

Borders NHS Board



NHS BORDERS PERFORMANCE SCORECARD – OCTOBER 2017

Aim

This paper aims to update the Board with NHS Borders latest performance towards the 2017/18 Local Delivery Plan (LDP) Standards and local Key Performance Indicators. The attached Performance Scorecard shows performance as at 31st October 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 period is outlined below:

LDP Standards	Aug-17	Sep-17	Oct-17
Green – achieving standard	13	11	11
Amber – nearly achieving standard	3	6	5
Red – outwith standard	15	14	15

Key Performance Indicators	Aug-17	Sep-17	Oct-17
Green – achieving standard	4	5	5
Amber – nearly achieving standard	1	1	0
Red – outwith standard	8	7	8

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

Areas of strong performance from the LDP Standards and Access to Treatment sections in the Scorecard for the position as at 31st October 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 August 2017 (latest available data) 0.05 days against the standard of 0.47 (page 19)
- 93.2% of all referrals were **triaged online** in October 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 June 2017 (latest available data) with 3641 against the standard of 3685 (page 24)
- **18 Weeks RTT** admitted pathway linked performance, non admitted linked performance and combined linked pathway performance continue to achieve the standard of 90% in September 2017 (latest available data) (pages 34-38)
- 100% of **all cases with a suspicion of cancer** were seen within **62 days** in September 2017 (latest available data) (page 42)
- 100% of patients **requiring treatment for cancer** were seen within **31 days** in September 2017 (latest available data) (page 43)
- 95.2% of patients stayed less than 4 hours from arrival to admission, discharge or transfer from A&E during October 2017 (page 44)
- 100% of patients were transferred to the **Stroke Unit within one day of admission** during September 2017 (latest available data) (page 46)

The Board are asked to note that the following standards have been outwith the 10% tolerance (red status) for 3 or more consecutive months at 31st October 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 7 consecutive months (page 13)
- **Smoking Cessation** – performance has been outwith the trajectory set for the full financial year 2016/17 and for the first quarter of 2017/18 (page 14)
- **Sickness Absence** – performance reported outwith the 10% tolerance for the 4.0% standard for a year (page 15)
- **New patient DNA rate** – performance has been outwith the 10% tolerance for the 4.0% standard for 5 consecutive months (page 17)
- **eKSF and PDP** – performance is outwith the standard set for the first 7 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 15 consecutive months (page 29-30)
- **12 week Treatment Time Guarantee** – performance reported outwith the standard for 14 consecutive months (page 31)
- **Admitted Pathway Performance** – performance reported outwith the 90% standard for 15 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 10% tolerance of the standard for 7 consecutive months (page 48)
- **Drugs and Alcohol Treatment Times** – performance has been outwith the standard for 3 consecutive months to October 2017 (page 50)

- **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 Development & Strategy Session 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 October 2017 Performance Scorecard.

Policy/Strategy Implications	Regular and timely performance reporting is an expectation of the Scottish Government
Consultation	Planning and Performance have consulted individual Clinical Boards to agree the information that will be reported on a monthly basis.
Consultation with Professional Committees	See above
Risk Assessment	Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders
Compliance with Board Policy requirements on Equality and Diversity	Please see attached Impact Equality Assessment Scoping Template
Resource/Staffing Implications	The implementation and monitoring of standards will require that Lead Directors, Managers and Clinicians comply with Board requirements

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Strategic Change & Performance		

Author(s)

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Meriel Carter	Planning & Performance Officer		



PERFORMANCE SCORECARD

As at 31st October 2017

October 2017

Planning & Performance

Month

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INTRODUCTION

DASHBOARD OF HEAT STANDARDS

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

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

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

Direction Symbols

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

LDP Standards

Every year the Scottish Government Health Department (SGHD) asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report is called the Local Delivery Plan (LDP) and forms an agreement on what Health Boards will achieve in the next year with SGHD. Boards are asked to work towards a number of key standards for the year which fit with the Government's health objectives. The Local Delivery Plan for 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 ↑	A ↑					
Dementia Post Diagnostic Support ¹ (2016/17 data)	A ↓	-	-	-	-	-	-					
Alcohol Brief Interventions ²	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑					
Smoking cessation successful quits in most deprived areas ³	-	-	R -	-	-	-	-					
Sickness Absence Reduced	R ↑	R ↓	R ↑	R ↑	R ↓	R ↑	R ↓					
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer ⁴	R ↓	A ↑	G ↑	G ↑	G ←	G ←	-					
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer ⁴	R ↓	G ↑	G ↑	G ←	G ←	G ←	-					
18 Wk RTT: 12 wks for outpatients	R ↓	R ↓	R ↓	R ↓	R ↓	R ↓	R ↑					
18 Wk RTT: 12 wks for inpatients	R ↑	R ↑	R ↑	R ↓	R ↓	R ↓	R ↑					
18 Wk RTT: 12 weeks TTG	R ↓	R ↓	R ↓	R ↓	R ↓	R ↓	R ↑					
18 Wk RTT: Admitted Pathway Performance ⁵	R ↓	R ↓	R ↓	R ↑	R ↓	R ↓	-					
18 Wk RTT: Admitted Pathway Linked Pathway ⁵	G ↓	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 ↓	A ↓	-					
18 Wk RTT: Non-admitted Pathway Linked Pathway ⁵	G ↑	G ↑	G ↓	G ↓	G ↑	G ↑	-					
Combined Performance ⁵	G ←	G ↑	G ↑	G ↓	A ↓	A ↓	-					
Combined Performance Linked Pathway ⁵	G ↑	G ↑	G ↓	G ↓	G ↑	G ↑	-					
6 Week Waiting Target for Diagnostics	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓	R ↓					
4-Hour Waiting Target for A&E	A ↑	A ↓	G ↑	G ↓	G ↑	A ↓	G ↑					
No CAMHS waits over 18 wks ⁶	G ↑	G ←	G ←	G ←	G ←	R ↓	R ↓					
No Psychological Therapy waits over 18 wks	R ↓	R ↓	R ↓	R ↓	R ↓	R ⁷ ↑	R ↓					
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G ↑	R ↓	R ↓	G ↑	R ↓	R ↓	R ↑					
No Delayed Discharges over 72 hours (3 days)	R ↓	R ↑	R ↓	R ↓	R ↑	R ↑	R ↓					
New patient DNA rate	R ↓	A ↑	R ↓	R ↑	R ↓	R ↓	R ↑					
Same day surgery ⁸	A ↓	G ↑	A ↓	A ↑	A ↓	-	-					
Pre-operative stay ⁸	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
Online Triage of Referrals	G ↑	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 ↑	R ↑					
PDP's Complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑					
Emergency OBDs aged 75 or over (per 1,000) ¹⁰	G ↓	A ↓	G ↑	-	-	-	-					
Admitted to the Stroke Unit within 1 day of admission ¹¹	R ↑	A ↑	G ↑	R ↓	G ↑	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 for August 2017 updated as unavailable 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-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
AHP Waiting Times		R ↓	R ↑	R ↑	R ↓	R ↓	R ↑	R ↑					
Cancellations	Hospital	R ↓	R ↑	R ↑	R ↓	R ↑	R ↑	R ↓					
	Clinical	A ↓	R ↓	R ↓	A ↑	R ↓	G ↑	R ↓					
	Patient	G ↓	G ↑	G ↑	G ↑	G ↓	G ↓	G ↓					
	Other	G ↔	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔					
Borders General Hospital Average Length of Stay		A ↑	A ↑	A ↓	A ↓	A ↑	A ↓	R ↓					
Community Hospitals Average Length of Stay		R ↓	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 9 weeks) ²		R -	R ↓	R ↑	R ↓	-	R -	R ↓					
Learning Disability Waiting Times (Patients waiting over 18 weeks) ³		-	-	R -	R ↓	R ↑	R ↔	R ↑					
Rapid Access Chest Pain Clinic		R ↑	R ↓	R ↑	G ↑	G ↔	G ↔	G ↔					
Audiology 18 Weeks Waiting Times		G ↔	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 reporting 18 weeks to 9 weeks. Data unavailable for August 2017 at time of reporting, therefore no September comparison

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 1 st 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

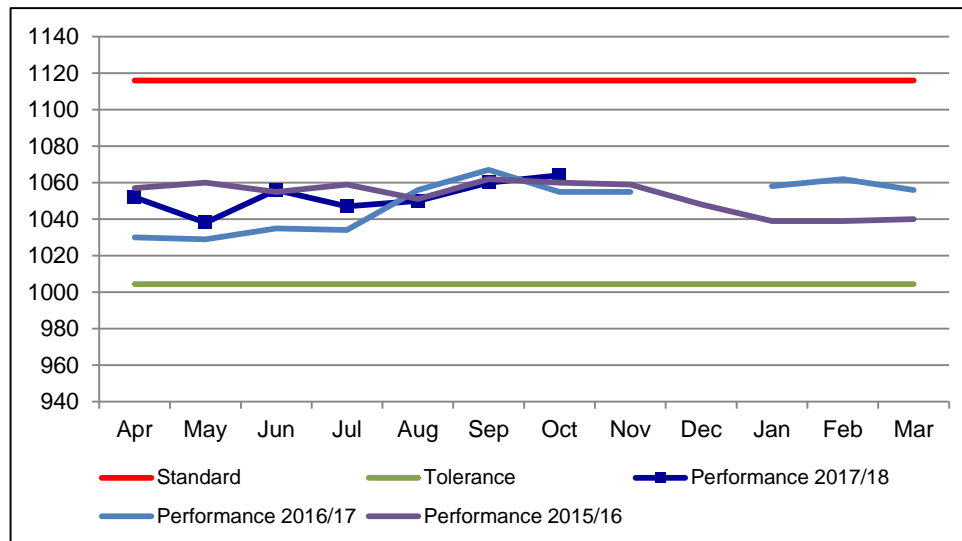
LDP Standards:

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	1064						
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.

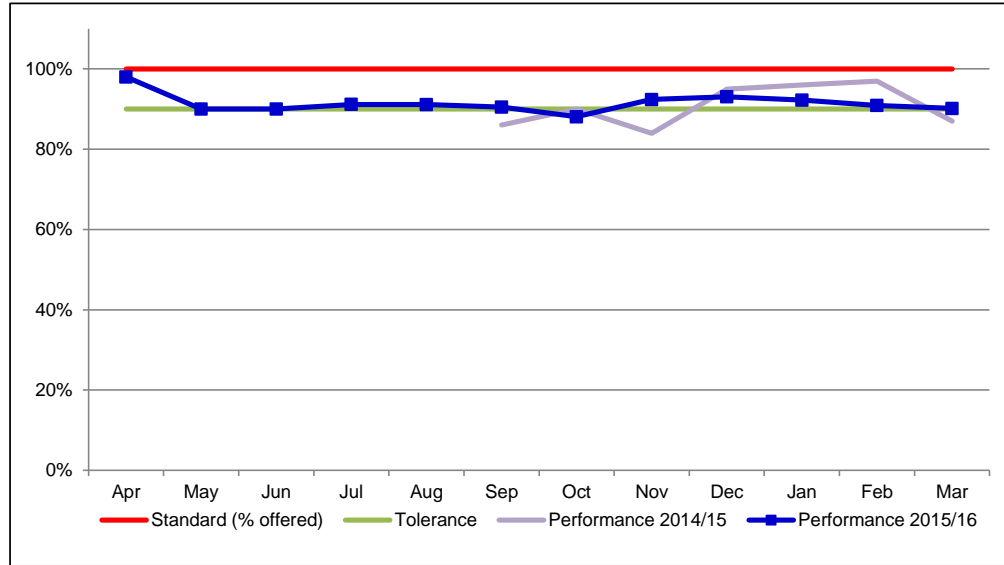
There are a number of reasons the standard is not improving - patients diagnosed with Dementia are not being recorded clearly on ePEX; resulting assessment letters and lack of clarity around the process GPs use to update the Dementia Register.

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. Update: the gap analysis work will be complete by 05/01/2018 - however early indications show that this will not have as much of a positive impact as predicted. Only an additional 11 patients have been identified so far to be added to the Register (from 19 practices). 10 patients came from the same practice. However, the exercise has been helpful in updating MH records.

Actions:

- A pathway has been mapped to highlight challenges from referral to diagnosis / communication with GPs
- A briefing paper on the gap analysis work will be completed by the target Operational Manager Lead
- Further actions will follow once the briefing paper has been discussed by the Mental Health Operational meeting.

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

1312

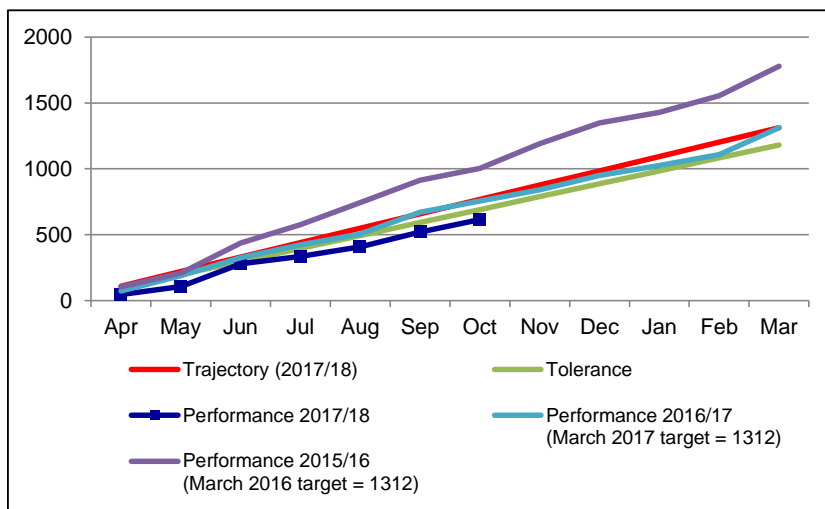
Tolerance

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	615					
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 October 2017 is at 80% of the trajectory. This is lower than performance at the same time in the previous year.

Factors contributing to this:

- **Local Enhanced Service (LES)** – the LES continues to have the most significant reduction in the number of ABI's from 418 to 239.
- **Cessation of Keep Well** – this work is no longer funded by Scottish Government and has ceased. In this time period last year there were 30 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.

Improvements include:

- **Emergency Department** - There continues to be an increase in the number of screenings and a smaller increase in the number of ABI's performed in ED 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 from December.

Smoking Quits

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

Standard

173

Tolerance

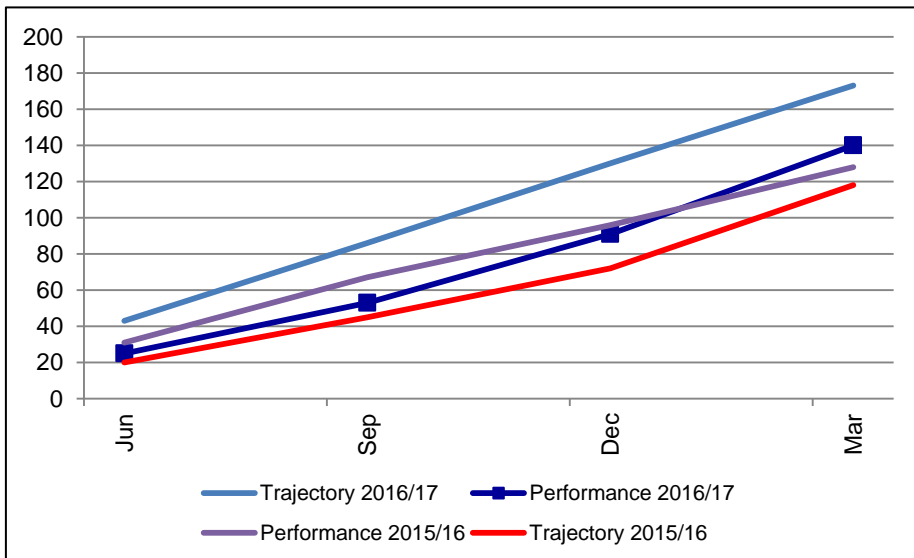
within 10%

Actual Performance (higher = better performance)

	Jun	Sep	Dec	Mar
Trajectory 2017/18	43	86	130	173
Performance 2017/18	29			
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 2017/18 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 Q1 2017/18 twelve week quit standard trajectory is 43 and 29 **successful smoking quits** were reported. This is compared to 25 in the same period last year. The standard remains challenging due to the drop in clients coming into service. Improvements in performance are likely only to be achieved through attracting more clients.

Actions:

- We have the support of Communications to continue pursuing appropriate and effective engagement.
- The Quit for Christmas campaign started in October continues in local surgeries. This is backed up by display boards in the BGH.
- Targeted facebook messages continue to be delivered and we also use the Small Change Big Difference social media to share messages.
- Smoking Cessation Advisor for the BGH provides brief advice training via PMAV sessions thus reaching a large number of staff. We are establishing improved pathways for patients between BGH and community pharmacies in areas not

Sickness Absence

Standard: Maintain Sickness Absence Rates below 4%

Standard

4.0%

Tolerance

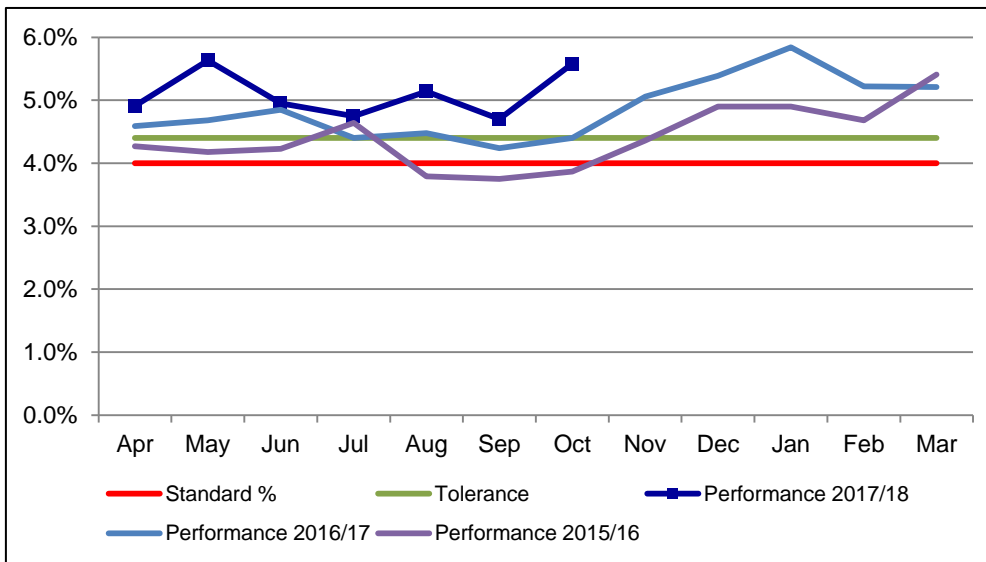
4.4%

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%	5.6%					
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 a 5.6% October 2017 **Sickness Absence** rate which is an increase of 0.9% from September 2017. The last NHS Scotland figure was 4.95% for the month of September 2017. A breakdown of sickness absence figures can be found on page 16.

Actions:

- HR continue to be a support service to the Clinical Boards by providing advice and support in managing sickness absence as well as proactively identifying areas where rates are high.
- Monthly sickness absence reports are provided to each Clinical Board, these detail trends, rates, the level of short term and long term sickness absence, and reasons for absence per department.
- A sickness absence annual report to March 2017 has been completed and identified areas 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	0.00					
Allied Health Professionals	0.00	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	0.00					
Nursing / Midwifery	17.02	24.38	21.82	12.71	7.17	1.11	9.22					
Grand Total	13.70	19.64	17.57	10.07	6.07	0.94	7.42					
Mental Health (Div/CHP)												
Administrative Services	6.73	4.64	1.77	0.75	9.39	4.54	7.06					
Allied Health Professionals	0.00	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	10.21					
Nursing / Midwifery	6.76	7.90	6.71	7.38	8.19	7.23	7.66					
Other Therapeutic	0.00	4.06	4.73	5.26	3.35	5.28	1.16					
Personal & Social Care	0.00	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	0.00					
Grand Total	5.77	6.59	5.73	6.38	7.55	6.73	6.97					
Primary, Acute & Clinical Services												
Administrative Services	3.19	4.84	4.37	5.42	3.72	3.34	2.28					
Allied Health Professionals	2.68	3.33	2.92	2.60	2.43	2.19	2.63					
Dental Support	4.68	5.25	4.42	4.81	9.03	2.50	8.02					
Health Care Sciences	3.19	5.59	4.16	4.20	5.43	2.92	4.98					
Medical & Dental	2.55	1.72	2.19	2.00	2.01	1.33	1.18					
Medical Support	0.00	0.00	0.00	0.00	1.30	0.00	0.00					
Nursing / Midwifery	5.94	6.51	5.44	5.42	6.14	6.32	7.45					
Other Therapeutic	0.00	0.00	0.00	0.00	4.28	0.00	2.67					
Personal & Social Care	0.00	16.55	23.97	1.07	0.82	3.12	7.06					
Support Services	4.42	5.88	5.76	6.58	6.60	7.88	2.79					
Grand Total	4.63	5.27	4.57	4.59	4.97	4.64	5.31					
Support Services (Div/CHP)												
Administrative Services	5.26	5.45	4.99	4.41	4.82	3.96	5.31					
Allied Health Professionals	0.00	4.00	0.00	3.91	1.56	0.59	1.41					
Health Care Sciences	0.00	0.00	0.00	10.78	2.94	0.00	1.89					
Medical & Dental	0.00	6.62	2.21	0.00	3.36	0.00	0.00					
Nursing / Midwifery	1.50	1.05	1.08	1.48	3.66	3.79	4.57					
Other Therapeutic	4.84	5.05	2.46	2.32	2.09	2.08	3.22					
Personal & Social Care	6.61	7.45	4.24	5.84	6.10	2.99	3.37					
Senior Managers	0.27	0.00	0.00	0.00	0.00	0.00	0.80					
Support Services	5.56	6.95	6.85	5.01	5.02	4.92	6.83					
Grand Total	4.98	5.72	5.17	4.30	4.50	4.05	5.56					

Outpatient DNA Rates

Standard: New patients DNA rate will be less than 4% over the year

Standard

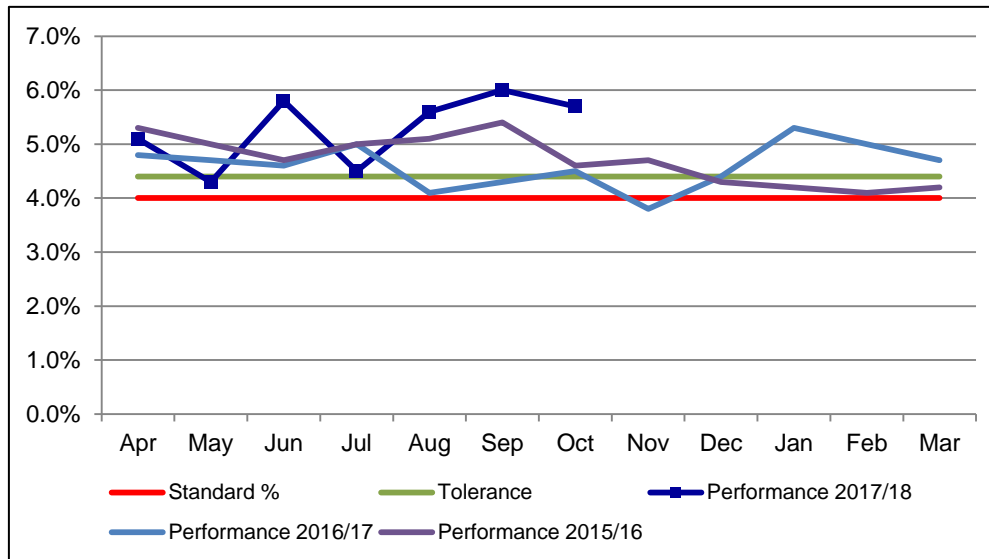
4.0%

Tolerance

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%	5.7%					
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 October 2017 is outwith the tolerance levels of the standard and overall remains variable.

There will be a "2018 Reducing DNA Campaign", postponed from 2017.

Actions:

- Staffing in Records is currently insufficient to assign staff where possible to telephone patients with a history of missed appointments.
- Support with poster design for the "2018 Reducing DNA Campaign" is ongoing.

Same Day Surgery

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

Standard

86.0%

Tolerance

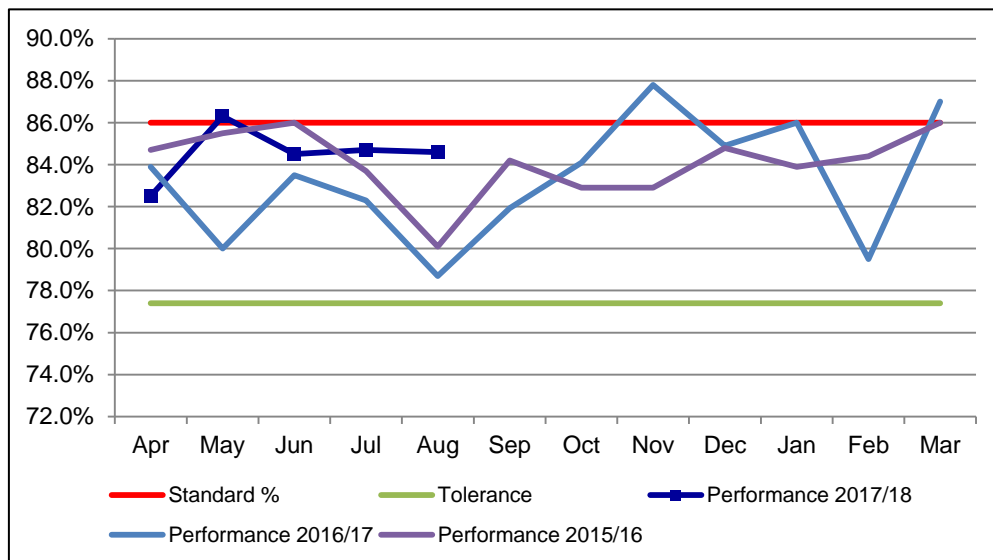
77.4%

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%	84.6%							
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 performance to treat patients as **day cases** (for BADS* procedures) 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: Reduce the days for pre-operative stay

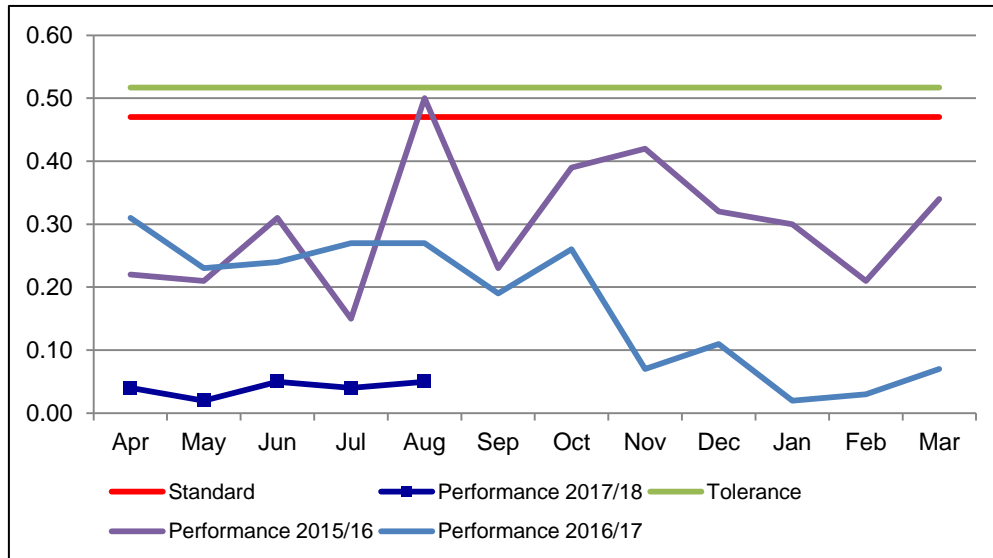
Standard
0.47

Tolerance
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	0.05							
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

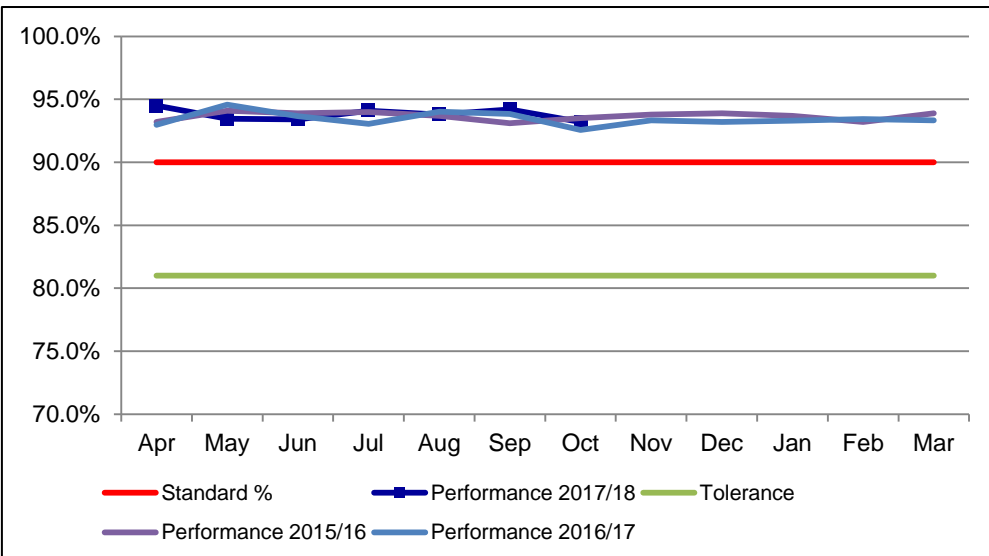
Standard: 90% of all referrals to be triaged online

Standard
90.0%

Tolerance
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%	93.2%					
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: Increase the proportion of new-born children breastfed at 6-8 weeks

Standard
33.0%

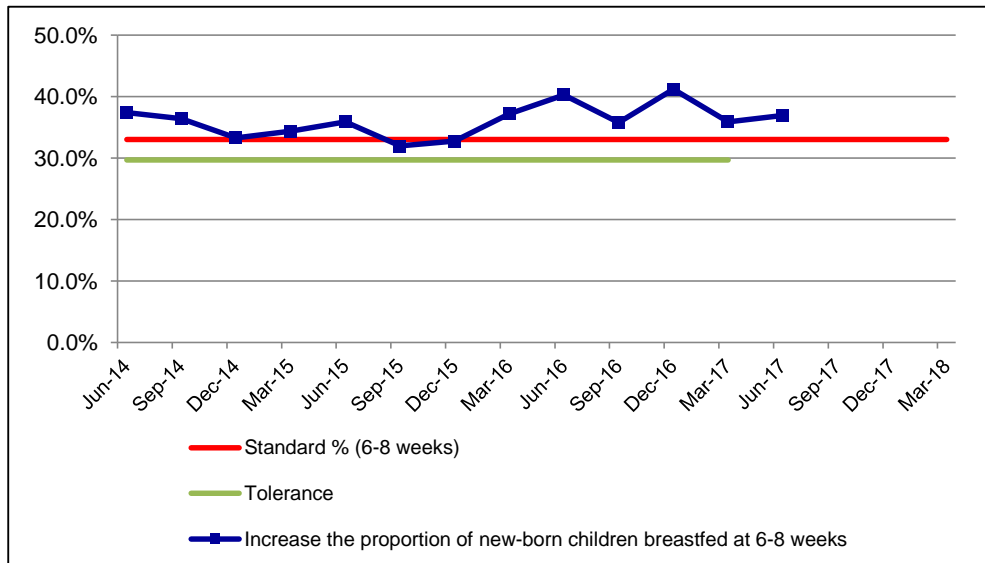
Tolerance
29.7%

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 January 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 quarter April - June 2017 performance exceeds the 33% standard by 4%.

Actions:

- A permanent Infant feeding/BFI Lead started in post on 9th October.
- Maternity staff and BFI Key Workers are actively working to ensure babies get the best start in Life.
- We are taking a ‘back to basics’ approach, focusing on 100% initiation of Skin to Skin for all babies.
- We continue to deliver and develop training for all staff.
- Focus on using Badgernet reports to identify training needs.
- We have a robust peer support programme (BIBS - Breastfeeding in the Borders Support), continuing to identify means to maintain and further develop this programme.

eKSF

Standard: 80% of all Joint Development Reviews to be recorded on eKSF

Standard

80.0%

Tolerance

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 ¹	2.5%	4.2%	6.1%	8.9%	12.3%	16.9%	22.8%					
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 & September data updated as unavailable at time of reporting

Personal Development Plans

Standard: 80% of all Personal Development Plans to be recorded on eKSF

Standard

80.0%

Tolerance

within 10%

Actual Performance (higher % = better performance)

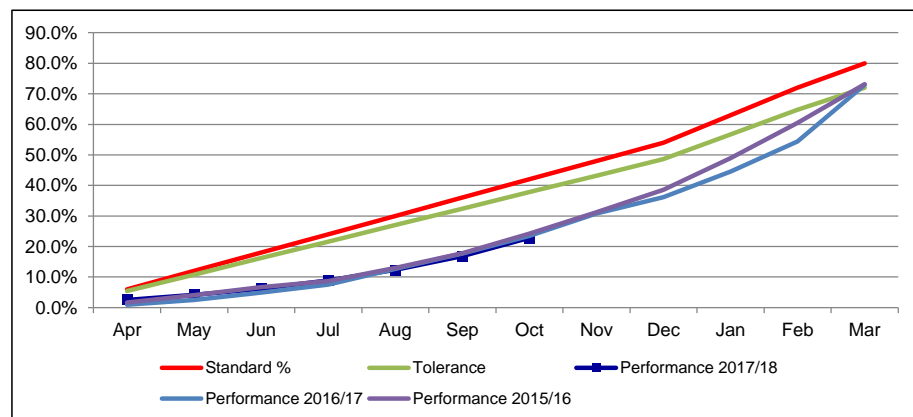
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	6.0%	12.0%	18.0%	24.0%	30.0%	36.0%	42.0%	48.0%	54.0%	63.0%	72.0%	80.0%
Performance 2017/18 ¹	4.0%	5.8%	7.5%	9.4%	13.5%	17.4%	22.4%					
Performance 2016/17	1.9%	4.1%	6.6%	9.9%	15.8%	20.9%	25.6%	31.3%	34.8%	40.5%	47.8%	60.8%
Performance 2015/16	4.0%	5.9%	7.7%	9.8%	14.6%	18.8%	22.1%	27.9%	34.7%	44.8%	51.6%	61.6%

¹ August & September data updated as unavailable at time of reporting

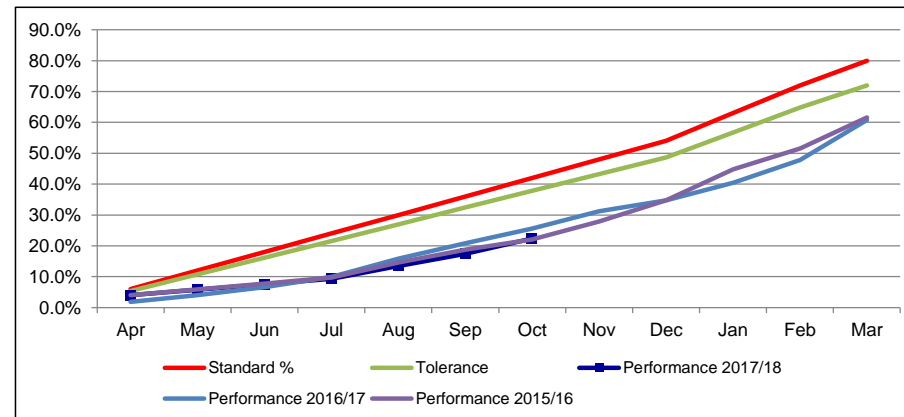
Please Note: Charts and supporting narrative are on the next page.

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 7 months of the year.

The Employee Director is the Executive lead, supporting the KSF Champions and reporting back to the Board Executive Team on a regular basis.

Regular reports are being sent out to all managers to highlight their percentages and to encourage the completion of Reviews and PDPs into e-KSF.

KSF Champions continue to support managers with this process.

Further information will be forthcoming to staff regarding the replacement system for eKSF – part of this work will be to ensure all relevant staff have an agreed post outline assigned and where possible all JDRs are completed by December / mid January 2018.

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

Reports are sent to Managers as requested, all departments have a process in place to ensure appraisals are planned, carried out and inputted on to eKSF appropriately.

BGH and P&CS

Work continues to meet with managers and staff to provide support with eKSF system and processes. Monthly reports are being produced and shared with managers and reviewers. Areas of concern are being highlighted to senior managers, trajectory of plans are updated and shared with teams.

Learning Disability Service

Work continues to ensure staff meet this standard.

Emergency Occupied Bed Days

Standard: Reduce Emergency Occupied Bed Days for the over 75s

Standard

3685

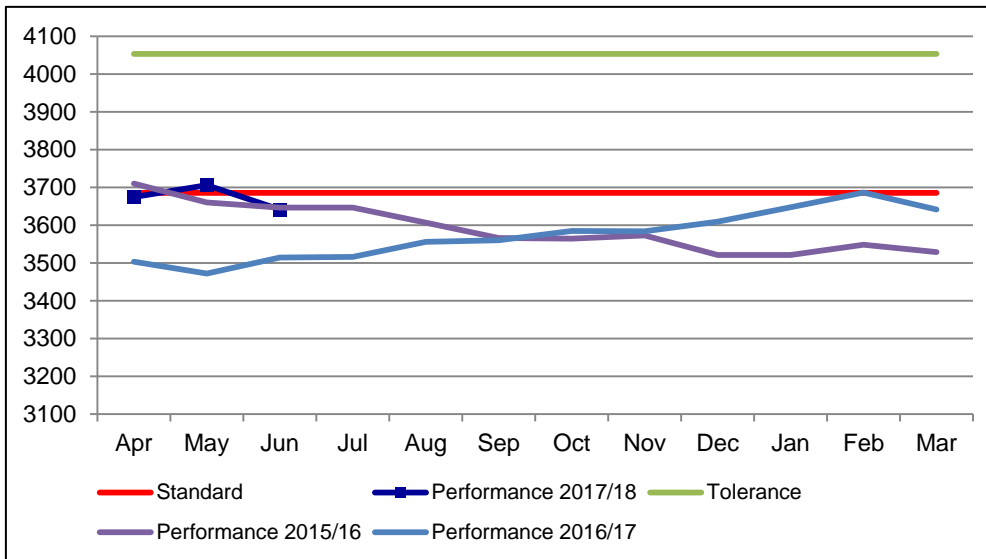
Tolerance

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	3674	3706	3641									
Performance 2016/17	3503	3472	3515	3516	3556	3560	3584	3584	3609	3647	3686	3641
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. Figures quoted here are a rate per 1,000 Borders population over 75



Narrative Summary:

There has been a steady increase in occupied beddays since June 2016. This coincides with an increase in delayed discharges from this period. However further analysis is required to identify potential causes.

Actions:

- There is 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: 12 weeks for first outpatient appointment	Standard	Tolerance
	0	1

Actual Performance (lower = better performance)

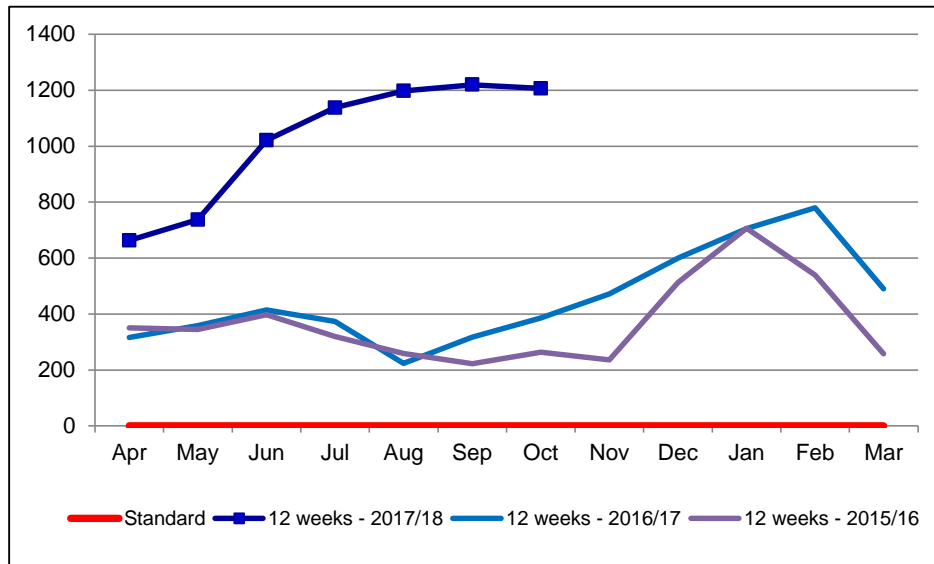
Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
74.4% (Jun 2017)	80.9% (Jun 2017)

	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	1207					
12 weeks - 2016/17	316	359	415	374	224	317	386	472	600	705	780	490
12 weeks - 2015/16	350	345	398	320	259	222	263	236	513	707	540	258
12 weeks - 2014/15	72	68	125	151	286	336	461	421	533	252	497	285

12 week breaches by specialty

2016/17	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Cardiology	3	31	47	59	64	119	130	161	153	173	190	174
Dermatology	183	283	322	272	178	270	305	439	446	493	547	586
Diabetes/Endocrinology	17	28	31	27	15	14	13	19	22	19	7	4
ENT						1	1		1			
Gastroenterology		19	37	32	10	9	32	57	85	105	85	74
General Medicine										3	1	
General Surgery		2	4	7	2	1	8	3	8	10	27	25
Gynaecology				1		1						
Neurology	7	19	16	4	1	2	17	45	60	54	70	65
Ophthalmology	2	53	70	143	87	99	88	168	216	193	201	210
Oral Surgery	167	50	24	8	4	1	44	63	79	77	46	33
Orthodontics	1	1			1							
Other	3	7	3	20	9	13	28	38	40	52	40	35
Pain Management	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	1
Urology	8	18	7	5		2	2	5	3	2	1	
All Specialties	472	600	705	780	490	663	737	1021	1138	1198	1220	1207

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



Narrative Summary:

The number of patients reported as waiting longer than 12 weeks has improved in October with extra activity being run across Cardiology, Gastroenterology and Oral Surgery however due to continuing capacity issues within a number of specialties, including Cardiology, Dermatology and Ophthalmology this still creates a long term issue. 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 it's longer term capacity issues.

Stage of Treatment - 12 Weeks Waiting Time for Inpatients

Standard: 12 Weeks Waiting Time for Inpatients

Standard
0

Tolerance
1

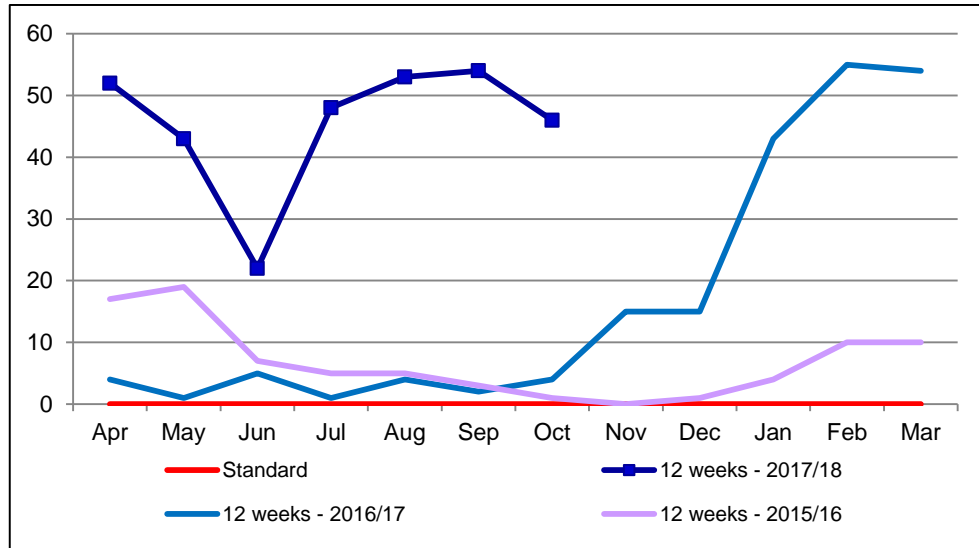
Actual Performance (lower = better performance)

	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	46					
12 weeks - 2016/17	4	1	5	1	4	2	4	15	15	43	55	54
12 weeks - 2015/16	17	19	7	5	5	3	1	0	1	4	10	10

12 week breaches by specialty

2016/17	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
ENT			3	1	1					1	2	2
General Surgery			1	2	1	3	10	4	2	4	1	
Gynaecology			1	1								
Ophthalmology									5	7	9	3
Oral Surgery				1	4					1	1	1
Other									1			
Trauma & Orthopaedics	15	15	37	49	48	49	32	18	40	40	41	40
Urology			1	1			1					
All Specialties	15	15	43	55	54	52	43	22	48	53	54	46

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



Narrative Summary:

At the end of October, the number of patients reported waiting over **12 weeks for inpatient treatment** reduced to 46. This was due to a smaller number of breaching Ophthalmology patients requiring treatment.

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: 12 Weeks Treatment Time Guarantee (TTG 100%)

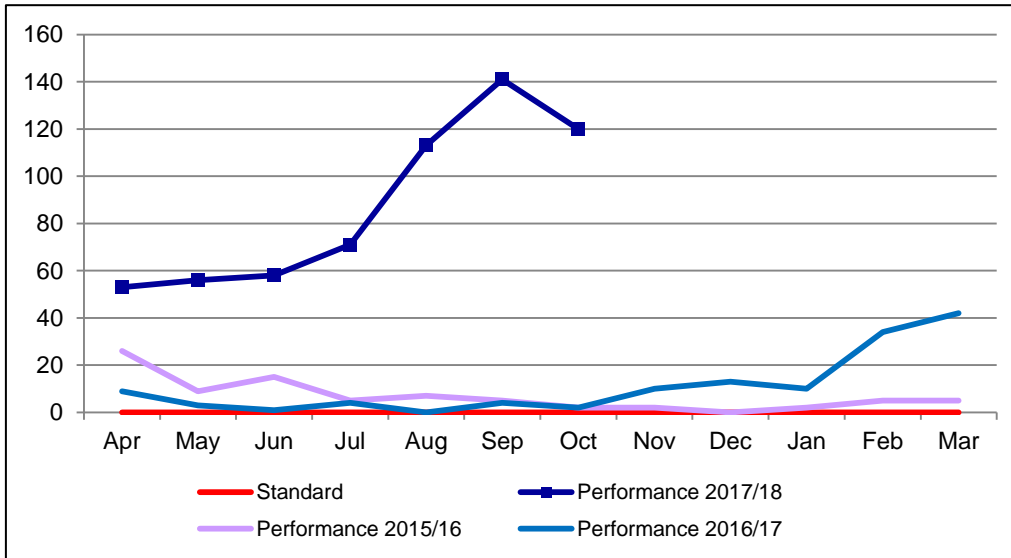
Standard
0

Tolerance
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	120					
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 October 120 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	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Unavailable	82	73	59	72	58	58	69	93	101	91	103	87	71
Patient Advised	44.1%	43.5%	47.6%	51.4%	40.8%	37.2%	41.8%	47.9%	50.2%	46.0%	55.7%	52.1%	45.2%
Unavailable	104	95	65	68	84	98	96	101	100	107	82	80	86
Medical	55.9%	56.5%	52.4%	48.6%	59.2%	62.8%	58.2%	52.1%	49.8%	54.0%	44.3%	47.9%	54.8%
Total Unavailable	186	168	124	140	142	156	165	194	201	198	185	167	157
Total % Unavailable	16.9%	17.3%	12.5%	13.2%	13.1%	14.3%	15.5%	18.9%	20.2%	17.9%	16.0%	14.2%	13.9%

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

Specialty	Available				Unavailable			
	0 - 9 Weeks	10 - 12 Weeks	12+ Weeks	Total	Medical Un-available	Patient Advised Un-available	Total	% Un-available
ENT	42	3	2	47	1	9	10	17.5%
General Surgery	124	25		149	14	10	24	13.9%
Gynaecology	44	3		47	5	1	6	11.3%
Ophthalmology	184	36	3	223	8	9	17	7.1%
Oral Surgery	34	15	1	50	1	2	3	5.7%
Other	23			23	2	2	4	14.8%
Trauma & Orthopaedics	267	56	40	363	47	34	81	18.2%
Urology	63	8		71	8	4	12	14.5%
Total	781	146	46	973	86	71	157	13.9%

Narrative Summary:

There has been a general downward trend over the past few months in the number of patients with patient advised unavailability that has decreased steadily since January. This is expected to increase as we move into the Christmas period. 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: Admitted Pathway Performance

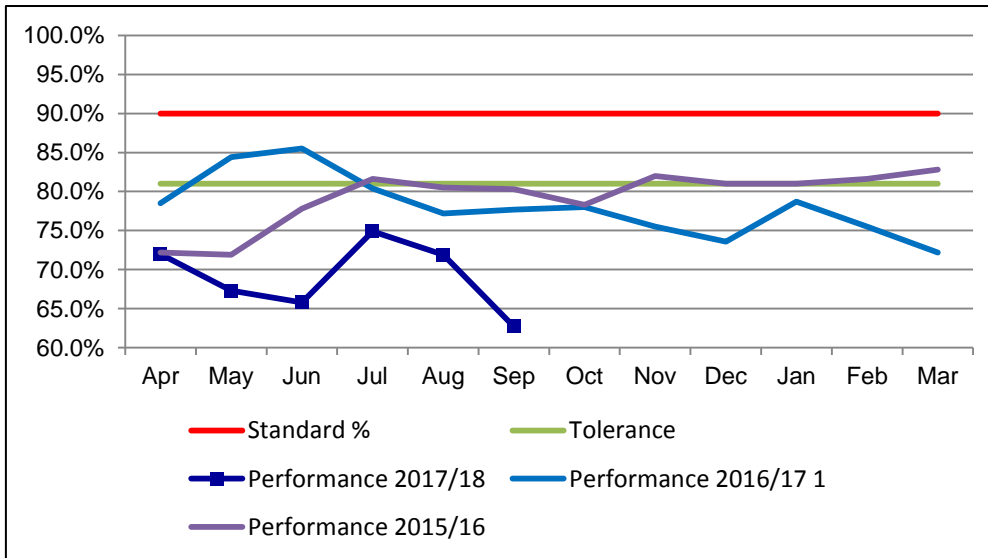
Standard
90.0%

Tolerance
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%	62.7%						
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. The performance has deteriorated due to long Outpatient and Inpatient combined waits mainly in Ophthalmology and Orthopaedic Surgery.

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: Admitted Linked Pathway Performance

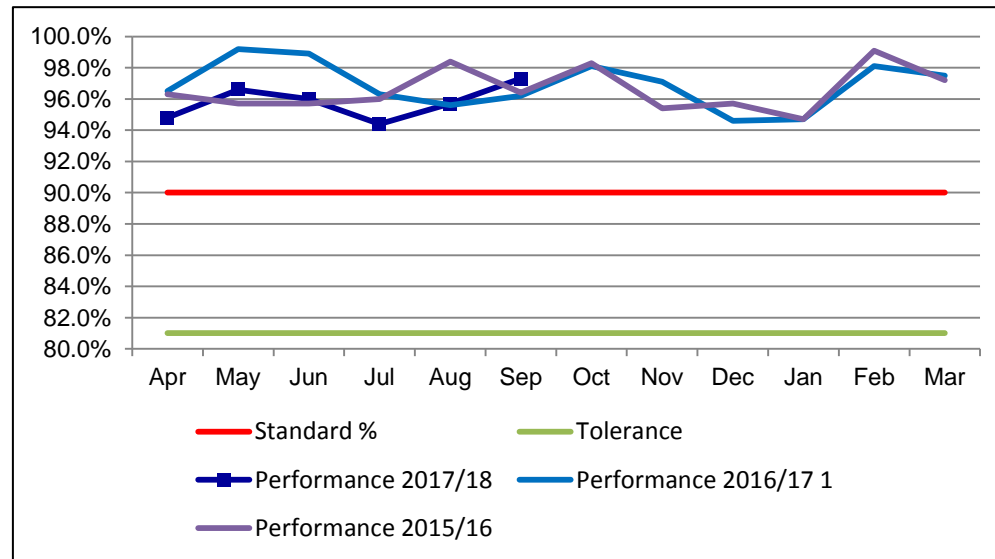
Standard
90.0%

Tolerance
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%	97.3%						
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: Non-Admitted Pathway Performance

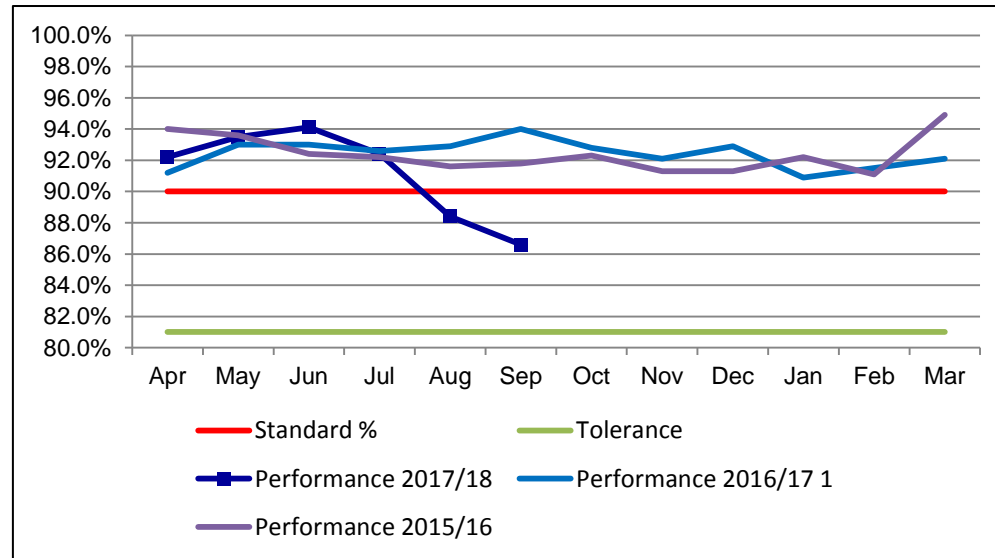
Standard
90.0%

Tolerance
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%	86.6%						
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 Cardiology and 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)

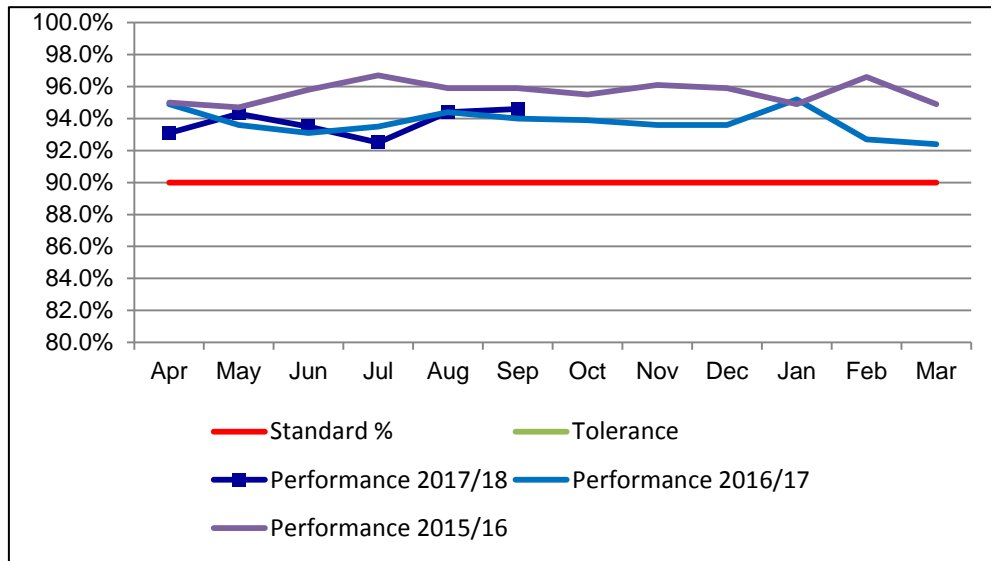
Standard: Non-Admitted Linked Pathway Performance

Standard
90.0%

Tolerance
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%	94.6%						
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: Combined Pathway Performance

Standard

90.0%

Tolerance

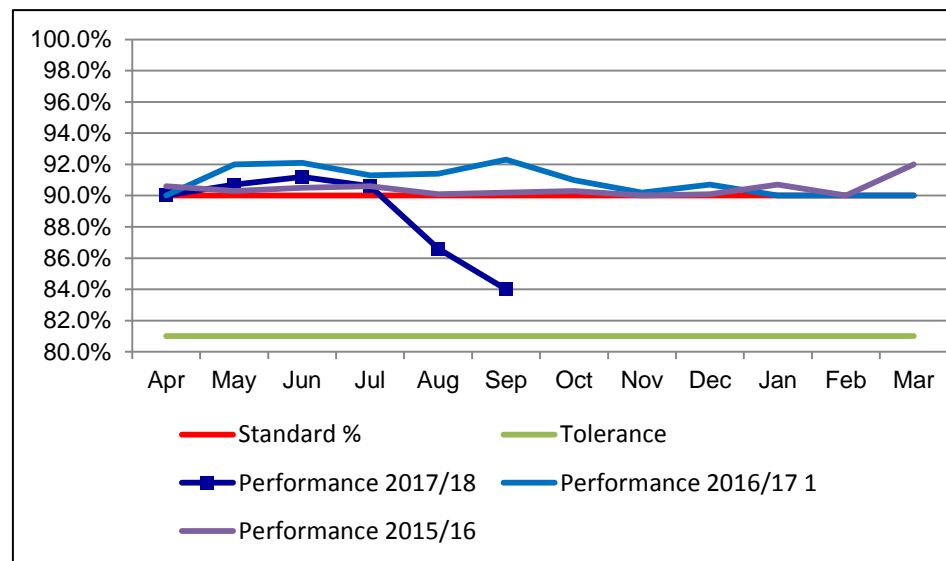
81.0%

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%	84.0%						
Performance 2016/17 ¹	90.0%	92.0%	92.1%	91.3%	91.4%	92.3%	91.0%	90.2%	90.7%	90.0%	90.0%	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%



Narrative Summary:

The national standard for NHS Boards RTT is to deliver 90% **combined performance**. In September 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 which has caused a combined wait of over 18 weeks. This is expected to worsen between now and March while extra activity is run in these specialties to reduce the waiting times. Additional funding was made available in October to start running additional clinics which commenced mid November. The performance blip was due to funding not been made available for the additional clinics earlier in the year and therefore due to various capacity issues i.e. staff shortages, demand was not being met.

Because the 18week RTT Combined Pathway Performance target is based on completed waits as the patients which have long waits are seen these will show as breaches. October is 86.1%, 84% prediction for November.

Actions:

- Work will continue during 2017/18 with the reduction in the number of 12 week breaches - a plan is in place to recover performance and achieve the target again by the start of 2018/19.

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

18 Weeks Referral to Treatment (RTT)

Standard: Combined Linked Pathway Performance

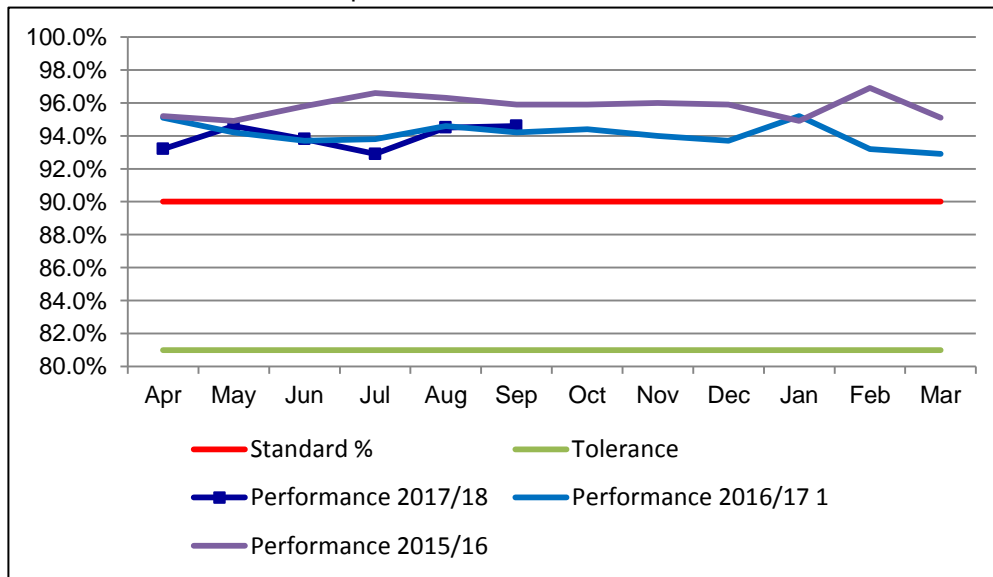
Standard
90.0%

Tolerance
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%	94.6%						
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: Waiting Target for Diagnostics - zero patients to wait over 6 weeks
(4 weeks is monitored locally as a stretch target)

Standard

0

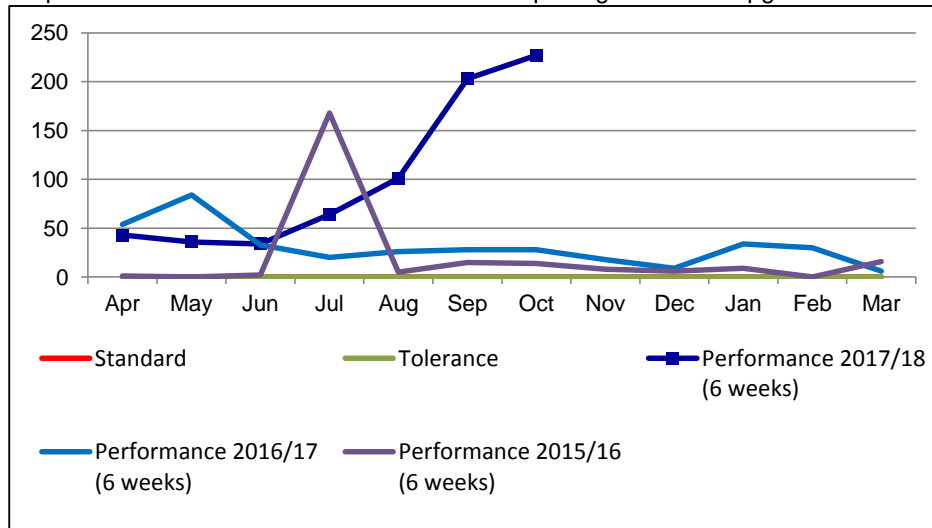
Tolerance

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	227					
Performance 2017/18 (4 weeks)	196	127	154	226	229	431	464					
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 unavailable at time for reporting due to the upgrade of 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.

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	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Endoscopy	-	-	-	-	-	-	-	-	-	-	-	-	-
Colonoscopy	-	-	-	25	29	6	36	18	6	7	-	-	-
Cystoscopy	-	-	-	8	-	-	-	-	-	-	-	-	1
MRI	-	-	-	1	1	-	3	18	27	56	100	187	189
CT	-	-	-	-	-	-	4	-	-	1	1	16	37
Ultra Sound (non-obstetric)	-	-	-	-	-	-	-	-	1	-	-	-	-
Barium	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	28	18	9	34	30	6	43	36	34	64	101	203	227

Diagnostic - 4 weeks	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Endoscopy	-	4	-	-	-	-	-	-	-	2	-	1	3
Colonoscopy	63	34	38	41	52	31	60	31	11	9	1	4	1
Cystoscopy	-	2	4	11	-	3	4	1	1	-	1	1	1
MRI	45	6	6	5	16	44	70	92	127	182	192	320	333
CT	33	5	8	2	25	34	52	-	13	30	33	97	103
Ultra Sound (non-obstetric)	-	8	-	-	2	2	10	3	2	-	-	-	18
Barium	-	3	-	-	-	-	-	-	-	3	2	8	5
Total	141	62	56	59	95	114	196	127	154	226	229	431	464

¹ September 2017 data has been updated as unavailable at time for reporting due to the upgrade of 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. Additionally the 3rd GI Consultant post has been filled and will be in post from December. The introduction of QFIT testing in January 2017 has allowed the more effective triaging and referral into Colonoscopy. A bid to the Scottish Government was successful in securing funding from March 2018 to continue this pilot for 3 further years.

Endoscopy – The 6 week standard has been met consistently and performance continues to be monitored.

Magnetic Resonance Imaging (MRI) & Computerised Tomography (CT) – The MRI service continues to be under pressure. The length of scans is increasing due to changing guidelines which has led to a reduction in throughput in terms of patient numbers. To combat this additional weekend sessions continue to be run however this is not keeping up with demand. A service proposal to meet current and future demand will be developed by the end of December 2017.

Ultrasound – The ultrasound service has staffing challenges at present due to multiple maternity leaves. Temporary hours have been recruited to and a locum is in place to offset the impact of this as far as 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	Jul to Sept 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%	100.00%
31-days standard	100%	100%	97.80%	100.00%	97.80%	98.20%	100%	98.18%	100%	100%	97.30%	96.90%	100.00%

Cancer Waiting Times

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

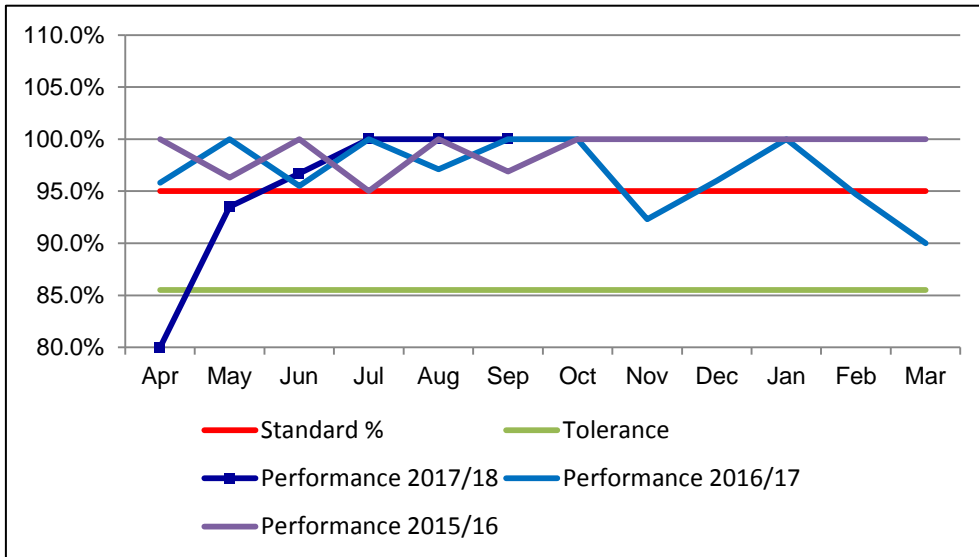
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
87.4% (Sept 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%	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 September 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

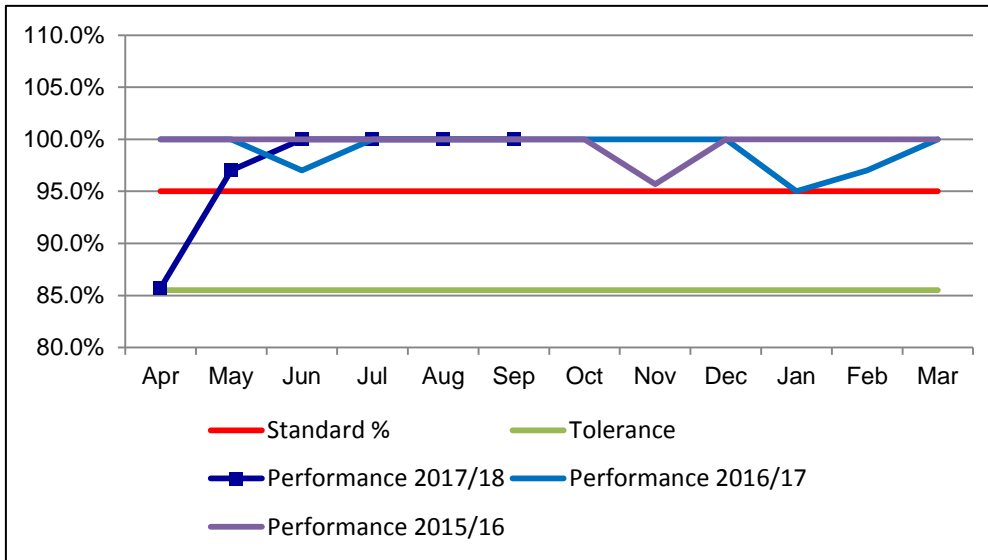
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
94.65% (Sept 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%	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 September 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

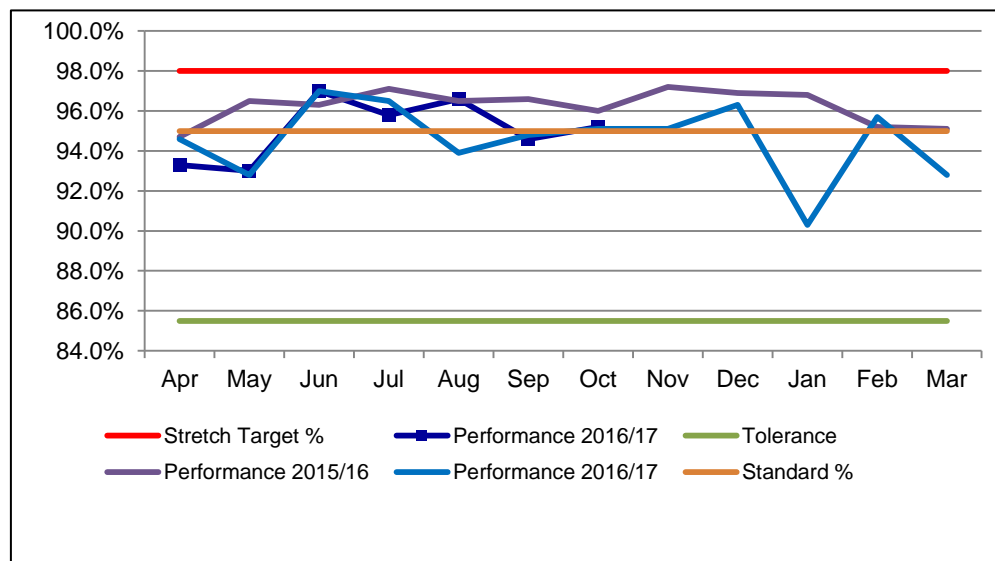
Standard: 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

Stretch Target	Standard	Tolerance
98.0%	95.0%	85.5%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
93.5% (Sept 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%	95.2%					
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	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Flow 1	97.0%	97.2%	98.3%	96.7%	97.7%	97.1%	96.9%	97.3%	98.4%	98.8%	98.9%	98.4%	98.8%
Flow 2	94.9%	92.2%	95.4%	92.9%	94.8%	92.5%	91.5%	91.8%	94.7%	93.6%	91.6%	89.5%	91.5%
Flow 3	92.3%	93.5%	93.4%	76.7%	92.5%	86.5%	92.0%	86.0%	95.1%	91.5%	93.7%	88.0%	89.5%
Flow 4	91.3%	91.9%	92.9%	87.6%	94.4%	82.1%	79.0%	85.5%	94.8%	91.7%	95.7%	94.5%	92.7%
Total	95.1%	95.1%	96.3%	90.3%	95.7%	92.8%	93.3%	93.0%	97.0%	95.8%	96.6%	94.6%	95.2%

Narrative Summary and Actions:

The Emergency Access Standard has increased since last month to between 95-98% performance. We achieved 95% standard for October. Flow 1 achievement confirmed above 98%.

The main reason for breaches was availability of beds, due to the rising number of Delayed Discharges. New initiatives will come on stream in December to reduce delayed discharges. There were a high number of breaches awaiting first medical assessment. This is related to a change in ED doctors and a loss of some experience.

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	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%	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%	77.8%																		
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

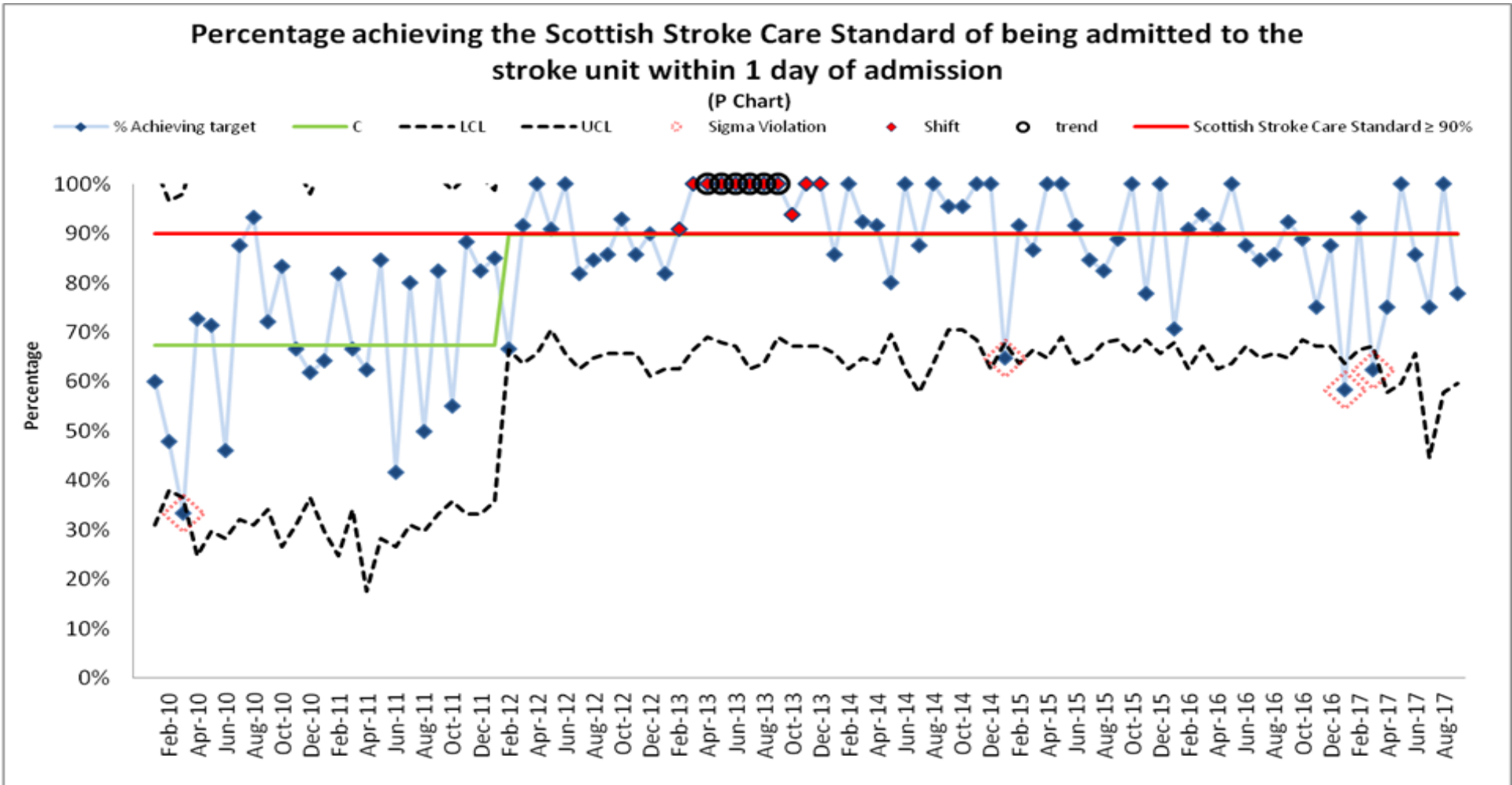
During September 2 out of 9 patients were not admitted to the Stroke Unit within 24 hours. One patient has other medical issues which resulted in the decision making and the other patient was not transferred in time. This has been raised with relevant staff.

Actions:

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

Please Note: Due to the time difference between the P&P deadline and the national extract deadline the Local Stroke report has a 1 month time lag. These reports are drawn from the Electronic Scottish Stroke Care Audit (eSSCA). A data snapshot is taken and used to compile these reports. Routine data collection and amendment takes place on a daily basis but data for more recent months should be interpreted with caution because delays in data entry may occur or data updates may be made after the snapshot was taken. The data in the tables above is reported at a point in time however the chart on the following page is updated monthly to reflect the most up to date information.

Stroke Bundle



Please Note: Due to the time difference between the P&P deadline and the national extract deadline the Local Stroke report will now have a 1 month time lag. These reports are drawn from the Electronic Scottish Stroke Care Audit (eSSCA). A data snapshot is taken and used to compile these reports. Routine data collection and amendment takes place on a daily basis but data for more recent months should be interpreted with caution because delays in data entry may occur or data updates may be made after the snapshot was taken. The chart is updated monthly to reflect the most up to date information. The data in the tables on the previous page is reported at a point in time.

Psychological Therapies Waiting Times

Standard: 18 weeks referral to treatment for Psychological Therapies

Standard	Stretch	Tolerance
90.0%	95.0%	81.0%

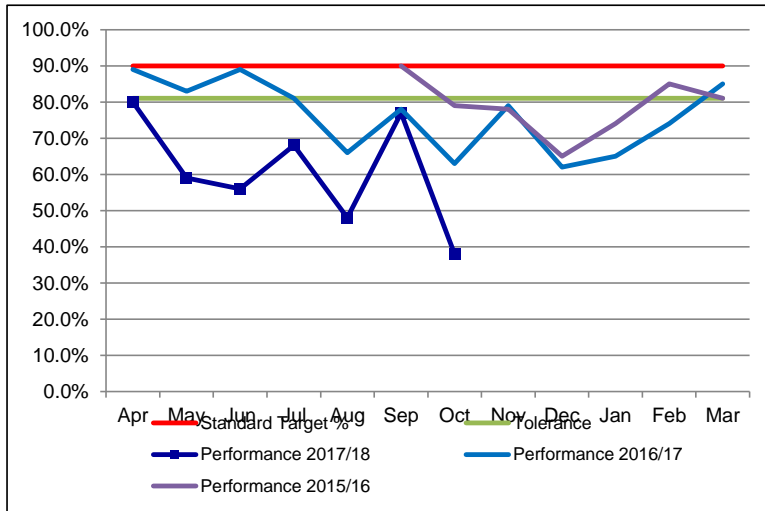
Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
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% ¹	77.0% ¹	38.0% ¹					
Total Patients Currently Waiting >18 Weeks:	93	102	129	132	120	140	132					
Performance 2016/17	89.0%	83.0%	89.0%	81.0%	66.0%	78.0%	63.0%	79.0%	62.0%	65.0%	74.0%	85.0%
Total Patients Currently Waiting >18 Weeks:	91	85	103	113	116	109	85	73	74	73	69	82
Performance 2015/16						90.0%	79.0%	78.0%	65.0%	74.0%	85.0%	81.0%
Total Patients Currently Waiting >18 Weeks:						22	53	62	55	50	68	83

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%

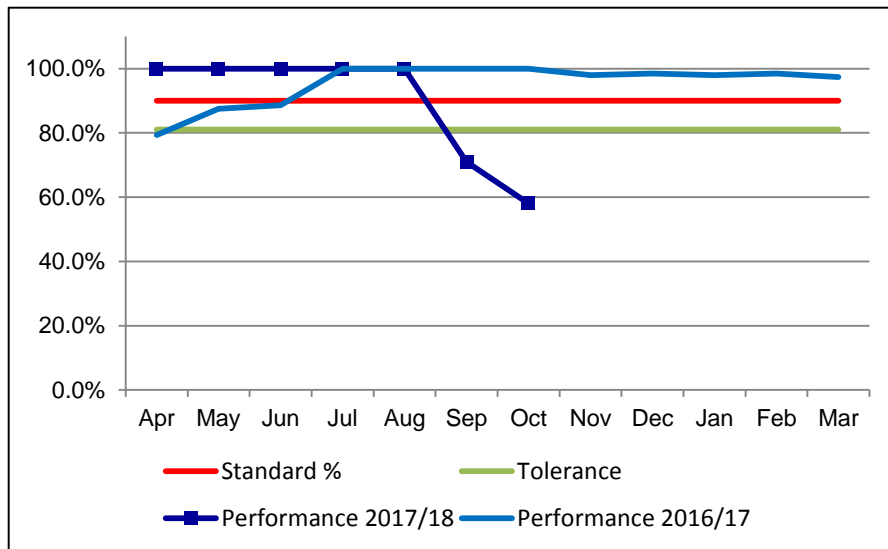
Actual Performance (higher % = better performance)

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% ²	71.0% ²	58.0%					
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



Narrative Summary:

The service consistently met both the national (90%) and local stretch (95%) standards for **CAMHS referral to treatment waiting times** between July 2016 and August 2017. However performance fell below both standards in September 2017 (71%) and October (58%).

The decrease in performance is due to vacant posts within the service, which have had a significant impact on the ability to meet the standards. Recruitment is underway and successful candidates are expected to start in post early in the New Year. Therefore it is expected that the service will meet the standards again by the end of March 2018.

Previously, referral criteria has been reviewed and amended to increase efficiency at point of receipt of referral and also at the final stages of the referral form being placed on SCI Gateway.

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.
- Continue to recruit to vacant posts.

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

90.0%

Tolerance

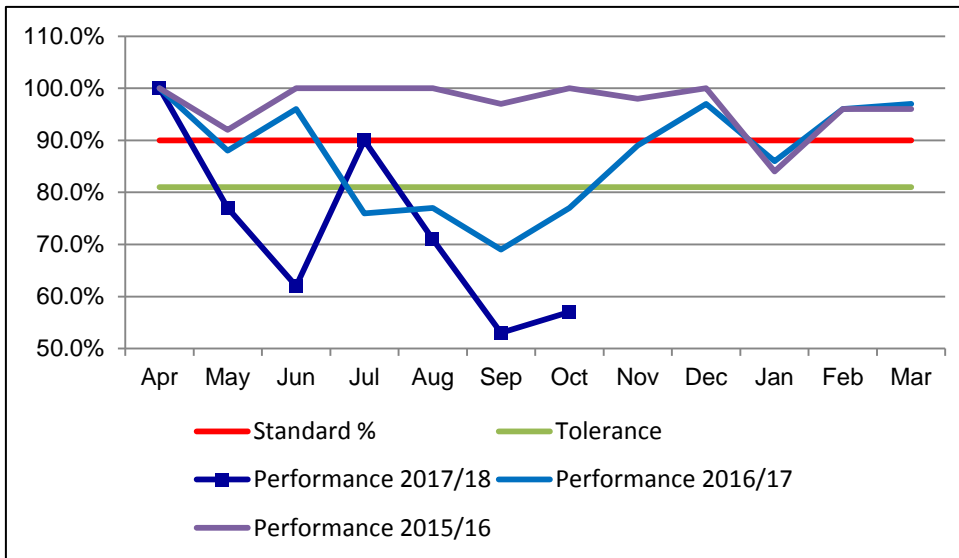
81.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance

93.0% (Aug 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%	57.0%					
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, 57% of clients started treatment within three weeks for the month of October.

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 57% of clients against a target of 90% for October

The BAS service has successfully recruited to the Team Manager post which will support 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. Significant efforts have been made in relation to the waiting times and improvement should be noted within the next reporting period.

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
0

Tolerance
1

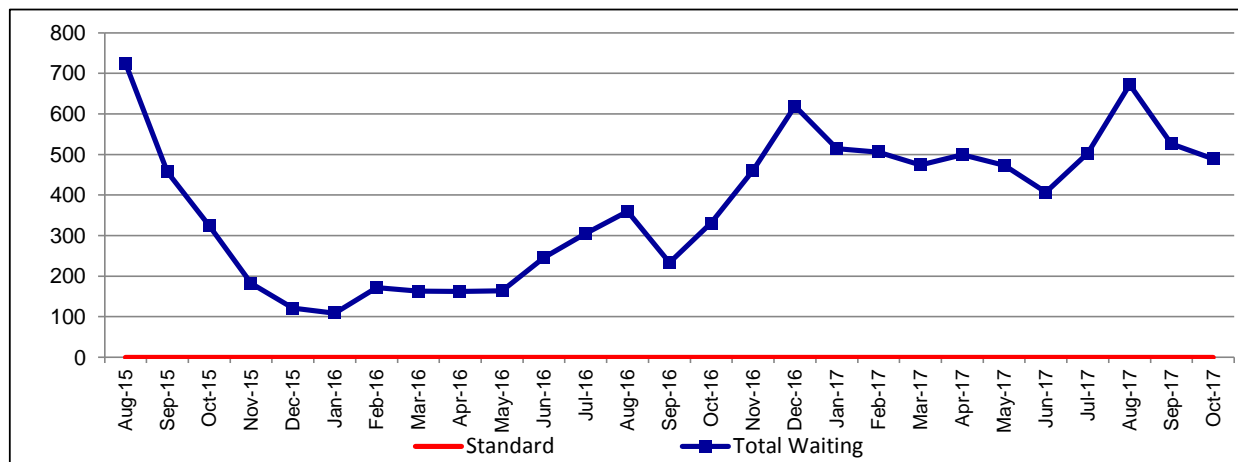
Actual Performance (lower = better performance)

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	331	461	619	514	506	474	499	473	407	503	672	526	489
Occupational Therapy	0	0	4	4	4	7	5	2	3	3	4	4	3
Physiotherapy	320	452	609	498	489	459	480	457	386	481	646	501	459
Podiatry	-	-	0	0	0	0	0	0	0	0	0	0	0
Speech & Language Therapy	2	0	0	0	0	0	0	1	0	1	2	1	1
Nutrition & Dietetics	9	9	6	12	13	8	14	13	18	18	20	20	26

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.

Paediatric services data is not included from September 2017 onwards as it is now recorded on EMIS and is currently unavailable. September totals have been amended.



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 programme 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

6.8% vacancy factor in October (11.8% within MSK speciality). 2.0wte locums were appointed in September to support waiting list management. 456 of patients are within MSK service with the remaining patients within older people services. Learning Disabilities and Paediatric physio data collection has moved onto EMIS. Mental Health to follow in November. Capacity across physiotherapy was reviewed with support of the Clinical Productivity Programme. New job plans were introduced across services to support staff. MSK templates being introduced in December 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 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 to work 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: Delayed Discharges - delays over 72 hours

Standard

0

Tolerance

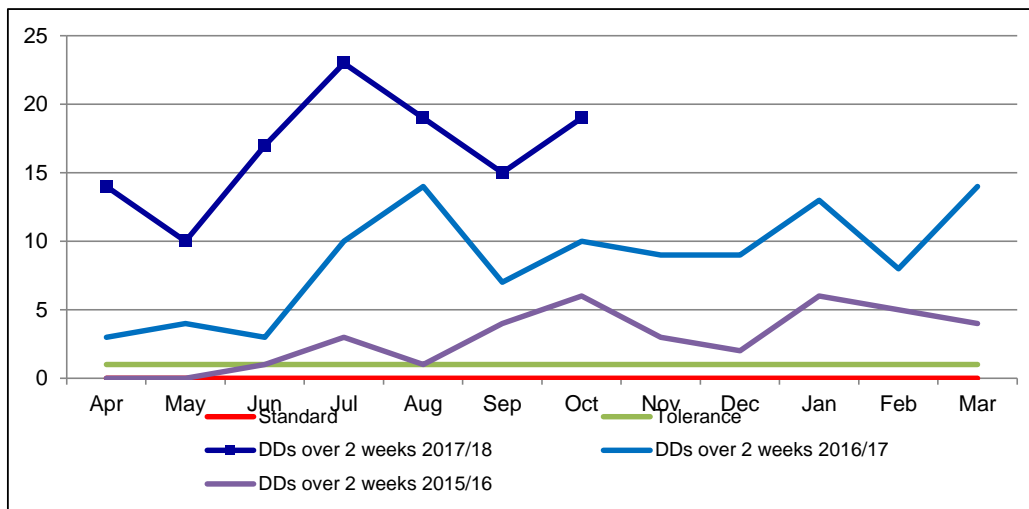
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Actual Performance (lower = better performance)

	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	19					
DDs over 72 hours (3 days) 2017/18	19	16	23	35	28	23	25					
Occupied Bed Days (standard delays)	814	664	675	984	872	831	920					
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.

In order to improve outcomes for patients and improve hospital flow a number of initiatives have been approved or are in the process of seeking approval. From 4th, December 2017, a discharge to assess facility which will be capable of admitting individuals when they are medically fit in order to undertake assessment in a more suitable environment, with a view to reducing dependence on formal services and building on strengths.

In Berwickshire, health care assistants have been employed to support discharge to home, working as part of a multi-disciplinary team in an area where it is challenging to secure traditional care at home packages. At this time, an additional pilot project is being discussed to develop a re-ablement approach to discharge straight from hospital with a dedicated team who will facilitate independence and reduce dependence on traditional services. Should assessment be required for on-going support, social work will work in partnership with colleagues in community health teams to better understand the critical needs of individuals in their own homes. This initiative will also contribute to reducing demand for residential care home placements by supporting individuals to retain and regain independent living skills for as long as possible.

Key Performance Indicators

Cancellations

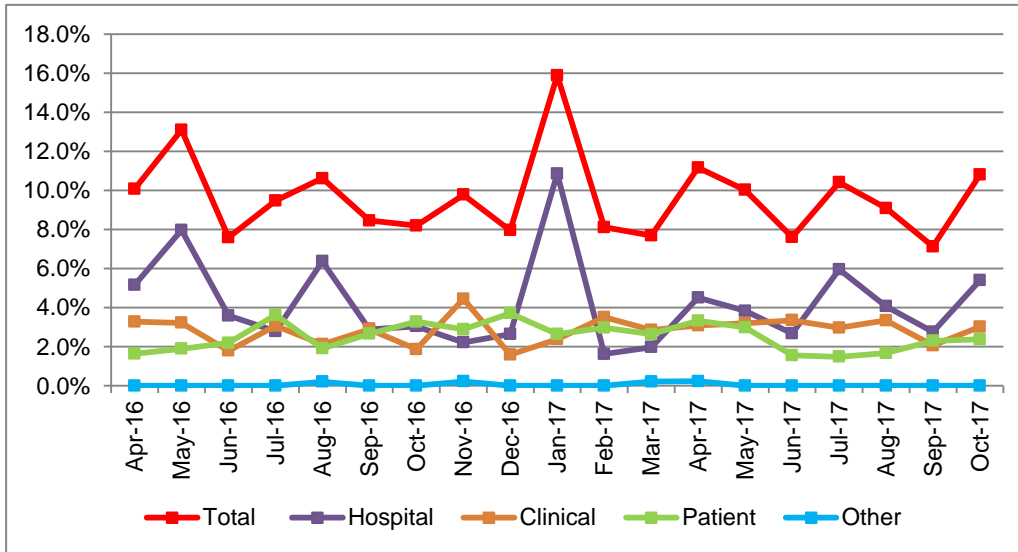
Hot Topic: Cancellations

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 %	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Total	9.8%	8.0%	15.9%	8.1%	7.7%	11.2%	10.0%	7.6%	10.4%	9.1%	7.1%	10.8%
Number	44	30	60	30	35	47	47	34	35	38	31	50
Hospital	2.2%	2.7%	10.8%	1.6%	2.0%	4.5%	3.8%	2.7%	6.0%	4.1%	2.8%	5.4%
Clinical	4.4%	1.6%	2.4%	3.5%	2.9%	3.1%	3.2%	3.4%	3.0%	3.3%	2.1%	3.0%
Patient	2.9%	3.7%	2.6%	3.0%	2.6%	3.3%	3.0%	1.6%	1.5%	1.7%	2.3%	2.4%
Other	0.2%	0.0%	0.0%	0.0%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%



Narrative Summary:

There was a deterioration of performance in October. 6 cancellations were due to no ward beds being available reflecting the pressure on the BGH bed base over this period. A further 3 cancellations were due to no ITU beds which was caused by an exceptionally busy period in ITU towards the end of October which carried on into November.

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 one elective bay to mitigate the impact of anticipated winter bed pressures and reduce the likelihood of cancellations over this period.

BGH Average Length of Stay

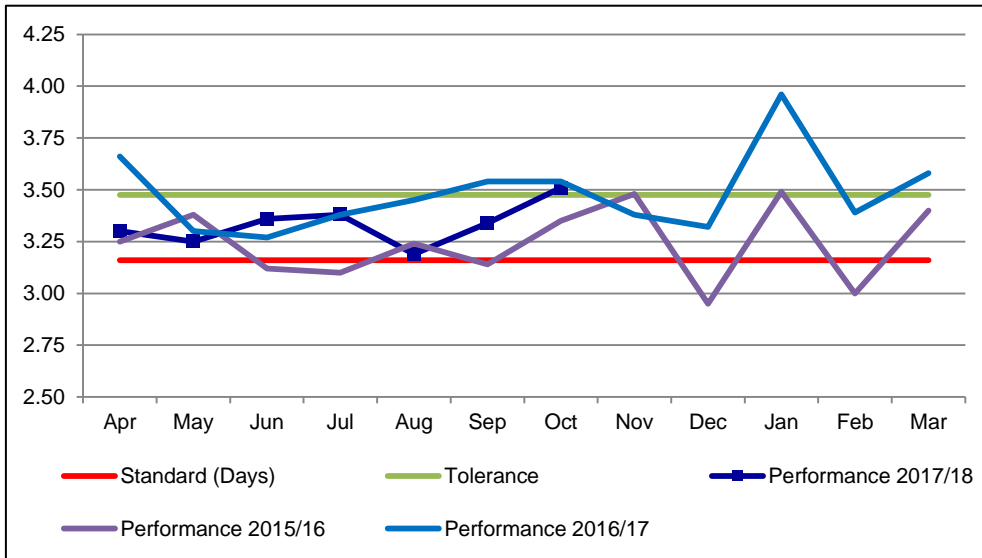
Standard: Reduce BGH Length of Stay

Target
3.16

Tolerance
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	3.51					
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 rose above 3.5 days in October. The increase is in Medicine and DME.

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. This is related to a 30% increase in Delayed Discharges between September and October. Average number of people delayed over 72 hours rose from 24.5 in September to 32 in October.

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: Reduce Community Hospital Average Length of Stay

Standard

18.0

Tolerance

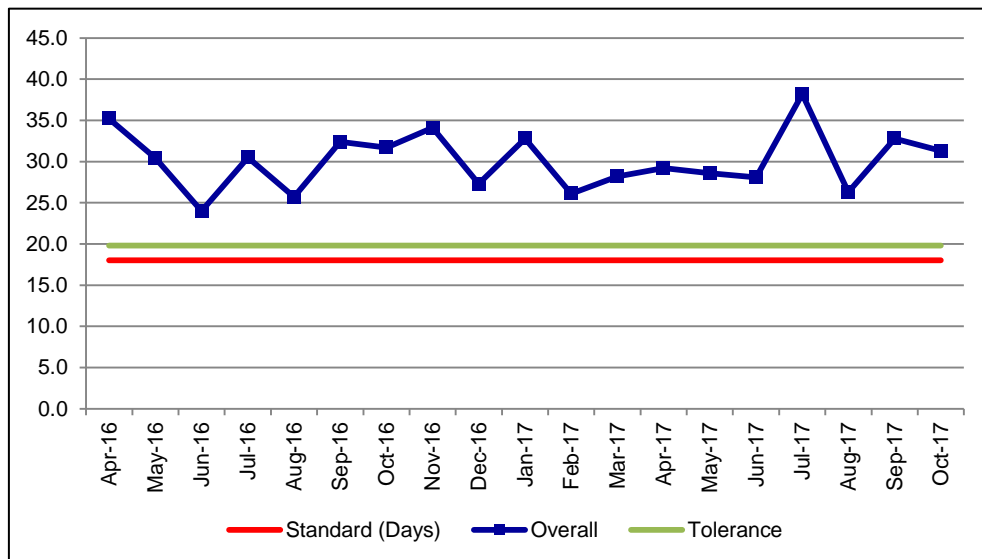
19.8

Actual Performance (lower = better performance)

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Standard (Days)	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0
Overall	34.1	27.3	32.8	26.1	28.2	29.2	28.6	28.1	38.2	26.3	32.8	31.3
Hawick	23.7	19.3	18.9	15.7	24.8	21.5	15.1	25.2	36.8	20.8	24.7	26.0
Hay Lodge ¹	35.2	20.4	70.1	29.5	36.5	23.7	34.3	26.2	34.2	49.4	41.6	30.9
Kelso	52.5	40.0	41.2	32.6	20.2	40.1	32.5	23.2	27.2	18.0	31.3	31.1
Knoll	35.3	56.4	31.3	37.5	38.2	40.2	54.4	42.9	78.3	32.6	39.1	39.6

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. The lack of care home places and packages of care is having a significant impact on the LOS. 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 was due to report by mid December , but has been delayed until mid January.
- A Community Hospital Project Board is being established to progress the recommendations made by Dr Anne Hendry.

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

Standard: Reduce Mental Health Average Length of Stay

Standard
Various

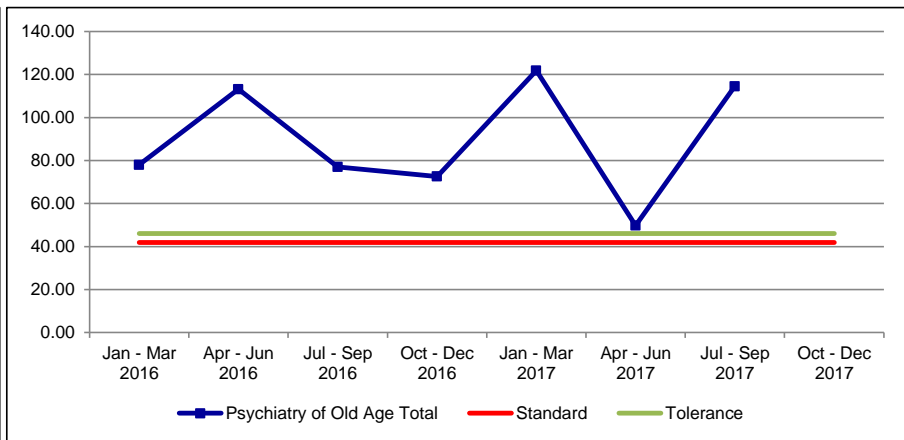
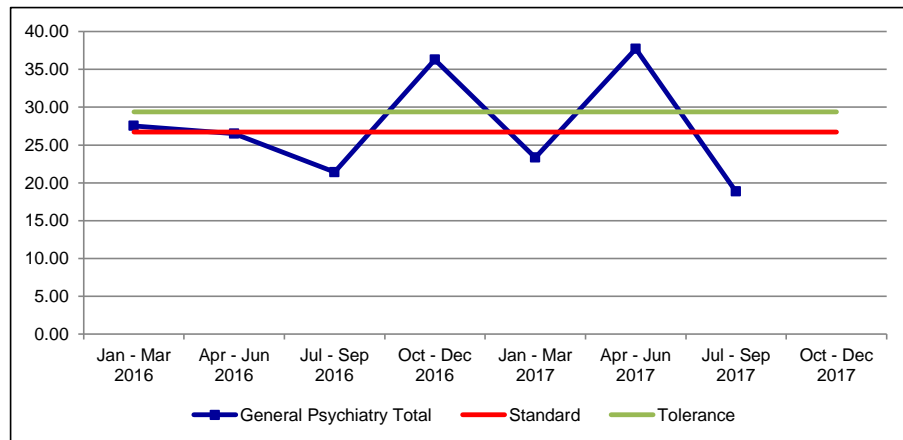
Tolerance
within 10%

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	
Cauldsheels	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. 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: Patients Waiting over 9 weeks as at month end

Standard

0

Tolerance

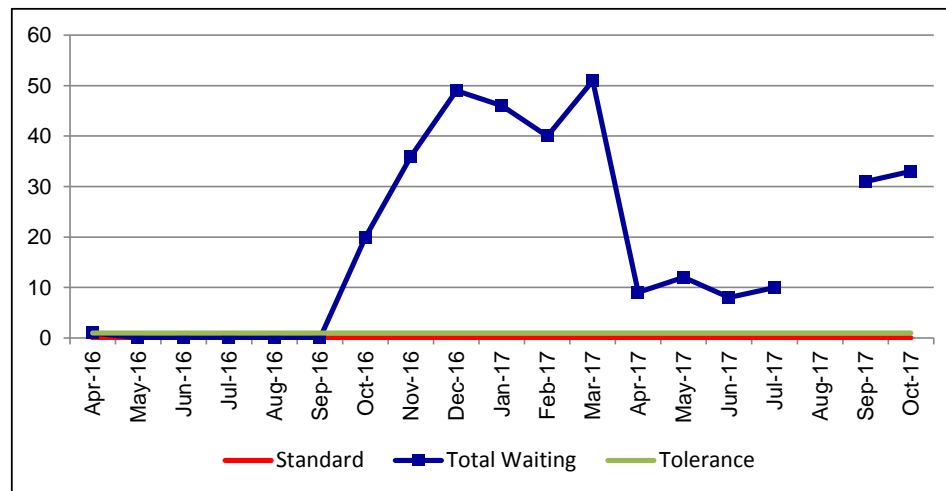
1

Actual Performance (lower = better performance)

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17 ¹	Sep-17	Oct-17
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	36	49	46	40	51	9	12	8	10	-	31	33
MH Older Adults - East	0	1	1	0	0	2	1	0	0	-	1	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	2	3	0	4	-	2	2
East Team	20	24	23	23	33	2	1	1	2	-	3	7
South Team	5	11	11	10	10	0	0	2	3	-	2	0
West Team	11	13	11	7	8	3	7	5	1	-	23	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 October 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: Monitor and reduce Learning Disability Waiting Times

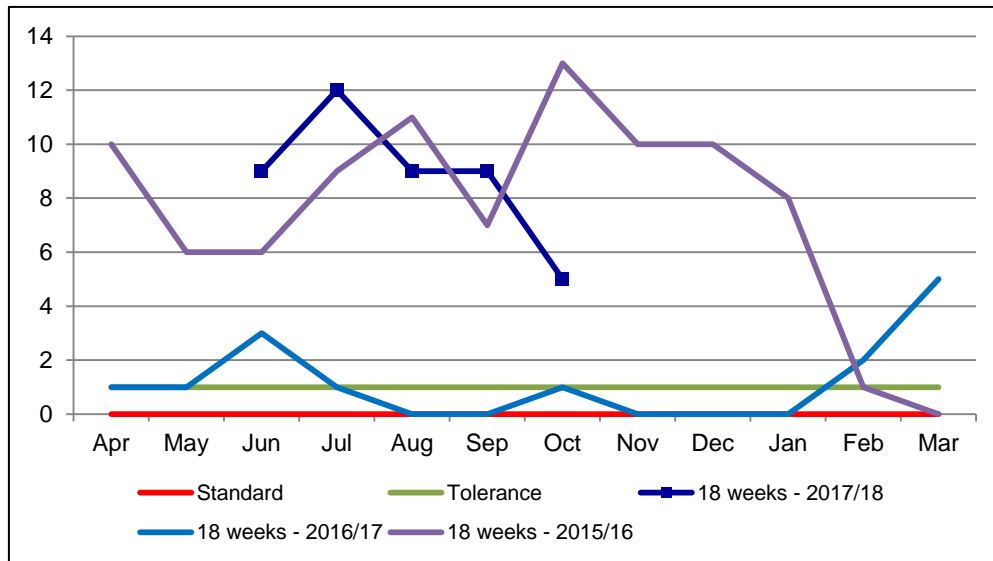
Standard
0

Tolerance
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	5					
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 5 **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 waiting breaches due to the recruitment of therapists into post. Actions continue as below.

Actions:

- Vacant posts have contributed to the increase in waiting times. A Psychologist started in post 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)

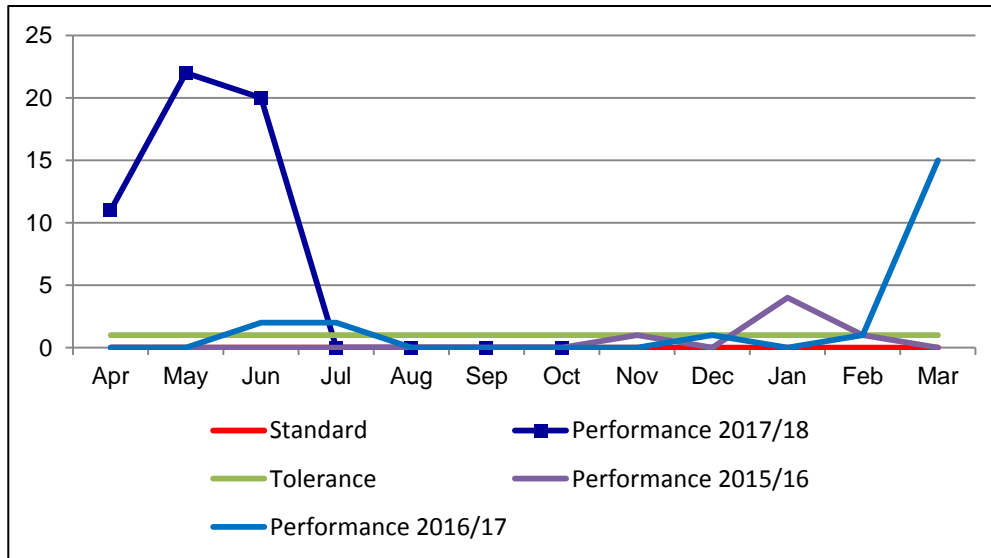
Standard: 1 Week Waiting Target for RACPC

Standard
0

Tolerance
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	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 October 2017 there were 0 patients waiting over **1 week for the Rapid Access Chest Pain Clinic**. The improvement has been sustained for 4 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: 18 Week Referral to Treatment for Audiology

Standard
90.0%

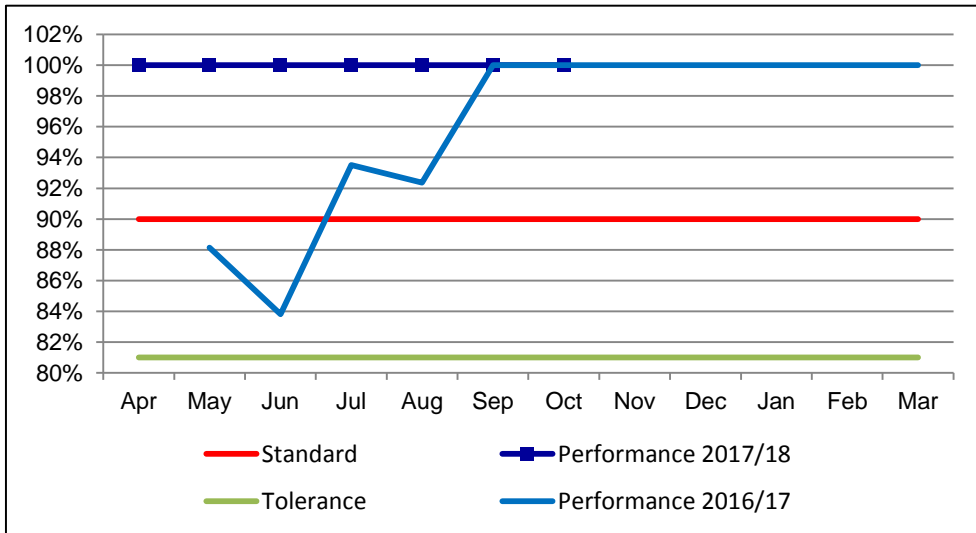
Tolerance
81.0%

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%	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	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: Supplementary staffing - agency spend per month

Standard

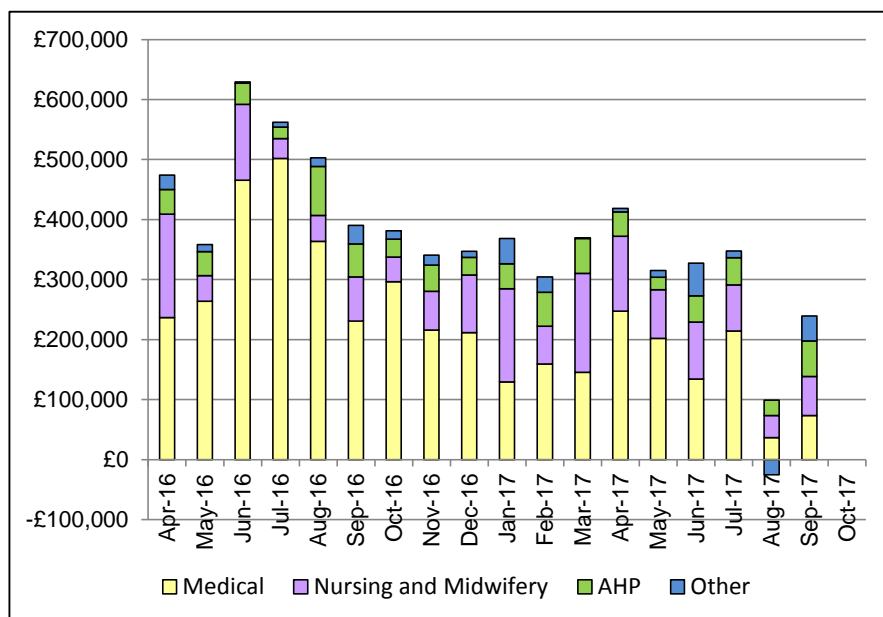
0

Tolerance

0

Actual Performance (lower = better performance)

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Medical	£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	£64,863	£96,168	£155,234	£62,839	£165,022	£124,708	£80,778	£95,194	£76,940	£36,821	£65,110	
AHP	£43,515	£29,487	£41,959	£56,410	£57,901	£40,298	£20,876	£43,664	£45,327	£25,717	£59,055	
Other	£16,768	£10,015	£42,159	£25,611	£1,328	£6,160	£11,033	£54,626	£11,197	£-25,138	£41,395	
Total Cost	£340,763	£347,045	£368,522	£304,396	£369,698	£418,687	£314,890	£327,453	£347,759	£74,096	£239,144	£0



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.

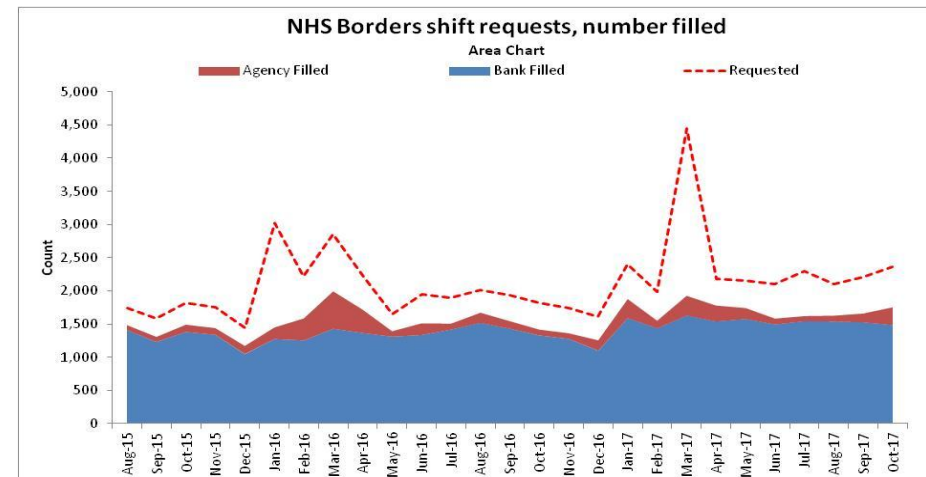
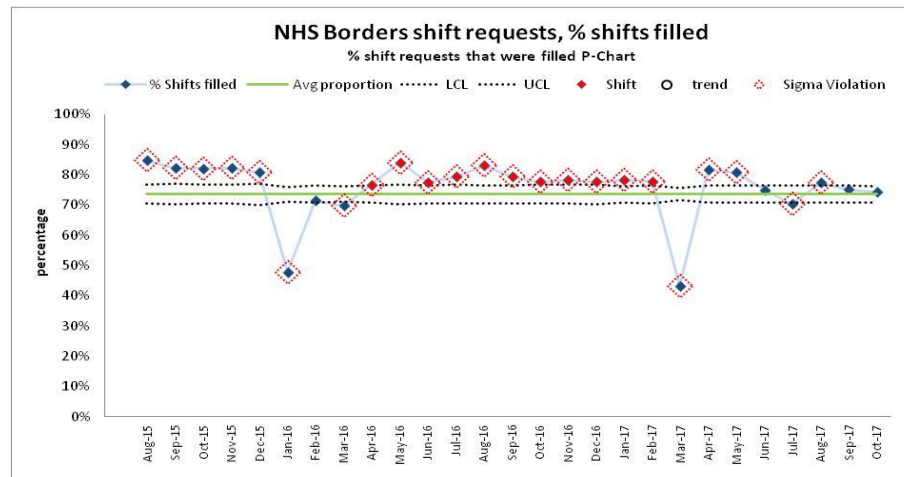
Actions:

- 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 rose for the second month in a row. An increase in October of 148 bank requests compared to September and an increase of 136 agency shifts.

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.

Overall - There has been an overall increase in requests for supplementary staff across NHS Borders for a second month. Possible contributing factors – Noro virus, school holidays and patient dependency.

BGH - Patient Dependency and 1-1's accounted for 570 shift requests within the BGH in October. The second highest month in the last 2 years.

Actions update:

- To date the open band 5 advert has received 2 applicants
- The Recruitment event on the 26th of October appointed 44 HCSW's and 2 Registered Nurses
- The service are looking at 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*

