Borders NHS Board

ACCESS TO TREATMENT REPORT AUGUST 2015

Aim

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

Summary

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 9 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 6 weeks. Locally the aim is to achieve a wait of no more than 4 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.

In 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 12 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	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec - 14*	*Jan-15*	*Feb-15*	*Mar-15*	*Apr-15*	*May-15*	*Jun-15*	*Jul-15*	*Aug -15*
9-12 weeks	167	159	127	141	157	181	150	133	98	115	70	57	70
>12weeks	20	23	11	6	5	30	52	27	17	19	7	5	5
Total Waiting	1,165	1,062	1,062	1,070	1,024	1,089	1,026	1,036	913	908	904	923	964

At the end of August the number of patients reported as waiting over 12 weeks continues to improve with a figure of 5 now reported. All of these are due to cancellations in General Surgery and Orthopaedics.

All patients 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 cancellations.

There are continuing challenges around capacity in Orthopaedics, and we are working through options to address these. During August and September, 6 weekends of operating have been organised with support of Synaptik, and plans are being developed to continue this into October.

Stage of Treatment – Outpatients

The improvement in the outpatient waiting times position continues in July and August 2015 for patients waiting over 12 weeks and a stable position of patients waiting over 9 weeks continues.

Table 2: New Outpatient Stage of Treatment – patients waiting

Available Outpatient	*Aug-14*	*Sep–14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb 15*	*Mar 15*	*Apr-15*	*May 15*	*Jun-15*	*Jul-15*	*Aug-15*
>9 weeks	805	897	962	941	1001	1059	959	698	757	751	743	682	725
>12weeks	286	429	461	421	533	525	497	285	350	346	398	320	259
Total Waiting	4,232	4,876	4,991	5,000	4,944	4,591	4,620	4,509	4,436	4,643	4,874	4,811	4,647

Outpatient waiting times have improved, but continue to be challenging, particularly within the Medical specialties.

Currently there are pressures within:

- Cardiology - capacity is an ongoing problem, and work is ongoing with the service to look for solutions.
- Chronic Pain - we are in the process of implementing revised administrative processes and additional short-term capacity.
- Dermatology - is a particular concern at present. An additional Consultant post has been approved, however there were no applicants for the substantive position and

a year-long locum has been recruited to commence in September 2015. In the interim, additional clinics for both urgent and non-urgent patients are being organised.

- Diabetics / Endocrinology - also continue to be challenging. Additional short-term capacity has been organised with local clinicians whilst a longer term solution is identified.

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 210 patients waiting over 15 weeks at end of June.
2. That 95% of patients are seen within 12 weeks by the end of 2015 (currently at 94%).

Our current trajectory is to deliver against these targets by end December 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)*	***Aug-14***	***Sep-14***	***Oct-14***	***Nov-14***	***Dec - 14***	***Jan-15***	***Feb-15***	***Mar-15***	***Apr-15***	***May-15***	***Jun-15***	***Jul-15***	***Aug-15***
>12week	5	21	15	9	27	40	40	35	26	9	15	5	7

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

As consistently reported, the TTG breach numbers can be affected by cancellations and other short-notice issues affecting theatre throughput. Currently it is predicted that there will be 5 breaches in September.

All of these are due to cancellations, and the patient due to receive treatment in September has requested this date.

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

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%.

Table 4: 18 weeks Referral to Treatment (RTT)

Perf	***Jul-14***	***Aug-14***	***Sep-14***	***Oct-14***	***Nov-14***	***Dec - 14***	***Jan-15***	***Feb-15***	***Mar 15***	***Apr-15***	***May 15***	***Jun-15***	***Jul-15***
Overall	91.5%	90.4%	90.6%	90.1%	90.0%	90.8%	90.1%	90.0%	90.1%	90.6%	90.3%	90.5%	90.6%
Admitted Pathways	77.4%	74.7%	78.5%	67.5%	72.4%	76.5%	71.3%	71.5%	71.6%	72.2%	71.9%	77.8%	81.6%
Non-admitted Pathways	93.9%	92.7%	92.4%	93.8%	92.8%	92.9%	92.3%	92.8%	93.2%	94.0%	93.6%	92.4%	92.2%

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.

It is anticipated that 18wks performance will continue to improve as outpatient waiting times are reduced.

Diagnostics

The national target is that no patient waits more than 6 weeks for one of a number of identified key diagnostic tests. Locally this target has been set at 4 weeks. A query was raised over the accuracy of the breach numbers within MRI and CT. Examination of the numbers found that the wrong date field was being used for reporting. This resulted in a significant increase in patients waiting over 4 weeks for MRI & CT in July 2015. The report has since been amended and the correct date field is now being used. Significant improvements can be noted from July to August 2015. At the end of August 2015 there were 5 breaches of the 6 week standard in cystoscopy. The 4 week performance is in Table 5:

Table 5: Diagnostic Performance over Four Weeks

Diagnostic	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb-15*	*Mar-15*	*Apr-15*	*May-15*	*Jun-15*	*Jul-15*	*Aug-15*
Endoscopy	0	0	0	0	0	0	0	0	0	7	6	23	15
Colonoscopy	23	0	23	7	43	37	9	5	10	9	14	29	15
Cystoscopy	2	5	9	15	26	1	0	8	18	4	5	9	9
MRI	0	0	0	1	0	0	0	0	0	2	15	270	96
CT	0	0	20	0	0	0	3	0	0	3	3	105	0
US (non obstetric)	4	0	43	82	101	56	0	0	0	0	3	1	12
Barium	1	0	0	0	0	0	0	0	0	0	1	0	0
Total	**30**	**5**	**95**	**105**	**170**	**94**	**12**	**13**	**28**	**25**	**47**	**438**	**147**

Please Note: August figures unavailable at time of reporting

Colonoscopy – colonoscopy waiting times improved in May 2015, but have deteriorated since then principally due to GI consultants returning to the weekday Medical on call rota. This will improve from October onwards when the new medical consultant comes into post which will allow the GI consultants to scope during their on call week. It will take approximately 16 sessions to clear back log and move into a waiting list balance.

Endoscopy – deterioration in performance principally due to extenuating circumstances resulting in a reduction in service provision. Extra UGI lists identified for Surgical Registrars. The endoscopy nurse specialist is also carrying out extra sessions.

MRI & CT – performance deteriorated during July 2015 as explained in the above narrative. The figures were further reviewed as the data field did not include the time to reporting. Consultant Radiologists increased the number of reporting sessions throughout August which has significantly improved the position.

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)

Unavailable	*Aug-14*	*Sept-14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb-15*	*Mar 15*	*Apr-15*	*May-15*	*Jun-15*	*Jul-15*	*Aug-15*
Un-avail patient advised	142 (64.8 %)	143 (64.1 %)	127 (57.0 %)	109 (54.5 %)	152 (62.8 %)	118 (58.4 %)	137 (60.4 %)	128 (59.0 %)	157 (65,4 %)	201 (70.0 %)	183 (65.4 %)	165 (66.8 %)	122 (60.7 %)
Un- avail medical	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 %)	86 (30.0 %)	97 (34.6 %)	82 (33.2 %)	79 (39.3 %)
In/pt day cases	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 %)	287 (24.0 %)	280 (23.6 %)	247 (21.1 %)	201 (17.3 %)

There has been a reduction in number of patients with patient advised unavailability. This is due to reduction in the number of patients requesting local health board treatment, following the planning of weekend operating lists in Orthopaedics.

Looking at medical unavailability, this has improved from 97 to 79 patients.

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 2015, 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.

Table 7: Cancer Waiting Times

Cancer Waiting Times	*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*	*Apr to Jun-15*
62-day standard	93.9%	98.84%	96.77%	98.77%	98.51%	97.44%	94.4%	98.7%
31-days standard	100%	98.44%	100%	100%	100%	100%	97.8%	100.0%

During April to June 2015 there was one breach of the 62-day target, a Urology patient who had treatment delayed for Brachytherapy treatment in NHS Lothian.

Delayed Discharges

The new national target of zero delays over 14 days came into place in April 2015.

As at the July 2015 Delayed Discharge Census, there were 4 patients waiting over 14 days and 10 patients waiting under 14 days.

As at the August 2015 Delayed Discharge Census, there was 1 patient waiting over 14 days and 10 patients waiting under 14 days.

In both May and June 2015 the Board reported 5 complex cases. In July there were 7 and in August there were 6.

Table 8: Delayed Discharges

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
No. Delayed Discharges over 2 weeks	8	1	3	4	1	5	3	0	0	0	1	4	1
Delayed Discharges under 2 weeks	5	6	7	2	12	2	9	4	4	1	8	10	10

Since the November 2014 census there has been a steady reduction in the occupied bed days lost due to standard delays.

As reported last time, performance in April and May 2015 was particularly good and as predicted this has not been maintained.

Since the start of June 2015 the number of delayed discharges has risen by a greater number than envisaged.

The average length of delay experienced by patients has been influenced by the difficulties MDTs have faced in managing AWI related delays and the volume of such patients within the system. Of particular concern has been the Partnership's performance against the 2 week target.

Senior Primary Care and Social Work managers have been working together to manage the causes of delays being reported. A recovery plan was agreed that included a commitment to:

- Expedite the filling of vacant posts within START
- Better utilisation of the Rapid Reaction Service
- Improved use of Flex beds
- An extension of the Improvement work within Community Hospitals by the Connected Care Team
- Further development of the Discharge Hub within BGH

This short term plan envisaged an improvement in performance such that by August 2015 the total number of delayed patients in the hospital system return to figure similar to those reported in April 2015.

The work reported previously being done to achieve further improvement in advance of next year's 72 hour target 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 9: AHP service performance against nine week target

AHP Service	*Aug-14*	*Sep-14*	*Oct-14*	*Nov-14*	*Dec-14*	*Jan-15*	*Feb-15*	*Mar-15*	*Apr-15*	*May-15*	*Jun-15*	*July-15*	*Aug-15*
Physiotherapy	1057	916	724	594	626	878	942	905	1042	1018	1037	987	728
Speech and Language Therapy	0	0	2	0	0	0	0	0	0	0	0	0	0
Dietetics	8	7	4	7	3	6	7	2	4	6	3	8	4 *
Podiatry	0	0	0	0	0	1	0	0	0	0	0	0	0
Occupational Therapy	14	13	9	8	13	8	7	6	11	11	9	10	14

*** Please Note:** August 2015 data for Dietetics should be treated as provisional

Physiotherapy

There are currently 664 patients waiting over 9 weeks for physiotherapy treatment. The Physiotherapy Service is implementing the new leadership structure which was agreed in May 2015 and is planned to be in place by end of December 2015. Where possible staffing gaps in service provision have been filled by temporary and locum staff: whilst the redesign is being implemented. The new structure will give stability to the service going forward. Within physiotherapy MSK service 2.0wte band 6 staff appointed for 18 months from July to reduce MSK waiting list.

The number of patients waiting over 9 weeks for physiotherapy has significantly reduced since July 2015 as result of backlog being addressed within the Musculoskeletal Service. Service is moving to NHS 24 MATS for self referrals. Impact predicted to divert 10-13% of referrals to self management.

A report was taken to the September 2015 meeting of the Strategy Board. Predicted MSK waiting times to reach 9 weeks mid March 2016, and 4 weeks by August 2016

Nutrition and Dietetics

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

Occupational Therapy

The waiting times within Occupational Therapy (OT) have fluctuated due to continued demand for specialist OT assessment within the Learning Disability Service (LDS). This combined with the vulnerability of there being only one specialist OT within the LDS and 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 stretched target remains at 98%.

Table 10: Performance against the emergency access standard.

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

The Board has maintained delivery of the Emergency Access Standard above the national standard of 95% in both July and August.

Closer daily review of all breaches is now in place and actions to address causes for breaches are being undertaken.

Breaches due to unavailability of beds have declined sharply from 27 in June to 11 in August.

The main cause for breaches in both July and August 2015 has been delay to first assessment. This is predominantly due to capacity for assessing and treating patients not matching demand at points during the day, particularly the evening and nights. Modelling of demand has been carried out and review of medical staffing scheduling. Additional medical staff are now on duty until midnight every day and will be extended to 3am during the winter as a test of change. Work to physically separate minor patients from more major cases is underway to try and maintain minor flow during periods of high demand. More detailed demand and capacity modelling of demand by hour is underway and will be used to adjust medical and nursing shift patterns.

Protocols are in development to streamline processes for surgical and orthopaedic patients being transferred to relevant wards in order to avoid delays waiting for specialty assessment. A project to establish MAU as the default location for all GP referrals to Medicine has commenced. This will reduce numbers of patients attending ED and delays due to waiting for medical review.

The close focus on the EAS standard will continue with the intention to achieve 98% performance in ED during the coming months.

Stroke Bundle

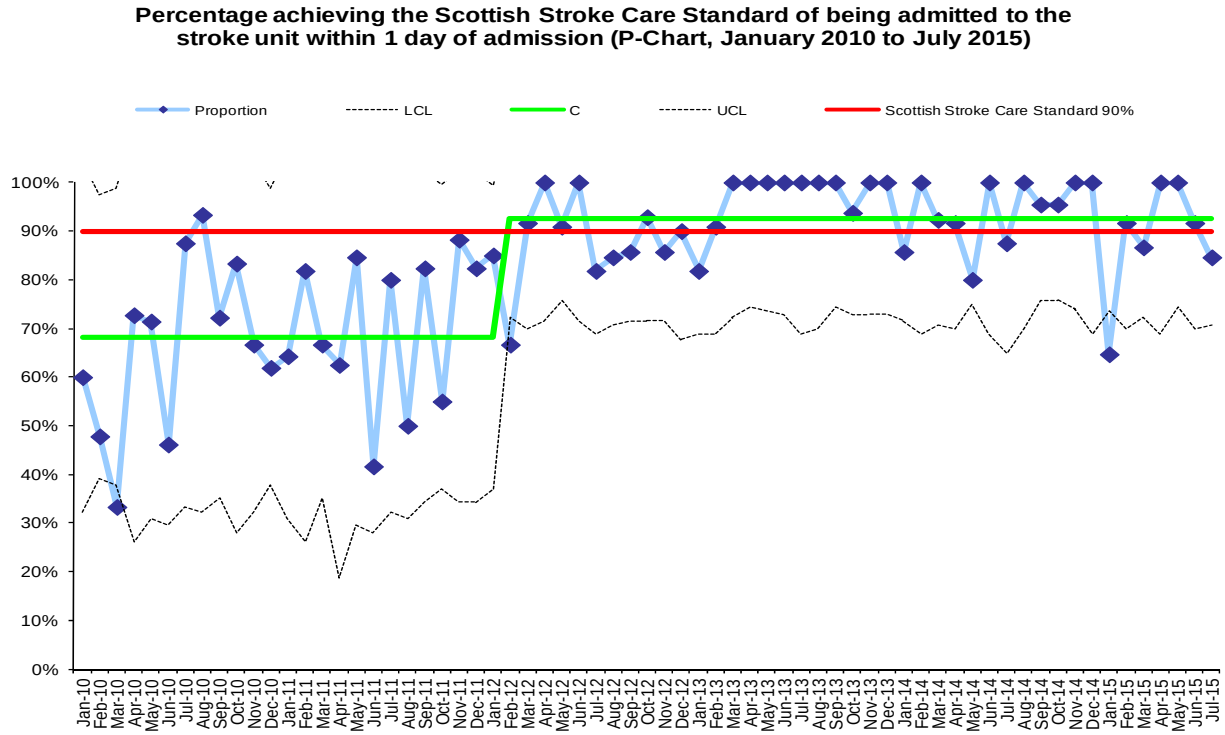
Having moved on from the HEAT target to Stroke BUNDLE measurement against individual patients, daily reporting of red/amber/green (RAG) status has consistently maintained the bundle elements as a high priority in care delivery.

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 2015 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.

All patients requiring access to the Stroke Unit have been transferred within the target timescales, unless they clinically required care elsewhere. 2 patients were on telemetry and requiring higher level of care however all other standards were fully met.



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). In Mental Health, this will apply to CAMHS, Psychological Therapies and Drug & Alcohol Treatments.

CAMHS

The requirement is that Health Boards will deliver 18 weeks referral to treatment (RTT) for Specialist Child and Adolescent Mental Health Services (CAMHS).

The target for waiting times is 90%. In the quarter to June 2015 CAMHS achieved 86.9% which is a reduction from the previous quarter (90.9%). As at the end of July 2015 there are 11 patients waiting over 18 weeks for this service.

Psychological Therapies

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

Performance is as reported below:

Table 11: Performance against 18 week RTT for Psychological Therapies

	Aug -14	***Sep - 14***	***Oct - 14***	***Nov - 14***	***Dec-14***	***Jan-15***	***Feb-15***	***Mar-15***	***Apr-15***	***May -15***	***Jun-15***	***Jul-15***	***Aug -15***
> 18 wks	87	73	106	60	75	46	38	42	33	28	37	31	27

Additional capacity has been recruited to reduce the number of patients waiting over 18 weeks.

As at the end of August, 16 of those patients waiting over 18 weeks have been offered an appointment in September 2015.

Drug & Alcohol Treatment

This is a national HEAT Standard where the ongoing requirement is to deliver 3 weeks RTT for 90% of progressed referrals. There is a local NHS Borders target of 95%.

Performance is consistently above the target with performance in April, May, June, July and August 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 ongoing challenges in Physiotherapy Waiting Times;
- the challenging context in delivering 4-hour ED standard;
- the challenges being faced to maintain no delays over 14 days for discharges and the requirement to work toward no delays over 72 hours.

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

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