Borders NHS Board

NHS BORDERS PERFORMANCE SCORECARD – MARCH 2018

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 March 2018.

Background

The monthly Performance Scorecard is presented regularly 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 and Psychological Therapy 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	Jan-18	Feb-18	Mar-18
Green – achieving standard	10	11	9
Amber – nearly achieving standard	5	5	6
Red – outwith standard	16	15	16

Key Performance Indicators	Jan-18	Feb-18	Mar-18
Green – achieving standard	4	3	2
Amber – nearly achieving standard	2	1	1
Red – outwith standard	7	9	10

Due to the transfer from Epex to Emis Community web, we have been unable to report performance against the CAMHS standard routinely. We have now produced a manual report which shows a significant decline in performance. We are undertaking a review of the manual report to ensure accuracy but we do believe that there has been a decline in performance against this target. An urgent and thorough examination of likely causative factors is underway. The current rationale for this reduction in performance is a combination of staffing availability and significant changes in management within the

service. All available staff are now prioritising patient appointments over and above less critical activity and we are urgently reviewing processes and practice to ensure the efficient use of resources. Longer term measures are being considered to ensure greater resilience going forward. We are aiming to significantly improve performance over the next few months and a return to meeting the HEAT target within 6 months.

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

Areas of strong performance from the LDP Standards and Access to Treatment sections in the Scorecard for the position as at 31st March 2018 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 **same day surgery** was achieved during January 2018 (latest available data) with 86.7% of patients being admitted on the day of surgery (page 18)
- The standard for **pre-operative stay** was achieved during January 2018 (latest available data) 0.06 days against the standard of 0.47 (page 19)
- 93.4% of all referrals were **triaged online** in March 2018, above the standard of 90% (page 20)
- 39.2% of new born children were **breastfed at 6-8 weeks** for the quarter October – December 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 February 2018 (latest available data) (pages 34-38)
- 100% of patients **requiring treatment for cancer** were seen within **31 days** in February 2018 (latest available data) (page 43)

The Board are asked to note that the following standards have been outwith the 10% tolerance (red status) for 3 or more consecutive months at 31st March 2018. 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 trajectory set for the full 2017/18 year (page 13)
- **Smoking Cessation** – performance has been outwith the trajectory set for the full financial year 2016/17 and for the first 2 quarters of 2017/18 (page 14)
- **Sickness Absence** – performance reported outwith the 10% tolerance of the 4.0% standard for the full 2017/18 year (page 15)
- **Outpatient DNA Rate** – performance has been outwith the 10% tolerance of the 4.0% standard for 3 consecutive months (page 17)
- **eKSF and PDP** – performance is outwith the standard set for the first 10 months of this year (latest available data) (page 22)
- **12 weeks Outpatient Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year (page 27-28)
- **12 weeks Inpatient Waiting Times** – performance reported outwith the standard for the full 2017/18 year (page 29-30)

- **12 week Treatment Time Guarantee** – performance reported outwith the standard for the full 2017/18 year (page 31)
- **Admitted Pathway Performance** – performance reported outwith the 90% standard for the full 2017/18 year (page 33)
- **6 week Diagnostic Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year (page 39)
- **Psychological Therapies Waiting Times** – performance reported outwith the 10% tolerance of the standard for 10 consecutive months (latest available data) (page 48)
- **CAMHS Waiting Times** – performance reported outwith the 10% tolerance of the standard for 3 consecutive months (latest available data) (page 49)
- **AHP Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year (page 51)
- **Delayed Discharges** – performance is consistently reported outwith the standard for the full 2017/18 year (page 55)

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

Summary

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

Recommendation

The Board is asked to **note** the March 2018 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	Performance against key indicators within this report have been reviewed by each Clinical Board and members of the Clinical Executive.
Risk Assessment	There are a number of standards that are not being achieved, and have not been achieved recently. For these standards service leads continue to take corrective action or outline risks and issues to get the standard back on trajectory. 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	Impact Equality Assessment Scoping Template has been completed. The implementation and monitoring of targets will require that Lead Directors, Managers and Clinicians comply with Board requirements.
Resource/Staffing Implications	The implementation and monitoring of standards will require that Lead Directors, Managers and Clinicians comply with Board requirements

Approved by

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

Author(s)

Name	Designation	Name	Designation
Carly Lyall	Planning & Performance Officer		

NHS Borders

PERFORMANCE SCORECARD

As at 31st March 2018

March 2018

Planning & Performance

Month

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Contents

INTRODUCTION

DASHBOARD OF HEAT STANDARDS

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

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

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

Direction Symbols

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

LDP Standards

Every year the Scottish Government Health Department (SGHD) asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report is called the Local Delivery Plan (LDP) and forms an agreement on what Health Boards will achieve in the next year with SGHD. Boards are asked to work towards a number of key standards for the year which fit with the Government's health objectives. The Local Delivery Plan for 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 ↑	A ↑	A ↓	A ↓	A ↑	A ↓
Dementia Post Diagnostic Support [1] (2016/17 data)	R -	-	-	R ↑	-	-	R ↑	-	-	-	-	-
Alcohol Brief Interventions [2]	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑
Smoking cessation successful quits in most deprived areas [3]	-	-	R -	-	-	R ↑	-	-	-	-	-	-
Sickness Absence Reduced	R ↑	R ↓	R ↑	R ↑	R ↓	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 ↔	G ↓	G ↑	G ↑	G ↓	A ↓	-
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [4]	R ↓	G ↑	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	-
18 Wk RTT: 12 wks for outpatients	R ↓	R ↓	R ↓	R ↓	R ↓	R ↓	R ↑	R ↑	R ↑	R ↓	R ↑	R ↑
18 Wk RTT: 12 wks for inpatients	R ↑	R ↑	R ↑	R ↓	R ↓	R ↓	R ↑	R ↓	R ↓	R ↓	R ↓	R ↑
18 Wk RTT: 12 weeks TTG	R ↓	R ↓	R ↓	R ↓	R ↓	R ↓	R ↑	R ↑	R ↑	R ↑	R ↓	R ↓
18 Wk RTT: Admitted Pathway Performance [5]	R ↓	R ↓	R ↓	R ↑	R ↓	R ↓	R ↑	R ↓	R ↑	R ↓	R ↓	-
18 Wk RTT: Admitted Pathway Linked Pathway [5]	G ↓	G ↑	G ↓	G ↑	G ↓	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 ↓	A ↑	A ↔	A ↑	A ↓	A ↑	-
18 Wk RTT: Non-admitted Pathway Linked Pathway [5]	G ↑	G ↑	G ↓	G ↓	G ↑	G ↑	G ↓	G ↑	G ↓	G ↑	G ↑	-
Combined Performance [5]	G ↔	G ↑	G ↑	G ↓	A ↓	A ↓	A ↑	A ↑	A ↔	A ↓	A ↑	-
Combined Performance Linked Pathway [5]	G ↑	G ↑	G ↓	G ↓	G ↑	G ↑	G ↓	G ↑	G ↓	G ↑	G ↑	-
6 Week Waiting Target for Diagnostics	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓
4-Hour Waiting Target for A&E	A ↑	A ↓	G ↑	G ↓	G ↑	A ↓	G ↑	A ↓	A ↓	A ↑	A ↑	A ↓
No CAMHS waits over 18 wks [6]	G ↑	G ↔	G ↔	G ↔	G ↔	R ↓	R ↓	R ↑	-	-	-	-
No Psychological Therapy waits over 18 wks [6]	R ↓	R ↓	R ↓	R ↓	R ↓	R [7] ↑	R ↓	R ↑	R ↑	-	-	-
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G ↑	R ↓	R ↓	G ↑	R ↓	R ↓	R ↑	R ↑	A ↑	A ↓	G ↑	G ↔
No Delayed Discharges over 72 hours (3 days)	R ↓	R ↑	R ↓	R ↓	R ↑	R ↑	R ↓	R ↓	R ↑	R ↑	R ↑	R ↓
New patient DNA rate	R ↓	A ↑	R ↓	R ↑	R ↓	R ↓	R ↑	A ↑	A ↔	R ↓	R ↑	R ↑
Same day surgery [8]	A ↓	G ↑	A ↓	A ↑	A ↓	A ↓	G ↑	G ↑	A ↓	-	-	-
Pre-operative stay [8]	G ↑	G ↑	G ↓	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
Online Triage of Referrals	G ↑	G ↓	G ↓	G ↑	G ↓	G ↑	G ↓	G ↑	G ↓	G ↑	G ↑	G ↑
Increase the proportion of new-born children breastfed at 6-8 weeks [9]	-	-	G ↑	-	-	G ↓	-	-	G ↑	-	-	-
eKSF annual reviews complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	- [10]	- [10]
PDP's Complete	R -	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	- [10]	- [10]
Emergency OBDs aged 75 or over (per 1,000) 11	G ↓	A ↓	G ↑	-	-	-	-	-	-	-	-	-
Admitted to the Stroke Unit within 1 day of admission [12]	R ↑	A ↑	G ↑	R ↓	G ↑	G ↔	R ↓	R ↓	R ↑	G ↑	R ↓	-

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 - data is reported quarterly
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 Data unavailable for CAMHS and Psychological Therapy at time of reporting due to system data moving the EMIS.
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 Data unavailable for February & March 2018 as the system is changing over to TURAS
11 There is a 6 month lag in reporting any data included is the most up to date data available.
12 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 ↑	R ↑	R ↓	R ↓	R ↓	- [1]
Cancellations	Hospital	R ↓	R ↑	R ↑	R ↓	R ↑	R ↑	R ↓	R ↓	R ↓	R ↓	R ↓	R ↑
	Clinical	A ↓	R ↓	R ↓	A ↑	R ↓	G ↑	R ↓	G ↑	G ↓	G ↓	R ↓	G ↑
	Patient	G ↓	G ↑	G ↑	G ↑	G ↓	G ↓	G ↓	R ↓	G ↑	R ↓	G ↑	R ↓
	Other	G ↔	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↓	R ↑
Borders General Hospital Average Length of Stay		A ↑	A ↑	A ↓	A ↓	A ↑	A ↓	R ↓	R ↓	A ↑	R ↓	R ↑	R ↓
Community Hospitals Average Length of Stay		R ↓	R ↑	R ↑	R ↓	R ↑	R ↓	R ↑	R ↓	R ↑	R ↓	R ↓	R ↑
Mental Health Average Length of Stay General Psychiatry Total [2]		-	-	R ↓	-	-	G ↑	-	-	A ↓	-	-	R ↓
Mental Health Average Length of Stay Psychiatry of Old Age Total [2]		-	-	R ↑	-	-	R ↓	-	-	R ↓	-	-	R ↑
Mental Health Waiting Times (Patients waiting over 9 weeks)		R -	R ↓	R ↑	R ↓	-	R -	R ↓	R ↓	R ↓	- [1]	- [1]	- [1]
Learning Disability Waiting Times (Patients waiting over 18 weeks)		-	-	R -	R ↓	R ↑	R ↔	R ↑	R ↑	R ↓	R ↓	R ↓	R ↑
Rapid Access Chest Pain Clinic		R ↑	R ↓	R ↑	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔	G ↓	R ↓	A ↑
Audiology 18 Weeks Waiting Times		G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↓	G ↓

Footnotes

1 Data unavaiable at time of reporting due to migration to EMIS

2 Mental Health ALOS reported quarterly

The following standards cannot be reported on a monthly basis and the table below indicates how progress will be reported.

Standard Area	Standard Descriptor	Standard Date	Standard	Frequency of Reporting
Cancer	Increase proportion of 1st stage breast, colorectal and lung diagnosis by 25%	Mar-18	25% increase	Managing Our Performance Report – 6 and 12 month intervals
Antenatal Services	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation	Mar-18	80%	Managing Our Performance Report – 6 and 12 month intervals
IVF	Commence IVF Treatment within 12 months	Mar-18	All patients	Managing Our Performance Report – 6 and 12 month intervals
CDI	Clostridium difficile infections per 1000 occupied bed days (0.32)	Mar-18	0.32 bed days	Managing Our Performance Report – 6 and 12 month intervals and the Healthcare Associated Infection, Prevention and Control Report
SAB2	SAB infections per 1000 acute occupied bed days (0.24)	Mar-18	0.24 bed days	Managing Our Performance Report – 6 and 12 month intervals and the Healthcare Associated Infection, Prevention and Control Report
GPAccess	48 hour access or advance booking to an appropriate member of the GP team (90%)	Mar-18	90%	Managing Our Performance Report – 6 and 12 month intervals
Breakeven	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement	Mar-18	-	Managing Our Performance Report – 6 and 12 month intervals

LDP Standards:

General

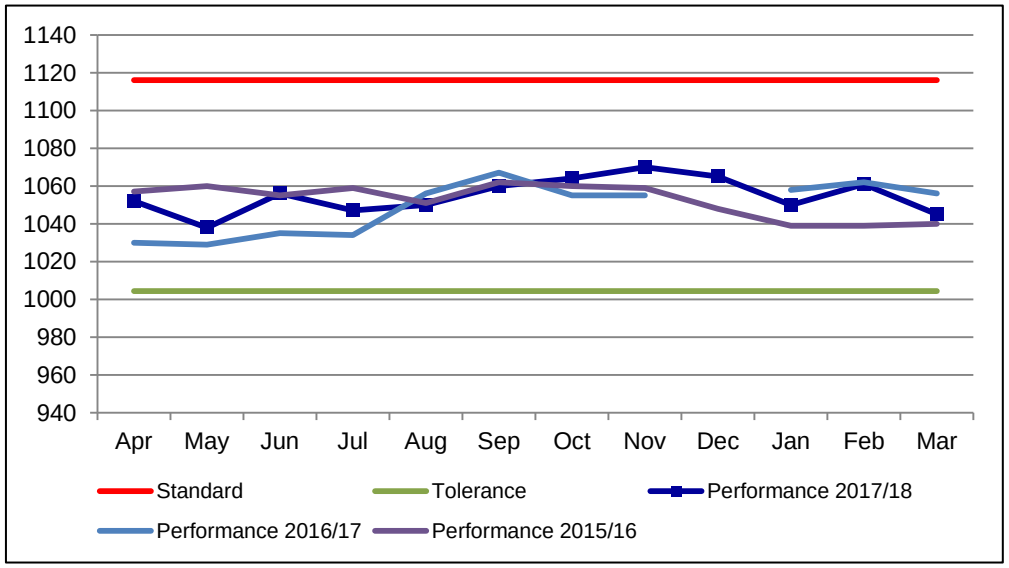
Diagnosis of Dementia

	Standard	Tolerance
Standard: Increase the number of patients added to the dementia register	1116	1004

Actual Performance (higher = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	1116	1116	1116	1116	1116	1116	1116	1116	1116	1116	1116	1116
Performance 2017/18	1052	1038	1056	1047	1050	1060	1064	1070	1065	1050	1061	1045
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 ideas around why the standard is not improving - patients diagnosed with Dementia may not be being recorded clearly on ePEX; assessment letters not including clear diagnosis, and lack of clarity around the process GPs use to update the Dementia Register.

The gap analysis work is now complete and data has been collated into an update report for the Clinical Executive Operational Group in March 2018. Although there was an increase in diagnoses in October and November 2017 as a result of this work, the gap analysis did not have the sustainable impact we hoped.

Actions:
- A pathway has been mapped to highlight challenges from referral to diagnosis / communication with GPs
- Gap analysis work is now complete as above.

Dementia - Post Diagnostic Support (PDS)

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

Actual Performance (higher % = better performance)

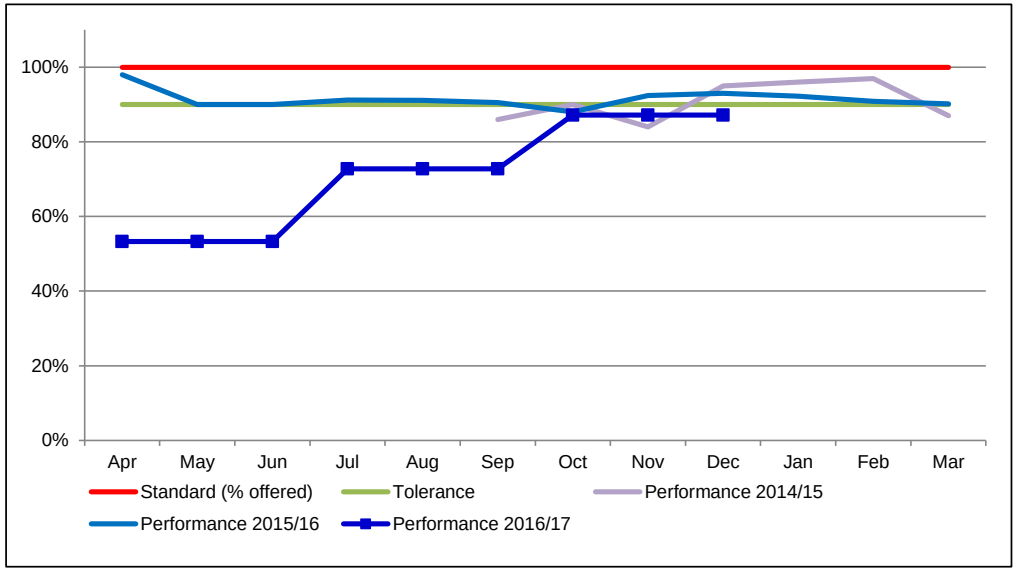
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (% offered)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of People who are referred for PDS and have been offered at least 12 months of PDS												
Performance 2016/17 [2]	137	137	137	151	151	151	153	153	153			
Performance 2015/16	135	140	166	186	205	220	229	255	281	297	310	321
Performance 2014/15						75	77	32	54	71	97	107
The Number of People who are Diagnosed with Dementia and Referred for PDS												
Performance 2016/17 [1]	-	-	-	-	-	-	-	-	-	-	-	-
Performance 2015/16	138	156	185	204	225	243	260	276	302	322	341	356
Performance 2014/15						87	86	38	57	74	100	123
Percentage offered at least 12 months of PDS												
Performance 2016/17 [2]	53%	53%	53%	73%	73%	73%	87%	87%	87%			
Performance 2015/16	98%	90%	90%	91%	91%	91%	88%	92%	93%	92%	91%	90%
Performance 2014/15						86%	90%	84%	95%	96%	97%	87%

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

[1] Data no longer available due to change in reporting method

[2] April - December 2016/17 data updated in January 2018 scorecard as data now in a format that can be accessed

Dementia - Post Diagnostic Support (PDS) *continued*



Narrative Summary:
Performance for **Dementia Post-Diagnostic Support** (PDS) had shown an improvement until October 2015 (year lag time) when the standard was outwith 10% tolerance. This has since improved.

Actions:
- A meeting is arranged with ISD to review and clarify the data reporting process - this has been postponed until the new recording process is in place
- A PDS checklist is in use within the older adults service to ensure appropriate pillars are delivered
- Consideration is being given to develop a leaflet for both patients (to outline expectations) and staff (to help delivery) - other health boards are being looked at for examples. A temporary post has been put in place to carry out this work and develop an overall PDS protocol.

Alcohol Brief Interventions (ABI)

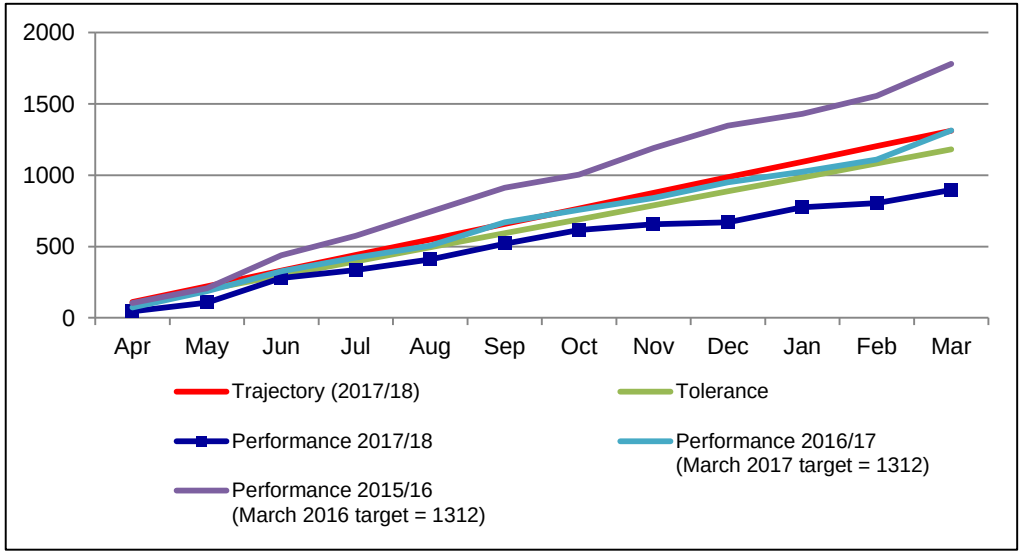
Standard: Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings	**Standard**	**Tolerance**
	1312	within 10%

Actual Performance (higher = better performance)

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.45% (Jun 2017)	52.74% (Jun 2017)

	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	656	670	776	805	897
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:
The total number of **Alcohol Brief Interventions (ABI)** delivered in 2017/18 was 897 against a target of 1312 (68%). As previously reported staff absence and turnover has had an impact on various areas including custody and A&E. Activity via LES is much lower than previous years despite reassurance about the status of the payment agreement for this year.

Actions:
- Custody suite - we have met with Police and NHS service for custody to review the pathway and establish training to increase performance. We are liaising with those above regarding processing data and planning training for new staff in Custody Suites.
- The vacant post of Substance Misuse Liaison Nurse in BGH as now been filled and anticipate numbers to improve for 2018/19.
- We are in the process of planning introduction of **ABI's in Health Visiting** (although these numbers will be low).
These actions will not impact on performance until after April 2018.

Smoking Quits

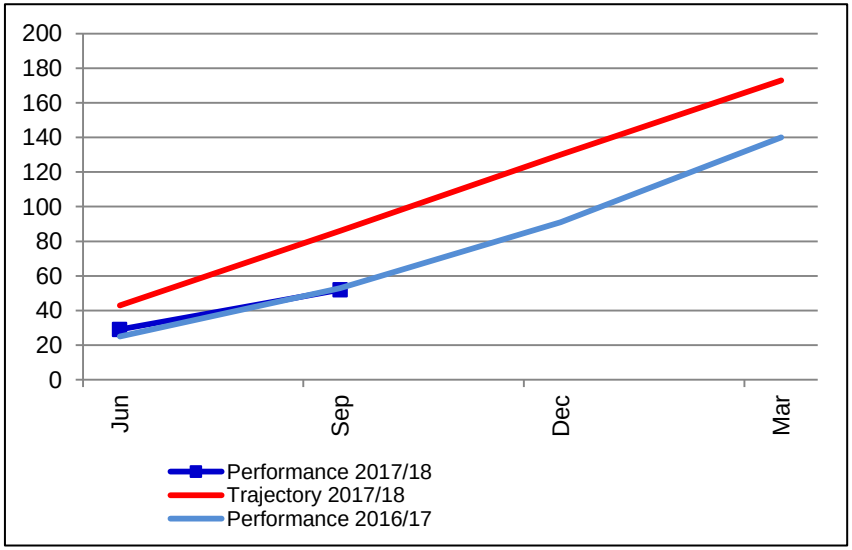
	Standard	Tolerance
Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas	173	within 10%

Actual Performance (higher = better performance)

	Jun	Sep	Dec	Mar
Trajectory 2017/18	43	86	130	173
Performance 2017/18	29	52		
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:
Verified ISD data for Q3 is due imminently and we are anticipating our data to show around 80 **smoking quit attempts** which is slightly down on the previous year. To date our number of overall quit attempts is similar to last year.

Actions:
- Quit Your Way (QYW) relies on referrals from colleagues in order to meet its target. To support this the following actions have been undertaken:
- Smoking cessation services have recently been incorporated into a national branding - Quit your way. We have worked with Communications to raise awareness of the branding and are refreshing information across surgeries etc.
- QYW continue to actively market via Facebook and displays within the hospital.
- QYW advisors are attending Stroke MCN in May to discuss an 'opt out' pathway and a session at Pulmonary Rehab group.
- A specialist training is planned in May for Midwifery colleagues to aim to increase engagement with pregnant smokers.

Sickness Absence

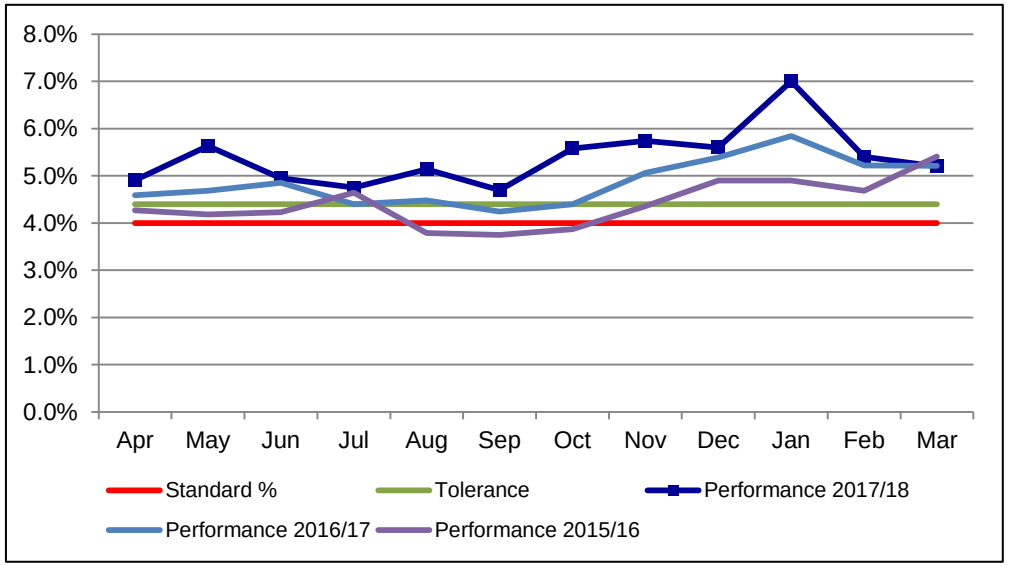
Standard: Maintain Sickness Absence Rates below 4%

Standard	Tolerance
4.0%	4.4%

Actual Performance (lower % = better performance)

Latest NHS Scotland Performance
5.22% (Feb 2018)

	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%	5.7%	5.6%	7.0%	5.4%	5.2%
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 reports a **Sickness Absence** rate in March of 5.2% which is an improvement of 0.2% from February 2018. The last NHS Scotland figure was 5.22% for the month of February 2018. 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 2018 has been completed and identified areas of further work to support the wellbeing of staff.

Sickness Absence *continued*

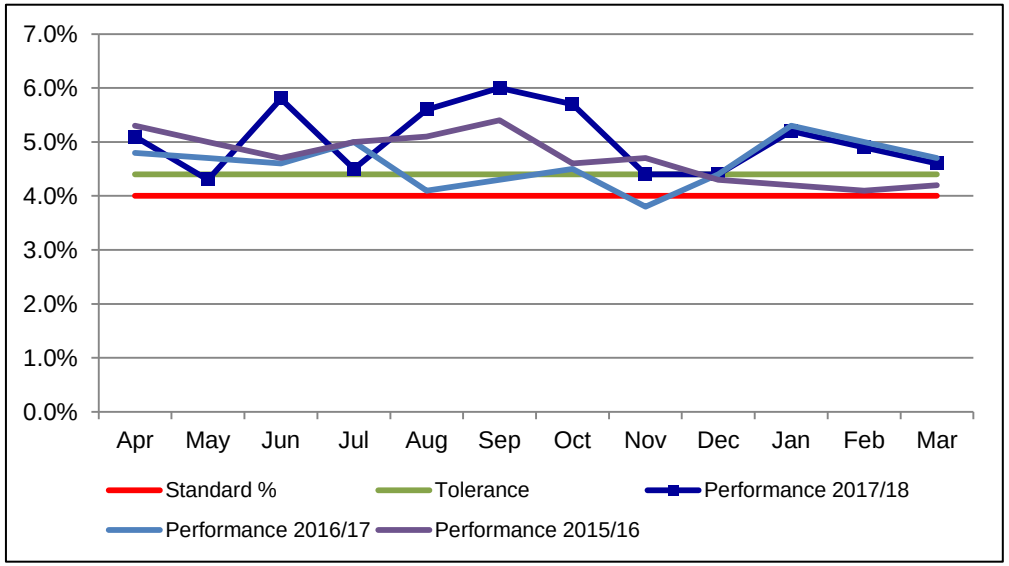
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Learning Disabilities (Div/CHP)												
Administrative Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.97	0.00	0.00
Allied Health Professionals	0.00	0.00	0.00	0.00	0.00	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	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	14.71	10.52	19.46	0.77	1.86
Grand Total	13.70	19.64	17.57	10.07	6.07	0.94	7.42	11.29	8.07	16.06	0.59	1.52
Mental Health (Div/CHP)												
Administrative Services	6.73	4.64	1.77	0.75	9.39	4.54	7.06	8.72	7.44	5.71	2.54	0.75
Allied Health Professionals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.46	3.03	16.23	12.05	0.00
Medical & Dental	3.43	1.61	4.45	7.07	5.53	8.03	10.21	6.79	6.80	4.58	0.93	2.40
Nursing / Midwifery	6.76	7.90	6.71	7.38	8.19	7.23	7.66	7.51	4.43	4.90	5.18	5.08
Other Therapeutic	0.00	4.06	4.73	5.26	3.35	5.28	1.16	2.58	3.54	4.61	2.53	1.91
Personal & Social Care	0.00	0.00	0.00	0.00	0.00	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	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	6.91	4.76	5.10	4.41	3.99
Primary, Acute & Clinical Services												
Administrative Services	3.19	4.84	4.37	5.42	3.72	3.34	2.28	3.23	3.66	5.55	3.17	4.70
Allied Health Professionals	2.68	3.33	2.92	2.60	2.43	2.19	2.63	5.10	4.77	6.26	6.36	6.13
Dental Support	4.68	5.25	4.42	4.81	9.03	2.50	8.02	10.21	4.76	3.84	5.45	7.77
Health Care Sciences	3.19	5.59	4.16	4.20	5.43	2.92	4.98	5.28	5.39	7.43	6.66	5.88
Medical & Dental	2.55	1.72	2.19	2.00	2.01	1.33	1.18	1.58	1.60	2.84	2.79	3.16
Medical Support	0.00	0.00	0.00	0.00	1.30	0.00	0.00	2.45	0.00	5.75	0.00	0.00
Nursing / Midwifery	5.94	6.51	5.44	5.42	6.14	6.32	7.45	6.48	7.39	8.51	6.11	6.68
Other Therapeutic	0.00	0.00	0.00	0.00	4.28	0.00	2.67	0.00	8.20	0.00	0.00	0.00
Personal & Social Care	0.00	16.55	23.97	1.07	0.82	3.12	7.06	4.68	2.46	4.93	5.84	0.58
Support Services	4.42	5.88	5.76	6.58	6.60	7.88	2.79	3.92	2.34	10.01	9.51	5.28
Grand Total	4.63	5.27	4.57	4.59	4.97	4.64	5.31	5.29	5.65	7.02	5.43	5.89
Support Services (Div/CHP)												
Administrative Services	5.26	5.45	4.99	4.41	4.82	3.96	5.31	5.23	4.52	5.95	4.02	3.37
Allied Health Professionals	0.00	4.00	0.00	3.91	1.56	0.59	1.41	16.93	0.00	1.30	10.48	6.45
Health Care Sciences	0.00	0.00	0.00	10.78	2.94	0.00	1.89	0.00	0.00	0.00	6.86	1.96
Medical & Dental	0.00	6.62	2.21	0.00	3.36	0.00	0.00	0.00	3.15	6.20	0.00	4.42
Nursing / Midwifery	1.50	1.05	1.08	1.48	3.66	3.79	4.57	5.76	9.07	10.14	7.23	3.78
Other Therapeutic	4.84	5.05	2.46	2.32	2.09	2.08	3.22	6.91	5.64	9.11	7.60	3.47
Personal & Social Care	6.61	7.45	4.24	5.84	6.10	2.99	3.37	2.83	5.50	6.48	6.05	9.79
Senior Managers	0.27	0.00	0.00	0.00	0.00	0.00	0.80	0.00	0.53	3.71	2.65	7.96
Support Services	5.56	6.95	6.85	5.01	5.02	4.92	6.83	7.22	6.92	7.93	7.09	5.32
Grand Total	4.98	5.72	5.17	4.30	4.50	4.05	5.56	6.14	5.80	7.21	5.90	4.45

Outpatient DNA Rates

	Standard	Tolerance
Standard: New patients DNA rate will be less than 4% over the year	4.0%	4.4%

Actual Performance (lower % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Performance 2017/18	5.1%	4.3%	5.8%	4.5%	5.6%	6.0%	5.7%	4.4%	4.4%	5.2%	4.9%	4.6%
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 March 2018 reports an slight improvement at 4.6%, the past 4 months have shown a similar trend to 2016/17.

Actions:
Staffing in Records is currently insufficient to assign staff where possible to telephone patients with a history of missed appointments.

Same Day Surgery

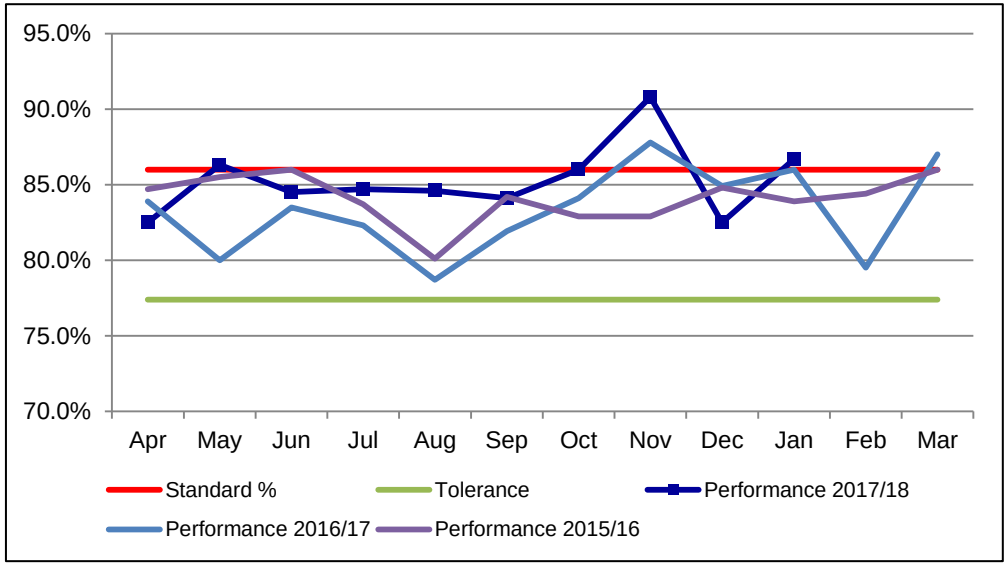
	Standard	Tolerance
Standard: 86% of patients for day procedures to be treated as Day Cases	86.0%	77.4%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
Performance 2017/18	82.5%	86.3%	84.5%	84.7%	84.6%	84.1%	86.0%	90.8%	82.5%	86.7%		
Performance 2016/17	83.9%	80.0%	83.5%	82.3%	78.7%	81.9%	84.1%	87.8%	84.9%	86.0%	79.5% [1]	87.0%
Performance 2015/16	84.7%	85.5%	86.0%	83.7%	80.1%	84.2%	82.9%	82.9%	84.8%	83.9%	84.4%	86.0%

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

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



Narrative Summary:
The standard 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*

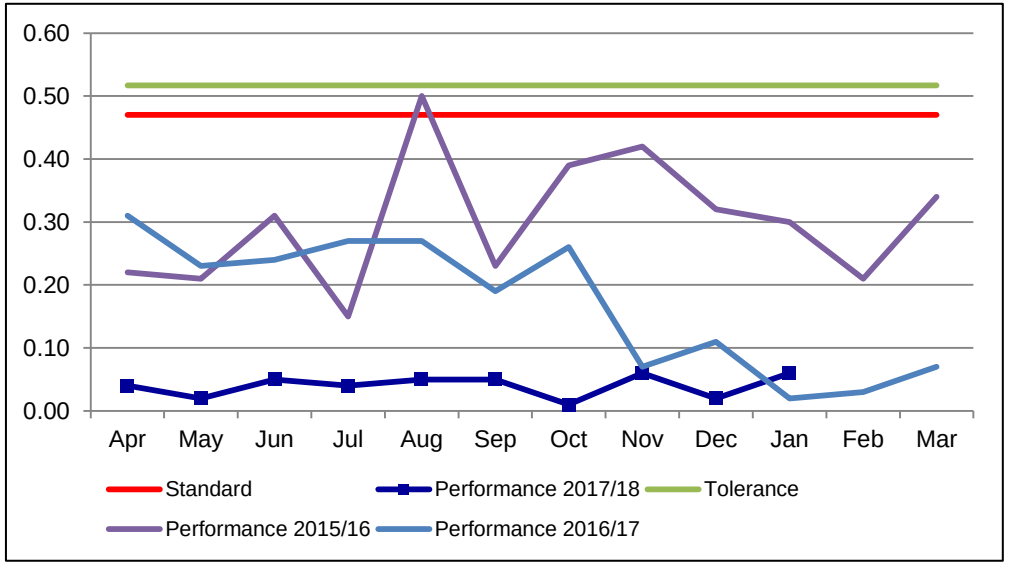
Pre-Operative Stay

	Standard	Tolerance
Standard: Reduce the days for pre-operative stay	0.47	0.52

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47
Performance 2017/18	0.04	0.02	0.05	0.04	0.05	0.05	0.01	0.06	0.02	0.06		
Performance 2016/17	0.31	0.23	0.24	0.27	0.27	0.19	0.26	0.07	0.11	0.02	0.03	0.07
Performance 2015/16	0.22	0.21	0.31	0.15	0.50	0.23	0.39	0.42	0.32	0.30	0.21	0.34

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



Narrative Summary:
The run chart shows that **pre-operative inpatient stays** in hospital are consistently within the target range. Performance against this measure is being sustained.

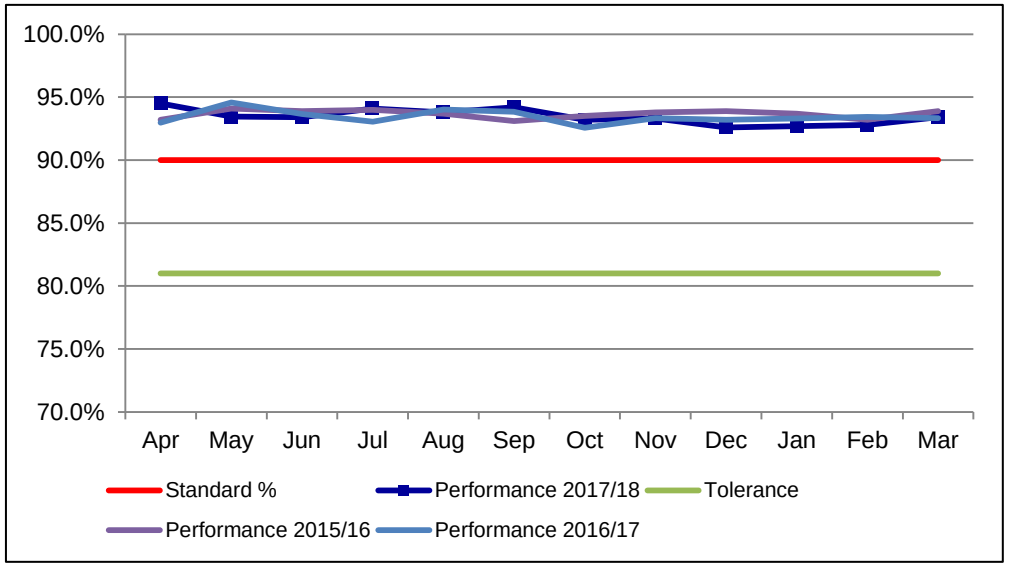
Actions:
- No further action planned at this time.

Online Triage of Referrals

	Standard	Tolerance
Standard: 90% of all referrals to be triaged online	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	94.5%	93.5%	93.4%	94.1%	93.8%	94.2%	93.2%	93.3%	92.6%	92.7%	92.8%	93.4%
Performance 2016/17	93.0%	94.6%	93.7%	93.0%	94.0%	93.8%	92.6%	93.3%	93.2%	93.3%	93.4%	93.3%
Performance 2015/16	93.2%	94.1%	93.9%	94.0%	93.7%	93.1%	93.5%	93.8%	93.9%	93.7%	93.2%	93.9%



Narrative Summary:
The chart shows the percentage of **electronic referrals** received for the month that have been **triaged** within 10 days of month end.

Actions:
- The goal remains to increase the number of referrals received and processed online.
- Dentists are now able to send referrals electronically via SCI Gateway.

Breastfeeding

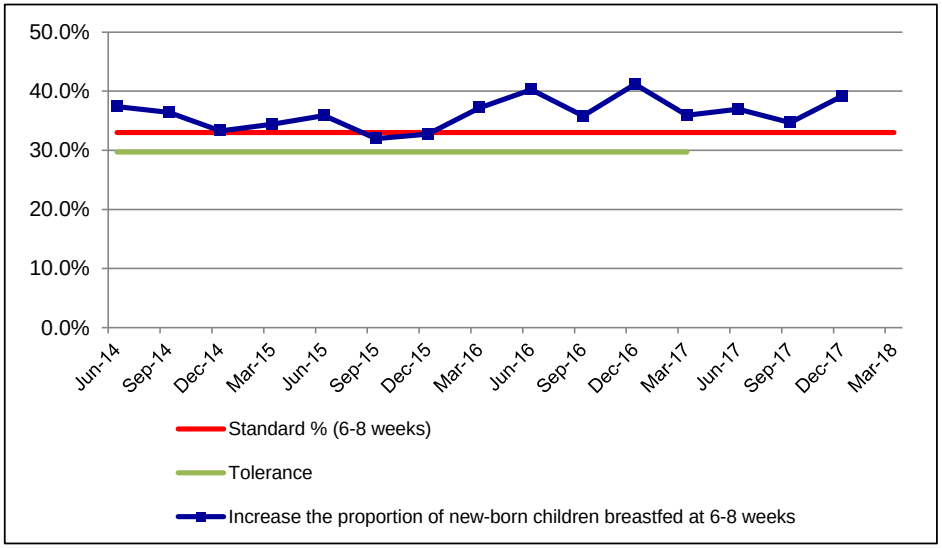
	Standard	Tolerance
Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	33.0%	29.7%

Actual Performance (higher % = better performance)

	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18
Standard % (6-8 weeks)	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%
Increase the proportion of new-born children breastfed at 6-8 weeks	35.9%	32.0%	32.8%	37.2%	40.3%	35.8%	41.2%	35.9%	37.0%	34.7%	39.2%	
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%	39.8%	50.2%	
Percentage Ever Breast Fed	-	-	-	60.50%	75.0%	72.4%	76.1%	68.5%	68.1%	69.9%	72.0%	

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 October - December 2017 performance has improved to 39.2%. No further figures released since December 2017.

Actions:.
- Maternity staff and BFI Key Workers are actively working to ensure babies get the best start in Life.
- We have a robust peer support programme (BIBS - Breastfeeding in the Borders Support) continuing to identify means to maintain and further develop this programme.
- Badgernet is enabling us to analyse feeding trends and pick up on issues on a monthly basis. Badgernet recording issues have been identified and actions planned.
- We are focusing on a back to basics approach, concentrating on the quality as well as the quantity of skin to skin time women are having with their babies.
- Focus on using Badgenet reports to identify training needs.
- To identify and evaluate current skin to skin experience an audit with postnatal women will be carried out from May onwards.

eKSF

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

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	6.0%	12.0%	18.0%	24.0%	30.0%	36.0%	42.0%	48.0%	54.0%	63.0%	72.0%	80.0%
Performance 2017/18 [1]	2.5%	4.2%	6.1%	8.9%	12.3%	16.9%	22.8%	29.3%	38.0%	53.6%	- [2]	- [2]
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

[2] Data unavailable from February 2018 due to change of system

Personal Development Plans

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

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	6.0%	12.0%	18.0%	24.0%	30.0%	36.0%	42.0%	48.0%	54.0%	63.0%	72.0%	80.0%
Performance 2017/18 [1]	4.0%	5.8%	7.5%	9.4%	13.5%	17.4%	22.4%	26.5%	31.6%	44.2%	- [2]	- [2]
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%

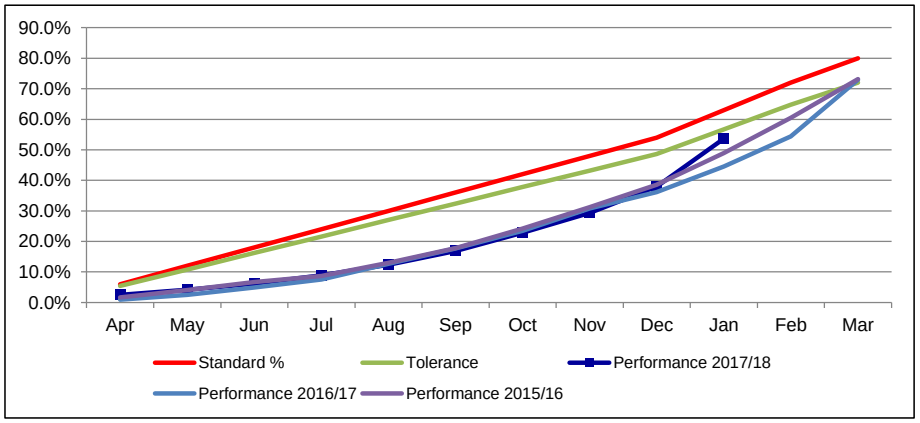
[1] August & September data updated as unavailable at time of reporting

[2] Data unavailable from February 2018 due to change of system

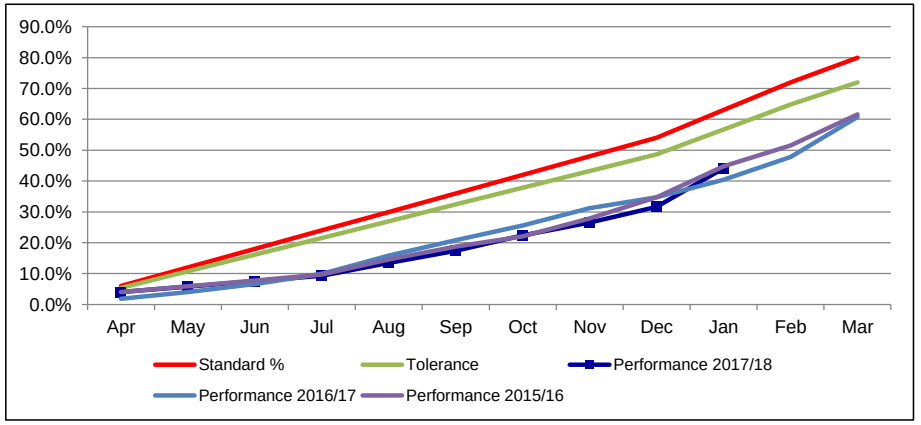
Please Note: Charts and supporting narrative are on the next page.

eKSF and Personal Development Plans *continued*

eKSF



PDP



Please Note: February & March 2018 data unavailable at time of reporting due to change in system

Narrative Summary:
The above chart shows that overall within NHS Borders the target set for recording **annual Joint Development Reviews (JDRs) for eKSF** is below trajectory for this year. As reported last month there is no mechanism to record Reviews/PDP's in February/March 2018 due to moving to a new system (Turas). Managers were encouraged to complete as many appraisals as possible before the end of January 2018. Outstanding reviews can be completed on paper and/or updated on Turas once live.

Regular reports were sent out to all managers to highlight their percentages and to encourage the completion of Reviews and PDPs into e-KSF. KSF Champions supported managers with this process.

The Turas Appraisal System was implemented from 2nd April 2018, eKSF changed to read only from 1st February 2018. Information has now been shared with all line managers and staff regarding the changes to the recording of Appraisal, PDPs and Objectives. Further communication will be forthcoming regarding next steps, training and support offered from ksf champions etc.

Mental Health:
Full performance reports were 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 had a process in place to ensure appraisals were planned, carried out and inputted on to eKSF appropriately by 30th January 2018 and Mental Health achieved this. (Completion of JDRs as at 31.01.18 - 81.40%, PDPs 80.26%) .

Support Services
Reports were sent to Managers as requested, all departments have a process in place to ensure appraisals were planned, carried out and input on to eKSF appropriately. (Completion of JDRs as at 01.01.18 - 66.5%, PDPs 62.20%)

BGH and P&CS
Work continued up to 31.01.18 to meet with managers and staff to provide support with eKSF system and processes. Monthly reports were produced and shared with managers and reviewers. Areas of concern were highlighted to senior managers, trajectory of plans are updated and shared with teams. (Completion of JDRs as at 31.12.17 -42.36%, PDPs 29.55%)

Learning Disability Service
Work continued up to 31.01.18 to ensure staff meet this standard. (Completion of JDRs as at 31.12.17 - 100%, PDPs 32.15%)

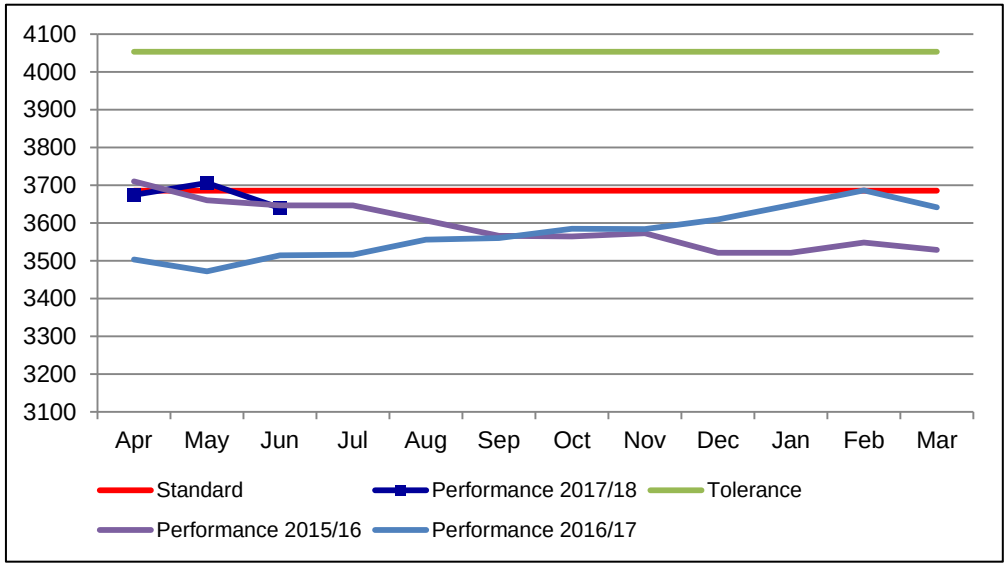
Emergency Occupied Bed Days

	Standard	Tolerance
Standard: Reduce Emergency Occupied Bed Days for the over 75s	3685	4054

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	3685	3685	3685	3685	3685	3685	3685	3685	3685	3685	3685	3685
Performance 2017/18	3674	3706	3640									
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 7 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 bed days** since June 2016. This coincides with an increase in delayed discharges from this period.

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.
- New models of care aimed at reducing delays are currently being tested, including a Hospital-to-Home model and 8 step down inpatient beds.

LDP Standards:

Access to Treatment

Access to Treatment Performance Summary

Overview

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

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

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

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

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

In 2017/18, the Board continues to face challenges in the achievement of our waiting times standards. However, although the pace of improvement is slower than planned, we are working steadily towards achievement of 12 week waits in both inpatients and outpatients.

Stage of Treatment - 12 Weeks Waiting Time for Outpatients

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

Actual Performance (lower = better performance)

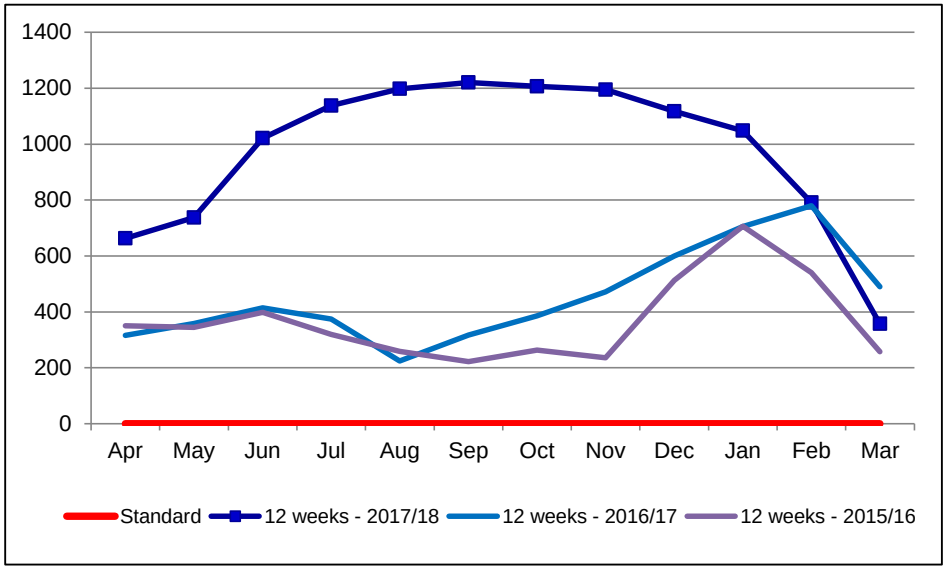
Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
74.4% (Jun 2017)	80.9% (Jun 2017)

	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	1195	1117	1048	791	357
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

2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cardiology	119	130	161	153	173	190	174	131	141	82	36	8
Dermatology	270	305	439	446	493	547	586	578	372	235	67	10
Diabetes/Endocrinology	14	13	19	22	19	7	4	2	1	1		
ENT	1	1		1					1		1	
Gastroenterology	9	32	57	85	105	85	74	57	42	18	9	3
General Medicine					3	1				2		3
General Surgery	1	8	3	8	10	27	25	14	22	28	11	2
Gynaecology	1											
Neurology	2	17	45	60	54	70	65	76	86	48	28	15
Ophthalmology	99	88	168	216	193	201	210	268	355	398	290	130
Oral Surgery	1	44	63	79	77	46	33	34	48	89	93	87
Orthodontics												
Other	13	28	38	40	52	40	35	33	38	27	19	9
Pain Management	26	14	8	2	1							1
Respiratory Medicine			1	1				1	6	14	14	22
Rheumatology												
Trauma & Orthopaedics	105	55	14	22	16	5	1		5	104	212	62
Urology	2	2	5	3	2	1		1		2	11	5
All Specialties	**663**	**737**	**1021**	**1138**	**1198**	**1220**	**1207**	**1195**	**1117**	**1048**	**791**	**357**

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



Narrative Summary:
The number of patients reported as waiting longer than **12 weeks for an outpatient appointment** has improved in March following extra activity that was run across Cardiology, Gastroenterology, Ophthalmology and Dermatology however due to continuing capacity issues within a number of specialties, including Cardiology and Ophthalmology this still creates a long term issue. NHS Borders achieved the target set by the Scottish Government to have less than 500 patients over 12 weeks by the end of March 2018 and achieved a total of 357 over 12 weeks. 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 however there has been no applicants for the post as yet. In the short term additional capacity is being provided from within the service.
- Dermatology: Job plans for existing Consultants are being reviewed. A GP with Special Interest post, has now been filled and are making a positive impact on the waiting list that is planned to continue until around December 2018.
- Diabetics / Endocrinology: While the service has no patients currently waiting over 12 weeks, there are still capacity problems within the service that will cause long term issues with patient waits. This is currently under review by the Diabetic consultants.
- Gastroenterology: The waiting lists has reduced to 10 weeks following extra capacity that was provided through a locum up until the end of March 2018. The resignation of one of the consultants left a gap in the provision of service which was filled again in mid December 2017. A change in clinics templates should result in a balanced waiting list with no patients breaching 12 weeks over the next year.
- Ophthalmology: There are ongoing challenges around clinic capacity, due to Consultant vacancies within the service. A collaboration between NHS Borders, Lothian and Fife is being undertaken to provide sustainable Ophthalmology services across the region.
- Oral Surgery: Referrals into the service have increased by around 51% against the planned capacity that is causing 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.
- **Respiratory Medicine:** There are capacity issues within the service that have been worsened by the departure of one of our consultants. This has left a gap in the service that has also led to some of our only Respiratory consultant's clinics cancelled while they cover the vacant post ward commitments.

Stage of Treatment - 12 Weeks Waiting Time for Inpatients

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

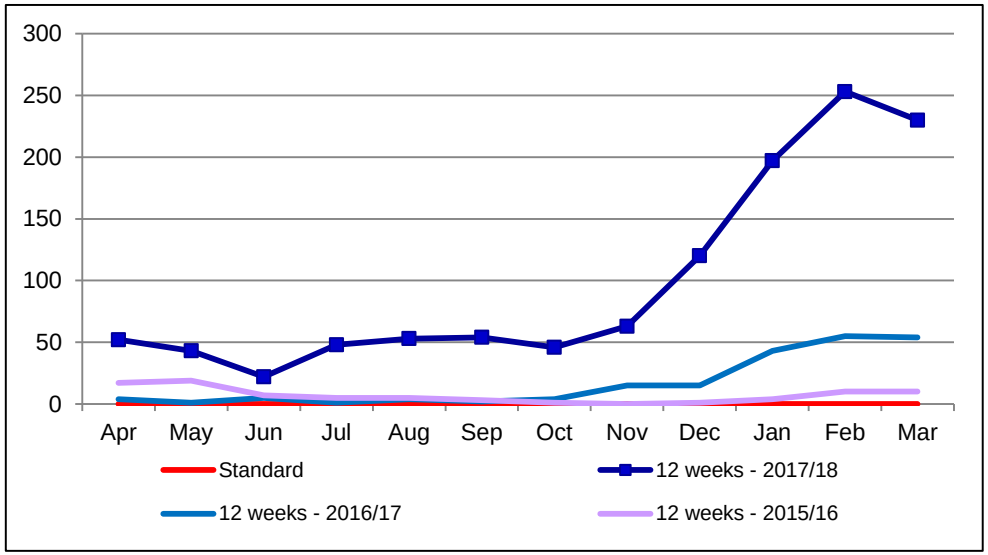
Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
12 weeks - 2017/18	52	43	22	48	53	54	46	63	120	197	253	230
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

2017/18	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
ENT					1	2	2		3	8	8	7
General Surgery	3	10	4	2	4	1		6	14	36	61	72
Gynaecology											2	
Ophthalmology				5	7	9	3	1			11	7
Oral Surgery					1	1	1	9	25	23	16	7
Other				1							16	16
Trauma & Orthopaedics	49	32	18	40	40	41	40	47	76	122	130	109
Urology		1							2	8	9	12
All Specialties	**52**	**43**	**22**	**48**	**53**	**54**	**46**	**63**	**120**	**197**	**253**	**230**

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



Narrative Summary:
At the end of March, the number of patients reported waiting over **12 weeks for inpatient treatment** reduced to 230 due to reduced additions to the Inpatient Waiting List over the winter period**.** The large number of breaching patients was due to short notice cancellations for bed availability and other urgent cases over the festive period. This now means that NHS Borders has patients breaching TTG in every specialty.

A number of patients are reported as breaching within the different areas because of the following: Orthopaedic Surgery - due to capacity, General Surgery - due to bed availability and the temporary cessation of Vasectomies, ENT - due to theatre and bed availability, Ophthalmology - due to Consultant leave, Oral Surgery - due to consultant capacity, and Urology - due to bed availability.

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

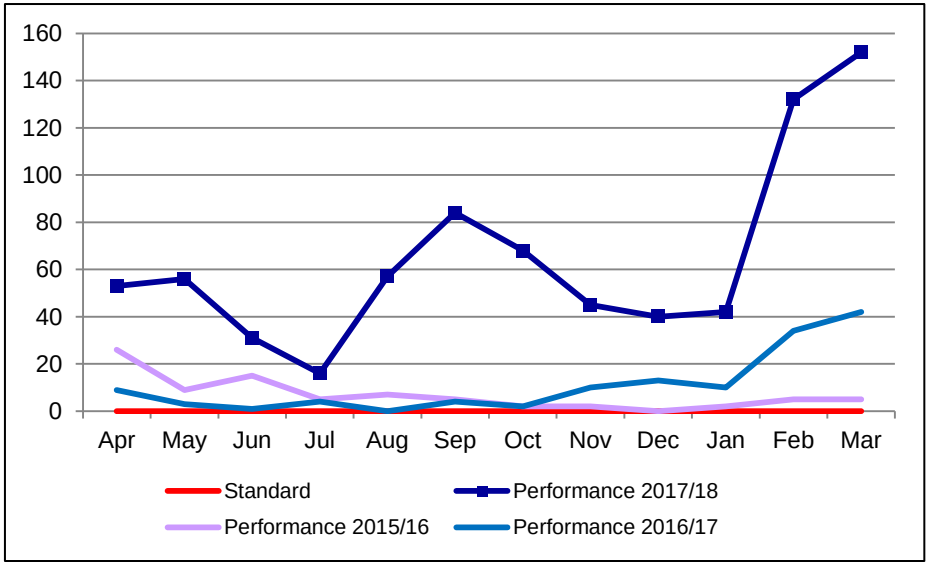
12 Weeks Treatment Time Guarantee

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

Actual Performance (lower = better performance)

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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Performance 2017/18	53	56	31	16	57	84	68	45	40	42	132	152
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 March 152 patients who previously breached their **Treatment Time Guarantee** (TTG) date were treated. Mainly due to the capacity problems within Orthopaedics and the cancellations over the past few months.

Actions:
- A plan is in place to sent around 50 Orthopaedic patients to independent sector establishments between February and March to reduce the impact of the TTG breaches and winter cancellations
- 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 where achievable.

Unavailability

To ensure continued delivery of Waiting Times targets, it is essential that patient unavailability is closely monitored and that patients are managed in accordance with national guidelines. Information regarding unavailability is shown below.

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

Unavailable	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Unavailable	58	69	93	101	91	103	87	71	63	62	53	60	75
Patient Advised	37.2%	41.8%	47.9%	50.2%	46.0%	55.7%	52.1%	45.2%	42.6%	40.3%	35.6%	37.3%	43.9%
Unavailable	98	96	101	100	107	82	80	86	85	92	96	101	96
Medical	62.8%	58.2%	52.1%	49.8%	54.0%	44.3%	47.9%	54.8%	57.4%	59.7%	64.4%	62.7%	56.1%
Total Unavailable	156	165	194	201	198	185	167	157	148	154	149	161	171
Total % Unavailable	14.3%	15.5%	18.9%	20.2%	17.9%	16.0%	14.2%	13.9%	14.6%	12.5%	11.8%	12.8%	12.9%

Table 2 - Monthly Unavailability by Specialty - as at 28th February 2018

	Available				Unavailable			
Specialty	**0 - 9 Weeks**	**10 - 12 Weeks**	**12+ Weeks**	**Total**	**Medical Un-available**	**Patient Advised Un-available**	**Total**	**% Un-available**
ENT	42	14	7	**63**	3	1	**4**	**6.0%**
General Surgery	152	41	72	**265**	18	18	**36**	**12.0%**
Gynaecology	27	2	0	**29**	6	6	**12**	**29.3%**
Ophthalmology	215	25	7	**247**	16	8	**24**	**8.9%**
Oral Surgery	19	2	7	**28**	4	6	**10**	**26.3%**
Other	25	9	16	**50**	3	2	**5**	**9.1%**
Trauma & Orthopaedics	212	39	109	**360**	38	28	**66**	**15.5%**
Urology	86	14	12	**112**	8	6	**14**	**11.1%**
Total	**778**	**146**	**230**	**1154**	**96**	**75**	**171**	**12.9%**

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 June 2017. This is expected to increase as we move into the school holiday 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.

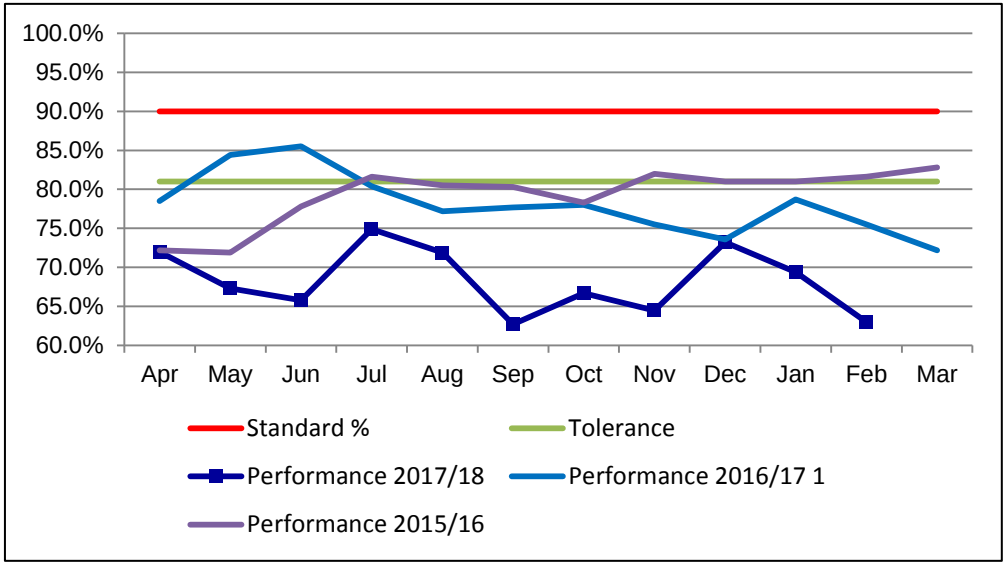
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Admitted Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	72.0%	67.3%	65.8%	74.9%	71.9%	62.7%	66.7%	64.5%	73.2%	69.4%	63.0%	
Performance 2016/17 [1]	78.5%	84.4%	85.5%	80.4%	77.2%	77.7%	78.0%	75.5%	73.6%	78.7%	75.5%	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.

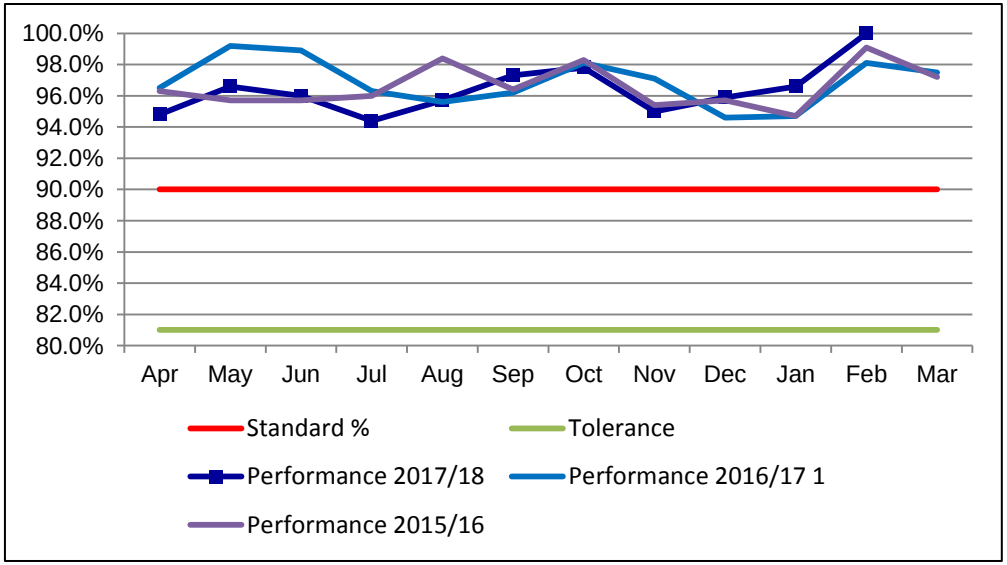
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Admitted Linked Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	94.8%	96.6%	96.0%	94.4%	95.7%	97.3%	97.8%	95.0%	95.9%	96.6%	100.0%	
Performance 2016/17 [1]	96.5%	99.2%	98.9%	96.3%	95.6%	96.2%	98.1%	97.1%	94.6%	94.7%	98.1%	97.5%
Performance 2015/16	96.3%	95.7%	95.7%	96.0%	98.4%	96.4%	98.3%	95.4%	95.7%	94.7%	99.1%	97.2%
Performance 2014/15	97.7%	97.0%	96.7%	95.3%	95.5%	97.5%	95.5%	95.0%	96.0%	97.9%	97.4%	95.5%

[1] November data has been updated from the clinical board dashboard due to further data validation by the Waiting Times Team.



Narrative Summary:
The run chart shows **admitted linked pathway performance** is consistently above 90%.

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

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

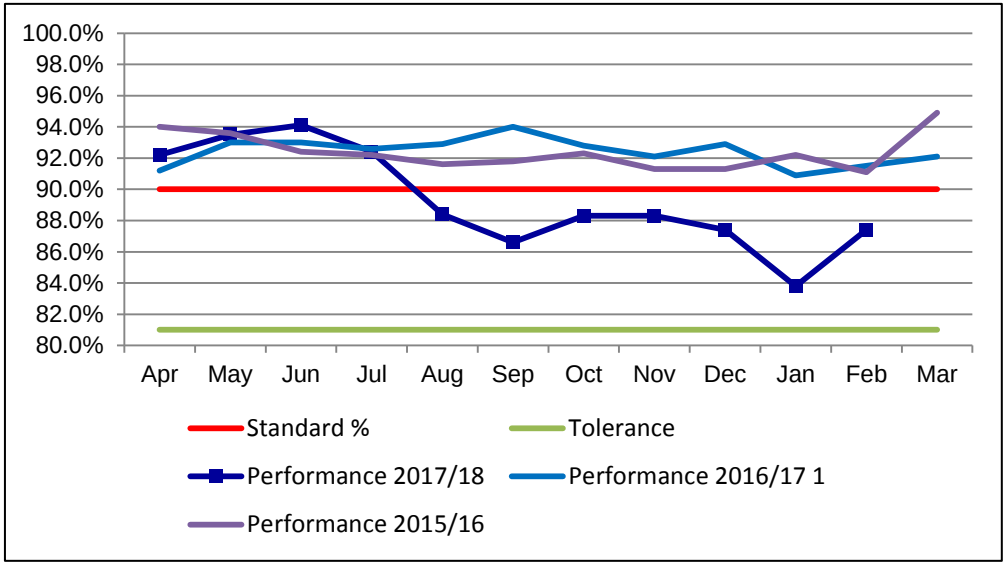
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Non-Admitted Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	92.2%	93.5%	94.1%	92.4%	88.4%	86.6%	88.3%	88.3%	87.4%	83.8%	87.4%	
Performance 2016/17 [1]	91.2%	93.0%	93.0%	92.6%	92.9%	94.0%	92.8%	92.1%	92.9%	90.9%	91.5%	92.1%
Performance 2015/16	94.0%	93.6%	92.4%	92.2%	91.6%	91.8%	92.3%	91.3%	91.3%	92.2%	91.1%	94.9%

[1] April data has been updated from the clinical board dashboard due to further data validation by the Waiting Times Team.



Narrative Summary:
The run chart shows that **non-admitted pathway performance** has dropped below 90%. This is mainly due to the large number of Cardiology, Dermatology and Ophthalmology patients that have exceeded 18 weeks for their first appointment.

Actions:
- Work will continue to ensure we get back to achieving the standard by April 2018 with the reduction in the number of 12 week breaches through additional Outpatient activity through consultant and Synaptik led sessions. (See pages 27-30 for specific narrative).

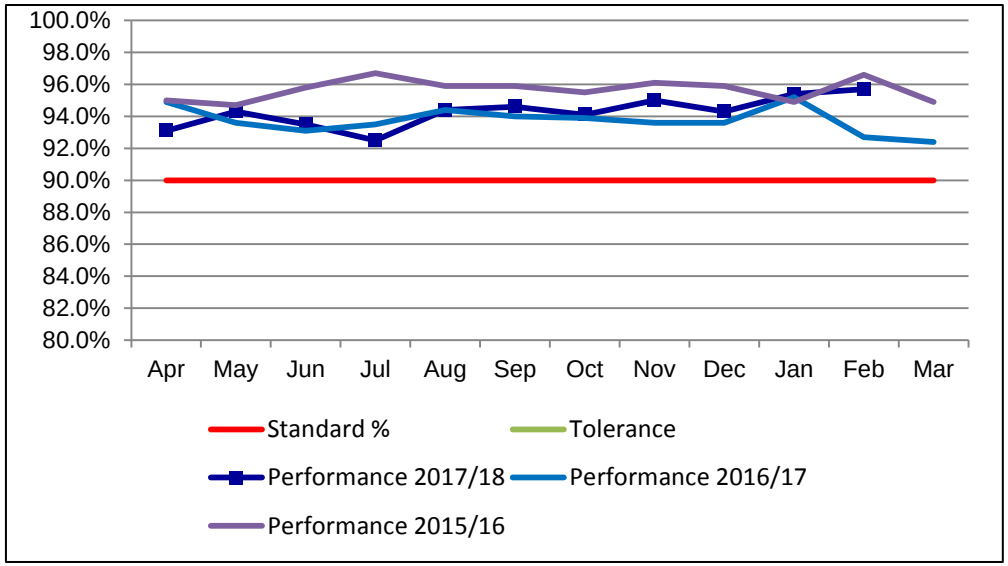
Please Note: From May 2016 18 Weeks RTT data will be reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Non-Admitted Linked Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	93.1%	94.3%	93.5%	92.5%	94.4%	94.6%	94.1%	95.0%	94.3%	95.4%	95.7%	
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.

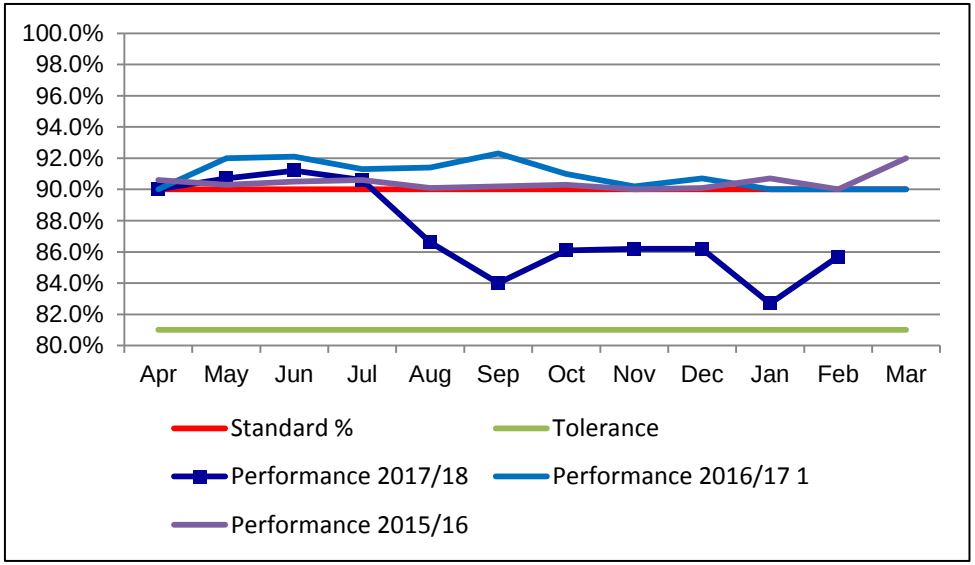
18 Weeks Referral to Treatment (RTT)

Standard: Combined Pathway Performance	**Standard**	**Tolerance**
	90.0%	81.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
81.33% (Oct 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%	86.1%	86.2%	86.2%	82.7%	85.7%	
Performance 2016/17 [1]	90.0%	92.0%	92.1%	91.3%	91.4%	92.3%	91.0%	90.2%	90.7%	90.0%	90.0%	90.0%
Performance 2015/16	90.6%	90.3%	90.5%	90.6%	90.1%	90.2%	90.3%	90.0%	90.1%	90.7%	90.0%	92.0%
Performance 2014/15	86.8%	88.4%	90.2%	91.5%	90.4%	90.6%	90.1%	90.0%	90.8%	90.1%	90.0%	90.1%



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

Narrative Summary:
The national standard for NHS Boards RTT is to deliver 90% **combined performance**. In February 2018 we did not meet the 90% target due to large numbers of patients being seen over 18 weeks in Outpatients particularly within Dermatology and Cardiology, 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 improve as we have cleared the majority of the backlog and are now treating the majority of Outpatient within 12 weeks. It is predicted that by April 2018 we will be achieving 90% combined performance for 18 Week RTT.

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

Actions:
- Work will continue during 2017/18 with the reduction in the number of 12 week breaches.

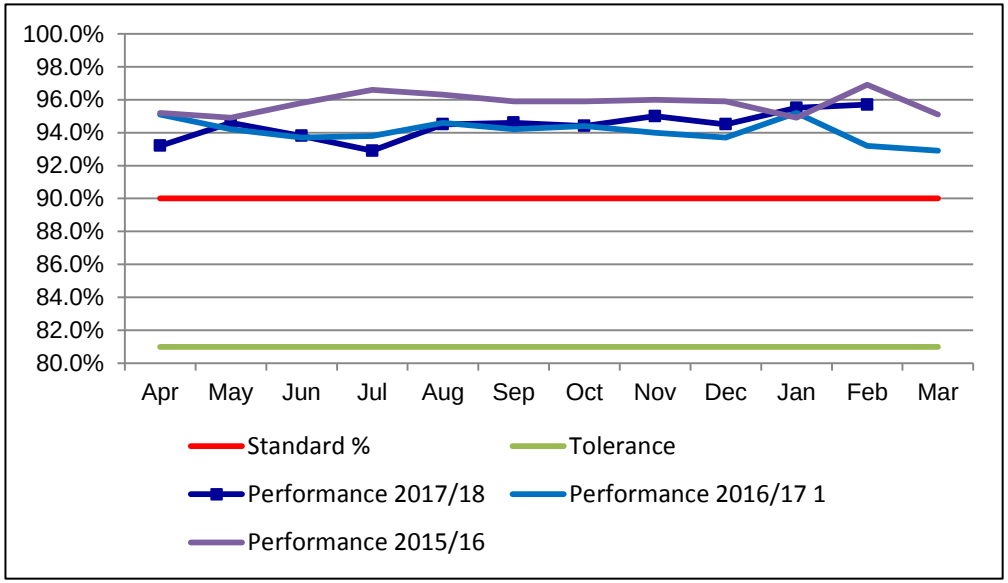
18 Weeks Referral to Treatment (RTT)

	Standard	Tolerance
Standard: Combined Linked Pathway Performance	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	93.2%	94.6%	93.8%	92.9%	94.5%	94.6%	94.4%	95.0%	94.5%	95.5%	95.7%	
Performance 2016/17 [1]	95.1%	94.2%	93.7%	93.8%	94.6%	94.2%	94.4%	94.0%	93.7%	95.2%	93.2%	92.9%
Performance 2015/16	95.2%	94.9%	95.8%	96.6%	96.3%	95.9%	95.9%	96.0%	95.9%	94.9%	96.9%	95.1%
Performance 2014/15	94.8%	94.0%	94.7%	95.2%	96.4%	94.9%	92.8%	96.4%	95.6%	96.2%	95.6%	95.6%

[1] November data has been updated from the clinical board dashboard due to further data validation by the Waiting Times Team.



Narrative Summary:
The run chart shows that currently NHS Borders continues to achieve the 90% **combined RTT linked pathway** standard.

Actions:
- No actions specified at present due to current high performance. Continue to monitor.

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

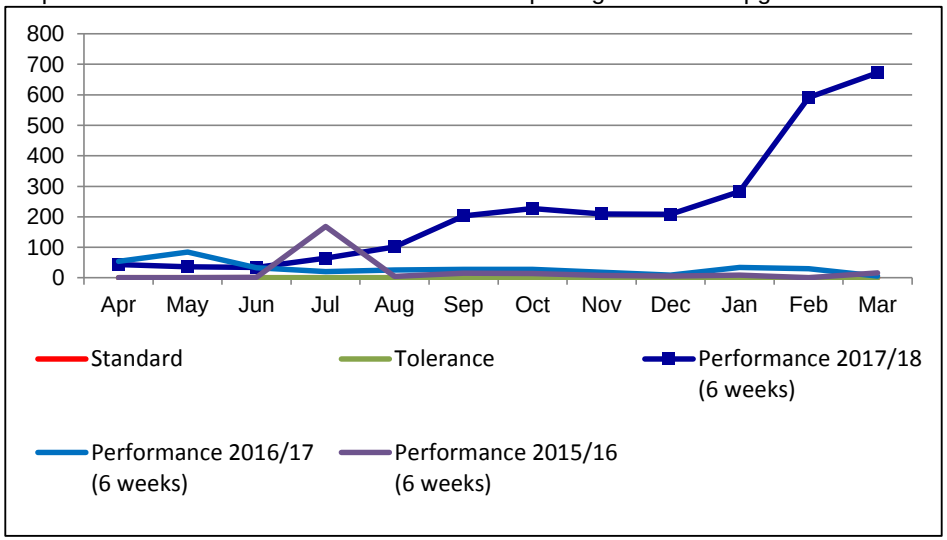
Diagnostic Waiting Times

	Standard	Tolerance
Standard: Waiting Target for Diagnostics - zero patients to wait over 6 weeks (4 weeks is monitored locally as an stretch target)	0	0

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Performance 2017/18 (6 weeks)	43	36	34	64	101	203	227	209	208	283	591	672
Performance 2017/18 (4 weeks)	196	127	154	226	229	431	464	385	474	393	591	
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 or RIS and the link to the reporting tool



Narrative Summary:
The national standard is that no patient waits more than **6 weeks** for one of a number of **identified key diagnostic tests**. Locally this standard has been set at 4 weeks.

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 and 6 week breaches. The 4 week performance is in the table below:

Diagnostic - 6 weeks	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Endoscopy	-	-	-	-	-	-	-	-	-	-	-	-	-
Colonoscopy	6	36	18	6	7	-	-	-	-	-	1	-	-
Cystoscopy	-	-	-	-	-	-	-	1	-	-	-	-	6
MRI	-	3	18	27	56	100	187	189	198	186	241	339	364
CT	-	4	-	-	1	1	16	37	11	4	4	11	43
Ultra Sound (non-obstetric)	-	-	-	1	-	-	-	-	-	18	28	2	25
Barium	-	-	-	-	-	-	-	-	-	-	9	1	2
Total	**6**	**43**	**36**	**34**	**64**	**101**	**203**	**227**	**209**	**208**	**283**	**353**	**440**

Diagnostic - 4 weeks	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Endoscopy	-	-	-	-	2	-	1	3	-	-	0	-	-
Colonoscopy	31	60	31	11	9	1	4	1	-	2	2	4	11
Cystoscopy	3	4	1	1	-	1	1	1	2	-	0	1	11
MRI	44	70	92	127	182	192	320	333	320	342	306	498	485
CT	34	52	-	13	30	33	97	103	54	51	21	54	96
Ultra Sound (non-obstetric)	2	10	3	2	-	-	-	18	8	76	54	26	60
Barium	-	-	-	-	3	2	8	5	1	3	10	8	9
Total	**114**	**196**	**127**	**154**	**226**	**229**	**431**	**464**	**385**	**474**	**393**	**591**	**672**

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

Narrative Summary and Actions:
Colonoscopy – The service continues to benefit from ring fenced Colon session performed by a locum General Surgeon who is in place until July 2018. The recent introduction of fit testing for bowel screening patients has seen an increase in demand for colonoscopy which may impact on waiting times. Additional GI nursing hours have been approved to manage increase in pre-assessment. This continues to be monitored.

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 lead 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.
Scottish Government funding has been secured to continue to run these sessions and an additional fixed term radiographer post which will help provide capacity to main staff in CT/MRI.

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	Oct to Dec 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%	97.30%
31-days standard	100%	100%	97.80%	100.00%	97.80%	98.20%	100%	98.18%	100%	100%	97.30%	96.90%	100.00%	100.00%

Cancer Waiting Times

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

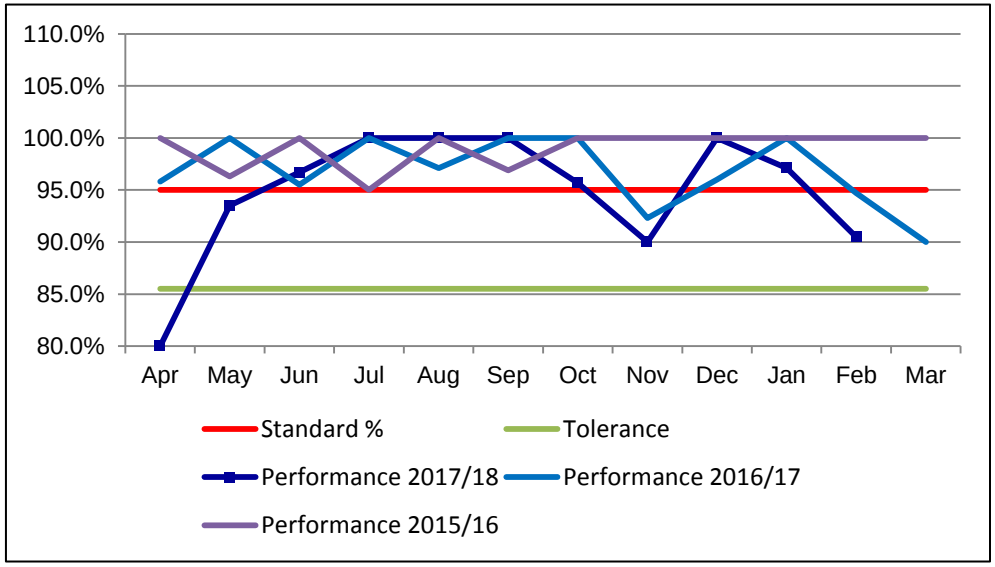
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
87.3% (Nov 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%	95.7%	90.0%	100.0%	97.1%	90.5%	
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** which was not achieved in February due to two patients breaching the standard. One was for radiotherapy and the other for a prostatectomy of which both procedures have long wait times for treatment.

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

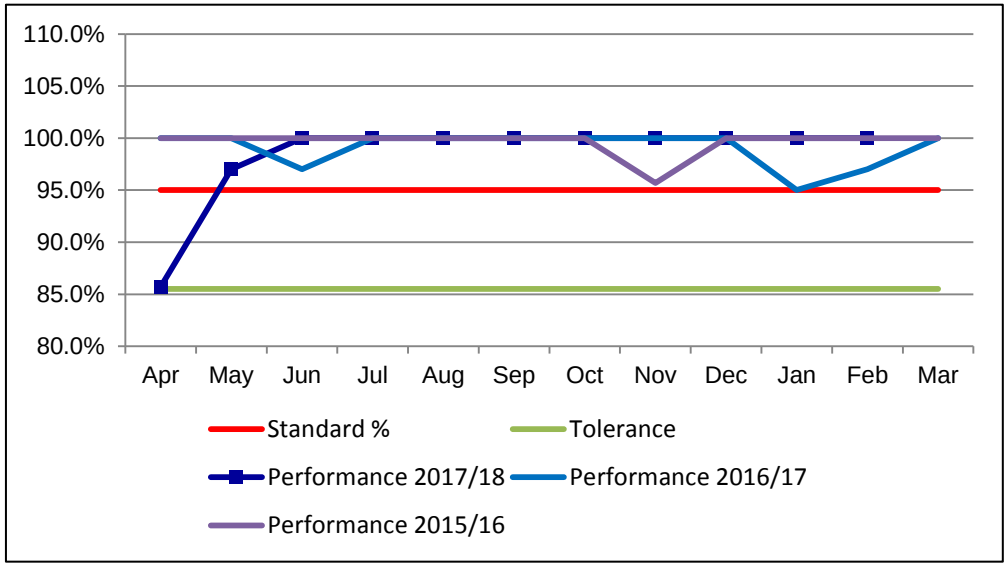
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
94.2% (Nov 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%	100.0%	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 February 100% of patients were treated within the standard.

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

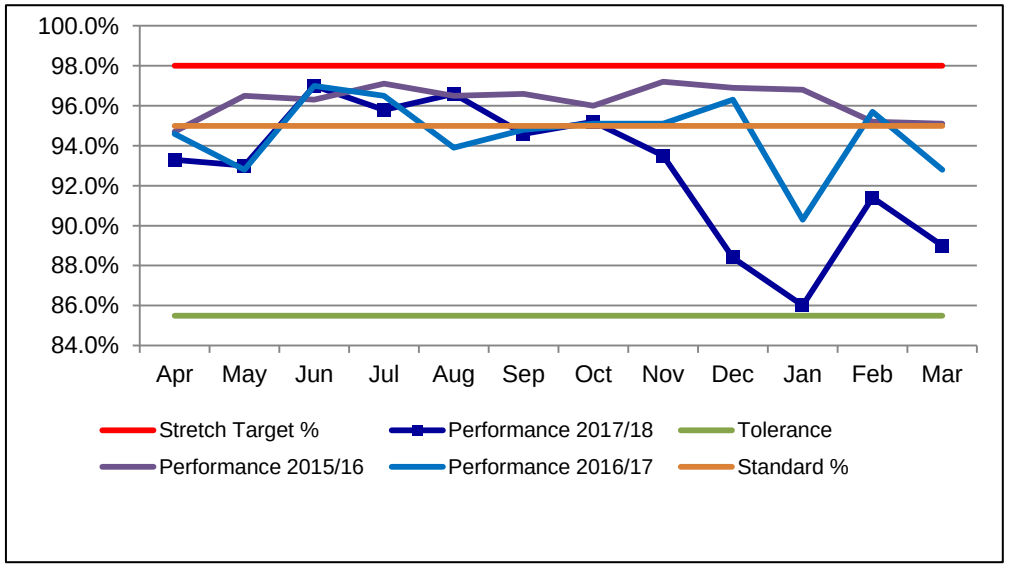
Standard: 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

Stretch Target	Standard	Tolerance
98.0%	95.0%	85.5%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
91.1% (Nov 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 2017/18	93.3%	93.0%	97.0%	95.8%	96.6%	94.6%	95.2%	93.5%	88.4%	86.0%	91.4%	89.0%
Performance 2016/17	94.6%	92.8%	97.0%	96.5%	93.9%	94.8%	95.1%	95.1%	96.3%	90.3%	95.7%	92.8%
Performance 2015/16	94.7%	96.5%	96.3%	97.1%	96.5%	96.6%	96.0%	97.2%	96.9%	96.8%	95.2%	95.1%
Performance 2014/15	96.0%	96.2%	94.9%	97.1%	94.9%	96.6%	96.9%	97.7%	90.7%	89.7%	91.2%	91.4%



Narrative Summary:
There has been a deterioration in **4 hour A&E** performance through November to February reflecting a difficult winter period, as seen in the Health Boards across the country. The EAS is a system measure and the system has responded to this pressure initiating a number of changes to ease the pressure on the BGH. Despite this, delayed discharges have more than doubled compared to this time last year, placing pressure on all patient flows, which has increased the number of breaches due to bed availability.

Actions:
Please see next page for continued Actions.

Accident & Emergency 4 Hour Standard *continued*

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

Emergency Access	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Flow 1	97.1%	96.9%	97.3%	98.4%	98.8%	98.9%	98.4%	98.8%	98.7%	97.00%	97.40%	98.00%	98.8%
Flow 2	92.5%	91.5%	91.8%	94.7%	93.6%	91.6%	89.5%	91.5%	91.6%	82.70%	83.70%	85.10%	81.3%
Flow 3	86.5%	92.0%	86.0%	95.1%	91.5%	93.7%	88.0%	89.5%	84.0%	74.80%	67.0%	83.00%	71.7%
Flow 4	82.1%	79.0%	85.5%	94.8%	91.7%	95.7%	94.5%	92.7%	88.8%	88.50%	81.1%	88.50%	86.2%
Total	**92.8%**	**93.3%**	**93.0%**	**97.0%**	**95.8%**	**96.6%**	**94.6%**	**95.2%**	**93.5%**	**88.40%**	**86.0%**	**91.40%**	**89.0%**

Narrative Summary and Actions:

There are a number of activities underway across the system to improve performance against the EAS, including:

- Establsihment of a new BGH Site & Capacity Team,
- Development of new monthly Unscheduled Care Improvement Forum to lead improvement activities,
- Refresh of key flow management processes at BGH,
- Development of community models to shift the balance of care.
- A full winter debrief has taken place across both Acute & Community Services.

Stroke Unit Admission

	Standard	Tolerance
Standard: Admitted to the Stroke Unit within 1 day of admission	90.0%	81.0%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	71.4%	87.5%	92.3%	66.7%	100.0%	100.0%	72.7%	61.5%	77.0%	100.0%	76.9%	
Performance 2016/17	88.9%	100.0%	83.3%	90.1%	93.3%	90.9%	86.7%	90.0%	84.6%	50.0%	100.0%	51.7%
Performance 2015/16	100.0%	100.0%	100.0%	84.0%	93.0%	94.0%	100.0%	88.0%	100.0%	84.6%	84.6%	93.3%
Performance 2014/15	91.0%	75.0%	89.0%	86.0%	100.0%	100.0%	100.0%	100.0%	100.0%	64.0%	91.0%	91.0%

Please Note: There is a 1 month lag time

Narrative:
The Scottish Stroke Care Standard for **admission to Stroke Unit Care within 1 day** of admission is 90%. The Stroke Care Bundle Standard is also 90%. This Bundle is made up of the following elements of the Scottish Stroke Care Standards:

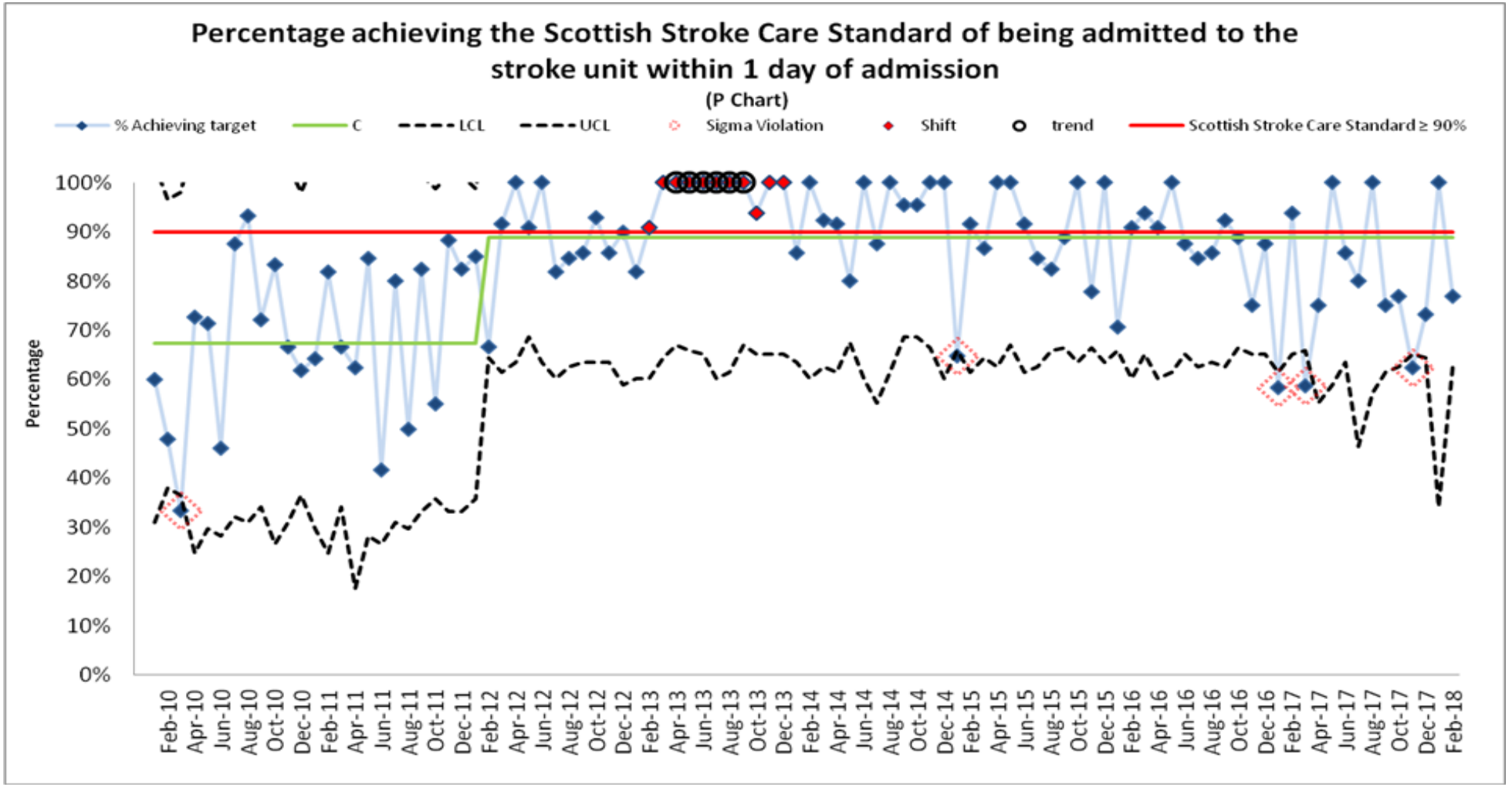
- admission to a dedicated Stroke Unit within 1 day of admission
- a swallow screen test within 4 hours of admission
- a brain scan within 24 hours of admission
- appropriate treatment initiated within one day of admission

Fail 1 – Required higher level of care
Fail 2 – Reason unknown as yet
Fail 3 – Confusion about when the 'clock' started (arrival in ED or admission to ward – patient arrived at 23:55 or only 5 minutes of day 0 left)

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
76.6% (Sept 2017)

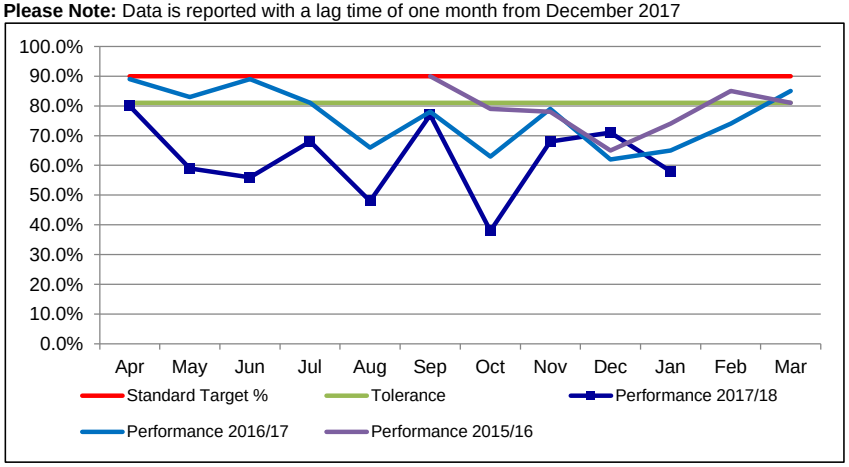
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Stretch Target %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Standard Target %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	80.0%	59.0%	56.0%	68.0%	48.0%	77.0%[1]	38.0%	68.0%	71.0%[2]	58.0%[2]	-[3]	-[3]
Total Patients Currently Waiting >18 Weeks:	93	102	129	132	120	140	132	129	87[2]	87[2]	-[3]	-[3]
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

[2] Psychological Therapy data does not include CAMHS or LD due to EMIS reporting delay

[3] Psychological Therapy data unavailable for February & March due to move to EMIS

Please Note: Data is reported with a lag time of one month from December 2017



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 have been undertaken by existing staff and locum psychologists have been employed on short term contracts 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)

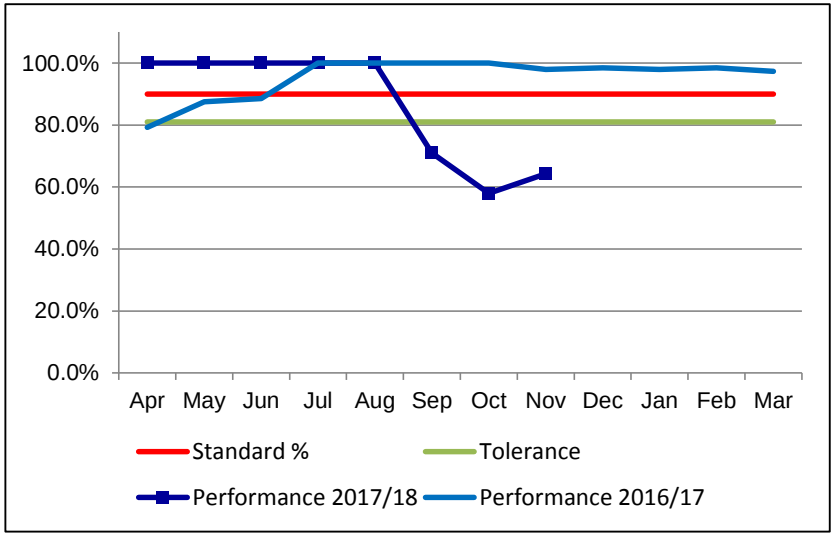
Latest NHS Scotland Performance
73.3% (Sept 2017)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Stretch Target %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	71.0%	58.0%	64.3%	- [2]	- [2]	- [2]	- [2]
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%

Please Note: Data will be reported with a lag time of one month from December 2018

[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] Data unavailable from the service at time of reporting due to transition to EMIS



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%), October (58%) and November (64%)

Based on previous performance, we estimate performance at 31st March 2018 to be between 70-80%. The main challenge in meeting the performance target is staffing, as previously reported in performance scorecard updates. CAMHS are still -1 WTE and may potentially be until August this year. Until this is rectified, we will be unlikely to achieve the target.

The service is still currently unable to report waiting times due to transition to a new electronic system, but a solution is in progress.

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. and in line with new system

Drug & Alcohol Treatment

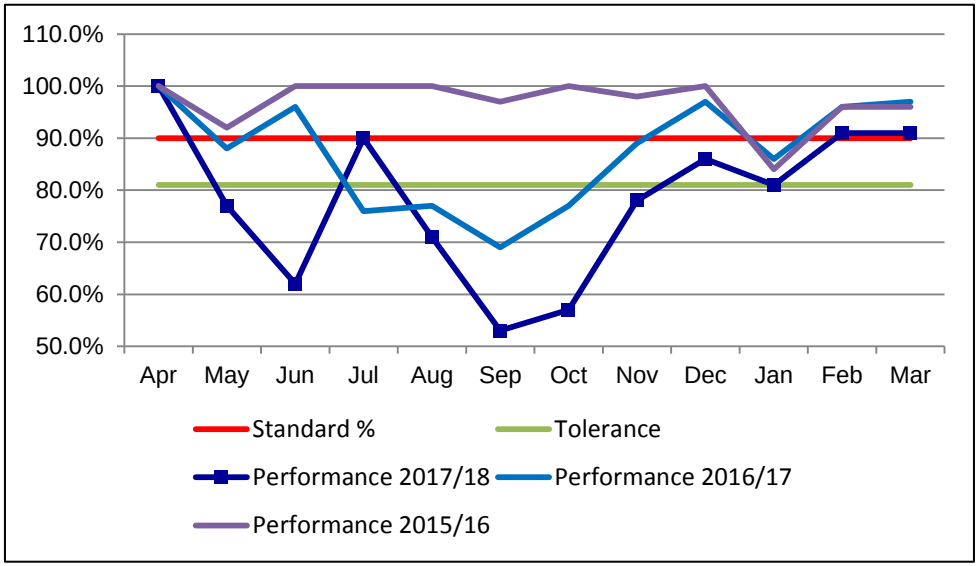
Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

Standard	Tolerance
90.0%	81.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
91.3% (Oct 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%	78.0%	86.0%	81.0%	91.0%	91.0%
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, 91% of clients started treatment within three weeks for the month of March 2018.

BAS - There has been a gap in staffing with the substance misuse nurse recruited to another post. A band 6 addictions nurse has been seconded to Addiction which has created a temporary gap in frontline services, this combined with 1 WTE on unplanned leave has posed further challenges for the service minting the waiting times target.

Actions:
- Solution remains of redistributing staffing from APTT service
- substance misuse nurse now in post and supporting short term with waiting times
- Team Manager taking a larger caseload temporarily to support the waiting times
- Band 6 post recruited to internally creating Band 5 post - is currently progressing through recruitment

AHP Waiting Times

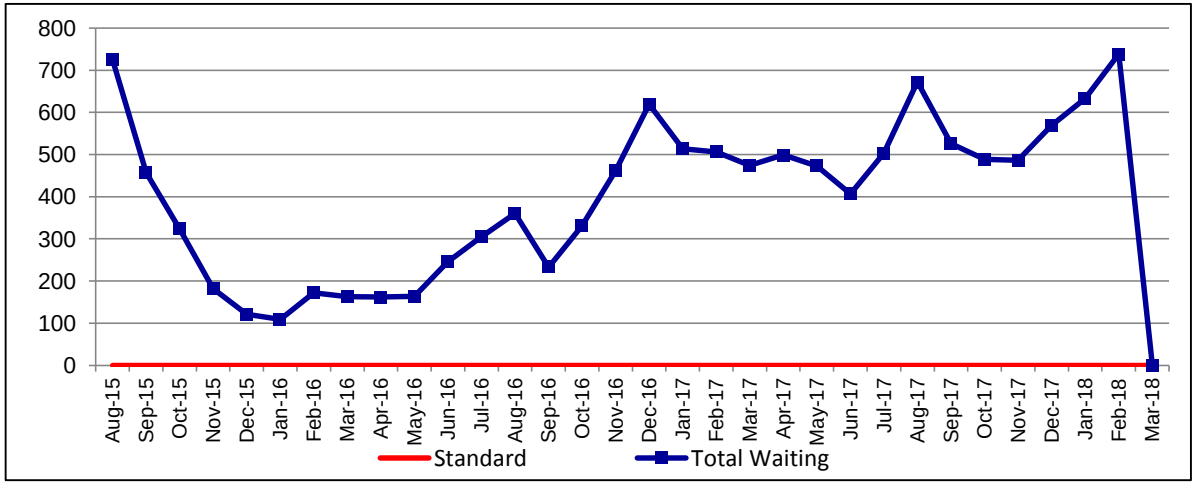
	Standard	Tolerance
Standard: Patients Waiting over 9 Weeks as at month end	0	1

Actual Performance (lower = better performance)

	Mar-17	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	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**474**	**499**	**473**	**407**	**503**	**672**	**526**	**489**	**486**	**569**	**633**	**738**	-[1]
Occupational Therapy	7	5	2	3	3	4	4	3	5	11	9	14	-[1]
Physiotherapy	459	480	457	386	481	646	501	459	461	527	571	636	-[1]
Podiatry	0	0	0	0	0	0	0	0	0	0	0	0	-[1]
Speech & Language Therapy	0	0	1	0	1	2	1	1	5	5	9	26	-[1]
Nutrition & Dietetics	8	14	13	18	18	20	20	26	15	26	44	62	

Please Note: 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 and October totals have been amended.

[1] From March 2018 AHP data is being recorded in EMIS (Paediatric data from Sept 2017) therefore data recording is presently unavailable.



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
1.0wte locum to end of January to support 25% MSK capacity gap due to vacancy and long term sickness. 554 of patients waiting are within MSK service with the remaining patients within older people services across localities. Learning Disabilities, Mental Health and Paediatric physiotherapy data collection has moved onto EMIS and therefore not included in attached report. Request in early January from senior leadership to re-direct physiotherapy staffing to inpatients, which has had a significant impact on outpatient waiting times; MSK physiotherapy waiting times as of end of February have increased to 643 patients waiting longer than 9 weeks. Optimising Orthopaedic Project will further increase referrals to physiotherapy MSK services, with an anticipated additional 30 patients per week for a 3-4 month period as patients are re-directed from orthopaedics to physiotherapy to support improvement in Orthopaedic conversion rate to surgery. Ongoing productivity review - MSK templates were introduced in December and being monitored over a three month period.

Podiatry
The admin team lead has secured admin to support the test of a centralised podiatry booking function. There have been issues within the admin team regarding the correct use of Trak, especially patient “unavailability”, “DNA” and “re setting the clock” and the team are working to reduce these admin errors.

Occupational Therapy
Due to move to EMIS recording, we are, at present unable to scan to show waiting times . We are not aware of any breaches within LD or paediatrics.

Speech & Language Therapy (SLT)
In the absence of a paediatric manager, paediatrics SLT continue to work towards a 9 week waiting time standard.
The Adult SLT team remain challenged with 2.6wte therapists working across Community and BGH since January resulting in the waiting time standard not being met. Additional capacity has been introduced to support Adult SLT.

Nutrition and Dietetics
Pressures continue in all dietetic services, waiting time aim continues to be 9 weeks, due to the migration to EMIS waiting times are not known at present. A fulltime locum dietitian has been recruited to manage the eating disorders caseload with the and a fixed term contract post is now in place. The current pressures in the acute dietetic service are impacting on community dietetic services as patients are being discharged before being seen. A locum dietitian is due to start on the 1st May for 6 weeks to increase acute dietetic capacity.

LDP Standards:

Performance in Partnership

Delayed Discharges

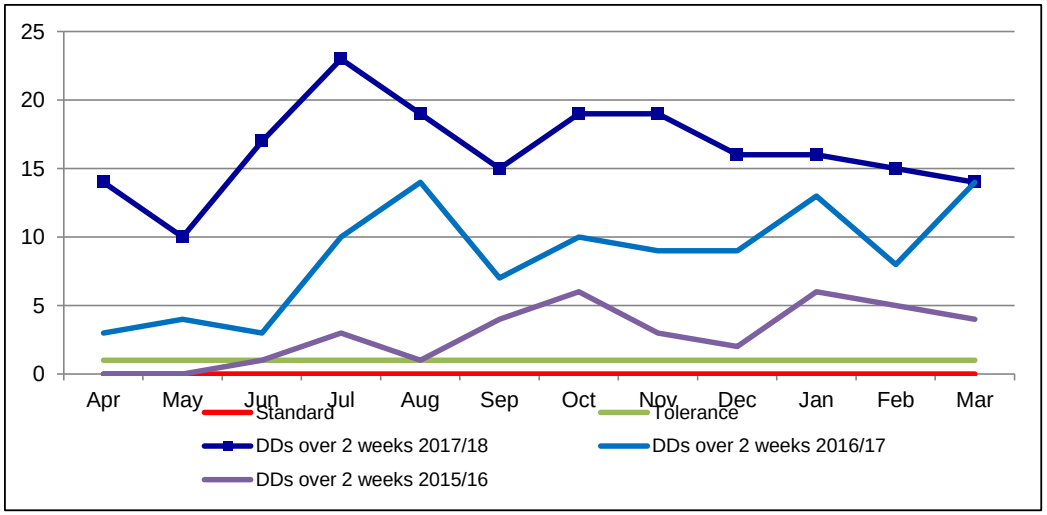
	Standard	Tolerance
Standard: Delayed Discharges - delays over 72 hours	0	1

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
DDs over 2 weeks 2017/18	14	10	17	23	19	15	19	19	16	16	15	14
DDs over 72 hours (3 days) 2017/18	19	16	23	35	28	23	25	34	32	26	18	28
Occupied Bed Days (standard delays)	814	664	675	984	872	831	920	996	1096	939	645	819
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 for **Delayed Discharges** 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 is 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, opened. The benefit of opening this facilty is now becoming evident with a reduction in the number of people delayed from discharge from the BGH. However, there continue to be significant challenges around timely discharges from community hospitals. We are currently considering how to change processes in order to improve patient pathways through community hospitals.

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

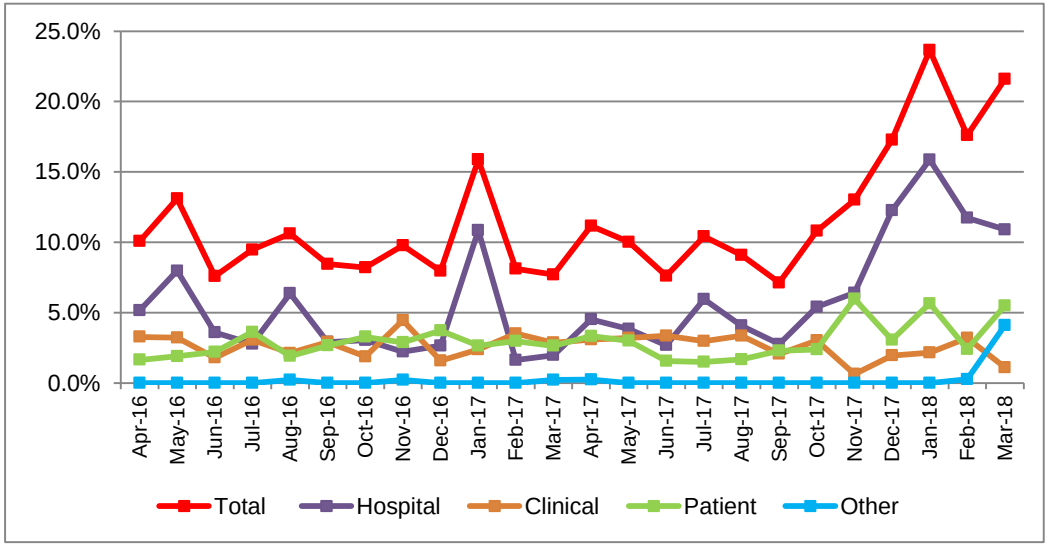
Hot Topic: Cancellations

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 %	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total	**11.2%**	**10.0%**	**7.6%**	**10.4%**	**9.1%**	**7.1%**	**10.8%**	**13.0%**	**17.3%**	**23.7%**	**17.6%**	**21.6%**
Hospital	4.5%	3.8%	2.7%	6.0%	4.1%	2.8%	5.4%	6.4%	12.3%	15.9%	11.7%	10.9%
Clinical	3.1%	3.2%	3.4%	3.0%	3.3%	2.1%	3.0%	0.6%	1.9%	2.2%	3.2%	1.1%
Patient	3.3%	3.0%	1.6%	1.5%	1.7%	2.3%	2.4%	6.0%	3.1%	5.6%	2.4%	5.5%
Other	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	4.1%



Narrative Summary:
The **hospital cancellation rate** reduced slightly in March but remains consistently high overall. Difficulty in protecting elective beds continues to adversely impact elective operating.

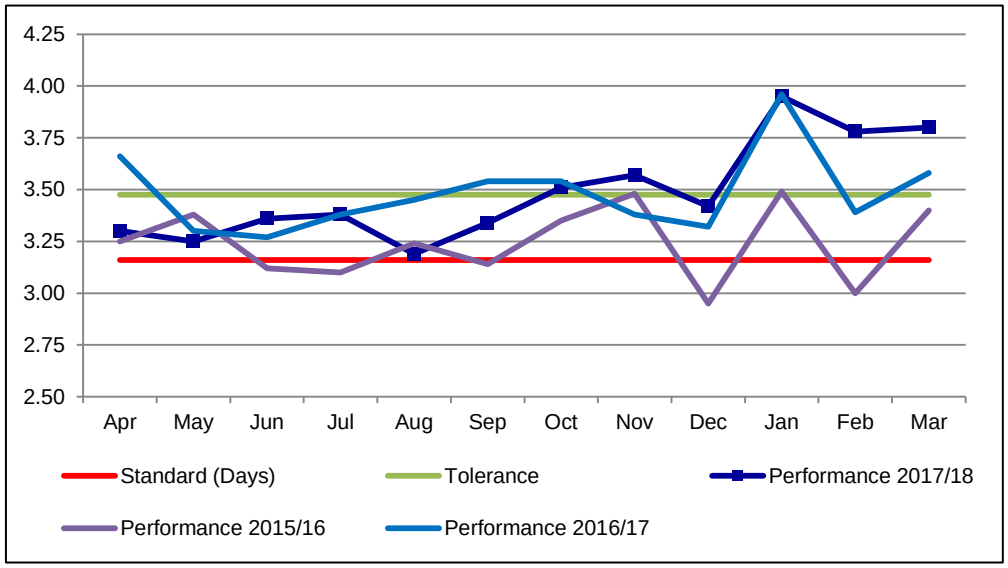
Actions:
- Recovery plan to re-establish elective ward.
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment.
- Weekly theatre scheduling meeting has been implemented, work is ongoing to improve this process with a view to maximising theatre utilization.
- Elective capacity being assessed week by week.
- Ward 8 remains open as inpatient area in order to protect elective bays in Ward 9. Day cases are being managed through DPU.

BGH Average Length of Stay

Standard: Reduce BGH Length of Stay	Target	Tolerance
	3.16	3.48

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (Days)	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16	3.16
Performance 2017/18	3.30	3.25	3.36	3.38	3.19	3.34	3.51	3.57	3.42	3.95	3.78	3.80
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:
BGH Length of Stay (LoS) deteriorated significantly through the winter period, to the equivalent of 20 additional beds at the BGH per day. This is partially due to the increase in delayed discharges since September 2017 and partially due to the subsequent increase in both boarded patients and elective cancellations.

Actions:
- BGH senior management team are working to recover full elective profile.
- a new Unscheduled Care Improvement Forum has been established to lead the reduction of LOS at BGH.
- 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)

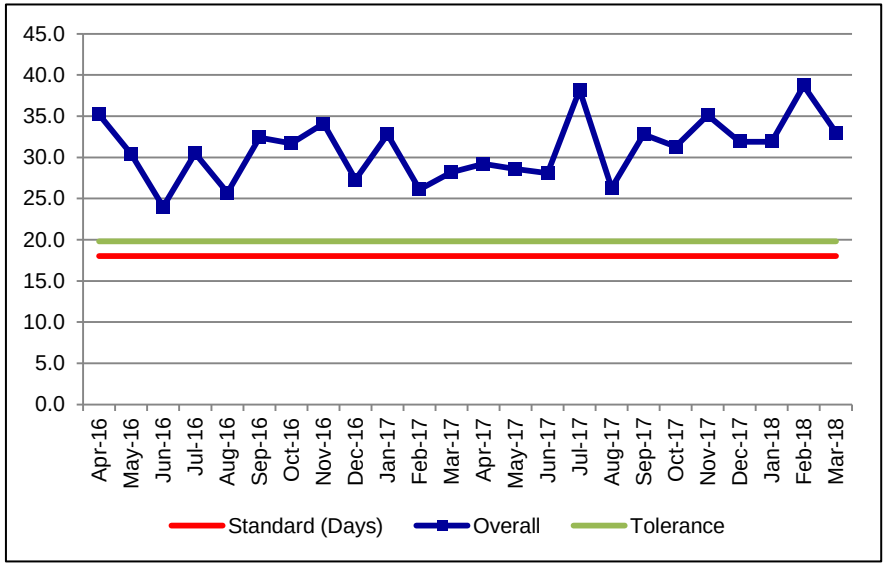
Standard: Reduce Community Hospital Average Length of Stay	**Standard**	**Tolerance**
	18.0	19.8

Actual Performance (lower = better performance)

	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 (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	**29.2**	**28.6**	**28.1**	**38.2**	**26.3**	**32.8**	**31.3**	**35.1**	**31.9**	**31.9**	**38.7**	**33.0**
Hawick	21.5	15.1	25.2	36.8	20.8	24.7	26.0	28.0	30.9	30.0	23.3	17.5
Hay Lodge [1]	23.7	34.3	26.2	34.2	49.4	41.6	30.9	43.7	26.8	31.0	60.2	33.0
Kelso	40.1	32.5	23.2	27.2	18.0	31.3	31.1	29.5	51.3	47.2	45.2	50.6
Knoll	40.2	54.4	42.9	78.3	32.6	39.1	39.6	44.9	27.8	26.1	42.9	56.7

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. As part of winter planning, additional beds have been opened in Haylodge, Hawick & the Knoll, total increase in capacity is 7, which may be contributing to the LOS.

Actions:
- A Hospital to home pilot has been introduced within the Berwickshire area to provide additional support to assist patients to return home. A similar approach will be introduced in the Hawick area.
- A final report has been produced by Dr A Hendry and recommendations are currently being considered and will be utilised to develop options on future models, which will aim to reduce LOS.

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

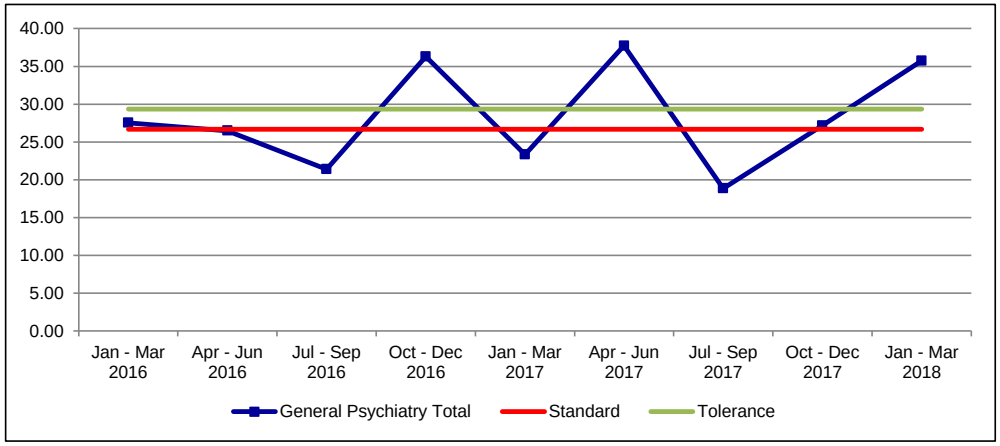
Standard: Reduce Mental Health Average Length of Stay	**Standard**	**Tolerance**
	Various	within 10%

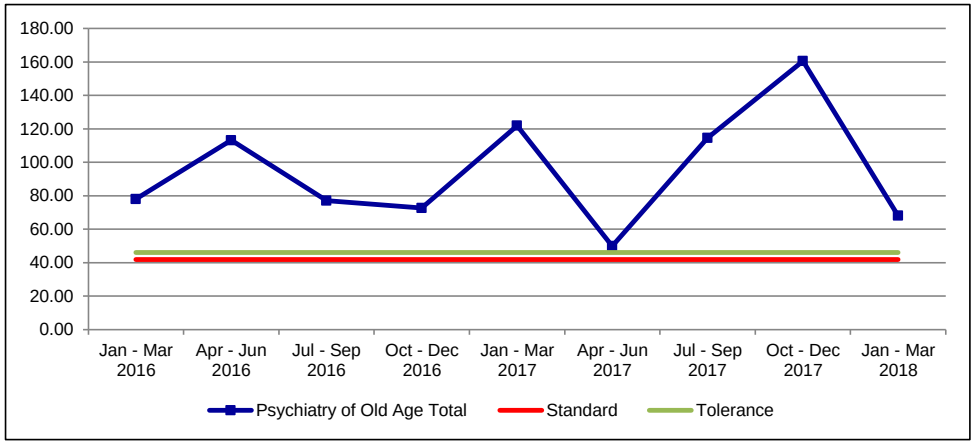
Actual Performance (lower = better performance)

	Standard (Days)	Jan - Mar 2016	Apr - Jun 2016	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	Jul - Sep 2017	Oct - Dec 2017	Jan - Mar 2018
Huntlyburn	17.70	19.79	23.93	17.56	15.04	16.41	23.94	16.40	26.19	21.63
The Brigs	42.83	53.78	43.00	69.00	134.28	48.24	68.38	25.90	32.53	101.29
General Psychiatry Total	**26.70**	**27.53**	**26.49**	**21.41**	**36.29**	**23.35**	**37.72**	**18.86**	**27.18**	**35.75**
Cauldshiels	26.95	75.38	105.50	109.07	115.22	86.80	52.14	104.70	178.20	73.56
Lindean	60.58	33.72	82.33	33.00	28.36	54.00	48.38	45.90	24.50	61.73
Melburn Lodge [1]	111.63	247.33	345.00	112.00	124.00	491.00	- [2]	545.50	616.00	90.00
Psychiatry of Old Age Total	**41.82**	**78.00**	**113.18**	**77.00**	**72.59**	**121.88**	**49.83**	**114.50**	**160.50**	**68.14**

[1] Figures are high due to various patients with waits of 1084 days and 654 days who were discharged

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





Narrative Summary:
Mental Health LOS can fluctuate, particularly for older adults, depending on the numbers of discharges and the length of time a patient has been within the facility and is quite often skewed by one or two long stay patients and small numbers of discharged per month. We have therefore moved to report ALoS on a quarterly basis. It is difficult to predict when the standard will improve however consideration is being given to how Length of Stay could be measured more meaningfully. Longer length of stay could potentially have a negative financial impact due to the cost of inpatient bed days. Work continues as described below.

Actions:
- LOS is monitored within the performance scorecard at monthly Mental Health meetings and picked up with Senior Charge Nurses by exception; there are no routine actions specific to this target but work is underway to ensure patients have EDD's on admission to Mental Health Wards (as appropriate).

Mental Health Waiting Times

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

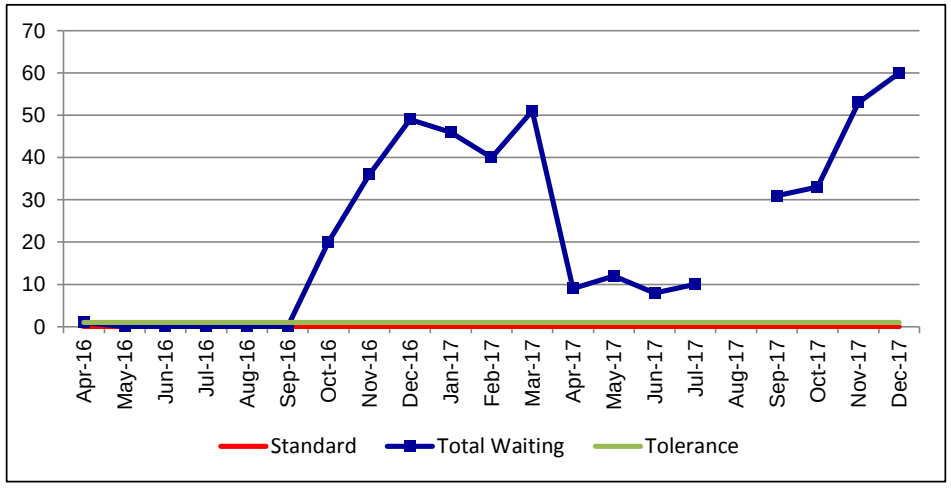
Actual Performance (lower = better performance)

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17[1]	Sep-17	Oct-17	Nov-17	Dec-17[2]	Jan-18[2]	Feb-18[2]	Mar-18[2]
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**51**	**9**	**12**	**8**	**10**	-	**31**	**33**	**53**	**60**	-	-	-
MH Older Adults - East	0	2	1	0	0	-	1	1	1	-	-	-	-
MH Older Adults - South	0	0	0	0	0	-	0	0	0	-	-	-	-
MH Older Adults - West & Central	0	2	3	0	4	-	2	2	0		-	-	-
East Team	33	2	1	1	2	-	3	7	14	15	-	-	-
South Team	10	0	0	2	3	-	2	0	0	0	-	-	-
West Team	8	3	7	5	1	-	23	23	38	45			

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

[2] Data unavailable due to reporting on EMIS

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:
Mental Health Waiting Times increased from June to December 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 and vacancies has impacted on the ability to meet the waiting times targets in East and West CMHTs.
- Sickness absence is now resolved and vacancies are filled and this will impact positively on waiting times. Further changes in personnel in East and West will have an impact on waiting times.

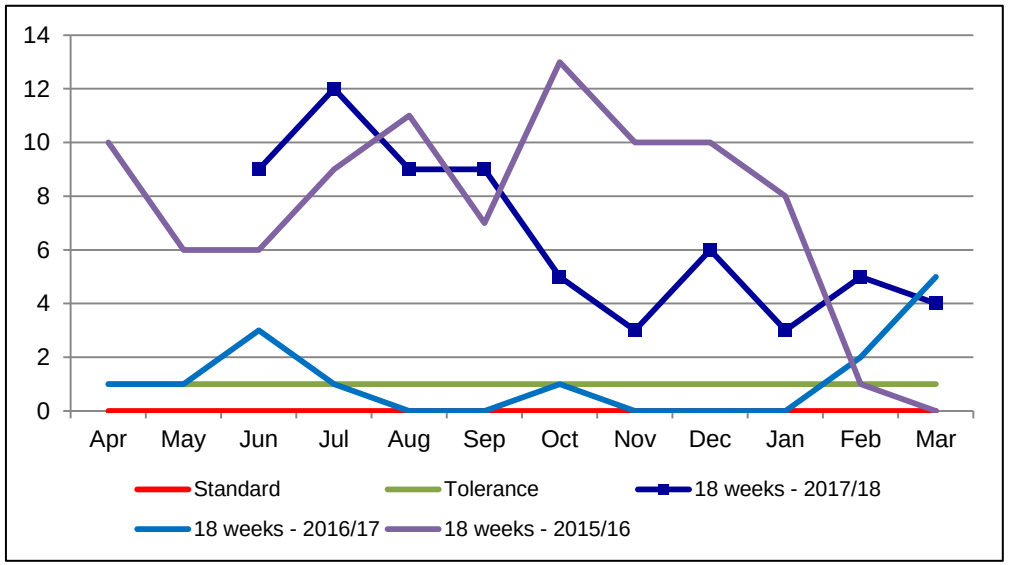
Learning Disability Waiting Times

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

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
18 weeks - 2017/18	-	-	9	12	9	9	5	3	6	3	5	4
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:
3 of 5 **Learning Disability waiting times** breaches in March 2018 were within Speech and Language Therapy. This is continuing to reduce in numbers and is monitored through Speech and Language therapy department. Details are reported into the Learning Disability service management team.

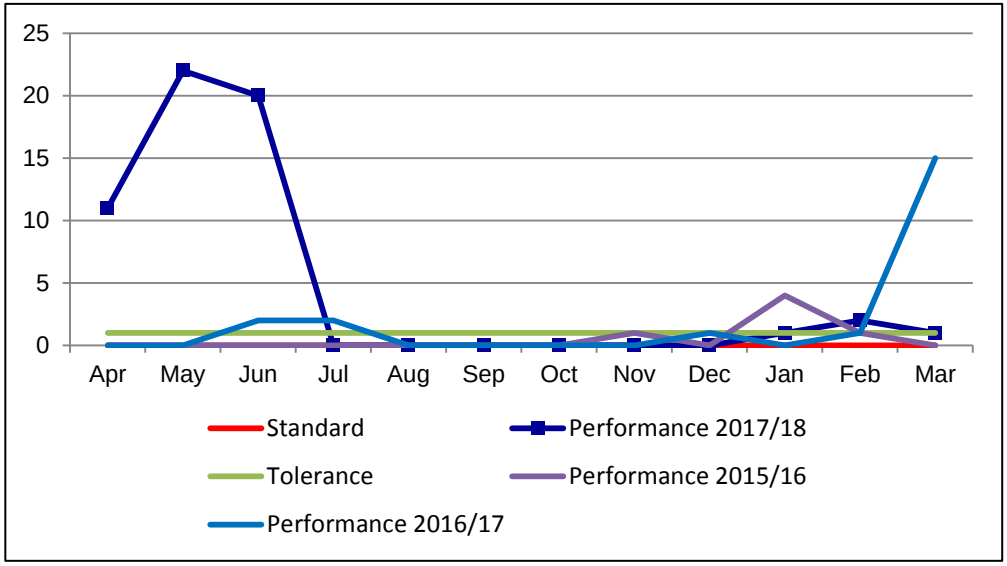
Actions:
- Continue to monitor and manage the waiting list within the performance scorecard at the Learning Disability Service management team meetings and action with appropriate managers

Rapid Access Chest Pain Clinic (RACPC)

	Standard	Tolerance
Standard: 1 Week Waiting Target for RACPC	0	1

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Performance 2017/18	11	22	20	0	0	0	0	0	0	1	2	1
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 March 2018 there was 1 patient waiting over **1 week for the Rapid Access Chest Pain Clinic.** The service manage 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

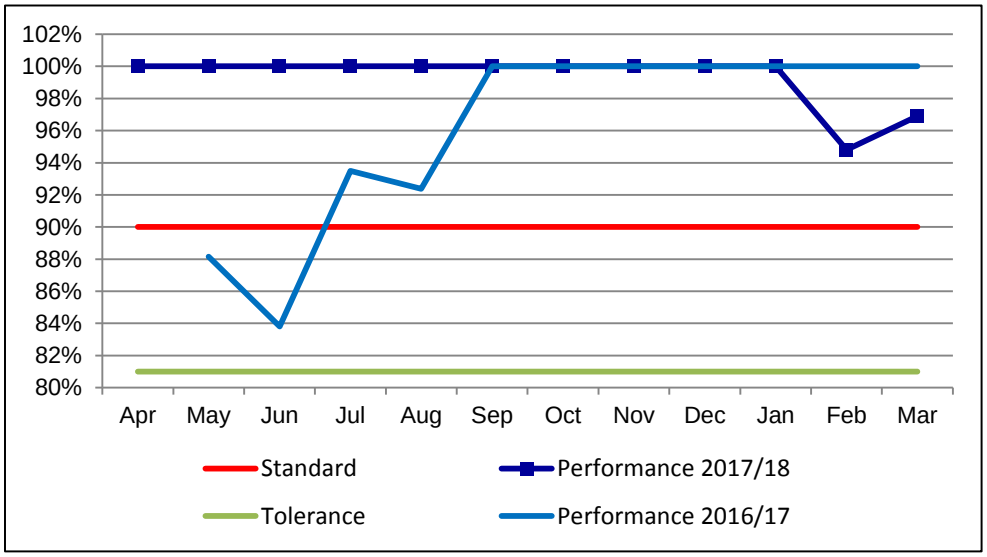
Standard: 18 Week Referral to Treatment for Audiology	Standard	Tolerance
	90.0%	81.0%

Actual Performance (lower number of patients with active wait = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.8%	96.9%
Patients with active wait over 18 Weeks 2017/18	0	0	0	0	0	0	0	0	0	0	14	8
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 had 8 breaches of the **18 week referral to treatment** standard in March 2018. This pattern is not expected to continue numbers of breaches are reducing.

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

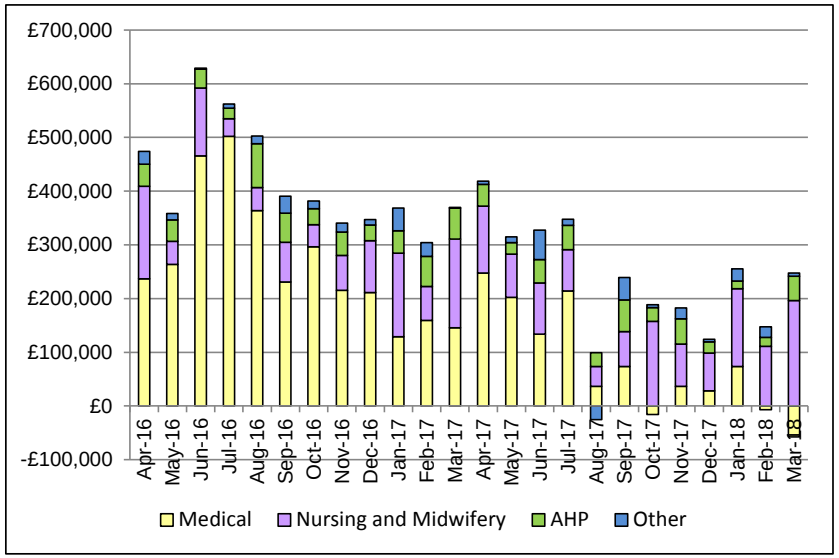
Workforce Section

Supplementary Staffing

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

Actual Performance (lower = better performance)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Medical	£247,521	£202,203	£133,969	£214,295	£36,696	£73,584	-£15,869	£36,560	£28,444	£73,802	-£6,994	-£57,438
Nursing and Midwifery	£124,708	£80,778	£95,194	£76,940	£36,821	£65,110	£157,753	£78,489	£70,270	£144,230	£111,112	£196,307
AHP	£40,298	£20,876	£43,664	£45,327	£25,717	£59,055	£25,144	£47,105	£20,519	£14,600	£16,793	£45,197
Other	£6,160	£11,033	£54,626	£11,197	-£25,138	£41,395	£5,632	£20,519	£4,881	£22,740	£19,311	£6,312
Total Cost	**£418,687**	**£314,890**	**£327,453**	**£347,759**	**£74,096**	**£239,144**	**£172,660**	**£182,673**	**£124,114**	**£255,372**	**£140,222**	**£190,378**



Narrative Summary:
NHS Borders **agency spend** on trained nursing increased significantly in the final quarter of the financial year due to additional costs incurred for agency staff to support additional beds related to delayed discharges, high levels of sickness cover and increased activity across the hospital linked to winter. Funding support from the IJB for the extra surge beds has been allocated to Nursing budgets.

Medical Agency - reduction in recorded spend in the final two months of the financial year is a result of updated information on agency usage received in February and in March in support of year end accrual relating to specialty registrars in both planned and unscheduled care, over than anticipated actual charges. There has been an overall reduction in agency spend in Acute Services. Medical agency usage recorded in January relates to medical cover in Mental Health and Ophthalmology.

AHP Agency - increase due to cover in Dietetics, Physiotherapy and Occupational Therapy. Physiological Measurement and Radiology use agency cover for vacancies.

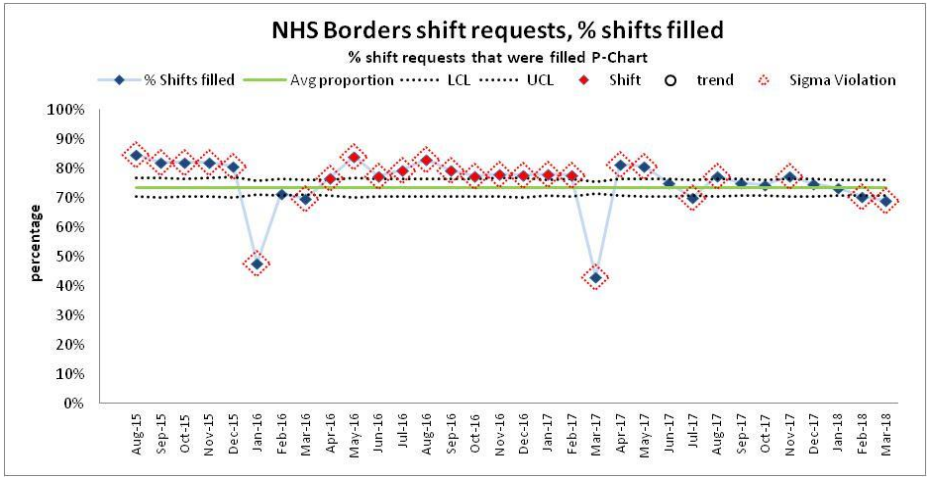
Other agency - costs to date relate to agency cover for Blood Sciences and IM&T agency staff. The increase in January and February relates to cover provided to the Microbiology service.

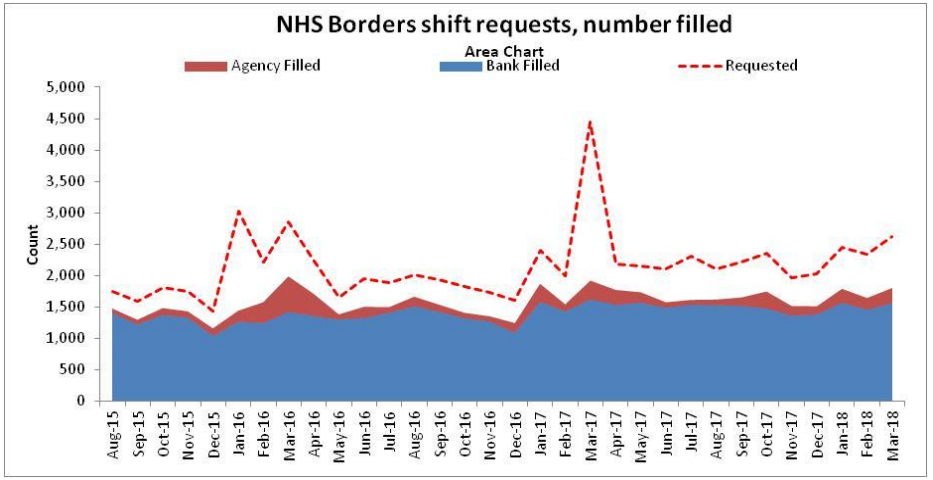
Actions:
- Recruitment following targeted training into key nursing posts in Acute Services and proactive management of sickness levels is required in order to see levels of expenditure brought into line with budgets.

Nurse Bank

Standard: NHS Borders Nurse Bank and agency shifts

NHS Borders Overall





Narrative Summary:
Overall the number of NHS Borders **shift requests** increased in March 2018 by 273 shifts, with 241 of those within the BGH. Extra beds within the BGH accounted for 600 shift requests in March with an additional 432 requests for patient dependency. Agency also decreased by 57 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 continues to be high levels of requests for supplementary staff across NHS Borders. Possible contributing factors extra beds, patient dependency and short notice sickness.

Actions update:
- The next planned recruitment event for both Health Care Support Workers (HCSW) and Registered Nurses will be held on the 3rd of May 2018. 51 HCSW's have been shortlisted and 19 Registered Nurses.

Nurse Bank *continued*