Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the Scottish Borders Integrated Joint Board

SUMMARY OF PERFORMANCE:
PRODUCED MARCH 2018 (using data up to end Dec 2017)

1. Unplanned Admissions

Part 1 - Emergency admissions for people aged 75+

What is this information and why is important to measure it?

Excellent emergency services are necessary when people are at a point of crisis or suffer serious injury. But many people who come to hospitals in emergencies could potentially have been offered better support or services earlier on, which would have prevented the need for them to go to hospital, or may have involved a planned visit to hospital instead.

Rates of emergency admissions in people aged 75 and over are of particular concern and have historically been higher in the Scottish Borders than across Scotland as a whole. Existing work within the Borders to reduce emergency admission rates needs to continue and be built on.

A reduction in this indicator should demonstrate improved partnership working. It should represent a shift from a reliance on hospital care towards proactive and coordinated care and support in the community. It should demonstrate the effectiveness of anticipatory care, identifying people who are at risk of emergency hospital admission, supporting people to be more confident in managing their long term conditions and providing coordinated care and support at home where safe and appropriate. Safe and suitable housing for people will also be important.

Data Source(s)

1. NSS Discovery. Emergency admissions to hospital as sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. The 28 day readmissions figures include beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are included) .
2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

Part 2 - Emergency admissions for falls, people aged 65+

What is this information and why is important to measure it?

With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major concern.

Falls can have a significant impact on an older person's independence and quality of life, impeding a person’s mobility and confidence. However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence based practices can prevent many falls and fractures in older people in the community setting. Rehabilitation services are also key to preventing repeat falls. In addition, the safety of a person’s immediate environment as well as their prescribed medicines will be important.

An economic evaluation published in 2013 estimated the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million (http://www.ncbi.nlm.nih.gov/pubmed/24215036) and without intervention is set to rise over the next decade as our population ages and the proportion with multi-morbidity and polypharmacy grows.

Data Source(s) and notes

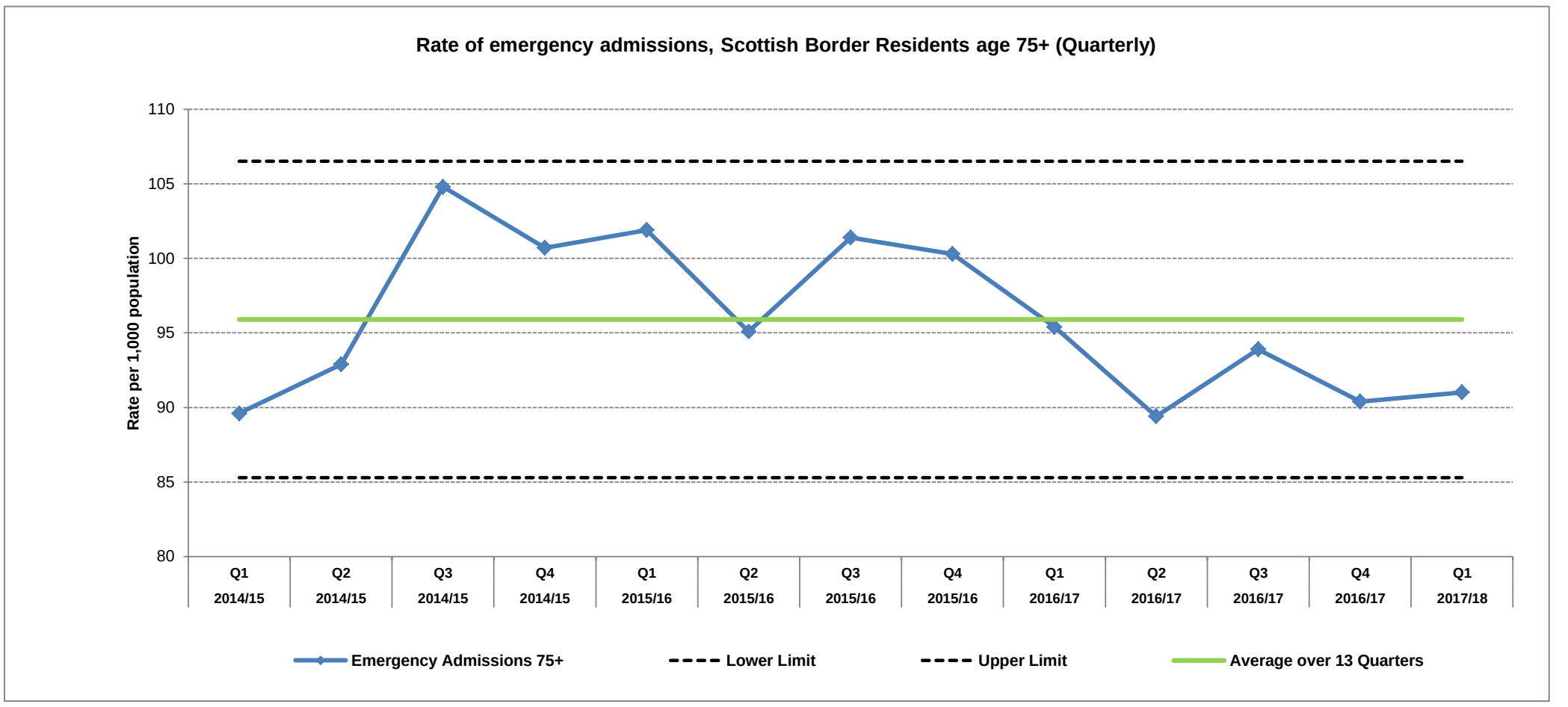
1. Emergency Hospital admissions due to falls are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.
2. Diagnostic codes used to identify falls are ICD-10 codes W00-W19.
3. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

1. Unplanned Admissions

Emergency Admissions, Scottish Borders residents age 75+

New - Changed to Quarterly

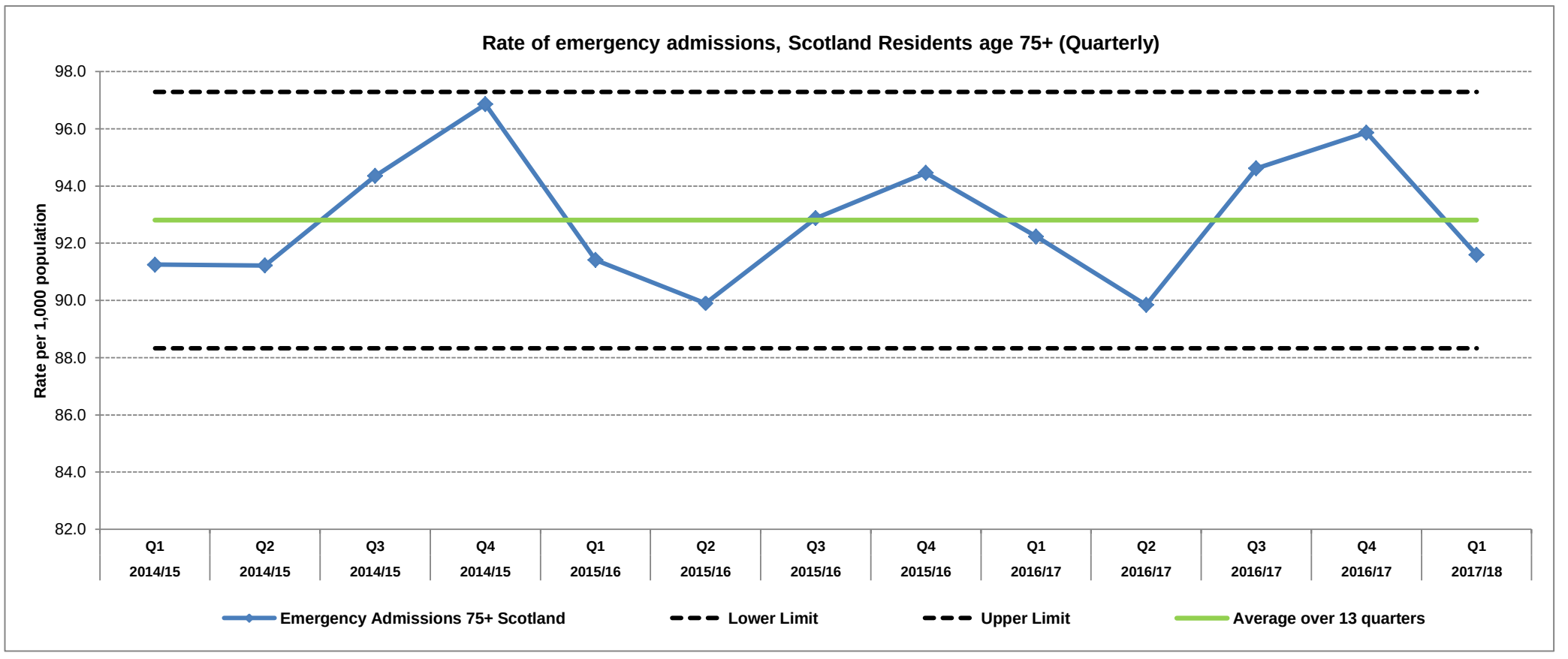
	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Number of Emergency Admissions, 75+	39,521	40,877	41,963	40,014	39,351	40,654	41,346	40,795	39,737	41,850	42,402	40,512
Rate of Emergency Admissions per 1,000 population 75+	92.9	104.8	100.7	101.9	95.1	101.4	100.3	95.4	89.4	93.9	90.4	91.0



Emergency Admissions, Scotland residents age 75+

New - Changed to Quarterly

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Number of Emergency Admissions, 75+	433,238	433,238	433,238	437,717	437,717	437,717	437,717	442,309	442,309	442,309	442,309	442,309
Rate of Emergency Admissions per 1,000 population 75+	91.2	94.4	96.9	91.4	89.9	92.9	94.5	92.2	89.8	94.6	95.9	91.6

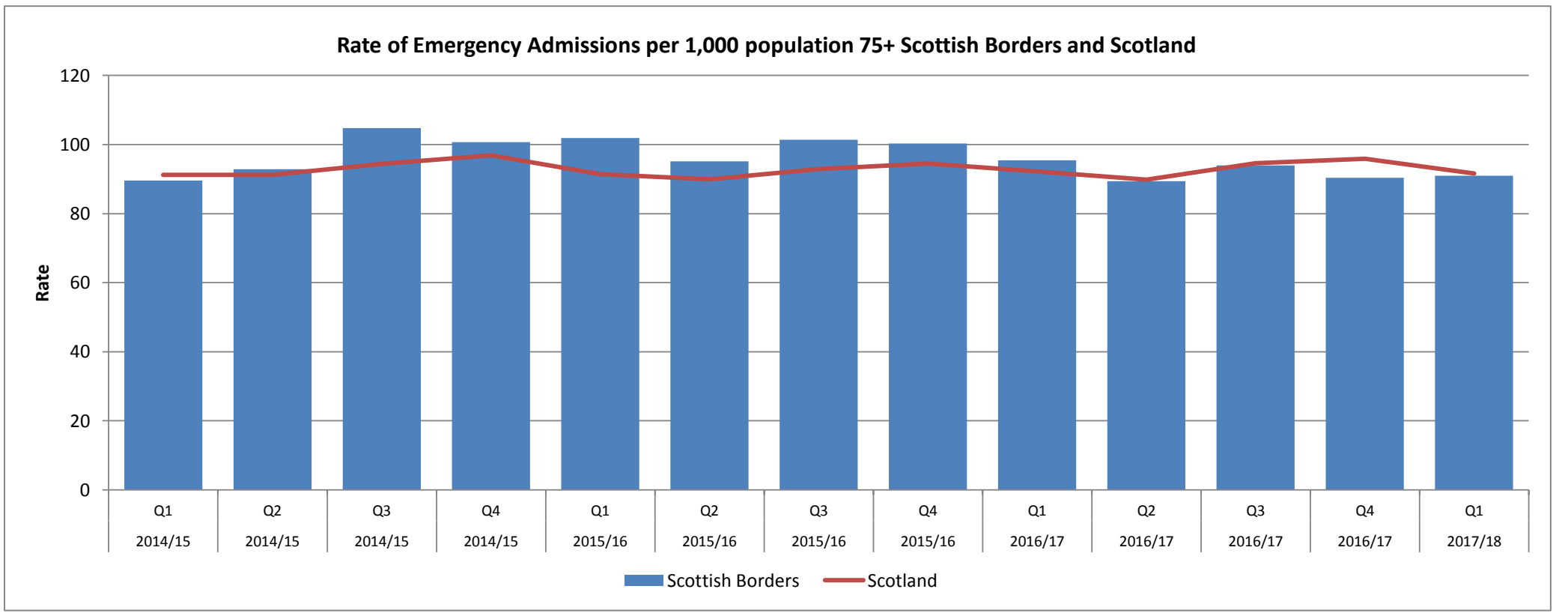


Emergency Admissions comparison, Scottish Borders and Scotland residents age 75+

New for this Quarter

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Rate of Emergency Admissions per 1,000 population 75+ Scottish Borders	92.9	104.8	100.7	101.9	95.1	101.4	100.3	95.4	89.4	93.9	90.4	91.0
Rate of Emergency Admissions per 1,000 population 75+ Scotland	91.2	94.4	96.9	91.4	89.9	92.9	94.5	92.2	89.8	94.6	95.9	91.6

1. Unplanned Admissions



How are we performing?

The rate of emergency admissions for Scottish Borders residents aged 75 and over has generally been decreasing since late 2014. However, the Borders rate has been higher than the Scottish average until the second quarter of 2016 (July-Sept). Since October 2016, quarterly rates have been similar to or lower than the Scottish average.

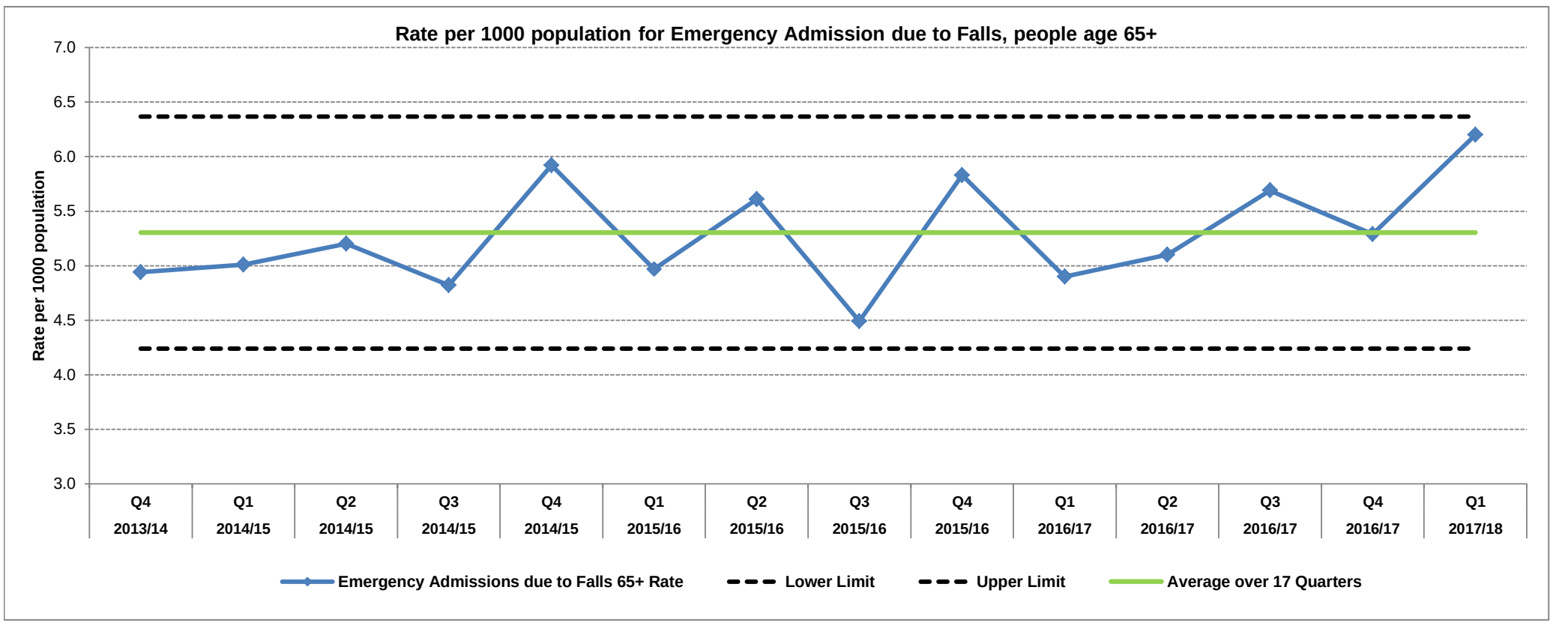
What are we doing to improve or maintain performance?

A number of improvement actions are underway which will continue to impact positively on this measure. These include the relocation of the Ambulatory Care Unit to the Medical Assessment Unit (MAU) annexe and expansion (from June 2017), work to prevent admission (especially in relation to respiratory illness), increased use of patient anticipatory care planning, the development of the Surgical Assessment Unit (autumn 2017), and work to maintain people with palliative needs at home (including hospice at home) (March 2018)

Emergency Admissions for falls, people aged 65+, rates per 1,000 population (aged 65+) in Scottish Borders residents

Updated: Apr-Jun'17

	Jul-Sep '14	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17	Apr-Jun'17
Rate of Emergency Admissions for falls per 1,000 population 65+	5.2	4.8	5.9	5.0	5.6	4.5	5.8	4.8	5.1	5.7	5.3	6.2

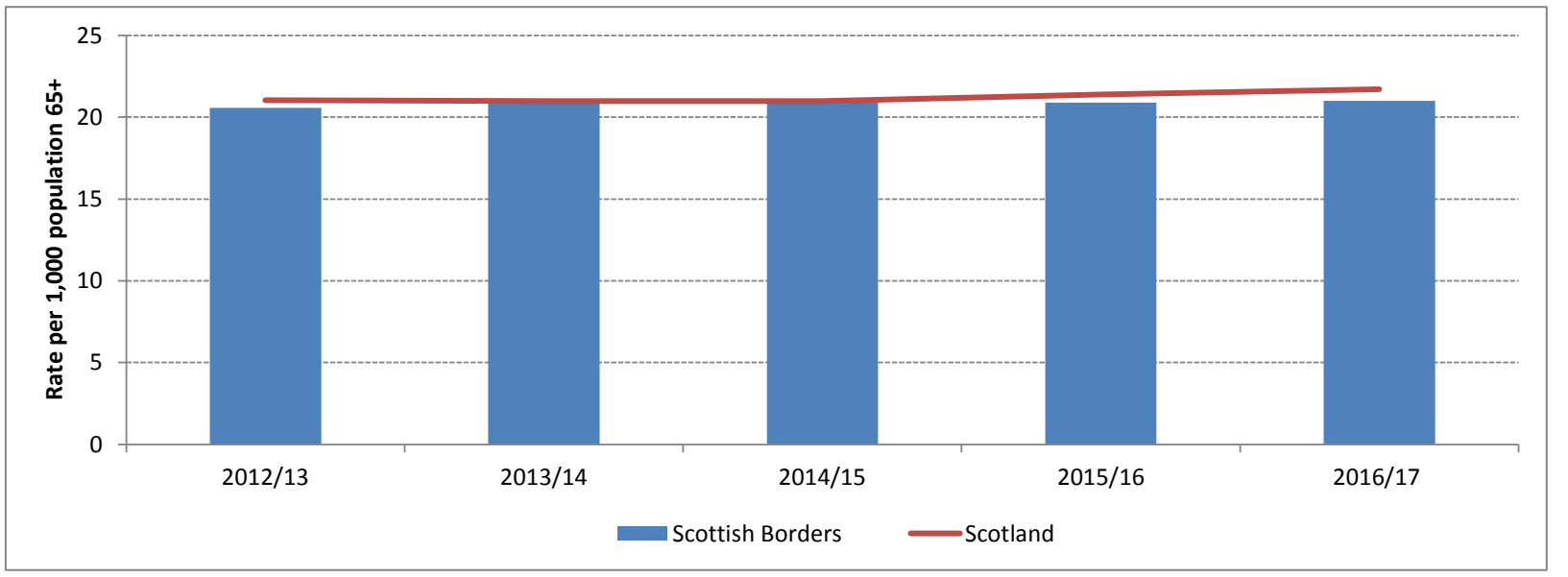


1. Unplanned Admissions

Emergency Admissions for falls, people aged 65+, rates per 1,000 population (aged 65+) in Scottish Borders and Scotland Residents

	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders	20.6	21.1	21.0	20.9	21.0
Scotland	21.0	21.0	21.0	21.4	21.6

Annual figures to 2016/17 refreshed to reflect increased completeness of national data



How are we performing?

The quarterly rate of emergency admissions for falls amongst Scottish Borders residents aged 65 and over has fluctuated since the start of the 2013/14 financial year, but has generally remained around 5 to 6 per 1,000 residents. Annual rates for the Scottish Borders 2013/14 and 2014/15 were very close to the Scottish averages, whilst in 2015/16 and 2016/17 they were slightly lower.

What are we doing to improve or maintain performance?

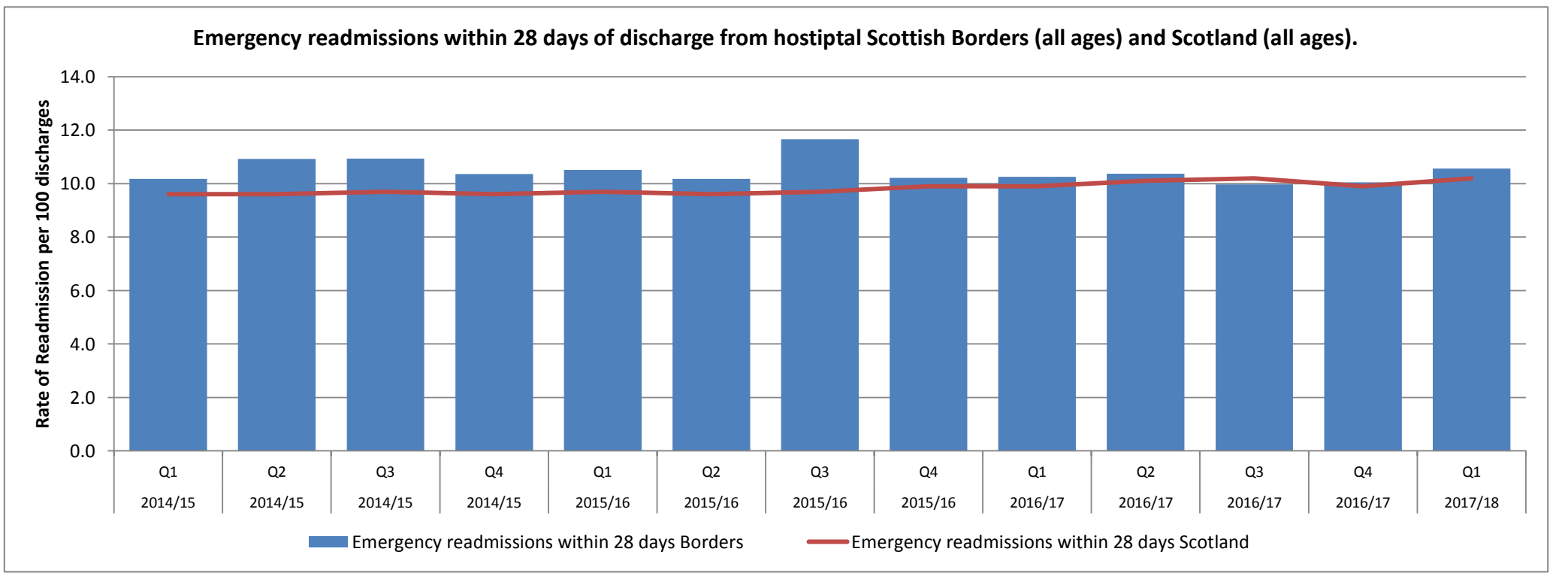
Following the publication of "The prevention and management of Falls in the Community (2014-2016) NHS Borders have been active in developing a process to implement the framework. A steering group was developed and meet monthly. This group has representation from Scottish Ambulance service and from Scottish Fire and Rescue service. In order to implement change a pilot site was selected. A single point of access has been agreed so that all calls from partner services go through a single number. A database is being developed so that over time we will have a list of vulnerable patients and repeat falls. A series of workshops for District Nurses were held in order to raise awareness of the pathway. The pathway has been introduced within a Pilot site on a phased basis and is now working in Kelso and expanding to Cheviot. We started with a target response time of a week and have reduced this to 4 days but not yet to the recommended 48 hours. This relates to staffing levels in then Out of Hours period. We will continue to roll out this pathway and strive to reduce response time over the coming year.

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

New for this Quarter

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

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
28-day readmission rate Scottish Borders (per 100 discharges)	10.9	10.9	10.4	10.5	10.2	11.7	10.2	10.3	10.4	10.0	10.0	10.6
28-day readmission rate Scotland (per 100 discharges)	9.6	9.7	9.6	9.7	9.6	9.7	9.9	9.9	10.1	10.2	9.9	10.2



How are we performing?

The quarterly rate of emergency readmissions within 28 days of discharge for Scottish Borders residents has fluctuated since the start of the 2014/15 financial year, but has generally remained around 10 to 11 readmissions per 100 discharges. The Borders rate has usually been higher than the Scottish average. The gap has slightly narrowed over time, although at least in part this will reflect improvments in the accuracy of NHS Borders' data.

What are we doing to improve or maintain performance?

Part of the reason for the Borders rate being slightly higher than the Scottish rate can be attributed to a known local challenge in relation to the coding of re-admissions (especially in relation to gynaecology and medical oncology), and work is underway to improve the use and consistency of codes. There is also an ongoing partnership challenge around the management and prevention of re-admission rates for older adults (across general and geriatric medicine).

2. Occupied Bed Days

What is this information and why is important to measure it?

It is possible for the number of emergency admissions to increase whilst emergency bed days reduce, and vice versa, so this measure is included to ensure a balanced view. Once a hospital admission has been necessary in an emergency, it is important for people to get back home as soon as they are fit to be discharged to avoid the risk of them losing their confidence and ability to live independently.

Health and Social Care Partnerships have a central role in this by providing community-based treatment and support options, “step down” care and home care packages to enable people to leave hospital quickly once they are well enough. Additionally, care homes should where appropriate be able to support people with a wider range of physical and mental frailty and needs.

Hospitals also have a role to play, by streamlining their processes and sharing best practice to ensure more people can leave hospital quickly once they are well enough. This will include improving rehabilitation and also reducing the possibility of infections, harm and injury all of which can result in longer stays.

Data Source(s)

1. Hospital bed-days are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions to beds coded as Geriatric Long Stay (which means the Borders' Community Hospitals are excluded) nor any acute psychiatric hospital beds.

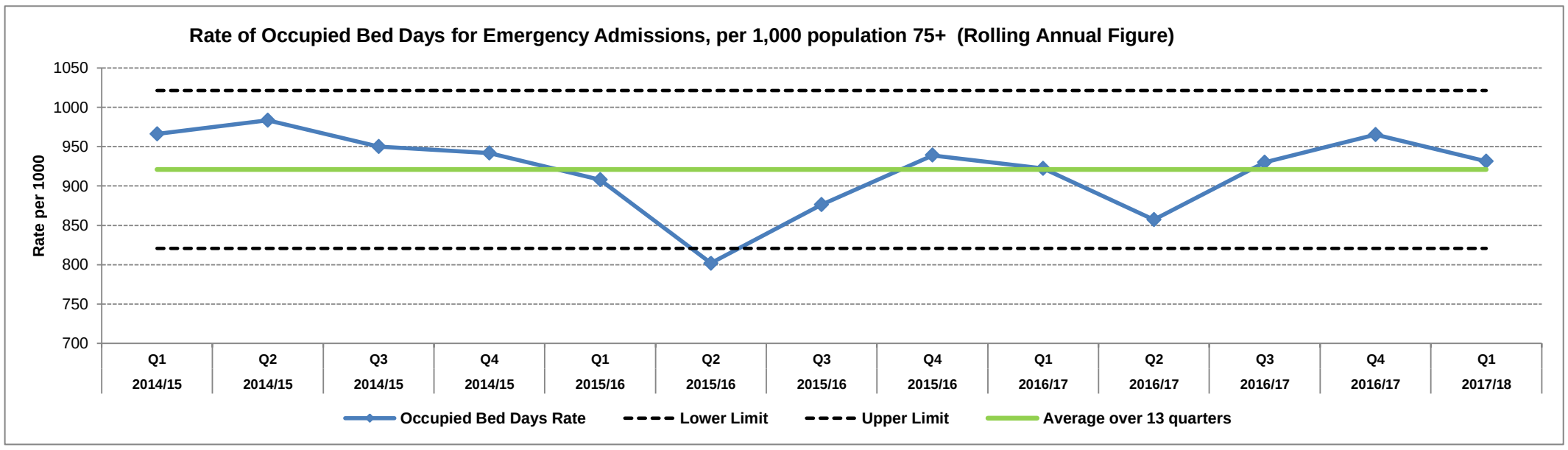
2. Rates per 1,000 population are based on National Records for Scotland (NRS) mid year population estimates.

2. Occupied Bed Days

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

Updated - Changed to Quarters

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Number of Occupied Bed Days for emergency Admissions, 75+	536,161	567,977	594,917	552,186	520,591	536,976	551,068	541,550	522,398	552053	567033	534754
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	984	950	942	908	802	876	939	922	857	930	965	931



How are we performing?

The quarterly occupied bed day rates for emergency admissions in Scottish Borders residents aged 75 and over have fluctuated over time but are lower than the Scottish averages. The Scottish rate has only twice gone below 1,200 per 1,000 population, while the Scottish Borders rate has never gone above 1,000 per 1,000 population.

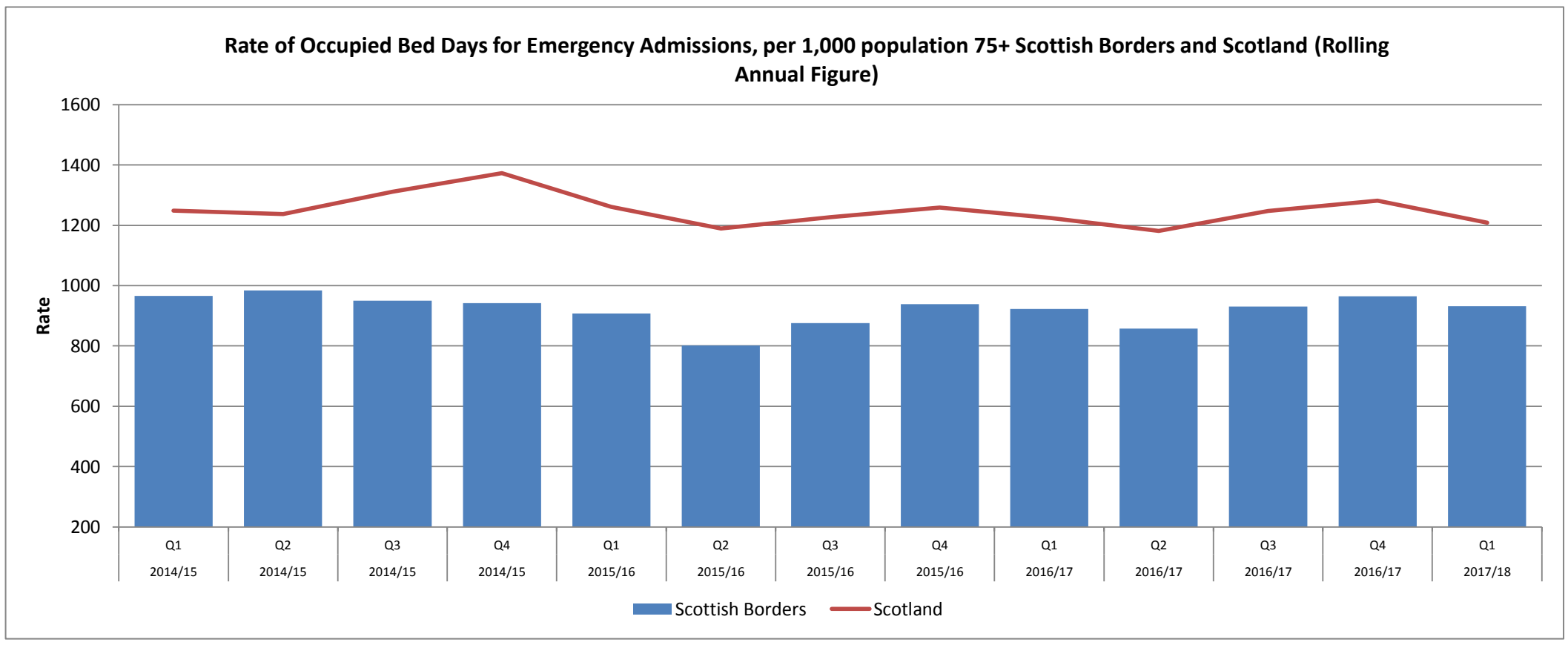
What are we doing to improve or maintain performance?

Work continues to reduce length of stay including an increase in 11am discharges, and the development of some initiatives to allow people to be discharged earlier (e.g. rapid access carers, expansion of transitional care etc. A focus on reducing delayed discharge remains a key challenge for the partnership.

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

Updated - Changed to Quarters

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish	984	950	942	908	802	876	939	922	857	930	965	931
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	1,238	1,311	1,373	1,262	1,189	1,227	1259	1224.4	1181.1	1248.1	1282	1209



3. Accident and Emergency Performance

What is this information and why is important to measure it?

The national standard for Accident & Emergency waiting times is that 95% of people arriving at an A&E Department in Scotland (including Minor Injury Units) should be seen and then admitted, transferred or discharged within 4 hours. NHS Boards are to work towards achieving 98% performance.

Although the standard is measured in the A&E Department, NHS Boards and Health and Social Care Partnerships are required to ensure that best practice is installed throughout the whole system, including health and social care, supporting joined up work to address wider issues of patient flow through each hospital that will safeguard timely access to services across the patient's journey and ensure the whole system works together effectively.

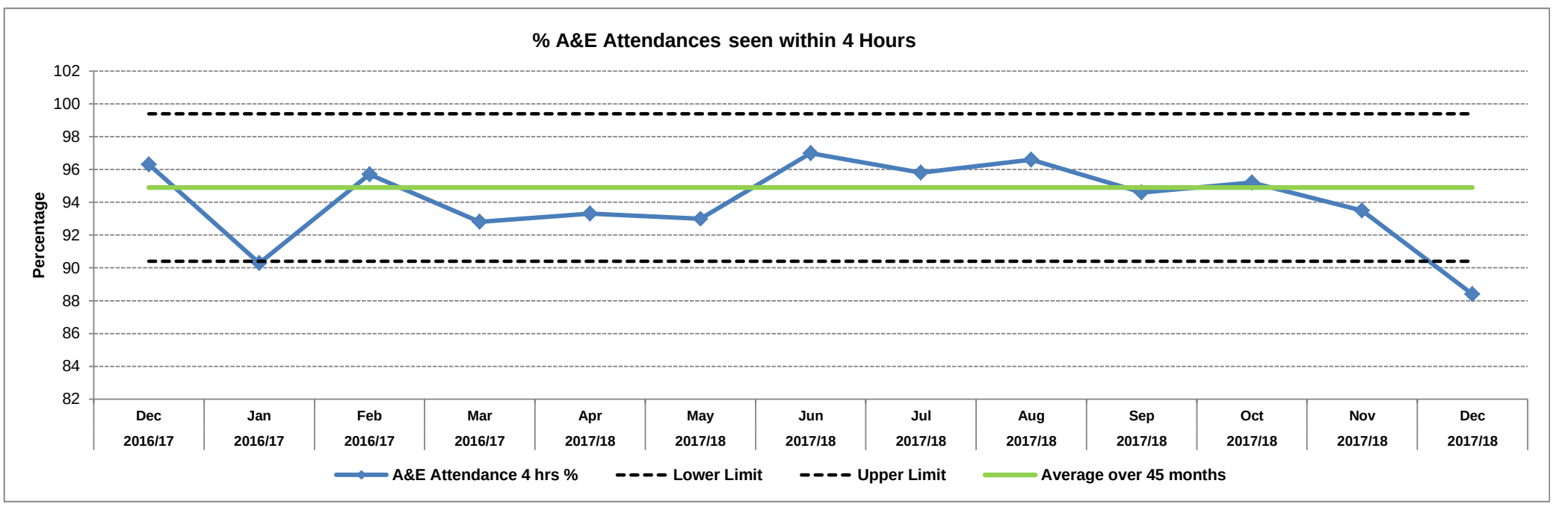
Data Source(s)
NHS Borders TrakCare system.

3. Accident and Emergency Performance

Accident and Emergency attendances seen within 4 hours

Quarter updated

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Number of A&E Attendances seen within 4 hours	2,323	2,079	2,401	2,567	2,679	2,556	2,515	2,571	2,661	2,599	2,405	2,624
% A&E Attendances seen within 4 hour	90.3	95.7	92.8	93.3	93.0	97.0	95.8	96.6	94.6	95.2	93.5	88.4



How are we performing?

Patients attending A&E and the Acute Assessment Unit (AAU) are routinely discharged within 4 hours. NHS Borders is working towards consistently achieving the 98% local stretch standard.

The 95% standard was achieved in June, July and August 2017. The main cause of breaches has been delays waiting for bed availability and reflects ongoing challenges in the discharge of complex patients.

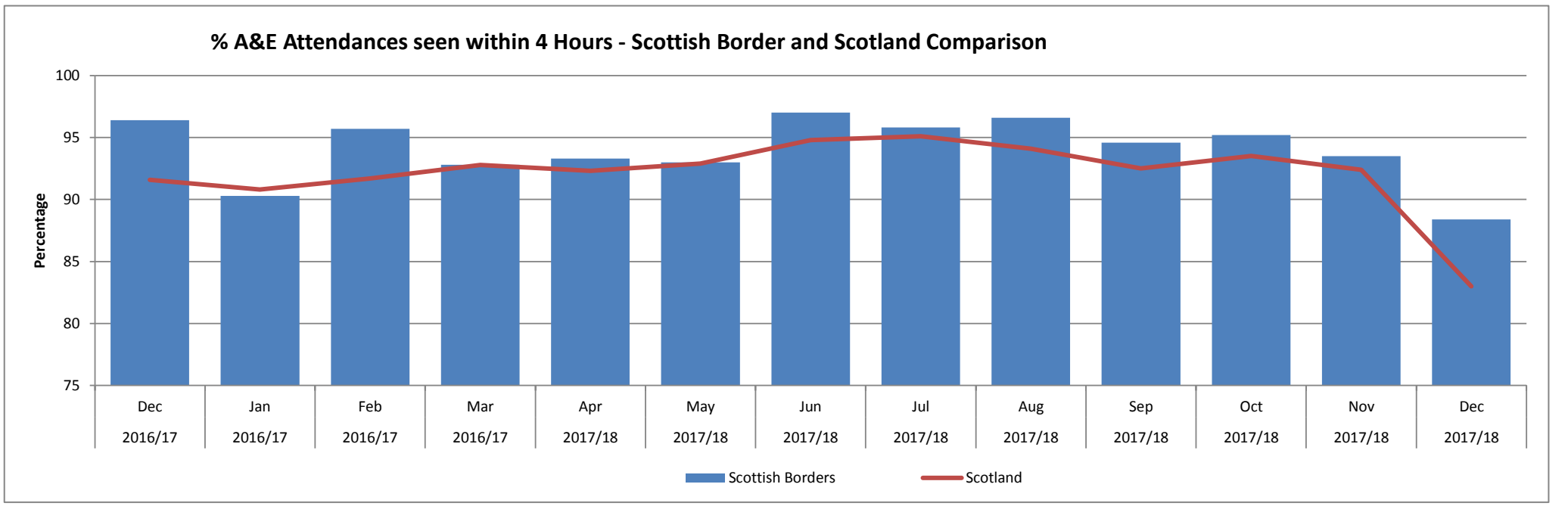
What are we doing to improve or maintain performance?

Whilst we expect total A&E attendances by end of 17/18 and 18/19 to be relatively static (albeit with anticipated seasonal fluctuation, as is reflected nationally too), the H&SCP has started working with GP clusters to increase support to people before they end up at A&E and after they have been there. We are also increasing capacity in the Borders Emergency Care Service (BECS – our "Out of Hours" service). Therefore we would expect A&E attendances to come down in the longer term as we build in more alternatives.

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

Quarter updated

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
% A&E Attendances seen within 4 hour Scottish Borders	90.3%	95.7%	92.8%	93.3%	93.0%	97.0%	95.8%	96.6%	94.6%	95.2%	93.5%	88.4%
% A&E Attendances seen within 4 hour Scotland	90.8%	91.7%	92.8%	92.3%	92.9%	94.8%	95.1%	94.1%	92.5%	93.5%	92.4%	83.0%



4. Delayed Discharge

What is this information and why is important to measure it?

A delayed discharge (often referred to in the media as "Bed Blocking") occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible. For example, a person's house may first need to be altered to help them get around, or there may not be a place available in a local care home.

A long delay increases the risk of the patient falling ill again, or losing vital life skills, independence or mobility. It could ultimately result in the patient having to be admitted to a care home due to the deterioration in their health and mobility.

Data Source(s)
Monthly Delayed Discharge Census, ISD Scotland.

1) The measures on numbers of discharges delayed by more than 72 hours/more than 2 weeks, are snapshots of the number of patients waiting to be discharged, on a single day in each month.

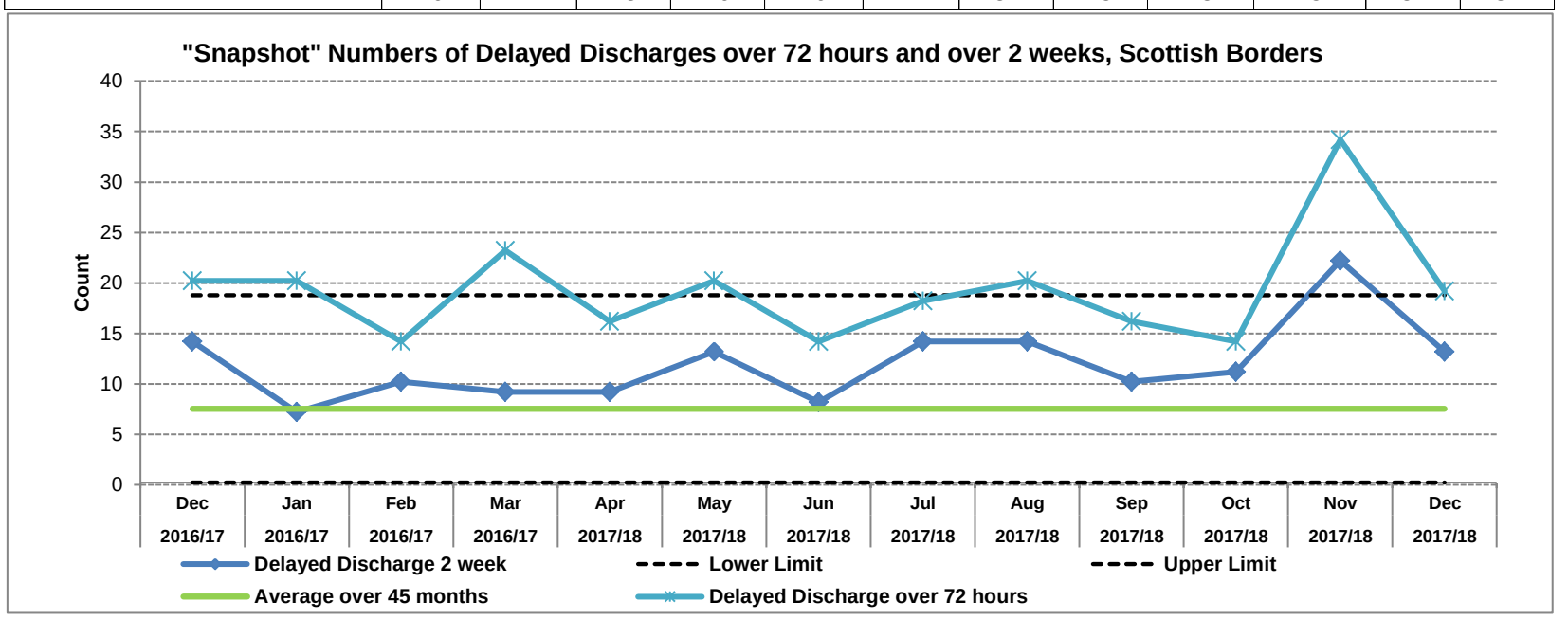
2) The measure of bed days associated with delayed discharges is based on all delayed discharges within the specified time period.

4. Delayed Discharge

Delayed Discharges (DDs)

Quarter updated

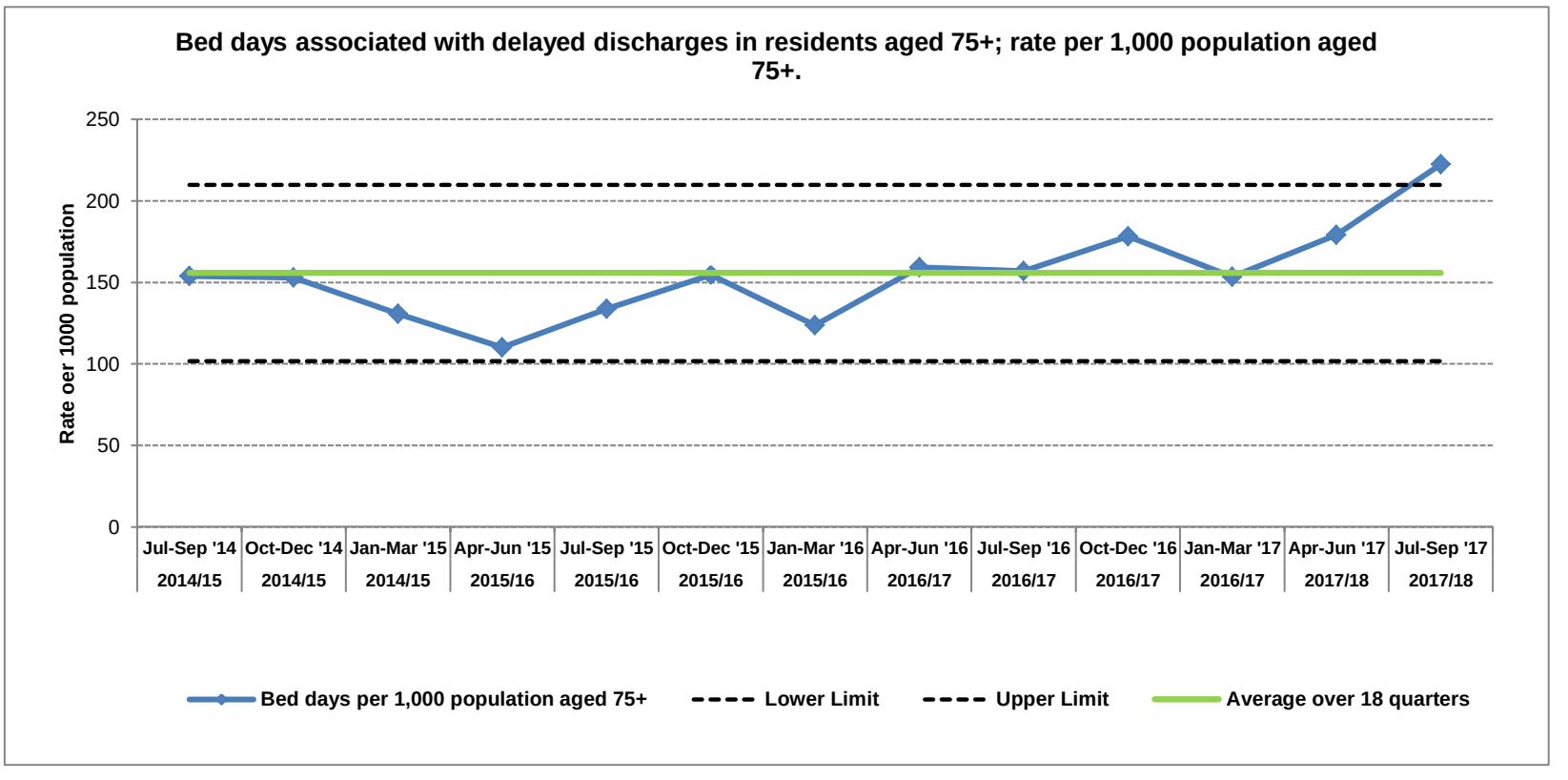
	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Number of DDs over 2 weeks	13	8	14	14	10	11	22	13	15	19	19	16
Number of DDs over72 hours	20	14	18	20	16	14	34	19	23	25	34	32



Please note the Delayed Discharge over 72 hours measurement has recently been implemented from April 2016.
It has been overlayed on this graph as an indicator of the new measurement (light blue line) however as data is limited we cannot provide a statistical run chart for this.
The DD over 2 weeks measurement has several years of data and has been plotted on a statistical run chart (with upper, lower limits and an average) to provide additional statistical information to complement the more recent 72 hour measurement.

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

	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17	Apr-Jun '17	Jul-Sep '17
Bed days per 1,000 population aged 75+	153	131	110	134	154	124	159	157	178	153	179	222

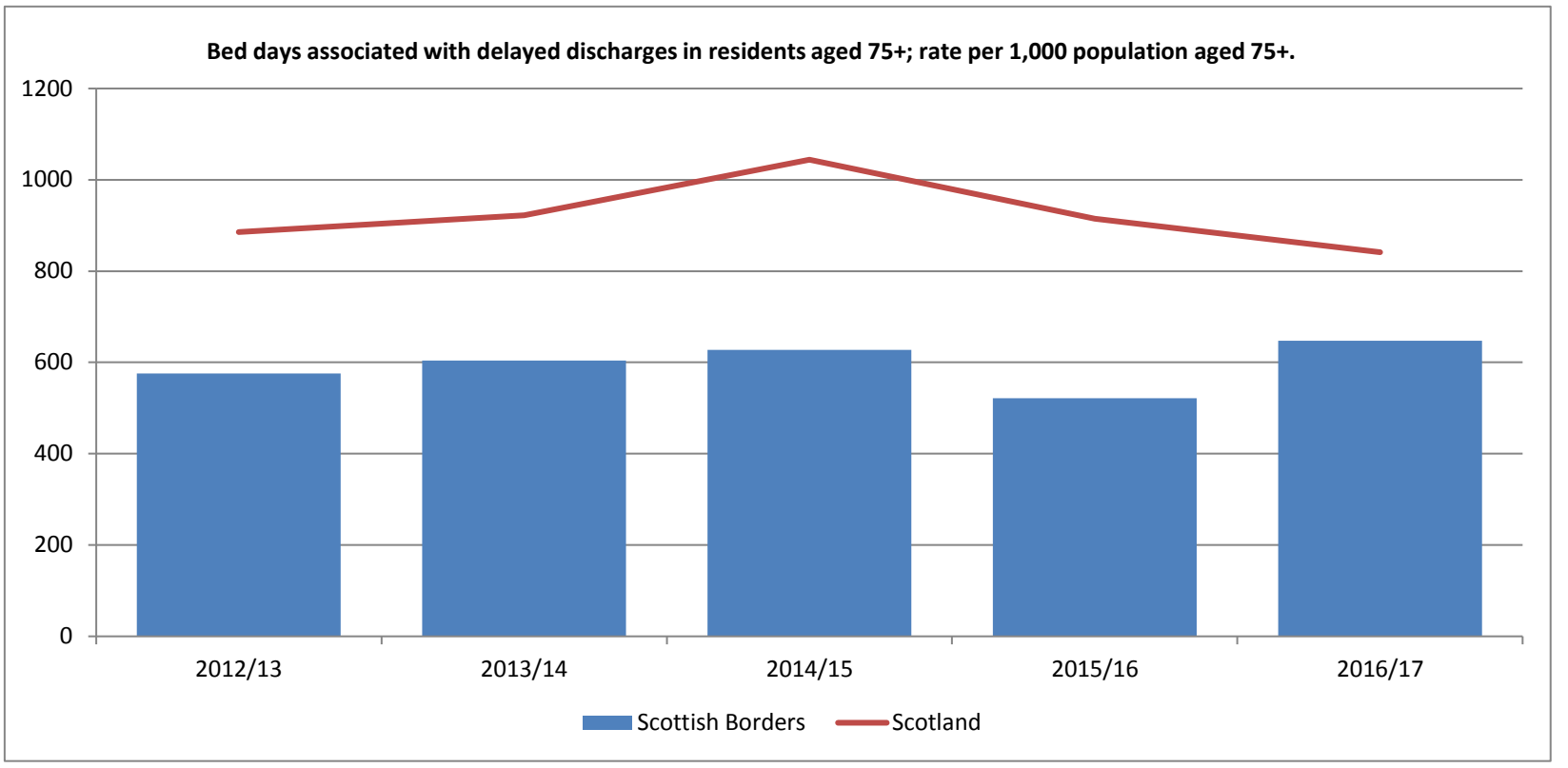


4. Delayed Discharge

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

	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders	575	604	628	522	647
Scotland	886	922	1044	915	842

No Change



Delayed Discharges at Census Point by Reason for Delay

Quarter updated

Reason for delay	2016 Jan	2017 Feb	2017 Mar	2017 Apr	2017 May	2017 Jun	2017 Jul	2017 Aug	2017 Sep	2017 Oct	2017 Nov	2017 Dec
Total delays at census point	**39**	**23**	**34**	**31**	**30**	**29**	**51**	**33**	**43**	**47**	**53**	**43**
Health and social care / patient and family related reasons	**33**	**16**	**26**	**21**	**24**	**21**	**42**	**23**	**31**	**34**	**39**	**33**
Total health and social care reasons	**32**	**16**	**25**	**21**	**22**	**18**	**37**	**21**	**30**	**31**	**36**	**30**
Assessment	1	-	2	1	-	4	1	-	1	1	2	8
Funding	-	-	-	-	-	-	-	-	-	-	-	-
Place availability	18	8	10	10	10	9	21	9	14	18	14	9
Care arrangements	13	8	13	10	12	5	15	12	15	12	20	13
Transport	-	-	-	-	-	-	-	-	-	-	-	-
Total patient and family related reasons	**1**	**-**	**1**	**-**	**2**	**3**	**5**	**2**	**1**	**3**	**3**	**3**
Disagreements	-	-	1	-	-	1	2	1	-	-	2	2
Legal/financial	-	-	-	-	2	1	1	1	1	1	1	1
Other	1	-	-	-	-	1	2	-	-	2	-	-
Total complex delays	**6**	**7**	**8**	**10**	**6**	**8**	**9**	**10**	**12**	**13**	**14**	**10**
Adults with incapacity (AWI)	4	4	5	4	3	6	7	9	11	12	14	10
Other complex reasons (not AWI)	2	3	3	6	3	2	2	1	1	1	-	-

4. Delayed Discharge

How are we performing?

The rate of bed days associated with delayed discharges for Scottish Borders residents aged 75 and over has fluctuated since the start of the 2013/14 financial year, but has generally remained around 100 to 200 per 1,000 residents. However, the rate for the second quarter of 2017/18 was higher than any previous quarter, as it increased to over 200 per 1,000 residents for the first time.

In terms of overall rates of occupied bed-days associated with delayed discharge for residents aged 75 and over, Borders has performed consistently better than the Scottish average. However, the local rate for 2016/17 as a whole was higher than for the preceding year.

Ongoing focus is being placed upon supporting the discharge of delayed patients awaiting their next stage of care across the system. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 Hour ED Standard, quality of care and ensuring people are in the right care setting, and the avoidance of disruption to planned surgical admissions.

There are weekly delayed discharge meetings with senior managers and senior colleagues from Scottish Borders Council and SB Cares, Chief Officer for Health and Social Care, and General Managers for Primary & Community Services and Unscheduled Care. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring and to implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

What are we doing to improve or maintain performance?

Following the work last year with Professor John Bolton, and aligned to winter planning, we have been continuing to grow capacity locally through the progressive implementation of three operational care facilities:

- The Transitional Care Facility in Galashiels has been operational from the start of January 2017 with 10 beds initially, rising to 16 since Dec 17.
- The "Discharge to Assess" (DTA) facility at Craw Wood (Tweedbank) has been operational from the start of December 2017 with 8 beds initially, rising to 15, with plans to increase to 23 if possible.
- The "Hospital to Home" service will be operational from the start of February 2018. This service will be able to support up to 30 people at a time.

Looking further ahead, the HSCP is working to increase capacity in community care options.

5. End of Life Care

What is this information and why is important to measure it?

This indicator measures the percentage of time spent by people in their last 6 months of life at home or in a community setting. It is derived by linking recorded deaths data with hospital bed day data to calculate the percentage of time spent outside hospitals in the last 6 months of people's lives. Accidental deaths are excluded.

It is now possible to predict the progress of many diseases, enabling a planned approach to palliative and end of life care in ways which reflect best practice and which, as far as is practicable, in accordance with the needs and wishes of patients, carers and their families. Health and Social Care Partnerships are expected to be able to influence this by commissioning
high quality end of life services, and working with communities, families and staff to enable discussion about planning for end of life. As more people have anticipatory care plans and as electronic palliative care summaries are rolled out throughout the country, then we should see a gradual increase in this measure in the medium to long term.

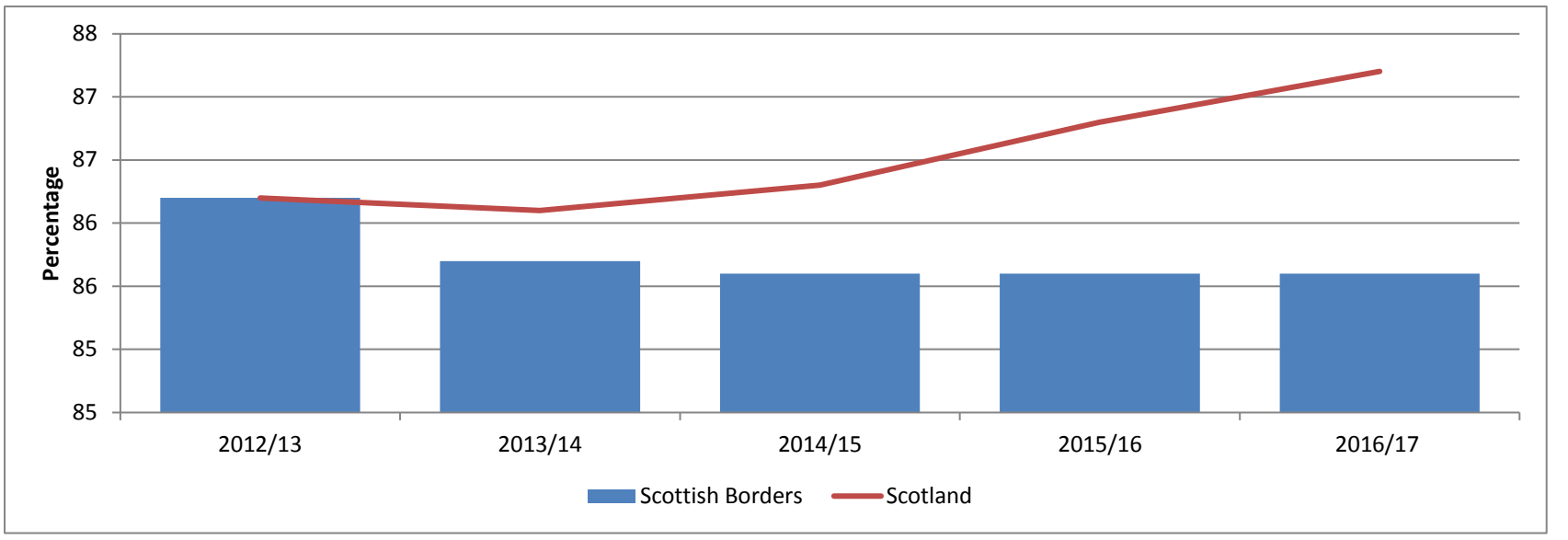
The indicator should ideally represent the wishes and choices for patients and their carers and also demonstrate the effectiveness of having a planned approach to end of life care. For an individual, the preferred place of care can change as their condition and/or family circumstances change over time, making this very difficult to measure and track. Therefore this indicator has been chosen by the Scottish Government as an alternative. The last six months of life was chosen as this is the period when most hospital admissions occur, and the period when clinicians would tend to plan end life care if the patient was not expected to live longer than 6 months.

Data Source(s)
This is the "Core Suite Integration Indicator" number 15, taken from Core Suite Indicator Workbooks for Health and Social Care Partnerships, ISD Scotland. Data taken from National Records for Scotland (deaths) and SMR records for acute/general hospitals, geriatric long stay beds, and acute psychiatric hospitals.

5. End of Life Care

Proportion of last 6 months of life spent at home or in a community setting. Updated - NEW

	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders %	86.2%	85.7%	85.6%	85.6%	85.6%
Scotland %	86.2%	86.1%	86.3%	86.8%	87.2%



How are we performing?

The percentage of last 6 months of life spent at home or in a community setting has appeared fairly consistent in the Borders from year to year since 2013/14 but in each case remains a little below the Scottish average, which is gradually increasing.

What are we doing to improve or maintain performance?

The partnership needs to continue to focus on improved data quality to better evidence the contribution of the Margaret Kerr Unit (MKU) which is on the Borders General Hospital site but provides palliative care in a more "homely" setting than in the main hospital wards.

From 2013 (when the unit opened) to early 2017, NHS Borders' submissions of SMR01 data to ISD did not allow ready differentiation between activity on the main BGH wards and activity within the MKU. However, with effect from early 2017, episodes of care within the MKU have been recorded using the significant facility code for palliative care unit, thus allowing differentiation between it and the "Large Hospital" setting.

Areas of development by the specialist team include MKU outreach providing ward based teaching and support - practical and clinical, MKU hospice at home to deliver the same level of care in the patient's home that is within the MKU, and sourcing care home beds for palliative patients - MKU care Home. Part of the role throughout is education of a wide range of staff throughout the patient journey in palliative care skills- through communications skills courses directed at difficult conversations, deteriorating patients and dealing with complaints, and a joint project with PATCH (a charity to support palliative patients in acute care) and St Columbas Education department, encouraging cross group and joint learning. We are also contributing to Borders carers education and are developing care home education.

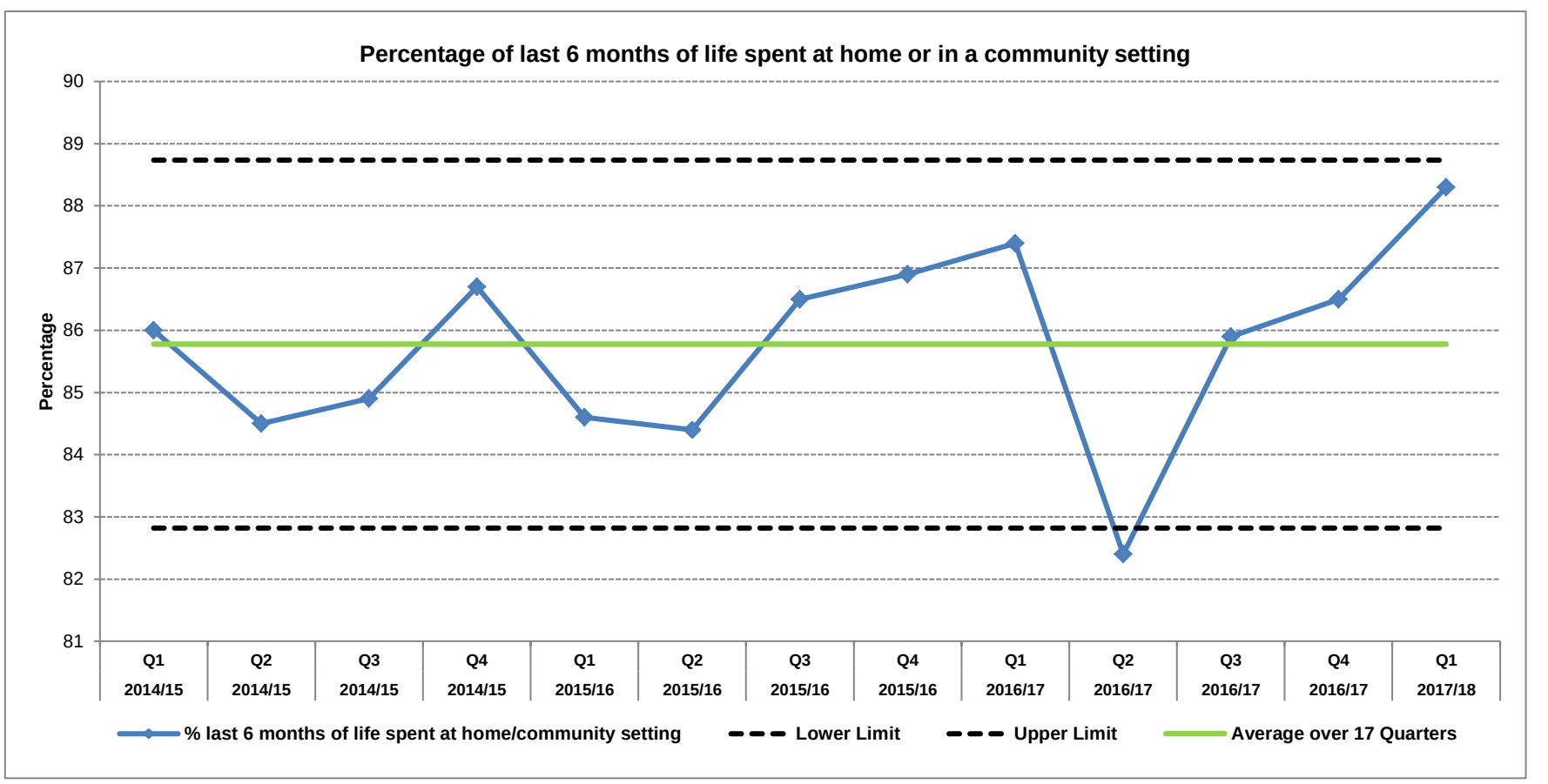
The local specialist palliative care team are in the process of developing a suite of outcome measures (including those validated through the Cicely Saunders institute) which were included in the recommendations sent in by the Scottish Partnership for Palliative Care, to the national work. These and other data the team are starting to collect will inform in greater detail the quality and extent of palliative care provision.
Overarching all of this, there is national work planned to progressively develop data recording, collection and reporting in order to gain better insight into provision of palliative care across a range of settings. We anticipate that Scottish Borders H&SCP, in common with other H&SCPs across Scotland, will be involved in discussions and work around this.

This measure has not been included on the Infographic summary as it is an annual measure only (and as such will be included in the annual report in July 2018

5. End of Life Care

Percentage of last 6 months of life spent at home or in a community setting **New for this quarter**

	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Percentage of last 6 months of life spent at home or in a community setting Scottish Borders	84.5	84.9	86.7	84.6	84.4	86.5	86.9	87.4	82.4	85.9	86.5	88.3



How are we performing?

In addition to the annual measure around end of life care (shown on the previous page), local quarterly data has been provided in relation to last 6 months of life (for Scottish Borders only). However, the very "spikey" nature of the figures requires the Integration Performance Group to investigate this measure further to explore the reasons for the fluctuations and assess its usefulness and accuracy within this performance scorecard. It may be that figure need to be treated on a "provisional" basis.

For this reason, it has not yet been included in the "Infographic summary" (presented at Appendix 1)

What are we doing to improve or maintain performance?

See commentary under annual measure on previous page, for actions relating to improvements around end of life care

6. Balance of Spend

Part 1 - % spent on community based care.

What is this information and why is important to measure it?

Health and Social Care Integration should allow Health and Social Care Partnerships to commission changes in the health and social care pathway that will optimise (where appropriate) community based care. For example, through intermediate care, anticipatory and preventative care. This ensures that emergency/non elective resources (staff, beds, equipment) are
used for those who need acute medical and trauma care.

Under integration it is expected that an increasing proportion of total health and social care spend should be on community-based services.

Data Source(s)
Integrated Resource Framework (IRF) Official Statistics generated from the "Source" reporting system for Health and Social Care Partnerships, ISD Scotland. Please note:-
1. All NHS services are included in total spend, including health services that are not covered by integration (such as planned outpatient and inpatient care).
2. Community-Based Care comprises all NHS community services, family health services including GP prescribing, and all social care expenditure excluding accommodation based social care services.
3. Institutional Care comprises all hospital-based care including outpatients, day case and day patients, plus accommodation-based social care services.
4. Figures shown here for 2013/14 differ from those shown in the Scottish Borders HSCP Strategic Plan as they have since been updated to incorporate Community Dental Services and Community Ophthalmic Services.

Part 2 - % of total spend on hospital stays where the patient (age 18+) was admitted as an emergency.

What is this information and why is important to measure it?

Health and Social Care Integration should allow Health and Social Care Partnerships to commission changes in the health and social care pathway that will optimise (where appropriate) community based care. For example, through intermediate care, anticipatory and preventative care. This ensures that emergency/non elective resources (staff, beds, equipment) are
used for those who need acute medical and trauma care.

Under integration it is expected that a decreasing proportion of total health and social care spend should be on unscheduled hospital care.

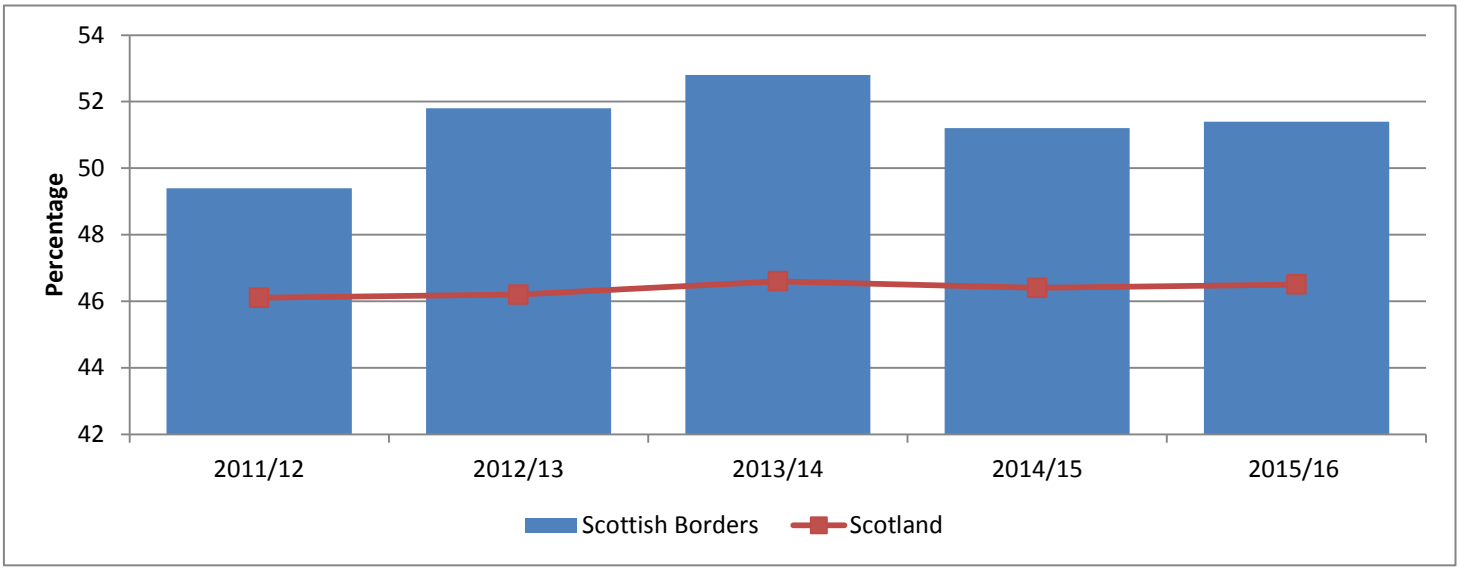
Data Source(s)
This is the "Core Suite Integration Indicator" number 20, taken from Core Suite Indicator Workbooks for Health and Social Care Partnerships, ISD Scotland.

6. Balance of Spend

Total Health and Social Care Expenditure

Updated with 2015/16 information

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Scottish Borders Total Spend (£ millions)	248.7	247.7	257.8	267.2	276.3	
Scottish Borders % spent on Community-Based care	49.4%	51.8%	52.8%	51.2%	51.4%	
Scottish Total Spend (£ millions)	11,675	11,782	12,109	12,620	13037	
Scottish % spent on Community-Based care	46.1%	46.2%	46.6%	46.4%	46.5%	



How are we performing?

The percentage of total health and care spend in the Borders that was accounted for by community-based services has been consistently higher than the Scottish average. Whilst this is a good baseline position for the Health and Social Care Partnership relative to Scotland, it will be important to ensure that the community service share is maintained/improved. The share for 2015/16 increased slightly relative to 2014/15.

What are we doing to improve or maintain performance?

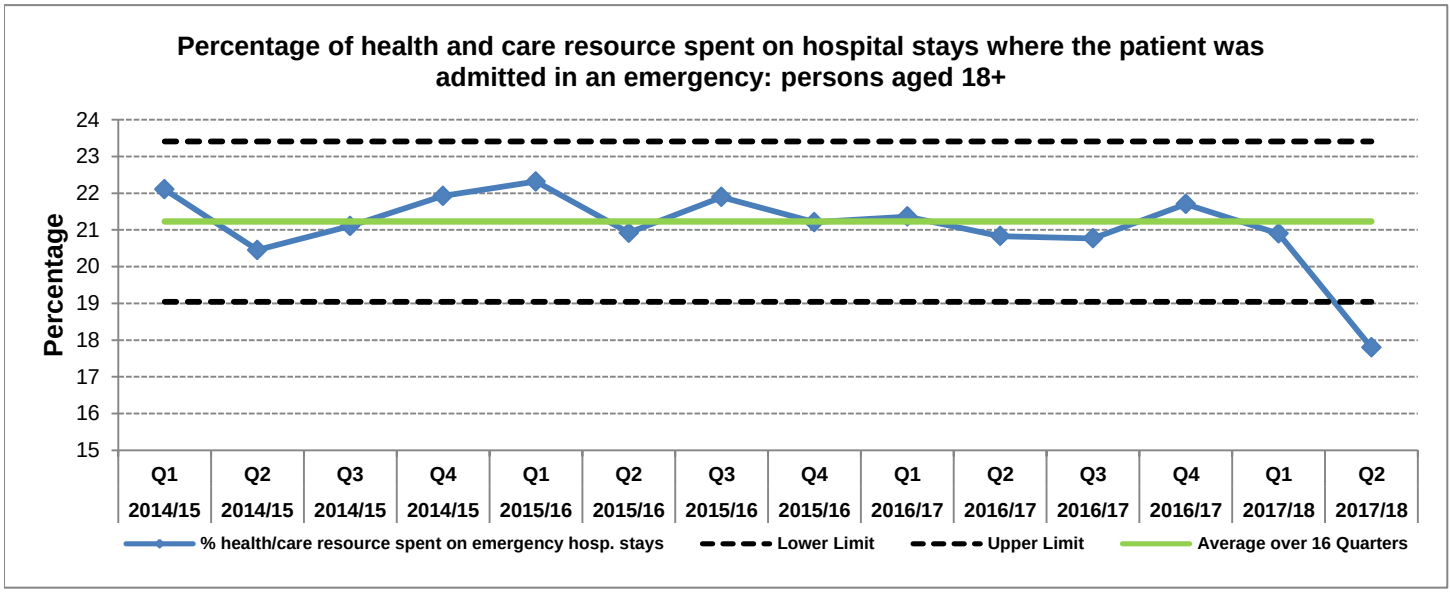
We will be examining this theme/objective as part of our review of our Strategic Plan in the first months of 2018 and the possibility and benefits of using more up to date local data on a "provisional" basis in relation to balance of spend.

6. Balance of Spend

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

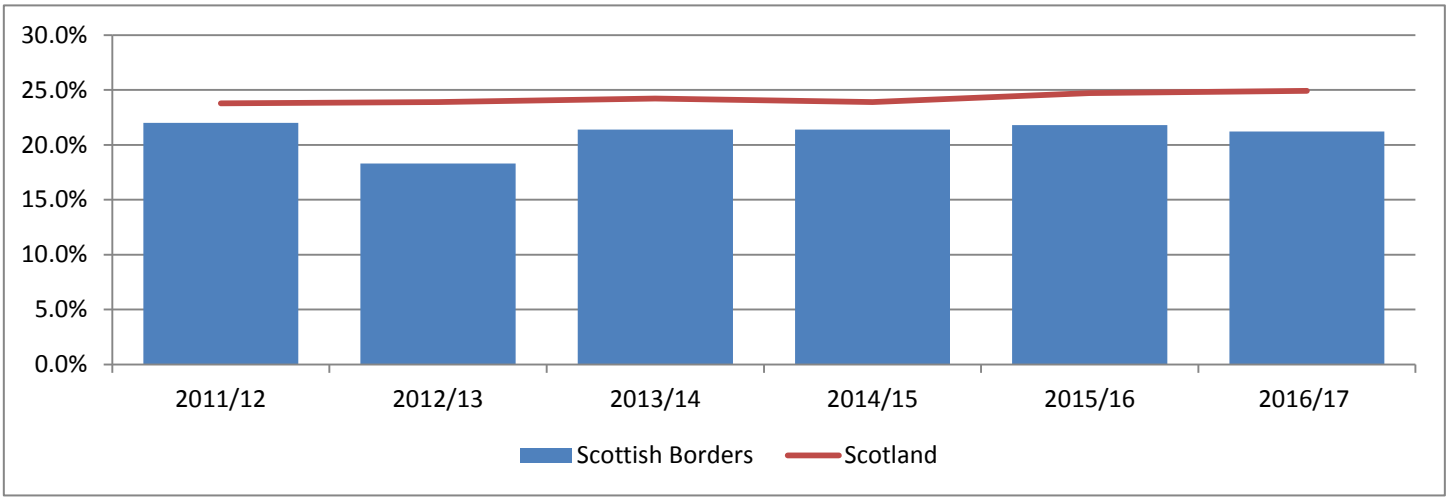
Updated - 2 new quarters

Quarter ending	Q3 2014-15	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18
% of health and care resource spent on emergency hospital stays	21.1	21.9	22.3	20.9	21.9	21.2	21.4	20.8	20.8	21.7	20.9	17.8



Figures for 2015/16 and 2016/17 revised to reflect updated costs reference data

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (P)
Scottish Borders	22.0%	18.3%	21.4%	21.4%	21.6%	21.2%
Scotland	23.8%	23.9%	24.2%	23.9%	24.7%	24.7%



How are we performing?

Scottish Borders has consistently performed slightly better than Scotland. However, there is no obvious downward (improving) trend, and as with other Health and Social Care Partnerships, Scottish Borders is expected to work to reduce the relative proportion of spend attributed to unscheduled stays in hospital.

6. Balance of Spend

What are we doing to improve or maintain performance?
Work continues to reduce emergency admissions to the BGH. The Long Term Conditions self-management project helps patients with chronic conditions to support themselves in the community. Also Anticipatory Care Plans are routinely created and shared between health and social care to make sure patients receive the support that they require in their own homes.

7. Social Care

Part 1 - Percentage of social care clients reporting that they feel safe.

What is this information and why is important to measure it?

All adults who require support receive a care assessment by an occupational therapist, social worker or a nurse. A care assessment looks at the emotional and social side of an individuals life as well as any physical difficulties they may be experiencing.

At the end of a care assessment the individuals views are recorded to give an indication of how they feel the support discussed during the assessment will make them feel.

Ensuring our assessments and social care provision allow an individual to remain at home and feel safe in their environment is a fundemental requirement for care within a community setting. If this care is correctly administered it will allow individuals to remain within the community and in their own homes for longer. By increasing our ability to successfully support individuals in the community, we reduce the impact on other services over time.

Data Source(s)

1. Do you feel safe? is a Social Care Survey measurement taken during a social care adult assessment . It is recorded on the SBC Framework System and collated on a monthly basis. The questions applies to any adult who has received (and completed) an adult social care assessment during the month.

Part 2 - People within SB with intensive care needs receiving support in a community setting rather than a care home.

What is this information and why is important to measure it?

This measurement considers how we are managing to support elderly clients to remain within the community rather than move into residential care. It reviews our ability to support clients to sustain an independent quality primarily through home care, however it considers other areas:

- Homecare service (irrespective of hours)
- Direct payment or SDS payment
- Living within an extra care housing facility (Dovecot)
- The number of clients age 65 or older supported within a community setting is then compared to those age 65 or older in a residential setting (Care Home).

Home care is one of the most important services available to local authorities to support people with community care needs to remain at home. Increasing the flexibility of the service is a key policy objective for both central and local government, to ensure that people receive the type of assistance which they need, when they need it.

The measurement only captures 'home care services' which are provided on an hourly basis. Other services which support people at home, such as laundry services, home shopping, community alarms and meals-on-wheels, are not included.
The measurement will be affected by the pattern of need and demand within the area, influenced by the age-structure of the elderly population, the distribution of poverty and ill health, household composition and other factors.

It will become increasingly important that we maximise our ability to support the elderly within the community as budget and financial considerations impact our service.

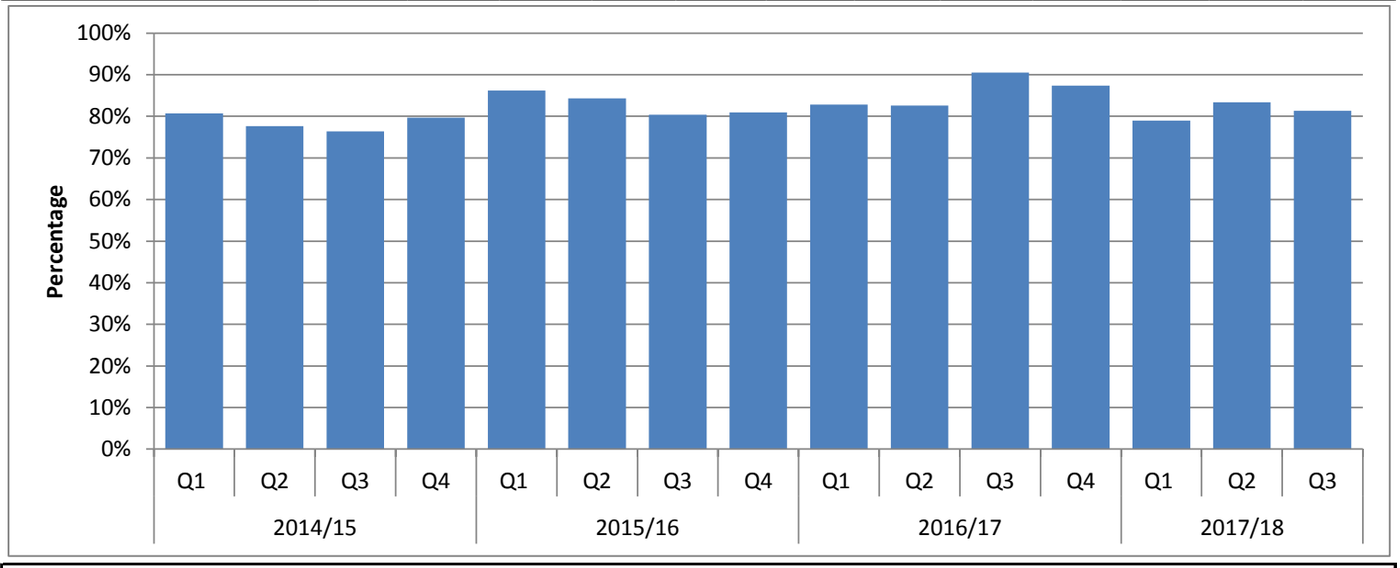
Data Source(s)

1. Report from SBC Framework System provided monthly for internal monitoring via the current reporting structure.

7. Social Care

Social Care Survey - Do you feel safe?

	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
Number of People Feeling Safe	659	690	638	624	629	585	445	502	504	514	527	458
Ave. % of People Feeling Safe	80%	86%	84%	80%	81%	83%	83%	91%	87%	79%	83%	81%



How are we performing?

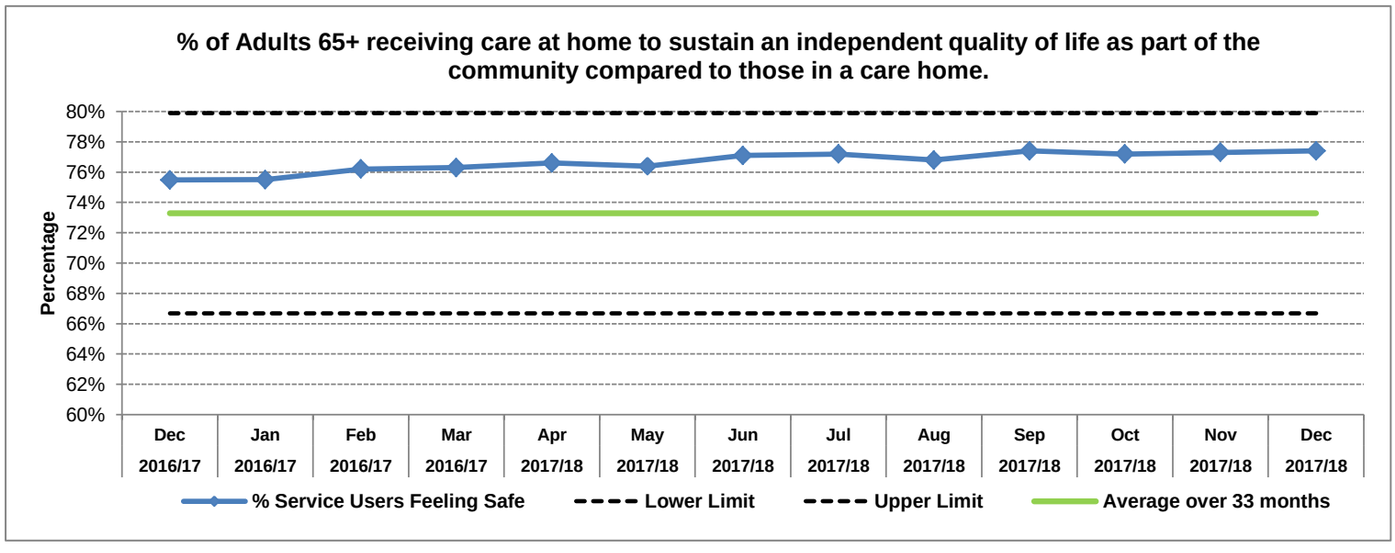
Fluctuating over the past 3 years, this indicator shows on average over 80% of those asked if they feel safe following a Social Care Adult Assessment answered yes.

What are we doing to improve or maintain performance?

This question has been consistently used to measure the outcome of a Social Care Assessment in which the clients needs are assessed and desired outcomes discussed. The methodology of collecting and measuring this outcome has changed over time and these inconsistencies may impact the measure. Further work is underway to find new and more specific outcome measures which will have more stringent collection methodology and provide a wider ranging outcome evaluation.

People within the Scottish Borders with intensive care needs receiving support in a community setting rather than a care home.

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Number of Adults 65+ within community.	2074	2126	2153	2176	2145	2291	2295	2243	2330	2311	2314	2302
% of Adults 65+ receiving care at home compared to those in a care home.	76%	76%	76%	76%	76%	77%	77%	77%	77%	77%	77%	77%



7. Social Care

How are we performing?

Since June 2016 this measure has been consistently better than the average over the past two years. This indicator shows we are actively supporting a large percentage of adults over 65 within a homely, community setting rather than a residential environment.

However, the fact that this indicator has remained at around 76/77% for the last 9 months could suggest that locally, our capacity within a community setting has been reached and should be addressed.

What are we doing to improve or maintain performance?

Locality based teams monitoring and assessing the needs of our clients ensure a more community based outcome for clients. Further emphasis on locality management of client will further maintain and improve this measure.

The current review of the Strategic Plan will include an examination of what data is available locally in relation to the theme of Social Care. The Integration Performance Group will also look at this indicator in more detail to ascertain the reasons for the apparent "plateauing" of performance.

8. Carers

Part 1 - Carers Centre Assessments - Support for Caring

A Carers Assessment includes a baseline review of several key areas including Support for Caring, Caring Choice, and Caring Stress based on the Quality of Life assessment tool. These areas are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for Carers.

Data Source(s)

1. Carer Centre Assessment responses to - Support for Caring questions
2. Carer Centre Assesment responses to - Caring Choice
3. Carer Centre Assesment responses to - Caring Stress

Part 2 - Carers Assessments offered and completed.

What is this information and why is important to measure it?

It is estimated that around 788,000 people are caring for a relative, friend or neighbour in Scotland. This includes around 44,000 people under the age of 18. A large percentage of these are currently not recognised as carers and are unpaid. Their contribution to caring within the community is substantial and could not be replaced.

The Carers (Scotland) Act will commence on April 1, 2018. There is a package of provisions within the Act designed to support carers' health and wellbeing. Local Authorities have a requirement to identify and support carers needs and personal outcomes.

Any carer who appears to have a need for support should be offered an assessment. The assessment is provided regardless of the amount or type of care provided, financial means or level of need for support.

Improving our methods of identifying and offering support to carers will ensure their contribution is recognised and complements the social care system currently in place.

Data Source(s)

1. Offered assessment data is extracted from the SBC Framework System and is a question asked during a Adult Assessment.

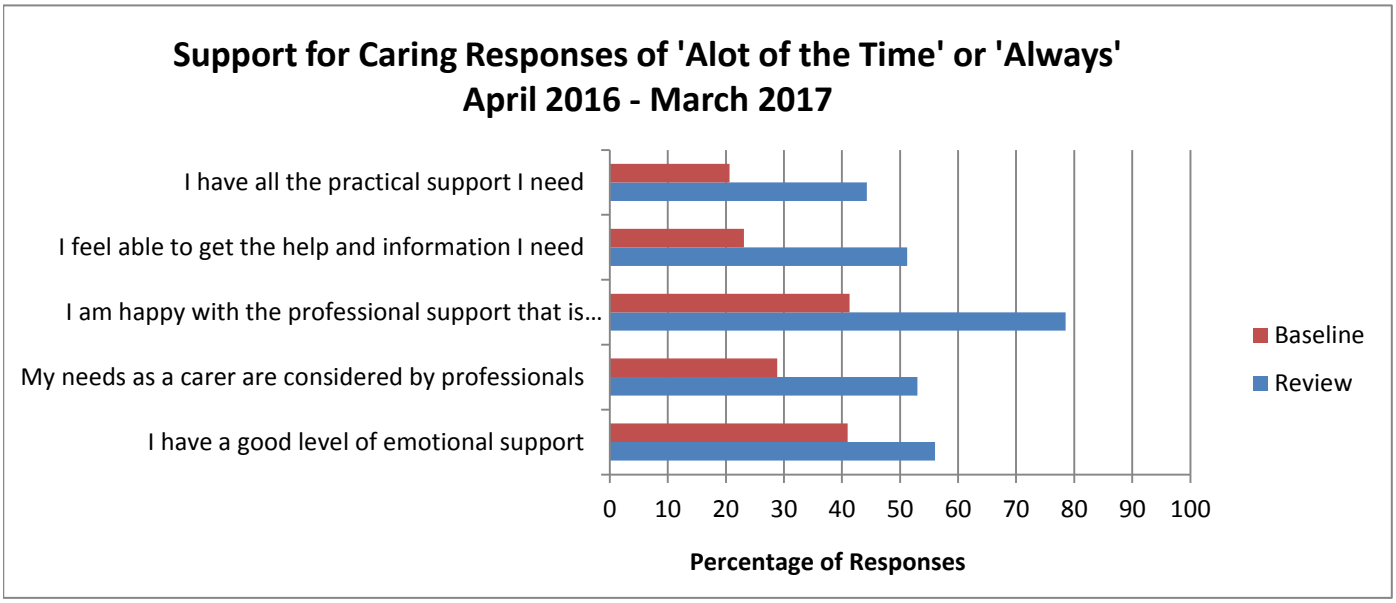
2. The Carer Centre provides a monthly count of all completed assessments for the Scottish Borders.

8. Carers

Carers Centre Assessments - Support for Caring

Due to changes in the Carer Centre Reporting Schedule we are awaiting updated information which will be available for the next Quarterly IJB report. There are therefore no changes to the data, graphs or commentary since the last report, on the next 4 pages.

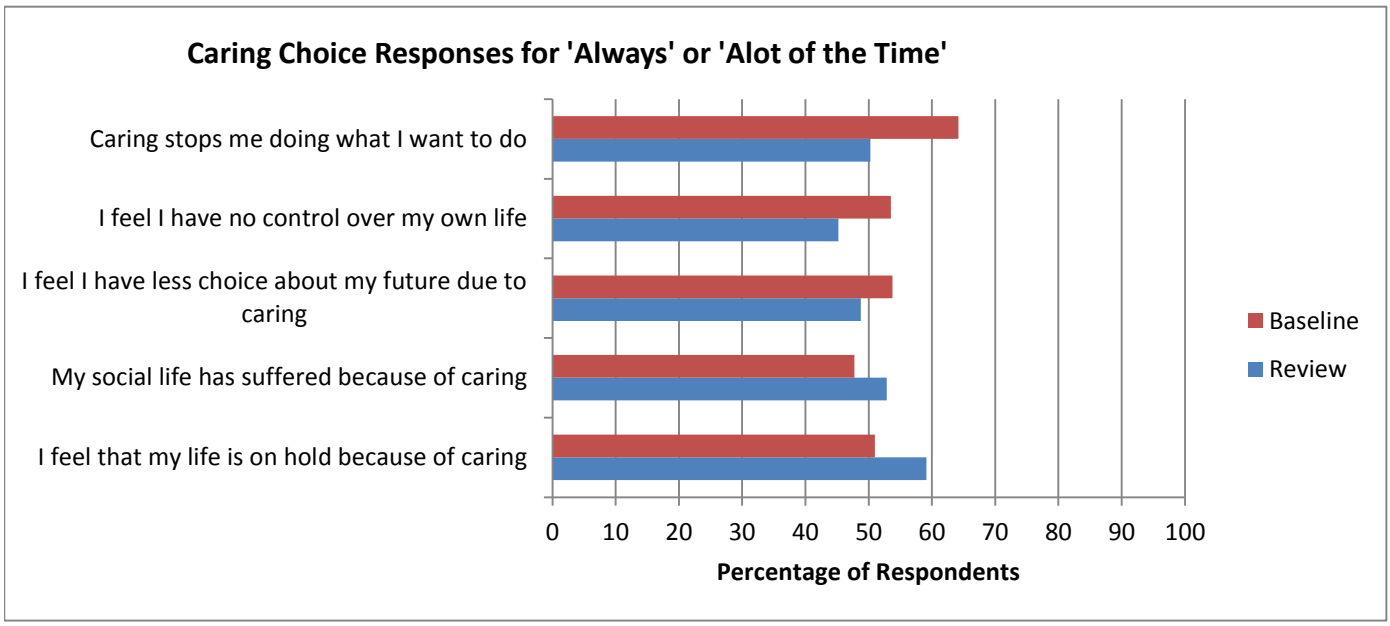
	Apr 2016 - Mar 2017									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot
I have a good level of emotional support	22	19	36	24	**41**	19	19	37	38	**38**
My needs as a carer are considered by professionals	6	24	36	36	**29**	29	24	26	28	**53**
I am happy with the professional support that is provided to me	23	19	31	29	**42**	42	37	28	26	**79**
I feel able to get the help and information I need	14	9	59	18	**23**	23	29	37	29	**52**
I have all the practical support I need	14	7	47	32	**21**	21	24	27	40	**45**



Carers Centre Assessments - Caring Choice

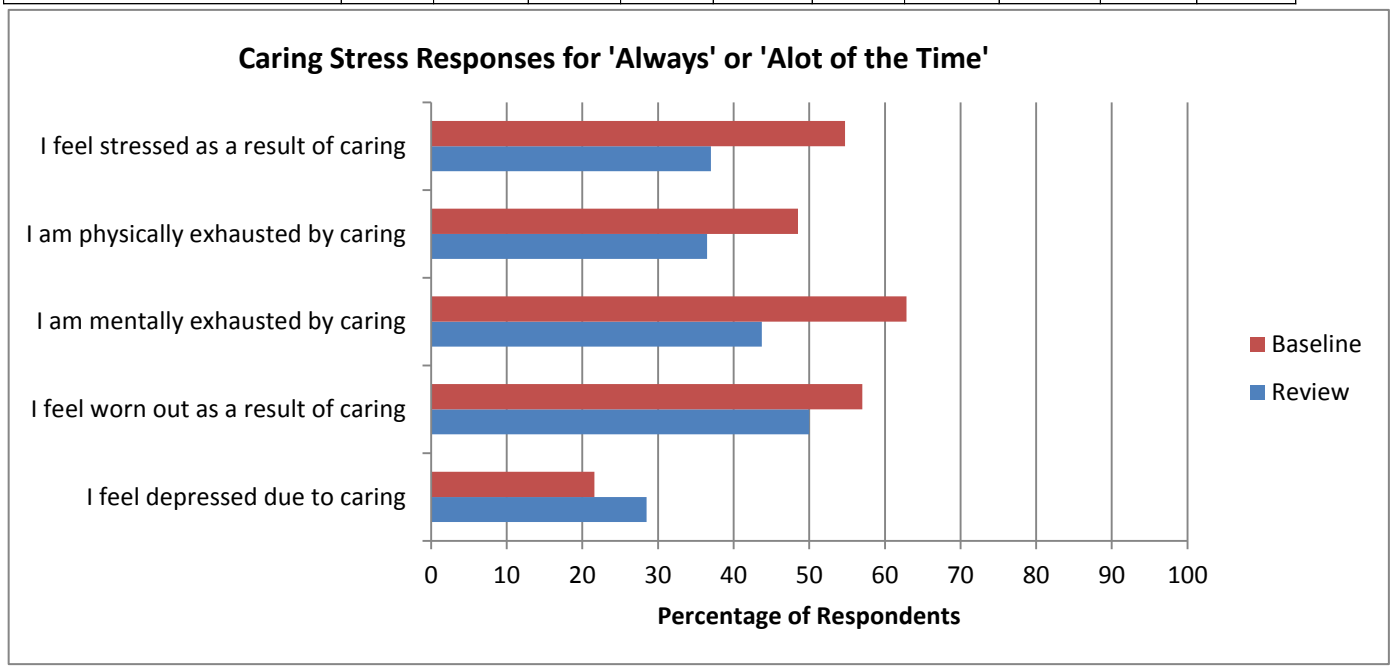
	Apr 2016 - Mar 2017									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot
I feel that my life is on hold because of caring	27	24	21	28	**51**	25	34	24	17	**59**
My social life has suffered because of caring	32	16	25	28	**48**	24	29	29	18	**53**
I feel I have less choice about my future due to caring	38	16	9	38	**54**	17	32	31	20	**49**
I feel I have no control over my own life	25	29	24	23	**54**	19	26	27	28	**45**
Caring stops me doing what I want to do	33	31	17	18	**64**	17	33	31	19	**50**

8. Carers



Carers Centre Assessments - Caring Stress

	Apr 2016 - Mar 2017									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot
I feel depressed due to caring	9	13	56	23	**22**	22	7	11	54	**29**
I feel worn out as a result of caring	45	12	38	6	**57**	16	34	39	12	**50**
I am mentally exhausted by caring	33	30	28	9	**63**	13	31	39	17	**44**
I am physically exhausted by caring	23	26	26	26	**49**	21	16	43	21	**37**
I feel stressed as a result of caring	29	25	40	5	**55**	13	25	48	15	**37**



8. Carers

How are we performing?

A Carers Assessment includes a baseline review of several key areas including Support for Caring, Caring Choice, and Caring Stress based on the Quality of Life assessment tool. These areas are reviewed within a 3 month to 12 month period depending on the level of need and the indicators from the initial baseline. This information is collated to measure individual outcomes for carers.

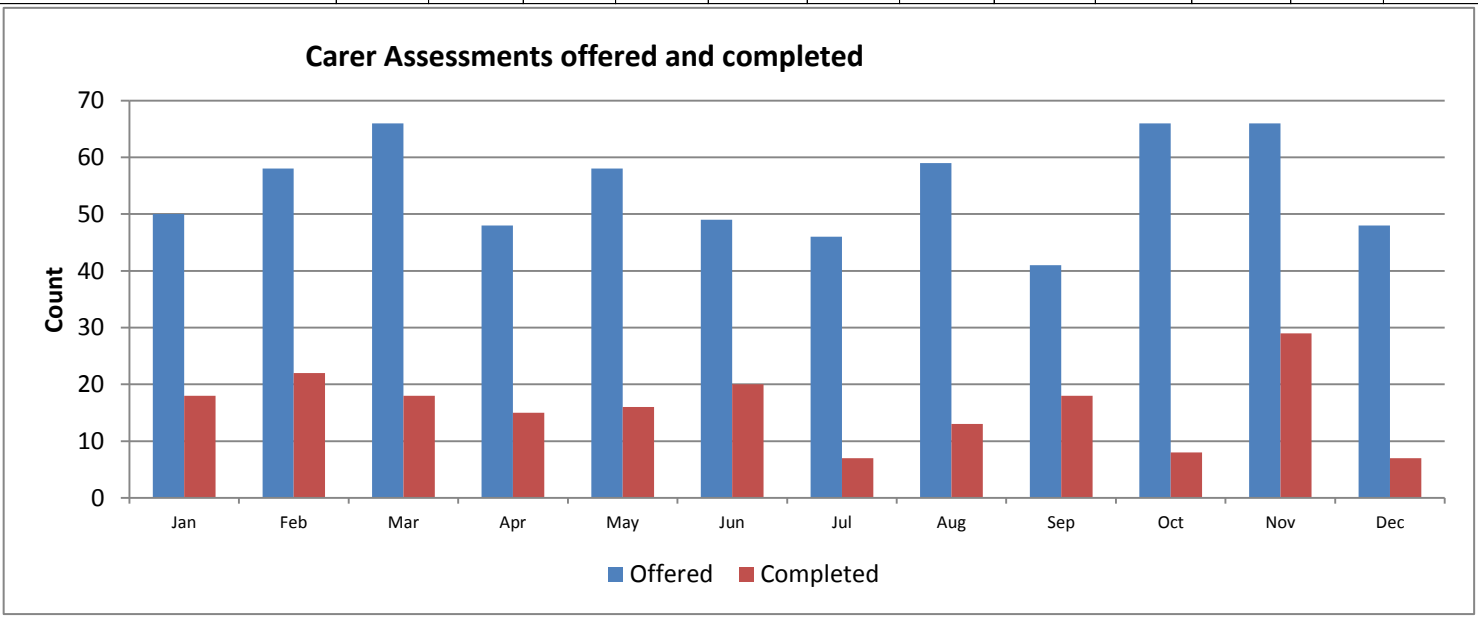
Data for April 2016 - March 2017 shows improvement between the baseline and review surveys in nearly all respects. There are just two exceptions to this – the questions under caring choices around Carers' social lives and feelings as to whether their lives have been put on hold.

What are we doing to improve or maintain performance?

The Carers (Scotland) Act 2016, which will be implemented from 1st April 2018, includes a range of duties on the Partnership and Scottish Borders Council to support Carers' health and wellbeing. These include a duty to provide support to adult and young Carers, based on the Carer's identified needs which meet the local eligibility criteria. The H&SCP is working to implement the requirements of the Act; in collaboration with the Carers Centre we have set up a Project Board and we are developing a structure to ensure Carers and Carer representatives participate in the planning process. It is anticipated that this will lead to an increase in the number of Carers who will seek support and in the range of support made available to Carers. The work of the Borders Carers Centre (commissioned by the Partnership) is a crucial component of the support offered to Carers.

Carers offered and completed assessments.

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Assessments offered during Adult Assessment	**50**	**58**	**66**	**48**	**58**	**49**	**46**	**59**	**41**	**66**	**66**	**48**
Carers Centre	18	22	18	15	16	20	7	13	18	8	29	7



How are we performing?

This information shows that during the last 12 months we offered of average 55 assessment to individuals who were identified as carers during a Social Work Adult Assessment. Within the same month the Carers Centre completed on average 16 assessments per month. Although these measurement are taken within the same month they may not relate to the same individuals, for example a person offered an assessment in January may not actually undergo an assessment until some time later. We expect over a year the total offered will be similar to the total completed.

8. Carers

What are we doing to improve or maintain performance?
Although the offering of an assessment to a carer identified during an adult assessment is not a new action, we have not regular recording or monitored the take up of the offer. With regular monitoring and review of this measure we can identify improvement we can make in the service to ensure uptake of the carers assessment is maintain or improved.

9. Other Relevant Measures

Part 1 - BGH and Community Hospital Patient/Carer/Relative '2 Minutes of Your Time' Survey

What is this information and why is important to measure it?

NHS Borders has introduced a proactive patient feedback system '2 minutes of your time', which comprises a brief survey of 3 quick questions. Feedback boxes are located within our acute hospital (the BGH), community hospital and mental health units. In addition patient feedback volunteers have been recruited and gather feedback from patients, carers and their relatives within clinical and public areas throughout the hospital. This enables us to look at changing the way in which we do things and ensuring our work has a more person centred approach.

Data Source(s)

NHS Borders

Part 2 - Integrated Care Fund Project Evaluations

What is this information and why is important to measure it?

It was recognised nationally, and evidenced locally, that the Reshaping Care for Older People Fund had worked well in encouraging the NHS , Local Authority, the third and independent sectors to work together to begin to redesign services for the future with a focus on older people.

It has now set more ambitions challenges; to be innovative, taking preventative approaches with the express intent to reduce inequalities across all adult services. This fund (Integrated Care Fund) is allocated to parnerships to help facilitate and drive forward the changes requied, tackling collectively the challenge associated with multiple and chronic conditions for all adults.

Several project have been established to focus on specific preventitive areas and this section summerises the project evaluations as they become available. During this quarter one project evaluation was available. More detail of each project and their evaluation findings are available via their 2 page summaries.

Data Source(s)

1. Community Equipment Service/Border Ability Equipment Service Relocation

Part 3 - Inspection of Older People's Services 2017: Action Plan Update

What is this information and why is it important?

In 2016/2017, the Care inspectorate undertook an inspection of Older People's Services in the Scottish Borders. In response to the inspection findings, an action plan was drafted. The action plan contains 13 high level actions and 60 sub actions, and is overseen by the IJB Leadership Team.

It is important that the issues identified by the Care Inspectorate are addressed in line with the timescales within the action plan (generally by end 2018, some into 2019) in order that we focus our collective resources on provided the best possible services for older people, to improve outcomes and quality of life. As there are both operational and reputational risks associated with delays in progressing the actions, this overview is intended to provide the IJB with assurance and highlight any areas of concern or delay.

Data Source

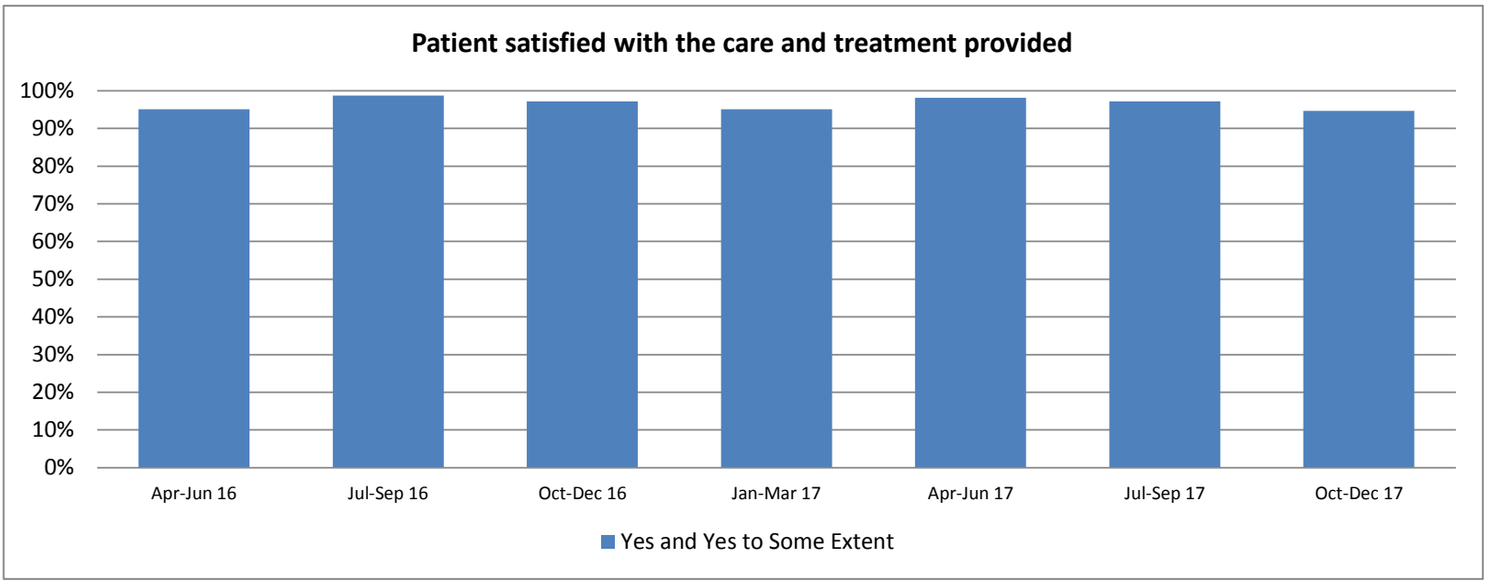
IJB Leadership Team Inspection Action Plan 2017

9. Other Relevant Measures

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

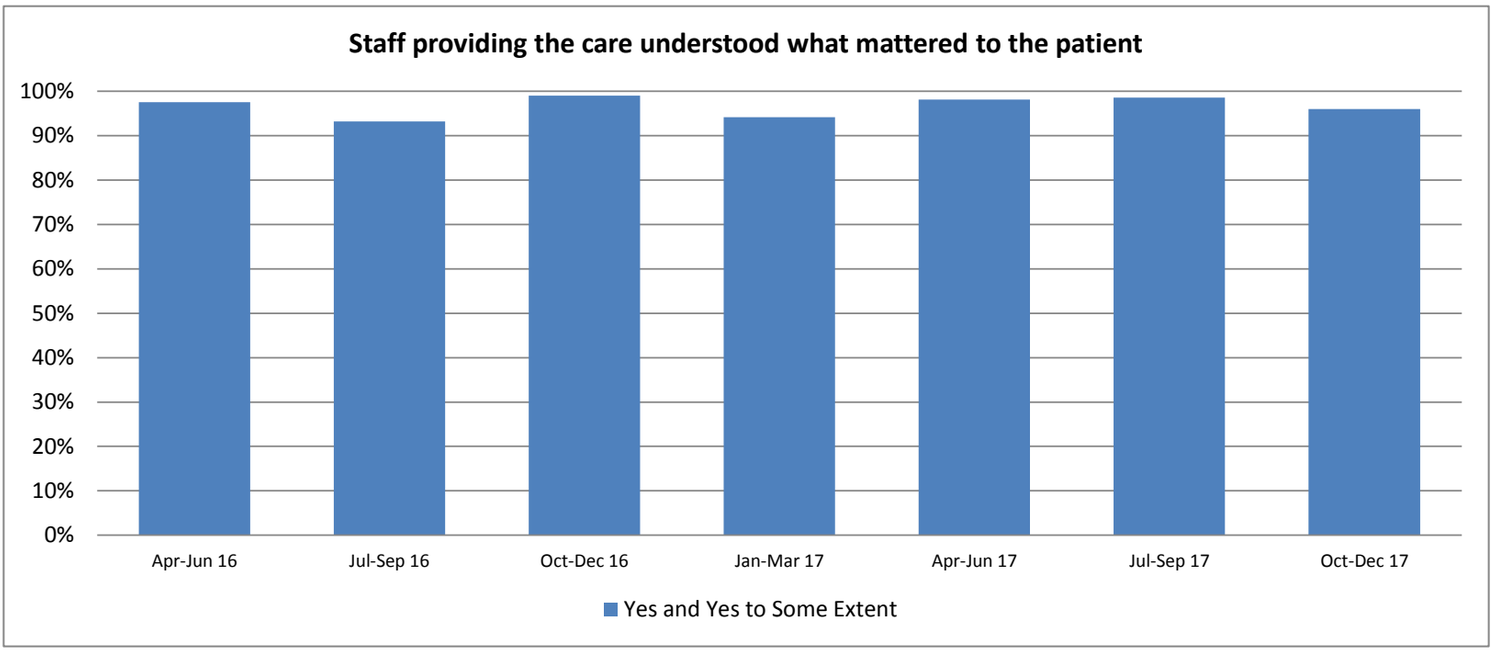
Q1 Was the patient satisfied with the care and treatment provided? Jul-Dec 2017 added

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Patients feeling satisfied or yes to some extent	232	160	105	116	105	206	141	
% feeling satisfied or yes to some extent	95.1%	98.8%	97.2%	95.1%	98.1%	97.2%	94.6%	



Q2 Did the staff providing the care understand what mattered to the patient? Jul-Dec 2017 added

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Staff providing the care understood what mattered to the patient, or yes to some extent	238	151	106	113	105	213	144	
% understood what mattered or yes to some extent	97.5%	93.2%	99.1%	94.2%	98.1%	98.6%	96.0%	



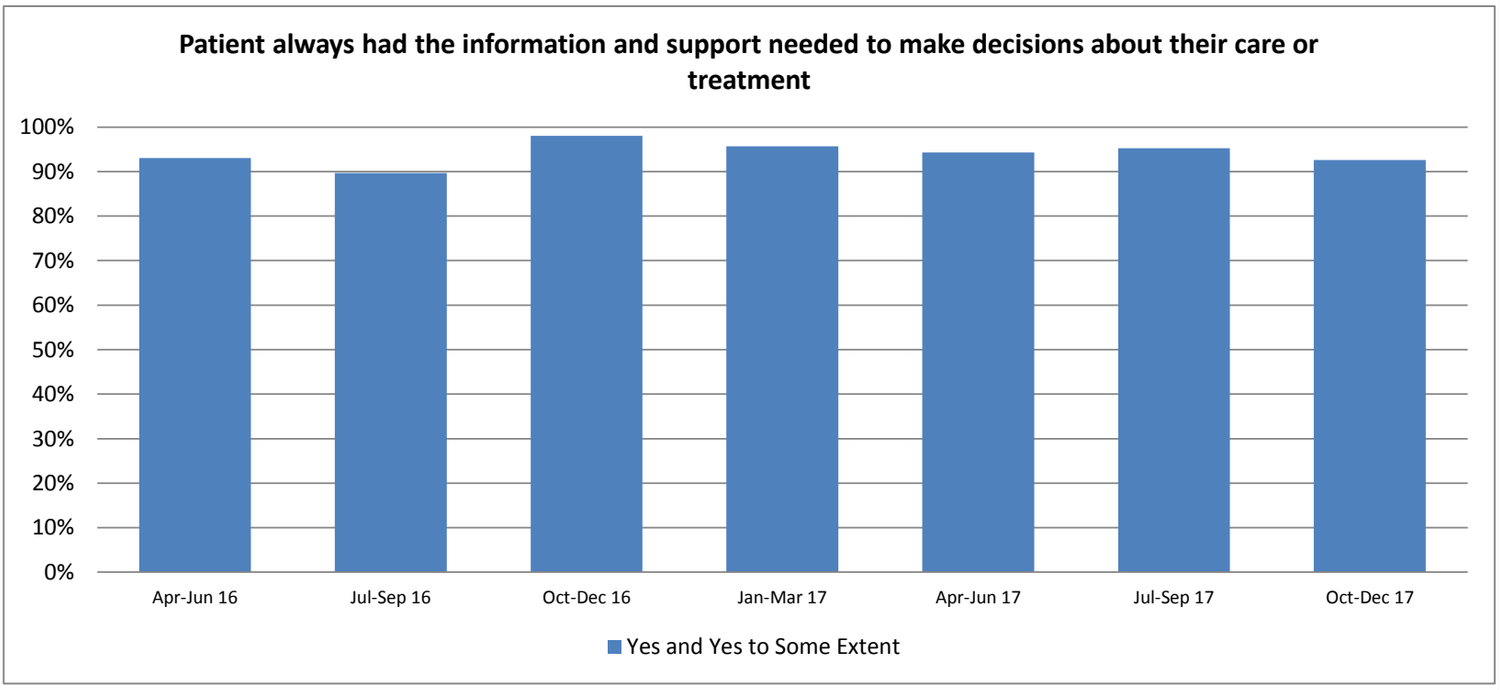
9. Other Relevant Measures

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

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

	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018
Patients always had the information and support needed to make decisions about their care or treatment, or yes to some extent	226	147	101	111	99	113	105	
% always had information or support, or yes to some extent	93.0%	89.6%	98.1%	95.7%	94.3%	95.2%	92.6%	

Jul-Dec 2017 added



How are we performing?

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

The positive response averages for the last 7 quarters are 96.5% for question 1, 96.7% for question 2 and 93.8% for question 3.

What are we doing to improve or maintain performance?

The feedback collected is reported to our clinical and public areas in a timely manner. Within our clinical areas this is displayed on their quality and safety information boards and in public areas this is visible in a 'You said, We did' report. This enables the public and staff to see what changes have been made as a result of feedback. This feedback is reported across the organisation and to the Board.

9. Other Relevant Measures

Integrated Care Fund Projects

Learning Disabilities Transition

What is this project and why is important?

This project focuses upon young people who have a diagnosed learning disability between the ages of 14 and 18 who are moving towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education. A Transition Development Officer was commissioned for 12 months from October 2016 to scope current pathways and develop a more consistent and coordinated approach.

Key Achievements

In year 1 of the project a first draft of the new pathway was developed and testing of this will take place in the current year. An information pack for families and staff has been produced. A named person has been identified for each family through the Local Area Coordinators and a training programme for this developed. More detailed evaluation will be available once the new pathway has been fully adopted.

Matching Unit

What is this project and why is important?

The Matching Unit is an administrative team created to match a home care service to the assessed needs of the client. This was established in Hawick in April 2017 and rolled out to all locality teams and START by October 2017. Prior to this service Care Managers spent a significant amount of time sourcing care individually.

Key Achievements

Care Managers were surveyed before and after the introduction of the service. The time spent securing care at home by Care Managers dropped from 20% to 9% of the working week which exceeded the target set (half the time spent).
Staff satisfaction with the new process is 90%, compared with 6% for the previous process for securing home care.
An initial survey of Care Providers suggested they would welcome the changes to the home care process.

Evidence / Case Study

John is 65 years old and lives with his wife Mary, he has a diagnosis of secondary progressive Multiple Sclerosis and mobilises with a zimmer frame, he has poor mobility and requires supervision as he is a high falls risk. He has had several falls in recent months in which he has been unable to get up from the floor.

John feels safe when Mary is at home however he does not like it when she is out, often calling her or waiting near the front door. John was diagnosed with dementia in January 2017.

Mary suffers from back pain and she is John's sole carer, she supports him with all personal care and transfers. John also gets up to use the bathroom several times a night with support from Mary. Mary acknowledges that her caring role has increased since John was diagnosed with dementia and that she finds some of the care tasks very tiring. She admits that she is suffering from considerable carers stress however she is also reluctant to accept any help at home.

The allocated OT care manager (Claire) had identified that both John and Mary were at risk while undertaking some of the care tasks and should Mary not be able to continue with her caring role then John would require a large package of care to support him at home.

Claire had identified a support plan for John but had not sent to the Matching Unit as neither Mary or John were agreeable to accepting help and felt they needed time to consider this.

John was admitted to hospital after a fall at home.

9. Other Relevant Measures

Claire received a call from the hospital ward to let her know that Mary was very tearful and anxious and very distressed that John was remaining in hospital. She had decided that she was taking him home against all medical advice. The nursing staff were very concerned about Marys ability to manage the care for her husband at home and contacted Claire.

What Happened:

As Claire had already identified a support package which was not yet put in place she did the following:

- Made a telephone call to the Matching Unit to advise of the situation and of the urgency of sourcing the package of care as soon as possible.
- Sent the support plan to her line manager for authorisation on Mosaic.

The Matching Unit were able to access the support plan on Mosaic and called round the providers in the area to source the care.

• Claire received a call from the Matching Unit 2 hrs later to advise her that the care package was starting that evening.

The Matching Unit carried out all other tasks to put this care in place. Claire's view is that if the care provision had taken longer given Marys stress levels it is unlikely that she would not have accepted the care.

What Would Have Happened Without The Matching Unit:

- Call round all four providers in the area to try to source the care
- Populate the support plan with: the provider, time, complete the budget workings and the costs.
- Complete a home care alert to send this to admin.
- Print and post/email the paperwork to the provider.
- Complete a case note
- Send herself an Initiation/Variation form
- Complete initiation/variation form
- Send Initiation/Variation form to finance.

Claire's feedback on this service:

'after the scenario this morning where a client's wife took her husband home from hospital against medical and nursing advice and the care plan authorised a few weeks ago was transferred to the Matching Unit at about 12.30pm and they have just called and care can start tonight……how efficient is that and no stress to me!' (Claire - OT care manager)

9. Other Relevant Measures

Inspection of Older People's Services 2017: Action Plan Update

How are we performing?

For each of the 13 high level actions, a set of sub-actions has been established, with responsible owners and expected completions dates. Progress is being made across all 13 high level actions. Of the 60 sub actions:

- 25 (42%) are now completed
- 33 (55%) are in progress and expected to meet timescales (one exception below)
- 2 (3%) are now overdue (details below)

In progress- exception

High level Action	Sub Action	Comments
9. Develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved	Develop and implement a detailed financial recovery plan to ensure that a sustainable financial position is achieved and agreed by the Integration Joint Board. (Expected completion date 31/03/2018)	On 2nd April EMT will consider a report on the 2018/19 IJB budget, including identification of savings, with a view to reporting this to IJB on 23rd April. Timescales within the action plan should then be revised accordingly

Overdue Action

High level Action	Sub Action	Comments
3. Further develop and implement the joint approach to early intervention and prevention (EI&P) services so there is a range of services working together that support older people to remain at home and help avoid hospital admission.	Hold a ½ day strategic review session to fully understand the current landscape and Identify the key components of a good EI & P approach for older people and identify gaps (Expected completion date 28/02/18)	There has been a delay in collating information due to staff absence and therefore to arranging the review event. Timescale to be amended. Session outputs will be used as part of future early intervention and prevention work with partners.
10. Ensure that there are clear pathways for accessing services and that eligibility criteria are developed and consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.	Develop a more robust hospital to home process (Expected completion date 31/01/18)	After considering various approaches, a simple "process and pathways paper" is being developed, and it is expected that this will be complete in the next 2 months (by end May 2018)

What are we doing to improve or maintain performance?

Relevant service managers and owners of the actions continue to prioritise the actions required to address the Care Inspectorate's areas of concern and the IJB Leadership Team, which meets weekly, will continue to monitor the detailed action plan.