



WAITING TIMES

1. INTRODUCTION

The purpose of the paper is to inform the NHS Board of the position at 31 May 2007 of the performance for waiting times compared to the planned trajectory identified in the Local Delivery Plan. The Plan has recently been updated to include the planned trajectory for 2007/08. The significant milestone is 31 December 2007 by which time many of the guarantees have to be delivered. A brief commentary is provided where performance in April is not in line with the trajectory and should be read in conjunction with the statistics shown in Appendix 1.

2. INPATIENTS AND DAY CASES

The six-month guarantee for inpatients and day cases has been maintained with no patients waiting over eighteen weeks at the end of My 2007. This represents continued delivery of a Ministerial Waiting Time Guarantee twelve months in advance of the guarantee date (31 December 2007).

Orthopaedics continues to represent a pressure. Recruitment of additional permanent staff continues, linked to service redesign. Additional capacity has been negotiated at Golden Jubilee and this will continue through 2007/08. In addition, discussions are continuing with Golden Jubilee over a proposal to establish a joint consultant appointment in Orthopaedics between NHS Lanarkshire and Golden Jubilee. This would be on a pilot basis for a period of eighteen months commencing November 2007. Due to the increase in permanent capacity with recruitment of additional clinical staff, it has proved possible to cease reliance on waiting list initiatives. The exception has been limited use of the Independent Sector for spinal services.

3. OUTPATIENTS

The number of outpatients waiting over eighteen weeks has reduced from 2986 to 2541 during May 2007. An analysis of the position at the end of April identified six specialties where the number of patients over eighteen weeks exceeded 100. Those specialties were Dermatology (605), ENT (331), Gynaecology (301), Neurology (109), Ophthalmology (301) and Orthopaedics (612). The NHS Board met recently with the Delivery Unit to discuss the position with each specialty and to discuss the actions taking place and planned over the coming months to reduce the number of patients over eighteen weeks. The Delivery Unit expressed satisfaction with the plans presented to them and shared the confidence of the NHS Board that the national guarantee

for out patients will be achieved by the end of calendar year 2007. They have however asked the NHS Board to revise the out patient trajectory to the end of the year and to share that with them in July 2007. Whilst each specialty is the subject of service redesign with involvement of colleagues from both primary and secondary care, it is also accompanied by measures to increase capacity through recruitment of additional clinical staff on a temporary as well as permanent basis. The priority of the former is to remove the backlog of activity whilst the latter aims to provide sustainable solutions to deliver a maximum wait of eighteen weeks. The programme of staff recruitment includes appointment of:

- Nurse specialists to deliver additional nurse led dermatology clinics; General Practitioners with a special interest in Dermatology.
- Nurse specialists to deliver nurse led tonsil clinics, advanced ear care and nasal clinics and nurse led services in primary care.
- Consultant staff in Neurology and Ophthalmology (short term).
- Physiotherapy and Podiatry staff as part of an extended scope practitioner service.

Internal waiting list initiatives are operating in each specialty to remove the backlog. This is supplementing routine activity together with the additional activity generated by staff recruitment and increased access to capacity at the Golden Jubilee Hospital. The capacity and demand work undertaken for each specialty gives confidence that the investments established to date and planned will deliver a sustainable solution to achieve a maximum wait of eighteen weeks.

In addition, there is work in progress to improve the referral process between primary and secondary care to ensure that referral information is robust and in a format that informs streaming of patients to the appropriate clinician. Current development of a clinical model for each specialty will also in time identify the optimal patient pathway with a clearer sense of where patients should most appropriately be seen, when and by whom. This will influence the nature and extent of demand on the hospital out patient service.

4. INPATIENTS/DAY CASES ASCs

There has been a further reduction in the number of patients with an ASC code. This reflects robust management of the ASC list linked to implementation of New Ways. The number of patients with an ASC code at end of May 2007 was 1597. This is in line with the trajectory. The target for end of calendar year 2007 is 750. The NHS Board met recently with the Delivery Unit to discuss the detail of the implementation plan. Confidence was expressed with the approach being adopted and progress achieved to date.

The Project Board, established to deliver the national guarantee by 31 December 2007, is meeting routinely with work in progress to spread awareness amongst staff in both primary and secondary care of the main implications of New Ways and how it is to be applied across Lanarkshire. It is anticipated that the new IT system to facilitate implementation of New Ways will be released for testing to the NHS Board in June 2007 with a 'go live' date of October 2007.

5. CANCER

Performance in breast cancer has met the expected target. Compliance for colorectal, ovarian and lung cancers was 92.3%, 100% and 82% respectively. One colorectal patient did not receive their first treatment within the guarantee period. Four lung patients fell into that category.

Publication of ISD national cancer returns for the period October to December 2006 highlighted issues of performance for selected tumour types in Lanarkshire. In particular performance in Urology and Upper GI fell below 50% compliance with national waiting time guarantee. This has prompted the Delivery Unit to organize a diagnostic visit to Lanarkshire to examine patient pathways in selected tumours. This will include Urology, Upper GI, Head and Neck and Lung. The diagnostic visit will provide the opportunity for clinicians from other NHS Boards to walk the current patient pathway for each tumour type and to advise the NHS Board of areas that in their view could be improved. This will be translated into an action plan with implementation the subject of monitoring and review. The diagnostic visit will take place on 27/28 June 2007.

Over the most recent six-month period, there has been improvement in performance for four tumour types. Those are breast, colorectal, lung and ovarian. In each, referral protocols have been agreed between primary and secondary care with recruitment of patient trackers for each tumour type. The referral process has included the introduction of 'straight to test' that has significantly reduced the patient journey. The process to improve performance in the remaining five tumour types (Urology, Upper GI, Head and Neck, Melanoma and Lymphoma) has been less focused although this has improved recently with development of draft referral protocol for each tumour type (the Urology referral was agreed and implemented in the first week of June 2007), the identification of activity backlog and the nature and extent of capacity required to deliver the guarantee that urgent GP referrals will receive their first treatment within 62 days of receipt of referral. For Urology that will result in the backlog being removed within seven weeks commencing 23 June with an immediate ability (with effect from 25 June) to manage new urgent GP referrals within the 62 day maximum period. Whilst this will result in a significant improvement in service to the patient it will impact on performance reporting with an increased number of patients being seen over the next two month period who will have exceeded 62 days. A similar piece of work is being undertaken for Upper GI and Head and Neck with an expectation that action plans to address the back log and deliver a service within the 62 day maximum wait will be agreed during July. That will be followed by action plans for Melanoma and Lymphoma.

A contributing factor to improved management of the patient journey is recruitment of patient trackers. To date nine trackers have been appointed. There is agreement that number should be increased to eleven with adjustments made to the number of tumour types covered by the patient trackers as well as line management arrangements. Appointments to those additional posts have now been made. From 25 June all nine tumour types will have a patient tracker reporting to a service manager in the appropriate surgical, medical or diagnostic division. Reporting to the NHS Board across all nine tumour types will commence on completion of the first 62-day cycle.

Protocols to more effectively manage inter hospital transfer of patients for investigation/treatment has recently been agreed at regional level. Discussions have taken place with colleagues in Greater Glasgow and Clyde and Ayrshire and Arran and there is work in progress to populate the agreements with relevant information and to move to implementation of and compliance with the agreement.

6. DIAGNOSTICS

The action plans for endoscopy and radiology are being implemented as reflected in the reduced maximum waits in line with the trajectory. No patient is currently waiting over nine weeks. The short-term initiatives in endoscopy and radiology are currently being replaced by permanent capacity to deliver and sustain the nine-week maximum wait beyond May 2007. Capacity is also being increased in line with the agreed business cases through purchase of equipment and

software upgrades. Some difficulties are being experienced in the recruitment of additional staff particularly in radiology and activity shortfalls are currently being met through internal waiting list initiatives.

By the end of calendar year 2007, it will be necessary to include investigations within an eighteen-week total patient journey. It will therefore be necessary to reduce further the maximum diagnostic wait to deliver the improved guarantee. Discussions within the Diagnostic Collaborative have identified the need for additional capacity in both radiology and endoscopy to enable the patient journey to be completed within the eighteen-week period. This, as previously, is linked to service redesign. The nature and extent of that additional capacity has been identified, the detail of which has been shared with the Delivery Unit. They have since expressed support for the plans submitted. The Delivery Unit has also indicated that a financial allocation will be released to support implementation of the plan. NHS Lanarkshire intend to reduce the maximum wait for radiology to four weeks by August 2007.

7. **UNSCHEDULED CARE**

Performance in May is 96% compliance. This is in line with the trajectory and is a level of performance that has been sustained over a number of weeks. It reflects actions taken by the Unscheduled Care Collaborative designed to reduce demand, improve patient flow and support staff to improve performance. Those measures have had a considerable impact. They include:

- Introduction of new medical staffing rotas within A&E Department at Wishaw General to provide additional manpower to address patient flows.
- All emergency admissions to Wishaw General are being tracked jointly on an individual patient basis to identify opportunities to reduce the number of 'avoidable admissions'. This will link to the care management pilot and the new arrangements for GP management of patients within care homes.
- The role of ward managers to deliver improved management and availability of medical and surgical bed has been given a major focus.
- A change has been made to the management of A&E and ECU at Wishaw General with secondment of the UCCP Programme Manager as the operational and clinical lead.

Each action is being monitored and reviewed by the Unscheduled Care Collaborative.

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