**Borders NHS Board**

# ACCESS TO TREATMENT REPORT FEBRUARY 2016

## 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* | *Feb-15* | *Mar-15* | *Apr-15* | *May-15* | *Jun-15* | *Jul-15* | *Aug-15* | *Sep-15* | *Oct-15* | *Nov-15* | *Dec-15* | *Jan-16* | *Feb-16* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 9-12 weeks | 150 | 133 | 98 | 115 | 70 | 57 | 70 | 60 | 57 | 47 | 82 | 115 | 88 |
| >12weeks | 52 | 27 | 17 | 19 | 7 | 5 | 5 | 3 | 1 | 0 | 1 | 4 | 10 |
| **Total Waiting** | 1,026 | 1,036 | 913 | 908 | 904 | 923 | 964 | 906 | 856 | 867 | 966 | 904 | 940 |

At the end of February the number of patients reported waiting over 12 weeks has increased, due to a number of short-notice cancellations during the first two months of 2016, mainly due to bed availability.

There are continuing long-term challenges around capacity in Orthopaedics, and we are working through options to address these. In the interim, weekend operating continues with the support of Synaptik.

## Stage of Treatment – Outpatients

The number of patients reported as waiting longer than 9 and 12 weeks has increased over the past two months, this is mainly due to issues within ENT and Oral Surgery.

**Table 2: New Outpatient Stage of Treatment – patients waiting**

| *Available Outpatient* | *Feb 15* | *Mar 15* | *Apr-15* | *May 15* | *Jun-15* | *Jul-15* | *Aug-15* | *Sep-15* | *Oct-15* | *Nov-15* | *Dec-15* | *Jan-16* | *Feb-16* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| >9 weeks | 959 | 698 | 757 | 751 | 743 | 682 | 725 | 653 | 756 | 813 | 1,008 | 1230 | 887 |
| >12weeks | 497 | 285 | 350 | 346 | 398 | 320 | 259 | 222 | 263 | 366 | 513 | 699 | 540 |
| Total Waiting | 4,620 | 4,509 | 4,436 | 4,643 | 4,874 | 4,811 | 4,647 | 4,642 | 4,847 | 4,867 | 4,783 | 4678 | 4390 |

Currently there are pressures within:

- Cardiology - capacity is an ongoing problem, and work is ongoing with the service to look for solutions to this.
- Chronic Pain - where we are in the process of implementing revised administrative processes and additional short-term capacity.
- ENT - is a particular concern at present. An additional Consultant post has been appointed, however there are still significant challenges around capacity. Two weekends of Synaptik clinics are planned for March, funded by Scottish Government.
- Diabetics / Endocrinology - also continue to be challenging. Additional short-term capacity has been organised with local clinicians whilst a longer term solution is identified.
- Oral Surgery – sickness absence of the Consultant Surgeon has led to significant pressures in this area. At present short term weekend locum cover has been organised mostly through Synaptik.

- Gastroenterology – demand for the service has been over the capacity of the service. We are currently organising extra clinics within the service to help with the increasing demand.
- Dermatology – we are currently organising extra clinics to help reduce the backlog of patients that are building up however coming into the summer months will see our demand further increase.

## 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)* | ***Feb-15*** | ***Mar-15*** | ***Apr-15*** | ***May-15*** | ***Jun-15*** | ***Jul-15*** | ***Aug-15*** | ***Sep-15*** | ***Oct-15*** | ***Nov-15*** | ***Dec-15*** | ***Jan-16*** | ***Feb-16*** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **>12week** | 40 | 35 | 26 | 9 | 15 | 5 | 7 | 5 | 2 | 2 | 0 | 2 | 5 |

The number of TTG breaches reported has started to increase 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.

The largest number of cancellations are to do the unavailability of beds within the hospital which is causing issues with the underutilisation of theatre lists.

## 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*** | ***Feb-15*** | ***Mar 15*** | ***Apr-15*** | ***May 15*** | ***Jun-15*** | ***Jul-15*** | ***Aug-15*** | ***Sep-15*** | ***Oct-15*** | ***Nov-15*** | ***Dec-15*** | ***Jan-16*** | ***Feb-16*** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall | 90.0% | 90.1% | 90.6% | 90.3% | 90.5% | 90.6% | 90.1% | 90.2% | 90.3% | 90.0% | 90.1% | 90.7% | 90.0% |
| Admitted Pathways | 71.5% | 71.6% | 72.2% | 71.9% | 77.8% | 81.6% | 80.5% | 80.3% | 78.3% | 82.0% | 81.0% | 81.0% | 81.6% |
| Non-admitted Pathways | 92.8% | 93.2% | 94.0% | 93.6% | 92.4% | 92.2% | 91.6% | 91.8% | 92.3% | 91.3% | 91.3% | 92.2% | 91.1% |

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 reduce due to the number of patient expected to breach in ENT, Gastroenterology and Dermatology. ENT in particular will be challenging during March 2016, due to the increased number of clock stops with Synaptik weekends, and this may result in performance being reported at less than 90%.

## 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. In February 2016 there were zero breaches over 6 weeks, the first time since May 2015. The 4 week performance is included in Table 5 below:

**Table 5: Diagnostic Performance over Four Weeks**

| *Diagnostic* | *Dec -14* | *Jan-15* | *Feb -15* | *Mar -15* | *Apr-15* | *May -15* | *Jun -15* | *Jul-15* | *Aug -15* | *Sep -15* | *Oct-15* | *Nov -15* | *Dec -15* | *Jan-16* | *Feb -16* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Endoscopy | 0 | 0 | 0 | 0 | 0 | 7 | 6 | 23 | 15 | 23 | 24 | 13 | 22 | 30 | 14 |
| Colonoscopy | 43 | 37 | 9 | 5 | 10 | 9 | 14 | 29 | 15 | 36 | 32 | 9 | 11 | 19 | 5 |
| Cystoscopy | 26 | 1 | 0 | 8 | 18 | 4 | 5 | 9 | 9 | 10 | 11 | 10 | 4 | 0 | 0 |
| MRI | 0 | 0 | 0 | 0 | 0 | 2 | 15 | 270 | 96 | 41 | 48 | 70 | 37 | 18 | 27 |
| CT | 0 | 0 | 3 | 0 | 0 | 3 | 3 | 105 | 0 | 9 | 27 | 18 | 23 | 5 | 8 |
| US (non obstetric) | 101 | 56 | 0 | 0 | 0 | 0 | 3 | 1 | 12 | 10 | 0 | 0 | 0 | 2 | 0 |
| Barium | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 8 | 0 |
| **Total** | **170** | **94** | **12** | **13** | **28** | **25** | **47** | **438** | **147** | **129** | **142** | **122** | **97** | **82** | **54** |

**Colonoscopy** – Trends have improved over the last 6 months but there is an anticipated pressure from May 2016 due to GI Consultants contributing more to General Medical rota. We will continue to monitor performance against the standard and discuss any corrective action with the service as necessary in order to adjust waiting times down to within the four week standard.

**Endoscopy** –
Deterioration in performance is due to increased referral rates and reduction in service provision to accommodate a training list for surgical registrars. Additional lists continue to be carried out by the Nurse Endoscopist to meet waiting times targets however increasing demand is putting pressure on the service. At present waiting time for urgent referrals is 4 weeks and this rises to 6 weeks for routine. The service will be looking at its demand and capacity, and succession planning, going forward.

**MRI & CT** – Consultant Radiologists have continued the increased number of reporting sessions with 14 additional sessions per month throughout January and February which has maintained the position. We continue to support additional ad hoc MRI, CT and Ultrasound sessions in order to maintain the current reported position. This remains under review as part of a wider Service review aimed at addressing capacity issues on a sustainable basis given current pressures.

## 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* | *Feb-15* | *Mar 15* | *Apr-15* | *May-15* | *Jun-15* | *Jul-15* | *Aug-15* | *Sep-15* | *Oct-15* | *Nov-15* | *Dec-15* | *Jan-16* | *Feb-16* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Un-avail patient advised | 137 (60.4 %) | 128 (59.0 %) | 157 (65,4 %) | 201 (70.0 %) | 183 (65.4 %) | 165 (66.8 %) | 122 (60.7 %) | 95 (53.7 %) | 81 (50.3 %) | 81 (48.2 %) | 60 (40.8 %) | 74 (44.8 %) | 81 (48.5 %) |
| Un- avail medical | 90 (39.6 %) | 89 (41.0 %) | 83 (34.6 %) | 86 (30.0 %) | 97 (34.6 %) | 82 (33.2 %) | 79 (39.3 %) | 82 (46.3 %) | 80 (49.7 %) | 87 (51.8 %) | 87 (59.2 %) | 91 (55.2 %) | 86 (51.5 %) |
| In/pt day cases | 227 (18.1 %) | 217 (20.9 %) | 240 (20.8 %) | 287 (24.0 %) | 280 (23.6 %) | 247 (21.1 %) | 201 (17.3 %) | 177 (16.3 %) | 161 (15.8 %) | 168 (16.2 %) | 147 (13.2 %) | 165 (15.4 %) | 167 (15.1 %) |

**Table 7: Monthly Unavailability by Specialty (as of 29th February 2016)**

| | Available | | | | Unavailable | | | |
|---|---|---|---|---|---|---|---|---|
| ***Specialty*** | **0 - 9 Weeks** | **10 - 12 Weeks** | **12+ Weeks** | **Total** | **Medical Unavailability** | **Patient Advised Unavailability** | **Total** | **Percentage Unavailable** |
| ENT | 47 | 2 | | 49 | 2 | 5 | **7** | 4.2% |
| General Surgery | 125 | 21 | 5 | 151 | 19 | 21 | **40** | 24.0% |
| Gynaecology | 69 | 3 | | 72 | 3 | 4 | **7** | 4.2% |
| Ophthalmology | 154 | 3 | | 157 | 7 | 4 | **11** | 6.6% |
| Oral Surgery | 40 | 3 | | 43 | 1 | 0 | **1** | 0.6% |
| Other | 108 | 1 | | 109 | 1 | 6 | **7** | 4.2% |
| Trauma & Orthopaedics | 242 | 35 | 5 | 282 | 46 | 39 | **85** | 50.9% |
| Urology | 67 | 10 | | 77 | 7 | 2 | **9** | 5.4% |
| **Total** | **852** | **78** | **10** | **940** | **86** | **81** | **167** | **15.1%** |

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 remained static at approximately 90 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 8: Cancer Waiting Times**

| *Cancer Waiting Times* | *Jan to Mar-14* | *Apr to Jun-14* | *July to Sept-14* | *Oct to Dec-14* | *Jan to Mar-15* | *Apr to Jun-15* | *Jul to Sep-15* | *Oct to Dec-15* |
|---|---|---|---|---|---|---|---|---|
| 62-day standard | 96.77% | 98.77% | 98.51% | 97.44% | 94.4% | 98.7% | 98.5% | 98.5% |
| 31-days standard | 100% | 100% | 100% | 100% | 97.8% | 100.0% | 97.8% | 98.2% |

During October to December 2015 there was one breach of the 62-day target, an ENT patient who had treatment delayed for Surgery, and one breach of the 31-day target, a Urology patient, receiving surgical treatment in NHS Borders who had treatment delayed by cancellation due to bed availability.

## Delayed Discharges

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

As at the February 2016 Delayed Discharge Census, there were 11 patients waiting over 14 days and 14 patients waiting under 14 days.

As at the January 2016 Delayed Discharge Census, there were 13 patients waiting over 14 days and 3 patients waiting under 14 days.

**Table 9: Delayed Discharges**

| | Nov - 14 | Dec - 14 | Jan -15 | Feb -15 | Mar -15 | Apr -15 | May-15 | Jun - 15 | Jul-15 | Aug -15 | Sep -15 | Oct -15 | Nov -15 | Dec -15 | Jan -16 | Feb -16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. Delayed Discharges over 2 weeks | 4 | 1 | 5 | 3 | 0 | 0 | 0 | 1 | 4 | 1 | 4 | 6 | 3 | 5 | 13 | 11 |
| Delayed Discharges under 2 weeks | 2 | 12 | 2 | 9 | 4 | 4 | 1 | 8 | 10 | 10 | 5 | 12 | 9 | 11 | 3 | 14 |

As reported last time, since the start of June 2015 the number of delayed discharges has risen by a greater number than envisaged.

The key reasons for delay experienced by patients has been influenced by a number of reasons. There are some issues relating to the unavailability of particularly complex care packages for home care in some areas; choices of care home placements; and a significant number of complex cases, specifically Adults with Incapacity related delays and one move only cases. There has been a subsequent reduction in performance against the 2 week target and the associated Bed Days occupied by people in delay. NHS and Social Work managers continue to work together to help address and manage the causes of delays being reported. Additional support is being given to the daily monitoring arrangements to ensure individual discharge plans are set and realised.

Dedicated Care Managers have been located in each of the Community Hospitals to provide a screen-out approach for social care requirements. This is being tested under the auspices of the Winter Plan.

Scottish Borders Council and NHS are reviewing the Guardianship and Adult capacity processes to see if we can improve performance. We are also working with SBCares, to improve access to home care.

The updated action plan relating to the achievement of the 72 hours will outline the whole system work required to achieve the target.

## 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 10: AHP service performance against nine week target**

| *AHP Service* | *Feb-15* | *Mar-15* | *Apr-15* | *Ma-15* | *Jun-15* | *Jul-15* | *Au-15* | *Sep-15* | *Oct-15* | *Nov-15* | *Dec-15* | *Jan-16* | *Feb-16* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Physiotherapy | 942 | 905 | 1042 | 1018 | 1037 | 987 | 728 | 439 | 327 | 147 | 88 | 68 | 126 |
| Speech and Language Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Dietetics | 7 | 2 | 4 | 6 | 3 | 8 | 4 | 5 | 9 | 9 | 3 | 7 | 15* |
| Podiatry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Occupational Therapy | 7 | 6 | 11 | 11 | 9 | 10 | 14 | 11 | 12 | 11 | 12 | 16 | 17 |

***** data not checked at time of report.

### Physiotherapy

As of end of February 2016 there were 126 patients waiting over 9 weeks for physiotherapy treatment. This is a significant improvement since July 2015. The Physiotherapy Service is implementing the new workforce profile which was agreed in May 2015 and this is planned to be in place by April 2016. 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 but will still have 16% vacancy as of 1 April 16.

Within Physiotherapy MSK service 2.0wte Band 6 staff have been appointed for 18 months from July 2015 to reduce MSK waiting list and support capacity to introduce new ways of working.

The service is implementing NHS 24 MATS for self referrals on 29th February 2016. Impact predicted to divert 10-13% of referrals to self management.

A report was taken to Strategy & Performance Committee in January 2016 outlining latest action plan. Currently MSK waiting times sitting at an average of 6 weeks. The service will

be working on areas for improvement particularly on DNAs which is currently sitting at 6%, Cancellations and introducing new models of care.

**Nutrition and Dietetics**
Dietetic breaches are predominantly related to capacity issues for highly specialised dieticians. Actual number of long waits less than reported as data checking not complete at time of report. Measures are in place to triage referrals and use clinic capacity effectively. Community dietetic service is under significant pressure, resulting in a reduction in clinic appointments for routine referrals. There will be a number of vacancies in the next 2 months – recruitment process started. The service is attempting to progress dietetic led IBS and Coeliac Disease clinics to improve care pathways and reduce pressure on GI clinics. The service planned to increase capacity of DESMOND programme but funding is not now available.

**Occupational Therapy**
The waiting times are for Learning Disability assessment services, where there is one Occupational Therapist Borders wide. Currently there has been a demand for specialist input to 3 housing projects for both individual and environmental assessments. This is time limited and the amount of work will reduce in the next 3-6 months, however we are also exploring support from OTs in SBC Housing and adaptations services. This will enable more focus on AMPS and Sensory Integration assessments to be undertaken. The waiting list is being reviewed and managed weekly within the LD Team.

## 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 11: Performance against the emergency access standard.**

| *Emergency Access* | *Feb-15* | *Mar-15* | *Apr-15* | *May-15* | *Jun-15* | *Jul-15* | *Aug-15* | *Sep-15* | *Oct-15* | *Nov-15* | *Dec-15* | *Jan-16* | *Feb-16* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Flow 1 | 97% | 97% | 98% | 98% | 98% | 99% | 97% | 99% | 98% | 99% | 99% | 99% | 99% |
| Flow 2 | 92% | 86% | 93% | 93% | 94% | 94% | 95% | 95% | 91% | 97% | 94% | 98% | 98% |
| Flow 3 | 81% | 85% | 96% | 96% | 96% | 97% | 97% | 94% | 94% | 93% | 96% | 91% | 91% |
| Flow 4 | 90% | 89% | 94% | 94% | 91% | 94% | 93% | 91% | 94% | 99% | 93% | 94% | 94% |
| **Total** | **91%** | **91%** | **95%** | **97%** | **96%** | **97%** | **96%** | **95%** | **96%** | **97%** | **96%** | **96%** | **96%** |

The Board has maintained delivery of the Emergency Access Standard (EAS) consistently above the national standard of 95% through January and February. This is as a result of close attention to patient flow and close monitoring and early escalation of patient delays. Over the winter period from December to January, there has been a reduction in breaches due to patients waiting for a medical beds, down from 431 to 67 over the period and no increase in breaches due to other reasons, including delay to first assessment.

EAS reported performance did not include the Acute Assessment Unit (AAU) in December and January, as attendances were recorded as admissions during this time. However, combined Emergency Department/AAU performance for December and January also

exceeded 95%. The Acute Assessment Unit performance is included in February data from 22nd February 2016.

We continue to aim to achieve the 98% local target for EAS performance.

**Stroke Bundle**

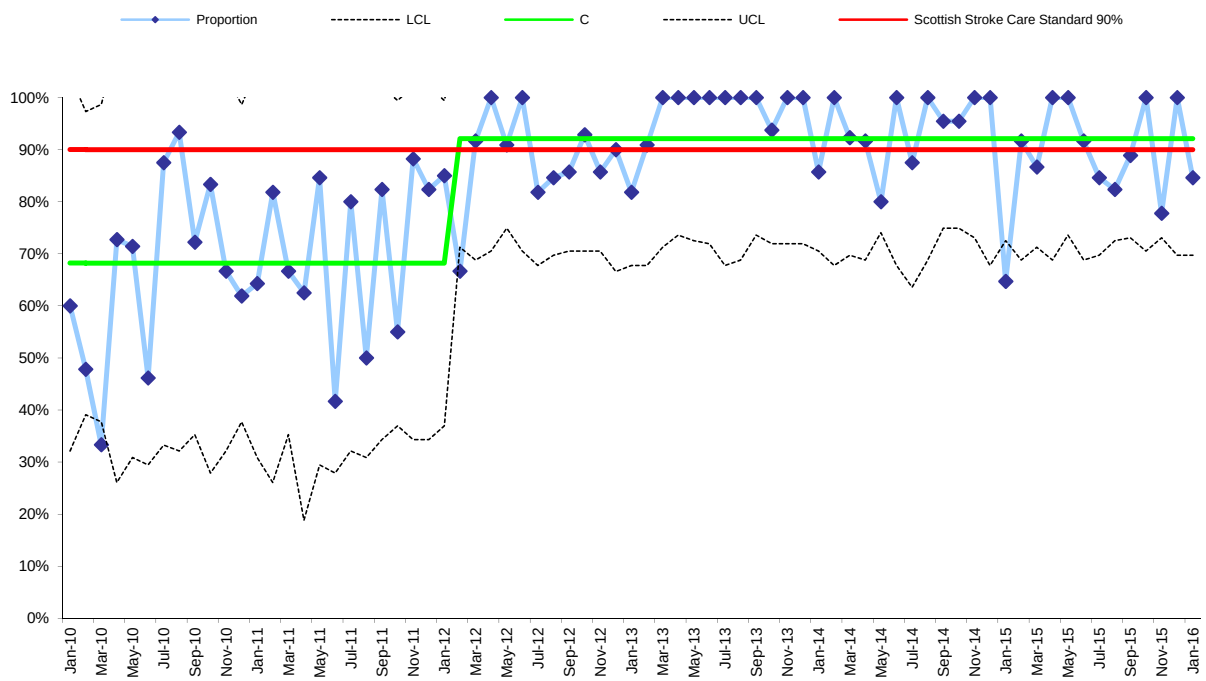
Having moved on from the HEAT target to Stroke BUNDLE measurement against individual patients, daily reporting of red/amber/green (RAG) status has consistently maintained the bundle elements as a high priority in care delivery.

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

The 90% standard for the full stroke bundle was missed in January 2016. This was due op 2 patients who did not transfer to the stroke unit within timescales – one was too unwell and required HDU support and one was planned to transfer to another Health Board who were unable to take them. One patient did not receive aspirin within first 24 hours, due to being discharged day after admission, prior to receiving first dose. All other standards continued at 100%.

**Percentage achieving the Scottish Stroke Care Standard of being admitted to the stroke unit within 1 day of admission (P-Chart, January 2010 to January 2016)**



## 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

In the quarter to December 2015 CAMHS achieved 76.7% performance, which is a reduction from the previous two quarters (86.9% to June 2015; 90.9% to March 2015).

As at the end of February 2016 there are 7 patients waiting over 18 weeks for this service which equates to 88.5% performance. We have not achieved green status by the end of February 2016 as we had aimed for but performance is improving and is expected to reach 90% over the coming months.

We continue to be challenged with the target as we have been unable to recruit a nurse and a Consultant Psychiatrist, both of which are key posts to support the delivery of the target.

A locum was put in place from Monday 9th November which will have an impact on waiting times, and we have implemented specific allocations meetings out with the MDT to retain focus on referrals and the waiting list.

## Psychological Therapies

The Psychological Therapies waiting times target is that 90% of patients will be seen within 18 weeks RTT.

Performance is as reported below:

**Table 12: Performance against 18 week RTT for Psychological Therapies**

| | ***Mar-15*** | ***Apr-15*** | ***May-15*** | ***Jun-15*** | ***Jul-15*** | ***Aug-15*** | ***Sep-15*** | ***Oct-15*** | ***Nov-15*** | ***Dec-15*** | ***Jan-15*** | ***Feb-15*** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Current wait> 18 wks** | 42 | 33 | 28 | 37 | 31 | 27 | 22 | *53* | *62* | *55* | *50* | *68* |
| **Actual Wait >18 wks (%)** | 83% | 62% | 63% | 74% | 61% | 64% | 90% | 79% | 78% | 65% | 74% | 85% |

In September, that target was met with 2 patients waiting >18 weeks received a Psychological Therapy (90%), however there was a reduction in the number of patients seen that month so this was a blip in the data.

Since low performance in December, there has been an increase to 85% of patents being seen within 18 weeks in February 2016 (against a target of 90%).

Actions continue as previously described, and we continue to allocate resources to the areas with the longest waits.

Some of the long waits are the result of a loss of expertise in a particular specialised therapy (EMDR) – which is difficult to replace as there is a 12 month training required. We have a member of staff having recently commenced training in EMDR.

**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%.

Overall performance has been consistently above the target throughout 2015/16 however in February 2016 decreased significantly to 84%. The Addaction Service had 5 clients not seen within the target and therefore the overall performance reduced to 84%. This was due to a combination of service capacity and also process issues which have now been resolved.

Actions ongoing to ensure performance continues above target are:

1. All referrals received by admin and promptly marked with date stamp.
2. Daily duty worker screens and disperses referrals to senior nursing staff to allocate.
3. Admin continue to monitor and manage RTT time until1st appointment attended.
4. Any problems are potential breaches are reported immediately to Team Manager and addressed.
5. Responsible managers meet quarterly to discuss performance and updates.

**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 |

**Approved by**

| Name | Designation | Name | Designation |
|---|---|---|---|
| Nicky Berry | Associate Nurse Director / Head of Midwifery & General Manager for Women's & Children's Services | Susan Manion | Chief Officer, Health and Social Care |

**Author(s)**

| Name | Designation | Name | Designation |
|---|---|---|---|
| Katie Morris | General Manager – Planned Care and Commissioning | | |