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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, 28th July, 2021** at **10.00 am** in 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** 26.05.2021	**Chair**	Attached
10.10	**4**	**MATTERS ARISING** Action Tracker	**Chair**	Attached
10.15	**5**	**FOR DECISION**		
		5.1 Scottish Borders Health and Social Care Integration Joint Board Audit Committee Annual Report 2020/21	**Audit Programme Chair**	Appendix 2021-12
		5.2 Annual Performance Report 2019/20	**Programme Manager**	Appendix 2021-13
		5.3 Primary Care Improvement Plan	**Chief Officer / GP Sub Chair**	Appendix 2021-14
11.15	**6**	**FOR NOTING**		
		6.1 Monitoring of the Health & Social Care Partnership Budget 2020/2	**Chief Financial Officer**	Appendix 2021-15

		6.2 Clinical & Care Governance Report 202/21	**Medical Director**	Appendix 2021-16
		6.3 Coldingham Branch Surgery	**General Manager P&CS**	Appendix 2021-17
		6.4 Strategic Planning Group Minutes	**Board Secretary**	Appendix 2021-18
11.55	**7**	**ANY OTHER BUSINESS**	**Chair**	
12.00	**8**	**DATE AND TIME OF NEXT MEETING** Wednesday 22 September 2021 10am to 12pm Microsoft Teams	**Chair**	Verbal

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 26 May 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
Cllr J Linehan
(v) Mrs L O'Leary, 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 Lynn McCallum, Medical Director
Mrs L Gallacher, Borders Carers Centre
Mrs J Smith, Borders Care Voice
Ms Linda Jackson, LGBTPlus
Mr S Easingwood, Chief Social Work Officer
Mr D Bell, Staff Side SBC
Ms G Russell, Partnership Chair 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 A Bone, Director of Finance NHS
Mr P McMenamin, Deputy Director of Finance NHS
Mr G McMurdo, Programme Manager SBC
Mrs S Horan, Deputy Director of Nursing & Midwifery
Dr Keith Allan, Associate Director of Public Health
Mr Chris Myers, General Manager P&CS NHS
Ms S Pratt, Executive Lead PCIP
Mr B Paris, SBC
Ms J Holland, Chief Operating Officer SBCares
Mr A McGilvray (Press)
Ms J Amaral

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Mrs Morag Low, Service User Rep, Mrs Nicky Berry, Director of Nursing, Midwifery & Operations and Dr Tim Patterson, Director of Public Health.

The Chair noted that this meeting was the last meeting for Nicky Berry who moved to the post of Director of Operations for NHS Borders from 1 June 2021.

The Chair welcomed Sarah Horan who would take up the role of Director of Nursing, Midwifery and AHPs for NHS Borders on 1 June 2021.

The Chair welcomed Dr Keith Allan, Associate Director of Public Health who was deputising for Dr Tim Patterson.

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 17 February 2021 were approved.

The minutes of the Extra Ordinary meeting of the Health & Social Care Integration Joint Board held on 24 March 2021 were approved. Two minor amendments had already been made to the minutes: Linda Jackson was present as the LGBT Rep; the spelling of the word “de minimis” has been corrected on page 3 paragraph 5.

4. MATTERS ARISING

4.1 Action 8: Mr Rob McCulloch-Graham assured the Board that a new approach was being taken to co-production by amalgamating the efforts of the IJB, NHS and SBC. The action on the action tracker would be subsumed into that new approach and he suggested it be removed from the action tracker.

Mr Tris Taylor sought assurance that the coproduction model would include long-term conditions in the development and delivery of community treatment & care services. Mrs Jenny Smith commented that since the onset of the COVID-19 Pandemic many developments in coproduction had been taken forward in the third sector and she welcomed an all encompassing approach to co-production.

4.2 Action 3: Mr Tris Taylor sought a timeline for the review of the Scheme of Integration. Mr Rob McCulloch-Graham confirmed that the Strategic Commissioning Plan (SCP) would be reviewed by April 2022 and the Scheme of Integration (SoI) target date would be after that date. He explained that the review of the SCP may impact on the SoI and therefore it would make sense to complete the SoI after the SCP review had completed. He further commented that there may be changes to the SoI required as a consequence of the Derek Feeley recommendations being accepted by the Scottish Government. To date those recommendations remained with the Scottish Government for consideration.

4.3 Action 4: The item would be completed that day as it was a matter for discussion on the meeting agenda.

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

5. BORDERS PRIMARY CARE IMPROVEMENT PLAN: UPDATE REPORT

Mrs Sandra Pratt provided an overview of the content of the report and updated the Board on the workstreams progress to date.

Cllr John Greenwell thanked Mrs Pratt for her comprehensive report and enquired if there were any risk assessments undertaken in regard to additional funding not being received. Mrs Pratt commented that there was a risk assessment undertaken for the full programme of work and she would be happy to share that with the Board in the next PCIP update.

Cllr Shona Haslam commented that in terms of funding, there would not be enough funding to do everything, so she enquired what would not be done. She further commented that the demand on mental health services was likely to increase as the pandemic abated and she enquired if support would remain available locally for people or if services would be centralised.

Dr Kevin Buchan commented that currently there were some 300 to 320 appointments a week for community mental health services which were being filled. There was further work to be finalised in regard to appointments moving to face to face meetings in the community with video appointments being carried out centrally, when COVID-19 restrictions were lifted.

Mrs Pratt commented that the work that was not being done related to community treatment and care and vaccination programmes. The CTAC workstream was complex and contained a variety of different things that it was addressing in bite size chunks.

Mrs Lucy O'Leary enquired if there was scope for integrated health and social care roles as well as mobilising services like the breast screening mobile unit instead of relying on fixed buildings. Mrs Pratt advised that there were different models for different worksteams so not all were centralised. Due to economies of scale and COVID-19 pandemic limitations a centralised hub way of working had been developed. There were also limitations on the space in general practices. In terms of mobile units they had been used previously and tended to be expensive however they were in the mix for discussion as possible solutions.

Further discussion focused on: model specialist; confirmation that HR and vacancy processes in both NHS Borders and Scottish Borders Council were completed; partnership colleagues had been invited to attend vaccination workshops; a need for bespoke governance for the amount of staff and transformative work being undertaken; the assets available in communities were often overlooked in planning the role out of partnership services; and we should do work to better understand the totality of the assets available and the opportunities to collocate and therefore improve access.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress of PCIP to date and supported the submission of the PCIP Implementation Tracker and associated documents to Scottish Government in accordance with their regular reporting

6. OLDER PEOPLE'S PATHWAYS DELIVERY GROUP

Mr Chris Myers provided an overview of the content of the report through a presentation.

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Mr Nile Istephan enquired what was not included and if enough attention was paid to pathway zero. Mr Brian Paris commented that it was a complicated and wide process when the approach taken was integrated with co-production involving stakeholders. He gave assurance that the programmes of work and workstreams sat in the localities and were connected and speaking to each other. A line had been drawn on those things that were in scope of pathway zero and a timeline had been agreed to ensure progress was made.

Mr Tris Taylor enquired about the reference to building on the findings accepted by the informative evaluation, the lessons were around the approach to what was delivered and around the systems and processes employed in setting up projects and programmes. He sought a quantification of expected benefits and suggested the same exercise were carried out as had been for the outcomes and outputs, as unless a starting point was identified there would be no baseline against which to track progress. He welcomed the presentation content of the public engagement intent.

Cllr Tom Weatherston agreed that it was a great piece of work. In terms of public engagement he commented that it had to be done correctly, potentially with a launch day and campaign to ensure the public understood it.

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

7. QUARTERLY PERFORMANCE REPORT, MAY 2021

Mr Graeme McMurdo presented the report and commented that concerns had been raised on the usefulness of the report as much of the data in the report was often out of date due to timelags with validated national comparison data. He drew the attention of the Board to Section 2 of the report which set out future reporting arrangements.

Cllr Shona Haslam commented that sections 4.2 and 4.3 were the same and enquired if that was an error. Mr McMurdo confirmed that it was.

Cllr Haslam enquired what the 2 strategic objectives were. Mr McMurdo commented that objective 1 was correct. Objective 2 was to make sure that when people had a health need identified, that they were diagnosed and triaged quickly and given access to the appropriate health input. If that involved hospital input they would be admitted and then discharged promptly.

Mr McMurdo commented that the regular report had been updated over the previous quarter to include extra social care measures. He also advised the Board that it had become difficult to look at performance improvement given the impact of the COVID-19 Pandemic.

Ms Lynn Gallacher commented that it was a useful report and highlighted in regard to carers, that they had managed to continue with carers support plans and to receive outcomes. However carers were becoming exhausted with the lack of access to social care and respite care. She was also aware of a reduction in packages of care being available and a longer waiting time for packages of care to be allocated. She suggested

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that information on social care provisions was required. Mr McMurdo welcomed the suggestion of more information to be provided in specific areas.

Cllr Haslam agreed that the data was not inclusive of social care. She further commented that it appeared to be hospital admission focussed and not about improving the health of the population. She suggested including data on oncology, diabetes and obesity would give the Board a broad view of how population health could be improved. She further sought data on Discharge to Assess.

Mr Rob McCulloch-Graham commented that a shortage of social care indicators had been identified around pathway zero. He suggested deep dives on social care indicators; short term packages of care; allocation of packages of care; discharge to assess; discharge through Home First; and being risk averse and prescribing too much care.

Mr Tris Taylor suggested setting targets, objectives and metrics. In terms of objective 1 he suggested a need to quantify health production in the community and formulating a metrics to capture unpaid health production to assist in measuring the health of the population. In terms of objective 3 he suggested an analysis of current community capacity against a baseline was required and an understanding of whole system assets. He further commented that in terms of delayed discharge performance, it was not improving and he questioned if the choices policy was being implemented and if the strategy that was in place was being delivered and if it was, was it actually correct.

Ms Jen Holland commented that there was a performance board in Scottish Borders Council around the health & social care partnership which looked at the breadth of social work and social care performance. A piece of work on social care performance indicators should conclude in the summer and would then be brought to the IJB for consideration and inclusion in performance reports going forward.

Mr McCulloch-Graham commented that in regard to respite care, the Scottish Government were aware of difficulties with respite care provision across Scotland and he anticipated that a funding stream might be made available. Meantime further work would be taken forward through the appropriate workstream.

Mr McMurdo thanked the Board for their input to changes to the report and emphasised the need for social care measures to be included and supplementing the report with what the IJB required in order for them to make fully informed decisions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the regular high-level quarterly performance report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the proposed changes to quarterly performance reporting (i.e.) to supplement the regular high-level quarterly performance report with more detailed and specific reporting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to ensure, in collaboration with the Chief Officer Health and Social Care Integration, that resource is identified for the production of performance reporting.

8. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET

Mr David Robertson provided a verbal update on the budget position as it was too early in the financial year to be able to provide the usual monitoring report. He confirmed that the outturn position was in line with the information previously provided to the Board with the requirement for additional resources to be provided by both NHS Borders and Scottish Borders Council.

Mr Robertson confirmed that the process of completion of the final accounts was proceeding and report would be received by the IJB Audit Committee in due course.

Mr Robertson commented that financial reporting to the IJB in future would be through quarterly updates. They would be less retrospective and more forward looking in terms of transformational activity, delivery of savings and shifting the balance of care.

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

9. ANY OTHER BUSINESS

9.1 Risk Strategy: Mr Rob McCulloch-Graham commented that there was an intention to bring a Risk Strategy paper to the next meeting of the IJB.

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

10. 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 28 July 2021, from 10am to 12noon, via Microsoft Teams.

The meeting concluded at 12.03.

Signature: ……
Chair

DRAFT

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. **26.05.21: Complete**: Item discussed at IJB on 26.05.21 and will be subsumed into coproduction.	

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

Action	Reference	Action	Action by:	Timescale	Progress	RAG

Number	in Minutes					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~~ April 2022	**23.09.20 Update:** Mrs Karen Hamilton enquired if the timescale for Action 3 was for the review to have been completed by the end of March 20201. Mr McCulloch-Graham confirmed that it was. **09.10.20: Update:** An initial review of the scheme is currently being taken forward and a timeline for completion is being worked up. **16.12.20: Update:** We intend to undertake a number of development sessions/workshops with board members and other stakeholders regarding the review of the Strategic Commissioning Plan. This work will inform any required amendments to the scheme of integration. The date for changes to the scheme will need to be determined after the review of the plan. **Update 26.05.21:** Mr Tris Taylor	G

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

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. **Complete:** Item discussed at IJB	

					meeting on 26.05.21.	

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

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 28 July 2021

Report By:	Karen Hamilton, Chair of SBIJB Audit Committee
Contact:	Jill Stacey, SBIJB Chief Internal Auditor (Scottish Borders Council's Chief Officer Audit & Risk)
Telephone:	01835 825036

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE ANNUAL REPORT 2020/21

Purpose of Report:	To provide Members with the IJB Audit Committee Annual Report 2020/21 that sets out how the IJB Audit Committee has fulfilled its remit and provides assurances to the Board.
Recommendations:	The Scottish Borders Health & Social Care Integration Joint Board is asked to: a) **Approve** the IJB Audit Committee Annual Report 2020/21 (Appendix 1) which sets out the performance in relation to its Terms of Reference and the effectiveness of the Committee in meeting its purpose and the assurances therein.
Personnel:	This report relates to Members of the IJB Audit Committee.
Carers:	There is no direct impact on carers arising from the contents of this report.
Equalities:	There are no direct equalities and diversities implications arising from the contents of this report.
Financial:	There are no direct financial implications arising from the contents of this report.
Legal:	The Scottish Borders Health and Social Care Integration Joint Board, established as a separate legal entity as required by the Public Bodies (Joint Working) (Scotland) Act 2014, is responsible for the strategic planning and commissioning of a wide range of integrated health and social care services across the Scottish Borders partnership area, based on resources which have been delegated to it by the partners, Scottish Borders Council and NHS Borders. The SBIJB is therefore expected to operate under public sector good practice governance arrangements which are proportionate to its transactions and responsibilities to ensure the achievement of the objectives of Integration. The IJB Audit Committee fulfilling its terms of reference is one of the key components of good governance and is critical to the capacity of the SBIJB to function effectively.
Risk Implications:	There is a risk that the IJB Audit Committee does not fully comply with best practice guidance thus limiting its effectiveness as a scrutiny body as a foundation for sound corporate governance.

	The completion of the annual self-assessment and identification and implementation of improvement actions as evidenced through this Annual Report will mitigate this risk.

Background

1.1 It is important that the IJB's Audit Committee fully complies with best practice guidance on Audit Committees to ensure it can demonstrate its effectiveness as a scrutiny body as a foundation for sound corporate governance for the Scottish Borders Health and Social Care Integration Joint Board.

1.2 The Chartered Institute of Public Finance and Accountancy (CIPFA) issued an updated guidance note Audit Committees Practical Guidance for Local Authorities and Police 2018 Edition (hereinafter referred to as CIPFA Audit Committees Guidance) which is deemed appropriate for the IJB under the legislative framework for integration authorities. It incorporates CIPFA's view of the role and functions of an Audit Committee. The CIPFA Audit Committees Guidance includes the production of an annual report on the performance of the Audit Committee against its remit for submission to the IJB.

2 Summary

2.1 The IJB Audit Committee carried out self-assessments of Compliance with the Good Practice Principles Checklist and Evaluation of Effectiveness Toolkit from the CIPFA Audit Committees Guidance during an Informal Session held on 8 March 2021 facilitated by the IJB's Chief Internal Auditor. The Annual Report 2020/21, along with the self-assessments, was considered by the Members of the IJB Audit Committee and agreed at its meeting on 14 June 2021.

2.2 The outcome of the self-assessments was a high degree of performance against the good practice principles and a medium degree of effectiveness. Further areas of improvement have been identified by the Committee.

2.3 The IJB Audit Committee Annual Report 2020/21 is designed both to provide assurance to the IJB's full Board on the effectiveness of the IJB Audit Committee in meeting its purpose and to provide some actions for the IJB Audit Committee to improve its effectiveness.

APPENDIX 1

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
AUDIT COMMITTEE
ANNUAL REPORT FROM THE CHAIR – 2020/21

This annual report has been prepared to inform the Scottish Borders Health and Social Care Integration Joint Board of the work carried out by its Audit Committee during the financial year. The content and presentation of this report meets the requirements of the CIPFA 'Audit Committees' Guidance to report to the full Board on a regular basis on the Committee's performance in relation to its Terms of Reference and the effectiveness of the Committee in meeting its purpose.

Meetings

The IJB Audit Committee has met 5 times on a virtual basis during the financial year on 8 June, 31 August, 21 October (extraordinary meeting) and 7 December 2020, and 8 March 2021 to consider reports pertinent to the audit cycle.

The remit of the IJB Audit Committee is to have high-level oversight of the IJB's framework of internal financial control, corporate governance, risk management systems and associated internal control environment.

To fulfil this remit, it sought assurance through material it received from Internal Audit, External Audit, other external scrutiny and audit bodies, and from Management, and it placed reliance on the Partners' governance arrangements and assurance frameworks.

The Committee scrutinised the IJB's unaudited Annual Accounts 2019/20 in August 2020 and the audited Annual Accounts 2019/20 in October 2020, prior to their presentation for approval by the IJB, and in doing so promoted effective public reporting to the integration authority's stakeholders and local community. The Committee also reviewed the Annual Governance Statement therein to assess whether it properly reflects the risk environment and whether the content is consistent with its own evaluation of the governance arrangements, based on evidence received during the year.

The Committee approved the Plans for work delivered by Internal Audit (provided by SBC's Internal Audit team) and External Audit (provided by Audit Scotland). It considered reports by Internal Audit and External Audit on their findings, conclusions and recommendations arising from their work, monitored the implementation of recommendations arising from Internal Audit and External Audit work, and considered assurance from relevant Internal Audit reports by Partners' Internal Auditors presented to their respective Audit Committees.

The Committee considered relevant national reports that give rise to introducing best practice arrangements or lessons learned.

The Minutes of IJB Audit Committee meetings were presented for noting by the IJB following their approval by the Committee, and the Committee referred any exceptional items to the IJB in accordance with its Terms of Reference.

Membership

The IJB appoints members to its Audit Committee, which consists of "at least four voting members of the IJB, excluding professional advisors, and one independent member appointed from an external source" as set out within its Terms of Reference. The membership, which is based on legislative requirements, does not adhere to the independence principles of good practice within CIPFA 'Audit Committees' Guidance for audit committees to be independent from the decision-making body for effective scrutiny. The independence of the IJB Audit Committee's role in the scrutiny process is partly addressed through the appointment of an Independent Member, who was appointed from the community for a fixed period to 31 October 2021, following an external recruitment and selection process.

The Committee membership during the year was Mrs K Hamilton (Chair), Mrs S Lam, Councillor J Greenwell, Councillor T Weatherston, and Mr J Wilson (Independent Member).

The attendance by each member at the Committee meetings throughout the year was as follows:

Member	8 June 2020	31 August 2020	21 October 2020	7 December 2020	8 March 2021
Mrs K Hamilton (Chair)	√	√	√	√	√
Mrs S Lam	√	√		√	√
Cllr J Greenwell	√	√	√	√	√
Cllr T Weatherston	√	√	√	√	√
Mr J Wilson (Independent Member)	√	√	√	√	√

Every meeting of the IJB Audit Committee in 2020/21 was quorate (i.e. at least three Members present).

All other individuals who attended the meetings are recognised as being "in attendance" only. The Chief Officer, those individuals fulfilling the Chief Financial Officer role, the Chief Internal Auditor, external auditors, and the Secretary (provided by NHS Borders) attend all Committee meetings to support the Committee.

Skills and Knowledge

Given the wider corporate governance remit of IJB Audit Committees and the topics covered by the external and internal audit functions, it is noteworthy that there is a range of skills, knowledge and experience that IJB Audit Committee members bring to the committee, not limited to financial and business management. This enhances the quality of scrutiny and discussion of reports at the meetings. No individual committee member would be expected to be expert in all areas.

Self-Assessment of the Committee

The annual self-assessment was carried out by members of the IJB Audit Committee on 8 March 2021 during an Informal Session facilitated by the IJB Chief Internal Auditor using the 'Good Practice Principles Checklist' and 'Evaluation of Effectiveness Toolkit' from the CIPFA 'Audit Committees' Guidance. This was useful for Members to ensure the Committee can demonstrate its effectiveness as a scrutiny body as a foundation for sound corporate governance for the IJB.

The outcome of the self-assessments for the Committee was a high degree of performance against the good practice principles and a medium degree of effectiveness. The following improvements have been identified:

- Utilise the Knowledge and Skills Framework to inform future learning and development needs of IJB Audit Committee members.
- Set up Informal Sessions prior to each Committee meeting as an opportunity for Members to discuss matters privately with Internal and/or External Auditors or to engage with officers to clarify matters or to engage in IJB Audit Committee learning and development.
- Consider arranging a meeting of Chairs of IJB, SBC and NHS Borders audit committees as an opportunity to share practice and understand the governance arrangements and assurance frameworks of the Partners.

Assurance Statement to the IJB

The IJB Audit Committee provides the following assurance to the Integration Joint Board:

- The IJB has received the Minutes of the IJB Audit Committee meetings throughout the year.
- The IJB Audit Committee has operated in accordance with its agreed Terms of Reference, and accordingly with the audit committee principles within the CIPFA Position Statement.
- It did this through material it received from Internal Audit, External Audit, other scrutiny and audit bodies, and assurance from Management, and it placed reliance on the Partners' governance arrangements and assurance frameworks. It focussed entirely on matters of risk management, internal control and governance.
- For all audit reports, the IJB Audit Committee considered whether it was satisfied that an adequate Management response was in place to ensure action would be taken to manage risk and address concerns on internal controls and governance arrangements.
- There is effective engagement by the Members of the IJB Audit Committee including appropriate scrutiny and challenge and questions relating to the business on the agendas.
- The IJB Audit Committee has reflected on its performance during the year in respect of its Audit functions, and has identified areas for improvements.

Recommendations of the Terms of Reference for the IJB Audit Committee for the coming year

None.

Karen Hamilton
Chair of IJB Audit Committee
May 2021

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 28 July 2021

Report By:	Robert McCulloch-Graham, Chief Officer for Integration
Contact:	Graeme McMurdo, Programme Manager, Scottish Borders Council
Telephone:	01835 824000 ext. 5501
ANNUAL PERFORMANCE REPORT 2020/21	
Purpose of Report:	To seek approval for the Health and Social Care Partnership Annual Performance Report 2020/21
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Propose** any changes to the draft APR. b) **Approve** the APR for publication, subject to the IJB directed changes being made.
Personnel:	The 2020/21 APR has been developed by the HSCP Leadership Team
Carers:	One of our Strategic Objectives is to "improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them". Successful delivery of this objective relies heavily on carers.
Equalities:	n/a
Financial:	n/a
Legal:	Production of the Annual performance Report is a legislative requirement. APRs are normally published by the end of July each year. As a result of Covid-19, this year's APR must be published by end November 2021.
Risk Implications:	n/a

1. Background

1.1 The legislatively required content of the Annual Performance Report (APR) is set out in the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. A further legislative requirement is that every Health & Social Care Partnership publishes their APR by 31st July each year. However, the legislation introduced last year as a result of the Covid-19 pandemic, has been extended and APRs must be published no later than 30th November 2021.

1.2 The 2020/21 APR covers the period April 2020 to March 2021 and as such encompasses a large part of the Covid-19 restrictions and lockdown.

1.3 As a legislative minimum, APRs must:

- Show performance in relation to the National Health & Wellbeing outcomes
- Include information on financial performance and best value
- Include information on Localities
- Include information on inspection of services

1.4 Our APR is structured around the HSCP strategic objectives. It includes all of the legislative requirements and also:

- "Spotlight" sections that highlight the impact of the pandemic over the last year
- The APR looks back at the priorities we set and details what was delivered (i.e.) "What we said / What we did"
- Looks forward to our priorities for 2021/22.

1.5 The appended APR is the MS Word version of the document. A published pdf version has been be developed by the SBC Communications and Graphics team – images from which have been shown in Section 2 of this covering report. It is the intention to publish the final pdf document, incorporating IJB changes, to our website as soon as possible.

1.6 There is one appendix to this report:
Appendix 1: Scottish Borders Health & Social Care Partnership Annual Performance report 2020/21 *(MS Word version)*

Section 2: Selected Images from pdf version of the APR. For IJB information

Scottish Borders Health & Social Care Partnership

ANNUAL PERFORMANCE REPORT 2020-2021

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

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THE BORDERS AT A GLANCE

OLDER

2019 small area population estimates for the Borders (NRS) indicates a total Borders population **115,510**. Of this, **25%** of the Borders population is **65+**, well above the Scottish average of **19%**.

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

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

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

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

To give some context, the population of the South-East Scotland area increased by 8.3% between 2008 and 2018. Percentage growth was highest in City of Edinburgh at 13.1% (59,980 pop. increase), followed by Midlothian at 12% (9,790) and East Lothian at 8.5% (8,210). The lowest percentage growth was Scottish Borders at 1.7% (1,910). Over the same period, for the 25-44 age group, the City of Edinburgh saw an increase of 20.1% while Scottish Borders saw a decrease of 18%. Between 2018 and 2043, the total number of Borders households is projected to increase by 7%, which is significantly lower than the 18% increase predicted for the South-East Scotland area.

COLDER

Our Winter Plan is a joint plan across the Council, NHS and the IJB, with all services focusing on actions to reduce admissions, speed up hospital processes, reduce delayed discharge, support care in the community and prevent hospital readmission. The 2020/21 Winter Plan was heavily impacted by the COVID-19 pandemic and focused on areas including:

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

BOLDER

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

409 social work cases allocated **per month** (12mth average to Feb 2021)

1,280 patients have gone through **Home First** (year to Nov 2020)

1,448 Homecare clients receiving **47,337** hours of homecare per month

HOMECARE PACKAGES
75% <10hrs per week
25% >10hrs per week

79% of people **discharged** to **home** from **Waverley Transitional Care Unit**

1,800 Community Alarms active in **individual's homes** in the Scottish Borders

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

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

#yourpart

2020/21 PARTNERSHIP PERFORMANCE AT A GLANCE

ANNUAL PERFORMANCE

• +ve trend over 4 reporting periods • compares well to Scotland average • compares well against local target	• trend over 4 reporting periods • comparison to Scotland average • comparison against local target	• -ve trend over 4 reporting periods • compares poorly to Scotland average • compares poorly to local target
KEY		
EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES) **85.5** admissions per 1,000 population (Financial Yr – 2020/21)	**ATTENDANCES AT A&E (ALL AGES)** **225.7** attendances per 1,000 population (Calendar Yr - 2020)	**RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)** **3,151** bed days per 1,000 population Age 75+ (Calendar Yr - 2020)
-ve trend over 4 periods Better than Scotland (112.1 – 2019/20) Better than target (91.9)	-ve trend over 4 periods Worse than Scotland (219.4 - 2020) Better than target (216)	+ve trend over 3 years Better than Scotland (3,997.6- 2020) Better than target (min 10% better than Scottish average)
Performance is positive but work will continue to prevent emergency hospital admissions	*The number of attendances at A&E requires more improvement*	*Performance is positive but Covid played a large part in this. Work will continue to reduce occupied bed days*
A&E WAITING TIMES (TARGET = 95%) **86%** of people seen within 4 hours (Financial Yr - 2020/21)	**NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)** **17** over 72 hours (Financial Yr - 2020/21 Average)	**"TWO MINUTES OF YOUR TIME" SURVEY – CONDUCTED AT BGH AND COMMUNITY HOSPITALS** **93.1%** overall satisfaction rate (Financial Yr - 2019/20 Average)
-ve trend over 4 periods Worse than Scotland (87.7% - 2019/20) Worse than target (95%)	+ve trend over 4 periods Better than target (23)	-ve trend over 4 periods Worse than target (95%)
A&E waiting time performance is below our target and needs to improve	*Reducing delayed discharges is a constant focus of the HSCP*	*We have a high satisfaction rate with hospital care but performance has declined*
EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES) **10.6** per 100 discharges from hospital were re-admitted within 28 days (Financial Yr - 2019/20)	**CARERS SUPPORT PLANS COMPLETED** **72%** of carer support plans offered that have been taken up and completed in the last quarter (Financial Yr - 2020/21)	**END OF LIFE CARE** **89.7%** of people's last 6 months was spent at home or in a community setting (Financial Yr – 2020/21)
-ve trend over 4 periods Worse than Scotland (10.5 - 2019/20) Worse than target (10.5)	+ve trend over 3 periods Better than target (40%)	+ve trend over 4 periods Better than Scotland (90.5% - 2020/21) Better than target (87.5%)
More work is required to reduce readmission rates	*The percentage of carer support plans completed continues to be good*	*This is improving, but more work is required to ensure that individuals can spend their last months of life in their chosen setting*

#yourpart

Partnership Priorities for 2020/21 – What we said

7. **Locality Operations**
We will define the locality model, agree the aims, principles, scope, outcomes and the delivery model. Locality teams will use this for guidance, but will also then be able to develop the model in line with the needs of their locality. Our locality model will build on the work of the Community Assistance Hubs and What Matters hubs – and will work closely with communities to provide a joined up Health and Social Care service response that meets local needs.

Key Achievements/Successes : What we did

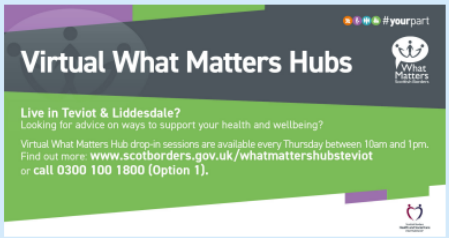
Healthy Living
The 'Paths to Health Walk-It' project forms part of the national initiative to improve Scotland's Health. The project aims to:

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

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

Key Achievements/Successes : What we did

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



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

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INTRODUCTION

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

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

However, I am privileged to lead a partnership of colleagues alongside a community which is determined to provide the best of care for the population of the Scottish Borders. Throughout the pandemic, we have seen the best of human spirit through the effort, sacrifice and resilience of individuals, communities and staff - a legacy which we must celebrate and preserve. Some examples of where Health and Social Care services have delivered a joint response to the challenges posed by COVID-19 include:

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

The Borders already had a number of service delivery challenges in regard to geographical spread of the population, transport provision (i.e.) getting from (a) to (b) and ensuring that all of our residents have access to the services they need; when they need them. Another example of how service continuity and workforce challenges of the pandemic were mitigated was through:

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

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

Annual Performance Report

This Annual Performance Report (APR) covers the period April 2020 – March 2021, which is essentially 12-months of pandemic restrictions and lockdown. As such, much of the content and the APR is Covid-related, including the 'spotlight' sections of the report, which highlight the impact of the pandemic on people and service delivery. The APR is broadly split into 6-areas providing narrative and data on how we have:

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

- Performed in inspections carried out by scrutiny bodies.

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

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

EXECUTIVE SUMMARY

The Scottish Borders Health and Social Care Partnership's Strategic Commissioning Plan (SCP) was first published in April 2016. It set out the Partnership's objectives for improving health and social care services for the people of the Borders.

Our Strategic Commissioning Plan was reviewed to cover the period 2018 to 2021; this refreshed version focused on the delivery of 3 strategic objectives and the associated challenges in delivering these.

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

Our Annual Performance Report (APR) sets out the Partnership's performance between April 2020 and March 2021, outlining our priorities for 2021/22 and reflecting back on performance since inception in April 2016. Delivery on the progress is structured under our 3 Strategic Objectives, which are:

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

Included in the report are 'spotlight' sections, reflecting on some of the key work that has taken place during 2020/21. In this year's report the spotlights cover:

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

The most up to date financial and performance data has been included in the report. Where it is not possible to show the latest information then the previous years' data has been used. Where the latest data is provisional, this is denoted as (p). In regard to performance, the following is included:

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

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

THE BORDERS AT A GLANCE

Older

2019 small area population estimates for the Borders [NRS] indicates a total Borders population of **115,510**. Of this, **25%** of the Borders population is **65+**, well above the Scottish average of **19%.**

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

Population by Locality

Locality	Aged 0-15	Aged 16-64	Aged 65+	
Berwickshire	3,365	12,077	5,478	***20,920***
Cheviot	2,921	10,816	5,576	***19,313***
Eildon	6,172	22,383	8,270	***36,825***
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Tweeddale	3,640	12,126	4,746	***20,512***
	19,023	***67,871***	***28,616***	***115,510***

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

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

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

Colder

Our Winter Plan is a joint plan across the Council, NHS and the IJB, with all services focusing on actions to reduce admissions, speed up hospital processes, reduce delayed discharge, support care in the community and prevent hospital readmission. The 2020/21 Winter Plan was heavily impacted by the COVID-19 pandemic and focused on areas including:

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- Extending 7 day service cover.
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- Weekend provision of pharmacy acute and other services

Bolder

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

409 social work cases allocated per month (12mth average to Feb 2021)	**1,280** patients have gone through Home First (year to Nov 2020)	**1,448** Homecare clients receiving **47,337** hours of homecare per month	Homecare packages: **75%** < 10hrs per week **25%** > 10hrs per week
79% of people discharged to home from Waverley Transitional Care Unit	**1,800** Community Alarms active in individual's homes in the Scottish Borders	**100%** of Borders cancer patients receive their first treatment within 31-days (from the date of the decision to treatment).	The Matching Unit arranges **180** packages of care per month *(a 10% increase on the previous year)*

2020/21 Partnership Performance at a Glance – Annual Performance

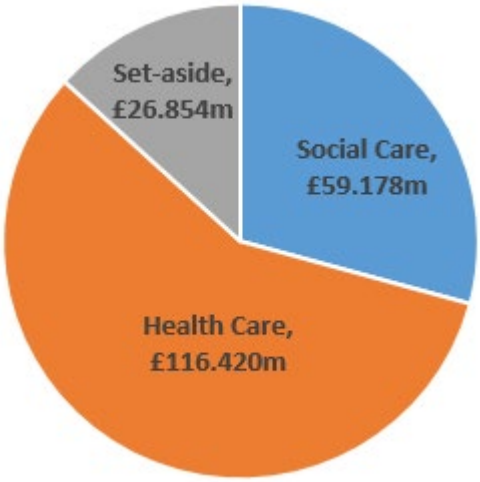
- +ve trend over 4 reporting periods
- compares well to Scotland average
- compares well against local target

- trend over 4 reporting periods
- comparison to Scotland average
- comparison against local target

- -ve trend over 4 reporting periods
- compares poorly to Scotland average
- compares poorly to local target

Emergency Hospital Admissions (Borders residents, all ages) **85.5** admissions per 1,000 population (Financial Yr – 2020/21) +ve trend over 4 periods Better than Scotland (112.1 – 2019/20) Better than target (91.9)	Attendances at A&E (all ages) **225.7** attendances per 1,000 population (Calendar Yr - 2020) +ve trend over 4 periods Worse than Scotland (219.4 – 2020) Worse than target (216)	Rate of Occupied Bed Days* for Emergency admissions (ages 75+) **3,151** bed days per 1,000 population Age 75+ (Calendar Yr - 2020) +ve trend over 3 years Better than Scotland (3997.6 – 2020) Better than target (min 10% better than Scottish average)
Performance is positive but work will continue to prevent emergency hospital admissions	***The number of attendances at A&E requires more improvement***	***Performance is positive but Covid played a large part in this. Work will continue to reduce occupied bed days***
A&E waiting times (Target = **95%**) **86%** of people seen within 4 hours (Financial Yr – 2020/21) -ve trend over 4 periods Worse than Scotland (87.7% - 2019/20) Worse than target (95%)	Number of delayed discharges ("snapshot" taken 1 day each month) **17** over 72 hours (Financial Yr – 2020/21 Average) -ve trend over 4 periods Better than target (23)	"Two minutes of your time" survey – conducted at BGH and Community Hospitals **93.1%** Overall satisfaction rate (Financial Yr - 2019/20 Average) -ve trend over 4 periods Worse than target (95%)
A&E waiting time performance is	***Reducing delayed discharges is a***	

below our target and needs to improve	*constant focus of the HSCP*	*We have a high satisfaction rate with hospital care but performance has declined*
Emergency readmissions within 28 days (all ages) **10.6** per 100 discharges from hospital were re-admitted within 28 days (Financial Yr – 2019/20) -ve trend over 4 periods Worse than Scotland (10.5 – 2019/20) Worse than target (10.5) **More work is required to reduce readmission rates**	Carers support plans completed **72%** of carer support plans offered that have been taken up and completed in the last quarter (Financial Yr – 2020/21) +ve trend over 3 periods Better than target (40%) ***The percentage of carer support plans completed continues to be good***	End of Life Care **89.7%** of people's last 6 months was spent at home or in a community setting (Financial Yr – 2020/21) +ve trend over 4 periods Worse than Scotland (90.5% - 2020/21) Better than target (87.5%) ***This is improving, but more work is required to ensure that individuals can spend their last months of life in their chosen setting***

Our Partnership Spend 2020/21	
During 2020/21 the Integration Joint Board spent: £202.452m. this was split:  	£ on emergency hospital stays **19.9%** of total health and care resource, for those Age 18+ was spent on emergency hospital stays (Financial Yr – 2019/20) +ve trend over 4 periods Better than Scotland (24.0% - 2019/20) Better than target (21.5%)

STRATEGIC OVERVIEW

The Public Bodies (Joint Working)(Scotland) Act 2014 established the legislative framework for the integration of health and social care services in Scotland. The Act obliges Integration Authorities to publish an Annual Performance Report (APR) to cover performance for the previous reporting year. The report *should* be published no later than four months after the end of the reporting year (i.e., the end of July) and should set out an assessment of the performance in planning and delivery of the integration functions for which the HSCP is responsible. However, as a result of the Covid-19 pandemic, the legislation was amended, allowing the delayed publication of 2020/21 Annual Performance Reports.

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

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

Underpinning the legislation are a set of 9 National Health and Wellbeing Outcomes. These are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

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

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

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

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

Navigating this complicated 'landscape' of legislation, National Health & Wellbeing Outcomes, Strategic Objectives and Priorities can be challenging. The table below shows how it all fits together.

Government Integration Legislation

National Outcomes	Strategic Objectives	Priority Workstream
Outcome 1: people are able to look after and improve their own health and wellbeing and live in good health for longer	**We will improve the health of the population and reduce the number of hospital admissions** ***How*** • By supporting individuals to improve their health • By improving the range and quality of community based services and reducing demand for hospital care • Ensuring appropriate supply of good quality and suitable housing ***Links*** National Outcomes: **1,2,3,5** SIP Workstream: **5,10**	1. Carer Support Services
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live as far as reasonably practicable, independently and at home or in a homely setting in their community		2. Locality Operations
Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected		3. Older People's Pathway
Outcome 4: Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services	**We will improve the flow of patients into, through and out of hospital** ***How*** • By reducing the time that people are delayed in hospital • By improving care/patient pathways to ensure a more coordinated, timely and person centered experience/approach • By ensuring people have a greater choice of different housing options which meet their long-term housing, care and support needs ***Links*** National Outcomes: **3,4,5,7** SIP Workstream: **3,8,9**	4. Technology
Outcome 5: health and social care services contribute to reducing health inequalities		5. Primary Care Improvement Plan
Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their role on their own health and wellbeing		6. Mental Health provision
Outcome 7: People using health and social care services are safe from harm	**We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them**. ***How*** • By supporting people to manage their own conditions • By improving access to health and social care services in local communities • By improving support to carers • By building extra care homes, including amenity and mixed tenure provision ***Links*** National Outcomes: ALL SIP Workstream: **1,2,4,6,7**	7. Learning & Physical Disability provision
Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide		8. Joint Capital Planning
Outcome 9: Resources are used effectively and efficiently in the provision of health an and social care services		9. Service Commissioning
		10. Workforce Support and provision

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

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

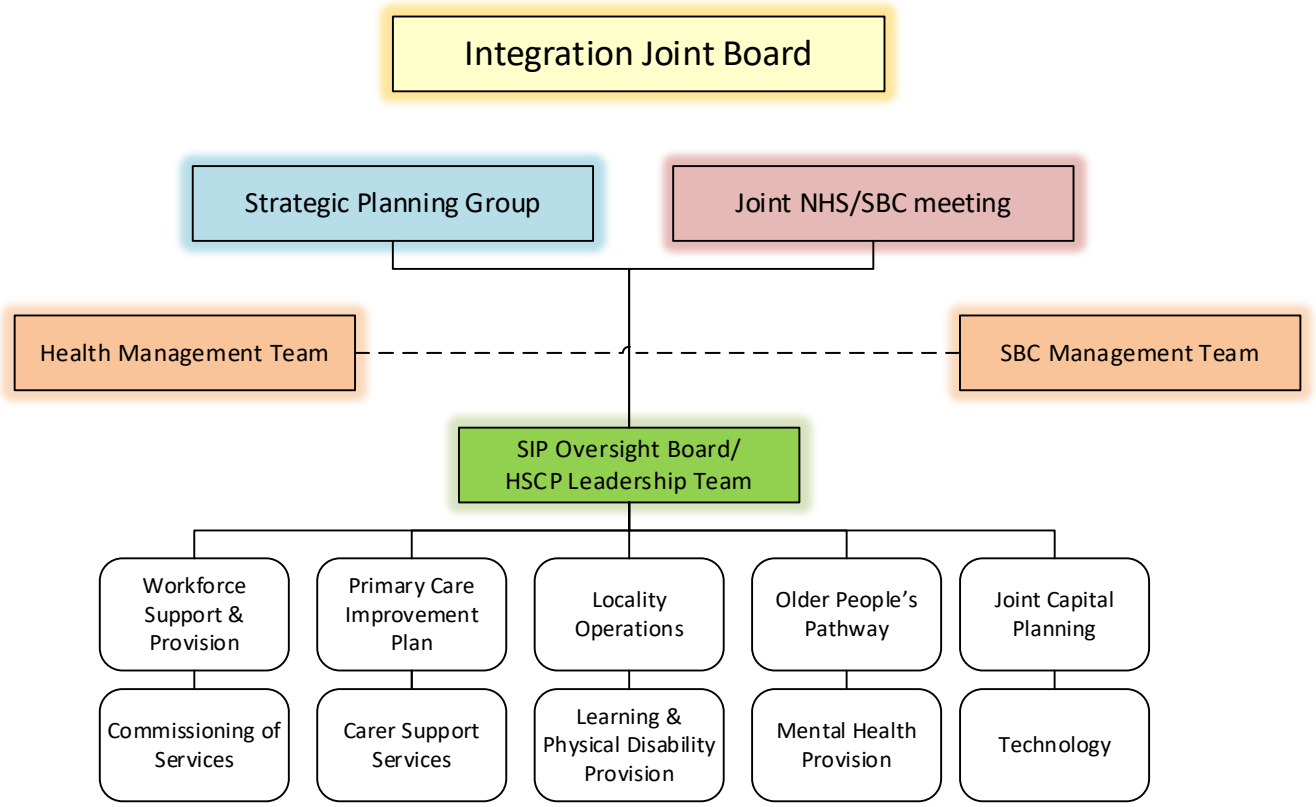
1. Resource management and control
2. Operational management and direction
3. Strategy and commissioning
4. Professional and clinical governance

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

GOVERNANCE AND ACCOUNTABILITY

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

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



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

The Strategic Planning Group (SPG) acts as an advisory committee to the Integration Joint Board (IJB). The role of the SPG is to identify and raise issues that may impact on the delivery of the local objectives set out in the Strategic Plan and against the agreed national outcomes. The group provides a forum for initial consultation and community engagement and to ensure effective links to each of the five Scottish Borders localities, which are:

- Berwickshire
- Cheviot
- Eildon

- Teviot & Liddesdale
- Tweeddale

The quarterly performance report for IJB contains a range of Health & Social Care performance measures aligned to the 3 Strategic Objectives. Quarterly performance reporting includes red, amber or green (RAG) status for each performance measure. The RAG status is based on a combination of performance against target, performance trend over time and performance in comparison to National results. Our Integration Performance Group (IPG) and SPG is responsible for the development of Partnership performance

The Internal Audit work for 2020/21 covered:

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

Within the Internal Audit Annual Assurance Report 2020/21, presented to the IJB Audit Committee in June 2021, the IJB Chief Internal Auditor's statutory opinion was that Scottish Borders IJB's governance arrangements, risk management and systems of internal control are adequate. Improvements made by Management during the year have been limited by the effect of the COVID-19 pandemic; however lessons learned from this have been noted. Further improvements in governance and internal control have been agreed by Management.

The IJB Audit Committee approved the Scottish Borders IJB Internal Audit Annual Plan 2021/22 in March 2021, which has a specific focus on the contracts and commissioning of service delivery to inform strategies and plans to meet the priorities in the Strategic Commissioning Plan.

KEY PARTNERSHIP DECISIONS 2020/21

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

April 2020:
• No meeting held because of the pandemic
May 2020:
• No meeting held because of the pandemic
June 2020:
• No meeting held because of the pandemic
July 2020:
• No meeting held because of the pandemic
19th August 2020 meeting:
• The Health & Social Care Integration Joint Board approved the new IJB Risk Management Policy • The Health & Social Care Integration Joint Board approved the refreshed IJB Risk Management Strategy • The Health & Social Care Integration Joint Board approved the Alcohol and Drugs Strategic Plan refresh. • The Health & Social Care Integration Joint Board agreed the transfer of resource between Primary Care Improvement Plan (PCIP) workstreams but within the total resource allocation for the programme in order to develop a Borders wide Primary Care Mental Health Service called "Renew". • The Health & Social Care Integration Joint Board directed actions to address the challenges and to mitigate risk identified in the regular Quarterly Performance Report. • The Health & Social Care Integration Joint Board agreed the revised priorities for the IJB in set out in the Strategic Implementation plan (SIP) in light of lessons learned from experiences within services in their response to the pandemic.
23rd September 2020 meeting:
• The Health & Social Care Integration Joint Board approved the Annual Performance Report (APR) for publication, subject to the IJB directed changes being made.
21st October 2020 meeting:
• The Health & Social Care Integration Joint Board approved the 2019/20 Annual Accounts.
November 2020:
• No meeting held
16th December 2020
• The Health & Social Care Integration Joint Board approved the IJB Business Plan and Meeting Cycle for 2021. • The Health & Social Care Integration Joint Board approved the appointment of Linda Jackson as a non-voting member of the Integration Joint Board of Scottish Borders. • The Health & Social Care Integration Joint Board supported the changes in reporting lines within the senior management team, outlined within the paper, to strengthen the "Strategic Commissioning" function of the Integration Joint Board. • The Health & Social Care Integration Joint Board directed actions to address the challenges and to mitigate risk identified in the regular Quarterly Performance Report.
January 2021

- No meeting held

17th February 2021 meeting:

- The Health & Social Care Integration Joint Board approved the revised Terms of Reference for the Strategic Planning Group with the two additions to the membership of Wendy Henderson (Scottish Care) and Alastair McLean (Vice-Chair Independent Care Providers Group).
- The Health & Social Care Integration Joint Board approved a 12-month delay in the update and refresh of the Scottish Borders HSCP Integration Strategic Commissioning Plan.
- The Health & Social Care Integration Joint Board agreed that work to update and refresh the plan uses the Health Improvement Scotland strategic planning: good practice framework as its basis.
- The Health & Social Care Integration Joint Board considered and agreed the Discharge Programme Evaluation recommendations:-
    - Home First should be the default and should better align with What Matters locality hubs and services to increase the balance of step up Intermediate Care (IC) and enable closer working with local Housing providers and Third sector support.
    - Bed based IC should be streamlined as a single pathway for older people with post-acute reablement / rehab / nursing care needs that cannot be met by Home First, particularly for residents in Central Borders.
    - The service budget for these projects should now be mainstreamed to enable strategic commissioning, substantive recruitment and workforce development as part of a comprehensive framework for integrated intermediate care in each locality. This will need to be maintained within the existing Transformation Fund limit of £2.2M, and will be included within the overall budget for IJB delegated services, to be agreed for 2021 to 2022.

24th March 2021 meeting:

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 1:

WE WILL IMPROVE THE HEALTH OF THE POPULATION AND REDUCE THE NUMBER OF HOSPITAL ADMISSIONS.

Objective 1: Background and Challenges

We are committed to helping older people to manage their own health better, improving fitness and reducing social isolation. We know that the number of older people in the Borders is increasing; 25% of the Borders population in 2020 is 65+; this is estimated to rise to 30% by 2030. This proportion of older people in the Borders is also increasing at a faster rate than the Scotland average. It is crucial that we continue to promote 'active ageing' as we know that many older people in Scottish Borders report poor health. We must continue to promote healthier lifestyles, earlier detection of disease and support to individuals to recover from and manage their conditions. The population of the Scottish Borders is spread over a large geographical area with many people living in rural locations, therefore services must continue to be provided locally with accessible transport arrangements in place.

Key to achieving positive change is by:

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

Objective 1: Spotlight – Workforce

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

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

SB Cares Rapid Response Team

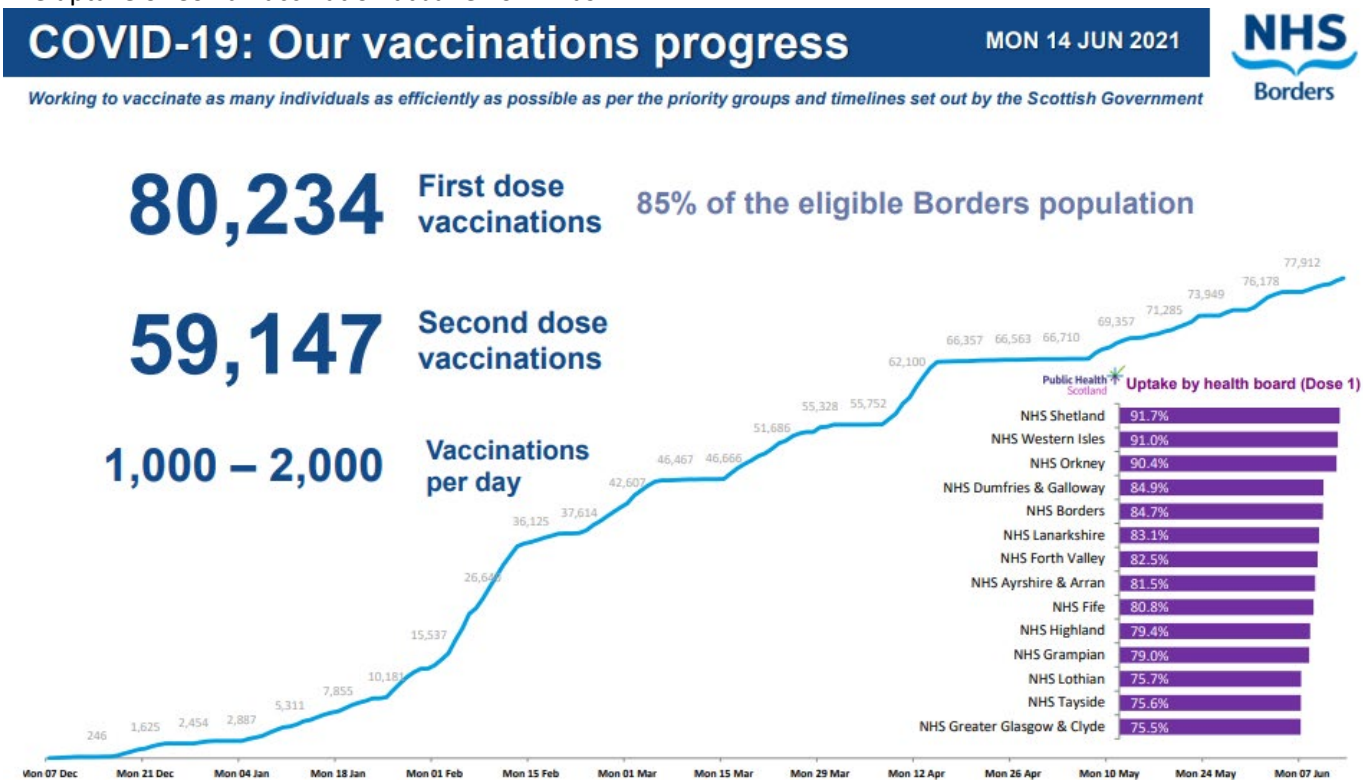
As part of the efforts to fight Covid-19, SB Cares homecare and residential care staff worked tirelessly to make sure that all operational practice adhered to rapidly changing guidance. The service informed stakeholders at every stage and ensured that all necessary materials and equipment were readily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

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

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

Age group	Uptake (%)
>65	88.4%
<65 (at risk)	98.5%
Pregnant ladies	63.6%
Primary school age	82.2%
2-5 year olds	43.7%

The uptake of Covid-vaccination at June 2021 was:



Acute staff
NHS Borders Acute Services has met unprecedented levels of challenge and activity over the last 12 months. The initial Spring-wave and then second larger COVID-19 wave required innovation, flexibility and leadership. Services had to innovate and develop new workforce models to ensure continued delivery of safe and sustainable services. This pandemic experience has enabled swift changes that could normally take years; teams have developed an improved hospital-wide perspective and responding to the requirement for rapid change is now considered business-as-usual. Assets have been developed that will prove critical for future service delivery (e.g.) during the pandemic, nurses were redeployed into high acuity areas such as Intensive Care Units (ICU) and High Dependency Units (HDU). Maintaining and updating these staffs' skills in HDU and ICU is continuing by the sharing of theatre and recovery staff to these areas. From April 2021 our community hospital patients have been able to have one visitor to the ward. This 'small' change has required, processes to be developed, a risk assessments completed, staff updated, consideration of flexibility with "essential visits", and visitor information updated. Every change to what has become the 'norm' requires a lot of work from a lot of people to communicate and implement successfully.

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

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

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

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

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

Objective 1: Priorities 2020/21 - What we said / What we did.

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

Partnership Priorities for 2020/21 – What we said

1. Primary Care Improvement Plan

One of the PCIP development areas within the GP Contract is the creation of "Additional Professional Roles" which includes the introduction of 1st contact Physiotherapists and the development of Community Mental Health Workers. Within the work to develop the latter, a "test of change" took place at O'Connell Street Medical Practice in October 2019. This was to test a "see and treat" Mental Health model where patients with mild to moderate anxiety and depression were seen by a mental health practitioner (rather than the GP) and offered evidence based psychological therapy depending on their needs. The aim is to evaluate how this could assist GPs as well as offering a more effective and efficient intervention for patients. This work will continue throughout 2020/21

Key Achievements/Successes : What we did

Vaccination Transformation Programme

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

Pharmacotherapy

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

Community Treatment & Care Services

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

Urgent Care

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

First Contact Physiotherapists

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

Community Mental Health Workers

A model was tested where patients with mild to moderate anxiety and depression were seen by a mental health practitioner and offered evidence based psychological therapy depending on their needs. PCIP funding of £354k was allocated to scale up the model in one area as a first phase but work was delayed mainly because of the pandemic. The "see and treat" model that utilises a skill mix/ Multi-Disciplinary Team approach, where assessment and treatment take place in a variety of settings/formats and are as patient led as possible. There are strong links with secondary care and complementary/commissioned services to ensure that patients are able to get the most appropriate help with as few barriers as possible. As highlighted above, £184k from Pharmacotherapy has been diverted to this model and it has

been agreed to name the new service "Renew". This service has been very warmly welcomed by our GP colleagues and they see the service as filling what was previously a significant gap in our provision.

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

Partnership Priorities for 2020/21 – What we said

2. Workforce Support and provision

The Covid-pandemic highlighted the importance of staff :
- being able to work remotely.
- having fewer paper-based processes.
- being able to access the technology they need.
- being trained to use the technology effectively.
- being able to work collectively and seamlessly across Health and Social Care.
- having the flexibility to deliver a range of services.

Work to take forward the Covid-19 lessons-learned in regard to the Health and Social Care workforce will continue throughout 2020/21.

Key Achievements/Successes : What we did

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

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

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

Objective 1: Partnership Priorities for 2021/22

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

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 2:

WE WILL IMPROVE THE FLOW OF PATIENTS INTO, THROUGH AND OUT OF HOSPITAL.

Objective 2: Background and Challenges

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

Key to achieving positive change is by:

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

Objective 2: Spotlight – Pandemic response in home care, residential care and Health

Care Homes and Care at Home

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

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

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

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

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

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

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

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

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

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

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

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

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

Partnership Priorities for 2020/21 – What we said

3. Older People's Pathway

Work will continue in regard to Older People's Pathway including developments to:
• Intermediate Care • Trusted Assessor • Reablement • Matching Unit • Older Person's Assessment Unit • Discharge Huddles

Key Achievements/Successes : What we did

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

(1) Waverley Transitional Care Unit

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

(2) Garden View Discharge to Assess

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

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

(3) Home First

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

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

(4) Matching Unit

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

(5) Strata

The Strata digital referral system is managing 800 referrals per month to care homes, intermediate care, the third sector

and Trusted Assessment, with Strata referrals to schedule homecare to commence shortly.

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

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

Partnership Priorities for 2020/21 – What we said

4. Joint Capital Planning

Capital investment is most often done to purchase, construct or develop a tangible asset (e.g.) property. This will continue, but on a partnership basis and will include:

- 60 bed care developments
- LD care developments
- Staff accommodation and technology

Key Achievements/Successes : What we did

Extra Care Housing

***Wilkie Gardens*, Langhaugh, Galashiels (Eildon Housing):**

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

***Todlaw, Duns* (Trust Housing)**

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

***Kelso* (Eildon Housing)**

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

Care Homes

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

Care Village

An outline design proposal for 2x 60-bed care village developments continues to be progressed. The accommodation is

based on self-contained 'units', with adjacent treatment space, retail/café and recreational facilities available on site for the use of residents and the wider community.

Partnership Priorities for 2020/21 – What we said

5. Service Commissioning

Commissioning and the recommissioning of services including:

- home care,
- our bed-base (acute, residential, intermediate care)
- reablement

…..will continue under the scrutiny of the SIP Oversight Board with the aim of re-contracting a number of services in 2022

Key Achievements/Successes : What we did

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

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

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

Objective 2: Partnership priorities for 2021/22

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

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 3:

WE WILL IMPROVE THE CAPACITY WITHIN THE COMMUNITY FOR PEOPLE WHO HAVE BEEN IN RECEIPT OF HEALTH AND SOCIAL CARE SERVICES TO BETTER MANAGE THEIR OWN CONDITIONS AND SUPPORT THOSE WHO CARE FOR THEM.

Objective 3: Background and Challenges

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

Key to achieving positive change is by:

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

The Borders Carers Centre is responsible for Carers Support Plans and can assist in putting together a plan centred around carer needs, giving access to appropriate information, advice and support – including support to access funding; training & workshops; emotional support; hospital support; counselling or support groups. Borders Carers Centre services are free and independent and all carers over the age of 18 years are supported. The centre, based in Galashiels, is also on hand if carers just need to chat on the phone to somebody who knows what they're going through.

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

Objective 3: Spotlight- Community Assistance Hubs (CAHs)

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

- Community response and…
- Health and Social Care

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

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

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

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

- NHS Inform provides the most update to date guidance on coronavirus, including mental health support. There is advice on how to stay informed, create a healthy home routine, stay connected with friends and family and where you can turn to for advice and guidance
- The Wellbeing Point on the NHS Borders website provides information about a range of support services available both locally and nationally that you may find helpful
- Clear Your Head provides advice on how to look after your mental wellbeing, including tips on how to stay positive and feel better
- SAMH has a developed specific information on COVID-19 and your mental wellbeing
- Age Scotland provides information and advice for anyone aged 50 and over, as well as a free, confidential helpline 0800 12 44 222 (Monday to Friday 9am-5pm)
- Alzheimer Scotland has a 24 hour Freephone Dementia Helpline 0808 808 3000
- The Royal Voluntary Service is providing a programme of themed online activities designed to help beat the boredom of isolation, as well as other hints and tips for staying active and connected
- Shared Care Scotland has developed a directory of short breaks for strange times. These include everything from online courses, virtual museums, exercise programmes, read-alongs, and websites for children and young people, as well as support services that are delivering online

The CAH approach helped to:

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

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

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

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

Locality	Shielders	Food only	Food & medication	Other
Berwickshire	773	208	39	29
Cheviot	834	181	66	59
Eildon	1,419	330	76	81
Teviot & Liddesdale	872	242	16	57
Tweeddale	643	115	27	51
Totals:	**4,541**	**1,076**	**224**	**277**

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

	Calls for week commencing….			
Call Type	***22/06/20***	***07/09/20***	***11/01/21***	***31/05/21***
Financial Support	37	2	163	6
Social Care & Health	41	15	32	10
General	156	38	182	29
Total:	**234**	**55**	**377**	**45**

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

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

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

Partnership Priorities for 2020/21 – What we said

6. Carer Support Services

We will improve accessibility to respite provision and further develop access to other sources of support both the community and across web/telephone services. We will continue working with Borders Carers Centre and Borders Care Voice to better understand the needs of carers and to work collectively to deliver the services they require.

Key Achievements/Successes : What we did

BOPPP

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

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

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

Dementia

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

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

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

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

Maternity Services

Maternity services at BGH were awarded the UNICEF UK Baby Friendly Initiative (BFI) Gold Award. NHS Borders is one of only three health boards in Scotland to receive this award in recognition of excellence and sustained practice in the support of infant feeding and parent-infant relationships.

Partnership Priorities for 2020/21 – What we said

7. Locality Operations

We will define the locality model, agree the aims, principles, scope, outcomes and the delivery model. Locality teams will use this for guidance, but will also then be able to develop the model in line with the needs of their locality. Our locality model will build on the work of the Community Assistance Hubs and What Matters hubs – and will work closely with communities to provide a joined up Health and Social Care service response that meets local needs.

Key Achievements/Successes : What we did

Healthy Living

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

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

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

Locality Planning

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

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

Partnership Priorities for 2020/21 – What we said

8. Technology

Technology is very closely linked to Workforce and we will continue to invest in technology for staff and invest in technology enabled care to help people live independently for as long as possible.

Key Achievements/Successes : What we did

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

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

Shifts	SB Cares
Posted	2,657
Filled	1,976
%	**74%**

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

online, and exploring hobbies and interests. Many of the people who were shielding in the initial phase have learned new skills such as how to make video calls with their friends and family, therefore helping to reduce social isolation.

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

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

Partnership Priorities for 2020/21 – What we said

9. Mental Health provision

Our Child and Adolescent Mental Health Service (CAMHS) is redesigning care pathways during 20/21. The adult mental health service will continue delivering the distress brief intervention service and, in collaboration with primary care will continue development of the community mental health model (where appropriate patients see a mental health professional rather than a GP) and are offered evidence based psychological therapy depending on their needs.

Key Achievements/Successes : What we did

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

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

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

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

Partnership Priorities for 2020/21 – What we said

10. Learning & Physical Disability provision

We will update our Physical Disability Strategy and implementation plan, explore options for a complex care unit for adults with learning disabilities and continue to progress shared lives, with the first service users commence placements during the latter half of 2020. Respite Care and short breaks provision will be reviewed and supported living provision, in collaboration with local Registered Social Landlords explored. A key objective within the next 2-years is to develop increased supported housing for adults with complex care needs, reducing the number of out of area placements required.

Key Achievements/Successes : What we did

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

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

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

Objective 3: Partnership priorities for 2021/2022

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

Workstream	Planned delivery during 2021/22
Carer Support Services The partnership recognises the essential work of carers – even more so throughout the Covid-19 pandemic – looking to the future, it is a precarious resource that requires support.	**Hear From You** As we look to recover and rebuild, we want to widen our network of public involvement support and reach in to all areas of the Borders community and to hear your views. We can then co-produce our approach to public involvement to ensure that it is inclusive, effective, fit for purpose and can be adapted to meet the changing needs of our communities as we emerge from the pandemic. Our aim is to establish a reference group of at least 200 people of varied age, background, location, interests in or experience of health conditions. You might have faced barriers in accessing healthcare, you might be part of a community you feel is under represented or seldom asked to express your views. Whoever you are and whatever you have to say we want to hear from you. You can do this in a number of ways: • email to public.involvement@borders.scot.nhs.uk • phone 0800 731 4052 (free of charge) • completing our online form • Sending us a note in the post to Public Involvement, Education Centre, Borders General Hospital, Melrose, TD6 9BS
	Engagement/Place-making Development of a Place Making approach to community engagement and participation across Borders communities. The place making proposals aim to build on, and link with, a wide range of existing and planned national, partnership and community work. In particular, the proposals aimed to build on the learning and experience of joint working with Communities and Partners in responding to the Covid-19 pandemic and to reflect the national ambition for a Resilient Recovery.
Locality Operations Early intervention, prevention, shared client cohorts, agile responses, close coordination of effort, all designed to reduce admissions and avoid/or slow progression to higher levels of care and health needs.	**Locality Model** Pre-Covid, What Matters hubs operated in each locality. The hubs allowed people to make appointments or drop in to see a member of the Social Work team for advice or support. The hubs were supported by the Red Cross, Local Area Coordinators and other partner organisations such as Chest Heart Stroke Scotland, Alzheimer's Scotland, Fire Scotland and the Food Train. Following the pandemic, development of a new Locality Hub model is essential. It will retain the ethos of the Community Assistance Hubs and provide wide ranging support in local communities, using a combination of physical and virtual hubs (e.g.) enabling people to have a more personal conversation through a video call similar to Skype or Facetime, using 'Near Me' technology currently used by NHS and Social Work staff. Going forward. the Locality Hub model will provide a much broader range of support than was previously available and will be supported by a number of services including adult social work, homelessness, welfare advice & benefits, local area coordination (older adults, mental health and learning disabilities), Health, the wellbeing service and Third Sector organisations such as the Red Cross. - Continue the trial and monitor the Teviot virtual What Matters Hub.

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

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Performance Summary

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

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

In 2020/21 the IJB controlled the direction of **£208,688m** of financial resource to support the delivery of its three strategic objectives. The split of the resource is shown below:

IJB Service Area	Base Budget (£'000)	Revised Budget (£'000)	Actual (£'000)	Variance (£'000)
1. Social Care Services				
Joint Learning Disability Service	16,399	17,167	17,047	120
Joint Mental Health Service	2,022	2,155	2,132	23
Joint Alcohol and Drug Service	142	101	95	6
Older People Service	25,195	23,413	23,841	(428)
Physical Disability Service	2,458	2,644	2,646	(2)
Generic Services	12,897	13,605	13,417	188
SBC Contribution	0	93	0	93
Social Care sub-total:	***59,113***	***59,178***	***59,178***	***0***
2. Health Services				
Joint Learning Disability Service	3,740	3,445	3,830	(385)
Joint Mental Health Service	15,980	17,215	16,925	290
Joint Alcohol and Drug Service	390	757	757	0
Prescribing	23,130	23,132	22,660	472
Generic Services	64,540	74,182	72,248	1,934
NHSB Additional Contribution	0	3,925	0	3,925
Health sub-total:	***107,780***	***122,656***	***116,420***	***6,236***
3. Set-aside Healthcare Services				
Accident & Emergency	2,830	3,132	3,634	(502)
Medicine & Long-Term Conditions	15,660	16,385	16,819	(434)
Medicine of the Elderly	6,230	7,099	6,401	698
Planned savings	(1,090)	(1,090)	0	(1,090)
NHSB-Funded Costs above Budget	0	0	(1,328)	0
Set-aside sub-total:	***23,630***	***25,526***	***25,526***	***0***
Overall:	**190,523**	**208,688**	**202,452**	**6,236**

Note: The 'set-aside' budget covers the in-scope integration functions of the NHS that are carried out in a large

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

Proportion of spend by reporting year, broken down by service

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

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

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

Overspend / Underspend

The HSCP reported an under-spend position of **£6.236m** against the delegated budget at 31st March 2021. This under-spend related to ring-fenced funding received by NHS Borders, slippage in service developments and cost pressures which have been carried forward. In order to achieve this additional allocations from each funding partner were required during the year, and at year end, to deliver a break even position overall. These amounted to **£0.093m** and **£3.925m** for social care and healthcare functions respectively.

In terms of the Health and Social Care Partnership set aside, the IJB directed **£25.526m** to NHS Borders in 2020/21. During the financial year, NHS Borders spent **£26.854m**, resulting in an over-spend of (**£1.328m)** within the Health Board functions. The over-spend position remains the responsibility of NHS Borders and as a result, has been absorbed within the overall health board financial position at outturn.

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

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

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

Area	Year Commence £'000m	Year End £'000m
Ring-fenced funding carried forward in delegated functions	3,168	9,404
Transformation Fund	396	714
Older People's Change Fund	178	122
Total:	**3,742**	**10,240**

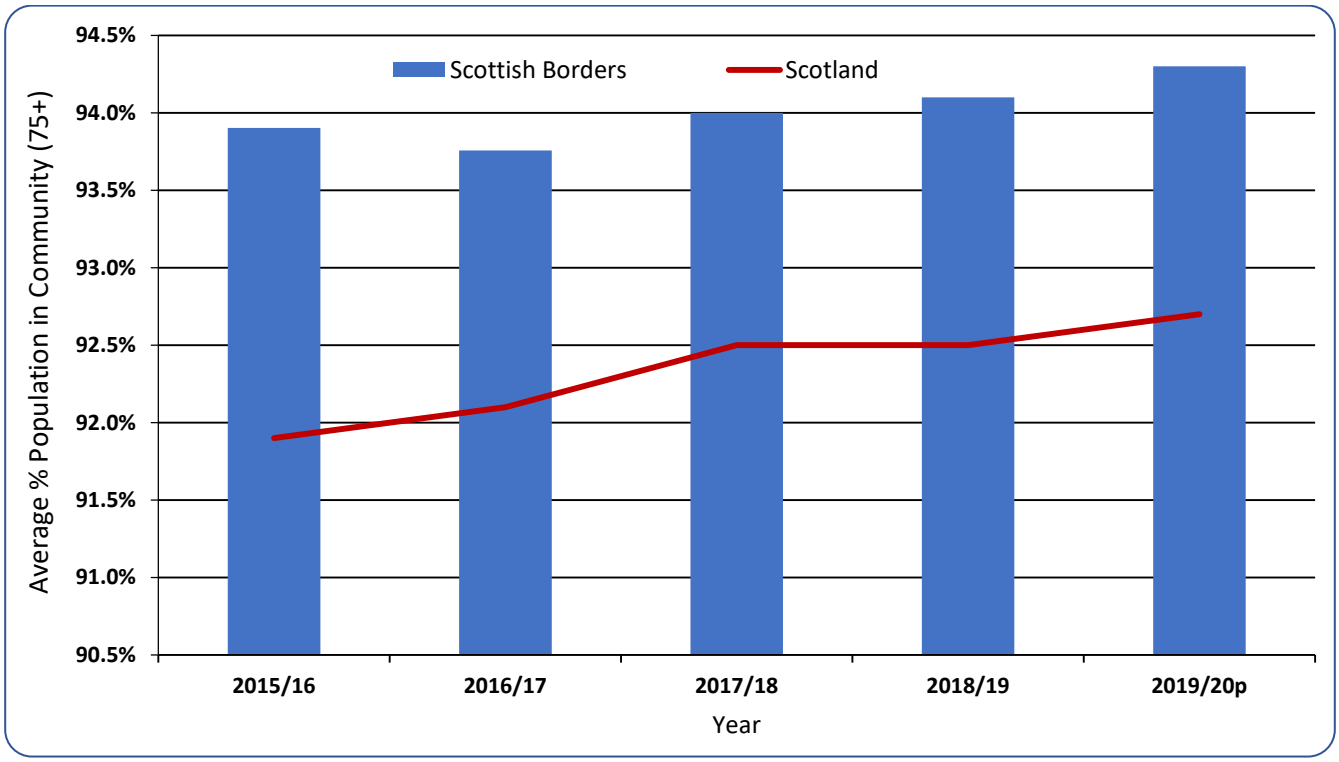
Balance of care

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

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

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

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



Best Value and BV Audit

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

Scottish Borders Council developed an Action Plan to progress improvements across all recommendations made in the 2019 Best Value Assurance Report by Audit Scotland. The actions below are aimed towards improving partnership working and lie within the responsibility of the IJB:

ACTION	Timescales	% COMPLETION	NOTES
Raise visibility of key policies and decisions across respective governance groups including Executive Management Team and	31-Jul-21	80%	The joint SBC and Health Group who meet regularly has improved the quick, formal joint discussion and decision on key policies and actions – many relating to pandemic response. It

Corporate Management Team.			is anticipated this group will continue to meet regularly post CV-19.
Enhance governance arrangements and clarity of role of respective partnership groups including Integrated Joint Board, Executive Management Team and Strategic Planning Group. Improving quality and availability of reports outlining proposals to enable these groups to plan and take decisions more effectively.	31-Jul-21	60%	At its December 2020 meeting, IJB approved changes in reporting lines within the senior management team to strengthen the "Strategic Commissioning" function of the Integration Joint Board. These changes enhance governance arrangements and joint working between SBC and Health.
Develop a model for localities that adopts a single structure for the management and provision of joint health and Social services.	31-Mar-22	50%	The Locality approach was accelerated by the demands of the pandemic/lockdown. Work is ongoing to specify local requirements, resource and structure. Virtual What Matters hubs will be re-established across all localities (current Teviot pilot). Work still to do includes full agreement on services in scope and staffing resource.
Ensure a joint financial and service plan that is fully endorsed by respective partners is prepared for IJB on an annual basis.	31-Jul-21	100%	March 2021 IJB agreed the joint budget. The changes to senior management team to strengthen the commissioning role of the IJB ensures that services and budgets are aligned to IJB delivery.

Our governance framework is the rules, policies and procedures by which the IJB ensures decision making is accountable, transparent and carried out with integrity. The Board has legal responsibilities and obligations to its stakeholders, staff and residents of the Borders area. The HSCP Senior Leadership Team (SLT) and the IJB ensures proper administration of its financial affairs. At the start, middle and end of the financial year, the IJB and its partners undertake a full review and evaluation of its degree of compliance with legislation and recommended best practice in relation to the Partnership's financial governance, planning, management and reporting arrangements and clear forward planning is in place to ensure full assurance to the Partnership going forward.

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

LOCALITY ARRANGEMENTS

Locality planning is a key tool in engagement, the identification of local issues and the delivery of the change. The IJB developed locality arrangements where professionals, communities and individuals can inform locality planning and redesign of services to meet local need in the best way. This is set up through 'Locality Working Groups' in each of the five localities:

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

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

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

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

Locality Population

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

Locality	Town name	All ages	Aged 0-15	Aged 16-64	Aged 65+	% 0-15	% 16-64	% 65+
Berwickshire	Ayton	**579**	86	314	179	*15%*	*54%*	*31%*
	Chirnside	**1,447**	324	808	315	*22%*	*56%*	*22%*
	Coldingham	**479**	61	279	139	*13%*	*58%*	*29%*
	Coldstream	**1,856**	233	968	655	*13%*	*52%*	*35%*
	Duns	**2,787**	472	1,612	703	*17%*	*58%*	*25%*
	Eyemouth	**3,500**	715	1,917	868	*20%*	*55%*	*25%*
	Greenlaw	**623**	73	399	151	*12%*	*64%*	*24%*
	Rural	**9,649**	1,401	5,780	2,468	*15%*	*60%*	*26%*
	Berwickshire total:	**20,920**	**3,365**	**12,077**	**5,478**	***16%***	***58%***	***26%***
Cheviot	Jedburgh	**3,826**	649	2,205	972	*17%*	*58%*	*25%*
	Kelso	**6,843**	1,044	3,786	2,013	*15%*	*55%*	*29%*
	St Boswells	**1,430**	241	737	452	*17%*	*52%*	*32%*
	Yetholm	**616**	79	301	236	*13%*	*49%*	*38%*
	Rural	**6,598**	908	3,787	1,903	*14%*	*57%*	*29%*
	Cheviot total:	**19,313**	**2,921**	**10,816**	**5,576**	***15%***	***56%***	***29%***
Eildon	Earlston	**1,713**	280	1,013	420	*16%*	*59%*	*25%*
	Galashiels	**12,622**	1,948	8,132	2,542	*15%*	*64%*	*20%*

	Lauder	**1,813**	437	1,012	364	*24%*	*56%*	*20%*
	Melrose	**2,500**	415	1,438	647	*17%*	*58%*	*26%*
	Newtown St Boswells	**1,497**	254	938	305	*17%*	*63%*	*20%*
	Selkirk	**5,503**	851	3,129	1,523	*15%*	*57%*	*28%*
	Stow	**706**	125	451	130	*18%*	*64%*	*18%*
	Tweedbank	**1,994**	341	1,269	384	*17%*	*64%*	*19%*
	Rural	**8,477**	1,521	5,001	1,955	*18%*	*59%*	*23%*
	Eildon total:	**36,825**	**6,172**	**22,383**	**8,270**	***17%***	***61%***	***22%***
Teviot and Liddesdale	Denholm	**706**	89	392	225	*13%*	*56%*	*32%*
	Hawick	**13,857**	2,391	8,151	3,315	*17%*	*59%*	*24%*
	Newcastleton	**796**	119	430	247	*15%*	*54%*	*31%*
	Rural	**2,581**	326	1,496	759	*13%*	*58%*	*29%*
	T&L Total:	**17,940**	**2,925**	**10,469**	**4,546**	***16%***	***58%***	***25%***
Tweeddale	Cardrona	**882**	204	538	140	*23%*	*61%*	*16%*
	Innerleithen	**3,171**	528	1,850	793	*17%*	*58%*	*25%*
	Peebles	**8,577**	1,480	4,874	2,223	*17%*	*57%*	*26%*
	Walkerburn	**700**	100	442	158	*14%*	*63%*	*23%*
	Rural	**5,372**	945	3,372	1,055	*18%*	*63%*	*20%*
	Tweeddale Total:	**20,512**	**3,640**	**12,126**	**4,746**	***18%***	***59%***	***23%***
	Scottish Borders:	***115,510***	***19,023***	***67,871***	***28,616***	***16%***	***59%***	***25%***
	SCOTLAND:	***5,463,300***	***921,397***	***3,497,758***	***1,044,145***	***17%***	***64%***	***19%***

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

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

INSPECTION OF SERVICES

Independent Review of Adult Social Care

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

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

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

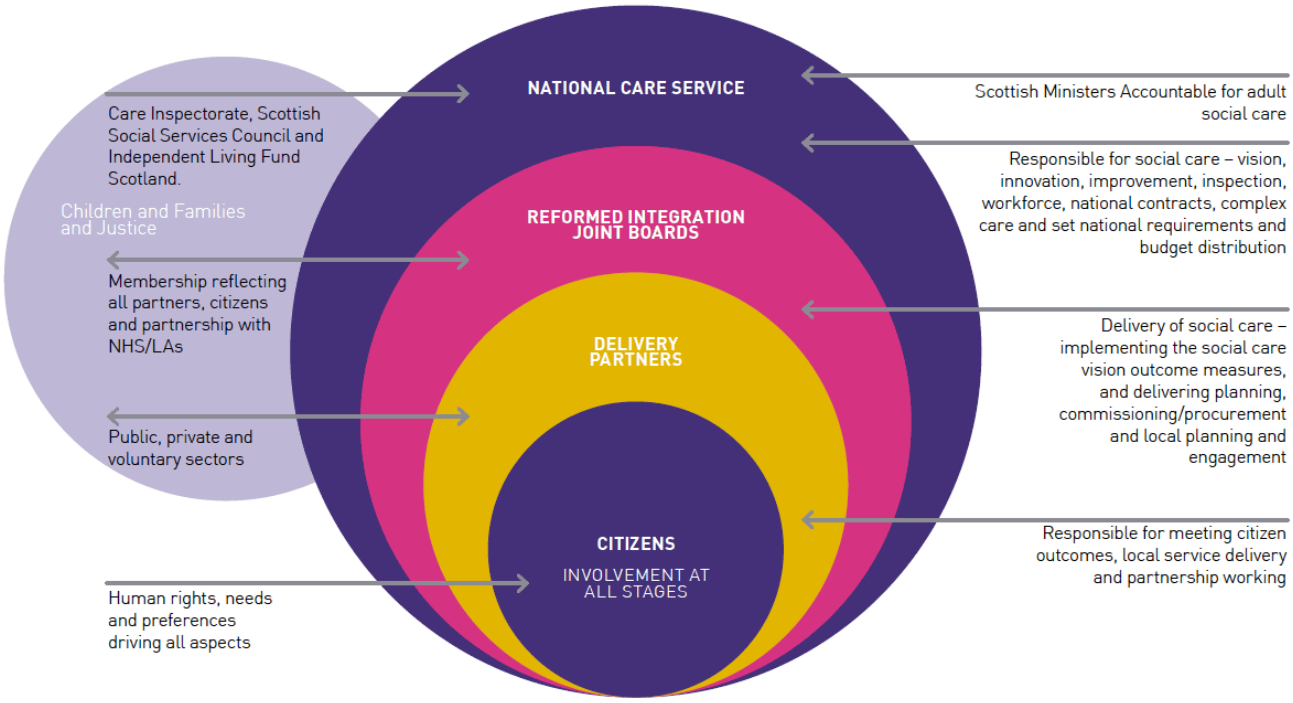
The vision is to have a system in place that replaces crisis with prevention and wellbeing; burden with investment; competition with collaboration and variation with fairness & equity. This 'culture-shift' places a high value on human rights, lived experience, co-production, mutuality and the common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

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

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

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

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



Health Inspections

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

Haylodge Hospital (Peebles)

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

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

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

Good practice	Areas for Improvement
• Evidence that learning from falls reviews have driven quality improvement work to reduce the number of falls. • Equipment and environmental cleanliness were good. • The nursing staff told us they were well	• Person centred care plans should be in place for all identified care needs. • Mealtime management must be improved to ensure that a consistent approach to mealtimes is implemented.

supported and kept up to date during the pandemic.	

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

Care Home Inspections

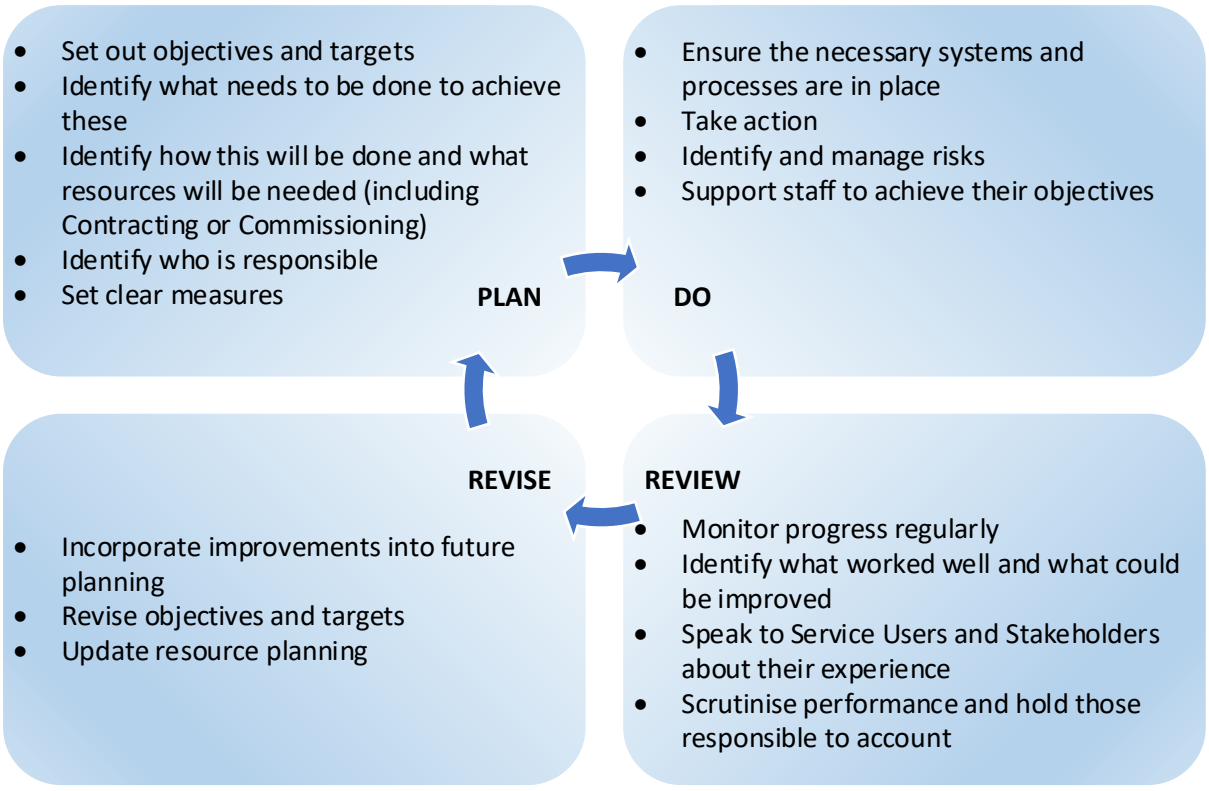
Advice from directors of Public Health in Scotland was that inspection visits would present a real risk of introducing and spreading COVID-19 in Scotland's care homes. Therefore, to limit the spread of COVID-19, and with agreement from Scottish Government the Care Inspectorate restricted their presence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

PERFORMANCE MONITORING FRAMEWORK SUMMARY

Performance Management Framework

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

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



Source: Adapted from Audit Scotland

Our performance measures

We report on a quarterly basis to IJB on a number of performance measures. These measures are aligned under our 3 Strategic Objectives and are designed to show the progress being made in delivery of the strategic objectives and the contribution made by the Partnership to the National Health and Wellbeing indicators. Each performance has a 'RAG' status. This Red/Amber/Green, classification is based, wherever possible, on a combination of performance against target, performance trend and performance against National data. The RAG status helps to highlights areas of good performance and also areas where action is required. Our latest quarterly performance (June 2021 IJB) is shown below:

Regular performance updates can be found here

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

Emergency Hospital Admissions (Borders residents, all ages) **22.1** admissions per 1,000 population	Emergency Hospital Admissions (Borders residents age 75+) **75.3** admissions per 1,000 population Age 75+	Attendances at A&E (all ages) **54.7** attendances per 1,000 population (Q3 – 2020/21)	£ on emergency hospital stays **16.4%** of total health and care resource, for those Age 18+ was spent on emergency hospital stays (Q3 – 2020/21)	The % of older people who receive a package of less than 10 hours of domiciliary care **69%** (Dec 2020)	The % of older people receiving long-term care whose care needs have decreased (from their initial assessment/latest review) **63%** (Dec 2020)

(Q3 – 2020/21)	(Q3 – 2020/21)				
+ve trend over 4 periods Better than Scotland (24.6 – Q2 2020/21) Better than target (27.5)	+ve trend over 4 periods Better than Scotland (83.3– Q3 2020/21) Better than target (90.0)	Flat trend over 4 periods Worse than Scotland (52.3 – Q3 2020/21) Better than target (70.0)	+ve trend over 4 periods Better than Scotland (24% - 2019/20) Better than target (21.5%)	-ve trend over 4 periods Worse than target (15%)	+ve trend over 4 periods Better than target (15%)

Summary:

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

Objective 1: Our plans for 2020/21

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

Objective 2: We will improve the flow of patients into, through and out of hospital

A&E waiting times (Target = **95%**) **86.5%** of people seen within 4 hours (Mar 2021)	Rate of Occupied Bed Days* for Emergency admissions (ages 75+) **1,179** bed days per 1,000 population Age 75+ (Q3 – 2020/21)	Number of delayed discharges ("snapshot" taken 1 day each month) **27** over 72 hours (Mar 2021)	Rate of bed days associated with delayed discharge **165** bed days per 1,000 pop aged 75+ (Q3 – 2020/21)	"Two minutes of your time" survey – conducted at BGH and Community Hospitals **95.5%** Overall satisfaction rate (Q4 - 2019/20)	The proportion of acute patients discharged to a permanent residential care bed without any opportunity for short-term recovery **71%** (Dec 2020)
-ve trend over 4 periods 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%)

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

Summary:

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

Objective 2: Our plans for 2019/20

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

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

Emergency readmissions within 28 days (all ages)	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)	**89.7%** of people's last 6 months was spent at home or in a community setting (Q4 – 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 Worse than Scotland (90.5% - 2020/21) 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.

Performance Change since HSCP inception

The table below gives a summary of the **long-term trend** for a range of performance measures used in the quarterly reporting. Full detail can be found in the Integration section of the website (*Appendix 2 of the Quarterly Reports*).

Key: Improving Performance ↑
Declining Performance ↓
Little change ↔

Measure	Data range	Long-Term Trend	Notes
Emergency admissions in Scottish Borders residents - all ages	Q1 2016/17 – Q4 2020/21	↑	There has been a general decrease in volume of emergency admissions. Over the period, the Partnership has performed better than the Scotland average for the majority of the time.
Rate of emergency admissions, Scottish Borders Residents age 75+	Q1 2016/17 – Q3 2020/21	↑	
Number of A&E Attendances per 1,000 population	Q1 2016/17 – Q4 2020-21	↑	The long-term indicates a reduction in A&E attendance over time.
Percentage of total resource spent on hospital stays, where the patient was admitted as an emergency (age 18+)	Q1 2016/17 – Q4 2020/21	↑	A reducing percentage of total budget is attributed to emergency hospital stays. The Partnership consistently performs better than the Scotland average.
Percentage of A&E patients seen within 4 hours	Apr 16 – Mar 21	↑	Over the entire period, the percentage of A&E patients seen within 4 hrs has improved. However, the 2020/21 performance of 85.6% needs to improve.
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	Q1 2016/17 – Q3 2020/21	↑	The occupied bed day (OBD) rate has reduced slightly over the long-term.
Numbers of Delayed Discharges over 72 hours ("snapshot")	Apr 16 – Mar 21	↓	Delayed discharge performance has decreased slightly over the long term.
Bed days associated with delayed discharges in residents aged 75+, per 1,000 population	Q1 2016/17 – Q4 2020/21	↑	Over the period the number of bed days associated with delayed discharge has reduced.

Emergency readmissions within 28 days of discharge from Hospital (all ages)	Q1 2016/17 – Q4 2020/21		The rate of emergency readmissions has increased. One of the desired outcomes of increased Locality working is prevention, including a reduction in emergency readmissions.
% of last 6 months of life spent at home or in a community setting	Q1 2016/17 – Q4 2020/21		The percentage of people able to spend their last 6 months of life at home or in a community setting has increased recently and also shows improved performance over the longer term.
Support for Carers	Q1 2017/18 – Q4 2020/21		The majority of unpaid carer Support Plans offered are subsequently completed.

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

Core suite of National indicators

The table below shows a summary of performance against the 23 National core suite indicators. (full details are shown in *Appendix 1)*.

The results for indicators 1-10 are based on the 2019/20 Scottish Government Health and Care Experience Survey (i.e.) recording peoples' perceptions. The results for indicators 11-23 are based on data. From the results below, it can be seen that Borders performance based on the data measures appears stronger than those measures based on people's perception.

Indicator		Title	Borders			Trend	Scotland**
			2013/ 14	**2017/ 18**	**2019/ 20**		
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	96%	94%	94%		93%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	79%	83%	81%		81%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%	74%	70%		76%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	78%	75%	70%		74%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	83%	85%		80%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	89%	88%	82%		83%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	80%	80%		80%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	41%	36%	32%		37%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	81%	86%	81%		83%

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

Source: *(1-9) Scottish Government Health and Care Experience Survey 2019/20*
*This national survey is **run every two years.** The Health and Care Experience survey for 2019/20 was published by the Scottish Government on 15 October 2020.*

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

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

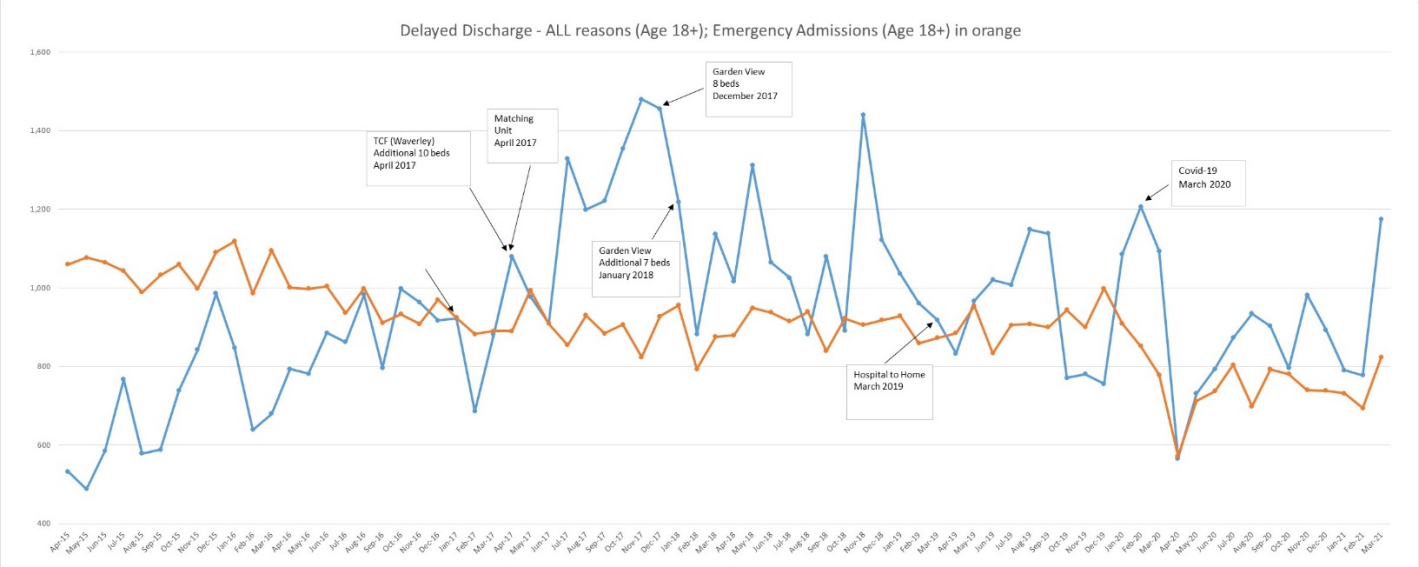
**SCOTLAND figure is latest full year available (2020/21 or 2019 calendar year where Financial Year not available)*
SOURCE: ISD Core Suite Indicator Updates

MSG measures

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

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

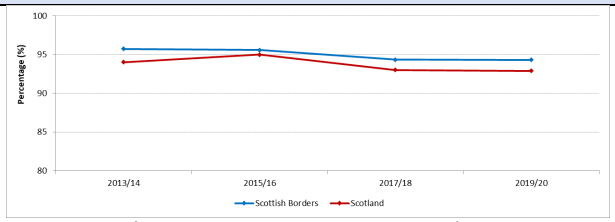
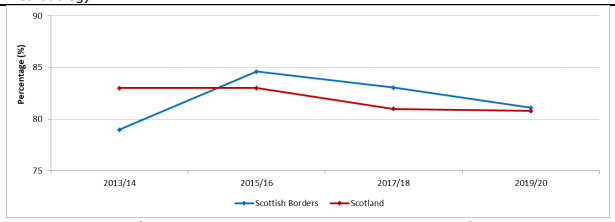
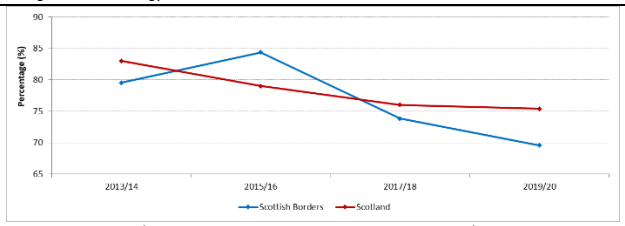
The graph bellow shows the delayed discharge (all reasons) in blue and emergency admissions (18+) in orange. Emergency admissions have been reducing. Delayed Discharge increased, levelled and has started to show a gradual decline.

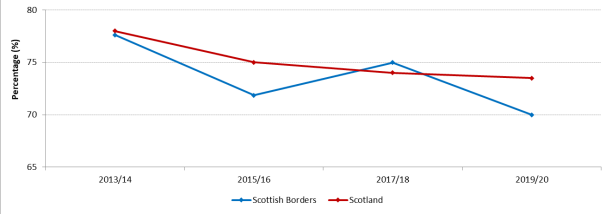
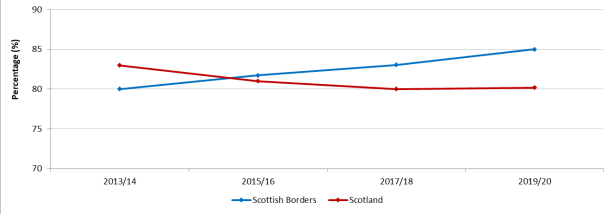
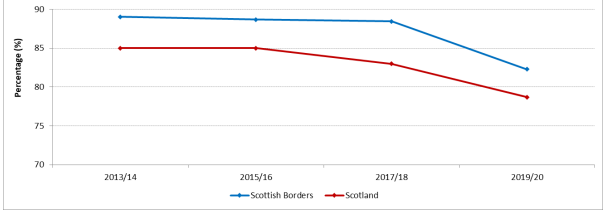
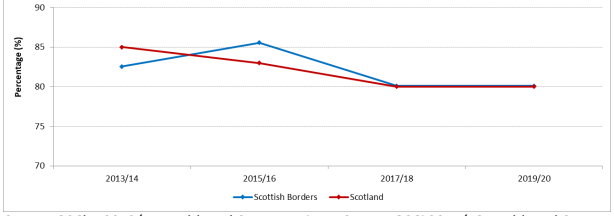
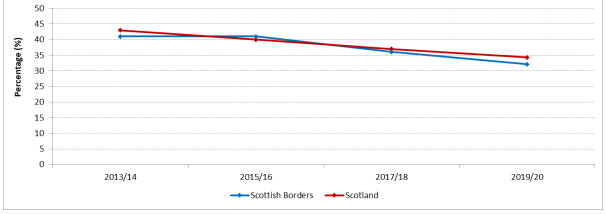


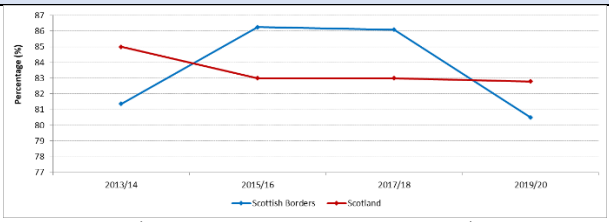
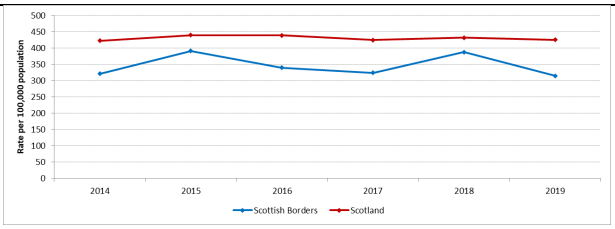
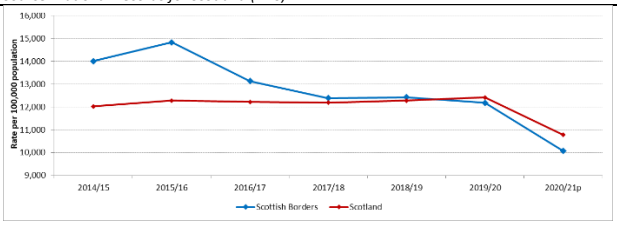
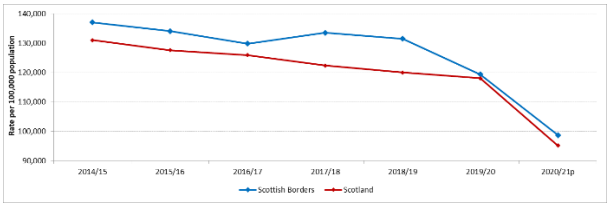
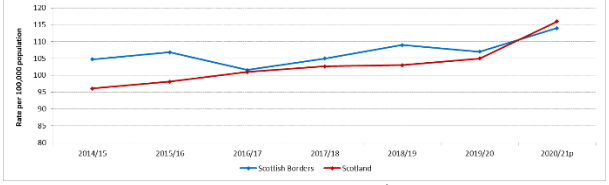
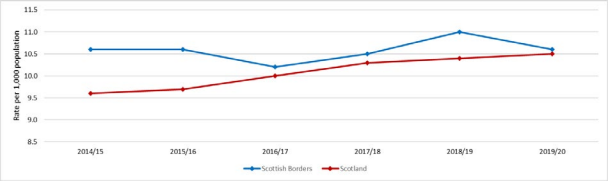
APPENDICES:

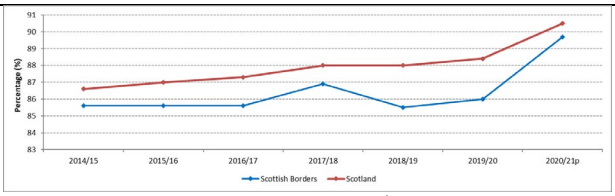
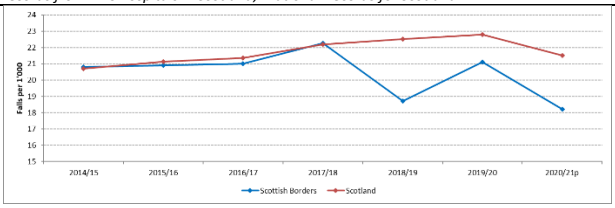
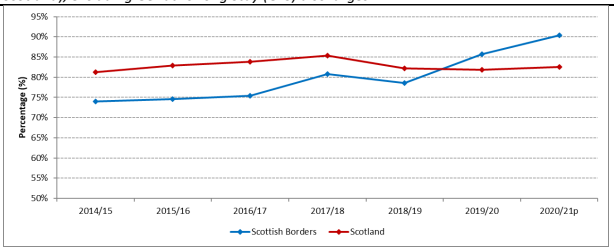
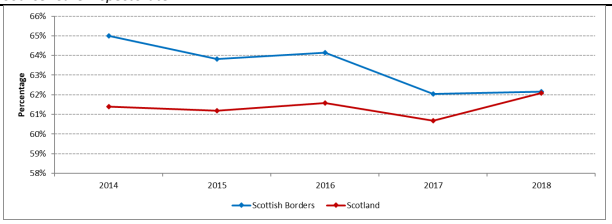
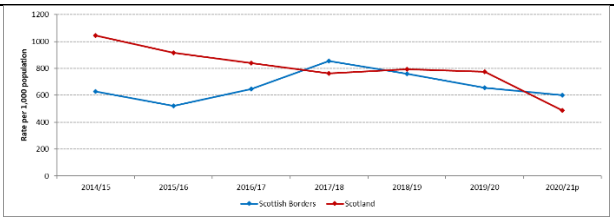
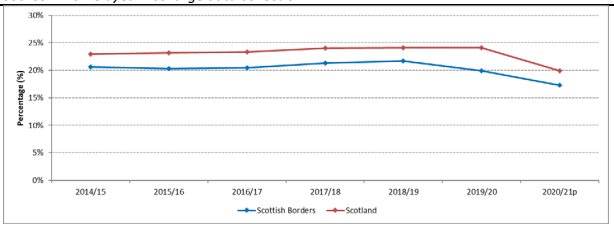
Appendix 1: Core Suite of Indicators

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

Indicator	Performance over time	Borders trend	Improvement actions and challenges
NI-1 Percentage of adults able to look after their health very well or quite well.	 *Source: Q52 - 2013/14 Health and Care Experience Survey, Q51 2015/16 Health and Care Experience Survey, Q40 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*		We will continue to improve information and advice available, and to promote Healthy Living.
NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible.	 *Source: Q36f - 2013/14 Health and Care Experience Survey, Q36g 2015/16 Health and Care Experience Survey, Q27f 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*		Technology is one of the priority areas in the Strategic Implementation Plan and we will continue to develop technology enabled care and support as one method of enabling people to remain as independent as possible at home.
NI-3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	 *Source: Q36b - 2013/14 Health and Care Experience Survey, Q36b 2015/16 Health and Care Experience Survey, Q27b 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*		Borders has a relatively high rate of Self-Directed Support We will continue to promote this and to ensure that there is choice in regard to the SDS options available locally.

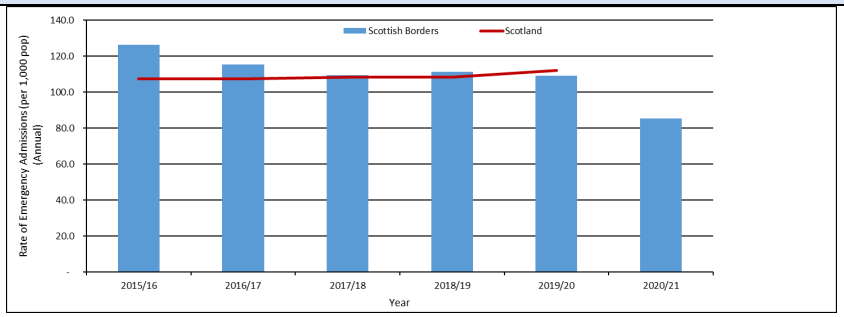
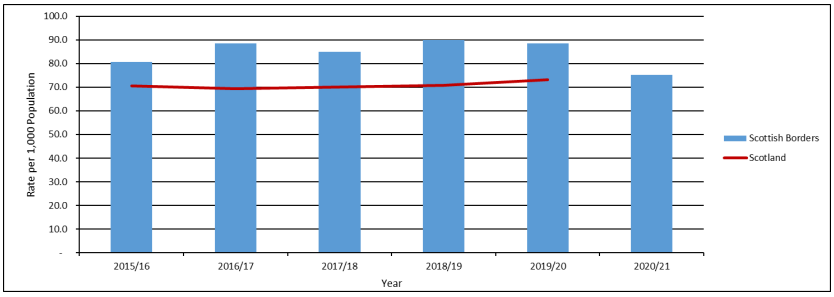
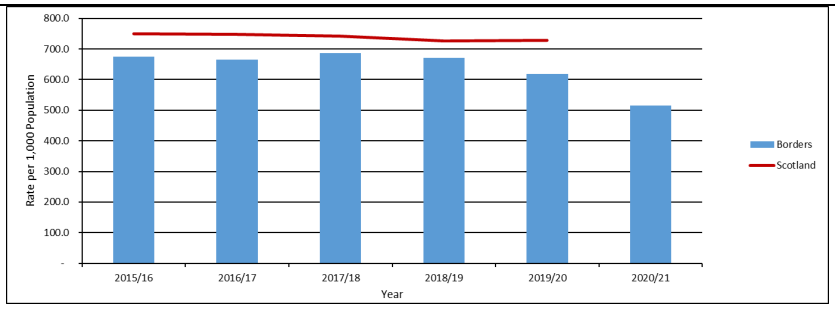
Indicator	Performance over time	Borders trend	Improvement actions and challenges
NI-4 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	 *Source: Q36e - 2013/14 Health and Care Experience Survey, Q36f 2015/16 Health and Care Experience Survey, Q27g 2017/18 Health and Care Experience Survey.* *Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*	↓	Work continues through the 'Older People's Pathway' to ensure that Health and Social Care services work seamlessly across acute care, rehabilitation, reablement, residential care and home care.
NI-5 Total % of adults receiving any care or support who rated it as excellent or good	 *Source: Q37 - 2013/14 Health and Care Experience Survey, Q37 2015/16 Health and Care Experience Survey, Q28 2017/18 Health and Care Experience Survey.* *Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*	↑	We will continue to seek the views of people receiving care (such as 2 minutes of your time survey) and will always seek to improve satisfaction rates with services.
NI-6 Percentage of people with positive experience of the care provided by their GP practice	 *Source: Q27 - 2013/14 Health and Care Experience Survey, Q25 2015/16 Health and Care Experience Survey, Q8d 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*	↓	The Primary Care Improvement Plan (PCIP) and improvements to our Locality arrangements will help to improve this.
NI-7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	 *Source: Q36h - 2013/14 Health and Care Experience Survey, Q36i 2015/16 Health and Care Experience Survey, Q27h 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*	↓	We will continue to seek the views of adults supported at home and to develop our locality model.
NI-8 Percentage of carers who feel supported to continue in their caring role.	 *Source: Q45f - 2013/14 Health and Care Experience Survey, Q45e 2015/16 Health and Care Experience Survey, Q32e 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*	↓	Support for Carers is a key priority in the Strategic Implementation Plan

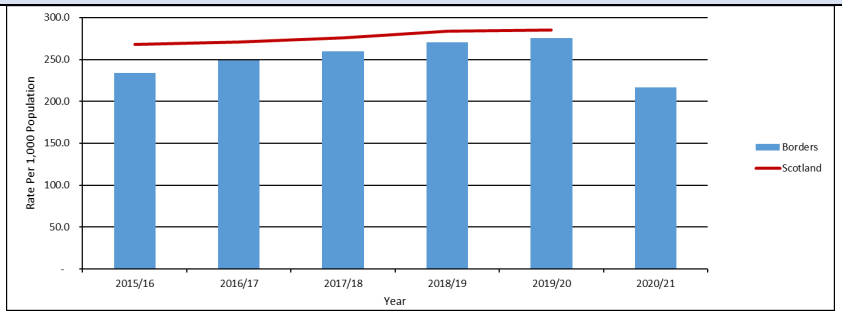
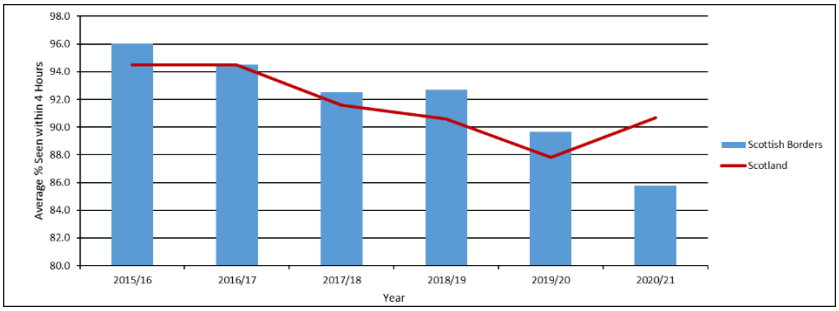
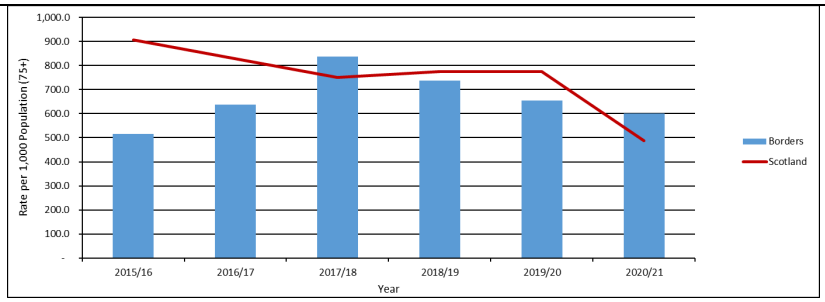
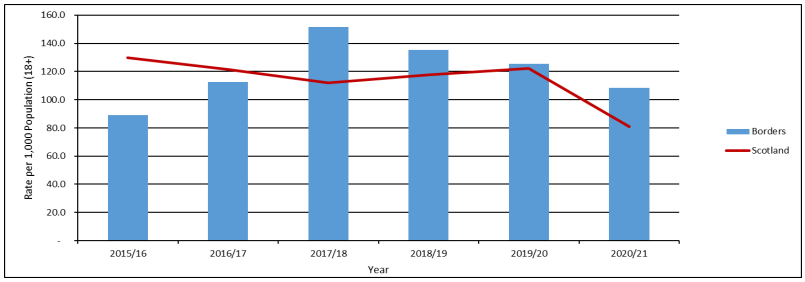
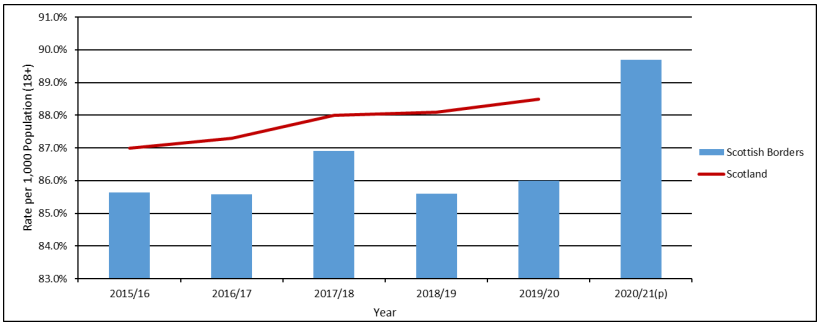
Indicator	Performance over time	Borders trend	Improvement actions and challenges
NI-9 Percentage of adults supported at home who agree they felt safe.	 *Source: Q36g - 2013/14 Health and Care Experience Survey, Q36h 2015/16 Health and Care Experience Survey, Q27e 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.*	↑	We will continue to seek the views of adults supported at home and to develop our locality model.
NI-10 Percentage of staff who say they would recommend their workplace as a good place to work.		Indicator under development	
NI-11 Premature mortality rate per 100,000 persons (Age Standardised mortality rate for people aged under 75)	 *Source: National Records for Scotland (NRS)*	↑	We will continue to look at ways to improve care and support for Older People
NI-12 Emergency admissions rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	 *Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland.*	↑	Work focused on preventing unplanned admissions, through creation of locality multi-disciplinary teams and community capacity.
NI-13 Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)	 *Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland)*	↑	Work at Locality level in communities will focus on admission prevention and therefore impact on emergency bed day rates.
NI-14 (a)Readmissions to hospital within 28 days of discharge (per 100,000 population). (b) Emergency readmissions within 28 days of discharge from hospital, Scottish Borders residents (all ages) (per 1,000 population)	 *Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges*  *Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but also adding in Borders Community Hospital beds).*	↓ ↓	Work progressing to reduce readmissions through increased community capacity and joined up care via multi-disciplinary teams.

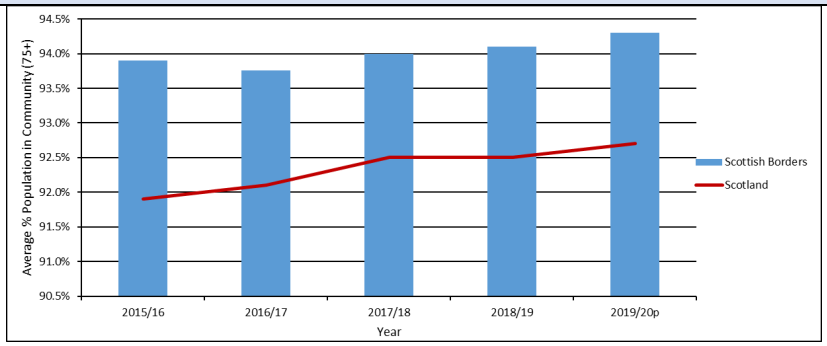
Indicator	Performance over time	Borders trend	Improvement actions and challenges
Bespoke Indicator to include Borders Community Hospital beds			
NI-15 Proportion of last 6 months of life spent at home or in a community setting (%)	 *Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland, National Records for Scotland*	↑	Improving data quality to allow hospice beds to be distinguished from acute beds and also commissioning additional care beds.
NI-16 Emergency hospital admissions due to falls - rate per 1,000 population aged 65+	 *Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges*	↑	Have trialed TEC solutions for falls prevention. More work required to improve
NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	 *Source: Care Inspectorate*	↑	Capital provision in place for the creation of extra care housing and additional care beds.
NI-18 Percentage of adults with intensive needs receiving care at home.	 *Source: Care Inspectorate*	↓	Changes to Locality arrangements and further development of Home First rehabilitation and reablement will support this
NI-19 Number of days people aged 75+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 75+)	 *Source: PHS Delayed Discharge data collection*	↓	Implementation of new discharge hub and trusted assessor will improve this. Capital investment in additional care beds (including intermediate care) will also improve this.
NI-20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (adults aged 18+)	 *Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges* *SMR04 (mental health inpatient records from NHS hospitals in Scotland* *Scottish Government Local Financial Return (LFR) 03*	↑	Work at Locality level in communities will focus on admission prevention and therefore impact on emergency admissions.
NI-21 Percentage of people admitted from home to hospital during the year, who		Under development	

Indicator	Performance over time	Borders trend	Improvement actions and challenges
are discharged to a care home.			
NI-22 Percentage of people who are discharged from hospital within 72 hours of being ready.		Under development	
NI-23 Expenditure on end of life care.		Under development	

Appendix 2: MSG Measures

Measure	Performance	Borders trend
1a. Number of emergency admissions (All Ages) *Source: SMR01, ISD*		
1b. Admissions from A&E (All Ages) *Source: A&E datamart, ISD*		
2. Number of unscheduled hospital bed days; acute specialties (All Ages) *Source: SMR01, ISD*		

Measure	Performance	Borders trend
3a. A&E attendances (All Ages) *Source: A&E datamart, ISD*		
3b. A&E % seen within 4 hours (All ages) *Source: A&E datamart, ISD*		
4. Delayed discharge bed days (i. 75+, ii. 18+) *Source: Delayed Discharges, ISD*	i.  ii. 	 
5. Percentage of last six months of life spent at Home or Community Setting *Source: Death records, NRS; SMR01, ISD; SMR04, ISD*		

Measure	Performance	Borders trend
6. Balance of care: Percentage of population in community or institutional settings (75+) *Source: SMR01, ISD; SMR04, ISD; Care Home Census, ISD; Social Care Census, SG; Population estimates, NRS*		

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 28 July 2021

Report By:	Chris Myers, General Manager, Primary and Community Services
Contact:	Chris Myers, General Manager, Primary and Community Services Dr. Kevin Buchan, Chair of GP Subcommittee Paul Mcmenamin, Deputy Director of Finance Cathy Wilson, Primary Care Clinical Services Manager
Telephone:	01896 826 455
PRIMARY CARE IMPROVEMENT PLAN UPDATE	
Purpose of Report:	The purpose of this report is to provide an update to the IJB on progress with the implementation of the Primary Care Improvement Plan, along with a note on the risks relating to the delivery of the programme.
Recommendations:	The Health & Social Care Integration Joint Board is asked to **note** the report, the risks, and actions being undertaken to reduce these risks.
Personnel:	Circa 70wte new posts will be established across a number of clinical and support services. All posts are resourced at a 52 week level in order to provide year round services.
Carers:	Patient safety is a core element of PCIP. PCIP will support patients to access the right care delivered by the most appropriate service in a timely fashion.
Equalities:	A Healthcare Inequalities Impact Assessment for the whole programme has been undertaken. For new workstreams, service specific Healthcare Inequalities Impact Assessments will be undertaken to ensure that the services appropriately ensure that the new services are not discriminating in their approach, that they widen access to opportunities, and promote the interests of people with protected characteristics.
Financial:	A ring fenced resource allocation of £3.2m over the PCIP programme from Scottish Government with the direct instruction from them that this cannot be used for saving targets or for any other purpose than the delivery of the PCIP. There is financial risk associated to insufficient recurrent funding for NHS Borders to either deliver all of the mandatory workstreams of the PCIP, and to not deliver these workstreams. Should these workstreams not be delivered, NHS Borders will be required to compensate GPs to deliver activity that will no longer be

	contractually obliged, at rates yet to be negotiated by the BMA and Scottish Government. The Scottish Government has been clear that should this be the case, GPs cannot be expected to be the default provider of these services in the future and it is expected that the expectation for GPs to deliver services within phase 1 of the MOU will cease at some point in the middle of 2022/23.
Legal:	The delivery of PCIP is part of the national GP Contract (2018) through a Memorandum of Understanding between BMA and Scottish Government (Health and Integrated Authorities).
Risk Implications:	• Financial risk • Availability of accommodation for staff • IT infrastructure • Recruitment issues

Primary and Community Services
Chris Myers, General Manager

SCOTTISH BORDERS INTEGRATED JOINT BOARD

PRIMARY CARE IMPROVEMENT PLAN OPERATIONAL AND FINANCE UPDATE

1. Executive Summary

The IJB is asked to note the report, the risks, and actions being undertaken to reduce these risks.

The purpose of this report is to provide an update to the IJB on progress with the implementation of the Primary Care Improvement Plan, along with a note on the risks relating to the delivery of the programme.

2. Background

2.1. GMS Contract

The Scottish Borders Primary Care Improvement Plan (PCIP) was originally developed in 2018 in line with the National Memorandum of Understanding between the Scottish Government, BMA, Integration Authorities and NHS Boards linked to the introduction of the 2018 GMS Contract in Scotland.

The agreed GMS Contract (2018) proposed a refocusing of the GP role as Expert Medical Generalists. This role builds on the core strengths and values of General Practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership.

The aim of the GMS Contract (2018) is to enable GPs to do their job to the top of their license and enable patients to have better care. This refocusing of the GP role requires some tasks currently carried out by GPs to be carried out by members of an enhanced Primary Care Multi-Disciplinary Team, where it is safe, appropriate, and improves patient care.

The key priorities developed in order to develop the broader Primary Care Multi-Disciplinary Team, are managed through individual workstreams under the Primary Care Improvement Plan Executive Committee. The following workstreams were agreed to transfer from General Practitioners to the developing Health and Social Care Partnership Primary Care Multi-Disciplinary Teams as part of the National Memorandum of Understanding by April 2021 at the latest:

- Pharmacotherapy Services
- Urgent Care Services
- Community Treatment and Care Services
- Vaccination Services
- Additional Professional Roles:
    - Community Link Workers
    - First Contact Practitioner Physiotherapists
    - Community Mental Health Services

2.2. Joint Letter - GMS Contract Update for 2021/22 and Beyond

As noted above, the original contractual position as part of the National Memorandum of Understanding was that all priority workstreams noted would be implemented by April 2021.

In December 2020, the Cabinet Secretary for Health and Wellbeing and the Chair of the BMA Scotland circulated a letter to Health and Social Care Partnerships and NHS Boards, noting an

updated position in relation to the timescales for the implementation of the transfer of the priority services from GPs to enhanced Primary Care Multi-Disciplinary Teams. In addition, this noted the contractual footing of the non-delivery of these workstreams.

Whilst the implementation order changed, the Cabinet Secretary and Chair of BMA Scotland were clear that NHS Boards and Health and Social Care Partnerships, and the public at large, to ensure the changes proposed here are done in ways that remain true to the Contract Offer commitments. We understand that this means that funding cannot be vired out of services that have been developed in line with the contract offer in 2018, even if they are not reflected in the updated deadlines on contractual delivery.

3. Updated deadlines for implementation of workstreams

This is summarised in the new chronological order associated to the updated deadlines for implementation in the table below:

Workstream	Implementation deadline (local RAG)	Contractual implication of non-delivery	Local commentary
Vaccination Services: Childhood and travel	1 October 2021 (Amber)	Historic income from vaccinations will transfer to the Global Sum 2022-23 including that from the five vaccination Directed Enhanced Services Should Practices continue to provide vaccinations, a new Transitionary Service will apply (to be negotiated by SGPC and the Scottish Government), and payments will be made to practices providing these services from 2022-23	Green for delivery, but amber due to recurrent financial risk. Non-recurrent funding available for 2021/22, and additional funding to be received for influenza vaccination, but insufficient recurrent funding for 2022/23
Vaccination Services: All other	April 2022 (Amber)		
Pharmacotherapy Services: Level One	April 2022 (Green)	Transitionary Service for practices without a Level One Pharmacotherapy service	Services not currently fully level one, however the PCIP Executive Committee is now confident that this will be implemented within the required timescales
Community Treatment and Care Services	2022-23 (Amber)	Transitionary Service for practices without access to the Community Treatment and Care Service	Amber for delivery and recurrent financial risk. Non-recurrent funding available for 2021/22, but insufficient recurrent funding for 2022/23
Urgent Care Services	2023-24 (Green)	Legislation will be amended so that Boards are responsible for providing an Urgent Care service to practices for 2023-24	ANP recruitment challenges, but green overall for delivery and service is funded
Additional Professional Roles: • Community Link Workers • First Contact Practitioner Physiotherapists • Community Mental Health Services	To be confirmed (Green)	An ‘endpoint’ for the additional professional roles commitment in the Contract Offer will be established by the end of 2021	Service In place and service is funded

3.1. Operational progress

3.1.1. Vaccination

The Vaccination Transformation Programme can be divided into five different work streams:

1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

It is expected that the Vaccination Transformation Programme will be delivered as required within the contractual timescales committed. This will be delivered in parallel with the Covid-19 booster programme, and with an expanded influenza vaccination programme.

Much experience has been developed through the longstanding delivery of the school immunisation programme and the pregnancy immunisation programme, along with more recent experience in delivering influenza and Covid-19 vaccinations at pace and scale since last Autumn. A Healthcare Inequalities Impact Assessment has been developed for vaccination that will be considered to ensure appropriate access for the population of the Scottish Borders. It is worth noting that the model of delivery will be varied depending on the cohort, informed by findings of the Healthcare Inequalities Impact Assessment and recent experience.

There is significant work associated to the development of the Vaccination Transformation Programme, and as a result the Primary and Community Services Clinical Board and NHS Borders Programme Management Office have brought in staff to support this work.

3.1.2. Pharmacotherapy

Level one pharmacotherapy describes the core elements of service. At present, significant work is being undertaken between the Phamacotherapy Lead, the PCIP Executive General Practitioner Workstream Lead, the Pharmacotherapy Team and General Practices to ensure an even distribution of level one service to all GPs within the Borders by April 2021.

3.1.3. Community Treatment and Care Services

Community treatment and care services include many non-GP services that patients may need, including (but not limited to):

- management of minor injuries and dressings
- phlebotomy
- ear syringing
- suture removal
- chronic disease monitoring and related data collection

Within the Scottish Borders, these treatments are provided by GP Practices, the existing NHS Borders Treatment Room infrastructure, along with secondary care Acute and Mental Health Services. In line with the principles of the Memorandum of Understanding, responsibility will transfer from GP Practices into HSCP delivered enhanced Treatment Rooms (Community Treatment and Care services). Work is being undertaken in a phased approach across Localities, Practices and Treatment Rooms in the Scottish Borders to standardise and enhance the process and increase the capacity to be able to deliver this service, starting with a pilot that has commenced in the Tweeddale Locality, which will be followed by expansion to the Teviot Locality, and across the Borders by the end of the year. There is significant work associated to the development of the service, and as a result a Project infrastructure is being recruited to with non-recurrent funding to support this.

The Community Treatment and Care Service will have a significant impact on shifting the balance of care, and improving local access to services. At present, we anticipate in the region of 145,000 treatments a year when this service is fully operational across this new Community model, but further detail will be confirmed in due course once we have more data from the pilots.

3.1.4. Urgent Care Services

There is an establishment of 15 Advanced Nurse Practitioners to deliver urgent care. This currently comprises of one lead ANP, plus 13 ANPs in training, with one vacancy. Once fully trained, Advanced Nurse Practitioners (ANPs) based in GP Practices will work to support unscheduled care (house visits or appointments) across all practices. It is challenging to recruit and retain staff, however, the Lead ANP, GP Lead for the Workstream and Associate Director of Nursing for Primary and Community Services continue to work with the ANP service to ensure that the risk is reduced and the service continues to develop. It is expected that by the updated deadline of 2023-24, following training of all ANPs, the service will be fully operational.

3.1.5. Additional Professional Roles

The Additional Professional Roles comprise Community Link Workers, First Contact Practitioner Physiotherapists and Community Mental Health Services. All three services are fully operational and working to good effect.

3.2. Finance

3.2.1 Recurrent funding

The Integration Authority received its annual PCIP funding letter from the Scottish Government on 29 June 2021. This letter outlined an earmarked-recurring allocation to the Scottish Borders of £3.296m for 2021/22. To date, £3.226m has been committed across 7 workstreams, leaving a residual balance of £0.070m unallocated.

Of the £3.226m committed, £0.105m relates to Community Treatment and Care Services (CTAC), whilst £0.000m has been committed towards the Vaccine Transformation Programme (VTP). At the current time, projected costs of these two workstreams / programmes are not yet clear as their model of delivery remain at the scoping and development phase. Nonetheless, there is likely to be a substantial gap between the level of funding allocation and forecast costs on a recurring basis, which at the time of the last return to the Scottish Government in late May 2021, was projected to be £2.946m, based on initial costed models for both CTAC and VTP. On-going development of delivery models, regular and frequent reporting to the Scottish Government and discussions between both the PCIP Executive Group and with the Scottish Government remain on-going in regard of prioritisation of resources and the funding of any projected shortfall in resource requirement.
On 5 July, the Scottish Government Vaccines Division confirmed in writing that for influenza vaccination (a component part of the Vaccination Transformation Programme), that:

> "Work will continue between Scottish Government and Health Board Directors of Finance to assess and to validate the financial additional costs and funding implications, both recurrent and non-recurrent, of the resourcing requirements that have been set out, which we expect will continue to develop, and from there to confirm any further financial allocations for 2021/22 and beyond."

In addition, the letter notes that:

> "The established funding and financial allocation processes the Scottish Government has in place will support and promote the process of building a permanent workforce. This should ensure that there are no barriers or delays in you progressing recruitment activities."

It is expected that this will reduce the financial risk to the implementation of the Primary Care Improvement Plan by in the region of £0.500m, although this has yet to be confirmed.

In separate correspondence, the Scottish Government notes that they have previously committed to the PCIF growing from £110 million to £155 million in cash terms between 2020-21 and 2021-22. This commitment has been met in full with the PCIF increasing to £155 million this year. In addition, the Scottish Government expect the PCIF funding to continue beyond this into 2022-23 and will write to Health and Social Care Partnerships with further detail on this in due course.

There is financial risk associated to insufficient recurrent funding for NHS Borders to either deliver all of the mandatory workstreams of the PCIP and / or an inability to deliver these workstreams as a direct result. Should these workstreams not be delivered, NHS Borders will be required to compensate GPs to deliver activity that will no longer be contractually obliged, at rates yet to be negotiated by the BMA and Scottish Government. The Scottish Government has been clear that should this be the case, GPs cannot be expected to be the default provider of these services in the future and it is expected that the expectation for GPs to deliver services within phase 1 of the MOU will cease at some point in the middle of 2022/23.

Nonetheless, due to the on-going uncertainty associated to the recurrent resourcing available, there remains ongoing risk of associated to a funding gap against the required delivery of the Primary Care Implementation Plan, with the potential for a cost pressure. A paper will be taken to the NHS Borders Board for further consideration of this risk, once further information is available.

3.2.2. Non-recurrent funding

The Scottish Government Health Finance wrote to all NHS Boards in February to notify them of an allocation of funding being made to Integration Authorities in respect of outstanding balances on the Primary Care Improvement Fund. The allocation represents the sum of Scottish Government held unused funding accumulated over the three years of the MoU 2018-2021. For NHS Borders this figure is £1.097m from 2018 to 2021. This is supplemented by carry forward of uncommitted non-recurring funding of £0.172m, amounting to a total non-recurring balance of resource available of £1.269m. To date, £0.993m of this spend has been committed to support the delivery of the priority areas of the Memorandum of Understanding on a non-recurrent basis as outlined in the table below, of which £0.745m has been notionally split between CTAC* (£0.545m) and VTP* (£0.200m).

On 29 June, the Scottish Government confirmed that any 2020-21 unused allocation should be invested in the implementation of PCIP in 2021-22 before new funding is used. It was also reiterated that spend must be directed on services in the Memorandum of Understanding, and that the PCIF is not subject to savings requirements and therefore cannot be used to address wider funding pressures.

As a result, there is no perceived ability for the IJB to carry forward this funding as any unspent funding will be offset against remaining allocations in 2021/22. There currently remains £0.276m uncommitted non-recurrent spend, however the use of this will be determined shortly for non-recurrent enabling initiatives. There is a requirement to report on spend to the Scottish Government by the 6 November at the latest.

3.2.3. Anticipated required funding by workstream, 2021-22

The table below outlines the funding committed by workstream, along with estimated costs/ income streams which are yet to be confirmed, highlighted with an asterix. Costs for the Community Treatment and Care (CTAC) Service and Vaccination Transformation Programme (VTP) are not yet clear as the model is being developed based on a developing pilot. In addition, the non-PCIP income is yet to be determined, albeit it is expected that this will be confirmed by August at the latest.

For 2021-22, the recurrent and non-recurrent funds available are expected to cover the costs of the PCIP's required commitments.

Workstream	PCIP R	PCIP NR	Enhanced CTAC / Winter NR*	SG Vaccination R*	Total	
	£m	£m	£m	£m	£m	
CTAC*	0.105	0.545	0.150		0.800	1,2
CTAC Workstream Development		0.069			0.069	
VTP*		0.200		0.536	0.736	3,4
Urgent Care	0.883	0.082			0.965	
Pharmacotherapy	0.896				0.896	
FCP	0.510				0.510	
RENEW	0.669				0.669	
CLW	0.150				0.150	
PCIP Programme	0.012	0.097			0.109	
Currently uncommitted	0.070	0.276			0.346	5
Total	**3.295**	**1.269**	**0.150**	**0.536**	**5.250**	

1 Commitment of £0.545m by PCIP Executive 15/04/21 to CTAC NR

2 £0.150m bid for NHS Borders Winter Plan funding yet to be formally confirmed

3 Commitment of £0.200m by PCIP Executive 15/04/21 to VTP NR

4 £0.536m additional recurring vaccination funding yet to be confirmed

5 £0.346m remains uncommited of which £0.070m is recurring and £0.276m is non-recurring

4. Recommendations

The IJB is asked to note the report, the risks, and actions being undertaken to reduce these risks.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 28 July 2021

Report By:	David Robertson, Chief Finance Officer SBC & Andrew Bone, Chief Financial Officer, NHS Borders
Contact:	David Robertson, Chief Finance Officer SBC & Andrew Bone, Chief Financial Officer, NHS Borders
Telephone:	01835 825012 / 01896 825555
MONITORING OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2020/21 AT 31 MARCH 2021	
Purpose of Report:	The purpose of this report is to update the IJB on the year end outturn position of the Health and Social Care Partnership (H&SCP) for 2020/21.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the final outturn position for the Partnership for the year to 31 March 2021; b) **Note** that the Health and Social Care partnership under-spent by £6.236m during the financial year relating entirely to slippage in the use of ring-fenced funding and planned investments, in addition to unutilised funding allocations for Covid-19 costs and that this has been carried forward to 2021/22 as part of the IJB earmarked reserve; c) **Note** that the outturn position includes additional funding vired to the Health and Social Care Partnership during the financial year in order to meet previously reported pressures across health and social care functions from managed efficiency savings within other non-delegated health board and local authority services.
Personnel:	There are no resourcing implications beyond the financial resources identified within the report.
Carers:	N/A
Equalities:	There are no equalities impacts arising from the report.
Financial:	No resourcing implications beyond the financial resources identified within the report. The report draws on information provided in finance reports presented to NHS Borders and Scottish Borders Council.
Legal:	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.
Risk Implications:	To be reviewed in line with agreed risk management strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership.

Background

2.1 The report relates to the final outturn position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and the budget relating to large-hospital functions retained and set aside for the population of the Scottish Borders (the "set-aside budget").

2.2 The outturn position is based on the available information presented to Scottish Borders Council and the Board of NHS Borders. It highlights the key areas of financial pressure experienced during the financial year, together with how a combination of additional funding from the Scottish Government, under-spends on core operational services as a result of activity reductions during the Covid-19 pandemic and the transfer of resource by both partner organisations into delegated services, has mitigated these areas of pressure.

Overview of Outturn Position at 31 March 2021

3.1 The paper presents the consolidated financial performance for the financial year to 31 March 2021. For both 2020/21 and 2021/22 financial years, the Health and Social Care Partnership approved its Financial Plan and Budget prior to the 1st April (2021/22 was approved at its meeting of 24th March 2021).

3.2 The Partnership reported an under-spend position of £6.236m against the Delegated Budget at 31 March 2021. This under-spend related to ring-fenced funding received by NHS Borders and slippage in service developments and cost pressures which have been carried forward to 2021/22. In order to achieve this however, additional allocations from each funding partner were required during the year and at year end to deliver a break even position overall. At the 31 March 2021, the additional allocations made were:

	£'000
Additional Allocations Delegated by Partners at 31 March 2021	
NHS Borders	3,925
Scottish Borders Council	93
	4,018

3.3 The reported position across delegated functions is summarised below:

Delegated Functions Total	**Base Budget £'000**	**Revised Budget £'000**	**Actual Outturn £'000**	**Outturn Variance £'000**
Joint Learning Disability Service	20,139	20,612	20,877	(265)
Joint Mental Health Service	18,144	19,471	19,152	319
Joint Alcohol and Drug Service	390	757	757	0
Older People Service	25,195	23,413	23,841	(428)
Physical Disability Service	2,458	2,644	2,646	(2)
Prescribing	23,130	23,132	22,660	472
Generic Services	77,437	87,787	85,665	2,122
NHSB / SBC Additional Contribution	0	4,018	0	4,018
	166,893	**181,834**	**175,598**	**6,236**

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3.4 During 2020/21 functions delegated to the Partnership experienced a range of budgetary variances. Drivers for this included:

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

3.5 Additional funding allocations were made by the Scottish Government during the year to mitigate the net financial pressures above. Additional contributions also required to be made by partners to deliver the reported position. At the end of the financial year, £0.093m of corporate support was provided to Health and Social Care functions by Scottish Borders Council and £3.925m of additional support was provided by NHS Borders. This additional budget delegated was primarily available as a result of under-spends and additional funding allocations across non-delegated Health and Social Care functions.

3.6 Legislation sets out that Integration Authorities are responsible for the strategic planning of hospital services most commonly associated with the emergency care pathway along with primary and community health care and social care.

3.7 In relation to the Large Hospital Budget Retained by NHS Borders and Set-Aside, an over-spend position has been reported by NHS Borders at 31 March 2021, summarised as:

Set Aside Healthcare Functions	**Base Budget £'000**	**Revised Budget £'000**	**Actual Outturn £'000**	**Outturn Variance £'000**
Accident & Emergency	2,830	3,132	3,634	(502)
Medicine of the Elderly	6,230	7,099	6,401	698
Medicine & Long-Term Conditions	15,660	16,385	16,819	(434)
Planned Savings & Actions	(1,090)	(1,090)	0	(1,090)
	23,630	**25,526**	**26,854**	**(1,328)**

3.8 In terms of the Healthcare budget retained by NHS Borders and set-aside, the IJB directed £25.526m to NHS Borders in 2020/21. During the financial year, NHS Borders spent £26.854m, resulting in an over-spend of (£1.328m) within these Health Board functions. The over-spend position remains the responsibility of NHS Borders and as a result, has been absorbed within the overall health board financial position

at outturn. The Health and Social Care partnership therefore is reporting a breakeven position at outturn summarised as:

Set Aside Healthcare Functions	**Base Budget £'000**	**Revised Budget £'000**	**Actual Outturn £'000**	**Outturn Variance £'000**
IJB-directed Set-Aside Functions	23,630	25,526	25,526	0
	23,630	**25,526**	**25,526**	**0**

3.9 The IJB approved its Reserves Policy in 2016/17. In 2020/21, the policy was again applied in order that the Health and Social Care Partnership may carry forward funding. This relates to ring-fenced funding allocations to NHS Borders, unspent Older People's Change Fund and Transformation Fund balances and uncommitted Covid-19 funding allocations.

3.10 The overall balance held in IJB reserves has increased at March 2021 by £6.236m to £10.240m. This reflects the impact of the pandemic on the IJBs planned investments in relation to whole system transformation, as well as increased slippage on ring-fenced allocations for which delivery is phased over more than one year. Within these ring-fenced allocations a residual balance is held against COVID-19 allocations not utilised in 2020/21 and which will be set against expenditure plans for 2021/22 in line with Scottish Government guidance.

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2020/21	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	20,139	20,877	20,612	20,877	(265)
Joint Mental Health Service	18,144	19,152	19,471	19,152	319
Joint Alcohol and Drugs Service	390	757	757	757	0
Older People Service	9,025	6,994	6,769	6,994	(225)
SB Cares	16,170	16,847	16,644	16,847	(203)
Physical Disability Service	2,458	2,646	2,644	2,646	(2)
Prescribing	23,130	22,660	23,132	22,660	472
Generic Services	77,437	85,665	87,787	85,665	2,122
Partner Contributions to Breakeven	0	0	4,018	0	4,018
Large Hospital Functions Set-Aside	23,630	26,854	26,854	26,854	0
Total	190,523	202,452	208,688	202,452	6,236

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Social Care Functions	2020/21	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	16,399	17,047	17,167	17,047	120	At outturn, social care functions are reporting a breakeven position. This has been delivered following the additional delegation of £0.093m to the IJB by Scottish Borders Council.
Joint Mental Health Service	2,164	2,227	2,256	2,227	29	The Learning Disability Service is reporting an underspend of £0.120m attributable to a small reduction community care package numbers and cost late in the financial year as is Mental Health.
Older People Service	9,025	6,994	6,769	6,994	(225)	Within the Older People Service, additional care costs have put pressure on the service amounting to £0.271m, although these are partially offset by £0.036m as a result of further reduced activity due to the Covid-19 pandemic and other minor miscellaneous underspends.
SB Cares	16,170	16,847	16,644	16,847	(203)	Within SB Cares, higher than anticipated running costs relating to the Hawick Community Support Service (HCSS) (£0.062m) have been prevalent, although these are offset by smaller underspends in other day centre budgets. Higher than anticipated food costs in Care Homes (£0.058m), pressure in Border Care Alarm budget relating to 2019-20 (£0.056m) are also reported, Staffing pressures at Saltgreeens Care Home (£0.051m) and a number of small variances consolidate to a £0.024m overspend constituting the balance.
Physical Disability Service	2,458	2,646	2,644	2,646	(2)	Within Generic Services, lower than anticipated Sensory Services expenditure (£0.045m), lower than anticipated CCA Finance Team and Professional Lead staffing costs (£0.048m). Carers Act costs lower than forecast (£0.026m). Also, lower than forecast locality based client care costs in Cheviot and Teviot localities (£0.071m). Care & Repair costs also lower than forecast (£0.023m). Other small variances creating an offseting £0.025m overspend.
Generic Services	12,897	13,417	13,605	13,417	188	
SBC Contribution to Breakeven	0	0	93	0	93	
Total	59,113	59,178	59,178	59,178	0	

MONTHLY REVENUE MANAGEMENT REPORT

Delegated Budget Healthcare Functions **2020/21** **At end of Month: March**

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	**3,740**	**3,830**	**3,445**	**3,830**	**(385)**	At outturn, healthcare functions are reporting a underspend of £6.236m. This has been delivered following the additional delegation of £3.925m to the IJB by NHS Borders and relates entirely to the carry forward of ringfenced resources unspent at the end of the financial year. This includes ringfenced funding allocations to IJB functions, slippage in earmarked investments within healthcare functions and unspent Covid-19 Scottish Government funding at the end of the financial year.
Joint Mental Health Service	**15,980**	**16,925**	**17,215**	**16,925**	**290**	
Joint Alcohol and Drugs Service	**390**	**757**	**757**	**757**	**0**	Learning Disability is reporting an overspend due to increased complex residential care placements (£0.455m) offset by £0.041m vacant band 5 nursing posts earlier in the year and £11k due to a Band 4 Admin vacancy.
Prescribing	**23,130**	**22,660**	**23,132**	**22,660**	**472**	
Generic Services	**64,540**	**72,248**	**74,182**	**72,248**	**1,934**	In relation to Mental Health, key area of pressure is within the Medical Locum / Agency budget which has reported an overspend in excess of £0.500m. This has been partially offset by savings within supplies due to the downturn in activity (£0.171m), vacancies across a number of MH services (£0.519m) and a reduction in commissioned services during the pandemic (£0.051m)
NHSB Contribution to Breakeven	**0**	**0**	**3,925**	**0**	**3,925**	A significant reduction in the volumes of presciption forms and items prescribed (7%) as a result of the pandemic has delivered an underspend in Prescribing of £0.472m. This is a trend that all boards have experienced nationally during 2020/21.
						Generic Services is reporting an overall underspend of £1.934m which in addition to unspent ringfenced funding and investments, relates also to: • Community Nursing- A reported underspend mainly due to vacancies during the year. partially offset by overspends across non pay budgets. • Community Hospitals. An underspend mainly as a result of vacant posts. • AHP Services – A reported underspend mainly within the staffing and relates to slippage in the establishment of the new operating model. • Dental Services – Significant vacancies and downturn in Dental activity as a result of the pandemic. • PACs other budgets – A reported overspend mainly due to the non-delivery of savings targets for 20/21 which remain unmet (£3.6m).
Total	**107,780**	**116,420**	**122,656**	**116,420**	**6,236**	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2020/21	At end of Month:	March

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,830	3,634	3,132	3,634	(502)	The set aside budget delivered an adverse variance attributable to the non-delivery of savings (£0.981m). This is offset by a reduction in Medicine of the Elderly during 2020/21 as a result of the reduction in hospital activity during the Covid-19 pandemic. A&E has seen higher than budgeted costs in respect of unscheduled activity and there has also been significant pressure experienced within General Medicine linked in part to increased activity as a result of the different model of delivery in place during 2020/21.
Medicine & Long-Term Conditions	15,660	16,819	16,385	16,819	(434)	
Medicine of the Elderly	6,230	6,401	7,099	6,401	698	
Efficiency savings	(1,090)	0	(1,090)	0	(1,090)	
NHSB Contribution to Breakeven	0	0	1,328	0	1,328	
Total	23,630	26,854	26,854	26,854	0	

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 28 July 2021

Report By:	Laura Jones, Head of Clinical Governance and Quality Susannah Flower, Associate Director of Nursing Primary and Community Services/Chief Nurse Health and Social Care Partnership Peter Lerpiniere, Associate Director of Nursing Mental Health and Learning Disabilities Elaine Dickson, Associate Director of Nursing Acute Services
Contact:	Laura Jones, Head of Clinical Governance and Quality
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CLINICAL AND CARE GOVERNANCE REPORT 2020/21	
Purpose of Report:	The purpose of this report is to provide the Integrated Joint Board (IJB) with an overview of Clinical and Care Governance within integrated services focusing on the areas of clinical effectiveness, patient safety and person centred care
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **note** this report.
Personnel:	Service and activities are being provided within agreed resources and staffing parameters with additional COVID 19 resources being deployed to support the pandemic response
Carers:	Non applicable
Equalities:	Compliant
Financial:	Service and activities are being provided within agreed resources and staffing parameters with additional COVID 19 resources being deployed to support the pandemic response
Legal:	Compliant
Risk Implications:	Each clinical board is monitoring clinical risk associated with the need to adjust services as part of the heightened pandemic response
Glossary	IJB - Integrated Joint Board CGC - Clinical Governance Committee PCS - Primary and Community Services BECS -Borders Emergency Care Service BUCC - Borders Urgent Care Centre BSH - Borders Sexual Health Service PDS - Public Dental Service SAERs - Significant Adverse Event Reviews SOP - Standard Operating Procedure

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	OPAH - Older People in Acute Hospitals HIS - Healthcare Improvement Scotland DNACPR - Do Not Attempt Cardio Pulmonary Resuscitation HEI - Healthcare Environment Inspection ADON - Associate Director of Nursing SCN - Senior Charge Nurse AHP - Allied Health Professions MUST - Malnutrition Universal Screening Tool HSCP - Health and Social Care Partnership RAG - Red, Amber, Green MH - Mental Health CMHTs - Community Mental Health Teams CAMHS - Child and Adolescent Mental Health Services MDT - Multidisciplinary Team MHOAS - Mental Health Older Adults Service RTT - Referral to Treatment Time SDMD - Scottish Drug Misuse Database MWC - Mental Welfare Commission BSDU - Borders Specialist Dementia Unit PMAV - Prevention of Aggression and Violence LD - Learning Disabilities PPE - Personal Protective Equipment ITU - Intensive Therapy Unit BGH - Borders General Hospital RNs - Registered Nurses CNO - Chief Nursing Officer HCSWs - Healthcare Support Workers CNMs - Clinical Nurse Managers TTG - Treatment Time Guarantee OPD - Outpatient Department ED - Emergency Department EAS - Emergency Access Standard GP - General Practitioner MAU - Medical Assessment Unit DME - Department of Medicine for the Elderly ISD - Information and Statistics Division HSMR - Hospital Standardised Mortality Rate CNORIS - Clinical Negligence and Other Risks Indemnity Scheme CLO - Central Legal Office SAEs - Significant Adverse Events SPSO - Scottish Public Sector Ombudsman

Integrated Joint Board
Clinical and Care Governance Report

Clinical Effectiveness

Primary and Community Services (PCS)

Work continues to meet the challenges and demands from workforce and service delivery across all facets of PCS. Patient safety, incident reporting and risk management continue to be a priority alongside staff governance and wellbeing.

The continuation on quality of service and the re-establishment of restricted services due to the present pandemic is of paramount importance to ensure that services delivered are as effective and efficient as possible in order to mitigate the impacts of the pandemic to as great an extent as possible.

With the changes in leadership within the PCS management team the opportunity has been taken to refresh the agenda, terms of reference and membership of the PCS clinical governance group. In addition to this, there is an agreed expectation that all service leads will report into the group allowing for engagement with the governance agenda and defined accountabilities. All members are aware that reports must be submitted into the chair prior to the monthly meetings, with relevant information being escalated/addressed at this meeting. The agenda has been cross referenced with recently completed Clinical Governance “stock take” to ensure all agenda items are included. This current report reflects discussions and contents of all the service reports collated prior to the PCS meeting. Services reporting in the PCS clinical governance group include:

- Borders Emergency Care Service (BECS)/Borders Urgent Care Centre (BUCC)
- Borders Sexual Health
- Care Homes
- Community Hospitals
- Community Nursing
- Dental
- Dietetics
- Health Visiting
- Home First
- Occupational Therapy
- Physiotherapy
- Podiatry and Orthotics
- School Immunisations Team
- School Nursing
- Speech and Language Therapy
- Audiology - this service will now be reporting under Acute Services Clinical Governance structure from May 2021

COVID 19 Impact on Primary and Community Services

Community Hospitals
Demand for the beds dropped slightly throughout April with Haylodge and Hawick both having a number of empty beds through the month. Due to pressures and concern relating to patient flow, Haylodge Hospital accepted “out of area patients”. The dependency of a number of patients remains high with complex mental health presentations causing some impact on the nursing time demands. Support is provided by the specialist nurses however this does impact on time spent with other patient groups.

Work has started relating to delayed discharges with a review of the current Moving on Policy. A number of patients who no longer need CH support are being progressed through this policy with support from the Clinical Service Manager/Clinical Nurse Manager/General Manager and Associate Nurse Director.

The main changes within the four community hospitals are the changes to patient visiting. Notification was received that on 26 April 2021, all patients would be able to have a visitor to the ward. Processes have been developed, a risk assessment completed and staff have been updated to implement the change. The visiting is not tier dependant and continues to allow flexibility with “essential visits”. Visitor’s information has been developed to ensure that expectations and rules are clear and fair but mainly person centred.

Community Nursing Services and Home First Service
Both services continue to support across the localities although some limitations in certain areas due to reduction in staffing and short term sickness. The community nursing team has seen increasing demand for their services in recent months.

Primary Care
The PACS Team have to evolve quickly in order to respond to day-to-day challenges whilst keeping its eye on overall goals to prepare and meet the future needs of the Borders’ population. Primary and community care is the most visible and commonly used part of our health system and its team has expanded significantly in the last year, but with so many cogs in the wheel – how do we ensure that everyone is on the same page?

Strategic direction refers to the plans that need to be implemented for an organisation to progress towards its vision and fulfill its goals. PACS have adopted the ‘One Page’ approach to drive staff engagement, alignment and focus throughout the wider team. It provides a one-page format to communicate its vision to all staff at every level and also give them an opportunity to feed into the design of setting priorities or objectives and come to a mutual agreement on how the outcomes will be delivered. The simple principle is that if the plan can fit on one page – it is achievable and realistic.

Borders Sexual Health Service (BSH)
The BSH service has had to dramatically change their ways of working over the last 12 months and while they continue to recover BSH to previous capacity have adopted many new approaches to delivering Sexual Health care.

Allied Health Professions
AHPs like many other specialities providing outpatient consultations have had to adjust their practice in line with national restrictions and have made wide use of Near Me consultations. AHPs have been critical in the ward based pandemic response maintaining effective rehabilitation services and timely discharge at a time of heightened demand.

Public Dental Service (PDS)
Dental services continue to by COVID 19 safety restrictions in relation to full remobilisation of services. Many dental staff have been deployed to support the COVID 19 pandemic response services which has been critical to the organisation response. Most staff have been gradually returning to substantive posts where possible. The PDS is trying to maintain contact with patients who are waiting to advise them of continued wait for routine examinations and car. In addition, the PDS is communicating with all primary care referrers to advise of waiting times for Paediatric GA.

Adverse Events
In order to have complete grip and control of the numbers of Significant Adverse Event Reviews (SAERs); stage of investigation and action planning PCS have initiated a process within the board. Each week the Quadumvirate have a core meeting with the following agenda:

1. Datix incidents – graded extreme
2. Updates from key meetings
3. Matters for decision
4. Quality
5. Staff governance
6. Finance
7. Performance

The outstanding SAERs are also highlighted under item 1. Further to this, there is now a process whereby admin support will follow up on the action plans from SAERs to ensure that these are completed within the timeframes recorded and this is then fed into the P&Cs clinical Governance meeting monthly. A Standard Operating Procedure (SOP) has been created to ensure that all members of the team understand the process relating to updating the action tracker for all SAERs on the shared drive, with all having secured access to the drive and an education session to show how to evidence the progress made with actions. There is further development underway to ensure there is a system to check that any learning from SAERs has been shared and actions sustained thereafter.

The process has had a positive impact with the number of “open” SAERs having dropped significantly over the last 4 months.

PCS have prepared a combined improvement plan for both falls and pressure damage to consolidate all the learning and actions resulting from falls and pressure damage reviews. This is monitored through the PCS clinical governance group.

Infection Control and Older People in Acute Hospitals Standards
The Older People in Acute Hospitals (OPAH) Standards were published in 2009 and were historically the basis of Healthcare Improvement Scotland (HIS) acute hospital inspections. Over the last 10 years these have been updated to the Care of Older People in Hospital Standards (2015) and augmented by Standards for Prevention and Management of Pressure Ulcers (2016), Food, Fluid and Nutritional Standards (2014), Do Not Attempt

Cardiopulmonary Resuscitation (DNACPR): Integrated Adult Policy – Decision Making and Communication (2016) and many other national standards and guidelines. In addition Healthcare Environment Inspection (HEI) have been absorbed into HIS and the standards under which their inspections were undertaken have also been absorbed.

HIS have recently restarted these formal, unannounced inspections within Scotland with a focus on Community Hospitals and Specialist Dementia Units.

In order to provide assurance the Associate Director of Nursing (ADON) for Primary and Community Services has led unannounced mock inspections across community hospitals, to continue to promote a strong focus on quality of care. Two hospitals were visited in July 2020 and a number of areas of good practice were identified during mock inspections in additions to areas for improvement. Themes which now form the basis of community hospital improvement work include:

1. Inconsistent approach to documentation, minimal correlation between assessments, care planning and monitoring of patients.
2. SSKIN not always completed on prescribed time.
3. Minimal documentation in relation to communicating discharge plans with families/relatives etc in the records.
4. Person Centred approach not always evident in documentation.
5. FFN- inconsistent approach to this- recording of oral intake- ensures that assessments correlate with food charts, SSKIN and care planning.
6. Evidence of getting to know me in patient's notes - although not always consistent
7. Evidence of AWI assessment and review at times - not always consistent
8. Consistency of cleaning schedules across community hospitals

Action plans were developed to address these points with progress made on each action. The progress of the actions is now monitored through the PCS Clinical Governance group and a follow up visit will take place in both sites to observe progress.

Haylodge Inspection
Unannounced Health Improvement Scotland Inspection action plan remains a live document. Work continues to achieve and address timely the 8 requirements. Progress made is demonstrated in the updated action plan, attached in the Appendix. This has been ratified by Chair of the Board and the Chief Executive prior to submitting to HIS on 27th April.

Patient Flow in Community Hospitals
In response to the pressures on whole system flow work is underway in community hospitals to processes to support timely discharge of patients.

Discharge huddles/planning have refocused under Senior Charge Nurse (SCN) ownership to ensure visibility simultaneously on each patient and the overarching Community Hospital flow. A key objective in these huddles is to lower and maintain minimal delays experienced by any patient. To further enhance this focus there is joint working between boards and partnerships to review and simplify and re-launch specific policy and guidance. This work includes a review of the "Moving on Policy" and education in relation to Adults with Incapacity, Guardianship and legislation.

A daily integrated huddle is in development to support whole system flow. This will focus on the pull systems from district nursing, home first, community hospitals to facilitate timely discharge.

Allied Health Professions (AHPs)
Following the appointment of an Associate Director AHPs in 2020, 2021 has seen the completion of the AHP leadership review which was started in 2018. This process has sought to establish a leadership structure across Dietetics, Speech and Language Therapy, Podiatry, Occupational Therapy and Physiotherapy that will provide the appropriate levels of operational, professional and strategic leadership.

A uni-professional model with a strong AHP-wide focus on governance and performance has been developed and is in the process of being implemented. In order to ensure that each service is providing governance and assurance in an equitable way, AHP services will be developing Service Specifications as part of an AHP-wide service review. These service specifications will clarify operational and financial parameters regarding service delivery alongside establishing a safety and quality dashboard to measure the impact and governance of each service.

This safety and quality dashboard will align with both the 'Back to Basics' governance group and the Access Board to ensure that reporting is in line with local process. Measures will include demand and capacity activity data, access times, complaints, patient reported outcome measures, relevant safety measures (falls, pressure damage, Datix reporting), clinical effectiveness measures (frailty scores, MUST, functional outcomes), and whole system impacts (d/c rates, re-admission rates, population health/ inequality impacts). The combination of the service specification will provide organisational assurance regarding the clinical, staff and financial governance of AHP services alongside the ongoing measurement of key performance indicators and governance measures that will be reported through the PCS and Board reporting structures.

Clinical and Care Governance Arrangements for Care Homes during COVID 19
In May 2020 arrangements were put in place to ensure appropriate clinical and care professionals across Health and Social Care Partnerships (HSCP) take direct responsibility for the clinical support required for each care home in their Board area.

A support and governance system has been established in support of care homes during COVID 19 with the Director of Nursing, Midwifery, AHPs and Operations taking accountability for leadership and guidance to care homes, and providing professional leadership and guidance to care at home.

In doing this the Director of Nursing, Midwifery, AHPs and Operations established an oversight group as directed by the Scottish Government. This group includes the Chief Social Work Officer, Chief Officer Health and Social Care Services, Chief Officer for SB Cares, Medical Director and Director of Public Health. In addition, a daily operational group meets to review data submitted from care homes and escalates any variance to the oversight group. Supportive assurance visits have taken place to all 23 homes to assess care looking specifically at infection prevention control practice, understanding and use of PPE and the fundamentals of care.

The responsibility for this has now transferred to the newly appointed Director or Nursing, Midwifery and AHPs

On completion of the supportive assurance visits themes were drawn out and action plans prepared. A Red, Amber Green (RAG) assessment tool was developed to prioritise actions. Care homes with Red and Amber actions were revisited again to seek assurance actions were completed or that a plan was in progress to address.

A lead Nurse role has recently been developed and appointed to which will provide professional support across all 23 care homes. The Lead Nurse is working to build strong relationships with care homes teams and has begun to update the proforma used to undertake the supportive assurance visits. A short life working group will support this work.

Development of a Care Home Team will further enhance the support and assurance for the care homes within the Borders. This will include two Senior Nurses and two Clinical Educators.

Mental Health (MH) Services
The 'Framework for Measuring and Monitoring safety' is now being consistently applied to support the Mental Health Governance Steering Group. The Mental Health Governance Steering Group meetings are held bi-monthly. The group monitors clinical and care governance across mental health services.

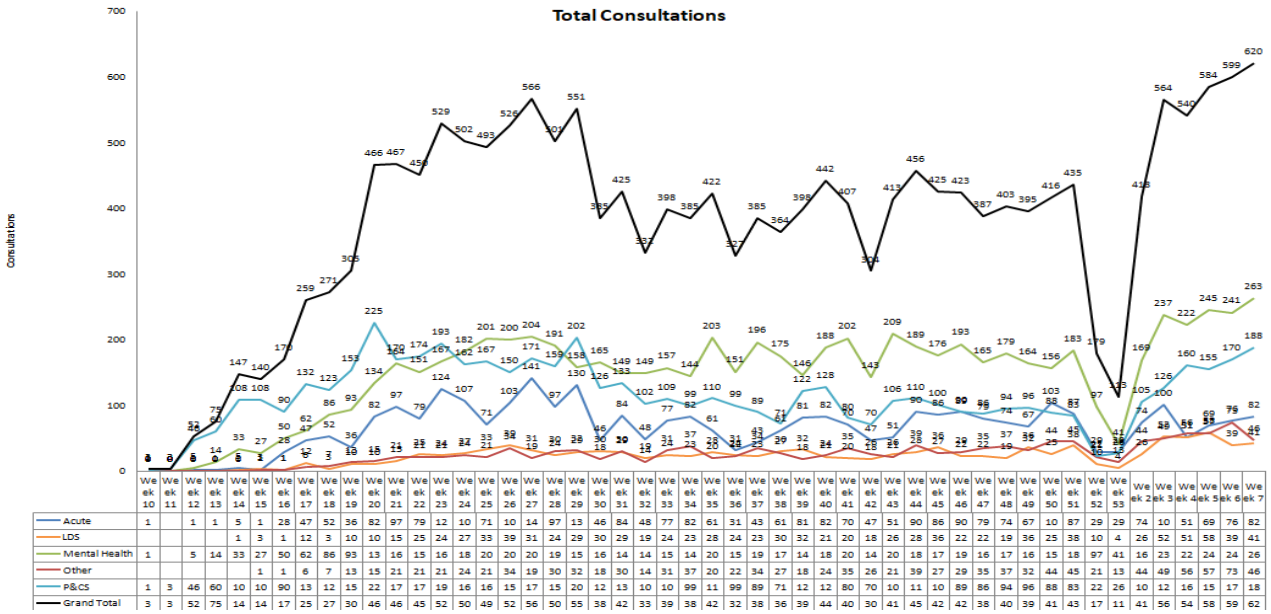
COVID 19 Impact on MH Services
MH services have adapted to respond to the COVID 19 pandemic. People continue to struggle with their mental health during the pandemic and particularly during periods of lockdown. Resources are being prioritised clinically to deliver care as safely and efficiently as possible.

Huntlyburn has experienced a period of increased occupancy and patient acuity in comparison to pre-pandemic levels. Staffing has been challenging due to a number of factors including ability to recruit and take up of bank and agency shifts. Staff from other mental health services have been deployed to provide support and to maintain safe staffing levels. In addition, the service has at times struggled to access specialist beds in tertiary centres this has further compounded the complex case mix in inpatient areas.

Near Me Consultations
Mental Health services have embraced the use of video-link appointments using the Near Me platform as demonstrated by the line graph below Near Me has become a valuable tool in our clinical practice.

While this is unsurprising, in as much as one would expect services where the patient - facing roles are often fundamentally about communication to be more adaptable to this technology, it does not come without challenge, concern and risk. MH services at times find it difficult to identify suitable premises to undertake Near Me appointments where patients are not confident they can maintain their confidentiality at home.

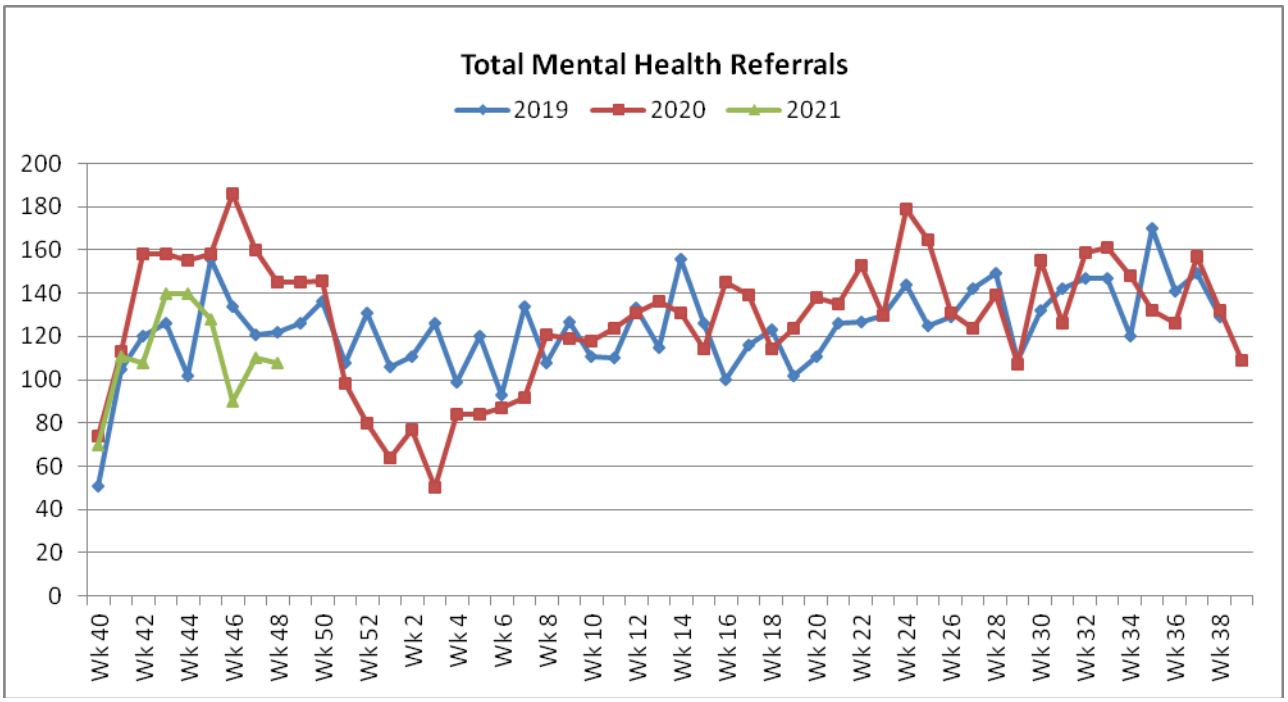
Graph 1 below give an indication of the use of Near Me across all services:



Recognising that Near Me is not the appropriate service delivery model for all people in all circumstances Mental Health services are, always factoring in guidance on PPE and risk management, moving to more face-to-face appointments. As attempts are made to move services back to their more traditional modalities there have been challenges relating to lack of access to clinic rooms. Options are being continually explored and the Executive Team are aware of the challenges.

Referrals to Mental Health Services

Graph 2 below notes the small but significant difference in referrals between 2019 and 2020. This is being most particularly felt by Community Mental Health Teams (CMHTs) and Child and Adolescent Mental Health Services (CAMHS):



The CMHTs have used continuous RAG rating for patients who have been referred to the service and those on current case loads, monitoring acuity and responding accordingly to the level of need required.

In the Adult teams the uptake of digital platform, Near me, has been high which has enabled assessments to continue however within the Older Adult service this has proved to be less so due to a difficulty in being able to access and use technology, therefore the face to face has increased to ensure care and treatment continues and crisis situations are avoided as much as possible.

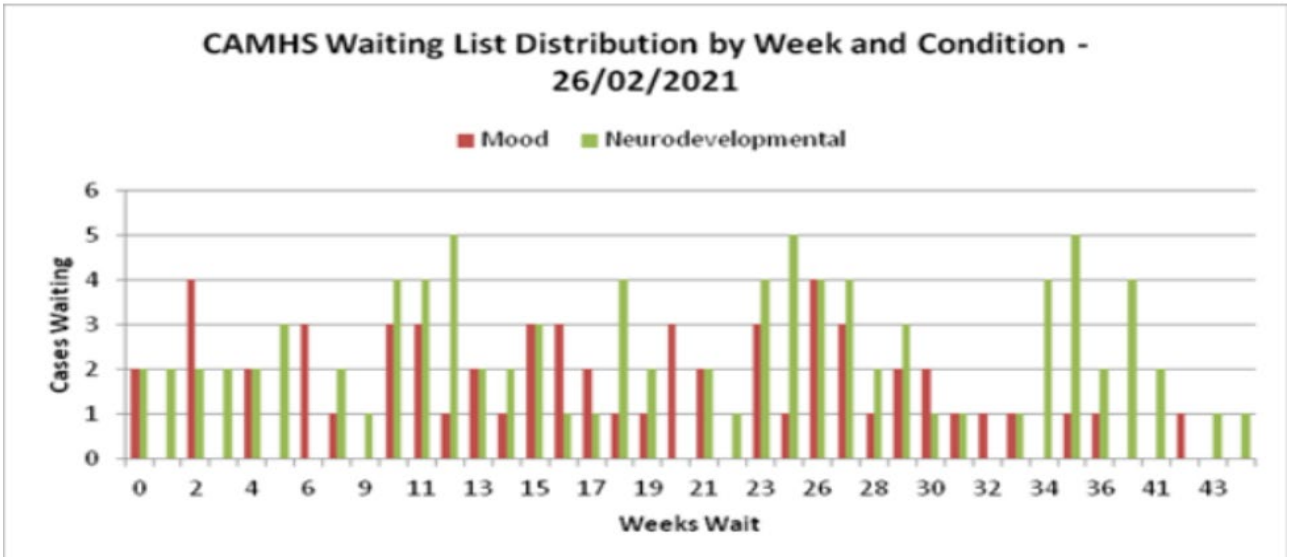
Recruitment within the Adult CMHTs has been a challenge for over two years with consequent impact on the service as a whole with additional impact from sickness/absence. All options are being explored relating to recruitment of Registered Mental Health Nurses. Ability to attract nurses with the necessary skills for the community is a national issue and is not unique to the Borders. A one year trial introduction of a peer support worker has been agreed to work alongside the Multidisciplinary Team (MDT) bringing additional skills and knowledge.

The Mental Health Older Adult Service is also facing significant vacancies, with an impact on the service. Recent recruitment will reduce some of that impact when staff commence appointments.

CAMHS

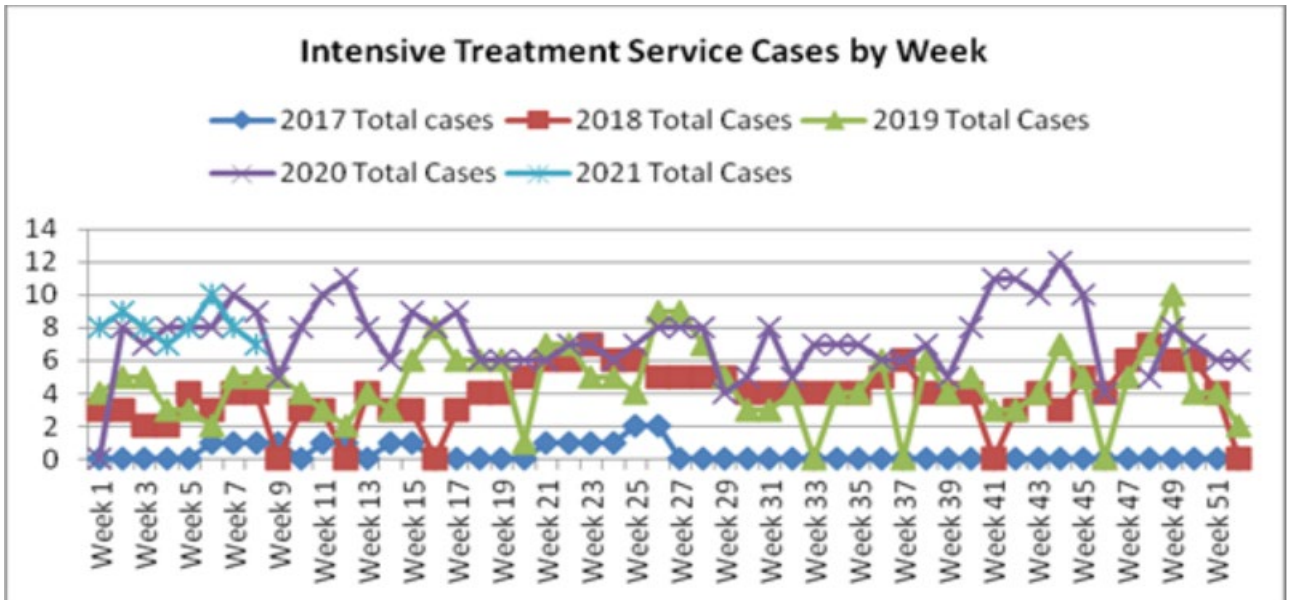
Throughout the pandemic clinicians have continued to provide both mental health and neurological developmental assessments, treatments and reviews for children and young people, irrespective of absences and vacancies within the service.

The service has used the RAG approach to review patients on the current case load and waiting list. Care plans and risk assessments have been reviewed and updated as necessary and clinicians have worked with the MDT to prioritise patients requiring ongoing support. Graph 3 below shows the CAMHS waiting list distribution between waiting lists for mood and neurological developmental disorders:



The impact of COVID 19 and lockdown on the mental health of young people can be seen in the Intensive Treatment Service which has seen an increase in referrals over the past few months. In this service, clinicians work with families to support children and young

people to stay at home as an alternative to hospital admission where clinically appropriate. Graph 4 details referrals to the intensive treatment service:



A temporary Nurse Led Opt in Assessment appointment system has commenced since January 2021 to ensure that patients on the CAMHS Referral to Treatment Time (RTT) waiting list are offered an appointment. The CAMHS Service Review is progressing well, working alongside the Scottish Government and bench marking against the CAMHS Mental Health Standards to peer CAMHS services across Scotland.

Borders Addiction Service
The pandemic has posed particular problems for the Addictions service as so much of their service can only be delivered in person.

Their performance as noted in the Scottish Drug Misuse Database (SDMD) is one to be proud of in any circumstance but in this context is particularly noteworthy:

- SDMD compliance with Drug and Alcohol Treatment Waiting Times for Borders was 98% (64.5% - nationally).
- NHS Borders was 2nd best performing board (NHS Shetland had 100% compliance).
- In 2019/20, 215 individuals had initial assessments for specialist drug treatment according to the Scottish Drug Misuse Database.

Full report can be found here: https://beta.isdscotland.org/find-publications-and-data/lifestyle-and-behaviours/substance-use/scottish-drug-misuse-database/

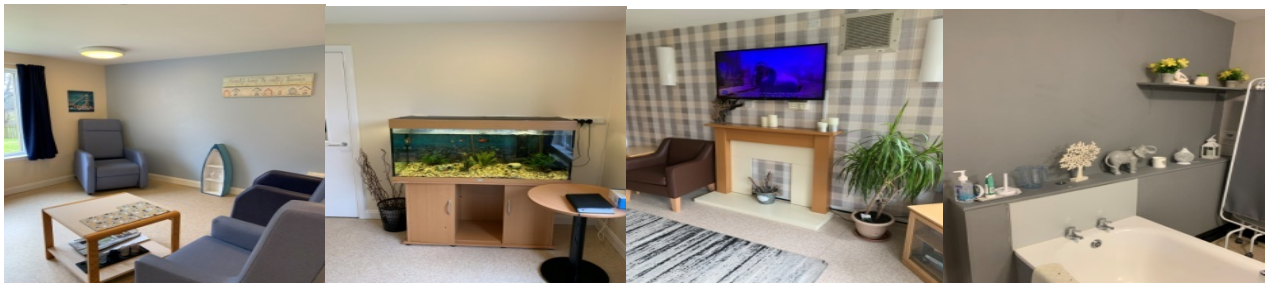
Borders Crisis Team
As many services did the Borders Crisis Team flexed their working practice in a number of ways during the specific demands of the pandemic, including taking direct telephone triage from the police and ambulance service, and direct referrals from BECS.

This has led to a threefold increase in the number of referrals to the service over the past year. In addition there are challenges in maintaining the duty rota for Junior Doctor which is a key step in the support process in giving the service resilience.

The service is currently reviewing the skill mix to offer Advanced Nursing Practice roles as part of the service development and to bolster service resilience.

East Brig

COVID 19 lockdown restrictions have introduced particular challenges to East Brig whose residents can be admitted for long-periods. Staff working at East Brig have undertaken to improve the experience of patients by working to improve the environment in their own time under these difficult circumstances. The pictures below provide some examples of the teams work to enhance the environment for patients:



Mental Welfare Commission (MWC) Visit to Borders Specialist Dementia Unit (BSDU)

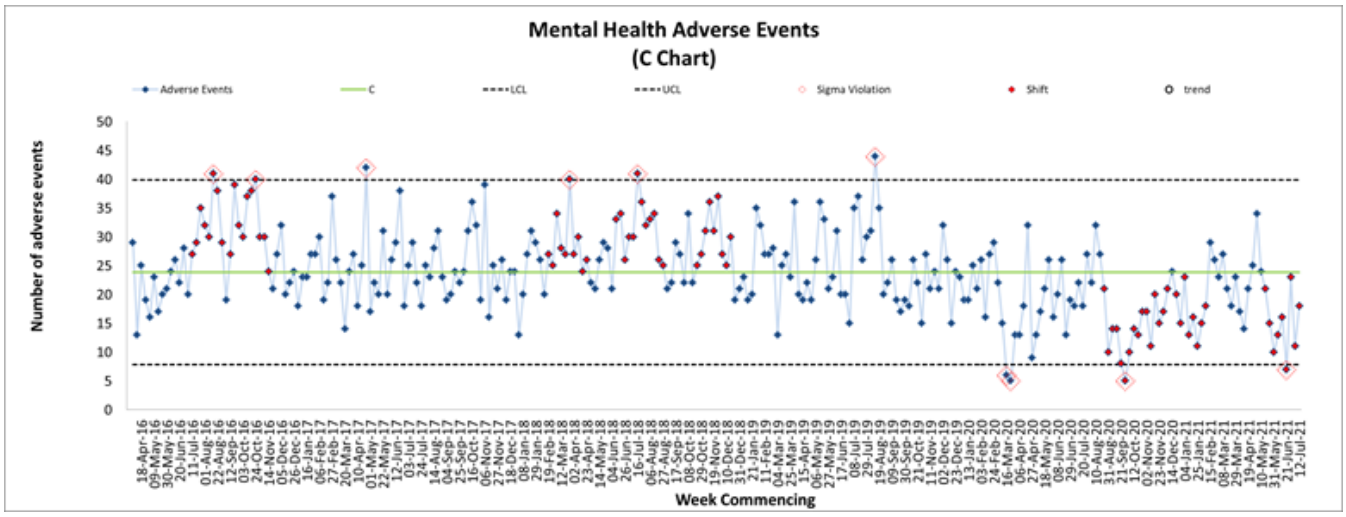
The MWC visited BSDU in February 20. Their report was misdirected and not received by MH services until December 20. In the main their comments were positive although there were three recommendations, all are responded to and complete.

Adverse Events in MH

All adverse events graded as having an outcome of major or extreme are considered significant enough to warrant a comprehensive review, usually this will be a SAER or a Management Review.

The MH clinical board has been behind in completion of the adverse event reviews for a number of reasons but we are working with Clinical Governance and Quality Department to ensure that we address the backlog. Since the last clinical governance meeting we have completed 7 SAER's and Management reviews. Action plans for these have been developed. As a number of events took place in Huntlyburn during a period of high occupancy and acuity the SCN, the Operational Manager and Associate Director of Nursing undertook a thematic review of these events. The findings have been shared with the Associate Medical Director and the wider team. The incidents were all different but there were commonalities in aspects of record keeping and changes have been undertaken to address this.

To support service wide learning from adverse events the Mental Health service produces an Adverse Event Update in newsletter format each month which contains the adverse events for the month, potential contributing factors and the reasons. Graph 5 details the adverse events in mental health service from April 2020 to March 2021:



Nutritional Care

Clinical risks associated with nutritional needs are highlighted in the daily safety brief including eating disorders, special dietary needs, and identified risks of choking and meal support.

The mental health board is working closely with regional colleagues to develop an Eating Disorder pathway which makes best use of the resources at our disposal and of our relationship with the Regional Eating Disorder Unit.

This remains a continuous service pressure Children Adolescent Mental Health Services (CAMHS) as nursing staff supervise meals for a number of patients.

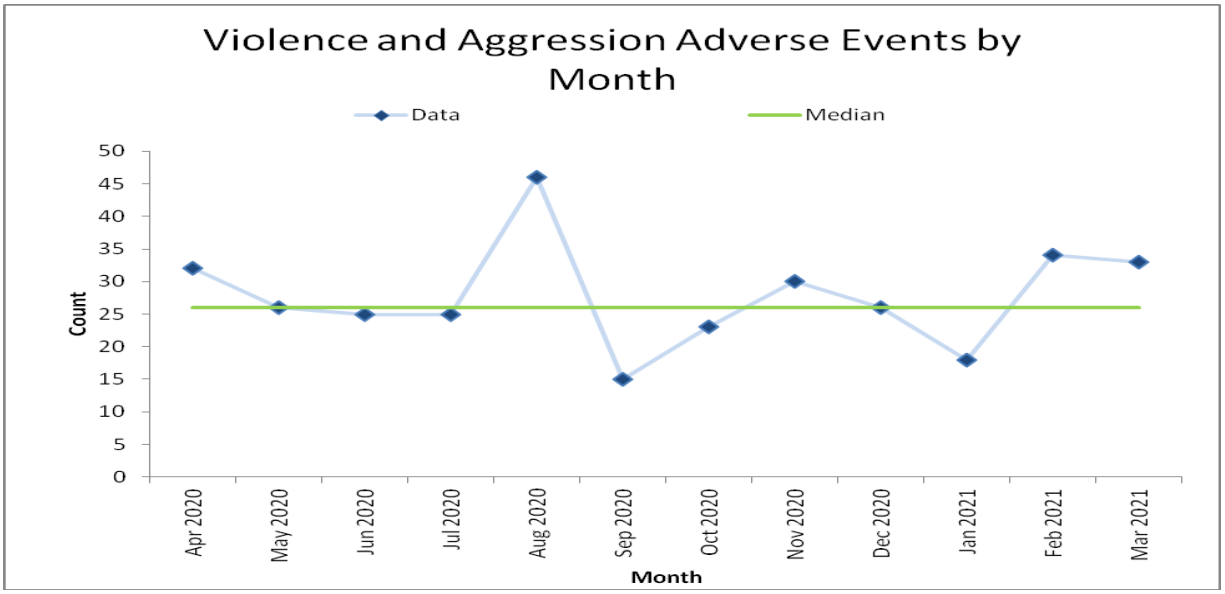
Falls

Cauldshiels closed in October 2019, and consequently we have concentrated the people with the highest level of distress and disability due to dementia. This is the patient population most likely to fall in our mental health units. However, the falls rate in mental health has reduced. This is not yet a sustained reduction but is showing encouraging signs. Graph 6 details the falls rate for mental health:

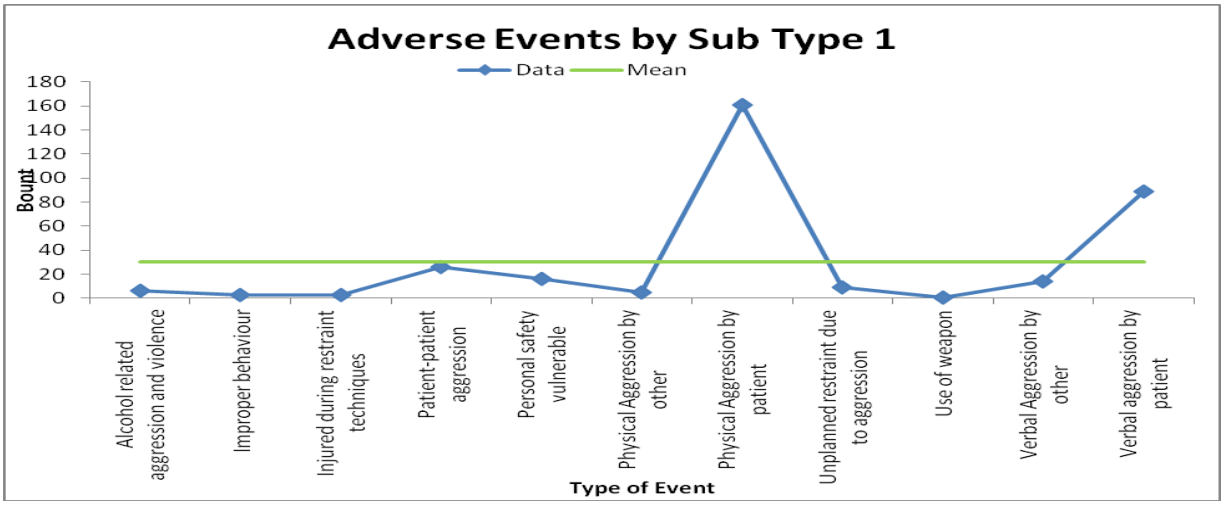
Violence and Aggression

Staff continue to work to reduce and eliminate incidents of violence and aggression in Mental Health services with particular emphasis on inpatient units. Staff have been supported in developing and applying restraint techniques which are COVID safe during the pandemic by the Prevention and Management of Aggressions and Violence (PMAV) team and guidance has been published by Scottish Government for the safe reintroduction of PMAV training in light of COVID 19.

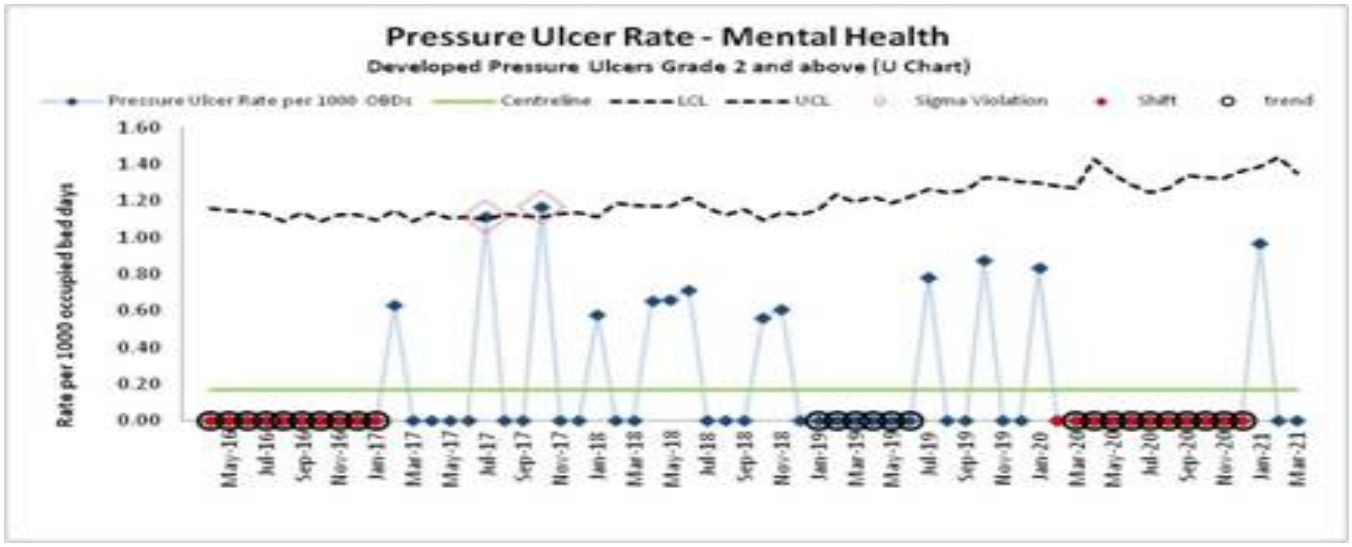
The numbers of incidents are continually monitored to review trends in particular in clinical areas. Graph 7 details the violence and aggression adverse events in mental health:



Graph 8 details the types of adverse events in mental health:



Tissue Viability
Graph 9 shows the pressure damage rate for mental health inpatient areas:

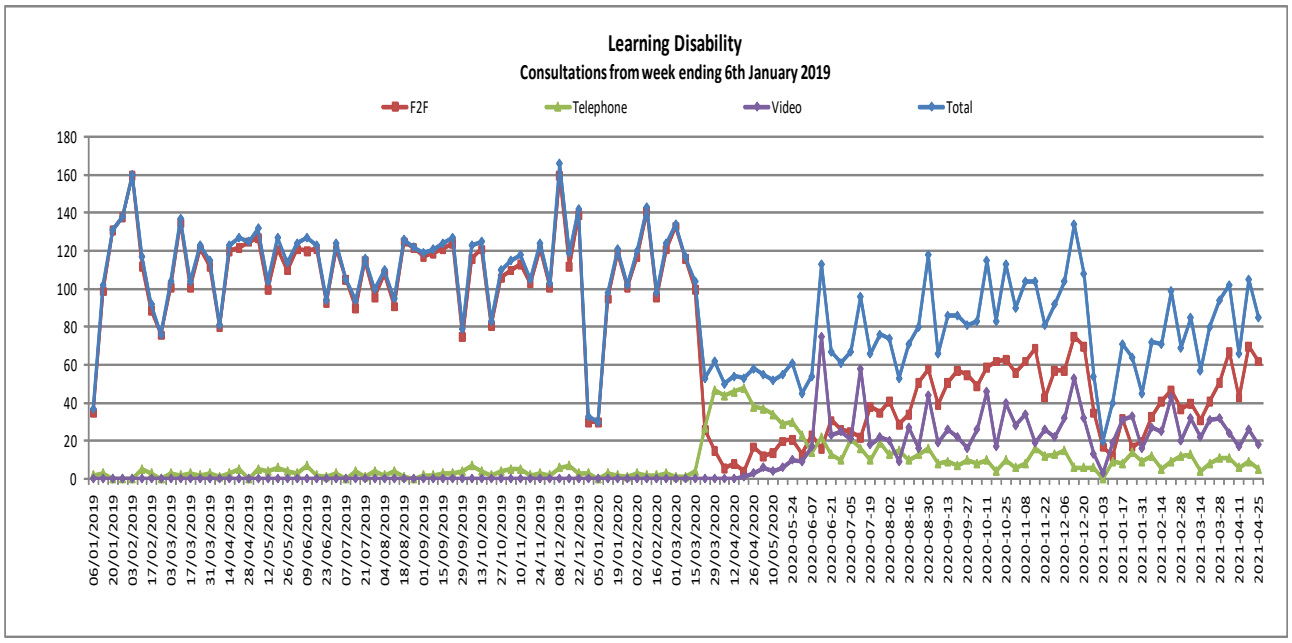


Tissue viability using the SSKIN bundle continues to be monitored via the daily inpatient safety huddle but remains as a very low rate in mental health inpatient areas.

Learning Disability (LD) Services

COVID 19 Impact on LD Services
Staff are now carrying out face to face contacts where there is no alternative method to deliver interventions. All other contacts are by telephone, Near Me or via conversations with carers.

The service continues to work to adapt and monitor the changes brought about by COVID 19 including the increased use of Near Me where appropriate as detailed in Graph 10:



The service has worked and continues to work to adapt to the changes brought about by COVID 19. Adaptions have been made to the way LD services are delivered to reduce the risks to patients and staff, taking into account the frequently changing pandemic position and advice from the Scottish Government.

COVID 19 risks to the service are detailed on the COVID 19 Risk Register. The LD services is working very closely, flexibly and innovatively with LD Service providers in the community to meet the need of this patient group and has periodically been required to work flexibly to support beyond their own service. Accessing Personal Protective Equipment (PPE) has been an issue for some providers but currently these issues have been resolved. Additionally there have been some challenges in the use of PPE causing elevated distress in some patients. Staff have had to address each case by applying and individualised risk assessment.

Out of Area LD Placements
Monitoring of out of area placements continues to be limited at the moment due to the restrictions however we are maintaining telephone contact with these services. Two of the placements inspection reports identify that they require improvement, we are liaising with them in relation to their action plans to improve:

1. North East of England, Residential Home ("Requires Improvement" CQC rating): – Patient fit and requesting to return to the Borders, has now been allocated a social worker to progress this. As yet there is still no community provision yet identified.

2. Staffordshire, Hospital – ("Requires improvement" CQC rating): –
   A number of Safeguarding issues have arisen regarding a patient of our service over the period from August 20 to February 21. These are reported as poor-handling, unexplained bruising on upper arm and chest (separate incidents) and non-intentional scratch to patient's face.

   A Social Worker visited patient on 22 April 2021 and reported that "the Managers had a sound knowledge of the patient with some well-informed assessments completed and is being looked after as well as can be expected". No concerns reported at the time of the visit.

   Staffordshire Safeguarding Team are now fully engaged and leading the process which gives a greater level of assurance. A Safeguarding Meeting was held on 29 April. There are two investigations ongoing in respect of the most recent concerns. There was agreement that the risk management plan in place is adequate. Measures include:
   - not using agency staff with this patient
   - all staff must sign a declaration that they have read patient's support plans before working with him
   - promoting female staff to work with patient
   - clear guidelines in respect of off-site visits

   The LD Service continues to monitor adherence to the management plan on an ongoing basis with regular digital and in-person reviews.

3. Dundee, Hospital ("Satisfactory") –
   The LSI and the 2 Adult Protection investigations are now concluded, actions and recommendations have been implemented.

Quality Network in Learning Disabilities
Scottish Borders Learning Disability Service is the first in Scotland to be part of a pilot to develop standards for Community Learning Disability Teams.

The draft standards have been developed and internally reviewed by members of the service. The service was due to undergo a peer review in January however this has been postponed due to COVID 19 and the team are seeking to reschedule.

Deaths of People with a Learning Disability
The English Learning Disability Mortality Review Report 2019 states that people with a learning disability die on average between 22 and 27 years younger than the general population (22 years for males, 27 years for females). COVID 19 will have an effect on these figures as researchers have found the death rate due to COVID 19 in people with a learning disability to be much higher. England has a system to review all deaths of people with a learning disability to identify areas of good practice or learning from events and care leading up to the persons' death, while no such systemic practice is embedded in Scotland the Borders LD service recognises this is good practice.

Following an unsuccessful bid for funding to develop a system across the LD Managed Clinical Network the Associate Director of Nursing for Mental Health and Learning Disabilities, working with the person's social worker and liaison nurse, reviewed the death of an individual with a learning disability who died in the BGH using the Mortality Review Form as a test case. The findings were positive and showed that this person had received appropriate and good quality care.

A small group of staff, led by the LD Advanced Nurse Practitioner are working to develop a proforma to review deaths of individuals who die in their own home. Once this is agreed the LD Service will review a random sample of deaths of people with a learning disability and share any areas of good practice or learning.

The LD service have recently established a link in the chain to ensure that where people known to the Learning Disability Service within the last year die from a drug related death and are reviewed by the Drug Related Death Group the LD Service will be invited to contribute and informed of the outcome.

COVID 19 Vaccinations
The Chief Nursing Officer wrote to Boards in relation to Learning Disability Nurses assisting with the vaccination of people with a learning disability.

There were 3 recommendations:

- Learning Disability Nurses should vaccinate people on their case load, as part of their day to day workload, as they will have an established relationship which will be helpful in supporting their clients to receive the vaccine.
- A Learning Disability Nurse Link Person should be identified to support the Boards COVID 19 Vaccination Operational Lead to deliver the programme to this cohort of patients.
- Learning Disability Nurses should be encouraged to join the local Nurse Bank with a view to vaccinating people with learning/intellectual disabilities and or eligible people with neurological developmental issues known to Primary Care Services where possible.

In the Borders the LD Nurses continue to support the administration of COVID vaccination programme to people with a learning disability.

Acute Services

COVID 19 Impact on Acute Services
Acute Services have faced significant challenges in 2020/21 in responding to the COVID 19 pandemic. This response has placed pressure on all services and significant compromises have been required in relation to the step down of elective services in line with national lockdown requirements to enable urgent and emergency services to respond. This has creating a large backlog of patients waiting for outpatient assessment and day case and inpatient treatment.

The planning for COVID 19 has been extensive and comprehensive. Regular modelling of demand has informed the flexing up and down of COVID wards and an additional Intensive Care Unit (ITU). The limitations of Borders General Hospital (BGH) building has presented several challenges in delivering a safe service which teams have worked hard to mitigate with support from colleagues in teams such as infection control and estates and facilities. The most significant challenges have centred on the limited number of single rooms and infection control issues relating to COVID 19 in 6 bedded bays; the limited staff changing or meeting space in clinical areas; and the existing ventilation system and piped oxygen supply.

Staffing
There are significant pressures on Registered Nursing numbers resulting from a number of things including the inability to recruit to vacancies, the additional services in operation as part of the ongoing COVID 19 response such as test and trace and the vaccination programme and the need to maintain services that were stepped down in the wave 1 response. Acute services continue to see a number of staff moving out to promoted positions in the community such as ANP positions and internally have a number of specialist nurse positions which are or will become vacant largely through staff retirement. In addition, there have been some early problems with the regional nurse bank model meaning fill rates have not been at the levels NHS Borders would normally expect.

All steps are being taken to divert Registered Nurses (RNs) to the areas of greatest need to maintain patient safety. The Chief Nursing Officer (CNO) has issued COVID 19 workforce guidance and NHS Borders is using this to guide the local approach. The supervisory time of Senior Charge Nurses (SCNs) has also now been adjusted to provide additional clinical hours as part of this response. In addition, the RN to patient ratios in acute services have been adjusted in line with the CNO workforce guidance to a 1 RN to 10 patient ratio. A proactive approach has been taken to recruitment of additional Healthcare Support Workers (HCSWs) to enhance the numbers of staff in each ward.

It is anticipated that staffing pressures are likely to continue given the pressures being seen across NHS Scotland in key disciplines. Ongoing steps are being taken to recruit on a permanent basis, recently offering posts to 21 students who are due to qualify later this year, in the short term bank and agency staff are being requested to cover vacancies, with a further advert currently live for RNs. Clinical Nurse Manager's (CNMs) and SCNs are considering whether the introduction of band 4 staff to their teams is appropriate to mitigate future risk. Consideration is being given to running a trial of the National Real

Time staffing tool across two ward areas recognising that running workload tools is an important part of recovery, to inform of potential areas to alter skill mix.

Out Patient Services

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

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

In response to increasing waiting times there are a number of actions that have been taken. Patients on outpatient, TTG and diagnostic waiting lists are carefully prioritised according to clinical need and the national clinical prioritisation guidance issued. Available capacity has been targeted to those patients in the highest clinical priority groups and urgent waits are monitored on a weekly basis to ensure these remain manageable and appropriate. There is also provision for patients on routine waiting lists to contact clinical teams to discuss any deterioration in their condition that may merit an appointment or treatment being expedited.

From the May 2021, Out Patient Department (OPD) appointments have gone up to 60% with an average of 20% virtual appointments, therefore 80% of OPD appointments are being met. We are actively reviewing social distancing arrangements to see if it would be safe to adapt pathways to increase capacity. This is in line with proposals being considered in other Health Board areas. Public Health and Infection Control guidance will be central to any proposals taken forward. We also have proposals under discussion to de-escalate our green pathways through ITU and Theatres in light of reduced risks. This will support an increase in Theatre capacity overall and move us towards delivering 60% of pre-COVID activity levels.

Colonoscopy referral rates have been significantly above historical level since the resumption of the national screening programme. This has increased colonoscopy waiting times for urgent patients to 6+ weeks. Additional weekend colonoscopy lists have been scheduled up to the end of September in order to address pressures. This is not expected to be an ongoing issue and we are anticipating referral rates to normalise during May as screening backlogs are recovered. Radiology waiting times remain manageable but are dependent on additional ad hoc capacity in order to maintain acceptable waits. Weekly monitoring remains in place.

Routine Surgery

Routine surgery has recommenced and is primarily being managed as a green pathway through ward 17, with capacity within ward 9 for those patients unable to meet the requirements of a green pathway. Green Pathway patients are advised at pre assessment that they should limit social contact for 14 days prior to admission; they are COVID tested 72 hrs before their surgery date and self-isolate for the 3 days from testing to admission.

Currently theatre capacity is running at 40% pre COVID levels, and has been shaped by both the different pathway processes established due to COVID 19 and nurse staffing levels to accommodate these. The service are currently looking at ways of being able to increase capacity to 60% and are benchmarking against processes being followed by other health boards.

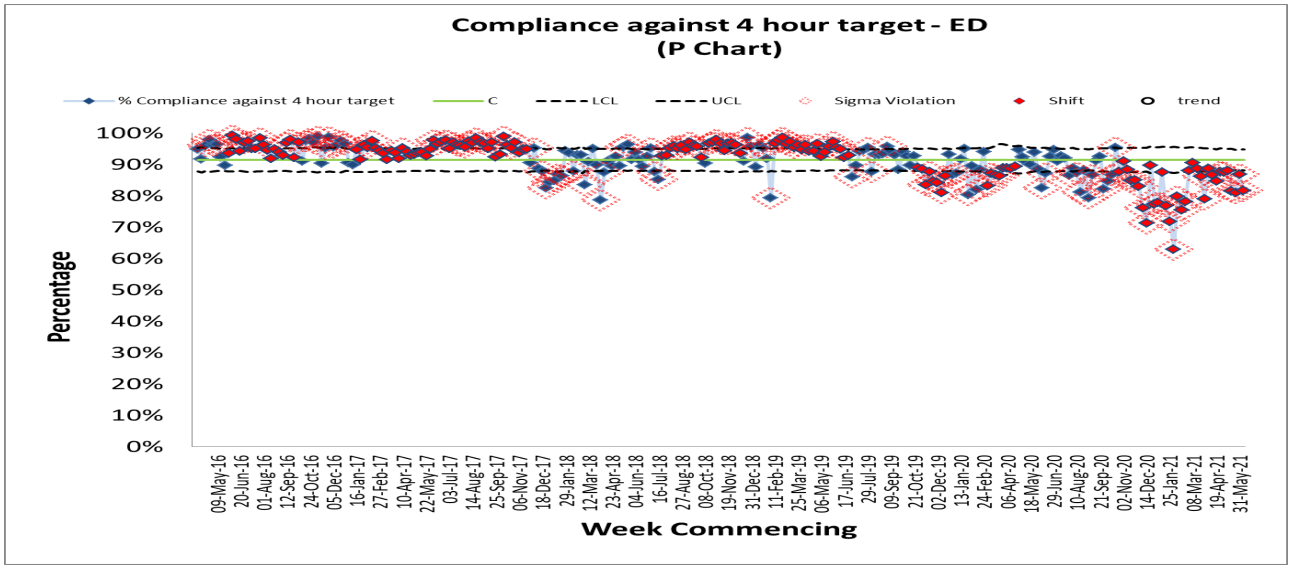
Increasing to 60% would facilitate a further 520 operations over a 6 month period. There are currently 1,733 patients waiting for routine operations in NHS Borders of which 589 have been waiting longer than one year.

Emergency Access

There has been significant pressure relating to unscheduled care with large numbers presenting to the Emergency Department (ED) for assessment and requiring admission. The Emergency Access Standard (EAS) for the first quarter of 2020/21 was:

- January 2021- 78.13%
- February 2021- 74.08%
- March 2021- 86.62% (including 2194 attendances and 284 breaches of the EAS)

Graph 11 details the compliance with the EAS:

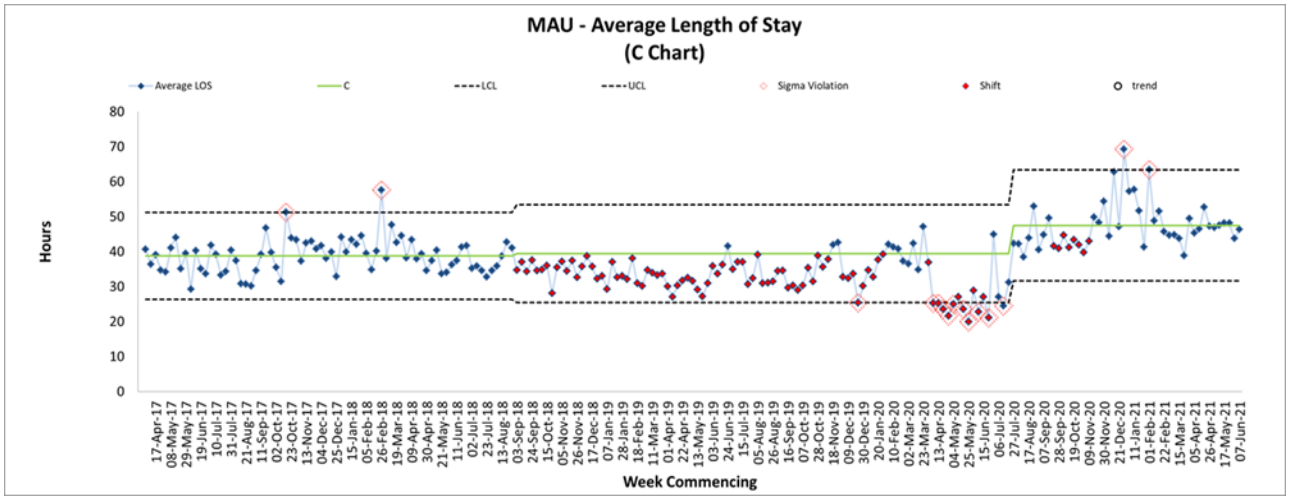


Quality improvement work is being taken forward with the ED and the wider system to improve flow now that COVID 19 levels are reduced and remobilisation activities are underway. A process mapping session has recently taken place from the patients' perspective from entering the ED through to the completion of episode of care in the department. This mapped key components of the patients' journey, which affects the overall length of stay in the ED. Nine areas for improvement were identified and Plan Do Study Act cycles are planned for each of these areas over the next three months.

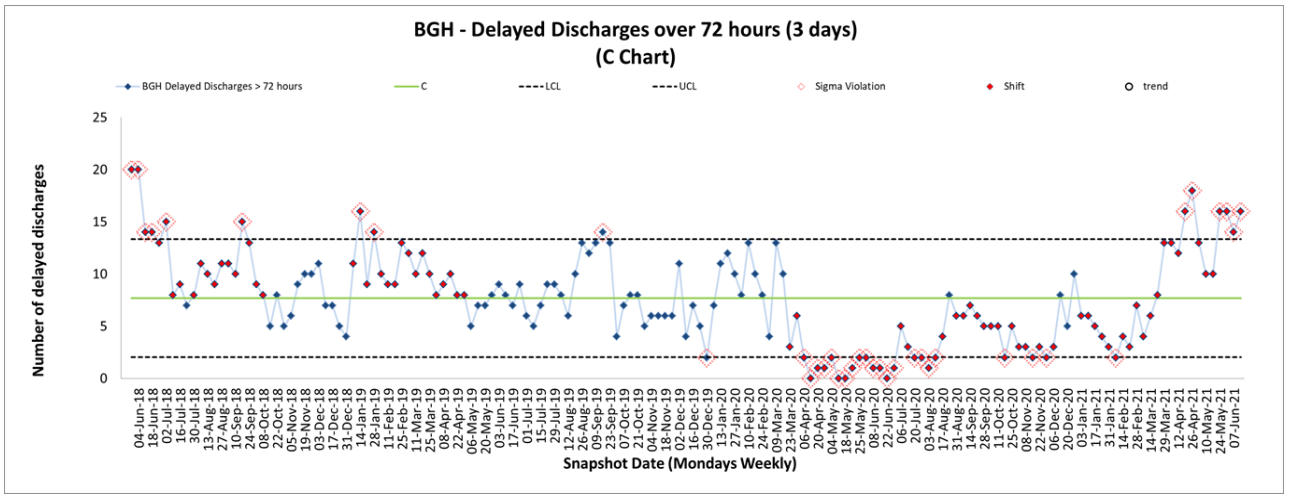
As part of the ongoing remobilisation of services, improvement work is underway to remove appropriate General Practitioner (GP) referrals out of the ED. GP referrals were moved out of ward areas and into the ED as part of the COVID 19 response last year to remove patients with unknown COVID 19 status from ward areas. The first test of change, moving Gynaecology patients into the Borders Urgent Care Centre, starts the week of 10 May. The second largest group of GP referred patients in the ED are GP medical referrals. A test of change is in development to move this activity late May 2021.

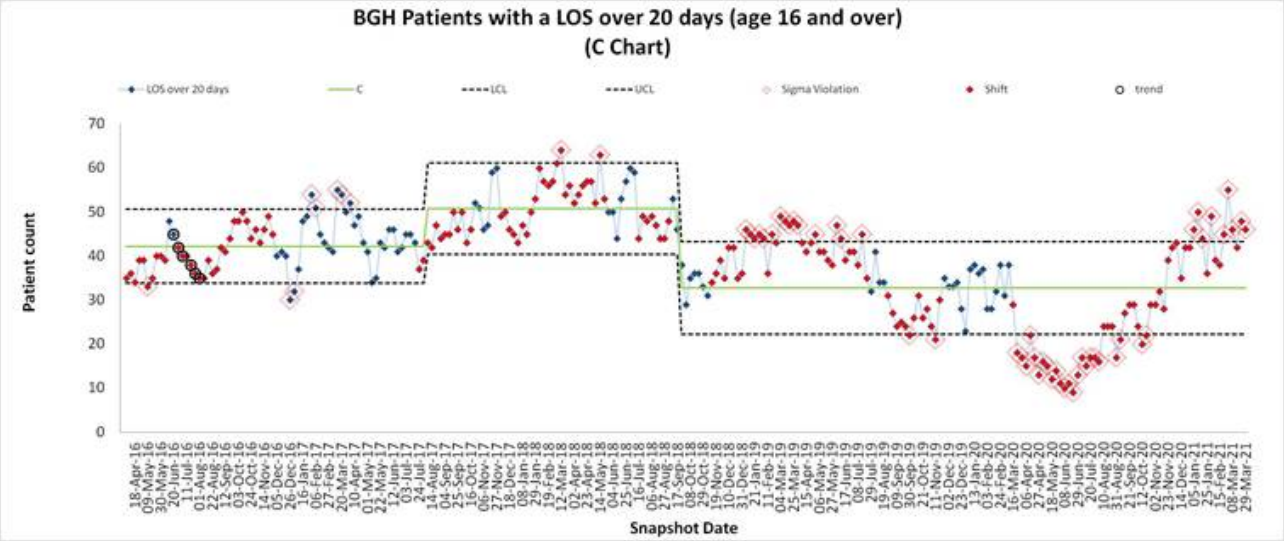
A whole system approach to achieving the EAS is being taken and a daily and weekly EAS breach review forum has been established with ownership from specialities to review their breaches and share their analysis and actions for improvement in a multi professional meeting. Ward processes to support patient flow are also being reviewed to drive forward the Daily Dynamic Discharge approach in every ward through a review of their current

ward huddles. Training and education sessions on good flow management practice for ward teams are planned.
Due to the constraints in the system resulting from COVID 19 and increasing length of stay in downstream areas the length of stay in the Medical Assessment Unit (MAU) has moved from a norm of 34 to 47 hours. Graph 12 shows the MAU length of stay:



The well established BGH Integrated Huddle is driving forward improvements in early discharge process planning through education and supporting the clinical teams in alternative options available for patients who cannot be discharged home. With the rise in longer lengths of stays and delayed discharges this group is developing a weekly process to involve the clinical teams to review all patients with a length of stay > 20 days cases and to support the decision making at ward level. Graphs 13 and 14 provide details of delayed discharges in the BGH and patients with a LOS over 20 days:





A Day of Care Plus Audit has been carried across all acute and community hospitals to assess the status of patients and if they are clinically fit for discharge and if so where they would be placed in their next stage of care. The outputs of this are now informing the improvement work underway.

Reshaping Urgent Care – BUCC
The Scottish Government have set a directive to redesign urgent care to ensure access to the right care, at the right place, at the right time, first time for patients within NHS Borders. A small local working group has been established and is planning and implementing change ideas.

The new urgent care model aims to direct service users to more appropriate and safer care closer to home; optimising clinical consultations through digital health; minimising the risk of crowding in the emergency department by scheduling attendances wherever possible.

Minor works have been completed within the Borders General Hospital to accommodate the BUCC situated in the previously named 'Day Hospital', services such as the COVID Assessment Centre, Borders Emergency Care Service and Ambulatory Care are now all functioning from this area. Regular updates are being received from the national teams and work us underway with a range of clinical staff to help support the services required.

Infection Control Update
In January 2021, audits were completed in MAU, CV1/CV2, CV3 and Department of Medicine for the Elderly 14 (DME 14). All areas achieved the required standard of >90% with the exception of MAU which achieved an overall score of 65%.

Infection Control has worked with MAU to identify a strategy for improvement. The following improvements have been initiated since the spot check:

- Designated domestic supervisor allocated to ward
- Increased continuity of domestic staff within the ward
- The domestic supervisor will provide Tristel Fuse and bed cleaning training to ward staff.

- The newly developed universal cleaning standards document is being rolled out in the ward; the document is still in the trial phase but will assist in increasing collaboration between nursing and domestic staff.
- Bed ownership- where possible, patients will be transferred on a trolley or wheelchair to reduce bed movement; this will allow staff to ensure beds in the ward are cleaned appropriately.
- SCN and CNM performing regular walk-rounds/spot checks.

A follow up check carried was carried out in March 2021 returning a score of 89%.

Maintained Improvements within some areas is something which requires a continued focus moving forward as we see areas achieving real improvement in the short term however this does not always appear to be sustained. CNM's continue to work both with SCN's completing rapid checks, and infection control team.

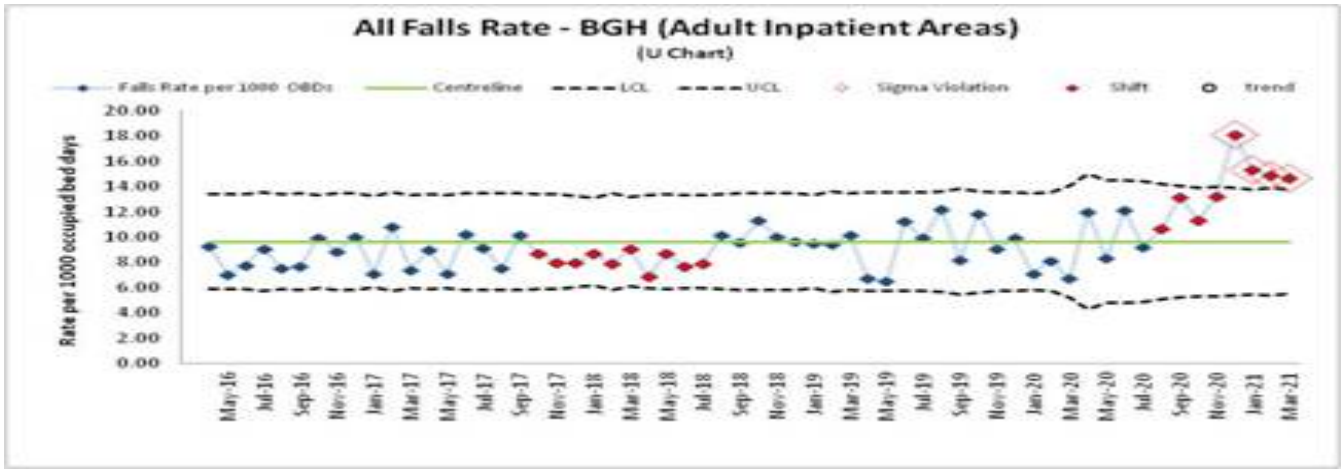
Unannounced Mock Inspection
A mock unannounced joint OPAH and HEI was carried out in October 2020. The internal inspection was completed to provide assurance, insight into areas for focus and feedback to the clinical and management team within BGH and for the Board.

This visit focused on OPAH Self assessment within three ward areas, MAU, DME and Ward 9 (Orthopaedics Unplanned Care) and used the rapid check templates for the inspection.

Themes that emerged were around general cleanliness and cleaning schedules. Documentation and assessments in particular around MUST screening. Actions plans for each area have been produced and are being worked on. Throughout all areas inspected staffs were noted to be engaged with the inspectors and had a good understanding of areas for improvement. Of note all of the patients and visitors fed back that they felt well cared for and understood the plan of care for them. Ward 9 had only a few minor issues in relation to equipment that required cleaning and had no issue with any documentation. The SCN was commended for her and her team and other areas have been encouraged to learn from the working practises within Ward 9.

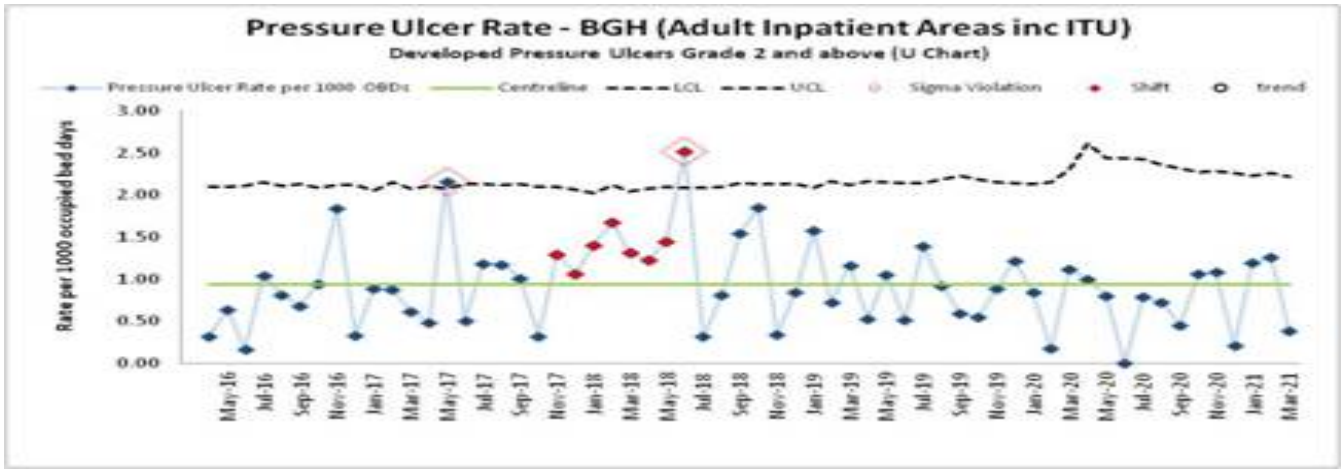
Falls
Acute services continue to see a number of falls across wards. This is a trend being noted across Scotland and is thought to partly be attributable to the apparent increase in number of patients presenting in a de-conditioned state and experiencing delirium. Additional bed and chair sensors have been purchased for each of the adult inpatient areas and reminders raised at morning safety brief in relation to importance of timely and accurate completion of patient assessments.

Our previous falls QI nursing lead from Clinical Governance has returned from her secondment and is re-establishing a focus on falls prevention along with the Back to Basics Falls group. The Strategic Falls lead is progressing with a gap analysis to refresh and refocus Fall's prevention work. Graph15 details the rate of falls across the BGH:



Pressure Ulcers

The Tissue Viability Nurse has now returned to post following her secondment to ITU during COVID, and is now reviewing and identifying the support required within the wards to help reduce developed Pressure Ulcer Incidence. Graph 16 details the pressure damage rate for BGH:



Patient Safety

Hospital Standardised Mortality Rate (HSMR)

Using HSMR

HSMR data, prepared by Information Services Division Scotland (ISD) includes all deaths within 30 days of admission to a specific hospital including deaths within that hospital and those out with that hospital. HSMR is a measurement tool which take crude mortality data and adjusts it to account for factors known to affect the underlying risk of death including age, gender, primary diagnosis, type and route of admission, number and severity of morbidities (this makes the calculation difficult to replicate locally).

The HSMR value for Scotland for the baseline year is 1. This allows quarterly hospital values to be compared to the baseline year for Scotland:

- If an HSMR value is less than 1 this means the number of deaths within 30 days for a hospital is less than expected.

- If an HSMR value is greater than 1 this means the number of deaths within 30 days for a hospital is more than expected.

However, if the number of deaths is more than predicted (HSMR is more than 1) this does not necessarily mean that these were avoidable deaths (i.e. that they should not have happened at all), or that they were unexpected, or attributable to failings in the quality of care. There are a number of factors which influence HSMR values these can include:

- random variation: number of observed deaths particularly in smaller hospitals.
- data quality: variations in completeness and accuracy of recording of data from patient records, particularly misattribution and coding of main diagnosis.
- palliative care provision: the level of palliative care and terminal care support services in the community for the local population.

HSMR cannot therefore be used as a standalone measure to make reliable judgements about the quality of care provided by a hospital. It can, however, be used alongside other clinical indicators within the NHS Borders quality dashboard to stimulate reflection on the way services are configured/delivered and to prompt quality improvement activity. If the HSMR is to be used to make comparisons between hospitals then it is essential that the measure is augmented by additional data from the dashboards to enable an understanding of what factors might be driving the overall figure.

NHS Borders HSMR – January 2020 to December 2020

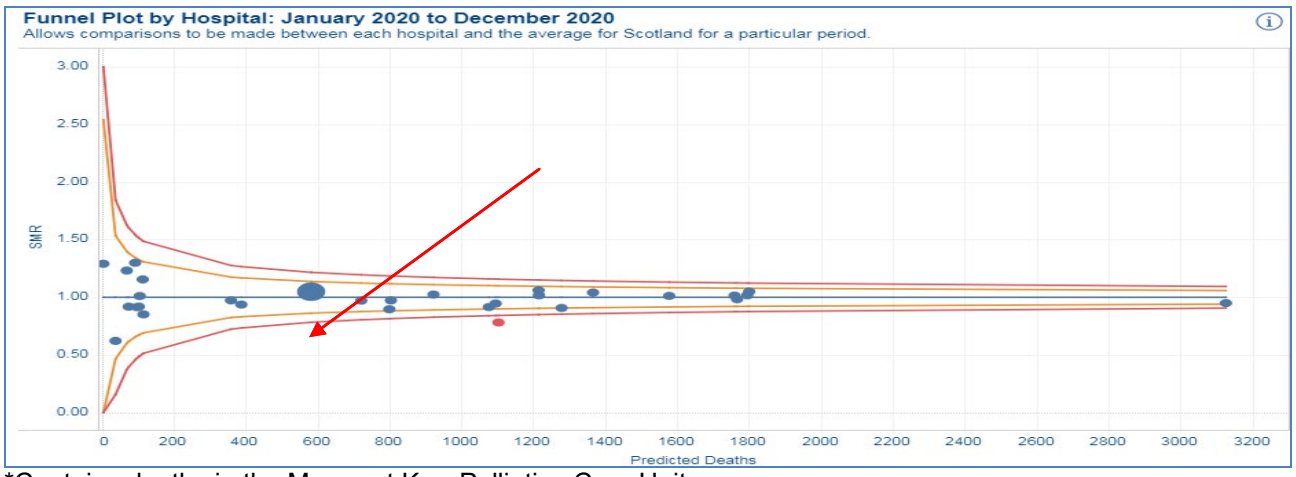
This is the eighth data release from ISD where the revised approach to calculating HSMR has been applied. These changes include:

1. re-base lining the model to a new initial three year reference period of April 2016 to March 2019. Further to this, advancing the reference period by three months for each future reporting period
2. aggregating speciality groupings within the modelling. At present, two overarching groups are used to categorise the patient activity
3. using a twelve month reporting period when drawing comparisons against the Scottish average (rather than three months used at present)

ISD have advised that the focus of HSMR will now be to allow hospitals to compare their outcomes to the Scottish average at a fixed point in time, in line with the English Summary Hospital-level Mortality Indicator, rather than monitor trends in HSMR over time. Therefore, there will no longer be quarterly data points available to indicate whether the rate is increasing or decreasing. A funnel plot will be provided by ISD to display each hospital's HSMR and the centreline will be set as 1 on this funnel plot so Boards can describe their progress against this baseline figure. Boards are now encouraged to monitor mortality trends over time using crude mortality which will continue to be provided quarterly.

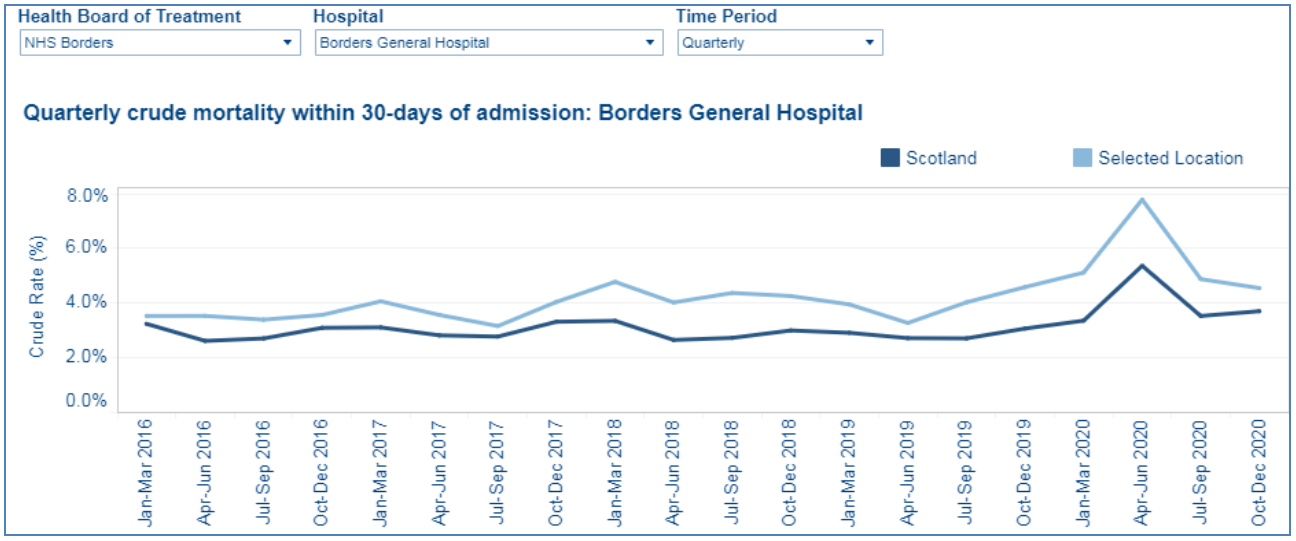
This release covers the first ten months of the COVID 19 pandemic from March to December 2020. During the pandemic hospitals have been required to adjust their normal ways of working to react at a local level and therefore the model methodology has been updated to ensure the emergency Index of Chronic Disease 10 codes assigned by the World Health Organisation are included within the primary diagnosis model adjustments.

The NHS Borders HSMR for the eighth data release under the new methodology is **1.05.** This figure covers the period **January 2020 to December 2020** and is based on 611 observed deaths divided by 583 predicted deaths. The funnel plot below shows **NHS Borders HSMR remains within normal limits** based on the single HSMR figure for this period therefore is not a trigger for further investigation:



*Contains deaths in the Margaret Kerr Palliative Care Unit

NHS Borders crude mortality rate is presented in Graph 17 below:



*Contains deaths in the Margaret Kerr Palliative Care Unit

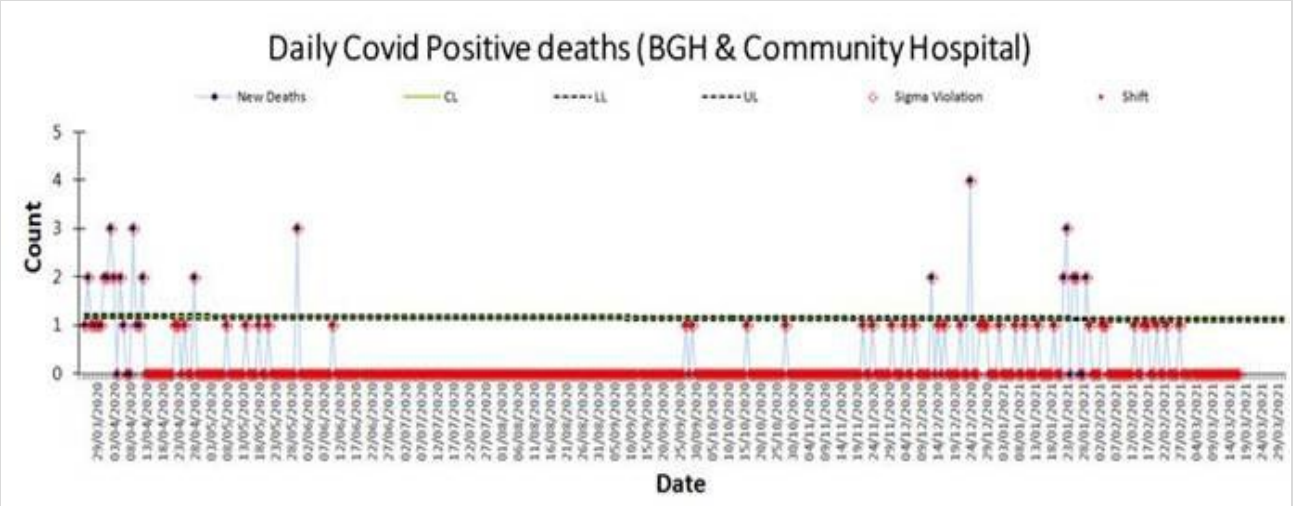
NHS Borders crude mortality rate for quarter October 2020 to December 2020 was **4.5%** following the trend across NHS Scotland. No adjustments are made to crude mortality for local demographics. It is calculated by dividing the number of deaths within 30 days of admission to the Borders General Hospital (BGH) by the total number of admissions over the same period. This is then multiplied by 100 to give a percentage crude mortality rate.

COVID 19 deaths have contributed to an elevated crude mortality rate for the last quarter of 2019/20 and first quarter of 2020/21. The significant reduction in the denominator, which is the number of admissions to the BGH, has further compounded the elevated rate in these two quarters.

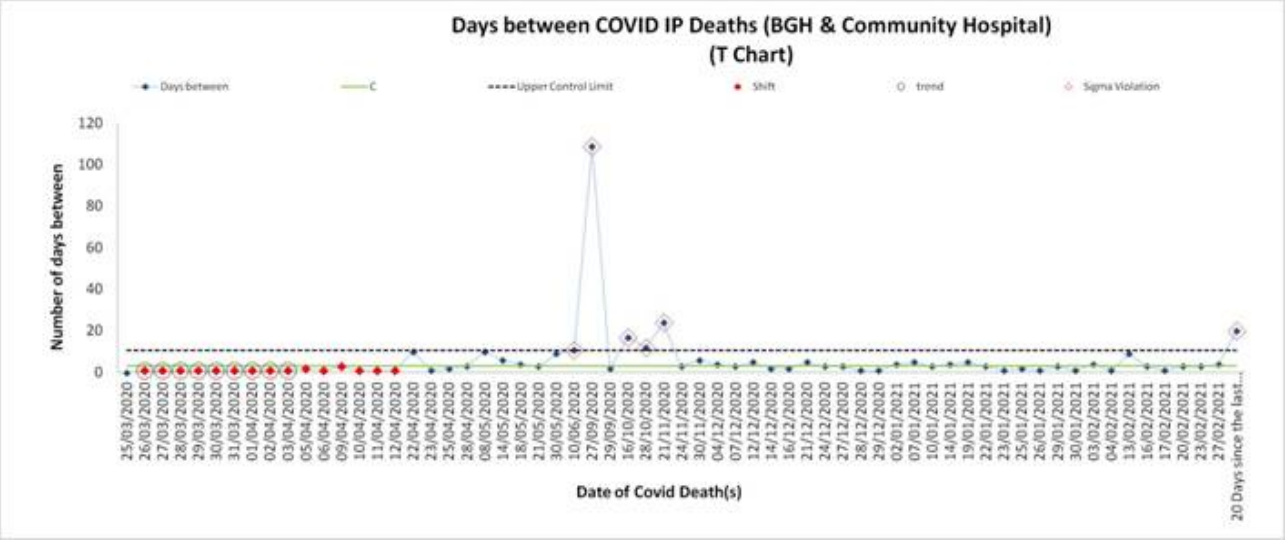
COVID 19 deaths between March 2020 and February 2021 occurring in a hospital within 30 days of admission have been reviewed for learning to inform the local delivery of care. In addition, the core mortality review programme has continued to review 20% of non-COVID 19 deaths in hospital within 30 days of admission. The collated summary of these reviews will be presented to the CGC in September 2021.

COVID 19 Deaths

There have been a total of 85 COVID 19 positive deaths in the BGH or NHS Borders Community Hospitals up to the 17 March 2021. Graph 18 shows the COVID positive deaths by day:



Graph 19 shows the days between COVID 19 deaths. As at the 19 March 2021 it has been 20 days since the last COVID 19 deaths in the BGH or NHS Borders community hospitals:



Claims

NHS Borders is part of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS), a not for profit, mutual scheme providing a pool of funds to meet financial claims on the NHS in Scotland, this provides cover for both clinical and safety (non-clinical) claims brought against the Board.

This report is based on a reconciliation of the Central Legal Office (CLO) monthly reports and NHS Borders database as at 1 July 2021.

Claims can be ongoing for a number of years. Estimated financial liabilities are significant and therefore a robust defence/investigation is required for each case. Robust investigation and defence where appropriate is essential to help ensure NHS Borders payments into the CNORIS fund is kept to its minimum.

Key Issues

Table 1 details the estimated total claims value at 1 July 2021:

	No of Claims	**Estimated Total Value of Claims (or estimate of remaining balance of adverse expenses) £**
Claims (Current)	36	2,154,000.00
Settled current financial year	0	
Outstanding from previous years	4	65,000.00
Closed other than Settled	3	
Reopened current financial year	0	
	TOTAL	**2,219,000.00**

Of the 36 current claims 7 had a Significant Adverse Event Review undertaken and 11 had previously been through the complaint process. To date no complaints have been settled in the current financial year.

Table 2 provides a summary of the main causes highlighted in the claim:

Causes/Issues	**As at 1 July 2021**
Investigation/diagnosis/treatment	15
Obstetric event	2
MESH (failure of surgical mesh)	3
Medication event	2
Clinical procedural problems	2
Patient experience	2
Slip/trip/fall on level	4
Self harming behaviours	1
Moving and Handling	1
Infection control	3
Data protection/confidentiality	1
Total	36

Table 3 outlines the percentage of ongoing claims by clinical board (including clinical and safety claims):

Acute Services	Primary, & Community Services	Mental Health	Corporate Services	Learning Disabilities
72%	0%	6%	22%	0%

Acute Services are expected to experience the highest percentage of claims due to the nature of the care being delivered.

Adverse Events

Adverse events are reported and managed through the electronic adverse recording system (Datix) system. Within the national framework the adverse outcome grading for all reported adverse events has been broken down into three categories:

Category 1 – Major or extreme adverse outcomes
Category 2 – Minor or moderate adverse outcomes
Category 3 – Negligible adverse outcomes

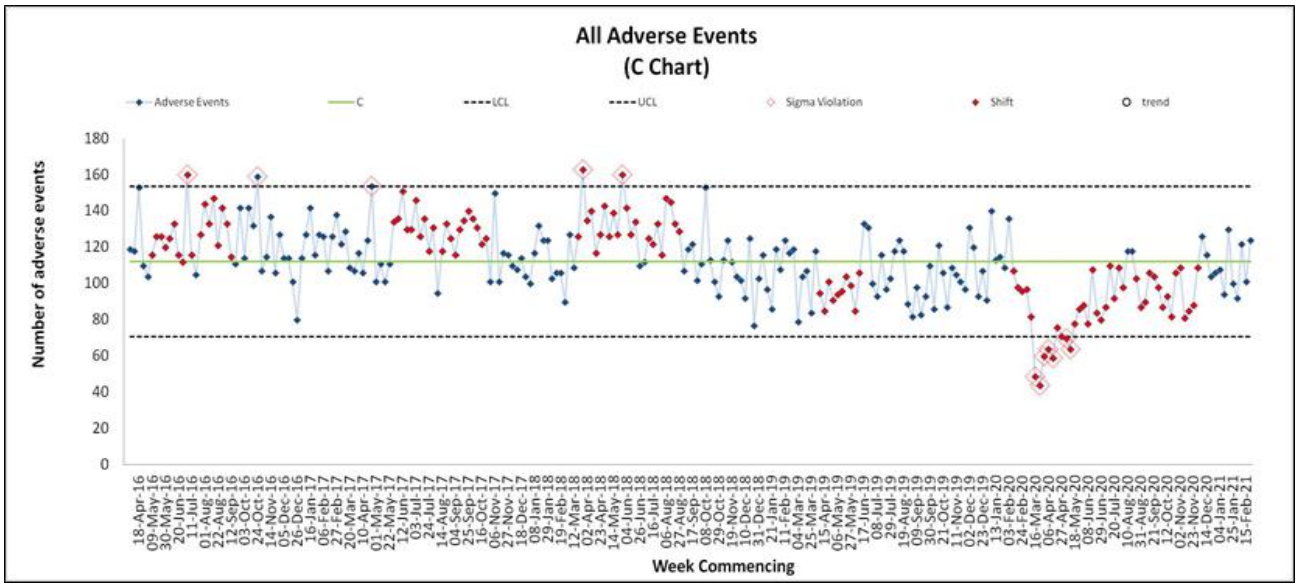
All adverse events will be subject to a review. The level of review will be determined by the extent of any harm caused to a person (the grading of the event) and decisions made by the Commissioning Manager and a triumvirate of senior managers within the organisation. The review will be either an:

Level 1: Significant Adverse Event Review
Level 2: Management Review
Level 2: Fall Review
Level 2: Pressure Ulcer Review
Level 3: Initial Review

One or more of these reviews may be completed and there will be occasions where, following a level 3 initial review, a category 1 event will be exempt from further review. This process is guided by the Adverse Event Management Policy which has been reviewed and updated to reflect the Duty of Candour requirements.

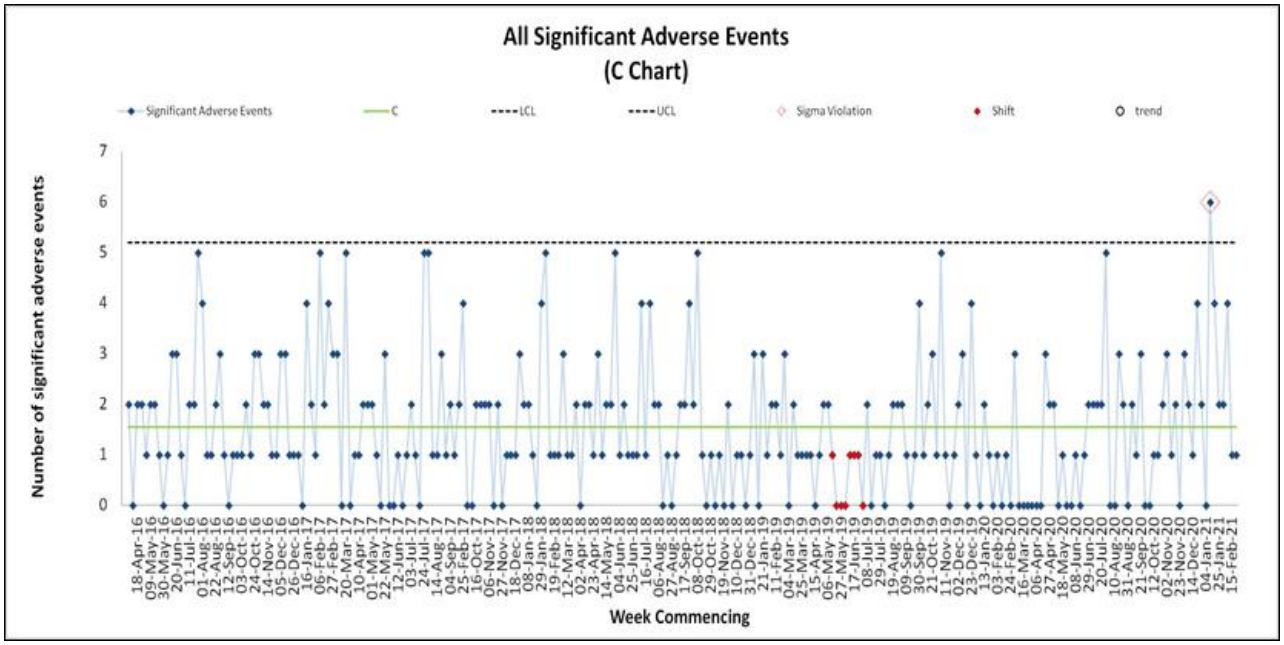
Adverse Event Activity

Graph 20 below shows all reported adverse events for the whole of NHS Borders over a 5 year trend to March 2021:



There was a reduction in adverse events during the period of February to June 2020 (during the first wave of COVID 19) as demonstrated in the shift below the average, returning to normal variation at the end of July. Another shift occurred below the average during August to November 2020 (second wave of COVID 19) returning to normal variation from December 2020 as activity has increased again. The reduction in reported adverse events during the first and second wave of COVID 19 mirrors the reduction in attendances, admissions and face to face consultations.

Graph 21 shows all Significant Adverse Events (SAEs - Major and Extreme):



This control chart highlights that at the beginning of January 2021 there was a breach in the upper control limit, a deep dive into this data concluded these were all relevant and spread across several areas with no trend. All significant adverse events are investigated to ensure any areas of concern are identified and that local systems, processes and practice can be addressed where required.
Table 4 detail's the SAE's where a review was in progress at the 31 March 2021 and the type of review which was underway:

Type of Review	Number of Reviews Underway
Level 1 Significant Adverse Event Review	13
Level 2 Management Review	10
Level 2 Fall Review	3
Level 2 Pressure Ulcer Review	11
Level 2 Drug Death Review	6
Level 2 Safety Management Review	1
Child Death Review	1
Awaiting Review Decision by Quadumvariate	5
Total	**50**

Since the end of March 2021 significant effort has been made to conclude SAERs which had been delayed due to the Wave 1 and 2 COVID 19 response and the current status of SAERs is 38 underway.

Table 5 details the 38 active SAE's on the system at 1 July 2021. These are distributed amongst the following services:

Service	Number of SAE's
Unscheduled Care	4
Planned Care & Commissioning	15
Primary & Community Services	4
Mental Health & Learning Disabilities (including Drug Death Reviews)	15
Total	**38**

Mental health services have been experiencing a period of heightened demand with several significant adverse events underway. The mental health management team has a plan in place to progress all open reviews and a dedicated group working on improvement plan implementation.

Table 6 shows the types of events of all SAE's on the system at 1 July 2021:

Type of Adverse Event	Number of SAE's
Pressure Damage	9
Tobacco/Alcohol/Illicit Substance Event	8
Suicide	6
Investigation, Diagnosis & Treatment Problems	4
Unexpected Death	3
Obstetric Event	2
Medication Event	2
Nutrition	1
Fall/Slip/Trip	1
Aggression &Violence/Personal Safety	1
Absconsion/Self Harming Behaviour	1
Total	**38**

During the pandemic response NHS Borders has made all attempts to continue to deliver Significant Adverse Event Reviews (SAERs) but have been unable to meet the normal timescales for delivery as a result of the reliance on senior clinical staff and managers as Lead Reviewers. Patient and families are being kept informed of any delays in concluded their review within the normal timescales. In the short term the Clinical Governance and Quality patient safety team have de-prioritised other work to devote as much capacity to support this as possible.

Learning and Improvement

The most prevalent type of adverse event during this period has been Falls/Slips and Trips. Further work is underway to gain a deeper understanding of recent increase in falls in the BGH and NHS Borders community hospitals. Each fall resulting in harm is subject to a falls review.

The Clinical Risk Coordinator has been working with the Primary and Community Services management team to develop overarching improvement plans for falls and pressure

damage to ensure appropriate actions are completed within an appropriate timeframe. These plans draw on themes identified from any falls and pressure damage reviews.

The Patient Safety team is focusing on delivering training to Senior Management and their Administration Team in relation to the learning and improvement plans / trackers to ensure these are prioritised and the designated responsible person(s) for the actions complete these in an appropriate timeframe.

Duty of Candour

Clinical Governance and Quality are liaising with the Infection and Prevention Control team to identify any definite and probable hospital acquired COVID 19 cases and consider if any cases would activate the Duty of Candour criteria for 'death of a person' and 'an increase in the person's treatment'. Due to the complexity of the global pandemic and the lack of clear guidance to Boards in relation to the application of the Duty in COVID 19 scenarios an assessment is required to confirm whether or not these cases were preventable within the first and second wave. This assessment needs to be done in the context of the policy and guidance in place at that point of the pandemic response. Discussions with other NHS Boards have confirmed that they have not yet enacted the Duty of Candour but are currently having similar discussions internally as to whether the Duty will apply to COVID 19 cases developed during a hospital outbreak or where delays to diagnosis and treatment have been identified in relation to the step down of services. This topic has been escalated for national discussion and guidance through the Medical Directors group and to the CLO. The CLO have now issued some advice which is being used to guide local decision making in this area.

A meeting was arranged with Clinical Governance and Quality, Medical Director, Director of Nursing, Midwifery and Allied Health Professionals together with the Infection and Prevention Control Team to agree if Duty of Candour should be applied to these cases given the highly infectious nature of COVID 19 and NHS Boards ability to eliminate all risk of transmission during a global pandemic.

Clinical Governance and Quality are focusing on the completion of the annual Duty of Candour report which will detail the application of the Duty of Candour in 2020/21. This will be submitted to the Chief Executive for approval prior to sending to the Scottish Government. The NHS Borders CGC will receive the annual report at the September 2021 meeting.

Enhanced Monitoring of Quality and Safety

During wave 2 of the pandemic response the Clinical Governance and Quality team provided an enhanced presence in inpatient wards to undertake core quality and safety audits and to follow up on any significant adverse events. This begun initially in Adult Inpatient areas across the BGH and was rolled out to Community Hospitals.

The patient safety team have been consistently reporting and collating data every week in the adult inpatient areas of the BGH. Each week this information is shared with management teams and feedback to the nurse in charge following each audit.

The data is supplied to teams, with a HEAT map and flash report, using these teams can easily identify learning opportunities specific to their areas. Improvement plans are currently being developed with the support of the patient safety team which are tailored to each area setting priorities for 2021/22.

This enhanced monitoring has extended to Community Hospitals and tailored improvement plans are also now in development for these areas to set the focus for the coming year.

Patient Safety Priorities for 2021

Moving into 2021/22 the priority following the COVID 19 pandemic response is to re-establish core patient safety priority groups. Following a review with the Directorate of Nursing and Medical Directorate and an assessment by the Clinical Governance and Quality team of key sources of data and intelligence the following areas will form that basis of the clinical priority work streams for our local programme in 2021/22:

1. Falls
2. Tissue Viability
3. Deteriorating Patient
4. Food, Fluid and Nutrition
5. Medicines
6. Communication and documentation
7. Frailty
8. Maternity
9. Paediatrics
10. Mental health

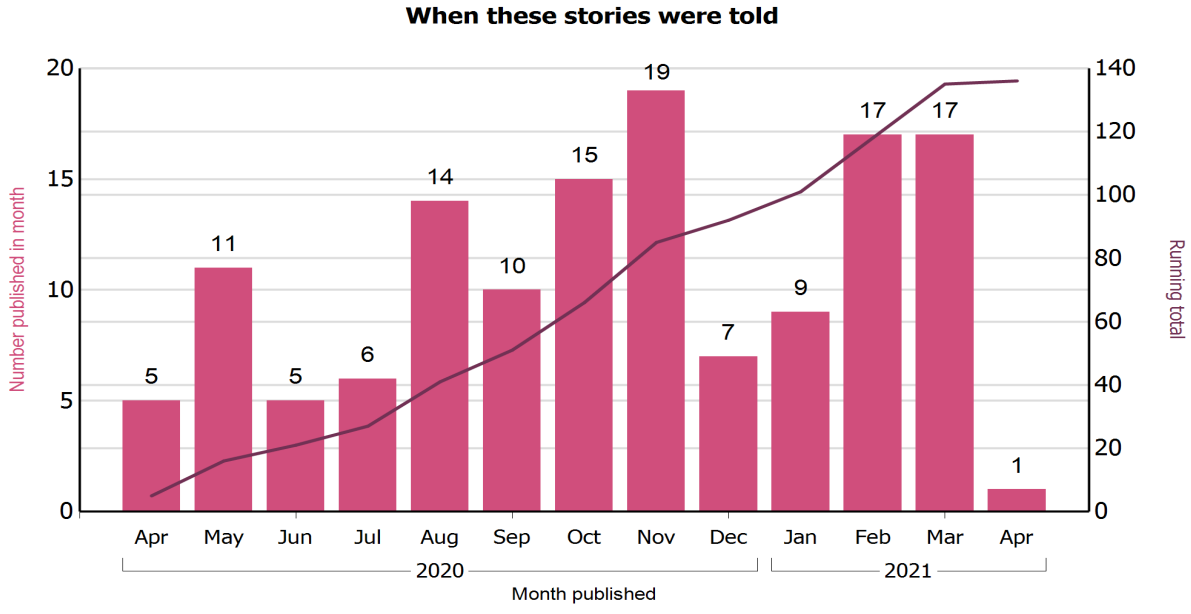
This programme of work will be directed by the Back to Basics Steering Group and strategic leads from across the Nursing and Medical Directorates and support by the Clinical Governance and Quality team.

Person Centred Care

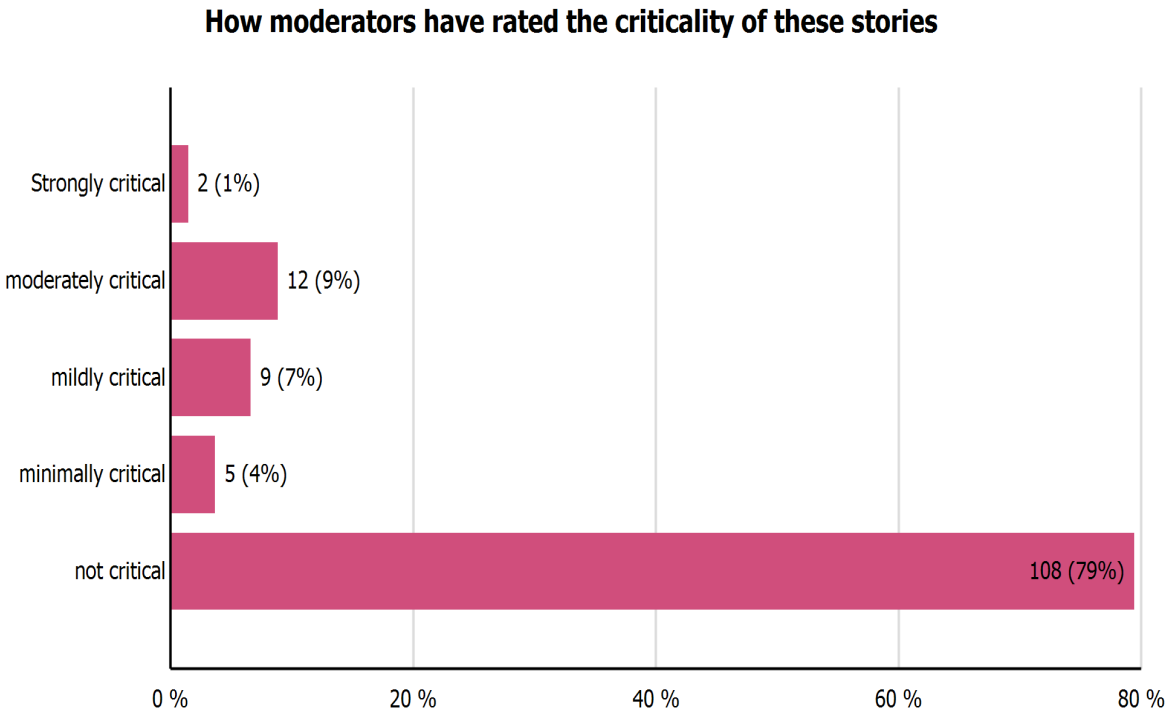
Patient Experience

Care Opinion

For the period 1 April 2020 to 31 March 2021 136 new stories were posted about NHS Borders on Care Opinion. Graph 22 below shows the number of stories told in that period, as at 7 May 2021 these 136 stories were viewed 21,912 times:



Graph 23 provides a description of the criticality of the 136 stories:



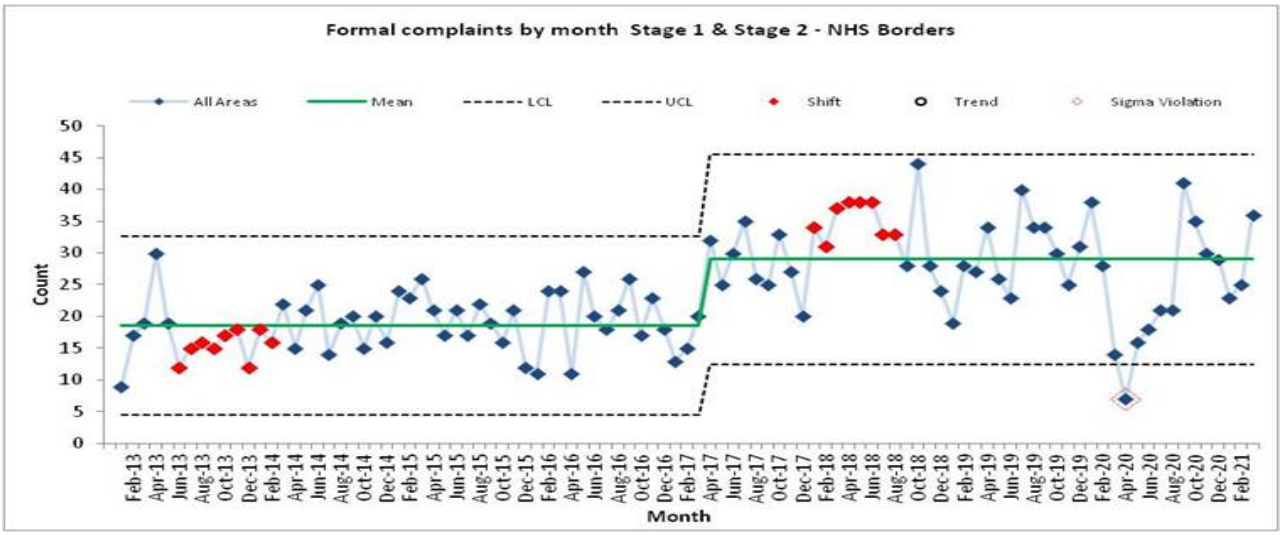
The two “Wordles” below summarise ‘what was good’ in Care Opinion posts for this period and ‘what could be improved’:

What was good?

What could be improved?

Complaints

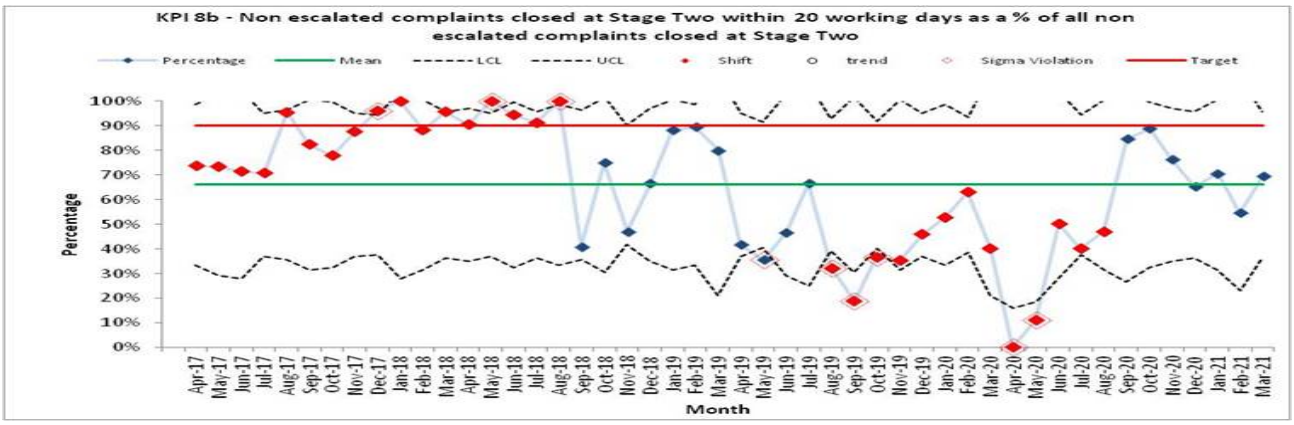
Graph 24 below gives the number of formal complaints received by month. There was a drop in complaints submitted between March and April 2020 during Wave 1 of the COVID 19 pandemic. The spike in complaints in September 2020 was due to the number of complaints received regarding flu vaccinations. However, the numbers of complaints have remained within normal variations between 1 May 2020 and 31 March 2021.



Following a review of the Clinical Governance and Quality function adjustments were made in 2019 to reposition some additional resources to the patient experience team in recognition of the increased workload in this area. Some early gains were made from this increase in capacity between September 2019 and February 2020.

During the wave 1 of the COVID 19 pandemic response the majority of patient experience team were deployed to support frontline clinical care. This greatly affected the ability to deliver responses within the 20 day timescale, in addition to frontline clinician's ability to respond to complaints investigations. Complainants were kept informed of this impact to our normal service and of any extensions to the timeline for responding to their concerns.

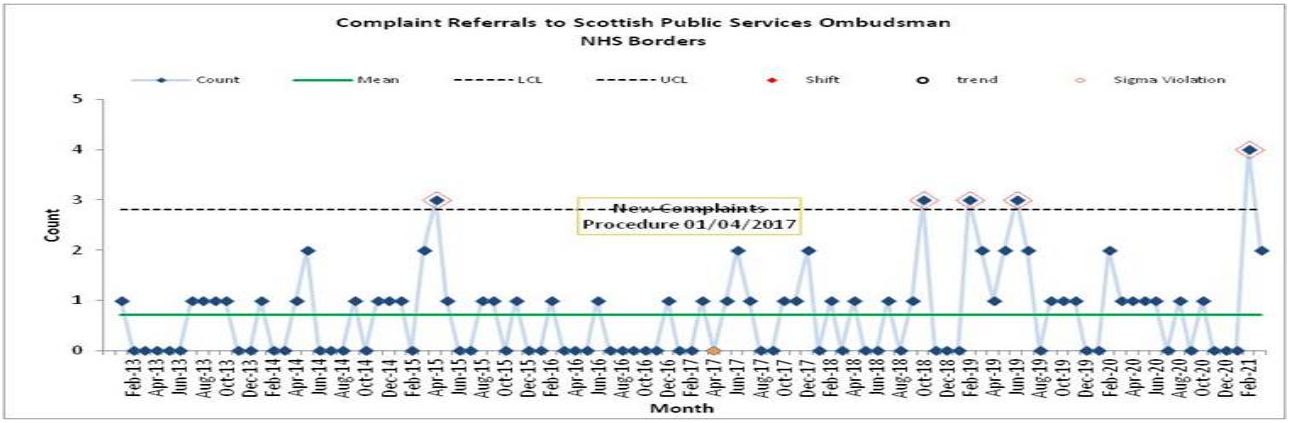
Further pressures have been experienced between September 2020 and March 2021 by informal patient experience queries generated through the large scale Flu and COVID 19 vaccination programmes. Additional short term capacity has been put in place to support this workload and to improve timeliness. In March 2021 70% of responses were sent within the 20 working day target. Graph 25 below shows the performance against the 20 working day timescale for responding to all non-escalated Stage 2 complaints.



Scottish Public Service Ombudsman (SPSO)
In relation to SPSO cases, due to the COVID 19 outbreak the SPSO office is currently not open to visitors. The SPSO are responding to emails and are operating a limited telephone service for complaints related enquiries.

The SPSO are the final stage for complaints about most devolved public services in Scotland including the health service, councils, prisons, water and sewerage providers, Scottish Government, universities and colleges. The additional scrutiny provided by the involvement of the SPSO is welcomed as this enables us a further opportunity to improve both patient care and our complaint handling processes.

Graph 26 below shows complaint referrals to the SPSO to March 2021:



New SPSO case referrals
Of the six new referrals the SPSO have confirmed they do not plan to take two of them any further, one related to planned care services so has not been detailed in this report:

Case 202007278 – received 16 February 2021
- This relates to nursing care, and the lack of follow up communication.
  - Low risk to Board reputation – SPSO have decided they will not take this complaint further and have closed their file.

A decision is awaited on the other four cases, two cases related to planned care services so have not been included below:

Case 202001654 – received 17 February 2021
- This relates to the medical care and treatment provided to a patient.
  - Medium risk to Board reputation

Case 202007186 – received 24 March 2021
- This relates to mental health care.
  - Low risk to Board reputation

Recent SPSO decisions

Of the nine decisions received from the SPSO five related to planned care services not under the remit of the IJB so the outcome has not been detailed for the purposes of this report. Of the other five decisions received one complaint was upheld, three were not and one required a follow up response to the complainant. For the one case which was upheld no further actions were required:

Case 201906679 – received 27 February 2020

- This relates to the medical care and treatment provided to a patient and the way medical staff have dealt with the patient.
  - The SPSO decided that this was not a complaint that they would take forward.

Case 201907297 – received 2 April 2020

- This relates to the medical and nursing treatment provided to a patient who attended the Borders General Hospital.
  - The case was not upheld by the SPSO

Case 201910096 – received 10 June 2020

- This relates to mental health care and treatment.
  - The SPSO upheld the complaint. However as NHS Borders had previously apologised to the complainant no further recommendations were made.

Case 202002063 – received 25 August 2020

- This relates to complaint handling and the decision not to respond to a complaint as the patient lacks capacity to provide consent.
  - The SPSO asked the Board to provide a further response to the complainant. This action was completed on 30 September 2020.

Cases Still awaiting decision from SPSO

There are two cases accepted by the SPSO for which NHS Borders await final decisions:

Case 201902208 – received 5 May 2020

- This relates to medical and nursing treatment; attitude of staff, loss of belongings and discharge arrangements.
  - Medium risk to Board reputation

Case 201909530 – received 7 October 2020

- This relates to medical treatment and the Board's complaint response.
  - Medium risk to Board reputation

Ethical Advice and Support during COVID 19

An NHS Borders COVID 19 Ethical Advice and Support Group was formed to undertake an advisory role to the Chief Executive, NHS Board and to frontline clinical teams (Terms of Reference attached). The group aimed to make ethical use of potentially limited health resources and to do so with transparent, consistent and equitable decision making support. The Group was developed to have a flexible approach and be readily available and able to offer timely support to clinical teams relating to:

- Complex decisions around withdrawal of care
- Situations where clinical decision makers feel uncomfortable with the application of national guidance
- Challenging decisions around escalation planning and ceilings of care
- Complex decisions related to patient discharge due to high clinical demand
- Challenges related to reduced ability to provide normal standards of care, in particular in the community or for patients at the end of their lives

The Group was guided by a set of ethical principles and guidance, where available, from national bodies and professional groups.

If the status of COVID 19 in any Clinical Board was triggered as “Red” by the COVID 19 Pandemic Committee, an operational Ethical Advice and Support Team would be triggered to provide accessible and responsive support on behalf of the group.

The group focused on reviewing plans for the worst case COVID scenarios, in relation to the demand which could have be imposed on frontline services, to ensure robust ethical consideration has been given to clinical protocols and decision making tools which would need to be enacted if demand was to exceed capacity. To date the group reviewed the following areas:

- Admission to hospital during COVID 19
- Oxygen provision during COVID 19
- Resuscitation processes during COVID 19
- Restraint processes during COVID 19
- Access to surgery during COVID 19
- Critical care provision during COVID 19
- Birth partner access for caesarean sections during COVID 19
- Care home testing during COVID 19
- Patient cohorting during COVID 19
- Access to cancer treatment during COVID 19

The group has stood down but remains available to be recalled should COVID 19 demand rise to a level which require service restrictions.

Volunteering

The volunteering programme was suspended in March 2020 by the Scottish Government to ensure the safety of our volunteers due to COVID 19. Healthcare Improvement Scotland provided Strategic Leads with guidance 'Volunteering in NHS Scotland – COVID-19: Shared practice and guidance for volunteering management in NHS Scotland' to support the recovery of the volunteering programme, this was released on 24 July 2020.

From this guidance low risk roles have been reinstated with no direct patient contact. Risk assessments and safe systems of work are being carried out by the relevant departments to ensure the volunteer's safe return as lockdown is eased.

Appendix

Improvement Action Plan

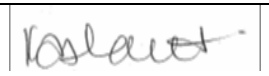
Healthcare Improvement Scotland: unannounced hospital inspection

Hay Lodge Hospital, NHS
Borders

Tuesday 8 December 2020

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair	**NHS board Chief Executive**
Signature 	Signature 
Name Karen Hamilton	Name Ralph Roberts
Date 16.02.2021	Date 16.02.2021

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1 2 4 8	NHS Borders must ensure that all older people who are admitted to hospital are accurately assessed in line with the national standards. This assessment includes nutritional screening and assessment, including oral health assessment, falls assessment and pressure ulcer risk assessment. There must be evidence of accurate reassessment, where required(see page 11). NHS Borders must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patient's condition or needs. The care plans should also reflect that patients are involved in care and treatment decisions (see page 12). NHS Borders must ensure that the SSKIN bundles are consistently and accurately completed to ensure that the frequency of repositioning is carried out within the prescribed timeframes. NHS Borders must ensure that all assessments are signed and dated. They must also ensure that loose-leaf documentation has patient identifiable details recorded. This should be at a minimum, the patient's full name, and date of birth or Community Health Index number.				

	NHS Borders Action:- a) NHS Borders will review the admission and transfer process including the completion of patient risk assessments to ensure consistency.	May 2021	Director of Nursing, Midwifery and Operations	December 2020 A review of the assessment documents identified an older version was in use at the time of the inspection. The new version is now in use facilitating recording of baseline weight assessments. April 2021 A new patient transfer document to improve communication for safe transfer has been developed, implemented and is now being tested with ongoing monitoring of compliance.	April 2021

	b) NHS Borders will support and coach staff to identify and address learning needs and ensure accurate completion of documentation.	October 2021	Associate Directors of Nursing	April 2021 73% of staff have had a training needs analysis completed through 1:1 meetings with the SCN. A training plan will be formulated once process has been completed.	
	c) Completion of patient risk assessments and care bundles with adherence to the NMC Code in relation to record keeping will be included in a programme of ward based audits. These will be reviewed at Clinical Board Governance Groups and NHS Borders Clinical Governance Committee.	May 2021	Associate Directors of Nursing	February 2021 An audit tool has been developed and piloted in the acute areas, this will be used to guide improvements at Hay Lodge April 2021 Ward quality audits of risk assessments and care bundles are now incorporated onto Trakcare with reporting through governance groups and committees. A weekly completion Log has been created and an SOP and audit Log are included in the RN training.	April 2021

	d) NHS Borders will develop and deliver an education programme in relation to Person Centered Care Planning.	October 2021	Excellence in Care Lead and Associate Directors of Nursing	Recent audit outcome demonstrates compliance with SSKIN completion at the prescribed frequency according to the Waterlow score. Completion of MUST within 24 hours of admission has improved with the most recent data showing 100% compliance. <u>February 2021</u> An education template for person centred care planning has been developed and used in acute wards. This will be utilised to deliver education at Hay Lodge Community Hospital	
3	NHS Borders must ensure that mealtimes are managed consistently in a way that ensures that patients are prepared for meals, including hand hygiene. The NHS board should also ensure that the principles of Making Meals Matter are implemented (see page 12).				

	NHS Borders Action:- e) NHS Borders will ensure that patients are prepared and supported appropriately prior to and during meal times.		Associate Director of Nursing , Primary and Community Services	Staff breaks are now allocated to ensure staff are present to prioritise and support patient meals.	December 2020
	f) NHS Borders will re-educate staff on the principles of Making Meals Matter and ensure this is integral to the ward routines.		Associate Director of Nursing , Primary and Community Services	Making Meals Matter principles are visible in the ward area and included on the ward Safety Brief.	February 2021
	g) NHS Borders will re-establish the role of meal time coordinator at Hay Lodge Community Hospital.			Mealtime coordinator role re-established. <u>April 2021</u> Weekly audits of the mealtime process are undertaken. An observational audit will also be completed every month to ensure compliance with the SOP.	February 2021

5 **6**	NHS Borders must ensure that personal protective equipment is worn appropriately by all staff groups (see page 15). NHS Borders must ensure that staff perform hand hygiene at the appropriate opportunities as per the World Health Organization (WHO) five moments for hand hygiene guidance (see page 15). **NHS Borders Action:-** h) NHS Borders has an established PPE Committee and a programme of refresher training that will be delivered in Hay Lodge Community Hospital. i) NHS Borders will conduct regular reviews of infection control practice including use of PPE and hand hygiene.	February 2021 March 2021	Head of Work and Wellbeing Clinical Nurse Manager	April 2021 PPE refresher training has been provided to staff at Hay Lodge Community hospital. Monthly hand hygiene audits are already conducted and an infection control spot check tool has been shared for use by the ward and Clinical Nurse Manager. A full SICPs audit was completed by the IPCT in March 2021 which identified 92% PPE compliance.	April 2021 April 2021

7	<u>NHS Borders must ensure improved communication between the estates team and ward staff (see page 15).</u> **NHS Borders Action:-** j) NHS Borders will produce a Standard Operating Procedure and educate Hay Lodge ward staff on using electronic reporting system for estates issues. k) Estates to attend regular team meetings with ward staff to discuss ad hoc and planned works.	April 2021 April 2021	Clinical Nurse Manager Head of Estates and Facilities	<u>April 2021</u> A SOP has been developed and implemented <u>April 2021</u> Joint Estates and ward meetings are scheduled to commence in May 2021.	April 2021

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 28 July 2021

Report By:	*Christopher Myers, General Manager, Primary and Community Services*
Contact:	*Cathy Wilson, Primary Clinical Services Manager*
Telephone:	*01896 826 455*
COLDINGHAM BRANCH SURGERY	
Purpose of Report:	The purpose of this report is to appraise the Integration Joint Board on the situation relating to Eyemouth Medical Practice's Coldingham Branch Surgery which the Practice has indicated is no longer sufficiently resilient or sustainable to remain viable. The paper asks the Integration Joint Board to note the process being undertaken to review these sustainability concerns by NHS Borders, along with the next steps.
Recommendations:	The Health & Social Care Integration Joint Board is asked to **note**: a) The current situation relating to the sustainability concerns of the Coldingham Branch Surgery. b) That a Short Life Working Group has been established with the aim of ensuring the safe and sustainable delivery of medical and pharmaceutical service that meets the needs of Scottish Borders Population in the area. In order to do this, we will ensure that the medical and pharmaceutical needs of the population are met using a combination of reviewing the: a. current sustainability risks; b. current staffing levels; c. accessibility of alternative provision of Dispensing Services including the access to the closest dispensing branch; and d. alternative delivery models. c) That a public consultation is currently being undertaken and is due to close on 9th August 2021. All patients registered with Eyemouth Medical Practice have been sent a letter informing them of the situation and to invite responses to the consultation. d) That an update paper will be drafted for a future Board meeting that will make recommendations on the future provision of services in Coldingham Branch Surgery.

Personnel:	No NHS workforce implications, albeit the situation impacts on practice staff
Carers:	Possible impacts on carers will be considered when the Healthcare Inequalities Impact Assessment will be undertaken
Equalities:	A Healthcare Inequalities Impact Assessment will be undertaken.
Financial:	• Potential minor impacts on finance to cover costs of public engagement • Use of internal staffing resource to manage within existing budgets
Legal:	• The Primary Medical Services (Scotland) Act 2004 • The National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995 • The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 • CEL 4 (2010) • Section 2B of the National Health Service (Scotland) Act 1978 • NHS Borders Pharmaceutical Care Services Plan 2020/21 • Scottish Government “Shaping the Future Together” Report of the Remote and Rural General Practice Working Group

Risk Implications:	• Risk of public / political concern, should the Branch Surgery not be deemed as sustainable.
	  ○ This risk is moderate due to impacts on those that use Coldingham Branch Surgery, however, there are alternative accessible options locally and it is hoped that work on public communications and engagement will reduce the risk
	• Risk of Covid-19 affecting NHS Borders ability to respond
	  ○ This risk will be tolerated and managed by prioritisation of other work

Primary and Community Services

Integration Joint Board

COLDINGHAM BRANCH SURGERY

1. Situation

1.1. On 8th June 2021, Eyemouth Medical Practice wrote to the General Manager for Primary and Community Services to note that the GP Partners no longer feel that they can offer a safe, sustainable Dispensing or Branch Surgery service that meets the needs of their patients using the Coldingham Branch (See Appendix 1).

2. Background

2.1. Eyemouth Medical Practice provides General Medical Services in Eyemouth and in a Branch Surgery in Coldingham. The Coldingham Branch Surgery offers a dispensing service from the branch surgery.

2.2. There are no patients who are registered at Coldingham surgery as this operates only as a branch surgery site from Eyemouth. The Coldingham dispensary has an eligible population of approximately 2,200 patients who are entitled to use the dispensing service. Information shows that approximately 500 patients use the service each month with an average number of items dispensed of approximately 3,000 / month.

2.3. In 2017, Eyemouth Medical Practice worked with NHS Borders to cease services at the Practice's former Cockburnspath Branch Surgery for sustainability and safety reasons.

3. Assessment

3.1. Following detailed discussions with the Partnership, it has become apparent that despite the significant efforts the Partners have made over a number of years to sustain the Coldingham Branch, there remain significant ongoing concerns:

- A high level of pressure being placed on the Eyemouth Medical Practice team to maintain the Branch Surgery and Dispensing Service in the context of a need to cover key areas such as annual leave and multiple sites. This has in turn had a significant impact on the Practice's ability to retain and recruit staff. If this is not addressed, then this will make future recruitment and the ongoing sustainability of Eyemouth Medical Practice increasingly challenging.

- There is a national shortage of GPs and this has made it increasingly challenging for the Practice to recruit GPs when former GPs have retired from the Practice. Eyemouth Medical Practice have diversified their workforce to continue to provide sufficient cover for the Practice's patients, but there have been significant challenges recruiting and

retaining staff as there have been poor recruitment prospects for both the dispensing and clinical teams.

- There are difficulties in ensuring appropriate governance and supervision of the dispensing service with a reduced number of GP Partner sessions resulting in increased patient dissatisfaction and dispensing errors.

- The Coldingham Branch Surgery is unable to offer a full range of clinical intervention to patients as the facilities there are limited. Therefore, if patients need a procedure or investigation then they have always had to travel to Eyemouth for a second appointment to complete an episode of care.

- The Coldingham Branch Surgery is not fit for modern General Practice and is also unable to offer a full range of clinical intervention to patients as the facilities there are limited. In addition, staff have to work alone when in the branch, and there is no chaperone service for patients in the Coldingham Branch**.**

3.2. A Short Life Working Group has been established with the aim of ensuring the safe and sustainable delivery of medical and pharmaceutical services that meets the needs of Scottish Borders Population in the area. In order to do this, the group will ensure that the medical and pharmaceutical needs of the population are met using a combination of reviewing the:

- current sustainability risks;
- current staffing levels;
- accessibility of alternative provision of Dispensing Services including the access to the closest dispensing branch; and
- alternative delivery models.

3.3. In addition, as part of the Communications and Engagement plan, all patients who are registered with Eyemouth Medical Practice have been sent a letter from NHS Borders outlining the situation and asking them to participate in a consultation. This consultation is open until 9th August and is inviting feedback on the impact should the Coldingham branch surgery close and dispensing services cease.

3.4. To date NHS Borders has received a good level of feedback from the consultation. Themes so far include:

- Transport – ability of individuals to use public transport, timings, cost, and distance from bus stops.
- Patient demographics – Coldingham generally has an older population.
- Availability of appointments at Eyemouth.
- Ability of Eyemouth pharmacy to manage additional workload.
- Parking and impact to local residents around the Eyemouth surgery.
- Feedback on practice management.

3.5. The Short Life Working Group (SLWG) will consider the feedback received from the public consultation and whether any action can be taken to address concerns. A Health Inequalities Impact Assessment will also be undertaken.

3.6. An update paper will then be drafted for a future Board meeting that will make recommendations on the future provision of services in Coldingham Branch Surgery. In addition, the Short Life Working Group will ensure that GP Subcommittee and Area Pharmaceutical Committee, along with all other relevant stakeholders, are briefed on the situation and the process being undertaken.

3.7. Since receiving the initial notification from the Practice, there has been a further change in circumstances which poses an additional challenge to the current and future service provision. The dual role Phlebotomist and Dispenser has handed in their notice to take up an opportunity to undertake nurse training and will be leaving the practice on 3rd September. Mitigating actions are being explored to allow the service to continue whilst the public consultation and service review is completed to enable the SLWG to provide the Board with a recommendation on the future provision of services in Coldingham.

Regulations associated to the provision of dispensing services

3.8. In contrast to Pharmaceutical Regulations[1] that outline that a Pharmacist may apply to be included in the pharmaceutical list for the provision of pharmaceutical services, or that a Pharmacist may give notice to withdraw their name from the pharmaceutical list to the NHS Board and their name will be removed; the process outlined that applies to General Practitioners is different. Paragraph 44 of "The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018"[2] notes that the onus is on the Health Board to authorise a General Practitioner Contractor to secure the provision of dispensing services if it is authorised or required to do so.

3.9. As a result, in the case of a General Practitioner Contractor noting concerns about the ongoing viability of their dispensing service, it is a decision for NHS Borders on whether to withdraw their requirement or authorisation of the Contractor to continue to provide a dispensing service.

3.10. This is in instances where the Health Board, is satisfied, after consultation with the Area Pharmaceutical Committee, by reason of:
(a) distance;
(b) inadequacy of means of communication; or
(c) other exceptional circumstances, that GP registered patients will have serious difficulty in obtaining from a pharmacist any drugs, medicines or appliances.

[1] The National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995. Available from: https://www.legislation.gov.uk/uksi/1995/414/made
[2] The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018. Available from: https://www.legislation.gov.uk/ssi/2018/66/made

Regulations associated to the closure of a Branch Surgery

3.11. There are no provisions in GMS Regulations associated to the closure of a Branch Surgery. However the public involvement provisions outlined in CEL 4 (2010)[3] would apply:

"The public involvement process should be applied in a realistic, manageable and proportionate way to any service development or change, including those that are time limited (temporary) or trialled through a pilot initiative, which will have an impact on the way in which people access or use NHS services. The process should be applied to any proposed service change."

Pharmaceutical Care Services Plan 2020/21

3.12. The current Pharmaceutical Care Services Plan 2020/21[4] concludes that the current service provision is adequate for the population's immediate needs. Within Berwickshire, there is currently pharmaceutical provision within 5 other locations, with the closest being in Eyemouth which is 3.6 miles away from the Coldingham Branch Surgery, accessible in 8 minutes by car or 17 minutes by public transport (bus).

Town	Community Pharmacies and Dispensing Practices	Distance from Coldingham	Travel time by car	Travel time by Public Transport
Coldingham	Dispensing Practice	-	-	
Eyemouth	GLM Romanes Pharmacy	3.6 miles	8m	17m
Chirnside	GLM Romanes Pharmacy	7.9 miles	16m	56m
Duns	GLM Romanes Pharmacy	13.7 miles	23m	34m
Coldstream	GLM Romanes Pharmacy	20.3 miles	36m	1h20m
Greenlaw	GLM Romanes Pharmacy	20.7 miles	25m	2h24m

Table 1 Berwickshire Pharmacy Provision

3.13. From an accessibility perspective, the closest pharmacy in Eyemouth has accessibility provisions including a hearing loop, wide door and aisle width (>800mm), a low counter height, suitable waiting area for wheelchairs and pushchairs and ramps and level access throughout.

Locality	Town	Community Pharmacies & Dispensing Practices	Hearing Loop	Door width 800mm or wider	Aisle width 800mm or wider	Counter Height between 750-800mm from floor	Suitable waiting area incl wheelchair/ Pushchair	Ramps & level access throughout	Automatic/ Semi automatic door open
Berwickshire	Chirnside	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	-
	Coldstream	GLM Romanes Pharmacy	✓	✓	✓	-	✓	✓	-
	Duns	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	-
	Eyemouth	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	-
	Greenlaw	GLM Romanes Pharmacy	-	✓	-	✓	-	-	-

Table 2 Accessibility of alternative dispensaries in Berwickshire

[3] Scottish Government. CEL 4 (2010). INFORMING, ENGAGING AND CONSULTING PEOPLE IN DEVELOPING HEALTH AND COMMUNITY CARE SERVICES. Available from: https://www.sehd.scot.nhs.uk/mels/cel2010_04.pdf

[4] NHS Borders Pharmaceutical Care Services Plan 2020/21. Available from: http://www.nhsborders.scot.nhs.uk/media/712063/Appendix-2020-37-Pharmaceutical-Care-Services-Plan-2020-21.pdf

3.14. In order to provide many of the additional services available to patients, community pharmacies must have a suitable environment that offers the patient the privacy expected of such services. The table below outlines the Confidential Services available in the surrounding Pharmacies.

Locality	Town	Community Pharmacies & Dispensing Practices	Privacy - Is a separate enclosed room available?	Sound proof & private	Located close to, or part of, main counter	And/or area screened from main retail area	Wheelchair accessible	Large enough for 2 people plus Pharmacist	Worktop /desk	Hand washing facilities
Berwickshire	Chirnside	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Coldstream	GLM Romanes Pharmacy	✓	✓	✓	✓	-	✓	✓	✓
	Duns	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Eyemouth	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Greenlaw	GLM Romanes Pharmacy	-	-	-	-	-	-	-	-

Table 3 Confidential Services available in alternative dispensaries in Berwickshire

3.15. In addition, there are around 82 patients living in the north of the Berwickshire area registered to Eyemouth Medical Practice who will have closer access to Pharmacies in Dunbar (East Lothian).

3.16. The Area Pharmaceutical Committee have been briefed on the situation and have been asked to consider the potential impact of ceasing dispensing services at Coldingham may have on the current Pharmaceutical Care Services Plan.

4. Recommendations

The NHS Borders Non Executive Directors are asked to note:

4.1. The current situation relating to the sustainability concerns of the Coldingham Branch Surgery.

4.2. That a Short Life Working Group has been established with the aim of ensuring the safe and sustainable delivery of medical and pharmaceutical service that meets the needs of Scottish Borders Population in the area. In order to do this, we will ensure that the medical and pharmaceutical needs of the population are met using a combination of reviewing the:

- accessibility of alternative provision of Dispensing Services including the access to the closest dispensing branch;
- current sustainability risks;
- current staffing levels; and
- alternative delivery models.

4.3. That a Communications and Engagement Plan has been developed. As part of this, all patients registered with Eyemouth Medical Practice have been sent a letter from NHS Borders outlining the situation and asking them to participate in a public consultation. This public consultation is open until 9th August. Feedback received will be considered as part of the review of the situation that will be undertaken by the Short Life Working Group.

4.4. That an update paper will be drafted for a future Board meeting that will make recommendations on the future provision of services in Coldingham Branch Surgery

5. That the Short Life Working Group will work to ensure that all relevant stakeholders are briefed appropriately on the situation and process.

Appendix 1

- Eyemouth Medical Practice letter to NHS Borders – 8th June 2021

Eyemouth Medical Practice

The Health Centre, Houndlaw Park, Eyemouth, Berwickshire, TD14 5DD. Tel: 018907 50599 Fax: 018907 51749

Dr David Cooksey
Dr Yaw Nyadu
Dr Kirsty Robinson

Tuesday 8th June 2021

Mr Christopher Myers
General Manager P&CS
NHS Borders

Dear Mr Myers,

I am writing on behalf of the partnership to initiate a dialogue with NHS Borders around the sustainability of our dispensing service from the Coldingham branch surgery. Sadly, we no longer feel that we can offer a safe, sustainable service and we feel that the needs of our patients would be better met by accessing the wider range of services offered by the local community pharmacy. This letter is written after comprehensive discussions within the partnership about the future resilience of the practice. Inevitably, the position regarding the dispensing service is inextricably linked to the provision of a branch surgery in Coldingham so we have taken the liberty of discussing both issues in this letter.

The practice has an increasing patient list which is set to continue to expand with the new housing developments planned for Eyemouth and Ayton. The reopening of the train station in Reston will also promote housing expansion in the locality as it becomes a viable commuter route into Edinburgh and Newcastle. The Coldingham dispensary has an eligible population of approximately 2,200 patients who are entitled to use the dispensing service. Information shows that approximately 880 patients use the service each month with an average number of items dispensed of approximately 3,000 / month.

Over the past few years, the practice has undergone immeasurable change. With the retirements of Dr Booth in 2015, Dr Mason in 2017 and Dr Holt in 2019 plus the departures of Drs Williams and Henderson in 2018, the partnership has reduced to three remaining partners. In March 2017 when the practice applied to close the Cockburnspath branch surgery site, our letter to the Board stated that we had an establishment of 46 GP sessions per week. This has now been reduced to 28 sessions. We remain committed to the partnership model and hope to offer our current salaried GP the opportunity of joining the partnership in the near future. As recruitment of GPs has been so difficult and unsuccessful over recent years, the practice has opted for diversification of the clinical workforce employing a paramedic practitioner and advanced nurse practitioner to strengthen the clinical team. Unfortunately, our paramedic practitioner has recently resigned from his post to relocate to the Highlands. It is of note however that nurse or paramedic practitioners are unable to contribute to the oversight of the dispensing service. To improve our chances of securing future clinicians and promote the benefits of the local area, the practice participates in GP and PCIP ANP training believing that this will showcase our practice strengths and provide experience of working in a more rural community. We are also currently offering a placement to a GP Returner.

The decision to request this change has been carefully considered over a lengthy period of time. Closing the branch premises and ceasing dispensing services will result in a net financial loss for the partnership but despite this, we believe that it is the correct approach to ensure that our business model is sustainable for the future. However, reducing the financial risk to our partnership is consistent with the approach of the new GMS contract. As partners we feel that it is imperative for us to focus our time and efforts on what we do well and currently operating the dispensary is inevitably diluting our contribution. It is our wish to consolidate our resources from a single base in Eyemouth and focus GP time on our role as expert medical generalists as defined by the new GMS contract. Prior to the Covid pandemic, a GP consulted at Coldingham surgery 4 mornings a week. Surgeries were booked from 9 to 11.30am so the visiting GP used the remainder of the session to sign prescriptions, check the dispensing of controlled

drugs, provide support to the dispensary staff and perform any local home visits. However, from March 2020 at the start of the pandemic, consulting at Coldingham was stopped due to the restrictions related to Covid-19 and has not resumed since. GMS services have instead been provided to all patients from Eyemouth. GP partners travel to Coldingham at least three times a week to oversee dispensing services but the return journey realistically results in the loss of a minimum of an hour of GP time on each visit day. This is time that we could be utilising for clinical care.

The travel distance by road between the Eyemouth and Coldingham practices is only 3.2 miles. Eyemouth Pharmacy currently provides a community pharmacy service from the centre of Eyemouth to the surrounding areas and a delivery service to many patients in the catchment area of the Coldingham dispensary who would be eligible for dispensing services. Many patients eligible for dispensing services who work in Eyemouth or who travel to Eyemouth for local services (shops, hairdressers, banks, dentist, cafes and takeaway food outlets) will already use Eyemouth Pharmacy to provide medication. We are also aware that patients based in Cockburnspath use pharmacy providers based in Dunbar. As a dispensary, Coldingham surgery is unable to provide over the counter medication sales and cannot provide services such as Pharmacy First so contractually it is limited to a very narrow range of medication services compared to a modern community pharmacy.

The partnership has always been keen to sustain dispensing services from Coldingham but despite long-standing membership of the Dispensing Doctors Association and use of their resources for members it has become increasingly difficult over recent years to stay up to date with regulations and guidance around good practice. Compliance with the Falsified Medicines Directive is an example of increased bureaucracy and complexity that has had a negative impact on the dispensary service. There are few colleagues who have knowledge in this area and it is difficult for GP partners to gain an understanding of the contractual basis and payment structure of this service. Dr Robinson has been a member of the national Scottish Government Dispensing Group for over two years but even with this involvement it is time consuming and challenging to practice as a dispensing doctor. In April 2020, the partnership commissioned an independent review of the dispensary by an experienced Practice Manager from Highland with expertise in this field. This confirmed that our administrative and financial processes were good and did not identify any significant areas for review or development. There is no doubt that the complexity of this additional role for GP partners is time consuming, stressful and contributing to the exceptional workload pressures that we are experiencing at the current time.

The increasing involvement of the NHS Borders pharmacotherapy team with the practice has highlighted the intricacies of our part-dispensing arrangements. Specific knowledge of our practice area and dispensing processes are currently required by pharmacotherapy team members to provide services to the practice. This makes it more difficult to provide cover for leave. As a result, the induction of new members is more complicated. The practice also finds the same difficulties with locum GPs, GP trainees and other associated or temporary staff.

In 2015 and 2017 the Coldingham surgery was subject to criminal damage and theft of drugs. This resulted in the need for expensive repairs and led to the decision to install CCTV in the premises. GP partners living locally need to be available as key holders at all times to respond to alarm activations. A liaison officer from Police Scotland performed a security review of the premises at the start of the Covid pandemic. A minor recommendation was made which was duly undertaken but despite these measures, we feel that our dispensing staff remain vulnerable when lone working at the premises. It would not be commercially viable to have two members of staff in the building at all times so our dispensing staff are vulnerable to abusive and criminal behaviour.

In late December 2020, one of the dispensing staff resigned from her position. Since then we have been unable to recruit a suitable individual to the vacancy despite a longstanding national job advert and

a notification on the practice website. There has been no interest in the post from a suitably qualified individual. The practice has a full time Lead Dispenser, a healthcare support worker providing temporary cover who is trained to dispense and a member of the reception team who is currently completing her "Buttercups" training. We are gravely concerned that our Lead Dispenser is under immense pressure currently and that there is little or no resilience within our dispensing team. This individual has taken minimal annual leave over the past 6 months but we feel that this is placing an unfair and unrealistic pressure upon her to single-handedly maintain the service. Business continuity was considered with Dr Sheena MacDonald on behalf of P&CS at the start of the Covid pandemic and as a result it was evident that dispensing practices had a unique vulnerability within the wider service as we were advised that NHS Borders pharmacists would not be able to work within our environments to assist with emergency cover.

Unfortunately, our staffing crisis has led to lengthier dispensing times than we would like over the past few months. This has inevitably resulted in an increase in patient dissatisfaction and complaints. We have also seen an increase in the number of dispensing errors made over recent months and this is inevitably the result of staff fatigue and workload pressures. The partnership has no desire to offer a poor or unreliable service to our patients hence the need for us to seek resolution to our dilemma by remedying this intolerable position without undue delay. In the absence of additional, trained staff this is something that we cannot easily rectify.

In the event of closure of the dispensary, the role of the Lead Dispenser would need to be reviewed. The practice has sought preparatory legal advice from an employment law specialist and is fully appraised of the correct process to follow. We will continue to be supported by this firm throughout the process to ensure that the member of staff involved is treated sensitively and fairly.

The above information primarily addresses the issues related to dispensing services. We are aware that the dispensing provision is very closed linked to the availability of branch surgery premises so the points raised below relate specifically to the latter.

1. Due to Covid restrictions, no clinical services have been provided from the Coldingham site since March 2020. Instead, over the past fourteen months patient care has been diverted to the Health Centre in Eyemouth. Patients have accommodated this change and the practice has not received any feedback outlining difficulty with this approach.
2. Coldingham branch surgery is unable to offer a full range of clinical intervention to patients as the facilities there are limited. Therefore, if patients need a procedure or investigation then they have always had to travel to Eyemouth for a second appointment to complete an episode of care.
3. Lone working by dispensers at the site is unsatisfactory for the reasons listed above.
4. Lone working at the site by clinicians results in an absence of peer support and advice from colleagues. This increases medico-legal risk and is stressful for clinicians. Isolated working can place clinicians at risk of accusations of misconduct from patients and sadly these events are becoming increasingly common for the profession.
5. A chaperone cannot be made available for consultations at Coldingham. This means that patients need to be asked to reschedule appointments at Eyemouth where a suitable trained person can be present for an examination. There is a risk that clinicians proceed without a chaperone in these circumstances in an attempt to avoid inconvenience to patients.
6. Opportunities for mentorship and supervision are limited at the branch surgery reducing the benefit of the additional consulting space.
7. Due to the small footprint of the surgery and the layout of the building, compliance with social distancing and Covid safety measures would be difficult. There is a single door for entry / exit and very limited space in the entrance vestibule and porch. It is currently difficult to control the movement of patients attending to collect medication so there would be little or no scope to

increase traffic with clinical consultations. To ensure that staff can take their rest breaks in a socially distanced manner, a consulting room is currently being used for this purpose.

8. In order for a GP to join the partnership, a substantial capital investment is required as a result of ownership of the Coldingham surgery. Nationally, partnership is becoming a less attractive option for GP colleagues. If partnership is a colleague's desired career choice then many are available without the need for capital investment. Thus, attempts to recruit a new GP partner to rural Eyemouth with the additional financial burden of a significant capital contribution have become increasingly difficult over recent years and may well become impossible. It is right that as a partnership we are mindful of the need to adapt our business model to ensure, as much as possible, a secure future. There are no other GP practices in the area so if the practice fails to recruit then the provision of general medical services to our community will be under serious threat.

To conclude and in summary, the practice wishes to consider the future of the dispensing service and branch surgery provision at Coldingham with Board colleagues as the partnership does not consider that either remain viable elements of our business model. We have reached this conclusion as a result of :-

i. Poor recruitment prospects for both the dispensing and clinical teams.
ii. An unacceptable level of stress being placed on our sole, Lead Dispenser to maintain a dispensing service despite the need for annual leave.
iii. Difficulty in ensuring appropriate governance and supervision of the dispensing service with a reduced number of GP partner sessions resulting in increased patient dissatisfaction and dispensing errors.
iv. Risks of both dispensers and clinicians lone working from the branch premises.

We would be more than happy to provide any further additional information that might be needed to support this application. The practice welcomes assistance and advice from other relevant members of the organisation to reach an acceptable solution to our current predicament. We thank you in advance for your support and look forward to hearing back from you in the near future.

Yours sincerely,

Dr K Robinson Dr D Cooksey Dr Y Nyadu

GP Partners

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 28 July 2021

Report by:	Iris Bishop, Board Secretary
Contact:	Iris Bishop, Board Secretary
Telephone:	01896 825525
STRATEGIC PLANNING GROUP MINUTES	
Purpose of Report:	To provide the Integration Joint Board with the minutes of the recent Strategic Planning Group meetings, as an update on key actions and issues arising from meetings held on 3 February 2021 and 5 May 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** these minutes.
Personnel:	As detailed within the minutes.
Carers:	As detailed within the minutes.
Equalities:	As detailed within the minutes.
Financial:	As detailed within the minutes.
Legal:	As detailed within the minutes.
Risk Implications:	As detailed within the minutes.

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Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 3 February 2021** at **10am** via Microsoft Teams

Present:
Malcolm Dickson, Non Executive NHS Borders (Chair)
Rob McCulloch-Graham, Chief Officer
Caroline Green, NHS Public Participation Network Representatives
Colin McGrath, Community Councillor
Diana Findlay, Public Member
Lynn Gallacher, Borders Carers Centre
Gerry Begg, Housing Strategy Manager
Graeme McMurdo, Programme Manager
Jenny Smith, Borders Voluntary Care Voice
Amanda Miller, Eildon Housing Association
Karen Lawrie, Partnership Lead for NHS Borders

In Attendance:
Laura Prebble, Minute Taker
Philip Lunts, Strategic Planning Lead for NHS Borders
Dr Anne Hendry, External Consultant
Susan Holmes, Principal Internal Auditor, SBC

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Dr Tim Young, Tim Patterson, Stuart Easingwood and Chris Myers.

The Chair confirmed the meeting was quorate.

Rob McCulloch-Graham announced the additional Agenda item - Discharge Programme Presentation to be presented by Philip Lunts and Dr Anne Hendry. Both were welcomed to the meeting.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 11 November 2020 were approved with one amendment. Pg 6, paragraph 2 of AOB – wording amended by removing ‘however that was already undertaken by the Elected Councillors on the IJB’.

3. MATTERS ARISING

IJB membership from the 3rd sector: IJB.membership is a responsibility of the SPG to advise the IJB on all matters regarding strategic planning which includes the makeup of the membership of the IJB to ensure they comply with the with the legislation in this case statutory instrument 2014 number 285 The Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014 so they do not fall foul of the authorities such as the CQC the Care quality commission. **Action**: Colin McGrath to circulate the relevant extract from the statutory instrument and ask Laura to ask the IJB to indicate who fills each role by name and sponsoring body.

Particularly groups described in paragraph (7) where there can be more than one in each group to insure proper coverage to achieve the main Integration planning principle that integration is "from the point of view of service -users" and is a key integration benchmark used by government authorities.

The **STRATEGIC PLANNING GROUP** noted the Action Tracker as complete after the IJB meeting on 17th February 2021.

4. DISCHARGE PROGRAMME PRESENTATION – For comment.

Rob McCulloch-Graham introduced Philip Lunts and Dr Anne Hendry. Philip Lunts presented a PowerPoint presentation on the formative evaluation of the 5 discharge programmes commissioned by the IJB over the last few years – Waverly Transition Care Facility, Garden View Discharge Facility, Hospital to Home (now Home First), Matching Unit and Strata Referral Management. Information and data has been collected to show the progress of the 5 projects. Costings are still to be completed but will be complete in time for the IJB meeting. The report was brought to SPG for comment before being presented to the IJB Board.

The aim of the programme is for patients to be discharged to these facilities while their care package is put in place and they either return to the community or to a nursing home. A small percentage will be readmitted to hospital.

Home First appears to be supporting patients with a lower need than anticipated. To consider if another form of support for lower need patients would be more suitable such as 3rd sector engagement.

The Matching Unit has now been mainstreamed and Rob McCulloch-Graham confirmed it is now part of SB Cares

Strata allows a single professional to make a referral. There currently is no access available from the community and a system is being developed to allow referrals in from the community.

Summary – All five initiatives have performed favourably. Almost all patients are transferred out from hospital within the government guidelines of 2 days. There is a clear reduction in the length of time the over 65s are staying in hospital. Services are delivering against their

targets. It is expected that once the costs and benchmark figures are confirmed these will give further evidence to support the success of the 5 projects.

The Borders now has a proper step up/step down service. However, there is a need for a further service for patients with lower needs.

Comments:
Caroline Green raised a concern about the higher rated of re-admission within the Home First service in the Borders compared to others. She is concerned it may be due to clinically unstable patients being sent home with care packages.
Rob McCulloch-Graham referred back to the statistics in the report where the evaluation of a large number of cases reflects the overall success of Home First. Philip Lunts confirmed that the Border's readmission rates are generally lower in the Borders than places without these programmes. He agreed that readmission cases should be reviewed. Dr Anne Hendry confirmed that a patient's condition can change quickly which may be the reason readmission to hospital.

Amanda Miller in her role of housing provider added that there is a real opportunity for extra capacity. She asked how to bring health partners in to their services, especially their Kelso plans which are in their early stages.

Action: Rob McCulloch-Graham to meet with Amanda Miller after this meeting to look at how to link resources.

Rob McCulloch-Graham proposed to take the conversation to the IJB to look at filling the gaps identified in this report i.e. staff retention as they are on short term contracts.

The Chair thanked Philip Lunts and Dr Anne Hendry for presenting the report. Rob McCulloch-Graham confirmed the report is really helpful as the services mature. SPG to take the evidence to the IJB to support the success of their projects.

Jenny Smith asked if there is enough 3rd sector representation. Rob McCulloch-Graham confirmed this will be developing further and contact will be made during the 10 work streams planned. They will make better use of the assistance hubs to engage with the 3rd sector in communities going forward. The 3rd sector are well placed to fill the gap identified for patients requiring a lower level of support. Jenny Smith offered her support.

5. PERFORMANCE REPORT

Graeme McMurdo provided an overview of the content of the report that was circulated to members yesterday. The figures in red still need to be updated before going to the IJB. The information is robust but out of date as it relies on national comparisons. Graeme McMurdo questioned how useful this report is going forward, in light of Covid-19. He asked if future reports should be more flexible; to focus more on commissioning projects or specifics such as the readmission rate. Jenny Smith, the Chair and others agreed that a change was merited. The Chair confirmed the data in the report was still required for Government reporting and was a public report providing a useful comparison nationally.

Rob McCulloch-Graham agreed the requirement for a balance of data that was timely. The Chair noted that a periodic deep dive into the data elements would be useful. Jenny Smith asked that the social care service users' experiences should also be included.

Action: Graeme McMurdo and Rob McCulloch-Graham to discuss what additional data could be included from the discharge programme and other IJB projects which would be useful for the SPG and IJB. Rob McCulloch-Graham noted that this would be an increased level of work and so Graeme McMurdo would require additional support. Rob McCulloch-Graham to raise the issue at the IJB.

Caroline Green requested a piece of work to look at the re-admission rates for Home First to investigate why they occur, with an aim to reducing the number of cases. However, the Chair noted that this authority has a lower rate of readmissions than other authorities and that the evaluation seems to disprove the readmissions rates are high.

Action: Rob McCulloch-Graham to take this discussion to the Health Board Chief Executive.

The Chair and Rob McCulloch-Graham thanked Graeme McMurdo for producing the report.

The **STRATEGIC PLANNING GROUP** noted the performance report and agreed a more flexible report would be beneficial, as well as the statistical reporting required by the Scottish Government contained in this current report.

6. MEMBERSHIP – INDEPENDENT SECTOR LEAD – Wendy Henderson

Rob McCulloch-Graham presented the paper recommending that Wendy Henderson become a member of the SPG, as the representation from the private sector care homes and care at home provdiers.. Rob McCulloch-Graham advised that he has been working closely with the private sector care homes during the pandemic and now meets with the owners on a monthly basis. Accountability is more accentuated at present with direct intervention having been required during the pandemic. This will help the conversations with the private sector going forward.

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The **STRATEGIC PLANNING GROUP** agreed to add Wendy Henderson to the SPG membership as the link to the independent sector care homes.

7. INDEPENDENT SECTOR PROVIDERS STRATEGIC ADVISORY GROUP – Terms of Reference

Rob McCulloch-Graham outlined the background of this group: At the start of the pandemic, the focus was on health services and the supply of PPE. It quickly became apparent that the emphasis was on the care settings. The Government advised H & SC partnerships to form a strategic advisory group to secure good practice, overseeing, monitoring, training and troubleshooting. Weekly conversations were happening on Teams at the start of the pandemic and were extremely useful. It was agreed that these meetings became more strategic and now occur monthly thus providing a direct link to the independent sector

providers in the Borders. Rob McCulloch-Graham is currently Chair, with Arthur McLean as Vice Chair. The group forms a link between the Health and Social Care partnership with the independent care home owners.

The Terms of Reference are proposed to formalise the group.

The **STRATEGIC PLANNING GROUP** approved the formation of the Independent Sector Providers Strategic Advisory Group and their Terms of Reference. The group to report to the SPG.

Action: Rob McCulloch-Graham to confirm if this needs to go to the IJB for approval.

8. COVID-19 UPDATE

Susie Thomson was welcomed to the Teams meeting to share the latest Covid-19 report that had been presented to the multi agency Covid-19 response group this week. Susie Thomson reports the data weekly to the group and has been asked by Rob McCulloch-Graham to share the data with the SPG today. .

The **STRATEGIC PLANNING GROUP** noted the report and the Chair thanked Susie Thomson for her presentation.

The presentation is attached to these minutes as an appendix.

9. LOCALITY WORKING GROUP

Rob McCulloch-Graham introduced the paper 'Live Community Conversation', looking at a different way of working with people in the community to develop the new community plans. The response has been mixed. The use of Microsoft Teams to communicate with the public is being considered and will be piloted in 1 area in March as a learning process – area not decided yet. Communication teams would publicise the online event. Those involved in the locality plans previously would be invited. It could be recorded and viewed later. There would be an opportunity to raise follow up questions.

Colin McGrath advised that similar work was being done in the area partnerships and they have found connectivity to be an issue for the public.

The Chair noted that it is imperative that no one is excluded from participating. Diana Findlay confirmed digital exclusion is a problem, whether through lack of connectivity due to location or not being able to afford broadband or a laptop but also being untrained on their use. You can apply to social enterprise groups for equipment but tutoring is required to use it. The Chair confirmed this is a valid point. Colin McGrath suggested using the SBC newspaper that is delivered to every household to reach everyone. Jenny Smith confirmed that the 3rd sector could help with IT equipment and expertise.

Action: Rob McCulloch-Graham and Jenny Smith to meet to discuss further. Amanda Miller confirmed there is funding available for connection.

The **STRATEGIC PLANNING GROUP** noted the discussion.

10. ANY OTHER BUSINES

Colin McGrath requested the NHS and SBC communications departments look into broadband connectivity within the Borders. To advise residents that they have to ask their supplier to be connected to 5G, for a small charge.

Caroline Green informed the group of the NHS 'Money Worries' app which is going live in a few weeks.

Diana Findlay asked who she can contact to discuss the nutriciousness of food being supplied to the public by the assistance hubs. She raised a concern that recipients may deteriorate if not.

Action: Rob McCulloch-Graham to contact Jenny Craig at SBC and ask her to email Diana Findlay to discus.

Jenny Smith advised that 3rd sector events in 2019/20 are to be rekindled in Teams format. IJB colleagues will be invited. Rob McCulloch-Graham confirmed that 3rd sector will be involved both locally and Borders wide.

The **STRATEGIC PLANNING GROUP** noted the discussion.

11. DATE AND TIME OF NEXT MEETING

The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 5 May 2021, at 10am to 12pm via Microsoft Teams.

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 5 May 2021** at **10am** via Microsoft Teams

Present:
Malcolm Dickson, Non Executive NHS Borders (Chair)
Rob McCulloch-Graham, Chief Officer
Colin McGrath, Community Councillor
Lynn Gallacher, Borders Carers Centre
Gerry Begg, Housing Strategy Manager
Graeme McMurdo, Programme Manager
Jenny Smith, Borders Voluntary Care Voice
Amanda Miller, Eildon Housing Association
Karen Lawrie, Partnership Lead for NHS Borders
Wendy Henderson, Independent Sector Lead
Lucy O'Leary, Non Executive NHS Borders (Chair from August 21)
Stuart Easingwood, Director of Social Work
Keith Allan, Consultant in Public Health Medicine
David Bell, Joint Staff Forum
Linda Clotworthy, NHS Staff Member
Susan Holmes, Principal Internal Auditor
Graeme McMurdo, Programme Manager

In Attendance:
Laura Prebble, Minute Taker

Philip Lunts, Strategic Planning Lead for NHS Borders
Gordon McLean, Strategic Partnership Manager, Macmillan Cancer Support
Bill Clark, Social Care Advisor, Macmillan Cancer Support
Clare Oliver, Communications Manager
Andrew Carter, Director of Workforce
Bob Salmond, Head of WDMS
Arthur McLean, Co Chair of Independent Sector Providers SAG

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Diana Findlay and Caroline Green.

The Chair confirmed the meeting was quorate.

The Chair welcomed both Wendy Henderson and Lucy O'Leary to their first meeting today.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 3 February 2021 were approved with the following amendments:

- Pg 2 – Colin McGrath's comments – **Action**: Colin to email amended wording to Laura Prebble to amend the Minute.
- Jenny Smith's organisation is Borders Care Voice – to remove 'voluntary'.

3. MATTERS ARISING

Action Tracker:
Item 2 - Rob McCulloch-Graham met yesterday with Amanda Miller and Nile Istephan from Eildon Housing. It was a productive and useful meeting to develop further the commissioning and capital strategy. To develop the relationship further. A further meeting is scheduled in 2 weeks. Jenny Smith added that there are a lot of exciting projects in the early design stage. To look at the gaps and share business strategy and look at how to this aligns with IJB. Rob noted there will be a new Health & Social Care Partnership commissioning plan/strategy by April 2022.
Item 3 – covered in today's Agenda.
Item 4 – To be discussed at BET on Friday.
Item 5 – Rob McCulloch-Graham emailed information to Diana Findlay.

The **STRATEGIC PLANNING GROUP** noted the Action Tracker as complete.

4. PERFORMANCE REPORT

Due to a delay in receiving the data, this report will be circulated to the group after the meeting.
Action: Graeme McMurdo to email report to all.

5. UPDATE ON PERFORMANCE REPORTING

Graeme McMurdo gave an outline of the proposal to update performance reporting. The quarterly report will remain the same as the public facing report for this group.
The proposal is to supplement the report with additional, more useful information. Future reports will aim to use more spotlight reporting to demonstrate what people are gaining from IJB services. Reporting will still include financial, details and how we are seeking to change and improve services through co-production. The reporting will aim to be more flexible so a report can look at current activity and show progress in particular across all IJB programmes including the 10 priorities within the Strategic Implementation Plan.

Graeme invited comments at the meeting or for people to contact him directly after the meeting.

Lynn Gallcher noted that it is difficult to capture co-production and asked if there was a way of measuring it. We need to be better at demonstrating outcomes. Wendy Henderson noted that her organisation uses the integrated impact assessment to track a process.

The **STRATEGIC PLANNING GROUP** agreed a more flexible report would be beneficial, to go ahead and develop additional data from an IJB and H & SC perspective.

6. TRANSFORMING CANCER CARE – Gordon McLean and Bill Clark

The Chair welcomed Gordon McLean and Bill Clark to the meeting.

Gordon McLean presented a PowerPoint presentation to the group – 'Macmillan's Improving the Cancer Journey – Proposal for the Borders Health & Social Care Partnership'. A discussion followed. Gordon had met with Rob McCulloch-Graham to discuss the programme earlier.

The programme focuses on the non-clinical and un-met social care needs. It is a multi-agency approach to improve the lives of people affected by cancer, enabling service users and utilising community assets both statutory and voluntary. The programme has been evaluated by Edinburgh University as delivering on 9 of the H & SC priorities and is being rolled out across Scotland and are looking to roll it out in the Borders with the help of the H & SC Partnership. Bill Clark added that this would be a good project for the Borders and would make a real measurable improvement for the lives of cancer patients and other serious illnesses, reducing the number of patients returning to hospital. There is a vibrant 3rd sector here in the Borders which will add to the programme.

The Chair thanked Gordon and Bill and asked if there were any comments from members.

Dr Keith Allan noted the level of assessment (5 yrs) speaks very well. Co-production is key. Net savings and a more efficient use of services can be made. Gordon added that there will be an investment of £320K which will last 3-5 years to fund link officers. They are looking to align with existing services to prevent duplication. A letter will be sent to service users to offer to link them with this service. A link worker would them visit them in their locality to understand their needs and determine their top 3-5 current priorities before moving on to the next level. In Glasgow, only 5% of those worked with required a a referral back into a clinical setting. The majority were signposted to voluntary and 3rd sector setting. David Bell raised the issue of the Borders being a rural community with poor public transport links. Gordon noted that this programme has worked well in super rural communities such as the Highlands. Link officers are based in localities; 1 per 100,000. It will be for local colleagues to decide how funds are best utilised. Bill added that the Borders is most similar to Fife where giving equal access is a challenge. Jenny Smith asked about how long before it will be up and running and if there will be a reporting mechanism for the efficacy of the service. Gordon confirmed noted that a robust quarterly report is produced as part of the programme governance. There will be a scoping first of each locality to understand the community assets. Bill added the programme needs service users and the 3rd sector to be involved with an investment strategy for the 3rd sector. Wendy Henderson said she would be very interested and would like to be involved in this programme, to inform the business models of the independent sector. Linda Clotworthy asked if volunteers who have already been through the journey or are still living with cancer would be used to assist in filling any gaps; people who know the issues and the processes. Bill noted this and stated that this works in other areas.

Rob thanked Gordon and Bill for attending the meeting today. The project will be a catalyst to co-production and coordination, knowing where the 3rd sector are in each locality. Strata software will allow services to be mapped and allow referral. .

The **STRATEGIC PLANNING GROUP** agreed the project will be a benefit for the Borders and Gordon will be asked to return to the SPG once the programme is up and running.

7. ADDRESSING HEALTH AND INEQUALITIES PROGRAMME – Philip Lunts

The Chair welcomed Philip Lunts to the meeting. Philip shared a PowerPoint presentation with the group. The programme looks at how to maximise the impact of NHS Borders in mitigating health inequalities. To identify groups and target work towards them. The most deprived make up 29% of the population and have 45% more deaths than average. Based on respiratory illness, older people are 1000% more likely to die. Occupation, deprivation, age, ethnicity and co-morbidities are health inequalities. BEM – 15% are employed by NHS so te organisation is well placed any health inequalities resulting from ethnicity. NHS Borders are proposing to take action, where it is possible. A 2 year programme focusing on 3 areas – gathering data, engaging with groups and individuals and NHS as an institution being the anchor.

Comments: It was good to see staff were recognised as communities. Keith Allan added that this is crucial to the health of the Borders. The inequalities have been exacerbated over the last year and the Scottish Government are consulting on how to address inequalities identified. Lynn Gallcher noted to include unpaid cares in this. Linda Clotworthy asked if the impact of Covid on mental health had been included. Philip advised that it looks at how people use our services and this will include mental health services as a priority. To explore if services are where they are needed most. The Equality and Diversity forum is back up and running and Philip confirmed they are involved.

The **STRATEGIC PLANNING GROUP** noted the content of the report and thanked Philip Lunts for his presentation.

8. HEALTH AND SOCIAL CARE ENGAGEMENT: CONVERSATION WITH COMMUNITIES – Clare Oliver

The Chair welcomed Clare Oliver to the meeting. New initiatives have taken place in the past month and have been successful. 60 people have come forward to support the new programme. There will also be a general event with an open invite to the community. Clare noted that they are keen to get the views of carers and service users. To make a plan on how to move forward and make sure conversations are meaningful. Rob McCulloch-Graham noted that concerns had been raised that there was a perception that work had not begun. Work is being done both in SBC and NHS and there is a greater need to publicise this. The progamme aims to develop a different relationship with residents of the Borders.

The **STRATEGIC PLANNING GROUP** noted the report and the Chair thanked Clare Oliver for her presentation.

9. WORKFORCE STRATEGY – Andrew Carter and Bob Salmond

The Chair welcomed Andrew Carter and Bob Salmond to the meeting.

Rob McCulloch-Graham noted that there has been a lot of work carried out by NHS, working with lots of partners, on the workforce strategy. There is still more work to be done. The focus is currently on NHS but the next stage is to expand to IJB and other areas. Graeme confirmed the information will be expanded and will be brought to SPG and IJB in the future.

Andrew presented a PowerPoint presentation of the early draft strategy, for comment.

The workforce strategy will help develop the workforce work stream. Andrew introduced Bob as the lead on this project. The aim is to have the right people at the right place, at the right time. To work more integrated than previously. Covid19 has made this a priority and so to use the lessons learnt to produce a 2021-24 integrated workforce plan. The Scottish Government have asked Health Boards and IJBs for a 1 year plan to give a compass bearing/direction of travel, as statutory agencies. A template was given to be completed in 7 weeks. Feedback is expected in a month's time.

A working group has been set up with partnership and stakeholder representation to focus on the 31st March 2022 deadline for the new 3 year plan. The group will ensure it engages with all partnerships next year.

The Chair thanked Andrew and Bob and invited comments from members.

Colin McGrath asked if the document could be paginated. Andrew noted that later draft versions have been but this is an earlier draft version brought for discussion. Colin asked if integration has taken place as intended by the IJB. Andrew noted that staff are on statutory contracts with NHS or SBC and have not merged but people are working closely. Bob noted that NHS staff have transferred from admin to hands on but not across H & SC. This has resulted in staff being re-skilled as an emergency response to the pandemic. Colin asked if this would continue, as a principle, and Bob confirmed they will have a protocol on how staff can be redeployed in the future. Colin asked if there are any problems recruiting staff in the Borders. Bob confirmed how links have been made with NHS Lothian and joint appointments made. Colin asked if he could share this information and Bob noted he would need to confirm this with management first. David Bell asked when a will there be a link between the 2 organisations as it has taken 2 years to get a basic outline. Andrew said he is happy to work with SBC and there will be workshops looking to get both staff to the same level. Part of the next 3 year plan. Jenny Smith added that the 3rd sector will want to contribute but do not have the resources to collect information. To be involved with the workforce work stream group. Andrew confirmed he is more than happy to work with the 3rd sector.

Lynn noted the importance on patients and unpaid carers of staff having the correct skills and competences to perform their job well and this should be included in the plan. There is a common theme around communication being an issue. Andrew reiterated the need for the right people in the right job at the right time with the right skills. A new training board has been set up to look at these issues. David Bell added further development across the whole of H & SC is needed.

Staff have moved into different setting during the pandemic working alongside other sectors when there have been issues. This has been done voluntarily and has been beneficial. A challenge – a blurring of edges for some professions. Jen Holland added that SBC want to develop a training route with training recognised across all areas. Colin noted that the community should be involved in decision making and that the integration of staff may have an impact on the community.

Linda Clotworthy added that communication has been a big issue raised by NHS staff. There is a need to look at other avenues of communication so information can reach staff on time. This is not just an NHS issue. A platform where staff can log on from anywhere to get the information they need. The Chair confirmed this is a good point raised. Andrew and Bob to look at a platform for those who do not have access to the internet. They confirmed SBC are looking at this as part of the digital transformation. Jen Holland added that this had been an issue noted that SBC are rolling out 'Total Mobile' which could be a good tool and a portal for all providers so everyone has access to information.

The **STRATEGIC PLANNING GROUP** noted the discussion.

10. ANY OTHER BUSINES

Rob McCulloch-Graham offered his sincere thanks to Malcolm Dickson for his chairing of this group for this term. Colin McGrath and others thanked him too. The Chair thanked members for their support. Lucy O'Leary was welcomed as the chair for the next term.

Colin McGrath asked about the concept of putting the service user at the centre and that their views mattered. The Community Empowerment Act gives empowerment to the community. Colin suggested replacing engagement with empowerment. Colin asked why The Equalities Act 2010 was quoted as it has been around for a long time. Philip explained that this was just for context for the group; a reminder of its importance. Colin advised that he has been asked by SBC to write to the Government for comments on The Community Empowerment (Scotland) act 2015. There will be significant changes that will affect the IJB.

The **STRATEGIC PLANNING GROUP** noted the discussion.

11. DATE AND TIME OF NEXT MEETING

The Chair confirmed the next meeting of the Strategic Planning Group would be held on Wednesday 4 August 2021, at 10am to 12pm via Microsoft Teams.