Borders NHS Board

ACCESS TO TREATMENT REPORT - APRIL 2015

Aim

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

Performance

INPATIENTS, DAYCASES, OUTPATIENTS AND DIAGNOSTICS

Overview

The performance of Health Boards in relation to Waiting Times 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.

Moving into 2015/16, the Board continues to face challenges in the achievement of our waiting times standards. However, although the pace of improvement is slower than planned, we are working steadily towards achievement of 9 week waits in both inpatients and outpatients.

Stage of Treatment – Inpatients and daycases

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	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*Jul-14*	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec -14*	*Jan-15*	*Feb-15*	*Mar-15*	*Apr-15**
>9weeks	115	123	115	120	101	167	159	127	141	157	181	150	133	98
>12weeks	16	4	11	8	5	20	23	11	6	5	30	52	27	17
Total Waiting	1,063	1,051	1,305	1,299	1,260	1,165	1,062	1,062	1,070	1,024	1089	1026	1036	913

As reported in the February Board report, numbers of patients waiting over 12 weeks rose sharply in January and February of this year. This number has started to improve over March and April. We are currently broadly on trajectory to achieve 9 week waiting times for most specialties by September. However, due to cancellations, the numbers of patients waiting over 12 weeks in General Surgery and Orthopaedics continues to remain at around 17. There were 40 procedures cancelled in April, as a result of a combination of theatre overruns, staffing challenges and bed pressures. A similar number of cancellations are expected in May. There are a range of workstrands in place to address the causes of these cancellations.

All but one patient currently waiting over 12 weeks have dates for treatment. However, we continue to carry the risk of further patients exceeding 12 weeks due to short notice cancellation.

In February, the Board heard that a number of patients waited over 12 weeks as a result of a failure of booking systems resulting in patients not being booked in time. With the reinforcement of policies and daily monitoring, there has been significant improvement in this situation, with 98% of available patients now booked within 9 weeks of joining the waiting list and 87% booked within 6 weeks of joining the waiting list, compared with 92% and 84% respectively in February 2015. This not only provides assurance that patients are not at risk of waiting over 12 weeks, but also offers a much improved service for patients.

Stage of Treatment – Outpatients

The improvement in the outpatient waiting times position noted in the February Board report has continued over March and April 2015.

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

Available Outpatient	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sep–14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb 15*	*Mar 15*	*Apr-15*
>9weeks	337	434	472	366	556	805	897	962	941	1001	1059	959	698	757
>12weeks	34	68	136	132	155	286	429	461	421	533	525	497	285	350
Total Waiting	4,198	4,092	4,327	4,507	4,502	4,232	4,876	4,991	5,000	4,944	4,591	4,620	4,509	4,436

Significant improvements have been seen in ENT and Gastroenterology. In ENT, there were just 6 patients waiting over 12 weeks at the end of April (down from 166 at the end of February) and 27 over 9 weeks (235 in February). This is as a result of some additional weekend clinics and the establishment of the third ENT consultant post. This improvement is expected to be sustained. Gastroenterology waits >12 weeks reduced from 91 to 22 and >9 week waits from 129 to 29. This was a result of a similar combination of external additional capacity and additional consultant and nurse clinics. Sustainability of this position is expected to be more problematic.

There has been a worsening position in:

- Dermatology, where numbers waiting >12 weeks rose to 85 (end Feb:10) and > 9 weeks to 196 (end Feb: 95). This is due to a capacity gap, which is expected to be resolved from July with arrangements for additional Dermatology support.
- Diabetes and General Medicine, where there are significant capacity issues. These are predominantly related to the Diabetes and Endocrinology service. Numbers waiting >12 weeks in General Medicine rose to 43 (end Feb: 26) and >9 weeks to 55 (end Feb: 33). A short-term solution to manage capacity through additional clinics and the use of a GP specialist are in place and should see an improvement in performance from July.
- Cardiology, where numbers >12 weeks rose to 25 (end Feb: 7) and >9 weeks rose to 59 (end Feb: 24). Arrangements for additional weekend clinics are being put in place and further work to identify sustainable solutions are underway. However, this is likely to be an ongoing area of risk.
- Rheumatology, where numbers >12 weeks rose to 39 (end Feb: 26) and >9 weeks rose to 53 (end Feb: 36). Additional locum capacity has been identified and should provide some short-term support. Long-term solution will be through recruitment to additional consultant post. This is underway.

It is anticipated that the overall number of outpatients waiting >12 weeks and >9 weeks is likely to worsen for June before improving in July. This is due to the timelag in implementing some of the capacity solutions identified above.

New national targets to improve the outpatient position require NHS Borders to ensure

1. That there are no patients waiting >15 weeks by the end of 2015. We are currently on trajectory to deliver this with 179 patients waiting over 15 weeks at end of May.
2. That 95% of patients are seen within 12 weeks by the end of 2015.

Our current trajectory is to deliver against these targets by end August 2015.

The 12 week Treatment Time Guarantee (TTG)

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

Table 3 Inpatient Performance Against TTG

Inpatient *(Available Patients)*	***Mar-14***	***Apr-14***	***May-14***	***Jun-14***	***Jul-14***	***Aug-14***	***Sep-14***	***Oct-14***	***Nov-14***	***Dec - 14***	***Jan-15***	***Feb-15***	***Mar-15***	***Apr-15***
>12week	37	14	10	9	6	5	21	15	9	27	40	40	35	26

The number of TTG breaches reported has started to decline as noted in the February Board report.

As consistently reported, the TTG breach numbers can be affected by cancellations and other short-notice issues affecting theatre throughput. In the February Board report, we predicted an expected 4 TTG breaches, based on the number of known patients over 12 weeks that were planned for treatment that month. Total predicted TTG breaches for May now stand at 9. This is as a result of;

- 7 cancellations due to theatre overrun, other urgent cases, bed availability and consultant absence
- 2 administrative and booking errors

Figures for subsequent months suggest that there will be between 12 and 16 TTG breaches in June, but this figure may rise as a result of in-month cancellations.

A further 4 patients are booked over 12 weeks in July and one in August.

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

Following review of data, the Board should note the following two issues regarding historical reporting of TTG breaches;

1. The final outturn of the impact of the Trak data error in calculating TTG date. We have now been able to validate the final numbers having submitted corrected data to the ISD warehouse for the months in question. The final validated position is consistent with what has already been reported to the Board for January, is 2 more for February and 1 more for March over what we had initially estimated, a total of 3 additional cases. Following identification of the configuration issue and resolution of this, NHS Borders commissioned an external review, and have subsequently implemented the recommendations from the review.

2. The retrospective recalculation of TTG returns based on revised ISD Data Warehouse figures. ISD have recently refreshed data in the national warehouse going back to October 2012 when TTG was introduced. They will shortly be publishing this historical data report. In common with other Boards, we have identified some differences in TTG numbers reported to the Board and the numbers that will be reported by ISD. These numbers are small but mean that there has been a 0.2% underreporting of TTG breaches to the Board during this period. We have reviewed every case that was not reported and identified reasons for their omission. Most of these relate to the fact that there was a manual element to the system for calculating unavailability at that time. This has no longer been the case since a Trak upgrade in the spring of 2014. A detailed report has been compiled and will be reviewed by the Access Management Group.

   A summary of the differences in monthly TTG reporting is presented below and demonstrates that we have complete understanding of the total position for the Board. NHS Borders position is similar to a number of other Boards.

TTG Breaches	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
No Previously Reported	37	17	8	9	8	5	19	15	9	28	40	38	34	26
Actual No Validated	37	14	10	9	6	5	21	15	9	27	40	40	35	26
Difference	0	-3	2	0	-2	0	2	0	0	-1	0	2	1	0

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	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*Jul-14*	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec -14*	*Jan-15*	*Feb-15*	*Mar 15*	*Apr-15*
Overall Admitted Pathways	90.1% 64.8%	90.4% 65.3%	90.6% 72.6%	90.2% 74.8%	91.5% 77.4%	90.4% 74.7%	90.6% 78.5%	90.1% 67.5%	90.0% 72.4%	90.8% 76.5%	90.1% 71.3%	90.0% 71.5%	90.1% 71.6%	90.6% 72.2%
Non-admitted Pathways	95.0%	94.5%	93.8%	92.8%	93.9%	92.68 %	92.4%	93.8%	92.8%	92.9%	92.3%	92.8%	93.2%	94.0%

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.

The non-admitted pathway performance has improved over March and April. There were improvements in both admitted and nonadmitted pathway performance in April. GI, Rheumatology. Paediatric Surgery, Orthopaedics and Audiology all saw improvements. There were deteriorating positions in Cardiology, Diabetes, and Chronic Pain for capacity reasons noted above. There was also deterioration in the position for ENT due to a reduction in numbers of patients seen and the ongoing effects of treating patients who had previously experienced long outpatient waits.

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. There has been a slight increase in patients waiting over 4 weeks for colonoscopy and cystoscopy. There was 1 breach of the 6 week standard in Cystoscopy. 4 week performance is in Table 5:

Table 5: Diagnostic Performance over Four Weeks

Diagnostic	*Mar -14*	*Apr -14*	*May -14*	*Jun -14*	*July -14*	*Aug -14*	*Sep -14*	*Oct - 14*	*Nov - 14*	*Dec -14*	*Jan -15*	*Feb -15*	*Mar -15*	*Apr -15*
Colonoscopy	1	0	0	0	15	23	0	23	7	43	37	9	5	10
Cystoscopy	2	7	12	16	8	2	5	9	15	26	1	0	8	18
MRI	0	0	0	0	22	0	0	0	1	0	0	0	0	0
CT	0	0	0	0	0	0	0	20	0	0	0	3	0	0
US (non obstetric)	2	0	0	0	0	4	0	43	82	101	56	0	0	0
Barium	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Total	**5**	**7**	**12**	**16**	**45**	**30**	**5**	**95**	**105**	**170**	**94**	**12**	**13**	**28**

- **Colonoscopy** – although colonoscopy waiting times have improved, they have stabilised at around 4 weeks currently. A small amount of additional capacity has been put in place on a short-term basis.

- **Cystoscopy** performance continues to be variable. Arrangements for additional cystoscopy capacity have been explored abut are problematic to establish, due to access to scoping rooms and clinical supervision requirements. A more detailed review of urology service provision is required to support this work.

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 to March is shown in Table 6 below.

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

Un-avail	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sept-14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb-15*	*Mar 15*	*Apr-15*
Un-avail patient advised	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 %)	128 (59%)	157 (65,4 %)
Un-avail medical	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 %)	89 (41.0 %)	83 (34.6 %)
In/pt day cases	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 %)	217 (20.9 %)	240 (20.8 %)

There has been an increase in numbers of patients with patient advised unavailability. This is due to an increase in numbers of patients requesting local health board treatment. Some of this increase is related to the management of patients whose procedures have been cancelled to ensure that they do not exceed their Treatment Time Guarantee.

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*
62-day standard	92.31%	93.9%	98.84%	96.77%	98.77%	98.51%	97.44%	94.4%
31-days standard	98.15%	100%	98.44%	100%	100%	100%	100%	97.8%

NHS Borders did 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. There were no further breaches in the quarter.

There have been no breaches in April and May of Quarter 2. There are two potential breaches of the 62-day standard in June. Both potential breaches are in Urology and are related to delays in treatment in Lothian. We are therefore predicting to achieve the 95% standard for Quarter 2.

There were two breaches of the 31-day standard in the quarter from Jan-Mar 2015, resulting in a quarterly return of 97.8%. This is above the 95% standard.

Delayed Discharges

The new national target of zero delays over 14 days came into place in April 2015. As at April 2015, there were 0 patients waiting over 14 days and 4 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**	**Mar-15**	**Apr-15**
No. Delayed Discharges over 2 weeks	6	10	10	8	1	3	4	1	5	3	0	0
Delayed Discharges under 2 weeks	11	6	8	5	6	7	2	12	2	9	4	4

NHS Borders has made 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.

The discharge hub model, mentioned in the previous Board report appears to have had some effect in supporting complex discharge arrangements and the test of change continues.

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	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*July-14*	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec - 14*	*Jan-15*	*Feb-15*	*Mar-15*	*Apr-15*
Physiotherapy	374	547	717	838	1076	1057	916	724	594	626	878	942	905	1042
Speech and Language Therapy	0	0	0	0	0	0	0	2	0	0	0	0	0	0
Dietetics	4	7	3	0	3	8	7	4	7	3	6	7	2	4
Podiatry	0	0	0	3	0	0	0	0	0	0	1	0	0	0
Occupational Therapy	10	14	14	10	10	14	13	9	8	13	8	7	6	11

The waiting list for Physiotherapy continues to worsen with current staffing capacity not meeting demand. Additional 2.0wte Band 6s have been appointed and will be in place from mid July to support MSK waiting times.

Telephone consultations are now taking place in 3 localities for MSK services. Additional telephone consultations have also taken place within respiratory services; respiratory waiting times are now less than 9 weeks.

Weekly review of status of waiting times, staffing and activity continues to be undertaken and staffing challenges addressed where possible.

The organisation has agreed to the implementation of the structure recommended by the external review for staffing at Bands 2-7 and requested that further work is undertaken by AHP Associate Director and Chief Officer for Health and Social Care to determine band 8 posts. The implementation process started in May with plans to have all posts in place within 16 weeks. This includes agreement to recruit permanently to currently vacant band 5 posts.

Nutrition and Dietetics

Dietetic breaches are predominantly related to capacity issues. Recruitment to vacant posts is ongoing. Measures to triage referrals are in place.

Occupational Therapy

The waiting times within OT have fluctuated due to continued demand for specialist OT assessment and the vulnerability of there being only one 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%.

Table 9 – Performance against the emergency access standard.

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

Delivery against the Emergency Access Standard has continued to be challenging but shows some indications of improvement. Flows 3 & 4, surgical flow and medical admissions, in particular, have shown some signs of improvement, potentially due to measures taken to improve patient flow within the hospital. This work will continue.

A focus on further improving Flow 1, minor injuries and illnesses, is planned to improve the EAS performance further

Stroke Bundle

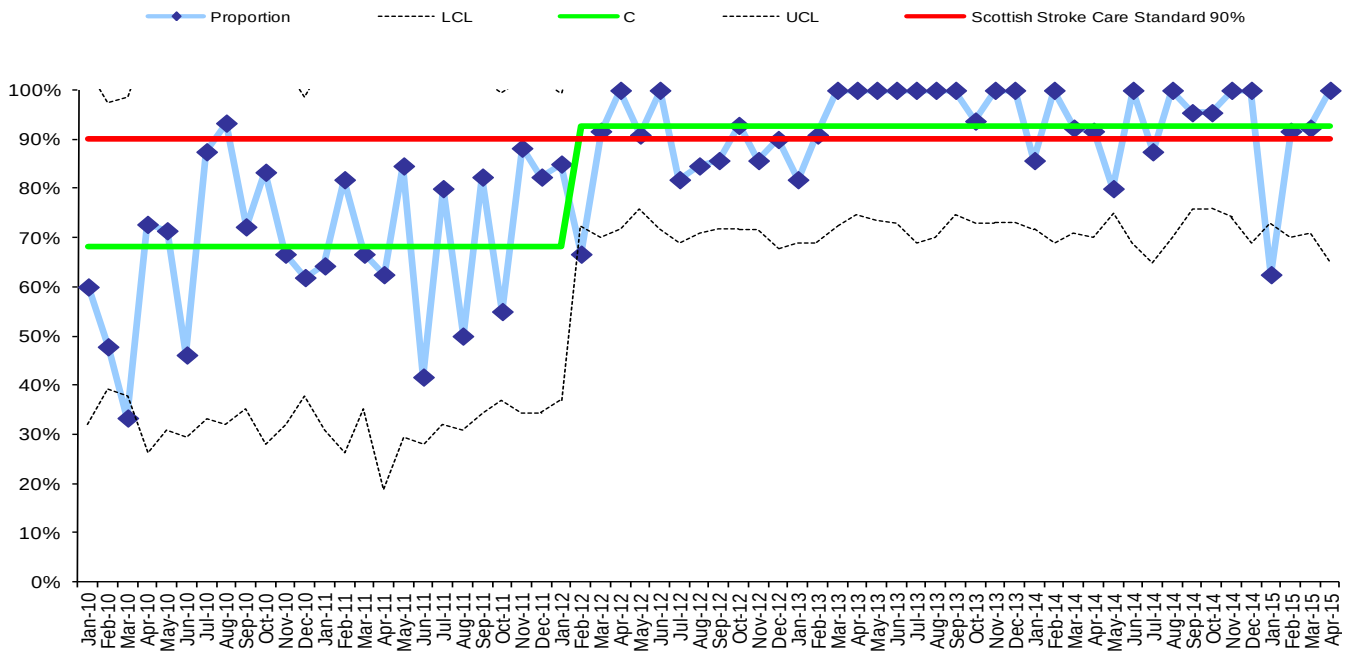
Having moved on from the HEAT target to Stroke BUNDLE measurement against individual patients, daily reporting of red/amber/green (RAG) status has consistently maintained the bundle elements as a high priority in care delivery.

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 was impacted in January by unscheduled care pressures and the nature of medical boarders in the stroke unit. Improvements in admission processes has helped sustain an improved position to April 2015.

Percentage achieving the Scottish Stroke Care Standard of being admitted to the stroke unit within 1 day of admission (P-Chart, January 2010 to April 2015)



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.

The target for waiting times is 90% and CAMHS continues to achieve this. In the quarter to March 2015 CAMHS achieved 90.9% Whilst this is within target, it would be preferable to be nearer 100% and we are working to achieve this. A plan has been developed to improve performance over the next three months.

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

	Mar -14	***Apr - 14***	***May-14***	***Jun-14***	***July-14***	***Aug-14***	***Sep - 14***	***Oct - 14***	***Nov-14***	***Dec-14***	***Jan-15***	***Feb-15***	***Mar-15***	***Apr-15***
> 18 weeks	93	106	98	81	66	87	73	106	60	75	46	38	42	33

Whilst we have made good progress, with a reduction in those waiting more than 18 weeks down from 82 in November 2014, to 33 in April 2015, we still have some way to go. There is currently a 0.5wte vacancy within a small team and this has a significant effect. This post is in the process of being advertised.

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 March at 98% and April 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

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