Borders NHS Board

NHS BORDERS PERFORMANCE SCORECARD – SEPTEMBER 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 30th September 2017.

Background

The attached Performance Scorecard is presented to the Clinical Executive Operational Group, Strategy & Performance Committee and the Board to enable members to monitor performance against national and local standards and performance indicators. Some stretch targets remain within the report for monitoring purposes however a RAG status is only applied to the national standard; these targets include Waiting Times Target for Diagnostics, Accident & Emergency 4 Hour Standard, CAMHS Waiting Times, Psychological Therapy Waiting Times and Drug & Alcohol Treatment Waiting Times.

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

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

LDP Standards	Jul-17	Aug-17	Sep-17
Green – achieving standard	16	13	11
Amber – nearly achieving standard	2	3	6
Red – outwith standard	13	15	14

Key Performance Indicators	Jul-17	Aug-17	Sep-17
Green – achieving standard	4	4	5
Amber – nearly achieving standard	1	1	1
Red – outwith standard	8	8	7

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

Areas of strong performance from the LDP Standards and Access to Treatment sections in the Scorecard for the position as at 30th September 2017 are highlighted below.

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

- The standard for **pre-operative stay** was achieved during July 2017 (latest available data) 0.04 days against the standard of 0.47 (page 19)
- 94.2% of all referrals were **triaged online** in September 2017, above the standard of 90% (page 20)
- 37.0% of new born children were **breastfed at 6-8 weeks** for the quarter April – June 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 linked performance and combined pathway linked performance continue to achieve the standard of 90% (latest available data) in august 2017 (pages 34-38)
- 100% of **all cases with a suspicion of cancer** were seen within **62 days** in August 2017 (latest available data) (page 42)
- 100% of patients **requiring treatment for cancer** were seen within **31 days** in August 2017 (latest available data) (page 43)
- 100% of patients were transferred to the **Stroke Unit within one day of admission** during August 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 (latest available data) against the standard of 90% (page 49)

The Board are asked to note that the following standards have been outwith the 10% tolerance (red status) for 3 or more consecutive months at 30th September 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 6 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 4.0% standard for 11 consecutive months (page 15)
- **New patient DNA rate** – performance has been outwith the 4.0% standard for 4 consecutive months (page 17)
- **eKSF and PDP** – performance is outwith the standard set for the first 6 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 14 consecutive months (page 29-30)
- **12 week Treatment Time Guarantee** – performance reported outwith the standard for 13 consecutive months (page 31)
- **Admitted Pathway Performance** – performance reported outwith the 90% standard for 14 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 6 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 September 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		

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NHS Borders

PERFORMANCE SCORECARD

As at 30th September 2017

September 2017

Planning & Performance

Month

1
2
3
4
5
6
7
8
9
10
11
12

Contents

	Page No.
Introduction	3
Summary of 2017/18 HEAT Standards Performance to Date	4
Summary of 2017/18 Key Performance Indicators to Date	7
LDP Standards that are not monitored on a monthly basis	9
LDP Standards - Performance & Narrative	10
Access to Treatment Report - LDP Standards	25
Performance in Partnership	53
Key Performance Indicators	56
Workforce	65

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 ↓	A ↑	A ↑						
Dementia Post Diagnostic Support [1] (2015/16 data)	A ↓	-	-	-	-	-						
Alcohol Brief Interventions [2]	R -	R ↑	R ↑	R ↑	R ↑	R ↑						
Smoking cessation successful quits in most deprived areas [3]	-	-	-	-	-	-						
Sickness Absence Reduced	R ↑	R ↓	R ↑	R ↑	R ↓	R ↑						
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [4]	R ↓	A ↑	G ↑	G ↑	G ↔	-						
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [4]	R ↓	G ↑	G ↑	G ↔	G ↔	-						
18 Wk RTT: 12 wks for outpatients	R ↓	R ↓	R ↓	R ↓	R ↓	R ↓						
18 Wk RTT: 12 wks for inpatients	R ↑	R ↑	R ↑	R ↓	R ↓	R ↓						
18 Wk RTT: 12 weeks TTG	R ↓	R ↓	R ↓	R ↓	R ↓	R ↓						
18 Wk RTT: Admitted Pathway Performance [5]	R ↓	R ↓	R ↓	R ↑	R ↓	-						
18 Wk RTT: Admitted Pathway Linked Pathway [5]	G ↓	G ↑	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 ↑	G ↓	A ↓	-						
18 Wk RTT: Non-admitted Pathway Linked Pathway [5]	G ↑	G ↑	G ↓	G ↓	G ↑	-						
Combined Performance [5]	G ↔	G ↑	G ↑	G ↓	A ↓	-						
Combined Performance Linked Pathway [5]	G ↑	G ↑	G ↓	G ↓	G ↑	-						
6 Week Waiting Target for Diagnostics	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓						
4-Hour Waiting Target for A&E	A ↑	A ↓	G ↑	G ↓	G ↑	A ↓						
No CAMHS waits over 18 wks	G ↑	G ↔	G ↔	G ↔	G ↔	R ↓						
No Psychological Therapy waits over 18 wks	R ↓	R ↓	R ↓	R ↓	R ↓	R [7] ↑						
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G ↑	R ↓	R ↓	G ↑	R ↓	R ↓						
No Delayed Discharges over 2 Wks	R ↓	R ↑	R ↓	R ↓	R ↑	R ↑						
New patient DNA rate	R ↓	A ↑	R ↓	R ↑	R ↓	R ↓						
Same day surgery [8]	A ↓	G ↑	A ↓	A ↑	-	-						
Pre-operative stay [8]	G ↑	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
Online Triage of Referrals	G ↑	G ↓	G ↓	G ↑	G ↓	G ↑						
Increase the proportion of new-born children breastfed at 6-8 weeks [9]	-	-	G ↑	-	-	-						
eKSF annual reviews complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑						
PDP's Complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑						
Emergency OBDs aged 75 or over (per 1,000) [10]	-	-	-	-	-	-						
Admitted to the Stroke Unit within 1 day of admission [11]	R ↑	A ↑	G ↑	R ↓	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 status have been updated for November due to reporting error.
6 CAMHS data unavailable for August 2017 at time of reporting
7 Psychological Therapy data does not include CAMHS or LD as unavailable at the time of reporting
8 There is a 2 month lag in data due to SMR recording
9 There is a lag time for national data, local data supplied and reported quarterly
10 There is a 6 month lag in reporting any data included is the most up to date data available.
11 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 ↓	R ↓	R ↑						
Cancellations	Hospital	R ↓	R ↑	R ↑	R ↓	R ↑	R ↑						
	Clinical	A ↓	R ↓	R ↓	R ↑	R ↓	R ↑						
	Patient	G ↓	G ↑	G ↑	G ↑	G ↓	G ↓						
	Other	G ↔	G ↑	G ↔	G ↔	G ↔	G ↔						
Borders General Hospital Average Length of Stay		A ↑	A ↑	A ↓	A ↓	A ↑	A ↓						
Community Hospitals Average Length of Stay		R ↓	R ↑	R ↑	R ↓	R ↑	R ↓						
Mental Health Average Length of Stay General Psychiatry Total [1]		-	-	R ↓	-	-	G ↑						
Mental Health Average Length of Stay Psychiatry of Old Age Total [1]		-	-	R ↑	-	-	R ↓						
Mental Health Waiting Times (Patients waiting over 18 weeks) [2]		R -	R ↓	R ↑	R ↓	-	R -						
Learning Disability Waiting Times (Patients waiting over 18 weeks) [3]		-	-	R -	R ↓	R ↑	R ↔						
Rapid Access Chest Pain Clinic		R ↑	R ↓	R ↑	G ↑	G ↔	G ↔						
Audiology 18 Weeks Waiting Times		G ↔	G ↔	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. Data unavailable for August 2017 at time of reporting, therefore no September comparion

3 No data available for April - May 2017 due to the migration to EMIS. June updated in August 2017.

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

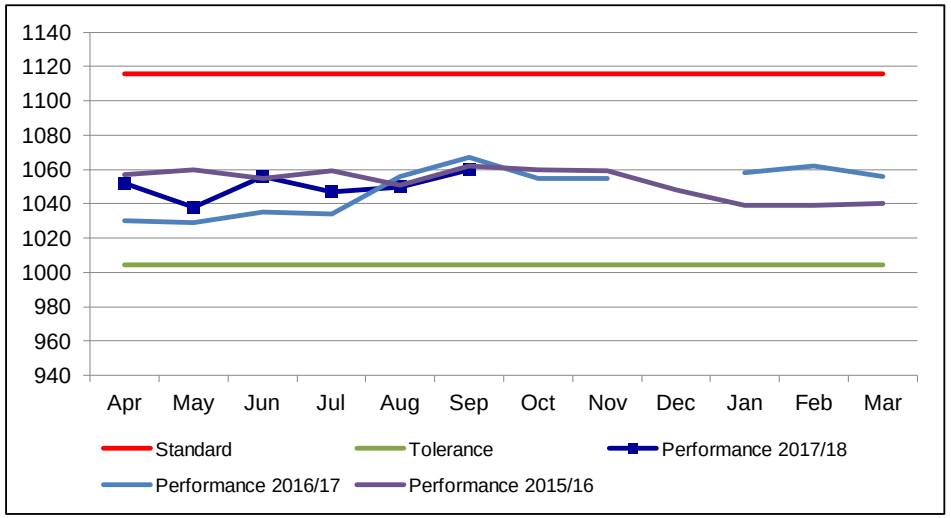
Diagnosis of Dementia

	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	1050	1060						
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 - patients diagnosed with Dementia are not being recorded clearly on ePEX; resulting assessment letters and lack of clarity around the process GPs use to update the Dementia Register.

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 is aimed to be completed by 30/09/2017.
Update: the gap analysis work is underway but not yet complete - however early indications show that this will not have as much of a positive impact as predicted. New target completion date is 30/11/2017 where the data will be reviewed and further actions will be determined.

Actions:
- A pathway has been mapped to highlight challenges from referral to diagnosis / communication with GPs
- 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 Communication with GPs to entry to Dementia Register process to identify any possible areas of improvement.

Dementia - Post Diagnostic Support (PDS)

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

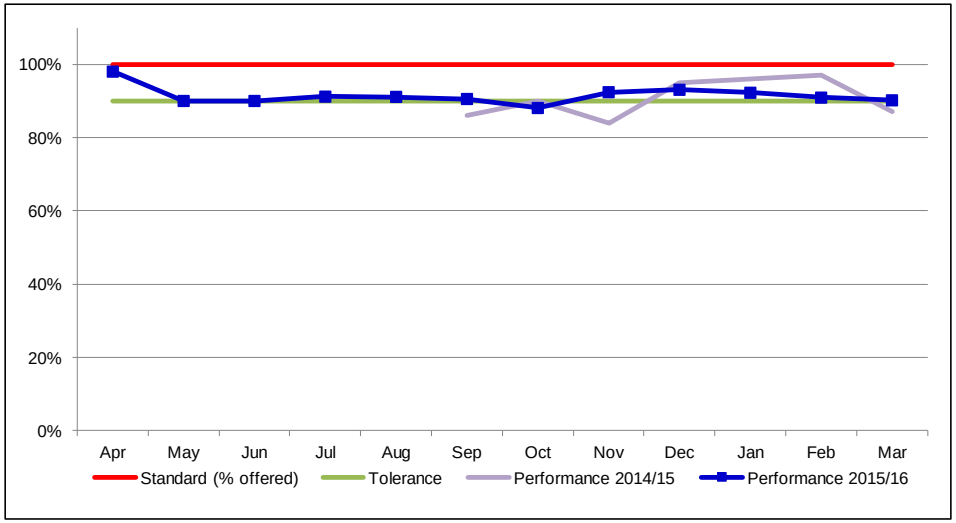
Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (% offered)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of People who are referred for PDS and have been offered at least 12 months of PDS												
Performance 2016/17												
Performance 2015/16	135	140	166	186	205	220	229	255	281	297	310	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. It is expected performance will improve by March 2018 due to the various actions underway

Actions:
- A meeting is arranged with ISD to review and clarify the data reporting process - this has been postponed until the new recording process is in place
- 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 are being looked at for examples. A temporary post has been put in place to carry out this work and develop an overall PDS protocol.

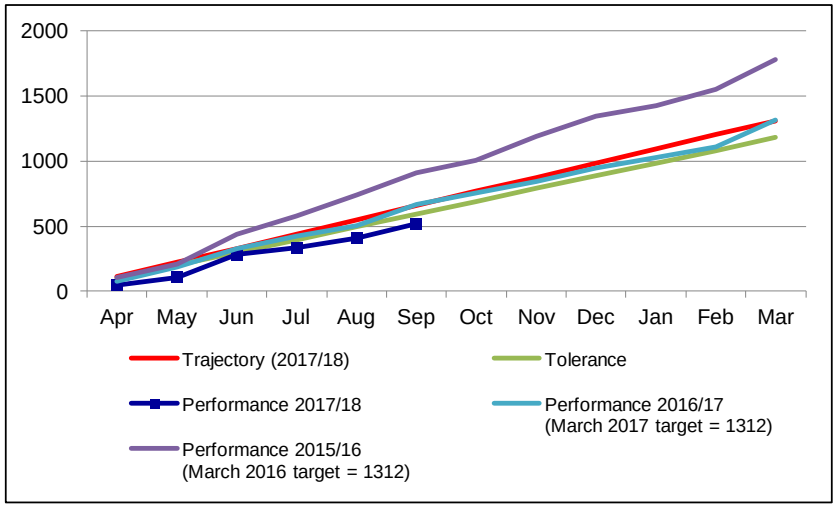
Alcohol Brief Interventions (ABI)

Standard: Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings	**Standard**	**Tolerance**
	1312	within 10%

Actual Performance (higher = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory (2017/18)	110	220	330	440	549	658	767	876	985	1094	1203	1312
Performance 2017/18	45	106	280	335	409	520						
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 (ABI) performance in September 2017 is at 79% of the trajectory (520/658). This is lower than performance at the same time in the previous year.

Factors contributing to this are:

Local Enhanced Service (LES) – the LES continues to have the most significant reduction in the number of ABI's from 373 to 223.

Cessation of Keep Well – this work is no longer funded by Scottish Government and has ceased. In this time period last year there were 26 delivered.

Change of reporting system in Antenatal – implementation of badgernet system in antenatal has meant we have been unable to confirm performance. We anticipate this will be available from December. We will be able to retrospectively report on this data.

Improvements include:

A&E - There continues to be an increase in the number of screenings and a smaller increase in the number of ABI's performed in E/D 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.

A variety of factors have impacted on performance this year. Improvements continue to be seen in Emergency Department. It is not anticipated that LES performance will improve over the year. As previously reported it is likely that our performance will remain below trajectory.

Actions

- Retrospectively report on data via the new badgernet maternity system

Smoking Quits

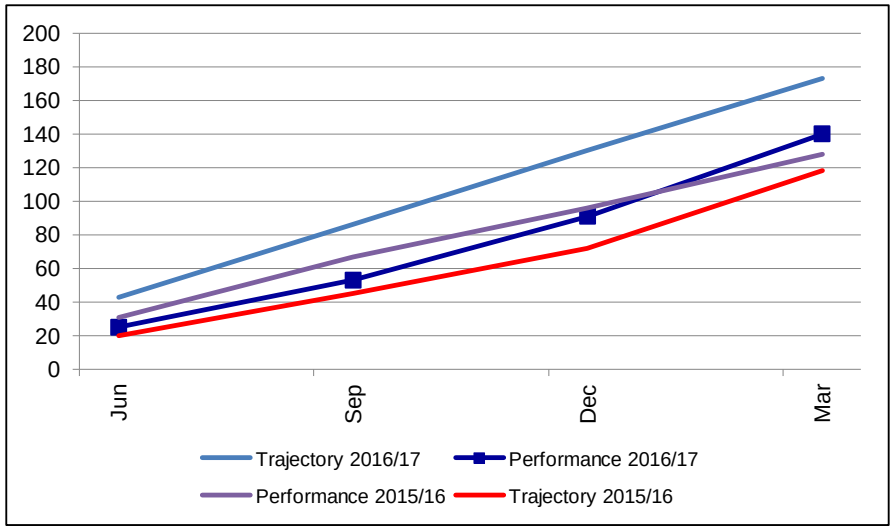
	Standard	Tolerance
Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas	173	within 10%

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:
- We started a Quit for Christmas campaign at the beginning of October, to encourage patients to quit smoking before Christmas.
- We have revised the referral procedures for secondary care following the change to referral through TrakCare, and updated the procedures within service to ensure equity of care.
- We have started a drop-in at the Chest Heart and Stroke Community Hub on Hawick High Street, to ease access to service, with good attendance at this early stage.

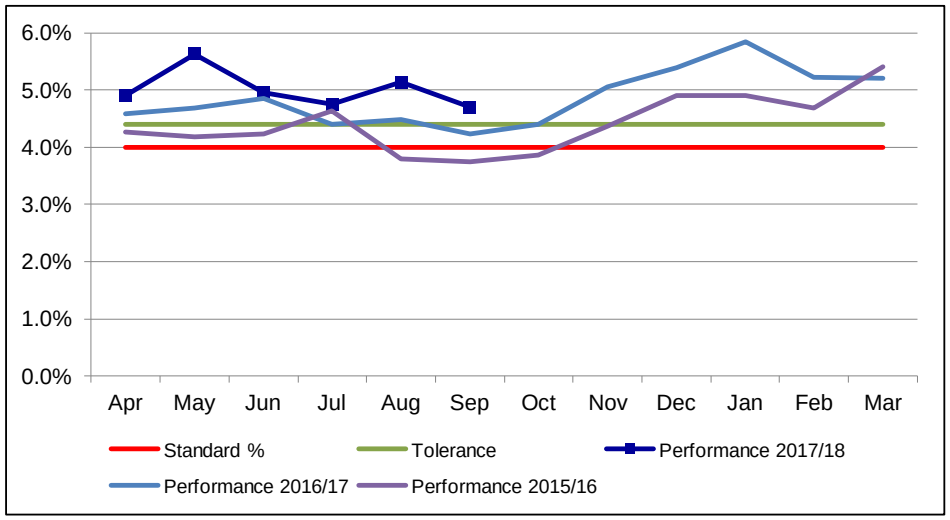
Sickness Absence

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

Actual Performance (lower % = better performance)

Latest NHS Scotland Performance
4.95% (Sept 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%	5.1%	4.7%						
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 4.7% September 2017 **Sickness Absence** rate improved by 0.4% from August 2017, and is better than the latest NHS performance for September 2017 at 4.95%. 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 of further work to support the wellbeing of staff.

Sickness Absence *continued*

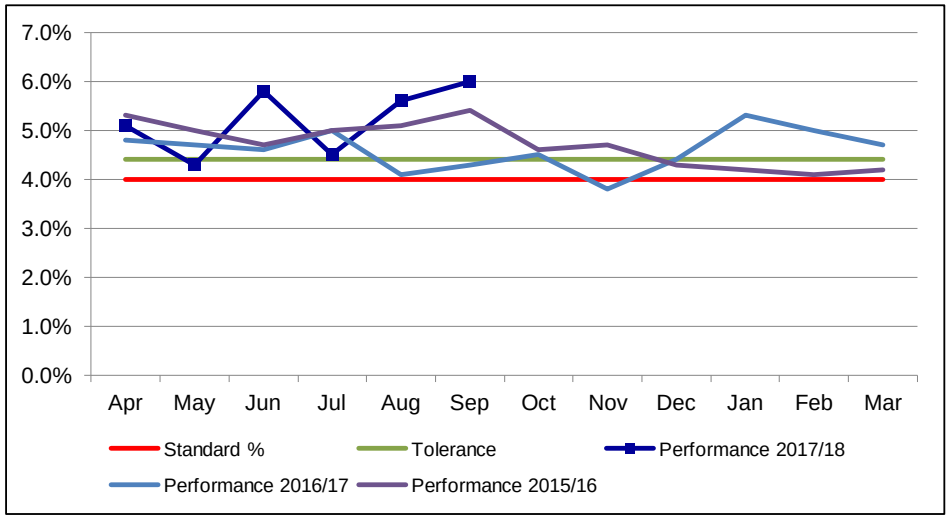
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Learning Disabilities (Div/CHP)												
Administrative Services	0.00	0.00	0.00	0.00	0.00	0.00						
Allied Health Professionals	0.00	0.00	0.00	0.00	0.00	0.00						
Medical & Dental	0.00	0.00	0.00	0.00	0.00	0.00						
Nursing / Midwifery	17.02	24.38	21.82	12.71	7.17	1.11						
Grand Total	13.70	19.64	17.57	10.07	6.07	0.94						
Mental Health (Div/CHP)												
Administrative Services	6.73	4.64	1.77	0.75	9.39	4.54						
Allied Health Professionals	0.00	0.00	0.00	0.00	0.00	0.00						
Medical & Dental	3.43	1.61	4.45	7.07	5.53	8.03						
Nursing / Midwifery	6.76	7.90	6.71	7.38	8.19	7.23						
Other Therapeutic	0.00	4.06	4.73	5.26	3.35	5.28						
Personal & Social Care	0.00	0.00	0.00	0.00	0.00	0.00						
Support Services	0.00	0.00	0.00	0.00	0.00	0.00						
Grand Total	5.77	6.59	5.73	6.38	7.55	6.73						
Primary, Acute & Clinical Services												
Administrative Services	3.19	4.84	4.37	5.42	3.72	3.34						
Allied Health Professionals	2.68	3.33	2.92	2.60	2.43	2.19						
Dental Support	4.68	5.25	4.42	4.81	9.03	2.50						
Health Care Sciences	3.19	5.59	4.16	4.20	5.43	2.92						
Medical & Dental	2.55	1.72	2.19	2.00	2.01	1.33						
Medical Support	0.00	0.00	0.00	0.00	1.30	0.00						
Nursing / Midwifery	5.94	6.51	5.44	5.42	6.14	6.32						
Other Therapeutic	0.00	0.00	0.00	0.00	4.28	0.00						
Personal & Social Care	0.00	16.55	23.97	1.07	0.82	3.12						
Support Services	4.42	5.88	5.76	6.58	6.60	7.88						
Grand Total	4.63	5.27	4.57	4.59	4.97	4.64						
Support Services (Div/CHP)												
Administrative Services	5.26	5.45	4.99	4.41	4.82	3.96						
Allied Health Professionals	0.00	4.00	0.00	3.91	1.56	0.59						
Health Care Sciences	0.00	0.00	0.00	10.78	2.94	0.00						
Medical & Dental	0.00	6.62	2.21	0.00	3.36	0.00						
Nursing / Midwifery	1.50	1.05	1.08	1.48	3.66	3.79						
Other Therapeutic	4.84	5.05	2.46	2.32	2.09	2.08						
Personal & Social Care	6.61	7.45	4.24	5.84	6.10	2.99						
Senior Managers	0.27	0.00	0.00	0.00	0.00	0.00						
Support Services	5.56	6.95	6.85	5.01	5.02	4.92						
Grand Total	4.98	5.72	5.17	4.30	4.50	4.05						

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%	5.6%	6.0%						
Performance 2016/17	4.8%	4.7%	4.6%	5.0%	4.1%	4.3%	4.5%	3.8%	4.4%	5.3%	5.0%	4.7%
Performance 2015/16	5.3%	5.0%	4.7%	5.0%	5.1%	5.4%	4.6%	4.7%	4.3%	4.2%	4.1%	4.2%



Narrative Summary:
The **DNA** rate in September 2017 is outwith the tolerance levels of the standard and overall remains variable.

There continues to be a delay in getting the poster design for the "2017 Reducing DNA Campaign." This work is ongoing and assistance with the poster design is being sought.

Actions:
- Continue to assign staff where possible to telephone patients with a history of missed appointments.

Same Day Surgery

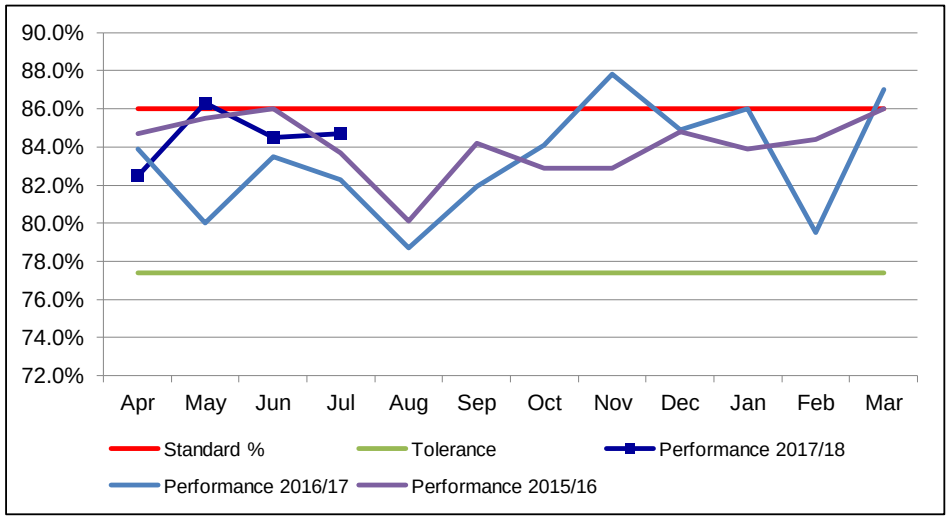
	Standard	Tolerance
Standard: 86% of patients for day procedures to be treated as Day Cases	86.0%	77.4%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
Performance 2017/18	82.5%	86.3%	84.5%	84.7%								
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 not achieved in July. Performance remains variable but within tolerances.

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*

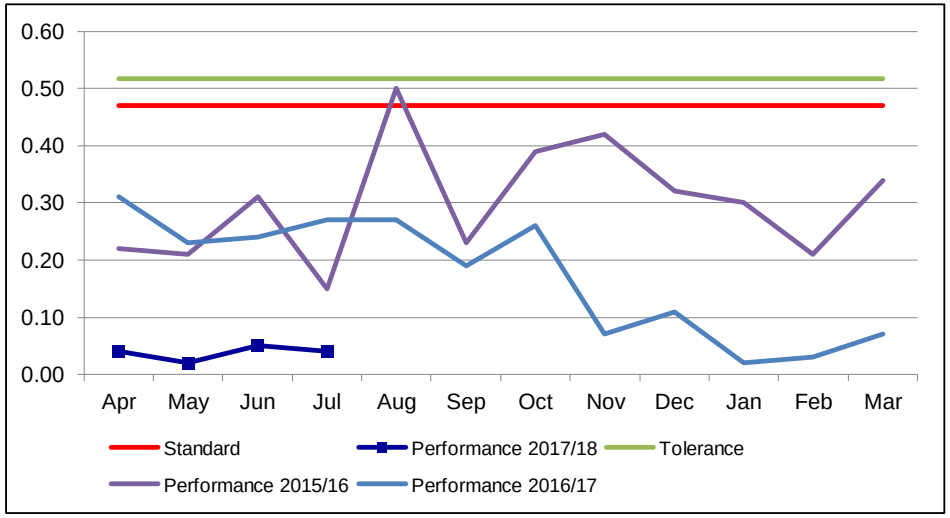
Pre-Operative Stay

	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	0.05	0.04								
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 consistently within the target range. Performance against this measure is being sustained.

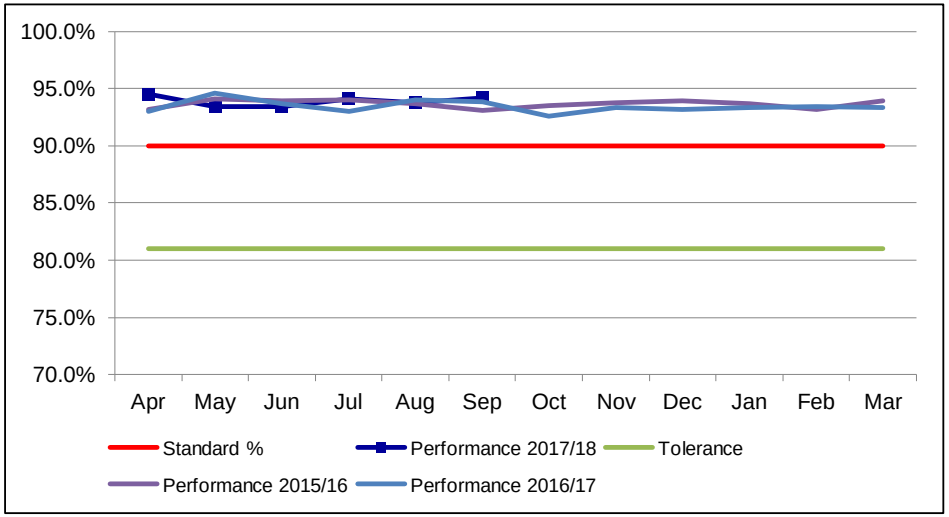
Actions:
- No further action planned at this time.

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%	93.8%	94.2%						
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.

Breastfeeding

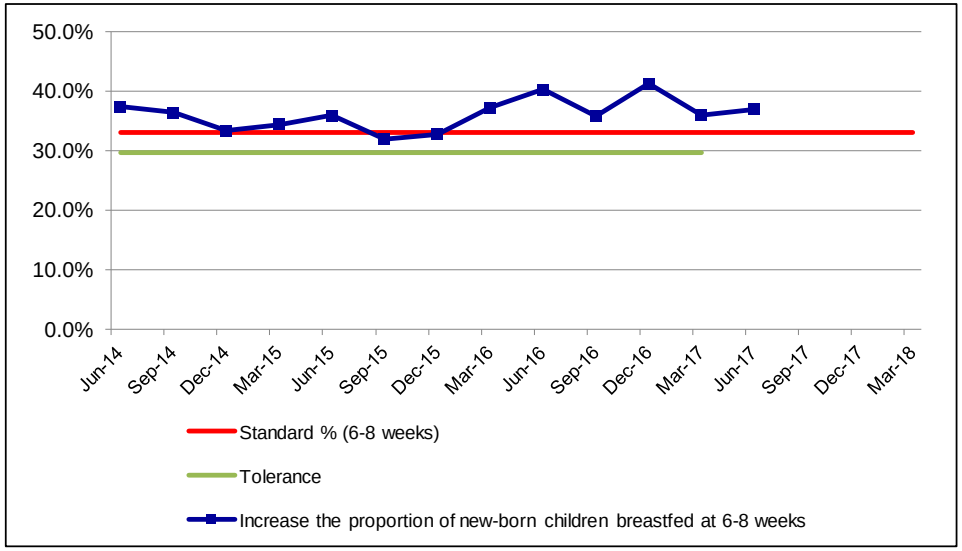
	Standard	Tolerance
Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	33.0%	29.7%

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%	37.0%			
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%	42.6%			
Percentage Ever Breast Fed	-	-	-	60.50%	75.0%	72.4%	76.1%	68.5%	68.1%			

Please Note: There is a lag time for national data, local data supplied quarterly. Data reporting changed from Janaury 2016 to report babies that were ever breast fed. March 2016 data is provisional due to the change over period and forms for reporting

[1] Breastfeeding on discharge from BGH is not longer reported on, replaced with % ever fed



Narrative Summary:
The standard to **increase the proportion of new-born children breastfed at 6-8 weeks** is measured quarterly and local data is supplied due to the time lag for national data. For the quarter April - June 2017 performance exceeded the 33% standard by 4%.

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%	12.3%	- [1]						
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%

[1] August data unavailable at time of reporting

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)

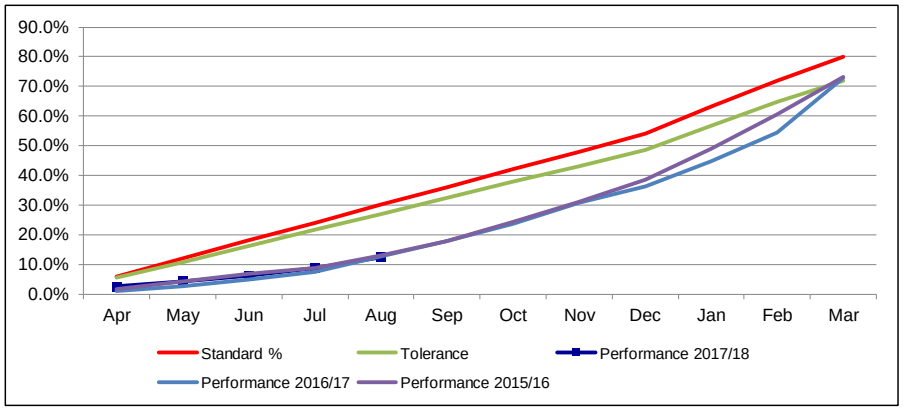
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	6.0%	12.0%	18.0%	24.0%	30.0%	36.0%	42.0%	48.0%	54.0%	63.0%	72.0%	80.0%
Performance 2017/18	4.0%	5.8%	7.5%	9.4%	13.5%	- [1]						
Performance 2016/17	1.9%	4.1%	6.6%	9.9%	15.8%	20.9%	25.6%	31.3%	34.8%	40.5%	47.8%	60.8%
Performance 2015/16	4.0%	5.9%	7.7%	9.8%	14.6%	18.8%	22.1%	27.9%	34.7%	44.8%	51.6%	61.6%

[1] August data unavailable at time of reporting

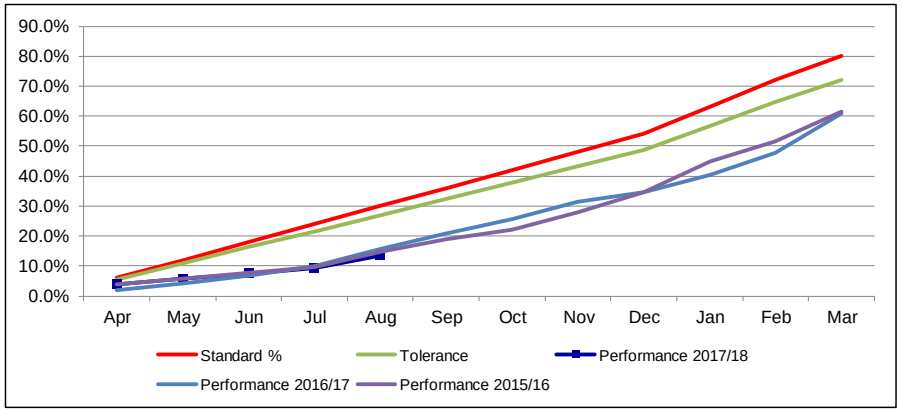
Please Note: Charts and supporting narrative are on the next page.

eKSF and Personal Development Plans *continued*

eKSF



PDP



Please Note: August data unavailable at time of reporting

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 5 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.

Mental Health:
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
The percentage of Reviews completed are higher than this time last year. 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.

Learning Disability Service
Work continues to ensure staff meet this standard position to end of October is 25% JDRs and 13% PDPs

KSF Champions are 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.

Discussions are taking place with HR and eksf Champions wit regard to the process moving towards implementation of Turas. Communication will be sent to staff Monday 6th November 2017.

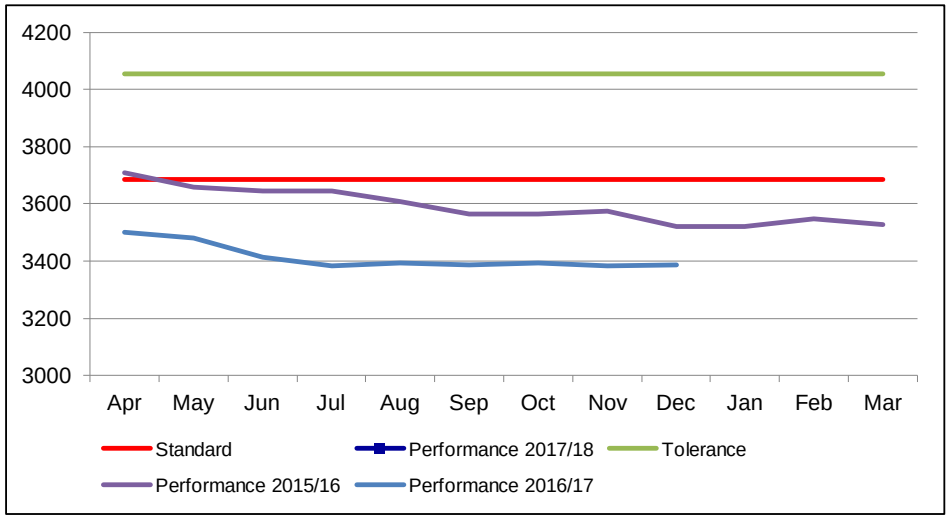
Emergency Occupied Bed Days

	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 Jan & Feb 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.
- We have been informed this standard will no longer be reported from October 2017 onwards by ISD. Work has started to review the standard and how / if this will be reporting going forward.

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)

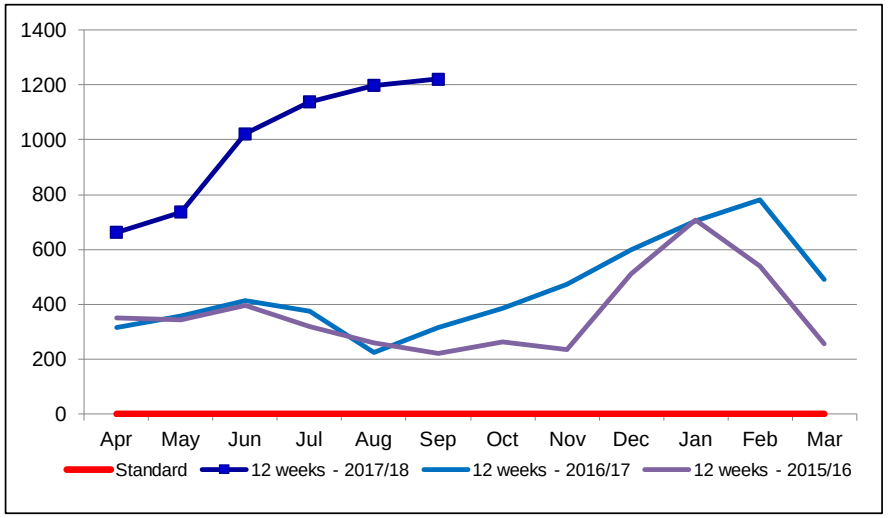
Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
74.4% (Jun 2017)	90.9% (Jun 2017)

	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	1198	1220						
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

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Cardiology		3	31	47	59	64	119	130	161	153	173	190
Dermatology	109	183	283	322	272	178	270	305	439	446	493	547
Diabetes/Endocrinology	19	17	28	31	27	15	14	13	19	22	19	7
ENT							1	1		1		
Gastroenterology	5		19	37	32	10	9	32	57	85	105	85
General Medicine											3	1
General Surgery	8		2	4	7	2	1	8	3	8	10	27
Gynaecology	1				1		1					
Neurology	1	7	19	16	4	1	2	17	45	60	54	70
Ophthalmology	0	2	53	70	143	87	99	88	168	216	193	201
Oral Surgery	151	167	50	24	8	4	1	44	63	79	77	46
Orthodontics		1	1			1						
Other	2	3	7	3	20	9	13	28	38	40	52	40
Pain Management	88	80	88	86	71	38	26	14	8	2	1	
Respiratory Medicine									1	1		
Rheumatology		1										
Trauma & Orthopaedics			1	58	131	81	105	55	14	22	16	5
Urology	2	8	18	7	5		2	2	5	3	2	1
All Specialties	**386**	**472**	**600**	**705**	**780**	**490**	**663**	**737**	**1021**	**1138**	**1198**	**1220**

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 August due to continuing capacity issues within a number of specialties, including Cardiology, Dermatology and Ophthalmology. NHS Borders is working towards a trajectory to reduce new outpatient waits to under 500 waiting over 12 weeks by the end of March 2018. A detailed deep dive was provided for NHS Borders Board in October 2017 with regards to the waiting times position.

Actions:
- Cardiology: Capacity is an ongoing problem, work is taking place with the service to look for solutions along with short term additional capacity. The position of a third Consultant has been approved and the recruitment process is due to commence shortly. In the short term consultants are undertaking additional sessions between October 2017 and March 2018 to work through the patients waiting in the queue.
- 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 December which will increase core capacity. Also a locum consultant is looking to offer some extra capacity until March 2018 to reduce the current backlog. Outpatients are also going to be using a patient focused booking approach when booking the long waiters to see if they still require an appointment which will be monitored by Waiting Times.
- Diabetics / Endocrinology: Short-term capacity has been organised and a new locum DME Consultant will be undertaking one clinic per week until March 2018 which has been having a very positive impact on the waiting times.
- Gastroenterology: The waiting lists has reduced to 20 weeks with extra capacity being provided through a locum that is in place until March 2018. The resignation of one of the consultants left a gap in the provision of service. The 3rd consultant post will be refilled from mid December and short term additional clinics will be run between December 2017 and 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. In the short term an additional locum is in place within the service to prioritise review patients and additional new patient clinics will be delivered between January and March 2018.
- Oral Surgery: Referrals into the service have increased by around 22% year on year that is causing capacity issues within the service. Additional clinics have been organised in the short term and the service is currently reviewing is longer term capacity issues.

Stage of Treatment - 12 Weeks Waiting Time for Inpatients

	Standard	Tolerance
Standard: 12 Weeks Waiting Time for Inpatients	0	1

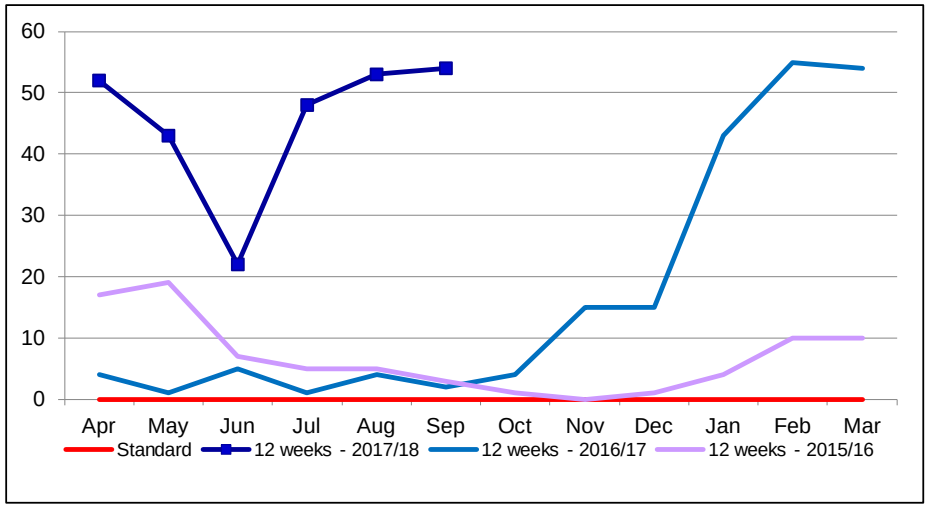
Actual Performance (lower = better performance)

	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	53	54						
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

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
ENT				3	1	1					1	2
General Surgery				1	2	1	3	10	4	2	4	1
Gynaecology				1	1							
Ophthalmology										5	7	9
Oral Surgery	1				1	4					1	1
Other										1		
Trauma & Orthopaedics	3	15	15	37	49	48	49	32	18	40	40	41
Urology				1	1			1				
All Specialties	**4**	**15**	**15**	**43**	**55**	**54**	**52**	**43**	**22**	**48**	**53**	**54**

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



Narrative Summary:
At the end of September, the number of patients reported waiting over **12 weeks for inpatient treatment** increased to 54**.** 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.

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.

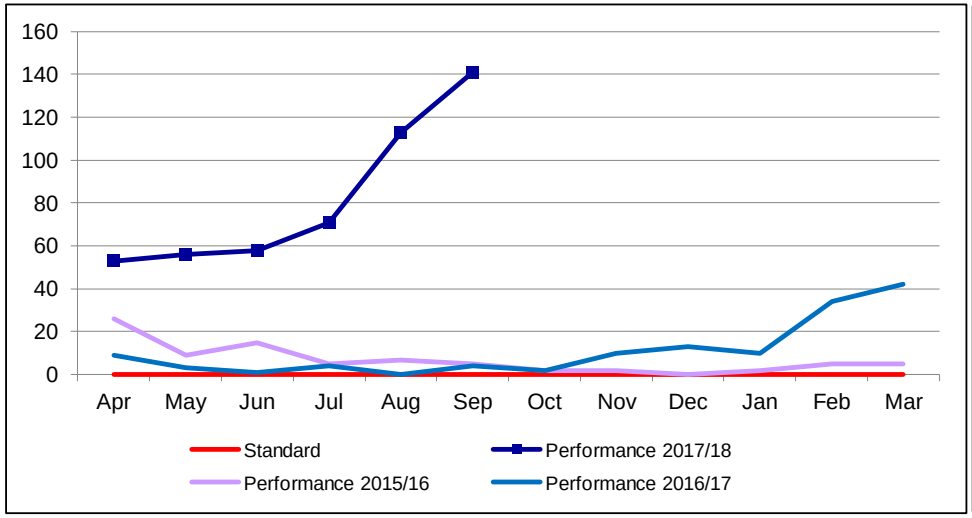
12 Weeks Treatment Time Guarantee

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

Actual Performance (lower = better performance)

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
81.0% (Jun 2017)	95.9% (Jun 2017)

	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	113	141						
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 September 141 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	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Unavailable	92	82	73	59	72	58	58	69	93	101	91	103	87
Patient Advised	48.4%	44.1%	43.5%	47.6%	51.4%	40.8%	37.2%	41.8%	47.9%	50.2%	46.0%	55.7%	52.1%
Unavailable	98	104	95	65	68	84	98	96	101	100	107	82	80
Medical	51.6%	55.9%	56.5%	52.4%	48.6%	59.2%	62.8%	58.2%	52.1%	49.8%	54.0%	44.3%	47.9%
Total Unavailable	190	186	168	124	140	142	156	165	194	201	198	185	167
Total % Unavailable	19.0%	16.9%	17.3%	12.5%	13.2%	13.1%	14.3%	15.5%	18.9%	20.2%	17.9%	16.0%	14.2%

Table 2 - Monthly Unavailability by Specialty - as at 30th September 2017

	Available				Unavailable			
Specialty	**0 - 9 Weeks**	**10 - 12 Weeks**	**12+ Weeks**	**Total**	**Medical Un-available**	**Patient Advised Un-available**	**Total**	**% Un-available**
ENT	51	3	2	**56**	1	8	**9**	**13.8%**
General Surgery	122	16	1	**139**	18	22	**40**	**22.3%**
Gynaecology	50	2		**52**	3	2	**5**	**8.8%**
Ophthalmology	195	46	9	**250**	10	8	**18**	**6.7%**
Oral Surgery	45		1	**46**	2	3	**5**	**9.8%**
Other	21	4		**25**	2	2	**4**	**13.8%**
Trauma & Orthopaedics	280	39	41	**360**	41	38	**79**	**18.0%**
Urology	78	2		**80**	3	4	**7**	**8.0%**
Total	**842**	**112**	**54**	**1008**	**80**	**87**	**167**	**14.2%**

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.

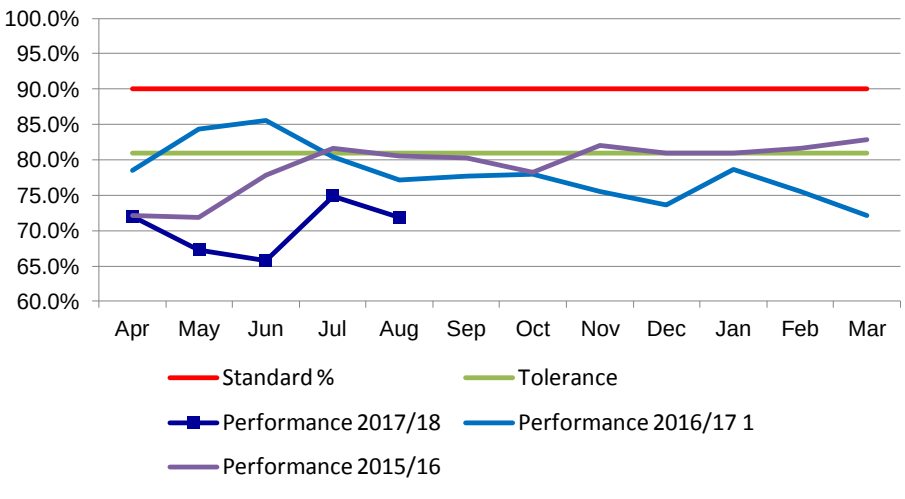
18 Weeks Referral to Treatment (RTT)

	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%	74.9%	71.9%							
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 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.

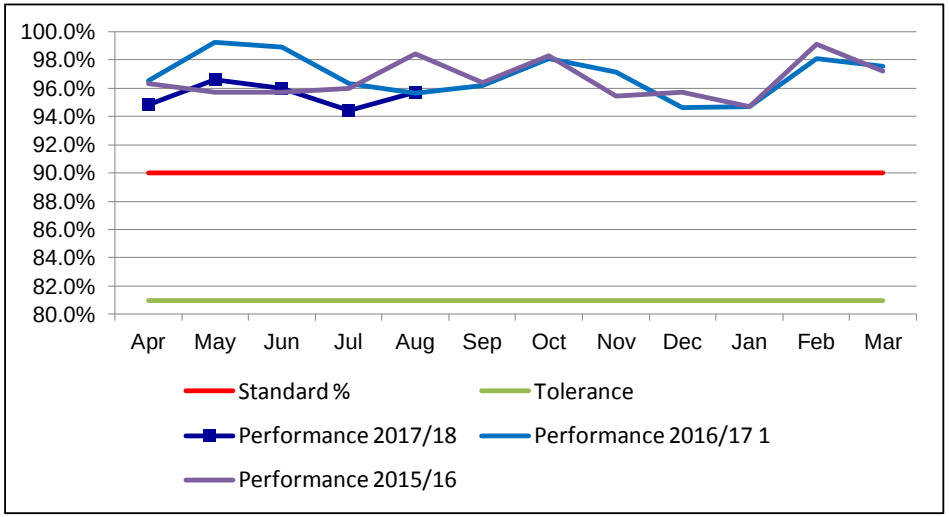
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: 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%	94.4%	95.7%							
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 **admitted linked 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.

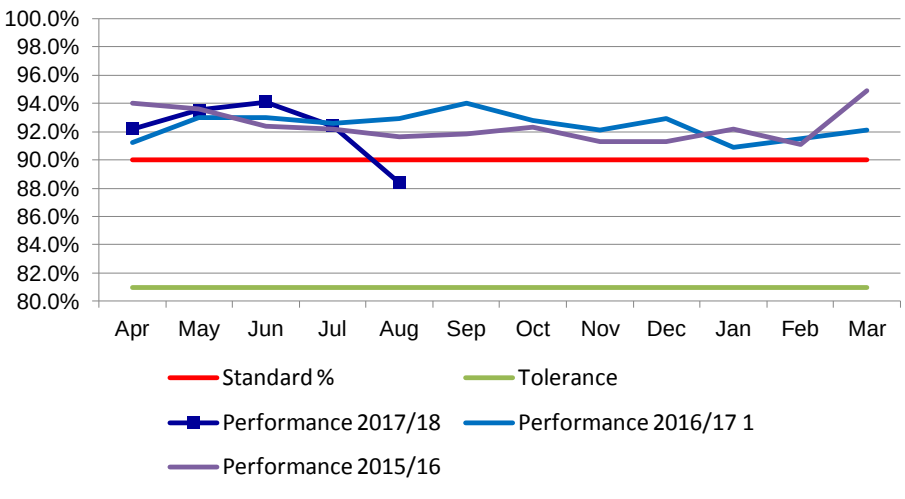
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Non-Admitted 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%	92.4%	88.4%							
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** has dropped below 90%. This is mainly due to the large number of Dermatology patients that have exceeded 18 weeks for their first appointment.

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).

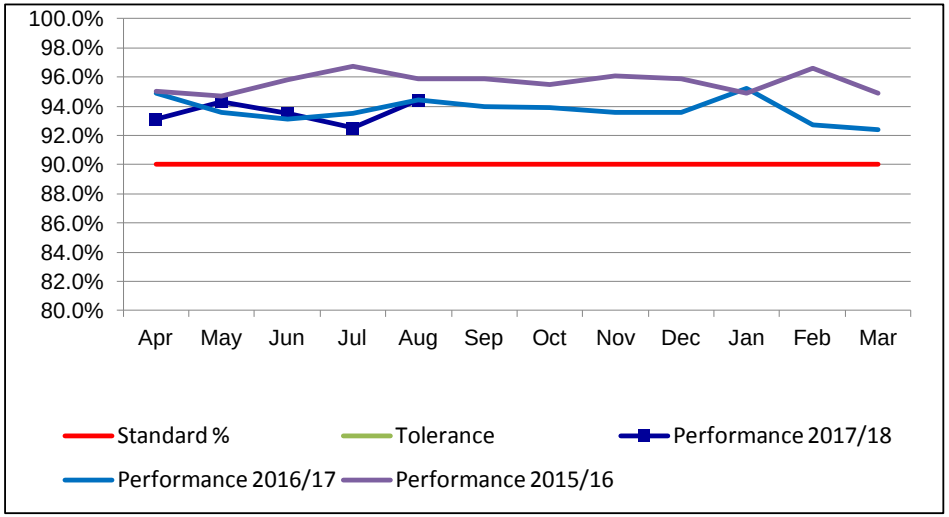
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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%	92.5%	94.4%							
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.

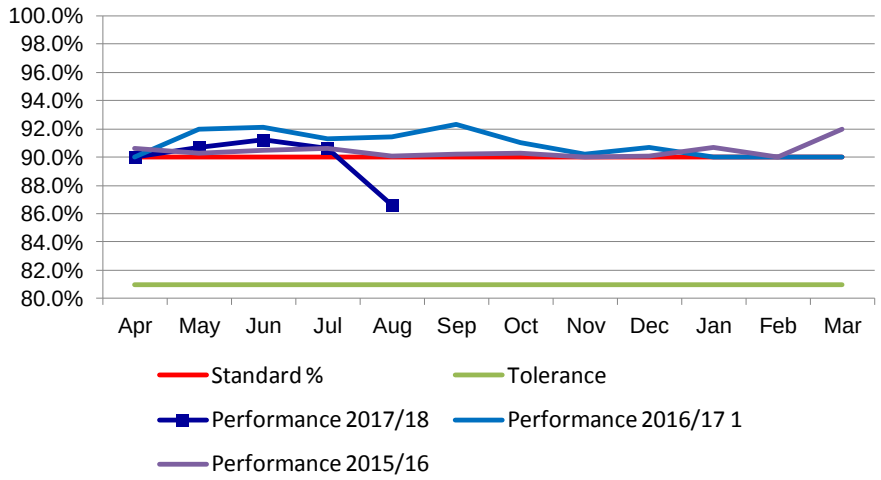
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Combined Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
83.17% (Jul 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	90.0%	90.7%	91.2%	90.6%	86.6%							
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**. In August 2017 we did not meet the 90% target due to large numbers of patients being seen over 18 weeks in Outpatients particularly within Dermatology, and longer waits for Ophthalmology and Orthopaedic Surgery for both Outpatient and Inpatient what caused a combined wait of over 18 weeks.

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.

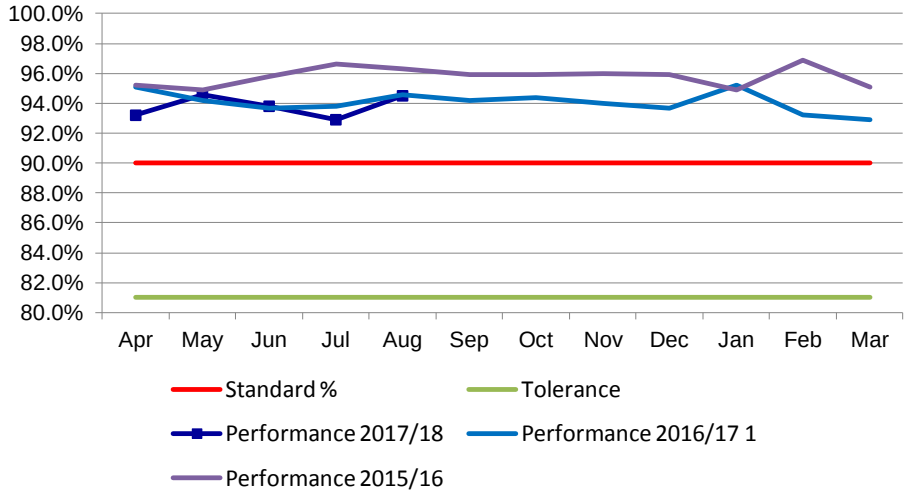
18 Weeks Referral to Treatment (RTT)

	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%	92.9%	94.5%							
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.

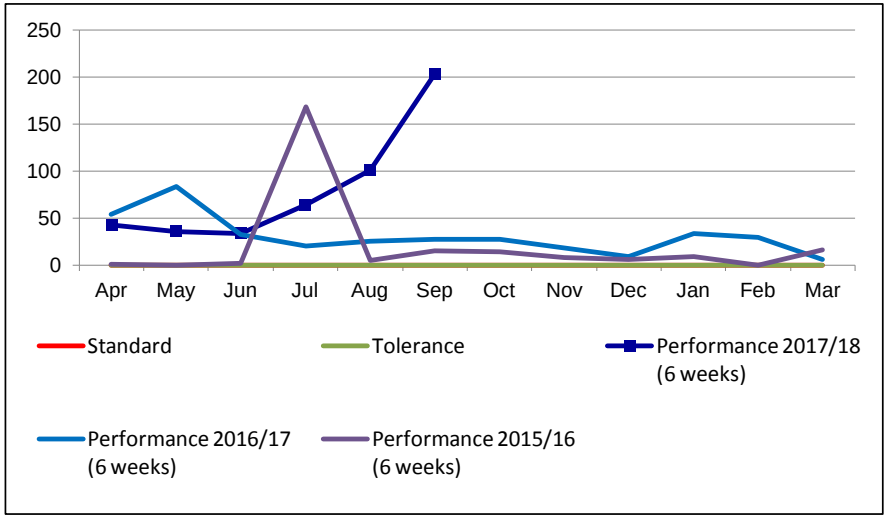
Diagnostic Waiting Times

	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	101	203						
Performance 2017/18 (4 weeks)	196	127	154	226	229	431						
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

[1] September 2017 data has been updated as unavailable at time for reporting due to the upgrade or RIS and the link to the reporting tool



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.

September 2017 data is unavailable at the time of reporting. There has been an update on the RIS system which has resulted in the reporting tool being incompatible. P&P are working with IT to resolve the issue and create a Business Objects report.

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	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Endoscopy	-	-	-	-	-	-	-	-	-	-	-	-	-
Colonoscopy	-	-	-	-	25	29	6	36	18	6	7	-	-
Cystoscopy	-	-	-	-	8	-	-	-	-	-	-	-	-
MRI	-	-	-	-	1	1	-	3	18	27	56	100	187
CT	-	-	-	-	-	-	-	4	-	-	1	1	16
Ultra Sound (non-obstetric)	-	-	-	-	-	-	-	-	-	1	-	-	-
Barium	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**28**	**28**	**18**	**9**	**34**	**30**	**6**	**43**	**36**	**34**	**64**	**101**	**203**

Diagnostic - 4 weeks	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Endoscopy	-	-	4	-	-	-	-	-	-	-	2	-	1
Colonoscopy	68	63	34	38	41	52	31	60	31	11	9	1	4
Cystoscopy	-	-	2	4	11	-	3	4	1	1	-	1	1
MRI	21	45	6	6	5	16	44	70	92	127	182	192	320
CT	14	33	5	8	2	25	34	52	-	13	30	33	97
Ultra Sound (non-obstetric)	-	-	8	-	-	2	2	10	3	2	-	-	-
Barium	-	-	3	-	-	-	-	-	-	-	3	2	8
Total	**103**	**141**	**62**	**56**	**59**	**95**	**114**	**196**	**127**	**154**	**226**	**229**	**431**

[1] September 2017 data updated as unavailable at time for reporting due to the upgrade or RIS and the link to the reporting tool

Narrative Summary and Actions:
Colonoscopy – The service continues to benefit from ring fenced Colon session performed by a locum General Surgeon who is in place until March 2018. This continues to cover the gap until the 3rd GI Consultant is in post. Additionally the introduction of QFIT testing in January 2017 has allowed the more effective triaging and referral into Colonoscopy. We are currently seeking Scottish Government funding to extend this pilot for an additional 3 years.

Endoscopy – The 4 week standard has been met consistently and performance continues to be monitored.

Magnetic Resonance Imaging (MRI) & Computerised Tomography (CT) – MRI has seen an increase in demand over the past year and radiographer scanning capacity is now at its limit. 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 by non-recurring Scottish Government funding to address access to diagnostic capacity for patients on the cancer pathway. Initial analysis of changes in demand have shown that the current capacity is no longer sufficient to meet the changing workload, and plan is being developed to secure additional capacity.

Ultrasound – The ultrasound service continues to be under pressure due to maternity leave and vacancy, however is managing to meet demand at present. It is anticipated that there will be a reduction in capacity towards the end of 2017 due to multiple maternity leaves within the service. The service is taking proactive action to minimise the impact where possible.

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	Apr to Jun 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%	92.30%
31-days standard	100%	100%	97.80%	100.00%	97.80%	98.20%	100%	98.18%	100%	100%	97.30%	96.90%

Cancer Waiting Times

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

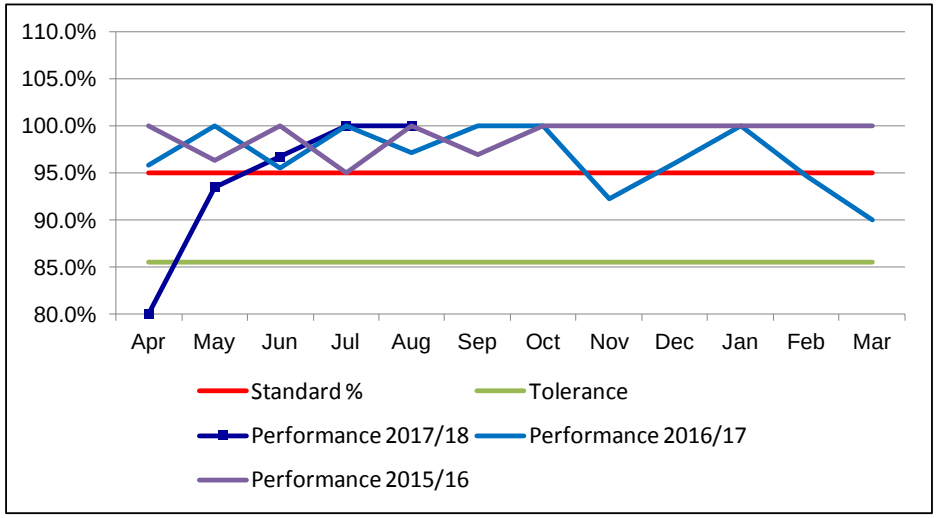
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
88.73% (Jul 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%	100.0%	100.0%							
Performance 2016/17	95.8%	100.0%	95.5%	100.0%	97.1%	100.0%	100.0%	92.3%	96.0%	100.0%	94.7%	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 August with performance at 100%.

Actions:
- Work continues 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

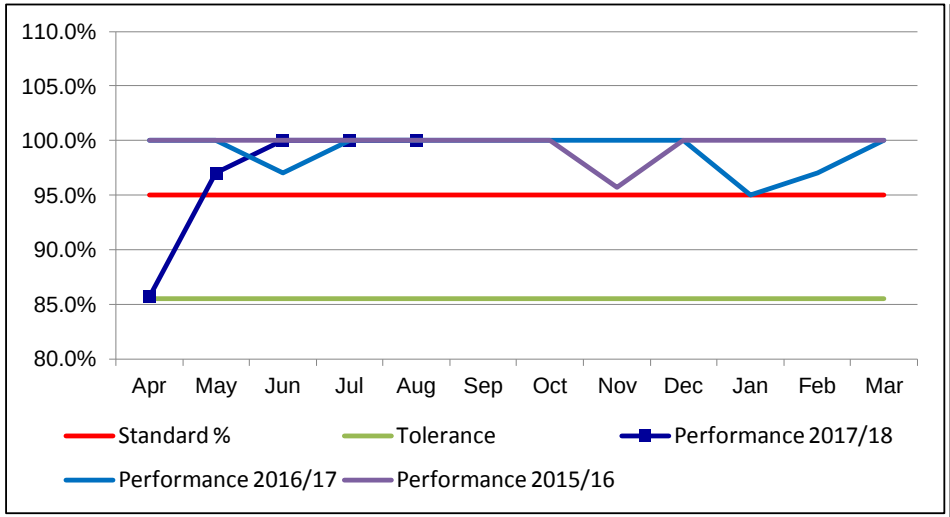
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
94.56% (Jul 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%	100.0%	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 August 100% of patients were treated within 31 days.

Actions:
- Work continues 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

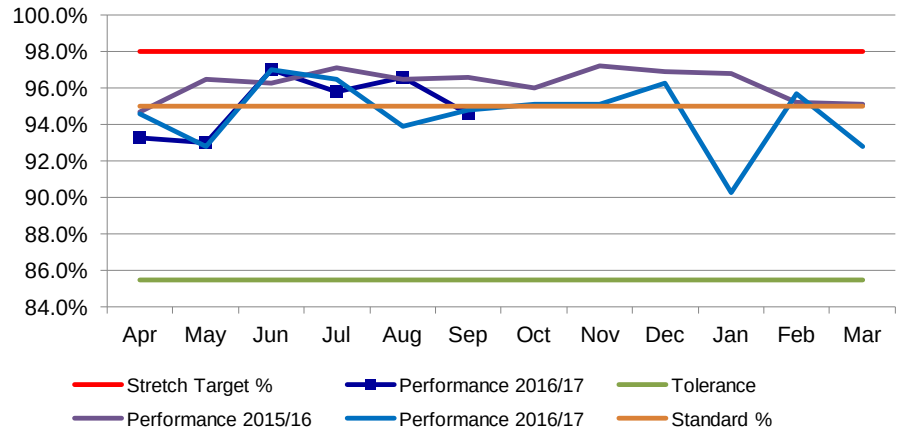
Standard: 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

Stretch Target	Standard	Tolerance
98.0%	95.0%	85.5%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
95.04% (Aug 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%	96.6%	94.6%						
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.

Actions:
Please see next page for further narrative and actions.

Accident & Emergency 4 Hour Standard *continued*

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

Emergency Access	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Flow 1	97.3%	97.0%	97.2%	98.3%	96.7%	97.7%	97.1%	96.9%	97.3%	98.4%	98.8%	98.9%	98.4%
Flow 2	90.8%	94.9%	92.2%	95.4%	92.9%	94.8%	92.5%	91.5%	91.8%	94.7%	93.6%	91.6%	89.5%
Flow 3	91.0%	92.3%	93.5%	93.4%	76.7%	92.5%	86.5%	92.0%	86.0%	95.1%	91.5%	93.7%	88.0%
Flow 4	91.5%	91.3%	91.9%	92.9%	87.6%	94.4%	82.1%	79.0%	85.5%	94.8%	91.7%	95.7%	94.5%
Total	**94.8%**	**95.1%**	**95.1%**	**96.3%**	**90.3%**	**95.7%**	**92.8%**	**93.3%**	**93.0%**	**97.0%**	**95.8%**	**96.6%**	**94.6%**

Narrative Summary and Actions:
The Emergency Access Standard dipped just below the 95% performance for the first time on 4 months. This was due to three separate days when we experienced high activity and high numbers of breaches. These were predominately related to difficulties in accessing beds. Work undertaken in June to minimise Flow 1 breaches has maintained Flow 1 performance above 98% for the past 4 months. We are now working to address issues that impact on our Flow 2&3, both within ED and AAU, and in relation to bed availability.

A review of delayed discharges has been commissioned and undertaken by Professor John Bolton and an action plan from this report has been 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.

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%	66.7%	100.0%							
Performance 2016/17	88.9%	100.0%	83.3%	90.1%	93.3%	90.9%	86.7%	90.0%	84.6%	50.0%	100.0%	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%

[1] Exceptionally small number for July resulting in poor performance

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:

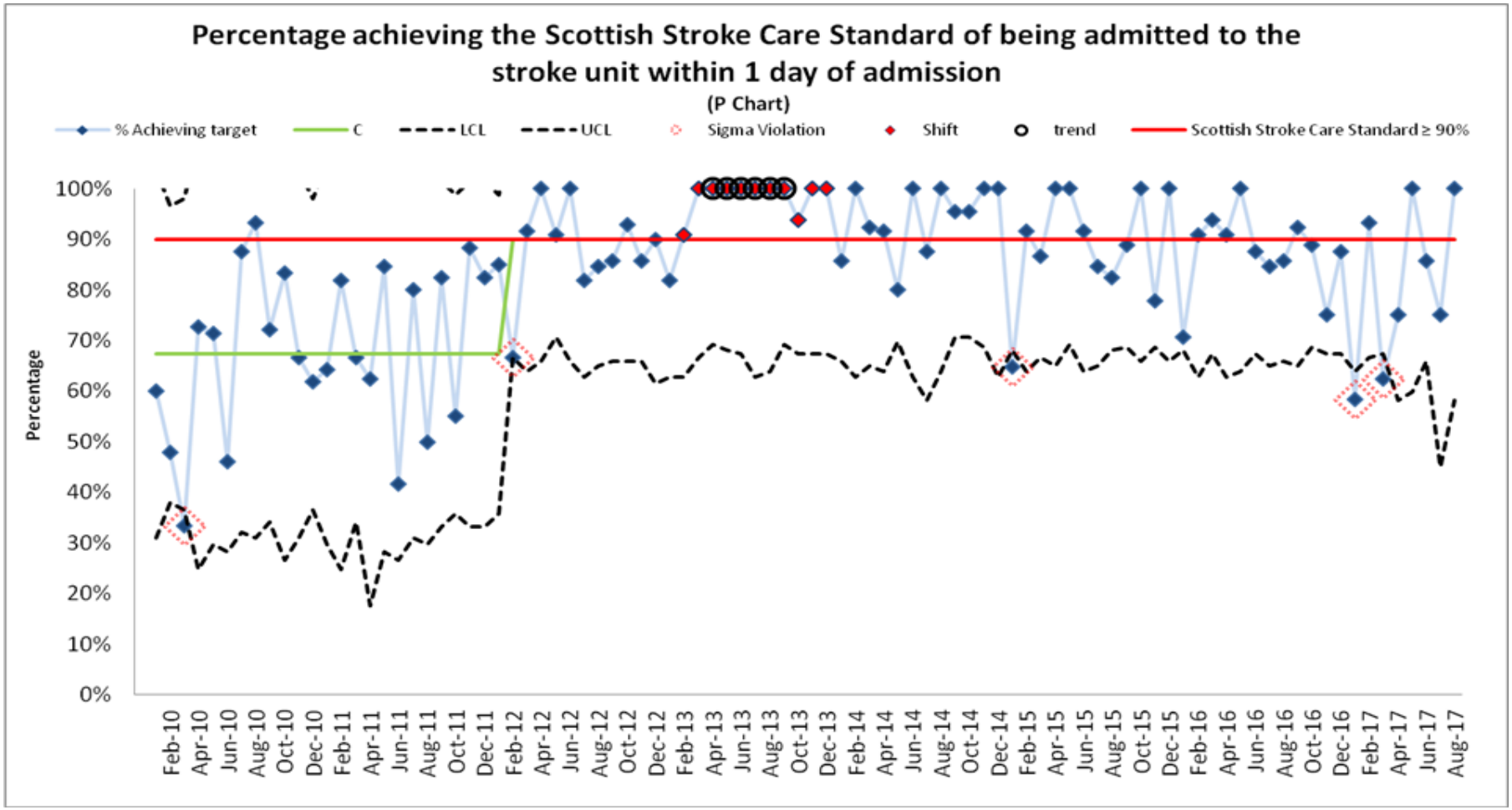
- admission to a dedicated Stroke Unit within 1 day of admission
- a swallow screen test within 4 hours of admission
- a brain scan within 24 hours of admission
- appropriate treatment initiated within one day of admission

During August 2017 all patients were admitted to the Stroke Unit within1 day of admission.

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	Stretch	Tolerance
90.0%	95.0%	81.0%

Standard: 18 weeks referral to treatment for Psychological Therapies

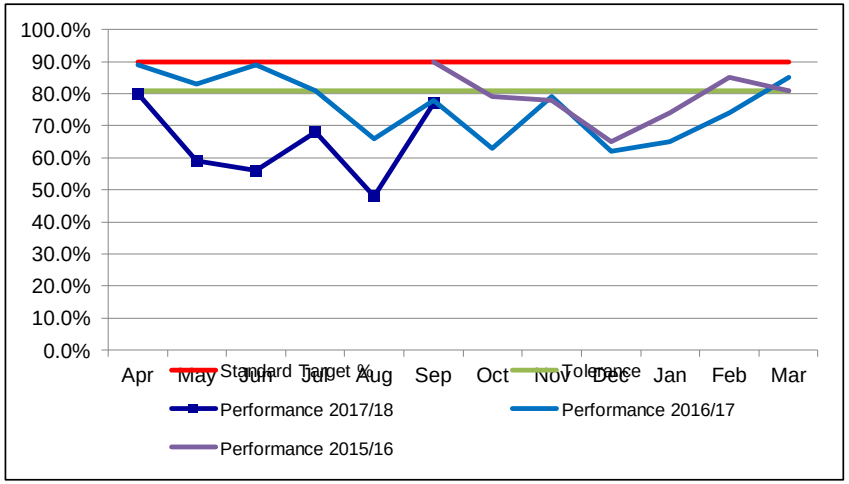
Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
72.4% (Jun 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%	48.0%	77.0%[1]						
Total Patients Currently Waiting >18 Weeks:	93	102	129	132	120	140						
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

[1] Psychological Therapy data does not include CAMHS or LD as unavailable at the time of reporting

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 for not meeting the target 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.
- Additional hours are being offered to existing staff, consideration is being given to running weekend clinic initiatives and costs/CV's are being looked at for locum psychologists to increase capacity to triage patients currently waiting and develop treatment plans thereafter.

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%

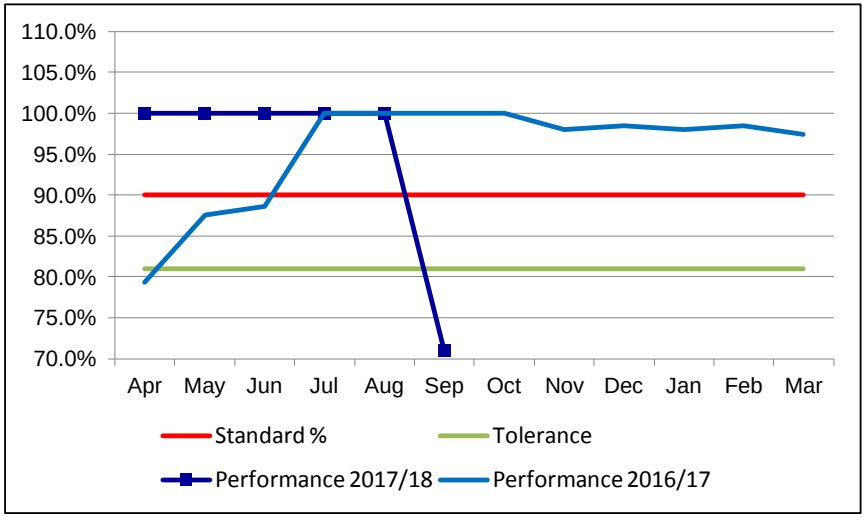
Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
80.74% (Jun 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%	100.0%	71.0%						
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 [1]	-	-	-	-	-	-	-	-	-	-	-	79.0%

[1] 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

2 August & September 2017 data updated as unavailable from the service at time of reporting (see narrative summary)



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.
- Review and amend reporting process to ensure not person-dependant.

Drug & Alcohol Treatment

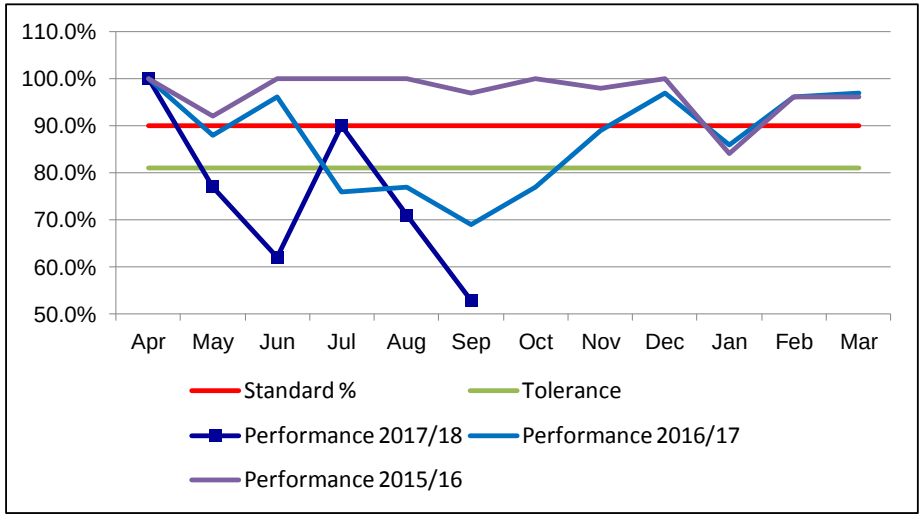
Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

Standard	Tolerance
90.0%	81.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
94.0% (Jul 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%	71.0%	53.0%						
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 to deliver **3 weeks RTT** for 90% of progressed drug & alcohol referrals. Overall, 53% of clients started treatment within three weeks for the month of September, and 72% of clients for Quarter 2.

The following is a breakdown of performance by service:
- There were no clients for Castle Craig Hospital
- Addaction exceeded the HEAT standard for Quarter 2 (94%)
- BAS saw 22% of clients against a target of 90% for Quarter 2

The BAS service is going through significant changes 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. The reduction in funding has also caused gaps in service due to vacancies not being recruited to, which has had an impact on waiting times.

Actions:
- Short term solution of redistributing staffing from APTT service and utilisation of substance misuse liaison nurse has reduced the waiting times significantly in the short term.
- Team Manager now in post (from 23rd October) and will progress overall review of referral/caseload/management and waiting times management which will have a positive impact on performance.

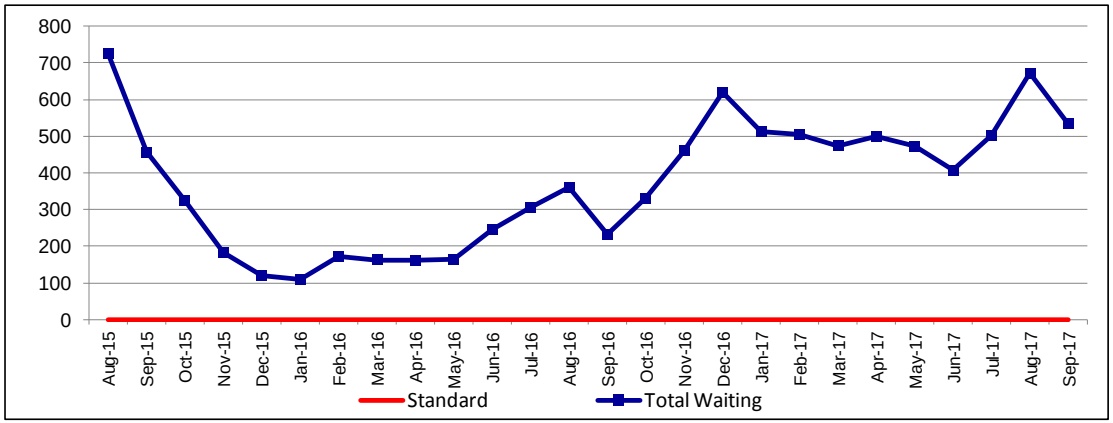
AHP Waiting Times

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

Actual Performance (lower = better performance)

	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**233**	**331**	**461**	**619**	**514**	**506**	**474**	**499**	**473**	**407**	**503**	**672**	**534**
Occupational Therapy	2	0	0	4	4	4	7	5	2	3	3	4	4
Physiotherapy	211	320	452	609	498	489	459	480	457	386	481	646	501
Podiatry	0	-	-	0	0	0	0	0	0	0	0	0	0
Speech & Language Therapy	0	2	0	0	0	0	0	0	1	0	1	2	4
Nutrition & Dietetics	20	9	9	6	12	13	8	14	13	18	18	20	25

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 has been identified as the standard which should be met from referral to initial appointment.

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. The project has now been handed over to the AHP Clinical Productivity Operational Group and the changes are being embedded as business as usual.

Physiotherapy
8.9% vacancy factor in September (25.7% within MSK speciality). 2.0wte locums appointed in September to support waiting list management. 442 of patients are within MSK service which is a significant improvement from August. The remaining patients are within older people services and paediatrics, again where we have capacity gaps.

Capacity across physiotherapy was reviewed with support of the Productivity Programme. New job plans were introduced across services to support staff. MSK templates will shortly be introduced and monitored over a three month period.

Podiatry
There have been issues within the admin team regarding the correct use of Trak, especially patient "unavailability" "DNA" and "re setting the clock". The admin team lead has has secured permission for temporary admin support to allow the current team to be released up to undertake further training.

Occupational Therapy
The waiting list within LD has improved during October 2017 in that there are now only 3 patients waiting over 9 weeks. Caseload management is ongoing within Occupational Therapy which is expected to release some capacity.

Speech & Language Therapy
In the absence of a paediatric manager, paediatrics SLT continue are working towards a 9 week waiting time standard.

Nutrition and Dietetics
Dietetic Lead remains absent, 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 (locum dietitian in post until the end of November 2017) and we urgently need to secure a longer term solution. Waiting times are to be sent to individual dieticians by administration staff, aim remains 9 weeks, issues with capturing waiting times from EMIS in paediatric and LD dietetic services. 1.0wte Community dietitian leaving post on the 28th November 2017 therefore anticipating waiting time breaches especially in the Eildon & Teviot localities.

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. The admin resource 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

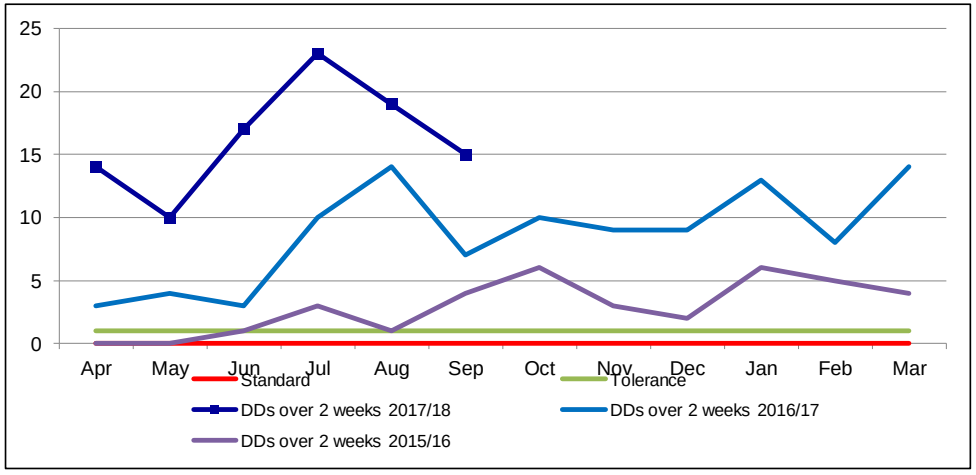
	Standard	Tolerance
Standard: Delayed Discharges - delays over 72 hours	0	1

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	19	15						
DDs over 72 hours (3 days) 2017/18	19	16	23	35	28	23						
Occupied Bed Days (standard delays)	814	664	675	984	872	831						
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). August 2017 data updated as provisional at time of reporting. September 2017 data is provisional at 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 is on the next page.

Delayed Discharges *continued*

Narrative Summary and Actions:
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.

There was a significant increase in younger adults requiring end of life care during August 2017. There are no facilities for nursing care for younger adults in the Scottish Borders. It takes longer to achieve a 'variation to registration' (see explanation below), longer than any of the adults in question were predicated to require end of life care for. In addition, where an adult could be care for at home, the on-going shortage of home care resources made it challenging to discharge within 72 hours.

Variation to registration - every care home has to apply to be registered and the registration process means that the care home must adhere to particular criteria. For example, the vast majority of care homes are for adults over the age of 65. It is not possible therefore for an adult under 65 to move there without the care home asking special permission from the Care Commission. This special permission is called a variation in registration. The process to achieve a variation in registration can take between 4 and 12 weeks and most care homes won't apply because it isn't worth to them financially, especially when most care homes in Scottish Borders Council area have waiting lists. Hence, if a person under 65 needs end of life care and can't be cared for at home they usually have to remain in hospital.

The IJB has recently created a new post, General Manager Patient Pathways, and made a temporary appointment, Dr Jane Prior, to take the lead role in overseeing and managing the "discharge" process, producing an overarching strategy and reviewing and revising policies and protocols. The postholder is responsible for developing strategy and implementing whole systems approaches to patient flow, inclduing strategies to reduce inpatient delays, in partnership with l clincial leads in all areas of inpatiient health care delivery. The post holder is also involved at a strategic and operatoinal level in developing discharge to assess facilities with a view to improving patient flow at the same time as ensuring that adults' needs are assessed in a more appropriate environment.

Key Performance Indicators

Cancellations

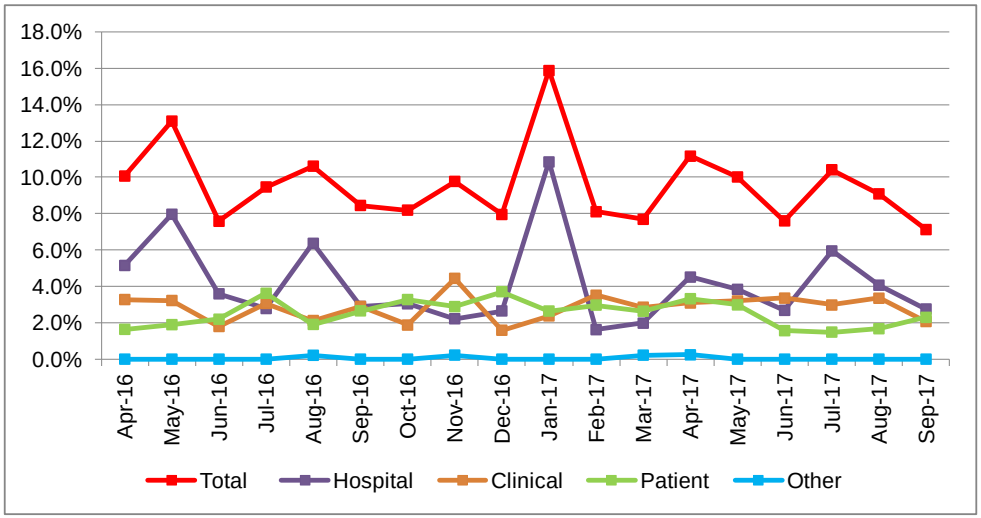
Hot Topic: Cancellations

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 %	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Total	**8.2%**	**9.8%**	**8.0%**	**15.9%**	**8.1%**	**7.7%**	**11.2%**	**10.0%**	**7.6%**	**10.4%**	**9.1%**	**7.1%**
Hospital	3.0%	2.2%	2.7%	10.8%	1.6%	2.0%	4.5%	3.8%	2.7%	6.0%	4.1%	2.8%
Clinical	1.9%	4.4%	1.6%	2.4%	3.5%	2.9%	3.1%	3.2%	3.4%	3.0%	3.3%	2.1%
Patient	3.3%	2.9%	3.7%	2.6%	3.0%	2.6%	3.3%	3.0%	1.6%	1.5%	1.7%	2.3%
Other	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%



Narrative Summary:
In September the overall percentage of **cancellations**, as well as hospital cancellations improved. High levels of consultant and anaesthetist sickness absence had a significant impact on performance over the summer months.

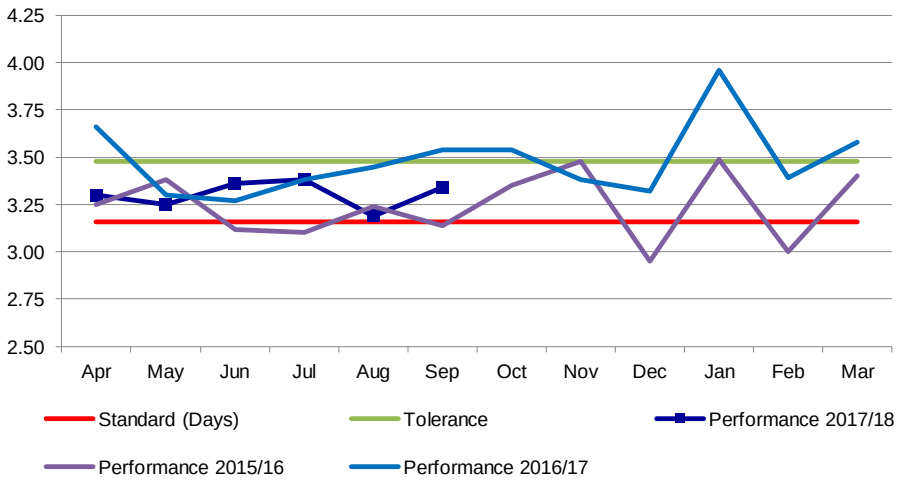
Actions:
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment.
- Individual review of clinical cancellations to ensure these could not have been foreseen at pre-assessment.
- Weekly theatre scheduling meeting has been implemented work is ongoing to improve this process with a view to maximising theatre utilisation.
- Inpatient elective operating over the festive period will be reduced to mitigate the impact of anticipated winter bed pressures and reduce the likelihood of cancellations over this period. Day case operating will be maximised during this time.

BGH Average Length of Stay

	Target	Tolerance
Standard: Reduce BGH Length of Stay	3.16	3.48

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (Days)	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16
Performance 2017/18	3.30	3.25	3.36	3.38	3.19	3.34						
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)

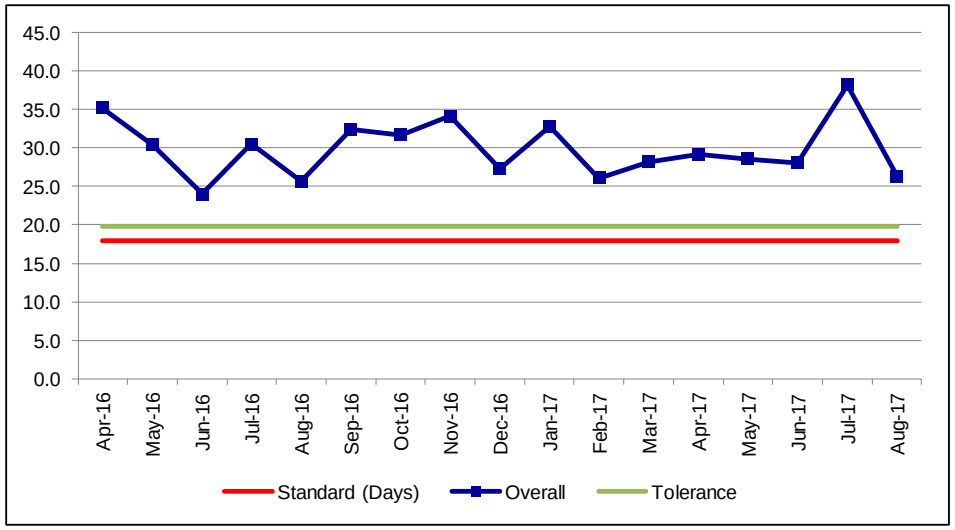
	Standard	Tolerance
Standard: Reduce Community Hospital Average Length of Stay	18.0	19.8

Actual Performance (lower = better performance)

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-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	19.0
Overall	**31.7**	**34.1**	**27.3**	**32.8**	**26.1**	**28.2**	**29.2**	**28.6**	**28.1**	**38.2**	**26.3**	**32.8**
Hawick	18.2	23.7	19.3	18.9	15.7	24.8	21.5	15.1	25.2	36.8	20.8	24.7
Hay Lodge [1]	50.3	35.2	20.4	70.1	29.5	36.5	23.7	34.3	26.2	34.2	49.4	41.6
Kelso	44.1	52.5	40.0	41.2	32.6	20.2	40.1	32.5	23.2	27.2	18.0	31.3
Knoll	33.4	35.3	56.4	31.3	37.5	38.2	40.2	54.4	42.9	78.3	32.6	39.1

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. Extended length of stay can be due to legal issues i.e. guardianship.

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 outline alternative options for alternative models.
- Work is being progressed in Kelso Community Hospital, to introduce dynamic daily discharge.

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

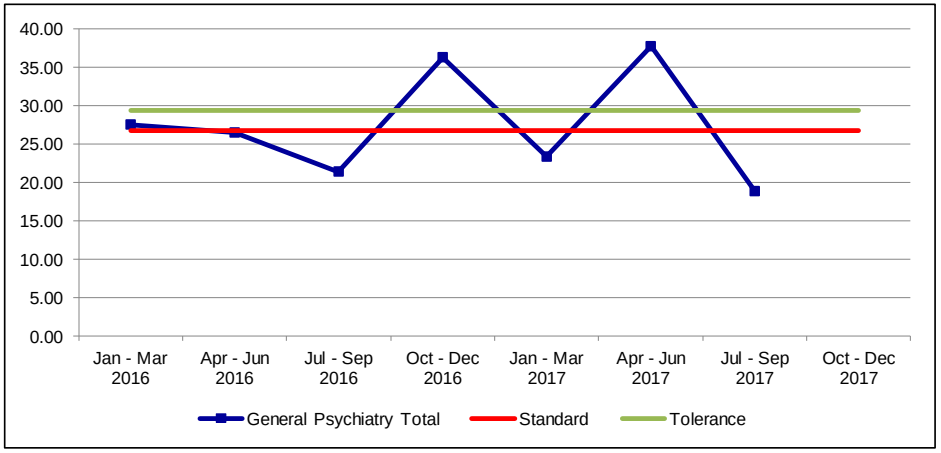
	Standard	Tolerance
Standard: Reduce Mental Health Average Length of Stay	Various	within 10%

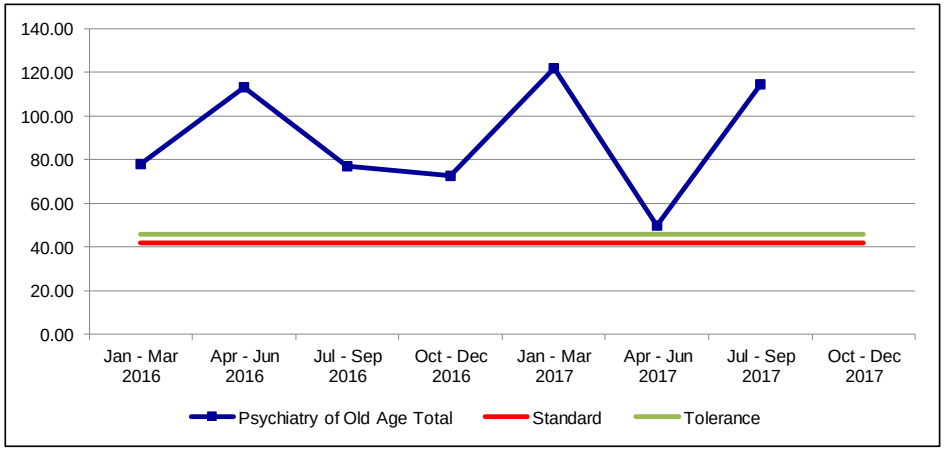
Actual Performance (lower = better performance)

	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	16.40	
The Brigs	42.83	53.78	43.00	69.00	134.28	48.24	68.38	25.90	
General Psychiatry Total	**26.70**	**27.53**	**26.49**	**21.41**	**36.29**	**23.35**	**37.72**	**18.86**	
Cauldshiels	26.95	75.38	105.50	109.07	115.22	86.80	52.14	104.70	
Lindean	60.58	33.72	82.33	33.00	28.36	54.00	48.38	45.90	
Melburn Lodge [1]	111.63	247.33	345.00	112.00	124.00	491.00	- [2]	545.50	
Psychiatry of Old Age Total	**41.82**	**78.00**	**113.18**	**77.00**	**72.59**	**121.88**	**49.83**	**114.50**	

[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).

Mental Health Waiting Times

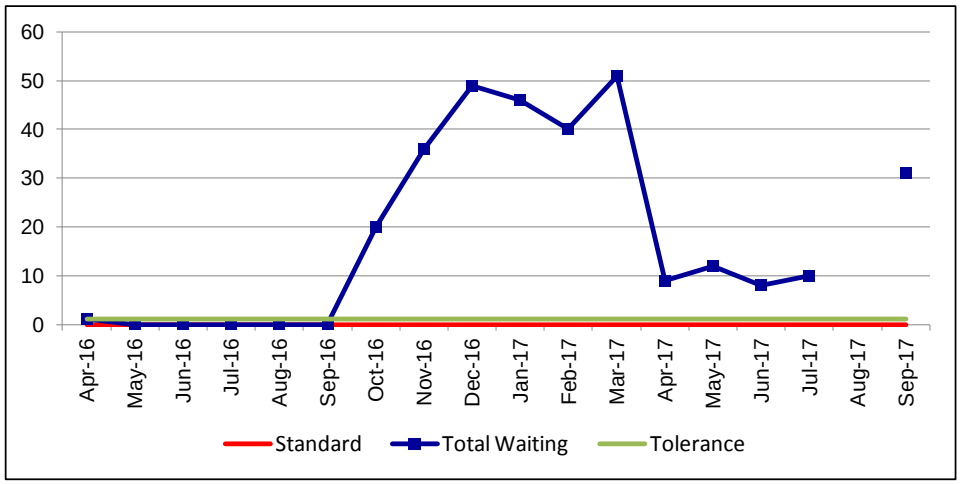
	Standard	Tolerance
Standard: Patients Waiting over 9 weeks as at month end	0	1

Actual Performance (lower = better performance)

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17[1]	Sep-17
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**20**	**36**	**49**	**46**	**40**	**51**	**9**	**12**	**8**	**10**	-	**31**
MH Older Adults - East	0	0	1	1	0	0	2	1	0	0	-	1
MH Older Adults - South	0	0	0	0	0	0	0	0	0	0	-	0
MH Older Adults - West & Central	0	0	0	0	0	0	2	3	0	4	-	2
East Team	6	20	24	23	23	33	2	1	1	2	-	3
South Team	6	5	11	11	10	10	0	0	2	3	-	2
West Team	8	11	13	11	7	8	3	7	5	1	-	23

[1] August 2017 data unavailable at the time of reporting

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 - this is no longer included and work continues to address Psychological Therapies waiting times as previously described.

Waiting times have increased in September 2017 due to reduced capacity within the West Team predominantly due to sickness absence and vacancies.

Actions:
- Continue to monitor and manage the waiting list within the performance scorecard at monthly Mental Health meetings, overall, and picked up with Team Managers by exception.
- Sickness absence in West Team is being managed as per policy - one nursing absence is ongoing, one medical absence has now resolved but has had an impact on waiting times.
- Vacancy in West Team has been advertised twice but unable to appoint, in the process of being readvertised.

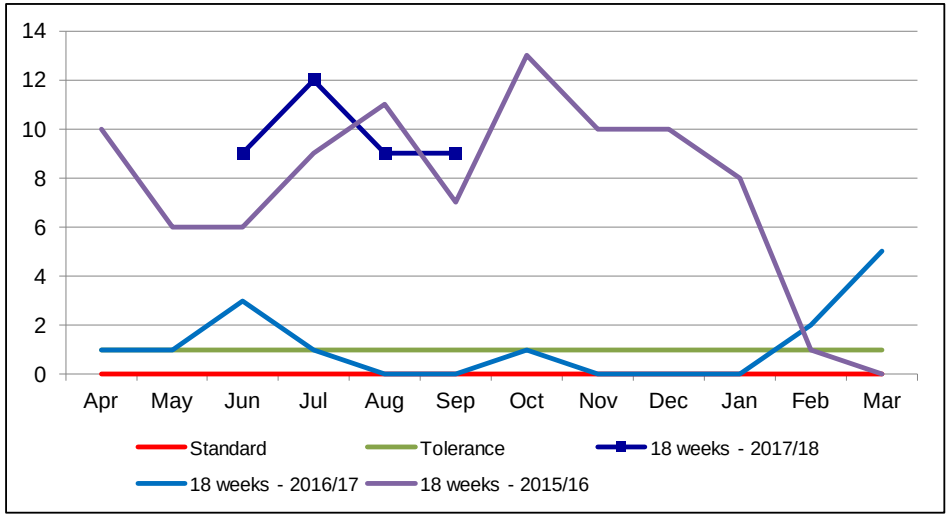
Learning Disability Waiting Times

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

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
18 weeks - 2017/18	-	-	9	12	9	9						
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 - May 2017 unavailable following the migration to EMIS, LD are working with HIS to resolve. June updated in August 2017.



Narrative Summary:
The 9 **Learning Disability waiting times** breaches in September 2017 were within Psychology and Speech and Language Therapy. There has been an improvement in the number of Speech and Language Therapy waiting breaches due to the recruitment of a therapist into post. Actions continue as below.

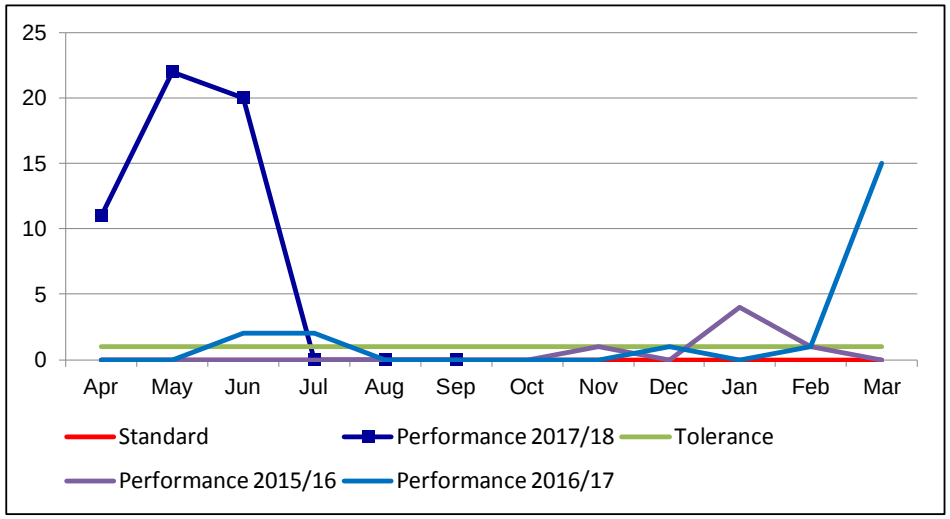
Actions:
- Vacant posts have contributed to the increase in waiting times. A Psychologist is due to be in post from mid October 2017 which will further help the improvement.
- Continue to monitor and manage the waiting list within the performance scorecard at the Learning Disability Service management team meetings and action 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	0	0						
Performance 2016/17	0	0	2	2	0	0	0	0	1	0	1	15
Performance 2015/16	0	0	0	0	0	0	0	1	0	4	1	0



Narrative Summary:
In September 2017 there were 0 patients waiting over **1 week for the Rapid Access Chest Pain Clinic.** The improvement has been sustained from the last 2 months. The service have managed their clinics to ensure appropriate access for patients and continue to monitor and manage the waiting list.

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

Audiology Waiting Times

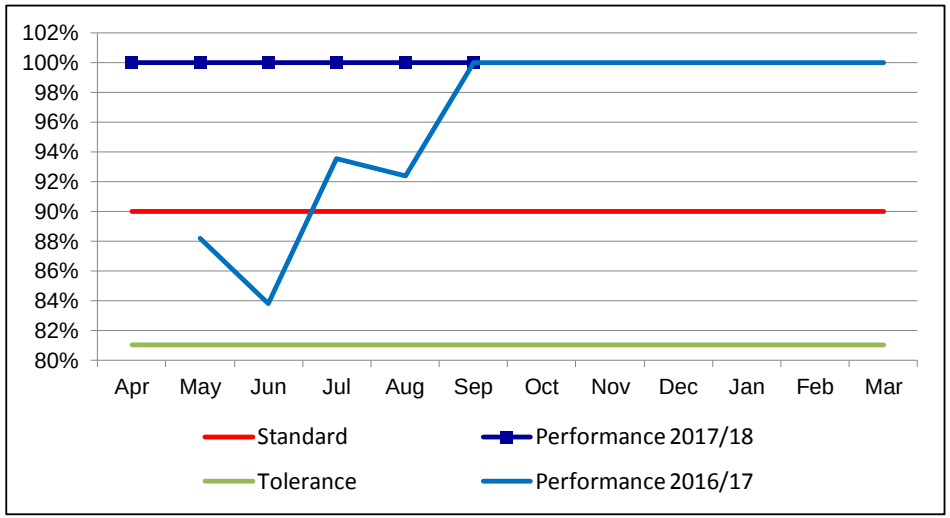
	Standard	Tolerance
Standard: 18 Week Referral to Treatment for Audiology	90.0%	81.0%

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

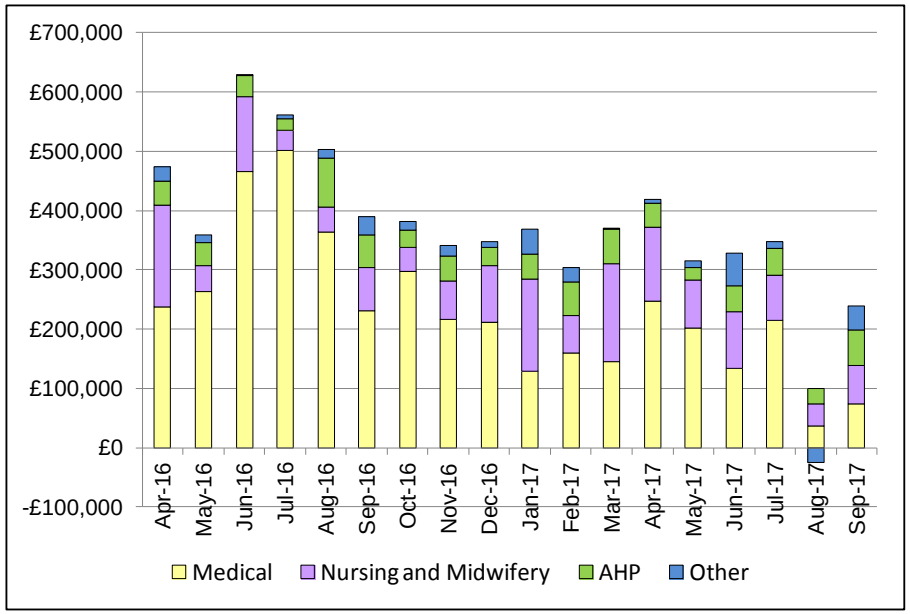
Workforce Section

Supplementary Staffing

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

Actual Performance (lower = better performance)

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Standard	0	0	0	0	0	0	0	0	0	0	0	
Medical	£296,560	£215,617	£211,375	£129,170	£159,536	£145,447	£247,521	£202,203	£133,969	£214,295	£36,696	£73,584
Nursing and Midwifery	£40,814	£64,863	£96,168	£155,234	£62,839	£165,022	£124,708	£80,778	£95,194	£76,940	£36,821	£65,110
AHP	£30,209	£43,515	£29,487	£41,959	£56,410	£57,901	£40,298	£20,876	£43,664	£45,327	£25,717	£59,055
Other	£13,908	£16,768	£10,015	£42,159	£25,611	£1,328	£6,160	£11,033	£54,626	£11,197	-£25,138	£41,395
Total Cost	**£381,491**	**£340,763**	**£347,045**	**£368,522**	**£304,396**	**£369,698**	**£418,687**	**£314,890**	**£327,453**	**£347,759**	**£74,096**	**£239,144**



Narrative Summary:
Approximately 25% of the spend on **agency nursing** reported in September 2017 is due to the continuing requirement to staff the extra surge beds related to delayed discharges, and the requirement for one to one care due to high patient dependency. The reason for the remainder of the agency spend has been recorded as sick leave cover and cover for vacant posts. The vacancies are in unscheduled care. High levels of spend on sickness cover are reported under ward 12, ward 4, MAU, ward 9 and ITU.

Medical Agency - spend recorded in September relates to locum consultant cover in Anaesthetics, Obstetrics& Gynaecology, Medical and DME.

AHP Agency - increased in September due to cover in dietetics, occupational therapy and physiotherapy. Physiological Measurement continue to use agency cover for vacancies.

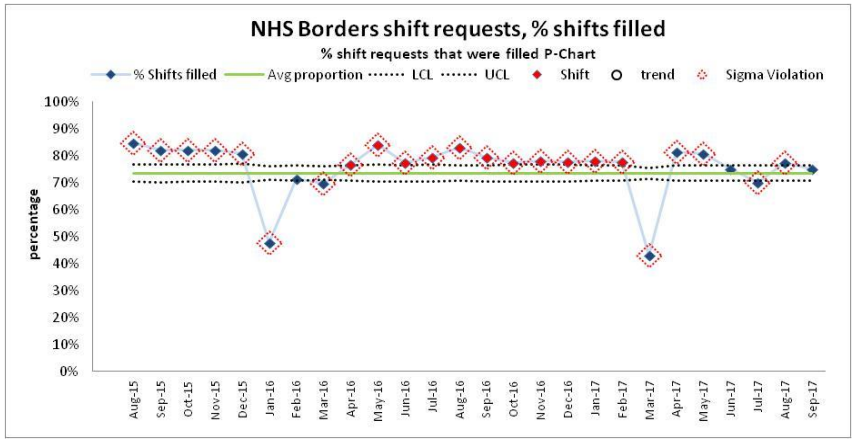
Other agency - Costs to date relate to agency cover for Blood Sciences and IM&T agency staff.

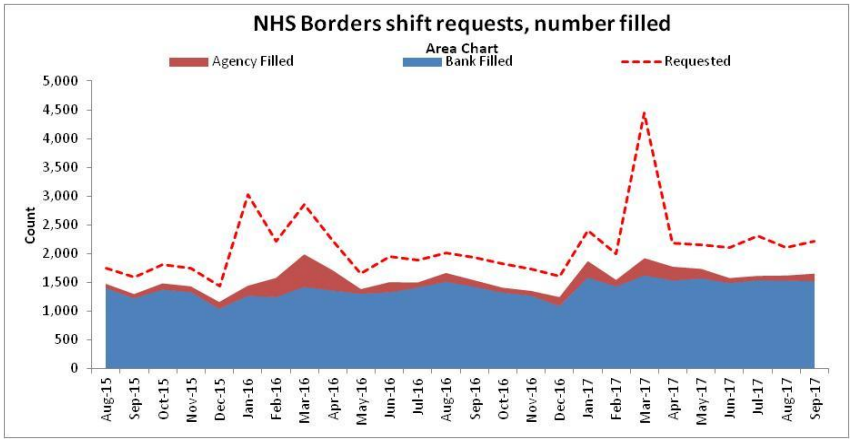
Actions:
- Recruitment following targeted training into key nursing posts in Acute Services and proactive management of sickness levels is anticipated to see levels of expenditure brought into line with budgets.

Nurse Bank

Standard: NHS Borders Nurse Bank and agency shifts

NHS Borders Overall





Narrative Summary:
Overall requests have risen in September compared to August and an increase in agency from 90 shifts to 134.

Every month the reasons for the requests for agency are shared with the service in order that we can understand why we are using agency staff. Requests are all reviewed and signed off by the Associate Director of Nursing to ensure that they are only used where clinical safety is compromised .

The BGH continue to have significant numbers of requests for 1-1's / patient dependency. For the last 5 out of 6 months this has accounted for the highest number of requests in excess of sickness and vacancies.

Within Primary Care sickness is the predominant reason for requesting bank nurse shifts.

Covering vacancies is the predominant reason within Mental Health.

Actions:
- The Nurse Bank will recruit to an open advert for band 5 nurses to increase the number of staff available to cover shifts.
- A recruitment event is planned for Thursday 26th of October for both Health Care Support Workers (HCSW) and Registered Nurses.
- The service are looking an different ways of providing one to one care and this is being piloted in ward 10/12 but we await a report on the outcome

Nurse Bank *continued*