Borders NHS Board

MANAGING OUR PERFORMANCE MID YEAR REPORT 2016/17

Aim

The aim of the 2016/17 Managing Our Performance (MOP) Mid Year Report is to report progress for the first six months of 2016/17 on the full range of HEAT standards and other key priority areas for the organisation.

Background

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

A review was carried out at the end of 2015/16 to sense check, streamline and reduce duplication to ensure a more consistent and standardised approach, it was agreed that an end of year and this mid year Managing Our Performance report will continue to be produced and reported to the NHSS Borders Board. This report is in addition to the Performance Scorecards that are produced and discussed at the Board, Strategy & Performance Committee, Clinical Executive Operational Group and Clinical Board Performance Reviews.

This 2016/17 Mid Year Managing Our Performance report has been updated to show performance in relation to the HEAT standards, Single Outcome Agreement and Corporate Objectives. The Local Delivery Plan action updates and HEAT standard performance against NHS Scotland are new sections within this Managing Our Performance Report.

Summary

The 2016/17 Mid Year Managing Our Performance is an important part of the organisational performance management framework as it provides a mechanism to report progress across the full range of HEAT standards and key performance indicators, and summarise performance during 2016/17, along with a selection of priority areas and Corporate Objectives.

Recommendation

The Board is asked to **note** the 2016/17 Mid 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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NHS Borders

MANAGING OUR PERFORMANCE MID YEAR REPORT 2016/17

September 2016

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 and local targets set through the local delivery plan process.

At the end of 2015/16 there was a review of all the scorecards which has sense checked, streamlined and reduced duplication to ensure a more consistent and standardised approach. The review provided the opportunity to improve and streamline the reporting process and to present the Board with clear and relevant performance information and a focus on actions to address performance which is off track. The new Performance Scorecard combines elements of the HEAT Scorecard, Access to Treatment Report and the Integrated Performance Scorecard into one report which is presented to the Clinical Executive Operational Group, Strategy & Performance Committee and the Board. Monthly Clinical Board scorecards and quarterly performance reviews remain in place, as well as this 6 monthly Managing Our Performance Report.

2016/17 Mid Year MOP

This 2016/17 Mid Year MOP Report includes an assessment of performance in relation to the HEAT standards, contributions to the Single Outcome Agreement and Corporate Objectives. The final section of the report provides an update on the commitments made in the 2016/17 Local Delivery Plan. The report shows trends for each target which can be reported on monthly, along with narrative describing progress made this year. As in previous versions, an update is included on the full range of HEAT standards, including those which cannot be reported on a monthly basis and are therefore not included in the Performance Scorecard. A RAG status has been applied to those targets not reported on a monthly basis and is based on performance at the end of September 2016 (or latest available performance).

Summary

This report allows Board members to see the mid year position for 2016/17 and assess what action is required to achieve the full range of HEAT standards and local key performance indicators by the end of the financial 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 standards for the year which fit with the Government's health objectives. As a new addition to this report, a summary update on actions taken towards the commitments made in the Local Delivery Plan is included.

Monitoring of Performance

For each Clinical Board (Primary, Acute and Community Services, Mental Health and Learning Disability Service) a monthly Performance Scorecard is produced which includes an assessment of performance towards achievement of the HEAT standards along with a range of locally set key performance indicators (KPIs). Standards from these three Scorecards are compiled into one Performance Scorecard which combines elements of what was the HEAT Scorecard, Access to Treatment Report and the Integrated Performance Scorecard. The Performance Scorecard is presented to the Clinical Executive Operational Group, Strategy & Performance Committee and the Board to provide a consistent format and method of reporting. Some locally set stretch targets remain within the report for monitoring purposes however the RAG status is applied to the national standard, these targets include; Waiting Times Target for Diagnostics, Accident & Emergency 4 Hour Standard, CAMHS Waiting Times, Psychological Therapy Waiting Times and Drug & Alcohol Treatment Waiting Times.

In addition to this 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.

2016/17 HEAT Standards and Local Indicators

This 2016/17 Mid Year MOP Report summarises performance for HEAT standards and local indicators from April 2016 to September 2016 that can be reported monthly, a trend graph and narrative is included for these. For standards which are not reported on a monthly basis Lead Managers have provided narrative to indicate whether they are on track for delivery and if not, to highlight planned actions.

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 progress towards embedding the Corporate Objectives.

***Please note*:**

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

3. 2016/17 HEAT STANDARDS

Summary of Performance

Strong Performance – Green targets

The following targets are meeting or have exceeded their trajectories or standards at the end of September 2016 (or latest available data):

- Alcohol Brief Interventions (page 9)
- Smoking cessation (page 9)
- Pre Operative stay (page 12)
- Online triage of referrals (page 12)
- Exclusive breastfeeding rate at 6-8 weeks check, local data (page 13)
- Emergency Occupied Bed Days for the over 75s (page 13)
- 18 weeks referral to treatment: non-admitted pathway performance (page 17)
- 18 weeks referral to treatment: combined performance (page 17)
- Treatment within 62 days for urgent referrals of suspicion of cancer (page 19)
- Treatment within 31 days of decision to treat for all patients diagnosed with cancer (page 19)
- Admission to the Stroke Unit with 1 day of admission (page 20)
- No CAMHS waits over 18 weeks (page 22)

Performance at Risk – Amber targets

Performance against the following standards was outwith the trajectory at the end of September 2016 (or latest available data):

- Diagnosis of Dementia (page 8)
- Post Diagnostic Support (page 8)
- Sickness absence reduced (page 10)
- New patient DNA rate (page 11)
- Day case rates (page 11)
- 4 hour waiting target for A&E (page 20)

Under Performing – Red targets

Performance was significantly outwith target for the following HEAT standards at the end of September 2016 (or latest available data):

- eKSF annual reviews completed (page 14)
- PDPs complete on eKSF (page 14)
- 12 weeks for outpatients (page 15)
- 12 weeks for inpatients (page 15)
- 18 weeks RTT: admitted pathway performance (page 16)
- 6 weeks waiting target for diagnostics (page 18)
- No psychological therapy waits over 18 weeks (page 21)
- 90% of alcohol/drug referrals into treatment within 3 weeks (page 22)
- No delayed discharges over 2 weeks (page 23)

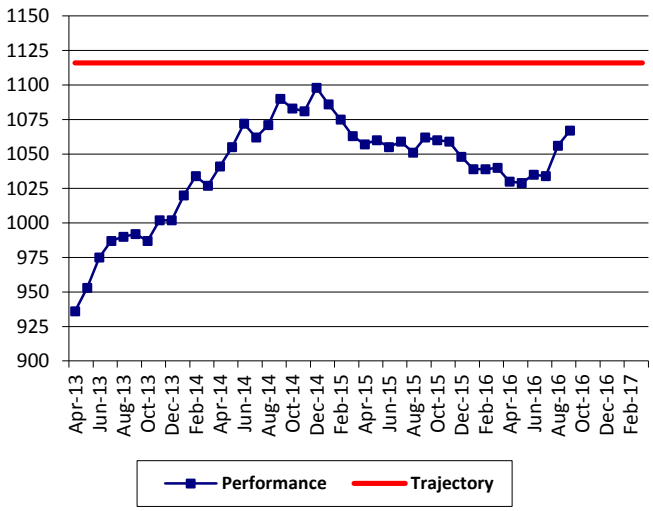
Further information on all the HEAT standards are detailed within the report and have been given a RAG (Red, Amber, Green) status based on the following key:

Current Performance Key			
R	Under Performing	Current performance is significantly outwith the trajectory set.	Exceeds the standard by 11% or greater
A	Slightly Below Trajectory	Current performance is moderately outwith the trajectory set.	Exceeds the standard by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory set	Matches or exceeds the standard.

Monthly Performance and Narrative of HEAT Standards

(*Please note time lag in data availability for some areas)*

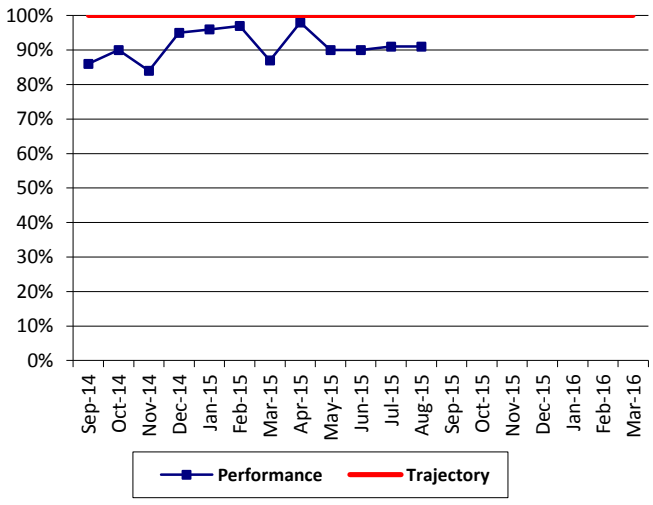
Standard: Diagnosis of Dementia	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	1116	1116	1067	A



The run chart shows the number of patients being added to the **Dementia Register** has increased over the last 2 months. This could be attributed to work being done with GP practices to ensure patients are being entered onto the dementia register. Work continues as described below to improve the position by March 2017.

- An exercise to review patients' dementia diagnosis recording on Epex is ongoing. This will be cross checked with the GP Dementia diagnosis database with those surgeries willing to participate.
- A pilot with Selkirk practice increased the number of diagnoses on the GP database (Selkirk area patients) by approximately 20%. It is anticipated that with this data validation exercise the target will be met.
- Practices have been identified to work with next - data is awaited from P&P to cross check ePEX against the register.

Standard: Dementia - Percentage offered at least 12 months of Post Diagnostic Support	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**August [1] 2015 Status**
	100%	100%	91%	A



Please Note: There is a 13 month time lag to show the full 12 months performance.

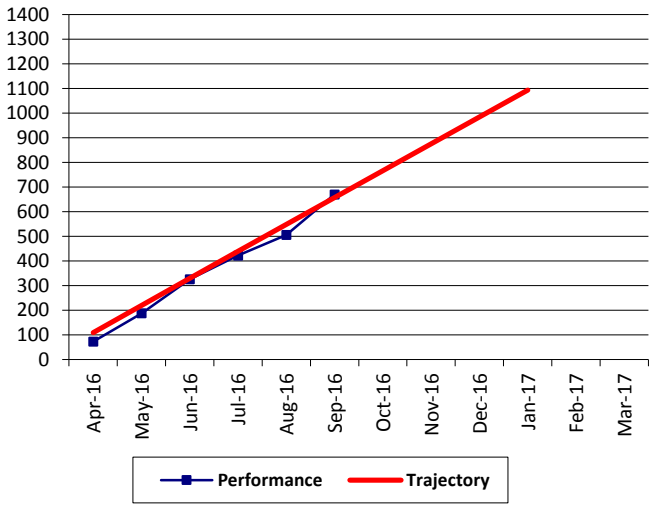
Performance for **Dementia Post-Diagnostic Support** (PDS) has been within the tolerance zone during the last 4 months. April 2015 (1 year lag time) reports the highest performance. Reporting of this standard commenced in September 2015 (September 2014 data), this was the first month the report was received nationally to enable local reporting.

The service is working towards the following actions to improve the position by March 2017.

- A short term working group is looking at improving delivery of PDS, this multi-disciplinary group has representation within the Focus on Dementia project, the lead body in supporting PDS processes.
- We have been accepted as a reporting pilot for data collection and will influence national data collection this work is being undertaken in partnership with ISD Data tool used July and August review in September.
- Post Diagnostic Support Excellence Programme has provided basis for further training for staff and informed action plan regarding further learning.

[1] The standard is that people newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support therefore August 2015 is the latest available data. There is a 13 month lag time to allow the full 1 year support to be report.

Standard: Alcohol Brief Interventions	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	1312	658	670	G



ABI delivery is on target for Quarter 2 although performance is lower than in previous years. Anecdotal feedback from GP colleagues suggests that previous good performance means patients within the practice have already been identified via ABI's and are followed up via appropriate conversations.

Ante-natal performance continues to be good following review of processes and delivery of training in February 2015/16.

Conversations are ongoing within A/E to increase number of referrals.

ABI delivery in wider settings continues via Police Custody Suites, Criminal Justice Social Work and Penumbra. Review of documentation in adult health and social care in progress.

Alcohol screening questions submitted for inclusion in updated BGH Unitary Records.

Standard: Smoking cessation successful quits in most deprived areas (cumulative)	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**March 2016[1] Status**
	173	118 (Mar 16)	128 (Mar 16)	G

Please Note: Data will be reported quarterly with a 6 month lag time to allow monitoring of the 12 week quit period.

The service successfully met the 2015/16 standard following a review of service delivery areas and reorganisation of staffing to address SIMD areas.

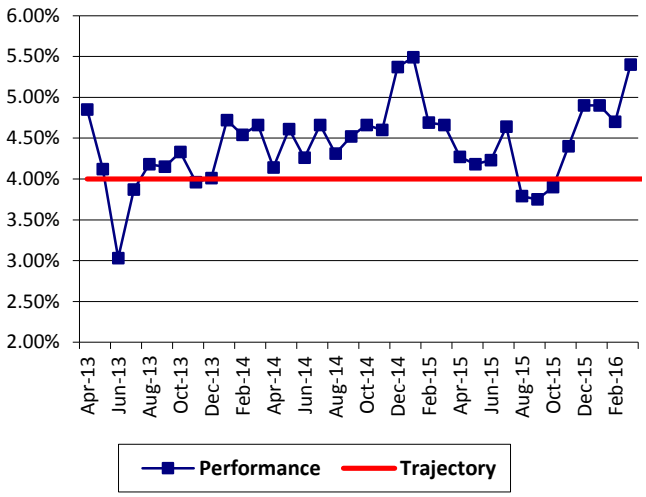
The standard for 2016/17 represents a 47% increase on the previous year. While data is not yet published for quarter 1 of 2016/17 (due to reporting lag) recent extracts confirm that performance is significantly lower than target (25 of 43 expected).

An advertising campaign on Radio Borders is in progress w/b 31/10/16 encouraging people to stop smoking for Christmas. This is supported with a press release and internal messages for staff. We will also take the opportunity to 'piggy back' messages about the new smoke free cars legislation though mid-November and early December.

Brief advice training for BGH staff has now reached over 100 colleagues and it is expected this will increase referrals to the service. Cessation advisors are building networks in the community and there is a new drop-in in Burnfoot Hub.

[1] There is a 6 month lag time for reporting to allow monitoring of the full 12 week quit period therefore latest available data is March 2016.

Standard: Maintain Sickness Absence Rates below 4%	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	4.0%	4.0%	4.2%	A



Cumulative sickness absence for year April 2015 – March 2016 is 4.36% - which is 0.80% lower than the NHS Scotland Average and is the lowest year end figure of the territorial boards and 0.35% lower than last year.

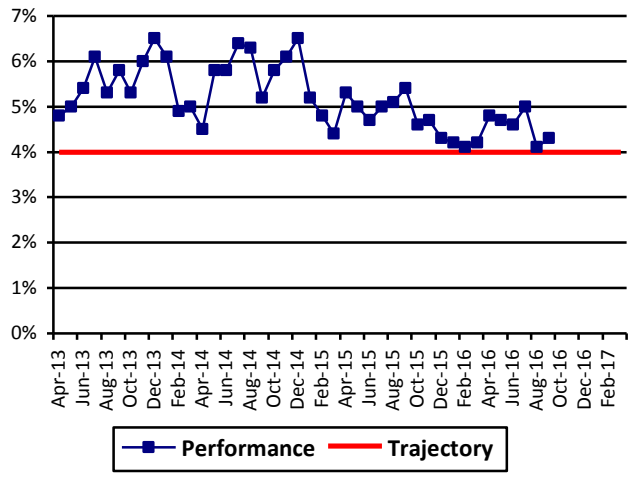
HR provide advice and support to managers to help manage sickness absence levels in line with the policy. HR are working together with Work and Well Being Services and line managers to manage long term sickness absence and have noted an increase number of ill health retirements/dismissals due to capability health reasons.

HR continue to be a support service to the clinical boards by providing HR advice and support in managing sickness absence, HR will recommend actions to be taken in line with the NHS Borders Sickness Absence Policy. HR also provide monthly sickness absence reports to each Clinical Board, these detail the level of short term and long term sickness absence levels in each department, provide the trends and the reasons for sickness absence. HR also proactively identify sickness absence "hot spots" and contact managers to enquire if any support is required in managing levels.

Managers are also required to complete a mandatory sickness absence e-learning module, attend a sickness absence training course and a refresher course.

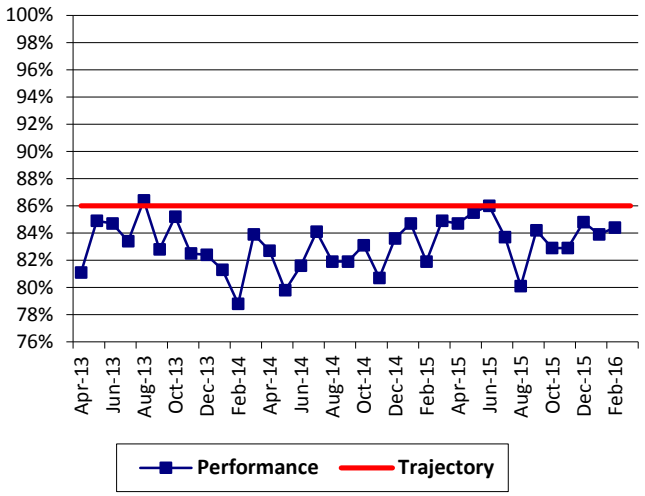
HR are continuing to work alongside Work and Wellbeing Services to provide advice and support to line managers to manage sickness absence levels. HR are continuing to revise sickness absence processes to ensure we are providing an efficient and supportive service to managers. Correspondence to managers indicating if employees are not meeting the expected level of attendance is being revised to indicate that action is recommended/required as well as reminding managers of actions that could / should be taken.

Standard: New patients DNA rate will be less than 4% over the year	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	4.0%	4.0%	4.3%	A



NHS Borders ran a media campaign on the impact of missed appointments in July / early August. This was a 6 week radio campaign, together with posters and inserts for patient letters highlighting the impact and cost of missed appointments. The continued reduction in the DNA rate suggests that this has been successful towards reducing the number of missed appointments.

Standard: 86% of patients for day procedures to be treated as Day Cases	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**July 2016** [1] **Status**
	86%	86%	82.3% (Jul 16)	A



Please Note: There is a 2 month lag time due to SMR reporting

In March 2016 the overall 86% HEAT standard for same day surgery (BADS procedures*) was achieved for the first time since June 2015 however this has not continued.

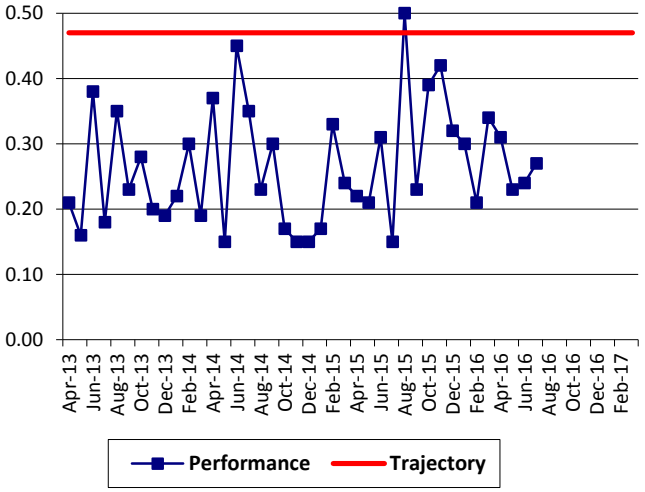
The main reasons for patients not being treated as a day case are:
- Anaesthetic or medical reasons
- Surgical reasons – e.g. bleeding, pain, unexpected problems during surgery, operation turned out to be more complex than anticipated
- Patient social status – no responsible adult at home or distance to travel

There is currently a redesign of theatres and surgical flow within the BGH which will enable repatriation and therefore should increase the number of day case procedures. The anticipated implementation of a new model will be in Winter 2016/17 subject to agreement of the new service model.

**British Association of Day Case Surgery*

[1] There is a 2 month time lag due to extracting the information from validated SMR1 data therefore latest available data is July 2016

Standard: Reduce the days for pre-operative stay	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**July 2016 [1] Status**
	0.47	0.47	0.27 (Jul 16)	G



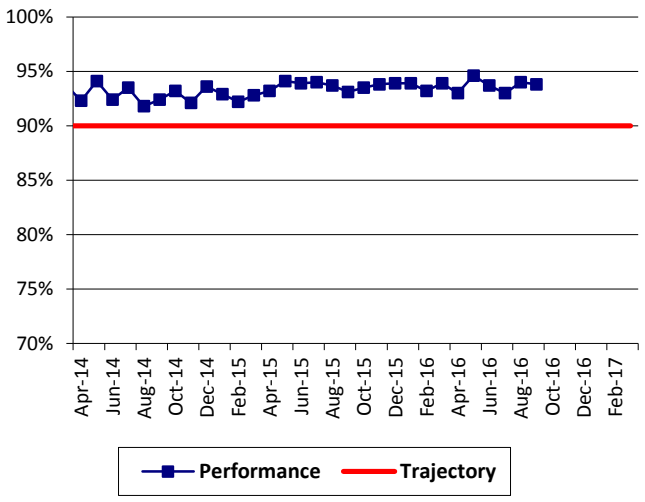
Please Note: There is a 2 month lag time due to SMR reporting

The run chart shows that pre-operative inpatient stays in hospital are generally low and within the trajectory set, with the exception of August 2015 when the rate increased. This is the only breach of standard recorded since April 2013 and performance has since returned to a normal position. The highest admissions the day before the patient's procedure are in orthopaedics.

Work has been carried out to reduce pre-admissions in orthopaedics through the theatres and surgical flow project - this change was implemented on 15th August 2016 and will therefore start to show in the August and September data.

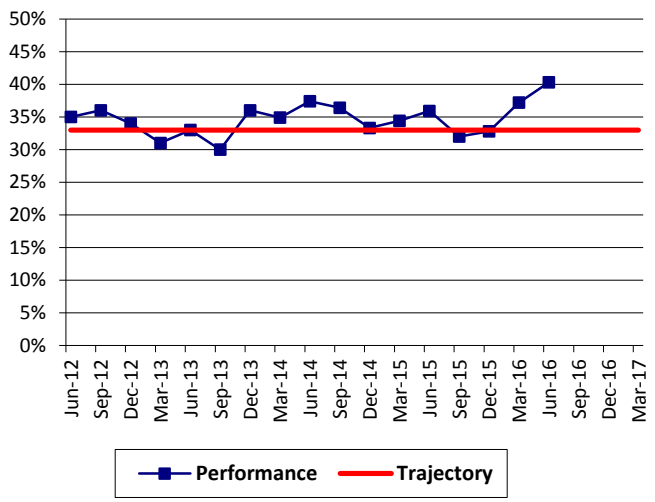
[1] There is a 2 month time lag due to extracting the information from validated SMR1 data therefore latest available data is July 2016

Standard: 90% of all referrals to be triaged online	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	90%	90%	93.8%	G



The run chart shows that overall the level of online eTriage of referrals continues to perform above the 90% standard and this is expected to continue.

Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**June 2016** [1] **Status**
	33%	33%	40.3% (Jun 16)	G



Please Note: There is a 3 month time lag as data is published quarterly for this target. Local data is used due to the extended time lag for national data.

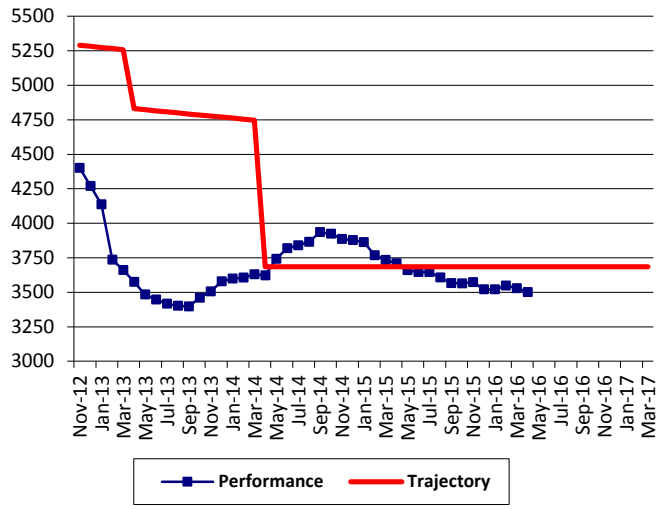
For the quarter April – June 2016 performance exceeded the 33% standard.

The services continue to work collaboratively with health improvement. All Maternity Staff and BFI key workers are actively working on ensuring babies get the best start in life, we have developed the following in 2016/17;

- Continuing to deliver training and updates to all staff.
- To maintain/continuing to improve performance we have increased the provision of peer supporters.
- Peer supporters working within Early Years Assessment team.
- Focus on improving breast feeding rates within Special Care Baby Unit.
- Skin to Skin initiated for all deliveries.

[1] There is a 6 month lag time for local data. It is reported quarterly and with a time lag to allow data collection at the 8 week review therefore latest available data is June 2016.

Standard: Reduce Emergency Occupied Bed Days for the over 75s	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**April 2016** [1] **Status**
	3685	3685	3501	G



Please note: There is a time lag in data being published for this target.

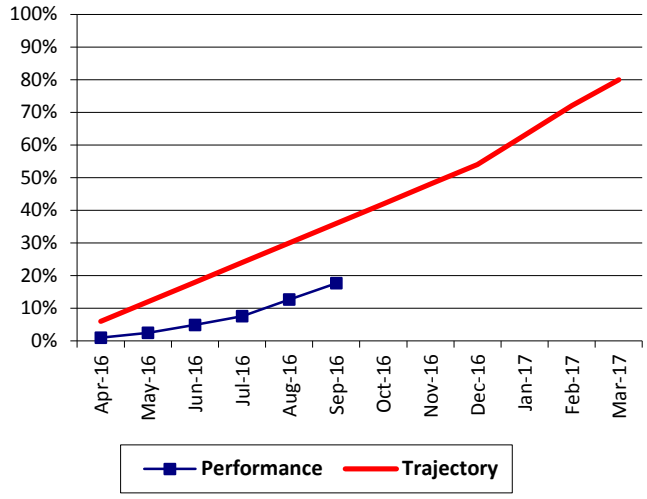
There has been good progress on delivery against this standard. We continue to work closely with partners in SBC to maintain progress and continue to improve.

Current actions include a strong focus on understanding and reducing delays for patients with a LoS of over 28 days. The Board Rounds in our Older People wards have also been reinvigorated with daily review and action to reduce delays.

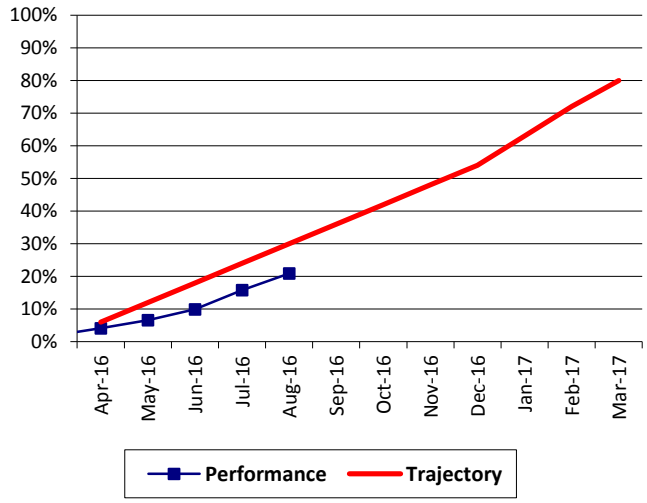
1 There is a 6 month lag time therefore latest available data is April 2016. Monthly, rolling year data shows the most recent available to an acceptable level of completeness (based on ISD's latest assessment of SMR record submissions and backlogs).

Standards:	2016/17 Standard	Current Standard	Mid Year Position	September 2016 Status
80% of all Joint Development Reviews to be recorded on eKSF	80%	36.0%	17.7%	R
80% of all Personal Development Plans to be recorded on eKSF	80%	36.0%	20.9%	R

Joint Development Reviews recorded on eKSF



Personal Development Plans recorded on eKSF



Overall NHS Borders is not meeting the trajectory. Reasons for this include a requirement to focus on clinical priorities preventing staff updating eKSF, therefore although quality conversations took place, and PDP's completed these haven't always been updated on eKSF.

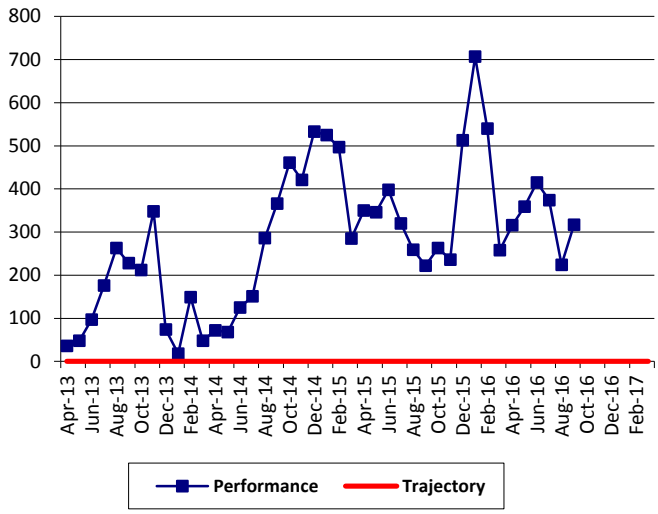
The KSF Champions continue to send out monthly reports that are measured against local trajectories. These reports are sent to Heads of Service/ Service Leads for cascading and further action. Performance against local trajectories is also monitored through Clinical Boards in their Performance Scorecards and Performance Reviews to ensure we continue to work towards the standard.

Training and 1:1 support continues to be available from KSF Champions.

The Employee Director is the Executive Lead and will support KSF Champions and reports back to the Board Executive Team on a regular basis.

Access to Treatment

Standard: 12 wks for Outpatients	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	0	0	317	R

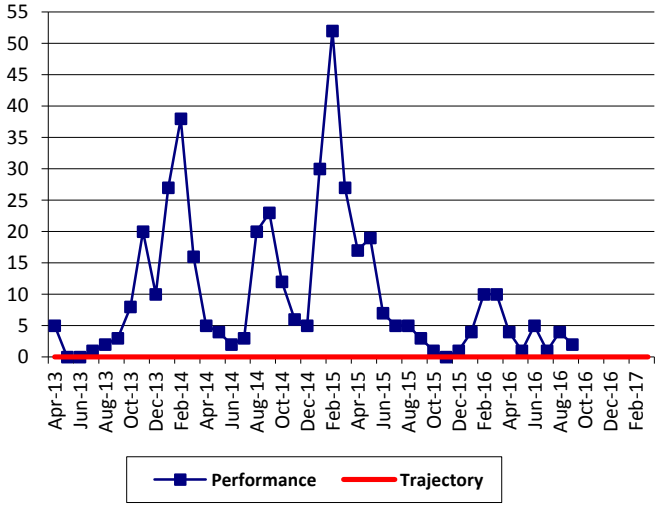


During the first 6 months of the year there have been challenges around some outpatient areas, and some success in others.

At present, the standard is not being met in Chronic Pain, Dermatology and Oral Surgery, and we are looking at options to improve in these areas.

During the last few months a significant volume of additional activity has taken place within ENT and Gastroenterology, which has seen considerable improvement in those areas.

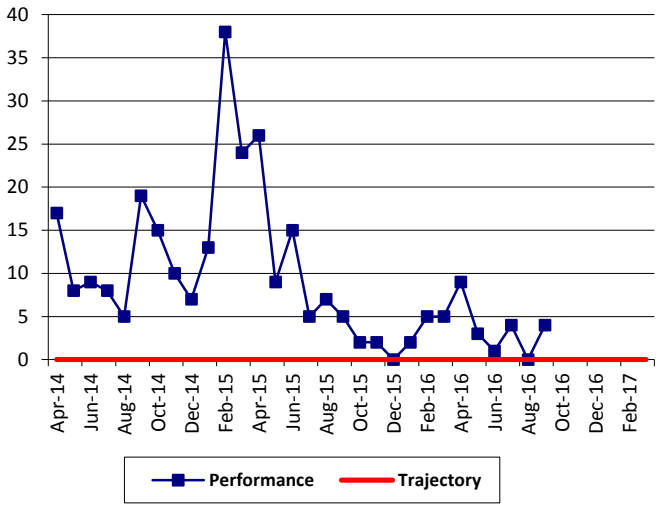
Standard: 12 wks for Inpatients	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	0	0	2	R



The 12 week standard for inpatient / day case treatment is largely being met, with the exception of short notice cancellations.

Weekend Orthopaedic operating, with support from Synaptik, has been very successful. However this ceased from August 2016, due to budgetary restrictions.

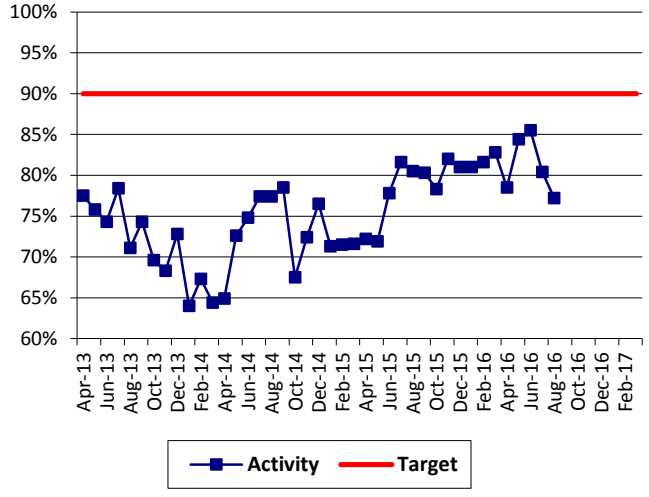
Standard: 12 Weeks Treatment Time Guarantee	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	0	0	4	R



The TTG standard for inpatient / day case treatment is largely being met, with the exception of short notice cancellations.

Weekend Orthopaedic operating, with support from Synaptik, has been very successful. However this ceased from August 2016, due to budgetary restrictions.

Standard: 18 Weeks Referral to Treatment Admitted Pathway Performance	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	90%	90%	77.2% (Aug 16)	R

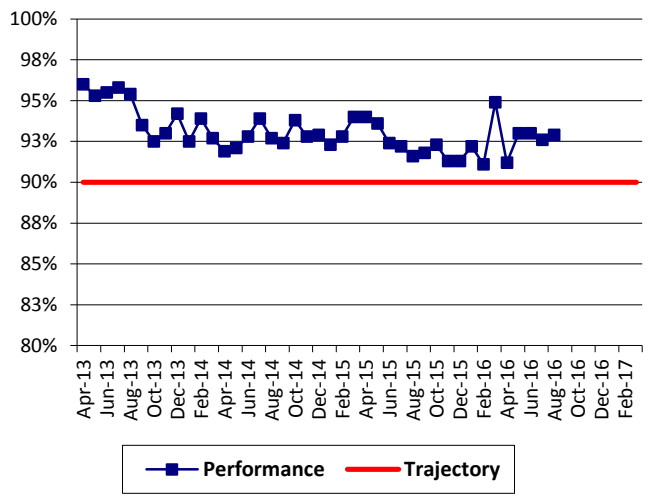


Please Note: There is a 1 month lag time for 18 Weeks RTT to allow accurate information to be reported in line with national reporting timelines.

18 weeks admitted pathway performance has generally improved over the past year, in line with improved waiting times for inpatient treatment.

This should improve as stage of treatment waiting times improve.

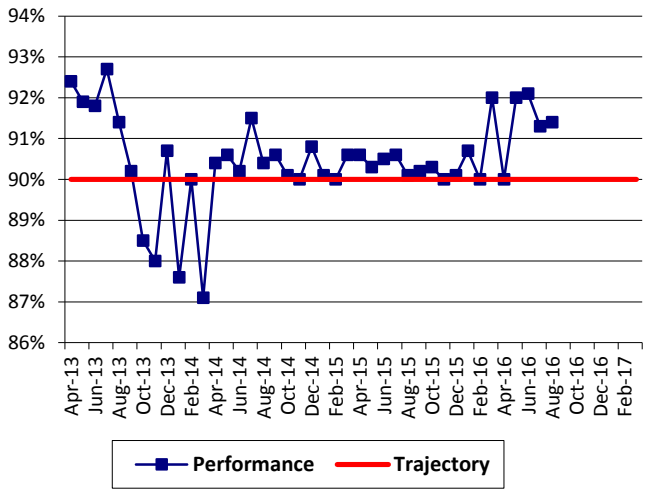
Standard: 18 Weeks Referral to Treatment Non-Admitted Pathway Performance	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	90%	90%	92.9%	G



Please Note: There is a 1 month lag time for 18 Weeks RTT to allow accurate information to be reported in line with national reporting timelines.

18 weeks non-admitted pathway performance has remained consistently above 92% and this is expected to continue.

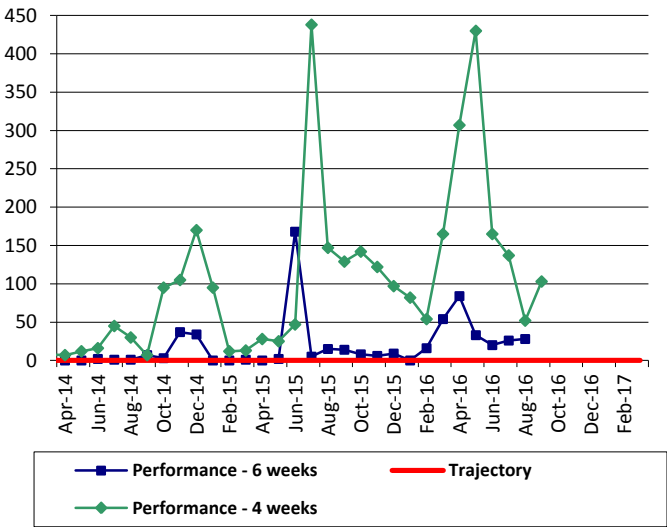
Standard: 18 Weeks Referral to Treatment Combined Performance	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	90%	90%	91.4%	G



Please Note: There is a 1 month lag time for 18 Weeks RTT to allow accurate information to be reported in line with national reporting timelines.

Overall 18 weeks combined performance has remained above 90%.

Diagnostic Waiting Times	2016/17 Standard	Current Standard	Mid Year Position	September 2016 Status
Standard: 6 Week Waiting Target for Diagnostics	0	0	28	R
Stretch: 4 Week Waiting Target for Diagnostics	0	0	103	-



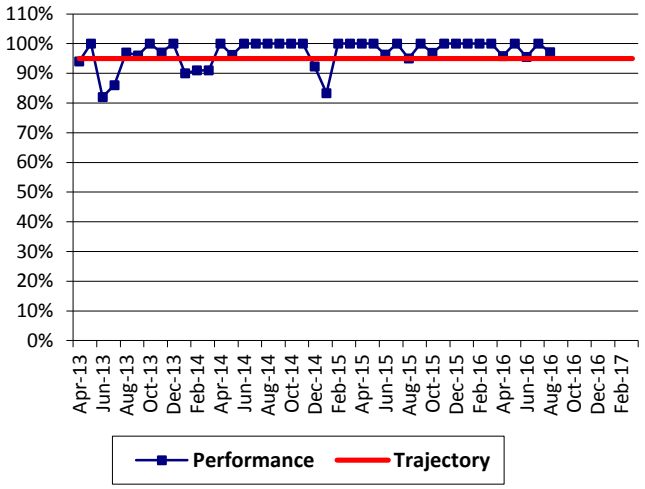
Performance against both the 4 week and 6 week standards has improved since the April 2016 however diagnostics services are still experiencing challenges in meeting demand.

Difficultly in recruiting to a vacant Sonographer post resulted increase in the number of patients waiting over 4 and 6 weeks early in the year. The service has received some funding from the Scottish Government for locum cover and this has brought the waiting times back within manageable levels at present. The service is currently training one Sonographer and plans are in place to start training an additional member of staff from early 2017.

CT and MRI waiting times were also challenging at the beginning of the year although are being managed by additional sessions being carried out by existing staff and locum radiologist cover. There is a mismatch in demand and capacity and the service is working with finance to reconcile funding streams with a view to creating a new radiologist post.

The biggest pressure point at present is Colonoscopy capacity with the changes to the General Medical Rota in May 2016 reducing the number of consultant sessions available. The service is looking to identify funding for a non-medical Endoscopist to provide additional capacity as well as providing internal succession planning.

Standard: 95% of all cases with a Suspicion of Cancer to be seen within 62 days	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**August [1] 2016 Status**
	95%	95%	97.1% (Aug 16)	G



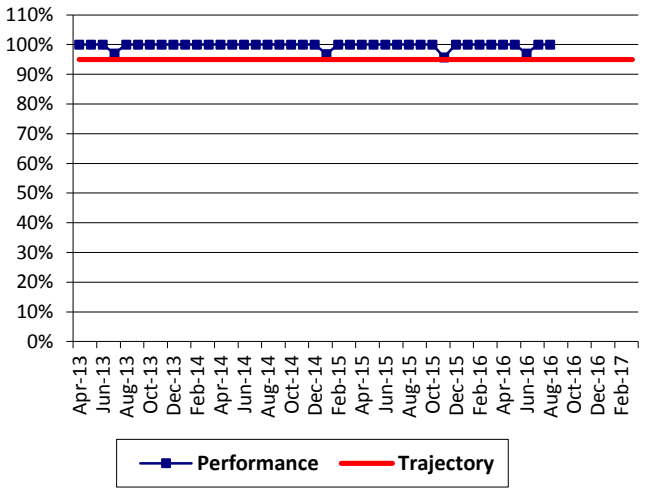
Please Note: Data is reported with a one month lag time due to national reporting

There remain some challenges around patients receiving specialised treatment in NHS Lothian, and also those requiring Colonoscopy locally, but generally Cancer waiting times performance has been consistently above 95%.

Due to the number of patients involved, this can be adversely impacted by delays to treatment for a small number of patients.

[1] Data is reported from the national monthly management information for Cancer Access Standards therefore there is a 1 month lag time and latest available data is August 2016.

Standard: 95% of all patients requiring Treatment for Cancer to be seen within 31 days	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**August [1] 2016 Status**
	95%	95%	100% (Aug 16)	G



Please Note: Data is reported with a one month lag time due to national reporting

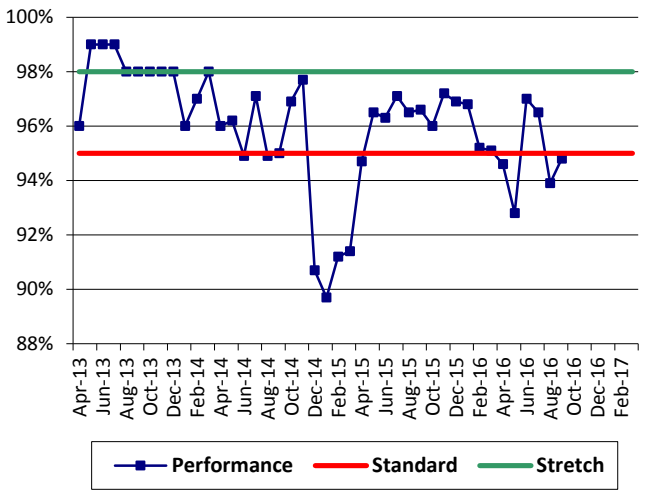
There remain some challenges around patients receiving specialised treatment in NHS Lothian, and also those requiring Colonoscopy locally, but generally Cancer waiting times performance has been consistently above 95%.

Due to the number of patients involved, this can be adversely impacted by delays to treatment for a small number of patients.

[1] Data is reported from the national monthly management information for Cancer Access Standards therefore there is a 1 month lag time and latest available data is August 2016.

Emergency Access Standard	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**

Standard: Accident & Emergency 4 Hour Standard	95%	95%	94.8%	A
Stretch: Accident & Emergency 4 Hour Stretched	98%	98%	94.8%	A

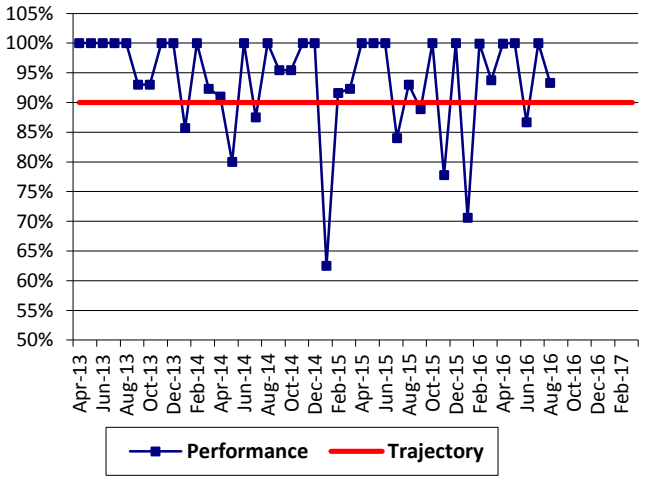


Our focus and aim continues to be to achieve 98% performance. Due to the recent drift in performance we have:

- Reviewed, along with national colleagues, our 6 Essential Actions action plan and ensured alignment of operational delivery.
- We have re-introduced the role of the daily Duty Manager, as senior manager with overall responsibility for safety and flow on a daily basis.
- We have remodeled medical in-patient flows to increase consistency and frequency of senior decision makers on the wards.
- We have a strong focus on discharges over the weekend to maintain flow.
- We are remodeling how we address patients experiencing delays in our Older People wards along with our partners.

We have introduced two safety questions to the hospital huddle and provide a daily message on reducing delays and improving patient experience by ensuring that patients are in the right place for their care.

Standard: Admitted to the Stroke Unit within 1 day of admission	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**August [1] 2016 Status**
	90%	90%	93.3% (Aug 16)	G



Please Note: There is a one month lag time for data.

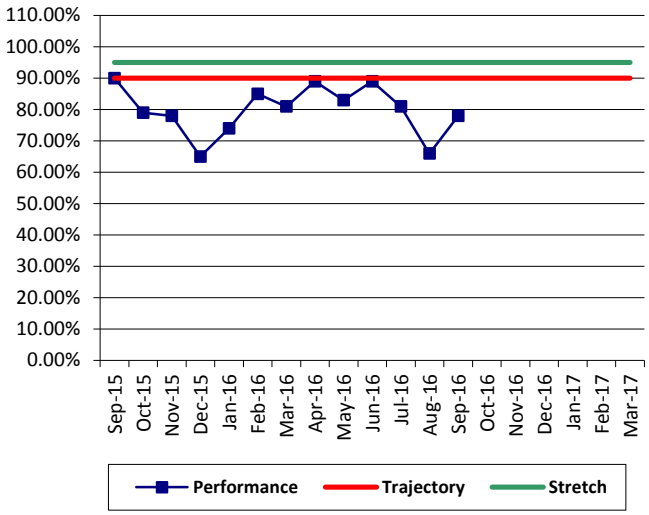
We continue to monitor and act on this on a daily basis to maintain and improve on performance. The stroke team review this daily and work with the wider hospital team to ensure these patients are prioritised for the stroke unit.

These reports are drawn from eSSCA. A data snapshot is taken and used to compile the monthly reports. Routine data collection and amendment takes place on a daily basis therefore data presented has been amended to reflect the most up to date accurate information.

[1] Stroke Unit Admission data is reported with a 1 month lag time due to the time difference between the scorecard deadline and the national extract deadline therefore latest available data is August 2016.

Standard: No Psychology Therapy waits over 18	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**

weeks	90% (95% stretch)	90% (95% stretch)	78%	R

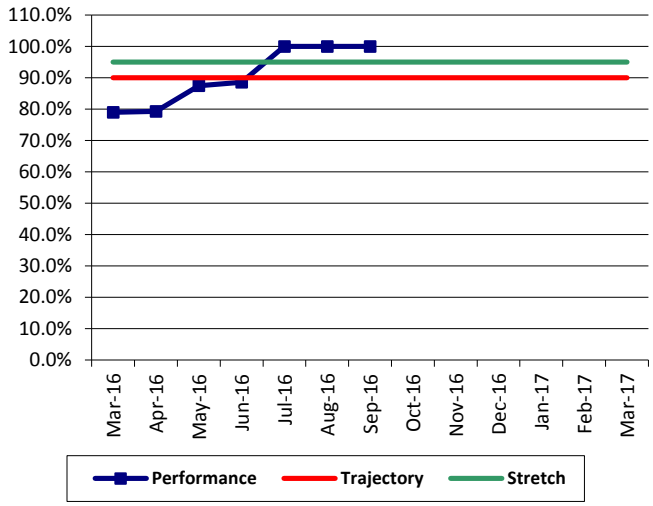


Please Note: Previous performance data is limited as data reporting changed for 2016/17 to the % of patients seen within 18 weeks.

Performance for Psychological Therapies referral to treatment continues to fall below 90%. It fluctuates on a monthly basis. The data is the average performance across all service areas. All but the adult teams are meeting the target including CAMHS. We are trying hard to treat in turn and longer than ideal waits will continue for some time. Of the 12 main health boards, nine have more WTE applied psychologists per 10,000 head of population than NHS Borders.

- We continue to allocate resources to the areas with the longest waits.
- In process of recruiting more psychologists funded by Scottish Government additional funds. The newly recruited Clinical Psychologist started in October.
- A project plan is being drawn up to address underlying demand and capacity issues across the four years the SG funding is in place.
- Continue to review how we can best deliver an efficient and effective service.
- Access to appropriate clinical space is an increasing challenge with recent renovation work in health centres adding to this pressure. The Space Utilisation group has been approached for solutions to this.
- Admin pressures are also a challenge, and work is underway to review procedures as well as the introduction of a text reminder system to tackle the high DNA and CNA rate.

Standard: No CAMHS waits over 18 weeks	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	90% (95% stretch)	90% (95% stretch)	100%	G



Please Note: No previous performance to report as data reporting has changed for 2016/17 to the % of patients seen within 18 weeks.

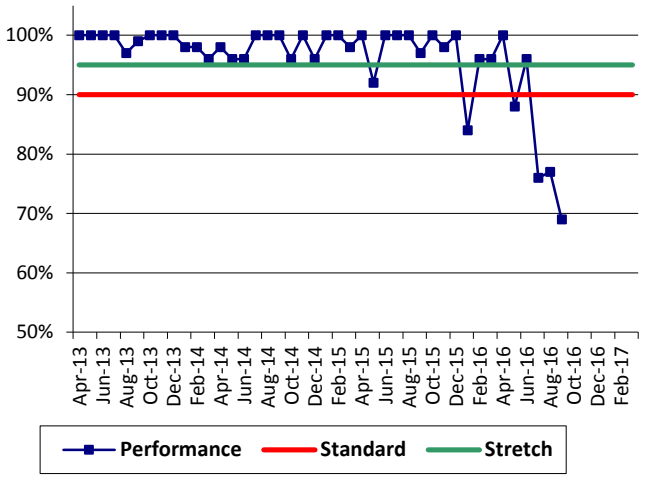
The service plans to remain within the standard. CAMHS continue to have staff turnover having direct impact within the service area and recruitment is almost complete into CAMHS of a temporary CAAP (Clinical and Applied Psychologist) and permanent Community Mental Health Team Nurse. We also have an increase in referrals into the tier 3 service with the absence of a full time Community Mental Health Worker.

The service is now implementing specific allocations meetings outwith the MDT to retain focus on referrals and the waiting list. This was implemented in January 2016 and continues to be maintained

The service have reviewed the waiting list and identified improvements in relation to the information available to the team.

The service is identifying any child waiting 15 weeks or over and ensuring they are allocated an appointment within the following three weeks wherever possible, to reduce the wait.

Standard: 90% of Alcohol/Drug Referrals into Treatment within 3 weeks	**2016/17 Standard**	**Current Standard**	**Mid Year Position**	**September 2016 Status**
	90% (95% stretch)	90% (95% stretch)	69%	R



This is a national HEAT standard where the ongoing requirement is to deliver 3 weeks RTT for 90% of progressed referrals. There is a local NHS Borders stretch target of 95%.

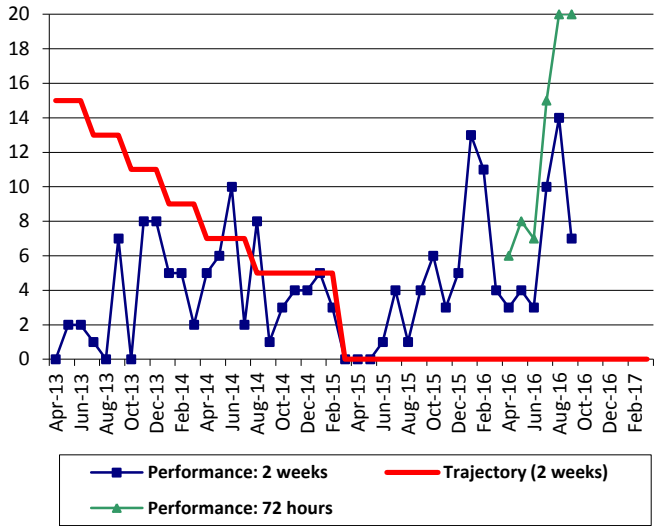
This target reflects performance within Borders Addiction Service (BAS) and Addaction. Addaction performance during quarter 2 was 97% and BAS performance was 48%, therefore overall for quarter 2 performance is 76%.

Over the past few months Borders Addiction Services have been struggling with a shortage of staff. However recently the service has managed to recruit and the impact of this is now having an effect in quarter 3. There were many other actions put in place which are now coming to fruition and although the figures remain low for September, we have in October met the government and local standard.

- The Primary Care Service remains temporarily closed.
- A half-time permanent Consultant post is currently being advertised
- A temporary Advanced Addiction Nurse Practitioner post is also advertised internally.

Performance in Partnership

Delayed Discharges	2016/17 Standard	Current Standard	Mid Year Position	September 2016 Status
Standard: Delays over 2 weeks	0	0	7	R
Standard: Delays over 72 hours	0	0	20	R



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.

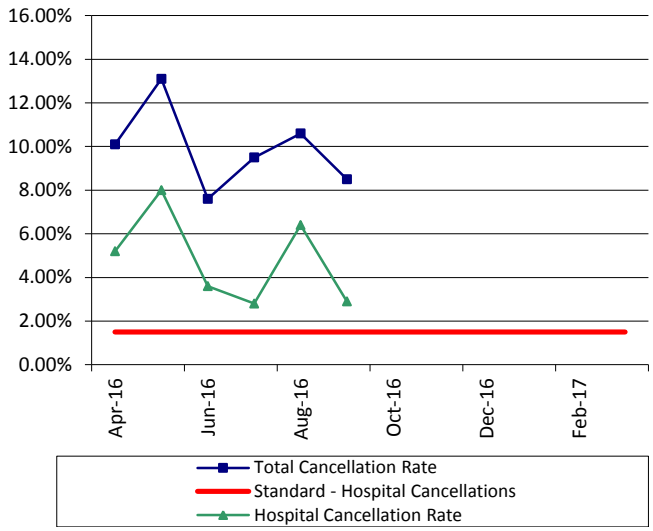
NHS Borders continues to face challenges with delayed discharges, which impacts on patient flow across our hospitals.

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.

Key Performance Indicators

Cancellations	2016/17 Standard	Current Standard	Mid Year Position	September 2016 Status
Total Cancellation Rate	-	-	8.5%	-
Hospital Cancellation Rate	1.5%	1.5%	2.9%	R

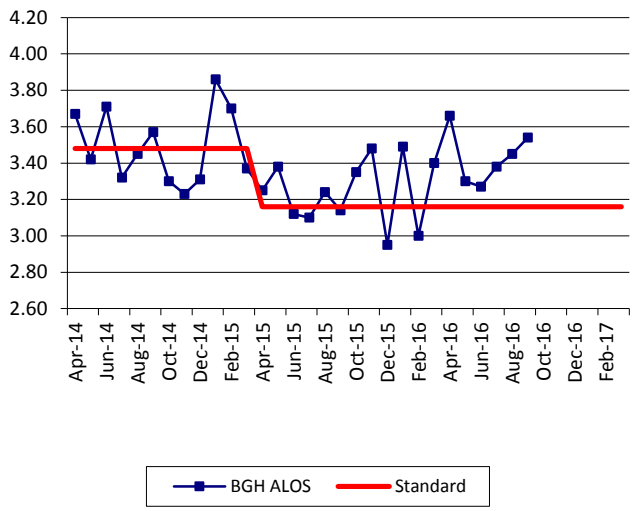


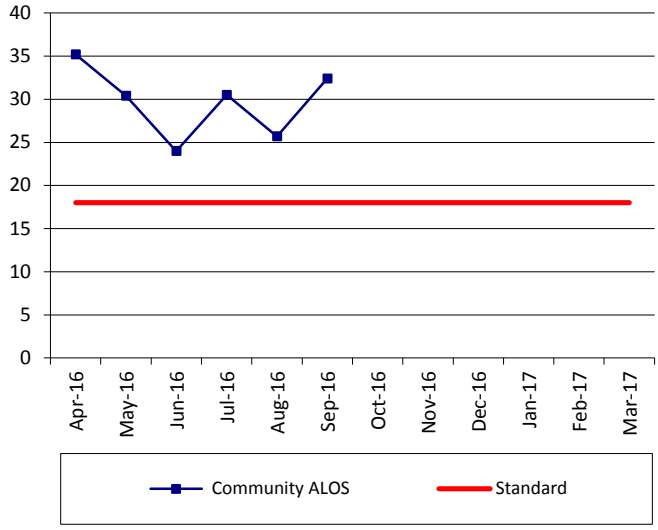
The percentage of hospital cancellations continues to be challenging however September 2016 shows an improvement due to smoothing of elective cases and the availability of beds.

The following actions are ongoing:
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment.
- Booking on the basis of average time per consultant to carry out procedure for Orthopaedics.
- Reviewing admissions per ward area per day and smoothing surgical flow via Institute of Healthcare Optimisation work.
- Reviewing data for Orthopaedics to see if reviewing lists has had an impact on cancellation rate and consider rollout to other specialties.
- Anaesthetics staffing reviewed through medical oversight group – action plan in place for recruitment.
- The service has implemented a process to review lists every Wednesday afternoon and develop a Standard Operating Procedure to lock down list and make any appropriate changes.

Detailed reviews of the reasons behind the lack of available beds are being undertaken by services on an ongoing basis in an effort to alleviate the pressures. The most significant action will be the implementation of the new theatres and surgical flow model - it is anticipated that this will be implemented in Winter 2016/17.

Average Length of Stay	2016/17 Standard	Current Standard	Mid Year Position	September 2016 Status
Borders General Hospital	3.16	3.16	3.54	R
Community Hospitals	18.0	18.0	32.4	R





Borders General Hospital

The average length of stay for the Borders General Hospital has risen in some areas however it is within control limits. New targets were introduced from May 2014, which took into account the latest analysis from the Bed Model. These took the 75th percentile values for Borders HRGs benchmarked against peers across England. In some instances this means that specialties now have a stretch target to further reduce lengths of stay, and the overall target for the BGH has reduced from 3.48 to 3.16.

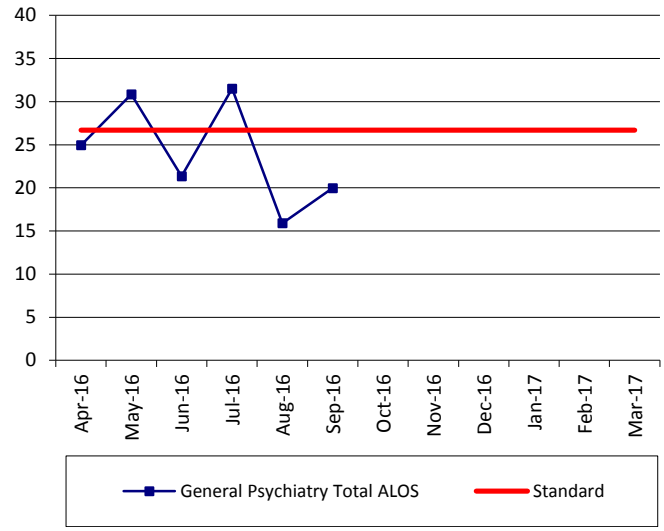
We continue to monitor and manage patient lengths of stay and are working to remodel the inpatient footprint across unscheduled and planned care by the Autumn/Winter of 2016 will also positively impact the overall length of stay.

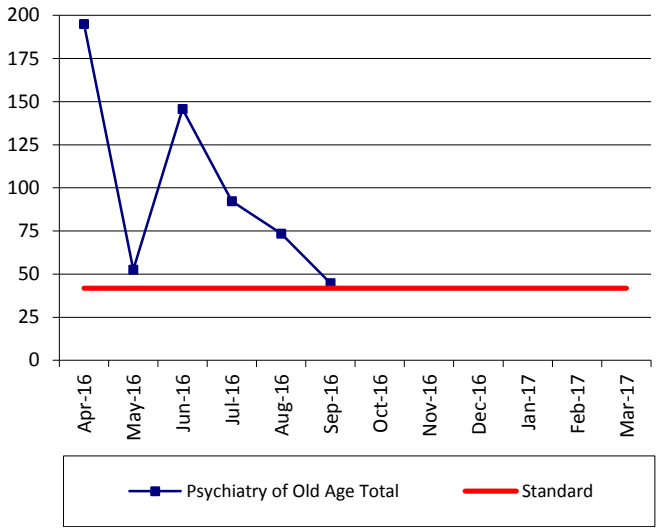
Community Hospitals

There continues to be challenges within Community Hospitals in terms of LoS performance. The level of patient complexity and limited availability of post hospital care requirements add to the challenge to reduce LoS.

Senior Management will continue to attend all MDTs and support patient flow along with the Clinical Community Manager attending and contributing to the Delayed Discharge Meetings and liaising with Social Work. The General Manager is contributing review of pathways to manage patients who lack capacity and is joint working with Social Work. Senior Management continue to address underlying issues of capacity of home care and residential home services within the community. There are daily and weekly reviews of community hospital discharge profiles

Average Length of Stay	2016/17 Standard	Current Standard	Mid Year Position	September 2016 Status
Mental Heath - General Psychiatry Total	26.70	26.70	19.96	G
Mental Heath - Psychiatry of Old Age Total	41.81	41.81	44.75	A





Mental Health

Mental Health LOS can fluctuate, particularly for older adults, depending on the numbers of discharges and the length of time a patient has been within the facility and is quite often skewed by one or two long stay patients and small numbers of discharged per month.

We continue to monitor LOS within the performance scorecard at monthly Mental Health meetings and it is picked up with Senior Charge Nurses by exception. Work is underway to ensure patients have EDD's on admission to Mental Health Wards (as appropriate).

Summary of Performance against NHS Scotland

The following table summarises the most recent performance available for NHS Borders against NHS Scotland, including the ranking (1 being the highest performing and 14 being the lowest performing) where data is available.

	Standard	Time Period (Latest available)	Source	NHS Borders	NHS Scotland Average	Rank (14)
HEAT Standards	Diagnosis of Dementia	Sep-16	Local	1067	-	-
	Dementia Post Diagnostic Support	Aug-15	Local	91%	-	-
	Alcohol Brief Interventions (% achieved against the target)	2015/16	ISD	138.0%	159.0%	6
	12 weeks successful quits in Smoking cessation in most deprived areas (% achieved against the target)	2015/16	ISD	108.5%	109.2%	6
	Sickness Absence Rate	2015/16	ISD	4.4%	5.2%	1
	New patients(DNA) rate	Jun-16	ISD	4.6% [1]	9.6% [1]	1
	Same day surgery	Jul-16	Local	82.3%	-	-
	Pre-operative stay reduced	Jul-16	Local	0.27	-	-
	Online Triage of Referrals	Sep-16	Local	93.8%	-	-
	Increase the proportion of new-born children breastfed at 6-8 weeks	2015/16	ISD	34.1%	28.2%	5
	eKSF Annual Reviews complete	Sep-16	Local	17.7%	-	-
	Personal Development Plans recorded on eKSF	Sep-16	Local	20.9%	-	-
	Reduce emergency Occupied Bed Days aged 75 or over (per 1,000)	Apr-16	ISD	3501	4617	2
Access to Treatment	12 Weeks Outpatient Waiting Time (% waiting over 12 weeks at month end)	Jun-16	ISD	9.2%	14.4%	5
	12 Weeks Inpatient Waiting Time (% waiting over 12 weeks at month end)	Jun-16	ISD	0.4%	7.0%	4
	18 Weeks RTT Combined Performance	Jun-16	ISD	92.1%	87.0%	3
	18 Weeks RTT Combined Linked Performance	Jun-16	ISD	93.7%	92.6%	10
	% waiting within the 6 week standard for a key diagnostic test	Jun-16	ISD	96.8%	92.2%	5
	95% target for treatment within 62 days for Urgent Referrals of suspicion of cancer	Apr - Jun 2016	ISD	97.2%	89.7%	1
	95% target for treatment within 31 days of decision to treat for all patients diagnosed with Cancer	Apr - Jun 2016	ISD	99.0%	95.6%	4
	98% of waits for A&E under 4 hours (local stretch)	Sep-16	ISD	94.8%	94.9%	-
	90% of admissions to the Stroke Unit within 1 day of admissions	Aug-16	Local	93.3%	-	-
	No Psychological Therapy waits over 18 weeks	Apr - Jun 2016	ISD	86.4%	81.2%	6
	No CAMHS waits over 18 weeks	Apr - Jun 2016	ISD	88.6%	77.2%	8
	90% of Alcohol/Drug Referrals into Treatment within 3 weeks	Apr - Jun 2016	ISD	95.6%	87.2%	6
Performance in Partnership	No Delayed Discharges over 3 days	Aug-16	NHS Performs	20	913	-

[1] Data is provisional

Progress on Targets Not Reported on a Monthly Basis

Cancer: Increase proportion of 1st stage breast, colorectal and lung diagnosis by 25%	**Current status:**	A
	Predicted status at end March 2017:	A

All NHS Boards will be expected to reach the same proportion of cancers diagnosed at stage 1 by the end of 2015 and for the Borders, this means an increase from 26.2% to 29%. The table below shows that for the years 2014-2015 26% of cancers were diagnosed at stage 1. Although NHS Borders has not reached the target, the percentage is higher than Scotland as a whole. It is widely accepted that it is unlikely that the DCE lung cancer campaign will contribute to the delivery of the HEAT target. At best we will see a shift in earlier staging, as symptomatic signs usually indicate more advanced cancer. Our Breast Screening uptake rates are already above the Scottish average, and the signs and symptoms of breast cancer are well known. Our aim therefore is to deliver the target primarily through an increase in bowel screening uptake. As achievement of the HEAT standard is most likely to be delivered by the bowel screening it is useful to look at the success of early cancer detection by this programme in more detail. Current figures show that Borders Bowel Screening Uptake has increased over the last two years reaching 63.5%, the highest uptake achieved in mainland Scottish Health Board, and over 5% more than the Scottish average. Key deliverables for the DCE programme 2015/16 have been :-

- To embed the knowledge and awareness about the early detection of cancer and lifestyle risk factors into routine processes and assessments within teams like the Health Living Network and Lifestyle Advisory Service and services working with vulnerable groups
- To have preventative messages that are clear for staff working in NHS Borders so that the opportunities delivered by the increased contact with the NHS from Detect Cancer Early are used to best effect to promote cancer prevention awareness and action
- To promote awareness of screening and warning signs and symptoms, which will lead to more people making contact with screening and symptomatic services
- To increase screening uptake rates in our deprived areas and vulnerable groups
- To ensure the sustainability of the DCE programme given the recent departure of the DCE coordinator following a promotion.

Cancer Network of Residence Code	Residence NHS Board Desc	Stage 1	
		Number	%
SCAN	NHS BORDERS	131	26.1%
SCOTLAND	**TOTAL**	**5,926**	**25.0%**

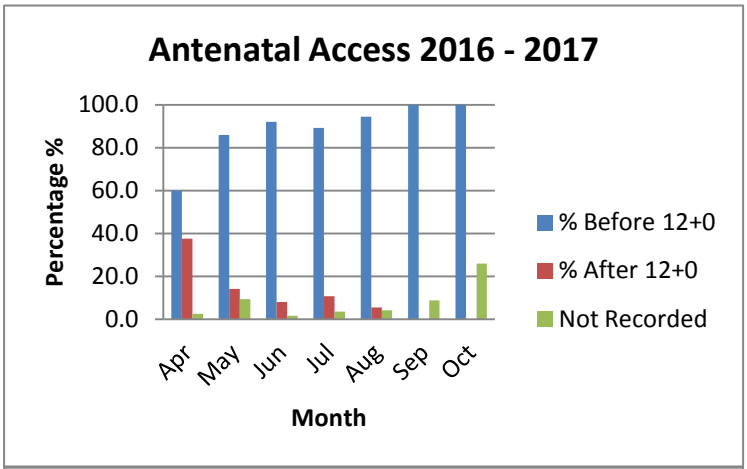
Antenatal Services: At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation	**Current status:**	G
	Predicted status at end March 2017:	G

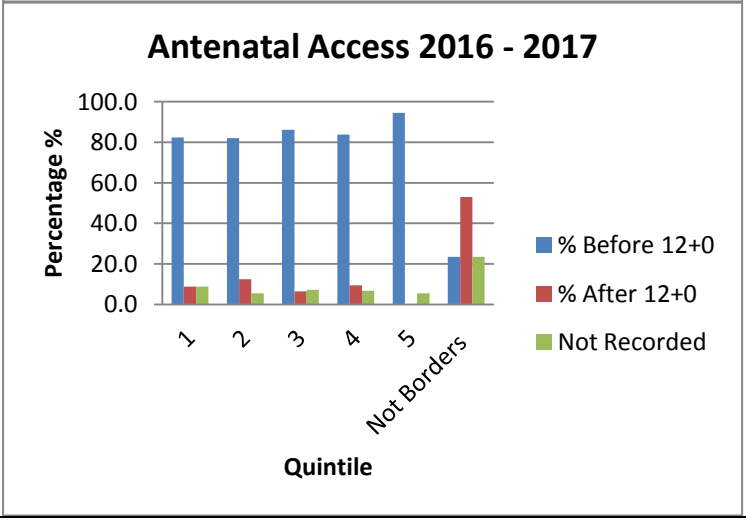
NHS Borders is currently achieving the target of greater than 80% of women booked by 12 weeks. Monitoring of performance is undertaken through the performance scorecards of Clinical Boards and reported to the Clinical Executive Operational Group.

Direct telephone lines to Community Midwifery support early booking for maternity care. Advertising campaigns with posters, and working with the GP Sub Group, help raise awareness and support regarding early booking with a registered practicing Midwife.

Data below is shown by both month and quintile. N.B New housing developments within NHS Borders have

not been allocated a quintile.





IVF: Commence IVF Treatment within 12 months	**Current status:**	G
	Predicted status at end March 2017:	G

There has been no change in the provision of IVF treatment, NHS Borders continues to refer patients requiring treatment to NHS Lothian.

From 1st April 2016 to 30th September 2016 there were 13 Full Cycles and 7 Thaw Cycles, with no delays against the 12 month standard.

GP Access: 48 hour access or advance booking to an appropriate member of the GP team (90%)	**Current status:**	G
	Predicted status at end March 2017:	G

The Government's GP Access LDP Standards Data Publication update is still awaited, with the last update available online referring to the period 2013/14. The narrative of the National Report for the Health and Social Care Experience Survey for 2015/16 does provide some commentary on the national results available to date: For the LDP standard, patients are considered to have been able to obtain two working day access if they were offered an appointment, but turned the appointment down due to the person they wanted to see being unavailable or the time not suiting them. Considering the results in this way, the National Report states

that overall, 91.8 per cent of patients were able to see or speak to a doctor or nurse within two working days, or were offered an appointment but either the person they wanted to see was unavailable or the time was not suitable. This is above the LDP standard of 90 per cent. However, it is also a modest drop from the previous survey (92.4 per cent). All but one NHS board met the 90 per cent standard.

http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16/LDP-GP

http://www.hace15.quality-health.co.uk/index.php/reports/health-board-reports/2467-nhs-borders-pdf/file

Within the past QOF year, Practices have once more reviewed and reported on their local access arrangements, following carrying out practice access analysis. For Board information, the demands on General Practice continue to increase, with ongoing difficulties regarding recruitment and retention of local GPs and a lack of GP locum availability.

Breakeven: Boards to operate within agreed revenue resource limit, capital resource limit and meet cash requirement	**Current status:**	R
	Predicted status at end March 2017:	A

At the end of September 2016 the Board is reporting an overspend position of £4.7m on revenue and break even on capital. The financial position at the end of the second quarter is giving cause for concern and based on projections at the end of September the Board is not on course to deliver its financial targets. The Director of Finance and Chief Executive are in dialogue with SGHSCD on the options available to the Board linked to the financial position and are currently working to put in place a recovery plan to address the financial position.

The main pressure areas are nursing and medical costs in the set aside budgets within the BGH, GP prescribing costs within IJB Directed Services and external health care providers.
The Board has a challenging savings target of £11.4m, (£8.7m recurring and £2.7m non recurring) for financial year 2016/17 and at the end of September £4.8m of savings has been delivered of which £2.8m is recurring.

Efficiency delivery is behind trajectory and based on information currently available there will be a shortfall of £3.3m in the overall programme. This forecast position has been built into year end planning. Based on the forecast year position on efficiency and taking account of any part year implementation plans there will be a recurring shortfall of £4.9m at the end of the financial year.

The capital plan is progressing. Expenditure in the first six months of the financial year relates to Roxburgh Street Replacement Surgery, the final phase of works at Melburn Lodge, the estates rolling programme and feasibility work linked to future projects. Due to slippage on a number of areas of the capital programme, principally the Theatre Ventiliation project and delivery of the Gamma Camera CT, with agreement of SGHSCD, capital resources will be utilized to support the pressure in operational budgets with projects completing fully funded in the new financial year.

Efficiency: Reduction in energy consumption and CO_2	**Current status:**	G
	Predicted status at end March 2017:	A

From April 2015 a new targeting regime for energy consumption and Greenhouse Gas Emissions reductions came into force across all NHS Boards and covers the period 2015-2020. From this date all sites within the Estate portfolio are taken into account when measuring against the target where previously only in-patient areas were included. The target set is a 6.5 % target reduction in energy consumption and Greenhouse Gas emissions by 2020, compared against a 2014/15 baseline.

NHS Borders 5 Year Target to 2020			
	Base Year	**2020 Target**	**Variance vs Base Year (%age)**
CO_2 Tonnes	**8,576**	**8,019**	**-6.50**
Energy kWh	**33,859,088**	**31,658,248**	**-6.50**
QUARTERLY	**CO_2**		

Current Quarter	Base Year Tonnes	Current Tonnes	Variance vs Base Year %
Qtr 2, 2016/17	3,813	3,421	-10.28

QUARTERLY ENERGY Current Quarter	Base Year kWh	Current kWh	Variance vs Base Year %
Qtr 2, 2016/17	14,253,284	12,696,466	-10.92

In the NHS Borders property portfolio the main site, Borders General Hospital, utilities approximately 68% of the organisations annual electricity and gas consumption.

In future years the delivery of the energy consumption target going forward will become increasingly challenging due to the increased usage of electrical equipment and the longer operating/opening hours both in the acute hospital and community properties. This has been recognized across the NHS in Scotland.

Treatment: SAB infections per 1000 acute occupied bed days (0.24)	**Current status:**	R
	Predicted status at end March 2017:	R
Treatment: Clostridium difficile infections per 1000 occupied bed days (0.32)	**Current status:**	G
	Predicted status at end March 2017:	G

Every SAB case and CDI case is subject to a rigorous review which includes a feedback process to the clinicians caring for the patient as well as the wider organisation through monthly Infection Control Reports. Any learning is translated into specific actions which are added to the Infection Control Work Plan with progress critically reviewed by the Infection Control Committee.

SABs are reported by cause to highlight themes and support targeted interventions. Between April and September 2016, 60% of SAB cases were community acquired. Whilst no recurring theme was identified for the 6 SAB cases that were hospital or healthcare associated during this period, there is ongoing improvement work to address each of the key risk factors relevant to these cases.

4. UPDATE ON CONTRIBUTION TO SINGLE OUTCOME AGREEMENT

Health Inequalities

Healthy Living Network	**Current status:**	G
	Predicted status at end March 2017:	G

HLN continues to work in partnership across Burnfoot, Eyemouth and Langlee. The team are partners on the CLD Learning Community Partnerships, the Health & Social Care Locality Working groups and Locality Planning Group. HLN have contributed to the CLD quality review process in Eyemouth and will support the Galashiels review. Volunteers continue to support locality work and will be involved in the forthcoming NHS Borders Investing in Volunteers (IIV) process.

The Burnfoot food security research process is complete; the supporting DVD is at final editing stages. A food festival launched the report locally and staff are working on dissemination and progressing recommendations. The first Participatory Budgeting information evening has taken place in Burnfoot, with £39,000 funding from Scottish Government Community Choices Fund a local steering group has been recruited and PB champions have signed up to raise the profile of PB. At a strategic level, HLN and SBC have had initial discussions about how to raise the profile of PB and generate discussion re: options post funding.

Community food mapping processes in Eyemouth and Langlee have led up to local events including: Langlee School holiday programme, supporting children and families to engage in good food work and physical activity, using produce from our CJS greenhouse project. We trialed a food co-operative, exchanging produce for ideas on what could work in Langlee. This project was supported by Health Scotland and the Grocer's Federation. We have plans to build on this consultation with a mobile food co-op and training that will support a presence in a number of sites across HLN.

Eyemouth is building on the success of its Streetfood Event with live demonstrations at this year's Wellbeing week, using locally sourced allotment produce and raising the profile of microwave cookery and Kitchen Canny under the theme of Eat Better Feel Better (SG Campaign). Eyemouth has used a Dragon's Den style approach to begin to think about how to prioritise their locality budget.

Eyemouth and Langlee are prioritising work with older people in the coming year, with a focus on prevention and linking to Diabetes UK. Langlee HLN are supporting the development of the first Diabetes UK peer support group in the Borders.

Partnership programmes with CJS Reconnect Women's Service and Borders College's Catering for Life continue to develop, both providing training and the opportunity to volunteer post programme, as a soft step to employment.

The Health Inequalities training programme has been tested out with a number of staff and community groups including NHS Borders, Scottish Borders Council, Borders College, Third Sector and HLN.

Tailored sessions have been developed for staff groups that support them to think about their own health and wellbeing and translate learning to their patients/clients/communities. Health Literacy Month has been promoted throughout October across our networks and in line with the national campaign, raising the profile as a foundation for promoting and facilitating training.

Healthy Living Network	Current status:	R
	Predicted status at end March 2017:	G

Arrangements to collocate HLN in Burnfoot within the Community Hub have progressed slower than expected due to situational factors beyond HLN's control. Burnfoot Community Futures are drafting a final version of a lease agreement with NHS Borders Estates, and through them the CLO, IT and Domestic Services have advised on and supported the process. HLN staff have begun to develop the activity programme and partnership work in a variety of locations across Burnfoot, including the HUB. We expect the full relocation to take place by Dec 16 at which point status will change to green.

Learning Disabilities	Current status:	G
	Predicted status at end March 2017:	G

The Learning Disability Service continues to work with partners on various streams of work which aim to tackle some of the health inequalities experienced by people with learning disabilities living in the Scottish Borders.

These include among others:

- Review of the 4 key collated themes of the 'The keys to life' action plan for the Scottish Borders including aspects of health improvement, work and volunteering and the positive impacts on people's.
- The 'A Healthier Me' key leads group organised a 'Big Lunch' event this summer and also a walking challenge as part of their input to tackling changes to health and lifestyle to improve outcomes for individuals. We will look at the way the group works and how to gather more information to evidence the effects of the various 'A Healthier Me' approaches in Spring 2017.
- The Health Equalities Framework (HEF) - an outcomes measurement tool – is fully implemented within the Learning Disability Nursing team. We are exploring ways of aggregating the data from this across the Borders to report outcomes and also considering how we share this across the Learning Disability Managed Care Network through the Project lead.
- Health Champions received their certification of completion in September 2016. We are exploring ways to enable them to be peer supporters.
- The Local Citizens Panels as part of the Learning Disability Governance structure continue to meet regularly and are working on the recommendations from their review. They are valuable members within the Learning Disability Governance Structure and also are active members in their local communities. We have widened the input of the Local Area Co-ordination team members in supporting the panels.
- The first Project Search pilot commenced this summer with 8 interns now participating in the programme which is aimed at supporting people with learning disabilities to gain skills to get into paid employment - in partnership with NHS Borders, Borders College and Scottish Borders Council.
- The learning disability Liaison Nurse has worked closely with Borders General Hospital in a variety of ways to improve the access to and experience of people with learning disabilities receiving treatment there.

Mental Health	Current status:	A
	Predicted status at end March 2017:	G

In January 2016 a Wellbeing and Mental Health Steering Group was established with the aim of improving physical health outcomes for people with a severe and enduring mental health problems. The group has representation from mental health services, Lifestyle Advisor Service and the Joint Health Improvement Team. A comprehensive Physical Health Check Tool has been developed that includes an assessment of general health, lifestyle, screening and medication side effects. The tool is currently being piloted and patients will receive an annual health check with a care plan to improve their physical health.

Pathways to services/opportunities that will improve patient's physical health are currently under development and includes; Lifestyle Advisor Service, Smoking Cessation, Live Borders and other community based support services.

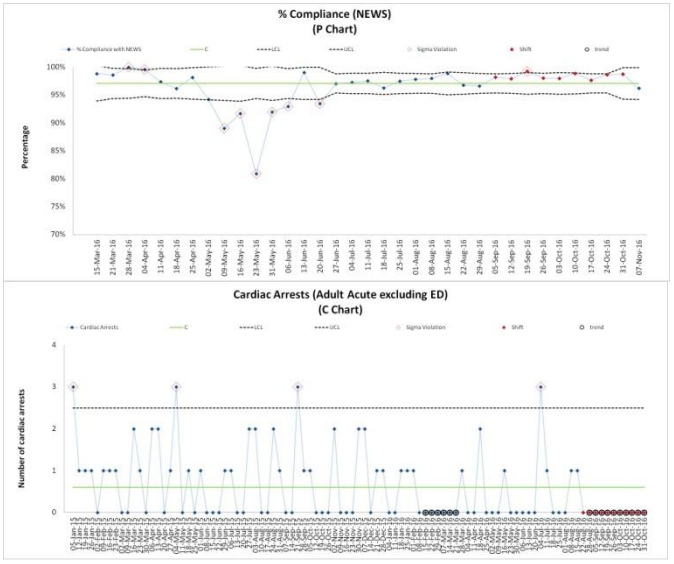
An audit tool has been developed that will monitor the health assessment process and outcomes.

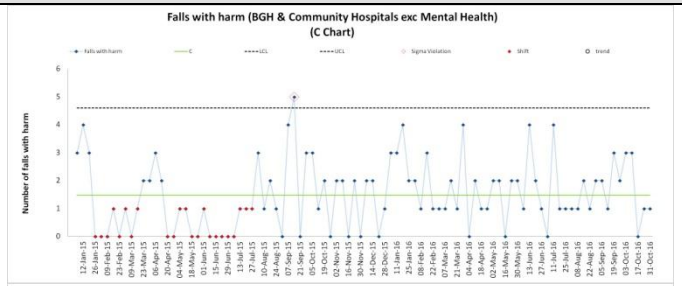
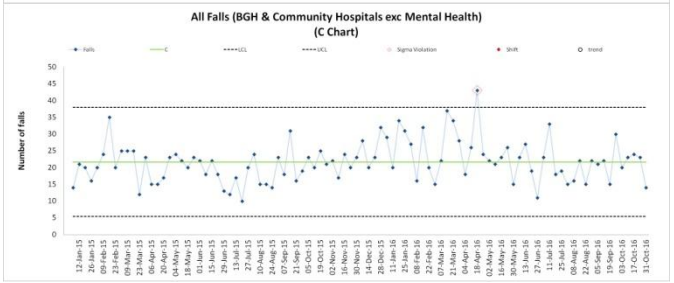
To support this work a bespoke program of training for mental health staff is planned between November 16 and March 17.This includes Raising the issue of smoking, health behavior change and awareness raising across a range of lifestyle topics.

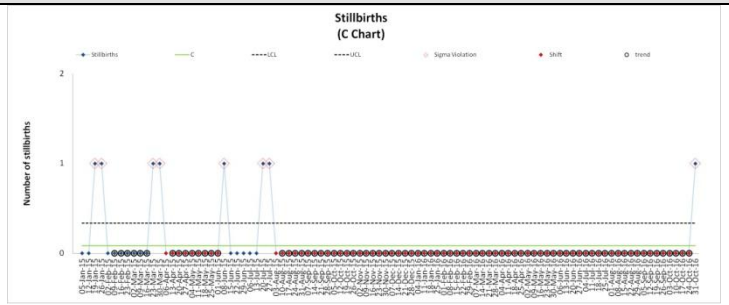
Additional capacity has been allocated to support smoke-free policy and guidelines for mental health services. Training is been delivered to mental health inpatient staff and voluntary organisations to raise awareness of tobacco issues and the support available to their client group, along with the development of referral pathways.

Further work is required to align the Tobacco Policy for mental health services with the NHS Borders Tobacco Policy.

5. CORPORATE OBJECTIVES

Corporate Objective		Progress to Date
Deliver safe, effective and high quality services	Deliver the Scottish Patient Safety Programme (SPSP)	NHS Borders hosted a site visit in November 2016 from the Healthcare Improvement Scotland (HIS) SPSP team. The visit spanned all workstreams of the safety programme including adult acute, medicines, Healthcare Associated Infections (HAI), maternity and paediatrics, mental health and primary care. The feedback from HIS about the visit was very positive and as well as sharing local success and learning for other areas to consider the national team were able to signpost to areas of good practice elsewhere in Scotland in support of the improvement priorities of the local safety programme this year. **Adult Acute** – Deteriorating Patient – Increased compliance has been noted in National Early Warning Scoring (NEWS) across the Borders General Hospital (BGH) in recent weeks, as monitored through the weekly Older People in Acute Hospitals (OPAH) monitoring programme. A positive shift has taken place in the last 10 weeks in the number of cardiac arrest, with zero arrests in a 10 week period. A new clinical handover system has been introduced taking place at 8am each morning. The aim is to share and pass over pertinent information about patients between the hospital at day and hospital at night staff to ensure there is a clear set of clinical priorities and oversight of the patients who require close observation. The feedback from staff so far is that this is a much improved system.  Falls – The rate of falls across NHS Borders has reduced largely attributed to the reduction in mental health older adult inpatient areas. Numbers remain consistent within the BGH and targeted improvement work has been initiated in the BGH to reduce falls. This will remain a top priority area this year.

Corporate Objective		Progress to Date
		  **Pressure Damage –** A new escalation and review process has been put in place to support the management of patients at risk of or who have developed pressure damage. The aim for the coming year is work towards developed pressure damage being a rare event whilst in NHS care and targeted work is underway with frontline staff, Senior Charge Nurses and ward based link nurses to achieve this. **Venous Thrombo-Embolism –** NHS Borders is working with HIS as a test site for the development of an approach to ensuring reliable risk assessment, care planning and treatment for patients at risk of blood clots. This project is involving a wide range of clinical staff to understand the barriers to reliable practice and develop systems and processes to support reliable practice on a day to day basis. There has also been a media campaign to raise public awareness. **Maternity Care and Paediatrics** – Maternity services have achieved 463 days without a stillbirth. The team is working to understand how this has been achieved and the contribution which several initiatives have made to this. In paediatrics a renewed focus has been placed on reliable use of the Paediatric Early Warning Scoring system to ensure deterioration is identified early and acted upon.

Corporate Objective		Progress to Date
		 **Mental Health** – NHS Borders are a test site for the work on observation practice in partnership with HIS. Good progress is being made in this area and in relation to reducing restraint and improving medicines practice. Testing is underway in the older adult wards to introduce NEWS. Several areas of good practice were noted in mental health during the recent HIS site visit. **Primary Care** – NEWS has now been implemented across the 4 community hospitals sites through the Health Foundation funded innovating for improvement award. This programme enabled the appointment of a clinical project manager who has worked with teams in the community hospitals, Borders Emergency Care Service (BECS), Scottish Ambulance Service, community nursing teams and care home staff to develop systems and processes for recognition and rescue of the deteriorating patient. This has included the development of an escalation and treatment plan to support the management of each patient in the community hospitals, the introduction of SBAR (Situation, Background, Assessment and Recommendation) communication tools when staff from community hospitals, community nursing teams and care homes call to escalate patients to the BECS out of hours service. This project has been extremely successfully and a further bid has been put forward to the Health foundation to allow this work to be spread further in care homes and nursing homes beyond the initial test areas.
	Communicate – listen to patients and ask 'what matters to you'	The NHS Borders *Health In Your Hands: What Matters to You?* public engagement exercise was launched at the NHS Borders Annual Review in September 2015 and concluded in March 2016. The main purpose of exercise was to give the public and staff an opportunity to tell us what was important to them to help NHS Borders shape future services and give consideration to future priorities. The exercise was also aimed at providing the chance for the Board to listen and to give an opportunity for people to give feedback and share their stories on the care that they have received in the past or recommendations for how they would like to receive care in the future should they require it. The Board wanted to provide a more broad and flexible approach to allow people to engage more easily and enable meaningful conversations with the public and staff. With this in mind 3 different tiers of engagement took place: • **Informal approach:** engaging with people at cafes, supermarkets, health centres, community hospitals, 'pop-up' stalls in the dining room at the BGH, from our patient feedback volunteers

Corporate Objective		Progress to Date
		• **Formal approach:** engaging with formal groups which already meet • **Targeted audience:** engagement with seldom heard and hard to reach groups The full report on the outputs and feedback from the engagement exercise was presented to Borders NHS Board in June 2016, when they agreed the next steps and a number of actions. This included that the learning and feedback captured through the engagement exercise will inform NHS Borders Public Involvement and Community Engagement Strategy and the progression of the Community Planning Partnership's collective approach to community engagement. Any service specific feedback was provided to the Head of Service for their information and action if required during the engagement exercise. This full report outlining was shared with the NHS Borders Public Reference Group who helped with the development of an easy-read flash summary report for the public and staff, which has now been publicised on the NHS Borders website and the staff intranet site. The *Health in Your Hands: What Matters to You?* 'flash' report provides a summary of the key themes from the engagement exercise. To view the full report which was presented to Borders NHS Board in June please click on this link. NHS Borders is very grateful for the time and effort people have contributed to this conversation and recognises that the health service is an important part of life for people from all communities across the Scottish Borders. Everyone will come into contact with such at some point in their lives be it through accessing services for themselves, for others or through their working lives as an NHS employee or as an employee of one of the organisations partners in service delivery. With this position comes the responsibility to ensure that NHS Borders provide services that match the needs of the local population and in a way that is accessible to all.
	Strive to meet and exceed the performance targets set for us by the governments and our own board	Strong performance management remains a key priority across all areas of NHS Borders. Reporting arrangements were reviewed during March and April 2016 and sense checked as to whether the needs and requirements of the Board were being met. It was an opportunity to take into account any changes in reporting requirements as a result of Health & Social Care Integration and the establishment of the Integrated Joint Board. By reviewing the current reporting framework we were able to reduce duplication, provide greater alignment and focus on LDP standards and targets and ensure a more consistent and standardised approach. The Performance Scorecard has been positively received by the organisation and to finalise the process a 6 month review will take place to ensure the information supplied is relevant and useful for the Board.
	Run an efficient organisation by living within our means and	As part of its agreed financial plan for 2016/17 NHS Borders is required to deliver £11.451m of cash releasing efficiencies of which £8.795m needs to be identified on a recurring basis. As at the end of September a total of £4.8m of the savings has been achieved and removed from operational budgets. Of that figure, to date £2.7m has been delivered on a recurring basis.

Corporate Objective		Progress to Date
	concentrating resources on front line services	Year to date, good progress is being made in support service areas and with agreed corporate schemes. However, overall delivery on schemes associated with transformational service change and workforce are proving to be much more problematic and remain the significant concern in relation to the release of sustainable savings At present we are forecasting delivery £8.1m of savings against the in year target of £11.4m of which £3.6m is anticipated will be delivered on a recurring basis. That means an anticipated shortfall on the efficiency programme during 2016/17 of £3.3m The current forecast suggests that of the £8.1m of savings identified only £3.9m will be delivered on a recurring basis after taking into account any full year impact of schemes started part way through the year. This represents a shortfall against the recurring year target of £4.9m. This shortfall will be carried forward into the 2017/18 and added to the requirement for savings that will arise as part of the financial planning and budget setting process for 2017/18. As part of the recovery plan work is progressing on how this recurring shortfall will be addressed going forward.
Improve the health of our population	Work with communities and our partner organisations in Scottish Borders Council and the Third Sector	NHS Borders works with our Community Planning Partners in the Scottish Borders Community Planning Partnership to work together with the community to plan and deliver better services which make a real difference to people's lives. The aims of the Scottish Borders Community Planning Partnership are: • making sure people and communities are genuinely engaged in the decisions made on public services which affect them; • allied to a commitment from organisations to work together, not apart, in providing better public services. Scottish Borders has a simple structure comprising a Community Planning Board, a Chief Officers Group and 5 locally based Area Forums. Board members include representation from the Scottish Borders Council, NHS Borders and a range of other public and third sector partner representatives. The Partnership has set its three priorities as follows: Growing our economy; reducing inequalities; maximising the impact of the low carbon economy.
	Harness the assets of our communities to encourage and facilitate self-help	The NHS Borders approach to improving health and well-being in the Borders is harness the assets of our communities to encourage and facilitate self-help. NHS Borders works with local organisations, planning groups, communities and individuals to: **1. Improve Access To, And Quality Of, Services And Facilities** For example: healthy living centres; youth facilities; sports facilities; location of primary (and some secondary) care services in neighbourhoods; targeted outreach; workforce development. **2. Proactively Support Healthy Lifestyles, Mental And Physical Health And Wellbeing** For example: smoking cessation programmes; exercise programmes and access to leisure

Corporate Objective		Progress to Date
		facilities; diet, cookery and healthy food projects; sexual health projects; alcohol and drug misuse projects; promotion of screening and vaccination programmes. **3. Target Vulnerable Groups** For example: early years and children; older people; people with alcohol and/or drugs problems; minority populations; teenage parents; those affected by long term health problems and disabilities. **4. Tackle 'Upstream' Influences On Health Outcomes** For example: welfare rights projects to improve income levels; improve access to employment related opportunities; improvements to neighbourhoods and green space; improvements to heating and security in homes; address social isolation. **5. Increase Partnership Working** For example: notably with health service, social services and third sector organisations. **6. Promote Community Involvement** For example: in planning and delivery of health interventions that increase involvement, choice and control.
	Target the most deprived areas of the Scottish Borders to reduce inequalities	Examples of Borders initiatives aiming to reduce tackle inequalities Borders by implementing such actions include: **Scottish Borders Community Planning Partnership** The Scottish Borders Community Planning Partnership Inequalities Theme Group has developed a high level strategic plan to tackle and reduce five key strands of inequalities in the Scottish Borders. This 'Reducing Inequalities Strategic Plan' sets out how Scottish Borders Council and its partners will fulfil our responsibilities, refreshing our commitment to tackling inequalities and strengthening the contributions made by all key partners and stakeholders. The Strategic Plan will focus activities which seek to reduce inequalities in the Borders on the groups who are identified at greatest risk of falling into the most disadvantaged circumstances and/or in those areas where there are the highest levels of deprivation. • Single households • Children in Poverty • Single Parents • Elderly • Long term sick/disabled • Homeless • Women and Girls The Plan aims to reduce the inequalities in health & wellbeing between the most and the least deprived people by addressing the following: • People who are socially disadvantaged have poor health outcomes and the design, the level and intensity

Corporate Objective		Progress to Date
		of local service provision should reflect that • All staff in statutory or non-statutory organisations need to understand their public health role in reducing health inequalities and appreciate how health inequalities affect the population they serve • Enhancing, developing and maintaining partnership working across the Borders to address the many factors leading to health inequalities • Partnership working at a local and national level • Through CPP and IJB established principles on reducing health inequalities from evidence based work and apply these in a proportionate way across the Borders. **Health & Social Care Partnership Integrated Joint Board** The Integrated Joint Board is currently consulting on a Strategic Plan and one of its key objectives is to reduce inequalities in the Borders. Once the Plan is agreed an implementation plan will support this important initiative. **Public Health Directorate** The Joint Health Improvement Team leads and supports work across the Scottish Borders to improve health and reduce health inequalities. The Directorate is leading on the development of a Scottish Borders Public Health Inequalities Action Plan, which will underpin the Community Planning Reducing Inequalities Strategy Plan and identify the key priorities for the Scottish Borders and its partners. **Health Promoting Organisations** The award winning 'Small Changes, Big Difference' campaign from NHS Borders aims to engage our staff, the public and businesses across the Borders to make small changes in their life and work practice to make a big difference to their own and other's health and wellbeing. A project group has been set within the Scottish Borders Council to develop an implementation plan for promoting relevant aspects of the 'Small Changes, Big Difference' campaign to SBC staff. **Alcohol And Drugs Partnership** The Scottish Borders Alcohol & Drugs Partnership (ADP) is tasked with delivering a reduction in the level of drug and alcohol problems amongst young people and adults in the Borders, and reducing the harmful impact on families and communities. ADP are committed to working with the Scottish Government, colleagues, people in recovery and local communities to tackle the problems arising from substance misuse. **Healthy Living Network** Borders Healthy Living Network (HLN) was established in 2003 and operates in the most deprived areas in the Borders (Eyemouth, Langlee and Burnfoot) and aims to reduce inequalities in health by empowering communities to identify and address health issues that are relevant to them. **Keep Well**

Corporate Objective		Progress to Date
		This service focuses of people from a more deprived background who are at higher risk of developing heart disease and strokes, and it assesses their risk and recommends lifestyle changes to reduce the risk and also refers to local GPs when appropriate for drug treatments. The service is run by the Lifestyle Advisor Support Service (LASS) and this means that the service can offer intensive support to help people change their lifestyle risk factor when required. **Third Sector Organisations** The Third Sector makes a direct impact on the wellbeing of citizens in our local communities and contributes to the improvement of its public services which support people with particular health issues e.g. diabetes, mental health, sensory impairment, etc. Third Sector organisations can be very effective in addressing the wider factors underlying health inequalities.
	Promote well-being with a strong focus on the healthy development of children	The vision for the NHS Borders Children & Young People's Health Strategy 2014-2018 states that we will ensure that children and young people achieve the best health outcomes by having access to safe, effective and person centred health services as close to their home and as early as possible. Children, young people and families will receive support to improve their wellbeing and develop safe and healthy lifestyles. Children and young people will: 1. Have the best possible start in life and improvement in their wellbeing 2. Have access to high quality person and family centred health care at the right time and in the right place 3. Receive care and support that is targeted for those who are vulnerable and at risk of poor health outcomes, including mental health 4. Be involved in decisions and planning that affect their health and when appropriate include their families too 5. Have an improved experience for their transition to adult health services The improvement framework identifies actions that are being progressed and will continue over the coming months. We have had a Joint Inspection of Children's Services by the Care Inspectorate which commenced in January 2016 and the report was published in June 2016; a multiagency improvement plan is in place and actions are progressing. We have recently launched a new Integrated Children's Plan across the partnership which clearly sets out the priorities for Children in the Borders with an overarching theme of reducing inequalities. Work has progressed on a multiagency basis to ensure implementation of the Children and Young People's Act (2014), in particular Parts 4, 5 and 18 in relation to the implementation of GIRFEC around the Child's Plan, Named Person Service and Wellbeing. The Supreme Court judgment on the Named Person Service

Corporate Objective		Progress to Date
		requires the Scottish Government to revise part of the legislation to ensure that it is compatible with the Data Protection Act and European Convention on Human Rights, particularly in relation to information sharing. The Named Person Service will be implemented across the partnership in line with the expected government implementation date of August 2017. Work is underway around the implementation of the Health Visiting Pathway and Health Visitors and Family Nurses are undertaking antenatal visits in line with the pathway. Working in tangent with Lothian as part of a hybrid model, an additional Family Nurse is currently being recruited in Borders. We have been able to recruit and train additional Health Visitors to support the Named Person service when implemented and the Health Visitor Integrated Pathway. By 2018 we will have an additional complement of 10 Health Visitors. Unlike other areas we have had no issue with recruitment. Scottish Borders has an above average uptake of child health reviews of young children at 27-30 months of age, with this being the third highest area in Scotland. 82% of children assessed in 2014/15 were meeting their developmental milestones which were greater than the Scottish average of 72. NHS Borders is working towards a target of 85% children about whom there are no concerns at their 27-30 month assessment. In relation to dental health in 2016, 76% of children in primary 1 were assessed as having no obvious sign of decay. This compares well to the national average of 69% and is the highest in Mainland Scotland. For primary 7 children, 84% had no obvious sign of decay in their permanent teeth, greater than the national average of 75% and the highest figure in Scotland. Dental registrations are an indication of the accessibility of preventative dental care. In Scottish Borders the rate of dental registration for children was 88.6%, in line with the national rate. Positively, children in Scottish Borders had the highest participation rate (regularly attending the dentist) in Scotland in 2015 for attending the dentist. Breastfeeding rates for those babies exclusively breastfed were increasing. By June 2016 40.3% of babies were exclusively breastfed at the 6-8 week review with the expected standard being 33% 95% of young children were fully immunised. The highest uptake in Scotland of flu vaccine in primary schools has been achieved.
Promote excellence in organisational behaviour	Be an excellent employer and become employer of choice	Over the past year NHS Borders has introduced Values Based Recruitment, an approach to help attract and select students, trainees and employees, whose personal values and behaviors align with an organisation's values. As part of this values based pre-employment induction and a values behavioral framework have been introduced. The key theme of our annual Local Workforce Conference on the 11th March 2016 was "Living our Values –

Corporate Objective		Progress to Date
		working in partnership with staff to support positive values in NHS Borders." An Internal Audit of Workforce Planning reviewed the processes used to develop the 2016-2019 Local Workforce Plan and as a result Workforce planning will become a core element of the Area Partnership Forum with a Subgroup of this Forum focusing on developing the plan and following its actions. This will stand alongside Terms & Conditions, Policy Development, Mandatory & Statutory Training, Staff Benefits Groups. These are all Co Chaired by a Manager and a Staff side Representative. Examples of training developed and delivered in Partnership between the trade unions, OH and HR are Sickness Absence Training and Job Evaluation Training. Partnership are currently focusing on raising the profile of the Area Partnership Forum and Partnership working. . The review of band 1 roles is now complete and with the majority of staff now Band 2.
	Value and treat our staff well to improve patient care and overall performance	The full roll out of iMatter has been achieved. There is a significant piece of work to be undertaken to deliver on the action plans as we note that we are in the lower bracket on the National SWAG Report. This is being explored from Board Executive Team downwards as well as across our organisation through discussions at the Area Partnership Forum. We continue to acknowledge and recognise good practice both clinically and non clinically through our annual Celebrating Excellence Awards and we acknowledge our staffs contributions to NHS Borders at end of service through a retirement ceremony which is attended by the Chair. We also have in place a retrial programme and are progressing the implementation of the Retrial PIN Policy via the Policy Development Group and Area Partnership Forum. We also now have a parental leave policy. We have just recently launched a Staff Benefits Microsite through the Staff Benefits Group, a sub group of the Area Partnership Forum. We were the first NHS Board to receive the Carers Award. Following this we have set up a steering group to progress through this award and embed the issue of staff as carers into our organisational ethos. We are currently reviewing the 'Whistle Blowing' policy and procedures to support staff in raising concerns and continue to use an electronic facility called Ask The Board.

Corporate Objective		Progress to Date
	Promote and engage leadership through: • Supporting a developmental culture • Showing genuine concern • Enabling • Inspiring others	NHS Borders recognises the importance of management and leadership capacity and capability in ensuring the delivery of safe, effective and high quality services for the people of the Scottish Borders and to support the 2020 vision. Promoting excellence in organisational leadership is embedded into the Staff Governance Action Plan. Using the Engaging Leadership Framework (Beverley Alimo-Metcalfe) NHS Borders is committed to promoting and engaging leadership through: • Supporting a developmental culture • Showing genuine concern • Enabling • Inspiring others By building this into local programmes as well as appraisal processes we will ensure that managers and leaders are clear about their role and responsibilities and enable performance to be managed appropriately. In addition the link between engaging leadership and employee engagement will be strengthened through the support of iMatter. Candidates from NHSB are put forward through National Leadership Programmes, which are run by NHS Education for Scotland. • Leading for the Future • Delivering the Future (currently on hold with NHS NES) • Playing to your Strengths Playing to your Strengths is also being developed locally with help from NES to support a small cohort of senior managers Staff have access to the Managers Development Network on-line and face to face sessions. Development of further work streams will support the six priority actions identified in the 2020 2015-16 implementation plan, in particular the adoption of value driven approaches, addressing the challenges around middle management and the development of more robust succession and talent management plans. NHS Borders Training & Development Department are working towards creating a Talent Management Programme. They work particularly in 'hot spots' – areas with issues around succession planning etc – to develop both professional and leadership talent in these specific departments for the future. In addition NHSB participates in the NHS Scotland Management Trainee Scheme, which has been very successful and includes hosting a trainee for a period of 3 years. A Scottish Public Sector Leadership Exchange Programme allows staff to swap into other Public Sector organisations, pairing up leaders across sectors to provide insight into different cultures, constraints and

Corporate Objective		Progress to Date
		opportunities within the public service. **Coaching & Mentoring** In conjunction with Scottish Borders Council, coaching and mentoring is available through training courses "Coaching for Success" and "Mentoring for Managers". Coaching is built in to the First Line Manager Training Programme. Through the Scottish Coaching Collaborative, there is access to coaches across the entire public sector in Scotland on a collaborative basis. This allows for the best match of both coach and kind of coaching and is free of charge, as NHSB coaches also take part in the scheme. Regular use of the Executive coaching is commissioned through the National Leadership Unit at NES. **Newly Qualified Practitioner Programme** The Newly Qualified Practitioner Programme provides a great opportunity for us to support and value newly qualified staff nurses within NHS Borders. The programme consists of 5 study days spread over 5 months; followed by 6 months where the NQPs will be supported to complete a small scale improvement project. The development that takes place within the Programme acts as evidence for the participants Flying Start professional development portfolios. The first cohort which began last November has completed the first 5 study days and a 2nd cohort started on the 24th May 2016. The aim of the NQP Programme is to develop confident reflective professional nurse practitioners with a commitment to life-long learning who are able to deliver high quality person centred, safe and effective care. At the end of the programme NQPs will have demonstrated within their clinical roles development of confidence and application of: • the principles of person-centred practice • values-based care • evidence-based practice • clinical decision making processes • effective leadership appropriate to their role Learning outcomes will be evidenced by the NQPs' Flying Start Portfolio entries and a presentation of a small scale improvement project at the end of the NQP Programme. There have been very positive and encouraging evaluations being returned. The main themes that emerge are: • Appreciation of time to constructively reflect on practice • Feeling supported by sharing experience with peers in an otherwise overwhelming experience of being newly qualified. • Support and guidance with portfolio development • Learning from experts in practice

Corporate Objective		Progress to Date
		Return to Practice We have actively supported the Return to Practice Programme for many years. We ran a successful joint programme with Lothian in the early 2000s & more recently have been taking students from Stirling, Cumbria and currently have an SLA with Glasgow Caledonian University (GCU). NHS Borders are offering placement to 2 nurses in September 2016 from GCU and will be advised whether 450 hours = 12 weeks or 300 hours = 8 weeks practice hours are required. The Scottish Ongoing Achievement Record is utilised. Over the past 5 years there have been 5 Physiotherapists who have successfully returned to practice, and in addition 1 further with an EU Registration who is currently being supported through the process of fulfilling the requirements to register with the HCPC, allowing her to take up a post as a Physiotherapist. **Careers Fair** A Careers Fair was held at Galashiels Academy in Spring 2016 and an NHS Borders Practice Education Facilitator attended on behalf of 'Healthcare Careers', promoting NHS Borders as a prospective employer for those wishing to pursue a career in healthcare. Recruitment colleagues from the 3 local Universities were invited and both QMU and University of Edinburgh attended, with NHSB Practice Education Facilitator representing Edinburgh Napier University on this occasion. The primary focus was on Healthcare and Allied Healthcare. The overall impression of the event was a very positive one. Moving forward we plan to access all 9 Borders High Schools and also highlight career opportunities in medicine in a bid to improve the numbers and quality of applications for careers in healthcare.

6. LOCAL DELIVERY PLAN ACTIONS IN THE FEEDBACK LETTER

Action	Owner	Progress Update	Planned Future Activities
Health Inequalities and Prevention - It is important that your Board maintains a focus on longer term outcomes and not just on short term activity on tackling inequalities and prevention. In addition, it remains important that you focus on the health of you own workforce as well as the wider environment for which you are responsible. The Health Promoting Health Service is a key part of this and we expect you to continue to retain a focus on this programme.	Allyson McCollam	The Scottish Borders CPP Reducing Inequalities strategy sets the priorities and high level outcomes and the Public Health led work on reducing health inequalities derives from this. This includes agreeing relevant measurable outcomes that are being aligned with the plans and priorities of relevant strategy groups in health and social care, for example the new physical disability strategy in development, and in wider settings eg in relation to community justice. Workforce health is being actively supported as set out in our HPHS annual report. Work and wellbeing services are involved as a partner in prevention and early intervention activities as part of our shared commitment to improve coordination, reach and impact. The Public Health led Small Changes Big Difference social marketing campaign in NHS and SBC supports staff, service users & patients to improve health.	The work described will be continued and developed in partnership.
Antenatal and Early Years - Boards should continue to work to achieve the Antenatal Access LSP standard that requires that 'At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation'.	Nicky Berry	NHS Borders is currently achieving the target of greater than 80% of women booked by 12 weeks. Monitoring of performance is undertaken through the performance scorecards of Clinical Boards and reported to the Clinical Executive Ops Group.	

Action	Owner	Progress Update	Planned Future Activities
Antenatal and Early Years - The Scottish Government has confirmed funding for a further 3-5 years for the Maternal and Children's Quality Improvement Programme as part of the Scottish Patient Safety Programme (SPSP). All Boards should continue to contribute to, and support, this important programme that will deliver improved outcomes in maternal, neonatal and paediatric care.	Julia Scott / Dawn Moss / Nicky Berry	NHS Borders is actively involved in the Maternal and Children's Quality Improvement Programme. There are a number of outcome measures such as: **<u>Maternity Care</u>** • Reduce stillbirth by 15% nationally • Post partum Haemorrhage • Safety briefs **<u>Neonatal Care</u>** • Harm from mechanical ventilation • Harm from invasive lines • Harm from transition of care • Increase natural feeding **<u>Paediatric Care</u>** • Serious safety events • Medication events • Child protection concerns Leadership and clinical engagement is crucial to ensure we continue to improve safety and outcomes for our babies, neonates and children.	

Action	Owner	Progress Update	Planned Future Activities
Antenatal and Early Years - Boards should also continue to take cognisance of messages in the annual MBBRACE-UK reports into Maternal Morbidity and Perinatal Surveillance. Those Boards which are flagged red or amber by the Perinatal Surveillance report should undertake an urgent review of their cases of stillbirth and neonatal mortality and ensure lessons are learned. All other Boards should also undertake the same critical process with all perinatal deaths to ensure we continue to reduce perinatal mortality across Scotland.	Nicky Berry	We are actively involved in the Scottish Patient Safety Programme Maternity and Children's Quality Improvement Collaborative and the Early Years Collaborative to improve the quality and safety of Children and Maternal healthcare. We have implemented both the: • AFFIRM study (Awareness of Fetal movements and Focusing Interventions Reduce Fetal Mortality) • GAP programme (**Growth Assessment Protocol).** We review all of our stillbirths through our local clinical governance process with any learning shared with parents and staff. Significant Adverse Events are undertaken with external review and joint reviews with NHS Lothian.	
Safe Care - It is important that in 2016-17, governance and leadership across managerial and clinical staff is embedded for SPSP and other area programmes, e.g. MCQIC, and that robust data collection and reporting mechanisms are in place to demonstrate these improvements.	Laura Jones / Julia Scott	NHS Borders have identified their own safety priorities, which include identification and rescue of the deteriorating patient across the system, medicines safety and care of the frail, elderly patient across the system. These mirror the national priorities which were identified in the report from the 90 day focus work. Progress against these areas is monitored by the Clinical Executive Operational Group and through the Board Clinical Governance Committee.	Restructure of the deteriorating patient workstream meeting – this will be chaired by the Medical Director, and an agreed, revised driver diagram will form the basis of improvement work. The Health Foundation funded projects – Deteriorating Patient in Community settings and Safety Monitoring and Measurement Framework testing work have now concluded but the testing work has spread, and now embedded in both areas. Data for improvement continues to be used as a means of identifying improvements.

Action	Owner	Progress Update	Planned Future Activities
Safe Care – Vale of Leven Inquiry - The Board should continue to implement the recommendations based on the feedback provided in your returns of January and Summer 2015.	Sam Whiting	NHS Borders has fully implemented all recommendations for Health Boards except recommendation 72 which will be completed by the end of November 2016.	The revised Adverse Event Policy will be submitted to the November 2016 meeting of the Clinical Executive Operational Group for formal approval.
Person-centred - We expect NHS Boards to continue to work on developing positive care experiences with a strong focus on the outcomes that matter to people using services, guided by the five "must do with me" principles of care. This extends to your efforts to implement the Strategic Framework on Palliative and End Of Life Care.	Laura Jones	NHS Borders continues to grow and develop the roles of volunteers to enhance patient experience. This has included the development of a schools programme within Melburn Lodge (the older adult mental health inpatient ward) in partnership with a new group of S6 pupils from Earlston High School. The patient feedback volunteer programme continues to develop to seek proactive feedback from patients, families and members of the public to influence local improvements. Additional volunteers have recently been recruited. Testing is underway of patient opinion at full subscription level with the Medical Assessment Unit, BGH involving senior clinical staff responding directly to feedback. The Public Partnership Forum has been reviewing its terms of reference to span Health & Social Care Integration to ensure that there is strong engagement with local communities and members of the public. Public members of the PPF have joined the Integrated Joint Board, Strategic Planning Group, Localities Planning Group and Localities Planning Sub Group. A review of PPF membership has taken place to ensure wide and diverse representation and a recruitment process is about to begin. The Strategic Framework on Palliative and End of Life Care is part of the Palliative Care managed networks approach to person centred care within Palliative Care services. There is a vision of end of life care which incorporates person centred care which is currently being developed by our End of Life Care Facilitator. There is public representation on our Palliative Care network and family involvement in development of facilities and services.	NHS Borders will work towards reaccreditation as an investing in volunteer's organisation at the start of next year. A targeted piece of work is being commissioned to look at the experience of patients and their carers at the transition from hospital to community care. This will focus on patients who are frail or who have dementia. This will help inform priority areas for integrated services and will be supported by Borders Voluntary Care Voice on behalf of NHS Borders and Scottish Borders Council. Borders NHS Board will consider full roll out of patient opinion at full subscription level at a Board meeting later this financial year. We have recently employed 2 staff nurses and will be employing a Quality Improvement Facilitator to develop outcomes and measurements using the OACC system. This also includes patient and relative views on care.

Action	Owner	Progress Update	Planned Future Activities
Person-centred - As the Complaints Standards Authority's review of the NHS complaints procedure concludes over the course of the year, we expect your Board to prepare to implement the revised procedure.	Laura Jones	NHS Borders have developed and tested a new complaints handling process to involve more direct contact with patients, families and staff. This method encourages reflective practice and aims to listen and learn from complaints.	A continued focus for the coming months will be on early resolution. Work is underway to test a 'Help' sign set at the side of the patients bed to make is easy for patients and their families to know how to raise a concern and to get a timely response from the nurse in charge or from the senior clinician on for the hospital that day. The new national complaints handling guidance is being reviewed against our local process to ensure consistency.
Primary Care - Boards are in the process of developing their final plans of new models of care / test of change initiatives, multi-disciplinary team working including working across sectors and actions being pursued to implement Sir Lewis Ritchie's review of out of hours primary care services.	Alasdair Pattinson / Annabel Howell	**Buurtzorg in the Borders** NHS Borders is progressing plans to introduce a Buurtzorg approach for community care across parts of region. Initial community engagement exercises have taken place with further sessions planned to gauge interest and support from a range of stakeholders within our local communities. This initiative will complement the range of other developments being supported through the Integrated Care Fund programme to test new models of care and pathway redesign. **Out of Hours** • Approval to proceed from Clinical Board in respect of ADASTRA upgrade to support use of the system outside the hospital when GPs and Nurses are out on patient visits • Further to ED Department accommodation scoping exercise, prioritisation of prospective elements within any future upgrade of facilities has now taken place. This exercise has included BECS participation to ensure opportunities for closer working are identified and best use of accommodation available can be made. • ANP in BECS appointed as part of PDSA aimed at supporting medical team in BECS • BECS drivers job descriptions are being rewritten to include the HCSW role, which will improve service efficiency, support AED when we have capacity, and help cover the deficit of	Ongoing community engagement sessions planned during November. • Unscheduled Care Leads to meet to review how best to work together to achieve ED medical model, support AAU and support the ambitions contained within the local Transforming Urgent Care Plan. • Unscheduled Care Division to put into place project leadership arrangements to deliver Transforming Urgent Care

Action	Owner	Progress Update	Planned Future Activities
		overnight SW care provision. • BECS continues to work on salaried OOH GP recruitment to reduce empty rota slots, and is working with P&CS to recruit to the Scottish Government funded recruitment & retention posts.	
Primary Care - Every General Practice should continue to take action to support the introduction of the post QOF (Transitional Quality Arrangements) revisions to the GMS contract in 2016-17.In particular, Boards are asked to consider what measures are being pursued in respect of developing productive GP Cluster arrangements, underpinned by strong local relationships.	Alasdair Pattinson / Annabel Howell	All practices have now identified their Practice Quality Lead (PQL). As prescribed by the TQA circular the PQLs will have 2 hours per month to fulfil their role. Having considered the remit of the Cluster Quality Lead (CQL), as described above, it is anticipated that the required time commitment for these roles will be at least x1 session per week for each cluster. This would need to be reviewed after 6 months to ensure sufficient time is being allocated. We have identified that the CQLs must be able to perform the following roles to ensure successful strong local relationships are developed and maintained: • Liaise and meet with the other CQLs to ensure consistency, sharing and learning from successful approaches – this could be virtual. • Liaise and meet with representatives from the IJB to ensure they are aware of the strategic direction from the IJB in terms of service delivery. • Liaise and meet with GP representatives to ensure that any proposed changes to working practices are acceptable to both the wider GP population and to the elected representatives of GP opinion – GP sub committee. • Liaise and meet with the locality coordinators to ensure the alignment of priorities. In terms of funding we have agreed with colleagues from Scottish Government that we can use part of the Primary Care Transformation Fund allocation to help us start the process however an outline plan in relation to the longer term use of the this fund needs to be discussed and should describe mechanisms to redesign the delivery of primary care activity that releases GPs to provide the CQL role in a cost neutral manner.	Approval for local cluster arrangement and cluster quality lead appointments to be sought by NHS Borders Board during December

Action	Owner	Progress Update	Planned Future Activities
Integration - Going forward, Partnerships' Strategic Plans will include all relevant services and we would expect to see NHS Board LDPs reflect plans to shift the balance of care and support Health and Social Care Partnerships in achieving the national health and wellbeing outcomes for Integration.	Eric Baijal	The Scottish Borders Health and Social Care Partnership, "Changing Health and Social Care for you" was discussed by both the NHS Board and the Council before being given final approval by the Integration Joint Board in March 2016. The plan describes the agreed scope of the partnership detailing the specific delegated services and has the very definite support of NHS Borders. It gives nine local objectives which map to the national outcomes as well as a high level description of the financial shift towards community care intended over the three year planning cycle.	Collaborative work to shift the balance of care is well underway. A number of redesign and business transformation projects are underway, some funded through the Integrated Care Fund. Some integrated strategies already exist such as that for alcohol and drugs. Integrated mental health and learning disability strategies have been developed. Locality co-ordinators have been mapping assets in each locality taking a co-production approach, involving communities, the Third Sector, parent organisations and other stakeholders. The views and preferences of individuals, clients and carers, are actively being actively sought as part of this process, which has been based on asset mapping with local communities Locality plans are expected for 31 March 2017. Regular performance monitoring report to the IJB has been instituted, while we continue to develop the performance monitoring framework. The need to identify local outcomes and indicators is recognised and work begun.

<table>
<tr><th>Action</th><th>Owner</th><th>Progress Update</th><th>Planned Future Activities</th></tr>
<tr>
<td>Scheduled Care - It is a legal requirement for all Boards to deliver the 12 weeks Treatment Time Guarantee. All Boards are expected to deliver the LDP standard of a maximum 12 weeks wait for first outpatient appointment (95% with stretch 100%). Boards will continue to be monitored against their compliance with the 18 weeks Referral to Treatment standard during 2016-17 (90%).</td>
<td>Katie Morris</td>
<td>To consistently achieve a 12 week wait for outpatient services

<table>
<tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>Standard</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>12 weeks - 2016/17</td><td>316</td><td>359</td><td>415</td><td>374</td><td>224</td><td>317</td></tr>
</table>

The number of patients reported as waiting longer than 12 weeks has increased in September due to ongoing issues within Dermatology, Gastroenterology and Pain Control that the service are trying to remedy.</td>
<td>NHS Borders has submitted short term capacity plans to the Scottish Government for additional waiting times capacity to support a reduction in over 12 week waits.

- Cardiology: capacity is an ongoing problem, work is ongoing with the service to look for solutions.
- Chronic Pain: Capacity issues within the service are causing a continuing concern with no identified solution.
- Dermatology: Currently is an issue until the appointment of the new Consultant that is due to start in January 2017. A review into the service is currently underway.
- Diabetics / Endocrinology: continues to be challenging. Short-term capacity has been organised with local clinicians whilst a longer term solution is identified.
- Oral Surgery: sickness absence had led to significant pressures in this area. The locum consultant has left and the new Consultants are expected to take over from January 2017. Locum weekend clinics are being organised to cover the service in the interim.
- Gastroenterology: The waiting lists have been reduced to 8 weeks however capacity issues within the service still require ongoing support to prevent patients going over 12 weeks.</td>
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Action	Owner	Progress Update	Planned Future Activities
Scheduled Care - The '*Getting Ahead'* Programme has been established and it is a requirement that the 2016-17 LDP includes, "assessments of activity requirements to ensure the best possible performance against elective waiting times during 2016-17 as well as the local work that will be carried out on the longer term objective of ensuring the optimal design, configuration and availability of services in the context of an ageing and growing population".	Katie Morris	NHS Borders has fully engaged with the "Getting Ahead" programme and submitted this as part of the LDP for 2016-17.	
Scheduled Care - During 2016-17 you are asked to share your monitoring of actual activity against your 2016-17 planned activity, as a basis for action and development in line with the National Clinical Strategy.	Katie Morris	Inpatient TTG weekly monitoring (latest return):  TTG weekly Template 1 - Oct 16.xlsx Outpatient TTG weekly monitoring (latest return):  New Outpatient Weekly Report - Sep	NHS Borders continues to submit activity against plan.

<table>
<tr><th>Action</th><th>Owner</th><th>Progress Update</th><th>Planned Future Activities</th></tr>
<tr><td>Cancer - NHS Boards are expected to deliver the cancer access standards in order to ensure timely diagnosis and treatment for cancer. I have asked the Cancer Delivery Team to work with Boards on a national basis to produce improvement plans for key cancer pathways. We will want to engage with your Board on this over the Summer.</td><td>Katie Morris</td><td>Two cancer standards are in place on which NHS Boards are asked to deliver:

- The 62 day urgent referral to treatment standard includes screened positive patients and all patients referred urgently with a suspicion of cancer.
- The 31 day standard includes all patients diagnosed with cancer (whatever their route of referral) from decision to treat to treatment.
- The current standard is that 95% of all eligible patients should wait no longer than 62 or 31 days.

Cancer Waiting Times standards are reported quarterly. NHS Borders had consistently achieved the 62-day standard over the previous 5 consecutive quarters and the 31-day standard has been achieved every quarter since it was established.

Cancer Waiting Times | Apr to Jun-16
62-day standard | 97.22%
31-days standard | 98.18%</td><td></td></tr>
<tr><td>Unscheduled Care – additional funding has been allocated to the six essential actions improvement programme for in order to progress a stronger set of objectives for Boards this year to deliver sustainable improvements. We also expect NHS Boards to focus on embedding all improvement initiatives and other measures implemented going forward over the next year (2016/17) into routine systems to ensure delivery and sustainability.</td><td>Phil Lunts / Erica Reid</td><td>Actions as identified in LDP and the 6EA improvement programme are being progressed. All actions are underpinned by sustainability plan.

Specific progress against actions is detailed below.</td><td></td></tr>
</table>

Action	Owner	Progress Update	Planned Future Activities
Unscheduled Care - Boards are required to focus on key themes in the year ahead, these objectives were outlined in your funding letter, dated 4 May. Delivering these objectives will require collaborative working with all partners across the health and social care system and the national unscheduled care team	Phil Lunts / Erica Reid	To address the objectives outlined in the 6 Essential Actions Funding Letter we are: • Working to increase weekend discharge and improve patient flow by maintaining a duty manager on site during the day at weekends, as well as the Hospital Bleep Holder Clinical Site Manager • Remodeling inpatient medical beds and processes to provide focus on maintaining required discharges by day • Continuing work to increase morning discharges. Although these have increased slightly from baseline, we are not maintaining consistent levels of performance • Reducing boarding by remodeling the medical footprint to match capacity to demand • Through work with IHO, establishing a single dedicated elective ward with protected beds to avoid cancellation of inpatient electives due to bed pressures • Developing daily and weekly discharge requirements by ward to match expected admission demand. We have commenced monitoring these within the medical unit as part of the reconfiguration of this area.	• We intend to consolidate the work described previously. • We are looking to introduce the concept of red and green days to highlight delays within patient flow • Implement IHO redesign of planned care beds to create elective ward o 7th December • Establish 7-day discharge planning across elderly care wards and Community Hospitals • Working to develop forward planning for weekend discharges • Explore potential for IHO in Medicine/DME
Unscheduled Care - Escalation and recovery plans should also exist at site and board level and should be continually monitored and reviewed to provide the necessary assurance that peaks in demand can be managed with minimum disruption to patients. Boards should have in place adequate senior clinical and non clinical management/support, on site in and out of hours, to deliver the required improvements.	Phil Lunts / Erica Reid	• An Admission, Discharge and Transfer Policy has been developed. • An Acute bed escalation policy provides detailed guidance on escalation and recovery during times of acute patient flow pressures. This has been reinforced through a training programme for Hospital Bleep Holders (the clinical site managers within the hospital) delivered by Unscheduled Programme Manager. • Redesign of medical inpatient footprint has been implemented to reduce length of stay and delay in accessing elderly care beds. • Duty Manager role has been re-established on a 7-day basis within the BGH.	• Revise ADT policy to reflect changes to inpatient footprint • Developing demand and resource capacity tracker across health and social care as part of winter planning. • Developing clear whole system escalation plans for discharge delays • Use of the LEWIS score tool to understand system pressures

Action	Owner	Progress Update	Planned Future Activities
Mental Health - Many NHS Boards have already put a lot of effort into reducing waiting times for access to psychological therapies and to Child and Adolescent Mental Health Services (CAMHS) and we want to continue to improve access to mental health services.	Simon Burt	<u>CAMHS Waiting Times:</u> The CAMHS HEAT Target states that 90% of patients will start treatment within 18 weeks of referral. Since the LDP was submitted, CAMHS Waiting Times have achieved 100% in July, August and September. While it is too early yet to determine whether this is a trend and therefore if any improvement measures have been successful, this performance is expected to continue. Actions taken to achieve the target include: • Introducing a Team Manager (TM) post in CAMHS • Refining improvement programme information and tools to enable the TM to utilise capacity appropriately • Reviewed and improved the admin process for recording and reporting waiting times • Revised the internal process for managing referrals and allocating patients to and from the waiting list • Advertised ADHD Nurse Post – recruitment was unsuccessful and therefore the service is considering how and when to re-advertise • The Team Manager and Operational Manager for the service are also now considering how to implement a level of data scrutiny once the admin process is complete and prior to submission to ISD. <u>Psychological Therapies Waiting Times:</u> The Psychological Therapies (PT) HEAT Target states that 90% of patients will start treatment within 18 weeks of referral. Since the LDP was submitted, PT Waiting Times have not reached the target and in fact performance has decreased to 78% in September 2016. Actions taken to date include: • Direct allocation – Interim 0.6 WTE Clinical Psychologist recruited • 0.5 WTE Clinical Psychologist recruited to develop or grow capacity within a tiered-care model for delivering Psychological Interventions to populations of Older People • Recruitment of 1 WTE CAAP – an addition of 0.5 WTE to current establishment • Job plans for these posts will demonstrate that post-holders have a significant commitment to training, coaching and	<u>CAMHS Waiting Times:</u> • Continue with actions detailed under progress update section • Consider if, when and how to re-advertise ADHD Nurse post • Consider how to ensure a level of scrutiny around waiting times data prior to submission to ISD • Team Manager to report to Operational Manager, Service Manager and General Manager on a bi-monthly basis with regards to improvement information / tools and how capacity is being utilised more effectively <u>Psychological Therapies Waiting Times:</u> • Review job plans for all staff trained in Psychological Therapies to ensure there is protected time to deliver PT • Instigate project to look at possible changes in practice and areas for improvement, e.g. model and coordinate future delivery of groups, review New to Review ratios, resolve lack of clinical space issues etc

Action	Owner	Progress Update	Planned Future Activities
		supervision of a range of staff. • Introduced text reminder system for PT appointments in one team as a test of change, and will review impact of this. The service has also received support from HIS Improvement Advisors and ISD Data Analysts to review waiting list management and recording processes.	
Community Planning Partnerships - During 2016-17 we expect your Board to monitor the local impact that the NHS is making in community planning and the role senior leaders are playing, particularly in the shift towards prevention, early intervention and tackling inequalities.	Allyson McCollam	Public Health leads the Health Inequalities strand of the CPP's Reducing Inequalities Strategy and has worked with partners to promote awareness of health inequalities, identify priorities and to coordinate efforts with other partnerships and strategy groups. Public Health staff continue to support capacity building through Health Improvement training programmes and awareness raising with a range of staff across the CPP and with community groups. Discussions are ongoing to build capacity for health inequalities impact assessment as part of the equality and diversity assessment process.	Areas for action include: • Improving planning and coordination of diabetes prevention and treatment • Cancer - prevention opportunities • Extending reach and uptake of screening programmes • Expansion of community food programme and development of Food and Health Alliance through Healthy Living Network • Small Change Big Difference social marketing campaign in NHS and SBC to support staff, service users & patients to improve health • Improved pathways to access physical activity opportunities in community and from health services • Alcohol harm reduction actions • Continued promotion of health literacy

Action	Owner	Progress Update	Planned Future Activities
Workforce - As part of the implementation of Everyone Matters, we expect Boards to deliver 2016-17 actions across the 5 priorities for action.	Bob Salmond / Jennifer Boyle	The Everyone Matters Implementation Plan for 2016-17 continues work on the local key priorities as identified in the staff governance action plan (the five priorities for action) and two further priorities: • Sustainable workforce • Workforce to deliver integrated services	**During 2016-17, activity will also focus on:** • Identifying workforce actions to help tackle health inequalities. • Developing a workforce to deliver integrated health and social care services across NHS Boards, local authorities and third party providers.
Workforce - Strengthening workforce planning continues to be the focus in 2016-17 for delivering a sustainable workforce and we expect to see evidence of this in your NHS Board workforce plan (to be published on your NHS Board website by end of August 2016) and in your NHS Board's detailed workforce projections which are due to be completed and returned to Scottish Government by the end June 2016. We remind Boards that the application of the Nursing and Midwifery Workload and Workforce Planning Tools are mandatory and should be used and documented in the development of Workforce Plans and workforce projections.	Bob Salmond / Jennifer Boyle	NHS Borders Local Workforce Plan and associated action plan has been submitted for an internal consultation period and subsequently approved by APF and SGC. Workforce Projections submitted to Scottish Government in line with timescale. Discussed at APF and SGC and approved by Chief Executive and Employee Director. Nursing and Midwifery Workload and Workforce Planning Tools have been applied in the development of the Local Workforce Plan and workforce projections. A senior nurse has recently been designated to be a lead for Workload and Workforce Planning tools.	Final draft to be approved by Chief Executive

Action	Owner	Progress Update	Planned Future Activities
Monitoring and Reporting LDP Progress - Your NHS Board should ensure that progress is actively monitored across all areas of the LDP and that appropriate local performance management arrangements are in place around each of the Strategic Improvement Priorities.	Steph Errington	A new Performance Scorecard has been developed for 2016/17 which gave an opportunity to evolve the information that is presented and focus on the core business of the LDP Standards, as well as reduce the number of overall local indicators. This focused report brings together key issues and hot topics in a standardised format to facilitate discussion around specific areas and continues to monitor the standards as set out in the Local Delivery Plan and hot topics that are a focus for NHS Borders. The review provided the opportunity to improve and streamline the reporting process and to present the Board with clear and relevant performance information and a focus on actions to address performance which is off track. The new Performance Scorecard is presented to the Clinical Executive Operational Group, Strategy & Performance Committee and the Board. Monthly Clinical Board scorecards and quarterly performance reviews remain in place and the 6 monthly Managing Our Performance Report will continue to be presented to the Board. Strong Performance Management remains a key priority across NHS Borders to ensure robust monitoring of key local and national standards and priorities. Performance Scorecards are embedded across the organisation and individual services continue to implement their own scorecards with the assistance of Planning and Performance.	