NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 30 November 2020**
Title:	**Performance Report**
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1. Purpose

This is presented to the NHS Board members for:
- Discussion

This paper relates to:
- Government policy/Directive

This aligns to the following NHS Scotland quality ambitions:
- Safe
- Effective
- Person Centred

2. Report summary

2.1 Situation

The health and social care system as a whole across Ayrshire and Arran continues to work collectively to effectively manage and safely respond to the ongoing challenges of COVID-19. Ayrshire and Arran moved into our remobilisation and recovery planning in July 2020 to restart as many of our normal services as possible, as safely as possible. Extensive plans have also been developed to ensure that we have the capacity that is necessary to deal with the continuing presence of COVID-19; and to prepare the health and care services for the winter season.

The Strategic Emergency Management Team (EMT) oversees the re-mobilisation and recovery plans and where relevant, high level summaries of current plans, provided by the Senior Responsible Officers for each service area, have been included within this report.

This report provides an overview of Unscheduled Care (2.3.1) and Planned Care (2.3.2) performance to ensure that NHS Board members are sighted on the corresponding impact of COVID-19 across the system as a whole.

NHS Board members are asked to discuss the information provided in this report which provides assurance that systems and procedures are in place to continue to monitor performance, including highlighting where the impact of COVID-19 has affected provision of unscheduled and planned care for our citizens.

2.2 Background

Cancelling outpatients and elective appointments; in addition to diagnostic tests at the outset of the current COVID-19 pandemic has had a significant impact on key compliance targets. Performance is therefore not truly comparable to system performance prior to the start of the period of the COVID-19 pandemic, as cancellation of non-urgent elective treatment was a necessary step to ensure the safety of the population.

Some waiting times measures remained stable throughout the initial response of COVID-19 and continue to remain stable or show improvement. These include targets around waiting times for Child and Adolescent Mental Health Services, Psychological Therapies, Drug and Alcohol Treatment and treatment targets for patients with Cancer.

2.3 Performance

Sections 2.3.1 and 2.3.2 include infographics for the most up to date local management information, with data for the same month in the previous year provided for comparison. A separate **Appendix (1)** includes trends in performance; an additional **Appendix (2)** compares NHS Ayrshire & Arran to NHS Scotland performance.

2.3.1 Unscheduled Care Performance

NHS Ayrshire & Arran – At a Glance
Unscheduled Care

Latest performance, with figures shown for same month of the previous year
Includes Scottish Government target (⊕), where applicable.

Emergency Departments

Site	Sep 2020	Sep 2019	Measure	Target
UHA	2,742	3,380	attendances at UHA Emergency Department	
UHA	92.9%	83.1%	ED attendees were treated, admitted or discharged within 4 hours of arrival	95%
UHA	7	81	ED attendees waited over 12 hours to be treated, admitted, or discharged	
UHC	5,124	6,384	attendances at UHC Emergency Department	
UHC	89.2%	95.0%	ED attendees were treated, admitted or discharged within 4 hours of arrival	95%
UHC	81	1	ED attendees waited over 12 hours to be treated, admitted, or discharged	

Medical and Surgical Bed Occupancy

Sep 2020	Sep 2019	Measure
94.1%	94.7%	occupancy of acute medical and surgical beds at University Hospital Ayr
86.9%	93.0%	occupancy of acute medical and surgical beds at University Hospital Crosshouse

Combined Assessment Units

Sep 2020	Sep 2019	Measure
1,461	1,562	presentations to UHA CAU
1,455	1,435	presentations to UHC CAU

Emergency Admissions*

Sep 2020	Sep 2019	Measure
800	826	admissions to UHA via ED/CAU
1,220	1,493	admissions to UHC via ED/CAU

Delayed Discharge

Numbers of patients whose discharge from hospital was delayed by 2 weeks or more for non-clinical reasons (target: 0)

	North Ayrshire HSCP		East Ayrshire HSCP		South Ayrshire HSCP	
	Sep 2020	Sep 2019	Sep 2020	Sep 2019	Sep 2020	Sep 2019
Patients	5	21	0	0	6	49

* Inpatient Admissions from the ED admitted directly into Medical or Surgical ward (excluding CAU) and Inpatient admissions from the CAU admitted to CAU (regardless of source) who are transferred to a medical or surgical ward (excluding discharges directly from the CAU)

Emergency Department

ED attendances at both sites initially experienced a significant reduction in ED attendances following the lockdown restrictions at the end of March 2020. However, ED attendances have generally been increasing since April 2020, returning to similar levels in August 2020 to that experienced in the pre-COVID-19 period. Data for September 2020 however indicates lower levels to August 2020 and the previous September.

Comparing September 2020 and September 2019, there were 638 fewer ED attendances in at UHA, representing an 18.9% decrease. The decrease is predominantly in relation to Flow 1 (Minor Injury) and Flow 2 (Acute Assessment, including Major Injury) attendances, with 338 fewer Flow 1 attendances in September 2020 than the previous year, a 25.0% decrease, and 242 fewer Flow 2 attendances, a 13.0% decrease.

Similarly at UHC, there were 1,260 fewer ED attendances in September 2020 than in September 2019, representing a decrease of 19.7%. There were 406 fewer Flow 1 (Minor Injury) attendances in September 2020 than the previous year, a decrease of 13.3%. In addition to this there were 764 fewer Flow 2 (Acute Assessment, including Major Injury) attendances, representing a decrease of 29.6%. There were 43 additional Flow 3 (Medical Admission) attendances, an increase 24.7%, and 133 fewer Flow 4 (Surgical Admission) attendances, a decrease of 22.8%.

The **ED 4-Hour Wait** compliance at NHS Board level remains below the 95% target with levels reducing to 90.5% in September 2020. Compliance had previously exceeded the 95% target in each of the calendar months between April 2020 and July 2020. Compliance at UHA in September 2020 was 92.9%, an increase of 9.8 percentage points when compared to the previous year. At UHC, compliance was 89.2% for September 2020, a decrease of 5.8 percentage points from the previous year.

The total number of **12 hour breaches** at UHA and UHC was 88 in September 2020; 7 at UHA and 81 at UHC. This is compared to three (3) in total recorded in the previous month and is also an increase on the combined total of 82 recorded in the same month of the previous year.

ED Attendances

As lockdown restrictions eased, attendances to ED started to rise from April 2020. Restrictions on citizens shielding have been lifted as of 31 July 2020 which has also impacted on emergency demand on our services. Although ED attendances are lower in September 2020 compared to September 2019, both sites have seen a significant increase in the number of COVID-19 positive patients presenting to the Acute sites since the middle of September 2020. This has presented a challenge in terms of appropriate space for these patients to be reviewed within ED and CAU.

Learning from the pandemic has led to the establishment of a National programme Redesigning Urgent Care which is utilising key factors such as National messaging, pre-hospital triage; and the use of virtual technology in 'scheduling the unscheduled'. Work has commenced around ED scheduling Minor Injuries activity. The Medical and Nursing teams are working to create scheduling criteria. Additional space at UHC has been identified to allow scheduling of Minor Injuries activity.

As part of the Redesigning Urgent Care programme, Primary and Secondary Care teams are working closely to develop the local Flow Navigation Centre with discussions focusing on modelling for activity and staffing required. The Critical Respiratory Hub included as part of the COVID-19 Assessment Pathway will form part of the Flow Navigation Centre. Work is underway around workforce planning, and also the agreement of referral criteria with GPs referring to the hub.

The ED 4-Hour Wait 95% standard and 12 hour breaches

September 2020 was a particularly challenging month for both UHA and UHC. The majority of our 12 hour breaches were patients who were delayed waiting for beds. Bed occupancy within Medical specialities was at 100% at times, with high acuity reported within the clinical areas. This meant that there were challenges with flow moving patients to downstream beds.

Improvement work is ongoing to sustain reduced occupancy levels and delays to ensure the 4-hour standard is met and that 12-hour breaches remain low. A dedicated workstream focused on reducing delays to discharge home will ensure that patients are not unnecessarily delayed within the acute setting, allowing increased bed availability.

Combined Assessment Units

CAU Presentations have reduced at UHA with 101 fewer presentations in September 2020 compared to September 2019, a decrease of 6.5%, whilst at UHC there were 20 additional presentations in September 2020 compared with the same month of the previous year, an increase of 1.4%.

In terms of sources of referral, the decrease at UHA is most prominent in GP referrals, with numbers down by 12.3%, 81 fewer referrals in September 2020 when compared with the same month of the previous year. Conversely at UHC, referrals from GPs have increased by 3.3% (+21) and from ‘Other’ sources by 37.3% (+25) during the same time period.

Note: ‘Other’ referral sources include referrals from Outpatient clinics, Radiology patients requiring immediate assessment, and Cancer patients referred via the national cancer helpline, however do not include elective return patients, who are instead recorded separately as outpatient attendances at the Acute Clinic.

Admissions and Occupancy

The numbers of Medical and Surgical Inpatient Admissions from ED and CAU have similarly experienced significant reduction since the outbreak of COVID-19, with 26 fewer admissions at UHA in September 2020 when compared to the previous year and 273 fewer admissions at UHC. These figures represent general Acute admissions, and so do not include admissions to intensive care or high dependency wards, which may be reasonably expected to have experienced significant increase during the current crisis. Maternity and Paediatric admissions are also not included within this data.

Bed occupancy for Acute Medical and Surgical wards has increased at both sites in recent months, having previously experienced a significant decrease following the outbreak of COVID-19. In September 2020, occupancy at UHA was recorded as 94.1% and at UHC was 86.9%.

Whilst these rates remain lower than the same month of the previous year, it represents an increase of 4.4 percentage points at UHA and a marginal decrease of 0.1 percentage points at UHC when compared with the previous August 2020 (UHA, 89.7%; UHC, 87.0%). The decrease at UHC could be to be as a result of a number of beds being protected for low risk patients, as well as a number of beds on site being closed on Infection Control advice due to patients being isolated after being in contact with someone diagnosed as COVID-19 positive. These beds have been unable to be used for a period of time but are considered available in the bed statistics.

Occupancy rates are based on a combination of medical and surgical beds. Bed occupancy within Medical specialities in UHC was at 100% at times during the month. Furthermore, occupancy is based on a count at midnight but this doesn’t reflect demands on beds during the busiest periods of the day. Therefore true occupancy levels are generally higher on both sites than the reported figures above would suggest.

Combined Assessment Units/CAU Presentations

The increase in GP Referrals and ‘Other sources’ to the CAU, along with a high number of suspected COVID-19 patients on the red pathway in CAU awaiting results, created a challenge due to lack of single rooms on site, and therefore impacted on the ability to safely transfer the patients ahead of test results being known.

In addition to scheduling Minor Injuries activity in the Emergency Department, there are opportunities to ‘schedule the unscheduled’ at the CAUs. When a GP referral is received at CAU, there may be instances where the individual does not have to be seen or assessed that day. Ensuring there are a range of suitable options will allow care to be delivered in a planned way for some patients.

Utilising all available capacity in our Medical Daycase Unit is one option currently being explored. Being able to access resources within the unit will allow call handlers in Initial Assessment to offer alternatives to admission and/or a planned admission where appropriate. All of this information/data gathering will support the establishment of an Ayrshire-wide Flow Hub.

Improvement work around scheduling GP referrals to smooth demand throughout the day at CAU at UHA has resulted in reduced waiting times for patients and an improved experience. We know that the peak demand in CAU occurs late morning and then mid-late afternoon. A recent test of change focused on scheduling people who travel independently to CAU once referred by their GP. Referrers are given an appointment time and asked that the person attends at that specific time for assessment.

Feedback from GP colleagues in South Ayrshire has been positive. We know that referrer practices will take time to change, but as it does, and referrers consider alternative options to admission, this is likely to have a positive impact on the 4 hour ED access and treatment standard.

Admissions and Occupancy

High levels of occupancy are an important indicator of a system under pressure. A lack of available beds has widespread consequences within the system.

Over the course of September 2020, there has been an increase in the number of COVID-19 patients within the hospitals. With ED attendances having risen again, this has been challenging with red and green pathways in place at the front door. A high number of suspected patients (on the red pathway) in the CAUs awaiting results can cause a bottleneck. Awaiting test results means that patients remain in the CAUs in single rooms until confirmation of their COVID-19 status is known, before they can be moved to a ward if required.

With the resurgence of COVID-19, capacity within the acute hospital settings has been extremely challenged. Surge capacity has been built in to the COVID-19 mobilisation plans which will be supported by an Escalation Policy describing trigger points and expected action. The Acute Services mobilisation group and the theatre group have approved the restart of surgical services in line with clinical prioritisation. This is having an impact on overall bed capacity and requires risk assessments for services to restart safely.

At UHA, an extreme team has been established, commissioned by the Site Director and Head of Service within South Ayrshire HSCP to explore and deliver a whole system response to quality urgent care, including frailty, within South Ayrshire HSCP and UHA ensuring delivery of urgent care only happens in a hospital setting where absolutely necessary. When patients' stays exceed 7 days there will be active appraisal of their care to assess whether this can be delivered in a more homely setting.

At UHC, weekly review of patients with stays exceeding 14 days has been undertaken since early August 2020. This has been led by a senior clinician with support from HSCP colleagues, Allied Health Professions (AHPs) and Quality Improvement teams.

Delayed Discharges

In preparation for the anticipated demand of people being treated for COVID-19, additional community bed capacity and adaptation of other services enabled patients defined as medically fit for discharge to be transferred to more suitable settings.

Delayed Discharges >2 Weeks (excluding complex code 9 delays) have fallen from a high of 84 patients in January 2020 to 11 patients by September 2020. There were 5 delays over 2 weeks for North Ayrshire HSCP residents at the end of September 2020, no change from the previous month but down by 16 from the previous year. For South Ayrshire HSCP residents there were 6 delays over 2 weeks at the end of September 2020, up by 1 from the previous month but down by 43 from the previous year. Performance in East Ayrshire HSCP has continued to meet the target of zero delays over 2 weeks.

Delayed Discharge Occupied Bed Days (OBDs) for all delay reasons have increased in September 2020, up by 9 bed days to a total of 2,133 in September 2020 compared to the previous month (August 2020: 2,124; September 2020: 2,133), however have decreased by 2,476 when compared with the previous year (September 2019: 4,609).

In North Ayrshire, there were 13 fewer OBDs in September 2020 than the previous month (August 2020: 552; September 2020: 539), in East Ayrshire, there were 133 additional OBDs (August 2020: 259; September 2020: 392), and in South Ayrshire there were 111 fewer OBDs (August 2020: 1,313; September 2020: 1,202).

East Ayrshire HSCP continues to actively manage transfers of care where hospital-based treatment is no longer clinically required and people can be more appropriately supported in another setting. The HSCP Hospital Team liaises daily with colleagues in Acute Services to identify East Ayrshire residents and to allocate immediately to facilitate timely care and support planning for individuals.

Recently, there has been a notable increase in the levels of complexity of support that the Hospital Team has been managing and some challenges in securing specialist facilities for long-term care to meet those needs.

Community teams have continued to play a central role in the response to COVID-19, with East Ayrshire Community Hospital (EACH), the Care at Home and District Nursing services in East Ayrshire having supported a number of people with suspected or confirmed COVID-19.

North Ayrshire HSCP continues to focus on delayed discharge activity as a priority. There is a review of process and reporting by senior managers to ensure quality of information is accurate and reported in a timely fashion. An improved approval process for care home and ‘care at home’ support is being developed to include overview and improved efficiency for decision making from senior managers, and support from the finance team to speed up processes following approvals. Daily scrutiny of performance remains in place and the interim Head of Service now seeks daily assurance around the position and actions taken. Meetings to ensure connectivity with acute and community services took place in early October 2020. A new hospital team manager has been appointed taking up post in October 2020. This will again improve on-site influence,

sooner detection of need, and ensure timely activity regarding the discharge arrangements required.

In **South Ayrshire HSCP**, there has been a continued focus on delayed discharges. The senior team within South Ayrshire have been meeting weekly to focus on supporting those who have waited longest to move and to identify areas for improvement across the system. This has resulted in a reduction in the average time waited for a care home place but for a time in September 2020 there were around 16 people waiting long periods due to guardianship processes. The management team have implemented improved processes to manage the application arrangements for Guardianship Orders. By early November 2020 this number had almost halved to 9 people awaiting the completion of Guardianship processes.

The Head of Community Health and Care Services and Director for University Hospital Ayr have commissioned an “extreme team” to focus on process improvement in pursuit of the aim to reduce delays. Six workstreams have been identified and small tests of improvement have been initiated.

Despite this work, in recent weeks referral numbers for care at home have increased significantly at a time when additional ‘care at home’ capacity has become fully utilised. This has resulted in rising numbers of delayed discharges. In order to address this increase, the Care at Home service has been allocated funding for a 6 month test of change post to reduce hospital delays. The post holder will work closely with Private Providers to arrange care packages to support people home from hospital on the day they are medically fit in line with a discharge to assess model. It is anticipated that the post will be filled at the beginning of November 2020.

2.3.2 Planned Care

NHS Ayrshire & Arran – At a Glance

Planned Care

Latest performance, compared with figures at same month of the previous year
Includes Scottish Government target (⊕) where applicable

Service Access

Sep 2020	Sep 2019	Measure	Target
43.9%	79.9%	of patients were waiting fewer than 12 weeks for a New Outpatient appointment	⊕ 95%
67.5%	80.1%	of patients waited fewer than 18 weeks from Referral to Treatment	⊕ 90%
28.1%	73.4%	of patients were waiting fewer than 12 weeks for Inpatient or day case treatment	

Child and Adolescent Mental Health

Sep 2020	Sep 2019	Target
92.1%	82.3%	⊕ 90%

of children and young people started treatment within18 weeks of initial referral to CAMH services

Psychological Therapies

Sep 2020	Sep 2019	Target
80.4%	74.1%	⊕ 90%

of patients started treatment within 18 weeks of their initial referral for psychological therapy

MSK

Sep 2020	Sep 2019	Target
64.9%	44.6%	⊕ 90%

of adult patients were waiting fewer than 4 weeks for MSK services

Drug and Alcohol Treatment

Sep 2020	Sep 2019	Target
99.1%	98.0%	⊕ 90%

of clients waited no longer than 3 weeks from referral to appropriate drug or alcohol treatment that supported their recovery

Cancer

Sep 2020	Sep 2019	Target
100.0%	97.6%	⊕ 95%

of patients started treatment within **31 days** following decision to treat

Sep 2020	Sep 2019	Target
88.6%	89.7%	⊕ 95%

of patients with suspicion of cancer started treatment within **62 days**

Diagnostics

Sep 2020	Sep 2019	Measure	Target
21.1%	50.8%	of patients were waiting fewer than 6 weeks for Endoscopy	⊕ 100%
49.6%	72.6%	of patients were waiting fewer than 6 weeks for Imaging	⊕ 100%

New Outpatients and Inpatient/DayCases

To effectively and safely manage the pressures of COVID-19, all routine Inpatient/Daycase surgery ceased with planned care surgery restricted to emergency and cancer/very urgent cases only. Emergency surgery continued in all specialties, and in some specialties a small number of very urgent cases continued. Outpatient activity was also scaled down to release key clinical staff to assist with emerging pressures, to allow adaptation of some Outpatient areas for other uses, and to reduce the public footfall in the hospital sites. These measures in turn have impacted on the number of patients waiting and as a direct consequence affected compliance against the National Waiting Times targets.

The Remobilisation process continues to prioritise planned care patient activity on the basis of clinical urgency rather than length of wait, therefore Inpatient/Daycase and New Outpatient compliance is expected to remain at a lower level, although services are being restarted safely and are being prioritised for the patients most at need.

New Outpatients

The National Waiting Times standard is that 95 per cent of patients should wait no longer than 12 weeks from referral to a first outpatient appointment (measured on month end Census).

At the end of September 2020, local management information indicates that 43.9% of patients waiting for a new outpatient appointment had been waiting 12 weeks or less. This is an increase of 1.8 percentage points, from 42.1% at August 2020. Prior to the impact of COVID-19, performance at February 2020 was 81.1%.

A comparison of the number of patients waiting as at 30 September 2020 compared to 29 February 2020 is outlined below:

	Number waiting (including unavailable waits)	As at 29 February 2020	As at 30 September 2020
New Outpatients	> 12 weeks	4,010	16,286

Source: Local monthly management reports, Information Team

New Outpatients

Patient referrals are prioritised in line with clinical priorities. Unscheduled Care and Urgent cases are the focus although clinical activities are expanding to manage an increasing number of new referrals categorised as “routine” and follow-up patients who were cancelled since the commencement of the pandemic.

Each speciality is working through a plan to consider the number and clinical priority of patients sitting on the waiting list. As new referrals are being received a number of services are initiating Active Clinical Referral Triage methodology where all referrals are triaged by a senior clinical decision maker to evidenced-based, locally agreed pathways after reviewing all the appropriate electronic patient records. Some cases are being prioritised for investigation through NHS Near Me and face-to-face consultation.

Clinicians are clinically reviewing the records of patients whose appointments were postponed. A range of alternative management strategies are being deployed including:

- prioritisation for telephone/NHS Near Me or face-to-face consultation;
- discharge when appropriate;
- patient initiated review pathways;
- clinical and management plan;
- ordering of investigations; and
- extending the horizon of the review date.

As at 9 September 2020, 4,889 new and 14,325 review consultations have been undertaken. Since the last report, we have made further progress in remobilising outpatient services and in comparison to September 2019, we have recovered 61% of new and 84% of review activity during the month of September 2020.

Inpatient/DayCases

The formal measure of performance against the 12 weeks Treatment Time Guarantee (TTG) for Inpatients/DayCases applies to patients seen (completed waits), however the number of patients waiting for treatment at a point in time (ongoing waits) is also a key measure in assessing NHS hospitals' performance. Data presented in previous NHS Board reports have been reported against ongoing waits under the banner of TTG compliance. This report now also includes performance in relation completed waits.

Local management information indicates that at the end of September 2020, 28.1% of patients who were waiting for their Inpatient/Daycase treatment, had to that date, waited less than 12 weeks (ongoing waits). This is an increase of 6.2 percentage points, from 21.9% at August 2020. Prior to the impact of COVID-19, performance at February 2020 was 71.8%.

A comparison of the number of patients waiting as at 30 September 2020 compared to 29 February 2020 is outlined below:

Ongoing Waits	Number waiting (including unavailable patients)	As at 29 February 2020	As at 30 September 2020
Inpatients / Daycases	> 12 weeks	1,103	3,090

Source: Local monthly management reports, Information Team

The Treatment Time Guarantee states that eligible patients must start to receive treatment within 12 weeks (84 days) of the treatment being agreed (this guarantee is based on completed waits). Local management data indicates that in quarter ending June 2020, there were only 814 patients admitted under this standard. This is 80.1% less than the previous quarter. Of those patients seen, 81.6% were seen within 12 weeks of referral. Since services have started to resume, the number of patients admitted has increased to 2,380 for quarter ending September 2020. Of those patients seen, 53.8% were seen within 12 weeks of referral.

Compliance in relation to completed waits has been affected by the measures put in place to effectively and safely manage the pressures of COVID-19, with only urgent or urgent cancer suspected cases being admitted which resulted in higher levels of compliance being recorded in quarter ending June 2020.

The Remobilisation process continues to prioritise planned care patient activity on the basis of clinical urgency rather than length of wait, therefore Inpatient/Daycase TTG compliance is expected to remain at a lower level, although services are being restarted safely and are being prioritised for the patients most at need.

A comparison of TTG (completed waits) performance is outlined below:

	Quarter Ending Dec-19	Quarter Ending Mar-20	Quarter Ending Jun-20	Quarter Ending Sep-20
<= 12 weeks	3,587	3,206	664	1,281
> 12 weeks	1,134	1,000	150	1,099
Total	4,721	4,206	814	2,380
% within 12 weeks	**76.0**	**76.2**	**81.6**	**53.8**

Source: Local monthly management reports, Information Team

Inpatient/Daycases

Surgical restart processes have been developed and monitoring of theatre utilisation is ongoing. Waiting list validation of inpatient waiting lists to ensure patients wish to proceed with surgery is being undertaken and will inform prioritisation of cases. In comparison to September 2019, we have recovered 69% of inpatient and daycase surgery in the month of September 2020.

A 10 week post-operative COVID-19 surveillance project was established in July 2020 where patients are contacted by telephone 7, 14 and 21 days after discharge from hospital to establish whether they have COVID-19 symptoms. To date, no patients have tested positive for COVID-19 after attending for an operation. A message campaign for the public on how COVID-19 has changed the way patients have operations is being developed and will focus on “your safety is important to us, now more than ever”.

18 Weeks Referral to Treatment

The target for 18 week Referral to Treatment (RTT) compliance is 90% and local management information indicates that following a month on month reduction from 93.4% in April 2020 to 65.0% in August 2020, compliance has increased by 2.5 percentage points to 67.5% at September 2020. Prior to the impact of COVID-19, performance at February 2020 was 79.7% and had been showing an improving trend.

It should be noted that this decrease in compliance has been affected by the measures put in place to effectively and safely manage the pressures of COVID-19, which resulted in higher than expected compliance being recorded in April and May 2020.

18 Weeks Referral to Treatment

The 18 weeks RTT measurement is based on the patients who have completed their treatment stage. At the current time where we are prioritising the reduced treatment capacity for Urgent Cancer Suspected (UCS) and Urgent patients, and less urgent patients are not being treated, the 18 weeks RTT measurement cannot be meaningfully compared to performance prior to the COVID-19 outbreak.

Diagnostics

The National Waiting Times standard is that 100% of patients should wait six weeks or less for a key diagnostic test.

Like other services, routine diagnostic services including x-rays and scans were suspended from mid-March 2020 in order to create additional capacity to support the emerging COVID-19 demand; and also to reduce the public footfall in the hospitals with the associated risk of increased transmission of the infection. Urgent and Urgent Cancer Suspected (UCS) imaging investigations have continued throughout. This has resulted in an increased backlog of patients awaiting routine imaging investigations and as a direct consequence affected compliance against the National Waiting Times targets.

Endoscopy services have been significantly impacted during the COVID-19 outbreak. Following initial COVID-19 guidance issued by the British Society of Gastroenterologists (BSG) in March 2020, all routine, urgent and UCS endoscopy investigations were stopped due to the available evidence around heightened risk to staff. Only emergency endoscopy procedures continued. Endoscopy at UHC was also impacted by the expansion of ICU facilities which extended into the Endoscopy recovery area. This impacted both on the backlog of patients awaiting an endoscopy investigation, but also impacted on the cancer pathway for both upper gastrointestinal (GI) and colorectal cancer, since upper GI endoscopy and colonoscopy are key investigations in these pathways.

Within **Diagnostics** local management information indicates that compliance against the 6 weeks Access Target of 100% for **Endoscopy** has decreased by 1.9 percentage points, from 23.0% at August 2020 to 21.1% at September 2020. Prior to the impact of COVID-19, performance at February 2020 was 63.8%. COVID-19 has impacted on the number of patients waiting over 6 weeks, which has continually increased each month from 735 as at the end of February 2020 to 2,819 as at the end of September 2020.

Imaging compliance against the 6 weeks Access Target of 100% has increased by 1.2 percentage points, from 48.4% at August 2020 to 49.6% at September 2020. Prior to the impact of COVID-19, performance at February 2020 was 73.0%. The number of patients waiting over 6 weeks has increased from 1,517 patients at the end of February 2020 to 3,463 patients at the end of September 2020, although there has been a 9.1% decrease from 3,811 patients at the end of August 2020.

The Remobilisation process is prioritising planned care patient activity on the basis of clinical urgency rather than length of wait, therefore Endoscopy and Imaging compliance is expected to remain at a lower level.

Endoscopy

Endoscopy services at both UHA and UHC have restarted. New pathways and processes have been adopted and are continually reviewed. An enhanced pre-booking phone consultation with patients is now in place, in addition to pre-procedure patient self-isolation and COVID-19 testing, post procedure surveillance initiative and a move to a team based planning and delivery of service (Ayrshire-wide “pooled” list). Access funding has now been secured and it is planned to introduce weekend endoscopy lists from November 2020 to further increase activity

By the end of September 2020 endoscopy services had remobilised 52% of its pre-COVID-19 capacity. Capacity continues to be prioritised for patients referred with an Urgent Suspicion of Cancer, and having reduced the number of patients waiting in that category the service is now progressing to investigate those referred on an ‘Urgent’ basis from October 2020. Presently there remains no capacity to investigate routine referrals.

To support clinical triage and to ensure that patients are investigated in a timely fashion, we have implemented quantitative faecal immunochemical testing (qFIT) from 6 September for new referrals. So far just over 200 patients have returned qFIT tests and a small number of those whose results indicated high risk had their colonoscopy procedure expedited. During October 2020 qFIT testing will also be undertaken for the existing list of patients waiting for colonoscopy on an ‘Urgent’ basis to again help identify any patients within that grouping who are at particularly high risk of having cancer.

We are working with the Golden Jubilee National Hospital (GJNH) to create additional colonoscopy capacity for NHS Ayrshire & Arran patients. It is anticipated that approximately 440 colonoscopies will be able to be performed at GJNH in 2020/21.

Implementation of two national initiatives related to endoscopy – Colon Capsule Endoscopy and Cytosponge are anticipated in the autumn. Both of these initiatives introduce other procedures for the investigation of GI symptoms, which is expected to aid the re-mobilisation of endoscopy. There has been some delay in the national roll out of both of these initiatives, but recent contact from Scottish Government colleagues is suggesting that the local implementation process will be able to start soon in NHS Ayrshire & Arran.

The national Bowel Cancer Screening programme had a re-start date of 12 October 2020.

Health Records and Digital Services staff have ensured that clinical services have been supported during COVID-19 to continue to modernise clinical administration processes. “Paperlite working” continues to be rolled out to allow the majority of outpatient consultations to be undertaken by accessing clinical information electronically from the Clinical Portal. All clinical information is loaded electronically into the portal to provide a comprehensive electronic patient record (EPR).

The Scottish Access Collaborative’s aim is to sustainably improve waiting times for patients waiting for non-emergency procedures. There are a number of initiatives that NHS Ayrshire & Arran are involved in, including, waiting list validation, team service planning, implementation of effective and quality interventions pathway (EQUiP) within Dermatology and Surgical Services, and Accelerating the Development of Enhanced Practitioners (ADEPt). Each of these initiatives is supported by a local designated lead and a project plan will be developed with clear milestones and outcomes.

Imaging

During COVID-19 there has been a significant reduction in the imaging service. To mitigate between the demand and reduced capacity it is proposed that evening and weekend sessions may run. The position below describes the current scanning service:

- CT scanning – weekend working was put in place during COVID-19. Funding has been identified to increase staffing to run some additional CT sessions. With investment it will be possible to increase CT scanning capacity by approximately 240 additional appointments/month through appointment of two locum radiographers for six months;
- MRI – Scottish Government has funded the provision of a mobile MRI van working seven days/week for six months, since July 2020;
- Ultrasound – routine and planned referrals are restarting. Maternity ultrasound continued largely unaffected during COVID-19;
- General x-ray – Plain film x-rays were provided at Ayrshire Central Hospital for GP referrals. GP general x-rays appointments will commence at UHC but capacity will be limited. Other community sites (EACH and Girvan) will be utilised for GP/Outpatient referrals;
- Breast screening – The symptomatic mammography service will move back to UHC from ACH, the clinic will run into evenings or be provided twice weekly to safely accommodation patients; and
- DEXA scanning – This service had a restart date in August 2020, with appointments lengthened to accommodate physical distancing. Patients are seen order of priority, working through patients cancelled due to COVID-19 then outstanding examinations.

Cancer

Throughout the initial COVID-19 outbreak, Cancer cases continued on a selected and risk-assessed case by case basis in most specialties with the exception of colorectal and upper gastrointestinal cancer surgery, where the risks were deemed too high. Some urgent/urgent cancer suspected (UCS) outpatient activity continued using a combination of telephone, video and face to face consultations as deemed appropriate.

Prior to COVID-19, the 31 day Cancer Target was consistently met and the 62 day Cancer target was on an improving trajectory, reaching 89.6% in February 2020. Performance levels continued to improve from March 2020 to August 2020, reaching 97.4% in April 2020 for the 62 day Cancer target. Performance levels remained high, however the number of patients being treated reduced throughout this time.

Local management information indicates that the **31 day Cancer target** of 95% continues to be met with an increase of 1.8 percentage points from 98.2% at August 2020 to 100.0% at September 2020. Compliance remains lower than the **62 day Cancer target** of 95%, with a decrease of 6.3 percentage points from 94.9% at August 2020 to 88.6% at September 2020. Cancer performance in relation to the 62 day Cancer target may have decreased with newly diagnosed cancer patients requiring treatment.

Cancer

The remobilisation of cancer services continues to be a priority and restart is being guided by clinical priority, equitable access and delivery of care in the safest possible environment. Some cancer services and surgery continued during COVID-19 but this was limited. A process to restart surgical pathways has been developed and as at August 2020 there were no notable backlogs for patients awaiting cancer surgery, however from September 2020 we have started to see more delayed colorectal cancer diagnoses being made. This was expected with the re-start of Endoscopy and the prioritisation of the cases most at risk of having cancer. We are therefore beginning to see this small backlog of cancer cases awaiting treatment and this is likely to continue as we catch up with the undiagnosed patients.

The delivery and prioritisation of cancer surgery will remain an agile and reactive process. It is recognised that the restarting of some diagnostic services such as Endoscopy is likely to result in increased numbers of cancer diagnoses resulting in a backlog of unmet need.

Golden Jubilee National Hospital is supporting Boards in the remobilisation of cancer surgery and additional endoscopy capacity. NHS Ayrshire & Arran has established some breast cancer surgery at GJNH.

Mental Health

Mental Health Services (including Learning Disabilities and Addiction Services) within Ayrshire and Arran continued to provide health and social care interventions based on contingency planning and RAG rating throughout the COVID-19 outbreak. Some aspects of care requiring or requested to be put on hold include; day care, respite, support packages and group work. However, alternative support arrangements were put in place to safeguard the individuals that this affected. Other aspects of care required to be expedited in order to deliver the Scottish Government's directive to redirect individuals away from EDs and provide care locally and safely through the use of digital technologies. Inpatient services continued to be delivered throughout the COVID-19 outbreak, albeit with an increased threshold for admission for only those most at risk, and some realignment of services to afford specific isolated assessment provision and specific areas to support those confirmed positive for COVID-19.

Mental Health – Psychological Therapies

The National Waiting Times Target is that 90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral.

Psychological Therapies waiting times continue to remain below the 90% compliance standard. However, waiting times have improved through the COVID-19 period, with the total number of patients waiting and the number waiting more than 18 weeks having both reduced. Psychological Therapies compliance has therefore increased by 4.7 percentage points, from 75.7% in August 2020 to 80.4% at September 2020. Prior to the impact of COVID-19, performance at February 2020 was 74.9%.

The Waiting Times for Psychological Therapies submitted as part of the Annual Operational Plan for 2020/21 reported a trajectory for 90% compliance by April 2021, assuming full staff capacity. The improvement actions and trajectories are currently being reviewed.

Psychological Therapies

Provision of Psychological Therapies has been maintained, as close to business as usual, from the outset of the pandemic using remote delivery (telephone and NearMe). While some Psychological Service staff were refocused on supporting staff wellbeing resources (e.g. Acute and Community Wellbeing Hubs) and contributing to essential service provision in their clinical teams, the majority of staff retained their usual work focus and moved to remote working.

Referral demand has reduced to varying extents across the Psychological Specialties. This has enabled staff to work through existing cases and to begin to work with new patients. Where possible, new patients have been started in waiting time order. The exception is where remote delivery has not been an option. Face-to-face clinics have been reinstated and patients not suitable for remote working are being prioritised.

There has however been a negative impact on waiting times within the Specialties of CAMHS and Community Paediatrics, where there has been low acceptance and suitability for remote working. This relates to the predominance of neurodevelopmental and neuropsychological work within these Specialties, and the limited evidence base and options to deliver these specialist assessments to children remotely.

Service provision had been paused in relation to: face-to-face assessment and treatment; neuropsychological assessment in adults; neurodevelopmental and neuropsychological assessment in children, and; therapeutic groups. To reinstate this provision, service adaptations and developments have been progressed and reported on in the mobilisation plan (August 2020 until March 2021). There are a number of actions being undertaken to improve performance and these include:

- Strong recruitment drive to fill all vacancies, including maternity leave cover;
- Continue remote delivery of psychological assessment and treatment where appropriate;
- Remote devices have been made available to all clinical staff and NearMe is now embedded in all Psychological Specialties;
- Re-instating face-to-face clinical contact in outpatient and inpatient settings from September 2020, prioritising longest waits and neurodevelopmental and neuropsychological assessment. Use a blended face-to-face/remote approach to remove barriers to accessing psychological input and to increase patient choice (e.g. using remote delivery initially to engage a new patient who is anxious or restricted in their ability to attend a clinic setting);
- Expand access to an increased range of Scottish Government supported digital options. We are working closely with the recently established TEC programme board to access the full range of new approaches. Our introduction of Silver Cloud has increased digital referrals for Cognitive Behavioural Therapy (CBT) based approaches by 50%, with further increase expected as our Acute colleagues begin to access the system. In addition, the planned roll-out in late October of the Internet-Enabled (IESO) CBT digital option will further increase our options within a tiered model of service delivery;
- Development of local guidelines, based on current national and international evidence base, to inform on remote delivery of neuropsychological and neurodevelopmental assessments. Increased number and range of specialist test materials have been purchased to enable implementation of the guidance;

- Implementation of a remote trans-diagnostic group therapy for Adults presenting with emotional regulation problems, commencing September 2020. It is estimated that this therapeutic group will be suitable for the majority of the patients waiting for Psychological input, removing or reducing the need for additional individual input;
- Re-instate training, clinical supervision and consultation to the wider workforce who are delivering psychological interventions, including clinicians training in Psychology and Psychological Therapies. This activity is key to increasing capacity in the wider workforce and will be expanded as the wider clinical staff group are released and given protected time for psychological work;
- Ongoing provision of dedicated Psychology input to staff wellbeing hubs in the Acute and Community settings until March 2021. This will maintain the positive momentum of these well utilised and highly valued supports until the Board review the longer-term staff wellbeing provision in January 2021.

Mental Health – CAMHS

The target for CAMHS is that 90 per cent of young people should commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral. Local management information indicates that compliance remains above this target but has decreased by 2.1 percentage points, from 94.2% in August 2020 to 92.1% at September 2020. Prior to the impact of COVID-19, performance at February 2020 was 94.6%.

Note: Up until February 2020, the waiting time clock was stopped at the point of First Treatment for CAMHS which included assessment as informed by skilled and knowledgeable Nurses and Allied Health Professionals (AHPs) who delivered an intense generic assessment which resulted in a clinical treatment plan and elements of treatment such as guided self-help and anxiety management. As of February 2020, there was a change in data recording guidance and the waiting clock was stopped only at the point of a First Treatment appointment with an assigned Clinician, irrespective of supports offered prior to that. 'Internal' referrals for CAMHS Clinician to CAMHS Clinician were also to be included. Internal referrals are for children/young people which have been open to the Service for some time, often years, who are requiring a short term intervention by another clinician as part of the over treatment programme.

Following discussions with Public Health Scotland and the Scottish Government in early September 2020, Internal Referrals are to be excluded for the Referral to Treatment standard in line with the defined standard but will be monitored locally; in addition to this, NHS Ayrshire & Arran were asked to revert back to the original definition used prior to February 2020.

As of 4 September 2020, waiting lists have been refreshed with the original formulation and re-submitted to Public Health Scotland and Scottish Government. The service acknowledges that the adjusted formula and improved RTT as a result is not a true reflection of what some of our children/young people/families /carers feel or experience. However, there is a distinction to be made between First Treatment and Date of Diagnosis. Some of the mental health presentations (ASD, ADHD, FASD) adhere to clinical guidelines (NICE/SIGN) which involves periods of observations in several environments (school, home, clinic). These observations, which are beyond CAMHS control, (school holidays, closures etc.), can extend the diagnostic process. The compliance figures reported within this report are based on the

refreshed formulation so may differ to figures reported in previous NHS Board and Performance Governance Reports.

CAMHS

As the service adapts to new clinical practices with the implementation of Near Me, access to CAMHS clinicians has been maintained. We are working with our Intensive Support Team to develop care pathways for young people who have experienced significant self-harm or poisoning post discharge from Acute hospital. To this end a pilot with North Ayrshire HSCP Service Access Social Work has been established. This pilot will allow for a more responsive approach to joint assessment of a young person without the immediate need for a formal referral.

The 'duty' service for the whole of Ayrshire is now delivered from Lister Street at University Hospital Crosshouse, as working relationships with Liaison and Crisis Resolution Team (CRT) are further developed in anticipation of closer working in an unscheduled way.

A key development as a result of the COVID-19 pandemic is the development of a co-produced medication and health monitoring pathway for young people with Attention Deficit Hyperactivity Disorder (ADHD), for those who are already diagnosed with the condition. A 'test of change' is being developed and it is hoped that this will comprise of 30 young people currently risk rated as amber due to their monitoring needs to engage in the programme.

Mental Health – Drug and Alcohol Treatment

The National Waiting Times target is that 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

Drug and Alcohol Treatment continues to meet and exceed the target of 90% with performance of 99.1% in September 2020. Prior to the impact of COVID-19, performance at February 2020 was 98.6%.

Addiction Services have continued to provide safe, essential alcohol and drug related support throughout the period of the COVID-19 pandemic. Staff have continued to offer all interventions during the last 3 months with more face to face appointments/visits being offered in addition to increased telephone contact. Staff have also been trialling out the use of Virtual Technology (Near Me). As part of the re-mobilisation plan, there will be increased face to face contacts for all new and existing clients.

Musculoskeletal

The National Waiting Times Target is that the maximum wait for AHP MSK Services from referral to first clinical out-patient appointment will be 4 weeks (for 90% of patients).

Local management information indicates that 64.9% of patients were waiting less than 4 weeks at the end of September 2020. This is an increase of 11.4 percentage points, from 53.5% at August 2020. Prior to the impact of COVID-19, performance at February 2020 was 53.1%.

Musculoskeletal

In March 2020, MSK staff were placed in other areas to help support with the COVID-19 pandemic. This created a back log of long waiting lists (5,958 patients) and current caseloads. As at 1 October 2020, MSK has reduced the number of patients on the waiting list to 1,198, with an average wait of 9 weeks. The current caseloads have now been cleared.

Tests of change are targeting new ways of managing referrals (Active Clinical Referral Triage) and reducing waiting times.

Escalation pathways to orthopaedic Advanced Practice Physiotherapists (APPs) are in place for patient safety. As we resume, the new norm will be virtual consultations, with face to face consultations guided by strict guidelines.

Outpatient areas have been risk assessed and face to face consultations re-started, albeit on a significantly reduced capacity due to infection prevention and control measures, and loss of clinical space. The significantly reduced face to face capacity has impacted on the waiting list and 4 week compliance target but clinic space is slowly increasing.

Digital, Social media and the public-facing web page have been increased significantly to provide self-management and exercise advice. Enhanced self-management information is being integrated into the clinical pathways which are currently being re-vamped to include virtual consultations and digital access for the whole patient pathway across whole systems.

Qualitative feedback has been sought for telephone and Near Me consultations with very positive feedback from patients and staff. The service will continue to evaluate new ways of working and are currently developing pathways for a whole systems approach.

Many MSK staff have been re-patriated to MSK services after working in the acute sector to help with the COVID-19 pandemic. These staff are now trained to return to the acute sector if required.

2.3.3 Quality/patient care

As we move to re-mobilising our services, systems and procedures continue to be in place to monitor and manage the impact of COVID-19 on our provision of unscheduled and planned care for our citizens and ensure high quality of care for patients.

2.3.4 Workforce

A sustainable workforce and recruitment levels are imperative across all services as we move to restart our services and prepare for any potential future outbreaks of COVID-19.

Workforce implications identified relate to COVID-19 related staff absences to ensure appropriate levels of capacity are maintained to manage demand.

2.3.5 Financial

The health and care system is ensuring appropriate levels of capacity are maintained to restart services but also to manage the demand in the event of any future COVID-19 outbreaks.

The impact of COVID-19 on the delivery of key performance targets and trajectories are routinely being assessed and monitored.

2.3.6 Risk assessment/management

There is a significant risk to the organisation in failing to manage the impact of COVID-19 however detailed plans are in place to ensure that the safety of patient care is prioritised.

Risks remain that unforeseen circumstances, e.g. ward closures due to illness or staff absence, could adversely affect system flow. Staff and service leads have contingency plans in place where possible.

The impact of COVID-19 on the delivery of key performance targets and trajectories are routinely being assessed and monitored.

2.3.7 Equality and diversity, including health inequalities

An Impact Assessment has not been completed as this paper provides an update on performance levels during and post the initial COVID-19 outbreak.

2.3.8 Other impacts

Best value:
Successful management of waiting times requires leadership, and engagement with clinical staff. The HSCP have increasing influence on Delayed Discharge performance through patient flow. Local performance management information is used to provide as up to date a position as possible in this report. Some information may change when the data is quality assured by Public Health Scotland in readiness for publication.

Compliance with Corporate Objectives:
The achievement of the waiting times targets set out within this paper complies with a number of the corporate objectives: improving health; safety/outcomes; quality of experience; equality; transforming and patient flow; supply and demand.

Local outcomes improvement plans (LOIPs):
The achievement of the targets provides better access to healthcare services and should therefore have a positive effect on the health inequalities priority within local LOIPs.

The achievement of the patients awaiting discharge targets will have a positive contribution towards the Outcomes for Older People priority.

2.3.9 Communication, involvement, engagement and consultation

There is no legal duty for public involvement in relation to this paper. Any public engagement required for specific service improvement plans will be undertaken as required.

2.3.10 Route to the meeting

The content discussed in this paper has been considered by the Senior Responsible Officer for each area. They have either supported the content, or their feedback has informed the development of the content presented in this report.

2.4 Recommendation

NHS Board members are asked to discuss the information provided in this report which provides assurance that systems and procedures are in place to monitor and manage the impact of COVID-19 on our provision of unscheduled and planned care for our citizens.

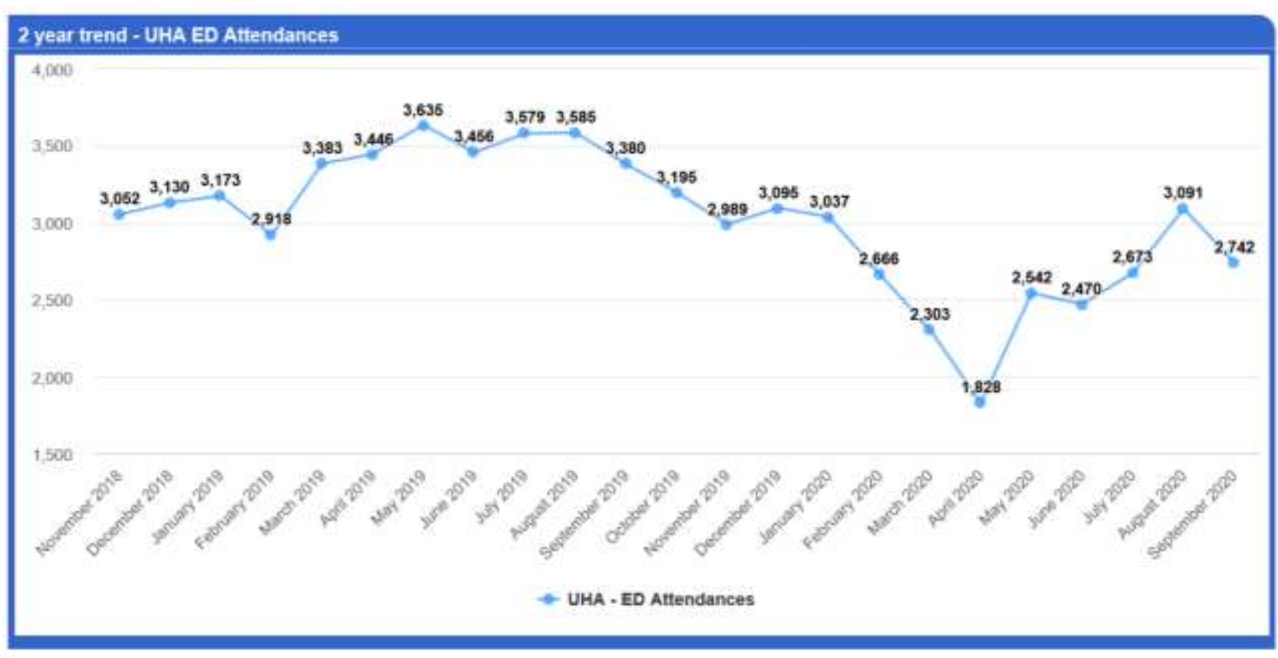
3. List of appendices

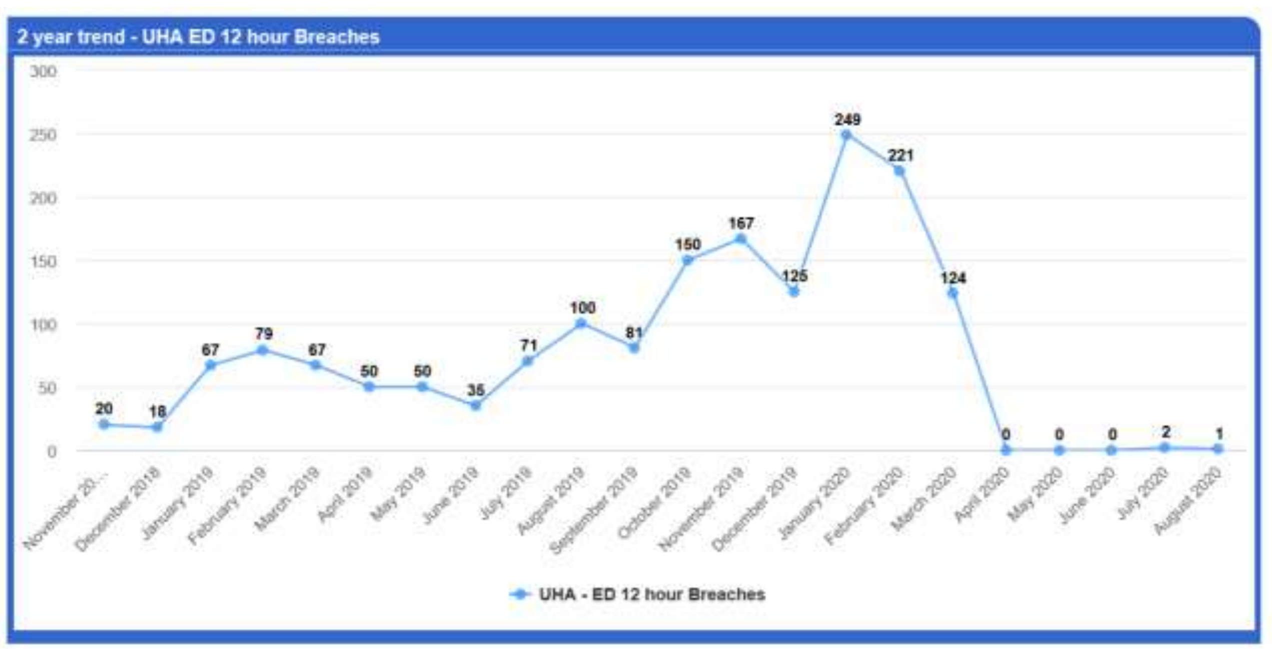
There are two Appendices to support this report.

Appendix 1 provides detailed trend charts.
Appendix 2 includes National comparisons.

Appendix 1

Trends in Unscheduled Care Attendances and Planned Care Performance




2 year trend - UHA ED 12 hour Breaches
300
250
200
150
100
50
0
20
18
67
79
67
50
50
35
71
100
81
150
167
125
249
221
124
0
0
0
2
1
November 20...
December 2018
January 2019
February 2019
March 2019
April 2019
May 2019
June 2019
July 2019
August 2019
September 2019
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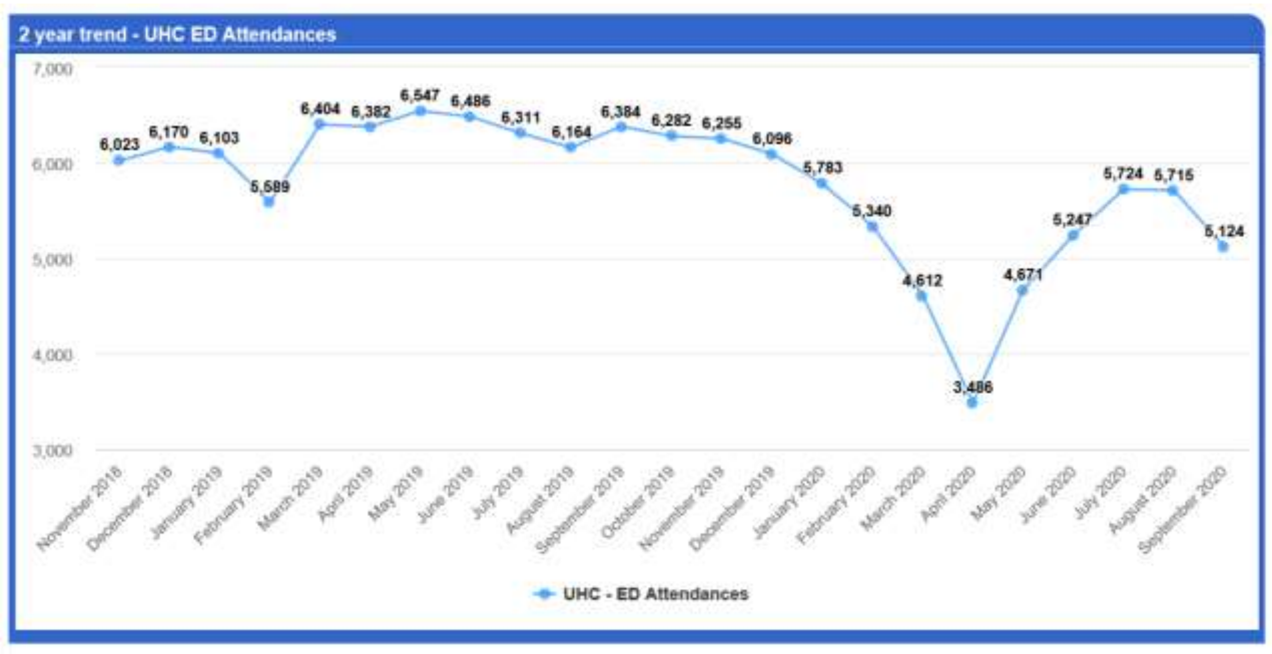
August 2020
UHA - ED 12 hour Breaches


2 year trend - UHC ED Attendances
7,000
6,000
5,000
4,000
3,000
6,023
6,170
6,103
5,589
6,404
6,382
6,547
6,486
6,311
6,164
6,384
6,282
6,255
6,096
5,783
5,340
4,612
3,486
4,671
5,247
5,724
5,715
5,124
November 2018
December 2018
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July 2019
August 2019
September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020
July 2020
August 2020
September 2020
UHC - ED Attendances

2 year trend - UHC ED 4hr Compliance
100%
90%
80%
70%
93.01%
89.935%
88.191%
88.765%
93.295%
90.903%
86.421%
95.034%
89%
85.196%
84.316%
82.865%
91.847%
98.279%
96.855%
93.368%
89.227%
November 2018
December 2018
January 2019
February 2019
March 2019
April 2019
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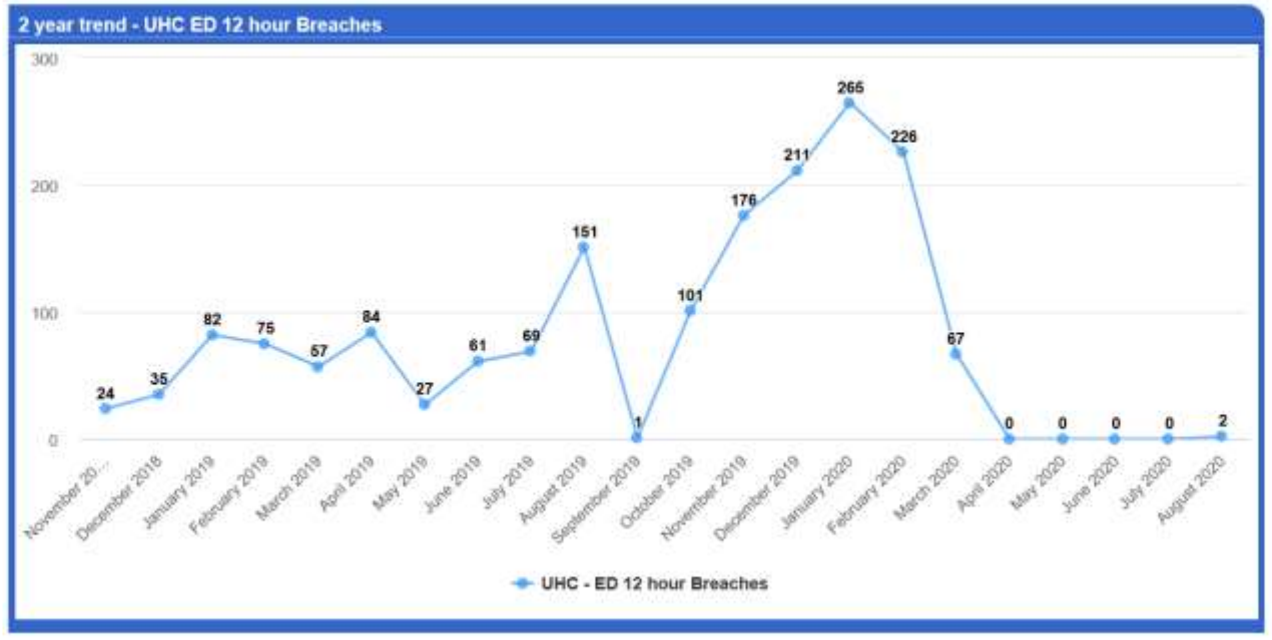
June 2019
July 2019
August 2019
September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020
July 2020
August 2020
September 2020
95% Target
UHC - ED 4hr Compliance



2 year trend - UHC ED 12 hour Breaches
300
200
100
0
24
35
82
75
57
84
27
61
69
151
1
101
176
211
265
226
67
0
0
0
0
2
November 20...
December 2018
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July 2019
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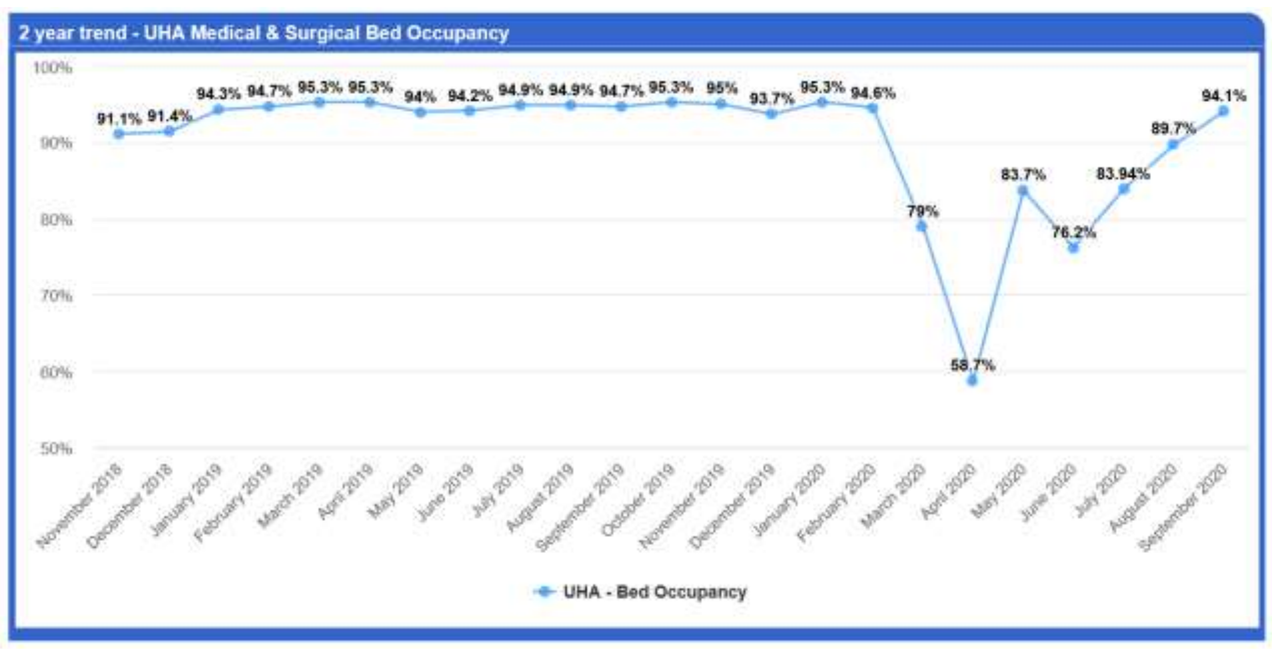
June 2020
July 2020
August 2020
UHC - ED 12 hour Breaches


2 year trend - UHA Medical & Surgical Bed Occupancy
100%
90%
80%
70%
60%
50%
91.1%
91.4%
94.3%
94.7%
95.3%
95.3%
94%
94.2%
94.9%
94.9%
94.7%
95.3%
95%
93.7%
95.3%
94.6%
79%
58.7%
83.7%
76.2%
83.94%
89.7%
94.1%
November 2018
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April 2019
May 2019
June 2019
July 2019
August 2019
September 2019
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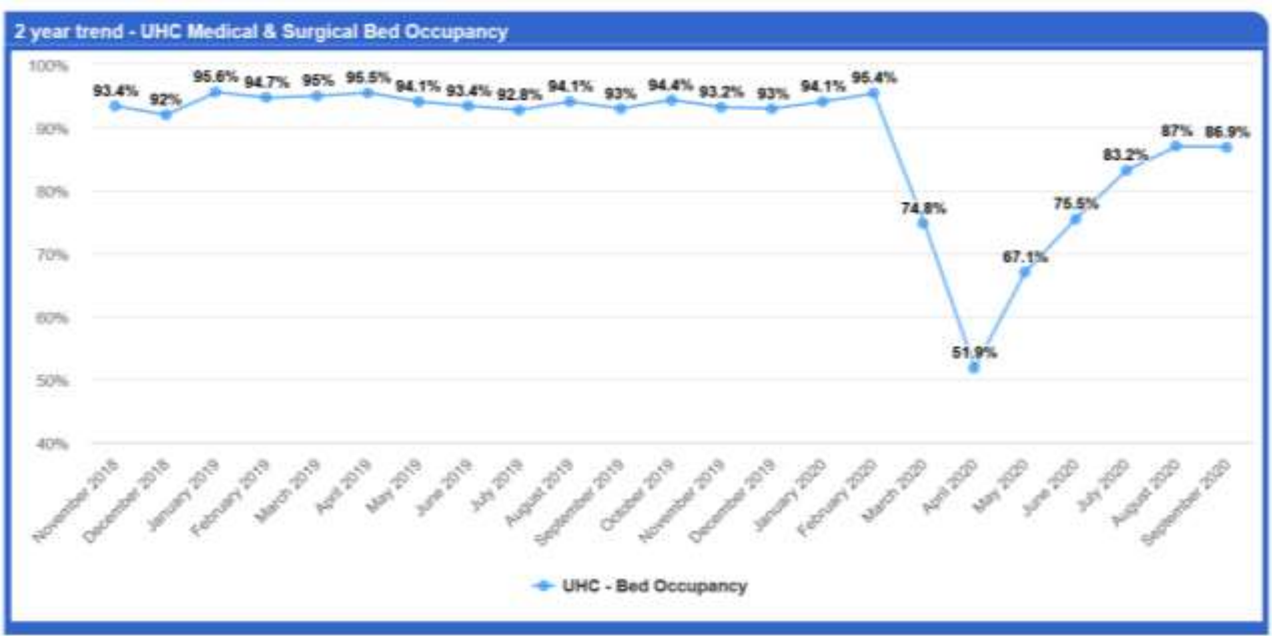
June 2020
July 2020
August 2020
September 2020
UHA - Bed Occupancy


2 year trend - UHC Medical & Surgical Bed Occupancy
100%
90%
80%
70%
60%
50%
40%
93.4%
92%
95.6%
94.7%
95%
95.5%
94.1%
93.4%
92.8%
94.1%
93%
94.4%
93.2%
93%
94.1%
95.4%
74.8%
51.9%
67.1%
75.5%
83.2%
87%
86.9%
November 2018
December 2018
January 2019
February 2019
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September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020
July 2020
August 2020
September 2020
UHC - Bed Occupancy

2 year trend - UHA CAU Presentations
2,000
1,750
1,500
1,250
1,000
750
1,573
1,600
1,765
1,465
1,735
1,657
1,715
1,617
1,633
1,528
1,562
1,605
1,532
1,573
1,635
1,446
1,197
979
1,218
1,222
1,502
1,537
1,461
November 2018
December 2018
January 2019
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August 2019
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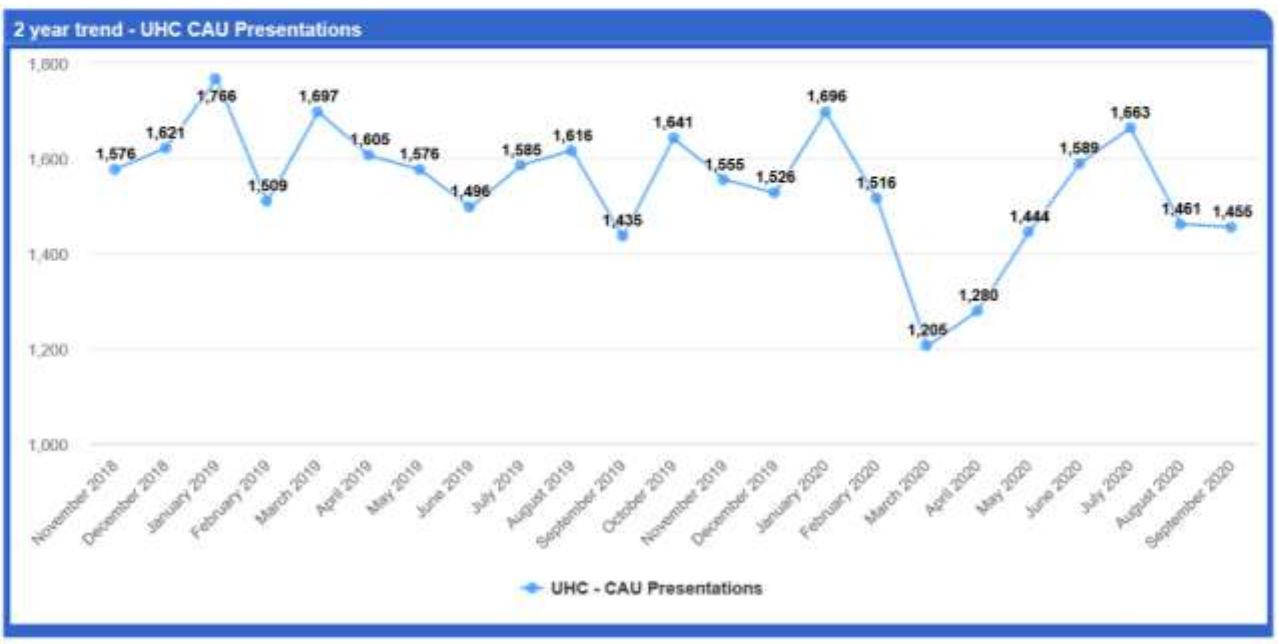
August 2020
September 2020
UHA - CAU Presentations


2 year trend - UHC CAU Presentations
1,800
1,600
1,400
1,200
1,000
1,576
1,621
1,766
1,509
1,697
1,605
1,576
1,496
1,585
1,616
1,435
1,641
1,555
1,526
1,696
1,516
1,205
1,280
1,444
1,589
1,663
1,461
1,456
November 2018
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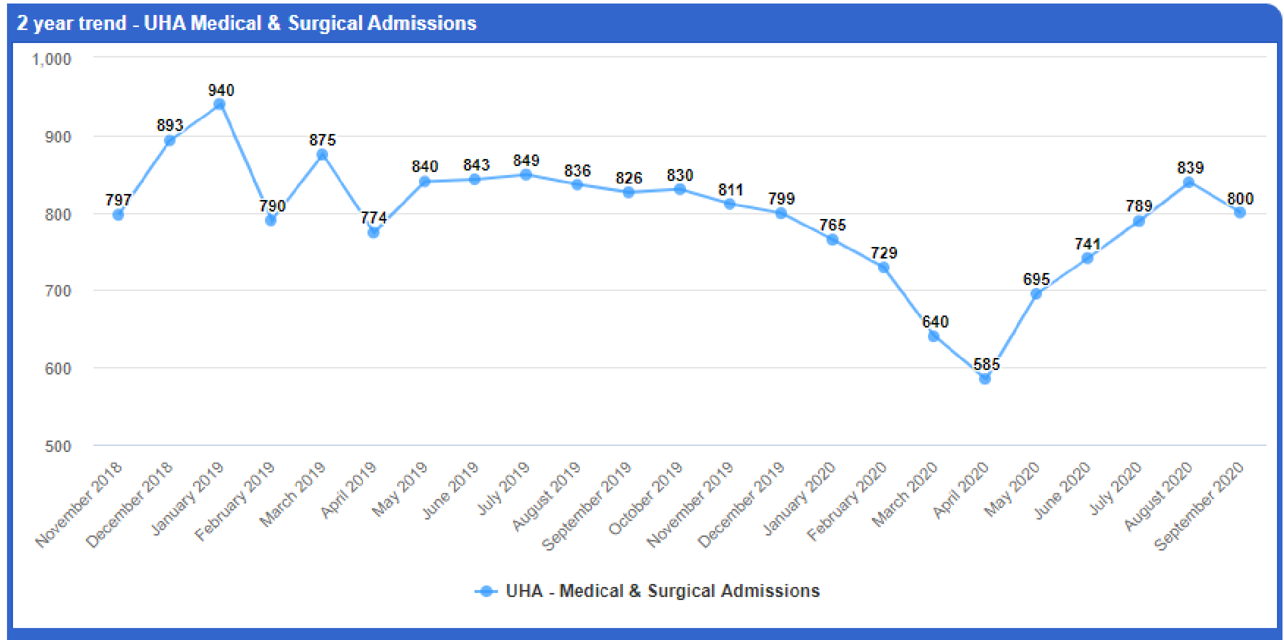
September 2020
UHC - CAU Presentations


2 year trend - UHA Medical & Surgical Admissions
1,000
900
800
700
600
500
797
893
940
790
875
774
840
843
849
836
826
830
811
799
765
729
640
585
695
741
789
839
800
November 2018
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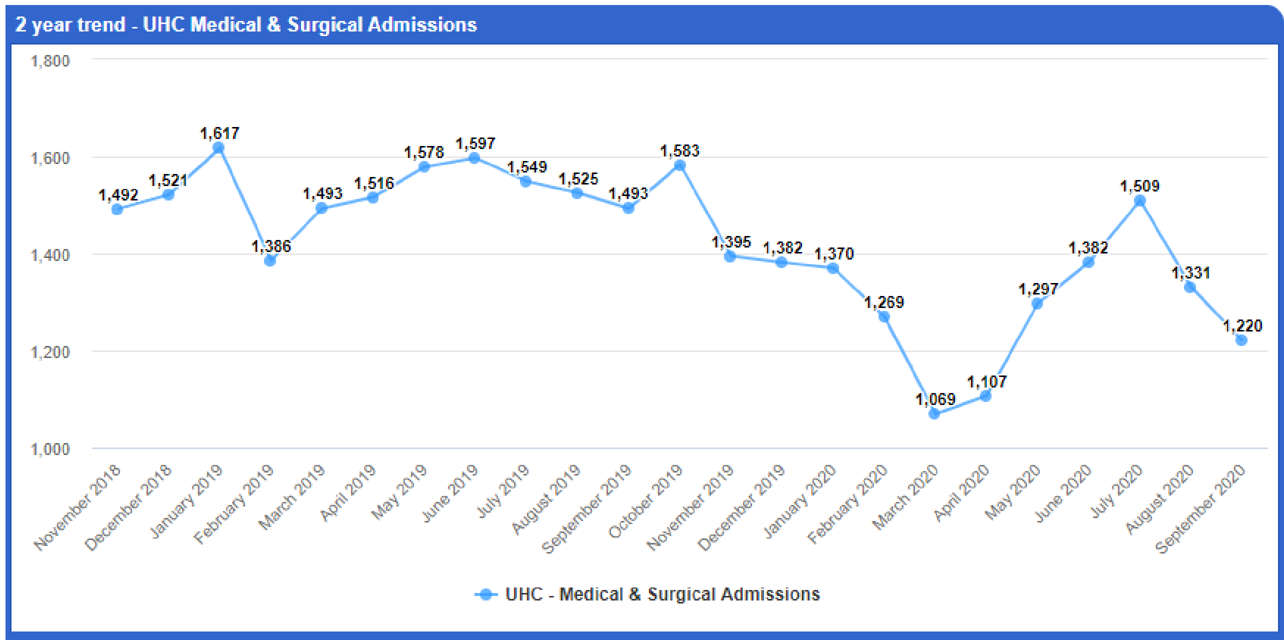
September 2020
UHA - Medical & Surgical Admissions


2 year trend - UHC Medical & Surgical Admissions
1,800
1,600
1,400
1,200
1,000
1,492
1,521
1,617
1,386
1,493
1,516
1,578
1,597
1,549
1,525
1,493
1,583
1,395
1,382
1,370
1,269
1,069
1,107
1,297
1,382
1,509
1,331
1,220
November 2018
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May 2020
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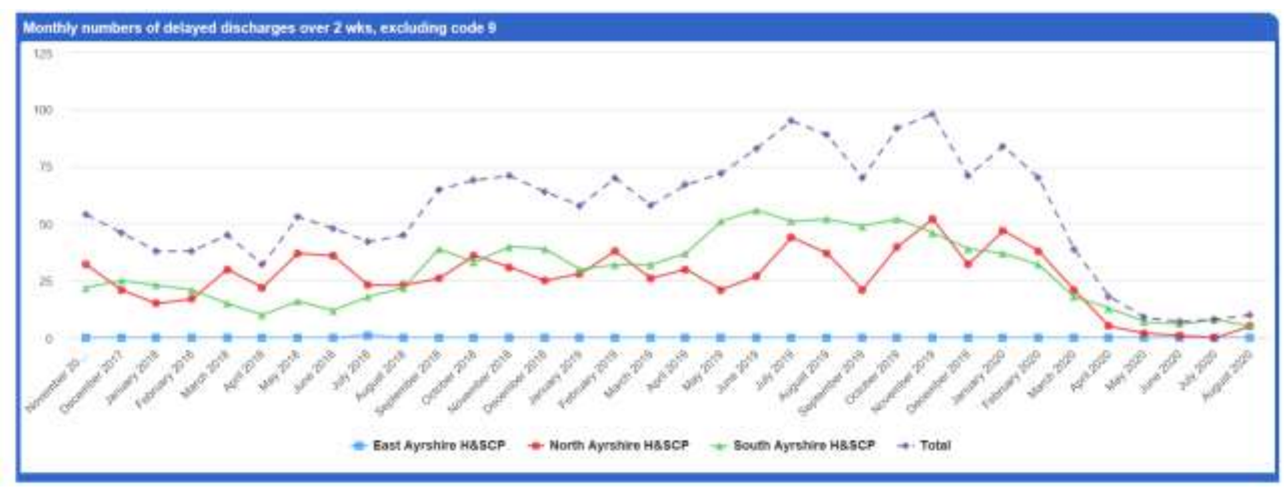
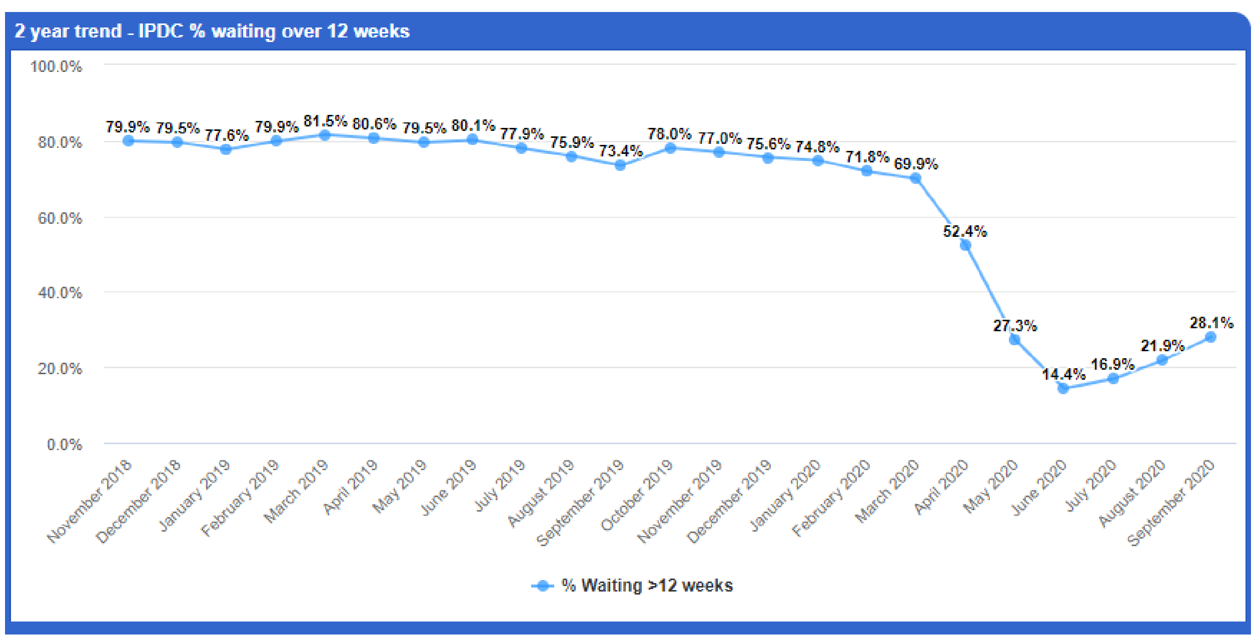
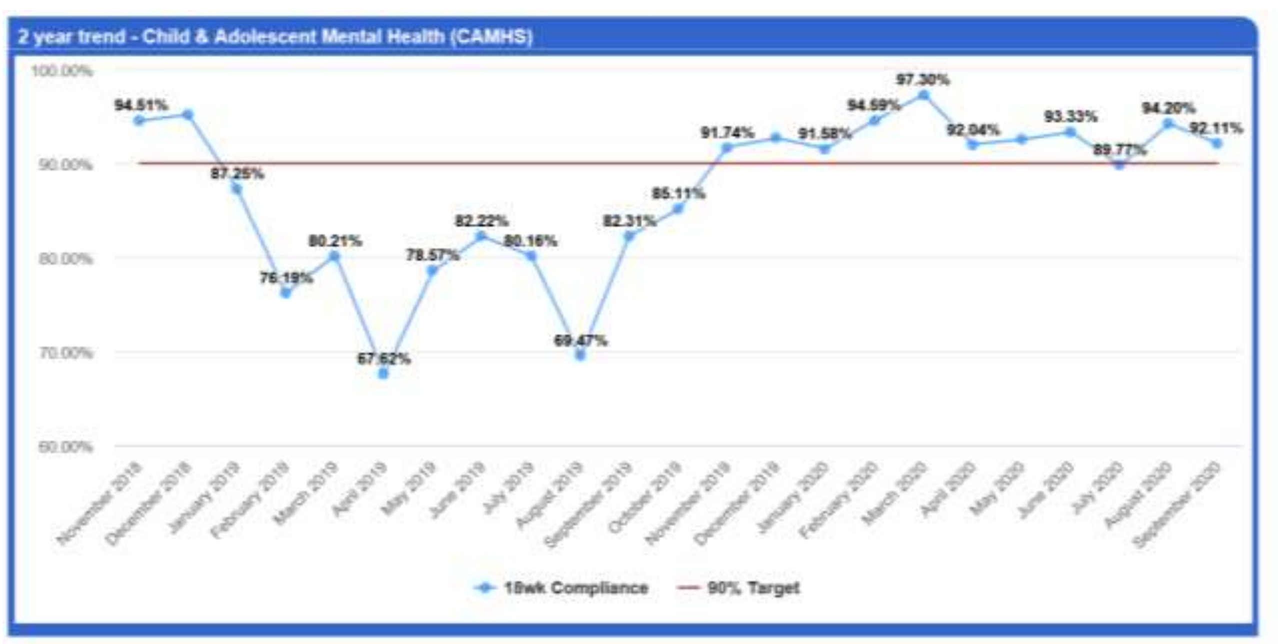
July 2020
August 2020
September 2020
UHC - Medical & Surgical Admissions

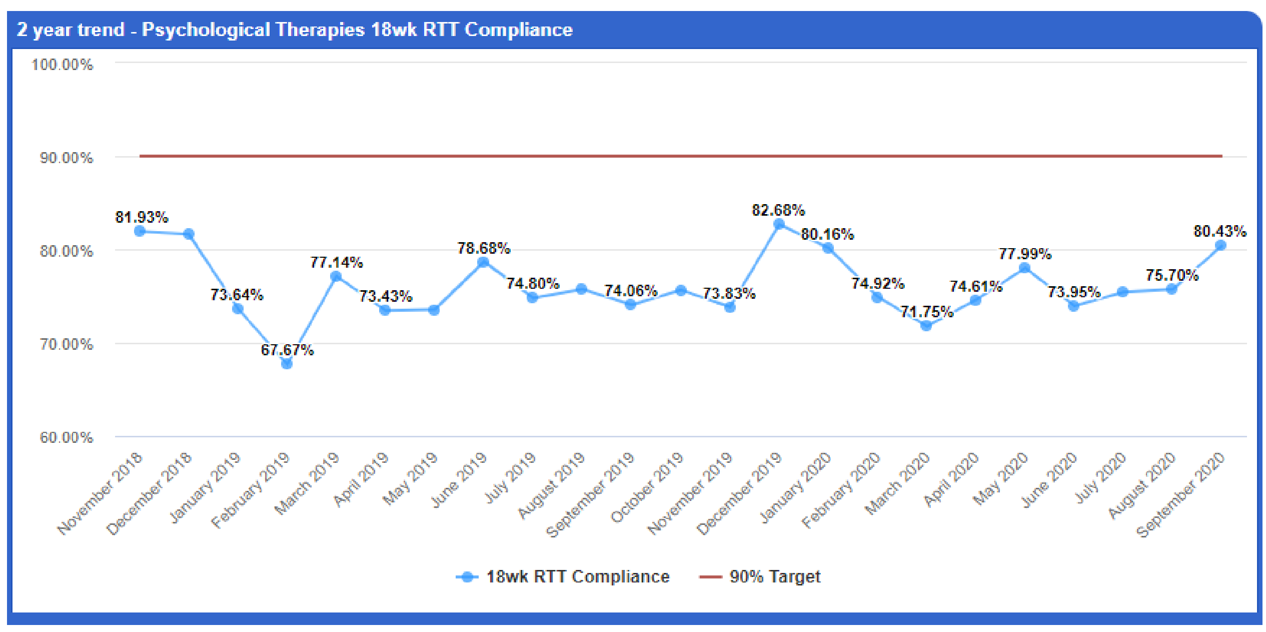

Monthly numbers of delayed discharges over 2 wks, excluding code 9
East Ayrshire H&SCP
North Ayrshire H&SCP
South Ayrshire H&SCP
Total

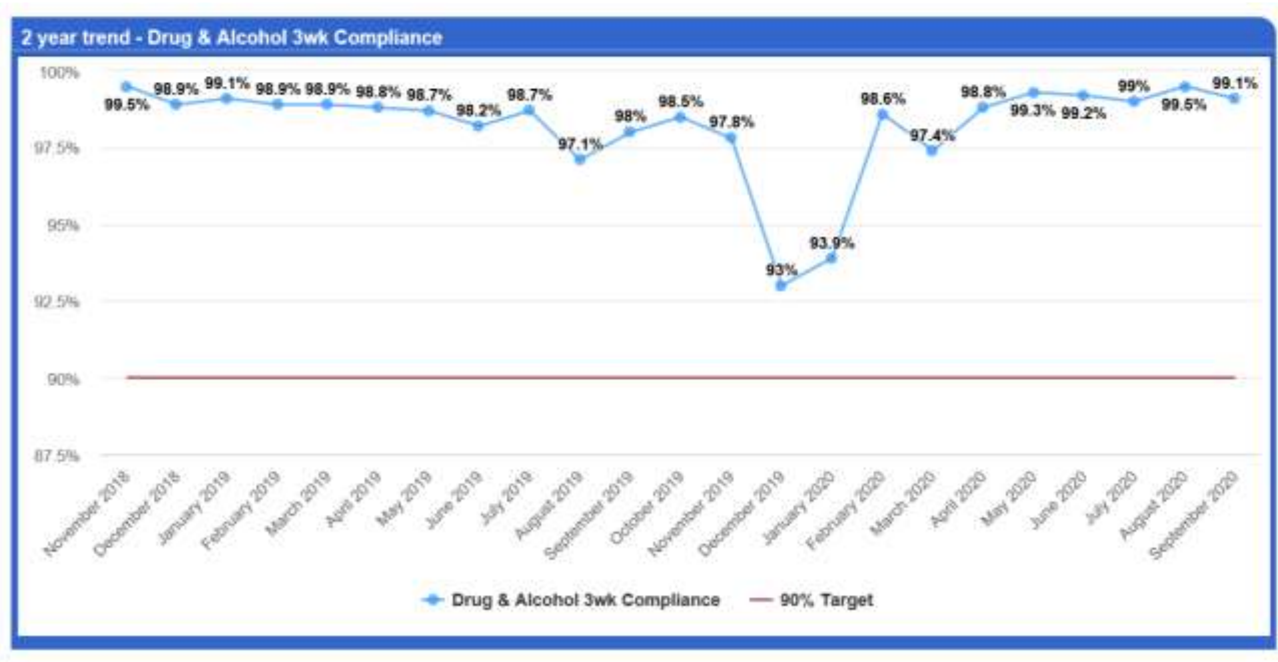
2 year trend - 12wk New Outpatients
80.1%
79.7%
78.5%
78.5%
82.7%
82.3%
82.7%
81.5%
83.0%
81.8%
79.9%
81.2%
81.7%
82.2%
80.8%
81.1%
80.4%
58.6%
35.4%
29.1%
36.7%
42.1%
43.9%
12wk New OP Compliance
95% Target

2 year trend - 18wk Referral to Treatment
78.53%
77.05%
75.66%
80.09%
79.30%
80.14%
80.61%
79.04%
82.16%
93.44%
91.52%
78.25%
72.22%
65.02%
67.52%
18wk RTT Compliance
90% Target


2 year trend - IPDC % waiting over 12 weeks
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
79.9% 79.5% 77.6% 79.9% 81.5% 80.6% 79.5% 80.1% 77.9% 75.9% 73.4% 78.0% 77.0% 75.6% 74.8% 71.8% 69.9% 52.4% 27.3% 14.4% 16.9% 21.9% 28.1%
November 2018 December 2018 January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September 2019 October 2019 November 2019 December 2019 January 2020 February 2020 March 2020 April 2020 May 2020 June 2020 July 2020 August 2020 September 2020
% Waiting >12 weeks


2 year trend - Child & Adolescent Mental Health (CAMHS)
100.00%
90.00%
80.00%
70.00%
60.00%
94.51% 87.25% 76.19% 80.21% 67.62% 78.57% 82.22% 80.16% 69.47% 82.31% 85.11% 91.74% 91.58% 94.59% 97.30% 92.04% 93.33% 89.77% 94.20% 92.11%
November 2018 December 2018 January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September 2019 October 2019 November 2019 December 2019 January 2020 February 2020 March 2020 April 2020 May 2020 June 2020 July 2020 August 2020 September 2020
18wk Compliance
90% Target


2 year trend - Psychological Therapies 18wk RTT Compliance
100.00%
90.00%
80.00%
70.00%
60.00%
81.93% 73.64% 67.67% 77.14% 73.43% 78.68% 74.80% 74.06% 73.83% 82.68% 80.16% 74.92% 71.75% 74.61% 77.99% 73.95% 75.70% 80.43%
November 2018 December 2018 January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September 2019 October 2019 November 2019 December 2019 January 2020 February 2020 March 2020 April 2020 May 2020 June 2020 July 2020 August 2020 September 2020
18wk RTT Compliance
90% Target


2 year trend - Drug & Alcohol 3wk Compliance
100%
97.5%
95%
92.5%
90%
87.5%
99.5%
98.9%
99.1%
98.9%
98.9%
98.8%
98.7%
98.2%
98.7%
97.1%
98%
98.5%
97.8%
93%
93.9%
98.6%
97.4%
98.8%
99.3%
99.2%
99%
99.5%
99.1%
November 2018
December 2018
January 2019
February 2019
March 2019
April 2019
May 2019
June 2019
July 2019
August 2019
September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020
July 2020
August 2020
September 2020
Drug & Alcohol 3wk Compliance
90% Target

2 year trend - MSK 4wk Compliance
100.0%
75.0%
50.0%
25.0%
0.0%
51.8%
35.7%
51.9%
57.1%
49.0%
52.1%
47.0%
47.0%
46.1%
43.8%
44.6%
45.7%
45.9%
38.1%
53.1%
53.1%
36.9%
5.8%
8.5%
16.5%
33.8%
53.5%
64.9%
November 2018
December 2018
January 2019
February 2019
March 2019
April 2019
May 2019
June 2019
July 2019
August 2019
September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020
July 2020
August 2020
September 2020
MSK 4wk Compliance
90% Target

WTIP - Cancer - 31 & 62 Day - NHSA&A vs Scotland
105%
100%
95%
90%
85%
80%
75%
98.1%
96.1%
95.1%
98.2%
99.1%
97.6%
94.2%
99%
99%
98%
100%
99.2%
100%
98.4%
97.3%
97.5%
98.2%
100%
78.4%
82.1%
82.2%
84.3%
81.7%
89.7%
89.2%
81.7%
87.9%
86.5%
89.6%
96.2%
97.4%
94.9%
91.8%
94.8%
94.9%
88.6%
April 2019
May 2019
June 2019
July 2019
August 2019
September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020
July 2020
August 2020
September 2020
95% Target
31-Day (NHS A&A)
62-Day (NHS A&A)
31-Day (Scotland)
62-Day (Scotland)

2 year trend - 6wk Endoscopy Access
125.0%
100.0%
75.0%
50.0%
25.0%
0.0%
56.7% 52.7% 44.9% 54.0% 54.4% 52.6% 50.9% 55.1% 53.9% 53.1% 50.8% 61.6% 71.6% 66.3% 59.8% 63.8% 52.2% 18.6% 15.1% 19.1% 22.1% 23.0% 21.1%
November 2018 December 2018 January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September 2019 October 2019 November 2019 December 2019 January 2020 February 2020 March 2020 April 2020 May 2020 June 2020 July 2020 August 2020 September 2020
6wk Compliance
100% Target

2 year trend - 6wk Imaging Access
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
68.6% 70.6% 66.8% 75.9% 75.6% 73.4% 70.4% 72.9% 69.3% 70.5% 72.6% 73.0% 79.6% 73.3% 66.4% 73.0% 63.9% 28.6% 26.3% 34.1% 40.8% 48.4% 49.6%
November 2018 December 2018 January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September 2019 October 2019 November 2019 December 2019 January 2020 February 2020 March 2020 April 2020 May 2020 June 2020 July 2020 August 2020 September 2020
6wk Compliance
100% Target

Appendix 2

Comparison with National Data

Planned Care Waiting Times Performance – NHS Ayrshire & Arran
(+) Improving position; (-) Worsening position; QE – Quarter ending

Measure	Latest National Published Data **NHS A&A**	Latest Local Data **NHS A&A**	Latest Local Data compared to Published data	Latest Published **Scotland** Data
New Outpatients	29.4% Jun 2020	43.9% Sep 2020	(+)	28.5% Jun 2020
Referral to Treatment*	78.3% Jun 2020	67.5% Sep 2020	(-)	77.8% Jun 2020
Inpatients/DayCases (Ongoing waits)	15.6% QE Jun 2020	28.1% Sep 2020	(+)	17.3% QE Jun 2020
CAMHS	92.5% QE Jun 2020	92.1% Sep 2020	(-)	61.7% QE June 2020
Psychological Therapies	72.9% QE Jun 2020	80.4% Sep 2020	(+)	74.3% QE Jun 2020
Drug and Alcohol	99.3% QE Jun 2020	99.1% Sep 2020	(-)	95.3% QE Jun 2020
MSK	46.7% QE Dec 2019	64.9% Sep 2020	(+)	45.4% QE Dec 2019
Cancer 31 Day	98.7% QE Jun 2020	100 % Sep 2020	(+)	97.1% QE Jun 2020
Cancer 62 Day	94.9% QE Jun 2020	88.6% Sep 2020	(-)	84.1% QE Jun 2020
Endoscopy	19.1% QE Jun 2020	21.1% Sep 2020	(+)	22.8% QE Jun 2020
Imaging	34.1% QE Jun 2020	49.6% Sep 2020	(+)	40.9% QE Jun 2020

* NHS Ayrshire & Arran data for July 2017 to May 2020 contain estimates for this measure. These estimates are deemed statistically robust by PHS.

Unscheduled Care Performance – NHS Ayrshire & Arran

(+) Improving position; (-) Worsening position

Measure	Latest National Published Data	Latest Local Information	Latest Local Information compared to latest Published data	Latest Published **Scotland** Data
ED 4 HR Compliance (%)	90.5% (Sep 2020)	90.5% (Sep 2020)	(No change)	92.1% (Sep 2020)
Delayed Discharges > 2 weeks (excluding code 9s)	11 (Sep 2020)	14 (26th Oct 2020)	(-)	328 (Sep 2020)