Borders NHS Board

NHS BORDERS HEAT PERFORMANCE SCORECARD – OCTOBER 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 31st October 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 31st October 2015.

Areas of strong performance in the Scorecard for the position as at 31st October 2015 are highlighted below:

- Smoking cessation successful quits in the most deprived areas exceeded the trajectory of 20 with 31 quits for quarter 1 of 2015/16 (latest available data) (page 7)
- To sustain and embed alcohol brief interventions (ABIs) exceeded the trajectory of 767 in October 2015 with 1004 ABI's being delivered (page 8)
- 93.5% of all referrals were triaged online in October 2015, above the standard of 90% (page 12)
- Sickness absence rates have been maintained below 4% for the 3 months with a rate of 3.87% reported in October 2015 (page 15)
- Treatment of cancer within 31 days of decision to treat for all patients diagnosed with cancer is consistently being achieved (page 16)
- Treatment of cancer within 62 days for urgent referrals of suspicion of cancer is also consistently being achieved (page 16)
- 18 Week RTT admitted pathway linked performance (page 19), and non-admitted pathway performance (page 21) are performing above 90% target in October 2015
- 18 Weeks RTT combined overall performance and combined pathway linked performance continue to perform above the standard of 90%, with 90.3% and 95.9% respectively in October 2015 (pages 22, 23)
- The Alcohol/Drug referrals into treatment within 3 weeks has exceeded the national standard of 90% and the local stretched target of 95% in October 2015 reporting 100% (page 27)
- During September 2015 (one month lag time) 94% of patients were admitted to the Stroke Unit within 1 day of admission, against a standard of 90% (page 31)

Areas where performance is outwith the tolerance of 10% in the Scorecard for the position as at 31st October 2015 are highlighted below:

- New patient DNA rate was 4.6% during October 2015 againt the standard of 4% (page 9)
- eKSF and PDPs recorded perform under the trajectories set during October 2015 (page 13 & 14)
- Outpatient and inpatient waits over 12 weeks are 263 and 1 respectively in October 2015 against a standard of 0 patients (page17 & 18)
- 18 Week RTT Admitted Pathway Performance for October 2015 was 78.3% which is outwith the standard of 90% (page 19)
- 142 breaches of the 4 week diagnostic waiting time target were reported in October 2015 (page 24)
- 8 patients were waiting over 18 weeks within the Child and Adolescent Mental Health Service at end of September 2015 (latest available data) (page 25)
- 12 breaches were reported against a standard of 0 psychological therapy waits over 18 weeks in October 2015 (page 26)

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 October 2015 HEAT Performance Scorecard (August 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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5

6

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10

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12

NHS Borders

HEAT PERFORMANCE SCORECARD

As at 31st October 2015

October 2015

Planning & Performance

Contents

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]	-	-	G -	-	-	-	-					
Alcohol Brief Interventions [2]	A -	A ↑	G ↑	G ↑	G ↑	G ↑	G ↑					
New patient DNA rate	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓	R ↑					
Same day surgery [3]	A ↓	A ↑	G ↑	A ↓	A ↓	-	-					
Pre-operative stay [3]	G ↑	G ↑	G ↓	G ↑	A ↓	-	-					
Online Triage of Referrals	G ↑	G ↑	G ↓	G ↑	G ↓	G ↓	G ↑					
eKSF annual reviews complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑					
PDP's Complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑					
Sickness Absence Reduced	A ↑	A ↑	A ↓	R ↓	G ↑	G ↑	G ↓					
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [4]	G ↔	G ↔	G ↓	G ↓	G ↓	G ↑	-					
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [4]	G ↔	G ↔	G ↔	G ↔	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 ↓	R ↑	R ↑	R ↓	R ↓					
18 Wk RTT: 12 wks for inpatients	R ↑	R ↓	R ↑	R ↑	R ↔	R ↓	R ↑					
18 Wk RTT: Admitted Pathway Performance	R ↑	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓					
18 Wk RTT: Admitted Pathway Linked Pathway	G ↑	G ↓	G ↔	G ↑	G ↑	G ↓	G ↑					
18 Wk RTT: Non-admitted Pathway Performance	G ↑	G ↓	G ↓	G ↓	G ↓	G ↑	G ↑					
18 Wk RTT: Non-admitted Pathway Linked Pathway	G ↓	G ↓	G ↑	G ↑	G ↓	G ↔	G ↓					
Combined Performance	G ↑	G ↓	G ↑	G ↑	G ↓	G ↑	G ↑					
Combined Performance Linked Pathway	G ↓	G ↓	G ↑	G ↑	G ↓	G ↓	G ↔					
4 Week Waiting Target for Diagnostics	R ↓	R ↑	R ↓	R ↓	R ↑	R ↑	R ↓					
No CAMHS waits over 18 wks [5]	R ↓	R ↑	R ↔	R ↓	R ↓	R ↑	R ↑					
No Psychological Therapy waits over 18 wks	R ↑	R ↑	R ↓	R ↑	R ↑	R ↑	R ↑					
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G ↑	G ↓	G ↑	G ↔	G ↔	G ↓	G ↑					
No Delayed Discharges over 2 Wks	G ↔	G ↔	A ↓	R ↓	A ↑	R ↓	R ↑					
4-Hour Waiting Target for A&E	A ↑	A ↑	A ↓	A ↑	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 ↔	G ↔	R ↓	G ↑	G ↑	-					
Diagnosis of dementia	A ↓	A ↑	A ↓	A ↑	A ↓	A ↑	A ↓					
Further Reduce Rate of Staph aureus bacteraemia [8]	-	-	-	-	-	-	-					
Further Reduce Rate of C. Diff (CDAD) cases in over 15s [8]	-	-	-	-	-	-	-					

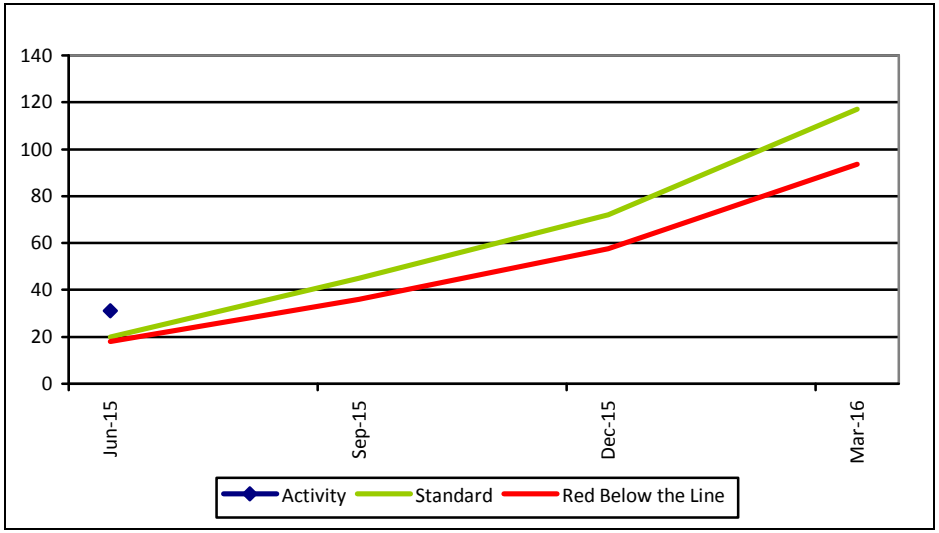
[1] Data is reported quarterly to allow monitoring of the 12 week quit period.
[2] Data should be treated as provisional as there is a reporting lag in some areas which means that data is not fully reconciled at time of reporting.
[3] There is a lag in data due to SMR recording.
[4] One month lag as 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	31	-	-	-	-	G

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 October 2015.



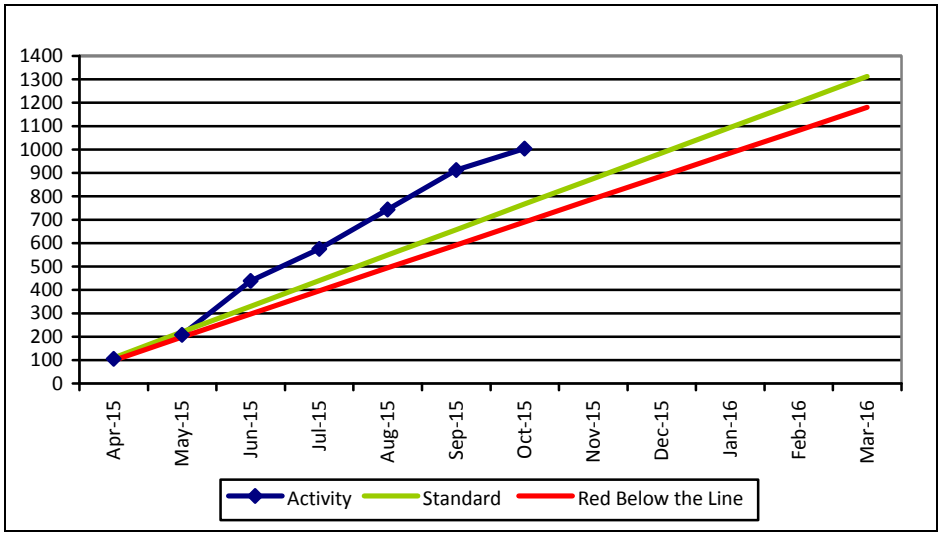
Data for **smoking cessation successful quits** has a lag time to allow monitoring of the 12 week standard quit period from 1st April 2015. The chart shows that the trajectory set for June 2015 (20) has been achieved with 31 successful quits.

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	767	105	208	438	575	744	913	1004						↑	G



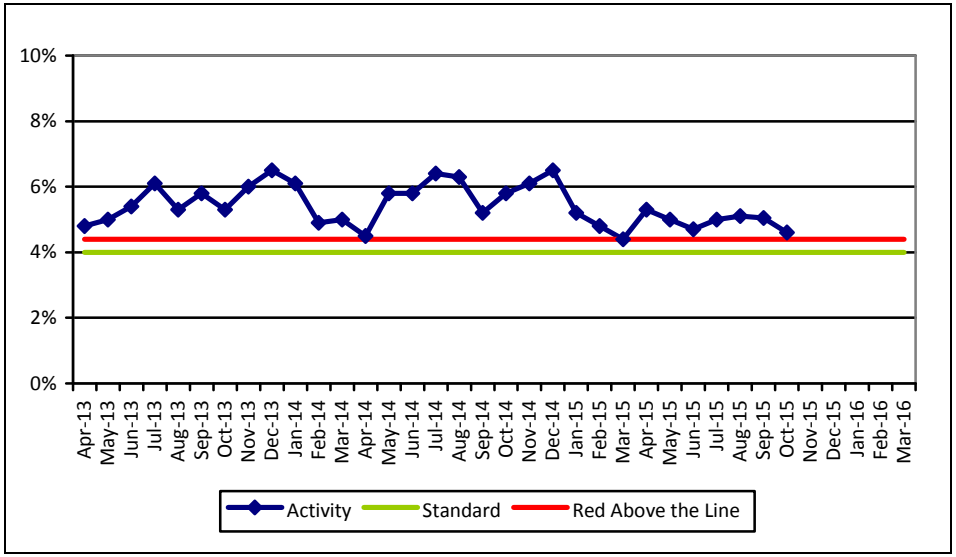
To sustain and embed **alcohol brief interventions** is a new standard for 2015/16. The run chart shows that performance at the end of October 2015 is ahead of trajectory. The service has predicted the standard will be achieved during 2015/16.

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%	5.0%	5.1%	5.4%	4.6%						↑	R



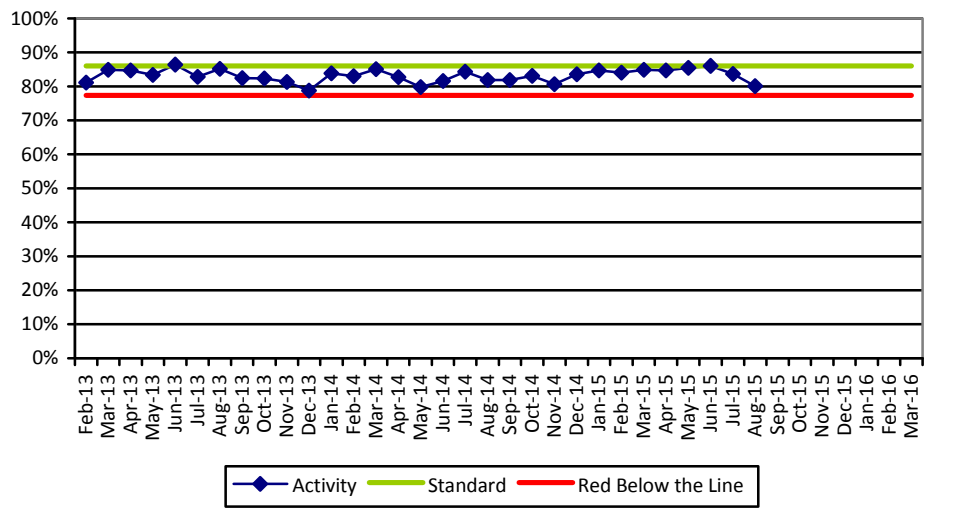
The run chart shows that the **DNA rate is** variable and performance is still outwith the 4% standard. The run chart also shows seasonal peaks in December and July / August.

Overall the trend for May - October 2015 has improved when compared with previous years. Improvements are due a combination of different factors; the management of Orthopaedic Trauma patients which traditionally had a high DNA rate, improved contact details for patients and an extended pilot from July 2015 of additional personal reminders for patients who have any DNA history. The additional reminders are to continue until the end of December 2015 when the impact will be analysed.

The next steps include exploring how as a whole system, from referral to appointment, we can improve patient attendance levels of those who have a high DNA rate.

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%	85.5%	86.0%	83.7%	80.1%	-	-						↓	A



For the first month since August 2013 the overall 86% HEAT standard for **same day surgery** (BADS procedures) was achieved in June 2015, however performance continues to fluctuate. The run chart shows performance has consistently been within 10% of the standard over the last year which demonstrates an increased trend in performance. This shift is due to the Pre-Operative Assessment process and the use of the Planned Surgical Admissions Unit as the 'norm' for a variety of procedures.

The Head of Service for General Surgery will be reviewing the occasions when patients are not treated as day cases, the broad reasons are:

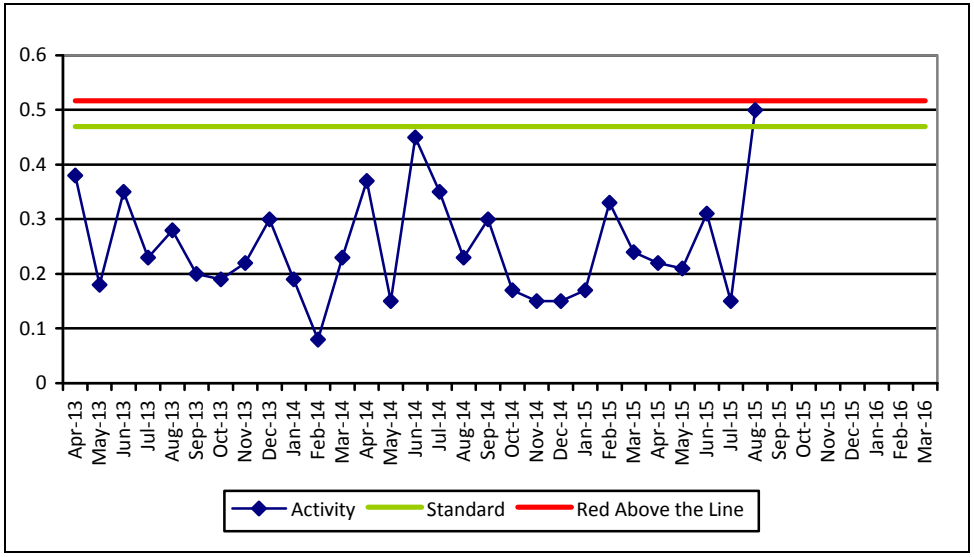
- Anaesthetic or medical reasons
- Surgical reasons – for instance bleeding, pain, unexpected problems during operation, operation turned out to be more complex than originally anticipated
- Patient social status – no responsible adult at home or distance to travel

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	0.21	0.31	0.15	0.50	-	-						↓	A

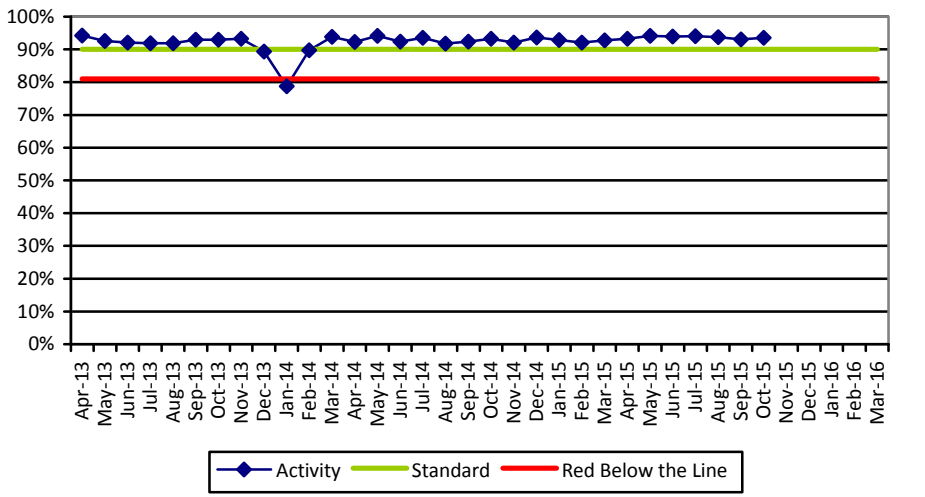


The run chart shows that **pre-operative inpatient stays** in hospital are generally low and within the trajectory set however in August the rate increased. This is the first breach of standard recorded since April 2013. The day case rates also decreased in August 2015 however both standards are within the 10% tolerance and achieve amber status.

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%	94.0%	93.7%	93.1%	93.5%						↑	G

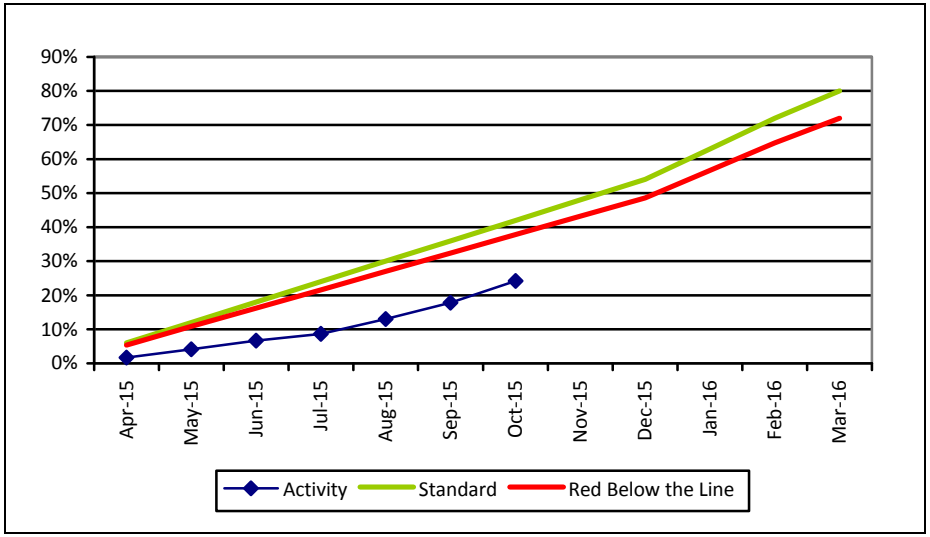


The run chart shows that overall the level of **online eTriage of referrals** continues to perform above the 90% standard.

The data is provided as a snapshot in time when the report is run. Performance for January 2014 has been rerun to check the data. Records have been updated since the original run and performance reports 93%, therefore achieving the target.

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

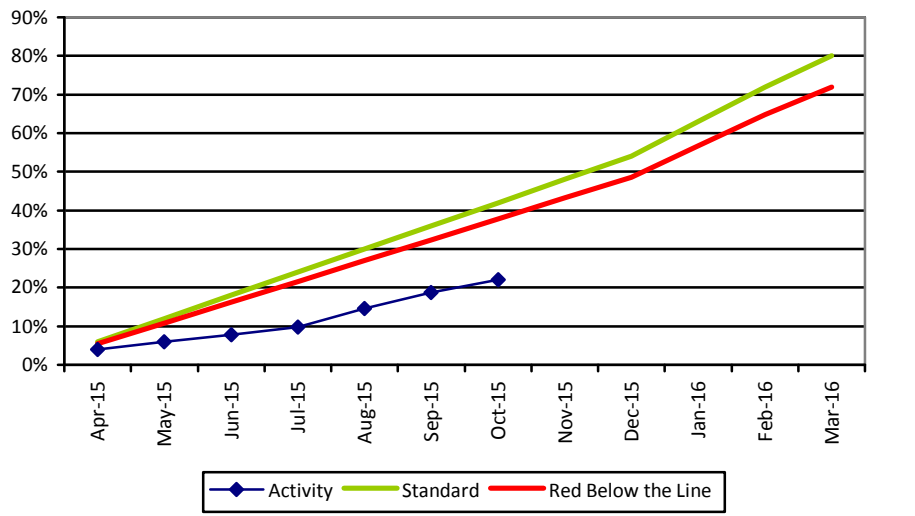
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
March 2016	80%	42%	1.67%	4.11%	6.72%	8.69%	13.01%	17.81%	24.21%						↑	R



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. KSF Champions continue to support and encourage managers to spread out reviews, and this topic was measure under the spotlight at the November Clinical Executive Operational Group meeting. Attendees are responsible for cascading concerns and providing support to managers to ensure JDR's are being progressed.

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

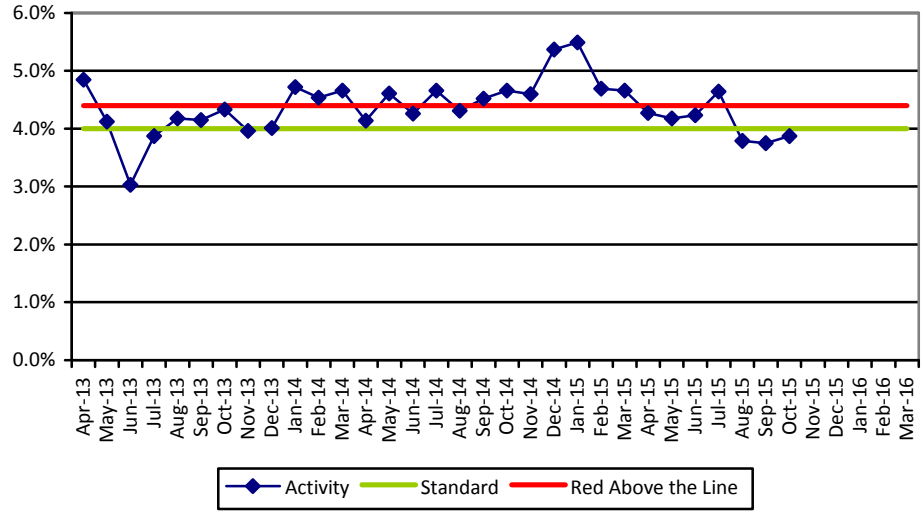
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
March 2016	80%	42%	4.00%	5.93%	7.71%	9.78%	14.61%	18.76%	22.06%						↑	R



The run chart shows that overall within NHS Borders the trajectory for recording **Personal Development Plans (PDPs) on eKSF** is not being 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.

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%	4.64%	3.79%	3.75%	3.87%						↓	G



The run chart shows the **Sickness Absence** standard has been over the last 3 months. Performance has been steadily improving since December 2014, with the exception of July 2015 when there was a slight increase in the percentage of employees with a recorded sickness absence.

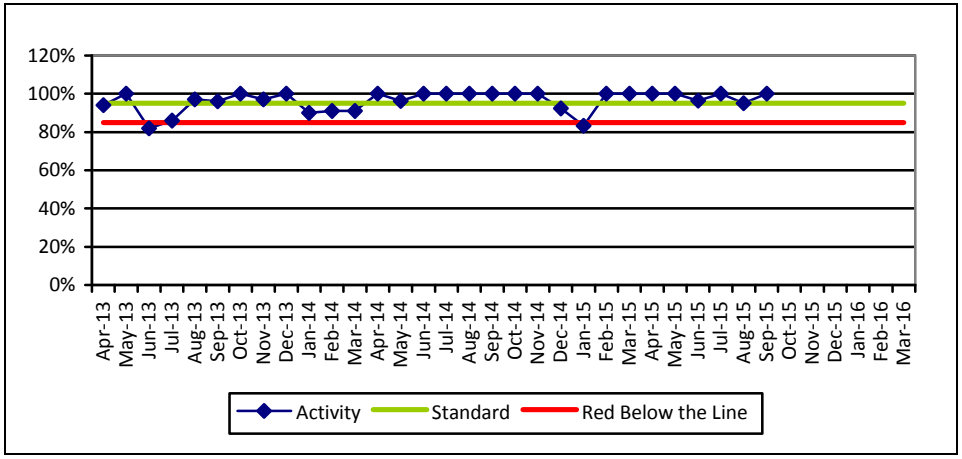
The Employee Relations Team sends out the monthly Reports that are agreed with the service to assist them in managing sickness absence. These are presented to Clinical Boards via Performance Scorecards.

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

The Employee Relations Team actively review Occupational Health Reports and suggest to the manager they may wish to have absence review meetings or case reviews with HR support where appropriate. A Sickness Absence Review Audit has recently been undertaken in one of our clinical boards to ensure policy and processes are being implemented consistently. A plan is being developed to roll this out to other service areas.

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%	96.3%	100%	95%	100%	-						↑	G

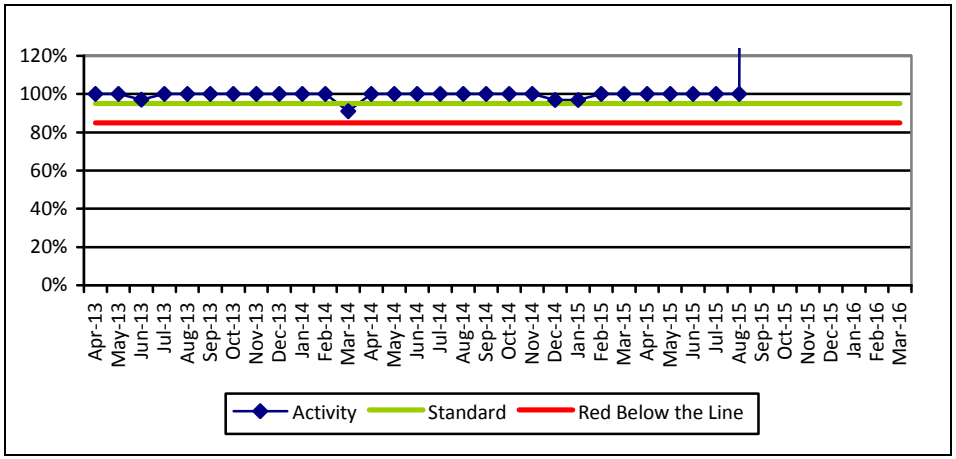


The run chart shows the standard, to **see patients with a suspicion of cancer within 62 days** is back on track and meeting the 95% compliance standard following the breaches in December 2014 & January 2015.

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%	100%	100%	100%	100%							↔	G

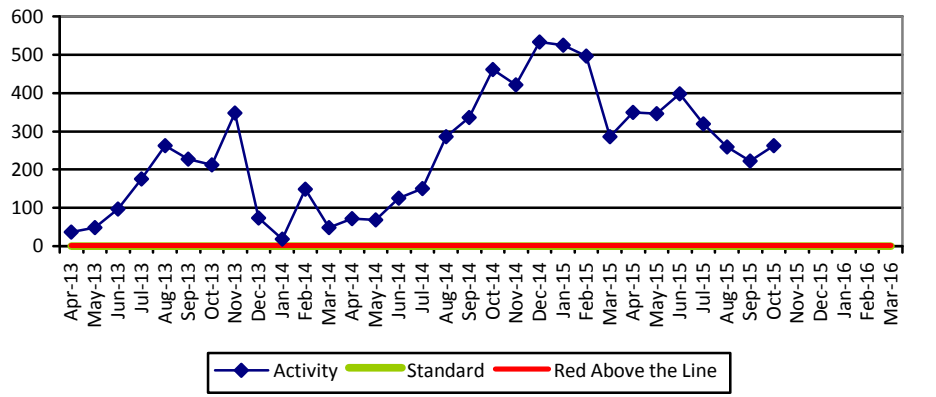


The run chart shows the standard, to **treat patients with cancer within 31 days of diagnosis** has been consistently achieved during 2014/15 and is expected to continue during 2015/16.

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	320	259	222	263						↓	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** continues to improve since the peak in December 2015.

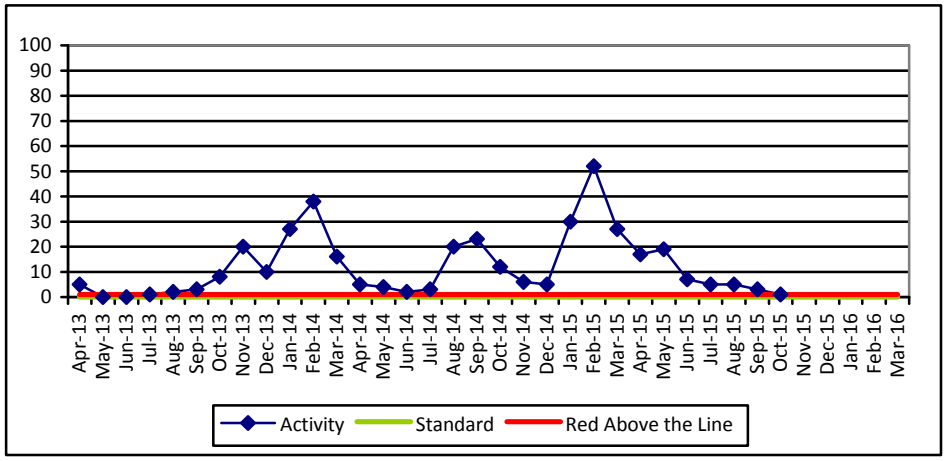
Action plans are in place to further improve performance, which include:

- Additional short-term capacity has been organised within Cardiology, Dermatology, Diabetics / Endocrinology, Neurology and Rheumatology.
- At present there is no ongoing solution to the shortages of capacity in Cardiology, Chronic Pain, Diabetes / Endocrinology and Gastroenterology
- Additional ENT and Oral Surgery Consultants have now taken up post, and an additional Consultant Rheumatologist has been appointed. A locum Respiratory Medicine Consultant has also been appointed.
- An additional Consultant Dermatologist post has been approved and advertised, but there were no applicants, however there is a potential long-term locum.

The main risks to delivery in March 2016 are around Chronic Pain, ENT and Gastroenterology, and work is ongoing with these Services to identify solutions.

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	5	5	3	1						↑	R



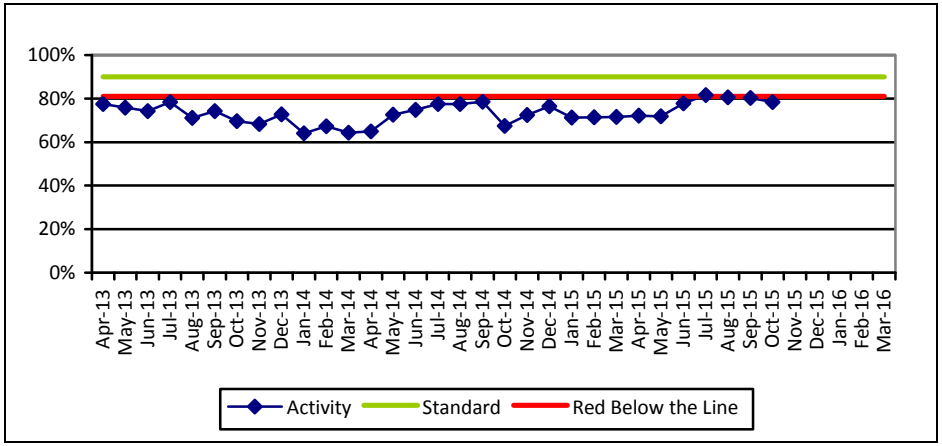
The run chart shows that performance has been variable against the **12 week waiting time for inpatients / day cases.** At the end of October 2015 the number of patients reported as waiting over 12 weeks continues to improve with a figure of 1 reported.

The following actions are in place to improve then maintain the position:

- Following recruitment to the additional ENT and Oral Surgery Consultant posts, there is now sufficient capacity within all specialties to deliver inpatient targets locally, with the exception of Orthopaedics.
- Orthopaedic capacity continues to be challenging on a long-term basis, however arrangements are in place to run weekend operating lists and use capacity at Golden Jubilee until March 2016, which will ensure that there is sufficient operating capacity to meet targets. Plans are being developed to ensure that the service is sustainable in the future.
- No patients have been sent for treatment in the Independent Sector to ensure delivery of TTG since August 2015, with the exception of Oral Surgery, where there are issues with unexpected Consultant leave.
- Capacity within some specialties, mainly Orthopaedics, has continued to be less than demand, and as a result there has been a requirement to offer patients treatment at other providers (Golden Jubilee and the Independent Sector).

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%	81.6%	80.5%	80.3%	78.3%						↓	R

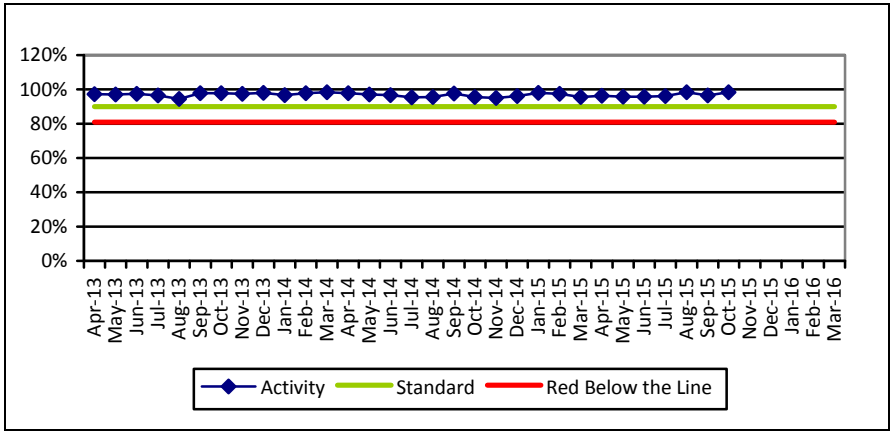


The run chart shows that **Admitted pathway performance towards 18 weeks Referral to Treatment** remains under the standard but improvements are visible over the last 5 months. Risks to achievement are particularly in Orthopaedics and Ear, Nose and Throat.

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

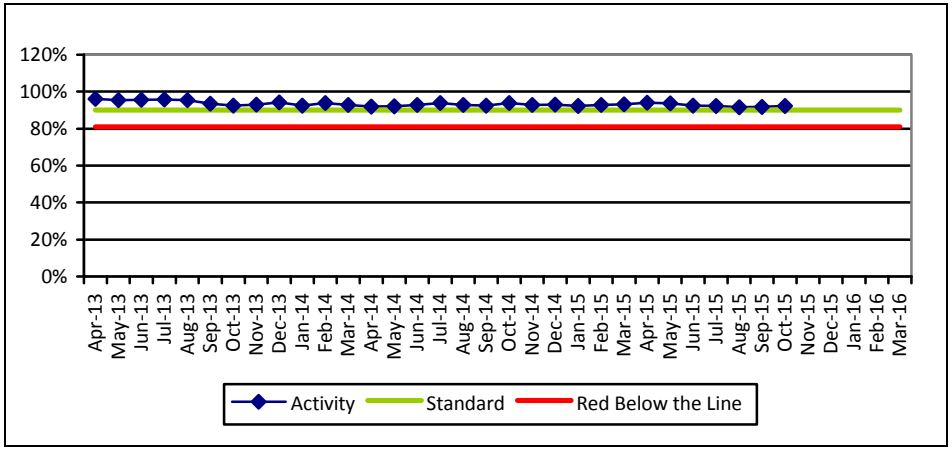
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	96.3%	95.7%	95.7%	96.0%	98.4%	96.4%	98.3%						↑	G



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

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%	92.2%	91.6%	91.8%	92.3%						↑	G



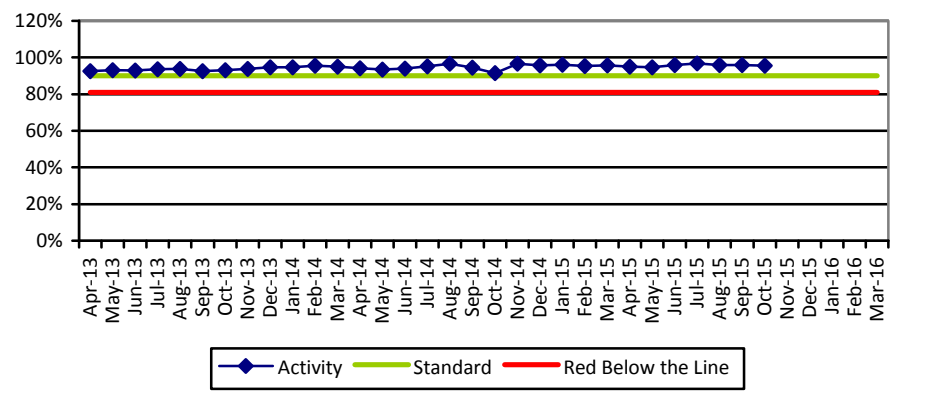
The run chart shows that performance for **non-admitted pathways** is consistently above 90%. Work will continue during 2015/16 to ensure the standard is maintained with the reduction in the number of 12 week breaches.

In particular the service will focus on the following actions:

- Audiology Waiting Times continue to be challenging, due to vacant posts within the Service. 32% of all breaches of the 18-week standard during September 2015 were within Audiology impacting on the total non-admitted pathway performance
- Clinic outcome codes completed by clinicians following outpatient appointment identify patients whose care is complete following outpatient attendance (non-admitted pathways). Current completion of clinic outcome codes is running at just under 90%. A focus on completion of clinic outcome codes is being introduced;
    - Clinicians who do not achieve 90% completion rate are contacted by e-mail to highlight performance and offer assistance to complete.
    - We will be exploring the establishment of electronic outcome coding to improve compliance

Standard: Non-Admitted Pathway Linked Performance

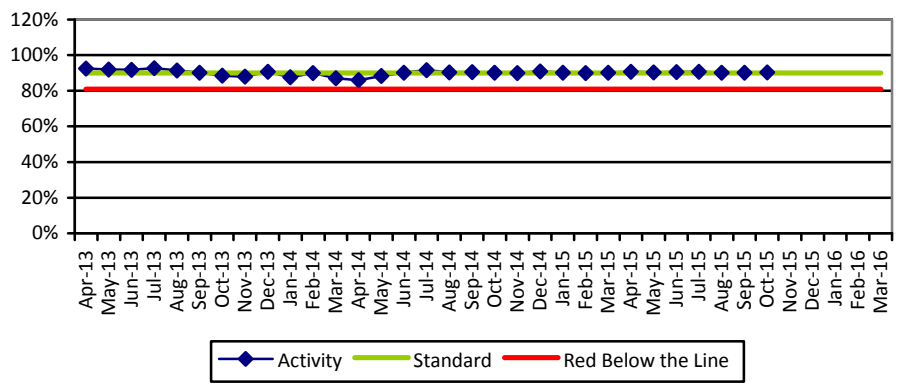
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	95.0%	94.7%	95.8%	96.7%	95.9%	95.9%	95.5%						↓	G



The run chart shows performance for **non-admitted linked pathways** is consistently above 90%. Work will continue to ensure the standard is maintained 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%	90.6%	90.1%	90.2%	90.3%						↑	G

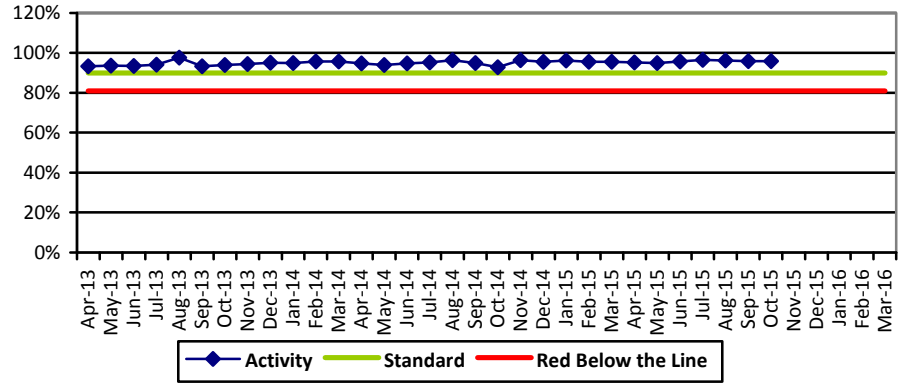


The run chart shows that currently NHS Borders continues to achieve the 90% **combined RTT** standard.

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 the 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%	96.6%	96.3%	95.9%	95.9%						↔	G

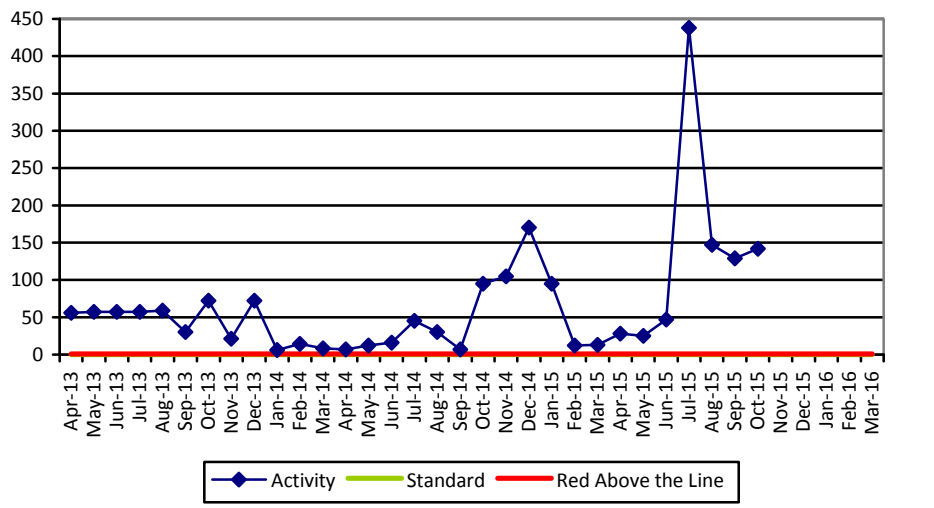


The run chart shows that currently NHS Borders continues to achieve the 90% **combined RTT linked pathway** standard.

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	438	147	129	142						↓	R



The run chart shows that performance for **Diagnostic Waiting Times** over 4 weeks is still outwith the standard set.

During the completion of a Radiology demand and capacity exercise in July 2015 for imaging tests, anomalies were identified in the data reporting. This has now been fully explored and the root cause has been identified - the report was pulling the incorrect data field and therefore was reporting the date the test was completed rather than the date the test was reported.

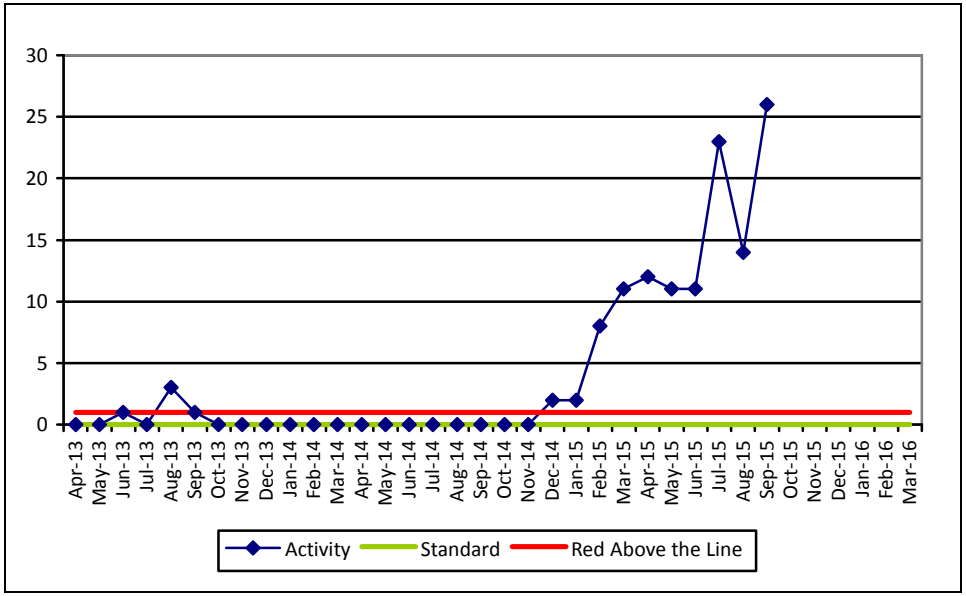
Within Radiology additional imaging lists and reporting capacity has been arranged however increased demand, particularly MRI will make reaching and sustaining a 4 week waiting time challenging without consolidating increasing baseline capacity on a permanent basis

Additional cystoscopy capacity has been agreed that will address long standing capacity issues. Upper GI and Colonoscopy are under discussion with a view to identification of additional capacity to address the current long waits.

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	11	23 [1]	14	8	-						↑	R

[1] July 2015 figure has been updated as incorrectly reported as 23



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.

As at the end of October 2015 there are 8 patients waiting over 18 weeks for this service, which is a reduction in performance.

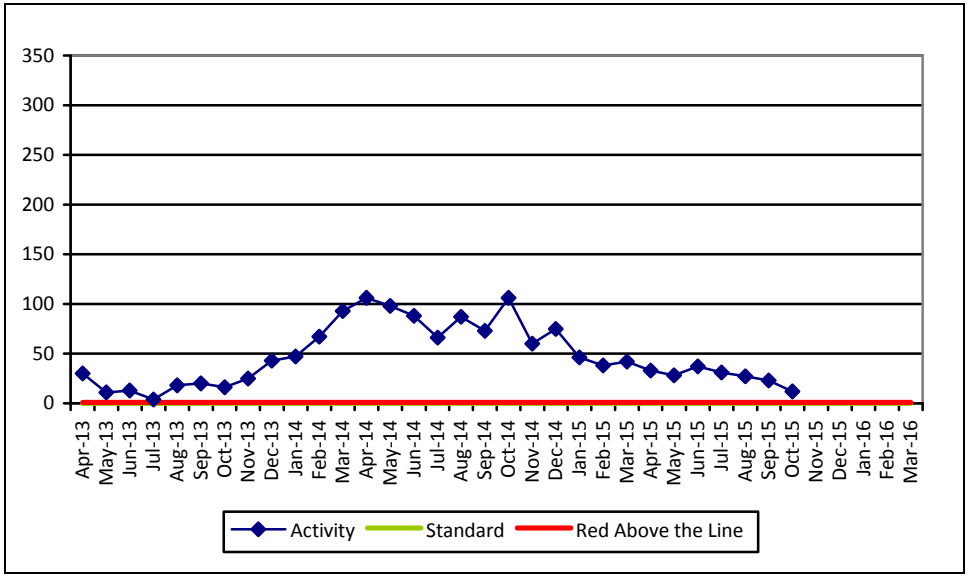
We continue to be challenged with the target of 90% seen within 18 weeks and have recruited additional staff. However have been unable to recruit to nurse and consultant psychiatrist posts, which are key posts to support the delivery of the target.

A locum has been put in place from Monday 9th November which should help with the waiting times, and we estimate that target will be back to green status by February 2016.

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	31	27	23	12						↑	R



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

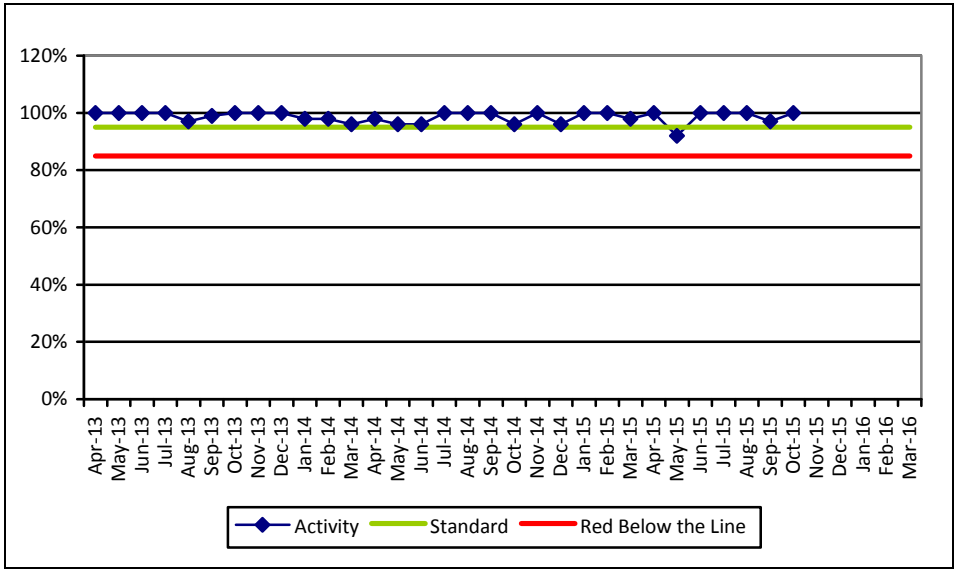
Additional capacity has been recruited to reduce the number of patients waiting over 18 weeks – this is evident in the steady reduction of patients waiting over 18 weeks.

The service continues to monitor progress and allocate resources to the areas with the longest waits.

Some of the long waits are the result of a loss of expertise in a particular specialised therapy – Eye Movement Desensitisation and reprocessing (EMDR) – which is difficult to replace as there is 12 month training programme required. A member of staff will be commencing training in the new year.

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

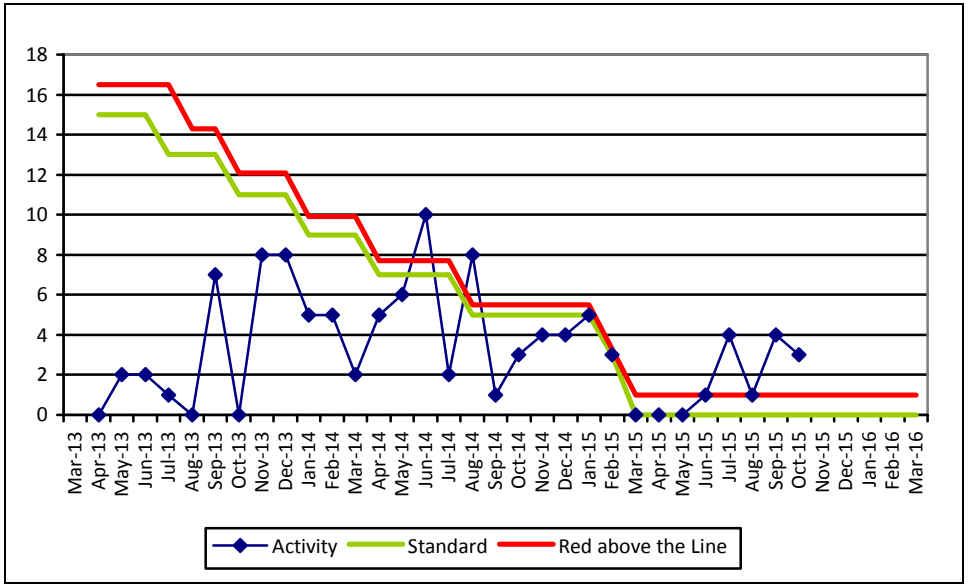
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	100%	92%	100%	100%	100%	97%	100%						↑	G



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. The local stretched target of 95% has been achieved over the last 3 months.

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	4	1	4	3						↑	R



The run chart shows 3 breaches against the standard that **no patients should be waiting more than 14 days to be discharged** into an appropriate care environment.

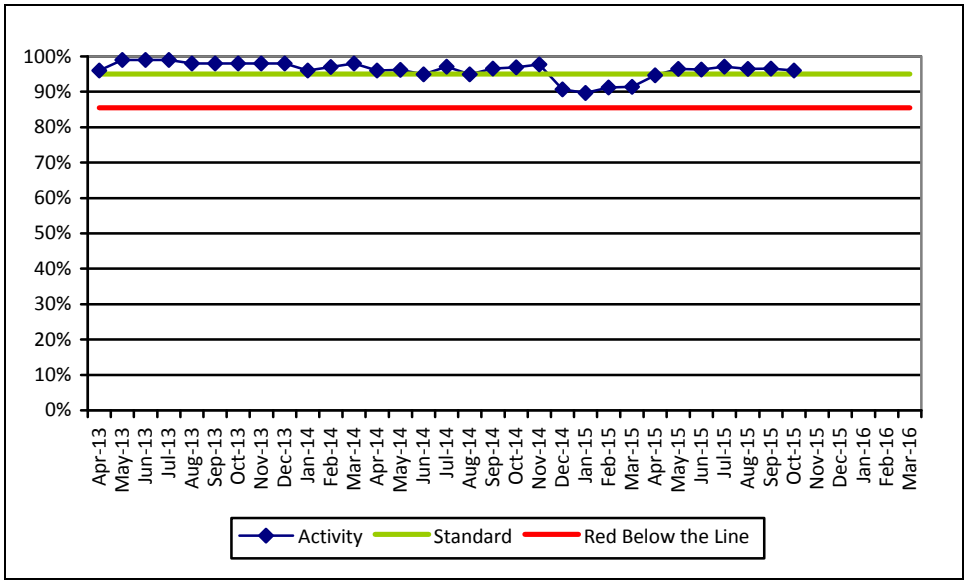
Since the start of June 2015 the number of delayed discharges has risen by a greater number than envisaged. During July 2015 a short term plan was developed to ensure performance returns to what was reported from March – May 2015. Work is ongoing to ensure the standard is achieved and further improvements continue in advance of next year's 72 hour target.

Senior Primary Care and Social Work managers have been working together to manage the causes of delays being reported. Daily monitoring of the delayed cases is in place to ensure individual discharge plans are set and realised.

A joint plan is being developed to support the partnership to achieve the 72 hour discharge target and will be agreed through operational structures during November.

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	98%	98%	94.7%	96.5%	96.3%	97.1%	96.5%	96.6%	96.0%						↓	A



Patients attending **A&E are routinely discharged within 4 hours.** NHS Borders continues to achieve the national standard of 95%. The 98% local standard has not yet been achieved in 2015.

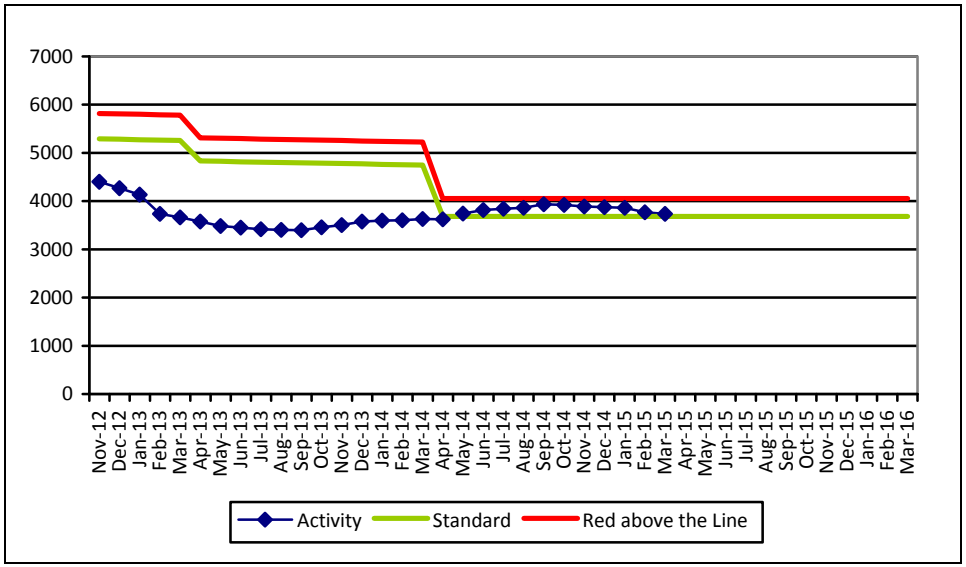
The Unscheduled Care Redesign programme is focused on increasing morning and weekend discharges to improve patient flow earlier in the day, The establishment of a Medical Assessment and Ambulatory Care Service with dedicated trolleys and chairs is planned to open in December and this will increase numbers of medical referrals attending Medical Assessment Unit directly. These patients will still be monitored against the 4 hours standard but this should improve overall flow and reduce pressures in ED.

Working patterns and processes for nurses and doctors are being reviewed against the known periods of highest activity to ensure that capacity matches predicted demand.

Pathways for patients being admitted to surgical and orthopaedic wards are being streamlined to reduce the length of stay in ED.

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

Standard Date	2015/16 Standard	Current Standard	Current Month (Mar 15)	Previous Month (Feb 14)	Performance	Status
Mar 2016	3685	3685	3734	3768	↑	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 2014.

The following actions are being taken to improve performance;

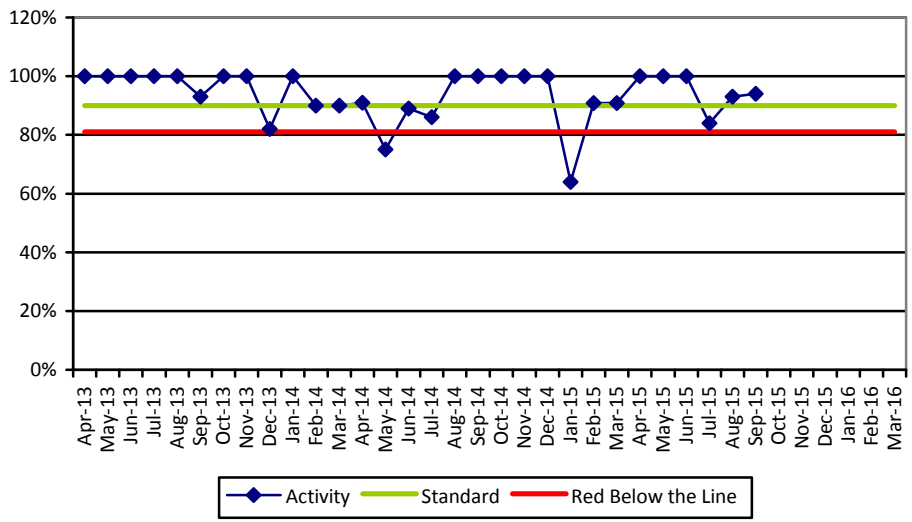
- Frail Elderly Project: this ensures that frail elderly patients receive Comprehensive Geriatric Assessment as soon as possible after admission. This provides rapid identification of needs and ensures patients are moved to appropriate care environment in a timely fashion
- Reduction in length of stay in Elderly Medicine Ward. This is ensuring more frequent throughput allowing patients to access Geriatric care more rapidly

Redesign of acute medical assessment. This ensures senior medical review of all patients soon after admission and decision-making around treatment plan.

Please note: There is a 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%	100%	84%	93%	94%	-						↑	G



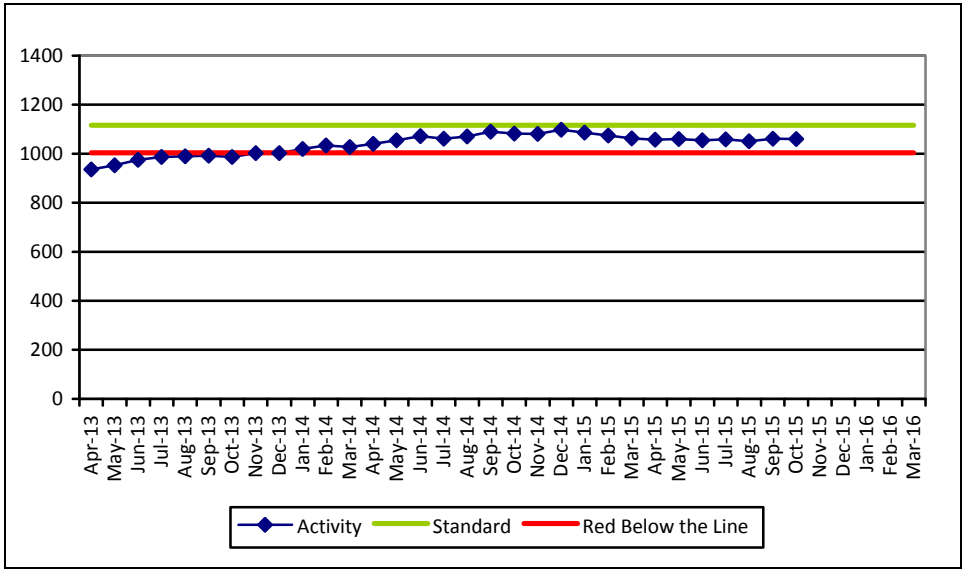
The run chart shows that target compliance for patients being **admitted to the Stroke Unit within 1 day of admission to hospital** has been maintained during 2015/16 with the exception of July 2015. This was due to a small number of patients who were clinically unsuitable to be transferred to the Stroke Unit at 1 day.

Current performance is expected to be maintained.

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 the Electronic Scottish Stroke Care Audit (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	1059	1051	1062	1060						↓	A



The run chart shows a slight increase in the number of patients being added to the **Dementia Register** with September 2015 reporting 1062 patients. Performance is variable and the number of patients on the register hasn't been as low since June 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 was 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.