Borders NHS Board

NHS BORDERS HEAT PERFORMANCE SCORECARD – AUGUST 2015

Aim

This paper aims to update the Board with NHS Borders latest performance towards the 2015/16 National Health Efficiency Access & Treatment (HEAT) standards, as set out in NHS Borders Local Delivery Plan. The attached HEAT Performance Scorecard shows performance as at 30th June 2015.

Background

Strong Performance Management remains a key priority across NHS Borders to ensure robust monitoring of key local and national standards and priorities. Performance Scorecards are embedded across the organisation and individual services continue to implement their own scorecards with the assistance of Planning and Performance.

Attached to this paper is the HEAT Performance Scorecard providing a summary of performance at 30th June 2015.

Areas of strong performance in the Scorecard for the position as at 30th June 2015 are highlighted below:

- To sustain and embed alcohol brief interventions (ABIs) exceeded the trajectory of 330 in June 2015 with 438 ABI's being delivered (page 8)
- The standard for pre-operative stay was achieved during April 2015 (latest available data) 0.22 days against the standard of 0.47 (page 11)
- 93.9% of all referrals were triaged online in June 2015, above the standard of 90% (page 12)
- Treatment of cancer within 31 days of decision to treat for all patients diagnosed with cancer was delivered for all cases during May 2015 - latest available data (page 16)
- Treatment of cancer within 62 days for urgent referrals of suspicion of cancer was delivered for all cases during May 2015 - latest available data (page 16)
- 18 Week RTT non-admitted pathway performance and both admitted and non-admitted linked pathways are performing well above 90% target in June 2015 (page 18 & 19)
- 18 Weeks RTT combined overall performance continues to perform above the standard of 90% (page 20)
- The Alcohol/Drug referrals into treatment within 3 weeks has achieved the national standard of 90% and the local stretched target of 95% throughout this financial year (page 24)
- During May 2015 (latest available data) 100% of patients were admitted to the Stroke Unit within 1 day of admission, against a standard of 90% (page 28)

Areas where performance is outwith the tolerance of 10% in the Scorecard for the position as at 30th June 2015 are highlighted below:

- New patient DNA rate was 4.7% which is higher than the standard of 4% (page 9)
- eKSF and PDPs recorded did not meet the trajectory in June 2015, reporting 6.72% and 7.71% respectively (page 13 & 14)
- Inpatient and outpatient waits over 12 weeks are 7 and 398 respectively against a standard of 0 patients (page 17)
- 18 Week RTT Admitted Pathway Performance for June 2015 was 77.8% which is outwith the standard of 90% (page 18)
- 47 breaches of the 4 week diagnostic waiting time were reported in June 2015 (page 21)
- 11 patients waited over 18 weeks within the Child and Adolescent Mental Health Service in May 2015 - latest available data (page 22)
- 37 breaches were reported against a standard of 0 psychological therapy waits over 18 weeks (page 23)

The format of the HEAT scorecard is unchanged for the 2015/16 financial year. There has been one addition, Alcohol Brief Interventions, which is a new HEAT Standard for 2015/16. The Local Delivery Plan (LDP) outlines HEAT Standards where as in the past the LDP focused largely on the delivery of the HEAT targets set by the Scottish Government. From 2015/16 these targets are to be known as LDP Standards. These Standards will continue to be closely monitored to maintain performance. Planning & Performance are will engage with the Board later in the year to agree the reporting format of the standards in 2016/17.

Summary

NHS Borders Board meetings continue to receive the HEAT Performance Scorecard highlighting the organisation's performance towards the national HEAT Standards. The format has been updated for this financial year to include trends for each standard and narrative on current performance.

Recommendation

The Board is asked to **note** the August 2015 HEAT Performance Scorecard (June 2015 performance).

Policy/Strategy Implications	Regular and timely performance reporting is an expectation of the Scottish Government
Consultation	Performance against key indicators within this report have been reviewed by each Clinical Board and members of the Clinical Executive
Consultation with Professional Committees	See above
Risk Assessment	Good progress is being made against key standards, but emerging pressure areas are identified in this report. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders

Compliance with Board Policy requirements on Equality and Diversity	Please see attached Impact Equality Assessment Scoping Template
Resource/Staffing Implications	The implementation and monitoring of standards will require that Lead Directors, Managers and Clinicians comply with Board requirements

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Workforce & Planning		

Author(s)

Name	Designation	Name	Designation
Carly Lyall	Planning & Performance Officer		

Month

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NHS Borders

HEAT PERFORMANCE SCORECARD

As at 30th June 2015

August 2015

Planning & Performance

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INTRODUCTION

DASHBOARD OF HEAT STANDARDS

The Dashboard of HEAT Standards shows the performance of each standard against a set trajectory. So that current performance can be judged symbols are used to show whether the trajectory is being achieved. These are shown in the table below:

Current Performance Key			
R	Under Performing	Current performance is significantly outwith the trajectory set.	Exceeds the standard by 11% or greater
A	Slightly Below Trajectory	Current performance is moderately outwith the trajectory set.	Exceeds the standard by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory set	Overachieves, meets or exceeds the standard, or rounds up to standard

So that the direction of travel towards the achievement of the standard can be viewed direction symbols are also included in the dashboard. These are shown below:

Direction Symbols

Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-

HEAT Standards

Every year the Scottish Government Health Department (SGHD) asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report is called the Local Delivery Plan (LDP) and forms an agreement on what Health Boards will achieve in the next year with SGHD. Boards are asked to work towards a number of key standards for the year which fit with the Government's health objectives. The Local Delivery Plan for 2015/16 sets out the HEAT Standards for NHS Borders.

Planned work with local partners such as Scottish Borders Council is also included.

Please note:

Some anomalies may occur in data due to time lags in data availability and national reporting schedules.

Performance on the HEAT standards is detailed within in this report. The following table summarises the achievements for the financial year 2015/16 to date, the arrows indicate performance and direction of travel towards achieving the standards compared to the previous month:

Indicator	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Smoking cessation successful quits in most deprived areas [1]	-	-	-									
Alcohol Brief Interventions [2]	A -	A ↑	G ↑									
New patient DNA rate	R ↓	R ↑	R ↑									
Same day surgery [3]	A ↓	-	-									
Pre-operative stay [3]	G ↑	-	-									
Online Triage of Referrals	G ↑	G ↑	G ↓									
eKSF annual reviews complete	R -	R ↑	R ↑									
PDP's Complete	R -	R ↑	R ↑									
Sickness Absence Reduced	A ↑	A ↑	A ↓									
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [4]	G ↔	G ↔	-									
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [4]	G ↔	G ↔	-									

Indicator	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
18 Wk RTT: 12 wks for outpatients	R ↓	R ↑	R ↓									
18 Wk RTT: 12 wks for inpatients	R ↑	R ↓	R ↑									
18 Wk RTT: Admitted Pathway Performance	R ↑	R ↓	R ↑									
18 Wk RTT: Admitted Pathway Linked Pathway	G ↑	G ↓	G ↔									
18 Wk RTT: Non-admitted Pathway Performance	G ↑	G ↓	G ↓									
18 Wk RTT: Non-admitted Pathway Linked Pathway	G ↓	G ↓	G ↑									
Combined Performance	G ↑	G ↓	G ↑									
Combined Performance Linked Pathway	G ↓	G ↓	G ↑									
4 Week Waiting Target for Diagnostics	R ↓	R ↑	R ↓									
No CAMHS waits over 18 wks [5]	R ↓	R ↑	-									
No Psychological Therapy waits over 18 wks	R ↑	R ↑	R ↓									
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G ↑	G ↓	G ↑									
No Delayed Discharges over 2 Wks	G ↔	G ↔	A ↓									
4-Hour Waiting Target for A&E	A ↑	A ↑	A ↓									
Emergency OBDs aged 75 or over (per 1,000) [6]	-	-	-									

Indicator	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Admitted to the Stroke Unit within 1 day of admission [7]	G ↑	G ↔	-									
Diagnosis of dementia	A ↓	A ↑	A ↓									
Further Reduce Rate of Staph aureus bacteraemia [8]	-	-	-									
Further Reduce Rate of C. Diff (CDAD) cases in over 15s [8]	-	-	-									

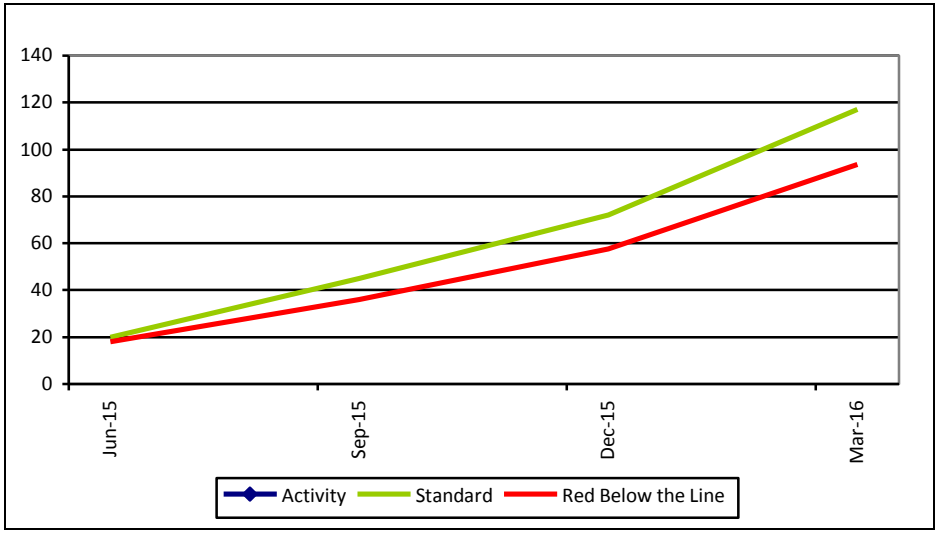
[1] Data is reported quarterly to allow monitoring of the 12 week quit period.
[2] Data should be treated as provisional as there is a reporting lag in some areas which means that data is not fully reconciled at time of reporting.
[3] There is a lag in data due to SMR recording.
[4] One month lag as data is supplied nationally.
[5] Due to verification processes for national reporting, with CAMHS there is a one month time lag in data.
[6] There is a lag in reporting of 6 months for this standard. Please see performance in the following section of this report.
[7] Data is provisional. Due to the time difference between the P&P deadline and the national extract deadline, this data (drawn from eSSCA) has a 1 month time lag. A data snapshot is taken and used to compile these reports. Routine data collection and amendment usually take place on a daily basis however data should be interpreted as provisional because delays in data entry may occur or data updates may be made after the snapshot was taken.
[8] Please Note: SABs & CDiff standards are reported via the Director of Nursing's regular Healthcare Associated Infection and Prevention report to the Board.

DASHBOARD OF HEAT STANDARDS

Standard: Smoking cessation successful quits in most deprived areas (cumulative)

Standard Date	2015/16 Standard	Current Standard	Jun 15	Sep 15	Dec 15	Mar 16	Performance	YTD
Maintain	117	20					-	-

Please Note: All figures are cumulative. Data is reported quarterly to allow monitoring of the 12 week quit period. There is a 4 month lag time for reporting to allow monitoring of the 12 week quit period therefore quarter 1 data will be available in August 2015.



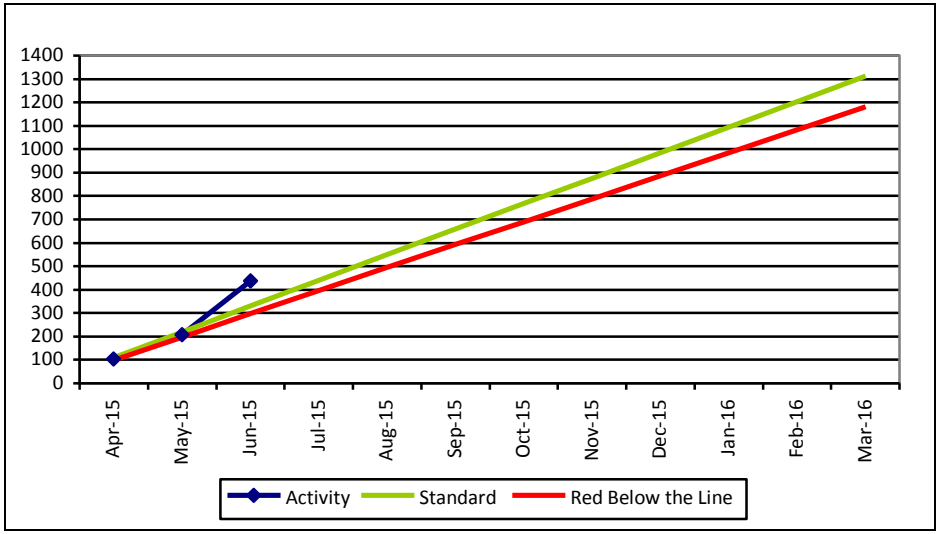
Data for **smoking cessation successful quits** will be available for reporting from end July 2015 to allow monitoring of the 12 week standard quit period from 1st April 2015.

The smoking cessation standard for 2015/16 has been adjusted by the Scottish Government to reflect the complexities and challenges recognised during 2014/15: 117 quits at 12 weeks in our most deprived communities. Locally, Public Health is working closely with Community Pharmacy, with the BGH and with Maternity services to continue to focus resources effectively and maintain a programme of work that combines prevention, protection and cessation. Public Health is also leading the development of a joint Tobacco Control Action Plan that will clarify the contribution of partner agencies in SBC and the third sector to deliver the objectives in the national strategy.

Please Note: Data will be reported with a 4 month lag time to allow monitoring of the 12 week quit period.

Standard: Sustain and embed alcohol brief interventions (cumulative)

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	1312	110	105	208	438										↑	G



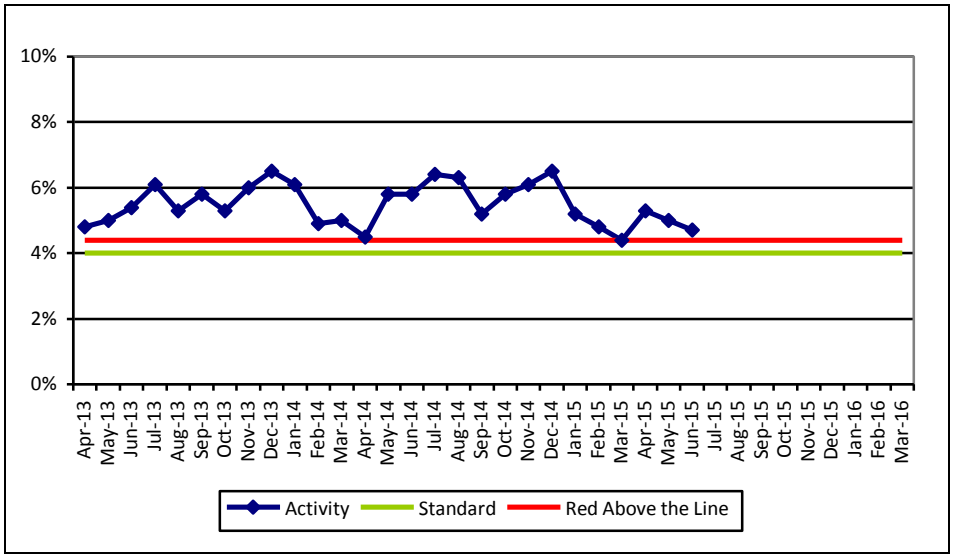
To sustain and embed **alcohol brief interventions** is a new standard for 2015/16. The run chart shows that performance at the end of June 2015 is ahead of trajectory. The service has predicted the standard will be achieved during 2015/16.

A Local Enhanced Services (LES) has been agreed with Primary Care to deliver alcohol screening and brief interventions.

There is a reporting lag in some areas which means that data is not fully reconciled at time of reporting therefore should be treated as provisional.

Standard: New patients DNA rate will be less than 4% over the year

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	4%	4%	5.3%	5.0%	4.7%										↑	R



The run chart shows that **DNA rates** have improved since the decrease in performance in April 2015 however performance is still outwith the 4% standard. The run chart also shows seasonal peaks in December and July / August. This is being factored into the Transforming Outpatients Project which is looking at ways to improve the DNA rate.

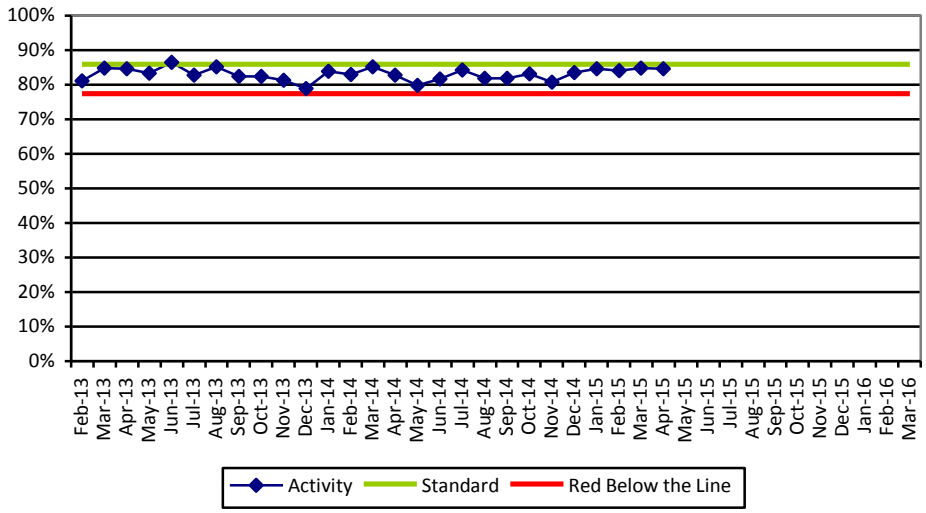
Various actions are planned to reduce the number of patients who fail to attend new outpatient appointments without notification, these include:

- Improve quality of patient contact details – it is now a 'must do' that reception staff check patients demographics, information messages are displayed on LCD screens in patient waiting areas
- A pilot commenced on 6th July to telephone patients, prior to their appointment, who have a DNA history. Results will be available from August

A stakeholder event is planned for August 2015 which will focus on engagement, look at initiatives carried out by other Boards and look at how our processes can be improved the increase performance

Standard: 86% of patients for day procedures to be treated as Day Cases

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	86%	86%	84.7%	-	-										-	A



Whilst **same day surgery** performance has not met the overall 86% HEAT standard since August 2013, the run chart shows that performance has consistently been within 10% of the standard. The last 5 month data shows an increased trend in performance.

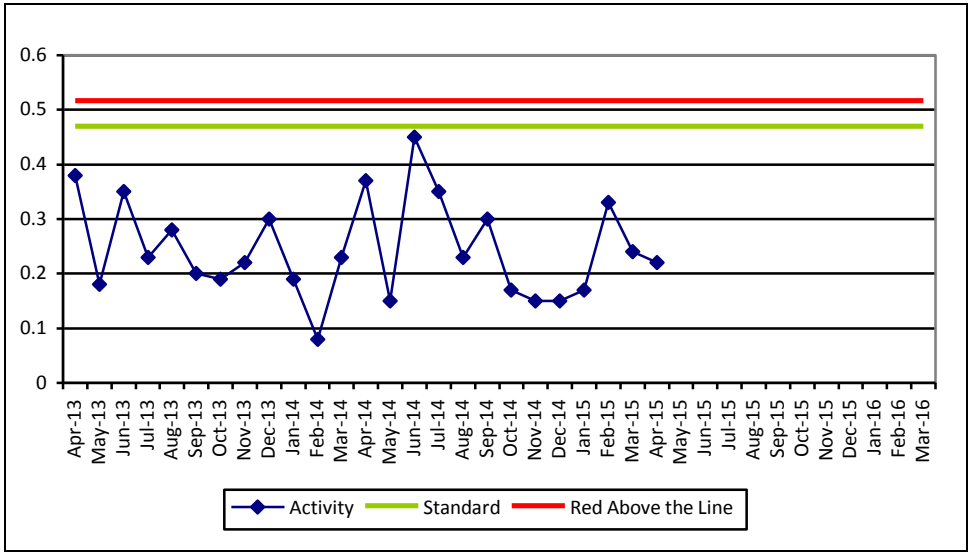
The procedures able to be listed for day case surgery fluctuate month on month as do the total number of inpatient procedures carried out. In order to understand the specific reasons why the target has not been met a review of day surgery by specialty will take place in August 2015.

Please Note: There is a two month time lag in data being published for this standard.

**British Association of Day Case Surgery*

Standard: Reduce the days for pre-operative stay

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	0.47	0.47	0.22	-	-										-	G



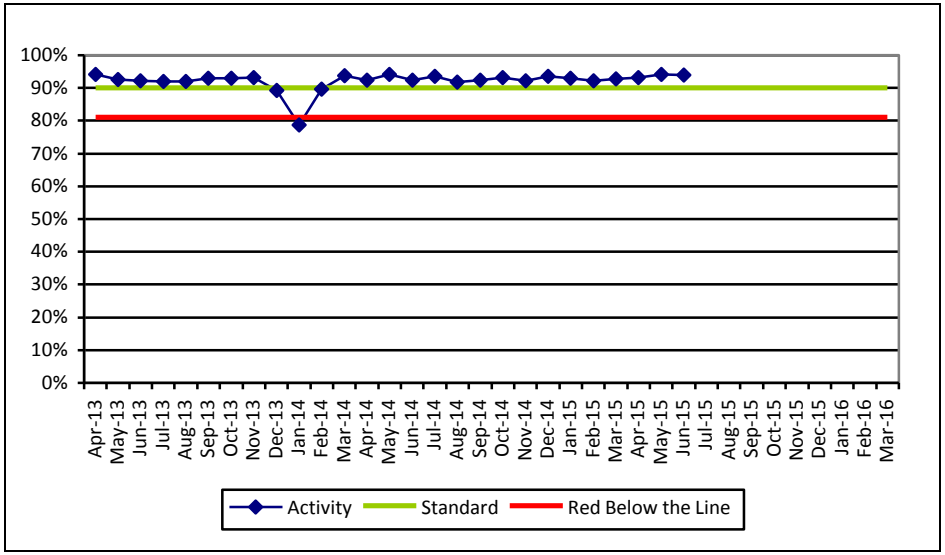
The run chart shows that pre-operative inpatient stays in hospital continue to be low and within the trajectory set. Performance has consistently been within the standard with **pre-operative length of stay** remaining under half a day since April 2013.

In March and April 2015 (latest available data) the pre-operative stay has improved. This is supported by a rigorous pre-assessment process and a dedicated Planned Surgical Admission Unit which patients can attend at 7.30am to be prepared for surgery on the day.

Please Note: There is a two month time lag in data being published for this standard.

Standard: 90% of all referrals to be triaged online

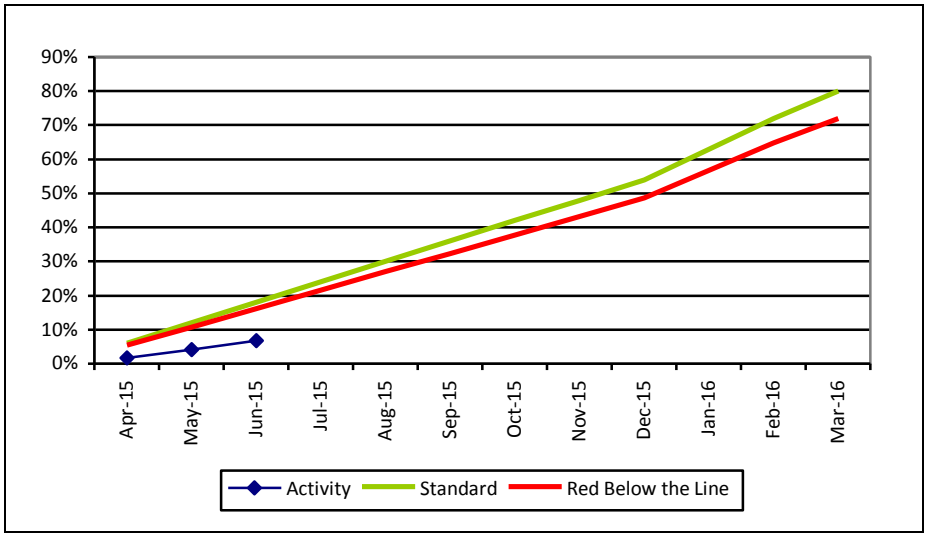
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	93.2%	94.1%	93.9%										↓	G



The run chart shows that overall the level of **online eTriage of referrals** continues to perform above the 90% standard.

Standard: 80% of all Joint Development Reviews to be recorded on eKSF

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
March 2016	80%	18%	1.67%	4.11%	6.72%										↑	R

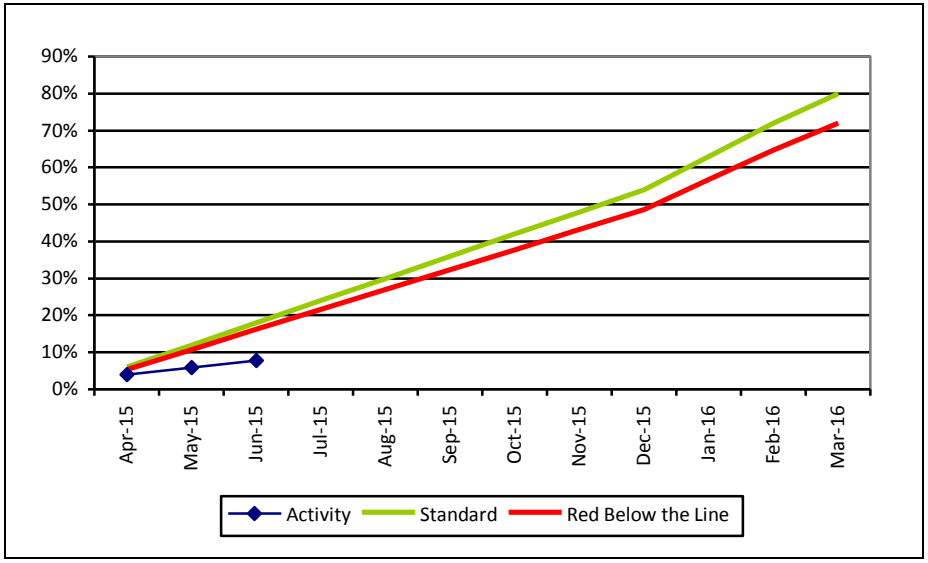


Please Note: Trajectory for 2015/16 is provisional and will be updated in July 2015.

The run chart shows that overall within NHS Borders the trajectory set for recording **annual Joint Development Reviews (JDRs) on eKSF** has not been met. The standard for recording JDR's on eKSF starts at the beginning of each financial year. The trajectory is set to ensure the standard of 80% of JDRs being recorded will be achieved by the end of March 2016. A common trend occurs which sees an increase in JDRs in quarter 4 however this is being monitored regularly and action plans are in place.

Standard: 80% of all Personal Development Plans to be recorded on eKSF

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
March 2016	80%	18%	4.00%	5.93%	7.71%										↑	R

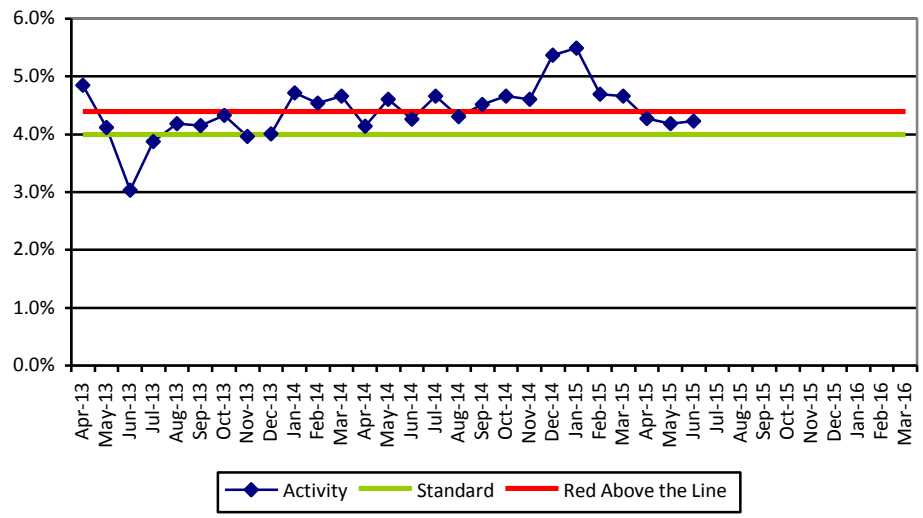


The run chart shows that overall within NHS Borders the trajectory for recording **Personal Development Plans (PDPs) on eKSF** has not been achieved. The standard for recording PDPs on eKSF starts at the beginning of each financial year. The trajectory is set to ensure the standard of 80% of PDPs being recorded will be achieved by the end of March 2016. A common trend occurs which sees an increase in recording in quarter 4 however this is being monitored regularly and action plans are in place.

Please Note: Trajectory for 2015/16 is provisional and will be updated in July 2015.

Standard: Maintain Sickness Absence Rates below 4%

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	4%	4%	4.27%	4.18%	4.23%										↓	A



The run chart shows that **Sickness Absence** rates have been steadily improving since December 2014 and have been within 10% of the standard for the past 3 months.

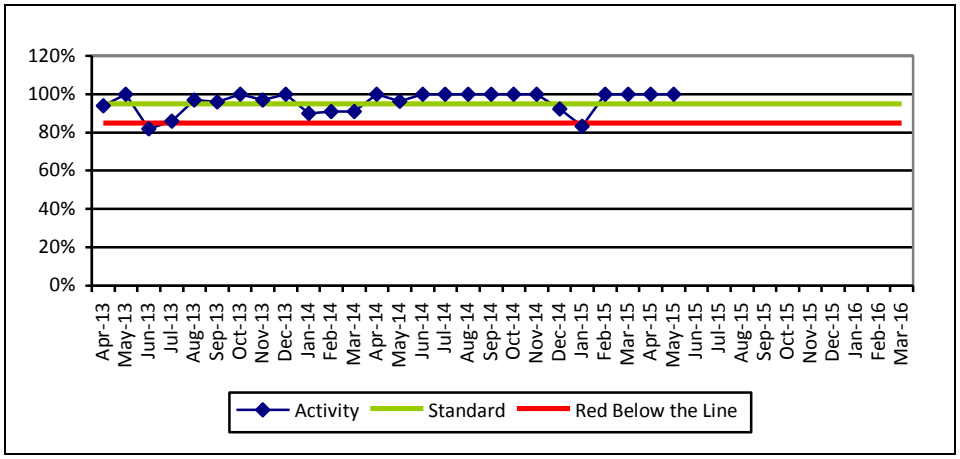
The Employee Relations Team sends out the monthly Reports that are agreed with the service to assist them in managing sickness absence. These are presented to Clinical Boards via Performance Scorecards.

Refresher Sickness Absence Training for line managers is ongoing for all managers who had undertaken the initial e-Learning and Classroom based training.

An action plan for 2015/16 is currently being refreshed.

Standard: 95% of all cases with a Suspicion of Cancer to be seen within 62 days

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	95%	95%	100%	100%	-										↔	G



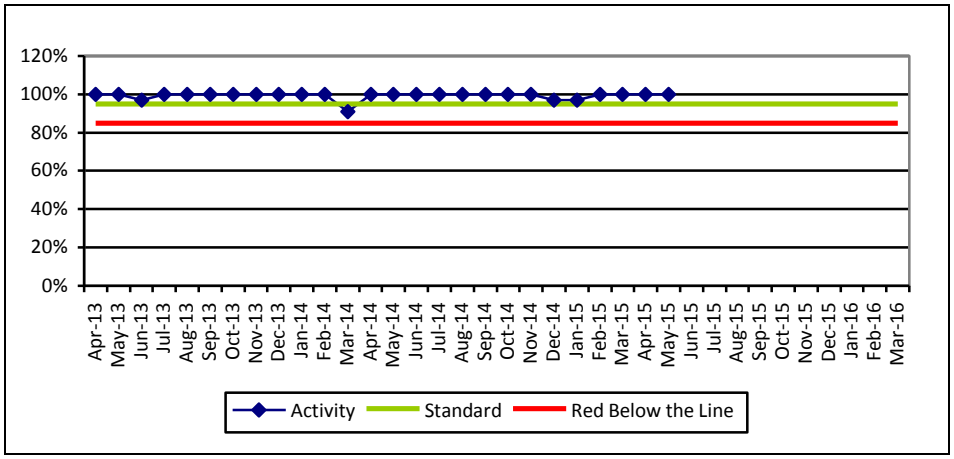
The run chart shows the standard, to **see patients with a suspicion of cancer within 62 days** is back on track at 100% compliance follwoing the breaches in December 2014 & January 2015.

The service experienced a high number of 62-day breaches in January. No further breaches were reported in February or March 2015. An action plan is in place to address the issues highlighted in the *End of Year Managing Our Performance Report* to prevent a future recurrence.

Please Note: There is a time lag of one month for this data

Standard: 95% of all patients requiring Treatment for Cancer to be seen within 31 days

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	95%	95%	100%	100%	-										↔	G

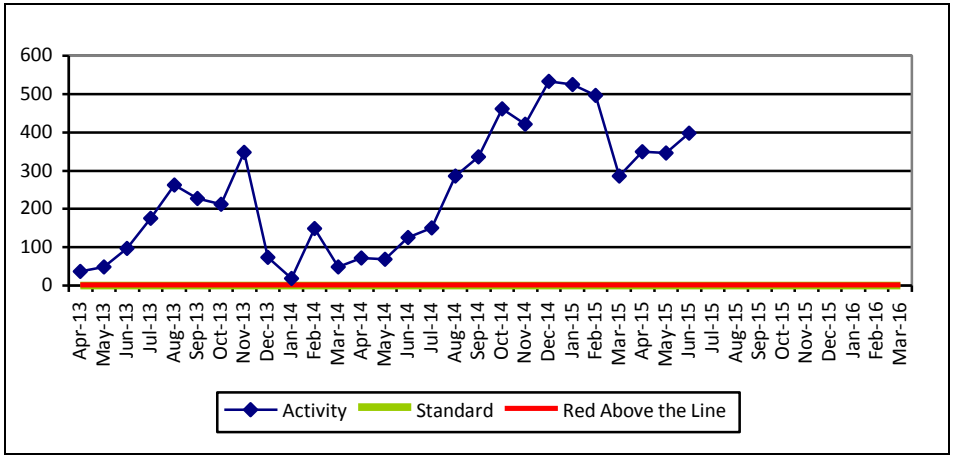


The run chart shows the standard, to **treat patients with cancer within 31 days of diagnosis** has been consistently achieved during 2014/15 and is expected to continue during 2015/16.

Please Note: There is a time lag of one month for this data

Standard: 18 wks: 12 wks for outpatients

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	0	0	350	346	398										↓	R

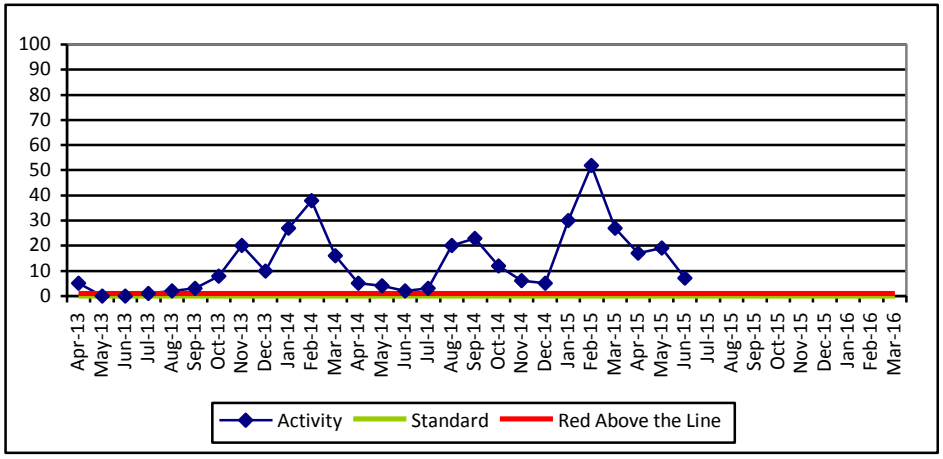


The run chart shows that performance towards the Stage of Treatment standard for patients to be **seen at an outpatient appointment within 12 weeks** has been mixed over the last year.

Additional capacity has been organised within Cardiology, Dermatology, Diabetics / Endocrinology, Gastroenterology and Rheumatology to improve the waiting times however there remain significant pressures in Cardiology, Chronic Pain and Diabetics / Endocrinology. Discussions are being held with these services around how these can be resolved in the short term.

Standard: 18 wks: 12 wks for inpatients

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	0	0	17	19	7										↑	R

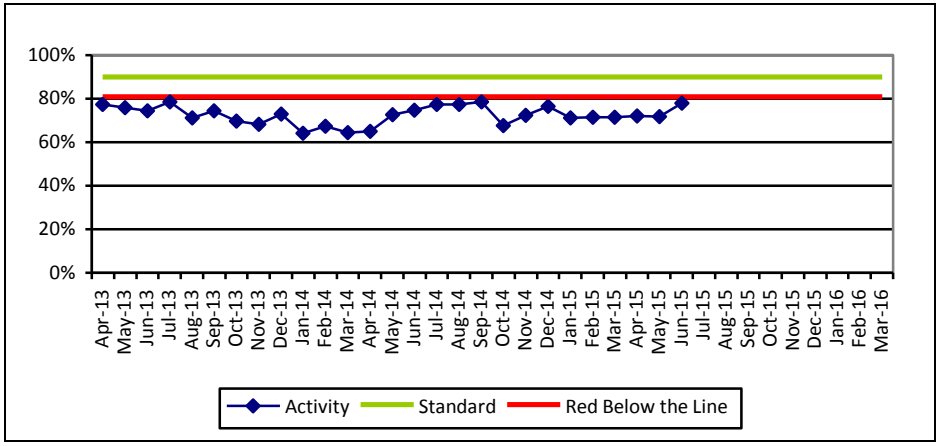


The run chart shows that performance has been variable against the **12 week Treatment Time Guarantee**. One contributing factor is loss of theatre capacity due to cancellations. During June 2015 there were 20 theatre cancellations for hospital related reasons, which include bed availability, emergency cases taking priority and running out of time on the theatre list. This is an improved position from May 2015 when there were 45 hospital cancellations.

A Treatment Time Guarantee plan has been developed and work is being undertaken ensure the standard is on track for delivery.

Standard: Admitted Pathway Performance

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	72.2%	71.9%	77.8%										↑	R

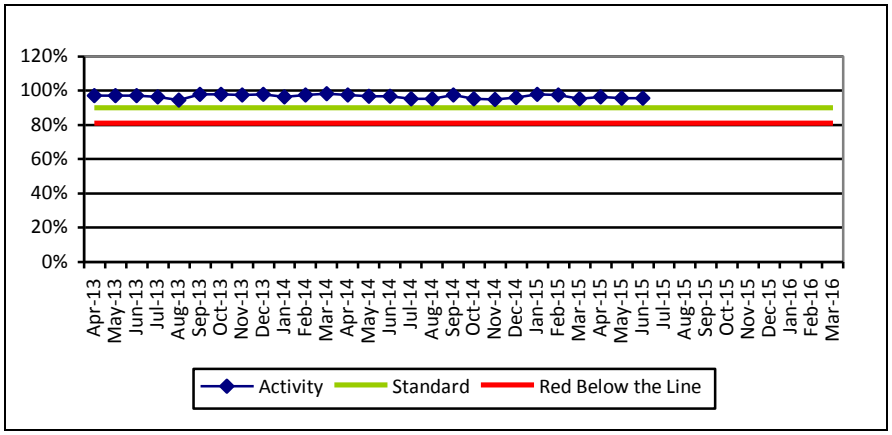


The run chart shows that **Admitted pathway performance towards 18 weeks Referral to Treatment** remains under the standard. An action plan is in place to reverse the trend. Risks to achievement are particularly in Orthopaedics and Ear, Nose and Throat.

An action plan has been developed for 2015/16 to return to 9 week waits for outpatient appointments, and this should result in an improvement in performance in this area.

Standard: Admitted Pathway Linked Performance

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	96.3%	95.7%	95.7%										↔	G



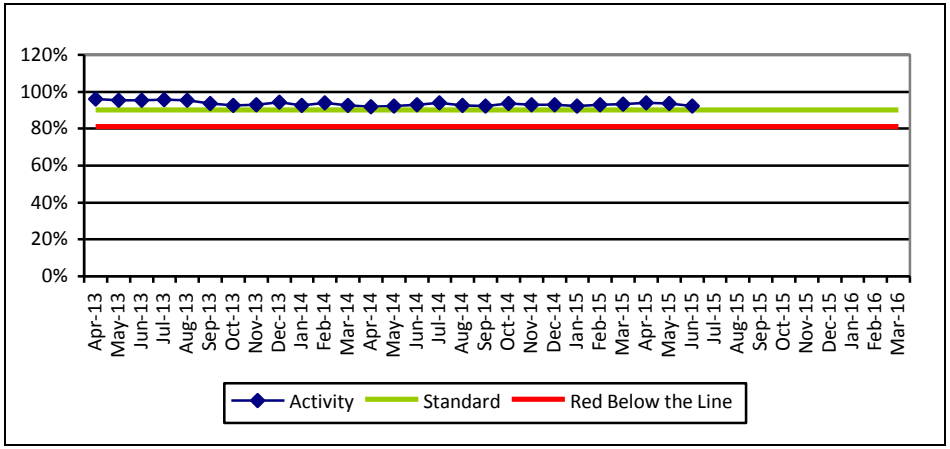
The run chart shows performance for the **linked pathway** is consistently above 90%. Work will continue to ensure the standard is achieved during 2015/16 with the reduction in the number of 12 week breaches.

A focus on completion of clinic outcome codes is being introduced which should improve the linked pathway performance;

- Clinicians who do not achieve 90% completion rate are contacted by e-mail to highlight performance and offer assistance to complete.
- The waiting times team with be exploring the establishment of electronic outcome coding to improve compliance

Standard: Non-Admitted Pathway Performance

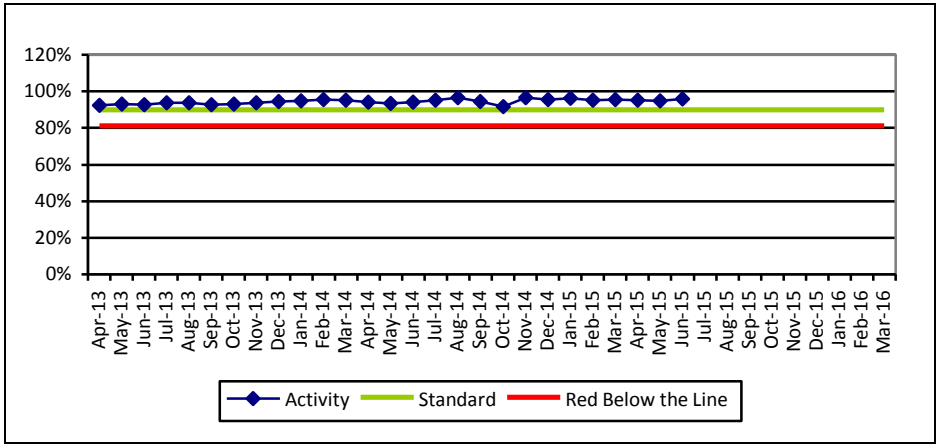
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	94.0%	93.6%	92.4%										↓	G



The run chart shows performance for **non-admitted pathways** is consistently above 90%. Work will continue during 2015/16 to ensure the standard is achieved with the reduction in the number of 12 week breaches.

Standard: Non-Admitted Pathway Linked Performance

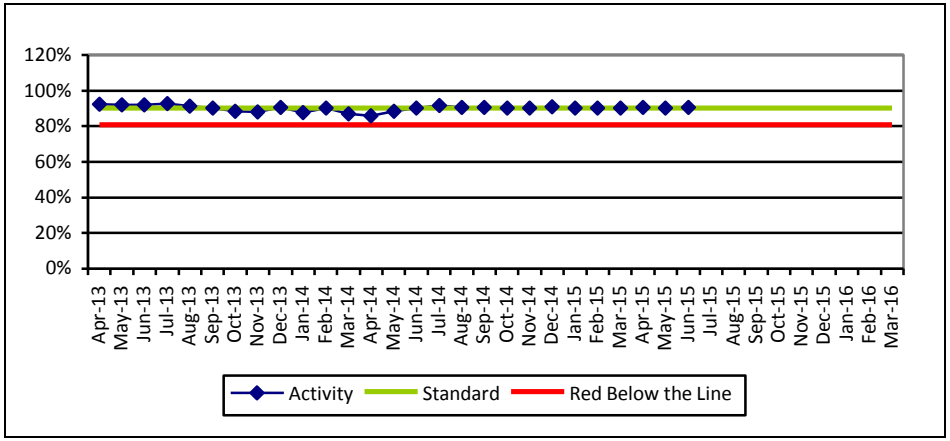
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	95.0%	94.7%	95.8%										↑	G



The run chart shows performance for **non-admitted linked pathways** is consistently above 90%. Work will continue to ensure the standard is achieved with the reduction in the number of 12 week breaches.

Standard: Combined Performance

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	90.6%	90.3%	90.5%										↑	G

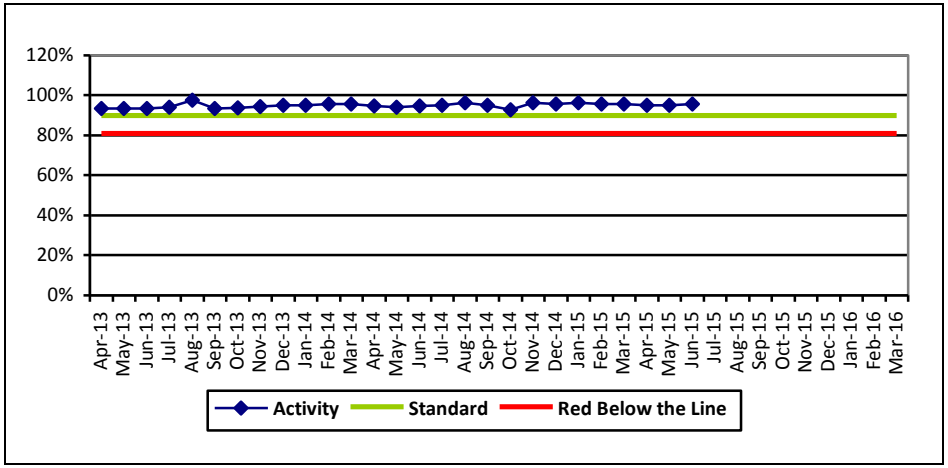


The run chart shows that currently NHS Borders continues to achieve the 90% **combined RTT** standard.

Performance has been very close to 90%, due to a drop in achievement against the admitted pathway performance (patients with an 18-weeks journey involving both outpatient and inpatient care). These risks are being managed within actions to deliver the 12-week stage of treatment standards.

Standard: Combined Pathway Linked Performance

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	95.2%	94.9%	95.8%										↑	G

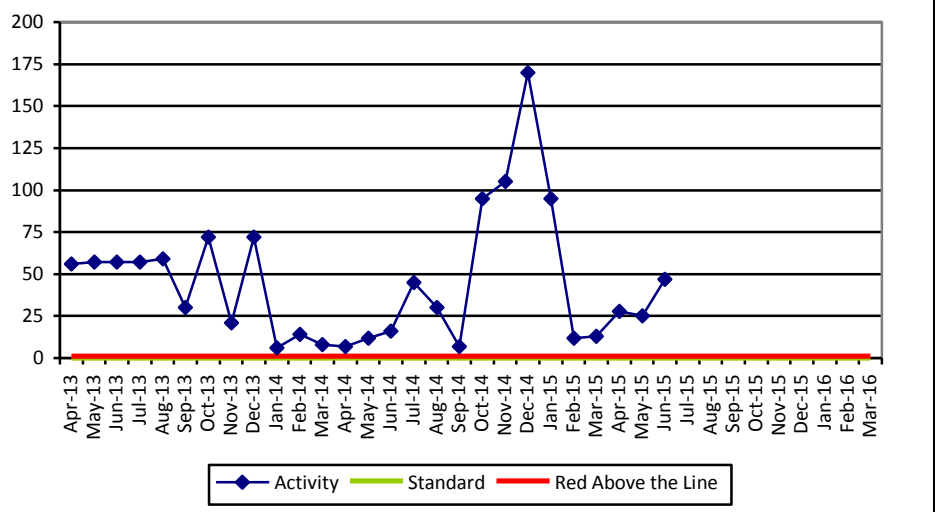


The run chart shows that currently NHS Borders continues to achieve the 90% **combined RTT linked pathway** standard.

A focus on completion of clinic outcome codes is being introduced which should improve the linked pathway performance.

Standard: 4 Week Waiting Target for Diagnostics

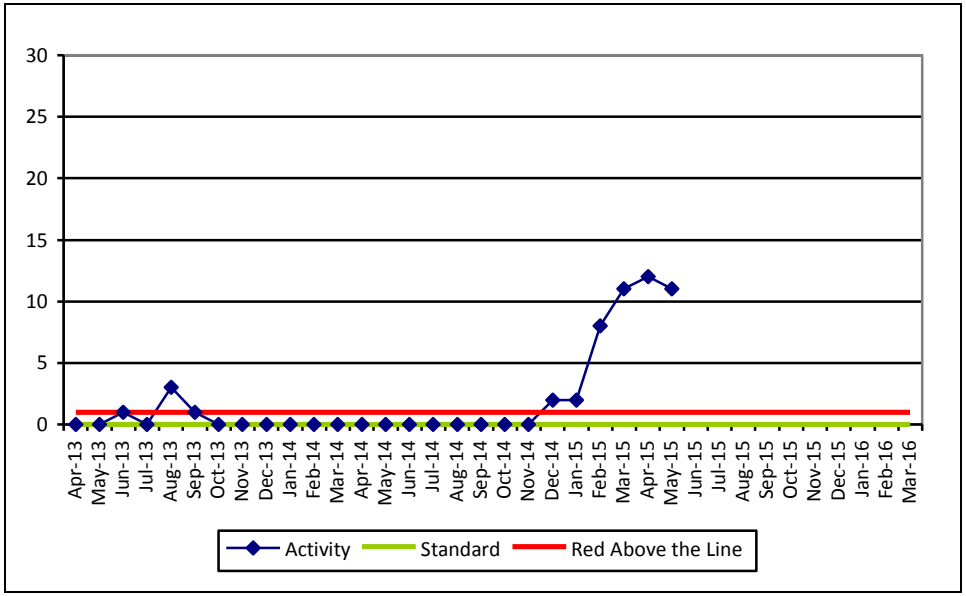
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	0	0	28	25	47										↓	R



The run chart shows that performance for **Diagnostic Waiting Times** over 4 weeks fluctuates from month to month, with June 2015 reporting 47 breaches. The split is as follows; 6 Endoscopy, 14 Colonoscopy, 5 Cystoscopy, 15 MRI, 3 CT, 3 Ultrasound and 1 Barium Studies. A range of initiatives to create additional colonoscopy capacity have been put in place. There is ongoing work to develop additional capacity for cystoscopy.

Standard: **No CAMHS waits over 18 weeks**

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	0	0	12	11	-										↑	R

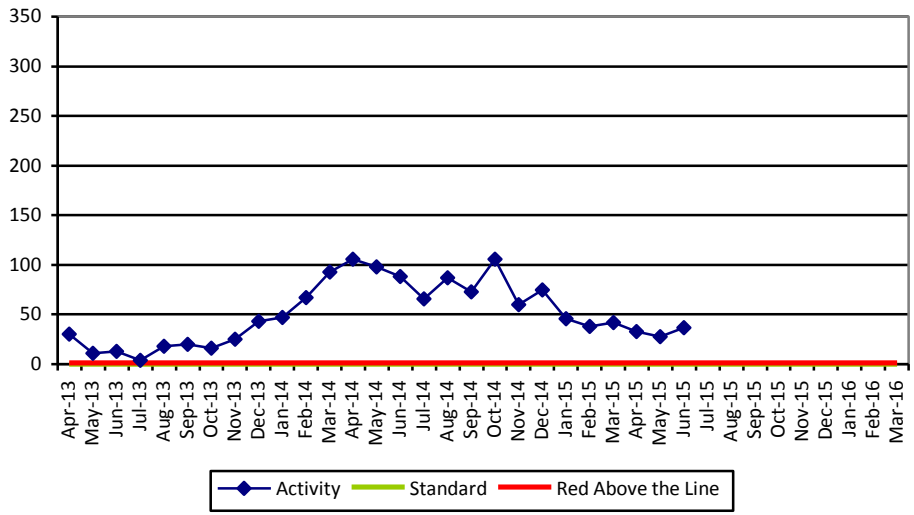


The Child and Adolescent Mental Health Service (CAMHS) continues to meet the standard of no waits over 26 weeks however the run charts shows there have been breaches of the stretched target of 18 weeks. This is due to a higher than normal referral rate & staff absence within the team. It is anticipated that this should improve as staff return to work.

Please Note: There is a one month time lag in data being published for this target.

Standard: No Psychological Therapy waits over 18 weeks

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	0	0	33	28	41										↓	R



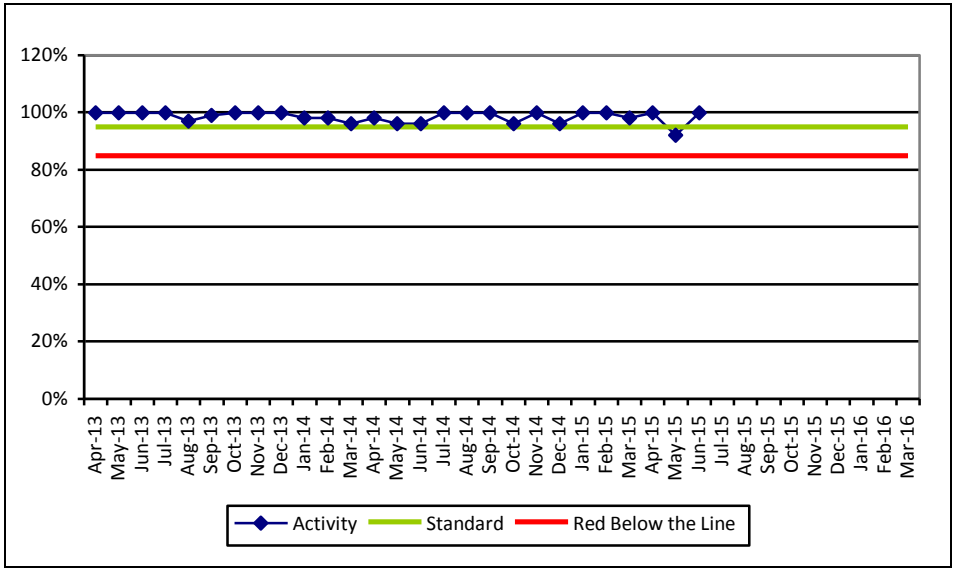
Waits over **18 weeks for psychological therapies** remain higher than expected, however performance continues to improve.

The largest driver on standard performance is the availability of sufficient staff trained in evidence based Psychological Therapies. The small service size does mean that there are greater consequences than larger providers associated with staff vacancies, maternity leave, sickness or other unforeseen absence. The inability to completely fill all vacant Clinical Psychology posts is resulting in these issues.

Work is aimed at increasing the number of staff who are delivering Psychological Therapies. As Clinical Psychologists already deliver significant amounts of Psychological Therapy, the approach is focused at escalating this with other Health and Social Care staff groups.

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

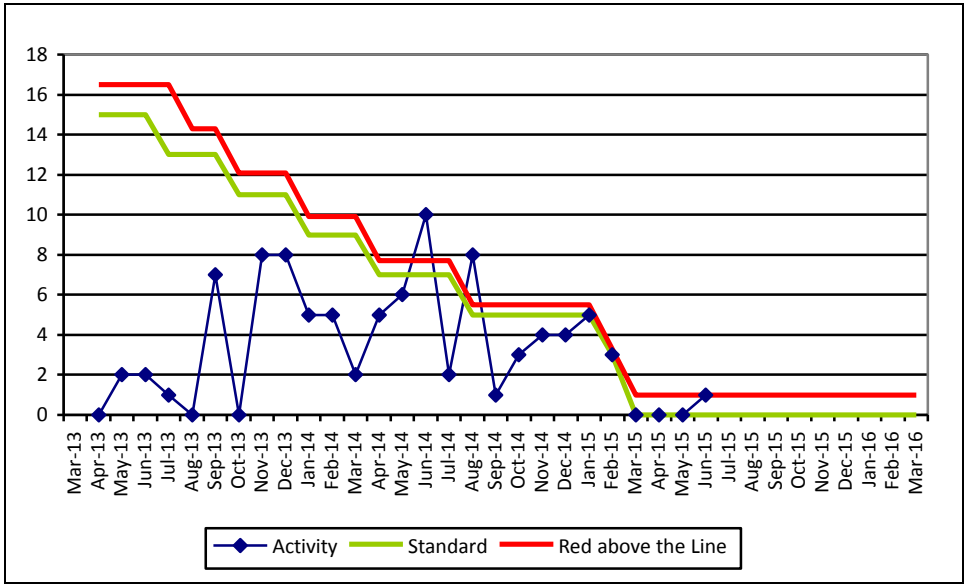
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	100%	92%	100%										↑	G



The run chart shows the national standard for **90% of all referrals to the drugs and alcohol service to be treated within 3 weeks** is being consistently achieved.

Standard: No Delayed Discharges over 2 weeks

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Mar 2015	0	0	0	0	1										↓	A

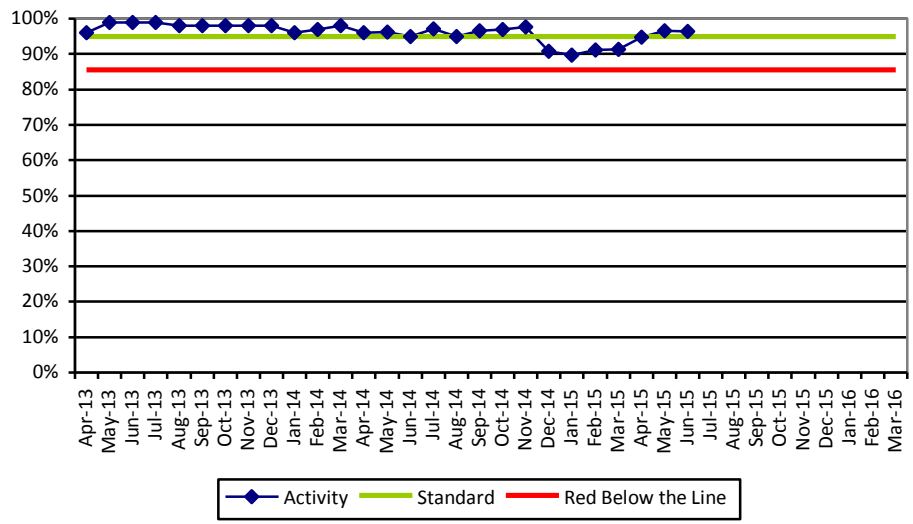


The run chart shows one breach against the standard that **no patients should be waiting more than 14 days to be discharged** into an appropriate care environment.

The original planned timescale in relation to the breach lapsed due to unexpected staff absence and losing a place at the appropriate facility. A firm plan is in place to achieve the new estimated date of discharge.

Standard: 4 Hour Waiting Target for A&E

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	95%	95%	94.7%	96.5%	96.3%										↓	A



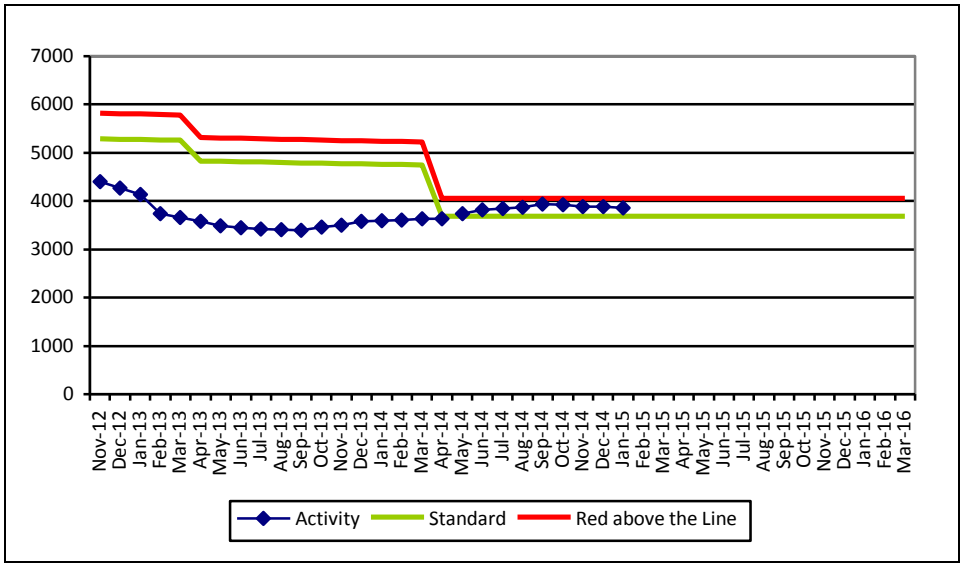
Patients attending **A&E are routinely discharged within 4 hours.** The current HEAT standard is for Boards to achieve 95% of attendances discharged within 4 hours. NHS Borders has kept a stretched target of 98%.

The run chart shows improved performance over the last 5 months and reports the national standard of 95% being achieved in May and June 2015.

Figures published by the Scottish Government on 21st June report that for week ending 12.07.15, there was a total of 478 A&E attendances at the BGH and performance against the four hour standard was 98.7%. This compares with the national figure of 95.4% for the same week.

Standard: Reduce Emergency Occupied Bed Days for the over 75s

Standard Date	2015/16 Standard	Current Standard	Current Month (Jan 15)	Previous Month (Dec 14)	Performance	Status
Mar 2016	3685	3685	3863	3878	↑	A



The run chart shows that performance against the **Emergency Occupied Bed Days** standard has not been achieved since April 2014 however a consistent improved position has been reported since September 2015.

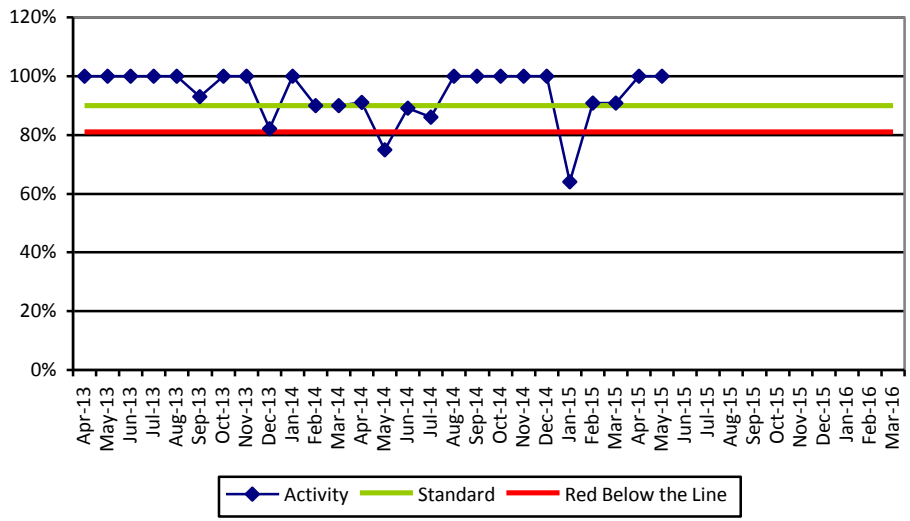
Whilst maintaining this level of performance has been challenging NHS Borders continues to perform well compared to the national average standard.

- The Local Enhanced Service for Anticipatory Care for Patients in Care Homes will continue in to 2015-16. The evidence so far demonstrates that the service has been of benefit to these patients and the creation of the electronic Anticipatory Care Plans (KIS) has been continuously increasing. These contain patient specific information and can be accessed by the Out of Hours service or Secondary Care when required.
- The Connected Care Programme Board is addressing issues associated with flow management across the NHS Borders care community and working between Health, Social Care and the Third Sector"

Please note: There is a six month time lag in data being published for this target.

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

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	100%	100%	-										↔	G

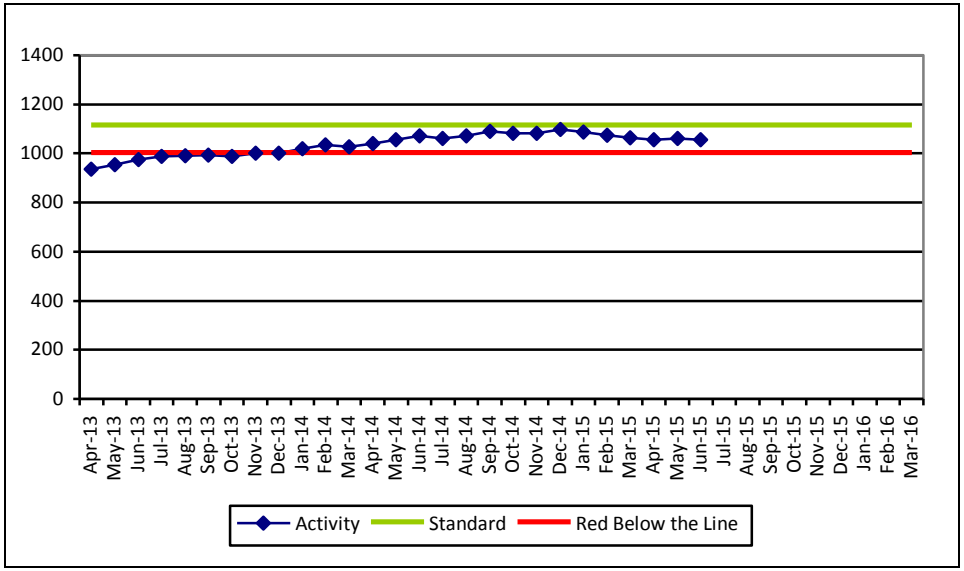


The run chart shows that target compliance for patients being **admitted to the Stroke Unit within 1 day of admission to hospital** has been achieved for 4 consecutive months. The single point outside the lower control limit in January 2015 can be attributed to lack of available beds. All other aspects of the bundle were delivered.

Please Note: Due to the time difference between the P&P deadline and the national extract deadline the Local Stroke report will now have a 1 month time lag. These reports are drawn from eSSCA. A data snapshot is taken and used to compile these reports. Routine data collection and amendment takes place on a daily basis but data for more recent months should be interpreted with caution because delays in data entry may occur or data updates may be made after the snapshot was taken.

Standard: Diagnosis of Dementia

Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	1116	1116	1057	1060	1055										↓	A



The run chart shows a drop in the number of patients being added to the **Dementia Register** since September 2014, with June 2015 reporting the same number as 13 months ago in May 2014.

The redesign of Mental Health Older Adult services is being completed, and Post Diagnostic Link Worker posts employed through Alzheimer Scotland are now in place assisting with clear referral pathways in health and social care.

The 2014/15 Enhanced Service programme has been designed to support an increase in community dementia case finding. All practices participating in the Care Homes LES are required to use a ratified dementia assessment tool (e.g. MMSE or 6CIT) annually in those without a current dementia diagnosis. Additionally, a Dementia service agreement in place since April 2014 supports case finding by GPs, including reviewing any existing vague or inappropriate cognitive decline codes. These measures combined have led to a significant increasing performance trend in relation to this target. The performance trajectory suggests that the target number of dementia diagnoses, based on the results of the national predictive tool mapping exercise, will be achieved by the end of this financial year as these activities progress.