Borders NHS Board

ACCESS TO TREATMENT REPORT AT JUNE 2014

AIM

The aim of this paper is to update the Board on progress against Waiting Time and other access guarantees, targets and aims.

INPATIENTS, DAYCASES, OUTPATIENTS AND DIAGNOSTICS

Overview

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

The building blocks to achieve access to treatment are known as the Stage of Treatment targets and these are set at 12 weeks for inpatient/daycase and 12 weeks for new outpatients. Locally the aim is to achieve nine weeks for each moving forward, in order to allow local flexibility and responsiveness in delivering for patients and also to address the difficulties encountered in particular this year.

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

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

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

Stage of Treatment – the building blocks

The Board has the following number of patients on its waiting lists shown against nine and 12 weeks waiting. There continue to be inpatients waiting over 12 weeks, with patient numbers remaining generally static over the last few months.

Table 1 Inpatient/daycase Stage of Treatment – patients waiting over 9 and 12 weeks

Available Inpatient/daycase	*Dec–13*	*Jan-14*	*Feb-14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*
>9weeks	90	247	133	115	123	115	120
>12weeks	10	27	38	16	4	11	8
Total Waiting	1,434	1,428	1,437	1,063	1,051	1,305	1,299

There continue to be challenges in Orthopaedics. All the patients waiting more than 12 weeks in June 2014 were Orthopaedic patients. Weekly monitoring of planned Orthopaedic procedures is being undertaken to ensure lists are fully populated and capacity fully utilised. As well as Orthopaedics, there are capacity challenges in ENT and Oral Surgery which are exacerbated by single-handed or small numbers of consultants.

For Outpatients, at the end of June 2014, 132 new outpatients were reported as waiting longer than 12 weeks.

Table 2 – New Outpatient Stage of Treatment – patients waiting over 9 and 12 weeks

Available Outpatient	***Dec-13***	***Jan–14***	***Feb - 14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***
>9weeks	365	567	391	337	434	472	366
>12weeks	59	166	167	34	68	136	132
Total Waiting	4,210	4,316	4,201	4,198	4,092	4,327	4,507

After an increase of patients waiting over 12 weeks in April and May, June has remained relatively static. The main areas of challenge are in Oral Surgery (56 patients) , ENT (17 patients) where extra short-term capacity has been put in place to reduce numbers waiting over 12 weeks and Gastroenterology, (26 patients). There were also 15 patients waiting longer than 12 weeks in Chronic Pain Service and 9 in Medical Paediatrics. The causes of these delays are being investigated in order to resolve underlying reasons.

The 12 week Treatment Time Guarantee (TTG)

TTG provides inpatient access within 12 weeks of an agreement with the patient to proceed to treat.

This Guarantee is directly linked to how long a patient is waiting for treatment, yet it is reported only following the delivery of the treatment to the patient. That is why it remains crucial to keep the Stage of Treatment targets in sight, as these are a precursor and indicator of any potential forthcoming breaches of the TTG.

There is, then, necessarily a difference in the timescales of reporting. Stage of Treatment breaches are reported when the patient wait exceeds 12 weeks whilst TTG breaches are reported once the patient is treated.

Table 3 below shows numbers of TTG patient breaches each month.

Table 3 Inpatient Performance Against TTG – patients who have exceeded TTG

Inpatient *(Available Patients)*	***Dec - 13***	***Jan - 14***	***Feb - 14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***
>12weeks	10	11	20	37	17	8	9

The high number of patients in March was a result of treating patients who exceeded TTG in the first quarter of 2014. The main reasons for these breaches were cancellations due to bed pressures and theatre overruns.

Although the position is improving, we are not where we want to be in terms of zero TTG breaches. The ongoing emphasis on booking both inpatients and outpatients 6 weeks ahead allows time to identify and address capacity gaps in services. However, we

continue to be vulnerable to short-notice cancellations where patients are booked close to or on breach date. Due to the limited consultant capacity in Oral Surgery and ENT, the ability to rebook cancelled patients within TTG can be difficult and these carry a significant risk of breach.

All but 1 TTG breach in May and June were Orthopaedics, where patients are predominantly still booked close to TTG date and cancellations have particular impact.

18 Weeks Referral to Treatment (RTT)

The national target for NHS Boards RTT is to deliver 90% combined admitted/non admitted performance, with a local "stretch" applied aiming to achieve an overall performance target of at least 95%, and the admitted pathway above 90%.

In June, the combined RTT performance was 90.2% and therefore the national target was met.

The admitted pathway performance is increasing but remains low, particularly impacted by ENT, Oral Surgery, Ophthalmology and Orthopaedics. Again, this illustrates how crucial the Stage of Treatment targets are, how they are the building block to delivering good all-round access for treatment.

The fall in non-admitted pathway performance is predominantly related to a reduction in Orthopaedic performance (94% in May to 93.1% in June) and Ophthalmology (95.2% to 92.6%) which, due to the large patient numbers in these specialties, have high impact. Extra outpatient capacity in both these areas has been put in place,.

Data recording in some specialties is lower than would be expected and this also impacts on reported performance. Clinicians whose recording of clinic outcomes falls below 90% are contacted to offer support to improve reporting.

Table 4: Overall Monthly Performance against 18 week RTT

Performance	***Dec - 13***	***Jan – 14***	***Feb - 14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***
Overall	92.0%	90.01%	90.0%	90.1%	90.4%	90.6%	90.2%
Admitted Pathways	72.9%	65.0%	67.3%	64.8%	65.3%	72.6%	74.8%
Non-admitted Pathways	95.1%	94.2%	93.9%	95.0%	94.5%	93.8%	92.8%

Diagnostics
The national target is that no patient waits more than six weeks for one of a number of identified key diagnostic tests. Locally this target has been set at four weeks.

The national target has been met and there are no patients awaiting diagnostics for more than six weeks. Details of the diagnostic waits over the local target of four weeks are included below in Table 5:

Table 5: Diagnostic Performance – number of patients waiting over Four Weeks

Diagnostic	***Dec - 13***	***Jan - 14***	***Feb - 14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***
Colonoscopy	1	5	0	1	0	0	0
Cystoscopy	8	4	0	2	7	12	16
MRI	3	6	0	0	0	0	0
CT	0	0	0	0	0	0	0
US (non obstetric)	52	0	14	2	0	0	0
Barium	8	0	0	0	0	0	0
Total	**72**	**21**	**14**	**5**	**7**	**12**	**16**

The Cystoscopy performance continues to be adversely impacted by the lack of capacity and the competing demands of diagnostic and surveillance cystoscopies. The main challenge to resolving this is access to scoping facilities to establish an additional list. A reallocation of rooms within the Endoscopy Unit may enable additional Cystoscopy activity to be undertaken.

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. Fortnightly meetings are in place to provide assurance that unavailability codes are being used appropriately across all services.

Information regarding unavailability is shown in Table 6 below.

Table 6: Monthly Unavailability Statistics

Unavailable	***Dec - 13***	***Jan – 14***	***Feb – 14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***
Unavailable: patient advised	202 (77.7%)	194 (75.2%)	212 (73.4%)	164 (61.7%)	147 (55.9%)	159 (64.4%)	154 (66.4%)
Unavailable: medical	48 (22.3%)	64 (24.8%)	77 (26.6%)	102 (38.3%)	116 (44.1%)	88 (35.6%)	78 (33.6%)
Inpatient/day cases	250 (17.6%)	258 (17.3%)	289 (20.1%)	266 (20.1%)	263 (21.5%)	247 (20.8%)	232 (19.8)

“Unavailable: Patient Advised” is the recognised national descriptor for those patients who have advised that they are unavailable for treatment on the dates offered often due to the fact that they have opted to remain longer on the waiting list in order to be treated at the Borders General Hospital or are otherwise unavailable due to for example, holidays or work arrangements.

"Unavailable: Medical" is the recognised national descriptor for patients who are not deemed to be medically fit for their operation at the current time.

Total percentage of patients on waiting list who are unavailable have remained stable.

Cancer Waiting Times

Two cancer standards are in place on which NHS Boards are asked to deliver.

- The 62 day urgent referral to treatment standard includes screened positive patients and all patients referred urgently with a suspicion of cancer.
- The 31 day standard includes all patients diagnosed with cancer (whatever their route of referral) from decision to treat to treatment.
- The current standard is that 95% of all eligible patients should wait no longer than 62 or 31 days.

There were no breaches of the 62-day standard in April, one in May 2014 and none in June. This represents an achievement of 98.7% for the April-June quarter. The 95% standard for the quarter will therefore be achieved; this will be the third consecutive quarter.

There are no significant issues with delivering the 31-day standard for the April - June 2014 quarter, and the quarterly performance is predicted to be 100%

Delayed Discharges

The current target for 2014/15 is to reduce to zero delays over four weeks. NHS Borders are working to what will be the new national target from April 2015 of 14 days. As at the census point of 15th June, there were ten patients waiting over 14 days. More detail is provided in Table 7 below:

Table 7: Delayed Discharges

Delayed Discharges as at 15th June Census

Table 5

Delay Category	Delayed Patients
0-7 days	2
7-14	4
Over 14	5
Over 28	5
Total Regular Delays	**16**
Complex	6
Code 100 - Reprovisioning	4
Grand Total	**26**

The code 100 – reprovisioning cases and the complex ones are not counted in the national census publications

Key points;

- Of the 10 patients delayed more than 14 days, 5 were delayed over 28 days, the current national target.
- Of the 6 complex cases, 5 related to adults with incapacity and 1 exercising statutory right of choice – interim placement not possible or reasonable.
- Delayed Discharge Operational Group predicting 0 delays over 28 days in July
- Delayed Discharge Operational Group organising a development session to ensure CEL 32 – "guidance on choosing a care home on discharge from hospital" is being adhered to and to provide an opportunity to incorporate Day of Care Audit outcomes into the discharge planning Process in advance of the 2 week target in 2015

ALLIED HEALTH PROFESSIONALS

Overview

For all Allied Health Profession (AHP) services, a local target of 9 weeks was identified as the standard which should be met from referral to initial appointment.

Table 8: AHP service performance against nine week target

AHP Service	***Dec-13***	***Jan–14***	***Feb-14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***
Physiotherapy	193	329	313	374	547	717	838
Speech and Language Therapy	0	1	0	0	0	0	0
Dietetics	4	4	3	4	7	6	0
Podiatry	0	0	0	0	0	0	3
Occupational Therapy	0	2	7	10	14	14	10

Physiotherapy

The Physiotherapy service continues to face challenges due to a variety of factors. An Improvement Plan is in place, a range of actions have been undertaken and more are in progress to stabilise and improve the position. Recruitment to vacant posts is underway as are a range of measures to address the current number of people waiting. Staff are working flexibly across Outpatient clinic sites to greatest areas of need and urgent referrals are being dealt with, in turn, by physiotherapists in other areas to maintain a safe service to patients.

To support junior staff at Haylodge and to help manage demand more effectively at this time the Senior Physiotherapist is relocating from West Linton and Innerleithen clinics to Haylodge Health Centre. Similarly, realignment has been made of senior clinical staff between Earlston, Selkirk and BGH.

Weekly actions to address the current demand and service delivery are being monitored and progressed with the Senior Physiotherapists.
Soon, referral systems will be centralised as will patient appointment booking processes.

The service is being supported to implement new approaches to assessment and treatment including telephone screening, group interventions and being encouraged to use learning from other Boards who have been part of a national MSK Redesign pilot.

In immediate terms, patients on the waiting list are being contacted to apologise for their wait for service and to check their current needs. GPs have been advised and offered additional information and resources to support referral management and improve access to the range of self management and information resources for patients.

Staff have now confirmed that, after allowing for clinical urgency, patients are being treated in turn, the Physiotherapy DNA policy is being adhered to without variation and agreed capacity levels are being delivered.

UNSCHEDULED CARE

Four Hour Emergency Access Standard

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

Table 9 – Performance against the emergency access standard.

Emergency Access	***Dec-14***	***Jan-14***	***Feb-14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***
Flow 1	99%	99%	99%	99%	99%	99%	99%
Flow 2	96%	97%	95%	97%	95%	91%	91%
Flow 3	97%	92%	94%	96%	93%	95%	90%
Flow 4	97%	95%	94%	96%	93%	92%	87%
Total	**98%**	**96%**	**97%**	**98%**	**96%**	**96%**	**95%**

To end of June 2014 we have had 11% more attendances at ED than same period in 2013.

Stroke Bundle

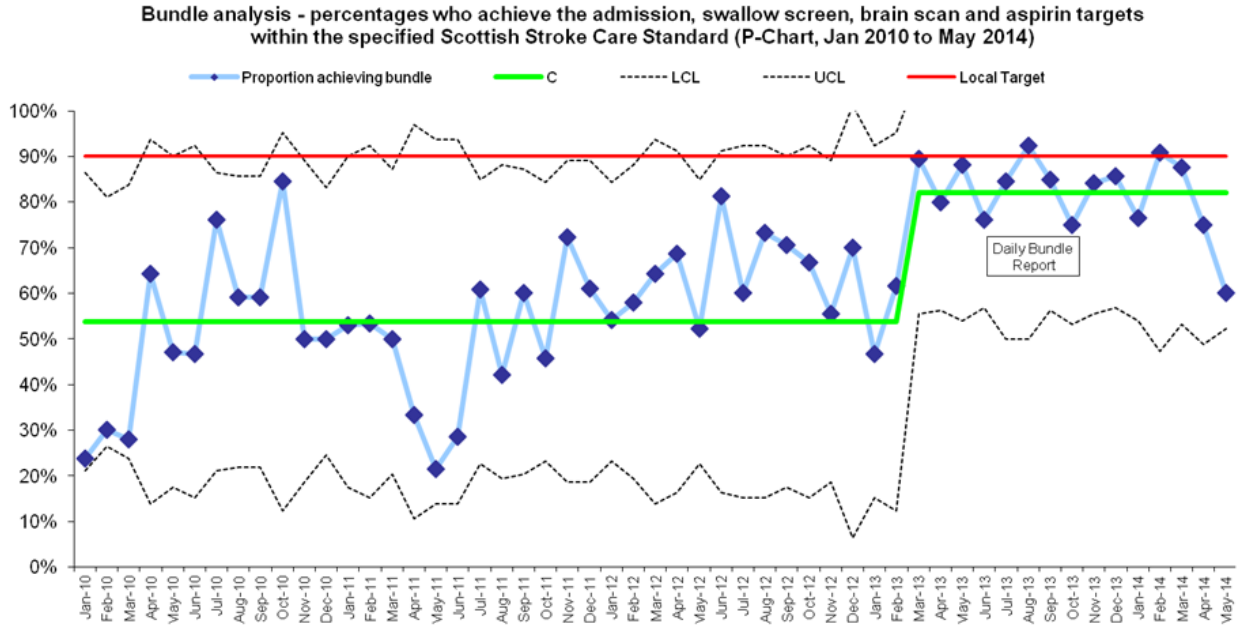
There is currently no HEAT target associated with Stroke. Health Boards are required to report against the Scottish Stroke Care Standards.

The Stroke Bundle is made up of elements of the Scottish Stroke Care Standards which are;

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

Performance against the bundle as at the end of May 2014 is represented in the diagram below; Training of ED staff to perform swallow screen assessment in the department has

led to the average swallow screen now being performed within 3 hours of admission to BGH.



MENTAL HEALTH

The Scottish Government has advised NHS Boards that they will evidence progress against national waiting time guarantees as reflected in the Local Delivery Plan (LDP). This will apply to CAMHS, Psychological Therapies and Drug & Alcohol Treatments.

CAMHS

The requirement is that from March 2013 Health Boards will deliver 26 weeks referral to treatment for Specialist Child and Adolescent Mental Health Services (CAMHS) reducing to 18 weeks by December 2014.

As at May 2013, the Service remains on track to deliver the target at the due date, with no patients reported waiting over 18 weeks since October 2013.

Psychological Therapies

The requirement is that from December 2014 Health Boards are expected to deliver 18 weeks RTT for Psychological Therapies.

Performance is as reported below:

Table 10 – Performance against 18 week RTT

	Dec-13	***Jan-14***	***Feb - 14***	***Mar - 14***	***Apr - 14***	***May-14***	***Jun-14***
> 18 weeks	25	43	67	93	106	98	81

The table above shows current waits for Psychological Therapy. There is significant Demand, Activity Capacity and Queue (DCAQ) work being undertaken by the service to plan for improved and more timely access.

Drug & Alcohol Treatment

This is a national HEAT Standard where the ongoing requirement is to deliver 3 weeks RTT for 90% of progressed referrals.

Performance is consistently above the target with June 2014 performance at 97%.

Recommendation

The Board is asked to note:

- the ongoing performance and the challenges associated with scheduled care in particular the TTG and Outpatient Stage of Treatment standards.
- The ongoing challenges in Physiotherapy Waiting Times
- The challenging context in delivering 4-hour ED standard.

Policy/Strategy Implications	Not applicable
Consultation	Not applicable
Consultation with Professional Committees	Not applicable
Risk Assessment	Leadership and engagement across all staff groups Capture of real time information. Maximisation of internal and external capacity
Compliance with Board Policy requirements on Equality and Diversity	Not applicable
Resource/Staffing Implications	As budgeted

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