Borders NHS Board

NHS BORDERS PERFORMANCE SCORECARD – SEPTEMBER 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 shows performance as at 30th September 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	Jul-16	Aug-16	Sep-16
Green – achieving standard	11	13	14
Amber – nearly achieving standard	9	5	6
Red – outwith standard	8	10	10

Key Performance Indicators	Jul-16	Aug-16	Sep-16
Green – achieving standard	3	8	7
Amber – nearly achieving standard	4	1	2
Red – outwith standard	6	4	4

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

- 670 Alcohol Brief Interventions were delivered by end of September 2016, ahead of the 658 trajectory (page 13)
- 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 July 2016 (latest available data) 0.27 days against the standard of 0.47 (page 18)
- 93.8% of all referrals were triaged online in September 2016, above the standard of 90% (page 19)
- 40.3% of new born children were breastfed at 6-8 weeks for the quarter April – June 2016 (latest available data) (page 20)
- The rate of Emergency Occupied Bed Days for the over 75s was achieved in April 2016 (latest available data) with 3501 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% (latest available data) in August 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 August 2016 (page 39)
- Treatment of cancer within 62 days for urgent referrals of suspicion of cancer is also consistently being achieved – latest available data August 2016 (page 40)
- 93.3% of patients (latest available data) were admitted to the Stroke Unit within 1 day of admission in August 2016 (page 43)
- 100% of patients were seen within 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services in September 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 30th September 2016 are highlighted below:

- eKSF and PDPs recorded performance under the trajectories set during August 2016 (page 21 & 22)
- 317 patients waited over 12 weeks for an outpatient appointment in September 2016 against a standard of 0 (page 26)
- 2 patients waited over 12 weeks for an inpatient appointment in September 2016 against a standard of 0 (page 27)
- In September 2016, 4 patients breached the 12 weeks Treatment Time Guarantee (page 28)
- 77.2% of patients were seen within 18 weeks referral to treatment for Admitted Pathway Performance in August 2016 (latest available data), against a national standard of 90% (page 30)
- 28 breaches of the 6 week diagnostic waiting time standard were reported in September 2016 (page 36)
- 78% of patients were seen within 18 weeks referral to treatment for Psychological Therapies in September 2016, against a national standard of 90% (page 45)
- 69% of patients were seen within 3 weeks of referral to receive appropriate drug or alcohol treatment that supports their recovery in September 2016, against a national standard of 90% (page 47)
- 233 patients waited over 9 weeks for AHP services against a standard of 0 patients in September 2016 (page 48)
- 7 patients were delayed more than 2 weeks to be discharged from hospital in September 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.

Some of the standards in the scorecard are reported with a time lag, the various reasons are outlined below.

Standard	Explanation
Dementia - Post Diagnostic Support *(page 11)*	The standard is that people newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support therefore there is a 13 month lag time to allow the full 1 year support to be reported.
Smoking Quits *(page 14)*	There is a 6 month lag time for reporting to allow monitoring of the full 12 week quit period.
Same Day Surgery *(page 17)*	There is a 2 month time lag due to extracting the information from validated SMR1 data. This is due to there being a national target of 6 weeks to complete coding of records before national submission so data is most complete after this point.
Pre-operative stay *(page18)*	There is a 2 month time lag due to extracting the data from information SMR1 data. This is due to there being a national target of 6 weeks to complete coding of records before national submission so data is most complete after this point.
Breastfeeding *(page 20)*	There is a 6 month lag time for local data. It is reported quarterly and with a time lag to allow data collection at the 8 week review.
Emergency Occupied Bed Days *(page 23)*	There is a 6 month lag time. Monthly, rolling year data shows the most recent available to an acceptable level of completeness (based on ISD's latest assessment of SMR record submissions and backlogs).
18 Weeks Referral to Treatment *(page 30-35)*	There is a 1 month time lag for this data to allow the Performance Scorecard to include the national ISD return information which gets submitted at the end of each month after the Scorecard deadline.
Cancer Waiting Times *(page 38-40)*	Data is reported from the national monthly management information for Cancer Access Standards therefore there is a 1 month lag time.
Stroke Unit Admission *(page 43)*	Stroke Unit Admission data is reported with a 1 month lag time due to the time difference between the scorecard deadline and the national extract deadline.

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 September 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		

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NHS Borders

PERFORMANCE SCORECARD

As at 30th September 2016

September 2016

Planning & Performance

Month

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Contents

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. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

Current Performance Key			
R	Under Performing	Current performance is significantly outwith the trajectory set.	Outwith the standard by 11% or greater
A	Slightly Below Trajectory	Current performance is moderately outwith the trajectory set.	Outwith 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 ↓	A ↔	A ↑	A ↔	-						
Alcohol Brief Interventions [2]	R	R ↑	A ↑	A ↑	A ↑	G ↑						
Smoking cessation successful quits in most deprived areas [3]	-	-	-	-	-	-						
Sickness Absence Reduced	R	R ↓	R ↓	A ↑	R ↓	A ↑						
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [4]	G	G ↑	G ↓	G ↑	G ↓	-						
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [4]	G	G ↔	G ↓	G ↑	G ↔	-						
18 Wk RTT: 12 wks for outpatients	R	R ↓	R ↓	R ↑	R ↑	R ↓						
18 Wk RTT: 12 wks for inpatients	R	A ↑	R ↓	A ↑	R ↓	R ↓						
18 Wk RTT: 12 weeks TTG	R	R ↑	A ↑	R ↓	G ↑	R ↓						
18 Wk RTT: Admitted Pathway Performance [5]	R	A ↑	A ↑	R ↓	R ↓	-						
18 Wk RTT: Admitted Pathway Linked Pathway [5]	G	G ↑	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 ↔	G ↓	G ↑	-						
18 Wk RTT: Non-admitted Pathway Linked Pathway [5]	G	G ↓	G ↓	G ↑	G ↑	-						
Combined Performance [5]	G	G ↑	G ↑	G ↓	G ↑	-						
Combined Performance Linked Pathway [5]	G	G ↓	G ↓	G ↓	G ↑	-						
6 Week Waiting Target for Diagnostics	R	R ↓	R ↑	R ↑	R ↓	R ↓						
4-Hour Waiting Target for A&E	A	A ↓	G ↑	G ↓	A ↓	A ↑						
No CAMHS waits over 18 wks	R	A ↑	A ↑	G ↑	G ↔	G ↔						
No Psychological Therapy waits over 18 wks	A	A ↓	A ↑	A ↓	R ↓	R ↑						
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G	A ↓	G ↑	R ↓	R ↑	R ↓						
No Delayed Discharges over 2 Wks	R	R ↓	R ↑	R ↓	R ↓	R ↑						
New patient DNA rate	R	R ↑	R ↑	R ↓	A ↑	A ↓						
Same day surgery [6]	A	A ↓	A ↑	A ↓	-	-						
Pre-operative stay [6]	G	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**
Online Triage of Referrals	G	G ↑	G ↓	G ↓	G ↑	G ↓						
Increase the proportion of new-born children breastfed at 6-8 weeks [7]	-	-	G ↑	-	-	-						
eKSF annual reviews complete	R	R ↑	R ↑	R ↑	R ↑	R ↑						
PDP's Complete	R	R ↑	R ↑	R ↑	R ↑	R ↑						
Emergency OBDs aged 75 or over (per 1,000) [8]	G ↑	-	-	-	-	-						
Admitted to the Stroke Unit within 1 day of admission [9]	A	G ↑	A ↓	G ↑	G ↑	-						
Diagnosis of dementia	A	A ↓	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 and reported 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 ↓	R ↓	R ↑						
Cancellations	Hospital	R	R ↓	R ↑	R ↑	R ↓	R ↑						
	Clinical	R	R ↑	G ↑	A ↓	G ↑	A ↓						
	Patient	G	G ↓	G ↓	A ↓	G ↑	G ↓						
	Other	G	G ↔	G ↔	G ↔	G ↓	G ↑						
Borders General Hospital Average Length of Stay		R	A ↑	A ↑	A ↓	A ↓	R ↓						
Community Hospitals Average Length of Stay		R	R ↑	R ↑	R ↓	R ↑	R ↓						
Mental Health Average Length of Stay General Psychiatry Total		G	R ↓	G ↑	R ↓	G ↑	G ↓						
Mental Health Average Length of Stay Psychiatry of Old Age Total		R	R ↑	R ↓	R ↑	R ↑	A ↑						
Mental Health Waiting Times (Patients waiting over 18 weeks)		A	G ↑	G ↔	G ↔	G ↔	G ↔						
Learning Disability Waiting Times (Patients waiting over 18 weeks)		A	A ↔	R ↓	A ↑	G ↑	G ↔						
Rapid Access Chest Pain Clinic		G	G ↔	R ↓	R ↔	G ↑	G ↔						
Audiology 18 Weeks Waiting Times [1]		-	A -	A ↓	G ↑	G ↓	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:

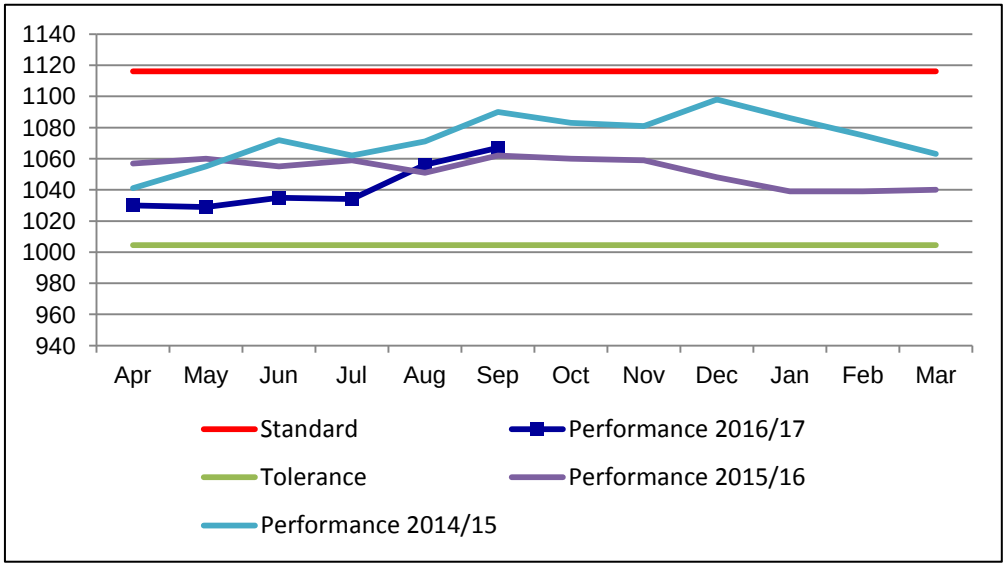
General

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	1056	1067						
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 increased in both August and September 2016. Work continues as described below.

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.
- Practices have been identified to work with next - data is awaited from P&P to cross check ePEX against the register.

Dementia - Post Diagnostic Support (PDS)

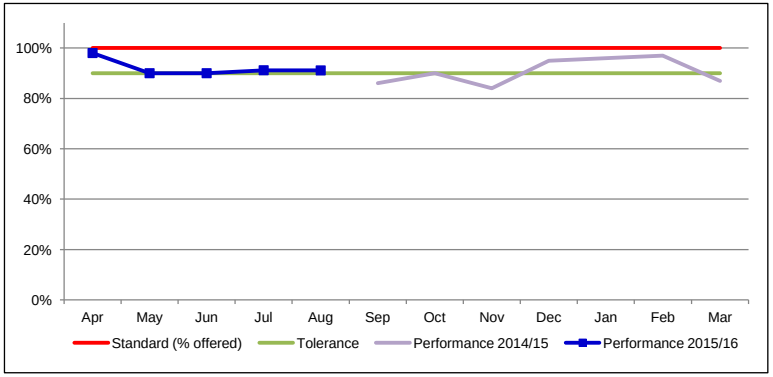
	Standard	Tolerance
Standard: People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support	100%	within 10%

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	166	186	205							
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	185	204	225							
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%	90%	91%	91%							
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 shown an improvement over the last 5 months (year lag time) and has been within 10% of the standard. 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 , August and September and will be reviewed in October.
- Post Diagnostic Support Excellence Programme has provided the basis for further training for staff and informed the action plan regarding further learning. This commenced at the end of August and is still being delivered.

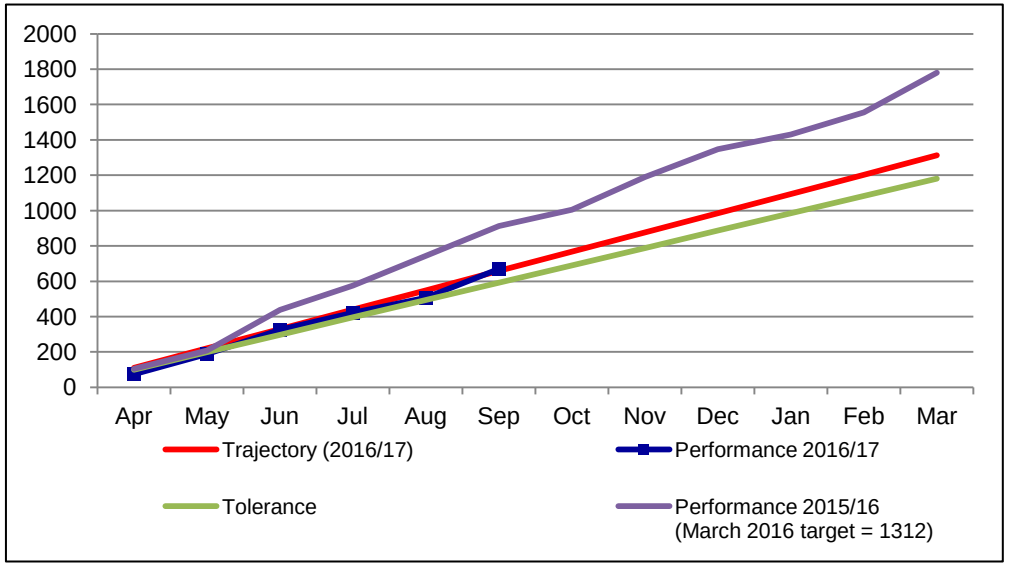
Alcohol Brief Interventions (ABI)

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	422	506	670						
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:
Performance is on target with 51% of the annual target delivered at the end of quarter 2. This is an improvement on last month due to some historical lag in reporting and one GP practice screening all patients attending during a short time period.

Actions:
- A&E performance remains low. ADP Support Team have offered to support the service. Conversations are ongoing.

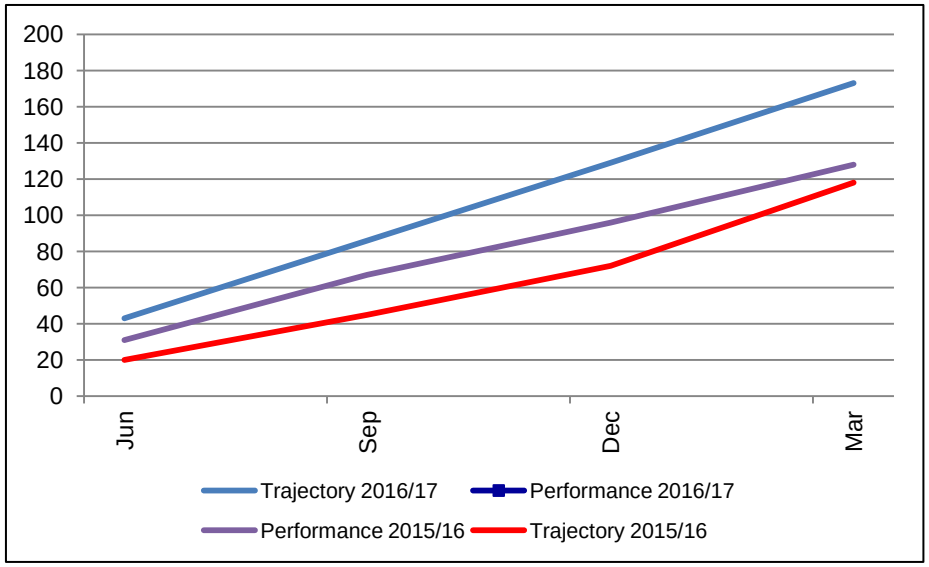
Smoking Quits

	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 6 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 2015/16 standard of 118 was achieved with 128 quits. The 2016/17 standard of 173 quits at 12 weeks represents a 47% increase compared to last year. Data for the first quarter of 2016/17 will be reported in December. This level of increase is likely to be challenging following the significant increase from the previous year. Currently performance is sitting at 25 quits. While this is likely to increase by time of national reporting it is unlikely that we will achieve target for this period.

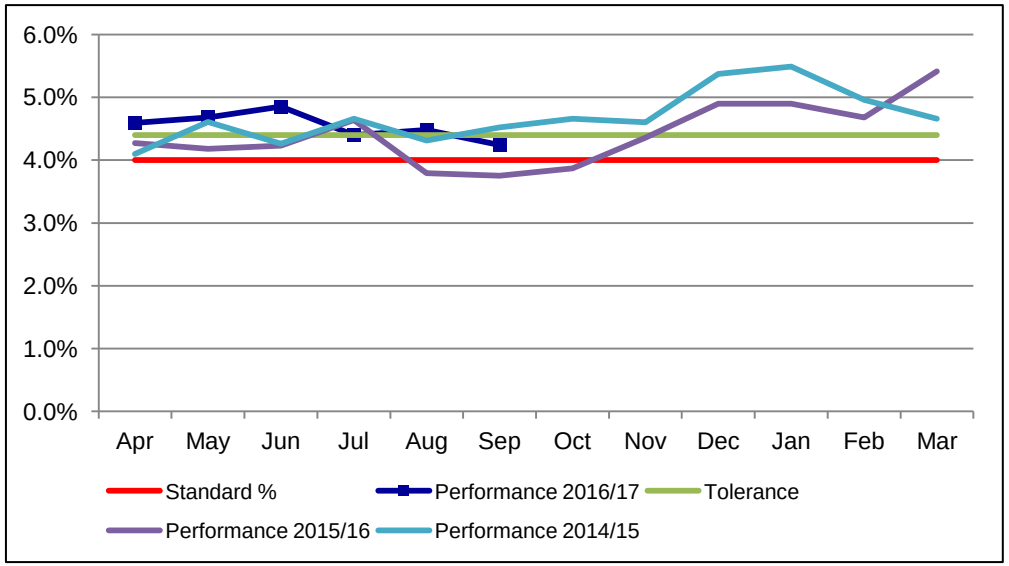
Actions:
- Quit4Good (cessation service) are working with mental health services to improve smoking cessation support and implementation of Smoke Free
- Local data will be monitored prior to national reporting to ensure work is underway to improve smoking cessation support to mental health services.
- motivational interviewing training planned to support delivery of target in community pharmacy setting

Sickness Absence

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

Actual Performance (lower % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Performance 2016/17	4.6%	4.7%	4.9%	4.4%	4.5%	4.2%						
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. September 2016 reports 4.2% which is within the tolerance set.

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.

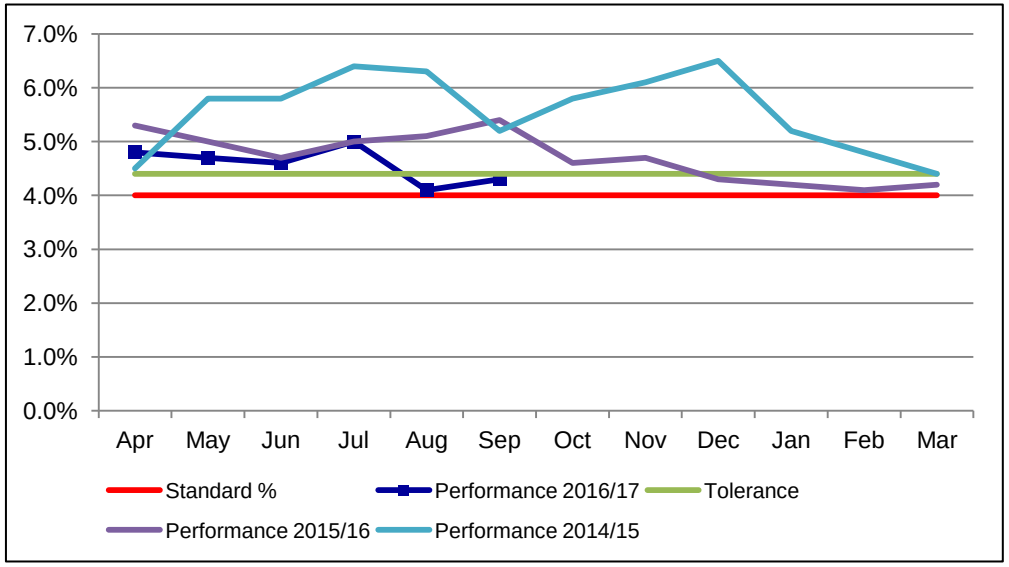
Actions:
- HR continue to be a support service to the Clinical Boards by providing advice and support in managing sickness absence as well as proactively identifying areas where rates are high.
- Monthly sickness absence reports are provided to each Clinical Board, these detail trends, rates, the level 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%	4.1%	4.3%						
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:
Following the 6 week media campaign on the cost and impact of missed appointments low DNA rate has continued to be lower than for the same months in previous years.

Actions:
- Exploring how to improve staffing for making telephone calls to patients with a history of missed appointments
- Further analysis of DNAs to see where future interventions are likely to be most effective.

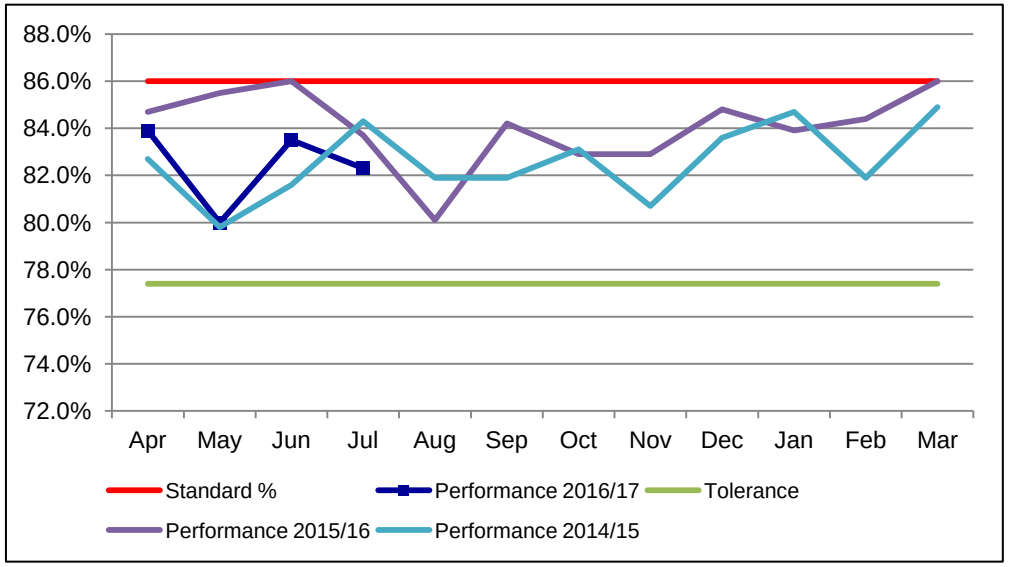
Same Day Surgery

	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%	83.5%	82.3%								
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 however this has not been sustained.

The main reasons for patients not being treated as a day case are:
- Anaesthetic or medical reasons
- Surgical reasons – e.g. bleeding, pain, unexpected problems during surgery, operation turned out to be more complex than 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*

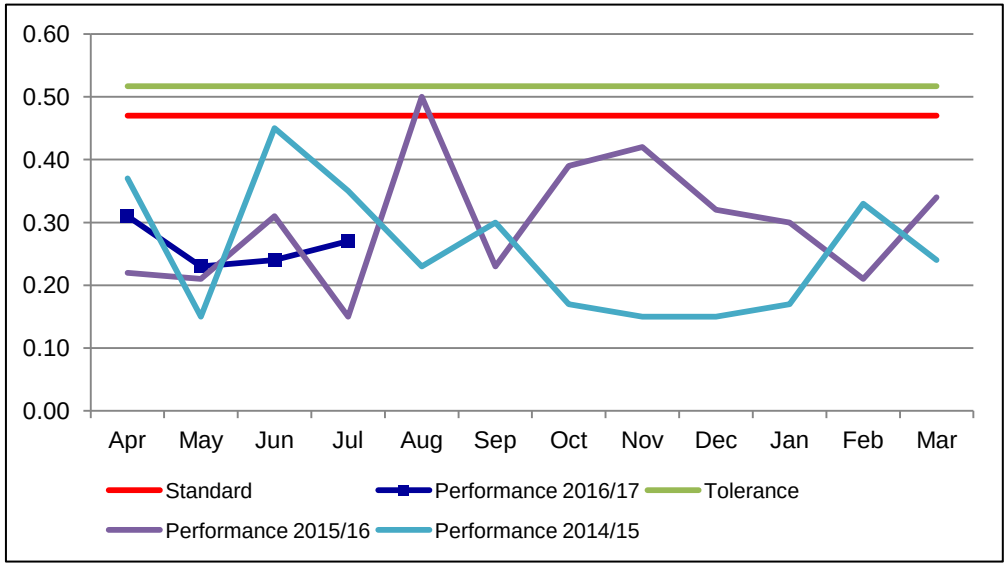
Pre-Operative Stay

	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	0.24	0.27								
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.

Work has been carried out to reduce pre-admissions in orthopaedics through the theatres and surgical flow project - this change was implemented on 15th August 2016 and will therefore start to show in the August and September data.

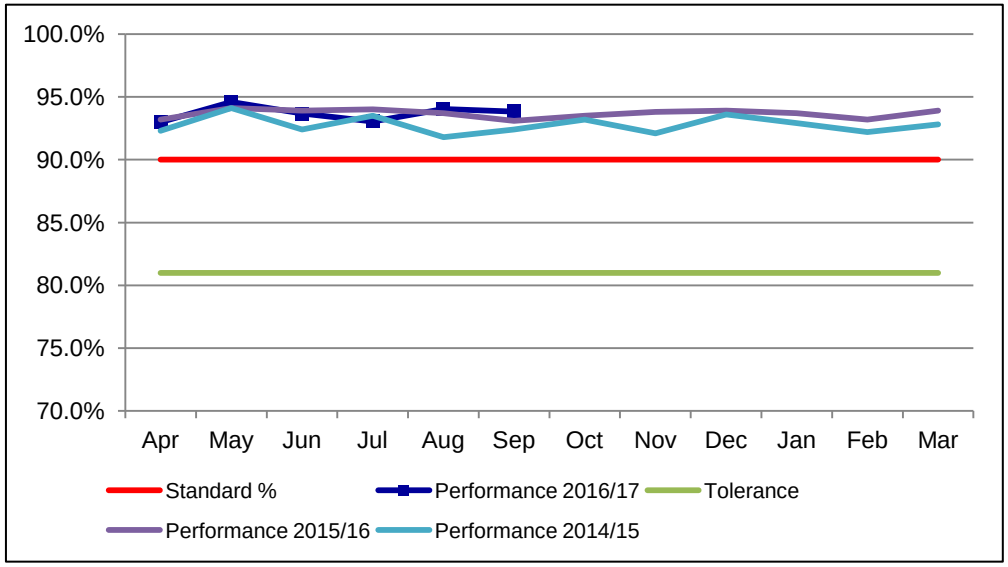
Actions:
- No further action planned at this time.

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%	94.0%	93.8%						
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:
- The longer term goal is to move to the Electronic Patient Record and to maximise the number processed online.

Breastfeeding

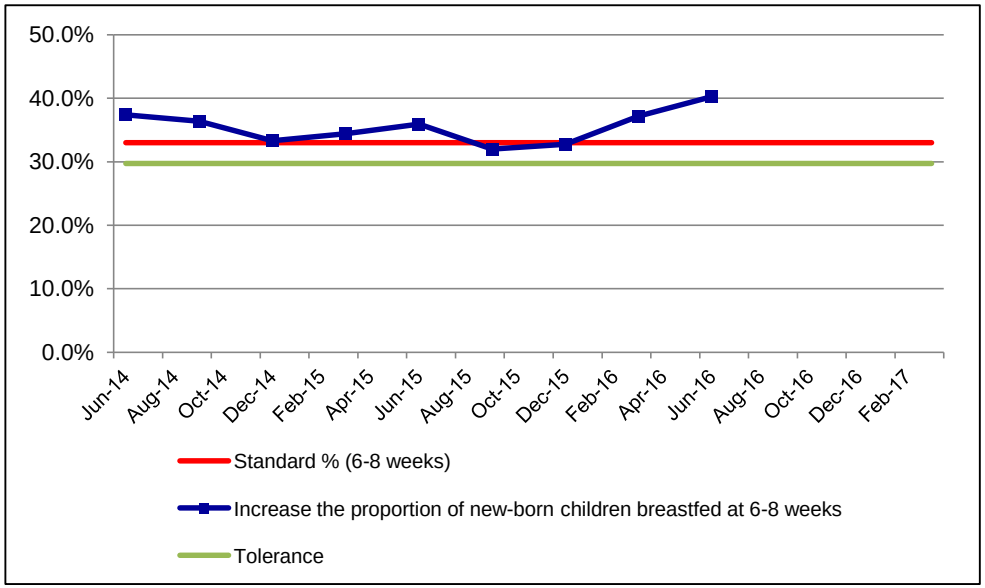
	Standard	Tolerance
Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	33.0%	29.7%

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%	40.3%			
Breastfeeding on discharge from BGH [1]	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%	32.6%	50.8%			
Percentage Ever Breast Fed	-	-	-	-	-	-	-	60.50%	75.0%			

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

[1] Breastfeeding on discharge from BGH is not longer reported on, replaced with % ever 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 April - June 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.

Actions:
- Maternity Staff and BFI key workers actively working on ensuring babies get the best start in life. All staff continue to attend training updates on BFI and Skin to Skin is initiated for all deliveries

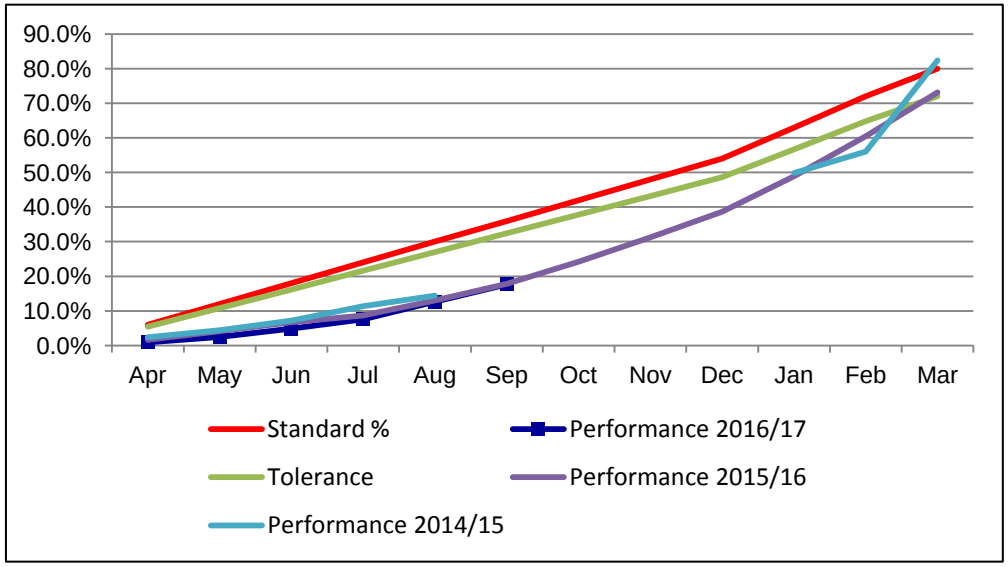
eKSF

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%	12.7%	17.7%						
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.

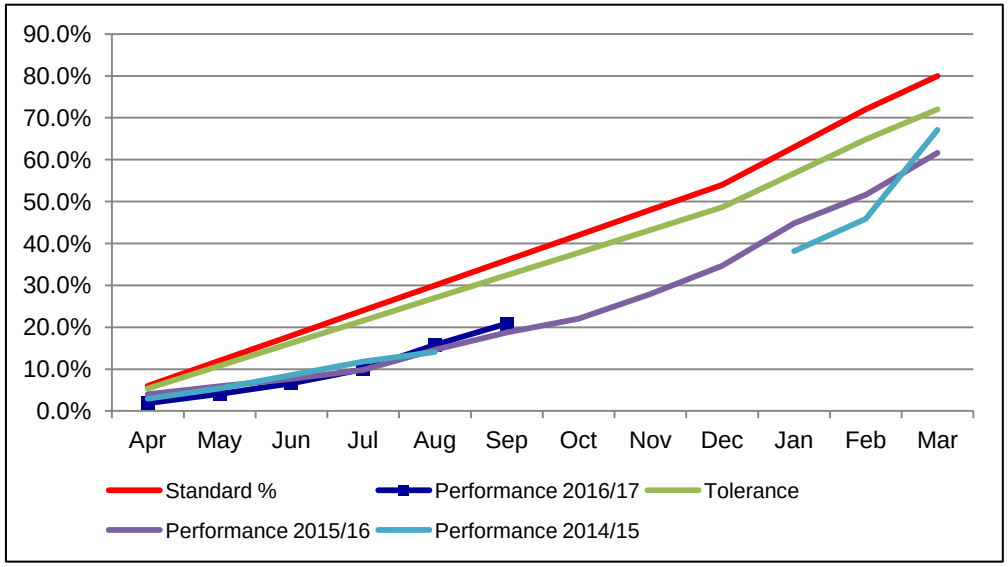
Personal Development Plans

	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%	15.8%	20.9%						
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 to date this 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.

Please Note: August 2016 figure submitted incorrectly (24.2%) therefore updated this month with correct data.

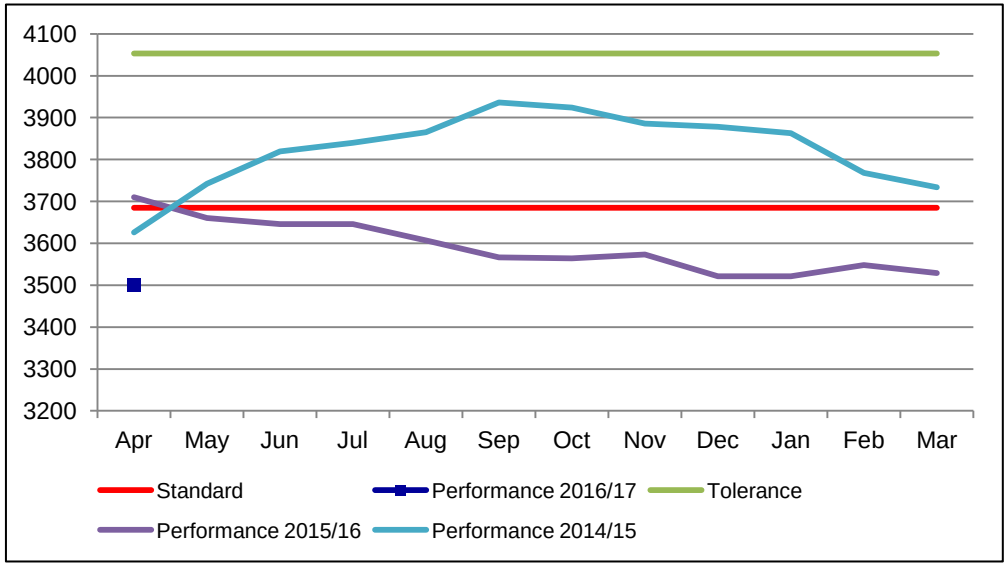
Emergency Occupied Bed Days

	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	3501											
Performance 2015/16	3710	3660	3646	3646	3607	3566	3564	3573	3521	3521	3548	3529
Performance 2014/15	3626	3742	3819	3840	3865	3936	3924	3886	3878	3863	3768	3734

Please note: There is a 6 month time lag in data being published for this target.



Narrative Summary:
Emergency Occupied bed days for over 75s have been on the whole reducing 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:
- The medical inpatient floor was remodelled in October to create one acute medical ward and two acute elderly care wards. This change is intended to stream frail elderly patients who are acutely unwell directly to an elderly care ward and avoid delays in medical wards. The redesign is intended to reduce overall length of stay by 0.6 days within the medical unit. The impact of these changes is being monitored daily.

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.

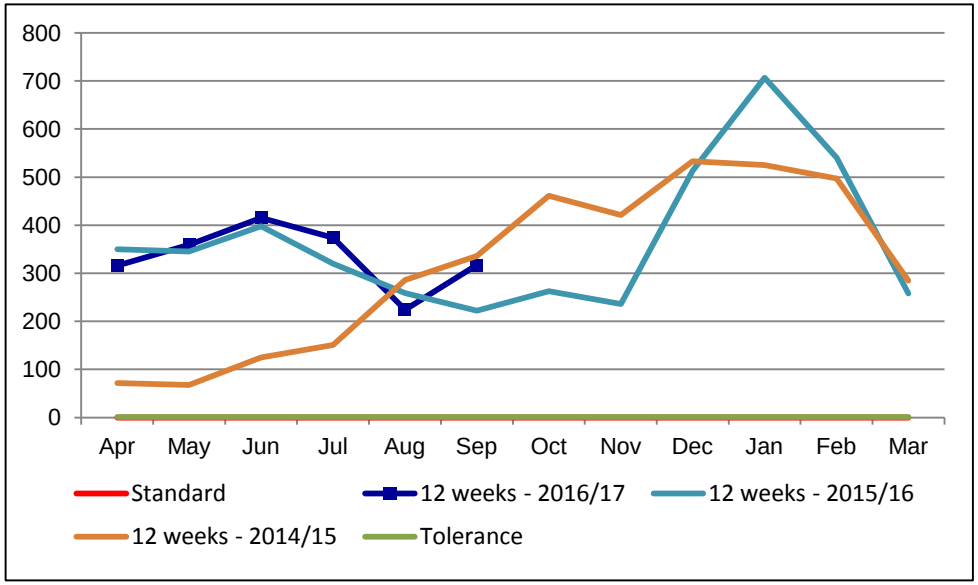
In 2016/17, the Board continues to face challenges in the achievement of our waiting times standards. However, although the pace of improvement is slower than planned, we are working steadily towards achievement of 12 week waits in both inpatients and outpatients.

Stage of Treatment - 12 Weeks Waiting Time for Outpatients

Standard: 12 weeks for first outpatient appointment	**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	316	359	415	374	224	317						
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 increased in September due to ongoing issues within Dermatology, Gastroenterology and Pain Control that the service are trying to remedy.

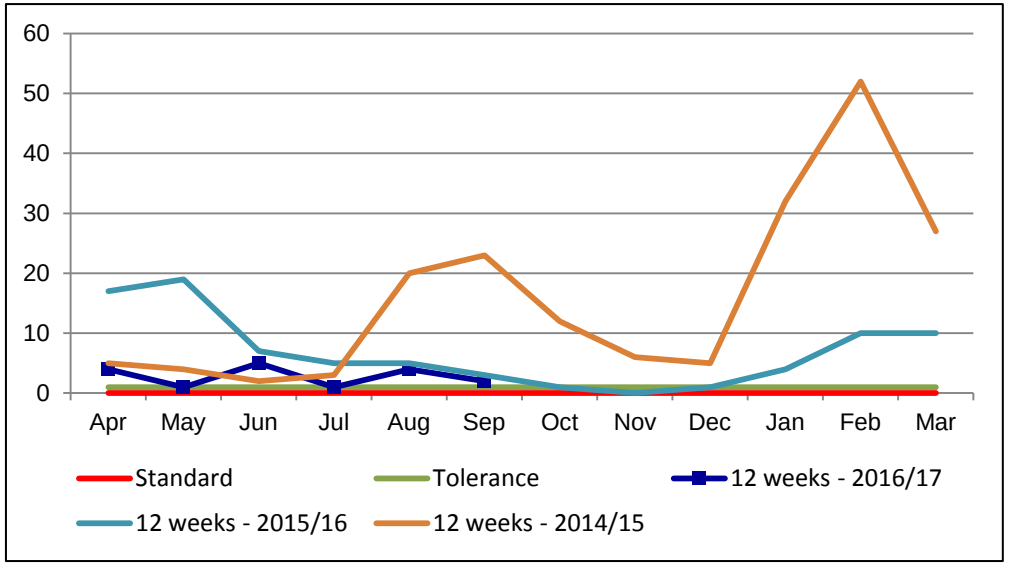
Actions:
- **Cardiology:** capacity is an ongoing problem, work is ongoing with the service to look for solutions.
- **Chronic Pain:** Capacity issues within the service are causing a continuing concern with no identified solution.
- **Dermatology:** Currently is an issue untill the appointment of the new Consultant that is due to start in January 2017. A review into the service is currently underway.
- **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 the new Consultants are expected to take over from January 2017. Locum weekend clinics are being organised to cover the service in the interim.
- **Gastroenterology:** The waiting lists have been reduced to 8 weeks however capacity issues within the service still require ongoing support to prevent patients going over 12 weeks.

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	4	2						
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 September, the number of patients reported waiting over **12 weeks for inpatient treatment** reduced to 2, following a number of short notice cancellations. This is expected to increase in the interim with the cessation of weekend operating for orthopaedics.

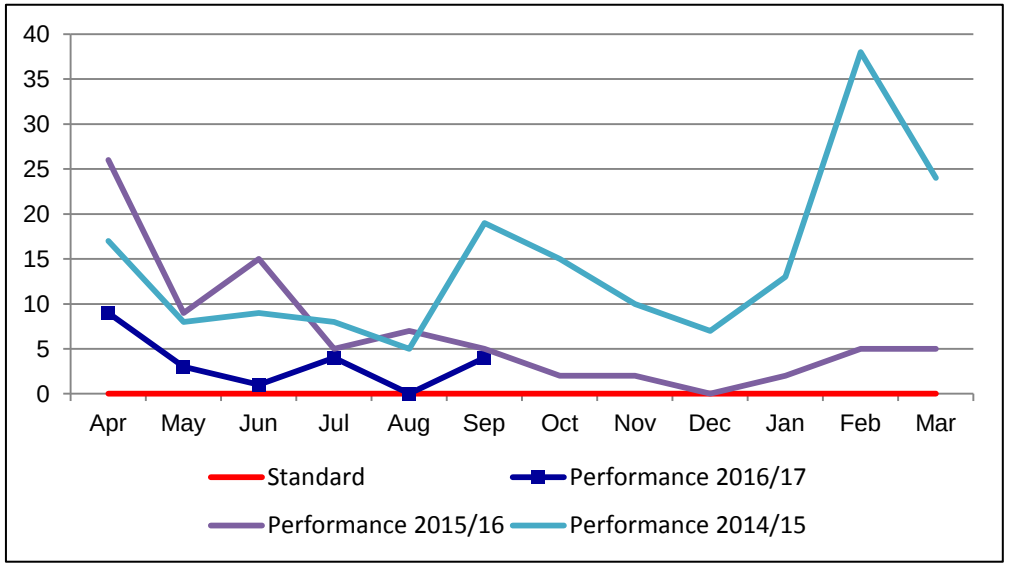
Actions:
- There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. We are working to minimise the impact of cessation of Synaptik operating lists with the implementation of the theatres and surgical flow project.

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	0	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:
In September we had 4 patients that breached their TTG date. 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.

Table 1 - Monthly Unavailability Statistics (Inpatient and daycase waiting list)

Unavailable	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Unavailable	95	81	81	60	74	81	70	83	90	107	115	115	92
Patient Advised	53.7%	50.3%	48.2%	40.8%	44.8%	48.5%	40.9%	46.4%	54.5%	55.2%	55.6%	55.8%	48.4%
Unavailable	82	80	87	87	91	86	101	96	75	87	92	91	98
Medical	46.3%	49.7%	51.8%	59.2%	55.2%	51.5%	59.1%	53.6%	45.5%	44.8%	44.4%	44.2%	51.6%
Total Unavailable	177	161	168	147	165	167	171	179	165	194	207	206	190
Total % Unavailable	16.3%	15.8%	16.2%	13.2%	15.4%	15.1%	15.9%	17.4%	15.1%	18.0%	19.1%	19.1%	19.0%

Table 2 - Monthly Unavailability by Specialty - as at 30th September 2016

	Available				Unavailable			
Specialty	**0 - 9 Weeks**	**10 - 12 Weeks**	**12+ Weeks**	**Total**	**Medical Un-available**	**Patient Advised Un-available**	**Total**	**% Un-available**
ENT	71	11	0	**82**	4	3	**7**	7.9%
General Surgery	122	7	0	**129**	28	24	**52**	28.7%
Gynaecology	49	2	0	**51**	7	3	**10**	16.4%
Ophthalmology	141	7	0	**148**	4	4	**8**	5.1%
Oral Surgery	17	2	0	**19**	1	3	**4**	17.4%
Other	211	7	0	**218**	0	5	**5**	2.2%
Trauma & Orthopaedics	268	19	2	**289**	43	46	**89**	23.5%
Urology	62	1	0	**63**	11	4	**15**	19.2%
Total	**941**	**56**	**2**	**999**	**98**	**92**	**190**	**16.0%**

Narrative Summary:
There has been a general upward trend over the past few months in the number of patients with patient advised unavailability however it has decreased in September due to the lack of local and public holidays.

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.

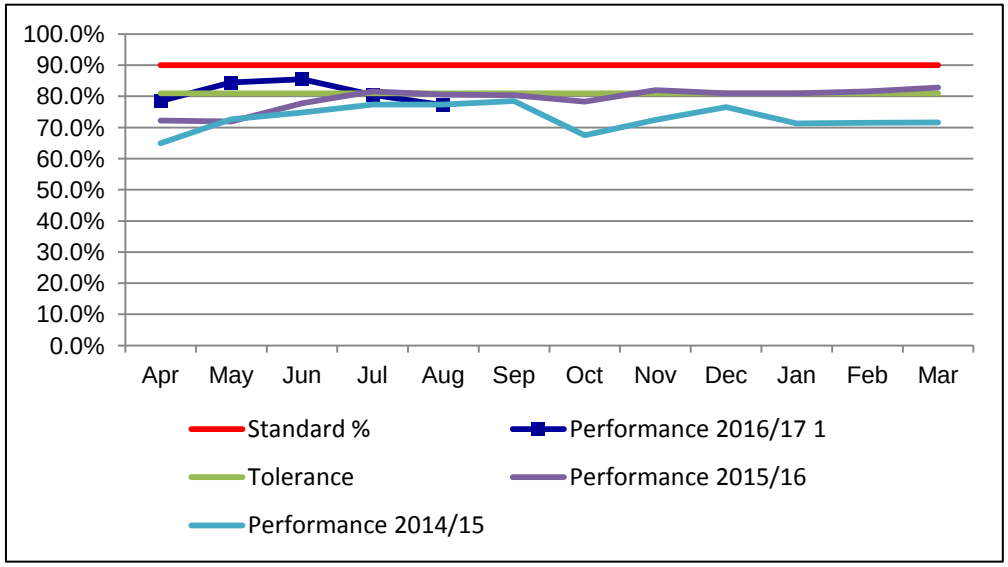
18 Weeks Referral to Treatment (RTT)

	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%	80.4%	77.2%							
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.

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

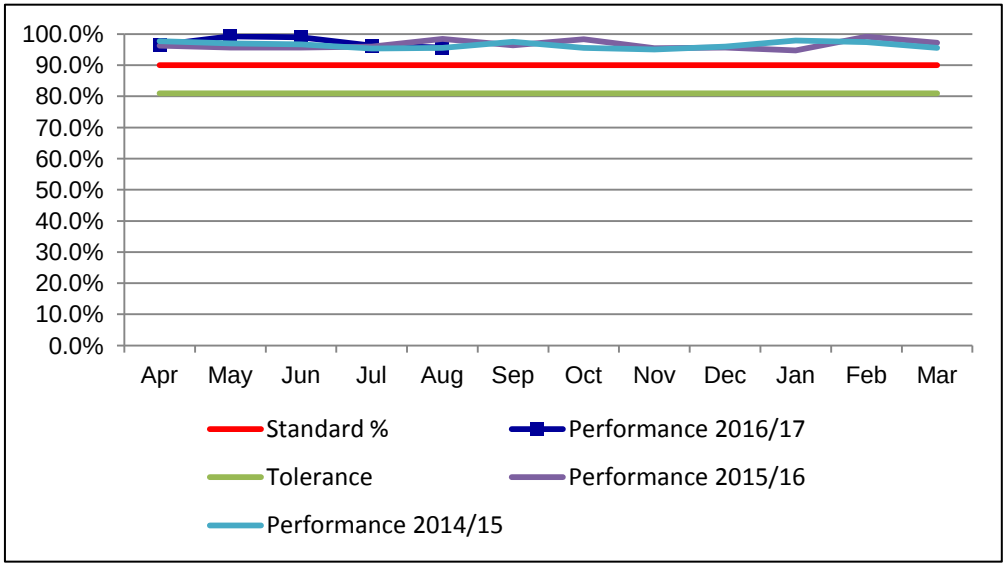
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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%	96.3%	95.6%							
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.

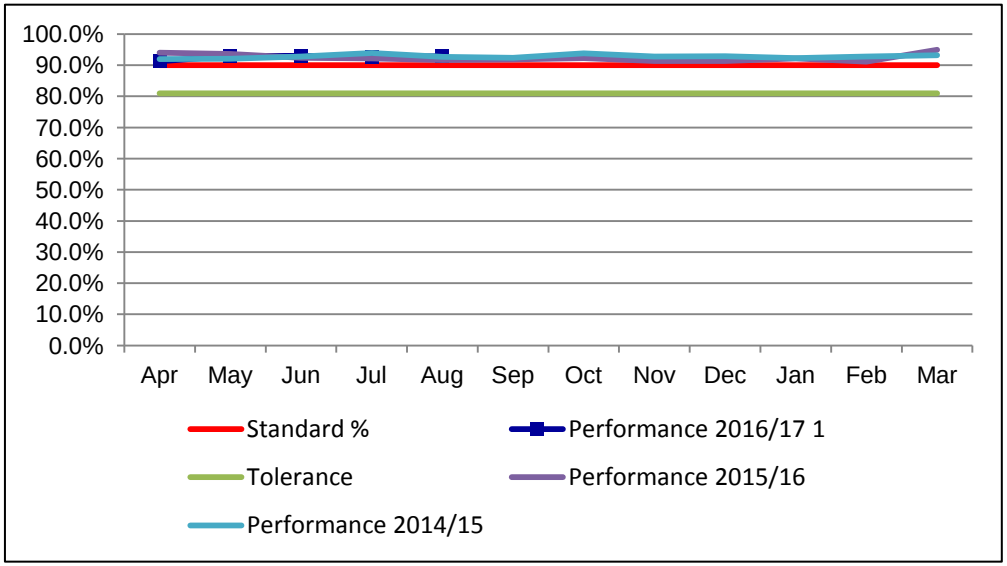
18 Weeks Referral to Treatment (RTT)

	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%	92.6%	92.9%							
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.

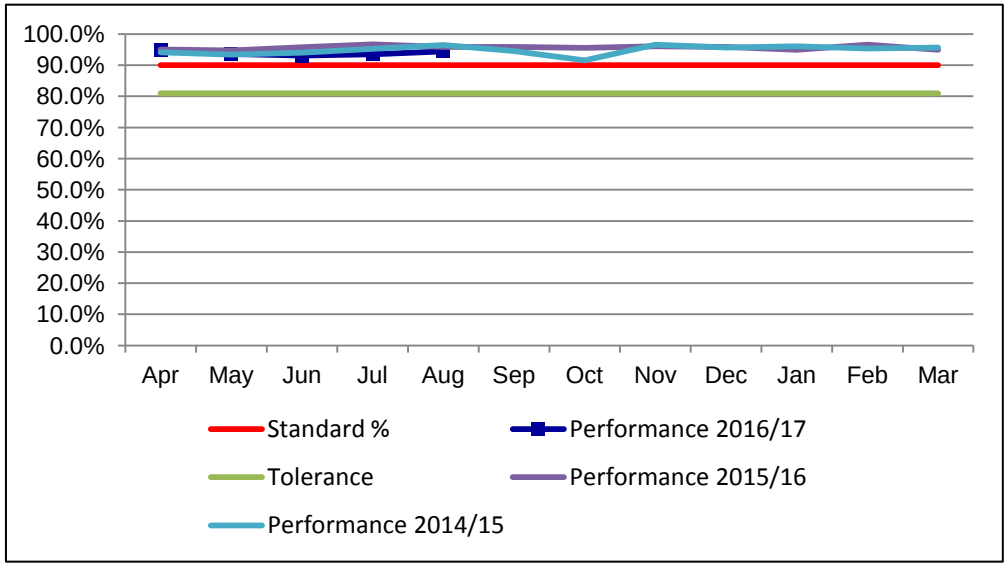
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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%	93.5%	94.4%							
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.

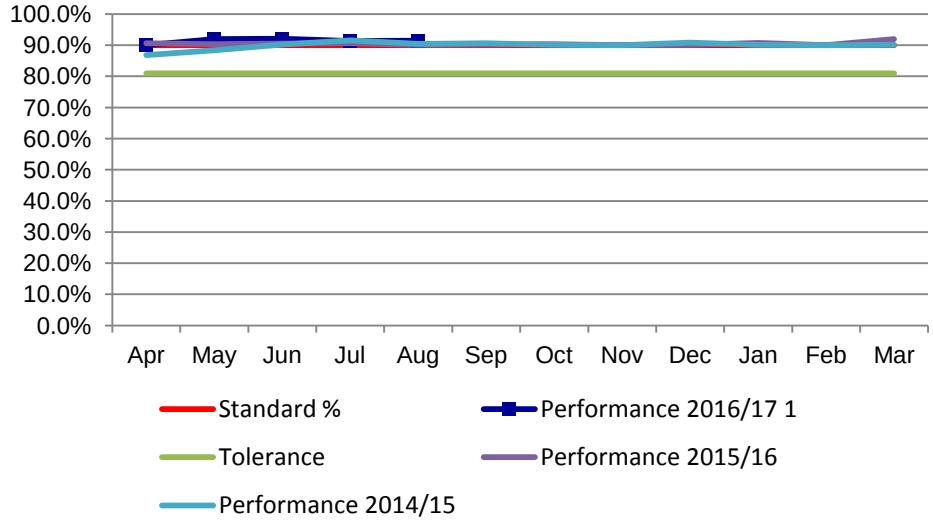
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Combined Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2016/17 [1]	90.0%	92.0%	92.1%	91.3%	91.4%							
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 standardsince June 2014. This has proven challenging over the last 12 months, due to a relatively poor performance on admitted pathways however this has been improving.

The 18wks performance has increased slightly due to the reduction of breaching patients in ENT and Gastroenterology as extra outpatient Synaptik clinics took place throughout July and August to clear the backlog. Audiology are also anticipating an improving performance as they have now cleared the backlog of breaching patients and are booking at 5 weeks for a new first appointment.

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.

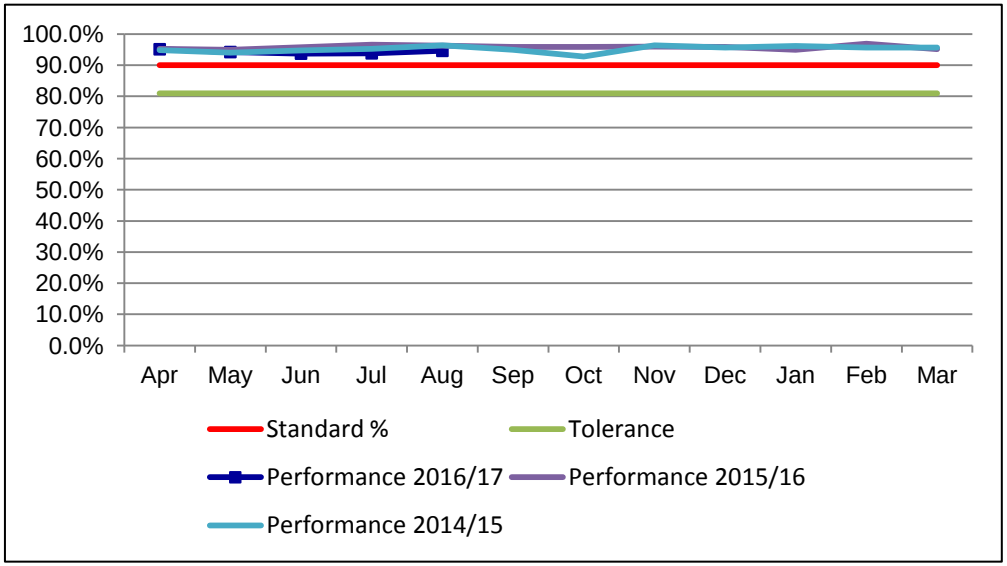
Actions:
- Work will continue during 2016/17 with the reduction in the number of 12 week breaches.

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%	93.8%	94.6%							
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.

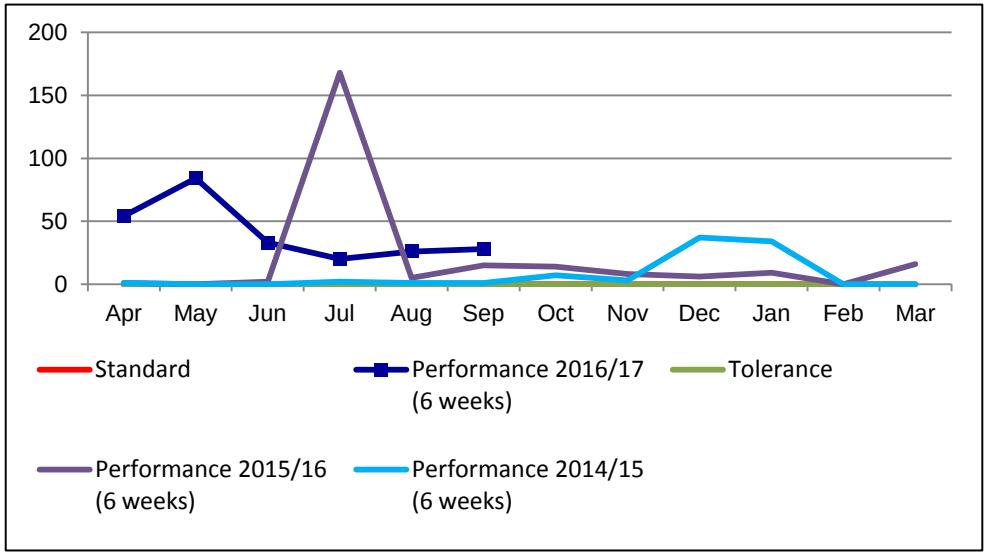
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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	26	28						
Performance 2016/17 (4 weeks)	307	430	165	137	52	103						
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. In September 2016 there has been a decrease in performance against both the 6 week and 4 week target.

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	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Endoscopy	24	13	22	30	14	39	21	27	2	1	0	0
Colonoscopy	32	9	11	19	5	20	32	38	62	34	40	68
Cystoscopy	11	10	4	0	0	0	1	0	0	1	1	0
MRI	48	70	37	18	27	53	93	102	23	18	10	21
CT	27	18	23	5	8	50	86	81	8	25	0	14
Ultra Sound (non-obstetric)	0	0	0	2	0	3	74	182	70	58	1	0
Barium	0	2	0	8	0	0	0	0	0	0	0	0
Total	**142**	**122**	**97**	**82**	**54**	**165**	**307**	**430**	**165**	**137**	**52**	**103**

Narrative Summary and Actions:

Colonoscopy – The service continues to experience capacity issues due to the GI consultants contributing more to the General Medical rota which has lead to a decrease in colonoscopy capacity. An action plan is being developed and will be taken to the Clinical Executive Strategy Group in November which will address capacity issues and demand optimisation strategies as well as succession planning in the service.

Endoscopy – Performance has been maintained this month with no patients waiting over 4 weeks.

Magnetic Resonance Imaging (MRI) & Computerised Tomography (CT) – the number of patients waiting over 4 weeks has increased slightly in September however none waited over 6 weeks. Consultants continue to do additional sessions to meet the demand on the service.

Ultrasound – The ultrasound service remains under pressure due to a vacant sonographer post which attracted no applicants after being advertised nationally this month. The Service is currently training a member of staff to be a Sonographer however they won't be qualified until June 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. The Scottish Government has allocated £38k funding to support the service with short term locum capacity whilst training is ongoing which has helped to reduce the number of 4 week breaches to 0 this month.

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%

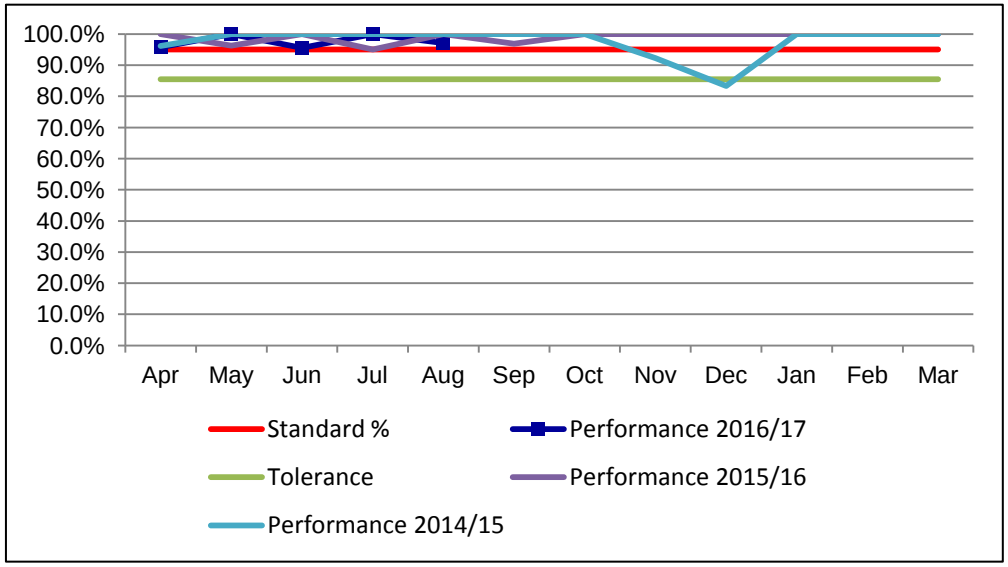
Cancer Waiting Times

	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%	100.0%	97.1%							
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 and continues into 2016/17.

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 Colonoscopy waiting time has increased dramatically after the GI Synaptik Sessions which could lead to a problem with Cancer Waiting Times. We are currently trying to organise additional internal capacity to support Colonoscopy sessions to reduce the risk of breaching patients.

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

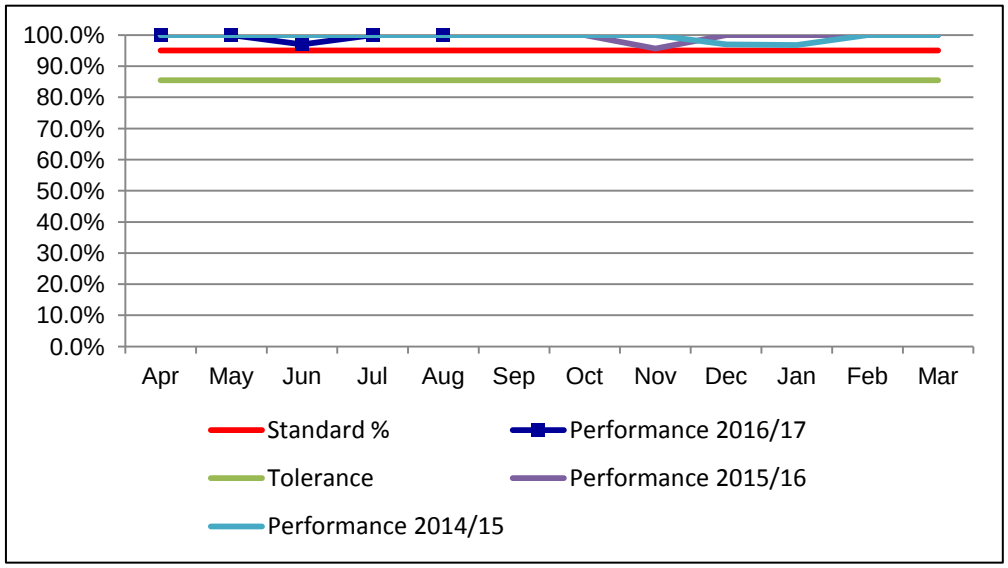
Cancer Waiting Times

	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%	100.0%	100.0%							
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 2015/16 and into 2016/17. 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 Colonoscopy waiting time has increased dramatically after the GI Synaptik Sessions which could lead to a problem with Cancer Waiting Times. We are currently trying to organise additional internal capacity to support Colonoscopy sessions to reduce the risk of breaching patients.

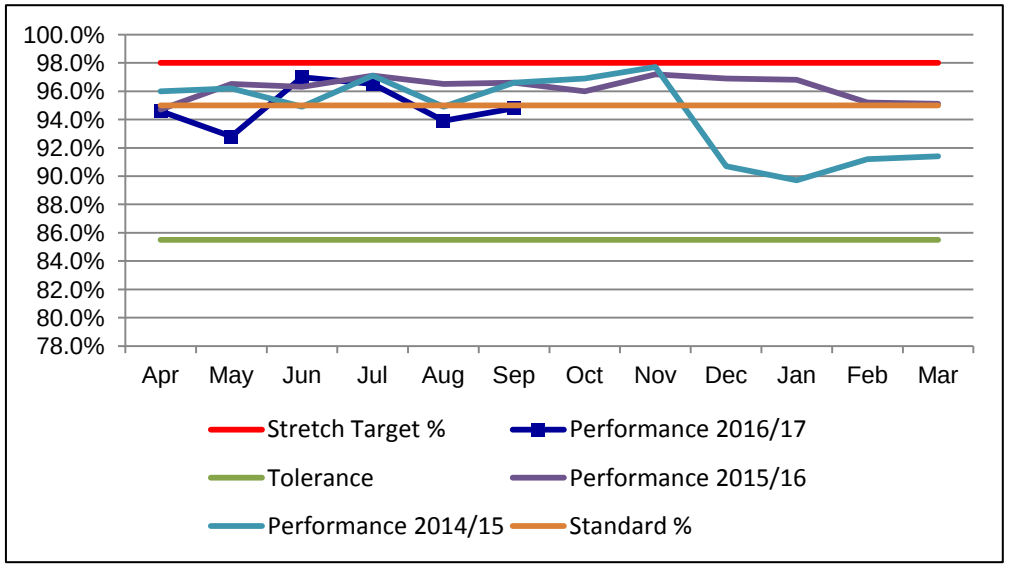
Please Note: There is a time lag of one month for this data.

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%	93.9%	94.8%						
Performance 2015/16	94.7%	96.5%	96.3%	97.1%	96.5%	96.6%	96.0%	97.2%	96.9%	96.8%	95.2%	95.1%
Performance 2014/15	96.0%	96.2%	94.9%	97.1%	94.9%	96.6%	96.9%	97.7%	90.7%	89.7%	91.2%	91.4%



Narrative Summary:
Patients attending **A&E are routinely discharged within 4 hours.** NHS Borders is working towards consistently achieving the 98% local stretched standard.

Following a challenging period in April, May and August, 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. Performance continues to fall short due to continued higher than expected levels of attendance characterised by spikes in activity.

Actions:
Please see next page for further narrative and 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	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Flow 1	99%	98%	99%	99%	99%	99%	98%	97%	96%	98%	98%	97%	97%
Flow 2	95%	91%	97%	94%	98%	98%	91%	94%	92%	95%	94%	93%	91%
Flow 3	94%	94%	93%	96%	91%	91%	92%	90%	87%	97%	95%	92%	91%
Flow 4	91%	94%	99%	93%	94%	94%	92%	93%	91%	92%	93%	83%	92%
Total	**95%**	**96%**	**97%**	**96%**	**96%**	**96%**	**95%**	**95%**	**93%**	**97%**	**97%**	**94%**	**95%**

Narrative Summary and Actions:
There continues to be challenges in accessing inpatient beds. The main issues are the number of delayed patients in the system and the challenges associated with increasing the number of discharges from the hospital before 11am. In addition spikes in numbers and acuity have come, particularly at times when ED staffing is reduced which has affected performance against the EAS.

- A robust co-ordination and escalation process is in place to support flow and ED is working with BECS to develop a more collaborative approach to enhance capacity and performance against the target.
- Medical and nursing staffing has been reviewed and a plan for revising staff rotas and establishments will be completed by the end of October 2016.
- The development of the emergency nurse practitioner and advanced nurse practitioner roles will be important in releasing medical capacity in respect of flows 2,3 and 4 without detriment to flow1.

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%	90.1%	93.3%							
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;

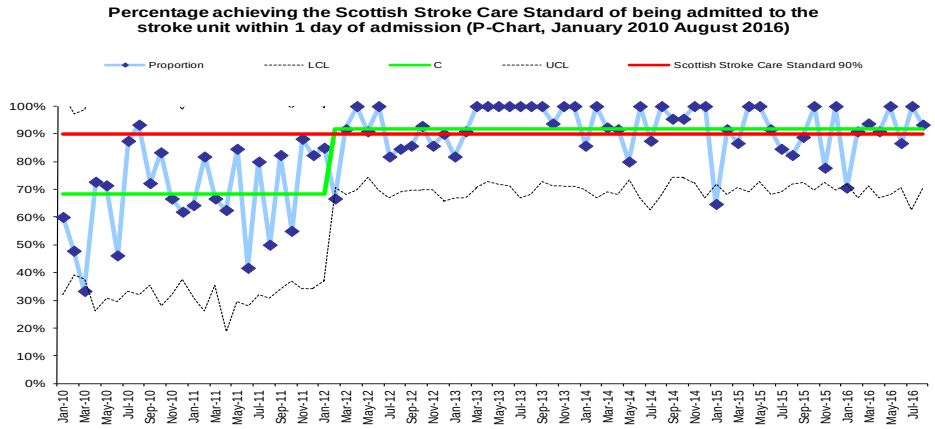
- admission to a dedicated Stroke Unit within 1 day of admission
- a swallow screen test within 4 hours of admission
- a brain scan within 24 hours of admission
- appropriate treatment initiated within one day of admission

However, our performance is measured against the national standard of number of patients waiting more than one day for admission to a Stroke Unit. In August 2016 the standard was achieved. Overall there were 3 bundle fails (one patient failed swallow and admission) 15 out of 18 patients had all elements of the bundle in a timely manner.

Actions:
- Process in place to ensure 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 - this is ongoing , work in progress

Please Note: Due to the time difference between the P&P deadline and the national extract deadline the Local Stroke report has 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

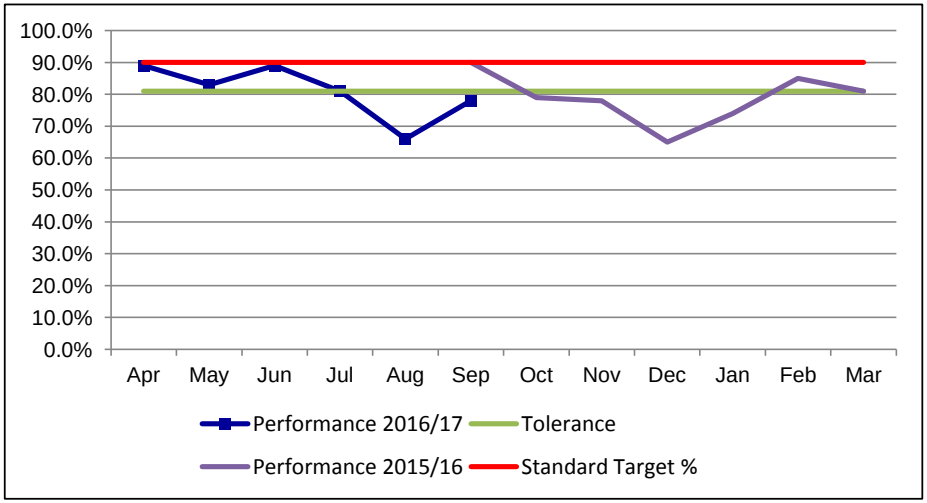
	Standard	Stretch	Tolerance
Standard: 18 weeks referral to treatment for Psychological Therapies	90.0%	95.0%	81.0%

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%	66.0%	78.0%						
Total Patients Currently Waiting >18 Weeks:	91	85	103	113	116	109						
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 fall below 90%. It fluctuates on a monthly basis. The data is the average performance across all service areas. All but the adult teams are meeting the target including CAMHS. We are trying hard to treat in turn and longer than ideal waits will continue for some time. Of the 12 main health boards, nine have more WTE applied psychologists per 10,000 head of population than NHS Borders.

Actions:
- Actions continue as previously described, and we continue to allocate resources to the areas with the longest waits.
- We are in the process of recruiting more psychologists funded by Scottish Government additional funds. The newly recruited Clinical Psychologist starts in October.
- A project plan is being drawn up to address underlying demand and capacity issues across the four years the SG funding is in place.
- We continue to review how we can best deliver an efficient and effective service.
- Access to appropriate clinical space is an increasing challenge with recent renovation work in health centres adding to this pressure. The Space Utilisation group have been approached for solutions to this.
- Admin pressures are also a challenge, and work is underway to review procedures as well as the introduction of a text reminder system to tackle the high DNA and CNA rate.

CAMHS Waiting Times

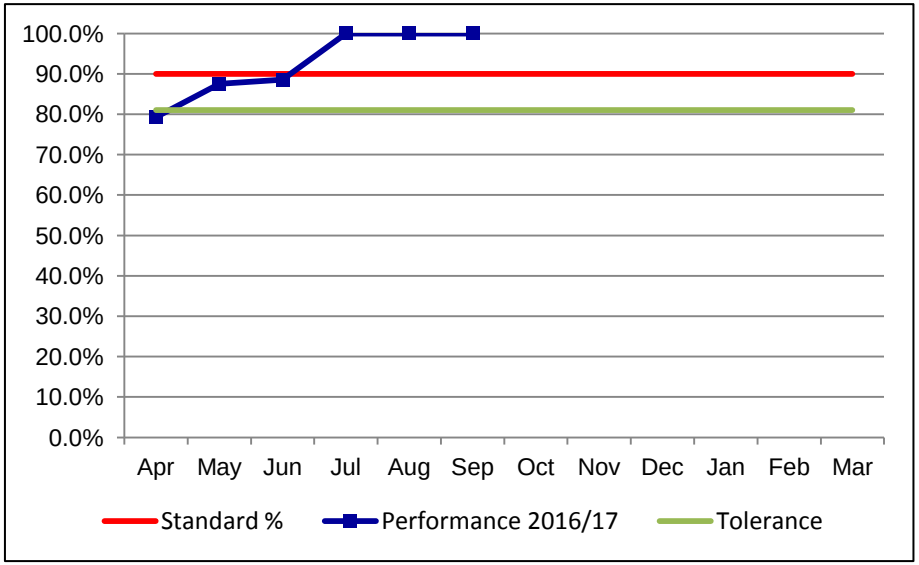
	Standard	Stretched	Tolerance
Standard: 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)	90.0%	95.0%	81.0%

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%	100.0%	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:
The service continues to remain within both the local and the stretched standards. CAMHS continue to have staff turnover having direct impact within the service area. Recruitment is almost complete into CAMHS of a temporary CAAP (Clinical and Applied Psychologist) and a permanent Community MH Team Nurse. There has been an increase in referrals into the tier 3 service with the absence of a full time Community Mental Health Worker.

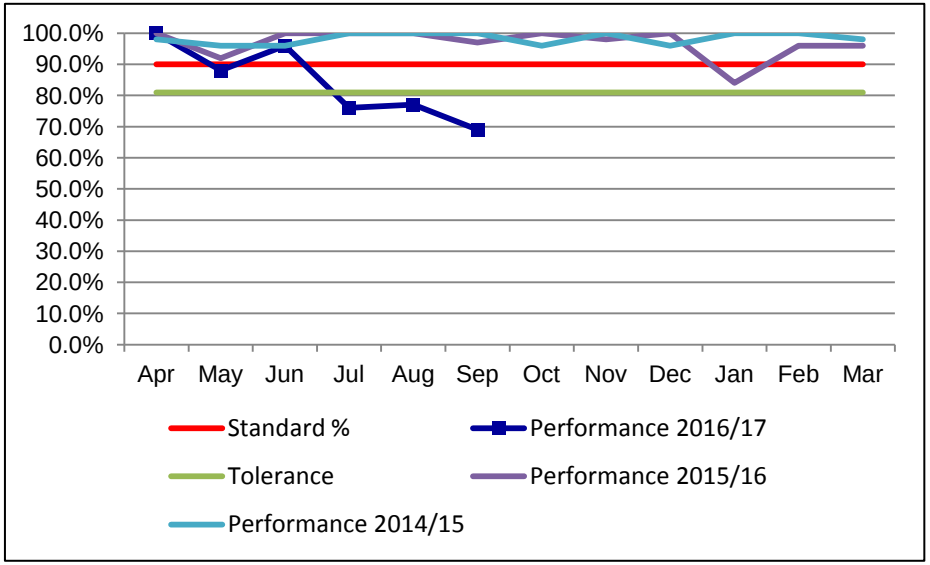
Actions:
- The service are now implementing specific allocations meetings outwith the MDT to retain focus on referrals and the waiting list. This was implemented in January 2016 and continues to be maintained .
- The service have reviewed the waiting list and identified improvements in relation to the 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%	77.0%	69.0%						
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%.

Over the past few months Borders Addiction Services have been struggling with a shortage of staff. However recently the service has managed to recruit and the impact of this is having an effect - this should be reflected in the overall figures next month. . Also there were many other actions put in place which are now coming to fruition and although the figures remain low for September, we have in October met the government and local standard.

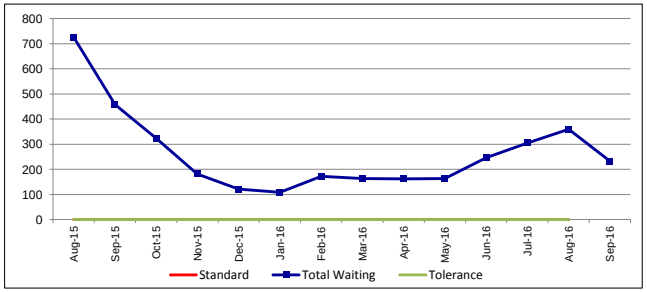
Actions:
- The Primary Care Service remains temporarily closed. A half-time permanent Consultant post is currently advertised and a temporary Advanced Addiction Nurse Practitioner post is also advertised internally.

AHP Waiting Times

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

Actual Performance (lower = better performance)

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Standard	0	0	0	0	0	0	0	0	0	0	0	0	
Total Waiting	**457**	**324**	**182**	**121**	**109**	**172**	**163**	**162**	**164**	**246**	**305**	**360**	**233**
Occupational Therapy	11	13	13	13	21	19	26	2	11	22	11	4	2
Physiotherapy	439	303	158	105	79	139	125	144	134	200	262	339	211
Podiatry	0	0	0	0	0	0	0	0	0	0	0	0	0
Speech & Language Therapy	0	1	1	0	0	0	2	4	1	2	2	3	0
Nutrition & Dietetics	7	7	10	3	9	14	10	12	18	22	30	14	20



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 (10%) are impacting on capacity. 3 locums are in place with a plan to reduce as the vacant posts are recruited to. Permission has been given to pre-load staffing - 2 additional band 5 staff appointed and awaiting start date. 2 SBARs were taken to the joint clinical board on 28th September to highlight capacity issues. There is support to close the non-cancer lymphodema waiting list. Plans are in place to re-align staff within the existing service to support additional lymphodema clinics from mid November for 24 weeks, this will clear patients who are currently on waiting list. Support to convert clinical MSK band 5 post to band 5 admin hours. This will reduce clinical capacity but ensure permanent funding/stability of the central booking service. The Physiotherapy Service is now reporting nationally on new MSK standard that 90% of patients will be seen within 4 weeks. 491 patients are waiting over 4 weeks with an average waiting time of 6 weeks.

Nutrition and Dietetics
Data in scorecards is at variance with service's own data due to data cleansing after the reports are run. Reduced staffing due to maternity leave, vacancies and some short term absences have reduced capacity in Community Dietetics and DESMOND programme. Recruitment has been successful and community dietetics is now fully staffed although remains under sustained pressure. We've put in some additional hours and the CD service should attain 9/52 waiting time target in coming months. Challenges remain in specialities such as GI, Diabetes Care, Mental Health, Learning Disability, DESMOND and eating disorders due to increased referral rates and limited capacity. Lack of EDSN is leading to extremely high caseloads for the part time specialist dietitian. Exploring sustainability of DESMOND with Diabetes team and MCN. Liaising with CAMHS and adult MH re eating disorders, including providing support and training to non specialist staff.

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 a reduce number of patients waiting for Occupational Therapy; 4 waiting over 9 weeks. The caseload and waiting list is reviewed regularly by the LD team manager alongside the Lead Occupational Therapist.

Podiatry
The Podiatry Service receives approximately 50 new referrals per week . Capacity is flexed as far as possible to meet demand for at risk foot referrals and MSK referrals. Trak allows changing of slots from review to new to accommodate spikes in demand. Staff can be moved across location in response to demand and Trak also allows the Service to project demand 3 weeks in advance and initiate changes to help meet that demand.
The establishment of a dedicated booking team helps ensure all clinics are fully booked, maximising available capacity. The Service moved to Trak appointing in April of 2016, a move which supports waiting time management and provides an overview for management, staff and the booking team.

Speech, Language & Therapy (Adults)
There have been some data processing issues with the Adult SLT over the last 3 months which have now been resolved, allowing the data to be more robust.

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

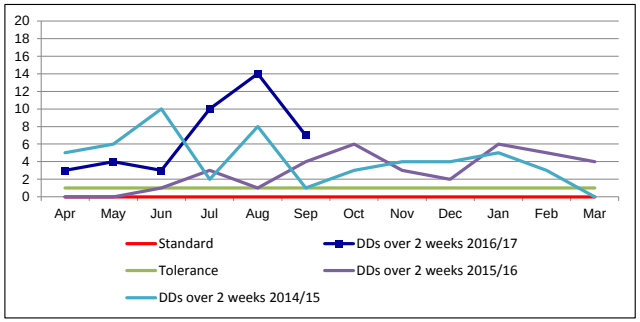
	Standard	Tolerance
Standard: Delayed Discharges - delays over 72 hours	0	1

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	14	7						
DDs over 72 hours (3 days) 2016/17	6	8	7	15	20	20						
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 last Thursday 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.

Actions:
- A comprehensive action plan has been produced with partners in SBC to address the challenges and progress on this is being monitored weekly.

A summary of the actions are described on the next page.

Delayed Discharges *continued*

Narrative Summary:
NHS Borders is facing significant challenges with delayed discharges, which continues to impact on patient flow within the Borders General Hospital and our four Community Hospitals.

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.

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, Chief Officer for Health and Social Care, and General Managers for Primary & Community Services and Unscheduled Care. The purpose of this meeting is to take cross service actions, escalated from daily and weekly monitoring and to implement the overall action plan taking short, medium and long term actions to help NHS Borders achieve the 72 hour standard.

Actions:
The Action Plan focuses on actions to address the main reasons for the delays currently experienced by patients across the hospital system. The key actions include:

- Senior Management attendance and support to Community Hospital Multi Disciplinary Meetings where anticipated delays are identified.
- The redesign of BGH/START Hub - to provide joint oversight and daily management of complex discharges, (BGH focus initially).
- Challenge to current assumptions for standard packages of care for people with high level needs.
- Development of a co-ordination function to identify and direct care home resources.
- Additional Telecare Support - development of a plan to introduce more technology to support aspects of community based care.
- Introduction of a transitional care facility to support step down care - redesign Waverly Care Home to introduce 16 further step down beds supported by ICF.
-The review of current practice for discharging patients who lack capacity which includes undertaking an appreciative enquiry approach to understand local challenges and create an improvement plan.

Key Performance Indicators

Cancellations

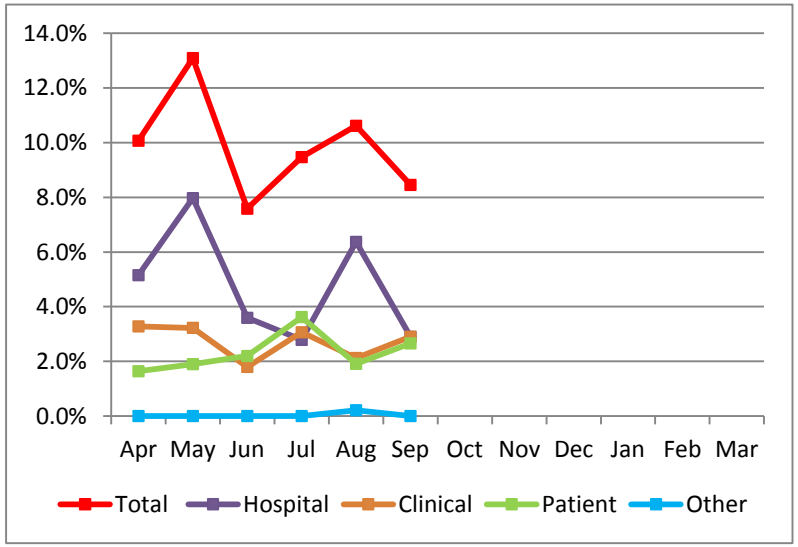
Hot Topic: Cancellations

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%	10.6%	8.5%						
Hospital	5.2%	8.0%	3.6%	2.8%	6.4%	2.9%						
Clinical	3.3%	3.2%	1.8%	3.1%	2.1%	2.9%						
Patient	1.6%	1.9%	2.2%	3.6%	1.9%	2.7%						
Other	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%						



Narrative Summary
The percentage of hospital cancellations had improved in June and July, but has deteriorated in August 2016 due to a lack of available beds. This has improved in September 2016 due to smoothing of elective cases and the availability of beds.

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 has implemented a process to review lists every Wednesday afternoon and develop a Standard Operating Procedure to lock down list and make any appropriate changes.

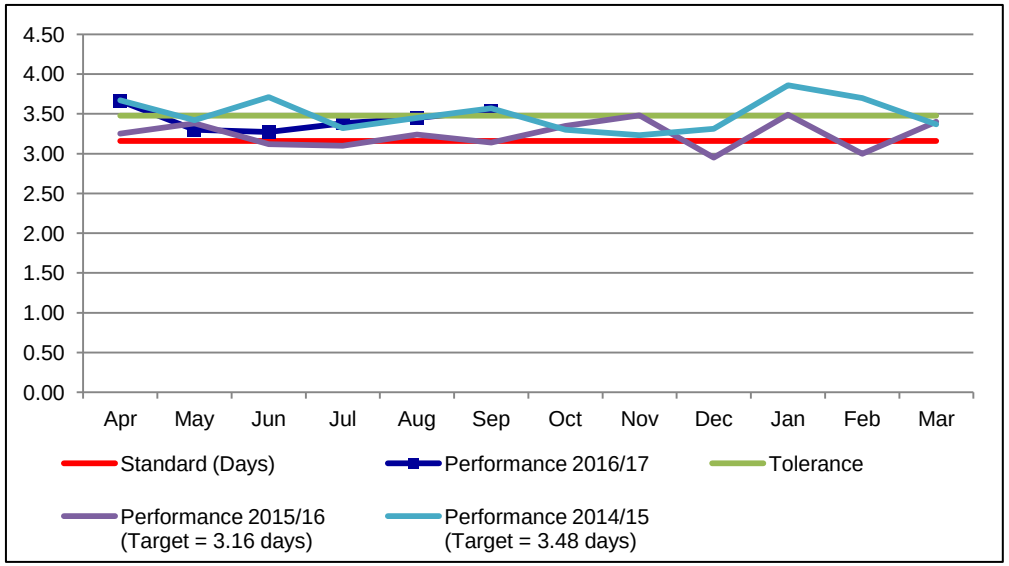
Detailed reviews of the reasons behind the lack of available beds are being undertaken by services on an ongoing basis in an effort to alleviate the pressures. The most significant action will be the implementation of the new theatres and surgical flow model - it is anticipated that this will be implemented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

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	3.45	3.54						
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/Winter of 2016 will also positively impact the overall length of stay.

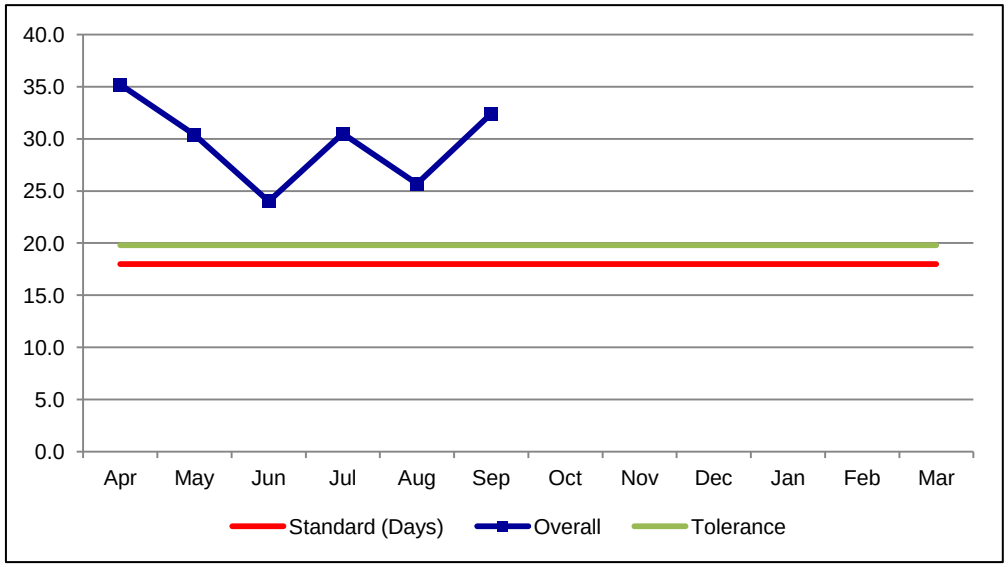
Community Hospital Average Length of Stay (LOS)

Standard: Reduce Community Hospital Average Length of Stay	**Standard**	**Tolerance**
	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**	**25.7**	**32.4**						
Hawick	24.3	25.1	22.3	25.5	17.8	20.3						
Hay Lodge	54.3	33.2	25.1	43.5	33.1	30.7						
Kelso	31.3	26.1	23.4	23.2	27.5	45.3						
Knoll	46.2	45.2	26.1	39.4	28.2	44.6						

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

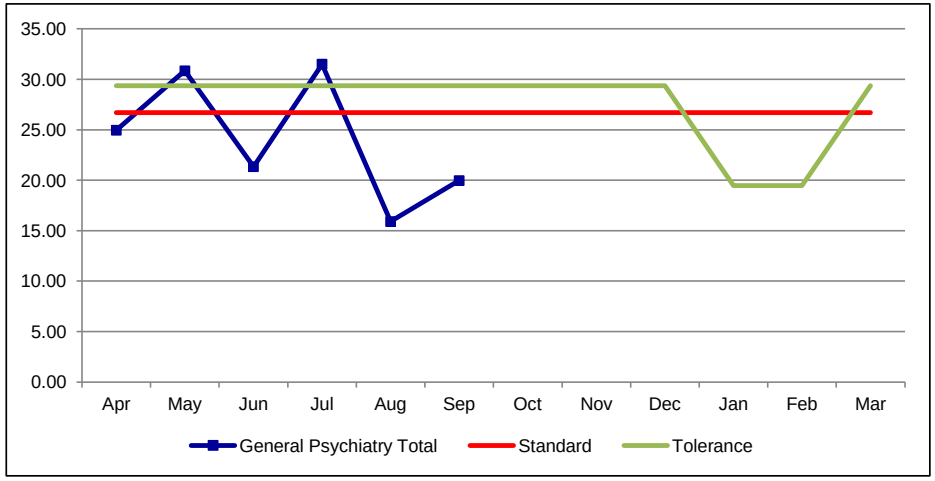
Actual Performance (lower = better performance)

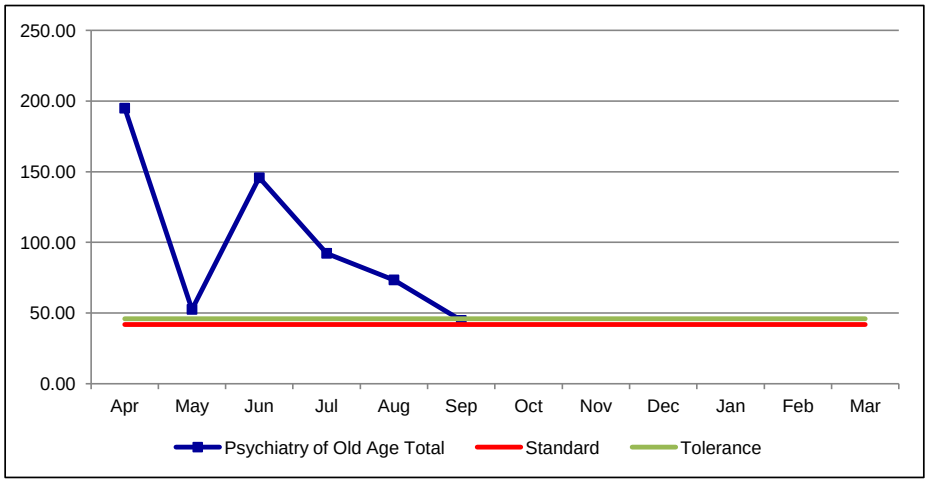
	Standard (Days)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Huntlyburn	17.70	22.06	35.52	14.90	21.00	15.50	8.64						
The Brigs [1]	42.83	34.20	11.50	64.30	33.30	27.00	303.00						
General Psychiatry Total	**26.70**	**24.95**	**30.84**	**21.34**	**31.50**	**15.90**	**19.96**						
Cauldshiels [2]	26.95	-	47.00	149.50	126.00	110.60	53.50						
Lindean	60.58	45.00	60.00	134.50	36.80	28.80	36.00						
Melburn Lodge [3]	111.63	345.00	-	-	112.00	-	-						
Psychiatry of Old Age Total	**41.82**	**195.00**	**52.57**	**145.75**	**92.27**	**73.45**	**44.75**						

[1] High number in September due to 1 patient being discharged

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

[3] High number in April due to 1 patient discharged in April 2016 with long length of stay and no discharges in May, June or August 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 and small numbers of discharged per month.

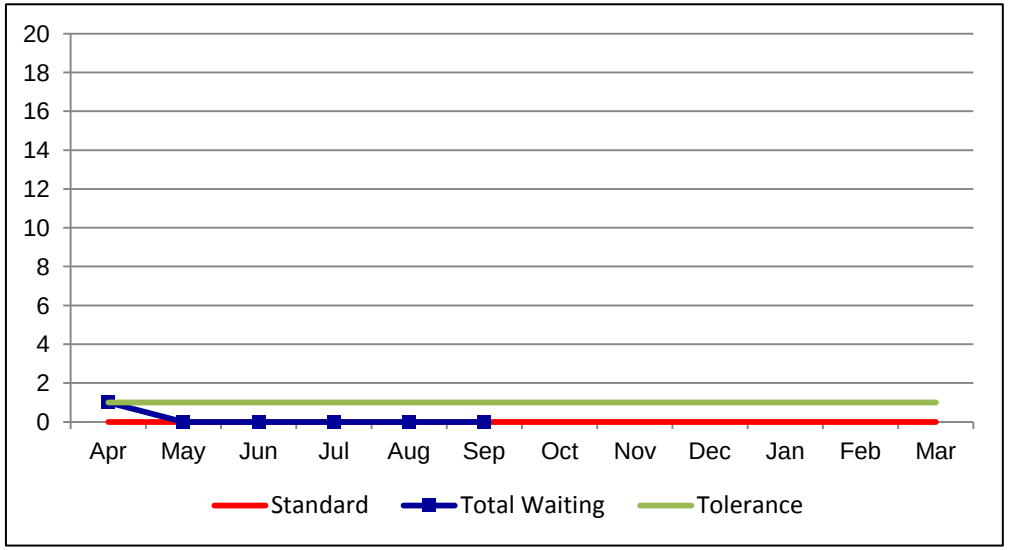
Actions:
- LOS is monitored within the performance scorecard at monthly Mental Health meetings and picked up with Senior Charge Nurses by exception. There are no routine actions specific to this target but work is underway to ensure patients have EDD's on admission to Mental Health Wards (as appropriate).
- work has been started with P&P to look at the recording of ALoS for mental health to make it more meaningful and to enable the data to be cross checked against other key performance indicators (i.e. delayed discharges, ward occupancy etc)

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

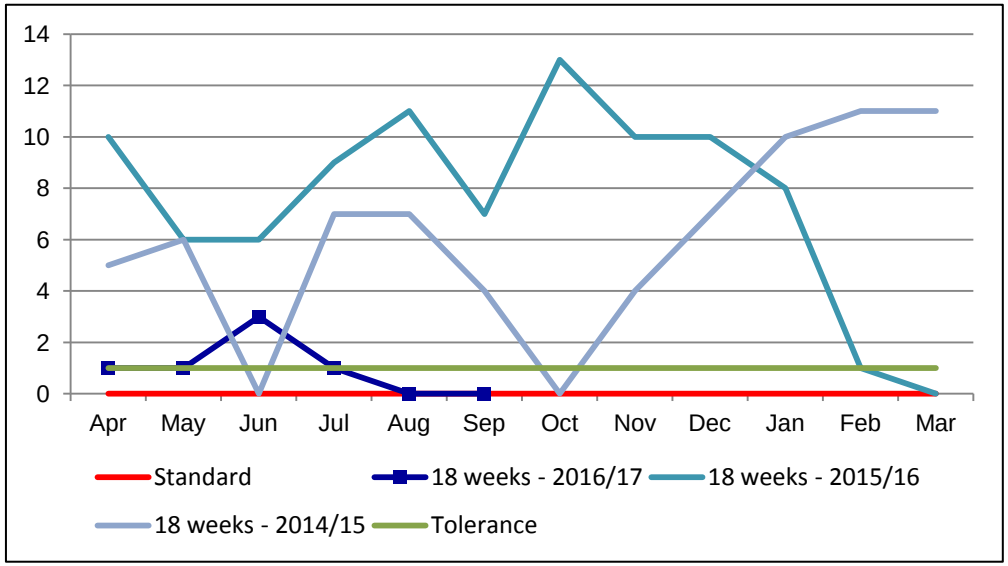
Actions:
- Continue to monitor and manage the waiting list within the performance scorecard at monthly Mental Health meetings and picked up with Team Managers by exception.
- Psychological Therapies waiting times should be included in these figures, as psychology is an integrated part of mental health teams - this is being actioned by Planning & Performance and will be in place next month.

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	0	0						
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 within the tolerance and achieving the standard over the last 3 months. No patients waited over 18 weeks in August and September 2016.

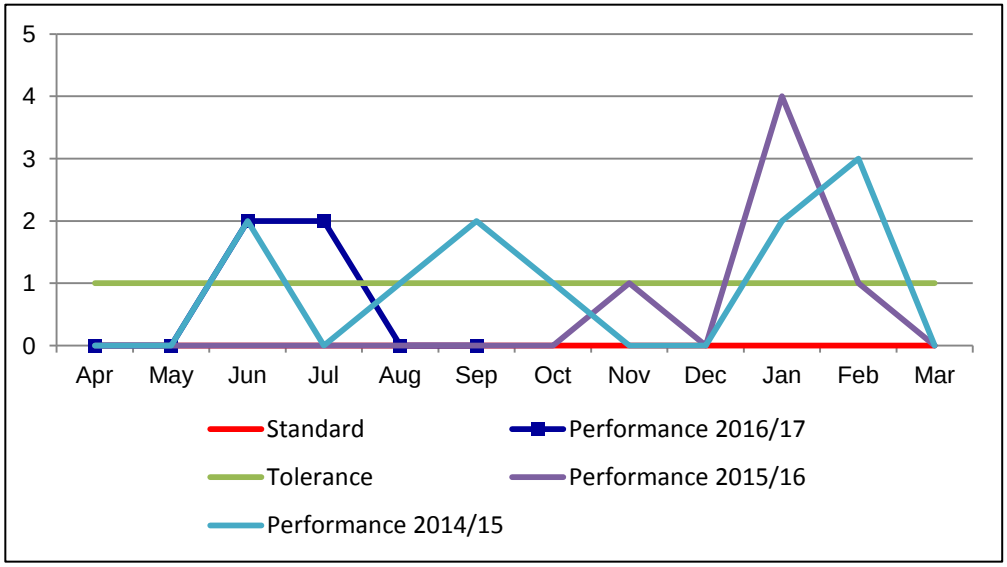
Actions:
- LD service and AHP lead working together to jointly support OT workload management.
- Continue to monitor and manage the waiting list.

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	0	0						
Performance 2015/16	0	0	0	0	0	0	0	1	0	4	1	0
Performance 2014/15	0	0	2	0	1	2	1	0	0	2	3	0



Narrative Summary:
The number of patients waiting over **1 week for the Rapid Access Chest Pain Clinic** has returned to 0 patients waiting in August and September. The 2 breaches in July 2016 are a result of a recording issue.

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

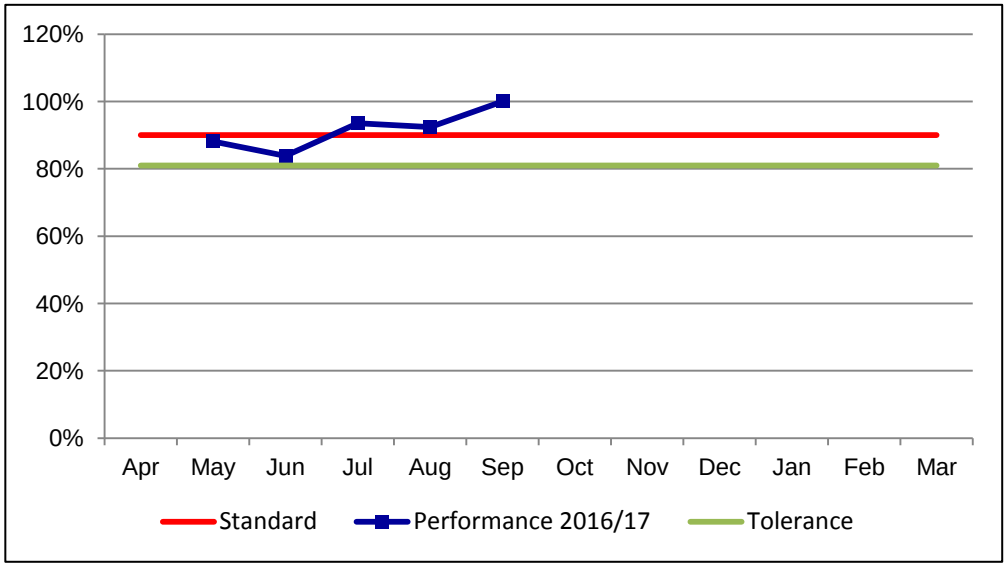
Audiology Waiting Times

	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%	92.37%	100.00%						
Patients with active wait over 18 Weeks		34	59	14	28	0						
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 Audiology service achieved 100% compliance of the 1**8 Week Referral to Treatment** standard in September 2016 and will endeavour to maintain this over the months ahead. The improvement in the waiting times is due to the service now having a full complement of staff.

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

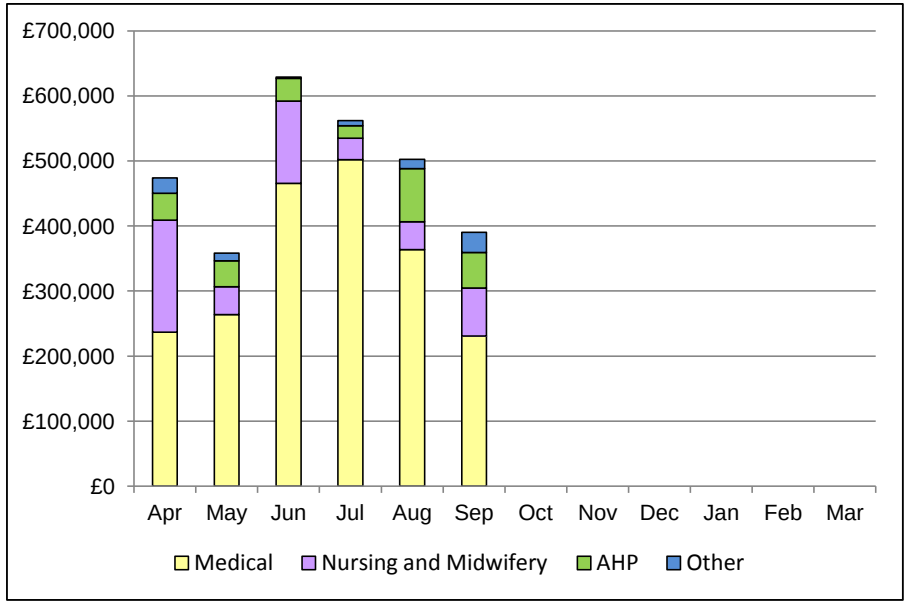
	Standard	Tolerance
Standard: Supplementary staffing - agency spend per month	0	0

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	£363,872	£230,613
Nursing and Midwifery	£172,119	£43,073	£126,542	£32,952	£42,743	£73,883
AHP	£41,435	£39,604	£35,067	£19,299	£81,660	£54,594
Other	£23,591	£11,810	£1,837	£7,740	£14,487	£31,203
Total Cost	**£473,863**	**£358,169**	**£629,121**	**£561,919**	**£502,762**	**£390,293**



Narrative Summary:
Agency Nursing has increased during the month of September and this is as a direct result of the surge beds being open during the month. AHP has reduced this month, however the spend is higher than anticipated due to a futher additional staff member supplied by Agency for PMT. 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 July, August and September is broken down below:

August 2016
Theatre £18,942
ITU £4,577

September 2016
Theatre £18,061
ITU £3,588

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