**Board Meeting:** 2 August 2018

**Subject:** Board Performance Report and Review of Corporate Balanced Scorecard

**Recommendation:** Members are asked to review and discuss corporate and divisional performance during the current reporting period

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1. **Introduction**

The Board is asked to discuss the content of the performance report covering matters discussed at the July 2018 meeting of the Performance and Planning Committee. This pack includes a snapshot of the waiting list position at 5 July 2018.

* Board Exception Report – Key Performance Indicators (KPIs)

1. Effective KPIs
2. Person-centred KPIs
3. Safe KPIs

* Divisional Exception Reports

(a) Surgical Services

(b) Regional and National Medicine

* Waiting lists – Cardiac Surgery, Thoracic Surgery, Cardiology, Coronary and Electrophysiology.
* Corporate Balanced Scorecard (Appendix 1)

**2 Review of Corporate Balanced Scorecard**

The Corporate Balanced Scorecard remains the key high level corporate performance report for the year, bringing together all elements of the Golden Jubilee Foundation and providing balanced reporting of performance across all governance strands: Clinical, Staff, Financial and Operational.

The scorecard is formally reviewed on an annual basis to ensure that the Key Performance Indicators (KPIs) provide assurance of operational performance and support delivery of local and national targets. The Performance and Planning Committee received change proposals and approved a number of alterations to the scorecard for 2018/19 which are summarised below.

In the compiling of the updated scorecard for 2018/19 some specific changes have been made which are detailed below.

**2.1 Scorecard Format**

The formatting of the scorecard has been reviewed, with the “Bed Occupancy and Waiting List” scorecard being presented in a new format.

The visualisation has been changed placing the emphasis on the chart making it easier to see how the KPI has functioned over time. The new view maintains a red, amber, green (RAG) status bar, providing visual information on a rolling 12 month period.

The adoption of the new view could support the inclusion of median values on the charts and the possibility of moving to Statistical Process Control (SPC) charts for appropriate KPIs.

The updated version currently includes the RAG status, corresponding occupancy levels as well having data labels on the charts.

* 1. **Clinical Governance Indicators**

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| No | KPI | Change | Rationale |
| 1.1 | **Number of complaints (stage 1 & stage 2) measured as a percentage against the volume of activity.**  ≤ 0.10% = Green  0.11% - 0.14% = Amber  ≥0.15% = Red | This KPI previously reported only the number of stage 2 complaints. | The reporting of only stage 2 complaints on the scorecard was the result of historic complaint reporting processes. Prior to the classification of complaints as either stage 1 or stage 2 only stage 2 complaints were considered actual complaints with those now classified as stage 1 complaints being considered as concerns.  Reporting both stage 1 and stage 2 complaints will provide a more accurate picture of patient issues, with a breakdown of the level of complaint still being available within the narrative.  Proposed tolerances have been set using the median as the green threshold with the red threshold being set to allow two standard deviations. |

* 1. **Staff Governance Indicators**

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| No | KPI | Change | Rationale |
| 2.4.1 & 2.4.2 | **Recruitment to Clinical** and **Non Clinical Vacancies** | Addition of two new KPIs | A recent audit of Human Resources recommended that monitoring of recruitment to vacancies be formally reported.  The new KPIs will initially be reported quarterly, but new updates to HR systems will improve data collection and facilitate monthly reporting.  The proposed KPIs will report the number and percentage of posts advertised in a set period that are successfully recruited to.  Due to the time taken for the recruitment process from the point of advertisement to a new member of staff taking up a role there will be a delay between the reporting period and the actual information being reported. |

* 1. **Golden Jubilee Conference Hotel Indicators**

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| No | KPI | Change | Rationale |
| 2.3 | **Conference Day Spend** | Remove from scorecard | This was removed from the hotel performance figures report. It is not a KPI that is used elsewhere within the hotel industry and it was felt that it did not provide a true reflection of hotel activity. |

* 1. **Golden Jubilee Research Institute Indicators**

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| No | KPI | Change | Rationale |
| 2.2 | **Motion Lab Analysis Income** | Addition to Scorecard | Monitoring of the income generated by Motion Lab analysis will provide visibility of the return on investment, with the target of £617,960 income expected by the end of year five of the lab. The targets have been set to reflect the five year income goal. |

**2.6 Scorecard changes agreed by Performance and Planning Committee**

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| No. | Scorecard | KPI | Change |
| 1.3 | GJNH | Stage 2 complaints upheld | Removed – This measure is related to the outcome of complaints which are already reported at the clinical governance group and has been removed to ensure the scorecard only reports on meeting target timescales. |
| 1.5 | GJNH | Level 1 Root Cause Analysis (RCAs) as a percentage of patient activity | Removed – As above, KPI is reported elsewhere and can lead discussion towards clinical governance issues. |
| 4.2.2 | GJNH | Treatment Time Guarantee (TTG): Percentage of patients admitted within 12 weeks. | Added |
| 4.4 | GJNH | Waiting List Audit | Quarterly Reporting |
| 5.3 | Bed Occupancy & Wait List | % Bed Occupancy - Critical Care Wards | Added |
| 6.1 & 6.2 | Bed Occupancy & Wait List | Stage of Treatment Time Guarantee (Heart & Lung only) | Targets Updated |
| 7.1, 7.2 & 7.3 | DOSA & Cancellations | Day of Surgery Admission (DoSA) Cardiac Surgery, Thoracic Surgery and Orthopaedic Surgery | Added |
| 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.7 & 8.8 | DOSA & Cancellations | Theatre Cancellations. Cardiac Surgery, Thoracic Surgery, Orthopaedics, Ophthalmology, General Surgery, Plastic Surgery, Endoscopy & Cardiology. | Added |
| 1.2 | GJ Conference Hotel | % of complaints responded to within 20 days | Removed – Hotel complaint numbers are very low and this KPI performance has been reported without exception at 100% over a prolonged period. It was agreed that there was minimal risk to compliance with removal from scorecard. |
| 2.1 | GJ Conference Hotel | Disciplinaries measured as a percentage of headcount | Removed – included within Foundation scorecard figures. |
| 2.2 | GJ Conference Hotel | Grievances (both collective and individual) measured as a percentage of headcount | Removed – included within Foundation scorecard figures. |
| 4.3 | GJ Conference Hotel | Conference Delegates | Added |
| 4.7 | GJ Conference Hotel | Review Pro Quality Score | Added |
| 4.1 | GJ Conference Hotel | Room Occupancy, Conference Room Utilisation, Not for Profit Percentage | Seasonal Target |
| 1.3 | GJ Research Institute | Recruitment to projects closed to recruitment in quarter | Targets Updated |
| 2.1 | GJ Research Institute | Income | Created by merging two existing KPIs |
| 1.1 | GJ Innovation | MDαT | Moved |

**3 Recommendation**

Board members are asked to note the update for the current reporting period and to discuss and note the outcome of the review of key performance indicators within the corporate balanced scorecard for 2018/19.

**Jill Young**

**Chief Executive**

**16 July 2018**

**(Carole Anderson, Head of Strategy and Performance)**

**Corporate Balance Scorecard**

The Performance and Planning Committee was presented with an updated format of the Corporate Balance Scorecard which increased the emphasis on the chart element rather than the Red, Amber, Green (RAG) status. We have introduced this change to increase the ability to track improvements within the reported Key Performance Indicators (KPI). The Committee approved the adoption of the updated format, which will also allow for future adoption of Statistical Process Control (SPC) charts within the scorecard for appropriate KPIs.

**Board Exception Report**

Improved performance ⇧

Same performance ⬄

Worse performance ⇩

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| **Effective Board Performance update – July 2018** | | | | | | | |
| KPI | Details | Tolerance | Mar 2018 | Apr 2018 | May 2018 | Target | On Track |
| Elective Acute Ward Bed Occupancy | Combined occupancy position for NSD, 2 East, 2 West, 3 East, 3 West | >90.1% = Red  86-90%= Green  78-85.9% = Amber  <77.9% = Blue | 78.5% | 75.4% | 77.6% | 86-90% | ⇧ |
| Interventional Cardiology Wards Bed Occupancy | Combined occupancy position for 2C, 2D and CCU | 87.4%- 100% = Red  81% -87.3% = Green  77%-80.9%= Amber  <76.9% = Blue | 85.9% | 86.5% | 84.6% | 81-87.3% | ⇩ |
| Critical Care Wards Bed Occupancy | Combined occupancy position for ICU1, ICU2, HDU2, HDU3 | ≥ 84.8% = Red  73 – 84.7% = Green  63.4 – 72.9% = Amber  ≤ 63.3% = Blue | 70.7% | 73.0% | 77.3% | 70-90% | ⇧ |
| **Analysis**  Bed occupancy was within target tolerances for the Interventional Cardiology and Critical Care wards, with the Elective Acute wards being 0.4% below the “amber” threshold. Work on improving the accuracy of the bed occupancy statistics is ongoing, however there is much greater confidence in the figures being representative of the occupancy within the wards. It is expected that an improvement in the elective acute bed occupancy should start to be recognised; the introduction of SPVU patients to 2 West has already increased bed occupancy on the ward, with redesign and a test of change to take place during August to create a satellite Surgical Day Unit (SDU) in 2 West. This development aims to reduce demand on the current SDU, increase Day of Surgery Admission (DOSA) rates across all specialties, improve flow in all wards, and increase occupancy in the neighbouring ward, 2 East. | | | | | | | |

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| **Effective Board Performance update – July 2018** | | | | | | | |
| KPI | Details | Tolerance | Apr 2018 | May 2018 | Jun 2018 | Target | On Track |
| Cardiac Surgery Cancellation Rate | Percentage of Cardiac Surgery patients cancelled within 24 hours of procedure | Achieved = Green  Not Achieved = Red | 14.5% | 15.1% | 10.0% | Incremental reduction from 16% to 8% by March 2019 | ⇧ |
| Thoracic Surgery Cancellation Rate | Percentage of Thoracic Surgery patients cancelled within 24 hours of procedure | Achieved = Green  Not Achieved = Red | 7.1% | 2.6% | 3.6% | Incremental reduction from 9% to 5% by March 2019 | ⇩ |
| Orthopaedic Surgery Cancellation Rate | Percentage of Orthopaedic Surgery patients cancelled within 24 hours of procedure | Achieved = Green  Not Achieved = Red | 4.6% | 1.6% | 5.1% | <3% | ⇩ |
| Ophthalmology Cancellation Rate | Percentage of Ophthalmology Surgery patients cancelled within 24 hours of procedure | Achieved = Green  Not Achieved = Red | 4.3% | 2.9% | 2.5% | <3% | ⇧ |
| **Analysis**  Theatre cancellations are a new addition to the corporate balance scorecard for 2018/19. Each specialty will be reported with a target which reflects the complexities within each area, with most areas having been assigned an improvement target to attain a reduction in the cancellation rate by March 2019, whilst Orthopaedics and Ophthalmology have agreed to maintain a cancellation rate of below 3%.  Cardiac Surgery has reported cancellation rates below the incrementally decreasing target for each month in 2018/19, with May having a cancellation rate of 10% against a 14.5% May target. The Thoracic Surgery cancellation rate for May and June has been comfortably below the 5%target set for March 2019. Orthopaedics recorded its lowest cancellation rate in the scorecard period at 1.6% in May; however this increased above the 3% target in June. Cancellations in Ophthalmology during May and June have been below the 3% threshold. | | | | | | | |

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| **Effective Board Performance update – July 2018** | | | | | | | |
| KPI | Details | Tolerance | Apr 2018 | May 2018 | Jun 2018 | Target | On Track |
| Treatment Time Guarantee (TTG) | Number of patients who have breached the TTG | 0 = Green  >0 = Red | 49 | 62 | N/A | 0 | ⇩ |
| Percentage of patients admitted within 12 weeks. (Heart & Lung, See & Treat Ophthalmology and See & Treat Orthopaedics only) | >95% = Green  <95% = Red | 97.3% | 97.6% | 96.7% | 95% | ⇩ |
| **Analysis**  The number of patients who breached the TTG increased during April and May. The percentage of patients who are not seen within 12 weeks is continuing to fall.  The number of Cardiac Surgery patients who have breached their TTG has started to decrease with work to improve the waiting list position starting to bear fruit. In May, nine patients waited over 12 weeks down from 12 in April.  Cardiology Electrophysiology continues to experience high volumes of referrals; the service is susceptible to external pressures due to the impact of changes to associated outpatient clinics being held elsewhere. Ongoing Waiting List Initiative clinics held by NHS Greater Glasgow and Clyde (GGC) to reduce their outpatient cardiology waiting list have continued to increase demand on our service which has impacted on waiting times and the number of patients who have breached their TTG. | | | | | | | |

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| **Person Centred Board Performance update – July 2018** | | | | | | | |
| KPI | Details | Tolerance | Mar 2018 | Apr 2018 | May 2018 | Target | On Track |
| Number of complaints (stage 1 & stage 2) measured as a percentage against volume of patient activity | Maintain at <0.10% of patient activity | ≤0.10% = Green  0.11-0.14% = Amber  ≥0.15% = Red | 5  (0.07%) | 9  (0.13%) | 10  (0.12%) | ≤0.10% | ⇩ |
| **Analysis**  This KPI has been updated for 2018/19 to report all complaints; previously only stage two complaints were reported. The new targets have been set using the last year’s worth of data, with the green threshold being set at the median, and the red threshold set to allow two standard deviations.  In April, a total of nine complaints were received; this comprised five stage one complaints and four stage two complaints. One of the stage two complaints was reported within Regional and National Medicine, the remaining eight related to Surgical Services. Two stage one complaints were not responded to within five days and required extensions as complainants could not be contacted. All April stage two complaints were responded to within 20 days.  In May, five stage one and five stage two complaints were received. Three were within Regional and National Medicine, six related to Surgical Services and one was within Corporate. All stage one complaints for May were responded to within five days, with one stage two complaint requiring additional details for the response and an extension as a consequence. | | | | | | | |

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| **Person Centred Board Performance update – July 2018** | | | | | | | |
| KPI | Details | Tolerance | Feb 2018 | Mar 2018 | Apr 2018 | Target | On Track |
| Sickness absence | Percentage hours lost due to staff sickness absence as reported via SWISS | Achieved = Green  Not achieved = Red | 4.78% | 5.49% | 4.78% | ≤4% | ⇩ |
| **Analysis**  Golden Jubilee Foundation (GJF) sickness absence was reported by Information Services Division (ISD) as being 4.78% for April 2018, this ranks the GJF as 13th out of 22 Health Boards for the year and below the 4.86% reported by NHSScotland as a whole. April’s sickness absence rate has shown an improvement on March’s figure of 5.49%, and is only the second time the sickness absence rate has been reported below 5% since October 2017.  ISD data reports GJF long term sickness absence for April at 1.80%, compared with an NHSScotland figure of 2.34%, with the GJF having the 7th lowest long term absence rate in Scotland.  With regard to short term sickness absence, ISD reports GJF at 2.98%. When compared against the national figure for April of 2.52%, the GJF is placed 19th out of 22 Health Boards.   |  |  |  |  | | --- | --- | --- | --- | |  | GJF | NHS Scotland | GJF position | | Overall | 4.78% | 4.86% | 13/22 | | Long term | 1.80% | 2.34% | 7/22 | | Short term | 2.98% | 2.52% | 19/22 | | | | | | | | |

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| **Surgical Services Division Performance Board Performance Update – July 2018** |

| **ISSUE** | **ACTION** | **RESPONSIBLE LEAD** | **TIMESCALE** |
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| Critical Care | There were no cancellations due to staffing pressures within Critical Care during May, with only two elective surgical cancellations as a result of funded bed availability.  The weekend model within Critical Care is under review due to an increase in the frequency of times when the unit required toremain open over the weekend. Data collection is underway to identify any factors contributing to unfunded Critical Care beds remaining open. During the month of May, the unit required to stay open over two of the four weekends.  Enhanced Recovery After Surgery (ERAS) work commenced in Critical Care, reviewing the possibility of introducing criteria led discharge. | Lynn Graham | Ongoing |
| Cardiac Surgery | The number of urgent inpatient cardiac referrals remains a dominant feature in the cardiac surgery workload, although some clearer predictability in the referral pattern is beginning to be seen and the impact and benefits of surgeon of the day is being realised. In May, nine patients were treated over the 12 week Treatment Time Guarantee. This figure has reduced when compared to the start of the year, with some continued recovery in terms of waiting list position beginning to be felt within the service.  The patient flow scheduling project has progressed further with the new cardiac specialist nurses starting in June and the administration project lead commencing in July. This has identified changes in role responsibilities, separating administration tasks from clinical, and identifying opportunities for improved clinical assessment and improvements to the pathway for patients.  Increased efforts to create opportunities for cardiac Day of Surgery Admission (DOSA) have commenced, with a short life project group focused on embedding DOSA within cardiac surgery.  The anaesthetic input at the cardiac pre-operative assessment clinic, which received further support from the Strategic Projects Group, continues to identify patients with co-morbidities who require intervention prior to surgery. There has been a continued positive reduction in medical cancellations at the same time as supporting the identification of DOSA patients.  Additional improvements to the Cardiac pathway were focused on in May; these included an intravenous (IV) Iron Clinic and a multi-disciplinary look at pre-habilitation. | Lynn Graham | Ongoing |
| Thoracic | The Thoracic Enhanced Recovery Forum has been re-established with a renewed focus on the principles of both ERAS and DOSA. Work continues to promote DOSA and pre-operative assessment as the norm where possible. This group is also reviewing protocols around criteria for discharge from key clinical areas in the pathway and carrying out a wholescale review of the datasets collected on thoracic performance to ensure that data collected is continually being used to implement improvement.  The service has continued to see a growth in referrals for thoracic surgery compared to previous years; a high proportion of these are on the 31-day cancer pathway, which is causing some operational challenges for the service. The number of patients treated close to 31 days is creeping upwards. As a consequence, two non-cancer patients were treated over nine weeks in May as priority was given to treating those on either an urgent or 31-day pathway. All patients were treated within the treatment time guarantee. | Lynn Graham | Ongoing |
| Orthopaedics | During March, the DOSA rate was 65%, increasing to 72% during April.  There were 27 total hip replacement patients discharged on post-operative day one during May, which equates to 16% of hip activity and exceeds the established trajectory. One total knee replacement patient was also discharged on post-operative day one. In total, post-operative day one discharge equated to 9% of overall joint activity during the month.  The Enhanced Monitoring Unit (EMU) has had two beds open when staffing has allowed. The service is working well which has led to a sustained reduction in the number of level two bed days required by orthopaedics.  Consensus has now been reached amongst the orthopaedic surgeons regarding arthroplasty follow up. This aligns with the national approach to only review patients when there is a clinical need. | Christine Divers | Ongoing |
| Ophthalmology | During May, the mobile theatre unit was exchanged for the clinic unit. This has provided more individual rooms and improved flow, with all lists now routinely populated with seven patients per session. This has contributed to ophthalmology activity being 53 cases ahead of plan for the month of May. Additionally the Degree of Surgical Difficulty 3 (DSD3) patients have also now, routinely, been scheduled in the mobile unit. | Lynn Graham | Ongoing |
| Theatre Utilisation | The cancellation report continues to be shared weekly and is scrutinised closely by the Service Mangers and clinical leads, specifically looking at areas of improvement.  The theatre cancellation rates have been reported within the scorecard report. | June Rogers | Ongoing |

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| **Regional and National Medicine Division Performance Board Performance Update – July 2018** |

| **ISSUE** | **ACTION** | **RESPONSIBLE LEAD** | **TIMESCALE** |
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| Scottish National Advanced Heart Failure Service (SNAHFS) Transplant Update | As at 3 July 2018, there were 22 active patients on the transplant waiting list, with two transplants carried out in the year to date.  Official notice has been received that a formal review of SNAHFS will be undertaken in 2018. The National Specialist Services Committee (NSSC) require NSD to review all national specialist services on a rolling basis to ensure services continue to meet the needs of the population, provide equitable access and is delivering the most clinically and cost effective service. | Lynne Ayton | Ongoing |
| Scottish Adult Congenital Cardiac Service (SACCS) | As of 3 July 2018, there were 1,504 patients on the SACCS return waiting list, an increase of 20 compared to the month previous, with 503 patients having a recall date prior to 30 June 2018. As previously cited, the SACCS service faces challenges as a result of the high return outpatient waiting list with demand significantly outstripping capacity. From the middle of July, the service will further be impacted by a reduction in Consultant clinical capacity. Actions being taken to reduce the waiting list include:   * additional Waiting List Initiative Saturday clinics; * increase in nurse led clinics; * increased clinic size with patients being seen by Senior Registrar; * review of consultant job plans to increase clinic capacity within existing paid sessions; and * ongoing review and management of waiting list.   The Regional and National Medicine leads are working closely to monitor and improve current waiting list pressures.  An Adult Congenital Heart Disease (ACHD) Peer Review is anticipated in 2018/19; this is welcomed as it will provide an opportunity to discover how our service compares to those around the UK. | Lynne Ayton | Ongoing |
| Interventional Cardiology Recovery Plan | As previously reported, there are significant pressures in Cardiology, partly driven by the increase in Electrophysiology (EP) referrals, and partly due to the overall capacity gap in coronary intervention compared to demand.  Utilising non-recurring funding from the Scottish Government, additional sessions are continuing to run on Saturdays where possible; these have reduced over the summer months due to difficulties with staffing availability. It is increasingly difficult to manage the capacity gap and maintain waiting times with 12 weeks.  As of 28 June, there were 951 available patients on Cardiology waiting lists, an increase of 155 patients since the beginning of May.  EP pressures have increased, with patients now waiting in excess of 20 weeks, with the position being exacerbated by increased clinics ongoing at NHS Greater Glasgow & Clyde (NHS GG&C), one Consultant being on maternity leave and another reducing cath lab activity to go on maternity leave from September.  Actions being taken to improve the EP position include:   |  |  | | --- | --- | | 1. | To ensure all core capacity is staffed where possible. | | 2. | Ongoing discussions with NHS GG&C and NHS Forth Valley to manage demand. Despite a conversation with NHS GG&C management, they will continue additional Arrythmia clinics for the forseeable future to deal with their own long waits for outpatient appointments. | | 3. | Referral criteria for referrals into the Arrhythmia clinic. | | 4. | Engagement of clinicians to agree how we prioritise the current capacity against current demand. | | 5. | Review of referral trends to identifiy any outliers. | | 6. | Ongoing discussions with Scottish Government National Services Division to agree the pathway and funding for the congenital EP patients. | | 7.  8. | Increase in activity through extended days and additional lists where possible  The possibility of SACCS EP patients receiving treatment from NHS England has been discussed. |   Coronary patients are not yet exceeding 12 weeks but are now being booked at 12 weeks. This allows for no fluctuations in urgent workflow. | Lynne Ayton | Ongoing |
| Transcatheter Aortic Valve Implantation (TAVI) | TAVI has been running successfully since 10 April 2018, with nine lists having been carried out by 28 June, and 20 patients successfully treated with excellent outcomes. | Lynne Ayton | Ongoing |
| Non-ST-Elevation Myocardial Infarction (NSTEMI) | Performance for treatment within 72 hours of referral for non high risk NSTEMI patients showed an improved position in May. The achievement of this target is multi-factorial, dependent on bed and lab capacity within GJNH, and capacity in other boards to repatriate their patients. The department continues to manage the flow on a daily basis, flexing up capacity where possible and utilising the additional two beds in Level 3.    GJNH has submitted a bid to the Scottish Government Transformation Fund to extend the direct NSTEMI pathway within the West of Scotland and externally across Scotland to optimise the benefits of reduced length of admission realised from direct admission. | Lynne Ayton | Ongoing |

**Cardiac Surgery Inpatient Waiting List**

This is a snapshot of the cardiac surgery inpatient waiting list as at 5 July 2018, with a total of 246 patients waiting for surgery. Approximately 73% of the total waiting list are patients who are on the available waiting list (180 patients) and 27% (66 patients) were unavailable.

Figure 2: The number of unavailable patients as a percentage of the total waiting list, was 21.5% (53 patients) were for medical reasons and 5.3% (13) were patient advised unavailability.

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| Figure 1 | Figure 2 |
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26h a total of 2 imentation.kforce plan tiated with the preffered model will be confirmede any barriers to the implimentation**Thoracic Surgery Inpatient Waiting List**

As of 5 July 2018, there were 76 patients (Figure 4) on the Thoracic Surgery Inpatient waiting list.

The distribution of patients is 89% (68 patients) on the available waiting list and 11% (8 patients) were on the unavailable list.

Figure 5: As a percentage of the total waiting list, there were no medically unavailable patients and 8 patients (10%) advised that they were unavailable. Patient advised unavailability continues to fluctuate in line with seasonal trends and holiday periods.

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| Figure 4 | Figure 5 |
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**Cardiology Inpatient Waiting List**

Figure 6 illustrates the number of cardiology patients on the waiting list during the last 26 weeks. As of 5 July 2018. a total of 1,005 patients were on the cardiology waiting list with around 95% (959) patients on the available list. In addition to this, 5% (46) of patients were unavailable. The number of people on the cardiology inpatient waiting list has increased by 18% on the previous reporting period (up from 847 patients).

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| Figure 6 |
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**Electrophysiology Waiting List and Coronary Waiting List**

Figure 7 shows that there are currently 213 available patients on the Electrophsiology (EP) waiting list. NHS GG&C has recently indicated that more funding had been received to deliver additional outpatient capacity; this has resulted in referrals to the service consistently exceeding capacity since July 2017.

As at 5 July 2018, Figure 8 shows that there were 649 available patients on the coronary waiting list, with over 77 waiting in excess of 9 weeks. The length of wait has increased to between 11-12 weeks, with continued weekend lists during this reporting period. No patients are waiting over 12 weeks.

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| |  |  | | --- | --- | | **Figure 7: Electrophysiology Waiting List** | **Figure 8: Coronary Waiting List** | |  |  | |  |