Borders NHS Board

MANAGING OUR PERFORMANCE END OF YEAR REPORT 2012/13

Aim

The aim of the 2012/13 Managing Our Performance (MOP) End of Year Report is to report progress during 2012/13 on the full range of HEAT targets and other key priority areas for the organisation.

Background

For a number of years, the organisation has produced a MOP report as a summary of progress across the range of targets and indicators at the mid way point and also at the end of each financial year.

This 2012/13 MOP Report has been updated to show performance in relation to the HEAT targets, Single Outcome Agreement and Corporate Objectives at the end of 2012/2013.

Summary

The 2012/13 End of Year MOP is an important part of the organisational performance management framework as it provides a mechanism to report progress across the full range of HEAT targets and summarise performance during 2012/13 along with a selection of priority areas and Corporate Objectives.

Recommendation

The Board is asked to **note** the 2012/13 End of Year Managing Our Performance Report.

Policy/Strategy Implications	Regular and timely performance reporting is an expectation of the Scottish Government
Consultation	Performance against key indicators within this report have been reviewed by each Clinical Board and members of the Clinical Executive
Consultation with Professional Committees	See above

Risk Assessment	Good progress is being made against key targets and pressure areas are identified in this report. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders
Compliance with Board Policy requirements on Equality and Diversity	The implementation and monitoring of targets will require that Lead Directors, Managers and Clinicians comply with Board requirements
Resource/Staffing Implications	The implementation and monitoring of targets will require that Lead Directors, Managers and Clinicians comply with Board requirements

Approved by

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MANAGING OUR PERFORMANCE END OF YEAR REPORT

2012/13

HEAT

June 2013

Planning & Performance

CONTENTS

1. EXECUTIVE SUMMARY

Background

For a number of years, NHS Borders Board has reviewed the performance of the organisation at each Board meeting and this has been facilitated through the production of performance reports showing progress towards achievement of the range of national targets set through the local delivery process. In addition to the monthly reports, the Managing Our Performance (MOP) report has been reviewed by the Board to assess performance across the full range of targets and indicators at the mid way point and also at the end of each financial year

Updates to 2012/13 End of Year MOP

This 2012/13 End of Year MOP Report has been further updated and now includes an assessment of performance in relation to the HEAT targets, contributions to the Single Outcome Agreement and Corporate Objectives throughout 2012/13. This report has been enhanced to show trends for each target which can be reported on monthly along with narrative describing the end of year position. As in previous versions, an update is included on the full range of HEAT targets, including those which cannot be reported on a monthly basis and are therefore not included in the HEAT Scorecard.

Summary

This report allows Board members to assess where action is required as we progress into 2013/14 to ensure delivery of the full range of HEAT targets and standards in the coming year.

2. INTRODUCTION

The Local Delivery Plan

Every year the Scottish Government Health Department (SGHD) asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report is called the Local Delivery Plan (LDP) and forms an agreement on what Health Boards will achieve in the next year with SGHD. Boards are asked to work towards a number of key targets for the year which fit with the Government's health objectives. These targets are called HEAT targets because they are separated under 4 different headings:

H Health Improvement
E Efficiency and Governance
A Access to Services
T Treatment for the individual.

Monitoring of Performance

For each Clinical Board, BGH, Primary and Community Services, Mental Health and Learning Disability a monthly Performance Scorecard is produced which includes an assessment of performance towards achievement of the HEAT targets, HEAT standards along with a range of locally set key performance indicators (KPIs). These 4 Scorecards are compiled into the Clinical Executive Scorecard which has been presented to the Clinical Executive Operational Group on a monthly basis.

At the Clinical Executive Operational Group discussions take place around the areas where performance is significantly off track and information is also provided with the Scorecard on action being taken to improve performance.

In addition to this monthly reporting, each Clinical Board attends a quarterly performance review where performance is monitored by the Board Executive Team and a quarterly Clinical Board Scorecard is reviewed.

Information is taken from the monthly Clinical Board Performance Scorecards to compile the HEAT Scorecard which is reviewed by NHS Borders Board at each Board meeting (bi-monthly). The HEAT Scorecard provides information on all targets and standards which can be reported on monthly and indicates whether performance is in line with agreed trajectories for each month of the year. The locally set KPIs are reviewed by the Strategy & Performance Committee in a similar fashion through the KPI Scorecard when they meet on a bi-monthly basis.

2012/13 HEAT Targets and Standards

This 2012/13 End of Year MOP Report summarises performance for all HEAT targets and standards from April 2012 to March 2013, which can be reported monthly and a trend graph and narrative is included for these. For targets which are not reported on a monthly basis Lead Managers have provided narrative to indicate whether targets are on track for delivery.

Single Outcome Agreement & Corporate Objectives

In section 4 and 5, information is included on planned work on the Single Outcome Agreement with local partners such as Scottish Borders Council and there is a summary of actions relating to a selection of the current Corporate Objectives.

***Please note*:**

- Some anomalies may occur in data due to time lags in data availability and national reporting schedules.

3. 2012/13 HEAT TARGETS

Summary of Performance

Strong Performance

Throughout 2012/13, the following targets have consistently achieved their trajectories and the target has been delivered:

- Number of inequalities targeted cardiovascular health checks
- Smoking cessation successful quits in most deprived areas
- Pre-operative stay (2 month lag for data)
- Online triage of referrals
- Cancer treatment within 62 and 31 days of decision to treat
- 18 Weeks RTT – non-admitted pathway performance and combined pathway performance
- No CAMHS waits over 26 weeks
- No delayed discharges over 4 Wks
- Admissions to the Stroke Unit within 1 day of admission.

Performance at Risk

Performance against the following targets was outwith the trajectory at the end of March 2013:

- Same day surgery rate
- Sickness absence rate
- 12 week waiting target for outpatients and inpatient treatment
- New patient DNA rate
- 18 Weeks RTT admitted performance
- 4-Hour waiting target for A&E
- Diagnosis of Dementia

Performance was significantly outwith trajectory for the following HEAT targets and standards and the target was not delivered at the end of March 2013:

- Psychological Therapy waits over 18 wks
- 4 week waiting target for diagnostic tests
- Reduction in the rate of A&E attendances.

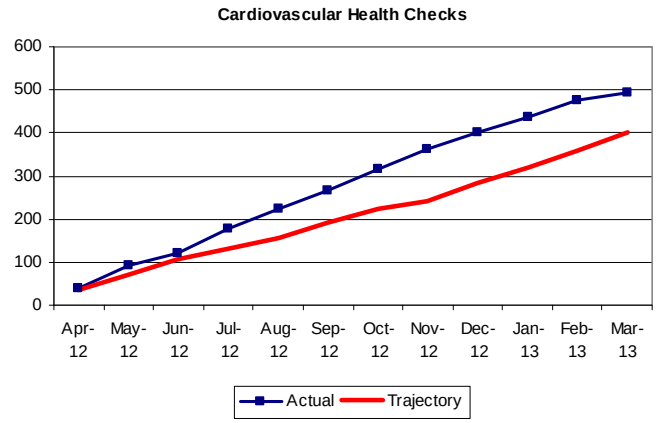
Further information on all the HEAT targets and standards are detailed within the report.

Monthly Performance and Narrative of Heat Targets

Standard: Number of Inequalities targeted cardiovascular health checks (Cumulative)

Target: 400

Performance: 493



493 health checks were carried out against a target of 400 (123% of target), with 90% delivered in 2012/13 in Primary Care.

Amongst the 9 GP practices signed up to deliver Keep Well, 83% of checks were delivered to households situated in a postcodes classified as the 40% most disadvantaged in Borders and 42% of checks were delivered to households situated in a postcode classified as the 20% most disadvantaged in Borders.

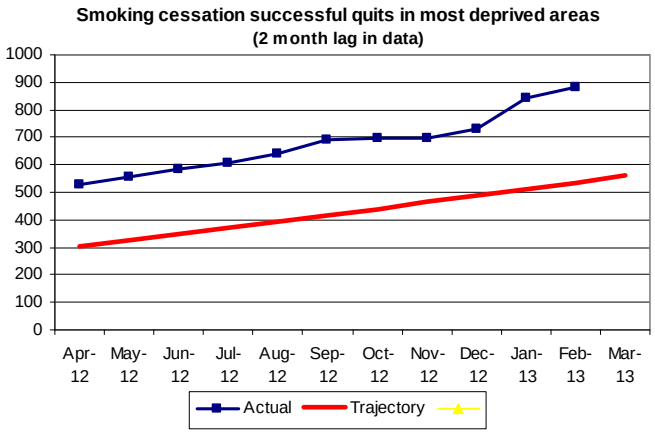
Amongst the 9 GP practices signed up to deliver Keep Well, 9.5% of checks identified people with an ASSIGN CVD 10 year risk score of 20% or more.

Note: Data updated from monthly scorecards to reflect national end of year submission

Health Improvement: Smoking cessation successful quits in most deprived areas (Cumulative)

Trajectory: 560

Performance: 882 (February data as there is a lag time)

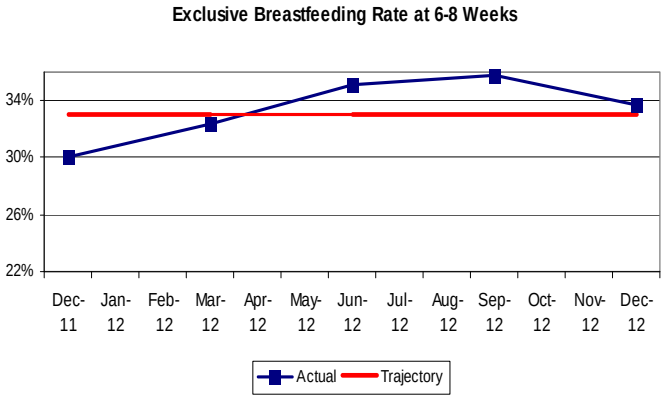


The Quit4Good Service has worked hard over the past year to improve the effective delivery of Services. The Service went through a LEAN redesign process to ensure that all systems and procedures were as streamlined as possible, enabling our Advisors to maximise the time they have available to treat patients. In addition through demand and capacity work we have identified those areas of greatest need in the Borders and have reoriented our services as a result of this. This ensures that we maximise our resources in the areas of greatest deprivation, thus further supporting meeting our HEAT target.

Standard: Exclusive Breastfeeding Rate at 6-8 Week Check

Target: 33%

Performance: 33.7% (December 2012)

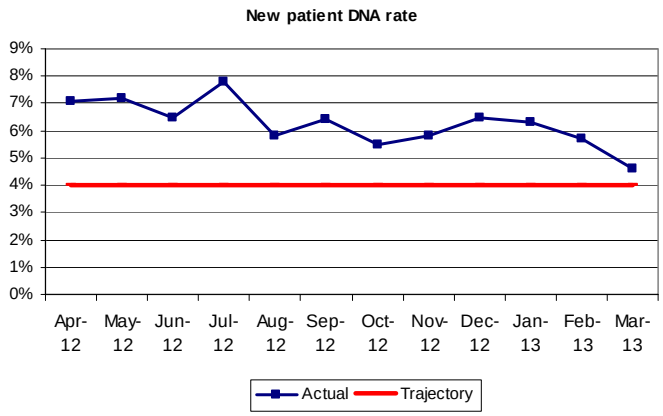


Implementation of the Baby Friendly Initiative standards in the Maternity Unit and in the CHP continued throughout 2012 working towards 'Stage 2' of the programme (subsequently achieved in April 2013). The focus has been on staff training, at the end of December 2012, 75% of eligible staff had completed training. Locality wide peer supporters and breast feeding support groups have been introduced to ensure adequate facilities exist in the community for women to access, maximising the potential to sustain breast feeding in the long term. Breast feeding rates are on an upward trajectory but there will always be quarterly fluctuations.

Standard: New Patient DNA Rate

Target: 4%

Performance: 4.6%



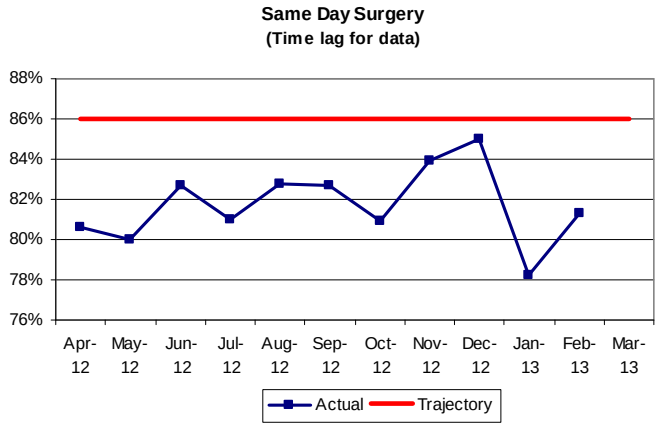
Service to automatically remind patients about outpatient appointments introduced in November 2012. End March position of 4.6% for new appointments is the lowest reported level to date. Publicity campaign to encourage patients to notify the service if they are not going to be attend an appointment run at the time of introducing the reminder service.

Work continues to improve the data quality of patient contact details to increase those patients who can be reminded about their appointment.

Standard: Same Day Surgery

Target: 86%

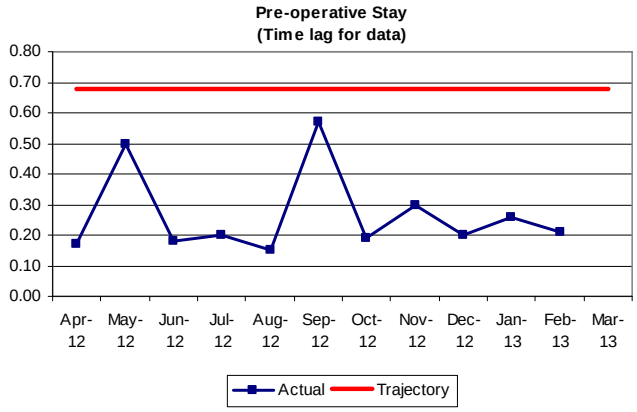
Performance: 81.3% (February as lag time)



Standard: Pre-operative Stay

Target: 0.68

Performance: 0.21 (February as lag time)

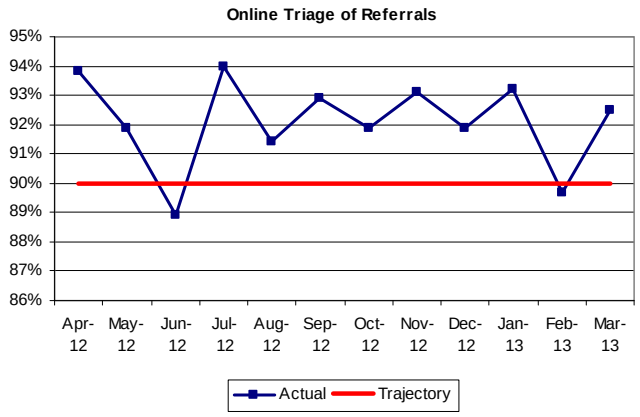


The Pre Surgery Admission Unit (PSAU) allows the majority of patients to be admitted on the day of surgery so for most patients there is no pre-op stay (Day Case and Elective) which is why the target has been achieved consistently. Links will be explored with the Pre-Assessment Clinic to move towards patients being brought in the night before their operation being very much an exception. The team is also exploring the process for the 1st Athroplasty patient on the list as they are still being brought in the night before to ensure they are available for the start of the list in the morning.

Standard: Online Triage of Referrals

Target: 90%

Performance: 92.5%



The level all online triage of referrals has been maintained at or above the target level of 90% for the majority of months in 2012/13.

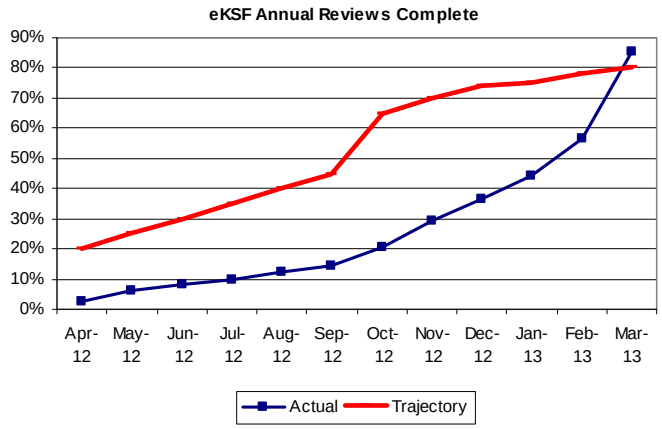
Implementation of the Eye Care Integration Project in 2013/14 will enable optometrists to make referrals electronically. Work will be ongoing to explore the feasibility of enabling Northumberland GP Practices to make referrals electronically.

Standard: eKSF Annual Reviews Complete and PDP's Complete on eKSF

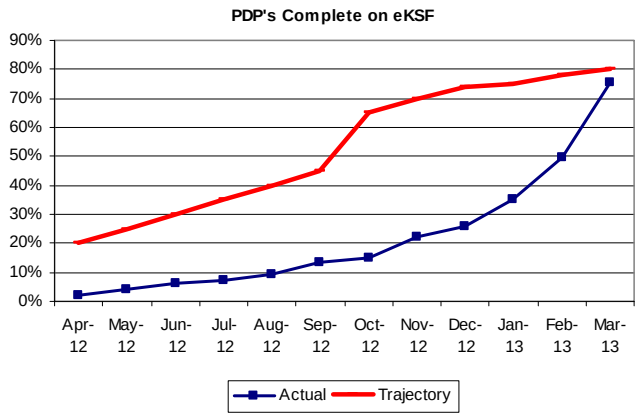
Trajectory: 80%

Appraisals: 85.40%

PDPs: 75.5%



NHS Borders exceeded the Heat Standard of at least 80% employees with Joint Development Reviews completed and signed off on eKSF for the period 2012/13. Clinical Board and Support Services Champions have supported managers, through regular position reporting, adhoc training and support where required. Progress against the trajectory is also built into performance scorecards and the monthly Workforce Report. As the Trend shows, although monthly trajectories were not met throughout the year, a high proportion of Reviews were undertaken between the months of January and March 2013 which enabled the target to be met.



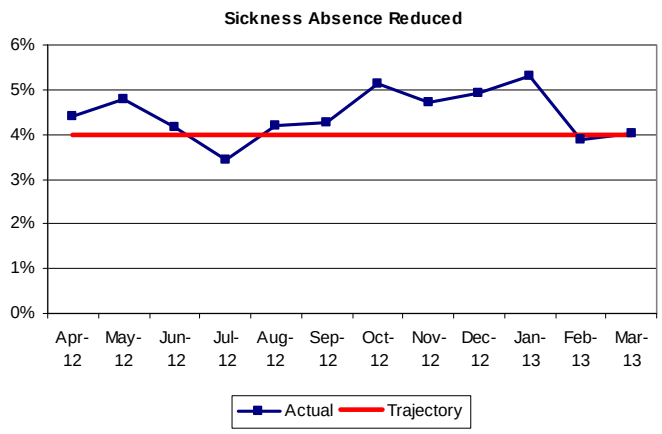
NHS Borders narrowly missed the Heat Standard of at least 80% employees with PDP's completed and signed off on eKSF for the period 2012/13. Monthly trajectories were not met throughout the year, and despite a high proportion of PDP's being recorded between the months of January and March 2013, the 80% target was not met. In order to achieve this in following years, it's important that Joint Development Reviews are distributed more evenly throughout the year, which would support the achievement of monthly trajectories for Reviews and PDP's recorded on eKSF. Clinical Boards and Support Services are revisiting their trajectories to ensure they are on track to achieve the 2013/14 target.

Data as at the end of March 2013. however locally managers were given to end of April to upload any outstanding reviews onto the system.

Standard: Sickness Absence Reduced

Target: 4%

Performance: 4.04%



Sickness Absence rates reduced significantly between January 2013 and end of March 2013, which has reversed the trend of steady growth in Sickness Absence rate since the Autumn months (the impact of norovirus was particularly significant). NHS Borders as a whole narrowly missed achieving the HEAT target of less than 4.00 % absence rate at the end of March. The cumulative Sickness Absence rate for the year 2012/13 was 4.27%, which is a significant improvement on last year's rate of 4.71%. Sickness Absence remains a key performance indicator in clinical board and support services score cards. NHS Borders have plans in place to reduce current levels of staff sickness absence. This is led by the partnership "Managing Sickness Absence" Working Group (with membership drawn from across the organisation including Occupational Health, management, staff side, partnership and HR) which will give whole system ownership to champion effective absence management.

1. Reactive interventions are in place e.g. improved reporting, tighter application of the policy and procedures and consistent management and occupational health processes for managing attendance including rehabilitation programmes to support staff back to work. Policy guides and FAQs for managers and staff have been available as an intranet resource pack.

2. Proactive interventions e.g. exploring key underlying reasons for sickness absence and planning proactively to address these, including occupational health support e.g. physiotherapy and counselling.

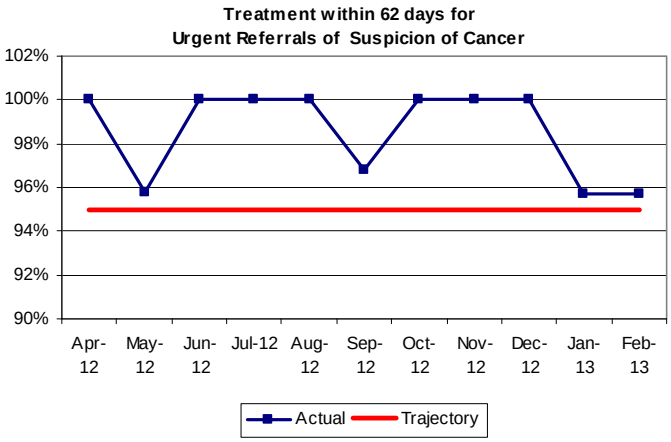
3. All managers have taken part in an e-learning module for the new absence policy and attended a classroom based joint teaching session by 31 December 2012.

The working group are currently agreeing a workplan for 2013/14 so that momentum is not lost and the improved performance is sustained.

Standard: Treatment within 62 days for Urgent Referrals of Suspicion of Cancer

Target: 95%

Performance: 95.7%



NHS Borders has consistently exceeded the 95% target for patients urgently referred to receive treatment within 62 days since 2009 and throughout 2012/13. This has been achieved through the hard work, commitment and high quality care provided by clinicians in the patient pathway, and through a robust and effective prospective tracking of patients. During 2012/13, the Hepatobiliary cancer pathway was redesigned to ensure patients are supported throughout their journey by a locally based nurse and help avoid delays in their pathway.

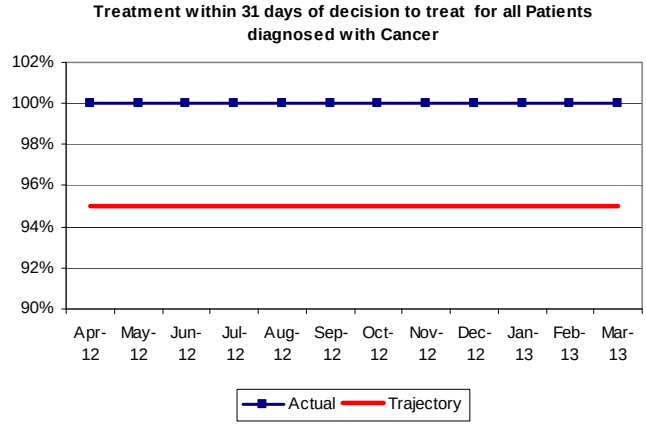
A revised tracking database is being introduced in 2013/14, which will allow tracking systems to be streamlined. This will make it much easier to see where a patient is on their pathway and whether they are on target to achieve the milestones in their journey. This will allow a more proactive approach in picking up and addressing potential delays and will release staff time to track patients through to the end of their treatment. It is anticipated this will reduce the number of patients who do not achieve 62 days and move us closer to ensuring that consistently 100% of patients are treated within 62 days.

For 2013/14, colonoscopy capacity has been increased as part of a drive to reduce colonoscopy waiting times to 2-3 weeks. This will provide an even more responsive service for patients and will reduce the likelihood of patients with bowel cancer exceeding the 62-day target. Work is being done with NHS Lothian to develop improved support for patients referred for treatment. As well as improving the patient experience, this will also reduce the risk of delays in patients being treated.

Standard: Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer

Target: 95%

Performance: 100%

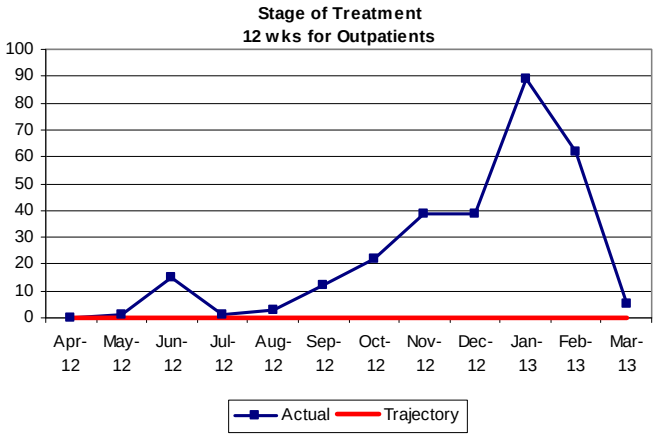


NHS Borders has maintained 100% achievement against the 31-day cancer waiting times target throughout the year. This is due to the commitment and high quality care delivered by NHS Borders range of cancer clinicians, supported by robust tracking process that prospectively follow every patient diagnosed with cancer to first treatment.

The tracking database is being revising and improved to allow the organisation to maintain this achievement and to track patient care to end of treatment, which will ensure no delays following first treatment.

Access: 12 weeks for Outpatients

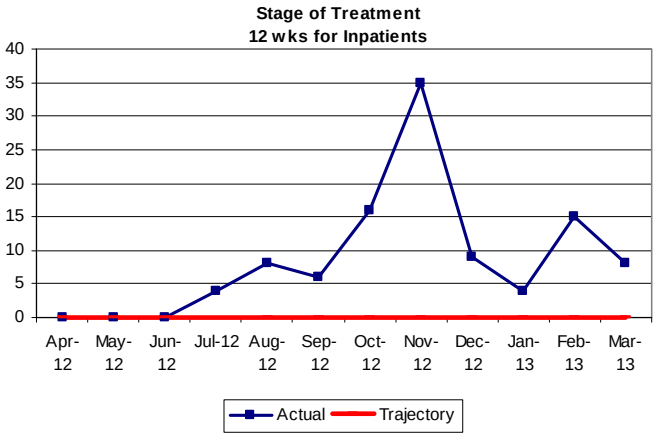
Target: 0 **Performance:** 5 R



Outpatient targets were broadly delivered during 2012/13. Recurring deficits in capacity have been identified in a number of specialties, including Dermatology, ENT and Urology. Additional short term capacity has been organised in these specialties, either through locums or by local clinicians undertaking additional sessions, whilst the service is working through the Productivity and Benchmarking process.

Access: 12 weeks for Inpatients

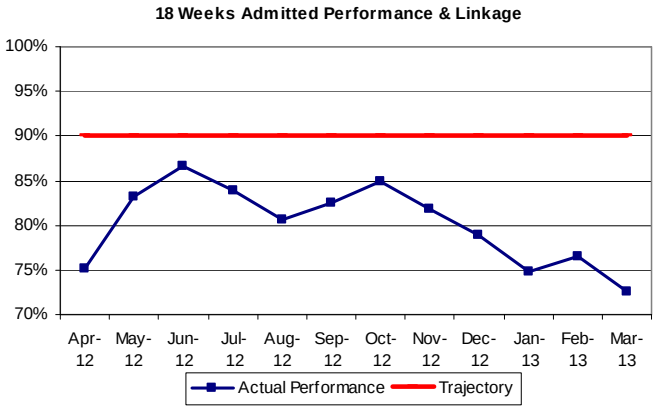
Target: 0 **Performance:** 8



Inpatient targets have broadly been delivered, although there continues to be a significant risk around Orthopaedics. During 2012/13 the Treatment Time Guarantee was introduced, and again this has been broadly delivered although there have been some challenges, particularly during February following problems in ASDU which limited elective operating.

Access: 18 Weeks Referral to Treatment**:** Admitted Performance

Target: 90% **Performance:** 72.5% R

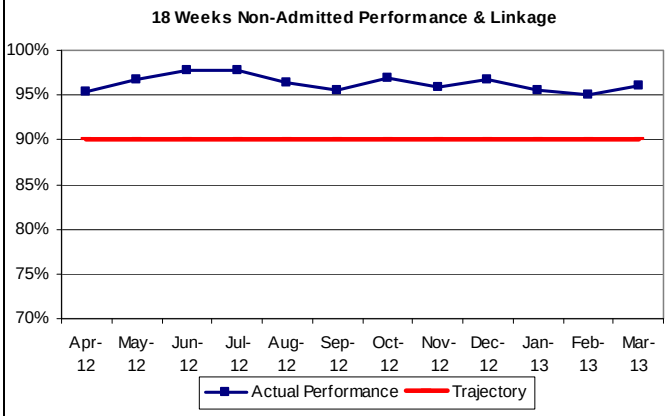


Performance in admitted pathways requires improvement, particularly in Orthopaedics. Detailed analysis is currently underway and steps are being taken to address this.

Data produced for scorecards at 12th of every month therefore does not include Audiology or Sexual Health data.

Access: 18 Weeks Referral to Treatment**:** Non-Admitted Performance

Target: 90% **Performance:** 96.0% G

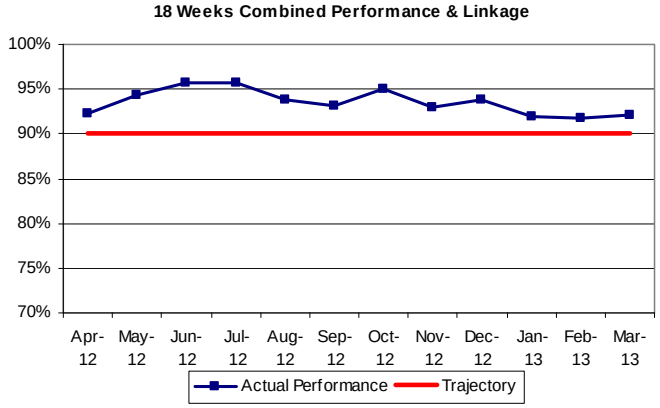


Data produced for scorecards at 12th of every month therefore does not include Audiology or Sexual Health data.

Performance in non-admitted pathways has been consistently above 95% during the year, although there have been some issues around Audiology. The service is exploring this further.

Access: 18 Weeks Referral to Treatment: Combined Performance

Target: 90% **Performance:** 92.1% G

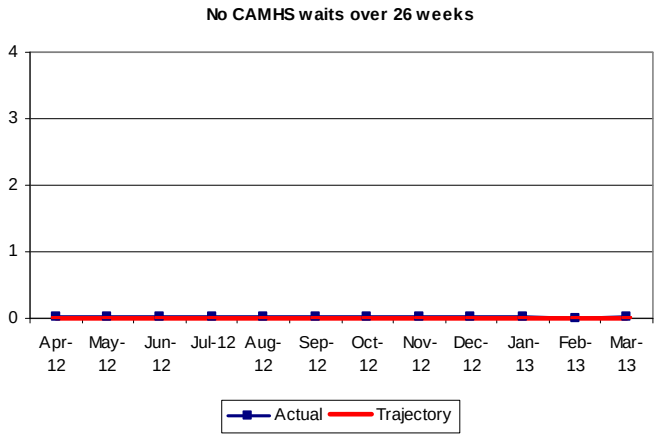


Data produced for scorecards at 12th of every month therefore does not include Audiology or Sexual Health data.

During 2012/13 NHS Borders continued to successfully deliver the national target of 90% of patients treated within 18wks of referral. Particular risks to continued delivery are around Audiology and Orthopaedics. Work is underway to address these issues.

Access: No CAMHS waits over 26 weeks

Target: 0 **Performance:** 0 G



Performance has been consistent with 100% of patients being seen within 26 weeks over 2012/13. The service continues to focus on the target and has embarked on a service improvement process during the latter part of 2012/13 to assist sustainability. This is important as the target will be stretched to 18 weeks ultimately. Performance against the target has been maintained in-year even though the service extended it's catchment up to age 18, though this has presented some challenges for target achievement.

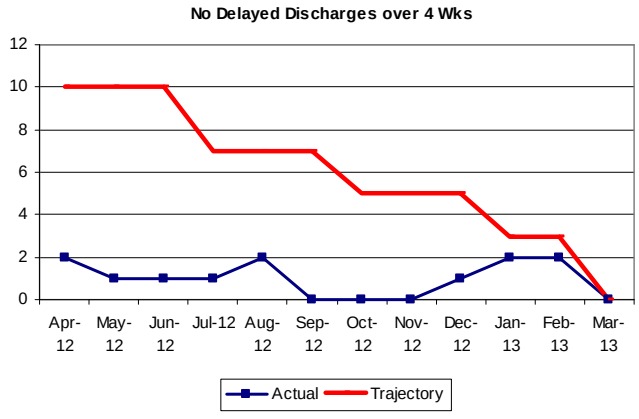
Access: No Psychological Therapy waits over 18 weeks

Target: 0 **Performance:** 25 R

The target was achieved for two months of the year with performance at the year end down overall. Delivery of the target has been challenged by two issues during the year. Firstly, clinical psychology staff deliver the bulk of the recordable target activity and this been challenged by vacancies resulting from maternity leave remaining unfilled. Responses to this have been to continue efforts to increase the amount of psychological therapy delivered by non-Psychology staff, seeking improvements in the supporting IT system to allow for better review and remedial action by managers and therapists and active recruitment to all vacant Psychology posts. The second issue relates to one particular psychological therapy which is group based, has a pre-commitment phase and is suitable for only a low number of people within the Borders. Due to the latter aspect, for example, waiting times can occur resulting from sufficient number of people being identified to run a new group series. Local colleagues are engaged in national discussions on the issue. Overall, work has taken place each month through an oversight group to actively review any longer waits, and improvements in data collection have assisted this. It is projected that the range of actions initiated during the year will allow for target achievement by the due date of December 2014.

Access: No Delayed Discharges over 4 weeks

Trajectory: 0 **Performance:** 0 G



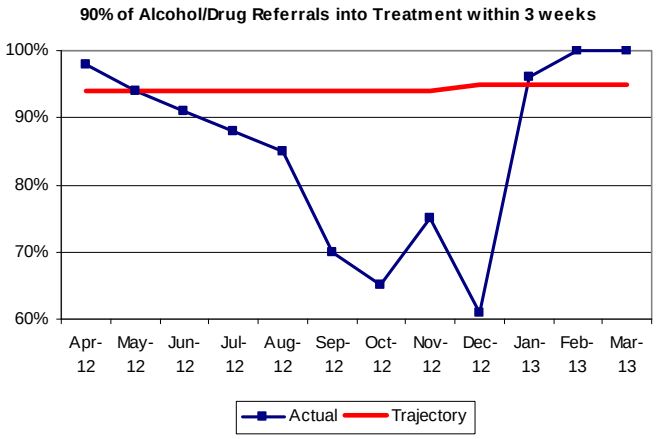
There has been good progress made in relation to understanding and jointly managing delayed discharges by NHS Borders and Scottish Borders Council over the last two years:

- The number of occupied bed days attributed to discharges has reduced significantly.
- The HEAT 6 and 4 week targets of zero total delayed discharges was achieved.
- A reduction in the total number of complex cases delayed discharges and associated mean length of stay.

Access: 90% of Alcohol/Drug Referrals into Treatment within 3 weeks

Trajectory: 95%

Performance: 100%

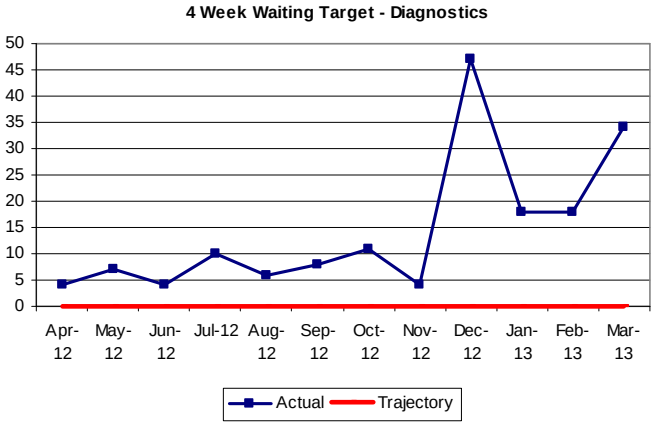


Having started the year with performance continuing on track, performance dropped significantly though has subsequently improved to ensure that the target was achieved ahead of the due date of March 2013. The shift is directly linked to the service having to respond to a number of staff vacancies during the year. With all posts filled by new starts, colleagues have worked effectively to ensure the backlog built up was cleared and performance sustained. Of specific note is performance hitting 100% against the national target of 90% and the local stretched target of 95%. Discussions have occurred with the Alcohol & Drugs Partnership (ADP) who fund some service staff to recognise the crucial importance of maintaining a level of funded posts to assist target achievement. This is important going forward as the target will now be retained unchanged as a HEAT Standard.

Standard: 4 Weeks Waiting Target for Diagnostics

Target: 0

Performance: 34



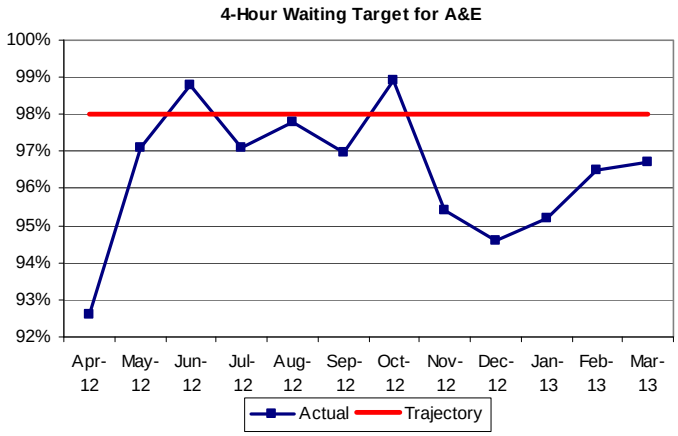
MRI and CT scanning are struggling to meet targets. Over the past 2 years demand has increased by approximately 15% in both modalities and there is not the capacity to accommodate this demand. Over the past 12 months the service has undergone Productivity and Benchmarking and are now recruiting staff to increase capacity in both modalities by 1 scanning day per week. This should allow the service to bring waiting times down within target by autumn 2013.

Patients undergoing a diagnostic cystoscopy are appointed on the surveillance cystoscopy list, which can then impact on the diagnostic waiting list. The number of patients waiting for this investigation varies from month to month which impacts on the waiting list size.

Mid monthly reports for all diagnostic services are now being produced so that any potential patients likely to breech the 28 days are identified prior to the end of the month.

Standard: 4 Hour Waiting Target for A&E

Target: 98% **Performance:** 96.7%



2012/13 has been a challenging year with regards to sustaining achievement against the 98% Emergency Access Standard within NHS Borders.

98% compliance was only achieved in 3 months of 2012/13 compared to 7 months the previous year. On 5 months of the year NHS Borders narrowly missed achievement, recording 97%. Our average performance across the 12 month period was 96.6% compared to 97.8% the previous year.

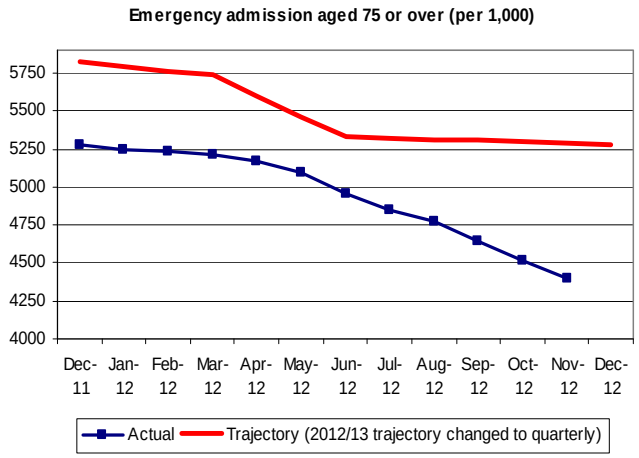
Reasons for this dip in performance are multi-factorial and whole systems work continues across NHS Borders and with our partners in Scottish Borders Council and Scottish Ambulance Service around small scale improvement measures to improve patient experience.

NHS Borders along with other Boards in Scotland experienced a prolonged norovirus season with a number of beds closed across the system and on four occasions whole ward closures was necessary to limit the risk and of spread of infection. These bed closures limited capacity for timely unscheduled admissions from ED.

Although overall our performance has been suboptimal NHS Borders do continue to be a high performing Board for EAS in Scotland.

Standard: Emergency Admission aged 75 and over (per 1,000)

Trajectory: 5298 (October 2012) **Performance:** 4401 (November 2012)



Note: There is a time lag with therefore the most recent data is shown

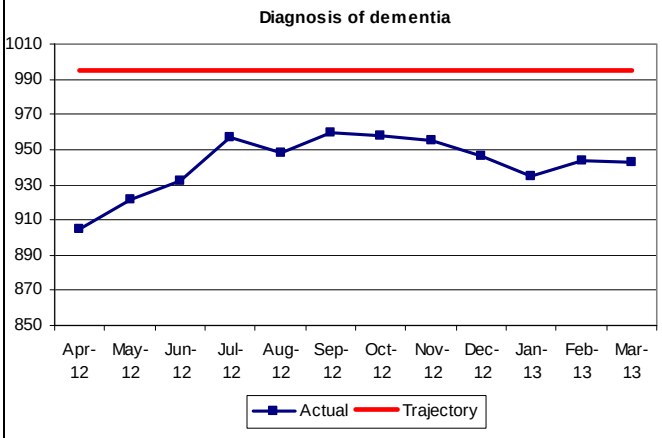
This target is being managed in conjunction with T10 and measures Emergency Admissions Rates per 100,000 of the population in respect of patients aged 75+. Performance in respect of this target has exceeded trajectory such that more challenging trajectory has been agreed for 2013/14.

Increasingly Primary and Community Care Services have been focusing on reducing avoidable admissions and supporting early discharge from hospital. Specific areas of activity include:

- QP indicators in QOF- Practices analysing attendance data and producing local improvement plans. End of year reports will also be produced to share best practice and highlight possible areas for improvement elsewhere within the health and social care system
- Polypharmacy – Local LES supporting face to face medication reviews for patients >65 years on 11 or more repeat items
- Anticipatory Care Plans – Enhanced Service in place for care home residents to reduce OOH Admissions, STACCATO Project and Palliative Care Direct Enhanced service and Palliative Care QOF indicators
- Primary Care input in Care homes enhanced to support admission prevention
- Development of Intermediate Care services within SBC Care Homes.

Treatment: Diagnosis of Dementia

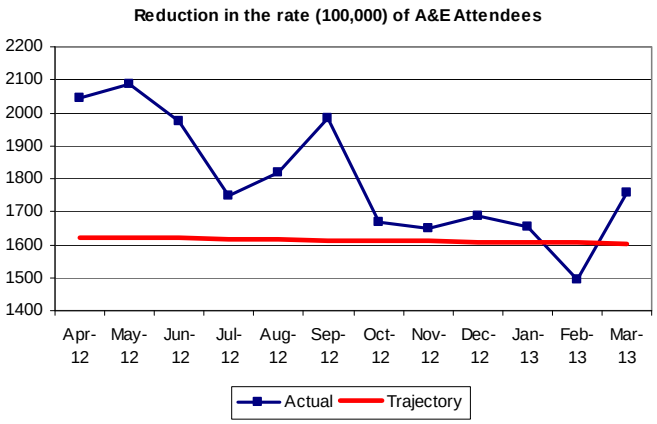
Target: 995 **Performance:** 943



Following positive performance earlier in 2012/13, performance has stalled subsequently with the target not being achieved. Focused work has continued throughout the year in an effort to improve target performance. This has included interrogation of local performance variations, individual discussions with the national clinical lead for dementia and senior SG colleagues and visiting another NHS Board to benchmark. Latterly, an external review has been commissioned with the Dementia Services Development Centre at Stirling University with work on this starting in May 2013. The focus will be a "deep dive" into local dementia services, systems and structures with a focus on identifying areas of new or increased endeavour towards target achievement.

Treatment: Reduction in rate (per 100,000) of A&E Attendees

Trajectory: 1603 **Performance:** 1759 R



NHS Borders has undertaken to achieve a reduction in the rate of attendance at A&E of 3.5% by the end of 2013/14. This is acknowledged to be an ambitious target for the Board given that in terms of total attendance rates when compared to the rest of Scotland it is the second best performer. NHS Borders position however drops to 5th in relation to T10 sites only, which indicates successful redirection by other Boards to alternative services.

NHS Borders performance at the end of March 2013 against the T10 Target was 1759 patients per 100,000 of the population against a trajectory of 1603. Over the course of the year performance has ranged from 1492 in February 2013 to 1985 in September 2012.

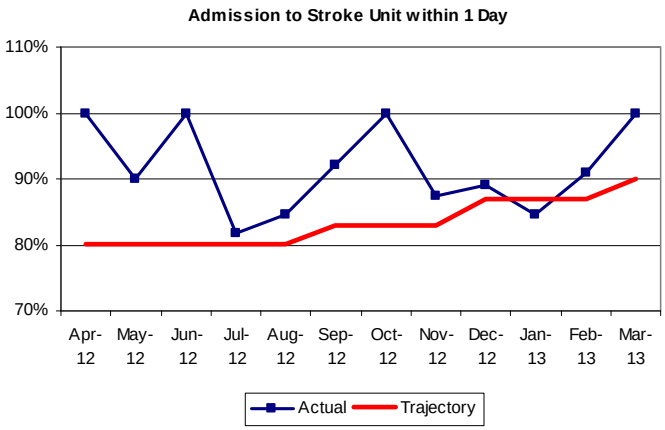
There is wide variation in attendance rates at A&E across Scotland with only 3 Boards currently performing beyond trajectory.

In NHS Borders the main areas for concern relate to:

- Attendance by patients aged 85+
- Flow 3 attendances which are related to patient flow through ED redirected there consequent of issues around medical beds availability
- Flow 1 attendances that might be redirected away from ED

Treatment: Admitted to the Stroke Unit within 1 day of admission

Trajectory: 90% **Performance:** 100% G



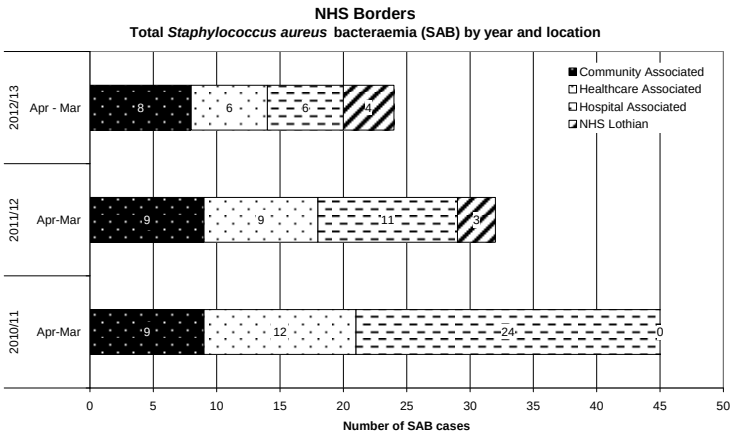
NHS Borders has achieved the HEAT 90% target for Admission to the Stroke Unit. The core Stroke team work with the Emergency Department and Medical Admissions staff to admit to the new 12 bedded Borders Stroke Unit.

Daily data from the Scottish Stroke Care Audit is available in real time. Patients who are not admitted to the Stoke Unit within 1 day of admission are exception reported.

Formal teaching and regular pathway feedback is essential to all stakeholders. The goal for 2013/14 is to improve consistency over seven days and resilience during periods of patient flow pressures to improve patient safety, care, outcome and experience.

Treatment: Further Reduce Rate of Staph aureus bacteraemia (cumulative)

Number of cases in 2012/13 = 24

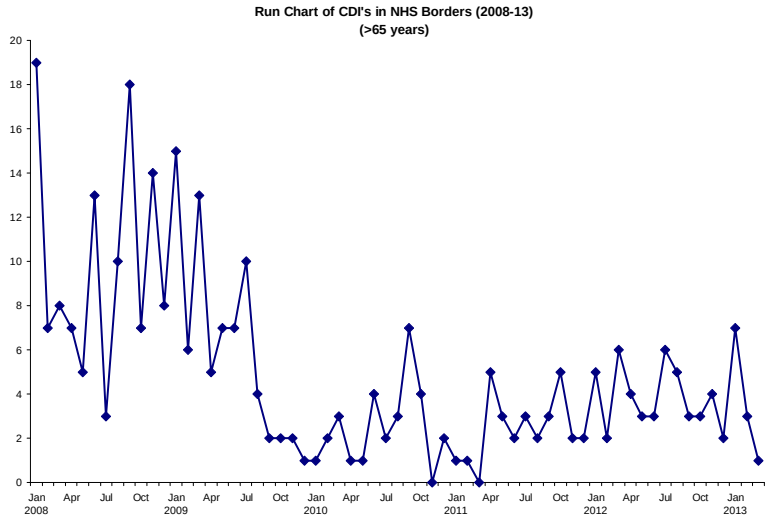


NHS Borders has a Scottish Government HEAT target to achieve a rate of 0.26 *Staphylococcus aureus* Bacteraemia (SAB) cases or less per 1000 acute occupied bed days by March 2013. Initial indications suggest NHS Borders is borderline to achieving this target. This position is unable to be confirmed against the HEAT target until official data is made available from Health Protection Scotland.

Significant improvements have been made with NHS Borders reducing the number of SABs by 25% this year (32 SABs 2011/12 : 24 SABs 2012/13) as displayed.

Treatment: Further Reduce Rate of C. Diff (CDAD) cases in over 65s (cumulative)

Number of cases in 2012/13 = 44



NHS Borders has a HEAT target to achieve a rate of 0.39 or less cases of *Clostridium difficile* infections (CDI) per 1000 total occupied bed days in patients aged 65 and over by the year ending March 2013. Initial indications suggest NHS Borders CDI rate is higher than the HEAT target. This position is unable to be confirmed until official data is made available from Health Protection Scotland.

NHS Borders, however, has made an excellent overall improvement since the 2008/9 period, as displayed in Figure 1. Recent surveillance indicates a leveling of the previous downward trend across NHS Scotland. A new Prevention of CDI Group has been established to address the issues related to CDI rates.

Progress on Targets Not Reported on a Monthly Basis

Health Improvement	
Reduce Suicide Rate between 2002 and 2013 by 20%	**Progress and achievements** Local data on suicide show a slight decrease over time in the number of suicides for the three year period 2009 – 2011 (Rolling 3 yr average. This brings the rate for Scottish Borders in line with the target. The main current areas of activity on suicide prevention are detailed below: **Awareness raising and community capacity building** A programme of events was held during Suicide Prevention Awareness Week (SPAW) (September 2012) across Borders which attracted over 100 people in all. The programme also included a series on Radio Borders giving information about sources of help available. Planning for this years SPAW is currently underway with a focus on raising awareness among the farming community. safeTALK training has been used as a means of ongoing awareness raising with local groups and organizations. **Support to vulnerable groups** The piloting of the Match Fit programme for men with low mood has been completed, the professionals pack has been produced and a men's health event will be held in June 2013 which will be followed by train the trainers events to build capacity for other organizations to deliver the material. Psychological services are supporting the delivery of this. The suicide prevention team has offered advice and support for those bereaved by suicide and works closely with Survivors of Bereavement by Suicide. Two mental health awareness sessions were also held for young carers over summer 2012. **Service and workforce development** The programme of training and skills development for frontline staff and community leaders is on-going. From April 2012 to March 2013 the following courses were delivered: • ASIST training: 5 courses delivered to 95 participants • STORM training:2 courses delivered, 1 in community mental health and 1 for CAMHS A pilot has been established in one high school to evaluate *That's Not Me* , an education pack developed for schools and partners working with young people to prevent suicide and to improve mental health and wellbeing. Subject to the results of the pilot, the pack will then be rolled out to other schools and youth settings. A discharge support project has been designed with mental health service users and providers. This offers practical resources and buddying support for people discharged from mental health services. **Organisational support** Planning has begun on a workplace initiative in SBC to facilitate access to support and advice to reduce workplace stress and support people at risk of poor mental health / suicide. This will be supported by organisational policies and procedures and management practices. The initiative is being undertaken in partnership with SBC HR, trade unions and the suicide prevention team. A similar initiative is also underway within NHS Borders. The aim that both organizations will sign the See Me pledge and show their commitment to reducing stigma around mental ill health.

	Challenges There is limited capacity in the suicide prevention specialists within the Joint Health Improvement Team to work on this wide ranging agenda. The national strategy for suicide prevention in Scotland, *Choose Life*, is in place to 2013. The Scottish Government is reviewing the next stage of the strategy, in which self harm will be one of the areas of priority. This will pose challenges locally. There are already indications that economic pressures arising from the recession and from welfare benefit reforms are creating significant stressors within local communities, with added risks of suicide. **How addressing** Close working with partners continues, to build capacity for suicide prevention across communities and within public services. The review and updating of the local action plan will have stakeholder input and will aim to reflect national priorities as appropriate for Scottish Borders. Links are being established with agencies that provide advice, support and training on financial issues and on employability. **Next steps** The local action plan will be updated in June 2013 in light of local consultation and pending new national strategy.
Completion rates for child healthy weight intervention programme	**Progress and achievements** The schools Fit4fun programme continues to be delivered in primary schools. Two further schools will have completed the programme between April and Dec 2012. The whole school approach continues to achieve high levels of engagement. The Q2 target completion rate was 25 children; 36 programme completions have been achieved. There is a time lag in processing data, but we are confident that the programme remains on target. The evaluation of the programme in 2011/ 12 was very positive. Findings have been used to refine programme delivery. Additional developments have been made to provide follow up physical activity programmes in participating schools. **Progress 2012 – 13** Fit4 fun was delivered in four primary schools during this period. The target number of programme completions was attained. Feedback from children and the schools participating has been very positive. Follow on activities and interventions with these schools have been planned for 13 -14 to reinforce the learning outcomes achieved, eg physical activity sessions; project work on snacks. **Challenges** Sustainability has been a continuing concern in view of: reliance on a small core delivery team; the short term nature of the intervention; and the multiple influences on child weight. Relevance hours made permanent. Short term additional capacity secured for food worker in schools, to enhance skill mix. Clearer pathways are required for children identified through Fit4fun as being obese. This has been clarified with Dietetics and School Health **Moving Ahead** With the active engagement of partners, work is being undertaken in a range of areas that will complement Fit4fun. This includes: extending the focus of the child healthy weight programme into early year's settings; updating guidance / resources for education settings on pack lunches and snacks; reviewing the healthy eating

	options for secondary school pupils. The capacity of the core delivery team is being boosted by working in partnership. Pathways to 1:1 support from Dietetics are being piloted for obese children who take part in Fit4fun. **Next steps** • Further delivery of Fit4fun in nursery settings for 2013 and closer integration with Maternal and Infant Nutrition programme • Extension of Fit4fun programme to support transition in to secondary school • Initiative to engage with young people through Youthchex grant programme Engagement with Education and Lifelong Learning on nutrition in schools / during lunch times in line with national legislation and guidance.
60% of 3 & 4 year olds to have fluoride varnishing twice a year	As of July 2012 , the HEAT target H9 is reported using a new method. All previously reported results based on the old method will remain unchanged, i.e. they will not be recalculated using the new method. The new method no longer has the fixed start date of 1st April 2010; rather, it looks at data spanning 12 months at a time. This first new iteration therefore spans the 12-month period from 1st April 2011 to 31st March 2012. Future iterations will increment forward by 3 months, so the start date used for the next iteration will be 1st January 2012. Each cohort will include all children aged 3 or aged 4 at the start point. The children's ages may change from 3 to 4 and from 4 to 5 during the 12-month study period. The cohort of children stays the same during the 12-month period, i.e. the same children are followed throughout 12 months; however, the cohort changes for each new 12-month period, as different children will be aged 3 and 4 at the next start point. For HEAT H9 reporting, only children who have had 2 or more fluoride varnish applications (FVAs) during the 12-month study period are considered. A child may be: • aged 3 at the time of a FVA and aged 3 at the time of their next FVA; or • aged 3 at the time of a FVA and aged 4 at the time of their next FVA; or • aged 4 at the time of a FVA and aged 4 at the time of their next FVA; or • aged 4 at the time of a FVA and aged 5 at the time of their next FVA SIMD quintile values are such that 1 = most deprived and 5 = least deprived. They are derived from the child's home address within the NHS board and CHP. **NHS Borders** There has improvement from 7.66% at the end of Sept 2012 to 11.20% at the end of Dec 2012. Most quintiles are showing a marked improvement apart from SIMD 4 . In the area of highest deprivation SIMD1 where NHS dental services deliver targeted services the figure *55.87% of children receiving 2 fluoride varnishes within one year has been achieved* **Benchmarking** National data indicates that although slightly below trajectory NHS Borders continues to benchmark well with it's statistical neighbours. **Summary** The oral health improvement team continue to support both the Independent General Dental Practitioners (GDP's) and the NHS Borders Salaried General Dental Practitioners to promote the use of fluoride varnishing , good oral hygiene and dietary

	advice in line with Childsmile practice. Since the introduction of payments for the GDP's last October 2012 there is a marked increase in the numbers of dentists now applying the varnish, which will support the NHS Borders Board in going some way to achieving the target.
80% of pregnant women in each SIMD will have booked for antenatal care by 12th week of gestation	**Progress and achievements** Barriers to early access – particularly in relation to women in known high-risk groups – are addressed through the Early Years Assessment Team, which has extensive networks and links with community services and resources to support women who may be at risk. Clear pathways are in place between maternity services and alcohol and drugs services and mental health services. As part of developing work on the new antenatal education programme, links are being established with community services and organisations who are likely to be in contact with high risk groups of women. This will be aided by the establishment of Early Years locality networks. these networks are now in place and are proving a valuable means to improve information sharing and co-ordination of activity within localities. the development of an integrated locality model for the delivery of early years services is being taken forward by partners Early access to antenatal care is being promoted in local communities, with the tailoring of information for high risk groups. The Healthy Living Network, with input from Health Improvement specialist on Maternal and infant Nutrition, run regular Bump to Baby events within local communities for expectant and new mothers and professionals. Feedback indicates these are useful sources of information, advice and signposting. Maternal and infant nutrition work is being focused on areas of high deprivation and works closely with EYAT and Family Centres. We are currently creating additional capacity though Community Food worker posts to support this work. Now in place The development and deployment of volunteer breastfeeding supporters is an additional resource that will be used to provide direct support women with breastfeeding and also to raise awareness with local communities. This support is now offered to all new mothers and a second cohort of volunteers are in training . Service improvement and workforce development are progressing on several fronts: • An action plan for NHS Borders to monitor the impact of welfare benefit reform on population health and on health care needs has been developed by Public Health & Planning and Performance. This includes actions to ensure front line staff are aware of impacts of reforms on key groups including expectant and new parents and of the advice, information and supports available. • The Smoking Cessation Service is working with Maternity services to improve CO monitoring and uptake of support among pregnant women who smoke. • The Alcohol and Drugs Partnership review of investment has engaged with Early Years Services and made recommendations for improvements in links between services • The CEL 41 Gender Based Violence Programme will complete training with midwifery staff by end 13 • The Pathways project, a new integrated domestic abuse programme, is now in place • Options are being considered to offer weight management support / signposting in the postnatal period

	Challenges Due to data availability limitations, it is difficult to gain an accurate picture of the characteristics of those who do not access antenatal care within the target time scale. The absence of an electronic maternity information system is a significant problem, this continues to be a pressing issue. No recurring funding has been identified for one of the two midwife posts within the Early Years Assessment Team beyond March 2014. **How addressing** A proposal for the development of a maternity information system has been developed, but funding has yet to be secured. **Next steps** Further development of areas of work as above to: • Improve data on access and on vulnerability and risk • Targeted work with key vulnerable groups through the antenatal education programme in community as part of the Early Years Collaborative Workstream 1 • Securing capacity within the EYAT to work with vulnerable families • Workforce development
Efficiency	
Boards to operate within agreed revenue resource limit, capital resource limit and meet cash requirement	NHS Borders remains on course to achieve all its financial targets. Progress is detailed in the regular finance report to the Board.
Reduction in energy based carbon emissions and energy consumption	NHS Borders has been monitoring its utility energy consumption, emissions and costs in excess of 15 years and reports this information on an annual basis to Health Facilities Scotland for inclusion in the NHS Scotland Annual Environmental Report. The information is also used to monitor compliance with HEAT targets which are reported by HFS quarterly. The latest available figures, from Q3 in 2012/13 compared with a 2009/10 base date, indicate that NHS B has exceeded the energy efficiency target by 1.54 % and under achieved the CO2 target by 1.64%. The phased introduction of biomass boilers in 2013 continuing into 2014 will ensure a reduction in emissions and compliance with the target. **Please Note:** There is a time lag for reporting therefore Q3 is the most up to date information available.
Treatment	
Increase proportion of 1st stage breast, colorectal and lung diagnosis by 25%	The HEAT target is due for delivery by 2015. The target is to achieve a 25% increase in the percentage of cancer (breast, lung and colorectal) cases diagnosed while in the first stages of the disease. The 25% increase is from the baseline year of 2010/11 NHS Boards have recently received their baseline staging data from ISD, and this data (sourced from cancer audit data) will form part of an official statistics publication

	by ISD on the 28th May, Boards will then be updated by SG on what this means for LDP's For NHS Borders, to deliver the HEAT target we have to detect **20** additional stage 1 cancers by 2015. The HEAT target is based on Board of Residence, rather than Board of Diagnosis. This is relevant for us in terms of local monitoring of the target, as Breast Screening patients who have their diagnosis and treatment in NHS Lothian are not part of our local audit database. We are currently awaiting feedback from ISD on the audit data we submitted for Q1, Q2 and Q3 of 2012, this will allow us to assess progress towards the target. Due to the retrospective nature of the audit data, and also the small numbers involved it is not possible to monitor progress against this HEAT target on a monthly basis. However, like other Boards, we are monitoring the impact of the social marketing campaigns already held for Breast (September 2012) and Bowel (February 2013) via changes in number of referrals to breast clinic and participation in the bowel screening programme. It is too early to assess what impact this is having on early diagnosis

4. UPDATE ON CONTRIBUTIONS TO SINGLE OUTCOME AGREEMENT

Critical issue: Health inequalities and early years

NHS Borders continues to work closely with Scottish Borders Council and other partners to take forward the joint Early Years Strategy for Scottish Borders. The local Early Years Change Fund in NHS supports agreed priorities within this joint strategy in relation to oral health, child healthy weight and maternal and infant nutrition.

With partners and through the Strategic Early Years Group, progress continues in establishing Early Years Networks in each locality across Borders. The Networks are chaired and co-ordinated by community nurse managers. Considerable work has been undertaking on workforce development in the NHS, particularly in relation to GIRFEC and to maternal and infant nutrition through the UNICEF BFI programme. Stage 2 accreditation for both community services and the maternity unit was confirmed in April 2013. NHS Borders, through the Joint Health Improvement Team, has also been able to pilot and establish a volunteer breastfeeding peer support project to support new mothers.

Work continues to ensure that services are working to revised guidelines for Children Affected by Parental Substance Misuse (CAPSM) guidelines, under the oversight of the Borders Alcohol and Drugs Partnership and Child Protection Committee. The recommendations arising form the recent ADP investment review include recommendations relating to early years, specifically to improve the linkages between adult services and early years services. Early stages of local engagement with the national Early Years Collaborative indicate that this will be an important focus for improvement work.

Tackling domestic violence continues as part of the wider Violence against Women Partnership and specifically through CEL 41 and the NHS is a partner in the Pathways project that is now operational, providing an integrated service to support women and families who experience domestic violence.

NHS Borders is a member of the Strategic Anti Poverty Partnership and in the work of the Community Planning Partnership to manage the impacts of the welfare benefit reforms. An action plan has been developed for NHS Borders, with an initial focus on awareness raising and on the identification of staff training needs. At community level, the work of the Early Years Assessment Team, which includes NHS staff, and the Healthy Living Network offer support to families affected by health inequalities. Work has recently begun to extend and adapt formal antenatal parenting education classes to ensure that community services, who are in contact with pregnant women, are able to support and signpost effectively. A need has been identified to focus in particular on mental health and well being and on access to money advice for expectant and new parents.

5. CORPORATE OBJECTIVES

Below is an update on selected actions progressed during 2012/13 which are outlined in the Corporate Objectives.

Corporate Objective	Action to Be Delivered	Progress to Date
Patient Safety	Patient Safety Combined Walkrounds	In November 2012, testing commenced with the amalgamation of the HEI/ OPAH and SPSP walkrounds in NHS Borders and the agreed format was agreed by the BET in February. Each member of BET is asked to lead one walkround per month accompanied by Clinical Governance and Quality team members/ Infection Control team members or OPAH team members, a Senior Charge Nurse from another clinical area and a BGH General Manager representative. Each area, including mental health units and community hospitals will be scheduled for a walkround twice per year. Non-Executives Directors are now invited to attend walkrounds.
	Improve Hospital Standardised Mortality Ratio (HSMR)	Despite ongoing debate internationally about how HSMR is constructed and used, several countries use HSMR as a tool to help monitor hospital mortality and identify opportunities for improving patient care. The overall aim of the Scottish Patient Safety Programme has been to reduce HSMR by 15% by the end of 2012, and this has recently been extended to 20% by the end of 2015. HSMR data includes all deaths within 30 days of admission to hospital including deaths within a hospital and those outwith a hospital. HSMR is a measurement tool which take crude mortality data and adjusts it to account for factors known to affect the underlying risk of death i.e. age, gender, primary diagnosis, type and route of admission, number and severity of morbidities (this makes the calculation difficult to replicate locally). NHS Borders have therefore asked ISD to provide data on HSMR on a monthly basis. There are a number of factors which influence HSMR values these can include: random variation in the number of observed deaths particularly in smaller hospitals, data quality including variations in completeness and accuracy of recording of data from patient records, particularly misattribution and coding of main diagnosis; and the level of palliative care and terminal care support services in the community for the local population. ISD recommend that to oversee HSMR in NHS Boards data should be regularly reviewed and that a systematic approach should be developed to review deaths. NHS Borders now review every death occurring in the BGH monthly under the direction of the Associate Medical Director for Clinical Governance. The mortality

		reviews use a 3x 2 matrix to ascertain episodes of 'harm' and 'error', and thus creates learning opportunities. The HSMR data is reported quarterly by ISD, and NHS Borders continues to show variation, since March 2012 variation in HSMR has been noted but no trend is yet evident up to December 2012.
	Ensuring alignment of the Clinical Quality Indicators (CQIs) with the Leading Better Care (LBC) Initiative	Scottish Executive Nurse Directors are promoting a zero tolerance to avoidable hospital acquired Pressure Ulcers. From November 2012, Boards will stop reporting CQI process outcomes for PAC and start to report the rate of pressure ulcers. Local improvement activity has had seen a positive shift in the rate from 1.2 to 0.3 per 1,000 bed days. Borders are currently awaiting a national Falls improvement bundle to align local improvement activity and reduce incidents of harm. Future reporting will include number of Falls with Harm and the Falls Rate per 1,000 bed days. National CQIs for community are currently being tested. A robust implementation plan incorporating development for all appropriate LBC Team Leaders will be developed when the indicators are released. Early testing is currently underway in the BGH with the Scottish Patient Safety Indicator (SPSI) which plans to align the work around falls, pressure ulcers, hospital acquired infection rates and cardiac arrests. This indicator is for acute care only.
	Specific progress under each of the work streams	<u>ACUTE</u> Leadership, Medicines Management, General Ward, Peri operative and Critical Care have all been in place since 2008 in NHS Borders. Locally, the focus is now on spread of all the key process measures within each of the workstreams beyond the pilot populations. The aim is to achieve reliability in these process measures to see a change in the outcome measures. <u>Maternity Care Quality Improvement Collaborative (MCQIC)</u> Paediatrics, maternity and neonates have been brought together under one collaborative. The paediatrics and neonatal workstream mirrors the adult workstream with focus on early warning scores and Peripheral vascular catheter maintenance bundles. Maternity launched in March 2012 ans currently collecting baseline data. <u>SEPSIS and VTE</u> Testing continues in ward 7 for sepsis, and ward 16 for VTE. National outcome measures are awaited. <u>MENTAL HEALTH</u> NHS Borders continues to be a pilot site for the mental health programme, focusing on risk assessment in The Brigs, and medicines management in

		Huntlyburn. PRIMARY CARE Patient Safety in Primary Care was launched in March 2013, and the initial Board planning session is scheduled for 22 May 2013. GP's will be asked to focus on the global trigger tool, the safety climate, and warfarin bundle.
	Delayed Discharges	In October 2011, two new HEAT Targets were announced by the Scottish Government. These states that by April 2013, no patient should wait more than four weeks from when they are clinically ready for discharge and subsequently by April 2015 no patient should wait more then two weeks until discharge. There has been good progress made in relation to understanding and jointly managing delayed discharges by NHS Borders and Scottish Borders Council over the last two years: • The number of occupied bed days attributed to discharges has reduced significantly. • The HEAT 6 and 4 weeks Targets of zero total delayed discharges achieved. • A reduction in the total number of complex cases delayed discharges and associated mean length of stay. As at April 2013 the partnership reported the continuing achievement of the what is now a four week HEAT Standard and performance ahead of trajectory in respect of the target number of delayed discharges over two weeks. Looking forward to 2015 there is a requirement to revise and implement a Joint Discharge and Transfer Policy to reflect the means by which the new target will be delivered. In addition Primary and Community Services will direct considerable improvement focus upon community hospitals promoting a number of interventions consistent with the Clinical Advisory Board Guidance on "Next Generation Capacity Management".
Health Improvement	Developing a Health Protection Plan in collaboration with SBC	Plan was due to be updated last year but delayed due to national review of Joint Health Protection Plans by Heath Protection Scotland published last year. Draft plan has now been produced and currently out for consultation with key SBC and NHS Borders stakeholders. Aim is to take plan to SBC CMT and NHS Borders

		BET in near future.
	Achieving "Gold" status in relation to Healthy Working Lives	NHS Borders is committed to attaining a Gold Healthy Working Lives Award by March 2015 in line with CEL 2012(1) Health Promoting Health Service: Action In Hospital Settings. Silver Award support activity is currently being maintained, with all relevant evidence being placed in an award portfolio. NHS Borders wide Healthy Working Lives Award Working Group including representatives from Staff Side, Occupational Health, Health & Safety Service and interested departments meets bi-monthly. Reports on the activity of this group are received by the Staff Governance committee via the OH&S Forum. Agenda, minutes and action tracker are evidence of activity towards Gold Award.
	Continuing to implement the Child Health and Child & Young People Mental Health Strategy and Workplan	**<u>Getting it Right for Every Child</u>** *Detail in multiagency GIRFEC work plan but highlights:* • There has been further consolidation of the Integrated Assessment Framework process including a pilot to assess revision and simplification of paperwork for clinicians and practioners .The threshold matrix tool 'Keeping Children Safe'. is now being used routinely by the staff at the Child Protection unit to inform interagency discussions about threshold around Child Protection referrals.. • The Scottish Government has continued to make funding available to support the regional approach to the development of resources to support GIRFEC .This group has produced an e learning resource to support the implementation of the named person role and advice for clinicians around chronologies. . **<u>Child Protection</u>** *Detail in NHS Borders Child Protection action plan but highlights:* • Two workshops were delivered in June 2012 and attended by 60 health staff from different disciplines. The workshops provided information about using policies to support practice, making a child protection referral and what to do if you have concerns about a child and the issue is not child protection. GP TIME session delivered in February 2012 • E-learning module for 'Child Protection Basic Knowledge and Understanding now available on Learn Pro • Quarterly Child Protection Update newsletter across all NHS Borders and GP's • Implementation of multiagency 'Underage Sexual Activity Policy' and

		internet resource **<u>Corporate Parenting</u>** *Detail in NHS Borders CEL 16 Action plan but highlights:* • The CEL 16 Steering group continues to progress the actions required to support the health needs of all Looked after Children(LAC) in the Scottish Borders which are detailed in the CEL 16 action plan. • All LAC population are seen by GP in first 48hrs of being accommodated • All under12's LAC are now seen by LAC paediatrician/doctor and all over 12's by LAC nurse for LAC Health assessment within 6 weeks of being accommodated. • Regular LAC /Child Protection drop ins now established across all five localities to provide further support and advice to clinicians **<u>SEAT Children and Young Peoples Planning Group</u>** *Detail in SEAT CYPHPG work plan but highlights:* • Continued monitoring of National Delivery Plan (NDP) for Specialist Children's Services through bi annual exception reporting • Continual development and monitoring of regional approach to support the work of the MCN Child Sexual Abuse **<u>Links with CAMHS</u>** • Two Value Stream Mapping events were held recently as part of the ICP development. This piece of work was looking at the development of systems to effectively manage referrals to Specialist CAMHS. This work involved stakeholders from Education, ICS, Social Work, CAMHS and a GP. • The Service is now taking young people up to aged 18 years as of 1st January 2013. The Service is still meeting the WTTT target of 26 weeks. This will be reducing to 18 weeks as of December 2013 and will require close monitoring to ensure we continue to achieve this target. Work is also underway to look at DCAQ supported by QUEST funding. • Tier 4 services continue to work well and this is monitored on an ongoing basis by the SEAT consortium. • The role of the Community Mental Health Workers has been reviewed over the last year. These posts are funded by the CYPPP and have been further embedded into ICS.
	Breastfeeding Initiative	Rachael Marples appointed in Dec 2011 to lead the implementation of this Global

		Infant Feeding Programme. The Standards: Ten Steps to Successful Breastfeeding and the Seven Point Plan for Sustaining Breastfeeding in the community reflect an evidence base which delivers best outcomes for mothers and babies. The programme follows a staged approach, with external Unicef assessors carrying out inspections at each stage, a pass allowing progression to the next stage. NHS Borders has quickly moved up through the initial stages. (Implementation visit Dec 11, Cert. of Commitment Feb 12, Stage One April 12) Throughout 2012/13 an intensive training programme has been underway, ensuring all professionals who have contact with pregnant women and new mothers and their families have had appropriate training in educating and supporting women with regard to their feeding choice. Following this, NHS Borders was successful in passing Stage 2 in April 2013. We are following a trajectory of implementation as dictated by our Chief Executive. We are currently aiming to apply for assessment of Stage 3 to take place in Dec 2013. this will see NHS Borders achieving full accreditation in two years as opposed to the five recommended by Unicef. Our breastfeeding rates are been following an upward trajectory since 2011. Annual figures for 2011/12 revealed and exclusive breastfeeding rate at the 6-8 wk point of 32.4% (up from 29.3% 2010/11). This put us second in Scotland overall compared with the other mainland Boards (up from 4th, now behind Lothian). Quarterly figures from 2012/13 show a continuing upward trend and we should have confidence that this year we will meet the Government Standard of 33.3%. The BFI work involves improving and changing work carried out in schools, nurseries, targeting populations, addressing inequalities, introducing sustainable support groups, peer support programmes, changing policy, practice and culture. A team of key workers (indigenous NHS Borders Staff) in all areas, both community and hospital, assist with the lead, completing tasks in addition to their current roles in order to achieve speedy implementation of this project.
Performance & Delivery	Delivering an appropriate Hospital at Night Service for Paediatrics to support sustainability of service provision	Out of hours Paediatric and Neonatal Hospital at Night service is now being delivered by Advanced Paediatric and Advanced Neonatal Nurse Practitioners (APNP & ANNP) on site as first responders to emergencies, with off site Consultant Paediatricians within a 20 minute recall distance. Recruitment difficulties have impacted on the unit's ability to fully provide emergency care out of hours overnight and at weekends without junior doctor cover. In addition, there is a gap in the 17.00-21.00 period which was not included

		at the start of this project. This has been covered previously by junior doctors in training and it was not clear at that time that this period was not an appropriate training opportunity for junior doctors. Work has begun to address this period in the first instance, and to outline the requirements for a full 24 hour service which is not reliant on doctors in training. Successful internal and external appointments have been made to APNP posts. Recruitment to ANNP posts has been a particular challenge. The inability to recruit externally has made the service reliant on the up-skilling of existing staff which has impacted on the timescales for delivery. It is anticipated that a full ANNP service will be in place by October 2014. There has been a smooth transition from junior doctor cover to ANP cover and robust measures are in place to evidence the development and training which the ANP's have undertaken and which has given them the knowledge and skills to carry out their advanced roles.
Structures & Processes	Statutory & Mandatory Training Plans	In Year 2, 2012-2013, The Statutory and Mandatory training subgroup of the Area Partnership Forum continued to meet on a regular basis to review, monitor and to identify ways to be more responsive to service requirements. In order to ensure that the group created sufficient statutory and mandatory training capacity for 2013/2014, an Organisational training needs analysis (TNA) was undertaken on survey monkey. This management responsibility for full support was required in order to ensure that the NHS Borders statutory and mandatory training requirements were identified & accounted for to ensure high quality, sustainable and safe patient care. The information from the Organisational TNA has been used to inform the number of training spaces required for each course over the year 2013/2014 to ensure training providers are reacting to manager's needs and requirements. The Clinical Executive Operational Group was updated in February 2013 with the progress of the Statutory and Mandatory training group and approved the suggested approaches to 2013/2014 Statutory and Mandatory training as follows The Statutory and Mandatory training group will ensure that • Statutory and Mandatory training will be organised and 2013-2014 training dates will be advertised in response to the numbers indicated on the Organisational TNA with the expectation that Managers will fill the places. • Reporting mechanisms will be refined bringing together **all** providers of

		Statutory and Mandatory training via the eESS training Sub Group to inform Clinical Boards & Support Services of attendances, DNA's and non-completions. • The TNA and reporting mechanisms will be improved using the lessons learned from this first Organisational TNA and will then be completed on an annual basis to inform the places required for the following year. The Organisation has agreed that • Each Line Manager will have an objective, as part of the annual appraisal cycle, outlining their responsibility for the organisation and the support of Statutory and Mandatory training of their staff. • Clinical Boards and Support Services will be held responsible for Statutory and Mandatory training of their staff as part of Performance Reviews.
	Management of Significant Adverse Events (SAE) Improvement Plan	Work is progressing against the plan led by Clinical Governance and Quality and Risk, Health and Saftey Teams through an Implementation Group which is meeting weekly with membership including Clinical Boards and Support Services. **Completed Actions** • Central Database for all SAE to provide assurance all Significant Events are investigated appropriately. • Create centralised Improvement Plan Tracker where evidence of completion of actions can be documented and assured. • Amalgamate Borders General Clinical Governance & Risk Management Groups to streamline reporting • Ensure there are explicit links with clinical risk management and local Scottish Patient Safety Programme • Incident Management Micro site is available on the Intranet • Integrated Incident Management Policy was approved Jan 2013 and published • TNA completed re use of Datix and management actions. Proposed training programme developed and being presented to CE- Ops Group. • Critical Incident Review Process within Mental Health has been reviewed to ensure aligned with NHS Borders Incident Management Policy • e-learning module for incident reporters now contained within Learn Pro. • All Significant Adverse Events from January 2011sent to HIS have a completed Investigate/review • Training for conducting an SAER has been organised for June & July 2013 specifically for SAER Chairs and SAER- Reviewers. • The implementation of Clinical Governance structures for Clinical services

		outwith a Clinical Board to ensure monitoring, learning, improvement and assurance has been completed.. **Actions In Progress** • Incident Management Protocol is in draft but will be finalized once the July review of the Incident Management Policy is completed. • Healthcare Governance Strategy is being developed which will include Risk Management Strategy • Develop and implement an investigation pack to enable standardisation of investigations across the Board, currently in draft to be issued after Incident Management Policy Review in July 2013 and following training for chairs and reviewers to be held in June/July. • Principles and guidelines to ensure integration and implementation with greater involvement of family/carer involvement and a clear person centred focus, values and approach. In draft within SOP. • Adapting learning and tools/approaches from other partnerships and Boards to ensure consistency with flexibility across different clinical areas- ongoing and included in draft documents. • Review systems and processes for learning from significant adverse events including learning from Complaints Investigations and SPSO/MWC Recommendations. To be included in protocol for conducting a review and the SOP. • Datix functions being reviewed and upgrade is now within test environment. • Learning and opportunities for improvement identified from reviews will be build into Reports across the Board to embed the learning and improvement from all incidents **Actions to be Delivered** • Benchmark performance on SAE handling with similar organisations Include a performance objective for learning from SAE & Complaints for all managers
	Increased Integration and Partnership Working	Integrated Working has been progressing at all levels. Strategically, the CHCP has supported the establishment of the post of Programme Director for Integration. This joint post will report to the Chief Executives of NHS Borders and Scottish Borders Council and will lead on establishing effective integration across alls sectors, including the establishment of the new Integrated Health and Social Care Partnership. Interviews are being planned for June. Work is underway to develop integrated budgets to meet the

		introduction of Integration in April 2014. The Joint Commissioning Strategy for Older People has been completed and is currently out for public engagement and review. It is planned for formal sign-off at the CHCP Board in June. The Strategy outlines a vision of delivering services that support older people as individuals to receive appropriate services when required whilst retaining control over how these are delivered. The Strategy sets out practical steps to achieve this and will form an important plank in the move to integration. The Older People's Change Fund is now focused on providing the support to deliver implementation of the Joint Commissioning Strategy in practice through projects testing innovative new ways of working. Services on the ground continue to develop into integrated models. The post of Joint Locality Manager for Cheviot has been approved and will be advertised in June. This post will be central to establishing an integrated health and social care team in the Cheviot locality, developing a model that will then be rolled out to other localities. Integrated community-based dementia services are now being established. The Change Fund is supporting a pilot project currently testing the provision of a single transport services for users of the SBC Day Centre and the NHS Day Hospital co-located in Haylodge Hospital. The transport is provided by SBC and has allowed the release of an ambulance to support acute discharges from the BGH. If successful this model will be rolled out to other localities, delivering significant efficiencies as well as providing more responsive transport services.