

Borders NHS Board**MANAGING OUR PERFORMANCE OUTTURN REPORT: JUNE 2009****Aim**

The aim of this report is to update the Board and allow members to assess the progress made by NHS Borders during the financial year 2008/09 against a number of key performance indicators and Corporate Objectives.

Background

Throughout 2008/09 NHS Borders Board received Key Monthly Performance Indicator Reports. These reports shared timely and accurate information on system-wide performance and allowed the Board to assess progress in meeting key targets on a month by month basis.

The Scottish Government agreed NHS Borders 2008/09 Local Delivery Plan HEAT trajectories in March 2008. The report therefore focuses on the key HEAT targets and key priority areas in delivering these. Where applicable and available, the individual measures and targets are reported against performance in the corresponding month from the previous year, as well as against the trajectory set in the LDP where appropriate.

Throughout the report the HEAT targets have been highlighted with the sign below.



In addition to the HEAT targets, an update is provided on performance against the full range of 2008/09 Corporate Objectives to review whether NHS Borders has met its key objectives.

Summary

The report is intended to share timely and accurate information on performance and allow the Board to assess progress in meeting key targets during 2008/09.

Recommendation

The Board is asked to **note** this report

Policy/Strategy Implications	Regular and timely performance reporting is an expectation of the Scottish Government given the development of Local Delivery Plans
Consultation	Not applicable
Consultation with Professional Committees	Not applicable
Risk Assessment	Good progress is being made against key targets, but emerging pressure areas are identified in this report. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders
Compliance with Board Policy requirements on Equality and Diversity	The implementation and monitoring of HEAT targets will require that Lead Directors, Managers and Clinicians comply with Board requirements
Resource/Staffing Implications	Any resource implications will be addressed through the Health Plan Prioritisation Process

Approved by

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**Managing Our
Performance**

**2008/09
Outturn Report**

June 2009

**Directorate of Planning
& Performance**

EXECUTIVE SUMMARY

In 2008/09 NHS Borders delivered very strong performance across the service.

During 2008/09 under the 18 weeks waiting time guarantee for Outpatient, Inpatient & Day case treatment, the maximum wait was reduced to 12 weeks and this was achieved in March 2009.

NHS Borders performed extremely well against the 62-day target for urgent referrals for cancer. The revised Audiology treatment target was achieved 2 months ahead of the trajectory in August 2008 and this has been maintained since then.

In Accident and Emergency, attendance figures throughout the year remained below the trajectory. In 10 out of 12 months, the 4 hour treatment target was maintained. This shows effective working across all specialties and clinical boards.

In Partnership with Scottish Borders Council we maintained the census target of zero delayed discharges with a delay of more than 6 weeks by April 2009.

There has been no change in Borders General Hospital Bed occupancy from 2007/08 as this has remained at 76%. There has been an increase in occupied bed days, from 91,230 in 2007/08 to 91,902 in 2008/09 whilst the bed complement has reduced from 323 to 316. The average length of stay has remained the same in 2008/09 as in 2007/08 at 4.6 days.

Community Hospital GP Acute bed occupancy has increased from 85% in 2007/08 to 94% in 2008/09. Occupied bed days have also increased from 27,634 to 29,365. During the period an average of 12.2 patients were treated per bed (2007/08 13.0) with an average length of stay of 28.2 (24.1 days).

Mental Health Bed Occupancy was higher than last year, at 82% (compared to 80%). Occupied bed days have increased from 34,784 to 37,590.

Overall we have ensured strong performance in the past year. A clear focus on the major deliverables coupled with strong teamwork has delivered excellent results. This report will be used to inform the Annual Review with the Scottish Government in September 2009.

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1 HIGH LEVEL KEY PERFORMANCE INDICATORS

Target	Trajectory	Actual March 2009	Difference	Direction 08/09 v 07/08	Current Performance
Child Healthy Weight Interventions*	96	27	69	N/A	⊗
Successful Smoking Quits*	600	548	52	N/A	⊗
CHI Usage at 95%	95%	96%	1%	↑	✓
Sickness Absence Reduced to 4%	4.0%	4.2%	0.2%	↑	⊗
2 Months Waiting Target for Urgent Cancer Referrals	95%	100%	5%	↔	☆
12 Week Waiting Target for Outpatients	0	0	0	↑	✓
12 Week Waiting Target for Inpatient and Day Cases	0	0	0	↑	✓
4 Week Waiting Target for Diagnostics*	0	22	22	↑	⊗
Reduction in the rate of A&E Attendances	2163	2087	76	↓	✓
4-Hour Waiting Target for A&E	98%	98%	0	↑	✓
25% of A&E attenders seen by Primary Care	20%	23%	3%	↔	☆
1 Week Waiting Target for RACPC	0	3	3	↔	⊗
18 Week Waiting Target for AHPs*	0	9	9	N/A	⊗
26 Week Waiting Target for Audiology*	0	0	0	N/A	☆
18 Week Waiting Target for Mental Health	0	0.8%	0.8%	↑	⊗
25% Reduction in <i>Staph aureus</i>	2	1	1	N/A	✓
No Delayed Discharges over 6 Weeks	0	0	0	↔	✓

Current Performance Key	
⚠	Under Performing Current performance is significantly below the trajectory set.
⊗	Below Trajectory Current performance is moderately below the trajectory set.
✓	Meeting Trajectory Current performance matches the trajectory set
☆	Over Performing Current performance exceeds the trajectory set.

Direction Symbols

Better performance than previous year	↑
No change in performance from previous year	↔
Worse performance than previous year	↓

At A Glance Summary

For 7 out of the 17 KPIs performance at the end of 2008/09 was improved
For 4 out of the 17 KPIs performance in 2008/09 remained the same

Notes

Progress against other HEAT targets such as reducing mortality from CHD and ensuring that everyone has access to their GP within 48 hours is reported throughout this report

Some measures were not reported in 07/08 so it has not been possible to make comparisons on performance. Some measures have been reported differently in 2008/09 so comparisons are not necessarily applicable.

2 Health Improvement

2.1 Achieve agreed completion rates for child healthy weight intervention programme by 2010/11

HEAT H3

Figure 1 – Number of child healthy weight interventions to the end of March 2009

No of interventions April 08 – March 09	Target for 2008/09
27	90

As at the end of March 2009, 27 Child Healthy Weight Interventions had been completed. The target for March 2009 was 90. A total of 3 MEND Programmes have been completed (17 interventions), with the remaining 10 interventions being carried out via a 1 to 1 with a Community Dietician. A further 17 interventions have been attempted, but consent not given (from either parent or child) and 6 interventions have started, but the child / family have dropped out of the programme, giving a total of 23 interventions attempted.

2.2 Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 – 2010/11

HEAT H6

Figure 2 – Number of Successful Quits (at one month post quit)

No of quits April 08 – March 09	Target for 2008/09
548	600

From April 2008 – March 2009 548 people successfully stopped smoking (4 week abstinence from quit date). Although below our trajectory for this year, should this level be sustained over the 3 year period we would overshoot our target by 12%. This equates to a 3 year cumulative target of 1465 quitters.

Please note there will be a slight under reporting due to delay in data gathering.

3 Efficiency and Governance

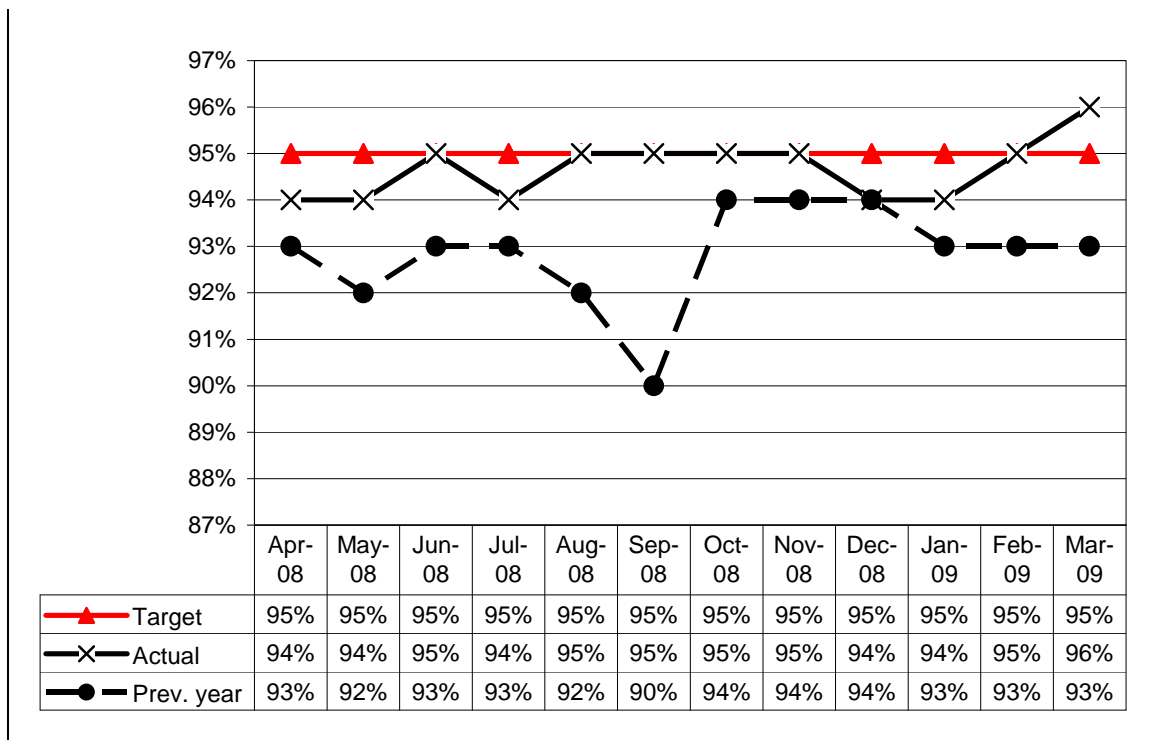
3.1 Universal utilisation of the Community Health Index (CHI)



NHS Borders' target is to maintain 95% as our previously agreed trajectory.

At the end of March 2009 CHI usage was at 96%, exceeding the trajectory of 95%. Throughout 2008/09, on average CHI useage was at 94.5% compared with an average of 93% in 2007/08.

Figure 3 – Overall Percentage Usage of CHI

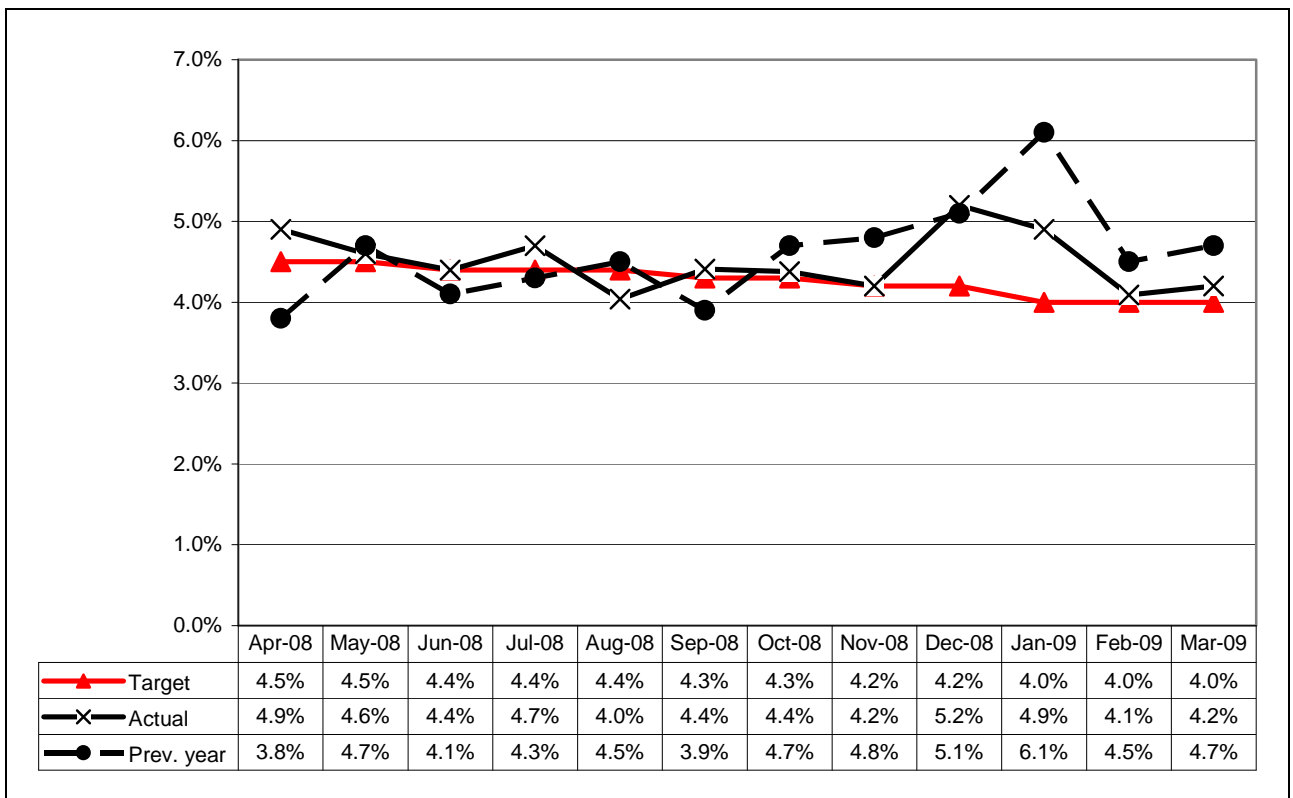


3.2 NHS Boards to achieve a sickness absence rate of 4% from March 2009

HEAT E2

As at the end of March 2009, sickness absence was at 4.2%, 0.2% above the trajectory target. This is a 0.1% increase from February 2009 (4.1%). The cumulative percentage for April 2008 – March 2009 is 4.65%, 0.65% above the annual target.

Figure 4 – Sickness Absence Rate



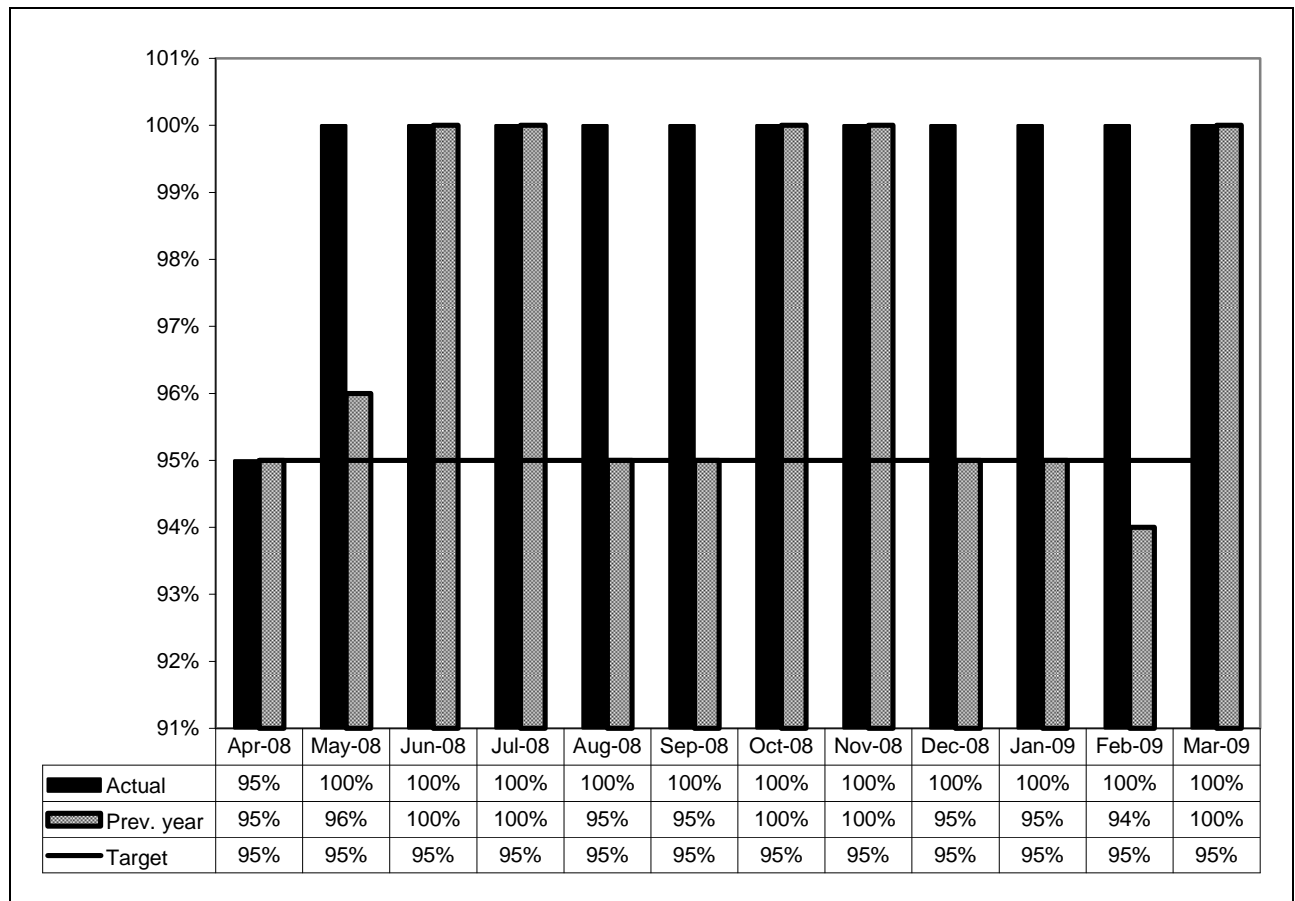
4 Access to Services

4.1 The maximum wait from urgent referral to treatment for all cancers is two months

HEAT A2

Based on the weekly management reporting information, as at the end of March 2009, there were no patients who waited consistently longer than 2 months for treatment from an urgent cancer referral. This trajectory of 95% has been exceeded for 49 weeks (since May 2008).

Figure 5 – Percentage of patients treated within two months



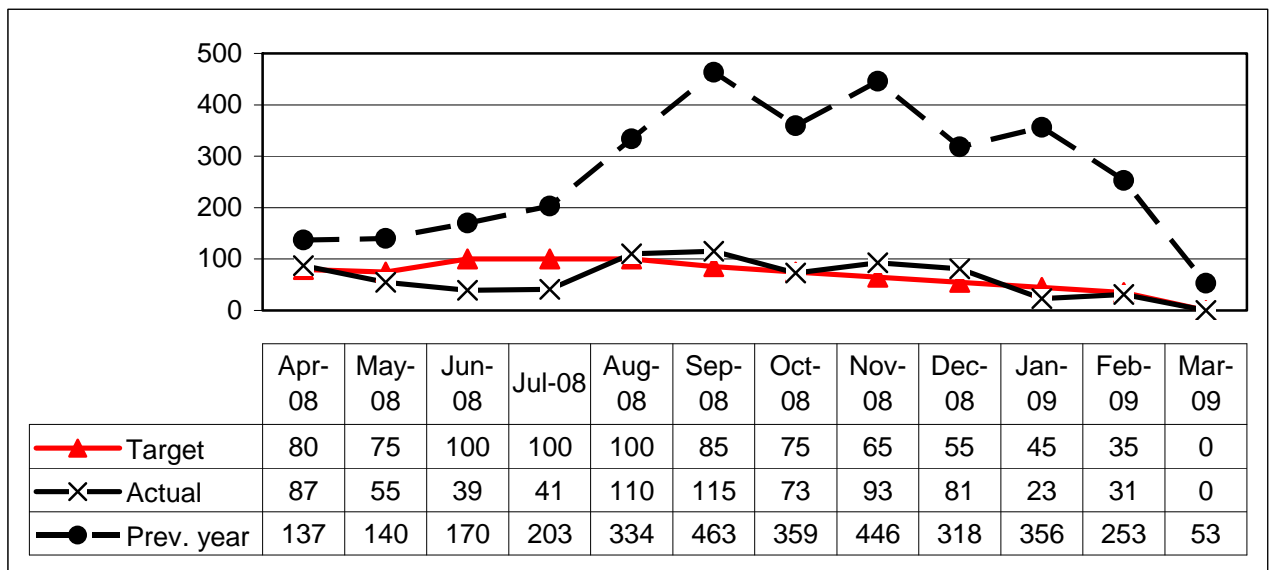
A robust tracking system is in place for all patients who are referred urgently with a suspicion of cancer. The creation of Cancer Tracker posts has supported this system by allowing robust monitoring of every patient along the entire cancer pathway. Where there are delays beyond pre-defined time limits, the Cancer Trackers initiate action in order to ensure that patients are not “lost” between different stages of their care, or between different specialists.

4.2 As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 12 weeks from GP referral to a first outpatient appointment from 31 March 2009

HEAT A4

In March 2009 the trajectory was reduced and this means that no patients should wait longer than 12 weeks for an outpatient appointment. In March 2009, this reduced target was achieved and no patients waited longer than this new 12 week target.

Figure 6 - Number of patients waiting longer than 12 weeks

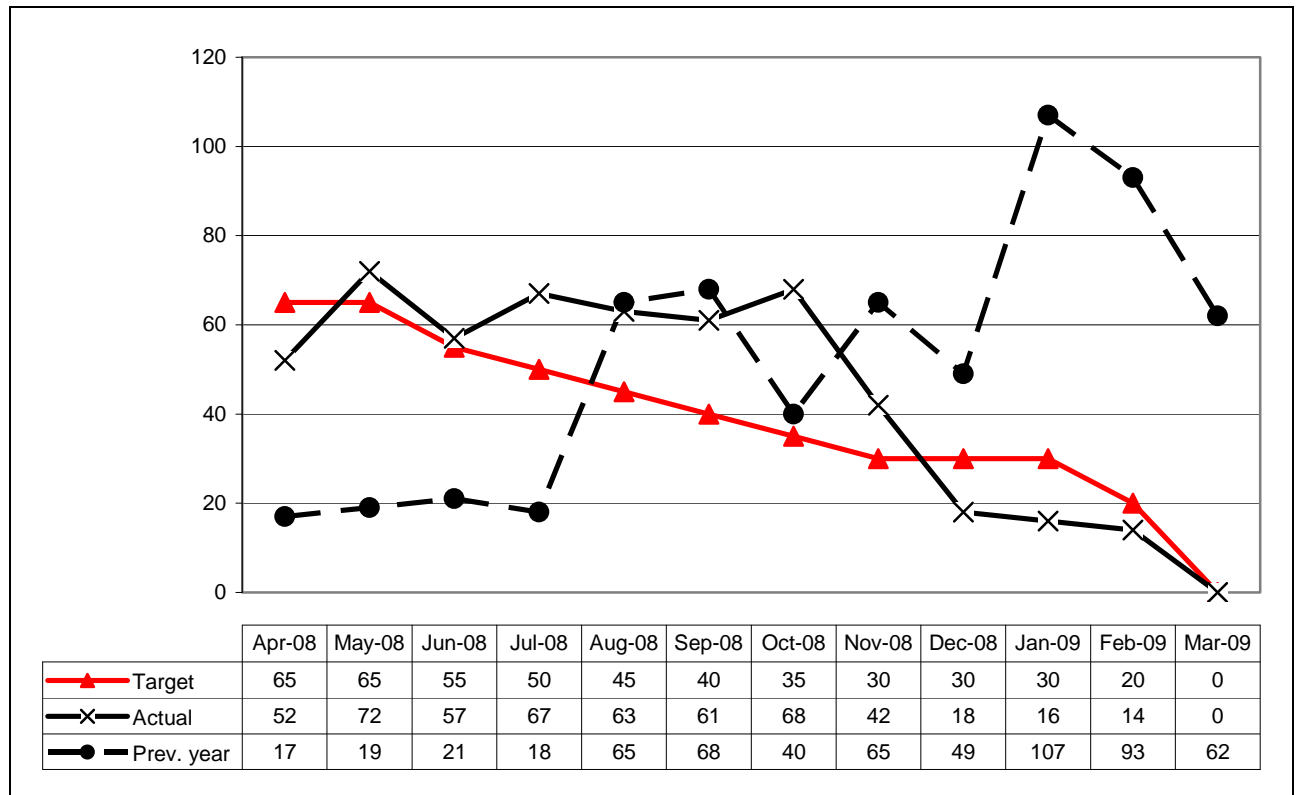


4.3 As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 12 weeks for inpatient or day case treatment from 31 March 2009

HEAT A5

In March 2009, the trajectory for inpatient and day case treatment was also reduced to 0 patients waiting over 12 weeks. This reduced target was achieved in March 2009 and no patients waited over 12 weeks

Figure 7 – Number of patients waiting longer than 12 weeks



4.3.1. Inpatients

During 2008/09 NHS Borders has maintained a maximum wait of 18 weeks and in March 2009 the new target of 12 weeks was achieved.

Figure 8 – Patients Waiting for Inpatient Treatment at Borders General Hospital, 2008/09

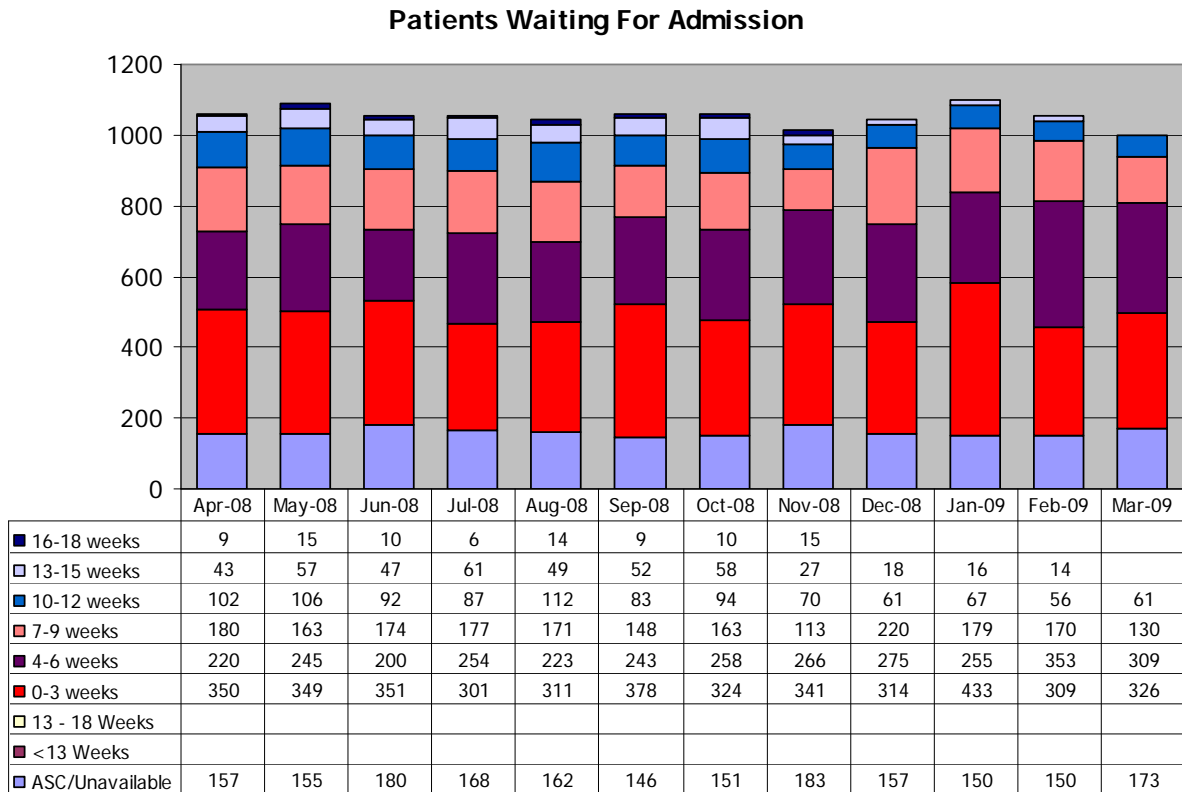


Table 1 – Patients Waiting for Inpatient Treatment, by Specialty, at Borders General Hospital; as at 31st March 2009

Specialty	Target (Weeks)	Patients Waiting							Total
		0-3 Weeks	4-6 Weeks	7-9 weeks	10-12 Weeks	13-15 Weeks	16-18 Weeks	Over 18 Weeks	
Colonoscopy	6	26							26
Dentistry	12	6							6
ENT	12	29	25	10	2				66
General Medicine	12	5	1						6
General Surgery	12	57	38	23	7				125
Gynaecology	12	24	42	20	4				90
Ophthalmology	9	49	62	17	1				129
Oral Surgery	12	14	11	5	2				32
Orthopaedic Surgery	12	75	110	45	42				272
Urology	12	41	20	10	3				74
Total		326	309	130	61				826

4.3.2 Outpatients

During 2008/09 NHS Borders has maintained a maximum wait of 18 weeks and is making progress towards a maximum wait of 12 weeks by March 2009.

Figure 9 - Patients waiting for a new outpatient appointment, 2008/09

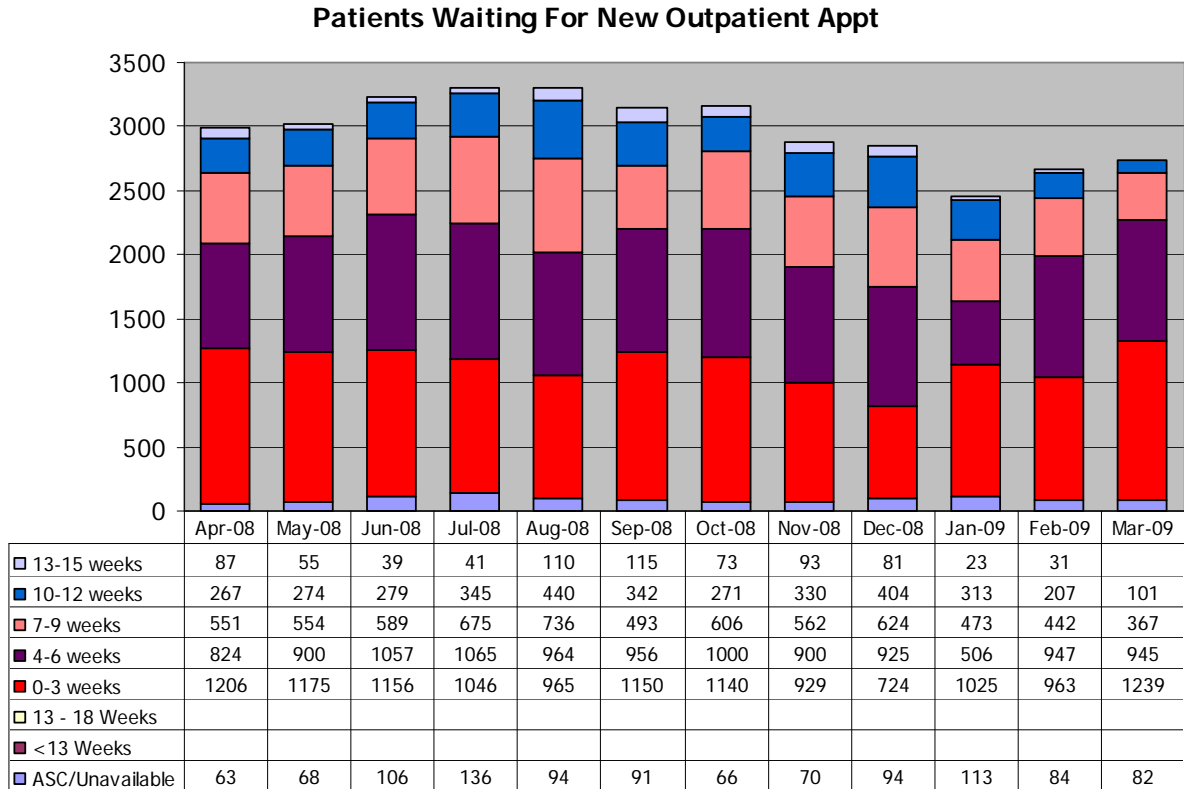


Table 2 – Patients Waiting for Outpatient Appointment, by Specialty, at Borders General Hospital; as at 31st March 2009

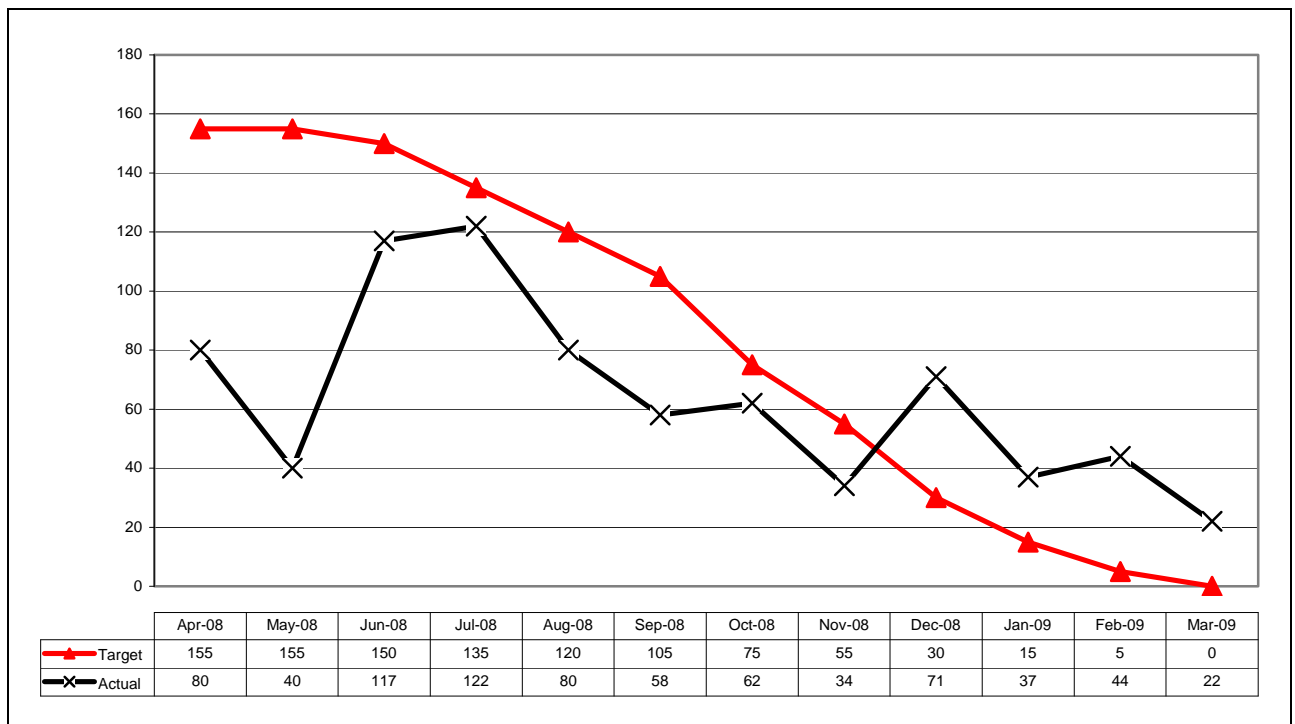
Selected Specialties	Target (Weeks)	Patients Waiting							Total
		0-3 Weeks	4-6 Weeks	7-9 Weeks	10-12 Weeks	13-15 Weeks	16-18 Weeks	Over 18 Weeks	
Anaesthetics	12	12	21	2					35
Cardiology	12	54	37	12	1				104
Clinical Oncology	12	4	1						5
Colposcopy	12								
Cystoscopy	12	2							2
Cystoscopy - Repeat	12	1							1
Dermatology	12	103	97	29	7				236
Dentistry	12	19	19	4	1				43
Diabetics	12	3	9	3					15
Endoscopy	6	43	1						44
ENT	12	105	108	63	4				280
Gastroenterology	12	46	36	2	2				86
General Medicine	12	9	2	2					13
General Surgery	12	138	118	56	11				323
Gynaecology	12	120	53	12	2				187
Haematology	12		2						2
Medical Oncology	12	1							1
Medical Paediatrics	12	28	20	14					62
Nephrology	12	7	7	4	2				20
Neurology	12	25	47	31	18				121
Ophthalmology	12	212	82	3					297
Ophthalmology - Minor Proc	12	14	4	2					20
Oral Surgery	12	30	39	27	21				117
Orthodontics	12	13	27	3	10				53
Orthopaedics	12	175	155	62	5				397
Prostate Biopsy	12	10							10
Respiratory Medicine	12	7	22	11	5				45
Rheumatology	12	14	10						24
Urology	12	27	28	25	12				92
Urology Haematuria (Cystoscopy)	6	17							17
All Specialties		1239	945	367	101				2652

4.4 As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 4 weeks for one of the 8 key diagnostic tests from 31 March 2009

HEAT A6

As at the end of March 2009 there were 22 patients waiting longer than 4 weeks for a key diagnostic test. During March, the trajectory has been reduced to 0 patients and although the target was not achieved, there has been a decrease of 50% in the number of patients waiting over 4 weeks from the previous month (44 patients).

Figure 10 – Number of patients waiting longer than 4 weeks



The table below shows waiting times as at the end of March 2009.

Table 3 - Waiting Times for Diagnostic Investigations as at 31st March 2009

Month	National Target	Local Target	Imaging Tests				Endoscopic Tests			
			MRI	CT Scan	Ultrasound	Barium Studies	Upper GI	Colonscopy	Cystoscopy	Lower GI*
Apr-08	6	4	5	5	5	5	6	7	6	7
May-08	6	4	5	5	5	4	5	4	7	4
Jun-08	6	4	8	8	4	4	5	4	3	4
Jul-08	6	4	7	7	7	6	4	5	4	5
Aug-08	6	4	7	7	7	6	6	7	7	7
Sep-08	6	4	5	6	5	6	7	14	7	14
Oct-08	6	4	6	5	5	5	3	4	8	4
Nov-08	6	4	6	6	6	3	4	4	6	4
Dec-08	6	4	5	7	6	4	4	3	6	3
Jan-09	6	4	6	5	5	4	4	3	8	3
Feb-09	6	4	6	5	5	3	3	3	5	3
Mar-09	6	4	6	4	4	4	7	4	4	4

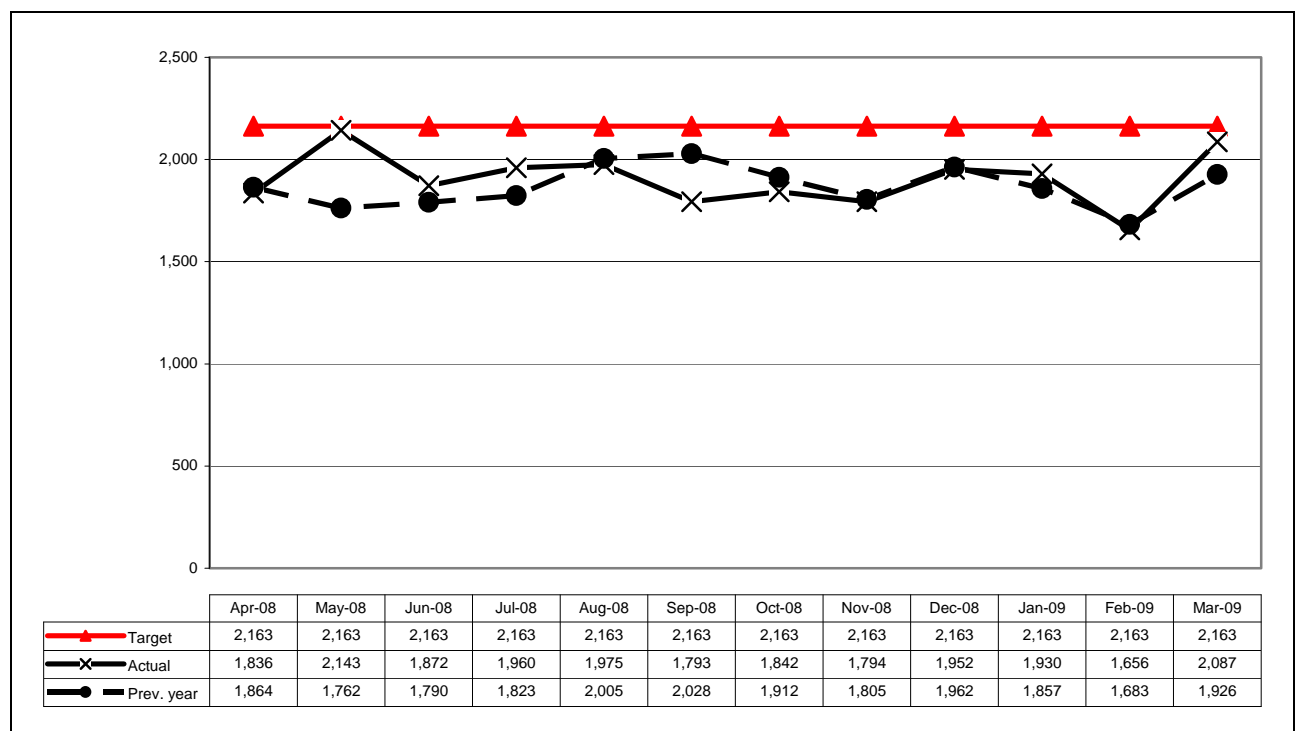
4.5 NHS Boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/7 to 2010/11; and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment

HEAT A7

4.5.1 Number of all attendances at A&E

During March 2009 2,087 patients attended A&E below the target of 2163. In 2008/09 a total of 22840 attended A&E, an average of 1903 per month. This was a slight decrease from 2007/08 when 22417 people attended A&E, an average of 1868 per month.

Figure 11 – Number of A&E Attendances

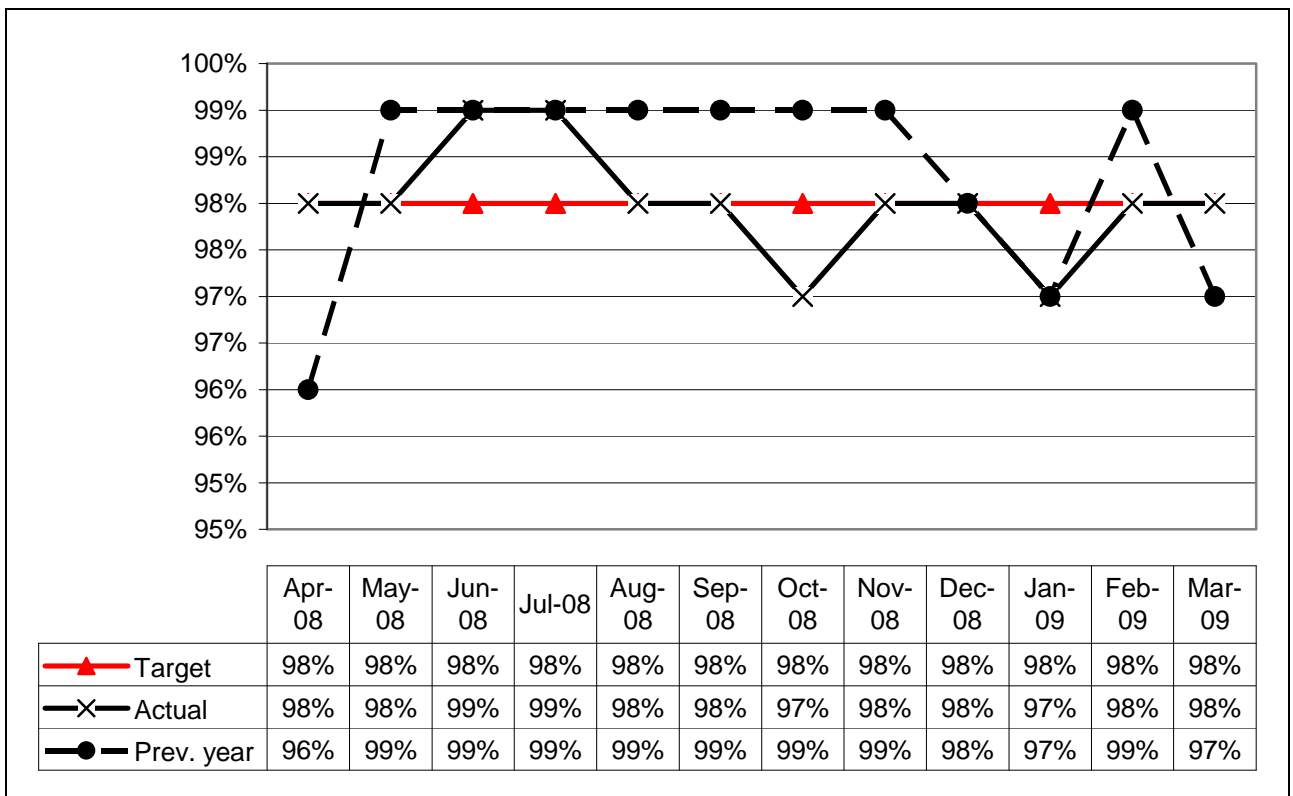


4.5.2 Percentage of patients that were seen within the 4-hour Waiting Target

HEAT A7

During March 2009 98% patients waiting were seen within 4 hours at A&E, with 52 patients not seen within this time. The percentage achieving the Emergency Access target for admissions to Surgery/Orthopaedics was 97% and Medical Admissions was 99%. Comparing March 2009 with March 2008 (97%), there is a 1% increase in the percentage of patients being seen within the target. During 2008/09 the on average 98% of patients were seen within 4 hours which was the same as in 2007/08.

Figure 12 – Percentage of patients seen within 4 hours

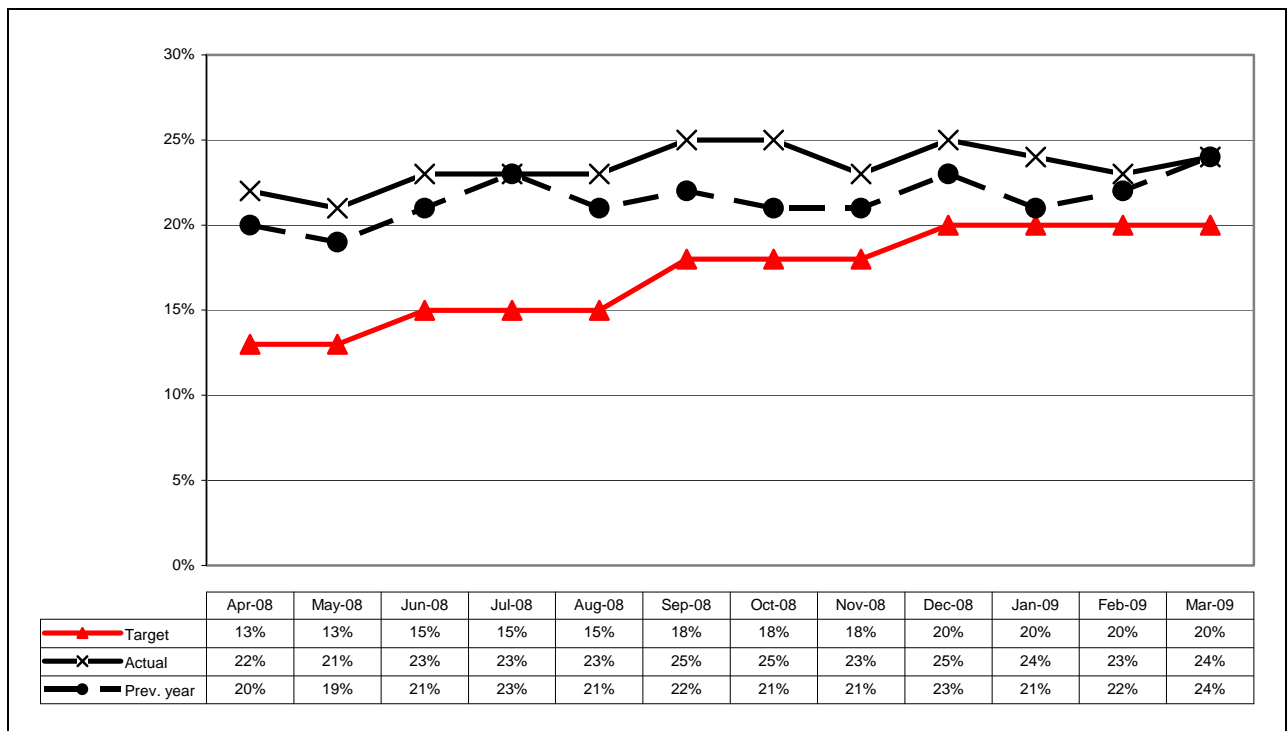


On the whole, the 4-hour Emergency Access Target, has been maintained as indicated in the figure above. There were only 2 months when the 98% target was not achieved. Challenges and pressures remain apparent in the month of January as 97% of patients were seen within 4 hours and this was the same as in January 2008.

4.5.3 Increase the number of Unscheduled Attenders at A&E being seen by Primary Care.

During March 2009 24% (530) of all attendees at A&E (2087 patients) were seen by Primary Care. This includes those seen by the A&E GP and those referred to BECS. Compared with March 2008 (24%), the percentage of A&E attenders seen by Primary Care has remained the same. On average in 2008/09 23% of all attendees at A&E were seen by Primary Care which has remained above the trajectory and is an increase in the average number seen in 2007/08 which was 21.5%.

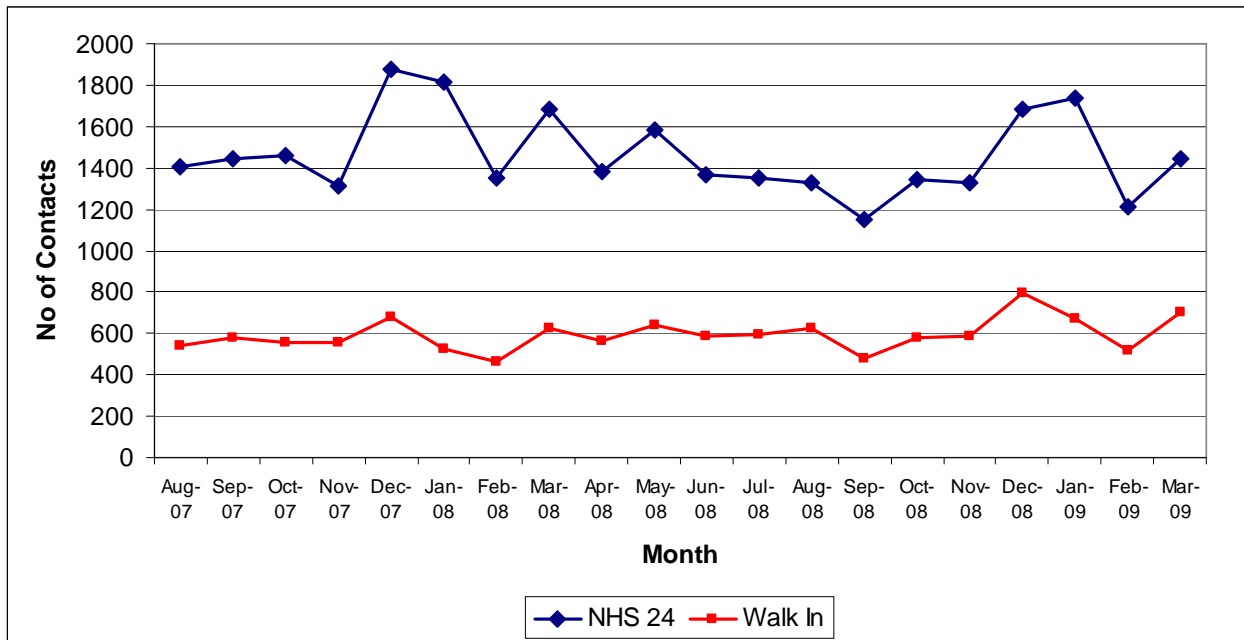
Figure 13 – Percentage of patients seen by the A&E GP



4.5.4 Borders Emergency Care Service (BECS) Activity

Figure 14 shows the trend of NHS 24 contacts from NHS Borders patients from August 2007 to March 2009. The % walk in figures based on total monthly activity ranges from 23-32.6% during this period, and was 32.6% during March 2009. As predicted the contacts to NHS 24 peak during the winter months, this can be seen for 2007 and rose again from December 2008 onwards. They stabilised during June to November 2008.

Figure 14 – BECS contacts by type



During the period August 07 to March 09 the breakdown of contacts in % terms is as follows:

- Patient attendances range from 47-52%, with 49% attending in March 09, the same figure as February 09.
- Home visits range from 21-27%, with 24% receiving a Home Visit in March 09.
- Telephone contacts range from 24-28%, with 27% of contacts in March 09 which is down slightly from February 09.

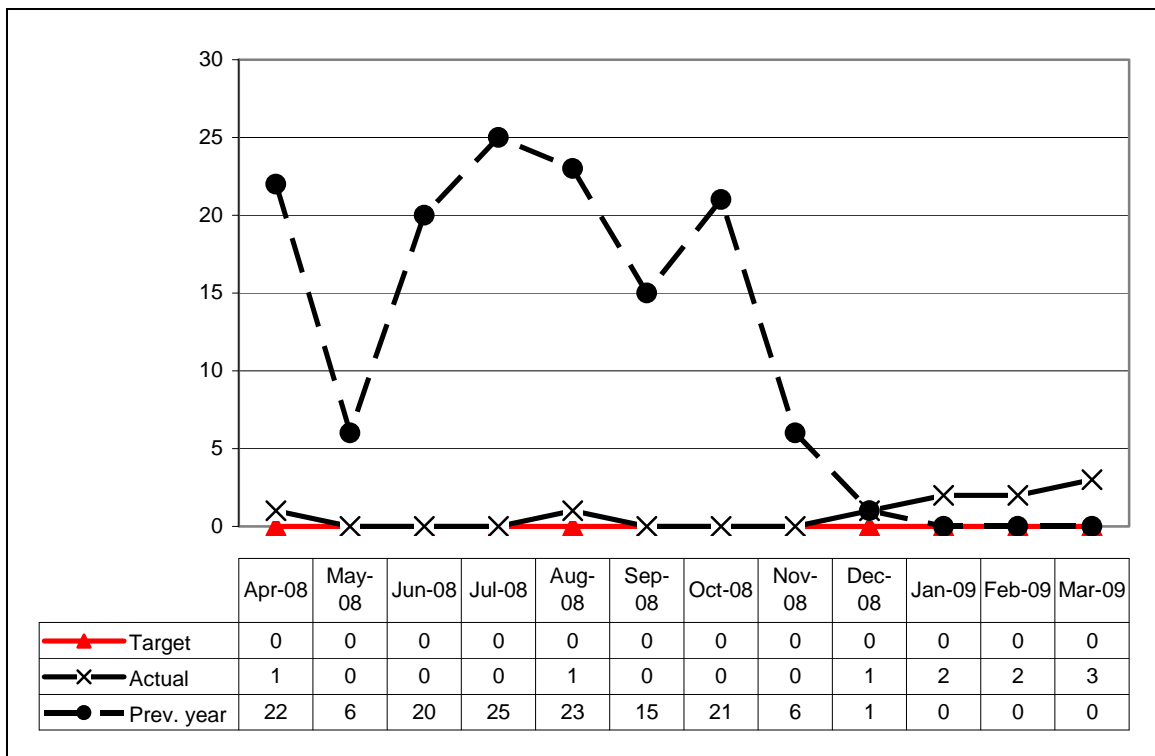
Activity levels are down when comparing March 08 with March 09 information (1,472 in 2009 compared to 1,634 in 2008).

4.6 Maximum wait will be 1 week from GP referral to Rapid Access Chest Pain Clinic (RACPC)

HEAT Standard

The expectation is that no patient will wait more than 1 week from GP referral to RACPC. As at the end of March 2009, there were 3 patients waiting longer than 1 week for the RACPC. In 2008/09, 10 patients were not seen within 1 week which is a significant improvement over 2007/08 when 139 patients were not seen within 1 week.

Figure 15 – Number of patients waiting longer than 1 week

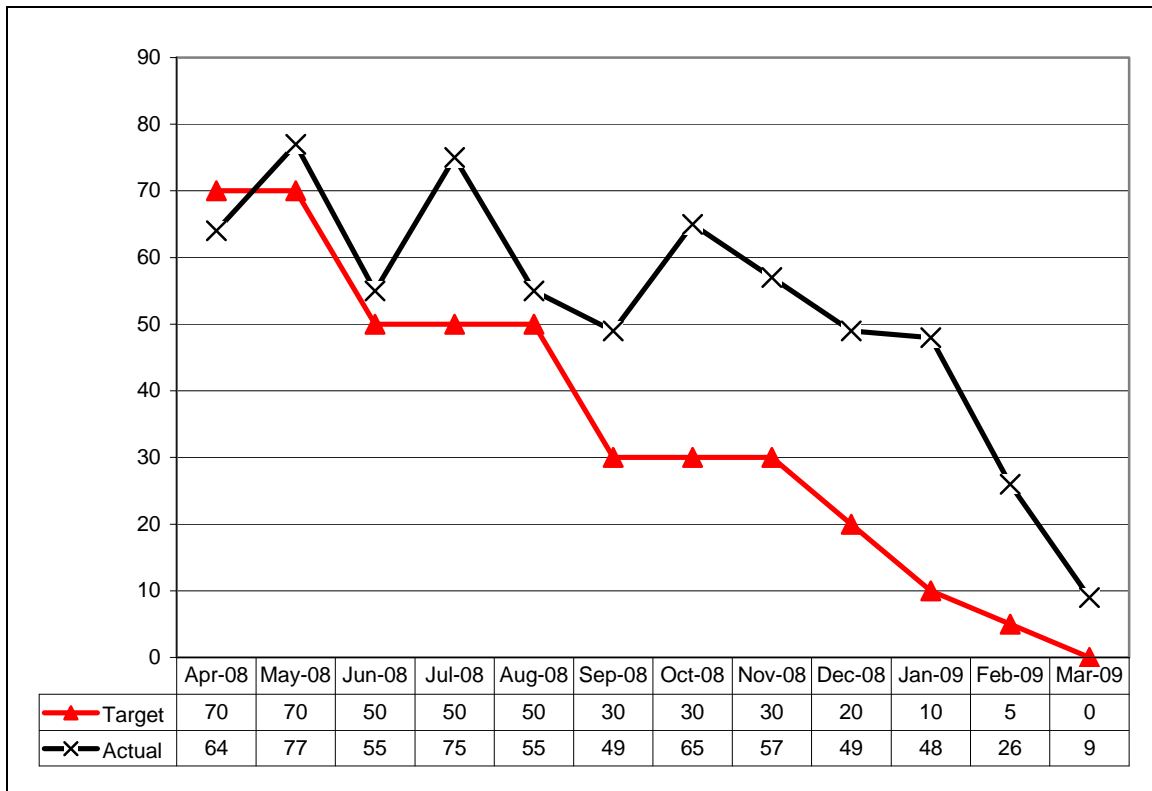


4.7 Allied Health Professionals (AHP): By March 2009 Referral processes and information systems will be developed and implemented across AHP therapy services to enable delivery of a maximum wait of 18 weeks from referral to 1st appointment (reducing to 15 weeks by March 2010 & 12 weeks by March 2011)

The local trajectory target was reduced in March 2009 to mean that no patients should wait over 18 weeks for an AHP appointment. At the end of March 2009, 9 patients waited more than 18 weeks. This figure breaks down between professional groups as: 6 in Community Physiotherapy, 2 in Speech and Language Therapy and 1 in Dietetics. The total of 9 patients is a reduction of 17 patients from February 2009.

Use of a locum physiotherapist has made a substantial difference to response to referrals by the Kelso team. This has resulted in a significant reduction in long waits for the community service. 23 waiting over 18 weeks in February 09 compared with 1 patient waiting in March 09.

Figure 16 - Number of patients waiting longer than 18 weeks



The following tables highlight AHP waiting times as at March 2009:

Table 4 – Physiotherapy Community Activity

	Patients Waiting							Total
	0-3 weeks	4-6 weeks	7-9 weeks	10-12 weeks	13-15 weeks	16-18 weeks	>18 weeks	
Paediatric Physio	2	6	2	1	2	7	3	23
Physio - Coldstream	20	11	5					36
Physio - Duns	31	41	18					90
Physio - Earlston	4	1	3		2			10
Physio - Eyemouth	34	15	9					58
Physio - Hawick	54		1	1	1	3	1	61
Physio - Jedburgh	6	6	1					13
Physio - Kelso	23	12	10	19	10	17	1	92
Physio - Mental Health	2	1						3
Physio - Peebles	27	1	4	1	1	2		36
Physio - Selkirk	21	15	3	1			1	41
Physio - West Linton	7	3	1	1				12
Physio Learning Disability	2	1				1		4
Total	233	113	57	24	16	30	6	479

Waiting list as at 31st March 2009 = 479

Longest wait = 37 weeks

Average Wait = 5.3 weeks

Mode (most frequent) is 0 to 3 weeks

Table 5 – Physiotherapy BGH Activity

Team	Patients Waiting							Total
	0-3 weeks	4-6 weeks	7-9 weeks	10-12 weeks	13-15 weeks	16-18 weeks	>18 weeks	
BGH Unspecified	27	2	2			1		32
Physio - BBS	1							1
Physio - DME	3							3
Physio - Hydrotherapy	9	2	1					12
Physio - Musculoskeletal	88	53	34	30	30	19		254
Physio - Obstetrics	1	1						2
Physio - Respiratory	7							7
Total	136	58	37	30	30	20	0	311

BGH Physiotherapy activity is now recorded on EPEX (previously TIARA) and has slight definitional differences in recording.

Waiting list at last day in month is: 311

Mode (most frequent) value is: 0-3 weeks

Table 6 – Occupational Therapy Community Activity

Team	Patients Waiting							Total
	0-3 weeks	4-6 weeks	7-9 weeks	10-12 weeks	13-15 weeks	16-18 weeks	>18 weeks	
BGH	9		5	1	1	1		17
Comm Hosp - Duns	3			2	2	3		10
Comm Hosp - Hawick	5	7	10	6	1	4		33
Comm Hosp - Peebles	3	2	3	6	3	2		19
Mental Health - Dementia	1							1
Mental Health - LD Patients		1	1	1				3
Mental Health - MHET			1	4	1	2		8
Mental Health - West Team				1				1
Paediatrics - Cheviot				1				1
Paediatrics - Eildon2								0
Rheumatology BGH		1	1		1			3
Total	21	11	21	22	9	12	0	96

Waiting List as at 31st March 2009 = 96

Longest Wait = 18 weeks

Average Wait = 8.6 weeks

Mode (most frequent value) is 10-12 weeks

Table 7 – Podiatry Activity

Team	Patients Waiting							Total
	0 - 3 weeks	4 - 6 weeks	7 - 9 weeks	10 - 12 weeks	13 - 15 weeks	16 - 18 weeks	Over 18 weeks	
Musculoskeletal - Teviot/Tweeddale		1	6	9	9			25
Ortho-triage				1				1
Paediatric Physio/Podiatry	5							5
Podiatry Berwickshire	51	26	21	2				100
Podiatry Eildon	44	24	6	1				75
Podiatry Teviot/Tweeddale	42	20	17					79
Rheumatology	4	4	1					9
Total	146	75	51	13	9	0	0	294

Waiting List as at 31st March 2009 = 294

Longest Wait = 14 weeks

Average Wait = 4 weeks

Norm (most frequent value) is 0-3 weeks

Table 8 – Speech and Language Therapy Activity

Team	Patients Waiting							Total
	0-3 weeks	4-6 weeks	7-9 weeks	10-12 weeks	13-15 weeks	16-18 weeks	>18 weeks	
SLT Adults	6	2	1					9
SLT Paed Team 1	13	5	3	1	3	3		28
SLT Paed Team 2	5	10	7	8				30
SLT Paed Team 3	8	8	2	1				19
SLT Paed Team 4	1							1
SLT Team - Deaf		1						1
ST - Learning Disability	2	4	1				2	9
Total	35	30	14	10	3	3	2	97

Waiting List as at 31st March 2009 = 97

Longest Wait = 26.7 weeks

Average Wait = 5.6 weeks

Mode (most frequent) value is 0-3 weeks

Table 9 – Nutrition and Dietetics Activity (Times Waited)

Team	Patients Waited							Total
	0 - 3 weeks	4 - 6 weeks	7 - 9 weeks	10 - 12 weeks	13 - 15 weeks	16 - 18 weeks	Over 18 weeks	
BGH Outpatients	4	5	9	3				21
BGH Inpatients	47	18	2				1	68
Comm Domiciliary	2	7						9
Comm Hosp MH Unit	17	6						23
HC Outpatients	15	39	31	15	4			104
Total	85	75	42	18	4	0	1	225

Longest Wait = 19 weeks

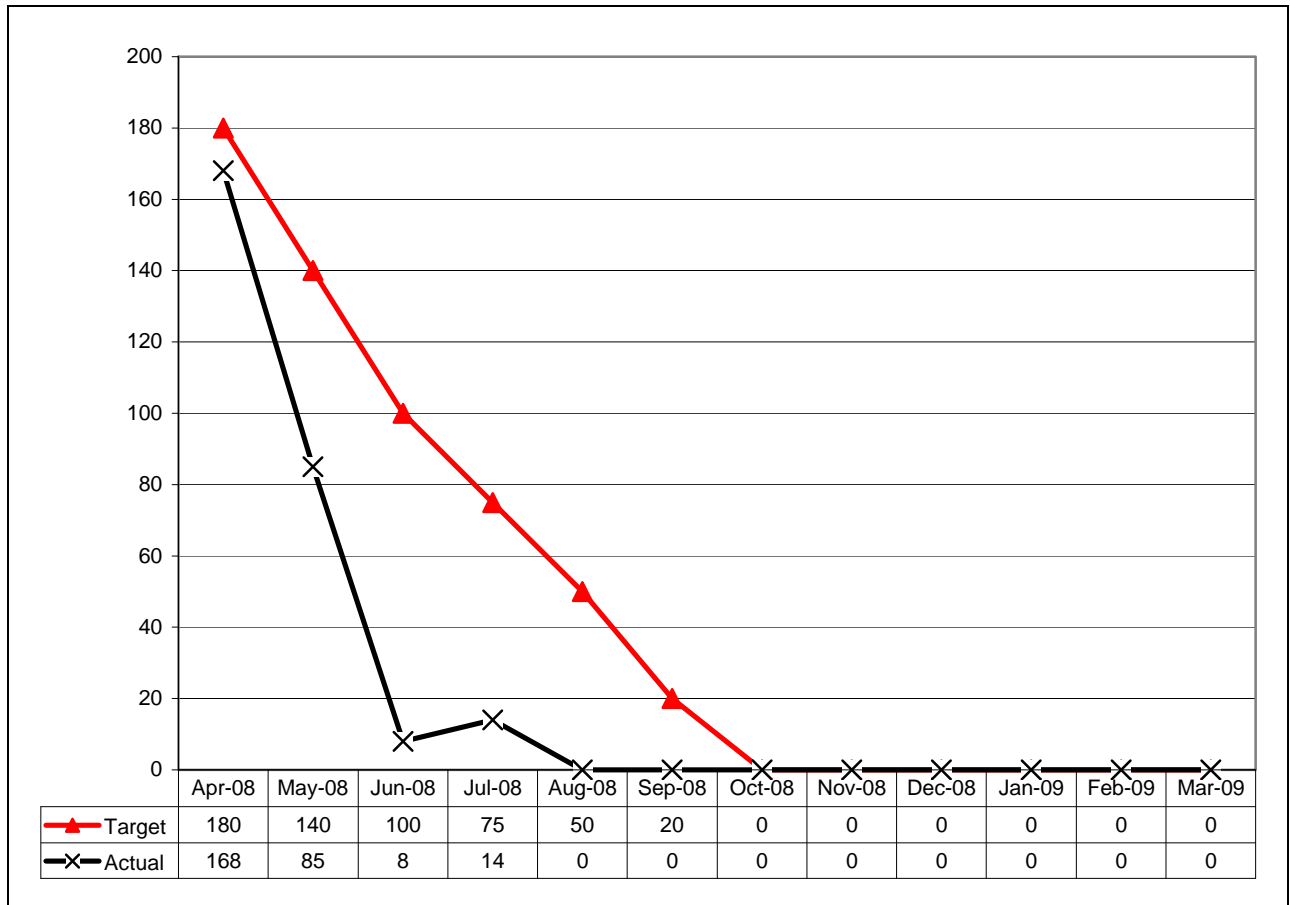
Average Wait = 5 weeks

Mode (most frequent value) is 0-3 weeks

4.8 Audiology: To reduce waiting times from GP referral to fitting of hearing aid to 26 weeks by 31 March 2009

As at the end of March 2009, there were no patients waiting longer than 26 weeks for Audiology and the expected wait for full treatment is now 12 weeks. The longest wait for assessment is 10 weeks and for fitting is 4 weeks. The target was met in August 2008, 2 months ahead of the trajectory.

Figure 17 – Number of patients waiting longer 26 weeks for Audiology

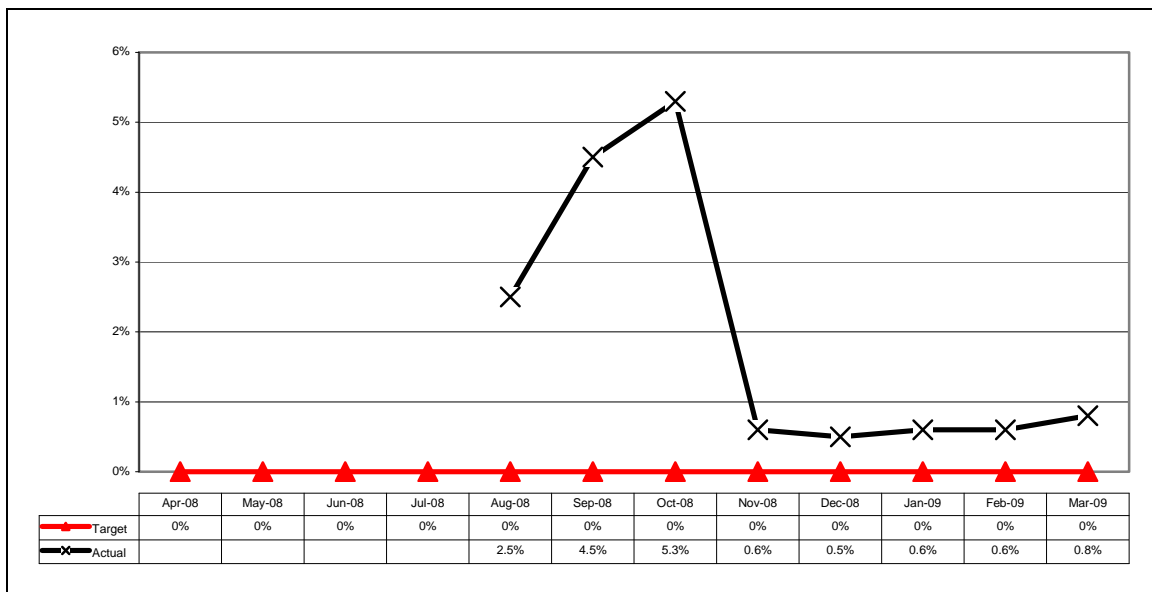


Waiting time for full treatment for new referrals is 12 weeks. This is a reduction of 3 weeks from March 2008. Substantial improvements in Audiology services have been made this year. This target has been maintained since then. During 2008/09 the longest wait for assessment was 21 weeks, and 9 weeks for fitting, which is an improvement on the year before.

4.9 Mental Health Waiting Times for New Outpatient Appointment

As at the end of March 2009 there were 265 patients waiting for a new outpatient appointment with 13 patients (5% of the total number) waiting longer than 18 weeks. In comparison, February 2009 had 261 patients waiting for a new outpatient appointment with 7 patients (3% of the total number) waiting longer than 18 weeks.

Figure 18 – Percentage of Mental Health patients waiting longer than 18 weeks (excluding BCAT and ADHD)



During 2008/09 there was an increase in the percentage of patients waiting over 18 weeks from the position at the end of 2007/08. The peak month was October 08 with 12.6%. By the end of March 09 this has declined to 5.1%, slightly up on the position in March 2008 of 4%.

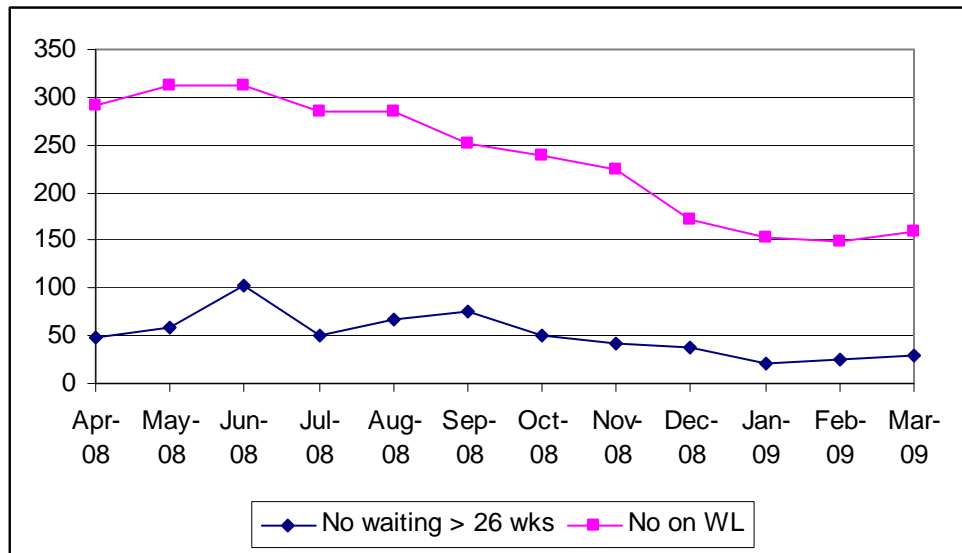
Table 10 – Mental Health Waiting Times

Date	Target (Weeks)	Patients Waiting							Delays	Total	Number Waiting Over 9 Wks	% Waiting Over 9 Wks	Number Waiting Over 18 Wks	% Waiting Over 18 Wks
		1-3 weeks	4-6 weeks	7-9 weeks	10-12 weeks	13-15 weeks	16-18 weeks	>18 weeks						
Apr-08	18	95	61	38	22	22	6	12	12	268	62	24.2%	12	4.7%
May-08	18	88	56	28	23	10	9	13	13	240	55	24.2%	13	5.7%
Jun-08	18	101	68	41	28	17	7	15	24	301	67	24.2%	15	5.4%
Jul-08	18	79	58	59	40	25	11	22	14	308	98	33.3%	22	7.5%
Aug-08	18	89	54	39	33	23	20	25	19	302	101	35.7%	25	8.8%
Sep-08	18	91	28	24	15	49	41	30	11	289	135	48.6%	30	10.8%
Oct-08	18	87	36	35	15	14	21	30	7	245	80	33.6%	30	12.6%
Nov-08	18	128	70	24	17	10	10	29	3	291	66	22.9%	29	10.1%
Dec-08	18	89	86	51	16	10	10	22	7	291	58	19.9%	22	7.6%
Jan-09	18	153	30	33	25	5	2	15	8	271	47	17.9%	15	5.7%
Feb-09	18	107	71	39	13	10	4	7	10	261	34	13.5%	7	2.8%
Mar-09	18	117	58	32	23	7	6	13	9	265	49	19.1%	13	5.1%

4.9.1 Psychological Services/Adult Mental Health:

The Graph below highlights trends of patients waiting for a new outpatient appointment:

Figure 19 - No of patients waiting more than 26 weeks/No of patients on waiting list



The table below highlights April 08 – March 09 position for psychological services:

Table 11 - April 08 – March 09 Position

Month	No waiting		% > 26 wks
	> 26 wks	No on WL	
Apr-08	49	291	17
May-08	59	313	18
Jun-08	103	313	33
Jul-08	51	284	18
Aug-08	67	286	23
Sep-08	76	251	30
Oct-08	51	238	21
Nov-08	41	225	18
Dec-08	37	171	22
Jan-09	21	152	14
Feb-09	25	149	17
Mar-09	29	160	18

Figure 20 – Percentage of Borders Community Addictions Team patients waiting longer than 18 weeks

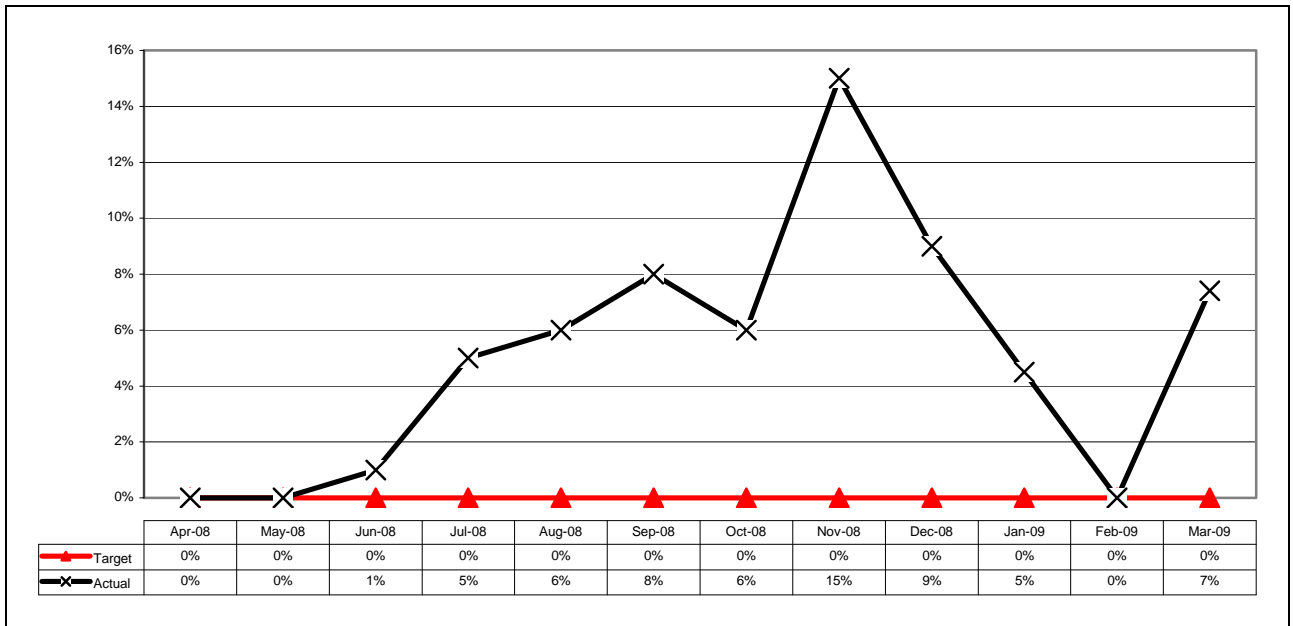
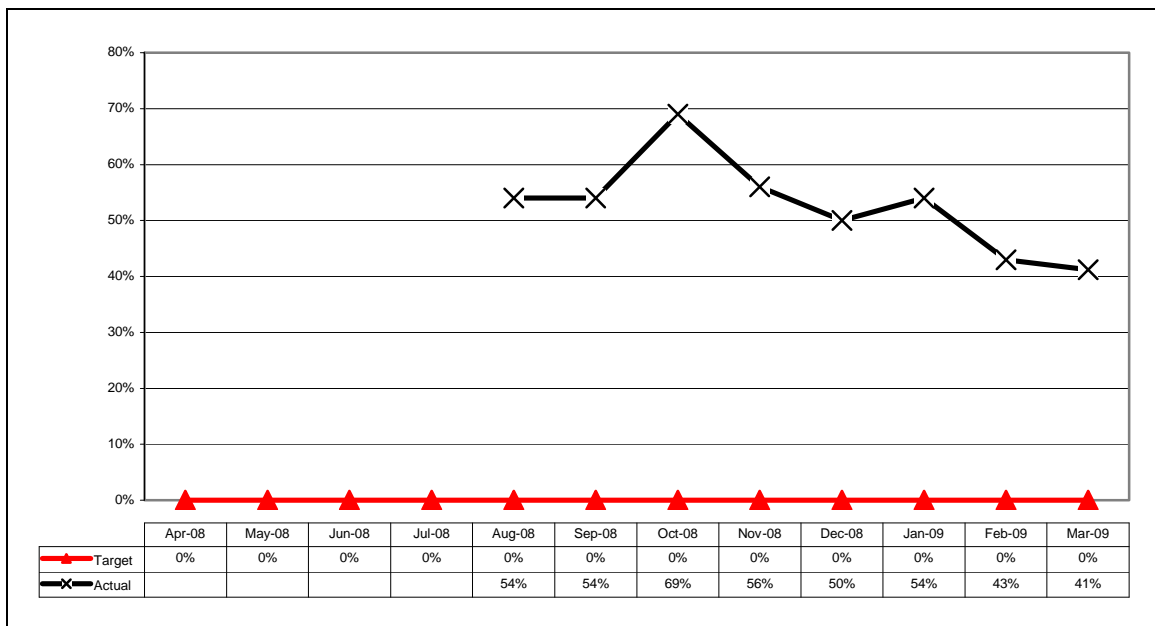


Figure 21 – Percentage of Child and Adolescent Mental Health Team patients waiting longer than 18 weeks for the ADHD Service



Please Note: ADHD Service waits were not disaggregated from the Child and Adolescent Mental Health Team until August 2008.

5 Treatment

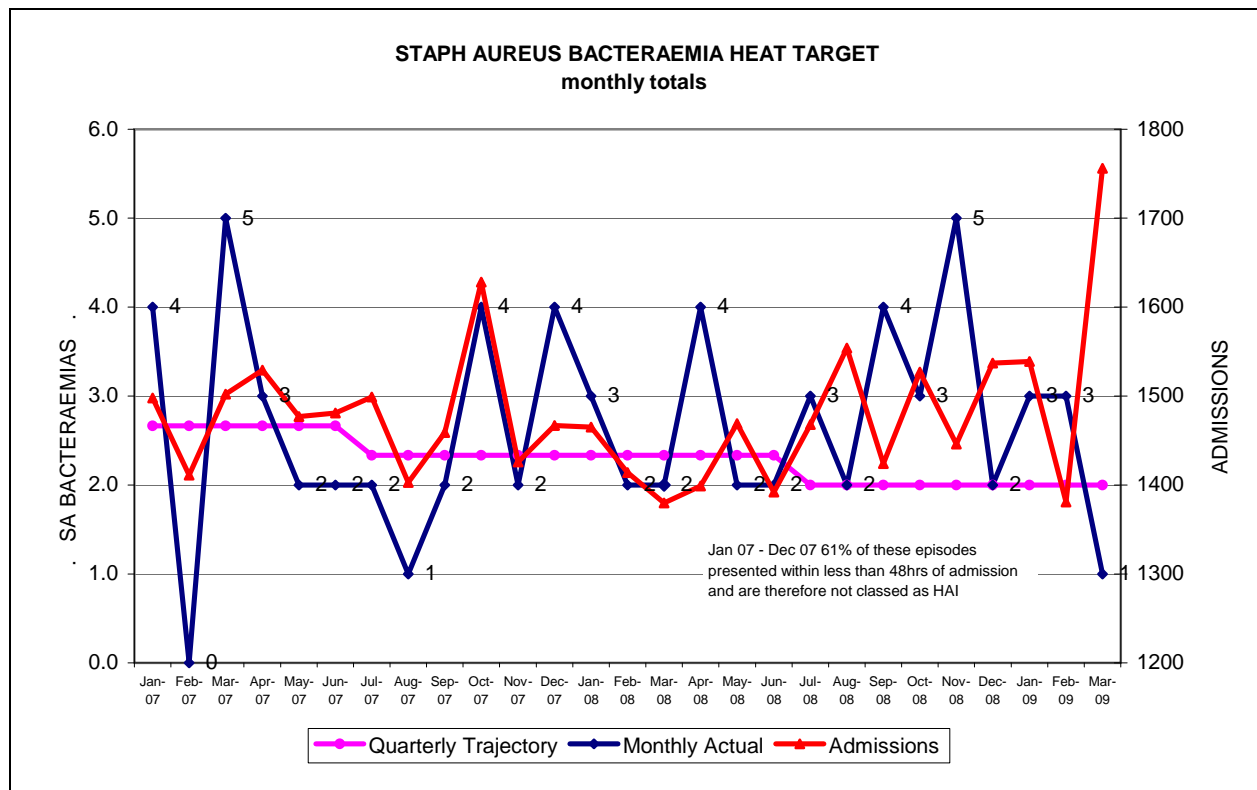
5.1 To reduce all *staphylococcus aureus* bacteraemia (including MRSA) by 25% by 2010

HEAT T5

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. This is a decrease of 3 isolate from December 2008 where there were 10 *staph. aureus* bacteraemia.

Please note that these figures have not been formally validated by Health Protection Scotland (HPS).

Figure 22 – Staph aureus Bacteraemia

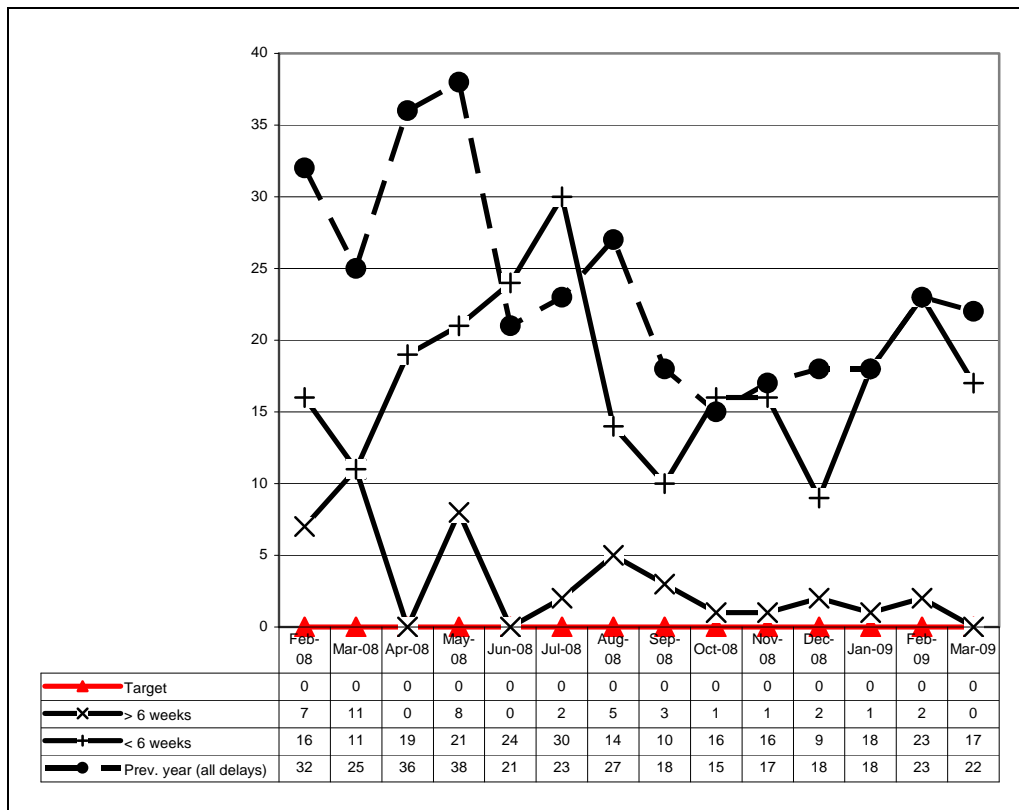


5.2 Delayed Discharges: The number of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting will be reduced to zero. Additionally, the number of patients delayed in short-stay beds will be reduced to zero.

HEAT Standard

As at 15th April 2009 there were 22 Delayed Discharges in total, 5 of these were complex cases and therefore did not count against the target. There were no delayed discharges over 6 weeks, therefore the Scottish Borders Partnership has successfully achieved the target of zero delays over 6 weeks.

Figure 23 – Delayed Discharges



The most common reason for delay includes 'awaiting placement within a Care Home', following by 9 exercising their right of choice of care home. The delayed discharge operational group actively attempts to progress cases through the choice of care home policy.

6 ACTIVITY

6.1 Borders General Hospital Activity

There were 20,145 inpatient episodes in total to the 31st March 2009. This was an increase of 2% over 2007/08. Day cases show an increase of 1.9% with 6,682 patients treated compared to 6,521 in 2007/08.

Table 12 – Inpatient Activity: Borders General Hospital 2008/09

Inpatient Activity: Inpatient Discharges and Daycases

	<i>Inpatient Discharges</i>			<i>Daycases</i>			<i>Total</i>		
	<i>Cumulative</i> 2007/08	<i>Cumulative</i> 2008/09	<i>Variance</i>	<i>Cumulative</i> 2007/08	<i>Cumulative</i> 2008/09	<i>Variance</i>	<i>Cumulative</i> 2007/08	<i>Cumulative</i> 2008/09	<i>Variance</i>
<i>Medical Services</i>									
Clinical Oncology	4	8	100%	992	1182	19%	996	1190	19%
Elderly Assessment	493	466	-5%	0	0	-	493	466	-5%
General Medicine	8047	8418	5%	773	959	24%	8820	9377	6%
General Practice	103	88	-15%	0	0	-	103	88	-15%
Haematology	186	120	-35%	1068	913	-15%	1254	1033	-18%
Palliative Medicine	106	124	17%	0	2	-	106	126	19%
Young Physically Disabled	1	0	-100%	0	0	-	1	0	-100%
Total	8940	9224	3%	2833	3056	8%	11773	12280	4%
<i>Surgical Services</i>									
ENT	176	141	-20%	290	285	-2%	466	426	-9%
General Surgery	2958	2730	-8%	347	372	7%	3305	3102	-6%
Ophthalmology	77	49	-36%	1117	1005	-10%	1194	1054	-12%
Oral Surgery	5	8	60%	549	437	-20%	554	445	-20%
Orthopaedics	1881	1996	6%	420	580	38%	2301	2576	12%
Rheumatology	1	5	400%	12	8	-33%	13	13	0%
Urology	428	451	5%	295	241	-18%	723	692	-4%
Total	5526	5380	-3%	3030	2928	-3%	8556	8308	-3%
<i>Women & Children</i>									
Gynaecology	1147	1249	9%	657	696	6%	1804	1945	8%
Medical Paediatrics	878	824	-6%	0	0	-	878	824	-6%
Obstetrics	2498	2681	7%	1	2	100%	2499	2683	7%
SCBU	133	167	26%	0	0	-	133	167	26%
Total	4656	4921	6%	658	698	6%	5314	5619	6%
<i>Anaesthetics</i>									
ITU	652	620	-5%	0	0	-	652	620	-5%
Total	652	620	-5%	0	0	-	652	620	-5%
Total	19774	20145	2%	6521	6682	2%	26295	26827	2%

Table 13 – Outpatient Activity: Borders General Hospital 2008/09

Outpatient Activity: *New and Total Attendances*

	<i>New Attendances</i>			<i>Review Attendances</i>			<i>Total Attendances</i>		
	<i>Cumulative</i> 2007/08	<i>Cumulative</i> 2008/09	<i>Variance</i>	<i>Cumulative</i> 2007/08	<i>Cumulative</i> 2008/09	<i>Variance</i>	<i>Cumulative</i> 2007/08	<i>Cumulative</i> 2008/09	<i>Variance</i>
<i>Medical Services</i>									
Cardiology	822	896	9%	1996	2684	34%	2818	3580	27%
Clinical Oncology	117	271	132%	693	1212	75%	810	1483	83%
Day Hospital Outpatients	980	823	-16%	1256	1035	-18%	2236	1858	-17%
Dermatology	1881	2303	22%	1693	2076	23%	3574	4379	23%
General Medicine	2506	2694	8%	6192	6083	-2%	8698	8777	1%
Haematology	134	174	30%	1472	1565	6%	1606	1739	8%
Medical Oncology	45	0	-100%	327	0	-100%	372	0	-100%
Nephrology	92	132	43%	480	566	18%	572	698	22%
Neurology	317	577	82%	202	433	114%	519	1010	95%
Total	6894	7870	14%	14311	15654	9%	21205	23524	11%
<i>Surgical Services</i>									
ENT	2019	2282	13%	1281	1502	17%	3300	3784	15%
General Surgery	2535	2612	3%	2063	2321	13%	4598	4933	7%
Ophthalmology	2908	3019	4%	5969	6155	3%	8877	9174	3%
Oral Surgery	1132	1053	-7%	254	572	125%	1386	1625	17%
Orthodontics	373	439	18%	1022	1191	17%	1395	1630	17%
Orthopaedics	4609	4562	-1%	6345	6610	4%	10954	11172	2%
Rheumatology	312	339	9%	843	982	16%	1155	1321	14%
Urology	546	816	49%	1395	1641	18%	1941	2457	27%
Total	14434	15122	5%	19172	20974	9%	33606	36096	7%
<i>Women & Children</i>									
Colposcopy	188	283	51%	263	276	5%	451	559	24%
Gynaecology	1813	2152	19%	2174	2383	10%	3987	4535	14%
Medical Paediatrics (Acute)	496	602	21%	1101	1072	-3%	1597	1674	5%
Medical Paediatrics (Community)	152	190	25%	497	523	5%	649	713	10%
Obstetrics	1108	1181	7%	3446	3159	-8%	4554	4340	-5%
PAU	1970	2490	26%	0	0	-	1970	2490	26%
Total	5727	6898	20%	7481	7413	-1%	13208	14311	8%
<i>Anaesthetics</i>									
Anaesthetics	181	223	23%	95	95	0%	276	318	15%
Total	181	223	23%	95	95	0%	276	318	15%
Total	27236	30113	11%	41059	44136	7%	68295	74249	9%

6.2 Mental Health Activity

The tables below indicate a 1% decrease in new referrals and a 10% increase in total contacts over 2007/08.

Table 14 – Mental Health Network by Team – Summary

Total Referrals

Team	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Total
BCAT	38	40	41	37	41	27	29	44	29	33	35	25	419
CAMH	31	29	37	33	21	32	32	33	40	43	45	49	425
EAST	22	18	25	21	21	31	27	22	25	28	19	29	288
Liaison	45	45	46	59	41	40	39	62	42	43	29	33	524
MHOAT	30	36	46	19	44	35	35	55	37	31	31	50	449
PECS	31	30	24	31	31	32	31	26	35	38	28	33	370
REH	0	0	0	0	0	0	0	0	0	0	0	0	0
SOUTH	26	20	18	20	27	24	24	21	18	23	28	21	270
WEST	23	30	22	26	23	36	26	37	26	33	27	32	341
Grand Total	246	248	259	246	249	257	243	300	252	272	242	272	3086
2007/8 Total	261	342	270	256	255	256	268	254	232	234	225	277	3130
Difference	-6%	-27%	-4%	-4%	-2%	0%	-9%	18%	9%	16%	8%	-2%	-1%

Total Contacts

Team	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Total
BCAT	505	500	455	453	504	524	582	503	507	596	489	582	6200
CAMH of which are	145	199	195	164	187	185	178	162	145	185	191	233	2169
ADHD (under CAMH)	29	29	49	23	18	34	25	44	15	36	50	45	397
EAST	227	238	230	223	241	233	305	245	218	279	220	285	2944
Liaison	105	84	72	61	66	47	63	72	35	39	39	32	715
MHOAT	233	255	250	238	231	317	242	260	314	344	321	312	3317
PECS	98	83	82	83	59	76	103	61	84	94	62	58	943
REH	316	330	312	317	291	323	338	279	336	303	268	311	3724
SOUTH	224	197	210	242	161	196	164	162	163	217	187	220	2343
WEST	250	200	218	191	217	197	263	242	265	285	200	220	2748
Grand Total	2103	2086	2024	1972	1957	2098	2238	1986	2067	2342	1977	2253	25103
2007/8 Total	1759	2166	1965	1729	1892	1715	2008	1969	1641	2060	1904	2006	22814
Difference	20%	-4%	3%	14%	3%	22%	11%	1%	26%	14%	4%	12%	10%

In 2008, the Poynder View Dementia Outreach pilot was launched and this may account for the increase in contacts for the service.

Please Note:

The total contacts for the Attention Deficit and Hyperactivity Disorder (ADHD) Project has been disaggregated from the Child and Adolescent Mental Health (CAMH) team. During March, there were 188 and 45 contacts for CAMH and ADHD respectively - a total of 233 for the CAMH team.

6.3 Bed Statistics and Performance

Borders General Hospital Bed Occupancy has remained the same as last year, at 76%. Occupied bed days, has increased slightly from 91,230 to 91,902, an increase of 0.73%.

During the period an average of 61.2 patients were treated per bed (2007/08 60.1.) with an average length of stay of 4.6 days, the same as 2007/08. An inpatient bed lay empty for a mean 1.4 days (1.5 days) between the discharge of one patient and the admission of the next.

Community Hospital GP Acute bed occupancy has increased from last year, at 94% (compared to 85%). Occupied bed days have also increased from 27,634 to 29,365. During the period an average of 12.2 patients were treated per bed (2007/08 13) with an average length of stay of 28.2 (24.1 days). The longest

average length of stay was within the Knoll at 42.2 days, with the shortest length of stay within Kelso at 22.8 days.

Table 15 – Summary Bed Utilisation Statistics

Clinical Board	% Occupancy	Throughput	Aver LOS
BGH 2007/08	76%	60.1	4.6
BGH 2008/09	76%	61.2	4.6
Community Hospital GP 2007/08	85%	13	24.1
Community Hospital GP 2008/09	94%	12.2	28.2
Mental Health 2007/08	80%		
Mental Health 2008/09	82%		

Table 16 - BGH Statistics and Performance

BGH Bed Utilisation Statistics; *Cumulative*

	Period	Bed Complement	Average Available Beds	Occupied Bed Days	% Occupancy	Discharges	Admissions	Daycases	Throughput	Average Length of Stay	Turnover 1
DME Assessment	2007'8	30	49	13010	73%	493	43	0	10.0	26.4	10.0
	2008'9	48	41	12644	85%	466	30	0	11.4	27.1	4.8
ENT	2007'8	2	2	167	27%	176	177	290	104.1	0.9	2.6
	2008'9	2	2	128	18%	141	139	285	73.0	0.9	4.1
General Medicine	2007'8	139	138	43893	87%	8047	7691	773	58.5	5.5	0.8
	2008'9	116	142	42758	83%	8418	8000	959	59.4	5.1	1.1
General Practice	2007'8	9	8	2598	93%	103	62	0	13.5	25.2	1.9
	2008'9	9	11	2435	59%	88	34	0	7.8	27.7	18.9
General Surgery	2007'8	37	30	8354	75%	2958	2764	347	97.2	2.8	0.9
	2008'9	37	32	8870	76%	2730	2533	372	85.7	3.2	1.0
Gynaecology	2007'8	14	10	2351	62%	1147	1120	657	109.7	2.0	1.3
	2008'9	14	11	2185	53%	1249	1222	696	111.1	1.7	1.5
Haematology	2007'8	0	3	1237	100%	186	166	1068	-	6.7	0.0
	2008'9	0	2	807	100%	120	103	913	-	6.7	0.0
ITU	2007'8	8	12	1632	36%	652	79	0	52.2	2.5	4.5
	2008'9	6	6	1533	70%	620	69	0	-	2.5	1.1
Medical Paediatrics	2007'8	8	8	1290	46%	878	876	0	114.7	1.5	1.7
	2008'9	8	8	1359	49%	824	824	0	109.0	1.6	1.7
Obstetrics	2007'8	19	19	3628	52%	2498	2494	1	131.4	1.5	1.3
	2008'9	19	19	3918	57%	2681	2685	2	141.8	1.5	1.1
Ophthalmology	2007'8	3	3	58	6%	77	77	1117	27.8	0.8	12.4
	2008'9	3	3	40	4%	49	50	1005	17.9	0.8	19.6
Oral Surgery	2007'8	0	0	4	100%	5	5	549	-	0.8	0.0
	2008'9	0	0	6	100%	8	11	437	-	0.8	0.0
Orthopaedics	2007'8	34	33	9190	77%	1881	1560	420	57.2	4.9	1.5
	2008'9	36	34	10607	85%	1996	1698	580	58.3	5.3	1.0
Pain Control	2007'8	0	0	0	-	0	0	0	-	-	-
	2008'9	0	0	0	-	0	0	0	-	-	-
Palliative Medicine	2007'8	6	3	1207	95%	106	50	0	30.4	11.4	0.6
	2008'9	6	8	1665	56%	124	60	2	15.1	13.4	10.7
Radiation Oncology	2007'8	0	0	18	100%	4	4	992	-	4.5	0.0
	2008'9	0	0	32	100%	8	8	1182	-	4.0	0.0
Rheumatology	2007'8	0	0	4	100%	1	1	12	-	4.0	0.0
	2008'9	0	0	13	100%	5	5	8	-	2.6	0.0
SCBU	2007'8	8	4	844	56%	133	132	0	32.2	6.3	5.0
	2008'9	8	4	1118	71%	167	165	0	38.7	6.7	2.7
Urology	2007'8	3	5	1395	84%	428	397	295	94.4	3.3	0.6
	2008'9	3	5	1419	85%	451	440	241	98.3	3.1	0.6
Young Physically Disabled	2007'8	3	2	350	48%	1	0	0	0.5	350.0	386.0
	2008'9	1	1	365	68%	0	0	0	0.0	-	-
Total	2007'8	323	329	91230	76%	19774	17698	6521	60.1	4.6	1.5
	2008'9	316	329	91902	76%	20145	18076	6682	61.2	4.6	1.4

Table 17 - Community GP Bed Statistics and Performance

Community Hospital Bed Utilisation Statistics - GP Acute; *Cumulative*

	Period	Bed Complement	Average Available Beds	Occupied Bed Days	% Occupancy	Discharges	Admissions	Throughput	Average Length of Stay
Hawick Hospital	2007'8	24.0	24.0	7446	85%	352	351	14.7	21.2
	2008'9	24.0	21.7	7111	90%	277	275	12.8	25.7
Hay Lodge Hospital	2007'8	23.0	24.8	8381	92%	302	309	12.2	27.8
	2008'9	23.0	26.0	9400	99%	302	321	11.6	31.1
Kelso Hospital	2007'8	24.8	24.8	6674	73%	355	355	14.3	18.8
	2008'9	24.0	24.1	7827	89%	344	339	14.3	22.8
Knoll Hospital	2007'8	13.0	14.8	5133	95%	140	147	9.5	36.7
	2008'9	12.0	13.7	5027	100%	119	118	8.7	42.2
Total	2007'8	84.8	88.4	27634	85%	1149	1162	13.0	24.1
	2008'9	83.0	85.6	29365	94%	1042	1053	12.2	28.2

Table 18 – Community Continuing Care Bed Statistics and Performance

Community Hospital Bed Utilisation Statistics - Continuing Care; *Cumulative*

	Period	Bed Complement	Average Available Beds	Occupied Bed Days	% Occupancy	Discharges	Admissions	Throughput	Average Length of Stay
Teviot Bank	2007'8	16.0	15.3	4638	83%	73	70	4.8	63.5
	2008'9	17.0	16.0	4498	77%	86	79	5.4	52.3
Hay Lodge Hospital	2007'8	23.0	21.2	5348	69%	72	56	3.4	74.3
	2008'9	23.0	15.4	3929	70%	47	43	3.0	83.6
Kelso Hospital	2007'8	16.0	16.0	4748	81%	81	82	5.1	58.6
	2008'9	16.0	13.7	4046	81%	65	63	4.7	62.2
Knoll Hospital	2007'8	15.0	13.2	4375	90%	55	52	4.2	79.5
	2008'9	15.0	11.1	3285	81%	54	48	4.9	60.8
Total	2007'8	70.0	65.7	19109	79%	281	260	4.3	68.0
	2008'9	71.0	56.3	15758	77%	252	233	4.5	62.5

Table 19 – Mental Health Bed Statistics and Performance

In Mental Health, Occupied Bed Days has decreased 7% from 37,590 in the period 2007/2008 to 34,784 in April 2008 – February 2009. % Bed Occupancy has increased from 80% to 82%. The average Length of Stay, comparing the two years has decreased from 52.3 to 48.4 days.

Mental Health Bed Utilisation Statistics: *Cumulative*

Specialty	Period	Bed Complement	Allocated Bed Days	Occupied Bed Days	% Occupancy	Pass Days	Discharges	Admissions	Daycases	Average Len	
Huntlyburn	General Psychiatry	2007'8	30	9421	7193	76	965	317	315	0	22.7
		2008'9	30	9147	7472	82	880	352	351	0	21.2
Huntlyburn	Learning disability	2007'8	0	93	93	100	10	4	3	0	23.3
		2008'9	0	117	117	100	5	6	5	0	19.5
Huntlyburn	Psychiatry of Old Age	2007'8	0	1448	1448	100	88	21	20	0	69.0
		2008'9	0	1122	1122	100	81	19	19	0	59.1
West Brig	General Psychiatry	2007'8	5	1830	1378	75	94	15	15	0	91.9
		2008'9	5	1825	1398	77	284	30	25	0	46.6
East Brig	General Psychiatry	2007'8	12	4292	3314	77	306	137	144	0	24.2
		2008'9	12	4161	3700	89	456	119	121	0	31.1
Galavale	General Psychiatry	2007'8	11	3920	3624	92	257	39	39	0	92.9
		2008'9	11	3183	3057	96	153	30	33	0	101.9
Galavale	Psychiatry of Old Age	2007'8	0	141	141	100	0	1	1	0	N/A
		2008'9	0	744	744	100	0	1	2	0	744.0
Galavale	Learning disability	2007'8	0	0	0	0	0	0	0	0	N/A
		2008'9	0	177	115	65	0	2	1	0	57.5
Melburn Lodge	Psychiatry of Old Age	2007'8	16	5856	5285	90	17	23	20	0	229.8
		2008'9	16	5840	4999	86	86	15	13	0	333.3
Poynder View	Psychiatry of Old Age	2007'8	16	5856	4153	71	186	27	25	0	153.8
		2008'9	16	2656	1500	56	69	22	11	0	68.2
Wilton View	Psychiatry of Old Age	2007'8	16	5856	4229	72	135	36	30	20	117.5
		2008'9	16	5840	4367	75	11	20	25	3	218.4
Cauldshiels	Psychiatry of Old Age	2007'8	20	7316	5937	81	92	98	95	0	60.6
		2008'9	20	7293	5883	81	153	101	107	0	58.2
The Range	Learning disability	2007'8	1	955	777	100	0	0	0	0	N/A
		2008'9	1	372	310	83	0	1	0	0	310.0
Total		2007'8	127	47002	37590	80	2152	719	708	20	52.3
		2008'9	127	42477	34784	82	2178	718	713	3	48.4

Please Note:

Poynder View closed to inpatients in September 2008 for the year and the Mental Health Older Adults Dementia Project is running in its place as a pilot.

6.4 Cancellations & DNAs

The figure below highlights hospital cancellations by specialty during 2008/09 compared with 2007/08.

Figure 24 – Hospital Cancellations by specialty

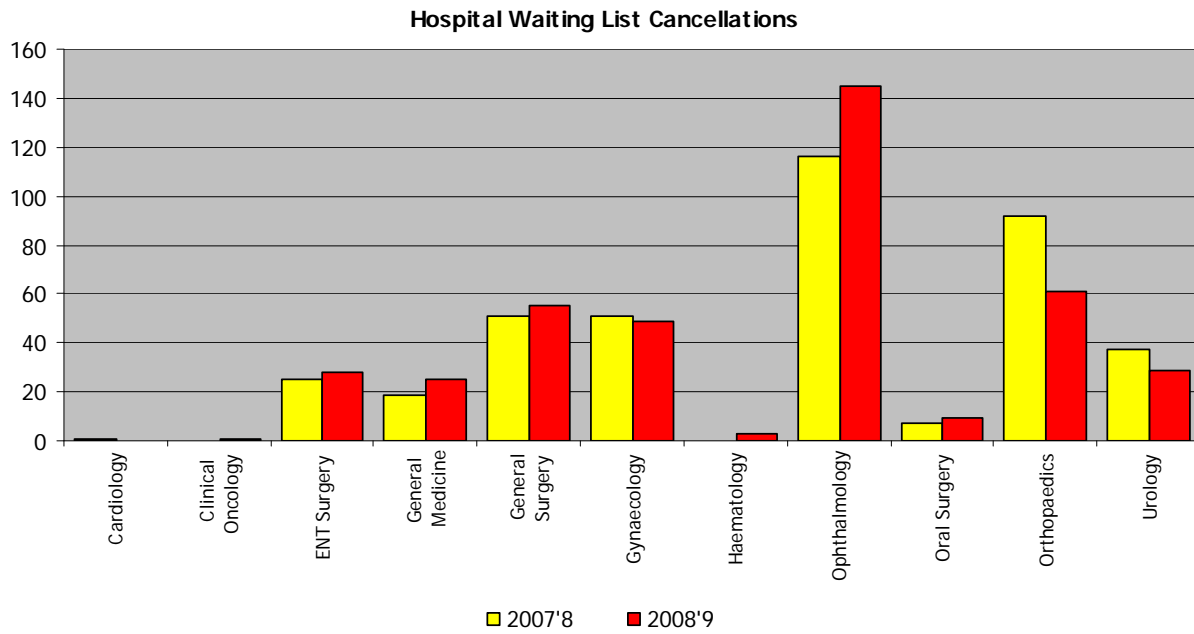


Table 20 – Patients failing to attend allocated appointments

Patients Failing to Attend Allocated Appointment

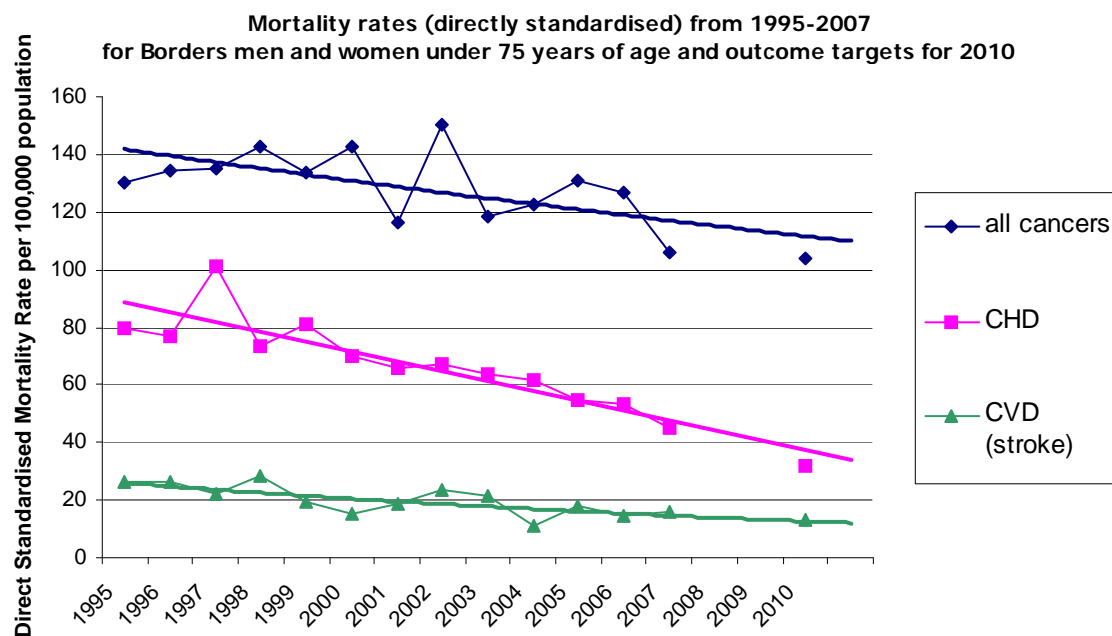
	<i>New Patients</i>				<i>All Patients</i>			
	Cumulative		Cumulative		Cumulative		Cumulative	
	Numbers	Percentage	Numbers	Percentage	Numbers	Percentage	Numbers	Percentage
	2007/08	2008/09	2007/08	2008/09	2007/08	2008/09	2007/08	2008/09
<i>Medical Services</i>								
Cardiology	43	54	5%	6%	214	310	7%	8%
Clinical Oncology	0	6	0%	2%	31	63	4%	4%
Dermatology	145	159	7%	6%	318	299	8%	6%
General Medicine	159	168	6%	6%	904	900	9%	9%
Haematology	5	7	4%	4%	82	76	5%	4%
Medical Oncology	0	0	-	-	14	0	4%	-
Nephrology	10	7	10%	5%	49	62	8%	8%
Neurology	35	37	10%	6%	58	70	10%	6%
Palliative Medicine	0	0	-	-	0	0	-	-
Total	397	438	-	-	1670	1780	-	-
<i>Surgical Services</i>								
ENT	146	153	7%	6%	311	322	9%	8%
General Surgery	170	176	6%	6%	390	403	8%	8%
Ophthalmology	139	164	5%	5%	534	601	6%	6%
Oral Surgery	85	93	7%	8%	124	114	8%	7%
Orthodontics	43	50	10%	10%	142	147	9%	8%
Orthopaedics	337	322	7%	7%	837	795	7%	7%
Rheumatology	8	11	3%	3%	32	52	3%	4%
Urology	52	56	9%	6%	189	184	9%	7%
Total	980	1025	-	-	2559	2618	-	-
<i>Women & Children</i>								
Colposcopy	26	25	12%	8%	95	89	17%	14%
Gynaecology	109	109	6%	5%	335	382	8%	8%
Medical Paediatrics (Acute)	42	30	8%	5%	234	167	13%	9%
Medical Paediatrics (Community)	18	22	11%	10%	104	119	14%	14%
Obstetrics	26	43	2%	4%	115	128	2%	3%
PAU	45	57	2%	2%	45	57	2%	2%
Total	266	286	-	-	928	942	-	-
<i>Anaesthetics</i>								
Anaesthetics	12	14	6%	6%	24	15	8%	5%
Total	12	14	-	-	24	15	-	-
Total	1655	1763	-	-	5181	5355	-	-

7 HEALTH IMPROVEMENT

Premature Mortality Rates

Mortality data for 2007 is included in Figure 25 below and tracks our progress against our local targets for CHD, stroke and cancer, included in the Joint Health Improvement Plan. Last year the 20% reduction target by 2010 for all cancers was looking challenging, however there was a welcome fall in the local mortality rate in 2007. Although this drop is statistically significant we should be cautious in assuming that this trend will continue in the future. The main influence on mortality rates between 2008 and 2010 will be risk factor change over the last decade, particularly the reduction in smoking prevalence. Changes in risk factors from 2008 and in screening and treatment services are unlikely to have a significant impact. CHD premature mortality shows a continuing downward trend. Hitting the 2010 target of a 60% reduction on the 1995 level will require continuing vigorous action on population risk factors, such as smoking, physical activity and diet. The need for this was emphasised by the increase in mean population levels of blood pressure, cholesterol and obesity from the 1998 Scottish Health Survey to 2003. Improvements in the management of heart attacks through thrombolytic drugs and primary angioplasty, and continued improvements in the secondary prevention of CHD through the QOF in primary care will also contribute to achieving this target. Finally, local progress towards the 50% reduction target for stroke is good and it seems likely that this will be achieved by 2010.

Figure 25 – Mortality Rates



Changes resulting from the adoption of ICD10 in January 2000 make the trends potentially discontinuous and therefore should be treated with some caution.

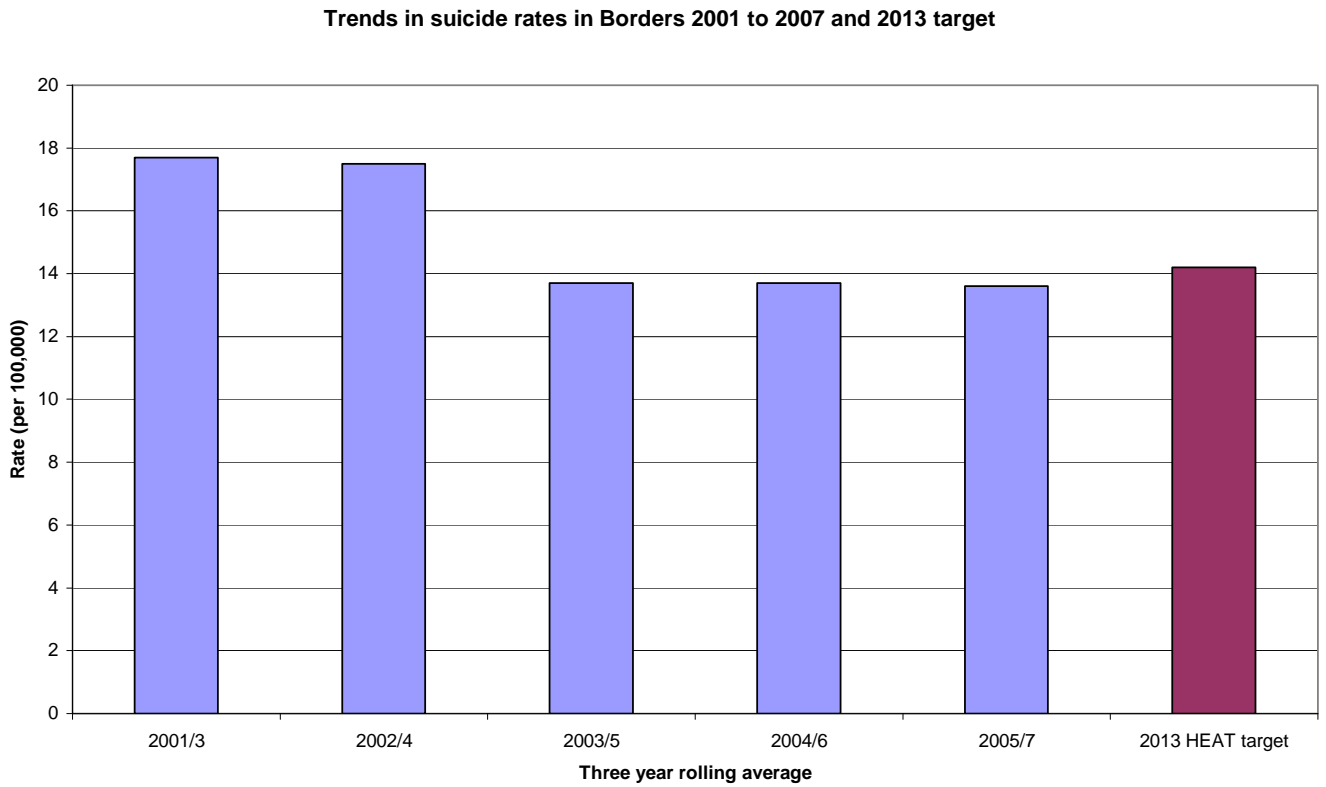
Population Risk Factor Trends

The Joint Health Improvement Plan 2007 Update and last year's Managing our Performance report provided data on other risk factors from the Scottish Health Survey of 2003 for the South of Scotland region (Borders, Dumfries and Galloway) and showed progress in a number of areas including smoking and physical activity levels in men and women. Unfortunately we do not have any new data to report on. However, the fourth Scottish Health Survey commenced in 2008 and Borders has purchased an expanded sample during 2008 and 2009. This will mean that we will have reliable data to review our progress in 2010, 2/3 years earlier than otherwise.

Suicide Rates

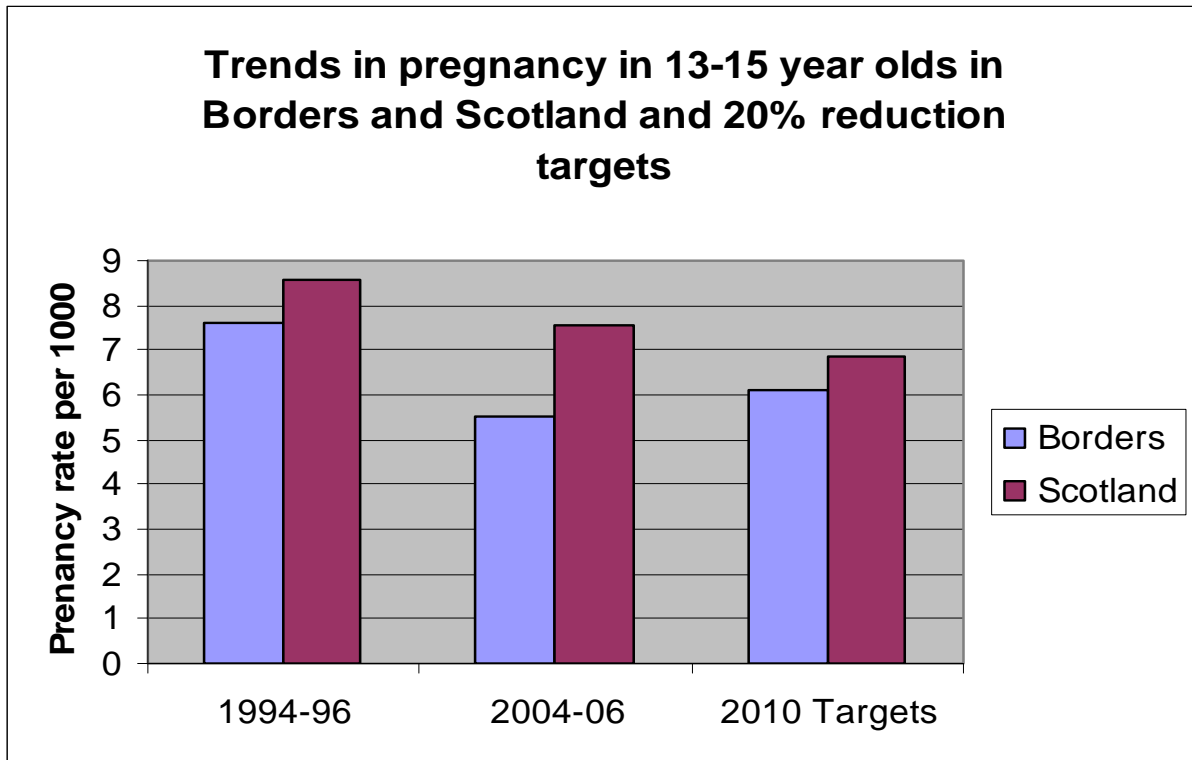
Fortunately the number of suicides in Borders is relatively small at approximately 15 each year, however, this does create difficulties in monitoring, in that variation year on year can be large and trends hard to see. Three year rolling averages are therefore being used to help iron out these annual fluctuations and help to see underlying trends. Figure 26 includes the latest confirmed data for 2007 and shows that the local rate is still below the 2013 target.

Figure 26 - Trends in Suicides



Teenage Pregnancy Rates

The pregnancy rate in 13-15 year olds in Borders, which is shown in Figure 27 continues at a level below the national target and below the rate for the country as a whole.

Figure 27 - Trends in Pregnancy Rates

Appendix 1 contains an update of progress against all health improvement HEAT targets. Progress is mixed and will require continued focused efforts over the next few years. The child healthy weight intervention target is the only one shown with a “red” status. This is a very difficult area in which to engage children and families and retain their involvement to the end of an intensive 10 week programme. This national target is also extremely ambitious with the result that many Boards are experiencing difficulties in achieving it. Nevertheless, corrective action has been taken which should increase local activity substantially, but may still fall short of this stretching target.

8 CORONARY HEART DISEASE STROKE, DIABETES, RESPIRATORY CONDITIONS

In response to the Coronary Heart Disease (CHD) and Stroke Strategy for Scotland and the Scottish Diabetes Framework, NHS Borders established Managed Clinical Networks (MCNs) in CHD, Stroke and Diabetes. A subsequent bid for resources from Scottish Government Health Department has supported the development of a Respiratory MCN

The MCNs are working progressively in:

- bringing together patients, carers and health professionals from all disciplines to identify local needs and priorities;
- adopting a patient-centred approach to service development
- bridging traditional boundaries and forging links with national and regional networks to address capacity issues and access to tertiary services.

All five MCNs in Borders work closely together to contribute to the overarching Long Term Conditions agenda and organisational targets linked with prevention of avoidable admission, reduction of length of stay and supporting self-management. The MCNs are all also key partners in taking forward the non-malignant palliative care work.

An accreditation process is currently being developed in line with national guidelines and will apply across the MCNs.

Coronary Heart Disease

In line with the National CHD and Stroke Strategy document, the Borders CHD MCN has contributed to the development of the Joint Health Improvement Plan, which includes current and future actions to prevent CHD and stroke. Joint funding from across the MCNs has been made available to support the development of the Keep Well programme in Borders. An important aspect of this programme will be to support the implementation of SIGN 97 e.g. progressing the nurse-led screening initiative developed under the auspices of the CHD MCN.

The Inpatient Chest Pain Service, which links closely with the unscheduled care programme is now established and feedback from this has been very positive to date. The MCN is undertaking work to review the Heart Failure pathways and cardiac rehabilitation programme and is currently assessing the feasibility of linking with the telehealthcare agenda in support of self-management and prevention of avoidable hospital admission

Strong links continue with tertiary centres and neighbouring MCNs with a view to planning cardiac services in the future, specifically looking at access to cardiac interventions.

Partnership working with Chest, Heart and Stroke Scotland (CHSS) is ongoing to develop wider support for patients with coronary heart disease, taking into

account the ‘Hearty Voices’ pilot, locally held sessions and the organisation of a specific event for the Borders. The partnership with CHSS is now developing more widely across the MCNs.

The CHD MCN is taking a lead role within the non-malignant palliative care work in developing anticipatory care plans and criteria to help define when someone is moving into an end-of-life phase of care.

Stroke

The Stroke MCN has now completed a review of its structure and workplan following a period of change in terms of acute service accommodation and MCN leadership. Dr Susan Kerr has been appointed as MCN Lead Clinician supported by Sandi Haines, Stroke Coordinator in a deputy role. In line with the other MCNs, the Stroke MCN Steering Group and sub-groups will be interagency and multi-disciplinary and will involve patients and carers.

Sub groups have been established to take forward the agreed priorities and workstreams which include: Patient Information; Audit & IT, Training & Education (which will feed into the LTC Training & Education Programme), Rehabilitation, Thrombolysis. Already, the thrombolysis programme has progressed and is nearing implementation. The MCN will develop a comprehensive stroke pathway which will provide the framework for these workstreams.

Diabetes

The Diabetes MCN has continued to work across care sectors. Work over the last twelve months has included the revision of clinical protocols in line with national standards and the establishment of an ICP for surgical patients with diabetes. The MCN has ongoing links with Public Health in the development and implementation of retinopathy screening programmes across Borders.

An insulin strategy has been developed and closer links with Children’s services have supported the use of insulin pumps in paediatric services. This has raised some additional challenges in terms of sustainability and capacity across the service. A specific clinic for adolescents with diabetes has also been established.

SCI-DC has been installed in all practices across the Borders and the clinical system is fully operational in the BGH. SCI DC is a comprehensive electronic patient record linking patient information from primary and secondary care All patients currently attending hospital clinics are recorded on SCI-DC clinical and have CHI, type of diabetes and date of diagnosis recorded. This system has facilitated the ongoing monitoring of diabetes services and enables NHS Borders to participate in the Scottish Diabetes Survey on an annual basis

A number of initiatives are under way to empower patients to take control of their diabetes and reduce complications. The MCN has developed a Website for patients which provides information on all aspects of care including emergencies. A standardised “information pack” for staff to give to patients has been agreed and is accessible to staff and patients via the web page. The

web page will “go live” within the next few weeks. The Diabetes team has also developed structured education programmes to maximise patient empowerment.

Training and Education is a key strand of the Diabetes MCN workplan. Training modules have been developed and delivered through the MCN as part of the Long Term Conditions Training & Education Programme. The next phase of the diabetes element of the programme is already underway, with secondment placements in place for practice nurses to experience acute care within BGH. Plans for the development of wider educational support from within the specialist nursing team are in progress and will incorporate education for acute services and outreach community support.

Specialist podiatry services for patients with diabetes continue to develop. This service is providing swifter access to specialist advice for patients with potentially serious problems in an attempt to avoid admission and minimise the potential for complications in this patient group. Foot screening and recording training is underway to ensure a consistent approach across the area.

Respiratory Conditions

The Respiratory MCN is still in the relatively early stages of development but has confirmed its strategic direction and workplan. Working groups have been established to take forward the identified workstreams.

A Scottish Enhanced Service (SES) was taken up by NHS Borders in 2008/09 which provided support to the work of the MCN in its development of COPD pulmonary rehabilitation by enabling the participation of GP practices. A COPD Pulmonary Rehabilitation programme has been developed and is to be trialled in August 2009. A further SES is currently in development in liaison with Primary & Community Services and will be considered by LNC in due course.

The Oxygen sub-group has developed clear assessment processes and protocols for use with patients who may require oxygen therapy. This work is being finalised and will then be rolled out across Borders.

The Spirometry sub group was formed to review the processes and protocols. A also training session for Practice Nurses was developed. This group has now achieved its initial aims, but will be reformed if issues arise which require attention.

In Spring 2009, the Breathe Easy group was successfully relaunched and the MCN will be supporting the group to promote World COPD in the Autumn.

The MCN have also agreed to be part of NHS QIS pilot for COPD draft Standards later this year.

Along with the CHD MCN, the Respiratory MCN is taking a key role in the work around Non-Malignant Palliative Care and is developing anticipatory care

plans and criteria to help define when an individual is moving into an end-of-life phase in their condition.

Long Term Conditions

“Living Well with Long Term Conditions in Adults” the Long Term Conditions (LTC) Strategy and workplan for Borders was approved by Borders CHCP in December 2009.

The work to develop the Strategy identified an “ideal” journey for someone living with long term conditions and existing good practice, as well as the challenges we face across Scottish Borders. It suggested a strategic response and workstreams to address these issues and is in line with the national Long Term Conditions Collaborative and CHP Long Term Conditions Toolkit requirements NHS Borders is participating in the LTC Collaborative and submits regular data and information as part of its programme of work.

Three main workstreams were prioritised to progress within the local LTC agenda: Communication/ Information Sharing, Intermediate Care and Self-management,

A Long Term Conditions website *“Borders Health in Hand”* has been developed. The website is a resource for people living with long term conditions which offers advice ,support and signposting.to relevant services or websites. The information has been translated into six languages to date and the next phase of development will see an expansion of content and scope of access.

An action plan for developing self-management approaches and programmes is under development and has been informed by feedback from a public event and liaison with voluntary and partner organisations. In addition, as part of a wider approach to anticipatory care, a generic crisis-management protocol has been developed and within the non-malignant palliative care work and the work being taken forward by the MCNs, anticipatory care plans and anticipatory social care plan are being progressed.

Intermediate Care now sits as a workstream of the Primary & Community Care Partnership Board, but the LTC agenda has been integral to the successful project bid to the Joint Improvement Team to develop a non bed based model of intermediate care.

A rolling LTC Training & Education Programme has been established with the first phase focussed on primary care and delivered under the auspices of the “TiME” programme. (Time for Multi-disciplinary Education) This has been successfully received with the first modules being delivered through the Diabetes MCN. The Respiratory MCN has developed specific modules and the wider content will be expanded according to need. The next phase of the process will look at training needs within acute services.

9 HEALTH CARE ASSOCIATED INFECTION

Progress has continued in addressing nationally set standards for HAI & Infection Control:

- New *NHS QIS Standards* were introduced in March 2008 and Compliance was subject to internal audit Sep 08. Following the internal audit a gap analysis and action plan for compliance with these new standards has been developed for the ICC and work is ongoing.
- 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. The criteria 'Not Met' await measuring tools from Health Protection Scotland for them to be implemented.
- 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. Hand Hygiene compliance is on trajectory to achieve the target of 100%. The latest audit shows a compliance of 95%.
- MRSA bacteraemia rate has remained within control limits for the last twelve quarters.
- Data submitted to Health Protection Scotland (HPS) for Staph. aureus bacteraemia indicates we are on track for the HEAT trajectory as outlined in the LDP.
- Infection Control are addressing Patient Focus Public Involvement (PFPI) goals through lay infection control volunteers and a now established public e-mail group.
- 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'. SEHD directed that 25% of audits should be undertaken with a member of the public, and three representatives have been active in their assistance and support.
- At Board level, the corporate objective for HAI: Infection Control was fully met: ie "Monitor progress and continued achievement in HAI standards and Infection Control policies throughout 2008/09"

Resources have been made available both locally through the Health Plan and centrally from the Scottish Government to provide an Infection Control budget, to resource rapid screening for MRSA. There are changes planned within the

Infection Control Team and these are being progressed with the input of the Scottish Government.

10 PATIENT FOCUS PUBLIC INVOLVEMENT

In 2008/09, the work of Patient Focus, Public Involvement (PFPI) was further progressed and developed. The Public Governance Committee (PGC) and the Clinical Governance Committee continue to provide oversight of this work both within NHS Borders and at regional and national levels. The Public Governance Committee 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 Clinical Governance Committee similarly has oversight of the Patient Safety and Patient Experience programmes and outcomes within NHS Borders.

During 2008/09 a dedicated Public Involvement & Communications Team was established to support this work and provide the direct link with management and staff within NHS Borders.

The main focus of PFPI work has remained with the two groups within NHS Borders which were created to provide a public perspective on existing and developing services. The Borders Public Partnership Forum (PPF) was established in 2007 and provides a public and community view on services jointly provided by Scottish Borders Council, NHS Borders and the Voluntary Sector. The Chair of PPF attends meetings of the CHCP as a full member. A sub-group of the PPF has been established to act as the Public Reference Group for the NHS Borders Strategic Change Programme. The other group is the Involving People Network (IPN) which has a current membership of 16. IPN members are involved with 25 programmes, projects and involvement opportunities including working on the following activities during 2008/09:

- 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 co-ordinated or facilitated through the Public Involvement & Communications office numbered:

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

These included dental services strategy, closure of branch surgeries in Yetholm & Morebattle and Oxton, the Strategic Change Programme, Roxburgh Street Surgery redesign, redesign of respiratory clinics, and proposed Patients' Rights Bill consultation.

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, following ongoing engagement with key stakeholders a Community Engagement event was held. At this event, key views and findings were brought together into a series of case studies which were approved by members attending the event. Among the key points that patients and the public wish to be considered as part of ongoing case study work are, 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. A list of the case studies topics is found below:

- Lay involvement in quality reviews in Primary Care services
- Building public involvement through an eGroup for Infection Control
- Improved access and awareness of physical health needs of people with a Learning Disability
- Reduction in Podiatry Waiting Times
- Improved interface between Health & Social Care Community Care services
- Public Reference Group for NHS Borders Strategic Change Programme.

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

During 2008/09, NHS Borders has been working towards implementing the guidance in the Scottish Government's Strategy for Volunteering. In February 2009 CEL 8 (2009) Guidance on Reimbursement of "Out of Pocket Expenses" for Volunteers within NHS Scotland was published, the guidance in this CEL is being implemented by NHS Borders as from 1st April 2009.

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.

11 STAFF GOVERNANCE AND WORKFORCE DEVELOPMENT

Workforce planning is a key element of strategic planning, and managing the changes taking place within the workforce, and the wider population, has been recognised as crucial if we are to secure the workforce we require to deliver services to the population of the Scottish Borders. Over the last 2-3 years NHS Borders has begun to build expertise and experience. Service managers who lead and run our services undertake the bulk of workforce planning, and NHS Borders has embarked on a programme to develop local workforce capacity and capability of service managers in compliance with the recognised six-step methodology.

The Framework for Local Workforce Plan (LWP) 2009 was agreed by the Workforce Board on 19th May 2009. All Clinical Boards are represented within the Board and has developed actions for specific areas or issues that they feel are particularly important to their staff. However, over the course of the year it has become apparent that actions have blended and good practice has ultimately been transferred and applied throughout NHS Borders. The workforce planning cycle for 2009 has begun and will include the submission of medical workforce projections following the issue of national guidance. A workforce statistical report has been developed to support the workforce plan and is issued on a quarterly/end of year basis. The Local Workforce Plan will be published on 1st October 2009 and the Strategic Change Programme will be a key feature illustrating how Workforce Planning is integrating with service and financial planning in response to future service challenges. The date specified in the Corporate Objective to produce the Workforce Plan is 31st March 2009, but it was agreed at the Workforce Board that this would be 1st October 2009.

Significant changes in skill mix and the plans to take this forward:

- Skill mix and role development through application of NHS Career Framework and KSF benefits. Successful NHS Borders SVQ Programmes in Care to develop the Health Care Support Worker role, including Acute and Community Services, .Pharmaceutical Services, Maternity Care Assistants and Allied Health Professionals. NHS Borders is investing in skilling up the current Healthcare Support workers over the next 5 years to pro-actively prevent gaps in the workforce. Maternity Care Assistants relevant to HEAT target H7;
- Extended roles e.g. Senior physiotherapists run their own clinics augmenting the medical support for orthopaedic clinics and successful extension of Radiographer reporting. – HEAT Target A10;
- Advanced roles e.g. Hospital at Night Practitioners and Paediatric/Neonatal Nurses undertaking Clinical Decision Making Module increase capacity;
- New roles for non-medical workforce solutions e.g. Physician Assistant (Anaesthesia) programme and Surgical Assistant;
- Specialist Nurses are creating anticipatory care plans for chronic disease management; this is successfully avoiding admissions and providing early support of discharge

- New specialist nurse roles have been developed within Cardiology, Diabetes, and Respiratory Medicine. Further development of ambulatory care, and development of criteria led discharges services are anticipated
- Ongoing development of the whole dental team i.e. across dentists, dental care professionals, oral health educators and dental administrative and clerical staff is key to Dental Services strategy.

During 2008/09, the Pay Modernisation Benefits Delivery Plan was approved by the Workforce Board and submitted to SGHD.

In 2008/09 a Staff Survey was produced and distributed amongst all staff. Response rates were good compared with national rates. The staff governance action plan was updated in light of the responses and this has been successfully audited.

12 FINANCE

After managing a recurring deficit for a number of years, NHS Borders returned to recurring balance in 2006/07 and this has been sustained through to the end of 2008/09. This is a significant achievement especially when set against a backdrop of managing the impact of pay modernisation; increasing drug and energy costs; increased referrals to specialist services and achieving shorter waiting times.

Sound budget management has again underpinned the position, and there was an excellent performance in delivering challenging efficiency savings targets in 2008/09.

In terms of detail, the Board spent (subject to audit) £201m last year, which was just £63,000 under the agreed operational budget. Subject to SGHD agreement, this funding will be carried forward to 2009/10 on a non-recurring basis.

Specific pressures that arose in 2008/09 included

- further increases in specialist referrals outwith the area;
- increases in drug costs in the primary care sector;
- significant investment being required in medical staffing in response to Modernising Medical Careers and the European Working Time Directive;
- Ongoing costs associated with Agenda for Change and
- Increased cost of risk sharing arrangements across NHS Scotland

Looking ahead, the new allocation formula (NRAC) highlights that NHS Borders remains significantly above its target allocation and therefore over the next few years the Board is likely to receive only the minimum agreed uplift. This will result in material pressures given the expected increases in population and demographic changes.

Given the UK economic outlook; likely lower levels of growth; ongoing cost pressures and the requirement to deliver at least 2% recurring efficiency savings in each year, it is clear that the performance in 2008/09 needs to be maintained and increased if NHS Borders is not to slip back into recurring deficit.

Capital expenditure in 2008/09 amounted to £6m, with £1.4m agreed to be carried forward to future years. The main schemes progressed were the two Dental Centres in Hawick and Coldstream.

13 CLINICAL GOVERNANCE

External Reviews and Inspections

The following reviews have taken place during 2008/09:

- **Integrated Care Pathway for Mental Health**

The final standards for Integrated Care Pathways for Mental Health were published in December 2007. GP referral guidance is at a final draft stage, and is currently with the GP sub-committee for consultation. The Borders Risk Assessment Tool (BRAT) and Crisis Card are also being revised in keeping with ICP developments. The development of the NHS Borders Mental Health Care Plan is in the early stages of development. A draft Communication and Education strategy has been developed and is currently out for comment and consultation.

NHS Borders has a nominated Accreditation Co-ordinator who is supporting our progress in achieving a foundation level accreditation within the agreed timescale of September 2009. A recent visit from one of the regional co-ordinators helped to ensure NHS Borders progress towards the appropriate level of accreditation.

- **Out-of-Hours Emergency Dental Care**

This peer review visit took place in December 2008. Overall the feedback was positive. Most challenges identified by NHS QIS are in the process of being addressed, led by the Service Manager through the use of gap analysis. The local report for NHS Borders was published in May 2009. The national overview is due for publication later in the year.

- **Learning Disabilities**

In February 2009, NHS Borders was assessed against Learning Disability Quality Indicators 2 (Promoting Inclusion & Wellbeing) and 3 (Meeting General Healthcare Needs). Feedback from the review team at the end of the visit was helpful and will support future development of this service. NHS Borders local report is expected to be published in early summer with the national overview following towards the end of 2009.

- **Food, Fluid & Nutritional Care in Hospitals**

The self-assessment documentation and evidence were submitted in February 2009 in preparation for the peer review visit to NHS Borders on April 2009. This review is the first to be completed using the online self-assessment tool developed by NHS QIS. While it is useful tool, there are some areas for development identified by NHS Borders that have been feedback to the NHSQIS team.

- **Clinical Governance & Risk Management**

The 2nd round of the Clinical Governance and Risk Management peer review process is currently underway within NHS Borders. The self-assessment was submitted along with supporting evidence in March 2009. Feedback from analysts was received in April 2009. It was noted that for a number of core areas NHS Borders did not meet the levels projected at the time of

2008/09 Out-turn report on performance submission. However, we were given the opportunity to comment further and refine our submission. The peer review visit to NHS Borders took place in May 2009.

Patient Safety

The Patient Safety Programme, which is focussed on prevention of harm and improvement in healthcare outcomes has now been running for 16 months and is on target with the Institute of Healthcare Improvement assessment scale for individual hospital performance. NHS Borders is demonstrating sustained improvement through outcome measures in Hand Hygiene, Sub acute Bacteraemia and C. Difficile rates. All the clinical work streams are at various stages of completion and spreading of the change processes has begun in the General Ward and Critical Care work streams. Members of staff from Borders Emergency Care Services and from Mental Health attended the most recent learning session in Glasgow in May 2009

Clinical Risk Management

In the year 2008/09 there was a total 2618 clinical adverse events reported. This figure demonstrates a slight increase on the year 2007/08 which saw a total of 2490 clinical adverse events reported. In the year 2008/09, 1155 of the total number of events reported were events with an 'actual outcome' and 1463 were recorded as a 'near miss'. Table 1 below breaks this down further.

Table 21 – Summary of clinical adverse event reporting

	2008/09		2007/08
	Events	Events with actual outcome	Events
Acute Services	1962	714	1617
Primary and Community Services	301	170	256
Mental Health Services	295	224	289
Learning Disability Service	43	41	317
BECS	17	6	11
Total	2618	1155	2490

The Clinical Risk Management Team follows up events with actual outcome graded as major or extreme. All of these do not necessarily go on to warrant fuller investigation through Root Cause Analysis (RCA). In 2008/09 a total of 8 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 total of 136 complaints were received during 2008/09 compared with 171 during 2007/08. These are broken down by Clinical Board/service area as follows:

Table 22 – Summary of Patient Feedback

	2008/09	2007/08
Acute Services	101 (75%)	130 (76%)
Primary & Community Services (includes Out of Hours Service)	25 (18%)	22 (13%)
Mental Health Services	10 (7%)	19 (11%)
Learning Disability Services	0	0
Total	136	171

A total of 2638 compliments and commendations were notified to the Clinical Governance Department during 2008/09; this represents only a small proportion of the thanks received by staff. The total patient feedback was therefore 2774 of which 5% were complaints and 95% compliments/commendations.

During 2008/09, two investigations took place in relation to NHS Borders and a report was subsequently published by the SPSO. The organisation accepted all the recommendations made by the SPSO within this report and appropriate action was taken to improve or alter working practices where necessary. The report was made available to all staff on the Intranet and to the public via the NHS Borders website.

Across all NHS organisations in Scotland, a total of 89 reports were published by the SPSO in the year. The reports for NHS Borders equate, therefore, to 2.2% of the total SPSO investigations.

Clinical Audit

Much of the clinical audit resource has continued to be invested in providing the growing national audit data requirements for cancers, Managed Clinical Networks and Hip Fracture / Access to Musculoskeletal Services. However, there has been a small increase in the number of local clinical audits registered during this year. The table below describes an overview of clinical audit activity.

A total of 83 locally driven audits were registered between April 08 and March 09. A summary of overall audit activity is at Table 3 below

Table 23 – Summary of Clinical Audits

Total Number NHS Borders audits registered April 2008– March 2009	83 (8% increase from 2007/08)
Audits carried forward from 07/08 (i.e. not completed in 08/09, continuous audits, registered towards end of year etc)	30
Total Number of Audits on register for year 08/09	113
Number of audits cancelled (i.e. no longer required, staff shortages etc)	4
Clinical Audit Support Team (CAST) Support	
Audits wholly completed by CAST	27/109 (25%)
Audit Tool development	29/109 (27%)
Audit Data Entry	33/109 (30%)
Audit Data Analysis& Report	33/109 (30%)
Audits still ongoing as of 1 April 09	37/109 (34%)
Report received from completed audit	56/109 (51%)
External national audits (not entered on Clinical Audit Register)	Total 9 All case ascertainment and data entry by CAST

The audit register collects detailed information and reports quarterly across the organisation and by clinical board. These reports are available on the Clinical Audit Support Team (CAST) intranet section.

Two successful half day Introduction to Clinical Audit courses were run in June and September 08 and twenty one clinical staff attended. Evaluation was positive. The course content has been reviewed in the light of feedback and will run again later this coming year.

The first Clinical Audit Oscars award took place at a lunchtime meeting on 4th March 2009. This award has been introduced to reward the top three clinical audit reports submitted during 2008/09, taking into account both the quality of the audit and the contribution to improving patient care.

Research Governance

The Research Governance process has been managed and maintained by the Clinical Governance Support Team since early 2008. However, in early 2009 a major review of the systems and process was undertaken to streamline the Research & Development function.

A new database has been created to record relevant information for each study along with the development of an action log to ensure progress of studies are monitored more effectively. General administration of the Research and Development function has become more streamlined with a procedure manual now in place to ensure consistency across all studies.

The Research Governance Committee now meets on 3 monthly basis and has an established remit. This will be reviewed in the near future to ensure that the remit of the group is kept up-to-date and meets the requirements of this function.

Weekly telephone meetings are now held between NHS Borders and NHS Lothian who provide guidance and support to the R&D function in the Borders. Discussions have taken place with NHS Lothian to see what functional aspects of Research & Development they can carry out on behalf of NHS Borders.

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 three organisation wide clinical policies; Bedrails, Consent to Treatment, and Standards for the Document Management of NHS Borders Clinical Policies, Procedures, Protocols and Guidelines have been developed and implemented. The Completion of Health Records Policy has also been reviewed.

Using the JBI resource and working with the Training and Development Team 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. The external guideline assessment and review process has been further refined and support infrastructure reviewed. The Clinical Guideline and Information Group has been reconstituted in recognition of the change in the role and function of the group over a period of time. The renamed Clinical Guidelines Operational Group will continue to oversee the dissemination, the assessment and monitoring of implementation of SIGN and NHS QIS guidance. A subgroup of CGOG holds a monthly business meeting and a meeting of the full group is held quarterly. Although smaller in number than the previous group, CGOG continues to have representation from Acute Services, Clinical Governance, Primary and Community Services, Training and Development and Public Representation.

During 2008/09 the following national guidelines were assessed locally:

Table 24 National Guidelines assessed

SIGN	10
NHSQIS Best Practice Statements	7
Evidence Notes	6
Health Technology Assessment	3
NICE Technology Appraisal	6
TOTAL	32

Work continues on the development of the Borders Public Information Support Site for You (BISSY), a web based patient information management system.

There are now 461 NHS Borders leaflets on the site.

14 SUMMARY

Overall we have ensured strong performance in the past year. A clear focus on the major deliverables coupled with strong teamwork has delivered excellent results. This report will be used to inform the Annual Review with the Scottish Government in September 2009.

Moving into 2009/10, the KPIR has been streamlined to allow more effective reporting to the Board. Work is currently underway to ensure that progress towards a wider range of HEAT targets is reported on a more frequent basis.

The range of HEAT targets and Corporate Objectives for 2009/10 will continue to challenge the Clinical Boards to deliver modern and efficient services whilst continuing to improve the quality of healthcare we provide for the people of the Borders.

Looking ahead to 2009/10 NHS Borders Board will receive monthly progress updates against key targets and priority areas across the service.