2009 Annual Review

Self Assessment

August 2009

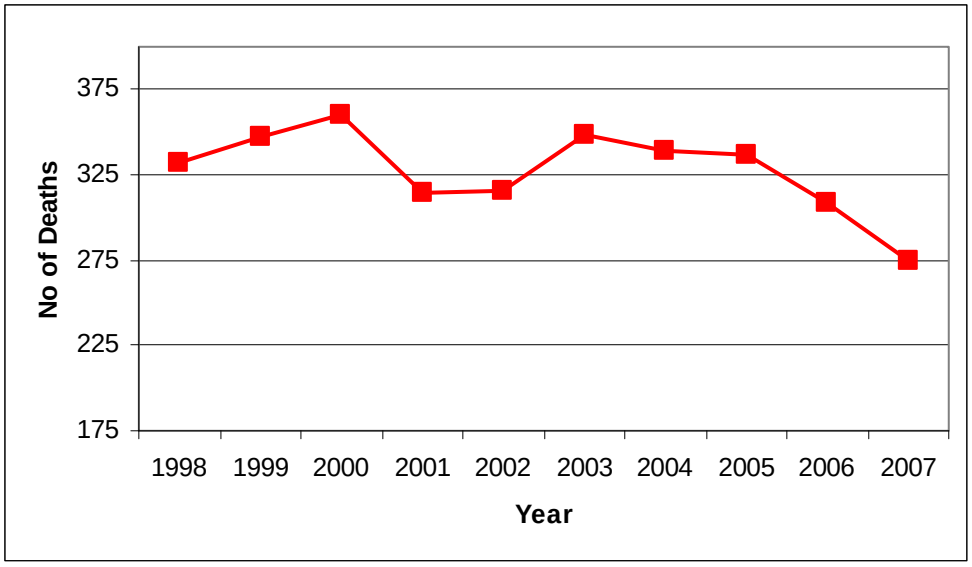
Directorate of Planning & Performance

IMPROVING HEALTH AND REDUCING INEQUALITIES

HEAT H1: Reduce mortality from CHD among the under 75s in deprived areas

Only two small areas in the Borders are included in this target and so assessment of progress is challenging. Generally, premature deaths from coronary heart disease (CHD) are continuing to decrease and have been on a downward trend since 2003. A broad range of targeted health intervention and service activity addresses the deprived areas and a Borders Keep Well programme is being developed, to be launched early 2010.

Premature Deaths from CHD in Borders – Men and Women



HEAT H2: 80 % of all 3-5 year old children to be registered with an NHS Dentist by 2010/11

No of children registered at end of December 2008	Trajectory – December 2008
66.3%	65%

The latest figures available at the end of 2008/09 were for December 2008. These include all 3-5 year olds registered with an NHS Dentist (not including children seen by community dental service or being seen by a private dentist). The opening of the new dental centres in Hawick and Coldstream will help to achieve the overall target of 80%.

HEAT H3: Achieve agreed completion rates for child healthy weight intervention programme by 2010/11

No of child health eight interventions at end of March 2009	Trajectory – March 2009
27	90

A further 23 interventions were attempted but were not successful with participants not completing. A further 30 families were contacted but permission was not given for the child to join the programme and it has been challenging to identify motivated families. Efforts will focus on increasing the number of interventions during 09/10 and 10/11 so that this target can be delivered.

HEAT H4: Achieve agreed number of screenings using the setting appropriate screening tool and appropriate alcohol brief intervention in line with SIGN 74 guidelines

No of interventions at end of March 2009	Trajectory – March 2009
211	500

Several developments are currently underway to meet trajectory targets in years 2 and 3 and these include: most GP practices participating in an alcohol local enhanced service (LES). Clinicians from these practices have had brief intervention (BI) training and activity is recorded via Bluebay. Lifestyle Advisor Service nurses also involved in delivering BIs. The Alcohol Liaison Nursing Service will be expanded in Accident and Emergency (A&E) and A&E and antenatal staff will be trained to screen and refer on. Two local practitioners are now trained in delivering BI training and are successfully training others.

HEAT H5: Reduce suicide rate between 2002 and 2013 by 20% supported by 50% of key frontline staff in mental health and substance misuse services, primary care and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010

No of staff trained at end of March 2009	Trajectory – March 2010
127	265

The Borders suicide rate is currently below the 2013 target. However the numbers of suicides are low and the rate is subject to small number variation. Almost 50% of key frontline staff have now been trained in using suicide assessment tools and suicide prevention training with the aim of reducing the local suicide rate and this is on track to meet the March 2010 target of 265 staff trained.

HEAT H6: Through smoking cessation services, support 8% of each Board's smoking population in successfully quitting (at one month's post quit) over the period 2008/09 – 2010/11

No of quitters at 4 weeks from stop date at end of December 2008	Trajectory – 2008 (calendar year)
538	600

Although performance is below the trajectory set for this year, should this level be sustained over the 3 year period we would overshoot the final target by 12%. This

equates to a 3 year cumulative target of 1465 quitters. Data collection has been changed for the purpose of national reporting following guidance from ISD.

HEAT H7: The proportion of new born children exclusively breastfed at 6-8 weeks in Borders to be maintained as a minimum at 33.3%

No of children exclusively breastfed at 6-8 weeks at end of December 2008	Trajectory – March 2009
31.4%	32.8%

The latest figures available at the end of 2008/09 are for December 2008. The breastfeeding rate was slightly below the target trajectory set for the end of March 2009, however this is the 5th highest rate in Scotland. An Infant Feeding Advisor will be appointed using funds allocated under CEL 36 and this post will update, finalise and support implementation of the local breastfeeding strategy with the priority being to raise the breastfeeding rates across the region.

HEAT Std: 95% update for all childhood vaccinations

NHS Borders uptake rates at 24 months of age for primary courses of diphtheria, tetanus, pertussis, polio, Hib and MenC remain high and stable at around 96% to 98%.

SHIFTING THE BALANCE OF CARE TOWARDS PRIMARY AND COMMUNITY CARE

In December 2008, "*Living Well with Long Term Conditions in Adults",* Borders Strategy for the Management of Long Term Conditions (LTC) was approved by the Community Health & Care Partnership, developed with input from Scottish Borders Council, Voluntary Sector organisations, individuals, carers, the Involving People Network and Public Participation Forum. A range of workstreams have been established to help avoid admissions and provide services within the community. The Managed Clinical Networks (MCNs) link directly into these and a summary of progress is found below:

Intermediate Care.
A bid is allowing non bed-based model of intermediate care based in two day hospitals to be developed, incorporating assessment; early identification of dementia; trial of a new transport model; carers's support and an enhanced Night Support Service.

Crisis-Management Sheet
A generic crisis-management sheet has been developed in consultation with individuals and carers. This will be included in a Local Enhanced Service (LES).

Anticipatory Social and Clinical Care Plans
These plans are being piloted with interagency collaboration and this will be evaluated by the LTC Collaborative national team. The Respiratory and CHD MCNs are developing anticipatory care plans and these will be built into a LES.

Non Malignant Palliative Care and End of Life Support
Guidelines are being developed to support people with LTC focusing initially on respiratory conditions and CHD including the End of Life (Liverpool) Care Pathway, anticipatory care plans and training & education about communicating with these patients and their carers.

Development of LTC Website
A website has been developed with support from NHS Education Scotland in partnership with two local employers and the local library service. The website is available in 6 languages. Further development is now underway. Other Health Boards have expressed an interest in replicating the model. This can be found at www.bordershealthinhand.scot.nhs.uk

Telehealthcare:
An interagency working group is looking at raising awareness of telehealthcare services and how the various strands might be taken forward within a coordinated framework. Specific telecare equipment is already being used and proving very effective.

LTC Training & Education Programme
The first phase of a "rolling" programme led by secondary care has been established with the focus on increasing skills in primary care services. The Diabetes MCN developed a series of sessions for the first phase and the Respiratory MCN will deliver phase two.

***"LTC Alliance Scotland"* Self-Management Fund bid**

A muli-agency bid has been submitted which focuses on enhancing the Red Cross Neighbourhood Link Worker and Buddies services. If successful this will:

- Expand the capacity of the Neighbourhood Links service with a Service co-ordinator permanently based within the recently established Social Work Hub team
- Develop the Buddy service to provide dementia buddies, appointment management buddies and rehabilitation buddies
- Develop a medicines usage toolkit to determine medication issues and risks with patients which would then lead to a pharmacy referral.

The outcome of the bidding process will be received in August.

Strategic Change Programme

Alongside the work connected with LTCs, the Strategic Change Programme will be a key vehicle for relocating services within primary and community services. As the programme progresses, opportunities will be explored to redesign services so that they are delivered closer to people at home.

ACCESS TO SERVICES INCLUDING WAITING TIMES

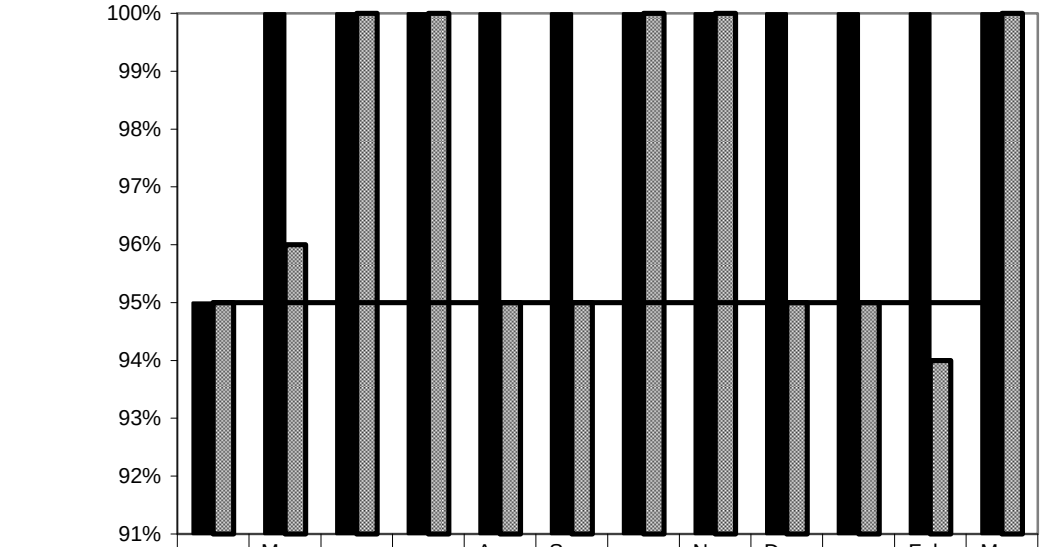
HEAT A1: Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours

All Practices comply and meet this target.

HEAT A2: To sustain delivery of two month waiting time from urgent referral to treatment for all cancers

2008/09 saw strong performance in this area with 100% of patients with an urgent referral treated within the two month target, exceeding the 95% target. The numbers of referrals are low and so this target is subject to small number variation.

Percentage of Patients Treated Within Two Months



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Prev. year	95%	96%	100%	100%	95%	95%	100%	100%	95%	95%	94%	100%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

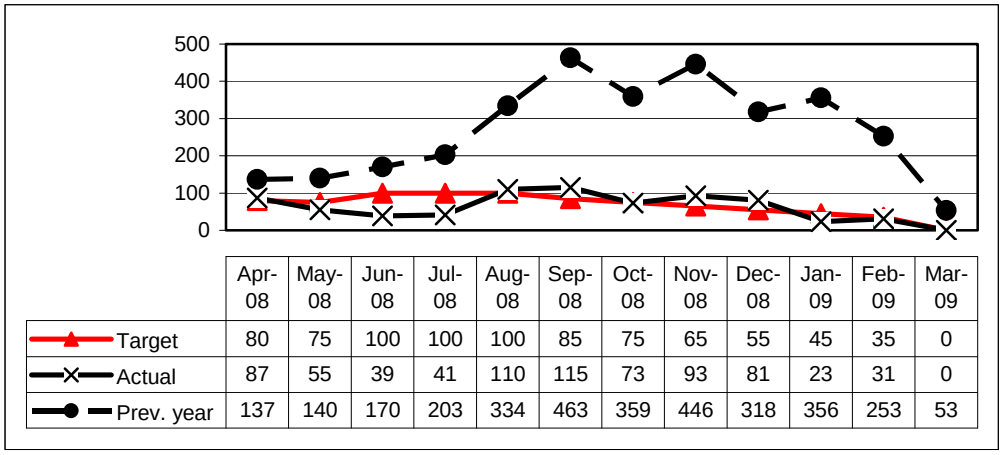
HEAT A3: To respond to 75% of category A calls within 8 minutes from April 2009 onwards across mainland Scotland

Liaison structures are in place between Scottish Ambulance Service and NHS Borders. A local ambulance group ensures that SAS and NHS Borders are utilising resources appropriately from admission to discharge and ensuring that pathways of care are appropriate for both agencies. In March 2009, national figures for SAS showed that this target was achieved, and 77.4% of life threatening calls were responded to within 8 minutes.

HEAT A4: As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks from GP referral to a first outpatient appointment from 31st March 2009

For 2008/09 the national target set was that no patient will wait longer than **15 weeks** from the 31st March 09, however NHS Borders set a lower local target of **12 weeks**. Sustained efforts in this area meant that this reduced target was achieved and no patients waited longer than 12 weeks from March 09 and this has been maintained since then.

No of Patients Waiting Longer Than 12 Weeks from GP Referral

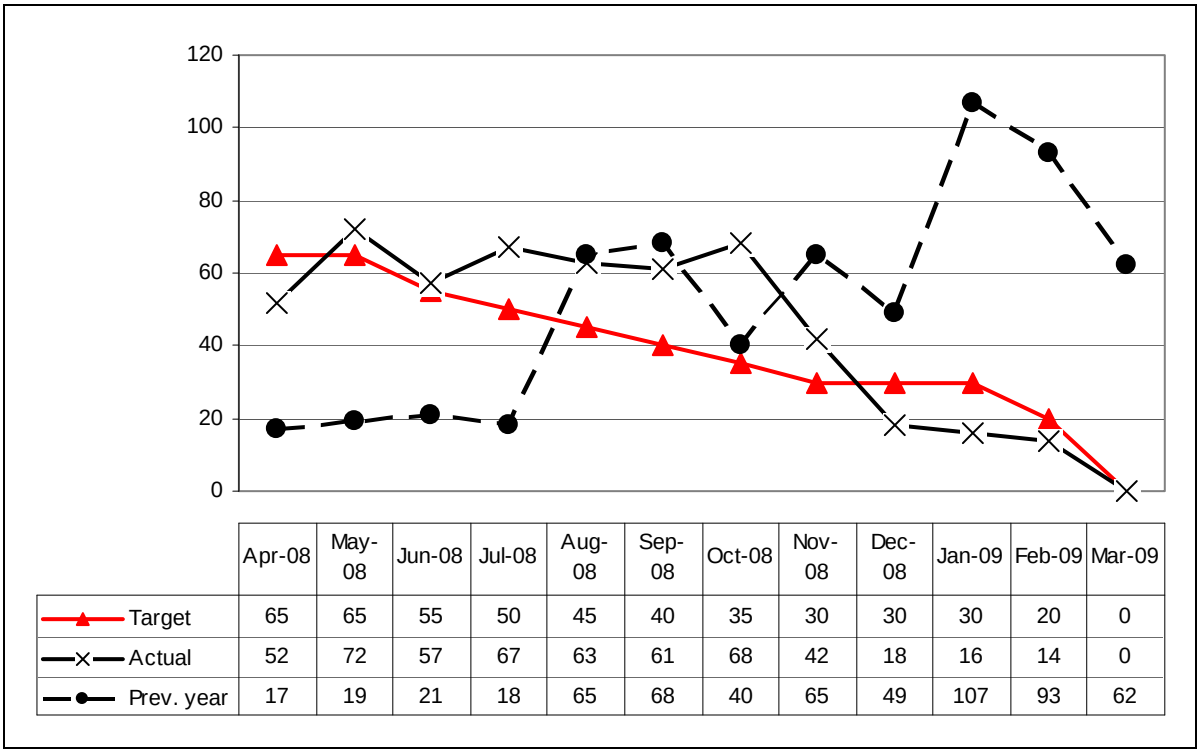


	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	80	75	100	100	100	85	75	65	55	45	35	0
Actual	87	55	39	41	110	115	73	93	81	23	31	0
Prev. year	137	140	170	203	334	463	359	446	318	356	253	53

HEAT A5: As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks for day case or in patient treatment from 31st March 2009

Again Borders set a lower target of **12 weeks**. Excellent performance meant that this reduced target was achieved and no patients waited longer than 12 weeks from March 09 and this has been maintained since then.

No of Patients Waiting Longer Than 12 Weeks for In Patient or Day Case Treatment

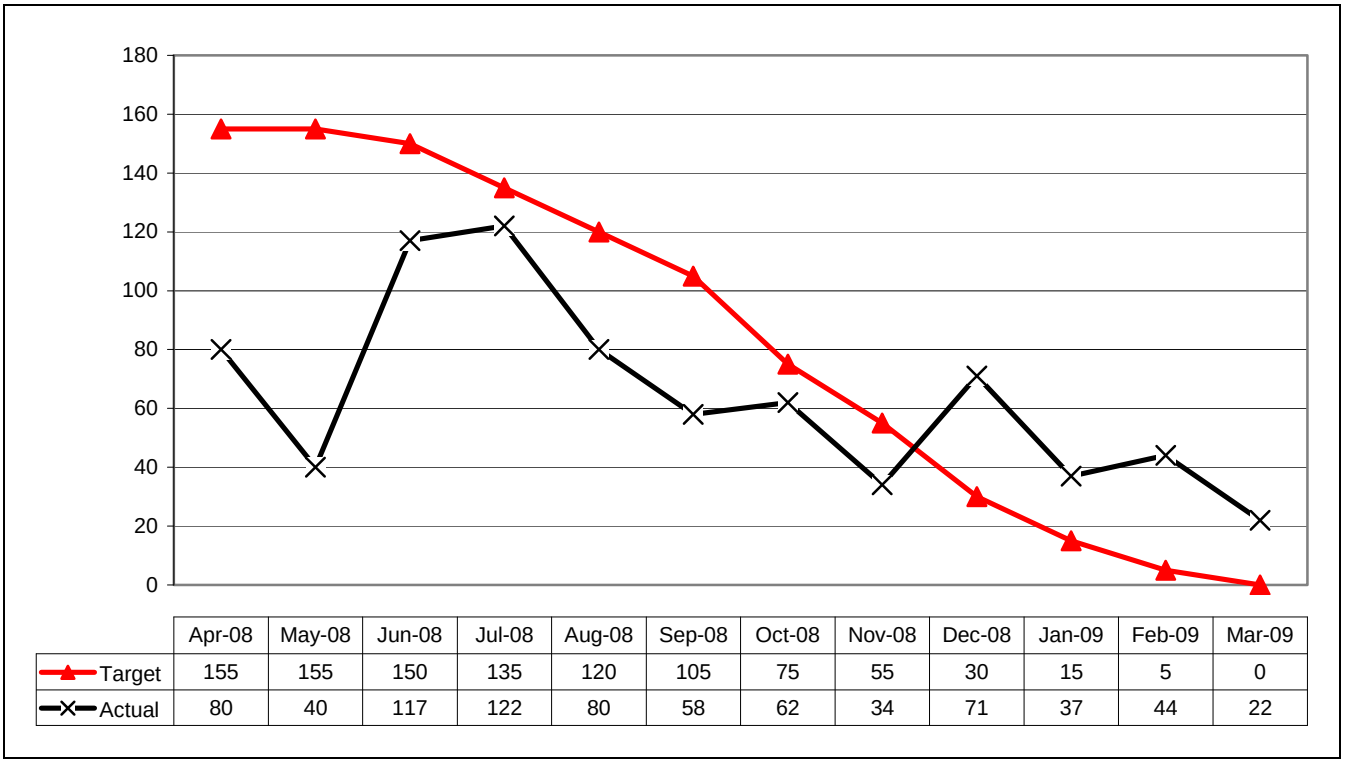


	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	65	65	55	50	45	40	35	30	30	30	20	0
Actual	52	72	57	67	63	61	68	42	18	16	14	0
Prev. year	17	19	21	18	65	68	40	65	49	107	93	62

HEAT A6: As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 6 weeks for one of the 8 key diagnostic tests from 31st March 2009

In 2008/09 Borders again set a lower target of **4 weeks** when the national target was set at **6 weeks**. At the end of March 2009, 22 patients were waiting longer than 4 weeks. By then, the trajectory has been reduced to 0 patients and although the target was not achieved, there was a decrease of 50% in the number of patients waiting over 4 weeks from February 09 (44 patients). Improvements have been made since then and in June 09 no patients waited over 4 weeks for a key diagnostic test.

No of Patients Waiting Longer Than 4 Weeks for a Key Diagnostic Test

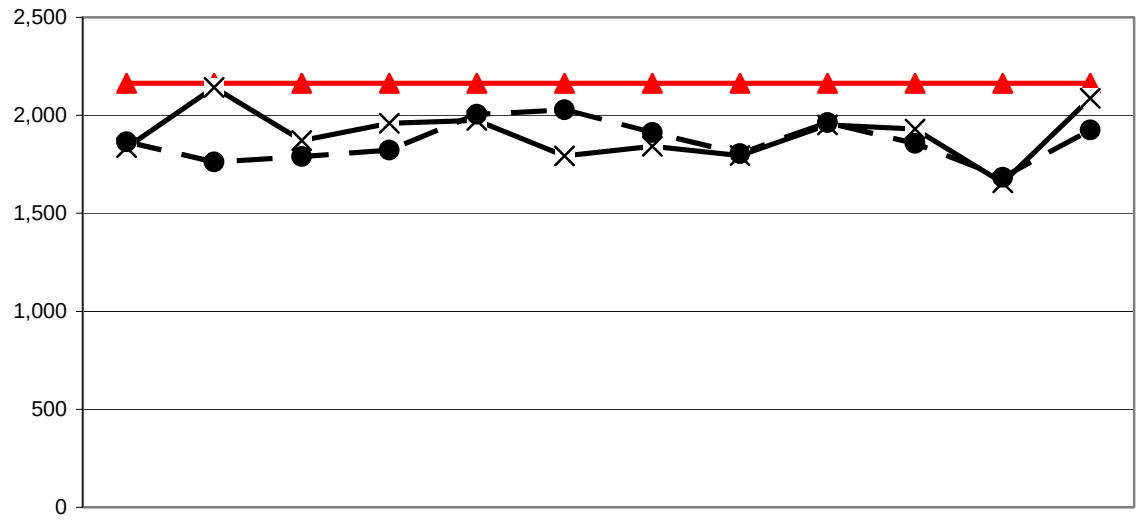


	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	155	155	150	135	120	105	75	55	30	15	5	0
Actual	80	40	117	122	80	58	62	34	71	37	44	22

HEAT A7: NHS Boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/7 to 2010/11; and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency (A&E) treatment

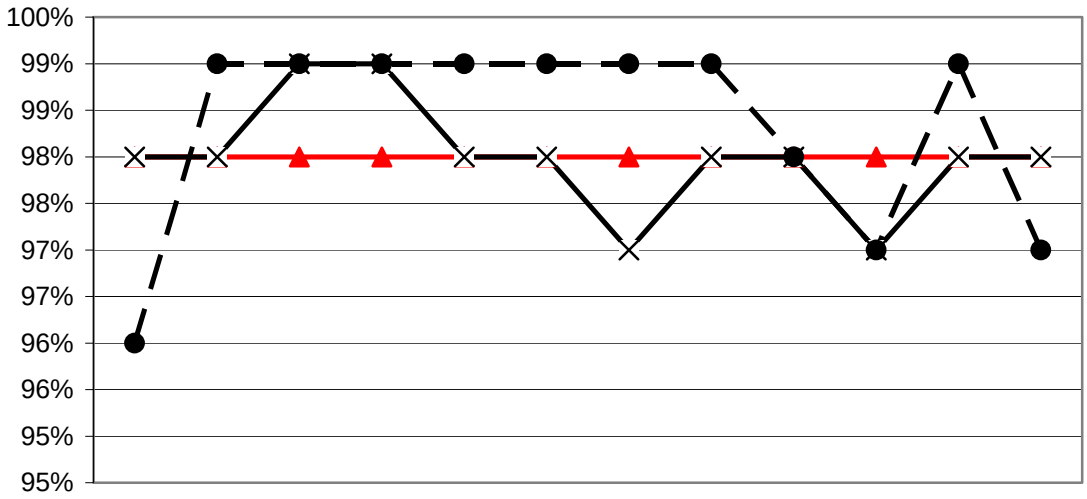
In 2008/09 a total of 22840 attended A&E, an average of 1903 per month and this was consistently below the trajectory. In 10 out of 12 months in 2008/09, 98% of patients were seen within 4 hours of arrival in A&E.

Attendances at A&E during 2008/09



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	2,163	2,163	2,163	2,163	2,163	2,163	2,163	2,163	2,163	2,163	2,163	2,163
Actual	1,836	2,143	1,872	1,960	1,975	1,793	1,842	1,794	1,952	1,930	1,656	2,087
Prev. year	1,864	1,762	1,790	1,823	2,005	2,028	1,912	1,805	1,962	1,857	1,683	1,926

Percentage of A&E Attenders Seen Within 4 Hours of Arrival in 2008/09



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Actual	98%	98%	99%	99%	98%	98%	97%	98%	98%	97%	98%	98%
Prev. year	96%	99%	99%	99%	99%	99%	99%	99%	98%	97%	99%	97%

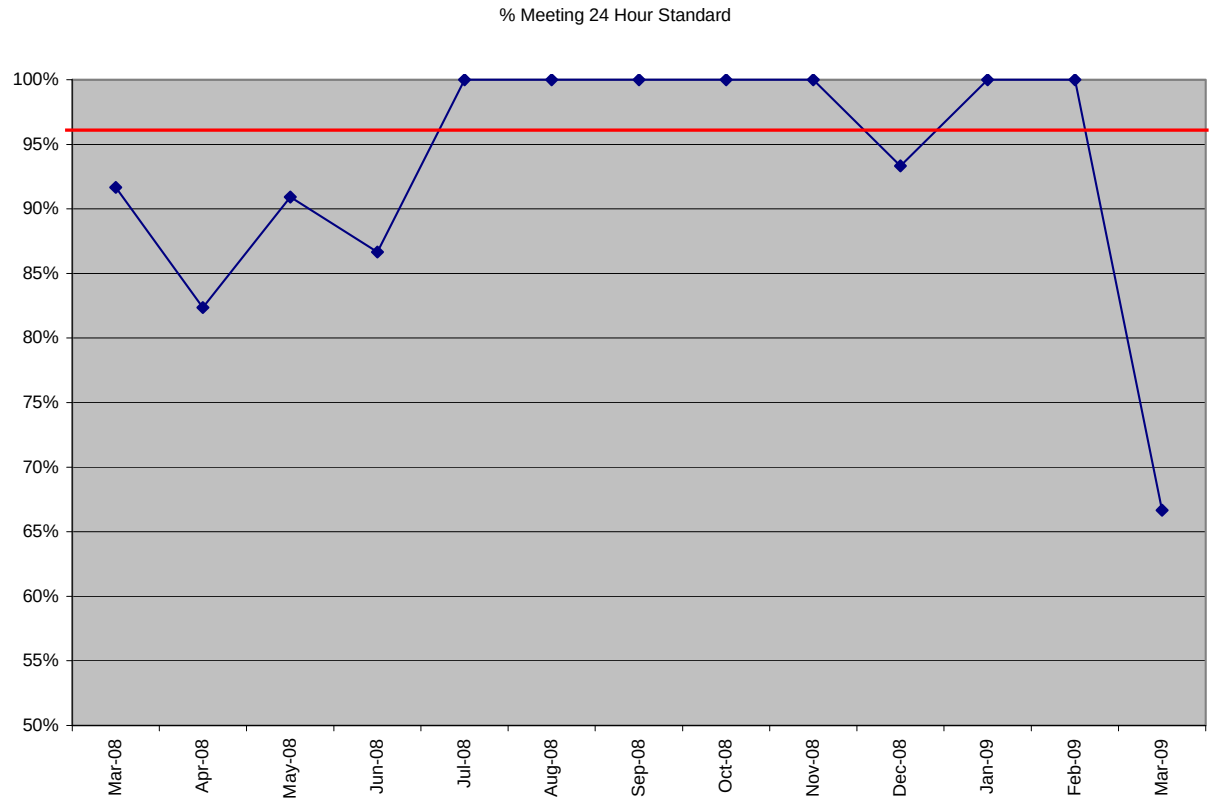
HEAT Std: Maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment

No one waited longer than 18 weeks for cataract surgery throughout 2008/09.

HEAT Std: Maximum wait from admission to a specialist unit to hip surgery, following fracture, will be 24 hours (subject to medical fitness and during safe operating hours)

During 7 out of 12 months in 2008/09 100% of patients had surgery within 24 hours. The target was not achieved in 5 months. Orthopaedic surgery capacity has been adjusted to improve our ability to deliver this target.

% of Patients Receiving Hip Surgery Within 24 Hours

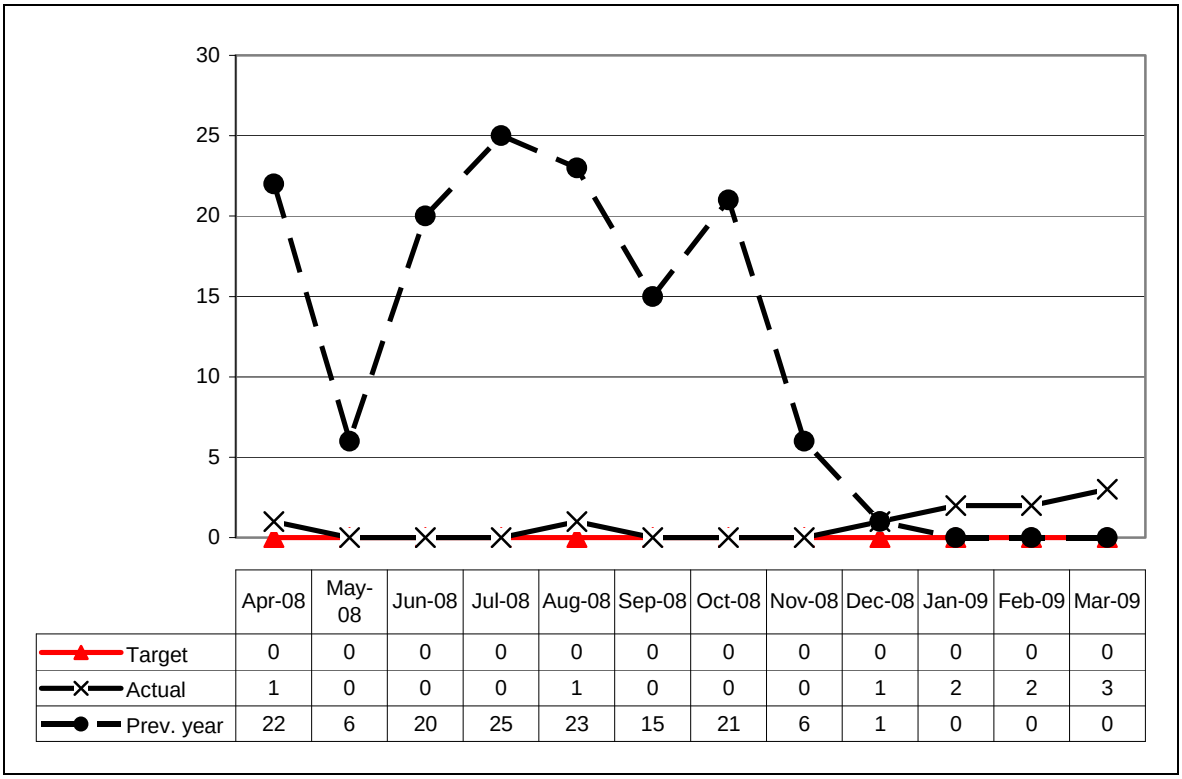


The number of patients requiring hip surgery is low therefore subject to low number variation. In March 2009 4 patients breached the 24 hour target due to complications with tests prior to surgery.

HEAT Std: Maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent and no patient will wait more than 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment

During 2008/09, the target of no patients waiting longer than 1 week to be seen in the rapid access chest pain clinic (RACPC) was generally maintained and performance was significantly improved from 2007/08.

No of Patients Seen in RACPC Within One Week of Referral



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	0	0	0	0	0	0	0	0	0	0	0	0
Actual	1	0	0	0	1	0	0	0	1	2	2	3
Prev. year	22	6	20	25	23	15	21	6	1	0	0	0

Access to Dental Services

2008/09 saw the opening of 2 new dental centres in Hawick and Coldstream which will help to improve access for local people.

SERVICE CHANGE AND REDESIGN, INCLUDING PATIENT FOCUS AND PUBLIC INVOLVEMENT

The Strategic Change Programme (SCP) was launched in 2008/09 in response to continued challenges around sustainability of service to review what, how, where and when NHS Borders delivers services to the people of the Scottish Borders. A number of pressures are to be faced in the coming years, such as a growing older population; reduced pool of younger workers from which to recruit; significant staff shortages in some key clinical areas; and a desire to focus on shifting the balance of care from hospital-based care to more community and preventative services. In addition, changes to the formula used to allocate funding to Health Boards in Scotland and efficiency savings targets mean that NHS Borders will need to find savings of at least £10 million to sustain its financial balance over the next 3 years. NHS Borders is working to deliver changes through the SCP which will:

- look at what staff, buildings and facilities we have and identify how we can make better use of them
- change our services, so that they meet the needs of people today and tomorrow and not those of the past
- look at referral and admission trends & service performance:
    - to reduce variation within Borders
    - to move towards the upper quartile of peer group benchmarks.

At each stage of this programme, active engagement with our staff, patients, public and our partner organisations such as Scottish Borders Council and Voluntary Organisations is taking place. A sub group of the Public Participation Forum has been established as a reference group for the programme.

There are six separate work streams within the SCP, each managed as an individual project. The six work streams are:

- <u>Operational Budget Savings</u>
  Seeking out all opportunities to reduce costs – building on work to date through savings programme
- <u>Improving Efficiency, Reducing Waste</u>
  A 1 year campaign to reduce waste and inefficient use of resources across the organisation
- <u>Productivity and Benchmarking</u>
  To provide managers and clinicians with reliable information about their services to allow them to compare with other Health Boards how well or otherwise they perform to help them to review their ways of working
- <u>Integrated Health Strategy</u>
  Making more efficient use of our hospitals; helping more people to avoid the need to go into hospital by investing more services to support people to be looked after at home. These changes will be realised over a ten year period
- <u>Continuous Improvement</u>
  Working alongside national initiatives such as the Collaboratives, focusing on 18 weeks Referral to Treatment, Long Term Conditions and Mental Health. This work stream will also include a number of other projects that we are undertaking including the Leading Better Care (Senior Charge Nurse Review) Project,

Productive Ward Pilot and the Patient Safety Programme – all of which are national initiatives

- Sustainable Workforce
  Current staffing models/grading structures will be reviewed and succession planning and redesign processes explored to decide how we recruit retain and afford our highly skilled workforce.

In recognition of the significant scale of the work contained within the change programme, robust programme and project management governance arrangements have been put in place. Each work stream has a Project Board and the Board Executive Team works as the executive arm of the Programme Board.

During 2008/09, a significant amount of analysis and modelling has been undertaken particularly through the Productivity & Benchmarking and Integrated Health Strategy work streams. This work will continue into 2009/10 to identify areas for efficiency improvements across NHS Borders services.

PATIENT FOCUS AND PUBLIC INVOLVEMENT (PFPI)

The Public Governance Committee (PGC) and the Clinical Governance Committee (CGC) continue to oversee this area both within NHS Borders and at regional and national levels. The PGC is accountable to NHS Borders Board for all aspects of Public Involvement work and for the impact of this on improved patient services and redesign. The CGC similarly has oversight of the Patient Safety and Patient Experience programmes and outcomes within NHS Borders.

Within NHS Borders, two groups provide a public perspective on existing and developing services; the Borders Public Partnership Forum and the Involving People Network. Members are involved with 25 projects and activity during 2008/09 has included:

- Borders General Hospital Endoscopy project
- Lauder Community Health Centre development
- Borders Renal Service Review
- NQIS Assessments
- Interview Panel for new Public Involvement Manager
- Poynder View Community pilot project for older people with dementia
- Mental Health Integration project –joint service NHS Borders & Social Work

During 2008/09 public consultations or engagement work numbered:

NHS Scotland National work	NHS Borders	Joint NHS Borders/Scottish Borders Council	Other involvement eg events	Total
10	15	5	2	32

Other methods of public participation are also in use and an infection control eGroup has been established which will help the Infection Control Team to deliver a service suitable and useful to patients, visitors and staff.

In May 2008, a Community Engagement event was held. Among the key findings from the event were better access to GP services, improving health & well-being, allied health professional appointment systems and waiting times, the joint working between health & social care services and infection control.

NHS Borders is a key supporter of the Scottish Borders Volunteering Compact. The Compact outlines a number of collaborative actions across the public/voluntary sector to increase alignment between NHS Borders (and other public services) with key voluntary groups and with users and carers.

In 2008/09 NHS Borders submitted a self assessment to the Scottish Health Council on its performance in relation to Patient Focus and Public Involvement. The Scottish Health Council verified that this self assessment was an accurate account of progress made.

IMPROVING TREATMENT FOR PATIENTS

HEAT T1: By 2008/09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency in-patient two or more times in a single year by 20% compared with 2004/05 and reduce by 10% emergency in patient beds for people aged 65 and over by 2008

	Total number of patients 65+ with 2+ emergency admissions	Trajectory – rate per 1000	Actual – rate per 1000
2008/09	1037*	37.4	47*

*The above figures are provisional. Work is underway to provide local information to monitor progress as data currently available has a time lag. As part of the Strategic Change Programme, a number of patient pathways are to be redesigned using LEAN methodologies including stroke, fractured neck of femur and patient flow and discharges processes within the BGH are to be reviewed. The LTC Collaborative is currently analysing care home admissions and the support required to avoid admissions. A group has been established in the BGH to look at reducing the current length of stay across a number of specialties.

HEAT T2: QIS clinical governance and risk management standards improving

The self assessment against these standards was submitted in March 2009 and the Peer Review took place in May 2009. The report from this visit will be issued in September 2009.

HEAT T3: Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10 and put in place the required support framework to achieve a 10% reduction in future years

Figures show a rise in prescribing in the 3rd quarter of 2008/09 after a consistent decline in 2008/09 and there has been a similar pattern across Scotland. Several initiatives have been developed to improve access to psychological therapies such as Beating the Blues, Doing Well and the pilot of an integrated care pathway. A number of practices have signed up to undertake a review of their anti depressant prescribing as part of their quality outcomes framework medicines management for 2009/10.

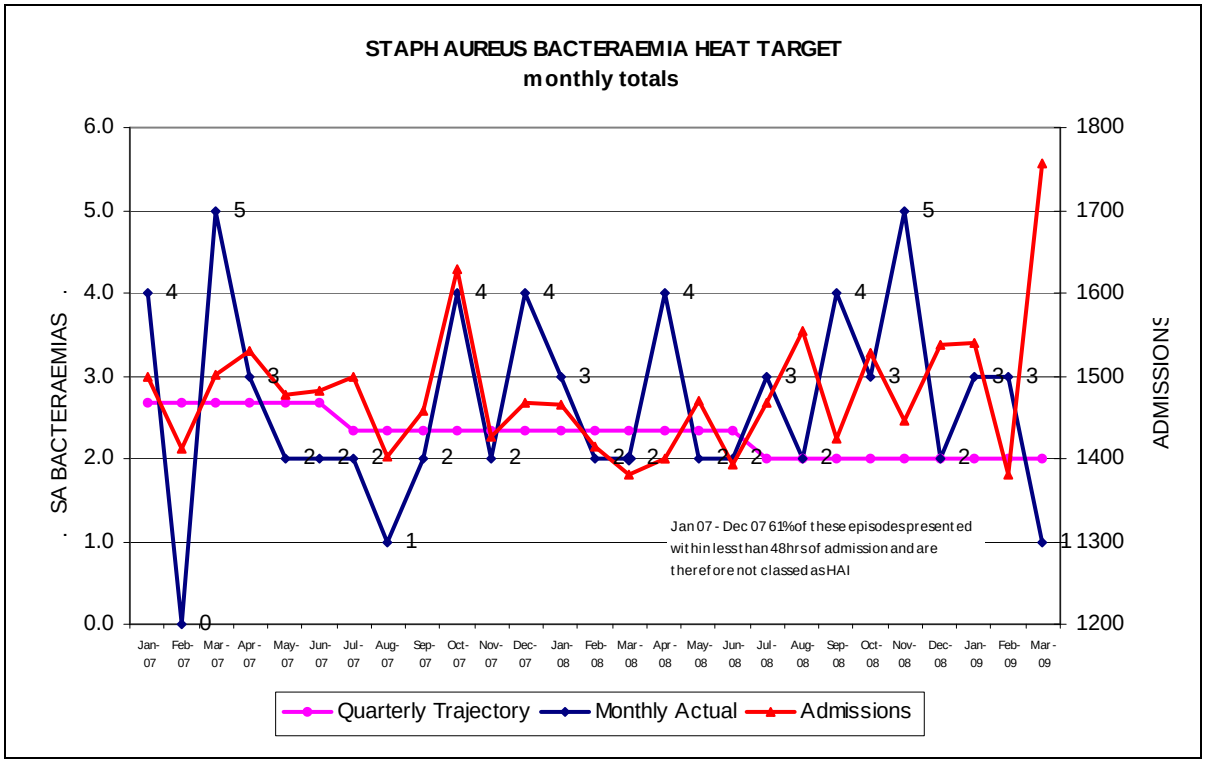
HEAT T4: Reduce the number of readmissions (within one year for those who have had a psychiatric hospital admission of over 7 days) by 10% by the end of December 2009

At the end of March 2009, readmission rates were currently more than the 10% reduction target. The majority of readmissions have been within 28 days so attention is being focused in this area. Work is also progressing on analysing length of stay.

HEAT T5: To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% in 2010

This target is measured against a quarterly trajectory. During the quarter ending March 2009 there were 7 *staphylococcus aureus* bacteraemia which is 1 bacteraemia above the trajectory target. Progress has been made as this is a decrease of 3 isolate from December 2008 where there were 10 *staph. aureus* bacteraemia.

Rates of Staph. Aureus Bacteriaemia



HEAT T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, asthma, diabetes or CHD from 2006/07 to 2010/11

	Average LoS – 08/09	Trajectory – 08/09
Diabetes	**10.2**	**5.4**
CHD	**8**	**6.3**
COPD	**9.2**	**7.2**
Asthma	**1**	**2.7**

A number of initiatives are underway to achieve the agreed reductions. A Local Enhanced Service has seen GPs using tools to identify patients at risk of admission/ readmission. A pulmonary rehabilitation programme is being developed and a Scottish Enhanced Service will support work around chronic obstructive pulmonary disease. Diabetes clinical protocols have been reviewed to reduce length of stay. A training & education programme has been developed aimed at staff in primary care.

HEAT T7: Improvement in the quality of the healthcare experience

The Patient Safety Programme is on target with the Institute of Healthcare mprovement assessment scale for individual hospital performance. NHS Borders is demonstrating sustained improvement through outcome measures in hand hygiene, sub acute bacteriemias and C. difficile rates.

HEAT T8: Increase the level of older people with complex care needs receiving care at home

At the end of March 2009, there was a 28.83% increase in the number of people receiving 10 hours or more of intensive home care, care home and geriatric long stay care. This is on track to meet the target of 30% set for March 2010.

HEAT T9: Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with dementia by March 2011

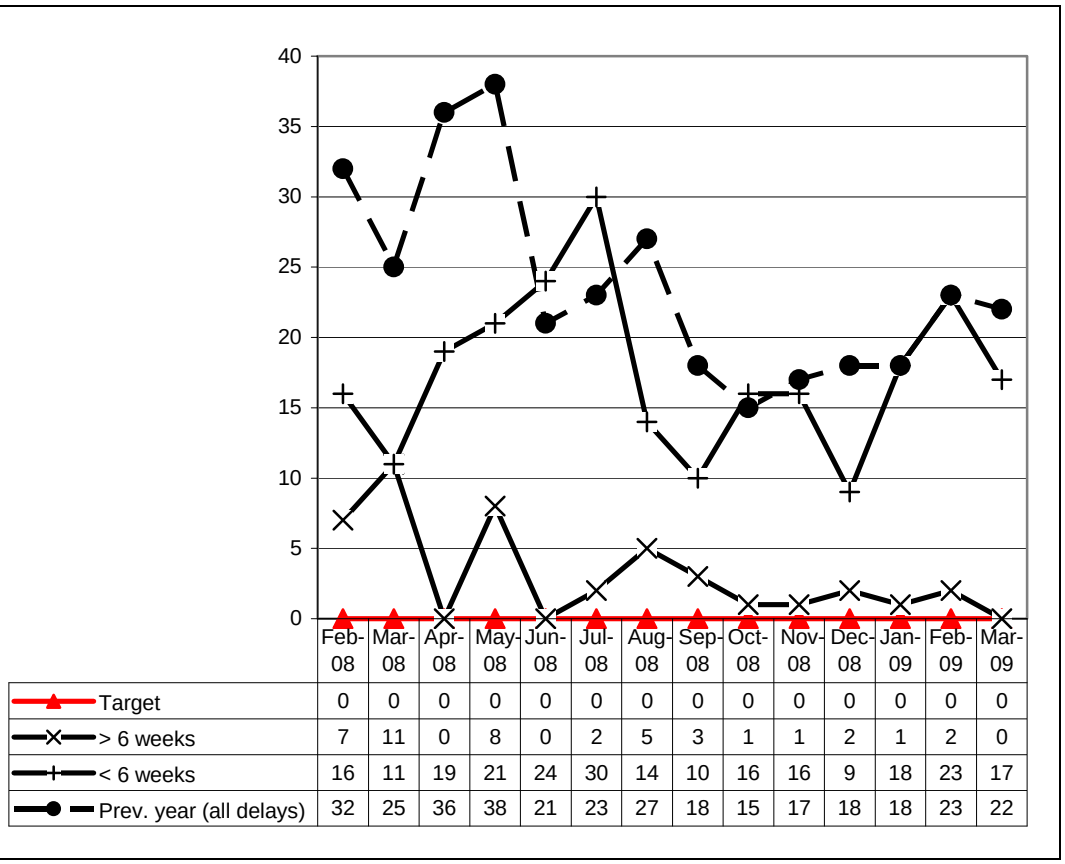
No of patients on dementia register – March 09	Trajectory – March 2009
592	655

All 592 patients on the register had reviews at 15 months. A community based outreach model to support patients with dementia is being piloted in Kelso and will be evaluated later this year. The development of an integrated care pathway began in June 09.

HEAT Std: The number of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting will be reduced to zero

In April 2009 there were 22 Delayed Discharges in total but none were waiting over 6 weeks.

No of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting



	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0
> 6 weeks	7	11	0	8	0	2	5	3	1	1	2	1	2	0
< 6 weeks	16	11	19	21	24	30	14	10	16	16	9	18	23	17
Prev. year (all delays)	32	25	36	38	21	23	27	18	15	17	18	18	23	22

HEAT Std: Cervical screening target 80% ongoing

Population coverage of cervical screening in the Borders is good at 83%, which exceeds the national target of 80%.

HEALTHCARE ACQUIRED INFECTION (HAI)

Progress to meet nationally set standards has progressed in a number of areas:

- Following the introduction of the *QIS Standards* in March 2008, a gap analysis and action plan for compliance with the standards was developed and work is ongoing on implementation
- Review of performance against *HAI Code of Practice* (2004) has shown compliance of 97% 'Met' or 'Partially Met' with 3% 'Not Met'. An action plan for full compliance is ongoing
- All mandatory HAI surveillance is in place and reporting on time. All national hand hygiene audits have been conducted to plan and submitted on time and compliance is on trajectory to achieve the target of 100%. The latest audit shows a compliance of 95%. A local audit to meet national deadlines is being conducted 20th - 31st July
- MRSA bacteraemia rate has remained within control limits for the last twelve quarters
- Data submitted to Health Protection Scotland (HPS) for MRSA bacteraemia indicates we are on track for the HEAT trajectory as outlined in the Local Delivery Ppan
- Infection Control are addressing Patient Focus and Public Involvement goals through lay infection control volunteers and an Egroup has been set up

- All five action plan steps laid down in the Scottish Management of Antimicrobial Resistance Action Plan (ScotMARAP) have been completed in NHS Borders and an antimicrobial management group will take this work forward, supported by an antimicrobial pharmacist
- The monitoring Framework for the *NHSScotland National Cleaning Services Specification* was implemented and audits undertaken as per the programme. Results have been consistently 'green'
- With funding and support from the Scottish Government, a rapid screening service for MRSA is being established. A universal MRSA screening document is being developed as per "HPS Project Initiation Document, MRSA Screening National Rollout".

CLINICAL GOVERNANCE

External Reviews and Inspections

The following reviews have taken place during 2008/09 with actions being taken forward to address the findings of each review:

- Integrated Care Pathway for Mental Health
- Out-of-Hours Emergency Dental Care
- Learning Disabilities
- Food, Fluid & Nutritional Care in Hospitals
- Preparatory work for Clinical Governance & Risk Management

Patient Safety

The Patient Safety Programme, has been running for 16 months and is on target with the Institute of Healthcare Improvement assessment scale for individual hospital performance and various workstreams are underway.

Clinical Risk Management

In 2008/09 there was a total 2618 clinical adverse events reported, an increase of 5% on the year 2007/08 (2490 events reported). 1155 of the total number of events reported were events with an 'actual outcome' and 1463 were recorded as a 'near miss'. The Clinical Risk Management Team follows up events with actual outcome graded as major or extreme. In 2008/09 a total of 8 Root Cause Analyses (RCA) were conducted, 6 in Acute Services and 2 in Primary & Community and a total of 5 Critical Incident Reviews using RCA methodology were carried out in Mental Health Services.

Patient Feedback

A breakdown of patient feedback received by the Clinical Governance department during 2008/09 is below.

Complaints received	% of Total Feedback Negative	Compliments Received	% of Total Feedback Positive

136	5%	2638	95%

In 2008/09, two investigations took place in relation to NHS Borders and a report was subsequently published by the Scottish Public Services Organisation (SPSO). The organisation accepted all recommendations made by the SPSO. The reports for NHS Borders equate to 2.2% of the total SPSO investigations across Scotland

Clinical Audit

Clinical audit has continued to support the national audit data requirements for cancers, Managed Clinical Networks and Hip Fracture / Access to Musculoskeletal Services. There has been a small increase in the number of local clinical audits registered with a total of 83 locally driven audits were registered between April 08 and March 09.

Research Governance

For 2008/2009 a total of 46 research projects were submitted seeking Research & Development Management approval. Of these 46 projects, 44 were approved, 2 were withdrawn on ethical grounds.

Clinical Effectiveness

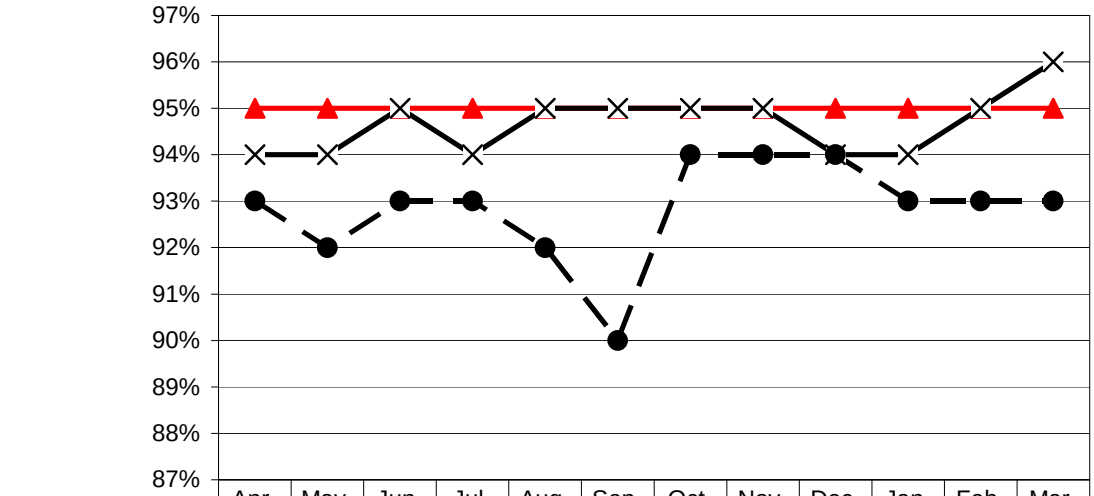
In the past year organisation wide clinical policies have been developed for Bedrails, Consent to Treatment, and Standards for the Document Management of NHS Borders Clinical Policies. The Completion of Health Records Policy has also been reviewed. A NHS Borders Clinical Procedures Manual is nearing completion. A database of NHS Borders clinical policies, procedures, protocols and guidelines has been developed and is in the process of being populated. A steady stream of SIGN guidelines and NHS QIS guidance has been published and progressed through the dissemination/assessment/review process.

FINANCE, EFFICIENCY AND WORKFORCE

HEAT E1: Universal utilisation of community health index (CHI)

The target of 95% was mainly met throughout 2008/09.

Overall Percentage Usage of CHI

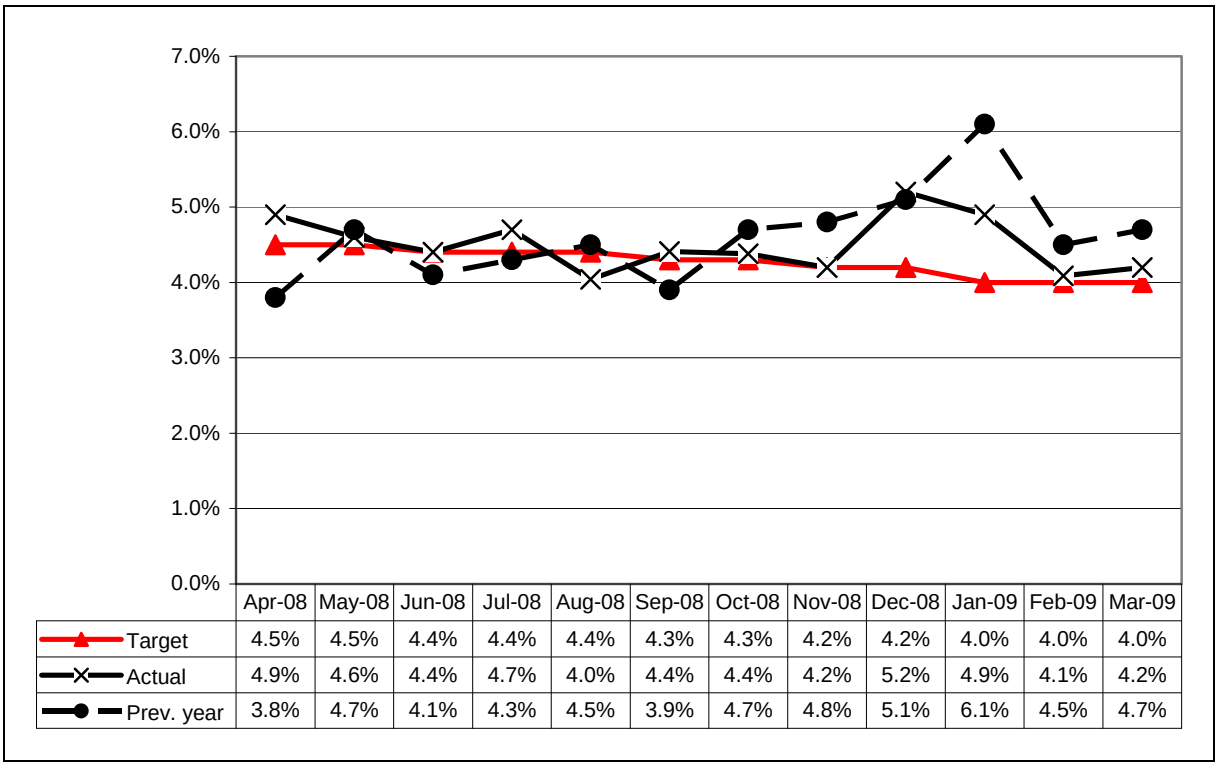


	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Actual	94%	94%	95%	94%	95%	95%	95%	95%	94%	94%	95%	96%
Prev. year	93%	92%	93%	93%	92%	90%	94%	94%	94%	93%	93%	93%

HEAT E2: NHS Boards to achieve a sickness absence rate of 4% from 31st March 2009

During the year, the cumulative percentage was 4.5% with the range going from 4% in August 08 to 5.2% in December 08. In March 09 the rate was just above the target at 4.2%. An Absence Management Action Plan is in place to help bring the rate down and work is ongoing to assist services in diagnosing and addressing areas of concern.

Sickness Absence Rate During 2008/09



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Target	4.5%	4.5%	4.4%	4.4%	4.4%	4.3%	4.3%	4.2%	4.2%	4.0%	4.0%	4.0%
Actual	4.9%	4.6%	4.4%	4.7%	4.0%	4.4%	4.4%	4.2%	5.2%	4.9%	4.1%	4.2%
Prev. year	3.8%	4.7%	4.1%	4.3%	4.5%	3.9%	4.7%	4.8%	5.1%	6.1%	4.5%	4.7%

HEAT E3: NHS Boards to ensure that all employees covered by Agenda for Change have an agreed personal development plan (PDP) by March 2009

The deadline for this was extended nationally to May 2009 and by then 100% of staff had a PDP in place.

HEAT E4: NHS Boards to deliver agreed improved efficiencies for first out patient attendance did not attends (DNA), non-routine average length of stay, review to new out patient attendance ratio and day case rate by March 2011

- First Out-patient Attendance DNA - March 09 Total DNA was 6%, meeting the target of 6.4%
- Non-routine inpatient average LoS – March 09 LoS was 4.79 days, meeting the trajectory target of 4.8 days
- Review to new outpatient ratio – as at Sept 08, the ratio was 1.47 exceeding the trajectory target of 2.89
- Day case rate – as at March 09, day case rate was 80%, slightly below the target of 81.2%.

HEAT E5: NHS Boards to operate within the agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement and secure on-going recurring financial balance

Subject to audit NHS Borders achieved all financial targets in 2008/09 and remained in recurring financial balance using the agreed measure of +/- £1m (0.5%).

HEAT E6: NHS Boards to meet their cash efficiency target and achieve all savings targets and develop future savings plans

The overall savings target was met in 2008/09. Plans are being developed for delivery in future years, principally routed in the Strategic Change Programme.

HEAT E7: To increase the percentage of new GP out patient referrals into Consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to 90% by 2010

Eight areas are now using Scottish Care Information (SCI) Gateway to process referrals electronically saving 24 hours over the previous process. There have been some delays, and the interim target of 10% at the end of March 2009 was not achieved but progress is now coming closer to meeting the trajectory. Implementing a more streamlined solution is being investigated and a number of standalone 3rd party application based solutions are being evaluated.

FINANCE

Financial Performance and Planning and Maintaining Financial Balance

NHS Borders integrated in 2003 and inherited a recurring deficit of £3m. As a result of the hard work of staff across the organisation this was addressed and the Board returned to recurring financial balance early in 2007. The Board has been successful in sustaining recurring balance throughout 2007/08 and 2008/09.

Revenue

NHS Borders achieved all financial targets in 2008/09.

In agreeing the financial plans for 2008/09 the Board was aware of a number of pressure areas particularly: -

- Cost of pay awards and ongoing costs arising from Agenda for Change reviews and increments which, taken together, increased the pay bill by £3.7m or almost 4% in 2008/09;
- Increases in the cost of drugs running at 6% overall;
- Increases in the cost of capital estimated at 8% due to building indexation;
- Increasing use of specialist services provided out-of-area due mostly to increasing population and more complex, but expensive, care becoming available;
- Additional medical staffing costs arising from changes to junior doctors training and working time regulations;
- Increasing demands on services, particularly renal services;
- Volatility in energy costs;

- Increasing cost of CNORIS contributions.

As part of the Efficient Government Programme, NHS Borders is committed to achieving at least 2% cash releasing, recurring efficiency savings for each of the three years 2008/09 to 2010/11. This efficiency saving equates to £3.2m per year, or almost £10m over the three years. This target was achieved in 2008/09 with the main programme areas described below.

NHS Borders recognised the need to make ongoing improvements in our efficiency and deliver significant savings, and established a Strategic Change Programme during the second half of 2007 to review existing strategies and present proposals that would release significant levels of recurring resource.

Overall the Strategic Change Programme encompasses the following themes: -

- General Savings, a general programme to identify inefficiencies, savings and income generation opportunities;
- Increasing Efficiency and Reducing Waste, joint work with staff to identify opportunities to reduce costs and act as a vehicle to communicate ideas and initiatives;
- Productivity and Benchmarking, comparing NHS Borders with other Boards using national data, and benchmarking within NHS Borders using comparable services;
- Integrated Health Strategy, designing options to re-shape how services are delivered;
- Continuous Improvement, a programme to identify opportunities to change the way we work;
- Sustainable Workforce, identifying pressure areas and opportunities from new contracts.

Some of these themes delivered efficiency savings in 2008/09, and we expect the important strategic re-design work, the integrated Health Strategy theme, to develop throughout 2009 and begin to deliver significant efficiency improvements by the end of 2010/11 at the latest.

During late 2008 and 2009 the potential impact of the economic outlook has heightened the importance and urgency of this work.

Looking at specific savings achieved during 2008/09, the programme for the year included:-

- Savings in drug costs £500k
- Additional income from Northumberland giving improved efficiency and sustainability in a range of BGH services - £500k
- Improved efficiency across all services provided by support services, estates and facilities releasing £1.1m.
- Reducing planned rolling programme capital expenditure in 2009/10 - £100k
- A range of strict controls on discretionary spending - £200k
- Strict controls on the filling of vacancies and use of bank and agency staff and a requirement for all managers to deliver a recurring 5% reduction in pay costs over two years by re-design and efficiency improvements £2m
- Realignment of in-patient services £400k

Progress was monitored monthly by an operational savings group and was reported to the Executive Team and the Board as part of the monthly reports. A formal quarterly review was also undertaken and reported to the Board.

In terms of operational budgets, the Board had a good year with the majority of budget managers delivering break-even or small underspends. Two areas of overspend which were a cause of concern were prescribing and clinical services provided out of area.

Overall, this outcome represented a great deal of hard work by clinical staff and managers and it is acknowledged that during the year some difficult choices and decisions had to be made.

Capital

NHS Borders successfully remained within its Capital Resource Limit for 2008/09.

The Board agreed a strategic capital plan in 2006/07 as part of the Getting Fit for the Future strategy. This programme was in response to the projected growth in population and changing demographic trends. The programme was based on welcome significant capital developments at the BGH, Primary Care and in Mental Health.

During 2008/09 we completed two major dental schemes in Coldstream and Hawick at a cost of £3m. Once fully established these schemes will help address dental access issues in the respective localities. We also commenced work on a reprovision of Endoscopy facilities at the BGH costing £2.4m, which will enable the commencement of Bowel Cancer Screening. Other schemes completed during the year, included a range of smaller schemes within the BGH and across Primary Care. Progress was made in bringing forward three community health centre schemes in Galashiels, Lauder and Jedburgh and we expect these to be substantially completed during 2010/11.

Given the work that is being taken forward as part of the Integrated Health Strategy strand of the Strategic Change Programme we will be reviewing the current capital plan, but expect our priorities to remain the front of BGH including BECC; the community health centre schemes and a reprovision of Functionally Ill Elderly facilities within Mental Health Services.