# Borders NHS Board

## NHS BORDERS PERFORMANCE SCORECARD – JULY 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 July 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.

A detailed breakdown of sickness absence data can be found on page 16. The data shows sickness absence rates by clinical board, split into job family. The layout of the sickness absence information is work in progress to ensure the Board are receiving information that is relative and useful. Further adjustments may be made in the coming months.

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

| **LDP Standards** | **May-17** | **Jun-17** | **Jul-17** |
|---|---|---|---|
| **Green** – achieving standard | 11 | 12 | 16 |
| **Amber** – nearly achieving standard | 4 | 5 | 2 |
| **Red** – outwith standard | 16 | 14 | 13 |

| **Key Performance Indicators** | **May-17** [1] | **Jun-17** [1] | **Jul-17** |
|---|---|---|---|
| **Green** – achieving standard | 4 | 3 | 4 |
| **Amber** – nearly achieving standard | 1 | 1 | 1 |
| **Red** – outwith standard | 8 | 9 | 8 |

[1] LD waiting times data unavailable to be reported this month therefore RAG status used for latest available data

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 July 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:

- 86.3% of patients were admitted on the **same day as their surgery** in May 2017 (latest available data) against the standard of 86.0% (page 18)
- The standard for **pre-operative stay** was achieved during May 2017 (latest available data) 0.02 days against the standard of 0.47 (page 19)
- 94.1% of all referrals were **triaged online** in July 2017, above the standard of 90% (page 20)
- 35.9% of new born children were **breastfed at 6-8 weeks** for the quarter January – March 2017 (latest available data) (page 21)
- 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 June 2017 (pages 34-38)
- 96.7% of **all cases with a suspicion of cancer** were seen within **62 days** in June 2017 (latest available data) (page 42)
- 100% of patients **requiring treatment for cancer** were seen within **31 days** in June 2017 (latest available data) (page 43)
- 95.8% of patients were discharged or transferred from **A&E and AAU within 4 hours** during June 2017 (page 44)
- 92.3% of patients were transferred to the **Stroke Unit within one day of admission** during June 2017 (latest available data) (page 46)
- 100% of patients were seen within 18 weeks referral to treatment for specialist **Child and Adolescent Mental Health Services** in July 2017 against the standard of 90% (page 49)
- 90% of patients waited less than 3 weeks for Drug & Alcohol treatment in July 2017 (page 50)

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 July 2017. Services have provided narrative and actions that are underway to improve performance. Details can be found within the scorecard on page references below.

- **Alcohol Brief Interventions** – performance outwith the trajectories set for 4 consecutive months (page 13)
- **Smoking Cessation** – performance was been outwith the trajectory set for the full financial year 2016/17 (page 14)
- **Sickness Absence** – performance reported outwith the 4% standard for 9 consecutive months (page 15)
- **eKSF and PDP** – performance is outwith the standard set for the first 4 months of this year (page 22)

- **12 weeks Outpatient Waiting Times** – performance is consistently reported outwith the standard (page 27-28)
- **12 weeks Inpatient Waiting Times** – performance reported outwith the standard for 12 consecutive months (page 29-30)
- **12 week Treatment Time Guarantee** – performance reported outwith the standard for 11 consecutive months (page 31)
- **Admitted Pathway Performance** – performance reported outwith the 90% standard for 12 consecutive months (page 33)
- **6 week Diagnostic Waiting Times** – performance is consistently reported outwith the standard (page 39)
- **Psychological Therapies Waiting Times** – performance reported outwith the 90% standard for 4 consecutive months (page 48)
- **AHP Waiting Times** – performance is consistently reported outwith the standard (page 51)
- **Delayed Discharges** – performance is consistently reported outwith the standard (page 55)

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 July 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 Strategic Change & Performance | | |

**Author(s)**

| Name | Designation | Name | Designation |
|---|---|---|---|
| Carly Lyall | Planning & Performance Officer | | |

NHS Borders

# PERFORMANCE SCORECARD

**As at 31st July2017**

## July 2017

**Planning & Performance**

**Month**

1

2

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**4**

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# Contents

# INTRODUCTION

## DASHBOARD OF HEAT STANDARDS

The Dashboard of Standards shows the performance of each standard against a set trajectory. To enable current performance to be judged, colour coding and letters are used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

| Current Performance Key | | | |
|---|---|---|---|
| **R** | Under Performing | Current performance is significantly outwith the trajectory set. | Outwith the standard by 11% or greater |
| **A** | Slightly Below Trajectory | Current performance is moderately outwith the trajectory set. | Outwith the standard by up to 10% |
| **G** | Meeting Trajectory | Current performance matches or exceeds the trajectory set | Overachieves, meets or exceeds the standard, or rounds up to standard |

So that the direction of travel towards the achievement of the standard can be viewed direction symbols are also included in the dashboard. These are shown below:

**Direction Symbols**

| | |
|---|---|
| Better performance than previous month | ↑ |
| No change in performance from previous month | ↔ |
| Worse performance than previous month | ↓ |
| Data not available or no comparable data | - |

**LDP Standards**

Every year the Scottish Government Health Department (SGHD) asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report is called the Local Delivery Plan (LDP) and forms an agreement on what Health Boards will achieve in the next year with SGHD. Boards are asked to work towards a number of key standards for the year which fit with the Government's health objectives. The Local Delivery Plan for 2017/18 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 2017/18 to date, the arrows indicate performance and direction of travel towards achieving the standards compared to the previous month:

| Indicator | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diagnosis of dementia | A ↓ | A ↓ | A ↑ | A ↓ | | | | | | | | |
| Dementia Post Diagnostic Support [1] (2015/16 data) | A ↓ | - | - | - | | | | | | | | |
| Alcohol Brief Interventions [2] | R - | R ↑ | R ↑ | R ↑ | | | | | | | | |
| Smoking cessation successful quits in most deprived areas [3] | - | - | - | - | | | | | | | | |
| Sickness Absence Reduced | R ↑ | R ↓ | R ↑ | R ↑ | | | | | | | | |
| Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [4] | R ↓ | A ↑ | G ↑ | - | | | | | | | | |
| Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [4] | R ↓ | G ↑ | G ↑ | - | | | | | | | | |
| 18 Wk RTT: 12 wks for outpatients | R ↓ | R ↓ | R ↓ | R ↓ | | | | | | | | |
| 18 Wk RTT: 12 wks for inpatients | R ↑ | R ↑ | R ↑ | R ↓ | | | | | | | | |
| 18 Wk RTT: 12 weeks TTG | R ↓ | R ↓ | R ↓ | R ↓ | | | | | | | | |
| 18 Wk RTT: Admitted Pathway Performance [5] | R ↓ | R ↓ | R ↓ | - | | | | | | | | |
| 18 Wk RTT: Admitted Pathway Linked Pathway [5] | G ↓ | G ↑ | G ↓ | - | | | | | | | | |

| Indicator | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 Wk RTT: Non-admitted Pathway Performance [5] | G ↑ | G ↑ | G ↑ | - | | | | | | | | |
| 18 Wk RTT: Non-admitted Pathway Linked Pathway [5] | G ↑ | G ↑ | G ↓ | - | | | | | | | | |
| Combined Performance [5] | G → | G ↑ | G ↑ | - | | | | | | | | |
| Combined Performance Linked Pathway [5] | G ↑ | G ↑ | G ↓ | - | | | | | | | | |
| 6 Week Waiting Target for Diagnostics | R ↓ | R ↑ | R ↑ | R ↓ | | | | | | | | |
| 4-Hour Waiting Target for A&E | A ↑ | A ↓ | G ↑ | G ↓ | | | | | | | | |
| No CAMHS waits over 18 wks | G ↑ | G → | G → | G → | | | | | | | | |
| No Psychological Therapy waits over 18 wks | R ↓ | R ↓ | R ↓ | R ↓ | | | | | | | | |
| 90% of Alcohol/Drug Referrals into Treatment within 3 weeks | G ↑ | R ↓ | R ↓ | G ↑ | | | | | | | | |
| No Delayed Discharges over 2 Wks | R ↓ | R ↑ | R ↓ | R ↓ | | | | | | | | |
| New patient DNA rate | R ↓ | A ↑ | R ↓ | R ↑ | | | | | | | | |
| Same day surgery [6] | A ↓ | G ↑ | - | - | | | | | | | | |
| Pre-operative stay [6] | G ↑ | G ↑ | - | - | | | | | | | | |

| Indicator | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Online Triage of Referrals | G ↑ | G ↓ | G ↓ | G ↑ | | | | | | | | |
| Increase the proportion of new-born children breastfed at 6-8 weeks [7] | - | - | - | - | | | | | | | | |
| eKSF annual reviews complete | R - | R ↑ | R ↑ | R ↑ | | | | | | | | |
| PDP's Complete | R - | R ↑ | R ↑ | R ↑ | | | | | | | | |
| Emergency OBDs aged 75 or over (per 1,000) [8] | - | - | - | - | | | | | | | | |
| Admitted to the Stroke Unit within 1 day of admission [9] | R ↑ | A ↑ | G ↑ | - | | | | | | | | |

**Footnotes**

1 There is a 1 year time lag to show the full 12 months performance therefore data is 2016/17 rather than 2017/18

2 There is a reporting lag in some areas which means that data is not fully reconciled at time of reporting therefore should be treated as provisional.

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

4 One month lag as data is supplied nationally.

5 From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines. Please note arrows and staus have been updated for Novemeber due to reporting error.

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

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

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

9 There is a 1 month lag for data. A data snapshot is taken and used to compile these reports. Routine data collection and amendment usually take place on a daily basis however data should be interpreted as provisional because delays in data entry may occur or data updates may be made after the snapshot was taken.

Performance on the Key Performance Indicators is detailed within in this report. The following table summarises the achievements for the financial year 2017/18 to date, the arrows indicate performance and direction of travel towards achieving the standards compared to the previous month:

| Indicator | | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AHP Waiting Times | | R ↓ | R ↑ | R ↑ | R ↓ | | | | | | | | |
| Cancellations | Hospital | R ↓ | R ↑ | R ↑ | R ↓ | | | | | | | | |
| | Clinical | A ↓ | R ↓ | R ↓ | R ↑ | | | | | | | | |
| | Patient | G ↓ | G ↑ | G ↑ | G ↑ | | | | | | | | |
| | Other | G ↔ | G ↑ | G ↔ | G ↔ | | | | | | | | |
| Borders General Hospital Average Length of Stay | | A ↑ | A ↑ | A ↓ | A ↓ | | | | | | | | |
| Community Hospitals Average Length of Stay | | R ↓ | R ↑ | R ↑ | R ↓ | | | | | | | | |
| Mental Health Average Length of Stay General Psychiatry Total [1] | | - | - | R ↓ | - | | | | | | | | |
| Mental Health Average Length of Stay Psychiatry of Old Age Total [1] | | - | - | R ↑ | - | | | | | | | | |
| Mental Health Waiting Times (Patients waiting over 18 weeks) [2] | | R - | R ↓ | R ↑ | R ↓ | | | | | | | | |
| Learning Disability Waiting Times (Patients waiting over 18 weeks) [3] | | - | - | - | R - | | | | | | | | |
| Rapid Access Chest Pain Clinic | | R ↑ | R ↓ | R ↑ | G ↑ | | | | | | | | |
| Audiology 18 Weeks Waiting Times | | G ↔ | G ↔ | G ↔ | G ↔ | | | | | | | | |

**Footnotes**

1 Mental Health ALOS reported quarterly

2 No comparison from March 2017 as Mental Health waiting times moved from reporting18 weeks to 9 weeks

3 No data available for April - June 2017 due to the migration to EMIS

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-18 | 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-18 | 80% | Managing Our Performance Report – 6 and 12 month intervals |
| IVF | Commence IVF Treatment within 12 months | Mar-18 | All patients | Managing Our Performance Report – 6 and 12 month intervals |
| CDI | Clostridium difficile infections per 1000 occupied bed days (0.32) | Mar-18 | 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-18 | 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-18 | 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-18 | - | Managing Our Performance Report – 6 and 12 month intervals |

# LDP Standards:

## General

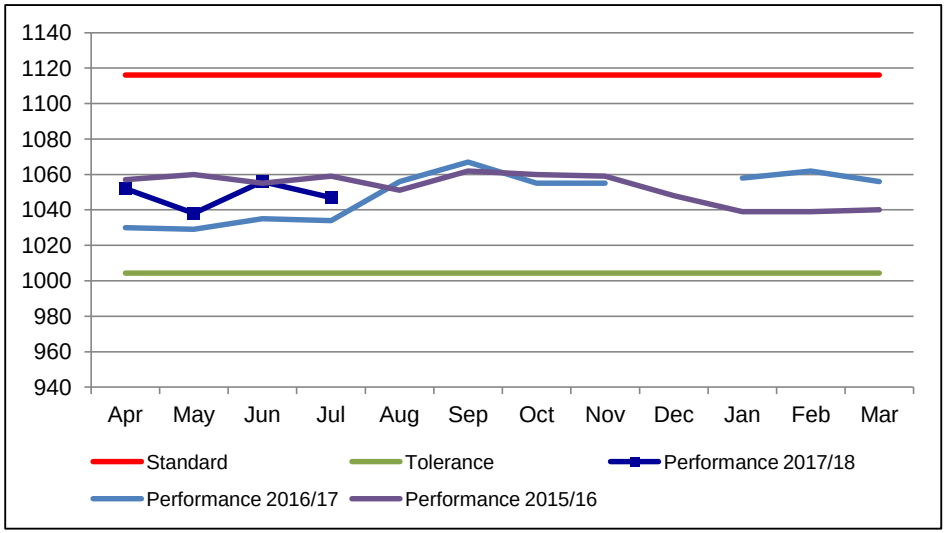
## Diagnosis of Dementia

| | 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 2017/18** | 1052 | 1038 | 1056 | 1047 | | | | | - | | | |
| **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 |

**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.

There are a number of reasons the standard is not improving - the pathway from referral to discharge for patients diagnosed with Dementia has been mapped and challenges identified include unclear diagnoses on ePEX; and resulting assessment letters and lack of clarity around the process GPs use to update the Dementia Register.

Sustainably, performance is expected to improve by the end of the financial year, however it is predicted that as soon as gap analysis work is completed (see below) there will be an increase in performance and the target will be met. This work was aimed to be completed by 30/09/2017 (revised from 31/07/2017) and the impact will be summerised in the coming months.

**Actions:**
- A pathway has been mapped (as mentioned above) to highlight challenges
- Gap analysis work is planned for August and September 2017 with GP practices (as previously done with Selkirk Practice earlier in the year)
- A meeting is being arranged with the GP lead to map the GP process for recording dementia diagnoses to identify areas to improve.

## Dementia - Post Diagnostic Support (PDS)

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

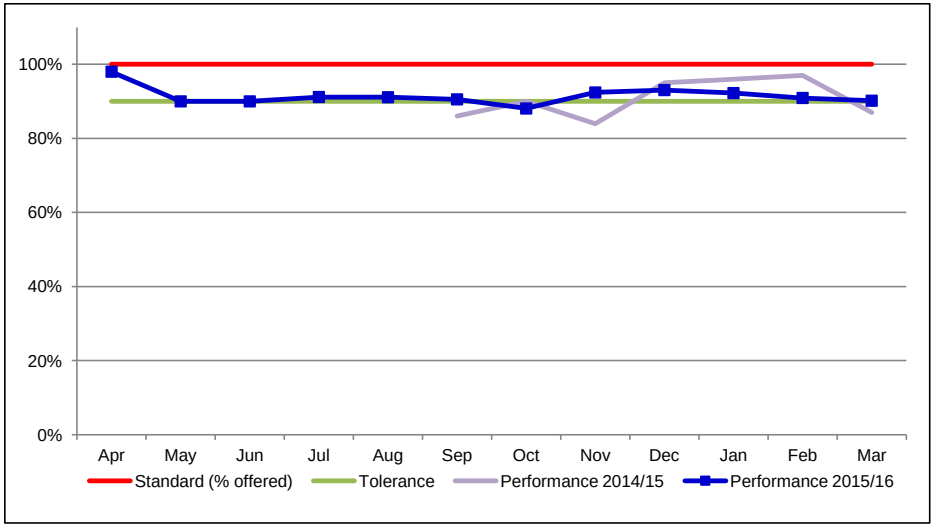
**Actual Performance** (higher % = better performance)

| | **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 | 321 |
| 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 | 356 |
| 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% | 90% |
| Performance 2014/15 | | | | | | 86% | 90% | 84% | 95% | 96% | 97% | 87% |

**Please Note:** Post Diagnostic Support data will be reported quarterly from April 2017 and will continue to have a lag time to allow the full 12 months to be reported.

Data unavailable for 2016/17. This is being investigated by P&P and the national team to source the data.

**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. The older adults service report lack of capacity, skills and understanding to deliver PDS effectively. There is also lack of clarity around the process for reporting PDS performance to ISD. It is expected performance will improve in March 2018.

**Actions:**
- A meeting is arranged with ISD to review and clarify the data reporting process
- A PDS checklist is in use within the older adults service to ensure appropriate pillars are delivered
- Consideration is being given to develop a leaflet for both patients (to outline expectations) and staff (to help delivery) - other health boards will be looked at for examples.

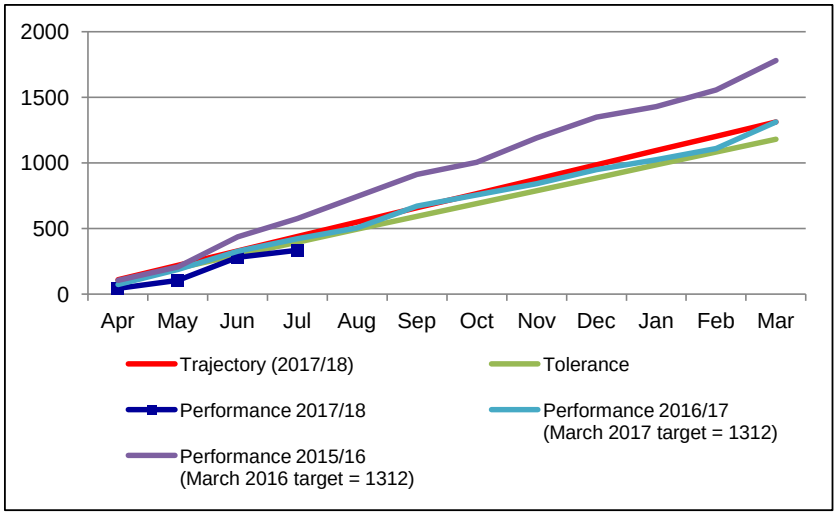
## Alcohol Brief Interventions (ABI)

| | 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 (2017/18)** | 110 | 220 | 330 | 440 | 549 | 658 | 767 | 876 | 985 | 1094 | 1203 | 1312 |
| **Performance 2017/18** | 45 | 106 | 280 | 335 | | | | | | | | |
| **Performance 2016/17** (March 2017 target = 1312) | 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 |

**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 in July 2017 is at 76% of the trajectory (335/440). This is lower than performance at this time in the previous year.

Factors contributing to this are:
**LES –** the LES continues to have the most significant reduction in the number of ABI's from 267 to 153.
**Cessation of Keep Well –** this work is no longer funded by Scottish Government and has ceased. In this time period last year there were 24 delivered.
**Change of reporting system in Antenatal –** implementation of badgernet system in antenatal has meant we have been unable to confirm performance. We will be able to retrospectively report on this data.

Improvements include:
**A/E -** There has been a large increase in the number of screenings and a smaller increase in the number of ABI's performed in A/E since training was delivered in June. We will be closely monitoring performance to ensure the new process is embedded and appreciate the support from colleagues.
**Sexual health –** Following enquiry about a reduction in the number of ABIs delivered in sexual health colleagues investigated potential cause and there has been an increase this month from 5 in the previous month to 22 in August.

**Actions**
- Retrospectively report on data via the new badgernet maternity system

## Smoking Quits

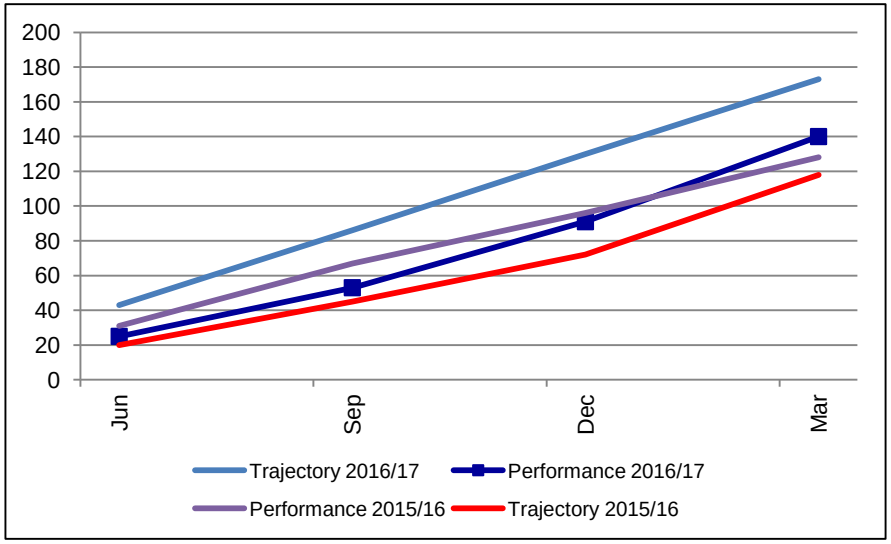
| Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas | Standard | Tolerance |
|---|---|---|
| | 173 | within 10% |

**Actual Performance** (higher = better performance)

| | Jun | Sep | Dec | Mar |
|---|---|---|---|---|
| **Trajectory 2017/18** | | | | |
| **Performance 2017/18** | | | | |
| **Trajectory 2016/17** | 43 | 86 | 130 | 173 |
| **Performance 2016/17** | 25 | 53 | 91 | 140 |
| **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 Q4 standard for successful 12 week **smoking quits** is 173. The final figure is 140 (81% of target), which has been confirmed by ISD (awaiting publication). Whilst we have not achieved our target (along with the majority of other Boards nationally) we have had a 9% increase in performance over the previous year. The Service has also had a 5.3% increase in the number of quit attempts in comparison to a 5% decrease in referrals into the service nationally.

**Actions:**
- BGH referrals are now through TrakCare as of the beginning of September 2017, to ease referral procedures.
- We are continuing with a sustained Facebook marketing campaign over the next 6 months as we believe our increase in quits is, as a result in increased awareness of the service.
- We are reviewing and updating our standard operating procedures to ensure service delivery is equitable and of a consistent quality.

## Sickness Absence

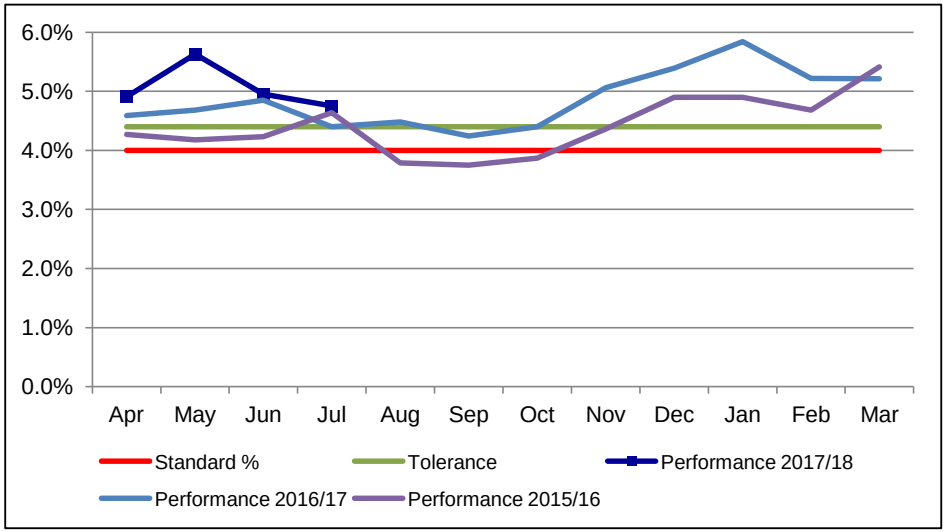
**Standard:** Maintain Sickness Absence Rates below 4%

| Standard | Tolerance |
|---|---|
| 4.0% | 4.4% |

**Actual Performance** (lower % = better performance)

| Latest NHS Scotland Performance |
|---|
| 5.0 % (June 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 2017/18** | 4.9% | 5.6% | 5.0% | 4.8% | | | | | | | | |
| **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% |




**Narrative Summary:**
The run chart shows that at 4.8% July 2017 **Sickness Absence** rate reduced by 0.2% from June 2017. A breakdown of sickness absence figures can be found on page 16.

**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.
- A sickness absence annual report to March 2017 has been completed and identified areas offurther work to support the wellbeing of staff.

## Sickness Absence *continued*

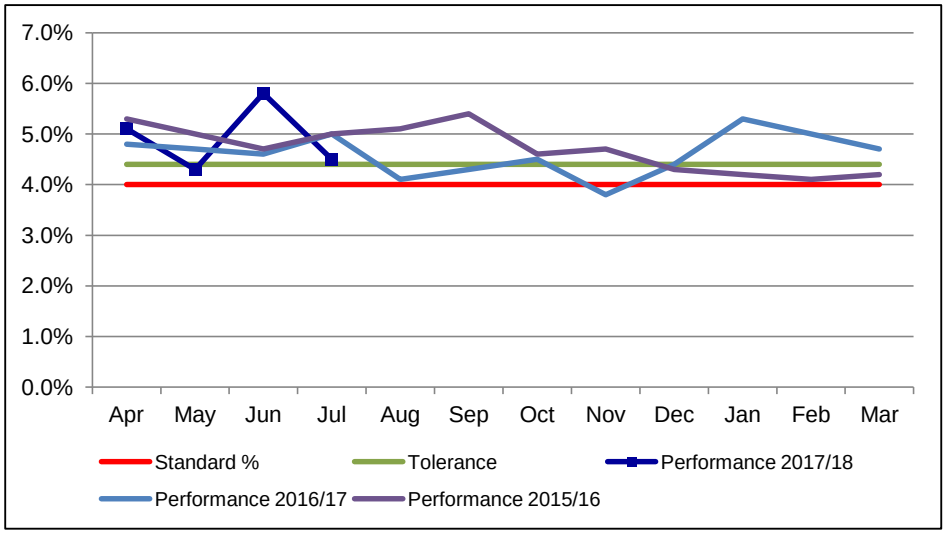
| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard %** | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% |
| **Learning Disabilities (Div/CHP)** | | | | | | | | | | | | |
| Administrative Services | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Allied Health Professionals | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Medical & Dental | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Nursing / Midwifery | 17.02 | 24.38 | 21.82 | 12.71 | | | | | | | | |
| **Grand Total** | 13.70 | 19.64 | 17.57 | 10.07 | | | | | | | | |
| **Mental Health (Div/CHP)** | | | | | | | | | | | | |
| Administrative Services | 6.73 | 4.64 | 1.77 | 0.75 | | | | | | | | |
| Allied Health Professionals | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Medical & Dental | 3.43 | 1.61 | 4.45 | 7.07 | | | | | | | | |
| Nursing / Midwifery | 6.76 | 7.90 | 6.71 | 7.38 | | | | | | | | |
| Other Therapeutic | 0.00 | 4.06 | 4.73 | 5.26 | | | | | | | | |
| Personal & Social Care | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Support Services | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| **Grand Total** | 5.77 | 6.59 | 5.73 | 6.38 | | | | | | | | |
| **Primary, Acute & Clinical Services** | | | | | | | | | | | | |
| Administrative Services | 3.19 | 4.84 | 4.37 | 5.42 | | | | | | | | |
| Allied Health Professionals | 2.68 | 3.33 | 2.92 | 2.60 | | | | | | | | |
| Dental Support | 4.68 | 5.25 | 4.42 | 4.81 | | | | | | | | |
| Health Care Sciences | 3.19 | 5.59 | 4.16 | 4.20 | | | | | | | | |
| Medical & Dental | 2.55 | 1.72 | 2.19 | 2.00 | | | | | | | | |
| Medical Support | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Nursing / Midwifery | 5.94 | 6.51 | 5.44 | 5.42 | | | | | | | | |
| Other Therapeutic | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Personal & Social Care | 0.00 | 16.55 | 23.97 | 1.07 | | | | | | | | |
| Support Services | 4.42 | 5.88 | 5.76 | 6.58 | | | | | | | | |
| **Grand Total** | 4.63 | 5.27 | 4.57 | 4.59 | | | | | | | | |
| **Support Services (Div/CHP)** | | | | | | | | | | | | |
| Administrative Services | 5.26 | 5.45 | 4.99 | 4.41 | | | | | | | | |
| Allied Health Professionals | 0.00 | 4.00 | 0.00 | 3.91 | | | | | | | | |
| Health Care Sciences | 0.00 | 0.00 | 0.00 | 10.78 | | | | | | | | |
| Medical & Dental | 0.00 | 6.62 | 2.21 | 0.00 | | | | | | | | |
| Nursing / Midwifery | 1.50 | 1.05 | 1.08 | 1.48 | | | | | | | | |
| Other Therapeutic | 4.84 | 5.05 | 2.46 | 2.32 | | | | | | | | |
| Personal & Social Care | 6.61 | 7.45 | 4.24 | 5.84 | | | | | | | | |
| Senior Managers | 0.27 | 0.00 | 0.00 | 0.00 | | | | | | | | |
| Support Services | 5.56 | 6.95 | 6.85 | 5.01 | | | | | | | | |
| **Grand Total** | 4.98 | 5.72 | 5.17 | 4.30 | | | | | | | | |

## 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 2017/18** | 5.1% | 4.3% | 5.8% | 4.5% | | | | | | | | |
| **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% |




**Narrative Summary:**
The **DNA** rate in July 2017 has improved but the rate still remains variable.

**Actions:**
- Continue to assign staff where possible to telephone patients with a history of missed appointments.
- A 2017 Reducing DNA campaign being planned - to refresh the 2016 posters .

## Same Day Surgery

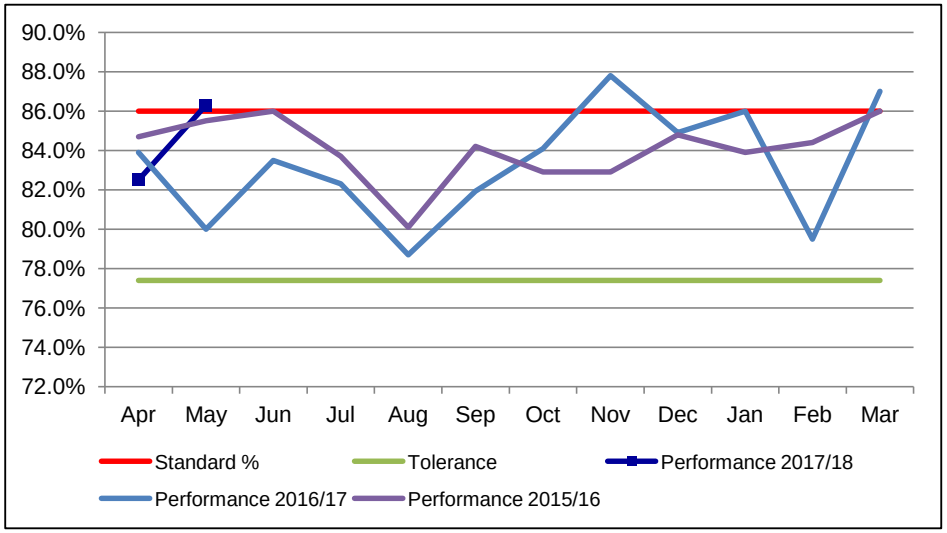
| | Standard | Tolerance |
|---|---|---|
| **Standard:** 86% of patients for day procedures to be treated as Day Cases | 86.0% | 77.4% |

**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 2017/18** | 82.5% | 86.3% | | | | | | | | | | |
| **Performance 2016/17** | 83.9% | 80.0% | 83.5% | 82.3% | 78.7% | 81.9% | 84.1% | 87.8% | 84.9% | 86.0% | 79.5% [1] | 87.0% |
| **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% |

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

[1] February 2017 data updated from monthly scorecard as reported incorrectly




**Narrative Summary:**
The standard to treat patients as **day cases** (for BADS* procedures) was achieved in May. Performance remains variable but within tolerances and over the last 8 months has shown an improvement when compared to the same period last year.

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:**
- Continue to monitor

**British Association of Day Case Surgery*

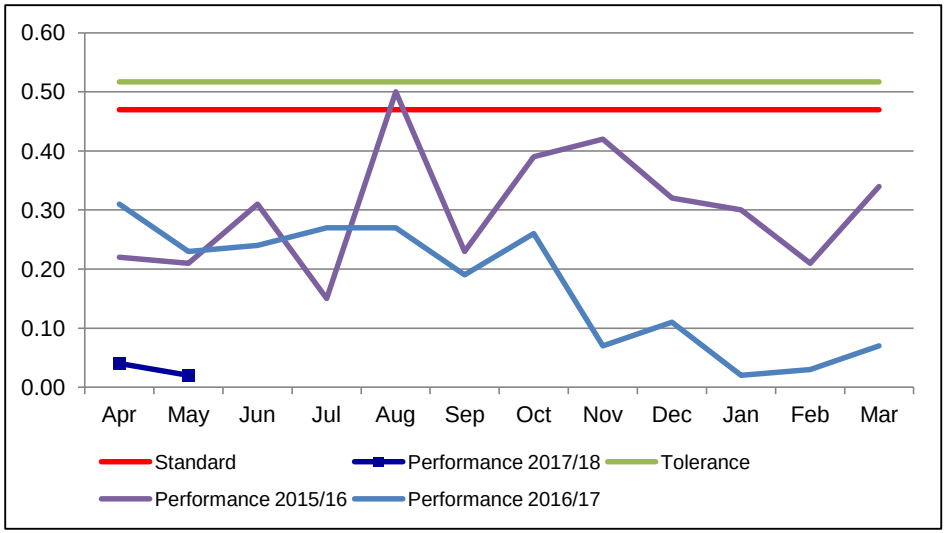
## Pre-Operative Stay

| | 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 2017/18** | 0.04 | 0.02 | | | | | | | | | | |
| **Performance 2016/17** | 0.31 | 0.23 | 0.24 | 0.27 | 0.27 | 0.19 | 0.26 | 0.07 | 0.11 | 0.02 | 0.03 | 0.07 |
| **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 |

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




**Narrative Summary:**
The run chart shows that **pre-operative inpatient stays** in hospital are generally low and show a downward trend. They are within the trajectory set, with the exception of August 2015 when the rate increased. This is a result of the work carried out as part of the IHO theatres and surgical flow project to reduce pre-operative stays in orthopaedics. Performance against this measure is being sustained.

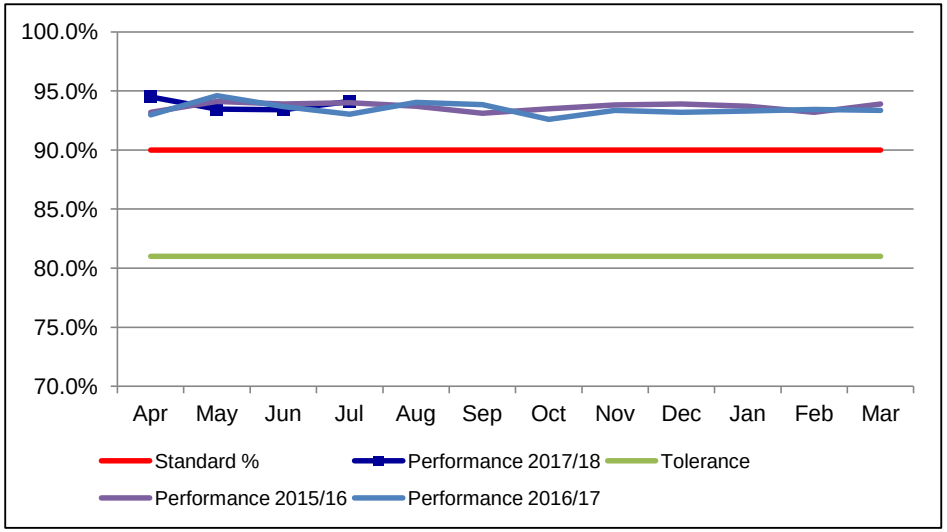
**Actions:**
- No further action planned at this time.

## 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 2017/18** | 94.5% | 93.5% | 93.4% | 94.1% | | | | | | | | |
| **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% |




**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.
- Dentists are now able to send referrals electronically via SCI Gateway.
- SCI Gateway to Berwick GP Practices will be operational by the end of August.
- A SBAR has been provided to the Head of Planning and Performance on the meaningfulness of this measure given the HEAT target was introduced in 2010 and has been monitored since, consistently achieving the standard over the reporting period.

## Breastfeeding

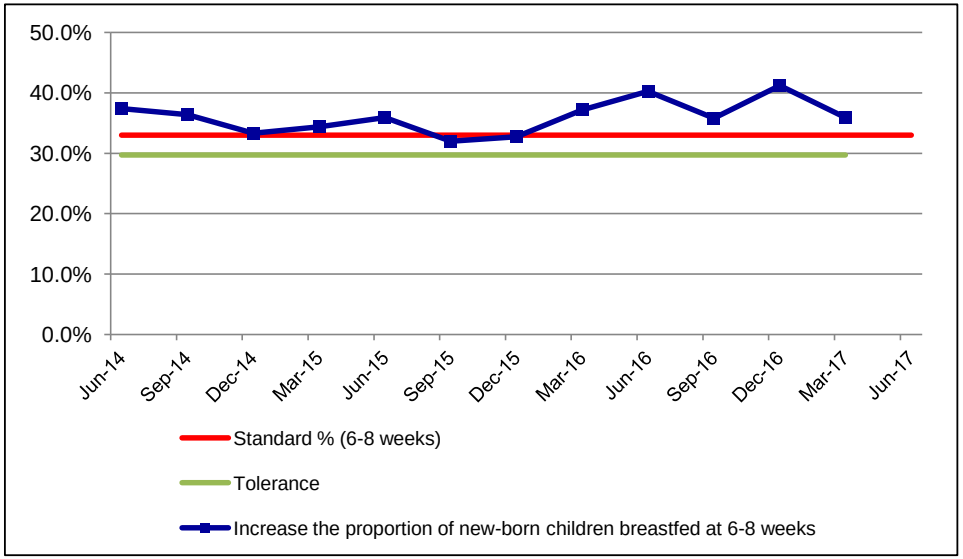
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Increase the proportion of new-born children breastfed at 6-8 weeks | 33.0% | 29.7% |

**Actual Performance** (higher % = better performance)

| | Jun-15 | Sep-15 | Dec-15 | Mar-16 | Jun-16 | Sep-16 | Dec-16 | Mar-17 | Jun-17 | Sep-17 | Dec-17 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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** | 35.9% | 32.0% | 32.8% | 37.2% | 40.3% | 35.8% | 41.2% | 35.9% | | | | |
| **Breastfeeding on discharge from BGH** [1] | 57.5% | 50.6% | - | - | - | - | - | - | - | - | - | - |
| **Breastfeeding at 10 Days** | 43.4% | 40.5% | 38.3% | 32.6% | 50.8% | 44.7% | 46.7% | 43.1% | | | | |
| **Percentage Ever Breast Fed** | - | - | - | 60.50% | 75.0% | 72.4% | 76.1% | 68.5% | | | | |

**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 January to March 2017, although performance decreased from 41.3% to 35.9%, the standard was achieved by 2.9%.

**Actions:**
- Permanent BFI lead appointed on 14th August and commences in post on 9th October.
- 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.
- Hospital and Community staff are now using Badgernet (the new maternity system) and we are working to maximise the breastfeeding information that can be reported on from this.

## 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 2017/18** | 2.5% | 4.2% | 6.1% | 8.9% | | | | | | | | |
| **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% |

## Personal Development Plans

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

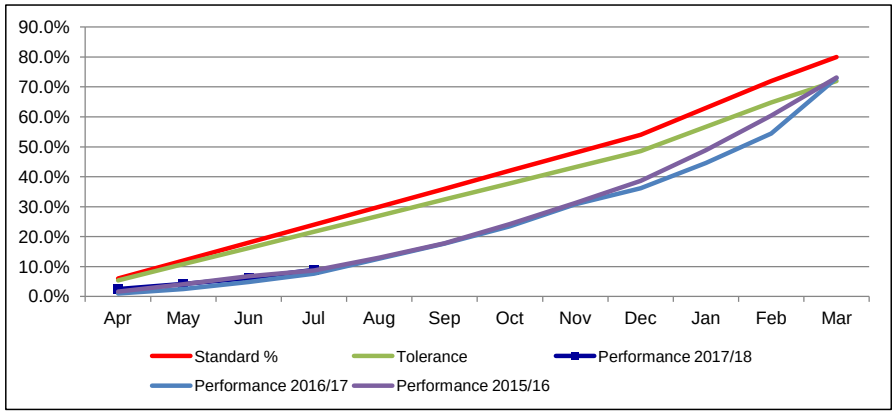
**Actual Performance** (higher % = better performance)

| | 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 2017/18** | 4.0% | 5.8% | 7.5% | 9.4% | | | | | | | | |
| **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% |

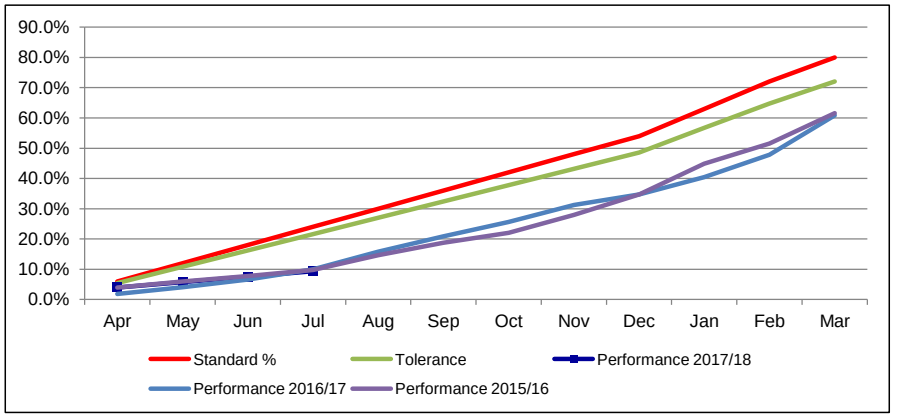
**Please Note:** Charts and supporting narrative are on the next page.

## eKSF and Personal Development Plans *continued*

**eKSF**




**PDP**




**Narrative Summary:**
The run chart shows that overall within NHS Borders the trajectory set for recording **annual Joint Development Reviews (JDRs) on eKSF** is outwith the 10% tolerance for the first 4 months of the year.

Regular reports are being sent out to all managers to highlight their percentages to encourage them to complete Reviews and PDPs on e-KSF.
The Employee Director is the Executive lead, supporting the KSF Champions and reporting back to the Board Executive Team on a regular basis.

KSF Champions continue to support and encourage managers to spread out reviews over the full year which should be reflected in the 2017/18 trajectory and continue to support staff and managers with password requests, post outlines and ad hoc training on the eKSF system where required

Appraisals planned for 2017/18 in March 2017 and trajectories submitted based on plans

**Mental Health:**
Trajectory at end of July was 15.5%, with reviews at 13.2% and PDP's at 13.5%. Although performance is slightly below trajectory, it is better than the same time last year (9.8% reviews and 11.1% PDP's), which indicates improved planning. Full performance reports continue to be sent to managers on a monthly basis, breaking down performance by team and staff name. Any areas not meeting trajectory are discussed at the weekly operational focus group meetings to support managers and encourage improved performance. All teams have a process in place to ensure appraisals are planned, carried out and inputted on to eKSF appropriately.

**Support Services**
Trajectory at the end of July was 16.60%, with reviews at 9.86% and PDP's at 13.36% . The percentage of Reviews completed are higher than this time last year (7.43%, PDP's are sitting the same). Reports are sent to Managers and managers who have been in touch have been sent a list of Employees who have a completed Review and PDP on e-KSF. All departments have a process in place to ensure appraisals are planned, carried out and inputted on to eKSF appropriately for the end of March.

**BGH and P&CS**
Work continues to meet with managers and staff to provide support with e-ksf system and processes. Monthly reports are being produced and shared with managers and reviewers. Trajectory of plans received showing position to end of December and March 2018 for completion of JDRs – Plans are outstanding within Primary Care, Planned Care and Unscheduled Care. KSF Champion is meeting with managers to assist in the completion of trajectories, extracting reports, movement of staff, passwords, assigning post outlines and training in the use of e-ksf

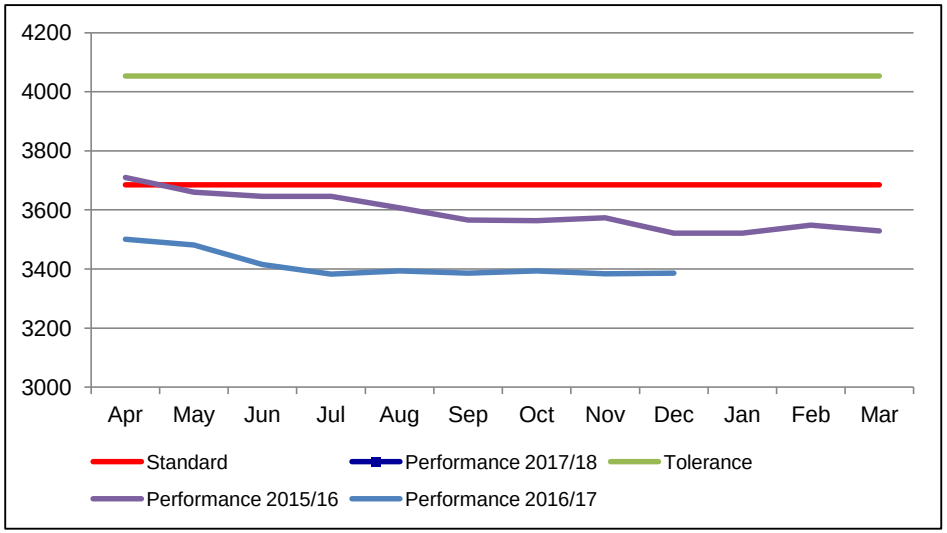
## Emergency Occupied Bed Days

| | 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 2017/18** | | | | | | | | | | | | |
| **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 |

**Please note:** There is up to a 6 month time lag in data being published for this target, however data unavailable for at time of reporting for January 2017.




**Narrative Summary:**
Over the past year (Dec 15 - Dec 16) there has been a fall in **emergency admissions** to the Borders General Hospital in persons over 75 years for Borders residents compared to Scotland as a whole. This is thought to be due to the impact of the redesign of Borders General Hospital services. These service changes include helping primary care teams access alternatives to hospital admission (including use of ambulatory care services); a rigorous approach to patient triage within the Emergency Department; and the introduction of a Frailty Service resulting in a more streamlined approach to patient care that ensures that patients receive the 'right care from the right person at the right time' to avoid or minimise their stay in hospital.

**Actions:**
- 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 6 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 2017/18, 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 |

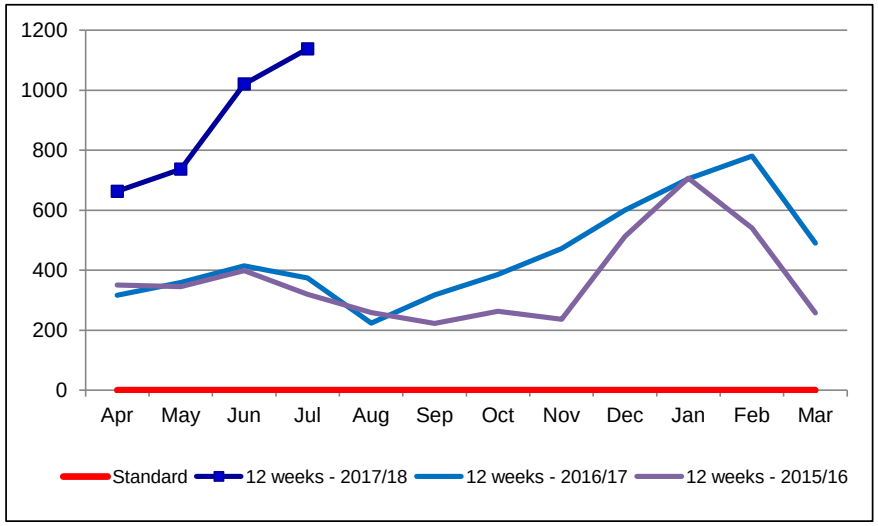
**Actual Performance** (lower = better performance)

| | 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 - 2017/18** | 663 | 737 | 1021 | 1138 | | | | | | | | |
| **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 | 252 | 497 | 285 |

**12 week breaches by specialty**

| **2016/17** | **Aug-16** | **Sep-16** | **Oct-16** | **Nov-16** | **Dec-16** | **Jan-17** | **Feb-17** | **Mar-17** | **Apr-17** | **May-17** | **Jun-17** | **Jul-17** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cardiology | | | | 3 | 31 | 47 | 59 | 64 | 119 | 130 | 161 | 153 |
| Dermatology | 27 | 85 | 109 | 183 | 283 | 322 | 272 | 178 | 270 | 305 | 439 | 446 |
| Diabetes/Endocrinology | 1 | 8 | 19 | 17 | 28 | 31 | 27 | 15 | 14 | 13 | 19 | 22 |
| ENT | 48 | 3 | | | | | | | 1 | 1 | | 1 |
| Gastroenterology | 42 | 10 | 5 | | 19 | 37 | 32 | 10 | 9 | 32 | 57 | 85 |
| General Medicine | | | | | | | | | | | | |
| General Surgery | | | 8 | | 2 | 4 | 7 | 2 | 1 | 8 | 3 | 8 |
| Gynaecology | | | 1 | | | | 1 | | 1 | | | |
| Neurology | | | 1 | 7 | 19 | 16 | 4 | 1 | 2 | 17 | 45 | 60 |
| Ophthalmology | 1 | 1 | 0 | 2 | 53 | 70 | 143 | 87 | 99 | 88 | 168 | 216 |
| Oral Surgery | 21 | 110 | 151 | 167 | 50 | 24 | 8 | 4 | 1 | 44 | 63 | 79 |
| Orthodontics | | | | 1 | 1 | | | 1 | | | | |
| Other | 2 | 5 | 2 | 3 | 7 | 3 | 20 | 9 | 13 | 28 | 38 | 40 |
| Pain Management | 74 | 93 | 88 | 80 | 88 | 86 | 71 | 38 | 26 | 14 | 8 | 2 |
| Respiratory Medicine | | | | | | | | | | | 1 | 1 |
| Rheumatology | | | | 1 | | | | | | | | |
| Trauma & Orthopaedics | 6 | | | | 1 | 58 | 131 | 81 | 105 | 55 | 14 | 22 |
| Urology | 2 | 2 | 2 | 8 | 18 | 7 | 5 | | 2 | 2 | 5 | 3 |
| **All Specialties** | **224** | **317** | **386** | **472** | **600** | **705** | **780** | **490** | **663** | **737** | **1021** | **1138** |

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




**Narrative Summary:**
The number of patients reported as waiting longer than 12 weeks has deteriorated in July due to continuing capacity issues within a number of specialties, including Cardiology, Dermatology and Ophthalmology.

**Actions:**
**- Cardiology:** Capacity is an ongoing problem, work is taking place with the service to look for solutions. The position of a third Consultant has been approved and the recruitment process is due to commence shortly.
**- Dermatology:** Job plans for existing Consultants are being reviewed. A GP with Special Interest post, has now been filled and are due to start in November.
**- Diabetics / Endocrinology:** Continues to be challenging. Short-term capacity has been organised and a new locum DME Consultant will be undertaking one clinic per week until March.
**- Gastroenterology:** The waiting lists have increased to 26 weeks with the resignation of one of the consultants that has caused issues with capacity. A third consultant has been appointed to start in December and a locum is also in place to increase capacity until March 2018.
**- Ophthalmology**: There are ongoing challenges around clinic capacity, due to Consultant vacancies within the service. A collaboration between NHS Borders, Lothian and Fife is being undertaken to provide sustainable Ophthalmology services across the region.
**- Oral Surgery:** With the new consultants in post we have seen a dramatic reduction in the number of outpatients breaching 12 weeks. Additional clinics have been organised in the short term, but there is not currently a plan for the longer term. Demand has increased by 23% when comparing the last 12 months to the 12 months before.

## Stage of Treatment - 12 Weeks Waiting Time for Inpatients

| | Standard | Tolerance |
|---|---|---|
| **Standard:** 12 Weeks Waiting Time for Inpatients | 0 | 1 |

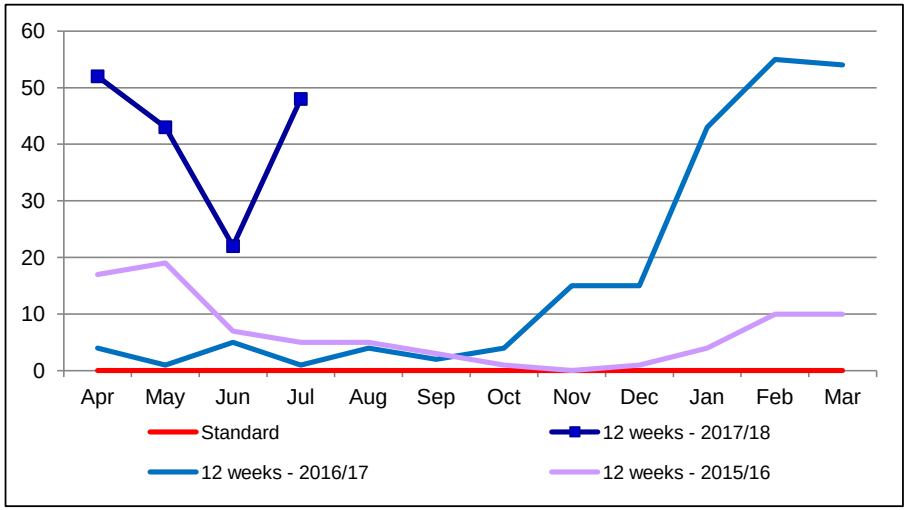
**Actual Performance** (lower = better performance)

| | 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 - 2017/18** | 52 | 43 | 22 | 48 | | | | | | | | |
| **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 week breaches by specialty**

| 2016/17 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ENT | | | | | | 3 | 1 | 1 | | | | |
| General Surgery | 2 | | | | | 1 | 2 | 1 | 3 | 10 | 4 | 2 |
| Gynaecology | | | | | | 1 | 1 | | | | | |
| Ophthalmology | | | | | | | | | | | | 5 |
| Oral Surgery | | | 1 | | | | 1 | 4 | | | | |
| Other | | | | | | | | | | | | 1 |
| Trauma & Orthopaedics | 2 | 2 | 3 | 15 | 15 | 37 | 49 | 48 | 49 | 32 | 18 | 40 |
| Urology | | | | | | 1 | 1 | | | 1 | | |
| **All Specialties** | **4** | **2** | **4** | **15** | **15** | **43** | **55** | **54** | **52** | **43** | **22** | **48** |

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




**Narrative Summary:**
At the end of July, the number of patients reported waiting over **12 weeks for inpatient treatment** increased to 48. This was expected, due to variations in the Orthopaedic clinic schedule.

A number of patients are reported as breaching within General Surgery, due to Consultant illness, and Ophthalmology, due to Consultant leave and productivity issues.

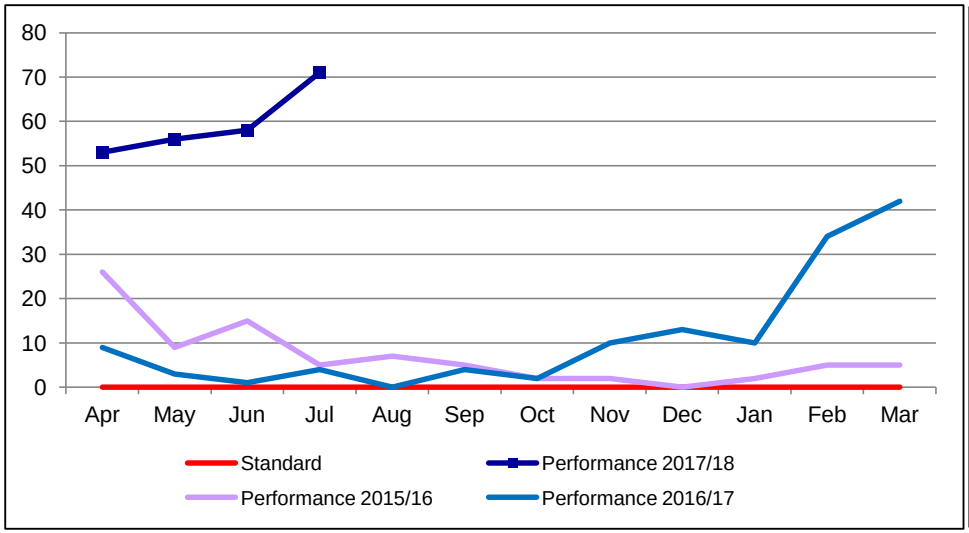
**Actions:**
- There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. We are working to minimise the impact of cessation of Synaptik operating lists with the implementation of the theatres and surgical flow project.
- A project is being undertaken to review productivity of Ophthalmology lists in DPU, with the aim of increasing this to be in line with other Health Board areas.

## 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 2017/18** | 53 | 56 | 58 | 71 | | | | | | | | |
| **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 |




**Narrative Summary:**
In July 71 patients breached their **Treatment Time Guarantee** (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 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unavailable | 115 | 115 | 92 | 82 | 73 | 59 | 72 | 58 | 58 | 69 | 93 | 101 | 91 |
| Patient Advised | 55.6% | 55.8% | 48.4% | 44.1% | 43.5% | 47.6% | 51.4% | 40.8% | 37.2% | 41.8% | 47.9% | 50.2% | 46.0% |
| Unavailable | 92 | 91 | 98 | 104 | 95 | 65 | 68 | 84 | 98 | 96 | 101 | 100 | 107 |
| Medical | 44.4% | 44.2% | 51.6% | 55.9% | 56.5% | 52.4% | 48.6% | 59.2% | 62.8% | 58.2% | 52.1% | 49.8% | 54.0% |
| Total Unavailable | 207 | 206 | 190 | 186 | 168 | 124 | 140 | 142 | 156 | 165 | 194 | 201 | 198 |
| Total % Unavailable | 19.1% | 19.1% | 19.0% | 16.9% | 17.3% | 12.5% | 13.2% | 13.1% | 14.3% | 15.5% | 18.9% | 20.2% | 17.9% |

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

| | Available | | | | Unavailable | | | |
|---|---|---|---|---|---|---|---|---|
| **Specialty** | **0 - 9 Weeks** | **10 - 12 Weeks** | **12+ Weeks** | **Total** | **Medical Un-available** | **Patient Advised Un-available** | **Total** | **% Un-available** |
| ENT | 45 | 4 | | **49** | 1 | 7 | **8** | **14.0%** |
| General Surgery | 148 | 18 | 2 | **168** | 17 | 23 | **40** | **19.2%** |
| Gynaecology | 49 | 1 | | **50** | 2 | 4 | **6** | **10.7%** |
| Ophthalmology | 167 | 21 | 5 | **193** | 12 | 8 | **20** | **9.4%** |
| Oral Surgery | 22 | 6 | | **28** | 0 | 5 | **5** | **15.2%** |
| Other | 24 | 2 | 1 | **27** | 1 | 0 | **1** | **3.6%** |
| Trauma & Orthopaedics | 232 | 60 | 40 | **332** | 44 | 54 | **98** | **22.8%** |
| Urology | 58 | 2 | | **60** | 14 | 6 | **20** | **25.0%** |
| **Total** | **745** | **114** | **48** | **907** | **91** | **107** | **198** | **17.9%** |

**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. This has increased as we move into the summer holidays. 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 90-100 patients.

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

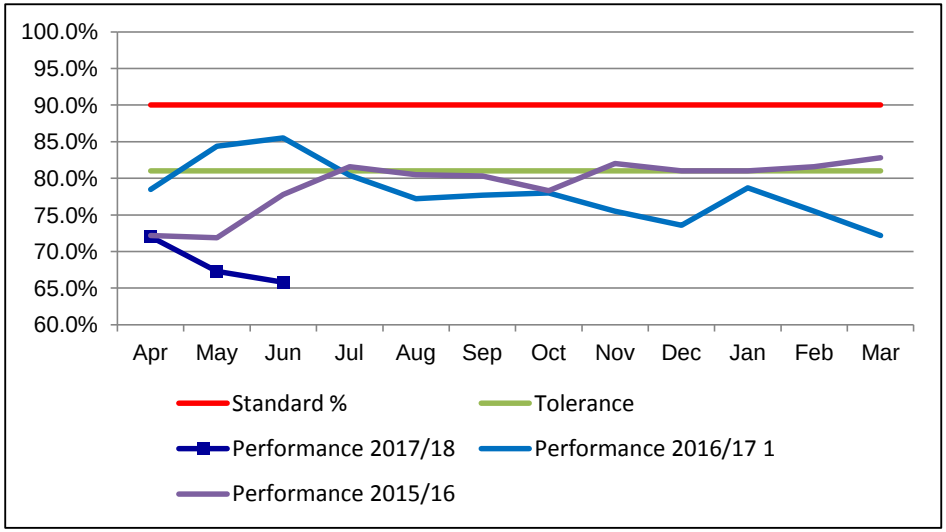
## 18 Weeks Referral to Treatment (RTT)

| | 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 2017/18** | 72.0% | 67.3% | 65.8% | | | | | | | | | |
| **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% | 72.2% |
| **Performance 2015/16** | 72.2% | 71.9% | 77.8% | 81.6% | 80.5% | 80.3% | 78.3% | 82.0% | 81.0% | 81.0% | 81.6% | 82.8% |

[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. (See pages 26-29 for specific narrative).

**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.

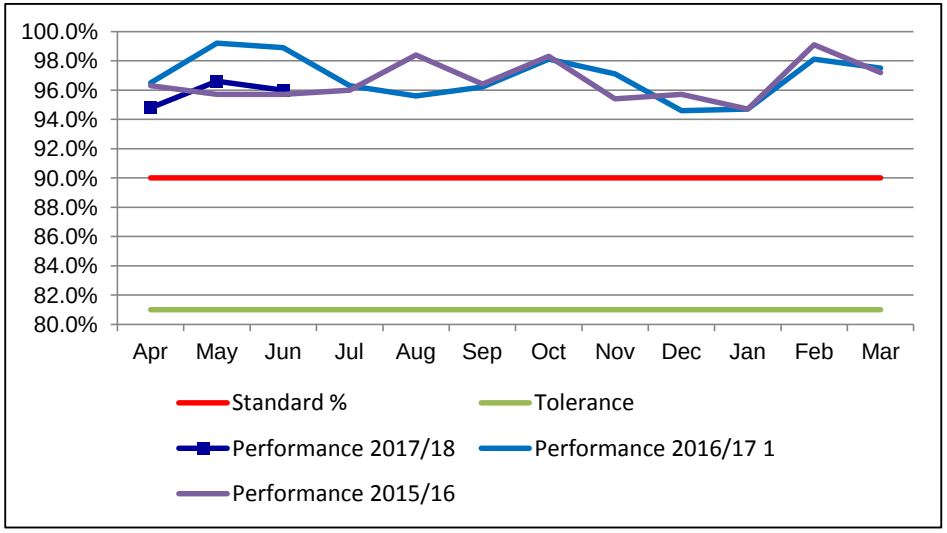
## 18 Weeks Referral to Treatment (RTT)

| | 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 2017/18** | 94.8% | 96.6% | 96.0% | | | | | | | | | |
| **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% | 97.5% |
| **Performance 2015/16** | 96.3% | 95.7% | 95.7% | 96.0% | 98.4% | 96.4% | 98.3% | 95.4% | 95.7% | 94.7% | 99.1% | 97.2% |
| **Performance 2014/15** | 97.7% | 97.0% | 96.7% | 95.3% | 95.5% | 97.5% | 95.5% | 95.0% | 96.0% | 97.9% | 97.4% | 95.5% |

[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 **admitted linked pathways** is consistently above 90%.

**Actions:**
- Work will continue to ensure the standard is maintained during 2017/18 with the reduction in the number of 12 week breaches. (See pages 27-30 for specific narrative).

**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.

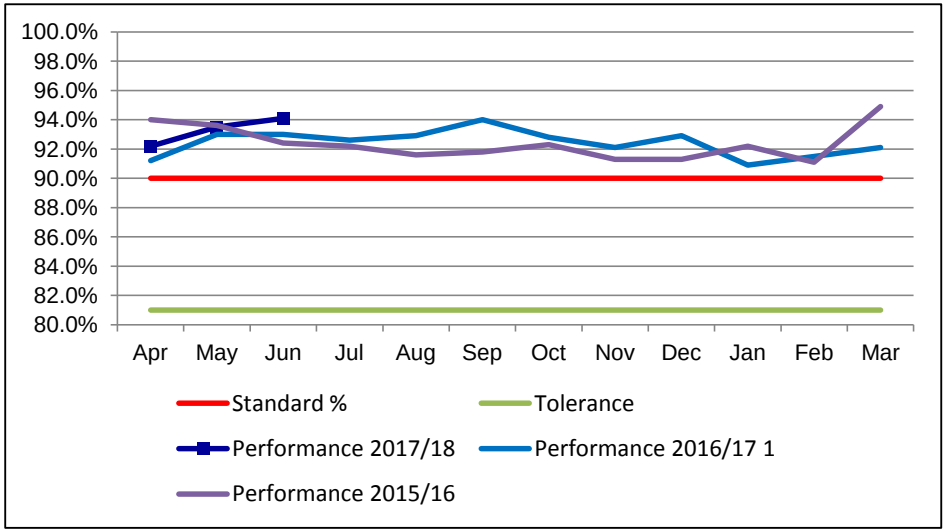
## 18 Weeks Referral to Treatment (RTT)

| | 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 2017/18** | 92.2% | 93.5% | 94.1% | | | | | | | | | |
| **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% | 92.1% |
| **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% |

[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 **non-admitted pathway performance** is consistently above 90%.

**Actions:**
- Work will continue to ensure the standard is maintained during 2017/18 with the reduction in the number of 12 week breaches. (See pages 27-30 for specific narrative).

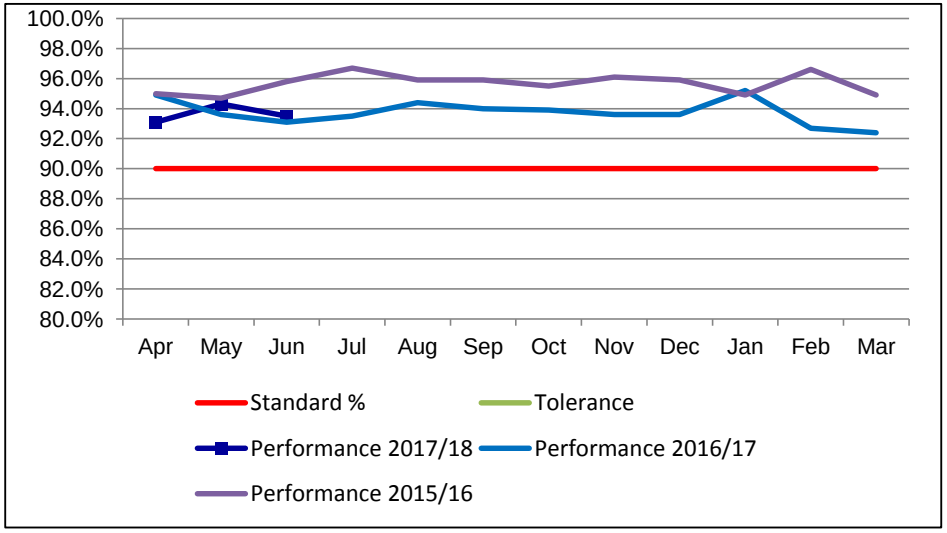
**Please Note:** From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

## 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 2017/18** | 93.1% | 94.3% | 93.5% | | | | | | | | | |
| **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% | 92.4% |
| **Performance 2015/16** | 95.0% | 94.7% | 95.8% | 96.7% | 95.9% | 95.9% | 95.5% | 96.1% | 95.9% | 94.9% | 96.6% | 94.9% |
| **Performance 2014/15** | 94.1% | 93.4% | 94.0% | 95.2% | 96.5% | 94.5% | 91.5% | 96.6% | 95.6% | 96.1% | 95.3% | 95.6% |




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

**Actions:**
- Work will continue during 2017/18 to ensure the standard is maintained with the reduction in the number of 12 week breaches. (See pages 27-30 for specific narrative).

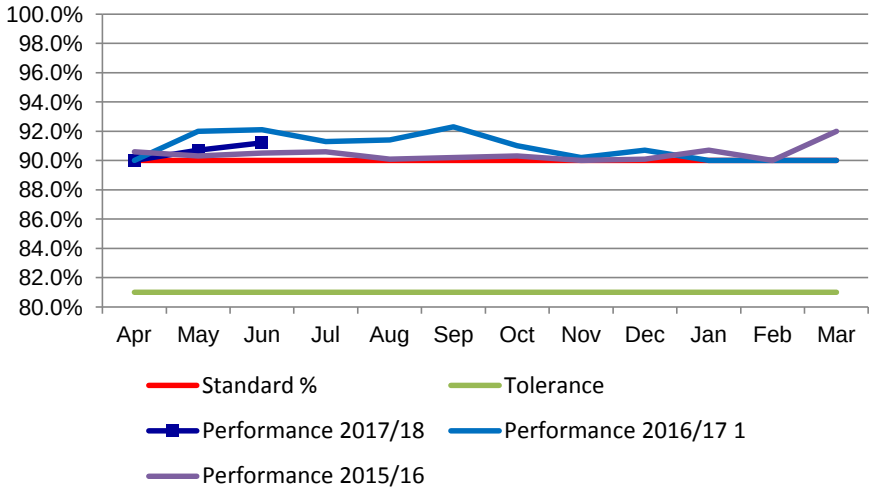
**Please Note:** From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

## 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 2017/18** | 90.0% | 90.7% | 91.2% | | | | | | | | | |
| **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% | 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% |




**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.

**Actions:**
- Work will continue during 2017/18 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. This should be resolved for the November report.

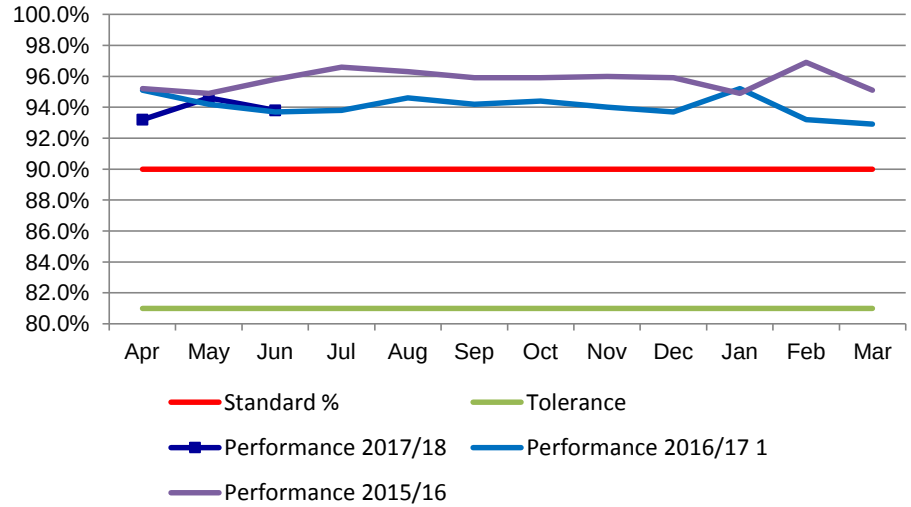
## 18 Weeks Referral to Treatment (RTT)

| | 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 2017/18** | 93.2% | 94.6% | 93.8% | | | | | | | | | |
| **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% | 92.9% |
| **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.

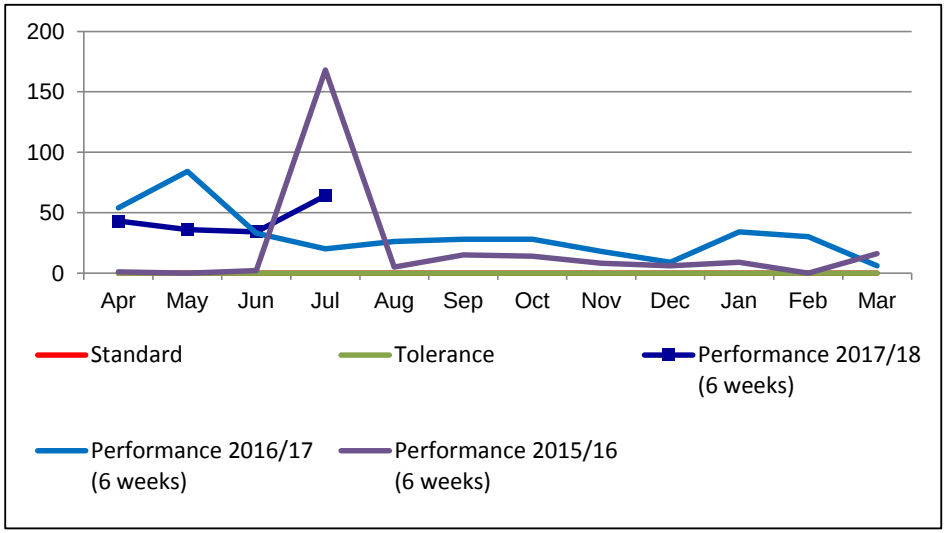
**Please Note:** From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

## 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 2017/18** (6 weeks) | 43 | 36 | 34 | 64 | | | | | | | | |
| **Performance 2017/18** (4 weeks) | 196 | 127 | 154 | 226 | | | | | | | | |
| **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 |




**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.

The deterioration of performance in July has largely been caused by increasing waits for MRI scanning.

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 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Endoscopy | - | - | - | - | - | - | | | | | | | |
| Colonoscopy | - | - | - | - | - | - | 25 | 29 | 6 | 36 | 18 | 6 | 7 |
| Cystoscopy | - | - | - | - | - | - | 8 | | | | | | |
| MRI | - | - | - | - | - | - | 1 | 1 | | 3 | 18 | 27 | 56 |
| CT | - | - | - | - | - | - | | | | 4 | | | 1 |
| Ultra Sound (non-obstetric) | - | - | - | - | - | - | | | | | | 1 | |
| Barium | - | - | - | - | - | - | | | | | | | |
| **Total** | **20** | **26** | **28** | **28** | **18** | **9** | **34** | **30** | **6** | **43** | **36** | **34** | **64** |

| Diagnostic - 4 weeks | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Endoscopy | 1 | | | | 4 | | | | | | | | 2 |
| Colonoscopy | 34 | 40 | 68 | 63 | 34 | 38 | 41 | 52 | 31 | 60 | 31 | 11 | 9 |
| Cystoscopy | 1 | 1 | | | 2 | 4 | 11 | | 3 | 4 | 1 | 1 | |
| MRI | 18 | 10 | 21 | 45 | 6 | 6 | 5 | 16 | 44 | 70 | 92 | 127 | 182 |
| CT | 25 | | 14 | 33 | 5 | 8 | 2 | 25 | 34 | 52 | | 13 | 30 |
| Ultra Sound (non-obstetric) | 58 | 1 | | | 8 | | | 2 | 2 | 10 | 3 | 2 | |
| Barium | | | | | 3 | | | | | | | | 3 |
| **Total** | **137** | **52** | **103** | **141** | **62** | **56** | **59** | **95** | **114** | **196** | **127** | **154** | **226** |

**Narrative Summary and Actions:**

**Colonoscopy –** The number of colonoscopy breaches continues to decrease with ring fenced locum consultant colon sessions secured to ensure there is no gap in service whilst the vacant GI consultant post is recruited to. This post is expected to be filled by the end of the year. Funding has been agreed for a nurse endoscopist/upper GI cancer nurse specialist which will provide additional nurse-led colonoscopy lists. This post is out for recruitment, however the first round has not attracted applicants, it has been readvertised more widely.

**Endoscopy –** The 4 week standard has been met consistently and performance is being monitored. 2 patients waited over 4 weeks in July and this has been impacted by annual leave and sickness over the summer months.

**Magnetic Resonance Imaging (MRI) & Computerised Tomography (CT) –** MRI has seen an increase in demand over the past year and scanning radiographer scanning capacity is now at its limit. Analysis of the change in demand is being completed to identify if additional resource will be required recurrently. As an interim measure additional weekend MRI scanning sessions are being run in order to bring down the waiting times particularly for urgent patients. This is being funded out of non-recurring Scottish Government funding to address access to diagnostic capacity for patients on the cancer pathway.

**Ultrasound** – The ultrasound service continues to be under pressure due to maternity leave and vacancy, however is managing to meet demand at present.

## 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 | Jan to Mar 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 62-day standard | 98.51% | 97.44% | 94.40% | 98.70% | 98.50% | 98.50% | 100% | 97.22% | 98.90% | 92.60% | 96.20% |
| 31-days standard | 100% | 100% | 97.80% | 100.00% | 97.80% | 98.20% | 100% | 98.18% | 100% | 100% | 97.30% |

## Cancer Waiting Times

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

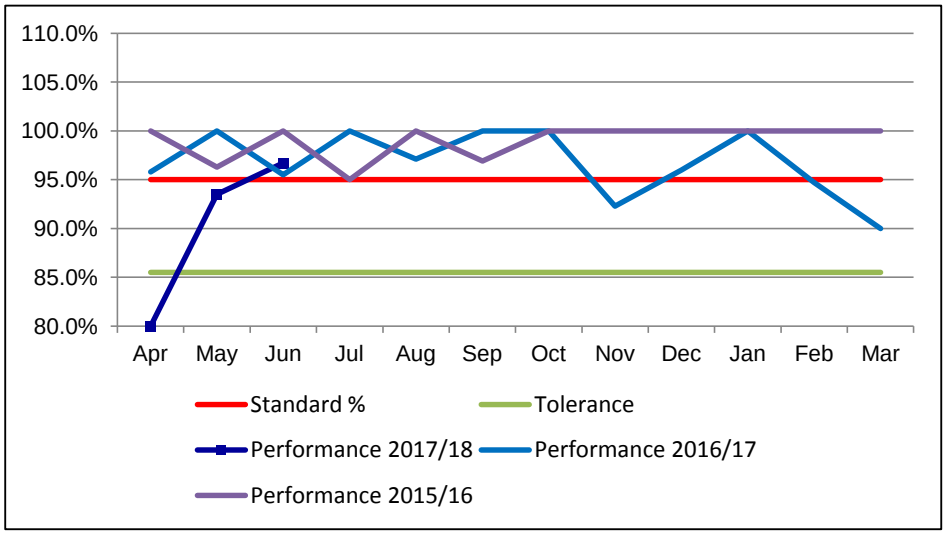
| Standard | Tolerance |
|---|---|
| 95.0% | 86.0% |

**Actual Performance** (higher % = better performance)

| Latest NHS Scotland Performance |
|---|
| 86.1% (May 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 2017/18** | 80.0% | 93.5% | 96.7% | | | | | | | | | |
| **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% | 90.0% |
| **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% |

**Please Note:** there is a 1 month lag time for data. February 2017 data updated from 96.0% to 94.7% as incorrectly reported.




**Narrative Summary:**
The run chart shows the standard, to **see patients with a suspicion of cancer within 62 days** was achieved in July with a performance of 100%.

**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. At present NHS Lothian only provide 2 slots per week to treat referred patients from other Boards. The local waiting times team have confirmed that NHS Borders patients are not being disadvantaged.
- The introduction of qFIT earlier this year has allowed Consultants to triage Colonoscopy activity. Fast track pathway for screening and qFIT blood detected; Standard pathway for qFIT blood not detected. This has made an impressive improvement in access to Colonoscopy for Screening 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

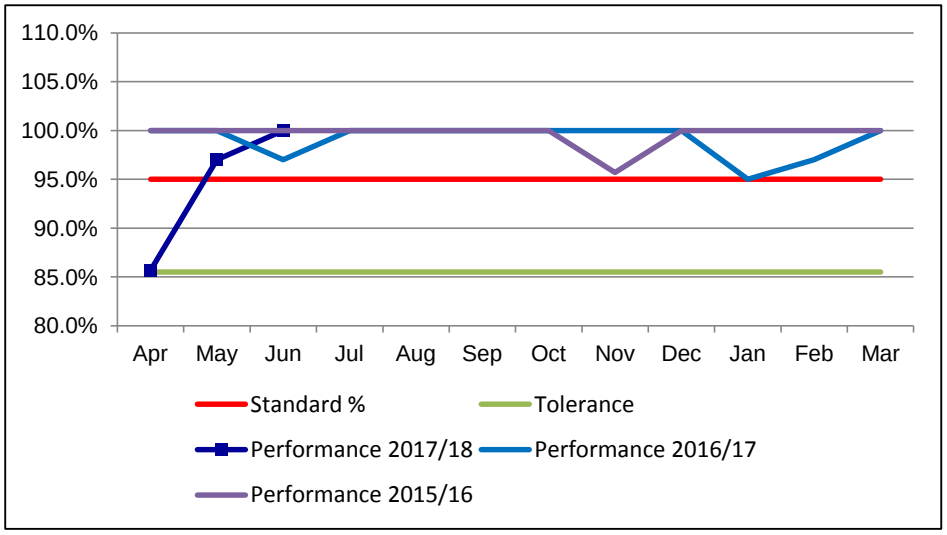
| Standard | Tolerance |
|---|---|
| 95.0% | 86.0% |

**Actual Performance** (higher % = better performance)

| Latest NHS Scotland Performance |
|---|
| 93.9% (May 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 2017/18** | 85.7% | 97.0% | 100.0% | | | | | | | | | |
| **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% | 100.0% |
| **Performance 2015/16** | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 100.0% | 100.0% | 100.0% | 100.0% |
| **Performance 2014/15** | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.0% | 96.8% | 100.0% | 100.0% |

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




**Narrative Summary:**
The run chart shows the standard, to **treat patients with cancer within 31 days of diagnosis**. In July 100% of patients were treated within 31 days.

**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 local waiting times team have confirmed that NHS Borders patients are not being disadvantaged.
- The introduction of qFIT earlier this year has allowed Consultants to triage Colonoscopy activity. Fast track pathway for screening and qFIT blood detected; Standard pathway for qFIT blood not detected. This has made an impressive improvement in access to Colonoscopy for Screening patients.

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

## Accident & Emergency 4 Hour Standard

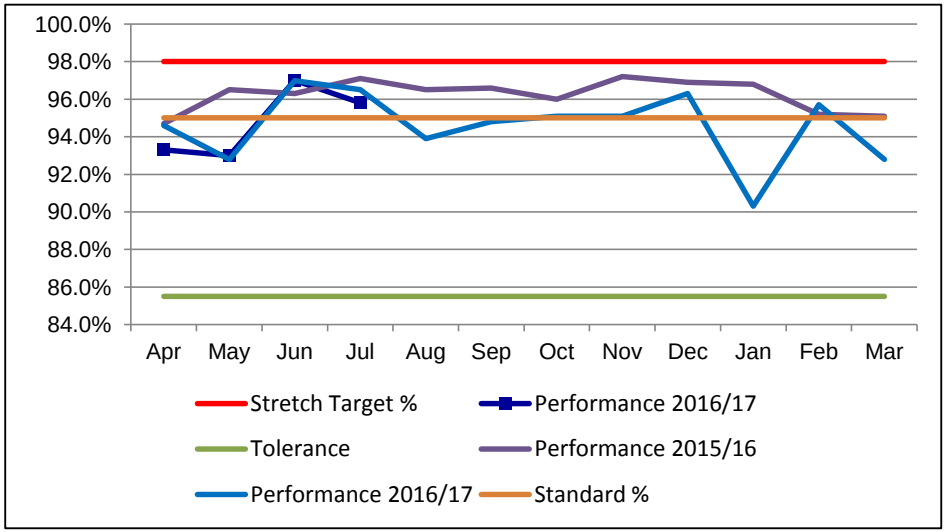
**Standard:** 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

| Stretch Target | Standard | Tolerance |
|---|---|---|
| 98.0% | 95.0% | 85.5% |

**Actual Performance** (higher % = better performance)

| Latest NHS Scotland Performance |
|---|
| 94.0% (May 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** | 93.3% | 93.0% | 97.0% | 95.8% | | | | | | | | |
| **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 stretch standard.

The 95% standard was achieved in both June and July 2017. The main cause of breaches has been delays waiting for bed availability and reflects ongoing challenges in the discharge of complex patients.

**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 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Flow 1 | 98.4% | 96.8% | 97.3% | 97.0% | 97.2% | 98.3% | 96.7% | 97.7% | 97.1% | 96.9% | 97.3% | 98.4% | 98.8% |
| Flow 2 | 94.0% | 92.9% | 90.8% | 94.9% | 92.2% | 95.4% | 92.9% | 94.8% | 92.5% | 91.5% | 91.8% | 94.7% | 93.6% |
| Flow 3 | 94.6% | 91.8% | 91.0% | 92.3% | 93.5% | 93.4% | 76.7% | 92.5% | 86.5% | 92.0% | 86.0% | 95.1% | 91.5% |
| Flow 4 | 92.7% | 83.0% | 91.5% | 91.3% | 91.9% | 92.9% | 87.6% | 94.4% | 82.1% | 79.0% | 85.5% | 94.8% | 91.7% |
| **Total** | **96.5%** | **93.9%** | **94.8%** | **95.1%** | **95.1%** | **96.3%** | **90.3%** | **95.7%** | **92.8%** | **93.3%** | **93.0%** | **97.0%** | **95.8%** |

**Narrative Summary and Actions:**
For a second month running the department has achieved the Emergency Access Standard, that said it is necessary to continue to work to improve performance in respect of Flow 3&4, such as consistently increasing morning discharges. The main cause of breaches during this time has been delays waiting for bed availability and reflects ongoing challenges in the discharge of complex patients.

A review of delayed discharges has been commissioned and undertaken by Professor John Bolton and an action plan from this report is being developed to reduce numbers of patients delayed within BGH and Community Hospitals.

Other breaches have been the result of waits for transport, delays in specialty review and delays in first assessment. Work is underway to review and improve all these areas.

Daily breach review and escalation processes have been refreshed and additional rigour introduced to ensure that patients are not delayed unnecessarily. There is ongoing work to define correct medical and nursing staffing levels in ED. This work is likely to conclude by the end of August.

**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 2017/18** | 71.4% | 87.5% | 92.3% | | | | | | | | | |
| **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% | 51.7% |
| **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:**
The 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:

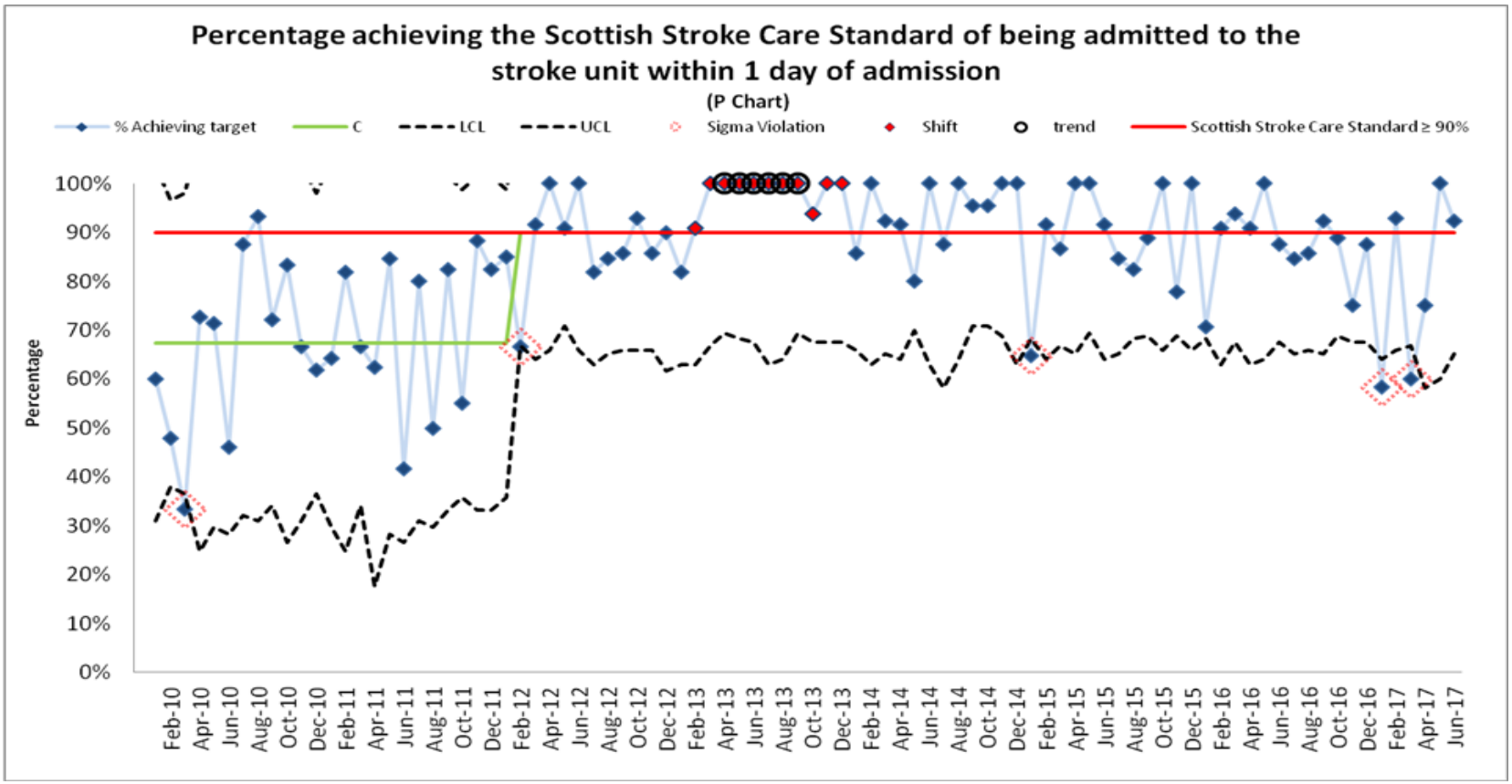
- admission to a dedicated Stroke Unit within 1 day of admission
- a swallow screen test within 4 hours of admission
- a brain scan within 24 hours of admission
- appropriate treatment initiated within one day of admission

During June, performance improved again. Due to small numbers of patients admitted, the target is significantly impacted by single breaches however detailed a review of all breaches are undertaken to identify causes and develop plan for resolution.

**Actions:**
- Process in place to ensure newly-admitted stroke patients have priority for admission to stroke unit within 1 day.
- Detailed analysis of all breaches to identify causes and potential solutions

**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. The data in the tables above is reported at a point in time however the chart on the following page is updated monthly to reflect the most up to date information.

## 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. The chart is updated monthly to reflect the most up to date information. The data in the tables on the previous page is reported at a point in time.

## Psychological Therapies Waiting Times

**Standard:** 18 weeks referral to treatment for Psychological Therapies

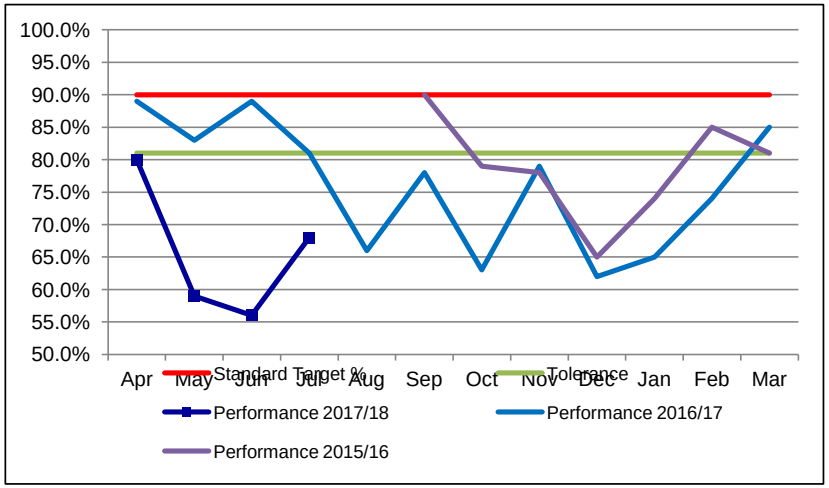
| Standard | Stretch | Tolerance |
|---|---|---|
| 90.0% | 95.0% | 81.0% |

**Actual Performance** (higher % = better performance)

| Latest NHS Scotland Performance |
|---|
| 73.7% (March 2017) |

| | 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 2017/18** | 80.0% | 59.0% | 56.0% | 68.0% | | | | | | | | |
| **Total Patients Currently Waiting >18 Weeks:** | 93 | 102 | 129 | 132 | | | | | | | | |
| **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 |

**Please Note:** Since September 2016 we 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. There are a number of reasons including lack of appropriate triage and suitability assessment; lack of standard diary templates / expectations; varying referral criteria and acceptance rates across the service; varying processes for supervision and caseload management; and long new to follow up ratios.

Sustainably, performance is expected to improve by 31/03/2018, however it should be noted that due to the number of patients already waiting over 18 weeks for treatment performance will decrease before it increases as these patients are seen.

**Actions:**
- A project group has been set up and meets weekly to discuss areas for improvement and implement actions. Actions already being taken forward include updating diaries to show number of available slots per week; updating diaries to include one suitability assessment slot per week; revising appointment booking process to fill these slots; agreeing a standard new to follow up ratio; considering the use of locum or additional clinics to tackle the backlog of patients waiting for treatment.; reviewing and reissuing admin recording process.
- The financial impact will be quantified once the decision is made around the use of locums. There is funding available via the improving access to psychological therapies fund.

## 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% |

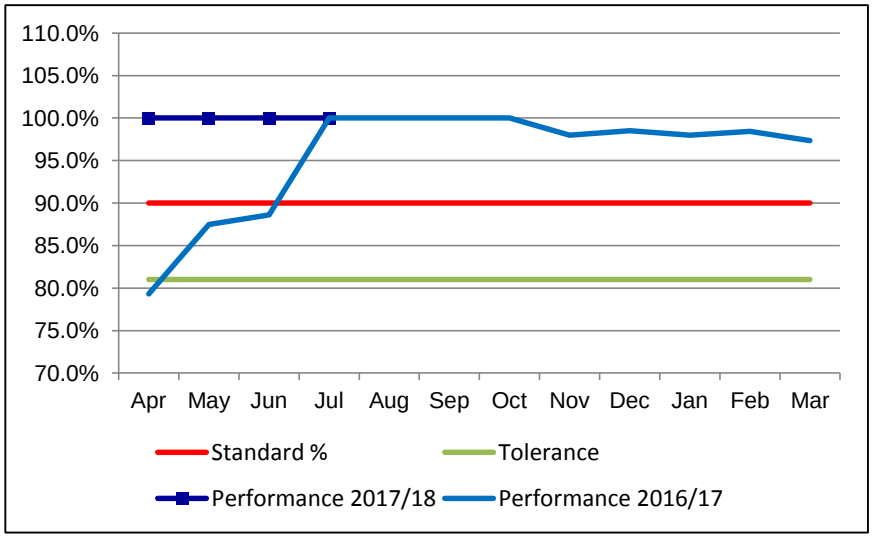
**Actual Performance** (higher % = better performance)

| Latest NHS Scotland Performance |
|---|
| 92.6% (March 2017) |

| | 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 2017/18** | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | | | |
| **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 meet both the local and the stretch standards for **CAMHS referral to treatment** which is expected to be maintained on an ongoing basis.

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.

A data recording anomaly was highlighted in April 2017 and work is underway to resubmit data from April 2016 onwards, however this is likely to have minimal impact on performance.

**Actions:**
- More detailed focus is now being given to rates of referrals and declined referrals examining reasons for decline.

## Drug & Alcohol Treatment

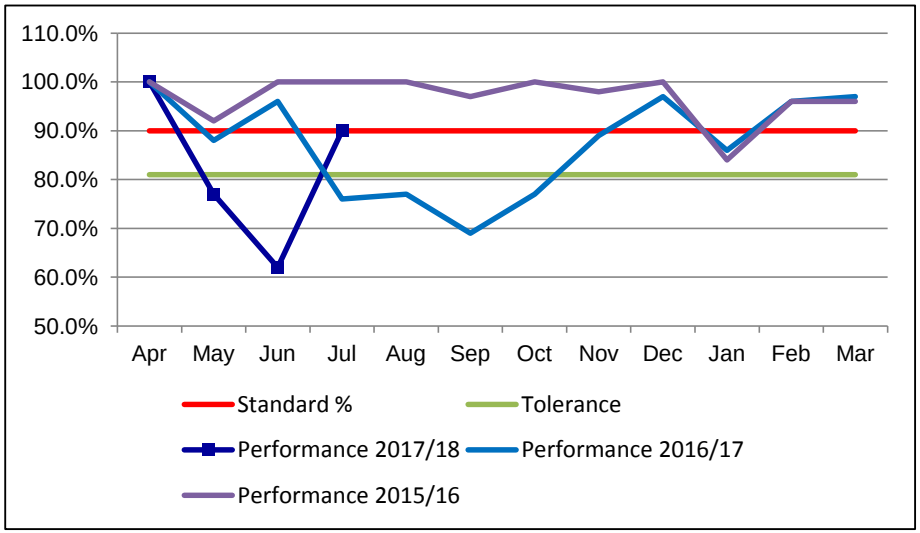
**Standard:** Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

| Standard | Tolerance |
|---|---|
| 90.0% | 81.0% |

**Actual Performance** (higher % = better performance)

| Latest NHS Scotland Performance |
|---|
| 94.0% (April 2017) |

| | 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 2017/18** | 100.0% | 77.0% | 62.0% | 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% |




**Narrative Summary:**
The national LDP standard has an ongoing requirement is to deliver **3 weeks RTT** for 90% of progressed drug & alcohol referrals. The Alcohol & Drugs Partnership (ADP) Executive considered its stretch target and agreed to concentrate on achieving the national standard consistently during this year.

The BAS service is going through significant change in relation to recruitment and retention incurring vacancies within the service, one of which is the team manager post, essential to maintain leadership and management throughout the service. Despite best efforts the service will find it challenging over the coming months to maintain the standard until the service is back to full establishment.

**Actions:**
- Progress recruitment to vacant posts within BAS.
- Team Manager starts mid-October 2017.

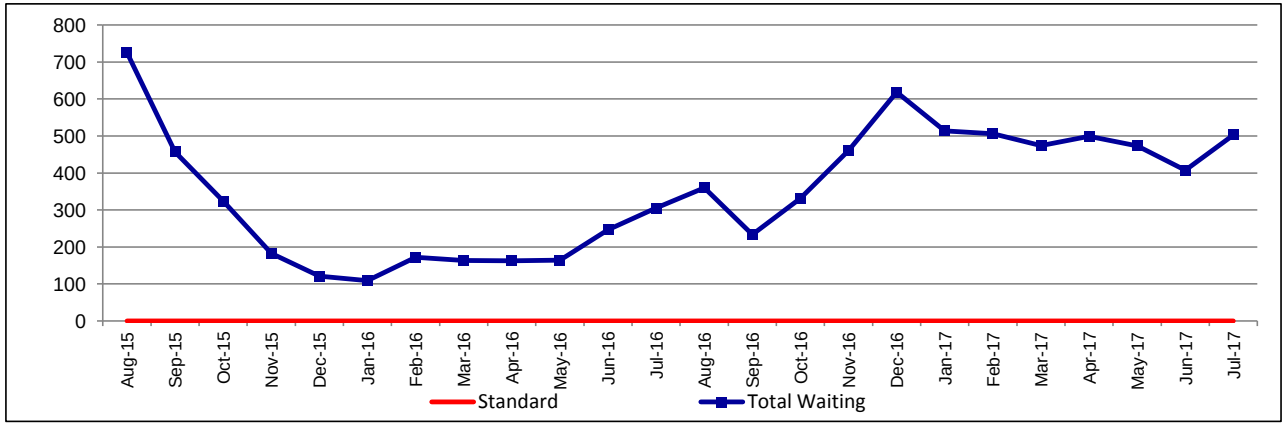
## AHP Waiting Times

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

**Actual Performance** (lower = better performance)

| | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Waiting** | **305** | **360** | **233** | **331** | **461** | **619** | **514** | **506** | **474** | **499** | **473** | **407** | **503** |
| Occupational Therapy | 11 | 4 | 2 | 0 | 0 | 4 | 4 | 4 | 7 | 5 | 2 | 3 | 3 |
| Physiotherapy | 262 | 339 | 211 | 320 | 452 | 609 | 498 | 489 | 459 | 480 | 457 | 386 | 481 |
| Podiatry | 0 | 0 | 0 | - | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Speech & Language Therapy | 2 | 3 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Nutrition & Dietetics | 30 | 14 | 20 | 9 | 9 | 6 | 12 | 13 | 8 | 14 | 13 | 18 | 18 |

**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. The 18 week program commenced w/c 17th April 2017.

**Physiotherapy**
Patient's waiting longer than 9 weeks deteriorated over last month due to staffing vacancies. 448 of patients are within MSK service and the remaining patients are mostly within older people neurology and community work stream and paediatrics. The AHP Management Review is underway which will support permanency and reduce the need for ongoing fixed term contracts and backfill arrangements. The review is supported by concurrent 18 week Clinical Productivity Programme. Vacancies are proactively being filled but there are still unfilled hours (currently 12.78% staffing vacancy). In addition the service has long term planned and unplanned sickness. Reduced to 1 locum to support vacancies and patient flow pressures within BGH.

**Nutrition and Dietetics**
In the absence of the Dietetic lead, admin staff are sending individual dietician's their waiting times for checking therefore it is not possible at this time to have a full service overview in order to confirm the accuracy of the data in the performance scorecard. Historically Dietetic service's own data indicates fewer breaches, this is due to patient choice, group education and non response to opt-in systems, which cannot be captured on ePex system.

A full time locum dietitian has been recruited to manage the adult and paediatric eating disorder caseload, which previously has had high waiting times due to lack of sufficient funding for the level of dietetic input required, this is compounded as we do not have an Eating Disorders Specialist Nurse.

The dietetic service remains under pressure due to a high demand and reduced capacity due to efficiency savings. Regular additional hours (from the dietetic budget) are used to run diabetes services such as DESMOND and TOBE, the future funding of these essential services needs explored as a matter of urgency with the Diabetes team. Challenges also remain in specialities such as GI and Mental Health due to increased referral rates and limited capacity. 0.37wte dietetic hours have been moved from supporting acute and community dietetic teams to implement OPAH recommendations following the unannounced inspection in June 2017. Adult and Paediatric DNA rates are above target, however benchmarks well against national norms. The migration to EMIS for paediatric dietetic staff and community dietician's who also see children has commenced, opt in and patient centred systems will continue.

**Occupational Therapy**
There are 2 LD clients who appear on epex waiting list, as LD have now gone over to emis we are unable to remove their names , Both have been seen . There was one paediatric breach , this has now been resolved .

**Podiatry**
There have been issues within the admin team regarding the correct use of Trak, especially patient "unavailability" "DNA" "re setting the clock".
The admin team lead has tried to address these issues within the team and has secured permission for a temporary admin person to allow the current team to be freed up to undertake update training, a suitable person from the bank is being sought at present.

**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

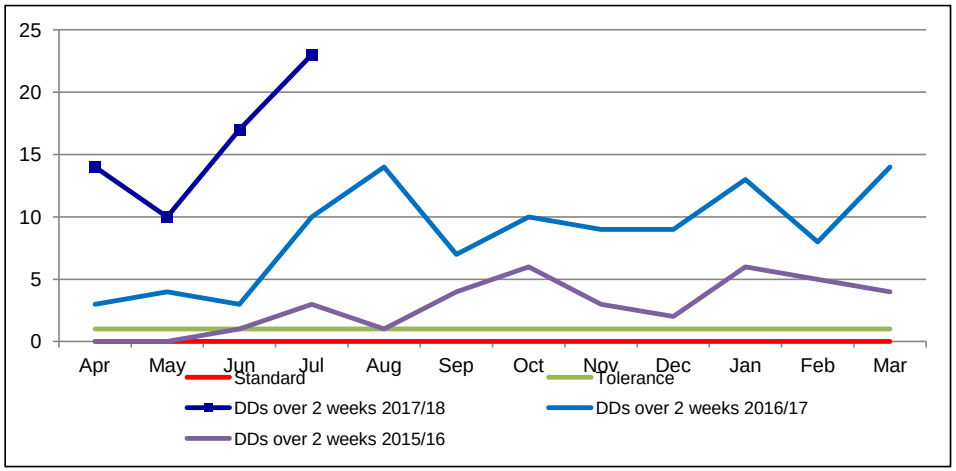
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Delayed Discharges - delays over 72 hours | 0 | 1 |

**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 2017/18** | 14 | 10 | 17 | 23 | | | | | | | | |
| **DDs over 72 hours (3 days) 2017/18** | 19 | 16 | 23 | 35 | | | | | | | | |
| **Occupied Bed Days (standard delays)** | 814 | 664 | 675 | 984 | | | | | | | | |
| **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 |

**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). July 2017 data is provisional at the time of reporting.




**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

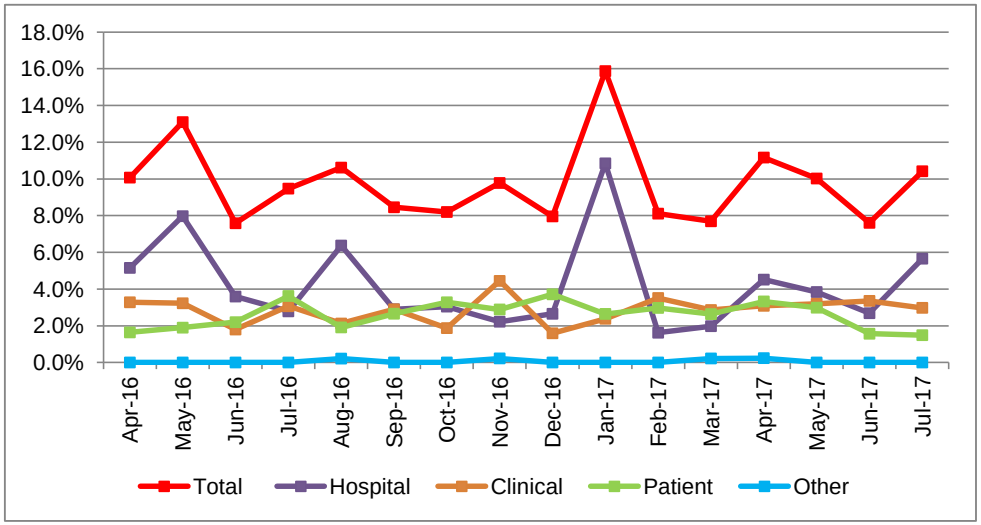
**Hot Topic:** Cancellations

**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 % | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **10.6%** | **8.5%** | **8.2%** | **9.8%** | **8.0%** | **15.9%** | **8.1%** | **7.7%** | **11.2%** | **10.0%** | **7.6%** | **10.4%** |
| **Hospital** | 6.4% | 2.9% | 3.0% | 2.2% | 2.7% | 10.8% | 1.6% | 2.0% | 4.5% | 3.8% | 2.7% | 5.7% |
| **Clinical** | 2.1% | 2.9% | 1.9% | 4.4% | 1.6% | 2.4% | 3.5% | 2.9% | 3.1% | 3.2% | 3.4% | 3.0% |
| **Patient** | 1.9% | 2.7% | 3.3% | 2.9% | 3.7% | 2.6% | 3.0% | 2.6% | 3.3% | 3.0% | 1.6% | 1.5% |
| **Other** | 0.2% | 0.0% | 0.0% | 0.2% | 0.0% | 0.0% | 0.0% | 0.2% | 0.2% | 0.0% | 0.0% | 0.0% |




**Narrative Summary:**
In July the overall percentage of **cancellations** increased. The number of non-clinical or capacity related cancellations rose from 12 in June to 19 in July, with the percentage of all procedures increasing 3% from 2.7% to 5.7%. 12 procedures were cancelled due to consultant or anaesthetist sickness, 5 due to being out of time, 1 due to an emergency taking priority and 1 due to unavailability of an ITU/HDU Bed.

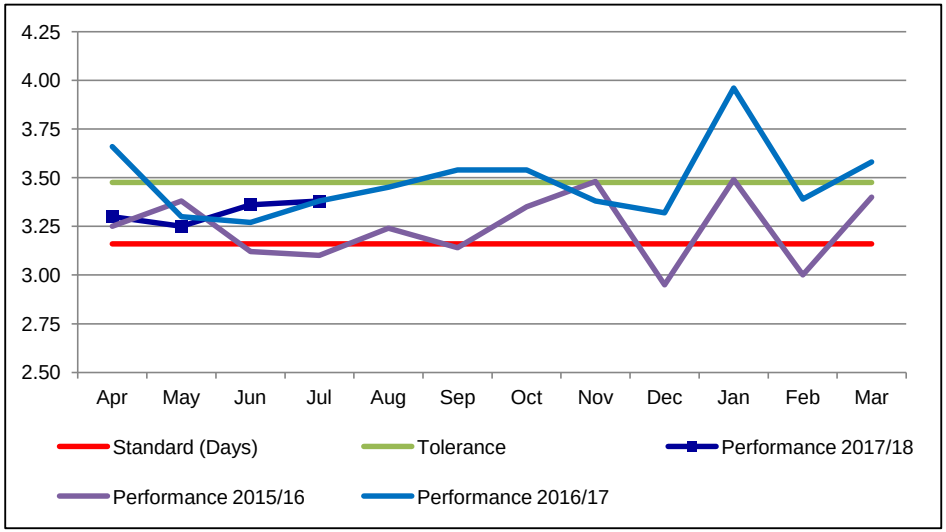
**Actions:**
- Implemented new weekly theatre scheduling meeting which will aims to maximise the utilisation of theatre slots and manage last minute changes.
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment.
- Individual review of clinical 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 2017/18** | 3.30 | 3.25 | 3.36 | 3.38 | | | | | | | | |
| **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** | 3.25 | 3.38 | 3.12 | 3.10 | 3.24 | 3.14 | 3.35 | 3.48 | 2.95 | 3.49 | 3.00 | 3.40 |




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

The number of delays in discharging patients to their next stage of care continues to have a significant impact on BGH length of stay and the requirement for additional surge beds and staffing.

**Actions:**
- Continue to monitor and manage patient lengths of stay and reset aim for LoS.
- 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)

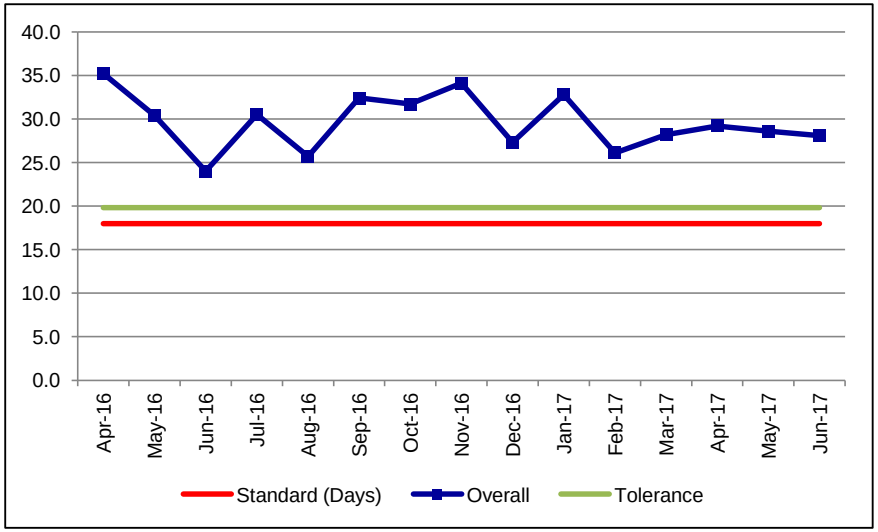
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Reduce Community Hospital Average Length of Stay | 18.0 | 19.8 |

**Actual Performance** (lower = better performance)

| | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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** | **25.7** | **32.4** | **31.7** | **34.1** | **27.3** | **32.8** | **26.1** | **28.2** | **29.2** | **28.6** | **28.1** | **38.2** |
| **Hawick** | 17.8 | 20.3 | 18.2 | 23.7 | 19.3 | 18.9 | 15.7 | 24.8 | 21.5 | 15.1 | 25.2 | 36.8 |
| **Hay Lodge** [1] | 33.1 | 30.7 | 50.3 | 35.2 | 20.4 | 70.1 | 29.5 | 36.5 | 23.7 | 34.3 | 26.2 | 34.2 |
| **Kelso** | 27.5 | 45.3 | 44.1 | 52.5 | 40.0 | 41.2 | 32.6 | 20.2 | 40.1 | 32.5 | 23.2 | 27.2 |
| **Knoll** | 28.2 | 44.6 | 33.4 | 35.3 | 56.4 | 31.3 | 37.5 | 38.2 | 40.2 | 54.4 | 42.9 | 78.3 |

**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:**
- There is a continued focus on MDTs to ensure that alternative packages of care are being found, which support patients to be moved from Community Hospitals.
- A review of the Community/Day Hospital model has been commissioned and will be lead by Dr Anne Hendry. This is due to report by mid December and will include options for alternative models.

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

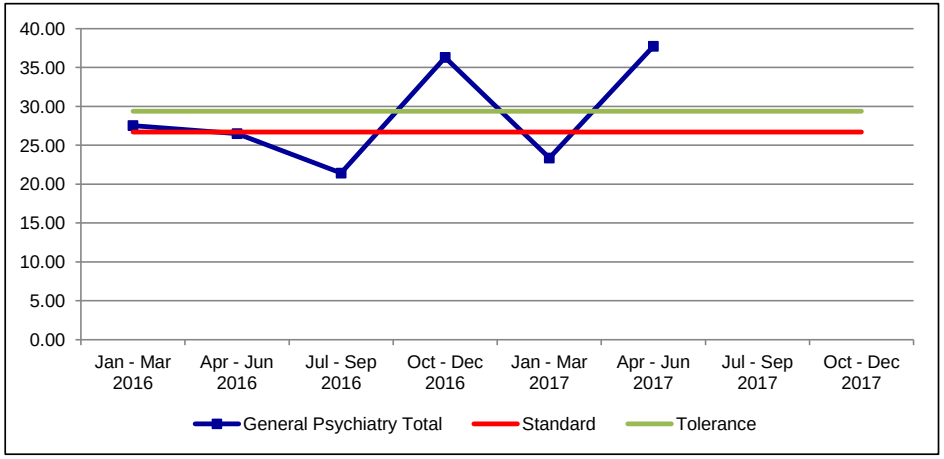
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Reduce Mental Health Average Length of Stay | Various | within 10% |

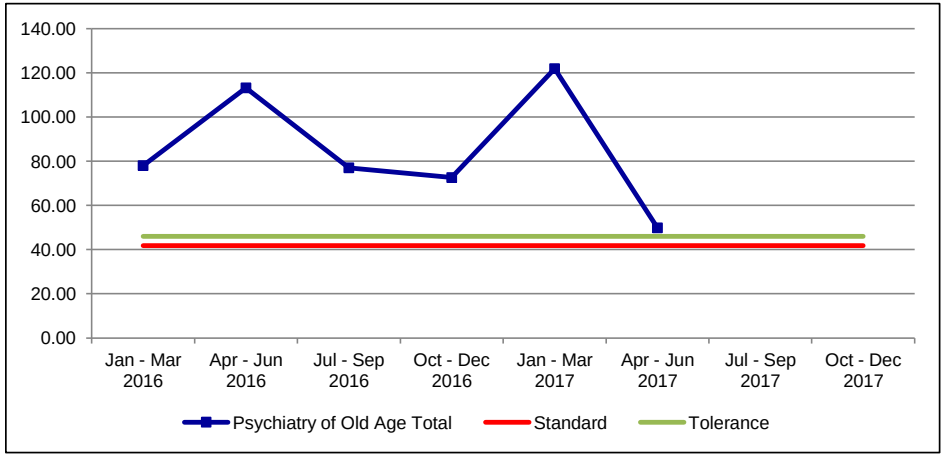
**Actual Performance** (lower = better performance)

| | 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 | 23.94 | | |
| The Brigs | 42.83 | 53.78 | 43.00 | 69.00 | 134.28 | 48.24 | 68.38 | | |
| **General Psychiatry Total** | **26.70** | **27.53** | **26.49** | **21.41** | **36.29** | **23.35** | **37.72** | | |
| Cauldshiels | 26.95 | 75.38 | 105.50 | 109.07 | 115.22 | 86.80 | 52.14 | | |
| Lindean | 60.58 | 33.72 | 82.33 | 33.00 | 28.36 | 54.00 | 48.38 | | |
| Melburn Lodge [1] | 111.63 | 247.33 | 345.00 | 112.00 | 124.00 | 491.00 | - [2] | | |
| **Psychiatry of Old Age Total** | **41.82** | **78.00** | **113.18** | **77.00** | **72.59** | **121.88** | **49.83** | | |

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

[2] No discharges from Melburn Lodge during April - June 2017




**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. It is difficult to predict when the standard will improve however consideration is being given to how Length of Stay could be measured more meaningfully. Longer length of stay could potentially have a negative financial impact due to the cost of inpatient bed days. 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 is ongoing 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).

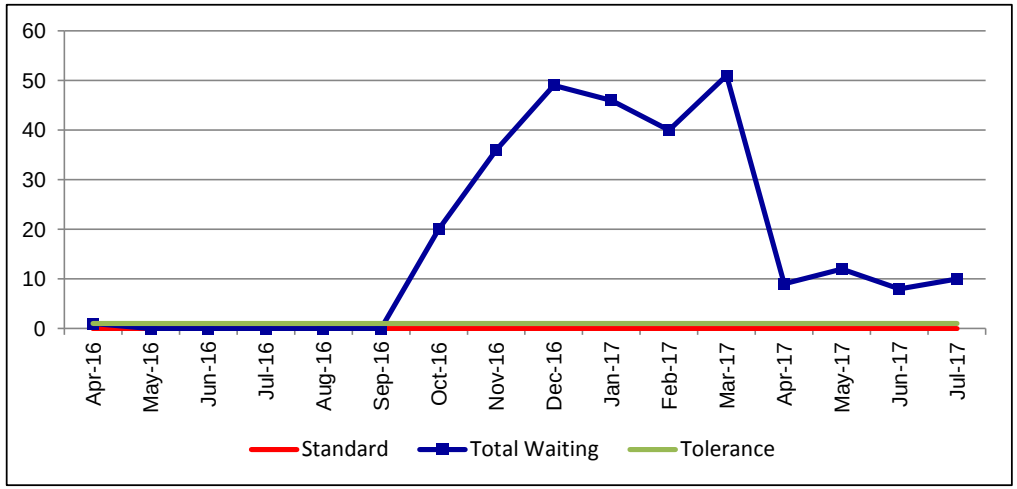
## Mental Health Waiting Times

| | Standard | Tolerance |
|---|---|---|
| **Standard:** Patients Waiting over 9 weeks as at month end | 0 | 1 |

**Actual Performance** (lower = better performance)

| | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Waiting** | **0** | **0** | **20** | **36** | **49** | **46** | **40** | **51** | **9** | **12** | **8** | **10** |
| MH Older Adults - East | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 2 | 1 | 0 | 0 |
| MH Older Adults - South | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MH Older Adults - West & Central | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 3 | 0 | 4 |
| East Team | 0 | 0 | 6 | 20 | 24 | 23 | 23 | 33 | 2 | 1 | 1 | 2 |
| South Team | 0 | 0 | 6 | 5 | 11 | 11 | 10 | 10 | 0 | 0 | 2 | 3 |
| West Team | 0 | 0 | 8 | 11 | 13 | 11 | 7 | 8 | 3 | 7 | 5 | 1 |

**Please Note:** Data for 2016/17 is monitored against 18 weeks and from October 2016 to March 2017 the Psychological Therapy Waits are included.




**Narrative Summary:**
The increase in waiting times in October 2016 to March 2017 is due to Psychological Therapies being included in this standard within this time frame. Work continues to address Psychological Therapies waiting times as previously described. Each team continues to monitor their waiting list. MHOAS West & Central are working with Planning & Performance with regards to data recording and reporting therefore this data should be treated as provisional.

**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 from 2017/18 the Psychological Therapies waiting times have been removed from this page.*

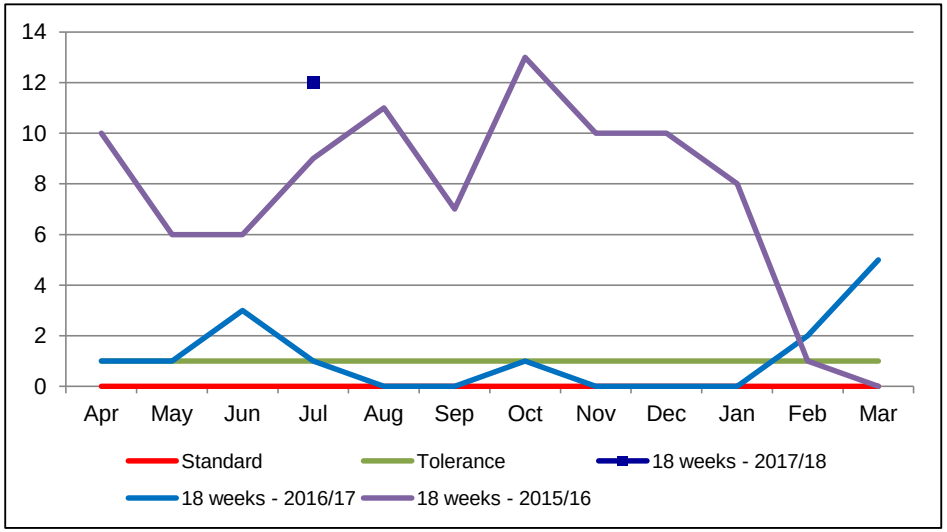
## Learning Disability Waiting Times

| 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 - 2017/18** | - | - | - | 12 | | | | | | | | |
| **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 |

**Please Note:** reports for April - Jun 2017 unavailable following the migration to EMIS, LD are working with HIS to resolve.




**Narrative Summary:**
The 12 **Learning Disability waiting times** breaches in July 2017 were within Psychology and Speech and Language Therapy. Data has been unavailable from April to June 2017 due to the migration onto EMIS and the smoothing of the reporting. Actions continue as below.

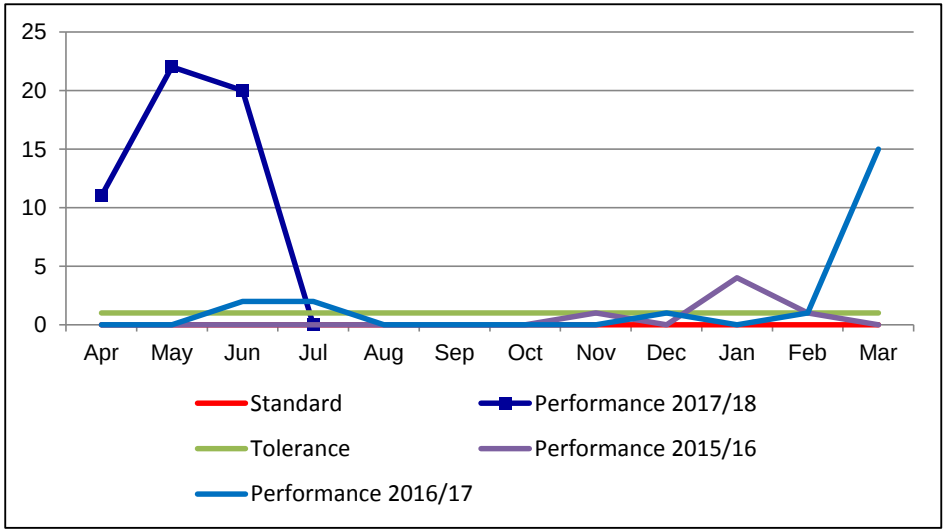
**Actions:**
- Vacant posts have contributed to the increase in waiting times. A recruitment process is being carried out in both disciplines.
- Continue to monitor and manage the waiting list within the performance scorecard at LD management team meetings and pick up with appropriate managers.

## 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 2017/18** | 11 | 22 | 20 | 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 |




**Narrative Summary:**
In July 2017 there were 0 patients waiting over **1 week for the Rapid Access Chest Pain Clinic** which is an improvement over the last 4 months. The service have managed their clinics to ensure appropriate access for patients and reduce the breaches in July 2017.

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

## Audiology Waiting Times

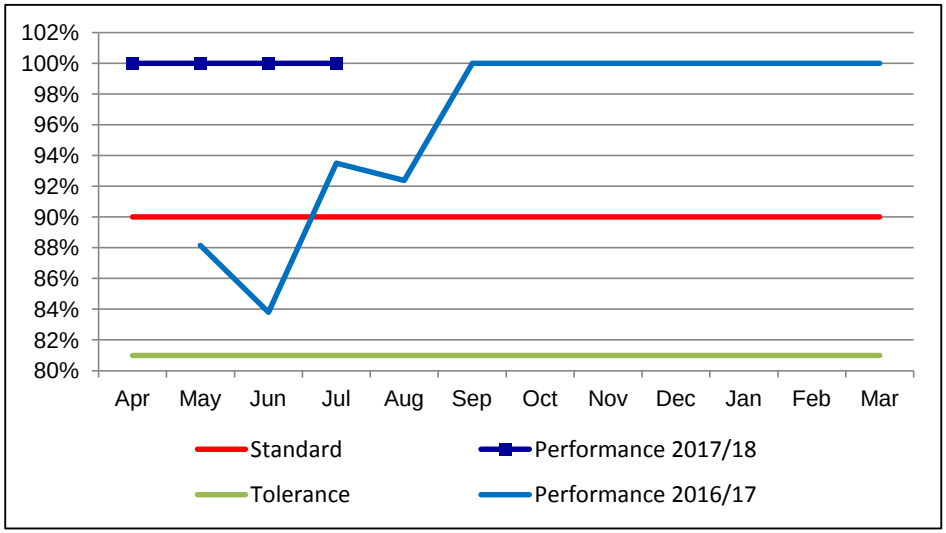
| | Standard | Tolerance |
|---|---|---|
| **Standard:** 18 Week Referral to Treatment for Audiology | 90.0% | 81.0% |

**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 2017/18** | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | | | |
| **Patients with active wait over 18 Weeks 2017/18** | 0 | 0 | 0 | 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 | - | - | - |

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** standard for 100% of patients. 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

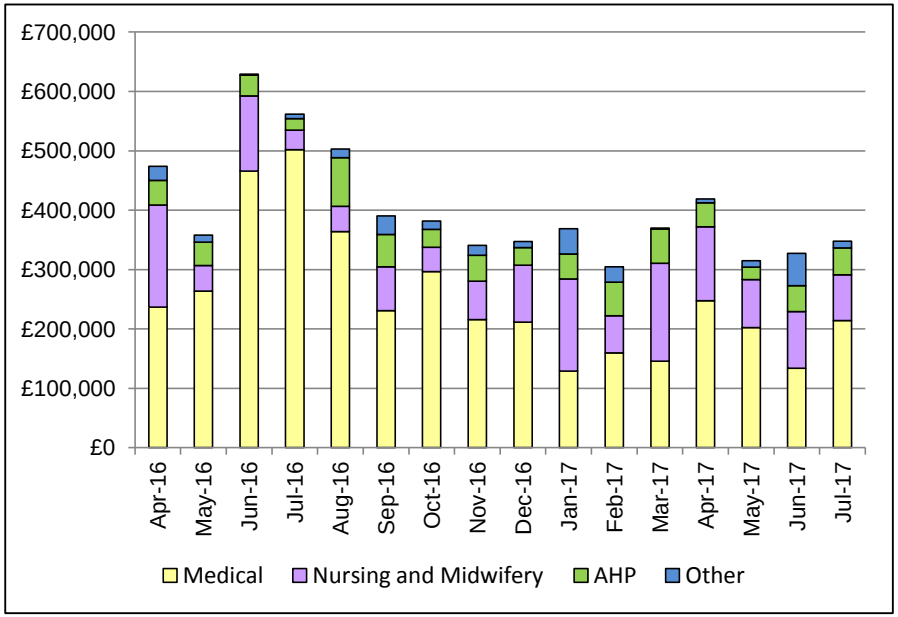
# Workforce Section

## Supplementary Staffing

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

**Actual Performance** (lower = better performance)

| | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Medical** | £363,872 | £230,613 | £296,560 | £215,617 | £211,375 | £129,170 | £159,536 | £145,447 | £247,521 | £202,203 | £133,969 | £214,295 |
| **Nursing and Midwifery** | £42,743 | £73,883 | £40,814 | £64,863 | £96,168 | £155,234 | £62,839 | £165,022 | £124,708 | £80,778 | £95,194 | £76,940 |
| **AHP** | £81,660 | £54,594 | £30,209 | £43,515 | £29,487 | £41,959 | £56,410 | £57,901 | £40,298 | £20,876 | £43,664 | £45,327 |
| **Other** | £14,487 | £31,203 | £13,908 | £16,768 | £10,015 | £42,159 | £25,611 | £1,328 | £6,160 | £11,033 | £54,626 | £11,197 |
| **Total Cost** | **£502,762** | **£390,293** | **£381,491** | **£340,763** | **£347,045** | **£368,522** | **£304,396** | **£369,698** | **£418,687** | **£314,890** | **£327,453** | **£347,759** |




**Narrative Summary:**
The usage of **agency nursing** in 2017/18 is mainly due to the continuing requirement to staff the surge beds related to delayed discharges. Absences due to high sickness and the requirement for one to one care due to high patient dependency throughout planned and unscheduled care. The spend has reduced in the last three months of this year due to the additional operational scrutiny and review of staffing rotas. **Medical agency** spend is continuing due to cover for maternity leave and sickness, additional activity and gaps in the rota.

**Actions:**
- Recruitment following targeted training into key nursing posts in Acute Services is anticipated to see levels of expenditure brought into line with budgets.
- It is anticipated that although vacancies will reduce later in the year some additional medical costs will be incurred to cover short terms gaps.