Borders NHS Board

NHS BORDERS PERFORMANCE SCORECARD – JULY 2018

Aim

This paper provides an update to the Board on the latest performance information as at 31st July 2018 and outlines a proposal to revise the format of future reports and timelines.

From 2018/19 Health Boards are no longer required to produce a Local Delivery Plan but instead to produce an Annual Operational Plan, in line with guidance received from Scottish Government in February 2018. The attached Performance Scorecard contains performance data relating to this first Annual Operational Plan for NHS Borders as well as some previous Local Delivery Plan standards and local Key Performance Indicators.

In light of the conversation at the Strategy & Performance Committee in October 2018, the paper also outlines the work that has been undertaken to revise the timeline and format of the performance reports.

Background

Performance Management remains a key priority across NHS Borders to ensure robust monitoring of key local and national standards and priorities.

Current Reporting

The current monthly Board Performance Scorecard format has been in place since April 2016 as part of our Performance Framework, and is presented to the Clinical Executive Operational Group, Strategy & Performance Committee and Board. It was re-drafted and updated for 2018/19 to enable members to monitor performance against the new Annual Operational Plan, previous HEAT and Local Delivery Plan standards and local key performance indicators.

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 is presented as a rolling 3 month period at each report and is shown over the page:

Annual Operational Plan	May-18	Jun-18	Jul-18
Green – achieving standard	7	6	6
Amber – nearly achieving standard	1	2	2
Red – outwith standard	7	7	7

Previous HEAT / LDP Standard and Key Performance Indicators	May-18	Jun-18	Jul-18
Green – achieving standard	8	8	9
Amber – nearly achieving standard	4	3	4
Red – outwith standard	13	14	12

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 against the Annual Operational Plan measures for the position as at 31st July 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:

- 100% of patients **requiring treatment for cancer** were seen within **31 days** in June 2018 (latest available data) (page 10)
- 90.6% of patients were treated within 18 Weeks for the combined pathway performance during June 2018 (latest available data) (page 21)

The Board is asked to note that the following Annual Operational Plan performance measures are outwith the 10% tolerance (red status) at 31st July 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 since the beginning of 2018/19 (page 11)
- **12 weeks Inpatient Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year and since the beginning of 2018/19 (page 13)
- **12 week Treatment Time Guarantee** – performance reported outwith the standard for the full 2017/18 year and since the beginning of 2018/19 (page 15)
- **18 weeks RTT Admitted Pathway Performance** – performance is consistently reported outwith the standard for the full 2017/18 year and for the first month of 2018/19 (page 17)
- **6 week Diagnostic Waiting Times** – performance is consistently reported outwith the standard for the full 2017/18 year and since the beginning of 2018/19 (page 23)
- **CAMHS Waiting Times** – performance reported outwith the 10% tolerance of the standard for 7 consecutive months (latest available data) (page 25)
- **Delayed Discharges** – performance reported outwith the standard for the full 2017/18 year and the since the beginning 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 can be undertaken through the Board’s Strategy & Performance Committee throughout the year if requested.

Proposal to amend the Report Format

There was a detailed discussion at the October Strategy & Performance Committee regarding the timeliness of reporting contained the Performance Scorecard and also the number of targets and KPIs contained within the report.

As a result the Planning & Performance Team has revisited the content of the monthly Strategy & Performance Committee and Board Performance Scorecard to make it more streamlined and focussed on a reduced number of key priorities. By adopting this approach the Board will be able to have a focussed discussion on the key priority areas contained within the Annual Operational Plan (abbreviated to AOP) and a smaller number of key standards.

The wider range of performance measures will continue to be presented to the Clinical Boards as part of their monthly clinical board scorecards and quarterly performance reviews. There will also be ongoing commitment to bring a full update to the Board on the whole range of performance measures in the Mid-Year and End of Year Managing our Performance Reports.

NHS Borders agreed Performance Management Framework Cycle is highlighted in Appendix 1.

The only change that these proposals would make to the performance management framework is at Level 4, when the wording would change to reflect the fact that the Board report “combines key priorities from the Clinical Board Scorecards based on AOP targets and LDP standards”.

It is proposed that the Annual Operational Plan and current LDP Standards performance measures would be presented in the revised scorecard, as per Table 1:

Table 1 – Proposed Content

Annual Operation Plan Key Targets
Treatment within 62 days for Urgent Referrals of Suspicion of Cancer
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer
12 weeks outpatient (for first Outpatient appointment)
Treatment Time Guarantee (TTG) - 12 weeks waiting time for Inpatients
6 Week Waiting Target for Diagnostics
No CAMHS waits over 18 wks
4-Hour Waiting Target for A&E
No Delayed Discharges over 72 hours (3 days)
Additional LDP Standards
18 Week Referral to Treatment
Diagnosis of dementia
Dementia Post Diagnostic Support
Drug and Alcohol Treatment Waiting Times
Alcohol Brief Interventions
Smoking cessation successful quits in most deprived areas
Sickness Absence Reduced
Emergency OBDs aged 75 or over (per 1,000) *(Not an LDP Standard, therefore from August 2018 data, the reporting measure will change to Emergency Admissions & Occupied Bed Days for Scottish Borders residents aged 75+ which is a key integration measure)*
No Psychological Therapy waits over 18 wks
90% of Alcohol/Drug Referrals into Treatment within 3 weeks

Along with the measures outlined in Table 1 we will also continue to report on supplementary staffing and Nursebank within the monthly report. Elearning will be reported through Staff Governance Committee reports.

There are a small number of previous LDP Standards (as listed in Table 2 below) which are currently reported in the 6 monthly Managing Our Performance Report as more regular data is not available. These would continue to be reported on twice per year:

Table 2 – Managing Our Performance Report LDP Standards (monthly data not available)

LDP Standards
Detecting Cancer Early
Early Access to Antenatal Services
IVF Waiting Times
Clostridium Difficile Infections
SAB (MRSA/MSSA)
GP Access
Financial Performance *(to provide monthly would duplicate the separate Finance Papers to the Board)*

As part of the proposed format revision, a number of measures would be reported to the Board on a twice yearly basis through the Managing Our Performance reports rather than on a monthly basis. These areas would remain, however, a key part of the monthly Clinical Board scorecards as well as the Quarterly Performance Reviews. These measures are detailed in Table 3:

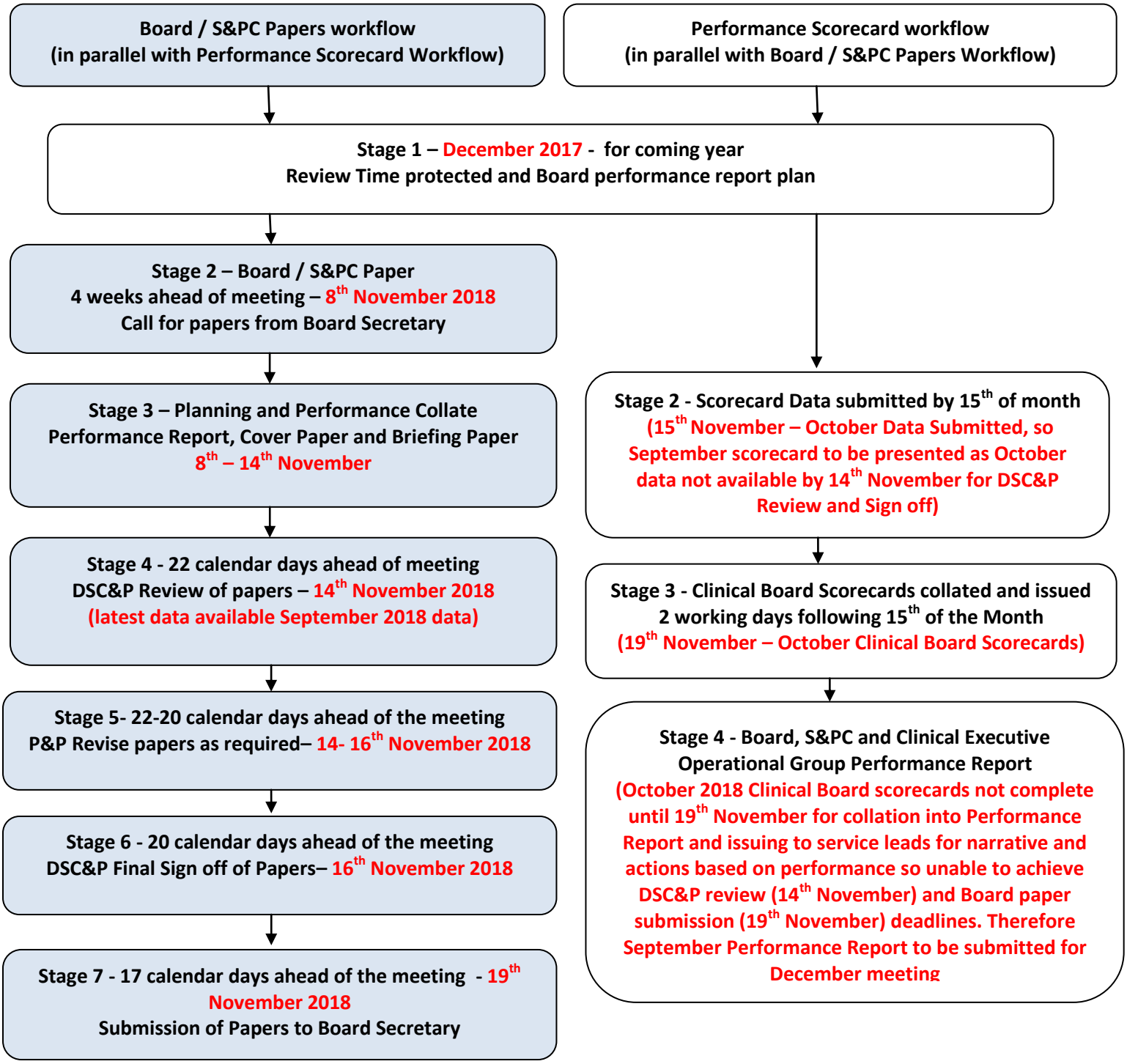
Table 3 – Other Measures

Measure	**Where reported:** • **MOP** • **Clinical Board Scorecard** (* Dashboard is included in the PACS and MH scorecard, and will be in both Acute and Primary Scorecards when PACS split) • **Quarterly Performance Review**
Admitted Pathway Performance	Dashboard, MOP & Quarterly Performance Review
Admitted linked Pathway Performance	Dashboard, MOP & Quarterly Performance Review
Non Admitted Pathway Performance	Dashboard, MOP & Quarterly Performance Review
Non Admitted linked Pathway Performance	Dashboard, MOP & Quarterly Performance Review
Combined Pathway Performance	Dashboard, MOP & Quarterly Performance Review
Combined linked Pathway Performance	Dashboard, MOP & Quarterly Performance Review
New Patient DNAs	Dashboard, MOP & Quarterly Performance Review
Same Day Surgery	Dashboard, MOP & Quarterly Performance Review
Pre Operative Stay	Dashboard, MOP & Quarterly Performance Review
Online Triage of Referrals	Dashboard, MOP & Quarterly Performance Review
Breastfeeding	Dashboard, MOP & Quarterly Performance Review
Joint Development Reviews	Dashboard, MOP & Quarterly Performance Review - Clinical Board breakdown unavailable at the moment but Turas team are working on it
Stroke Unit Admissions	Dashboard, MOP & Quarterly Performance Review
AHP Waiting Times	MOP, PACS Scorecard & Quarterly Performance Review
Cancellations	MOP, PACS Scorecard & Quarterly Performance Review
BGH Average Length of Stay	MOP, PACS Scorecard & Quarterly Performance Review
Community Hospital Average Length of Stay	MOP, PACS Scorecard & Quarterly Performance Review
Mental Health Average Length of Stay	MOP, PACS Scorecard & Quarterly Performance Review
Mental Health Waiting Times	MOP, PACS Scorecard & Quarterly Performance Review
Learning Disability Waiting Times	LD Scorecard & Quarterly Performance Review
Rapid Access Chest Pain Clinic	PACS Scorecard & Quarterly Performance Review
Audiology Waiting Times	PACS Scorecard & Quarterly Performance Review

It should be noted that in addition to the standard reports, additional performance reports on particular areas can be requested by the Board at any time.

Performance Scorecard - Timeline

Data availability, collation timelines, scorecard review/validation and board paper submission deadlines dictate the timeliness of the data which can be presented at each board. An example timeline, with key dates highlighted, based on performance scorecard preparation and submission for the December 2018 Board meeting (September Performance Report) is outlined below:



Annual leave, public holidays and capacity within the various services can impact on the ability to respond to requests for data and narrative to inform the performance reports. When necessary, the Planning & Performance team negotiate and agree extensions within the various stages of the timeline with the Board Secretary to ensure that the absolute deadline for submission of papers to the Board is achieved.

As previously agreed with the Board, it has received monthly performance scorecards in consecutive order, even if the scorecard has not been the latest one available, to ensure that all performance scorecards have been noted at the board.

This has been revisited to assess if more timely information would be possible. In order to bring the Board up to date with latest scorecard available for presentation, it is recommended that the September 2018 Performance Scorecard in the new format is brought to the December meeting. As outlined in the above section this is the latest available data that could be brought forward to the December meeting. This will mean that the Board has not been presented with August 2018 position but performance for the previous months is included in the trend tables for each measure along with supporting narrative and ongoing actions provided by the services.

Going forward the most recent scorecard which will available for each meeting is detailed in table 4 below. Please note, due to submission deadlines, the November 2018 scorecard would be available for the January and February 2019 meetings. It is therefore recommended that there is no Performance Scorecard presented to the February Strategy & Performance Committee:

Table 4 : Schedule of performance reports

Meeting – 2018-19	**Dec 2018**	**Jan 2019**	**Feb 2019**	**Mar 2019**	**Apr 2019**	**May 2019**	**Jun 2019**	**Jul 2019**	**Aug 2019**	**Sep 2019**	**Oct 2019**	**Nov 2019**	**Dec 2019**
Public Board		**17**		**7**	**4**		**27**	**No meeting**		**5**	**3**		**5**
Strategy & Performance Committee	**6**		**7**			**2**			**1**			**7**	
Scorecard that could be presented (most up to date due to data availability and paper submission and review deadlines)	**Sep 2018**	**Nov 2018**	**None**	**Dec 2018**	**Jan 2019**	**Feb 2019**	**Apr 2019**		**May 2019**	**Jun 2019**	**Jul 2019**	**Aug 2019**	**Sep 2019**

By adopting this approach the Board will be able to have a focused discussion on the key priority areas contained within the AOP alongside current NHS Performs LDP standards which were contained within our previous LDP.

Moving to a more streamlined and focussed scorecard will also reduce the burden on operational service as well as within the Planning and Performance Team, releasing capacity to progress other priorities.

The Implementation of Tableau

As part of the Information Strategy approved by the Clinical Executive Strategy Group earlier this year, Planning & Performance outlined the need to implement a Business Intelligence Reporting tool to support NHS Borders to become a data driven organisation.

Subsequently, NHS Borders will introduce “Tableau” to provide financial information / reports (beginning in Dec 2018) as part of a national contract, Tableau enables the provision of a suite of dashboards and reports for operational and performance measures with minimal costs (as the user licenses that come as part of the finance implementation will enable users to access operational / performance dashboards).

The Business Intelligence Lead for NHS Borders is undertaking a Proof of Concept with National Services Scotland (NSS) using Tableau to develop a Whole System Flow Dashboard. Following this, they plan to implement Tableau as a managed technical service to provide us with the ability to create a suite of dashboards and reports for operational / performance measures.

This will support the organisation to have faster and more accurate reporting, provide access to information for analysis and planning, enable better decision making and improve data quality. It is important to note that some of the data we report on to the Board, comes from ISD and published information therefore there will still be a lead time for some of the measures. It is planned that the Proof of Concept work with NSS will conclude before the end of 2018. The level of funding required to implement Tableau from January 2019 is currently being assessed and will be brought forward through appropriate routes for consideration.

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.

In line with discussions at the Strategy and Performance Committee in October it is proposed to update the current content of the Performance Scorecard with a view to making it more streamlined and focussed on key priorities contained within our Annual Operational Plan alongside current NHS Performs LDP Standards which were contained within our previous LDP. The wider range of performance measures will continue to be presented to the Clinical Boards as part of their monthly clinical board scorecards and quarterly performance reviews. There will also be ongoing commitment to bring a full update to the Board on the fuller range of performance measures in the Mid-Year and End of Year Managing our Performance Reports

As part of the Information Strategy the need was outlined to implement a Business Intelligence Reporting tool to support NHS Borders to become a data driven organisation. NHS Borders will therefore use Tableau to provide financial information / reports (beginning in Dec 2018); this provides us with an opportunity to implement Tableau to provide a suite of dashboards and reports for operational and performance measures.

The implementation of Tableau will support the organisation to have faster and more accurate reporting, provide access to information for analysis and planning, make better decisions and improve data quality. It is important to note that some of the data we report on to the board, comes from ISD and published information therefore there will still be a lead time for some of the measures. It is planned that the Proof of Concept work with NSS will conclude before the end of 2018.

Recommendation

The Board is asked to:

- **note** the updates contained within the July 2018 Performance Scorecard;
- **note** the work underway to develop Tableau; and
- **approve** the new reporting format and timetable.

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

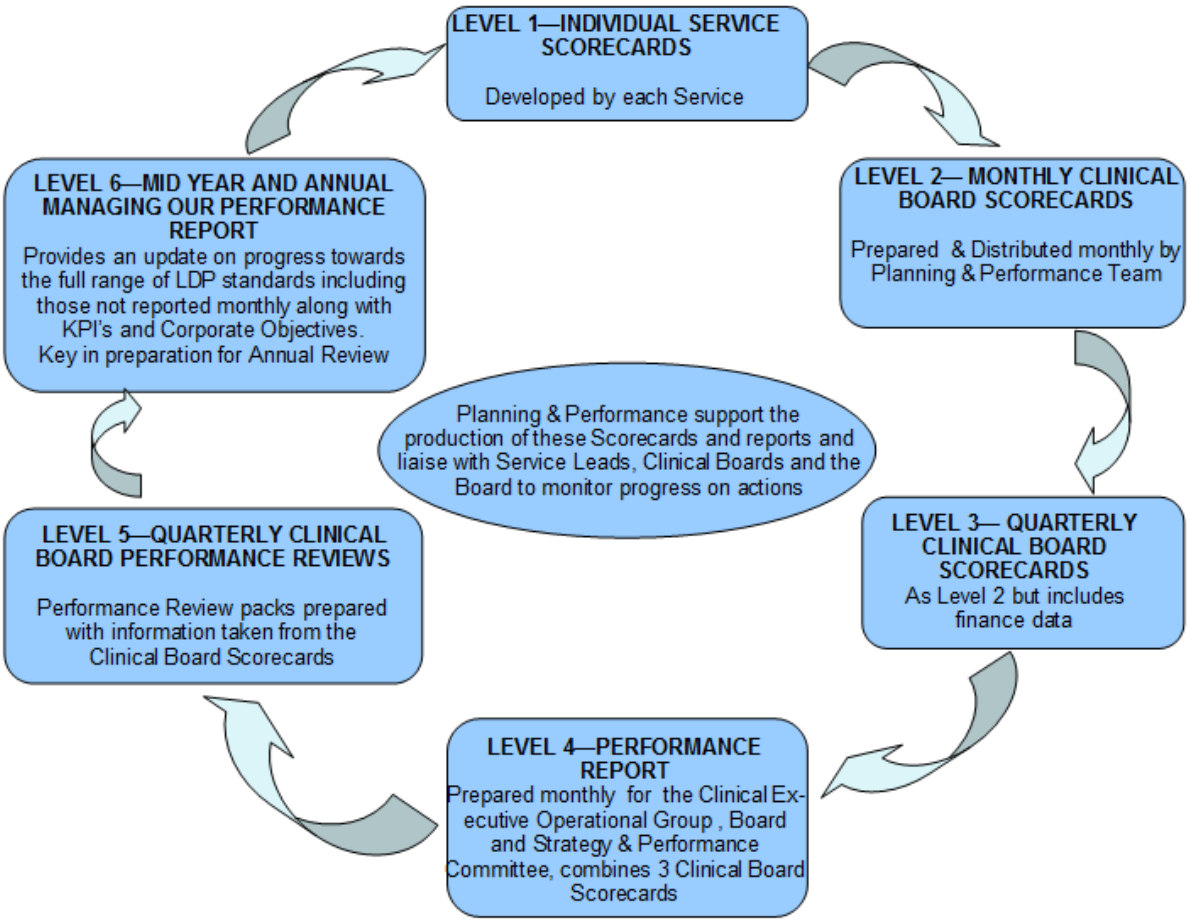
Approved by

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

Author(s)

Name	Designation	Name	Designation
Karen Shakespeare	Planning and Performance Manager		

Appendix 1 – NHS Borders Performance Management Framework



NHS Borders

PERFORMANCE SCORECARD

As at 31st July 2018

July 2018

Planning & Performance

Month

1

2

3

4

5

6

7

8

9

10

11

12

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	-

Performance Measures

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 Annual Operational Plan Performance Measures, previous HEAT & LDP Standards and local Key Performance Indicators.

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]	G -	G ↑	A ↓	-								
Treatment within 31 days of decision to treat for all Patients diagnosed with Cancer [1]	G -	G ↔	G ↔	-								
18 Wk RTT: 12 wks for outpatients	R -	R ↑	R ↑	R ↓								
18 Wk RTT: 12 wks for inpatients	R -	R ↑	R ↓	R ↓								
18 Wk RTT: 12 weeks TTG	R -	R ↓	R ↑	R ↑								
18 Wk RTT: Admitted Pathway Performance [2]	R -	R ↓	R ↓	-								
18 Wk RTT: Admitted Pathway Linked Pathway [2]	G -	G ↑	G ↑	-								
18 Wk RTT: Non-admitted Pathway Performance [2]	G -	G ↑	G ↑	-								
18 Wk RTT: Non-admitted Pathway Linked Pathway [2]	G -	G ↓	G ↑	-								
Combined Performance [2]	G -	G ↑	G ↓	-								
Combined Performance Linked Pathway [2]	G -	G ↓	G ↑	-								
6 Week Waiting Target for Diagnostics	R -	R ↑	R ↓	R ↓								
No CAMHS waits over 18 wks	R -	R ↑	R ↓	R ↑								
4-Hour Waiting Target for A&E	A -	A ↑	A ↓	A ↓								
No Delayed Discharges over 72 hours (3 days)	R -	R ↑	R ↓	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.

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)	-	-	-	-								
Alcohol Brief Interventions [2]	R -	R ↑	R ↑	R ↑								
Smoking cessation successful quits in most deprived areas [3]	-	-	-	-								
Sickness Absence Reduced	R -	R ↑	R ↓	R ↓								
New patient DNA rate	R -	R ↓	R ↓	R ↓								
Same day surgery [4]	A -	A ↓	-	-								
Pre-operative stay [4]	G -	G ↑	-	-								
Online Triage of Referrals	G -	G ↑	G ↔	G ↓								
Increase the proportion of new-born children breastfed at 6-8 weeks [5]	-	-	-	-								
eKSF annual reviews complete [6]	R -	R ↑	R ↑	R ↑								
Emergency OBDs aged 75 or over (per 1,000) [7]	-	-	-	-								
Admitted to the Stroke Unit within 1 day of admission [8]	G -	G ↑	R ↓	-								
No Psychological Therapy waits over 18 wks [9]	R -	R ↓	R ↑	-								
90% of Alcohol/Drug Referrals into Treatment within 3 weeks	G -	G ↑	G ↓	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 [10]		-	-	-	-								
Cancellations	Hospital	R -	A ↑	R ↓	R ↑								
	Clinical	R -	G ↑	G ↑	R ↓								
	Patient	G -	G ↓	G ↑	G ↓								
	Other	G -	G ↔	G ↔	G ↔								
Borders General Hospital Average Length of Stay		R -	A ↑	A ↓	A ↑								
Community Hospitals Average Length of Stay		R -	R ↑	R ↓	R ↓								
Mental Health Average Length of Stay General Psychiatry Total [11]		-	-	G ↑	-								
Mental Health Average Length of Stay Psychiatry of Old Age Total [11]		-	-	R ↓	-								
Mental Health Waiting Times (Patients waiting over 9 weeks)		- [12]	- [12]	- [12]	- [12]								
Learning Disability Waiting Times (Patients waiting over 18 weeks)		R -	R ↑	R ↑	A ↑								
Rapid Access Chest Pain Clinic		A -	R ↓	G ↑	G ↔								
Audiology 18 Weeks Waiting Times		G -	G ↑	- [12]	- [12]								

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 One month lag time for Psychological Therapy waits
10 Data unavailable due to transition to EMIS reporting
11 Mental Health ALOS reported quarterly
12 Data unavailable at time of reporting

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

62 Day Cancer - 95% of all cases with a Suspicion of Cancer to be seen within 62 days

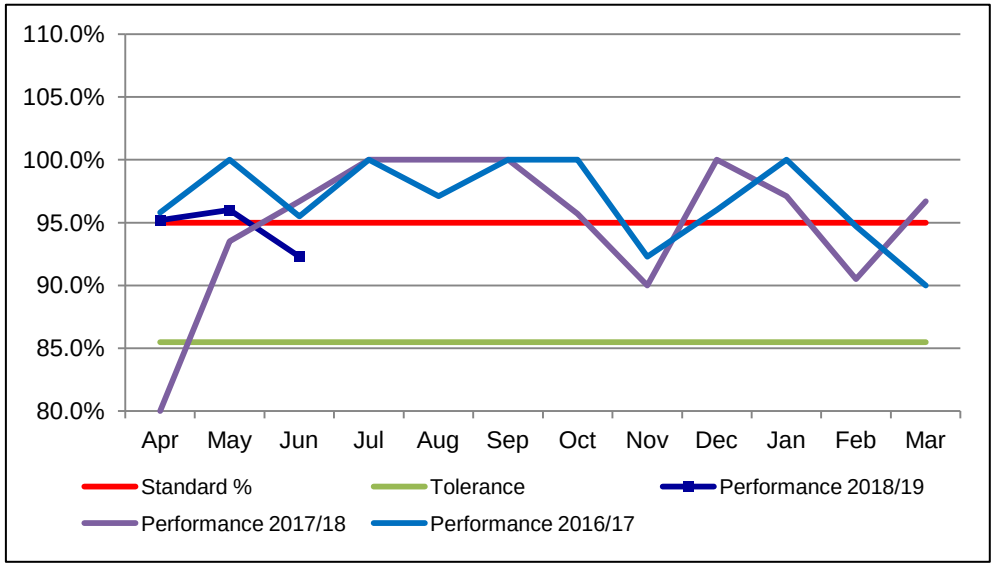
Standard	Tolerance
95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
82.4% (June 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	95.2%	96.0%	92.3%									
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 not achieved in June 2018. This is due to two breaches of the 62 day standard, one for long waits for a Breast appointment and the other due to long waits for diagnostics between NHS Borders and NHS Lothian.

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 breast patient waited 31 days for initial appoinment which lead to the delay in treatment. Additional 2 clinics were run to bring waiting list back on schedule.

Cancer Waiting Times

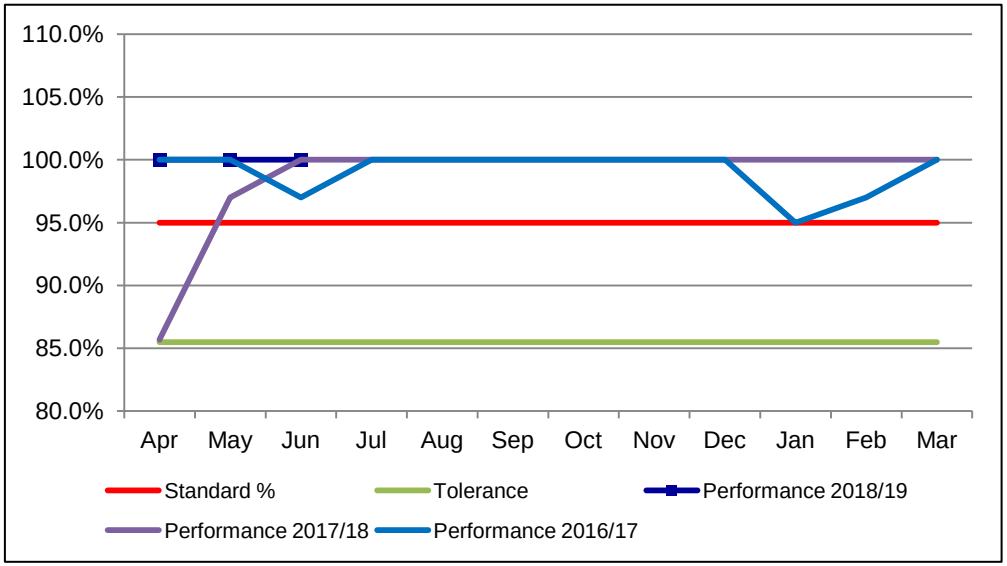
	Standard	Tolerance
31 Day Cancer - 95% of all patients requiring Treatment for Cancer to be seen within 31 days	95.0%	86.0%

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
95.4% (June 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	100.0%	100.0%	100.0%									
Performance 2017/18	85.7%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	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 June 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.

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)

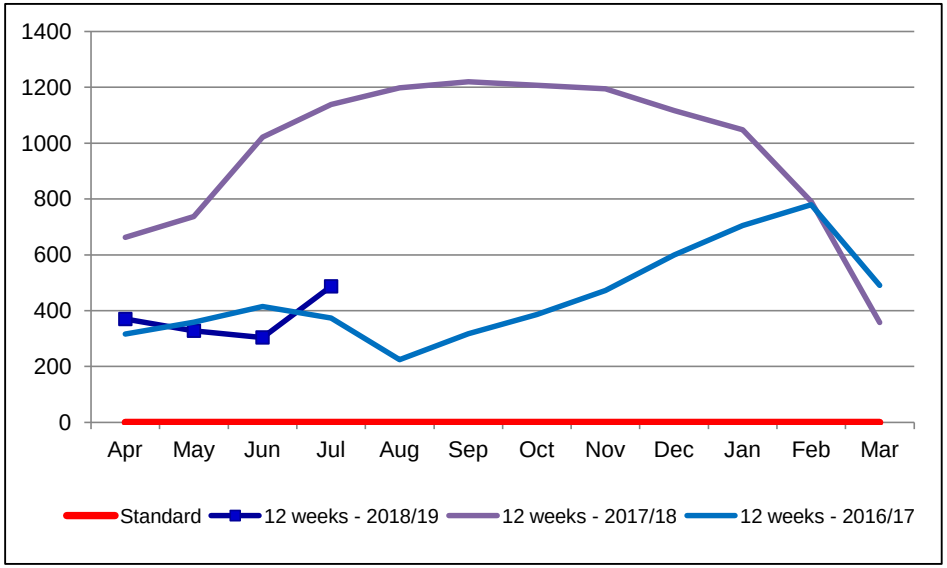
Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
75.1% (Mar 2018)	91.7% (Mar 2018)

	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	328	304	487								
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	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Cardiology	173	190	174	131	141	82	36	8	4			
Dermatology	493	547	586	578	372	235	67	10	4			
Diabetes/Endocrinology	19	7	4	2	1	1			2	3	2	2
ENT					1		1					
Gastroenterology	105	85	74	57	42	18	9	3	3	1		2
General Medicine	3	1				2		3	3	3		
General Surgery	10	27	25	14	22	28	11	2	12	26	2	21
Gynaecology												1
Neurology	54	70	65	76	86	48	28	15	14	20	34	31
Ophthalmology	193	201	210	268	355	398	290	130	87	24	17	5
Oral Surgery	77	46	33	34	48	89	93	87	146	180	188	194
Orthodontics									2			
Other	52	40	35	33	38	27	19	9	11	13	11	37
Pain Management	1							1		1	1	1
Respiratory Medicine				1	6	14	14	22	25	34	14	12
Rheumatology												
Trauma & Orthopaedics	16	5	1		5	104	212	62	54	20	33	176
Urology	2	1		1		2	11	5	3	3	2	5
All Specialties	**1198**	**1220**	**1207**	**1195**	**1117**	**1048**	**791**	**357**	**370**	**328**	**304**	**487**

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



Narrative Summary:
The number of patients reported as waiting longer than 12 weeks for an outpatient appointment has increased in July mainly due to a reduction in new patient Orthopaedic Surgery clinics.

Actions:
- Cardiology: Capacity is an ongoing problem. A third Consultant has been appointed with a view to start imminently. In the short term additional capacity is being provided from within the service.
- Dermatology: 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: Patients are starting to go over 12 weeks due to capacity problems within the service. This is currently under review by the Diabetic consultants along side service management. The review is expecetd to continue well into 2019/20.
- Gastroenterology: The waiting lists has reduced to 9 weeks following extra capacity that was provided through a locum up until the end of March 2018. 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 50% 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. The review is expecetd to conclude by March 2019.
- **Respiratory Medicine:** There are capacity issues within the service that have been worsened by the departure of one of our consultants. This has left a gap in the service that has also led to some of our only Respiratory consultant's clinics while they cover the vacant posts ward commitments. Short term capacity is being used through external providers to reduce the breaching patients in the interim.

Stage of Treatment - 12 Weeks Waiting Time for Inpatients

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

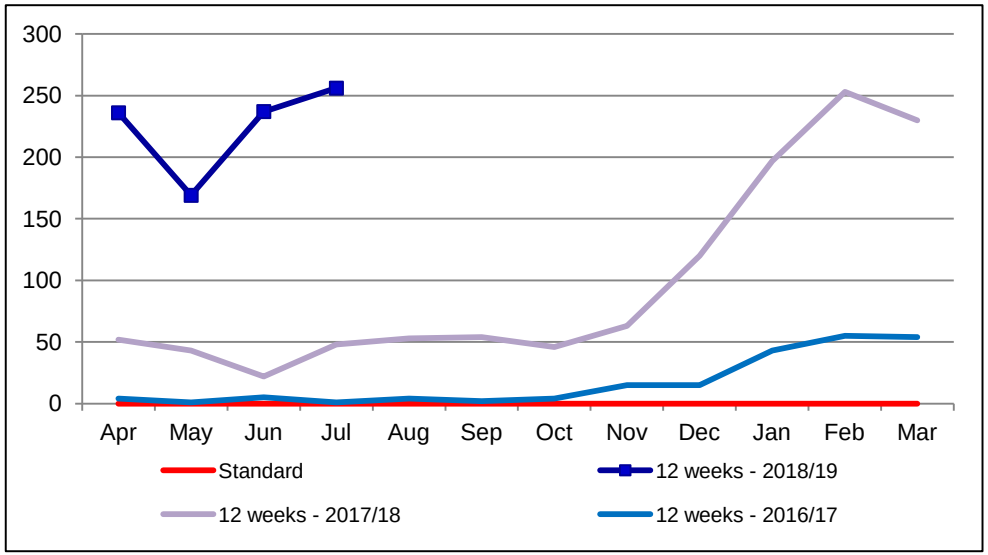
Actual Performance (lower = better performance)

	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	169	237	256								
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	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
ENT	1	2	2		3	8	8	7	9	3	3	1
General Surgery	4	1		6	14	36	61	72	84	43	38	37
Gynaecology							2					
Ophthalmology	7	9	3	1			11	7	8	9	57	77
Oral Surgery	1	1	1	9	25	23	16	7	4	4	5	13
Other							16	16	9	8	10	14
Trauma & Orthopaedics	40	41	40	47	76	122	130	109	102	90	118	111
Urology					2	8	9	12	20	12	6	3
All Specialties	**53**	**54**	**46**	**63**	**120**	**197**	**253**	**230**	**236**	**169**	**237**	**256**

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



Narrative Summary:
At the end of July, the number of patients reported waiting over **12 weeks for inpatient treatment** increased to 267. The large number of breaching patients was due capacity issues and short notice cancellations for bed availability. This now means that NHS Borders has patients breaching TTG in every specialty except Gynaecology and Paediatric Surgery.

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. The improvement in General Surgery in April and May was due to the vasectomies waiting over 12 weeks that were operated on during month which has again ceased due to a vacancy within the service.
ENT - due to theatre and bed availability
Ophthalmology - due to Consultant leave
Oral Surgery - due to consultant capacity
Urology - due to bed availability

Actions:
- There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. We are working to minimise the impact of cessation of Synaptik operating lists with the implementation of the theatres and surgical flow project.
- A project was undertaken to review productivity of Ophthalmology lists in DPU, with the aim of increasing this to be in line with other Health Board areas. The project is now complete, timesclaes have been realigned to reflect regional work and plan to advertise for an optomet rist by end of 2018 . The impact of this review is expected to commence in early 2019.
- Short - medium term additional capacity has been organised through an external locum for Ophthalmology in August to utilise empty lists due to consultant leave.

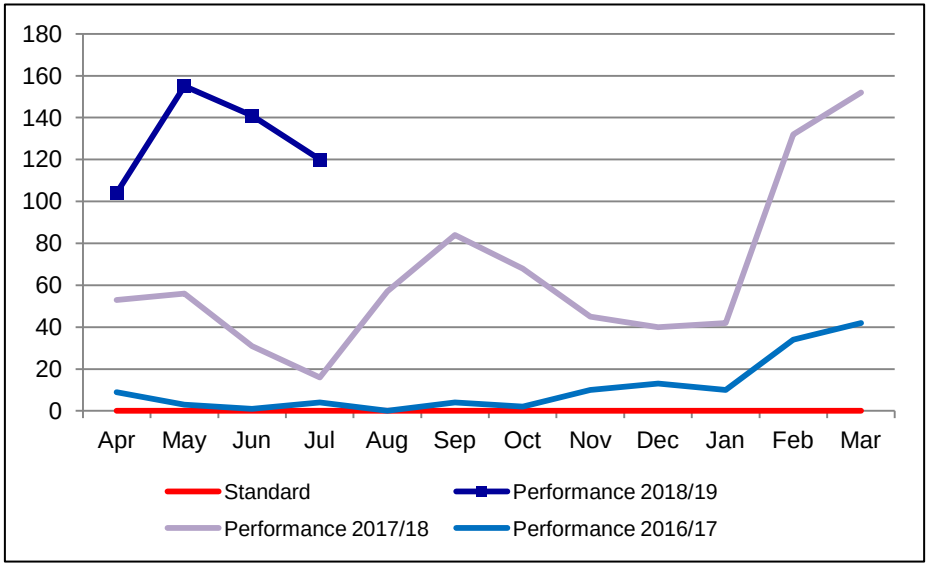
12 Weeks Treatment Time Guarantee

	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)
75.88% (Mar 2018)	84.54% (Mar 2018)

	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	155	141	120								
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 July 120 patients who previously breached their **Treatment Time Guarantee** (TTG) date were treated. This was mainly due to the capacity problems within Orthopaedics.

Actions:
- Short notice cancellations are reviewed on a daily basis.
- Work is ongoing to ensure cancellations are minimised and decisions are made as soon as possible.
- An Institute for Healthcare Optimisation (IHO) project is looking to address surgical flow; however the service are reviewing on a weekly basis to determine any risk of cancellations and take appropriate action.
- Cancelled patients are rebooked as soon as possible to accommodate their TTG date where possible.
- MSK Hubs with First Contact Practitioners are expected to go live in early 2019/20 with the aim of reducing the number of physio sites from 8 to 4, this will increase physiotherapy capacity as there will be less travel time required.

Unavailability

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

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

Unavailable	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Unavailable	91	103	87	71	63	62	53	60	75	71	70	99	85
Patient Advised	46.0%	61.7%	52.1%	45.2%	42.6%	40.3%	35.6%	37.3%	43.9%	42.5%	42.7%	49.5%	51.8%
Unavailable	107	82	80	86	85	92	96	101	96	96	94	101	79
Medical	54.0%	47.9%	47.9%	54.8%	57.4%	59.7%	64.4%	62.7%	56.1%	57.5%	57.3%	50.5%	48.2%
Total Unavailable	198	167	167	157	148	154	149	161	171	167	164	200	164
Total % Unavailable	17.9%	16.0%	14.2%	13.9%	14.6%	12.5%	11.8%	12.8%	12.9%	12.9%	11.9%	11.9%	16.5%

Table 2 - Monthly Unavailability by Specialty - as at 31st July 2018

	Available				Unavailable			
Specialty	**0 - 9 Weeks**	**10 - 12 Weeks**	**12+ Weeks**	**Total**	**Medical Un-available**	**Patient Advised Un-available**	**Total**	**% Un-available**
ENT	32	10	1	**43**	3	3	**6**	**12.2%**
General Surgery	67	53	39	**159**	18	25	**43**	**21.3%**
Gynaecology	28	3	0	**31**	0	7	**7**	**18.4%**
Ophthalmology	49	98	79	**226**	11	10	**21**	**8.5%**
Oral Surgery	11	8	14	**33**	3	1	**4**	**10.8%**
Other	11	4	15	**30**	2	1	**3**	**9.1%**
Trauma & Orthopaedics	57	69	116	**242**	30	34	**64**	**20.9%**
Urology	43	16	5	**64**	12	4	**16**	**20.0%**
Total	**298**	**261**	**269**	**828**	**79**	**85**	**164**	**16.5%**

Narrative Summary:
There has been a general upward trend over the past few months in the number of patients with patient advised **unavailability** that has increased steadily since January 2018 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.

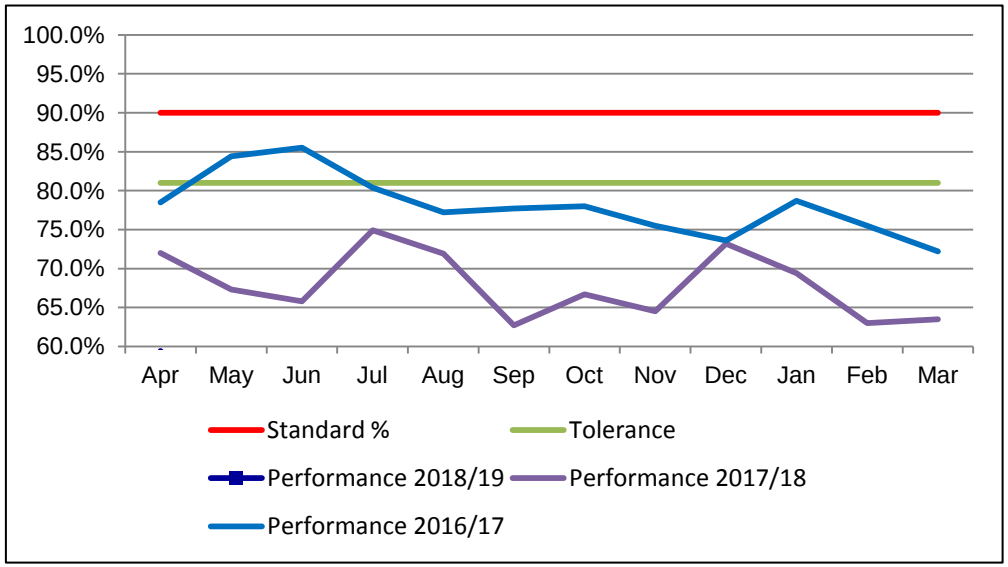
Actions:
- Ensure unavailability is closely monitored and that patients are managed in accordance with national guidelines.

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	59.4%	48.5%	45.5%									
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:
- A Scottish Government plan is in place for 2018/19 for all at risk specialties to prevent the majority of patients waiting longer than 12 weeks by the end of the financial year. All waiting lists are expected to achieve 12 weeks by end of March 2019, apart from Orthopaedics which is expected to achieve 18-26 weeks .

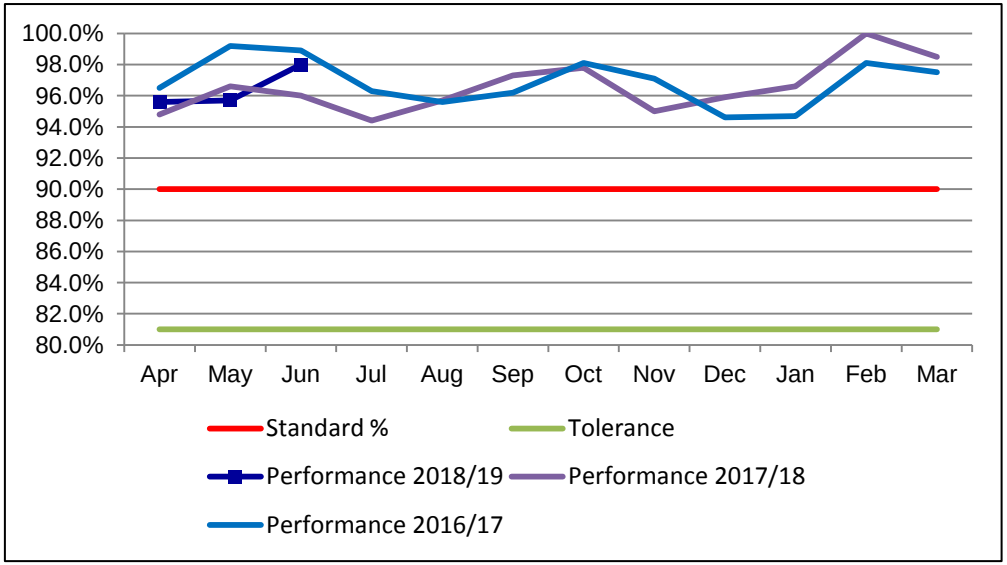
Please Note: 18 Weeks RTT data isreported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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	95.6%	95.7%	98.0%									
Performance 2017/18	94.8%	96.6%	96.0%	94.4%	95.7%	97.3%	97.8%	95.0%	95.9%	96.6%	100.0%	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 2018/19 with the reduction in the number of 12 week breaches.

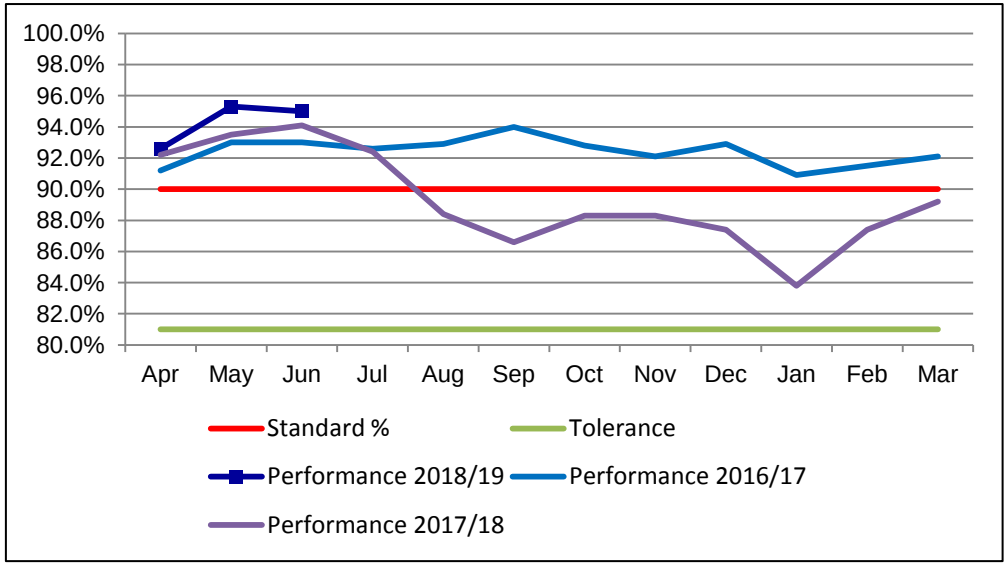
Please Note: 18 Weeks RTT data is reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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	92.6%	95.3%	95.0%									
Performance 2017/18	92.2%	93.5%	94.1%	92.4%	88.4%	86.6%	88.3%	88.3%	87.4%	83.8%	87.4%	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 increased to over 90% following the extra activity provided at the start of this year to reduce the long waiters.

Actions:
- A Scottish Government plan is in place for 2018/19 for all at risk specialties to prevent the majority of patients waiting longer than 12 weeks by the end of the financial year. All waiting lists are expected to achieve 12 weeks by end of March 2019, apart from Orthopaedics which is expected to achieve 18-26 weeks .

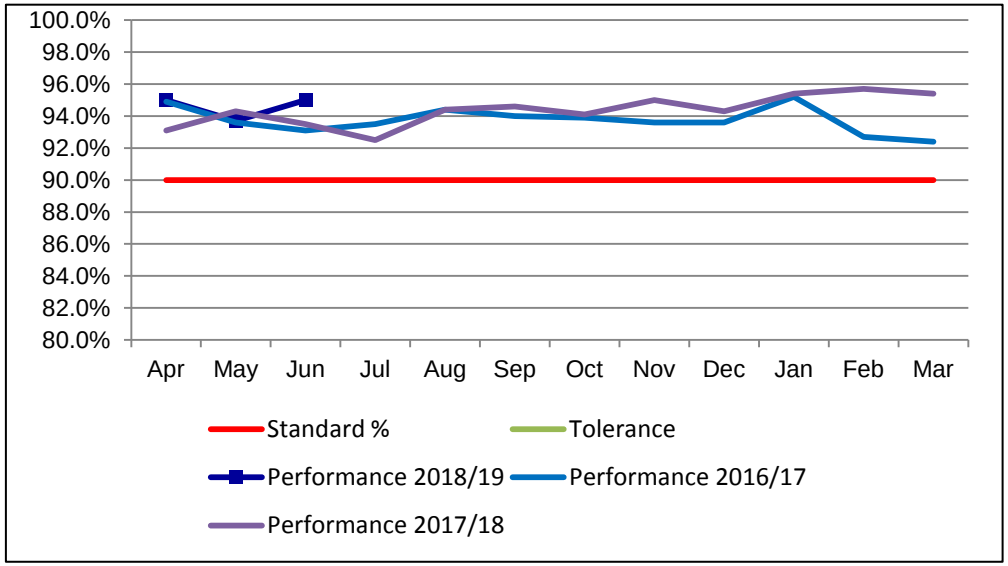
Please Note: 18 Weeks RTT data is reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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	95.0%	93.7%	95.0%									
Performance 2017/18	93.1%	94.3%	93.5%	92.5%	94.4%	94.6%	94.1%	95.0%	94.3%	95.4%	95.7%	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 2018/19 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.

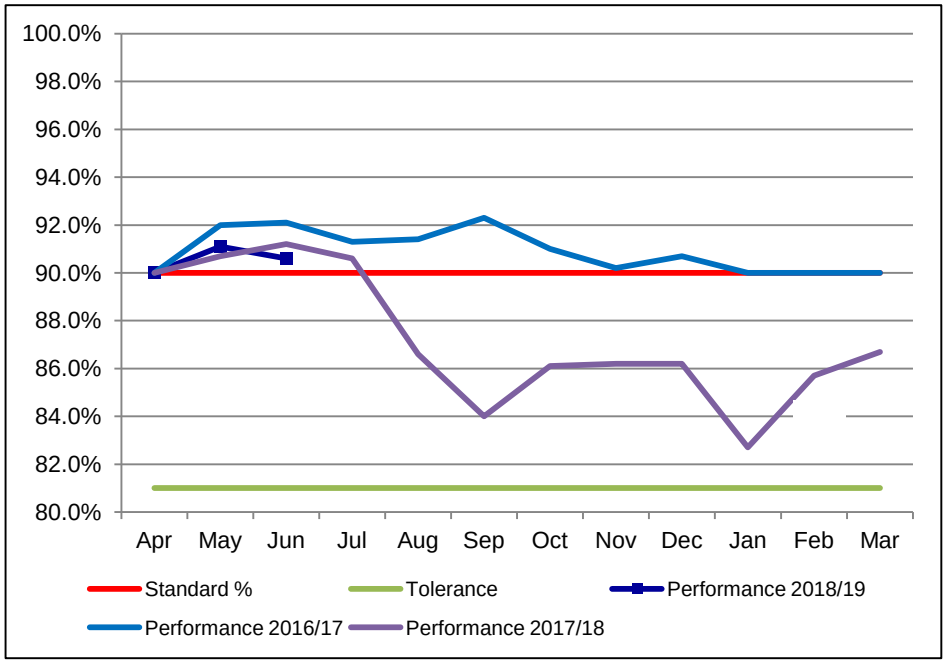
18 Weeks Referral to Treatment (RTT)

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

Actual Performance (higher % = better performance)

Latest NHS Scotland Performance
81.2% (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	90.0%	91.1%	90.6%									
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 June 2018 the 90% standard was met following extra activity provided towards the end of 2017/18 to reduce the experienced waiting times in all specialties. However due to capacity issues particularly within Dermatology and Cardiology, Ophthalmology and Orthopaedic Surgery for both Outpatients and Inpatients this is expected to slowly decline towards the end of the year.

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

Actions:
- Work will continue during 2018/19 with the reduction in the number of 12 week breaches.

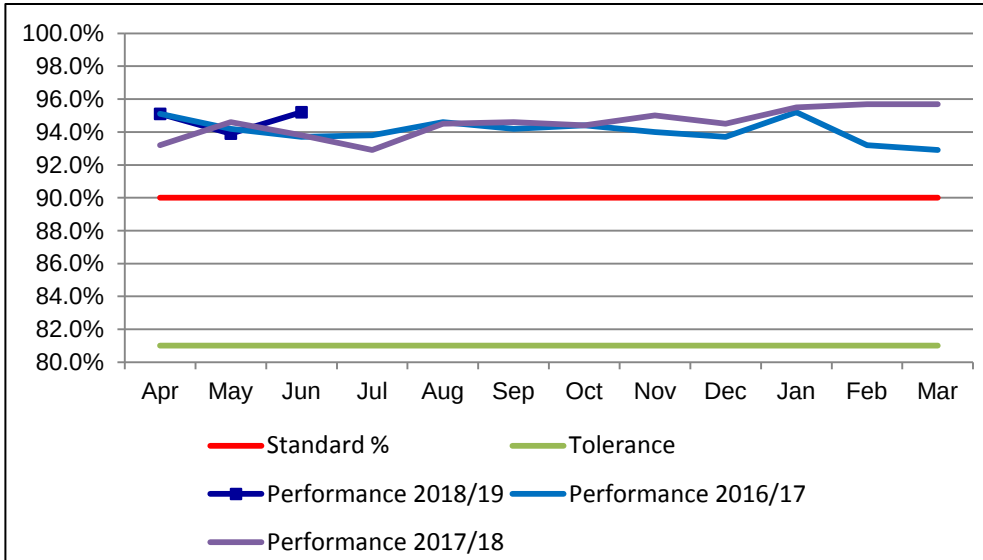
Please Note: 18 Weeks RTT data is reported with a one month lag time to allow accurate information to be reported inline with national reporting timelines.

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	95.1%	93.9%	95.2%									
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.

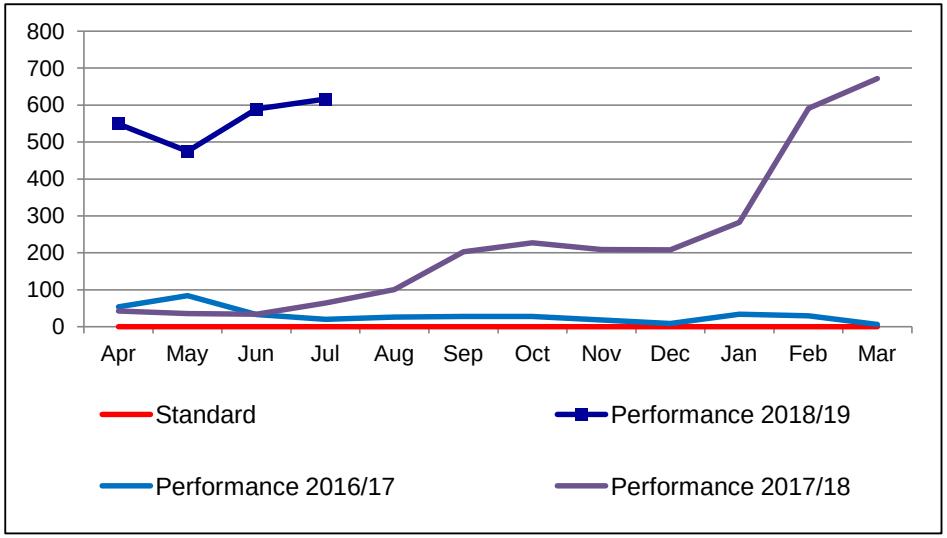
Diagnostic Waiting Times

	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	475	589	616								
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**.

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	Jul-17	Aug-17	Sep-17[1]	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Endoscopy	-	-	-	-	-	-	-	-	-	-	-	-	-
Colonoscopy	7	-	-	-	-	-	1	-	-	-	8	24	23
Cystoscopy	-	-	-	1	-	-	-	-	6	-	-	-	-
MRI	56	100	187	189	198	186	241	339	364	438	387	449	453
CT	1	1	16	37	11	4	4	11	43	70	63	72	115
Ultra Sound (non-obstetric)	-	-	-	-	-	18	28	2	25	29	14	38	25
Barium	-	-	-	-	-	-	9	1	2	12	3	6	0
Total	**64**	**101**	**203**	**227**	**209**	**208**	**283**	**353**	**440**	**549**	**475**	**589**	**616**

[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 sessions 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. Scottish Government funding has been secured to continue to run evening and weekend sessions and an additional fixed term radiographer post will help provide capacity to main staff in CT/MRI. Additional sessions have been booked starting in October. This follows recruitment and using part time staff working additional hours which will continue to show a positive impact in waiting times. We have managed to staff 2 additional days per week in CT using this approach.

Ultrasound – The ultrasound service has had staffing challenges due to maternity leave but this has resolved. We have 0.2 WTE vacancy but permanent part time staff are working additional hours to minimize the impact of this in the short term.

A Recovery Plan for MRI, CT & Colonoscopy is in place with support of additonal Scottish Government funding for waiting times. The wait expected for all areas by March 2019 is 6 weeks with the exception of MRI and CT which is expeted to be 12 weeks.

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%

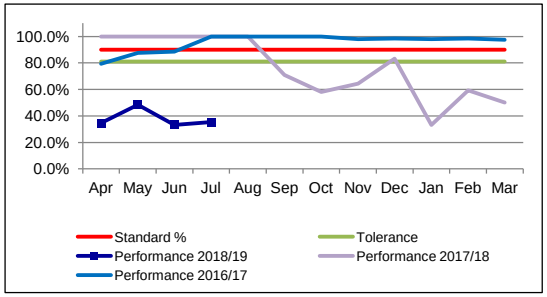
Actual Performance (higher % = better performance)

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%	48.5%	33.3%	35.3%								
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:
Performance in June 2018 for **CAMHS** remains outwith the 90% standard.

Actions:
- Senior management oversight - Fortnightly HEAT standard meetings held with senior management team in CAMHS and General Manager
- **Recruitment -** Recruitment to the vacant Band 6 CPN post and additional over establishment FTC Band 6 CPN has now failed on 2 occasions to attract suitable candidates. We have now developed a Band 5/6 development Post with an associated competency frameork to allow a Band 5 applicant to train to Band 6 level. We will be advertising 2 permanent Band 5/6 development posts and an additional Band 5/6 fixed term contract to cover maternity leave for an existing post holder. Interviews for the 8c Head of Psychology taking place 29th October. Current post holder leaving 16th November. Recruiting to 8a psycholgist post will commence shortly (retirement of current post holder. Temporary cover in place until April 19.
- **Additional clinics -** Weekly additional clinics will be run utilising CPN and possibly other professionals who have offered to work overtime.
- **Work flow -** We are implementing a new to follow up ratio for Psychology and CPN staff. This will allow us to identify new appointment slots for weekly allocation and set a standard for follow ups. Robust caseload management in place for CPN staff
Caseload activity reports produced by Performance and planning evidencing staffing activity levels
- **Management -** Operational Manager for CAMHS now work full time supporting CAMHS
- **Admin support -**Band 5 admin manager MH service placed in CAMHS for an initial 3 month period to focus on developing efficient/lean admin processes
- **ADHD -** Transferring review ADHD patients to ADHD nusre freeing up Consultant capacity
- **Current position/impact -** June 2018 – Total waiting = 193 – Waiting over 18 weeks = 43

Summary - despite our inability to recruit the existing staff team have reduced the overall waits by 57 patients and the numbers waiting over 18 weeks by 15. The impact upon the HEAT standard in the short term will remain negative as we treat in turn and focus on the long waits. However as the overall waiting list has significantly reduced we anticipate over the next couple of months performance will improve. Our trjectory was to reach the standard by December 2018, however as recruitment has been unsuccesfull to date this will not be achieved. If we recruit to the Band 5/6 development posts we will have some increased capacity and this will increase as they develop and achieve against the competency based training programme. Although we should see significant improvement in performance by December 2018 it is likely that we will not achieve the 90% performance until April 2019.

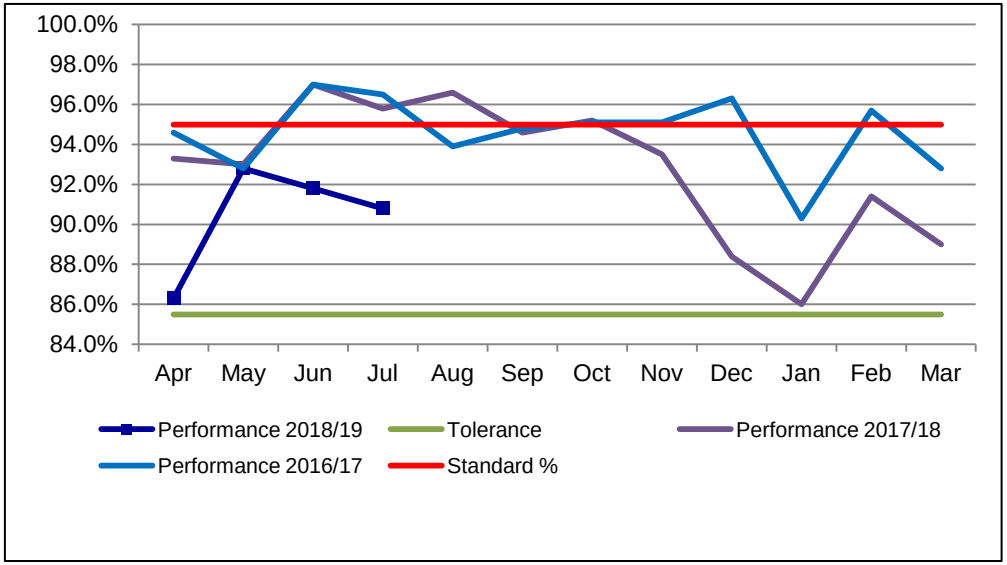
Accident & Emergency 4 Hour Standard

	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
91.9% (May 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%	92.8%	91.8%	90.8%								
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 was a deterioration in **4 hour A&E performance** through November to April reflecting a difficult winter period, as seen in the Health Boards across the country. The standard is still struggling to be delivered with performance for July 90.8%.

Actions:
Please see next page 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	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Flow 1	98.8%	98.9%	98.4%	98.8%	98.7%	97.00%	97.40%	98.00%	98.8%	95.7%	97.0%	97.1%	95.5%
Flow 2	93.6%	91.6%	89.5%	91.5%	91.6%	82.70%	83.70%	85.10%	81.3%	82.1%	87.5%	84.2%	84.5%
Flow 3	91.5%	93.7%	88.0%	89.5%	84.0%	74.80%	67.0%	83.00%	71.7%	68.7%	87.2%	85.8%	85.9%
Flow 4	91.7%	95.7%	94.5%	92.7%	88.8%	88.50%	81.1%	88.50%	86.2%	80.5%	86.8%	84.3%	82.4%
Total	**95.8%**	**96.6%**	**94.6%**	**95.2%**	**93.5%**	**88.40%**	**86.0%**	**91.40%**	**89.0%**	**86.3%**	**92.8%**	**91.8%**	**90.8%**

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

- Development of new monthly Unscheduled Care Improvement Forum to lead improvement activities. There have now been four meetings of this group focussing on ward flow improvement, Ambulatory Care and the Winter Review
- Re-launch of Daily Dynamic Discharge for the BGH started June 2018 with a second MDT event due to be held August 2018. Further improvement activites are planned for the Autumn
- new Ambulatory Care project established to reduce LOS to 0 days
- Refresh of key flow management processes at BGH
- weekly multi-professional BGH & IJB Delayed Discharge and Extended (> 28 day) Length of Stay group, which has met three times now and is showing early results
- The 2018/19 Winter plan is close to being finalised

Please Note:
Flow Groups are as follows: Flow 1 - Minor Injury & Illness; Flow 2 - Acute Assessment - includes Major Injuries;
Flow 3 - Medical Admissions; Flow 4 - Surgical Admissions

Delayed Discharges

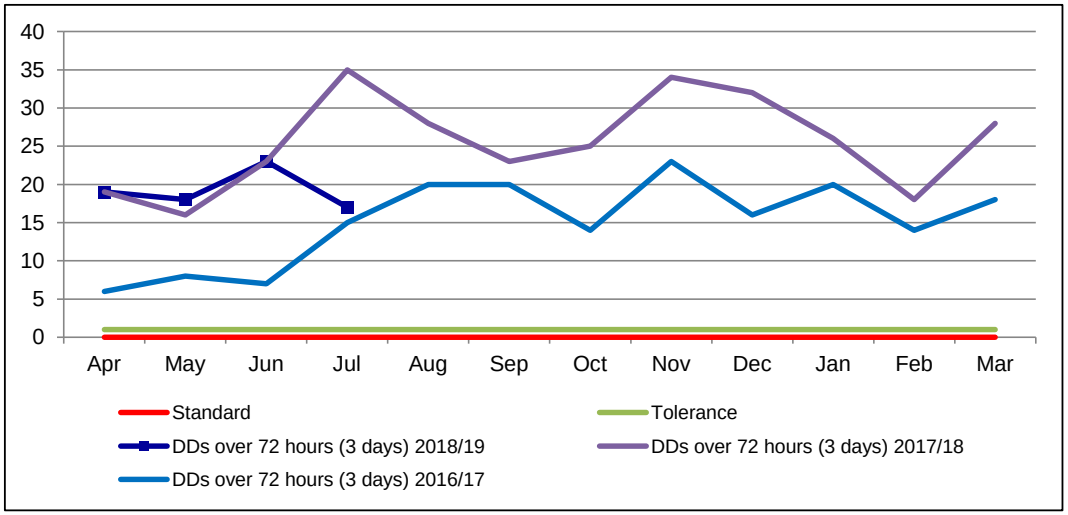
	Standard	Tolerance
Standard: Delayed Discharges - delays over 72 hours	0	1

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	12	17	11								
DDs over 72 hours (3 days) 2018/19	19	18	23	17								
Occupied Bed Days (standard delays)	722	848	718	658								
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

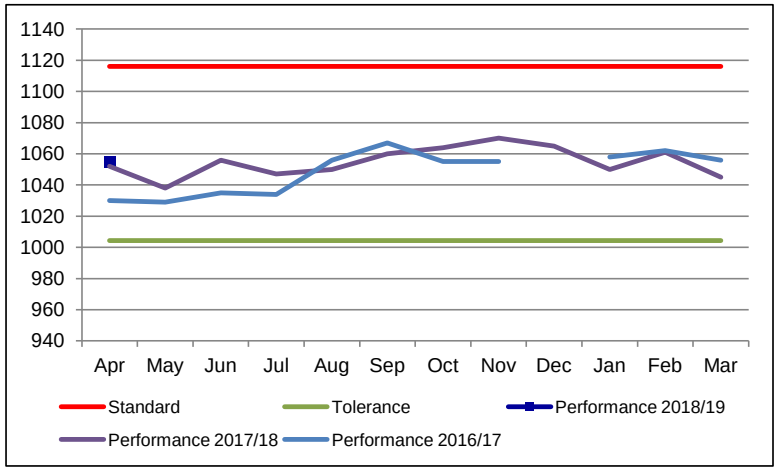
	Standard	Tolerance
Standard: Increase the number of patients added to the dementia register	1116	1004

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	- [2]	- [2]	- [2]								
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	- [1]	1058	1062	1056

[1] Data unavailable for December 2016 at time of reporting

[2] Data unavailable for May - July 2018 at time of reporting due to National system access and reporting issues (fixed in Septemebr 2018)



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 theories around why the standard is not improving - patients diagnosed with Dementia are being recorded on EMIS we will continue to monitor and hope to see improvement.

We are evaluating whether the proportion of people referred from Primary Care to Secondary Care for an assessment of cognitive function who are subsequently given a diagnosis of dementia is higher than would be expected; which may indicate referrals are made later in the disease process.

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)

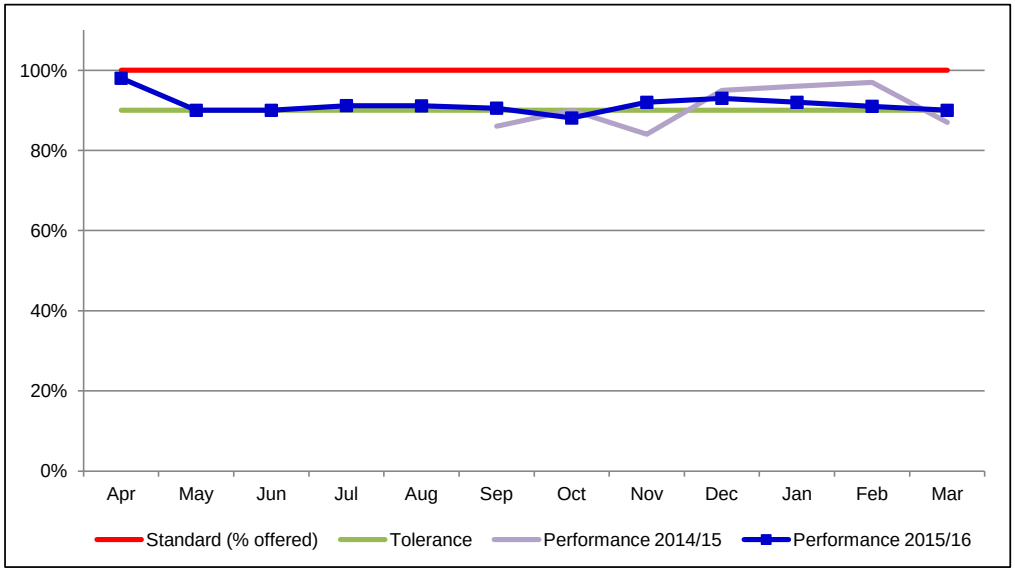
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard (% offered)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of People who are referred for PDS and have been offered at least 12 months of PDS												
Performance 2017/18[1]	-	-	-	-	-							
Performance 2016/17[1]	137	137	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
The Number of People who are Diagnosed with Dementia and Referred for PDS												
Performance 2017/18[2]	-	-	-	-	-							
Performance 2016/17[2]	-	-	-	-	-	-	-	-	-	-	-	-
Performance 2015/16	138	156	185	204	225	243	260	276	302	322	341	356
Performance 2014/15						87	86	38	57	74	100	123
Percentage offered at least 12 months of PDS												
Performance 2017/18[1]	-	-	-	-	-							
Performance 2016/171	53%	53%	53%	73%	73%	73%	87%	87%	87%	-	-	-
Performance 2015/16	98%	90%	90%	91%	91%	91%	88%	92%	93%	92%	91%	90%
Performance 2014/15						86%	90%	84%	95%	96%	97%	87%

Please Note: There is a 1 year time lag to show the full 12 months performance and a 1-2 month time lag for the receipt of data.

[1] Data unavailable at time of reporting

[2] Data no longer available due change in reporting method

Dementia - Post Diagnostic Support (PDS) *continued*



Narrative Summary:
Performance for **Dementia Post-Diagnostic Support** (PDS) is currently at 90%.

In 2017 the dementia diagnosis HEAT standard changed to become part of the local delivery standards to include PDS with diagnosis.

It is anticipated that engagement with PDS including date of diagnosis will increase locally with live and accurate data from EMIS.

Actions:
- ISD will issue a revised data set for PDS in October 2018.
- EMIS went live in November 2017 and a new PDS template is currently being tested in line with new data set which goes live on 1st April 2019.
- NHS Borders met with ISD in July 2018 and continue to attend national PDS leads group.
- An information leaflet for both patients (to outline expectations) and staff (to assist with delivery) is being developed in partnership with the Borders Dementia Working Group and Health Improvement Scotland.

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%

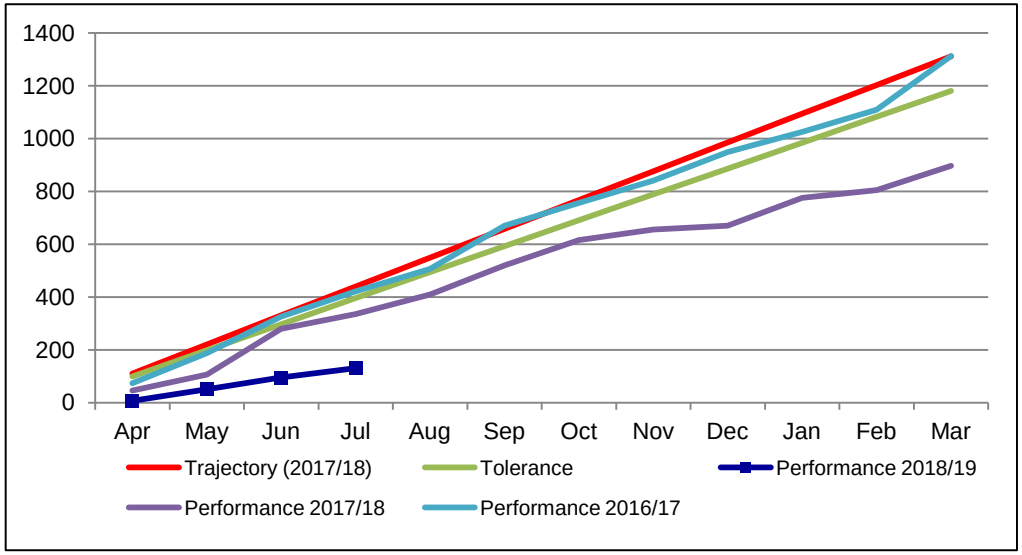
Actual Performance (higher = better performance)

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	7	51	95	130								
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

[1] Please note numbers for June 2018 are low as not all data has been received due to annual leave within the service

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 July remains low. As reported last month the biggest decrease is in Primary Care via the Local Enhanced Service (LES). A decision was taken by LNC in January to end these arrangements therefore there are zero ABI's from this setting. In 2016/17 Primary Care performed 707 ABI's which fell to 410 in 2017/18.

Actions:
- Problems with badgernet reporting have now been isolated which was due to a coding error. We anticipate that we will be able to report on some antenatal ABI's going forward.
- Health Visitors have now been trained and reporting processes nearing completion.
- Police Custody suites are now reporting on activity.
- We are now able to report on ABI's in adult health and social care following review of reporting mechanisms.
- We have asked colleagues in Primary Care to consider how best to approach ABI's in the shifting context e.g. AHPs in Primary Care.

Smoking Quits

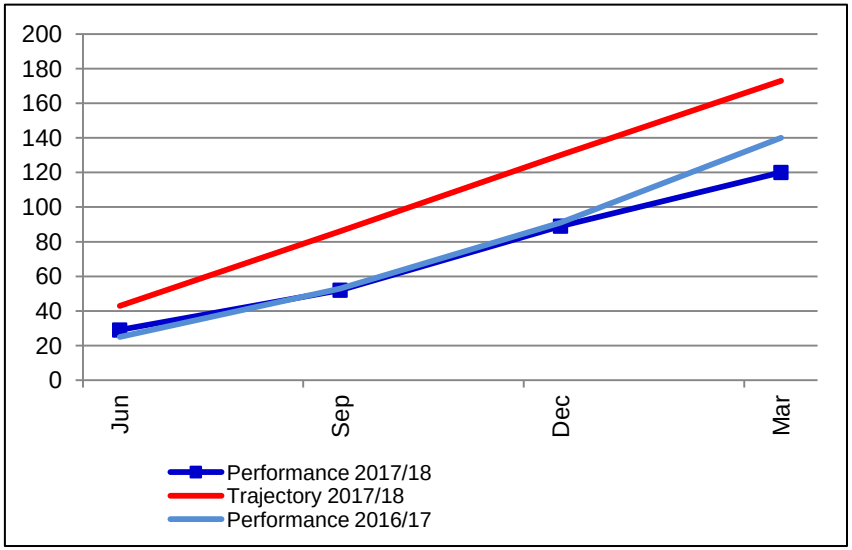
Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas	**Standard**	**Tolerance**
	173	within 10%

Actual Performance (higher = better performance)

	Jun	Sep	Dec	Mar
Trajectory 2017/18	43	86	130	173
Performance 2017/18	29	52	89	120
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 October 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

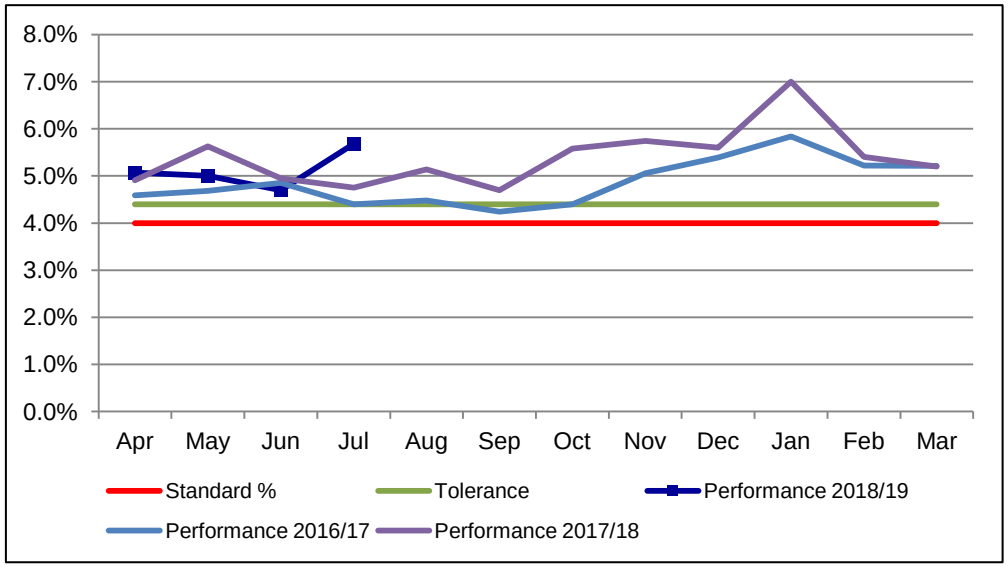
Standard: Maintain Sickness Absence Rates below 4%

Standard	Tolerance
4.0%	4.4%

Actual Performance (lower % = better performance)

Latest NHS Scotland Performance
5.15% (Jul 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%	5.0%	4.7%	5.7%								
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 July of 5.7% which is an increase of 1% from June 2018. The last NHS Scotland figure is 5.15% for the month of July 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.
- An analysis of sickness absence for Nursing and Midwifery staff was presented to the CE Operational group and actions identified from this to progress.

Sickness Absence *continued*

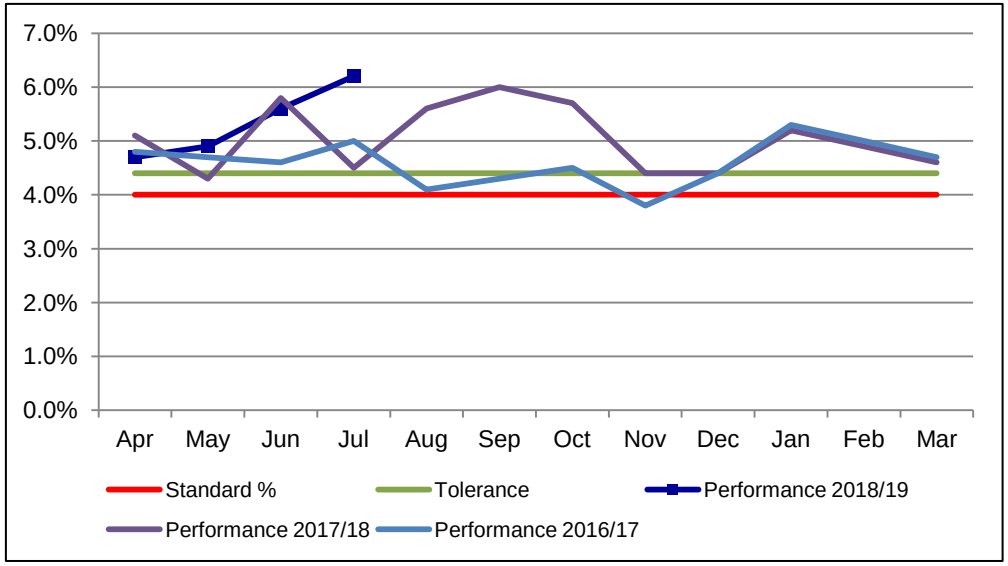
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Learning Disabilities (Div/CHP)													
Administrative Services	0.00	0.00	0.00	0.00	0.00	0.00	7.97	0.00	0.00	0.00	0.00	0.00	0.00
Allied Health Professionals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	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	12.71	7.17	1.11	9.22	14.71	10.52	19.46	0.77	1.86	0.00	0.00	4.16	2.47
Grand Total	**10.07**	**6.07**	**0.94**	**7.42**	**11.29**	**8.07**	**16.06**	**0.59**	**1.52**	**0.00**	**0.00**	**3.25**	**1.93**
Mental Health (Div/CHP)													
Administrative Services	0.75	9.39	4.54	7.06	8.72	7.44	5.71	2.54	0.75	1.03	1.53	1.79	6.24
Allied Health Professionals	0.00	0.00	0.00	0.00	0.46	3.03	16.23	12.05	0.00	2.38	0.00	13.23	12.94
Medical & Dental	7.07	5.53	8.03	10.21	6.79	6.80	4.58	0.93	2.40	1.73	2.86	0.88	1.76
Nursing / Midwifery	7.38	8.19	7.23	7.66	7.51	4.43	4.90	5.18	5.08	5.8	6.25	5.44	6.56
Other Therapeutic	5.26	3.35	5.28	1.16	2.58	3.54	4.61	2.53	1.91	0.99	2.19	5.46	5.12
Personal & Social Care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	22.99	0.00	0.00	0.00
Support Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total	**6.38**	**7.55**	**6.73**	**6.97**	**6.91**	**4.76**	**5.10**	**4.41**	**3.99**	**4.41**	**4.95**	**4.82**	**6.07**
Primary, Acute & Clinical Services													
Administrative Services	5.42	3.72	3.34	2.28	3.23	3.66	5.55	3.17	4.70	3.41	3.09	4.21	4.33
Allied Health Professionals	2.60	2.43	2.19	2.63	5.10	4.77	6.26	6.36	6.13	6.62	6.06	4.98	4.61
Dental Support	4.81	9.03	2.50	8.02	10.21	4.76	3.84	5.45	7.77	7.04	3.73	9.36	3.3
Health Care Sciences	4.20	5.43	2.92	4.98	5.28	5.39	7.43	6.66	5.88	5.73	1.65	6.44	2.5
Medical & Dental	2.00	2.01	1.33	1.18	1.58	1.60	2.84	2.79	3.16	2.78	2.43	4.11	3.88
Medical Support	0.00	1.30	0.00	0.00	2.45	0.00	5.75	0.00	0.00	0.00	0.00	0.00	0.00
Nursing / Midwifery	5.42	6.14	6.32	7.45	6.48	7.39	8.51	6.11	6.68	6.59	6.86	5.41	7.25
Other Therapeutic	0.00	4.28	0.00	2.67	0.00	8.20	0.00	0.00	0.00	0.00	0.00	0.00	7.31
Personal & Social Care	1.07	0.82	3.12	7.06	4.68	2.46	4.93	5.84	0.58	0	0.99	3.12	3.45
Support Services	6.58	6.60	7.88	2.79	3.92	2.34	10.01	9.51	5.28	4.54	3.27	6.19	8.09
Grand Total	**4.59**	**4.97**	**4.64**	**5.31**	**5.29**	**5.65**	**7.02**	**5.43**	**5.89**	**5.66**	**5.42**	**5.23**	**5.97**
Support Services (Div/CHP)													
Administrative Services	4.41	4.82	3.96	5.31	5.23	4.52	5.95	4.02	3.37	3.16	2.29	4.73	5.26
Allied Health Professionals	3.91	1.56	0.59	1.41	16.93	0.00	1.30	10.48	6.45	0.00	15.59	0.00	0.00
Health Care Sciences	10.78	2.94	0.00	1.89	0.00	0.00	0.00	6.86	1.96	3.95	0.00	1.05	1.05
Medical & Dental	0.00	3.36	0.00	0.00	0.00	3.15	6.20	0.00	4.42	0.00	0.00	0.00	0.00
Nursing / Midwifery	1.48	3.66	3.79	4.57	5.76	9.07	10.14	7.23	3.78	2.54	4.58	9.98	2.68
Other Therapeutic	2.32	2.09	2.08	3.22	6.91	5.64	9.11	7.60	3.47	3.82	3.62	6.48	4.88
Personal & Social Care	5.84	6.10	2.99	3.37	2.83	5.50	6.48	6.05	9.79	5.34	8.32	0.00	9.36
Senior Managers	0.00	0.00	0.00	0.80	0.00	0.53	3.71	2.65	7.96	0.00	0.00	1.59	0.00
Support Services	5.01	5.02	4.92	6.83	7.22	6.92	7.93	7.09	5.32	5.30	5.87	5.36	5.07
Grand Total	**4.30**	**4.50**	**4.05**	**5.56**	**6.14**	**5.80**	**7.21**	**5.90**	**4.45**	**4.09**	**4.23**	**5.21**	**4.93**

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%	4.9%	5.6%	6.2%								
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 July 2018 reports a decrease in performance at 6.2%.

Actions:
- Exploring improving patient information on what to expect and what is expected of them when they are referred to Secondary care.

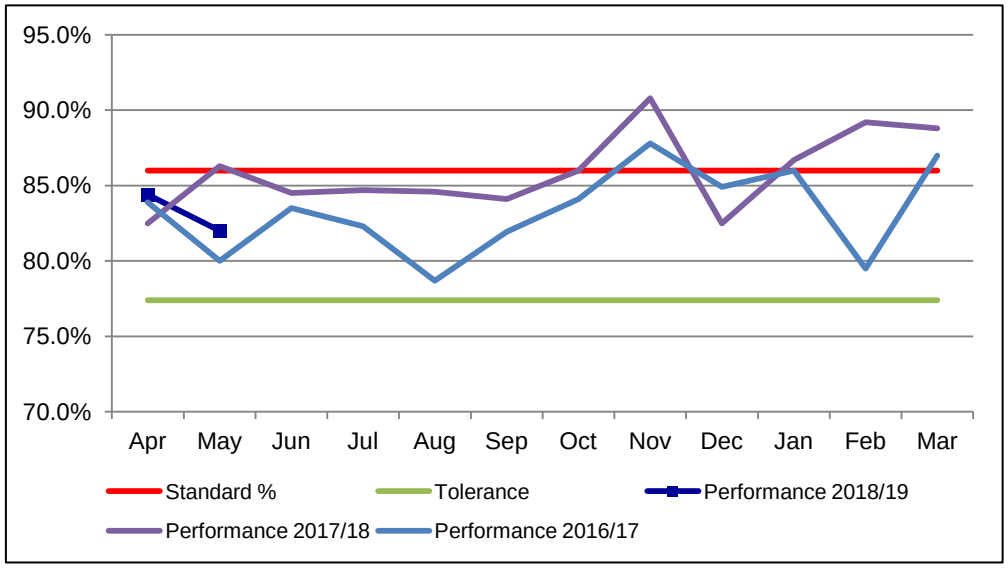
Same Day Surgery

	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	84.4%	82.0%										
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%	88.8%
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*

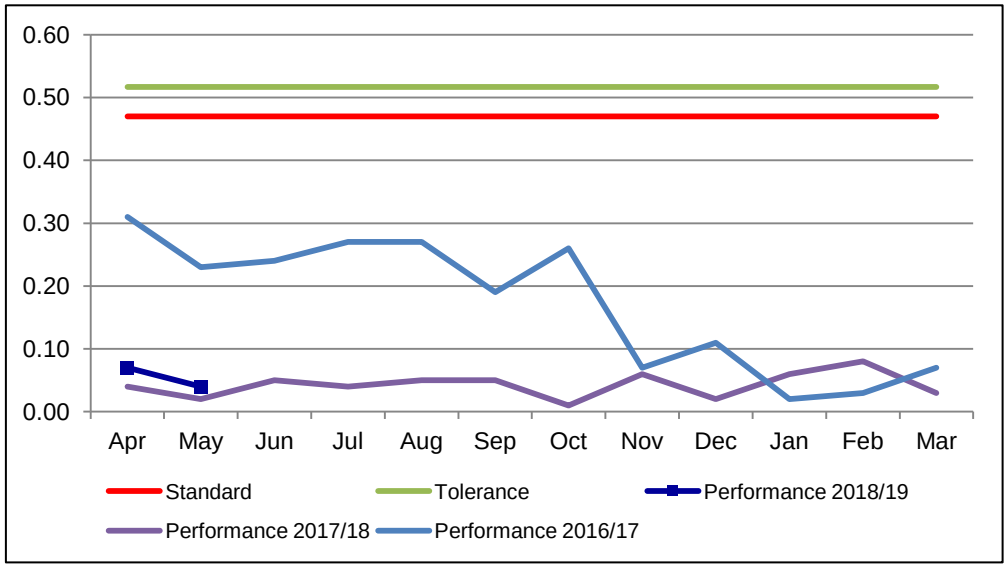
Pre-Operative Stay

	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	0.07	0.04										
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	0.03
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.

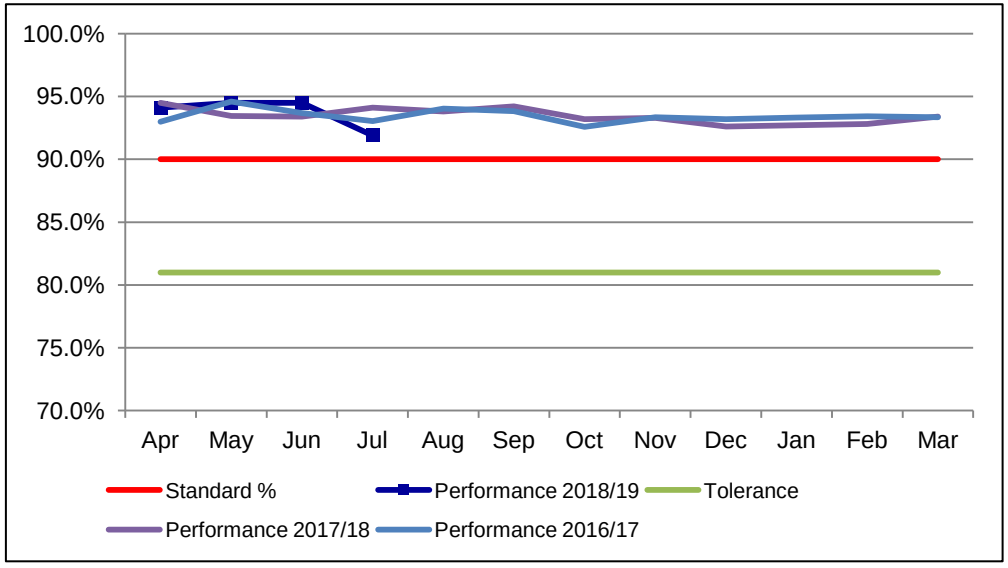
Actions:
- No further action planned at this time.

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%	94.5%	94.5%	91.9%								
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.

Breastfeeding

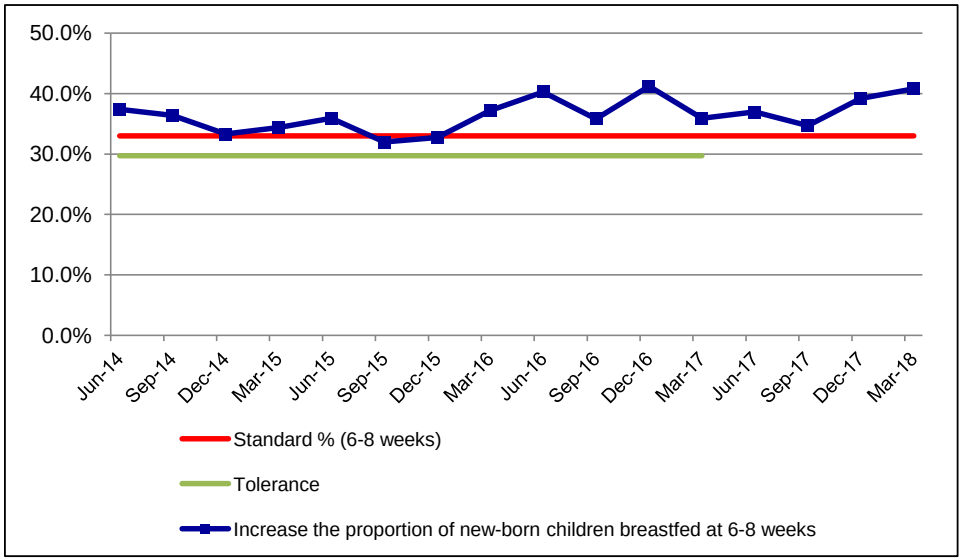
	Standard	Tolerance
Standard: Increase the proportion of new-born children breastfed at 6-8 weeks	33.0%	29.7%

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%	40.8%
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%	47.0%
Percentage Ever Breast Fed	-	-	-	60.50%	75.0%	72.4%	76.1%	68.5%	68.1%	69.9%	72.0%	71.7%

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 December 2017 to March 2018 performance has improved to 40.8%.

Actions:
- We are continuing to focus 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 and supporting responsive feeding.
- Completing and evaluating our skin to skin audit, report due early Autumn.
- In July and August we will commence our annual UNICEF BFI audit of staff and families.
- Recruitment undertaken to increase BiBS presence in BGH. Training to support this planned in September 2018.
- Developing new bedside resources for staff, volunteers and families.

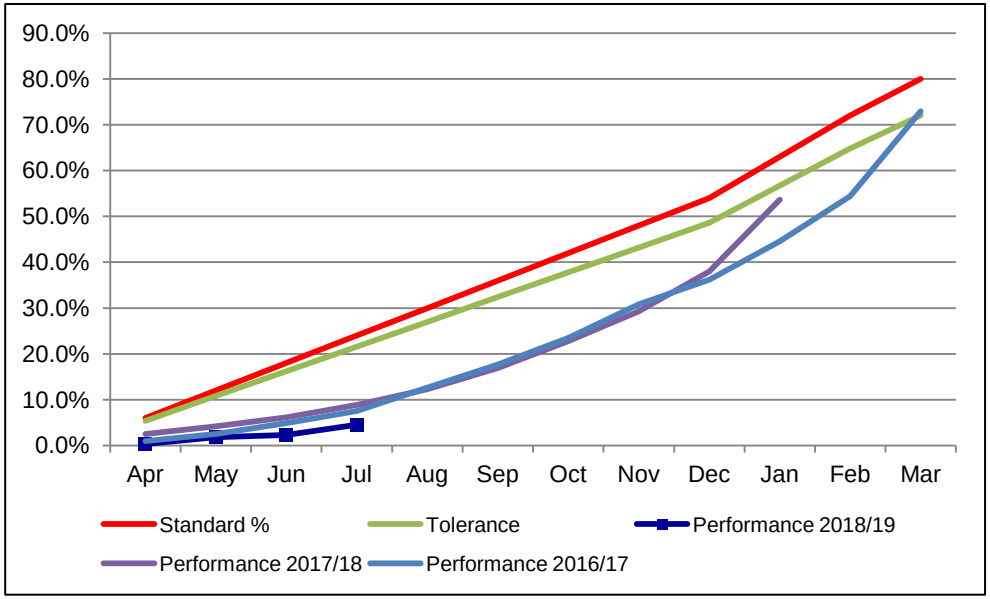
Joint Development Reviews

	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	0.4%	1.8%	2.3%	4.6%								
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 due to change in reporting system



Narrative Summary:
Data for **Joint Development Reviews** to be recorded on Turas (previously eKSF) has now been updated since April 2018.

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. Information has now been shared with all line managers and staff regarding the changes to the recording of Appraisal, PDPs and Objectives.

Actions:
Further communication will be forthcoming regarding next steps, training and support offered from ksf champions etc.

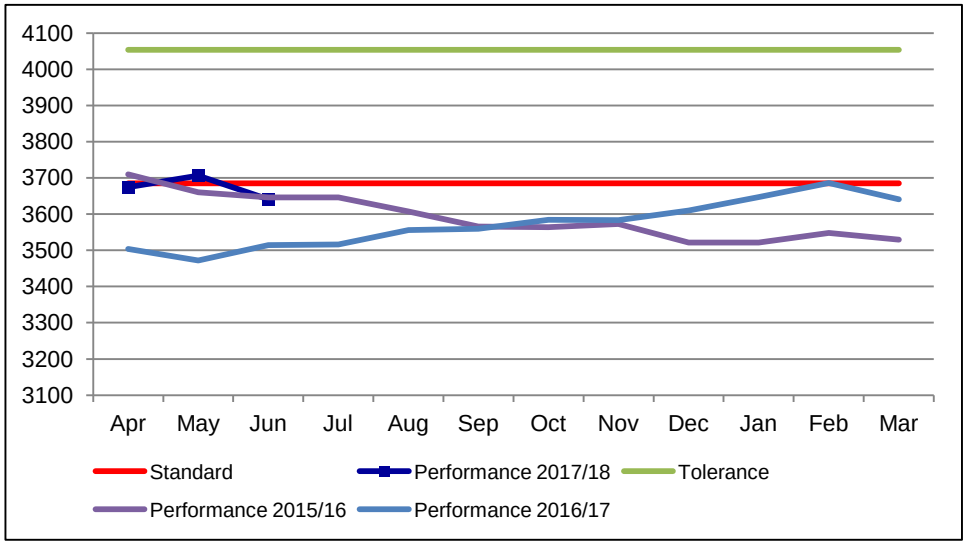
Emergency Occupied Bed Days

	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 2018/19												
Performance 2017/18	3674	3706	3641									
Performance 2016/17	3503	3472	3515	3516	3556	3560	3584	3584	3609	3647	3686	3641
Performance 2015/16	3710	3660	3646	3646	3607	3566	3564	3573	3521	3521	3548	3529

Please note: There is 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	92.0%	100.0%	69.2%									
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

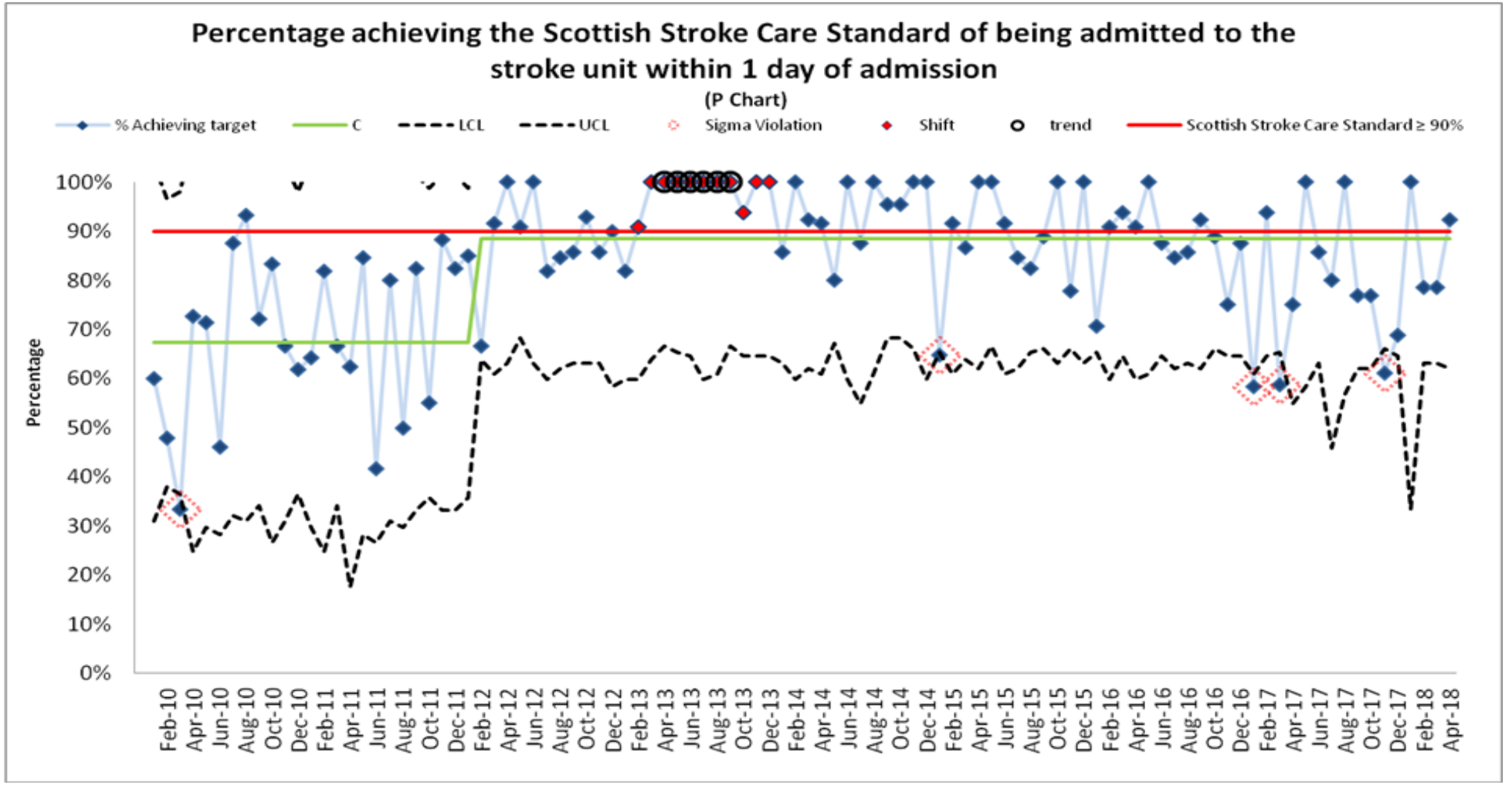
The standard was achieved in April and May 2018. There were 13 stroke admissions in June with initial diagnosis of stroke, only 9 patients were admitted to the stroke unit within 1 day which lead to a breach of target at 69.2% for the month of June. To achieve 90% we required 12/13 patients to be admitted on day 1. The reasons for the 4 patients which were not admitted are noted below:

- 1 patient was post thrombolysis and stayed in HDU ward 5 appropriately until stable for BSU.
- 1 was planned to come but a discharge from BSU to Berwick was cancelled and the bed became unavailable.
- 1 patient resolved symptoms but remained on MAU a further day for abdominal investigation(unrelated to stroke)
- 1 patient was identified to BSU as having been admitted on the Sunday(admission by Monday 00;00) but was actually admitted 23;47 on the Sat.(day of admission is day 0 regardless of time,admission to stroke unit is by midnight on day 1)

All 4 Patients received the appropriate CT scan,swallow screen assessment and aspirin as per the Stroke bundle as appropriate. All were also seen by the appropriate AHP's from the stroke team as required.
BSU nursing staff continue to pull patients from MAU and stroke coordinator visits MAU on a daily basis to identify and encourage medical staff to refer all stroke patients in a timely manner to stroke referral inbox for review by stroke team and transfer to BSU.

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	Tolerance
90.0%	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
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	68.0% [2]	65.0% [3]	77.0% [4]									
Total Patients Currently Waiting >18 Weeks:	95 [2]	67 [3]	79									
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

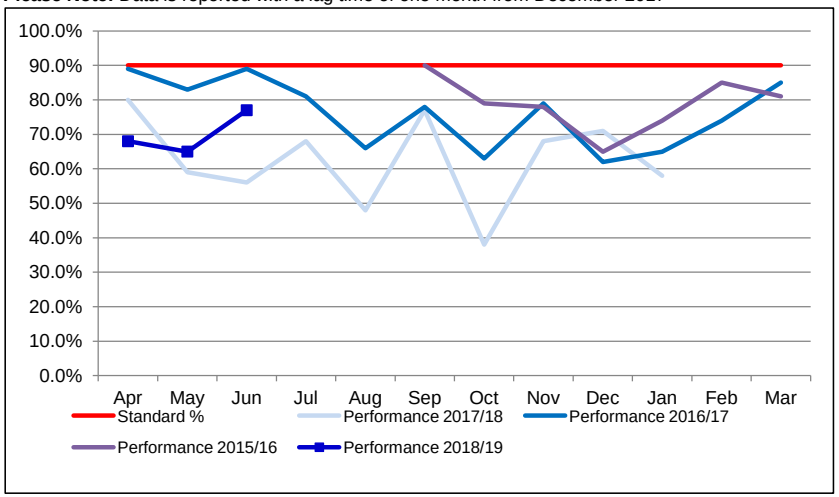
[1] Psychological Therapy data does not include CAMHS or LD as unavailable at the time of reporting

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

[3] Psychological Therapy data does not include CAMHS or LD due to EMIS reporting delay, but does include the Doing Well Service and DBT Team for the first time

[4] Psychological Therapy data for LD and CAMHS is NOT included (due to EMIS reporting delay and staff absence respectively). Data for Dialectical Behaviour Therapy (DBT) Team now included, as well as anxiety management patients starting treatment with the Doing Well Service

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

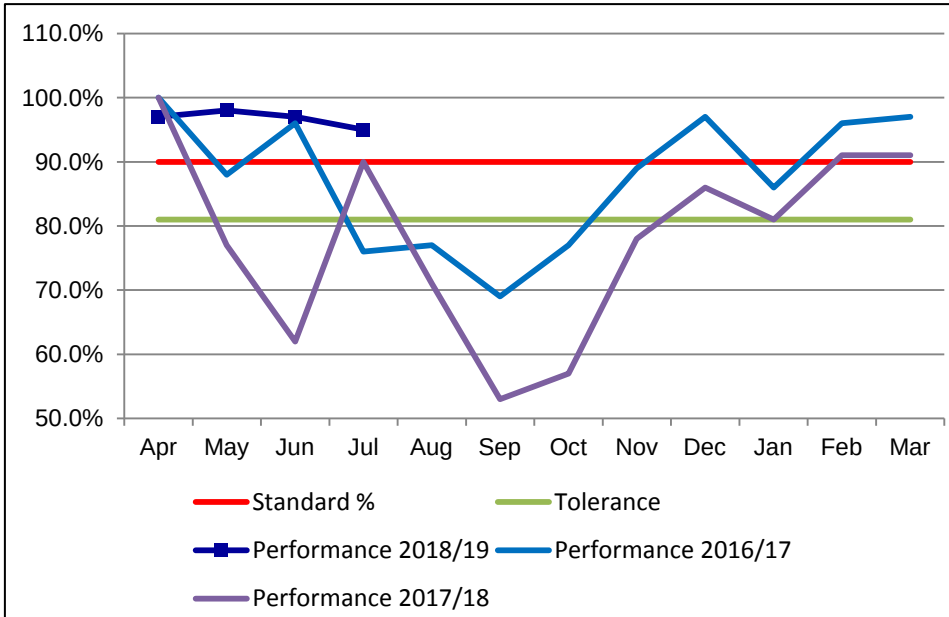
Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

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%	98.0%	97.0%	95.0%								
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:
The national LDP standard has an ongoing requirement to deliver **3 weeks RTT** for 90% of progressed drug & alcohol referrals. Overall, 98% of clients started treatment within three weeks for the month of June 2018.

Borders Addiction Service - The service is fully established at present and this reflects the ongoing success in meeting the 90% standard. Consideration will be given in relation to the pending challenges of retaining patients within the service and what impact this may have on the service moving forward. Nil report for June due to admin unplanned leave recognising person dependant system, will be addressed and assurance given that process will be addressed.

Actions:
- The national agenda will have implications on current service delivery, the development of an operational document should support this moving forward

AHP Waiting Times

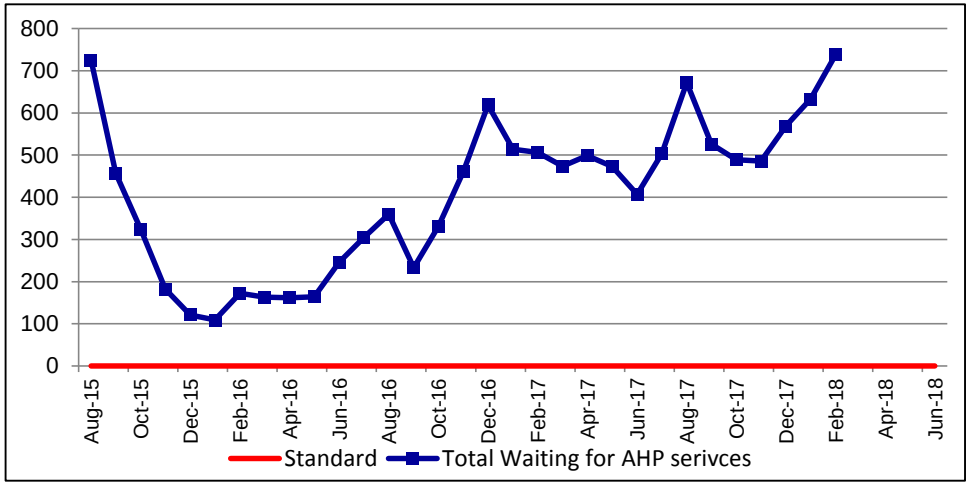
Standard: Patients Waiting over 9 Weeks as at month end	**Standard**	**Tolerance**
	0	1

Actual Performance (lower = better performance)

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting for AHP serivces	**503**	**672**	**526**	**489**	**486**	**569**	**633**	**738**	-[1]	-[1]	-[1]	-[1]	-[1]
Occupational Therapy	3	4	4	3	5	11	9	14	-[1]	-[1]	-[1]	-[1]	-[1]
Physiotherapy	481	646	501	459	461	527	571	636	-[1]	-[1]	-[1]	-[1]	-[1]
Podiatry	0	0	0	0	0	0	0	0	-[1]	-[1]	-[1]	-[1]	-[1]
Speech & Language Therapy	1	2	1	1	5	5	9	26	-[1]	-[1]	-[1]	-[1]	-[1]
Nutrition & Dietetics	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 - Based on current local unvalidated data (due to EMIS reporting not currently being available) the current position is reporting as 690 patients are waiting over 9 weeks within physiotherapy services of which 659 are within MSK services, 24 within Paediatrics and remaining across elderly services.

The current vacancies combined with a high level of sickness is resulting in staffing gap across Physiotherapy Services. 2.0wte locums were appointed until 31st August, to support patient flow within BGH and Waverley Transitional Care. (These figures are based on local unvalidated data as EMIS reporting nit currently available)

New Project Board set up to support MSK/Orthopaedic Re-design with a focus on patients seeing the right person at the right time for MSK conditions. In preparation, MSK physiotherapy diaries were revised, increasing new patient capacity. Waiting list cleansed, removing patients from waiting list mid July. As anticipated there has been an increase in referrals to physiotherapy MSK services as patients are re-directed from orthopaedics, which commenced in July.

Podiatry - The administration team lead have secured a temporary admin post until March 2019 to support the test of a centralised booking function for podiatry.

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

Speech & Language Therapy (SLT) - Paediatric SLT continue to work towards a 9 week waiting time standard.
The Adult SLT team remain challenged with 2.6wte therapists working across Community and BGH. Additional capacity through locum cover and a 12 month fixed term post has been put in place to provide extra support.

Nutrition and Dietetics - Significant pressures continue in all Dietetic services. The waiting time aim continues to be 9 weeks, however due to the migration to EMIS waiting times are not known at present, data generated so far has been inaccurate and amendments are required to capture accurate reports (some waiting times e.g. for Community Dietetics are on Trakcare). GI Dietitian OPD waits are currently at least 14 weeks. A 12 month (0.8wte) Dietitian started on the 18/6/18 to manage the eating disorders caseload. An acute locum Dietitian has been employed (May-Aug 2018) to deal with increased referrals following the revised MUST training. Paediatric Dietetics are managing very high caseloads and also covering the majority of the Teviot locality community paediatric caseload due to high waiting times there

EMIS Community Web was rolled out to all community and Mental Health Services starting with the Learning Disability Service in April 2017. The last planned service (Adult AHPs) went live with EMIS Web in March 2018. As part of the implementation, a Business Objects Universe was built by NHS Borders developers and EMIS Health developed a daily Data Extract from EMIS. The initial work on this was completed earlier this year and since then NHS Borders Developers have been working along with Planning & Performance and service contacts to build, refine and produce performance and operational reports. This work has highlighted a number of data quality issues and an assessment is currently underway to determine to extent of this and develop a plan to address in order to be able to correct and submit data for SMRs and produce reports that are accurate for waiting times. The initial focus will be on correcting data to provide accurate reporting on Waiting Times Performance and correct data quality going forward so ongoing reporting is robust. It is anticipated that the full assessment and plan for addressing historic months will be completed by end of October 2018.

Cancellations

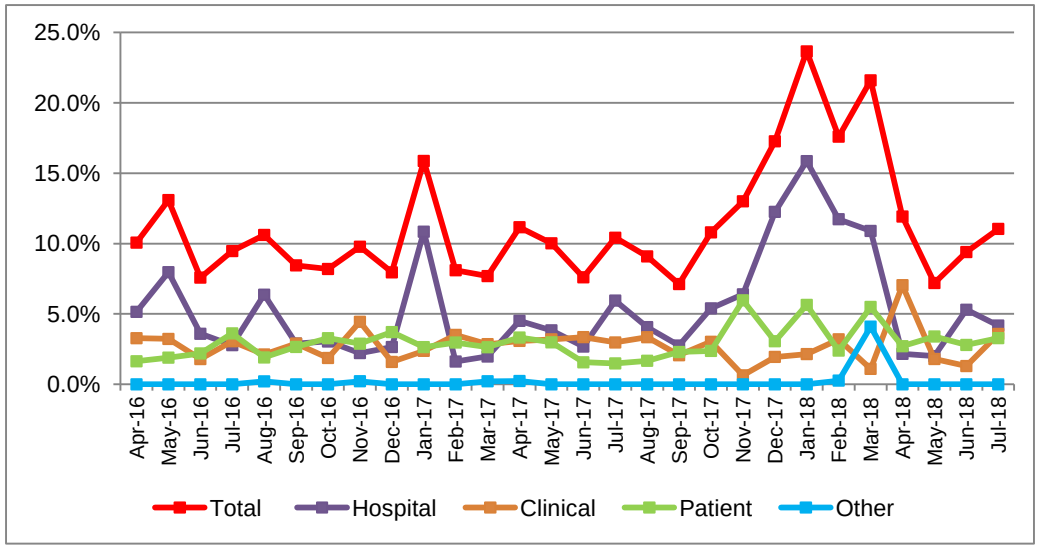
Hot Topic: Cancellations

Target & Tolerance

[1] Hospital Cancellation Rate – <1.7% Green, 1.7% Amber, >2.1% Red
[2] Clinical Cancellation Rate – <2.5% Green, 2.5% Amber, >3.2% Red
[3] Patient Cancellation Rate – <3.5% Green, 3.5% Amber, >3.8% Red
[4] Other Cancellation Rate – <0.5% Green, 0.6% Amber, >0.7% Red

Actual Performance (lower % = better performance)

Cancellation Rate %	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Total	**9.1%**	**7.1%**	**10.8%**	**13.0%**	**17.3%**	**23.7%**	**17.6%**	**21.6%**	**11.9%**	**7.2%**	**9.4%**	**11.0%**
Hospital	4.1%	2.8%	5.4%	6.4%	12.3%	15.9%	11.7%	10.9%	2.2%	2.0%	5.3%	4.2%
Clinical	3.3%	2.1%	3.0%	0.6%	1.9%	2.2%	3.2%	1.1%	7.0%	1.8%	1.3%	3.6%
Patient	1.7%	2.3%	2.4%	6.0%	3.1%	5.6%	2.4%	5.5%	2.7%	3.4%	2.8%	3.3%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	4.1%	0.0%	0.0%	0.0%	0.0%



Narrative Summary:
Difficulty in protecting elective beds continues to adversely impact elective operating and **cancellations**. The incidence of hospital and clinical cancellations is lower than in previous months however there is an increase in patients cancellations.

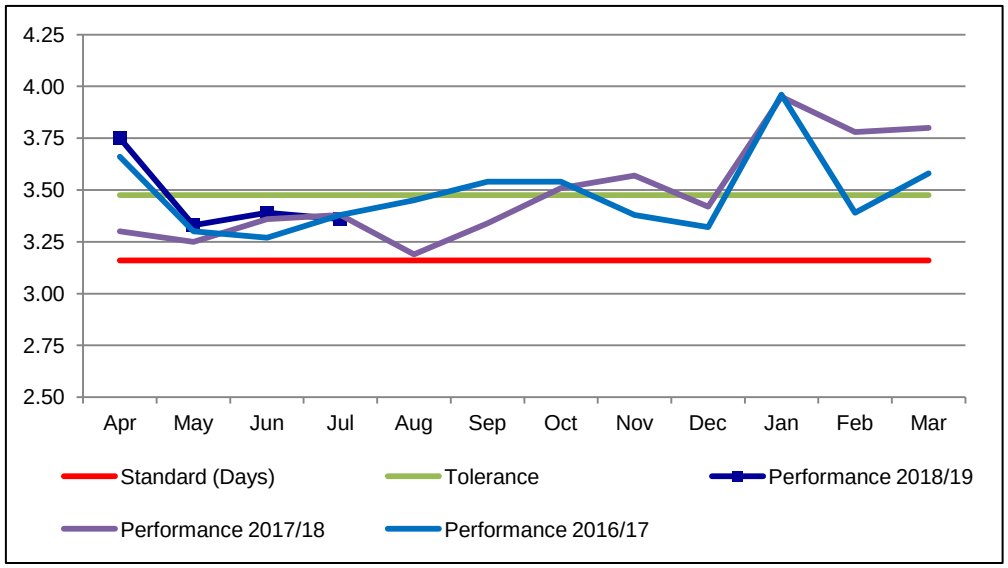
Actions:
- Weekly review of orthopaedic theatre lists 6 weeks in advance – planning for staffing, theatre time and equipment
- Weekly theatre scheduling meeting has been implemented, work is ongoing to improve this process with a view to maximising theatre utilisation
- Elective capacity being assessed week by week
- While Cancer and Urgent cases will take priority, orthopaedics will be given priority over all other routine procedures leading up to December this will potentially cause a backlog within other specialties. We anticipate that we will have capacity to recover in January during which Orthopaedic inpatient operating will cease as part of the winter plan.

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	3.33	3.39	3.36								
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. May - July demonstrated a recovery of this prolonged LOS.

Actions:

- Daily Dynamic Discharge is being rolled lout across all wards,
- 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 is in early planning stages with a new Programme Board being considered.
- A new BGH Delayed Discharge and Extended LOS group is being established to problem-solve and ensure those patients with longest LOS have a clear discharge plan. This group is in its third week and showing early promise.

Community Hospital Average Length of Stay (LOS)

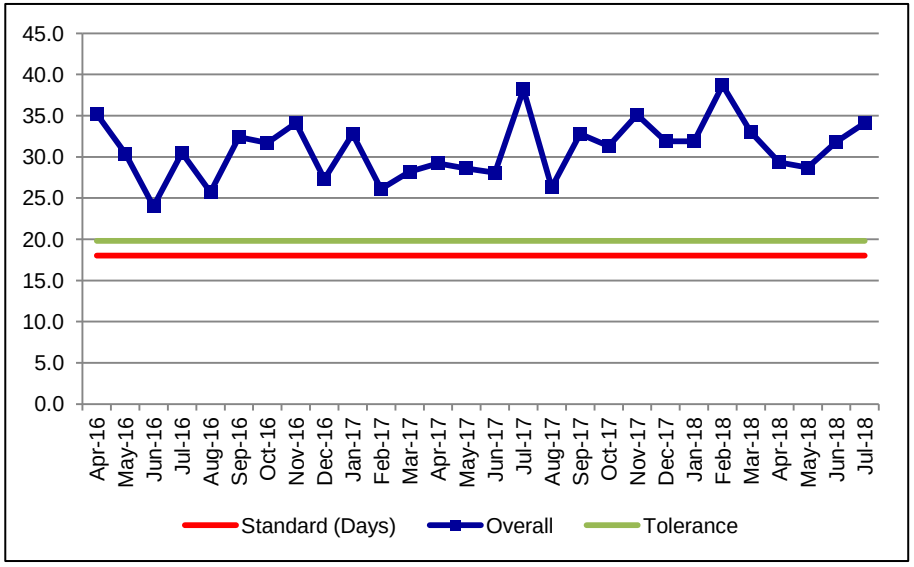
	Standard	Tolerance
Standard: Reduce Community Hospital Average Length of Stay	18.0	19.8

Actual Performance (lower = better performance)

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-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	**26.3**	**32.8**	**31.3**	**35.1**	**31.9**	**31.9**	**38.7**	**33.0**	**29.3**	**28.7**	**31.8**	**34.1**
Hawick	20.8	24.7	26.0	28.0	30.9	30.0	23.3	17.5	17.5	28.6	26.3	23.9
Hay Lodge [1]	49.4	41.6	30.9	43.7	26.8	31.0	60.2	33.0	31.7	20.3	24.4	33.6
Kelso	18.0	31.3	31.1	29.5	51.3	47.2	45.2	50.6	38.9	34.3	37.7	38.5
Knoll	32.6	39.1	39.6	44.9	27.8	26.1	42.9	56.7	39.8	33.9	44.6	47.5

Please Note: Data is Current Month's Ave LoS (incl DD's).

[1] January 2107 Hay Lodge is reporting a high LoS due to a low number of discharges (10) against the occupied bed days (701).



Narrative Summary:
There continues to be challenges within **Community Hospitals** in terms of **LOS performance.** The level of patient complexity and limited availability of post hospital care requirements add to the challenge to reduce LOS. The lack of care home places and packages of care is having a significant impact on the LOS. Extended length of stay can be due to legal issues i.e. guardianship.

Actions:
- Hospital to Home projects have been established in Hawick and the Berwickshire area, with a third established in Central area to support flow through both the community hospitals and BGH.
- A project brief is being developed based on the A Henry and J Bolton work. Time lines etc. are still to be finalised regarding delivery of the projects.
- START Teams are being integrated into Community Hospitals, to support better communication and discharge planning.

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

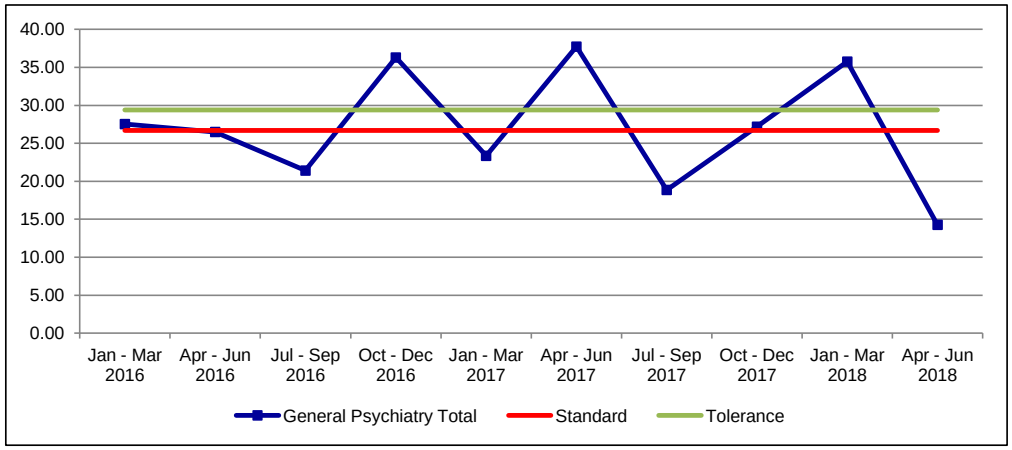
Standard: Reduce Mental Health Average Length of Stay	**Standard**	**Tolerance**
	Various	within 10%

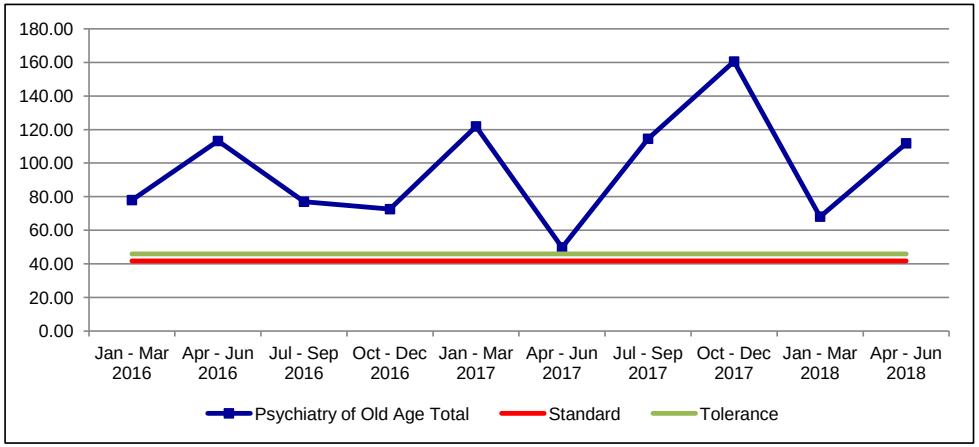
Actual Performance (lower = better performance)

	Standard (Days)	Apr - Jun 2016	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	Jul - Sep 2017	Oct - Dec 2017	Jan - Mar 2018	Apr - Jun 2018
Huntlyburn	17.70	23.93	17.56	15.04	16.41	23.94	16.40	26.19	21.63	15.02
The Brigs	42.83	43.00	69.00	134.28	48.24	68.38	25.90	32.53	101.29	10.00
General Psychiatry Total	**26.70**	**26.49**	**21.41**	**36.29**	**23.35**	**37.72**	**18.86**	**27.18**	**35.75**	**14.27**
Lindean	60.58	82.33	33.00	28.36	54.00	48.38	45.90	24.50	61.73	64.45
Melburn Lodge [1]	111.63	345.00	112.00	124.00	491.00	- [2]	545.50	616.00	90.00	688.00
Psychiatry of Old Age Total	**41.82**	**113.18**	**77.00**	**72.59**	**121.88**	**49.83**	**114.50**	**160.50**	**68.14**	**111.80**

[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

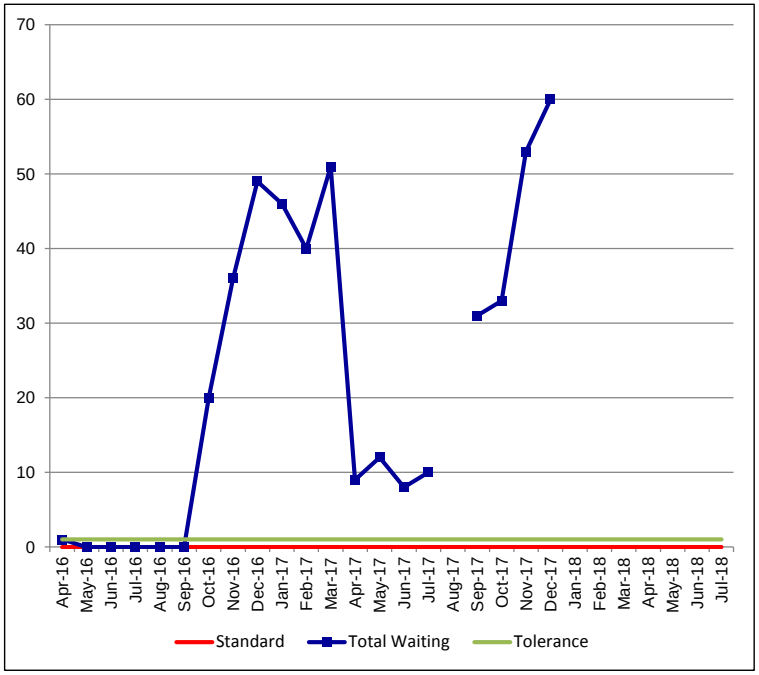
Standard: Patients Waiting over 9 weeks as at month end	**Standard**	**Tolerance**
	0	1

Actual Performance (lower = better performance)

	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]	May-18[2]	Jun-18[2]	Jul-18[2]
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Waiting	**10**	-	**31**	**33**	**53**	**60**	-	-	-	-	-	-	-
MH Older Adults - East	0	-	1	1	1	-	-	-	-	-	-	-	-
MH Older Adults - South	0	-	0	0	0	-	-	-	-	-	-	-	-
MH Older Adults - West & Central	4	-	2	2	0	-	-	-	-	-	-	-	-
East Team	2	-	3	7	14	15	-	-	-	-	-	-	-
South Team	3	-	2	0	0	0	-	-	-	-	-	-	-
West Team	1	-	23	23	38	45	-	-	-	-	-	-	-

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

[2] Data unavailable due to reporting on EMIS



Narrative Summary:

Mental Health Waiting Times increase has continued due to reduced capacity within the West Team predominantly due to sickness absence and vacancies.

Actions as at July 2018:

- 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 , this will impact positively on waiting times as appointments have been made internally. Further changes in personnel in East and West will have an impact on waiting times.

EMIS Community Web was rolled out to all community and Mental Health Services starting with the Learning Disability Service in April 2017. The last planned service (Adult AHPs) went live with EMIS Web in March 2018. As part of the implementation, a Business Objects Universe was built by NHS Borders developers and EMIS Health developed a daily Data Extract from EMIS. The initial work on this was completed earlier this year and since then NHS Borders Developers have been working along with Planning & Performance and service contacts to build, refine and produce performance and operational reports. This work has highlighted a number of data quality issues and an assessment is currently underway to determine to extent of this and develop a plan to address in order to be able to correct and submit data for SMRs and produce reports that are accurate for waiting times. The initial focus will be on correcting data to provide accurate reporting on Waiting Times Performance and correct data quality going forward so ongoing reporting is robust. It is anticipated that the full assessment and plan for addressing historic months will be completed by end of October 2018.

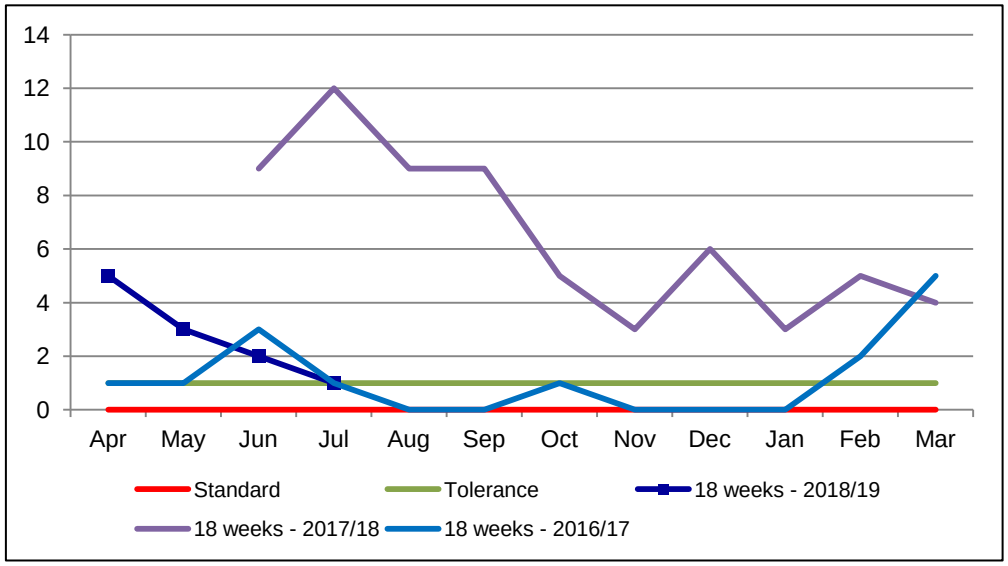
Learning Disability Waiting Times

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	3	2	1								
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:
The 1 **Learning Disability waiting times** breach in July 2018 was within Psychology - for assessment.

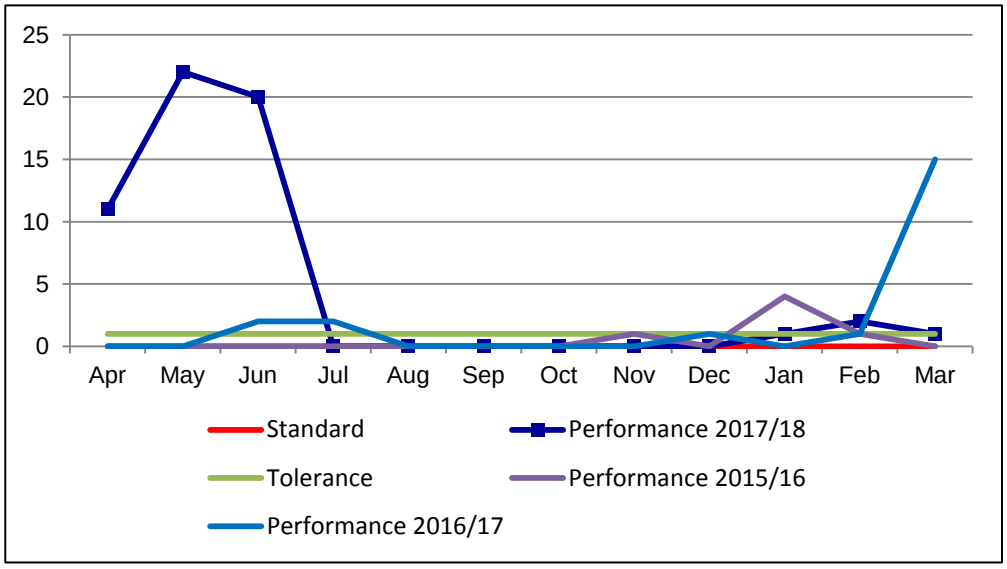
Actions:
- Continue to monitor the waiting list within the performance scorecard at the Learning Disability Service management team meetings and action with appropriate managers.

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	5	0	0								
Performance 2017/18	11	22	20	0	0	0	0	0	0	1	2	1
Performance 2016/17	0	0	2	2	0	0	0	0	1	0	1	15
Performance 2015/16	0	0	0	0	0	0	0	1	0	4	1	0



Narrative Summary:
There were no breaches of the 1 week waiting target for the Rapid Access Chest Pain Clinic in July 2018 .

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

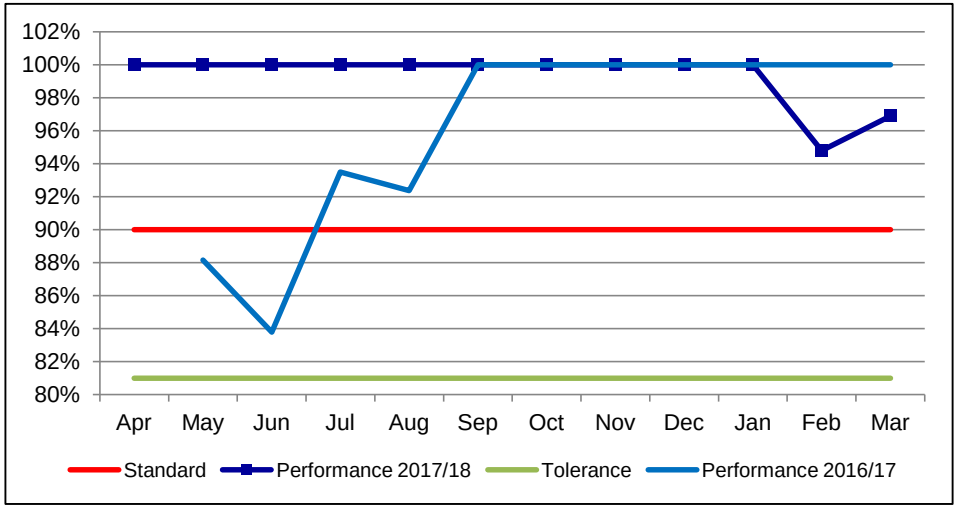
Audiology Waiting Times

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

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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2018/19	99.0%	100.0%	-[1]	-[1]								
Patients with active wait over 18 Weeks 2018/19	1	0	-	-								
Performance 2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.8%	96.9%
Patients with active wait over 18 Weeks 2017/18	0	0	0	0	0	0	0	0	0	0	14	8
Performance 2016/17	-	88.2%	83.8%	93.5%	92.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Patients with active wait over 18 Weeks 2016/17	-	34	59	14	28	0	0	0	0	0	0	0
Patients with active wait over 18 Weeks 2015/16	6	19	49	89	77	95	32	-	86	-	-	-

[1] Data unavailable for June & July 2018.



Narrative Summary:
Audiology had no breaches of the **18 week referral to treatment** standard in May 2018 (latest available data).

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

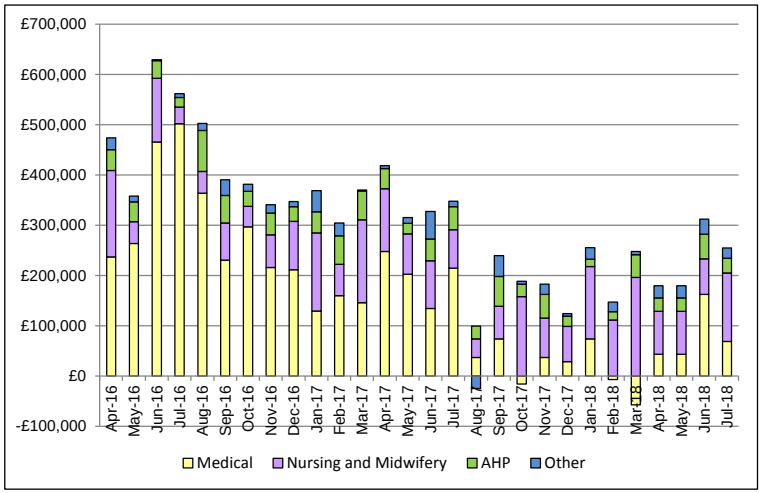
Supplementary Staffing

	Standard	Tolerance
Standard: Supplementary staffing - agency spend	0	0

Actual Performance (lower = better performance)

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Medical	£36,696	£73,584	-£15,869	£36,560	£28,444	£73,802	-£6,994	-£57,438	£43,127	£43,127	£162,154	£68,428
Nursing and Midwifery	£36,821	£65,110	£157,753	£78,489	£70,270	£144,230	£111,112	£196,307	£85,150	£85,150	£71,151	£136,864
AHP	£25,717	£59,055	£25,144	£47,105	£20,519	£14,600	£16,793	£45,197	£27,222	£27,222	£48,958	£29,158
Other	-£25,138	£41,395	£5,632	£20,519	£4,881	£22,740	£19,311	£6,312	£24,241	£24,241	£29,844	£19,927
Total Cost	**£74,096**	**£239,144**	**£172,660**	**£182,673**	**£124,114**	**£255,372**	**£140,222**	**£190,378**	**£179,740**	**£179,740**	**£312,107**	**£254,377**

Please Note: April 2018 data unavailable at time of reporting



Narrative Summary:
NHS Borders **agency spend** on trained nursing has continued into 2018-19 financial year with the reasons for incurring additional staffing costs related to delayed discharges, high levels of sickness cover and patient acuity. Additional beds are open throughout the BGH and the Knoll. Agency staff are also being used to cover vacancies in ED.

Medical Agency - Spend recorded on Medical Agency has reduced in July as a result of actual charges replacing estimates in Ophthalmology and Mental Health to cover vacancies and maternity leave. Agency locum cover for registrars in Orthopaedics, General Medicine and ED to cover vacancies. Agency costs in Out of Hours to cover gaps in the service due to sickness and vacancies.
AHP Agency - movement in spend due to reduction in agency cover for Dietetics. Continued agency usage in Physiotherapy, Occupational Therapy and Speech Therapy. Physiological Measurement for vacany cover with Radiology usage for maternity cover.
Other agency - costs to date relate to agency cover for Blood Sciences and IM&T agency staff.

Actions:
- Recruitment event following targeted training into key nursing posts in Acute Services. The Associate Director of Nursing has introduced weekly meetings with Clinical Service Managers to review the nursing position in order to ensure that sickness ansence is managed as per policy and to confirm that all use of supplmentary staff is linked to patient safety.

In follow up to the the recent dicussion at the October 2018 S&PC when the June 2018 Performance Report was reviewed the NHS Borders bank fill rates for registered nurses is 45% and for HCSW 78% (based on most recent figures available at 19/10/18). The fill rate for registered nurses is artificially low due to the fact that allocate on arrival shift to cover for short notice gaps. These shifts are being entered on to the system with a variety of start and finish times to make them as attractive as possible to the widest range of registered bank nurses. Due to the number of registered nurses available each day it would be impossible for all of these shifts to be filled.

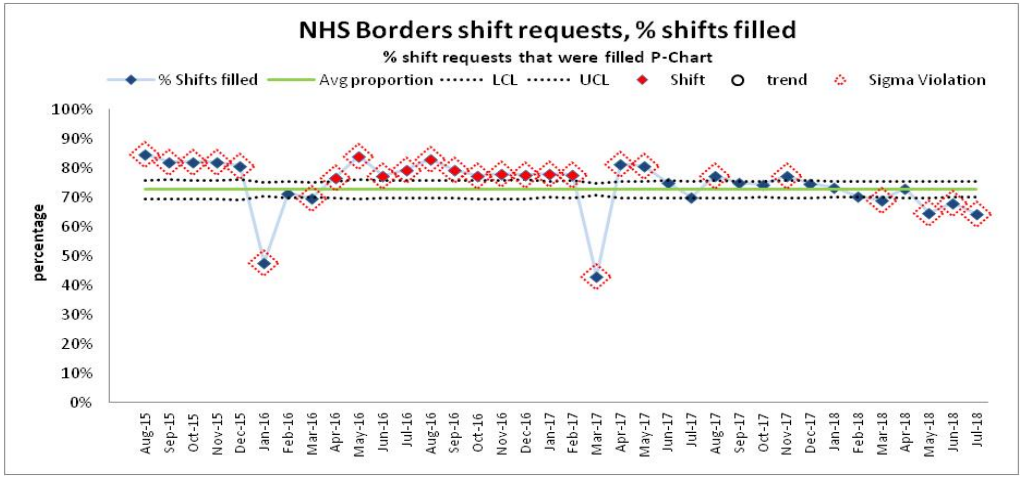
Bank requests in NHS Borders are at a high rate due to the on going recruitment difficulties in registered nurses. SCN are now completing rosters 6 weeks in advance, and are therefore identifying gaps proactively and request bank shift according.

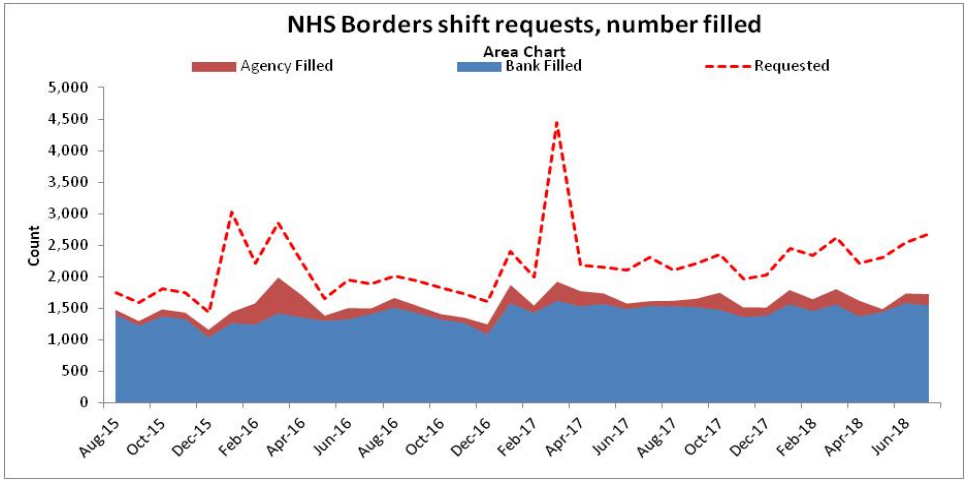
It should be noted that the fill rate for registered nurses is 45%, but shift are not left unfilled where patient safely is an issue. The SCN will either make an amendment to the roster or as a final step agency shifts will be agreed by the Associate Director of Nursing . Ensuring patient and staff safety is the overriding factor when staffing within a is considered.

Nurse Bank

Standard: NHS Borders Nurse Bank and agency shifts

NHS Borders Overall





Narrative Summary:
Overall the number of NHS Borders bank and agency shift requests increased further in July 2018.

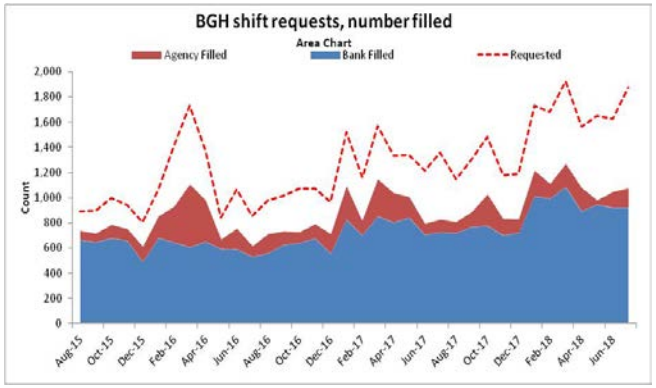
Sickness across NHS Borders accounted for 943 shift requests and was the highest reason across all 3 clinical boards.

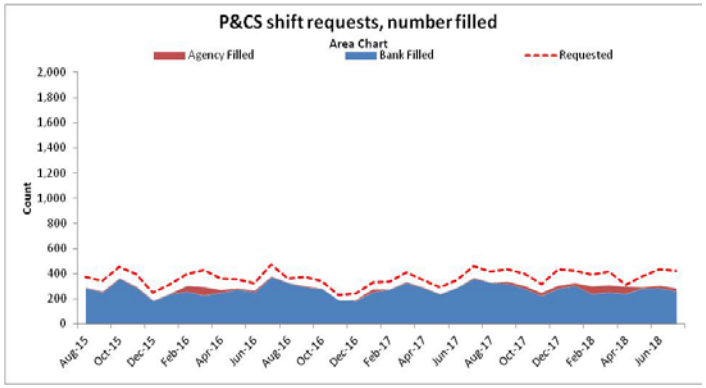
Every month the reasons for the requests for agency are shared with the service in order that we can understand why we are using agency staff. Requests are all reviewed and signed off by the Associate Director of Nursing to ensure that they are only used where clinical safety is compromised.

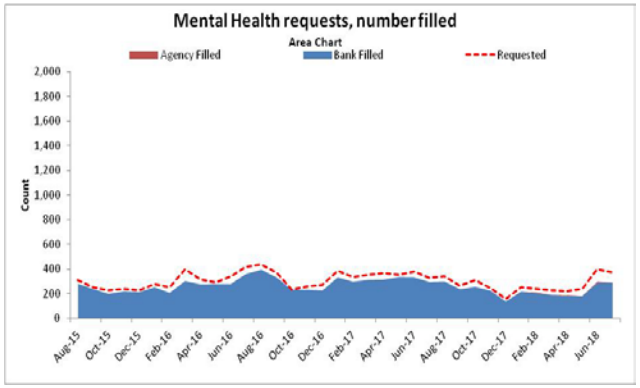
Overall - There continues to be high levels of requests for supplementary staff across NHS Borders.

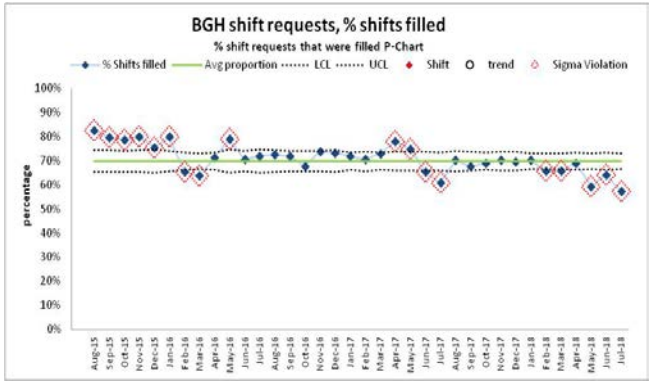
Actions update:
There is a planned registered nurse recruitment event on the 24th of August for both substantive posts and the Nurse Bank.

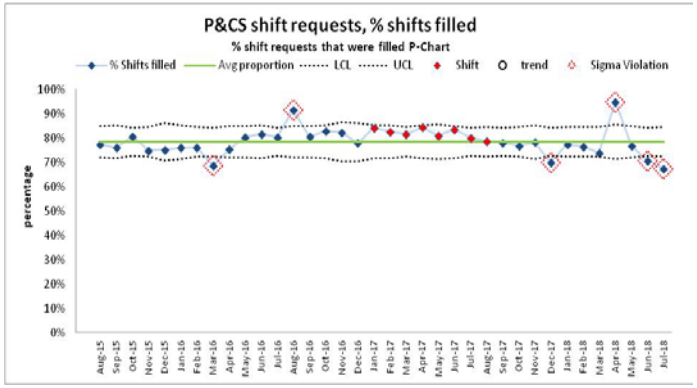
Nurse Bank *continued*

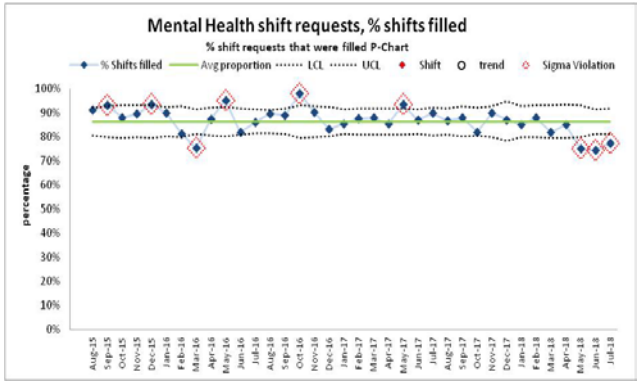












eLearning

Standard: 100% of NHS Borders employees complete statutory & mandatory eLearning	Standard	Tolerance
	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%	85.7%	85.8%	89.9%								
Infection Control	84.5%	84.0%	83.9%	86.7%								
PMAV	74.9%	74.5%	74.6%	77.7%								
Fire safety (eLearning)	65.8%	67.1%	68.4%	70.0%								
Datix	61.3%	62.1%	65.5%	69.9%								
Information Governance	58.5%	59.9%	65.7%	67.1%								
Moving & Handling	59.6%	60.3%	62.4%	61.6%								
Public Protection	13.5%	25.9%	39.9%	46.7%								

Narrative Summary:
Implementation of the new Course Booking System on LearnPro identified widespread non compliance with **Mandatory Statutory training.** Considerate progress has been made since implementation as you will note from the monthly Core Statutory and mandatory training report.

Course of the month was introduced in March 2018 as a new approach to bring an organisational focus on completion of one of the core statutory and mandatory courses. Performance has improved in all areas since introduction.

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 eLearning compliance.

Actions:
- A monthly report will be sent to the Board Executive Team and General Managers.
- To meet the new NHS Scotland Firecode SHTM 83: Part 2, fire safety training standards, role specific classroom training for fire marshalls will be introduced alongside bi-annual elearning and annual workplace based competency assessments for all staff. A pilot is planned for Autumn 2018. The current statutory and mandatory classroom training was intended for specific target groups but was attended by wider staff groups. This resulted in the compliance rate being artificially low as based on all staff. Therefore the statutory classroom training currently reported has been removed and will be replaced by the annual workplace based competency assessments once implemented.
- Data quality checks for staffing lists are currently underway to ensure the HR and training records are consistent.
- Line Managers will be asked to populate role mandatory training plans by the end of October 2018.

Key:

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