NHS BORDERS

2012 Annual Review

Self Assessment

Progress against 2012 Annual Review action points

There were 7 items highlighted in the Annual Review held on the 30th September 2011. Progress updates against these actions can be found throughout the self assessment.

Action point 1:
Keep the Health Directorates informed of progress with the local implementation of the Quality Strategy and Change Fund

Please see agenda items 4, page 9 and 6, page 16

Action point 2:
Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection

Please see agenda item 3, page 7

Action point 3:
The Board should continue to build on progress against waiting times targets as it moves towards the 18-week referral to treatment target

Please see agenda item 4, page 13

Action point 4:
Keep the Health Directorates up to date with progress on the local efforts to meet the breastfeeding HEAT target

Please see agenda item 2, page 5

Action point 5:
Ensure there are robust plans in place to ensure delivery of the Dementia Diagnoses HEAT target by March 2012

Please see agenda item 6, page 17

Action point 6:
Work in partnership with the local authority to improve performance on delayed discharges, reducing the overall length of delays and bed days lost

Please see agenda item 6, page 11

Action point 7:
Continue to achieve financial in-year and recurring financial balance; and keep the Health Directorates informed of progress in implementing the local efficiency savings programme

Please see agenda item 7, page 19

Contents

Agenda Item 2:

Everyone has the best start in life and is able to live longer healthier lives

Agenda Item 3:

Healthcare is safe for every person, every time

Agenda Item 4:

Everyone has a positive experience of healthcare

Agenda Item 5:

Staff feel supported and engaged

Agenda Item 6:

People are able to live well at home or in the community

Agenda Item 7:

Best use is made of available resources

Agenda Item 2 Everyone has the best start in life and is able to live longer healthier lives

HEAT Target: Achieve agreed completion rates for child healthy weight intervention over the three years ending March 2014

At the end of March 2012, 121 children had completed Child Weight Interventions.

No of child health weight interventions at end of March 2012	Trajectory – March 2012
121	100

HEAT Target: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2011/12

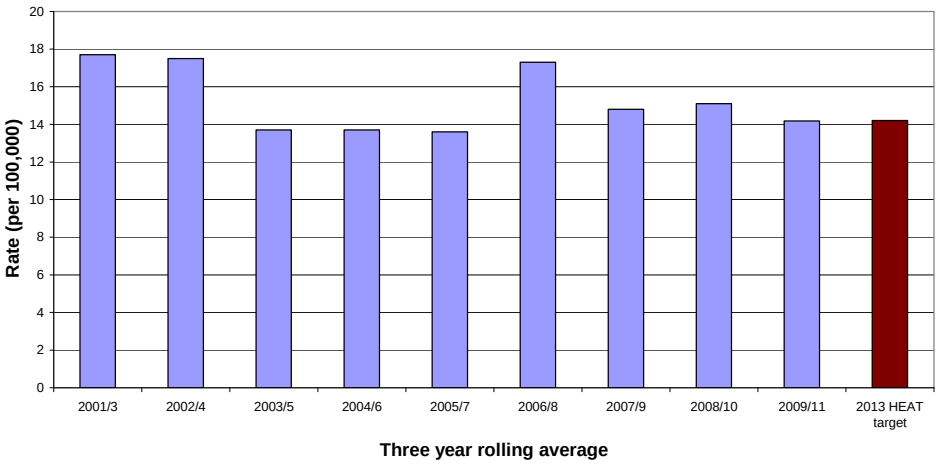
At the end of March 2012, a total of 2,727 alcohol brief interventions had been delivered over the year, more than double the target. These interventions covered A&E, antenatal and primary care settings, although Primary Care accounted for the majority of interventions.

No of appropriate alcohol brief interventions April 2011 - March 2012	Trajectory – March 2012
2,727	1,247

HEAT Target: Reduce suicide rate between 2002 and 2013 by 20%

To help deliver a reduction in suicide rates frontline staff are still being trained in suicide prevention techniques on a regular basis. The rolling average for 2009-11 shows that for the first time Borders are below the target of 14.2 per 100,000 population at 14.18. This is likely to fluctuate year on year due to the small numbers involved.

Trends in suicide rates in Borders 2001 to 2011 and 2013 target



HEAT Target: Through smoking cessation services, support the Board's smoking population in successfully quitting (at one month post quit) in the 40% most-deprived Board SIMD areas over the three years ending March 2014

This target measures the total number of the smoking population who have been supported to quit for a period of a month or longer in the 40% most deprived SIMD areas of the Board. As at 31st March 2012 NHS Borders have achieved 474 successful quits equating to 170% of our target.

Smoking population who has successfully quit at one month at the end of March 2012	HEAT target for end March 2012	Successful one month quits achieved as % of those needed
474	280	169.3%

HEAT Target: At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

The target of 38% by December 2011 was not met in NHS Borders; it was below trajectory at 1.35%. This target is measured on the worst performing Scottish Index of Multiple Deprivation category (SIMD). This means all categories (there are 5) should reach the target for both 3 and 4 year olds.

There is an improvement in the best performing category which are the 4 year olds in the most deprived areas from 24.7% to 33.2% by March 2012, The lowest performing category was 3 year olds in the most affluent areas of the Borders with only 2.25% being achieved, which was below the current trajectory of 4% by March 2012. However, the figures do show an improvement in all categories for both 4 and 5 year olds which will be due to the recent changes to the SDR and a reflection of the work being done within the Childsmile school and nursery and Practice programmes.

HEAT Standard: The proportion of new born children exclusively breastfed at 6-8 weeks in Borders to be maintained as a minimum at 33.3%

The latest annual rates available are for 2010 – 2011 which shows that 29.3% of babies in Borders were being exclusively breastfed at 6-8 weeks, which is below the standing target of 33.3%. The most recent quarterly figures to December 2011 show a rate of 30%, although the quarter before showed a rate of 36%. NHS Borders' performance remains higher than the Scottish average, which in 2010/11 was 26.5%.

In December 2011, NHS Borders confirmed its commitment to seeking accreditation with the UNICEF Baby Friendly Initiative and passed Stage 1 of this process in April 2012. Key developments by September 2012 include:

- A combined maternity and community breastfeeding policy agreed and in place. This includes a written policy and communication strategy on breast milk substitutes
- 50% of community and maternity staff will have been trained in breastfeeding management as required by UNICEF

- A practice audit to ensure compliance with policy has been undertaken and the action plan generated is being implemented
- A successful pilot volunteer peer support project has been developed in a local high deprivation area and this will be rolled out more widely in due course
- Developments are in progress with the local authority partner to promote breastfeeding in public buildings and premises

No of children exclusively breastfed at 6-8 weeks at end of Dec 2011	Ongoing Target
30%	33.3%

HEAT Target: Achieve agreed number of inequalities targeted cardiovascular health checks during 2011/12

This target was met with a total of 402 health checks completed by the end of March 2012. Of this total, 83% of the checks were delivered in primary care, 11% in the workplace and the remainder in community pharmacies.

No of cardiovascular health checks completed at March 2012	Target – March 2012
402	390

Contributions to Single Outcome Agreements (SOA)

Critical issue: Health inequalities and early years

NHS Borders continues to work closely with Scottish Borders Council and other partners to take forward the joint Early Years Strategy for Scottish Borders. The local Early Years Change Fund will support agreed priorities within this joint strategy:

- Development of locality based Early Years Networks, led by community nursing
- Redesign of the locality model for Early Years Services
- Workforce development in line with the common core skills framework
- Development of capacity within communities through volunteering and peer mentoring

In relation to substance misuse, Children Affected by Parental Substance Misuse (CAPSM) guidelines have been developed by our local Alcohol and Drugs Partnership and Child Protection Committee and implementation is being refined further to embed the named person as the next stage.

Tackling domestic violence continues as part of the wider Violence against Women Partnership and specifically through CEL 41. The extensive training programme continues to have good uptake including participation from midwifery and community nursing staff. NHS Borders has active involvement in the pioneering new Pathways project integrated service delivery model to support women and families who experience domestic violence.

With reference to poverty and low income NHS Borders is currently scoping the impact of the welfare benefit reforms and implications of the recession for population health needs. This includes ensuring clear pathways are in place for patients and families to access advice services as appropriate. Community based programmes delivered in Borders Healthy Living Network areas actively engage with families – including fathers / male carers - on low income to enhance community capacity, promote healthy living and address barriers to health. Increasingly these community programmes are planned and delivered in partnership with SBC Community Learning and Development.

In addition to the above, the local antenatal education programme is being revised in line with the National Education Scotland (NES) national resource materials. The community component of the programme is being linked into the newly established early years locality networks to maximize reach and engagement and to ensure consistency of messages for expectant parents.

The midwives in the local integrated Early Years Assessment Team continue to work with vulnerable families and it is anticipated that the breastfeeding volunteer peer supporters will work closely with this client group.

Agenda Item 3 Healthcare is safe for every person, every time

Healthcare Acquired Infection (HAI)

The prevention and control of infection is a high priority for NHS Borders.

- NHS Borders continues to participate in the National Surgical Site Infection Surveillance for the mandatory procedures of hip arthroplasty and caesarean section. During 2011/12 NHS Borders also conducted SSI surveillance on knee arthroplasty and breast surgery. During 2011/12, the infection rates for all these procedures remained better than or around the Scottish average.
- National Hand Hygiene Audits continue. Compliance stands at 94.2% for 2011/12.
- In 2011/12, NHS Borders achieved 97% overall compliance in cleaning audits against the *NHSScotland National Cleaning Services Specification*.
- NHS Borders has embedded public involvement in infection control activities.
- NHS Borders has maintained an MRSA screening programme that exceeds the SGHD minimum requirements and includes use of the national Clinical Risk Assessment (CRA) tool.
- NHS Borders Antimicrobial Management Team meets quarterly and continues to review antimicrobial prescribing data, audit data and antimicrobial resistance data
- Review of antimicrobial guidelines is ongoing in response to clinical and microbiological drivers, including minimising use of antibiotics associated with C. difficile.
- An Antimicrobial Nurse continues to support audit and education relating to antimicrobial prescribing.
- Twice-weekly antimicrobial ward rounds by the Antimicrobial Pharmacist and the Consultant Microbiologist continue, reviewing the use of restricted antibiotics and patients with complicated antimicrobial prescribing issues.
- A Standard Infection Control Precautions e-learning unit has been developed for all staff to complete. To date, 85% of all staff have completed this module.

- The programme of inspections by Senior Nurses continues, that was established within Borders General Hospital using a standardised tool based on the HEI Inspectorate HAI and OPAH tools.
- The programme of inspections by Executive Directors with Senior Managers also continues.

In order to strengthen our routine infection control activity the following work has been implemented:

- Investment and upgrade to the infection control IT system (ICNet) to improve data provision and enhance infection surveillance
- Implementation of an improved infection control audit programme developed by the Infection Prevention Society

HEAT Targets: Further reduce healthcare associated infections so that by March 2013 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections (CDI) in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.

In the year ending March 2012, NHS Borders had a rate of 0.32 SAB cases per 1000 acute occupied bed days which was higher than the target. However, this represents a 29% improvement on the previous year. NHS Borders maintains a learning and improvement cycle to support further reductions in the number of SAB cases.

In the year ending March 2012, NHS Borders achieved a CDI rate of 0.37 cases per 1000 total occupied bed days, achieving the target.

Patient Safety

2012 has seen the commencement of several new work streams - the Paediatric programme, the venous thromboembolism (VTE) and Sepsis collaborative which commenced in April 2012, the start of the Mental Health pilot in August 2012 and the end of the Primary Care pilot project in June 2012. As a result of this pilot undertaken by NHS Borders, NHS Tayside and NHS Grampian, Patient Safety in Primary Care is expected to commence nationally in March 2013.

Spread of all the key changes (including testing, training, communication) is underway beyond the pilot populations throughout the Borders General Hospital within the five initial workstreams: general ward, peri-operative, medicines management, critical care and leadership.

Infection control data for ITU continues to show sustained improvement with safe processes now implemented. The team have had sustained improvement in the process measures (above 95% for 9 months or more). Regarding medicines management, improvements have been made with medicines reconciliation in the two pilot areas, and plans are afoot to spread to paediatrics. General ward teams are also continuing to show improvements, in the care of the deteriorating patient and in their infection control data. The peri-operative workstream continues to be committed to patient safety and on going testing is showing improvements in processes across all the theatres. Executive

walkrounds continue to take place within NHS Borders providing staff and executives alike with opportunities for discussion and action planning around patient safety issues.

NHS Borders has had one site visit from HIS this year, in May 2012 to discuss the sepsis and VTE collaboratives, and the mental health 'travelling team' are prepared for the first learning session at the end of August.

Older People in Acute Hospitals Inspections

NHS Borders was involved in the pilot for Healthcare Improvement Scotland-led Older People in Acute Hospitals (OPAH) inspections in October 2011. Building on this experience we have conducted a programme of Executive Team inspections through the year and in July 2012 we received an OPAH inspection.

Agenda Item 4 Everyone has a positive experience of healthcare

The Quality Strategy is crucial in making sure everyone has a positive experience of their interface with the healthcare system. NHS Borders has focused the organisation's '20:20 Vision' and Corporate Objectives on quality ambitions and healthcare outcomes. The Workforce Plan for 2012/13 also promotes working towards quality throughout the Health Board. Through the contribution to the Participation Standard and the development of the new National Person Centred Health & Care Programme and the results of the Better Together Patient Experience Survey NHS Borders can monitor positive experience. National reporting on progress towards the Scottish Patient Safety Programme, Clinical Quality Indicators and Healthcare Acquired Infection measures show the implementation of quality.

Patient Experience (2011/12)

As discussed delivering high quality care is at the heart of the work of NHS Borders and ensuring the best possible experience for every patient is a fundamental part of this.

Better Together Patient Experience Programme: Inpatient Survey 2010/11

The results of the 2010/11 Better Together Patient Experience Programme inpatient survey results were published in August 2011, which demonstrated that NHS Borders did well compared with the 2010 results and that they were in line with the national averages.

During 2011/12, the Borders General Hospital (BGH) has developed improvement plans, based on the five bottom inpatient survey results of 2010/11, with their BGH Participation Group (which was established in September 2010). These improvement plans have been based on the following:

- Patients being bothered by 'noise at night'
- Knowing who is in charge of the ward
- Assistance with arranging transport
- Danger signals to watch for after discharge from hospital
- Being told hold long an A&E wait would be

NHS Borders submitted an abstract on their 'Noise at Night' project, under the category of person-centred, for the NHSScotland Event held in June 2012, which was selected to be displayed at the event.

NHS Borders has received the interim results for the 2011/12 Inpatient Survey, which are due to be published on 28 August 2012. The BGH Management Team and the BGH Participation Group will be working during 2012/13 on required improvements identified from this survey.

NHS Scotland Participation Standard

Following a national evaluation of the Participation Standard self assessment process 2010/11, the Scottish Health Council (SHC) decided not to undertake a formal assessment for 2011/12. Instead, Health Boards were asked to develop improvement plans based on the Better Together Patient Experience Programme survey results, and feedback from the Participation Standard self assessment.

During 2011/2012, Public Involvement (NHS Borders) have worked with lead officers from each Clinical Board area to support them to produce and take forward their improvement plans. Primary & Community Services have produced a Public and Patient Involvement Action Plan. Acute, Mental Health & Learning Disability Services have been working to actions in line with a number of outcomes which include: improve the participation experience of service users/public involvement members; staff are aware of the views of service users/public; service users have been involved in the redesign work of the service; services and patient care is improved as a result of robust patient experience input; the public/patients have the opportunity to influence the decision making processes within NHS Borders.

Examples of services which have been implemented by Clinical Boards to improve patient experience include:

- 'Intentional Rounding' has been introduced in two Community Hospital Teams and three Acute Hospital Ward Teams. This approach aims to provide better than expected care by using a regular routine of individualised patient checks in hospital. Rounding is "patient" rather than "task" focused. At predetermined times, a nurse checks in with the patient, not to 'do something to' them, but to find out if they are comfortable and if there is anything they need. It includes meeting the identified needs and checking the patient environment to ensure that it is clean and uncluttered and that everything is in reach of the patient.

- Gala Resource Centre (an integrated day service for mental health service users provided by NHS Borders and Scottish Borders Council) have adapted and introduced an assessment schedule. This involves service users assessing their own needs and subsequently planning their own Recovery Plan. Service user involvement in planning and evaluating the service is a continued priority. Gala Resource Centre continues to show commitment to "mutual" working with services users through participation.

- The Mental Health Rehabilitation Service has made steady progress to introducing Recovery focussed care. Their most recent Scottish Recovery Indicator 2 (SRI2) audit showed strengths in care planning that empowered service users to participate in planning towards their recovery. They are fully involved in writing plans that help them

to understand the care and treatment being delivered by professionals and whenever possible includes involvement from carers and relatives.

Public Involvement (NHS Borders) have also co-ordinated a number of improvements including the Public Partnership Forum (PPF) improvement plan. Also, the PPF formal working agreement between the Scottish Borders Community Health & Care Partnership (CHCP) and the PPF was approved by the CHCP Board in January 2012. This confirms the support the CHCP provides to the PPF in recognising it as the mechanism for maintaining effective dialogue with the local community and confirms what the PPF and CHCP expect of each other.

The NHS Borders process for Co-ordinating Public/Patient Engagement continues to be embedded within services for use when informing, engaging and consulting with public/patients on service delivery and redesign.

Following the review of the Participation Standard, Health Boards are being asked to undertake a self assessment for the 2012/13 reporting period. The self assessment will focus solely on Section 3 of the Standard which is Corporate Governance, and will provide an opportunity for NHS Borders to demonstrate improvement in embedding PFPI across their organisation.

HEAT Target: Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.

During 2011/12, NHS Borders have continued the sustained effort to reduce Occupied Bed Days across the board, with a particular emphasis on the 75+ age group. The table below shows the latest provisional figures for the rolling year to February 2012 per 1000 population.

	Total rate of Occupied Bed Days for patients 75+	**Target – rate per 1000**	**Difference**
Feb 2012	5,286	5,734	-8.3%

HEAT Standard: Delayed Discharges over 6 weeks

The Partnership between NHS Borders and Scottish Borders Council has in place joint management arrangements to ensure that no client waits longer than 6 weeks to be discharged from hospital into a more appropriate care setting. It has also created a joint fund to minimise delays in the discharge process. The Partnership has also progressed a range of initiatives aimed at ensuring discharges are managed within a revised joint Adult Patient Discharge and Transfer Policy so that best practice is achieved within the context of service change. These include:

- Co-location of services and departments in Cheviot and Tweeddale areas
- Service Improvements supported by the Change Fund and NHS Borders Business Improvement Support Team in areas such as Anticipatory Care, Social Work Referral Processes and Social Work Out of Hours Services

- A refocusing of Multi-Disciplinary Team meeting arrangements including the introduction of daily “board rounds” to ensure patient flow
- Patient Flow Action Team meetings to ensure discharge and transfer arrangements are supported by senior managers where required to avoid disruption within acute services
- A Joint Stakeholder Event supported by the national Joint Improvement Team to promote best practice in Discharge Planning and Management
- Development of a Discharge Management Joint Performance Scorecard
- Joint Service Self Assessment using the Self Assessment Tool developed by the Joint Improvement Team

The Scottish Borders Partnership has met the target of zero delays over 6 weeks as at the April 2012 census, and the 2 quarterly census points previously. Performance has improved dramatically over the last year with less patients being delayed, for shorter timescales than in 2010/11. The standard remains a key priority across both NHS Borders and Scottish Borders Council.

HEAT Standard: Continue to provide 48 hour access or advance booking to an appropriate member of the GP Practice team

During 2011/12 Borders GP Practices achieved 94% for the PE7 QOF indicator, which measures patients access to a consultation with a health professional within 2 working days.

HEAT Target: The maximum wait from urgent referral to treatment for all cancers is 62 days (target 95%)

The target of 95% was achieved in all 12 months during 2011/12. 100% was achieved in 8 months.

HEAT Target: 95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat

95% or over of all patients in 2011/12 diagnosed with cancer began treatment within 31 days of the decision to treat. 100% of patients were seen within the 31 day target throughout the year.

HEAT Standard: 18 weeks referral to treatment, no patient will wait longer than 12 weeks from GP referral to a first outpatient appointment

As at 31 March 2012 NHS Borders had 2 patients waiting longer than 12 weeks for an outpatient appointment.

HEAT Standard: 18 weeks referral to treatment, no patient will wait longer than 9 weeks for inpatient or day case treatment

As at 31 March 2012 NHS Borders had 1 patient waiting over 9 weeks for an inpatient admission.

HEAT Standard: No patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment (target 98%)

In March 2012, 96% of patients were seen by A&E within 4 hours which was below the target of 98%. The target of 98% was achieved in 8 out of 12 months during 2011/12.

HEAT Target: Deliver 18 week referral to treatment from 31 December 2011.

NHS Borders is continuing to deliver the national targets for inpatients and outpatients, although there are some challenges.

Significant work is being undertaken in implementing and embedding Demand and Capacity work to ensure that within the organisation demand and capacity are matched and systems are performance managed.

Over the next 12 months we will be implementing prospective management of 18 weeks pathways, and are particularly working to improve performance for those patients on admitted pathways.

HEAT Target: To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013

The interim target for this measure was 80% as at March 2012. This was achieved in the quarter January to March 2012 with a total of 81% stroke patients being admitted to the stroke unit on the day or the day following presentation at hospital.

Since March 2012 the Borders General Hospital (BGH) has been successfully admitting more than 90% of all stroke patients to the stroke unit within one day of admission. This HEAT target was to be achieved by March 2013. Success in this target can be attributed to two developments over the last few months. Firstly a daily HEAT report of all stroke patients within the BGH was introduced in January. This is circulated to all Bed Managers, relevant Ward Managers and the Stroke Unit and alerts teams to patients that need to be transferred to the appropriate care environment.

In March 2012 a stroke bundle sticker was also introduced to the Medical Admissions ward and the Emergency Department. This immediately highlights that the patient requires stroke care. As this has been so successful locally the National Advisory Committee for Stroke (NACS) has requested that this good practice is shared nationally for other Health Boards to implement. Patients admitted to a Stroke Unit within one day of presentation have achieved more national stroke standards than those admitted after this or those never admitted to a Stroke Unit.

Agenda Item 5 Staff feel supported and engaged

Staff Governance

NHS Borders sees a crucial role in promoting staff governance for Local Partnership Forum (LPF) Chairs and "staff governance champions" within each Clinical Board and feels this has helped to increase staff awareness of the Borders Staff Governance Action Plan (SGAP). Clinical Boards are now reporting their progress with staff governance actions during their performance reviews. The Health Board feels the service is fully involved in delivering Staff Governance objectives through the ownership of the staff governance champions working in partnership with the LPF Chairs in each Clinical Board. However, there is still much work to do to increase knowledge and understanding of the action plan and the revised Staff Governance Standard.

In the last Staff Survey, 1726 staff took part in NHS Borders, a 51% response rate and the highest return of any mainland NHS Board. This in itself is a measure of staff engagement.

For the questions related to the Employee Engagement Index a majority of responses in most areas showed improvement compared to 2008. A roadshow was held with the Employee Director and head of Workforce Development visiting each Local Partnership Forum and Clinical Board meeting to present the staff survey findings for their own locality or service. This was to inform the response from each Clinical Board in the form of their priority staff governance actions.

Standard 1 - WELL INFORMED

The team brief system was reviewed for its effectiveness. The model developed in partnership identifies a cascade system for key organisational messages and 2 way feedback. Other initiatives implemented within the SGAP include the "Ask the Board" intranet site and the Chief Executive Forums held in each locality.

Standard 2 - APPROPRIATELY TRAINED

As well as KSF commitments, we would highlight internal training controls, which include prioritisation of statutory and mandatory training along with efficiency indicators. This ensures that planning of training is prioritised based on risk.

Standard 3 - INVOLVED IN DECISIONS THAT AFFECT THEM

Partnership arrangements of three Local Partnership Forums ensure a rolling agenda of local priorities and also service, financial and workforce planning to ensure LPF role as an influential partner on strategic issues and service redesign. LPF chairs are members of key decision making bodies e.g. Board Operational Group, Clinical Boards and sub committees and attendees at redesign events for Efficiency Programme. We are working to ensure there is effective and early involvement of staff and their representatives in all service redesign proposals. APF members are kept informed of the workforce implications of service redesign through a regular Service redesign inventory – a dashboard of service redesign which incorporates a workforce risk assessment.

Standard 4 - TREATED FAIRLY AND CONSISTENTLY

There is an employment policy framework and NHS Borders has a clear process to implement PIN Guidelines including a fast track of new PIN Guidelines with a model policy. There is regular reporting of workforce statistics to APF and Clinical Boards

including equality and diversity statistics. Equality and diversity assessment of new policies and service developments is a standard.

Standard 5 - PROVIDED WITH AN IMPROVED AND SAFE WORKING ENVIRONMENT

The OHS Forum has revised and implemented the prevention and management of Stress at Work action plan including a revised Dignity at Work Policy and associated action plan – based on the Respect Toolkit. A relaunch of the respect campaign was undertaken in June 2012. The introduction of workplace mediation is due to be completed by the end of the year.

Workforce Planning

Our Workforce Plan will support the achievement of the Quality Strategy which recognises the importance of staff engagement, a quality culture and ongoing learning and development for staff. NHS Borders are involved in the development of the monitoring system which will help us assess progress towards the 3 Quality Ambitions and the 6 Quality Outcomes. The Board is committed to workforce planning as a partnership activity. Our workforce planning cycle commenced with a partnership workforce conference in March 2012. The APF were fully involved in the preparation of this year's Local Workforce Plan and received a presentation on the workforce projections. We aim to achieve workforce reductions through a process of natural wastage and turnover and the measures we apply are designed to safeguard the employment security of our permanent staff. This is a firm and sincere commitment but we know people may have to work differently as we redesign our services. Some of the initiatives in place to reduce workforce costs whilst not impacting on the permanent workforce include Vacancy Control, Redeployment and use of Fixed Term Contracts.

HEAT Standard: NHS Boards to achieve a sickness absence rate of 4% from 31st March 2009

NHS Borders have a plan in place to reduce current levels of staff sickness absence. This is led by the partnership "Managing Sickness Absence" Working Group (with membership drawn from across the organisation including Occupational Health, management, staff side, partnership and HR) which will give whole system ownership to champion effective absence management.

1. Reactive interventions e.g. improved reporting, tighter application of the policy and procedures and consistent management and occupational health processes for managing attendance including rehabilitation programmes to support staff back to work.

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

3. All managers are required to have taken part in an e-learning module for the new absence policy by 30 April 2012 and a classroom teaching session by 31 December 2012

- The sickness absence rate for the rolling period May 2011 until April 2012 was 4.17%. This is an improvement from same period last year when the sickness absence rate was 4.50%

Agenda Item 6 People are able to live well at home or in the community

The Scottish Borders Community Health and Care Partnership has established a Reshaping Care for Older People Board, bringing together the 4 partners within the integration agenda (HNHS, Local Authority, Third Sector, Independent Sector) to oversee the Change Fund for Older People , but also a range of work to integrate and develop services to shift the balance of care, including co-location and integration projects in both the Cheviot and Tweeddale localities; the Council's Transforming Older Peoples Services programme; and the Joint Commissioning Strategy for Older people.

The Change Fund programme has enabled the development and testing of Whole System Performance Measures and return on investment work to calculate effectiveness of changes to care services. Feedback from the Scottish Government recognised that local plans are well-developed and build on previous work. The Partnership has also advanced the Integrated Resource Framework, so that it is close to being person-specific.

The Partnership has undertaken a series of locality workshops with communities to identify key themes to consider within our 10-year Joint Commissioning Strategy. These themes along with a Local Needs Assessment for Older People and some service user stories helped develop a forward-thinking and ambitious person-centred Joint Commissioning Strategy for Older People, which is currently being approved for consultation.

In Primary Care the Quality and Productivity indicators for QOF (QPQOF) 2011 / 12 focussed on three key areas: Referrals, Admissions and Prescribing. Each had the aim of supporting patients to be managed in a primary care setting wherever possible, supporting clinicians to maintain and develop clinical skills and knowledge and improving the patient experience and pathway. Clinical pathways were reviewed, protocols and guidance put in place around Fractured Neck of Femur, Knees and Management of DVTs.

Also, Extra Contractual Referrals to NHS Lothian were reviewed and the use of an electronic resource for GPs "RefHelp" was encouraged. RefHelp holds clinical guidelines, protocols and pathways as well as links to relevant reference points and websites. Current prescribing processes were also reviewed. The 2012 / 13 QPQOF peer review process is currently underway and is covering Referrals, Admissions and A&E attendances.
In addition Enhanced Services were also established for, for example:

Anticipatory Care: this provided a standardised and integrated approach to anticipatory care planning, using an electronic tool (STACCATO) to identify potential risks for clients and signposting to supports. Evaluation of the pilot, including feedback from the LES is now informing the next steps in 2012/13

Polypharmacy: to review people of 75 years who are on 11 or more medications with the aim of improving compliance, reducing waste and preventing avoidable hospital admission. Also, Direct Enhanced Services were established for: Palliative Care, GP Extended Hours & Osteoporosis.

Mental Health

HEAT Standard: Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with dementia by March 2011

At 31st March 2012 the position against the HEAT target was an achievement of 912 against a target of 995.

NHS Borders has further developed its delivery plan to support the diagnosis of dementia in Primary Care or specialist Mental Health Services. There has been an increase in the number of people added to dementia registers over the past year. This suggests that sustainable processes are in place overall but these require ongoing review to ensure that they are applied across the whole health system.

However, NHS Borders must continue work to initially identify more people with dementia to meet the current target.

Number of people with a diagnosis of a dementia on the QOF dementia register as a percentage of Dementia Prevalence	Target March 2011	Performance at March 2012
56.0% (target 61%)	995 individuals	912 individuals

HEAT Target: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

Throughout 2011/12 the Borders voluntary and statutory drugs and alcohol services, including the NHS Borders Addictions Service, have been seeing 90% of all clients within three weeks from referral to treatment. This is a national HEAT target. This performance has continued into 2012/13. At the end of March 2012, 93% of all clients received treatment to support their recovery within three weeks. This target has been achieved and maintained two years before the target date of March 2013. Success in this target has been facilitated in part by the start up of the Prescribing and Support Service (PASS) to provide a dedicated service for stable clients working on recovery. This frees up staff to work more quickly with new clients.

HEAT Target*:* Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; and 18 weeks referral to treatment for Psychological Therapies from December 2014

There have been no CAMHs referrals that have waited over 26 weeks during 2011/12. Work is ongoing regarding the referral to treatment for Psychological Therapies. Overall, Borders are on track to meet the target by December 2014. An important step in this process will be the implementation of a new Patient Management System for Mental

Health. Borders are also currently liaising on a national pilot with the Quality and Efficiency Support Team (QuEST) on reviewing clock stops for patient waiting times in Mental Health.

Agenda Item 7 Best use is made of available resources

Continue to achieve financial in-year and recurring financial balance

The financial challenge that the public sector is embracing is clear and well understood. We are in a period of financial challenge that has not been seen for many years and it is essential that services are provided and developed appropriately within the financial envelope provided. In order to continue to deliver quality patient care the organisation must keep a firm grip on its finances as well as drive efficiency which is critical to service delivery and public credibility. That means having a clear focus that is firmly and openly set on providing patient care that is safe, effective and affordable.

- **Revenue**

NHS Borders achieved all financial targets in 2011/12 with a small underspend of £0.06m recorded at the end of the financial year. During the year the Board had to deal with a number of financial pressures as well as a challenging savings target.
Overall this outcome represented a great deal of hard work by clinical staff and managers.

- **Capital**

NHS Borders successfully remained within its Capital Resource Limit for 2011/12.
The main focus of capital work during 2011/12 was the alteration work carried out at Jedburgh Health Centre, the creation of the health hub at Haylodge in Peebles and the Accident and Emergency scheme within BGH.

- **Efficiency**

A key element of the Board's plan to attain a financial breakeven outturn in 2011/12 was the achievement of its cost efficiency target.

The Board approach continues to ensure delivery of the required savings through an efficiency savings programme made up of a number of individual schemes, rather than assigned targets. Each scheme within the programme is run as an individual project, with individual project owners responsible for developing and delivering an efficiency plan. For each project a Project Initiation Document, project plan and savings trajectory are required to be approved by the Strategy Group. As schemes are agreed by the Strategy Group the project plan implementation and savings trajectory are monitored through the Efficiency Board and expected to deliver. The Efficiency Board receives monthly updates on all plans thereby ensuring any need for corrective action is taken promptly and reports routinely to the Clinical Executive Operational Group.

During the financial year 2011/12 £7.1m of savings were delivered. A key element of financial sustainability is that the recurring element of the cost efficiency target is achieved. Following conclusion of projects which started part way through 2011/12 £5.6m recurring savings have been identified, over-achieving the target of £5.4m and

ensuring that there is no recurring requirement carried forward into the next financial year which would increase the financial risk for the organisation.

In the 2012/13 LDP NHS Borders has put in place plans which result in NHS Borders achieving a recurring balanced budget.

Keep the Health Directorates informed of progress in implementing the local efficiency savings programme

As part of the monthly monitoring returns which are submitted to the Health Directorate, NHS Borders gives an update on the efficiency savings programme. In addition on a quarterly basis the Director of Finance meets with representatives of the Finance Health Directorate where Efficiency is a standing item on the agenda.

NHS BORDERS — ANNUAL REVIEW
AT A GLANCE OUTCOMES 2011/12

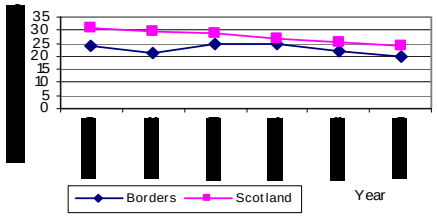
People are living longer

Life Expectancy	Male		Female	
	1998-2000	2008-10	1998-2000	2008-10
Borders	75.1	77.5	79.9	81.2
Scotland	72.9	75.8	78.4	80.4
Change		2.4		1.3

Healthy Life Expectancy is above the Scottish average

Healthy Life	Male	Female
Borders	70.4	74.2
Scotland	66.3	70.2
Difference	4.1	4.0

Low Smoking 16+ Rates



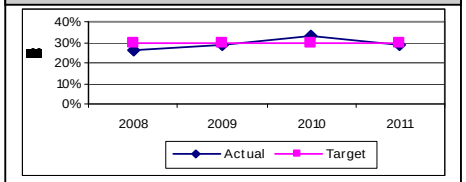
More Drugs and Alcohol patients are being seen within 3 weeks

In January to March 2012 94% of all drugs and alcohol patients were seen within 3 weeks from referral due to improved case management.

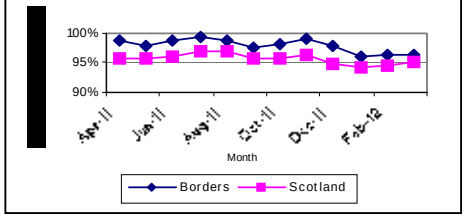
Most patients are treated within 18 wks

At March 2012 92% of patients were treated within 18 weeks of onward referral to other services; meeting the national target of 90%.

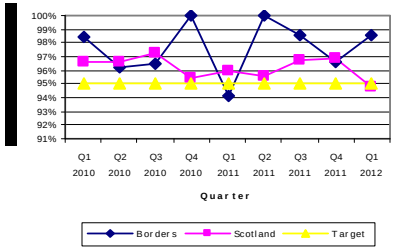
Nearly 30% of people with complex needs are being cared for at home



Waiting times at A&E are shorter than the Scottish Average



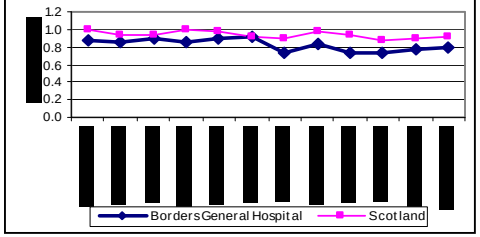
97% Cancer Waits with urgent referrals are seen within 62 days



Dementia Register is below Target

Dementia Register	Mar 11	Mar 12
Value	864	912
Target	995	995
Difference	131	83

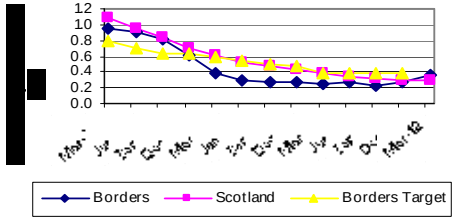
BGH Mortality Rates are Low



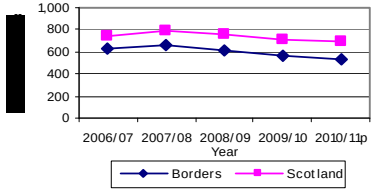
Patient satisfaction levels with local health services have increased

From 2007 when 87% patients were not dissatisfied with the service there has been an increase in satisfaction to 2010 when 94% were not dissatisfied.

C Diff Infections are usually below Scottish average



The number of Alcohol-related Hospital Discharges has decreased



NHS BORDERS ANNUAL REVIEW 2012
AT A GLANCE HEAT TARGET PERFORMANCE AS AT MARCH 2012

- **Alcohol brief interventions** completed in the year 2011/12 totalled **2,727** compared to the planned 1,247, 119% above target.
- The number of **smokers successfully quitting** for a month was 317 as at December 2011, 51% **above the target** of 210.
- The number of **child healthy weight interventions completed** was 121 for 2011/12; 21% **above the target** of 100.
- Patient journeys **from referral to treatment** were **within 18 weeks** for 92% of all cases in December 2011.
- **96%** of patients waiting in **A&E** did so for **less than 4 hours** at December 2011.
- Between January and March 2012 94% of patients waiting for **drugs or alcohol treatment** were seen **within 3 weeks**.
- During 2011/12 94% of patients had **access within 48 hours** to their **GP Practice Team**.
- At 15th April 2012 **no patients** were waiting **over 6 weeks** to be **discharged** from hospital.
- In March 2012 there were **912 people** on the **dementia register**.
- Rates of **C Diff** identified in NHS Borders hospitals at March 2012 were **within planned levels**. **Stapphyloccocus aureus bacteraemia** identifications were above plan for 2011/12 but have **reduced by 29%** from 2010/11.
- **100%** of patients **urgently** referred for **cancer treatment** began treatment **within 31 days** of decision to treat in October to December 2011.
- During January to March 2012 **81%** of all **stroke patients** were **admitted to the stroke unit** on the day or the day following presentation at hospital