Andrew Bone referred to Section 5 of the report and the description of how that worked in practice and the potential level of support required against the non delivery of savings. He advised that the

mechanism for the delivery of savings for the NHS Borders had been suspended over the last year due to the COVID-19 Pandemic. Work was being taken forward in order to identify a realistic level of savings to be delivered in year.

Cllr Haslam enquired about non recurring brokerage. Mr Bone advised that it was a combination of NHS monies and Scottish Government brokerage. A gap of £5.4m had been identified and discussions with the Scottish Government for support were ongoing.

Mr Malcolm Dickson enquired in regard to the reserves, what was already committed and how it would be used if there were slippages in the savings target. Mr Bone commented that in reality due to the uncertainty of expenditure in the current year, a final figure could not be put on what the reserve would be. However given the impact of COVID-19 he expected the figure to double. He further emphasised that those funds were all directed for investment programmes.

Mr Tris Taylor enquired about any unproductive antagonisms to achieving an agreeable financial position. Mr Robertson commented that there were encouraging signs this year that partners (IJB, NHS, SBC) were moving more effectively together on the construction of the budget and had a common understanding of the challenges faced in 2021/22. Mr Robertson commented that in terms of outcomes if funding was retained by SBC and NHS, in essence that funding would be delegated back to SBC and the NHS through direction from the IJB.

Mr Taylor enquired about the 1.5% transfer. Mr Robertson clarified that in regard to the 1.5%, it was a deminimous target set by the Scottish Government to ensure that monies were transferred to the IJB as a minimum amount. He was pleased to be able to report that the allocation to the IJB was in excess of the 1.5% prescribed.

Mr Rob McCulloch-Graham commented that this year had been completely different to previous experiences in formulating the financial plan. Due to the pandemic and different personalities he said he had found it refreshing to pull the financial plan together with Mr Andrew Bone and Mr David Robertson. In terms of culture the difficulties experienced in the past were no longer present. In terms of strategy he suggested the IJB was in an exciting position in looking at a joint strategy across Scottish Borders Council and NHS Borders with the IJB as the catalyst for that joint strategy.

Mrs Karen Hamilton echoed that the joint working over the past year had felt more integrated and congratulated Mr Robertson and Mr Bone for pulling together the financial plan in the absence of an IJB Chief Financial Officer.

Mrs Hamilton enquired if there was any update on the appointment of a Chief Financial Officer for the IJB. Mr McCulloch-Graham commented that appointments were being finalised following the restructure of the commissioning and strategy function.

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.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that in line with the scheme of integration any expenditure in excess of these delegated budgets in 2021/22 will

require to be funded by additional contributions from Partners provided all appropriate steps have been taken to deliver a balanced position.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that Partner bodies expect a financial impact from the work to address Covid-19. This paper assumes these costs will be separately identified and will not impact on the delegated function budgets.

4. ANY OTHER BUSINESS

There was none.

5. DATE AND TIME OF NEXT MEETING

The Chair confirmed that the next meeting of the Health & Social Care Integration Joint Board would be held on Wednesday 21 April 2021 at 10am to 12noon, via Microsoft Teams.

SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Scottish Borders Health and Social Care PARTNERSHIP

Meeting held 8 May 2019

Agenda Item: Primary Care Improvement Plan (April 2019-March 2020)

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
8	7	Future development session to be led by service users and primary care leads in regard to long term conditions.	Rob McCulloch-Graham	TBA	In light of Covid-19, it was suggested that this session is delayed until safe to do so. **23.09.20 Update:** Mr Rob McCulloch-Graham commented that with the use of MS Teams he was hopeful that plans to address the action would be secured in the next 8-10 weeks. **16.12.20: Update:** The current pressures on staff teams responding to C19 continue to prevent progress on this action.	R

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2	7	Evaluation report of new Primary Care Mental Health Service, funded through PCIP.	Rob McCulloch-Graham Kevin Buchan	August 2021	**In Progress**	G

Agenda Item: Strategic Implementation Plan & Priorities

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
3	11	Undertake a review of the Scheme of Integration.	Rob McCulloch-Graham Iris Bishop	March 2021	**23.09.20 Update:** Mrs Karen Hamilton enquired if the timescale for Action 3 was for the review to have been completed by the end of March 20201. Mr McCulloch-Graham confirmed that it was. **09.10.20: Update:** An initial review of the scheme is currently being taken forward and a timeline for completion is being worked up. **16.12.20: Update:** We intend to undertake a number of development sessions/workshops with board members and other stakeholders regarding the review of the Strategic Commissioning Plan. This work will inform any required amendments to the scheme of integration. The date for changes to the scheme will need to be determined after the review of the plan.	G

Meeting held 16 December 2020

Agenda Item: Quarterly Performance Report, November 2020

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
4	11	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that Cllr David Parker, Rob McCulloch-Graham and Graeme McMurdo would discuss the format of the performance report outwith the meeting.	Rob McCulloch-Graham Graeme McMurdo	April 2021	**In Progress:** The content, the purpose and the effectiveness of the current performance reporting in enabling IJB to direct corrective action requires discussion. Meetings to be arranged.	A

KEY:	
R	Overdue / timescale TBA
A	<2 weeks to timescale
G	>2 weeks to timescale

Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and GP sub-committees to monitor progress of primary care reform across their localities, and in line with service transfer as set out within the Memorandum of Understanding.

The **MoU Progress tab** should be used through local discussions between Integration Authorities and GP sub-committee to agree on progress against the six MoU priority services as well as that the barriers that areas are facing to full delivery. Integration Authorities should provide information on the number of practices in their area which have no/partial/full access to each service. The sum of these should equal the total number of practices in each area. Please only include numbers (or a zero) in these cells; comments boxes have been provided to supply further information.

If you are funding staff through different funding streams, for example, mental health workers through Action 15 funding, please include this information in the relevant section so we are aware that you are taking steps to recruit staff in this area.

The **Workforce and Funding Profile tab** should allow Integration Authorities to consider financial and workforce planning required to deliver primary care improvement, and reassure GP sub-committee of progress.

For the workforce numbers and projections, we are limiting our questions to WTE numbers, but are also asking you to provide headcounts for community links workers so that we can monitor progress towards the commitment to 250 additional CLWs.

If you are funding staff through different funding streams, for example, recruiting mental health workers in Action 15, do not record these in Table 1. However, they should be included in Tables 2 and 3 to inform workforce planning.

We have included new rows this time at the foot of Tables 1 and 3 (shaded in red). Please include here your estimate of total required spend (Table 1), and total required staff (Table 3) in order to reach full delivery across each of the services.

We would also ask that this local implementation tracker be updated and shared with Scottish Government by **31st May 2021.**

Covid PCIP 4

Health Board Area:	
Health & Social Care Partnership:	
Total number of practices:	

MOU PRIORITIES

2.1 Pharmacotherapy	**Practices with no access by 31/3/21**
Practices with NO Pharmacotherapy service in place	
Practices with Pharmacotherapy level 1 service in place	
Practices with Pharmacotherapy level 2 service in place	
Practices with Pharmacotherapy level 3 service in place	

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this?

2.2 Community Treatment and Care Services	**Practices with no access by 31/3/21**
Practices with access to phlebotomy service	
Practices with access to management of minor injuries and dressings service	
Practices with access to ear syringing service	
Practices with access to suture removal service	
Practices with access to chronic disease monitoring and related data collection	
Practices with access to other services	

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this?

2.3 Vaccine Transformation Program	**Practices with no access by 31/3/21**
Pre School - Practices covered by service	
School age - Practices covered by service	
Out of Schedule - Practices covered by service	

Adult imms - Practices covered by service	
Adult flu - Practices covered by service	
Pregnancy - Practices covered by service	
Travel - Practices covered by service	

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this?

2.4 Urgent Care Services	**Practices with no access by 31/3/21**
Practices supported with Urgent Care Service	

What assumptions are you using to determine full delivery, and what specific barriers that you are facing to achieving this?

Additional professional services

2.5 Physiotherapy / MSK	**Practices with no access by 31/3/21**
Practices accessing APP	

comment / supporting information

2.6 Mental health workers (ref to Action 15 where appropriate)	**Practices with no access by 31/3/21**
Practices accessing MH workers / support through PCIF/Action 15	
Practices accessing MH workers / support through other funding streams	

What are the specific barriers to your practices receiving a full MH service? Please attach a copy of your Mental Health action plan if you hav

2.7 Community Links Workers	**Practices with no access by 31/3/21**
Practices accessing Link workers	

Comment / supporting information

2.8 Other locally agreed services (insert details)	**Practices with no access by 31/3/21**
Practices accessing service	
Comment / supporting information	

2.9 Issues FAO National Oversight Group
Please detail the impact of Covid on the PCIP process and where you are in that process. How has Covid impacted previous projected delivery

Funding and Workforce profile

Health Board Area:	
Health & Social Care Partnership:	

Table 1: Spending profile 2018 - 2022 (£s)

Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend			339167			
2019-20 actual spend			308574			
2020-21 actual spend			206541	54000	105000	12000
2021-22 planned spend						
Total planned spend	0	0	854282	54000	105000	12000
Total spend required for full delivery	588000	147330	259000	14800	986111	786445

Table 2: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 6: Community link
TOTAL headcount staff in post as at 31 March 2018	
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	5

INCREASE in staff headcount (1 April 2020 - 31 March 2021)	0
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	0
TOTAL headcount staff in post by 31 March 2022	5

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 3: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and			Service 4: Urg
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs
TOTAL staff WTE in post as at 31 March 2018	2.3	1.4	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	3.0	0.2	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	3.4	4.2	0.0	0.0	0.0	7.0
INCREASE in staff WTE (1 April 2020 - 31 March 2021)	1.0	7.2	2.3	0.0	0.0	7.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	0.0	0.0	0.0	0.0	0.0	2.0
TOTAL staff WTE in post by 31 March 2022	9.7	13.0	2.3	0.0	0.0	16.0
Total staff (WTE) required for full delivery		7.4	14.9	13.5	12.5	

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comment: The financial template reflects actual levels of spend as they relate to the profile of staff recruitment ie part year co
central team have been allocated to the services. Funding from Action 15 relates to the 2019-20 3.7wte stat under Mental Hea
the objectives detailed in the MoU. In terms of VTP the staff costs relate to direct salary costs of vaccinators for delivery of vac
Borders is through a central vaccination team staffed and delivered by NHS Borders, which has identified further costs relating
total spend required for full delivery and the associated wte are included under the additional funding required for full deliver

caveated as there is further work necessar to confirm a final agreed model for the delivery of PCIP CTAC.

Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
364560		177206		45089	4000
217521	23000	352271	16100	97350	4000
260400	29000	598213	46600		
842481	52000	1127690	62700	142439	8000
				172000	28000

gent Care (advanced practitioners)		Service 5: Additional professional roles			Service 6: Community link workers
Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
0.0	0.0	0.0	0.0	0.0	0.0
0.0	0.0	0.0	0.0	0.0	0.0
0.0	0.0	3.7	3.4	0.0	4.5
0.0	0.0	14.3	5.8	0.0	0.0
0.0	0.0	0.0	0.0	0.0	0.0
0.0	0.0	18.0	9.2	0.0	4.5
					6.3

osts in year and full year recurring costs the subsequent year. Non recurring funding to support the
alth workers. The total wte staff required for full delivery is the additional wte required to deliver all of
ccination services included under the MoU. A fully costed model to provide vaccination services in NHS
g to infrastructure and overhead costs to support VTP sevices for PCIP. These costs are included in the
y. Full costs are also included for the delivery of a proposed NHS Board CTAC service. These costs are

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 26 May 2021

Report By:	Chris Myers, General Manager, Primary and Community Services Brian Paris, Chief Officer, Adult Social Work and Care
Contact:	christopher.myers@borders.scot.nhs.uk brian.paris@scotborders.gov.uk
Telephone:	01896 826455 (Chris Myers)
OLDER PEOPLE'S PATHWAYS DELIVERY GROUP	
Purpose of Report:	To provide assurance to the Integrated Joint Board that the Older People's Pathway Delivery Group has updated its approach to ensure that the Formative Evaluation of the Discharge Programme recommendations are appropriately progressed
Recommendations:	The Health & Social Care Integration Joint Board is asked to: • Note the approach being taken to progress with the continued development of the Older People's Pathway following on from the approval of the 'Formative Evaluation of the Discharge Programme' at the IJB's February 2021 meeting.
Personnel:	n/a
Carers:	Community based responses including unpaid carers / third sector / other support for Older People's Pathways are included in the proposed scope for the Older People's Pathways. As a result, there will be engagement with this group and the Older People's Pathways Delivery Group will interface with the IJB's Carer's Workstream and Localities Operations Groups.
Equalities:	An EQIA has not yet been carried out, but will be developed as part as the programme progresses.
Financial:	By improving productivity, it is expected that this workstream will reduce overall future costs to the system and support improved sustainability in the delivery of older people's pathways.
Legal:	Considerations around the legal framework for discharges will be undertaken
Risk Implications:	No significant risks to note. The work on Older People's Pathways should reduce financial and workforce risks over the long term.

Situation

The work of the Older People's Pathways Delivery Group has been underway since 2019. The Delivery Group is one of ten Strategic Implementation Plan workstreams and reports into the Strategic Implementation Plan Programme Board.

Now that the Formative Evaluation of the Discharge Programme has been endorsed by the Integrated Joint Board, the Older People's Pathway has been working to refine its approach to ensure that the recommendations are enacted. This report aims to provide the Integrated Joint Board with assurance that this work is underway, and outlines the developing approach and scope of the group.

Background

The Older People's Pathway oversaw the development of the Discharge Programme services: Waverley, Garden View, Home First, Strata and Matching Unit, and worked to implement recommendations from:

- The Prof. Bolton and previous Prof. Hendry review recommendations[1&2]
- The DOCA+ audit results[3]
- The Institute for Public Care 'Commissioning out of hospital care services to reduce delays' report published in March 2020[4]
- The quadruple aim of healthcare[5]

The group have focused on the development of four Older People's Pathways; pathways 0-3, in line with the framework adopted across most of the UK, and summarised below.

In addition, the group has made good progress in implementing a number of new initiatives including the development of Trusted Assessment and Discharge to Recover then Assess in Home First (pathway 1).

[1] Bolton J, Report for Scottish Borders Council and Borders NHS on care pathways and delayed discharge, Feb 2017
[2] Hendry A, Review of the Clinical Model for Community Hospitals in Scottish Borders, Jan 2018
[3] DOCA+ - a point prevalence survey of all hospital patients on a fixed day in August 2018 undertaken by a team of senior professionals and clinicians to assess whether individual patients could be cared for out of hospital. The audit found that 46% of BGH and 68% on community hospital inpatients could have been cared for in a non-hospital setting with appropriate service support
[4] https://ipc.brookes.ac.uk/publications/commissioning-out-of-hospital-care-services-to-reduce-delays
[5] Bodenheimer T, Sinsky T, From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider, The Annals of Family Medicine November 2014, 12 (6) 573-576, https://www.annfammed.org/content/12/6/573.full

Assessment

Problem statement

The HSCP has identified the need to better coordinate and improve services for older people. The evidence base shows that if we coordinate the delivery of older people's health and social care services to better meet their needs, this will reduce ill health and hospitalisation. It is known that too many older people remain in hospital when they could be cared for more appropriately and achieve better outcomes in a more enabling setting.

Vision

Our vision is to 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.

Implementing the recommendations of the 'Formative Evaluation of Discharge Programme'

In February 2021, the IJB accepted the Formative Evaluation of Discharge Programme recommendations, summarised below:

- Develop a route map for intermediate care / nested locality models
- Review Home First and align to localities
- Consider development of locality Geriatric and Palliative Care expertise
- Core intermediate care / reablement dataset
- Enabling infrastructure: Strata, Integrated Discharge Hub, Trusted Assessment, more efficient allocation by Matching Unit and Locality Hubs
- Explore opportunities from OPP/Joint Digital Strategy
- Merge and enhance Waverley and Garden View (complete)

The Older People's Pathways Delivery Group has considered how to adapt its approach to implement these recommendations, and consultation has occurred with the HSCP Leadership Team, the NHS Borders Executive Team, Joint SBC/NHS Strategic Group and the Strategic Implementation Plan Programme Board.

It has been recognised that prevention, early intervention and supported self-management need to be a focus in line with the strategic vision for health and social care set out by the Health and Social Care Delivery Plan[6], and 'Recover, Restore, Renew' CMO Annual report 2020-21.[7]

Approach

A 'Programme approach' will be adopted to manage and plan what is recognised as a broad scope interfacing with a large number of stakeholders and services. A Programme Board / Delivery Group has been established and a range of Project Workstreams will be established relevant to the scope below. A Programme Manager is in post, and additional support is being sought in the respect of a Project Support Officer, and Data Analyst Support.

The Delivery Group will continue to work to develop the four intermediate care pathways. There will be significant engagement with older people, staff and Third Sector colleagues at a locality level. This will be complemented by data analysis. It is expected that this approach will support the Programme to better understand the level of need in each locality, and will support the development of a 'service specification'

[6] Scottish Government. Health and Social Care Delivery Plan (2016). Available from: https://www.gov.scot/publications/health-social-care-delivery-plan/

[7] Scottish Government. Recover, Restore, Renew. Chief Medical Officer for Scotland Annual Report 2020-21. Available from: https://www.gov.scot/publications/cmo-annual-report-2020-21/

for older people's services on a locality level. Essentially, we will ask older people about their experiences and needs to develop our approach to service provision.

Sustainability is a key part of the Programme's vision, and so the Programme will aim to redesign and improve services, using sustainable models that reduce future costs.

It is recognised that there are a broad spectrum of health and social care services can support older people with their health and social needs. These are summarised in the figure below.

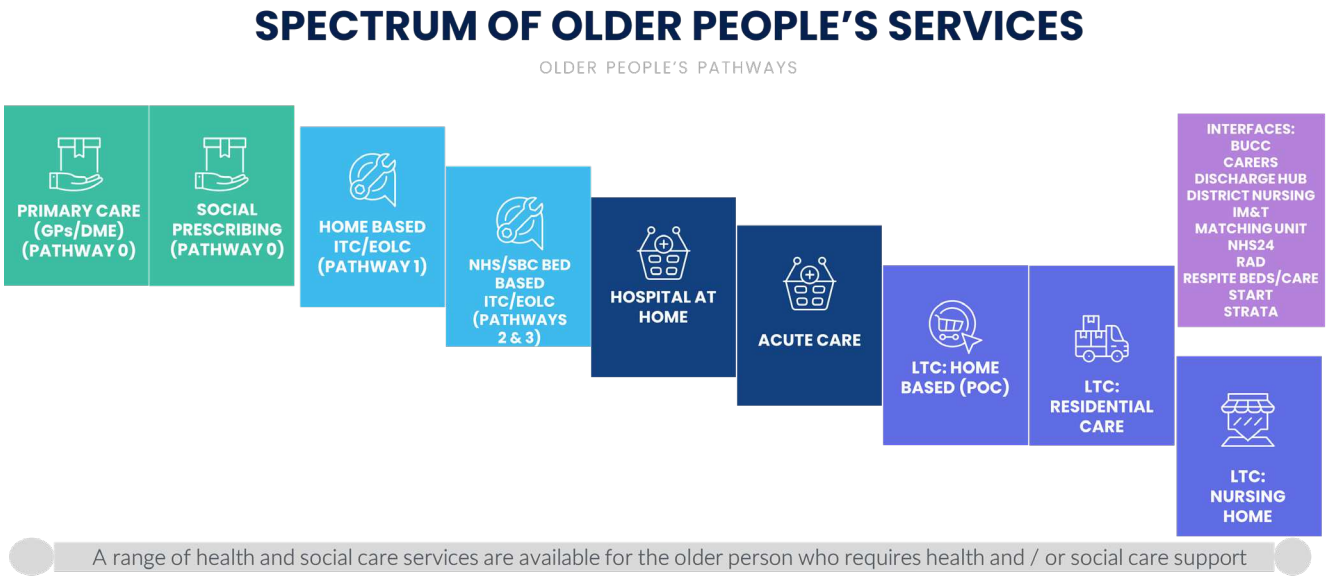


Figure 1: Spectrum of Older People's Services

DME (Geriatric Service), GP (General Practice), ITC (Intermediate Care), EOLC (End of Life Care), LTC (Long Term Care), POC (Package of Care), BUCC (Borders Urgent Care Centre), RAD (Rapid Access Discharge Service)

Scope

The scope of the Older People's Pathway Delivery Group does not attempt to cover the full spectrum of services, as there are other Strategic Implementation Plan workstreams which cover elements of this spectrum (e.g. Localities Operations, Technology Support and Enabled Care, Carer Support, Commissioning).

The scope outlined below includes work that will occur predominantly within the Older People's Pathway Delivery Group, but it is worth noting that:

- Due to the overlap with the localities agenda, much of the 'Pathway 0' work will be undertaken within the Strategic Implementation Plan's Localities Operations Group, which is an important interface with the 'Older People's Pathways Delivery Group). This is currently being worked through between the two groups.
- The recommendation from the 'Formative Evaluation of the Discharge Programme's relating to the development of locality palliative care services will be explored as part of a wider Palliative Care Review.

Pathway 0 (Locality support)

The Primary Medical and Social Care interface across pathway 0 involved in prevention, early intervention and supported self-management. This includes:

- Primary medical involvement in the management of older people's health, anticipation of ill health and admission avoidance :–
    - The interface between GPs and DME in supporting the older person requiring support
    - Consideration of how the role of the GP a) currently fits and b) opportunities for GP practices / older people (e.g. links with social care/localities, poly pharmacy etc)
    - The potential for interested GP clusters to take forward frailty / older people's work
    - Potential for Day Hospitals to reduce ill health

- Social prescribing (Prevention of admission and after discharge)
    - Community based responses including unpaid carers / third sector / other support for Older People's Pathways
    - Technology support
- Mental health links with pathway 0, including Mental Health for Older Adults Service (MHOAS)
- Forging links between primary care and social prescribing
- Monitoring and reducing admissions from long term care: home care, and residential care
    - Physical health
    - Mental health: Interface with Community Hospital and Care Home Assessment Team (CHAT)
    - Supporting older adults with a Learning Disability (e.g. early onset dementia for people with Downs Syndrome)
    - Social needs

Pathway 1 – Domiciliary Intermediate / step up care (Home First)

- Home First and its scope and composition, including opportunities for an integrated health and social care re-ablement model (Prevention of admission and after discharge)
- Opportunities for step-up into Home First
- The potential for a Hospital at Home model
- Palliative care at home – interfaces with palliative care review

Pathways 2 and 3

- Standardisation of approach
- Opportunities for step-up into bed based intermediate care
- Mental health: Interface with Community Hospital and Care Home Assessment Team (CHAT)

Geriatric services

- Department of Medicine of the Elderly services in the BGH
- Potential for community provision of Geriatric services (including configuration of DME service, , MDT frailty clinic, and urgent assessment clinic for the elderly)

Data

- Development of core datasets
- Development of benchmarking

Enabling infrastructure

- Rapid Access Discharge Service
- Matching Unit
- START
- Respite beds
- DME front door model
- Ensuring appropriate and safe processes for discharge

Out of scope / interfaces

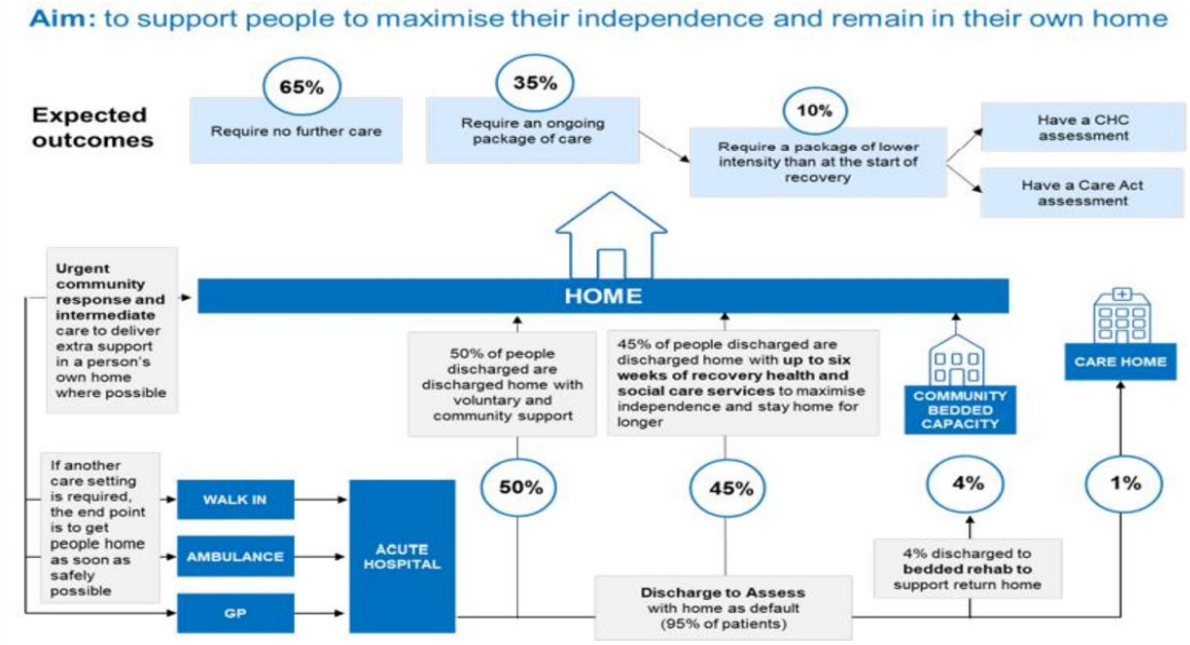
- Specialist Dementia services
- Older People's Housing
- General health services that older people use
- District Nursing service
- Benefits advice and financial services (pensions etc)
- Services paid for directly by individuals privately
- Palliative Care in relation to Older People's Pathways – this will be explored as part of the wider Palliative Care Review

- Strata
- Borders Urgent Care Service
- NHS24
- Long term care out with the scope noted above

Objectives/outcomes

Measurable objectives/outcomes are noted below. These will be refined in line with national benchmarks, once the Project Team are in place, and the Programme Initiation Document has been signed off. The range of objectives being explored is outlined below:

- Prevention of hospital admissions
  - Rate of A&E visits by locality
  - % of A&E visits that resulted in an emergency admission by locality
  - Rate of emergency admissions by locality
- Reduced length of stay in hospital
- Reduced demand for social care services after a hospital stay
- Long-term care need reduction following re-ablement
- Rate of 30-day emergency readmission
- Reduction in overall bed-based costs
- Reduction in costs of long-term care



Deliverables and indicative timescales

Timescales below are from the sign-off of the Programme Initiation Document, which will occur after the Scottish Borders Integrated Joint Board:

- Complete core dataset 3 months
- Implement OPAA 3 months
- Conclude Legal Discharges group and launch new approach 3 months
- Develop DME / GP community interface in first locality 3 months
- Draw conclusions on Hospital at Home model – mid July 3 months
- Implement step-up in Home First and launch new Home First model 5 months
- Standardised evidence based tool for dependency 6 months
- Implement intermediate care benchmarking 6 months

- Complete locality engagement in first locality 6 months
- Develop service specification for first locality 6 months
- Implement step-up model in first locality 6 months
- Complete locality engagement in second and third cluster 10 months
- Develop service specification for second and third cluster 10 months
- Implement step-up model in second and third cluster 10 months
- Complete locality engagement in fourth and fifth cluster 14 months
- Develop service specification for fourth and fifth cluster 14 months
- Implement step-up model in fourth and fifth cluster 14 months

Recommendation

The Integrated Joint Board is asked to note and support the approach being undertaken on the older people's pathways agenda.

Report prepared by:

Chris Myers
General Manager, Primary and Community Services

Brian Paris
Chief Officer, Adult Social Work

On behalf of the Older People's Pathways Delivery Group

May 2021

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 26 May 2021

Report By	Robert McCulloch-Graham, Chief Officer for Integration
Contact	Graeme McMurdo, Programme Manager, Scottish Borders Council
Telephone:	01835 824000 ext. 5501

QUARTERLY PERFORMANCE REPORT, MAY 2021
(latest available data at April 2021)

Purpose of Report:	To propose changes to quarterly performance reporting for Integration Joint Board (IJB) and also to provide the regular high level quarterly performance report for IJB consideration.
Recommendations:	Health & Social Care Integration Joint Board is asked to: a) Note the regular high-level quarterly performance report. b) Agree the proposed changes to quarterly performance reporting (i.e.) to supplement the regular high-level quarterly performance report with more detailed and specific reporting. c) Ensure, in collaboration with the Chief Officer Health and Social Care Integration, that resource is identified for the production of performance reporting.
Personnel:	*n/a*
Carers:	*n/a*
Equalities:	A comprehensive Equality Impact Assessment was completed as part of the review and refresh of the Strategic Commissioning Plan. This is due for refresh by 1st April 2022.
Financial:	*n/a*
Legal:	*n/a*
Risk Implications:	*n/a*

1. Background

1.1 The regular quarterly performance report has been presented to SPG and IJB in a similar format for 2 plus years. The report itself is a concise and informative public-facing performance summary document that is published regularly to the Social Care and Health section of the public website.

1.2 Over this period, IJB has noted the quarterly reports and requested that content changes be made, including the addition of more social care measures. However because of the high level nature of the quarterly report, whilst being a useful public-pacing report, it has had limited effectiveness in generating debate at Board level and/or providing the basis for IJB service change direction and action.

1.3 The 16th December 2020 IJB meeting questioned the fundamental purpose and value of the quarterly performance report especially in the context of the COVID-19 pandemic. Of particular concern was that the data presented in the report can often be 3-6 months out of date, or more.

1.4 The reason for this data delay is that the quarterly report has traditionally used data that can be compared nationally. This requires submission of the data and subsequent validation of it – all of which takes time. In a 'stable' system this may not be a significant issue as trends change relatively slowly over time and it is useful to compare Borders to other HSCPs and Nationally. However, the Covid-19 pandemic has changed everything and changed it very quickly.

1.5 It seems clear that pre-Covid that the quarterly report, whilst being a valuable public-facing document, was not routinely used by SPG and IJB for strategic decision making. During the pandemic:

- the data lag in the reporting has become an even greater issue, as was highlighted by IJB at its December meeting.
- there have been difficulties in attributing how much of any performance change is based on the Covid-impact as opposed to the actions taken to deliver 'genuine' performance improvement.

2. Future Reporting – Proposals

2.1 Whilst the 'Public Bodies (Joint Working) (Scotland) Act 2014' Integration Legislation is quite prescriptive in regard to Annual Performance Reporting, there is very little guidance for quarterly performance reporting.

2.2 The quarterly report as it stands remains an easily digestible report, where data can be compared nationally and trends can be seen. Amending the report to use local data could mean that the data is more to date, but there is a risk that it will not be nationally comparable, completely accurate or fully robust.

2.3 To better reflect IJBs increased focus on strategic commissioning, the regular report to the Board could be supplemented by additional reporting focused on specific areas and utilising:

- An increased use and analysis of local data and performance measures.
- An increased use of narrative and measures that assist IJB in evaluating whether what is being commissioned is effective in delivering desired

outcomes and whether it is value for money – effectively providing IJB with regular evaluations on specific commissioned services (in an agreed format) together with suggested recommendations.

3 Recommendation

3.1 It is recommended that the existing quarterly report (attached) continues to be produced and continues to be the IJB public-facing performance document.

3.2 It is recommended that this report is supplemented on a regular basis by more focused and in-depth evaluation-style reporting to IJB using narrative, performance measures and financial information to demonstrate that desired outcomes of IJB strategic commissioning are being delivered.

4 Regular Quarterly Performance Report

4.1 Narrative against the quarterly performance report is shown below. This narrative is structured under the three strategic objectives. There are two appendices:

Appendix 1 provides a high level, "at a glance" summary. This is the public-facing quarterly performance document. The MS Word version attached will be converted into a fully graphic'd version for publication.

Appendix 2 provides further details for each of the measures including more information on performance trends and analysis.

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

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 has been followed by an increase (easing of Lockdown#1 restrictions) and then a plateau (possibly as a result of Lockdown#2 restrictions). 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 restrictions 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 will decrease. 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.

4.3 **Strategic Objective 2: We will improve health of the population and reduce the number of hospital admissions**

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.

4.4 **Strategic 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**

The quarterly rate **of emergency readmissions within 28 days of discharge** peaked at Q1 2020/21 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 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.

1. Changing Health & Social Care for You

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

Summary of Performance for Integration Joint Board: MAY 2021

This report provides an overview of quarterly performance under the 3 Strategic Objectives within the Health & Social Care Partnership Strategic Plan, with **latest available data at end March 2021**. Annual performance is included in our latest Annual Performance Report (2019/20)

KEY		
• +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

How are we doing?

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

Emergency Hospital Admissions (Borders residents, all ages)	Emergency Hospital Admissions (Borders residents age 75+)	Attendances at A&E (all ages)	£ on emergency hospital stays	The % of older people who receive a package of less than 10 hours of domiciliary care	The % of older people receiving long-term care whose care needs have decreased (from their initial assessment/latest review)
22.1 admissions per 1,000 population (Q3 – 2020/21)	**75.3** admissions per 1,000 population Age 75+ (Q3 – 2020/21)	**54.7** attendances per 1,000 population (Q3 – 2020/21)	**16.4%** of total health and care resource, for those Age 18+ was spent on emergency hospital stays (Q3 – 2020/21)	**69%** (Dec 2020)	**63%** (Dec 2020)
+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)	+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%**)	Rate of Occupied Bed Days* for Emergency admissions (ages 75+)	Number of delayed discharges ("snapshot" taken 1 day each month)	Rate of bed days associated with delayed discharge	"Two minutes of your time" survey – conducted at BGH and Community Hospitals	The proportion of acute patients discharged to a permanent residential care bed without any opportunity for short-term recovery
79.1% of people seen within 4 hours (Jan 2021)	**1,179** bed days per 1,000 population Age 75+ (Q3 – 2020/21)	**27** over 72 hours (Mar 2021)	**165** bed days per 1,000 pop aged 75+ (Q3 – 2020/21)	**95.5%** Overall satisfaction rate (Q4 - 2019/20)	**71%** (Dec 2020)
-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 (min 10% better than Scottish average)	-ve trend over 4 periods Worse than target (23)	+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%)

*From 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)	End of Life Care	Carers support plans completed	Support for carers: change between baseline assessment and review. Improvements in self-assessment:	The proportion of people who require long-term care after a period of short-term reablement/rehabilitation	The proportion of older people who receive a period of domiciliary care before entering residential care
11.1 per 100 discharges from hospital were re-admitted within 28 days (Q3 – 2020/21)	**89.4%** of people's last 6 months was spent at home or in a community setting (Q3 – 2020/21)	**68%** of carer support plans offered have been taken up and completed in the last quarter (Q4 – 2020/21)	Health and well-being Managing the caring role Feeling valued Planning for the future Finance & benefits (Q4 – 2020/21)	**17%** (Dec 2020)	**71%** (Dec 2020)
-ve trend over 4 Qtrs Worse than Scotland (10.8 – Q3 2020/21) Worse than target (10.5)	+ve trend over 4 Qtrs Better than Scotland (88.4% - 2019/20) Better than target (87.5%)	+ve trend over 4 Qtrs Better than target (40%)	+ve impact No Scotland comparison No local target	-ve trend over 4 periods Worse than target (25%)	-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.

Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the
Scottish Borders Integration Joint Board **June 2021**

SUMMARY OF PERFORMANCE:
Latest available Data at end April 2021

Structured Around the 3 Objectives in the Strategic Plan:

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

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

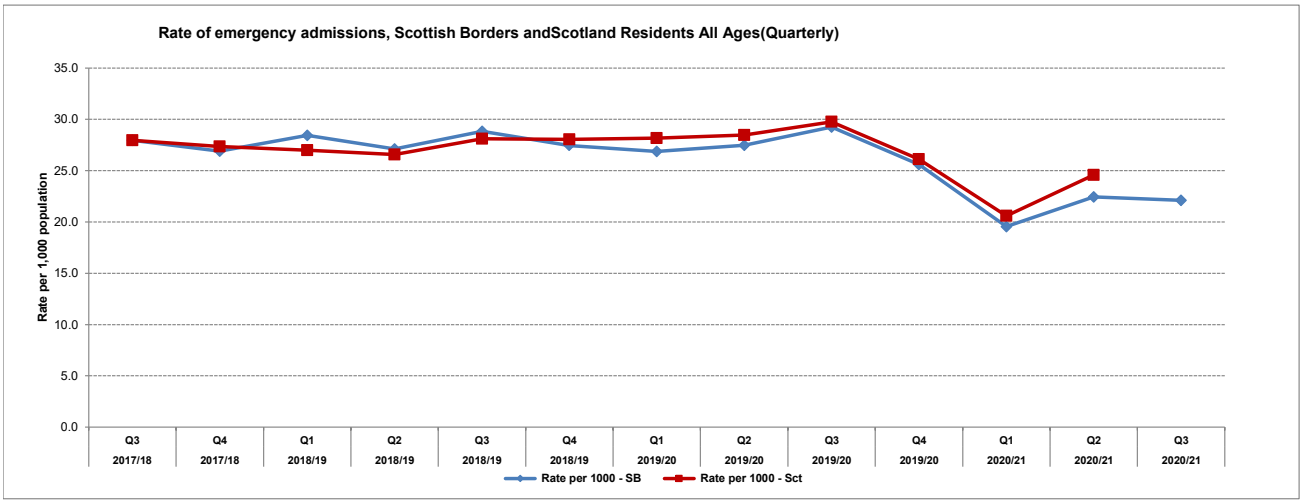
Objective 3: We will improve the capacity within the community for people who have been in receipt of health and social care services to manage their own conditions and support those who care for them

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

Emergency Admissions, Scottish Borders residents All Ages

Source: MSG Integration Performance Indicators workbook (SMR01 data)

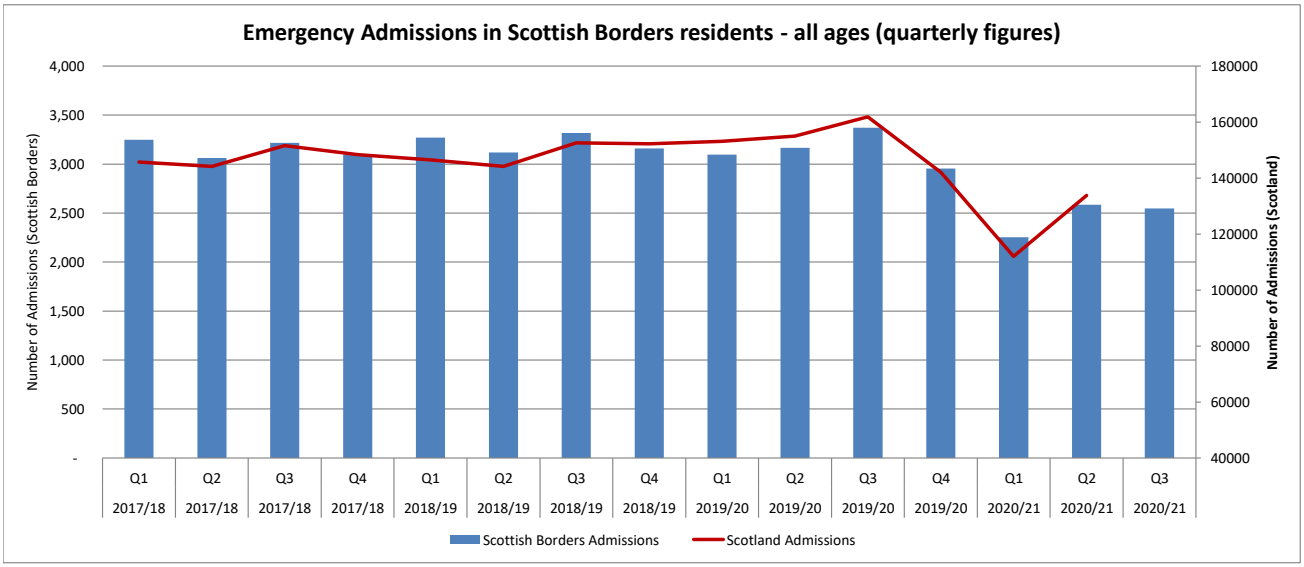
	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Scottish Borders - Rate of Emergency Admissions per 1,000 population	28.0	26.9	28.4	27.1	28.8	27.5	26.9	27.5	29.3	25.6	19.6	22.4	22.1
Scotland - Rate of Emergency Admissions per 1,000 population All Ages	27.9	27.3	27.0	26.6	28.1	28.1	28.2	28.5	29.8	26.1	20.6	24.6	-



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

Source: MSG Integration Performance Indicators workbook (SMR01 data)

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Number Scottish Borders Emergency Admissions - All Ages	3,217	3,096	3,271	3,120	3,317	3,158	3,097	3,166	3,372	2,953	2,254	2,586	2,547
Number Scotland Emergency Admissions - All Ages	151,607	148,365	146,500	144,177	152,552	152,223	153,176	154,966	161,865	142,079	112,034	133,783	-



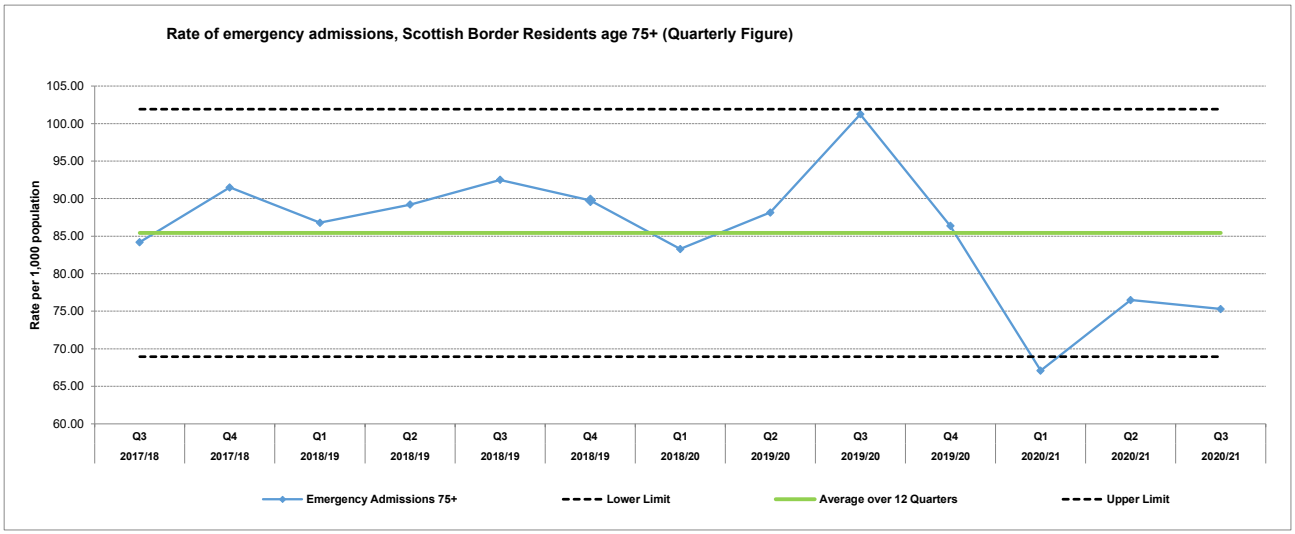
How are we performing?

The rate of emergency admissions continues to see minor fluctuations between quarters. Emergency Admission rates significantly reduced in both Q4 19/20 and Q1 20/21. This is reflective of the impact of the Covid-19 pandemic and the National measures introduced to reduce the spread of the virus. This rose again in Q2, following a similar trend to that of the rest of Scotland.

Emergency Admissions, Scottish Borders residents age 75+

Source: NSS Discovery

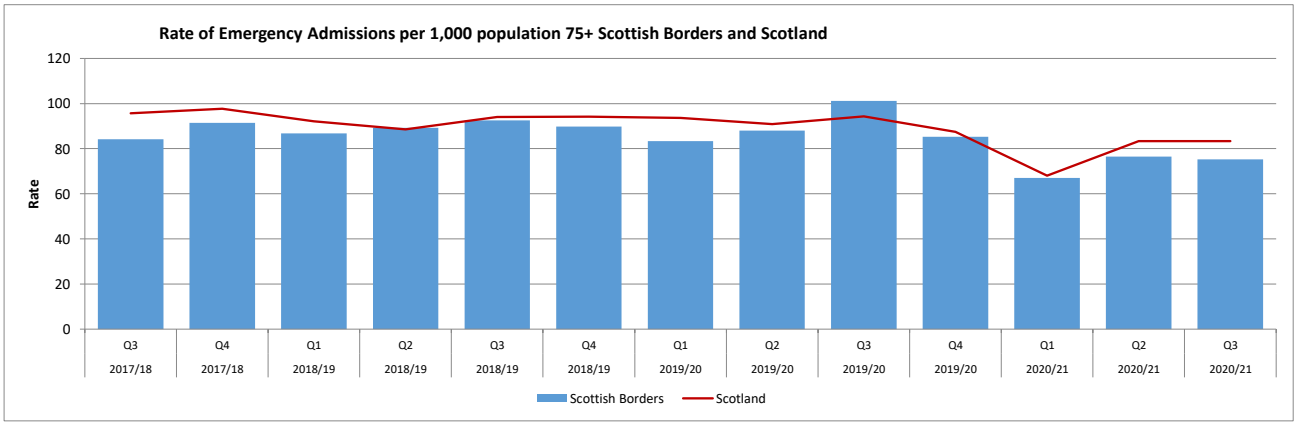
	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Number of Emergency Admissions, 75+	1,009	1,096	1,040	1,069	1,108	1,076	1,020	1,079	1,239	1,057	846	965	947
Rate of Emergency Admissions per 1,000 population 75+	84.2	91.5	86.8	89.2	92.5	89.8	83.3	88.2	101.2	86.4	67.1	76.5	75.3



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

Source: NSS Discovery

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Rate of Emergency Admissions Scottish Borders	84.2	91.5	86.8	89.2	92.5	89.8	83.3	88.1	101.2	85.3	67.1	76.5	75.3
Rate of Emergency Admissions 75+ Scotland	95.8	97.7	92.2	88.5	94.0	94.2	93.7	90.8	94.4	87.5	68.0	83.4	83.3



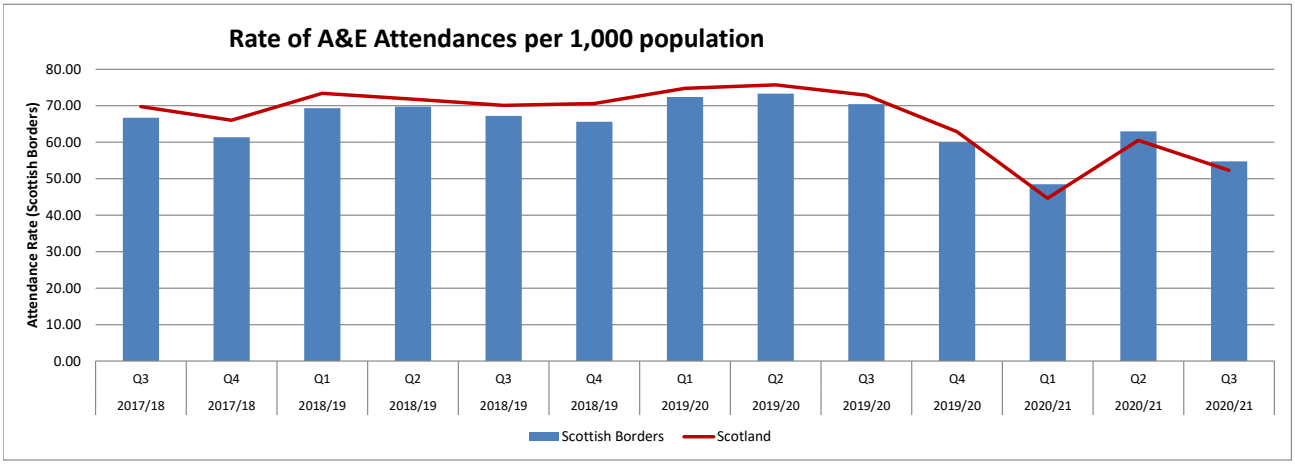
How are we performing?

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

Rate of A&E Attendances per 1,000 population

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

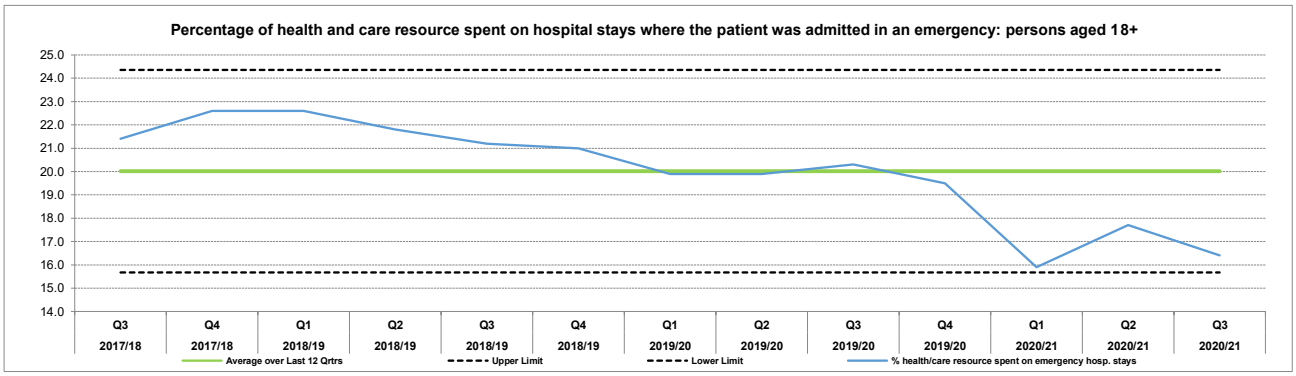
	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Rate of Attendances, Scottish Borders	66.7	61.4	69.4	69.7	67.2	65.6	72.4	73.3	70.5	60.0	48.5	63.0	54.7
Rate of Attendances, Scotland	69.7	66.1	73.4	71.8	70.1	70.6	74.8	75.7	72.9	62.9	44.6	60.5	52.3

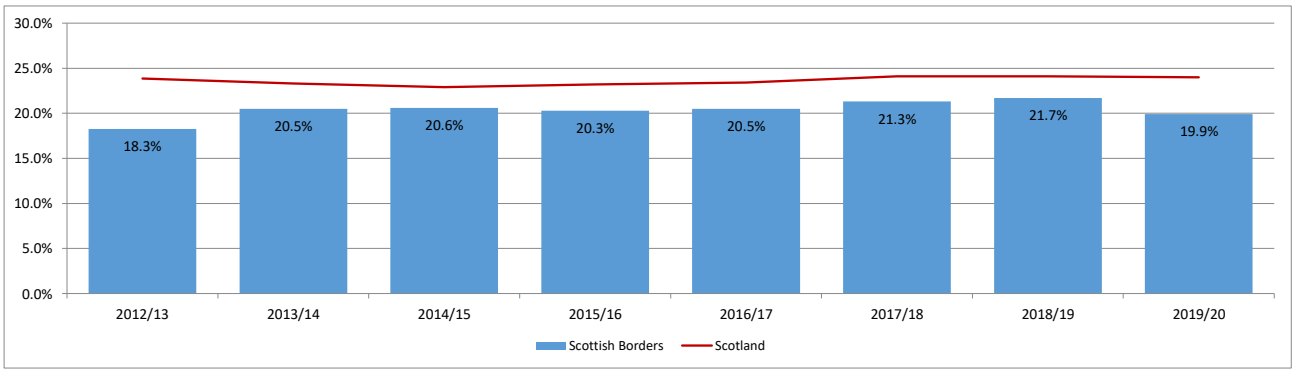


Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency: persons aged 18+

Source: Core Suite Indicator workbooks

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2018/19	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
% of health and care resource spent on emergency hospital stays (Scottish Borders)	21.4	22.6	22.6	21.8	21.2	21.0	19.9	19.9	20.3	19.5	15.9	17.7	16.4





How are we performing?

The onset of the Covid-19 pandemic (Q4 19/20 onwards) saw the rate of A&E attendances drastically reduce, with Q1 20/21 showing the lowest rate over the last 3 years. However, Q2 20/21 (Jul-Sept 20) has seen this rise to almost 'normal' levels at 62.4 admissions per 1,000 of the population. This behaviour mirrors that of the overall Scottish rate although it should be noted that in both Q1, Q2 & Q3 of 20/21 the Borders rate was greater than Scotland's.

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

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

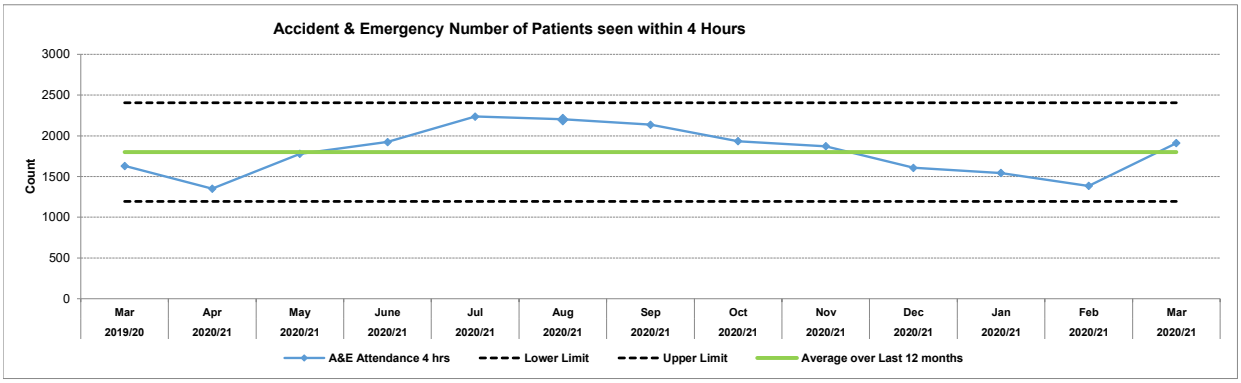
NB: December 2019, the denominator for this indicator now includes dental and ophthalmic costs. As a result, the % of spend has slightly decreased. The Table and Charts above have been updated to reflect the altered % as a result of this change.

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

Accident and Emergency attendances seen within 4 hours- Scottish Borders

Source: NHS Borders Trakcare system

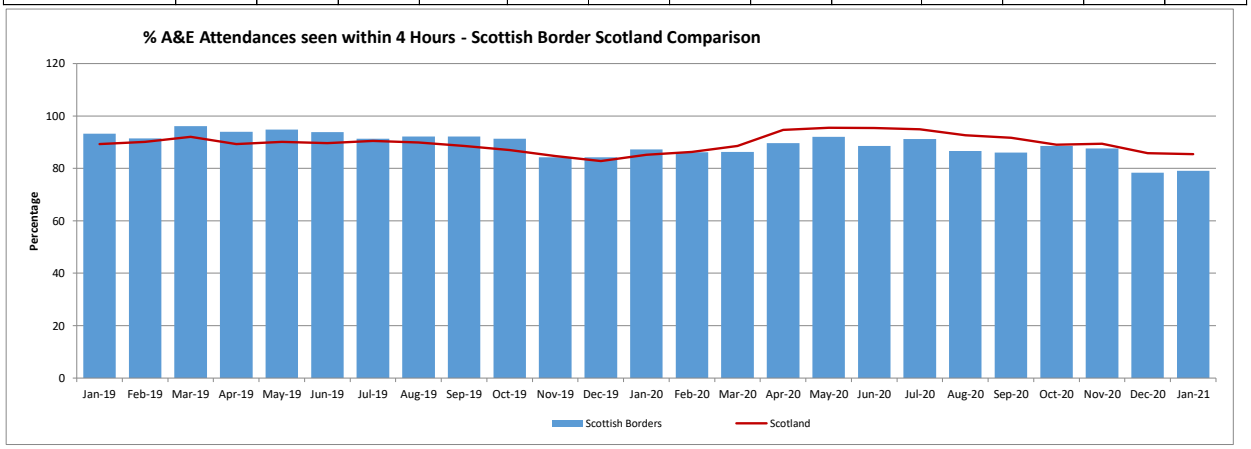
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of A&E Attendances seen within 4 hours	1631	1351	1779	1923	2237	2201	2136	1934	1871	1608	1543	1385	1910



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

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

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
% A&E Attendances seen within 4 hour Scottish Borders	87.3	86.2	86.3	89.6	92.1	88.6	91.2	86.7	86.1	88.6	87.6	78.4	79.1
% A&E Attendances seen within 4 hour Scotland	85.2	86.3	88.6	94.7	95.5	95.4	94.9	92.6	91.7	89.1	89.4	85.8	85.5



How are we performing?

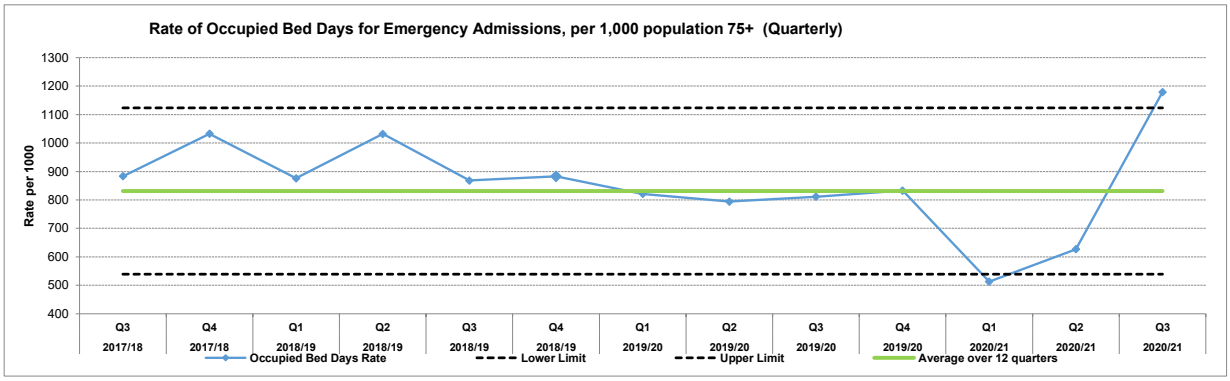
Historically, NHS Borders consistently performed better than the Scottish comparator for A&E waiting times; however, Borders has fallen below the Scottish Average in 11 of the last 12 months reported, with the gap widening significantly since the onset of the Corona Virus pandemic in March 2020.

Performance against this measure showed a positive trend over the year 2018/19, peaking in March 2019 at 96.1%. In contrast to this, the chart shows a negative trend in 2019/20. The 95% target was met once in the last 2 years. NHS Borders are working towards consistently achieving an ambitious local 98% standard; therefore, action is required to improve A&E waiting times.

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

Source: NSS Discovery

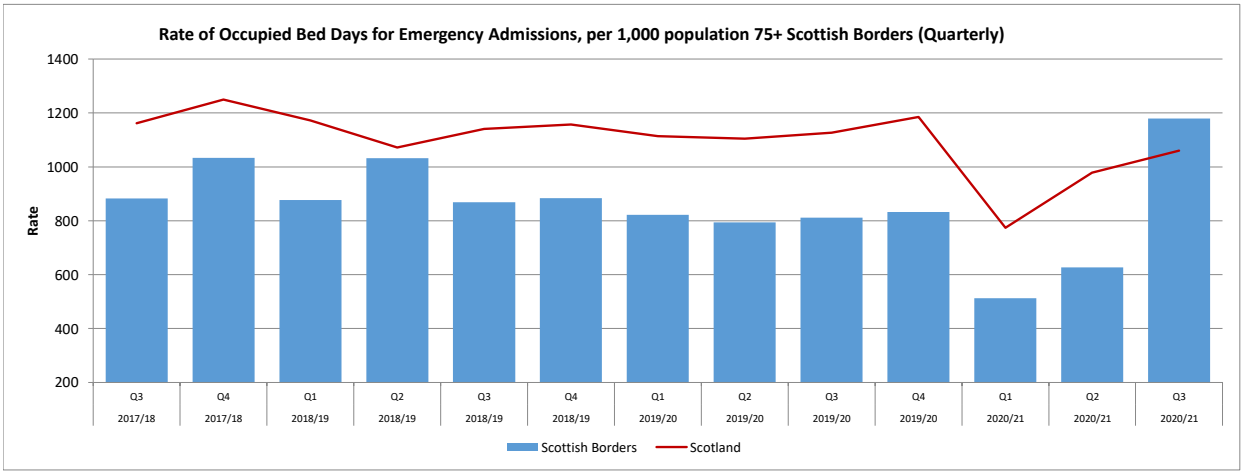
	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Number of Occupied Bed Days for emergency Admissions, 75+	883	1033	876	1032	868	883	822	794	812	833	513	627	1179
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	10582	12377	10523	12356	10407	10587	10056	9719	9933	10505	6471	7903	14861



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

Source: NSS Discovery

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	883	1033	876	1032	868	883	822	794	812	833	513	627	1179
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1161	1250	1172	1072	1141	1157	1114	1105	1127	1185	774	979	1060



How are we performing?

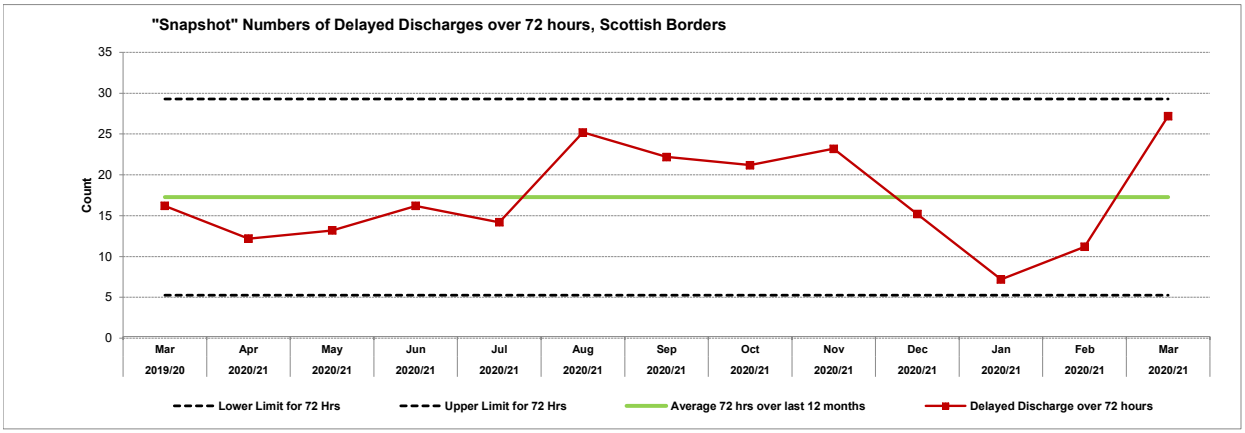
NB: Data for Community Hospitals is included in both Bed Days measures from Q3 2020/21 onwards.

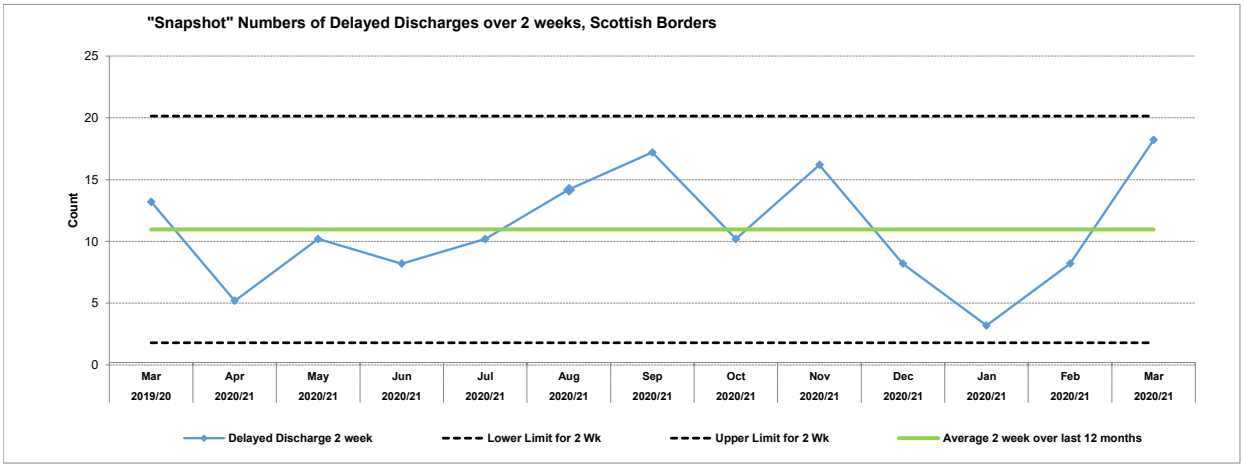
The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75+ has fluctuated over time but has remained lower than the Scottish Average; however, the Borders rate is greater than Scotland in Q3 20/21 when Community Hospitals are included.
There is a notable reduction in occupied bed days for Emergency admissions since Q2 of 2017/18, drawing the Border's figure further from the Scotland average. The graph shows a positive trend over the last 3 years with an overall reduction in occupied bed days.

Delayed Discharges (DDs)

Source: EDISON/NHS Borders Trakcare system

	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of DDs over 2 weeks	13	5	10	8	10	14	17	10	16	8	3	8	18
Number of DDs over 72 hours	16	12	13	16	14	25	22	21	23	15	7	11	27





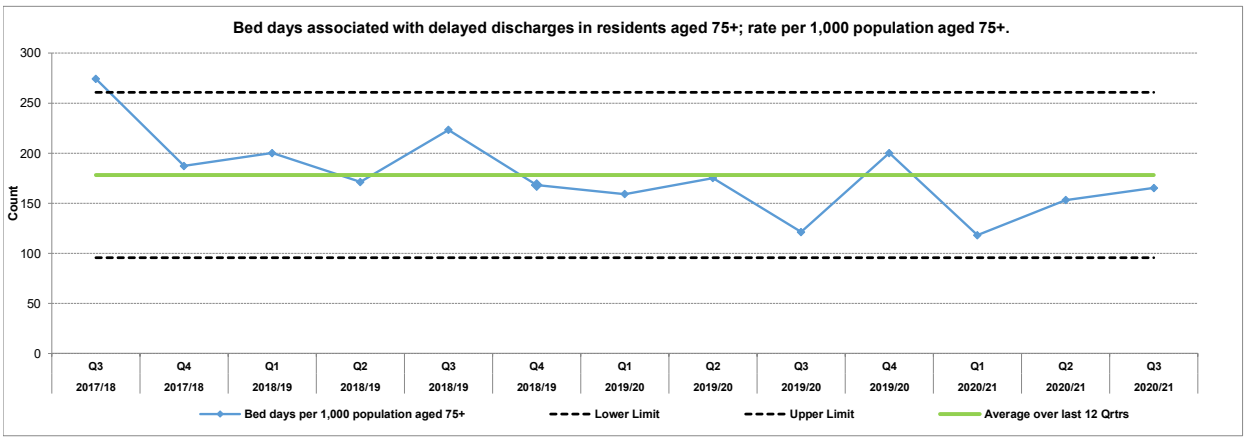
Please note the Delayed Discharge over 72 hours measurement has been implemented from April 2016.

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

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

Source: Core Suite Indicator workbooks

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
Bed days per 1,000 population aged 75+	274	187	200	171	223	168	159	175	121	200	118	153	165



How are we performing?

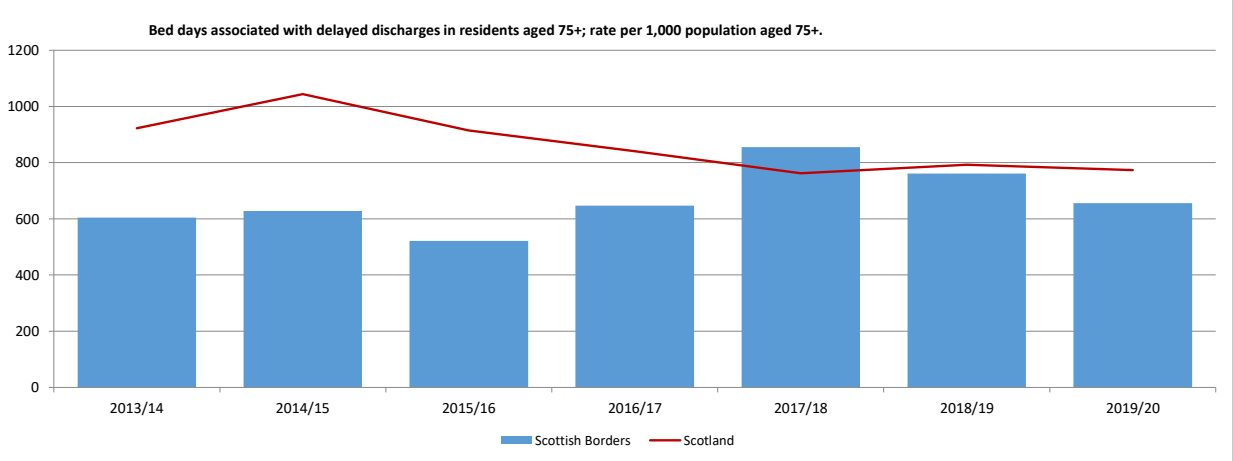
Although, at the onset of the Corona Virus pandemic there was a reduction in the number of delayed discharges, this was short-lived and these have again been on an increasing trend since May 20. December 2020 demonstrates a drop in delayed discharges; this is in-line with the previous year although the 2020 figure is higher than in 2019.

The rate of bed days associated with delayed discharges (75+) for quarter 3 of 2017/18 was higher than any previous quarter, increasing to over 250 per 1,000 residents for the first time. Quarter 3 for 18/19 had a similar spike to the same period the previous year, seeing the second highest rate over the past 2 years. An exception to this pattern is Q3 19/20 where the rated dropped rather than spiked, although a spike in Q4 followed. The overall trend for this measure is positive. NHS Borders is facing significant challenges with Delayed Discharges, which continues to impact on patient flow within the Borders General Hospital and our four Community Hospitals. The measure has an overall positive trend over the last 3 years, although, Q4 2019/20 shows a significant increase to 200 days, which is above the average and well above the 180 day target.

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

Source: Core Suite Indicator workbooks

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Scottish Borders	604	628	522	647	855	761	656
Scotland	922	1044	915	841	762	793	774



How are we performing?

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

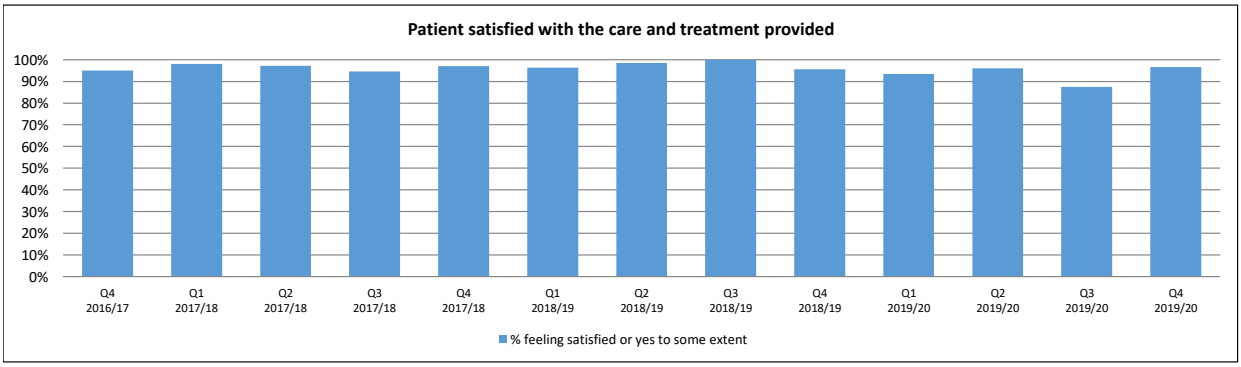
*Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account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

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

Source: NHS Borders

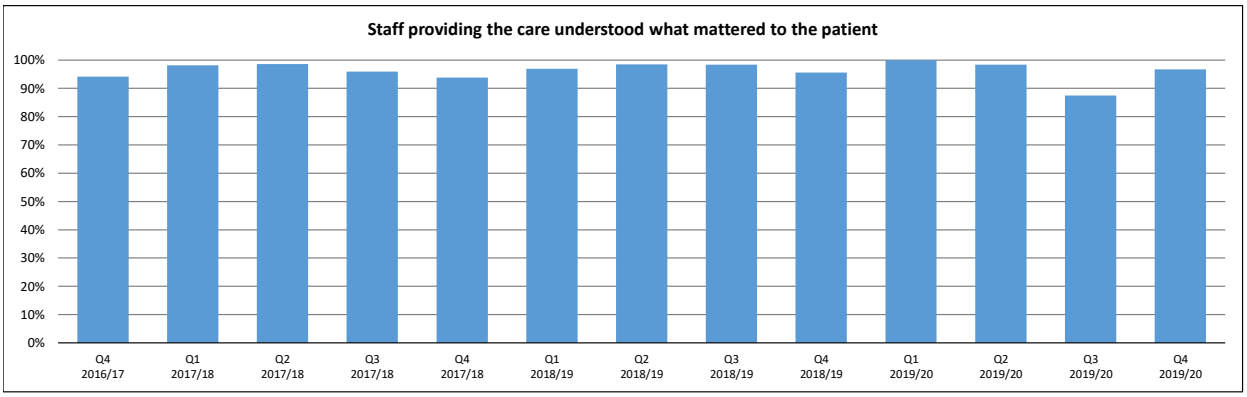
Q1 Was the patient satisfied with the care and treatment provided?

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



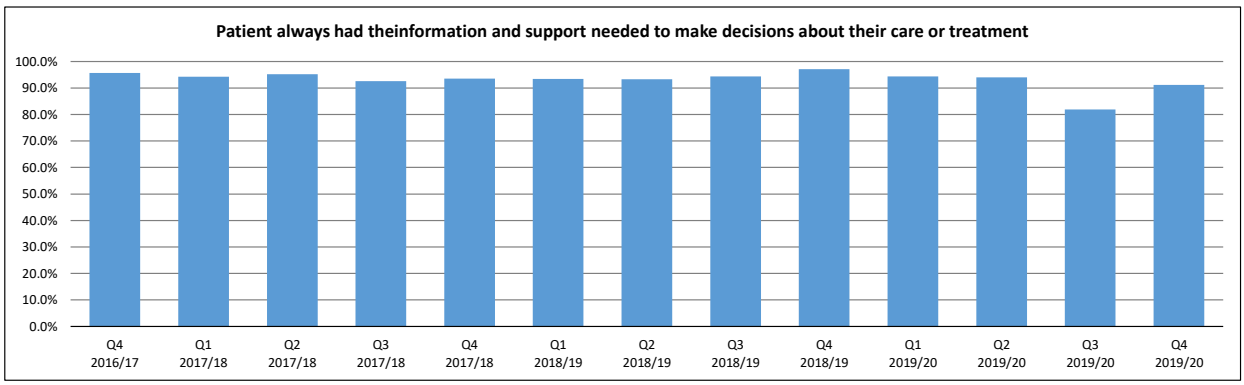
Q2 Did the staff providing the care understand what mattered to the patient?

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



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

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



How are we performing?

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

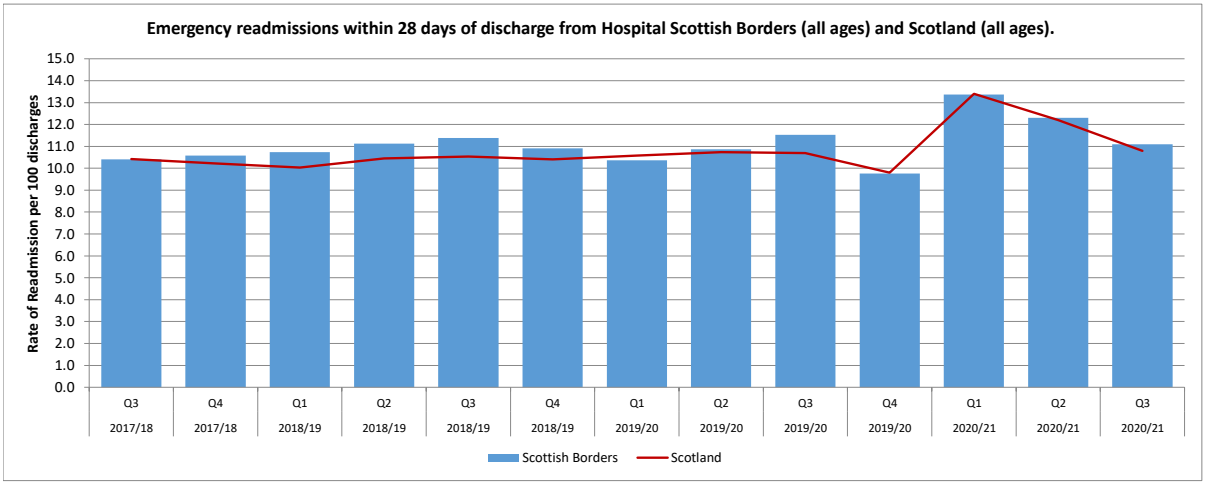
Overall, Borders scores well with an average 95.5% satisfaction rate. Patient satisfaction shows a positive trend over time and the latest overall average achieves the 95% target. *Please note the Patient Survey has been suspended from the start of the corona virus pandemic. This is due to the survey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

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

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

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

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



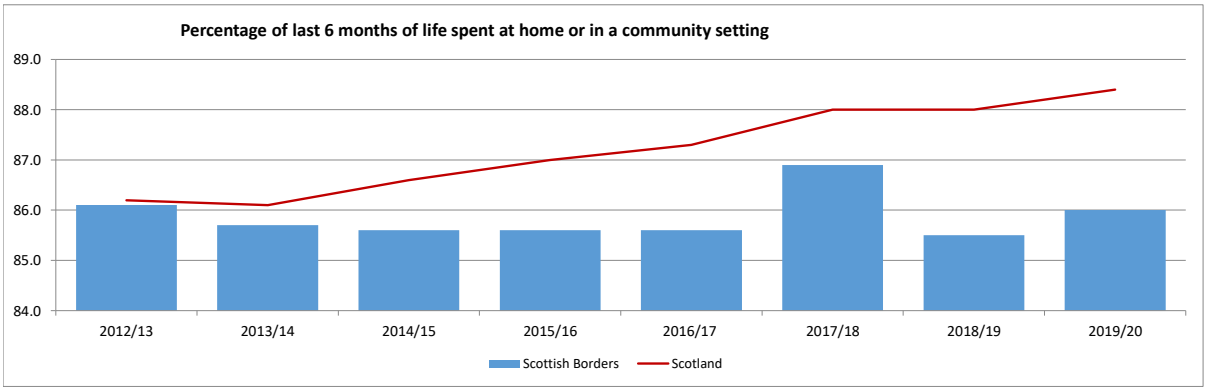
How are we performing?

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

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

Source: Core Suite Indicator workbooks

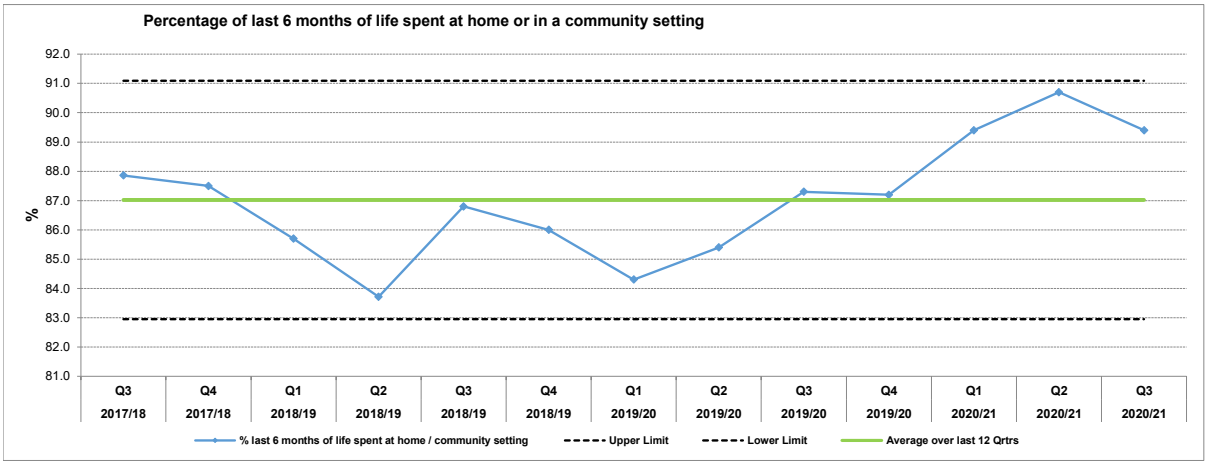
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Scottish Borders	86.1	85.7	85.6	85.6	85.6	86.9	85.5	86.0
Scotland	86.2	86.1	86.6	87.0	87.3	88.0	88.0	88.4



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

Source: Core Suite Indicator workbooks

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21
% last 6 months of life spent at home or in a community setting Scottish Borders	87.9	87.5	85.7	83.7	86.8	86.0	84.3	85.4	87.3	87.2	89.8	90.7	89.4



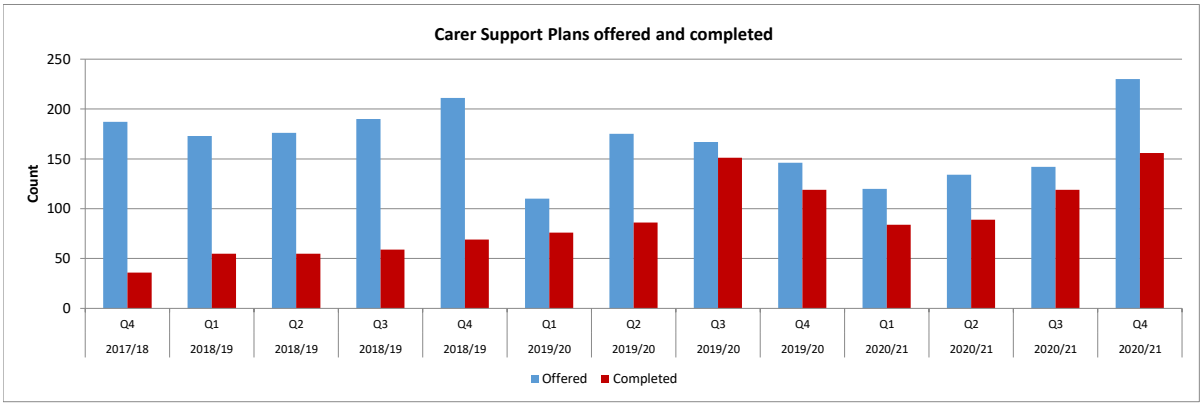
How are we performing?

The percentage of last 6 months of life spent at home or in a community setting remains below the Scottish average. Following a drop in 2018/19, 2019/20 saw performance improve for this measure. The first two quarters of 20/21 demonstrates continued improvement against this indicator. Q2 20/21 demonstrates the highest % in the last 3 years for people spending the last 6 months at home or in a Community setting.

Carers offered and completed Carer Support Plans

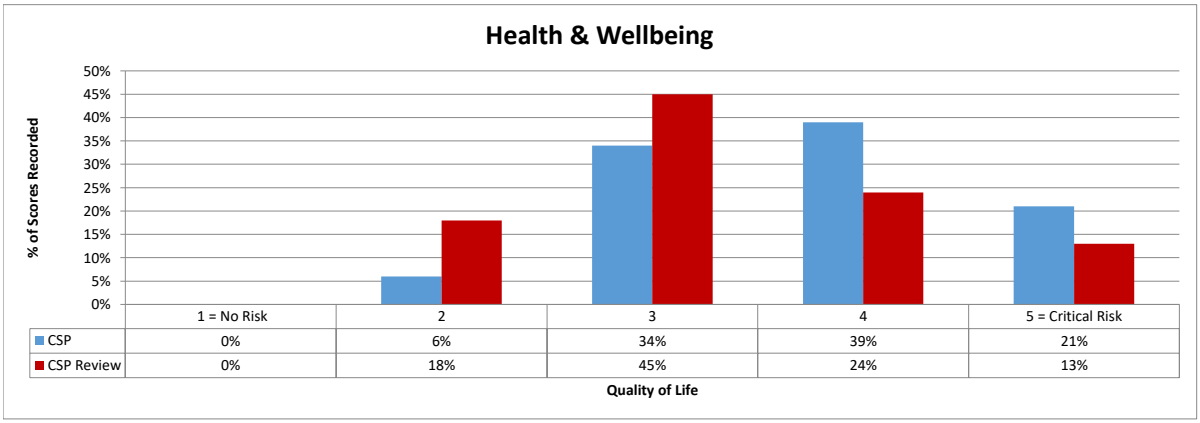
Source: Borders Carers Centre

	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Carer Support Plans Offered	187	173	176	190	211	110	175	167	146	120	134	142	230
Carer Support Plans Completed	36	55	55	59	69	76	86	151	119	84	89	119	156



Health and Wellbeing (Q4 2020/21)

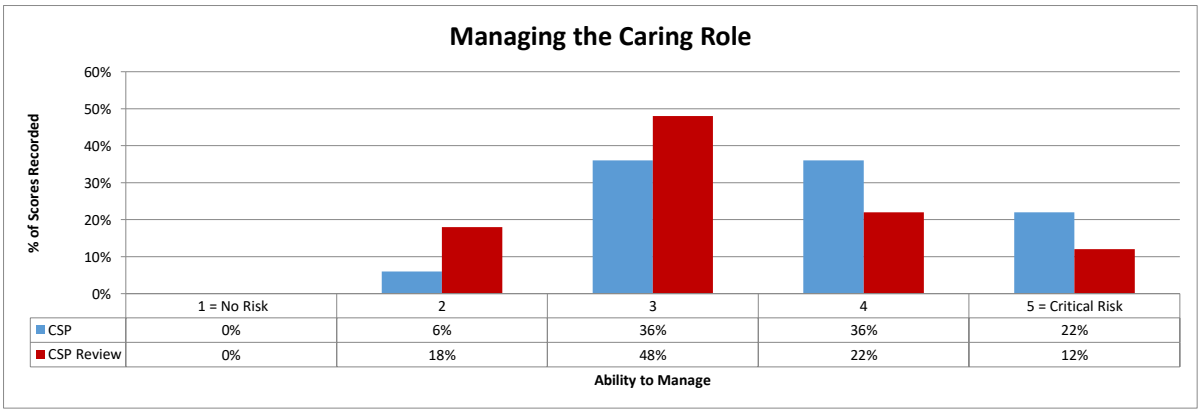
I think my quality of life just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0%	6%	34%	39%	21%
CSP Review	0%	18%	45%	24%	13%

Managing the Caring role (Q4 2020/21)

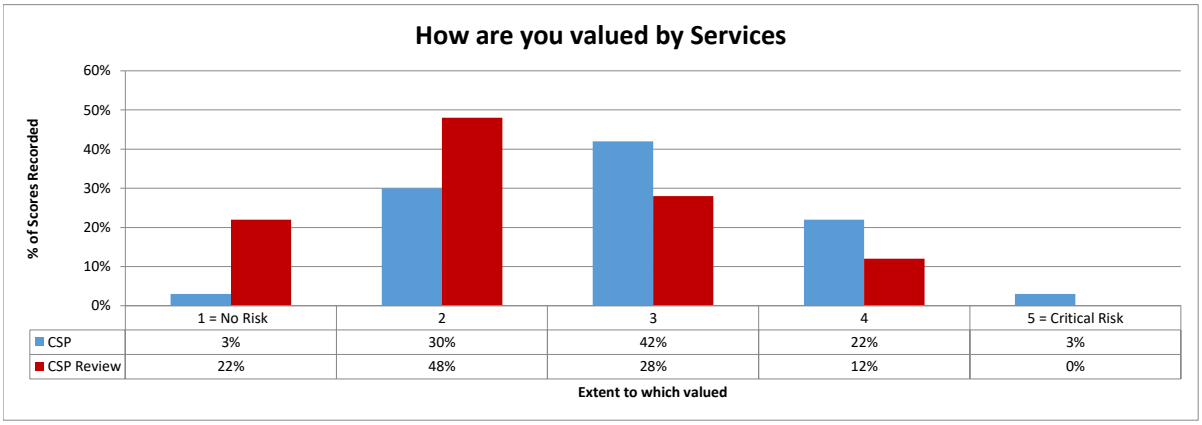
I think my ability to manage my caring role just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	0%	6%	36%	36%	22%
CSP Review	0%	18%	48%	22%	12%

How are you valued by Services (Q4 2020/21)

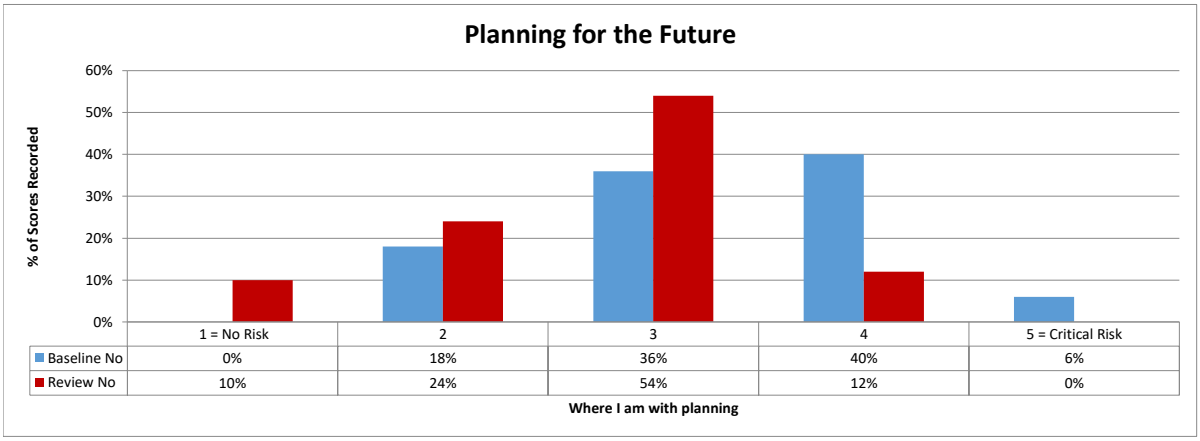
I think the extent to which I am valued by services just now is:



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	3%	30%	42%	22%	3%
CSP Review	22%	48%	28%	12%	0%

Planning for the Future (Q4 2020/21)

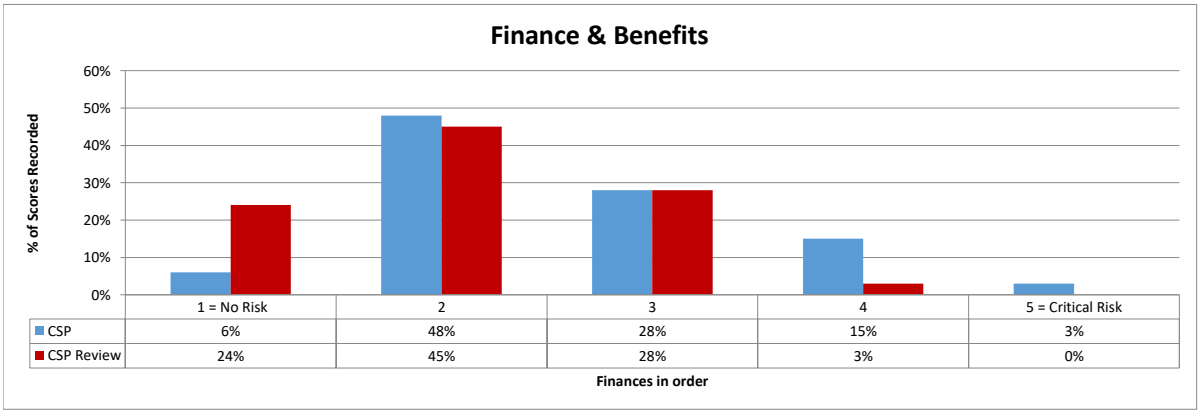
I think where I am at with planning for the future is:



	1 = No Risk	2	3	4	5 = Critical Risk
Baseline No	0%	18%	36%	40%	6%
Review No	10%	24%	54%	12%	0%

Finance & Benefits (Q4 2020/21)

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



	1 = No Risk	2	3	4	5 = Critical Risk
CSP	6%	48%	28%	15%	3%
CSP Review	24%	45%	28%	3%	0%

How are we performing?

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

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

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