Borders NHS Board

NHS BORDERS HEAT PERFORMANCE SCORECARD – DECEMBER 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 December 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.

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

- Smoking cessation successful quits in the most deprived areas exceeded the trajectory of 45 with 67 quits for quarter 2 of 2015/16 (latest available data) (page 7)
- To sustain and embed alcohol brief interventions (ABIs) exceeded the trajectory of 985 in December 2015 with 1348 ABI's being delivered (page 8)
- The standard for pre-operative stay was achieved during October 2015 (latest available data) 0.39 days against the standard of 0.47 (page 11)
- 93.9% of all referrals were triaged online in December 2015, above the standard of 90% (page 12)
- Treatment of cancer within 31 days of decision to treat for all patients diagnosed with cancer is consistently being achieved – latest available data November 2015 (page 17)
- Treatment of cancer within 62 days for urgent referrals of suspicion of cancer is also consistently being achieved – latest available data November 2015 (page 17)
- 18 Week RTT admitted pathway linked performance (page 20), and non-admitted pathway performance (page 21) are performing above 90% target in December 2015
- 18 Weeks RTT combined overall performance and combined pathway linked performance continue to achieve the standard of 90%, with 90.0% and 96.0% respectively in December 2015 (pages 22)
- The Alcohol/Drug referrals into treatment within 3 weeks has exceeded the national standard of 90% and the local stretched target of 95% in December 2015 reporting 100% (page 28)
- The rate of Emergency Occupied Bed Days for the over 75s was achieved in June 2015 (latest available data) with 3646 against the standard of 3685 (page 29)

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

- eKSF and PDPs recorded perform under the trajectories set during December 2015 (page 13 & 14)
- Sickness absence rates are outwith the 4% standard with 4.90% reported in December 2015 (page 15)
- Outpatient and inpatient waits over 12 weeks are 513 and 1 respectively in December 2015 against a standard of 0 patients (page18 & 19)
- 18 Week RTT Admitted Pathway Performance for December 2015 was 82.0% which is outwith the standard of 90% (page 20)
- 97 breaches of the 4 week diagnostic waiting time target were reported in December 2015 (page 23)
- 19 patients were waiting over 18 weeks within the Child and Adolescent Mental Health Service at end of November 2015 (latest available data) (page 24)
- 15 breaches were reported against a standard of 0 psychological therapy waits over 18 weeks in December 2015 (page 25)
- During November 2015 (one month lag time) 88% of patients were admitted to the Stroke Unit within 1 day of admission, against a standard of 90% (page 30)

The targets at risk of delivery at 31st March 2016 are highlighted below:

- New patients DNA rate
- Same day surgery
- eKSF and PDPs recorded
- Sickness Absence
- Outpatient and inpatient waits over 12 weeks
- 18 Week RTT Admitted Pathway Performance
- 4 week diagnostic waiting time target
- Child and Adolescent Mental Health Service waiting times
- Psychological therapy waits over 18 weeks
- Delayed Discharges over 2 Wks
- 4-Hour Waiting Target for A&E (98% stretched target)
- Admission to the Stroke Unit within 1 day
- Diagnosis of dementia

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 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 December 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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HEAT PERFORMANCE SCORECARD

As at 31st December 2015

February 2016

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]	-	-	G -	-	-	G ↑	-	-	-			
Alcohol Brief Interventions [2]	A -	A ↑	G ↑	G ↑	G ↑	G ↑	G ↑	G ↑	G ↑			
New patient DNA rate	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓	R ↑	R ↓	A ↑			
Same day surgery [3]	A ↓	A ↑	G ↑	A ↓	A ↓	A ↑	A ↓	-	-			
Pre-operative stay [3]	G ↑	G ↑	G ↓	G ↑	A ↓	G ↑	G ↓	-	-			
Online Triage of Referrals	G ↑	G ↑	G ↓	G ↑	G ↓	G ↓	G ↑	G ↑	G ↑			
eKSF annual reviews complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑			
PDP's Complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑			
Sickness Absence Reduced	A ↑	A ↑	A ↓	R ↓	G ↑	G ↑	G ↓	A ↓	R ↓			
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [4]	G ↔	G ↔	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 ↔	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 ↓	R ↓	R ↓			
18 Wk RTT: 12 wks for inpatients	R ↑	R ↓	R ↑	R ↑	R ↔	R ↓	R ↑	G ↑	A ↓			
18 Wk RTT: Admitted Pathway Performance	R ↑	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓	A ↑	- [5]			
18 Wk RTT: Admitted Pathway Linked Pathway	G ↑	G ↓	G ↔	G ↑	G ↑	G ↓	G ↑	G ↓	- [5]			
18 Wk RTT: Non-admitted Pathway Performance	G ↑	G ↓	G ↓	G ↓	G ↓	G ↑	G ↑	G ↓	- [5]			
18 Wk RTT: Non-admitted Pathway Linked Pathway	G ↓	G ↓	G ↑	G ↑	G ↓	G ↔	G ↓	G ↑	- [5]			
Combined Performance	G ↑	G ↓	G ↑	G ↑	G ↓	G ↑	G ↑	G ↓	- [5]			
Combined Performance Linked Pathway	G ↓	G ↓	G ↑	G ↑	G ↓	G ↓	G ↔	G ↑	- [5]			
4 Week Waiting Target for Diagnostics	R ↓	R ↑	R ↓	R ↓	R ↑	R ↑	R ↓	R ↑	R ↑			
No CAMHS waits over 18 wks [6]	R ↓	R ↑	R ↔	R ↓	R ↓	R ↑	R ↓	R ↓	-			
No Psychological Therapy waits over 18 wks	R ↑	R ↑	R ↓	R ↑	R ↑	R ↑	R ↑	R ↑	R ↓			
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G ↑	G ↓	G ↑	G ↔	G ↔	G ↓	G ↑	G ↓	G ↑			
No Delayed Discharges over 2 Wks	G ↔	G ↔	A ↓	R ↓	A ↑	R ↓	R ↑	R ↑	A ↑			
4-Hour Waiting Target for A&E	A ↑	A ↑	A ↓	A ↑	A ↓	A ↑	A ↓	A ↑	A ↓			
Emergency OBDs aged 75 or over (per 1,000) [7]	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
Admitted to the Stroke Unit within 1 day of admission [8]	G ↑	G ↔	G ↔	R ↓	G ↑	G ↑	G ↑	A ↓	- [9]			
Diagnosis of dementia	A ↓	A ↑	A ↓	A ↑	A ↓	A ↑	A ↓	A ↓	A ↓			
Further Reduce Rate of Staph aureus bacteraemia [10]	-	-	-	-	-	-	-	-	-			
Further Reduce Rate of C. Diff (CDAD) cases in over 15s [10]	-	-	-	-	-	-	-	-	-			

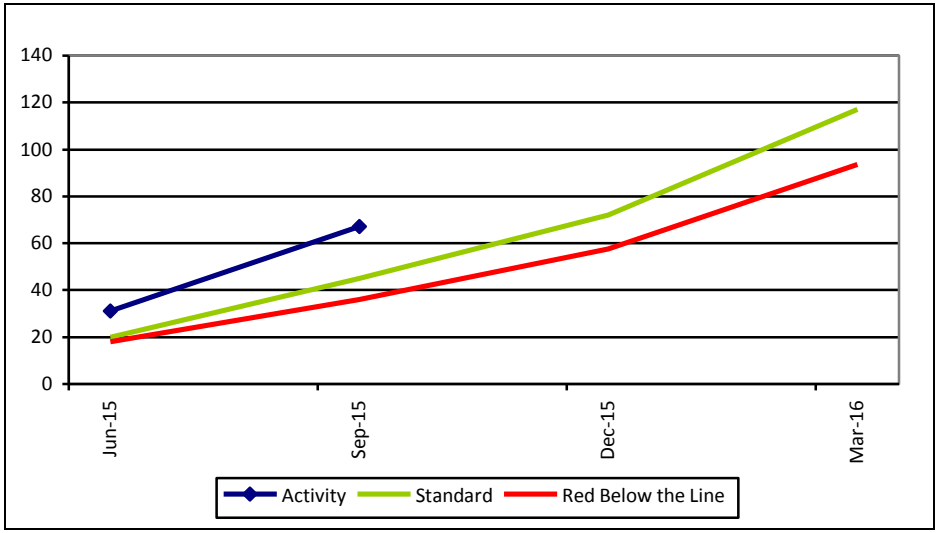
[1] Data is reported quarterly to allow monitoring of the 12 week quit period.
[2] Data should be treated as provisional as there is a reporting lag in some areas which means that data is not fully reconciled at time of reporting.
[3] There is a lag in data due to SMR recording.
[4] One month lag as data is supplied nationally.
[5] December data unavailable at time of reporting
[6] Due to verification processes for national reporting, with CAMHS there is a one month time lag in data.
[7] There is a lag in reporting of 6 months for this standard. Please see performance in the following section of this report.
[8] 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.
[9] December data unavailable at time of reporting
[10] 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	45	31	67	-	-	↑	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.



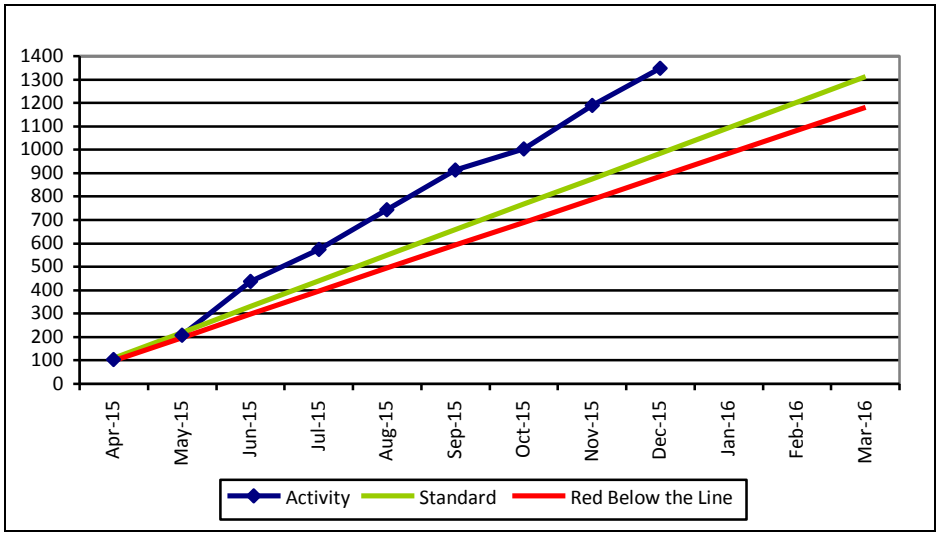
Data for **smoking cessation successful quits** has a lag time to allow monitoring of the 12 week standard quit period from 1st April 2015. The chart shows that the trajectory set for September 2015 (45) has been achieved with 67 successful quits.

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	985	105	208	438	575	744	913	1004	1190	1348				↑	G



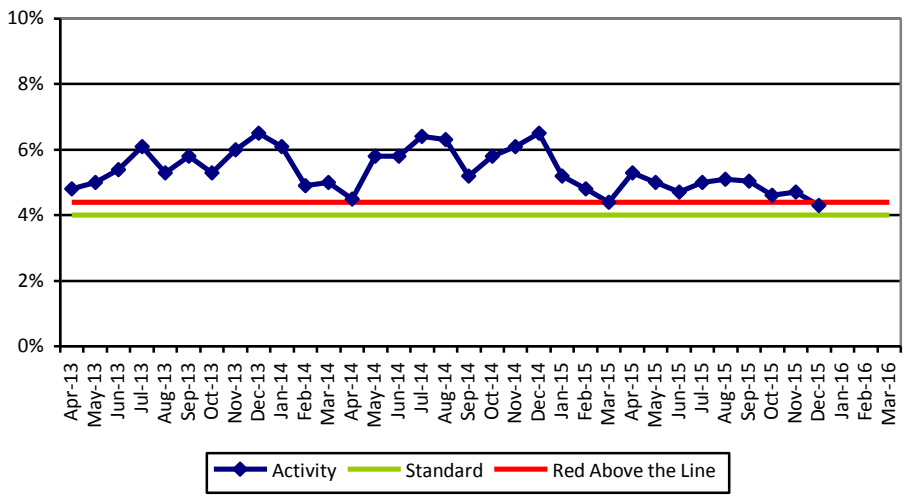
To sustain and embed **alcohol brief interventions** is a new standard for 2015/16. The run chart shows that performance at the end of December 2015 is ahead of trajectory (985). The service has predicted the standard will be achieved during 2015/16.

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%	4.7%	4.3%				↑	R



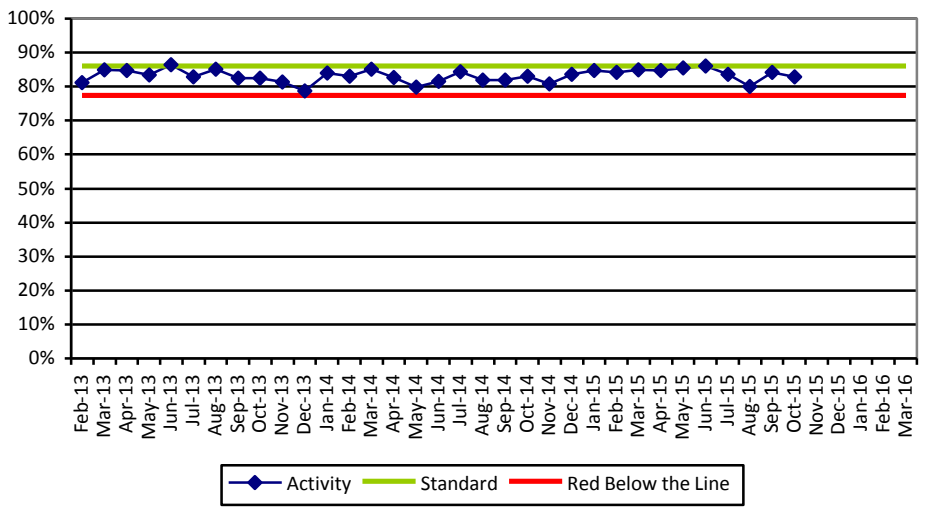
The run chart shows that the **DNA rate is** variable and performance is still outwith the 4% standard. The run chart also shows seasonal peaks in December and July / August.

Overall the trend for May - December 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.

A media campaign will be launched on 1st March 2016 to engage with the public on the impact of DNA's.

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%	84.2%	82.9%	-	-				↓	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. 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 main reasons for patients not being treated as a day case are:

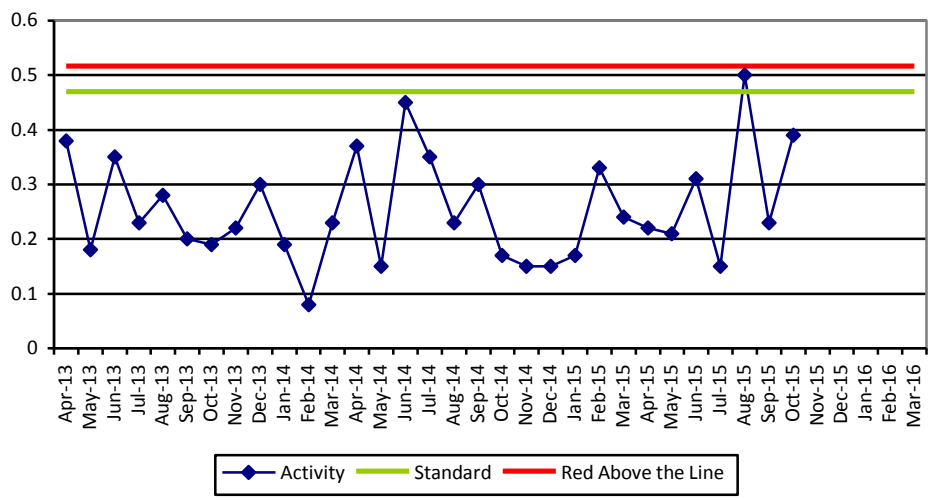
- Anaesthetic or medical reasons
- Surgical reasons – for instance bleeding, pain, unexpected problems during operation, operation turned out to be more complex than originally anticipated
- Patient social status – no responsible adult at home or distance to travel

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	0.23	0.39	-	-				↓	G

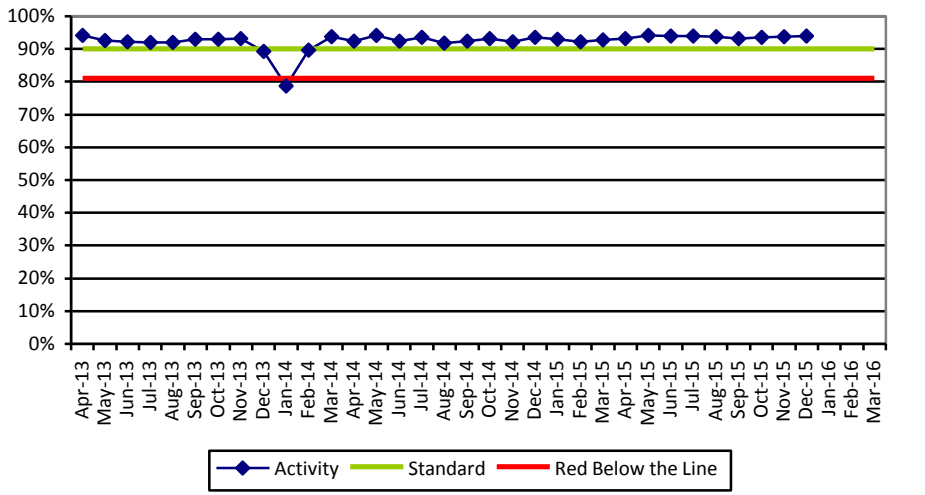


The run chart shows that **pre-operative inpatient stays** in hospital are generally low and within the trajectory set however in August the rate increased. This is the only breach of standard recorded since April 2013 and performance has since returned to a normal level position.

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%	93.8%	93.9%				↑	G

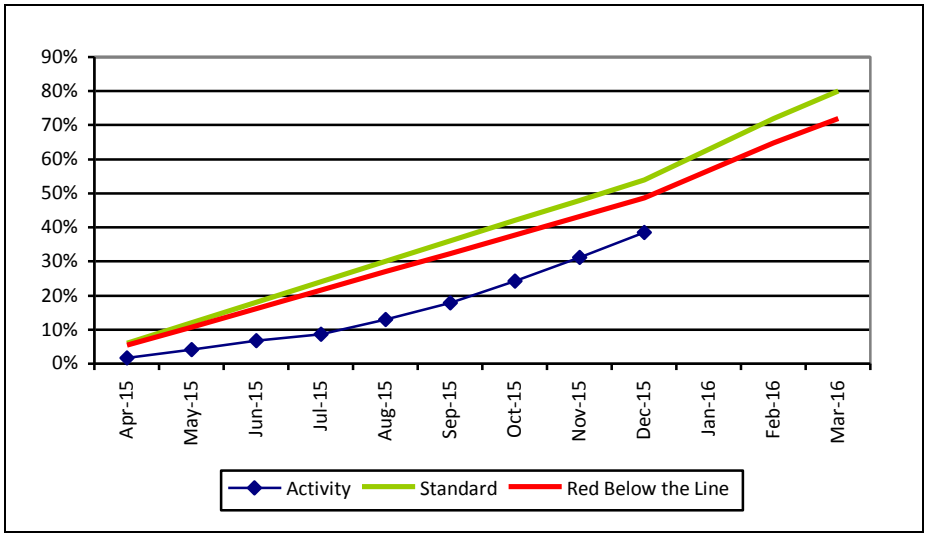


The run chart shows that overall the level of **online eTriage of referrals** continues to perform above the 90% standard.

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

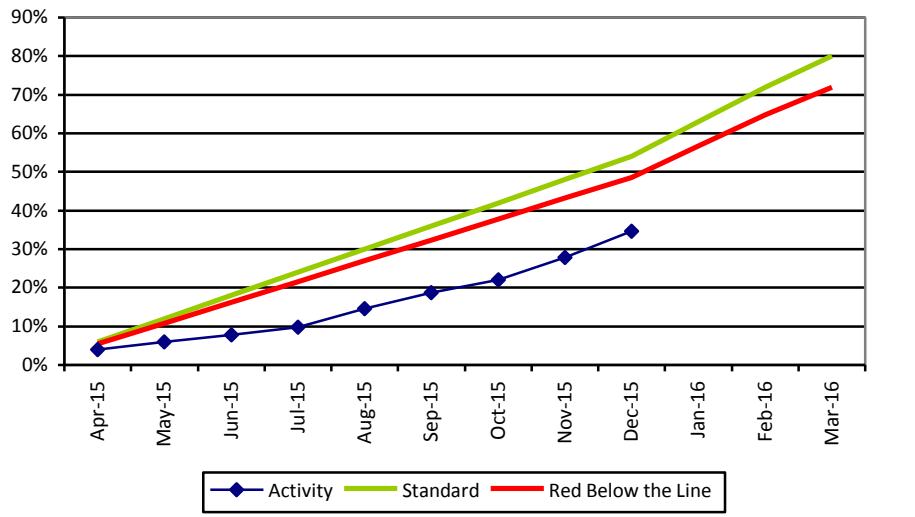
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
March 2016	80%	54%	1.67%	4.11%	6.72%	8.69%	13.01%	17.81%	24.21%	31.23%	38.60%				↑	R



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 which provided an additional focus on the standard. 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

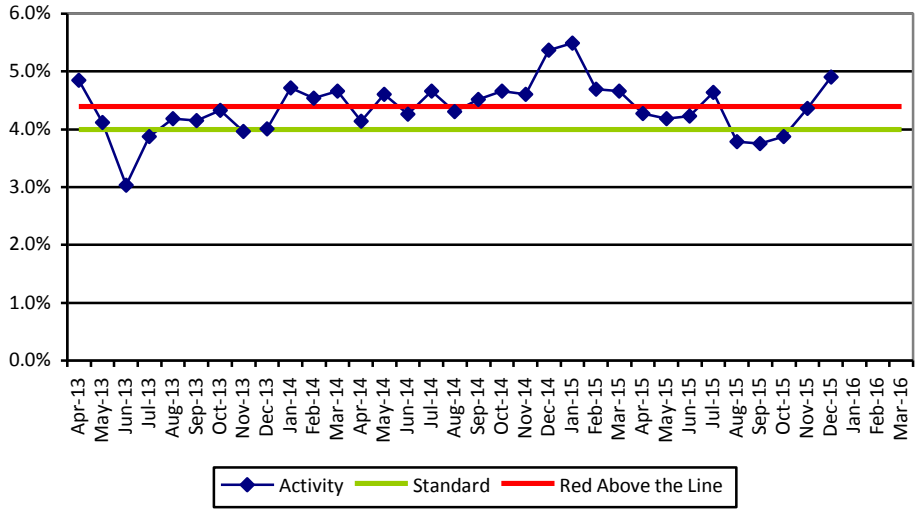
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
March 2016	80%	54%	4.00%	5.93%	7.71%	9.78%	14.61%	18.76%	22.06%	27.92%	34.68%				↑	R



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%	4.36%	4.90%				↓	A



The run chart shows the **Sickness Absence** standard was achieved for 3 consecutive months however the last 2 months the rate of sickness absence has increases.

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.

Further information on sickness absence rates can be found on page16.

Breakdown of Sickness Absence Data – *December 2015 data*

Borders General Hospital Division	%
BGH Mgmt and Cancer Services	4.33
Diagnostics Services	2.48
Medicine	5.23
Planned Care	5.49
Women and Children Services	6.83
Total	**5.19**

Learning Disabilities Division	%
LD Nursing	**2.09**

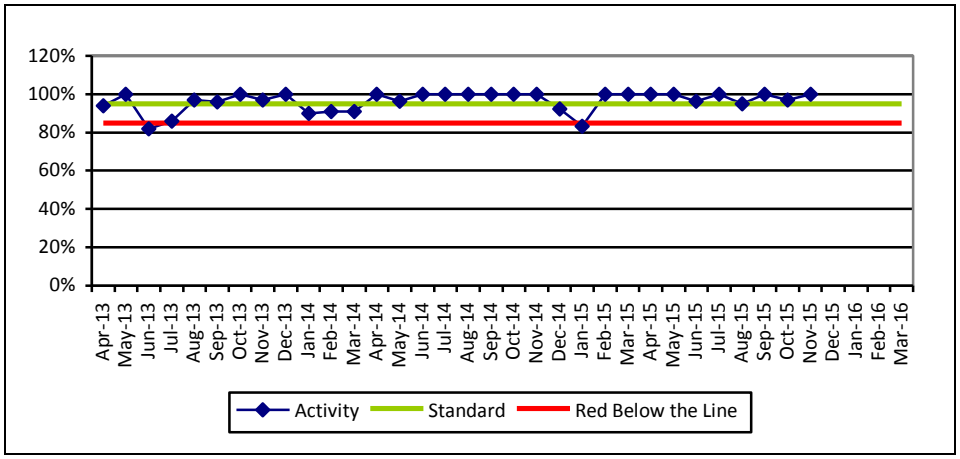
Primary and Community Division	%
Allied Health Professionals	2.91
Berwickshire Locality	6.95
Cheviot Locality	5.11
Dental Services	3.44
Eildon Locality	13.32
Lifestyle Adviser Service	6.36
PC Snr Mgmt, Admin & Spec Services	3.33
Sexual Health	20.30
Teviot Locality	6.40
Tweeddale Locality	6.46
Total	**5.52**

Support Services Division	%
Child Health Network	0.00
Clinical Governance	0.68
Commissioning	0.00
Estates and Facilities	5.09
Finance	2.92
IM&T	1.75
Infection Control	16.16
NHSB Board	0.00
Nurse Bank	0.00
Org Change and Development	0.00
Pharmacy	3.60
Public Health	5.12
Spiritual Care	0.00
Workforce and Planning	1.44
Total	**3.74**

Mental Health Division	%
MH Community Teams	5.85
MH Day Units	0.00
MH Management and Admin	7.38
MH Wards	5.98
Psychiatry	0.00
Psychological Services MH	7.34
Total	**5.67**

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%	96.9%	100%	-				↑	G

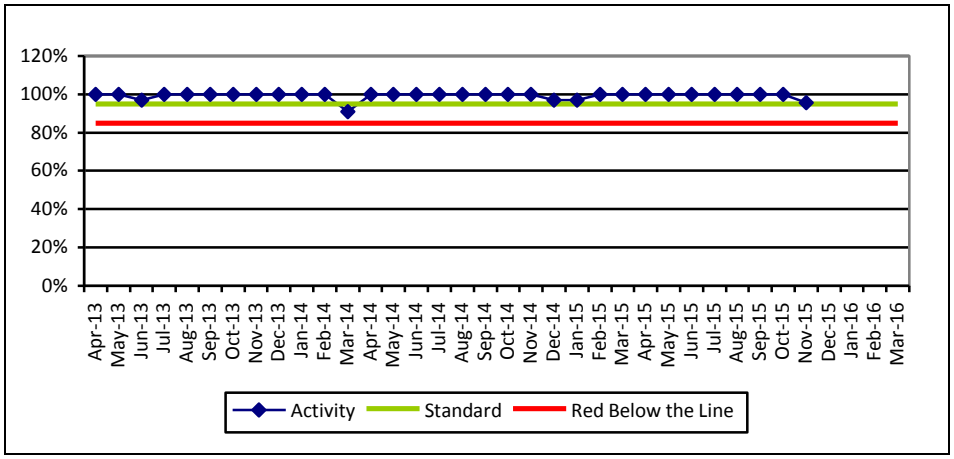


The run chart shows the standard, to **see patients with a suspicion of cancer within 62 days** is back on track and meeting the 95% compliance standard following the breaches in December 2014 & January 2015. The standard has been consistently achieved during 2015/16.

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%	100%	95.7%	-				↓	G

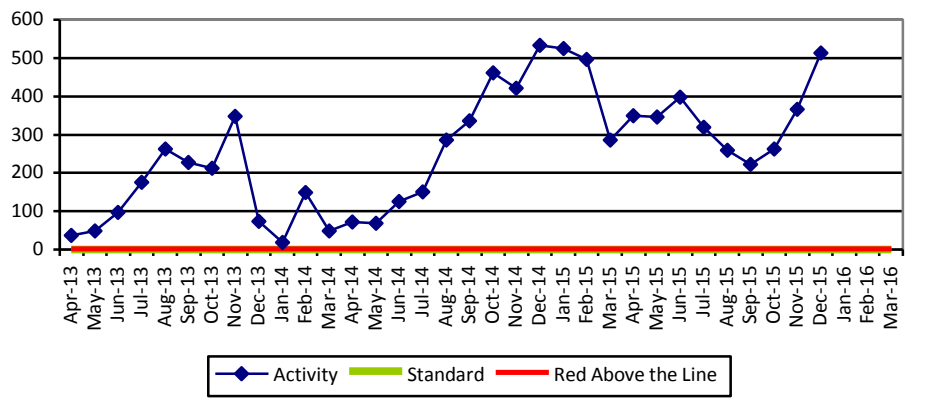


The run chart shows the standard, to **treat patients with cancer within 31 days of diagnosis** has been consistently achieved during 2014/15 and during 2015/16. This is expected to continue.

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	366	513				↓	R



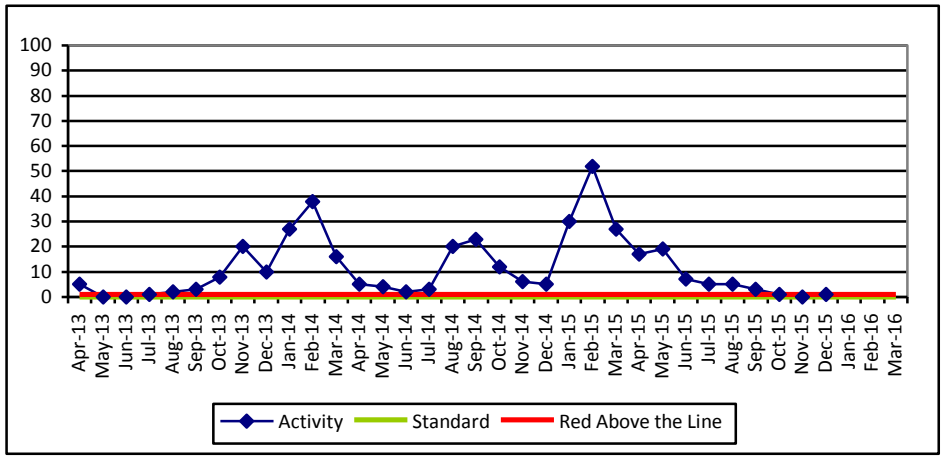
The run chart shows that performance towards the Stage of Treatment standard for patients to be **seen at an outpatient appointment within 12 weeks** has decreased over the last 3months following an improved position.

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

- Cardiology – capacity is an ongoing problem, and work is ongoing with the service to look for solutions to this
- Chronic Pain – the service are in the process of implementing revised administrative processes and additional short-term capacity
- ENT – is a particular concern at present. An additional Consultant post has been appointed, however there are still significant challenges around capacity
- Diabetics / Endocrinology – also continue to be challenging. Additional short-term capacity has been organised with local clinicians whilst a longer term solution is identified
- Oral Surgery – sickness absence of the Consultant Surgeon has led to significant pressures in this area. At present short term weekend locum cover has been organised mostly through Synaptik

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	0	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 December 2015 the number of patients reported as waiting over 12 weeks was 1. This was due to a short notice cancellation.

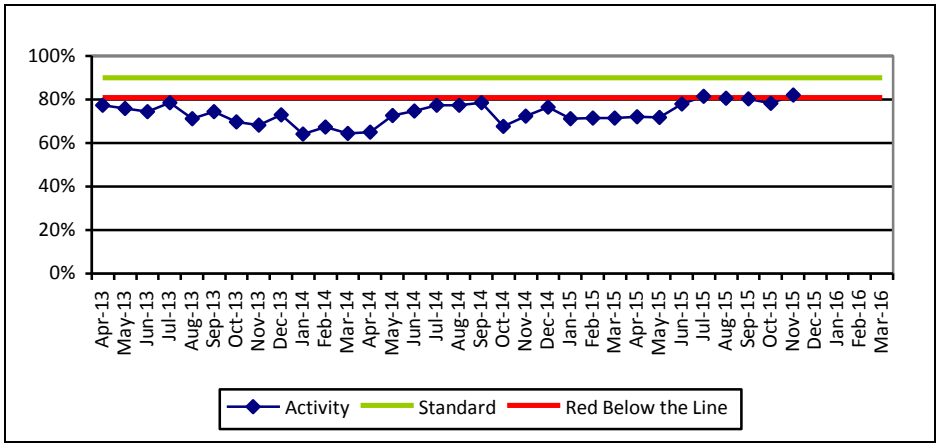
We continue to carry the risk of further patients exceeding 12 weeks due to short notice cancellation. There have been a number of cancellations during January and the number of reported breaches is predicted to increase.

There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. In the interim, weekend operating continues with the support of Synaptik, with in total 20 weekends of additional operating now planned.

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%	82.0%	- [1]				↑	R

[1] December data unavailable at time of reporting



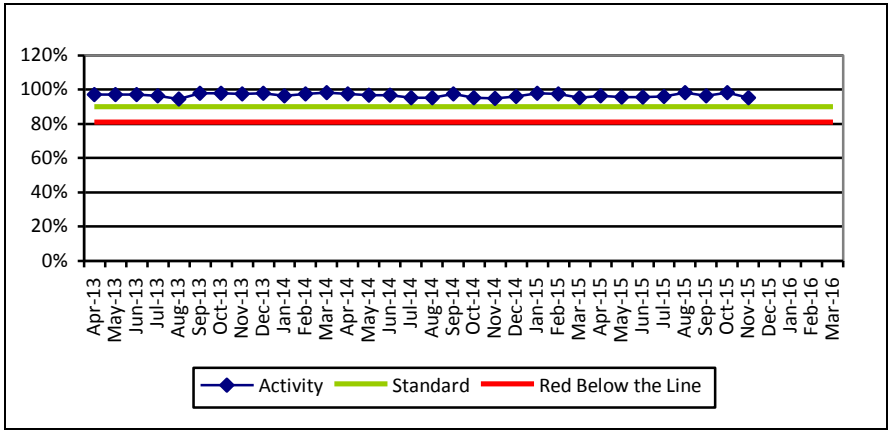
The run chart shows that **Admitted pathway performance towards 18 weeks Referral to Treatment** remains under the standard but improvements are visible over the last 5 months.

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%	95.4%	- [1]				↓	G

[1] December data unavailable at time of reporting

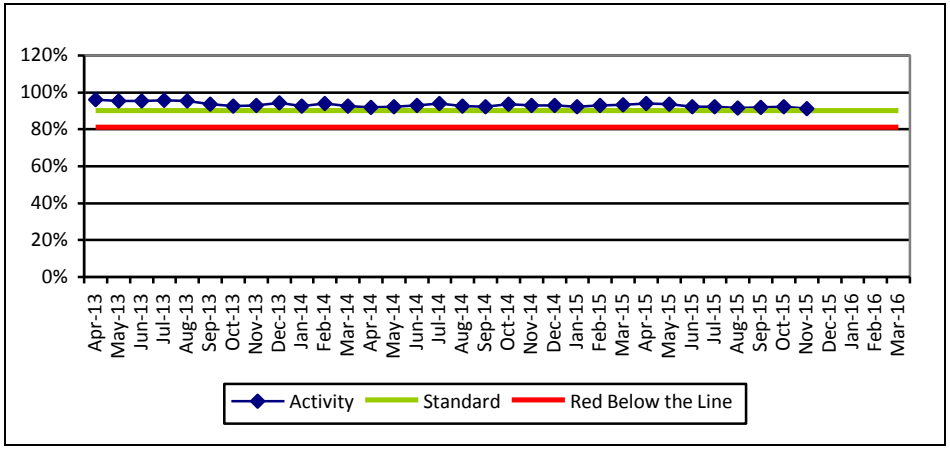


The run chart shows performance for the **linked pathway** is consistently above 90%. Work will continue to ensure the standard is maintained during 2015/16 with the reduction in the number of 12 week breaches.

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%	91.3%	- [1]				↑	G

[1] December data unavailable at time of reporting

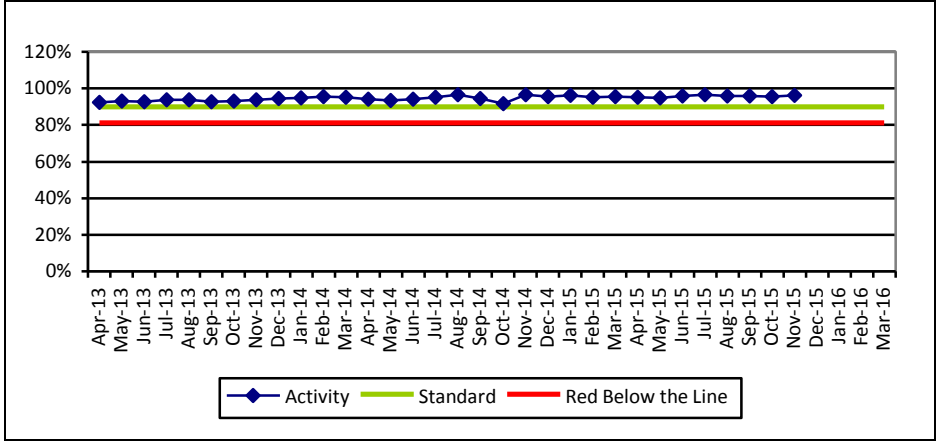


The run chart shows that performance for **non-admitted pathways** is consistently above 90%. Work will continue during 2015/16 to ensure the standard is maintained with the reduction in the number of 12 week breaches.

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%	96.1%	- [1]				↑	G

[1] December data unavailable at time of reporting

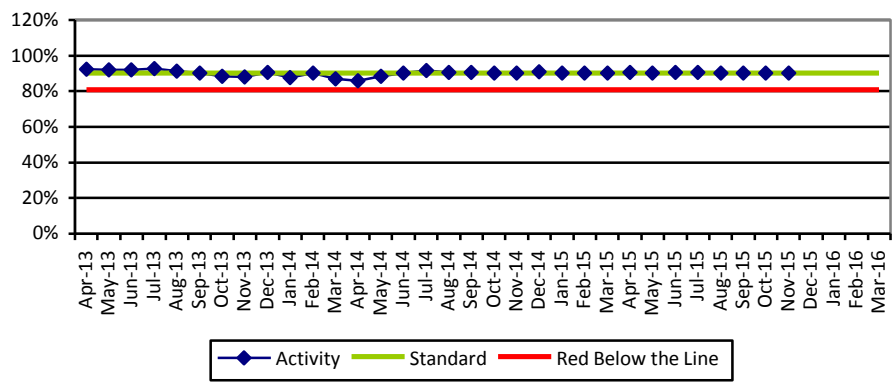


The run chart shows performance for **non-admitted linked pathways** is consistently above 90%. Work will continue to ensure the standard is maintained with the reduction in the number of 12 week breaches.

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%	90.0%	- [1]				↓	G

[1] December data unavailable at time of reporting



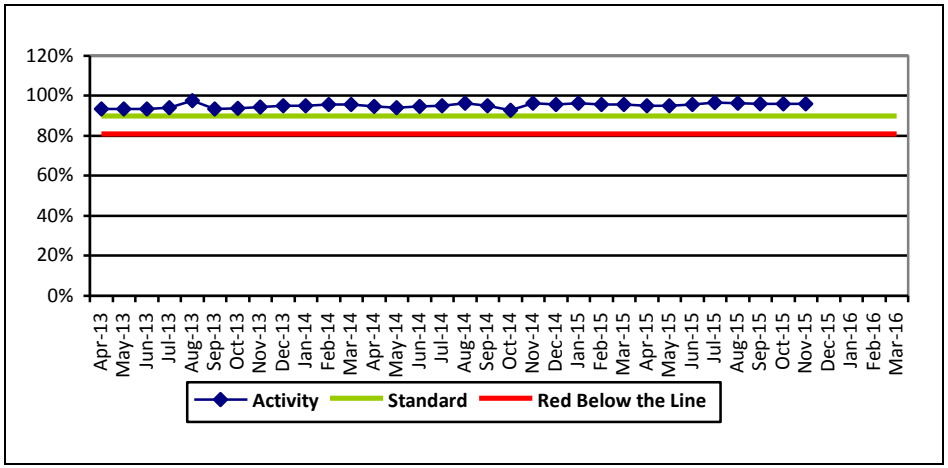
The run chart shows that currently NHS Borders continues to achieve the 90% **combined RTT** standard.

Performance has been very close to 90%, due to patients requiring both outpatient and inpatient care and the increased outpatient waiting times in some specialties. 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%	96.0%	- [1]				↑	G

[1] December data unavailable at time of reporting

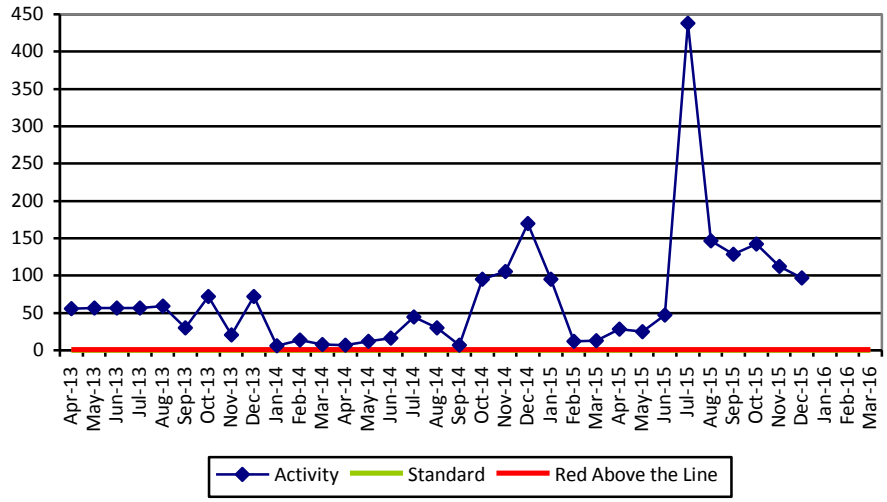


The run chart shows that currently NHS Borders continues to achieve the 90% **combined RTT linked pathway** standard.

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	122 [1]	97				↑	R

[1] November 2015 data updated as incorrectly reported as 112 in the monthly scorecards

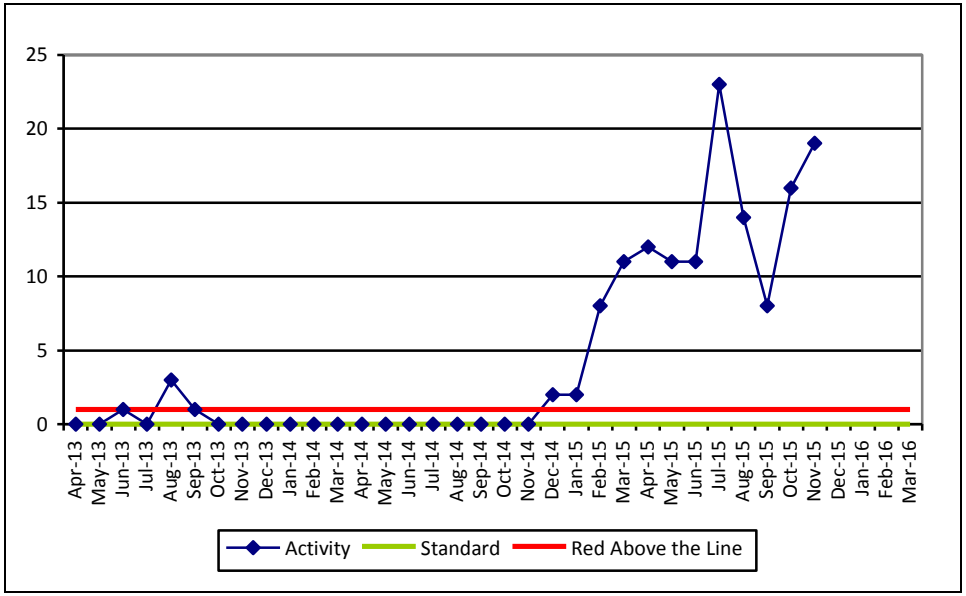


The run chart shows that performance for **Diagnostic Waiting Times** over 4 weeks is still outwith the standard set.

MRI & CT continue to be the pressure areas. Consultant Radiologists continued the increased number of reporting sessions with 14 additional sessions per month throughout November and December which has maintained the position. We continue to support additional ad hoc MRI and CT sessions in order to maintain the current reported position. This remains under review as part of a wider Service review aimed at addressing capacity issues on a sustainable basis given current pressures.

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	16	19	-				↓	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.

In the quarter to December 2015 CAMHS achieved 76.7% performance, which is a reduction from the previous two quarters (86.9% to June 2015; 90.9% to March 2015).

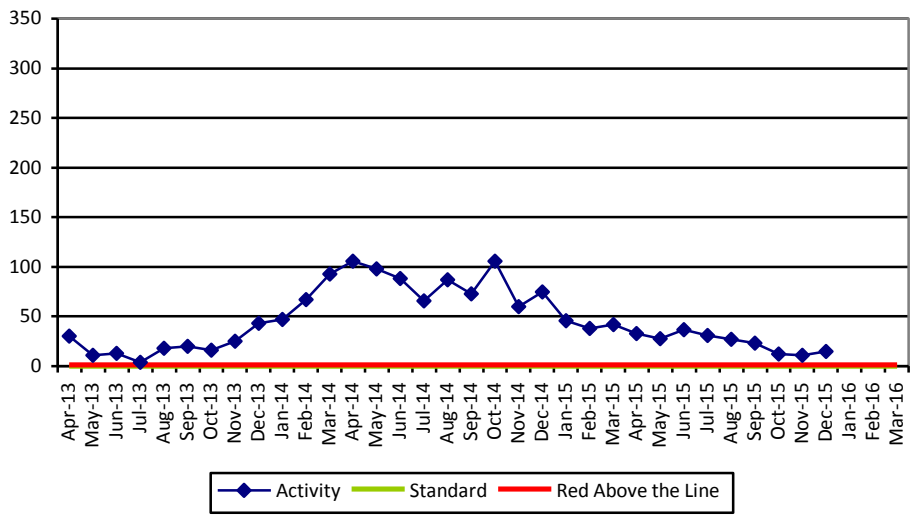
The service continues to be challenged with the standard of 90% seen within 18 weeks despite having recruited additional staff. The service has been unable to recruit to nurse and consultant psychiatrist posts, which are key posts to support the delivery of the target.

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	11	15				↓	R



Since September there has been a decrease in performance of **18 weeks RTT for psychological therapies**, resulting in 65% of being seen within 18 weeks in December 2015 (against a target of 90%).

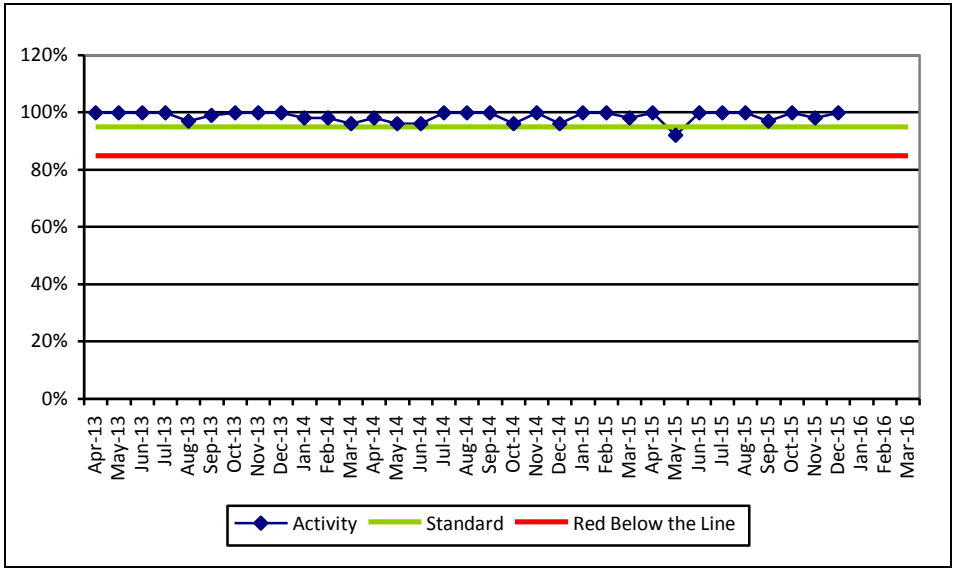
The service continues to monitor progress and allocate resources to the areas with the longest waits.

Some of the long waits are the result of a loss of expertise in a particular specialised therapy (EMDR) – which is difficult to replace as there is a 12 month training required. We have a member of staff having recently commenced training in EMDR.

Please Note: From October 2015 reporting was changed to the number of patients who waited over 18 weeks for RTT - as per the agreement at the Mental Health Performance Review.

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

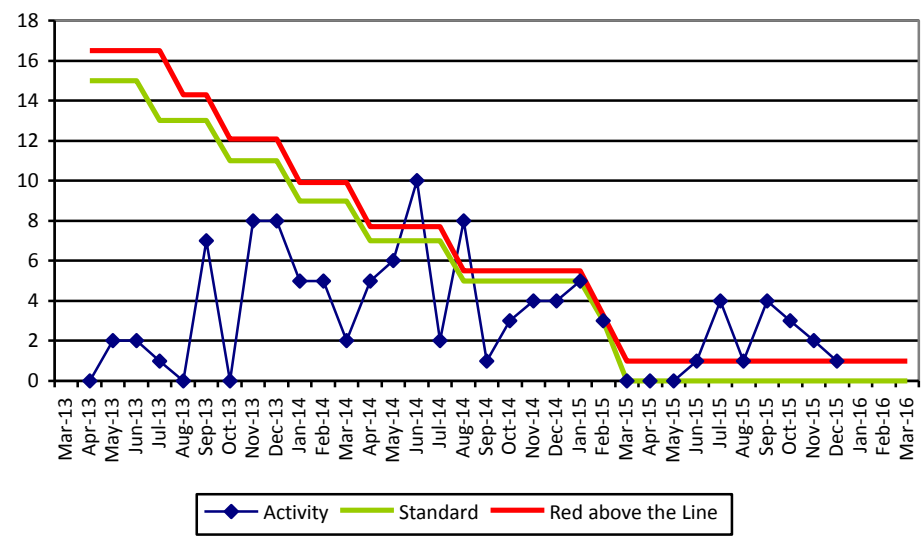
Standard Date	2015/16 Standard	Current Standard	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Performance	YTD
Maintain	90%	90%	100%	92%	100%	100%	100%	97%	100%	98%	100%				↑	G



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 7 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	2	1				↑	A



The run chart shows 1 breaches against the standard that **no patients should be waiting more than 14 days to be discharged** into an appropriate care environment.

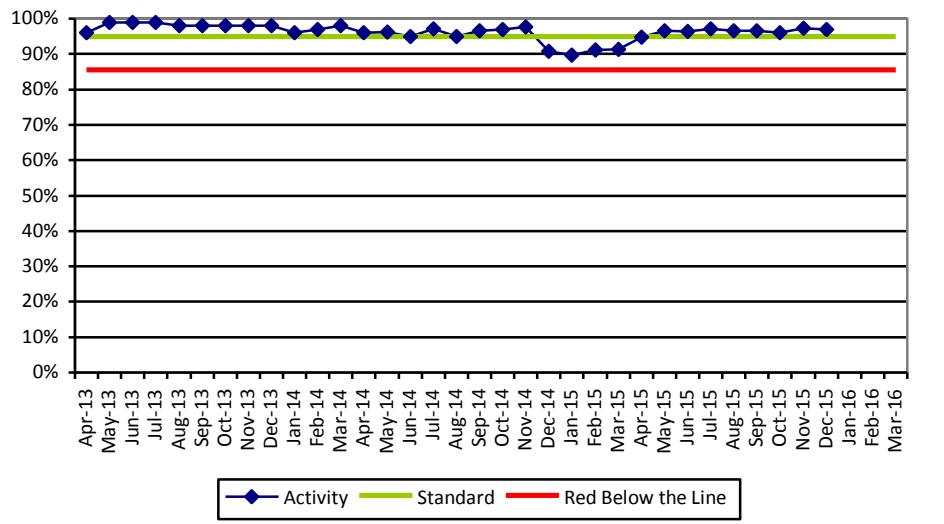
The key reasons for delay experienced by patients has been influenced by the current difficulties relating to the unavailability of home care, choices of care home placements and a significant number of complex cases, specifically Adults With Incapacity related delays and one move only cases. Of particular and ongoing concern has been the Partnership's performance against the 2 week target and the associated Occupied Bed Days lost. This has increased month on month since September 2015.

Dedicated Care Managers have been located in each of the Community Hospitals to provide a screen-out approach for social care requirements. This is being tested under the auspices of the Winter Plan.

Scottish Borders Council are also working with the main providers of Home Care, SBCares, to ensure turnover of homecare hours is in place to assist with improved patient flow.

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%	97.2%	96.9%				↓	A



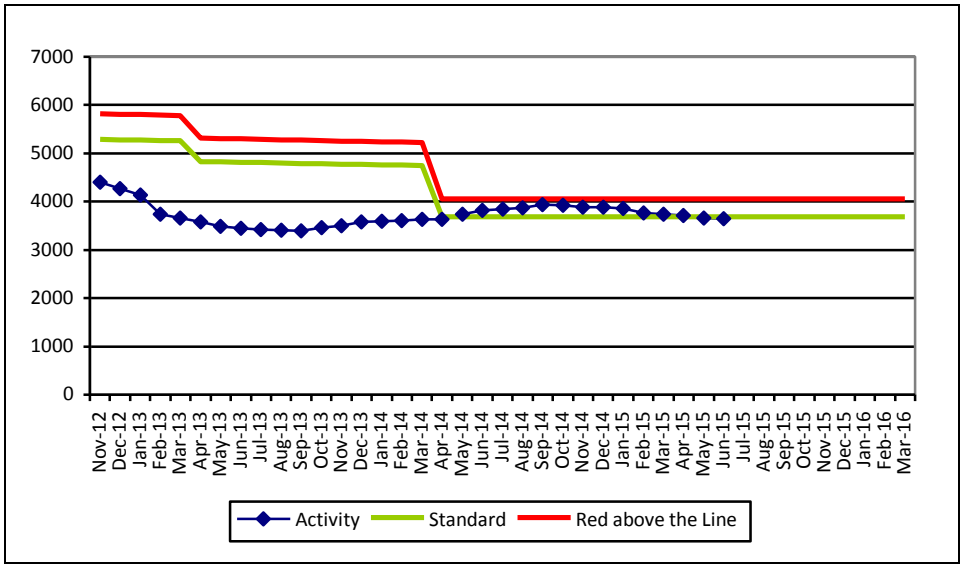
Patients attending **A&E are routinely discharged within 4 hours.** NHS Borders continues to achieve the national standard of 95%. The 98% local standard has not yet been achieved in 2015.

The major cause of breaches over the last 3 months continues to be due to wait for medical bed. The significant reduction in performance for flow 3 reflects similar reductions in performance during the same period in previous years. However, the number of Flow 3 patients has reduced by 65% as a result of the opening of the Acute Assessment Unit (AAU) in December 2015.

AAU performance is not currently being reported as part of the Emergency Access Standard, as these patients are currently being admitted. Patients in AAU are however being monitored against the 4-hour standard. An upgrade to the Trak reporting system will allow AAU performance to be reported as part of the EAS standard from March onwards. Achievement against combined ED and AAU performance in both December and January was above the 95% national standard.

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

Standard Date	2015/16 Standard	Current Standard	Current Month (Jun 15)	Previous Month (May 14)	Performance	Status
Mar 2016	3685	3685	3646	3660	↑	G



The run chart shows that performance against the **Emergency Occupied Bed Days** standard is back on track with the last 2 months reporting improved performance.

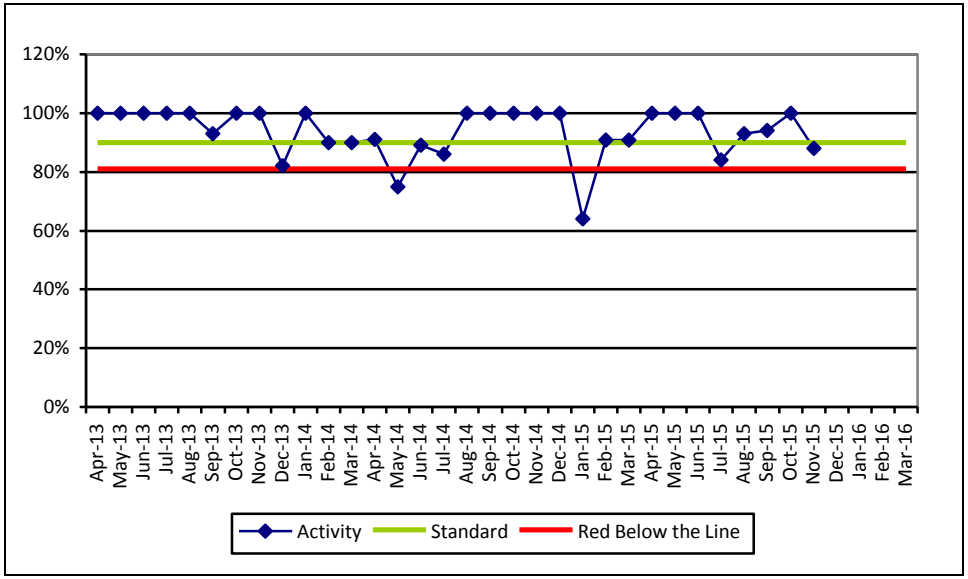
The following actions are being taken to improve performance;

- 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
- The 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%	100%	88%	-				↓	A



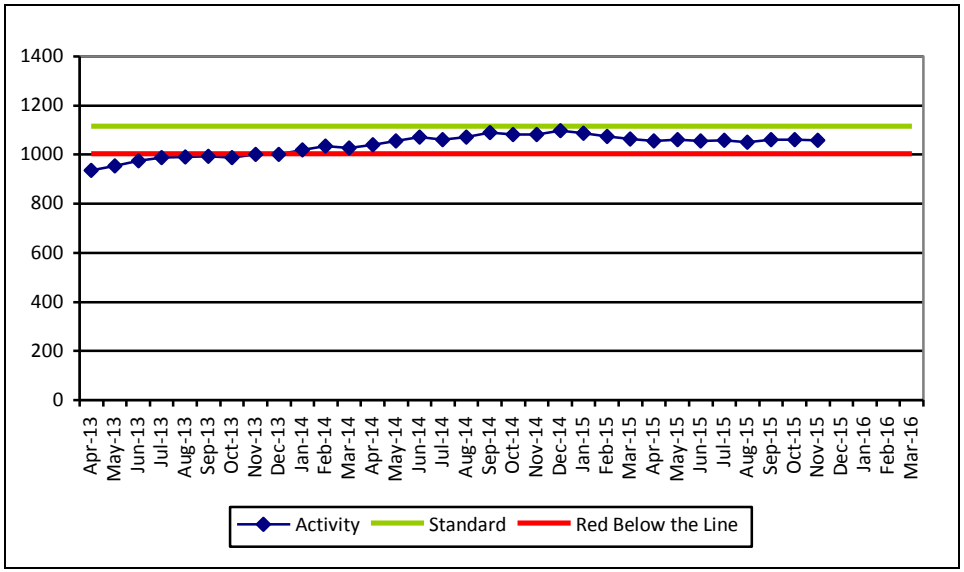
The run chart shows that target compliance for patients being **admitted to the Stroke Unit within 1 day of admission to hospital** has been maintained during 2015/16 with the exception of July & November 2015. All patients requiring access to the Stroke Unit have been transferred within the target timescales, unless they clinically required care elsewhere. 2 patients were on telemetry and required s higher level of care, however all other standards were fully met.

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	1059	- [1]				↓	A

[1] December data unavailable at time of reporting



The run chart shows the number of patients being added to the **Dementia Register** has been static over the last 18 months.

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.