



CHANGING HEALTH & SOCIAL CARE FOR YOU

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

SUMMARY OF PERFORMANCE FOR INTEGRATION JOINT BOARD OCTOBER 2018

This report provides an overview of quarterly performance under the 3 strategic objectives within the revised Strategic Plan, with **latest available data at the end of September 2018**. A number of annual measures that have been updated recently are included in the [Annual Performance Report 2017/18](#)

+ve trend/Scottish Borders compares well to previous period/to Scotland	-ve trend/some concern from previous period or when compared to Scotland	Little change/little difference over time/to Scotland
KEY		

HOW ARE WE DOING?

OBJECTIVE 1

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

EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS, ALL AGES) 28 admissions per 1,000 population (April - June 2018) Little change over 4 Qtrs Higher than Scotland	EMERGENCY HOSPITAL ADMISSIONS (BORDERS RESIDENTS AGE 75+) 86.8 admissions per 1,000 population Age 75+ (April - June 2018) -ve trend over 4 Qtrs Similar to Scotland	ATTENDANCES AT A&E 7,966 attendances (April - June 2018) -ve trend over 4 Qtrs Trend similar to Scotland	£ ON EMERGENCY HOSPITAL STAYS 23.7% of total health and care resource , for those Age 18+ was spent on emergency hospital stays (Jan - March 2018) -ve trend over 4 Qtrs Lower than Scotland
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Main Challenges

Although rate of emergency admissions has fluctuated over the last 4 quarters, it is showing a downward (+ve) trend over the longer term. The rate of emergency admissions for Scottish Borders (SB) residents aged 75+ has generally been decreasing over the longer term but there has been an increase over the last 4 quarters. In relation to spend on emergency hospital stays, Borders has consistently performed slightly better than Scotland. However, there has been a gradual increase since 2014/15. As with other Health and Social Care Partnerships, we are expected to work to reduce the relative proportion of spend attributed to unscheduled stays in hospital.

Our plans during 2018 to support this objective

Develop Local Area Co-ordination; redesign day services; continue Community Link Worker pilot in Central and Berwickshire areas; expand the scope of the Matching Unit, the "hospital to home" project (which is working to support frail elderly patients in their own homes) and Neighbourhood Care to focus on keeping people out of hospital.



OBJECTIVE 2

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

A&E WAITING TIMES (TARGET = 95%)	NO. OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)	RATE OF OCCUPIED BED DAYS* FOR EMERGENCY ADMISSIONS (AGES 75+)	NUMBER OF DELAYED DISCHARGES ("SNAPSHOT" TAKEN 1 DAY EACH MONTH)	RATE OF BED DAYS ASSOCIATED WITH DELAYED DISCHARGE
91.8% of people seen within 4 hours	10,523 bed days for admissions of people aged 75+	876 bed days per 1000 population Age 75+	17 over 72 hours 11 over 2 weeks (July 2018)	204 bed days per 1,000 population Aged 75+
(June 2018)	(April - June 2018)	(April - June 2018)		(Jan - March 2018)
+ve trend over 4 Qtrs (although lower than target)	Little change over 4 Qtrs	-ve trend over 4 Qtrs	+ve trend over 4 Qtrs	Little change over 4 Qtrs
Similar to Scotland		Lower than Scotland (although see note*)		Higher than Scotland

*Occupied Bed Days in general/acute hospital beds such as Borders General Hospital. This does not include bed days in the four Borders' community hospitals.

"TWO MINUTES OF YOUR TIME" SURVEY, CONDUCTED AT BGH AND COMMUNITY HOSPITALS				(April - June 2018)
SATISFACTION WITH CARE & TREATMENT	96.3%	STAFF UNDERSTANDING OF WHAT MATTERED	96.9%	PATIENTS HAD INFO AND SUPPORT NEEDED
Little change over 4 Qtrs		Little change over 4 Qtrs		Little change over 4 Qtrs

Main Challenges

Improving trend in relation to A&E, although the 95% target is not yet being met (also the case for Scotland). Quarterly occupied bed day rates for emergency admissions in SB residents age 75+ have fluctuated over time but are lower than the Scottish averages (although see note above*). Quarterly rate of bed days associated with delayed discharges back down to 204 in Q1 18/19. % of patients satisfied with care, staff & information in BGH and Community hospitals remains high.

Our plans during 2018 to support this objective

Continue to support a range of "Hospital to Home" and "Discharge to assess" models to reduce delays (for adults who are medically fit for discharge); develop "step-up" facilities to prevent hospital admissions and increase opportunities for short-term placements, as well as a range of longer term transformation programmes to shift resources and re-design services.

OBJECTIVE 3

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

EMERGENCY READMISSIONS WITHIN 28 DAYS (ALL AGES)	END OF LIFE CARE	CARERS OFFERED SUPPORT PLANS V COMPLETE	SUPPORT FOR CARERS: change between baseline assessment and review. Improvements in self-assessment
10.6 per 100 discharges from hospital were re-admitted within 28 days (April - June 2018)	87.9% of people's last 6 months was spend at home or in a community setting	175 offered 52 completed	Health and well-being Managing the caring role Feeling valued Planning for the future Finance & benefits
(April - June 2018)	(Jan - March 2018)	(June - August 2018)	(June - August 2018)
-ve trend over 4 Qtrs Higher than Scotland	Little change over 4 Qtrs Similar to Scotland	+ trend over 4 months	+ trend over 4 months

Main Challenges

Quarterly rate of emergency readmissions within 28 days of discharge for SB residents has fluctuated over longer term, but has remained under 11, higher than the Scottish average. Gap has narrowed, due in part to improvements in the accuracy of NHS Borders' data coding. SB quarterly data has been provided in relation to end of life care- the national comparator is annual data. Latest available data for Carers shows an increase in completed assessments & Carer support plans.

Our plans during 2018 to support this objective

Further development of "What Matters" hubs; Support for Transitional Care as a model of service delivery for people 50+; redesign of care at home services to focus on reablement; increase provision of Extra Care Housing; roll out of Transforming Care after Treatment programme; ongoing commissioning of Borders Carers Centre to undertake assessments and care support plans.