**Borders NHS Board**

## NHS BORDERS PERFORMANCE SCORECARD – APRIL 2018

### Aim

This paper aims to update the Board with NHS Borders latest performance towards the 2018/19 Annual Operational Plan performance measures, previous HEAT & Local Delivery Plan standards and local Key Performance Indicators.

2018/19 is NHS Borders first Annual Operational Plan which replaces the need for a Local Delivery Plan. The Annual Operational Plan has been produced in line with guidance received from Scottish Government in February 2018. The attached Performance Scorecard shows performance as at 30th April 2018.

### Background

The monthly Performance Scorecard is presented regularly to the Clinical Executive Operational Group, Strategy & Performance Committee and the Board. It has been re-drafted and updated for 2018/19 to enable members to monitor performance against the Annual Operational Plan, previous HEAT and Local Delivery Plan standards and local key performance indicators.
+
In 2018/19 we are not reporting on stretch targets, which were previously Diagnostics 4 week's target, CAMHS waiting times at 95% and the Emergency Access Standard at 98%. The performance scorecard focuses on nationally set standards and targets.

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. 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:

| Annual Operational Plan | Feb-18 * | Mar-18 * | Apr-18 |
|---|---|---|---|
| Green – achieving standard | - | - | 7 |
| Amber – nearly achieving standard | - | - | 1 |
| Red – outwith standard | - | - | 7 |

| Previous HEAT / LDP Standard and Key Performance Indicators | Feb-18 * | Mar-18 * | Apr-18 |
|---|---|---|---|
| Green – achieving standard | - | - | 8 |
| Amber – nearly achieving standard | - | - | 2 |
| Red – outwith standard | - | - | 15 |

* No previous comparison due to change in format of scorecard for new Annual Operational Plan
Some standards are not included due to transition to EMIS reporting

There is an addition to the April 2018 scorecard which details NHS Borders compliance against Statutory and Mandatory eLearning. Further information can be found on page 64. A summary RAG dashboard for the year is included on pages 4 - 6 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 Annual Operational Plan measures for the position as at 30th April 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:

- 96.7% of patients **with a suspicion of cancer** were seen within **62 days** in March 2018 (latest available data) (page 9)
- 100% of patients **requiring treatment for cancer** were seen within **31 days** in February 2018 (latest available data) (page 10)

The Board are asked to note that the following Annual Operational Plan performance measures are outwith the 10% tolerance (red status) at 30th April 2018. Services have provided narrative and actions that are underway to improve performance. Details can be found within the scorecard on page references below:

- **12 weeks Outpatient Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year and the first month of 2018/19 (page 11)
- **12 weeks Inpatient Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year and the first month of 2018/19 (page 13)
- **12 week Treatment Time Guarantee** – performance reported outwith the standard for the full 2017/18 year and the first month of 2018/19 (page 15)
- **18 weeks RTT Admitted Pathway Performance** – performance is consistently reported outwith the standard for the full 2017/18 year (page 17)
- **6 week Diagnostic Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year and the first month of 2018/19 (page 23)
- **CAMHS Waiting Times** – performance reported outwith the 10% tolerance of the standard for 4 consecutive months (page 25)
- **Delayed Discharges** – performance reported outwith the standard for the full 2017/18 year and the first month of 2018/19 (page 28)

The attached Scorecard contains information from the respective service leads around the reasons for non delivery of the 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 Annual Operational Plan, previous HEAT and LDP standards and local Key Performance Indicators.

**Recommendation**

The Board is asked to **note** the April 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 measures within this report have been reviewed by each Clinical Board and members of the Clinical Executive. |
| **Risk Assessment** | There are a number of measures that are not being achieved, and have not been achieved recently. For these measures service leads continue to take corrective action or outline risks and issues to get them 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 the measures 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 30th April 2018**

## April 2018

**Planning & Performance**

**Month**

**1**

2

3

4

5

6

7

8

9

10

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# Contents

# INTRODUCTION

## DASHBOARD OF 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 was called the Local Delivery Plan (LDP) and formed an agreement on what Health Boards will achieve in the next year with SGHD. From 2018/19 Boards are no longer required to produce an LDP but will be required to produce Annual Operational Plans which will form the LDP standards.

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 Annual Operational Plan Performance Measures is detailed within in this report. The following table summarises the achievements for the financial year 2018/19 to date, the arrows indicate performance and direction of travel towards achieving the measures compared to the previous month:

**Please Note:** there is no comparison for April 2018 due to it being the first month of the new financial year

| Indicator | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Treatment within 62 days for Urgent Referrals of Suspicion of Cancer [1] | - | | | | | | | | | | | |
| Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [1] | - | | | | | | | | | | | |
| 18 Wk RTT: 12 wks for outpatients | R - | | | | | | | | | | | |
| 18 Wk RTT: 12 wks for inpatients | R - | | | | | | | | | | | |
| 18 Wk RTT: 12 weeks TTG | R - | | | | | | | | | | | |
| 18 Wk RTT: Admitted Pathway Performance [2] | - | | | | | | | | | | | |
| 18 Wk RTT: Admitted Pathway Linked Pathway [2] | - | | | | | | | | | | | |
| 18 Wk RTT: Non-admitted Pathway Performance [2] | - | | | | | | | | | | | |
| 18 Wk RTT: Non-admitted Pathway Linked Pathway [2] | - | | | | | | | | | | | |
| Combined Performance [2] | - | | | | | | | | | | | |
| Combined Performance Linked Pathway [2] | - | | | | | | | | | | | |
| 6 Week Waiting Target for Diagnostics | R - | | | | | | | | | | | |
| No CAMHS waits over 18 wks [3] | - | | | | | | | | | | | |
| 4-Hour Waiting Target for A&E | A - | | | | | | | | | | | |
| No Delayed Discharges over 72 hours (3 days) | R - | | | | | | | | | | | |

**Footnotes**

1 One month lag as data is supplied nationally.

2 One month lag time to allow accurate information to be reported inline with national reporting timelines.

2 One month lag time for CAMHS data.

Performance on previous HEAT & LDP standards, as well as local Key Performance Indicators is detailed within in this report. The following table summarises the achievements for the financial year 2018/19 to date, the arrows indicate performance and direction of travel towards achieving the measures compared to the previous month:

**Please Note:** there is no comparison for April 2018 due to it being the first month of the new financial year

| Indicator | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diagnosis of dementia | A - | | | | | | | | | | | |
| Dementia Post Diagnostic Support [1] (2017/18 data) | R - | | | | | | | | | | | |
| Alcohol Brief Interventions [2] | R - | | | | | | | | | | | |
| Smoking cessation successful quits in most deprived areas [3] | - | | | | | | | | | | | |
| Sickness Absence Reduced | R - | | | | | | | | | | | |
| New patient DNA rate | R - | | | | | | | | | | | |
| Same day surgery [4] | - | | | | | | | | | | | |
| Pre-operative stay [4] | - | | | | | | | | | | | |
| Online Triage of Referrals | G - | | | | | | | | | | | |
| Increase the proportion of new-born children breastfed at 6-8 weeks [5] | - | | | | | | | | | | | |
| eKSF annual reviews complete [6] | - | | | | | | | | | | | |
| PDP's Complete [6] | - | | | | | | | | | | | |
| Emergency OBDs aged 75 or over (per 1,000) [7] | - | | | | | | | | | | | |
| Admitted to the Stroke Unit within 1 day of admission [8] | R - | | | | | | | | | | | |
| No Psychological Therapy waits over 18 wks | R - | | | | | | | | | | | |
| 90% of Alcohol/Drug Referrals into Treatment within 3 weeks | G - | | | | | | | | | | | |

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AHP Waiting Times | | - | | | | | | | | | | | |
| Cancellations | Hospital | R - | | | | | | | | | | | |
| | Clinical | R - | | | | | | | | | | | |
| | Patient | G - | | | | | | | | | | | |
| | Other | G - | | | | | | | | | | | |
| Borders General Hospital Average Length of Stay | | R - | | | | | | | | | | | |
| Community Hospitals Average Length of Stay | | R - | | | | | | | | | | | |
| Mental Health Average Length of Stay General Psychiatry Total [9] | | - | | | | | | | | | | | |
| Mental Health Average Length of Stay Psychiatry of Old Age Total [9] | | - | | | | | | | | | | | |
| Mental Health Waiting Times (Patients waiting over 9 weeks) | | - [10] | | | | | | | | | | | |
| Learning Disability Waiting Times (Patients waiting over 18 weeks) | | R - | | | | | | | | | | | |
| Rapid Access Chest Pain Clinic | | A - | | | | | | | | | | | |
| Audiology 18 Weeks Waiting Times | | G - | | | | | | | | | | | |

**Footnotes**

1 There is a 1 year time lag to show the full 12 months performance therefore data is 2016/17 rather than 2017/18 - 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 There is a 2 month lag in data due to SMR recording
5 There is a lag time for national data, local data supplied and reported quarterly
6 No data available from February 2018 due to move to the new system, Turas.
7 There is a 6 month lag in reporting any data included is the most up to date data available.
8 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.
9 Mental Health ALOS reported quarterly
10 Data unavaiable at time of reporting due to migration to EMIS

The following previous HEAT / LDP 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-19 | 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-19 | 80% | Managing Our Performance Report – 6 and 12 month intervals |
| IVF | Commence IVF Treatment within 12 months | Mar-19 | All patients | Managing Our Performance Report – 6 and 12 month intervals |
| CDI | Clostridium difficile infections per 1000 occupied bed days (0.32) | Mar-19 | 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-19 | 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-19 | 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-19 | - | Managing Our Performance Report – 6 and 12 month intervals |

# Annual Operational Plan: Performance Measures

## Cancer Waiting Times

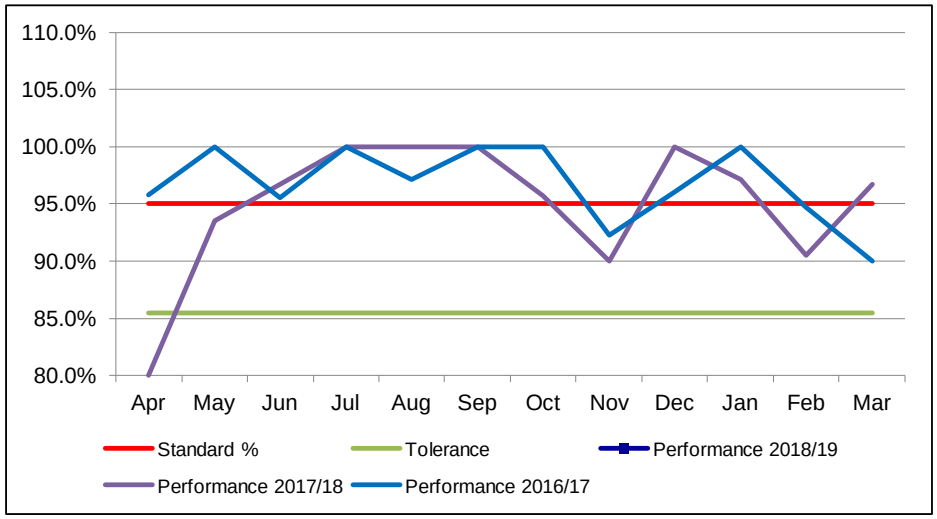
| | Standard | Tolerance |
|---|---|---|
| **62 Day Cancer -** 95% of all cases with a Suspicion of Cancer to be seen within 62 days | 95.0% | 86.0% |

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

| Latest NHS Scotland Performance |
|---|
| 86.6% (Mar 2018) |

| | 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 2018/19** | | | | | | | | | | | | |
| **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% | 96.7% |
| **Performance 2016/17** | 95.8% | 100.0% | 95.5% | 100.0% | 97.1% | 100.0% | 100.0% | 92.3% | 96.0% | 100.0% | 94.7% | 90.0% |

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




**Narrative Summary:**
The run chart shows the standard, to **see patients with a suspicion of cancer within 62 days** which was achieved in March 2018.

**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.

## Cancer Waiting Times

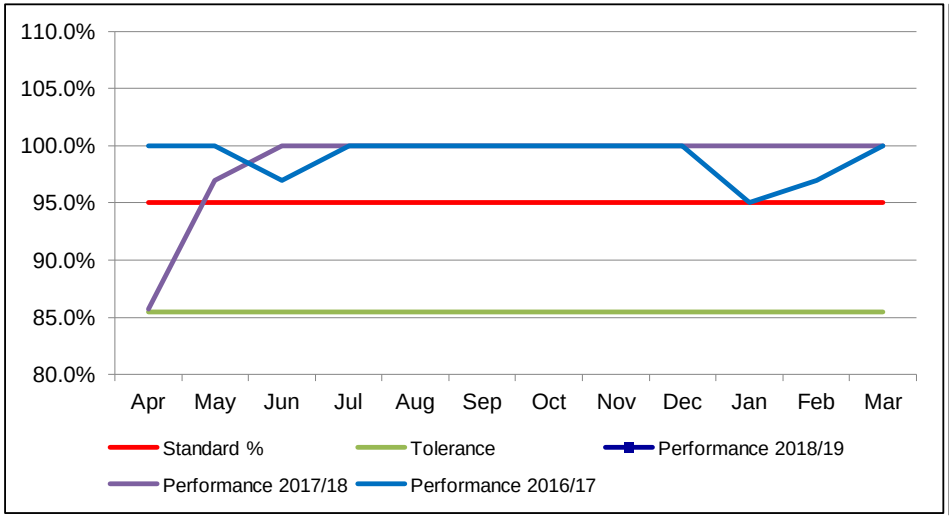
| | Standard | Tolerance |
|---|---|---|
| **31 Day Cancer -** 95% of all patients requiring Treatment for Cancer to be seen within 31 days | 95.0% | 86.0% |

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

| Latest NHS Scotland Performance |
|---|
| 93.1% (Mar 2018) |

| | 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 2018/19** | | | | | | | | | | | | |
| **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% | 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% |

**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.

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

| | Standard | Tolerance |
|---|---|---|
| **12 Weeks Outpatients -** 12 weeks for first outpatient appointment | 0 | 1 |

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

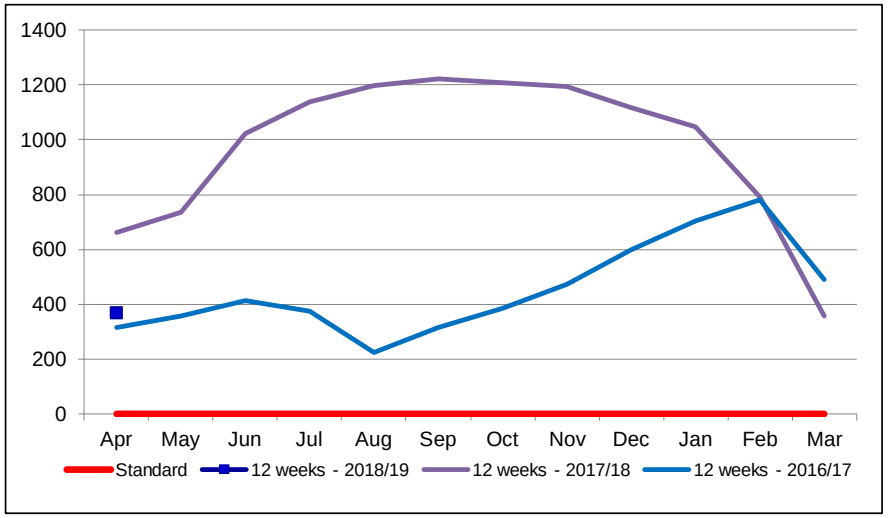
| Latest NHS Scotland Performance | NHS Borders Performance (as a comparative) |
|---|---|
| 70.1% (Dec 2017) | 79.6% (Dec 2017) |

| | 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 - 2018/19** | 370 | | | | | | | | | | | |
| **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 week breaches by specialty**

| 2017/18 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cardiology | 130 | 161 | 153 | 173 | 190 | 174 | 131 | 141 | 82 | 36 | 8 | 4 |
| Dermatology | 305 | 439 | 446 | 493 | 547 | 586 | 578 | 372 | 235 | 67 | 10 | 4 |
| Diabetes/Endocrinology | 13 | 19 | 22 | 19 | 7 | 4 | 2 | 1 | 1 | | | 2 |
| ENT | 1 | | 1 | | | | | 1 | | 1 | | |
| Gastroenterology | 32 | 57 | 85 | 105 | 85 | 74 | 57 | 42 | 18 | 9 | 3 | 3 |
| General Medicine | | | | 3 | 1 | | | | 2 | | 3 | 3 |
| General Surgery | 8 | 3 | 8 | 10 | 27 | 25 | 14 | 22 | 28 | 11 | 2 | 12 |
| Gynaecology | | | | | | | | | | | | |
| Neurology | 17 | 45 | 60 | 54 | 70 | 65 | 76 | 86 | 48 | 28 | 15 | 14 |
| Ophthalmology | 88 | 168 | 216 | 193 | 201 | 210 | 268 | 355 | 398 | 290 | 130 | 87 |
| Oral Surgery | 44 | 63 | 79 | 77 | 46 | 33 | 34 | 48 | 89 | 93 | 87 | 146 |
| Orthodontics | | | | | | | | | | | | 2 |
| Other | 28 | 38 | 40 | 52 | 40 | 35 | 33 | 38 | 27 | 19 | 9 | 11 |
| Pain Management | 14 | 8 | 2 | 1 | | | | | | | 1 | |
| Respiratory Medicine | | 1 | 1 | | | | 1 | 6 | 14 | 14 | 22 | 25 |
| Rheumatology | | | | | | | | | | | | |
| Trauma & Orthopaedics | 55 | 14 | 22 | 16 | 5 | 1 | | 5 | 104 | 212 | 62 | 54 |
| Urology | 2 | 5 | 3 | 2 | 1 | | 1 | | 2 | 11 | 5 | 3 |
| **All Specialties** | **737** | **1021** | **1138** | **1198** | **1220** | **1207** | **1195** | **1117** | **1048** | **791** | **357** | **370** |

## 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** 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 and the number of breaches increased in April 2018. 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. 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 made worse 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 being cancelled while they cover the vacant posts ward commitments.

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

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

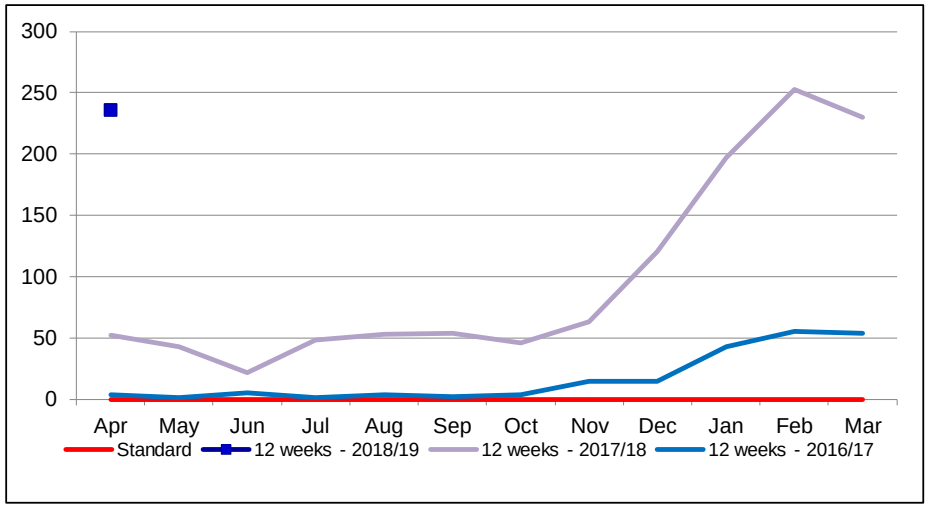
**Actual Performance** (lower = better performance)

| | 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 - 2018/19** | 236 | | | | | | | | | | | |
| **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 week breaches by specialty**

| 2017/18 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ENT | | | | 1 | 2 | 2 | | 3 | 8 | 8 | 7 | 9 |
| General Surgery | 10 | 4 | 2 | 4 | 1 | | 6 | 14 | 36 | 61 | 72 | 84 |
| Gynaecology | | | | | | | | | | 2 | | |
| Ophthalmology | | | 5 | 7 | 9 | 3 | 1 | | | 11 | 7 | 8 |
| Oral Surgery | | | | 1 | 1 | 1 | 9 | 25 | 23 | 16 | 7 | 4 |
| Other | | | 1 | | | | | | | 16 | 16 | 9 |
| Trauma & Orthopaedics | 32 | 18 | 40 | 40 | 41 | 40 | 47 | 76 | 122 | 130 | 109 | 102 |
| Urology | 1 | | | | | | | 2 | 8 | 9 | 12 | 20 |
| **All Specialties** | **43** | **22** | **48** | **53** | **54** | **46** | **63** | **120** | **197** | **253** | **230** | **236** |

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




**Narrative Summary:**
At the end of April, the number of patients reported waiting over **12 weeks for inpatient treatment** increased to 236. 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 except Gynaecology.

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.
- 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.
- Short term additional capacity has been organised through an external locum for Ophthalmology in August to utilise empty lists due to consultant leave.

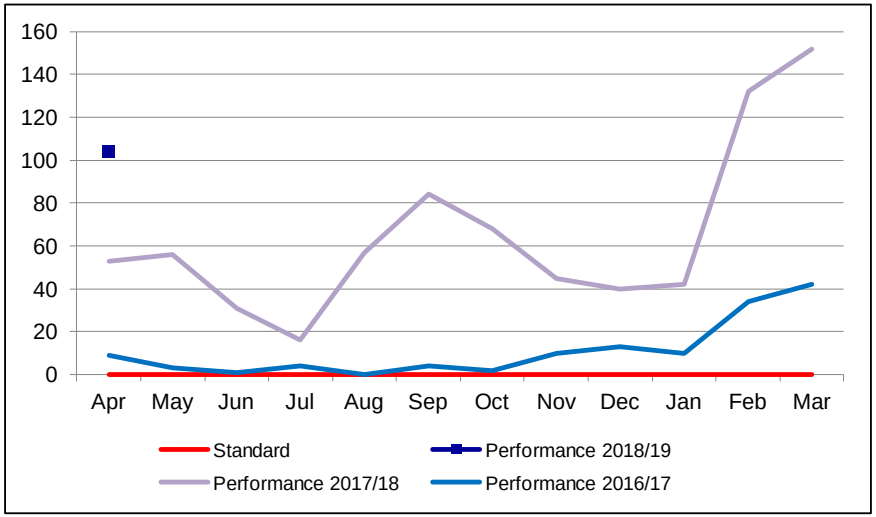
## 12 Weeks Treatment Time Guarantee

| | Standard | Tolerance |
|---|---|---|
| **12 weeks TTG -** 12 Weeks Treatment Time Guarantee (TTG 100%) | 0 | 0 |

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

| Latest NHS Scotland Performance | NHS Borders Performance (as a comparative) |
|---|---|
| 80.59% (Dec 2017) | 91.34% (Dec 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 2018/19** | 104 | | | | | | | | | | | |
| **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 |




**Narrative Summary:**
In April 104 patients who previously breached their **Treatment Time Guarantee** (TTG) date were treated. The breaches were mainly due to the capacity problems within Orthopaedics and the cancellations over the past few months.

**Actions:**
- Short notice cancellations are reviewed on a daily basis.
- Work is ongoing to ensure cancellations are minimised and decisions are made as soon as possible.
- An Institute for Healthcare Optimisation (IHO) project is looking to address surgical flow; however the service are reviewing on a weekly basis to determine any risk of cancellations and take appropriate action.
- Cancelled patients are rebooked as soon as possible to accommodate their TTG date where possible.

## 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 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unavailable | 69 | 93 | 101 | 91 | 103 | 87 | 71 | 63 | 62 | 53 | 60 | 75 | 71 |
| Patient Advised | 41.8% | 47.9% | 50.2% | 46.0% | 55.7% | 52.1% | 45.2% | 42.6% | 40.3% | 35.6% | 37.3% | 43.9% | 42.5% |
| Unavailable | 96 | 101 | 100 | 107 | 82 | 80 | 86 | 85 | 92 | 96 | 101 | 96 | 96 |
| Medical | 58.2% | 52.1% | 49.8% | 54.0% | 44.3% | 47.9% | 54.8% | 57.4% | 59.7% | 64.4% | 62.7% | 56.1% | 57.5% |
| Total Unavailable | 165 | 194 | 201 | 198 | 185 | 167 | 157 | 148 | 154 | 149 | 161 | 171 | 167 |
| Total % Unavailable | 15.5% | 18.9% | 20.2% | 17.9% | 16.0% | 14.2% | 13.9% | 14.6% | 12.5% | 11.8% | 12.8% | 12.9% | 12.9% |

### Table 2 - Monthly Unavailability by Specialty - as at 30th April 2018

| | Available | | | | Unavailable | | | |
|---|---|---|---|---|---|---|---|---|
| **Specialty** | **0 - 9 Weeks** | **10 - 12 Weeks** | **12+ Weeks** | **Total** | **Medical Un-available** | **Patient Advised Un-available** | **Total** | **% Un-available** |
| ENT | 40 | 4 | 9 | **53** | 3 | 5 | **8** | **13.1%** |
| General Surgery | 120 | 21 | 84 | **225** | 14 | 23 | **37** | **14.1%** |
| Gynaecology | 34 | 1 | | **35** | 4 | 6 | **10** | **22.2%** |
| Ophthalmology | 193 | 55 | 8 | **256** | 13 | 7 | **20** | **7.2%** |
| Oral Surgery | 29 | 5 | 4 | **38** | 6 | 2 | **8** | **17.4%** |
| Other | 32 | 6 | 9 | **47** | 2 | 1 | **3** | **6.0%** |
| Trauma & Orthopaedics | 237 | 34 | 102 | **373** | 42 | 22 | **64** | **14.6%** |
| Urology | 70 | 12 | 20 | **102** | 12 | 5 | **17** | **14.3%** |
| **Total** | **755** | **138** | **236** | **1129** | **96** | **71** | **167** | **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.

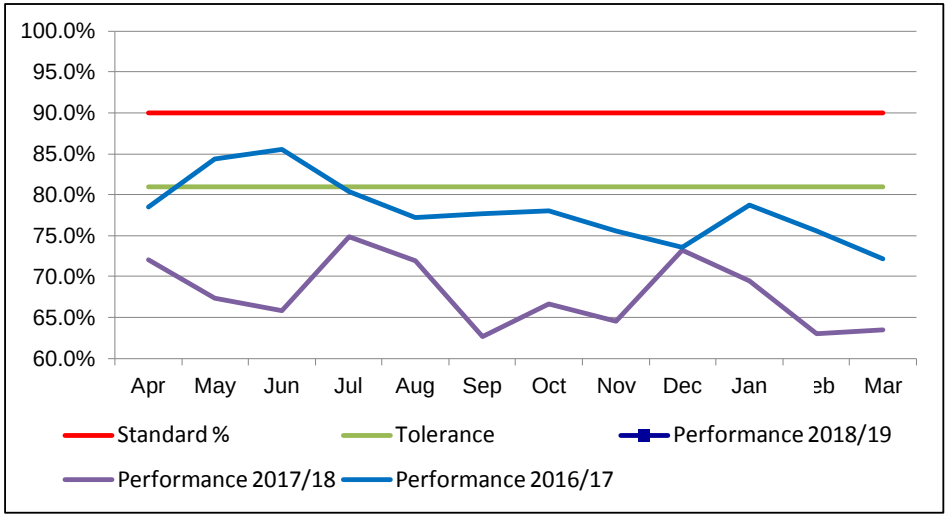
**Actions:**
- Ensure unavailability is closely monitored and that patients are managed in accordance with national guidelines.

## 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 2018/19** | | | | | | | | | | | | |
| **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% | 63.5% |
| **Performance 2016/17** | 78.5% | 84.4% | 85.5% | 80.4% | 77.2% | 77.7% | 78.0% | 75.5% | 73.6% | 78.7% | 75.5% | 72.2% |




**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.

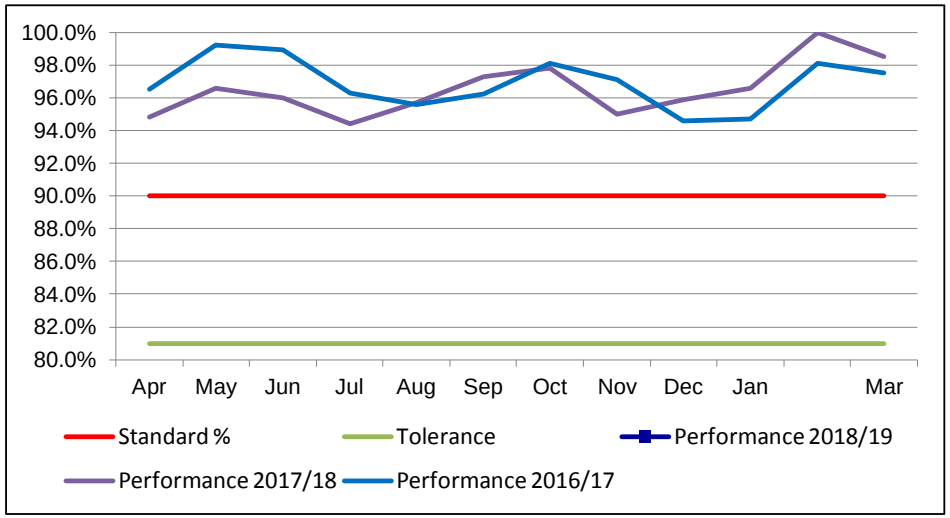
**Please Note:** 18 Weeks RTT data isreported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

## 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 2018/19** | | | | | | | | | | | | |
| **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% | 98.5% |
| **Performance 2016/17** | 96.5% | 99.2% | 98.9% | 96.3% | 95.6% | 96.2% | 98.1% | 97.1% | 94.6% | 94.7% | 98.1% | 97.5% |




**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.

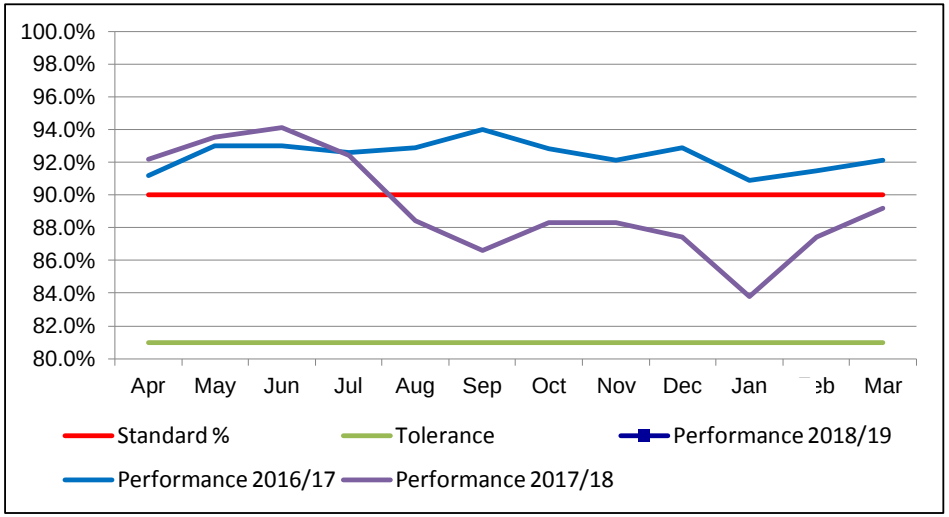
**Please Note:** 18 Weeks RTT data is reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

## 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 2018/19** | | | | | | | | | | | | |
| **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% | 89.2% |
| **Performance 2016/17** | 91.2% | 93.0% | 93.0% | 92.6% | 92.9% | 94.0% | 92.8% | 92.1% | 92.9% | 90.9% | 91.5% | 92.1% |




**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.

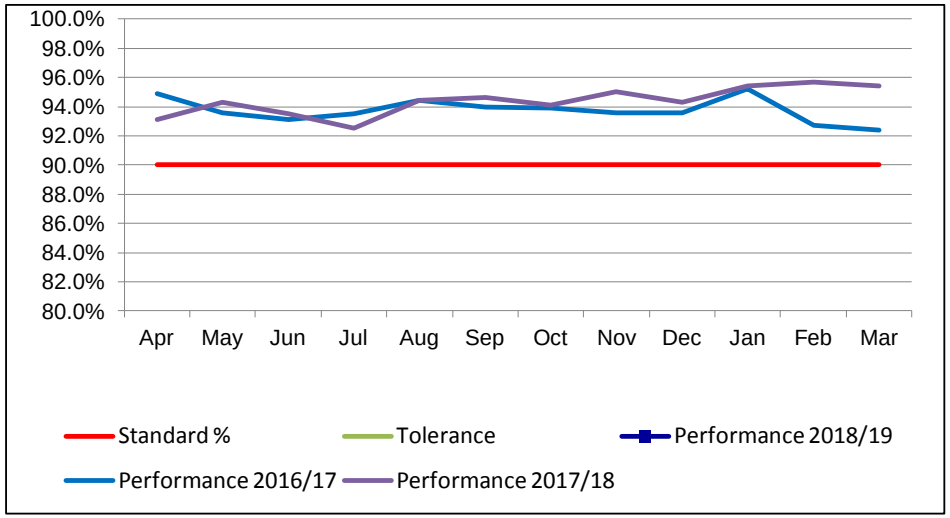
**Please Note:** 18 Weeks RTT data is reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

## 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 2018/19** | | | | | | | | | | | | |
| **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% | 95.4% |
| **Performance 2016/17** | 94.9% | 93.6% | 93.1% | 93.5% | 94.4% | 94.0% | 93.9% | 93.6% | 93.6% | 95.2% | 92.7% | 92.4% |




**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.

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

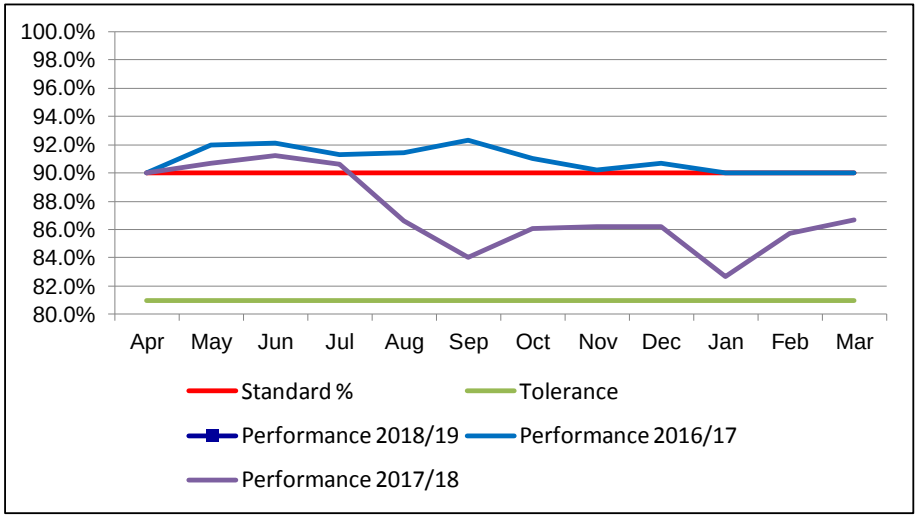
## 18 Weeks Referral to Treatment (RTT)

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

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

| **Latest NHS Scotland Performance** |
|---|
| 80.96% (Feb 2018) |

| | **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 2018/19** | | | | | | | | | | | | |
| **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% | 86.7% |
| **Performance 2016/17** | 90.0% | 92.0% | 92.1% | 91.3% | 91.4% | 92.3% | 91.0% | 90.2% | 90.7% | 90.0% | 90.0% | 90.0% |




**Narrative Summary:**
The national standard for NHS Boards RTT is to deliver 90% **combined performance**. In March 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.

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

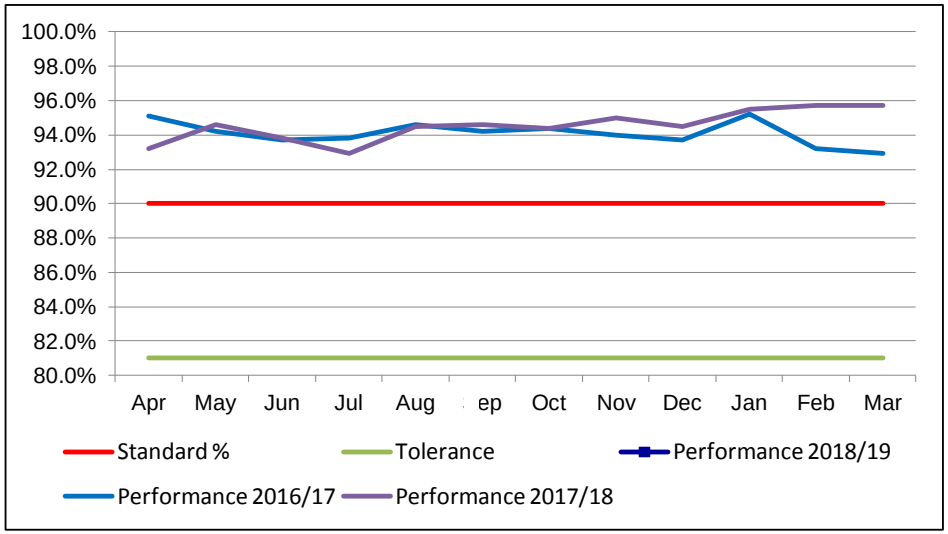
**Please Note:** 18 Weeks RTT data is reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

## 18 Weeks Referral to Treatment (RTT)

| | Standard | Tolerance |
|---|---|---|
| **Standard:** Combined 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 2018/19** | | | | | | | | | | | | |
| **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% | 95.7% |
| **Performance 2016/17** | 95.1% | 94.2% | 93.7% | 93.8% | 94.6% | 94.2% | 94.4% | 94.0% | 93.7% | 95.2% | 93.2% | 92.9% |




**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:** 18 Weeks RTT data is reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

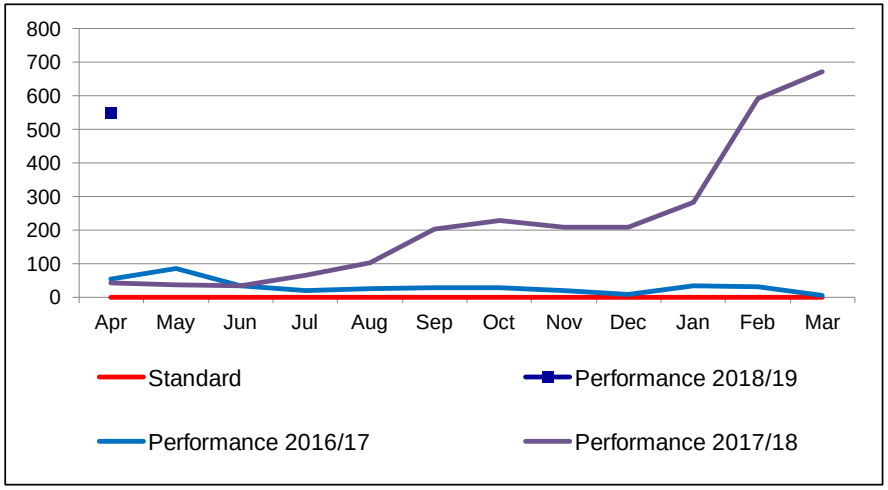
## Diagnostic Waiting Times

| | Standard | Tolerance |
|---|---|---|
| **Waiting Target for Diagnostics -** zero patients to wait over 6 weeks | 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 2018/19** | 549 | | | | | | | | | | | |
| **Performance 2017/18** | 43 | 36 | 34 | 64 | 101 | 203 [1] | 227 | 209 | 208 | 283 | 591 | 672 |
| **Performance 2016/17** | 54 | 84 | 33 | 20 | 26 | 28 | 28 | 18 | 9 | 34 | 30 | 6 |

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




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

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. The breakdown for each of the 8 key diagnostics tests is below

| Diagnostic - 6 weeks | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Endoscopy | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Colonoscopy | 36 | 18 | 6 | 7 | - | - | - | - | - | 1 | - | - | - |
| Cystoscopy | - | - | - | - | - | - | 1 | - | - | - | - | 6 | - |
| MRI | 3 | 18 | 27 | 56 | 100 | 187 | 189 | 198 | 186 | 241 | 339 | 364 | 438 |
| CT | 4 | - | - | 1 | 1 | 16 | 37 | 11 | 4 | 4 | 11 | 43 | 70 |
| Ultra Sound (non-obstetric) | - | - | 1 | - | - | - | - | - | 18 | 28 | 2 | 25 | 29 |
| Barium | - | - | - | - | - | - | - | - | - | 9 | 1 | 2 | 12 |
| **Total** | **43** | **36** | **34** | **64** | **101** | **203** | **227** | **209** | **208** | **283** | **353** | **440** | **549** |

[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.

## CAMHS Waiting Times

**18 weeks CAMHS -** 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)

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

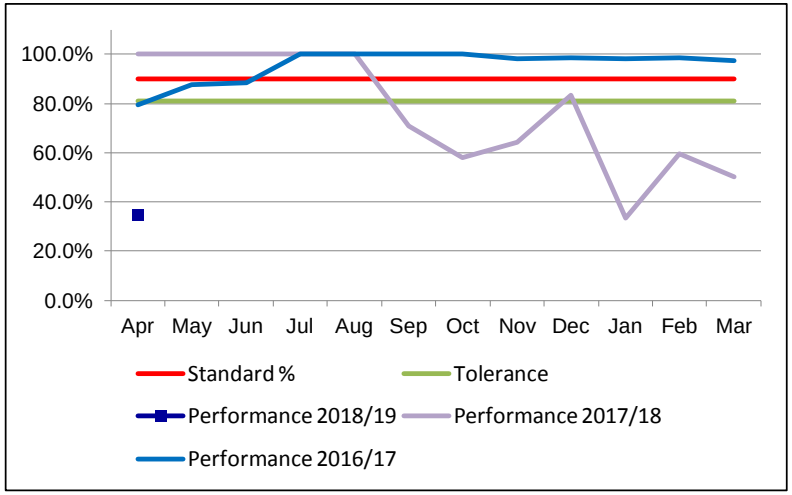
**Actual Performance** (higher % = better performance)

| Latest NHS Scotland Performance |
|---|
| 70.6% (month of Mar 2018) |

| | 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 2018/19** | 34.6% | | | | | | | | | | | |
| **Performance 2017/18** | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 71.0% | 58.0% | 64.3% | 83.3% [1] | 33.3% [1] | 59.4% [1] | 50.0% [1] |
| **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% |

**Please Note:** Data is reported with a lag time of one month

[1] Data unavailable from the service at time of reporting due to transition to EMIS therefore updated in April 2018




**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 has fallen below both standards from September 2017 (71%) to April 2018 (34.6%).

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 and data has been updated from December 2017. 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 standard within 6 months.

**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
- Continue to manage staffing gap appropriately.
- Review current waiting times management
- Implement robust caseload management

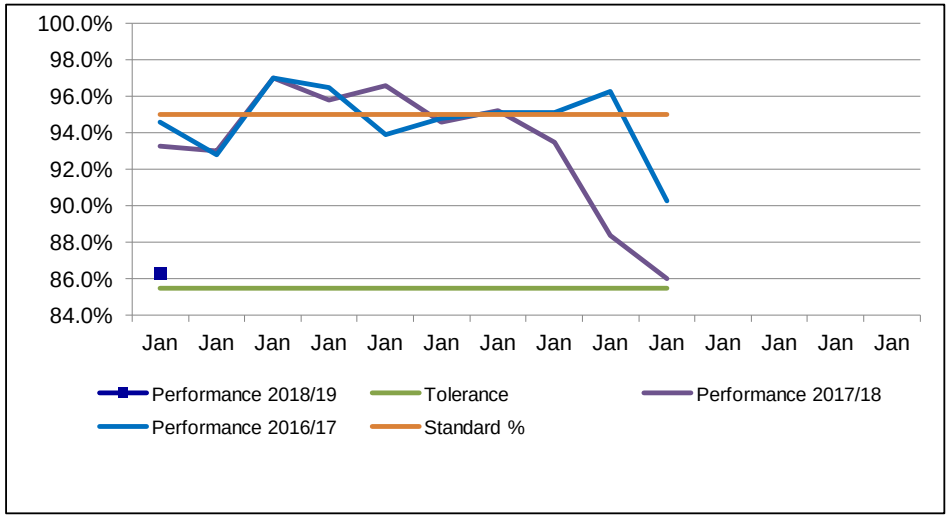
## Accident & Emergency 4 Hour Standard

| | Standard | Tolerance |
|---|---|---|
| **4 hour A&E -** 4 hours from arrival to admission, discharge or transfer for A&E treatment (95%) | 95.0% | 85.5% |

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

| Latest NHS Scotland Performance |
|---|
| 86.0% (Mar 2018) |

| | 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 2018/19** | 86.3% | | | | | | | | | | | |
| **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% |




**Narrative Summary:**
There has been a deterioration in **4 hour A&E** performance through November to April reflecting a difficult winter period. The Emergency Access Standard (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.

| Emergency Access | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Flow 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% | 95.7% |
| Flow 2 | 91.5% | 91.8% | 94.7% | 93.6% | 91.6% | 89.5% | 91.5% | 91.6% | 82.70% | 83.70% | 85.10% | 81.3% | 82.1% |
| Flow 3 | 92.0% | 86.0% | 95.1% | 91.5% | 93.7% | 88.0% | 89.5% | 84.0% | 74.80% | 67.0% | 83.00% | 71.7% | 68.7% |
| Flow 4 | 79.0% | 85.5% | 94.8% | 91.7% | 95.7% | 94.5% | 92.7% | 88.8% | 88.50% | 81.1% | 88.50% | 86.2% | 80.5% |
| **Total** | **93.3%** | **93.0%** | **97.0%** | **95.8%** | **96.6%** | **94.6%** | **95.2%** | **93.5%** | **88.40%** | **86.0%** | **91.40%** | **89.0%** | **86.3%** |

**Narrative Summary and Actions:**
There are a number of activities underway across the system to improve performance against the EAS, including:
- Establishment 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 which is being used to inform various pieces of work and planning for next winter.

## Delayed Discharges

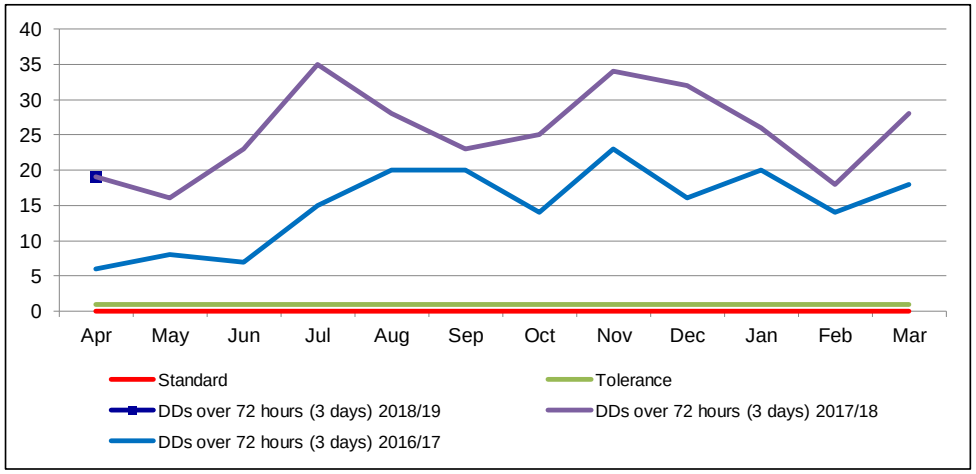
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Delayed Discharges - delays over 72 hours | 0 | 1 |

**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 2018/19** | 19 | | | | | | | | | | | |
| **DDs over 72 hours (3 days) 2018/19** | 19 | | | | | | | | | | | |
| **Occupied Bed Days (standard delays)** | 722 | | | | | | | | | | | |
| **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 |

**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 opened, with a view to reducing dependence on formal services and building on strengths. 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.

# Other Key Indicators

Previous HEAT and LDP Standards and Local Key Performance Indicators

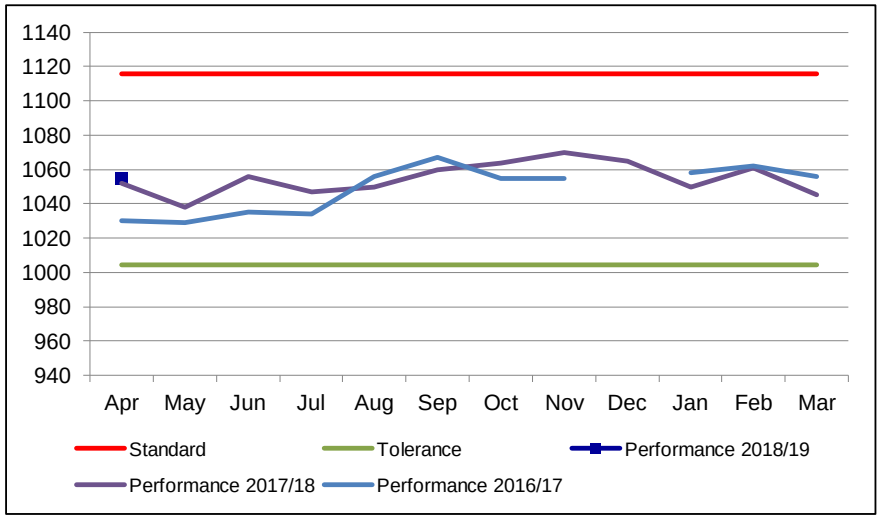
## Diagnosis of Dementia

| | 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 2018/19** | 1055 | | | | | | | | | | | |
| **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 |

**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 was collated into an update report for the Clinical Executive Operational Group in March 2018. It was agreed to follow up this standard with GP Sub and cluster leads in the first instance. Awareness work is being carried out through Public Health to emphasise the support available through the NHS for those undiagnosed and coping at home, as diagnosis will likely lead to the correct treatment.

**Actions:**
- A pathway has been mapped to highlight challenges from referral to diagnosis / communication with GPs

## Dementia - Post Diagnostic Support (PDS)

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

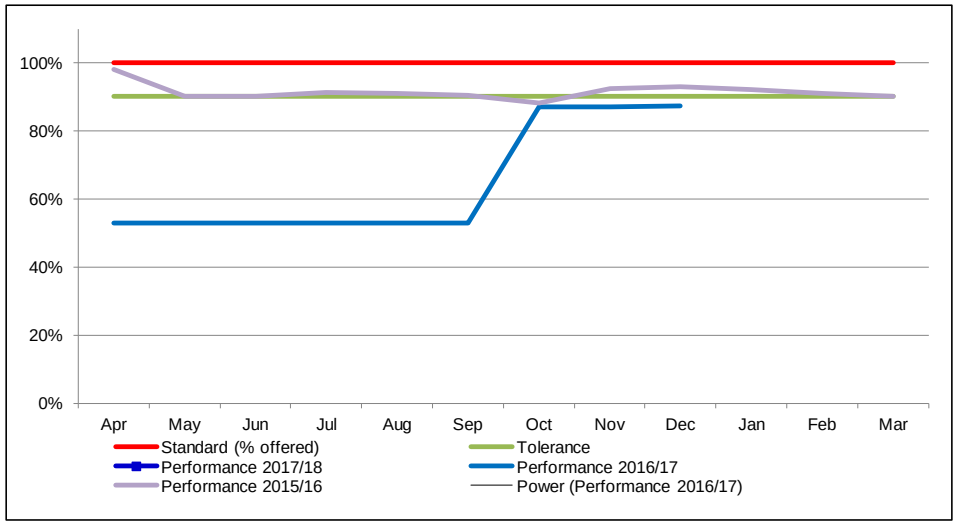
**Actual Performance** (higher % = better performance)

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard (% offered)** | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Number of People who are referred for PDS and have been offered at least 12 months of PDS** | | | | | | | | | | | | |
| Performance 2017/18 | | | | | | | | | | | | |
| Performance 2016/17 [1] | 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 |
| **Percentage offered at least 12 months of PDS** | | | | | | | | | | | | |
| Performance 2017/18 | | | | | | | | | | | | |
| Performance 2016/17 [1] | - | - | 53% | - | - | 53% | - | - | 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] 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)

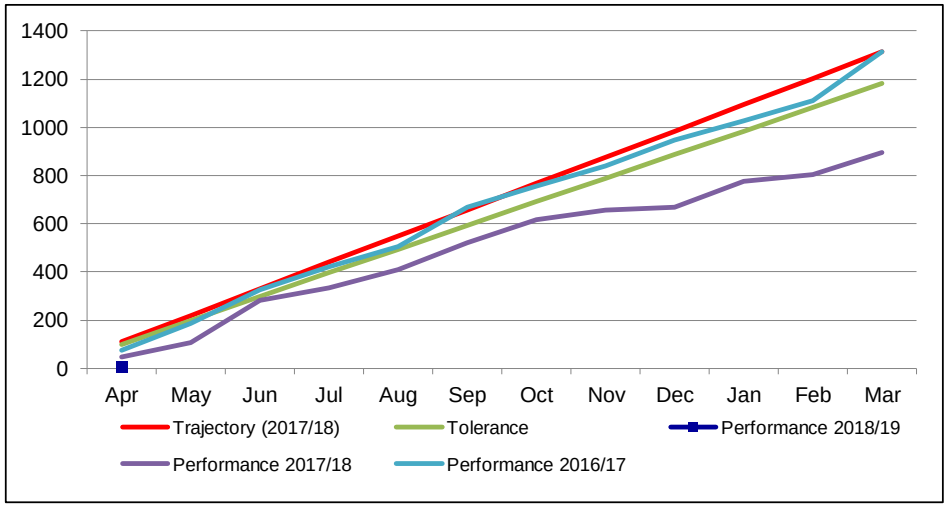
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings | 1312 | within 10% |

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

| Latest NHS Scotland Performance | NHS Borders Performance (as a comparative) |
|---|---|
| 117.0% (2017/18) | 68.4% (2017/18) |

| | 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 2018/19** | 6 | | | | | | | | | | | |
| **Performance 2017/18** | 45 | 106 | 280 | 335 | 409 | 520 | 615 | 656 | 670 | 776 | 805 | 897 |
| **Performance 2016/17** | 73 | 188 | 326 | 422 | 506 | 670 | 756 | 841 | 949 | 1025 | 1109 | 1313 |

**Please Note:** Standard is1312 by end of March every year, it then resets back to 0 every April and cumulative reporting starts again.
There is a reporting lag in some areas which means that data is not fully reconciled at time of reporting therefore should be treated as provisional.




**Narrative summary:**
**Alcohol Brief Interventions (ABI)** performance in April is significantly down on the same period last year within only 6 delivered. The biggest decrease is in Primary Care via the Local Enhanced Service. A decisions was taken in January to end this arrangements therefore there are zero ABI's from this setting.

**Actions:**
- We are unable to report on antenatal at the moment so anticipate an improvement was reporting issues resolve.
- We have reviewed the system in Custody and identified that staff turnover has led to a breakdown in the arrangements. Further training is scheduled.
- Training is scheduled for Health Visitors to introduce ABI in that setting.

## Smoking Quits

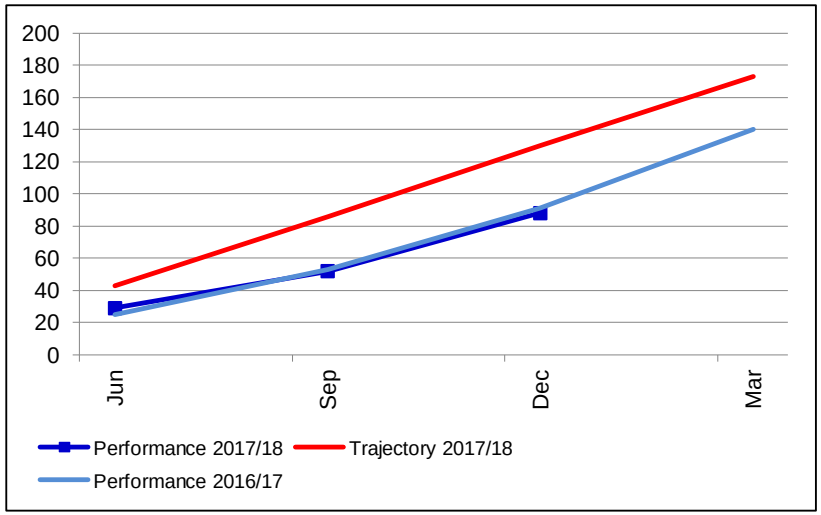
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas | 173 | within 10% |

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

| | Jun | Sep | Dec | Mar |
|---|---|---|---|---|
| **Trajectory 2017/18** | 43 | 86 | 130 | 173 |
| **Performance 2017/18** | 29 | 52 | 88 | |
| **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 3 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 Q4 is due in July 2018 and we are anticipating our data to show data on **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:**
- The main challenge for the service is to ensure referral rates are maintained so we continue to market via facebook, have included adverts in local GP publications.
- Advisors maintain displays in their GP surgeries and other local venues (e.g. leisure centres).
- Engagement with pregnant women remains low despite 'opt out' processes in place within midwifery. Midwifery training took place on 23 May 2018 to explore how to increase engagement, with 9 midwives attending.

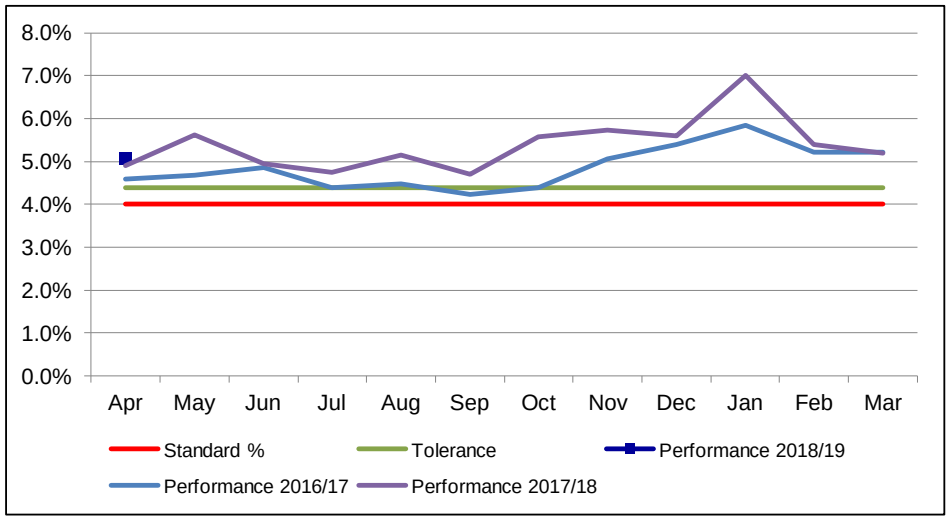
## Sickness Absence

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

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

| Latest NHS Scotland Performance |
|---|
| 5.11% (Mar 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 2018/19** | 5.1% | | | | | | | | | | | |
| **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% |




**Narrative Summary:**
The run chart reports a **Sickness Absence** rate in April of 5.1% which is an improvement of 0.1% from March 2018. The last NHS Scotland figure is 5.11% for the month of March 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 is being developed and will identify areas of further work to support the wellbeing of staff

## Sickness Absence *continued*

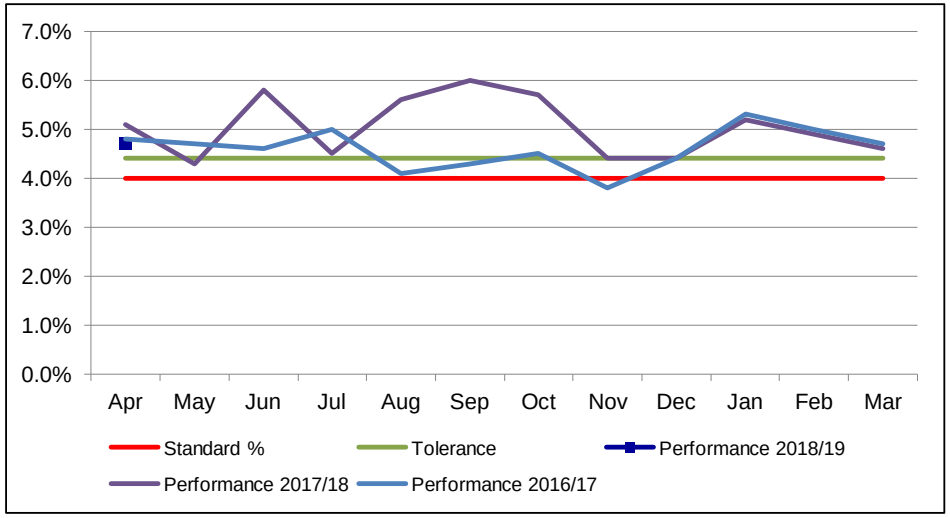
| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard %** | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% |
| **Learning 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 | 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 | 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 | 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 | 0.00 |
| **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 | 0.00 |
| **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 | 1.03 |
| 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 | 2.38 |
| 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 | 1.73 |
| 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 | 5.8 |
| 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 | 0.99 |
| 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 | 22.99 |
| 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 | 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 | 4.41 |
| **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 | 3.41 |
| 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 | 6.62 |
| 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 | 7.04 |
| 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 | 5.73 |
| 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 | 2.78 |
| 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 | 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 | 6.59 |
| 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 | 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 | 0 |
| 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 | 4.54 |
| **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 | 5.66 |
| **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 | 3.16 |
| 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 | 0.00 |
| 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 | 3.95 |
| 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 | 0.00 |
| 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 | 2.54 |
| 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 | 3.82 |
| 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 | 5.34 |
| 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 | 0.00 |
| 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 | 5.30 |
| **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 | 4.09 |

## 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 2018/19** | 4.7% | | | | | | | | | | | |
| **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% |




**Narrative Summary:**
The **DNA** rate in April 2018 reports an slight decrease in performance at 4.7%, the past 5 months have shown a similar trend to 2016/17.

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

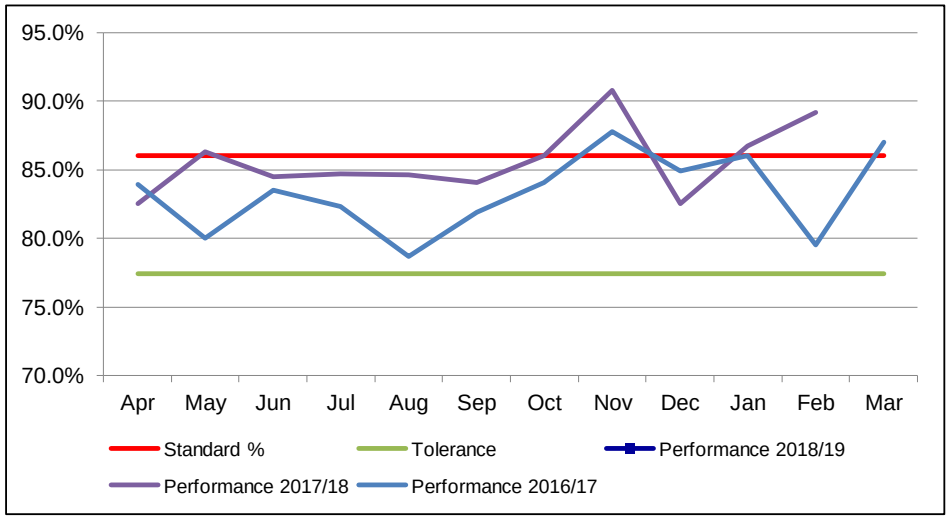
## Same Day Surgery

| | 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 2018/19** | | | | | | | | | | | | |
| **Performance 2017/18** | 82.5% | 86.3% | 84.5% | 84.7% | 84.6% | 84.1% | 86.0% | 90.8% | 82.5% | 86.7% | 89.2% | |
| **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% |

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




**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*

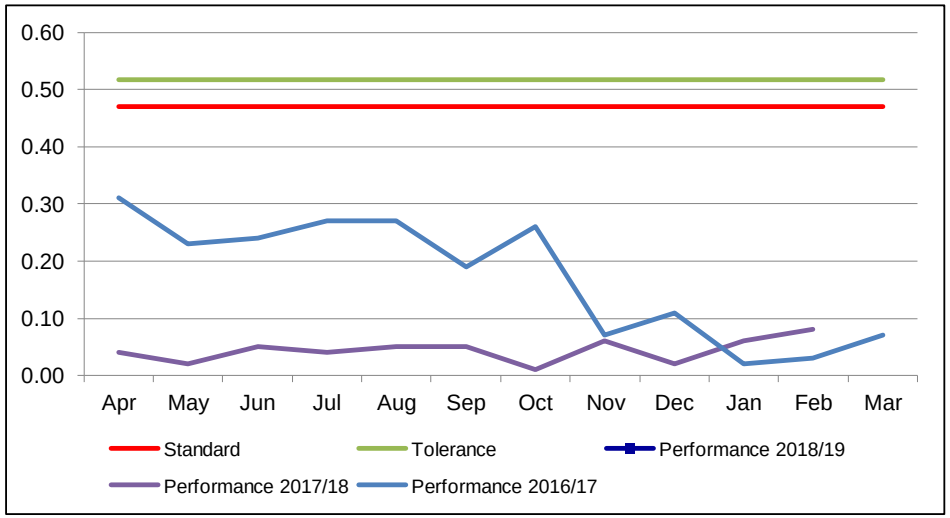
## Pre-Operative Stay

| | 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 2018/19** | | | | | | | | | | | | |
| **Performance 2017/18** | 0.04 | 0.02 | 0.05 | 0.04 | 0.05 | 0.05 | 0.01 | 0.06 | 0.02 | 0.06 | 0.08 | |
| **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.

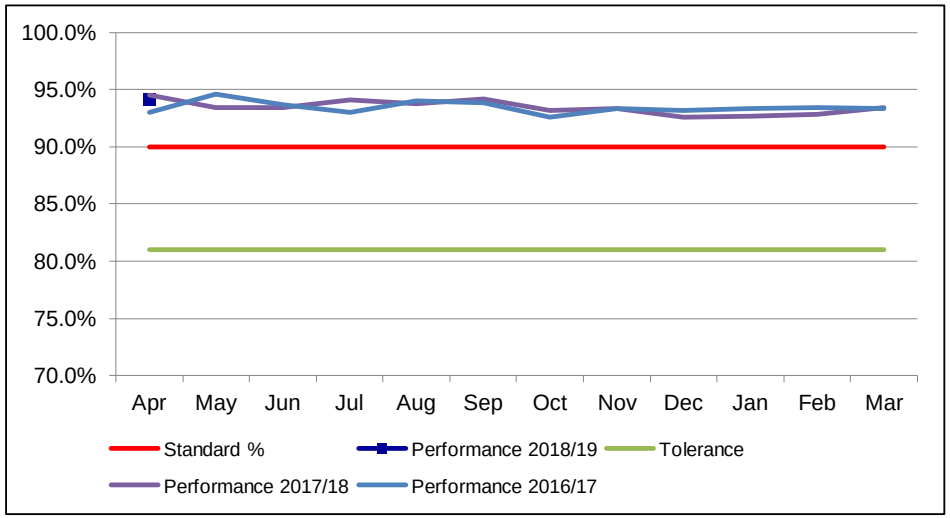
**Actions:**
- No further action planned at this time.

## 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 2018/19** | 94.1% | | | | | | | | | | | |
| **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% |




**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

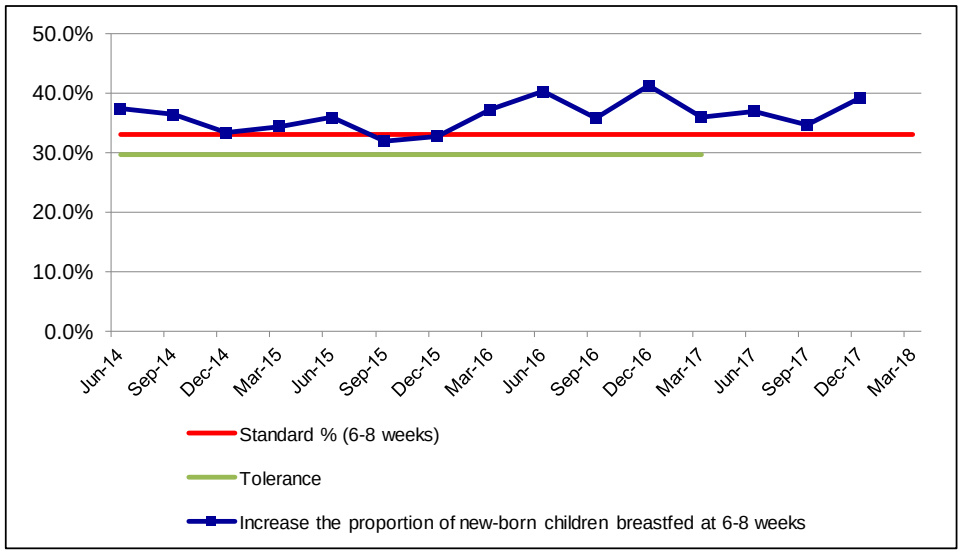
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Increase the proportion of new-born children breastfed at 6-8 weeks | 33.0% | 29.7% |

**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 Turas (previously 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 2018/19** | - [1] | | | | | | | | | | | |
| **Performance 2017/18** | 2.5% | 4.2% | 6.1% | 8.9% | 12.3% | 16.9% | 22.8% | 29.3% | 38.0% | 53.6% | - [1] | - [1] |
| **Performance 2016/17** | 1.0% | 2.5% | 4.9% | 7.6% | 12.7% | 17.7% | 23.5% | 30.8% | 36.2% | 44.6% | 54.4% | 72.9% |
| **Performance 2015/16** | 1.7% | 4.1% | 6.7% | 8.7% | 13.0% | 17.8% | 24.2% | 31.2% | 38.6% | 48.9% | 60.5% | 73.1% |

[1] 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)

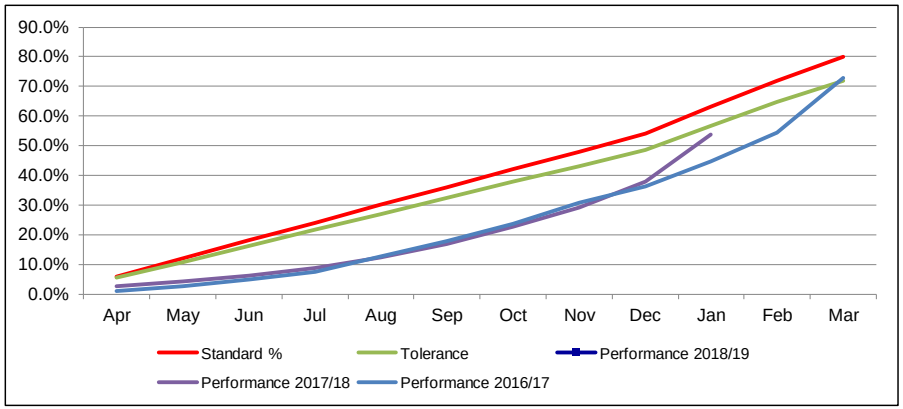
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard %** | 6.0% | 12.0% | 18.0% | 24.0% | 30.0% | 36.0% | 42.0% | 48.0% | 54.0% | 63.0% | 72.0% | 80.0% |
| **Performance 2018/19** | - [1] | | | | | | | | | | | |
| **Performance 2017/18** | 4.0% | 5.8% | 7.5% | 9.4% | 13.5% | 17.4% | 22.4% | 26.5% | 31.6% | 44.2% | - [1] | - [1] |
| **Performance 2016/17** | 1.9% | 4.1% | 6.6% | 9.9% | 15.8% | 20.9% | 25.6% | 31.3% | 34.8% | 40.5% | 47.8% | 60.8% |
| **Performance 2015/16** | 4.0% | 5.9% | 7.7% | 9.8% | 14.6% | 18.8% | 22.1% | 27.9% | 34.7% | 44.8% | 51.6% | 61.6% |

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

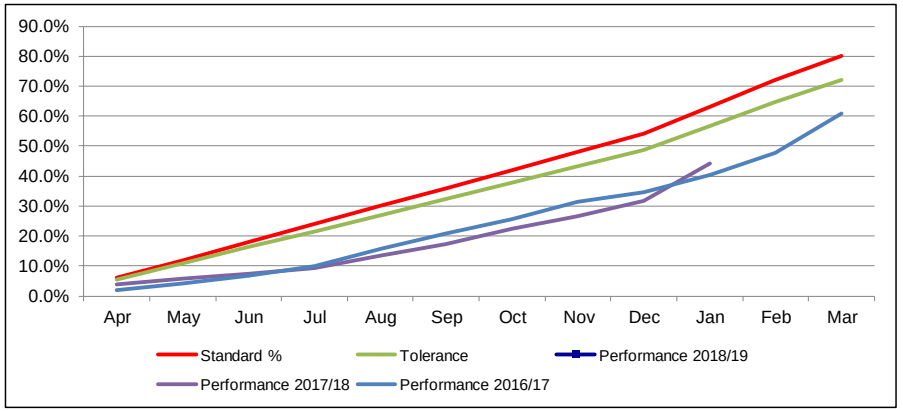
**Please Note:** Charts and supporting narrative are on the next page.

## 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:**
As reported last month there is no mechanism to record Reviews and PDP's since February 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.

The Turas Appraisal System was implemented from 2nd April 2018, eKSF changed to read only from 1st February 2018. There has been little activity to date however the SWISS data download is imminent. 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.

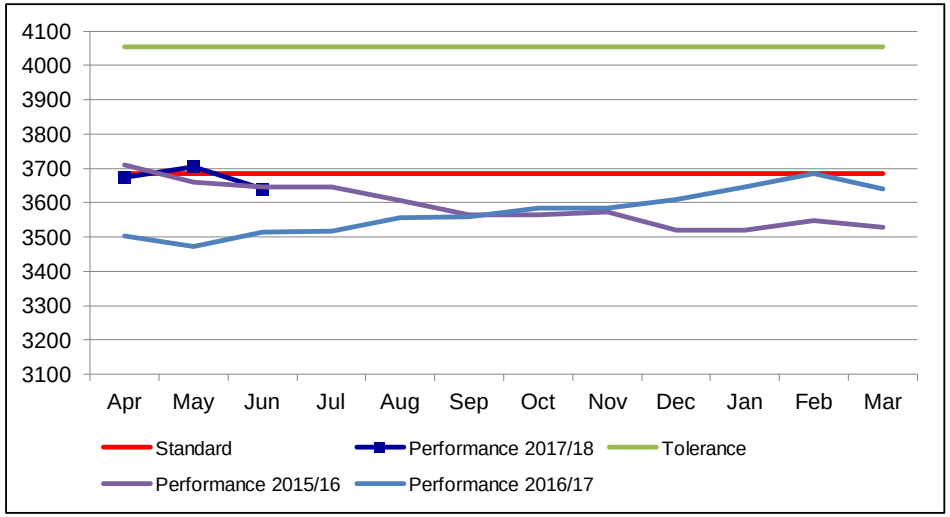
## Emergency Occupied Bed Days

| | 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 a time lag in data being published for this standard. 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.

## 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 2018/19** | | | | | | | | | | | | |
| **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% | 72.7% |
| **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% |

**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

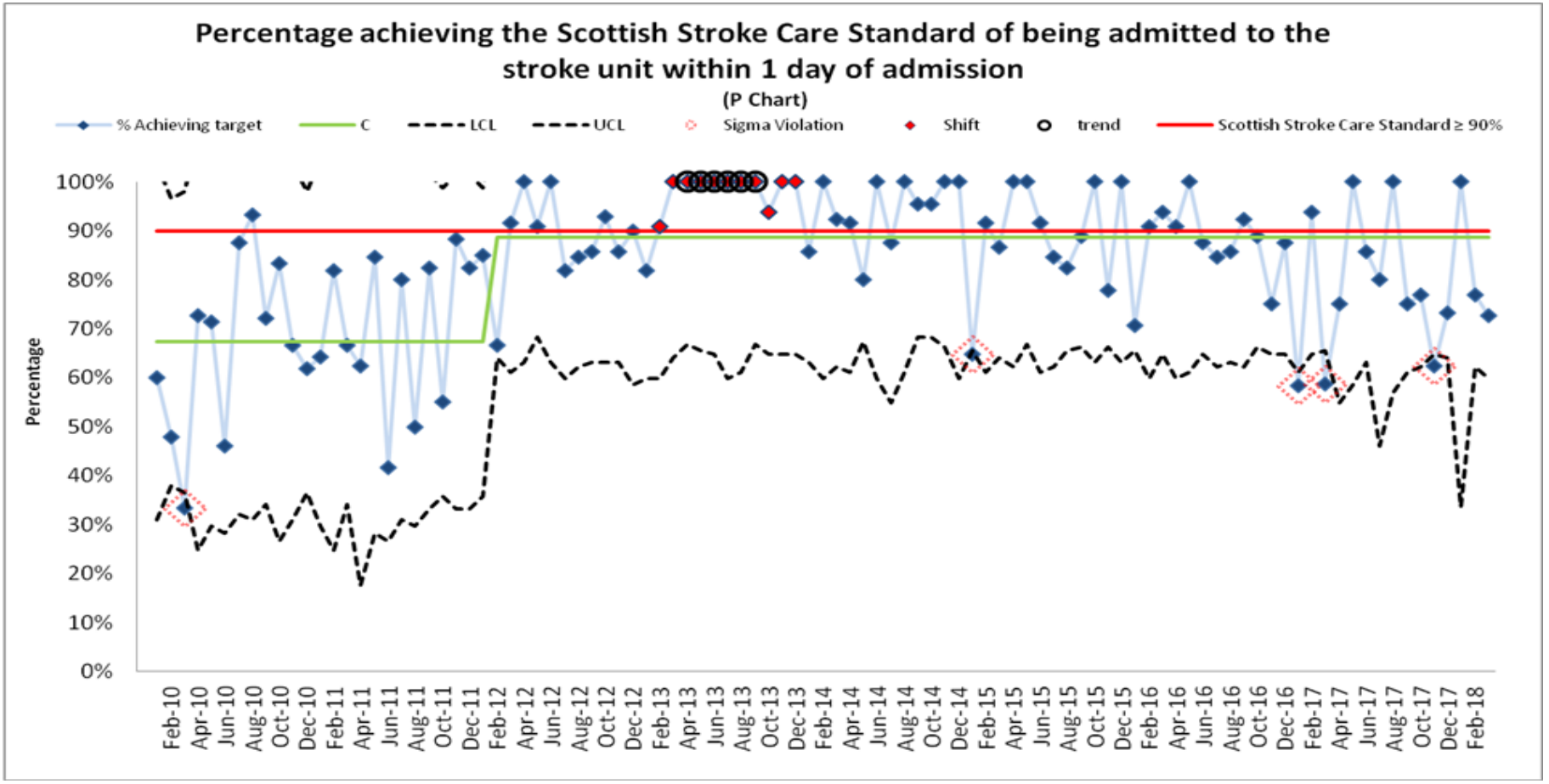
In March 2017 there were 3 fails from a total of 11 eligible patients, the reasons were as follows;
Fail 1 – Late transfer unclear from notes
Fail 2 – Reason unknown as yet
Fail 3 – Male bay in BSU closed for flu, no side rooms available

New stroke patients are all now reviewed at the 08:30 and 13:45 Daily Planning Meetings to ensure there is a plan to accommodate these patients in the Stoke Unit.

**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 |
|---|
| 78.7% (month of Mar 2018) |

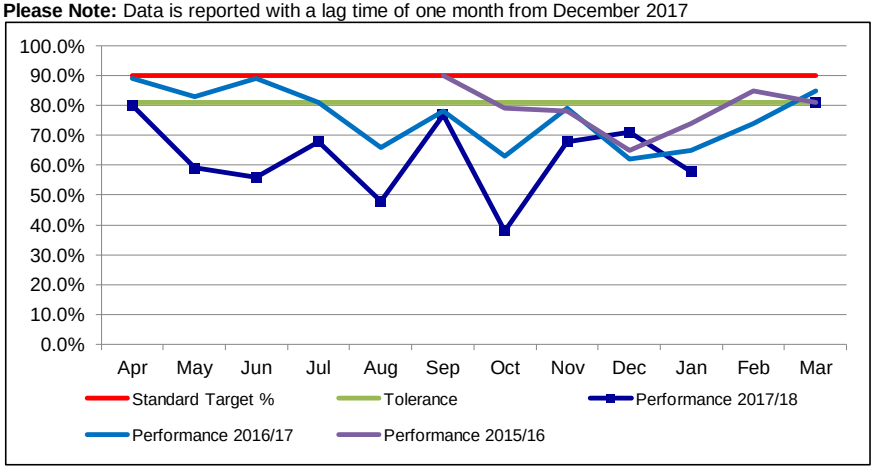
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Stretch Target %** | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |
| **Standard Target %** | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% |
| **Performance 2018/19** | 68.0% | | | | | | | | | | | |
| **Total Patients Currently Waiting >18 Weeks:** | 95 | | | | | | | | | | | |
| **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] | 81.0% |
| **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.

**Actions:**
- A project group has been set up and meets weekly with the remit to plan and action a range of initiatives to reduce PT waiting times.
- 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.

## Drug & Alcohol Treatment

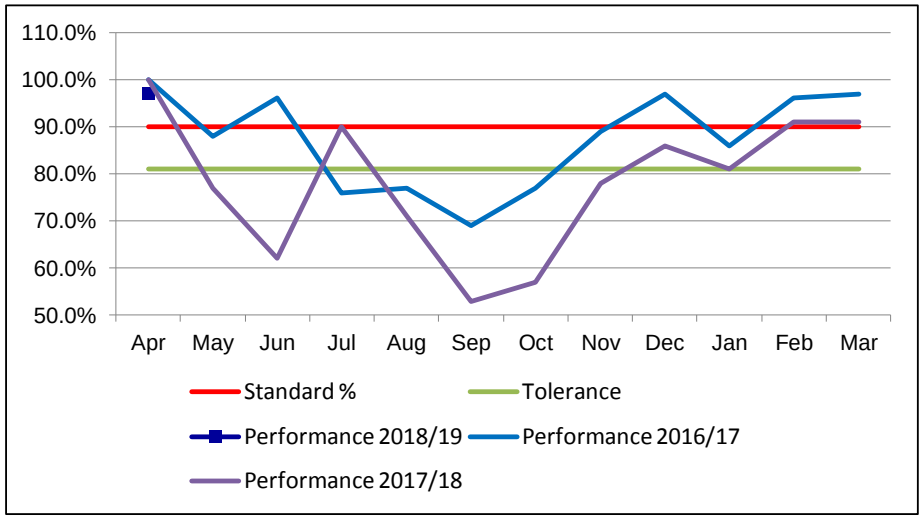
**Standard:** Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

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

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

| Latest NHS Scotland Performance |
|---|
| 93.5% (quarter Jan - Mar 2018) |

| | 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 2018/19** | 97.0% | | | | | | | | | | | |
| **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% |




**Narrative Summary:**
There is an ongoing requirement to deliver **3 weeks RTT** for 90% of progressed drug & alcohol referrals. Overall, 97% of clients started treatment within three weeks for the month of April 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

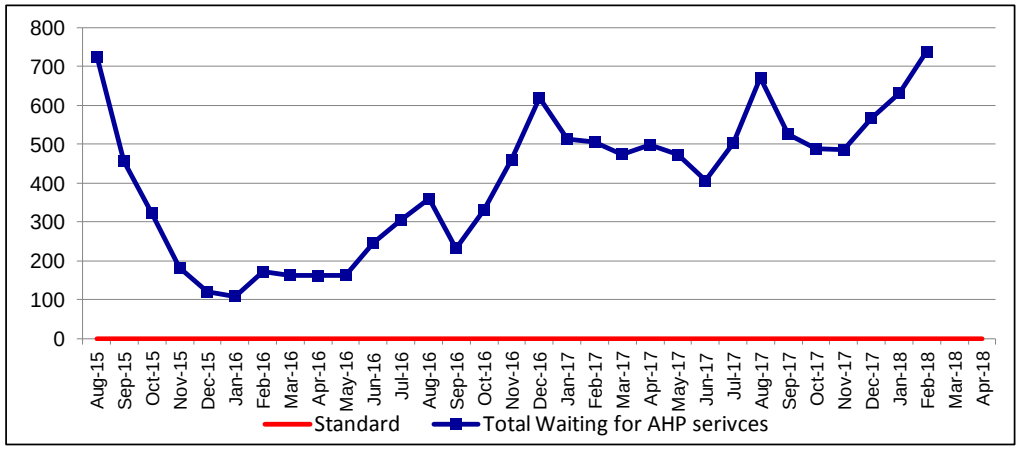
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Patients Waiting over 9 Weeks as at month end | 0 | 1 |

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

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Waiting for AHP serivces** | **499** | **473** | **407** | **503** | **672** | **526** | **489** | **486** | **569** | **633** | **738** | - [1] | - [1] |
| Occupational Therapy | 5 | 2 | 3 | 3 | 4 | 4 | 3 | 5 | 11 | 9 | 14 | - [1] | - [1] |
| Physiotherapy | 480 | 457 | 386 | 481 | 646 | 501 | 459 | 461 | 527 | 571 | 636 | - [1] | - [1] |
| Podiatry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - [1] | - [1] |
| Speech & Language Therapy | 0 | 1 | 0 | 1 | 2 | 1 | 1 | 5 | 5 | 9 | 26 | - [1] | - [1] |
| Nutrition & Dietetics | 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. No additional physiotherapy resources to support shift. Ongoing productivity review - MSK templates were introduced in December and being monitored over a three month period.

**Podiatry**
The admin team lead has secured temporary 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 2.6wt therapists working across Community and BGH since January resulting in the waiting time standard not being met. Additional capacity is currently being sought to support Adult SLT.

**Nutrition and Dietetics**
Significant pressures continue in all dietetic services, waiting time aim continues to be 9weeks, 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 plan to recruit to a fixed term contract in the next 6weeks. 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 6weeks to increase acute dietetic capacity. Paediatric Dietetics are managing very high caseloads and also covering all the Eildon and majority of the Teviot locality community paediatric caseload due to staff sickness in Galashiels and children unable to be seen in a safe time frame in Hawick. A small number of additional hours are being used (5hrs/week) in Eildon locality to provide some backfill for the member of staff who is off work at present. The catering and specialist weight management dietitian is due to finish on the 27/4/18 therefore there will be a gap in service anticipated to be for at least 4weeks, capacity in the dietetic specialist weight management service will be significantly reduced. Dietetics have not had a Lead Dietitian for nearly 1year, 3 x Band 7 team leads continue to respond to management requests reducing clinical time available.

## Cancellations

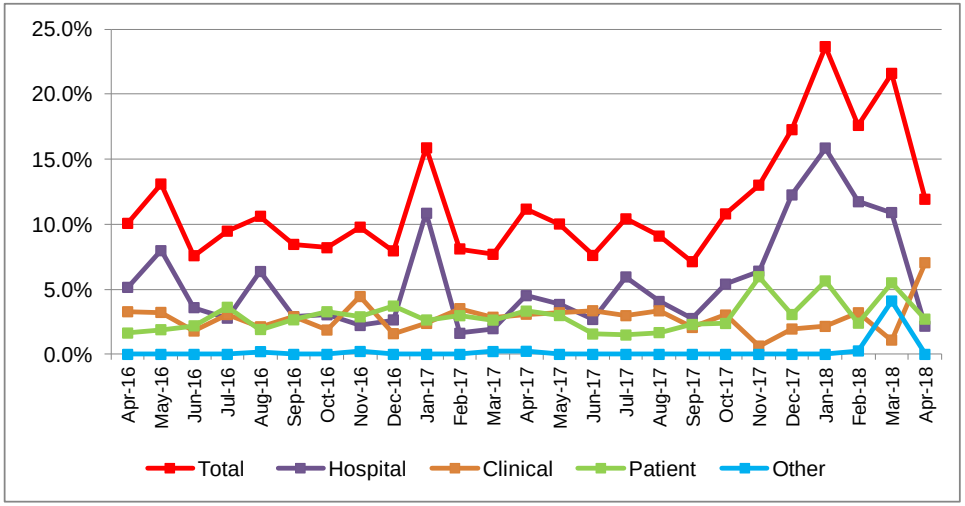
**Hot Topic:** Cancellations

**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 % | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **10.0%** | **7.6%** | **10.4%** | **9.1%** | **7.1%** | **10.8%** | **13.0%** | **17.3%** | **23.7%** | **17.6%** | **21.6%** | **11.9%** |
| **Hospital** | 3.8% | 2.7% | 6.0% | 4.1% | 2.8% | 5.4% | 6.4% | 12.3% | 15.9% | 11.7% | 10.9% | 2.2% |
| **Clinical** | 3.2% | 3.4% | 3.0% | 3.3% | 2.1% | 3.0% | 0.6% | 1.9% | 2.2% | 3.2% | 1.1% | 7.0% |
| **Patient** | 3.0% | 1.6% | 1.5% | 1.7% | 2.3% | 2.4% | 6.0% | 3.1% | 5.6% | 2.4% | 5.5% | 2.7% |
| **Other** | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.3% | 4.1% | 0.0% |




**Narrative Summary:**
The cancellation rate improved in April but remains consistently high. Difficulty in protecting elective beds continues to adversely impact elective operating.

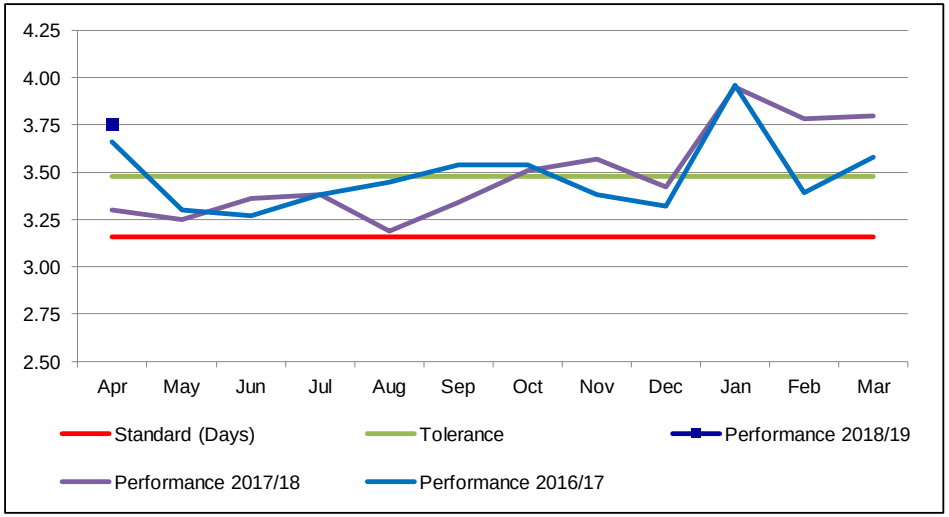
**Actions:**
- Recovery plan to re-establish elective ward.
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment.
- Weekly theatre scheduling meeting has been implemented, work is ongoing to improve this process with a view to maximising 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 2018/19** | 3.75 | | | | | | | | | | | |
| **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 |




**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)

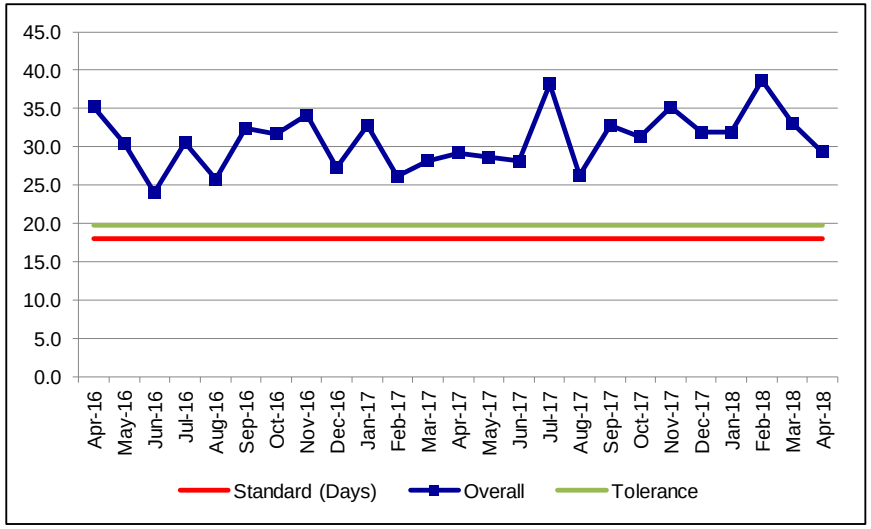
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Reduce Community Hospital Average Length of Stay | 18.0 | 19.8 |

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

| | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-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** | **28.6** | **28.1** | **38.2** | **26.3** | **32.8** | **31.3** | **35.1** | **31.9** | **31.9** | **38.7** | **33.0** | **29.3** |
| **Hawick** | 15.1 | 25.2 | 36.8 | 20.8 | 24.7 | 26.0 | 28.0 | 30.9 | 30.0 | 23.3 | 17.5 | 17.5 |
| **Hay Lodge** [1] | 34.3 | 26.2 | 34.2 | 49.4 | 41.6 | 30.9 | 43.7 | 26.8 | 31.0 | 60.2 | 33.0 | 31.7 |
| **Kelso** | 32.5 | 23.2 | 27.2 | 18.0 | 31.3 | 31.1 | 29.5 | 51.3 | 47.2 | 45.2 | 50.6 | 38.9 |
| **Knoll** | 54.4 | 42.9 | 78.3 | 32.6 | 39.1 | 39.6 | 44.9 | 27.8 | 26.1 | 42.9 | 56.7 | 39.8 |

**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

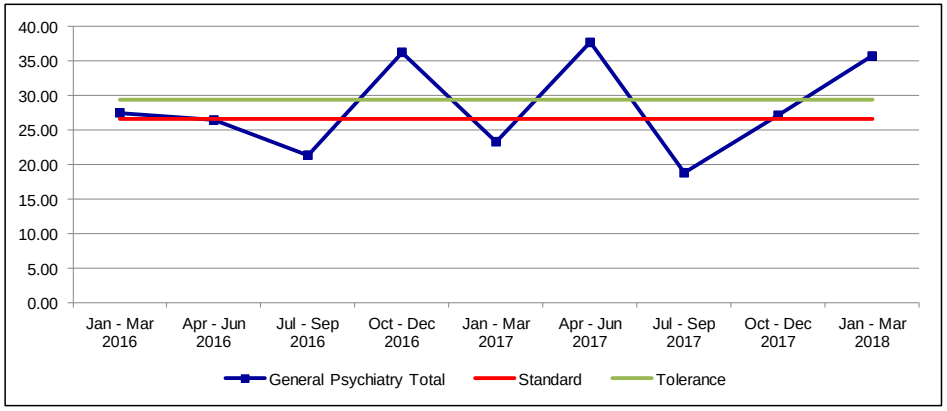
| | Standard | Tolerance |
|---|---|---|
| **Standard:** Reduce Mental Health Average Length of Stay | Various | within 10% |

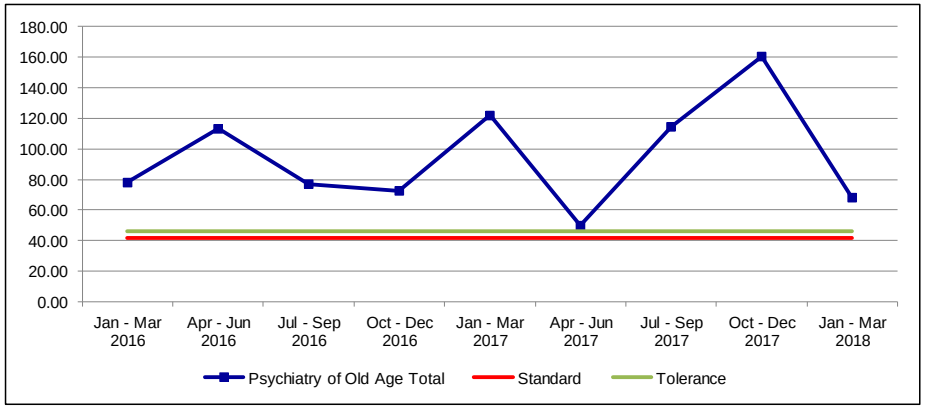
**Actual Performance** (lower = better performance)

| | Standard (Days) | Jan - Mar 2016 | Apr - Jun 2016 | Jul - Sep 2016 | Oct - Dec 2016 | Jan - Mar 2017 | Apr - Jun 2017 | Jul - Sep 2017 | Oct - Dec 2017 | 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 |

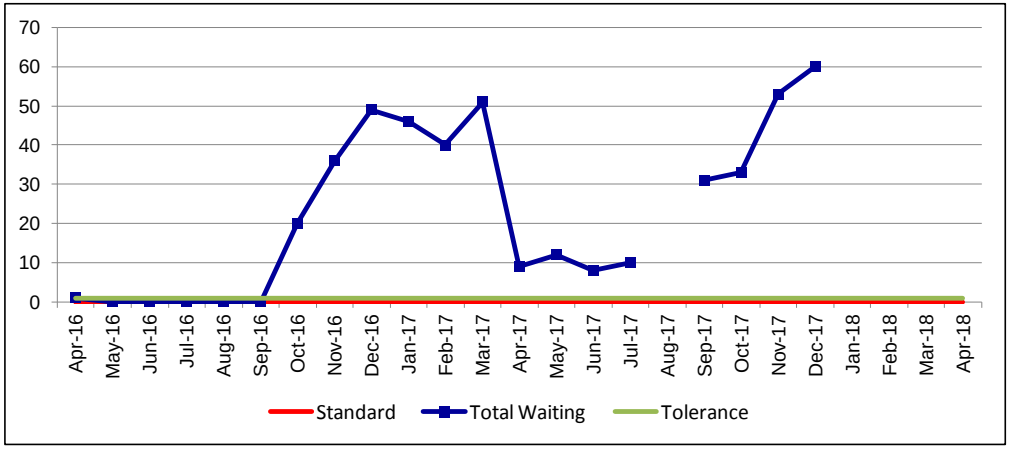
**Actual Performance** (lower = better performance)

| | 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] | Apr-18[2] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard** | 0 | 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.

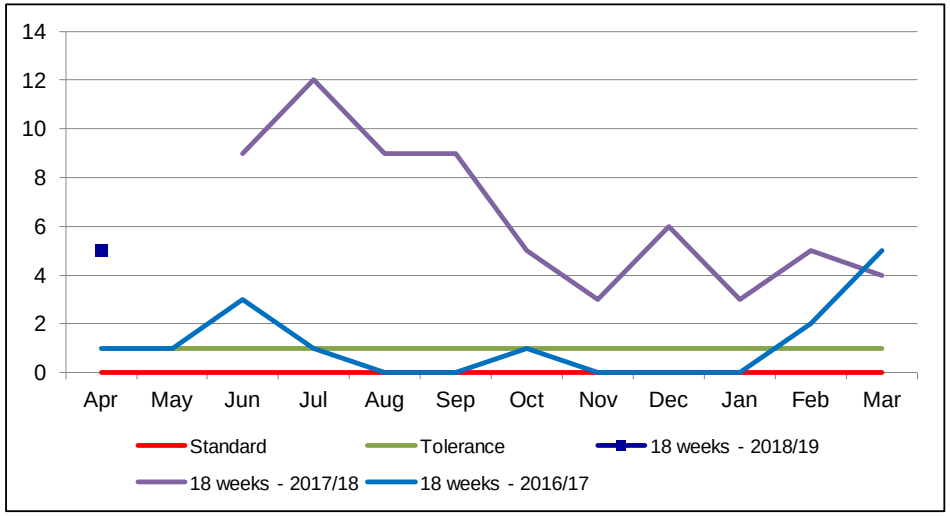
## Learning Disability Waiting Times

| 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 - 2018/19** | 5 | | | | | | | | | | | |
| **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 |

**Please Note:** Reports for April - May 2017 unavailable following the migration to EMIS, LD are working with HIS to resolve. June 2017 updated in August 2017.




**Narrative Summary:**
3 of 5 **Learning Disability waiting times** breaches in April 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.

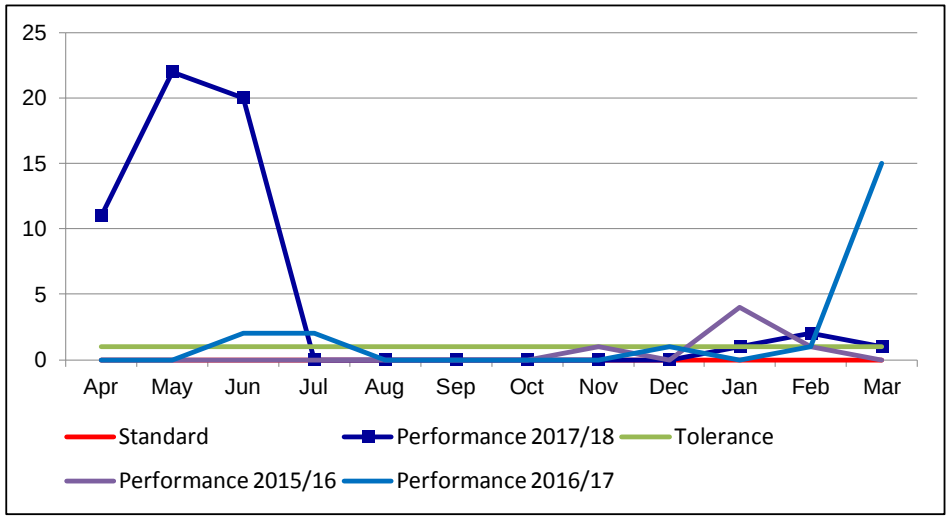
**Actions:**
- Continue to monitor and manage the waiting list within the performance scorecard at the Learning Disability Service management team meetings and action with appropriate managers

## 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 2018/19** | 1 | | | | | | | | | | | |
| **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 April 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

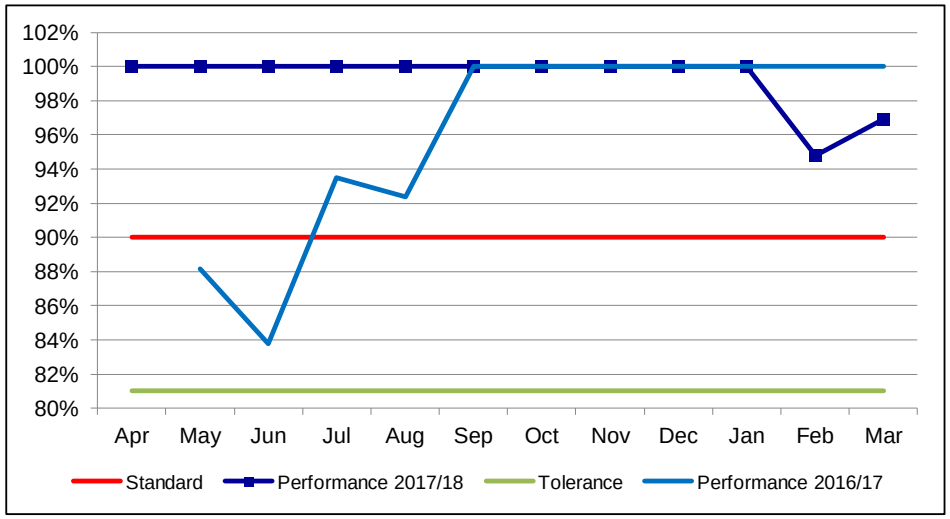
| | Standard | Tolerance |
|---|---|---|
| **Standard:** 18 Week Referral to Treatment for Audiology | 90.0% | 81.0% |

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

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard** | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% |
| **Performance 2018/19** | 99.0% | | | | | | | | | | | |
| **Patients with active wait over 18 Weeks 2018/19** | 1 | | | | | | | | | | | |
| **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 1 breach of the **18 week referral to treatment** standard in April 2018. This numbers of breaches are reducing ans expect to be back at 100% next month.

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

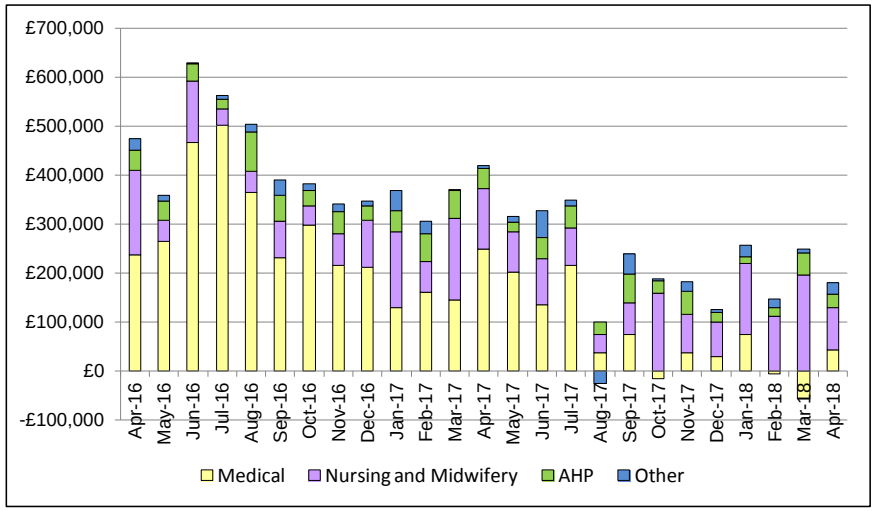
## Supplementary Staffing

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

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

| | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standard** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Medical** | £202,203 | £133,969 | £214,295 | £36,696 | £73,584 | -£15,869 | £36,560 | £28,444 | £73,802 | -£6,994 | -£57,438 | £43,127 |
| **Nursing and Midwifery** | £80,778 | £95,194 | £76,940 | £36,821 | £65,110 | £157,753 | £78,489 | £70,270 | £144,230 | £111,112 | £196,307 | £85,150 |
| **AHP** | £20,876 | £43,664 | £45,327 | £25,717 | £59,055 | £25,144 | £47,105 | £20,519 | £14,600 | £16,793 | £45,197 | £27,222 |
| **Other** | £11,033 | £54,626 | £11,197 | -£25,138 | £41,395 | £5,632 | £20,519 | £4,881 | £22,740 | £19,311 | £6,312 | £24,241 |
| **Total Cost** | **£314,890** | **£327,453** | **£347,759** | **£74,096** | **£239,144** | **£172,660** | **£182,673** | **£124,114** | **£255,372** | **£140,222** | **£190,378** | **£179,740** |

**Please Note:** April 2018 data unavailable at time of reporting




**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.

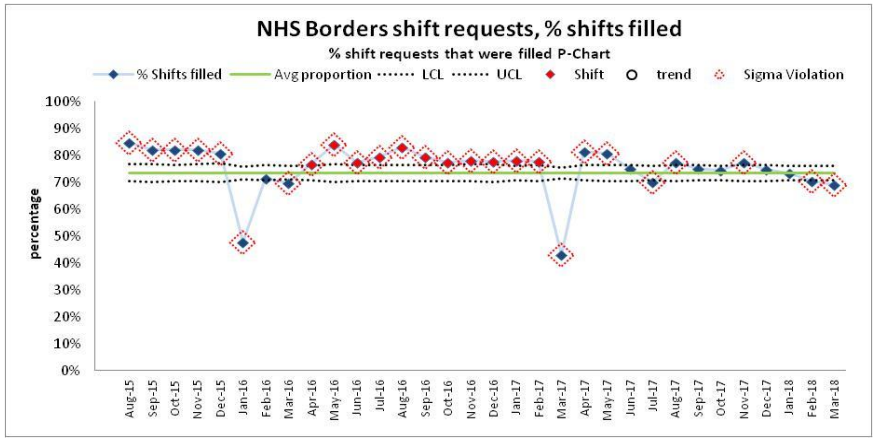
**Other agency -** costs to date relate to agency cover for Blood Sciences and IM&T agency staff. The increase in January and February relates to cover provided to the Microbiology service.

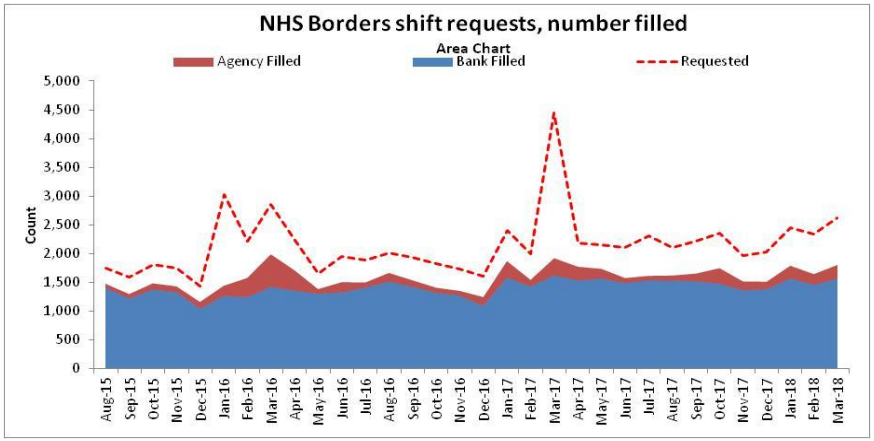
**Actions:**
- Recruitment following targeted training into key nursing posts in Acute Services and proactive management of sickness levels is required in order to see levels of expenditure brought into line with budgets.

## Nurse Bank

**Standard:** NHS Borders Nurse Bank and agency shifts

**NHS Borders Overall**




**Please Note:** April 2018 data unavailable at time of reporting

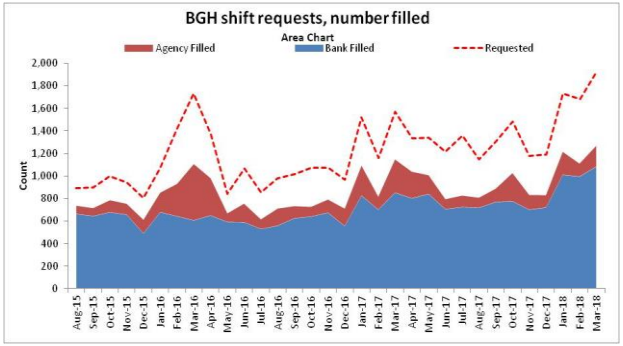
**Narrative Summary:**
Overall the number of NHS Borders **shift requests** increased in March 2018 by 273 shifts, with 241 of those within the BGH. Extra beds within the BGH accounted for 600 shift requests in March with an additional 432 requests for patient dependency. Agency also decreased by 57 shifts.

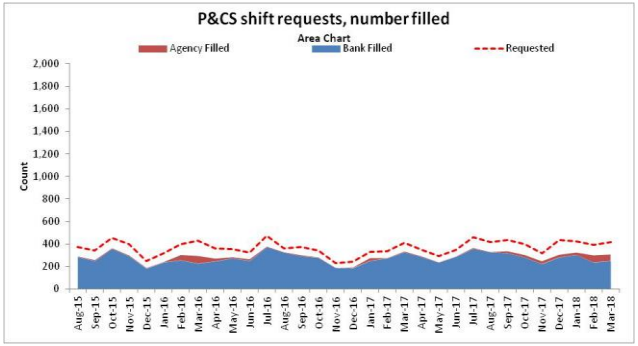
Every month the reasons for the requests for agency are shared with the service in order that we can understand why we are using agency staff. Requests are all reviewed and signed off by the Associate Director of Nursing to ensure that they are only used where clinical safety is compromised .

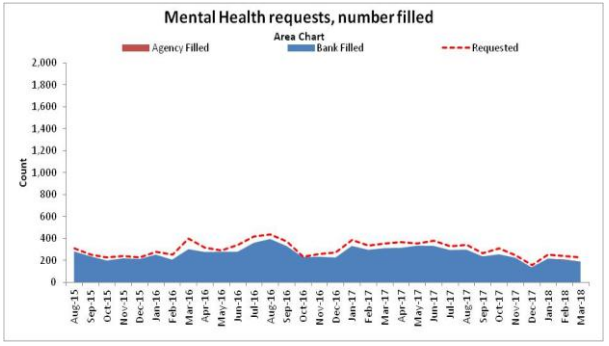
**Overall -** There continues to be high levels of requests for supplementary staff across NHS Borders. Possible contributing factors extra beds, patient dependency and short notice sickness.

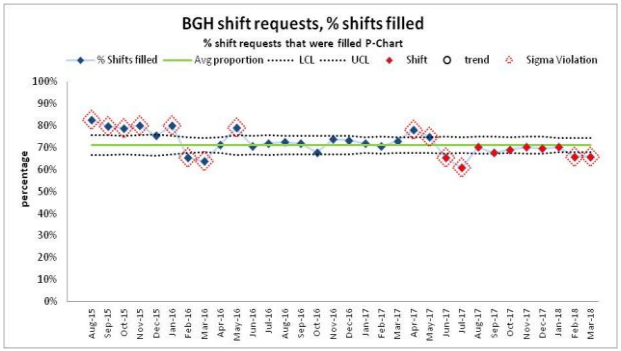
**Actions update:**
- The next planned recruitment event for both Health Care Support Workers (HCSW) and Registered Nurses will be held on the 3rd of May 2018. 51 HCSW's have been shortlisted and 19 Registered Nurses.

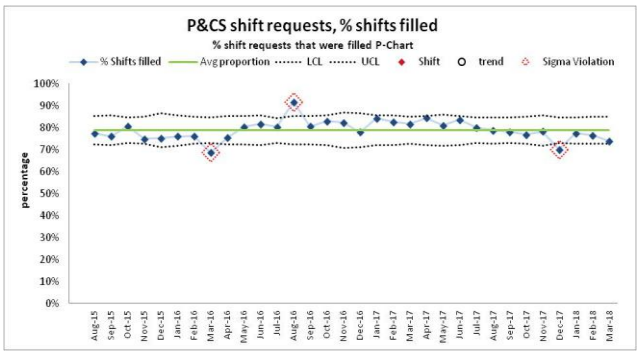
## **Nurse Bank** *continued*

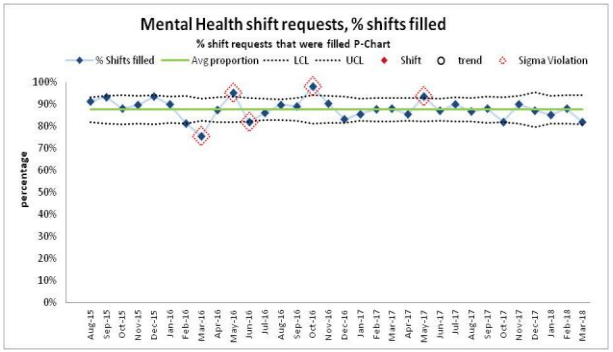


## eLearning

| Standard | Standard | Tolerance |
|---|---|---|
| **Standard:** 100% of NHS Borders employees complete statutory & mandatory eLearning | 100% | 10% |

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

| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Equality & Diversity | 86.9% | | | | | | | | | | | |
| Infection Control | 84.5% | | | | | | | | | | | |
| PMAV | 74.9% | | | | | | | | | | | |
| Fire safety (eLearning) | 65.8% | | | | | | | | | | | |
| Datix | 61.3% | | | | | | | | | | | |
| Information Governance | 58.5% | | | | | | | | | | | |
| Moving & Handling | 59.6% | | | | | | | | | | | |
| Public Protection | 13.5% | | | | | | | | | | | |
| Statutory Fire Training (classroom) | 9.4% | | | | | | | | | | | |

**Narrative Summary:**
Implementation of the new Course Booking System on LearnPro has identified widespread non compliance with **Mandatory Statutory training.**

Due to the current position, Training & Development have identified the compliance categories (key to the right), which mirror NHS Lothian and will be used to RAG status the eLearning compliance.

**Actions:**
- A quarterly report will be submitted to the Board Executive Team, with the General Managers receiving it monthly.

**Key:**

| | |
|---|---|
| Dark Green | 80+ |
| Light Green | 70 - 79.9 |
| Amber | 60 - 69.9 |
| Red | 0 - 59.9 |