NHS BORDERS

2016 Annual Review

Self Assessment

Progress against 2015 Annual Review action points

There were 6 items highlighted in the Annual Review held on the 17th September 2015. Progress updates against these actions can be found throughout the self assessment.

Action point 1:
Make sustained progress in achieving smoking cessation targets.

Please see section 3.1, page 29

Action point 2:
Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safety, including delivery of all action plans arising from HEI and OPAH inspections.

Please see section 2.1, page 19 - 28

Action point 3:
Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection, with particular emphasis on SABs.

Please see section 2.1, page 19 - 21

Action point 4:
Keep the Health and Social Care Directorates informed on progress towards achieving all access targets and standards, in particular for Outpatient appointments and Psychological Therapies.

Please see section 1.1, page 11 - 16

Action point 5:
Continue to make progress against the staff sickness absence standard.

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Action point 6:
Continue to deliver financial in-year and recurring financial balance, and keep the Health and Social Care Directorates informed of progress in implementing the local efficiency savings programme.

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3: Effective

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

3.2: Staff feel supported and engaged

3.3: Best use is made of available resources

Acronyms

BGH **Borders General Hospital**

CAMHS **Child and Adolescent Mental Health Service** – NHS Boards must ensure they deliver faster access and treatment for specialist Child and Adolescent Mental Health Services.

CEL **Chief Executive Letters** - Scottish Government Health Directorates guidance issued to NHS Boards

C.diff or CDI **Clostridium difficile Infections** - the most important cause of hospital-acquired diarrhoea. People who have been treated with broad spectrum antibiotics, people with serious underlying illnesses and the elderly are at greatest risk.

CPD **Continuing Professional Development**

GMS **General Medical Services contract** – the contract between the individual GP contractors and the NHS to provide medical services.

HEI **Healthcare Environment Inspectorate** - established in April 2009 to undertake at least one announced and one unannounced inspection to all acute hospitals across NHSScotland every 3 years. Remit now expanding to cover wider range of healthcare facilities.

HIS **Healthcare Improvement Scotland** - helps NHSScotland and independent healthcare providers to deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise services to provide public assurance about the quality and safety of that care.

HSMR **Hospital Standardised Mortality Ratio** - an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

ISD **Information Services Division** - provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care and facilitates robust planning and decision making.

MRSA **Methicillin Resistant Staphylococcus Aureus** - a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

OPAC **Older People in Acute Care** - Health Improvement Scotland carries out a programme of inspections to provide assurance that the care of older people in acute hospitals is of a high standard.

QOF **Quality and Outcomes Framework** – this is a system for the performance

management and payment of general practitioners (GPs) in the National Health Service (NHS) in England, Wales, Scotland and Northern Ireland. It was introduced as part of the new general medical services (GMS) contract in April 2004, replacing various other fee arrangements.

SABs **Staphylococcus Aureus Bacteraemias** - a group of different infections (such as MRSA, MSSA) that are caused by staphylococcus bacteria. One of the biggest challenges in treating staphylococcal infections is that many strains of the S. aureus bacteria have developed resistance against a number of different antibiotics.

SPSP **Scottish Patient Safety Programme** - is being implemented in every acute hospital in the country to steadily improve the safety of hospital care.

1 PERSON CENTRED

1.1 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 '2020 Vision', and Corporate Objectives, on quality ambitions and healthcare outcomes. The Workforce Plan for 2015/16 also promoted working towards quality throughout the Health Board. NHS Borders closely monitors a number of clinical quality and patient experience indicators to assess the overall quality of care delivered through its services.

Public Involvement and Patient Experience, 2015-16
NHS Borders has integrated existing public involvement and patient experience work streams into an overall person centred programme of work. These work streams include the Patient Rights (Scotland) Act (2011), complaints, feedback, person centred care projects, advocacy, carer support, voluntary sector engagement, volunteering, public involvement and patient experience. Regular patient feedback reports are provided to NHS Borders Board including feedback received through social media platforms and patient stories. Oversight of delivery of the Person Centred Care work programme is provided by NHS Borders Clinical Executive Operational Group and assurance is provided to the Boards Clinical and Public Governance Committees. Leadership of Public Involvement and Patient Experience sits with the Clinical Governance and Quality Department alongside responsibility for the workstreams of safety, clinical effectiveness and patient flow reflecting the ambitions of the Healthcare Quality Strategy and enabling alignment across quality improvement initiatives.

Consistent and high quality public involvement and patient experience work is achieved through the implementation of NHS Borders Process for Coordinating Public/Patient Engagement. Part of the process involves monthly meetings with the Scottish Health Council which helps to provide external assurance that our public/patient engagement is of a high quality. This year the main topics of work with the Scottish Health Council centred on the re-provision of the Galavale mental health rehabilitation service, as well as work to evolve the Public Partnership Forum to span health and social care.

During 2015/16 NHS Borders continued to improve its public involvement and patient experience work streams by, for example, increasing the number of public involvement members, volunteers and strengthening the roles of local patient and public involvement groups. This has included the Health in Your Hands: What Matters to You? public engagement exercise. The main purpose of this exercise was to give the Borders public an opportunity to tell us what was important to them to help NHS Borders shape future services and give consideration to future priorities. The exercise was also aimed at providing the chance for the Board to listen and to give an opportunity for people to give feedback and share their stories on the care that they have received in the past or recommendations for how they would like to receive care in the future should they require it.

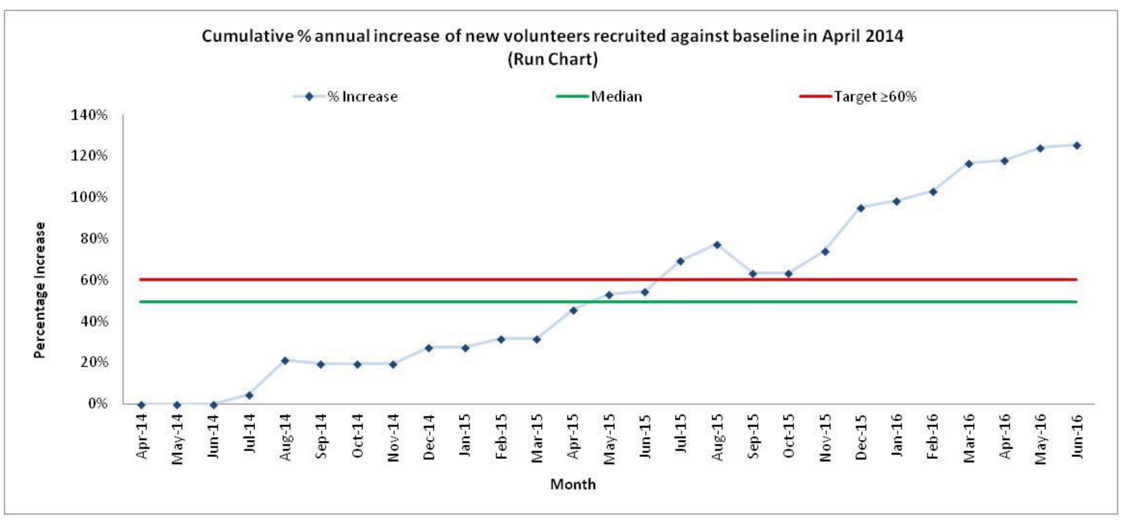
A wide range of responses were received from over 700 conversations, including members of the public, patients, carers, family, visitors, staff and stakeholders. This feedback will be used to support future service planning and will help inform the development of NHS Borders Public Involvement and Community Engagement Strategy and future engagement exercises; will be shared with Community Planning Partners as we develop a collective approach to community engagement; provide direct feedback around any individual services to Heads of Service for

their information and action if required; and a summary report will be produced for the public and our staff on the exercise and next steps.

Volunteering

NHS Borders is committed to involving volunteers in enhancing patient experience and holds the Investing in Volunteers award demonstrating that NHS Borders can evidence high quality volunteer management and in particular that volunteers are treated in a consistent way to staff.

NHS Borders hosted a volunteer's celebration event in December 2015 to thank volunteers for their contribution to enhancing patient experience. At this event the Chairman, John Raine, reinforced NHS Borders' commitment to growing and expanding our partnership with volunteers. Internally we set a stretch aim to increase the number of active volunteers by 60% in 2014/15 to enhance the patient's experience. This aim was achieved by April 2015 as outlined in the graph below:



NHS Borders has a total of 162 people volunteers in addition to a further 38 volunteers who actively work to fundraise as 'Friends of the BGH and Community Hospitals'. Newly created roles in 2015/16 include Activity Volunteers in Hay Lodge Hospital, Gala Day Unit and in Melburn Lodge. The Melburn Lodge volunteers are a group of S6 pupils from Earlston High School who volunteer with us during their last year at High School to gain experience in a healthcare setting while supporting the ward with their meaningful activity programme. A Music Therapy Volunteer now visits Mental Health inpatient and day units. In addition, there are 6 volunteers supporting the Early Years Centres in Hawick, Selkirk and Eyemouth.

There is also a network of 42 volunteers who support our Public Partnership Forum, Public Reference Group and our BGH Participation Group.

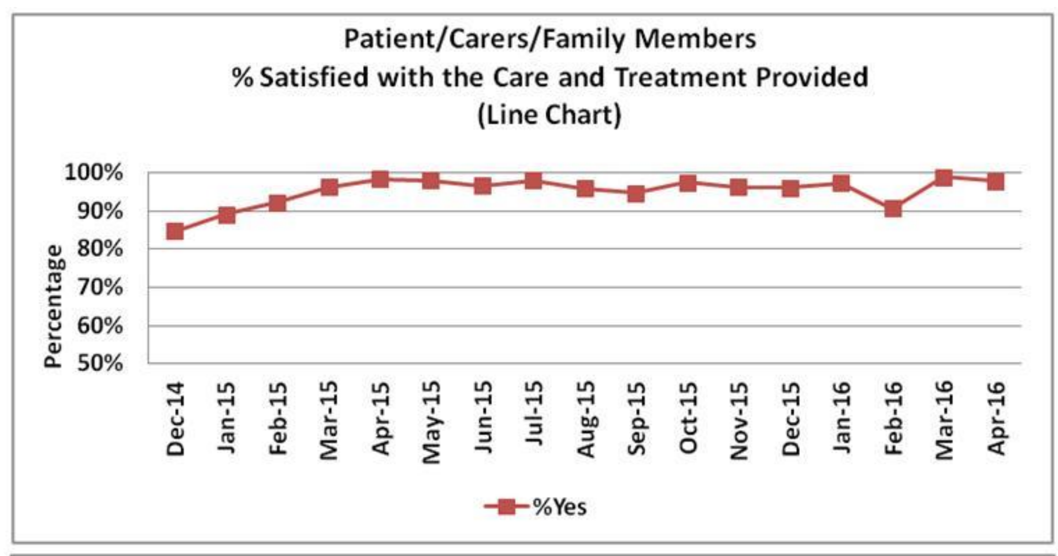
The volunteer steering group continues to meet 3 times a year and one of the group's main functions is to oversee the volunteering improvement plan. The group has overseen the development in 2015/16 of:

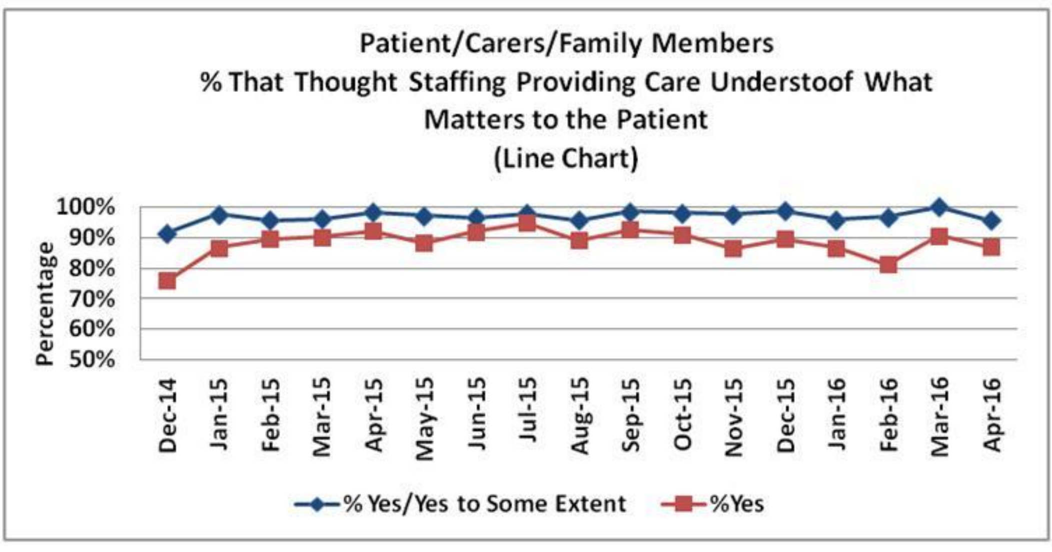
- a revised and updated 'Volunteering in NHS Borders' policy
- a new leaflet to inform potential volunteers of what steps to take to becoming involved. The leaflets have been distributed to community hospitals and health centres
- a quarterly core training programme covering statutory and mandatory training in collaboration with Board topic leads. All new volunteers will be asked to attend this

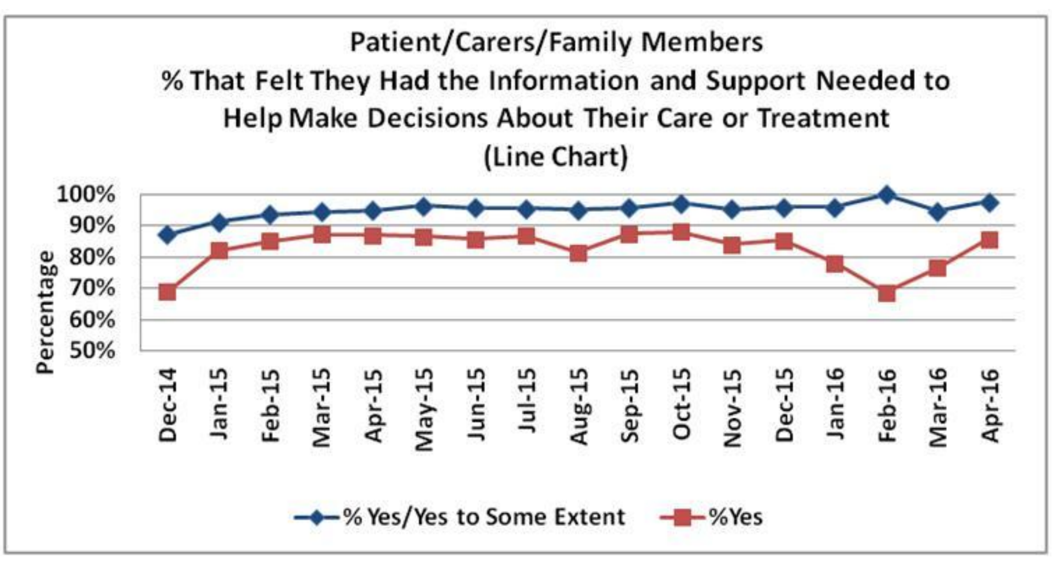
session within 6 months of commencement in their roles as part of the recruitment process. The first successful training session took place in November 2015. In addition volunteers are now invited to attend the newly formatted corporate induction programme
- a new national volunteer information system in the Borders to maintain accurate and complete records of all volunteers. This new system has introduced a robust and consistent approach to the monitoring of volunteer activity and allowing regular reporting on different elements of the volunteer journey.

Proactive Patient Feedback
NHS Borders collects patient feedback through many different means including patient opinion, public involvement, patient stories, complaints and commendations, surveys, Scottish Public Sector Ombudsman reports and through its proactive patient feedback system introduced in 2014/15.

There are a total of 16 patient feedback volunteers registered, providing support across multiple services and departments within NHS Borders. The graphs below outline the response from the core questions asked by patient feedback volunteers of patients, carers, relatives and visitors.







Complaints, Concerns and Commendations
A new approach to complaints handling has been introduced since November 2015. Changes to the approach have included an increase in the amount of direct dialogue and face to face meetings with patients, families and staff as part of the investigation and follow up process. This model, whilst requiring additional steps and greater involvement from a wider range of staff is felt to be delivering a better outcome for those who have taken the time to provide feedback on NHS Borders services. Following testing the focus is now on embedding the new process and on seeking further feedback from patients and families on the process.

A patient information sign that will be placed next to the patients beside and will provide details on how patients, carers and relatives can seek advice if they feel their care is not safe or of good quality is being tested in the Women's and Children's service within the BGH.

Person Centred Care Projects
Quality and safety information boards are displayed in the main corridor of inpatient areas containing information on staffing, patient feedback and quality of care were tested throughout 2015. These information boards are used by staff to share information across the multidisciplinary team to drive improvement by making quality, safety and staffing information more visible. This also allows us to promote a culture of openness and transparency about quality of care. We are in the process of putting in place similar boards for all the adult inpatient wards in the BGH.

As a result of strong support from patients, relatives and staff, staff name badges will be re-introduced to NHS Borders in 2016. NHS Borders are embracing Dr Kate Granger's 'hello my name is…' campaign and looking for ways to support and implement this within NHS Borders. This campaign is centred on encouraging and reminding healthcare staff about the importance on introductions during the delivery of care.

In April 2015 a person centred care plan which incorporates 'what matters to me' was rolled out across all wards in the BGH and in Community Hospitals.

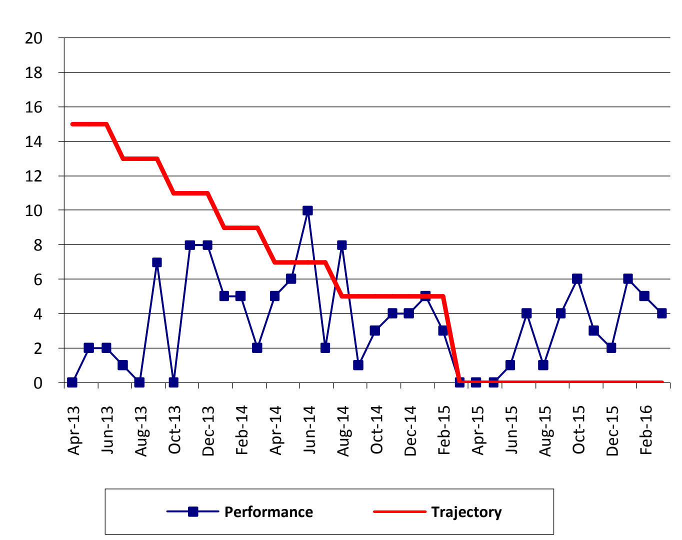
Many of the wards in the BGH now operate person centred visiting which means there is a greater degree of flexibility from ward staff on when carers and relatives can visit.

In 2015/16 dementia champions were introduced to wards in the BGH and the Community Hospitals to develop effective relationships with patients with dementia and their families. Through coaching and mentoring by the Alzheimer's Dementia Nurse Consultant the dementia champions will cascade this learning to their colleagues.

Meaningful activities play a vital role in the care of patients with Dementia. Playlist for Life continues to be used as part of the meaningful activity programme in Melburn Lodge. There has been interest from colleagues in the community mental health teams to explore how playlists can be captured from patients earlier in their diagnosis. Ward 9 in the BGH tested the use of knitted toggle mitts to reduce agitation in dementia patients.

Standard: No Delayed Discharges over 2 weeks

Trajectory: no delays over 2 weeks	**2015/16 Performance:** 36 delays over 2 weeks



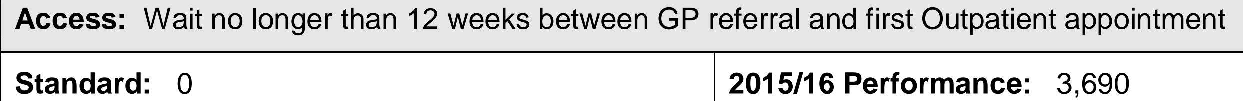
The key reasons for delay experienced by patients are currently being influenced by the following issues:

1. Care at home – we continue to be challenged in sourcing care at home across the Borders.
2. Choices of care home placements and availability thereof
3. A number of complex cases with a significant length of stay

Ongoing focus is being placed upon supporting the discharge of delayed patients awaiting their next stage of care across the system. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 Hour ED Standard, quality of care and ensuring people are in the right care setting, and the avoidance of disruption to planned surgical admissions.

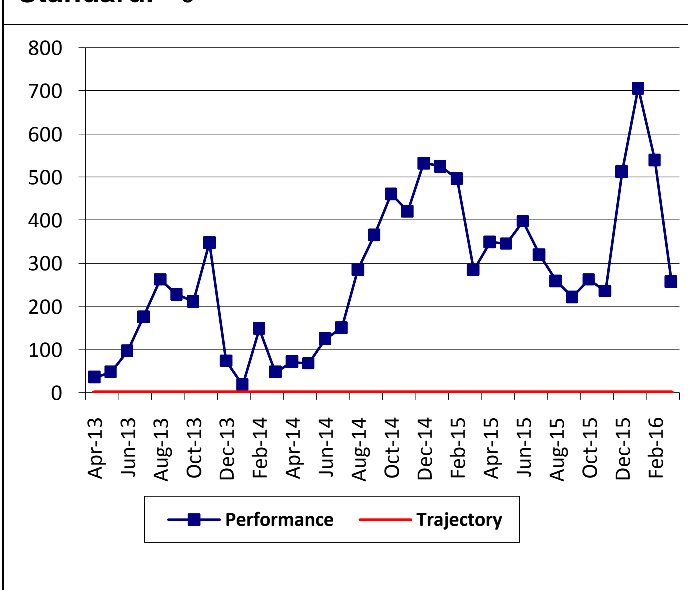
There are weekly delayed discharge meetings with senior managers and senior colleagues from Scottish Borders Council and SB Cares including the Head of Delivery Support, Chief Officer for Health and Social Care, Director of Nursing, Midwifery and Acute Services and General Managers for Primary & Community Services and Unscheduled Care, amongst others and they have been meeting since the beginning of January to add impetus to the improvement required. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring and to implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

A comprehensive list of actions is being developed and will be closely monitored during 2016/17.



Access: Wait no longer than 12 weeks between GP referral and first Outpatient appointment

Standard: 0	**2015/16 Performance:** 3,690



Significant progress has been made around Outpatient Waiting Times during 2015/16, with the majority of specialties now booking within 12 weeks. There were, however, 258 patients waiting over 12 weeks at the end of March 2016 for their first outpatient appointment.

There remain challenges within ENT, Gastroenterology and Chronic Pain. NHS Borders has received extra funding from Scottish Government to support additional activity within ENT and Gastroenterology up to the end of September 2016, and it is anticipated that this will support improvement in these areas. Further work will be required to resolve these issues on a longer term basis however.

In Chronic Pain, managers are working with the Service to identify a sustainable solution for the future.

Access: Wait no longer than 12 weeks for Inpatient or Day Case Treatment

Standard: 0	**2015/16 Performance:** 83

55 50 45 40 35 30 25 20 15 10 5 0

Apr-13 Jun-13 Aug-13 Oct-13 Dec-13 Feb-14 Apr-14 Jun-14 Aug-14 Oct-14 Dec-14 Feb-15 Apr-15 Jun-15 Aug-15 Oct-15 Dec-15 Feb-16

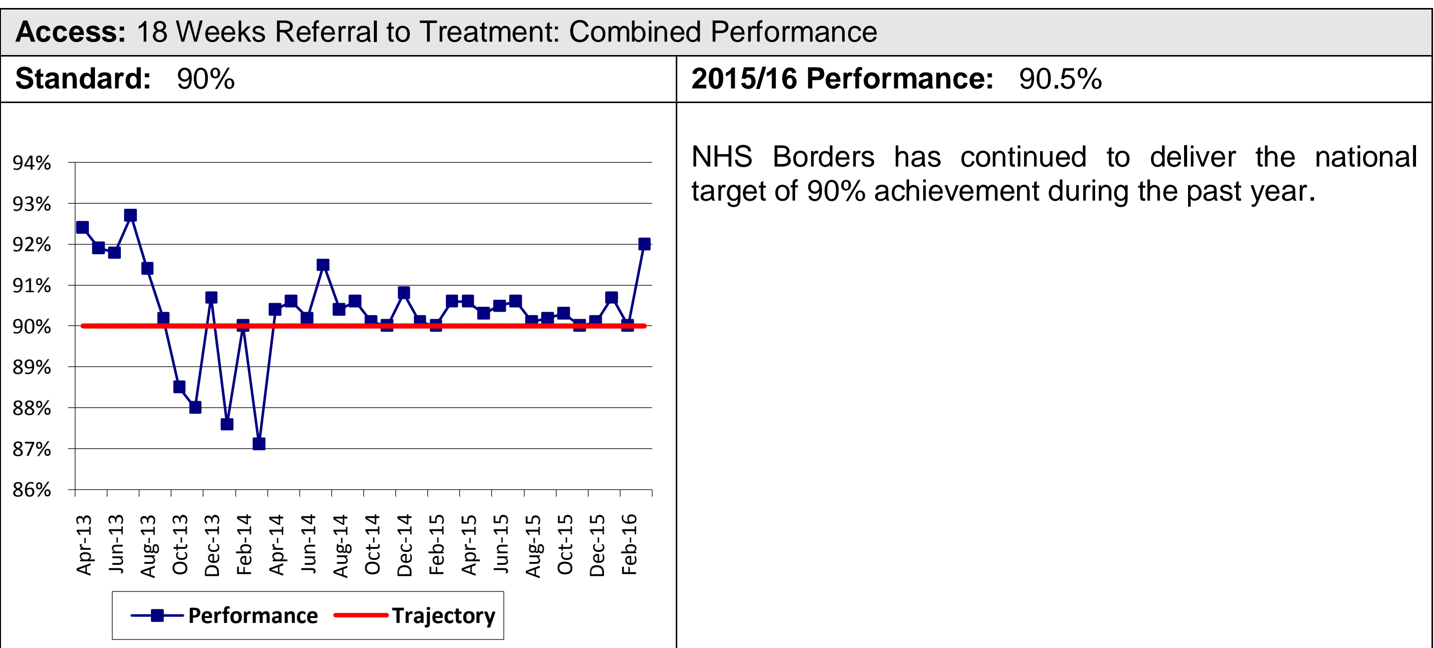
Performance Trajectory

Significant progress has been made around Inpatient Waiting Times during 2015/16, with all Specialties now booking within 12-weeks.

All patients currently reported as breaches have been as a result of short-notice cancellations which continue to remain a risk.

Access: 18 Weeks Referral to Treatment: Combined Performance

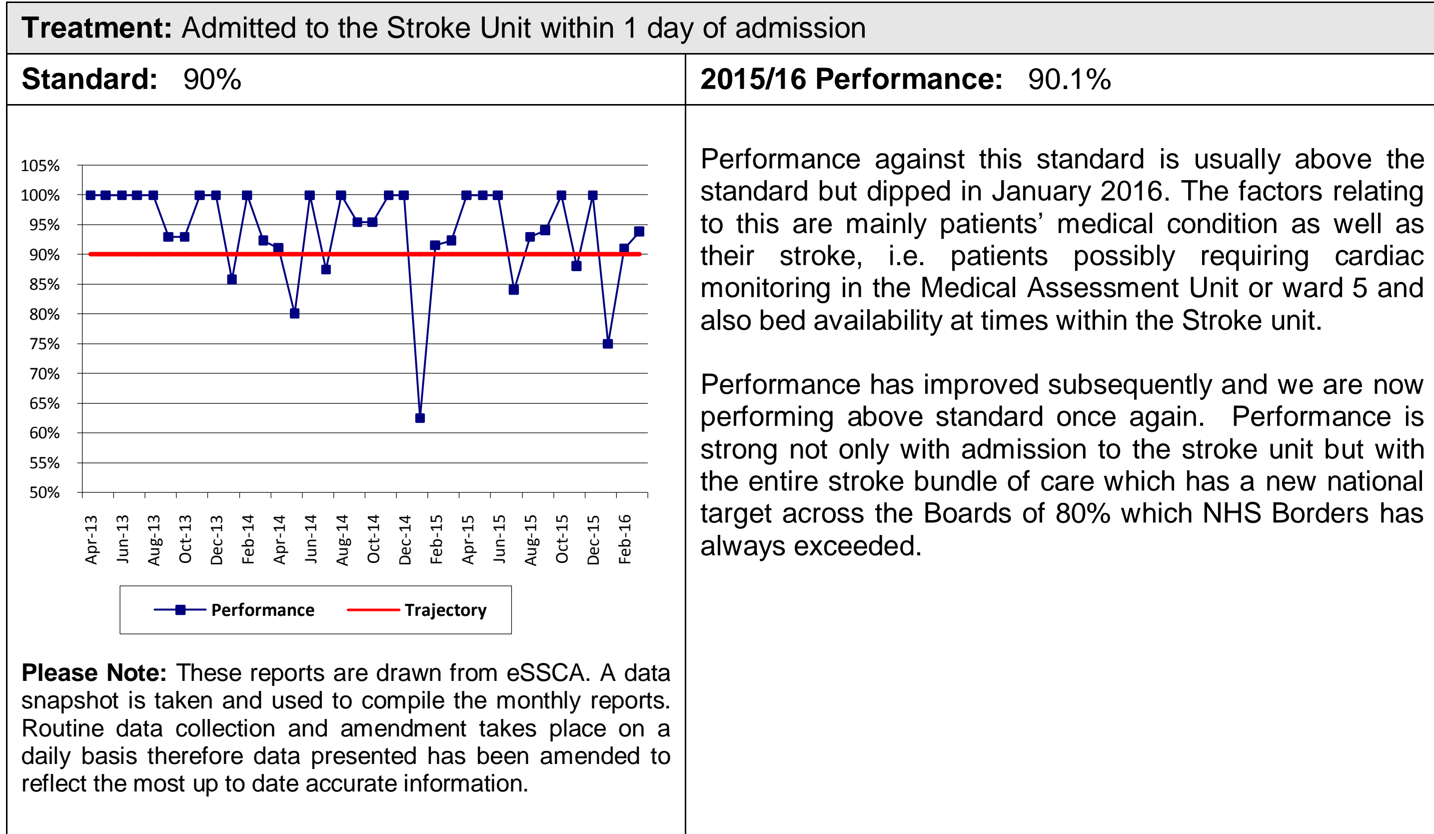
Standard: 90% | **2015/16 Performance:** 90.5%



NHS Borders has continued to deliver the national target of 90% achievement during the past year.

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

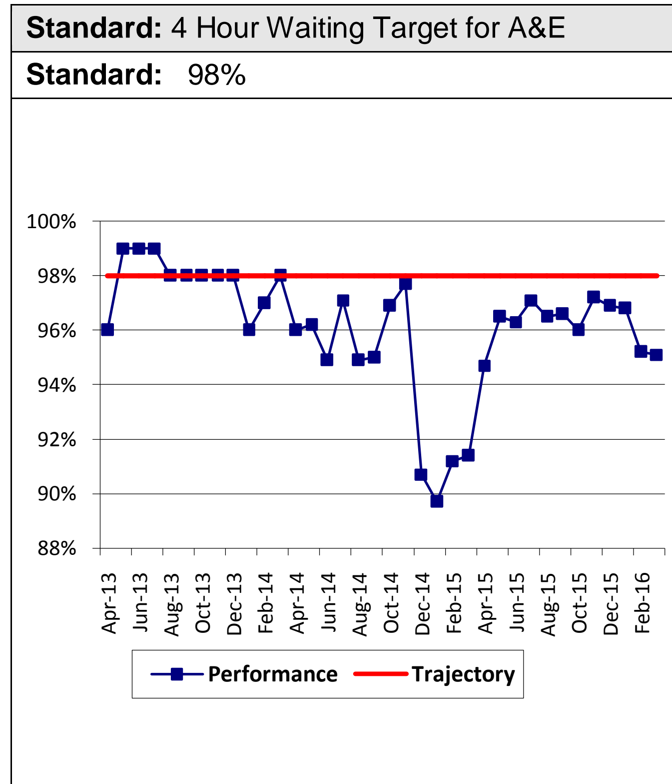
Standard: 90% | **2015/16 Performance:** 90.1%



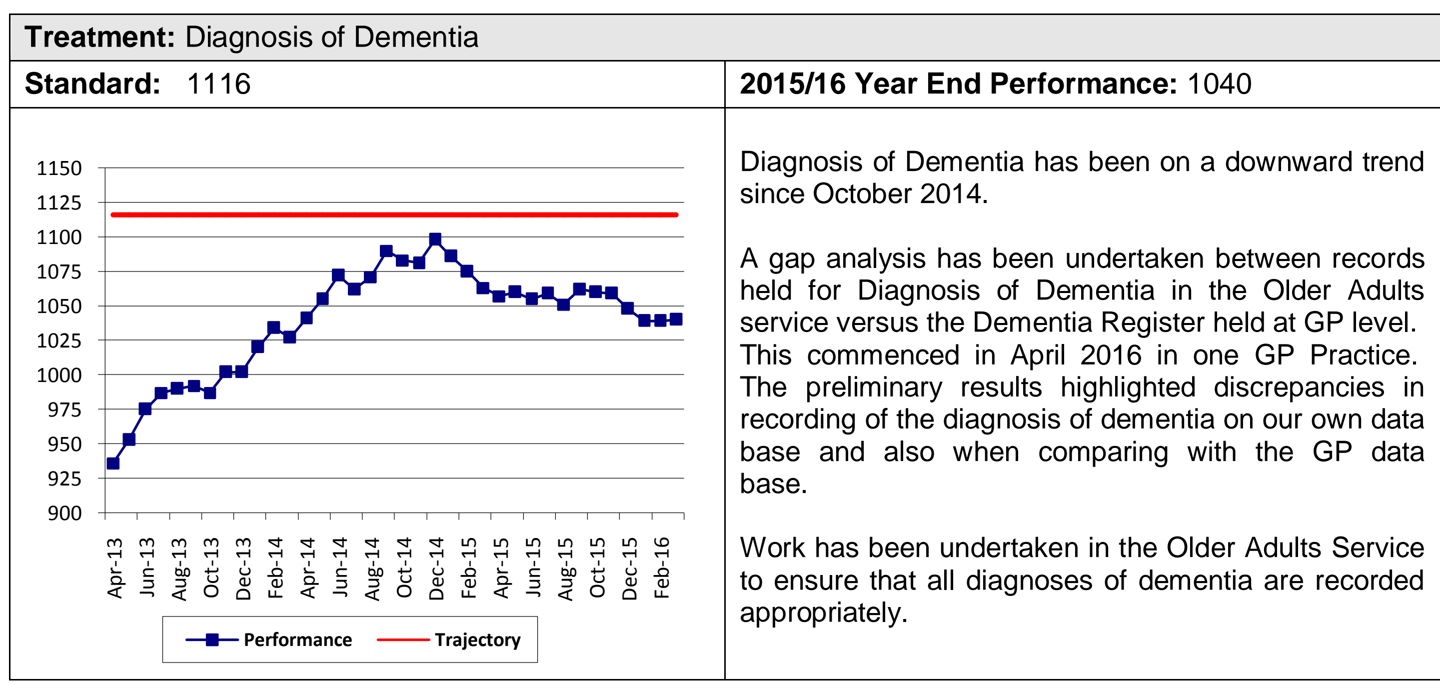
Please Note: These reports are drawn from eSSCA. A data snapshot is taken and used to compile the monthly reports. Routine data collection and amendment takes place on a daily basis therefore data presented has been amended to reflect the most up to date accurate information.

Performance against this standard is usually above the standard but dipped in January 2016. The factors relating to this are mainly patients' medical condition as well as their stroke, i.e. patients possibly requiring cardiac monitoring in the Medical Assessment Unit or ward 5 and also bed availability at times within the Stroke unit.

Performance has improved subsequently and we are now performing above standard once again. Performance is strong not only with admission to the stroke unit but with the entire stroke bundle of care which has a new national target across the Boards of 80% which NHS Borders has always exceeded.

Standard: 4 Hour Waiting Target for A&E	
Standard: 98%	**2015/16 Performance:** 96.2%
	Although emergency activity has been challenging, the Board has continued to deliver on or close to the 95% Emergency Access Standard during 2015/16. The challenges have been related to: 1. Availability of beds 2. Delays to first medical assessment in ED A Recovery Plan has been developed to drive improvements targeted at delivering the 98% Emergency Access Standard. These actions are focused on increasing morning discharge rate, improving use of the discharge lounge and developing and implementing a package of measures to improve time to first assessment within the Emergency Department. A weekly Unscheduled Care huddle has been established, bringing together clinical staff, managers and data and project support to review the weekly data and develop and monitor actions to improve this.

Mental Health

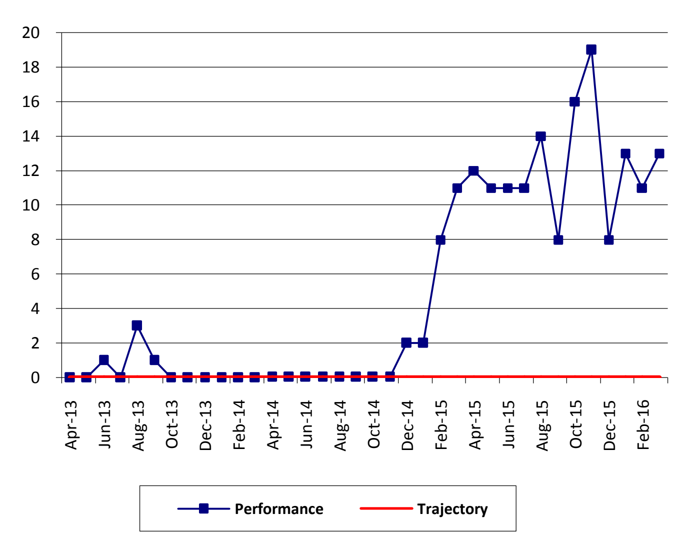


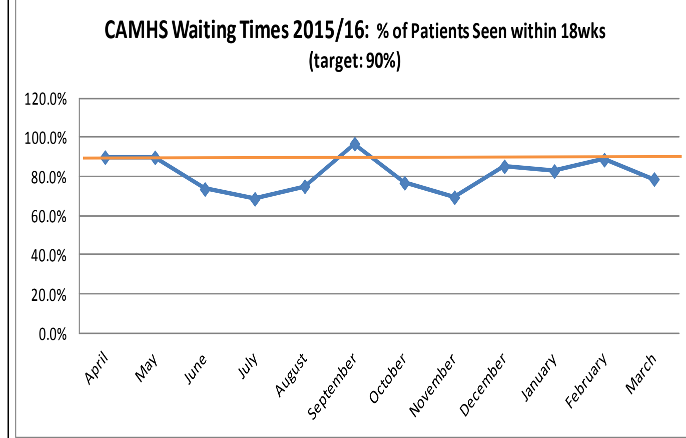
Treatment: Diagnosis of Dementia	
Standard: 1116	**2015/16 Year End Performance:** 1040
(chart)	Diagnosis of Dementia has been on a downward trend since October 2014. A gap analysis has been undertaken between records held for Diagnosis of Dementia in the Older Adults service versus the Dementia Register held at GP level. This commenced in April 2016 in one GP Practice. The preliminary results highlighted discrepancies in recording of the diagnosis of dementia on our own data base and also when comparing with the GP data base. Work has been undertaken in the Older Adults Service to ensure that all diagnoses of dementia are recorded appropriately.

Access: No CAMHS waits over 18 weeks

Standard: 0

2015/16 Performance: 147





In the quarter to March 2016, as reported by ISD, CAMHS achieved 83.5% performance (target 90%), which is an increase from 76.7% in December 2015 and 78% in September 2015, but a decrease from 86.9% in June 2015.

As at the end of March 2016 there were 13 patients waiting over 18 weeks for this service which equates to 79% performance. Green status was not achieved by the end of February 2016 as previously estimated.

Early indication of April 2016 performance shows 79.2%.

The service continues to be challenged with the target, having been unable to recruit a nurse and a Consultant Psychiatrist to CAMHS, both of which are key posts to support the delivery of the target and have been vacant since mid-2015.

A locum was put in place from Monday 9th November 2015 and a nurse has now been in post since the 15th February 2016, both of which will have an impact on waiting times, and the service has implemented specific allocations meetings out with the multi-disciplinary team meeting to retain focus on referrals and the waiting list.

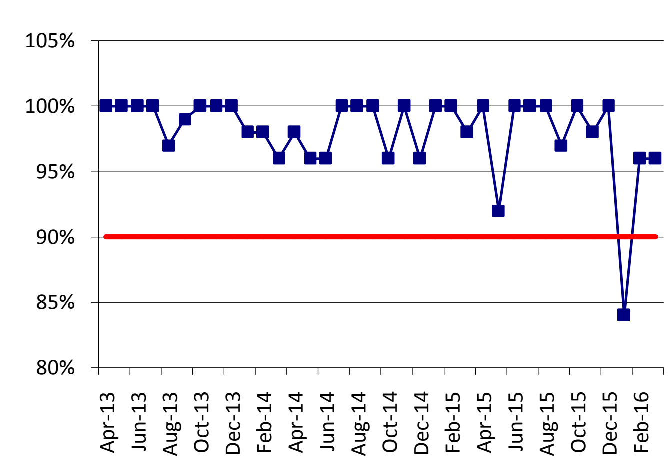
The Scottish Government has recently allocated funding to health boards in Scotland, over a period of four years, to improve access to both CAMHS and Psychological Therapies. A project plan is currently being drawn up detailing how the Mental Health Service plans to use this funding to improve CAMHS waiting times, and a short life working group is being set up to manage the project plan.

In 2016/17 the data will be reported to reflect the HEAT standard that 90% of patients will be seen within 18 weeks of referral to treatment rather than no patient will wait over 18 weeks.

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

Standard: 90%

2015/16 Performance: 97%



The Addiction Services have had another successful year in achieving this target. Overall performance has been consistently above the target throughout 2015/16 however in January 2016 decreased significantly to 84%. The Addaction Service (voluntary service) had 5 clients that were not seen within the target and therefore the overall performance reduced. This was due to a combination of service capacity and also process issues which have now been resolved.

Performance increased again in February/March 2016 to 96%, which is above the national and local target.

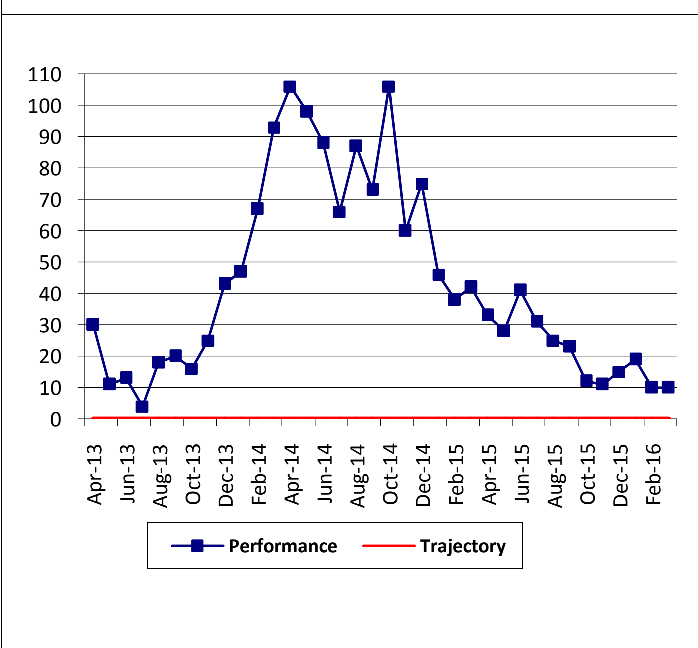
Actions ongoing to ensure performance continues above target are:

1. All referrals received by admin and promptly marked with date stamp.
2. Daily duty worker screens and disperses referrals to senior nursing staff to allocate.
3. Admin continue to monitor and manage Referral to Treatment time until 1st appointment attended.
4. Any problems are potential breaches are reported immediately to Team Manager and addressed.
5. Responsible managers meet quarterly to discuss performance and updates.

Access: No Psychological Therapy waits over 18 weeks

Standard: 0

2015/16 Performance: 145



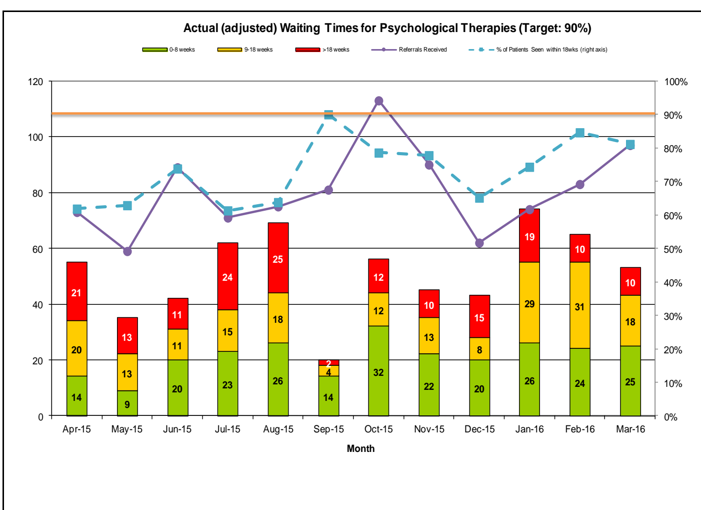
Performance increased significantly in February 2016, following particularly low performance in December 2015, however fell back to 81% in March 2016.

Early indication of April 2016 performance shows 89% however there were fewer than average patients seen and therefore this increased performance may not continue into May 2016.

In September, that target was met with 2 patients waiting >18 weeks to receive a Psychological Therapy (90%), however there was a reduction in the number of patients seen that month so this was a blip in the data.

Actions continue as previously described, and we continue to allocate resources to the areas with the longest waits.

Some of the long waits are the result of a loss of expertise in a particular specialised therapy (EMDR) –



which is difficult to replace as there is 12 months of training required. We have a member of staff having recently commenced training in EMDR.

The Scottish Government has recently allocated funding to health boards in Scotland, over a period of four years, to improve access to both CAMHS and Psychological Therapies. A short life working group is being set up to draw together a project plan for using the funding to improve Psychological Therapies Waiting Times.

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

There is active work ongoing across the whole health and social care system within the Scottish Borders to further enhance the ability of people to live well at home and in their community. Work is underway to meet the requirements of health and social care integration delivered through locality planning of services designed to meet health and social care needs, delivered in a homely environment where possible. Locality Coordinators have been appointed to progress with work over the coming 12 month period. Proposals for allocation of integrated care funding to support initiatives providing credible alternatives to hospitalisation are now taking shape and will form part of our transformational change plan this year.

Feedback received from the Scottish Government has recognised that local plans are well-developed and build on previous work carried out.

This year has seen the further development of the ‘Connected Care Programme’ which has been able to continue into a third year remaining focussed on progressing the aim of optimising whole system patient flow. Initial success which saw a drop in the number of patients delayed in hospital due to waits for allied health professionals, senior decision making and social care intervention, has been sustained throughout year two. This has been supported by continued use of flex beds in care home settings, ongoing involvement of Red Cross reducing dependency on social work referral and need for allocation of care packages for a number of people at discharge. This continues to contribute to the aspiration of delivery of person centred care. The past year has also seen attention directed towards reducing readmissions including in depth analysis of the data enabling identification of persons with frequent readmission to hospital. Focus has also widened to include the Community Hospitals building on the success of the model implemented in the acute hospital’s Department of Medicine for the Elderly Ward, through the use of test of change approach, regular Multi-Disciplinary Team meetings working to a set script to ensure all are working towards a single discharge goal and estimated date of discharge for each patient have been established in the four community hospitals.

The project looks at the patient journey across the whole system seeking to maximise the Partnership’s ability to provide the right care in the right place by looking at processes, provision of alternatives to admission and blocks to effective flow. The next phase is to progress development of the Discharge Hub towards an Intelligence Hub to support improvement in

discharge planning, further work in respect of readmissions through engagement of GPs and Physicians in the acute hospital to review patient records in order to identify where potential opportunities exist to use alternatives to hospital admission, development of anticipatory care planning with people who are frequently readmitted to hospital and further integrate with locality planning to develop care capacity in the community setting.

At the heart of the Quality Strategy is an ambition to ensure that all services are developed on the basis that they support older people to stay well and independent in their own homes. Key to this strategic aim is the development of a seamless frailty pathway. We have been working as one of two national pilot sites with the Health Foundation on a key piece of work looking at the frailty pathway across the whole system. Our aim is to remove unnecessary barriers, avoid double doing and to design our service around patients to deliver care where it is right for the patient, rather than convenient for the service. Achievements have been that every inpatient over 65 now receives a screening test for frailty; and a robust multi-disciplinary frailty care pathway is in place that makes sure frail positive inpatients receive a comprehensive geriatric assessment within 24 hours. Robust methodology is now embedded to manage patient safety in the hospital more effectively.

In Primary Care work is underway to progress the requirements described in the new General Medical Services Transitional Quality Arrangement (GMS TQA) guidance and will be subject to the relevant approval processes over the coming weeks and months.

Over the last year, Pharmacy has introduced a number of services to help people in the community. Women aged 16 -65 with an uncomplicated urinary tract infarction can now visit their pharmacy for an assessment and treatment if appropriate. In the first 6 months around 70 consultations took place in the Borders' pharmacies.

The sick day rules card was introduced last year to inform people on specific medicines what to do if they have sickness and diarrhoea. This was supported by a medicine review service introduced in January. Patients are encouraged to make an appointment with their pharmacist to discuss the medicines identified in the sick day rules care, review how they take their medicines and provide support and advice if necessary.

A Discharge Support Technician is now available in Borders General Hospital to help patients with their medicines prior to discharge from hospital. Some patients will be followed up in community if required. The aim of the post is to help patients and carers to be better informed about medicines and may help reduce medicine-related readmissions. A peer support process is in place to help build confidence in the pharmacists providing this service.

Also Direct Enhanced Services were established for: Palliative Care, GP Extended Hours and Contraceptive Implant insertion.

A new enhanced service was set up to facilitate practice to practice referral for itemised services covered by enhanced service arrangements (e.g. coil fitting, minor surgery).

Work with the Health Foundation is almost complete, introducing the National Early Warning Score (NEWS) to help with the early recognition and rescue of the deteriorating patient in the community setting. It is believed that this new system will aid all clinicians, including nurses and paramedics, with decision making about where the most appropriate place for a patient to

receive care is. Please also see the Patient Safety section of this report for further information on NHS Borders' work with the Health Foundation.

A trial of paramedic practitioners, supporting GPs with daytime unscheduled care, has already been achieved. Currently, discussions are taking place about how best to role out this new way of working so more GP practices can benefit from this added support. In return, the Scottish Ambulance Service can up-skill its work force so that they are better placed to safely leave patients at home when appropriate.

There are challenges around GP recruitment. There have been difficulties recruiting to both in-hours and out of hours posts within the last year.   Work is ongoing to try to address these issues.

2 SAFE CARE

2.1 Healthcare is safe for every person, every time

2.1.1 Healthcare Acquired Infection (HAI)

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

- NHS Borders has achieved a 33% reduction in SAB cases in 2015/16 compared with 2014/15.
- Staphylococcus aureus Bacteraemia (SAB) cases are reviewed and reported by cause to highlight themes and support targeted interventions. During 2015/16, there was a reduction in each of the top recurring themes identified in 2014/15.
- NHS Borders continues to participate in the National Surgical Site Infection Surveillance (SSI) for the mandatory procedures of hip arthroplasty and caesarean section. NHS Borders also conducts SSI surveillance on knee arthroplasty and colorectal surgery. NHS Borders SSI rate is not, and has never been, a statistical outlier from the rest of Scotland.
- NHS Borders continues to conduct monthly Hand Hygiene Audits. Throughout 2015/16 overall compliance levels were always above 96%.
- NHS Borders cleaning compliance is generally higher than the national average.
- NHS Borders has embedded public involvement in infection control activities.
- NHS Borders has maintained an MRSA screening programme that exceeds the Scottish Government Health Department (SGHD) minimum requirements and includes use of the national Clinical Risk Assessment (CRA) tool.
- NHS Borders achieved 100% compliance with the National MRSA Screening Key Performance Indicator in each quarter in 2015/16.
- NHS Borders Antimicrobial Management Team meets every two months 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.*
- 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.
- NHS Borders has maintained a programme of senior leadership inspections and safety walkrounds across NHS Borders using standardised processes. The leadership walkrounds allow senior leaders to have structured conversation about patient safety and person centred care with frontline staff. The leadership inspection programme is to ensure that patient/staff safety and the organisations policies are implemented.

- A programme of Infection Control spot checks is maintained to confirm that systems and processes are operating as intended. Detailed monthly reports of compliance by location are circulated to all Senior Charge Nurses, operational managers and senior managers as well as non-executive Directors. The Infection Prevention and Control Team also undertake a programme of audits to monitor compliance with infection control policy.

  The timescale for follow-up infection control audits has previously been based on the total (average) audit score achieved in the initial audit. This focus on the overall audit score could lead to false assurance and failure to address significant areas of non-compliance within specific sections of audit. To address this, all infection control audits are now conducted as follows:

  1) Every prioritised area is subject to one full audit per year
  2) A follow-up audit of all non-compliant issues is conducted within 3 months of the initial full audit. Any remaining issues that have not been addressed are escalated to the Infection Control Manager (ICM).

- NHS Borders supported the European Antibiotic Awareness Day in 2015 by promoting the UK Antibiotic Guardian campaign. Borders had the highest uptake of Antibiotic Guardians of any mainland Scottish Board

- In November 2015, the Healthcare Environment Inspectorate (HEI) published their report on the unannounced follow-up inspection of Borders General Hospital operating theatres of the 29th and 30th September 2015.

  The report confirmed that all 7 requirements previously identified in their previous inspection were met.

Treatment: Further Reduce Rate of Staph aureus bacteraemia (cumulative)
NHS Borders did not achieve the *Staphylococcus aureus* Bacteraemia (SAB) March 2016 LDP Standard rate of 24.0 cases or less per 100,000 acute occupied bed days. The most recent Health Protection Scotland report on surveillance of *Staphylococcus aureus* Bacteraemia (SAB) in Scotland shows that in the year ending March 2016, NHS Borders had a rate of 35.4 SAB cases per 100,000 acute occupied bed days compared with a rate for NHS Scotland of 32.4. Every SAB case and CDI case is subject to a rigorous review which includes a feedback process to the clinicians caring for the patient as well as the wider organisation through monthly Infection Control Reports. Any learning is translated into specific actions which are added to the Infection Control Work Plan with progress critically reviewed by the Infection Control Committee. SABs are reported by cause to highlight themes and support targeted interventions. During 2015/16, there was been a reduction in each of the top recurring themes identified in 2014/15. Through this approach, NHS Borders has achieved a 33% reduction in SAB cases in 2015/16 compared with 2014/15. This approach will be maintained during 2016/17.

Treatment: Further Reduce Rate of C. Diff (CDAD) cases in over 65s (cumulative)
NHS Borders did achieve the *Clostridium difficile* infection (CDI) March 2016 LDP Standard rate of 32.0 cases or less per 100,000 total occupied bed days in patients aged 15 and over. The most recent Health Protection Scotland report on surveillance of *Clostridium difficile* infection (CDI) in Scotland shows that in the year ending March 2016, NHS Borders had a rate of 17.5 CDI cases per 100,000 total occupied bed days compared with a rate for NHS Scotland of 33.1. Every CDI case is subject to a review to identify any learning for improvement. The work of the Antimicrobial Management Team continues to be important in monitoring and supporting improvement in antimicrobial stewardship.

2.1.2 Patient Safety

The Scottish Patient Safety Programme (SPSP) is one of a family of national improvement programmes developed over recent years in relation to the national Healthcare Quality Strategy. These programmes draw on improvement methodology advocated by the Institute for Healthcare Improvement. SPSP now contains four distinctly identified workstreams as follows:

- Acute Adult
- Primary Care
- Mental Health
- MCQIC (incorporating Paediatrics, Maternal Care & Neonates)

The Scottish Patient Safety Programme (SPSP), now part of Healthcare Improvement Scotland's Improvement Hub which supports improvement across health and social care, is a unique national programme that aims to improve the safety of healthcare and reduce the level of harm experienced by people using healthcare services. SPSP aims to support National Health and Wellbeing Outcome 7: People using health and social care services are safe from harm (Scottish Government 2015).

Patient Safety in Acute Care

There have been significant changes happening from April 1st at national level, with the amalgamation of Healthcare Improvement Scotland with the Joint Improvement Team (JIT) and the Quality, Efficiency and Support Team (QUEST).

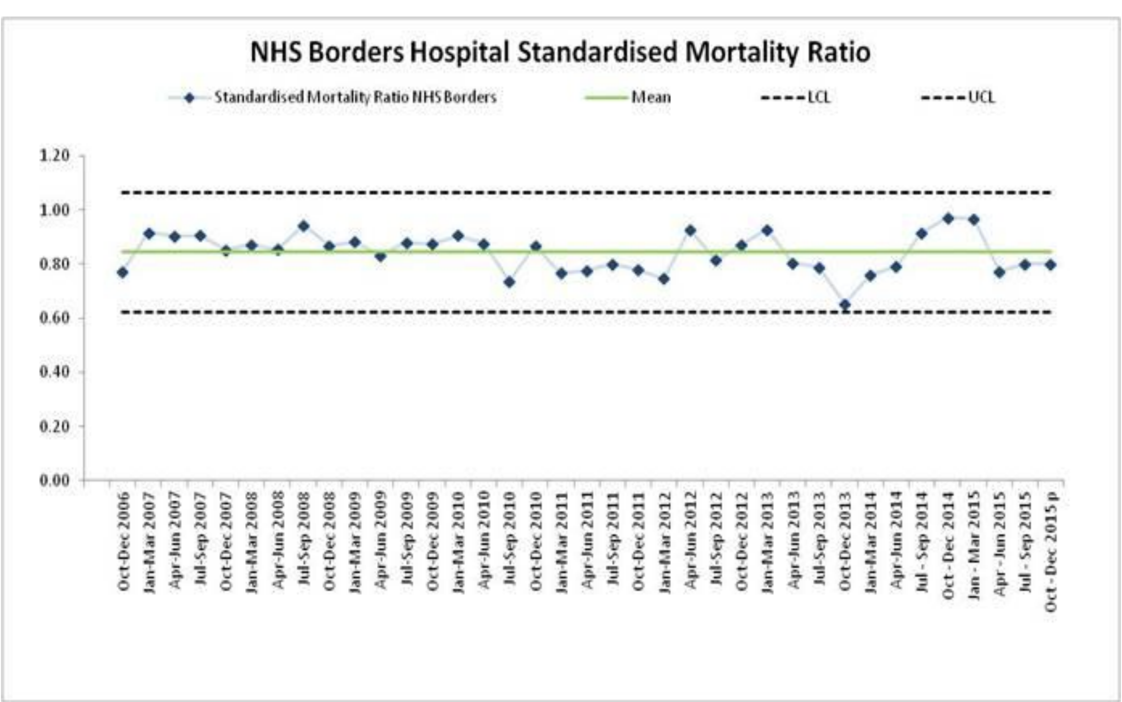
The results of a 90 day consultation period recommend that the financial year (2016-2017) is used to embed and spread existing work in the areas of pressure ulcers, falls, catheter-associated urinary tract Infection (CAUTI), deteriorating patient, including cardiac arrest and sepsis and medicines reconciliation.

Hospital Standardised Mortality Ratio (HSMR)

The initial aim of the Scottish Patient Safety Programme was to reduce HSMR by 15% by December 2012 which was then extended to 20% by December 2016.

HSMR cannot be used as a standalone measure to make reliable judgements about the quality of care provided by a hospital. It can, however, be used alongside other clinical indicators within the NHS Borders quality dashboard to stimulate reflection on the way services are configured/delivered and to prompt quality improvement activity.

Please see chart 1 below outlining HSMR for NHS Borders:

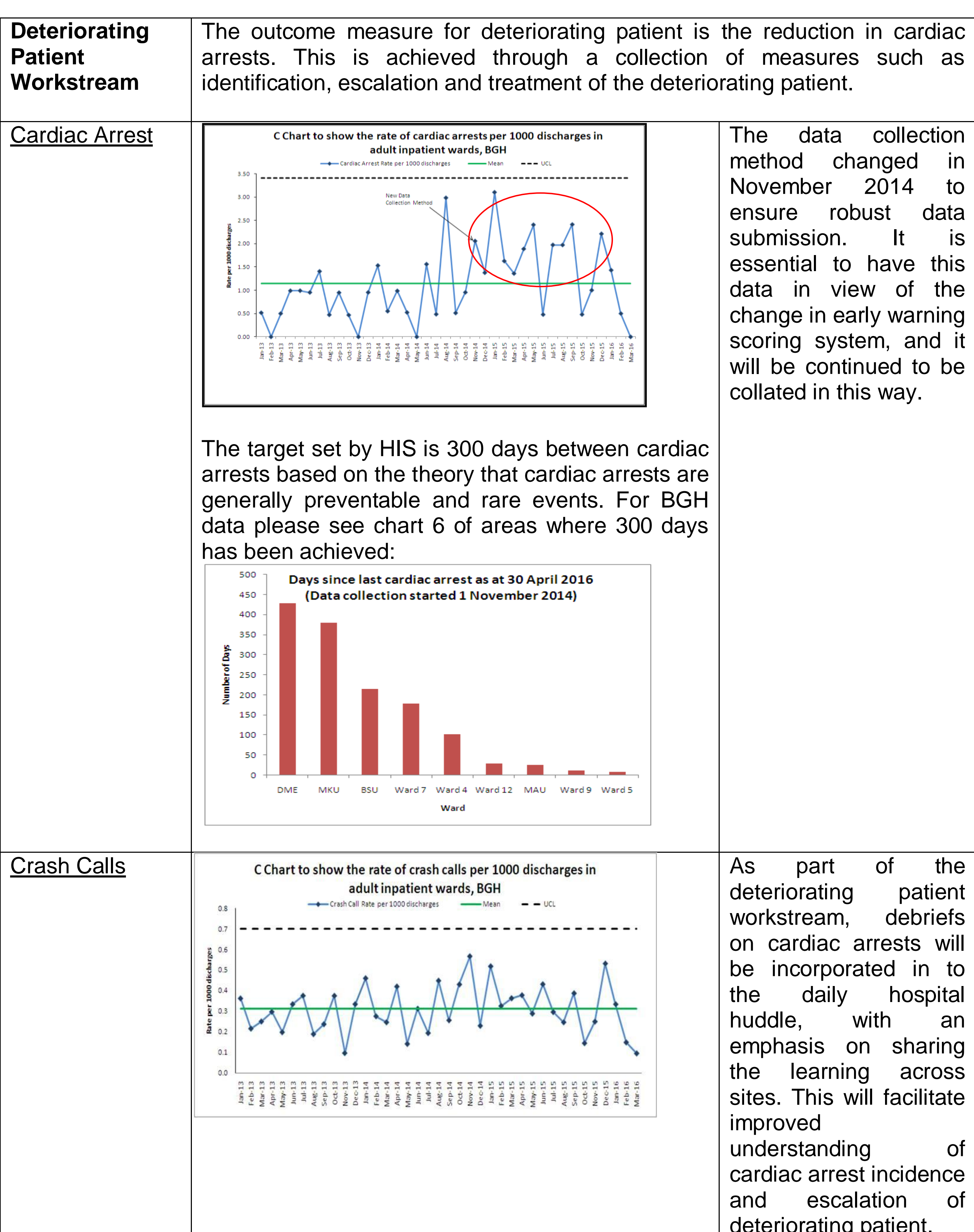


The data shows normal variation with an HSMR of 0.80 for Dec-Mar 2015.

Chart 2: HSMR data for Borders General Hospital (BGH) and Scotland:

This measure will continue to be measured and monitored although changes are being made centrally to the calculation of HSMR.

Deteriorating Patients/Cardiac Arrests:



Deteriorating Patient Workstream	The outcome measure for deteriorating patient is the reduction in cardiac arrests. This is achieved through a collection of measures such as identification, escalation and treatment of the deteriorating patient.	
<u>Cardiac Arrest</u>	The target set by HIS is 300 days between cardiac arrests based on the theory that cardiac arrests are generally preventable and rare events. For BGH data please see chart 6 of areas where 300 days has been achieved:	The data collection method changed in November 2014 to ensure robust data submission. It is essential to have this data in view of the change in early warning scoring system, and it will be continued to be collated in this way.
<u>Crash Calls</u>		As part of the deteriorating patient workstream, debriefs on cardiac arrests will be incorporated in to the daily hospital huddle, with an emphasis on sharing the learning across sites. This will facilitate improved understanding of cardiac arrest incidence and escalation of deteriorating patient.

Early Warning Scores	Current data shows high reliability with this process measure across all inpatient areas.	It has been agreed that the frequency and accuracy of early warning scores continue as a means of accurately monitoring the changeover of early warning scoring systems, which occurred in November 2015.
Handovers	A side effect of the introduction of National Early Warning Score (NEWS) has shown that the SBAR tool (situation, background, assessment and recommendation) is not reliably used throughout the Organisation when calling either the Hospital at Night team or the Critical Care Outreach Team for assistance.	It has been agreed that the focus of safety improvement work for 2016/17 will focus on ensuring SBAR communication is implemented reliably, with particular emphasis on handovers.
Structured Review and Response	These two measures are not currently measured in NHS Borders.	It has been agreed, that in line with the Connected Care programme, some testing work for these measures will commence.
Sepsis	The sepsis six bundle performance data show reliability in the Emergency Department, and variation elsewhere.	This will remain a priority for 2016/17.
DNACPR (Do Not Attempt Cardiopulmonary Resuscitation):	Through the daily OPAH work currently being undertaken, improvements are being made in DNACPR form completion and accuracy.	Following the publication of guidance from the Resuscitation Council, the British Medical Association and the Royal College of Nursing, whilst not forming part of SPSP, NHS Borders will undertake improvement work with the aim of 95% of patients who have DNACPR have documented evidence of effective patient/ family involvement (including reasons for not doing so).

Pressure Ulcers:
The following graph (chart 3) demonstrates all new grade 2 and above pressure ulcers acquired after admission/transfer to a BGH inpatient area, where assessment and clinical history did not ascertain damage had started prior to admission. This chart shows normal variation in pressure ulcer cases.

Chart 3:

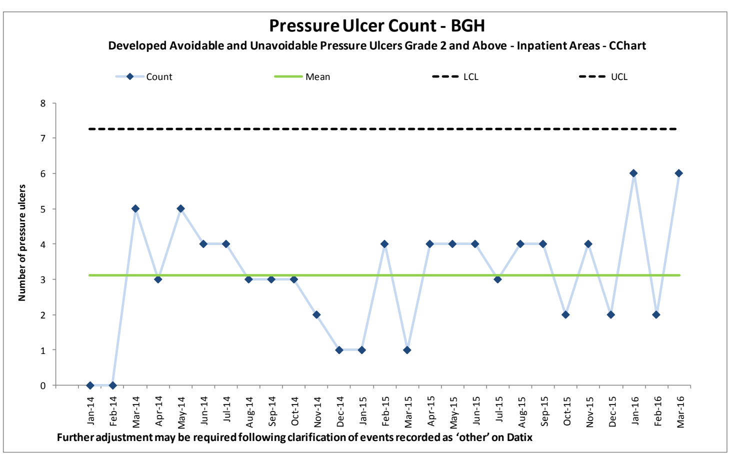
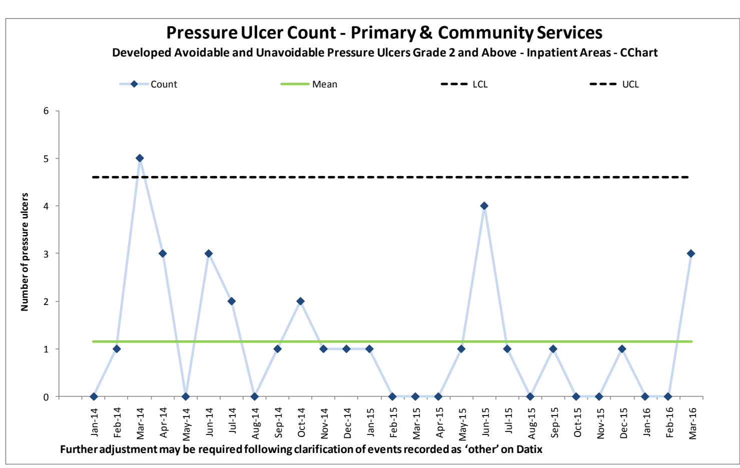


Chart 4 shows the reduction in pressure ulcer rate in the community, including community hospitals, between July 2015 and February 2016.

Chart 4:



As one of the four priority areas for the Nursing Directorate, it has been agreed that the clinical improvement facilitators and clinical nurse managers will continue to undertake quality improvement in this area. A new escalation protocol has been implemented which includes highlighting cases at the hospital safety huddle. All pressure sores will be subject to a clinical review with the staff on the ward, to ensure immediate care improvements are made and lessons learnt. Pressure injury management has been embedded in registered nurse and clinical nurse manager objectives.

Falls:
The second phase of the Scottish Patient Safety Programme (SPSP) aimed to achieve a 25% reduction in all falls from 2012/13 to December 2015, and 20% reduction in falls with harm in acute inpatient care, while promoting recovery, independence and rehabilitation. Falls measures form an integral part of the revised measurement plan and results show that Borders have achieved a 50% reduction in all falls and a 62% reduction in falls with harm as at December 2015. As one of the four priority areas for the Nursing Directorate and of (OPAH) workstream Clinical Improvement Facilitators and Practice Education Facilitator will continue to undertake progress improvements in the areas with the highest numbers of falls.

Venous Thromboembolism
NHS Borders were successful in securing a year's funding from Healthcare Improvement Scotland to test process around assessment and administration of prophylaxis. The associate improvement advisor has been recruited, a steering group set up and baseline data has been gathered to inform the testing.

Patient Safety in Primary Care
As with the acute care programme, the focus in NHS Borders for 2016- 17 will be on embedding existing workstreams in to Primary care. These are:

- Safety Culture
- Safer Medicines (Medicines Reconciliation and High Risk Medicines)
- Safety Across the Interface

Patient Safety in Mental Health
No changes have been made nationally to the mental health programme. Locally, it has been shared with older adult wards that will start by undertaking the staff climate survey. Process measures have already started to be collected on medicines errors and medicines reconciliation.

Patient Safety in Maternity, Neonates and Paediatrics (McQIC)
No changes have been made nationally to the McQIC programme. The focus for the coming year will be to embed process measures in peripheral vascular cannula care, medicines, with preliminary testing on hypothermia and the deteriorating patient, child protection and reducing readmissions. Multi agency work will be incorporated in to the three workstreams, with medicines and deteriorating patient the over arching focus.

Adverse Event Management
NHS Borders continues to develop the process of reviewing adverse events in a timely manner, with a focus on identifying learning and driving improvements in practice. Approval timescales are now reported on senior charge nurse scorecards, and reported in the monthly updates at the clinical governance meetings.

Health Foundation
Innovating for Improvement Bid
NHS Borders were successfully shortlisted to be interviewed for to bid for funding for an innovative project which involved developing a model of recognition and rescue of the deteriorating patient across the Community. This project is nearing its completion and showing benefits of early recognition, decision making, recognition and rescue of deteriorating patients in Community hospitals and settings. Funding ceases at the end of September 2016.

Safety Measurement and Monitoring
In April 2014 the Health Foundation published a Safety Measurement and Monitoring Framework prepared by Charles Vincent. The Health Foundation invited key organisations to apply to test the framework. Healthcare Improvement Scotland (HIS) was specifically invited to submit a proposal with two delivery partners which were NHS Borders and NHS Tayside. NHS Borders has undertaken two separate projects, one a 'ward to Board' data monitoring and measurement project, and the other testing the Framework at pathway level, which was the frailty pathway.

2.1.3 Clinical Effectiveness and Governance

NHS Borders Effective function within Clinical Governance and Quality incorporates a number of different strands including clinical information and audit, research and innovation, local policy and patient information management, oversees the dissemination and coordinates assessment of implementation of Scottish Intercollegiate Guidelines Network (SIGN) and Healthcare Improvement Scotland guidance and national standards, preparation for inspections and analysis of significant national reports. Through these different strands NHS Borders is able to ensure that evidence based and best practice, is shared, implemented and embed in the patient care being delivered to the Borders population.

NHS Borders continues to be committed to growing its research and innovation portfolio. Significant progress has been made in developing the organisations participation in non-commercial research in the last five years. NHS Borders concluded participation in a large commercial research study. This gastroenterology study saw NHS Borders maintain the achievement of the highest recruiter in the UK. Subsequent to this success NHS Borders has received numerous feasibility requests to participate in further gastroenterology studies and was awarded a study within research into Crohn's disease.

Quality dashboards continue to be used and refined. This enables teams to assess and visualise variation improving ability to make informed decisions about the care of NHS Borders patients. Dashboards are used to monitor and measure providing assurance and drive focussed improvements in the quality of care. This work is aligned to improvement work underway to strengthen clinical leadership.

Further to successful testing of quality and safety information boards in a number of inpatient areas during 2014/15, NHS Borders rolled out the use of these to all inpatient areas in 2015/16. The plan is that the temporary display boards put up in 2015/16 will be replaced with permanent bed and bay boards. The boards are intended to improve the ward environment and ensure that clear and transparent information is available to patients, relatives, carers, visitors and staff. Information displayed on the boards will include such things as staffing, patient feedback and clinical quality indicators. It is also the intention to utilise the above bed boards to include information on "what matters to me" to improve patient care and experience.

Nursing and midwifery continuing professional development (CPD) /revalidation objectives linked to appraisal and personal development planning has been implemented in a number of wards in NHS Borders. Work continues on the spread of this to all areas. The aim is to enable nurses and midwives to evidence the skills and behaviours required to deliver the highest standard of care within their wards and specialist areas. The framework involves 4 key organisational priority objectives:

1. **Pressure Area Care:** To eliminate patient harm from pressure ulcers
2. **Falls:** To eliminate patient harm from falls
3. **Food Fluid & Nutritional Care:** To ensure patients experience of eating and drinking enhances their health and well being
4. **Deteriorating Patient:** To prevent harm from unidentified deterioration, sepsis, and cardiac arrest

Designed as an integral part of the performance management system, managers are utilising the framework to help staff attain optimum standards within their current job and to select the right learning and development activities to assist planning their CPD/revalidation needs. This approach aims to align individual performance for personal, professional and organisational success.

Senior Charge Nurses (SCNs) have oversight and set the strategic direction for the wards improvement journey however, each CPD objective is devolved to a member of their team who acts as the Link Nurse for a topic area. The Link Nurse responsibilities include assurance of the standard identified including: ward learning resources; staff education and training; and measurement /audit.

Time is provided during the working day for the link nurses to complete CPD objective responsibilities. They are also released to attend link updates and other study opportunities deemed necessary to fulfill this role. Individual benefits of the Link Nurse role include achieving dynamic evidence for professional revalidation and creating opportunities for career and leadership development. Organisational benefits include reaping rewards of proactive succession planning while assuring high standards of quality nursing care and patient experiences.

2.1.4 Older People in Acute Care Review

Following a determination on a complaint by the Scottish Public Services Ombudsman (SPSO) in December 2015 NHS Borders contacted Healthcare Improvement Scotland (HIS) and requested a review of our complaints process and quality of care.

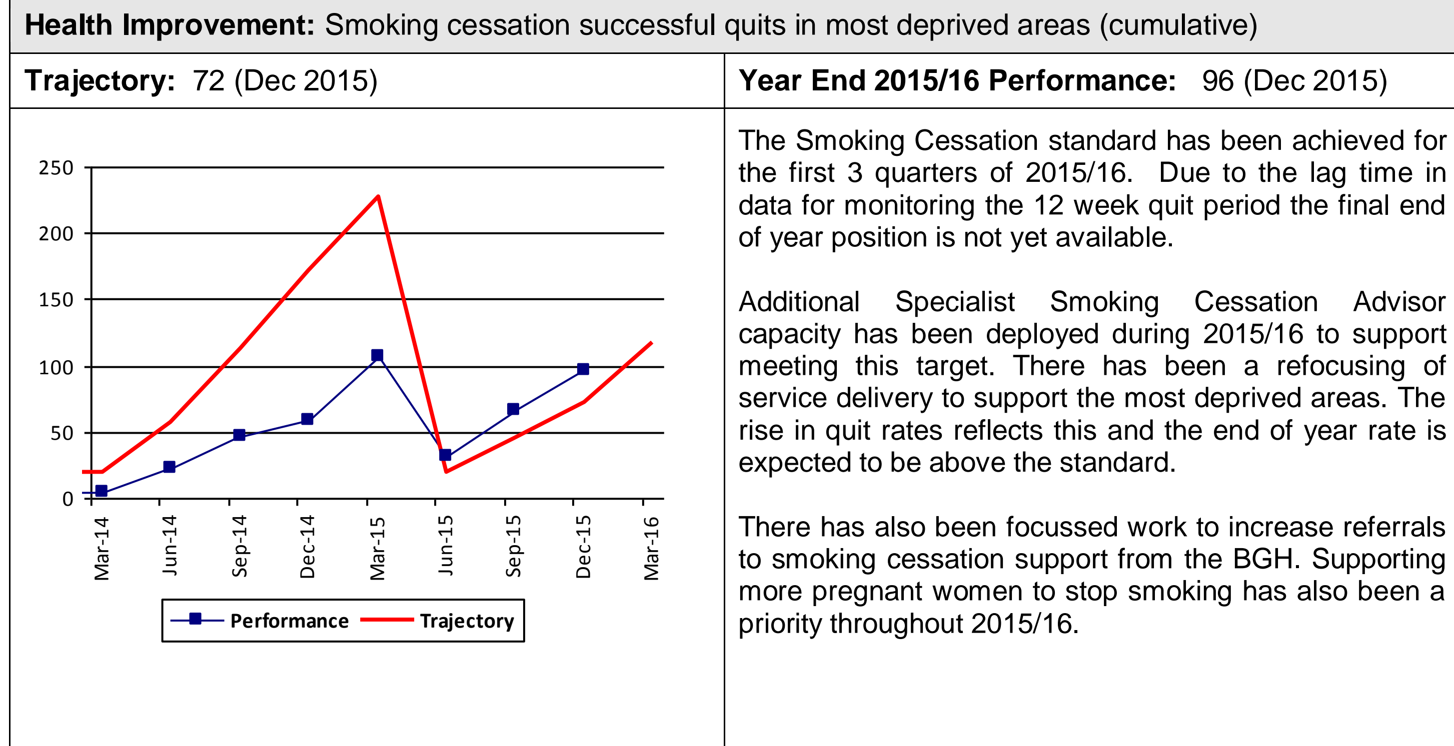
The Healthcare Improvement Scotland (HIS) Older People in Acute Hospitals (OPAH) Inspectorate Team visited the Borders General Hospital to inspect the Acute Hospitals performance in relation to the Older People in Acute Care (2002) Standards. An unannounced inspection took place between Tuesday 12 and Thursday 14 April 2016. HIS returned on the 26 April to undertake a review of complaints which included meeting with staff to hear about the NHS Borders approach to learning from feedback and complaints, adverse events and cases investigated by the Scottish Public Services Ombudsman.

We have taken action on initial verbal feedback given at that time.

We are currently awaiting the publication of the Review Report.

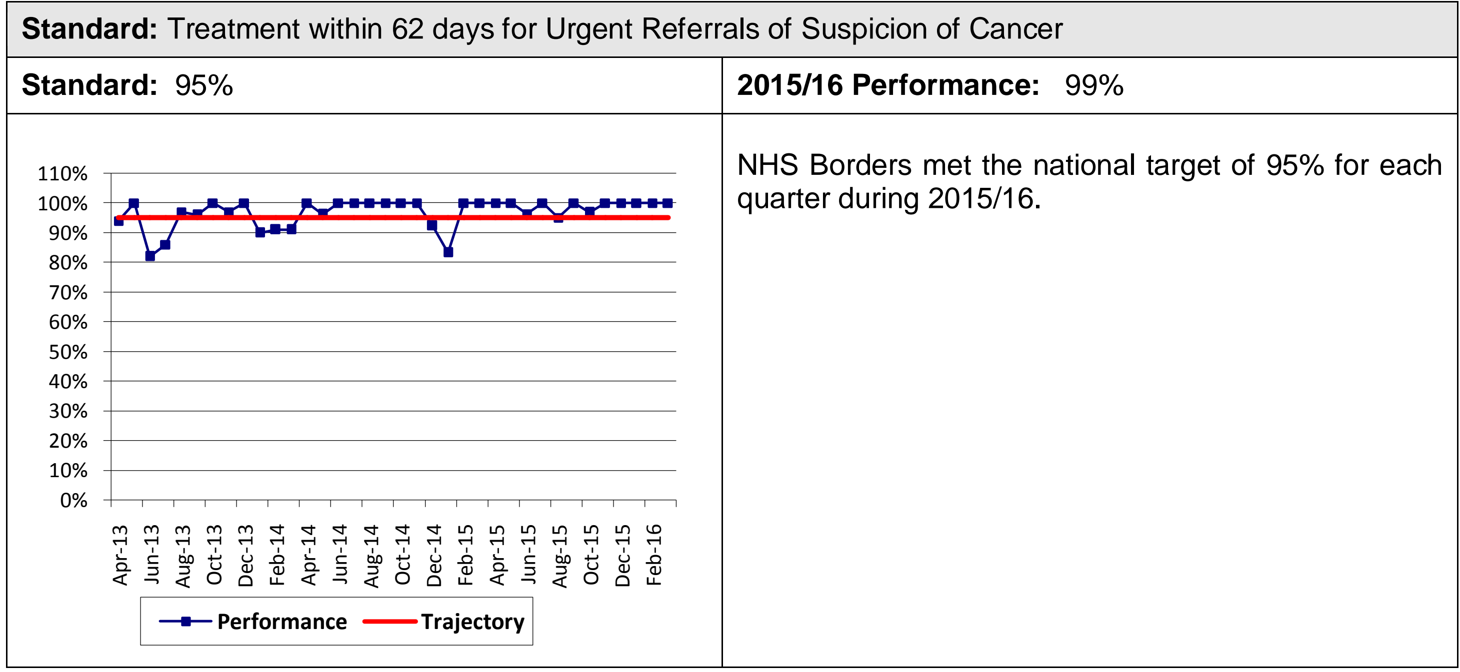
3 EFFECTIVE

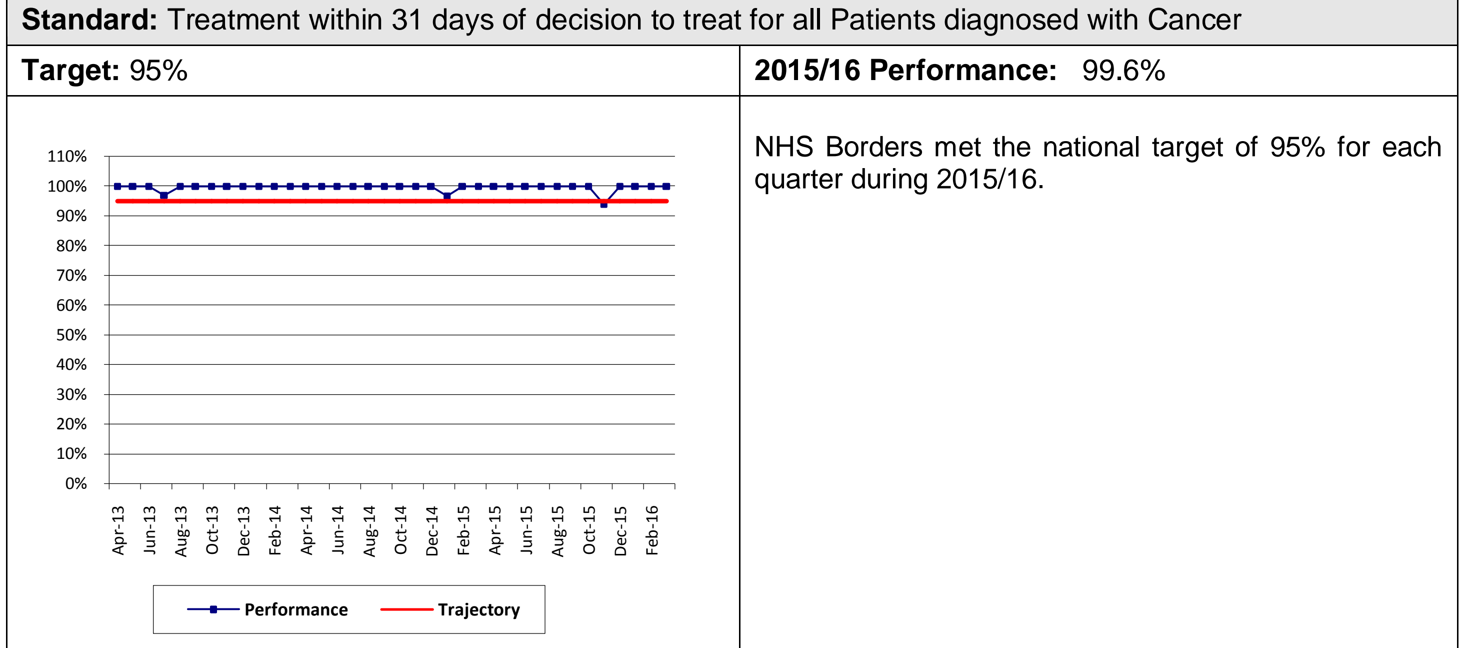
3.1 Everyone has the best start in life and is able to live longer healthier lives



Health Improvement: Smoking cessation successful quits in most deprived areas (cumulative)	
Trajectory: 72 (Dec 2015)	**Year End 2015/16 Performance:** 96 (Dec 2015)
	The Smoking Cessation standard has been achieved for the first 3 quarters of 2015/16. Due to the lag time in data for monitoring the 12 week quit period the final end of year position is not yet available. Additional Specialist Smoking Cessation Advisor capacity has been deployed during 2015/16 to support meeting this target. There has been a refocusing of service delivery to support the most deprived areas. The rise in quit rates reflects this and the end of year rate is expected to be above the standard. There has also been focussed work to increase referrals to smoking cessation support from the BGH. Supporting more pregnant women to stop smoking has also been a priority throughout 2015/16.

Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	
Standard: 33%	**2015/16 Performance:** 34.4% (Sep14 – Sep15)
40%, 35%, 30%, 25%, 20%, 15%, 10%, 5%, 0% Jun-12, Sep-12, Dec-12, Mar-13, Jun-13, Sep-13, Dec-13, Mar-14, Jun-14, Sep-14, Dec-14, Mar-15, Jun-15, Sep-15, Dec-15, Mar-16 Performance Trajectory **Please Note:** There is a 3 month time lag as data is published quarterly for this target. Local data is used due to the extended time lag for national data.	The services continue to work collaboratively with health improvement. We appointed to the Baby Friendly Initiative Lead post in August 2015 and have developed the following in 2015/16: • A whole town approach to breast feeding in Selkirk through improvement methodology. • A drop in breastfeeding clinics in Early Years Centre. • Continuing to deliver training and updates to all staff. • To maintain/continuing to improve performance we have increased the provision of peer supporters • Peer supporters working within Early Years Assessment team • Focus on improving breast feeding rates within Special Care Baby Unit.

Standard: Treatment within 62 days for Urgent Referrals of Suspicion of Cancer	
Standard: 95%	**2015/16 Performance:** 99%
	NHS Borders met the national target of 95% for each quarter during 2015/16.

Standard: Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer	
Target: 95%	**2015/16 Performance:** 99.6%
	NHS Borders met the national target of 95% for each quarter during 2015/16.

3.2 Staff feel supported and engaged

The development of a health and social care partnership in the Scottish Borders gives partners the opportunity to better plan and commission service changes and improvements in outcomes for the population. It will also mean much closer working and joined up services for individuals and communities.

Through 2016-17, the first year of the Integrated Authority, in line with the NHS Borders Local Delivery Plan and the Scottish Borders Council Corporate Plan, two target areas have been identified for us to focus our activities in meeting the local objectives - supporting people at home and the wellbeing of our staff.

A key focus is on Primary Care, specifically supporting people at home and the following actions are contained within the Health & Social Care Integration Commissioning & Implementation Plan for year one to achieve local objectives.

- We will make services more accessible and develop our communities
- We will improve prevention and early intervention
- We will reduce avoidable admissions to hospital
- We will provide care close to home
- We will deliver services within an integrated care model
- We will seek to enable people to have more choice and control
- We will further optimise efficiency and effectiveness
- We will seek to reduce health inequalities

Staff will be kept informed of progress via regular newsletters and communication updates.

Workforce Matters

NHS Borders held a successful Local Workforce Conference on 11th March 2016. The key theme was "Living our Values – working in partnership with staff to support positive values in NHS Borders." The conference was aimed at frontline staff and included powerful presentations around living our values from our Chief Executive, and staff engagement from our Employee Director. Interactive Workshops further explored these values and included specific sessions on Implementing Values, Care and Compassion (Dementia Interaction) and Dignity and Respect (Social Media). Positive evaluation has lead to agreement to re-run the Workforce Conference on 1st November 2016 to enable more frontline staff to hear the core messages and engage in the workshops. Outcomes/Actions from the Local Workforce Conference will feed into our 3 year Local Workforce Plan for 2016-19.

Our Workforce Planning continues to focus on the 2020 Workforce Vision, setting out a commitment in our Corporate Objectives to valuing the workforce and treating people well.

Recognising that a positive staff experience will lead to better patient care the staff experience employee engagement tool, iMatter, will complete its roll-out across all of NHS Borders by the end of 2016.

With a focus on improving staff engagement through listening to staff and action planning in teams, iMatter has the potential to improve efficiency and effectiveness as engaged staff feel more valued at work and are more productive. Agreed organisational actions from the overall NHS Borders iMatter report are being taken forward through the Staff Governance action planning process.

We see the big message of 2020 Workforce Vision compared to previous workforce plans is to emphasise and embed our shared values in NHS Borders, these are:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

In addition, all staff have the opportunity to complete a NHS Scotland Staff Survey anonymously. The survey gathers information on all staff views which will feed into policy-making for the NHS at both a national and local level. Importantly, it is a means of finding out how staff feel about working in NHS Borders, how well they feel they are being managed and to what extent the NHS Scotland Staff Governance Standards are being met.

The most recent Survey was completed in August/September 2015 and the results were published in December 2015. 49% of NHS Borders staff completed this and of those who completed the survey, they said that: they are happy to go the extra mile, have confidence and trust in line-managers and get help and support needed from colleagues. The Survey results are reflected in the Staff Governance Action Plan which includes corporate actions and has been taken through the Area Partnership Forum to support its delivery.

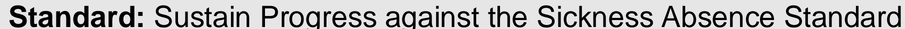
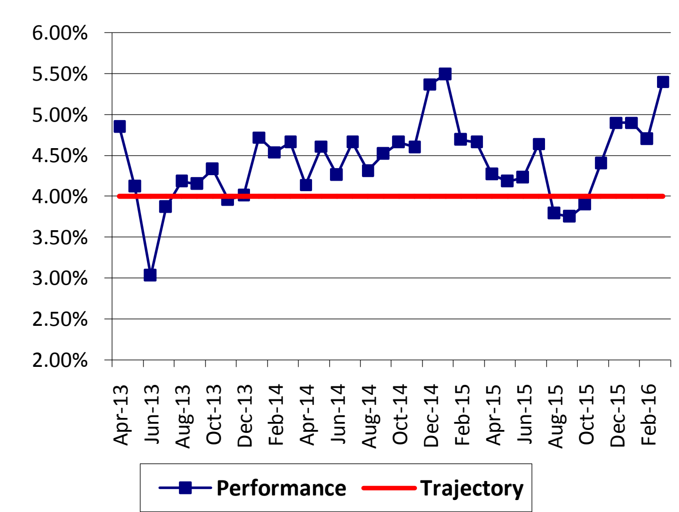
NHS Borders also take a Values Based Approach to recruitment to our vacant posts. Candidates are sent our Behavioural Framework, and Interviews/Assessment Centres include exercises to ensure candidates demonstrate behaviours and competencies which underpin our core values.

The local Workforce Plans will support the Board's Clinical Strategy and outline how NHS Borders can work differently because of these changes. The Clinical Strategy recognises that NHS Borders benefits from a dedicated workforce which is committed to providing the highest quality services for patients. However the workforce itself is becoming older and NHS Borders needs to plan how this demographic challenge will be addressed by the year 2020.

NHS Borders Local Workforce Plan 2016-19 is currently out for consultation until 3rd August 2016. Consultation response will be considered and a final version created in partnership with staff and their representatives with discussion at Area Partnership Forum.

Every year along with all NHS Boards in Scotland, NHS Borders publishes workforce projections. This year we are projecting an increase in Nursing and Midwifery staff. We also have a commitment to pre-emptive employment within Nursing & Midwifery where we have recruited staff for a Fixed Term post (e.g. Winter Surge, hard to fill community posts) permanently, with the intention to slot them into future workforce gaps. Pre-emptive employment is also being introduced as a mechanism to recruit permanent staff in advance of vacancies coming up in an effort to fill vacancies timeously. We are also projecting an increase in Medical staff. There are plans for more active recruitment measures including using social media, a medical recruitment micro-site with videos of current consultants extolling the virtues of NHS Borders and living in Scottish Borders, and revamped and attractive job descriptions.

A number of efficiency projects within NHS Borders impact on our workforce including Transforming Outpatients, Review of Day Hospital Services, Surgical flow etc. All services undertaking a Workforce Review will use appropriate Workforce Planning tools (e.g. Six Step Workforce Planning Methodology) to make sure the optimum affordable workforce required to deliver services is in place.

Standard: Sustain Progress against the Sickness Absence Standard 	
Standard: 4% 	**2015/16 Performance:** 4.36%
	The cumulative sickness absence rate for the year April 2015 – March 2016 is 4.36% - which is 0.80% lower than the NHS Scotland Average and is the lowest year end figure of the territorial boards and 0.35% lower than last year. HR continue to be a support service to the clinical boards by providing HR advice and support in managing sickness absence, HR will recommend actions to be taken in line with the NHS Borders Sickness Absence Policy. HR also provide monthly sickness absence reports to each Clinical Board, these detail the level of short term and long term sickness absence levels in each department, provide the trends and the reasons for sickness absence. HR also proactively identify sickness absence “hot spots” and contact managers to enquire if any support is required in managing levels. Managers are also required to complete a mandatory sickness absence e-learning module, attend a sickness absence training course, a refresher course and complete a refresher e-learning module. A promoting attendance and wellbeing project has commenced to review and develop existing practices to further support the management of attendance at work. HR are continuing to revise sickness absence processes to ensure we are providing an efficient and supportive service to managers. Correspondence to managers indicating if employees are not meeting the expected level of attendance is being revised to indicate that action is recommended/required as well as reminding managers of actions that could / should be taken.

3.3 Best use is made of available resources

Continue to achieve financial in-year and recurring financial balance

The financial outlook the public sector is facing and the challenges this brings is clearly understood. In order to continue to deliver quality patient care the organisation must keep a firm grip on its finances as well as drive improved quality and 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 and includes efficiency plans and goals. The creation of the Integrated Joint Board from 1 April 2016 adds a further complexity to financial planning.

Revenue
NHS Borders achieved all financial targets in 2015/16 with a small underspend of £0.090m recorded on its revenue budget 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 2015/16 with a small underspend of £6,000 recorded on capital at the year end. The Board approved a capital plan for the year which delivered the following.

- Progress on the Roxburgh Street Replacement Surgery in Galashiels with the Procurement Partner Stage 1 approved and ongoing work on Stage 2 detailed design and construction contract. This included the demolition of the former Ambulance Station on the site for the new build which is anticipated will start early in 2016/17.
- Completion of an upgrade, reconfiguration and provision of additional accommodation at Selkirk Health Centre. –
- Progress on the Board's Estates Rationalisation Programme with the disposal of 2 properties - West Grove, Melrose and 12-14 Roxburgh Street in Galashiels. The Board also relocated services from 2 rental properties to Board owned property.
- Completion of a significant IM&T Active Directory and Desktop Transformation Project covering the Borders General Hospital and all General Practitioner Health Centre sites.
- Relocation of Community Mental Health Teams and the Mental Health Crisis Team onto the Huntlyburn site in Melrose.
- Upgrade of the Mental Health Inpatient Ward at Melburn Lodge.
- Detailed design work for the planned replacement of the Theatre Ventilation Units at Borders General Hospital.
- Continuing investment in rolling replacement programmes for NHS Borders Estate (£751k) and Medical Equipment (£435k)

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Efficiency
A key element of the Board’s plan to attain a financial breakeven outturn in 2015/16 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 an individual project sponsor 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 the target was met in full with £6.911m of savings delivered. A key element of financial sustainability is the recurring element of the cost efficiency target. Within the overall target for increased efficiency the recurring target of £5.1m element was not fully achieved with a shortfall of £1.6m at the end of the financial year. This was the first year in a significant period of time that NHS Borders had failed to fully meet in year its savings target on a recurring basis. The shortfall of £1.6m has been carried forward into 2016/17 and as such increases the requirement for recurring savings for the new year by this amount.

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.