Borders NHS Board

NHS BORDERS PERFORMANCE SCORECARD – MARCH 2017

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 31st March 2017.

Background

The attached Performance Scorecard is presented to the Clinical Executive Operational Group, Strategy & Performance Committee and the Board to enable members to monitor performance against national and local standards and performance indicators. Some stretch targets remain within the report for monitoring purposes however a RAG status is only 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.

Performance Management remains a key priority across NHS Borders to ensure robust monitoring of key local and national standards and priorities. Where comparable data is readily available, an NHS Scotland position has been included in the scorecard. We are in conversation with National Services Scotland (NSS) to establish what data and reports are available to expand on the information that is currently provided. A more detailed comparison against the rest of Scotland is provided in the Managing Our Performance Report which is presented to the Board every 6 months.

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

LDP Standards	**Jan-17**	**Feb-17**	**Mar-17**
Green – achieving standard	13	14	14
Amber – nearly achieving standard	6	4	7
Red – outwith standard	12	13	10

Key Performance Indicators	**Jan-17**	**Feb-17**	**Mar-17**
Green – achieving standard	6	4	4
Amber – nearly achieving standard	0	2	2
Red – outwith standard	7	7	7

A summary RAG dashboard for the year is included on pages 4 - 7 of the report, which gives an overview of performance, and whether it is improving or deteriorating from month to month.

Areas of strong performance from the LDP Standards and Access to Treatment sections in the Scorecard for the position as at 31st March 2017 are highlighted below. Supporting

narrative and ongoing actions have been provided by the services and are detailed in the Scorecard, with the page numbers referenced below:

- The **Alcohol Brief Intervention** standard was achieved for 2016/17. Performance was 1313 against the standard of 1312 (page 13)
- 86.0% of patients were admitted on the **same day as their surgery** in January 2017 (latest available data) against the standard of 86.0% (page 17)
- The standard for **pre-operative stay** was achieved during January 2017 (latest available data) 0.02 days against the standard of 0.47 (page 18)
- 93.3% of all referrals were **triaged online** in March 2017, above the standard of 90% (page 19)
- 41.2% of new born children were **breastfed at 6-8 weeks** for the quarter October – December 2016 (latest available data) (page 20)
- The rate of **Emergency Occupied Bed Days** for the over 75s was achieved in December 2016 (latest available data) with 3386 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 February 2017 (pages 33-37)
- **Treatment of cancer within 31 days** of decision to treat for all patients diagnosed with cancer is consistently being achieved – latest available data February 2017 (page 42)
- 100% of patients were admitted to the **Stroke Unit within 1 day of admission** during February 2017 (latest available data) (page 45)
- 97.4% of patients were seen within 18 weeks referral to treatment for specialist **Child and Adolescent Mental Health Services** in March 2017 against the standard of 90% (page 48)
- 97% of clients waited no longer than 3 weeks for appropriate **Drug or Alcohol Treatment** during March 2017 (page 49)

The Board are asked to note that the following standards have been outwith the 10% tolerance (red status) for 3 or more consecutive months at 31st March 2017. Services have provided narrative and actions that are underway to improve performance. Details can be found within the scorecard on page references below.

- **Sickness Absence** – performance reported outwith the 4% standard for 5 consecutive months (page 15)
- **DNA rate** for new patients has been outwith the 4% standard for 3 consecutive months (page 16)
- **PDPs** – performance recorded outwith the trajectories set for the full financial year (page 22)
- **12 weeks Outpatient Waiting Times** – performance reported outwith the standard for 12 consecutive months during this financial year (page 26-27)
- **12 weeks Inpatient Waiting Times** – performance reported outwith the standard for 8 consecutive months (page 28-29)
- **12 week Treatment Time Guarantee** – performance reported outwith the standard for 7 consecutive months (page 30)
- **Admitted Pathway Performance** – performance reported outwith the 90% standard for 8 consecutive months (page 32)
- **6 week Diagnostic Waiting Times** – performance reported outwith the standard for the full financial year (page 38)

- **AHP Waiting Times** – performance reported outwith the standard for 12 consecutive months during this financial year (page 50)
- **Delayed Discharges** – performance reported outwith the standard for 12 consecutive months during this financial year (page 53)

The attached Scorecard contains information from the respective service leads around the reasons for non delivery of the target / standards and the actions being taken to address these. A performance "deep dive" on those areas which remain off track will be undertaken through the Board's Strategy & Performance Committee throughout the year.

Summary

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

Recommendation

The Board is asked to **note** the March 2017 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 Planning & Performance		

Author(s)

Name	Designation	Name	Designation
Carly Lyall	Planning & Performance Officer		

NHS Borders

PERFORMANCE SCORECARD

As at 31st March 2017

March 2017

Planning & Performance

Month

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INTRODUCTION

DASHBOARD OF HEAT STANDARDS

The Dashboard of Standards shows the performance of each standard against a set trajectory. To enable current performance to be judged, colour coding and letters are used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. 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
Diagnosis of dementia	A	A ↓	A ↑	A ↓	A ↑	A ↑	A ↓	A ↔	- [1]	A ↑	A ↑	A ↓
Dementia Post Diagnostic Support [2] (2015/16 data)	A	A ↓	A ↔	A ↑	A ↔	A ↔	R ↓	A ↑	A ↑	A ↑	-	-
Alcohol Brief Interventions [3]	R	R ↑	A ↑	A ↑	A ↑	G ↑	A ↑	A ↑	A ↑	A ↑	A ↑	G ↑
Smoking cessation successful quits in most deprived areas [4]	-	-	R	-	-	R ↑	-	-	-	-	-	-
Sickness Absence Reduced	R	R ↓	R ↓	A ↑	R ↓	A ↑	A ↓	R ↓	R ↓	R ↓	R ↑	R ↔
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [5]	G	G ↑	G ↓	G ↑	G ↓	G ↑	G ↔	A ↓	G ↑	G ↑	A ↓	-
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [5]	G	G ↔	G ↓	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔	G ↓	G ↑	-
18 Wk RTT: 12 wks for outpatients	R	R ↓	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓	R ↓	R ↓	R ↓	R ↑
18 Wk RTT: 12 wks for inpatients	R	A ↑	R ↓	A ↑	R ↓	R ↓	R ↓	R ↓	R ↔	R ↓	R ↓	R ↑
18 Wk RTT: 12 weeks TTG	R	R ↑	A ↑	R ↓	G ↑	R ↓	R ↑	R ↓	R ↓	R ↑	R ↓	R ↓
18 Wk RTT: Admitted Pathway Performance [6]	R	A ↑	A ↑	R ↓	R ↓	R ↑	R ↑	R ↓	R ↓	R ↑	R ↓	-
18 Wk RTT: Admitted Pathway Linked Pathway [6]	G	G ↑	G ↓	G ↓	G ↓	G ↑	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 [6]	G	G ↑	G ↔	G ↓	G ↑	G ↑	G ↓	G ↓	G ↑	G ↓	G ↑	-
18 Wk RTT: Non-admitted Pathway Linked Pathway [6]	G	G ↓	G ↓	G ↑	G ↑	G ↓	G ↓	G ↓	G ↔	G ↑	G ↓	-
Combined Performance [6]	G	G ↑	G ↑	G ↓	G ↑	G ↑	G ↓	G ↓	G ↑	G ↓	G ↔	-
Combined Performance Linked Pathway [6]	G	G ↓	G ↓	G ↓	G ↑	G ↓	G ↑	G ↓	G ↓	G ↑	G ↓	-
6 Week Waiting Target for Diagnostics	R	R ↓	R ↑	R ↑	R ↓	R ↓	R ↔	R ↑	R ↑	R ↓	R ↑	R ↑
4-Hour Waiting Target for A&E	A	A ↓	G ↑	G ↓	A ↓	A ↑	G ↑	G ↔	G ↑	A ↓	G ↑	A ↓
No CAMHS waits over 18 wks	R	A ↑	A ↑	G ↑	G ↔	G ↔	G ↔	G ↓	G ↑	G ↓	G ↑	G ↓
No Psychological Therapy waits over 18 wks	A	A ↓	A ↑	A ↓	R ↓	R ↑	R ↓	A ↑	R ↓	R ↑	R ↑	A ↑
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G	A ↓	G ↑	R ↓	R ↑	R ↓	R ↑	A ↑	G ↑	A ↓	G ↑	G ↑
No Delayed Discharges over 2 Wks	R	R ↓	R ↑	R ↓	R ↓	R ↑	R ↓	R ↑	R ↔	R ↓	R ↑	R ↓
New patient DNA rate	R	R ↑	R ↑	R ↓	A ↑	A ↓	R ↓	G ↑	A ↓	R ↓	R ↑	R ↑
Same day surgery [7]	A	A ↓	A ↑	A ↓	A ↓	A ↑	A ↑	G ↑	A ↓	G ↑	-	-
Pre-operative stay [7]	G	G ↑	G ↓	G ↓	G ↔	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
Online Triage of Referrals	G	G ↑	G ↓	G ↓	G ↑	G ↓	G ↓	G ↑	G ↓	G ↑	G ↑	G ↓
Increase the proportion of new-born children breastfed at 6-8 weeks [8]	-	-	G ↑	-	-	G ↓	-	-	G ↑	-	-	-
eKSF annual reviews complete	R	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	A ↑
PDP's Complete	R	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑
Emergency OBDs aged 75 or over (per 1,000) [9]	G ↑	G ↑	G ↑	G ↑	G ↓	G ↑	G ↓	G ↑	G ↓	-	-	-
Admitted to the Stroke Unit within 1 day of admission [10]	A	G ↑	A ↓	G ↑	G ↑	G ↓	A ↓	G ↑	A ↓	A ↓	R ↓	G ↑

Footnotes

1 Data unavailable from the service for December 2016

2 There is a 1 year time lag to show the full 12 months performance therefore data is 2015/16 rather than 2016/17

3 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.

4 Data is reported quarterly, with a time lag, to allow monitoring of the 12 week quit period.

5 One month lag as data is supplied nationally.

6 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. Please note arrows and staus have been updated for Novemeber due to reporting error.

7 There is a 2 month lag in data due to SMR recording

8 There is a lag time for national data, local data supplied and reported quarterly

9 There is a 6 month lag in reporting any data included is the most up to date data available.

10 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 ↑	R ↓	R ↓	R ↓	R ↑	R ↑	R ↑
Cancellations	Hospital	R	R ↓	R ↑	R ↑	R ↓	R ↑	R ↓	R ↑	R ↓	R ↓	G ↑	A ↓
	Clinical	R	R ↑	G ↑	A ↓	G ↑	A ↓	G ↑	R ↓	G ↑	G ↓	R ↓	A ↑
	Patient	G	G ↓	G ↓	A ↓	G ↑	G ↓	G ↓	G ↑	A ↓	G ↑	G ↓	G ↑
	Other	G	G ↔	G ↔	G ↔	G ↓	G ↑	G ↔	G ↓	G ↑	G ↔	G ↔	G ↓
Borders General Hospital Average Length of Stay		R	A ↑	A ↑	A ↓	A ↓	R ↓	R ↔	A ↑	A ↑	R ↓	A ↑	R ↓
Community Hospitals Average Length of Stay		R	R ↑	R ↑	R ↓	R ↑	R ↓	R ↑	R ↓	R ↑	R ↓	R ↑	R ↓
Mental Health Average Length of Stay General Psychiatry Total [1]		-	-	G ↑	-	-	G ↑	-	-	R ↓	-	-	G ↑
Mental Health Average Length of Stay Psychiatry of Old Age Total [1]		-	-	R ↓	-	-	R ↑	-	-	R ↑	-	-	R ↓
Mental Health Waiting Times (Patients waiting over 18 weeks)		A	G ↑	G ↔	G ↔	G ↔	G ↔	R ↓	R ↓	R ↓	R ↓	R ↑	R ↓
Learning Disability Waiting Times (Patients waiting over 18 weeks)		A	A ↔	R ↓	A ↑	G ↑	G ↔	A ↓	G ↑	G ↔	G ↔	R ↓	R ↓
Rapid Access Chest Pain Clinic		G	G ↔	R ↓	R ↔	G ↑	G ↔	G ↔	G ↔	A ↓	G ↑	A ↓	R ↓
Audiology 18 Weeks Waiting Times [2]		-	A -	A ↓	G ↑	G ↓	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔

Footnotes

1 Mental Health ALOS moved to quarterly reporting in October 2016 after discussion with the service and as agreed at the Mental Health Performance Review

2 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

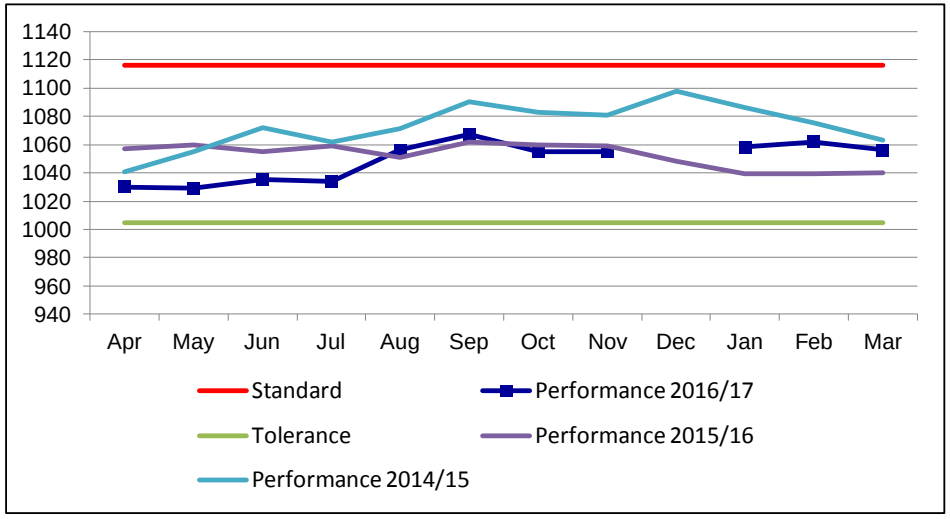
Diagnosis of Dementia

	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	1055	1055	-	1058	1062	1056
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

Please Note: Data unavailable for December 2016 at time of reporting



Narrative Summary:
The run chart shows the number of patients being added to the **Dementia Register** continues to fluctuate on a monthly basis but overall has increased from April 2016 to February 2017, but down again in March. Work continues as described below.

Actions:
- An exercise to review patients' dementia diagnosis recording on ePEX is ongoing.
- A pilot gap analysis of diagnoses on ePEX against the Dementia register was carried out with Selkirk practice and increased the number of diagnoses recorded for Selkirk area patients by approximately 20%.
- The above process is going to be carried out with all GP practices willing to participate - a letter has been drafted for Consultants from each area to send to the relevant practice.
- It is anticipated that with this data validation exercise the target will be met.

Dementia - Post Diagnostic Support (PDS)

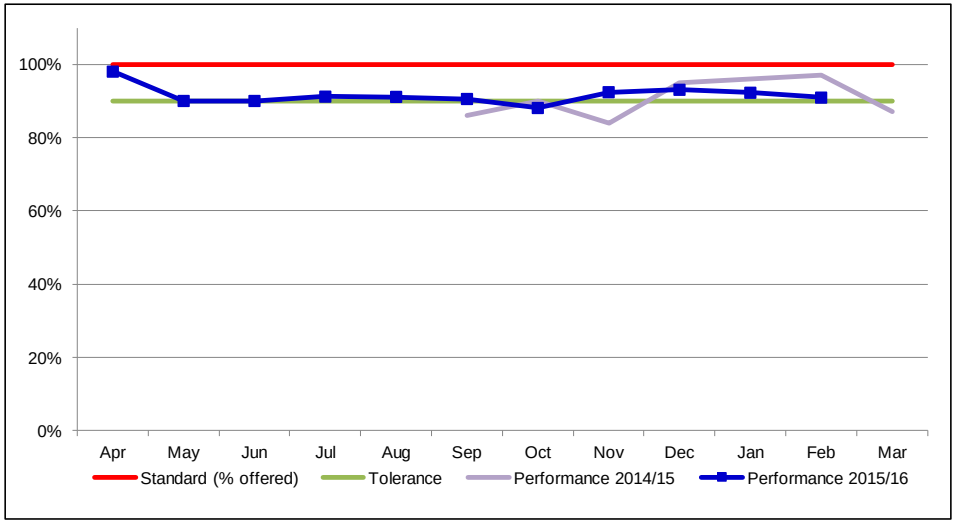
	Standard	Tolerance
Standard: People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support	100%	within 10%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (% offered)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of People who are referred for PDS and have been offered at least 12 months of PDS												
Performance 2016/17												
Performance 2015/16	135	140	166	186	205	220	229	255	281	297	310	
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	243	260	276	302	322	341	
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%	91%	88%	92%	93%	92%	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) had shown an improvement until October 2015 (year lag time) when the standard was outwith 10% tolerance. This has since improved.

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 to will influence national data collection. This work is being undertaken in partnership with ISD data tool which was reviewed in October 2016 and has now been formalised into the National programme.
- Post Diagnostic Support Excellence Programme has provided the basis for further training for staff and informed the action plan regarding further learning. The final cohort of staff were trained in March 2017.

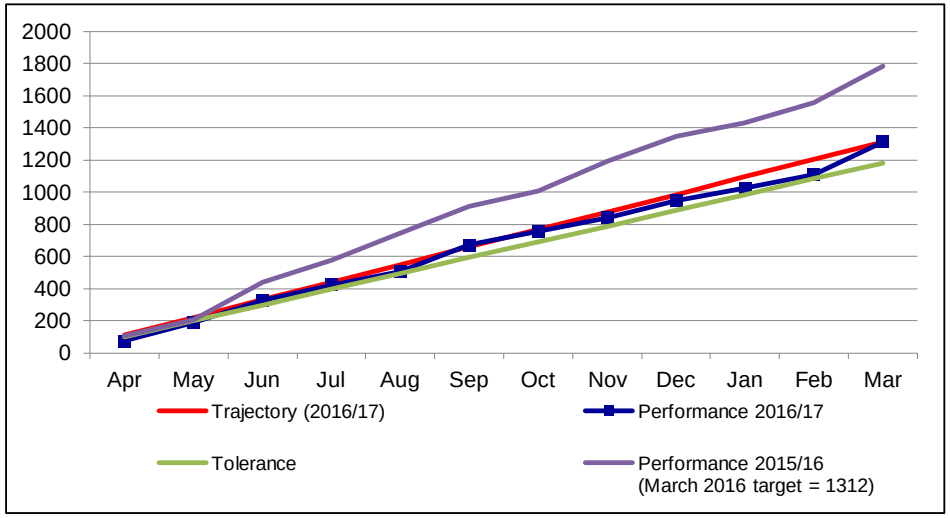
Alcohol Brief Interventions (ABI)

	Standard	Tolerance
Standard: Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings	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	756	841	949	1025	1109	1313
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:

Alcohol Brief Intervention performance for 2016/17 is 1313 against the standard of 1312 (100%). There are still low levels of screening in Accident & Emergency. The Alcohol & Drugs Partnership Support Team and Substance Misuse Liaison Nurse have provided training to relevant staff and agreed a process, however, this is not yet embedded. The team are liaising with managers to improve this.

It is anticipated performance in 2017/18 will be lower following the cessation of the Local Enhanced Service agreement for ABI's with Primary Care.

Actions:

- Continue to support Accident & Emergency.

Smoking Quits

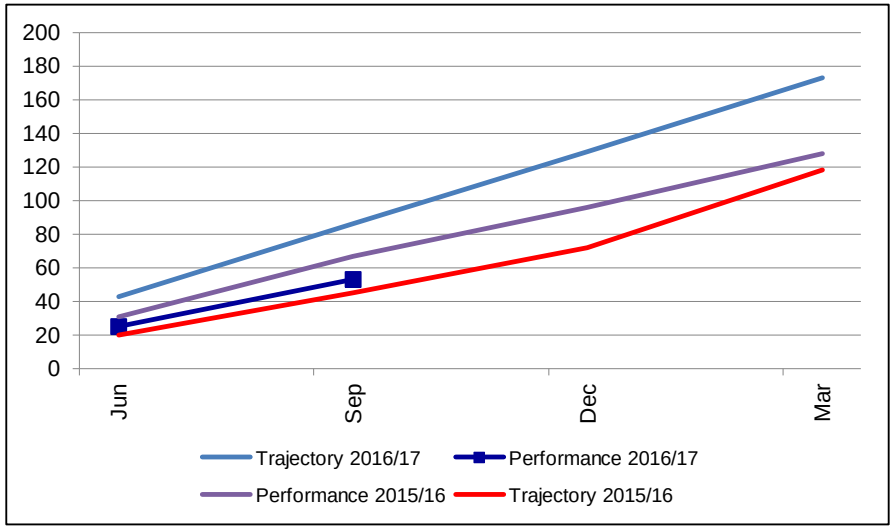
Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas	Standard	Tolerance
	117	within 10%

Actual Performance (higher = better performance)

	Jun	Sep	Dec	Mar
Trajectory 2016/17	43	86	129	173
Performance 2016/17	25	53		
Trajectory 2015/16	20	45	72	118
Performance 2015/16	31	67	96	128

[1] Quarter 1 of 2016/17 should be treated as provisional

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:
The Q2 standard for successful 12 week **smoking quits** is 86. Currently there are 53 recorded (62% of target). Nationally there has been a reported 5% drop in referrals to services and this is reflected locally.

Actions:
- New marketing materials have been developed.
- We are monitoring referral sources to confirm any impact of the facebook and radio campaign. The reach of our facebook page has increased.
- New health behaviour change toolkit developed with a trainee health Psychologist being implemented across the Smoking Cessation team in February 2017 to increase successful quits.
- A Smoking Cessation Advisor clinic has started in Teviot Medical Practice in Hawick from January 2017 to increase accessibility.

Sickness Absence

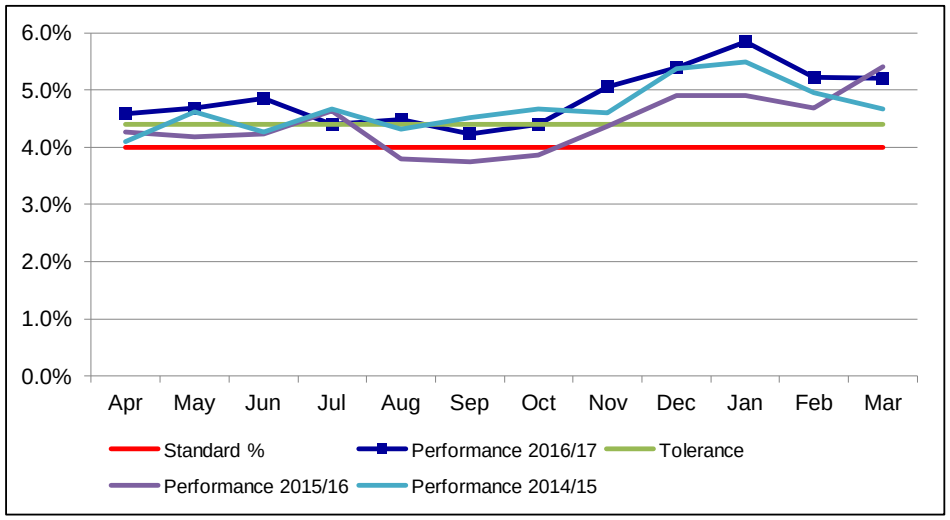
Standard: Maintain Sickness Absence Rates below 4%

Standard	Tolerance
4.0%	4.4%

Actual Performance (lower % = better performance)

Latest NHS Scotland Performance
4.99% (February 2017)

	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%	4.4%	5.1%	5.4%	5.8%	5.2%	5.2%
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 that at 5.2% the **Sickness Absence** rate was outwith the standard in March 2017.

Cumulative sickness absence for the year to February 2017 was 4.86% which is 0.33% lower than the NHS Scotland average of 5.19%.

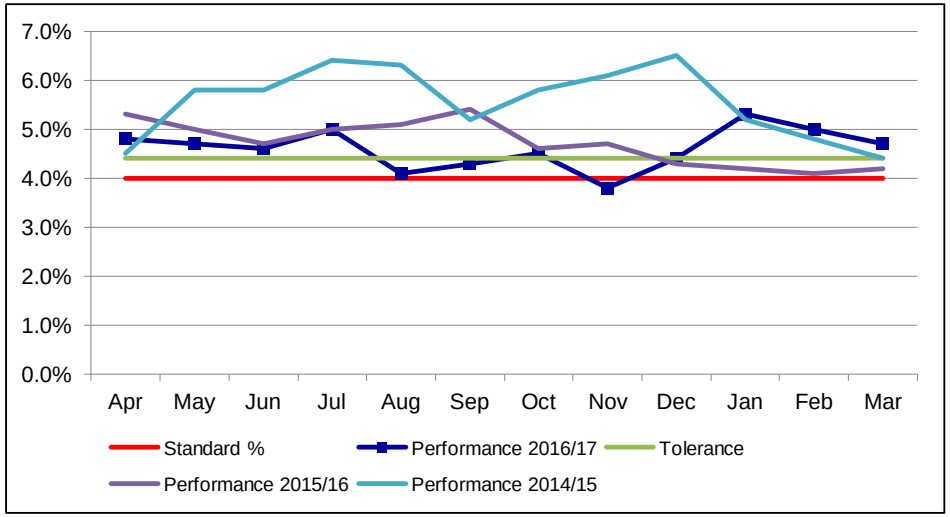
Actions:
- HR continue to be a support service to the Clinical Boards by providing advice and support in managing sickness absence as well as proactively identifying areas where rates are high.
- Monthly sickness absence reports are provided to each Clinical Board, these detail trends, rates, the level of short term and long term sickness absence and reasons for absence per department.
- An Attendance Management and Wellbeing project undertook a deep dive analysis of all nursing episodes in BGH, and other skill groups to identify key themes which have informed a new action plan for 2017/18.

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%	4.5%	3.8%	4.4%	5.3%	5.0%	4.7%
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 successful reduction in **DNA** levels after the 6 week media campaign in July / August 2016, in the latter part of 2016 showed some improvement. The DNA rate during January 2017 increased, however over the past 2 months it has been reducing.

Actions:
- Continue to assign staff where possible to telephone patients with a history of missed appointments.
- Exploring a refresh of the posters for a 2017 DNA campaign.

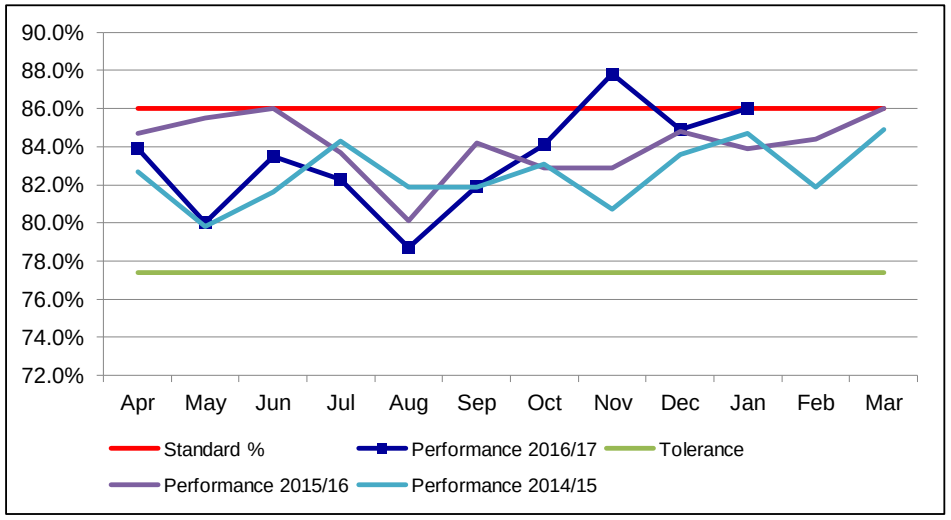
Same Day Surgery

	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%	78.7%	81.9%	84.1%	87.8%	84.9%	86.0%		
Performance 2015/16	84.7%	85.5%	86.0%	83.7%	80.1%	84.2%	82.9%	82.9%	84.8%	83.9%	84.4%	86.0%
Performance 2014/15	82.7%	79.8%	81.6%	84.3%	81.9%	81.9%	83.1%	80.7%	83.6%	84.7%	81.9%	84.9%

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



Narrative Summary:
A overall improvement has been reported over the last 5 months with November 2016 and January 2017 achieving the overall 86% HEAT standard for **same day surgery** (BADS* procedures).

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:
- Ongoing redesign of Theatres and surgical flow within BGH which will enable repatriation and therefore should increase the number of Day Case procedures. Implementation of the new agreed service model took place in November 2016 and this will be monitored for success over the year.

**British Association of Day Case Surgery*

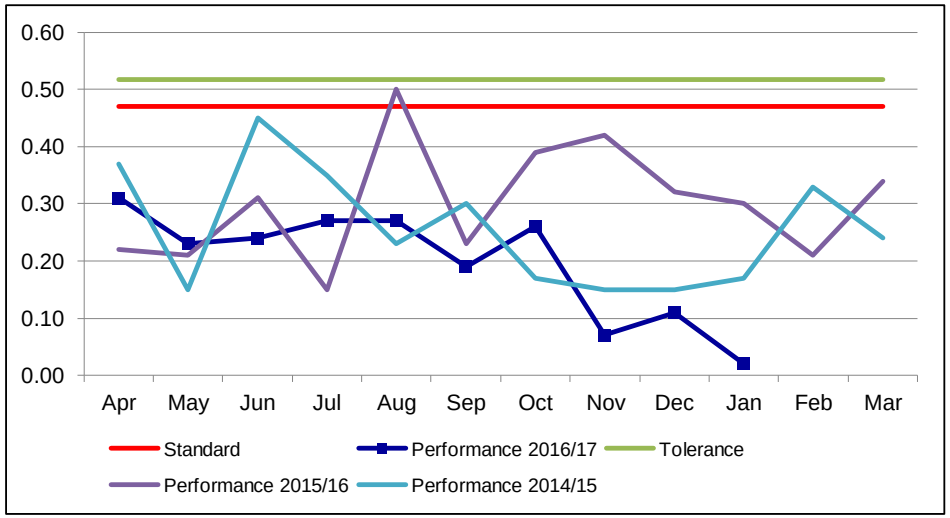
Pre-Operative Stay

	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	0.27	0.19	0.26	0.07	0.11	0.02		
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. showing a downward trend 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.

Since 15th August 2016, we have continued to ensure we are keeping our pre-admission rate to a minimum. All preadmissions are based on valid medical or social reasons which meant pre-admission could not be avoided. We are also monitoring the impact on theatre start time as a result of no pre-admission and to date there has been no negative impact.

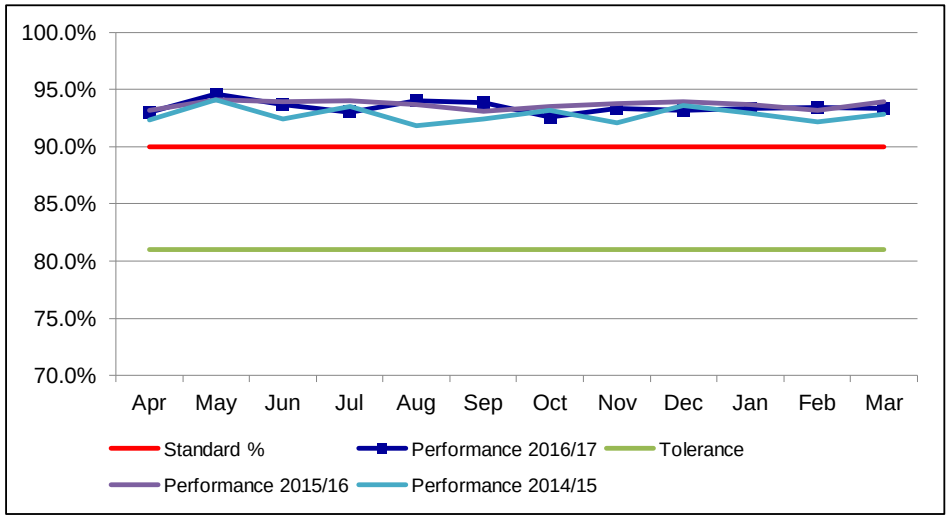
Actions:
- No further action planned at this time.

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%	92.6%	93.3%	93.2%	93.3%	93.4%	93.3%
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 chart shows the percentage of **electronic referrals** received for the month that have been **triaged** within 10 days of month end.

Actions:
- The goal remains to increase the number of referrals received and processed online.
- Work is ongoing to enable Dentists to send referrals electronically via SCI Gateway. This should be in place from April 2017 and will result in more triaged electronically.
- Explore providing SCI Gateway to Berwick GP Practices.

Breastfeeding

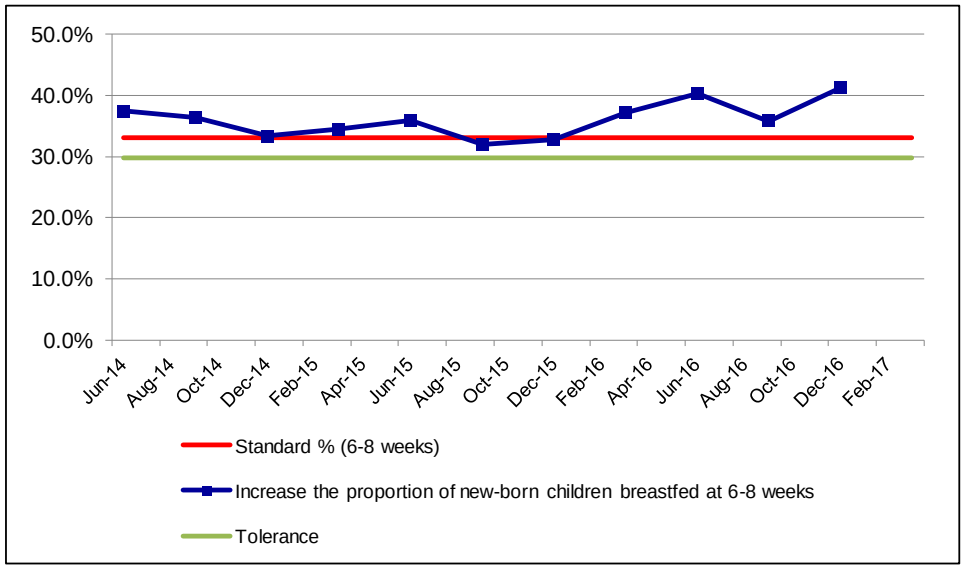
	Standard	Tolerance
Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	33.0%	29.7%

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%	35.8%	41.2%	
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%	44.7%	46.7%	
Percentage Ever Breast Fed	-	-	-	-	-	-	-	60.50%	75.0%	72.4%	76.1%	

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. March 2016 data is provisional due to the change over period and forms for reporting

[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 October to December 2016 performance exceeded the 33% standard.

NHS Borders successfully achieved UNICEF BFI re-accreditation in December 2016.

Actions:
- Maternity Staff and BFI key workers actively working to ensure babies get the best start in life. All staff continue to attend training updates on BFI Breastfeeding and Relationship Building and Skin to Skin is initiated for all deliveries.
- NHS Borders has an active peer support programme offered to all breastfeeding women.

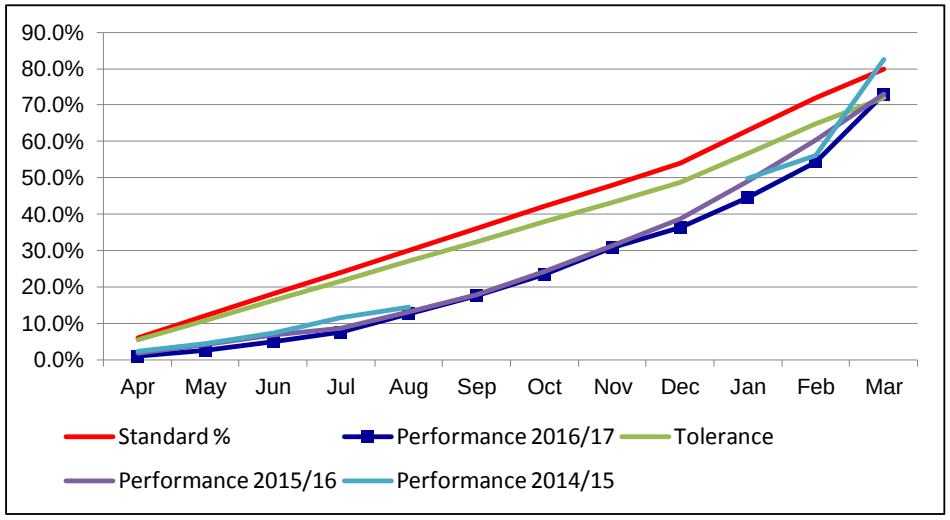
eKSF

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

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	6.0%	12.0%	18.0%	24.0%	30.0%	36.0%	42.0%	48.0%	54.0%	63.0%	72.0%	80.0%
Performance 2016/17	1.0%	2.5%	4.9%	7.6%	12.7%	17.7%	23.5%	30.8%	36.2%	44.6%	54.4%	72.9%
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 within the 10% tolerance for the year.

Actions:
- An email has been circulated from the Director of Workforce & Planning and the Employee Director reminding staff of the importance and instructions on how sign of reviews
- KSF Champions continue to support and encourage managers to spread out reviews over the full year which should be reflected in the trajectory.

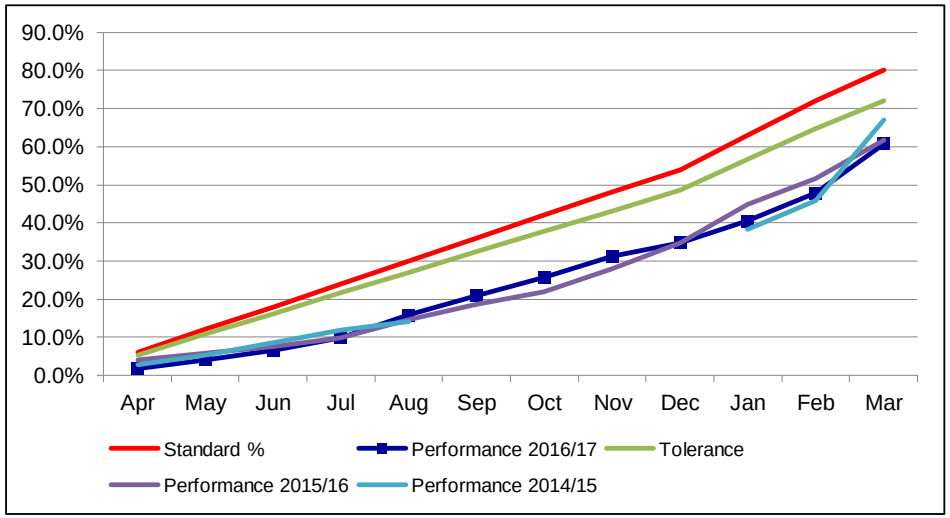
Personal Development Plans

	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%	25.6%	31.3%	34.8%	40.5%	47.8%	60.8%
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 this year.

Actions:
- Regular reports are 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 trajectory.

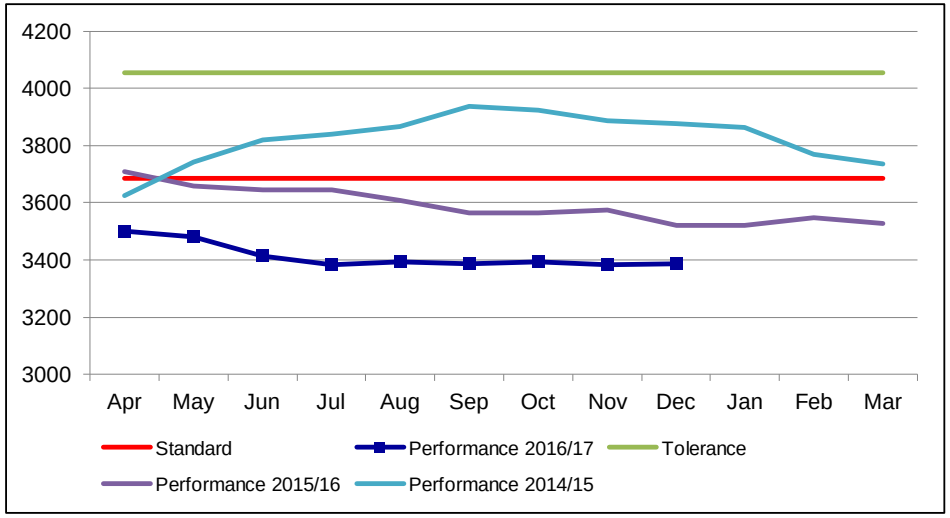
Emergency Occupied Bed Days

	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	3481	3415	3383	3393	3386	3393	3384	3386			
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 up to 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.

Actions:
- The medical inpatient floor was remodelled in October 2016 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.
- There is also an increase in partnership working across health and social care to reduce delays for people requiring support on discharge home. The outcomes of this remodelling will be reviewed by end of March. There continue to be delays in transitions of care and we are working closely with partners to address these.

LDP Standards:

Access to Treatment

Access to Treatment Performance Summary

Overview

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

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

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

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

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

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

Stage of Treatment - 12 Weeks Waiting Time for Outpatients

	Standard	Tolerance
Standard: 12 weeks for first outpatient appointment	0	1

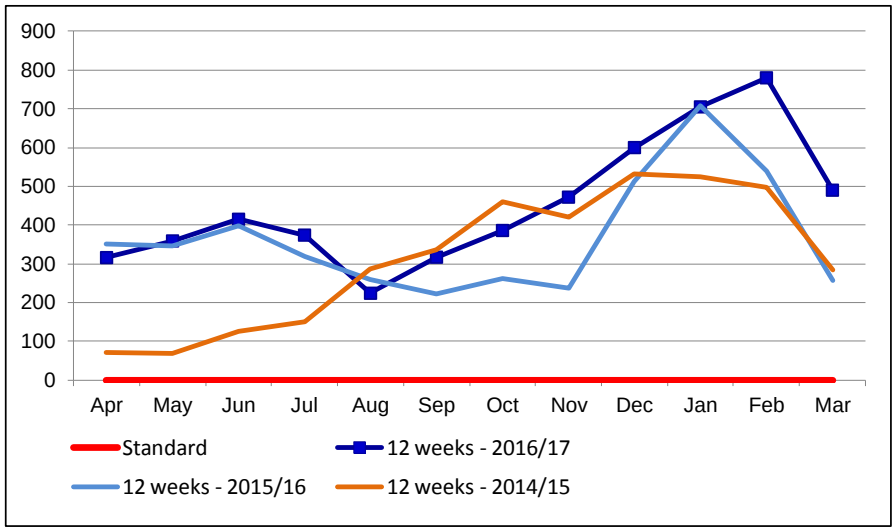
Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
12 weeks - 2016/17	316	359	415	374	224	317	386	472	600	705	780	490
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

12 week breaches by specialty

2016/17	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Cardiology	1							3	31	47	59	64
Dermatology	3	1	27	34	27	85	109	183	283	322	272	178
Diabetes/Endocrinology		1	2	3	1	8	19	17	28	31	27	15
ENT	172	223	239	172	48	3						
Gastroenterology	76	89	106	95	42	10	5		19	37	32	10
General Medicine												
General Surgery	1	1	1	1			8		2	4	7	2
Gynaecology		1					1				1	
Neurology			1	1			1	7	19	16	4	1
Ophthalmology	17			2	1	1	0	2	53	70	143	87
Oral Surgery					21	110	151	167	50	24	8	4
Orthodontics								1	1			1
Other	11	5		5	2	5	2	3	7	3	20	9
Pain Management	16	34	38	60	74	93	88	80	88	86	71	38
Respiratory Medicine												
Rheumatology								1				
Trauma & Orthopaedics					6				1	58	131	81
Urology	19	4	1	1	2	2	2	8	18	7	5	
All Specialties	**316**	**359**	**415**	**374**	**224**	**317**	**386**	**472**	**600**	**705**	**780**	**490**

Stage of Treatment - 12 Weeks Waiting Time for Outpatients *continued*



Narrative Summary:
The number of patients reported as waiting longer than 12 weeks has improved in March due to extra activity provided within Dermatology and Gastroenterology. It is however predicted to increase again in April due to ongoing issues within these specialties.

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 however the service has been taking a proactive response to referrals and this having a positive effect on their waiting list.
- Dermatology: currently is an issue due to long term consultant illness and the new consultant that was due to start in January has declined the post. A review into the service is currently underway. Also we have received funding from the Scottish Government to support extra clinics to help reduce the breaching patients.
- Diabetics / Endocrinology: continues to be challenging. Short-term capacity has been organised with local clinicians whilst a longer term solution is identified.
- Oral Surgery: the new consultants came into post at the start of January so we expect the Outpatient Waiting Lists to reduce over the coming months.
- 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	Tolerance
Standard: 12 Weeks Waiting Time for Inpatients	0	1

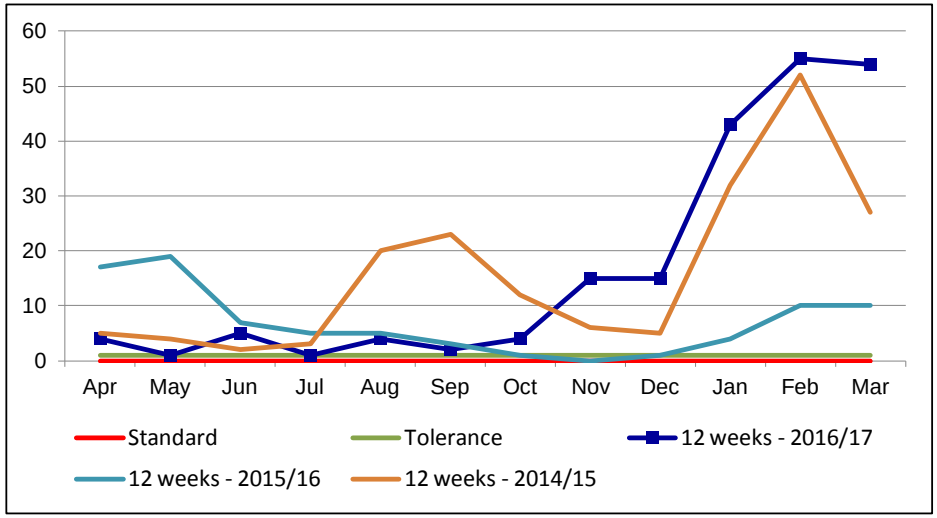
Actual Performance (lower = better performance)

	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	4	15	15	43	55	54
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

12 week breaches by specialty

2016/17	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
ENT	1									3	1	1
General Surgery	1			1	2					1	2	1
Gynaecology										1	1	
Ophthalmology												
Oral Surgery			1				1				1	4
Other												
Trauma & Orthopaedics	1	1	4		2	2	3	15	15	37	49	48
Urology										1	1	
All Specialties	**3**	**1**	**5**	**1**	**4**	**2**	**4**	**15**	**15**	**43**	**55**	**54**

Stage of Treatment - 12 Weeks Waiting Time for Inpatients *continued*



Narrative Summary:
At the end of March, the number of patients reported waiting over **12 weeks for inpatient treatment** reduced to 54. This is expected to increase in the interim with the cessation of weekend operating for Orthopaedics as outlined to the Board in December 2016.

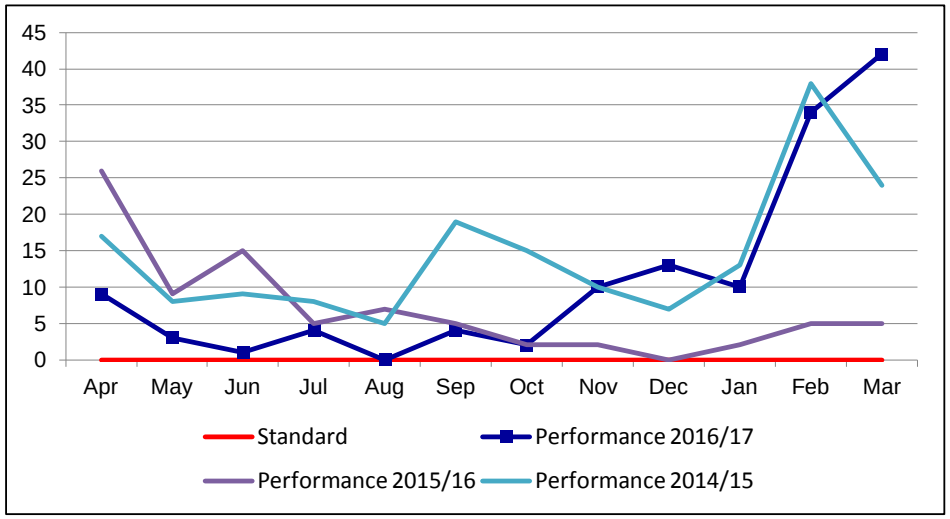
Actions:
- There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. We are working to minimise the impact of cessation of Synaptik operating lists with the implementation of the theatres and surgical flow project.

12 Weeks Treatment Time Guarantee

	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	2	10	13	10	34	42
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 March we had 42 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.
Following the implementation of the combined elective ward, cancellations due to bed availability have reduced, although there are still theatre capacity issues within Orthopaedics.

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	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Unavailable	70	83	90	107	115	115	92	82	73	59	72	58	58
Patient Advised	40.9%	46.4%	54.5%	55.2%	55.6%	55.8%	48.4%	44.1%	43.5%	47.6%	51.4%	40.8%	37.2%
Unavailable	101	96	75	87	92	91	98	104	95	65	68	84	98
Medical	59.1%	53.6%	45.5%	44.8%	44.4%	44.2%	51.6%	55.9%	56.5%	52.4%	48.6%	59.2%	62.8%
Total Unavailable	171	179	165	194	207	206	190	186	168	124	140	142	156
Total % Unavailable	15.9%	17.4%	15.1%	18.0%	19.1%	19.1%	19.0%	16.9%	17.3%	12.5%	13.2%	13.1%	14.3%

Table 2 - Monthly Unavailability by Specialty - as at 31st March 2017

	Available				Unavailable			
Specialty	**0 - 9 Weeks**	**10 - 12 Weeks**	**12+ Weeks**	**Total**	**Medical Un-available**	**Patient Advised Un-available**	**Total**	**% Un-available**
ENT	50	7	1	**58**	1	3	**4**	**6.5%**
General Surgery	165	13	1	**179**	20	11	**31**	**14.8%**
Gynaecology	41	1	0	**42**	3	5	**8**	**16.0%**
Ophthalmology	188	12	0	**200**	10	4	**14**	**6.5%**
Oral Surgery	40	3	4	**47**	4	2	**6**	**11.3%**
Other	18		0	**18**	2	0	**2**	**10.0%**
Trauma & Orthopaedics	220	54	48	**322**	34	26	**60**	**15.7%**
Urology	66	5	0	**71**	24	7	**31**	**30.4%**
Total	**788**	**95**	**54**	**937**	**98**	**58**	**156**	**14.3%**

Narrative Summary:
There has been a general downward trend over the past few months in the number of patients with patient advised unavailability that has decreased steadily since January. Trauma & Orthopaedics and General Surgery have higher levels of unavailability due to the number of patients that wish to delay their treatment for as procedures within these specialties generally tend to have longer recovery times that impacts on the patients availability around their commitments. 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.

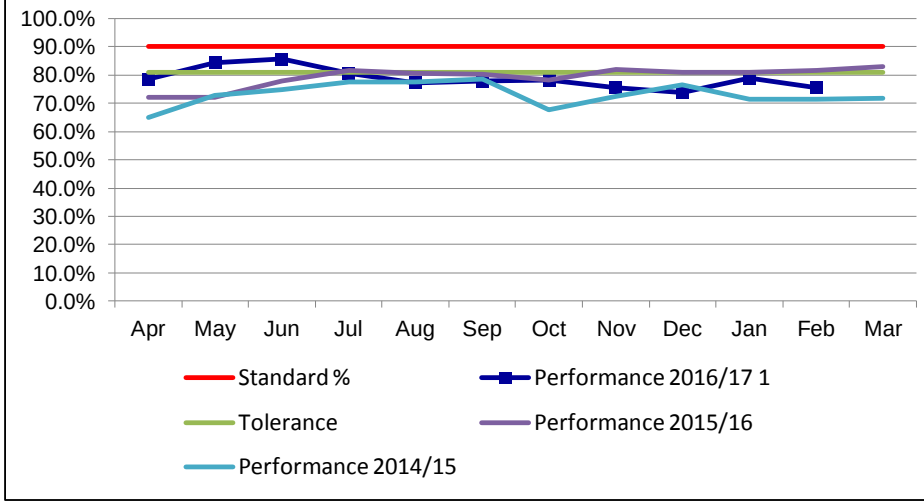
18 Weeks Referral to Treatment (RTT)

	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%	77.7%	78.0%	75.5%	73.6%	78.7%	75.5%	
Performance 2015/16	72.2%	71.9%	77.8%	81.6%	80.5%	80.3%	78.3%	82.0%	81.0%	81.0%	81.6%	82.8%
Performance 2014/15	64.9%	72.6%	74.8%	77.4%	77.4%	78.5%	67.5%	72.4%	76.5%	71.3%	71.5%	71.6%

[1] April & November 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.

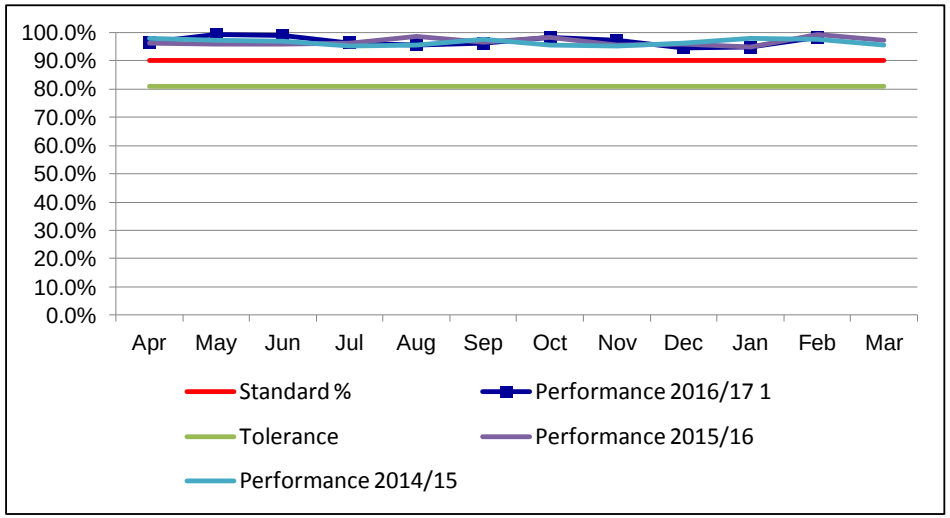
18 Weeks Referral to Treatment (RTT)

	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 [1]	96.5%	99.2%	98.9%	96.3%	95.6%	96.2%	98.1%	97.1%	94.6%	94.7%	98.1%	
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%

[1] November 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 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.

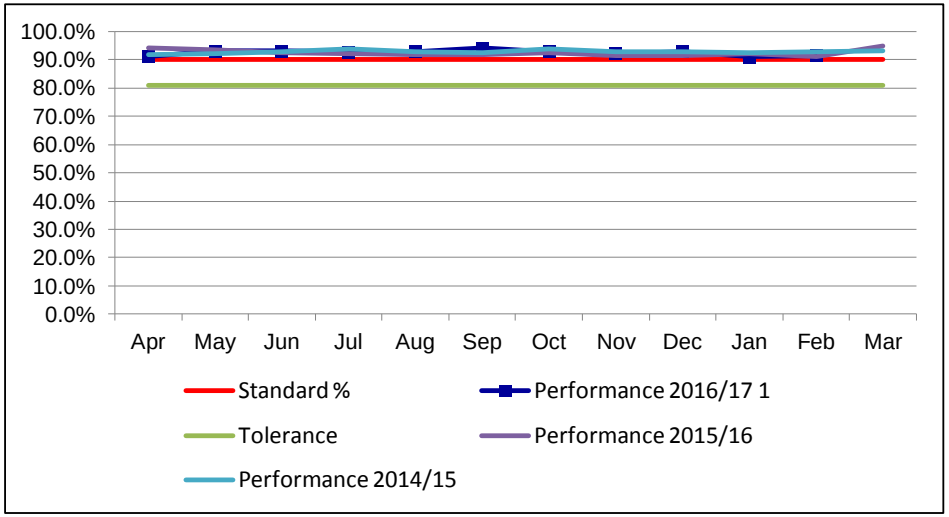
18 Weeks Referral to Treatment (RTT)

	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%	94.0%	92.8%	92.1%	92.9%	90.9%	91.5%	
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 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.

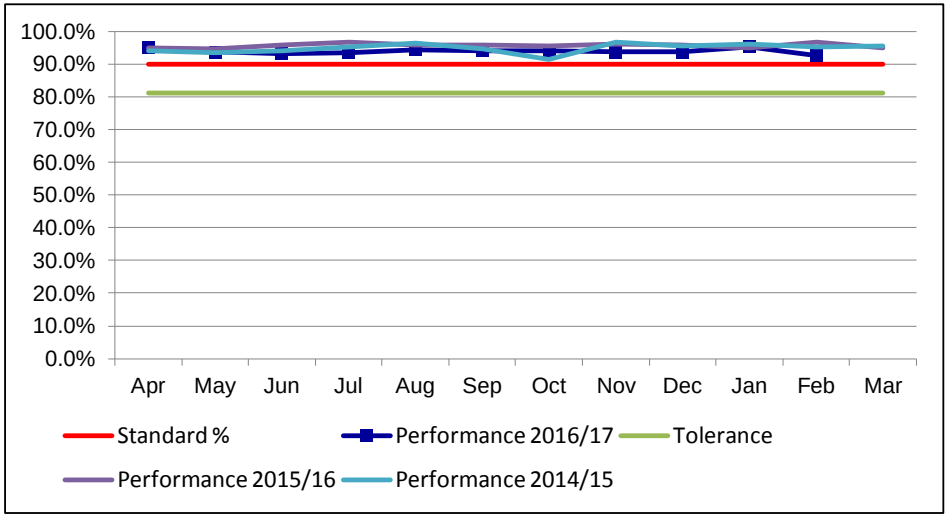
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Non-Admitted 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%	94.0%	93.9%	93.6%	93.6%	95.2%	92.7%	
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.

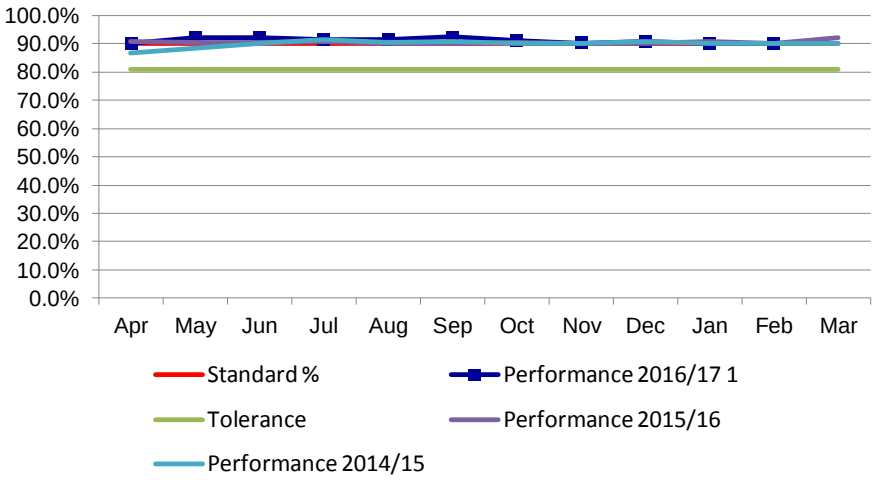
18 Weeks Referral to Treatment (RTT)

	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%	92.3%	91.0%	90.2%	90.7%	90.0%	90.0%	
Performance 2015/16	90.6%	90.3%	90.5%	90.6%	90.1%	90.2%	90.3%	90.0%	90.1%	90.7%	90.0%	92.0%
Performance 2014/15	86.8%	88.4%	90.2%	91.5%	90.4%	90.6%	90.1%	90.0%	90.8%	90.1%	90.0%	90.1%

[1] April & November 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 standard for NHS Boards RTT is to deliver 90% combined performance. NHS Borders has consistently achieved the 90% national standard since June 2014. This has proven challenging over the last 12 months, due to a relatively poor performance on admitted pathways. Audiology are 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.

The initial 18 Weeks RTT reporting function is over reporting breaches. This does not affect the national reporting as there is a lengthy validation process in place. The issue is that the report does not show the clock stops for each pathway, it counts the last appointment linked to the pathway and excludes all previous clock stops. This drastically increases the amount of time required to validate records to ensure we meet the national standard. Once the 90% standard is achieved there is no further validation.

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.
- The Waiting Times team are working with IM&T to secure senior developer time to resolve the reporting issue within the Business Objects Universe.

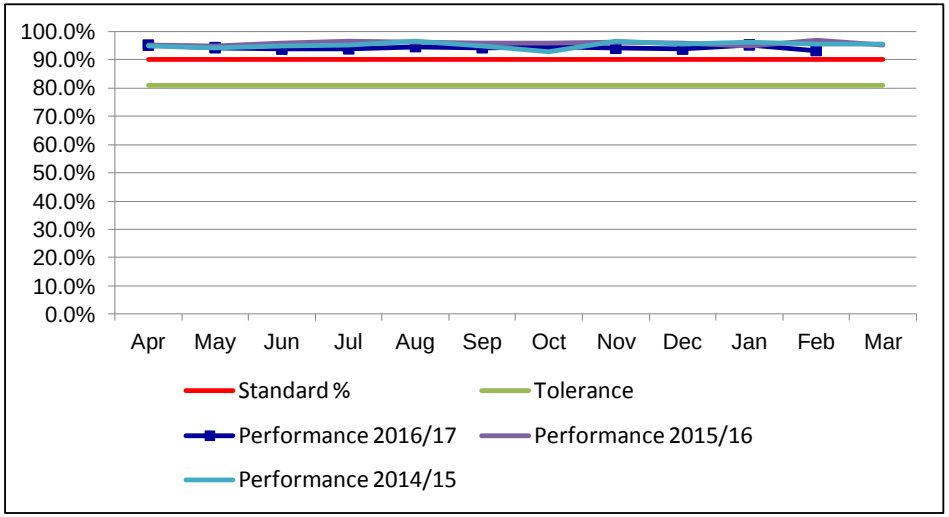
18 Weeks Referral to Treatment (RTT)

	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 [1]	95.1%	94.2%	93.7%	93.8%	94.6%	94.2%	94.4%	94.0%	93.7%	95.2%	93.2%	
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%

[1] November 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 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.

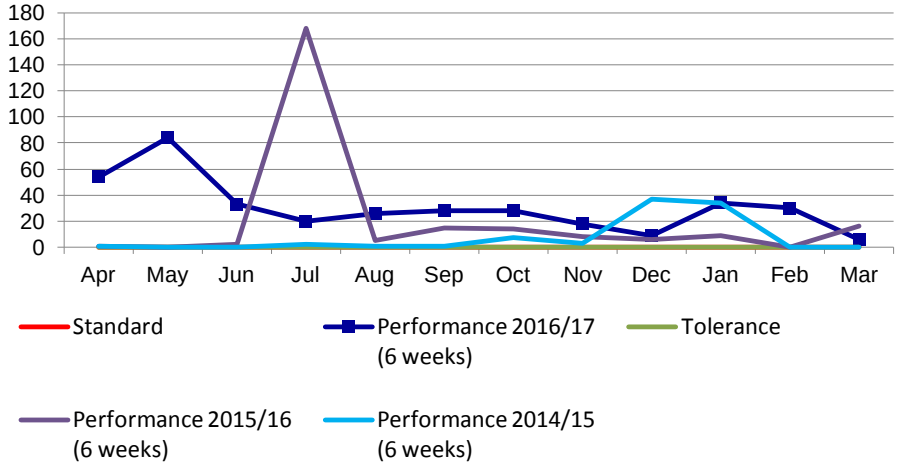
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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	28	18	9	34	30	6
Performance 2016/17 (4 weeks)	307	430	165	137	52	103	141	62	56	59	95	114
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. Work is underway to review capacity plans for radiology and endoscopy.

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 - 6 weeks	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Endoscopy	-	-	-	-	-	-	-	-	-	-	0	0	0
Colonoscopy	-	-	-	-	-	-	-	-	-	-	25	29	6
Cystoscopy	-	-	-	-	-	-	-	-	-	-	8	0	0
MRI	-	-	-	-	-	-	-	-	-	-	1	1	0
CT	-	-	-	-	-	-	-	-	-	-	0	0	0
Ultra Sound (non-obstetric)	-	-	-	-	-	-	-	-	-	-	0	0	0
Barium	-	-	-	-	-	-	-	-	-	-	0	0	0
Total	**16**	**54**	**84**	**33**	**20**	**26**	**28**	**28**	**18**	**9**	**34**	**30**	**6**

Diagnostic - 4 weeks	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Endoscopy	39	21	27	2	1	0	0	0	4	0	0	0	0
Colonoscopy	20	32	38	62	34	40	68	63	34	38	41	52	31
Cystoscopy	0	1	0	0	1	1	0	0	2	4	11	0	3
MRI	53	93	102	23	18	10	21	45	6	6	5	16	44
CT	50	86	81	8	25	0	14	33	5	8	2	25	34
Ultra Sound (non-obstetric)	3	74	182	70	58	1	0	0	8	0	0	2	2
Barium	0	0	0	0	0	0	0	0	3	0	0	0	0
Total	**165**	**307**	**430**	**165**	**137**	**52**	**103**	**141**	**62**	**56**	**59**	**95**	**114**

Narrative Summary and Actions:
Colonoscopy – The service continues to experience capacity issues however the number of patients waiting over 6 weeks has reduced significantly this month due to a higher number of removals. A plan for providing additional capacity through the recruitment of a non-medical endoscopist was approved at the April Strategy Group.

Endoscopy – Performance is being actively monitored.

Magnetic Resonance Imaging (MRI) & Computerised Tomography (CT) – Consultants continue to do additional sessions to meet the demand on the service. Approval to appoint an additional consultant was agreed at the April Strategy Group.

Ultrasound – The ultrasound service is managing current demand with use of a locum to fill a vacant band 7 post and currently has one member of staff undergoing training with plans to train a further staff member over the next year.

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. Monthly performance and supporting narrative can be found on the next page.

Cancer Waiting Times	July to Sept 2014	Oct to Dec 2014	Jan to Mar 2015	Apr to Jun 2015	Jul to Sept 2015	Oct to Dec 2015	Jan to Mar 2016	Apr to Jun 2016	Jul to Sep 2016	Oct to Dec 2016
62-day standard	98.51%	97.44%	94.40%	98.70%	98.50%	98.50%	100%	97.22%	98.90%	92.60%
31-days standard	100%	100%	97.80%	100.00%	97.80%	98.20%	100%	98.18%	100%	100%

Cancer Waiting Times

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

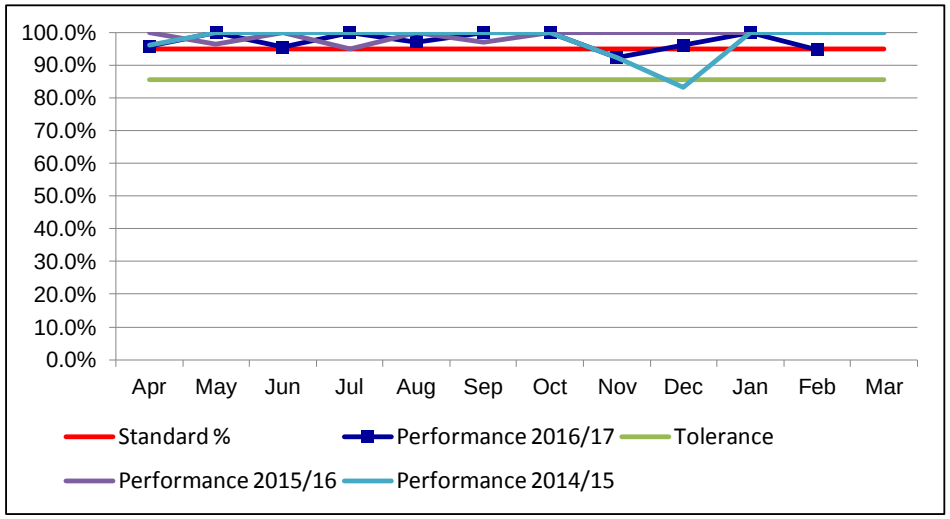
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
87.3% (February 2017)

	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%	100.0%	100.0%	92.3%	96.0%	100.0%	94.7%	
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** was not achieved in November 2016 and February 2017. In November there were two patients who breached the standard.

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 after the GI Synaptik sessions were stopped 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: 95% of all patients requiring Treatment for Cancer to be seen within 31 days

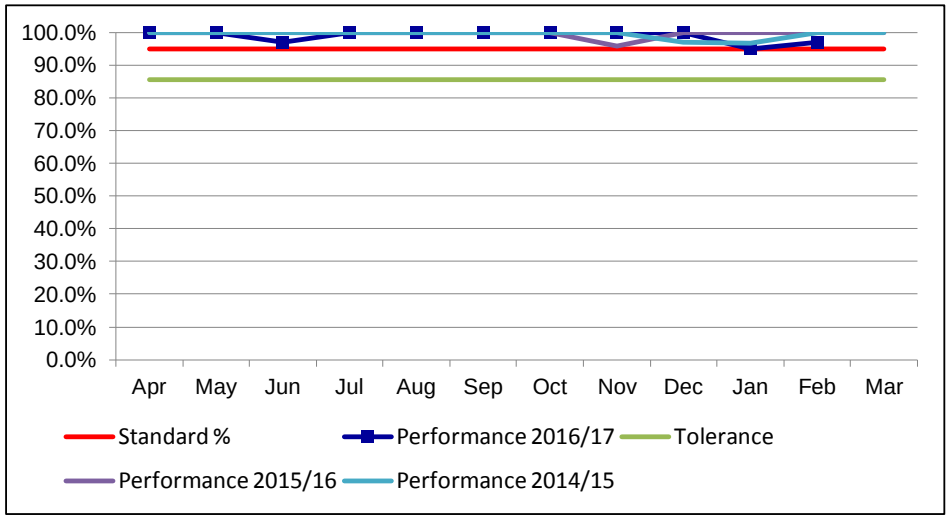
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
94.8% (February 2017)

	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%	100.0%	100.0%	100.0%	100.0%	95.0%	97.0%	
Performance 2015/16	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%
Performance 2014/15	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	96.8%	100.0%	100.0%

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



Narrative Summary:
The run chart shows the standard, to **treat patients with cancer within 31 days of diagnosis** has been consistently achieved during 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 after the GI Synaptik sessions were stopped 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

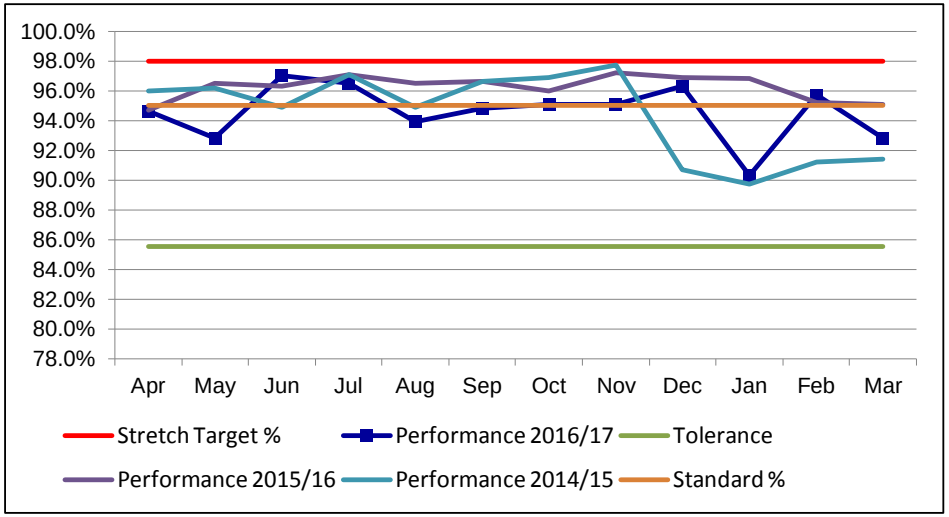
Standard: 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

Stretch Target	Standard	Tolerance
98.0%	95.0%	85.5%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
92.5% (February 2017)

	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%	95.1%	95.1%	96.3%	90.3%	95.7%	92.8%
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 and AAU are routinely discharged within 4 hours.** NHS Borders is working towards consistently achieving the 98% local stretched standard.

Following an improvement in performance in February, there was a marked deterioration in performance against the Emergency Access Standard in March with 173 breaches of the standard and a performance of 92.8%. There were 5 days when there were more than 10 breaches - 3 of these days were Monday, reflecting challenges in inpatient flow over the weekends. This was predominantly related to challenges in inpatient flow, with 50% of breaches due to patients waiting for beds to become available. Breaches related to wait for assessment within ED were just 7.5% in January and show a consistent fall since December.

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	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Flow 1	98%	97%	96%	98%	98.4%	96.8%	97.3%	97.0%	97.2%	98.3%	96.7%	97.7%	97.1%
Flow 2	91%	94%	92%	95%	94.0%	92.9%	90.8%	94.9%	92.2%	95.4%	92.9%	94.8%	92.5%
Flow 3	92%	90%	87%	97%	94.6%	91.8%	91.0%	92.3%	93.5%	93.4%	76.7%	92.5%	86.5%
Flow 4	92%	93%	91%	92%	92.7%	83.0%	91.5%	91.3%	91.9%	92.9%	87.6%	94.4%	82.1%
Total	**95%**	**95%**	**93%**	**97%**	**96.5%**	**93.9%**	**94.8%**	**95.1%**	**95.1%**	**96.3%**	**90.3%**	**95.7%**	**92.8%**

Narrative Summary and Actions:
There was an average 77 attendances through ED and AAU each day, an increase of approximately 6 attendances per day compared to January and February. Much of the pressure on inpatient flow was related to an increase in delayed discharges occupied bed days.

We have introduced a new process for identifying and delivering 11am discharges. This will help with availability of beds earlier in the day, especially on Mondays, when bed pressures tend to be most challenging.

A new action plan for addressing delayed discharges is being developed following the John Bolton review.

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%	90.9%	86.7%	90.0%	84.6%	50.0%	100.0%	
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:
Scottish stroke care standard for admission to Stroke unit care within 1 day of admission is 90%. The stroke care bundle standard is also 90%. This Bundle is made up of the following elements of the Scottish Stroke Care Standards;

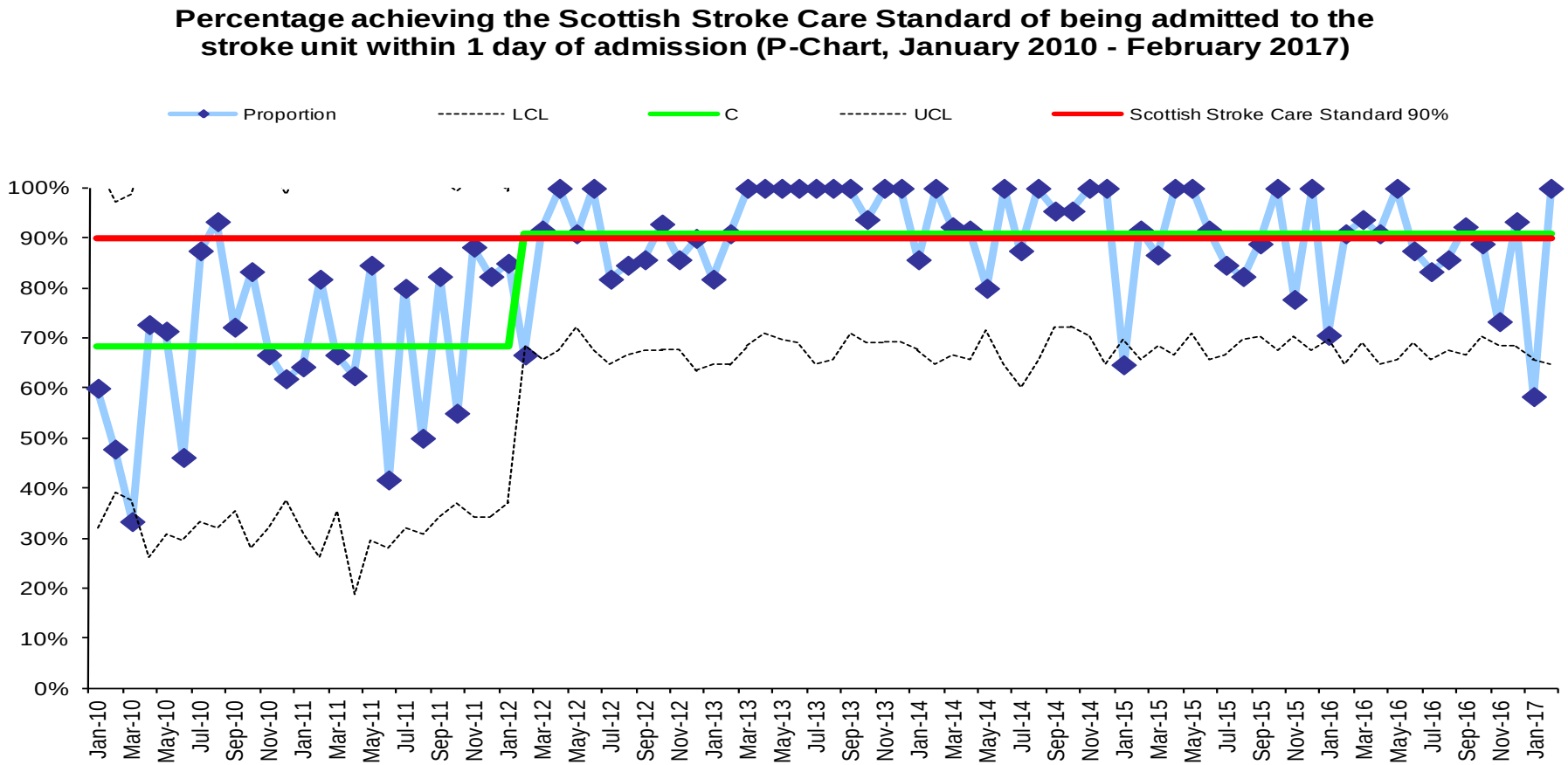
- admission to a dedicated Stroke Unit within 1 day of admission
- a swallow screen test within 4 hours of admission
- a brain scan within 24 hours of admission
- appropriate treatment initiated within one day of admission

During February, performance returned to 100% with all patients admitted to the Stroke Unit within 1 day of admission.

Actions:
- Process in place to ensure newly-admitted stroke patients have priority for admission to stroke unit within 1 day.

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

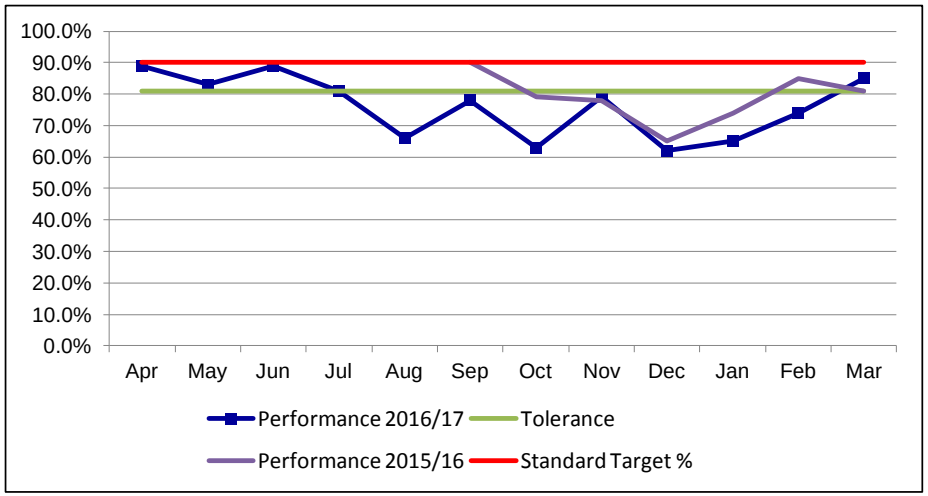
	Standard	Stretch	Tolerance
Standard: 18 weeks referral to treatment for Psychological Therapies	90.0%	95.0%	81.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
77.5% (December 2016)

	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%	63.0%	79.0%	62.0%	65.0%	74.0%	85.0%
Total Patients Currently Waiting >18 Weeks:	91	85	103	113	116	109	85	73	74	73	69	82
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

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. Work continues as described below.

Actions:
- Actions continue as previously described, and we continue to allocate resources to the areas with the longest waits.
- A project plan has been drawn up to address underlying demand and capacity issues across the four years the SG funding is in place - project support is currently being sourced.
- 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 and a project has commenced. No feed back has been received however there is an action from the March Performance Review to look at progress.
- Work is underway to review admin reporting procedures
- A text reminder system has been introduced in the East/West Team to tackle the high DNA and CNA rate.

CAMHS Waiting Times

Standard: 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)

Standard	Stretched	Tolerance
90.0%	95.0%	81.0%

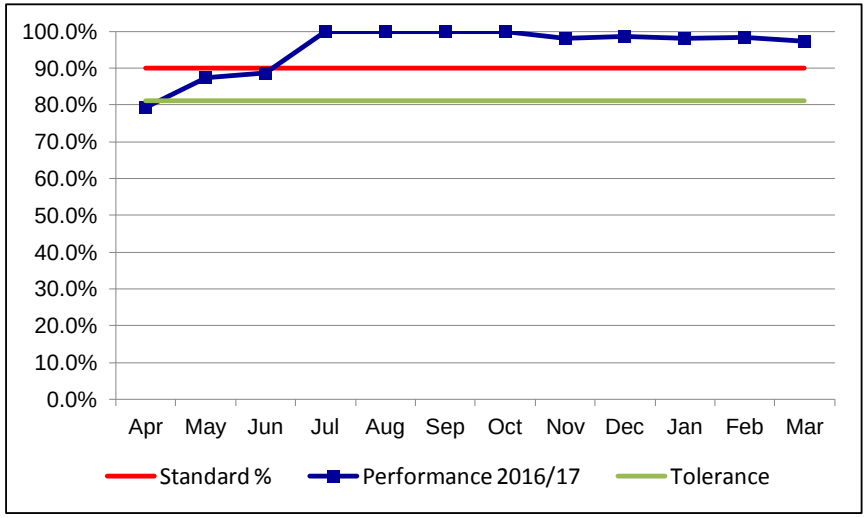
Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
82.5% (December 2016)

	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%	100.0%	98.0%	98.5%	98.0%	98.4%	97.4%
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 for **CAMHS referral to treatment**. CAMHS staff turnover is now more stabilised, having direct impact within the service area. Recruitment is almost complete for a temporary Clinical and Applied Psychologist (CAAP) and a permanent Community Mental Health Team Nurse is now in post. We are still unable to recruit to a permanent Consultant psychiatrist post, this will be re-advertised. There has been an increase in referrals into the tier 3 service with the absence of a full time Community Mental Health Worker. In December 2016, January 2017 and February 2017 performance was maintained at 98%, work continues as described below to sustain achievement of the target.

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 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.
- Referral criteria has been reviewed and amended to increase efficiency at point of receipt of referral, also at final stages of referral form being placed on sci gateway for GP referrals in an attempt to reduce declined referrals.

Drug & Alcohol Treatment

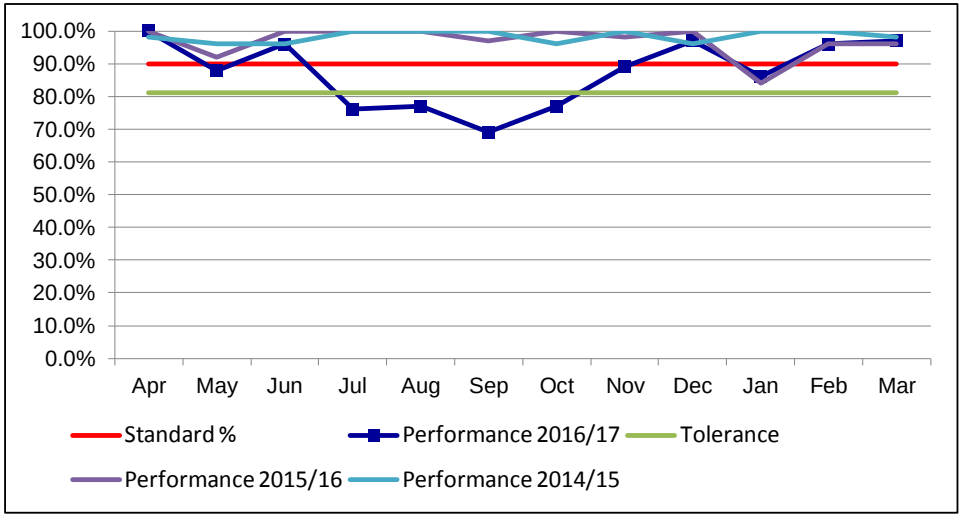
Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

Standard	Stretched	Tolerance
90.0%	95.0%	81.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
93.0% (January 2017)

	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%	77.0%	89.0%	97.0%	86.0%	96.0%	97.0%
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 LDP 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%.

Both the national and local target has been maintained for the end of March with 97% of individuals starting treatment within 3 weeks

Actions:
- The Addaction Service are continuing to look at internal systems to improve on management of referrals and waiting times.

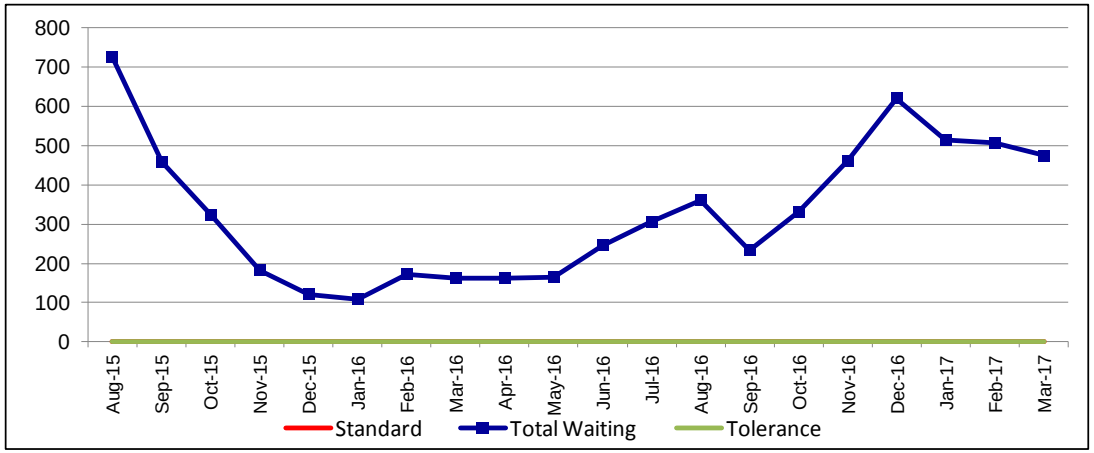
AHP Waiting Times

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

Actual Performance (lower = better performance)

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**163**	**162**	**164**	**246**	**305**	**360**	**233**	**331**	**461**	**619**	**514**	**506**	**474**
Occupational Therapy	26	2	11	22	11	4	2	0	0	4	4	4	7
Physiotherapy	125	144	134	200	262	339	211	320	452	609	498	489	459
Podiatry	0	0	0	0	0	0	0	-	-	0	0	0	0
Speech & Language Therapy	2	4	1	2	2	3	0	2	0	0	0	0	0
Nutrition & Dietetics	10	12	18	22	30	14	20	9	9	6	12	13	8

Please Note: October & November 2016 data does not include podiatry. This is due to the service moving onto TrakCare and accurate reporting unavailable for the scorecard deadline.
December 2016 data updated for Podiatry. Previously reported as 10 however data was entered incorrectly.



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.

For information, phase B of the AHP Clinical Productivity programme was approved by the Strategy Group in April 2017 and commenced w/c 17th April 2017.

Physiotherapy
Patient's waiting longer than 9 weeks had been improving however they are slowly increasing as a result of staffing gaps. 405 patients sit within MSK services. Remaining patients sit mostly within Care of Elderly / Neurology workstream, and Paediatrics.
There are 2.9 WTE vacancies with Care of Elderly / Neurology but there are new staff starting in April 2017. Paediatrics vacant hours are due to maternity leave. Non-cancer lymphodema waiting list has not cleared. 9% clinical vacancy - 3 locums to end of March to fill vacancies and support patient flow pressures within BGH.

Nutrition and Dietetics
Data in scorecards can be at variance with service's own data. Dietetic service's own data (currently being checked) indicates fewer breaches. This is partly due to patient choice and non response to opt-in systems, which cannot be captured on ePex system. Reduced staffing due to maternity leave, vacancies and some sickness absences have reduced capacity in Community Dietetics and DESMOND programme. Recruitment has been successful and community dietetics is now at full complement although remains under pressure due to high demand, and reduced capacity due to efficiency savings. We have put in some additional hours from existing resource. Challenges remain in specialities such as GI, Diabetes Care, Mental Health, 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 future and funding of DESMOND with Diabetes team. Liaising with CAMHS and Adult Mental Health re eating disorders, including providing support and training to non specialist staff. Adult and Paediatric DNA rates above target, however benchmarks well against national norms. Opt in and patient centred systems are used. Awaiting migration to Trak for paediatric appointments and some other dietetic clinics to enable text reminder system to be used.

Occupational Therapy
2 Paediatrics and 1 Learning Disability breaches within Occupational Therapy. These will be addressed in April.

Podiatry
There have been issues within the admin team regarding the correct use of Trak, especially patient "unavailability" and "re setting the clock". The admin team lead has addressed these issues within the team but it may take a few weeks to ensure they are all eliminated. Once new staff member in place, training will be provided for all the team.
The Podiatry Service continues to receive approximately 50/60 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.

Speech, Language & Therapy (Adults)
Adult SLT continue to meet this target ensuring patients are offered timely interventions.

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

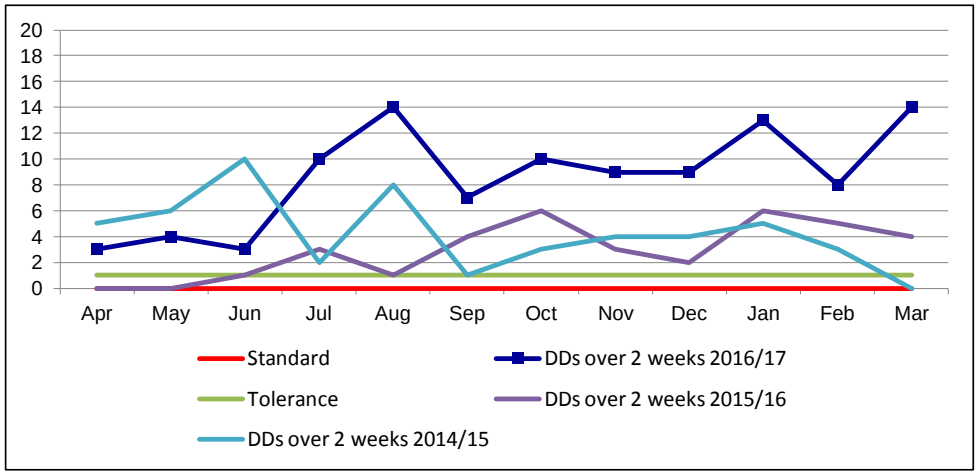
	Standard	Tolerance
Standard: Delayed Discharges - delays over 72 hours	0	1

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	10	9	9	13	8	14
DDs over 72 hours (3 days) 2016/17	6	8	7	15	20	20	14	23	16	20	14	18
Occupied Bed Days (standard delays)	537	466	516	638	758	596	703	796	759	749	507	682
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: The census date changed nationally in July 2016 from 15th of every month to the last Thursday of every month

Please Note: National data is used for monthly occupied bed days (standard delays only). March 2017 data is provisional as data has not yet been released.



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.

Daily Actions:
- Joint Daily Review of Delayed Cases: undertaken across acute and community hospitals
- Senior Management attendance at all Community Hospitals' MDTs and BGH Board Rounds to unblock, challenge and support with individual issues as appropriate.
- Formal Delayed Discharges Operational Group: cross sector representation:
- Ad Hoc meetings of Executives and Senior Managers across Social Work & Health called in times of pressure or for specific case issues to support & maintain discharge processes.
- Daily oversight of care home capacity in order to identify vacancies across the system which can then be used to support discharges.
- Revised application of Choices Policy and utilisation of Interim Move letters.
- Daily oversight of care at home capacity (through START and Locality Team Leaders)
- Overview of all patients in all community hospital wards which assists in establishing a discharge profile for all community hospitals and supports appropriate transfer/discharge planning and early identification of any potential blockages to discharge.

Further work underway and planned:
- Professor John Bolton has been commissioned to work with us to help to improve Delayed Discharges and Patient Flow across the system. This will inform subsequent work to improve community hospital LOS, effective use of community capacity across home care and care homes, pathway development, thresholds and risk management and improve patient safety.
- Dr Anne Hendry, HIS National Clinical Lead for Integrated Care and Consultant Geriatrician has agreed to work with us to review and develop our community & day hospital model. This fits well with and will build upon the outcomes from Professor Bolton's work.
- The introduction of a Matching Unit is underway, with recruitment now complete.
- Within BGH, work is underway to support the early identification of patients who have the potential to become delayed discharges in order to plan "upstream" , identifying and removing potential blocks to discharge, putting in place appropriate processes etc . MDTs and Board Rounds will be revised to accommodate this approach. If this proves to be effective, the aim would be to roll out to community hospitals.
- Social Work are working to develop the care at home market and part of this is the review of recruitment & retention of care at home staff.
- Plans to review and remodel Rapid Response services are being developed by Social Work which will allow an out of hours home care response. The focus of this service will be prevention of admission. This redesign will be developed in full liaison with BECS.
- Work is to be progressed with Mental health to consolidate the MDT processes and manager advocate role in order to gain a better understanding of their patient profile.

Key Performance Indicators

Cancellations

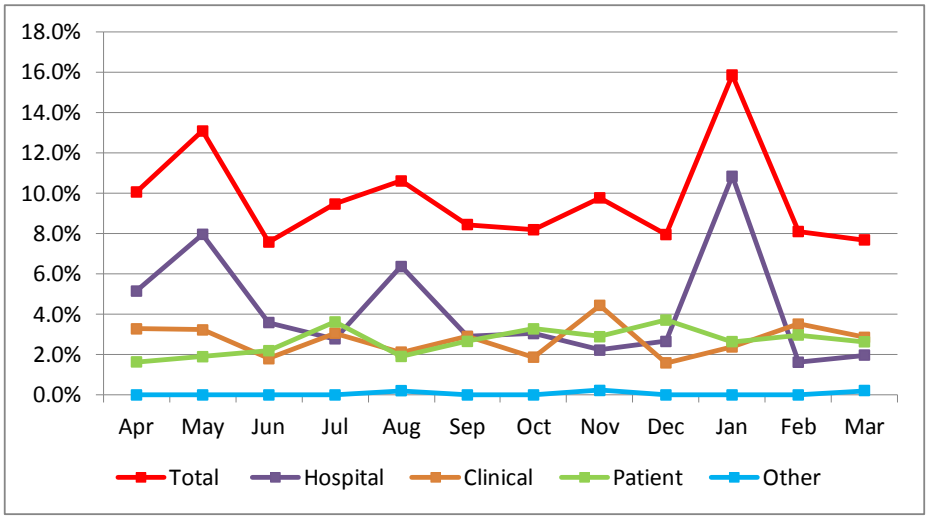
Hot Topic: Cancellations

Target & Tolerance

[1] Hospital Cancellation Rate – <1.7% Green, 1.7% Amber, >2.1% 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%**	**8.2%**	**9.8%**	**8.0%**	**15.9%**	**8.1%**	**7.7%**
Hospital	5.2%	8.0%	3.6%	2.8%	6.4%	2.9%	3.0%	2.2%	2.7%	10.8%	1.6%	2.0%
Clinical	3.3%	3.2%	1.8%	3.1%	2.1%	2.9%	1.9%	4.4%	1.6%	2.4%	3.5%	2.9%
Patient	1.6%	1.9%	2.2%	3.6%	1.9%	2.7%	3.3%	2.9%	3.7%	2.6%	3.0%	2.6%
Other	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%



Narrative Summary:
In March the percentage of hospital cancellations increased slightly however performance in better than it has been throughout the financial year.

The Smoothing processes implemented through IHO has improved management of elective activity.

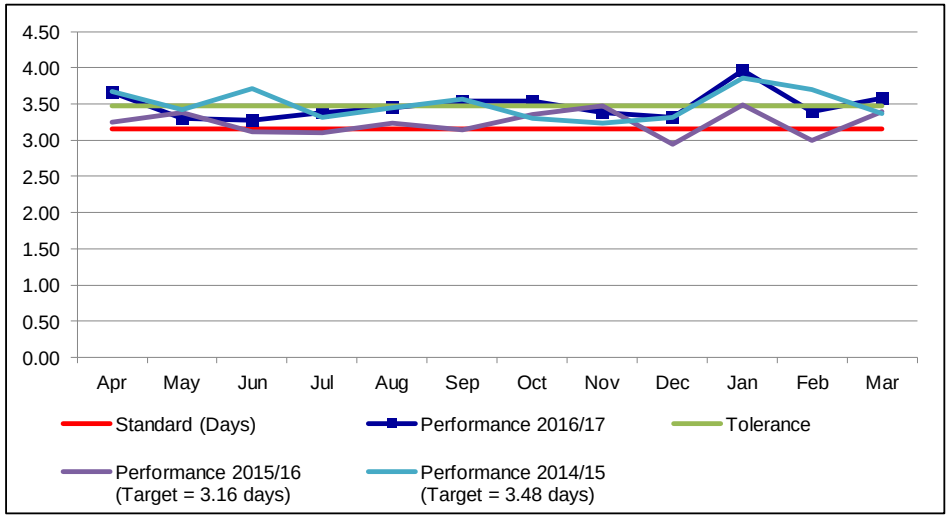
Actions:
- Implementation of IHO remodelling of elective in-patient capacity and theatre scheduling commenced in December 2016 is ongoing.
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment.
- Reviewing admissions per ward area per day and smoothing surgical flow via Institute of Healthcare Optimisation work.
- Individual review of clinical cancellations to ensure these could not have been foreseen at pre-assessment.

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	3.54	3.38	3.32	3.96	3.39	3.58
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 the 75th percentile values for Borders HRGs benchmarked against peers across England. This means that the overall target for the BGH has reduced from 3.48 to 3.16.

The length of stay in the BGH was negatively impacted over the winter period by the increasing number of delayed discharges, both within the BGH and within Community Hospitals and additional beds required for unscheduled patients.

Actions:
- Continue to monitor and manage patient lengths of stay and reset aim for LoS.
- Remodelling of Medical Pathways commenced in October.
- IHO remodelling of Elective pathways commenced in November and elective beds put back in place from end of January 2017.
- Focused work to reduce length of stay in Elderly care with partners across health and social care.
- Beginning to explore data to commence IHO process for medical pathways.

Community Hospital Average Length of Stay (LOS)

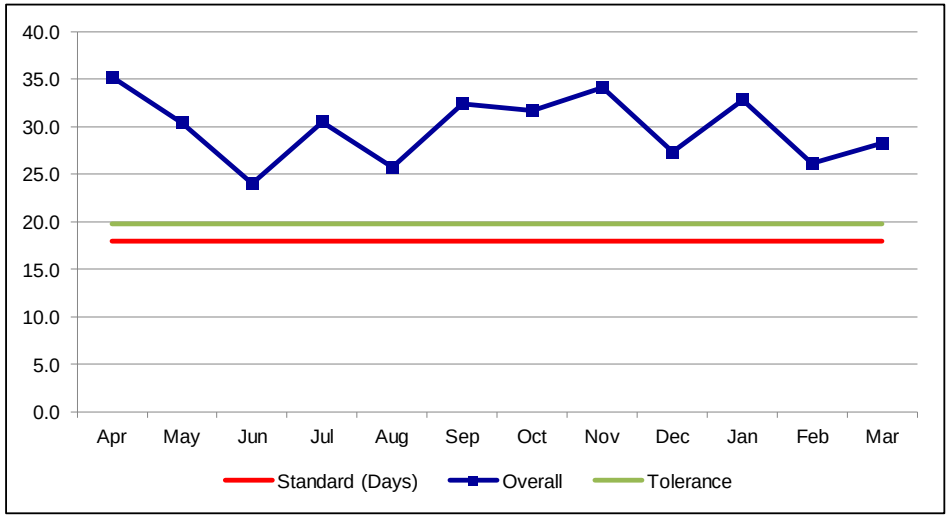
	Standard	Tolerance
Standard: Reduce Community Hospital Average Length of Stay	18.0	19.8

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (Days)	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0
Overall	**35.2**	**30.4**	**24.0**	**30.5**	**25.7**	**32.4**	**31.7**	**34.1**	**27.3**	**32.8**	**26.1**	**28.2**
Hawick	24.3	25.1	22.3	25.5	17.8	20.3	18.2	23.7	19.3	18.9	15.7	24.8
Hay Lodge [1]	54.3	33.2	25.1	43.5	33.1	30.7	50.3	35.2	20.4	70.1	29.5	36.5
Kelso	31.3	26.1	23.4	23.2	27.5	45.3	44.1	52.5	40.0	41.2	32.6	20.2
Knoll	46.2	45.2	26.1	39.4	28.2	44.6	33.4	35.3	56.4	31.3	37.5	38.2

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

[1] January 2107 Hay Lodge is reporting a high LoS due to a low number of discharges (10) against the occupied bed days (701).



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

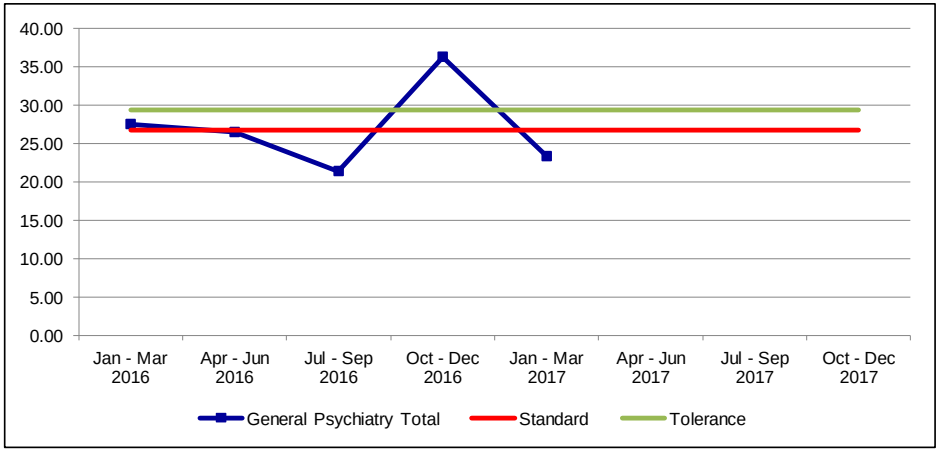
	Standard	Tolerance
Standard: Reduce Mental Health Average Length of Stay	Various	within 10%

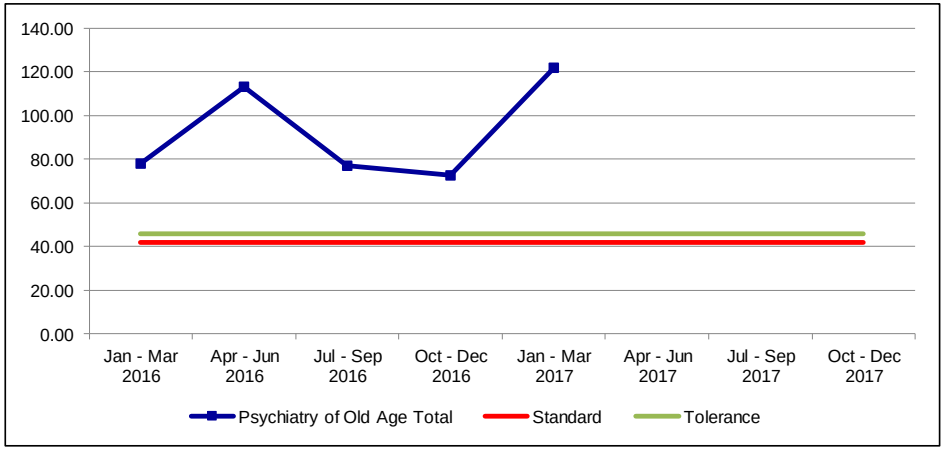
Actual Performance (lower = better performance)

	Standard (Days)	Jan - Mar 2016	Apr - Jun 2016	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	Jul - Sep 2017	Oct - Dec 2017
Huntlyburn	17.70	19.79	23.93	17.56	15.04	16.41			
The Brigs	42.83	53.78	43.00	69.00	134.28	48.24			
General Psychiatry Total	**26.70**	**27.53**	**26.49**	**21.41**	**36.29**	**23.35**			
Cauldshiels	26.95	75.38	105.50	109.07	115.22	86.80			
Lindean	60.58	33.72	82.33	33.00	28.36	54.00			
Melburn Lodge [1]	111.63	247.33	345.00	112.00	124.00	491.00			
Psychiatry of Old Age Total	**41.82**	**78.00**	**113.18**	**77.00**	**72.59**	**121.88**			

[1] January - March quarterly figure is high due to 2 patients with waits of 1084 days and 654 days who were discharged

Please Note: Mental Health LOS will now be measured quarterly due to the small number of dicharges. As discussed and agreed with the Mental Health Clinical Board.





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. We have therefore moved to report ALoS on a quarterly basis. Work continues as described below.

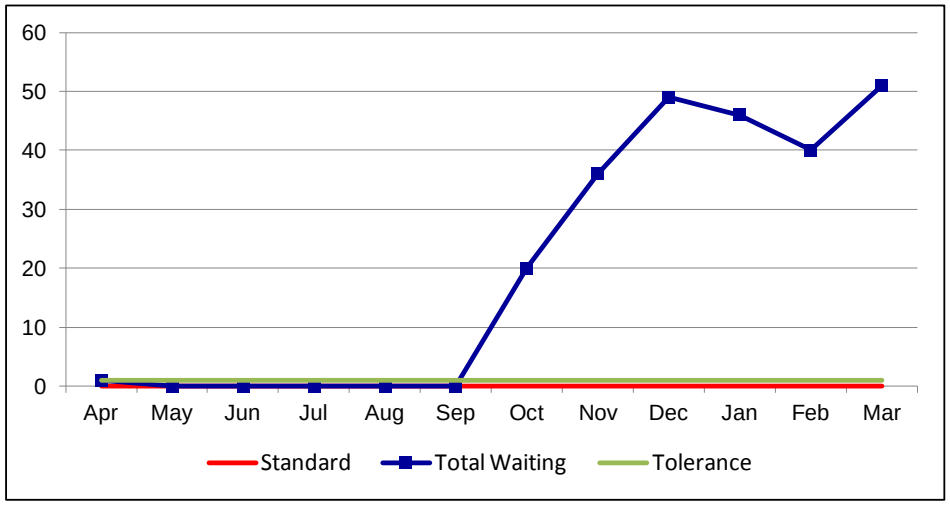
Actions:
- LOS is monitored within the performance scorecard at monthly Mental Health meetings and picked up with Senior Charge Nurses by exception.
- There are no routine actions specific to this target but work is underway to ensure patients have EDD's on admission to Mental Health Wards (as appropriate).
- Work has been commenced with P&P for the 2017/18 scorecard 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**	**20**	**36**	**49**	**46**	**40**	**51**
MH Older Adults - East	0	0	0	0	0	0	0	0	1	1	0	0
MH Older Adults - South	0	0	0	0	0	0	0	0	0	0	0	0
MH Older Adults - West	0	0	0	0	0	0	0	0	0	0	0	0
East Team	1	0	0	0	0	0	6	20	24	23	23	33
South Team	0	0	0	0	0	0	6	5	11	11	10	10
West Team	0	0	0	0	0	0	8	11	13	11	7	8



Narrative Summary:
The increase in waiting times in October 2016 to March 2017 is due to Psychological Therapies now being included in this target as described below. Work continues to address Psychological Therapies waiting times as previously described. 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.
- Continue actions on the Psychological Therapies standard as described on page 45.

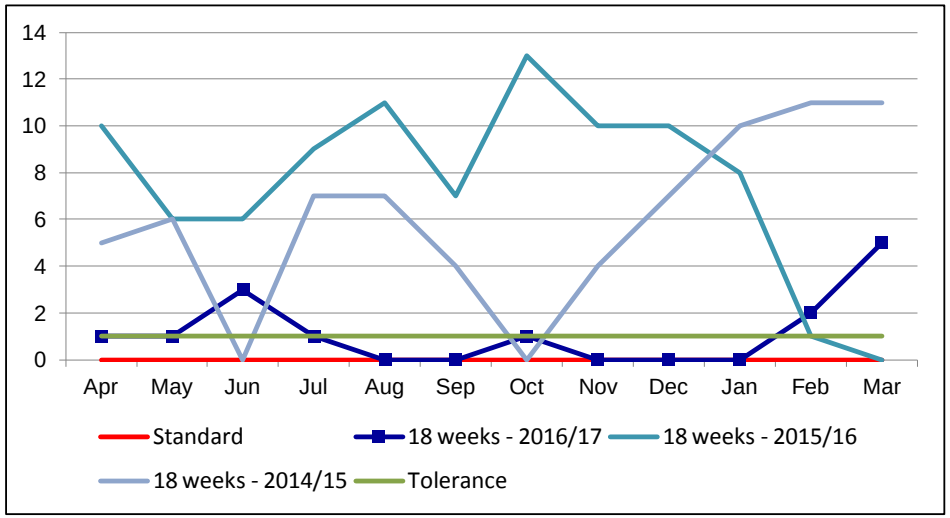
It should be noted that the Community Team Waiting Times and Psychological Therapy waiting times targets are different, at 9 weeks and 18 weeks respectively. Therefore in 2017/18 the Psychological Therapies waiting times will be removed from this page.

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	1	0	0	0	2	5
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 only achieved the standard in 2 of the past 6 months. The 5 breaches in March 2017 were within Psychology and Speech and Language Therapy. Actions continue as below.

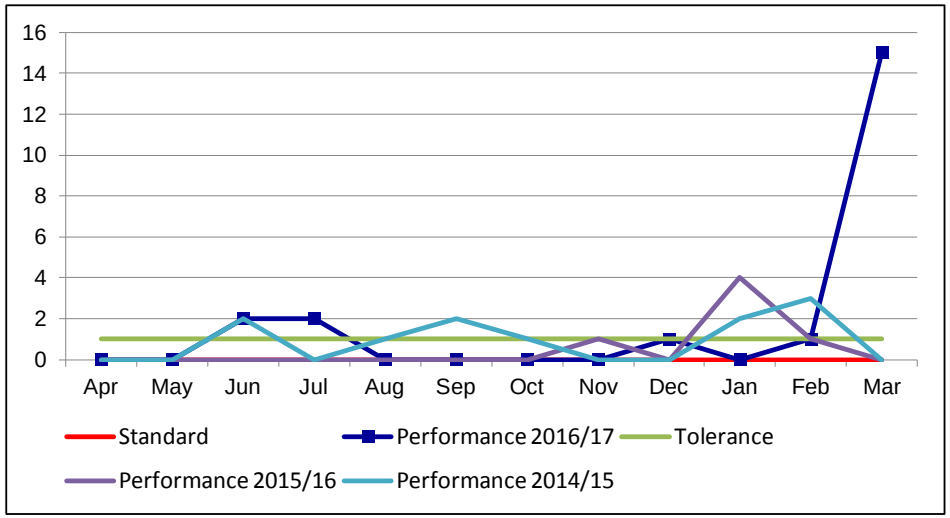
Actions:
- Risk assessment carried out on the 1 breach in Psychology
- Vacant post in Speech and Language Therapy has contributed to increasing waiting times in this area. A skill mix exercise has been undertaken and recruitment to post process initiated.
- Continue to monitor and manage the waiting list within the performance scorecard at LD management team meetings and pick up with appropriate managers.

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	0	0	1	0	1	15
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:
In March 2017 there were 15 patients waiting over **1 week for the Rapid Access Chest Pain Clinic.** All of the breaches were due to demand and capacity issue, there was an abnormally high referral rate. The referral rate has since settled and it is not expected to be a continuous issue.

It is predicted that there will be another number of breaches for April 2017 due to no cover for 2 clinics in 1 week, when the Cardiologist was on annual leave. This is expected to continue with 5 RACP clinics potentially being cancelled over the next 3 months during periods of annual leave.

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

Audiology Waiting Times

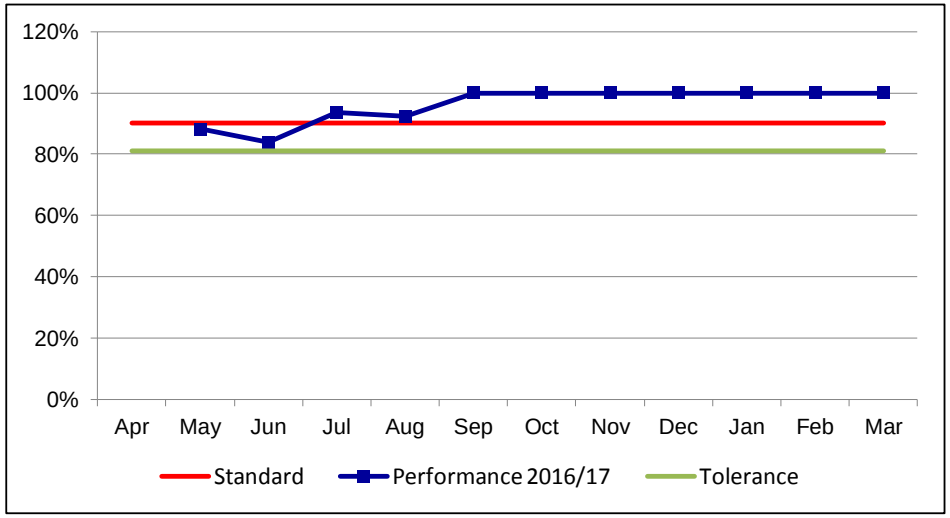
	Standard	Tolerance
Standard: 18 Week Referral to Treatment for Audiology	90.0%	81.0%

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		88.2%	83.8%	93.5%	92.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Patients with active wait over 18 Weeks 2016/17		34	59	14	28	0	0	0	0	0	0	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.

February 2017 data updated for March scorecard as unavailable at time of reporting



Narrative Summary:
Audiology continues to meet the 18 week referral to treatment target. We are currently working on reducing the wait further for all patients and developing services

Actions:
- The service will continue to monitor productivity and identify areas for streamlining
- We are currently working hard to reduce the waits further

Workforce Section

Supplementary Staffing

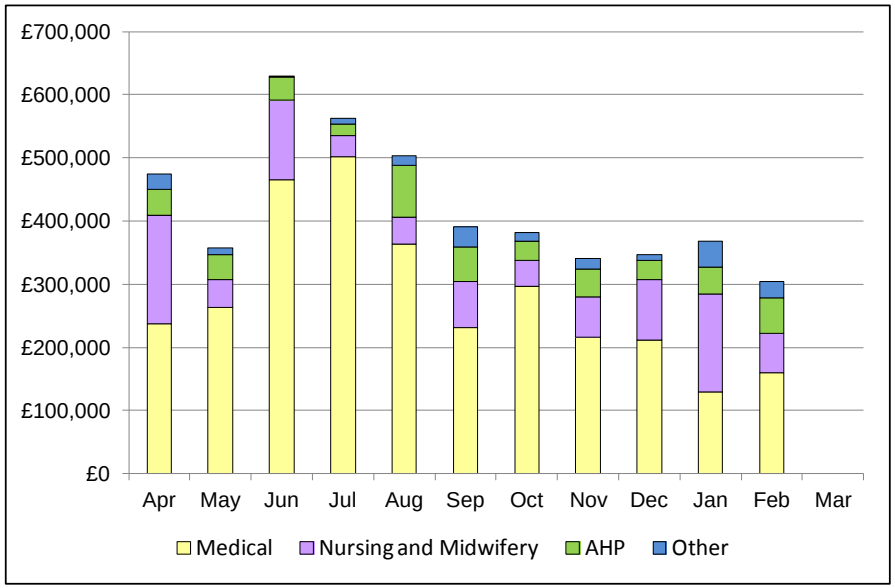
	Standard	Tolerance
Standard: Supplementary staffing - agency spend per month	0	0

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	£296,560	£215,617	£211,375	£129,170	£159,536	
Nursing and Midwifery	£172,119	£43,073	£126,542	£32,952	£42,743	£73,883	£40,814	£64,863	£96,168	£155,234	£62,839	
AHP	£41,435	£39,604	£35,067	£19,299	£81,660	£54,594	£30,209	£43,515	£29,487	£41,959	£56,410	
Other	£23,591	£11,810	£1,837	£7,740	£14,487	£31,203	£13,908	£16,768	£10,015	£42,159	£25,611	
Total Cost	**£473,863**	**£358,169**	**£629,121**	**£561,919**	**£502,762**	**£390,293**	**£381,491**	**£340,763**	**£347,045**	**£368,522**	**£304,396**	



Please note: *The update for March 2017 is unavailable at the time of reporting due to the ongoing year end work within Finance.*

Narrative Summary:
Agency Nursing has reduced in February, however the need to staff the surge beds and pressures throughout planned and unscheduled care has continued. Theatres and ITU recorded spend in the month has decreased due to reduced theatre availability resulting in cancellations to elective surgery. Theatre and ITU agency spend are recognised as specialist areas which require specialist activity and skill mix. 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 January and February is broken down below:

February 2017
Theatre £5,983
ITU £2,146

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