Borders NHS Board

NHS BORDERS PERFORMANCE SCORECARD – JULY 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 31st July 2016.

Background

The attached Performance Scorecard combines elements of the HEAT Scorecard, Access to Treatment Report and the Integrated Performance Scorecard into one report which is presented to the Clinical Executive Operational Group, Strategy & Performance Committee and 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 and 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.

The RAG status summary for a rolling 3 month is outlined below:

LDP Standards	**May-16**	**Jun-16**	**Jul-16**
Green – achieving standard	8	12	11
Amber – nearly achieving standard	7	8	9
Red – outwith standard	11	8	8

Key Performance Indicators	**May-16**	**Jun-16**	**Jul-16**
Green – achieving standard	4	5	3
Amber – nearly achieving standard	3	2	4
Red – outwith standard	6	6	6

Areas of strong performance from the LDP Standards and Access to Treatment sections in the Scorecard for the position as at 31st July 2016 are highlighted below:

- Smoking cessation successful quits in the most deprived areas exceeded the 2015/16 standard of 118 with 128 quits at the end of March 2016 (page 14)

- The standard for pre-operative stay was achieved during May 2016 (latest available data) 0.23 days against the standard of 0.47 (page 18)
- 93.0% of all referrals were triaged online in July 2016, above the standard of 90% (page 19)
- 37.2% of new born children were breastfed at 6-8 weeks for the quarter January – March 2016 (latest available data) (page 20)
- The rate of Emergency Occupied Bed Days for the over 75s was achieved in February 2016 (latest available data) with 3548 against the standard of 3685 (page 23)
- 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 May 2016 (pages 31-35)
- Treatment of cancer within 31 days of decision to treat for all patients diagnosed with cancer is consistently being achieved – latest available data June 2016 (page 39)
- Treatment of cancer within 62 days for urgent referrals of suspicion of cancer is also consistently being achieved – latest available data June 2016 (page 40)
- The national standard of 95% was achieved in July 2016 with 96.5% of patients discharged from A&E within 4 hours (page 41)
- 100% of patients were seen within 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services in July 2016 against the standard of 90% (page 46)

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 31st July 2016 are highlighted below:

- New patient DNA rate was outwith the 4% standard at 5.0% in July 2016 (page 16)
- eKSF and PDPs recorded performance under the trajectories set during July 2016 (page 21 & 22)
- 374 patients waited over 12 weeks for an outpatient appointment in July 2016 against a standard of 0 (page 26)
- 4 patients breached their TTG date during July 2016 against a standard of 0 (page 28)
- 20 breaches of the 6 week and 137 breaches of the 4 week diagnostic waiting time standards were reported in July 2016 (page 36)
- 76% of patients were seen within 18 weeks referral to treatment for the Alcohol & Drug service in July 2016, against a national standard of 90% (page 47)
- 305 patients were waiting over 9 weeks for AHP services against a standard of 0 patients in July 2016 (page 48)
- 9 patients were delayed more than 2 weeks to be discharged from hospital in July 2016 (page 51)

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 July 2016 Performance Scorecard.

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		

Author(s)

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NHS Borders

PERFORMANCE SCORECARD

As at 31st July 2016

July 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 HEAT 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] (2015/16 data)	A	A ↓	-	-								
Alcohol Brief Interventions [2]	R	R ↑	A ↑	A ↑								
Smoking cessation successful quits in most deprived areas [3]	-	-	-	-								
Sickness Absence Reduced	R	R ↓	R ↓	A ↑								
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [4]	G	G ↑	G ↓	-								
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [4]	G	G ↔	G ↓	-								
18 Wk RTT: 12 wks for outpatients	R	R ↓	R ↓	R ↑								
18 Wk RTT: 12 wks for inpatients	R	A ↑	R ↓	A ↑								
18 Wk RTT: 12 weeks TTG	R	R ↑	A ↑	R ↓								
18 Wk RTT: Admitted Pathway Performance [5]	R	A ↑	A ↑	-								
18 Wk RTT: Admitted Pathway Linked Pathway [5]	G	G ↑	G ↓	-								

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: Non-admitted Pathway Performance [5]	G	G ↑	G ↔	-								
18 Wk RTT: Non-admitted Pathway Linked Pathway [5]	G	G ↓	G ↓	-								
Combined Performance [5]	G	G ↑	G ↑	-								
Combined Performance Linked Pathway [5]	G	G ↓	G ↓	-								
6 Week Waiting Target for Diagnostics	R	R ↓	R ↑	R ↑								
4-Hour Waiting Target for A&E	A	A ↓	G ↑	G ↓								
No CAMHS waits over 18 wks	R	A ↑	A ↑	G ↑								
No Psychological Therapy waits over 18 wks	A	A ↓	A ↑	A ↓								
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G	A ↓	G ↑	R ↓								
No Delayed Discharges over 2 Wks	R	R ↓	R ↑	R ↓								
New patient DNA rate	R	R ↑	R ↑	R ↓								
Same day surgery [6]	A	A ↓	-	-								
Pre-operative stay [6]	G	G ↑	-	-								

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
Online Triage of Referrals	G	G ↑	G ↓	G ↓								
Increase the proportion of new-born children breastfed at 6-8 weeks [7]	-	-	-	-								
eKSF annual reviews complete	R	R ↑	R ↑	R ↑								
PDP's Complete	R	R ↑	R ↑	R ↑								
Emergency OBDs aged 75 or over (per 1,000) [8]	-	-	-	-								
Admitted to the Stroke Unit within 1 day of admission [9]	A	G ↑	A ↓	-								
Diagnosis of dementia	A	A ↓	A ↑	A ↓								

Footnotes

1 There is a 1 year time lag to show the full 12 months performance therefore data is 2015/16 rather than 2016/17
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 One month lag as data is supplied nationally.
5 From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.
6 There is a 2 month lag in data due to SMR recording
7 There is a lag time for national data, local data supplied quarterly
8 There is a 6 month lag in reporting any data included is the most up to date data available.
9 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.

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	R ↓	R ↓	R ↓								
Cancellations	Hospital	R	R ↓	R ↑	R ↑								
	Clinical	R	R ↑	G ↑	A ↓								
	Patient	G	G ↓	G ↓	A ↓								
	Other	G	G ↔	G ↔	G ↔								
Borders General Hospital Average Length of Stay		R	A ↑	A ↑	A ↓								
Community Hospitals Average Length of Stay		R	R ↑	R ↑	R ↓								
Mental Health Average Length of Stay General Psychiatry Total		G	R ↓	G ↑	R ↓								
Mental Health Average Length of Stay Psychiatry of Old Age Total		R	R ↑	R ↓	R ↑								
Mental Health Waiting Times (Patients waiting over 18 weeks)		A	G ↑	G ↔	G ↔								
Learning Disability Waiting Times (Patients waiting over 18 weeks)		A	A ↔	R ↓	A ↑								
Rapid Access Chest Pain Clinic		G	G ↔	R ↓	R ↔								
Audiology 18 Weeks Waiting Times [1]		-	A -	A ↓	G ↑								

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:

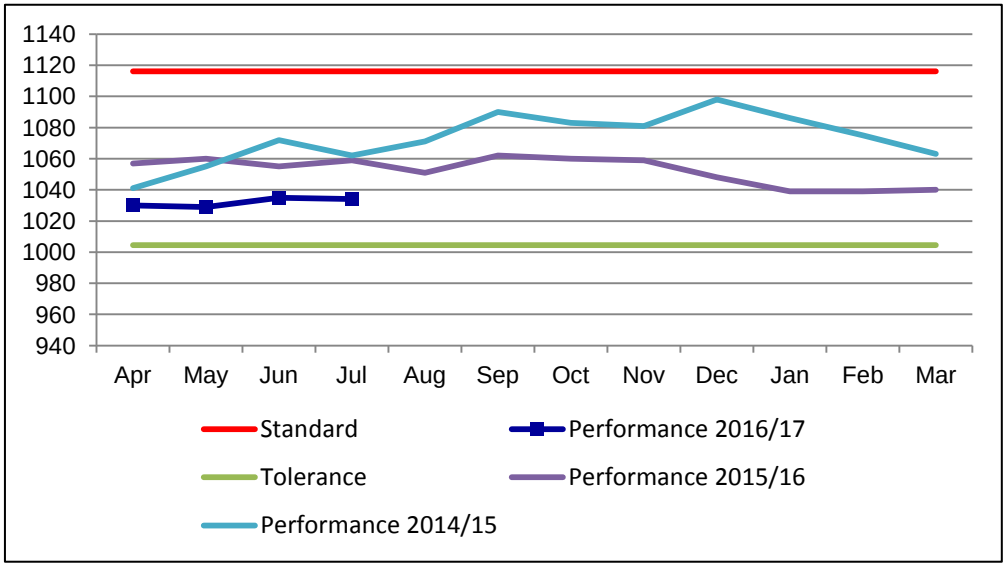
General

Diagnosis of Dementia

	Standard	Tolerance
Standard: Increase the number of patients added to the dementia register	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	1029	1035	1034								
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 gradually decreasing over the last 18 months.

Actions:
- An exercise to review patients' dementia diagnosis recording on Epex is ongoing. This will be cross checked with the GP Dementia diagnosis database with those surgeries willing to participate. A pilot with Selkirk practice increased the number of diagnoses on the GP database (Selkirk area patients) by approximately 20%. It is anticipated that with this data validation exercise the target will be met. The timescale will depend on how we can engage and work with primary care. Work is on going within the service.

Dementia - Post Diagnostic Support (PDS)

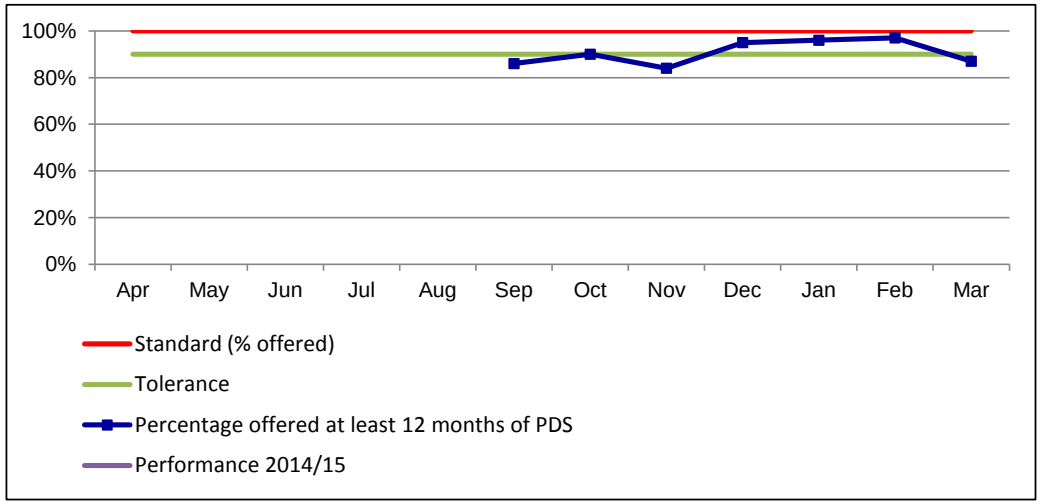
	Standard	Tolerance
Standard: People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support	100%	within 10%

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	135	140										
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	138	156										
Performance 2014/15						87	86	38	57	74	100	123
Percentage offered at least 12 months of PDS												
Performance 2016/17												
Performance 2015/16	98%	90%										
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 8 months however April 2015 (1 year lag time) reports the highest performance. 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.
- We have been accepted as a reporting pilot for data collection and will influence national data collection this work is being undertaken in partnership with ISD Data tool used July and August review in September.
- Post Diagnostic Support Excellence Programme has provided basis for further training for staff and informed action plan regarding further learning. Commencing End of August .

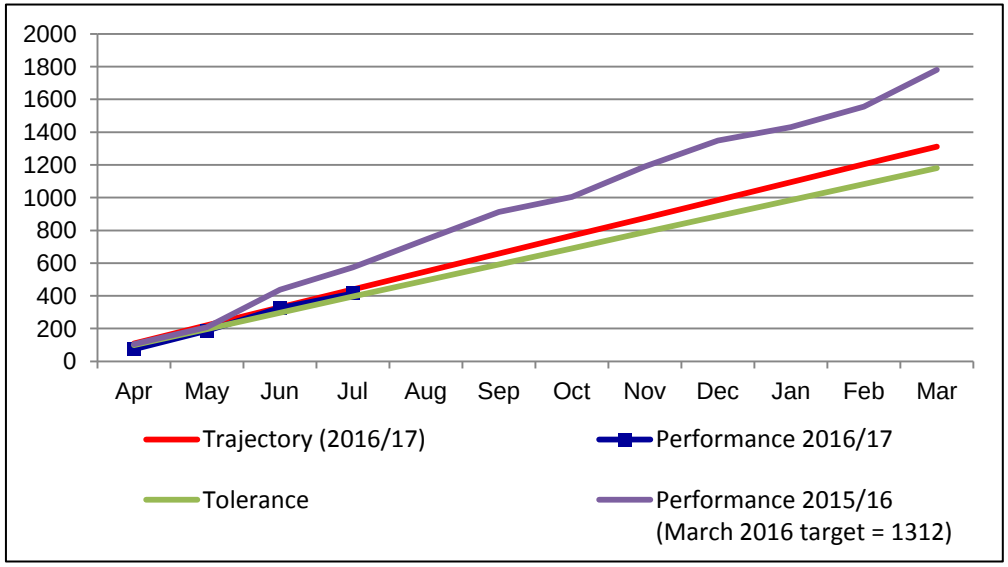
Alcohol Brief Interventions (ABI)

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	188	326	415								
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

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.



Narrative Summary:
At the end of July 2016 we have achieved 32% of the annual target for 2016/17 of 1312 **alcohol brief interventions** (ABI's) delivered, however the monthly trajectory was not achieved. Recorded ABI's at this stage are 160 lower than in July 2015, the most significant reductions in performance are in Police Custody Suite and via the Primary Care LES.

Actions:
- Contact will be made with the leads in the areas showing the most significant reductions.

Please Note: Data will be amended in August 2016 submission as not available for all areas at the time of sending to P&P.

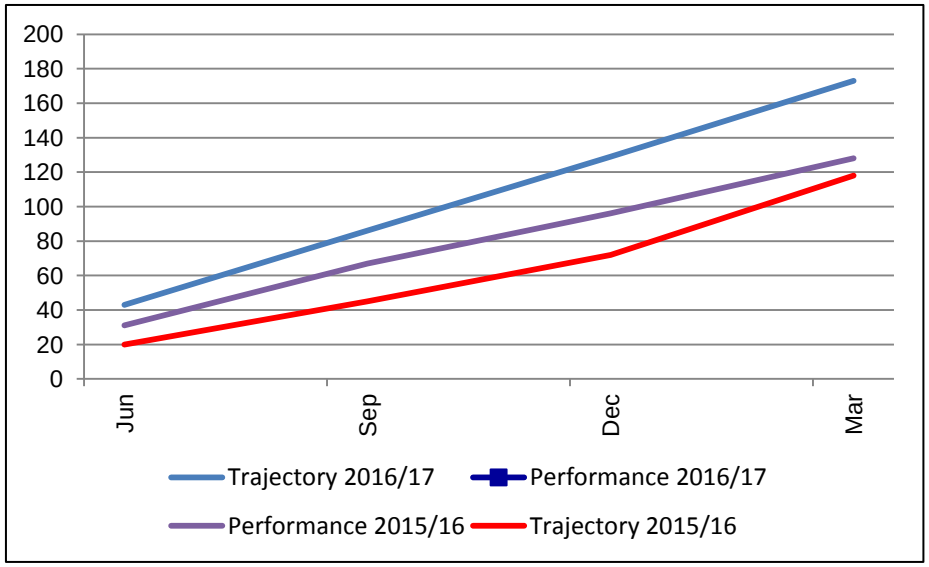
Smoking Quits

	Standard	Tolerance
Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas	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	118
Performance 2015/16	31	67	96	128

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 March 2016 (118) has been achieved with 128 successful quits This is an improvement on 2014/15 performance of 77% (72 quits delivered).

The performance target for 2016/17 for NHS Borders is to deliver 173 successful quits at 12 weeks in our most deprived communities. This represents a 47% increase compared to the previous target. Data will be reported in December. This level of increase is likely to be challenging following the significant increase over the previous year.

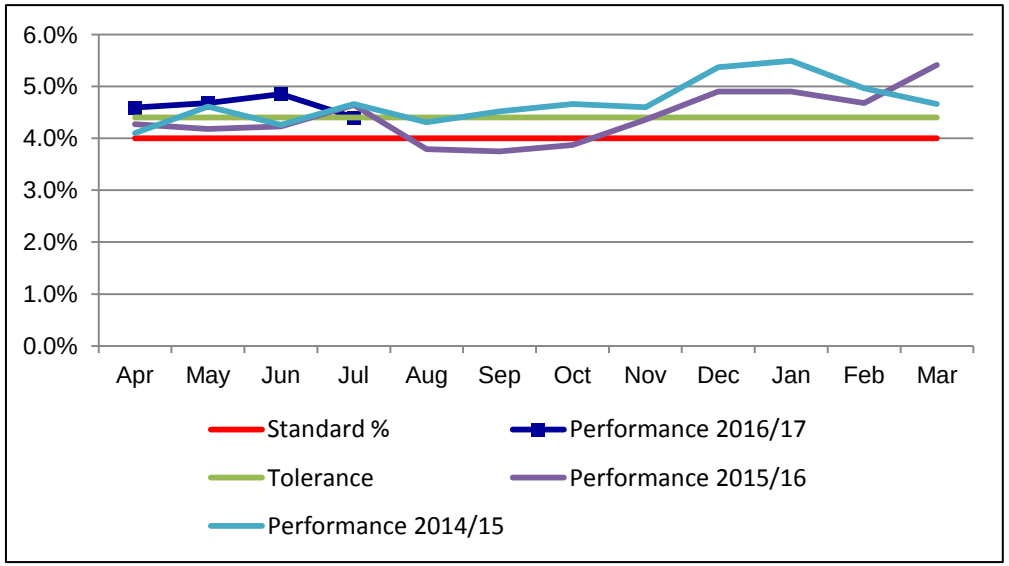
Actions:
- Quit4Good (cessation service) are working with mental health services to improve smoking cessation support and implementation of Smoke Free
- Local data will be monitored prior to national reporting to ensure work is underway to improve smoking cessation support to mental health services.

Sickness Absence

	Standard	Tolerance
Standard: Maintain Sickness Absence Rates below 4%	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%	4.7%	4.9%	4.4%								
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 2015/16 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 2014/15.

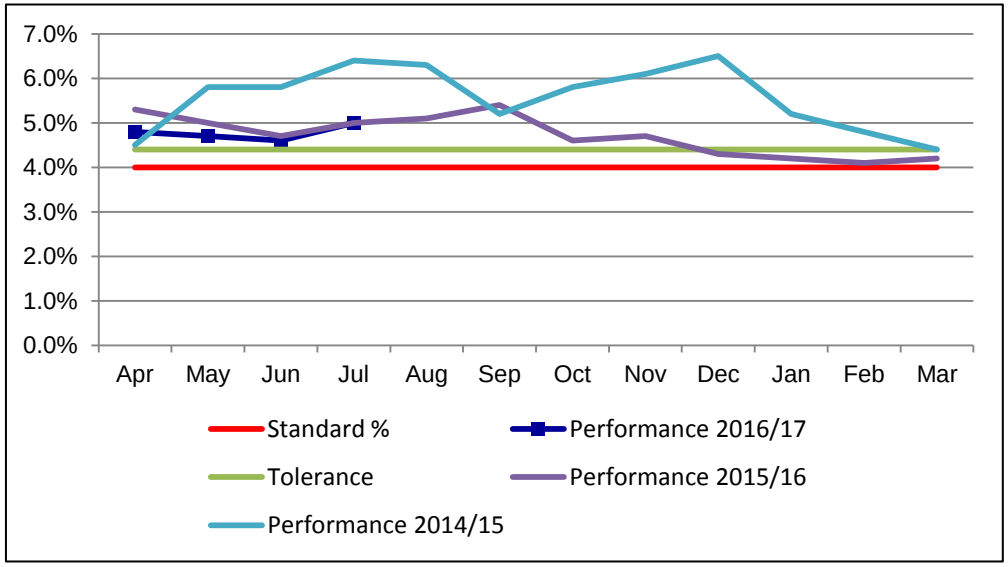
Actions:
- HR continue to be a support service to the Clinical Boards by providing advice and support in managing sickness absence as well as proactively identifying areas where rates are high.
- Monthly sickness absence reports are provided to each Clinical Board, these detail trends, rates, the level of short term and long term sickness absence and reasons for absence per department.
- 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%	4.7%	4.6%	5.0%								
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. Overall the trend for 2015/16 improved however the DNA level has increased over the last few months. This is due to a combination of it not being possible to sustain the staffing to telephone patients with a history of DNA, and a failure in the SMS messaging system.

In July 2016 NHS Borders' media campaign on the impact of missed appointments commenced. This was a 6 week radio campaign and press releases supported with posters and inserts for patient letters highlighting the impact and cost of missed appointments.

Actions:
- Monitoring process that SMS Messaging is operational reviewed and improved
- Exploring how to improve staffing for making telephone calls to patients with a history of missed appointments

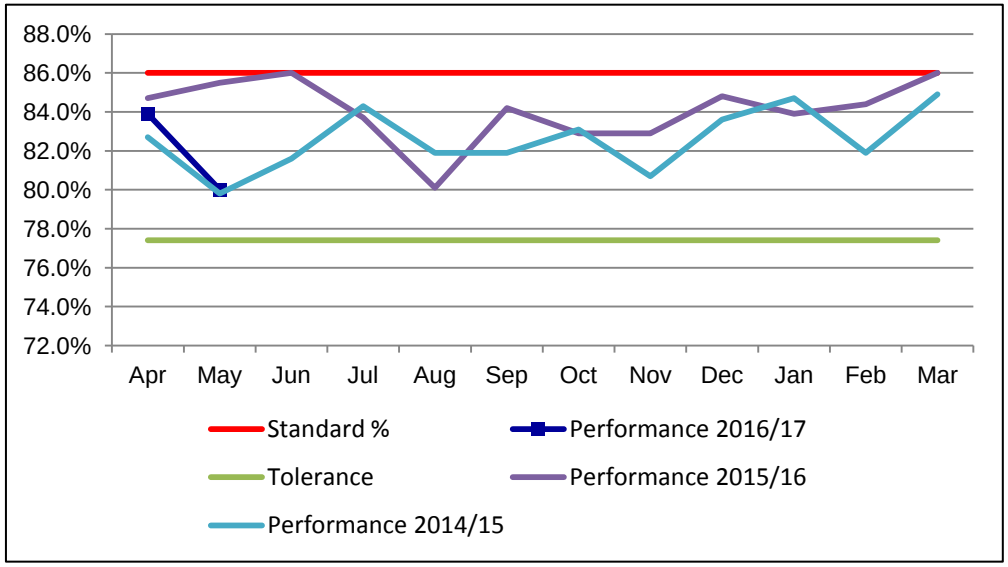
Same Day Surgery

	Standard	Tolerance
Standard: 86% of patients for day procedures to be treated as Day Cases	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	83.9%	80.0%										
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%	86.0%
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 March 2016 the overall 86% HEAT standard for **same day surgery** (BADS procedures) was achieved for the first time since June 2015.

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. The anticipated implementation of a new model will be in Winter 2016/17 subject to agreement of the new service model.

**British Association of Day Case Surgery*

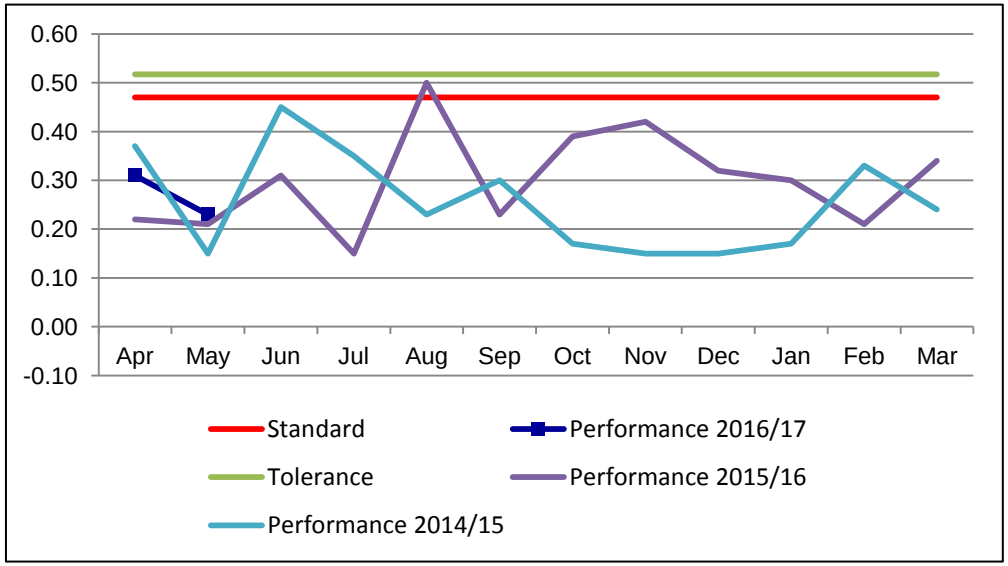
Pre-Operative Stay

	Standard	Tolerance
Standard: Reduce the days for pre-operative stay	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	0.31	0.23										
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	0.34
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, with the exception of August 2015 when the rate increased. This is the only breach of standard recorded since April 2013 and performance has since returned to a normal position. The highest admissions the day before the patients procedure are in orthopaedics.

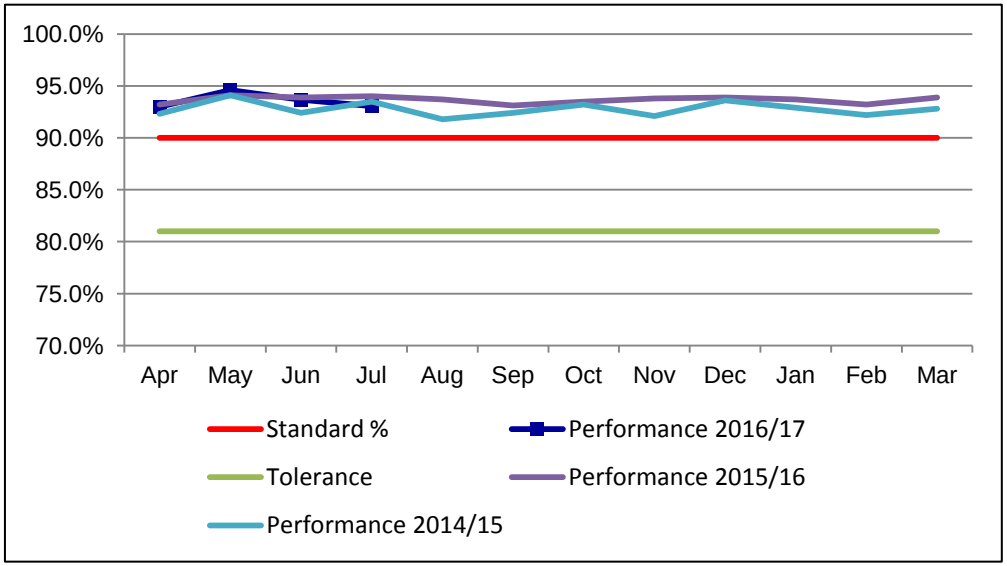
Actions:
- Further work through the redesign of theatres and surgical flow in 2016/17 should reduce the number of orthopaedic patients admitted the night before their procedure which would further reduce pre-operative inpatient stays. This will be implemented in Autumn/Winter 2016/17.

Online Triage of Referrals

	Standard	Tolerance
Standard: 90% of all referrals to be triaged online	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%	94.6%	93.7%	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.

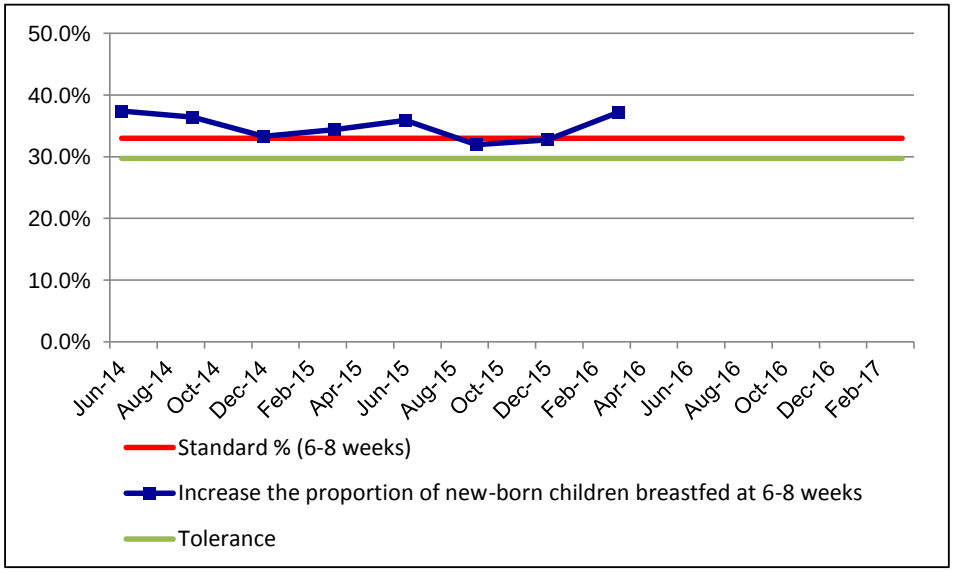
Breastfeeding

	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 % (6-8 weeks)	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%	32.8%	37.2%				
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%	38.3%	30.9%				
Percentage Ever Breast Fed	-	-	-	-	-	-	-	60.50%				

Please Note: There is a lag time for national data, local data supplied quarterly. Data reporting chnaged from Janaury 2016 to report babies that were ever breast fed



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 January - March 2016 performance exceeded 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 October 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 and should be resolved by quarter 2 of 2016/17.

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

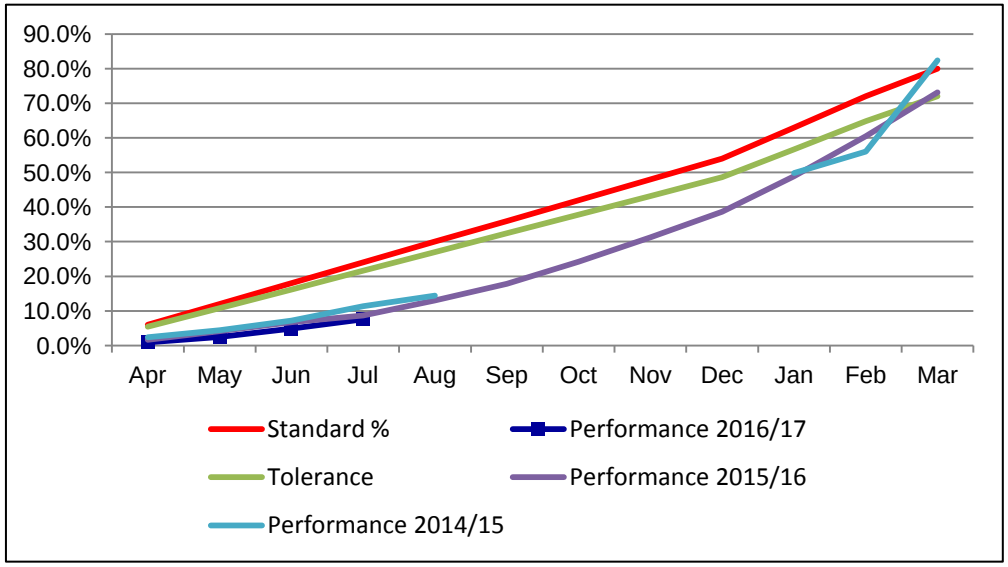
eKSF

Standard: 80% of all Joint Development Reviews to be recorded on eKSF	Standard	Tolerance
	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%	2.5%	4.9%	7.6%								
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 this 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.

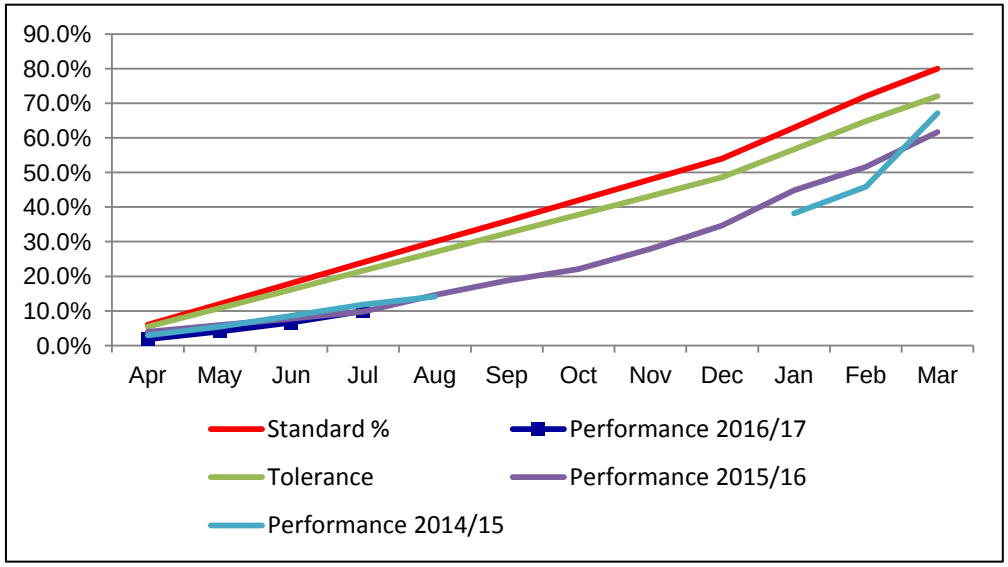
Personal Development Plans

	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%	4.1%	6.6%	9.9%								
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 three months of the 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.

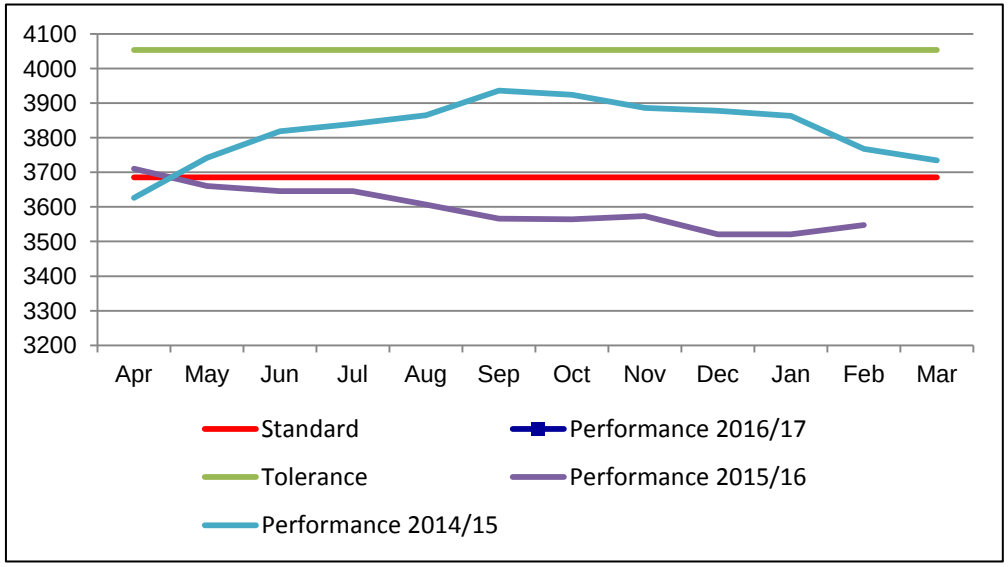
Emergency Occupied Bed Days

	Standard	Tolerance
Standard: Reduce Emergency Occupied Bed Days for the over 75s	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	3521	3521	3548	
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 have been reducing consistently since September 2014, following redesign work to reduce waits for patients requiring rehabilitation and elderly care beds. The redesign of acute medicine, commenced in September 2015 and the establishment of the Acute Assessment Unit in December 2015, supported by the Rapid Assessment and Discharge Team have resulted in further step reductions in occupied bed days.

Actions:

- Move to model of acute geriatrician from September 2016. This will ensure all frail elderly patients admitted s acute medical emergencies will receive Comprehensive Geriatric Assessment within 24 hours.
- From October 2016, reconfiguration of the medical inpatient footprint will result in 2 acute geriatric wards, taking patients directly from MAU.
- The combination of these measures is anticipated to reduce occupied bed days for over 75s by approximately 10%.

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.

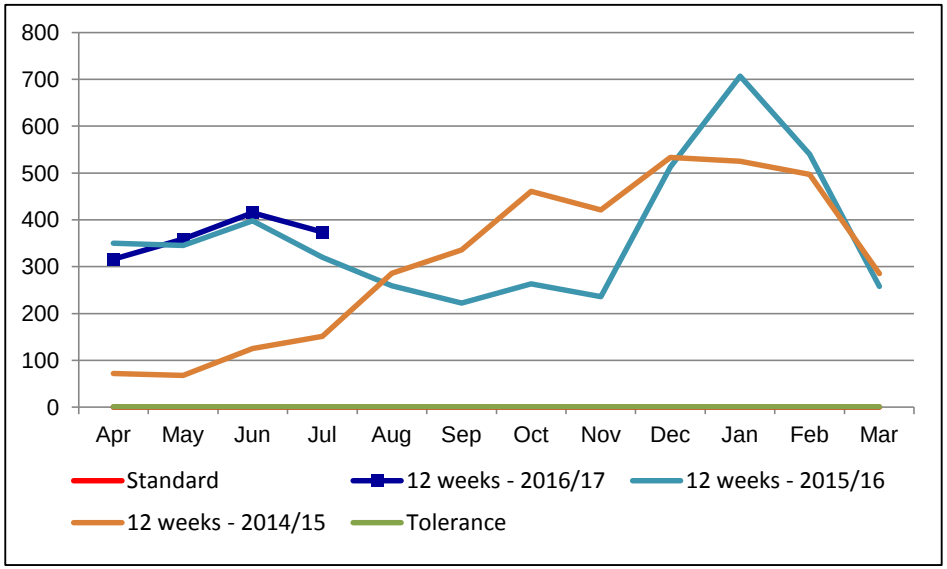
In 2016/17, the Board continues to face challenges in the achievement of our waiting times standards. However, although the pace of improvement is slower than planned, we are working steadily towards achievement of 12 week waits in both inpatients and outpatients.

Stage of Treatment - 12 Weeks Waiting Time for Outpatients

	Standard	Tolerance
Standard: 12 weeks for first outpatient appointment	0	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
12 weeks - 2016/17	316	359	415	374								
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 improved in July. There are still ongoing issues within ENT, Gastroenterology and Pain Control that the service are trying to remedy. Scottish Government has funded additional sessions in ENT and Gastroenterology, and it is anticipated that these will show significant improvements over the next few months.

Actions:

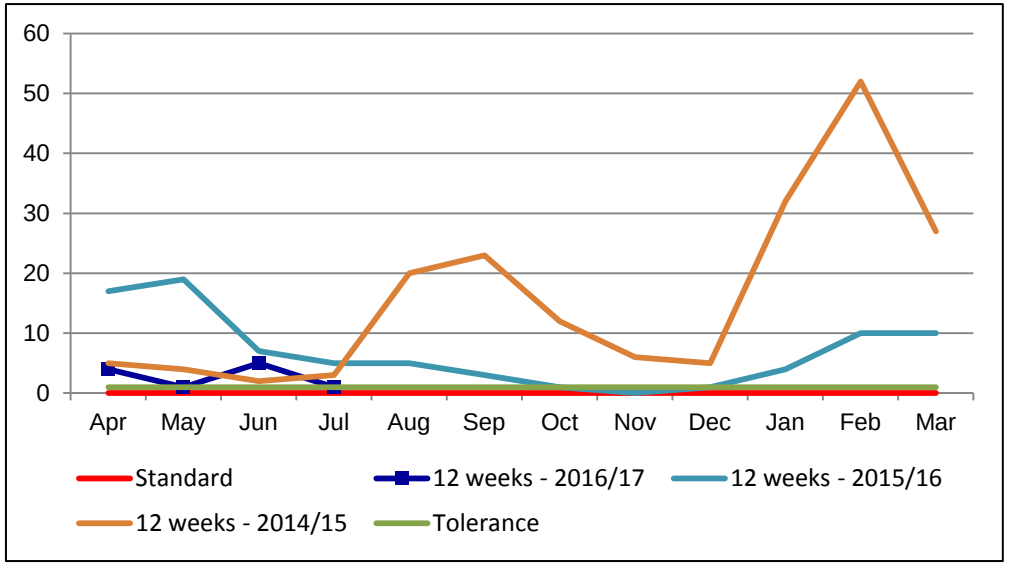
- **Cardiology:** capacity is an ongoing problem, work is ongoing with the service to look for solutions.
- **Chronic Pain:** in the process of implementing revised administrative processes and additional short-term capacity.
- **Diabetics / Endocrinology:** continues to be challenging. Short-term capacity has been organised with local clinicians whilst a longer term solution is identified.
- **Oral Surgery:** sickness absence had led to significant pressures in this area. The locum consultant has left, and interviews are scheduled for September. Locum weekend clinics are being organised to cover the service in the interim.
- **Gastroenterology:** demand for the service has been over the capacity of the service. Currently organising extra clinics within the service to help with the increasing demand. We have also been given some free Synaptik clinics from the Scottish Government which have now begun.

Stage of Treatment - 12 Weeks Waiting Time for Inpatients

Standard: 12 Weeks Waiting Time for Inpatients	**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
12 weeks - 2016/17	4	1	5	1								
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 July the number of patients reported waiting over **12 weeks for inpatient treatment** reduced to 1, following a number of short notice cancellations.

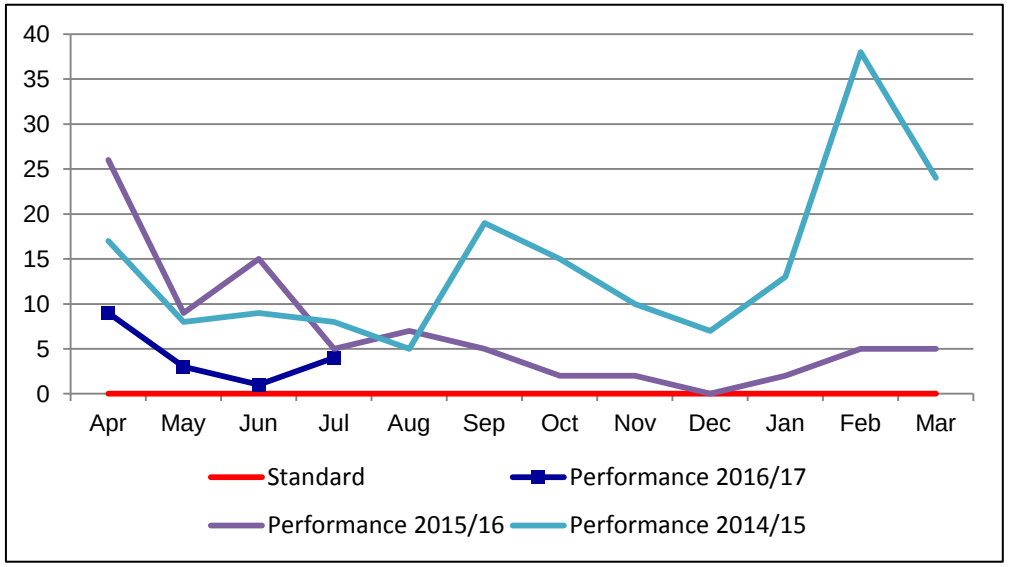
Actions:
- There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. In the interim weekend operating continues until end August 2016, with the support of Synaptik.
- The Scottish Government has allocated £250,000 to assist in the delivery 18 Weeks RTT, maximum 12 weeks Stage of Treatment for Outpatient Waits, maximum 6 weeks Diagnostic Waits for the 8 Key Tests and achievement of the maximum 12 weeks Treatment Time Guarantee.

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	3	1	4								
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 July 2016. As consistently reported, the TTG breach numbers can be affected by cancellations and other short-notice issues affecting theatre throughput, and this was a result of patients cancelled during June.

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

Actions:
- Short notice cancellations are reviewed on a daily basis.
- Work is ongoing to ensure cancellations are minimised and decisions are made as soon as possible.
- An 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.
- Cancelled patients are rebooked as soon as possible to accommodate their TTG date.

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	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Unavailable	165	122	95	81	81	60	74	81	70	83	90	107	115
Patient Advised	66.8%	60.7%	53.7%	50.3%	48.2%	40.8%	44.8%	48.5%	40.9%	46.4%	54.5%	55.2%	55.6%
Unavailable	82	79	82	80	87	87	91	86	101	96	75	87	92
Medical	33.2%	39.3%	46.3%	49.7%	51.8%	59.2%	55.2%	51.5%	59.1%	53.6%	45.5%	44.8%	44.4%
Total Unavailable	247	201	177	161	168	147	165	167	171	179	165	194	207
Total % Unavailable	21.1%	17.3%	16.3%	15.8%	16.2%	13.2%	15.4%	15.1%	15.9%	17.4%	15.1%	18.0%	19.1%

Monthly Unavailability by Specialty - as at 31st July 2016

	Available				Unavailable			
Specialty	**0 - 9 Weeks**	**10 - 12 Weeks**	**12+ Weeks**	**Total**	**Medical Un-available**	**Patient Advised Un-available**	**Total**	**% Un-available**
ENT	39	2	0	**41**	3	3	**6**	12.8%
General Surgery	139	24	1	**164**	22	28	**50**	23.4%
Gynaecology	48	5	0	**53**	10	2	**12**	18.5%
Ophthalmology	139	5	0	**144**	3	3	**6**	4.0%
Oral Surgery	10	0	0	**10**	1	3	**4**	28.6%
Other	162	4	0	**166**	4	11	**15**	8.3%
Trauma & Orthopaedics	210	31	0	**241**	38	56	**94**	28.1%
Urology	52	5	0	**57**	11	9	**20**	26.0%
Total	**799**	**76**	**1**	**876**	**92**	**115**	**207**	**19.1%**

Narrative Summary:
There has been a general downward trend in the number of patients with patient advised unavailability. This is due to the weekend operating lists in Orthopaedics. There is more capacity locally therefore less patients are offered treatment elsewhere. This imporves the unavailability as patients do not defer themselves to wait for treatment.

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.

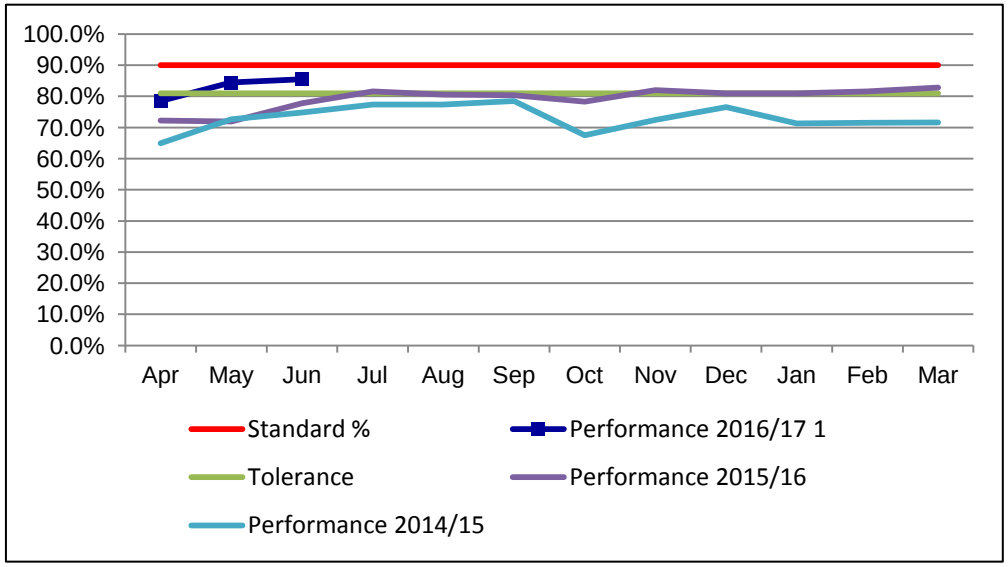
18 Weeks Referral to Treatment (RTT)

	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%	84.4%	85.5%									
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.

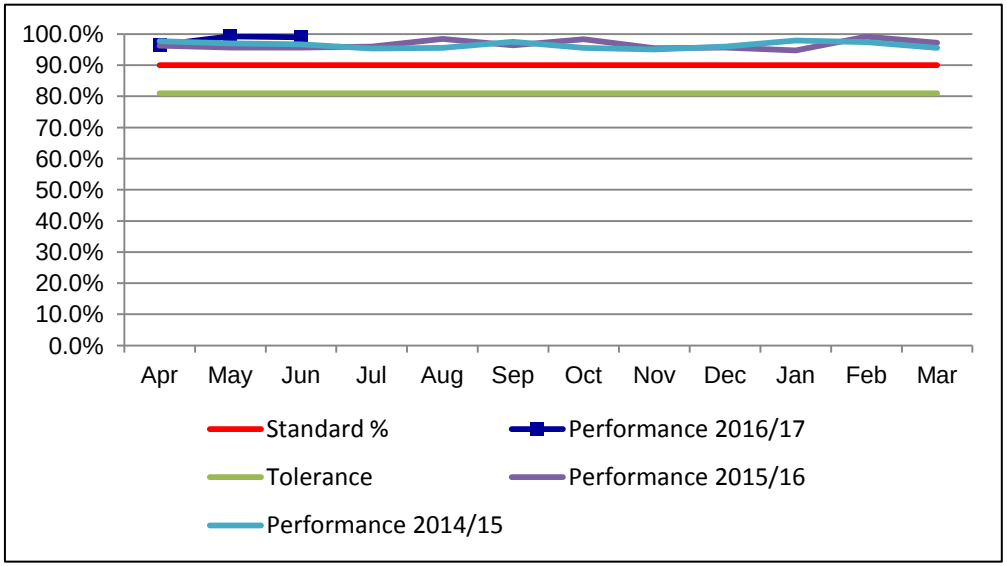
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: 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	96.5%	99.2%	98.9%									
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.

Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

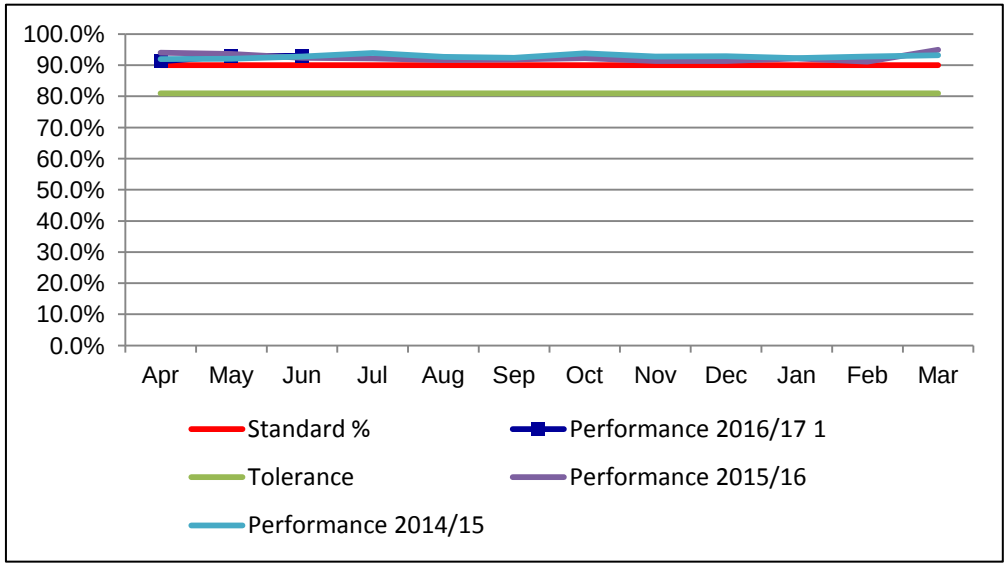
18 Weeks Referral to Treatment (RTT)

	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%	93.0%	93.0%									
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.

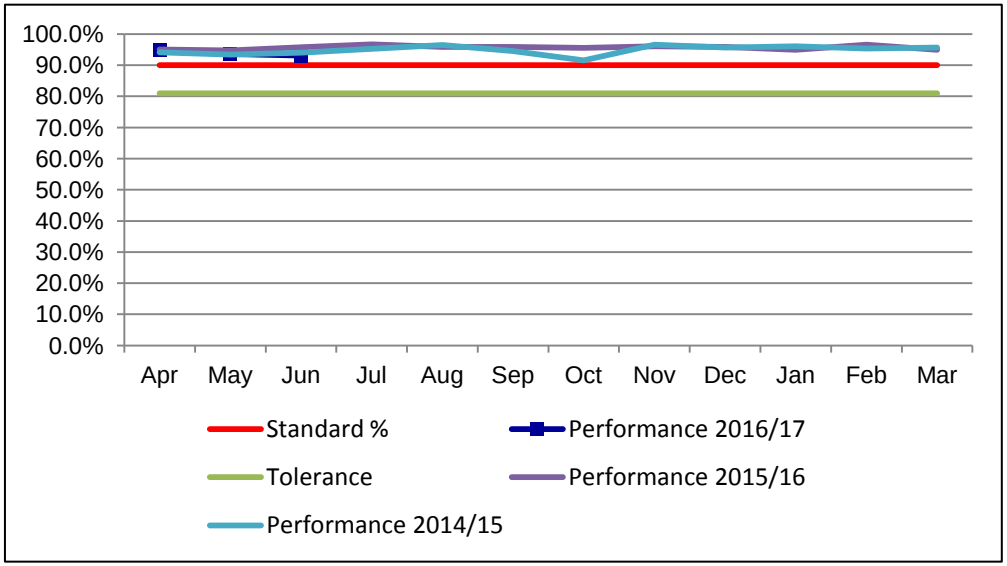
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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%	93.6%	93.1%									
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.

Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

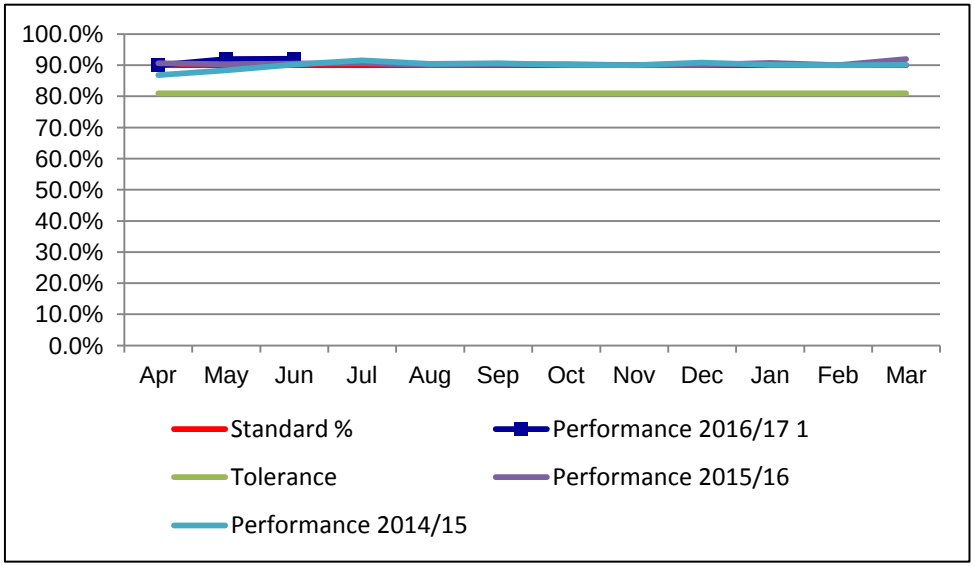
18 Weeks Referral to Treatment (RTT)

Standard: Combined 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 [1]	90.0%	92.0%	92.1%									
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.



Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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 as extra outpatient Synaptik clinics take place throughout July and August to clear the backlog. Audiology are also anticipating poorer performance until they can clear the backlog of patients within their service.

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.

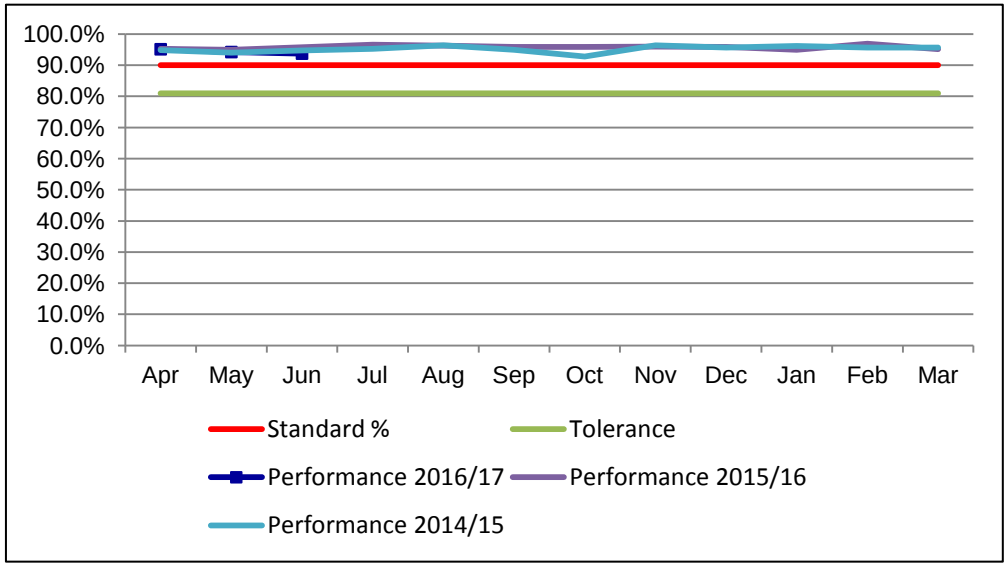
Actions:
- Work will continue during 2016/17 with the reduction in the number of 12 week breaches.

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%	94.2%	93.7%									
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.

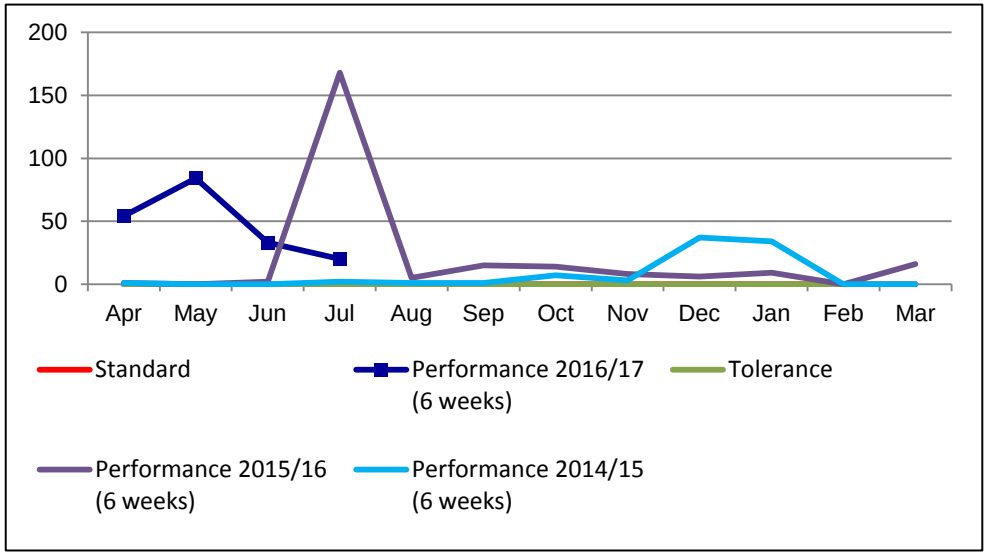
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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	84	33	20								
Performance 2016/17 (4 weeks)	307	430	165	137								
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 standard is that no patient waits more than 6 weeks for one of a number of identified key diagnostic tests. Locally this standard has been set at 4 weeks. July 2016 has seen a continued improved performance against both the 4 week and 6 week standard.

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	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Endoscopy	15	23	24	13	22	30	14	39	21	27	2	1
Colonoscopy	15	36	32	9	11	19	5	20	32	38	62	34
Cystoscopy	9	10	11	10	4	0	0	0	1	0	0	1
MRI	96	41	48	70	37	18	27	53	93	102	23	18
CT	0	9	27	18	23	5	8	50	86	81	8	25
Ultra Sound (non-obstetric)	12	10	0	0	0	2	0	3	74	182	70	58
Barium	0	0	0	2	0	8	0	0	0	0	0	0
Total	**147**	**129**	**142**	**122**	**97**	**82**	**54**	**165**	**307**	**430**	**165**	**137**

Narrative Summary and Actions:

Colonoscopy – The service continues to experience capacity issues due to the GI consultants contributing more to the General Medical rota.

Endoscopy – Performance has improved this month with no breaches over 6 weeks. This is partly associated with a reduction in GP referrals after a communication was sent out clarifying referral criteria, the referral rate will be monitored for 3 months to evaluate this impact of this. Additional lists continue to be carried out by the Nurse Endoscopist to meet waiting times.

Magnetic Resonance Imaging (MRI) & Computerised Tomography (CT) – MRI performance has been maintained in July but CT capacity has slipped slightly. Fewer additional sessions were carried out in July due to the availability of consultants which accounts for this change.

Ultrasound – The ultrasound service remains under pressure due to a vacant sonographer post which attracted no applicants after being advertised nationally this month. Short term locums continue to be utilised over the summer months to maintain the service. The Service is currently training a member of staff to be a Sonographer however they won't be qualified until 2017. Due to the challenging recruitment environment the service hopes to begin training another member of staff in Sonography next year to address sustainability issues, however funding is yet to be identified for this.

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 5 consecutive quarters and the 31-day standard has been achieved every quarter since it was established.

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	Apr to Jun-16
62-day standard	98.51%	97.44%	94.40%	98.70%	98.50%	98.50%	100%	97.22%
31-days standard	100%	100%	97.80%	100.00%	97.80%	98.20%	100%	98.18%

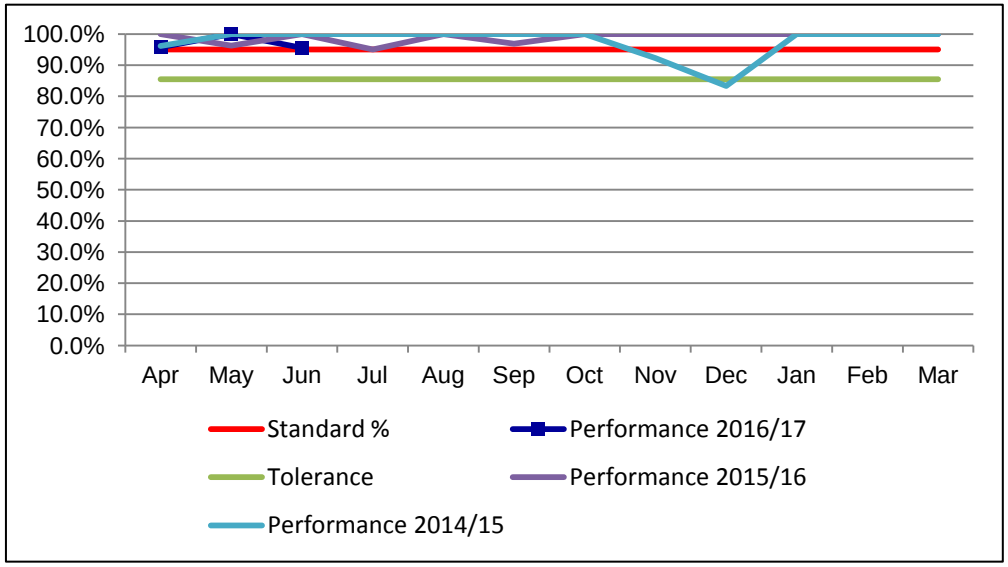
Cancer Waiting Times

	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	95.8%	100.0%	95.5%									
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.
- The Scottish Government has released £75k in non-recurring revenue to ensure cancer patients are continued to be prioritised and treated within the expected waiting times wherever clinically possible.

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

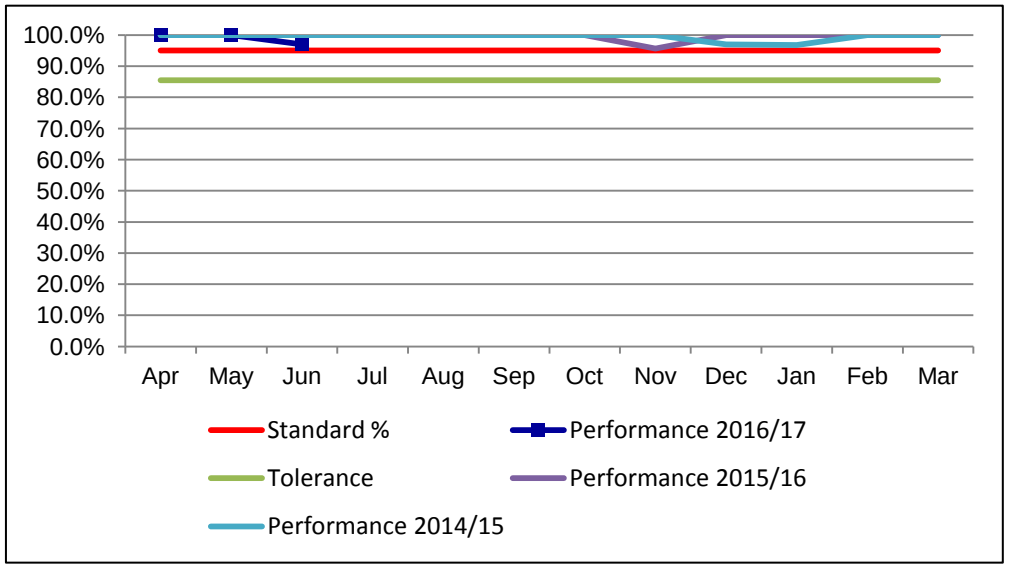
Cancer Waiting Times

	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	100.0%	100.0%	97.0%									
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



Narrative Summary:
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.
- The Scottish Government has released £75k in non-recurring revenue to ensure cancer patients are continued to be prioritised and treated within the expected waiting times wherever clinically possible.

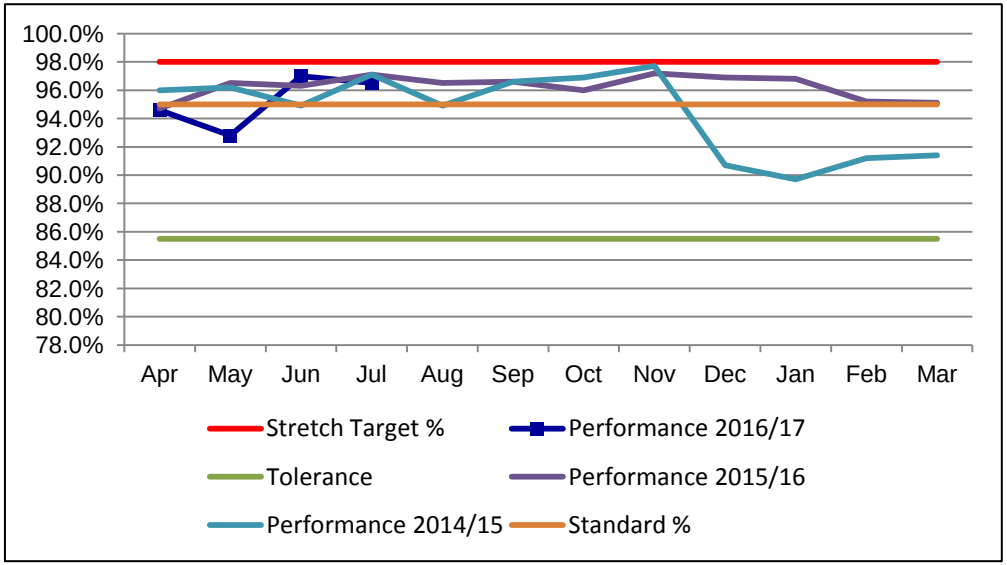
Please Note: There is a time lag of one month for this data

Accident & Emergency 4 Hour Standard

Standard:	Stretch Target	Standard	Tolerance
4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)	98.0%	95.0%	85.5%

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%	92.8%	97.0%	96.5%								
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.** We are working towards consistently achieving the 98% national stretch aim by October 2016. Following a challenging period in April and May, when attendances increased by 10% compared to the previous year the national standard of 95% was achieved in June and July 2016, reporting 97% and 96.5% respectively. We are currently working to a trajectory to achieve 97% in August, 97.5% in September and 98% by October.

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	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Flow 1	98%	99%	97%	99%	98%	99%	99%	99%	99%	98%	97%	96%	98%	98%
Flow 2	94%	94%	95%	95%	91%	97%	94%	98%	98%	91%	94%	92%	95%	94%
Flow 3	96%	97%	97%	94%	94%	93%	96%	91%	91%	92%	90%	87%	97%	95%
Flow 4	91%	94%	93%	91%	94%	99%	93%	94%	94%	92%	93%	91%	92%	93%
Total	**96%**	**97%**	**96%**	**95%**	**96%**	**97%**	**96%**	**96%**	**96%**	**95%**	**95%**	**93%**	**97%**	**97%**

Narrative Summary and Actions:
In July 2016, NHS Borders achieved the 95% Emergency Access Standard.

In both April and May, there were challenges in accessing inpatient beds, partly related to the number of delayed discharges within the system, which resulted in a number of breaches. In May, in particular, there were a significant number of occasions (5 compared to 1 in April) when there were more than 10 breaches in ED. These occasions were related to delays in first assessment by a doctor. Work to review medical staffing arrangements is underway. A more robust coordination and escalation process has been established. Performance is now being monitored in detail on a daily basis and an EAS recovery plan is in place. Medical and nursing staffing is being reviewed, based on a review of changes in ED presentations by time and day, and a plan for revising staffing models will be completed by end August for medical staff and end September for nursing staff. The expansion of Emergency Nurse Practitioner numbers and roles will be integral to this work. This will ensure that Flow 1 patients consistently achieve 98% stretch target, and will release medical capacity to focus on Flows 2, 3 and 4.

Please 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	88.9%	100.0%	83.3%									
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:
Standard is measured against a stroke bundle. The Stroke Bundle is made up of the following elements of the Scottish Stroke Care Standards;

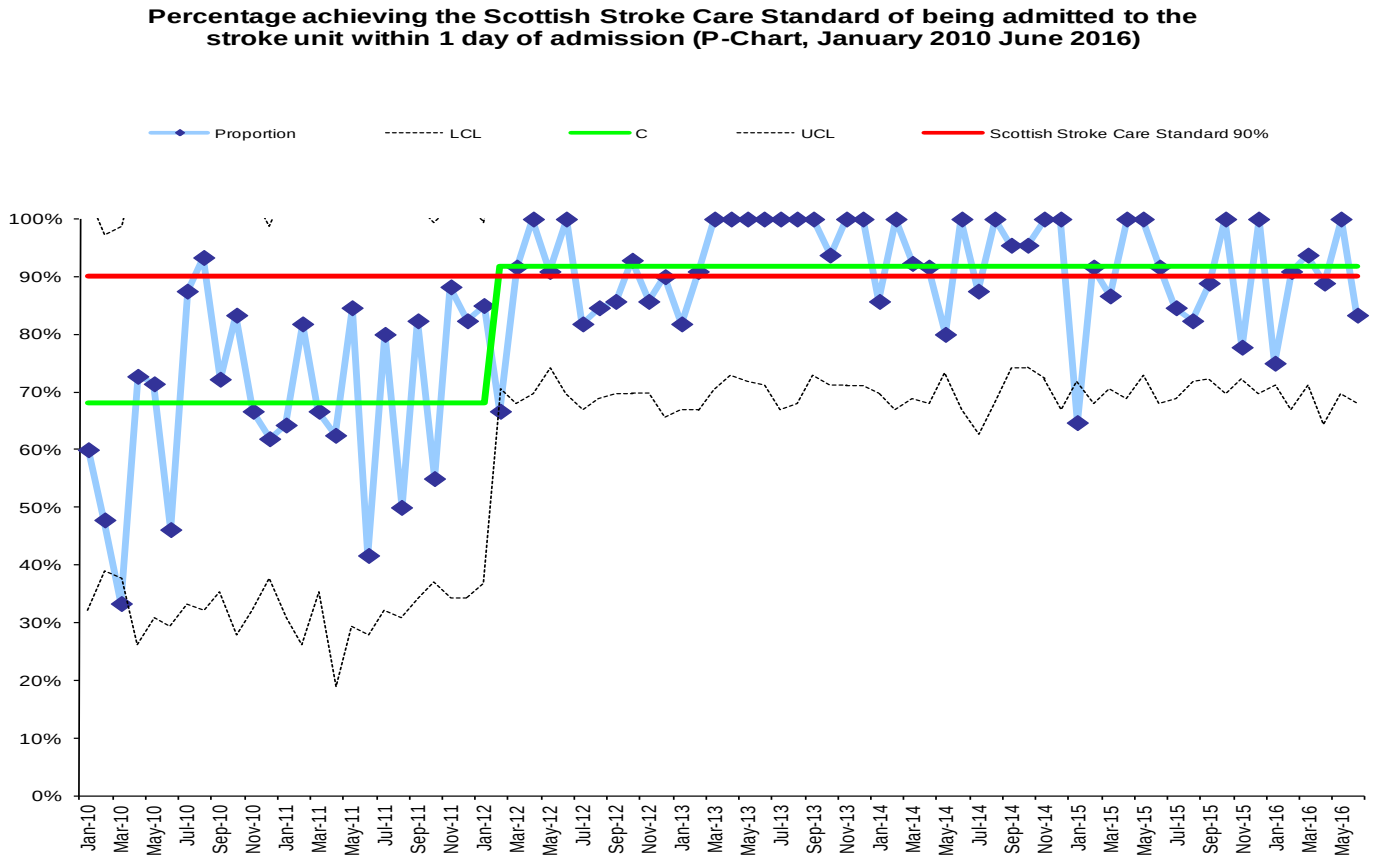
- admission to a dedicated Stroke Unit within 1 day of admission
- a swallow screen test within 4 hours of admission
- a brain scan within 24 hours of admission
- appropriate treatment initiated within one day of admission

However, our performance is measured against the national standard of no patients waiting more one day for admission to a Stroke Unit. In May 2016 the standard was achieved. In June 2016, two patients were not admitted to the stroke unit within 1 day of admission
- 1 patient's admission was delayed due to a delay in referral
- 1 patient was appropriately discharged on day 2 and was therefore not admitted to the stroke unit

Actions:
- Ensure that newly-admitted stroke patients have priority for admission to stroke unit within 1 day
- Review staffing levels within stroke unit and develop escalation plans to allow opening of additional beds when required

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

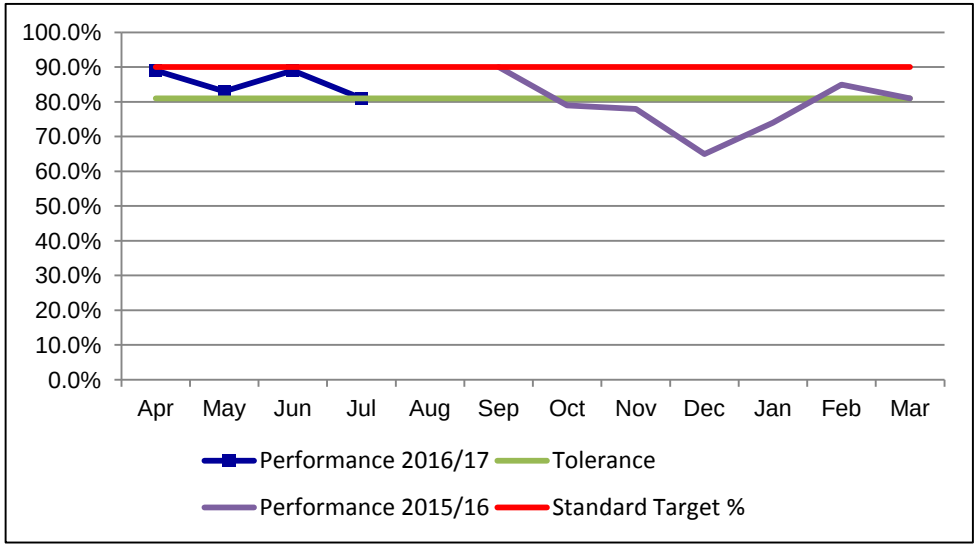
	Standard	Stretch	Tolerance
Standard: 18 weeks referral to treatment for Psychological Therapies	90.0%	95.0%	81.0%

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%	83.0%	89.0%	81.0%								
Total Patients Currently Waiting >18 Weeks:	91	85	103	113								
Performance 2015/16						90.0%	79.0%	78.0%	65.0%	74.0%	85.0%	81.0%
Total Patients Currently Waiting >18 Weeks:						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 for **Psychological Therapies referral to treatment** continues to fluctuate between 80 – 90% on a monthly basis. April 2016 reports 89% however there were fewer than average patients seen and therefore performance increased - this is an anomaly in the data rather than the start of an upward trend in performance.

Actions:
- Actions continue as previously described, and we continue to allocate resources to the areas with the longest waits.
- A Clinical Psychologist has been recruited for the East/West Team (where the majority of breaches & biggest waiting list is) using the Scottish Government funding to improve access to Psychological Therapies.
- A project plan is being drawn up to address underlying demand and capacity issues across the four years that SG funding is in place.
- Clinical space has been identified and earmarked for delivering Psychological Therapies in Gala Resource Centre and Galavale, with some minor works to take place before this is utilised.

CAMHS Waiting Times

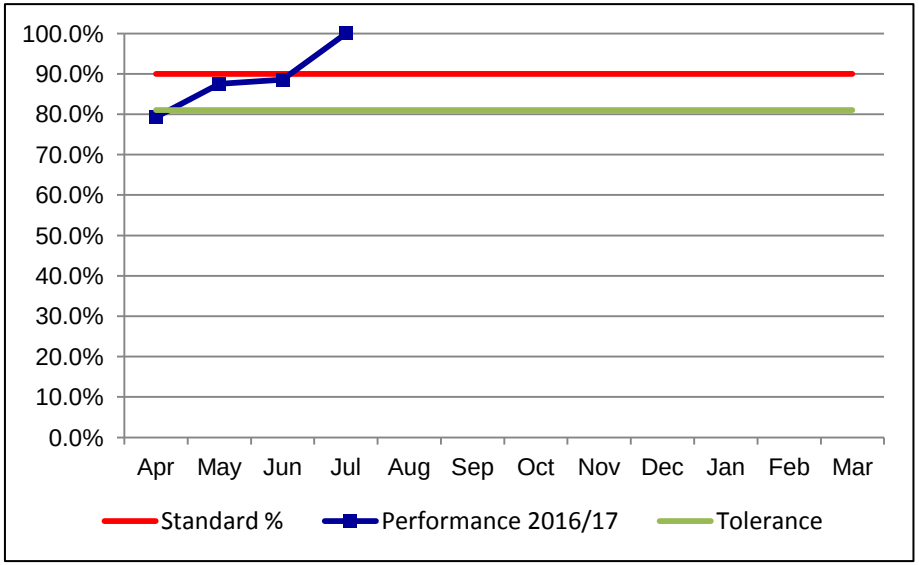
	Standard	Stretched	Tolerance
Standard: 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)	90.0%	95.0%	81.0%

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	79.3%	87.5%	88.6%	100.0%								
Performance 2015/16	-	-	-	-	-	-	-	-	-	-	-	79.0%

Please Note: there is no longer a 1 month lag time as the reporting process within the service has changed. Data will now be avaible in current 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:

As at the end of June 2016, performance was 88.6%. Green status was not achieved by the end of February 2016 as previously estimated, but we predicted that it would be reached in July 2016. July performance has now been reported and reached 100%.

The CAMHS service has had a particular challenge with sickness / absence, key staff leaving the service and being unable to appoint replacement consultant psychiatrist which had an impact on the ability to achieve the standard previously.

Actions:

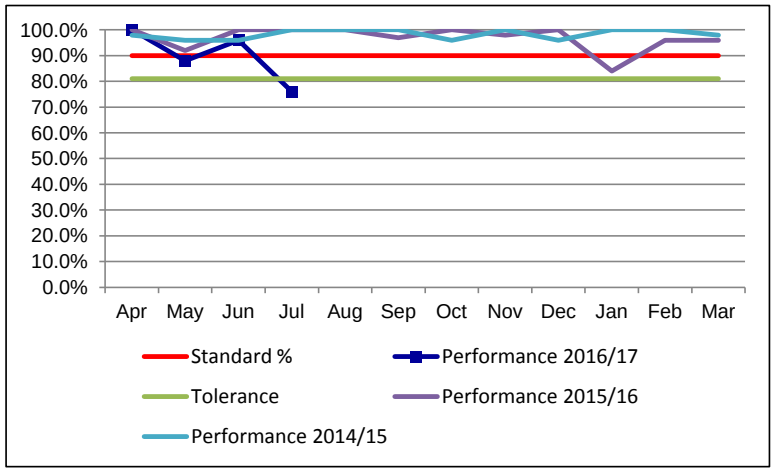
- The service are now implementing specific allocations meetings outwith the MDT to retain focus on referrals and the waiting list. This was implemented in January 2016 and continues to be maintained .
- The service have reviewed the waiting list and identified improvements in relation to the information available to the team.
- The service is identifying any child waiting 15 weeks or over and ensuring they are allocated an appointment within the following three weeks wherever possible, to reduce the wait.

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 %	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%	88.0%	96.0%	76.0%								
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%.

NHS Borders Addiction Services during this financial year are going through a period of staff shortage which is as a result of staff leaving the service and being unable to recruit to posts. This applies particularly to the Consultant post. The service is not in a position to attract to temporary posts which have emerged as a result of the announcement that NHS Borders Addiction Services may be expected to make 20% savings on their budget supplied by ADP from 1st April 2017. (Full funding is in place for 2016/17). The delay in announcement of Drug Treatment and Testing Oorder (DTTO) budget and then no interest in the temporary backfill post which had to be re-advertised is a further issue. Finally there are gaps between people leaving and recruiting and there is impact to the service with the introduction of the new parental leave policy.

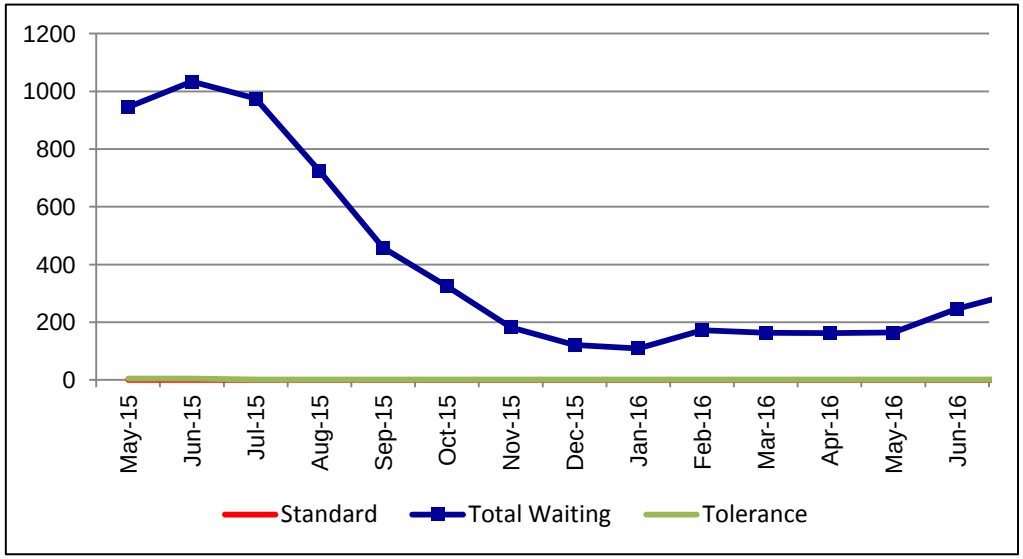
Actions:
All these issues have had a significant impact on the waiting times. The potential 20% savings will have a continued impact on capacity for the services, however, there is potential to improve the situation over the short term by the following actions:
- The temporary band 5 post has been recruited to and the service hopes that the person will be able to take up post in the near future.
- The Primary Care Service has been closed temporarily due to lack of referrals and the band 6 nurse has been moved into the Community Addictions Team. We hope to advertise the Consultant post again in the near future once the 20% savings have been confirmed.
- We will be advertising the 20 hour band 6 post that is about to be vacated.
- Admin have recruited to a band 3 Secretary post to replace the one day temporary vacancy and the person should take up post by the beginning of September.
- An audit of every service user's case file is being undertaken to ensure quality, care.

AHP Waiting Times

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

Actual Performance (lower = better performance)

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**975**	**725**	**457**	**324**	**182**	**121**	**109**	**172**	**163**	**162**	**164**	**246**	**305**
Occupational Therapy	12	16	11	13	13	13	21	19	26	2	11	22	11
Physiotherapy	955	705	439	303	158	105	79	139	125	144	134	200	262
Podiatry	0	0	0	0	0	0	0	0	0	0	0	0	0
Speech & Language Therapy	0	0	0	1	1	0	0	0	2	4	1	2	2
Nutrition & Dietetics	8	4	7	7	10	3	9	14	10	12	18	22	30



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
Ongoing clinical gaps (15%) are impacting on capacity. 3 locums in place with a plan to reduce as the vacant posts are recruited to. 3 x band 5 staff are starting at the end July / beginning of August. Permission has been given to pre-load staffing - 2 additional band 5 staff for 1 year to fill gaps.

The Physiotherapy Service is now reporting nationally on new MSK target of 90% of patients seen within 4 weeks. 590 patients are waiting over 4 weeks with an average waiting time of 6 weeks.

Nutrition and Dietetics
Data provisional as being checked by the dietetic service lead.

Occupational Therapy
The waiting time breaches are for Learning Disability (LD) 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. There are 10 Occupational Therapy breaches for LD on the waiting list, made up of 8 waiting over 9 weeks and 1 waiting over 18 weeks. The caseload and waiting list is reviewed regularly by the LD team manager alongside the Lead Occupational Therapist.

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

LDP Standards:

Performance in Partnership

Delayed Discharges

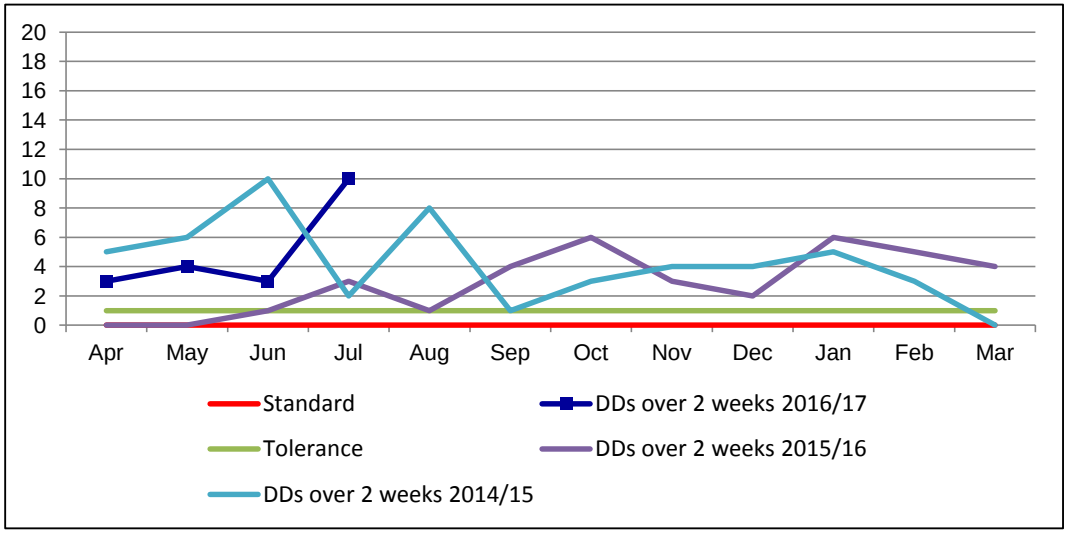
	Standard	Tolerance
Standard: Delayed Discharges - delays over 72 hours	0	1

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
DDs over 2 weeks 2016/17	3	4	3	10								
DDs over 72 hours (3 days) 2016/17	6	8	7	15								
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).

Please Note: The census date changed nationally in July 2016 from 15th of every month to the end of every month



Narrative Summary:
A new national target of zero delays over 72 hours came into force on 1st April 2016. New definitions for recording delayed discharges were introduced on the 1st July 2016.

NHS Borders continues to face challenges with delayed discharges, which impacts on patient flow across our hospitals.

SBC hosted Professor John Bolton to help shape our local improvement plan.

Actions:
No action update received from service.

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 and total capacity in Care Homes in Borders, particularly for more complex cases.
- A number of complex cases with a significant length of stay.
- An increasing trend in large packages of home care.

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. There is currently a daily meeting to review progress across the system.

Actions:
- Review Home Care and Rapid Response availability and use, continue with increases in staffing of SBCares and continue to investigate alternative providers.
- Update on refurbishments of Salt Greens and Waverley and timeline to reopening of beds
- Home Care availability, implement Matching Unit
- A redesign of the Discharge Hub and streamlining of the process has begun.
- Host advisory visit from JIT (completed in March) and John Bolton (from Glasgow) - due in August.
- Revise NHS Discharge Policy and Processes based on output from JIT visit
- Implement 72hr reporting approach
- 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
- 3 workshops undertaken to review the current pathway for patients that lack capacity and recommendations for changes to current practice proposed.

Key Performance Indicators

Cancellations

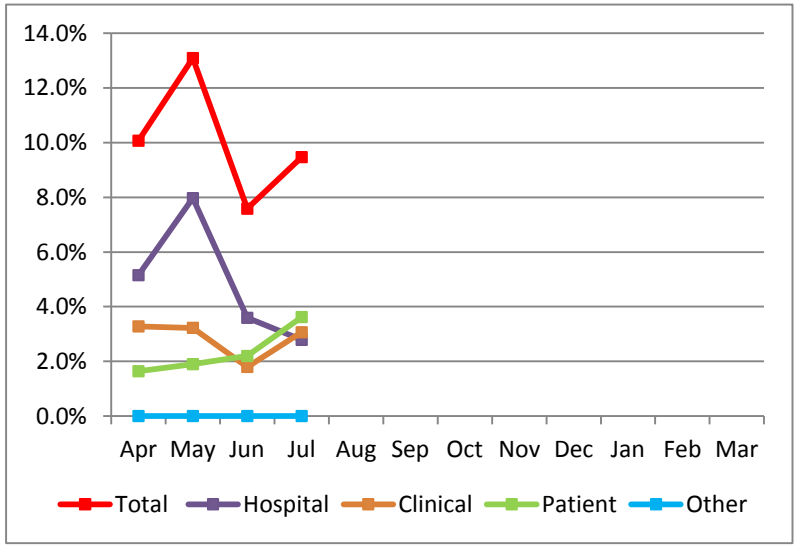
Hot Topic: Cancellations

Target & Tolerance

[1] Hospital Cancellation Rate – <1.5% Green, 1.5% Amber, >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%	13.1%	7.6%	9.5%								
Hospital	5.2%	8.0%	3.6%	2.8%								
Clinical	3.3%	3.2%	1.8%	3.1%								
Patient	1.6%	1.9%	2.2%	3.6%								
Other	0.0%	0.0%	0.0%	0.0%								



Narrative Summary
The percentage of hospital cancellations has impoved. The percentage of all procedures has also reduced from 13.1% in May to 7.6% in June. The % of hospital cancellations reduced significantly to 1.8% with w/c 27th June reporting 0 hospital cancellations.

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.

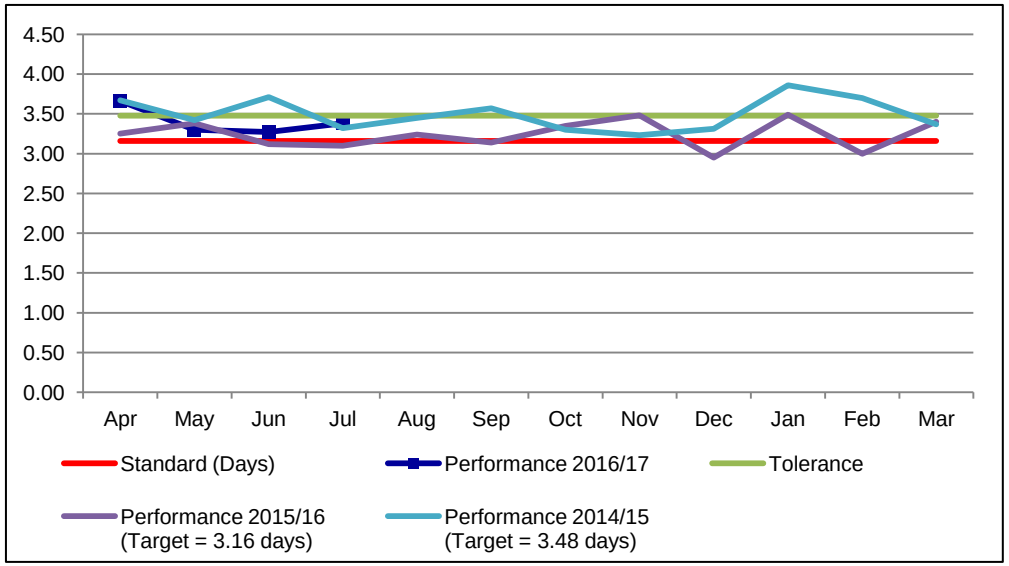
Detailed reviews of the reasons behind the lack of available beds are being undertaken by services on an ongoing basis in an effort to alleviate the pressures. The most significant action will be the implementation of the new theatres and surgical flow model - it is anticipated that this will be implemented in Winter 2016/17 subject to agreement.

BGH Average Length of Stay

Standard: Reduce BGH Length of Stay	Target	Tolerance
	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	3.30	3.27	3.38								
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.

New targets were introduced from May 2014, which took into account the latest analysis from the Bed Model. These took 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.
- Work to remodel the inpatient footprint across unscheduled and planned care by the autumn of 2016 will also positively impact the overall length of stay.

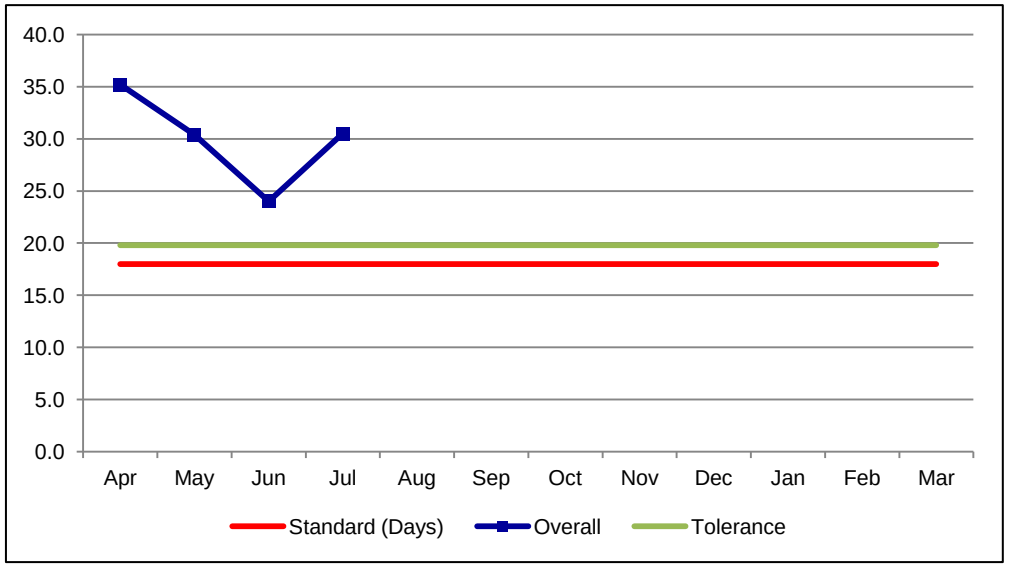
Community Hospital Average Length of Stay (LOS)

	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**	**30.4**	**24.0**	**30.5**								
Hawick	24.3	25.1	22.3	25.5								
Hay Lodge	54.3	33.2	25.1	43.5								
Kelso	31.3	26.1	23.4	23.2								
Knoll	46.2	45.2	26.1	39.4								

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



Narrative Summary:
There continues to be challenges within Community Hospitals in terms of LoS performance. The level of patient complexity and limited availability of post hospital care requirements add to the challenge to reduce LoS. Some of the long term delayed cases have recently been discharged

Actions:
- Senior Management attending all MDTs and support patient flow
- Clinical Community Manager attending and contributing to the Delayed Discharge Meetings and liaising with Social Work
- General Manager contributing review of pathways to manage patients who lack capacity
- General Manager joint working with Social Work. Senior Management to address underlying issues of capacity of home care and residential home services within the community.
- Daily/Weekly review of community hospital discharge profiles.
- Undertake self assessment against LOS best practice recommendations

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

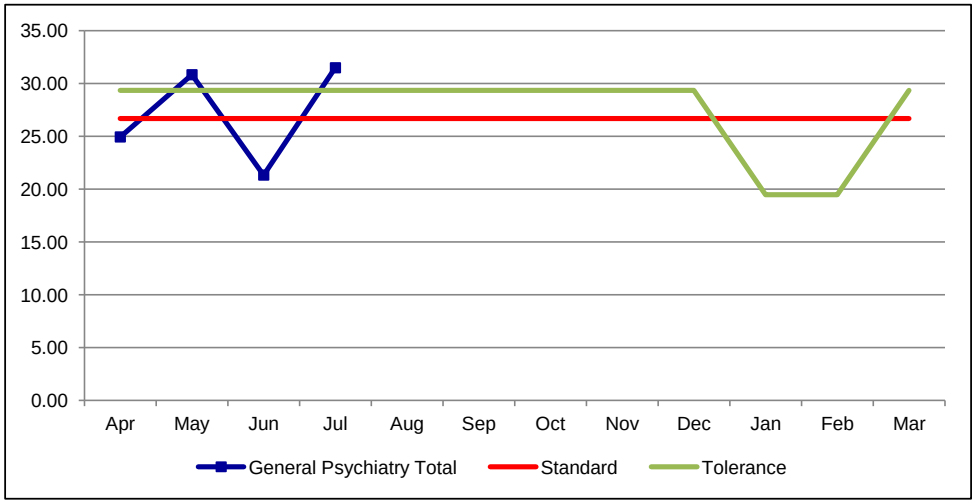
Standard: Reduce Mental Health Average Length of Stay	Standard	Tolerance
	Various	within 10%

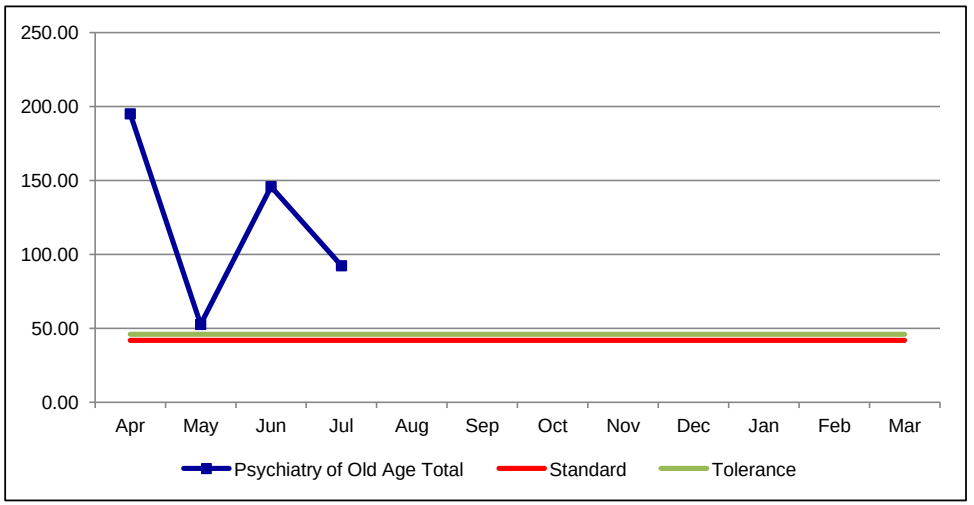
Actual Performance (lower = better performance)

	Standard (Days)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Huntlyburn	17.70	22.06	35.52	14.90	21.00								
The Brigs	42.83	34.20	11.50	64.30	33.30								
General Psychiatry Total	**26.70**	**24.95**	**30.84**	**21.34**	**31.50**								
Cauldshiels [1]	26.95	-	47.00	149.50	126.00								
Lindean	60.58	45.00	60.00	134.50	36.80								
Melburn Lodge [2]	111.63	345.00	-	-	112.00								
Psychiatry of Old Age Total	**41.82**	**195.00**	**52.57**	**145.75**	**92.27**								

[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 and no discharges in May or June 2016





Narrative Summary:
Mental Health LOS can fluctuate, particularly for older adults, depending on the numbers of discharges and the length of time a patient has been within the facility and is quite often skewed by one or two long stay patients. There were no discharges from Melburn Lodge in May or June 2016; it is a long stay ward and therefore by nature of these patients, length of stay will be increased.

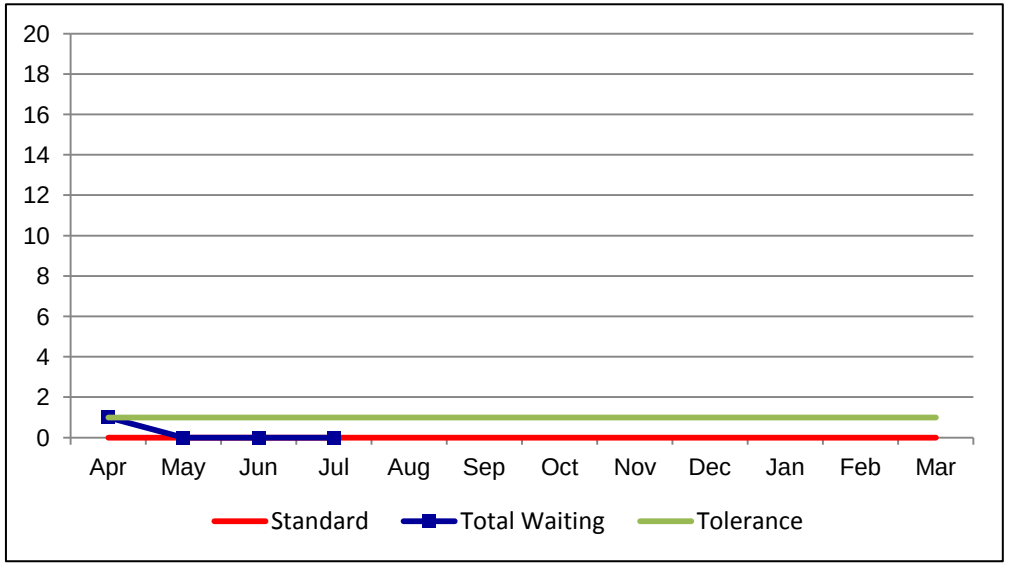
Actions:
- LOS is monitored within the performance scorecard at monthly Mental Health meetings and picked up with Senior Charge Nurses by exception. There are no routine actions specific to this target but work is underway to ensure patients have EDD's on admission to Mental Health Wards (as appropriate).

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**	**0**	**0**	**0**								
MH Older Adults - East	0	0	0	0								
MH Older Adults - South	0	0	0	0								
MH Older Adults - West	0	0	0	0								
East Team	1	0	0	0								
South Team	0	0	0	0								
West Team	0	0	0	0								



Narrative Summary:
Performance is green for all areas in this reporting month and the service is robust in the management of this target with very small numbers of patients being seen over 18 weeks. Each team continues to monitor their waiting list.

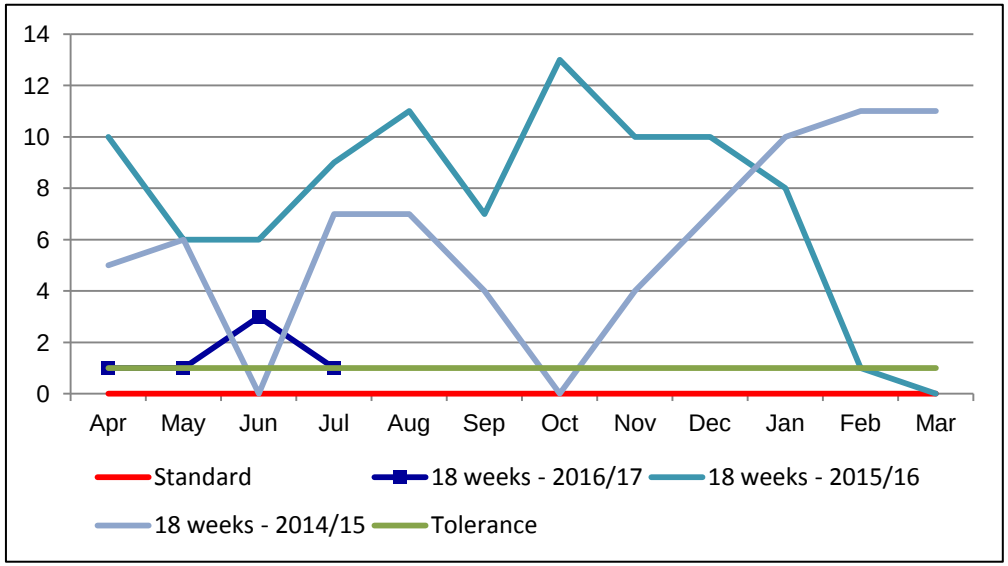
Actions:
- Continue to monitor and manage the waiting list within the performance scorecard at monthly Mental Health meetings and picked up with Team Managers by exception.

Learning Disability Waiting Times

HEAT Standard: Monitor and reduce Learning Disability Waiting Times	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
18 weeks - 2016/17	1	1	3	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 5 months. There is 1 patient waiting for an Occupational Therapy appointment.

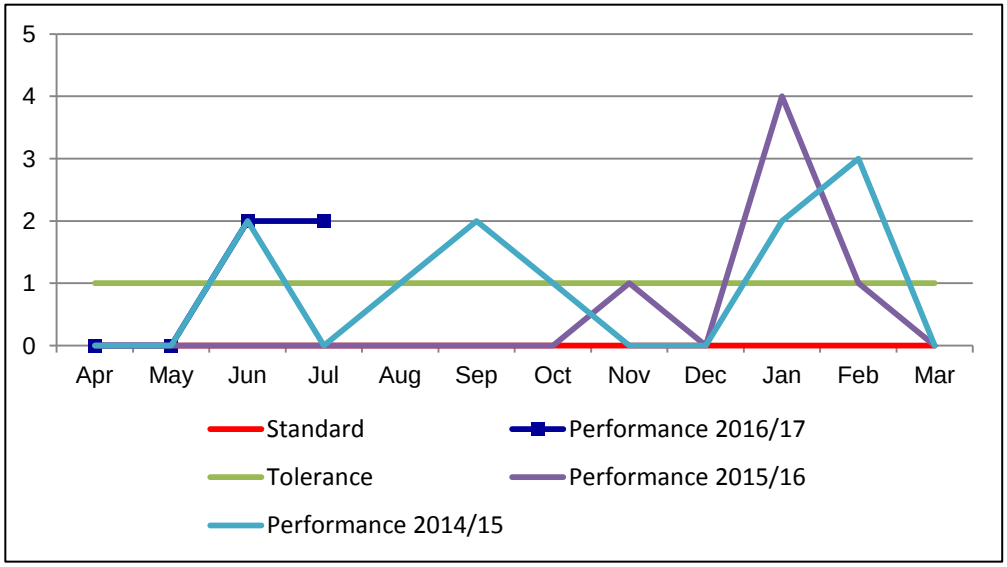
Actions:
- LD service and AHP lead working together to jointly support OT workload management.
- Continue to monitor and manage the waiting list.

Rapid Access Chest Pain Clinic (RACPC)

	Standard	Tolerance
Standard: 1 Week Waiting Target for RACPC	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	0	2	2								
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 however the 2 breaches in July 2016 are a result of a recording issue.

Actions:
- Continue to monitor and manage the waiting list.

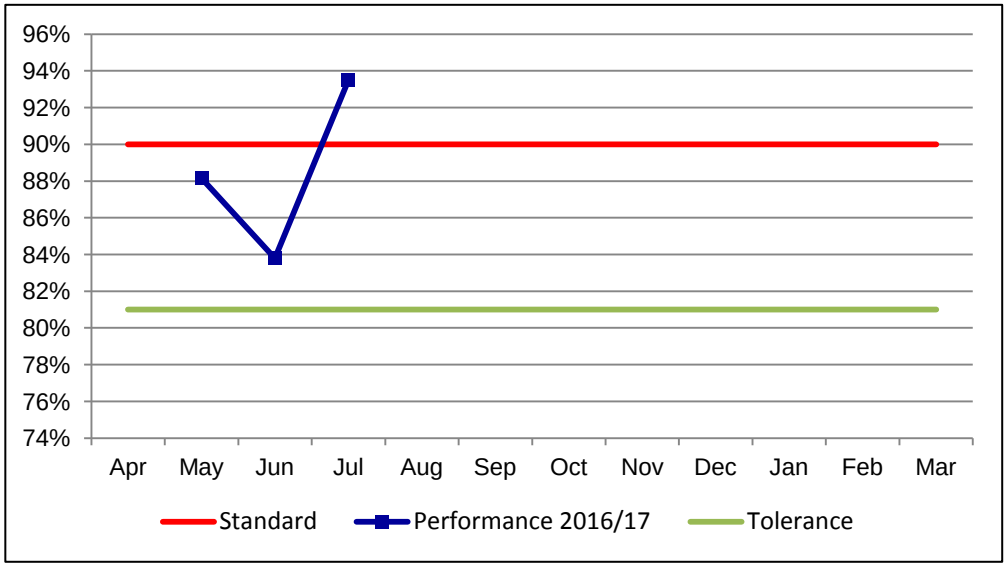
Audiology Waiting Times

	Standard	Tolerance
Standard: 18 Week Referral to Treatment for Audiology	90.0%	81.0%

Actual Performance (lower number of patients with active wait = 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		88.15%	83.80%	93.50%								
Patients with active wait over 18 Weeks		34	59	14								
Patients with active wait over 18 Weeks 2015/16	6	19	49	89	77	95	32		86			
Patients with active wait over 18 Weeks 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:
The standard of 90% of patients being seen within 18 weeks referral to treatment for Audiology was achieved in July 2016.

The audiology service now has a full compliment of staff and processes have been put in place to reduce waiting times across the service. July saw a significant increase in the number of patients being seen within the 18 weeks target set by the Scottish government.

Actions:
- The Service continues to undergo a thorough data cleansing exercise with support from the Waiting Times team which is improving the accuracy of data reported
- The service will continue to monitor productivity and identify areas for streamlining

Workforce Section

Supplementary Staffing

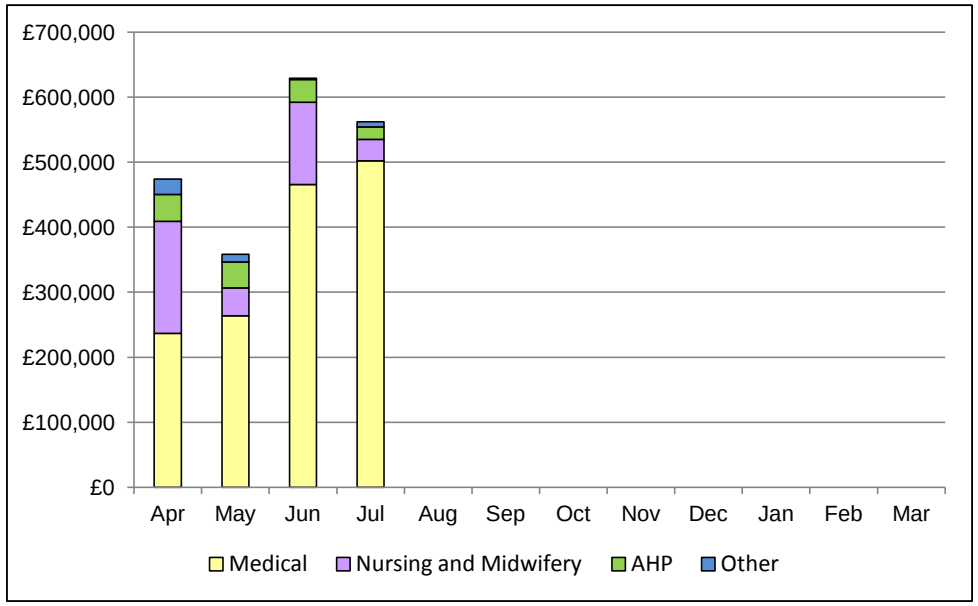
	Standard	Tolerance
Standard: Supplementary staffing - agency spend per month	0	0

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

Medical	£236,718	£263,682	£465,675	£501,928
Nursing and Midwifery	£172,119	£43,073	£126,542	£32,952
AHP	£41,435	£39,604	£35,067	£19,299
Other	£23,591	£11,810	£1,837	£7,740
Total Cost	**£473,863**	**£358,169**	**£629,121**	**£561,919**



Narrative Summary:
Theatre and ITU agency spend is tolerated as these are specialist areas which require specialist activity and skill mix and there is limited suitability of trained staff on the bank for these areas.

Theatre and ITU agency spend is included in the Nursing and Midwifery spend figure and the spend in these specialised areas for June & July is broken down below:

June 2016	**July 2016**
Theatre £21,841	Theatre £15,229
ITU £47,761	ITU £6,867

Actions:
- Ongoing rolling recruitment events are continuing to increase bank staff numbers and availability.
- All agency requests are being review by the director of nursing and finance team member
- Rotas within the hospital are also being reviewed to ensure maximum use of available staffing