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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, 22nd September, 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 financia identifying the relevant agenda item a*	**Chair**	Verbal
10.05	**3**	**MINUTES OF PREVIOUS MEETING** 3.1 26.05.2021 3.2 28.07.2021	**Chair**	(Pages 3 - 16)
10.10	**4**	**MATTERS ARISING** 4.1 Action Tracker (Attached.)	**Chair**	(Pages 17 - 20)
10.15	**5**	**FOR DECISION**		
	5.1	Strategic Risk Register Update	**Chief Internal Auditor**	(Pages 21 - 32)
	5.2	Outline Business Case - Complex Care Unit for Adults with a Learning Disability	**General Manager MH&LD**	(Pages 33 - 46)
	5.3	Scottish Borders Care Home Modelling	**Strategic Planning Lead**	(Pages 47 - 98)
	5.4	Appointment of External Member of IJB Audit Committee	**Chair of Audit Committee**	(Pages 99 - 100)

	5.5	Annual Performance Report 202/21	**Programme Manager**	(Pages 101 - 202)
	5.6	Scheme of Integration Update and Timetable	**Chief Officer**	(Pages 203 - 206)
11.30	**6**	**FOR NOTING** Monitoring and Forecast of The Health And Social Care Partnership Budget 2021/22 At 30 June 2021	**Chief Financial Officers**	(Pages 207 - 214)
11.55	**7**	**ANY OTHER BUSINESS**	**Chair**	
12.00	**8**	**DATE AND TIME OF NEXT MEETING** Wednesday, 15 December 2021 10am to 12pm Microsoft Teams	**Chair**	

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, Mrs Netta Meadows, Chief Executive 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.

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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

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 28 July 2021** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr T Weatherston
Dr K Buchan GP
Dr L McCallum, Medical Director
Mr D Bell, Staff Officer SBC
(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
Mr N Istephan, Chief Executive, Eildon Housing
Ms V McPherson, Partnership Chair NHS
Dr T Patterson, Director of Public Health
Mrs L Gallacher, Borders Carers
Mrs J Smith, Borders Care Voice
Mr S Easingwood, Chief Social Work and Public Protection Officer
Ms L Jackson, LGBTPlus

In Attendance:

Miss I Bishop, Board Secretary
Mr R Roberts, Chief Executive NHS
Mrs N Meadows, Chief Executive SBC
Mr D Robertson, Chief Financial Officer SBC
Mr A Bone, Director of Finance NHS
Ms J Holland, Chief Operating Officer SBCares
Ms S Bell, Communications Manager SBC
Ms C Oliver, Communications Manager NHS
Mr G McMurdo, Programme Manager, SBC
Ms S Flower, Chief Nurse Health & Social Care Partnership
Mrs L Jones, Head of Quality & Clinical Governance NHS
Ms S Holmes, Principal Internal Auditor SBC
Mr C Myers, General Manager Primary & Community Services NHS
Ms M Baird, Programme Manager NHS

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr Shona Haslam, Cllr Elaine Thornton-Nicol, Cllr J Linehan, Mrs Morag Low, Service User Rep, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs and Mrs Jill Stacey, Chief Internal Auditor.

1.2 The Chair welcomed Mrs Sue Holmes, Principal Internal Auditor who was deputising for Mrs Jill Stacey.

1.3 The Chair welcomed Mrs Susie Flower, Chief Nurse Health & Social Care Partnership who was deputising for Mrs Sarah Horan.

1.4 The Chair welcomed guest speakers to the meeting including Mr Chris Myers and Mr Graeme McMurdo.

1.5 The Chair confirmed that Cllr John Greenwell had stood down as a voting member of the Integration Joint Board (IJB) and had been replaced by Cllr Jenny Linehan.

1.6 The Chair formally recorded Mr Malcolm Dickson, Non Executive and Vice Chair of the IJB would stand down from the IJB on the conclusion of his appointment as a Non Executive with NHS Borders on 31 July 2021. The Chair recorded the thanks of the IJB to Mr Dickson for his tenure on the IJB and chairmanship of the Strategic Planning Group and wished him a long and happy retirement.

1.7 The Chair confirmed that the Health Board at its meeting on 1 April 2021 had agreed that Mrs Lucy O'Leary, Non Executive would replace Mrs Sonya Lam as a voting member of the IJB and the IJB Audit Committee and would also be nominated as the Vice Chair of the IJB as per the Scheme of Integration on Mr Dickson's appointment conclusion. The Chair welcomed Mrs O'Leary to the meeting.

1.8 The Chair commented that the Health Board would make a further Non Executive appointment to the IJB in due course.

1.9 The Chair announced that Mrs Morag Low, Service User Rep had decided to step down from the IJB as she has decided to return to work as part of the immunisation team as a vaccinator. He recorded his congratulations to her on going back to work on the front line and wished her well for the future.

1.10 The Chair announced that Mr Rob McCulloch-Graham had decided to retire from his post as Chief Officer in the autumn and a recruitment process had been launched for a new appointment to be made.

1.11 The Chair confirmed that the meeting was not quorate and therefore no formal decisions could be made by the IJB at the meeting.

2. DECLARATIONS OF INTEREST

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

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

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 26 May 2021 were amended to record the apologies of Mrs Netta Meadows.

The minutes would be resubmitted to the next meeting of the IJB for formal approval.

4. MATTERS ARISING

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

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

5.1 Mrs Karen Hamilton provided an overview of the content of the report which outlined the activity of the IJB Audit Committee over the course of the past year.

5.2 Mr Tris Taylor enquired if the Audit Committee had looked at care and quality issues. Mrs Hamilton confirmed that the Audit Committee was an assurance body to review and examine audit reports and had cognisance of quality and care but would not have any direct impact.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** deferred approval of the IJB Audit Committee Annual Report 2020/21 until the next formal IJB meeting.

6. ANNUAL PERFORMANCE REPORT 2019/20

6.1 Mr Rob McCulloch-Graham recorded his thanks to Mr Graeme McMurdo for producing such a major piece of work.

6.2 Mr McMurdo provided an overview of the content of the report and highlighted that publication would take place in November and the content of the report was set by legislation as it was a report to the Scottish Government and had to include performance data. He commented that narrative had been included on the response of services during the pandemic and he had included examples at each spotlight objective.

6.3 Discussion focused on: understanding if the level of need for chronic conditions had been met and at what level; strengthening input from public health to get the needs assessment done for the next chapter; were the targets ambitious enough; page 46 tables needed amending; strengthening the “What we did section” in terms of carers, respite, older peoples survey, dementia and maternity; page 8 show “shifting the balance of care” as a movement over time; as a public facing document it required communications input to make it more short and snappy; lack of benchmarking information; what we said we would do, what we did and what we didn’t do appeared to be all mixed together leading to confusing statements; page 33 on last years’ priorities for carers support and progress made, could be strengthened; should it have a collaborative statement to show it had been coproduced by partners; and the inclusion of benchmarking data should allow a greater transparency of reporting.

6.4 Mr McMurdo commented that he would amend the tables on page 46; would work with Lynn Gallacher on the “What we did section”; as the document was a legislative requirement it did not lend itself to being easily digestible in the public domain and a short executive summary public facing document would help that; in terms of benchmarking information he agreed that it would be helpful to have benchmarking data in order to set targets and see

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progress over time. He advised that the format of the report could be changed but the indicators shown had to be included and he welcomed the support to form a baseline of data.

6.5 Cllr Weatherston suggested more emphasis was given to healthy lifestyles.

6.6 Mrs Lynn Gallacher suggested more emphasis also be given to the third sector role in being a quality partner supporting the partnership to achieve its strategic aims.

6.7 Mr McCulloch-Graham commented that he was keen that comparisons in data were included in the report and more of the progress against the benchmarking data for the whole of Scotland would be emphasised. He further commented that the Annual Report was focused on the past year and the Commissioning Strategy would be the document that would focus on future years.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** discussed the draft Annual Performance Report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** wished to suggest the APR be demitted to the Strategic Planning Group and would make a formal decision on that at the next quorate meeting.

7. PRIMARY CARE IMPROVEMENT PLAN UPDATE

7.1 Mr Chris Myers presented the Primary Care Improvement Plan update to appraise the Board on the high level progress made on the implementation of the plan, progress of workstreams and a number of associated risks including financial risks.

7.2 Dr Kevin Buchan advised that services had been delivered that were helpful to GPs and highlighted physiotherapy services as an example. In terms of the Renew service he advised that there would be more people being medicated without that service and the development of the PCIP allowed GPs to get to a certain level to deliver complex care locally.

7.3 Discussion focused on: equality issues; patient experience; significant amount of underspend; and potential impact of long Covid.

7.4 Mr Myers confirmed that a Health Inequality Assessment had been undertaken for the whole programme and the individual workstreams had yet to complete them. However the Vaccination workstream given its advanced state had completed an HAII. In terms of patient feedback there had not been much received and that area would be looked at in the future. With regard to underspend the uncommitted line showed £346k uncommitted for the current financial year and the following financial year was likely to be a recurrent gap of £2.4m when the assumed £500k vaccination funding was taken off, so there was not a significant underspend for uncommitted funding. As carry forwards were not permitted all funding would be committed.

7.5 Dr Buchan commented that long Covid would revert back to GPs given it was a complex group of symptoms that GPs were best placed to recognise and advise on and the support from the PCIP would allow GPs to elevate to the Medical General experts that they were.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report, the risks, and actions being undertaken to reduce the risks.

Ms Linda Jackson left the meeting.

8. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET 2020/21

8.1 Mr David Robertson presented the formalised position as outlined at the previous meeting which reflected the financial performance of the IJB to 31 March 2021. He highlighted the financial bottom line which was wholly attributable to ring fenced funding carried forward, with the position realised after significant contributions were made to the IJB by the partners throughout the year. He further drew the attention of the Board to sections 3.3 and 3.4 of the report, set aside budge and the overall balance held by the IJB.

8.2 Mrs Lynn Gallacher noted that costs appeared to be lower than had been expected and she enquired how funding had been used and sought a breakdown of the £1.56m additional monies to the Borders for the implementation of the Carers Act. Mr Robertson confirmed that he would share the breakdown of the carers fund money and the use of the additional funding with Board members for absolute clarity of funding streams.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the final outturn position for the Partnership for the year to 31 March 2021;

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

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

9. CLINICAL & CARE GOVERNANCE REPORT 2020/21

9.1 Mrs Laura Jones introduced the report and highlighted that the report sat alongside the Chief Social Work Officer report. The significant theme through the report was clinical prioritisation of services and the need to distribute professional groups across a wide range of services to support the response to the pandemic. She drew the attention of the Board to the remobilisation of services and the pressure points that remained in the system which included emergency access systems, elective pressures, community services pressures, and staffing pressures. She also highlighted the inspection of Hay Lodge and the recommendations and actions that had been progressed on the back of the inspection report.

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9.2 Mrs Lucy O'Leary enquired how the pressure points could feed into the future commissioning strategy of the IJB and as a general reader she found the report difficult to navigate and would appreciate paragraph numbering in future.

9.3 Mrs Jones commented that she would be happy to change the format of the report in future. She advised in terms of the pressure points that a detailed review of the Child, Adolescent Mental Health service (CAMHS) and Psychological Therapies service had been undertaken. A long term business plan was required and would be routed through the IJB.

9.4 Mr Rob McCulloch-Graham commented that the commissioning of services around CAMHS to prevent the flow into CAMHS would assist. He suggested that could potentially be achieved by commissioning more resource into the Renew service, which currently focused on adults but could then deal with Adolescents and Children and would then reduce the impact on CAMHS. So it would be about how the IJB commissioned differently instead of doing more of the same.

9.5 Mr Malcolm Dickson enquired about the funding arrangements for support into care homes. Mrs Suzie Flower highlighted that funding was non recurrent, however there had been a commitment to support the team long term to work with care homes and support residents.

9.6 Mrs Lynn Gallacher enquired about the term "deteriorating patients", given some carers were reporting that people were being discharged from hospital with more cognitive decline then when they were admitted. Mrs Jones clarified that "deteriorating patients" referred to the state of the patient on admission to hospital as patients were more acutely ill with the need for either life saving intervention or treatment for end of life care. Patient acuity was monitored through the NEWS system which was run in all inpatient areas. Also as part of the clinical improvement work it was apparent that patients were presenting in a more deconditioned state to hospital and on discharge. It was a trend across NHS Scotland as well as increase in falls and the impact of the pandemic on patient deterioration on admission was unclear at present.

9.7 Dr Lynn McCallum welcomed the point and suggested it reinforced the need to shift the balance of care from the secondary care hospital based model into the community to get people home as quickly as possible and to provide rehabilitation in their own home.

9.10 Mr Ralph Roberts flagged to the Board that some of the issues in the report were extremely significant in terms of current service pressures on the whole system. In the context of the IJB being that whole system it was important that members understood it was the most significant pressure on the system ever seen in a summer. It was important to think about in terms of strategic commissioning going forward and also in terms of operational oversight.

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

10. COLDINGHAM BRANCH SURGERY

10.1 Mr Chris Myers provided an overview of the content of the report.

10.2 Dr Lynn McCallum commented that she had spent the previous afternoon in Eyemouth at the Medical Practice and had an in-depth conversation with the GPs about the Coldingham Branch Surgery. She commented that it was evident that there had been a lot of soul searching amongst the GP partners who had worked to the best of their ability to maintain the service for as long as possible. They had been disheartened by the feedback they had received given they were working long days and missing out on family time in order to keep the branch surgery open.

10.3 The Chair commented that it could not have been an easy decision for GPs to make to withdraw from the branch surgery.

10.4 Mr Nile Istephan enquired if similar pressures existed across all Medical Practices across the region and what that would mean for the provision of services Borders wide. He also commented that he was mindful that where additional housing provision was made there was a direct read across to associated services for the population.

10.5 Mr Myers confirmed that the situation was not unique to Eyemouth and other GP practices faced other challenges such as recruitment of GPs.

10.6 Dr McCallum commented that whilst there were a number of larger GP Practices there were a significant number of smaller practices with only 3-4 GPs and if one was unwell or retired it had a massive impact on the remaining GPs and could derail those Practices. Sustainability and the current climate and workload the GPs were operating in were phenomenal and could not be underestimated. The PCIP would go some way to mitigating some areas such as assisting with workload, but there was further work to be done on retirement options, recruitment and career options.

10.7 Dr Buchan commented that currently the Borders were down by 10 partner GPs which equated to about 10% and made GP Practices fragile. GPs had been blindsided by the change in the GMS contract which made the central belt more attractive to GPs and caused difficulties with rural GP recruitment. The main key for Borders was the quality of life and work life balance that it offered. Although the language during discussion had been predominantly negative with the support of the PCIP there was still a huge positivity on where GPs were and what they could do in the future.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current situation relating to the sustainability concerns of the Coldingham Branch Surgery.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a Short Life Working Group had 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.

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The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a public consultation was currently being undertaken and was due to close on 9th August 2021. All patients registered with Eyemouth Medical Practice had been sent a letter informing them of the situation and to invite responses to the consultation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that an update paper would be drafted for a future Board meeting that would make recommendations on the future provision of services in Coldingham Branch Surgery.

11. STRATEGIC PLANNING GROUP MINUTES

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

12. ANY OTHER BUSINESS

12.1 No further items of business were raised.

13. DATE AND TIME OF NEXT MEETING

13.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 22 September 2021, from 10am to 12noon, via Microsoft Teams.

SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Meeting held 19 August 2020

Agenda Item: Primary Care Improvement Plan: Update

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

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	G

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

Meeting held 28 July 2021

Agenda Item: Minutes of the Previous Meeting

Action	Reference	Action	Action by:	Timescale	Progress	RAG

Number	in Minutes					Status
1	3	The minutes would be resubmitted to the next meeting of the IJB for formal approval.	Iris Bishop	September 2021	**Complete:** Minutes included in 22 September 2021 meeting pack.	

Agenda Item: Scottish Borders Health and Social Care Integration Joint Board Audit Committee Annual Report 2020/21

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2	5	The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** deferred approval of the IJB Audit Committee Annual Report 2020/21 until the next formal IJB meeting.	Iris Bishop	September 2021	**Complete:** Report included in 22 September 2021 meeting pack.	

Agenda Item: Annual Performance Report 2019/20

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
3	6	The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** wished to suggest the APR be demitted to the Strategic Planning Group and would make a formal decision on that at the next quorate meeting.	Rob McCulloch-Graham	September 2021	**In Progress:** Decision to be made at the 22 September 2021 meeting.	G

KEY:	
	Overdue / timescale TBA
	<2 weeks to timescale
	>2 weeks to timescale

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 22 September 2021

Report By:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact:	Jill Stacey (Chief Officer, Audit and Risk) Emily Elder (Corporate Risk Officer)
Telephone:	Jill Stacey – 01835 825036 Emily Elder -01835 824000 Ext: 5818

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD STRATEGIC RISK REGISTER UPDATE

Purpose of Report:	The purpose of this report is to provide Members of the Board with an update of the most recent review of the IJB Strategic Risk Register as it is important that the Board is kept informed of the IJB's key risks and the actions undertaken to manage these risks.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Consider** the IJB Strategic Risk Register to ensure it covers the key risks of the IJB; b) **Note** the actions in progress to manage the risks; and c) **Note** that a further risk update will be provided in December 2021.
Personnel:	In line with the role and responsibilities, the IJB's Chief Officer has carried out the current review of the IJB Strategic Risk Register on 26th August and 2nd September 2021, supported by SBC's Corporate Risk Officer.
Carers:	There are no direct carers' impacts arising from the report.
Equalities:	There are no equalities impacts arising from the report.
Financial:	There are no direct financial implications arising from the proposals in this report.
Legal:	Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.
Risk Implications:	Risk Management arrangements will assist the IJB making informed business decisions and provide options to deal with potential problems in line with its agreed Risk Management Strategy within its governance arrangements.

Background

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

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

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

2.4 While the Risk Management Policy and Strategy states that six monthly risk reviews should be presented to the Board in June and December each year, the disruption caused by Covid-19 during 2020 and ongoing into 2021 has meant that only one report was formally presented to IJB full Board on 19 August 2020, and this one on 22 September 2021. The aim going forward is to align with the agreed schedule and as such the next strategic risk update will be presented to the IJB full Board in December 2021.

Summary

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

3.2 The IJB Chief Officer carried out a management review of the risk register on 27 July 2020, presented in August 2020. Subsequently, there were also reviews in February and May 2021. The most recent management review of the IJB Strategic Risk Register has taken place on 26th of August and 2nd September 2021 (over a spilt session), taking into consideration the continued impact of Covid-19 and, to a certain extent, Brexit, on governance, commissioning and service delivery arrangements. The review was undertaken by the IJB's Chief Officer in line with his role and responsibilities and was supported by SBC's Corporate Risk Officer.

3.3 As part of this review, a further risk for the IJB and delegated services, was considered, potentially arising from the Scottish Government consultation on the National Care Review. Any proposals for change in structure and uncertainty over the future delivery of health and social care policy could result in a delay of implementing strategic commissioning decisions by the IJB.

3.4 A high level summary of the IJB's Strategic Risk Register, which sets out the strategic risks associated with the achievement of objectives and priorities within the

IJB's Strategic Plan, is shown in Appendix 1. There are currently 10 risks on the IJB Strategic Risk Register; one Red, eight Amber and one Green.

3.5 Changes on specific risks for the IJB to note since the previous report to the IJB Board on 19 August 2020 include:

- IJB002 (Efficient use of resources), while remaining Amber, has increased from a score of 9 to a 12 (after previously being reduced from a 12 to a 9 in February 2021, as a result of improvements in joint working, greater transparency and lessons learned from Covid-19). At the most recent review the likelihood was reassessed from 3 (Possible) to 4 (Likely) to reflect the fact that the risk description has been updated to give reference to the need for an effective Commissioning Plan, without which the direction of resources may not facilitate the achievement of expected outcomes or best value. It has been acknowledged that strong direction is needed from the IJB in order to make most effective and efficient use of resources and while a Commissioning Plan is being developed it is has not yet been agreed or implemented. Once in place the plan will have a significant and positive impact on this risk, allowing for a greater understanding of the nature of demand for services and the read across from health to social care (e.g. the balance of care).

- IJB003 (Future market for care), while remaining Amber, has increased from a score of 8 to a 12 (after previously being reduced to an 8 from a 12 in May 2021, reflecting the fact that partners and external providers had become much more experienced and able to react efficiently and effectively to the challenges brought about by Covid-19 by e.g. increasing capacity where needed). At the most recent review the likelihood was reassessed from 2 (Unlikely) to 3 (Possible) as we are currently falling short on packages of care, with demand surpassing our current ability to supply.

- IJB006 (Workforce that is fit for purpose), has changed significantly from an Amber (6) to a Red (16) with the risk score increasing in terms of both likelihood, from a 2 (Unlikely) to a 4 (Likely), and impact, from a 3 (Moderate) to a 4 (Major). This increase is a result of the ongoing impacts of Covid-19 on staff sickness/absences and the requirement to self-isolate from contact with positive cases, all of which has led to a significant shortage of staff across all services. There has also been a notable impact on service users in the form of greater increases in admissions to hospital, increases in delayed discharges through an inability to allocate care and the ultimate need to postpone elective surgeries which has a knock on impact to secondary care.

- IJB009 (Programmes and project management), while remaining Amber has increased from a score of 6 to a 9. At the most recent review the likelihood was reassessed from a 2 (Unlikely) to a 3 (Possible) to express the fact that the current CO is soon to retire, and that the CFO post remains vacant. The need to recruit to these posts, in line with the required changes to the management structure previously identified as being necessary, have a direct bearing on the continuity and subsequent success of programmes and projects. The advent of the Feeley review of adult social care further complicates the aforementioned plans to revisit the management

structure/leadership team, and only when the two vacant posts are filled can changes be made that will ultimately facilitate the implementation of the recommendations stemming from the review.

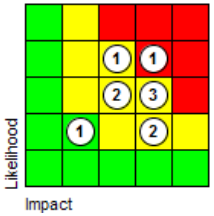
3.6 This report and the IJB Strategic Risk Register are intended to provide the Board with assurance that the strategic risks associated with the achievement of objectives and priorities within the IJB's Strategic Plan are being effectively managed and monitored.

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

3.8 The IJB Strategic Risk Register will continue to be reviewed alongside the implementation of the Strategic Plan by the IJB's Chief Officer on a quarterly basis with support from SBC's Corporate Risk Officer. A further update will be presented to the Board in December 2021 i.e. on a six monthly basis in line with the IJB's Risk Management Policy and Strategy.

IJB Risk Register (Summary)

Last Reviewed on: 26th August & 2nd September 2021



Scottish Borders
Health and Social Care
PARTNERSHIP

Risk Code	Risk Title	Risk Description	Risk Score	Status	Trend	Last Review Date	Risk Approach	Update
IJB001	Cultural change	If the required change in culture is not achieved then the delivery of the Partnership's strategic objectives may be delayed or may not be fully met	8 Major - Unlikely			26-Aug-2021	Treat	**Update from meeting with RMcC-G on 26.08.2021:** It is still the case that the advent of the Pandemic has demanded closer working of the senior Executive Teams of the Council and Health Services. Communications have improved and there is a greater understanding of agendas across organisations within the partnership. As per the previous update and with regards to Internal Control "Joint NHS/SBC Meetings" it should be noted that these meetings have now moved to fortnightly and a further TOR is being developed as progress has been made in response to both Covid-19 and the ongoing work of the IJB. Also, with regards to Internal Control "Appointment of temporary Director of Finance" - In light of the Feeley Report and the expected changes within the Executive Teams of NHSB and SBC a further review is underway for the IJB Exec Team which will include the appointment of a CFO. It should be noted that the current Chief Officer is now retiring in October 2021. The appointment process for a new CO as well as a new CFO has begun and a new Linked Action has been added to reflect this. Internal Control "Permanent Chief Officer" has also been reassessed and changed from Fully to Partially Effective in light of this. It was also noted that there is a continuing risk that new appointments might not be made and if so interim arrangements for both positions will be introduced. No change to Current Risk score at this review.

IJB002	Resources	If we do not ensure that an effective Commissioning Plan is agreed, and the required resource are directed by the IJB and allocated by NHSB and SBC then we may not secure the expected outcomes or achieve best value.	12 Moderate - Likely			26-Aug-2021	Treat	**Update from meeting with RMcC-G on 26.08.2021:** Risk Description has been amended from "If we do not ensure that resource directed by the IJB is used efficiently and effectively then we may not achieve best value" to read "If we do not ensure that an effective Commissioning Plan is agreed, and the required resource are directed by the IJB and allocated by NHSB and SBC then we may not secure the expected outcomes or achieve best value. Risk Factors updated to include: "Lack of a Strategic Commissioning Plan; Lack of joined-up working and shared understanding; Lack of strong direction from the IJB; Vacant senior posts; Increased pressure on care service (e.g. from demand); Failure to understand demand and subsequent resource requirements." Risk Consequences updated to include: "Negative financial implications; Negative impacts on ability to fund care if balance of care cannot be amended; Resources are not effectively or efficiently used; Demand outstrips supply." New Linked Action "Develop Strategic Commissioning Plan" added, assigned to the IJB with a placeholder date of 31.03.2022. *Action also to be assigned to the new CO once in post.* As per the last review and with reference to Internal Control "Appointment of temporary Director of Finance" - In light of the Feeley Report and the expected changes within the Executive Teams of NHSB and SBC a further review is underway for the IJB Exec Team. It should be noted that the recruitment process for the appointment of a new CO and CFO is underway and a new Linked Action has been added to reflect this. The Joint Executive Team TOR has been agreed and support for the development of the Strategic Commissioning Plan has been allocated. There is a continuing risk, however, that this support may not be sufficient. Further work on the restructure of all Exec Teams across the partnership (reflected as a Linked Action) should reduce the likelihood to a 2 (Unlikely). Current Risk score reassessed and Likelihood increases from 3 (Possible) to 4 (Likely), while Impact remains the same.

IJB003	Future market for care	If the future market for care is insufficient to meet increasing demand then there may be gaps in service provision and poor outcomes/choices	12 Major - Possible			26-Aug-2021	Treat	**Update from meeting with RMcC-G on 26.08.2021:** As per the last review Covid-19 has developed more sufficiency within the community to care for those in lesser need, therefore we have been able to increase capacity. However, the impact of another cluster outbreak within one or more care homes, would significantly reduce our ability to staff at the required level. Relationships with independent care providers has also improved significantly. We are currently modelling demand for both hospital beds and residential care capacity. This will inform a further review of the IJB Strategic Plan, which will aim to recommission to an appropriate level of residential care. We expect to reduce the Likelihood of this risk to a 1 (Remote) following the implementation of this plan. Target Risk updated to reflect this and given a due date of 31.03.2023. It should also be noted that Scottish Care have been contracted with to employ an Independent Care Sector Representative. Funding for this post is currently short-term from slippage and it will need to be mainstreamed within the 2022/23 budget agreement *(consider adding this representative as an Internal Control at the next review).* Internal Control "Strategic Oversight Group" has been removed and replaced with "Joint Executive Team and the Senior Management Group for the Strategic Commissioning Plan". Control assessed as Partially Effective. With regards to Linked Action "Market Facilitation Plan" it is worth noting that we continue to meet to discuss this. We have appointed an independent co-ordinator to help pull this together. No change to % completion at this review. Linked Action "Review of IJB SIP" has been updated to read "...as part of the development of the new Strategic Commissioning Plan". No change to % completion at this review. Current Risk score reassessed and as we are short on packages of care Likelihood increases from 2 (Unlikely) to 3 (Possible). Impact remains the same.

IJB004	Stakeholder engagement	If we do not ensure that we have a partnership approach when communicating and engaging with stakeholders then we may fail to get them to play their part in delivering the partnership's strategic objectives	9 Moderate - Possible			26-Aug-2021	Treat	**Update from meeting with RMcC-G on 26.08.2021:** With the publication of the Feeley Report Scot Gov is considering its recommendations. As part of this a major consultation exercise began on 08.08.2021 and will conclude of 18.10.2021. The intended outcome of the consultation is the creation of a National Care Service which will have major implications on the whole of the Health and Social Care Partnership, along with the future of LAs and NHS Boards. There is an expectation that the consultation will be wide ranging and fully inclusive and IJBs have been given a specific role as champion for the consultation across all parties. The risk with this is that parties will have differing and potentially opposing views and this could present difficulties for the IJB in terms of challenges relating to culture and relationships. With regards to Linked Action "New Integrated Communications Strategy..." it is worth noting that the meetings between SBC and NHS Comms Teams have started again. The due date for this action has been amended from 31.07.2021 to 01.01.2022. No change to Current Risk score at this review but Target Risk revisited and due date changed from 31.10.2021 to 30.04.2022.
IJB005	Delegated Budget	If both Partners do not sufficiently and rigorously plan and manage their Efficiency and Savings Programmes then the delegated budget may continue to overspend leading to inability to commission sufficient services to deliver the strategic objectives	12 Major - Possible			02-Sep-2021	Treat	**Update from meeting with RMcC-G on 02.09.2021:** Even though the IJB has still to appoint its Chief FO, the interim measures in place which include SBC Director of Finance acting as the Section 95 Officer for the IJB, have operated well. Both SBC and NHSB Directors of Finance continue to work closely with the CO, and are supported by the financial leads within the Council and NHSB. This arrangement although working well does place significant stress across the three agencies. We are currently advertising the CFO post which will remedy this. A new Linked Action has been added to reflect this along with the need to recruit a new CO as the current one is retiring. Budget planning and monitoring have continued and has been further complicated by the requirement to fund additional services and provide further resources as demanded by the current pandemic. These officers identified here have successfully implemented additional budgets through the Scottish Government's Remobilisation Funds. Work continues to secure the joint budget plan for 2021/22 and we expect this to complete before the end of this calendar year. No change to Current Risk Score at this review.

SRB006	Workforce	If we do not have a workforce fit for purpose now and in the future then the Partnership may fail to deliver on the strategic objectives leading to poor outcomes	16 Major - Likely			02-Sep-2021	Treat	**Update from meeting with RMcC-G on 02.09.2021:** As per the last review and with reference to Brexit there have been no negative impacts felt yet in terms of workforce availability. However, it has proved difficult, in general, to appoint mid-range Social Workers. We also continue to develop a new marketing model to promote the Scottish Borders as an attractive place to live and work, with attractive employers and subsequent opportunities. Due date of Linked Action "Develop a new marketing model..." has been updated and changed from 01.06.2021 to 31.03.2022 and it should be noted that this is being undertaken by the workforce workstream of the SIP which is led by Clair Hepburn and Andrew Carter. Although we have experienced little impact as yet from Brexit, there has been a significant impact from the Covid-19 pandemic. This has been due to sickness/absence and the requirement for staff to self-isolate after contact with a positive case. We have seen significant shortages of staff across all services. The biggest impact on service users has been through: greater admissions to hospital; increases in delayed discharges through an inability to allocate care (both residential and homecare); and ultimately the need to postpone elective surgeries which has impacts on secondary care. Risk Factors and Consequences have both been updated to reflect this. Linked Action "Work underway with Borders College..." is ongoing but as more is still to be done on this the due date has been changed from 31.07.2021 to 31.03.2022. Internal Control "New GMS contract" has been reassessed and changed from Fully to Partially Effective. New Internal Control "Staff flexibility increased to provide support in e.g. home and residential care settings and creation of a care and nursing staff mix" has been added and assessed as Fully Effective, reflecting one of the measures we had available to offset the effects of Covid-19 on the workforce if needed. It is worth noting that while this was developed we did not need to implement it to a great extent. New Internal Control "To facilitate the skill mix, support and advice are provided along with monitoring across the whole care provision through the Oversight Care/Operational Group" has also been added and assessed as Fully Effective. Lastly, new Internal Control "Independent Care Sector provides

								mutual support across different companies and share staff" added and assessed as Partially Effective. In light of the impacts that Covid-19 has had on the workforce and the subsequent knock-on impacts to e.g. delayed discharges, the allocation of care and postponement of elective surgeries, the Likelihood of this risk has increased from a 2 (Unlikely) to a 4 (Likely) while the Impact has increased from 3 (Moderate) to 4 (Major). Similarly, the original Target Risk was felt to be unachievable in the current context within which we are operating and given the knock-on impacts of Covid-19, that hitherto were completely unforeseen, the Target Risk has also been reassessed and revised up from a Likelihood of 1 (Remote) to 3 (Possible) and from an Impact of 3 (Moderate) to a 4 (Major), with a date of 01.05.2022. Once we have reached the new Target will look to revise it down again.
IJB007	Supplier failure	If a significant supplier was unexpectedly unable to fulfil their contract then there may be a serious gap in service provision leading to risk of harm and reputational damage	12 Major - Possible			02-Sep-2021	Treat	**Update from meeting with RMcC-G on 02.09.2021:** As per the last review it remains true that improved communications and relationships with providers has reduced the likelihood of a supplier failing as there are early alert systems in place and we can react as a commissioner much quicker to prevent failure. However, the current pandemic continues to put pressure on this risk. New Internal Control "Monitoring visits, weekly reports and unannounced visits by the Care Inspectorate (all reporting to CHOG)" added and assessed as Fully Effective. No change to Current Risk Score at this review and similar to other risks in the series, going forward the aim is to reduce the Likelihood from 3 (Possible) to 2 (Unlikely) by which point we will be in line with the Target.
IJB008	Harm to service users	If someone under the care of the IJB comes to harm because of a failure attributed to the Partners then this may result is significant reputational damage	8 Major - Unlikely			02-Sep-2021	Treat	**Update from meeting with RMcC-G on 02.09.2021:** Pre-pandemic we acknowledged that some improvements were needed across the fabric of our care estate and with our independent partners. Then, during the pandemic we have also registered some challenges with regards to infection control which were exacerbated by the age and format of the existing care estate. This has been mitigated to some extent by the level of staffing that has been required in each of the care homes. Risk Factors updated to include: "Age and format of care and partner estate/ failure to make improvements to fabric of estate and; With regards to Covid-19 some aspects of current estate has negative impacts on ability to maintain infection control e.g. ventilation."

								Internal Control "Monthly meetings with External Providers to increase Oversight" has been reassessed and changed from Partially to Fully Effective. We are in the process of co-producing a Commissioning Strategy with external partners to provide additional capacity and in so doing rectify some of the poor aspects of the existing estate. This has been added as a Linked Action, assigned to RMcC-G (this will change when the new CO is appointed) and given a due date of 31.12.2022. There is no change to the Current Risk score at this review and the risk remains stable.
IJB009	Programmes/ projects management	If we fail to manage and appropriately resource major programmes/projects undertaken simultaneously then we may be unable to achieve objectives	9 Moderate - Possible			02-Sep-2021	Treat	**Update from meeting with RMcC-G on 02.09.2021:** As per the last update the restructure intended has been impacted by further changes within the Exec Teams of NHSB, SBC and IJB. In addition, with the advent of the Feeley review of adult social care more time is required to determine the shape and function of the Exec Teams across the three organisations, to deliver health and social care. Linked Action "Implement changes to management structure..." has been updated to reflect this and the due date changed from 31.10.2021 to 01.05.2022. The current CO is retiring imminently and as such the opportunity has been taken to review the required skill mix for the leadership team of the IJB. Both the CO and CFO posts are being appointed to now and once in place they will lead on the creation of a new leadership team for the IJB to support and prepare for the recommendations of the Feeley Report. Risk Factors updated to reflect that fact that the current CO is retiring and that the CFO post remains vacant at present. Current Risk score has been reassessed and the Likelihood has increased from a 2 (Unlikely) to a 3 (Possible) as we have yet to appoint to the two aforementioned posts, or put in place the team, however this is only a matter of time. There is no change to the Impact of this risk which remains 3 (Moderate). Target Risk date has been amended from 31.10.2021 to 01.05.2021 in line with the Linked Action.

IJB010	Data Breach	If the Partners lose sensitive data or use data inappropriately then we may be in breach of data protection legislation resulting in fines and reputational damage	4 Minor - Unlikely			02-Sep-2021	Treat	**Update from meeting with RMcC-G on 02.09.2021:** It is worth reiterating that the risk of data breaches lies within the two host agencies. The IJB may have reputational damage, as a result of any failure within the organisations. The Leadership Team of the IJB working within the host agencies, abide by internal controls to mitigate this risk. All staff need to undertake training on data protection through respective agencies. Board members also need to complete an equivalent but this has not happened. We have restarted the Data Governance/Data Control Group *(check with IJB).* There is also a joint NHS/IJB group that focuses on the governance of data and they meet around 4 times per year. This has been added as a new Internal Control and assessed as Fully Effective. With regards to Linked Action "Find out about Mandatory Data Protection Training..." there is a need to have a conversation with the IJB, as indicated above, to find out about the mandatory training that Board members undertake. Risk Management Approach changed from Tolerate to Treat until we know more about the mandatory training undertaken by the Board. No change to Current Risk score at this review.

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 22 September 2021

Report By:	Rob McCulloch- Graham, Chief Officer Health & Social Care
Contact:	Simon Burt, General Manager Mental Health & Learning Disabilities
Telephone:	01896 827152

OUTLINE BUSINESS CASE – COMPLEX CARE UNIT FOR ADULTS WITH A LEARNING DISABILITY

Purpose of Report:	To set out the need for the development of a complex care unit within the Borders to enable the repatriation of adults with a learning disability from out of area placements and to meet future demand. The full outline business case is attached to this report.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the need for additional local capacity within the provision for Adults with Complex Needs. b) To **support** the inclusion of the charity "Cornerstone" to deliver an 8-10 bed complex care facility at Tweedbank as part of the Tweedbank development plan.
Personnel:	None
Carers:	This provision will have a positive impact on carers by providing local suitable accommodation preventing the need to travel out of area. The need for this resource was identified through the development of the Learning Disability Commissioning Strategy which involved consultation with a wide range of stakeholders including family carers.
Equalities:	An EQIA will be carried out
Financial:	Financial implications are detailed within the main report. The total recurring annual saving to the partnership is estimated as £416k
Legal:	Legal and contractual advice has been sought to date and will be on-going as the project develops.
Risk Implications:	• Land would need to be 'gifted' to Cornerstone, thereafter Cornerstone would invest in the development of a purpose built facility at an agreed location in the Borders and meet all of the construction and design costs for the project. • Contractual safeguards will need to be established to

	ensure that the Borders Health & Social Care partnership have the choice to have priority to the 8 – 10 placements. • The proposal is to construct a facility for 8-10 clients in the Borders. There is demand for >10 places, therefore we will continue to require a number of OOA placements. • NHS Borders will need to provide health care services to the tenants (this will be mitigated by the increased likelihood of the provision of high quality local care and support facilities this unit will deliver). • The estimated recurring savings are to the combined Health and Social care budget for Learning Disability services and not solely to one or the other partner organisation.

BUSINESS CHANGE & TRANSFORMATION
Outline Business Case Sept 2021

Recommendations:

1. *The Joint Board recognises and notes the need for additional local capacity within the provision for Adults with Complex Needs.*
2. *The IJB is recommended to support the inclusion of the charity "Cornerstone" to deliver an 8-10 bed complex care facility at Tweedbank as part of the Tweedbank development plan.*

Department	**Health & Social Care**	**Project Manager**	**Susan Henderson**
Service	**Learning Disability**	**Budget Holder**	**Simon Burt**
Project Title	**Complex Care Unit**	**Date signed off**	**14-09-21**
Service Director	**Robert McCulloch-Graham**		

BUSINESS OBJECTIVE – EXECUTIVE SUMMARY:

Background/Current Operating Model

There is a need in the Borders for a local resource to accommodate adults with a learning disability who have high care needs due to complex behaviours.

As at September 2021 there are 17 out of area (OOA) placements for this client group, spread across a large geographical area (across Scotland and England) (Appendix 1). Of these, we anticipate that 6 would be appropriate for this type of support arrangement at the present time.

Out of Area placements can be difficult to source, are often expensive and can be challenging to monitor in relation to quality and safety. Out of area arrangements also make family access difficult which is significantly detrimental to wellbeing.

Reasons for change

The 2018 Scottish Government report, "Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs" concluded that all adults with learning disabilities, including those with complex needs, should experience meaningful and fulfilled lives. This covers where individuals live, as well as the services that they receive. The report stressed that some people with learning disabilities and complex needs are living far from home or within NHS hospitals and that there is an urgent need to address this issue.

One of the recommendations of the recent Independent Review of Adult Social Care is for people to stay in their own communities and to exercise as much autonomy as possible in decisions about their lives.

On 16 February 2021, in a Parliamentary debate on the Independent Review, the Cabinet Secretary announced the "Community Living Change Fund" fund which consisted of £20 million "*to deliver a redesign of services for people with complex needs, including intellectual disabilities and autism, and those who have enduring mental health problems*". A letter to IJB Chief Finance Officers, NHS Directors of Finance and LA Directors of Finance (24th March 2021) gave further guidance as to how the Fund should be allocated and emphasised in Annex B under the sign off arrangements for accessing the Fund that they "*must bring in to play the wider resources under discussion,*

including large hospital budgets (the "set aside"), third sector funding and housing contributions." The fund will focus on delivering a proper sense of home for people with complex needs, including those who have encountered lengthy hospital stays or who might have been placed outside of Scotland, and who could, and should, be more appropriately supported closer to home". The full £20m was allocated to Integration Authorities, via NHS Boards, in February 2021. NHS Borders share of this fund is £377,966 (non-recurring).

Demand

In May 2021, 11 of the OOA placements were split between; 7 residential-based + 4 Hospital-based. Assessment of these individuals indicated that a number could be appropriately repatriated back to the Borders.

Currently there are 17 people placed out of area (Sept 2021) who are suitable for a return at some point in the future; 2 of these people are delayed in hospital placements out of area, awaiting more suitable placements.

6 of these people are deemed suitable for this type of complex care unit if ready to open in 2024/25.

There are a further 19 people placed in other areas throughout the UK who consider their existing placement to be their home and there is no commissioning intention for that to change unless circumstances change significantly.

Predicted Future Demand

In addition to the identified 6 people who would be appropriate for this type of placement, if open in 2024/25 based on current and past data, we have identified a further 3 young people from our "Transitions Tracker", giving a total possible requirement for 9 permanent placements from 2024/25. The historical data shows that over the last 10 years we have required between 11 and 6 complex care placements per year.

In addition, we recommend further exploration towards one additional placement being used as a more appropriate place of safety when required, in place of Huntlyburn Ward, BGH when detention in a healthcare setting is not required.

In summary the historical data and our analysis of the current number of suitable people for a complex care unit supports the need for a local complex care unit with between 6 and 10 placements.

Strategic goal

The guidance outlines that the funding should be used to:

- redesign the way services are provided for people with complex needs
- repatriate those people inappropriately placed outside of Scottish Borders and to deliver the aspiration of the 'Coming Home' report and Community Living Fund guidance
- reduce the delayed discharges of people with complex needs
- mitigate the challenge of monitoring the quality, safety and outcomes of out of area placements.

Options considered

1. To continue purchasing private/3rd sector social care and hospital placements as and when required.

   Evaluation

   As per the financial details for our placements, the cost of private hospital and 3rd sector placements are in general higher than what a locally commissioned service would be. In addition, as can be seen from Appendix 1, the geographical spread of placements contravenes the strategic direction nationally and locally to accommodate people closer to home. Monitoring quality and safety is also problematic.

2. Formal commissioning process.

   Evaluation
   Go out to the Market with commissioning needs and aspirations. Previous soft market testing and local experience shows that this type of service and support is difficult to source, staff and sustain from Providers who are not currently delivering to this level of support arrangement. There is a significant lack of this type of resource within Scotland already.

3. Council provided services

   Evaluation
   SBC do not have the in-house capacity, expertise or experience in developing and managing supported accommodation services of this nature.

4. Cornerstone

   Evaluation
   Cornerstone has formally asked us to provide suitable accessible land to develop a Complex Care Unit as part of their business strategy. As this dovetails with our established commissioning need we will review the type of formal commissioning required and establish nomination preferences and protocols. There is currently land available in the Council's Lowood development site.

Preferred option

Option 4, Cornerstone

Cornerstone has been working with the LD service on the potential development of a Complex Care Unit (CCU) in the Borders. Cornerstone is a leading provider of services for people with disabilities and other support needs. Cornerstone supports more than 2,700 people each year, delivering services within 19 local authority areas across Scotland.

In 2019, their Baxter View facility in Dumbarton (West Dunbartonshire), which is a purpose built facility for up to 10 individuals with complex needs and challenging behaviours, received an exemplary Care Inspectorate report, highlighting the quality of care and support and the management of the facility. The scores received were backed up by evidence and observations including:

- people's activities were tailored to meet their genuine personal interests,
- people developed their physical and mental health, and helped form new relationships.
- "*I like living here, I have fun with the staff*.", and "*The staff are brilliant. They feel like family*."

Discussions with Cornerstone to date have focused on the feasibility of developing a similar facility in the Borders.

High Level Plan/Preferred Option

The preferred option is to partner with Cornerstone to deliver an 8-10 bed complex care facility at Tweedbank as part of the Tweedbank development plan.

Links to Strategic/Corporate Priorities

Our local Learning Disabilities Commissioning Strategy (Appendix 2) identified a commissioning need to provide

more locally based step up and step down facilities to allow for appropriate hospital discharges and prevent unnecessary admissions. A series of Scottish Government reports, reviews and strategies have also recommended a similar commissioning need as set out below:

"The Same as you?" recommended that "but for a few people, health and social care should be provided in their own homes or in a community setting, alongside the rest of the population". It was clear that people's home should not be in hospital. This is also emphasised in the Hospital Based Complex Clinical Care guidance from May 2015, which says "as far as possible, hospitals should not be places where people live – even for people with on-going clinical needs. They are places to go for people who need specialist short-term or episodic care. Hospitals are highly complex institutions which should focus on improving the health of people with acute conditions before discharging them back into the community".

The 2018 'Coming Home' Scottish Government report concluded that all adults with learning disabilities, including those with complex needs, should experience meaningful and fulfilled lives. This covers where individuals live, as well as the services that they receive. The report stressed that some people with learning disabilities and complex needs are living far from home or within NHS hospitals and that there is an urgent need to address this issue.

The recent Independent Review of Adult Social Care recommends that "investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives". On 16 February 2021, in a Parliamentary debate on the independent review, the Cabinet Secretary announced the "Community Living Fund". This fund would consist of £20 million "to deliver a redesign of services for people with complex needs, including intellectual disabilities and autism, and those who have enduring mental health problems. The fund will focus on delivering a proper sense of home for people with complex needs, including those who have encountered lengthy hospital stays or who might have been placed outside of Scotland, and who could, and should, be more appropriately supported closer to home". The full £20m was allocated to Integration Authorities, via NHS Boards, in February 2021 NHS Borders share of this fund is £377,966 (non-recurring).

In February 2021 a paper was taken to Council advocating CoSLA's Place Principle (2019):
"A more joined-up, collaborative and participative approach to services, land and buildings, across all sectors within a place, enables better outcomes for everyone and increased opportunities for people and communities to shape their own lives."

This development would enable us to further support this initiative for people who have traditionally been excluded due to lack of local provision and enable them to flourish, nearer their families, in their own communities.

IMPLEMENTATION STRATEGY:

Timescales & Key Milestones

Task	Who	Timescale
Corporate discussion and agreement	SBC/Health/IJB	3 months
Site option identification / preferred site agreed		
Governance, roles & responsibilities agreed		
Land options and agreement (i.e.) gift, lease etc….	Cornerstone/ SBC	3 months
Detailed design, preparation & submission of planning application	Cornerstone/ SBC	3 months
Building warrant application & approval	Cornerstone/ SBC	3 months
Tender process	Cornerstone/ SBC	2 months
Contract award and mobilisation	Cornerstone/ SBC	1 month
Construction	Cornerstone/ SBC	9 months
		24 months

Challenges

- There is a legal requirement to provide suitable care and support under the NHS and Community Care Act. A range of Government reports have made specific recommendations that services for adults with intellectual disabilities and complex needs must allow clients to be supported closer to home.

- The Hospital Based Complex Clinical Care guidance, states "as far as possible, hospitals should not be places where people live – even for people with on-going clinical needs. They are places to go for people who need specialist short-term or episodic care. Hospitals are highly complex institutions which should focus on improving the health of people with acute conditions before discharging them back into the community".

- Monitoring placement quality can be challenging with out of area placements, even more so when this placement is out with Scotland. With OOA placements there is a reliance on other Authorities to manage Adult Protection concerns, monitor quality and to provide specialist community learning disability support.

Stakeholder engagement and approach

The 2016-19 Scottish Borders Learning Disability Strategic Commissioning Plan was developed through wide consultation with service users, carers and other stakeholders. Here the gap was highlighted in terms of " TIER 4A" accommodation i.e. accommodation for adults with enhanced levels of support requirements:
"We currently fund some people, in this enhanced model of support but in out-of-area only placements. We do not currently have appropriate support and accommodation arrangements available to manage this level of support locally."

The new Commissioning Strategy is in draft format which continues to highlight the need for this type of service development.

Extract from Scottish Borders Learning Disability Strategic Plan 2016-19:

- consider models of care for development at Tier 4a
- build on the business case to consider the purchase of beds at Tier 4b from NHS Lothian
- progress plans to repatriate any people identified as appropriate to return to Borders

- improve upon current performance of numbers of reviews for all placements
- increase the uptake of Carers Assessments
- ensure carers are signposted for support and are aware of their rights
- in line with the Carers Act ensure carers are supported to make emergency plans
- recognise carers as "Partners in Care"
- evaluate the Intensive Support Service
- develop the local Behaviours that Challenge pathway to ensure that learning disability staff and support provider staff are equipped to support people appropriately in place.

In addition to this consultation on the strategic plan, Local Citizens Panel members have continued to emphasise this gap in service provision and need to have this type of support arrangement locally.

Dependencies & Risks (Resources, stakeholders for example)

- Land would need to be 'gifted' to Cornerstone, thereafter Cornerstone would invest in the development of a purpose built facility at an agreed location in the Borders and meet all of the construction and design costs for the project.
- Contractual safeguards will need to be established to ensure that the Borders Health & Social Care partnership have the choice to have priority to the 8 – 10 placements.
- The proposal is to construct a facility for 8-10 clients in the Borders. There is demand for >10 places, therefore we will continue to require a number of OOA placements.
- NHS Borders will need to provide health care services to the tenants (this will be mitigated by the increased likelihood of the provision of high quality local care and support facilities this unit will deliver).
- The estimated recurring savings are to the combined Health and Social care budget for Learning Disability services and not solely to one or the other partner organisation.

FINANCIAL IMPLICATIONS/FINANCIAL BENEFITS

Detail of financial savings

In area provision (IAP) of facilities for this client group is anticipated to be more cost effective than the out of area (OOA) model. In-area provision also helps to deliver the aspirations of the 'Coming Home' report and the Independent Review of Adult Social Care. Currently the Learning Disability Service spends £2.47m per annum on out of area placements (split £1.57m NHS Borders + £0.90m SBC).

- The average current weekly cost for OOA placements ranges from:
  :- £1,665 to £5,023 for **residential** placements (avg; £3,131 per week)
  :- £3,430 to £10,844 for **hospital** placements (avg; £6,286 per week)
- The current average cost for 11 clients is £4,278 per client per week.
- Cost per client for the proposed new facility is estimated to be £3,250 per week (based on figures from Cornerstone 2 years ago. We will confirm with them if this reflects the current pricing structure).
- Based upon the assumptions stated in the table below, there will be a combined estimated recurring saving to the Health and Social Care Partnership of circa £416k pa once all 8 clients have been admitted.

It would not be feasible, practical or advisable to repatriate all 17 clients to the Borders into this model of support. One reason being that the proposed complex care facility will take time to complete; another reason being that the facilities they currently reside in may now be considered as their home. However for some of the current clients and ideally for the majority of future clients, the Borders CCU could be the facility of choice, with potential average savings ranging from approx. -£100 to +£1,000 per client per week. We will continue to explore

alternative options, where appropriate, for people placed out of area.

On 16 February 2021, Government announced a £20m Community Living Change Fund to "deliver a redesign of services for people with complex needs, including intellectual disabilities and autism, and those who have enduring mental health problems. The fund focuses on delivering a proper sense of home for people with complex needs, including those who have encountered lengthy hospital stays or who might have been placed outside of Scotland, and who could, and should, be more appropriately supported closer to home". The full £20m was allocated to Integration Authorities, via NHS Boards, in February 2021. The Borders share of this fund is £377,966. (Non-recurring). The table below sets out the estimated financials and assumptions for the project:

	£'000s			
	2024/25	2025/26	2026/27	Total
SBC Capital Investment	0	0	0	0
Est. no clients	4	6	8	8
Est. OOA cost (cumulative)	884	1,326	1,768	3,996
Est. CCU costs (cumulative)	676	1,014	1,352	3,042
Est. savings (cumulative)	208	312	416	936
Total recurring annual saving				416

Financial Assumptions:	OOA Cost (pw)	IAP Cost (pw)
	4,250	3,250

Other assumptions

- CCU will take 2 years (minimum) to complete; therefore 2024/25 will be soonest that any in area placement will be available.
- It is assumed that the Borders will develop an 8- 10 bed facility.
- It is assumed that capacity will need to be built up over time therefore 4 clients initially, moving to 8 – 10 as part of a transitioning plan.
- Void costs will need to be included for the first 2 years as numbers build to 8 – 10 clients. This will have a cost impact upon savings in year 1 and 2.
- There will be some on-going void costs as and when placements become available (a working assumption of 10% voids pa is prudent for planning purposes).
- Capital costs will be met by the provider.

BENEFIT REALISATION/NON FINANCIAL BENEFITS

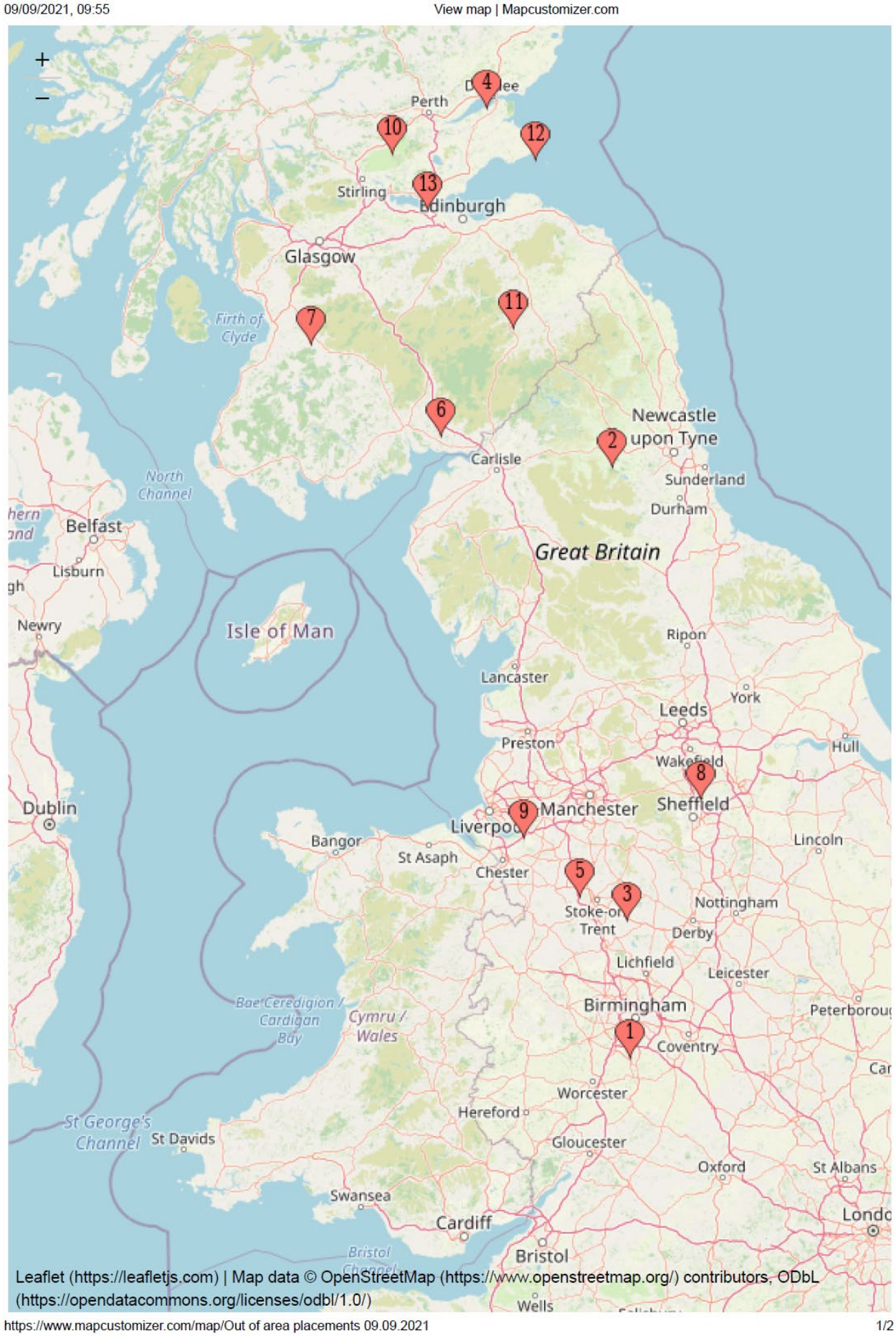
Outcomes/Critical Success Factors for the Project:

Non-Financial Benefits (User/service)

1. Improved outcomes for clients and their families for in area placements

2. Improved monitoring/control of quality, safety and outcomes
3. Reduced delayed Discharges

Appendix 1 - Out of area placements geographical map shows 13 localities out with Scottish Borders for the current 17 people.



Cygnet, Wast Hills Hospital	Alvechurch CP, Bromsgrove, Worcestershire, West Midlands, England, B38 9ET, United Kingdom
Oaklands, Danshell	Sandhoe, NE46 4JT, UK
The Woodhouse, Elysium Healthcare	Cheadle, ST10 4QU, UK
Cygnet, Wallace Hospital	Dundee City, Scotland, DD3 9AG, United Kingdom
David Lewis Community Home	Alsager, Cheshire East, North West England, England, ST7 2SL, United Kingdom
Trinity House, Danshell	Dumfries and Galloway, DG11 2DS, United Kingdom
Catrine Bank, Daldorch	East Ayrshire, KA5 6NA, United Kingdom
Low Laithes, Hesley Group	Barnsley, S73 8SU, United Kingdom
Gateway Recovery Centre	Halton, North West England, England, WA8 6PD, United Kingdom
Ochill Tower	Perth and Kinross, Scotland, PH3 1AD, United Kingdom
At home but needs placement	Scottish Borders, Scotland, TD7 4QW, United Kingdom
Ragfield House, Anstruther	Fife, Scotland, KY10 3XG, United Kingdom
Daleview, Lynebank Hospital	Dunfermline, Fife, Scotland, KY11 4UW, United Kingdom

Appendix 2 -

www.scotborders.gov.uk/downloads/file/3230/scottish_borders_learning_disability_strategic_commissioning_plan_2016_-2019

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 22 September 2021

Report By:	Phillip Lunts, Strategic Planning Lead, NHS Borders
Contact:	Phillip Lunts, Strategic Planning Lead, NHS Borders
Telephone:	Via Teams or 07747 763963
SCOTTISH BORDERS CARE HOME MODELLING – FINAL REPORT	
Purpose of Report:	To present IJB with the finding of deep dive review of care home demand and capacity and 10-year forward modelling
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Consider** this report and recommendations.
Personnel:	Details in paper
Carers:	Details in paper
Equalities:	Equalities Impact Assessment should be carried out as part of engagement with service users and communities
Financial:	This is a demand and capacity modelling exercise. Financial considerations should be taken into account in development of recommendations
Legal:	N/A
Risk Implications:	Risks are implicit in report. Full risk assessment should be undertaken as part of development of recommendations

Executive Summary:

A modelling exercise was undertaken by Public Health Scotland to advise on demand for and commissioning of care home beds in Scottish Borders for next 10 years (to 2030).

Demographic modelling indicates that there would be a need for 187 additional care home beds within the Scottish Borders by 2030. This represents an annual increase of between 14 and 20 care home admissions per year

However, past experience is that care home demand will not increase proportionately to demographic change.

- Between 2009 and 2019, care home bed numbers in Scottish Borders increased by just 1%, despite a 20% increase in the population aged 75 and over. This disparity is shared across Scotland with a Scotland overall change of -1% during this period.

- Scottish Borders has 3rd lowest number of care home residents per head population in Scotland and has been amongst lowest 4 local authorities for past 10 years (2009 to 2019).

Analysis of data indicates Scottish Borders:

- is a low outlier in terms of care home bed provision
- has one of the higher average ages for admission to care home
- benchmarks low for paid homecare provision
- Has slightly higher than average rates of people providing unpaid care
- Has higher than average provision of age-specific housing provision for older people

Studies show that fewer older people enter care homes in rural areas compared to urban area and this may be related to closer family support networks. This suggests older people in the Borders manage to remain at home longer than in other places.

There is a further range of evidenced measures for reducing care home admissions that are not currently robustly applied in the Scottish Borders.

This analysis suggests that;

- It is likely that action could be taken to avoid the modelled demographic demand
- Planned and coordinated action could be undertaken to further reduce care home demand
- Future planning for older people should build on the existing features of the Borders community to develop a mixed model of provision to maintain older people at home longer, age-specific housing models and reprovision of care homes as flexible facilities, incorporating a range of levels of care support including long-term care
- Engagement with older people, service users, carers and service providers in the Borders should be undertaken to establish what models of service provision would work best for each community

Scottish Borders Care Home Modelling

Overview of current findings

26th July 2021

The Ask

- Aim:
  - 10-year projection of care home demand for older people to underpin commissioning plan
- Output:
  - expected changes in 24-hour care demand broken down by
    - residential care,
    - nursing care
    - specialist care provision
  - worse case and best case scenarios (potential for mid-range scenario)
- Methodology:
  - expected demographic changes in population at a locality level with adjustments for other predicted changes (migration etc).
- Assumptions to be applied to the model:
  - Expected changes in population frailty or dependency levels
  - Expected changes in dementia prevalence and need for 24-hour care
  - **Impact of changes in models of care on demand for 24-hour care**

Note on data

- 3 data sources
  - Care Home Census – end March snapshot survey of all care home residents in each area
  - SBC Care Home resident data – end March snapshot of SBC-funded care home residents (all locations)
  - NRS Population Projections

- Challenges
  - Reconciling two different datasets
  - Snapshot data – does not reflect in-year variation

EXECUTIVE SUMMARY

Summary

- Demographic projection predicts need for additional 187 care home places by 2030 (30% increase)
  - This represents between **14-20** additional care home places per year

HOWEVER

- Borders benchmarks in lowest 4 LAs for care home places
- No change in Borders care home places between 2009 and 2019 despite 20% increase in >75 Borders population
- Borders benchmarks in lowest 6 LAs for home care packages
- Borders has a higher than average rate of people providing unpaid care
- Borders has the 6th highest rate of age-specific housing for older people

- Rurality and community/family support may be maintaining more people at home

- % of residents who remain in their own locality is directly related to the number of care home beds in a locality (0.91 correlation)

Implications

- Measures that could reduce demand for care home bed increases (from stakeholder meetings)
  - Intensive Rehabilitation support
  - Staff Education on appropriate referrals to care homes
  - Provision of early intervention and crisis support
  - Actions to
    - address lack of social contacts/loneliness and isolation
    - reduce cognitive deterioration and functional decline
  - Actions to support healthy living - 'Live Well, Eat Well', Dementia-friendly communities
  - Different approach to managing pathway from hospital to care
  - Support for Carer Stress and burnout (esp higher dependency clients)
- Alternative housing approaches may also reduce care home demand
- Could reduce the 14-20 additional care home admissions/year
- Location of care home beds influences number of residents who stay in own locality

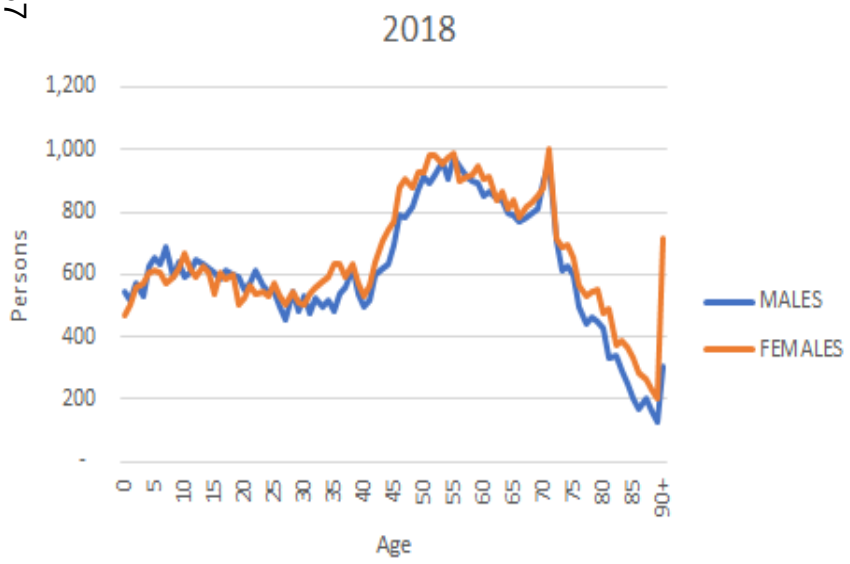
Summary

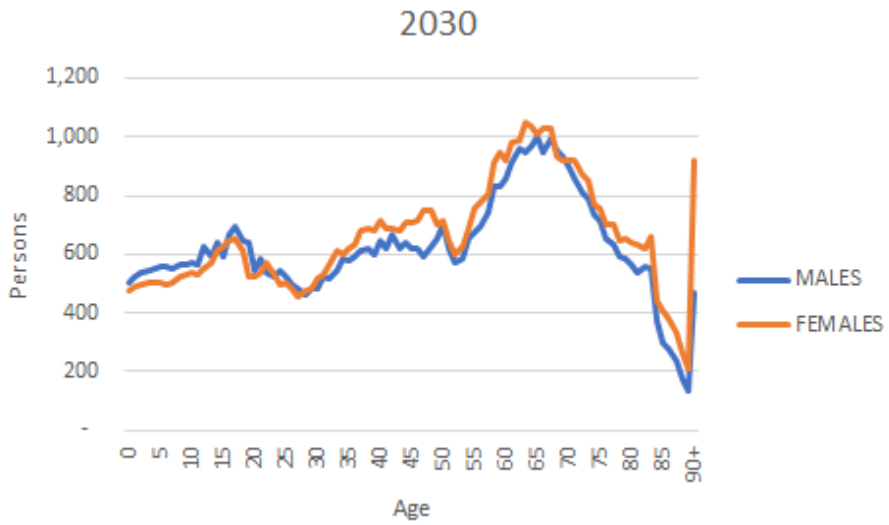
- Scottish Borders has low number of care home beds per head
- This may be linked to
  - Fitter population
  - Better housing options
  - Higher levels of family support
- Based on demographic changes only, there is a predicted demand for 187 additional care home beds by 2030 (14-20 additional admissions per year)
- However there was no increase in care home beds over past 10 years
- There are a range of evidence-based initiatives that could reduce demand for care home beds in the future
- There is a need to explore the expectations of what care can be provided at home, in age-specific housing and in care homes in the future

DETAILED ANALYSIS

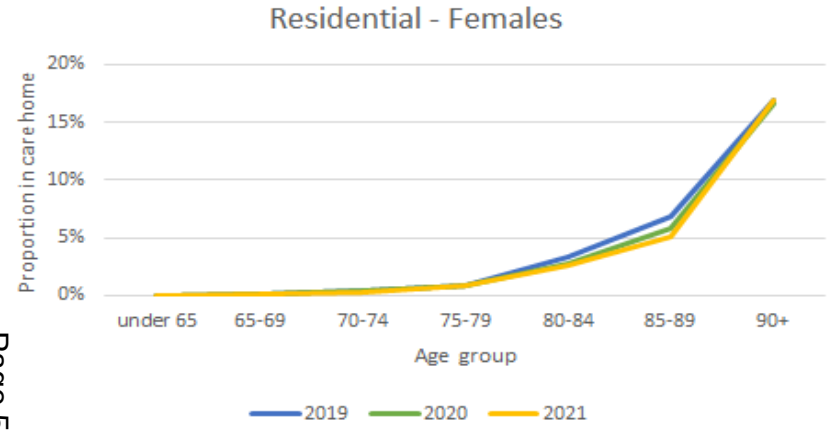
Phase 1: demographic modelling: Population analysis

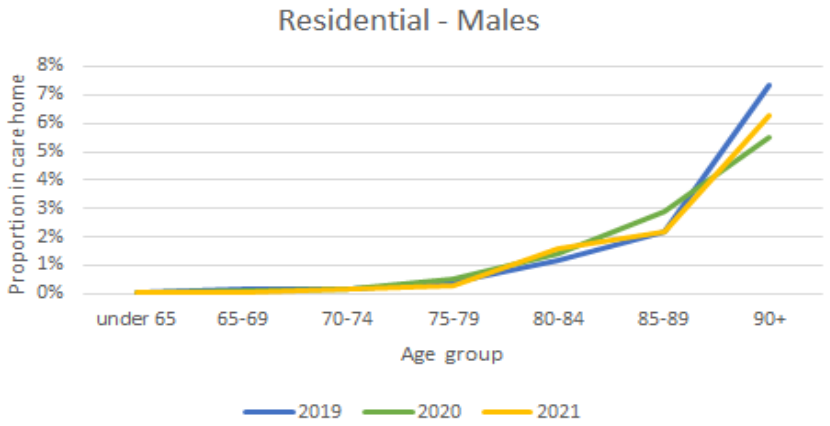
- Borders population currently dominated by people aged 50-70.
- By 2030,
  - 75+ population expected to grow by >20%,
  - overall population will increase by about 1%.

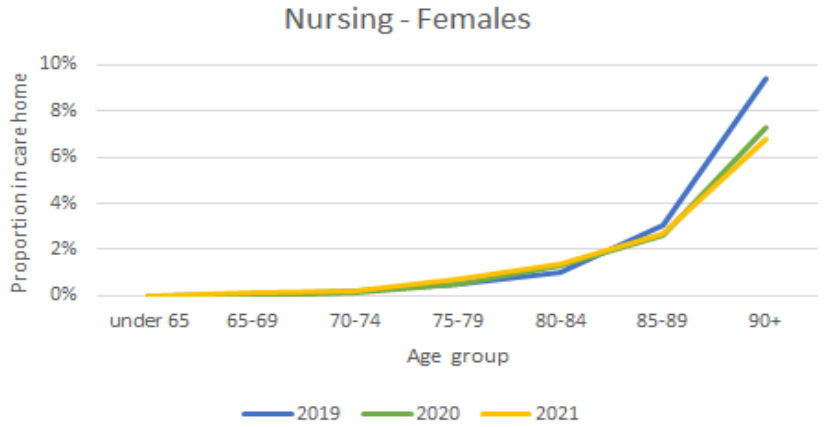


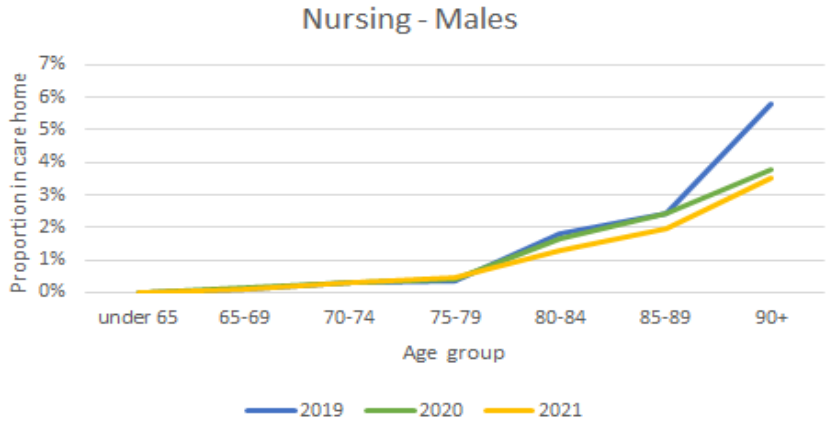


Percentage of population in long-term residential care (SBC-funded)



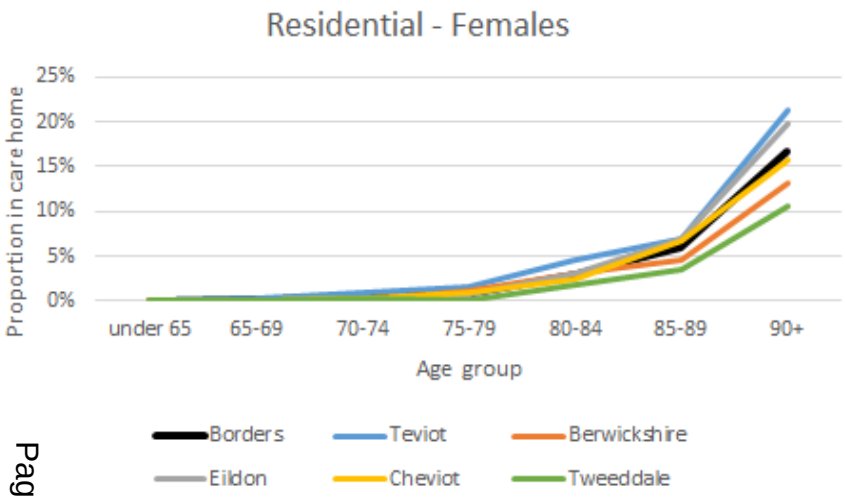


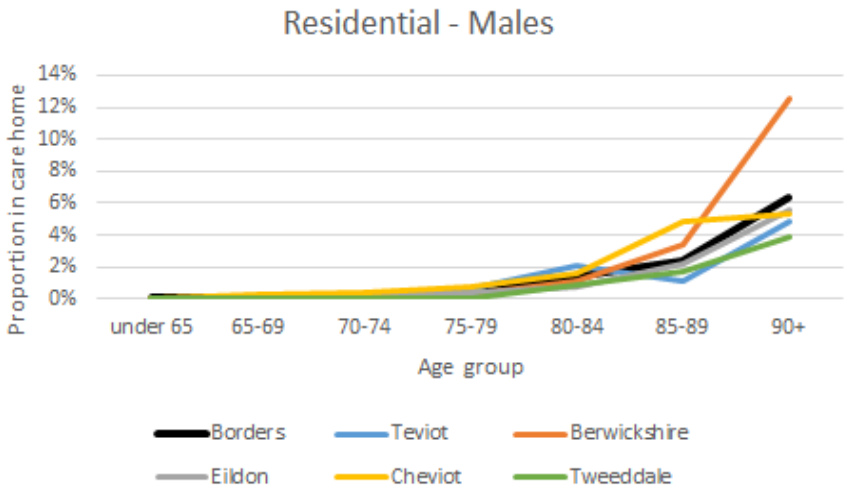


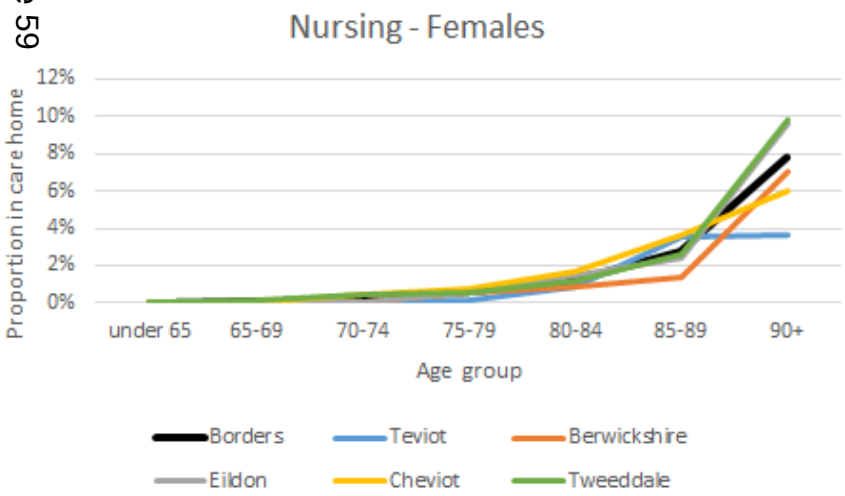


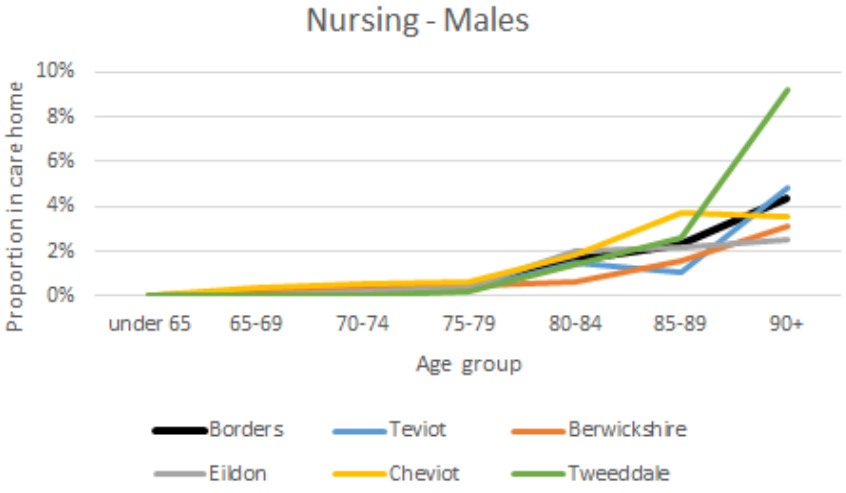
- Females - 3.5% of 80-84, 9% of 85-90 and 25% of 90+ pop. live in care homes
- Males – 3% of 80-84, 5% of 85-90 and 10.5% of 90+ pop. live in care homes

Percentage by locality









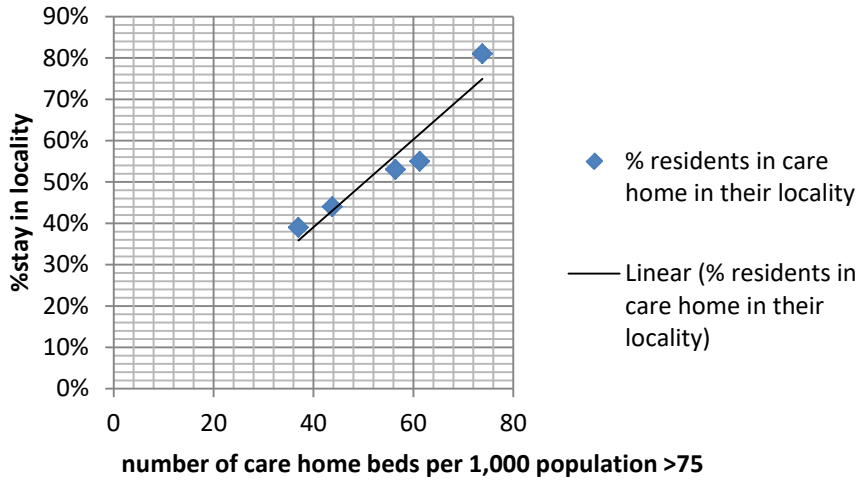
- Relatively little difference in care home occupancy by locality
- Tweeddale high for nursing home residents, Berwickshire high for male residential

Do people go into care homes in their locality?

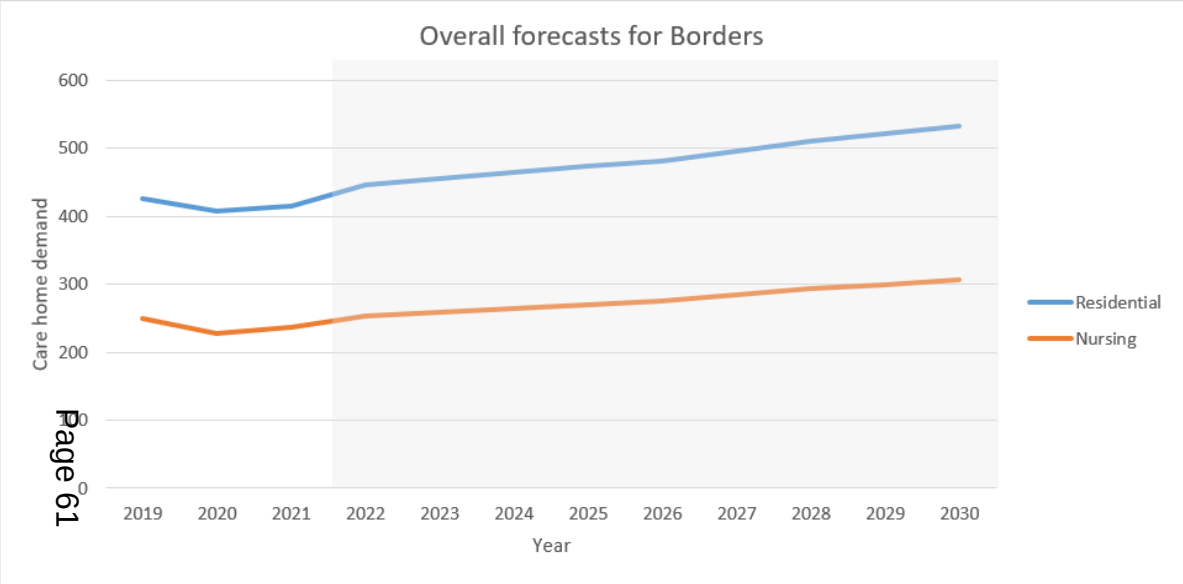
		Care home locality					
		Berwickshire	Cheviot	Eildon	Teviot and Liddesdale	Tweeddale	Outwith Borders
Client locality	Berwickshire	**39%**	5%	3%	2%	1%	50%
	Cheviot	18%	**53%**	11%	7%	1%	10%
	Eildon	2%	25%	**55%**	9%	4%	7%
	Teviot and Liddesdale	1%	12%	4%	**81%**	0%	2%
	Tweeddale	1%	13%	17%	1%	**44%**	26%

- Majority of residents go into care homes in their locality - Teviot (81%), Eildon (55%), Cheviot (53%)
- 50% of Berwickshire care home residents live outwith Borders (mostly Berwick)

There is a clear correlation (.91) between number of care home beds in a locality and % of residents who remain in their own locality



Care home demographic demand forecasting



Based on demographic change only, we can expect an increase of **187** beds by 2030
Residential:28% increase
Nursing: 29% increase

Year	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Care home residents - Residential	415	445	454	465	473	482	496	510	522	532
% increase from 2021	-	7%	9%	12%	14%	16%	20%	23%	26%	28%
Care home residents - Nursing	237	253	259	265	271	276	285	293	300	306
% increase from 2021	-	7%	9%	12%	14%	16%	20%	24%	27%	29%

NB: SBC-funded placements – in and out of area

Future demand by year

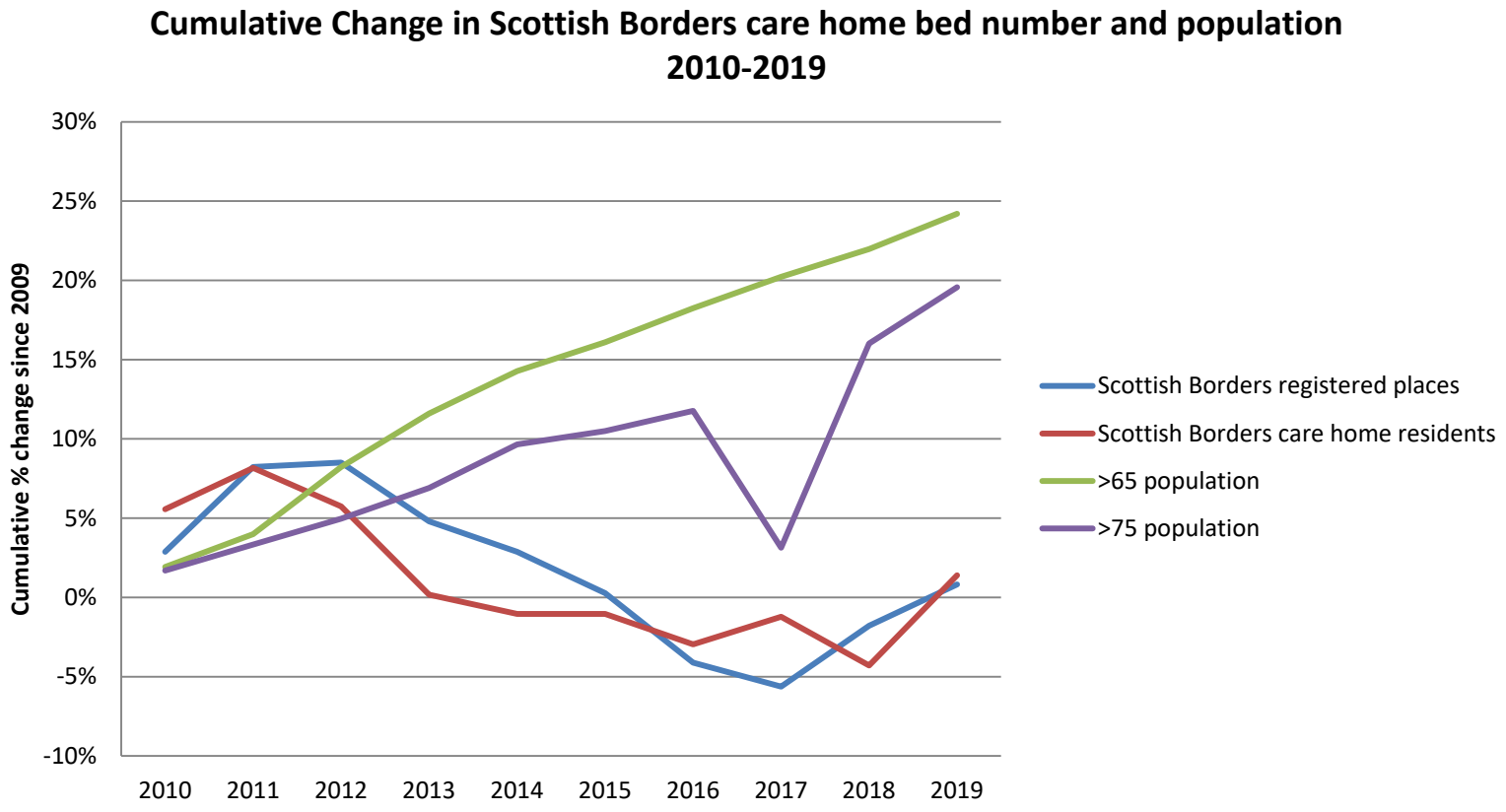
- Large jump in 2022 – probably data adjustment issue
- 2023-2026: increase of 14-17 beds/year.
- 2027-2029: increase of 19-23 beds/year.
- This equates to 14-20 **additional** admissions/year

(Ave length of stay for Borders residents is 0.78 (nursing) to 1.4 (residential) yrs)

Annual increase	2022	2023	2024	2025	2026	2027	2028	2029	2030
Care Home residents - residential	30	9	11	8	9	14	14	12	10
Care Home residents - nursing	16	6	6	6	5	9	8	7	6
Care Home residents - Total	46	15	17	14	14	23	22	19	16
Extra admissions/year	14	16	13	13	22	20	18	15	14

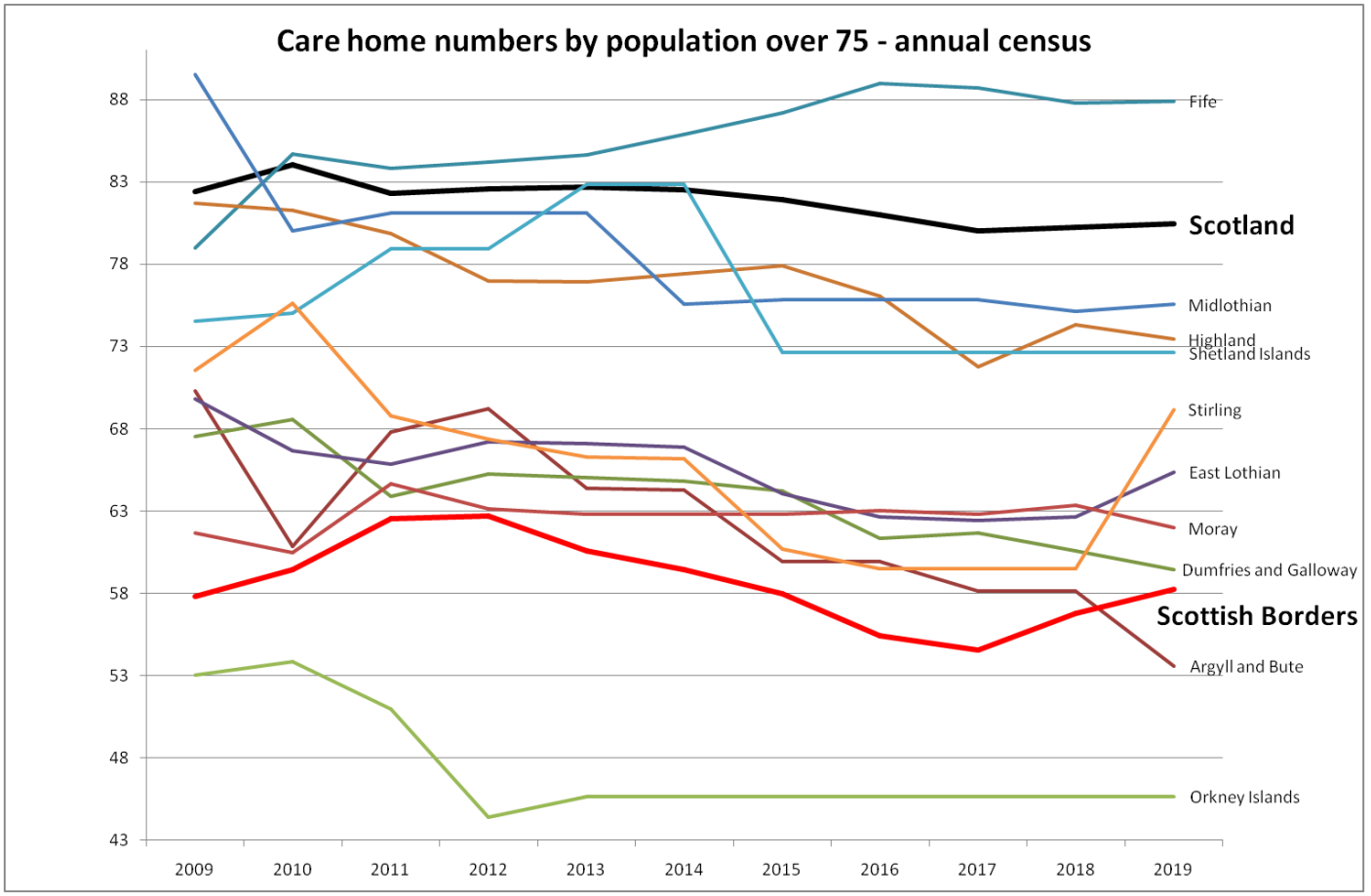
Care home places in Borders

- Between 2009 -2019:
  - >75 population in the Borders increased by 20% and >65 by 24%
  - Care home beds & care home residents increased by 1%



How do we compare?

Borders amongst 4 LAs with lowest rate of care home beds per head population for past 10 years (with Orkney, Argyll and Bute and D&G)

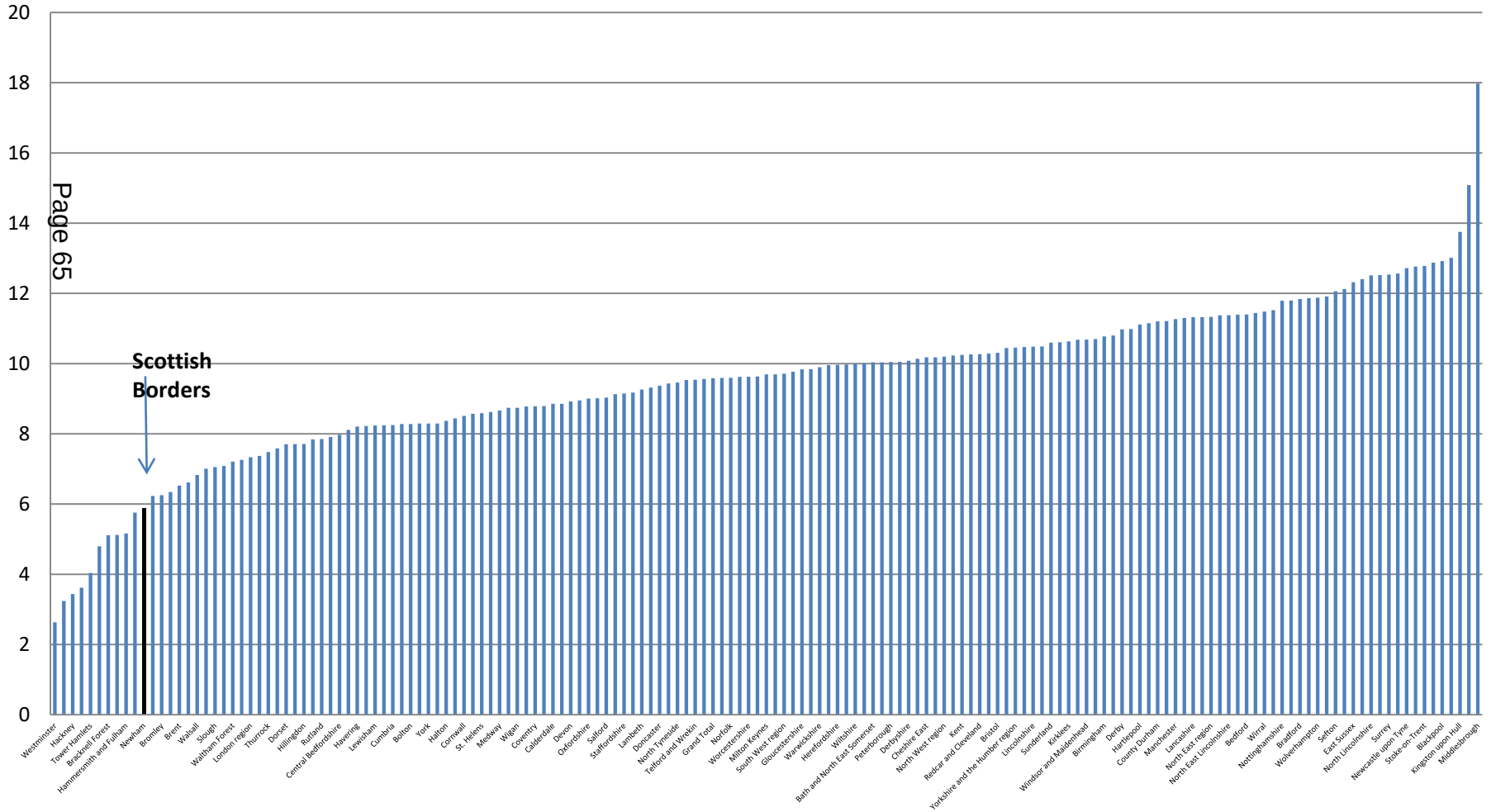


NB: Data from Scottish Care Home Census reports total care home beds in Borders – but closely correlates to SBC-funded care home numbers (.73-.98)

And the 12th lowest in England!

Care home bed numbers per 100 population over 75, 2019

English LAs plus Scottish Borders

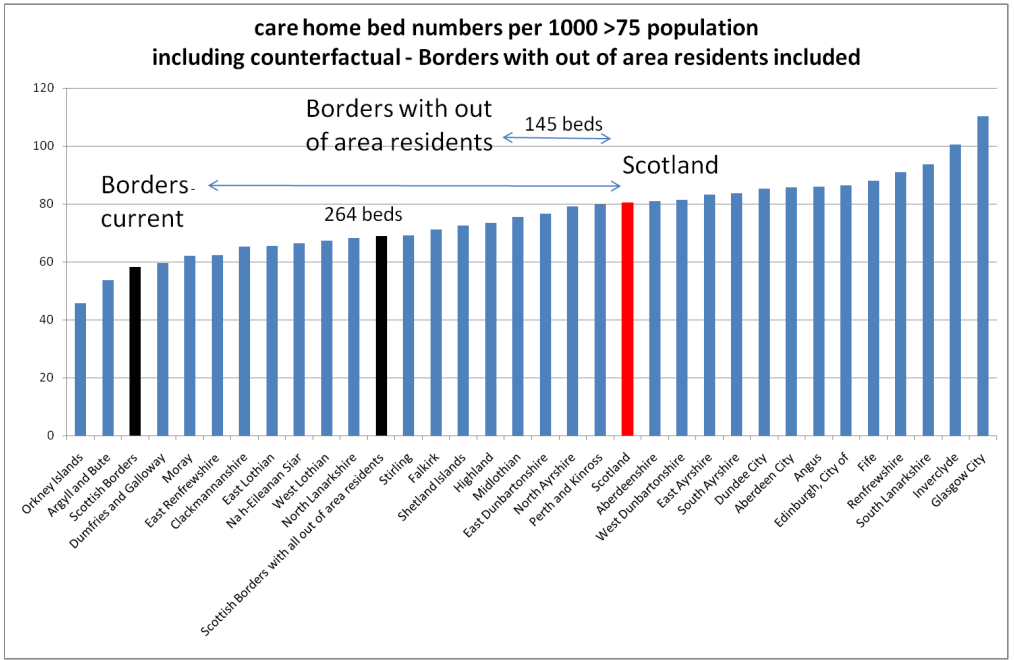


Are Borders care home residents accommodated out of area?

- SBC-funded out of area placements consistently around 20%
- Rate of out of area placements for other LAs unknown
- Out of area placements –
  - Berwick (53) – nearly all Berwickshire residents
  - Edinburgh (44) = up to 50% Tweeddale residents
  - Other areas (37)

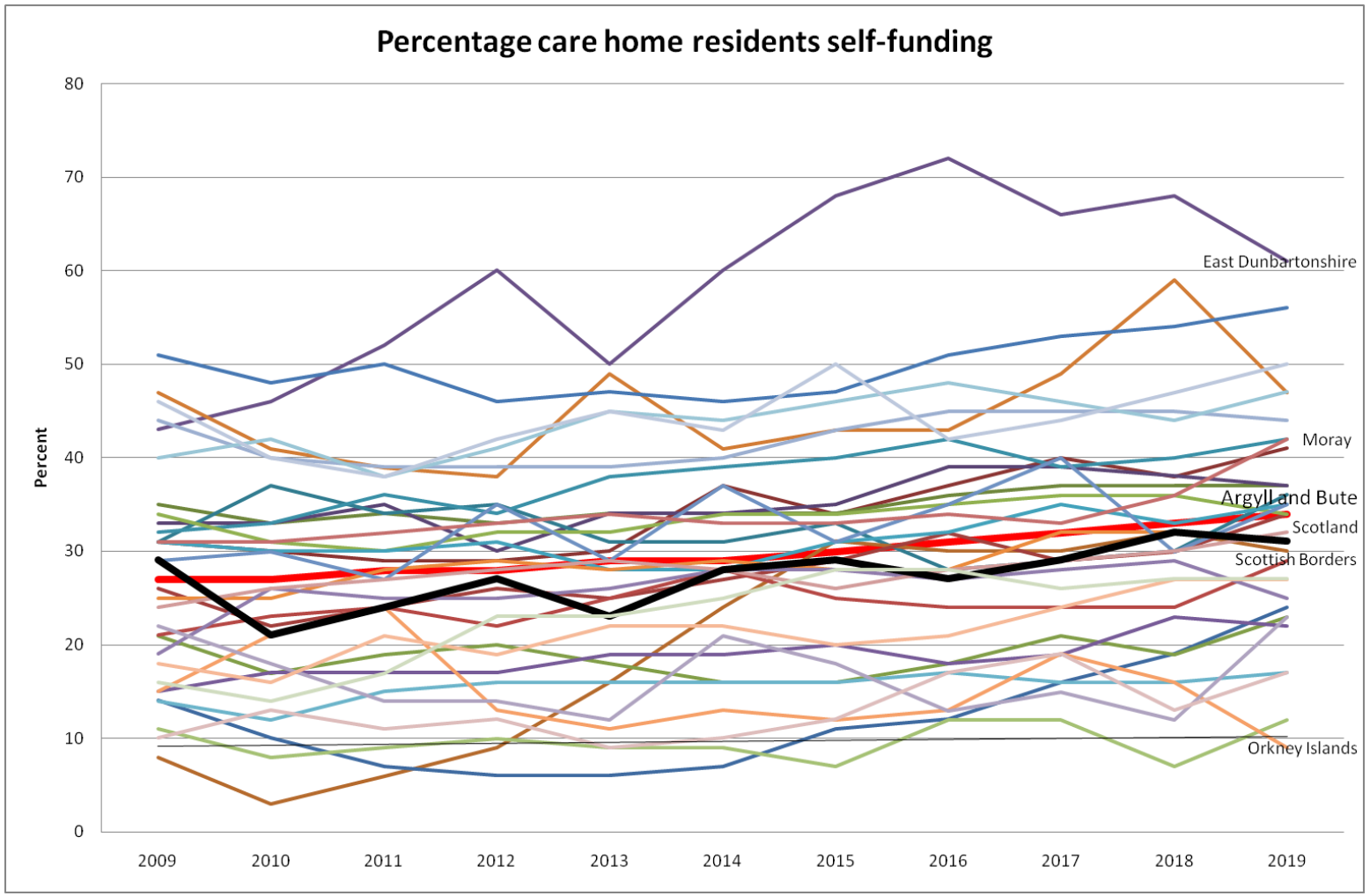
Counter-factual check:

if all out-of-area residents were in Borders care homes, Borders would still be well below Scottish average



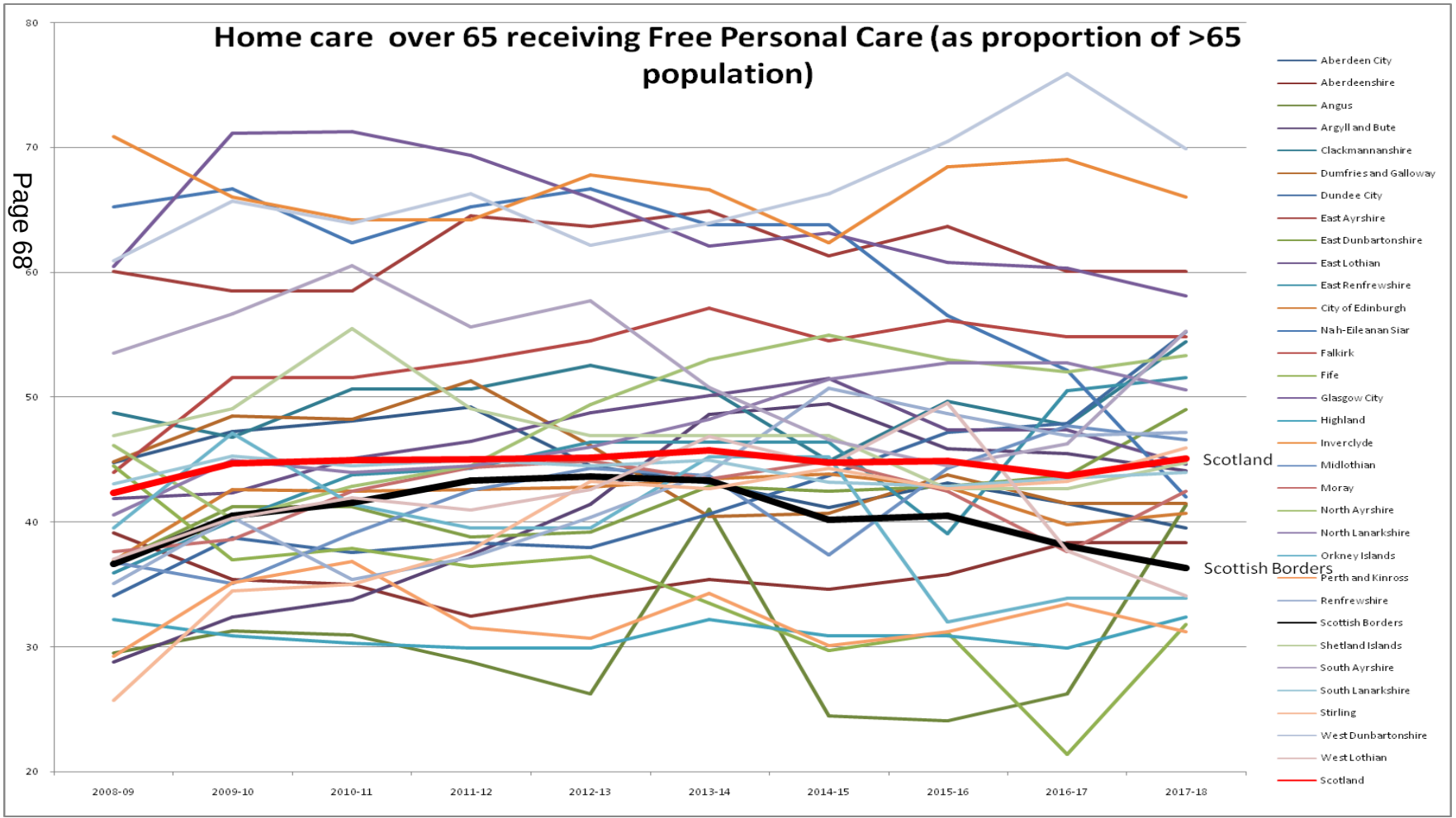
Is there a higher proportion of Borders residents self-funding?

- Scottish Borders slightly below Scottish average



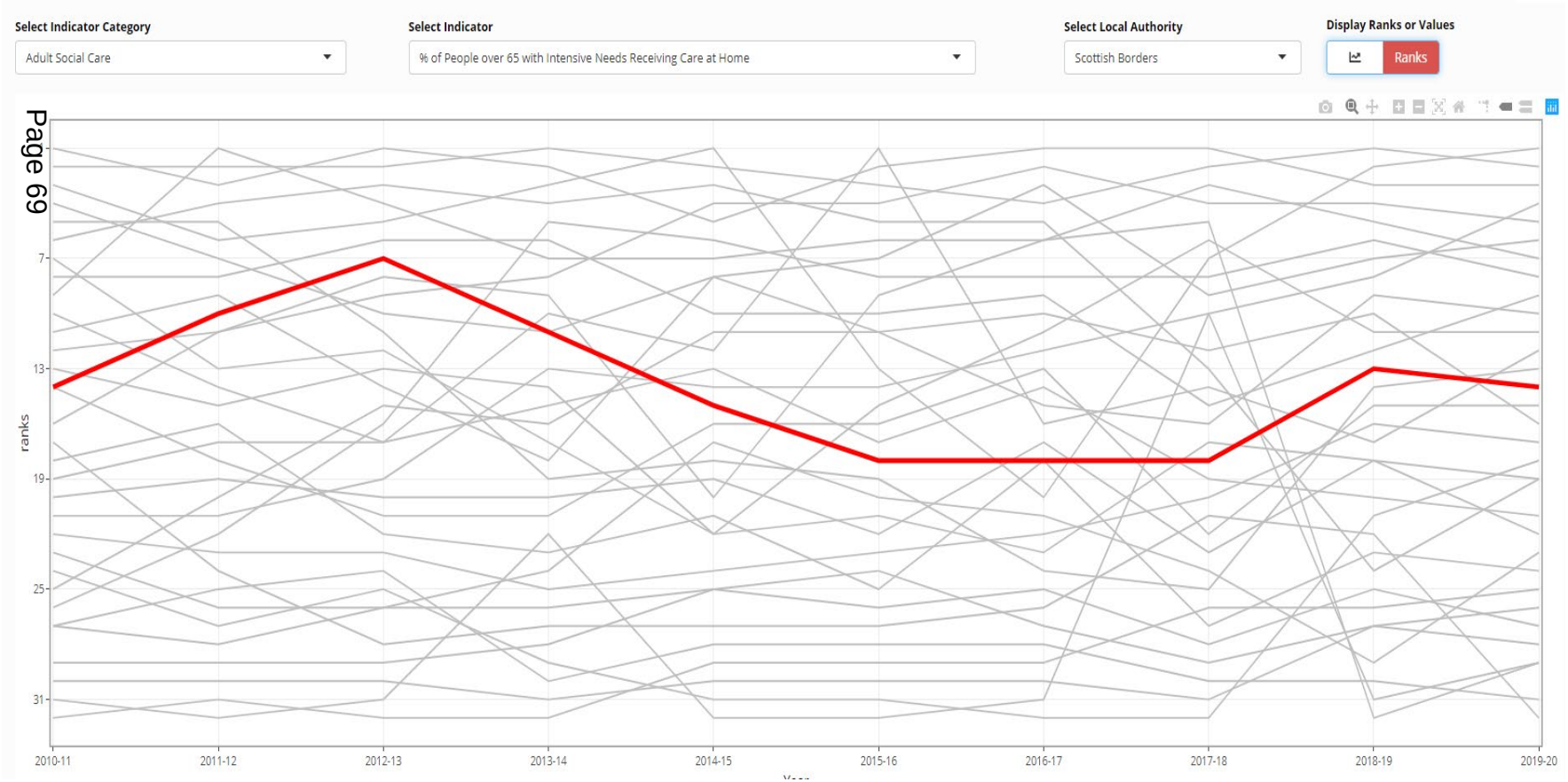
Is there a higher proportion of older people receiving care at home in Borders?

- Scottish Borders has 6th lowest level of care packages



Are older people home care packages larger (more intensive) in Borders?

- Scottish Borders ranks 14th out of 32 for level of care hours (below Argyll & Bute, Orkney, D&G and Stirling but above Moray)



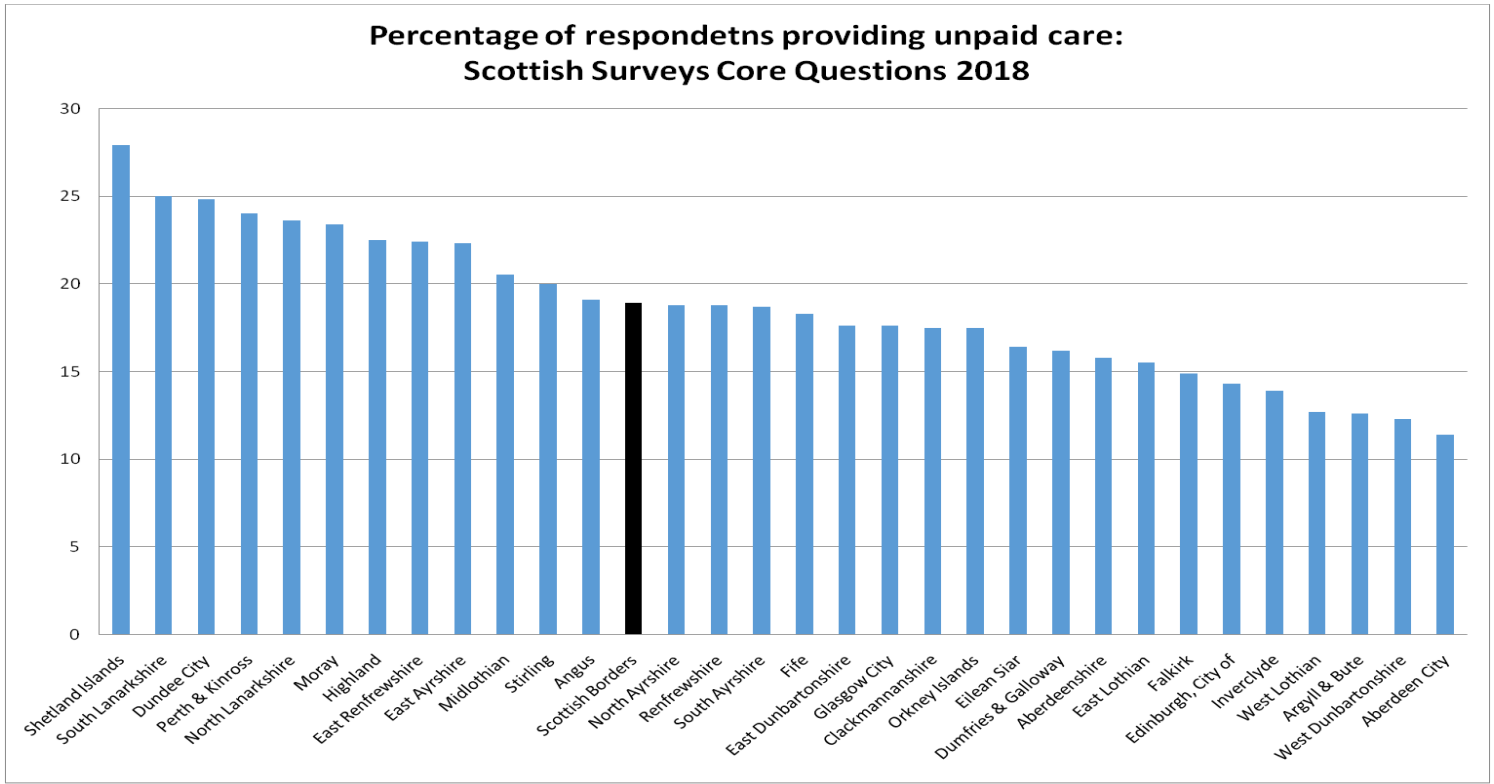
Do more older people receive unpaid care in the Borders?

Unclear picture

2018 SHS: Scottish Borders slightly above average -pop. providing unpaid care

- No correlation -unpaid care levels and pop. density or no. care home beds

- Carers Centre: 'high level of unmet need'
  - Estimated 15,000 carers



Carers Centre feedback

Reasons for lower level of placements:

- Level of care home placements – budget-driven
- Unmet needs
- Quality of care homes

Main impact – higher dependency group

- Reduction in respite care
- Closure of day centres
- Deterioration during Covid
  - Isolation
  - Dementia

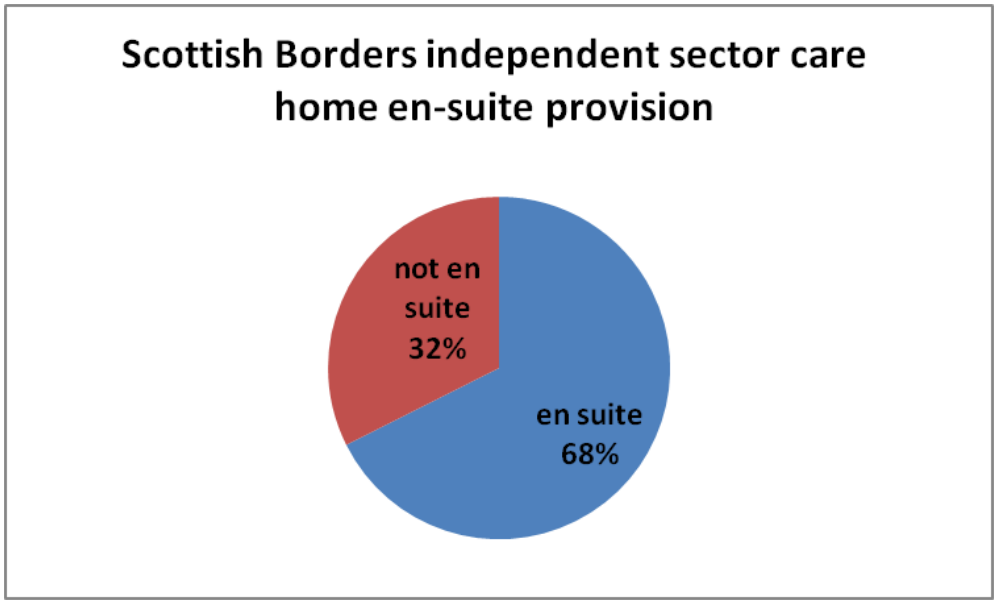
IS THERE HUGE UNMET NEED??

Care Home Estate

- All SBC Care Home buildings >32 years old

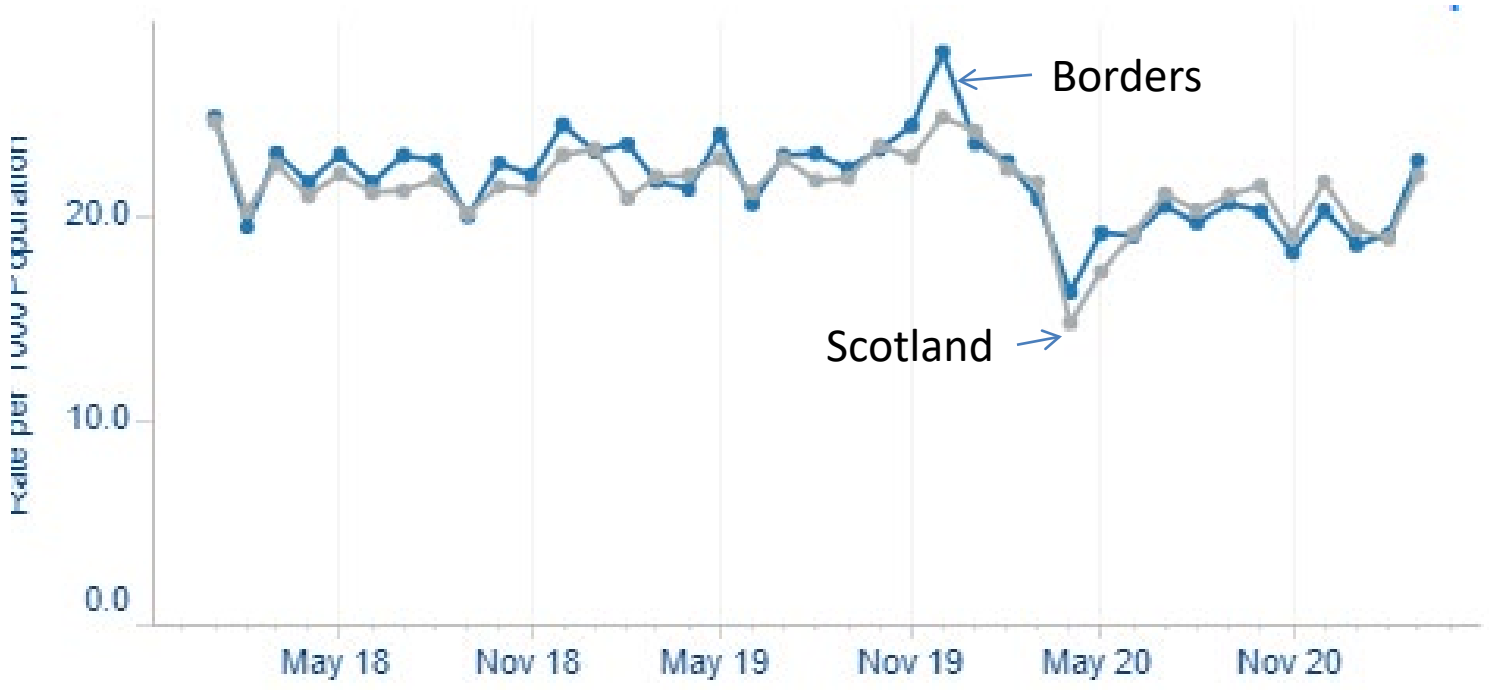
Home	Capacity	Town	Locality	Built	Age
St Ronan's	25	Innerleithen	Tweeddale	1968	53
Grove House	22	Kelso	Cheviot	1976	45
Waverley	26	Galashiels	Eildon	1982	39
Deanfield	35	Hawick	Teviot	1987	34
Saltgreen's	35	Berwickshire	Berwickshire	1989	32
Garden View	25	Tweedbank	Eildon	-	-

- 32% of independent sector accommodation not en-suite



Unmet need - Do more older people get admitted to hospital ?

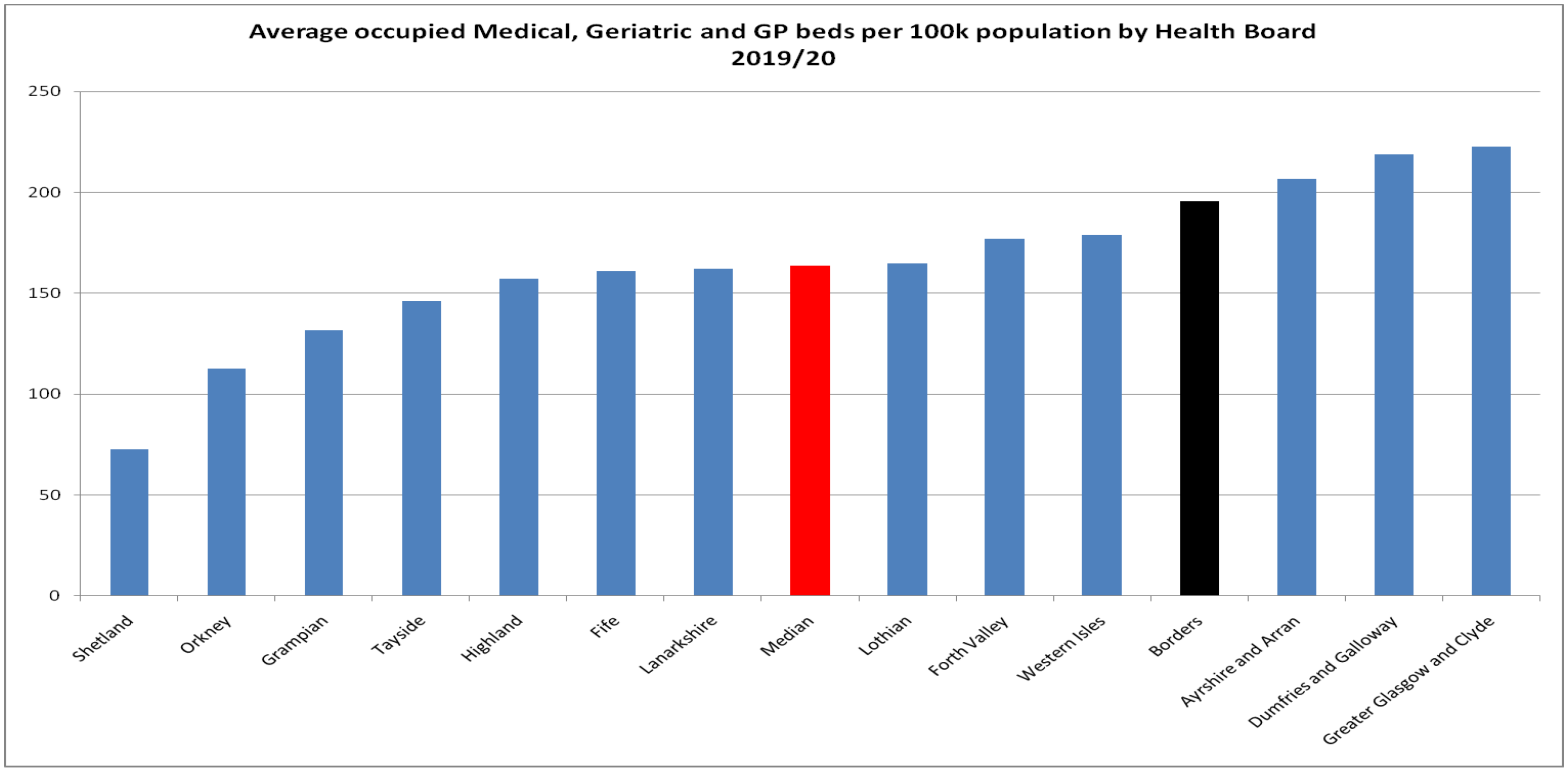
Borders rate of emergency admissions per 1000 70+ population is close to the national average



This suggests that Borders does not have a disproportionate number of older people admitted to hospital due to breakdown in care

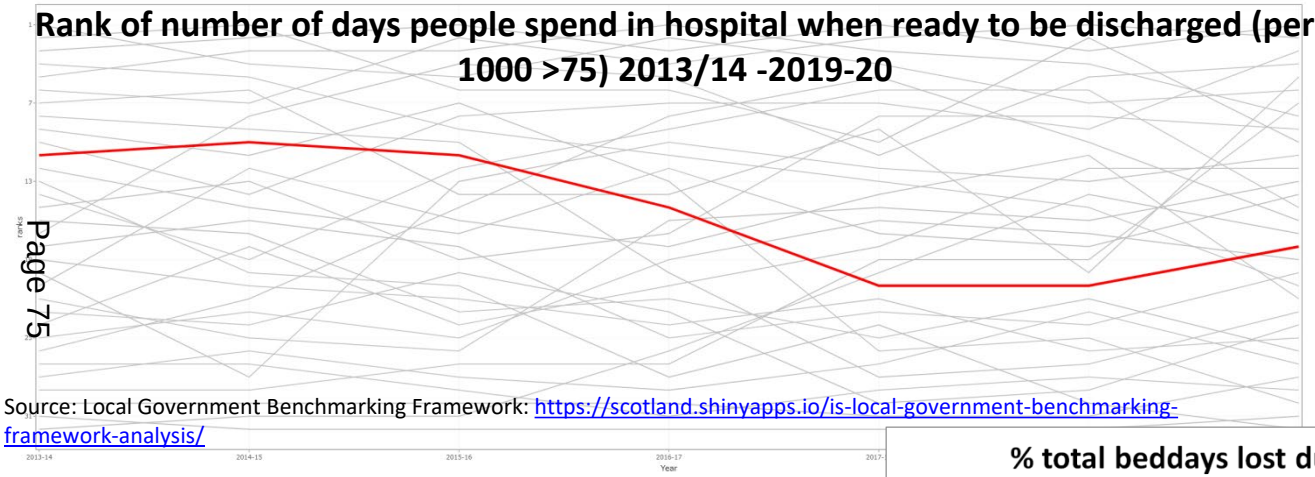
Unmet need - Are there more hospital beds in place of care home beds?

- Borders has 36 more medical, older people and community hospital beds than median for Scotland
- However, there is no correlation between number of hospital beds and number of care home beds across Scotland (0.2)



Unmet need – are more older people delayed waiting for care home?

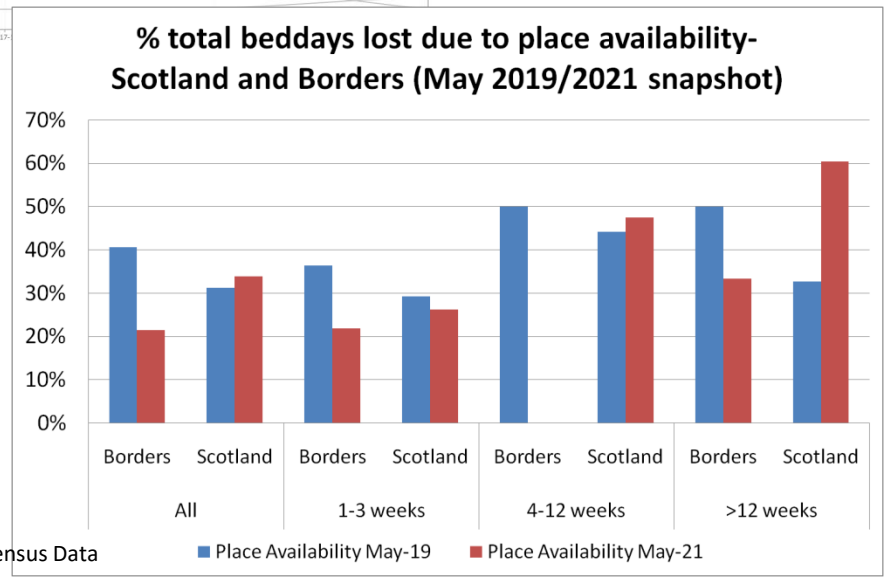
Borders does not have disproportionate level of delays for care home beds



Source: Local Government Benchmarking Framework: https://scotland.shinyapps.io/is-local-government-benchmarking-framework-analysis/

Borders ranks 18th (out of 32) for number of days lost to delayed discharges

May snapshot indicates Borders is close to Scottish average for days lost due to waits for care home beds

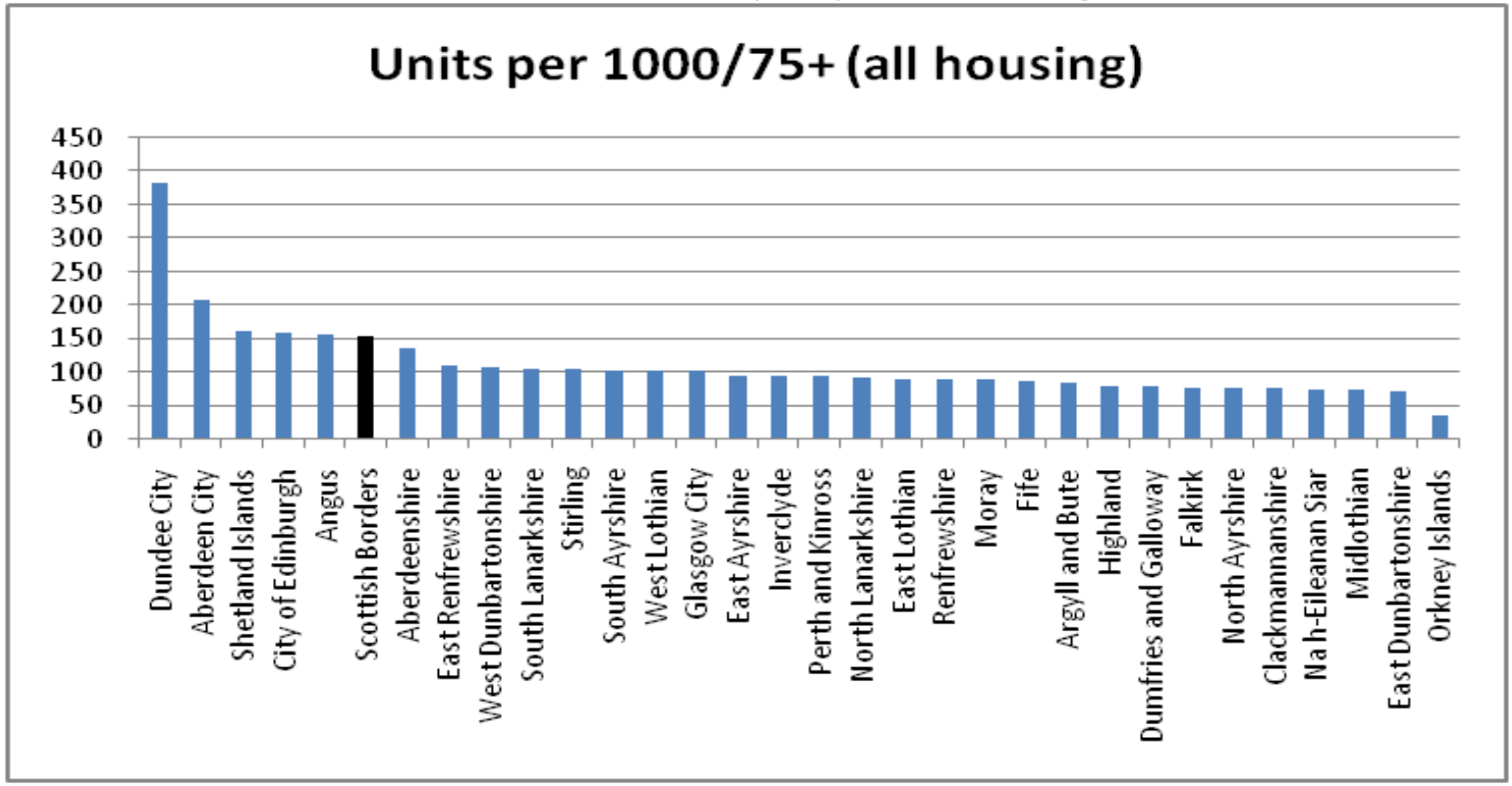


Source: Delayed Discharge Census Data

Are more older people living in Extra Care Housing/Housing with Care?

Scottish Borders is 6th highest rate for age-designated housing for older people but 16th highest for Extra Care Housing

- There is moderate correlation -older peoples housing and pop. density
- There is minimal correlation - older peoples housing & care home bed nos.



Are older people in Borders healthier?

GOOD…

- A lower percentage of people aged over 60 in the Scottish Borders claim Pension Credit compared to Scotland.
- The proportion of over 65s who assess their general health as "good / very good" has increased by 10% from 61% in 2012 to 71% in 2016.
- Fewer people aged 65 and older say they have a long-term condition compared to the level for Scotland.

•Borders has lowest rate of antipsychotic prescribing in Scotland for >75s

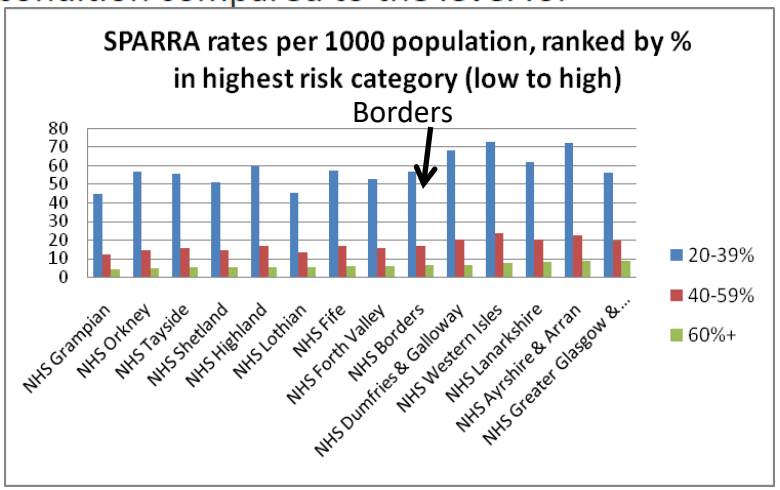
NOT SO GOOD…

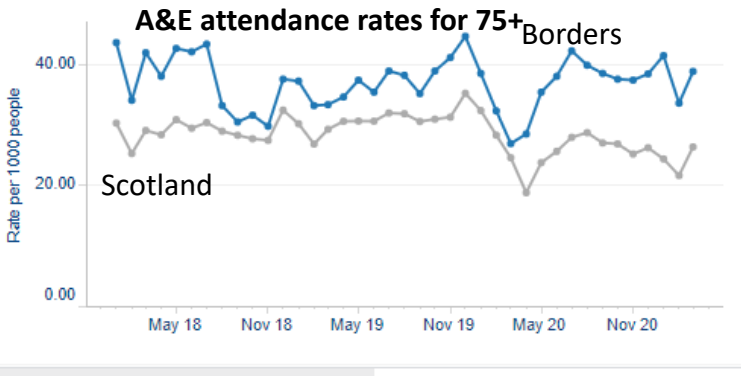
•Borders has the 4 highest admission rate and 3rd highest bedday rate for falls

•Borders has sixth highest rate of very high risk older people on SPARRA

•>75 A&E attendance rates are 1/3rd higher than Scottish average

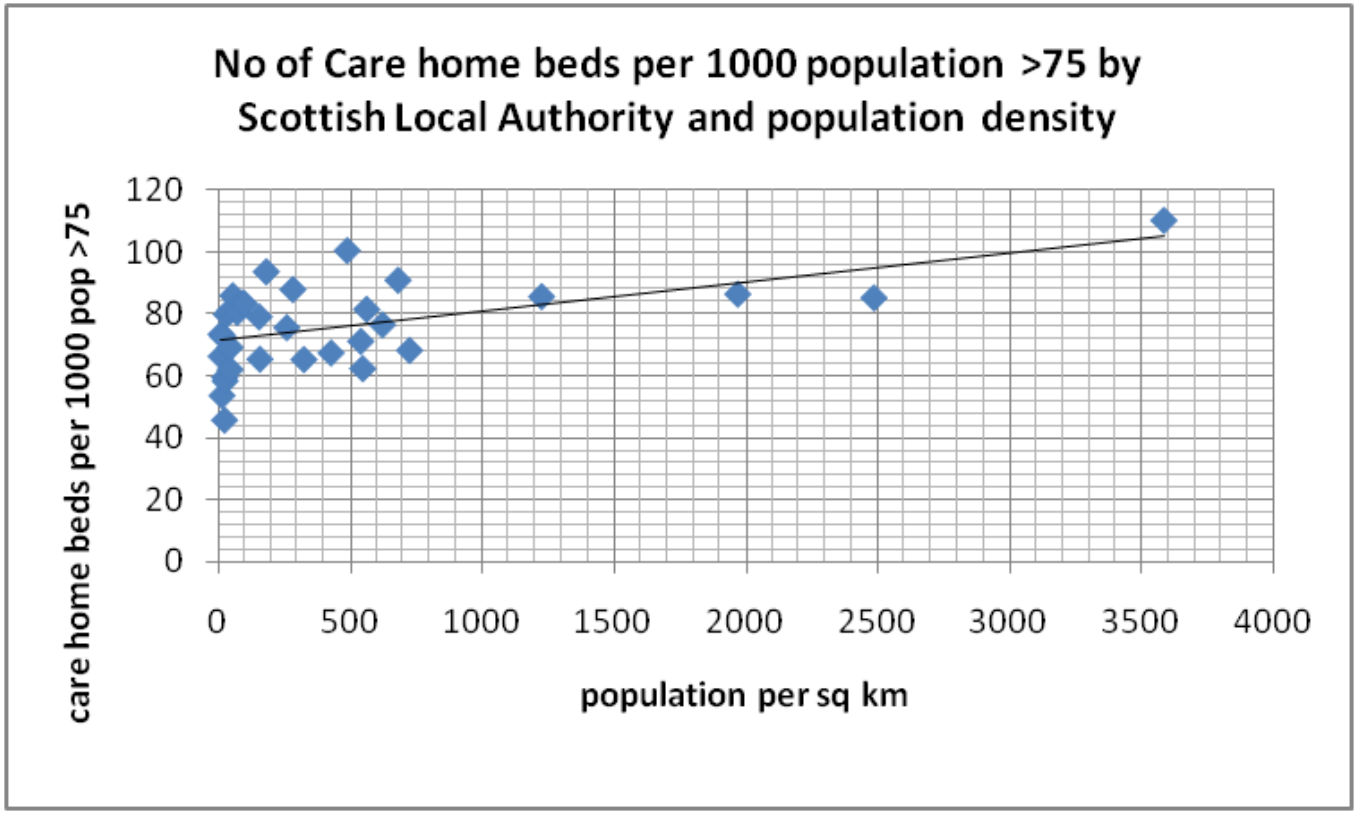
MIXED BAG OF DATA





Rural areas have lower numbers of care home beds

- There is a clear correlation (.75) between very high and very low population density and number of care home beds – correlation is less clear for intermediate density



What might be different in rural areas?

- Populations who have lived in an area for > 25 years have stronger informal (family) networks (but less use of community supports) Burholt et al, **The impact of residential immobility and population turnover on the support networks of older people living in rural areas: Evidence from CFAS Wales,** *Popul Space Place. 2018;**24:e2132.*** https://doi.org/10.1002/psp.2132
- Admissions to care homes in rural areas are 75% of urban and intermediate areas – due to better family support (N. Ireland study) McCann et al, Urban and rural differences in risk of admission to a care home: A census-based follow-up study , http://dx.doi.org/10.1016/j.healthplace.2014.09.009

How might we reduce care home admissions?

- Deterioration in cognition and behavioural and psychological symptoms, and caregiver burden were strongest predictors for dementia sufferer admission to care home : Toot et al, Causes of nursing home placement for older people with dementia: a systematic review and meta-analysis, https://www.cambridge.org/core/journals/international-psychogeriatrics/article/causes-of-nursing-home-placement-for-older-people-with-dementia-a-systematic-review-and-metaanalysis/62B350693121CB1E1B109714A58CD343

- Domiciliary multidimensional assessment and follow-up visits – 34% reduction
- Dementia carer training – delays admission to care homes by 20 months
- Short term rehabilitation – reduces care home admissions Lewis, 2007, https://www.kingsfund.org.uk/sites/default/files/Predicting%20book%20final.pdf)

- Care giver distress = 3rd strongest predictor for care home admissions (Bettini et al, 2017, https://link.springer.com/article/10.1186/s12913-017-2671-8)
- Loneliness as risk factor - ?20% of reasons for admission (Hanratty, 2018, https://academic.oup.com/ageing/article/47/6/896/5051695?login=true)

Stakeholder suggested areas/ideas

1. Rehabilitation support - Work underway - steering group
2. Staff Education to reduce inappropriate referrals (based on a number of reviews of care home referrals)
3. Provision of early intervention and crisis support
   - Community MDTs, Older Peoples Assessment Area, Intensive Home care (eg Tayside)
4. Actions to address lack of social contacts/loneliness and isolation and to reduce cognitive deterioration and functional decline
5. Supporting healthy living
   1. 'Live Well, Eat Well', Dementia-friendly communities (building on success of Innerleithen & Eyemouth)
   2. Digital support, Locality support
6. Different approach to managing pathway from hospital to care homes –
   - Home First, other step down arrangements
7. Support for Carer Stress and burnout (esp higher dependency clients)
   - Directory of community support, Step-up care, Respite, Access to day centres

Commissioning implications of modelling

- Avoidance of 14-20 care home admissions/year would avoid need for additional care home capacity
- There are a range of evidenced measures not currently routinely undertaken that could reduce demand
  - Staff Education to help identify appropriate referrals to care homes
  - Provision of early intervention and crisis support, including intensive short-term rehab.
  - Actions to
    - address lack of social contacts/loneliness and isolation
    - reduce cognitive deterioration and functional decline
  - Actions to support healthy living - 'Live Well, Eat Well', Dementia-friendly communities
  - Different approach to managing pathway from hospital to care (i.e. step-down assessment)
  - Support for Carer Stress and burnout (esp. higher dependency clients)

Further work with service users and carers should be undertaken to determine the best ways of providing support

Location of care home beds influences number of residents who stay in own locality. Decisions on provision of care homes should therefore be taken with this in mind

- Data and evidence suggests that family support and community provision may reduce care home requirements.
  - A mixed model approach to provision of support for older people, including a focus on non-care home housing options and bed-based support to assess and rehabilitate potential care home residents may be helpful
- The age and provision of current private and local authority care home provision would suggest a need for reprovisioning of existing care home capacity
-
- As a matter of priority, there should be work to explore the views of care home residents, potential care home residents, carers and the local community on the nature, type and location of future care home facilities
-

Scottish Borders Care Home Modelling – Final Report

7th September 2021

Executive Summary:

A modelling exercise was undertaken by Public Health Scotland to advise on demand for and commissioning of care home beds in Scottish Borders for next 10 years (to 2030).

Demographic modelling indicates that there would be a need for 187 additional care home beds within the Scottish Borders by 2030. This represents an annual increase of between 14 and 20 care home admissions per year

However, past experience is that care home demand will not increase proportionately to demographic change.

- Between 2009 and 2019, care home bed numbers in Scottish Borders increased by just 1%, despite a 20% increase in the population aged 75 and over. This disparity is shared across Scotland with a Scotland overall change of -1% during this period.
- Scottish Borders has 3rd lowest number of care home residents per head population in Scotland and has been amongst lowest 4 local authorities for past 10 years (2009 to 2019).

Analysis of data indicates Scottish Borders:

- is a low outlier in terms of care home bed provision
- has one of the higher average ages for admission to care home
- benchmarks low for paid homecare provision
- Has slightly higher than average rates of people providing unpaid care
- Has higher than average provision of age-specific housing provision for older people

Studies show that fewer older people enter care homes in rural areas compared to urban area and this may be related to closer family support networks. This suggests older people in the Borders manage to remain at home longer than in other places.

There is a further range of evidenced measures for reducing care home admissions that are not currently robustly applied in the Scottish Borders.

This analysis suggests that;

- It is likely that action could be taken to avoid the modelled demographic demand
- Planned and coordinated action could be undertaken to further reduce care home demand
- Future planning for older people should build on the existing features of the Borders community to develop a mixed model of provision to maintain older people at home longer, age-specific housing models and reprovision of care homes as flexible facilities, incorporating a range of levels of care support including long-term care
- Engagement with older people, service users, carers and service providers in the Borders should be undertaken to establish what models of service provision would work best for each community

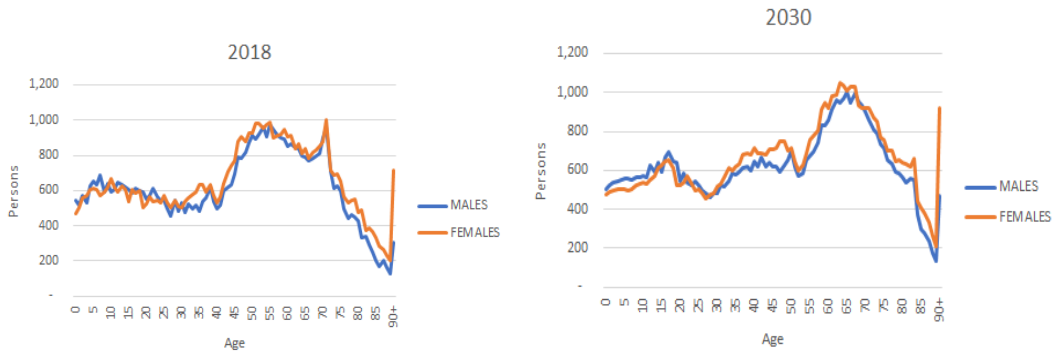
Full Report

1. The 'Ask': Modelling of a 10-year forward projection of 24-hour care demand for older people to inform strategic commissioning was undertaken between April and August 2021.

2. Methodology: expected demographic changes in population at a locality level with adjustments for other predicted changes (migration etc).
    a. Assumptions applied to the model:
        i. Expected changes in population frailty or dependency levels – evidence suggests that these track age-specific demographic changes
        ii. Expected changes in dementia prevalence and need for 24-hour care -– evidence suggests that these track age-specific demographic changes
        iii. **Impact of changes in models of care on demand for 24-hour care**

3. Note on data
    a. 3 data sources
        i. Care Home Census – end March snapshot survey of all care home residents in each area[1]
        ii. SBC Care Home resident data – end March snapshot of SBC-funded care home residents (all locations)
        iii. NRS Population Projections[2]
    b. Challenges
        i. Reconciling two different datasets
        ii. Snapshot data – does not reflect in-year variation

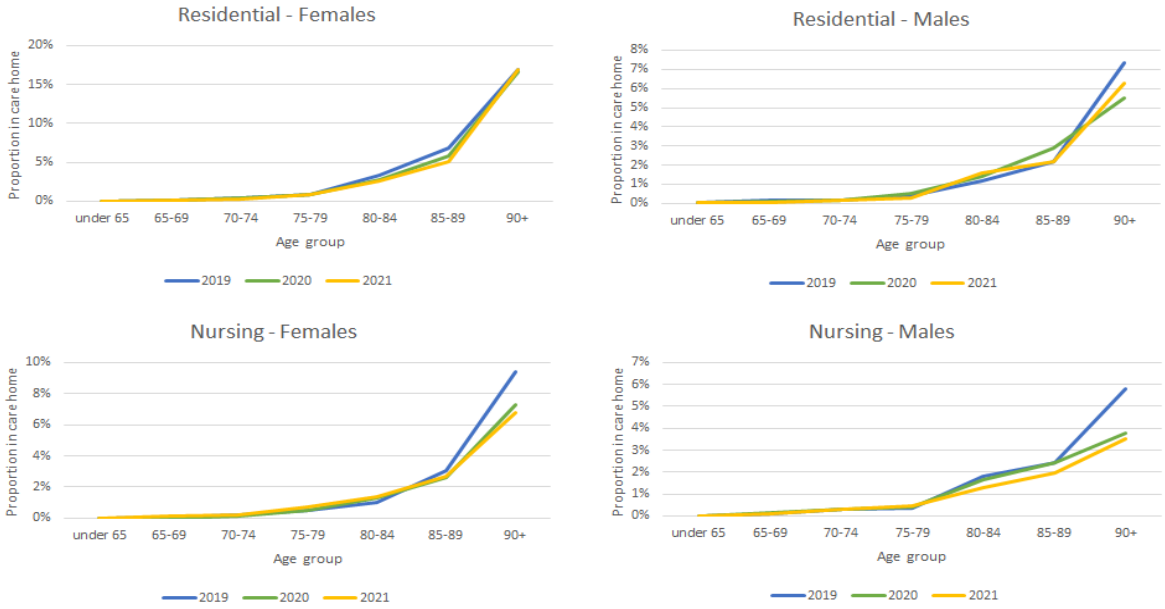
4. **Phase 1: demographic modelling:**
    a. Population analysis
        i. Borders population is currently dominated by people aged 50-70.
        ii. By 2030, 75+ population expected to grow by >20%,
        iii. Overall population will increase by about 1%.



    b. Percentage of population in long-term residential care (SBC-funded)

Age group	Females	Males
80-84,	3.5%	3%
85-90	9%	5%
90+	25%	10.5%

[1] https://www.publichealthscotland.scot/publications/care-home-census-for-adults-in-scotland/care-home-census-for-adults-in-scotland-statistics-for-2009-to-2019/
[2] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/sub-national-population-projections/2018-based



c. Long-term residential care by locality

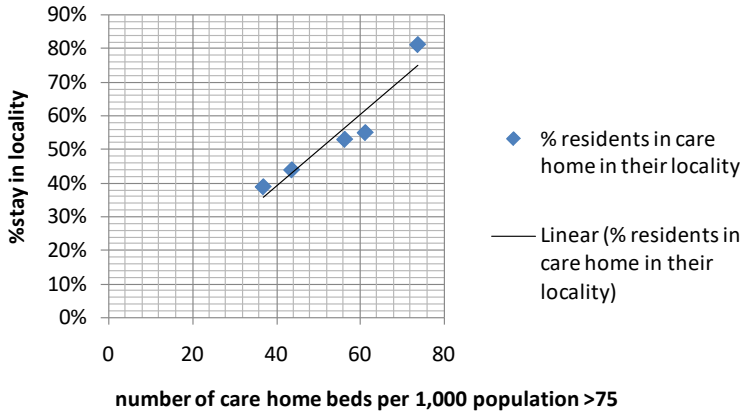
i. Majority of residents go into care homes in their locality - Teviot (81%), Eildon (55%), Cheviot (53%)

ii. 50% of Berwickshire care home residents live outwith Borders (mostly Berwick)

		Care home locality					
		Berwickshire	Cheviot	Eildon	Teviot and Liddesdale	Tweeddale	Outwith Borders
Client locality	Berwickshire	**39%**	5%	3%	2%	1%	50%
	Cheviot	18%	**53%**	11%	7%	1%	10%
	Eildon	2%	25%	**55%**	9%	4%	7%
	Teviot and Liddesdale	1%	12%	4%	**81%**	0%	2%
	Tweeddale	1%	13%	17%	1%	**44%**	26%

Source: PHS

iii. There is a clear correlation (.91) between number of care home beds in a locality and % of residents who remain in their own locality



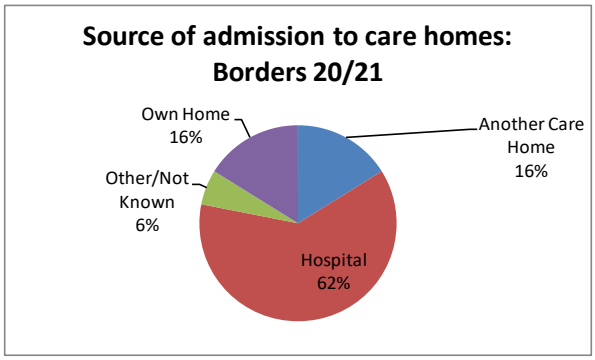
iv. Further research to find out whether older people requiring long-term care wish to remain in their locality is recommended

d. Care home admissions.

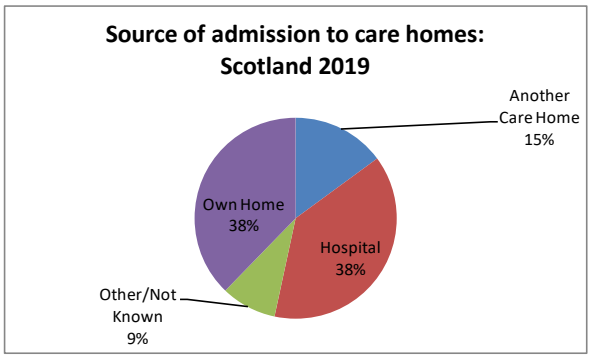
i. Source of admission. Based on one year (20/21) Strata data, Borders has a higher rate of admission direct from hospital to care home than Scotland as a

whole (62% compared to 38% of all admissions). Admissions direct from home are 16% compared to 38% for Scotland. This could either reflect inappropriate decisions being made on care home placement in hospital or a trend where older people remain at home until they become so frail that hospital admission is required.

NB: Scottish Borders data relates to council-funded placements only. Scotland data will include self-funders

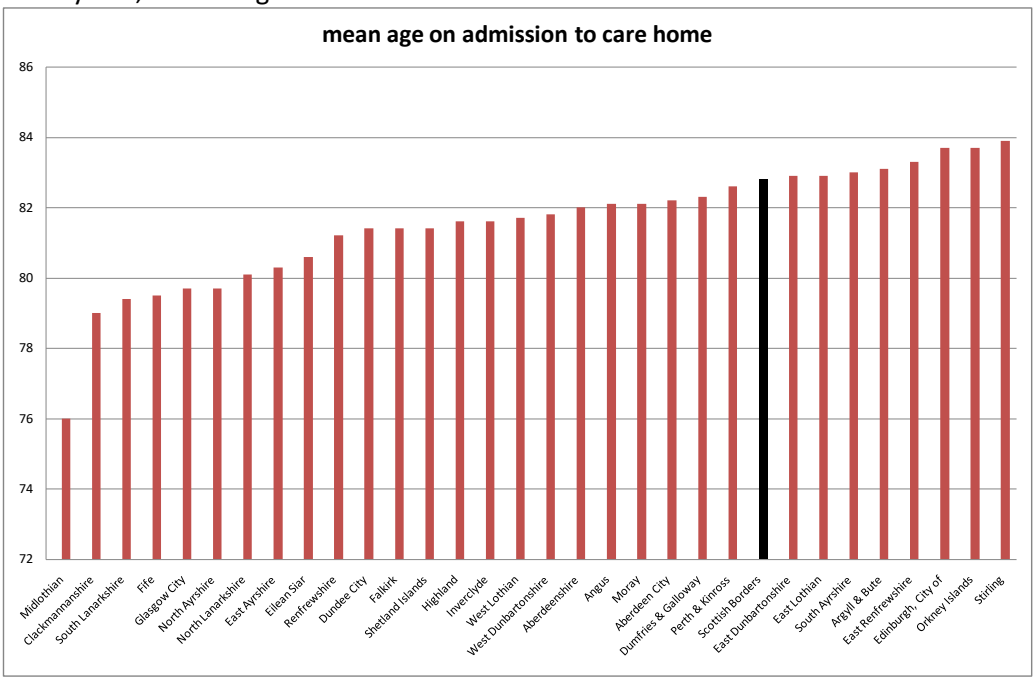


Source: Strata



Source: Care Home Census

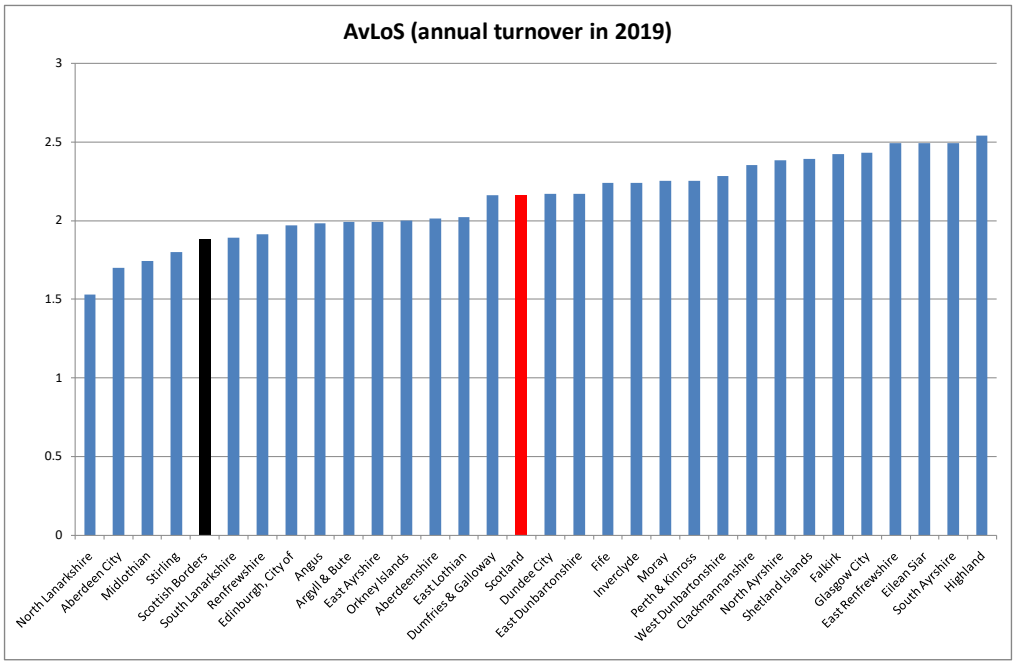
ii. Age on admission The average age of admission to a care home in the Borders is 82.8 years, the 9th highest across Scotland:



Source: Care Home Census

iii. The mean length of time that a Scottish Borders resident stays in a care home is 1.4 years (residential) and 0.8 years (nursing).

iv. Scottish Borders had 5th lowest crude LoS (total occupants divided by discharges) calculated by turnover in Scotland in 2019



Source: Care Home Census

e. Care home demographic demand forecasting
   i. Based on demographic change only, we can expect an increase of 187 beds by 2030
      1. Residential:28% increase
      2. Nursing: 29% increase

Year	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Care home residents - Residential	415	445	454	465	473	482	496	510	522	532
% increase from 2021	-	7%	9%	12%	14%	16%	20%	23%	26%	28%
Care home residents - Nursing	237	253	259	265	271	276	285	293	300	306
% increase from 2021	-	7%	9%	12%	14%	16%	20%	24%	27%	29%

Source: PHS

NB: The model indicates a jump in demand of 46 beds. However, this is likely to be a data adjustment issue and not reflect actual demand

f. From 2023-2026, there is a predicted increase of 14-17 beds/year.

g. From 2027-2029, there is a predicted increase of 19-23 beds/year.

h. Therefore the increase in overall bed demand equates to 14-20 **additional** admissions/year :

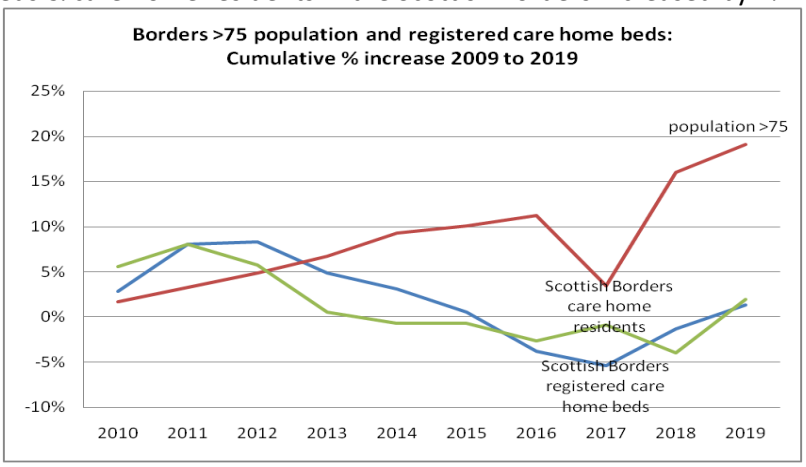
Annual increase	2022	2023	2024	2025	2026	2027	2028	2029	2030
Care Home residents - residential	30	9	11	8	9	14	14	12	10
Care Home residents - nursing	16	6	6	6	5	9	8	7	6
Care Home residents - Total	46	15	17	14	14	23	22	19	16
Extra admissions/year	14	16	13	13	22	20	18	15	14

5. Phase 2: Analysis of past trends in demand for care home places in Borders

a. From 2009-2019 the population over 75 in the Borders increased by 20% and over 65 by 24%

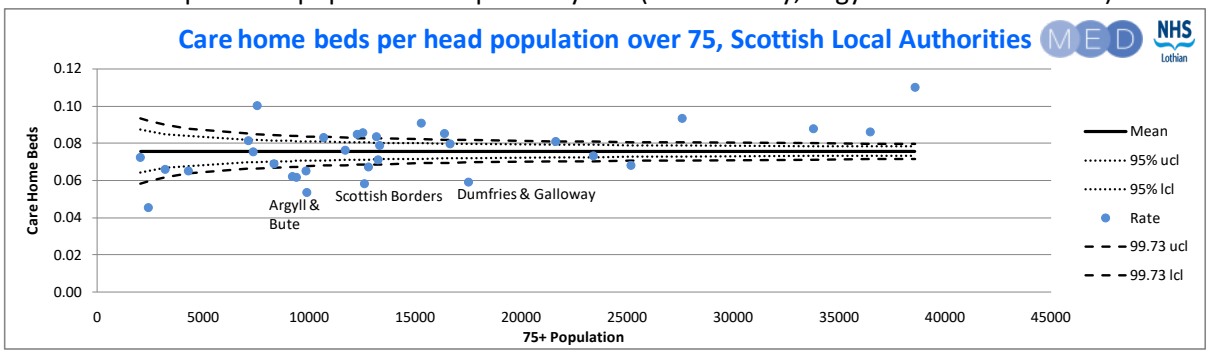
b. People over 75 comprised 66% of care home residents. Those over 65 formed 97%.

c. Care home beds & care home residents in the Scottish Borders increased by 1%



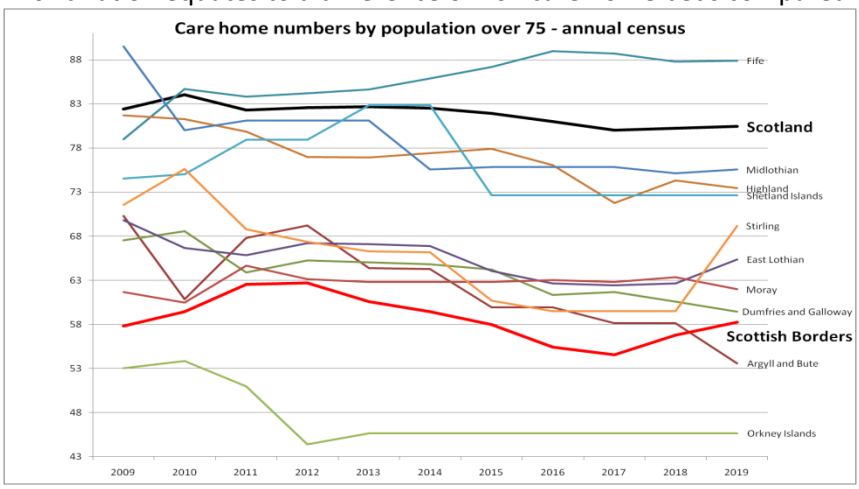
Source: Care Home Census, NRS Population Projections

d. The Scottish Borders has been amongst the 4 Local Authorities with lowest rate of care home beds per head population for past 10 years (with Orkney, Argyll and Bute and D&G)



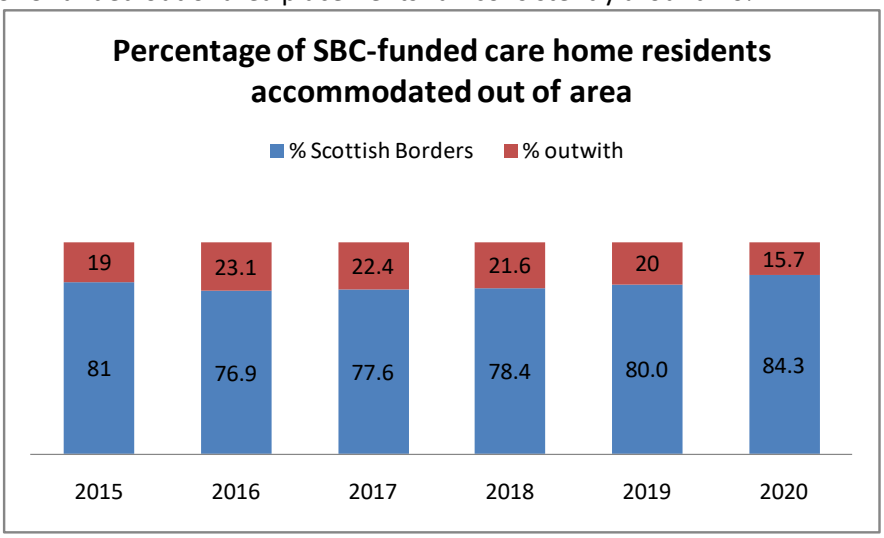
Source: Care Home Census, 2019 data

e. This variation equates to a difference of 264 care home beds compared to Scottish average



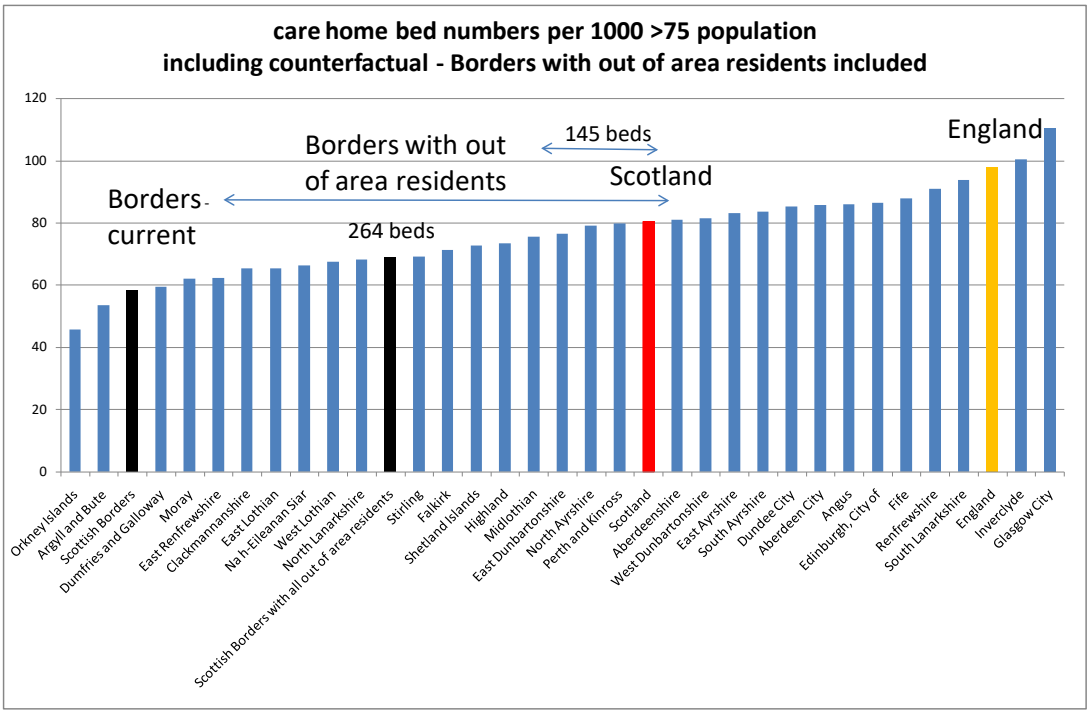
Source: Care Home Census, NRS Population Projections

f. SBC-funded out of area placements run consistently around 20%.



Source: SBC data

We are not able to access comparative data from other Local Authorities. However, if all out-of-area residents are incorporated into total Borders care home provision, Scottish Borders care home rate remains 145 beds lower than Scottish average (this assumes no other LA has out-of-area residents):



Source: Care Home Census,:Public Health England Palliative and End of Life Care Profiles https://fingertips.phe.org.uk/end-of-life#gid/1938133060/ati/6

6. Health of the Older Population

Older People in the Borders may be fitter and therefore have reduced need for care home provision than other populations. There is no single measure that can provide this data. A basket of measures provides a mixed message:

a. A lower percentage of people over 60 in Scottish Borders claim Pension Credit than Scottish average
b. Proportion of over 65s who assess their general health as 'good/very good' has increased by 10% from 61% in 2012 to 71% in 2016

c. Fewer people aged 65 and over say they have a long-term condition than the Scottish average (all from Scottish Borders Strategic Assessment 2020)

d. Borders has lowest rate of antipsychotic prescribing in Scotland for >75s

However:

e. Borders has the 4th highest hospital admission rate and 3rd highest bedday rate for falls

f. Borders has sixth highest rate of very high risk older people on SPARRA

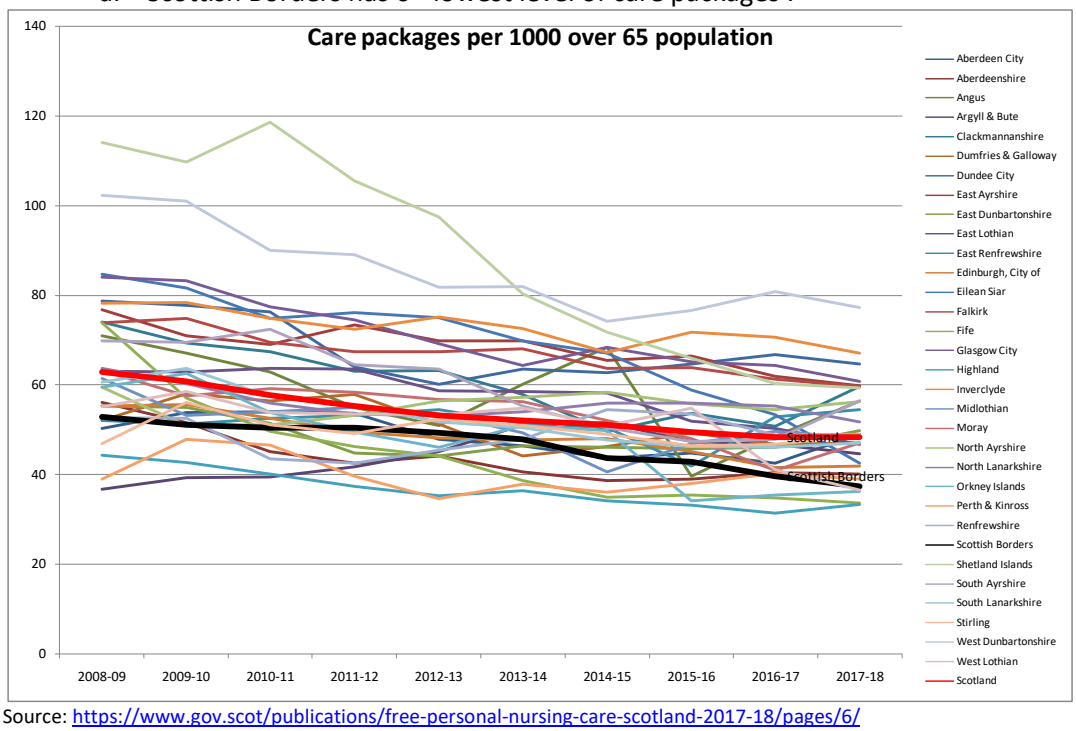
g. >75 A&E attendance rates are 1/3rd higher than Scottish average (all from PHS Discovery)

This suggests that older people in the Borders see themselves as fitter than other areas, but actual usage of services suggests that levels of health are similar to most of Scotland.

7. Analysis of provision of alternatives to care home

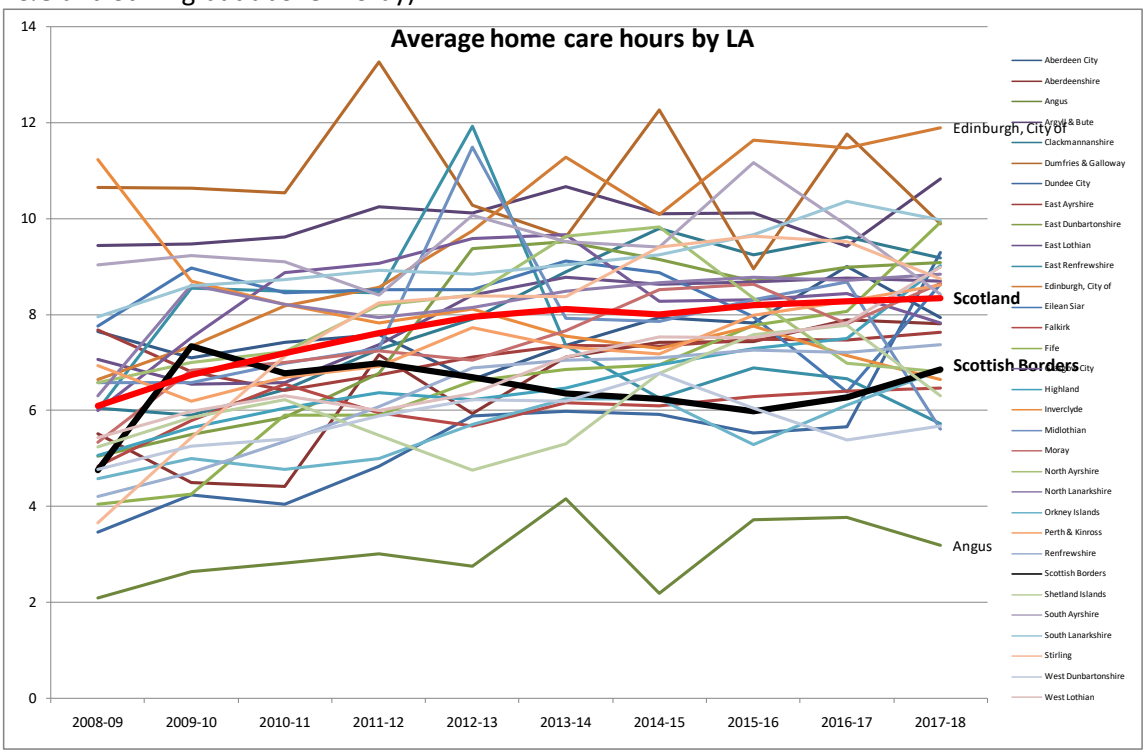
a. Home Care rates: The lower rate of care home residents may be reflected in higher rates of home care within the Borders.

a. Scottish Borders has 6th lowest level of care packages :



Source: https://www.gov.scot/publications/free-personal-nursing-care-scotland-2017-18/pages/6/

b. Scottish Borders ranks 14th out of 32 for level of care hours (below Argyll & Bute, Orkney, D&G and Stirling but above Moray)

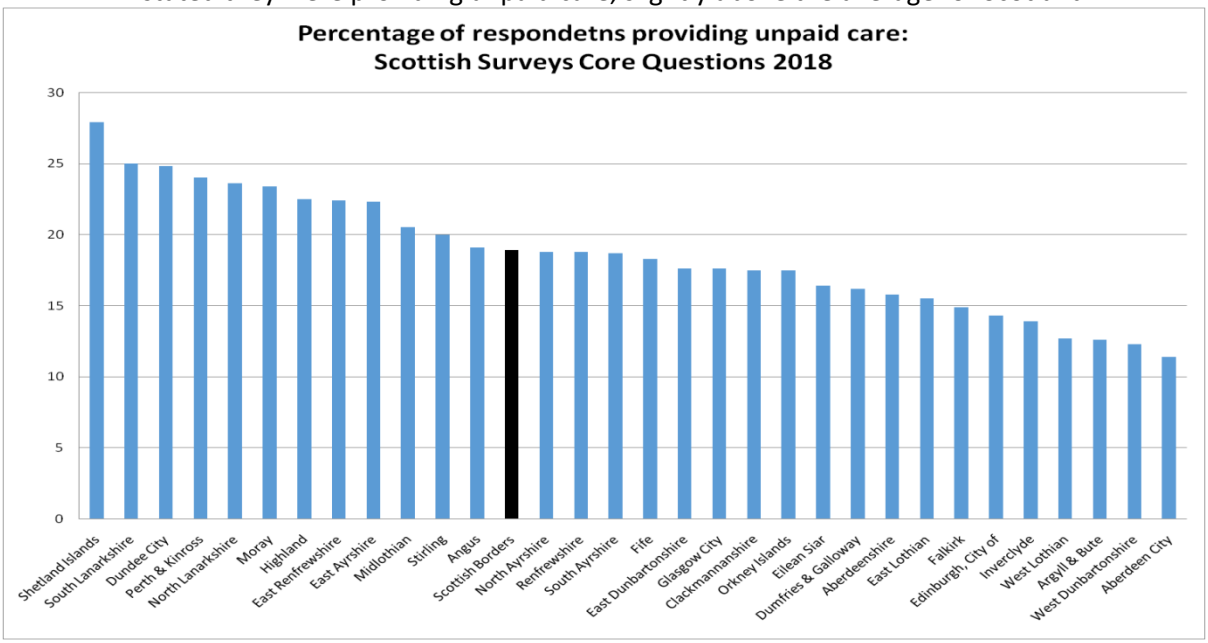


Source: https://www.gov.scot/publications/free-personal-nursing-care-scotland-2017-18/pages/6/

f. Unpaid care

a. There is no definitive data on unpaid carers for older people. There is some evidence that people in the Scottish Borders provide higher levels of unpaid care than other parts of Scotland:

b. In the Scottish Household Survey for 2018, 18% of Scottish Borders respondents stated they were providing unpaid care, slightly above the average for Scotland:



Source: https://statistics.gov.scot/resource?uri=http%3A%2F%2Fstatistics.gov.scot%2Fdata%2Funpaid-care-provision-sscq

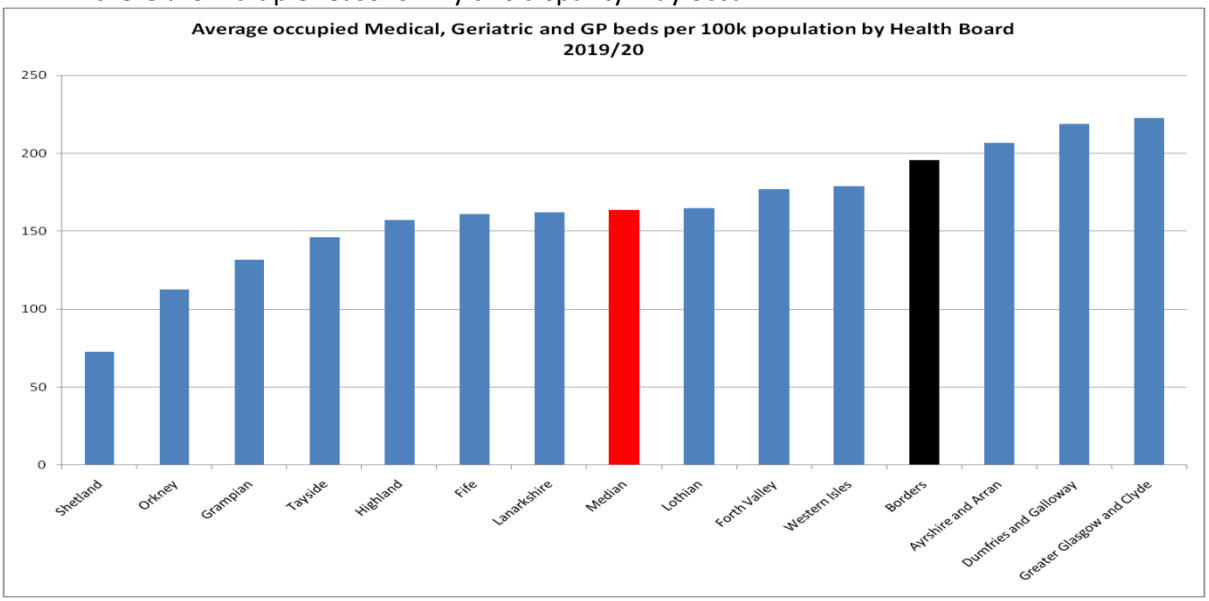
c. Feedback from the Scottish Borders Carers Centre was that there were very high numbers of unpaid carers supporting older people with high dependency needs

d. However, there was no indication that there were higher levels of care breakdown leading to emergency hospital admission – Borders rates for older people were similar to Scottish average:

Source: PHS Discovery

c. Hospital beds.

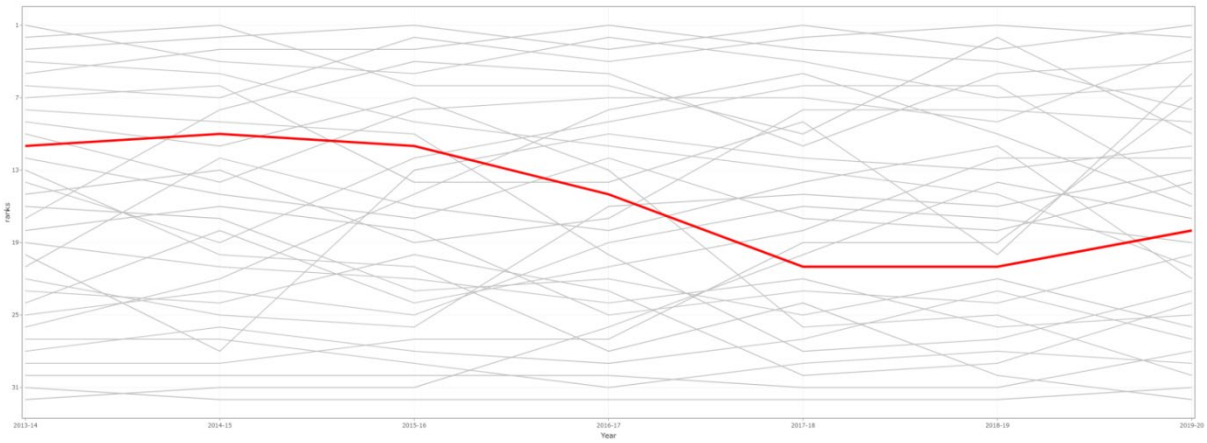
a. Borders does have a higher number of hospital beds for older people than the Scottish average weighted for age. However, there is no correlation between numbers of hospital beds and numbers of care home beds by Health Board, and there are multiple reasons why this disparity may occur.



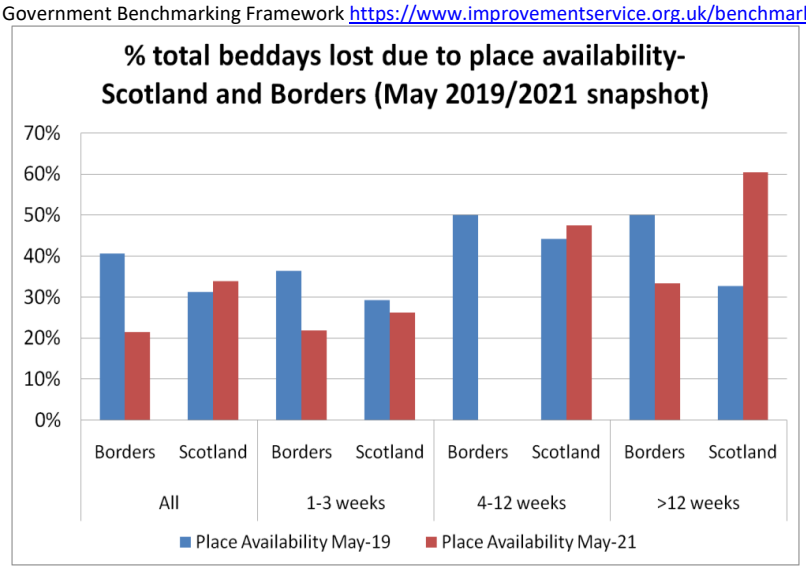
Source; https://www.publichealthscotland.scot/publications/acute-hospital-activity-and-nhs-beds-information-quarterly/acute-hospital-activity-and-nhs-beds-information-quarterly-quarter-ending-31-december-2020/data-files/

b. Delayed Discharges. Borders has not been an outlier in terms of beddays lost to delayed discharges during this period and had slightly lower rates of beddays lost specifically due to waits for care homes than Scotland as a whole on a Snapshot analysis in May 2021.

Rank of number of days people spend in hospital when ready to be discharged (per 1000 >75) 2013/14 -2019-20

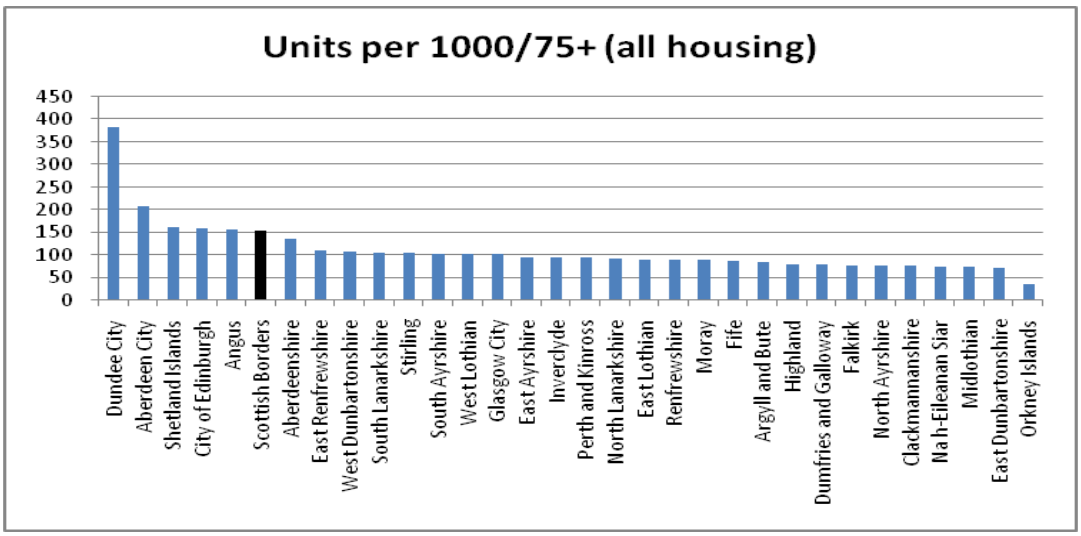


Source:Local Government Benchmarking Framework https://www.improvementservice.org.uk/benchmarking/explore-the-data



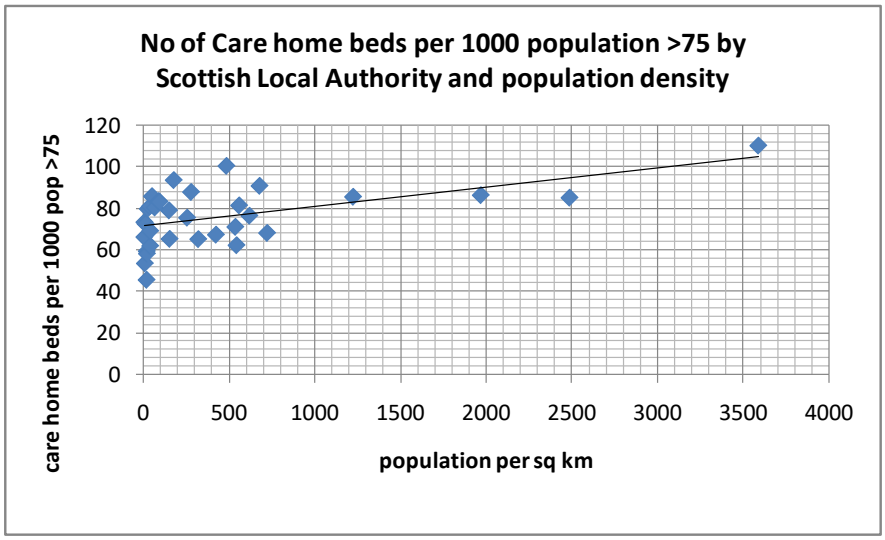
Source: PHS Discovery

d. Housing. The Scottish Borders has the 6th highest rate across Scottish Local Authorities for provision of age-designated housing for older people in Scotland, although ranks 13th for Extra Care Housing.



Source: HLN/Mears: The market for extra care housing:
https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Reports/HLIN-Mears_ECH_Market_Analysis.pdf

e. Rurality. There is a clear correlation (.75) between very high and very low population density in Scotland and number of care home beds. This correlation is less clear for intermediate density areas



Source:https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

Two studies have explored older peoples support networks in rural areas compared to urban areas:

- Burholt et al (2018) studied Welsh populations and found that populations who have lived in an area for > 25 years have stronger informal (family) networks (but less use of community supports)[3].
- McCann et al reviewed care home admissions in Northern Ireland and found that admissions in rural areas were 75% of urban and intermediate areas, which they attributed to better family support[4]

8. **Prevention of care home admission**
   a. A reduction in care home admissions of between 14 and 20 per year would avoid the need to expand the care home bed base in the Scottish Borders. This represents between 5% and 7% of annual care home admissions (2019 numbers).
   b. There is an evidence base for risk factors for care home admission:
      i. Deterioration in cognition and behavioural and psychological symptoms, and caregiver burden were strongest predictors for dementia sufferer admission to care home (Toot et al (2017), [5]:
      ii. According to Bettini et al (2017), care giver distress was 3rd strongest predictor for care home admissions[6]
      iii. Hanratty (2018) estimated that loneliness was a risk factor in 20% of care home admissions[7]

[3] Burholt et al, The impact of residential immobility and population turnover on the support networks of older people living in rural areas: Evidence from CFAS Wales, *Popul Space Place. 2018;**24:e2132.*** https://doi.org/10.1002/psp.2132

[4] McCann et al, Urban and rural differences in risk of admission to a care home: A census-based follow-up study , http://dx.doi.org/10.1016/j.healthplace.2014.09.009

[5] Toot et al, Causes of nursing home placement for older people with dementia: a systematic review and meta-analysis, https://www.cambridge.org/core/journals/international-psychogeriatrics/article/causes-of-nursing-home-placement-for-older-people-with-dementia-a-systematic-review-and-metaanalysis/62B350693121CB1E1B109714A58CD343

[6] Bettini et al, 2017, https://link.springer.com/article/10.1186/s12913-017-2671-8

[7] Hanratty, 2018, https://academic.oup.com/ageing/article/47/6/896/5051695?login=true

c. Factors that can reduce care home admission include
    i. Domiciliary multidimensional assessment and follow-up visits – 34% reduction
    ii. Dementia carer training – delays admission to care homes by 20 months
    iii. Short term rehabilitation – reduces care home admissions[8]
d. It has been observed that there is relatively little coordinated work underway to address any of these risk factors within Scottish Borders currently. This would suggest that there are opportunities to impact care home admissions by focusing on these areas
e. A review of potential opportunities to do this undertaken by a senior stakeholder group (details attached in appendix 1) suggested the following areas:
f. Stakeholder suggested areas/ideas
    i. Rehabilitation support - Work underway and steering group established
    ii. Staff Education to reduce inappropriate referrals (based on a number of reviews of care home referrals)
    iii. Provision of early intervention and crisis support, e.g., Community MDTs, Older Peoples Assessment Area, Intensive Home care (e.g. Tayside)
    iv. Actions to address lack of social contacts/loneliness and isolation and to reduce cognitive deterioration and functional decline
    v. Supporting healthy living , e.g., 'Live Well, Eat Well', Dementia-friendly communities (building on success of Innerleithen & Eyemouth), Different approach to managing pathway from hospital to care homes – Home First, other step down arrangements
    vi. Support for Carer Stress and burnout (esp. higher dependency clients), e.g., Directory of community support, Step-up care, Respite, Access to day centres

9. **Conclusion and Recommendations**
a. . It is essential that this analysis is balanced by an in-depth exploration of what service users, carers, service providers and local communities consider they need.
b. To avoid or reduce an increase in demand for care home placements requires the avoidance or reduction between 14 and 20 care home admissions/year

c. Stakeholder sessions and evidence from literature suggest a range of measures that could reduce demand for care home bed increases
    i. Staff Education to help identify appropriate referrals to care homes
    ii. Provision of early intervention and crisis support, including intensive short-term rehab.
    iii. Actions to
    iv. address lack of social contacts/loneliness and isolation
    v. reduce cognitive deterioration and functional decline
    vi. Actions to support healthy living - 'Live Well, Eat Well', Dementia-friendly communities
    vii. Different approach to managing pathway from hospital to care (i.e. step-down assessment)
    viii. Support for Carer Stress and burnout (esp. higher dependency clients)
d. Further work with service users and carers should be undertaken to determine the best ways of providing support

e. Location of care home beds influences number of residents who stay in own locality. Decisions on provision of care homes should therefore be taken with this in mind

[8] Lewis, 2007, https://www.kingsfund.org.uk/sites/default/files/Predicting%20book%20final.pdf

f. The potential evidence that family support and community provision may reduce care home requirements suggests that a mixed model approach to provision of support for older people should be considered, including a focus on non-care home housing options and bed-based support to assess and rehabilitate potential care home residents

g. The age and provision of current private and local authority care home provision would suggest a need for reprovisioning of existing care home capacity

h. **This is a data analysis only and has not taken into account the assumptions, understanding and expectations of those using service or their carer**. As a matter of priority, there should be work to explore the views of care home residents, potential care home residents, carers and the local community on the nature, type and location of future care home facilities

Appendix 1: Stakeholders involved in this analysis

Report completed by Phillip Lunts

Demographic Modelling: Sarah Watt, Scott Jackson, Public Heath Scotland

Supported by;
Meriel Carter – Analytical Team Lead, Business intelligence, NHS Borders
Gary Tait – Information Assistant, Social Work, Scottish Borders Council
Graeme McMurdo, Programme Manager, Scottish Borders Council

Stakeholder Group
Susannah Flower, Associate Director of Nursing, Primary and Community Services, NHS Borders
Brian Paris, Chief Officer – Adult Social Work and Social Care, Scottish Borders Council
Paul Williams - Associate Director of AHPs, NHS Borders
Julie Glen - Operations Director, SB Cares
Susan Chisholm – Service Manager, SB Cares
Rachel Stewart. Clinical Director, Medicine for the Elderly, BGH, NHS Borders
Jennifer Lonnen, Consultant Geriatrician, NHS Borders
Kathleen McGuire, External Consultant, Borders Health and Social Care Partnership

I would also like to acknowledge support from
Katy Moffat - Planning and Performance Co-ordinator, NHS Borders
Anne Hendry - Director, International Foundation for Integrated Care Scotland
Pete Knight – Consultant in Health and Social Care Data
Lynn Gallagher – Borders Carers Centre Manager

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 22 September 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
APPOINTMENT OF EXTERNAL MEMBER OF IJB AUDIT COMMITTEE	
Purpose of Report:	To seek approval for the extension of the appointment of the external member of IJB Audit Committee.
Recommendations:	The Scottish Borders Health & Social Care Integration Joint Board is asked to: **Approve** the extension of the appointment of Mr Jim Wilson as External Member of the Scottish Borders Health and Social Care Integration Joint Board Audit Committee to 31 October 2024.
Personnel:	This report relates to the membership 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:	Good governance will enable the IJB to pursue its vision effectively as well as underpinning that vision with mechanisms for control and management of risk.
Risk Implications:	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. Extending the appointment of the external member of IJB Audit Committee for a further three years enables independence and objectivity within the membership to mitigate this risk and ensures continuity within the IJB Audit Committee membership.

1 Background

1.1 It is important that the IJB 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 CIPFA Audit Committees Guidance sets out CIPFA's view of the role and functions of an Audit Committee (Position Statement), includes a self-assessment checklist and an effectiveness toolkit, and recommends as best practice the inclusion of at least one independent member.

2 Summary

2.1 The IJB at its meeting on 19 February 2020 approved the appointment of Mr Jim Wilson as External Member of the Scottish Borders Health and Social Care Integration Joint Board Audit Committee to 31 October 2021. The latter date was the remaining term of appointment of the previous incumbent, who had resigned.

2.2 The proposal is to seek a 3-year extension to the appointment of the current external member of the IJB Audit Committee, Mr J Wilson, to 31 October 2024. Mr J Wilson has expressed an interest in continuing as the external member of Scottish Borders IJB Audit Committee. The Chair of IJB Audit Committee is supportive of this proposal.

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 22 September 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) **Approve** the APR for publication.
Personnel:	The 2020/21 APR has been developed by the HSCP Leadership Team and the Strategic Planning Group
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:	The implementation of the IJB strategies aims to support the improvement of the health of the population and to narrow the health equality gap that exists within the communities of the Borders.
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 It is a legislative requirement for every Health & Social Care Partnership to produce an Annual Performance Report (APR). The legislatively required content of the 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 extended this deadline and this year the APR must be published no later than 30th November 2021.

1.2 As a legislative minimum, APRs must include:

- Performance in relation to the National Health & Wellbeing outcomes
- Performance in relation to the Partnership's Strategic Plan
- Comparison between reporting year and previous years (up to a maximum of 5-years)
- Information on financial performance and Best Value
- Information on Localities
- Information on inspection of services
- Details of any review of the Strategic Plan

1.3 Our 2020/21 APR follows the same format as our previous two APRs which were well received by IJB members, Scottish Government and the Inspectorate. It is also broadly similar in structure and content to other Partnership APRs.

1.4 Our APR is structured around the three Borders HSCP strategic objectives. It covers all of the legislatively required areas and also includes:

- "Spotlight" sections highlighting the impact of the Covid-pandemic and response to it.
- "What we said"/"What we did" in relation to the priorities we set last year.
- Look forward to priorities for 2021/22.

1.5 The draft APR was presented at the July 2021 IJB for approval, subject to IJB suggested changes/updates. The IJB meeting was unfortunately not quorate and it was requested that the report be discussed at the Strategic Planning Group and retuned to a later IJB for approval, with amendments incorporated. The draft APR and IJB feedback were presented at the Strategic Planning Group meeting in early August. Suggested changes and updates have been incorporated into the APR, as attached.

1.6 There are two appendices to this report:

Appendix 1: Scottish Borders Health & Social Care Partnership Annual Performance report 2020/21

Appendix 2: APR numbers summary referencing selected data

Scottish Borders **Health & Social Care** Partnership

ANNUAL PERFORMANCE REPORT 2020-2021

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

Scottish Borders
Health and Social Care
PARTNERSHIP

CONTENTS

SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERSHIP ANNUAL PERFORMANCE REPORT 2020/2021

INTRODUCTION

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

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

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

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

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

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

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

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

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

Annual Performance Report

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

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

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

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

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

EXECUTIVE SUMMARY

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

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

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

Our Annual Performance Report (APR) sets out the Partnership's performance between April 2020 and March 2021, outlining our priorities for 2021/22 and reflecting back on performance since inception in April 2016.

Delivery on the progress is structured under our 3 Strategic Objectives, which are:

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

Included in the report are 'spotlight' sections, reflecting on some of the key work that has taken place during 2020/21.

In this year's report the spotlights cover:

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

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

In regard to performance, the following is included:

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

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

THE BORDERS AT A GLANCE

OLDER

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

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

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

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

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

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

COLDER

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

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

BOLDER

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

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

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

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

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

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

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

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

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

2020/21 PARTNERSHIP PERFORMANCE AT A GLANCE
ANNUAL PERFORMANCE

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

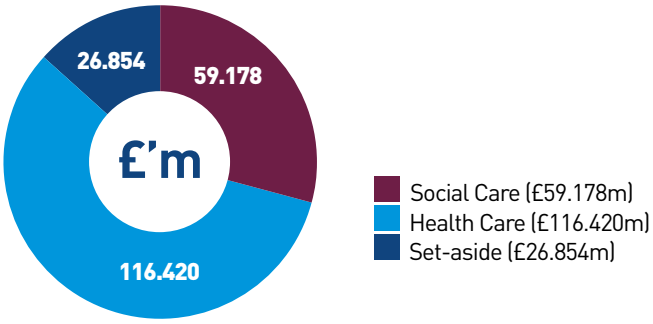
KEY

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

OUR PARTNERSHIP SPEND IN 2020/21

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

THIS WAS SPLIT:



£ ON EMERGENCY HOSPITAL STAYS

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

+ve trend over 4 periods
Better than Scotland (24.0% - 2019/20)
Better than target (21.5%)

STRATEGIC OVERVIEW

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

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

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

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

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

Our three strategic objectives are:

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

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

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

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

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

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

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

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

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

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

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

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

Health and Social Care Services which are integrated

ADULT SOCIAL CARE SERVICES*

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

ACUTE HEALTH SERVICES (PROVIDED IN A HOSPITAL)*

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

COMMUNITY HEALTH SERVICES*

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

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

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

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

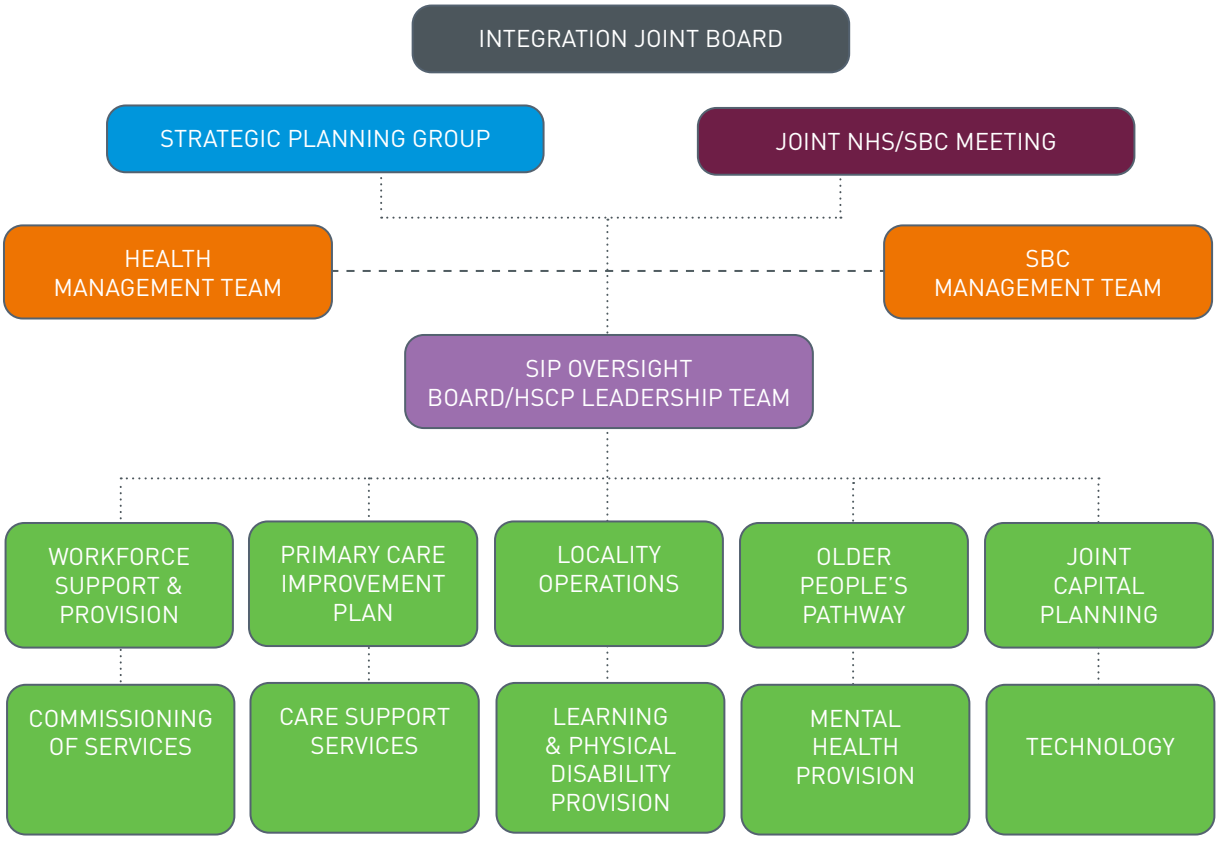
These changes will support the IJB in fulfilling its function as a strategic commissioning body and provide greater managerial capacity in both quality and compliance with policy.

GOVERNANCE AND ACCOUNTABILITY

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

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

H&SC Partnership Governance Structure



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

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

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

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

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

The Internal Audit work for 2020/21 covered:

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

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

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

KEY PARTNERSHIP DECISIONS 2020/21

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

During 2020/21, the Board:

April 2020:
- No meeting held because of the pandemic

May 2020:
- No meeting held because of the pandemic

June 2020:
- No meeting held because of the pandemic

July 2020:
- No meeting held because of the pandemic

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

23rd September 2020 meeting:

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

21st October 2020 meeting:

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

November 2020:

- No meeting held

16th December 2020

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

January 2021:

- No meeting held

17th February 2021 meeting:

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

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

24th March 2021 meeting:

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 1

OBJECTIVE 1

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

Objective 1: Background and Challenges

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

Key to achieving positive change is by:

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

Objective 1: Spotlight – Workforce

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

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

SB Cares Rapid Response Team

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

Education Hubs

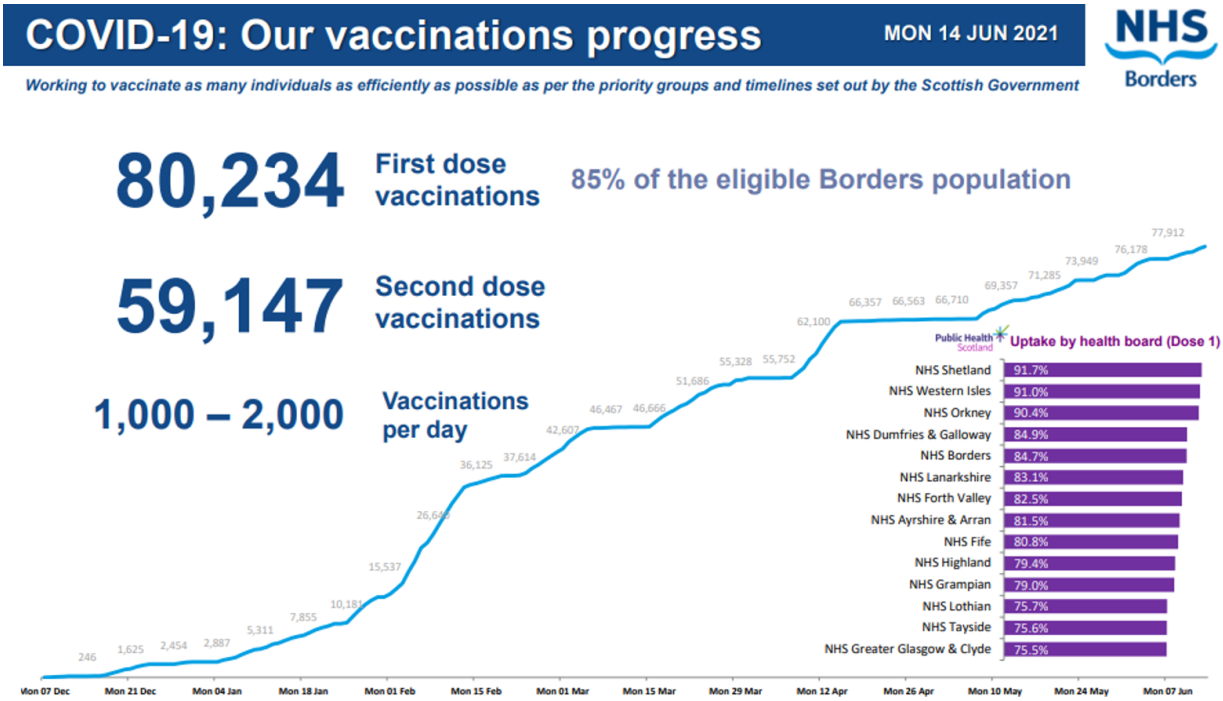
When the lockdown restrictions resulted in students being unable to attend school, Education Hubs were established to provide vital support, every day of the week, for the children of key workers and vulnerable families. The Hubs were supported by a range of HSCP staff working alongside summer students,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

Vaccinator Workforce

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

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

The uptake of Covid-vaccination at June 2021 was:



Acute staff

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

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

Staff Wellbeing

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

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

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

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

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

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

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

Partnership Priorities for 2020/21 – What we said

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

Key Achievements/Successes : What we did

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

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

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

Key Achievements/Successes : What we did

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

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

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

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

Partnership Priorities for 2020/21 – What we said

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

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

Key Achievements/Successes : What we did

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

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

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

Objective 1: Partnership Priorities for 2020/2022

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

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 2

OBJECTIVE 2

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

Objective 2: Background and Challenges

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

Key to achieving positive change is by:

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

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

Care Homes and Care at Home

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

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

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

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

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

Community Care Review Team (CCRT)

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

Infection Control

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

Resilience Meetings

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

Waiting Times

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

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

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

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

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

Partnership Priorities for 2020/21 – What we said

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

Key Achievements/Successes : What we did

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

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

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

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

Key Achievements/Successes : What we did

3) Home First

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

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

(4) Matching Unit

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

(5) Strata

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

The evaluation concluded that:

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

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

Partnership Priorities for 2020/21 – What we said

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

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

Key Achievements/Successes : What we did

Extra Care Housing

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

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

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

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

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

Partnership Priorities for 2020/21 – What we said

5. **Service Commissioning**
   Commissioning and the recommissioning of services including:

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

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

Key Achievements/Successes : What we did

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

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

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

BOPPP

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

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

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

Objective 2: Partnership Priorities for 2021/2022

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

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

PROGRESS AGAINST STRATEGIC OBJECTIVE 3

OBJECTIVE 3

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

Objective 3: Background and Challenges

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

Key to achieving positive change is by:

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

The Borders Carers Centre is responsible for Carers Support Plans and can assist in putting together a plan centred around carer needs, giving access to appropriate information, advice and support – including support to access funding; training & workshops; emotional support; hospital support; counselling or support groups.

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

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

Objective 3: Spotlight - Community Assistance Hubs (CAHs)

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

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

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

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

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

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

Some examples of signposting from the CAH webpages included:

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

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

The CAH approach helped to:

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

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

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

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

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

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

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

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

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

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

Partnership Priorities for 2020/21 – What we said

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

Key Achievements/Successes : What we did

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

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

Partnership Priorities for 2020/21 – What we said

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

Key Achievements/Successes : What we did

Healthy Living

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

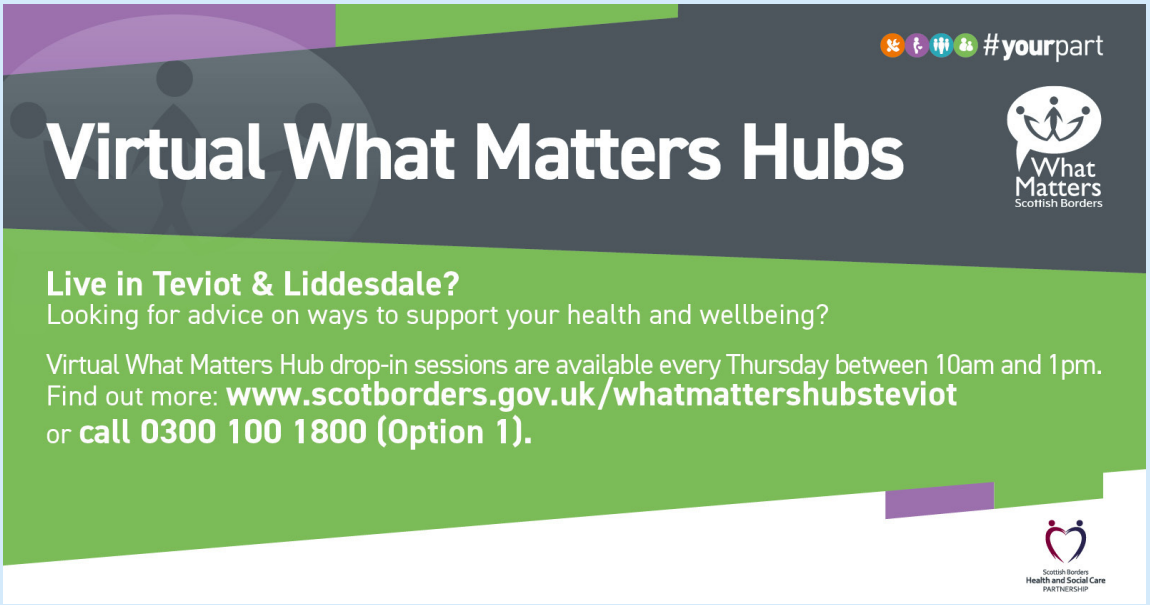
- Encourage exercise as part of a healthy lifestyle
- Promote walking as an ideal way of getting fit and relieving stress
- Create safe and social walks where all feel welcome
- Create links with partners and networks
- Recruit, train and support volunteers

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

Key Achievements/Successes : What we did

Locality Planning

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



Dementia

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

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

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

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

Key Achievements/Successes : What we did

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

Partnership Priorities for 2020/21 – What we said

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

Key Achievements/Successes : What we did

Meetings tech

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

Sirenum

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

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

Key Achievements/Successes : What we did

Connecting Scotland

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

Community Alarms

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

Self-care/advice

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

Partnership Priorities for 2020/21 – What we said

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

Key Achievements/Successes : What we did

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

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

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

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

Partnership Priorities for 2020/21 – What we said

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

Key Achievements/Successes : What we did

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

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

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

Objective 3: Partnership Priorities for 2021/2022

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

WORKSTREAM	PLANNED DELIVERY DURING 2021/22
Carer Support Services The partnership recognises the essential work of carers – even more so throughout the Covid-19 pandemic – looking to the future, it is a precarious resource that requires support.	**Carers Workstream** Continued development of the Carers workstream to ensure that carers have a strong voice in the direction and strategic planning of services.
	Hear From You As we look to recover and rebuild, we want to widen our network of public involvement support and reach in to all areas of the Borders community and to hear your views. We can then co-produce our approach to public involvement to ensure that it is inclusive, effective, fit for purpose and can be adapted to meet the changing needs of our communities as we emerge from the pandemic. Our aim is to establish a reference group of at least 200 people of varied age, background, location, interests in or experience of health conditions. You might have faced barriers in accessing healthcare, you might be part of a community you feel is under represented or seldom asked to express your views. Whoever you are and whatever you have to say we want to hear from you. You can do this in a number of ways: • email to public.involvement@borders.scot.nhs.uk • phone 0800 731 4052 (free of charge) • completing our online form • Sending us a note in the post to Public Involvement, Education Centre, Borders General Hospital, Melrose, TD6 9BS

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

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

FINANCIAL PERFORMANCE AND BEST VALUE: SUMMARY

Financial Performance Summary

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

IJB financial governance includes:

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

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

The split of the resource is shown below:

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

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

Proportion of spend by reporting year, broken down by service

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

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

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

Overspend / Underspend

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

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

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

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

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

Balance of care

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

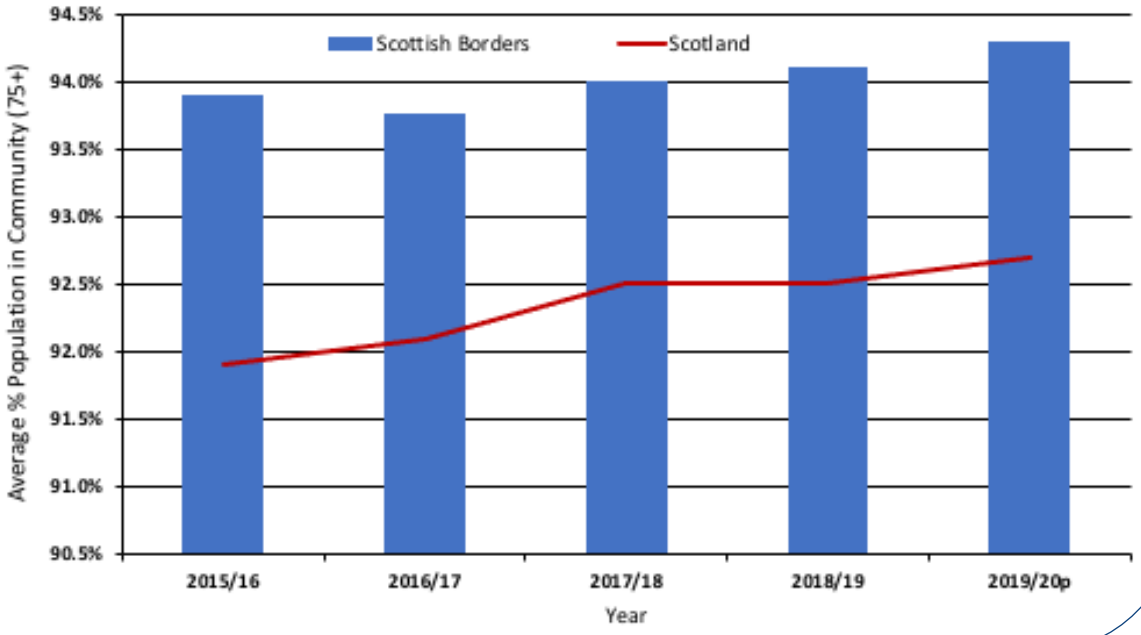
The development of Locality based services is a vital part in regard to investment in early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting carers and supporting independent living.

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

The data below indicates that:

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

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



Best Value and BV Audit

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

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

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

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

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

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

LOCALITY ARRANGEMENTS

Locality planning is a key tool in engagement, the identification of local issues and the delivery of the change. The IJB developed locality arrangements where professionals, communities and individuals can inform locality planning and redesign of services to meet local need in the best way.

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

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

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

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

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

Locality Population

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

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

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

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

INSPECTION OF SERVICES

Independent Review of Adult Social Care

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

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

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

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

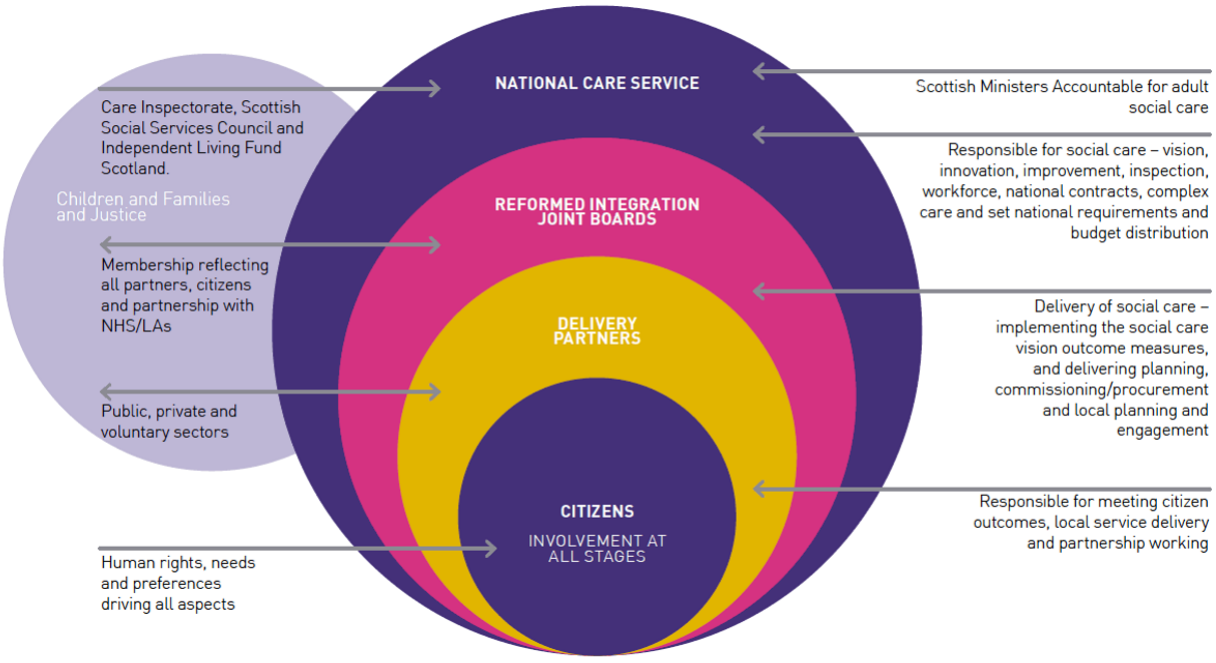
The vision is to have a system in place that replaces crisis with prevention and wellbeing; burden with investment; competition with collaboration and variation with fairness & equity. This 'culture-shift' places a high value on human rights, lived experience, co production, mutuality and the common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

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

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

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

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



Health Inspections

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

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

The inspectors:

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

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

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

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

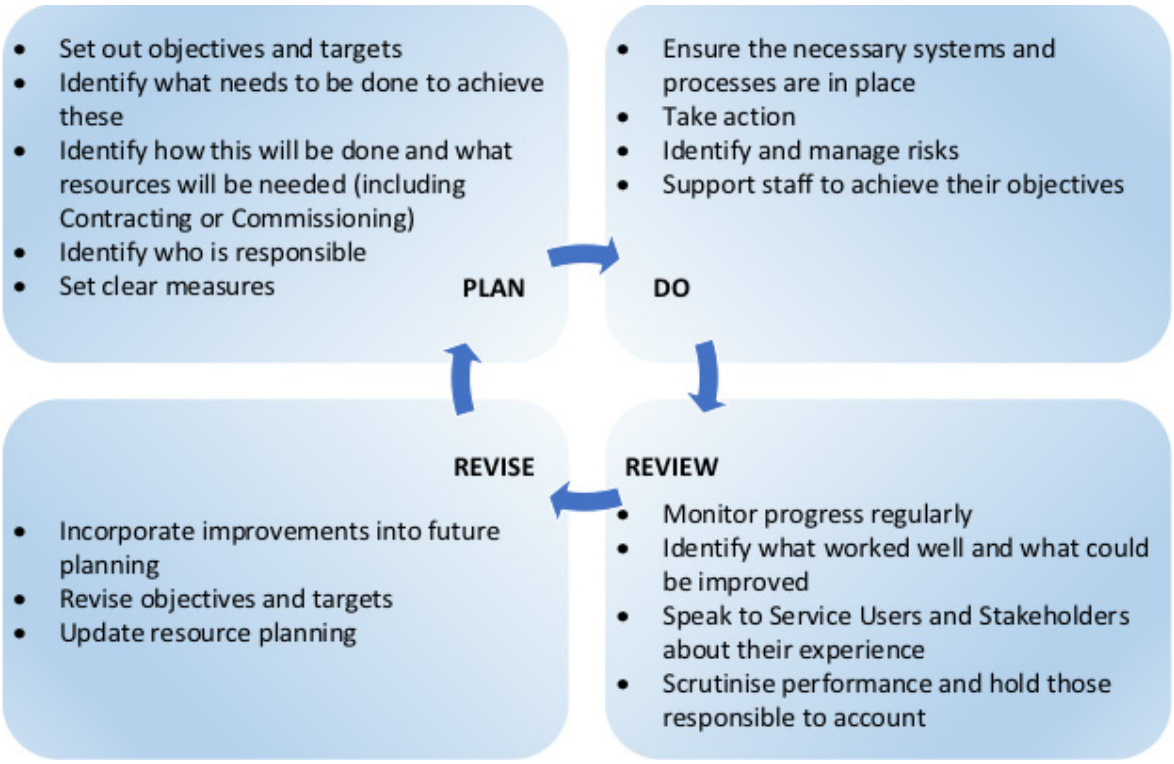
Care Home Inspections
Advice from directors of Public Health in Scotland was that inspection visits would present a real risk of introducing and spreading COVID-19 in Scotland's care homes. Therefore, to limit the spread of COVID-19, and with agreement from Scottish Government the Care Inspectorate restricted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

PERFORMANCE MONITORING FRAMEWORK SUMMARY

Performance Management Framework

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

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



Source: Adapted from Audit Scotland

Our performance measures

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

Our quarterly measures are shown below:

Regular performance updates can be found here

HOW ARE WE DOING?

OBJECTIVE 1

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

EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES) **22.1** **admissions** per 1,000 population (Q3 - 2020/21)	**EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS AGE 75+)** **75.3** **admissions** per 1,000 population **Age 75+** (Q3 - 2020/21)	**ATTENDANCES AT A&E (ALL AGES)** **54.7** **attendances** per 1,000 population (Q3 - 2020/21)
+ve trend over 4 periods **Better than Scotland (24.6 – Q2 2020/21)** **Better than target (27.5)**	**+ve trend over 4 periods** **Better than Scotland (83.3– Q3 2020/21)** **Better than target (90.0)**	**Flat trend over 4 periods** **Worse than Scotland (52.3 – Q3 2020/21)** **Better than target (70.0)**
£ ON EMERGENCY HOSPITAL STAYS **16.4%** of **total health and care resource**, for those **Age 18+ was spent** on **emergency hospital stays** (Q3 - 2020/21)	**THE % OF OLDER PEOPLE WHO RECEIVE A PACKAGE OF LESS THAN 10 HOURS OF DOMICILIARY CARE** **69%** (Dec 2020)	**THE % OF OLDER PEOPLE RECEIVING LONG-TERM CARE WHOSE CARE NEEDS HAVE DECREASED (FROM THEIR INITIAL ASSESSMENT/LATEST REVIEW)** **63%** (Dec 2020)
+ve trend over 4 periods **Better than Scotland (24% - 2019/20)** **Better than target (21.5%)**	**-ve trend over 4 periods** **Worse than target (15%)**	**+ve trend over 4 periods** **Better than target (15%)**

Summary:

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

Objective 1:
Our plans for 2020/21

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

OBJECTIVE 2

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

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

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

Summary:

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

Objective 2: Our plans for 2019/20

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

OBJECTIVE 3

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

EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES)

11.1

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

(Q3 - 2020/21)

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

END OF LIFE CARE

89.7%

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

(Q4 – 2020/21)

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

CARERS SUPPORT PLANS COMPLETED

68%

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

(Q4 - 2020/21)

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

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

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

(Q4 - 2020/21)

+ve impact
No Scotland comparison
No local target

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

17%

(Dec 2020)

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

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

71%

(Dec 2020)

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

Summary:

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

Objective 3: Our plans for 2019/20

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

Performance Change

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

KEY

▲ Improving Performance ▼ Declining Performance ◄ ► Little change

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

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

Core suite of National indicators

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

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

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

OUTCOME INDICATORS

INDICATOR		BORDERS			TREND	SCOTLAND **
		2013/14	2017/18	2019/20		
NI - 1	Percentage of adults able to look after their health very well or quite well	96%	94%	94%	▼	93%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	79%	83%	81%	▲	81%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%	74%	70%	▼	76%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	78%	75%	70%	▼	74%
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	83%	85%	▲	80%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	89%	88%	82%	▼	83%
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	80%	80%	▼	80%
NI - 8	Total combined % carers who feel supported to continue in their caring role	41%	36%	32%	▼	37%
NI - 9	Percentage of adults supported at home who agreed they felt safe	81%	86%	81%	▲	83%
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	-	-	-	-	-

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

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

DATA INDICATORS

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

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

MSG measures

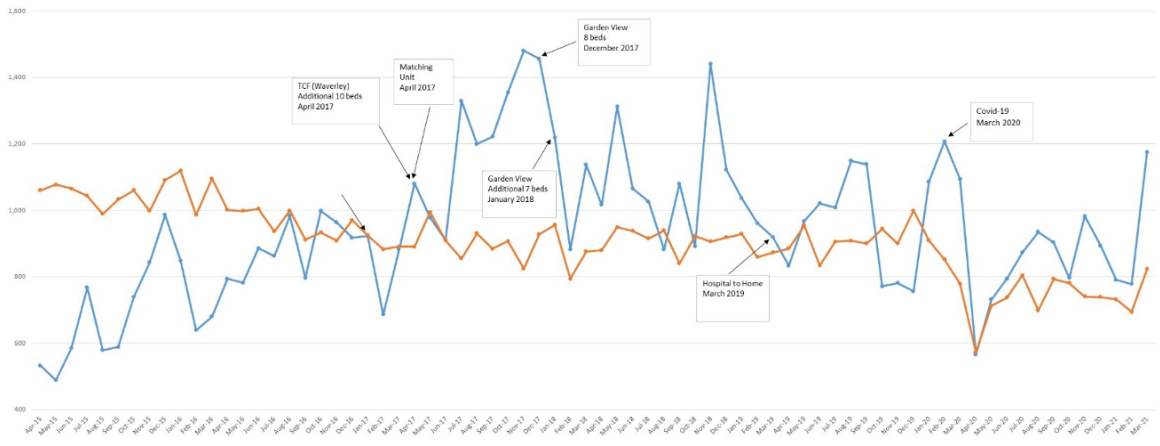
A summary of the Ministerial Strategy Group (MSG) measures we use are shown below. Additional detail is shown in Appendix 2.

BORDERS MSG 2020/21 TARGETS

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

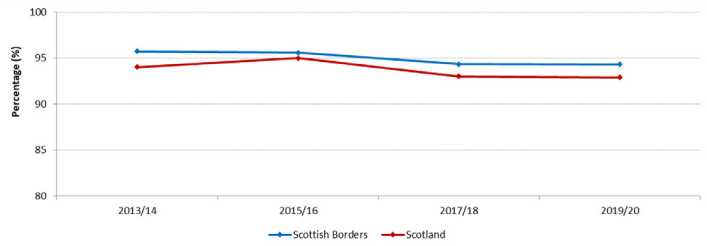
The graph below shows the delayed discharge (all reasons) in blue and emergency admissions (18+) in orange. Emergency admissions have been reducing. Delayed Discharge increased, levelled and has started to show a gradual decline.

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



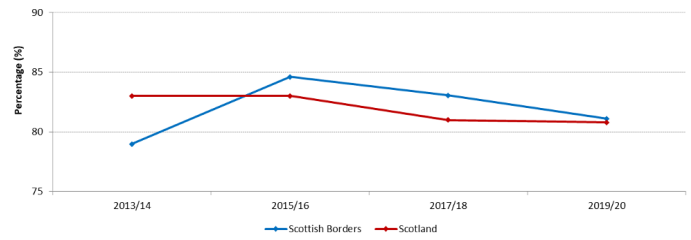
APPENDIX 1
CORE SUITE OF INDICATORS

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

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

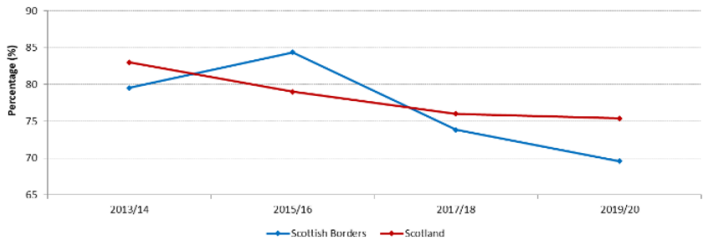
Source: Q52 - 2013/14 Health and Care Experience Survey, Q51 2015/16 Health and Care Experience Survey, Q40 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

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

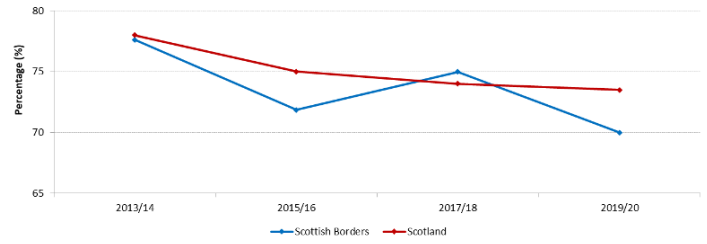
Source: Q36f - 2013/14 Health and Care Experience Survey, Q36g 2015/16 Health and Care Experience Survey, Q27f 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

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

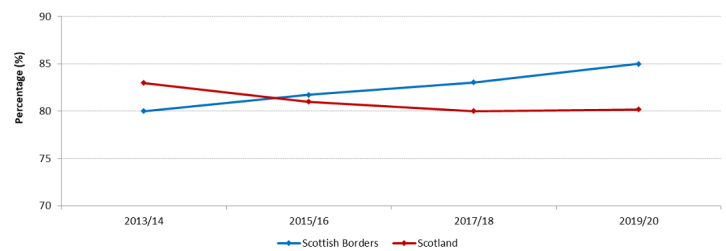
Source: Q36b - 2013/14 Health and Care Experience Survey, Q36b 2015/16 Health and Care Experience Survey, Q27b 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

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

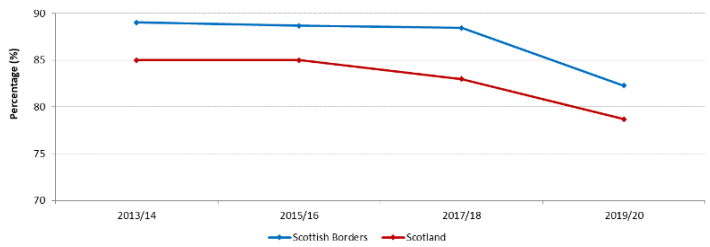
Source: Q36e - 2013/14 Health and Care Experience Survey, Q36f 2015/16 Health and Care Experience Survey, Q27g 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

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

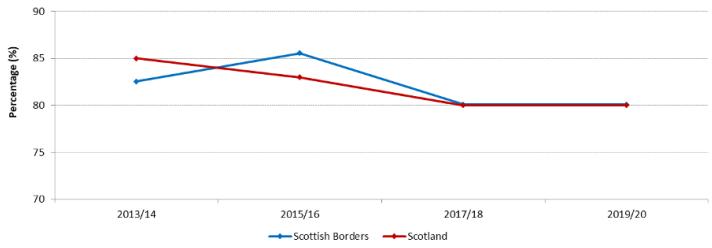
Source: Q37 - 2013/14 Health and Care Experience Survey, Q37 2015/16 Health and Care Experience Survey, Q28 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

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

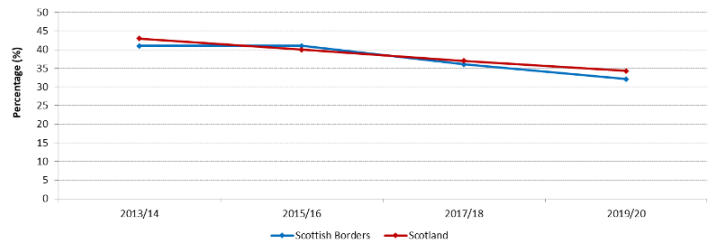
Source: Q27 - 2013/14 Health and Care Experience Survey, Q25 2015/16 Health and Care Experience Survey, Q8d 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

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

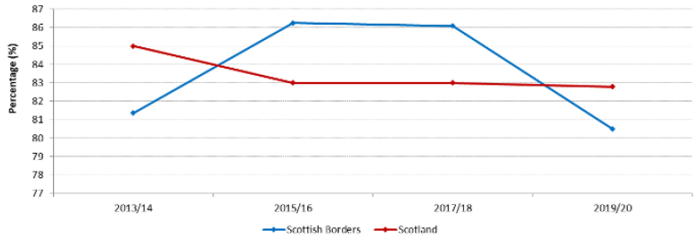
Source: Q36h - 2013/14 Health and Care Experience Survey, Q36i 2015/16 Health and Care Experience Survey, Q27h 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

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

Source: Q45f - 2013/14 Health and Care Experience Survey, Q45e 2015/16 Health and Care Experience Survey, Q32e 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

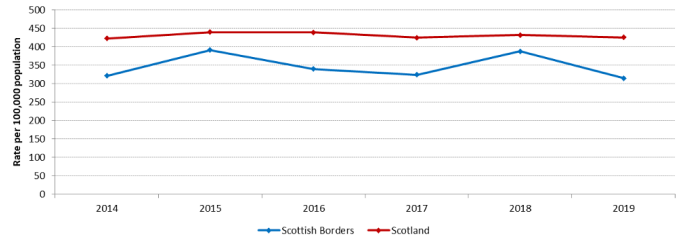
PERFORMANCE	BORDERS TREND	IMPROVEMENT ACTIONS AND CHALLENGES
	▲	We will continue to seek the views of adults supported at home and to develop our locality model.

Source: Q36g - 2013/14 Health and Care Experience Survey, Q36h 2015/16 Health and Care Experience Survey, Q27e 2017/18 Health and Care Experience Survey. Please note figures for 2019/20 are not directly comparable to figures in previous years due to changes in methodology.

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

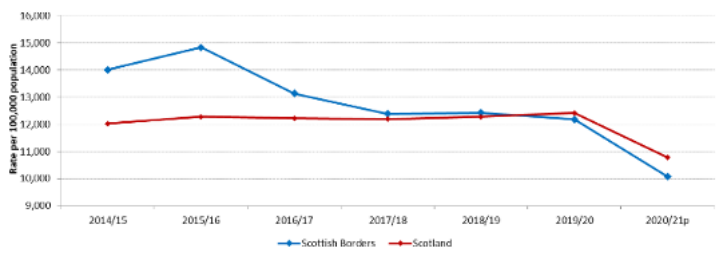
Indicator under development.

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

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

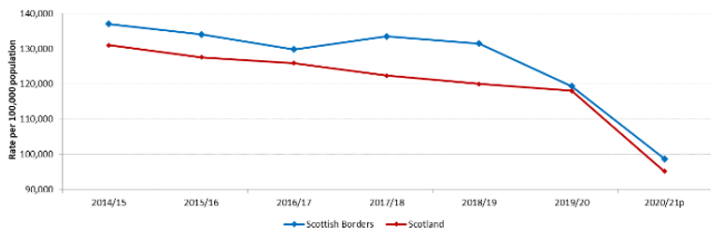
Source: National Records for Scotland (NRS)

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

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

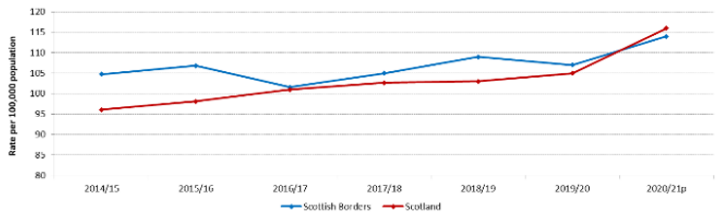
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland.

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

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

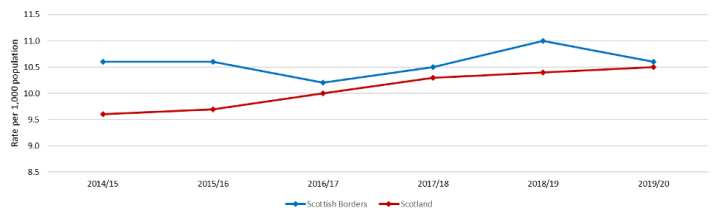
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland).

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

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

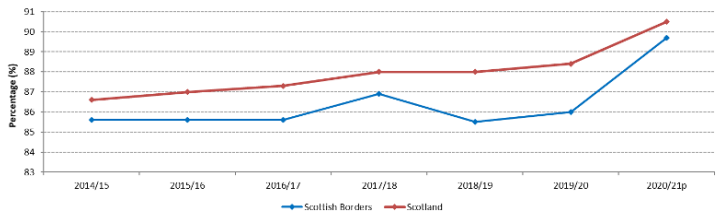
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges.

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

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

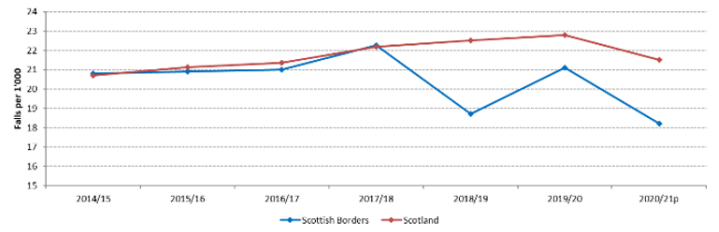
Source: ISD LIST bespoke analysis of SMR01 and SMR01-E data (based on "NSS Discovery" indicator but also adding in Borders Community Hospital beds).

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

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

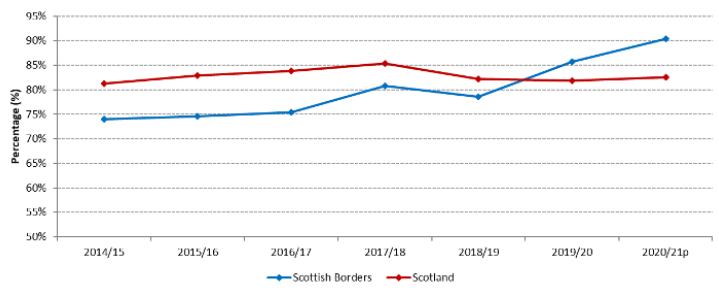
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), including Geriatric Long Stay (GLS) discharges, SMR04 (mental health inpatient records from NHS hospitals in Scotland, National Records for Scotland.

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

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

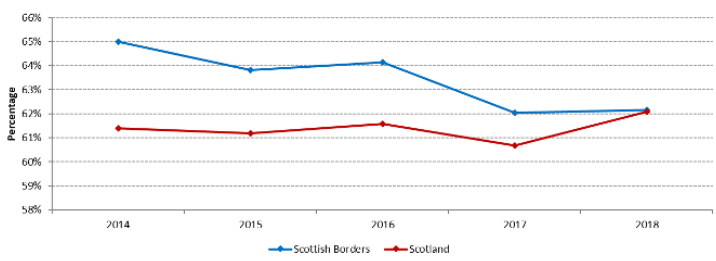
Source: PHS - SMR01 (acute discharges from non-obstetric/non-psychiatric NHS hospitals in Scotland), excluding Geriatric Long Stay (GLS) discharges.

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

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

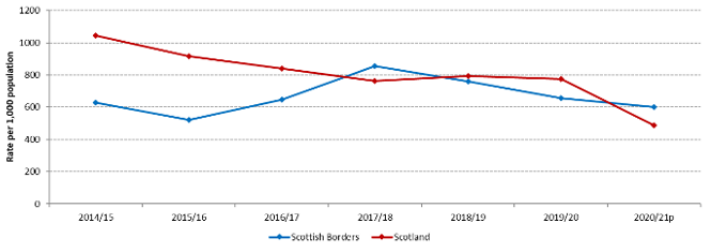
Source: Care Inspectorate

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

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

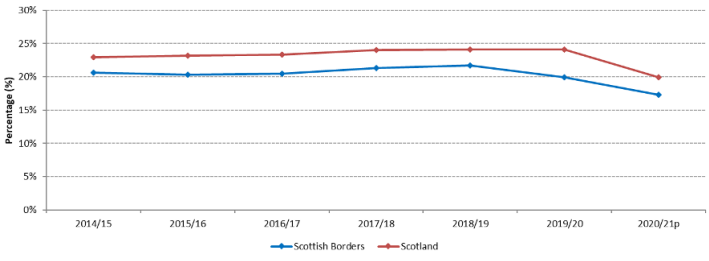
Source: Care Inspectorate

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

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

Source: PHS Delayed Discharge data collection.

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

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

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

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

Indicator under development.

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

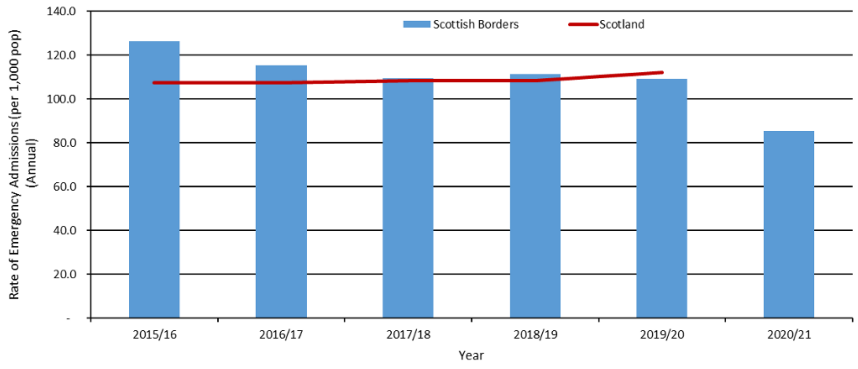
Indicator under development.

NI-23 Expenditure on end of life care

Indicator under development.

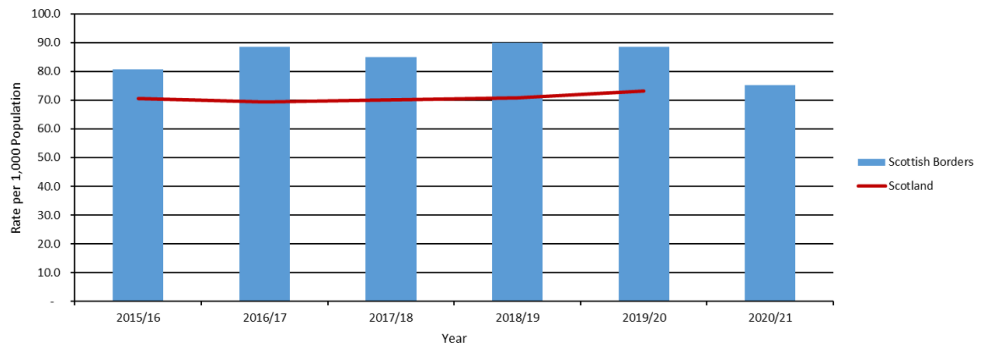
APPENDIX 2
MSG MEASURES

1a Number of emergency admissions (All Ages)

PERFORMANCE	BORDERS TREND
	▲

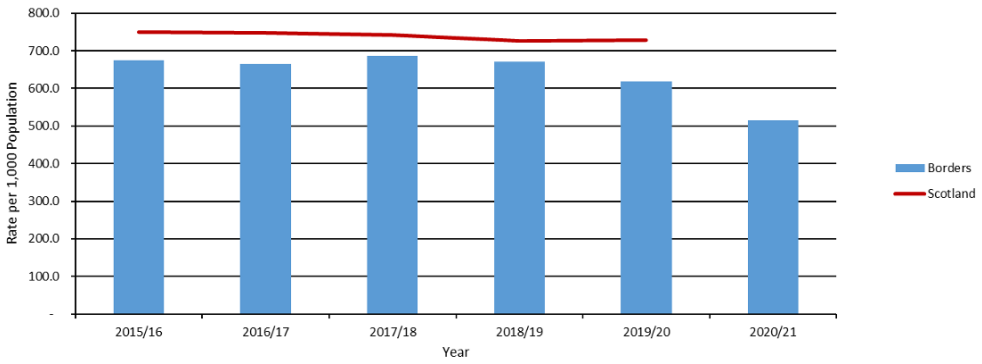
Source: SMR01, ISD

1b Admissions from A&E (All Ages)

PERFORMANCE	BORDERS TREND
	▼

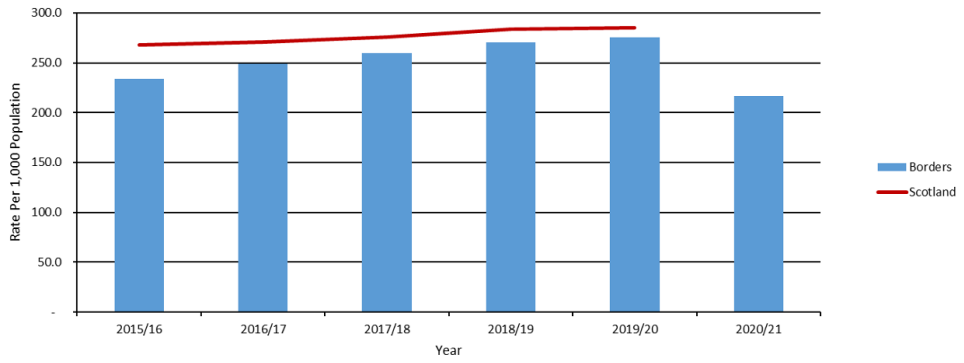
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▲

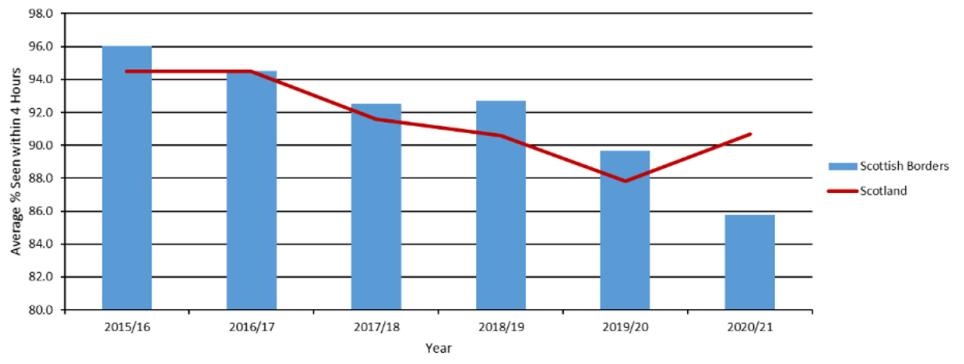
Source: SMR01, ISD

3a A&E attendances (All Ages)

PERFORMANCE	BORDERS TREND
	▼

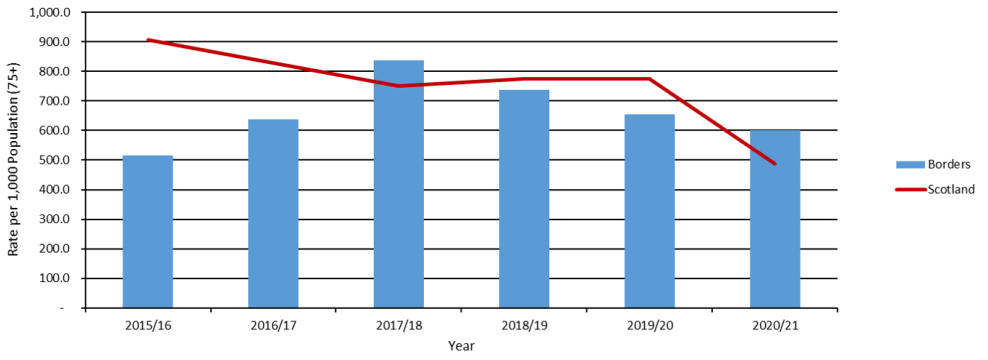
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▼

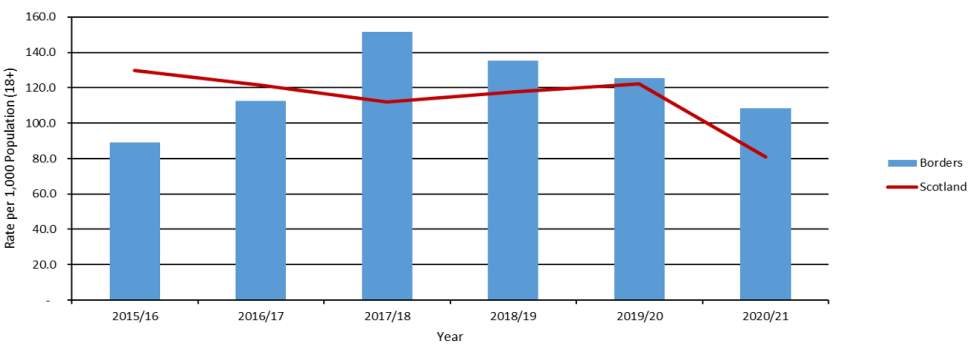
Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▼

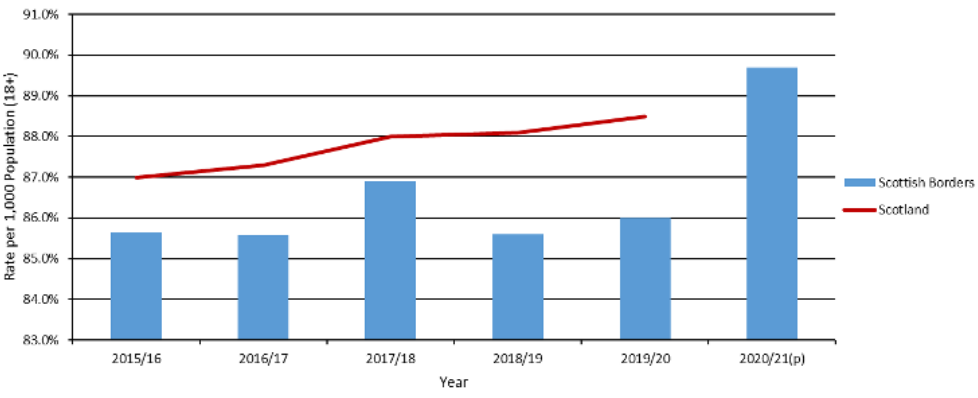
Source: Delayed Discharges, ISD

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

PERFORMANCE	BORDERS TREND
	▼

Source: Delayed Discharges, ISD

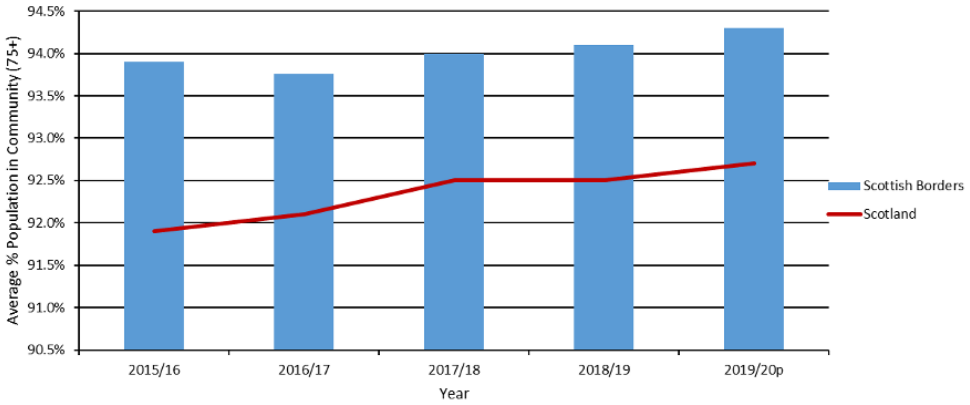
5 Percentage of last six months of life spent at Home or Community Setting

PERFORMANCE	BORDERS TREND
	▲

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

Source: A&E datamart, ISD

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

PERFORMANCE	BORDERS TREND
	▲

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

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Scottish Borders Health and Social Care PARTNERSHIP

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Scottish Borders Health & Social Care Partnership

ANNUAL PERFORMANCE REPORT SUMMARY 2020-2021

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

Scottish Borders Health and Social Care PARTNERSHIP

1. CONTEXT

The fifth Annual Performance Report for the Scottish Borders Health and Social Care Partnership (full version) 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) ßWe 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

2020/2021 has been a hugely challenging year. Many people have suffered as a result of the wider impacts of the COVID-19 pandemic, particularly those already most disadvantaged; the pressure on health and social care services has been intense but these services have delivered a joint response to the challenges posed by COVID-19.

The following summarises our Annual report in numbers.

2. SERVICE DELIVERY DURING COVID

- **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.

409 social work cases allocated **per month**

(12mth average to Feb 2021)

(a 3% increase on the same period in the previous year)

1,280 patients have gone through **Home First**

(year to Nov 2020)

(> 20% increase on the previous year)

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

(4% increase in hours on the previous year)

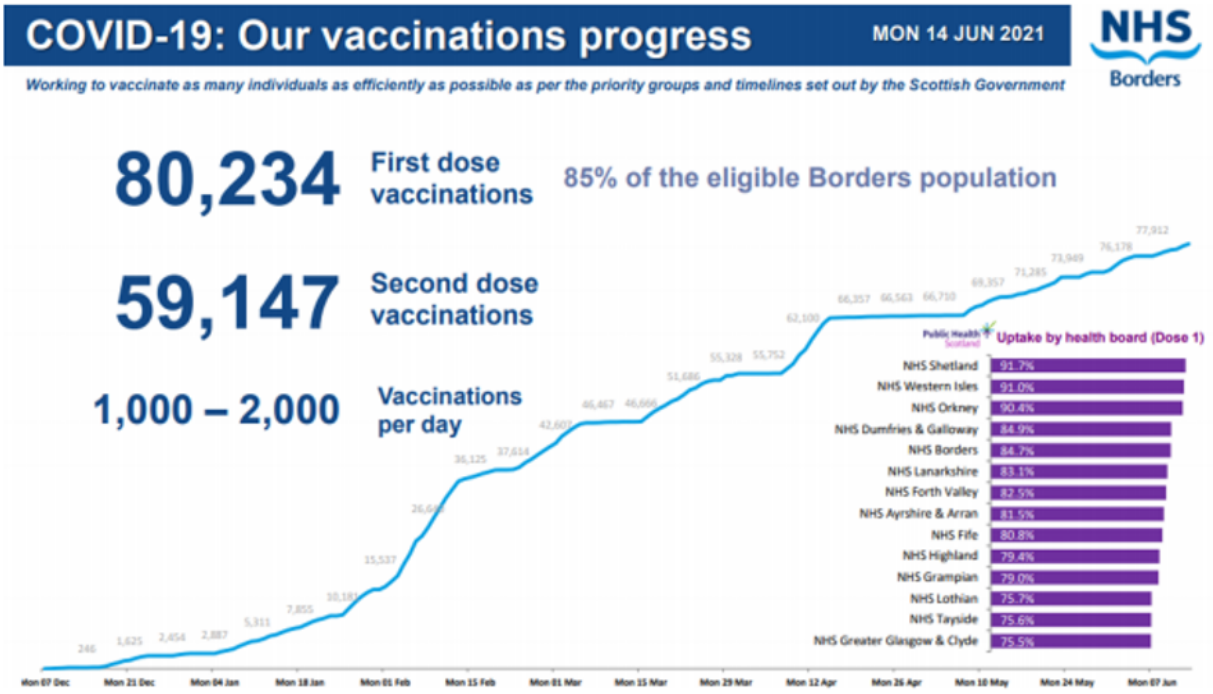
8.4 working days to **complete** a **Social Work assessment**

(a 1% decline on the previous year)

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

The Matching Unit arranges **180 packages** of **care per month**

(a 10% increase on the previous year)



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.

The number of individuals supported during Covid

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**

3a. 2020/21 PERFORMANCE AGAINST SET TARGETS

BETTER THAN TARGET	CLOSE TO TARGET	NOT ON TARGET
EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES) **85.5 admissions** per **1,000 population** (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)	**A&E WAITING TIMES (TARGET = 95%)** **86%** of **people** seen **within 4 hours** (Financial Yr - 2020/21)
-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 (90.5% - 2020/21)** **Better than target (87.5%)**	**-ve trend over 4 periods** **Worse than Scotland (87.7% - 2019/20)** **Worse than target (95%)**
RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+) **3,151 bed days** per **1,000 population Age 75+** (Calendar Yr - 2020)	**ATTENDANCES AT A&E (ALL AGES)** **225.7 attendances** per **1,000 population** (Calendar Yr - 2020)	**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 3 years **Better than Scotland (3,997.6 - 2020)** **Better than target (min 10% better than Scottish average)**	**-ve trend over 4 periods** **Worse than Scotland (219.4 - 2020)** **Better than target (216)**	**-ve trend over 4 periods** **Worse than Scotland (10.5 - 2019/20)** **Worse than target (10.5)**

3b. PERFORMANCE SINCE HSCP INCEPTION (2016)

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.

4. PERFORMANCE AGAINST NATIONAL MEASURES

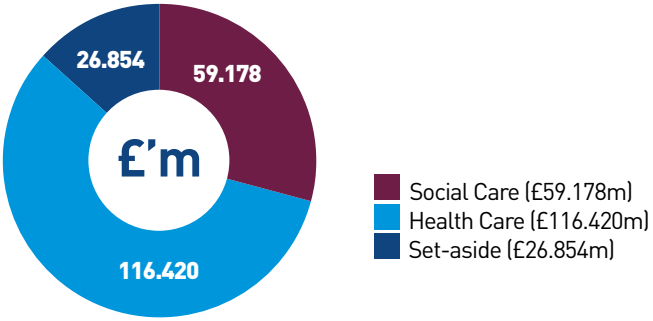
INDICATOR		BORDERS			TREND	SCOTLAND **
		2013/14	2017/18	2019/20		
NI - 1	Percentage of adults able to look after their health very well or quite well	96%	94%	94%	▼	93%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	79%	83%	81%	▲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

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

5. BUDGET AND SPEND

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

THIS WAS SPLIT:



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%**

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Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 22 September 2021

Report By:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact:	Rob McCulloch-Graham, Chief Officer Health & Social Care
Telephone:	-
SCHEME OF INTEGRATION UPDATE AND TIMETABLE	
Purpose of Report:	The Health & Social Care Partnership Integration Scheme is due for renewal and refresh. The purpose of this report to IJB is to provide the background to this and to propose a timeline for this work to progress
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Approve** the timeline for the review of the Scottish Borders HSCP Integration Scheme. b) **Agree** that the Integration Scheme review is progressed through the Strategic Planning Group.
Personnel:	n/a
Carers:	Consultation on the reviewed Integration Scheme is required with representatives from key stakeholder groups.
Equalities:	An Integrated Impact Assessment should be carried out as part of the review
Financial:	A reviewed Integration Scheme could have financial implications
Legal:	An up to date Integration Scheme is a legislative requirement under the Public Bodies (Joint Working) (Scotland) Act 2014
Risk Implications:	There is a legal risk to not having an up to date Integration Scheme in place

1. Background

1.1 As part of the work for establishing local arrangements for integration, the Public Bodies (Joint Working) (Scotland) Act 2014 required each Health Board and corresponding Local Authority to jointly prepare an Integration Scheme setting out which integration model was to apply, the functions to be delegated, and the financial arrangements and payments for the functions. The legislation also requires the Local Authority and Health Board to review the Integration Scheme before the expiry date, which is five years after the scheme was approved in parliament. This means that many Integration Schemes are now currently due for review.

1.2 Whilst amendments to Integration Schemes were made in 2017/18 to reflect the implementation of the Carers (Scotland) Act 2016, many of the Schemes have not been comprehensively reviewed, including a full consultation, since they were first approved in 2015. This includes the Scottish Borders Integration Scheme.

1.3 The Act is clear that there is no requirement to produce a successor scheme, but that the current scheme requires a *review*. Government guidance is that Health Boards and Local Authorities should ensure that they jointly carry out the minimum requirement of a review, and that the review is acknowledged jointly and formally. The review can note anything that requires further work between partners and can set out plans for the completion of this work at a later date, including the production of a successor scheme. Meanwhile, the current Integration Scheme will remain in force.

1.4 Guidance stresses the importance that Integration Schemes reflect any changes that have occurred since they were last approved and to also that stakeholders are involved in determining the arrangements of integrated health and social care services for their areas

1.5 Scottish Government has requested that each Partnership provides a timeline for when they plan to carry out their Integration Scheme reviews, consultations and revisions; and that every effort is made to provide this timeline by the end of September 2021.

2.1 **Requirements to consult**

The 2014 Act sets out the requirements for carrying out consultations when reviewing and revising Integration Schemes. This includes that the views of consultees must always be sought on whether changes to the Integration Scheme are necessary or desirable as well as on any proposed changes, even if changes are not initially deemed necessary. These views must be taken into account along with any other issues consultees wish to raise.

2.2 The guidance states that stakeholders always be given the opportunity to provide feedback on any issues they wish to raise with regards to the Integration Scheme and not just the proposed changes. This is to ensure that integrated services can be planned and led locally in a way which is engaged with the community. This also ensures that the review and revision of an Integration Scheme is not solely led by the small number of people involved in the IJB, Health Board and Local Authority but rather by the population that will be affected by the Schemes.

2.3 The prescribed stakeholders who must be consulted are set out in The Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014, with

detailed guidance on community engagement and participation for NHS Boards, IJBs and Local Authorities being found in Planning with People.

3.1 **Reviewing and approving the Scheme**
If, following a review and consultation, any changes to the Integration Scheme are needed or desirable then a revised Integration Scheme must be formally prepared, consulted on and submitted to Scottish Ministers for approval. This includes changes considered to be 'minor' or 'technical', including changes to tense and tone.

3.2 Before submitting the revised Scheme for approval, it is advisable that legal advice on the content is sought to ensure the Scheme fulfils the requirements of the 2014 Act.

3.3 If no changes are identified within the Integration Scheme then confirmation of the completed review, including all relevant consultation, should still be forwarded to Scottish Government.

4. Timeline

Integration Scheme Review	Sep-21				Oct-21				Nov-21				Dec-21				Jan-22				Feb-22				Mar-22			
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12	Wk 13	Wk 14	Wk 15	Wk 16	Wk 17	Wk 18	Wk 19	Wk 20	Wk 21	Wk 22	Wk 23	Wk 24	Wk 25	Wk 26	Wk 27	Wk 28
1 ***Set up***	←	—	—	→																								
Draft and agree the timeline for the Review	■	■	■																									
Issue timeline to Government				■																								
Specify governance and approval process for reviewed Scheme	■	■	■																									
Identify the Lead for the review	■	■	■																									
Assign the Team (Resource) for the review	■	■	■	■																								
2 ***Review***				←	—	—	—	—	—	—	—	—	—	—	—	—	—	→										
The Change/Feedback recording system and method specified				■	■																							
Initial Review of the current Scheme ***(First pass)***				■	■	■																						
First pass areas requiring update identified and recorded							■																					
Consultees/enagement partners identified and contacted				■	■	■	■																					
Consultation and Communications plans defined				■	■	■	■	■																				
Full review and consultation of the Scheme ***(Second pass)***								■	■	■	■	■	■	■	■													
Second pass areas requiring update identified and recorded													■	■	■													
Equality Impact Assessment completed									■	■	■	■	■	■	■													
Scheme updated with all identified changes (***First + Second pass***)																		■										
Implications of the changes specified (financial & service)																		■										
3 **Formally Agree the reviewed Scheme of Integration**															←	—	—	—	—	—	—	—	—	—	—	—	—	→
Board reports/covering reports written (including summaries/powerpoints etc…)															■			■	■	■	■	■						
Communications written and approved (public, partner etc….)															■			■	■	■	■	■	■	■				
SPG approval of the new Scheme																			■	■	■	■						
Health Management Team / Council Management Team approval of new Scheme																					■	■	■	■				
Council/Health Board/IJB Member briefings undertaken where required																			■	■	■	■	■	■				
Health Board / Council / IJB approval of new Scheme																							■	■	■	■	■	
New scheme sent to Government (including record of all changes and consultees)																												■

Xmas

Notes and assumptions:

1) 4-week months shown for simplicity. Slightly more time availble than shown above
2) Assumes approval of the scheme requires Health Board, Council and IJB sign off - therefore time will be needed if co-ordinating & planning presentations to all of these meetings

Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 22 September 2021

Report By	David Robertson, Chief Finance Officer SBC & Andrew Bone, Chief Financial Officer, NHS Borders
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MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 30 JUNE 2021

Purpose of Report:	The purpose of this report is to update the IJB on the forecast year end position of the Health and Social Care Partnership (H&SCP) for 2020/21 based on available information to the 30 June 2021.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the forecast adverse variance of (£5.951m) for the Partnership for the year to 31 March 2022 based on available information b) **Note** that whilst the forecast position includes costs relating to mobilising and remobilising in respect of Covid-19, it also assumes that all such costs will again be funded by the Scottish Government in 2021/22. c) **Note** that the position includes additional funding vired to the Health and Social Care Partnership during the first quarter by Scottish Borders Council to meet reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services and funding brought forward in respect of Covid-19 expenditure. **d) Note** that any expenditure in excess of the delegated budgets in 2021/22 will require to be funded by additional contributions from the partners in line with the approved scheme of integration
Personnel:	There are no resourcing implications beyond the financial resources identified within the report. Any significant resource impact beyond those identified in the report that may arise during 2021/22 will be reported to the Integration Joint Board.
Carers:	N/A
Equalities:	There are no equalities impacts arising from the report.

Financial:	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. Both partner organisations' Finance functions have contributed to its development and will work closely with IJB officers in delivering its outcomes.
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 initial forecast position on both the budget supporting all functions delegated to the partnership (the "delegated budget") and the budget relating to large-hospital functions retained and set aside for the population of the Scottish Borders (the "set-aside budget").

2.2 The forecast position is based on the available information presented to Scottish Borders Council and the Board of NHS Borders. It highlights the key areas of financial pressure at 30 June 2021. NHS Borders and Scottish Borders Council, at the time of preparation of this report have yet to consider an updated monitoring position beyond month 3. Further reports will be brought to the IJB as the financial year progresses on a regular and frequent basis. As this happens, further analysis and refinement as a result of the impact of the Covid-19 pandemic on activity levels, mobilisation costs, remobilisation plans and associated costs, lost income and unachievable savings will take place.

Overview of Monitoring and Forecast Position at 30 June 2021

3.1 The paper presents the consolidated financial performance for the period to end of June 2021 (month 3). Although this position includes a forecast of the year end outturn members should be aware that this forecast remains subject to a number of risks and uncertainties which are likely to result in substantial revision as greater certainty is attained over the next few months.

3.2 At the end of month 3, functions delegated to the partnership are forecasting an adverse projected pressure of £3.839m and the large hospital budget retained and set-aside is forecasting a similarly adverse pressure of £2.112m. Within delegated functions, following the delegation of additional budget to social are functions by Scottish Borders Council, an overall breakeven position is currently projected and the £3.839m adverse pressure therefore sits entirely across healthcare functions, mainly attributable to the forecast non-delivery of financial efficiency savings.

Efficiency Savings

3.3 Forecasts include the estimated impact of non-delivery of savings plans. This position remains under review and will be updated following the conclusion of the NHS Quarter One review process and ongoing review and challenge of assumptions across Scottish Borders Council's Fit for 2024 and NHS Borders' Financial Turnaround Programmes.

	Targeted Savings per Financial Plan £m	Projected Savings to be Delivered £m	Shortfall £m
Healthcare Functions	(4.740)	(0.290)	4.450
Social Care Functions	(3.356)	(2.576)	0.780
	(8.096)	(2.866)	5.230

Year End Forecast

Healthcare functions

3.4 The NHS forecast at month 3 is based on detailed review currently being undertaken through the Q1 review process. As such, members should recognise that the forecast is presented as an indication of current expenditure trend and is unlikely to be a full representation of the likely outturn position. Additional costs relating to Covid-19 are included, with the expectation that these will be funded by the Scottish Government. Presently, NHS Borders' is presenting forecast savings undelivered in full, until assurance that these will be funded also. Beyond the additional costs of Covid-19, including the non-delivery of planned savings on which the financial plan is predicated, operational functions are still reporting a reduction in core activity over the first quarter that net of the additional costs of Covid-19 and undelivered savings, results in a favourable position at the end of month 3.

3.5 At the end of June, delegated healthcare functions are reporting a favourable variance on core operational budgets of £0.611m. This is primarily attributable to a delay in recruitment to vacancies during the first 3 months due to Covid-19 and a continued reduction in core activity such as Dental Services over the first quarter and includes net reductions in spend across Primary and Community Services and Mental Health / Learning Disability services.

Social Care functions

3.6 At 30 June, Scottish Borders actual spend to date on social care functions, as stated in Appendix 1, was (£2.775m). This unusual position of reporting net income instead of spend is attributable to a number of factors specific to 2021/22. These relate to the upfront transfer of social care funding and health board resource transfer from NHS Borders during the first quarter for the whole of the financial year to enable local authority cash-flow, Scottish Government Covid-19 funding for social care sustainability and the offset of 2020/21 funding allocations brought forward into 2021/22.

3.7 The Scottish Borders Council forecast at month 3 is based on detailed monthly monitoring during the first 3 months of the financial year. It is noted that in order to

deliver a breakeven position, social care functions assume all Covid-19 costs included within the Local Mobilisation Plan, including undelivered efficiency savings, will be funded by the Scottish Government in full.

Large Hospital functions retained and set-aside

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

General

3.9 Additional costs of Covid-19 to date, together with the opportunity cost of undeliverable financial plan savings, continues to outweigh any financial benefit and reduced cost within core operational services attributable to a reduction in activity during the first quarter of 2021/22. This position may be mitigated considerably when a clearer picture of likely funding allocations from the Scottish Government emerges. It is expected that at the time of reporting next to the IJB, some clarity will have been given, at least for the first quarter of the financial year.

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

- Ongoing analysis and reporting of the Health and Social Care Partnership's (and wider NHS Borders' and Scottish Borders Council's) local mobilisation plan financial models
- Further review, challenge and remodelling of planned efficiency savings programmes as increased capacity is rebuilt
- Ongoing engagement with other partnerships, health boards, local authorities and, in particular, the Scottish Government over likely funding scenarios
- Review of all costs, expenditure profiles, future commitments and refinement of assumptions for projected expenditure to the end of the year

MONTHLY REVENUE MANAGEMENT REPORT

Summary	2021/22	At end of Month:	June

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000
Joint Learning Disability Service	19,595	4,764	20,319	20,295	24
Joint Mental Health Service	19,211	4,975	21,560	21,845	(285)
Older People Service	9,880	(6,723)	9,157	9,157	0
SB Cares	16,924	4,303	16,425	16,425	0
Unidentified savings	(4,740)	0	(4,740)	(290)	(4,450)
Physical Disability Service	2,734	682	2,499	2,499	0
Prescribing	23,132	5,619	23,132	23,037	95
Generic Services	67,468	19,666	84,470	83,693	777
Large Hospital Functions Set-Aside	24,211	7,058	26,120	28,232	(2,112)
Total	178,415	40,344	198,942	204,893	(5,951)

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	**16,122**	**3,783**	**16,775**	**16,775**	**0**	In JLDS, Proposed virement includes the transfer of £780k from Covid-19 reserves in relation to undeliverable service savings.Remaining pressure of £729k relates to new and increasing client care package costs, including clients transitioning from Children's Services. Within PWPD, is currently forecasting pressures in relation to increased client care costs. These are being investigated and are anticipated to be brought in line with budget before the year end. Across Older People, underspends resulting from higher than anticipated Self Directed Support - Direct Payment funds clawback £171k as well as lower than anticipated locality based community care and residential care costs (£157k). In SBCares, Service pressure relates to permanently lower than anticipated forecast income from Bordercare Alarms (£26k) - reduction potentially due to other providers in the marketplace offering similar products for lower price. In addition, proposed 2020-21 financial plan income growth in this area of £75k will not be realised. In addition £34k staffing pressure relating to the continued recruitment of an additional Service Manager due to operational pressures. These overspends are off-set by underspends in Homecare and Care Home services.
Joint Mental Health Service	**2,196**	**475**	**2,177**	**2,177**	**0**	
Older People Service	**9,880**	**(6,723)**	**9,157**	**9,157**	**0**	
SB Cares	**16,924**	**4,303**	**16,425**	**16,425**	**0**	
Physical Disability Service	**2,734**	**682**	**2,499**	**2,499**	**0**	
Generic Services	**6,339**	**255**	**6,937**	**6,937**	**0**	
Total	**54,195**	**2,775**	**53,970**	**53,970**	**0**	

MONTHLY REVENUE MANAGEMENT REPORT

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

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Joint Learning Disability Service	3,473	981	3,544	3,520	24	Mental Health is currently experiencing significant financial pressure within its medical budget due to the inability to recruit consultant staff and the resultant use of agency locums (£261k). A small forecast underspend in Primary Care Prescribing is also projected (£95k) due to the reduced level of items and forms issued over the financial year end. This position is likely to change going forward however as we are now starting to see a trend of increased volumes again as services continue to remobilise. Planned savings within NHS Borders (£4.450m) that are forecast not to be delivered due to CV-19. Scottish Borders Council savings offset by virement from non-delegated functions. Primary and Community Services (Generic Services) is also forecasting an underspend position due to a combination of both ongoing vacancies across Community Hospitals, AHP services and District Nursing, together with a general saving due to reduced service activity during the first half of the financial year as a result of the ongoing impact of Covid-19 (£777k).
Joint Mental Health Service	16,616	4,399	18,978	19,263	(285)	
Joint Alcohol and Drugs Service	399	101	405	405	0	
Prescribing	23,132	5,619	23,132	23,037	95	
Targeted savings	(4,740)	0	(4,740)	(290)	(4,450)	
Allocated Non Recurring Savings Projects	0	0	0	0	0	
Allocated Brokerage	0	0	0	0	0	
Generic Services						
Independent Contractors	30,069	7,502	30,246	30,246	0	
Community Hospitals	5,770	1,438	5,831	5,721	110	
Allied Health Professionals	6,531	1,644	7,178	7,082	96	
District Nursing	3,701	984	4,090	4,040	50	
Generic Other	15,058	7,843	30,188	29,667	521	
Total	100,009	30,511	118,852	122,691	(3,839)	

MONTHLY REVENUE MANAGEMENT REPORT

Large Hospital Functions Set-Aside	2021/22	At end of Month:	June

	Base Budget £'000	Actual to Date £'000	Revised Budget £'000	Projected Outturn £'000	Outturn Variance £'000	Summary Financial Commentary
Accident & Emergency	2,762	1,012	3,245	4,048	(803)	Accident and Emergency is experiencing significant cost pressure as a result of additional nursing as a result of increased activity / triage and also in response to the Covid-19 pandemic. Work is ongoing to identify the full extent of the latter in order that it can be included within the local mobilisation plan and be funded by further Covid-19 allocations. Within Medicine and Long-Term conditions, the adverse position is entirely attributable to increased drugs spend. A small downturn in activity is the main driver of the favourable forecast position in DME. In terms of efficiency savings, this is the set-aside share of recurring acute savings related to NHS Borders overall allocated targets this year - Total £3.2m.
Medicine & Long-Term Conditions	16,187	4,449	17,463	17,796	(333)	
Medicine of the Elderly	6,352	1,597	6,502	6,388	114	
Turnaround Savings Target	(1,090)	0	(1,090)	0	(1,090)	
Allocated Non Recurring Savings Projects	0	0	0	0	0	
Allocated Brokerage	0	0	0	0	0	
Total	24,211	7,058	26,120	28,232	(2,112)	