Borders NHS Board

NHS BORDERS PERFORMANCE SCORECARD – APRIL 2016

Aim

This paper aims to update the Board with NHS Borders latest performance towards the 2016/17 Local Delivery Plan (LDP) Standards and local Key Performance Indicators. The attached Performance Scorecard is the first scorecard in its new format and shows performance as at 30th April 2016.

Background

Previously a number of standard reports were produced to report performance to the Clinical Executive Operational Group, Strategy & Performance Committee and NHS Borders Board. The attached Performance Scorecard is the result of a review which has sense checked, streamlined and reduced duplication to ensure a more consistent and standardised approach. The review has provided the opportunity to improve and streamline the reporting process and to present the Board with clear and relevant performance information and a focus on actions to address performance which is off track.

Developing the new Performance Scorecard has been an opportunity to evolve the information that is presented and focus on the core business of the LDP Standards, as well as reduce the number of overall of indicators. This focused report brings together key issues and hot topics in a standardised format to facilitate discussion around specific areas.

The Performance Scorecard combines elements of the HEAT Scorecard, Access to Treatment Report and the Integrated Performance Scorecard into one report which will be presented to the Clinical Executive Operational Group, Strategy & Performance Committee and the Board. Monthly Clinical Board scorecards and quarterly performance reviews will remain in place and the 6 monthly Managing Our Performance Report will continue to be presented to the Board.

The report continues to monitor the standards as set out in the Local Delivery Plan and includes hot topics that are a focus for NHS Borders; i.e. Cancellations. Some stretch targets remain within the report for monitoring purposes however a RAG status will only be applied to the national standard, these targets include; Waiting Times Target for Diagnostics, Accident & Emergency 4 Hour Standard, CAMHS Waiting Times, Psychological Therapy Waiting Times, Drug & Alcohol Treatment Waiting Times

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.

A workforce section is being created which will be included in the next Performance Scorecard and will be reported to the NHS Borders Board on 4th August 2016.

Areas of strong performance from the LDP Standards and Access to Treatment sections in the Scorecard for the position as at 30th April 2016 are highlighted below:

- Smoking cessation successful quits in the most deprived areas exceeded the trajectory of 72 with 96 quits for quarter 3 of 2015/16 (latest available data) (page 13)
- The standard for pre-operative stay was achieved during February 2016 (latest available data) 0.21 days against the standard of 0.47 (page 17)
- 93.0% of all referrals were triaged online in April 2016, above the standard of 90% (page 18)
- The rate of Emergency Occupied Bed Days for the over 75s was achieved in November 2016 (latest available data) with 3573 against the standard of 3685 (page 22)
- 18 Weeks RTT admitted pathway linked performance, non-admitted pathway performance, non admitted linked performance, combined overall performance and combined pathway linked performance continue to achieve the standard of 90% in April 2016 (pages 30-34)
- Treatment of cancer within 31 days of decision to treat for all patients diagnosed with cancer is consistently being achieved – latest available data March 2016 (page 38)
- Treatment of cancer within 62 days for urgent referrals of suspicion of cancer is also consistently being achieved – latest available data March 2016 (page 39)
- During March 2016 (one month lag time) 93.3% of patients were admitted to the Stroke Unit within 1 day of admission, against a standard of 90% (page 42)
- The Alcohol/Drug referrals into treatment within 3 weeks has exceeded the national standard of 90% in April 2016 reporting 100% (page 46)
- A total of 162 patients waited over 9 weeks for AHP services in April 2016 (page 47)
- 3 patients were delayed over 2 weeks to be discharged from hospital at the census point in April 2016 (page 50)

Areas where performance is outwith the tolerance of 10% in the LDP standards and Access to Treatment sections of the Scorecard for the position as at 30th April 2016 are highlighted below:

- People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support - latest available position (page 10 & 11)
- To sustain and embed alcohol brief interventions was not achieved in April with 73 ABIs delivered against the trajectory of 110 (page 12)
- Sickness absence rates are outwith the 4% standard with 4.60% reported in April 2016 (page 14)
- New patient DNA rate was outwith the 4% standard at 4.8% in April 2016 (page 15)
- eKSF and PDPs recorded perform under the trajectories set during April 2016 (page 20 & 21)
- Outpatient and inpatient waits over 12 weeks are 316 and 4 respectively in April 2016 against a standard of 0 patients (page 25 & 26)
- 18 Week RTT Admitted Pathway Performance for April 2016 was 78.5% which is outwith the standard of 90% (page 29)

- 54 breaches of the 4 week diagnostic waiting time target were reported in April 2016 (page 35)
- 79% of patients were seen within 18 weeks RTT for the Child and Adolescent Mental Health Service at end of March 2016, against the standard of 90% (latest available data) (page 45)

Others areas of strong and challenging performance are included within the main report and are summarised in the Key Performance Indicator dashboard on page 7.

Summary

NHS Borders Board meetings will receive the Performance Scorecard highlighting the organisation's performance towards the national LDP Standards and local Key Performance Indicators.

Recommendation

The Board is asked to **note** the June 2016 Performance Scorecard (April 2016 performance).

Policy/Strategy Implications	Regular and timely performance reporting is an expectation of the Scottish Government
Consultation	Planning and Performance have consulted individual Clinical Boards to agree the information that will be reported on a monthly basis.
Consultation with Professional Committees	See above
Risk Assessment	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		

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Carly Lyall	Planning & Performance Officer		

PERFORMANCE SCORECARD

As at 30th April 2016

June 2016

Planning & Performance

Month

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INTRODUCTION

DASHBOARD OF HEAT STANDARDS

The Dashboard of Standards shows the performance of each standard against a set trajectory. To enable current performance to be judged, colour coding and letters are used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status.

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	-

LDP 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 2016/17 sets out the LDP Standards for NHS Borders.

The Performance Scorecard includes data and narrative to report on the LDP Standards, local Key Performance Indicators and Delegated Performance.

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 LDP standards is detailed within in this report. The following table summarises the achievements for the financial year 2016/17 to date, the arrows indicate performance and direction of travel towards achieving the standards compared to the previous month:

Indicator	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Dementia Post Diagnostic Support [1]	-											
Diagnosis of dementia	A											
Alcohol Brief Interventions [2]	R											
Smoking cessation successful quits in most deprived areas [3]	-											
Sickness Absence Reduced	R											
New patient DNA rate	R											
Same day surgery [4]	A											
Pre-operative stay [4]	G											
Online Triage of Referrals	G											
Increase the proportion of new-born children breastfeb at 6-8 weeks [5]	-											
eKSF annual reviews complete	R											
PDP's Complete	R											
Emergency OBDs aged 75 or over (per 1,000) [6]	-											

Indicator	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
18 Wk RTT: 12 wks for outpatients	R											
18 Wk RTT: 12 wks for inpatients	R											
12 Weeks Treatment Time Guarantee	R											
18 Wk RTT: Admitted Pathway Performance	R											
18 Wk RTT: Admitted Pathway Linked Pathway	G											
18 Wk RTT: Non-admitted Pathway Performance	G											
18 Wk RTT: Non-admitted Pathway Linked Pathway	G											
Combined Performance	G											
Combined Performance Linked Pathway	G											
6 Week Waiting Target for Diagnostics	R											
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [7]	-											
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [7]	-											
4-Hour Waiting Target for A&E	A											
Admitted to the Stroke Unit within 1 day of admission [8]	-											

Indicator	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
No Psychological Therapy waits over 18 wks	R											
No CAMHS waits over 18 wks [9]	-											
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G											
No Delayed Discharges over 2 Wks	R											
No Delayed Discharges over 72 hours (3 days) [10]	R											

Please Note: Direction arrows will be added next month when performance can be compared

Footnotes

1 There is a 1 year time lag to show the full 12 months performance. Reporting on this standard commenced in October 2015.
2 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.
3 Data is reported quarterly, with a time lag, to allow monitoring of the 12 week quit period.
4 There is a 2 month lag in data due to SMR recording
5 There is a lag time for national data, local data supplied quarterly
6 There is a 6 month lag in reporting an data included is the most up to date data available.
7 One month lag as data is supplied nationally.
8 There is a 1 month lag for data. 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 Due to verification processes for national reporting with CAMHS, there is a 1 month lag in data. Data shows number of patients seen against the 90% target.
10 No trajectory set for 72 hours delayed discharges, therefore for reporting the number of delayed discharges are measured over 3 days and the RAG status is applied aiming for 0 breaches

Performance on the Key Performance Indicators is detailed within in this report. The following table summarises the achievements for the financial year 2016/17 to date, the arrows indicate performance and direction of travel towards achieving the standards compared to the previous month:

Indicator		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
AHP Waiting Times		R											
Cancellations	Hospital	R											
	Clinical	R											
	Patient	G											
	Other	G											
Supplementary Staffing Spend		R											
Borders General Hospital Average Length of Stay		R											
Community Hospitals Average Length of Stay		R											
Mental Health Average Length of Stay General Psychiatry Total		G											
Mental Health Average Length of Stay Psychiatry of Old Age Total		R											
Mental Health Waiting Times (Patients waiting over 18 weeks)		A											
Learning Disability Waiting Times (Patients waiting over 18 weeks)		A											
Rapid Access Chest Pain Clinic		G											
Audiology 18 Weeks Waiting Times [1]		-											

Please Note: Direction arrows will be added next month when performance can be compared

Footnotes

1 Data unavailable April 2016 due to staffing issues within the service.

The following standards cannot be reported on a monthly basis and the table below indicates how progress will be reported.

Standard Area	Standard Descriptor	Standard Date	Standard	Frequency of Reporting
Cancer	Increase proportion of 1st stage breast, colorectal and lung diagnosis by 25%	Mar-17	25% increase	Managing Our Performance Report – 6 and 12 month intervals
Antenatal Services	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation	Mar-17	80%	Managing Our Performance Report – 6 and 12 month intervals
IVF	Commence IVF Treatment within 12 months	Mar-17	All patients	Managing Our Performance Report – 6 and 12 month intervals
CDI	Clostridium difficile infections per 1000 occupied bed days (0.32)	Mar-17	0.32 bed days	Managing Our Performance Report – 6 and 12 month intervals and the Healthcare Associated Infection, Prevention and Control Report
SAB2	SAB infections per 1000 acute occupied bed days (0.24)	Mar-17	0.24 bed days	Managing Our Performance Report – 6 and 12 month intervals and the Healthcare Associated Infection, Prevention and Control Report
GPAccess	48 hour access or advance booking to an appropriate member of the GP team (90%)	Mar-17	90%	Managing Our Performance Report – 6 and 12 month intervals
Breakeven	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement	Mar-17	-	Managing Our Performance Report – 6 and 12 month intervals

LDP Standards:

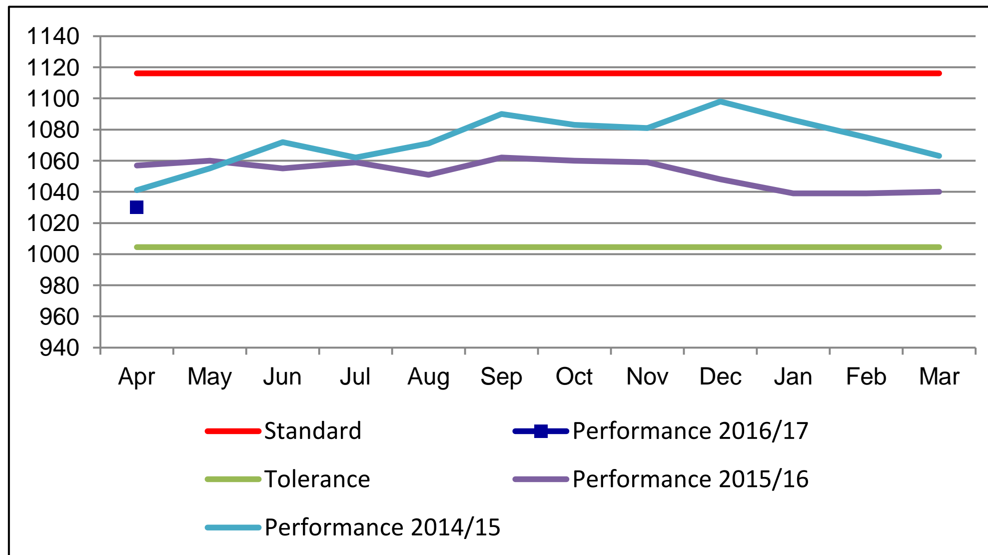
General

Diagnosis of Dementia

Standard: Increase the number of patients added to the dementia register	**Standard**	**Tolerance**
	1116	1004

Actual Performance (higher = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	1116	1116	1116	1116	1116	1116	1116	1116	1116	1116	1116	1116
Performance 2016/17	1030											
Performance 2015/16	1057	1060	1055	1059	1051	1062	1060	1059	1048	1039	1039	1040
Performance 2014/15	1041	1055	1072	1062	1071	1090	1083	1081	1098	1086	1075	1063



Narrative Summary:
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.

Actions:
An exercise to review patients' dementia diagnosis recording is commencing to check for any missing diagnoses codes. It is anticipated that with this data validation exercise the target will be met.

Dementia - Post Diagnostic Support (PDS)

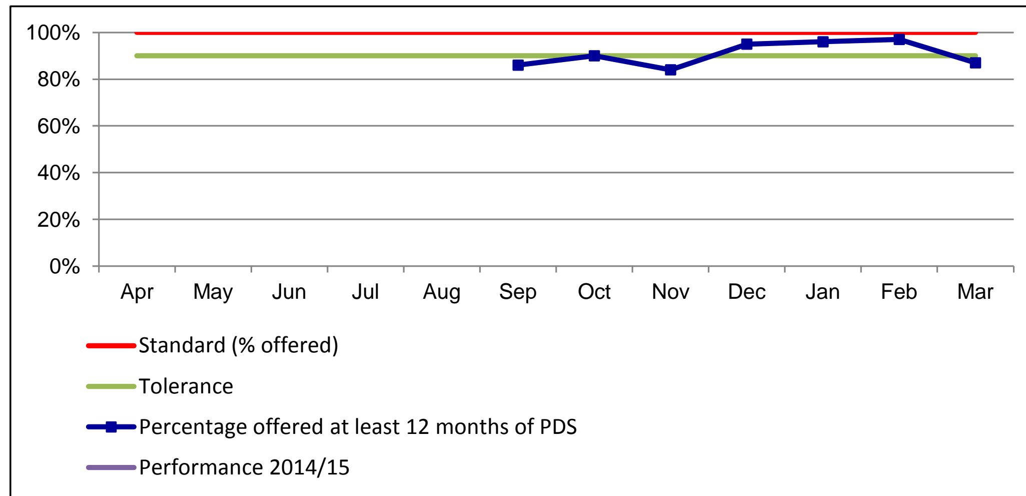
	Standard	Tolerance
Standard: People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support	100%	within 10%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (% offered)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of People who are referred for PDS and have been offered at least 12 months of PDS												
Performance 2016/17												
Performance 2015/16												
Performance 2014/15						75	77	32	54	71	97	107
The Number of People who are Diagnosed with Dementia and Referred for PDS												
Performance 2016/17												
Performance 2015/16												
Performance 2014/15						87	86	38	57	74	100	123
Percentage offered at least 12 months of PDS												
Performance 2016/17												
Performance 2015/16												
Performance 2014/15						86%	90%	84%	95%	96%	97%	87%

Please Note: There is a 1 year time lag to show the full 12 months performance.

Dementia - Post Diagnostic Support (PDS) *continued*



Narrative Summary:
Performance for **Dementia Post-Diagnostic Support** (PDS) has been variable over the last 7 months. Reporting of this standard commenced in September 2015, this was the first month the report was received nationally to enable local reporting.

Actions:
A short term working group is looking at improving delivery of PDS, this multi-disciplinary group has representation within the Focus on Dementia project, the lead body in supporting PDS processes. A training programme has been delivered to community staff to reinforce the principles of person centred Post Diagnostic Support and are underpinning this with Post Diagnostic Support Excellence Programme.

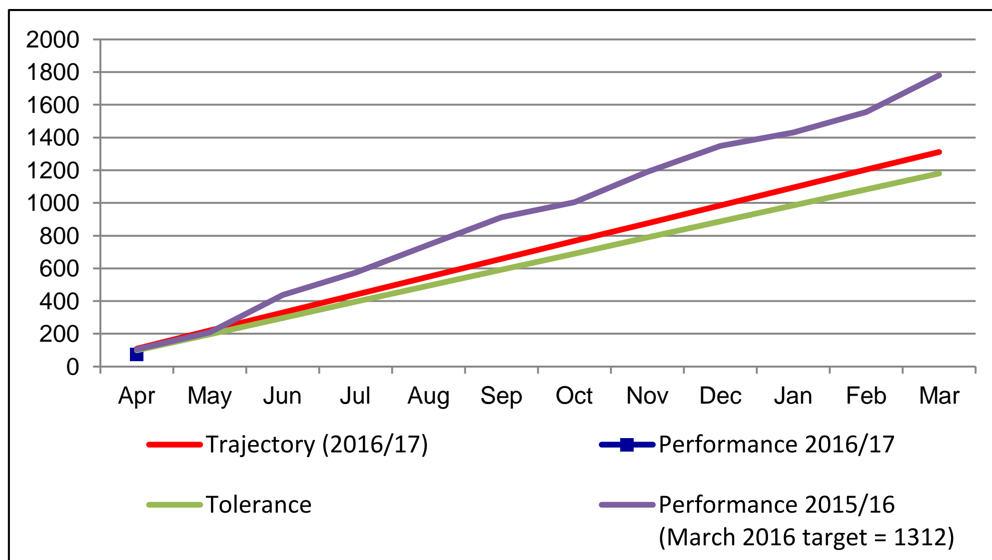
Alcohol Brief Interventions

Standard: Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings

Standard	Tolerance
1312	within 10%

Actual Performance (higher = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory (2016/17)	110	220	330	440	549	658	767	876	985	1094	1203	1312
Performance 2016/17	73											
Performance 2015/16 (March 2016 target = 1312)	105	208	438	575	744	913	1004	1190	1348	1430	1555	1780
Performance 2014/15 (March 2015 target = 1247)	147	295	429	603	760	930	1180	1288	1391	1517	1680	1803



Narrative Summary:
The trajectory for sustain and embed **alcohol brief interventions** was not achieved in April with 73 ABIs delivered against the trajectory of 110.

Due to reporting processes ABI data is often updated historically, particularly at the start of the financial year. It is anticipated the standard will be achieved, however, there is work ongoing in particular areas where performance and/or reporting requires improvement.

Actions:
- A&E and BGH: meeting scheduled to discuss performance in these areas
- Criminal Justice: reporting appears to underestimate performance therefore meeting scheduled to investigate causes

Please Note: 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.

Smoking Quits

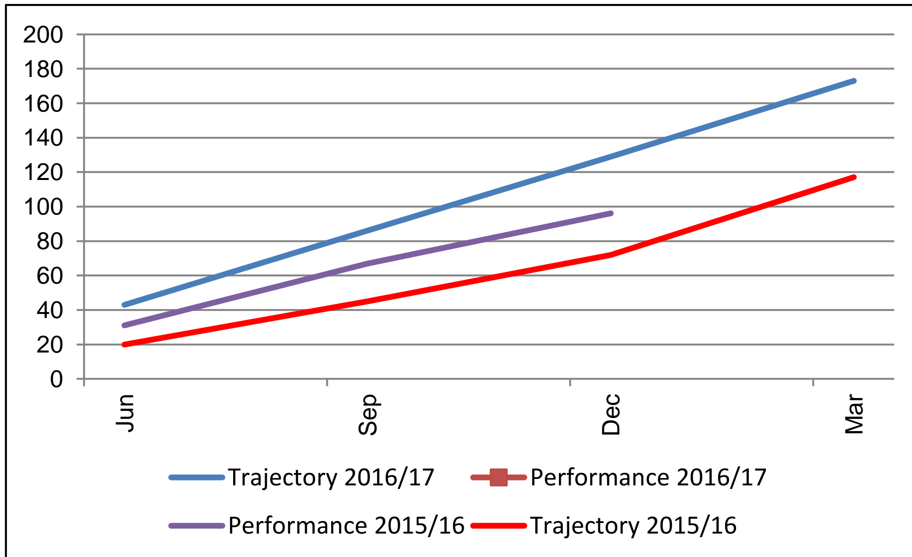
Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas

Standard	Tolerance
117	within 10%

Actual Performance (higher = better performance)

	Jun	Sep	Dec	Mar
Trajectory 2016/17	43	86	129	173
Performance 2016/17				
Trajectory 2015/16	20	45	72	117
Performance 2015/16	31	67	96	

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.



Narrative Summary:
Data for **smoking cessation successful quits** has a lag time to allow monitoring of the 12 week standard. The chart shows that the trajectory set for December 2015 (72) has been achieved with 96 successful quits.

The performance target for 2016/17 for NHS Borders is to deliver a challenging 173 successful quits at 12 weeks in our most deprived communities (40% SIMD areas). This represents a 47% increase compared to the previous target and is the second highest increase in Scotland.

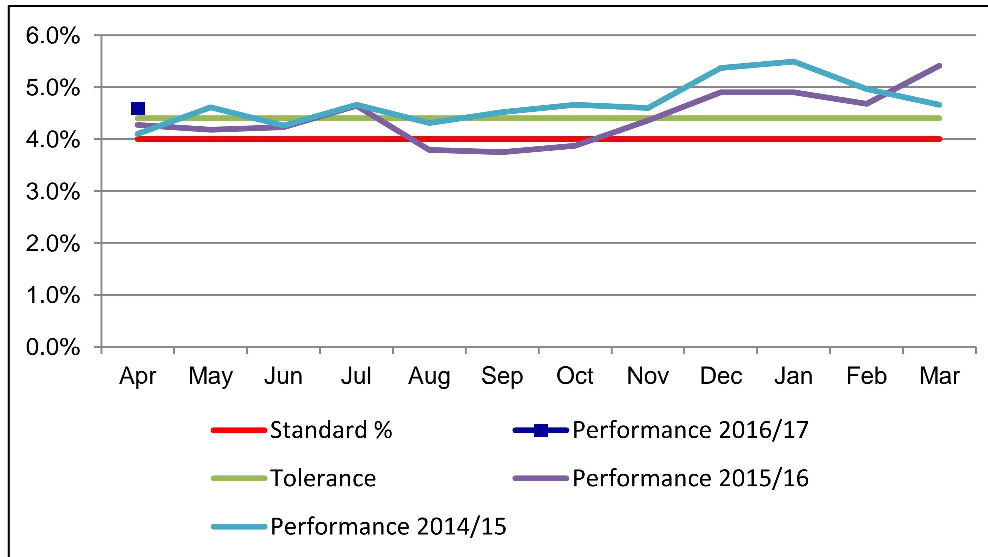
Actions:
For 2016/17, work is underway to improve smoking cessation support to mental health services.

Sickness Absence

Standard: Maintain Sickness Absence Rates below 4%	Standard	Tolerance
	4.0%	4.4%

Actual Performance (lower % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Performance 2016/17	4.6%											
Performance 2015/16	4.3%	4.2%	4.2%	4.6%	3.8%	3.8%	3.9%	4.4%	4.9%	4.9%	4.7%	5.4%
Performance 2014/15	4.1%	4.6%	4.3%	4.7%	4.3%	4.5%	4.7%	4.6%	5.4%	5.5%	5.0%	4.7%



Narrative Summary:
The run chart shows the **Sickness Absence** standard was achieved for 3 consecutive months (August – October 2015) however during the following months the rate of sickness absence has gradually increased.

Cumulative sickness absence for year April 2015 – March 2016 was 4.36% - which is 0.80% lower than the NHS Scotland Average. NHS Borders reports the lowest year end figure of the territorial boards which is 0.35% lower than last year.

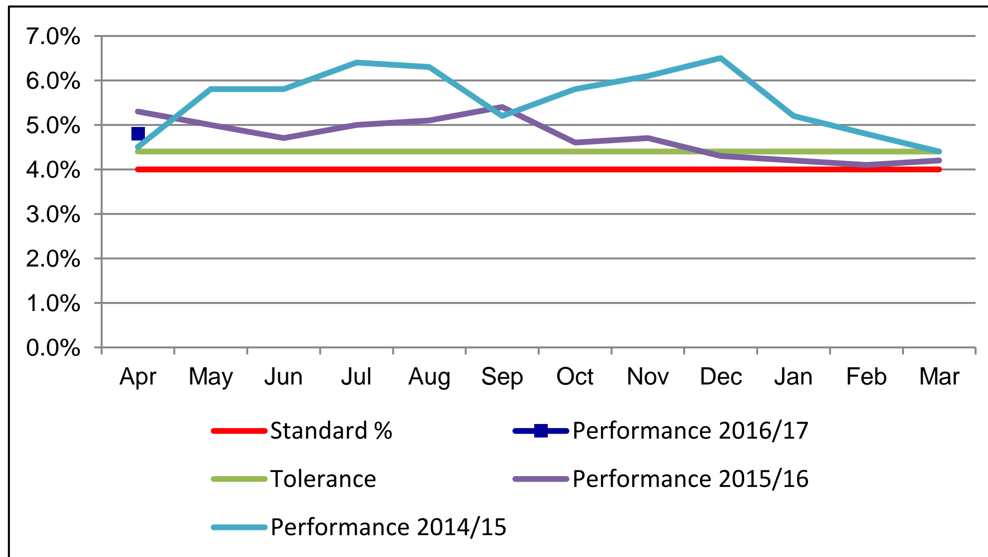
Actions:
HR continue to be a support service to the clinical boards by providing HR advice and support in managing sickness absence as well as proactively identifying sickness absence "hot spots." They provide monthly sickness absence reports to each Clinical Board, these detail the level of short term and long term sickness absence levels in each department. The reports also detail the trends and the reasons for sickness absence.
An Attendance Management and Wellbeing project has commenced to identify specific initiatives designed to improve employee well-being and promote further attendance at work.

Outpatient DNA Rates

	Standard	Tolerance
Standard: New patients DNA rate will be less than 4% over the year	4.0%	4.4%

Actual Performance (lower % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Performance 2016/17	4.8%											
Performance 2015/16	5.3%	5.0%	4.7%	5.0%	5.1%	5.4%	4.6%	4.7%	4.3%	4.2%	4.1%	4.2%
Performance 2014/15	4.5%	5.8%	5.8%	6.4%	6.3%	5.2%	5.8%	6.1%	6.5%	5.2%	4.8%	4.4%



Narrative Summary:
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 2015/16 has improved when compared with the previous year. 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.

Actions:
A media campaign is currently being finalised to remind patients of the importance of advising if they do not wish to attend an appointment, and to ensuring we have their up to date contact details.

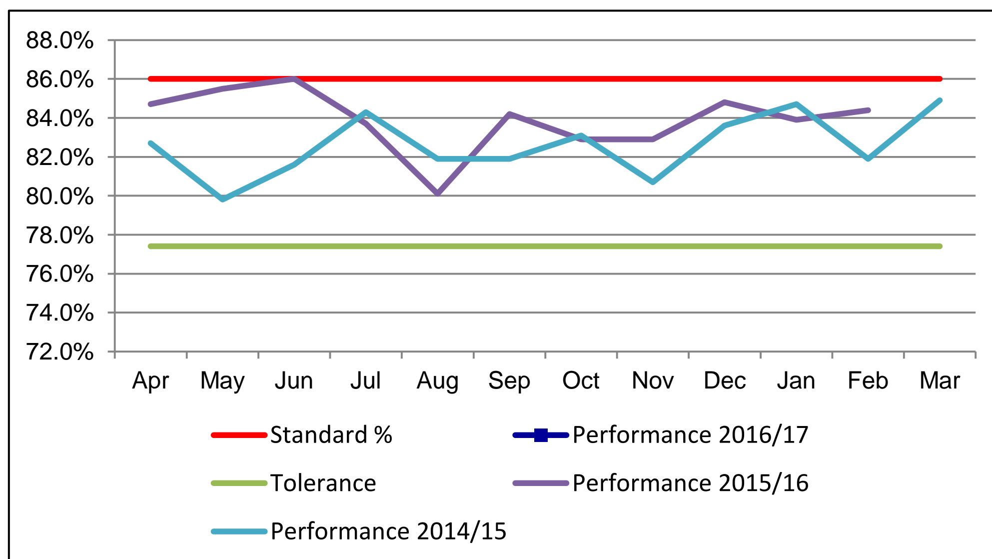
Same Day Surgery

Standard: 86% of patients for day procedures to be treated as Day Cases	Standard	Tolerance
	86.0%	77.4%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
Performance 2016/17												
Performance 2015/16	84.7%	85.5%	86.0%	83.7%	80.1%	84.2%	82.9%	82.9%	84.8%	83.9%	84.4%	
Performance 2014/15	82.7%	79.8%	81.6%	84.3%	81.9%	81.9%	83.1%	80.7%	83.6%	84.7%	81.9%	84.9%

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



Narrative Summary:
In June 2015 the overall 86% HEAT standard for **same day surgery** (BADS procedures) was achieved for the first time since August 2013, however performance continues to fluctuate thereafter.

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

Actions:
Currently redesigning theatres and surgical flow within the BGH which will enable repatriation and therefore should increase the number of day case procedures.

**British Association of Day Case Surgery*

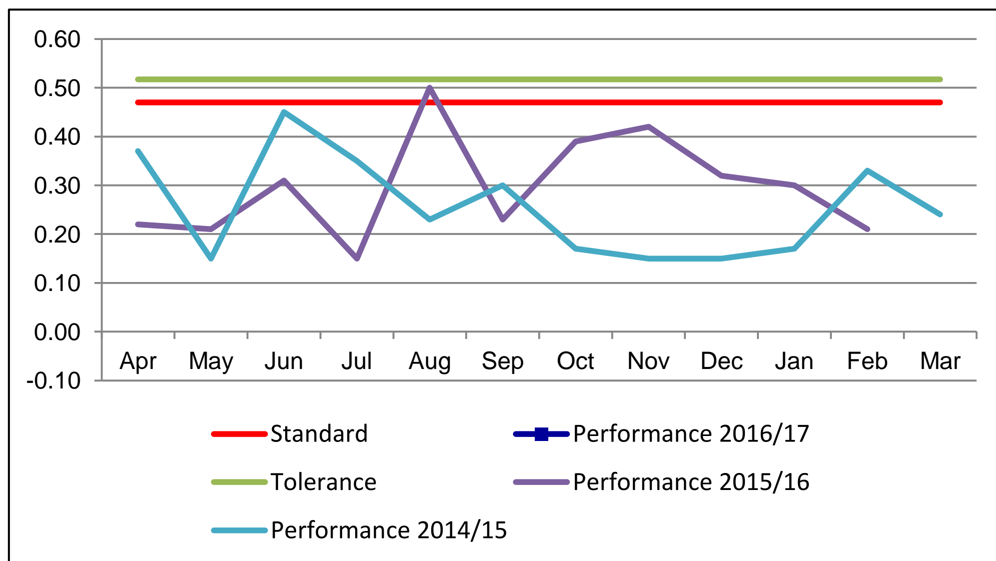
Pre-Operative Stay

Standard: Reduce the days for pre-operative stay	**Standard**	**Tolerance**
	0.47	0.52

Actual Performance (lower = better performance)

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Standard	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47
Performance 2016/17												
Performance 2015/16	0.22	0.21	0.31	0.15	0.50	0.23	0.39	0.42	0.32	0.30	0.21	
Performance 2014/15	0.37	0.15	0.45	0.35	0.23	0.30	0.17	0.15	0.15	0.17	0.33	0.24

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



Narrative Summary:
The run chart shows that **pre-operative inpatient stays** in hospital are generally low and within the trajectory set however in August 2015 the rate increased. This is the only breach of standard recorded since April 2013 and performance has since returned to a normal level position. The highest admissions the day before the patients procedure is in orthopaedics.

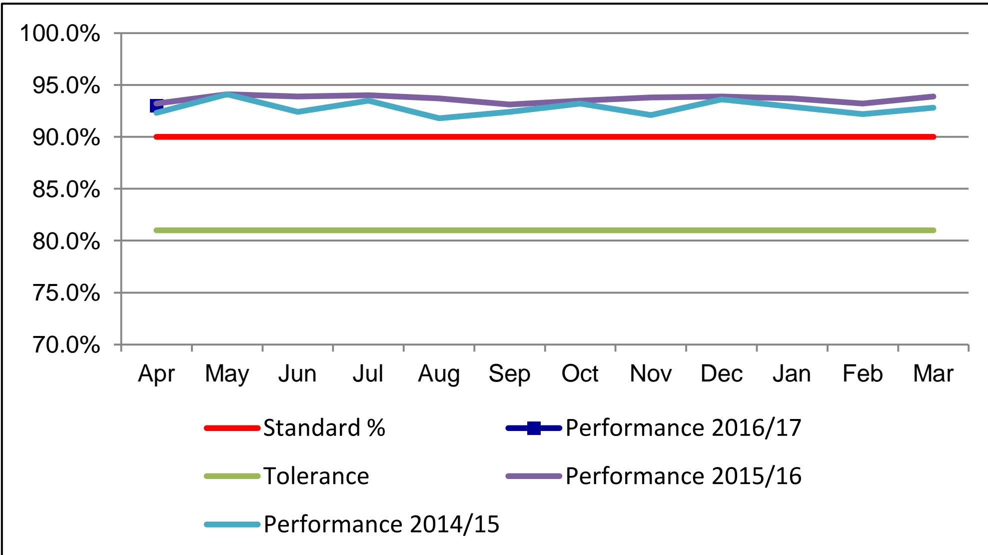
Actions:
Further work through the redesign of theatres and surgical flow in 2016/17 should reduce the number of patients admitted the night before their procedure.

Online Triage of Referrals

Standard: 90% of all referrals to be triaged online	Standard	Tolerance
	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17	93.0%											
Performance 2015/16	93.2%	94.1%	93.9%	94.0%	93.7%	93.1%	93.5%	93.8%	93.9%	93.7%	93.2%	93.9%
Performance 2014/15	92.3%	94.1%	92.4%	93.5%	91.8%	92.4%	93.2%	92.1%	93.6%	92.9%	92.2%	92.8%



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

Actions:
Over the past year the focus has been on maintaining strong performance for this target. The longer term goal is to move to the Electronic Patient Record and to maximise the number processed online.

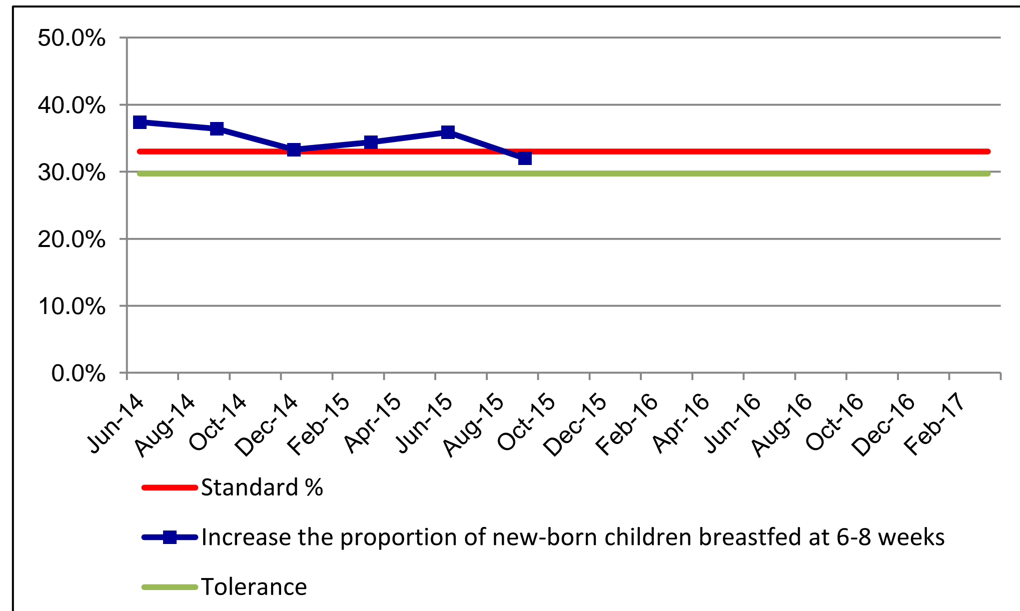
Breastfeeding

	Standard	Tolerance
Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	33.0%	29.7%

Actual Performance (higher % = better performance)

	Jun-14	Sep-14	Dec-14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17
Standard %	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%
Increase the proportion of new-born children breastfed at 6-8 weeks	37.4%	36.4%	33.3%	34.4%	35.9%	32.0%						
Breastfeeding on discharge from BGH	52.9%	54.9%	48.9%	50.7%	57.5%	50.6%						
Breastfeeding at 10 Days	42.9%	43.4%	41.6%	44.3%	43.4%	40.5%						

Please Note: There is a lag time for national data, local data supplied quarterly



Narrative Summary:
The standard to **increase the proportion of new-born children breastfed at 6-8 weeks** is measured quarterly and local data is supplied due to the time lag for national data. For the quarter July - September 2015 performance was slightly outwith the 33% standard.

NHS Borders was assessed for re-accreditation in May 2016 with the recommendation to UNICEF's Designation Committee being to approve re-accreditation. The organisation expect to hear the outcome by the end of May 2016.

The collection method for the data changed nationally in February 2016. The service are working through the validation of the data for quarter October - December 2015, therefore babies born in December will have their 6-8 week review recorded on the new collection method. This is a transition period an should be resolved by quarter 2 of 2016/17.

Actions:
BFI Lead is actively working on the four themes that will enable us to improve our breast feeding rates.

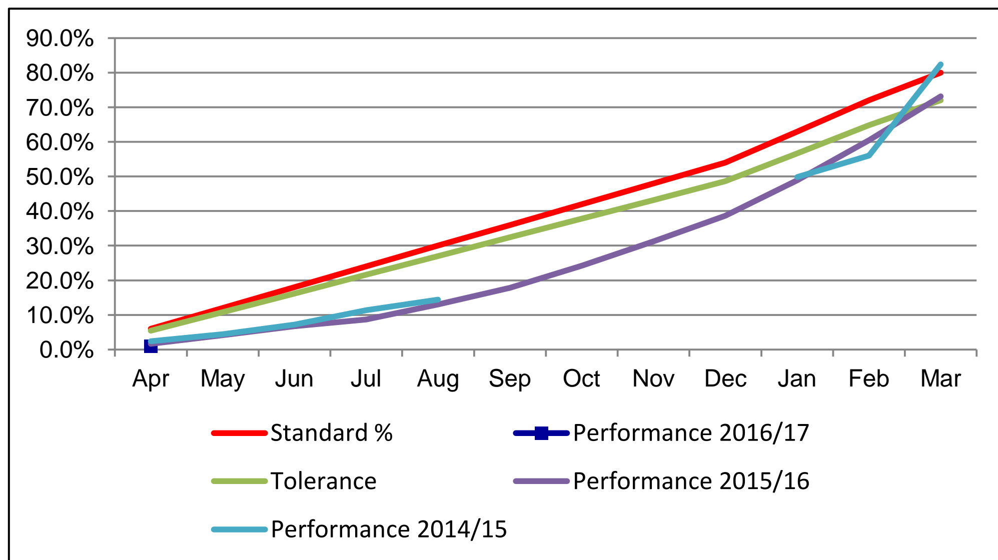
eKSF

	Standard	Tolerance
Standard: 80% of all Joint Development Reviews to be recorded on eKSF	80.0%	within 10%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	6.0%	12.0%	18.0%	24.0%	30.0%	36.0%	42.0%	48.0%	54.0%	63.0%	72.0%	80.0%
Performance 2016/17	1.0%											
Performance 2015/16	1.7%	4.1%	6.7%	8.7%	13.0%	17.8%	24.2%	31.2%	38.6%	48.9%	60.5%	73.1%
Performance 2014/15	2.4%	4.4%	7.2%	11.4%	14.4%					49.8%	56.0%	82.4%

[1] Sept - Dec 2014 data unavailable due to reporting issue



Narrative Summary:
The run chart shows that overall within NHS Borders the trajectory set for recording **annual Joint Development Reviews (JDRs) on eKSF** is outwith the 10% tolerance for the first month of the financial year. The trajectory is set to ensure the standard of 80% of JDRs being recorded will be achieved by the end of March 2017.

Actions:
KSF Champions continue to support and encourage managers to spread out reviews over the full year which should be reflected in the 2016/17 trajectory when it is confirmed.

Please Note: Trajectory to be confirmed, current trajectory based on 2015/16 agreed trajectory.

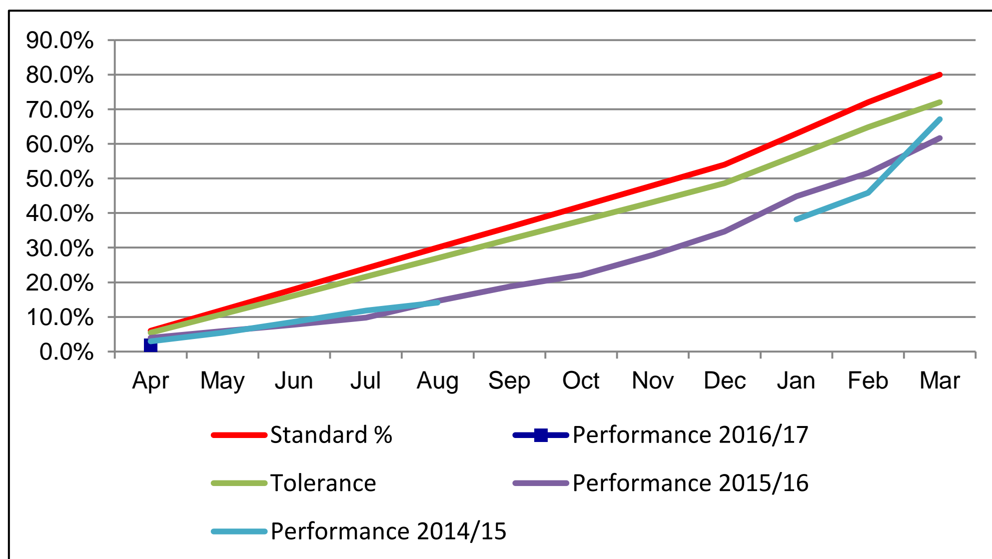
Personal Development Plans

	Standard	Tolerance
Standard: 80% of all Personal Development Plans to be recorded on eKSF	80.0%	within 10%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	6.0%	12.0%	18.0%	24.0%	30.0%	36.0%	42.0%	48.0%	54.0%	63.0%	72.0%	80.0%
Performance 2016/17	1.9%											
Performance 2015/16	4.0%	5.9%	7.7%	9.8%	14.6%	18.8%	22.1%	27.9%	34.7%	44.8%	51.6%	61.6%
Performance 2014/15	2.9%	5.4%	8.6%	11.8%	14.1%					38.2%	45.9%	67.1%

[1] Sept - Dec 2014 data unavailable due to reporting issue



Narrative Summary:
The run chart shows that overall within NHS Borders the trajectory for recording **Personal Development Plans (PDPs) on eKSF** has not been achieved in the first month of the financial year.

Actions:

- Regular reports are being sent out to all managers to highlight their percentages to encourage them to complete Reviews and PDPs on e-KSF.
- The Employee Director is the Executive lead, supporting the KSF Champions and reporting back to the Board Executive Team on a regular basis.
- KSF Champions continue to support and encourage managers to spread out reviews over the full year which should be reflected in the 2016/17 trajectory when it is confirmed.

Please Note: Trajectory to be confirmed, current trajectory based on 2015/16 agreed trajectory.

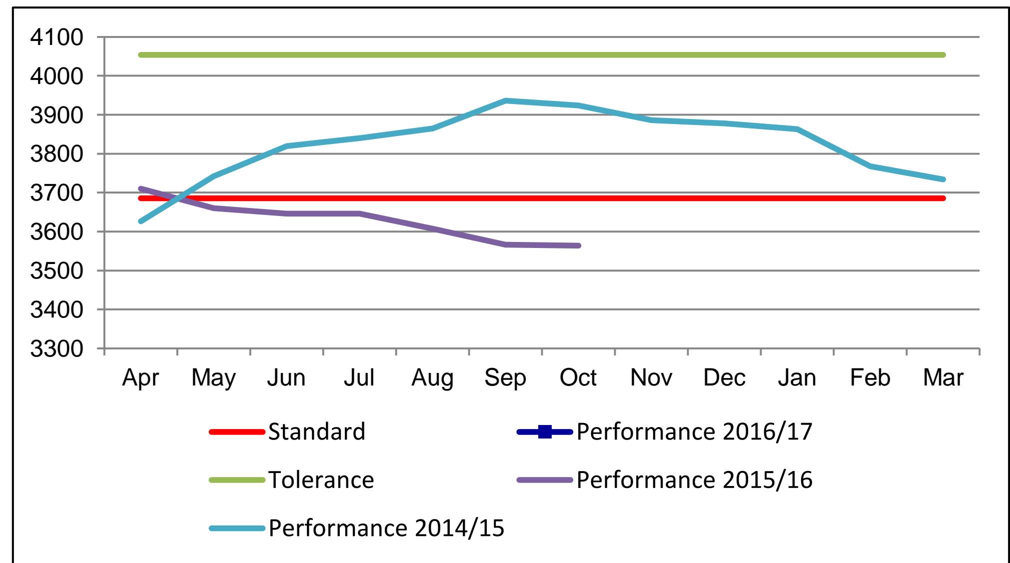
Emergency Occupied Bed Days

Standard: Reduce Emergency Occupied Bed Days for the over 75s	**Standard**	**Tolerance**
	3685	4054

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	3685	3685	3685	3685	3685	3685	3685	3685	3685	3685	3685	3685
Performance 2016/17												
Performance 2015/16	3710	3660	3646	3646	3607	3566	3564	3573				
Performance 2014/15	3626	3742	3819	3840	3865	3936	3924	3886	3878	3863	3768	3734

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



Narrative Summary:
Emergency Occupied bed days for over 75s has been reducing consistently since September 2014, following redesign work to reduce waits for patients requiring rehabilitation and elderly care beds.

Actions:
Continue to use the Acute Assessment Unit which opened in December 2015, supported by the Rapid Assessment and Discharge Team which together have focused on avoiding admission for frail elderly patients where possible.

LDP Standards:

Access to Treatment

Access to Treatment Performance Summary

Overview

The performance of Health Boards in relation to Waiting Times is measured against the number of weeks a patient waits for treatment.

The building blocks to achieve this access to treatment are known as the Stage of Treatment targets and these are set at 12 weeks for inpatient/daycase and 12 weeks for new outpatients.

These Stage of Treatment targets support the delivery of two other commitments that Health Boards report upon: firstly, the Treatment Time Guarantee (TTG) which takes the existing target of 12 weeks for inpatient/daycase treatment and strengthens it in law; secondly an additional target to treat at least 90% of patients within 18 weeks from a referral by a GP to start of treatment. This is known as Referral to Treatment (RTT).

This is supported by Diagnostic waiting times where the waiting times standard for a number of key diagnostic tests is a maximum of six weeks. NHS Borders has to ensure that the diagnostic test and verified report is received by or made available to the requester within 6 weeks. Locally the aim is to achieve a wait of no more than 4 weeks.

Each of these is taken in turn below, in order, to provide the Board with an informed narrative of the position and steps to achieve the challenges faced.

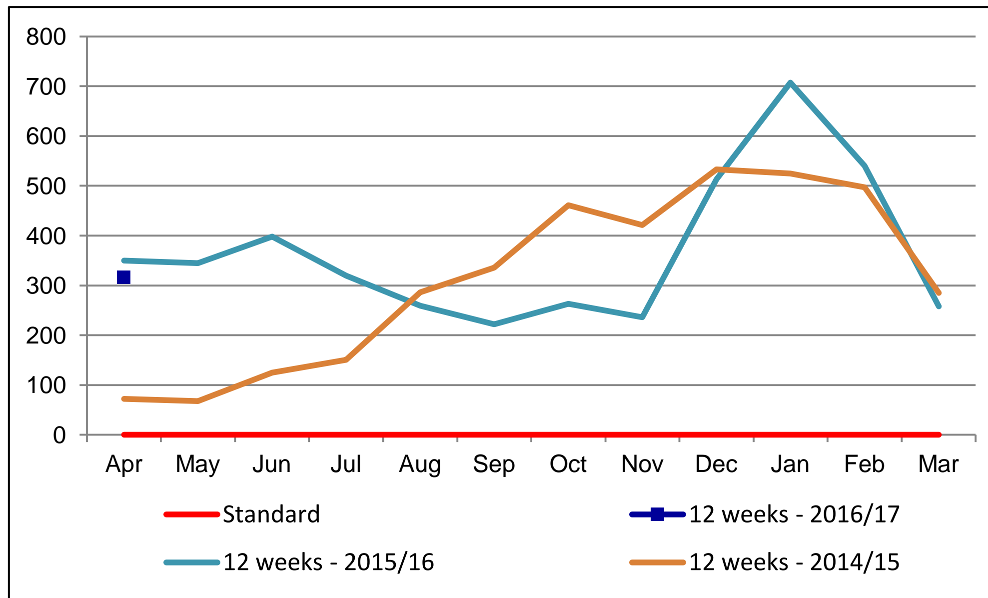
In 2016/17, the Board continues to face challenges in the achievement of our waiting times standards. However, although the pace of improvement is slower than planned, we are working steadily towards achievement of 12 week waits in both inpatients and outpatients.

Stage of Treatment - 12 Weeks Waiting Time for Outpatients

	Standard	Tolerance
Standard: 12 weeks for first outpatient appointment	0	0

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
12 weeks - 2016/17	316											
12 weeks - 2015/16	350	345	398	320	259	222	263	236	513	707	540	258
12 weeks - 2014/15	72	68	125	151	286	336	461	421	533	525	497	285



Narrative Summary:
The number of patients reported as waiting longer than 12 weeks has reduced over the past two months. However there are still ongoing issues within ENT, Gastroenterology and Pain Control.

Actions:
Cardiology - capacity is an ongoing problem, and work is ongoing with the service to look for solutions to this.

Chronic Pain - where we 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 - continues to be challenging. Short-term capacity has been organised with local clinicians whilst a longer term solution is identified.

Oral Surgery – sickness absence of the Consultant Surgeon had led to significant pressures in this area. A locum has been appointed for 3 months from May 2016.

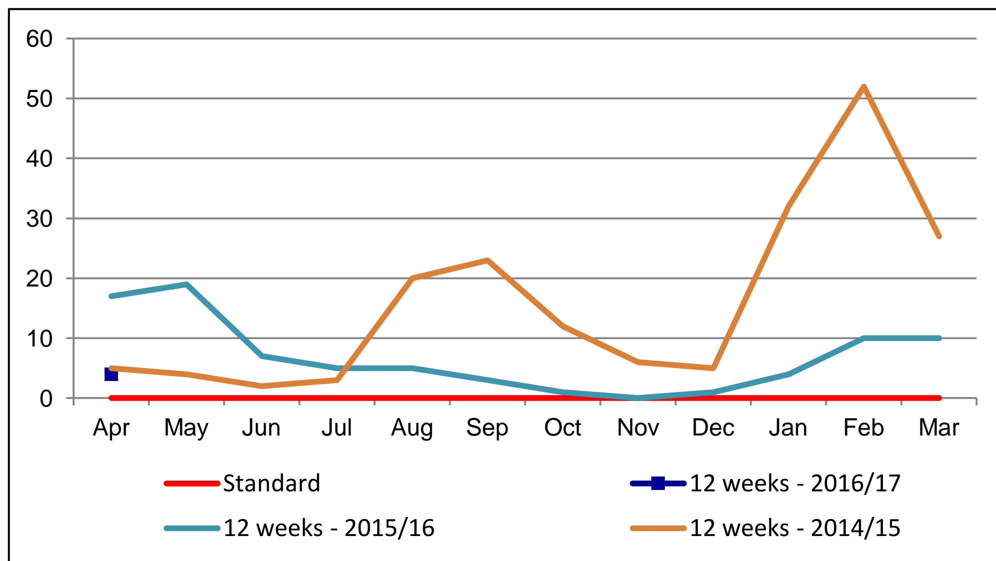
Gastroenterology – demand for the service has been over the capacity of the service. We are currently organising extra clinics within the service to help with the increasing demand.

Stage of Treatment - 12 Weeks Waiting Time for Inpatients

Standard: 12 Weeks Waiting Time for Inpatients	Standard	Tolerance
	0	0

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
12 weeks - 2016/17	4											
12 weeks - 2015/16	17	19	7	5	5	3	1	0	1	4	10	10
12 weeks - 2014/15	5	4	2	3	20	23	12	6	5	32	52	27



Narrative Summary:
At the end of April the number of patients reported waiting over **12 weeks for inpatient treatment** has decreased. This has followed an increase in patients waiting over target in February/March 2016 due to the number of cancellations that took place at short-notice.

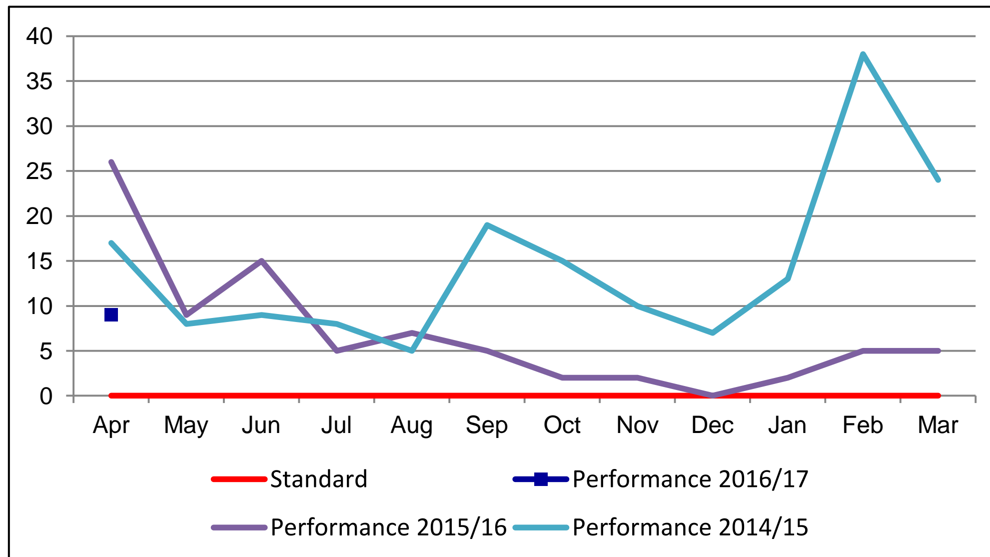
Actions:
There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. In the interim weekend operating continues, with the support of Synaptik.

Stage of Treatment - 12 Weeks Waiting Time for Inpatients

	Standard	Tolerance
Standard: 12 Weeks Treatment Time Guarantee (TTG 100%)	0	0

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Performance 2016/17	9											
Performance 2015/16	26	9	15	5	7	5	2	2	0	2	5	5
Performance 2014/15	17	8	9	8	5	19	15	10	7	13	38	24



Narrative Summary:
The number of TTG breaches reported increased in April 2016. As consistently reported, the TTG breach numbers can be affected by cancellations and other short-notice issues affecting theatre throughput.

The largest number of cancellations are to do with the unavailability of beds within the hospital which is causing issues with the underutilisation of theatre lists.

Actions:
- Short notice cancellations are reviewed on a weekly basis.
- Work is ongoing to ensure cancellations are minimised and decisions are made as soon as possible
- Institute for Healthcare Optimisation (IHO) project is looking to address surgical flow; however the service are reviewing on a weekly basis to determine any risk of cancellations and take appropriate action.

Unavailability

To ensure continued delivery of Waiting Times targets, it is essential that patient unavailability is closely monitored and that patients are managed in accordance with national guidelines. Information regarding unavailability is shown below.

Monthly Unavailability Statistics (Inpatient and daycase waiting list)

Unavailable	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Unavailable	157	201	183	165	122	95	81	81	60	74	81	70	83
Patient Advised	65.4%	70.0%	65.4%	66.8%	60.7%	53.7%	50.3%	48.2%	40.8%	44.8%	48.5%	40.9%	46.4%
Unavailable	83	86	97	82	79	82	80	87	87	91	86	101	96
Medical	34.6%	30.0%	34.6%	33.2%	39.3%	46.3%	49.7%	51.8%	59.2%	55.2%	51.5%	59.1%	53.6%
Total Unavailable	240	287	280	247	201	177	161	168	147	165	167	171	179
Total % Unavailable	20.8%	24.0%	23.6%	21.1%	17.3%	16.3%	15.8%	16.2%	13.2%	15.4%	15.1%	15.9%	17.4%

Monthly Unavailability by Specialty - as at 30th April 2016

	Available				Unavailable			
Specialty	**0 - 9 Weeks**	**10 - 12 Weeks**	**12+ Weeks**	**Total**	**Medical Un-available**	**Patient Advised Un-available**	**Total**	**% Un-available**
ENT	53	7	1	**61**	2	3	**5**	2.80%
General Surgery	136	6	1	**143**	22	20	**42**	23.50%
Gynaecology	57	3		**60**	10	4	**14**	7.80%
Ophthalmology	91	2		**93**	7	6	**13**	7.30%
Oral Surgery	29	1		**30**	3	4	**7**	3.90%
Other	142			**142**	1	2	**3**	1.70%
Trauma & Orthopaedics	197	39	2	**238**	33	39	**72**	40.20%
Urology	77	8		**85**	18	5	**23**	12.80%
Total	**782**	**66**	**4**	**852**	**96**	**83**	**179**	**17.40%**

Narrative Summary:
There has been a reduction in the number of patients with patient advised unavailability. This is due to a reduction in the number of patients requesting local health board treatment, following the planning of weekend operating lists in Orthopaedics.

Looking at medical unavailability, this has remained static at approximately 90 patients.

Actions:
Ensure unavailability is closely monitored and that patients are managed in accordance with national guidelines.

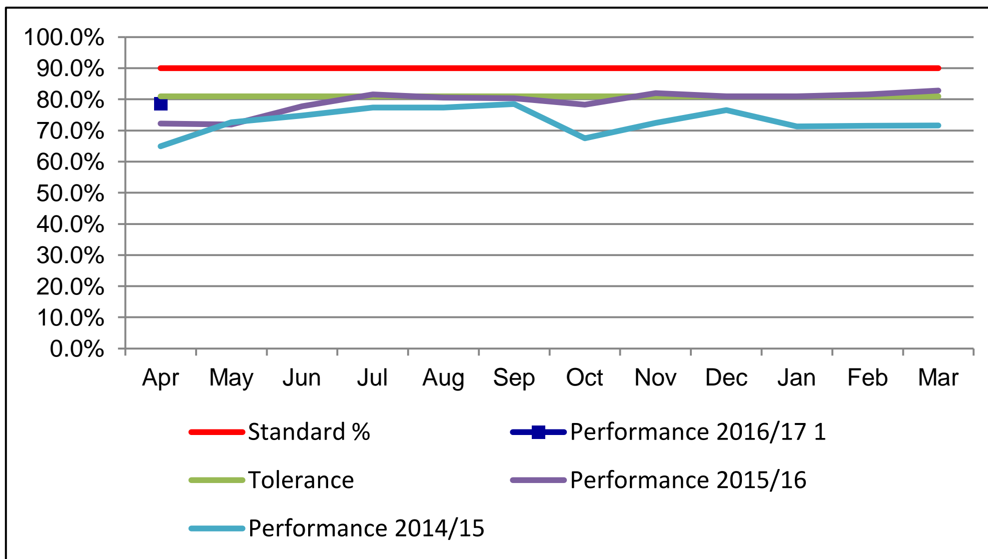
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Admitted Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17 [1]	78.5%											
Performance 2015/16	72.2%	71.9%	77.8%	81.6%	80.5%	80.3%	78.3%	82.0%	81.0%	81.0%	81.6%	82.8%
Performance 2014/15	64.9%	72.6%	74.8%	77.4%	77.4%	78.5%	67.5%	72.4%	76.5%	71.3%	71.5%	71.6%

[1] April data has been updated from the clinical board dashboard due to further data validation by the Waiting Times Team.



Narrative Summary:
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 6 months.

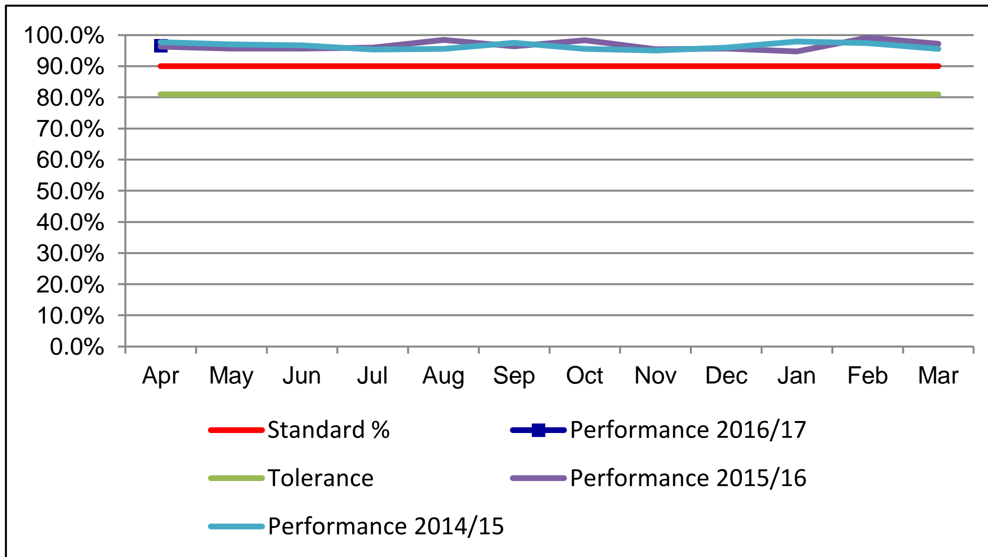
Actions:
Actions are in place to improve the Outpatient and Inpatient waiting times, as these improve the admitted pathway performance should increase.

18 Weeks Referral to Treatment (RTT)

Standard: Admitted Linked Pathway Performance	Standard	Tolerance
	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17	96.5%											
Performance 2015/16	96.3%	95.7%	95.7%	96.0%	98.4%	96.4%	98.3%	95.4%	95.7%	94.7%	99.1%	97.2%
Performance 2014/15	97.7%	97.0%	96.7%	95.3%	95.5%	97.5%	95.5%	95.0%	96.0%	97.9%	97.4%	95.5%



Narrative Summary:
The run chart shows that performance for the **linked pathway** is consistently above 90%.

Actions:
Work will continue to ensure the standard is maintained during 2016/17 with the reduction in the number of 12 week breaches.

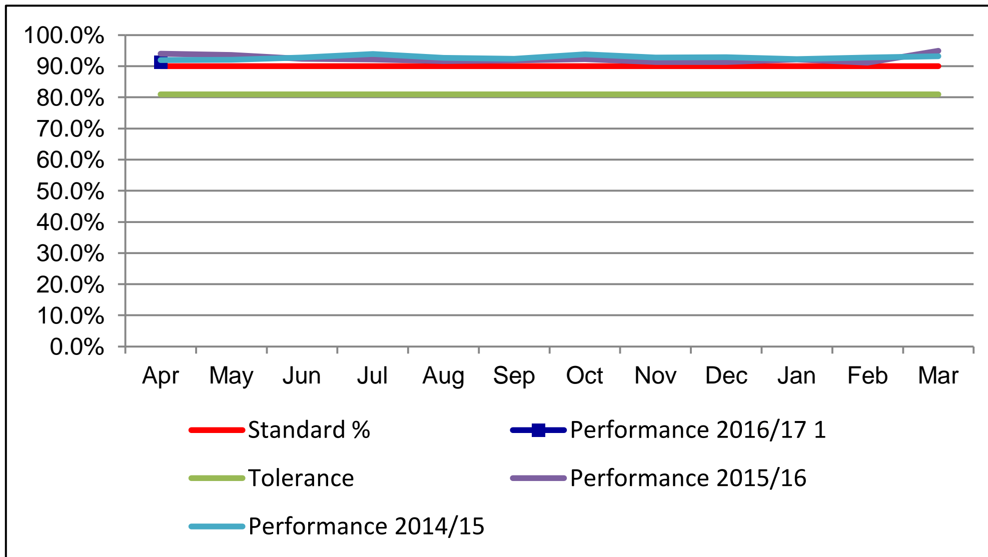
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Non-Admitted Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17 [1]	91.2%											
Performance 2015/16	94.0%	93.6%	92.4%	92.2%	91.6%	91.8%	92.3%	91.3%	91.3%	92.2%	91.1%	94.9%
Performance 2014/15	91.9%	92.1%	92.8%	93.9%	92.7%	92.4%	93.8%	92.8%	92.9%	92.3%	92.8%	93.2%

[1] April data has been updated from the clinical board dashboard due to further data validation by the Waiting Times Team.



Narrative Summary:
The run chart shows that performance for **non-admitted pathways** is consistently above 90%.

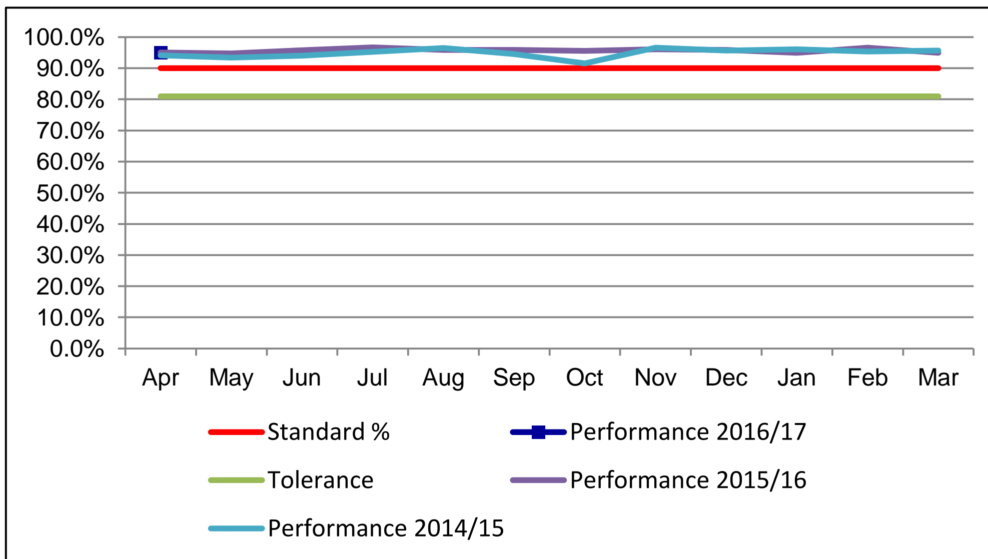
Actions:
Work will continue during 2016/17 to ensure the standard is maintained with the reduction in the number of 12 week breaches.

18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Non-Admitted Linked Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17	94.9%											
Performance 2015/16	95.0%	94.7%	95.8%	96.7%	95.9%	95.9%	95.5%	96.1%	95.9%	94.9%	96.6%	94.9%
Performance 2014/15	94.1%	93.4%	94.0%	95.2%	96.5%	94.5%	91.5%	96.6%	95.6%	96.1%	95.3%	95.6%



Narrative Summary:
The run chart shows that performance for **non-admitted linked pathways** is consistently above 90%.

Actions:
Work will continue during 2016/17 to ensure the standard is maintained with the reduction in the number of 12 week breaches.

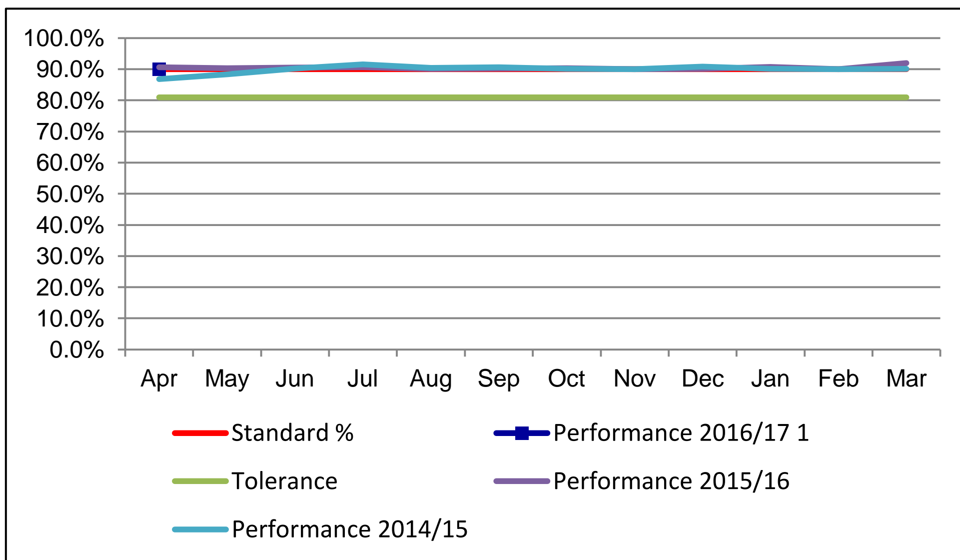
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Combined Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17 [1]	90.0%											
Performance 2015/16	90.6%	90.3%	90.5%	90.6%	90.1%	90.2%	90.3%	90.0%	90.1%	90.7%	90.0%	92.0%
Performance 2014/15	86.8%	88.4%	90.2%	91.5%	90.4%	90.6%	90.1%	90.0%	90.8%	90.1%	90.0%	90.1%

[1] April data has been updated from the clinical board dashboard due to further data validation by the Waiting Times Team.



Narrative Summary:
The national target for NHS Boards RTT is to deliver 90% combined admitted/non admitted performance. NHS Borders has consistently achieved the 90% national standard. This has proven challenging over the last 12 months, due to a relatively poor performance on admitted pathways however this has been improving.

It is anticipated that 18wks performance will reduce due to the number of patients expected to breach in ENT and Gastroenterology. Audiology have also given a very poor performance through the 18 week pathway as they are currently increasing productivity in the service to clear through the backlog of breaching patients causing these to be reported as 18 week breaches. This is expected to continue for the next few months until they have cleared all of their breaching patients.

After confirmation from ISD that we can include Physiotherapy data into our reporting, for the time being, this has counter-balanced the breaching patients from the previously mentioned specialties and significantly increased the Non-Admitted Pathways performance.

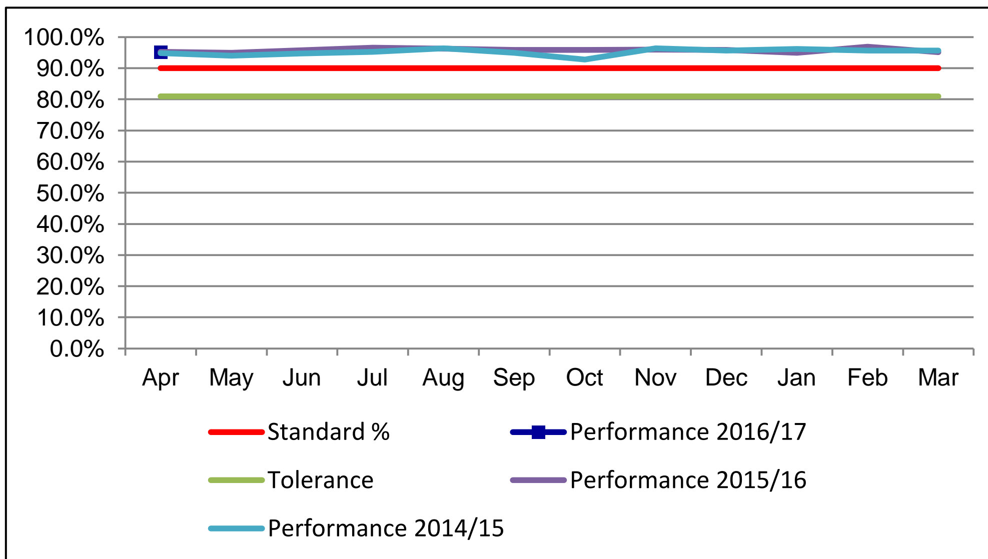
Actions:
Work will continue during 2016/17 with the reduction in the number of 12 week breaches.

18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Combined Linked Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17	95.1%											
Performance 2015/16	95.2%	94.9%	95.8%	96.6%	96.3%	95.9%	95.9%	96.0%	95.9%	94.9%	96.9%	95.1%
Performance 2014/15	94.8%	94.0%	94.7%	95.2%	96.4%	94.9%	92.8%	96.4%	95.6%	96.2%	95.6%	95.6%



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

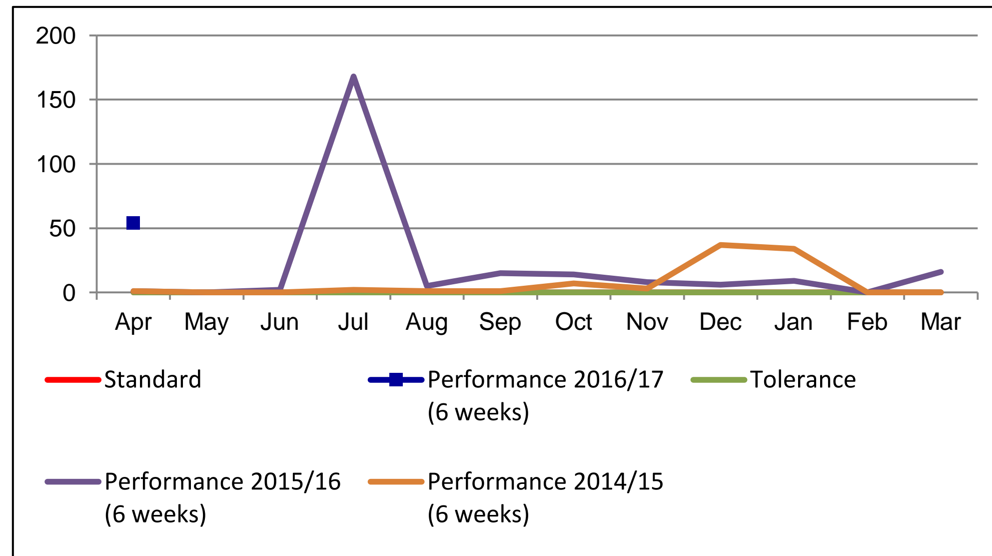
Actions:
No actions specified at present due to current high performance. Continue to monitor.

Diagnostic Waiting Times

	Standard	Tolerance
Standard: Waiting Target for Diagnostics - zero patients to wait over 6 weeks (4 weeks is monitored locally as an stretch target)	0	0

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Performance 2016/17 (6 weeks)	54											
Performance 2016/17 (4 weeks)	307											
Performance 2015/16 (6 weeks)	1	0	2	168	5	15	14	8	6	9	0	16
Performance 2015/16 (4 weeks)	28	25	47	438	147	129	142	122	97	82	54	165
Performance 2014/15 (6 weeks)	1	0	0	2	1	1	7	3	37	34	0	0
Performance 2014/15 (4 weeks)	7	12	16	45	30	7	95	105	170	95	12	13



Narrative Summary:
The national target is that no patient waits more than 6 weeks for one of a number of identified key diagnostic tests. Locally this target has been set at 4 weeks. After a period of improved performance there has been a significant increase in the number of 4 week breaches.

A breakdown of performance, supporting narrative and actions can be found on the next page.

Diagnostic Waiting Times *continued*

The national standard is that no patient waits more than 6 weeks for one of a number of identified key diagnostic tests. Locally a stretch target has been set at 4 weeks. After a period of improved performance there has been a significant increase in the number of 4 week breaches. The 4 week performance is in the table below:

Diagnostic	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Endoscopy	7	6	23	15	23	24	13	22	30	14	39	21
Colonoscopy	9	14	29	15	36	32	9	11	19	5	20	32
Cystoscopy	4	5	9	9	10	11	10	4	0	0	0	1
MRI	2	15	270	96	41	48	70	37	18	27	53	93
CT	3	3	105	0	9	27	18	23	5	8	50	86
Ultra Sound (non-obstetric)	0	3	1	12	10	0	0	0	2	0	3	74
Barium	0	1	0	0	0	0	2	0	8	0	0	0
Total	**25**	**47**	**437**	**147**	**129**	**142**	**122**	**97**	**82**	**54**	**165**	**307**

Narrative Summary and Actions:

Colonoscopy – Trends have improved over the last 6 months but there is an anticipated pressure from May 2016 due to GI Consultants contributing more to General Medical rota. We will continue to monitor performance against the standard and discuss any corrective action with the service as necessary in order to adjust waiting times down to within the four week standard.

Endoscopy – Deterioration in performance is due to increased referral rates and reduction in service provision to accommodate a training list for surgical registrars. Additional lists continue to be carried out by the Nurse Endoscopist to meet waiting times targets however increasing demand is putting pressure on the service. At present waiting time for urgent referrals is 4 weeks and this rises to 6 weeks for routine. The service will be looking at its demand and capacity, and succession planning, going forward.

Magnetic Resonance Imaging (MRI) & Computerised Tomography (CT) – Consultant Radiologists have continued the increased number of reporting sessions with 14 additional sessions per month. We continue to support additional ad hoc MRI, CT and Ultrasound sessions in order to maintain the current reported position. There is reduced capacity in Radiology at present which is having an adverse impact on MRI and CT waiting times. We are exploring the use of locum and external reporting capacity as a potential solution to the deficit in Radiology capacity. We are advertising the vacant sonographer post nationally with increased hours to attract more interest. A wider service review looking particularly at sustainable radiology capacity is ongoing.

Ultrasound – the ultrasound service is coming under pressure due to a vacant sonographer post that has had no applicants initially. The post is being advertised nationally with increased hours to attract interest. Additionally, a short term locum has been secured for a week in June and we are looking to recruit a bank sonographer to provide us with ad hoc additional capacity until we are able to fill the vacancy.

Cancer Waiting Times

Two cancer standards are in place on which NHS Boards are asked to deliver:

- The 62 day urgent referral to treatment standard includes screened positive patients and all patients referred urgently with a suspicion of cancer.
- The 31 day standard includes all patients diagnosed with cancer (whatever their route of referral) from decision to treat to treatment.
- The current standard is that 95% of all eligible patients should wait no longer than 62 or 31 days.

Cancer Waiting Times standards are reported quarterly. NHS Borders had consistently achieved the 62-day standard over the previous 4 consecutive quarters and the 31-day standard has been achieved every quarter since it was established. This quarter however 100% compliance for both the 31-day and 62-day standards were met meaning that every patient was treated in time.

Cancer Waiting Times	July to Sept-14	Oct to Dec-14	Jan to Mar-15	Apr to Jun-15	Jul to Sept-15	Oct to Dec-15	Jan to Mar-16
62-day standard	98.51%	97.44%	94.40%	98.70%	98.50%	98.50%	100%
31-days standard	100%	100%	97.80%	100.00%	97.80%	98.20%	100%

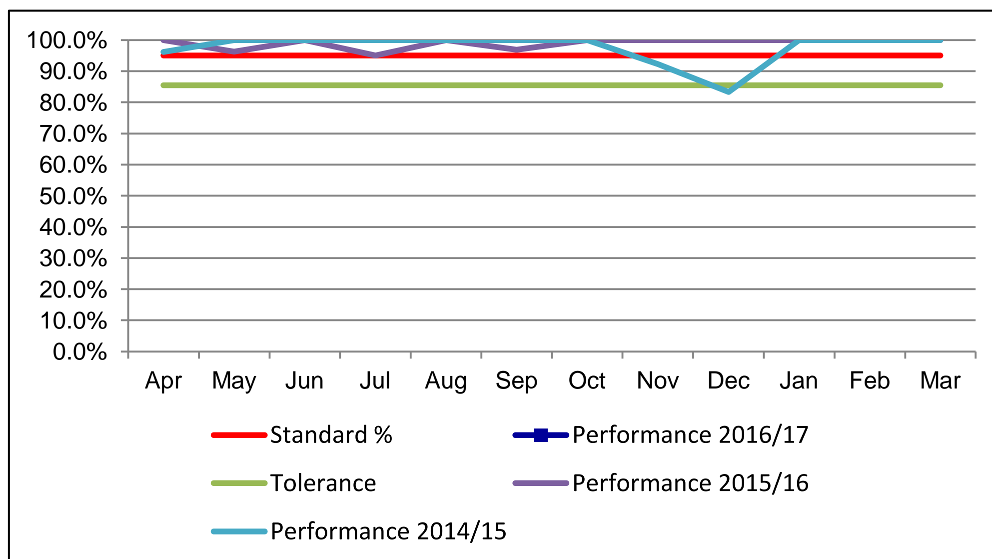
Cancer Waiting Times

	Standard	Tolerance
Standard: 95% of all cases with a Suspicion of Cancer to be seen within 62 days	95.0%	86.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Performance 2016/17												
Performance 2015/16	100.0%	96.3%	100.0%	95.0%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Performance 2014/15	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	83.3%	100.0%	100.0%	100.0%

Please Note: there is a 1 month lag time for data



Narrative Summary:
The run chart shows the standard, to **see patients with a suspicion of cancer within 62 days** has been consistently achieved during 2015/16. This is expected to continue.

Actions:
Work is ongoing to find a solution for patients waiting on treatment in NHS Lothian, in particular those waiting on specialised procedures. This is due to an increased demand within the Prostate and Lung surgical patients and patients that require Prostate Brachytherapy as at present NHS Lothian only provide 2 slots per week to treat referred patients from other Boards.

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

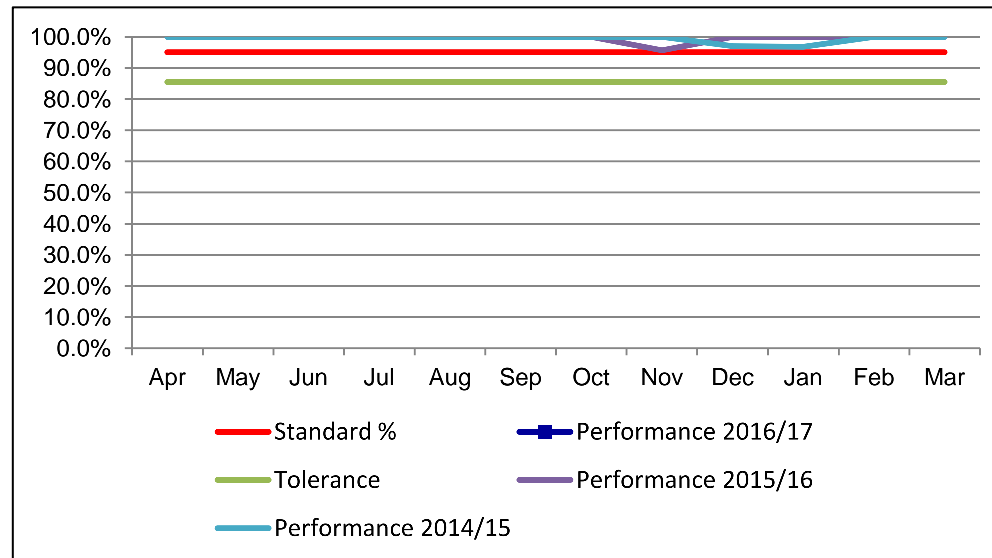
Cancer Waiting Times

	Standard	Tolerance
Standard: 95% of all patients requiring Treatment for Cancer to be seen within 31 days	95.0%	86.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Performance 2016/17												
Performance 2015/16	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%
Performance 2014/15	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	96.8%	100.0%	100.0%

Please Note: there is a 1 month lag time for data



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.

Actions:
Work is ongoing to find a solution for patients waiting on treatment in NHS Lothian, in particular those waiting on specialised surgery. This is due to an increased demand within the Prostate and Lung surgical patients and patients that require Prostate Brachytherapy as at present NHS Lothian only provide 2 slots per week to treat referred patients from other Boards.

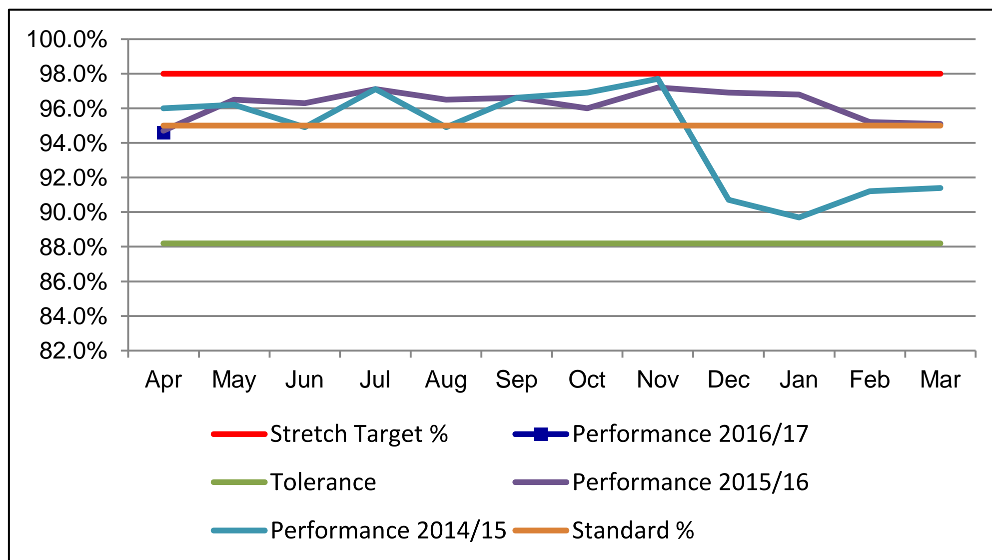
Accident & Emergency 4 Hour Standard

Stretch Target	Standard	Tolerance
98.0%	95.0%	85.5%

Standard: 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Stretch Target %	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Performance 2016/17	94.6%											
Performance 2015/16	94.7%	96.5%	96.3%	97.1%	96.5%	96.6%	96.0%	97.2%	96.9%	96.8%	95.2%	95.1%
Performance 2014/15	96.0%	96.2%	94.9%	97.1%	94.9%	96.6%	96.9%	97.7%	90.7%	89.7%	91.2%	91.4%



Narrative Summary:
Patients attending **A&E are routinely discharged within 4 hours.** NHS Borders continues to achieve the national standard of 95%. The 98% local stretch target was not achieved in 2015/16.

Actions:
Please see next page for further actions.

Accident & Emergency 4 Hour Standard *continued*

The Board is required to ensure that the maximum length of time from arrival at Accident & Emergency to admission, discharge or transfer is four hours for at least 95% of patients. The local stretched target remains at 98%.

Emergency Access	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Flow 1	98%	98%	98%	99%	97%	99%	98%	99%	99%	99%	99%	98%	97%
Flow 2	93%	93%	94%	94%	95%	95%	91%	97%	94%	98%	98%	91%	94%
Flow 3	96%	96%	96%	97%	97%	94%	94%	93%	96%	91%	91%	92%	90%
Flow 4	94%	94%	91%	94%	93%	91%	94%	99%	93%	94%	94%	92%	93%
Total	**95%**	**97%**	**96%**	**97%**	**96%**	**95%**	**96%**	**97%**	**96%**	**96%**	**96%**	**95%**	**95%**

Narrative Summary and Actions:

Although emergency activity has been challenging, the Board has continued to deliver on or close to the 95% Emergency Access Standard until end of April 2016. The 95% standard has not been achieved in May 2016. The challenges have been related to:

1. Availability of beds
2. Delays to first medical assessment in ED

A Recovery Plan has been developed to drive improvements targeted at delivering 98% Emergency Access Standard. These actions are focused on increasing morning discharge rate, improving use of the discharge lounge and developing and implementing a package of measures to improve time to first assessment within the Emergency Department.

A weekly Unscheduled Care huddle has been established, bringing together clinical staff, managers and data and project support to review the weekly data and develop and monitor actions to improve this.

An action plan is being developed to increase morning discharges to 40% of total for the day .

Note: Flow Groups are as follows: Flow 1 - Minor Injury & Illness; Flow 2 - Acute Assessment - includes Major Injuries; Flow 3- Medical Admissions; Flow 4- Surgical Admissions

Stroke Unit Admission

	Standard	Tolerance
Standard: Admitted to the Stroke Unit within 1 day of admission	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17												
Performance 2015/16	100.0%	100.0%	100.0%	84.0%	93.0%	94.0%	100.0%	88.0%	100.0%	84.6%	84.6%	93.3%
Performance 2014/15	91.0%	75.0%	89.0%	86.0%	100.0%	100.0%	100.0%	100.0%	100.0%	64.0%	91.0%	91.0%

Please Note: There is a 1 month lag time

Narrative:
Having moved on from the HEAT target to Stroke BUNDLE measurement against individual patients, daily reporting of red/amber/green (RAG) status has consistently maintained the bundle elements as a high priority in care delivery.

The Stroke Bundle is made up of the following elements of the Scottish Stroke Care Standards;

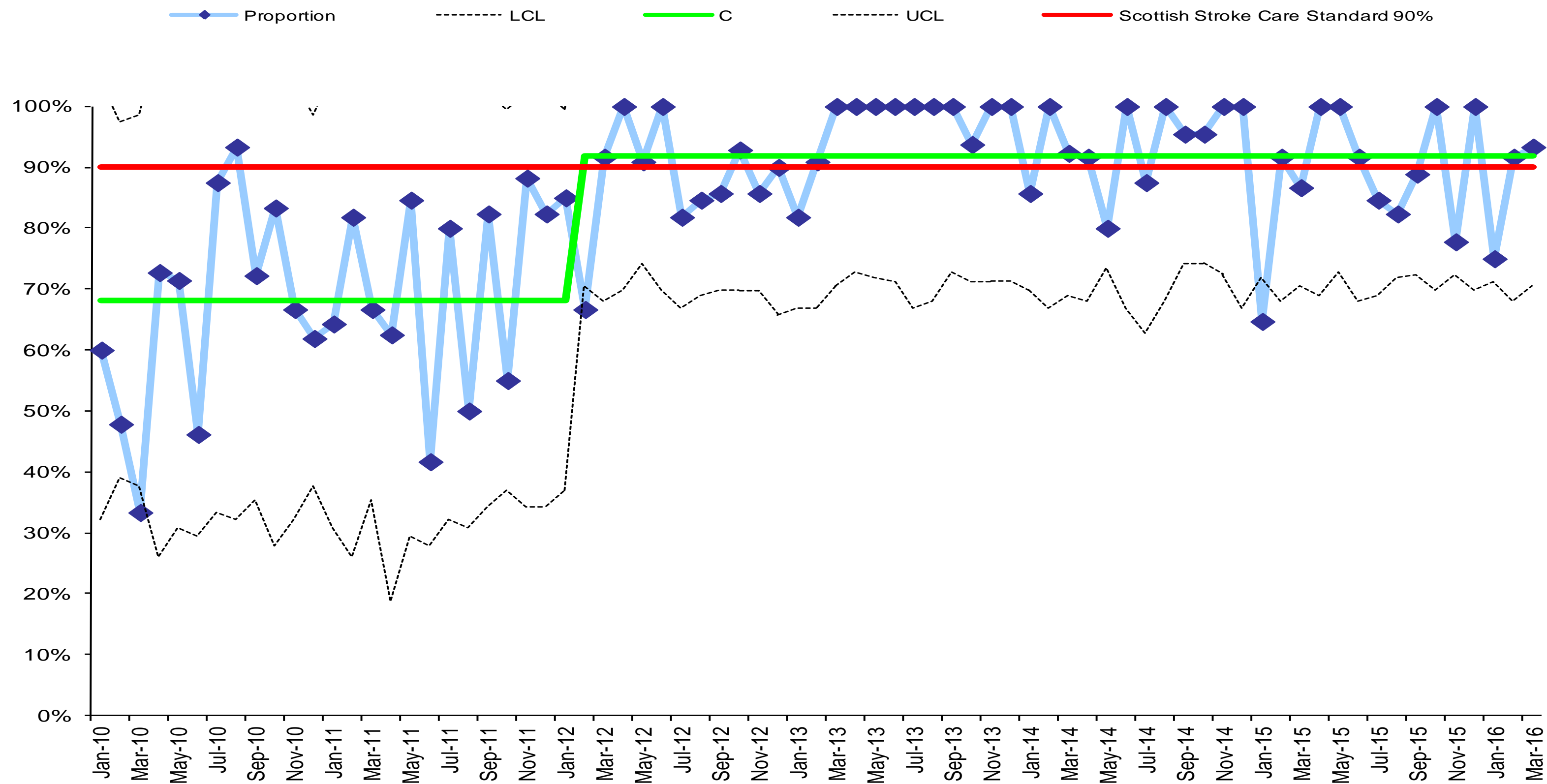
- admission to a dedicated Stroke Unit within 1 day of admission
- a swallow screen test on day of admission
- a brain scan within 24hours of admission
- appropriate treatment initiated within one day of admission

The 90% standard for the full stroke bundle was met in March 2016 (1 month lag time). There was 1 patient who did not transfer to the stroke unit within timescales due to a change of diagnosis on day two. All other standards continued at 100%.

Actions:
Continue to assess patients early and plan for admission to the stroke unit within 24 hours when beds are available.

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.

Stroke Bundle



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.

Psychological Therapies Waiting Times

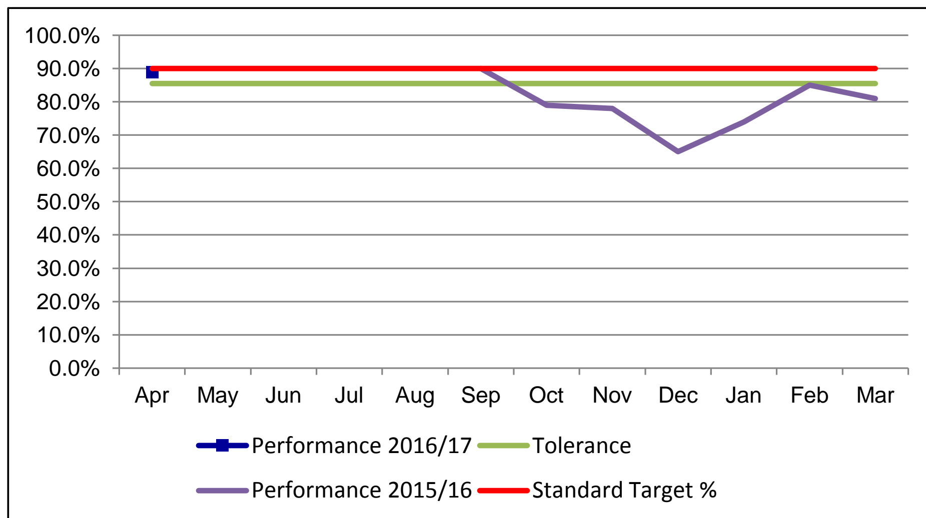
	Standard	Stretch	Tolerance
Standard: 18 weeks referral to treatment for Psychological Therapies	90.0%	95.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Stretch Target %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Standard Target %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17	89.0%											
Current wait> 18 wks	91											
Performance 2015/16						90.0%	79.0%	78.0%	65.0%	74.0%	85.0%	81.0%
Current wait> 18 wks						22	53	62	55	50	68	83

Please Note: there is a 1 month lag time for data, limited previous performance to report as data reporting has changed for 2016/17

We now report the % of patients seen within 18 weeks rather than the number of patients waiting over 18 weeks



Narrative Summary:
Performance increased significantly in February 2016, following particularly low performance in December 2015, however fell back to 81% in March 2016. April 2016 performance shows 89% however there were fewer than average patients seen and therefore performance increased, it may not continue into May 2016. In September, that target was met with 2 patients waiting >18 weeks received a Psychological Therapy (90%), however there was a reduction in the number of patients seen that month so this was a blip in the data.

Actions:
Actions continue as previously described, and we continue to 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.

The Scottish Government has recently allocated funding to health boards in Scotland, over a period of four years, to improve access to both CAMHS and Psychological Therapies. A short life working group is being set up to draw together a project plan for using the funding to improve Psychological Therapies Waiting Times.

CAMHS Waiting Times

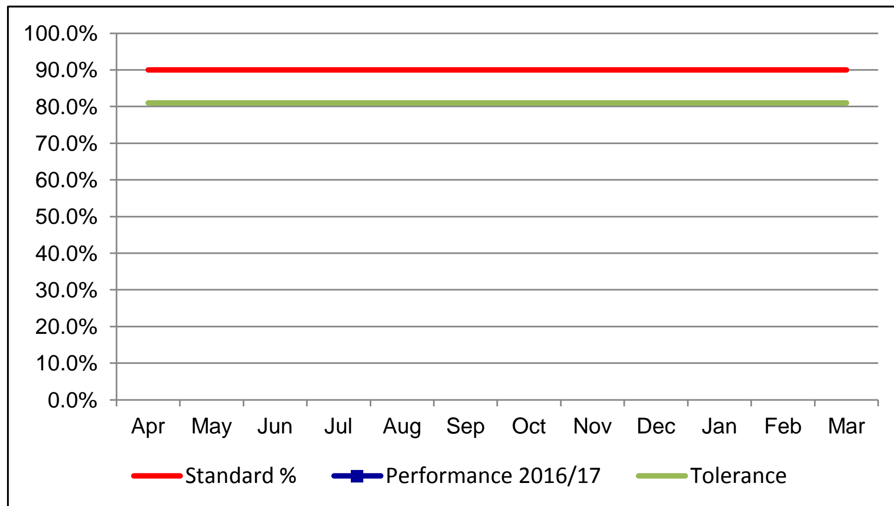
	Standard	Stretched	Tolerance
Standard: 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)	90.0%	95.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Stretch Target %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17												
Performance 2015/16	-	-	-	-	-	-	-	-	-	-	-	79.0%

Please Note: there is a 1 month lag time therefore April's data will be available next month

No previous performance to report as data reporting has changed for 2016/17 to the % of patients seen within 18 weeks - narrative reflects data held by the service



Narrative Summary:

In the quarter to March 2016, as reported by ISD, CAMHS achieved 83.5% performance, which is an increase from 76.7% in December 2015 and 78% in September 2015, but a decrease from 86.9% in June 2015.

As at the end of March 2016 there were 13 patients waiting over 18 weeks for this service which equates to 79% performance. Green status was not achieved by the end of February 2016 as previously estimated. Early indication of April 2016 performance shows 79.2%.

The service continues to be challenged, having been unable to recruit a nurse and a Consultant Psychiatrist, both of which are key posts to support the delivery of the target and have been vacant since mid-2015.

Actions:

A locum was put in place from Monday 9th November 2015 and a nurse has now been in post since the 15th February 2016, both of which will have an impact on waiting times, and the service has implemented specific allocations meetings out with the multi-disciplinary team meeting to retain focus on referrals and the waiting list.

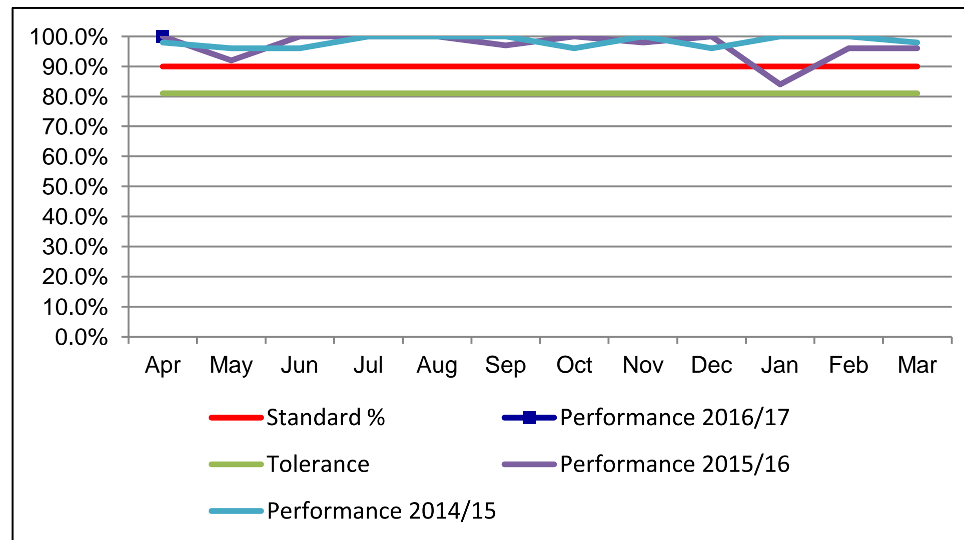
The Scottish Government has recently allocated funding to health boards in Scotland, over a period of four years, to improve access to both CAMHS and Psychological Therapies. A project plan is currently being drawn up detailing how the Mental Health Service plans to use this funding to improve CAMHS waiting times, and a short life working group is being set up to manage the project plan.

Drug & Alcohol Treatment

	Standard	Stretched	Tolerance
Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	90.0%	95.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Stretch Target %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17	100.0%											
Performance 2015/16	100.0%	92.0%	100.0%	100.0%	100.0%	97.0%	100.0%	98.0%	100.0%	84.0%	96.0%	96.0%
Performance 2014/15	98.0%	96.0%	96.0%	100.0%	100.0%	100.0%	96.0%	100.0%	96.0%	100.0%	100.0%	98.0%



Narrative Summary:
This is a national HEAT Standard where the ongoing requirement is to deliver 3 weeks RTT for 90% of progressed referrals. There is a local NHS Borders stretch target of 95%.

Overall performance has been consistently above the target throughout 2015/16 however in February 2016 decreased significantly to 84%. The Addaction Service had 5 clients not seen within the target and therefore the overall performance reduced to 84%. This was due to a combination of service capacity and also process issues which have now been resolved. Performance increased again in March 2016 to 96%, which is above the national and local target.

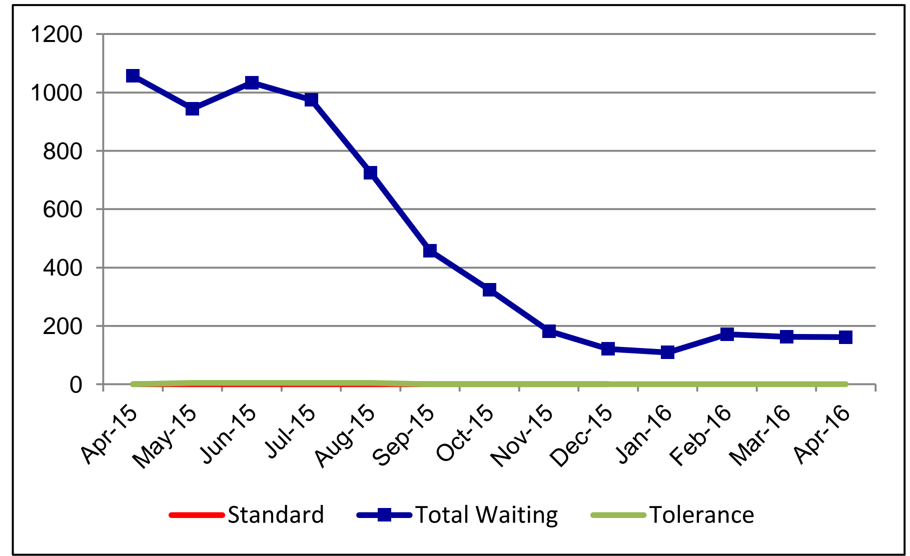
Actions:
1. All referrals received by admin and promptly marked with date stamp.
2. Daily duty worker screens and disperses referrals to senior nursing staff to allocate.
3. Admin continue to monitor and manage RTT time until1st appointment attended.
4. Any problems are potential breaches are reported immediately to Team Manager and addressed.
5. Responsible managers meet quarterly to discuss performance and updates.

AHP Waiting Times

Standard: Patients Waiting over 9 Weeks as at month end	**Standard**	**Tolerance**
	0	1

Actual Performance (lower = better performance)

	May-15	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**945**	**1034**	**975**	**725**	**457**	**324**	**182**	**121**	**109**	**172**	**163**	**162**
Occupational Therapy	10	10	12	16	11	13	13	13	21	19	26	2
Physiotherapy	929	1018	955	705	439	303	158	105	79	139	125	144
Podiatry	0	0	0	0	0	0	0	0	0	0	0	0
Speech & Language Therapy	0	0	0	0	0	1	1	0	0	0	2	4
Nutrition & Dietetics	6	6	8	4	7	7	10	3	9	14	10	12



AHP Waiting Times *continued*

Narrative Summary and Actions:
For all Allied Health Profession (AHP) services, a local target of 9 weeks was identified as the standard which should be met from referral to initial appointment.

Physiotherapy
As of end of April 2016 there were 153 patients waiting over 9 weeks for physiotherapy treatment.

The Physiotherapy Service is now reporting nationally on new MSK target of 90% of patients seen within 4 weeks. 431 patients are waiting over 4 weeks with an average waiting time of 6 weeks.

The Physiotherapy Service is continuing to implement the new workforce profile following re-design. Current clinical gaps (17% vacancy across physiotherapy services) are reducing benefit of additional capacity appointed to MSK, but are being actively addressed via recruitment process and temporary appointment of locums. The MSK service implemented NHS 24 MATS for self referrals at the end of February 2016. The new system will support a proportion of patients to self management rather than automatic referral to physiotherapy.

Nutrition and Dietetics
Dietetic breaches are predominantly related to capacity issues for highly specialised dieticians. Actual number of long waits less than reported as data checking not complete at time of report. Measures are in place to triage referrals and use clinic capacity effectively. Community dietetic service is under significant pressure, resulting in a reduction in clinic appointments for routine referrals. There will be a number of vacancies in the next month – recruitment process started. The service is attempting to progress dietetic led IBS and Coeliac Disease clinics to improve care pathways and reduce pressure on GI clinics. The service planned to increase capacity of DESMOND programme but funding is not now available.

Occupational Therapy
The waiting times are for Learning Disability assessment services, where there is one Occupational Therapist Borders wide. Currently there has been a demand for specialist input to 3 housing projects for both individual and environmental assessments. This is time limited and the amount of work will reduce in the next 3-6 months, however we are also exploring support from OTs in SBC Housing and adaptations services. This will enable more focus on AMPS and Sensory Integration assessments to be undertaken. The waiting list is being reviewed and managed weekly within the LD Team.

Please Note: data reported is provided by the Planning & Performance Team however it does not match data run by the service. The data on Trak supports MSK waiting times and is well supported and accurate however data on epex was in the past reviewed by administration resource within the service on a regular basis. There may be anomalies with the service data at the moment as there is currently sickness absence within admin resource which is impacting on cleansing of data. A plan is now in place with the admin leadership.

LDP Standards:

Delegated Performance

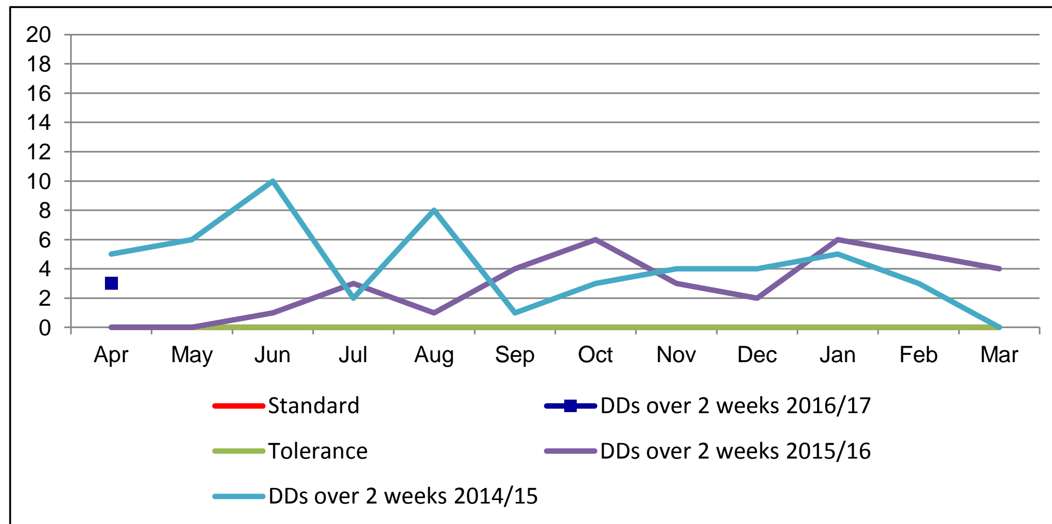
Delayed Discharges

	Standard	Tolerance
Delegated Performance: Delayed Discharges - over 72 hours	0	0

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
DDs over 2 weeks 2016/17	3											
DDs over 72 hours (3 days) 2016/17	6											
DDs over 2 weeks 2015/16	0	0	1	3	1	4	6	3	2	6	5	4
DDs over 2 weeks 2014/15	5	6	10	2	8	1	3	4	4	5	3	0

Please Note: Delayed Discharges over 72 hours is a new target that is being monitored. (Target date has not yet been confirmed).



Narrative Summary:
The new national target of zero delays over 14 days came into place in April 2015.

As at the March 2016 Delayed Discharge Census, there were 4 patients waiting over 14 days and 8 patients waiting under 14 days.

As at the April 2016 Delayed Discharge Census, there were 3 patients waiting over 14 days and 10 patients waiting under 14 days.

Please Note: Data for October 2015 – February 2016 has been updated due to an error in the HEAT Scorecard reporting by the Planning & Performance Team. The data will be amended in future performance reports with a footnote added. There was no impact on the national reporting and figures reported nationally are correct.

Delayed Discharges *continued*

Narrative Summary:
As reported last time, since the start of June 2015 the number of delayed discharges has risen by a greater number than envisaged.

The key reasons for delay experienced by patients are currently being influenced by challenges relating to the following issues:

- Care at home – we continue to be challenged in sourcing care at home across the Borders.
- Choices of care home placements and availability thereof
- A number of complex cases with a significant length of stay
- Boarded patients in the BGH

Ongoing focus is being placed upon supporting the discharge of delayed patients awaiting their next stage of care across the system. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 Hour ED Standard, quality of care and ensuring people are in the right care setting, and the avoidance of disruption to planned surgical admissions.

There are weekly delayed discharge meetings with senior managers and senior colleagues from Scottish Borders Council and SB Cares including the Head of Delivery Support, Chief Officer for Health and Social Care, Director of Nursing, Midwifery and Acute Services and General Managers for P&CS and Unscheduled Care, amongst others and they have been meeting since the beginning of January to add impetus to the improvement required. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring and to implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

Actions:
- Review Rapid Response availability and use
- Update on refurbishments of Salt Greens and Waverley and timeline to reopening of beds
- Home Care availability, implement Matching Unit
- Redesign START Hub
- Host advisory visit from John Bolton (Glasgow)
- Revise NHS Discharge Policy and Processes based on output from JIT visit
- Implement 72hr reporting approach
- Initiatives to reduce admissions list of projects to be developed along with leads and timeframes
- Criteria around packages of care and assessments
- Discharge to assess unit and a change by Care Managers to a “pull” approach to Discharge from our current “push” model
- Communication Plan with Medical, Nursing and AHP staff around revised Discharge Policy and responsibilities
- Continue to review other areas lessons

Key Performance Indicators

Cancellations

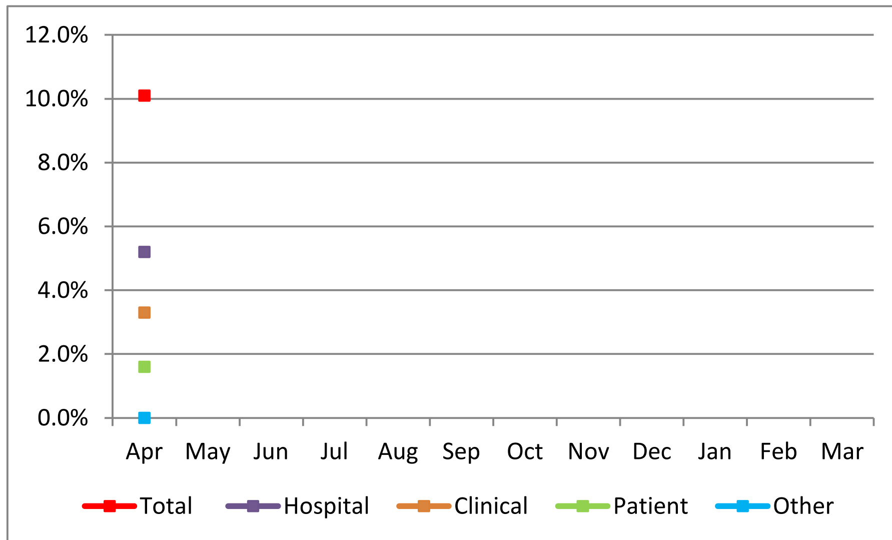
Hot Topic: Cancellations

Target & Tolerance

[1] Hospital Cancellation Rate – <1.5% Green, 1.5% Amber, (balloon raised), >1.7% Red
[2] Clinical Cancellation Rate – <2.5% Green, 2.5% Amber, >3.2% Red
[3] Patient Cancellation Rate – <3.5% Green, 3.5% Amber, >3.8% Red
[4] Other Cancellation Rate – <0.5% Green, 0.6% Amber, >0.7% Red

Actual Performance (lower % = better performance)

Cancellation Rate %	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	**10.1%**											
Hospital	5.2%											
Clinical	3.3%											
Patient	1.6%											
Other	0.0%											



Narrative Summary
The number of hospital cancellations remained the same in April as in March at 22 but the percentage of all procedures has increased from 4.1% in March to 5.2% in April. 12/22 of these cancellations were because no beds were available.

Actions:
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment
- Booking on the basis of average time per consultant to carry out procedure for orthopaedics
- Reviewing admissions per ward area per day and smoothing surgical flow via Institute of Healthcare Optimisation work.
- Reviewing data for orthopaedics to see if reviewing lists has had an impact on cancellation rate and consider rollout to other specialties.
- Anaesthetics staffing reviewed through medical oversight group – action plan in place for recruitment.
- The service is looking to implement a process to review lists every Wednesday afternoon and develop a Standard Operating Procedure to lock down list and make any appropriate changes.

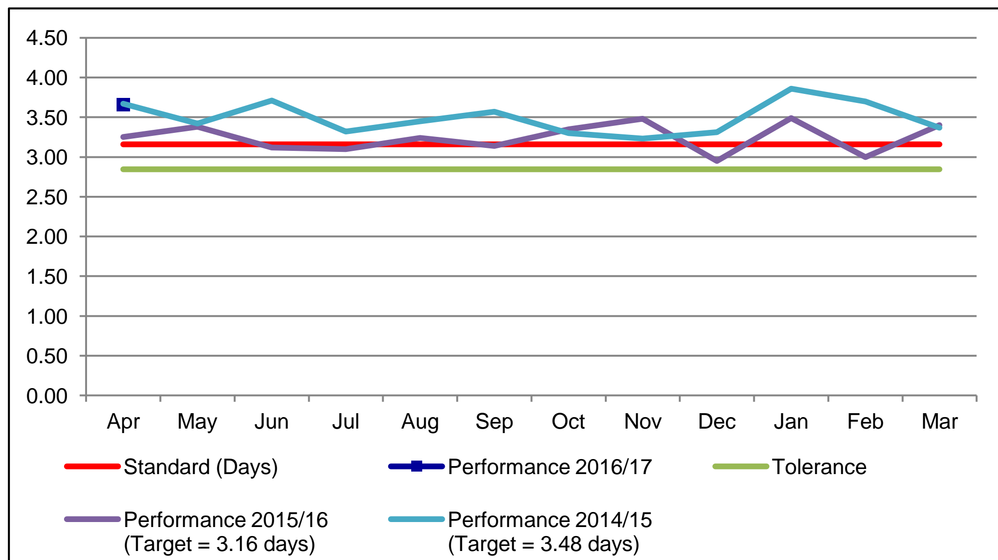
Detailed reviews of the reasons behind the lack of available beds are being undertaken by services on an ongoing basis in an effort to alleviate the pressures.

BGH Average Length of Stay

	Target	Tolerance
Standard: Reduce BGH Length of Stay	3.16	3.48

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (Days)	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16
Performance 2016/17	3.66											
Performance 2015/16 (Target = 3.16 days)	3.25	3.38	3.12	3.10	3.24	3.14	3.35	3.48	2.95	3.49	3.00	3.40
Performance 2014/15 (Target = 3.48 days)	3.67	3.42	3.71	3.32	3.45	3.57	3.30	3.23	3.31	3.86	3.70	3.37



Narrative Summary:
The average length of stay for the Borders General Hospital has risen in some areas however it is within control limits at 3.66 for April 2016.

New targets were introduced from May 2014, which take into account the latest analysis from the new Bed Model. These take the 75th percentile values for Borders HRGs benchmarked against peers across England. In some instances this means that specialties now have a stretch target to further reduce lengths of stay, and the overall target for the BGH has reduced from 3.48 to 3.16.

Actions:
Continue to monitor and manage patient lengths of stay.

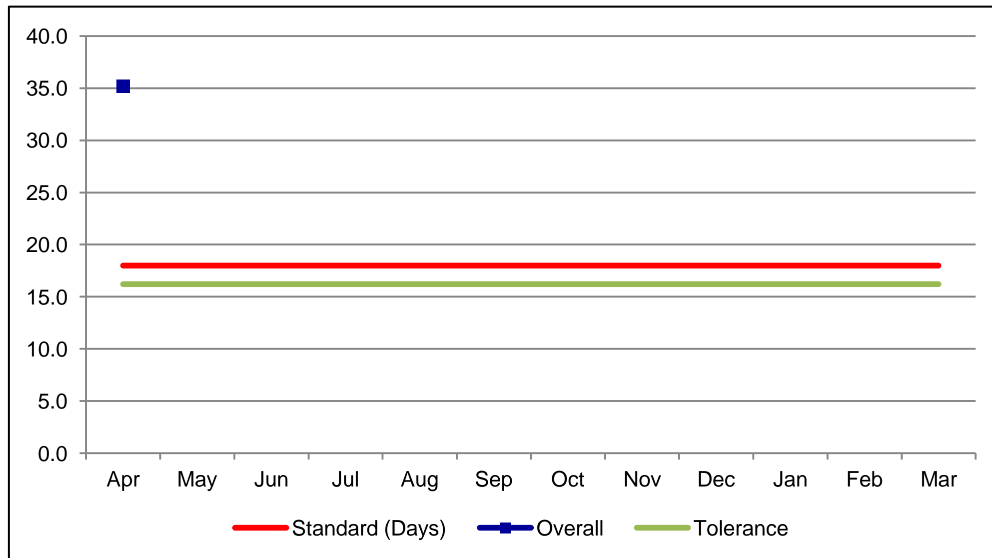
Community Hospital Average Length of Stay (LOS)

	Standard	Tolerance
Standard: Reduce Community Hospital Average Length of Stay	18.0	19.8

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (Days)	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0
Overall	**35.2**											
Hawick	24.3											
Hay Lodge	54.3											
Kelso	31.3											
Knoll	46.2											

Please Note: Data is Current Month's Ave LoS (incl DD's)



Narrative Summary:
There continues to be pressures within Community Hospitals in terms of LOS. Pressure is increased by the level of complexities of some o f the patients requirement and the need for long term placements. Point of care remain an issue in some localities particularly in outlying locations.

Actions:
- The Clinical Community Manager to attend all MDTs and support patient flow.
- Clinical Community Manager attending and contributing to the Delayed Discharge Meetings and liaising with Social Work
- General Manager joint working with Social Work to address underlying issues of capacity of caring services within the community
- Clinical Bridge meetings looking at trak access for District Nurse team in order for them to "pull patients" out of hospitals or to anticipatory care plan to avoid admissions

Mental Health - Average Lengths of Stay (LOS) – IHS Standard

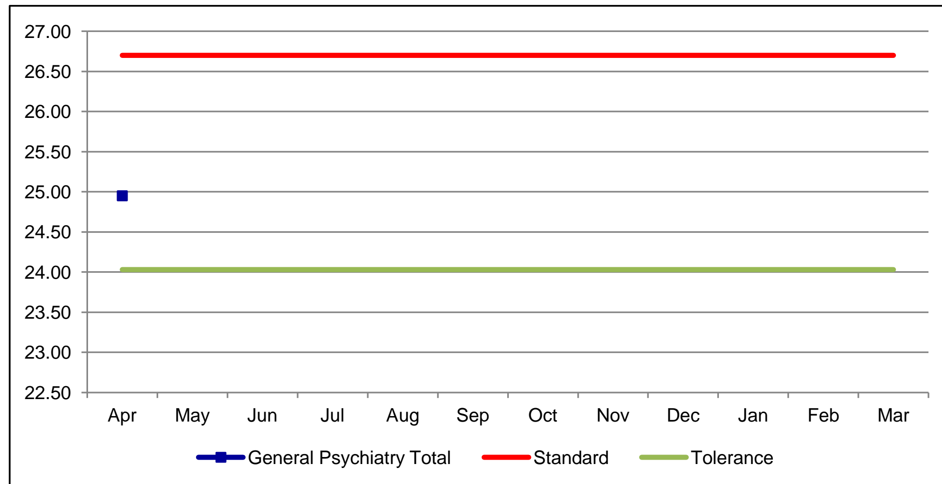
	Standard	Tolerance
Standard: Reduce Mental Health Average Length of Stay	Various	within 10%

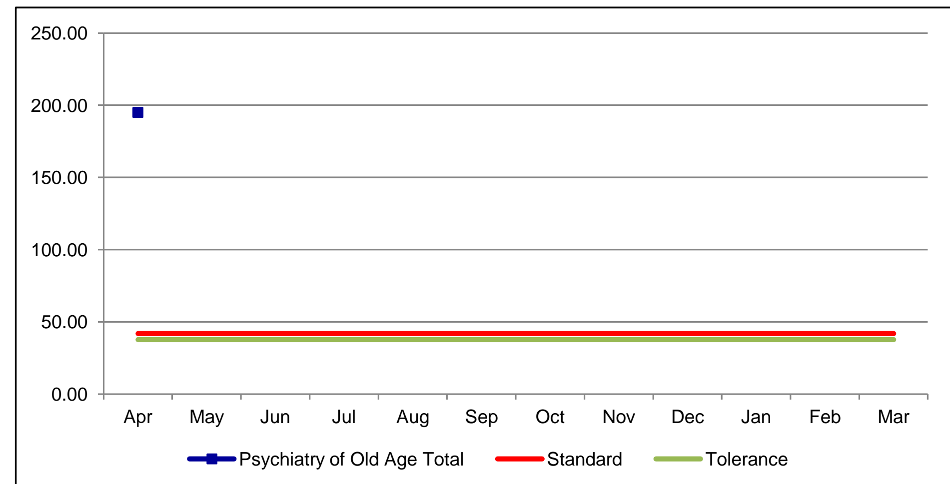
Actual Performance (lower = better performance)

	Standard (Days)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Huntlyburn	17.70	22.06											
The Brigs	42.83	34.20											
General Psychiatry Total	**26.70**	**24.95**											
Cauldshiels [1]	26.95	-											
Lindean	60.58	45.00											
Melburn Lodge [2]	111.63	345.00											
Psychiatry of Old Age Total	**41.82**	**195.00**											

[1] There were no discharges from Cauldshiels in April 2016

[2] High number in April due to 1 patient discharged in April 2016 with long length of stay





Narrative Summary:
Mental Health LOS can fluctuate depending on the numbers of discharges and the length of time a patient has been within the facility.

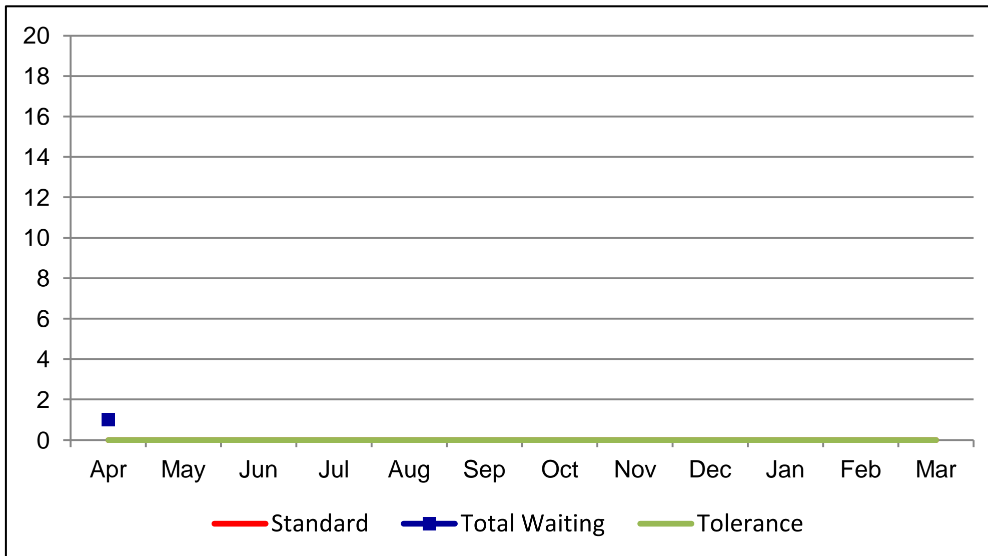
Actions:
Maintain performance in giving all patients Estimated Dates of Discharge on admission.

Mental Health Waiting Times

	Standard	Tolerance
Standard: Patients Waiting over 18 weeks as at month end	0	1

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	1											
MH Older Adults - East	0											
MH Older Adults - South	0											
MH Older Adults - West	0											
East Team	1											
South Team	0											
West Team	0											



Narrative Summary:
Performance is usually robust towards this target with very small numbers of patients being seen over 18 weeks. Each team continues to monitor their waiting list.

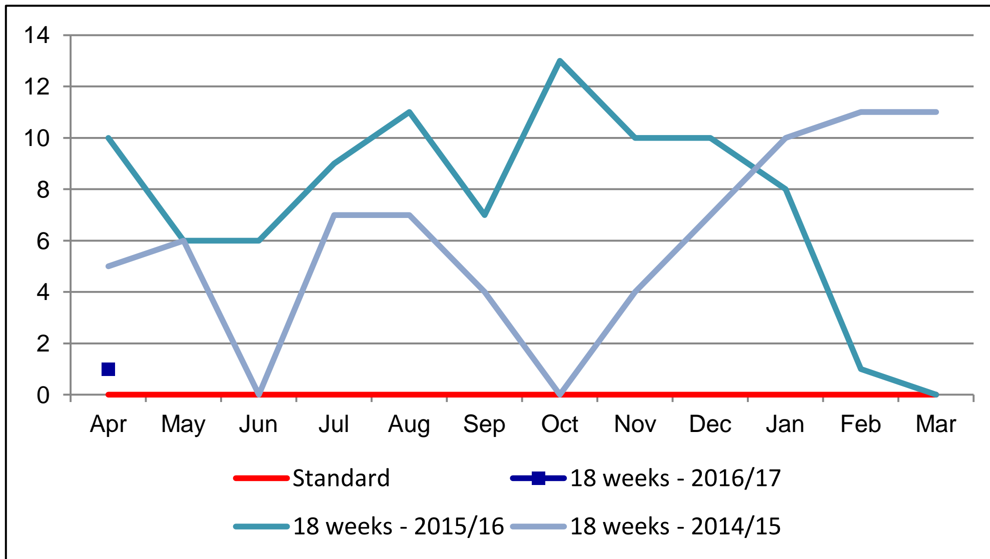
Actions:
Continue to monitor and manage the waiting list.

Learning Disability Waiting Times

	Standard	Tolerance
HEAT Standard: Monitor and reduce Learning Disability Waiting Times	0	1

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
18 weeks - 2016/17	1											
18 weeks - 2015/16	10	6	6	9	11	7	13	10	10	8	1	0
18 weeks - 2014/15	5	6	0	7	7	4	0	4	7	10	11	11



Narrative Summary:
Learning Disability waiting times over 18 weeks has been consistently low over the last 3 months. The 1 patient is waiting for a specialist autism diagnostic Psychology assessment appointment. Due to staff absence in the service, and the specialist nature of the appointment, this patient has not been able to be seen within target.

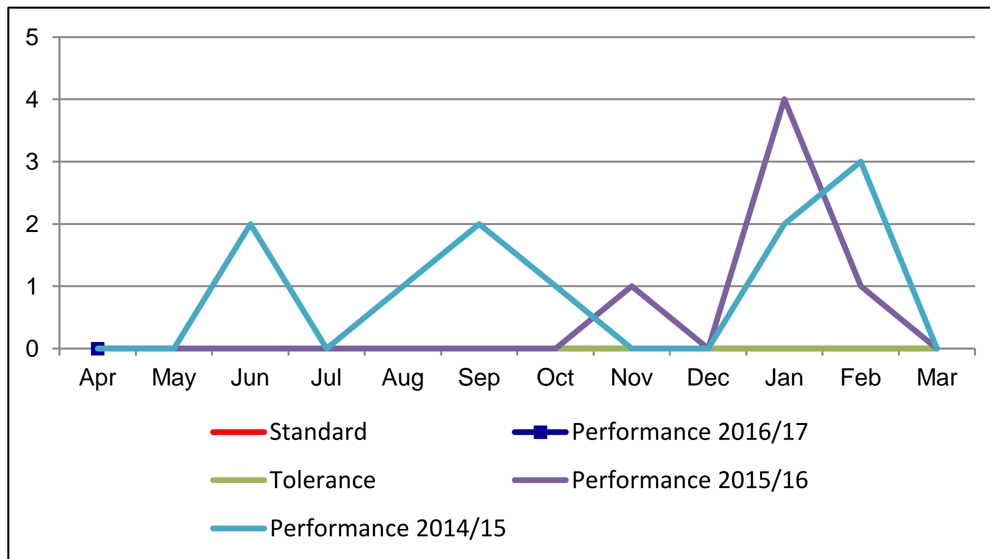
Actions:
Continue to monitor and manage the waiting list.

Rapid Access Chest Pain Clinic (RACPC)

Standard: 1 Week Waiting Target for RACPC	**Standard**	**Tolerance**
	0	1

Actual Performance (lower = better performance)

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Performance 2016/17	**0**											
Performance 2015/16	0	0	0	0	0	0	0	1	0	4	1	0
Performance 2014/15	0	0	2	0	1	2	1	0	0	2	3	0



Narrative Summary:
The number of patients waiting over **1 week for the Rapid Access Chest Pain Clinic** is consistently low.

Actions:
Continue to monitor and manage the waiting list.

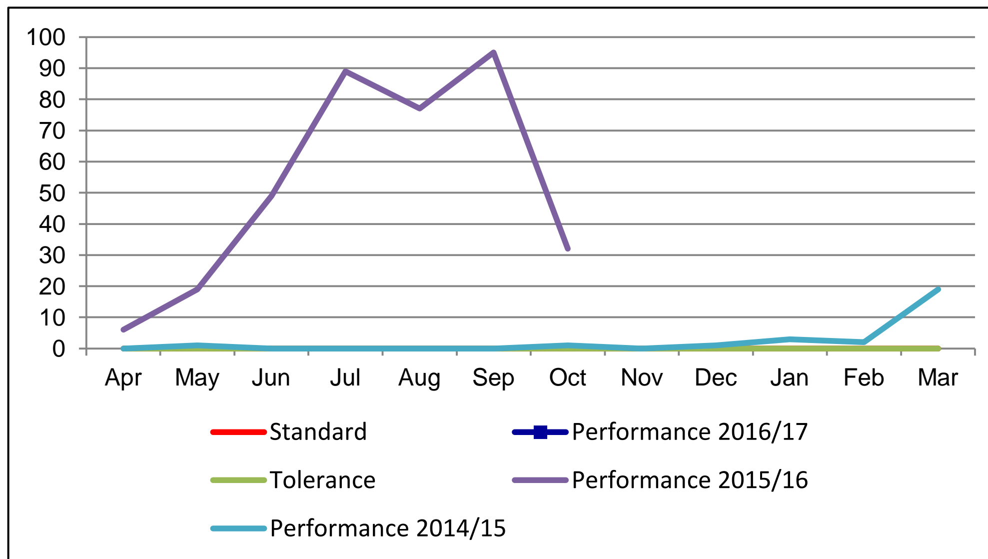
Audiology Waiting Times

	Standard	Tolerance
Standard: 18 Week Referral to Treatment for Audiology	0	1

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Performance 2016/17												
Performance 2015/16	6	19	49	89	77	95	32		86			
Performance 2014/15	0	1	0	0	0	0	1	0	1	3	2	19

No data available for November 2015 and January - April 2016 due to staffing issues within the service.



Narrative Summary:
There has been deterioration in the waiting time for audiology services in 2015/16 Quarter 3, in comparison to 2015/16 Quarter 2. The service is now fully staffed which should see waiting times improve.

Actions:
- Work with Audiology Lead to review clinic templates to ensure most effective use of time.
- Additionally the service is undergoing a thorough data cleansing exercise with support from the Waiting Times team. It is anticipated that this exercise will improve the accuracy of reporting and reduce the number of reported breaches.