Borders NHS Board

ACCESS TO TREATMENT REPORT AT FEBRUARY 2015

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

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

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

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.

The Board has faced a difficult year in managing access standards due to significant capacity challenges in a number of areas. Although, we continue to face ongoing challenges, we are making steady progress in delivering and sustaining positive improvements.

Stage of Treatment – the building blocks

The Board has the following number of patients on its waiting lists, including the number waiting over 9 and 12 weeks.

Table 1 Inpatient/daycase Stage of Treatment – patients waiting at end of month by specialty

Available Inpatient /daycase	*Jan-14*	*Feb-14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*Jul-14*	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec - 14*	*Jan-15*	*Feb-15*
>9weeks	176	133	115	123	115	120	101	167	159	127	141	157	181	150
>12weeks	27	38	16	4	11	8	5	20	23	11	6	5	30	52
Total Waiting	1,232	1,437	1,063	1,051	1,305	1,299	1,260	1,165	1,062	1,062	1,070	1,024	1089	1026

The December Board report noted that we were progressing towards a zero position for patients waiting beyond 12 weeks. However, it further noted that the impact of cancellations related to pressures on patient flow would have a significant negative impact on the position for patients waiting over 12 weeks.

This impact has been further worsened by a booking systems failure. For a combination of reasons, Orthopaedic patients with 12-week guarantee dates in the last week in February were not contacted and scheduled in time to avoid exceeding the 12-week guarantee. This has resulted in 32 patients in this period exceeding the 12-week guarantee date.

This was a failure both to follow protocol and of monitoring systems. Robust action has been taken to rectify the immediate situation and reinforce monitoring systems to avoid this happening again. Measures include clarification of staff member roles in managing and escalating pressures with booking, daily monitoring of numbers of patients unbooked and additional resource focused on orthopaedic booking. As a result of these measures, we expect to have no patients unbooked more than 9 weeks after they join the waiting list by the end of March.

The predicted position for end March is that there will be 26 patients waiting over 12 weeks. 20 of these are expected to be treated in April, with the remainder over May to July.

We continue to carry risks of further patients exceeding 12 weeks due to short-notice cancellations.

Progress towards achieving 9-week waits for all inpatients and daycases has been challenging, for a number of reasons. We are working to a trajectory to reduce waits for all specialties other than General Surgery and Orthopaedics to 9 weeks by July 2015.

In the previous Board report, it was noted that expected improvement in the outpatient position had not been achieved by December, but would start to impact from February onwards.

Table 2a – New Outpatient Stage of Treatment – patients waiting

Available Outpatient	*Jan 14*	*Feb 14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sep–14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb 15*
>9weeks	401	391	337	434	472	366	556	805	897	962	941	1001	1059	959
>12weeks	166	167	34	68	136	132	155	286	429	461	421	533	525	497
Total Waiting	4316	4,201	4,198	4,092	4,327	4,507	4,502	4,232	4,876	4,991	5,000	4,944	4,591	4,620

Numbers waiting over 9 and 12 weeks have fallen over January and February 2015.

The additional capacity for ENT noted in the December report has reduced the numbers waiting over 12 weeks to 166 (December 261) and over 9 weeks to 235 (December: 365). Further additional capacity is planned to reduce numbers over 9 and 12 weeks with a trajectory to zero by June 2015 and should be sustained.

There have also been further reductions in patients waiting over 9 & 12 weeks in Oral Surgery and Dermatology. The December Board report predicted zero 12-week waits in these specialties by end February. Actual position was Oral Surgery: 3, Dermatology: 10.

Continuing areas of challenge are in

- **Gastroenterology** where numbers over 12 weeks have increased once again to 91 (75 in December) and over 9 weeks to 129 (102 in December). Additional short-term capacity is being put in place to manage current waits. Work is underway to agree a longer-term solution to establish sustainable capacity.
- **Chronic Pain** where there are 53 patients waiting greater than 12 weeks. Booking practices require to be redesigned. This process is taking longer than anticipated.
- **Orthopaedics**. There has been a short-term increase in Orthopaedic numbers waiting over 12 weeks to 58 (December: 28) and 9 weeks to 161 (December 138). It is expected to reduce 12-week waits back to zero by April.

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.

The table below shows reported numbers of TTG breaches each month.

Table 3 Inpatient Performance Against TTG

Inpatient *(Available Patients)*	***Jan-14***	***Feb-14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***	***Jul-14***	***Aug-14***	***Sep-14***	***Oct-14***	***Nov-14***	***Dec-14***	***Jan-15***	***Feb-15***
>12week	11	15	37	17	8	9	8	5	19	15	9	28	40	38

As reported in the previous Board report, the impact of the TTG Trak data error and the cancellations during January are reflected in the increased number of patients treated beyond Treatment Time Guarantee in January and February.

Although we predicted to treat these patients by the end of March, further cancellations, unavailability of patients and the further impact of the failure to book patients within time that we experienced at the end of February will mean that we will continue to treat patients beyond TTG date after March.

We predict the following patients exceeding TTG will be treated in March (41 patients), April (20 patients), May (4 patients) and June (1 patient). There is 1 patient currently scheduled for treatment in July.

As noted above, we continue to be at risk of further TTG breaches due to short-notice cancellation.

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%.

Perf	***Jan-14***	***Feb-14***	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***	***Jul-14***	***Aug-14***	***Sep-14***	***Oct-14***	***Nov-14***	***Dec-14***	***Jan-15***	***Feb-15***
Overall	90.1%	90.0%	90.1%	90.4%	90.6%	90.2%	91.5%	90.4%	90.6%	90.1%	90.0%	90.8%	90.1%	90.0%
Admitted Pathways	65.0%	67.3%	64.8%	65.3%	72.6%	74.8%	77.4%	74.7%	78.5%	67.5%	72.4%	76.5%	71.3%	71.5%
Non-admitted Pathways	94.2%	93.9%	95.0%	94.5%	93.8%	92.8%	93.9%	92.68%	92.4%	93.8%	92.8%	92.9%	92.3%	92.8%

NHS Borders has consistently achieved the 90% national standard. This has proven challenging over the last 12 months, due to a relatively poor performance on admitted pathways.

January and February 2015 have been particularly challenging months. This is due to deterioration in performance in admitted pathways as a result of patients waiting longer for initial outpatient appointments and delays as a result of cancellations; and deterioration in non-admitted performance partly due to extra activity in ENT, Dermatology and Oral Surgery to see patients who have been waiting prolonged periods. Improvement in waits for outpatients will significantly improve RTT performance.

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.

Diagnostic performance has significantly improved over January and February. There were 12 patients waiting over 4 weeks at the end of February and zero patients waiting over 6 weeks. Details of the diagnostic waits over the local target of four weeks are included below in Table 5:

Table 5: Diagnostic Performance over Four Weeks

Diagnostic	*Jan-14*	*Feb - 14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb-15*
Colonoscopy	0	0	1	0	0	0	15	23	0	23	7	43	37	9
Cystoscopy	0	0	2	7	12	16	8	2	5	9	15	26	1	0
MRI	6	0	0	0	0	0	22	0	0	0	1	0	0	0
CT	0	0	0	0	0	0	0	0	0	20	0	0	0	3
US (non obstetric)	0	14	2	0	0	0	0	4	0	43	82	101	56	0
Barium	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Total	**6**	**14**	**5**	**7**	**12**	**16**	**45**	**30**	**5**	**95**	**105**	**170**	**94**	**12**

These improvements are a result of:

- **Colonoscopy** performance has improved over January and February. Activity has exceeded demand during this period, partly due to increased availability of consultants. Performance is expected to worsen in March and April due to annual leave. Attempts to secure short-term locum support have been unsuccessful but other options to increase capacity are now being explored. It is unlikely that these will be implemented before the end of April. The situation continues to be monitored weekly with the clinicians to address capacity issues.
- **Cystoscopy** performance has improved. Arrangements for ad-hoc additional lists to reduce waits should be in place by end March.
- **Ultrasound.** There continues to be significant staffing and capacity challenges in Ultrasound. However additional activity, including weekend working and locum support, has brought waiting list back down below 4 weeks for February. Staffing should improve with return of staff from absence in March. However, there is an ongoing deficit in capacity compared to demand. A long-term plan to manage capacity is being developed and there will continue to be a reliance on additional short-term cover until this is resolved.

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 in Table 6 below.

Table 6: Monthly Unavailability Statistics (Inpatient and daycase waiting list)

Un-avail	*Jan – 14*	*Feb – 14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sept -14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb-15*
Un-avail patient advised	194 (75.2%)	212 (73.4%)	164 (61.7%)	147 (55.9%)	159 (64.4%)	154 (66.4%)	169 (71.6%)	142 (64.8%)	143 (64.1%)	127 (57.0%)	109 (54.5%)	152 (62.8%)	118 (58.4%)	137 (60.4%)
Un- avail medical	64 (24.8%)	77 (26.6%)	102 (38.3%)	116 (44.1%)	88 (35.6%)	78 (33.6%)	67 (28.4%)	77 (35.2%)	80 (35.9%)	96 (43.0%)	91 (45.5%)	90 (37.2%)	84 (41.6%)	90 (39.6%)
In/pt day cases	258 (17.3%)	289 (20.1%)	266 (20.1%)	263 (21.5%)	247 (20.8%)	232 (19.8%)	236 (20.4%)	219 (18.8%)	223 (18.8%)	223 (19.7%)	200 (18.0%)	242 (21.9%)	202 (17.7%)	227 (18.1%)

“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.

There has been little change in the numbers and type of unavailable patients. There has been a slight drop in patient-advised unavailability, as patients availability improves after the Christmas period. .

Cancer Waiting Times

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

- The 62 day urgent referral to treatment standard includes screened positive patients and all patients referred urgently with a suspicion of cancer.

- The 31 day standard includes all patients diagnosed with cancer (whatever their route of referral) from decision to treat to treatment.

- The current standard is that 95% of all eligible patients should wait no longer than 62 or 31 days.

Cancer Waiting Times standards are reported quarterly. Until Quarter Jan-Mar 15, NHS Borders had consistently achieved the 62-day standard over the previous 5 consecutive quarters and the 31-day standard has been achieved every quarter since it was established;

Cancer waiting times	*Apr to Jun-13*	*July to Sept-13*	*Oct to Dec-13*	*Jan to Mar-14*	*Apr to Jun-14*	*July to Sept-14*	*Oct to Dec-14*	*Jan to Mar-15 (predicted)*
62-day standard	92.31%	93.9%	98.84%	96.77%	98.77%	98.51%	97.44%	93.75%
31-days standard	98.15%	100%	98.44%	100%	100%	100%	100%	98.01%

NHS Borders will not achieve the 95% standard for the 62-day cancer pathway for Jan-Mar 2015. In January 2015, we experienced 4 breaches of the 62-day standard. 2 of these breaches were as a result of surgical cancellations due to lack of ITU beds. New arrangements have been put in place to reduce the risk of cancellations for this reason in future. The other 2 breaches were Urology patients delayed for surgical treatment in Lothian. This is a recurring challenge and has been raised with NHS Lothian and at a regional and national level.

We are not expecting any further breaches in the remainder of the quarter, and we would expect to return to achievement of the standard in the quarter Apr-June 2015.

There was one breach of the 31-day standard in the quarter from Jan-Mar 2015, resulting in a quarterly return of 98.01%. This is above the 95% standard.

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 February 2015, there were 3 patients waiting over 14 days and 9 patients waiting under 14 days. More detail is provided in Table 7 below:

Table 7: Delayed Discharges

	May-14	**Jun-14**	**Jul-14**	**Aug-14**	**Sept-14**	**Oct-14**	**Nov-14**	**Dec - 14**	**Jan-15**	**Feb-15**
No. Delayed Discharges over 2 weeks	6	10	10	8	1	3	4	1	5	3
Delayed Discharges under 2 weeks	11	6	8	5	6	7	2	12	2	9

NHS Borders is making good progress in achieving the new national target. The use of Flex “step down” care home places for assessment or interim move purposes has contributed to this positive position. There were 12 patients in flex beds as at 15 March. The Delayed Discharge Operations Group forecasts achievement of the 14 day target by the time of the March census.

The National Discharge Task Force has recommended that Integrated Boards are asked to demonstrate improvement against the following indicators:

- *The proportion of adults discharged within 72 hours of their ready for discharge date*
- *Bed days lost to delayed discharge*

If implemented it is envisaged that there would be a lead-in time of between 6 and 12 months. The Task Force therefore recommends that we use the proposed 2 week standard from April 2015 until the new measures can be rolled out.

The Task Force further recommends that improvement trajectories are set for the rate of bed days spent in hospital after emergency admission, and not just the proportion of the days that are recorded as delays.

A test of change has commenced within BGH to develop a discharge hub, whose focus will be to achieve discharge within 72 hours of referral

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	*Jan–14*	*Feb-14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec - 14*	*Jan-15*	*Feb-15*
Physiotherapy	329	313	374	547	717	838	1076	1057	916	724	594	626	878	942
Speech and Language Therapy	1	0	0	0	0	0	0	0	0	2	0	0	0	0
Dietetics	4	3	4	7	3	0	3	8	7	4	7	3	6	7
Podiatry	0	0	0	0	0	3	0	0	0	0	0	0	1	0
Occupational Therapy	2	7	10	14	14	10	10	14	13	9	8	13	8	7

As predicted in the previous Board report, the waiting list for Physiotherapy has worsened with current staffing capacity not meeting demand. Current vacancies are out to advert, with an additional 2.0wte band 6 for 18 months to support MSK waiting times: this is the predicted time it will take to clear waiting list to 4 weeks if all vacancies are filled.

2 training sessions have taken place to support staff moving to new way of working (telephone consultation & exit strategies to community), with a plan to implement in Peebles first and roll out from April 2015. Self-management information shared with GPs and referral process updated on Ref help.

Weekly review of status of waiting times, staffing and activity continues to be undertaken and staffing challenges addressed where possible. However the service has not yet achieved a sustainable position where capacity matches demand.

The external review commissioned via P&B and AHP Associate Director to review capacity, demand and workforce profile has been shared with the Physiotherapy Service and progress towards staffing review at Productivity and benchmarking is being made.

Nutrition and Dietetics

Capacity remains less than demand as there is not currently a full complement of staff. Posts are being progressed through the vacancy process.

DESMOND courses now have 3 new trainers and capacity for programme has increased by 35% and some additional clinics have been agreed.

Occupational Therapy

The waiting times within OT have fluctuated due to continued demand for specialist OT assessment and the vulnerability of there being only on OT with historically no 52 week cover

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 December performance was 91%.

Table 9 – Performance against the emergency access standard.

Emergency Access	*Jan-14*	*Feb-14*	*Mar-14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sep-14*	*Oct-14*	*Nov - 14*	*Dec - 14*	*Jan-15*	*Feb-15*
Flow 1	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	99%	97%	97%	97%
Flow 2	97%	95%	97%	97%	95%	91%	91%	93%	91%	89%	89%	94%	91%	86%	92%
Flow 3	92%	94%	96%	96%	93%	95%	90%	96%	89%	90%	95%	96%	82%	79%	81%
Flow 4	95%	94%	96%	96%	93%	92%	87%	95%	90%	92%	92%	98%	85%	85%	90%
Total	**96%**	**97%**	**98%**	**98%**	**96%**	**96%**	**95%**	**97%**	**95%**	**95%**	**97%**	**98%**	**91%**	**90%**	**91%**

The Emergency Access Standard continues to be challenging for the Board. Performance has been impacted by ongoing pressures on inpatient beds. A detailed action plan and trajectory to improve the underlying causes resulting in this performance is in place and is being reviewed on a weekly basis.

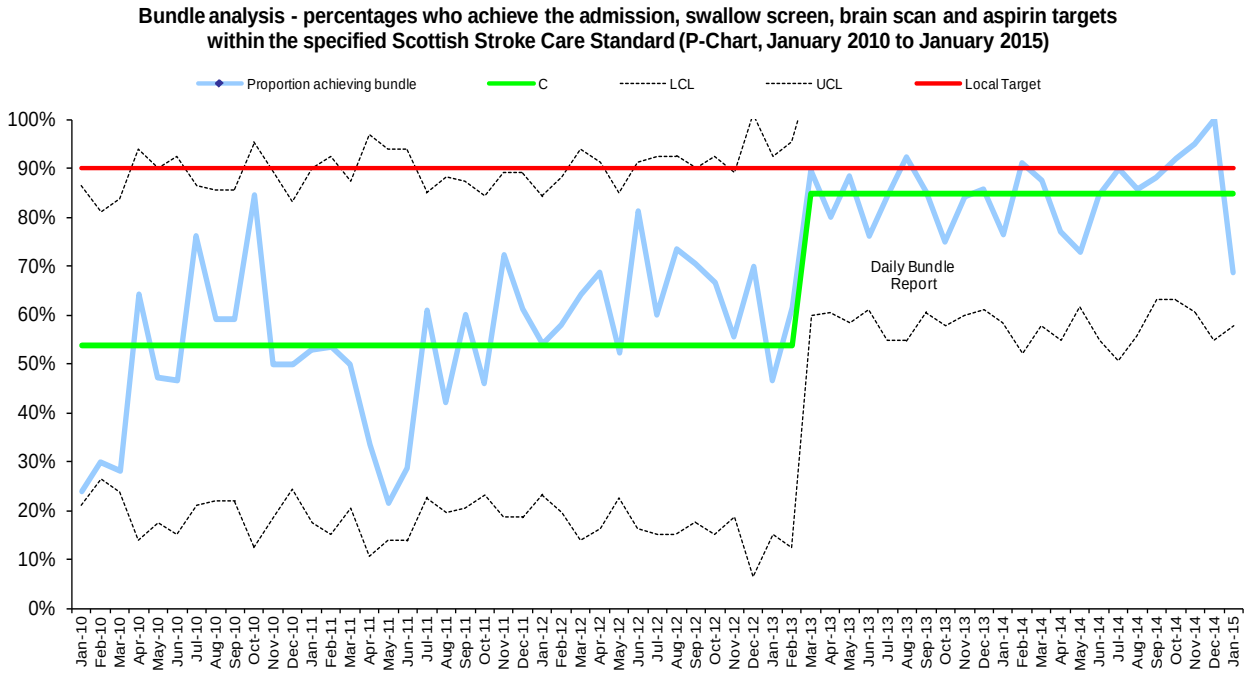
Stroke Bundle

Having moved on from the HEAT target to Stroke BUNDLE measurement against individual patients, daily reporting of red/amber/green (RAG) status has consistently maintained the bundle elements as a high priority in care delivery.

The Stroke 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 on day of admission
- a brain scan within 24hours of admission
- appropriate treatment initiated within one day of admission

Compliance with the bundle has been impacted in January by the unscheduled care pressures experienced. A contributing factor to this has been the nature of medical boarders in the stroke unit and the team are working on a protocol to try and manage this more effectively in the future. All other elements of the bundle were completed within time for each patient.



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.

CAMHS have not achieved this target in December 2014 and January 2015 with two breaches reported each month. This is mainly due to a combination of high levels of staff absence and a marked increase in referrals for young people requiring intensive home treatment. Ongoing DCAQ work is identifying areas where clinical time can be increased.
NB There is a 1 month lag in reporting due to national verification requirements.

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

	Jan-14	***Feb - 14***	***Mar -14***	***Apr - 14***	***May-14***	***Jun-14***	***July-14***	***Aug-14***	***Sep - 14***	***Oct - 14***	***Nov-14***	***Dec-14***	***Jan-15***	***Feb-15***
> 18 weeks	43	67	93	106	98	81	66	87	73	106	60	75	46	38

The table above shows current waits for Psychological Therapy. There is significant work being undertaken by the service to plan for improved and more timely access. This has a

main focus of increasing the delivery of therapy by non Clinical Psychology qualified therapists. This will assist with maintaining performance by reducing reliance on a small group of clinicians.

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 performance in both January and February 2015 at 100%.

Recommendation

The Board is asked **to note:**

- the ongoing challenges associated with scheduled care in particular the TTG and Outpatient Stage of Treatment standards and the work to address these
- the predicted performance against TTG for April to June and the actions taken to address future performance
- The ongoing challenges in Physiotherapy Waiting Times
- The challenging context in delivering 4-hour ED standard.

Policy/Strategy Implications	Scottish Government imperative that Boards comply with access to treatment targets and guarantees
Consultation	Clinical services contribute as appropriate
Consultation with Professional Committees	Leadership and engagement across all staff groups
Risk Assessment	Capture of real time information. Maximisation of internal and external capacity
Compliance with Board Policy requirements on Equality and Diversity	Yes, planning includes ensuring compliance
Resource/Staffing Implications	As budgeted

Approved by

Name	Designation	Name	Designation
Evelyn Rodger	Director of Nursing and Midwifery, Interim Director of Acute Services	Susan Manion	Chief Officer, Health and Social Care

Author(s)

Name	Designation	Name	Designation
Phillip Lunts	Executive Lead for Access and General Manager Cancer Services		