Scottish Borders
Health and Social Care
PARTNERSHIP

QUARTERLY PERFORMANCE REPORT UPDATE JUNE 2017

Aim

1.1 The aim of this report is to provide a quarterly performance update to the Integration Joint Board (IJB). The report highlights how the quarterly performance scorecard has evolved since the last report in February 2017.

Background

2.1 The performance reporting scorecard for the IJB was originally developed to include the six themes defined by the Ministerial Strategy Group (MSG) for Health and Community Care. These themes are:

1. unplanned admissions;
2. occupied bed days for unscheduled care;
3. A&E performance;
4. delayed discharges;
5. end of life care;
6. balance of spend between institutional and community care.

2.2 The themes identified by the MSG are heavily weighted to hospital care and in recognition of this the performance report presented to the IJB in February 2017 included an additional section headed Social Care which included reports on local data collated via the Social Care Survey and the number of carers assessments completed by the Carers Centre.

2.3 Since the last quarterly performance report the scorecard has been developed to include additional locally defined themes which relate to other measures with a primary, community or social care focus as well as an additional measure on unplanned admissions.

2.4 A summary of the additional measures included in the June 2017 report is given below:

Theme	Measure(s)
1. Unplanned Admissions	Emergency admissions to hospital as a result of falls, patients aged 65+
4. Delayed Discharges	Bed-days associated with delayed discharges of patients aged 75+
8. Carers	Carers Centre Survey of Carer Outcomes: • Support for Caring • Caring Choices • Carer stress
9. Other Relevant Measures	"Two minutes of your time" survey for NHS Borders' hospital patients. All available measures relating to evaluation of Integrated Care Fund (ICF) projects.

Summary

3.1 In a number of areas Borders is demonstrating improvement locally and/or good performance compared to Scotland. These include unscheduled occupied bed day rates, balance of spend measures, increases in the percentage of older adults looked after in the community rather than in care homes, and in the positive impacts of the five ICF projects included in this report. These are all examples of improvements/successes that could be built upon.

3.2 Areas of challenge as illustrated in this performance report include:-

- Rates of emergency admissions have reduced in recent months however remain above the Scottish average. The development and implementation of the Falls Strategy could be an important contributor to further reductions in emergency admissions.
- A&E performance and Delayed Discharges remain ongoing challenges.
- There is a need to improve the consistency and robustness of social care client outcomes reporting.
- There is clear scope to improve outcomes for Carers; the work to implement the requirements of the new legislation will assist with this.
- Palliative care is one of the key themes in the National Health and Social Care Delivery Plan and an area for reporting to the Ministerial Strategy Group. The recording of data relating to the Margaret Kerr Unit requires review and amendment.

3.3 Given the many elements of integrated care and the wide range of services delegated to Health and Social Care Partnership it is anticipated that performance reporting to the IJB will further develop over time to include reporting at locality level and more specific reports on particular groups of service users and staff.

Recommendation

The IJB is asked to:

1. **Note** the additional themes and measures for reporting;
2. **Note** the key performance issues highlighted;
3. **Advise** of any further measures to be included in future quarterly performance reports.

Policy/Strategy Implications	This report gives an update on Partnership performance reporting which is directly related to the delivery of local objectives as detailed in the Strategic Plan.
Consultation	The performance report has been prepared in partnership with NHS Borders and SBC performance teams.
Risk Assessment	A number of risks in relation to partnership performance have been highlighted in the report.
Compliance with requirements on Equality and Diversity	A comprehensive Equality Impact Assessment was completed as part of the strategic planning process.
Financial Implications	Financial implications outlined in finance reports.

Approved by

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Scottish Borders
Health and Social Care
PARTNERSHIP

Quarterly Performance Report for the Scottish Borders Integrated Joint Board

June 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 are higher in 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. Hospital admissions 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.

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.

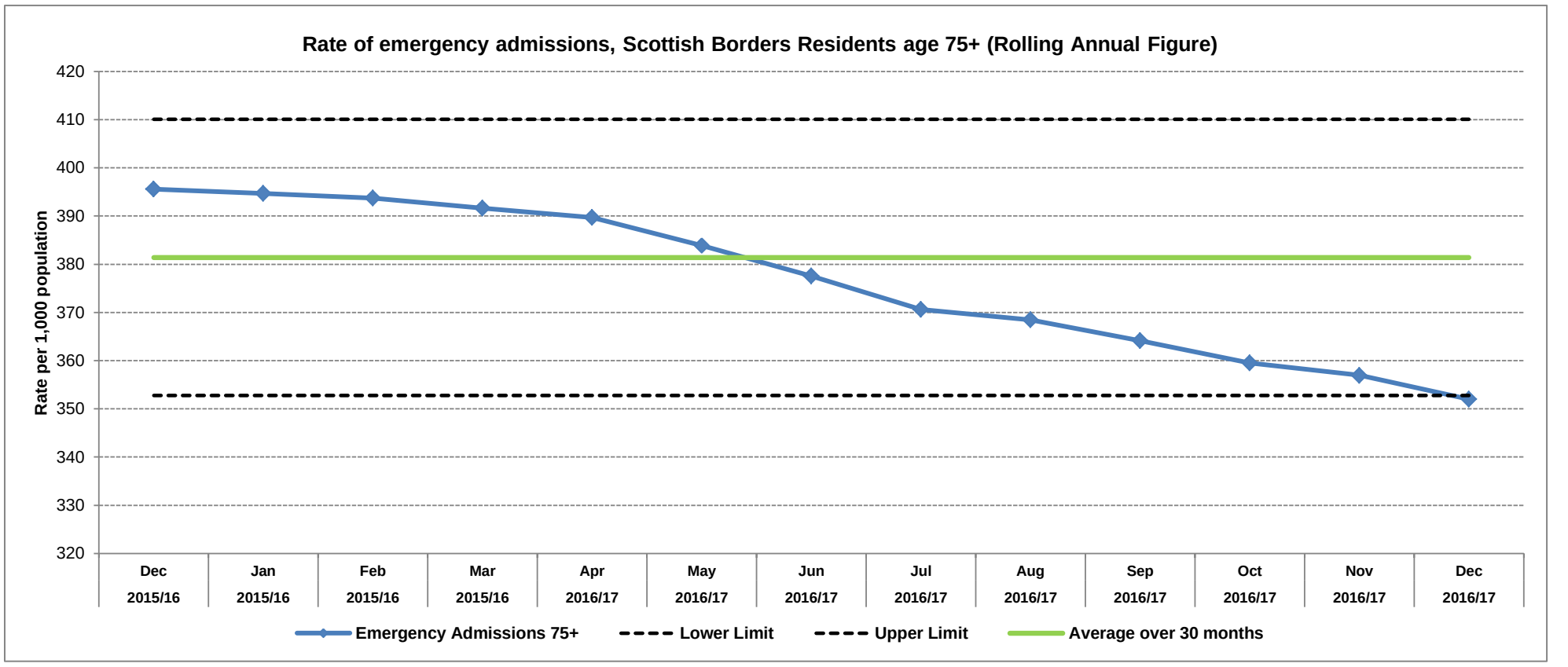
Data Source(s) and notes

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

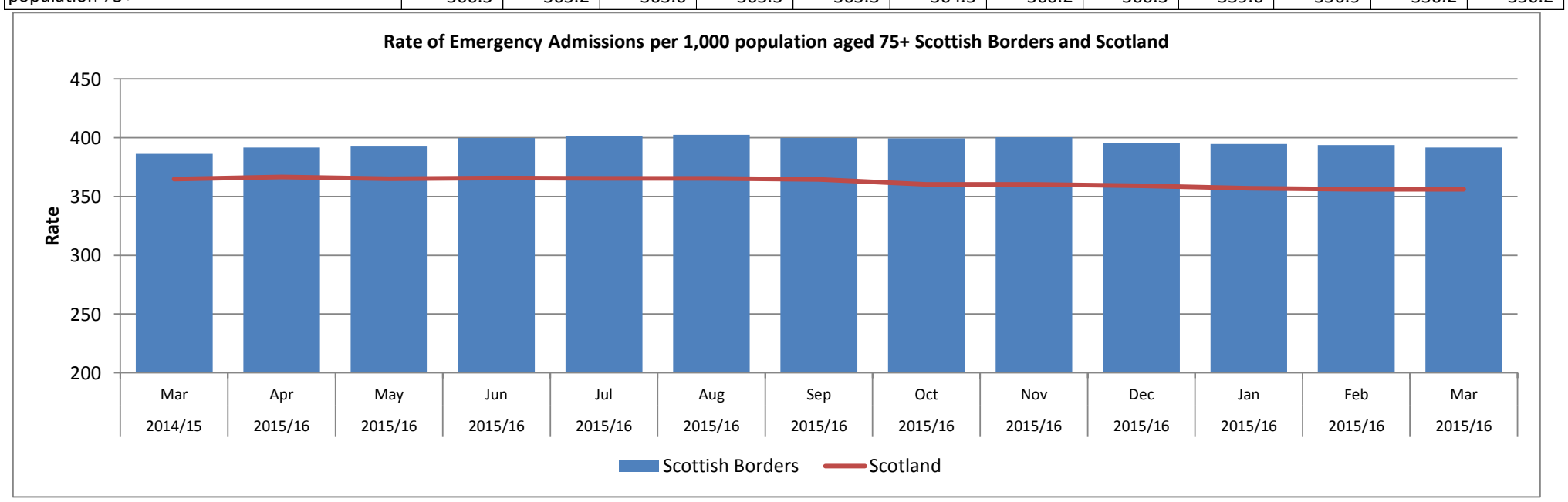
Emergency Admissions, Scottish Borders residents age 75+

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Emergency Admissions, 75+	4,543	4,475	4,401	4,320	4,295	4,245	4,191	4,161	4,103			
Rate of Emergency Admissions per 1,000 population 75+	389.7	383.9	377.5	370.6	368.4	364.2	359.5	357.0	352.0			



Emergency Admissions, Scotland residents age 75+

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Number of Emergency Admissions, 75+	158,770	158,228	158,380	158,330	158,263	157,923	157,684	157,707	157,150	156,222	155,922	155,916
Rate of Emergency Admissions per 1,000 population 75+	366.5	365.2	365.6	365.5	365.3	364.5	360.2	360.3	359.0	356.9	356.2	356.2



How are we performing?

The rate of emergency admissions for the over 75 age group in Scottish Borders is decreasing: the rate was increasing gradually to August 2015 but from that point has seen a gradual decrease, in line with the Scottish trend. The Borders rate at March 2016 (latest published data point for Scotland) is higher than the national average. There is a lag time in data points as rates are produced from a nationally available source from ISD, based on data submitted by all the Health Boards that has been validated. There may be slight under-reporting for December 2016.

What are we doing to improve or maintain performance?

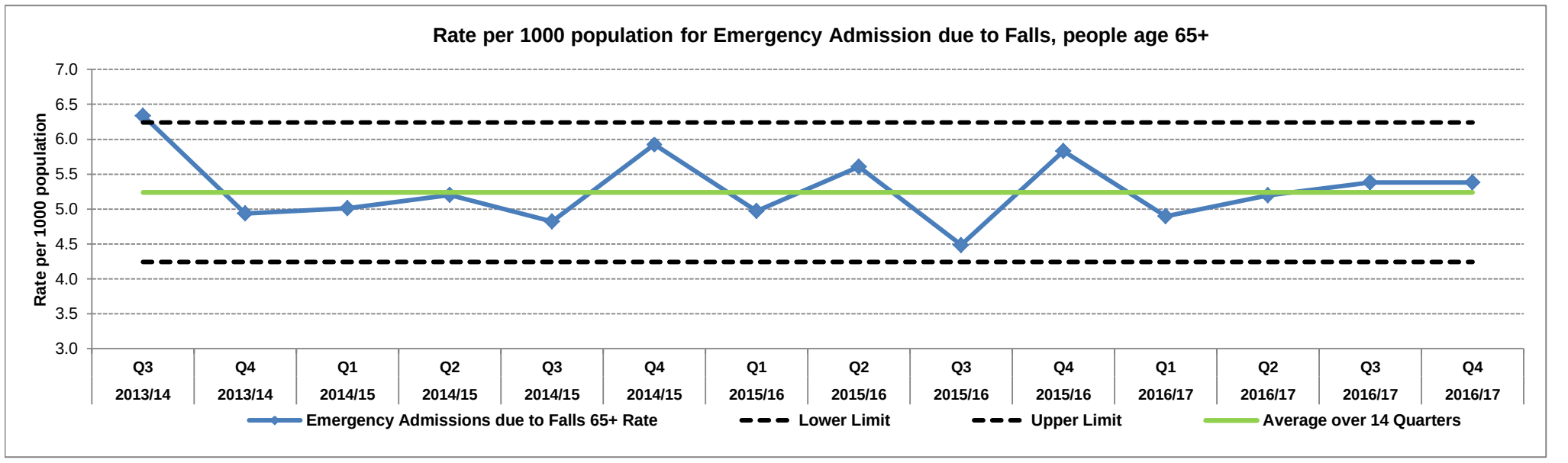
We are undertaking work to reduce emergency admissions for common conditions, focusing on developing pathways for patients with common respiratory and cardiac conditions to be reviewed and managed within their own homes and on reducing readmission rates.

Use of the Acute Assessment Unit has improved our emergency admission rate allowing patients to receive tests and monitoring then discharge rather than being admitted into the hospital (Medical Assessment Unit) for this.

1. Unplanned Admissions

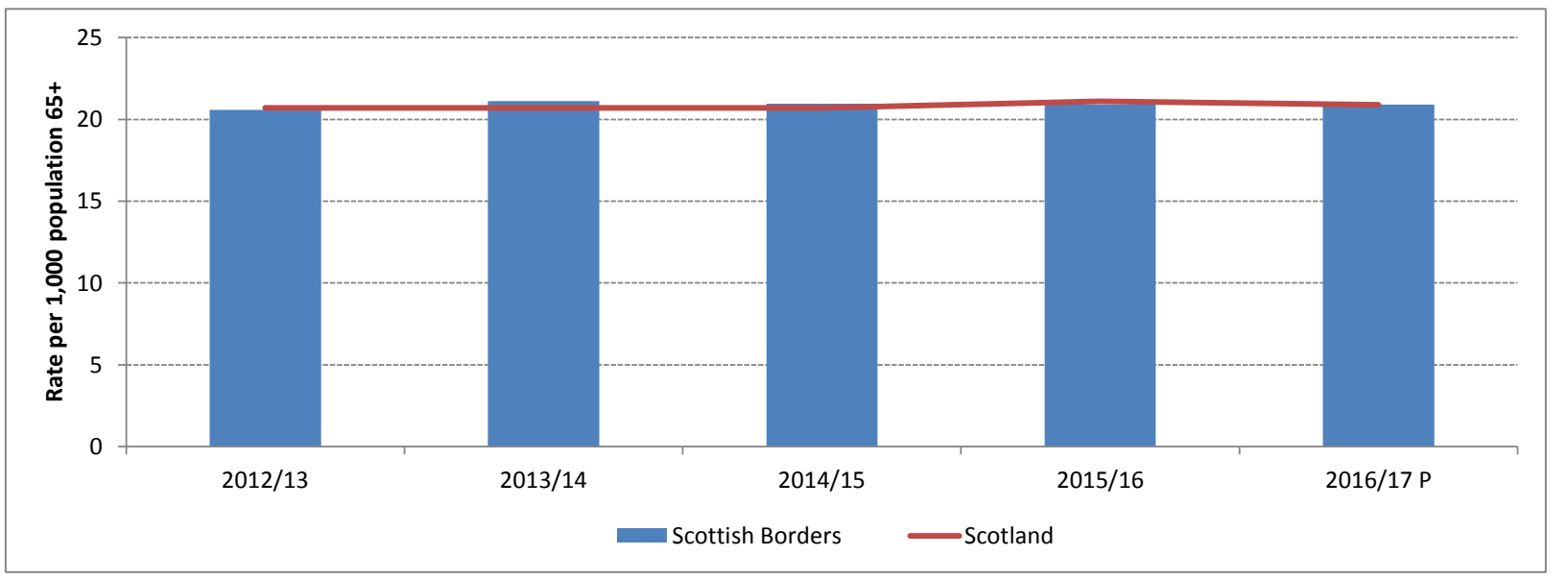
Emergency Admissions for falls, people aged 65+, rates per 1,000 population (aged 65+) in Scottish Borders residents

	Apr-Jun '14	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
Rate of Emergency Admissions for falls per 1,000 population 65+	5.0	5.2	4.8	5.9	5.0	5.6	4.5	5.8	4.8	5.1	5.7	5.3



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 (provisional)
Scottish Borders	20.6	21.1	21.0	20.9	20.9
Scotland	20.7	20.7	20.7	21.1	20.9



How are we performing?

Since 2012/13 the rate of admissions due to falls in Borders residents aged 65+ has been very close to the Scottish average.

What are we doing to improve or maintain performance?

Work of the Borders Falls Steering Group is ongoing, including to finalise the draft Falls Strategy (with Action Plan) for 2017-19. This will be informed by a shared self-assessment exercise using the 'Prevention and Management of Falls in the Community' tool.

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)

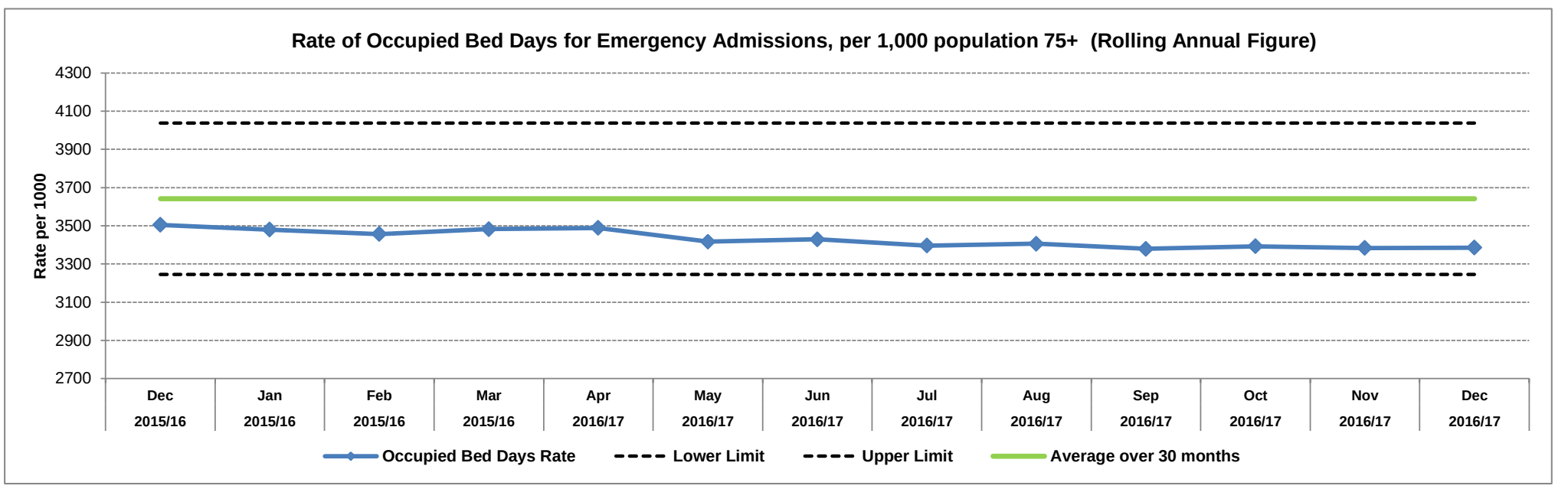
1. Hospital bed-days are sourced from SMR01 (inpatient/daycase episodes of care in general/acute hospitals such as Borders General Hospital and the Royal Infirmary of Edinburgh). They apply to Borders residents admitted to any general/acute hospital in Scotland. These figures do not include admissions 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+

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Occupied Bed Days for emergency Admissions, 75+	40,671	39,832	39,972	39,592	39,702	39,396	39,555	39,445	39,470			
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+	3489	3417	3429	3396	3406	3380	3393	3384	3386			



How are we performing?

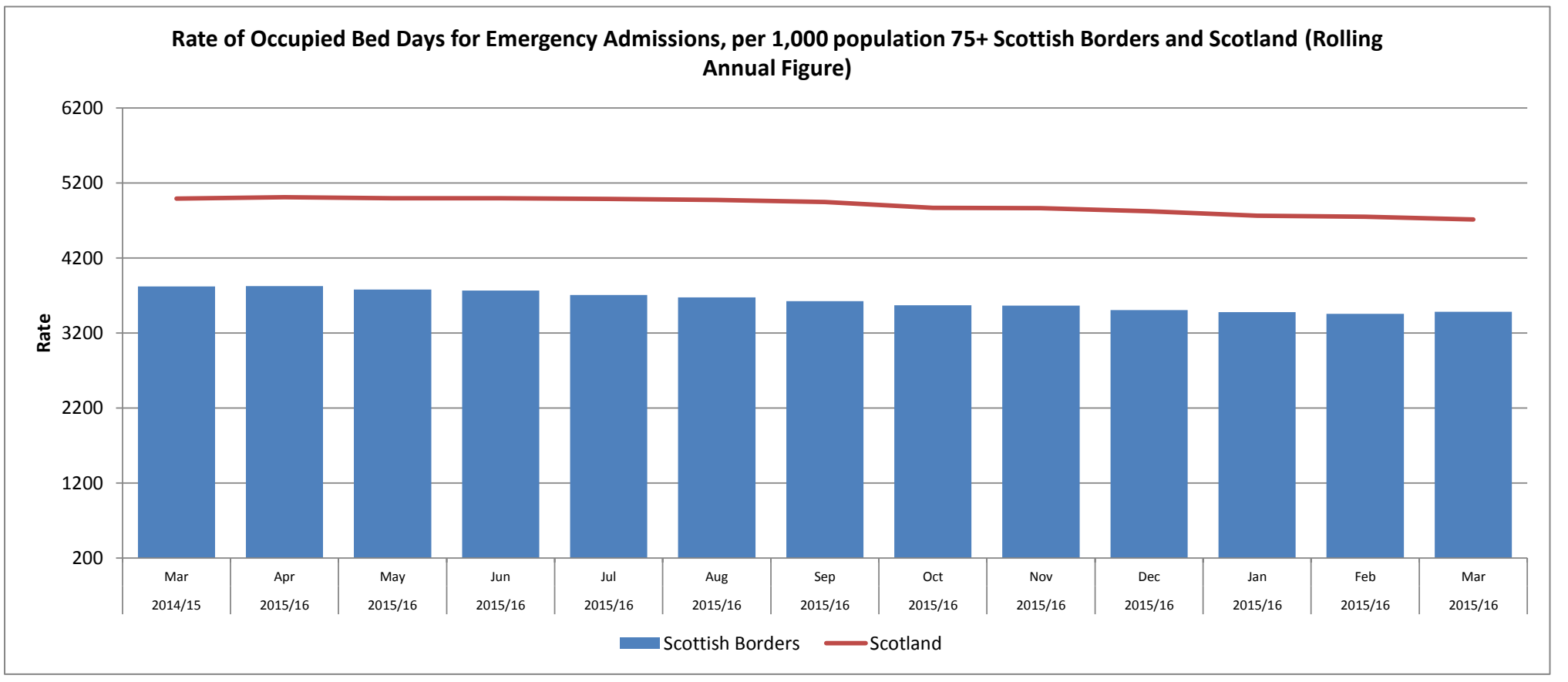
Emergency Occupied bed days for over 75s have been on the whole reducing since September 2014, following redesign work to reduce waits for patients requiring rehabilitation and elderly care beds.

What are we doing to improve or maintain performance?

The medical inpatient floor was remodelled in October 2016 to create one acute medical ward and two acute elderly care wards. This change is intended to stream frail elderly patients who are acutely unwell directly to an elderly care ward and avoid delays in medical wards. The redesign is intended to reduce overall length of stay by 0.6 days within the medical unit. There is also an increase in partnership working across health and social care to reduce delays for people requiring support on discharge home. There continue to be delays in transitions of care and we are working closely with partners to address these.

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

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scottish Borders	3,824	3,782	3,765	3,707	3,675	3,627	3,570	3,567	3,505	3,480	3,454	3,483
Rate of Occupied Bed Days for Emergency Admissions, per 1,000 population 75+ Scotland	5,013	4,998	4,996	4,989	4,976	4,948	4871.62	4866.16	4824.01	4764.4	4750.2	4713.73



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.

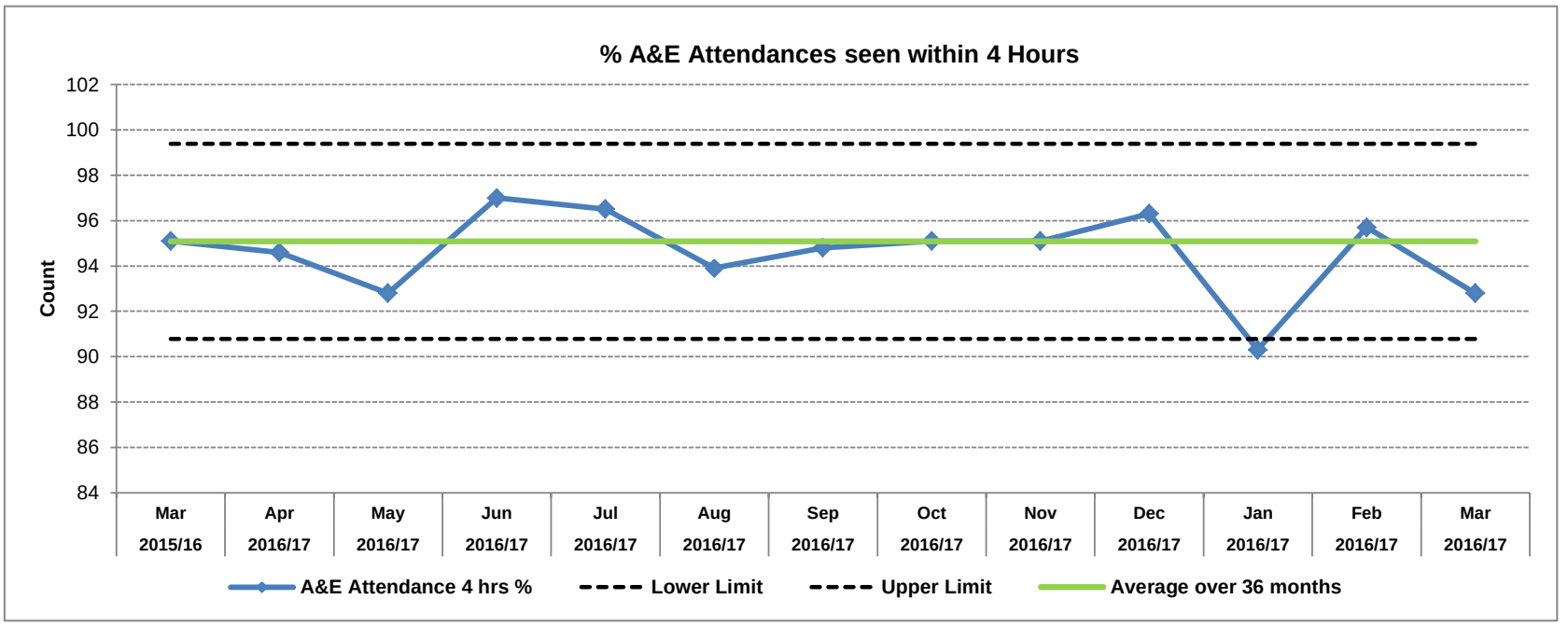
Although the standard is measured in the A&E Department, NHS Boards and Health and Social Care Partnerships are required to ensure that best practice is installed throughout the whole system, including health and social care, supporting joined up work to address wider issues of patient flow through each 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

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of A&E Attendances seen within 4 hours	2,389	2,735	2,436	2,406	2,555	2,506	2,465	2,244	2,319	2,323	2,079	2,401
% A&E Attendances seen within 4 hour	94.6%	92.8%	97.0%	96.5%	93.9%	94.8%	95.1%	95.1%	96.3%	90.3%	95.7%	92.8%



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 stretched standard.

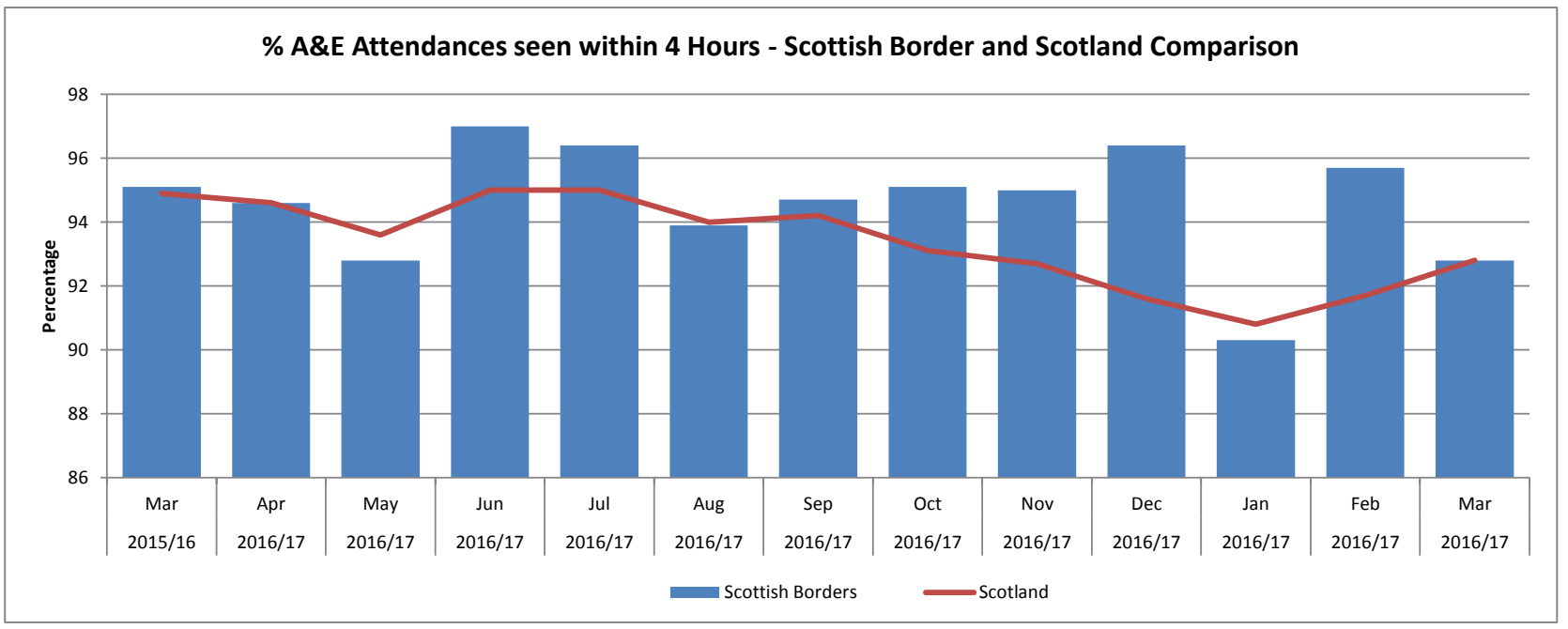
Following an improvement in performance in February, there was a marked deterioration in performance against the Emergency Access Standard in March with 173 breaches of the standard and a performance of 92.8%. There were 5 days when there were more than 10 breaches - 3 of these days were Monday, reflecting challenges in inpatient flow over the weekends. This was predominantly related to challenges in inpatient flow, with 50% of breaches due to patients waiting for beds to become available. Breaches related to wait for assessment within ED were just 7.5% in January and show a consistent fall since December.

What are we doing to improve or maintain performance?

especially on Mondays, when bed pressures tend to be most challenging.
A new action plan for addressing delayed discharges is being developed following the John Bolton review (more detail of which is given under Theme 4, Delayed Discharges).

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

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
% A&E Attendances seen within 4 hour Scottish Borders	94.6%	92.8%	97.0%	96.4%	93.9%	94.7%	95.1%	95.0%	96.4%	90.3%	95.7%	92.8%
% A&E Attendances seen within 4 hour Scotland	94.6%	93.6%	95.0%	95.0%	94.0%	94.2%	93.1%	92.7%	91.6%	90.8%	91.7%	92.8%



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.

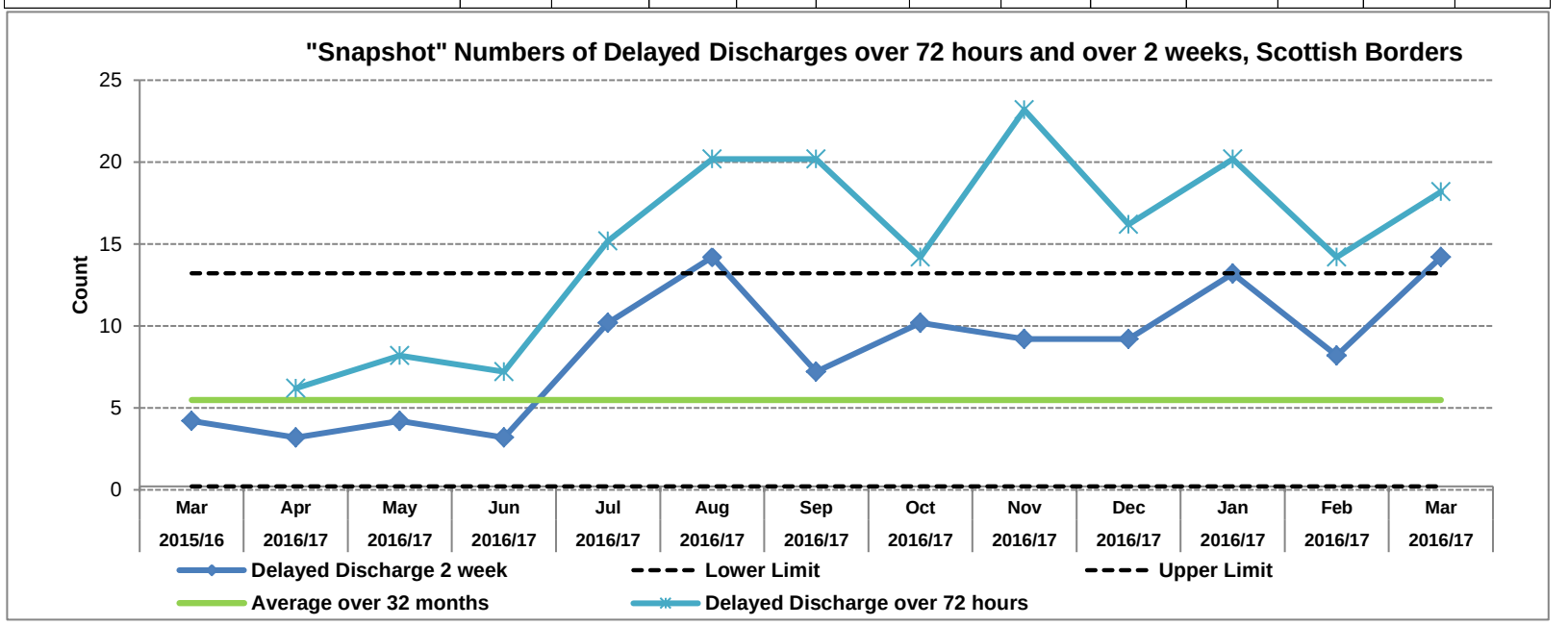
1) The measures on numbers of discharges delayed by more than 72 hours/more than 2 weeks, are snapshots of the number of patients waiting to be discharged, on a single day in each month.

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)

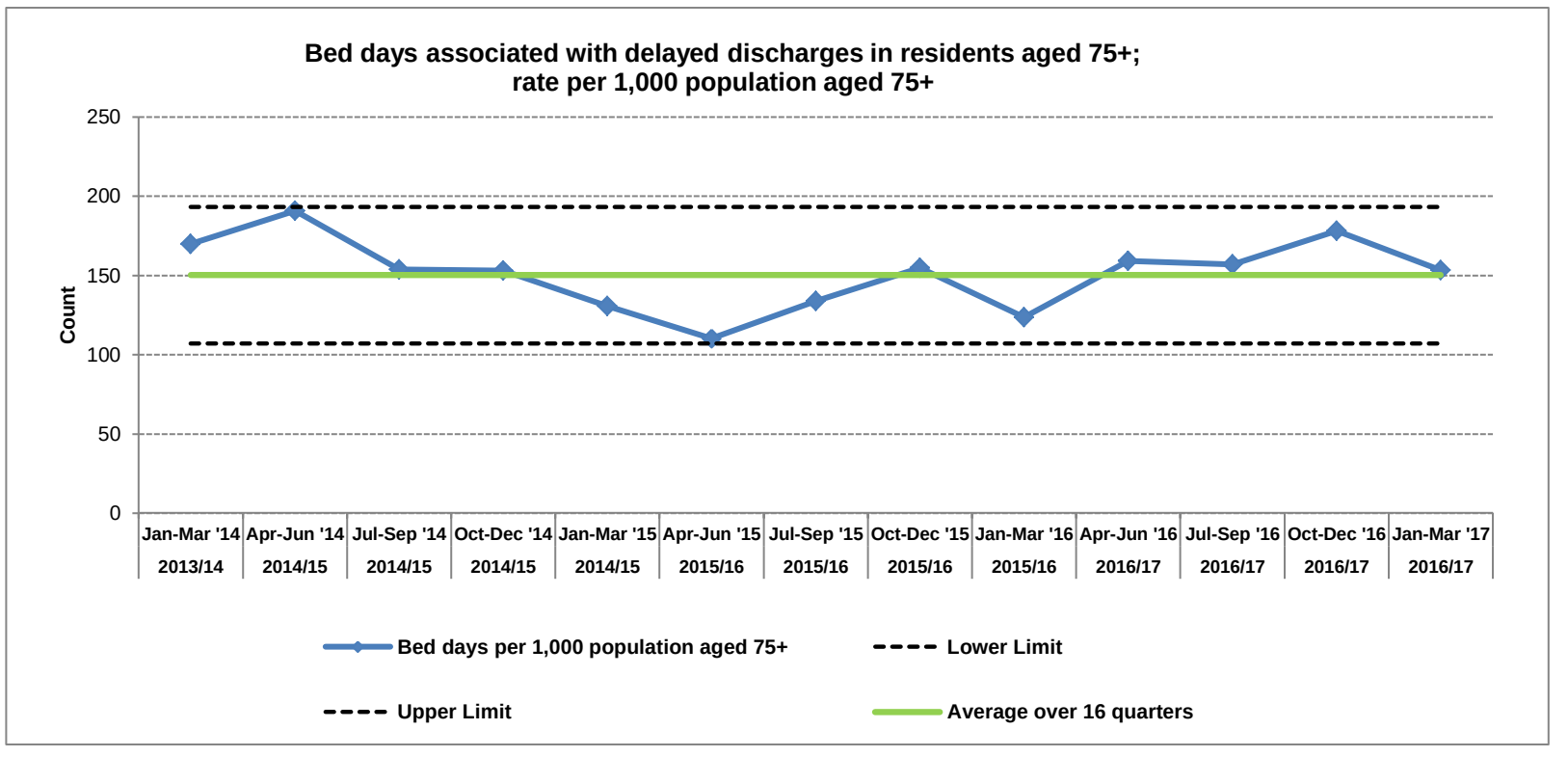
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of DDs over 2 weeks	3	4	3	10	14	7	10	9	9	13	8	14
Number of DDs over72 hours	6	8	7	15	20	20	14	23	16	20	14	18



Please note the Delayed Discharge over 72 hours measurement has only 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 to less than one year 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+

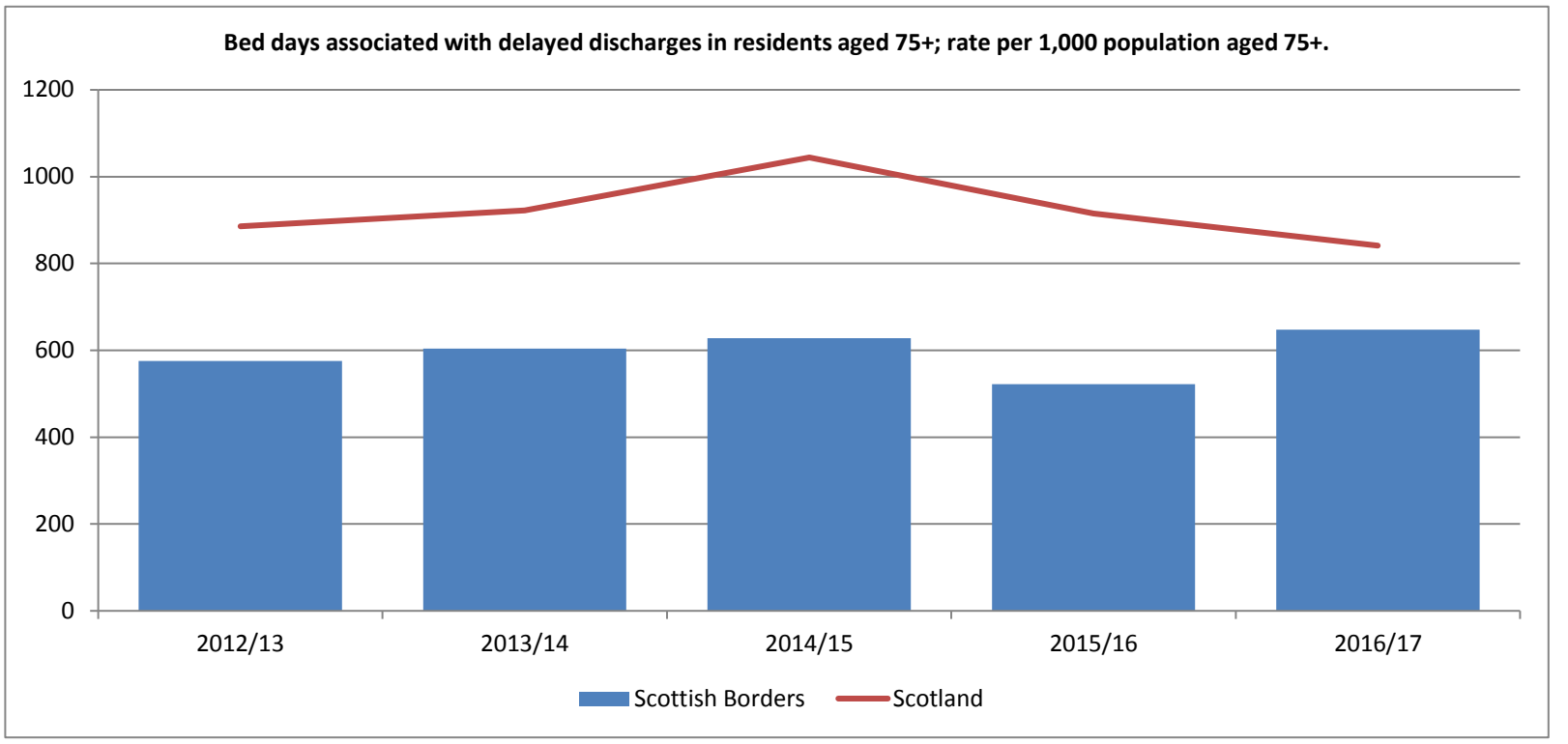
	Apr-Jun '14	Jul-Sep '14	Oct-Dec '14	Jan-Mar '15	Apr-Jun '15	Jul-Sep '15	Oct-Dec '15	Jan-Mar '16	Apr-Jun '16	Jul-Sep '16	Oct-Dec '16	Jan-Mar '17
Bed days per 1,000 population aged 75+	191	154	153	131	110	134	154	124	159	157	178	153



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	



How are we performing?

In terms of overall rates of occupied bed-days associated with delayed discharge, 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.

A new national target of zero delays over 72 hours came into force on 1st April 2016. New definitions for recording delayed discharges were introduced on the 1st July 2016. NHS Borders is facing significant challenges with delayed discharges, which continues to impact on patient flow within the Borders General Hospital and our four Community Hospitals.

The key reasons for delay experienced by patients are currently being influenced by challenges relating to the following issues:
- Care at home – we continue to be challenged in sourcing care at home across the Borders.
- Choices of care home placements and availability thereof and total capacity in Care Homes in Borders, particularly for more complex cases.
- A number of complex cases with a significant length of stay.

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?

Further work underway and planned:
- Professor John Bolton was commissioned to work with us to help to improve Delayed Discharges and Patient Flow across the system. This will inform subsequent work to improve community hospital LOS, effective use of community capacity across home care and care homes, pathway development, thresholds and risk management and improve patient safety. He reported back in early April 2017 and an action plan to redress his recommendations is being progressed.

- Dr Anne Hendry, HIS National Clinical Lead for Integrated Care and Consultant Geriatrician has agreed to work with us to review and develop our community & day hospital model. This fits well with and will build upon the outcomes from Professor Bolton's work.

4. Delayed Discharge

What are we doing to improve or maintain performance?

- In early 2017/18 a Matching Unit was introduced, the role of which is to source the provision of home care to meet assessed need, to free up care managers' time to undertake assessment. Recruitment is now complete with a Team Leader and 3 Matching unit co-ordinators now in post based in Hawick Town Hall. The Unit went live in the Hawick area on 17th April and was rolled out to Tweeddale on 22nd May and the home care waiting list in Peebles has been significantly reduced in a short period with care being sourced quickly and efficiently. The Matching Unit will continue to be rolled out throughout the Borders.

- Within BGH, work is underway to support the early identification of patients who have the potential to become delayed discharges in order to plan "upstream", identifying and removing potential blocks to discharge, putting in place appropriate processes etc. MDTs and Board Rounds will be revised to accommodate this approach. If this proves to be effective, the aim would be to roll out to community hospitals.

- Social Work are working to develop the care at home market and part of this is the review of recruitment & retention of care at home staff.

- Plans to review and remodel Rapid Response services are being developed by Social Work which will allow an out of hours home care response. The focus of this service will be prevention of admission. This redesign will be developed in full liaison with BECS.

- Work is to be progressed with Mental health to consolidate the MDT processes and manager advocate role in order to gain a better understanding of their patient profile.

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.

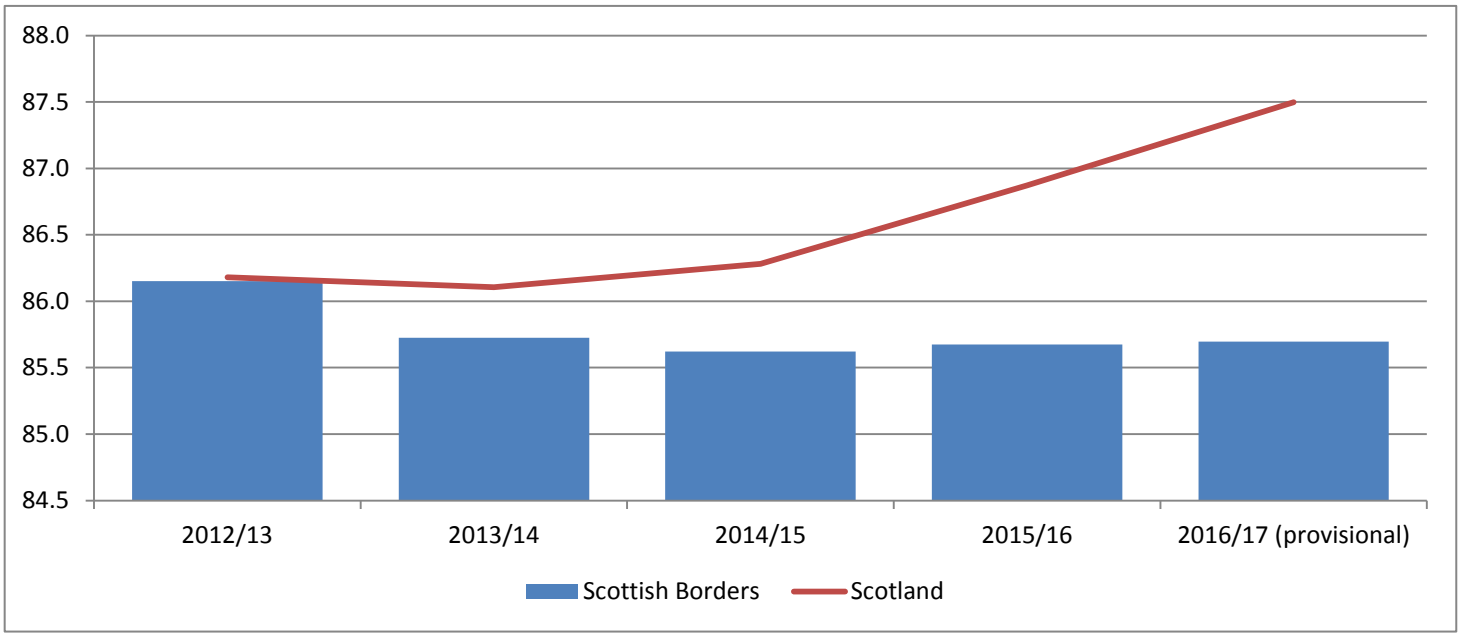
The indicator should ideally represent the wishes and choices for patients and their carers and also demonstrate the effectiveness of having a planned approach to end of life care. For an individual, the preferred place of care can change as their condition and/or family circumstances change over time, 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.

	2012/13	2013/14	2014/15	2015/16	2016/17 (provisional)	
Scottish Borders %	86.2%	85.7%	85.6%	85.7%	85.7%	
Scotland %	86.2%	86.1%	86.3%	86.9%	87.5%	



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?

Part of the reason for the Borders' figures appearing lower than average will be related to the way in which stays at the Margaret Kerr Unit (MKU) are recorded. This specialist palliative care unit, which opened at Borders General Hospital in January 2013, provides a range of care that in other parts of Scotland are often provided in hospices (run by voluntary/independent sector organisations). This means that what in many other areas might be identified as time in a community setting has been, for the Borders, instead recorded as time in a hospital setting. From April 2017 onwards, changes have been implemented to the recording of stays within the MKU so it will be possible to more readily distinguish in national databases between it and the wards in the main BGH.

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.

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)

"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.

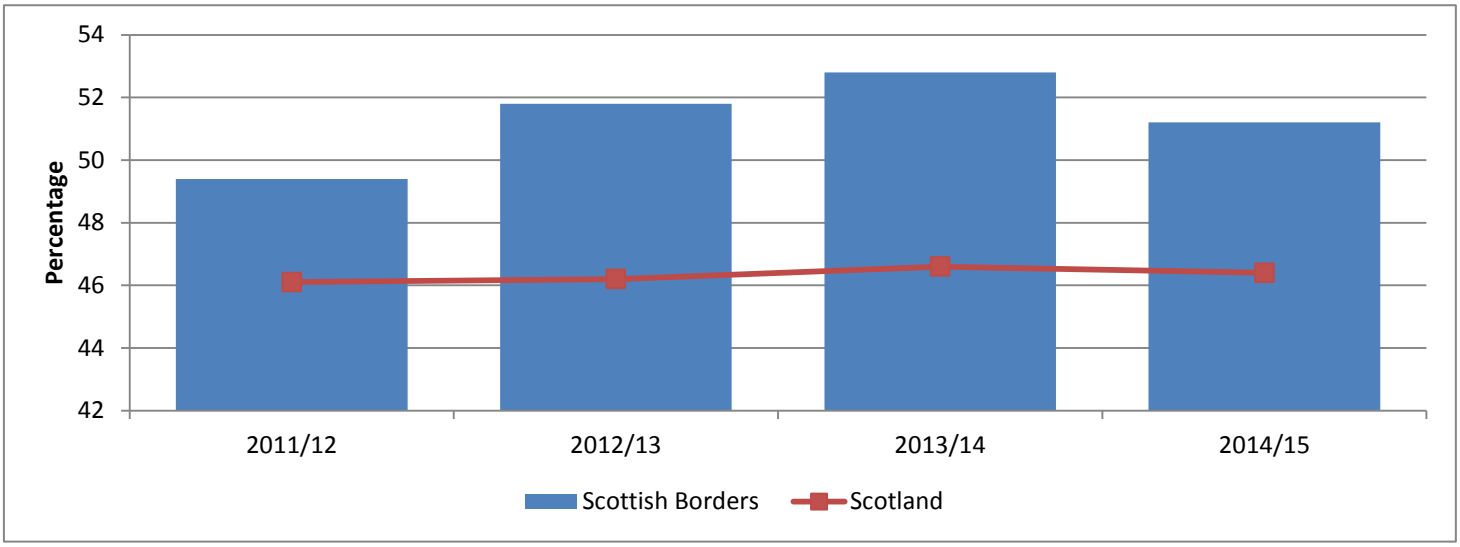
Data Source(s)

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

	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		
Scottish Borders % spent on Community-Based care	49.40%	51.80%	52.80%	51.20%		
Scottish Total Spend (£ millions)	11,675	11,782	12,109	12,620		
Scottish % spent on Community-Based care	46.10%	46.20%	46.60%	46.40%		



How are we performing?

In the four years 2011/12 to 2014/15 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 2014/15 dropped relative to that for 2013/14. We anticipate figures for 2015/16 will be available to us at the end of June 2017, when they are published as Official Statistics.

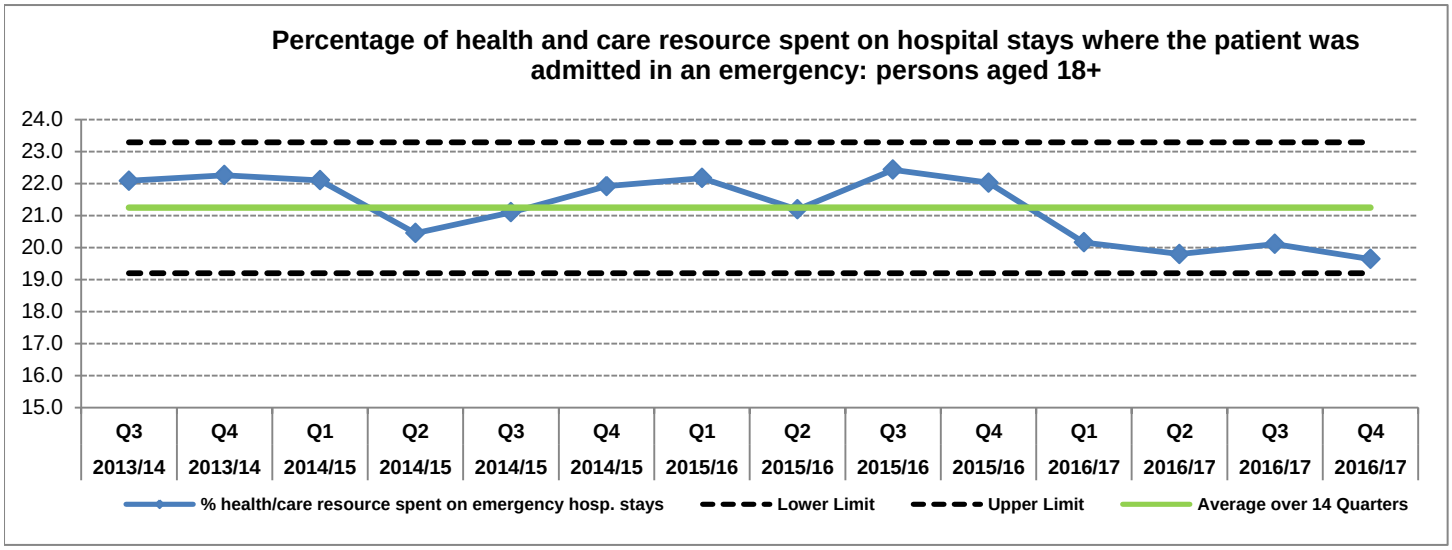
What are we doing to improve or maintain performance?

There are a wide range of factors that impact on the balance of spend between acute and community based services. Following the work that John Bolton has carried out on discharge flows there is a requirement for re-ablement services in the community. An action plan is being developed to follow this through. The Buurtzorg pilot is also underway looking at a new model for community based services to support patients at home. This will deliver improvements in a person-centred holistic model for both health and social care in the community.

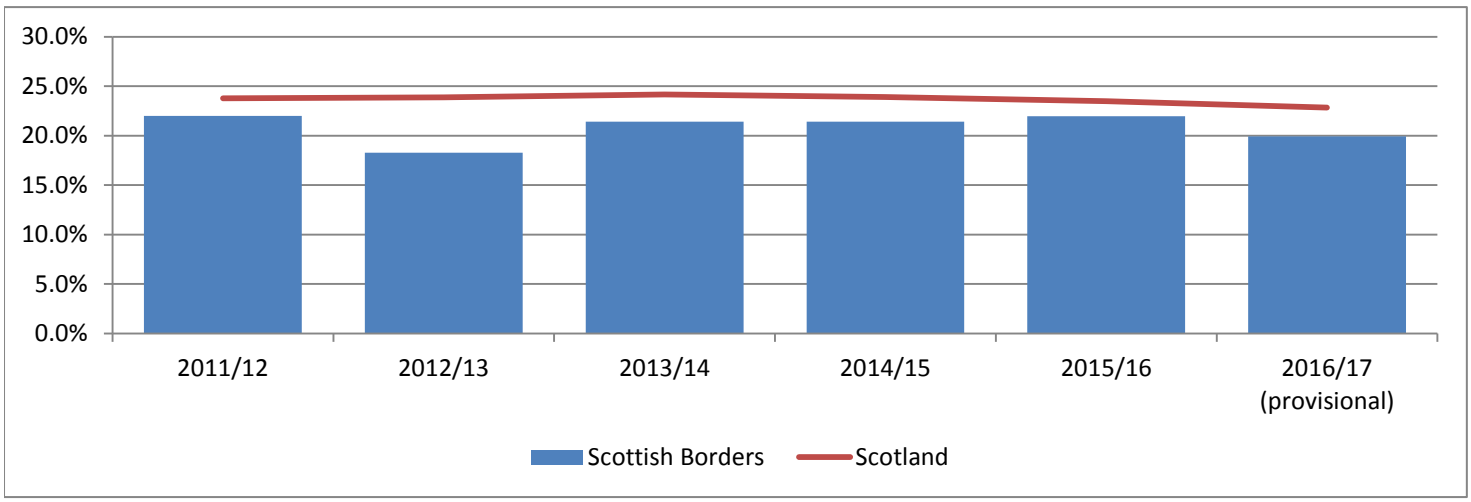
6. Balance of Spend

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

Quarter ending	Apr-Jun '14	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
% of health and care resource spent on emergency hospital stays	22.1	20.5	21.1	21.9	22.2	21.2	22.4	22.0	20.2	19.8	20.1	19.6



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (P)
Scottish Borders	22.0%	18.3%	21.4%	21.4%	22.0%	19.9%
Scotland	23.8%	23.9%	24.2%	23.9%	23.5%	22.8%



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.

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.

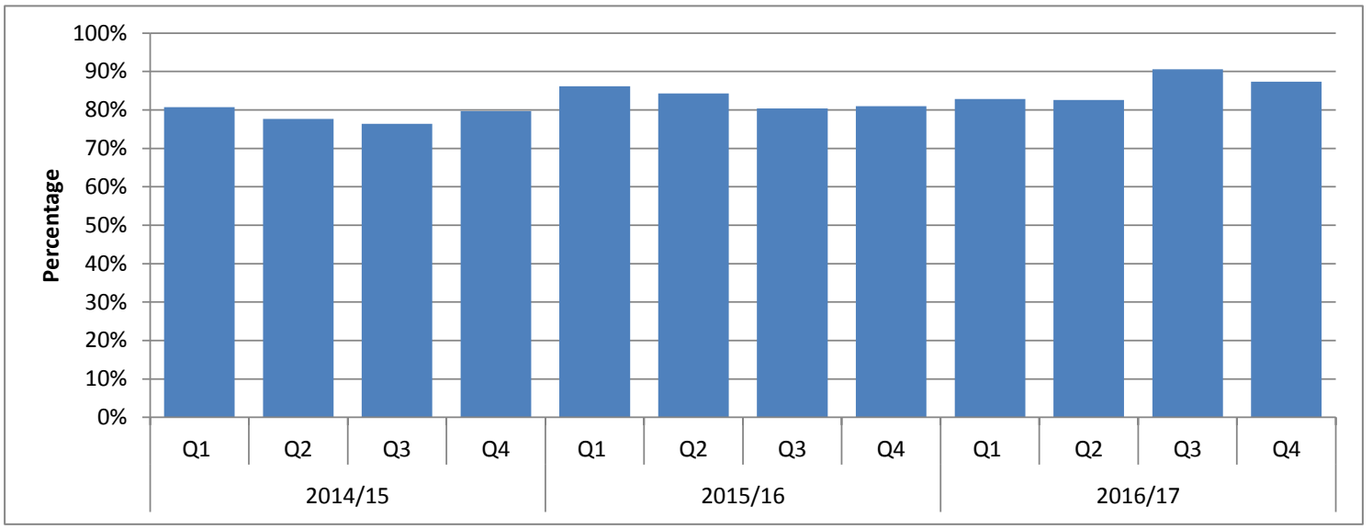
Data Source(s)

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?

	Q1 2014/15	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
Number of People Feeling Safe	559	562	504	659	690	638	624	629	585	445	502	504
Ave. % of People Feeling Safe	81%	78%	76%	80%	86%	84%	80%	81%	83%	83%	91%	87%



How are we performing?

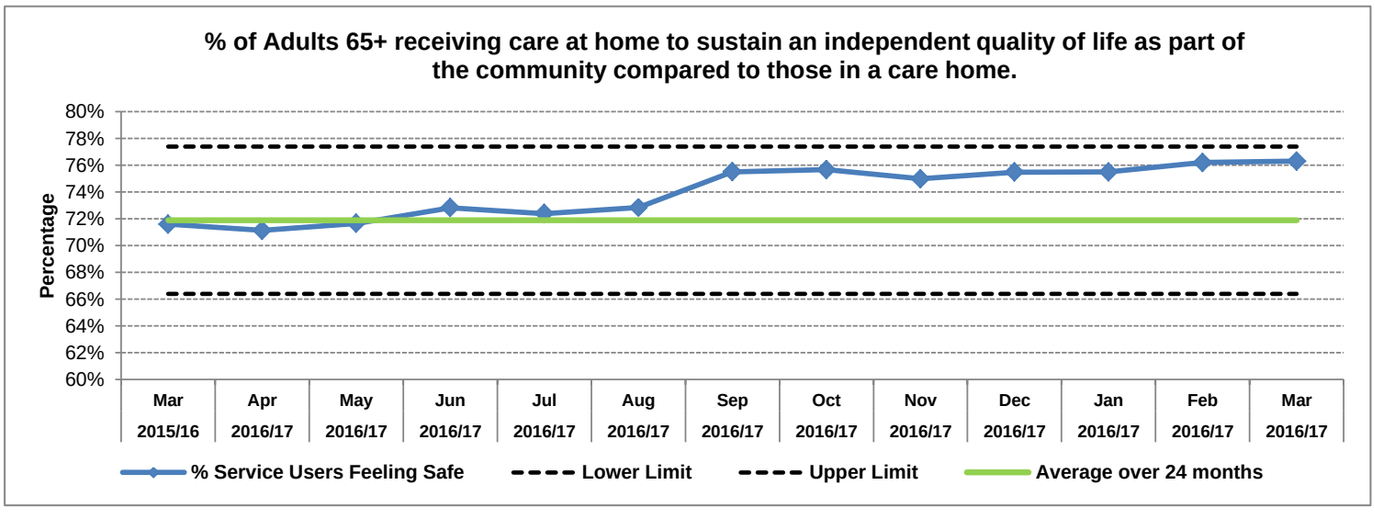
Fluctuating over the past 3 years, this indicator shows on average over 80% of those asked if they feel safe following a Social Care Adult Assessment answered yes.

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.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number of Adults 65+ within community.	1563	1619	1716	1710	1766	2032	2019	1988	2018	2074	2126	2153
% of Adults 65+ receiving care at home compared to those in a care home.	71%	72%	73%	72%	73%	76%	76%	75%	75%	76%	76%	76%



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.
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.

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 Center Assessment responses to - Support for Caring questions
2. Carer Center Assesment responses to - Caring Choice
3. Carer Center 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)

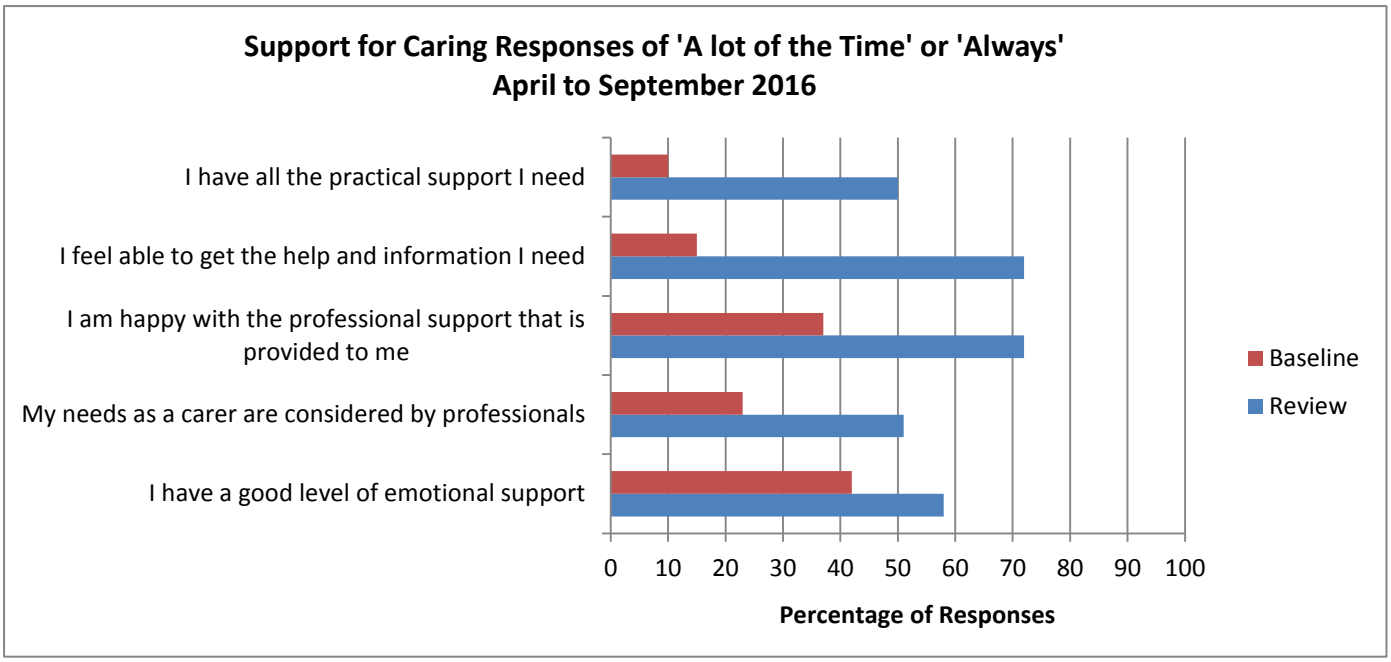
1. Offered assessment data is extracted from the SBC Framework System and is a question asked during a Adult Assessment.

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

8. Carers

Carers Centre Assessments - Support for Caring

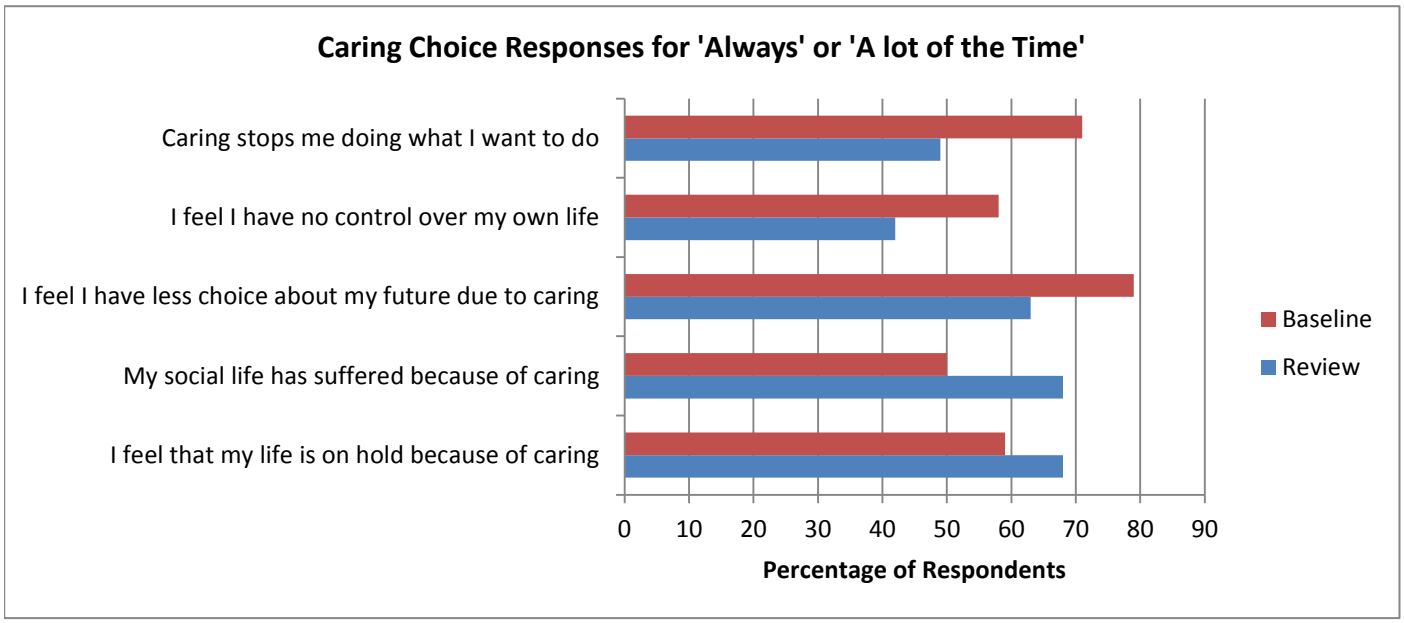
	Apr-Sep 2016									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always / A lot
I have a good level of emotional support	21	21	28	30	**42**	21	37	35	7	**58**
My needs as a carer are considered by professionals	2	21	35	42	**23**	22	29	21	28	**51**
I am happy with the professional support that is provided to me	23	14	35	28	**37**	37	35	14	14	**72**
I feel able to get the help and information I need	8	7	64	21	**15**	28	44	21	7	**72**
I have all the practical support I need	7	3	40	50	**10**	22	28	36	14	**50**



Carers Centre Assessments - Caring Choice

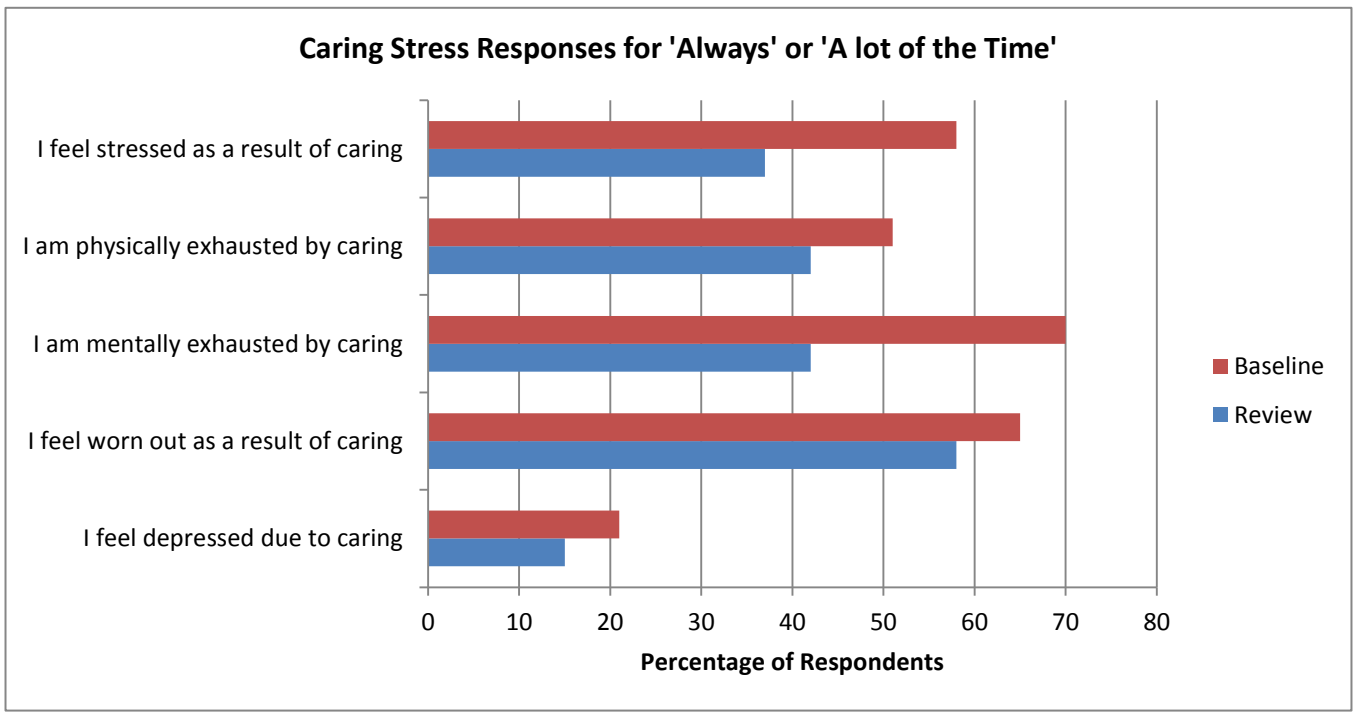
	Apr-Sep 2016									
	Baseline %					Review %				
	Always	A lot of the Time	Some of the Time	Never	Total: Always/ A lot	Always	A lot of the Time	Some of the Time	Never	Total: Always / A lot
I feel that my life is on hold because of caring	45	14	28	13	**59**	44	24	22	12	**68**
My social life has suffered because of caring	50	0	35	15	**50**	45	23	35	7	**68**
I feel I have less choice about my future due to caring	65	14	0	21	**79**	28	35	23	14	**63**
I feel I have no control over my own life	30	28	14	28	**58**	21	21	22	36	**42**
Caring stops me doing what I want to do	57	14	15	14	**71**	28	21	36	15	**49**

8. Carers



Carers Centre Assessments - Caring Stress

	Apr-Sep 2016									
	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	7	14	51	28	**21**	8	7	57	28	**15**
I feel worn out as a result of caring	50	15	35	0	**65**	21	37	28	14	**58**
I am mentally exhausted by caring	35	35	22	10	**70**	14	28	35	23	**42**
I am physically exhausted by caring	23	28	14	35	**51**	21	21	36	22	**42**
I feel stressed as a result of caring	30	28	35	7	**58**	14	23	42	21	**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.

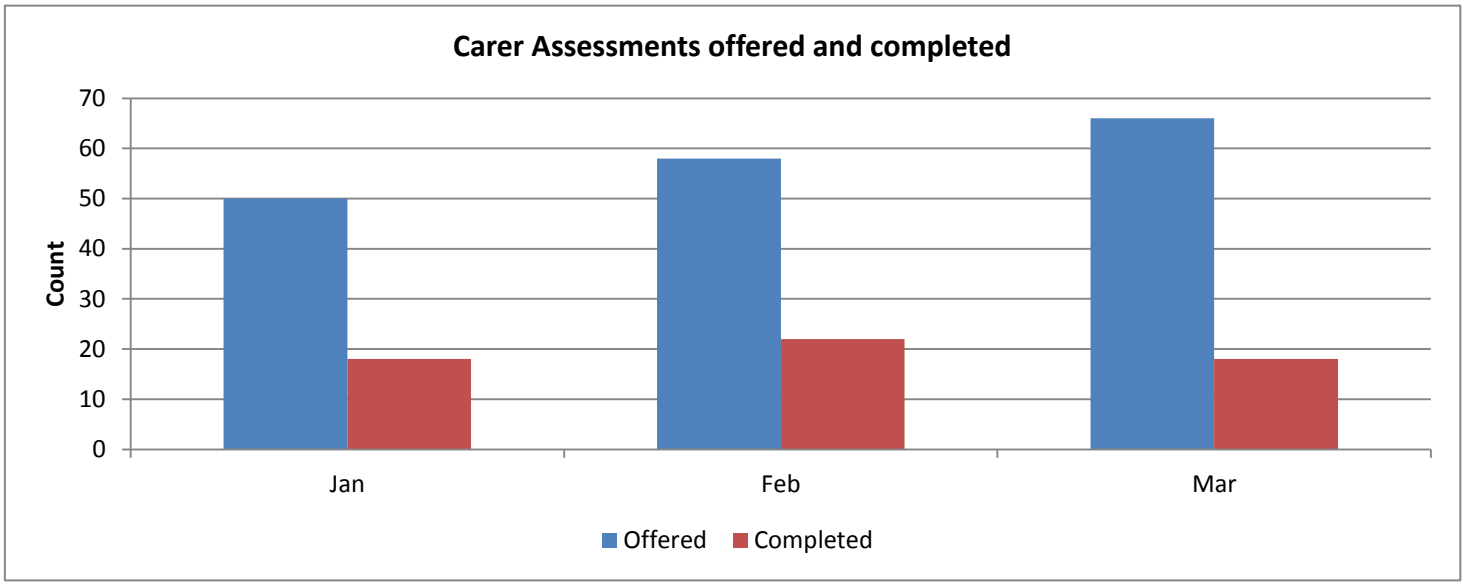
Data for April-September 2016 shows improvement between the baseline and review surveys in nearly all respects. There are just two exceptions to this – the questions under caring choices around Carers' social lives and feelings as to whether their lives have been put on hold.

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.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	###
Assessments offered during Adult Assessment										**50**	**58**	**66**
Carers Centre	New measure. Recording started in 2017									18	22	18



How are we performing?

This information shows that during the last quarter of 2016/17 we offered of average 58 assessment to individuals who were identified as carers during a Social Work Adult Assessment. Within the same month the Carers Centre completed on average 20 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. More detail of each project and their evaluation findings are available via the 2 page summaries.

Data Source(s)

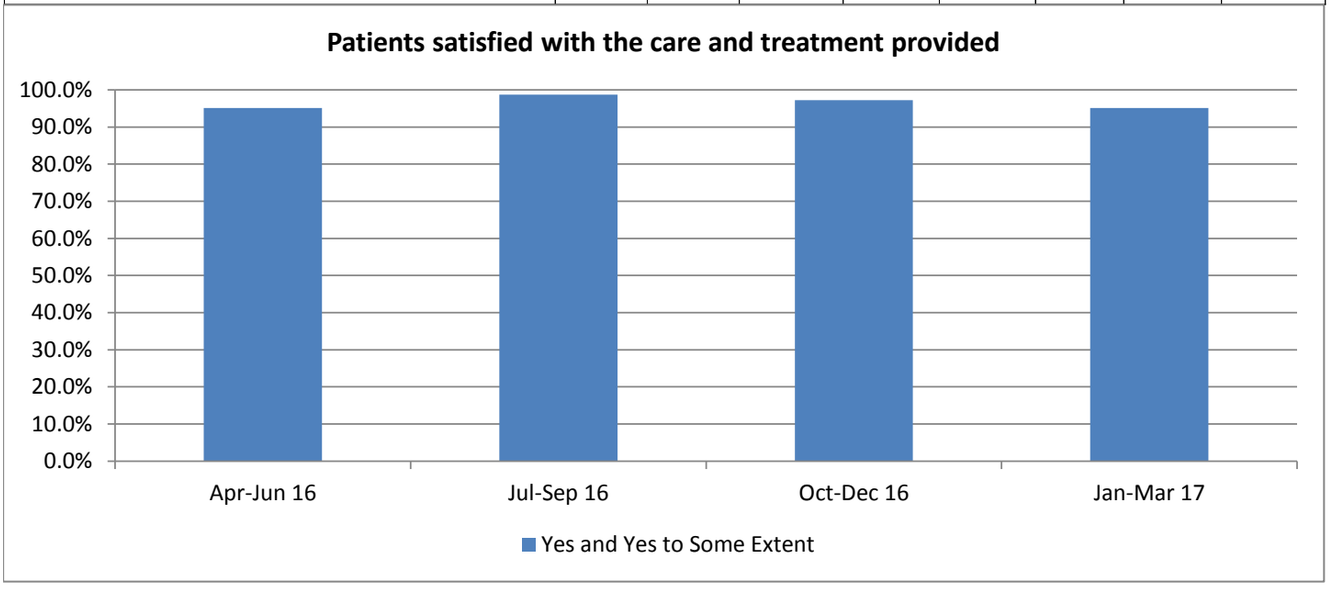
1. Borders Community Capacity Building (Apr-16 to Mar-17)
2. My Home Life (Feb-16 to Jan-17)
3. Community Transport Hub
4. Long Term Conditions (Jan-14 to Dec-16)
5. 'Stress and Distress Training'

9. Other Relevant Measures

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

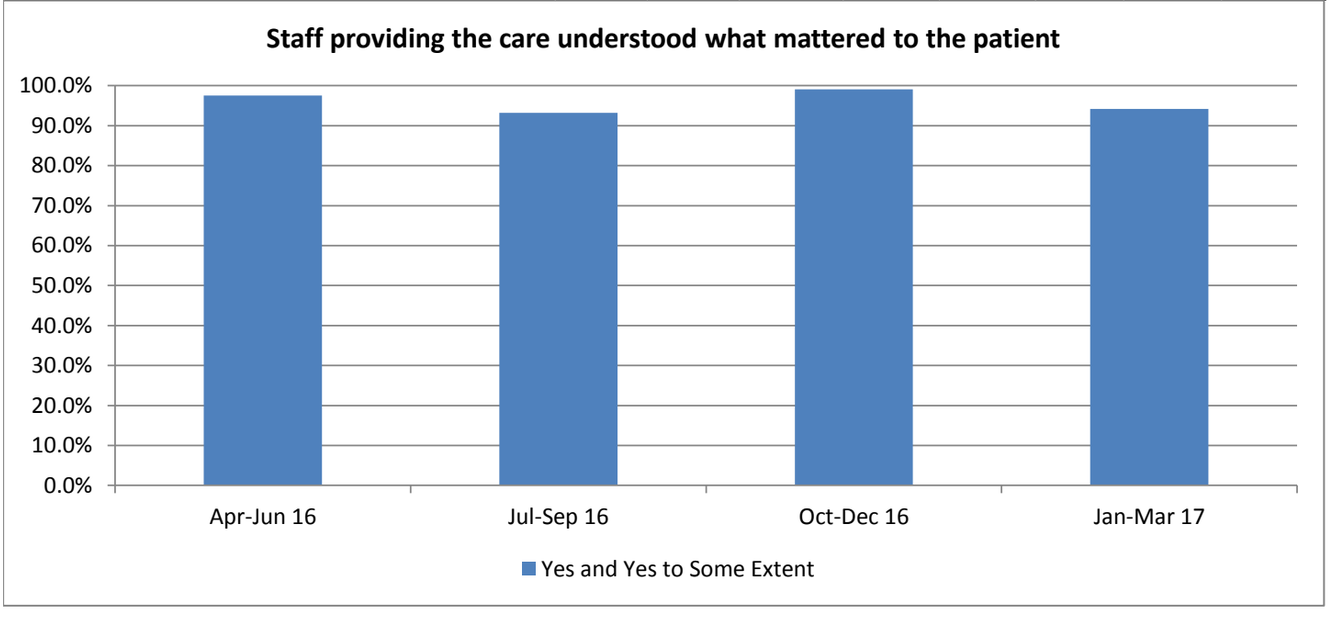
Q1 Was the patient satisfied with the care and treatment provided?

	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				
% feeling satisfied or yes to some extent	95.1%	98.8%	97.2%	95.1%				



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

	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				
% understood what mattered or yes to some extent	97.5%	93.2%	99.1%	94.2%				

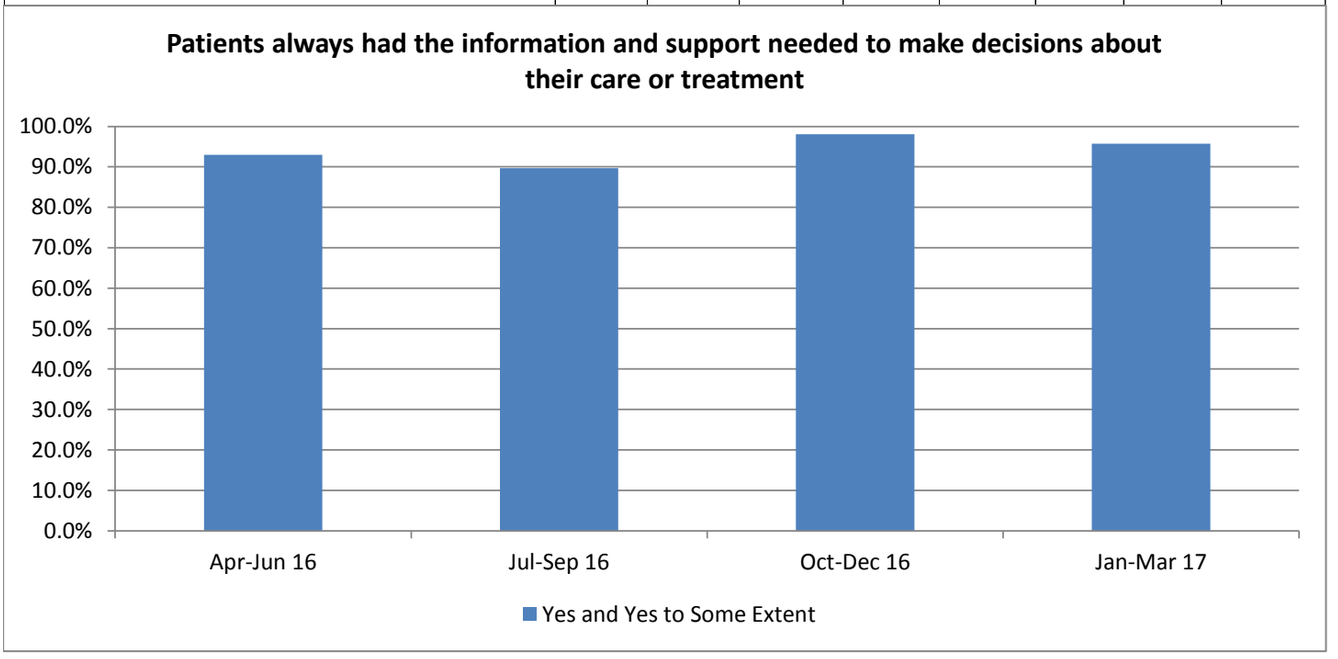


9. Other Relevant Measures

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				
% always had information or support, or yes to some extent	93.0%	89.6%	98.1%	95.7%				



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 year are 96% for questions 1 and 2 and 94% 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

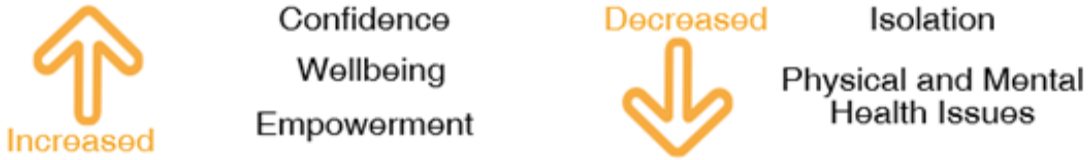
Integrated Care Fund Projects

Borders Community Capacity Building (Apr-16 to Mar-17)

What is this project and why is important?

The purpose of the community Capacity Building project is to encourage the development of social capital within communities to allow them to become stronger and more self-reliant through the use of evidence based investment.

Key Findings



My Home Life (Feb-16 to Jan-17)

What is this project and why is important?

Care home managers were provided funding to complete the My Home Life leadership support programme. The aim was to promote quality of life for those living, dying, visiting and working in care homes through relationship-centred and evidence-based practice.

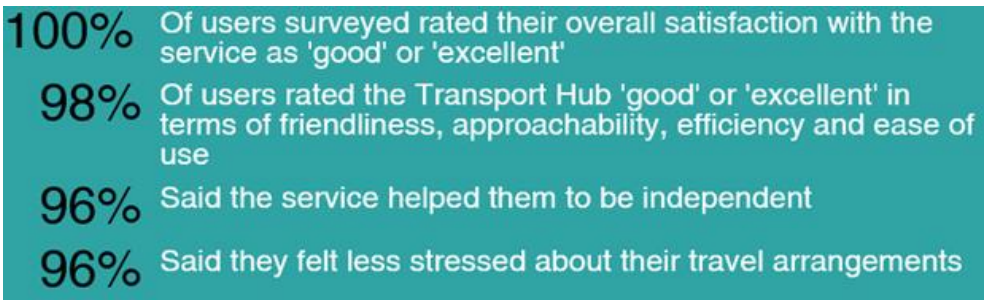
Key Findings

Community Transport Hub

What is this project and why is important?

The purpose of the Community Transport Hub is to create a coordinated approach to community transport provision across the Scottish Borders.

Key Findings



9. Other Relevant Measures

Long Term Conditions (Jan-14 to Dec-16)

What is this project and why is important?

This project was designed to support improvements in the shared-management of Long Term conditions amongst older people in the Borders.

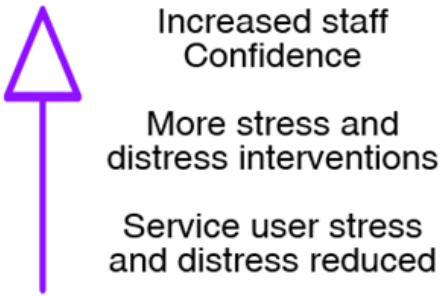
Key Findings

Stress and Distress Training'

What is this project and why is important?

The Stress and Distress Training Project is a 2 year project funded by the ICF, which delivers training in a psychologically informed model to staff within Health, Social Care, Third and Independent Sector in the Scottish Borders. The training teaches staff a proven approach to understanding and intervening in stress and distressed behaviours in people with dementia. The aim of this approach is to improve the care and outcomes for people with dementia and thier families.

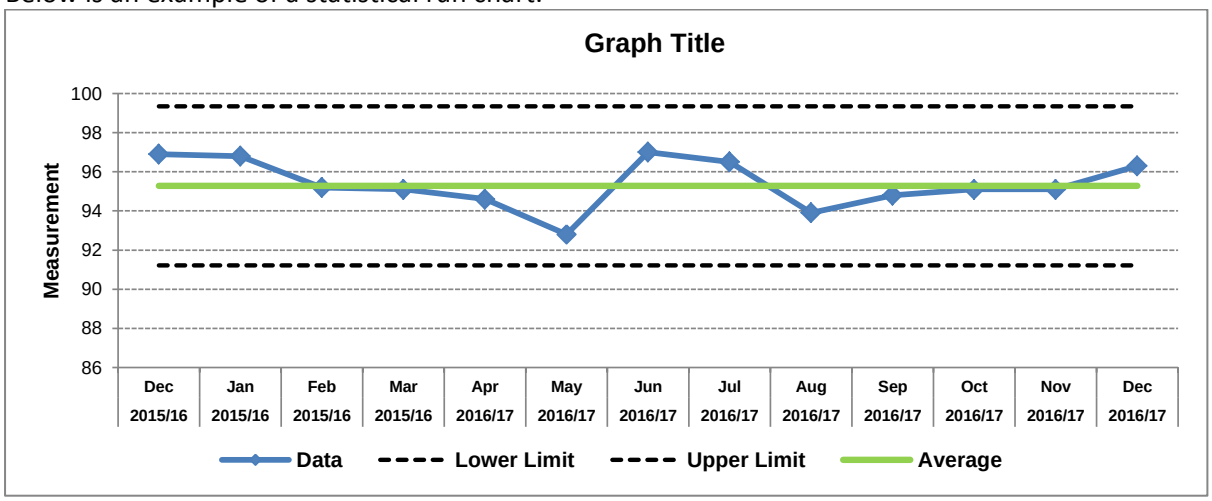
Key Findings



Background: Explanation of the line charts in this report.

A run chart or Statistical Process Control (SPC) chart is a graphical display of data over time. They are used to visually analyse processes according to time or sequential order. They are useful in assessing process stability, discovering patterns in data, and facilitating process diagnosis and appropriate improvement actions.

Below is an example of a statistical run chart.



- The blue line in this graph is showing the data for a performance measure, plotted over a succession of months.
- The green line shows the average value of the measure over a longer time period
- The statistical run chart then adds an upper and lower limit sometime referred to as the Upper Control Limit (UCL) and Lower Control Limit (UCL). These are shown as bold black dashed lines.

To find the upper and lower limit we use a statistical measurement known as standard deviation which in essence takes the data over a long period of time (for example over 24 points or in this case months) and works out what variation would be expected. From the expected variation it is then possible to put an upper and lower limit on the run chart.

How to read a statistical run chart

If the blue line (Data) goes above or below the dotted line this should be noted. It is saying the measurement has moved out with what would normally be 'expected' on the basis of random variation. If the data returns back in between the dotted lines when next measured it could be considered extraordinary but not an 'issue'. Where the measurement moves out with the dotted lines for a period more than 3 consecutive times then is would be considered a change which is not likely to be due to chance, not an anomaly but likely to indicate a change in the process/data measurement. These are the points which we need to review and pay attention to.

Another area to consider is the movement of the line above or below the average (green line). We will be taking the average over a long period of time (24 months or more normally) and any consistent movement of the data above the line (or below) would indicate an increase/decrease in the process. E.g. if the blue line is consistently above the green line, this would indicate a consistent increase (which may be an improvement or worsening, depending on the measure).