

## Borders NHS Board



### MANAGING OUR PERFORMANCE: 2009/10 OUTTURN REPORT

#### Aim

The aim of this report is to update the Board and allow members to assess the progress made by NHS Borders against the full range of HEAT targets, Key Performance Indicators and Corporate Objectives during 2009/10.

#### Background

Throughout 2008/09 NHS Borders Board received Key Monthly Performance Reports (KPIR). These reports shared timely and accurate information on system-wide performance and allowed the Board to assess progress in meeting key targets. At the beginning of 2009/10 it was agreed that the Board would no longer receive the full KPIR but instead a condensed version would be presented monthly. This has allowed the Board to have a more focused discussion on areas where performance has been deviating from the planned trajectory and the reasons for this and this has been further enhanced for 2010/11 with the introduction of the Board HEAT Scorecard. The Board may continue to request further information on performance when it is required and this shorter report also allows members to recognise when performance meets and surpasses targets.

The Out Turn Managing Our Performance (MOP) report is an end of year analysis on the range of indicators contained in the KPIR during 2009/10 and provides a commentary on performance up to the end of March 2010, along with information on progress during the full 12 months of 2009/10. The MOP is found at **Appendix 1**.

The MOP gives a summary of performance of the range of HEAT targets and KPIs which can be reported on a monthly basis. For HEAT targets which cannot be reported on a monthly basis, a table has been included in each section which details which HEAT targets are reported through the MOP and which are reported through the Corporate Objectives appendix.

The 2009/10 Corporate Objectives, as approved at the June 2009 Board meeting, requires progress to be reported to the Board on a 6 monthly basis. Please refer to **Appendix 2** for the update on Corporate Objectives progress again at the end of March 2010.

At the Board meeting in November 2009, it was agreed that the following workplans which were originally included as Corporate Objectives CO8 – C10, CO33-CO34, CO47, CO66-67 were removed and these are reported through the SOA reporting mechanisms so as to avoid double reporting. Full details can be found in Appendix 2.

## Summary

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

## Recommendation

The Board is asked to **note** the 2009/10 Out Turn Managing Our Performance Report.

<b>Policy/Strategy Implications</b>	Regular and timely performance reporting is an expectation of the Scottish Government given the development of Local Delivery Plans
<b>Consultation</b>	Aspects of information contained within the MOP has already been reviewed by the Board and the Clinical Executive
<b>Consultation with Professional Committees</b>	Aspects of information contained within the MOP has already been reviewed by the Board and the Clinical Executive
<b>Risk Assessment</b>	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
<b>Compliance with Board Policy requirements on Equality and Diversity</b>	The implementation and monitoring of HEAT targets will require that Lead Directors, Managers and Clinicians comply with Board requirements
<b>Resource/Staffing Implications</b>	Any resource implications will be addressed through the Health Plan Prioritisation Process

## Approved by

Name	Designation	Name	Designation
June Smyth	Assistant Director of Planning & Performance		

## Author(s)

Name	Designation	Name	Designation
Susan Yates	Planning & Performance Officer		



**MANAGING  
OUR  
PERFORMANCE  
2009/10  
Out Turn Report**

**JUNE 2010**

**Planning &  
Performance**

# CONTENTS

---

- 1 Introduction & Guide**
- 2 Health Improvement**
- 3 Efficiency**
- 4 Access to Services**
- 5 Treatment Appropriate to the Patient**
- 6 Activity & Bed Utilisation**
- 7 Summary**

# 1 INTRODUCTION & GUIDE

---

The aim of this report is to update the Board and allow members to assess the progress made by NHS Borders against a number of key performance indicators and deliverables during 2009/10.

This report has been structured to align performance reporting to the HEAT Framework contained within the Local Delivery Plan (LDP) targets for 2009/10, as set out by the Scottish Government. The report also aims to capture challenges and key performance measures across NHS Borders.

The key performance areas covered in this document are as follows:

- Health Improvement
- Efficiency
- Access to Services
- Treatment
- Activity & Bed Utilisation

## How to use this report

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.

The 2009/10 LDP HEAT targets or standards have been highlighted throughout this document with the sign below.



## Performance against Trajectory

When NHS Borders sets a target to be achieved, whether a reduction in waiting times or a decrease in sickness absence, a performance trajectory is set which will allow services to plan how they will progress and meet the target. Regular reporting enables NHS Borders to monitor actual operational performance against key measures.

Current Performance Key		
<b>R</b>	Under Performing	Current performance is significantly outwith the trajectory set.
<b>A</b>	Below Trajectory	Current performance is moderately outwith the trajectory set.
<b>G</b>	Meeting Trajectory	Current performance matches the trajectory set

**Direction Symbols**

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

**Table 1 –Performance against HEAT Targets and Key Performance Indicators at the end of March 2010**

Target type	Target Descriptor	Target Date	Target	Trajectory	Current	Direction	Commentary	Current Performance
HEAT H4	Alcohol Brief Interventions	Mar 2011	3210	1855	1211	↑	Performance moderately outwith the trajectory set	<b>A</b>
HEAT H6	Smoking cessation for 1 month or over	Mar 2011	1,465	997	1209	↑	Performance exceeded the trajectory set.	<b>G</b>
HEAT E7	Online Triage of Referrals	Dec 2010	90%	60%	16%	↑	Performance moderately outwith the trajectory set	<b>A</b>
HEAT	CHI Usage at 95%	Mar 2009	95%	95%	98%	↑	Performance exceeded the trajectory set.	<b>G</b>
HEAT Standard	Sickness Absence Reduced to 4%	ongoing	4.0%	4.0%	4.3%	↑	Current performance is moderately outwith the trajectory set	<b>A</b>
HEAT A9	2 Months Waiting Target for Urgent Cancer Referrals	Mar 2009	95%	95%	96%	↓	Performance exceeded the trajectory set	<b>G</b>
HEAT A10-1	9 Week Waiting Target for Outpatients	Mar 2010	0	0	0	↑	Achieved trajectory	<b>G</b>
HEAT A10-2	9 Week Waiting Target for Inpatient and Day Cases	Mar 2010	0	0	0	↑	Achieved trajectory	<b>G</b>

Target type	Target Descriptor	Target Date	Target	Trajectory	Current	Direction	Commentary	Current Performance
HEAT Standard	4 Week Waiting Target for Diagnostics	Mar 2009	0	0	0	↔	Achieved trajectory	<b>G</b>
HEAT Standard	4-Hour Waiting Target for A&E	Mar 2009	98%	98%	97%	↑	Performance moderately outwith the trajectory set.	<b>A</b>
Key Priority	1 Week Waiting Target for RACPC	Mar 2009	0	0	2	↓	Performance moderately outwith the trajectory set.	<b>A</b>
Key Priority	15 Week Waiting Target for AHPs	Mar 2010	0	0	66	↑	Performance moderately outwith the trajectory set	<b>A</b>
Key Priority	26 Week Waiting Target for Audiology	Mar 2010	0	0	5	↑	Performance moderately outwith the trajectory set	<b>A</b>
Key Priority	18 Week Waiting Target for Mental Health	Mar 2010	0	0%	3%	↓	Performance moderately outwith the trajectory set	<b>A</b>
Key Priority	25% of A&E attenders seen by Primary Care	Mar 2011	20%	20%	22%	↓	Performance exceeded the trajectory set.	<b>G</b>
HEAT	Readmissions to psychiatric beds over 7 days	Dec 2010	119	119	75	↓	Performance exceeded the trajectory set	<b>G</b>
HEAT	Reduction in the rate of A&E and MIU Attendances	Mar 2011	1,911	2,163	2,132	↓	Performance exceeded the trajectory set	<b>G</b>
HEAT T11-1	25% Reduction in Staph aureus	Mar 2011	2	2	9	↓	Performance significantly below the trajectory set	<b>R</b>
HEAT T11-2	30% Reduction in C. Diff (CDAD)	Mar 2011	6	6	3	↓	Performance exceeded the trajectory set	<b>G</b>
HEAT Standard	No Delayed Discharges over 6 Weeks	ongoing	0	0	3	↔	Performance moderately below the trajectory set	<b>A</b>

## 2 Health Improvement

---

**Table 2 - Health Improvement HEAT Targets**

Heat Target	Reported in MOP	Reported in Corporate Objectives Appendix
H2 80% of all three to five year old children to be registered with an NHS dentist by 2010/11		✓
H3 Achieve agreed completion rates for child healthy weight intervention programme by 2010/11		✓
H4 Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11	✓	
H5 Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010		✓
H6 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	✓	
H7 Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11		✓
H8 Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2009-10		✓

**2.1 Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11**



The trajectory for this target is cumulative. At the end of March 2010 a cumulative total of 1211 brief interventions (BI) had taken place compared with the trajectory of 1855. Discussions have taken place recently with the Scottish Government HEAT Delivery Team and a revised trajectory and action plan has been developed to ensure delivery of this target in 2011. Going forward there will be regular communication with members of the Delivery Team to identify approaches which have been successful in other areas and agree solutions for local issues. Intensive monitoring of activity by the Alcohol & Drugs Partnership is taking place. Support is to be provided for Primary Care with action plans developed for each GP practice to enable more BIs to be completed. 1-1 coaching is to be provided for staff to improve confidence in their ability to raise the issue of alcohol with patients and Health Visitors and District Nurses are to become involved in delivering BIs. Within A&E, the model of delivery of BIs is being reviewed to increase the number taking place. Antenatal Staff are revisiting training to increase ability to ask “difficult questions” with their client group.

**Table 3 – Number of Alcohol Brief Interventions Completed**

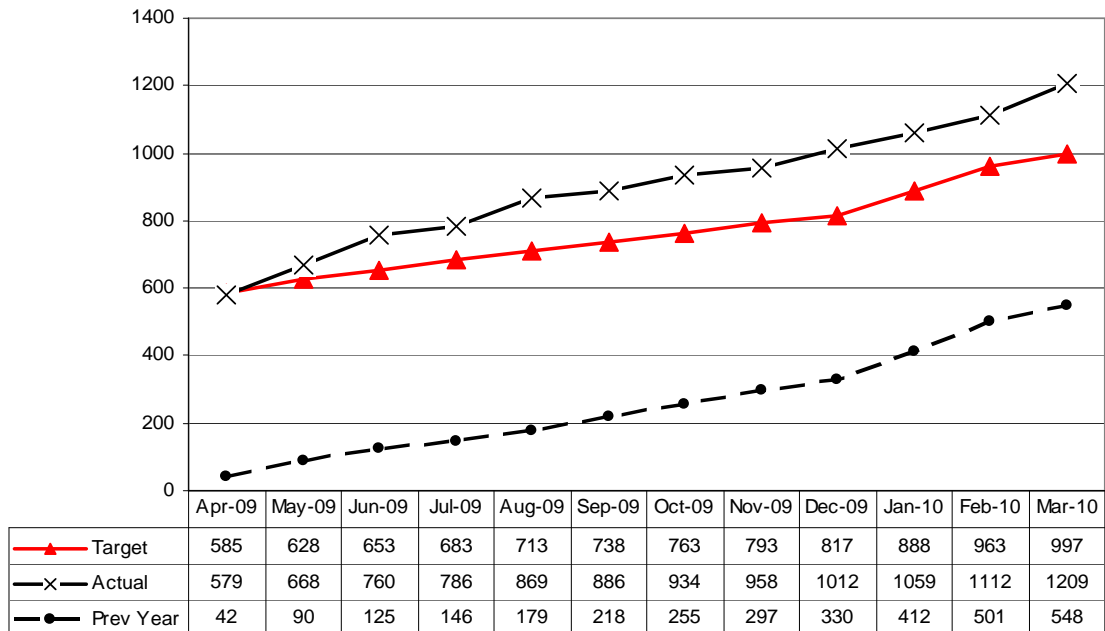
No of interventions at end of March 2010	Cumulative trajectory – end March 2010
1211	1855

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



This target measures the total number of the smoking population who have been supported to quit for a period of a month or longer. The trajectory is based on the cumulative number of smokers who quit over the three year period of 2008/9 to 2010/11. For the month of March 2010 the number of sustained quits is 21% over the trajectory at 1209 compared to 997. Since March 2009, a further 661 people have been supported to stop smoking and performance against this target has been consistently above the trajectory since May 2009.

**Figure 1 – Number of Smokers Quit Post 4 Weeks**



### 3 Efficiency

**Table 4 – Efficiency HEAT Targets**

Heat Target	Reported in MOP	Reported in Corporate Objectives Appendix
E4 NHS Boards to deliver agreed improved efficiencies for 1 <sup>st</sup> outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011		✓
E5 NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement		✓
E6 NHS Boards to meet their cash efficiency target		✓
E7 To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed electronically to 90% from December 2010	✓	
E8 NHS Scotland to reduce emissions over the period to 2011	✓	
E9 Achieve universal utilisation of CHI (radiology requests)	✓	
E10 NHS Boards to ensure at least 80 per cent of staff covered by Agenda for Change to have their annual Knowledge Skills Framework development reviews completed and recorded on e-KSF by March 2011		✓
Std NHS Boards to achieve a sickness absence rate of 4% from March 2009	✓	

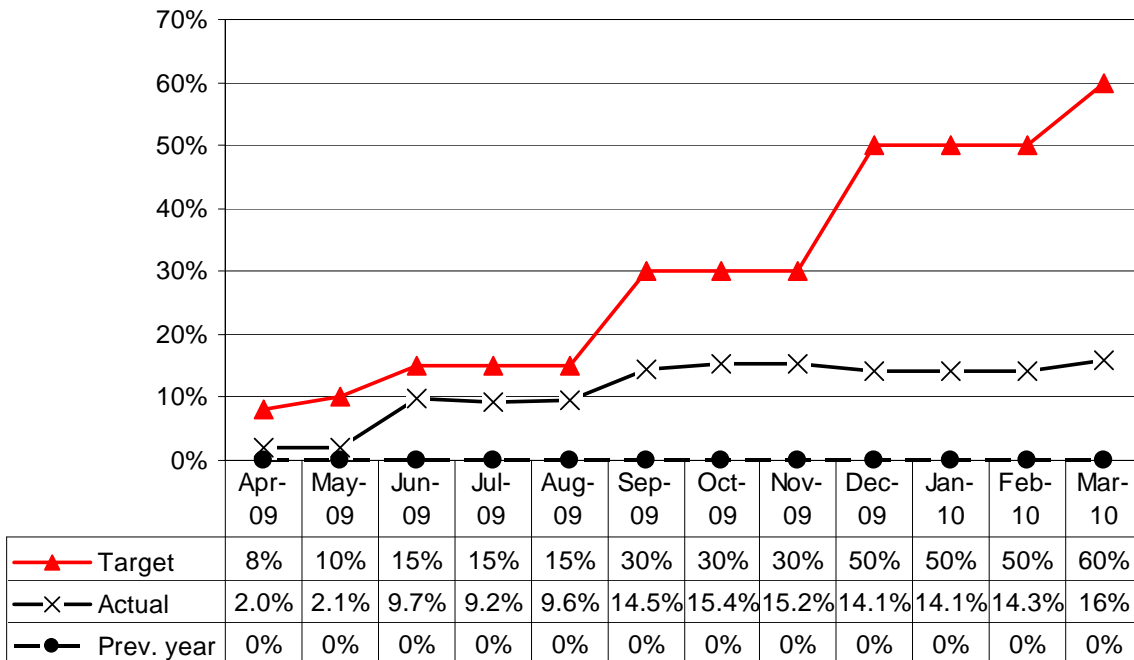
### 3.1 Online triage of GP Outpatient Referrals



NHS Borders' target is to increase the percentage of new GP outpatient referrals into Consultant led secondary care services that are triaged online to 90% from December 2010. The target for March 2010 is to reach 60% of these referrals being triaged online.

In March 2010, the percentage of GP referrals which were triaged electronically was at 16% which is a slight increase from February 2010 (14.3%). SCI Gateway is now the accepted method of making referrals to all Consultant led specialties and all GPs are now using this system. It is also being introduced into a number of AHP services and Mental Health, although the roll out to these areas has been delayed due to upgrade issues with the software. Developing this single point of referral which is both reliable and fully auditable with a method of tracking referrals will help encourage use of it thereby increasing the number of referrals over the coming months. Due to the number of roll outs and developments within the implementation project, the Project Team expect the number of referrals to remain around 14-15% until mid 2010 and then to jump up above trajectory to around 90%.

**Figure 2 – % of GP Referrals to Consultant Led Triaged Electronically**



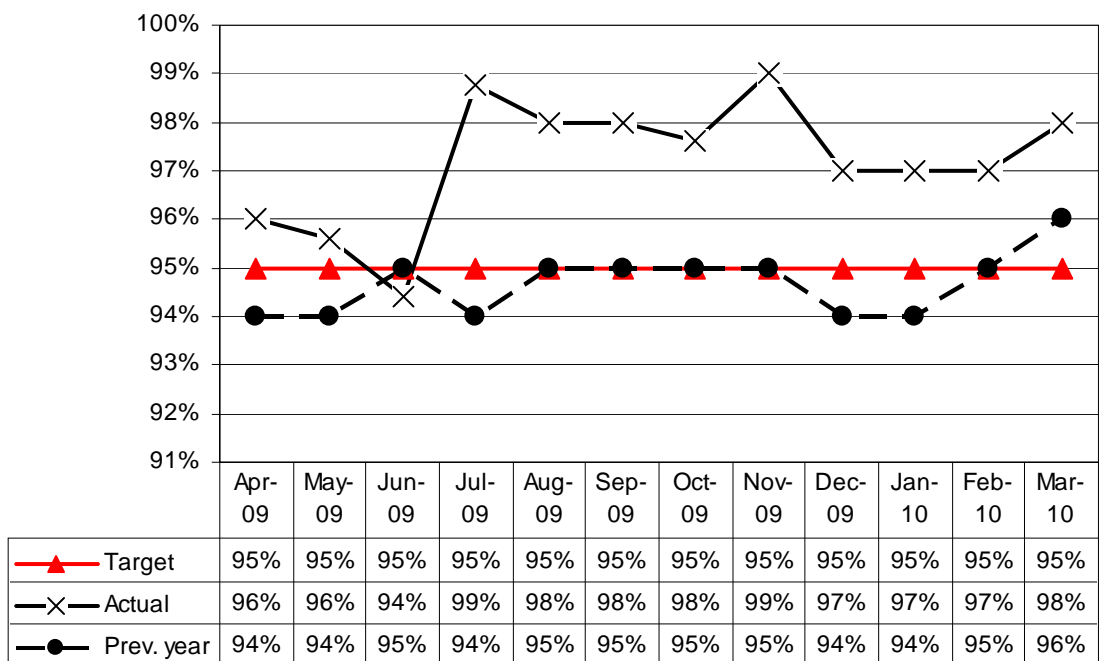
### 3.2 Universal utilisation of the Community Health Index (CHI)



NHS Borders' target is to maintain 95% utilisation of CHI as our previously agreed trajectory. Monitoring of the target in a specific clinical setting from April 2009 onwards has looked at Radiology records.

In March 2010 98% of radiology requests had a CHI number which is 3% above the trajectory. This target was achieved in 11 out of 12 months in 2009/10.

**Figure 3 – Overall Percentage Usage of CHI**

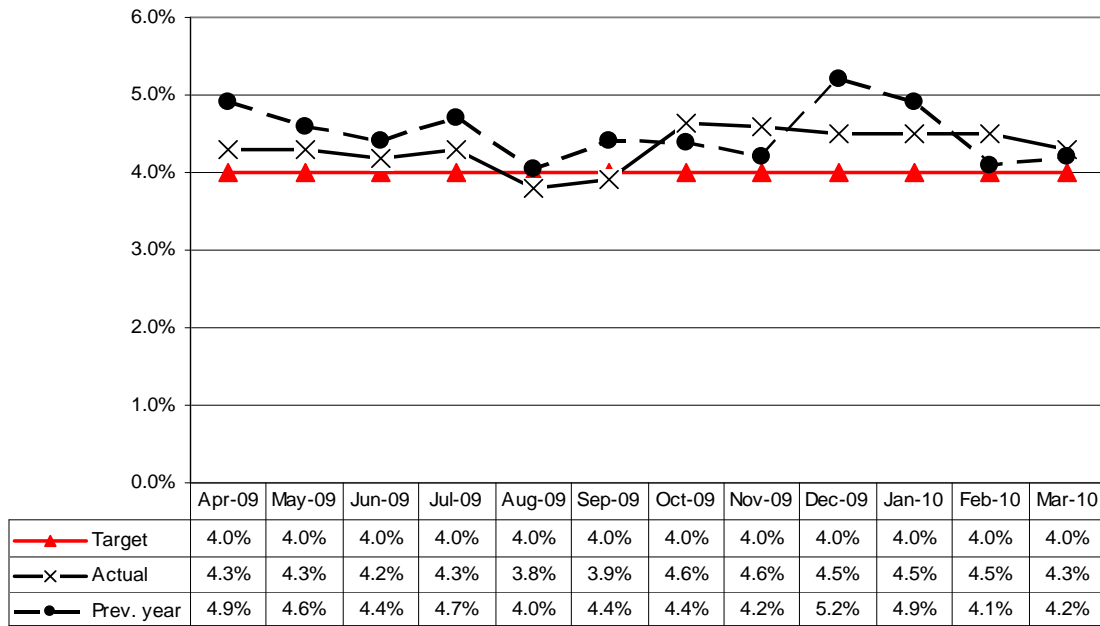


### 3.2 NHS Boards to achieve a sickness absence rate of 4% from March 2009.



As at the end of March 2010, sickness absence was at 4.3%, 0.3% above the trajectory target. This rate was slightly reduced from February 2010 and this was higher than the figure for February 2009 which was 4.1%. The overall rate for 2009/10 was 4.48%.

**Figure 4 – Sickness Absence Rate**



## 4 Access to Services

**Table 5 – Access to Services HEAT Targets**

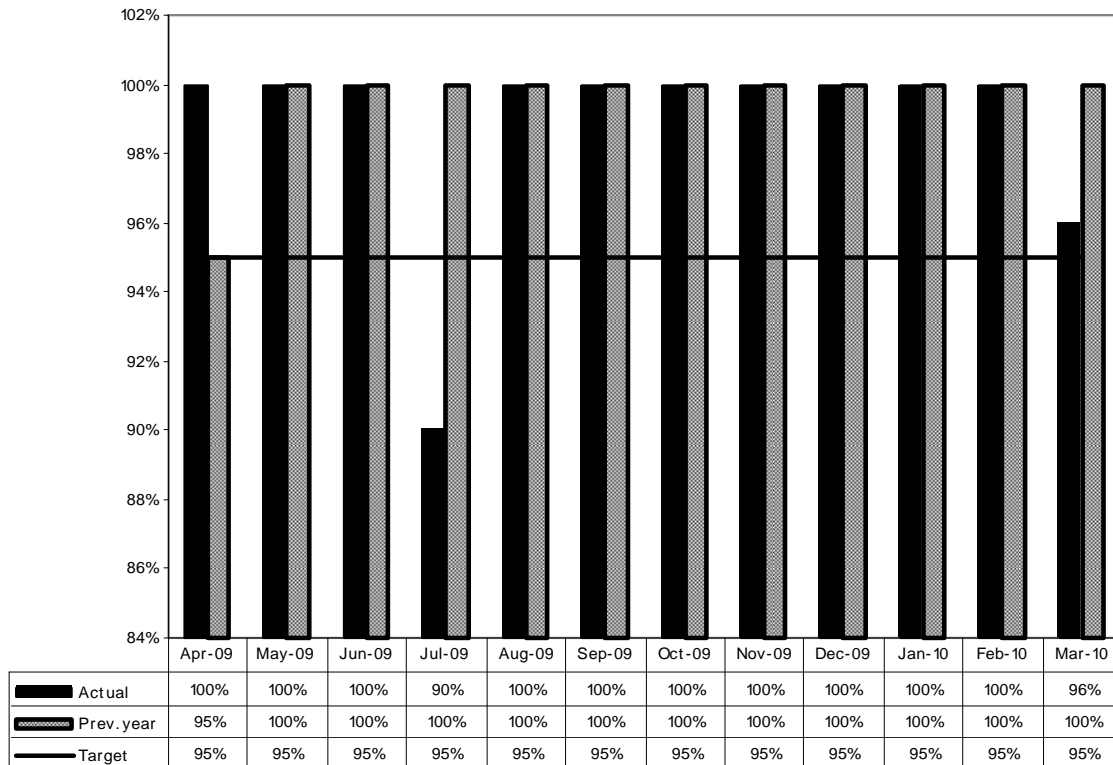
Heat Target	Reported in MOP	Reported in Corporate Objectives Appendix
A8 Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11		✓
A9 The maximum wait from urgent referral with a suspicion of cancer to treatment is 62 days; and the maximum wait from decision to treat to first treatment for all patients diagnosed with cancer will be 31 days from December 2011	✓	
A10 Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 12 weeks from being placed on a waiting list to admission for an inpatient or day case treatment from 31 March 2010	✓	
A11 To offer drug misusers faster access to appropriate treatment to support their recovery		✓
A12 NHS Boards to deliver faster access to Child and Adolescent Mental Health Services		✓
Std 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	✓	
Std From the end of 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment	✓	

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



In March 2010, 96% of patients with an urgent cancer referral were treated within 62 days. The target of 95% has been achieved in 11 months out of 12 months during 2009/10 with 100% of patients treated within 62 days in 10 months out of 12.

**Figure 5 – Percentage of patients treated within two months**

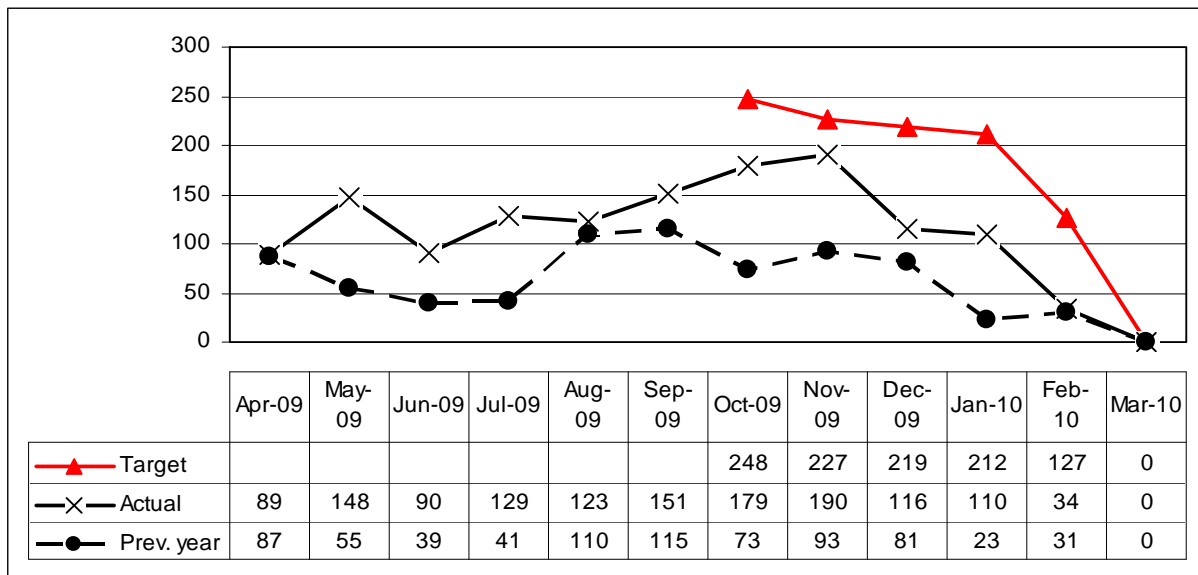


**4.2 As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 12 weeks from GP referral to a first outpatient appointment from 31 March 2009**

HEAT A10

At the NHS Borders Board meeting in November 2009 the revised trajectory for the local target that no patients should wait longer than 9 weeks for an outpatient appointment was approved. This was set as the target to reduce waits to 12 weeks by March 2010 had been achieved at that point. In March 2010 this target was achieved and no patients waited over 9 weeks for an outpatient appointment.

**Figure 6 - Number of patients waiting longer than 12 weeks – Outpatient Appointment**

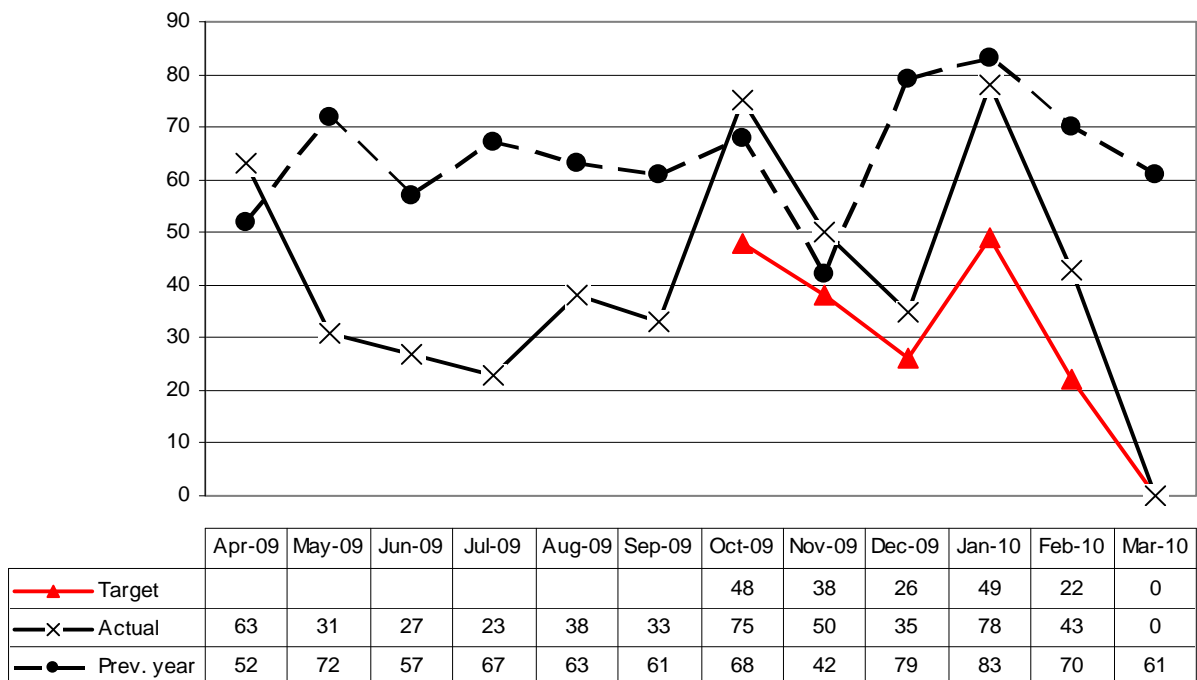


**4.3 As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 12 weeks for inpatient or day case treatment from 31 March 2009**

HEAT A10

At the NHS Borders Board meeting in November 2009 the revised trajectory for the local target that no patients should wait longer than 9 weeks for inpatient or day case treatment was approved. This was set as the target to reduce waits to 12 weeks by March 2010 had been achieved at that point. In March 2010 this target was achieved and no patients waited over 9 weeks for inpatient treatment.

**Figure 7 – Number of patients waiting longer than 12 weeks – Inpatient Treatment**

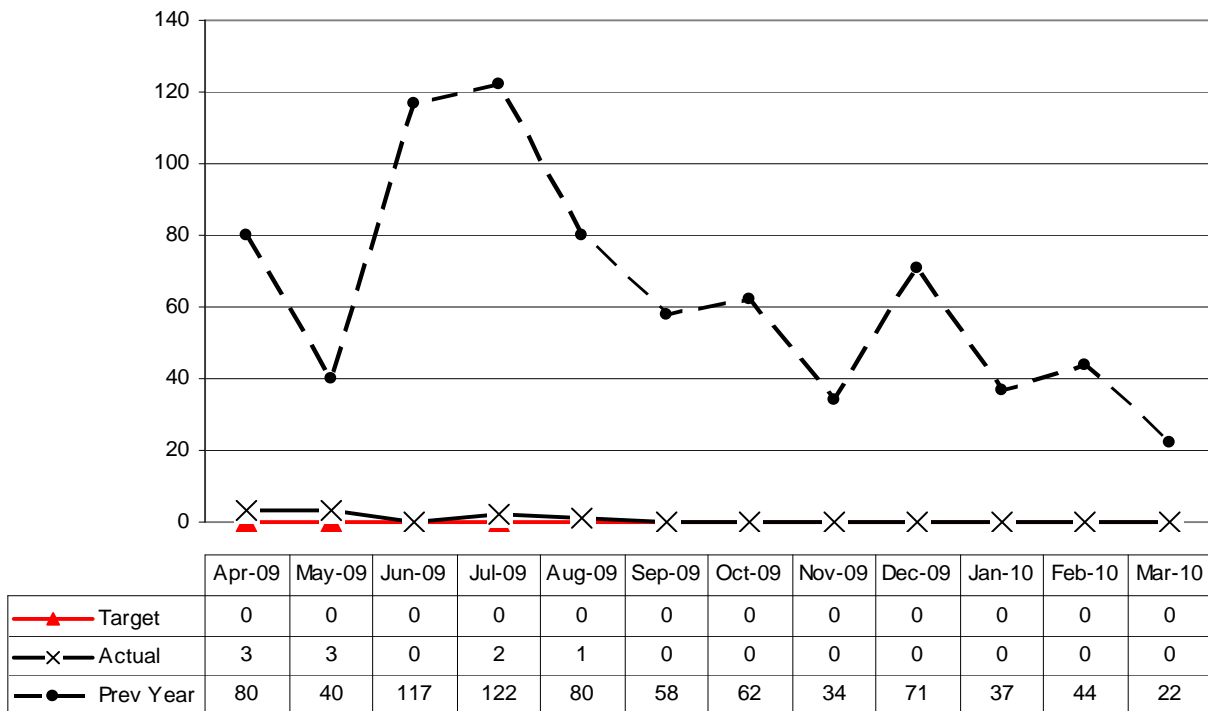


**4.4 As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 4 weeks for one of the 8 key diagnostic tests from 31 March 2009**



In March 2010, no patients waited more than 4 weeks for a key diagnostic test. This target was achieved in 7 out of 12 months in 2009/10 and was achieved consistently since September 2009. This is a considerable improvement over 2008/09 performance.

**Figure 8 – Number of patients waiting longer than 4 weeks**

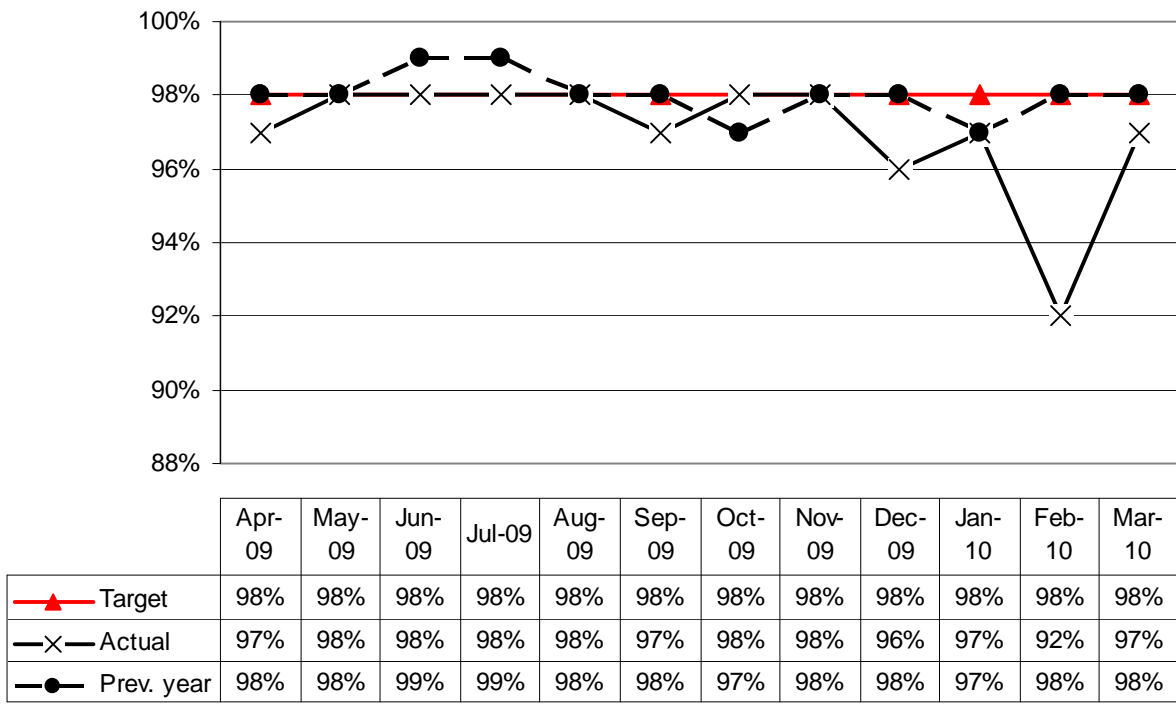


**4.5 From the end of 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment**



In March 2010, 97% of patients were seen by A&E within 4 hours which is slightly below the target of 98%. The target of 98% was achieved in 6 out of 12 months during 2009/10. Following a significant drop in performance experienced in February 2010, a short term working group was set up to examine issues being experienced within A&E and to draw up an Action Plan to implement solutions to ensure patients are seen within the 4 hour target. In March, actions implemented by the Group delivered an improvement in performance with an increase of 5% in the number of people seen within the 4 hour target.

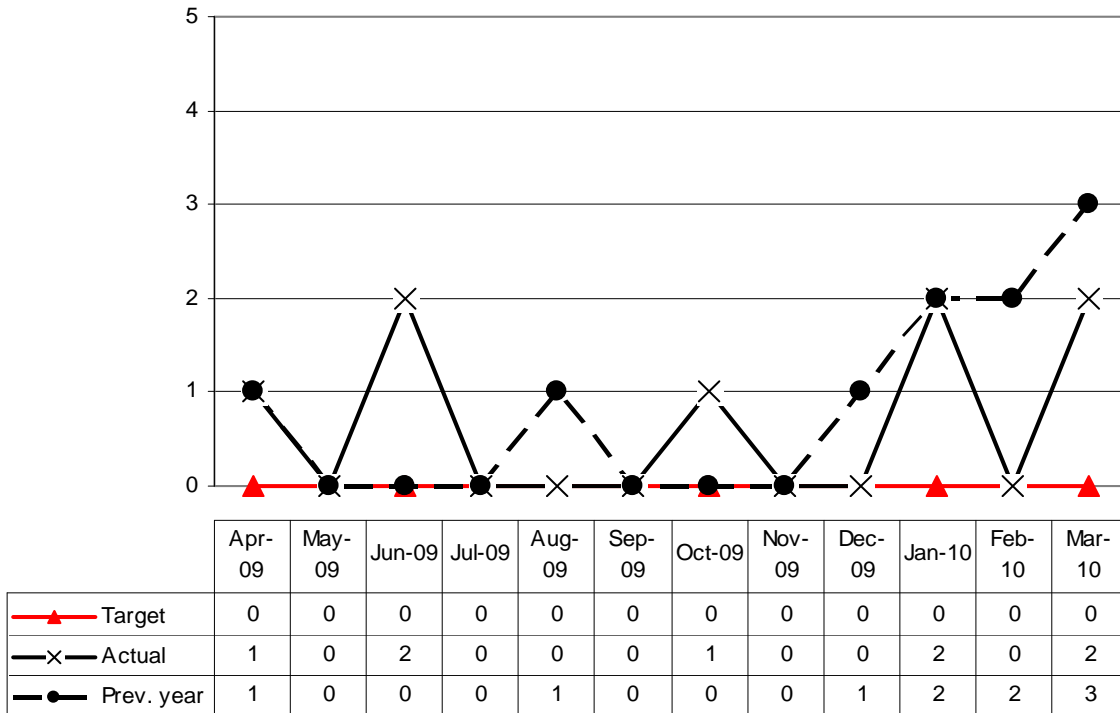
**Figure 9 – Percentage of patients seen within 4 hours**



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

The expectation is that no patient will wait more than 1 week from GP referral to being seen in the RACPC. In March 2010, 2 patients waited longer than 1 week from referral to being seen in the RACPC. This target was achieved in 7 months out of 12 in 2009/10.

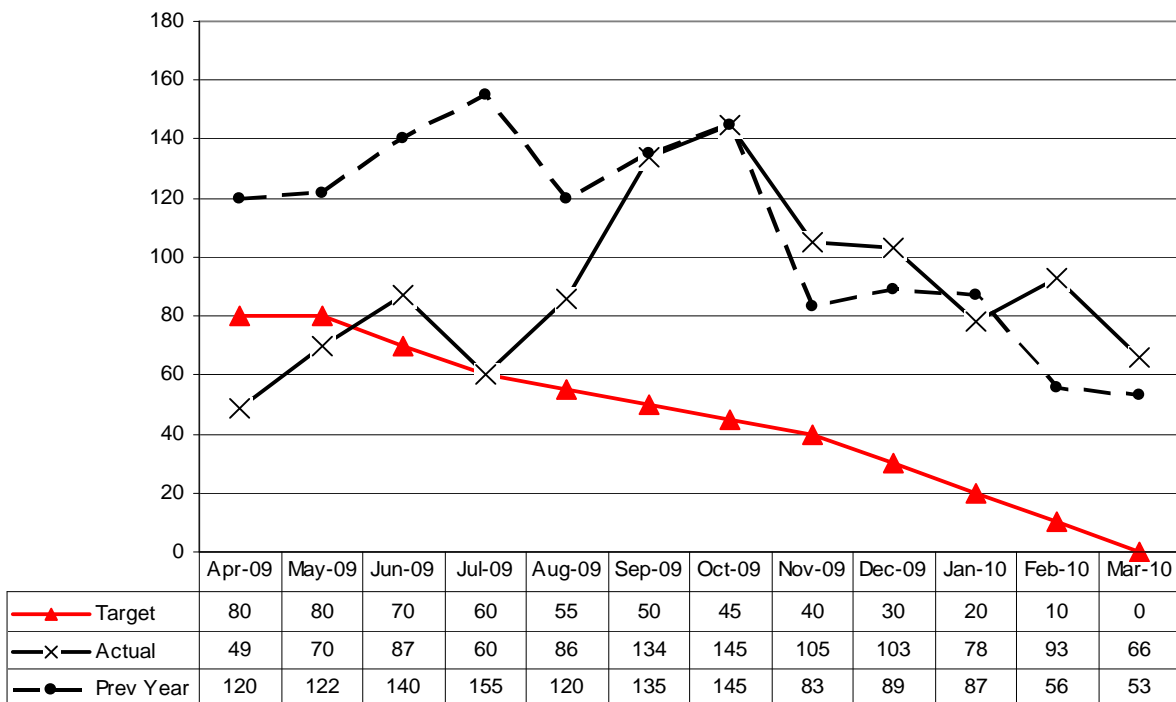
**Figure 10 – Number of patients waiting longer than 1 week**



**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. From April 09 onwards to March 2010 the second stage of this target is to be achieved, meaning that no patients should wait over 15 weeks for an AHP appointment. At the end of March 2010 there were 66 patients waiting over 15 weeks. This figure breaks down between professional groups as: 16 in Community Physiotherapy, 14 in BGH Physiotherapy, 26 in Speech and Language Therapy, and 8 in Occupational Therapy. The total of 66 patients is a decrease of 27 patients from February 2010 and is 66 over the target of 0 patients. It is useful to note that as of the 15th April the waiting times position for AHP services improved. This is the result of further tidying of the data as well as increased effort to make more new appointments available. Work is continuing to ensure that no patients wait over 15 weeks before moving on to the lower target of 12 weeks maximum wait in 2010/11.

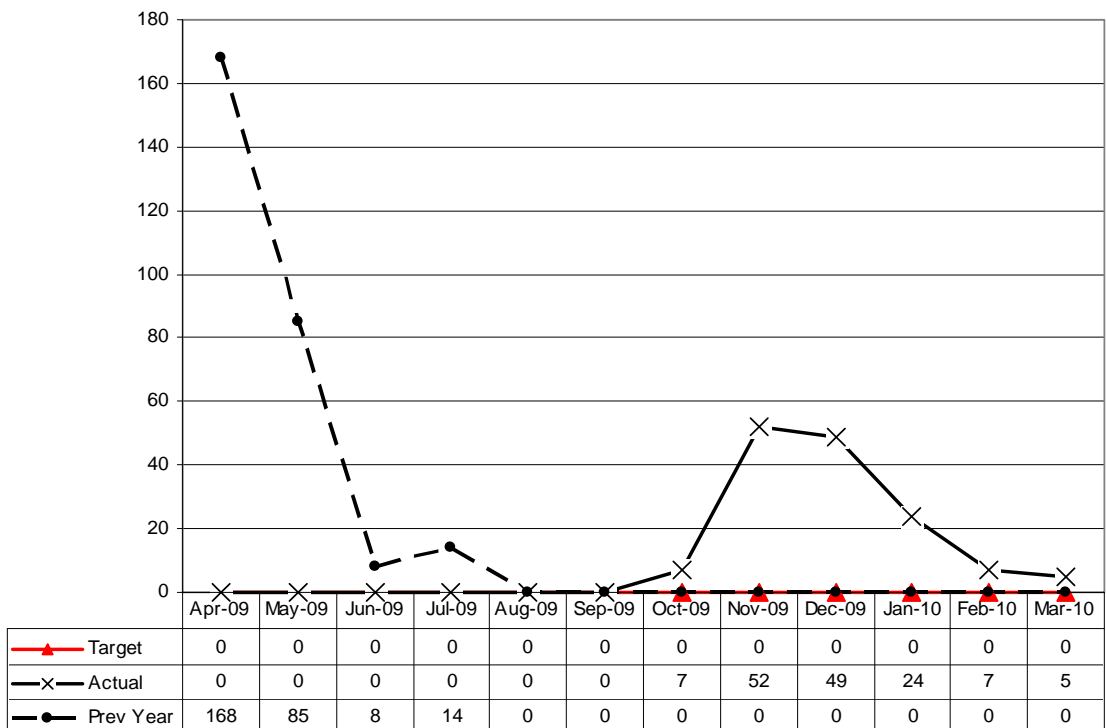
**Figure 11 - Number of patients waiting longer than 15 weeks**



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

Following the changeover to a new computer system in July 2009, issues are still being experienced with the reporting of data. Planning & Performance are continuing to work with Audiology staff to resolve these issues. The latest report run at the end of March 2010, showed there were 5 patients waiting over 26 weeks for a first appointment and these patients were all children. There were no waits over 26 weeks for fitting. Due to the issues being experienced with reporting, it is thought that the report is currently not showing an accurate picture of waits. Due to continued work, confidence in reporting is improving and this work should be complete by mid 2010.

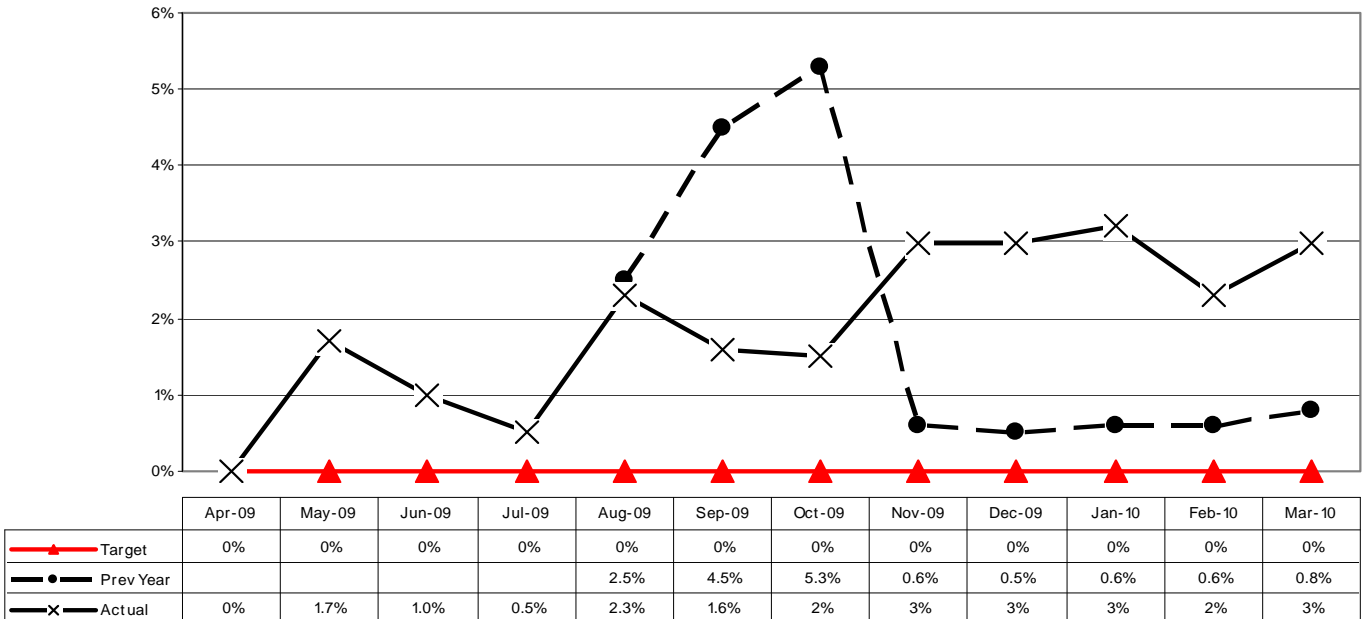
**Figure 12 – Number of patients waiting longer 26 weeks for Audiology**



### 4.9 Mental Health Waiting Times for New Outpatient Appointment

As at the end of March 2010 there were 371 patients waiting for a new outpatient appointment with 9 patients (3% of the total number) waiting longer than 18 weeks. In comparison, February 2010 had 339 patients waiting for a new outpatient appointment with 8 patients (3% of the total number) waiting longer than 18 weeks.

**Figure 13 – Percentage of Mental Health patients waiting longer than 18 weeks (excluding BCAT and ADHD)**



## 5 Treatment Appropriate to Patient

**Table 6 - Treatment HEAT Targets**

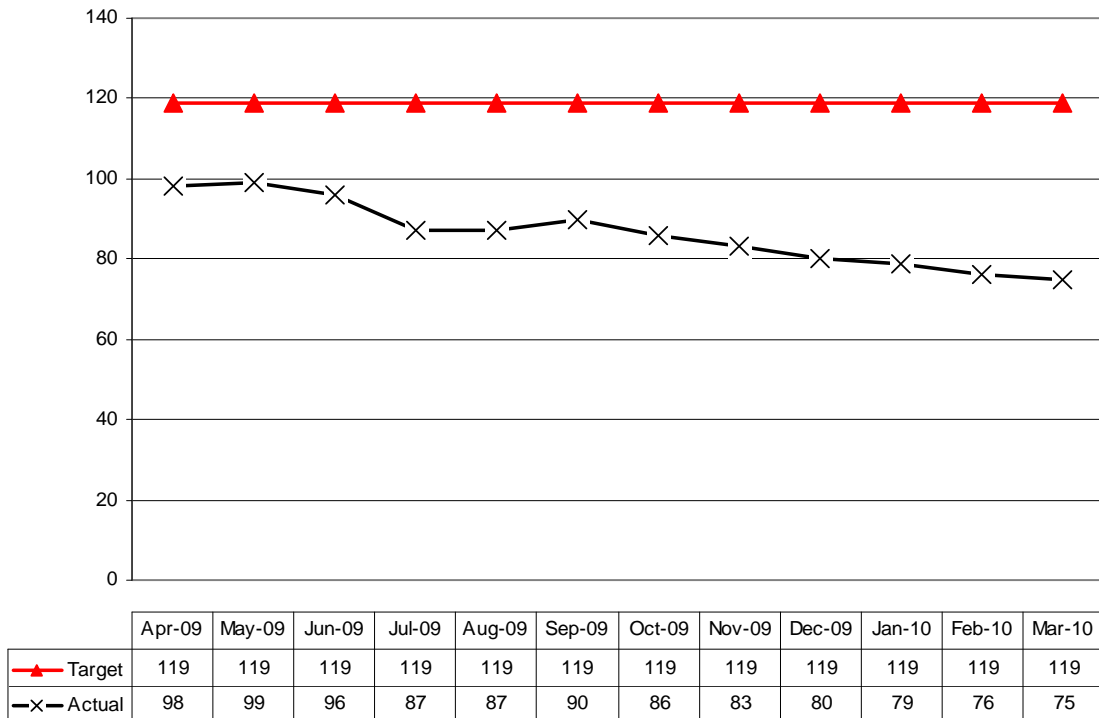
Heat Target	Reported in MOP	Reported in Corporate Objectives Appendix
T2 QIS clinical governance and risk management standards improving		✓
T3 Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years		✓
T4 Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009)	✓	
T7 Improvement in the quality of healthcare experience		✓
T8 Increase the level of older people with complex care needs receiving care at home		✓
T9 Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011		✓
T10 To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11	✓	
T11 To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010; to introduce and comply with local antimicrobial policies by 2010; and to reduce the rate of C.diff infection in hospitals by at least 30% by 2011	✓	
T12 By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05		✓
Std 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	✓	

**5.1 Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009)**



This target measures the number of readmissions to psychiatric hospital beds. The readmissions are measured on a rolling year's cycle from date of admission (for first ward stay with a duration of 7 days or over). There were 75 readmissions fitting the criteria for this target in the period March 2009 to March 2010, showing strong performance at 37% below the trajectory. The benchmarking data for this target based on calendar year ending 2004 showed 132 readmissions. This target has been achieved each month throughout 2009/10.

**Figure 14 – Number of psychiatric hospital admissions**



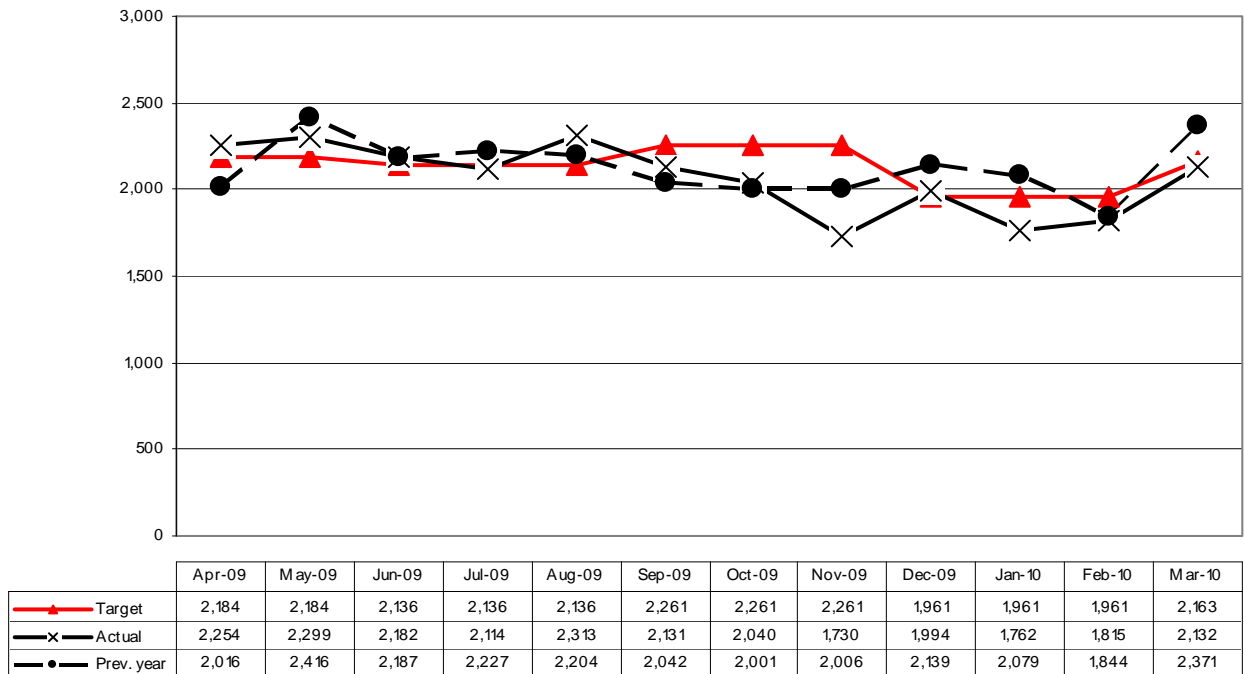
Please Note: Data for the last 7 days of the month may not be included due to the nature of the measurement of this target. Also non-Border readmissions are unknown at this time. Actual figures for April 2009 onwards have been reworked in line with national recording alterations.

**5.2 To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11.**

**HEAT T10**

This section has been remodelled to include not only the BGH A&E attendances but also those seen in the 4 Minor Injury Units located in Community Hospitals. During March 2010, 2,132 patients attended A&E and the MIUs which 1% under the trajectory of 2163. This total comprises 1,905 A&E and 277 MIU attendances. The is an increase of 317 attendances from February 2010, however it is a 9% reduction from February 2009 where there were 2,371 attenders.

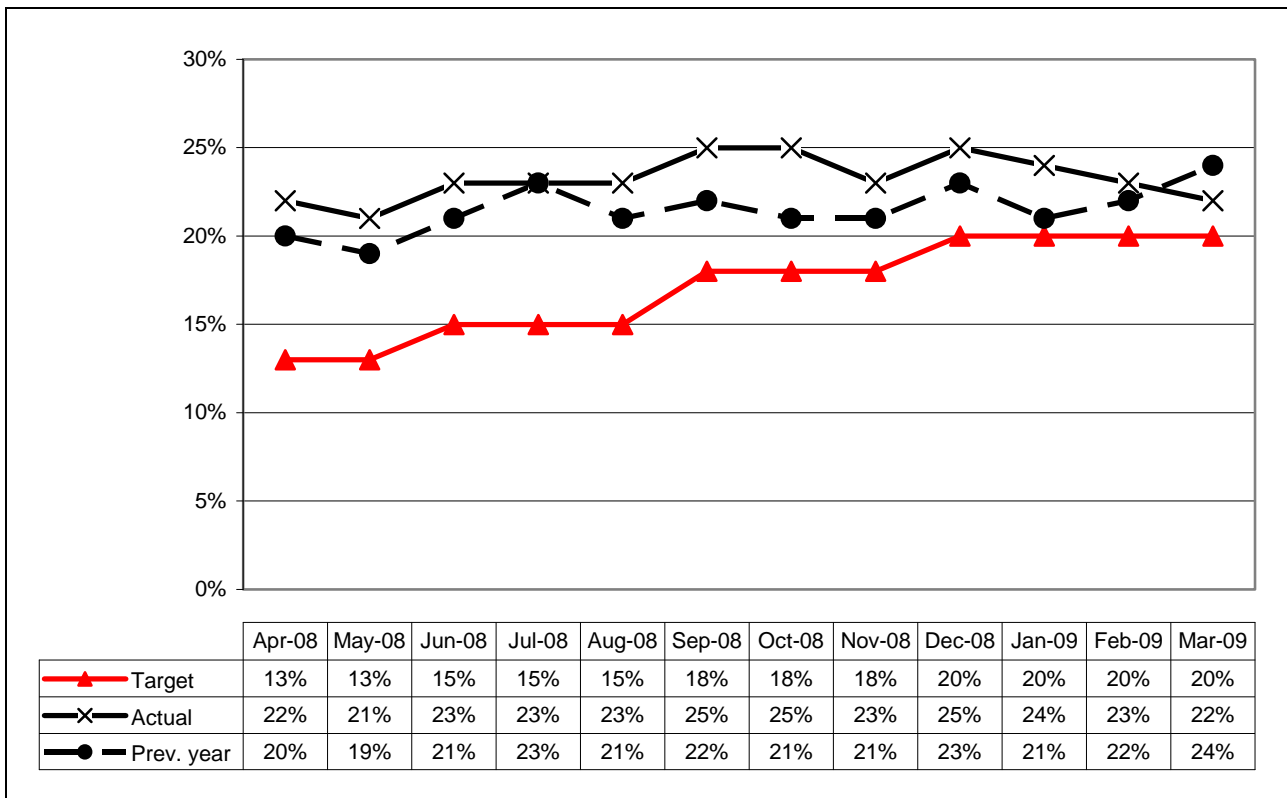
**Figure 15 – Number of A&E and MIU Attendances**



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

During March 2010 20% (381) of all attendees at A&E (1,905 patients) were seen by Primary Care. This includes those seen by the A&E GP and those referred to BECS. This target has been achieved consistently each month throughout 2009/10.

**Figure 16 – Percentage of patients seen by the A&E GP**



**5.4 To reduce all *staphylococcus aureus* bacteraemia (including MRSA) by 30% by 2010; to introduce and comply with local antimicrobial policies by 2010; and to reduce the rate of C.diff infection in hospitals by at least 30% by 2011**

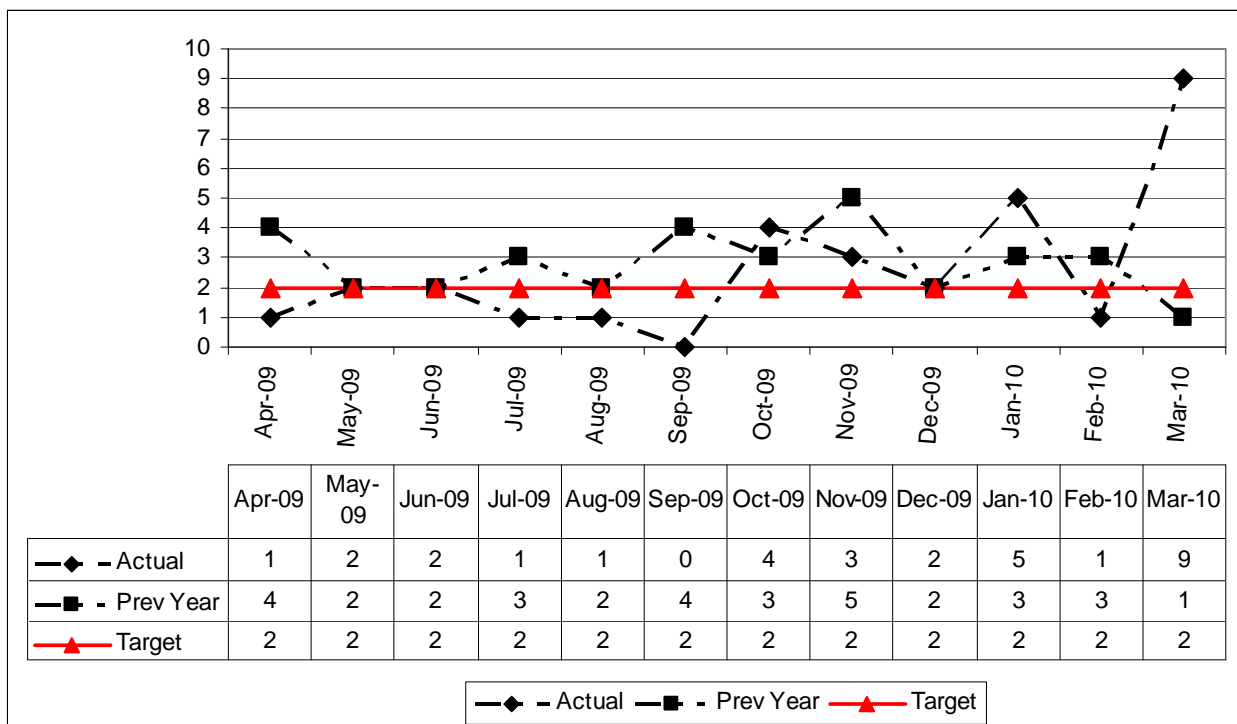
HEAT T11

**5.4.1 To reduce all *staphylococcus aureus* bacteraemia (including MRSA) by 30% by 2010**

This target is measured against a quarterly trajectory. During the quarter ending March 2010 there were 15 *staphylococcus aureus* bacteraemia which is 9 bacteraemia above the trajectory target. This is an increase of 6 isolates from December 2009 where there were 9 *staph. aureus* bacteraemia. The figure of 15 is an increase of 8 bacteraemia from the same period in 2008/09. As a result of this significant increase in the infection rates, there has recently been increased surveillance and root cause analysis is also taking place.

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

**Figure 17 – Staph. aureus Bacteraemia**



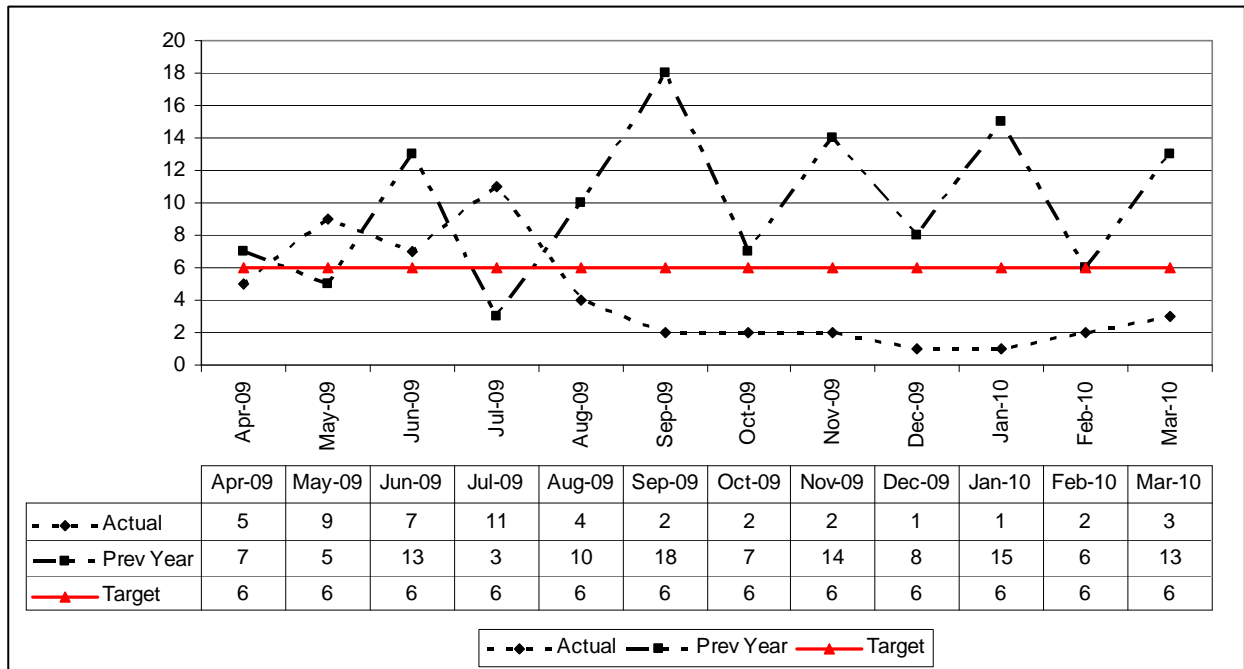
### 5.4.2 To reduce the rate of all C.diff infection by at least 30% by 2011

HEAT T11

This is a new target for 2009/10 onwards. The trajectory has been set at 18 CDADs per quarter. For the quarter ending March 2010 there were 6 cases, well below the trajectory of 18 and this is one more case than in the quarter ending December 09. In the same period in 2008/9, there were 34 Clostridium Difficile infections and so 2009/10 has seen an improvement in performance.

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

**Figure 18 – Clostridium Difficile Associated Disease Cases**



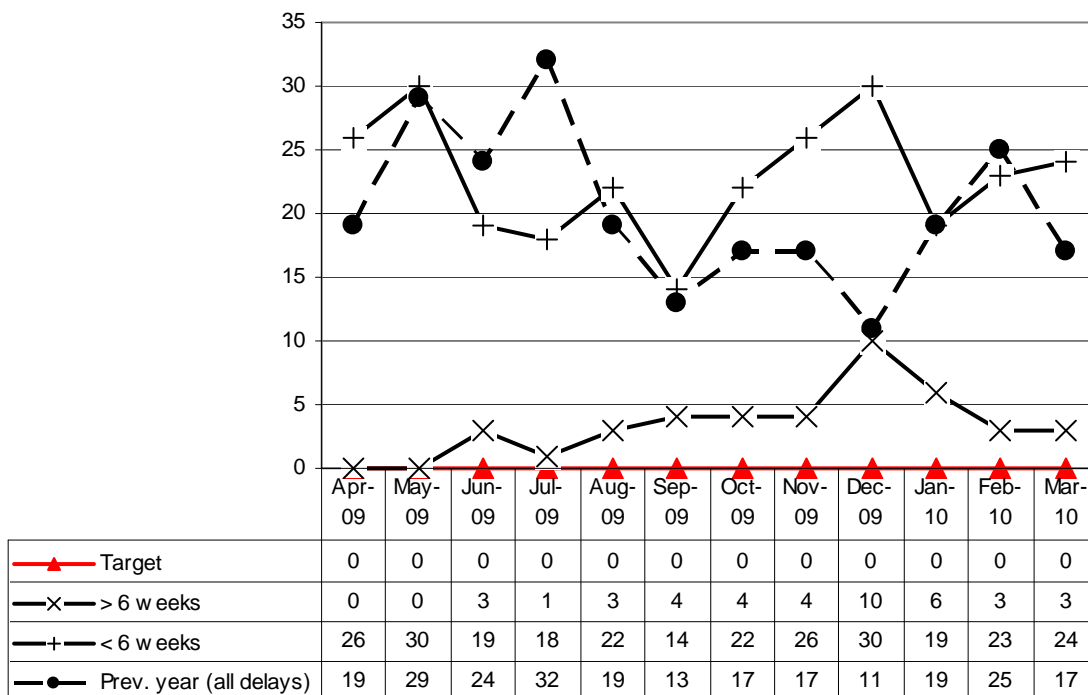
**5.4 Delayed Discharges: The number of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting will be reduced to zero. Additionally, the number of patients delayed in short-stay beds will be reduced to zero.**



As at 15<sup>th</sup> March 2010 there were 27 Delayed Discharges in total; 7 of these are complex cases and therefore do not count against the target. There were 3 patients with a delay of more than 6 weeks.

Scottish Borders Partnership did not meet the target of zero delayed discharges over 6 weeks in March 2010 and this target was only achieved in 2 out of the 12 months in 2009/10. The quarterly Census was only achieved in April 2009.

**Figure 19 – Delayed Discharges**



The most common reason for delay includes 'awaiting completion of Social Work assessment'. 2 patients are exercising their right of choice of care home, the delayed discharge operational group are actively attempting to progress these cases through the choice of care home policy.

## 6 Activity & Bed Utilisation

### 6.1 Activity

This table summarises activity across NHS Borders for the period to 31<sup>st</sup> March 2010. This data has been taken from the monthly activity reports. Average Lengths of Stay provided on a monthly basis will differ from the quarterly Bed Model information as they show crude rates compared to HRG level adjusted stays, however this remains a clear indicator of the direction of travel required to achieve organisational efficiency aims.

**Table 6 – Summary of Activity; Period Ending 31<sup>st</sup> March 2010**

<b>Acute Activity</b>	<b>2008'9</b>	<b>2009'10</b>	<b>Variance</b>	
			<b>Numbers</b>	<b>%</b>
<b>Inpatients</b>				
Medical Services	9241	8925	-316	-3%
Surgical Services	5382	4870	-512	-10%
Women & Children	4923	5260	337	7%
Anaesthetics	620	397	-223	-36%
<b>Total</b>	<b>20166</b>	<b>19452</b>	<b>-714</b>	<b>-4%</b>
<b>Daycases</b>				
Medical Services	3055	2872	-183	-6%
Surgical Services	2927	3126	199	7%
Women & Children	699	633	-66	-9%
<b>Total</b>	<b>6681</b>	<b>6631</b>	<b>-50</b>	<b>-1%</b>
<b>New Outpatients</b>				
Medical Services	7869	7993	124	2%
Surgical Services	15122	14997	-125	-1%
Women & Children	6908	5403	-1505	-22%
Anaesthetics	223	124	-99	-44%
<b>Total</b>	<b>30122</b>	<b>28517</b>	<b>-1605</b>	<b>-5%</b>
<b>Review Outpatients</b>				
Medical Services	15650	15603	-47	0%
Surgical Services	20974	21365	391	2%
Women & Children	7418	7394	-24	0%
Anaesthetics	95	88	-7	-7%
<b>Total</b>	<b>44137</b>	<b>44450</b>	<b>313</b>	<b>1%</b>
<b>Community Inpatient Activity <sup>1</sup></b>				
GP Acute (Discharges)	1130	1106	-24	-2%
Continuing Care (Occupied Bed Days)	15758	13705	-2053	-13%
<b>Mental Health</b>				
Mental Health (Occupied Bed Days)	34784	30707	-4077	-12%

<sup>1</sup> Includes activity at all locations, including BGH

## 6.2 Bed Utilisation

### 6.2.1 BGH Bed Occupancy

The number of Occupied Bed Days has decreased by 9% from 91,385 in 2008/09 to 83,586 in 2009/10. The % Bed Occupancy has remained the same at 76%. Throughput has increased from 61.3 patients in 2008/09 to 64.7 in 2009/10 and the Turnover Interval has reduced from 1.4 days to 1.3 days. Length of stay across the BGH has decreased slightly from 4.5 to 4.3 days.

**Table 7 – BGH Bed Utilisation Statistics; Cumulative**

	Period	Bed Complement	Average Available Beds	Occupied Bed Days	% Occupancy	Discharges	Admissions	Daycases	Ward Attenders	Throughput	Average Length of Stay	Turnover I
Elderly Assessment	2008'9	48	41	12644	85%	466	30	0		11.4	27.1	4.8
	2009'10	30	30	10551	96%	383	17	0		12.8	27.5	1.0
ENT	2008'9	2	2	128	18%	141	139	285	2	73.3	0.9	4.1
	2009'10	2	2	114	16%	120	121	209	0	62.3	1.0	4.9
General Medicine	2008'9	116	142	42756	83%	8435	8029	959	13	59.5	5.1	1.1
	2009'10	117	131	39823	83%	8177	7770	847	46	62.2	4.9	1.0
General Practice	2008'9	9	11	2435	59%	88	34	0		7.8	27.7	18.9
	2009'10	9	6	2123	98%	64	17	0		10.8	33.2	0.7
General Surgery	2008'9	37	32	8754	76%	2730	2532	372	4	86.5	3.2	1.0
	2009'10	37	32	8097	70%	2567	2299	483	3	81.3	3.2	1.3
Gynaecology	2008'9	14	11	2188	53%	1252	1225	696	21	111.3	1.7	1.5
	2009'10	14	12	1805	42%	1258	1228	630	0	105.7	1.4	2.0
Haematology	2008'9	0	2	807	100%	120	103	912	11	-	6.7	0.0
	2009'10	0	3	1270	100%	141	120	801	0	-	9.0	0.0
ITU	2008'9	6	6	1533	70%	620	69	0		103.2	2.5	1.1
	2009'10	6	4	1273	79%	397	91	0		-	3.2	0.9
Medical Paediatrics	2008'9	8	8	1337	49%	825	824	1	1395	109.5	1.6	1.7
	2009'10	8	8	1445	49%	982	978	1	1157	122.5	1.5	1.5
Obstetrics	2008'9	19	19	3916	57%	2679	2683	2	3	141.7	1.5	1.1
	2009'10	19	19	3593	52%	2854	2842	2	3	151.2	1.3	1.2
Ophthalmology	2008'9	3	3	42	4%	50	51	1005	20	18.3	0.8	19.1
	2009'10	3	3	35	3%	44	49	1325	10	14.8	0.8	23.9
Oral Surgery	2008'9	0	0	6	100%	8	11	435	2	-	0.8	0.0
	2009'10	0	0	3	100%	4	4	365	1	-	0.8	0.0
Orthopaedics	2008'9	36	34	10228	82%	1998	1697	581	0	58.2	5.1	1.1
	2009'10	36	36	9779	74%	1719	1630	517	0	47.7	5.7	2.0
Palliative Medicine	2008'9	6	8	1668	56%	124	61	2		15.1	13.5	10.7
	2009'10	6	5	1529	89%	147	76	1		31.2	10.4	1.3
Radiation Oncology	2008'9	0	0	32	100%	8	8	1182	0	-	4.0	0.0
	2009'10	0	0	12	100%	12	12	1223	0	-	1.0	0.0
Rheumatology	2008'9	0	0	13	100%	5	5	8	0	-	2.6	0.0
	2009'10	0	0	5	100%	3	3	7	0	-	1.7	0.0
SCBU	2008'9	8	4	1118	71%	167	165	0	8	38.7	6.7	2.7
	2009'10	8	4	972	65%	166	169	0	3	40.7	5.9	3.1
Urology	2008'9	3	5	1415	85%	450	440	241	0	98.3	3.1	0.6
	2009'10	3	4	1120	77%	413	403	220	0	103.7	2.7	0.8
Young Physically Disabled	2008'9	1	1	365	68%	0	0	0		0.0	-	-
	2009'10	0	1	37	9%	1	0	0		0.9	37.0	364.0
Total	2008'9	316	329	91385	76%	20166	18106	6681	1479	61.3	4.5	1.4
	2009'10	298	301	83586	76%	19452	17829	6631	1223	64.7	4.3	1.3

Average available beds show borrowing & lending between specialties and temporary beds used.

## 6.2.2 Community Hospital Bed Occupancy

For GP Acute beds in Community Hospitals, Occupied Bed Days have shown a decrease of 4% when comparing 2008/09 with 2009/10 from 29365 to 27973. For the same period, % Occupancy has remained the same at 94% and Discharges have remained the same at 10422. Average Length of Stay has decreased from 28.2 to 26.8 days. Admissions have decreased slightly from 1053 in 2008/09 to 1044 in 2009/10.

The Percentage Occupancy for Continuing Care beds has increased from 77% in 2008/09 to 78% in 2009/10. Occupied Bed Days has decreased by 13% and there has been a 23% reduction in discharges (252 – 08/09 to 194 – 09/10) and a 19% reduction in admissions (233 – 08/09 to 188 – 09/10).

**Table 8 – Community Hospital Bed Utilisation Statistics**

	Period	Bed Complement	Average Available Beds	Occupied Bed Days	% Occupancy	Discharges	Admissions	Throughput	Average Length of Stay
Hawick Hospital	2008'9	21.8	21.7	7111	90%	277	275	12.8	25.7
	2009'10	19.7	19.9	6558	90%	299	302	15.0	21.9
Hay Lodge Hospital	2008'9	21.8	26.0	9400	99%	302	321	11.6	31.1
	2009'10	18.5	23.8	8706	100%	286	285	12.0	30.4
Kelso Hospital	2008'9	24.0	24.1	7827	89%	344	339	14.3	22.8
	2009'10	24.0	24.2	8006	90%	347	353	14.3	23.1
Knoll Hospital	2008'9	10.9	13.7	5027	100%	119	118	8.7	42.2
	2009'10	9.5	13.2	4703	97%	110	104	8.3	42.8
Total	2008'9	78.5	85.6	29365	94%	1042	1053	12.2	28.2
	2009'10	71.7	81.1	27973	94%	1042	1044	12.8	26.8

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	2008'9	16.0	16.0	4498	77%	86	79	5.4	52.3
	2009'10	17.0	15.2	4063	73%	61	63	4.0	66.6
Hay Lodge Hospital	2008'9	19.8	15.4	3929	70%	47	43	3.0	83.6
	2009'10	23.0	12.2	3160	71%	40	31	3.3	79.0
Kelso Hospital	2008'9	13.9	13.7	4046	81%	65	63	4.7	62.2
	2009'10	16.0	11.3	3427	83%	51	49	4.5	67.2
Knoll Hospital	2008'9	14.1	11.1	3285	81%	54	48	4.9	60.8
	2009'10	15.0	9.5	3055	88%	42	45	4.4	72.7
Total	2008'9	63.8	56.3	15758	77%	252	233	4.5	62.5
	2009'10	71.0	48.2	13705	78%	194	188	4.0	70.6

Please Note: seasonal bed reductions agreed from May 09 have been factored into these statistics and this is showing as proportionate bed complement numbers.

### 6.2.3 Mental Health Bed Occupancy

In Mental Health, Occupied Bed Days have decreased by 12%, in 2008/09 there were 34,784 beds occupied, compared to 30,707 in 2009/10. % Bed Occupancy has remained the same at 81% these 2 periods. The Average Length of Stay, comparing the two periods has increased from 48.4 to 49 days. In 2009/10 there were 7% fewer discharges (718 – 08/09 and 627 09/10) and 4% fewer admissions (713 – 08/09 and 688 09/10).

**Table 9 – 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	2008'9	30	9147	7472	82	880	352	351	0	21.2
		2009'10	30	8617	5951	69	935	342	404	0	17.4
Huntlyburn	Learning disability	2008'9	0	117	117	100	5	6	5	0	19.5
		2009'10	0	259	259	100	9	10	10	0	25.9
Huntlyburn	Psychiatry of Old Age	2008'9	0	1122	1122	100	81	19	19	0	59.1
		2009'10	0	1000	1000	100	112	17	14	0	58.8
West Brig	General Psychiatry	2008'9	5	1825	1398	77	284	30	25	0	46.6
		2009'10	5	1825	1556	85	156	35	27	0	44.5
East Brig	General Psychiatry	2008'9	12	4378	3700	85	456	119	121	0	31.1
		2009'10	12	4174	3640	87	335	101	117	0	36.0
Galavale	General Psychiatry	2008'9	11	3183	3057	96	153	30	33	0	101.9
		2009'10	11	3322	3034	91	95	11	10	0	275.8
Galavale	Psychiatry of Old Age	2008'9	0	744	744	100	0	1	2	0	744.0
		2009'10	0	332	332	100	39	2	0	0	166.0
Galavale	Learning disability	2008'9	0	177	115	65	0	2	1	0	57.5
		2009'10	0	30	60	200	0	0	0	0	-
Melburn Lodge	Psychiatry of Old Age	2008'9	16	5840	4999	86	86	15	13	0	333.3
		2009'10	16	5840	5137	88	14	14	17	0	366.9
Poynder View	Psychiatry of Old Age	2008'9	16	2656	1500	56	69	22	11	0	68.2
		2009'10	16	0	0	0	0	0	0	0	-
Wilton View	Psychiatry of Old Age	2008'9	16	5840	4367	75	11	20	25	3	218.4
		2009'10	16	5405	4318	80	26	18	13	0	239.9
Cauldshiels	Psychiatry of Old Age	2008'9	20	7293	5883	81	153	101	107	0	58.2
		2009'10	20	6983	5420	78	188	77	76	0	70.4
The Range	Learning disability	2008'9	1	372	310	83	0	1	0	0	310.0
		2009'10	1	0	0	0	0	0	0	0	-
Total		2008'9	127	42694	34784	81	2178	718	713	3	48.4
		2009'10	127	37787	30707	81	1909	627	688	0	49.0

Please Note:

Poynder View closed to inpatients in September 2008 and following a successful pilot, a resource centre and outreach service was established to provide a new model of care for Dementia patients in the Eastern Borders.

Huntlyburn and Galavale beds are designated as General Psychiatry, but other specialties borrow beds from those complements.

## 7 Summary

---

Performance against the key HEAT targets across health improvement, efficiency, access and treatment including activity and bed utilisation within NHS Borders has been brought to the attention of lead managers/clinicians across the service.

Trajectories are being closely monitored through clinical boards and actions are being drawn up to deliver on these targets.

Throughout 2007/08 NHS Borders Board received Key Monthly Performance Reports. These reports shared timely and accurate information on system-wide performance and allowed the Board to assess progress in meeting key targets. It was agreed that these reports should continue on a monthly basis during 2008/09, and onwards.

The Scottish Government agreed NHS Borders Local Delivery Plan HEAT trajectories in March 2009. In order to structure and align this report around the HEAT targets and trajectories the report has been given a new format. The report therefore now focuses on the key targets and 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 trajectories set in the LDP.



**NHS BORDERS CORPORATE OBJECTIVES:**

**MANAGING OUR PERFORMANCE**

**END OF YEAR PROGRESS REPORT 2009/10**

## Corporate Objectives Progress Report: 2009/10

---

This report reflects the progress against the Corporate Objectives 2009/10. The Objectives have been set around the 4 Key Ministerial Priorities, as follows:

- **Health Improvement for the People of the Scottish Borders** – improving healthy life expectancy
- **Efficiency and Governance Improvements** – continually improve the efficiency of the NHS
- **Access to Services** – recognising patients' need for quicker access to NHS Services
- **Treatment Appropriate to Individuals** – ensuring patients receive appropriate services

This report focuses on performance during the 12 months of 2009/10 and uses the information available at the end of March 2010. For certain targets, an assessment of performance has been made based on activity data at the end of March 2010 and for other targets, the focus has been on performance throughout the year and data gathered to make this assessment may be a cumulative total.

The **Lead Director** is the Board Executive Team Director with corporate responsibility for that action. The Lead Director will identify appropriate Service Leads to manage and monitor the achievement of the actions on a day-to-day basis. In a number of instances there may also be a Director highlighted within brackets; this indicates the Director supporting the achievement of the objective. The **Lead Manager/Clinician** is the Manager/Clinician with operational responsibility for achieving and monitoring the actions.

Progress against the Corporate Objectives is summarised using the performance key below:

Current Performance Key	
Red	At risk: little or no progress made
Amber	Progress made but possible slippage on planned timescale
Green	Action completed or on course for completion

Current Status of Progress	No of Objectives at each Status 2009/10
Green	41
Amber	18
Red	2

## HEALTH IMPROVEMENT FOR THE PEOPLE OF THE SCOTTISH BORDERS

	Corporate Objective	Lead Director	Lead Manager/ Lead Clinician	Deadline for Completion	Status
CO1 <b>HEAT H2</b>	80% of all three to five year old children to be registered with an NHS dentist by 2010/11	Eric Baijal, Director of Public Health	Marion Woods - Service Manager – P&CS	31/03/10	A
<p>The latest available figures are for September 2009 when 71.7% of 3 to 5 year old children were registered with an NHS dentist which is below the trajectory of 76%. In addition to this 6% of 3-5 year olds are in care of the Community Dental Services. The Childsmile initiative is continuing to target families to support access to Dental Services and parents are encouraged to register children with a Dentist as early as possible. Children remain a priority group for the salaried Dental Service and currently there is a waiting time of up to 2 months for children to be registered</p>					
CO2 <b>HEAT H3</b>	Achieve agreed completion rates for child healthy weight intervention programme by 2010/11	Eric Baijal, Director of Public Health	Alan Mordue – Consultant in Public Health/ Cath Young – Health Promotion Manager	31/03/10 but ongoing to 2010/11	A
<p>As at the end of March 2010, a total of 63 interventions had been completed. The target for this period was 84 interventions. A further 6 interventions were attempted but participants did not complete. A further 25 families were contacted but permission was not given for the child to join the intervention and it has been challenging to identify motivated families. Interventions due to finish at end of June will give a potential total of interventions 8 by the 30<sup>th</sup> June 2010. A cumulative target of 194 interventions should be completed by the end of March 2011. This is the reviewed target agreed by the Scottish Government in February 2010. Following a meeting with the Scottish Government on 6<sup>th</sup> May, criteria for participation onto interventions has been revised hence a further 8 have been added to the total giving 79 as at the end of May 2010. Work is now ongoing with the updated criteria to increase the numbers attending healthy lifestyle interventions and a plan of action using a whole school approach will be developed by end of May 2010 which will achieve the target of 194 by March 2011. Awareness raising training for key partner staff (Active Schools Co ordinators and Borders Sports &amp; Leisure Trust) has gone extremely well and will support the development of the action plan. A challenge to recruitment onto programmes is how to approach the topic of obesity with families therefore a “Asking the question” training being is planned for health professionals and other partner staff for August 2010 in conjunction with Health Scotland. To improve recruitment rates, drop in events for parents and children in areas where interventions are to take place have been held and every child between 7 and 13 has had a flyer advertising the event. School nurses are using the Child Health Surveillance data to identify children in a geographical area and writing to them with a</p>					

personal invitation to the open event. However there can be strong opposition from parents to this approach. The postcard flyers have increased self-referrals to the interventions; however referrals from Health professionals, in particular school nurses, are still highest.					A
CO3 <b>HEAT H3</b>	Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention in line with SIGN 74 guidelines by 2010/11	Eric Baijal, Director of Public Health	Julie Murray – ADP Strategic Co-ordinator	31/03/10 but ongoing to 2010/11	
The trajectory for this target is a cumulative target. At the end of March 2010 a cumulative total of 1211 brief interventions (BI) had taken place compared with the trajectory of 1855. Discussions have taken place recently with the Scottish Government HEAT Delivery Team and a revised trajectory and action plan has been developed to ensure delivery of this target in 2011. Going forward there will be regular communication with members of the Delivery Team to identify approaches which have been successful in other areas and agree solutions for local issues. Intensive monitoring of activity by the Alcohol & Drugs Partnership is taking place. Support is to be provided for Primary Care with action plans developed for each GP practice to enable more BIs to be completed. 1-1 coaching is to be provided for staff to improve confidence in ability to raise issue of alcohol with patients and Health Visitors and District Nurses are to become involved in delivering BIs. Within A&E, the model of delivery of BIs is being reviewed to increase the number taking place. Antenatal Staff are revisiting training to increase ability to ask “difficult questions” with their client group.					G
CO4 <b>HEAT H5</b>	Reduce suicide rate between 2002 and 2013 by 20% supported by 50% of key frontline staff in mental health and substance misuse services, primary care and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010	Eric Baijal, Director of Public Health	Cath Young – Health Promotion Manager/	31/03/10 but ongoing to 2010/11	
At the end of March 2010, 139 frontline staff had received suicide prevention training. This is 76% of the total (184) to be trained by the end of December 2010. A&E staff are still to be trained and discussions are taking place regarding additional training dates to accommodate their needs. The staff group with the largest number still to be trained is GPs and training is to be made available during GP protected learning sessions in August and November. A further 9 training courses are planned to take place before the end of 2010 with sufficient capacity on each course to provide places for the remaining 45 staff to be trained.					

CO5 <b>HEAT H6</b>	Through smoking cessation services, support 8% of each NHS Board's smoking population in successfully quitting (at one month post quit) over the period 2008/09 -2010/11	Eric Baijal, Director of Public Health	Alan Mordue – Consultant in Public Health/ Cath Young – Health Promotion Manager	31/03/10 but ongoing to 2010/11	G
At the end of March 2010, 1209 people had been supported to stop smoking (at one month post quit) which is 21% above the target of 997. Performance has been consistently above the trajectory since May 2009.					
CO6 <b>HEAT H7</b>	Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11	Sheena Wright – Director of Nursing & Midwifery	Elaine Cockburn – Head of Midwifery	31/03/10 but ongoing to 2010/11	A
The latest figures available are for the end of September 2009 when 30.7% of babies were being exclusively breastfed which is slightly below the trajectory of 33%. An Infant Nutrition Adviser is now in post who is looking at ways of promoting breastfeeding in the Community setting including identifying breastfeeding friendly nurseries and exploring ways of signposting within shops and restaurants. Links are being further developed between Midwives, Health Visitors and Food Workers. There may be the possibility of providing training for Maternity Assistants to enable them to support breastfeeding. A campaign is being planned for Breastfeeding Awareness week with material being developed for local radio, TV and the press. The local website is being updated and marketing material is being developed to promote the website.					
CO7 <b>HEAT H8</b>	Achieve agreed number of inequalities targeted cardiovascular health checks during 2009/10	Eric Baijal, Director of Public Health	Alan Mordue – Consultant in Public Health/ Cath Young – Health Promotion Manager	31/03/10 but ongoing to 2010/11	A
Keep Well health checks started in the workplace setting in December 2009 and in Primary Care and Community Pharmacies in February 2010. A total of 47 checks were completed by the end of March 2010, slightly below the year end target of 60. The target for 2010/11 is 390 and progress so far is good, in April alone over 80 were delivered. The Scottish Government have recently announced that central funding will continue beyond March 2011. It is currently unclear the level of support that NHS Borders will receive. Because of this, and to ensure as efficient a service as possible, a re-design of the service alongside other anticipatory care initiatives, such as the Lifestyle Adviser Support Service and Counterweight, is being considered. The challenge during 2010/11 will be to maintain progress against the H8 target whilst also taking forward the re-design work.					

**EFFICIENCY AND GOVERNANCE**

	<b>Corporate Objective</b>	<b>Lead Director</b>	<b>Lead Manager/ Lead Clinician</b>	<b>Timeline</b>	<b>Status</b>
CO11 <b>HEAT Std E1</b>	Lab requests with a valid CHI (Universal use of CHI target)	Ross Cameron – Medical Director	Jackie Stephen – Head of IM&T	31/03/10	G
This target remains a HEAT standard however monitoring now takes place on radiology requests. Please refer to CO15 below.					
CO12 <b>HEAT Std E2</b>	NHS Boards to achieve a sickness absence rate of 4% from 31 March 2009	Louise Hamilton-Welsh – Director of Workforce	BET/ Clinical Executive	31/03/10	A
There is a lag in reporting on this target and SWISS data has not been received for March 2010. In February 2010 the rate was 4.5% which is above the trajectory of 4%. During 2009/10, there have only been 2 months when sickness absence was below the target of 4%					
CO13 <b>HEAT E4</b>	NHS Boards to deliver agreed improved efficiencies for first out-patient attendance DNA, non-routine in-patient average length of stay, review to new out-patient attendance ratio and day case rate by March 2011	Ralph Roberts – Chief Operating Officer	Rachel Bacon – General Manager - BGH	31/03/10 but ongoing to 2010/11	G
At the end of March 2010, the following was achieved: DNA rate – 6% (target 5.8%), non routine in patient average length of stay 4.4 days (target 4.7), review to new out patient attendance was 1.68 (target 2.8), day case rate – 88.7% (target – 89%).					
CO14 <b>HEAT E5</b>	NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement and secure on-going recurring financial balance	Jane Davidson – Director of Finance	All	31/03/10 but ongoing to 2010/11	G
All targets were achieved both in terms of revenue and capital budgets. The Board ended the year with a £1 million underspend as had been forecast.					

CO15 HEAT E6	NHS Boards to meet their cash efficiency target	Jane Davidson – Director of Finance	All	31/03/10 but ongoing to 2010/11	A
Good progress was made towards savings targets although a recurring balance of £636,000 was carried forward into the new financial year.					
CO16 HEAT E7	To increase the percentage of new GP out-patient referrals into consultant led secondary care services that are managed electronically to 90% from December 2010	Ross Cameron – Medical Director	Jackie Stephen – Head of IM&T	31/03/10 but ongoing to 2010/11	A
In March 2010, the percentage of GP referrals which were triaged electronically was at 16% which is a slight increase from February 2010 (14.3%). SCI Gateway is now the accepted method of making referrals to all Consultant lead specialties and all GPs are now using this system. It is also being introduced into a number of AHP services and Mental Health, although the roll out to these areas has been delayed due to upgrade issues with the software. Developing this single point of referral which is both reliable and fully auditable with a method of tracking referrals will help encourage use of it thereby increasing the number of referrals over the coming months. Due to the number of roll outs and developments within the implementation project, the Project Team expect the number of referrals to remain around 14-15% until mid 2010 and then to jump up above trajectory to around 90%.					
CO17 HEAT E8	NHS Scotland to reduce emissions over the period to 2011	Ralph Roberts – Chief Operating Officer	David McLuckie – Director of Facilities & Estates	31/03/10 but ongoing to 2010/11	G
Through implementing a range of projects during 2009 - 2010 as detailed in the Carbon Management Plan, NHS Borders has been able to reduce emissions significantly without major capital expenditure. Further projects will be progressed from feasibility to practical completion during 2010 -2011 however financial input will be required. The target which was set was a 4% reduction in emissions per annum. From April 2009 to March 2010 the actual reduction for NHS Borders was 9.65%. The target for 09/10 was 99731 GJ and the actual GJ used was 93381.					

CO18 HEAT E9	Achieve universal utilisation of CHI (radiology requests)	Ross Cameron – Medical Director	Jackie Stephen – Head of IM&T	31/03/10	G
In March 2010 98% of radiology requests had a CHI number which is 3% above the trajectory. This target was achieved in 11 out of 12 months in 2009/10.					
CO19 HEAT E10	NHS Boards to ensure at least 80 per cent of staff covered by Agenda for Change to have their annual Knowledge Skills Framework development reviews completed and recorded on e-KSF by March 2011	Louise Hamilton-Welsh – Director of Workforce	Claire Burke – Workforce Planning & Development Manager, Julie Roberts – Corporate Business Training Manager	31/03/10 but ongoing to 2010/11	R
To further the implementation of KSF and to support the achievement of the next HEAT target, Clinical Board Sponsors and KSF Champions have been identified within each of the Clinical Boards and Support Services to help embed KSF into NHS Borders. Clinical Board Sponsors are responsible for working with KSF Champions to drive and monitor progress. Facilitated Action Plans have been developed to support Managers and targeted training and support is still being made available throughout the organisation. Progress is being reported through the KSF Steering Group, the Workforce Board and the BET. It is important that Clinical Boards take ownership of this target and do not underestimate the significant amount of work still to be done to reach this target.					
CO20	Work towards a joint single Equality Duty with Partners	Louise Hamilton-Welsh – Director of Workforce	Louise Hamilton-Welsh – Director of Workforce	31/03/10	A
The pilot of an NHS Borders hosted joint E&D service with the Scottish Borders Council ended at the end of March 2010. There is discussion underway regarding a joint but differently focused role hosted by SBC around the same agenda. Work was progressed during the pilot and can be resumed across both organisations. Locally; auditing, measuring and monitoring of existing equality schemes continues in order to bring these together with the key action plans to refine this under the single equality duty when this progresses – planned for Spring 2011.					

CO21	Agree and implement an Equality & Diversity Strategy	Louise Hamilton-Welsh – Director of Workforce	Geraldine Bouglas – Lead for Equality & Diversity	31/03/10	G
NHS Borders has a Race, Disability and Gender Equality schemes in place. These each have clear action plans to implement the equality duties. Regular reporting is in place to the JEAT, Public Governance Committee and the BET on progress being made against the action plans and ensuring compliance with the equality duties. Annual reporting to the Equality and Human Rights Commission is also in place.					
CO22	Establish a Joint Service Level Agreement with Scottish Borders Council for Advocacy Services	Sheena Wright – Director of Nursing & Midwifery	Karen McNicoll – Head of Public Involvement & Communications	31/03/10	G
Joint service level agreements with the Scottish Borders Council Social Work Department are in place to provide independent advocacy services across the Borders. Work is ongoing with the Scottish Borders Council and the Borders Advocacy Forum to develop an updated advocacy plan for 2011 – 2014.					
CO23	Review options for future provision of GP IT	Ross Cameron – Medical Director	Jackie Stephen – Head of IM&T	31/03/10	G
NHS Borders General practices have recently indicated their support for joining a consortium with Greater Glasgow & Clyde support to procure the EMIS GP IT system. A business case will be presented to NHS Borders Board in June 2010.					
CO24	Ensure active engagement in developing an SOA for 2010/11 that reflects strategic priorities	Sheena Wright – Director of Nursing & Midwifery	Karen McNicoll – Head of Public Involvement & Communications	31/03/10	G
Through the Voluntary Sector Liaison Group the Voluntary Sector is being supported to produce and publish a SOA Strategic Framework for the Third Sector. Continued contribution and participation in strategic prioritisation sessions for 2010/11 is anticipated through the Borders Strategic Board membership and Officers Group convened by SBC.					

CO25	Procure new patient management system	Ross Cameron – Medical Director	Jackie Stephen – Head of IM&T	31/03/10	G
This project is progressing in adherence with nationally set timescales. A business case was approved by the Board with the chosen supplier being Trakcare. Workshops have been taking place run by Trakcare to demonstrate the system with appropriate staff groups and to determine the Scottish Foundation system which is to be implemented across 5 Health Boards.					
CO26	Develop and implement an action plan based on the staff survey results	Edwina Cameron – Employee Director, Louise Hamilton-Welsh – Director of Workforce	All relevant managers	31/03/10	G
The staff governance action plan has been streamlined. A series of highlights and lowlights along with Clinical Board Reports and comparative data from the staff survey have been used to complete this process.					
CO27	Continued co-ordination, implementation and delivery of the Strategic Change Programme (SCP) and its component projects/workstreams	Callum Campbell Chief Executive	June Smyth – Assistant Director – Planning & Performance	31/03/10	G
All of the Component Projects were operational, with Lead Directors and Project Managers in place during the year. The Project Managers Group ensured that there were no overlaps in work and the SCP Programme Board met quarterly during 2009-10. During Spring 2010 all Projects were successfully embedded into the organisation within services utilising the revised meeting groups. The outstanding work within the change programme has now been cross referenced to NHS Borders Corporate Objectives for 2010/11, with scrutiny of outcomes and project goals monitored through NHS Borders Performance Management and Reporting Arrangements.					
CO28	Continued delivery of the SCP - Operational Budget Savings workstream	Ralph Roberts – Chief Operating Officer & Ross Cameron – Medical Director	Tim Cameron – CHCP Project Officer	31/03/10	G
The overall aim of the Project was to identify and progress budgetary savings initiatives and track the delivery of the agreed savings targets for each Clinical Board and Corporate Services on an annual basis. Moving forward the foundations set within this stream will built upon and inform NHS Borders Efficiency Programme which will be critical in ensuring NHS Borders is able to continue to face its challenges and deliver a safe, quality healthcare service.					

CO29	Continued delivery of the SCP - Improving Efficiency, Reducing Waste	Edwina Cameron – Employee Director & Jane Davidson – Director of Finance	TBC	31/03/10	G
An energy audit of NHS Borders' Newstead site was completed and 'hints and tips' were developed to ensure less energy is wasted. Findings were also circulated to GP practices to assist in reducing energy use Borders wide. Encouraging staff to suggest ways to improve efficiency and reduce waste will be taken forward by NHS Borders Efficiency Programme to allow the organisation to continue to reduce non essential expenditure and encourage staff to take ownership of this.					
CO30	Continued delivery of the SCP - Productivity and Benchmarking	Chief Executive & Ross Cameron – Medical Director	Tim Cameron – CHCP Project Officer	31/03/10	G
The work stream concentrated its efforts on 4 key areas of work: Community Hospitals, GP Referrals, AHP Productivity, and Clinical Delivery identifying where services appear not to perform well compared to others inside or outside NHS Borders and then asked staff to look at how they can improve compared to others. The project is currently focused on workforce modelling and looking at areas such as whole time equivalents and skill-mix for clinical areas. This will help inform areas such as succession planning and ensure that staffing levels across clinical areas are safe and equitable. This work will now be reported through the Clinical Executive.					
CO31	Continued delivery of the SCP - Continuous Improvement	Ralph Roberts – Chief Operating Officer	Phillip Lunts – Head of Improvement & Support Team	31/03/10	G
The various projects within the Continuous Improvement theme weave through the work of the Clinical Boards, Support Services and other SCP projects including 18 weeks Referral to Treatment and Long Term Conditions and Mental Health Collaboratives. Projects are progressing in line with their respective plans, including the rollout of LEAN across the organisation.					
CO32	Continued delivery of the SCP - Sustainable Workforce	Louise Hamilton-Welsh – Director of Workforce & Edwina Cameron – Employee Director	Geraldine Bouglas – HR Policy Development Manager	31/03/10	G
Activities are continuing within the theme with a particular focus on supporting the work of the Integrated Health Strategy project. This work will continue to underpin all NHS Borders day to day activities and service redesign initiatives and will be monitored through established performance routes, the Local Delivery Plan and Corporate Objectives.					

CO33	Implementation and delivery of Children and Young People's Planning Partnership work plan (09/10 activities)	Ralph Roberts – Chief Operating Officer	Mandy Brotherstone – Childrens' Services Managers	31/03/10	G
NHS Borders continues to work in partnership with partner agencies through the CYPPP. Work stream Groups to deliver the outcomes within the work plan feed directly in to the SOA. These groups now report on a regular basis to the CYPPP to inform on progress on targets and emerging issues. During 2009/10 Transforming Children's Services was implemented which strives to deliver child centred services as close to their home as possible following the principles of Getting It Right For Every Child.					

**ACCESS TO SERVICES**

	<b>Corporate Objective</b>	<b>Lead Director</b>	<b>Lead Manager/ Lead Clinician</b>	<b>Timeline</b>	<b>Status</b>
CO35 <b>HEAT Std A3</b>	To respond to 75% of Category A calls within 8 minutes from April 2009 onwards across mainland Scotland	Scottish Ambulance Service (SAS)	Ralph Roberts – Chief Operating Officer / June Nelson – Lead for Unscheduled Care	31/03/10	<b>G</b>
Liaison structures are in place between Scottish Ambulance Service and NHS Borders. A local ambulance group ensures that SAS and NHS Borders are utilising resources appropriately from admission to discharge and ensuring that pathways of care are appropriate for both agencies. In March 2009, 77.5% of 999 calls across Scotland were responded to within 8 minutes.					
CO36 <b>HEAT A6</b>	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	Ralph Roberts – Chief Operating Officer	Rachel Bacon – General Manager - BGH	31/03/10 but ongoing to 2010/11	<b>G</b>
In March 2010, no patients waited more than 4 weeks for a key diagnostic test. This target was achieved in 7 out of 12 months in 2009/10 and was achieved consistently since September 2009. This is a considerable improvement over 2008/09.					
CO37 <b>HEAT A7</b>	...,and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment	Ralph Roberts – Chief Operating Officer	Rachel Bacon – General Manager - BGH	31/03/10 but ongoing to 2010/11	<b>A</b>
In March 2010, 97% of patients were seen by A&E within 4 hours which is slightly below the target of 98%. The target of 98% was achieved in 6 out of 12 months during 2009/10.					
CO38 <b>HEAT A8</b>	Provide 48 hour access or advance booking to an appropriate member of the GP Practice team by 2010/11	Ralph Roberts – Chief Operating Officer	Jackie Morton – General Manager – P&CS	31/03/10 but ongoing to 2010/11	<b>A</b>
In 2009/10 Borders GP Practices achieved 96.83% for the PE7 QOF indicator, which looks at patients being able to access a consultation with a health professional within 2 working days.					

CO39 <b>HEAT</b> <b>A9</b>	The maximum wait for urgent referral with a suspicion of cancer to treatment is 62 days; and the maximum wait from decision to treat to first treatment of all patients diagnosed with cancer will be 31 days from December 2011	June Smyth – Assistant Director, Planning & Performance	Philip Lunts – Head of Improvement & Support Team	31/03/10 but ongoing to 2010/11	<b>G</b>
In March 2010, 96% of patients with an urgent cancer referral were treated within 62 days. The target of 95% has been achieved in 11 months out of 12 months during 2009/10 and in 10 months 100% of patients were treated within 62 days.					
CO40 <b>HEAT</b> <b>A10</b>	Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 12 weeks from being placed on a waiting list to admission for an inpatient or day case treatment from 31 March 2010	Ralph Roberts – Chief Operating Officer	Rachel Bacon – General Manager - BGH	31/03/10 but ongoing to 2010/11	<b>G</b>
At the NHS Borders Board meeting in November 2009 the revised trajectory for the local target that no patients should wait longer than 9 weeks for an outpatient appointment or inpatient treatment was approved. This was set as the target to reduce waits to 12 weeks by March 2010 had been achieved at that point. In March 2010 no patients waited over 9 weeks for an outpatient appointment or inpatient treatment.					
CO41 <b>HEAT</b> <b>A11</b>	To offer drug misusers faster access to appropriate treatment to support their recovery (09/10 activities)	Ralph Roberts – Chief Operating Officer	Graham Allison – Joint Manager – Mental Health	31/03/10	<b>G</b>
Initial work on developing an ICP has commenced.					
CO42 <b>HEAT</b> <b>A12</b>	NHS Boards to deliver faster access to Child and Adolescent Mental Health Services (09/10 activities)	Ralph Roberts – Chief Operating Officer	Graham Allison – Joint Manager – Mental Health	31/03/10 but ongoing to 2010/11	<b>G</b>
Work is ongoing nationally regarding CAMHS remit and referral criteria. A local strategic group has also been established to consider workforce and financial considerations.					

CO43	Develop and agree business case for local expansion of dialysis care which reflects needs assessment	June Smyth – Assistant Director, Planning & Performance	Rachel Bacon – General Manager - BGH	31/03/10	G
This is being progressed through Framework Scotland and building work will commence during summer 2010.					
CO44	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)	Ralph Roberts – Chief Operating Officer	Alasdair Pattinson – Clinical Locality Manager	31/03/10	A
From April 09 onwards to March 2010 the second stage of this target was to be achieved, meaning that no patients should wait over 15 weeks for an AHP appointment. At the end of March 2010 there were 66 patients waiting over 15 weeks. This figure breaks down between professional groups as: 16 in Community Physiotherapy, 14 in BGH Physiotherapy, 26 in Speech and Language Therapy, and 8 in Occupational Therapy. The total of 66 patients is a decrease of 27 patients from January 2010 and is 66 over the target of 0 patients. It is useful to note that as of the 15th March the waiting times position for AHP services improved. This is the result of further tidying of the data as well as increased effort to make more new appointments available. Work is continuing to ensure that no patients wait over 15 weeks before moving on to the lower target of 12 weeks maximum wait in 2010/11.					
CO45	Develop a travel planning strategy	Ralph Roberts – Chief Operating Officer	David McLuckie – Director of Facilities & Estates	31/03/10	G
An Integrated Patient Transport Strategy (IPTS) is almost complete and will be issued for consultation in June. The IPTS will provide a set of recommendations and an action plan for a more coordinated utilisation of available Patient Transport providers.					

CO46	Continued delivery of the SCP - Integrated Health Strategy	Ross Cameron - Medical Director & June Smyth - Head of Planning & Performance	June Smyth – Assistant Director – Planning & Performance / Angela Moody – Planning & Performance Manager	31/03/10	G
<p>The development and planning work within the Integrated Health Strategy theme will now be taken forward within the 4 key themes which were prioritised for further work: BGH, Community Hospitals, Older Peoples Campus and Mental Health Services. These themes have been aligned to the relevant Clinical Boards, although in the case of the Older People’s Campus a whole system approach is required. The relevant liaison Executives will provide overall leadership to the work themes with lead managers (General Managers in most cases) having overall responsibility and accountability for taking the work forward.</p>					

**TREATMENT APPROPRIATE TO THE INDIVIDUAL**

	<b>Corporate Objective</b>	<b>Lead Director</b>	<b>Lead Manager/ Lead Clinician</b>	<b>Timeline</b>	<b>Status</b>
CO48 <b>HEAT Std</b>	To achieve 0 delayed discharges over 6 weeks	Ralph Roberts – Chief Operating Officer	Jackie Morton – General Manager – P&CS	31/03/10	A
In March 2010, there were 3 delayed discharges over 6 weeks. Achieving the target of 0 delays is a key priority for both Health and Social Work and a multi agency group meets on a weekly basis to review delayed discharges with the aim of ensuring that whenever possible, there are no discharges over 6 weeks. By April 2010, there were no delayed discharges over 6 weeks.					
CO49 <b>HEAT T2</b>	QIS clinical governance and risk management standards improving	Sheena Wright - Director of Nursing & Midwifery	Erica Nisbet – Clinical Governance Co-ordinator	31/03/10	G
A peer review of our performance against the NHSQIS Clinical Governance and Risk Management Standards was conducted by NHSQIS in May 2009. The report from this review was published in November 2009. This report demonstrated improvement in several areas. Though we did not reach our centrally set trajectory of a score of 9, our overall score improved from 6 to 7 (out of a possible 12). An action plan for improvement has been developed. Actions are 'owned' by the directors and leads for each of the criteria. Progress against the action plan will be monitored by the Clinical Governance Committee through quarterly reporting. Co-ordination of the action plan reporting will be supported by the Lead for Delivery Support.					
CO50 <b>HEAT T3</b>	Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10 and put in place the required support framework to achieve a 10% reduction in future years	Ralph Roberts – Chief Operating Officer	Graham Allison – Joint Manager – Mental Health	31/03/10	A
The latest available data is for December 2009. At this time, the rate of anti-depressant prescribing was at approximately 37 per capita per year. This was just above the trajectory of 36.21 and below the Scottish rate of 37. However the trend for prescribing was on an upward trend at this point and it is unclear when this trend will begin to decrease.					

CO51 <b>HEAT T4</b>	Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over seven days by 10% by the end of December 2009)	Ralph Roberts – Chief Operating Officer	Graham Allison – Joint Manager – Mental Health	31/03/10	G
During March 2010 there were 76 readmissions which fell within this target which is below the trajectory of 119 and this target has been achieved since April 2009. The majority of readmissions have been within 28 days so attention is being focused in this area. Work is also progressing on analysing length of stay.					
CO52 <b>HEAT T6</b>	To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, asthma, diabetes or CHD from 2006/07 to 2010/11	Ralph Roberts – Chief Operating Officer	Sandra Pratt – LTC/MCN Manager	31/03/10 but ongoing to 2010/11	G
A Local Enhanced Service for Anticipatory Care and Prevention of Admissions has been introduced for 2010/11 which supports the use of anticipatory care plans, self-management plans and crisis-management sheets. A Scottish Enhanced Service (SES) has been established for COPD, building upon the previous SES and with a focus on pulmonary rehabilitation and care planning. A Diabetes SES has been developed to support a shift in the balance of care from secondary to primary care settings and is currently being considered within the GP Local Negotiating Committee processes. The MCNs continue to take forward their action plan and have established education modules within the Long Term Conditions Training & Education Programme. Provisional figures for 2009/10 show that there was a rate 1700 episodes that fall within this target which is slightly below the trajectory of 1735 episodes. This is calculated based on 08/09 population figures.					
CO53 <b>HEAT T7</b>	Improvement in the quality of health care experience	Sheena Wright - Director of Nursing & Midwifery	Phillip Lunts Head of BIST Frances Mason, Patient Safety Programme Manager	31/03/10	A
NHS Borders was recently visited by the Institute of Healthcare Improvement (IHI) and the NHS Quality Improvement Scotland (NQIS) Faculty Team. The feedback was very encouraging, helpful and positive. The final report has not yet arrived but action plans have been developed for each work stream based on their recommendations, which are now being progressed. The Faculty Team were particularly impressed with the successful improvements implemented by the Critical Care Team, (e.g. 540 + patient days with no Central Line Infections) and invited them to show case their work at a session in Glasgow. NHS Borders					

<p>has now been asked to present at 5 out of the 6 Learning Sessions held since the programme was commenced in January 2008. All work stream teams in NHS Borders continue to work on the Scottish Patient Safety Programme demonstrating implementation of the key changes. These changes are being measured for the impact on clinical care through the process and outcome measures as well as identifying our challenges and organisational learning The most recent IHI assessment scale is awaited following our local report submission. All medical wards and surgical wards are now engaged in the programme. Orthopaedics and Obstetrics are the next phase of spread. The National Paediatric Patient Safety Programme is also about to commence.</p>					
CO54 <b>HEAT T8</b>	Increase the level of older people with complex care needs receiving care at home	Ralph Roberts – Chief Operating Officer	Jackie Morton – General Manager – P&CS	31/03/10	G
<p>At the end of March 2010, the number of people receiving 10 hours or more of intensive home care, care home and geriatric long stay care increased to 31.67%. This was an increase from March 2009 when the figure was 28.83% and is above the target of 30%</p>					
CO55 <b>HEAT T9</b>	Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with dementia by March 2011	Ralph Roberts – Chief Operating Officer	Graham Allison – Joint Manager – Mental Health	31/03/10 but ongoing to 2010/11	A
<p>Local MH Collaborative colleagues and NHS Borders Service Improvement are working with Primary and Community Services, Mental Health Services, Social Care and the voluntary sector to strengthen existing approaches and develop new ways of joint working that will identify those individuals with dementia and ensure access to appropriate support.</p>					
CO56 <b>HEAT T10</b>	To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11	Ralph Roberts – Chief Operating Officer	Sandra Pratt – LTC/MCN Manager	31/03/10 but ongoing to 2010/11	G
<p>This target includes both BGH A&amp;E attendances and attendances at the 4 Minor Injury Units located in Community Hospitals. During March 2010 2,132 patients attended A&amp;E and the MIUs which is 1% under the trajectory of 2163. This total comprises 1,905 A&amp;E and 277 MIU attendances. The is an increase of 317 attendances from February 2010, however it is a 9% reduction from February 2009 where there were 2,371 attenders. During 2009/10 a T10 “Steering Group” has been established to oversee the delivery of an agreed Action Plan. Audits have been carried out to understand patient flows and patient profiles across A&amp;E and the four Minor Injury Units (MIUs). Two forms of audit have been used: one from the patient’s perspective which has identified why people attended A&amp;E and the other a multi-disciplinary review of individual cases attending on randomly chosen dates. The outcomes of the audits have informed the Action Plan and supported the need to review referral processes</p>					

and management of patient transfer to the Medical Assessment Unit, which has been taken forward as a "Lean" Redesign Programme. An Anticipatory Care and Prevention of Admissions Enhanced Service has been established which includes the use of a generic crisis management protocol, specific anticipatory care plans and anticipatory social care planning as well as specific protocols for the management of DVTs. Building on the support for self-management, the Long Term Conditions website "Borders Health in Hand" is in place.						
CO57.1 <b>HEAT T11</b>	To reduce all <i>staphylococcus aureus</i> bacteraemia (including MRSA) BY30% by 2010; to introduce and comply with local antimicrobial policies by 2010	Sheena Wright - Director of Nursing & Midwifery	Adam Wood - Infection Control Nurse	31/03/10 but ongoing to 2010/11		R
During March 2010 there were 9 <i>staphylococcus aureus</i> bacteraemia which is 7 bacteraemia more than the trajectory target. This is an increase of 8 bacteraemia from February 2010. This target has been achieved in 8 months out of 12 during 2009/10. As a result of the significant increase in the infection rates in March, increased surveillance and root cause analysis is now taking place.						
CO57.2 <b>HEAT T11</b>	To reduce the rate of C diff infection in hospitals by at least 30% by 2011	Sheena Wright - Director of Nursing & Midwifery	Adam Wood - Infection Control Nurse	31/03/10 but ongoing to 2010/11		G
For C Diff infection, the trajectory was set at 18 CDIs per quarter. For the quarter of the year (January – March 2010) 7 cases were reported compared to the trajectory of 18. For the month of March 2010 there were 3 cases, 3 below the monthly trajectory of 6. This target has been achieved in 9 months out of 12 during 2009/10.						
CO58 <b>HEAT T12</b>	By 2010/11 NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05	Ralph Roberts – Chief Operating Officer	Sandra Pratt – MCN/LTC Manager	31/03/10 but ongoing to 2010/11		A
The work described above linked to HEAT targets T6 and T10 also contributes to the delivery of T12. In addition, Lean redesign programmes for Discharge Processes and the Stroke Pathway have focussed on reducing bed days and in liaison with Primary & Community Services, it is anticipated that the Lean programme over 2010/11 will include review of community services. As part of the national Joint Improvement Team Demonstrator Programme, an interagency intermediate care model is being trialled in two Day Hospital locations with the aim of supporting early discharge and preventing admission. As part of this initiative, Mental Health Services will deliver training in the management of dementia to the Night Support Service so that if a carer becomes ill out of hours, then a Night Support Service care worker can be brought in immediately to support the person with dementia from having to be admitted to hospital. Work continues to develop more robust data collection and analysis which will inform further development of the action plan. The latest available data shows that at the end of December 2009, when there						

were 3681 emergency bed days (per 1000 population) for the over 65s. This is close to the trajectory for March 2010 of 3340 bed days per 1000 population.					
CO59	Subject to Board approval of OBC for Borders Emergency Care Centre ensure robust and effective procurement of suppliers consistent with Frameworks Scotland	June Smyth – Assistant Director, Planning & Performance	Angela Moody – Planning & Performance Manager	31/03/10	G
Work is being progressed within the BGH Clinical Board to consider whether there are other alternatives to BECC which will achieve the objectives in a more efficient way and at reduced cost, although it is still recognised that there would still be a requirement to modernise and improve the environment for A&E and out of hours services at the BGH.					
CO60	Progress development of RONIC to implementation of a new Community Nursing Team	Jackie Morton – General Manager – P&CS	Jan Macdonald – Project Manager - RONIC	31/03/10	G
NHS Borders was one of 4 areas across Scotland to develop and pilot a proposed new model of nursing in the community. During the pilot, engagement with the project was variable and many questions about the new model were posed. Despite this almost 60 Community Nurses from the disciplines of District Nursing, Health Visiting and School Nursing undertook the transitional education provided by Queen Margaret University in Edinburgh and have utilised this education to look at new and innovative ways of managing their caseloads. The education also gave the nurses the opportunity to look at closer working within teams and across disciplines to provide an enhanced service to meet the changing needs of the population of the Borders. The initial project has now finished however each of the boards participating in the pilot will be reviewed as part of the evaluation of the original project and this will take place in the Autumn. There is continued commitment from the Scottish Government to modernise Community Nursing. To support this all Health Boards in Scotland are now working together at to ensure that Nurses working in the community have the right skills and knowledge to meet the needs of the population across all ages as we progress through the 21 <sup>st</sup> century. NHS Borders is represented nationally on the steering group by Sheena Wright, Director of Nursing and Midwifery and Dr Sheena MacDonald, Associate Medical Director, P&CS. The new model will consider work streams associated with particular age ranges and each has a sub group leading on these developments. NHS Borders has representation from clinicians in all subgroups and a local modernizing nursing in the community committee continues to meet quarterly.					

CO61	To produce affordable business cases for the redevelopment of primary health care facilities for Roxburgh Street Practice, Galashiels, Lauder and Jedburgh	June Smyth - Assistant Director, Planning & Performance	Warwick Shaw - General Manager – Premises & Capital Development	31/03/10	G
This has now been approved and will be delivered throughout 2010/2011.					
CO62	Consistent with Living and Dying Well and the Delivery Plan, progress improvements in palliative care	June Smyth – Assistant Director, Planning & Performance	Phillip Lunts – Lead – Cancer & Palliative Care, Elaine Peace – Nurse Consultant, Palliative Care	31/03/10	G
The local delivery plan is being monitored and a national visit has now taken place.					
CO63	Progress secondary care premises/capital works e.g. Endoscopy	Ralph Roberts – Chief Operating Officer	Warwick Shaw - General Manager – Premises & Capital Development	31/03/10	G
This work is now complete and the capital plan continues to be reviewed.					
CO64	Develop and agree a Public Involvement Strategy	Sheena Wright – Director of Nursing & Midwifery	Karen McNicoll – Head of Public Involvement & Communications	31/03/10	G
The Public Involvement and Communications Team is reviewing the public involvement structures and processes that are currently in place. A Public Involvement Strategy for 2010-2013 is in development in consultation with partners.					
CO65	Develop and agree Maternity Services Strategy	June Smyth - Assistant Director, Planning & Performance	Elaine Cockburn – Head of Midwifery	31/09/09	A
This work is ongoing and will be consulted upon during Autumn 2010.					

At the NHS Borders Board meeting in November 2009, it was agreed that the following Corporate Objectives would be removed and be reported back through the SOA reporting mechanisms to avoid double reporting.

Objective No	Detail
CO8	Implementation and delivery of joint health improvement team work plan
CO9	Support the delivery, through social work, of the Housing strategy partnership work plan
CO10	Implementation and delivery of Alcohol & Drugs partnership (DAAT) work plan
CO33	Implementation and delivery of Children & Young peoples planning partnership work plan
CO34	Implementation and delivery of Data Sharing partnership work plan
CO47	Implementation and delivery of Learning Disabilities work plan
CO66	Implementation and delivery of Mental Health and Wellbeing partnership work plan
CO67	Implementation and delivery of Primary & Community Care partnership work plan